

Prescriptions for Excellence in HEALTH CARE

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Building an Accountable Care Organization in Camden, NJ

By Jeffrey Brenner, MD

As our nation surpasses \$2.5 trillion in health care spending¹ - \$1 of every \$5 spent - health reform efforts will increasingly focus on reducing costs. Expanding coverage is relatively easy; lowering costs is much harder. Today every stakeholder in the health delivery system is working to maximize revenue by increasing market share and volume. Fifty years of learned behavior will be difficult to change, even if changes are made to the reimbursement system.

Policy makers must begin to lay the groundwork for the new behaviors that must emerge (ie, the ability to collaborate across institutions, coordinate care, improve safety/quality, share data, share resources, expand primary care, conduct regional health planning). Sadly, organizations capable of facilitating these activities do not exist in most regions.

For too long we have depended on entities far removed from the point of care to change provider and hospital behavior. Health insurers have used preferred contracts, referrals/precertification, and remote nurse call centers. In general, these blunt tools for altering behavior have failed to lower health care costs. Providers and hospitals have learned how to subvert these cost control efforts. Moreover, the highest cost patients do not

respond to remote nurse call centers with no face-to-face contact.

Ultimately all health care is local. Driving down costs and improving quality will require health care providers to work together with hospitals and social service providers on a collaborative mission that focuses on the needs of their patients and community.

Evidence from the Dartmouth Atlas

The importance of the local health care marketplace has been highlighted by the Dartmouth Atlas,² which demonstrates unacceptable regional variations in cost and health care utilization for Medicare patients. The Atlas shows that costs in a state, region, city, or hospital are tied more to health care supply than patient need. Indeed, high-cost regions are characterized by:

- Oversupplies of specialists and hospitals
- Ineffective use of primary care
- Uncoordinated and often unnecessary services of no benefit to the patient.

The behavior, costs, and utilization in a region are tied to the complex relationships and habits that develop

between primary care physicians, hospitals, and specialists. Researchers have documented that patients who receive health care in a highly integrated system, such as Kaiser Permanente, receive higher quality care at a lower cost.

Atlas researchers are calling for the creation of an integrated health delivery organization that mimics the behavior of tightly integrated organizations. These Accountable Care Organizations (ACOs) would use payment arrangements as incentives for local providers and hospitals to provide high-quality, efficient, cost-effective, and integrated care. Payment reforms might include gainsharing, bundled payments, no payment for readmissions, pay for performance, expanding primary care through the patient-centered medical home, and global capitations.

Building the Camden Coalition of Healthcare Providers

Local health care providers have been working for 8 years to build the Camden Coalition of Healthcare Providers (CCHP), a nonprofit organization committed to improving the quality, capacity, and accessibility of the health care delivery system in Camden, NJ.³

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The Coalition built a citywide health database using claims data from 3 local hospitals. The database now contains the name, address, date of birth, date of admission, insurance status, diagnosis codes, charges, and receipts for every Camden City resident who has been to a local hospital or emergency room (ER) from 2002 through 2007. These data revealed that 50% of the city's residents use an ER or hospital every year - twice the national rate. The vast majority of these visits are for acute and chronic problems that could be prevented with better access to primary care.

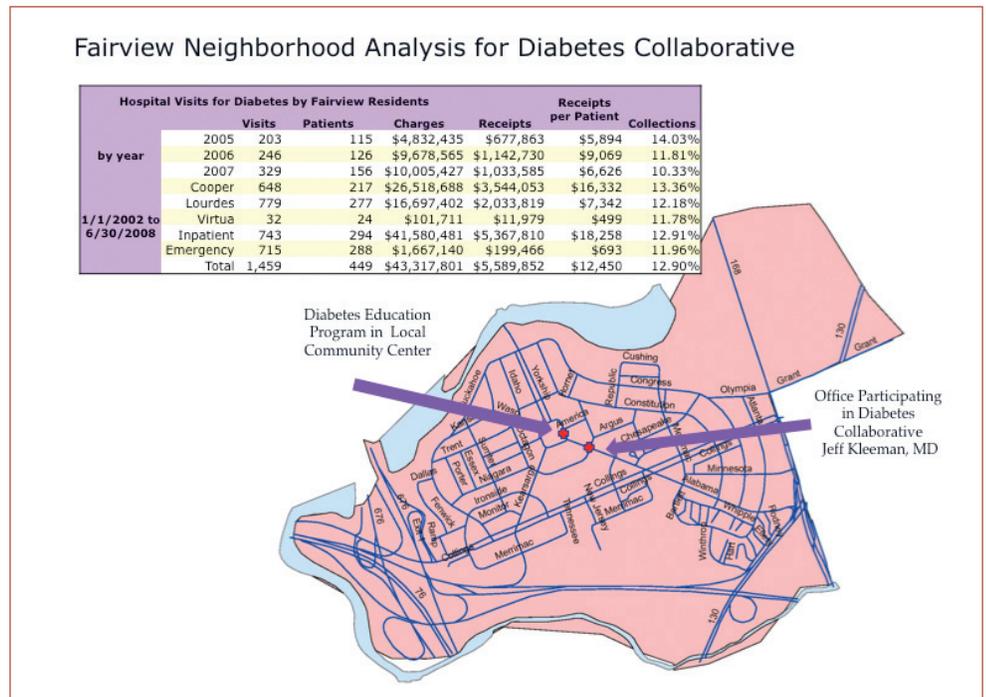
From 2002 to 2007, 13% of the patients accounted for 80% of the costs (mostly to Medicaid and Medicare) and 20% of the patients generated 90% of the costs. The most expensive patient had \$3.5 million in receipts. The top 1% of patients (1035 residents) visited the ER and hospital between 24 and 324 times.

