



Addressing Chronic Illness in Low-Income Populations through Innovative Health Service Delivery Practices: The AtlantiCare Special Care Center, 2007–13

PROJECT DATA

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The Dartmouth Center for Health Care Delivery Science

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TABLE OF CONTENTS

Introduction	3
Contextual Conditions	5
Tracing the Implementation Process	8
Lessons Learned	19

In Brief

- **Development Challenge:** In the Atlantic City area, the sickest 10–20 percent of patients accounted for a disproportionate share of health care costs. AtlantiCare and Local 54 wanted to improve care while reducing costs.
- **Program Solution:** AtlantiCare and the trust that administered UNITE HERE Local 54’s health insurance plan collaborated to open a Special Care Center that would provide and coordinate intensive primary care, reduce reliance on specialists, and encourage greater compliance by patients with their health regimens.
- **Program Result:** Despite serving a challenging population of poor and ethnically diverse patients, the Special Care Center exceeded national quality benchmarks for ER visits per capita, hospital admissions per capita, average length of hospital stay, and prescription fill rate. Cost savings were estimated at \$175–\$200 per member per month, net of program costs, for payers. The SCC is frequently cited as one of a number of innovative efforts to improve health outcomes while also lowering health expenditures.

Executive Summary

UNITE HERE Local 54, the hospitality workers union in Atlantic City, New Jersey, needed to reduce health care costs to its members while providing better care to those with chronic, but manageable, illnesses. Most of Local 54’s members

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were low-wage casino and hotel workers. Many spoke little English, worked two jobs, and suffered from chronic pain and other health problems related to their working and living conditions. Access to transportation was difficult.

Local 54's Trust partnered with AtlantiCare, a major health care provider in Atlantic City, to open a Special Care Center (SCC) that would provide intensive primary care to a carefully chosen set of chronically ill patients. Both the union and AtlantiCare saw advantages in transitioning from the traditional fee-for-service model to a model of monthly payment per patient, which rewarded effective lower-cost care. Each could benefit from the creation of the SCC: the union could ensure better, more cost-effective care for its members, and AtlantiCare could ensure better community health – and help lead in a national move toward community health orientation.

Local 54 and AtlantiCare divided the work necessary to start the SCC. AtlantiCare had an extensive network of relationships with community medical providers, which the SCC would need to build its patient base and already had the data needed to figure out which providers were delivering cost-effective care. The union would need to deliver a sufficient number of patients to justify the capital costs of building and staffing a new outpatient clinic and, over time, delivering evidence of the cost effectiveness of the model. SCC staff would be AtlantiCare employees.

Pricing issues reflected the different goals of the parties. Local 54 discovered that AtlantiCare was accepting lower reimbursements from other payers and not passing savings from drug pricing deals on to Local 54 members. Resolution of these issues was hindered by claims of the need for confidentiality.

The first medical director of the SCC was unable to carry out the SCC's goals because he was used to the traditional fee-for-service structure. The goals of flattened hierarchy, the transfer of traditional MD duties to MD-supervised nurses and health coaches, and reduced use of specialists were not met early on.

Health coaches were essential partners in effective primary care. Health coaches were the key to patient engagement. Health coaches had to be able to identify health care goals that were meaningful to their patients and encourage them to stay on track. Their ability to connect with and motivate patients was more important than prior education or experience in health care. Health coaches had to be able to innovate on the job and be given permission to do so. It was also important to match the language and ethnic profiles of coaches and patients.

The health care hierarchy had to be flattened. Because patients spent most of their time at the clinic with their health coaches, the input of the health coaches was critical to the effectiveness of their care. During the regular meetings in which patient care was discussed, doctors, nurse practitioners, and health coaches all contributed to the decisions made on patient care.

An adequate number of patients had to be recruited. The trust invited potential patients who met the criteria for using the SCC to health fairs, where they received screenings, tours of the facility, and an opportunity to meet the medical staff. Participants in the SCC were promised free clinic visits and some medications without copayments. The SCC later added mental health services, smoking-cessation programs, and substance abuse counseling after concluding that patients who needed those services could be treated effectively.

SCC maintained its financial viability by rethinking the use of certain medical tests and devices. Changes were made to the procedures for sleep studies, colonoscopies, Type II diabetic care, and cardiac care, all resulting in cost savings.

Some disagreements between the parties remained. The trust was unable to access complete pricing data and SCC patient records. AtlantiCare objected to the trust's refusal to disclose insurance claims information, which it wanted to use to help assess the SCC's cost effectiveness.

Positive results led to the decision to open a second SCC facility to serve AtlantiCare's own suburban employees. Although the data were not always complete, the SCC's internal analysis showed significant decreases in outpatient procedures, hospitalizations, ER visits, and endocrinology consultations by diabetic patients. Moreover, despite serving a challenging population of poor and ethnically diverse patients, the SCC was exceeding national quality benchmarks for ER visits per capita, admissions per capita, average length of hospital stay, and prescription fill rate.

Opening a second facility created new challenges. New health coaches had to be trained and provided with experience, an expensive and time-consuming process. Eligible AtlantiCare employees and families were slow to accept SCC-type care because they were reluctant to give up their existing physician relationships. SCC contracts also met with resistance from payers whose internal systems were based on traditional fee-for-service arrangements.

AtlantiCare worked with community medical providers to increase coordination of care. AtlantiCare

subsidized the conversion from paper to electronic medical records for some providers and encouraged greater cooperation between community medical providers and AtlantiCare's hospitalists.

Introduction

By his own description, Eugene Allen was barely alive when he arrived, slumped in a wheelchair and tethered to oxygen, at the Special Care Center (SCC) in Atlantic City, New Jersey.

Months earlier, blood clots in his right leg had catastrophically broken loose, shooting up into his pulmonary artery to collapse his lung function. He'd spent three months on a mechanical ventilator in a hospital intensive care unit, most of the time unconscious, and fought a dangerous hospital-acquired infection. Hardly anyone expected him to survive because, in addition to the blood clots, Allen was massively overweight at 480 pounds. Years of smoking, drinking, erratic work hours, and bad sleep had undermined nearly every one of his organ systems.

As the ambulance crew rolled him up to the SCC's reception desk, there was next to nothing left in Allen's tank and he knew it, darkly questioning the point of further treatment.

"Good morning, Mr. Allen," the receptionist said cheerfully. "We're glad you're here."

Allen had never experienced a cheerful welcome in a medical office. As a general rule, he avoided doctors. A chef by profession, he'd spent 30 years working in restaurants, the last 19 of them on the hotel side of Atlantic City's casino business. He sought medical care in a crisis or when prodded by his wife, who worked as a supervisor in a rival casino and through whom he received his insurance.

Allen had experienced health care as impersonal and sometimes demeaning. "They'd give me a prescription and say, 'Here, take this and come back in a week.'" No explanation, no advice, sometimes not even eye contact. His job was to answer questions and follow orders. When his right leg began to swell—Allen did not realize this could be due to life-threatening blood clots—he chose not to seek care.

The SCC was an entirely different experience, and not just because of its upbeat atmosphere. Allen didn't realize it at the time, but he'd entered health boot camp.

The SCC operated on the principle that much greater effort in primary care to engage patients as partners in their health delivered better clinical results and slashed total costs by reducing hospital stays, emergency room (ER) visits, and consultations with expensive specialists.

Through the SCC, Allen received medicines, therapies, and guidelines for diet, exercise, and lifestyle change. It was, of course, one thing to issue such prescriptions, quite another to ensure that patients actually followed through. To accomplish that, the SCC employed health coaches to build ongoing relationships with patients and their families. The SCC also employed doctors, both to deliver care and to supervise the coaches. But patients interacted most frequently with the coaches, who engaged them through a mix of personally tailored care, education, encouragement, and, when necessary, demands delivered with the vigor of Marine Corps drill sergeants. Allen described his experience this way:

Irma was my coach. Our first meeting, she says to me, "You know what? We're going to fix you up. We're going to get you better than what you look like now." And I was like, "I don't know. I don't know if that's possible, especially the way I'm feeling now." She said, "You'll be all right, you'll see."

Later, I was having trouble adjusting to the medications and felt tired all the time. I had just learned to walk again but I wasn't walking that good. All I wanted to do was just sit around. Irma said, "Listen, I understand you don't feel good, but you have to get up and walk or your muscles will turn back to jelly." And she would call me up at home, three times a week at least, and say, "Did you walk today?"

Then, when I went to the SCC for an appointment, everybody would be in on it. They'd see me walk by and say, "Hey, Eugene, did you do what Irma told you to do?" And I'd be like, damn, what's going on here? It makes you think these people really care. And that makes you think, well, I'm going to make myself walk. At first, I walked maybe three blocks and back to my house. After a while it started becoming enjoyable. So then I walked four blocks. Now I walk 14 miles a week and I'm down to 380 pounds. By next summer, I'm planning to be 260.

