Curing Camden

How One City Became a Model
for Smarter, More Affordable Healthcare

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ABOUT THIS BOOK

"Fixing this is going to be like landing someone on the moon."

—Dr. Jeffrey Brenner, founder and executive director of the Camden Coalition of Healthcare Providers

As the president's federal healthcare overhaul dominated the national news, I reported on our country's medical system at the local level. For the *Philadelphia Inquirer*, I wrote a half dozen stories about an innovative healthcare nonprofit in Camden, New Jersey, a city known nationally as one of the country's poorest and most violent. The articles, published from 2010 to 2012, centered on the role of the nonprofit, the Camden Coalition of Healthcare Providers, in combatting falls, violence, diabetes, and other issues in the troubled city. Versions of the published articles are included here, along with a previously unpublished profile about the nonprofit's founder.

The reporting in this book, which took me from the living rooms of Camden residents to the halls of the New Jersey State House in Trenton and beyond, spans three years. This project highlights how Camden—a city that is battling some of the nation's highest crime and poverty rates—could be the first U.S. city to bend the cost curve by lowering healthcare costs while improving care. The ideas in this book could be translated into practice across the country. And, if the efforts in Camden succeed, the city could become a national model.

Some of my reporting was funded by journalism grants. Two stories published in the summer of 2012—about diabetes and violence—were completed with the help of the Dennis A. Hunt Fund for Health Journalism, administered by the California Endowment Health Journalism Fellowships, a program of the University of Southern California's Annenberg School for Communication & Journalism. The MetLife Foundation Journalists on Aging Fellowship supported my story on falls—the number-one cause of injury-related hospital visits for Camden residents—in partnership with New America Media and the Gerontological Society of America.

CHAPTER 1: CREATING A CITYWIDE HEALTH RECORD

Adapted from an article published Monday, Oct. 11, 2010

In a move to improve medical care and cut unnecessary services, Camden's three health systems will begin to go live Monday with a citywide health record, which should enable doctors to better know their patients' medical histories.

The Camden Health Information Exchange is one of the most advanced of a small number of efforts nationally that seek to create broader medical-record systems, experts said.

Unless patients opt out during any hospital visit, anyone with a Camden address will be included in the records exchange, making their recent hospital admissions, hospital-based lab and radiology results, medical tests, and discharge reports part of the database.

Stringent safety protections will be included, too. Doctors will need written consent from patients each time they want to access the records.

After a soft launch of the system that begins Monday and is likely to last a few weeks, the medical records in the database will be available when needed by physicians from other health centers.

The exchange is an effort by the Camden Coalition of Healthcare Providers, a city nonprofit group that teamed up with Cooper University Hospital, Lourdes Health System, and Virtua Health.

The shared database is meant to improve hospital care by making it easier for doctors to track patients, especially those with chronic conditions, and reduce costs from repeat tests, said Jeffrey Brenner, the coalition's executive director and a family-practice physician in Camden.

Brenner said he expected the database would save money by improving care coordination.

A study by the Harvard School of Public Health last year found that eliminating redundant tests would have saved U.S. hospitals $8 billion in 2004 alone. With the new database, the cost savings in Camden "could pretty quickly add up into the millions," Brenner estimated. "Everyone realizes that when we don't share information, the patients suffer."

Staff members from the three hospitals have been meeting with Brenner's team regularly since the spring of 2009. "This is brand new work," Brenner said. "There are [less developed] examples around the country, but it's a steep learning curve."

The collaboration is unusual and much needed, said physician Richard Baron, chief executive officer of Greenhouse Internists in the Mount Airy neighborhood of Philadelphia, who wrote an article last spring for the *New England Journal of Medicine* on electronic health records.

"In most communities, it's been very difficult to get disparate players in the same room to even talk about what they're beginning to do in Camden," he said. "There's a very strong sense within Camden . . . [that] we really need to do something differently."

In most cities, including Philadelphia, patients can move among different hospitals and emergency departments, and the doctors who treat them may not know their care history. So tests, prescriptions, and other procedures can be duplicated.

Because many Camden residents visit the city's hospitals regularly, Brenner said he expected about half of the city's 77,000 residents will be part of the database within a year.

Each of the three health systems is contributing $50,000 a year to the effort, Brenner said. The Merck Company Foundation is also donating $50,000.

The project's second phase, which could come within 12 months, will add laboratories, radiology providers, primary-care physicians, and other hospitals to the information exchange, Brenner said.

The Camden database is one of four health-information exchange programs in New Jersey receiving funding through the federal stimulus package, according to the state Health Department. The Camden effort will receive about $1 million, while the other projects—in South Jersey's Shore counties, in Newark, and in northern and central New Jersey—will each get $3.5 million.

The Camden database could serve as a model to other cities, said Poonam Alaigh, New Jersey's health commissioner. "It's very important," she said, "especially because if we can learn about improving clinical outcomes in the most vulnerable, then you know you can make an impact when it comes to the larger population."

Alexander Hatala, president of Lourdes Health System, said the Camden exchange "provides a great learning laboratory for what healthcare will look like under healthcare reform," passed in the spring. "What healthcare reform is all about is person-centered care and value-based purchasing."

The health information exchange will help physicians to track their patients better, especially those who require frequent care and visit many emergency departments, said James Dwyer, Virtua's chief medical officer. Without the system, patient data recorded in each hospital might not reach other physicians, he said.

Patients also may forget to mention the care they've received or a hospital visit they've had, added Emma Brandon, director of clinical information systems at Cooper University Hospital. The more accurate information available to doctors, she said, the better the patient care.

If the database shows a patient is bouncing from hospital to hospital, Lourdes' Hatala said, that might be a red flag that the person is without a primary-care provider. That knowledge could help hospital caregivers link the patient to a doctor.

CHAPTER 2: TREATING THE CITY'S HEALTHCARE ILLS

Written in July 2011

Camden is known nationally for its record violence and crushing poverty. But if a dedicated family physician there succeeds in his decade-long effort to drive down medical costs—while improving healthcare quality—the city of 77,000 will get a new spin on its story.

Dr. Jeffrey Brenner, a Cooper University Hospital physician and executive director of the Camden Coalition of Healthcare Providers, was instrumental in state legislation passed this year to create a citywide accountable-care organization (ACO) in Camden. The effort could enable providers to keep some savings if they meet quality benchmarks for patients and is expected to be quickly followed by similar collaborations elsewhere in the state. This three-year Medicaid demonstration project, a key component of national health reform, is meant to improve healthcare through prevention and personalized care, while cutting costs for unnecessary treatments.