Targeting Super Utilizers

The database provided critical information that eventually galvanized support from local stakeholders and foundations to target high-cost/high-needs patients. These patients have significant barriers to care including homelessness, substance abuse, severe chronic illnesses, physical disability, and mental health problems. The chief advantage of a citywide coalition is its ability to encourage collaboration and data sharing among hospitals, to identify common challenges, and to address the challenges with coordinated solutions. Our project tracking data showed an initial decrease in these individuals' utilization parameters and an improvement in their collections rate.

For much of Camden's population, reducing ER and hospital utilization will require transforming local primary care offices into high-performing, modern, patient-centered medical homes, with features such as multidisciplinary care teams, electronic health records, open-

Figure 1. Neighborhood-Level Analysis of Diabetics Using Local Emergency Departments and Hospitals



access scheduling, and patient registries. In reality, primary care providers and clinics operating in underserved communities struggle to keep their offices open. Unsafe communities, break-ins, low reimbursement rates, complex patients, and difficult insurance requirements create monumental challenges to providing high-quality care. Our Coalition has begun to lay the groundwork for transitioning local practices into National Committee for Quality Assurance-certified medical homes through monthly office manager meetings, provider education programs, individual practice assessments, and technical assistance.

Camden Diabetes Collaborative

Recently, the CCHP received a \$2 million, 5-year grant from the Merck Foundation to build the Camden Diabetes Collaborative. The goals of this collaborative include:

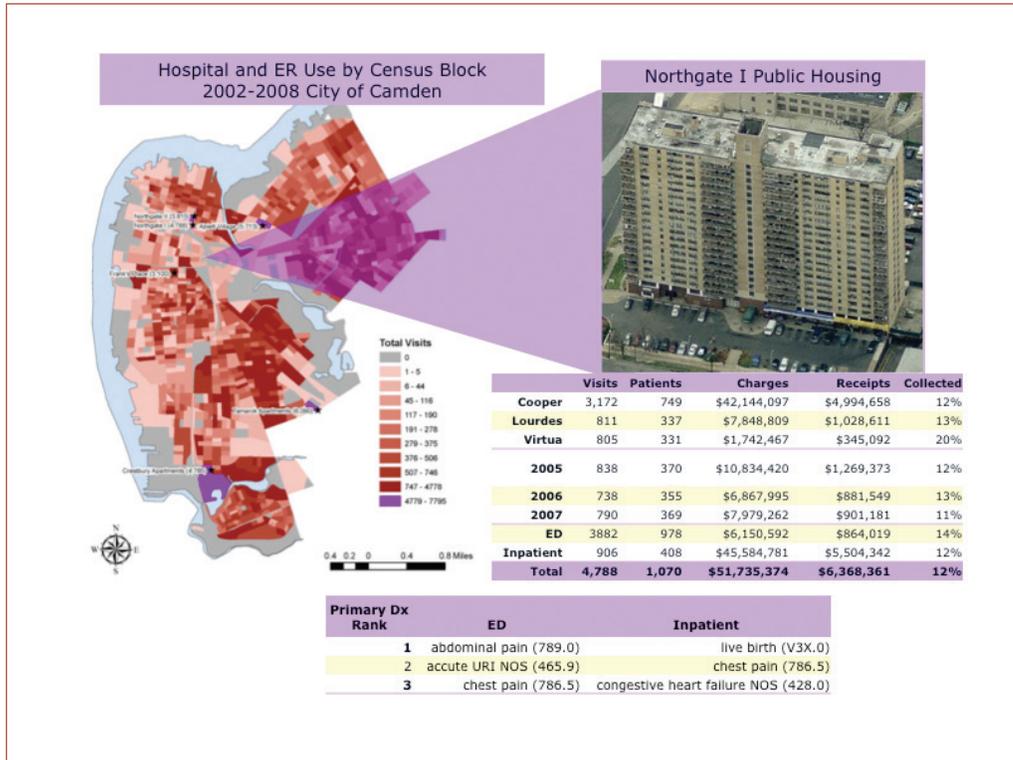
- To transform 10 local practices into patient-centered medical homes using the Chronic Care Model for patients with diabetes

- To develop accessible, neighborhood-based diabetic education programs with ongoing peer-led self-management programs
- To target high-cost/high-needs patients with diabetes via a mobile outreach team in partnership with local primary care providers
- To improve the capacity of local medical day programs to care for their patients with diabetes
- To create new opportunities for patient education using CDs, DVDs, and the local cable access channel

Much of this effort is driven by the hospital claims data assembled in the health database. The Coalition has mapped the claims data for diabetic patients at the neighborhood level (Figure 1). The next step will be to match individual primary care billing data with the hospital data, allowing the Coalition to identify the hospital

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Figure 2. ER/Hospital Use by Census Block: Claims Data Analysis for One "Hot Spot"



and ER utilization of the patients in each practice, regardless of payer.