Allen's turnaround illustrates the type of success the SCC aspires to: improving the health of its patients through a comprehensive approach that leverages

the work of its health coaches. It exchanges standard fee-for-service payments for a monthly per-patient fee that allows doctors and health coaches to focus on the complex needs of each individual in their care and, crucially, achieve a level of patient engagement that contributes to better patient experiences and health outcomes. An unusual and still experimental operation, the SCC has its own story, one rich with insight into the inner workings and failings of the U.S. health care system. This case study tells that story from 2007, when the SCC began operation, to 2012. This five-year period covers the design and initial implementation of the SCC and examines some of the obstacles to setting up this innovative practice.

Although the SCC, and the approaches that it has put into practice, are still being tested and adapted, the care model appears to be successful in achieving two interlocking goals—lowering costs and improving health outcomes by increasing the quality of care. Analyses have shown that outpatient procedures, hospitalizations, and ER visits have all declined among SCC patients. Moreover, the SCC has exceeded national quality benchmarks for ER visits per capita, admissions per capita, average length of hospital stay, and prescription fill rate within a low-income, ethnically diverse population. It has done all this while achieving considerable cost savings.

At the time of writing, other organizations are replicating and scaling this model. AtlantiCare itself has expanded by opening a second location. Iora Health, whose CEO was intimately involved in setting up the AtlantiCare SCC, is opening similar primary care practices across the country. A number of case studies and reviews of complex care experiences identify the AtlantiCare SCC as a success story. Around the United States, there are many innovative efforts underway to improve health care delivery, increase the quality of care, and contain costs (Sanger-Katz 2015; Gawande 2011; Patel, Nadel, and West 2014; Hong, Siegel, and Ferris 2014; Bodenheimer 2013). This case study tells the story of how one innovative practice was brought into being and how it overcame delivery challenges in the course of implementation.

Development challenge: Improving the health of low-income workers with chronic conditions while reducing costs.

The AtlantiCare SCC was designed to focus on a high-need, complex population that consumed a disproportionate amount of health services and resources: the sickest 10–20 percent of patients.

In Atlantic City, many of these patients were members of UNITE HERE Local 54, the hospitality industry’s union. Most members of Local 54 were low-wage casino and hotel workers: cooks, waiters, maids, cocktail servers, and janitors. They often worked two jobs, and many suffered from chronic pain and other health problems related to their working and living conditions. Those with chronic conditions generated over half the costs to the insurance fund that provided their health coverage. The improvement in health outcomes for the sickest, most expensive patients through the approaches shown in this case study can drive broader efforts among health and social care sectors to contain rising health care costs.

Delivery Challenge: Effectively engaging patients with diverse needs and health issues and their families to ensure transformative changes in behavior.

Dr. Rushika Fernandopulle quite literally starts to twitch when he discusses the deficiencies of the U.S. health care system. Compact and roundish, with lively dark eyes and a sardonic wit, he described one of his many peeves:

We want people to take their medicine, right? So why exactly are we putting co-pays on it, especially with low-wage workers? It’s stupid to nickel and dime them for ten bucks and risk them ending up in the ER for \$10,000!

Many walls of illogic buttress the U.S. health care system. Some of those that affect the behavior of patients and providers, such as payment models that undermine conscientious medical practice, clinical job descriptions that fail to incorporate patients’ needs, and insurance formulas that discourage patients from filling their prescriptions, stand in the way of getting effective treatments to patients.

Fernandopulle developed a model in which case managers and health coaches worked with doctors to help patients better understand and manage their conditions. It became clear that a health coach’s most critical skill was the ability to form a strong personal bond with patients, to engage with them as people and win them over as partners in achieving better health. This required communicating in the patients’ language and understanding their culture. It demanded a new kind of health care worker, not just more of the same. Nurses, even with their years of education and clinical training, weren’t necessarily right for the job. Fernandopulle elaborated on the concept of engagement:

Engagement is a fundamentally different thing than education. Everyone knows that smoking is

bad for them. Everyone knows you shouldn't eat the cheeseburger. But to get people to act on that knowledge requires engagement. You can't outsource engagement to a call center with an 800 number, where the patient speaks to a different person every time. Coaches must be available to the patients by email, by phone, by text message. They also must regularly reach out to the patients, check up on them, and help them make appointments. Ninety percent of the magic is in the relationship that the coaches build with the patients.

To put engagement into practice, Fernandopulle and his colleagues convened and collaborated with stakeholders, built effective bridges to the community, and developed the role of the health coach to achieve a level of patient engagement that would result in better health for individuals and the population to be served.

Contextual Conditions

Fernandopulle's Work for Boeing Influenced His Ideas for Redesigning the Health Care System

In 2007, Fernandopulle's small consulting firm, Renaissance Health, was helping Boeing to reduce its health care costs. The firm had been hired by Dr. Arnold Milstein, who headed the U.S. clinical consulting practice for Mercer Human Resources Consulting (Mercer), a prominent global human resources consulting firm. With funding from the California HealthCare Foundation, Milstein had assembled a 12-person national expert team to design a new model for primary care, an Ambulatory Intensive Caring Unit for patients with complex medical conditions (MHRC 2005).

Milstein persuaded Boeing to give the model a try. The company was motivated to do so because its major rival, the European-based Airbus, had a tremendous health care cost advantage thanks to the government-sponsored health care systems in the countries where Airbus employed most of its workers. The strategy, outlined in an 80-page report from Mercer, was to spend more on primary care for the 10 percent of Boeing's workers and family members who accounted for the highest costs to the company health plan; most of these patients suffered from incurable illnesses, like

diabetes and heart disease, with potentially expensive complications.

According to the Mercer analysis, roughly 20 percent of people in an employee group account for 60 percent of the costs. (Subsequent estimates by others are in the same ballpark.) Closer examination reveals that most of these patients have at least one and more often several chronic illnesses, such as diabetes or heart disease, and suffer frequently from complications. Compared with other workers, they also see more specialists, who charge fees higher than those charged by generalists, and who tend to perform more costly procedures.

To control costs in this population, the Mercer report outlined an approach that is conceptually similar to that of hospital intensive care units, where the sickest patients get round-the-clock attention until they are deemed stable. The Mercer variant was to use this high-touch method in a primary care setting dedicated solely to patients with unstable chronic illnesses. They would receive comprehensive medical care and extensive education and support for the management of their conditions.

The research team projected that this level of support, including encouragement for regular exercise, proper diet, and other healthful practices, would result in dramatic per patient cost savings through reductions in big-ticket expenses, such as hospitalizations, emergency room visits, and unnecessary use of specialists. The report estimated a 23 percent savings from keeping patients healthy and thus avoiding the need for care, a 5 percent savings from delivering primary care more efficiently, and a 20 percent savings through better selection of, and coordination with, specialists. Subtracting the expense of the additional primary care staff needed to accomplish these goals, the report projected a net savings of 27–40 percent.

Fernandopulle's firm led the effort at Boeing; Milstein provided oversight through regular conversations. Both would have preferred to build a system from scratch, tailored to the complex health care needs of this population, but Boeing was unwilling to ask its employees to change doctors. So Fernandopulle assembled, in effect, a system patch. Boeing's employees would continue to see their own doctors, but case managers and health coaches would work with the doctors to help patients better understand and manage their conditions. The patch, what Fernandopulle described as a "wraparound" model, was simply grafted onto established medical practices and processes. (Some of Boeing's providers used a variant

of the patch, allowing Boeing employees to keep their existing doctors but also see a second provider.)

Initially, physicians serving Boeing's sickest employees welcomed the idea, which came with bonus payments to cover the cost of hiring health coaches and other extras. The theory that these supportive services could reduce overall expenses was quickly proved: even after subtracting the added cost of more intensive primary care, Boeing's health care costs for the target population came down by an estimated 20 percent.¹

But Fernandopulle was dissatisfied, not only with the results of the experiment at Boeing, but with similar results published by leading systems, such as Johns Hopkins and Geisinger. What bothered him was that these organizations were top-notch players. They had the best leadership, clinicians, and infrastructure, as well as deep resources. Fernandopulle was skeptical that such results could be replicated across the U.S. health care system.

Sustainability of the wraparound model was also a concern. In the Boeing experiment, Fernandopulle watched doctors who initially welcomed the idea become disenchanted over time. Applying different standards of care, based solely on whether a particular patient was in Boeing's program, made them uneasy. Fernandopulle explained:

It was ethically bad. The doctors began colorcoding charts so they could know which patients not to offer extra supportive services. One doctor said to me, "You know, every day I'm losing a little piece of my soul. Back when I was just doing standard crappy care, I was OK, because at least it was the same crappy care for all patients. But now that I see that there's a better way... I can't do this anymore."

