Camden Coalition

Nurse Led Care Conference

October 3, 2019

Presenters

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Camden Coalition for Healthcare Providers

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Today's Objectives

1. Explain complex care and the various models of Nurse-led care at the Camden Coalition
2. Demonstrate the roles for nurses of all degree levels within this discipline
3. Demonstrate how to build, support, and promote a resilient nurse-led workforce.
4. Create a data-driven culture to demonstrate the impact and value of nurse-led care

Nurse Led Complex Care

At the Camden Coalition with patients;

With the South Jersey Population;

Across the country with partners.

Our Vision & Mission describe our goal of a transformed healthcare system rooted in Camden and spreading across the country.

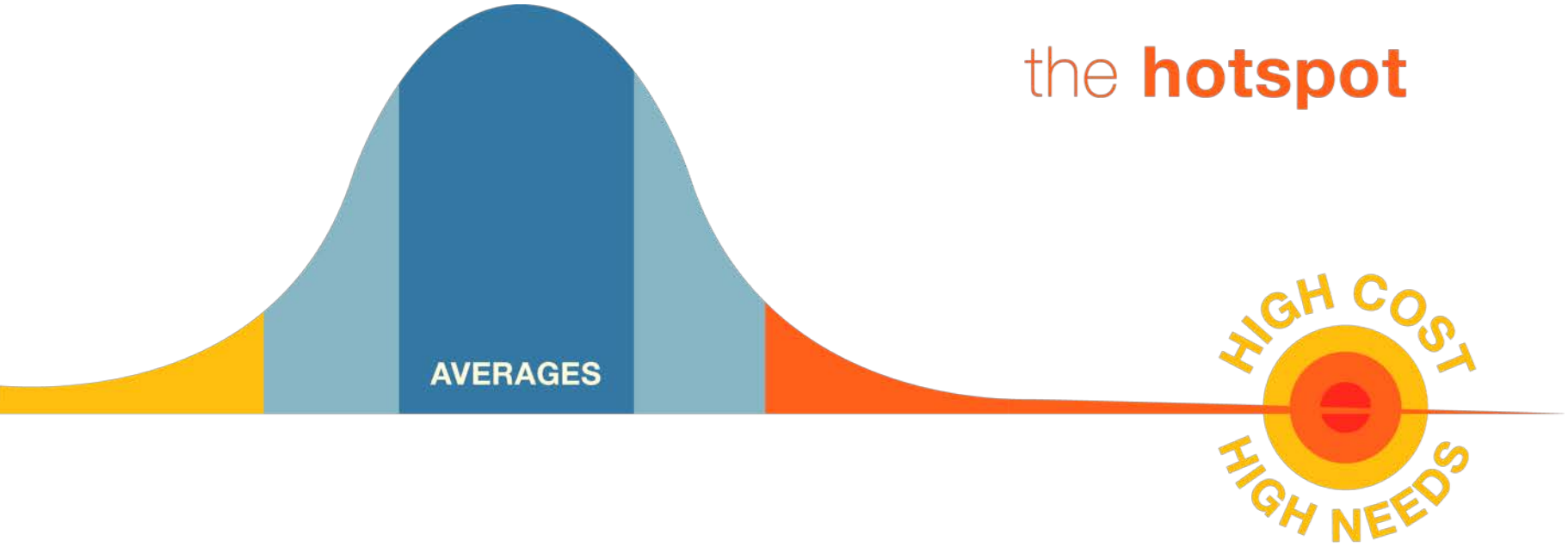
VISION

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.

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.

Complex care is a **person-centered** approach to address the needs of people whose combinations of medical, behavioral health, and social challenges result in extreme patterns of healthcare utilization and cost. **Complex care works at the individual and systemic levels**: it coordinates better care for individuals while **reshaping ecosystems of services and healthcare**. By better addressing complex needs, complex care can reduce unnecessary spending in both healthcare and social services sectors.

