The Camden Model

An integrated community-led safety-net Accountable Care Organization

Achieving a triple bottom-line

1. Better care for highest need patients and communities
2. Reducing health care costs
3. A sustainable model for improving health outcomes in underserved communities
Main idea

Apply the principles and practices of community organizing to reorganize a fragmented health care delivery system

Context: Camden Health Data

- 2002 – 2009 with Lourdes, Cooper, Virtua data
  - 480,000 records with 98,000 patients
  - 50% population use ER/hospital in one year
- Leading ED/hospital utilizers citywide
  - 324 visits in 5 years
  - 113 visits in 1 year
- Total revenue to hospitals for Camden residents $460,000,000 + charity care
  - Most expensive patient $3.5 million
  - 30% costs = 1% patients
  - 80% costs = 13% patients
  - 90% costs = 20% patients
Top 10 ER Diagnosis 2002-2007 (317,791 visits)

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>465.9</td>
<td>ACUTE UPPER RESPIRATORY INFECTION (head cold)</td>
<td>12,549</td>
</tr>
<tr>
<td>382.9</td>
<td>OTITIS MEDIA NOS (ear infx)</td>
<td>7,638</td>
</tr>
<tr>
<td>079.99</td>
<td>VIRAL INFECTION NOS</td>
<td>7,577</td>
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<tr>
<td>462</td>
<td>ACUTE PHARYNGITIS (sore throat)</td>
<td>6,195</td>
</tr>
<tr>
<td>493.92</td>
<td>ASTHMA NOS W/ EXACER</td>
<td>5,393</td>
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<tr>
<td>558.9</td>
<td>NONINF GASTROENTERI (stomach virus)</td>
<td>5,037</td>
</tr>
<tr>
<td>789.09</td>
<td>ABDOMINAL PAIN-SITE NEC</td>
<td>4,773</td>
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<tr>
<td>780.6</td>
<td>FEVER</td>
<td>4,219</td>
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<tr>
<td>786.59</td>
<td>CHEST PAIN NEC</td>
<td>3,711</td>
</tr>
<tr>
<td>784.0</td>
<td>HEADACHE</td>
<td>3,248</td>
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</tbody>
</table>

Hospital and Emergency Visits by Block (January 2002 - June 2008)

Northgate I public housing

<table>
<thead>
<tr>
<th>Year</th>
<th>Visits</th>
<th>Patients</th>
<th>Charges</th>
<th>Receipts</th>
<th>Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>538</td>
<td>447</td>
<td>$10,624,429</td>
<td>$1,265,372</td>
<td>12%</td>
</tr>
<tr>
<td>2006</td>
<td>538</td>
<td>447</td>
<td>$6,865,965</td>
<td>$881,549</td>
<td>13%</td>
</tr>
<tr>
<td>2007</td>
<td>538</td>
<td>447</td>
<td>$7,979,262</td>
<td>$931,851</td>
<td>11%</td>
</tr>
<tr>
<td>2008</td>
<td>538</td>
<td>447</td>
<td>$6,150,592</td>
<td>$984,019</td>
<td>14%</td>
</tr>
<tr>
<td>Total</td>
<td>4,788</td>
<td>2,070</td>
<td>$51,735,374</td>
<td>$6,386,361</td>
<td>12%</td>
</tr>
</tbody>
</table>

Primary Diagnosis

- abdominal pain (789.0)
- acute URI NOS (465.9)
- chest pain (786.5)
- congestive heart failure NOS (428.0)
1. Promote collaboration among providers and between providers and the community
2. Build public will for fundamental changes in the delivery of care
3. Directly engage residents in “hot-spot” neighborhoods and populations
4. Train local residents to participate in decision-making over health care resources

Community Engagement Model
1. Promote collaboration among providers and between providers and the community

CCOP community leaders have travelled to Trenton to testify in support of state community-driven ACO legislation

2. Build public will for fundamental changes in the delivery of care

CCOP community leaders have travelled to Trenton to testify in support of state community-driven ACO legislation
Hot Spot Listening:

(1) Organizers visit people in neighborhoods that are generating high-levels of emergency room visits, to hear people’s experience

(2) Organizers engage local institutions (congregations, schools, etc...) as partners.

(3) Organizers find potential leaders in the community and bring them together to identify priorities for improving care and allocating shared savings.

3. Directly engage residents in “hot-spot” neighborhoods and populations

On March 22, 2011 300 Camden residents gathered with local, state and federal officials for a ribbon-cutting ceremony for a new nurse practitioner clinic in North Gate II
A Covenant for a Healthier Community

For too long the residents of the City of Camden have suffered long waits in the emergency room, difficulty getting timely access to primary care, and repeated visits to the hospital for preventable reasons. Fixing this problem will require a dramatic change by everyone: patients, providers, insurance companies, hospitals, and the State of New Jersey.

