What’s Next? The Value of Evidence from the Camden Coalition and CareMore Health to Inform Complex Care Program Design

March 31, 2020

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Questions?

To submit a question, click the Q&A icon located at the bottom of the screen.
Welcome & Introductions
Agenda

- Welcome and Introductions
- Lessons from the Camden Coalition’s Complex Care Management Program
- Lessons from CareMore Health’s Complex Care Management Program
- Implications for Investing in Complex Care
- Moderated Q&A
Today’s Presenters

Kelly Craig, MSW, Chief Strategy and Information Officer, Camden Coalition

Farhad Modarai, DO, Associate Regional Medical Officer, CareMore Health

Sara Kaplan-Levenson, MPH, MSW, Vice President of Complex Care, Maimonides Medical Center

Allison Hamblin, MSPH, President and CEO, Center for Health Care Strategies

Aaron Truchil, Director of Strategy and Analytics, Camden Coalition

Brian W. Powers, MD, Director of Population Health Strategy and Analytics, CareMore Health

David Labby, MD, PhD, Health Strategy Advisor, Health Share of Oregon
About the Better Care Playbook

Robust online resource center offering the latest knowledge on promising practices for people with complex health and social needs

Provides practical how-to guidance to inform health system leaders, payers, policymakers and others on strategies to improve care for high-need, high-cost populations

Coordinated by the Center for Health Care Strategies through support from seven leading national health care foundations — *Arnold Ventures, The Commonwealth Fund, The John A. Hartford Foundation, Milbank Memorial Fund, Peterson Center on Healthcare, the Robert Wood Johnson Foundation, and The SCAN Foundation.*

[www.BetterCarePlaybook.org](http://www.BetterCarePlaybook.org)
Recent Contributions to the Evidence Base

January 9, 2020

Health Care Hotspotting — A Randomized, Controlled Trial

SPECIAL ARTICLE

Amy Finkelstein, Ph.D., Annetta Zhou, Ph.D., Sarah Taubman, Sc.D., and Joseph Doyle, Ph.D.

February 10, 2020

Impact of Complex Care Management on Spending and Utilization for High-Need, High-Cost Medicaid Patients

Brian W. Powers, MD, MBA; Farhad Modarai, DO; Sandeep Palakodeti, MD, MPH; Manisha Sharma, MD; Nupur Mehta, MD; Sachin H. Jain, MD, MBA; and Vivek Garg, MD, MBA
## Overview of Camden Coalition and CareMore Health Studies

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Camden Coalition</th>
<th>CareMore Health</th>
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<tbody>
<tr>
<td>2+ hospital admissions in prior 6 months; 2+ chronic conditions; and at least 2 of the following: difficulty accessing services, lack of social support, coexisting mental health condition, active drug habit, homelessness, use of 5+ active outpatient medications</td>
<td>Top 5% of total medical expenditures in prior year, top 5% in predictive model for future medical costs, or care team member nomination. Additionally, either: 2+ inpatient admissions in prior year, 3+ ED visits in prior year, or 2+ chronic conditions</td>
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<tr>
<td>Baseline utilization</td>
<td>1.72 inpatient admissions in 0-6 months prior; 0.74 inpatient admissions in 7-12 months prior</td>
<td>1.28 inpatient admissions in year prior</td>
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<tr>
<td>Care team composition</td>
<td>Registered nurses, social workers, licensed practical nurses, community health workers, and health coaches</td>
<td>Community health workers, social workers, and primary care physicians</td>
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<tr>
<td>Length of intervention</td>
<td>90 days</td>
<td>12 months</td>
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<tr>
<td>Measures</td>
<td>180-day hospital readmission</td>
<td>Total medical expenditures, inpatient bed days, ED visits, inpatient admissions, care center visits, specialist visits</td>
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Lessons from the Camden Coalition’s Complex Care Management Program

Kelly Craig, MSW, LSW
Chief Strategy & Information Officer

Aaron Truchil
Director of Strategy & Analytics

Camden Coalition of Healthcare Providers
We are working toward a transformed healthcare system to improve the well-being of individuals with complex health and social needs.
A small number of individuals account for a disproportionate amount of healthcare costs & utilization.
Our Model

Daily Triage

Bedside Engagement

Community Visits

Care Planning
Formed research partnership to

- **Test** our theory of change
- **Contribute** to the evidence base for complex care
The question: At 180 days after a hospital discharge, do patients enrolled in the Camden Core Model experience a lower rate of hospital readmissions?
The Trial: 2014-2017

• Enrolled people with very high levels of hospital utilization, and health and social complexity

• Iterated the model throughout to reflect new learnings and ecosystem changes

• Stable funding reduced risk to the organization and patients
The answer: Care management alone cannot remedy lifetimes of complexity.
Results: At 180 days...

- **Similar readmission rates** in the control and intervention groups
- **Increased SNAP participation rates** in intervention groups

*Did not measure programmatic goals such as increasing patients’ self-efficacy or strengthening relationships with medical providers*
Key Takeaways

• **We were successful in identifying** a medically and socially complex population.