We believe that designing the healthcare system to effectively care for individuals with complex health and social needs has the potential to bend the cost-curve.

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 built a staff with diverse backgrounds. Nurses serve in roles across the organization – front line clinicians, program managers, consultants, organizational leaders.

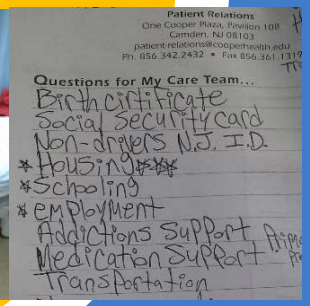
Complex Care at the Patient Level

The Camden Core Model is our nurse-led complex care management intervention. It stresses authentic, face-to-face interaction with the highest-need, highest-cost patients.

Daily Triage

Bedside Engagement

Community Visits



Care Planning

Our nurses and CHWs use the **COACH Model** & our tenets of care to build authentic healing relationships, work with patients toward sustained behavior change & track progress on their goals.

Connect tasks with vision and priorities

Observe the normal routine

Assume a coaching style

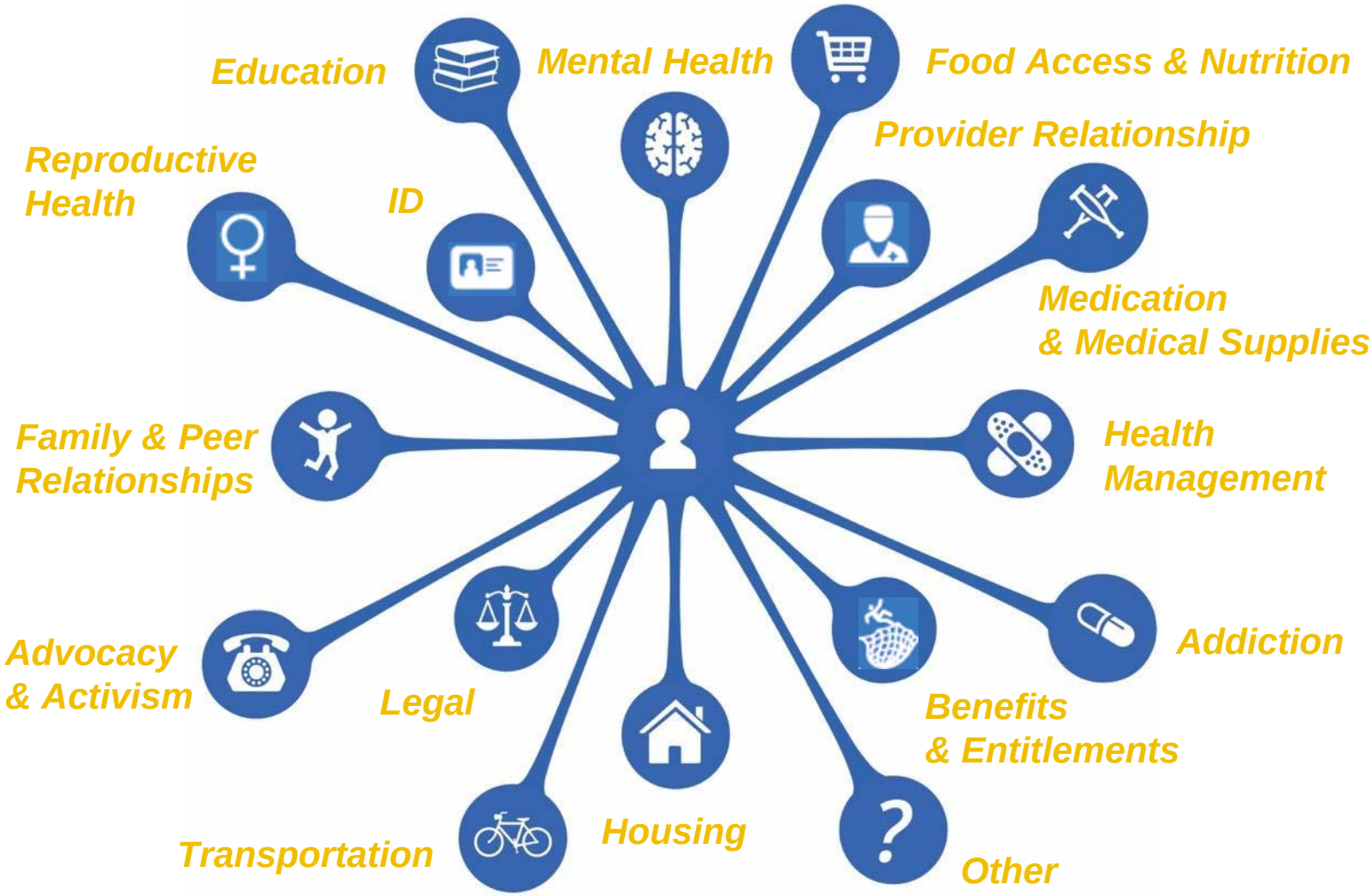
Create a care plan

Highlight progress with data

Our Tenets of Care

- Motivational interviewing
- Trauma-informed care
- Authentic healing relationships
- Accompaniment

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 the success of our model.

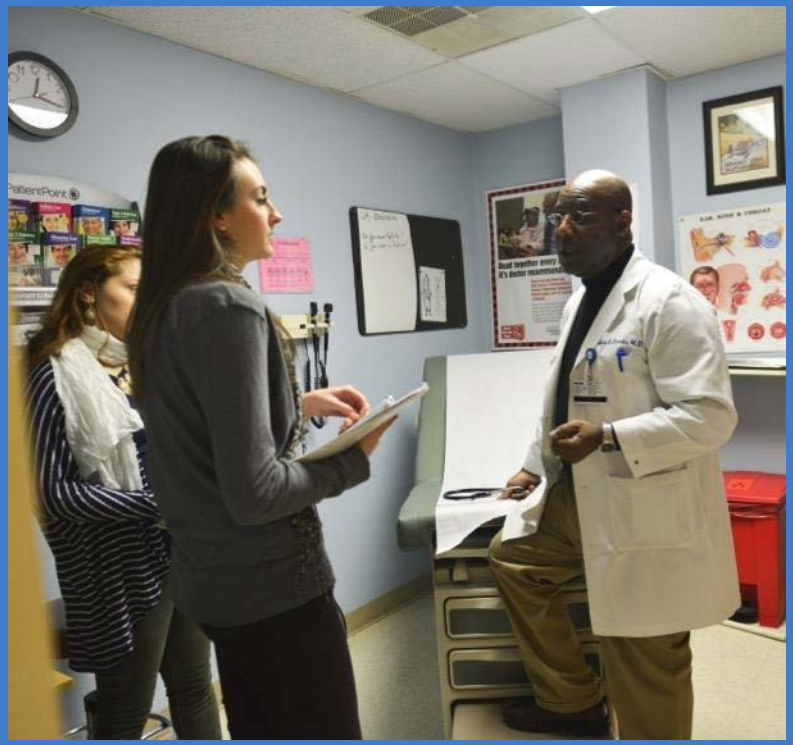
Complex Care at the Population Level

At the population health level the Nursing perspective contributes a not only a clinical lens, but also helps ensure that patients and clinicians are involved in co-designing these approaches

- Making Data Available
- Local Convening

- Co-designing interventions with partners
- Coaching on care while also empathizing with partners challenges and elevating issues

At the practice-level, we meet with clinical partners monthly to review workflow activation, clinical cases, and data fed by our Health Information Exchange.