- We pledge to work together for a healthier city.
- We pledge to collaborate, even when it gets hard.
- We pledge to have hard, honest discussions and use data to find our way.
- We pledge to set aside old ideas and seek new solutions.
- We pledge to be accountable for measurable improvements over time.
- We pledge to work towards a system where patients can find timely access to high quality healthcare services.
- We pledge to not call 911 or go to the emergency room when there are better options for care.
- We pledge to eat well, get plenty of sleep, and exercise.
- We pledge to ask questions and take enough time to listen deeply.
- We pledge to address the poverty, unsafe living conditions, and environmental contamination that lead to poor health outcomes in Camden.
- We pledge to look after one another because caring and compassion from neighbors, family, friends, and fellow parishioners are the best ways to prevent illness.
- We pledge to seek a different way to pay for healthcare that rewards good outcomes and creates a healthier community.
The Camden “Community Engagement” Model

- Community Engagement
- Shared Savings
- Data sharing
- Reduced emergency room utilization
- Identification of high cost geographies and populations
- Engaging residents in hot-spot communities
- Targeted “high-touch” interventions

Overview of the Camden Coalition of Health Care Providers

- 20 member board, incorporated non-profit
- Foundation and hospital support
- Projects-
  - Camden Health Database
  - Citywide Care Management Project
  - Camden Diabetes Collaborative
  - Camden Health Information Exchange
  - Citywide Violence Intervention
Key interventions
Camden Coalition of Healthcare Providers

- Community Coalition-building
- Data Analysis and Sharing
  - Claims data
  - Local health information exchange (HIE)
- Special Needs Medical Home
  - High Utilizer Teams
  - Nurse Practitioner clinics
- Primary Care Transformation
- Community Engagement
  - Community Organizing
  - Lay Health Education and Professional Health Education

Initial Project Outcomes for Patients in Citywide Care Management Project
Measured as rates per month before and after the intervention at 1:1 ratio
N=36 patients

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Before</th>
<th>After</th>
<th>Absolute Change</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charges</td>
<td>$1,218,010</td>
<td>$531,203</td>
<td>-$686,807</td>
<td>-56.4%</td>
</tr>
<tr>
<td>Receipts</td>
<td>$83,992</td>
<td>$55,642</td>
<td>-$28,350</td>
<td>-33.8%</td>
</tr>
<tr>
<td>Collections rate</td>
<td>6.9%</td>
<td>10.5%</td>
<td>3.6%</td>
<td>51.9%</td>
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<tr>
<td>Emergency Visits</td>
<td>43,532</td>
<td>29,363</td>
<td>-14.169</td>
<td>-32.6%</td>
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<tr>
<td>Inpatient Visits</td>
<td>18,063</td>
<td>7,850</td>
<td>-10.214</td>
<td>-56.5%</td>
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</tbody>
</table>
SENATE, No. 2443
STATE OF NEW JERSEY
214th LEGISLATURE
INTRODUCED DECEMBER 6, 2010

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)

SYNOPSIS
Establishes Medicaid Accountable Care Organization Demonstration Project in DHS.

CURRENT VERSION OF TEXT
As introduced.
NJ Medicaid ACO Pilots

- Community-based non-profit
- Geographic Collaboration
  - 100% inpatient hospitals
  - 75% of primary care providers
  - At least 4 behavioral health providers
- Payer participation
  - Mandatory Medicaid FFS
  - Optional Medicaid HMO’s

NJ Medicaid ACO Pilots

- Gainsharing or shared savings model
  - No change in current mode of payment
- State plays the role of intermediary
  - Recognizing ACO’s
  - Ensures appropriate use of gainsharing funds
- Rutgers State Center for Health Policy
  - Helps calculate gainsharing payments
- Two cities ready (Camden, Trenton) and other cities exploring
National learning community to support replication across communities

Learning community supported by training, shared infrastructure and direct on-site consulting.

Tier I
- Buy-in among key hospital and primary care providers
- Data set to track results
- Public support for integrated systems change
- Non-profit structure in place to fully implement an integrated care delivery model

Tier II
- Have a structure for collaboration among stakeholders
- Have identified a targeted geography or population
- Ready to begin implementing elements of the model

Tier III
- Participating in cross-site trainings
- Receiving Technical Assistance consulting
- Meeting with potential local champions
- Listening to community priorities

Partnership of:
- PICO National Network
- Camden Coalition of Health Care Providers,
- Center for Health Care Strategies
- Rutgers Center for State Health Policy

Implications for Health Care Delivery System Demonstration Projects

1. Community organizing is an integral component to sustainable change
2. Greatest and most immediate benefit from focusing on the highest need communities and patients
3. Need for real community representation in ACO governance
4. Part of shared savings should be reinvested in improving population health