Camden Coalition Overview

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AGENDA

- **Introduction**: Camden & the Camden Coalition
- **Our Care Interventions**: Local innovation
- **Our Data-Driven Approach**: Using data at the individual, institutional and systems levels
- **Our Systems Impact**: Convening, Advocacy & Technical Assistance
Building a Citywide, All-Payer, Hospital Claims Database to Improve Health Care Delivery in a Low-Income, Urban Community

Kennen Gross, PhD, MPH; Jeffrey C. Brenner, MD; Aaron Truchil, MS; Ernest M. Post, MD; and Amy Henderson Riley, MA, CHES
Camden residents experience poor health outcomes despite disproportionate spending on healthcare.
In Camden & across the country a small number of outlier individuals account for a disproportionate amount of healthcare costs & utilization.

- **Healthcare hotspotting** is the strategic use of data to target evidence-based services to complex patients with high utilization.

- These patients are experiencing a mismatch between their needs and the services available.
Camden Coalition was originally established to improve care models for complex individuals in Camden. **Overtime, we evolved locally and expanded nationally to build a field of complex care.**

- **2002** Frustrated Camden Medicaid providers meet over breakfast to improve care for Camden residents.
- **2007 & 2009** Camden Coalition receives major grant funding from RWJF and the Merck Foundation.
- **2010** Camden Coalition launches the city’s first Health Information Exchange.
- **2011** NJ legislation establishes a Medicaid Accountable Care Organization Demonstration Project.
- **2013** Camden Coalition launches Good Care Collaborative, a statewide coalition to advocate for sensible Medicaid reform.
- **2014** Camden Coalition incorporates as a 501(c)(3) and launches the 7-Day Pledge.
- **2015** Camden Coalition is one of three organizations certified as a Medicaid ACO in NJ.
- **2016** Camden Coalition announces the launch of the National Center for Complex Health and Social Needs.
- **2018** Kathleen Noonan begins as new CEO, the Coalition is awarded an accountable health communities grant, and the Medicaid ACO is extended.
Our Vision & Mission describe our goal of a transformed healthcare system rooted in Camden and spreading across the country.

**VISION**

A transformed healthcare system that ensures every individual receives whole-person care rooted in authentic healing relationships.

**MISSION**

Spark a field and movement that unites communities of caregivers in Camden and across the nation to improve the wellbeing of individuals with complex health and social needs.
We believe that designing the healthcare system to effectively care for individuals with complex health and social needs has the potential to bend the cost-curve.

**Patients with complex health and social needs may have:**

- Multiple chronic illnesses
- A substance use disorder
- A mental health diagnosis
- Early-life trauma
- Unstable housing
- Unreliable transportation
- Inconsistent employment
- Social isolation
- Criminal justice involvement
In addition to their own personal barriers to better care, individuals with complex health and social needs also face systemic issues in the healthcare system.

**Patients with complex health and social needs may face:**

- Access barriers
- Fragmented care
- Duplicative services
- Historic mistrust
We work locally, regionally & nationally to define the field of complex care & transform the delivery of care to individuals with complex needs.

We envision care delivery for people with complex needs that:

- Is person-centered
- Addresses the needs of the whole person
- Embraces inclusive team structures and works across sectors
- Is data-driven
- Is designed in partnership with individuals and communities
Camden Coalition works to improve the health & well-being of individuals with complex health & social needs in the Camden region.
As neutral conveners, Camden Coalition works regionally & nationally to transform systems of care through advocacy, field development, training & technical assistance.
Our Care Interventions: Local Innovation
At the Camden Coalition, our local patient-facing interventions use healthcare hotspotting to target the most complex individuals.
We use sixteen domains to engage individuals in bedside care planning. **Most of them are non-medical.**
The Camden Core Model is our primary form of intervention. There are key aspects of this model that facilitate its applicability across specialized patient populations.

- Triage
- Bedside engagement and care planning
- Home visits & medicine reconciliation
- Accompaniment to primary care and specialist visits within 7 days of hospital discharge
- Real-time feedback loops
- Graduation

**Patient Identification** → **Engagement at Hospital** → **Community-Based Care Management**
Hiring the right people & a commitment to self- & team-care is essential to the success of our model.
We use the COACH Model & our tenets of care to work with patients toward sustained behavior change & to track progress on their goals.

Our Tenets of Care
- Motivational interviewing
- Trauma-informed care
- Authentic healing relationships
- Accompaniment
- Harm reduction
- Patient-centered
- Strength-based
The Core of Care Management: The Role of Authentic Relationships in Caring for Patients with Frequent Hospitalizations

Charlotte Grinberg, BA, Margaret Hawthorne, MPH, Marianna LaNoe, PhD, Jeffrey Brenner, MD, and Dawn Mautner, MD, MS
Kenneth was a Housing First participant we first found in the Camden Coalition Health Information Exchange.
Once an individual is identified, our care team goes to the hospital to engage with them at bedside to assess interest in enrolling in our program.
After discharge, our care team meets patients in their homes (within 3 days) & accompanies them to primary care visits (within 7 days).
Patients graduate from our short-term intervention based on their individual complexity.
7 Day Pledge is our core practice-facing model that seeks to connect hospitalized patients to their primary care physician within 7 days of discharge.

- 7 Day Pledge uses data to generate buy-in from primary care practices and highlight progress.
- The program relies on champion team-members within each practice.
- Incentivizing both patients and practices to participate is an essential component of the program.
All of our interventions incorporate our approach to care and system-improvement.