One example of a shared city-wide workflow is 7 Day Pledge

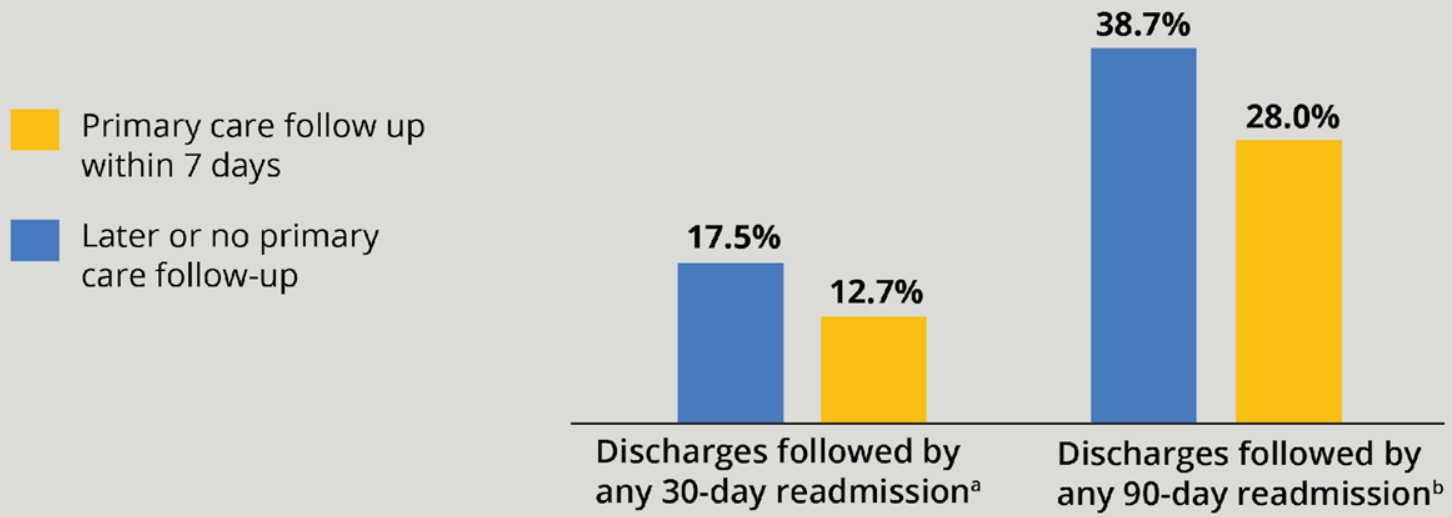
a program to re-connect hospitalized patients to their primary care physician within 7 days of discharge.

When we evaluated our 7 Day Pledge program, we found that it reduced hospital readmissions.

7-DAY PLEDGE

Reducing hospital readmissions

Readmissions are lower when a hospital discharge is followed by a primary care follow-up within seven days:



[a]Difference, 4.8%; 95% CI, 0.52%-9.17%; P=0.03 [b]Difference, 10.7%; 95% CI, 4.98%-16.36%; P=.002
Percentages are based on 450 discharges followed by a primary care appointment within 7 days and 450 matched records in which the patient did not have a primary care appointment within 7 days.
Source: "Outcomes of a citywide campaign to reduce Medicaid hospital readmissions with connection to primary care within 7 days of hospital discharge," 2019, doi:10.1001/jamanetworkopen.2018.7369.

Camden Coalition of Healthcare Providers

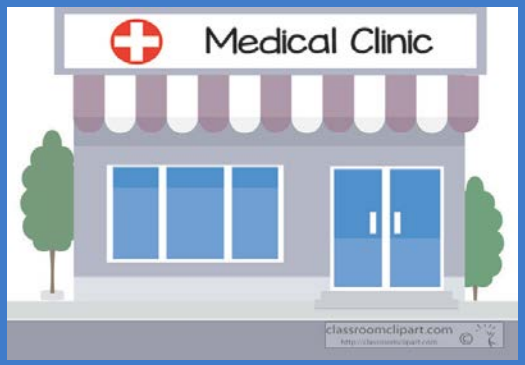
As a neutral convener, we bring organizations together to approach shared challenges and priorities to transform systems of care.

