



Camden Coalition
of Healthcare Providers

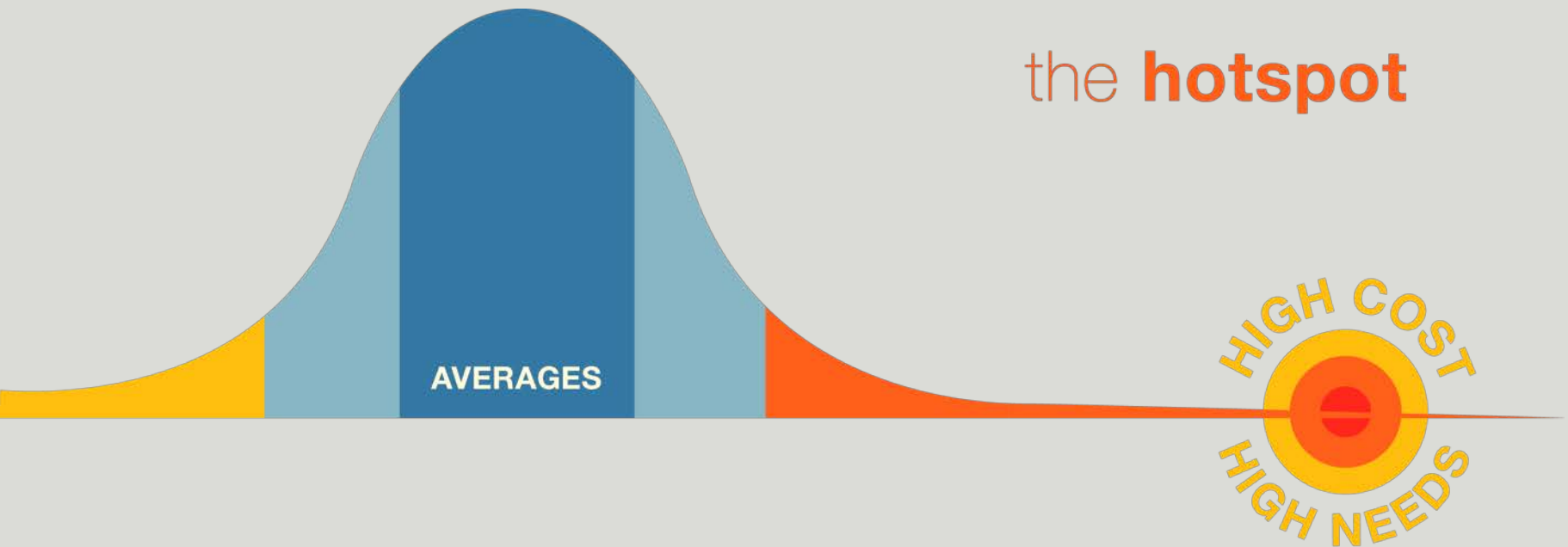
Innovations in Community Based Care
November 7, 2019

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



Source: Source: [Kaiser Family Foundation analysis of Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services](#)— January 2019

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, heterogeneous 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.

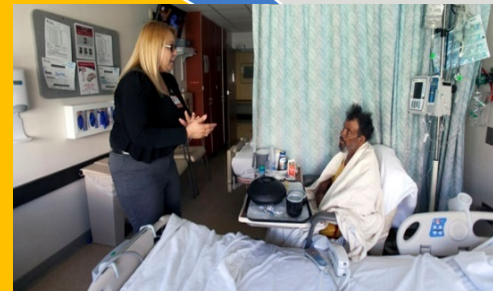


The Camden Core Model is our nurse-led complex care management intervention, it stresses authentic, face-to-face interaction with patients.

