Improving Outcomes and Reducing Costs for Patients with Complex Health and Social Needs

Carter Wilson
Agenda

- What is Complex Care?
- Who is the Camden Coalition?
- What are we doing?
- Where are we going?
What is complex care?

Complex care seeks to improve the health and well-being of a relatively small, heterogeneous group of people who repeatedly cycle through multiple health care, social service, and other systems **but do not derive lasting benefit**.
As a whole, 1% of patients account for 30% of healthcare receipts and 10% accounts for 74%
In Camden and 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.
Who are complex care patients?

Conceptual Model of a Starter Taxonomy for High-Need Patients

1. Clinical and functional groups
   - Children with complex needs
   - Non-elderly disabled
   - Multiple chronic
   - Major complex chronic
   - Frail elderly
   - Advancing Illness

2. Behavioral and social assessment
   - Behavioral Health Factors
   - Social Risk Factors

Note: For this taxonomy, functional impairments are intrinsically tied to the clinical segments.
Who is the Camden Coalition?
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.
The City of Camden is the largest urban center in southern NJ - home to 76,000 people, with about 1.1M in three-county metro area.

- Camden City’s population is 49% Hispanic and 48% African American. 46% of residents speak a non-English language, predominantly Spanish.

- About 40% of the city’s residents are poor, and 60% receive some type of public insurance, with Medicaid being most common.

- Camden City has among the worst health outcomes in the state – in bottom five of 21 counties.

- Crime rates in Camden are on the decline. In 2017, the city experienced the lowest homicide rate since the 1980s.

- New Jersey is one of the wealthiest states in the country with a median household income of $72,000; yet, Camden’s median household income is $26,000. Similarly, while the state has low unemployment rate of approximately 4%, Camden hovers at about 9%.
Camden Health Data

- 2002 – 2011 with local hospital data
- 500,000+ records with 98,000 patients
- 50% population use ER/hospital in one year

50% of population use the ER/hospital in one year
Camden Health Data

• 2002 – 2011 with local hospital data
  • 500,000+ records with 98,000 patients
  • 50% population use ER/hospital in one year
### 1 Patient’s Hospital Utilization

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER Visits</td>
<td>102</td>
</tr>
<tr>
<td>Admissions</td>
<td>54</td>
</tr>
<tr>
<td>Total CT Scans</td>
<td>147</td>
</tr>
<tr>
<td>CT Scan-Head</td>
<td>73</td>
</tr>
</tbody>
</table>
Our Roots: from primary care to community support
Questions for My Care Team...

- Birth Certificate
- Social Security Card
- Non-driver’s N.J. I.D.
- Housing
- Schooling
- Employment
- Addictions Support
- Medication Support
- Airmarcare Project
- Transportation
- Phone Communication
- Clothing
- Food - Welfare?
The Camden Coalition of Healthcare Providers
18,755 people with an arrest

93,344 people visiting the hospital

12,541 people overlap

18,755 people with an arrest

226 people with dual sector high utilization

5 years, ever having a Camden address
7+ police encounters
16+ emergency department visits
Non-violent, medically very complex drug offenders \( (N = 37) \)

Non-violent, with mental health complexity, arrested mostly for petty crimes \( (N = 65) \)

Assault victims with mental health complexity & addictions, committing crimes against others \( (N = 59) \)

Male drug offenders, some with violence arrests, with few hospitalizations and less prevalent serious mental illness \( (N = 65) \)
Distribution of Absences

- Students: Total Absences
- 50+ absences
What are we doing?
The Camden Coalition of Healthcare Providers

Camden Core Model
Connection to Primary Care
Housing First
Reentry Program
Maternal Health
Addiction Treatment
Medical-Legal Partnership
Community Care Management - Structure

- Triage
- Bedside Engagement
- Care Planning

- Home Visits
- Accompaniment
- Graduation
Community Care Management - Structure

- Staff effort is heavily frontloaded: more than 20% of staff effort occurs in the first two weeks of enrollment
- 70% of care coordination effort occurs face-to-face
- Indicators of social vulnerability -- housing instability and behavioral health needs -- were associated with more time-intensive program enrollments
Community Care Management - RCT
Coalition supported Adventist Health in co-designing a model with multi-system high utilizers

Adventist Health

• Based in Lake County, CA
• County has the poorest health outcomes in CA – addiction, fires, access issues

Project Restoration

• County-wide cross-sector collaborative (Police, Fire, EMS, Criminal Justice, Mayor, Health, Social Services, Education)
• Shared data
• Process improvements to change root cause
The Camden Coalition launched our Housing First model in response to the significant rates of homelessness facing patients with complex health and social needs in the city of Camden.