Carrying out the legislation—arguably the tougher battle—is the next campaign for this soft-spoken physician, who has been working with quiet determination to change how healthcare is provided and funded in Camden. Frustrated by patients getting low-quality medical care at exorbitant costs, Brenner has spent a decade working to revamp the broken system. He's partnered with hospitals, doctors and nurses, churches, advocates, and residents to care for hospital super users, fight back against the diabetes epidemic, harness the city's violent youth, and create a health record system shared by medical providers throughout the city.

Brenner has spoken far and wide to promote his accountable-care legislation. He explained to Rutgers–Camden health law students that the bill would help lower costs by integrating Camden's healthcare delivery system. Brenner told New Jersey's former health commissioner that the legislation would improve healthcare in the broken city. And he described to a group of church fundraisers how the bill could make his work sustainable through shared savings.

In healthcare circles, Brenner has become something of a rock star. His reputation is national. The former New Jersey health commissioner, Poonam Alaigh, described Brenner as "a great leader." NJBIZ.com named him one of the 50 most powerful people in New Jersey healthcare, alongside legislators and hospital CEOs. And early this year, the *New Yorker* magazine featured Brenner's efforts as an example of promising work that could lower healthcare costs in American communities.

But Brenner is a reluctant rock star. He'd rather talk about his agenda than himself. Rather than touting his own achievements, he steers conversation toward his team of healthcare providers, data sleuths, administrators, and volunteers. And he admits that he doesn't know if his ACO—his most ambitious undertaking—will work. His only choice, though, is to try. "Fixing this is going to be like landing someone on the moon," Brenner said.

From the research lab to a primary-care practice

A native of Gloucester Township, New Jersey, Brenner didn't set out to be a family doctor. Despite his passion for patients like those he cared for in Camden, Brenner's studies at the Robert Wood Johnson Medical School steered him toward a more removed career in neurological research. But he joined with a group of fellow students who wanted to start providing care to New Brunswick residents and gain more hands-on experience.

The group enlisted the support of Dr. Steven Levin, a young, dedicated family practitioner who was then leading a low-income health clinic. Levin opened Brenner's eyes to community medicine and became his mentor. "He just got really caught up in the needs of the underserved. He completely turned around," Levin said. "It's not about Jeff Brenner. It's about the work he's doing. This is not a trip he's taken for notoriety. He strongly, passionately believes in what he's doing."

After his residency in Seattle, Brenner and his future wife, Jenny Greenberg, decided to move east. Brenner submitted applications in Philadelphia and Camden, and Cooper University Hospital answered first. Brenner and Greenberg embraced Camden. They moved into the Cooper Grant neighborhood in 1998. They married and had two children. Greenberg became a city planner, while Brenner practiced at Cooper.

After five years with Cooper, Brenner broke off to launch his own East Camden family-care practice. He enlisted Marynez Burgos to manage his new office, an oasis of wicker chairs, scented oils, and themed exam rooms. "I went anywhere he went," she said. "I knew that if I went with him he would back me up."

Brenner made his patients feel the same way, Burgos said. If a patient had multiple medical issues—and a worried family who wanted to meet with Brenner—the doctor would close his office and bring the group in to chat in the waiting room. Brenner helped uninsured patients get coverage. He held a diabetic group meeting every Wednesday morning, helping patients check their blood sugar, learn to cook healthy meals, and manage their condition. Aside from patients who requested narcotics, Burgos said, "I never really heard him say 'no' to anybody."

While Brenner frequently attended seminars to stay updated on the latest trends in healthcare, Burgos said he also provided for his staff members. During the Philadelphia Flower Show, Brenner closed the office and paid for a staff field trip there. And every Thursday, he gathered the staff to talk about the week. They discussed what went right and wrong, and what they could do to help troubled patients, such as those who couldn't pay their bills.

But the demands of being a primary-care doctor in Camden were starting to take a toll on Brenner. "He spent a lot of late nights in the office," Burgos said. "There were times when I would call Jeff and he'd be at the office until eight o'clock at night." Sometimes Burgos drove by the office on weekends, when it was closed, and spotted Brenner's car parked outside. When she called him, he'd say, "I have so much work to do, so much to catch up on."

Not only was Brenner spending more hours at the office, he was becoming more frustrated with the roadblocks he faced, such as insurance carriers that didn't allow patients to choose their own doctors. "He would get upset if he saw things that weren't fair happening. Or he would get upset if he tried to help someone [and] he couldn't," Burgos said. "I used to tell him, 'Jeff, you're trying to save the world again.'"

The "Holy Grail" of healthcare data

Brenner realized there was another way to understand the scope of Camden's healthcare problem. While he got the worm's eye view at the office by getting personal accounts from his patients, Brenner didn't yet have the big picture. As a citizen member of the Camden police reform commission, Brenner learned how law-enforcement officials in other cities used data and mapping to target crime-fighting efforts. Brenner set out to make his own healthcare maps, launching a three-year struggle to collect claims data from Camden's three hospitals. With the help of community and clergy members on the hospital boards, Brenner began receiving the data in 2002. "It's the Holy Grail," he said. "No one else in the country has it."

As he combed through pages of data, Brenner was shocked by his findings. He realized that, in a two-year period, most of the Camden population will visit a hospital at least once—a statistic that is twice the national rate. And Brenner found that the 10 most common reasons for emergency department visits were

all primary-care issues, ranging from a headache to the common cold. He discovered that the top 1 percent of Camden hospital users racked up $375 million in charges over five years. Brenner saw this huge sum of money paid to hospitals, much of it to treat primary-care maladies, while family practices in the city were on their last legs. "We were spending a lot of money in Camden and not getting our money's worth," he said. "This is the beginning of something important."

Brenner wanted to shout his findings from the rooftops—or at least tell the newspapers that healthcare in Camden was all wrong. But, worried the hospitals would take the data away, he chose a different route. "I needed to community organize in my own community," Brenner said, "which is doctors." He pulled together a group of local physicians for a monthly breakfast meeting. In discussing their most complex patients, the providers realized they all had the same patients. "This was empowering for all of us," Brenner said. This was the beginning of Brenner's coalition.

Brenner was so intrigued by the complex patients and the people in his data—such as a city resident who visited emergency departments and hospitals 118 times in one year—he began seek them out. The myth about these complicated patients, Brenner said, had been that they simply liked going to the emergency room. But the truth, Brenner said, is that "we don't have better choices." While hospital waiting rooms were packed with patients who simply needed chicken soup and aspirin, Brenner said, primary-care appointments in Camden had weeks- or months-long waiting lists.

Back at Brenner's practice, the doctor was watching his insurance reimbursements fall—ironically at the same time both the city and the whole country needed primary-care physicians more than ever. Brenner's continuing research showed him why it was so hard to practice there. New Jersey's healthcare system is specialist-oriented, rather than primary care–friendly. It ranks number one in inpatient spending during the last two years of life, according to the Dartmouth Atlas, a project that uses Medicare data to document how medical resources are distributed.

