A Coalition Creates a Citywide Care Management System

Increasing and improving access to primary and specialty care for Camden, N.J.’s most vulnerable residents

SUMMARY

In Camden, N.J., hospital costs reach more than $100 million every year for its 77,344 residents.¹ Some 30 percent of these costs come from just 1 percent of patients. Many of these patients frequent the hospital emergency departments (EDs) and inpatient wards, visit emergency rooms habitually for easily treatable conditions, or seek care for advanced conditions that could have been prevented with earlier diagnosis and treatment. To address this problem, the Camden Coalition of Healthcare Providers (CCHP)—a collaborative of practitioners, health centers, and hospitals—developed and implemented programs to connect high utilizers of health care services with primary care providers, and to help them transition smoothly among care settings.

In 2007, CCHP developed an intervention where care management teams moved high-utilizing patients to an appropriate primary care setting, focusing first on psychiatric care and mental health services and then on care for patients with type 2 diabetes. In 2011, CCHP built on this initial work and developed another intervention to improve transitions between different levels of care. In 2012, CCHP combined these two interventions into one initiative called Link2Care.

Key Results

- Of 108 patients being actively managed by the initial care management teams as of June 2010, 48 showed progress toward stability with decreased emergency department and hospital utilization, progress toward diabetes self-management, and improved clinical measures such as blood glucose levels.

- Between the launch of Link2Care in mid-2012 through early 2014, the program has made substantial progress in meeting its goal of getting patients into primary care within seven days of hospital discharge, decreasing the average number of days to initial primary care visit from 22.21 at the start of the initiative to 8.00 in early 2014.

¹ Citywide claims data.
Funding
The Robert Wood Johnson Foundation (RWJF) supported CCHP’s projects with three grants\(^2\) totaling $650,000 to the Cooper Foundation through RWJF’s *New Jersey Health Initiatives* program.\(^3\)

THE PROBLEM
Camden, N.J., across the Delaware River from Philadelphia, is the poorest city in the country, with 42.5 percent of the population living below the poverty line (U.S. Census Bureau, 2011).

Being poor often coincides with poor access to health care. Citywide claims data for 2003 showed that the majority of the high number of visits to the ED or hospitals were for preventable conditions that are treatable by a primary care provider.

Frequently, patients coming to Camden’s hospitals and EDs have difficulty accessing primary care offices. They also have a complex mix of psychiatric, social, medical, and substance abuse problems that received no coordinated care from the health delivery system. The wait time for medical subspecialist appointments is often several months.

THE PROJECT & ITS RESULTS
In 2003, the Camden Coalition of Healthcare Providers (CCHP)—a collaborative of practitioners, health centers, and hospitals—launched an effort to improve the quality, capacity, and accessibility of the health care system for vulnerable residents living in the city. Jeffrey C. Brenner, MD, serves as executive director and medical director of CCHP. See Grantee Story for more information on Brenner.

Beginning in February 2006, CCHP created a citywide care management system to connect the high-utilizers with primary care, helping them transition smoothly among care settings.

Going Where Patients Are
In the project’s first care management effort, launched in 2007, a team comprised of a family physician, nurse practitioner, medical assistant, and social worker provided transitional primary care aimed at moving patients to an appropriate primary care setting.

\(^2\) Grant ID# 56562 ($50,000; February 1, 2006 through June 30, 2007), Grant ID# 62061 ($300,000; July 1, 2007 through June 30, 2010), Grant ID# 69124 ($300,000; July 1, 2011 through September 30, 2013).

\(^3\) For more results of *New Jersey Health Initiatives*, see the Program Results Report on the program. It also provides links to all the projects in the program on which separate program results reports have been written.
“The project is all about working with high-utilizing patients,” said Susan Liu, MPA, in 2010, CCHP’s assistant director at the time about the original care management program.