- As the care team and patients continued to identify housing as one of the biggest barriers for individuals, we began conversations on the state and local levels to establish a Housing First program in Camden.

- In 2015, with support from the NJ Department of Community Affairs in the form of vouchers and a state budget allocation, we launched our Housing First program.

- The program is supported with 50 project-based and 15 tenant-based vouchers, a $500K state budget allocation, local funding, and private funding.
Every story is unique: Meet Peter

- 51-year old African American male
- COPD exacerbation, Acute Asthma Exacerbation, Hypertension, GERD
- Generalized Anxiety Disorder, Major Depressive Disorder
- In remission from Substance Disorder Dependence from Alcohol
- Homeless (1+ year in shelter)
- Limited income (~$200/month)
An internal evaluation of our Housing First program demonstrates the impact housing can have on an individual’s utilization of the hospital. Once patients are housed, both their inpatient and emergency department use declines.
UnitedHealthcare is expanding their housing program to 30 markets, targeting an expected 350 patients with annual health-care spending >$17M

America’s Largest Health Insurer Is Giving Apartments to Homeless People

A radical fix for the U.S. health-care crisis.

By John Tozzi
7 Day Pledge 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.
7 Day Pledge reduces inpatient readmissions

Reducing hospital readmissions

Readmissions are lower when a hospital discharge is followed by a primary care follow-up within seven days:

- **Primary care follow up within 7 days**: 38.7%
- **Later or no primary care follow-up**: 28.0%

Discharges followed by any 30-day readmission: 17.5% vs. 12.7%
Discharges followed by any 90-day readmission: 28.0%

*Difference, 4.8%; 95% CI, 0.5%-9.1%; P=0.03*  
*Difference, 10.7%; 95% CI, 4.9%-16.3%; P=0.002*

Percentages are based on 450 discharges followed by a primary care appointment within 7 days and 450 matched records in which the patient did not have a primary care appointment within 7 days.

Similar emergency room workflow was ineffective at reconnecting patients to primary care.

Only 7% of records reviewed did the workflow successfully connect to PCP.
Our research found that though many patients were connected to primary care, few were receiving behavioral health treatment.

Among Camden Core Model patients with a PCP and screened by our clinical psychologist:

- **Only 17%** with a mental health condition were receiving treatment from a mental health provider
- **Only 10%** of those with an active substance use disorder were receiving treatment for their disorder
Where are we going?
An initiative of the Camden Coalition, The National Center serves as a professional home for individuals and organizations caring for people with complex health and social needs, uniting and amplifying their efforts to improve care nationwide.
National Center Activities

- **Field and Movement Building.** The National Center plays a central role in generating support and momentum for complex care initiatives.
  - **Defining** what the field of complex care is and aims to do
  - **Convening** model builders and care deliverers

- **Educating on Core Complex Care Topics.** The National Center develops practical resources to support complex care professionals and programs.

- **Providing Technical and Complex Assistance.** The National Center offers high-touch support for organizations at various stages of program development and delivery.
Defining Blueprint for Complex Care

• Drives a collective strategy for the complex care field to help it reach its potential

• Collaboration between the National Center, CHCS, and IHI funded by The Commonwealth Fund, the Robert Wood Johnson Foundation, and The SCAN Foundation

• Includes an assessment of the current state of the field and actionable recommendations

• Serves as a framework to guide collective work as a field for years to come, so we need your active involvement
Defining - assessment of the field of complex care

<table>
<thead>
<tr>
<th>Framework Component</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared Identity</td>
<td>- Stakeholders agree on the problems to address</td>
<td>- The field lacks a shared language</td>
</tr>
<tr>
<td></td>
<td>- The community shares principles and goals</td>
<td>- There has been confusion on who comprises the target population</td>
</tr>
<tr>
<td></td>
<td>- The potential community of stakeholders is vast and diverse</td>
<td></td>
</tr>
<tr>
<td>Standards of Practice</td>
<td>- Validated care models and promising practices exist and are spreading</td>
<td>- Data sharing limitations hamper progress</td>
</tr>
<tr>
<td></td>
<td>- Common features of promising models and practices have been identified</td>
<td>- There is a shortage of providers prepared to deliver complex care</td>
</tr>
<tr>
<td>Knowledge Base</td>
<td>- A growing evidence base demonstrates complex care’s positive impact</td>
<td>- Current metrics do not reflect whole-person outcomes</td>
</tr>
<tr>
<td></td>
<td>- Segmentation of the target population is improving</td>
<td>- Stakeholders disagree on the types of evaluation that are necessary</td>
</tr>
<tr>
<td></td>
<td>- A community of researchers is emerging</td>
<td></td>
</tr>
<tr>
<td>Leadership and Grassroots Support</td>
<td>- Complex care is a high priority for many healthcare providers, policymakers, and philanthropies</td>
<td>- People with lived experience are not adequately included</td>
</tr>
<tr>
<td></td>
<td>- Influential stakeholders in key segments of the field are increasing buy-in</td>
<td>- Multiple barriers impede cross-discipline and cross-sector partnerships</td>
</tr>
<tr>
<td>Funding and Supporting Policy</td>
<td>- The shift toward value-based payment supports complex care investment</td>
<td>- Healthcare-based programs struggle with financing in a shifting payment environment</td>
</tr>
<tr>
<td></td>
<td>- Public investment has accelerated interest in complex care</td>
<td>- Social and behavioral health services are funded differently and less robustly than healthcare</td>
</tr>
</tbody>
</table>
Defining - Blueprint recommendations