While specialists master one field, primary-care doctors like Brenner wear countless hats. In addition to their paid work of seeing patients, they're responsible for reviewing laboratory results, researching conditions, and calling patients, all of which are unpaid. "I was running to the mailbox every day and opening checks, hoping I [could] make payroll on Friday," Brenner said. "We pay for volume, but we don't pay for quality and outcomes."

Brenner had to make a choice. To help his practice survive, he could stop accepting Medicaid patients and kick the rest to the curb—a prospect that made his stomach turn. He could sprint from exam room to exam room, squeezing in as many paying patients a day as possible. Or he could leave the practice behind to tell the story of how the healthcare system wastes money on bad care and set out to fix it.

A coalition is born

With a heavy heart but hope for the future, Brenner sold his practice to Cooper. He made the coalition his full-time work and focused on his biggest drivers: to make the delivery system function better, to see reductions in hospital visits, and to provide better primary care and access in Camden. If Brenner found it was possible in one of the nation's most dangerous and impoverished cities to at once improve healthcare and lower healthcare costs, he reasoned his theory could hold true just about anywhere else in the country. When you're testing a hypothesis in science, Brenner said, you want to go to an extreme environment. "Camden is an extreme environment," he said.

By trading in his doctor's whites for an advocate's jacket and tie, Brenner became a full-time agent for change. He hired a nurse, a medical assistant, a social worker, diabetes experts, and administrators. The coalition's board topped 20 members, including representatives from Camden's three hospitals, city physicians, and others. "I want Camden to be a hotbed of innovation where people say, 'How did Camden do that?'" Brenner said.

As the coalition grew, so did its initiatives. An outgrowth of Brenner's visits to frequent hospital users was the Care Management Program, made up of a nurse, a medical assistant, and several other practitioners who visit about 50 frequent users and poorly controlled diabetics at home. The coalition-run Citywide Diabetes Collaborative, funded by a $2 million Merck Company Foundation grant, is revamping 10 Camden primary-care practices and expanding diabetes education in the city. A violence-prevention program targets Camden youth who are at risk for assaults. And, last October, the coalition achieved another feat of collaboration by launching an information exchange that made the hospital records of participating Camden residents available at all three city hospitals.

As his team fanned out across Camden, Brenner continued his data work. An outlier in the costs category that caught his eye was Northgate II, a high-rise near the Benjamin Franklin Bridge to Philadelphia that houses seniors and the disabled. Northgate II residents racked up more medical charges than tenants of just about any other building in the city. Brenner discovered that from 2002 to 2009, Northgate II residents were charged about $100 million in hospital bills and the hospitals collected about $16 million of it.

Eager to meet the people behind the numbers, Brenner teamed up with Camden Churches Organized for People, a group of Camden congregations that work together to fight the city's problems. He met Pilar Perry, a 40-something Northgate II resident who saw so many ambulances at Northgate II she assumed the building held doctors' offices; Gordon Johnson, another resident and 64-year-old Camden native who walked more than a mile each way to the clinic that provides his insulin; and others. "It's changed my life," Brenner said. Soon, he and residents were discussing barriers to healthcare and brainstorming ways to break them down.

In the fall, Brenner brought together a group of residents to talk about that $16 million they spent on hospital care. If they could get that money back to put toward their health, how would they use it? Brenner produced a "healthcare menu" that included options such as a cardiologist for $500,000 a year and a diabetes educator for $50,000. The group chose to spend their hypothetical cash on two nurse practitioners, an occupational or physical therapist, and a counselor, explaining that some residents visit the emergency room because their bones ache or simply because they need to talk.

Camden gets state—and national—recognition

It took just a few months for Brenner to turn the hypothetical into a reality. On a late March afternoon, Northgate II residents flooded the building's community room for the ribbon cutting of their new medical clinic. Some residents leaned on walkers and dragged oxygen tanks, while others carried signs that read "Bring Health Reform Home" as they filed past a table stocked with healthy sandwiches and apples.

Even with buttoned-up politicians in the room—the dignitaries included Richard Gilfillan, acting director of the Center for Medicare and Medicaid Innovation; Congressman Robert Andrews; and Camden Mayor Dana Redd—the event took on a celebratory, even religious, tone. When the Rev. Heyward Wiggins of Camden Bible Tabernacle Church said the clinic would be Northgate II's first medical office, a woman said, "Hallelujah." When he read from the Book of John, the audience nodded and responded. Northgate II residents, Wiggins said, would "be made whole."

Brenner said the opening of the clinic represented a "community-based solution" to a healthcare problem. He described his ACO bill's movement through the state legislature, saying, "Together we're going to change how healthcare is delivered in America." Gilfillan, formerly a family doctor in Trenton, agreed that the nation was watching Camden. "The Camden model is racing across the country like wildfire," he said. Senator Robert Menendez described Brenner and his team as "rock stars in the United States Senate" and said that Kathleen Sebelius, secretary of the Department of Health and Human Services, told him she'd been reading about Camden's efforts.

Pilar Perry, one of the Northgate II residents who met Brenner, sat up front with the dignitaries, spoke about her own healthcare struggles, and helped cut the clinic's red ribbon. Before the event, Perry said she felt empowered by her building's status. "I like the fact that we're number one," she said. "We're going to be the model, the example." Later, Perry was even more jubilant. "We finally won," she said. "Victory!"

Though pleased with the results, Brenner wasn't yet ready to claim victory himself. Projects like the Northgate II clinic couldn't survive—much less thrive—without his accountable-care legislation. In January, Brenner had held an accountable-care seminar in Trenton. He planned the event for months, bringing together healthcare providers, hospital executives, policy makers, lawyers, and business owners. At the event, he'd pledged that the ACO was "a promise to do something different." From there, Brenner ramped up his efforts advocating for his proposal statewide. He met with political leaders, took on several speaking engagements each week, and chatted at length with reporters. "If the delivery system worked, I'd just go back to seeing patients," Brenner said. "Running around the state and talking to politicians, it's pretty stressful."

The challenge of finding sustainable success

Brenner's efforts in Trenton paid off. But despite the celebration around the legislation's passage, some healthcare experts urged caution about the expectations surrounding ACOs. Lawton Robert Burns, chair of the Health Care Management Department at Wharton School, argued that ACOs should not be expected to solve healthcare's cost conundrum. "Just to improve quality isn't easy. Then you have the burden of improving quality" without increasing costs, he said. "The real nirvana is: Can you improve quality and cut costs? That gets really difficult."