“They are largely homeless, socially complex, are substance abusers, have mental illness, and have poorly managed chronic disease. We will see our patients in the ED or hospital if they wind up there, but otherwise we see them at home, in a shelter, on the street—wherever they are.”

Project staff first focused on providing psychiatric care and mental health services, which are in short supply in Camden, according to Liu. When CCHP received a $2 million, five-year grant from the Merck Foundation in February 2009 (mid-way through the RWJF funding) to implement a citywide diabetes care collaborative, the team shifted its focus to diabetes care, as many high-utilizing patients have diabetes.

The team used what they learned in delivering comprehensive and coordinated diabetes care to high utilizers with type 2 diabetes to create a model of care that was applicable to mental health, asthma, heart disease, and other conditions.

**Results**

CCHP staff reported the following results from the first care management effort in an August 2010 report to RWJF:

- Over the three years of the care management project (July 2007 through July 2010), the care management team provided outreach to about 312 patients and assessed their medical and social needs.
- By June 2010, the team was actively managing 108 patients; 60 of whom required weekly or biweekly in-home visits and phone calls to monitor progress.
- Of these 60 patients, CCHP reported that 48 patients demonstrated progress toward stability, with decreased ED and hospital utilization, as well as improved diabetes self-management, and better clinical measures (e.g., blood glucose levels). They still required on-site (e.g., home, shelter, etc.) primary care, however.

**Linking Care Management and Care Transitions**

Building upon the work of the care management teams, in November 2011, CCHP launched an intervention to improve care transitions. This time, two teams that each included an RN, an LPN, and several health coaches enrolled patients at the hospital and accompanied them across the spectrum of care and through transitions among and within facilities (e.g., medical offices, community health centers, nursing homes, and dialysis centers).
In July 2012, combining the lessons learned of both the care management and care transitions teams, CCHP merged the two interventions into one care management initiative, which they called Link2Care.

The nurse-led Link2Care teams include one RN, two LPNs, two health coaches, and one community health worker. A master’s level social worker and an outreach specialist provide additional social and behavioral health support as needed.

The Link2Care teams work with more than 10 primary care practices, including two federally qualified health centers—and with patients, families, and key community health and social services resources to help stabilize patients who have frequent hospital admissions, prevent avoidable readmissions, and reduce unnecessary hospital utilization. Although the length of the intervention is individualized, the teams work with patients for an average of about 90 days.

A Health Information Exchange, launched in 2010 (not funded by RWJF), facilitates the sharing of clinical data among hospitals, physician practices, and other providers in Camden. The Link2Care teams have access to admission, discharge, and transfer information in real time, allowing an automatic, data-driven referral process. In addition, they can bring up-to-date laboratory, radiology, consult, and other data from the patient’s hospital stay to the primary care appointment, ensuring a safe transition to outpatient care.

**Results**

CCHP staff reported these results of Link2Care to RWJF:

- Between September 30, 2012 and September 30, 2013, Link2Care identified 885 individuals through the Health Information Exchange for triage, of whom 269 were determined to be eligible for the intervention and assigned to a care team. Of the eligible patients, 146 were enrolled in the initiative by their primary care provider.

- Both Camden federally qualified health centers have received Patient-Centered Medical Home Recognition from the National Committee for Quality Assurance (NCQA).

- Between the launch of Link2Care in mid-2012 through early 2014, the program has made substantial progress in meeting its goal of getting patients into primary care within seven days of hospital discharge, decreasing the average number of days to initial primary care visit from 22.21 at the start of the initiative to 8.00 in early 2014.

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4 Patient-Centered Medical Home Recognition is awarded by NCQA to primary care practices that provide first contact (by personal clinician), and continuous, comprehensive, whole- person care for patients across the practice. Whole-person care includes comprehensive care and self-management support and emphasizes the spectrum of care needs, such as routine and urgent care, mental health care, preventive care, and assistance in changing health habits and making health care decisions.
The 80 patients enrolled at least six months in Link2Care showed a 46 percent reduction in average hospital admissions in the six months after enrollment (1.7 admissions) compared with the six months before enrollment (3.2 admissions). However, no comparison group that could allow determination of a true statistical difference between Link2Care and regular care was studied.