In the first year, each practice will be asked to work with the Coalition's high utilizer team to target 4 of their most expensive diabetic patients. The database will be used to measure outcomes.

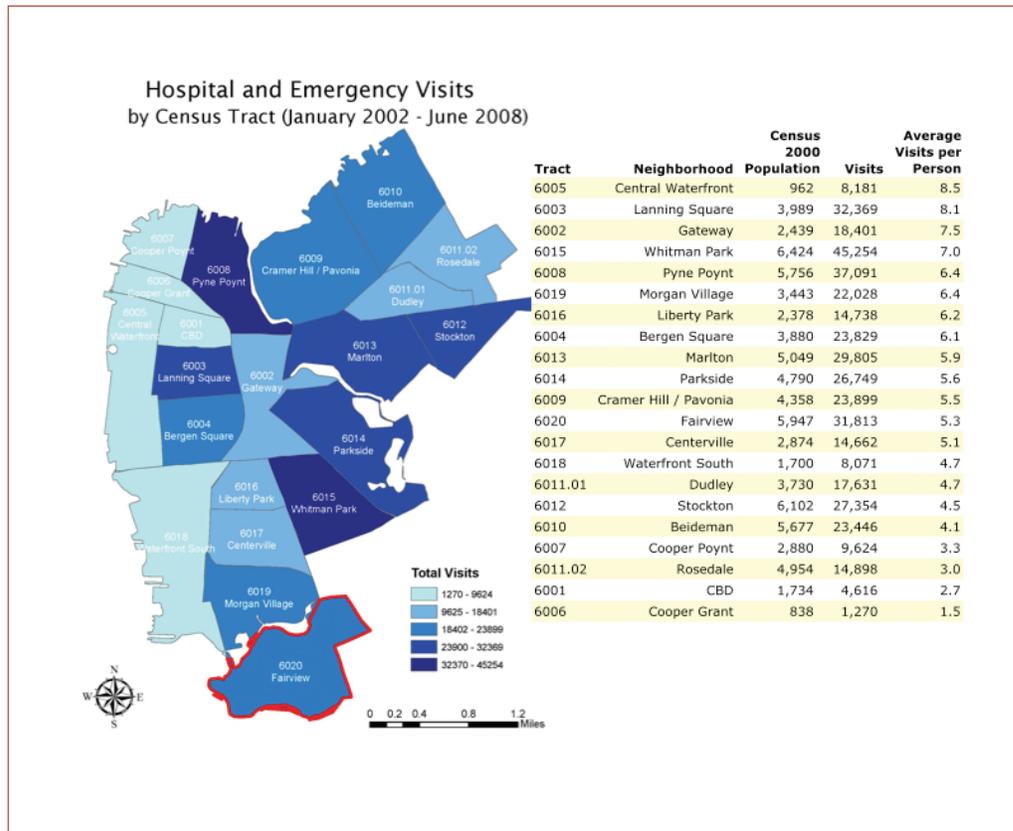
Expanding the Analysis

Using the citywide claims database, the Coalition has begun to expand its analysis to find key opportunities to reduce costs by reducing ER and hospital utilization across the community (Figures 2 and 3).

Building an Accountable Care Organization

As noted previously, ACOs are envisioned as voluntary community-based groups of providers capable of delivering coordinated, high-quality, and cost-effective care. The providers, from various corporations and/or group practices, would receive incentive-based, gainsharing payments in exchange for lowering costs and increasing quality.

Figure 3. Analysis of ER/Hospital Use at the Census Tract Level



CCHP hospital data show that patients who make excessive use of ER and hospital services move from ER to ER and hospital to hospital. In Camden, an ACO would be an integrated group of providers from all 3 local hospitals that focuses exclusively on the special services needs of the underserved patient population. An ACO is most likely to succeed in a small, poor, underserved community like Camden because the market penetration of Medicaid and Medicare is quite high, reducing the amount of coordination necessary between payers.

The CCHP is beginning to exhibit much of the behavior necessary within an ACO, including the ability to understand and use claims data, the linkages needed to build

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collaborations between medical and social service providers, the capacity to provide targeted care management to high-cost/high-needs patients, and the relationships with primary care providers to help with their transformation into patient-centered medical homes.

Jeffrey Brenner, MD is a Clinical Instructor in Family Medicine at the Robert Wood Johnson Medical School in Camden, New Jersey. He is the Medical Director and Founder of the Camden Coalition of Healthcare Providers. He can be reached at: jeffrey.brenner@verizon.net.

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