Yet some local programs have already seen success using models similar to Brenner's. In Doylestown, Pennsylvania, the nonprofit Health Quality Partners, which is not an ACO, launched a Medicare demonstration project in 2002 along with 15 other sites nationwide. Nine years later, this program was the only one that hadn't been terminated for failure to save Medicare money, said Dr. Ken Coburn, president and chief executive of Health Quality Partners.

The nonprofit valued patient education, self-management coaching, and support as key components of the initiative, Coburn said. The project included group health programs focused on weight loss, exercise, and fall prevention. "We tried to assemble as complete and as robust a set of interventions [as] we could," Coburn said. The organization made its service package available in the community and made half of its contacts with patients in person. On top of that, it wrapped the program in a management system that uses data collected by nurses and primary-care offices to track patients. The other big plus: the project was tested using a randomized control trial. Such a trial, in which a project's efforts are compared to those of a control group, is a must for those producing new medications and treatments, but is difficult to perform on such programs. Yet it provided "a great degree of confidence [in] what the impact of the model has been," Coburn said.

Coburn cautioned that just because his project has seen positive results—it reduced participants' rate of death by nearly 25 percent, he said—doesn't mean that the ACO model is a magic bullet. "If people think that just by launching an ACO we're going to get early improvements," they'll be let down, Coburn said. "We're going to be woefully disappointed with what we get out of the ACO effort if we don't add to it a commitment" to do research and development on these new models.

With the passage of the New Jersey ACO legislation, Brenner said he hopes Camden's ACO will make all of his efforts more sustainable by sharing savings with the coalition and the state.

Rita Giordano, a staff writer for the Philadelphia Inquirer*, contributed to this report.*

CHAPTER 3: PROTECTING AGAINST A FALLING RISK

Adapted from an article published Wednesday, March 23, 2011

In Camden, America's second-most violent city, assaults make headlines. But another serious injury in the city of 77,000 is sending hundreds of Camden residents to the hospital every year, racking up millions in medical charges and, in some cases, shortening lives: falls.

Falls—down steep stairways, on cracked pavement, in slippery bathrooms—cause more hospital visits for Camden residents than any other injury, according to a recent analysis by the nonprofit data warehouse CamConnect, where Dr. Jeffrey Brenner is a board member. From 2002 to 2009, Camden residents made more than 17,000 trips to the hospital for fall-related injuries. That's nearly double the number of hospital visits during the same period for injuries sustained from assaults.

This isn't just a Camden problem. Nationally, one in three seniors falls every year, and this is the leading cause of injury death for people 65 and older, according to the Centers for Disease Control and Prevention. The costs are staggering. In 2000, direct medical costs of falls totaled more than $19 billion, said the CDC, which is encouraging groups to create programs nationwide.

Hospitals from Virtua in South Jersey to Holy Redeemer Health System in Meadowbrook have efforts to help prevent falls, as does Bayada Nurses, a home health agency. Chester and Montgomery Counties both have state-funded fall prevention efforts.

But Camden providers are armed with detailed data on falls, including citywide statistics that many other regions don't have. And local providers, including the city's biggest hospital, are using the knowledge to battle against falls—and their costs. "It's not only identifying risk factors for [people who have fallen]," said Kathleen Devine, Cooper University Hospital's senior director for emergency and trauma services. "It's actually connecting them to resources in the community."

Most falls in older adults are caused by a combination of inherent risk factors—poor balance and gait, medication side effects, limited vision—and environmental factors, such as a wet floor or an unsecured throw rug, said Roberta Newton, a noted fall expert and a physical therapy professor at Temple University. "Most often, it's when the older adult performs the routine activities of daily living" that falls occur, she said.

That was the case for Vera Jenkins, an 82-year-old lifelong Camden resident, who decided she'd skip the five-block drive from her home to the Macedonia AME Church one Sunday last October. "That was just one day I decided to walk," she said, "because it was such a beautiful morning."

Jenkins fell on the walk to church, likely tripping over a break in the sidewalk. She didn't feel hurt and her glasses hadn't even slipped off, so she continued on. But after Jenkins saw that her top lip had swollen up to her nose, she went to Cooper. She was treated for bruising and now wears a brace to strengthen her right leg.

But what might be worse than the ongoing physical pain is the mental trauma: Jenkins is afraid to fall again. "After it happened, I'm walking like a baby," she said. "No matter where I'm walking outside, I really pay attention." She hasn't walked to church since her fall. During the winter, Jenkins skipped church and her job as a school monitor to avoid the slippery snow and ice. She sometimes walks in the street to avoid uneven sidewalks. "I think you will find most seniors are afraid of falling," Jenkins said, "because there is so much damage that can be done."

Falls are the leading cause of fractures in older adults and of traumatic brain injuries, according to the CDC, and fall-related injuries can increase the risk of early death. Mary Lachant, a Cooper trauma research coordinator, said that like Jenkins, many first-time fall victims are afraid of falling again. "It's like a vicious cycle," she said, explaining that falls can reduce physical activity because the victim often fears another fall and limits activity as a result. But a sedentary lifestyle actually weakens patients, making them more likely to fall again.

Some people who fall get back up and resume their active lifestyle, Newton said. But for others, "there is this beginning, slow decline in their physical capability. That spiral could lead to admission into a nursing home."

SAFER Steps, a new fall prevention program at Cooper, is trying to avoid hospital readmission among people who have fallen. After watching the hospital's fall-related patient load increase—despite the trauma center's community presentations on fall prevention—the hospital set out to find a better model. "If you look at the fall prevention programs that are out there," Devine said, "it's pretty generic vanilla education."

Cooper teamed up with Jeffrey Brenner, and in October launched a program that combines fall education and resources with in-home visits from Cooper staff. After discharge from the hospital, the SAFER Steps team visits participating patients at home. There, a nurse, physical therapist, and community advocate identify risks that could lead to future falls.

In some homes, for instance, "the flooring in the bathroom is like an ice skating rink when it gets wet," Devine said. But often the potential hazards are less obvious, such as the vision problems of a patient who hadn't had an eye exam in two decades. "A lot of these people live alone and they have multiple medical problems," said Lachant, who works on the program. "They're on multiple medications. There are vision problems. Trip-and-falls happen. In a lot of cases, they don't realize they're 85 years old and they can't do what they did when they were 60 or 65."

Once the dangers are highlighted, the team connects the patient with resources to fix them—everything from a referral for an eye exam to a new walker and a tutorial with a physical therapist on how to use it. For Jenkins, one of the program's first patients, the problems were inside her home. Through a partnership with St. Joseph's Carpenter Society, in which Cooper buys supplies and the society donates labor, Jenkins will have carpeting put down in her bathroom and two small ramps built in her doorways.