**Daily
Triage**



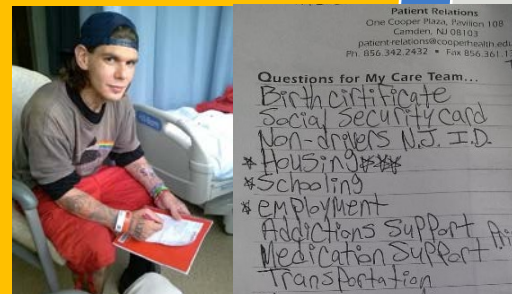
**Bedside
Engagement**



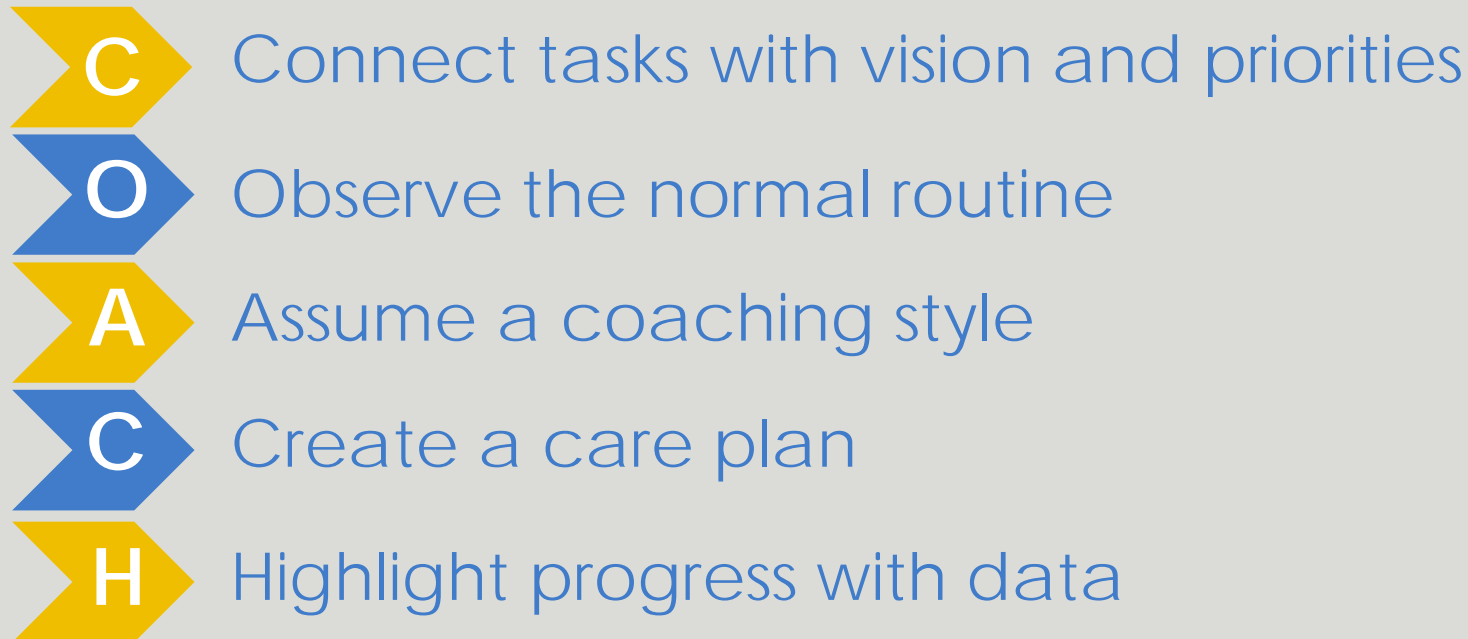
**Community
Visits**



**Care
Planning**



Our care team uses the **COACH Model** to build relationships, work with patients toward sustained behavior change & track progress on their goals.

