

Camden Coalition Accountable Care Organization Gainsharing Plan

Section 1: Accountable Care Organization (ACO) Goals, Objectives, and Strategies

ACO Goals

The Camden Coalition ACO seeks to provide better care at lower costs for all Medicaid beneficiaries receiving care in Camden, NJ. The ACO engages hospitals, primary care, specialty and behavioral health providers, social services, community organizations, and local residents to work collectively to improve healthcare delivery, particularly for the most vulnerable and high cost patients. The ACO operates a number of citywide programs and supports members' separate efforts to improve care. The initiatives often coordinate traditional medical care with critical social services to address patients' comprehensive needs.

ACO Objectives and Strategies

The ACO's major strategies to improve quality and reduce costs are:

- use of data to coordinate care and drive innovation to address patients with complex needs
- care coordination and prompt follow-up primary care to prevent of avoidable hospital readmissions
- improving primary care capacity, particularly for specific high risk populations (e.g. women of child-bearing age)
- patient and community education and engagement
- expansion of mental health and substance use treatment
- programs and advocacy to improve, expand, and coordinate transportation, social services, and other social factors that impact health.

The major current ACO initiatives are discussed in greater detail below.

Use of health information technology to support population health

The ACO is committed to making health information technology and data actionable to identify opportunities for clinical interventions, coordinate care, and reduce unnecessary testing. The ACO's regional health information exchange (HIE) is the backbone of the ACO. The ACO has developed customized reports that allows the HIE to serve as a centralized system for population health surveillance to identify individuals that need clinical intervention and trigger clinical workflows. The ACO continues to expand its data sources, functionality, and user base and connect to other HIEs.

Reducing hospital readmission through Community Based Care Coordination and prompt follow-up primary care

Camden has some of the highest rates of per capita hospital utilization (both inpatient and emergency department) in New Jersey. The ACO provides an intensive care coordination program for individuals who are the highest users of the hospital

system (2+ hospital admissions within 6 months) and have the highest likelihood of readmission due to social, behavioral, and economic factors. An interdisciplinary care management team, including behavioral health specialists, identifies patients in the hospital through a regional health information exchange (HIE) and work intensively in the community with patients for an average of 90 days. The interdisciplinary team provides both clinical and social support, including home based medication reconciliation, support for medication adherence, and connection to resources in the community, to help patients achieve personal goals, enable better, health and reduced use of the hospital.

Research shows that seeing a primary care doctor within 7 days of leaving the hospital is likely to prevent a return visit to the emergency room or hospital. Based on this, the ACO and its primary care practices (PCP) have prioritized follow-up care for patients on discharge from the hospital through a program known as the 7 Day Pledge campaign. Seeing a provider within 7 days of hospital discharge has several potential benefits including: re-establishing caring patient-provider relationships, support in understanding discharge paperwork and medication adherence, discussion of overall health needs, and connection to support services. PCPs have modified scheduling practices and, with assistance from Camden Coalition staff, seek to schedule a comprehensive follow-up appointment within seven days of discharge from the hospital. The HIE produces a daily list of hospitalized patients attributed to each PCP and the PCP receives additional compensation from the ACO for conducting a more thorough visit for each patient treated within 7 or 14 days of discharge. Patients also receive transportation and incentives to attend the follow-up appointment (See: Exhibit 01-2016 Quality Plan).

Reducing ED utilization

Through the 7-day pledge the ACO reaches patients who are frequent users of the ED. Additionally, the ACO is working on a pilot to specifically target patient who have visited the ED 5 or more times in the last 6 months with no inpatient admissions. The goal of this pilot is to develop a standardized community based workflow with an interdisciplinary care management team to identify frequent users of the ED while they are in the hospital, and work with them in the community to help connect them to resources and achieve personal goals to reduce ED readmissions.

Improving maternal and child health

Camden Delivers aims to improve health among women of childbearing age. The program seeks to connect women to early pre-natal care and connect women to primary care after delivery. There is additional care coordination for pregnant women with multiple chronic illnesses. Data from the perinatal risk assessment, an assessment conducted during pregnancy to identify women at high risk for fetal or infant death or infant morbidity, has been added to the HIE to facilitate greater awareness of complicating social factors and coordination among women's health

providers. The goal of the assessment is to prevent or treat conditions associated with poor outcomes and to connect women to appropriate resources and services.