The team follows patients over several months, monitoring whether their suggestions have been taken and, most importantly, if the patient has fallen again. So far, none have. There is no charge to patients or their insurance providers. Once the program hits the one-year mark, the Cooper team plans to look for grant funding to expand.

A 2008 report by the CDC encouraged the creation of such community-based fall prevention programs for older adults. The report emphasized the need for education about risk factors and prevention, exercise classes, medication review by a health professional, vision assessment and correction, and a home safety assessment, including modifications if necessary.

Bayada Nurses, a home healthcare company based on Moorestown, NJ, also focuses on falls—even for patients who have never taken a tumble. Fall prevention has always been a staple of patient assessment for Bayada, staff members said. But its importance has increased as hospital stays have grown shorter, they said, leaving some discharged patients weaker and less educated about their own home care.

Paul Martin Jr., 70, suffered a stroke a decade ago that weakened the right side of his body, yet he still navigated the stairs and hallways of his longtime Camden home. But after a recent bout with ulcerative colitis confined him to a hospital bed for three weeks, Martin's strength deteriorated. Despite two weeks of rehabilitation, his endurance was low and he couldn't walk without support, said Abayomi Ramos, Martin's physical therapist from Bayada. Martin was classified as a high fall risk.

After an initial assessment in December, Ramos worked with Martin on walking up and down the stairs and getting up from his favorite chair with a single attempt. Martin saw physical improvement—he answers the door much faster now—but he also became educated about how a fall could endanger his active lifestyle. "If you're independent and you have that drive," he said, "you'll try not to do things that are going to harm you."

It's no surprise that hospital readmissions are a major focus of fall prevention efforts, considering how quickly the costs related to fall hospitalizations add up. When Newton studied fall-related hospitalizations among North Philadelphia residents about five years ago, she found that an average hospital stay for a fall injury cost $23,000. Another 2005 study found that the average hospitalization cost for a fall injury is $17,500.

In recent years, Philadelphia hospitals have increased their focus on falls occurring within hospital walls. The ECRI Institute, a nonprofit that researches approaches to improving patient care, in 2007 gathered representatives from 15 Philadelphia-area hospitals to discuss fall prevention tactics.

Following the seven-month program, several hospitals launched medication review procedures to identify patients at high fall risk, said ECRI's Kathryn Pelczarski. For those patients, hospitals added increased precautions, such as bed exit alarms, to prevent falls. Hospitals also developed a list of medications that could compound fall risk—for example, certain antidepressants can cause dizziness and blurred vision—and distributed it to nurses.

Elsewhere around the country, researchers are devising ways to reduce fall hospitalization costs—especially as baby boomers start to hit senior status.

Last year at the Gerontological Society of America conference, a University of South Florida doctoral student presented research indicating that gardening, which has the potential to improve or maintain balance and gait speed, might indirectly prevent or reduce falls. The researcher, Tuo-Yu Chen, said that as one of the most common physical activities among older adults, gardening might be a beneficial addition to fall prevention programs. The psychic benefits of gardening would be a bonus.

This article was written as part of the MetLife Foundation Journalists on Aging Fellowship in partnership with New America Media and the Gerontological Society of America.

CHAPTER 4: IMPROVING DIABETES CARE

Adapted from an article published Friday, Nov. 18, 2011

A health coalition won a $3.45 million grant Thursday to strengthen care for diabetics in Camden, a city where diabetes rates far exceeding the national average add to medical costs and detract from residents' quality of life.

The grant from the Bristol-Myers Squibb Foundation is intended to enhance and deepen a three-year-old, citywide diabetes collaborative, officials said.

Most of the money will go to two or three primary-care practices, expected to be chosen next month. It will allow these practices to individualize care by, for example, hiring nurse coordinators to track diabetics, or hiring peer educators to help patients navigate the healthcare system.

"We're going to have the resources that people up until now only dreamed of," said Steven Kaufman, a Cooper University Hospital diabetes specialist and staff endocrinologist for the Camden Coalition of Healthcare Providers.

The award, to be spread over five years, is the largest single grant for the coalition, a nonprofit with two dozen employees that was founded several years ago by Jeffrey Brenner, the family physician working to improve healthcare in the city.

For Camden diabetics, the funding will mean access to personalized resources they never had before, said Mark DiFilippo, who managed the coalition's diabetes collaborative until taking on other duties recently.

These new resources will allow nurses to know whether patients have been sent to the emergency room with high blood sugar, and even allow nurses to visit them in the hospital, he said. Peer educators will connect patients with diabetes-education classes in their neighborhoods. Patients will receive one-on-one mentoring from an endocrinologist and have access to social workers who can help with medication and housing.

"We're talking about a really individualized, customized model of care," DiFilippo said. "By and large, [patients] should expect to improve their diabetes outcomes."

With this new funding, DiFilippo said, the coalition is trying to lower two major hurdles for primary care in Camden: time and money. There are too few primary-care providers in the city, and each of them is spread too thin, he said. Not only that, but they don't have enough financial support to do this specialized work. "They couldn't hire a nurse-care coordinator on their own," DiFilippo said.

In addition to the resources for patients, participating practices will also receive coaching on team-based care to help ease the primary provider's burden. "The whole staff will work as a team," DiFilippo said, adding that the goal is for primary clinicians to focus on patient care while delegating other duties to staff members.

The new grant is one of eight totaling $18.4 million announced by the Bristol-Myers Squibb Foundation to aid populations disproportionately affected by type 2 diabetes. Nearly 13 percent of adults in Camden have diabetes, well above the national average, said Patricia Doykos, director of the foundation.

Minority and poor populations generally are at high risk of developing type 2 diabetes, which has risen dramatically nationwide, in tandem with obesity. Philadelphia's adult diabetes rate is also about 13 percent. North of Philadelphia in Bucks County, by contrast, the rate is 8 percent. "For us, focused on disparities," Doykos said, "we saw that Camden clearly has a need."

Other recipients include Duke University Medical Center, which received $6.25 million to launch community interventions for diabetics; and Feeding America, a charity that will use $3.1 million to pilot food-bank partnerships providing diabetes care.

The foundation is separate from the giant pharmaceutical company, although the latter's CEO, Lamberto Andreotti, is the former's chairman. Bristol-Myers Squibb has major facilities in New Jersey, and it markets several diabetes drugs, including Onglyza and Glucophage.

Nationally, medical expenses for people with diabetes are more than two times higher than for those without it. The condition is estimated to cost more than $174 billion annually in the United States.

In Camden, 29 percent of inpatient hospital costs in 2009 were for treating diabetics for various conditions, not necessarily related to diabetes, according to the data nonprofit CamConnect.