• **Results show us a path forward** that relies on strong cross-sector ecosystems

• **We are expanding our research** and analysis to learn even more
Thank you!

Camden Coalition of Healthcare Providers

www.camdenhealth.org
@camdenhealth

800 Cooper St., 7th Floor
Camden, NJ 08102
Complex Care Management for High-Need, High-Cost Medicaid Patients

Lessons from a Randomized Controlled Quality Improvement Trial
Background + Setting

5% of CareMore’s Medicaid patients in TN drive the majority of spending and have complex care needs

Patient Characteristics

- Multiple chronic conditions
- Co-occurring behavioral health disorders
- Chronic disability
- Complex social needs (e.g. housing, safety)
Conceptual Model

Characterize the unique drivers of poor health and avoidable spending for high-need, high-cost Medicaid patients
Eligibility

Identify patients at risk for poor outcomes and avoidable spending who are likely to benefit from complex care management

Top 5% Spending (Historical)

Top 5% Spending (Projected)

Staff Referral

Inclusion Criteria (any)
- ≥ 2 IP Admissions
- ≥ 3 ED Visits
- ≥ 2 Chronic Conditions

Exclusion Criteria (any)
- Cognitive Impairment
- SMI w/o medical comorbidities
- Active Malignancy
- Pregnant or Peri-Partum
- Currently in LTC facility

Eligible for Program
Staffing

Assemble a multi-disciplinary team with capacity to identify and address the medical and non-medical drivers of poor health and avoidable spending

Community Health Worker

Primary Care Physician

Social Worker
Complex Care Planning

Conduct a comprehensive assessment of health and social needs to develop tailored, focused care plans targeting the most impactable drivers of poor health and high spending.

1. Conduct Comprehensive Assessment
   - Custom Built Surveys + Tools
   - Medical History and Record Review

2. Prioritize Drivers of Poor Outcomes and High Costs
   - Medical Complexity and Health Trajectory
   - Environmental and Social Supports
   - Self-Management and Behavioral Health
   - Care Coordination and Engagement

3. Develop Custom Care Plan
Follow-Up

Provide frequent, structured follow-up to engage patients, identify barriers, and revise care plan

- **Weekly**
  - Care team reviews care plan
  - Check-in call between CHW and patient

- **Monthly**
  - In-person appointment at care center
  - Care team reviews care plan with patient

- **Ad Hoc**
  - CHW accompanies patient to appointments
  - PCP/CHW visit patient in hospital/rehab
Primary Outcomes

Complex care management was associated with significant reductions in spending and inpatient utilization

Total Medical Expenditures

$7,732 Lower
(95% CI -$14,914, -$550)
p = 0.03

IP Bed Days

4.25 Fewer
(95% CI -5.13, -3.36)
p = <0.001
Subgroup Analysis

Complex care management had the greatest impact among patients identified via staff referral vs. claims-based algorithms.

- **Total Medical Expenditures**
  - Staff Referral: -400%
  - Claims-Based Algorithms: -300%

- **Inpatient Bed Days**
  - Staff Referral: -200%
  - Claims-Based Algorithms: -100%

**Effect of Complex Care Management**

(% Change from Baseline)
Key Lessons

1. Targeting and Selecting Patients
2. Outcomes and Metrics
3. Care Team Composition and Roles
4. Cross-Sector Partnerships
Targeting and Selecting Patients

- Avoid focusing entirely (if at all) on historical “super utilizers”

- Work backwards—think about the types of patients most likely to benefit from a specific model or program, and build an identification strategy from there

- Integrate, and prioritize, insights and referrals from clinicians and other care team members
Outcomes and Metrics

- Rigorous methods are critical when evaluating programs focused on high-need, high-cost patients

- Patient experience and health outcomes are difficult to measure outside of traditional research settings, but essential to understanding the value and impact of new care models

- As a field, we need to move beyond focusing solely on cost savings, and build an evidence base for the cost effectiveness of delivery interventions
Care Team Composition and Roles

- Programs with an integrated model for addressing medical and social risk are poised to be most effective.

- Community-based, non-medical team members have a central role to play in programs for high-need, high-cost Medicaid patients.
Cross-Sector Partnerships

- Addressing the social drivers of health requires partnerships with community-based organizations and social-safety-net institutions—health care organizations can’t do this all on their own.

- Blind referrals are rarely effective. It is necessary to build trusting, longitudinal relationships that facilitate warm handoffs and referrals.
Implications for Investing in Complex Care

Sara Kaplan-Levenson, MPH, MSW, Vice President of Complex Care, Maimonides Medical Center

David Labby, MD, PhD, Health Strategy Advisor, Health Share of Oregon
Question & Answer
Questions?

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Share Your Successes on the Playbook

- Have you established a promising practice?
- Published a study about your complex care program?

The Playbook welcomes content submissions to help spread best practices in complex care.

www.BetterCarePlaybook.org
Thank you!

Please complete the evaluation survey.