Quarterly ACO Dinners

City-wide Care Management Meetings

Community Advisory Committee Meetings

Building population health approaches, but focusing on how to bring together perspectives to make sure appropriate resources are available for complex patients.



MAT Operations Coaching

- Highlighting importance of training and supporting prescribers AND non prescribers
- Translating lessons to primary care
- Providing clinical partners with connections to data, social service, policy, and patient perspectives

Complex Care at the System Level

Mercy Health Saint Mary's
Grand Rapids, MI

The National Center
for Complex Health and Social Needs

Partnerships

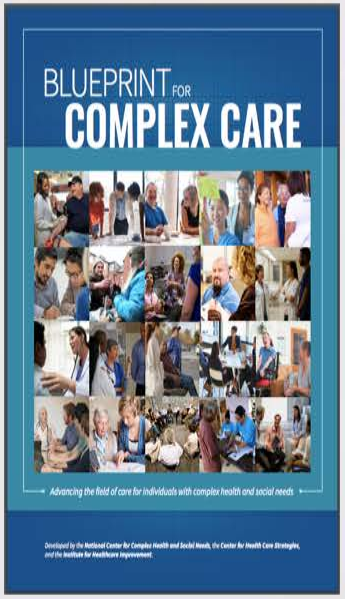
AARP Real Possibilities

Center to Advance Palliative Care™ capc

CHCS Center for Health Care Strategies, Inc.

Institute for Healthcare Improvement

Field Development & Curriculum



Model Co-Design

Camden Coalition's National Center 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

Regional One Health

- Public Health Safety Net system Memphis, TN.
- No Medicaid expansion – 34% uninsured population
- ONE Health Program
- Hospital Based Complex Care Intervention
- Strong focus on SDOH
- Process Improvements: Food Access, Transportation, Housing Accelerator, Behavioral Health Partnership, Benefits, Medications, Employment

Health Affairs Article:
https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00999


POPULATION HEALTH
HONORABLE MENTION

Adventist Health Clear Lake

Lake County, California

- Ranked last in health outcomes
- 75% of county burned in wildfires of the past 5 years
- High rates of poverty and substance misuse