Other unresolved questions swirled around the role of health coaches, including whom to hire. Fernandopulle recalled, "To be honest, we made up the job description of health coach as we went along." Early efforts at the Seattle-based Virginia Mason Medical Center were instructive. Fernandopulle elaborated: "Nurses at Virginia Mason were basically told, 'You're the health coaches for these patients,' and they weren't given much direction."

Figuring out the structure and skill set necessary for successful health coaching took time and a lot of trial and error, according to Fernandopulle:

It's like any other design process. You do it and then watch really closely. You've got to be on the ground, sitting with the health coach and with the patient, figuring out what's working and what's not working. And when you find something that works, you stick with it.

In addition to direct observation, Fernandopulle learned by talking to others around the country and around the world. For example, he studied Malaysia's system of using community health workers for prenatal care, which contributed to excellent birth results. As noted above, it became clear that a health coach's most critical skill was the ability to form a strong personal bond with patients—to engage with them as people and win them over as partners in achieving health. This concept of engagement would become crucial to the model of health care that Fernandopulle would put into practice in Atlantic City.

Fernandopulle longed for a chance to put the ideas underpinning the Boeing project to work in a setting built from the ground up. As he put it, "If you need to get across the country in five hours you don't bolt wings on a car; you invent an airplane."

Local 54 Needed to Provide Better Care at a Lower Cost

In addition to Boeing, Milstein sent the Mercer report to another client, Elizabeth Gilbertson, who ran a Taft-Hartley trust fund that provided health insurance benefits to the 11,500 members of UNITE HERE Local 54, a hospitality industry union in Atlantic City, and 12,500 members of their families.² Reading the Mercer report on the train to work one morning, Gilbertson was so intrigued with the intensive primary care concept that she called Milstein as soon as she reached her office. "It was 6:00 in the morning in California," Gilbertson recalled. "His wife said he was sleeping. I was terribly embarrassed, but that's how excited I was."

1 This was an estimate of the ongoing savings Boeing could achieve; it excluded startup costs and consulting fees. See Milstein, Arnold, Pranav P. Kothari, Rushika Fernandopulle, and Theresa Helle. 2009. "Are Higher-Value Care Models Replicable?" *Health Affairs Blog*, October 20. <http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable/>.

2 Taft-Hartley trust funds are established under the federal Taft-Hartley Act of 1947, which regulated labor unions in the United States. The trusts are entities separate from employers and unions that provide benefits to union members and their families. Trust assets are managed by a board of trustees whose members are equally divided between management and labor. The trust receives a per-hour-of-labor contribution established through collective bargaining.

Gilbertson was acutely aware of how difficult it was for these workers to navigate the complex U.S. health care system. Most members of Local 54 were low-wage casino and hotel workers: cooks, waiters, maids, cocktail servers, and janitors. Many were also new immigrants whose command of English varied. They often worked two jobs, and many suffered from chronic pain and other health problems related to their working and living conditions.

In addition to the language barrier, many did not have easy access to transportation and perceived an intimidating social distance between themselves and their white-coated health care providers.

Gilbertson was also bothered by how directly union members suffered from rising insurance premiums. Despite successful contract negotiations with the casino industry, many union members had seen nearly every penny of their raises consumed by rising deductions for health benefits. That's why the 2005 Mercer report grabbed her attention. In addition to presenting a convincing clinical model for intensive outpatient primary care, the report projected enormous savings on overall health care costs. Gilbertson and Milstein had worked together for more than a decade on various strategies to reduce health care costs without sacrificing the quality of patient care. While collaborating in Las Vegas, for example, they had identified wide variations in practice from one physician to the next and had achieved substantial savings by creating a physician network that excluded the 50 highest-cost providers in a network of 1,800 physicians.

Gilbertson's interest in delivering better care for less money to members of Local 54 was also personal, which helped fuel the professional risks she would take to make the SCC in Atlantic City a reality. As a community organizer in the 1960s and later as a public health student at Yale University, the plight of poor people with inadequate access to health care disturbed Gilbertson deeply. She became a nurse, hoping to make a difference, but she quickly became disenchanted with the relative powerlessness of nurses in the health care hierarchy. This led the feisty Gilbertson to take on leadership roles in collective bargaining for nurses and, ultimately, to her position with Local 54's Trust.

Gilbertson decided that the intensive primary care model for the Trust's highest-cost patients was worth testing on Local 54 workers based in Atlantic City. Of course, it remained to be seen whether the assumptions in the report would play out in reality.

Existing Health Care in Atlantic City and AtlantiCare

As Dr. Katherine Schneider surveyed the buffet at the church breakfast, she realized she would have to make some off-the-cuff amendments to the speech she had been invited to deliver. The food choices made her heart sink: doughnuts, coffee cakes, scrambled eggs, sausage, bacon, and pancakes.

"There were no fruits, no vegetables—no options for people who were trying to lose weight or watch their salt or sugar intake," said Schneider, who at the time was a senior vice president in charge of community outreach and health engagement at AtlantiCare, the dominant health system in the Atlantic City region. She watched in dismay as a diabetic with amputated legs wheeled himself up to the buffet. In her subsequent remarks to the church group, Schneider pointedly commented on the insensitivity of this kind of hospitality to people with health problems.

The experience was emblematic of Schneider's uphill battle to change attitudes about health and health care. George Lynn, the CEO of AtlantiCare until 2007, had dramatically expanded AtlantiCare from a hospital to a much broader health care system. Then, prior to his retirement, he expanded this comprehensive approach further, making community health AtlantiCare's first priority. The push was sustained by his successor, David Tilton. Keeping the residents of Atlantic City healthy, Lynn and Tilton both knew, would require innovation. It would require AtlantiCare to push health-oriented ideas and practices beyond the walls of hospitals and clinics. Tilton tapped Schneider to make that happen.

Atlantic City and surrounding Atlantic County belong on any short list of places desperately in need of innovation in health care. The county has consistently ranked as one of the worst in New Jersey on such health factors as obesity, smoking, rates of preventable hospitalizations, and other factors that undermine health, such as unemployment, school dropout rates, and percent of children living in poverty (County Health Rankings and Roadmaps 2012). With casinos and hotels making up the city's primary industry, the residential population mirrored that of Local 54's membership: ethnically diverse, poor, and unhealthy.

AtlantiCare, on the other hand, was doing quite well. The company had consistently operated profitably, unlike most of its counterparts in New Jersey. Staff turnover was

low, and operations were high quality. In fact, AtlantiCare would garner considerable national recognition in 2009, winning a coveted Malcolm Baldrige National Quality Award, the nation's highest presidential honor for organizational quality and performance excellence.

The company's flagship hospital, AtlantiCare Regional Medical Center (ARMC) in Atlantic City, seemed to be sitting pretty as the region's only full-service provider. The next closest hospital was a 20–30 minute drive away, and many low-wage workers in Atlantic City had little access to transportation. As a result, the hospital had substantial pricing power. It could, in theory, charge insurance plans and self-insured employers whatever it wanted for its medical services.

But AtlantiCare was not a world unto itself. Its nonprofit board included prominent members of the community who made Lynn aware of the burden that high health care costs placed on the local economy. Atlantic City no longer competed solely with distant Las Vegas as a gaming destination. A proliferation of new casinos up and down the East Coast was siphoning off business. It did not take a sophisticated eye to see, even on a quick visit, that the city's heyday had passed. Lynn's and, subsequently, Tilton's interest in improving community health, thereby bringing down health care costs, was genuine, albeit somewhat atypical for hospital CEOs. After all, healthier people meant reduced demand for AtlantiCare's services. The executives' interest, however, was not purely altruistic. Because of AtlantiCare's market dominance, its fate was tied to that of Atlantic City. Lynn and Tilton knew that out-of-control health care costs could hurt both. Furthermore, if AtlantiCare did nothing, it left the door open for a competitor to come into the market, implement a lower-cost model of care, and win the insurance contracts that AtlantiCare counted on to stay in business.

There was also the potential for short-term gains. For one thing, the AtlantiCare system—two hospitals, laboratories and testing facilities, numerous outpatient specialty clinics, primary care clinics, a community health center for the homeless, fitness centers, day care centers, and a home health care agency—was the largest noncasino employer in Atlantic City, with more than 5,000 employees. By changing its orientation to improving and preserving community health rather than waiting for people to get sick, AtlantiCare might significantly reduce its own costs of providing health care benefits. Finally, the system's hospitals were operating close to capacity. The target population for outreach and health

improvement was people with chronic illness, typically a low-margin clientele compared with surgical patients. Therefore, short-term profitability was likely to be higher if fewer chronically ill patients were in the hospital.

