

PROFILES IN INNOVATION



Jeffrey Brenner, MD, is the founder and executive director of the Camden Coalition of Healthcare Providers, a non-profit organization dedicated to improving the health of high-cost, high-need patients in Camden, New Jersey. Dr. Brenner is a family physician who has practiced in Camden for 15 years. He is also on faculty at the Robert Wood Johnson Medical School.

ABOUT THE INNOVATOR

Looking for a career in medicine that promised both rigor and challenge, Dr. Jeffrey Brenner was an aspiring neuroscientist, until he discovered that the field of primary care offered an opportunity to tackle some of the most persistent challenges in health care. He now leads the Camden Coalition of Healthcare Providers (CCHP), and has become one of the most visible and vocal change agents for rethinking the way care is delivered to vulnerable patient populations.

Dr. Brenner started out practicing primary care in Camden in 1998, settling into one of the country's most crime-ridden and impoverished cities. Although committed to the work and his patients, he became increasingly frustrated by how little improvement most patients made, and the extent to which their health problems were compounded by issues he could not treat in his clinic, such as poverty, housing, and lack of access to supportive services.

In 2002, Dr. Brenner began convening monthly breakfasts with providers from Camden's many clinics and hospitals who eventually coalesced around the idea of working across systems and using innovative and non-traditional approaches to improve patient care. The following year, this informal working group became the provider-driven CCHP.

He garnered national attention following an article written about his efforts in the *New Yorker* in January 2011, called "The Hot Spotters." The article, authored by Dr. Atul Gawande, told the story of how Dr. Brenner was inspired by his time as a citizen-member of the Camden police reform commission to look at medical data in a new way. The commission explored a technique known as CompStat to map neighborhood crime and allocate police resources more appropriately. Using the same principles, Dr. Brenner began exploring local hospital utilization data. He knew that many of Camden's highest utilizing patients were showing up repeatedly in area hospitals, but was amazed to discover that a huge percentage of these patients resided in two buildings within just a couple of blocks from each other, and were racking up astronomical medical costs.

"The problem with health care is that if something doesn't work, we just 'ad hoc' it every day instead of coming together as a team and saying, 'Okay, we're going to tolerate some failures but we're going to track them as a team and do a systematic redesign of the intervention to catch those failures.'"

After officially becoming CCHP, the group was able to secure foundation funding to hire a small staff, including a nurse practitioner and a social worker, to provide medical and care coordination services to high cost, complex patients throughout Camden. One of the organization's earliest endeavors strategically targeted the buildings with high concentrations of complex patients. In one of these buildings, called Northgate 2, the Coalition worked with community groups, residents, and a local primary care organization to open a two-room primary care office on site.

Under Dr. Brenner's guidance, CCHP has grown to a staff of over 40 people, ranging from health coaches to physicians to researchers. It has forged relationships with individuals and organizations throughout the community, and is operating a series of programs specifically designed to work with Camden's highest-need residents. Beyond Camden's borders, Dr. Brenner is now actively involved in efforts to replicate CCHP's model elsewhere in New Jersey through the development of accountable care organizations, and in communities across the U.S. through a Health Care Innovation Challenge grant from the Center for Medicare and Medicaid Innovation.

The Center for Health Care Strategies' Complex Care Innovation Lab, made possible by Kaiser Permanente Community Benefit, is bringing together leading innovators working to improve care for vulnerable populations with complex medical and social needs. Participants will explore new ways to advance complex care delivery at the local, state and national level. These profiles highlight Innovation Lab participants. For more information, visit www.chcs.org.

ABOUT THE INNOVATION

Camden Coalition of Healthcare Providers

Program Description: The Camden Coalition of Healthcare Providers (CCHP) is a non-profit dedicated to improving the care of Camden's sickest and highest-cost patients. It launched its first care management team in 2007, taking referrals from local emergency room (ER) physicians, hospitals, and social workers. The program targeted patients who touched ERs and/or had inpatient visits, and worked with them to prevent readmissions and provide comprehensive, short-term care coordination services. Today, CCHP operates two distinct care management interventions: an outreach team that serves the highest-need patients across Camden (Link2Care), and a second team that serves a panel of patients drawn exclusively from two primary care offices participating in practice redesign activities (Integrated Diabetes Care (IDC)). The programs use real-time hospital data fed through CCHP's Health Information Exchange, which was created and continues to be run by the organization.

Population: Camden residents identified through data analysis as being high-utilizers of health care services, the vast majority of whom are Medicaid or Medicare beneficiaries. Since its inception, CCHP has served approximately 300 patients.

Delivery Model: To identify patients, staff review admissions, discharge, and ER visit data on a daily basis via the Health Information Exchange, which contains patient data from over 100 area providers and two Camden hospitals. Outreach staff meet with patients at the bedside following a hospital admission and determine if they are ready to change the way they interact with the health care delivery system and manage their health. Staff visit enrolled patients at their homes within 24-48 hours of discharge, accompany them to a primary care visit within seven days, and provide linkages to specialty care, social services, and other necessary resources. Patients may be served for 30 days, 60 days, or longer, depending on the intensity of their needs. Teams are nurse-led, and also have health coaches, community health workers, and social workers available for consultation.

Financing: In 2012, CCHP, via Cooper University Hospital, was awarded a \$2.8 million Health Care Innovation Award to expand the Link2Care program.* CCHP also has grant funding through various foundations, including Bristol-Meyers Squibb, Merck (which funds IDC), and the Robert Wood Johnson Foundation. CCHP also receives funding from five local hospitals. Its current annual operating budget is about \$5 million.

KEYS TO SUCCESS

1. **Have a high tolerance for risk, failure, and imperfection**, but make "lots of small bets," as learning from failures can be far more instructive than analyzing successes;
2. **Create flexible delivery systems that can be easily adapted** based on program outcomes and/or feedback; and
3. **Do not over-invest in IT infrastructure** – organizations may be surprised at how much they can do on their own with commonly available data analysis, database, and mapping tools.

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Spotlight: Serving Only Those Who Are Ready

Although CCHP's care management models are unique in many ways, one notable feature is that the practice transformation initiative (IDC) focuses only on patients who are deemed "ready to change." As Dr. Brenner explains, CCHP's ability to show long-term outcomes "would reduce to zero," if the organization did not target patients this way. "It's been a real challenge for us to come to consensus that some patients aren't ready to change, and that we can't afford to work with them," he says.

To determine who is ready for change, the CCHP has adapted the University of Rhode Island Change Assessment (URICA), a validated tool, which uses motivational interviewing and the stages of change theory to probe into a patient's mindset and circumstances. Enrolled patients are provided services for only up to 90 days.

CCHP believes that the emphasis on a 30-60 day intervention helps keep the outreach teams and patients goal-driven with a concrete plan and timeframe in place. Although it is not unusual for patients to cycle through the care management intervention repeatedly, CCHP still sees this brief intervention timeframe as being much more cost-effective than providing on-going care coordination services. These models allow CCHP to serve more people in a given year than a traditional long-term case management program, enabling the team to reach what Dr. Brenner calls the low-hanging fruit. "I believe that there are lots of really, really sick, complex, expensive people out there who just need a 30-, 60-, or 90-day touch to tip over into self-management," he says.

Dr. Brenner believes that this model will not only yield large savings, but also highlights the need for an entirely separate system of care for high-cost patients who require long-term care coordination.