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

AdventistHealth

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

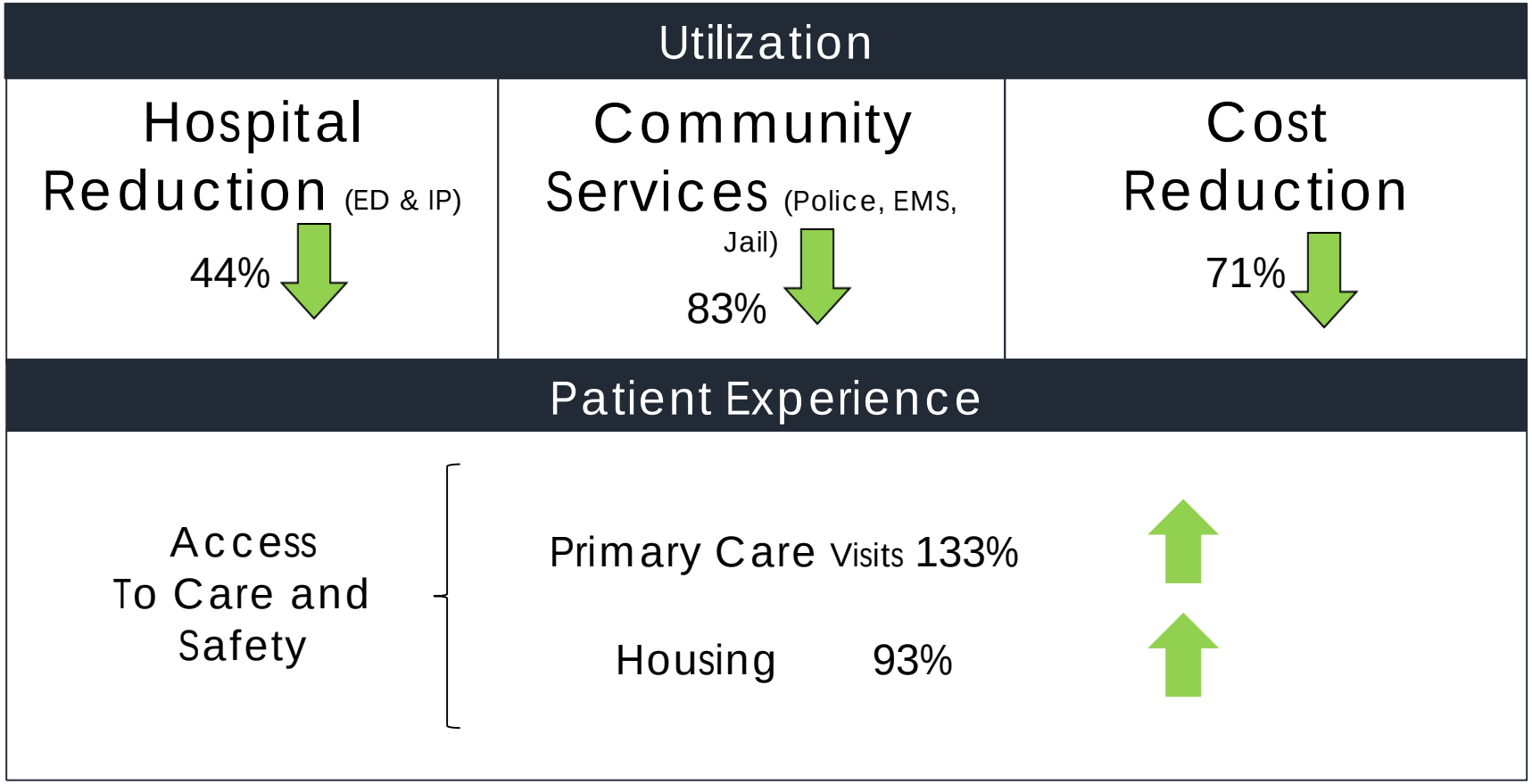
Project Restoration

- 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.



Hardin, et al. Cross-Sector Collaboration for Vulnerable Populations Reduces Utilization and Strengthens Community Partnerships. Manuscript submitted to JIEP *(copy on file with author)*