- **Housing First**: Intervention focused on providing access to permanent housing and wrap-around services.
- **Camden Delivers**: Intervention addressing maternal health & addiction.
- **Camden RESET (ReEntering Society with Effective Tools)**: Intervention focused on helping individuals who frequent the Camden-area hospitals and the Camden County Jail.
- **Medical-Legal Partnership**: Helping individuals in all our interventions who need legal assistance.
- **7-Day Pledge**: Citywide transition of care program connecting hospitalized patients back to primary care.
- **Accountable Health Communities**: A program that screens 70,000 individuals in Camden, Burlington, and Gloucester county for social determinates of health.
Once enrolled in our core model, different patient cohorts have reduced both emergency and inpatient use of the hospital.

### Reduced Emergency Department Utilization

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<tr>
<th>Cohort</th>
<th>6-month Pre</th>
<th>6-month Post</th>
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<tbody>
<tr>
<td>Cohort 1</td>
<td>5.3</td>
<td>2.6</td>
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<td>Cohort 2</td>
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### Reduced Inpatient Utilization

United: Camden ACO vs Comparison Group, Preventable INP Admissions per 1,000 Enrollees

Internal data from 179 Horizon and 67 United patients. Pre/post analyses cannot eliminate “regression to the mean” and therefore cannot attribute cause.
Our Housing First program has also successfully reduced both emergency and inpatient hospital use among our patient population.
Our 7-Day Pledge program has shown that hospital readmissions & emergency department visits are reduced for Camden patients who see their PCP within 7 days, relative to those who do not.

<table>
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<tr>
<th>Timing of PCP Appointment</th>
<th>Number of Hospital Readmissions per 100 Patients</th>
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<tbody>
<tr>
<td>30 Days</td>
<td>24, 69, 134</td>
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<td>90 Days</td>
<td>30, 84, 156</td>
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<td>180 Days</td>
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Number of hospital readmissions per 100 patients 30, 90, & 180 days after Hospital discharge, by timing of PCP appointment.
Our Data-Driven Approach:
Using data at the individual, institutional and systems levels
We rely on a robust, interconnected data infrastructure to support both our patient & practice-facing interventions, as well as our systems-level policy work.

**Real-time data from 4 health systems, vendor-managed.**

**Home-grown PostgreSQL database.**

**Research & quality improvement.**

**Internal performance & care tracking**

**Camden ARISE**
Camden ARISE is a cross-sector data initiative that brings together data from healthcare, criminal justice & other sectors. The data are used to inform intervention design as well as research & evaluation.

Existing Data Sharing
- Hospital claims from 5 regional health systems
- Camden County Police Department (arrest, call-for-service, & overdose)
- Camden County Corrections & State Prison data
- Enrollment, truancy, & suspension data
- Property Data
- Perinatal Risk Assessment data
- Medicaid Claims data
Camden ARISE revealed a significant overlap in the number of people utilizing both the county jail and city hospitals.

The diagram below shows the overlap between police and hospital data from 2010 – 2014.

- Police arrest data: 18,755 individuals
- Overlap: 12,541 individuals (67%)
- Hospital claims data: 93,344 individuals
Cross-sector data sharing is essential to complex care. Medical data only provides limited insight into the issues affecting an individual or community.
“It’s easier to stay on top of you taking your medicine when you have a good environment like this. It’s not being homeless where you gotta go hide your medicine. Then you gotta go get it. Then you gotta get – the bathroom’s 400 yards away. And it’s crazy. This here’s stable. Your medicine’s there. Here’s your bathroom. No problem.”

“I could be dead somewhere because with my asthma. [...] Ever since I moved in here, I haven't been in the hospital once. Now that's a blessing. Going from being in the hospital in 2015, 28 times from January until August, and then getting housing November of 2015 and moving here... and still to today, [I] haven't been in the hospital.”
Our Systems Impact:
Convening, Advocacy & Technical Assistance
The Camden Coalition is working regionally and nationally to transform the delivery of care to individuals with complex health & social needs.

INTERVENTIONS

New Jersey Advocacy

National Field Development

Technical Assistance

DATA

SYSTEMS
At a fundamental level, we believe that to transform the delivery system, we must lift up the consumer voice.

**National Consumer Scholars Program:**
Provides scholarships to individuals with lived experience to attend our annual national conference.

**Consumer Advisory Council:**
Serves as part of our governance structure to provide community oversight to our work.
On the national level, the Camden Coalition is working to organize & educate the emerging field of complex care through the National Center for Complex Health and Social Needs.

The National Center collaborates with other complex care experts across the country to:

- Develop best practices
- Inform policy
- Foster an engaged and accessible community to develop a complex care framework
- Teach others
Every year the National Center hosts a conference, “Putting Care at the Center” in a new city to grow our reach. This year’s conference will be held in Chicago, Illinois, December 5-7.

Tickets available at www.centering.care
The Blueprint for Complex Care is a collaborative initiative of the National Center to assess & coordinate the vision for the field of complex care.

- The Blueprint, to be released in the Fall and highlighted at the National Center conference, will provide a roadmap for the development of the field of complex care.

- This project is in close partnership with the Institute of Healthcare Improvement and the Center for Health Care Strategies.
Our Student Hotspotting program is educating the next generation of healthcare professionals.

Interprofessional teams of students around the country engage people with complex health and social needs in their community.

Students learn interprofessional practice and team-based care in an actual patient engagement program.

In 2018 we launched 4 hubs to scale the work:

- Samuel Merrit University
- Southern Illinois University
- Thomas Jefferson University
- University of Utah