As it turned out, AtlantiCare's decision to move toward a community health orientation anticipated national health system changes to come. The U.S. Affordable Care Act of 2010 outlined a gradual shift from fee-for-service arrangements to payments based on patient outcomes—how well they do as a result of treatment. Shared risk between health care providers and payers was the new byword in health policy circles, meaning that if patients got out of the hospital faster or avoided hospitalization altogether, providers could pocket some of the savings. Conversely, if predicted results were not achieved, providers could be on the hook for the cost of additional treatment.

AtlantiCare's leadership recognized that local employers were nearing the limit of their ability to absorb price hikes for health insurance. In 2012, the market reached the dreaded tipping point. Amid great fanfare over the opening of a new casino with 5,000 desperately needed new jobs (75,000 people reportedly applied) came word of the employment package: Prospective employees were being offered a \$6,500 bonus if they opted out of the company's health insurance plan. Schneider explained the chilling implications for AtlantiCare:

If you've got credit card debt from being unemployed or a mortgage about to go into foreclosure, you're going to take the \$6,500. And there goes our paying customer. If this is the beginning of a trend, if all employers start doing this, it could be very disruptive.

Indeed. The AtlantiCare Regional Medical Center was the region's federally designated safety net institution, meaning it was obligated to take care of everyone who showed up, even if they had no insurance. With change looming, AtlantiCare was motivated to shake things up for the better.

Tracing the Implementation Process

When Gilbertson first saw the Mercer report, she was in the midst of negotiating a new contract with AtlantiCare to provide health services to union members and their families. Gilbertson gave then-CEO Lynn a copy of the report, hoping to start a dialogue about how best to care

for Local 54's patient population, specifically those using the most health services. But Lynn took the discussion in another direction. AtlantiCare would build and operate the new clinic, he announced, and then asked a startled Gilbertson, "Would the union like to be a customer?"

Gilbertson didn't like that at all. The clinic was her organization's idea and she wanted to run it. But AtlantiCare owned the local health care service infrastructure and the union had little choice but to comply. Bowing to reality, Gilbertson proposed a joint project. Lynn moved fast, tapping the hospital's chief operating officer, Margaret Belfield, to take charge of the project and giving her *carte blanche* to assemble an implementation team and spend whatever was needed to design and construct the new clinic. Belfield initially was reluctant—she already had too many projects reporting to her—but soon was caught up in the excitement of working on a future-oriented, innovative, build-from-scratch project. She was supported by a small consulting team, led by Milstein and provided by Gilbertson's trust. The arrangement was similar to that at Boeing. Fernandopulle worked on-site, while Milstein provided oversight.

Navigating Politics and Personalities

Fernandopulle found himself in the middle of a charged dialogue between Gilbertson and Belfield. Both women began their careers as nurses but decided early on to pursue administrative roles out of frustration with the relative powerlessness of clinical nurses of their era. Smart and politically savvy, they'd risen through the male-dominated health care hierarchy to positions of national leadership. Neither gave ground easily.

The battle was over who controlled which aspects of the soon-to-be-created SCC's operations. Gilbertson was in a weak position. There was no way around the reality that patients in the new clinic would require many services from AtlantiCare. The hospital also had an extensive network of relationships with community physicians, which the clinic would need to build its patient base. Unlike in Seattle, where a major player like Boeing could contract directly with large physician groups, the physician workforce in Atlantic City was scattered among hundreds of tiny practices—one or two MDs plus a modest office staff. Practically speaking, Gilbertson's trust could not negotiate with every one of them, and it did not have access to the data needed to figure out which were delivering

cost-effective care. Gilbertson felt handicapped; a major portion of the savings projected in the Mercer report was to come from better selection and coordination of specialists. She'd have to rely on AtlantiCare.

The negotiations resulted in an unusual partnership between labor and hospital, and an agreement to evenly split the costs of running the clinic. But Belfield won on control of staff—they would be hospital employees. The union's job would be to deliver a sufficient number of patients to justify the capital costs of building and staffing a new outpatient clinic and, over time, to deliver evidence of the cost effectiveness of the model.

Both Gilbertson and Belfield embraced, professionally and personally, the goal of helping low-wage workers achieve the best possible health. However, Gilbertson had to realize savings for her union's health plan while Belfield had to operate with an eye toward AtlantiCare's financial and strategic interests. These interests were, of course, in direct conflict, at least in the short term and especially over pricing of services. Gilbertson had understood from her earliest conversations with Lynn that as a result of their multiyear partnership with AtlantiCare, Local 54 would receive preferred pricing on hospital services. When, several years later, AtlantiCare attempted to increase charges to Local 54, she investigated:

I learned that other AtlantiCare customers had been paying substantially less. It radically undermined my good feeling about the partnership because I visualized every pricing inequity coming straight out of the pockets of the low-wage workers that I was fighting for.

There was also a clash over pharmacy prices. As the region's federally designated safety net facility for poor and uninsured patients, ARMC's in-house pharmacy had access to drugs at greatly discounted prices. Nonetheless, the hospital marked up the cost of some drugs that were provided to the union's health plan rather than passing on the low government rate. Although the drugs were still sold more cheaply than at retail prices, Gilbertson wanted the math out in the open. Belfield resisted. AtlantiCare's attorneys were anxious about privacy issues and other AtlantiCare administrators preferred to withhold the information for business reasons. It just didn't make sense, in their view, to share with a customer what they were paying to suppliers, especially where those prices were highly variable.

Fernandopulle did his best to referee this critically important relationship between AtlantiCare and Local 54. He insisted, as the go-between, on full access to both information systems, and both sides acquiesced. Nonetheless, the operating reality fell well short of the ideal of transparency. Gilbertson would continue to feel shortchanged on information about clinical operations, while Belfield complained about inadequate access to insurance claims data. Like Belfield, Gilbertson defended the latter by citing the advice of her organization's attorneys, who were concerned about violating confidentiality clauses in contracts with the union's many providers. Sharing claims data with AtlantiCare could easily have breached those clauses.

And these were not the only tensions the SCC would have to overcome.

Finding the Right People

It took quite some time for the SCC to get past early hiring mistakes.

The first medical director was one. Fernandopulle tried counseling, coaching, and cajoling but nothing worked. Gilbertson, Milstein, and Belfield were also anxious to rectify the situation. Although the medical director had claimed during interviews to believe in the SCC's model—flattened hierarchy, the transfer of traditional MD duties to MD-supervised nurses and health coaches, and reduced use of specialists—he was unable to put these ideas into practice. From the first day, he operated the SCC like a traditional office practice, referring patients to specialists outside the SCC and scheduling patients for multiple visits instead of using a comprehensive team approach. Fernandopulle elaborated:

He was, unfortunately, executing through the old playbook. He wanted to be part of the community and, frankly, didn't want to do the head-bashing job of cutting out specialists. We had about 200 Type II diabetics seeing outside endocrinologists. That's very expensive to the union. We had stable hypertensives going for routine checkups with cardiologists every three months. That's ridiculous! So we just had to stop all that madness. He wasn't willing to do it because he wanted to be buddies with the other doctors.

Further discussions led to a mutual parting of ways. Belfield, who was the AtlantiCare administrator in charge of SCC employees, acknowledged the hiring mistake but

considered it more than just a one-off error. It wouldn't be easy for people from the traditional system to adapt to the SCC's way of doing business. The SCC's operating concept of using coaches to help patients manage their illnesses bucked the prevailing medical culture in the United States, in which doctors sat at the top of the pecking order and everyone else, including patients, passively followed orders.

Fernandopulle agreed to step in as medical director until a replacement could be hired, handing off his other consulting work to his partners. It turned out to be a fantastic learning experience for him; he discovered that running the SCC was a lot harder than conceptualizing it:

The health issues of low-wage earners have a lot to do with having a really crappy life. The health care system can't fix that. But it can respond with caring, with we're-not-going-to-give-up-on-you encouragement. The system also needs to tailor care to the patient population. Affluent, educated patients tend to want to know every detail about the pathophysiology of their disease, and health coaches have to be trained to provide that. In Atlantic City, however, patients may not give a damn about the pancreas pumping out insulin to metabolize blood sugar, but you still have to find a way to get them to take their meds and eat right.

The team of Fernandopulle, Belfield, and Gilbertson powered their way through challenge after challenge to take the SCC from concept to reality—for example, putting in place an electronic medical records system, a pharmacy, and metrics for assessing progress. Gilbertson explained her motivation for investing substantial time and energy even though she did not have direct operational responsibilities:

I have come to believe that the passivity of most purchasers has played a significant role in the US health care crisis. Even though the trust is a relatively small payer, we have found that when we engage, we are able to get results.

Although the Mercer paper was the original inspiration, the team did not feel compelled to follow its prescriptions in every detail. The needs in Atlantic City were unique.