Primary Care Capacity Improvement

The ACO and its Quality Committee engages PCPs in a comprehensive quality improvement program focused on the seven quality metrics contained in the ACO's contracts with United and Horizon. The program features a quarterly dinner/lecture series for clinical and administrative champions at each practice; monthly individual practice meetings to review performance scorecards and develop targeted improvements; and a robust Quality Committee committed to continuous improvement of primary care within the ACO. Individual PCPs within the ACO are pursuing patient centered medical home certification, expanded use of electronic medical records, open-access scheduling, greater use of integrated, team-based care, and other initiatives to effectively and efficiently address the complex needs of patients in primary care.

Patient education and peer support

The ACO is committed to patient education and peer support to help those who suffer from chronic illness better manage their disease and avoid hospitalization. The ACO and its partners provide evidence-based patient education programs for diabetes and other chronic illnesses in both English and Spanish. The ACO operates the Faith In Prevention program that works with faith-based organizations to deliver health and nutrition education, create environmental changes in the community that promote health, and mobilize FBOs to support their community members when they are discharged from the hospital.

Expanding and Integrating Mental Health and Substance Use Treatment

The ACO is committed to expanding access to mental health and substance use treatment particularly for Medicaid beneficiaries. Members of the ACO are engaged in a comprehensive study and planning initiative known as the South Jersey Behavioral Health Innovation Collaborative. Members are also pursuing every opportunity to expand services and develop models of integrated, team-based care that comprehensively addresses the physical, behavioral, and psychological needs of patients.

Social Determinants

Social and economic factors play a significant role in the overutilization of acute health care services and the poor health outcomes experienced in Camden. The ACO is working with New Jersey Medicaid and its transportation broker to improve the quality and reliability of non-emergency medical transportation. The ACO has also developed a supportive housing program focused on individuals who are chronically homeless and high utilizers of the hospital system.

Some members of the ACO have additional care coordination services that are available to work with its own Medicaid patients. The ACO works closely with each member organization to ensure that care coordination is deployed efficiently and effectively.

Camden ARISE (Administrative Records Integration for Service Excellence)

Finally, through Camden ARISE, the ACO is working with local stakeholders to understand the relationships between high utilization of the hospital, homeless services, and criminal justice involvement using integrated data sets. The goals are to better understand how individuals access a range of public services in order to develop and evaluate programs that better serve the needs of the most vulnerable residents.

Section 2: Quality Standards

As described above the Camden Coalition ACO is pursuing multiple strategies to achieve its goal of improving quality and reducing costs for all Medicaid beneficiary. In coordination with MCO providers United and Horizon, the ACO identified the following 7 quality metrics to assess performance (Exhibit 01-2016 Quality Plan).

1. **7-day post-hospital follow-up visits for hospitalized patients:** The ACO aims to increase the percentage of patients reconnecting with primary care within 7 days of inpatient hospital discharge.
2. **7-day post-hospital follow-up visits for emergency department high-utilizers (patients with 5+ ED visits in a 6 month window):** The ACO aims to increase the percentage of patients reconnecting with primary care within 7 days of ED discharge.
3. **Onset of prenatal care (Healthcare Effective Data and Information Set (HEDIS) measure):** The ACO aims to increase the percentage of deliveries that receive a prenatal care visit in the first trimester of pregnancy.
4. **Attendance at postpartum appointment (HEDIS measure):** The ACO aims to increase the % of deliveries that have an OB post-partum visit within 21-56 days of delivery.
5. **Cervical cancer screens (HEDIS measure):** The ACO aims to increase the percentage of women ages 21-65 years of age who are screened with cytology in a three-year period and women ages 30-65 who are screened with cytology/HPV co-testing within a five-year period.
6. **Breast cancer screen (HEDIS measure):** The ACO aims to increase the percentage of women ages 50-74 years of age who have at least one mammogram to screen for breast cancer in a two-year period.

7. **Patient Satisfaction:** The ACO aims to increase the percentage of “satisfied” and “Very Satisfied” responses on the Patient Satisfaction survey (more details about the survey in Sections 6-7)..

Benchmark periods and targets

The ACO established a contract with United Healthcare in December 2013, marking December 2013 through November 2014 as the baseline year (Year 0) to specify the benchmark periods and targets for the seven quality metrics. During the baseline year, the ACO developed and refined the data infrastructure necessary to track the quality metrics. The target for year 1 (Dec 2014 to Nov 2015) is to improve performance on all seven metrics over Year 0. At the close of Year 1, the ACO and United will then converge on targets for Year 2.