1. Develop core competencies
2. Develop quality measures
3. Enhance and promote integrated, cross-sector data infrastructures
4. Identify research and evaluation priorities
5. Engage allied organizations and champions through strategic communications and partnership
6. Value the role of people with lived experience
7. Strengthen local cross-sector partnerships
8. Promote expanded public investment in innovation, research, and service delivery
9. Leverage alternative payment models to promote flexible and sustainable funding
10. Create a field coordination structure that facilitates collective action and systems-level change
11. Foster peer to peer connections and learning dissemination
The Field Coordinating Committee seeks to align the major institutions leading the field’s development and ensure that vital perspectives are included.

Members include the National Center, Center for Health Care Strategies, Institute for Healthcare Improvement, Community Catalyst, and Alliance for Strong Families and Communities.

The FCC is currently focused on activating central activities outlined in the Blueprint and increasing the social sector’s involvement.
• Complex care practice requires different knowledge, skills, and abilities than traditional practice
• 15 diverse complex care professionals and consumers will spend the next year developing an initial set of statements defining what these KSAs are
• The core competency statements will target program leadership as they hire and train staff, and will serve as an initial step towards the development of structured training and curricula
Defining - Complex Care Principles

PRINCIPLES OF COMPLEX CARE

- Person-centered
- Data-driven
- Team-based
- Equitable
- Cross-sector
Defining – Quality Measures

Develop quality measures

• Standard quality measures for complex care are needed to accelerate learning and quality improvement, and enable providers to demonstrate value to payers and other stakeholders

• Funded by the National Center, Institute for Healthcare Improvement is leading an effort to develop these measures aimed at demonstrating impact on patient wellbeing and overall health

• Mirroring the core competencies project, a diverse set of stakeholders will be engaged in this year-long project
Foster peer to peer connections and learning dissemination

• Putting Care at the Center is the annual conference of the National Center

• The 5th convening will be held on October 28-30, 2019 in Philadelphia

• 2019 conference held in Memphis with the theme: It takes and ecosystem
Convening – National Consumer Scholars

Value the role of people with lived experience

- The national Center’s Consumer Scholar program aims to amplify the consumer voices by providing opportunities for consumers to contribute to major initiatives and develop their own workstreams.

- 15 consumers, sponsored by host organizations from across the country, receive training advocacy practices, story sharing, and core complex care topics

- Consumer scholars host webinars, attend and present at the national conference, and participate in field defining working groups
The National Center has launched a pilot to support three convenings of regional complex care stakeholders across the country to address barriers in their own communities.

**Atlanta Regional Collaborative for Health Improvement (ARCHI)**
Convening: local partners developing a real-time, rapid referral network in Atlanta

**California Association for Public Hospitals/Safety Net Institute**
Convening: 25 regional coalitions sharing best practices on activating peer health workers

**Jefferson Healthcare, Washington State**
Convening: rural providers developing cross-system/sector workflows for older adults
Educating – Student Hotspotting

- Annual program that trains interprofessional teams of students from schools across the country to apply patient centered approach
- Uncover root cause of high utilization, learn patient stories and lift up systems barriers
- Connect in homes and community
- Share learning with our institutions and broader complex care community
The National Center seeks to support organizations with tools and resources as they launch complex care programs and develop a supportive ecosystem in their community.

Workstreams:
- Collect, curate, and disseminate tools and resources for complex care programs and ecosystems
- Support three health systems with little to no experience developing complex care programs and ecosystems
- Host tools and resources on online learning management system
Thank you!

National Center for Complex Health and Social Needs
An initiative of the Camden Coalition of Healthcare Providers

www.nationalcomplex.care
@natlcomplexcare

800 Cooper St., 7th Floor
Camden, NJ 08102