Because of the trust's investment in the consulting team, Fernandopulle benefited from advice from many of

the nation's top thinkers in primary care, developing a list of principles to make the venture a success:

- Make the SCC an option, not a requirement, for patients
- Build the SCC team from scratch
- Don't employ anyone who does not choose to be a part of the SCC
- Hire lots of new people
- Do only one thing: high-intensity primary care
- Offer incentives to attract patients, such as free medications
- Do not use a fee-for-service payment model

Finding a permanent medical director took more than a year. It was not easy to recruit qualified candidates whose families were willing to relocate to Atlantic City. Also, it was clear that the medical director was going to be unpopular, luring patients away from local primary care physicians and curtailing lucrative referrals to specialists. Fernandopulle observed wryly, "It was not the way to get invitations to play golf."

Finally, in August 2009, Fernandopulle was able to hand over the reins to Ines Digenio, a family medicine physician whom Schneider recommended; she knew Digenio from her residency at Middlesex Hospital in Connecticut.

At first glance, Schneider and Digenio seem to have little in common. Schneider is buttoned-down, somewhat given to corporate argot, and matter-of-fact about the slow pace of change. Digenio, on the other hand, has no use for meetings populated in part by nitwits and routinely hurls around words like "insane," "stupid," and "nonsensical" to describe various health system practices. Yet, in building the SCC, they were mutual admirers who shared a common vision of how the system ought to relate to patients.

Digenio brought an additional strength to the SCC leadership team: experience working in resource-poor parts of Africa and South America. This gave her valuable insight into how best to employ care providers with any level of education. Whether the SCC could deliver on its promise of better health at lower cost depended on the abilities of its frontline providers—health coaches—to deliver high-quality clinical results. Some had no more than a high school education.

With Digenio in place, Fernandopulle stepped down as medical director; he later cofounded Iora Health, a startup network of intensive primary care clinics with operating principles that were grounded in what he had

learned through his experiences at the SCC, Boeing, and other similar projects.

Hiring Health Coaches, Flattening Hierarchy, and Making the SCC Run

A slender woman in her early 50s, Ines Digenio took over as the SCC's medical director in 2009. The native of Uruguay described herself as "never blinking under pressure, just getting more revved up." She was equally adept in English and Spanish at cajoling patients into taking better care of themselves.

Digenio quickly grasped that health coaches were the key to patient engagement. Therefore, she worked to match the language and ethnic profiles of coaches and patients. Seventy percent of SCC staff spoke languages other than English, among them Spanish, Hindi, Gujarati, and Creole.

Digenio also realized that health coaches had to be able to innovate on the job and be given permission to do so. The type of person called for was different from traditional medical support personnel hired for expertise in a particular technical skill, such as phlebotomy or heart monitoring. Health coaches had to be able to identify health care goals that were meaningful to their patients. For example, if a patient expressed frustration about having to take so many medications, the coach might skillfully redirect that frustration into motivation and a plan to lose weight, thereby reducing medication dependence.

For this reason, Digenio interviewed candidates as much for their personality traits as for their résumé qualifications. For the former, she looked for a "spirit of wanting to help people"; for the latter, she looked for evidence of that spirit, such as community volunteer work. Common sense and problem-solving skills were also prerequisites. In interviews, Digenio asked open-ended questions, such as "How would you handle a difficult patient?" rather than something an applicant would know from class or a book, such as "How do you take a blood pressure?" Other types of questions probed for "street smarts," cultural understanding, and a natural ability to connect with people (for an example of how all these skills came together in the daily routines of the health coaches, see box 1).

Once hired, the health coaches were put through rigorous training, including role playing in which one coach might act as a recalcitrant patient while another tried to engage them in working toward a health goal (see box 2 for an example of a discussion between a health coach and a patient).

Box 1 Experiences of a Health Coach

“Ay, caramba!” exclaimed health coach Milagros Laya as she listened to Carlos Santiago (name changed to protect privacy) recite what he’d eaten in the previous week. A Type II diabetic, Santiago had been in dangerous condition when he had arrived at the SCC, his blood sugar exceeding 400 mg/dl (normal is under 100 mg/dl). Despite several instructional sessions on diet, exercise, and proper use of blood glucose–moderating medicines, Santiago’s blood sugar remained over 300 mg/dl.

Santiago, a big man in his 40s who worked in food service at one of the casino hotels, insisted that he was sticking to his diet. But Laya persisted. “Tell me what you ate yesterday,” she demanded in Spanish, hands on hips. Santiago could not help but laugh at the sight of petite Laya getting up into his face on the suspicion that he dared to disregard her instructions. He hastened to reassure her, and slowly the truth came out, revealing several misunderstandings that persisted in spite of instructional handouts and personal coaching:

- Santiago appropriately cut down on flour tortillas because they are high in carbohydrates and therefore easily converted to sugar in his blood. But he substituted corn tortillas, not realizing that they too were high in carbohydrates.
- He did not increase his dose of insulin as instructed in the previous visit because he felt fine.
- He stopped drinking soda and other sugary beverages but continued to drink orange juice because it is natural and he thought it was good for him.
- He dropped his exercise regimen in order to get more hours at work because he needed the extra money for a trip to Colombia to visit his family.

Laya recorded all of this information on her laptop for review by one of the SCC’s doctors. By the time Santiago left, he had a new prescription and more detailed and firmly delivered instructions on when and why he had to take the medicine, even if he felt well. Laya customized the standard diabetes diet instruction sheet with new—and emphatically scrawled—prohibitions for her patient: “No jugos de naranjas! No tortillas de maiz! Mas agua, mas vegetales, menos carbs!” Santiago took the paper from her hand and, responding to her smile, bowed theatrically in a promise of better performance.

The SCC’s philosophy was to take initiative, not to wait for patients to make appointments. Health coaches were responsible for their patients whether or not those patients were in the office. Accordingly, Laya scheduled a follow-up appointment for a few days before Santiago’s vacation. She planned to reinforce the diet restrictions and make sure he was well stocked with medicines. Laya knew the appointment would be a bit too soon to measure a lasting improvement in Santiago’s compliance, but she hoped nonetheless for at least a small drop in blood glucose. That would mean progress, and it would reinforce in Santiago’s mind the causal relationship between dietary changes and his lab results.

Laya, a 35-year-old native of Peru, was 14 when her family immigrated to the United States. Her parents found work as pot washers in the casino kitchens while Laya applied herself to learning English and completing high school. She worked briefly as an administrative assistant at the Sands Casino but then decided to go back to school to become a cardiac technician. Her career path veered in another direction the day the SCC manager called the vocational counselors at Laya’s school to let them know about the SCC’s newly created position of health coach, and they forwarded Laya’s résumé.

Having spent years escorting her parents to medical appointments because their English was poor, Laya understood firsthand how bewildering the U.S. health care system could be to people from another culture. She felt a kinship with many SCC patients and made use of her life experience to build empathic relationships with patients and motivate them to work toward goals, the way Eugene Allen’s health coach encouraged his walking regimen. In turn, Laya drew personal satisfaction from being able to help her patients improve their health.

As one of the SCC’s first health coaches, Laya had been both eyewitness and hands-on tester as the SCC understanding of the health coach role evolved. She reflected:

It is a continuous learning experience. For example, we had to learn how to dress. When we started, we wore regular clothes to show that we were different from the doctors and nurses. But we realized that the patients wanted us to look like medical people if they were going to discuss their medical problems with us. So now we wear scrubs like the nurses but in a different color.

Box 2 Example of Health Coach Dialogue with Patient

Larider Ruffin, a Creole-fluent native of Haiti and a nurse practitioner at the SCC, presented a typical pull-no-punches exchange:

Ruffin: I understand you are a new diabetic and that this can be life changing and hard for you. We can help you manage the diabetes, but it's going to take a lot of work from you. You have to make dietary and lifestyle changes. The walking around that you do at work is not what I'm talking about when I say walking for exercise. You have to move in a way that raises your heart rate. How do you feel about that?

Patient: I've never thought about my diet my entire life. I eat what's convenient. I used to exercise a lot but now I have a family, I have a job, I don't have time, and you are making me very nervous.

Ruffin: I understand, and it's OK to feel the way you're feeling. But research shows that lifestyle changes are key, not only to control diabetes but also hypertension, obesity, and other problems as well. You don't have to change everything at once, and we'll work together step-by-step to reach our goal. If you don't have time to go to the gym, think about taking the stairs at work instead of the elevator. When you go to the store, think about parking as far away as possible so you have to walk farther with your groceries. These little things make a difference.

Patient: What will happen to me if I don't do these things?

Ruffin: You will be totally dependent on medications and, unfortunately, they can't do the job alone. So your blood sugar levels will rise and your organs—your kidneys, eyes, heart, circulation—will be hurt by this excessive sugar. You may end up on dialysis, have a heart attack, go blind, or have a foot amputated. These are all preventable complications of diabetes. So it is in your interest to let us help you move forward with a good plan of care so you don't get these complications. Many people live normal lives with diabetes.