The Horizon NJ Health contract was initiated in February 2015 with the first full month of data being March 2015. As a result, March 2015 through February 2016 serves as the baseline year (Year 0) for the Horizon contract. Similarly to the United contract, the ACO aims to improve performance on all seven metrics in Year 1 over Year 0. At the close of Year 1, concrete targets will be set for each metric in Year 2.

Data collection

The ACO has implemented a series of data systems and sources to assess progress on the quality measures. These data systems include a regional health information exchange, a web-based HIPAA compliant database *TrackVia* utilized by all partner primary care practices for data capture, a monthly scorecarding system to assess performance and claims data and other community based data sets.

For measures 1 and 2, *7-day post-hospital follow-up visits*, the ACO utilizes the HIE to identify all hospitalizations and ED utilizations for patients in the ACO, which serves as the denominator. For each utilization, the primary care practices in the ACO input in real time into *TrackVia* whether a follow-up appointment was achieved and the date of the follow up appointment in order to determine whether it fell within 7 days of discharge. While this data is self-reported by the practices, once a year it is triangulated with claims data from the payers for validation. We will work together to resolve any discrepancies.

For measures 3-6, the HEDIS measures, the ACO receives periodic extracts of data from United and Horizon to retrospectively assess progress. Finally, the ACO receives community based data sets to identify trends and progress for a subset of the HEDIS measures. The ACO receives Perinatal Risk Assessment data from the Southern New Jersey Perinatal Cooperative which allows tracking of the date women attended their first prenatal appointment (Measure #3). Additionally, the ACO pushes to OB/GYN practices in Camden lists of women who are due for their postpartum appointment and receives monthly updates on which patients did

arrive to their postpartum appointment (Measure #4). This data is logged in TrackVia in the same manner as 7-day post-hospital follow-up data. The ACO is still working on ways to capture self-reported data for cervical and breast cancer screens. This data is received periodically from United and Horizon to retrospectively track progress. The last metric Patient Satisfaction is discussed in more detail later in this plan.

The ACO has developed a scorecarding system to create a real-time feedback loop to assess performance against quality measures. Monthly the ACO uses Tableau to produce data visualizations of progress in key quality measures (Exhibit 02- De-Identified Scorecard). All ACO providers participate in monthly scorecard meetings with the Camden Coalition team to review operations, monthly deliverables, and progress and barriers to achieving quality measure targets.

The ACO will also be evaluated on a set of mandatory and voluntary quality metrics chosen by New Jersey Division of Medical Assistance and Health Services (NJ Medicaid) (Exhibit 03- NJ Medicaid Quality Metrics). The ACO has selected the following voluntary metrics, in addition to the 21 mandatory metrics:

Metric Type	Metric
Preventive	Cervical cancer screening
Chronic	Diabetic HbA1C Testing
Chronic	Diabetic LDL Screening
Chronic	Diabetic Eye Exam
Chronic	Use of Appropriate Medications for People with Asthma
Chronic	30-day Readmission rate following AMI

.As part of the ACO Demonstration Project, Rutgers Center for State Health Policy (CSHP) will use claims data to develop and report the baseline measurements of each state quality metric in the first year and annual scores for each metric in subsequent years.

Section 3: Cost-Savings Methodology

The ACO cost savings methodology will follow the recommendations put forward by Rutgers Center for State Health Policy (CSHP). In a July, 2012 publication (Exhibit 04-Approach for Savings Calculation), CSHP had proposed broad recommendations for calculating savings in Medicaid spending, building upon the framework established by the Medicare Shared Savings Program (MSSP), with several modifications to account for programmatic and population differences. The methodology uses the CDPS risk adjustment methodology.

To the extent that future iterations of this methodology are put forward, any shared saving methodology with the state and MCOs would be informed by these future iterations. It is anticipated and appropriate that these methodologies will iterate

and evolve based on the ever changing landscape of healthcare reform. It is important for the ACO and its partners to continuously re-examine and evolve methodology to ensure success for all stakeholders.

The ACO's contracts with Horizon and United each specify a cost-savings methodology. The United contract follows the Rutgers methodology but uses United's IPRO risk adjustment tool (Exhibit 05-United Contract). The Horizon contract specifies its own methodology for calculating savings (Exhibit 06- Horizon Contract). Both are being implemented according to the contractual timelines.

Section 4: Savings Allocation

The ACO is entitled to up to 50% of net shared savings in each of its MCO contracts. Each contract has a slightly different methodology for calculating how much of the shared savings the ACO receives, depending on the size of the shared savings and the achievement of quality metrics (Exhibit 05-United Contract; Exhibit 06- Horizon Contract).

