

Camden Coalition

Description: A citywide coalition of hospitals, primary care providers, and community representatives that collaborate to deliver better healthcare to the most vulnerable citizens in the Camden area. The goal of this coalition is to improve care and reduce healthcare costs. The coalition members share information through the Camden Health Information Exchange. The availability of real-time data and cross disciplinary care teams allows for identification of patients with high rates of hospitalization and ED use and the ability to connect them with the right care teams to address their most complex needs.

Interview Summary:

Conversation focused on the Camden Care Management Initiative –

- Focus is on patients who cycle through the healthcare system the most (core strategy of reducing costs)
- Engage patient during an inpatient visit once patient is identified as a candidate for the care management initiative
 - Use claims data to identify patients who have been admitted to the hospital >2 times in the past 6 months
 - Plus, other inclusion/exclusion criteria. Inclusion criteria consists of – 3 points of vulnerability, 2 or more chronic conditions, 5 or more meds, difficulty accessing services (e.g.; non-compliant, language barrier, low health literacy, mental health disease, homeless, active drug use, uninsured)
 - IP visit is used as initial contact because they have found it targets people with highest needs where largest impact is possible
- Goal for patients identified to be in the CM initiative is to get into a primary care physician within 7 days of discharge
 - Team assigned to them visits them in the home 72 hours post-discharge
 - Team also accompanies patients to appointments if necessary
 - Team is flexible to meet patient needs, but usually includes: RN, LPN, CHW and other community based supports as needed
 - Team continues to visit the patient in the home every 7 days usually for up to 180 days, but longer if necessary
 - Patients complete a shared care plan and are regularly assessed for readiness to transition out of the program (evaluated for motivation to engage and sustain in active health management) – patients are placed into different care plan domains based on their primary set of needs/barriers and this helps define the required care team
- There are several metrics followed to assess program success
 - Internally developed risk scoring system developed – made up with components of social support for health, self-perception of health, etc. – monitor to see if this goes down for patients and use to determine what was effective in driving down.
 - Hospital readmissions at 30, 60 and 90 days – moving needle here
 - Community based scorecards – include process metrics like:
 - Visited patient in home within 3 days post-discharge

- PCP visit within 7 days post-discharge
 - Completed Med reconciliation
 - Scorecard helps support culture of continuous feedback – providing data helps start the conversation about what is working well vs not working well
- They have several contracts/community relationships that support needs of patients.
 - Contract with Rutgers to provide behavioral health care and health consultants
 - Work with local syringe program
 - Contract with methadone clinic
- Host learning sessions with primary care practices to explore patient and/or practice barriers
 - Dinner series to discuss barriers to access in city, evaluation of scorecards, training needs, etc.
 - Have often found that a practice centric issue are practices not fully optimizing HIE system
 - Helps identify ways to engage primary care (e.g.; working on bringing real-time data to providers to improve care coordination and communication across the continuum)