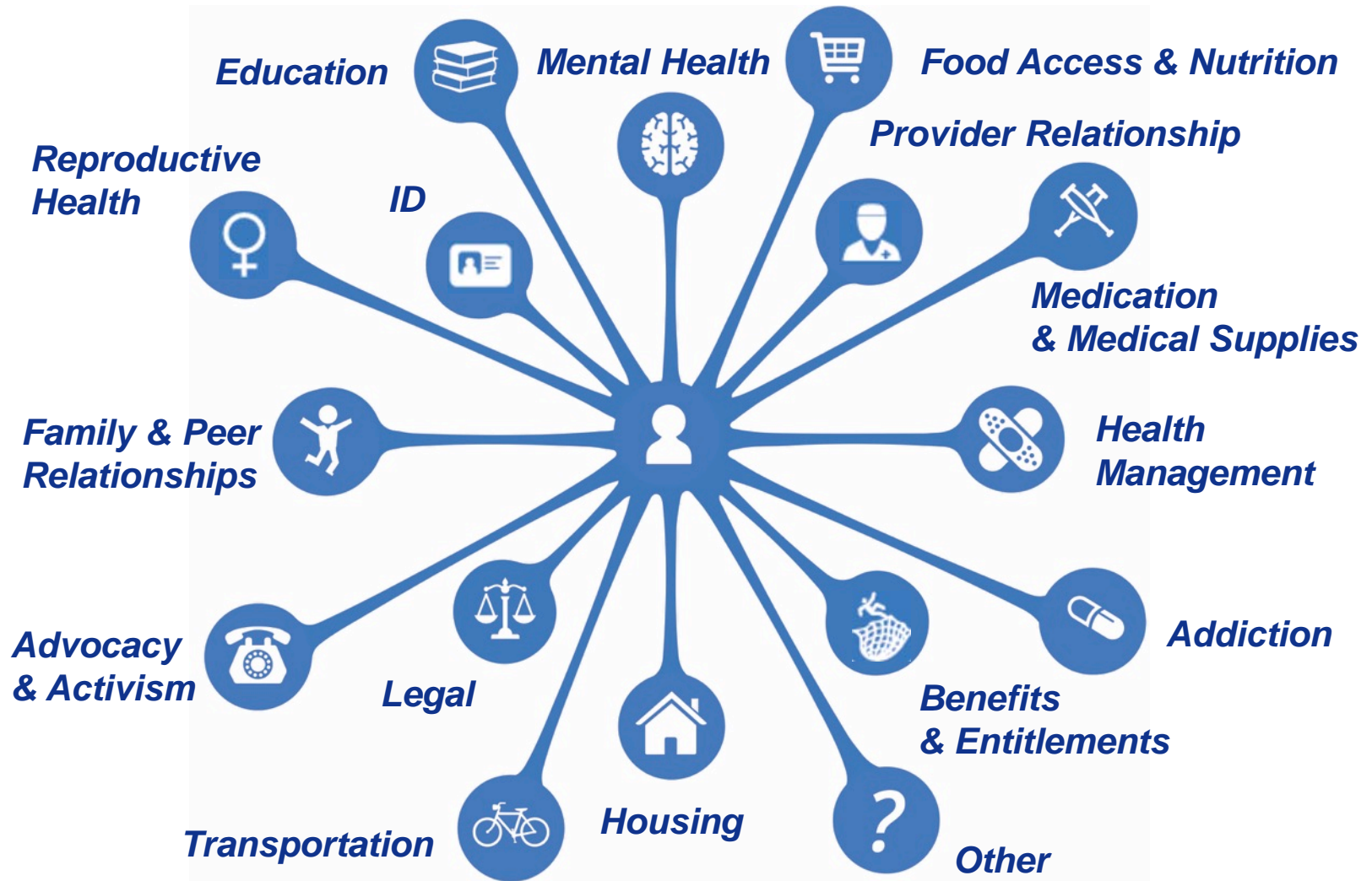


Our Tenets of Care

- 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 re-design 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