The ACO will reinvest shared savings in activities that further the objectives of the ACO Demonstration Project, including payments for improved quality and patient outcomes, interdisciplinary collaboration for complex patients, expanded access for high risk patients, expansion of medical homes, support for the infrastructure of the ACO, and expansion of healthcare workforces and services.

The strategic planning committee of the ACO developed a shared savings reinvestment process to identify, prioritize, fund, and evaluate ACO activities. This reinvestment process is participatory and broadly inclusive of input from Coalition members and the Camden public. The Board of Directors of the ACO reviewed and adopted the proposed reinvestment process on 28 October 2015 (Exhibit 07- Gainsharing Reinvestment Resolution). The five step reinvestment process is described below.

- 1. Produce financial model-** The Finance Committee of the ACO will engage in a participatory budgeting process to develop a financial summary of the resources coming into the ACO through a variety of sources, including shared savings, and ACO expenses.
- 2. Identify and prioritize investment opportunities-** The Community Advisory Council and the Quality Committee of the ACO will identify and prioritize investment opportunities. City-wide need will be assessed through available data and input from the public and Coalition. From this, strategic areas for investment and potential interventions will be developed. The committees will then review, cost, and prioritize potential interventions.
- 3. Reconcile Financial Model-** Once shared savings is received and prioritized interventions are costed, the Finance Committee will reconcile the financial model to identify any potential gaps where additional funding may be needed.

4. **Select and Implement Interventions-** The ACO strategic planning committee will review the reconciled financial model and prioritized interventions to select and recommend interventions for implementation. The Executive Committee of the ACO will provide final approval on interventions to implement.
5. **Evaluate-** For each selected intervention, targets and metrics will be developed to monitor progress. The Quality Committee is charged with performance based monitoring of the ACO to ensure performance standards are being met. As necessary, the Quality Committee will develop corrective action plans for practices if needed to bring performance up to required levels. Finally on a quarterly basis, the Quality Committee provides reports to the ACO Board of Directors summarizing progress on the performance standards. The ACO Quality Committee Policy describes this process in detail (Exhibit 08-Quality Committee Policies).

Section 5: Public Input

The Camden Coalition ACO values consumer participation. In 2013, the Camden Coalition hosted a series of three public meetings to educate the community about the ACO and to better understand the community's highest priorities among health care needs. In 2014, the Camden Coalition formed a Community Advisory Council (CAC) with volunteers who attended the meetings in 2013 to provide strategic oversight and help engage and educate the public. The CAC is coordinated by a steering committee of five board members and continues to grow. It currently consists of more than 25 Camden residents and meets monthly.

In 2015, the CAC hosted a series of three meetings to understand the public's health care priorities. Participants were asked to rank potential areas for health care investment. . The following areas of need were ranked highest:

- Access to Quality Mental Health & Substance Abuse Services
- Enhanced Care Coordination
- Access to Quality Preventative Health Services
 - Expanded Dental Services
 - Invest in Primary Care Facilities (Professional Development, Customer Service, Culture & Sensitivity Training)
- Chronic Disease Prevention
- Chronic Disease Management
- Reducing Obesity & Food Insecurity
 - Farming and Neighborhood Gardens - Fresh, Local Produce
 - Exercise Classes for Better Health
 - Quality grocery stores
- Public Health Education
- Enhance healthcare services for seniors
- Education for Camden City Residents to Become Medical Professional

In February 2016, the Camden Coalition ACO released a draft of a plain language summary of this gainsharing plan in Spanish and English on its website and through its partner organizations. The ACO feedback form and feedback phone line (described below) were modified to receive input into the gainsharing plan. On February 25th, the ACO held a public meeting to review and receive feedback on the gainsharing plan. After the feedback period closed, distribution channels and feedback were summarized in Exhibit 09 (Exhibit 09- ACO Gainsharing Plan Public Input). The Board of Directors of the ACO reviewed and adopted the finalized ACO gainsharing plan on 20 April 2016 (Exhibit 10-Gainsharing Resolution).

Section 6-7: Patient Experience & Patient Feedback

The ACO has developed two mechanisms to capture information about the patient experience, and to act upon findings to improve quality of care. These mechanisms are 1) an annual Patient Satisfaction survey and 2) a citywide feedback system accessible to patients and individuals working in the healthcare system in Camden.