Digenio set up a continuous training environment for health coaches, with one-hour sessions each week on specific subjects, such as how to do a foot exam for a diabetic. Even so, the hiring and training process was not foolproof. The SCC let coaches go in as little as three months if they proved unable to handle the job.

The Huddle: The Flattened Hierarchy in Action

This scene was typical of mornings at the SCC. After nervously summarizing her overnight cases for Digenio and other colleagues, a recently hired SCC health coach relaxed into a wide grin for the triumphant finale of her report: “No hospital admissions, no ER visits!”

“Yes!” cheered Digenio, throwing up her arms like an Olympian crossing the finish line.

Sitting at the head of the long conference table, SCC manager Sandy Festa allowed herself a brief celebratory smile and then briskly called the meeting back to order. Festa and Digenio presided over this all-important staff meeting every morning. Called the huddle, it was a mandatory assembly of the SCC's health coaches, physicians, nurse practitioners, nurses, front-desk nonclinical staff, and other team members, during which case activity over the previous 24 hours was reviewed. Everyone in the huddle had a laptop computer

and worked from a common record, making notations alongside patients' names as decisions about their care were reached. There was a striking absence of hierarchy in huddle discussions. Health coaches did not hesitate to speak up; the patients being discussed were as much theirs as the doctors'. The physicians were respectful of the contributions of the health coaches, nurses, and nurse practitioners. After case reviews, the huddle morphed into a planning meeting for the day, with staff duties assigned fluidly as patient needs demanded.

Unlike in a typical primary care clinic, patients spent most of their time with health coaches. Though some coaches had only a high school education, they were ably trained to do patient interviews and measure pulse rates, blood pressure, and weight and perform other technical tasks. Coaches also provided patients with a wealth of educational information on medical conditions. Most critically, they were trained in techniques to motivate patients to change their behavior and improve their health. Nurse practitioners and physicians supervised and supported health coaches in their relationships with patients and discussed each patient visit with the coach. They also intervened to assign patients to a new health coach when the relationships weren't productive. When patients were actively sick, they saw nurse practitioners, who, in turn, were supervised and supported by physicians when situations exceeded the nurse practitioners' level of

knowledge and comfort. Physicians also saw patients by appointment when test results or health coach reports indicated the need for a medical reassessment, generally about three to four times a year.

Ultimate responsibility in the SCC rested with Digenio for medical matters and with Festa for operations. Like Digenio, Festa was experienced in delivering quality care in an environment of tightly constrained resources. A social worker by profession, she previously had run a health center for the homeless. “We were making amazing progress with the homeless, and I figured that if it could be done with the homeless, it could be done with anyone,” she recalled. Both Festa and Digenio were no-nonsense managers with high expectations of performance from staff and patients alike.

Typical of the wide range of issues addressed in the huddle was the one with which Festa kicked off the meeting one morning: “We’re going to start today with my problem case of the moment, which I want solved by the end of the day,” she announced. A patient had called Digenio at home late the night before to cancel her morning appointment with the doctor, saying she had a sore throat and wanted to sleep in. It was a flagrant breach of SCC protocol, which required patients to communicate through health coaches. Festa fixed a stony gaze on the patient’s health coach. “I will call her and deal with that right after the meeting, and it will not happen again,” the coach said quickly. As the huddle progressed, each of the 13 people around the table took a turn reporting his or her active cases. Festa gave direction on procedural matters, Digenio on medical. A patient wanted gastric band surgery to lose weight. Responded Digenio: Not until she takes the informational course and knows what’s involved and what’s expected of her afterward. Someone else wanted to quit smoking. Festa: “Health coaches, you must coordinate these cases with the smoking-cessation nurse practitioner.”

Although medical issues dominated huddle discussions, the financial bottom line was always in view. A significant part of the staff’s educational role was to counteract the misinformation patients picked up on the street or from television or from their grandmother’s cache of home remedies. Digenio elaborated:

When patients go to Google for medical information, we have to have a big discussion afterwards. They don’t worry about their diabetes; they want the medicine they saw on TV that promises wonderful things but

has nothing whatsoever to do with diabetes. Sometimes they think what I prescribe is not as good because it’s not on TV.

In taking a hard line with patients, however, Digenio and the other SCC staff had to walk a careful line. In choosing to build the clinic from scratch rather than wrap its services around the existing medical establishment, the SCC’s designers recognized they would be asking patients to give up their personal doctors and, in some cases, longstanding, trusted relationships. Therefore, their loyalty would have to be won through quality of care and a caring spirit that, as with Eugene Allen, motivated the hard work required of patients to achieve better health.

Recruiting Patients and Managing Financial Viability

The trust took the leadership role in recruiting patients to join the SCC, experimenting with several methods, including the all-time favorite marketing tool of health care organizations: a community health fair and open house. The trust invited over 100 members to each fair, analyzing past claims data to select invitees. Once at the fair, participants received a standard biometric screening, literature on healthy living, a pitch for why they might want to join the SCC, a tour of the facility, and a chance to meet the staff, including the doctors.

Several carrots were dangled to sweeten the deal. In addition to same-day appointments, patients were promised free medicine and free clinic appointments—no \$5, \$10, or \$20 copays, as is common with conventional insurance coverage. Because patients with multiple chronic conditions could have upward of a dozen prescriptions, this was a powerful lure.

The SCC was physically attractive, particularly in comparison to its surroundings in downtown Atlantic City, an area of rundown hotels and strip joints. Indeed, the SCC was located in one of the city’s snazziest buildings (not counting the spectacularly gaudy casinos that dominate the city’s skyline). The corner lot was attractively landscaped with flowering shrubs and benches under shade trees. Inside, a serene color scheme greeted patients, who reached the second-floor treatment area by elevator and waited for their appointments in comfortably furnished lounges. Patients also had the convenience of an on-site pharmacy.

The SCC also tried to persuade prospective patients that care at the SCC would make them healthier. Most who came to the open houses wanted to at least give the SCC a try, and about three-fourths stayed, eventually agreeing to give up all of their outside doctors, including specialists. To cement this obligation, Local 54 changed its benefit policies so that if a union member opted into the SCC but went to an outside doctor anyway, the union was not obligated to pay the bill. Over time, patients got the message, though not all of them were happy about it.

As the SCC expanded to accept patients with other sources of insurance, contracts with those payers were structured to provide lump-sum payments per patient per month rather than the traditional fee-for-service arrangement. Thus, the SCC became responsible financially in addition to clinically for the well-being of each patient.

From the SCC's perspective, it was critical to get the right patients to sign up. The comprehensive and expensive primary care offered by the SCC wasn't needed by most people. It made sense to invest this much time and effort up front only when money was likely to be saved downstream through prevented crises and hospitalizations.

Gilbertson used claims data and predictive modeling to identify union or family members most likely to benefit, but the team did not entirely embrace such a formulaic approach. "We kept asking, 'Is this a chronic care program or a high-cost program?'" explained Fernandopulle. "They're not the same, though there is huge overlap." The team decided to exclude some very sick, high-cost patients, including those with serious psychoses and people with certain chronic conditions, such as AIDS and multiple sclerosis. The reasoning was that health coaching was unlikely to affect the course or severity of these illnesses.

As the SCC gained experience, patients were added who did not fit any sort of data-driven formula. "They could be patients with chronic conditions, but they could also have other things that we could help with," Fernandopulle said. "It could be end-of-life care. It could be people who just don't deal well with sort of trivial problems."

The Mercer study's projected cost reductions presumed exclusion of people with mental illness on the assumption that they couldn't reliably carry out treatment plans, whether diet and exercise, blood sugar testing, or other self-care regimens. But the Boeing experiment had revealed that as many as 70 percent of

patients with complex and severe chronic conditions suffered from depression or had other mental health issues. Some also smoked and abused alcohol and drugs. So the SCC explicitly included mental health services, smoking-cessation programs, and substance abuse counseling. (The SCC did not typically accept patients whose primary or only condition was mental illness or substance abuse.) Although AtlantiCare and the trust were somewhat anxious about pushback from patients who wanted to join the SCC but were turned away, nobody ever complained.

Not surprisingly, the team experienced resistance from community doctors who lost patients to the SCC. Belfield and Digenio mollified some by offering to include them in an AtlantiCare network of preferred providers for purposes of patient referrals.

Digenio's experience working in developing nations had given her a keen eye for wasteful practices in U.S. health care. From her first day as SCC medical director, she insisted on knowing the price tag on everything so she could pounce on wasteful practices before they harmed the clinic's long-term viability.