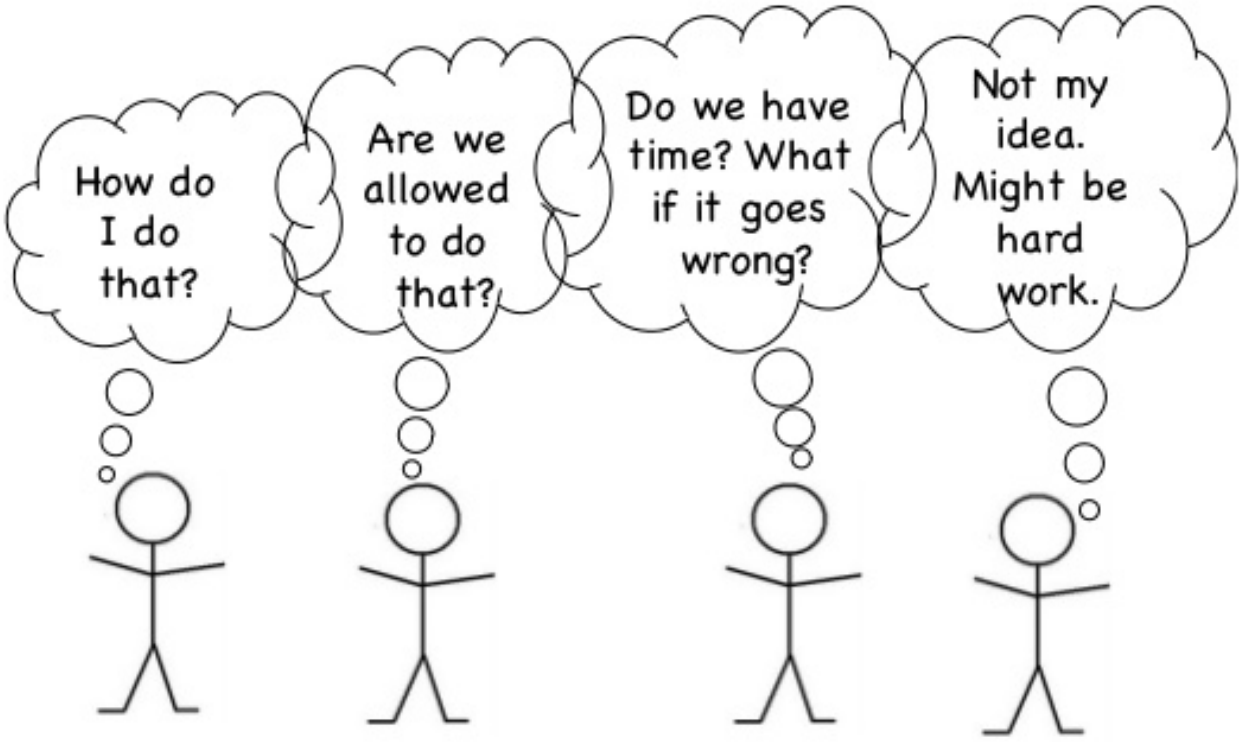

Why I
went to the
emergency
room…


What
matters
most to
providers


What
matters
most
to **teams**

Pathway to Transformation

Reasons People Resist Change



Momentum

Complex care not only spans patient and system-level perspectives, but it also is important to highlight the contributions of nurses across all degree levels.

LPN – Opportunities for roles in the community-based care settings

RN – Increasing role of medical case managers, as well as public health nurses

MSN – Bringing programmatic and systems perspective that is grounded in clinical care

All roles can step into leadership, advocacy, and bridging across communities and roles.

“The beauty of nursing is that it truly is an art an a science. The essence of the art of caring for people is the ability to build a connection with another human being with the goal of improving that person's health and overall wellness. The best nurses, regardless of the little letters behind their names, are able to build these authentic connections with patients while applying their medical knowledge to help patients identify and reach their health goals. ”

– Camden Coalition Nurse

- Systems Thinking
- Data Informed
- Collaboration
- Social Justice
- Whole Person View
- Process Improvements

Translating Your Skills to Population Health

From the Navigator to the Advocate

"Nurses are more trusted, as you know, than any other profession and are woven into the fabric of communities in ways other health care practitioners are not. We need to leverage the skills, the perspectives and the trust that nurses have gained, as well as their role as a hub in health care delivery to enable them, where possible, to change the equation fundamentally shaped by social determinants."