Patient Satisfaction Survey

Survey Development

The Camden Coalition Quality Committee developed a citywide Patient Satisfaction Survey to be administered in all of the primary care practices participating in the ACO. The survey addresses both access and quality of care, through a 16 items that respondents rank on a 5 point scale as well as provide open ended written feedback (Exhibit 11- Patient Satisfaction Survey).

Survey Administration

The survey is administered annually (in June, July and August) to all practices in the ACO, to produce a sample representative of all ACO practices. Summer Associates collect at least 700 surveys, with a minimum of 25 surveys from each practice location. Practices with higher patient volume are sampled at a higher rate. The survey is administered, to patients who agree to participate, at various times throughout the day and week within each practice. This varying of times and days allows for a broader pool of patients surveyed. A team of trained bachelor's level summer associates distribute the surveys to patients while they wait for their appointments in the practice waiting area. Surveys are written in both English and Spanish. Summer Associates are available to administer the survey orally in English or Spanish if needed.

Survey Analysis

The Camden ACO conducts the analysis of patient surveys. The quantitative data is analyzed for each question and comparisons are made with previous years and with the city as a whole. A general inductive approach¹ is utilized to analyze and code the qualitative data according to the theme of responses and then tabulated to show the volume of certain categories of barriers. The results of the 2015 patient survey

¹ Reference on general inductive approach to analyze qualitative data:
<http://legacy.oise.utoronto.ca/research/field-centres/ross/ct1014/Thomas2006.pdf>

analysis are attached for illustration (Exhibit 12: Patient Satisfaction Survey Results 2015).

Survey Result Reporting

The Patient Satisfaction Survey data is shared broadly with the Coalition's Board of Directors, Quality Committee, and Community Advisory Committee; Managed Care Organizations; and primary care practice and hospital leadership. Clinical redesign staff use the results to work with primary care providers to improve quality and access to care in their respective practices

Citywide Feedback System

The ACO citywide feedback system is a centralized portal for all positive and constructive feedback related to healthcare in the city of Camden. The portal is an online web form that anyone can access from the internet or a smartphone (Weblink: English: <http://www.camdenhealth.org/feedback/>; Spanish: Spanish: <http://www.camdenhealth.org/reaccion/>), as well as a phone number (856-365-9510 x2095) that feeds directly to a voicemail box that is checked every day by a Program Manager for Quality Improvement, and overseen by a Director of Clinical Redesign Initiatives. Individuals can enter feedback into the online portal or leave a message on the phone line in real time, twenty-four hours a day. Individuals entering feedback are given the option to include their full name, phone number and/or email address for the Coalition to reach them with a response to their feedback. Within 5 business days of receipt of the feedback, the ACO will respond to acknowledge receipt of the feedback and update on the status of the resolution.

Section 8: Hospital Revenue

The Camden Coalition of Healthcare Providers Medicaid ACO provides a low risk bridge towards value-based care for local hospitals. Healthcare across the United States and New Jersey is being driven swiftly towards value-based care, a model marked by payment models that shift risk away from payers and towards providers. These models incent certain high-quality outcomes along with decreases in the overall cost of care for a patient population under the care of a provider. Value-based care is being widely and increasingly embraced by private and public payers, employers, healthcare thought leaders, patients, and their advocates. For hospitals to thrive in this new environment they must develop sophisticated capabilities such as care coordination, health informatics, quality measurement and improvement, and population health management, especially for the care of chronic and behavioral health conditions.

While it is possible that the improvements in the health and healthcare of the patients served by local hospitals through the efforts of The Camden Coalition of

Healthcare Providers Medicaid ACO could lead to reductions in fee-for-service revenue, these reductions will be modest and effect receipts with relatively low profit margins. Furthermore, given that many admissions are in fact necessary and represent high-quality care, only a subset of admissions will be affected by ACO activities.

An analysis of five years of visit data from three New Jersey hospitals revealed that Medicaid patients accounted for 26% of total inpatient admissions, yet only 17% of receipts. More drastically, Medicaid patients accounted for 33% of Emergency Department visits, yet only 16% of receipts. Medicaid receipts per visit totaled 56% of that of other payer types for inpatient visits, and only 39% for emergency department visits.

While the risk of impact of the Camden Coalition of Healthcare Providers Medicaid ACO on local hospital revenue is modest, the capabilities developed through participation in the Medicaid ACO will be fully transferrable to the Medicare and private insurance arenas, and will enable them to compete and thrive in the new realities of value- based care.