And pounce she did when a data report showed an unusually high number of sleep studies ordered for patients complaining of insomnia. Each study cost upward of \$3,000. Digenio's dismay at the trend leaped to fury when she discovered that one of the patients referred to the sleep lab had taken a tranquilizer during the test in order to fall asleep, thus utterly undermining the value of the test. Technicians had failed to discover and note this in the patient's report, despite having had trouble rousing her the next morning. "My mind blew," recalled Digenio. "Such a waste! I was like, 'What are you doing?'"

In a retrospective review of sleep study cases, Digenio found that patients had been referred for sleep studies without even being asked common sense questions, such as "Are you on the night shift?" or "Do you work two jobs?" Nonetheless, Local 54's insurance plan was paying for the studies and for \$800 continuous positive airway pressure (CPAP) devices that patients used at night to counteract snoring and episodes of sleep apnea.

Digenio tracked down the patients on CPAP therapy and discovered that a significant number weren't using the machines as instructed and some weren't using them at all. Yet Local 54's insurance plan kept paying the monthly rental fees. "One patient I spoke to in Spanish told me her machine was in the corner, full of dust," Digenio recalls. "I asked her why, and she said her husband didn't like the

noise and didn't want his wife sleeping next to him with a mask over her face."

These discoveries led Digenio to redesign the assessment of insomnia to educate SCC patients on lifestyle patterns that can disrupt the natural sleep cycle as well as on the influence of substances such as alcohol. The result was significantly fewer SCC patients undergoing sleep studies and using CPAP therapy.

Even though health coaches were at the heart of the SCC care model, Digenio knew that rooting out wasteful expenditures was critically important if the SCC was to achieve cost and quality goals. She systematically targeted numerous areas for rethinking business as usual, among them the prescribing of brand-name drugs when lower cost generic versions were available. To enforce physician sensitivity to cost in writing prescriptions, Digenio negotiated with Local 54 to change its insurance plan to develop a list of drugs, mostly generics, that could be dispensed to patients for free. If patients insisted on an expensive drug that was not on the list, they were charged a standard copay. (At least one SCC provider reported feeling frustrated by the effort it took to appeal the restriction on brand-name drugs when patients did not respond to treatment or had adverse reactions to the generic formulation.)

Digenio also focused on reducing ER visits after finding that an alarming number of SCC patients were being seen for problems she believed could easily have been treated at the clinic. Further, she worked with the hospital administration to strengthen the coordination between the SCC and hospitalists. Costs came down in the form of fewer admissions, shorter hospital stays, fewer redundant tests, and fewer consultations with specialists.

Colonoscopy procedures were also redesigned to provide better quality care and cost savings. Before Digenio arrived, the SCC was acting like a typical primary care office practice, referring patients for this screening test for colon cancer and other bowel problems to specialists in the community. The specialists charged Local 54 for three separately billed services: pre- and postprocedure appointments, and the colonoscopy itself. Digenio found that many SCC patients with poor English skills did not understand the instructions given in the preprocedure appointments and were unable to understand findings or communicate concerns in the follow-up visit. The SCC, whose multilingual health coaches were hired from patients' ethnic communities, stepped in to take over these preparatory and follow-up visits, thereby saving extra

charges to Local 54's insurance plan and ensuring that patients were well prepared on the day of the procedure.

Finally, Digenio discovered that the SCC could cut back on cardiology consults by caring for stable hypertensives in-house, consulting when necessary, but not on a routine basis. Similarly, the SCC also provided comprehensive care to all Type II diabetics, except for a handful of very sick patients who relied on implanted insulin pumps and required expert attention from community-based endocrinologists.

To bring about these and other changes, Digenio found herself spending a lot of time on the phone with specialists who consulted on SCC patients. In many ways, the conversations resembled the educational pitch made to patients joining the SCC—outlining a new approach to health care delivery based on improved patient self-management and judicious use of expensive tests and treatments. She asked specialists to align their treatment of SCC patients accordingly and made clear that the SCC would be partnering only with specialists who did so. The pitch won the cooperation of specialists who wanted the SCC's patient volume.

The choice of specialists was largely at Digenio's discretion. Gilbertson had hoped to apply statistical methods, similar to what she had done in Las Vegas, to identify the highest-cost specialists and eliminate them from the network. But data on physician performance were harder to come by in Atlantic City.

Managing Disagreements and Scaling Up

Glancing at her calendar, Gilbertson girded herself for another not-so-informative meeting on the progress and performance of the SCC. She considered these every-other-month oversight meetings to be far less productive than sessions focused on tackling administrative challenges, reviewing health plan provisions, and discussing positive and critical feedback from members of Local 54. The oversight meetings seemed to be little more than performances for hospital senior executives on how great everything was going at the SCC. Gilbertson continued to chafe at being shut out of pricing data and SCC patient records. Eager to learn whether the SCC model was delivering the results for which it had been created, Gilbertson and Milstein arranged for a private and unpublished study by a Harvard economist, which estimated savings based on a model grounded in SCC data from the 16-month period starting when Fernandopulle took charge as director. Milstein cautiously described

these preliminary results as promising and indicative of nearly a 20 percent reduction in cost.

Meanwhile, Belfield, Digenio, and Festa were frustrated by the Trust's refusal to disclose insurance claims information, which they wanted to use to help assess the SCC's cost effectiveness. The experience informed the SCC's stance in contract negotiations with new payers. Claims transparency was written into the contracts.

To measure how well they were doing, SCC leadership developed a scorecard to measure five performance areas: health quality metrics; hospital and ER admission and readmission rates; financial performance; staff satisfaction; and patient satisfaction. Assembling this data was not easy, even on patients whose payers were providing claims data, because each payer had its own recording-keeping system that had to be deciphered and painstakingly rendered into a standard format for analysis. Though the sample size was small, the easiest data to analyze were from AtlantiCare's own employees. To supplement spotty claims data on other patients, the SCC staff learned to generate measures of performance directly from patients' electronic health records.

Although the data were not always complete, exciting trend lines were emerging. Based on the SCC's internal analysis, outpatient procedures declined by 23 percent, hospitalizations by 41 percent, ER visits by 48 percent, and diabetic patients' visits to endocrinologists by more than 90 percent. Moreover, despite serving a challenging population of poor and ethnically diverse patients, the SCC was exceeding national quality benchmarks for ER visits per capita, admissions per capita, average length of hospital stay, and prescription fill rate. The SCC estimated cost savings of \$175–\$200 per member per month for payers.

These savings were net of the approximately \$50 per member per month cost for intensive primary care and dispensing prescription medicines without copayments. In a public report to the community, the SCC estimated net cost savings at 12.3 percent (AtlantiCare 2011).³ Even as the SCC delivered such favorable results, Belfield continued to view the clinic as an R&D project, an experiment. Whenever she met with SCC staff to review results, Belfield probed their fundamental assumptions: What needs to be changed? Why do we operate this way?

Why shouldn't we try this alternative? Among her goals was to create an experimentation-oriented environment in which egos were left at the door and anyone could challenge anyone else's positions.

That said, by 2011, the leadership team's confidence in the SCC model was high enough that the focus shifted to growth. A second SCC was planned for a site 13 miles outside Atlantic City, a more convenient location for AtlantiCare's suburban employees. There was every expectation that the model could be replicated within a year.

To embed the SCC's clinical systems, operating norms, and culture in the new facility, Digenio became medical director of both SCCs and transferred seasoned health coaches to mentor new hires. As there were no schools for health coaches, the SCC team had to train them on the job. All new hires rotated through the Atlantic City SCC as part of their training. A certain amount of information about chronic diseases and their treatment, as well as techniques for interviewing patients, could be packaged into standardized training modules. But new health coaches also needed to learn through experience, and some lessons were very specific to the needs of the patient population. Watching the replication process, Belfield became concerned with the amount of time invested in training new health coaches. It implied slow growth for the intensive primary care model.

The time required to train health coaches was not the only barrier to broader adoption of the model. One of Belfield's biggest disappointments was the slow acceptance of SCC-type care by eligible AtlantiCare employees and families. They simply weren't signing up in the desired numbers. The team discussed possible changes in benefit plans to encourage participation. Getting patients to give up their existing physician relationships seemed to be the major sticking point.

Schneider also ran into resistance from payers. Although senior executives seemed to embrace the concept, convincing middle managers was harder. SCC contracts were exceptions to common practice and took these managers out of their comfort zones. It was also more work for them, because the insurance companies' internal systems were based on traditional fee-for-service arrangements.

Schneider had watched the SCC's progress with excitement and pride. But she also believed the clinic's stellar results were misleading as an indicator of intensive primary care's potential impact in the population. The SCC had picked the "low-hanging fruit"—patients so woefully ill served by the traditional fee-for-service

³ In 2012, Gilbertson and Milstein both expressed caution about drawing conclusions prematurely. That year, they were working on a separate cost analysis with a larger sample size.

system that measureable improvement was relatively easy to achieve.