**Making a Difference with Care Management: John’s Story**

When the team first met John at the hospital in December 2012, he had been admitted to the hospital twice in six months with complications of diabetes and addiction to crack cocaine. He had also visited the emergency room three times during that period.

Like many patients, John had recently experienced a trauma: his mother had passed away. At the age of 37, he began using crack cocaine. John says that it is a challenge avoiding drugs in a place like Camden where they are so prevalent. His drug usage made him unable to control his diabetes.

The team connected John to primary care and specialty providers, diabetes self-management education, behavioral health, and other supportive services in the community. As of October 2013, John had not been back to the hospital and reported he is no longer using crack cocaine. He said that he is managing his diabetes and feeling motivated in other areas of his life. John credits CCHP with helping him get to where he is today.

**LESSONS LEARNED**

1. **Use data to drive the creation and implementation of a care management system.**
   “The fact that we had the database to start made a big difference,” said Liu.

2. **Build relationships at the service level to start.** “We laid low for several years and developed relationships with emergency department physicians and social workers,” said Liu.

   “Dealing first with the CEOs wouldn’t have worked. It is better to work with the people doing the work. Once you have that—and can show an impact in a data-driven way—then you can talk to executive level administration.”
3. **Conduct an initial assessment while the patient is still in the hospital and connect the patient with a primary care practice within seven days of discharge in order to have the best chance of preventing readmissions.** To improve the potential for timely connection with primary care, CCHP has built relationships with primary care offices to help them redesign their offices to improve efficiency and expand capacity. (Project Staff)

4. **Realize that there may be a limit to the number of patients that staff can handle without compromising patient care.** Considerably staff time and resources were required to help patients overcome the many barriers to timely receipt of health care services (e.g., lack of housing, income restrictions, minimal resources for behavioral health services, etc.). To ensure long-term health improvements, the project had to keep enrollment and panel size reasonably small so that patient care was not compromised. (Project Staff)

**AFTERWARD**

In July 2012, CCHP received a three-year, $2.7 million Health Care Innovation Award from the Center for Medicare & Medicaid Services to expand its care management work in the city of Camden.

As of March 2014, under another federal Health Innovation grant that is led by Rutgers University, CCHP is providing technical assistance to organizations in four cities (Allentown, Pa.; Aurora, Colo.; Kansas City, Mo.; and San Diego) as they develop their own intervention programs for “super utilizers”—people who overuse emergency departments and hospital inpatient services.

CCHP staff provides information about Link2Care to other organizations around the country through conferences, webinars, site visits, and open houses. A social media strategy is also part of their communications plans.

In addition, in November 2011, RWJF started a $2.5 million national program, *Improving Management of Health Care Super Utilizers*, that is leveraging the work of CCHP. The initial targets are communities participating in RWJF’s program *Aligning Forces for Quality* (AF4Q). RWJF’s signature effort to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities, and provide models for national reform. The program runs through October 2014. Brenner is the program’s director.

With one grant, the Camden team shares expertise and resources with selected AF4Q communities to enable them to develop local approaches to care for their community’s super utilizers.

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5 Grant ID# 69569 ($900,000; December 15, 2011 through December 14, 2014).
With an additional grant to the Cooper Foundation, Brenner and his team are building and stabilizing the leadership of CCHP to:

- Meet clinical, policy, workforce-development, and data-analytic needs
- Develop a sustainable business plan for CCHP
- Support the development of programs for super utilizers nationwide by creating and sharing core program resources and creating local centers of excellence

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6 Grant ID# 71469 ($1,700,000; December 15, 2013 through December 14, 2015).
BIBLIOGRAPHY

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

Article


GRANTEE STORY

Jeffrey C. Brenner, MD (posted October 2012)