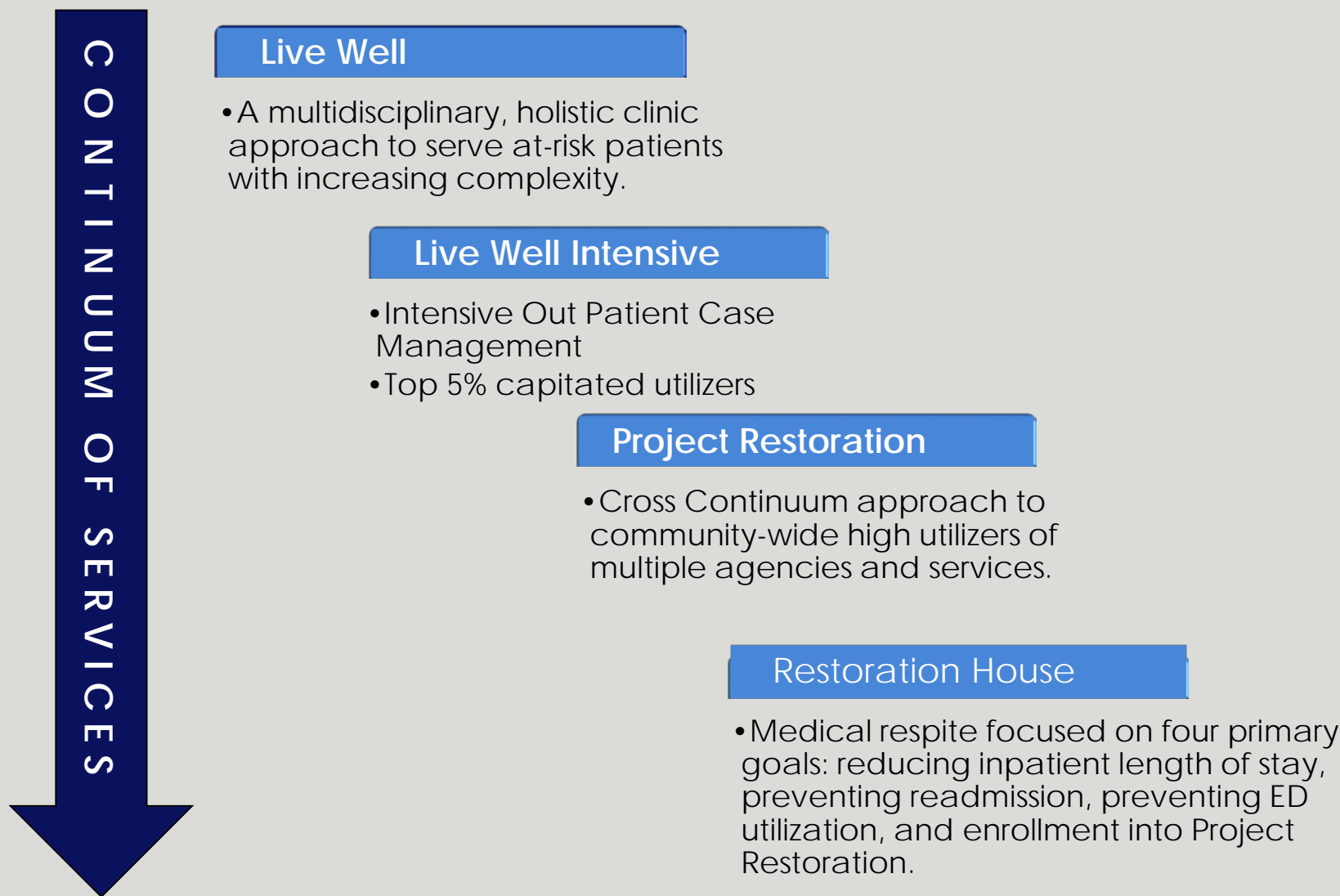
- Based in Lake County, CA
- County has the poorest health outcomes in CA – addiction, fires, access issues