Schneider's mission was bigger in scope. It was not to build one clinic, but to reform the entire AtlantiCare system, reducing the cost of care and making residents of Atlantic City healthier in the process. It was a huge undertaking whose impact might not be discernible for years. Schneider elaborated:

It's a total game changer. We are asking, what do we want to look like as an organization in five years? The hospital is a critically important piece, but it's not the center of the universe anymore. The bottom line is we're all going to take a haircut, but we'll stay in business. As I've learned from hanging around Washington excessively in the last 18 months, the choices are Track A, which is reinventing ourselves, or Track B, which is having fees cut and patients diverted elsewhere by insurance companies looking for a better deal on unit price alone.

Schneider's was a job that did not always make her popular, even within AtlantiCare. After all, she was working to reduce the hospital's traditional revenue streams. Yet, Schneider saw no alternative. If AtlantiCare did not move beyond traditional boundaries, it would likely be trapped in a death spiral of ever-shrinking reimbursements for the acute care of increasingly sick people, often underinsured or uninsured.

Nonetheless, change at AtlantiCare was slow. Among Schneider's and Belfield's frustrations was that AtlantiCare clinicians and administrators rarely sought out Digenio and Festa for their expertise, even as the SCC's accomplishments achieved national recognition and the duo was frequently invited to present at national conferences.

The impetus for change took on new urgency in 2012 with the prospect of AtlantiCare's achieving certification as a Medicare Accountable Care Organization. This would make the company eligible for contracts with private and government insurers to be the "medical home" for people 65 and older. To receive this designation, AtlantiCare had to show that it was capable of providing an integrated continuum of care, including hospital, outpatient, and follow-up services.

This was no small hurdle. Most patients in Atlantic City were cared for by private physicians who also covered the hospital ER. There was no infrastructure for collaborative practice, such as a common electronic medical-record system, to coordinate care.

Building on Digenio's experiment with hospitalists, Schneider began working with top-level hospital administrators, including Belfield, to expand the number of hospitalists from 3 to 26, covering not just SCC patients but all patients. Community physicians were phased out of ER coverage, and hospitalists determined the need for consultations with specialists on a case-by-case basis. Schneider also identified a physician workforce imbalance in Atlantic City—lots of specialists but not enough primary care physicians. So she pushed AtlantiCare to open six new neighborhood-based urgent care centers to treat sick and injured people who were without access to a regular doctor.

In addition, Schneider worked to redesign the relationships between the hospital and community physicians. Only those with demonstrated patient management skills or willingness to transform their practices were being invited into new networks that the hospital, in turn, planned to contract out to payers. The intent was to create a virtual version of the SCC, plus a big multispecialty physician practice. To be accepted into the network, physicians had to commit to using electronic health records, hand off their hospitalized patients to hospitalists, use nurse case managers to support patients' health goals, guarantee same-day access to patients with acute problems, adopt some SCC-like practices for chronically ill patients, and offer patients better options after hours than "go to the ER." The requirements were extremely disruptive to business as usual. Some physicians resisted the changes. Schneider observed that these typically were older physicians who had been successful under the fee-for-service model and hoped to "hang on" to traditional practice styles until they retired.

AtlantiCare responded with incentives, recognizing the difficulties that small independent practices faced in covering transition costs. For example, the company offered grants to defray the cost of converting paper files to electronic health record systems. It also experimented with embedding health coaches in community physicians' offices. Results, however, matched Fernandopulle's experience in Seattle: The doctors couldn't stand differentiating the way they treated patients, giving some patients supportive SCC-style care while denying it to others. The lesson Schneider drew from these experiments was that a lot of the magic in the SCC was due to its being built from the ground up.

Perhaps the biggest challenge to the changes championed by Schneider was the slow pace of change

in the reimbursement system for health care services. She was confident that outcome-based payments would eventually replace fee-for-service, but when? Schneider elaborated:

The big question is whether we try to change the care first or change the money first. If we change the care too quickly, before the money is adequate, we hurt ourselves financially. For example, we have put case managers in the ER to divert admissions, even though no one's paying us for the case manager and every admission we divert is lost revenue. On the other hand, if the money changes first, you might not have the capabilities you need.

Schneider also recognized that health is not solely, or even primarily, within the control of the health care system. The population has to make healthier lifestyle choices than soda for breakfast and channel surfing instead of exercise. To this end, AtlantiCare offered community health education programs and sponsored exercise groups and community gardens. To curtail obesity and forestall the potential onset of Type II diabetes, the company developed children's health promotion programs in partnership with 80 elementary schools. As an employer, AtlantiCare also began requiring members of its health plan to undergo biometric assessments and, if needed, work with health coaches or accept higher insurance copays.

None of these initiatives will produce results tomorrow. Ten years from now? Maybe. Schneider sometimes gets discouraged—and flinches at the backlash from her often unpopular messages. That's why she was so surprised to receive a second invitation from the church group she'd talked to about the absence of healthy choices on their breakfast spread. Curious, she accepted. Her hosts could not have been more welcoming as they ushered Schneider over to the buffet table to view a veritable feast for her eyes: Turkey bacon! Egg Beaters! Yogurt! Fresh fruit!

It was progress.

Lessons Learned

The success of the intensive primary care model in delivering improved individual and population-wide health resulted from consistent stakeholder and community engagement, new roles within care teams, and flattened organizational structures.

This case shows relentless focus on citizen outcomes, as the concept of the SCC prioritizes what patients need and offers relevant interventions across a broad spectrum of need to ensure that individual health is improved and unnecessary health expenditures are avoided. Indeed, much of what made the SCC distinctive—health coaches and Digenio's pruning of expenditures for ineffective or unnecessary treatments, for example—was built around improving outcomes while containing costs.

Keeping track of evidence of what worked and what didn't was critically important to meeting the SCC's twin objectives of improving clinical outcomes and lowering costs. This started when patients were brought into the program: Gilbertson used a data-driven approach to recruitment, with sophisticated analytics to determine who needed the SCC's services the most.

Developing the Health Coach Role: Adaptive Development and Flattening Hierarchies

One of the key health care delivery innovations of the SCC was the use of the health coach, drawing in part on observations from developing countries and adapting these insights to the U.S. context. This important and demanding role is new to the U.S. health system. When Fernandopoulle first introduced it, considerable tinkering was necessary to determine the right blend of skills needed for the job, and how the coaches would fit into the health care delivery system. Starting without a specific blueprint, it became clear that health coaches did not need deep medical knowledge; indeed, few health coaches had a background in medicine. Rather, successful health coaches were “people people,” able to persuade, comfort, and motivate patients to keep up with diet plans, medications, and exercise regimens. Personal characteristics often prevailed in this job. So did the ability to speak the patient's language, allowing health coaches to reach out to patients in diverse communities and immigrant populations. To effectively integrate health coaches into the health care delivery system, it was important for them to be empowered and on a level playing field with doctors and management. While the SCC did not blow up the traditional hierarchy, it flattened it, allowing for a more equal exchange during discussions of patients, opening the floor to more points of view, and bringing all relevant insights to the table in devising a course of treatment. Adaptation in developing

the role of the health coach was very important, as the role emerged from a process of trial and error in the course of design and implementation. For instance, the innovative use of health coaches for preparing patients for colonoscopies or monitoring people with high blood pressure had an impact on both outcomes and the bottom line.

Engagement with the Community

Another crucial driver of success was the taking of initiative outside the walls of the SCC itself. This meant engaging with the community to change habits and help reinforce behavior change, from the broad-based (community health outreach in 80 schools) to more incremental discussions (talking about nutrition choices with individual church congregations). It also meant close collaboration with Local 54 to handle outreach to potential patients and steer them to where they needed to be. Moreover, it required sensitivity to the specific cultural characteristics of the target population, including issues of language.

Coordinating Stakeholders and Leadership for Change

A strong, tight leadership team was crucial to pushing the SCC forward. Although strong personalities were not always in total agreement, without their commitment the SCC model would not have moved forward. It was crucial to get the right people in place, and, once there, to empower them to make necessary changes. The partnership between the union and the hospital was unusual, with each side needing to uphold its part of the bargain—the union delivering more patients, and the hospital committing to lower costs for their clients.

It also proved necessary to keep multiple stakeholders on the same page. Although in theory the incentives of AtlantiCare and the union were largely aligned, maintaining this alignment sometimes required adjustments to practices, as when Gilbertson agreed to let AtlantiCare take the lead on the SCC, effectively committing all parties to a particular approach. Fernadopulle's early refereeing also helped to ameliorate some tensions over transparency and information sharing. Sometimes fragmentation of effort proved a hindrance (for example, when disagreements over

information sharing made it harder to track analytics). Ultimately, what held multiple stakeholders together was a commitment to the goal of delivering better outcomes for the people that both the union and the hospital wanted to help through innovations in health care delivery. Necessity was, in some ways, the handmaiden to coordination and compromise.

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