Complications of uncontrolled diabetes can be staggering. It is the leading cause of kidney failure, non-traumatic lower-limb amputations, and new cases of blindness, as well as a major cause of heart disease and stroke. According to the Centers for Disease Control and Prevention, diabetes is the seventh leading cause of death in the United States.

If rates continue to rise along the current trajectory, one in three Americans will have diabetes by 2050, said Ann Albright, a diabetes expert at the CDC. "These are big problems," she said, "and we need big solutions for them."

The Camden coalition initiated its diabetes efforts in 2009 with a $2 million, five-year grant from the Merck Company Foundation. Under that program, projects ranged from a care-management team that visited struggling diabetics to the creation of three diabetes education classes, one in Spanish.

A major part of the Merck-funded work involved transitioning Camden primary-care practices to patient-centered medical homes, a growing model that involves team-based primary care. Some practices implemented electronic health-record systems funded by the coalition, while others launched open-access scheduling, which made most office appointments available the same day they were made.

The goal was for the new technologies to increase efficiency, giving providers more time with patients and reducing no-show rates, which would boost revenue.

The grant announced Thursday will be directed to practices that may compete for the award. They must already have an electronic health-record system, said DiFilippo, the coalition project manager, or have plans to start one. A team of coalition board members will choose practices by the end of December.

The goal extends beyond improving care for Camden diabetics, he said, to reach patients on a broader scale. "Everything we're doing we believe deeply in," DiFilippo said. "We're hoping to become a model nationwide."

CHAPTER 5: KEEPING DIABETICS HEALTHY

Adapted from an article published Monday, June 11, 2012

While driving in 2007, Jeanine Freeman suddenly went blind. An elderly passenger had to reach over and put her Dodge Caravan in park. Freeman's blindness lasted for about three days—all due to her out-of-control diabetes. And over the next few years, the 48-year-old woman was in and out of local hospitals battling nerve damage and other complications from a disease she'd had since her 20s.

Late last year, help came from a nurse with the nonprofit Camden Coalition of Healthcare Providers, who visited Freeman at her home in the city's Centerville section. The nurse watched as Freeman checked her blood sugar levels. She provided a pillbox to organize her medications. She put Freeman on a meal schedule and advised her to substitute tuna and grilled chicken for pasta and hot dogs. And she connected her to a diabetes specialist. "It's under control now," Freeman said of her diabetes. "I don't have problems with it."

Controlling diabetes and reducing costly hospital stays are two goals of Jeffrey Brenner, the coalition's executive director. Backed by several large grants, including a recent $2.8 million federal Health Care Innovation Award, Brenner and his team are undertaking one of the nation's most important healthcare experiments. They aim to halt the inexorable rise in health costs in part by caring for patients more effectively in one of the country's poorest cities.

Much of their focus is on diabetes. "If you improve the care for diabetics," Brenner said, "you improve the care for lots of complex patients."

A $5 million patient

The coalition started by looking deeply at the city's dysfunctional health system. Hospital bills showed that half of city residents use the ER each year, often for minor problems. Just 13 percent of patients were responsible for more than 80 percent of the costs. One Camden patient alone rang up nearly $5 million in charges over five years.

The coalition has responded by organizing teams to reach out to the sickest patients and put a nurse-led clinic in the apartment building Northgate II. It helps primary-care practices get electronic medical records and offer patients more same-day appointments so they can avoid the ER. And it even works to reduce shootings by meeting with people involved in those incidents and helping them escape the cycle of violence.

State legislation enacted last summer will help Brenner take his ambitious approach to the next level, creating a Medicaid ACO in Camden. The effort could enable providers to keep some savings if they meet quality benchmarks for patients. "An ACO, in my mind, is made up of lots of well-run projects that add up to better care at lower cost," Brenner said. "We've been putting the training wheels on and learning how to build the components."

Focus on diabetes

Diabetics will continue to be a focus of the group's effort. In Camden, 29 percent of inpatient hospital costs went to treat diabetics in 2009, according to the data nonprofit CamConnect. Nationwide, medical expenses for diabetics are more than double than for people without the disease.

The most common form of diabetes, type 2, occurs when the pancreas does not make enough insulin to regulate blood sugar normally. Symptoms include high blood-sugar levels, increased appetite and thirst, fatigue, and blurred vision. There is no cure.

Treatment typically requires a regimen of healthy eating, regular exercise, and oral medication or insulin injections. "There is no simple, straightforward solution for the vast majority of people," said Arthur Chernoff, chair of the Division of Endocrinology at Albert Einstein Healthcare Network in Philadelphia.

Camden's diabetes rate is higher than the national average. CamConnect says nearly 13 percent of the city's adults are diabetic, compared with a national rate of 11.3 percent.

That's partly because of Camden's demographics. Poor people in dangerous communities tend to be at higher risk for obesity because they lack access to healthy foods and safe places to exercise. Also, according to the Centers for Disease Control and Prevention, diabetes risk is 77 percent higher for blacks and 66 percent higher for Latinos than for whites. Camden is about 48 percent black and 47 percent Hispanic.

Innovations in care

Innovative approaches to diabetes control are becoming even more important as federal healthcare reform progresses to cover more people and stretches the already short supply of primary-care doctors.

The Camden coalition augments doctor visits with a care-management team that makes home visits and gives nutrition education classes. "You need a multipronged effort to change the management of chronic illnesses in Camden," said Steven Kaufman, the coalition's staff endocrinologist and a diabetes specialist at Cooper.

One thing that makes the coalition's approach exemplary is its focus on "trying to get a critical mass of effort" to help underserved diabetics, said Ann Albright, director of the CDC's Division of Diabetes Translation.

Since the coalition landed a $2 million, five-year grant from the Merck Company Foundation in 2009, it has been transforming 10 city primary-care practices to patient-centered medical homes. A $3 million grant last year from the Bristol-Myers Squibb Foundation will accelerate practice changes at Virtua's Kyle W. Will Family Health Center and River Road Primary Care.

Six city practices have implemented electronic health-record systems, some funded by the coalition. Patrick Ervilus, a nurse practitioner in Cramer Hill, said the coalition gave his practice such a system, along with training. "We're able to be more effective in tracking down [patients] who are in need the most," he said.

How to avoid complications

While access to primary care is key to diabetes control, patients largely face the disease on their own. To educate Camden's diabetics, the coalition helped launch three classes in the city, including one in Spanish.

At a typical class at the Fairview Village Community Center last year, the topic was blood glucose monitoring. Francine Grabowski, a registered dietitian and certified diabetes educator, led the class, outlining the dangers of blood sugar surges, which had plagued two of the class participants in the previous week. Grabowski showed the class foods they could eat, such as fruit snacks, if their blood sugar dropped.

When talk shifted to meat and protein, Grabowski urged participants to make sure the protein per serving of meat was at least double the fat per serving. She passed around food packages and asked class participants to read the nutritional information.

