5% of the population accounts for 50% of the cost

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.
What is Complex Care?

Complex care seeks to improve the health and well-being of a relatively small, heterogenous group of people who repeatedly cycle through multiple health care, social service, and other systems but do not derive lasting benefit.
Our Vision & Mission is a transformed healthcare system to improve the wellbeing of individuals with complex health and social needs.

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 redesigned ‘ecosystems’ for individuals with complex health and social needs have the potential to bend the cost-curve, and improve quality of life.

**To do this we:**

- Work to improve the health & well-being of individuals with complex health & social needs in the Camden region through our nurse-led care intervention

- Work regionally & nationally to transform systems of care through advocacy, field development, training & technical assistance
To do this work, the Coalition has staff with diverse backgrounds. Clinical Teams include nurses (RNs and LPNs), community health workers, social workers and navigators with lived experience.
The Camden Core Model is our nurse-led complex care management intervention, it stresses authentic, face-to-face interaction with patients.
Our care team uses the **COACH Model** to build relationships, work with patients toward sustained behavior change & track progress on their goals.

- **COACH**
  - Connect tasks with vision and priorities
  - Observe the normal routine
  - Assume a coaching style
  - Create a care plan
  - Highlight progress with data

**Our Tenets of Care**
- Motivational interviewing
- Trauma-informed care
- Authentic healing relationships
- Accompaniment
- Harm reduction
- Patient-centered
- Strength-based
We use sixteen domains to engage individuals in bedside care planning. Most of them are non-medical.
Hiring the right people & a commitment to self- & team-care is essential to success.

Core Practices

• Behavioral based Interviewing
• Daily Huddles
• Team Case Conferences
• Behavioral Health benefits
Camden Coalition’s national technical assistance team has worked with dozens of institutions across the country, co-creating interventions tailored to unique population and institutional context.

**Types of Projects:**
- Model Co-Design
- COACH model implementation
- Care Coordination redesign and training
- Community Collaboratives
- Addiction Treatment and Behavioral Health

**Types of Partners:**
- Health Systems
- FQHCs & CMH
- Communities
- Payers
- Government
- National Associations
We worked with Adventist Health co-designing a model with multi-system high utilizing community members – vulnerable older adults.

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
Alongside Adventist Health leaders, we developed a continuum to address complexity.

**CONTINUUM OF SERVICES**

- **Live Well**
  - A multidisciplinary, holistic clinic approach to serve at-risk patients with increasing complexity.

- **Live Well Intensive**
  - Intensive Out Patient Case Management
  - Top 5% capitated utilizers

- **Project Restoration**
  - Cross Continuum approach to community-wide high utilizers of multiple agencies and services.

- **Restoration House**
  - Medical respite focused on four primary goals: reducing inpatient length of stay, preventing readmission, preventing ED utilization, and enrollment into Project Restoration.
The team worked with 28 patients over the first 12 months and saw reduced utilization and strengthened community partnerships.

<table>
<thead>
<tr>
<th>Utilization</th>
<th>Patient Experience</th>
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<tbody>
<tr>
<td><strong>Hospital Reduction</strong> <em>(ED &amp; IP)</em></td>
<td><strong>Access To Care and Safety</strong></td>
</tr>
<tr>
<td>44%</td>
<td><strong>Primary Care Visits</strong> 133%</td>
</tr>
<tr>
<td><strong>Community Services</strong> <em>(Police, EMS, Jail)</em></td>
<td><strong>Housing</strong> 93%</td>
</tr>
<tr>
<td>83%</td>
<td></td>
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<tr>
<td><strong>Cost Reduction</strong></td>
<td></td>
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<tr>
<td>71%</td>
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Key Components to the Model Delivery

- Design to the unique population in the community
- Use data to explore “what is the problem we’re trying to solve”
- Map the existing assets and partners in the market
- Integrate comprehensive assessment including social determinants of health
- Ask patients what matters most to them
- Include patients and family caregivers in design
- Design structures for team rapid cycle process improvement to impact root cause
Competencies and Facilitators for Innovation

Core competencies for all Staff:

- Addressing social determinants of health (housing, food security, transportation, safety, social isolation)
- Linking across sectors to develop a shared plan of care
- Trauma informed care
- Motivational Interviewing

Policy Levers:

- Demonstrate value with a total cost of care lens
- Value based payment initiatives that provide direct reimbursement for care coordination roles
References


Resources

https://www.nationalcomplex.care/

https://www.bettercareplaybook.org/

https://www.nationalcomplex.care/our-work/blueprint-for-complex-care/
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