- C. Alicia Georges at the Future of Nursing Philadelphia Town Hall

Questions

Resources for Learning

The National Center for Complex Health and Social Needs

https://www.nationalcomplex.care/

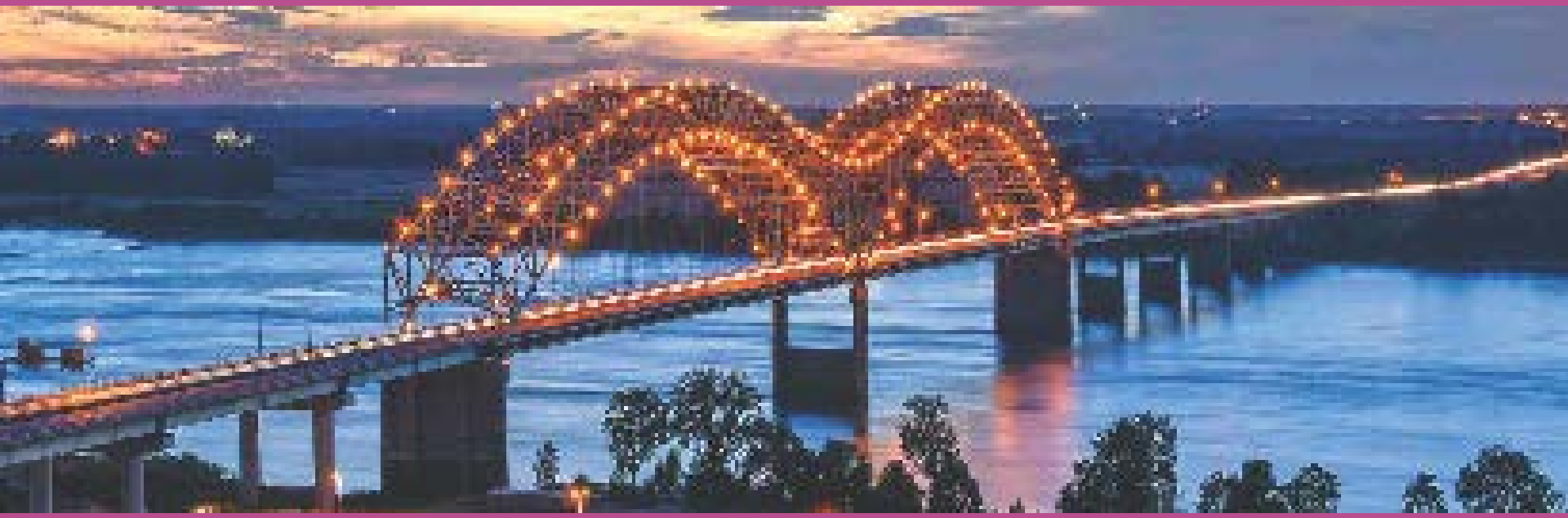
the Playbook

https://www.bettercareplaybook.org/

Save the Date: *Putting Care at the Center 2019*

November 13 – 15, 2019 | Memphis, Tennessee

www.centering.care



This year's conference will be co-hosted with Regional One Health

Publications

- Hardin, L. & Trumbo, S. (April 2019). Taking care of Charlie helped one California town nearly halve hospital use. STAT. *https://www.statnews.com/2019/04/08/taking-care-charlie-reduce-hospital-use/*
- Nickitas, D., Middaugh, D., & Feeg, V. (2019). Policy and Politics for Nurses and other Health Professionals 3rd edition. Burlington, MA: Jones & Bartlett Learning. Case Study Changing the Delivery System for Complex Patients, Contributing Author
- Hardin, L., Kilian, A., & Spykerman, K. (2017). Competing health systems and complex patients: An interprofessional collaboration to improve outcomes and reduce healthcare costs. *Journal of Interprofessional Education and Practice, 7, 5-10.* http://jieponline.com/article/S2405-4526(16)30103-3/pdf
- Hardin L, Kilian A, Muller L, Callison K, & Olgren M. (2016). Cross-Continuum Tool is Associated with Reduced Utilization and Cost for Frequent High-Need Users. The Western Journal of Emergency Medicine, 18(2), 189–200. doi:10.5811/westjem.2016.11.31916
- Hardin L, Kilian A, & Olgren M. (2016). Perspective on Root Causes of High Utilization that Extend Beyond the Patient. *Population Health Management*. doi:10.1089/pop.2016.0088
- Hardin L. (2016). Restoring Dignity for Vulnerable Populations: Changing the System for Complex Patients. *Health Progress, January-February, 28-32. https://www.chausa.org/docs/default-source/health-progress/restoring-dignity-for-vulnerable-populations-changing-the-system-for-complex-patients.pdf?sfvrsn=0.*