Carmen Camacho, an animated 64-year-old diabetic, discovered a package of breakfast sausage with twice as much fat as protein. "You're not buying meat," Grabowski pointed out. "You're buying fat."

Noting that she'd seen this sausage sold for just 88 cents, Camacho said, "People have to live on an income."

Diabetes education encourages patients to be more self-reliant, said Chernoff, the Einstein endocrinologist, who is not affiliated with the Camden effort. "If the patient is empowered to take care of themselves and learns how to do it, that's a huge step in solving and dealing with and avoiding a lot of the complications that can emerge."

The coalition's care-management team, which helped Freeman, steps in when Camden diabetics need more support than weekly classes can provide. The team initially focused on the highest users of ER care, but now targets high-cost hospital patients identified by UnitedHealthcare's Medicaid unit in Camden.

Peering into a patient's refrigerator and medicine cabinet gives providers "invaluable pieces of information," Chernoff said. "There are some people with whom it might make the difference [between] having 15 or 20 trips to the hospital versus none." Equally important is access to a case manager during off hours, when the only other option for care might be the ER, Chernoff said.

So far, indications of success for the Camden diabetes initiative are anecdotal. Brenner said a thorough study will take six to nine months to complete.

Administrators from Camden's three hospitals—Lourdes, Virtua, and Cooper—said the coalition had improved primary care and cut unneeded admissions and costs.

"The coalition gives us hope that we can really make a difference for the population," said Joan M. Gray, director of ambulatory services at Virtua Camden. "Whereas everyone was struggling individually before, working as a group truly feels different. We have a vision of what it can be."

This reporting was supported by the Dennis A. Hunt Fund for Health Journalism, administered by the California Endowment Health Journalism Fellowships, a program of the University of Southern California's Annenberg School for Communication & Journalism.

CHAPTER 6: HELPING VIOLENCE VICTIMS

Adapted from an article published Monday, June 18, 2012

A turning point can come at an unexpected time in a person's life. For Isaiah Jones, it was getting shot at age 19.

By his own admission, Jones was in the drug trade, and a 2009 arrest and subsequent guilty plea to a lesser charge made him want to get out. A man Jones knew was unhappy with this decision, and shot him once in the left knee while he stood in front of his Camden home, court records show. "He got mad 'cause I ain't do nothing for him," Jones recalled. "It was either, 'you get down with me, or you lay down.'"

Jones chose another way out. He hooked up with Victor Murray, who runs the Camden GPS Program, a violence-prevention effort for the city's assault victims. Murray helped Jones get mental healthcare, apply for jobs, and alter the trajectory of his life. "Victor, he a friend of mine," Jones said of Murray. "I can tell him whatever. He understands. He's a little more than a friend because he can go out and make things happen."

In Camden, violence is so common that it has become a public health concern. With 77,000 residents, Camden is often ranked among the country's most violent cities. In 2010, FBI crime data documented over 1,000 aggravated assaults—more than 13 for every 1,000 residents, which is five times the national rate.

These assaults lead to much medical misery. From 2002 to 2009, Camden residents made 9,361 trips to the hospital due to injuries from assaults, data show.

The Camden Coalition of Healthcare Providers launched Camden GPS in 2010 to provide what could be called preventive medicine for assaults. Murray became the nonprofit's intervention specialist.

Funded by grants, Camden GPS is poised to become part of an ambitious effort, an ACO, a three-year Medicaid project that seeks to improve care and drive down costs. The coalition offers many strategies to keep people healthier. It collects data to discern trends and work to improve care of the sickest and most costly patients, among many others.

The coalition's executive director, Jeffrey Brenner, was instrumental in getting state legislation passed last year to authorize the ACO.

Camden GPS tries to stop the cycle of violence and help assault victims avoid future hospital stays. The effort usually begins when a young gunshot or stabbing victim comes through Cooper's emergency room. If the victim is a city resident and 24 or younger, hospital staff members alert Murray, who visits the victim, usually in the hospital, to talk about how he or she got there.

This real-time response catches victims in the moments of reflection that often follow a violent episode. "They realize they need something better," said Murray, 27, who grew up in Camden.

Jones fits that description. He told Murray how he ended up jobless, on probation, and recovering from a shooting.

When Jones was 10, two men fatally shot his parents in their Wilmington home. After living a few years with family in Virginia, Jones moved in with an elderly aunt in Camden. For the 13-year-old, the drug dealing and shootings in his new city were surreal. "It was like a movie to me when I came here," he said.

But within a few years, Jones said, he became part of that culture. "My aunt gave me $5 a day," he said. "I'm 16. I'm not going to survive on $5 a day. By the time I get home, I'm hungry."

Jones said he began selling drugs, and was arrested in July 2009. "After I caught my charge, I slowed down," Jones said. He pleaded guilty to fleeing arrest and served a few weeks in jail.

His girlfriend gave birth to their daughter in March 2010, and seven weeks later Jones was shot. He had been stabbed in a melee several years before, but the shooting shook him. He started talking in his sleep. He'd dream that he was trying to run away from his assailant, but that his feet moved so slowly he couldn't escape.

After hearing his account, the Camden GPS team knew Jones was an ideal candidate for the program. "We want to grab the kid and hold their hand while they're going back out in their life," said Judyann Gillespie, senior program director of adolescent counseling at the Center for Family Services, which works with Camden GPS. "He's a classic example of where systems should have intervened many years ago."

Like Jones, most participants in Camden GPS have had run-ins with the law and become parents at an early age. Many are high school dropouts. Some were the victims of wrong-place, wrong-time violence, but most were targeted. "We don't discriminate," Murray said. "A victim is a victim."

In most cities, victims are released from the hospital without much guidance on how to reenter the world. "Historically, they have just sent them back out on the street," said ER physician Patty Vitale, the Cooper liaison for Camden GPS. "We are saving the system a lot if we can keep these kids out of trouble and get them to be productive in society."

As with the coalition's medical programs, a major goal is to save taxpayers money. "Projects that touch people's lives individually can make a substantial impact on the city," Brenner said. "If you target the right people who are at transition moments in their life, the resources can be really well used."

Those resources differ for each participant. One assault victim needed transportation to a medical appointment in Sewell approximately 13 miles away to have sutures removed, Murray said. Murray got him a ride, averting a much more expensive ER visit.

For a participant who needed furniture, Murray found some on Craigslist and enlisted friends to help deliver it. When another yearned to play the piano, Murray set out to find an instructor. "It's more than just the gunshot or the stab wound that needs to be healed," Murray said. "It's the person as a whole."

For Jones, Murray battled to secure public assistance and funding for violent crime victims. He arranged counseling and drove him to the appointments in Haddonfield, several miles away.