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

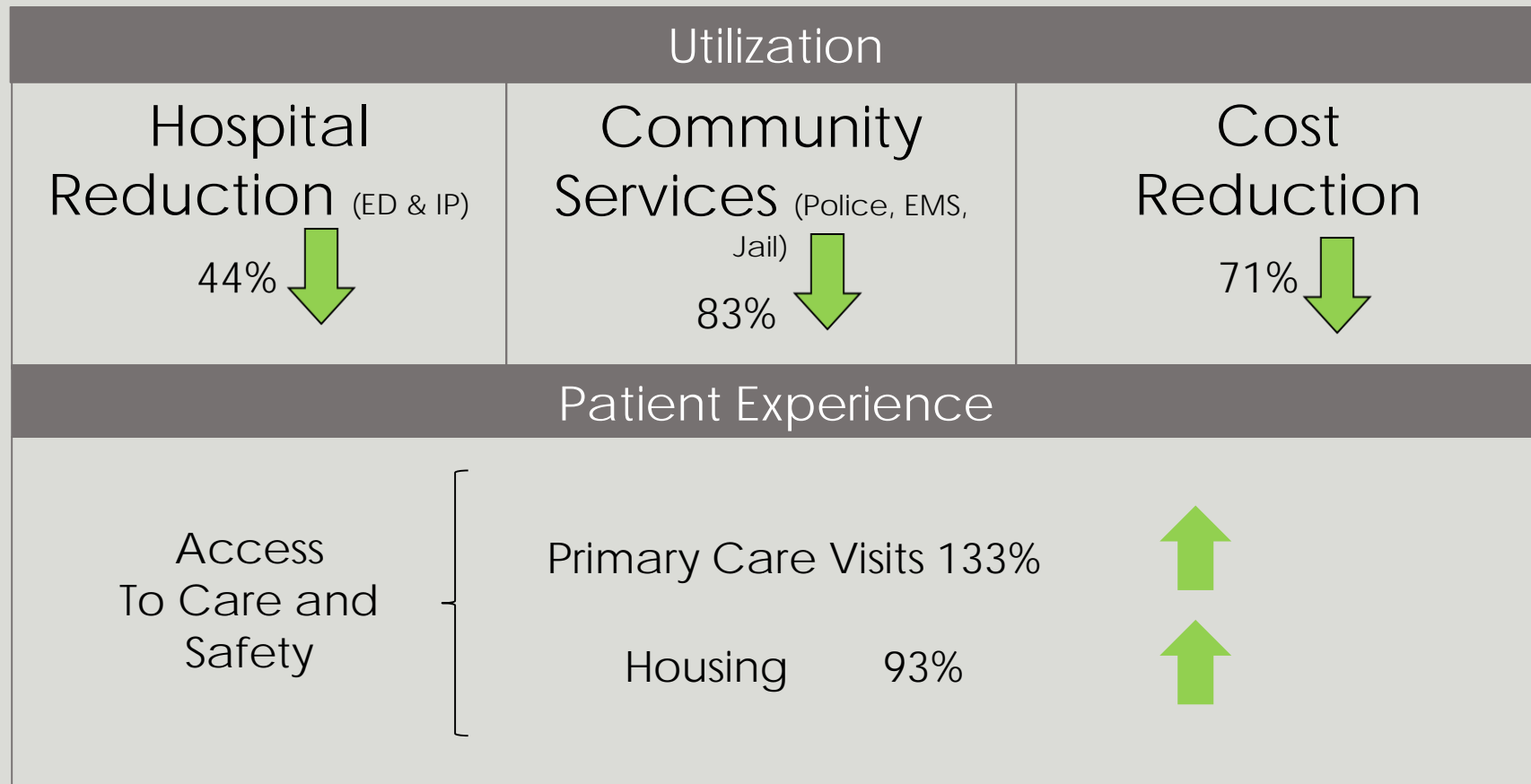


Alongside Adventist Health leaders, we developed a continuum to address complexity.





The team worked with **28** patients over the first **12** months and saw reduced utilization and strengthened community partnerships.



Hardin, et al. Cross-Sector Collaboration for Vulnerable Populations Reduces Utilization and Strengthens Community Partnerships. JIEP <https://www.sciencedirect.com/sciencedirect/pii/S2405452619301247>



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 care givers 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

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Resources



The National Center
for Complex Health and Social Needs

the Playbook



<https://www.nationalcomplex.care/>

<https://www.bettercareplaybook.org/>

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



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