He connected Jones' girlfriend with a part-time job and watched over Jones' shoulder as he filled out job applications. A temporary bakery job Jones secured didn't last in part because he still can't stand for long periods due to the shooting.

Undaunted, Murray smelled the fried chicken Jones was cooking during a home visit one day, and encouraged him to consider cooking school.

Murray worked with 30 victims for eight months after the program's inception in February 2010. Funding problems forced him to stop taking referrals for a time, but now he has 21 participants and is slowly growing the group.

Camden GPS is one of at least a dozen programs nationwide—including Healing Hurt People at Drexel University in Philadelphia—that try to help victims of violence beginning in the hospital. Research on the effectiveness of these programs is promising but inconclusive.

A study of Caught in the Crossfire, an Oakland, California, program, found that young people served by the program were 70 percent less likely to be arrested and 60 percent less likely to have any criminal involvement in the future compared with the control group.

The Violence Intervention Program in Baltimore found no significant difference in the number of arrests between those helped and a control group, but those in the control group were more likely to be arrested for and convicted of violent crime.

Since the Camden GPS launched, Murray said, only two participants have landed back in the hospital. Brenner said there are not enough cases yet to measure the project's success.

So far, the approach has helped Jones, who has resisted old habits. Now a father of two, Jones, 21, has had no more violent incidents. He asks Murray to avoid certain streets when they drive together, fearing former associates will spot him and pressure him back into drugs.

This reporting was supported by the Dennis A. Hunt Fund for Health Journalism administered by The California Endowment Health Journalism Fellowships, a program of the University of Southern California's Annenberg School for Communication & Journalism.

AFTERWORD

Since the most recent of the articles included here was published more than a year ago and I no longer cover the coalition's work regularly, I asked Brenner for an update in August 2013. Here's what's going on with the coalition now:

The state has issued a draft of its regulations for ACOs. It's expected the state will begin accepting ACO applications in early 2014. (The Camden coalition's application was turned in months ago.)

The Camden health-information exchange is growing to encompass residents and healthcare providers throughout the region, not just those in Camden. Along with the three hospital systems already participating, another southern New Jersey medical center, Kennedy Health System, is poised to join the exchange.

The health-information exchange is also changing the coalition's care-coordination project, in which teams consisting of a nurse, a health outreach worker, and a social worker visit patients in their homes. Every morning, the teams receive a list from the exchange showing patients who have been hospitalized overnight and they use that list, rather than referrals, to determine which patients need their services. The long-term goal is for every Camden healthcare provider to wake up every day to a list of his or her patients who have been hospitalized. "How do you catch every hospitalized patient in every practice in the city?" Brenner said.

A data analysis of Northgate II found that only about 30 of its 600 residents drive the building's inpatient hospitalization rates. Because those 30 residents are often sick, disabled, and unable to visit the building's clinic meant to help them, the coalition is adding care coordination in Northgate II by hiring a program manager and nurse to visit the neediest residents. "I want to bend the cost curve in one building" before opening more clinics, Brenner said. "I feel like we're finally homing in on the right strategy."

While continuing diabetes education classes, home visits, and other work, the coalition's Camden Citywide Diabetes Collaborative is focusing its efforts on redesigning how primary-care practices treat diabetics. The coalition is taking a deep dive into two practices to perfect workflows, data elements, training modules, and more. The goal is to be ready to deploy this model across the city when the ACO flips on.

Along with continuing the violence-prevention program, the coalition has added a new effort centered on pregnancy and parenting. This keeps with the primary mission of the coalition's projects: to reach patients at a catalytic moment when they face choices about what to do next and how to take care of themselves. "Are you ready to change and do you want to start living your life in a different way?" Brenner asked. "How do we do that?"

SOURCES

Chapter 1

A study by the Harvard School of Public Health last year found that eliminating redundant tests would have saved U.S. hospitals $8 billion in 2004 alone:

Jha, Ashish K., et al. "Improving Safety and Eliminating Redundant Tests: Cutting Costs in U.S. Hospitals," *Health Affairs* 28, no. 5 (September/October 2009), http://content.healthaffairs.org/content/28/5/1475.full.

Chapter 3

Nationally, one in three seniors falls every year, and this is the leading cause of injury death for people 65 and older, according to the Centers for Disease Control and Prevention. The costs are staggering. In 2000, direct medical costs of falls totaled more than $19 billion, said the CDC, which is encouraging groups to create programs nationwide:

CDC, "Falls Among Older Adults: An Overview," http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html.

Falls are the leading cause of fractures in older adults and of traumatic brain injuries, according to the CDC, and fall-related injuries can increase the risk of early death:

CDC, "Falls Among Older Adults: An Overview," http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html.

A 2008 report by the CDC encouraged the creation of such community-based fall prevention programs for older adults. The report emphasized the need for education about risk factors and prevention, exercise classes, medication review by a health professional, vision assessment and correction, and a home safety assessment, including modifications if necessary:

CDC, "Preventing Falls: How to Develop Community-based Fall Prevention Programs for Older Adults," 2008, http://www.cdc.gov/HomeandRecreationalSafety/images/CDC_Guide-a.pdf.

Chapter 4

Nationally, medical expenses for people with diabetes are more than two times higher than for those without it. The condition is estimated to cost more than $174 billion annually in the United States:

CDC, "National Diabetes Fact Sheet," 2011, http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.

Complications of uncontrolled diabetes can be staggering. It is the leading cause of kidney failure, nontraumatic lower-limb amputations, and new cases of blindness, as well as a major cause of heart disease and stroke. According to the Centers for Disease Control and Prevention, diabetes is the seventh leading cause of death in the United States:

CDC, "National Diabetes Fact Sheet," 2011, http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.

Chapter 5

Also, according to the Centers for Disease Control and Prevention, diabetes risk is 77 percent higher for blacks and 66 percent higher for Latinos than for whites. Camden is about 48 percent black and 47 percent Hispanic:

CDC, "National Diabetes Fact Sheet," 2011, http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.

Chapter 6

In 2010, FBI crime data documented over 1,000 aggravated assaults—more than 13 for every 1,000 residents, which is five times the national rate:

FBI, "New Jersey: Offenses Known to Law Enforcement," 2010, http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2010/crime-in-the-u.s.-2010/tables/table-8/10tbl08nj.xls.

A study of Caught in the Crossfire, an Oakland, California, program, found that young people served by the program were 70 percent less likely to be arrested and 60 percent less likely to have any criminal involvement in the future compared with the control group:

Youth Alive, "Caught in the Crossfire: Closing the Revolving Door of Violence," 2010, http://www.youthalive.org/caught-in-the-crossfire/.

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