Lessons from the Camden Coalition's Core Model RCT

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NORTH AMERICA

Camden Coalition

Camden Core Model & Path to RCT

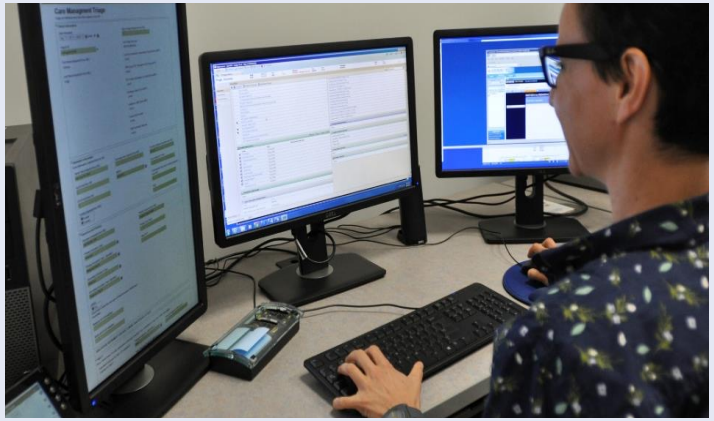
CAMDEN CORE MODEL

- Interdisciplinary (RN, SW, CHW, +), community-based care management program targeting patients with complex health and social needs

- Population
  - 18-80yr olds, Camden City residents
  - 2+ hospital admissions in 6 months
  - 2+ chronic conditions
  - 2+ markers of complexity (e.g. mental health, substance use, homelessness)
  - Predominantly Medicaid & Medicare

- Key components
  - Engage at hospital bedside
  - Frequent home visits
  - Connection to PCP/specialty care
  - Medication reconciliation
  - Personalized care planning
  - Broader care coordination and other support

- Time limited (~90 days)
- Model evolving through continuous quality improvement



Path to RCT

- Significant national attention with proliferation of value-based payment models
- Stable multi-year funding (CMMI grant)
- Early (non-randomized) evaluation efforts encouraging
- Opportunity to partner with J-PAL North America and help promote more rigorous evaluation of social care programs

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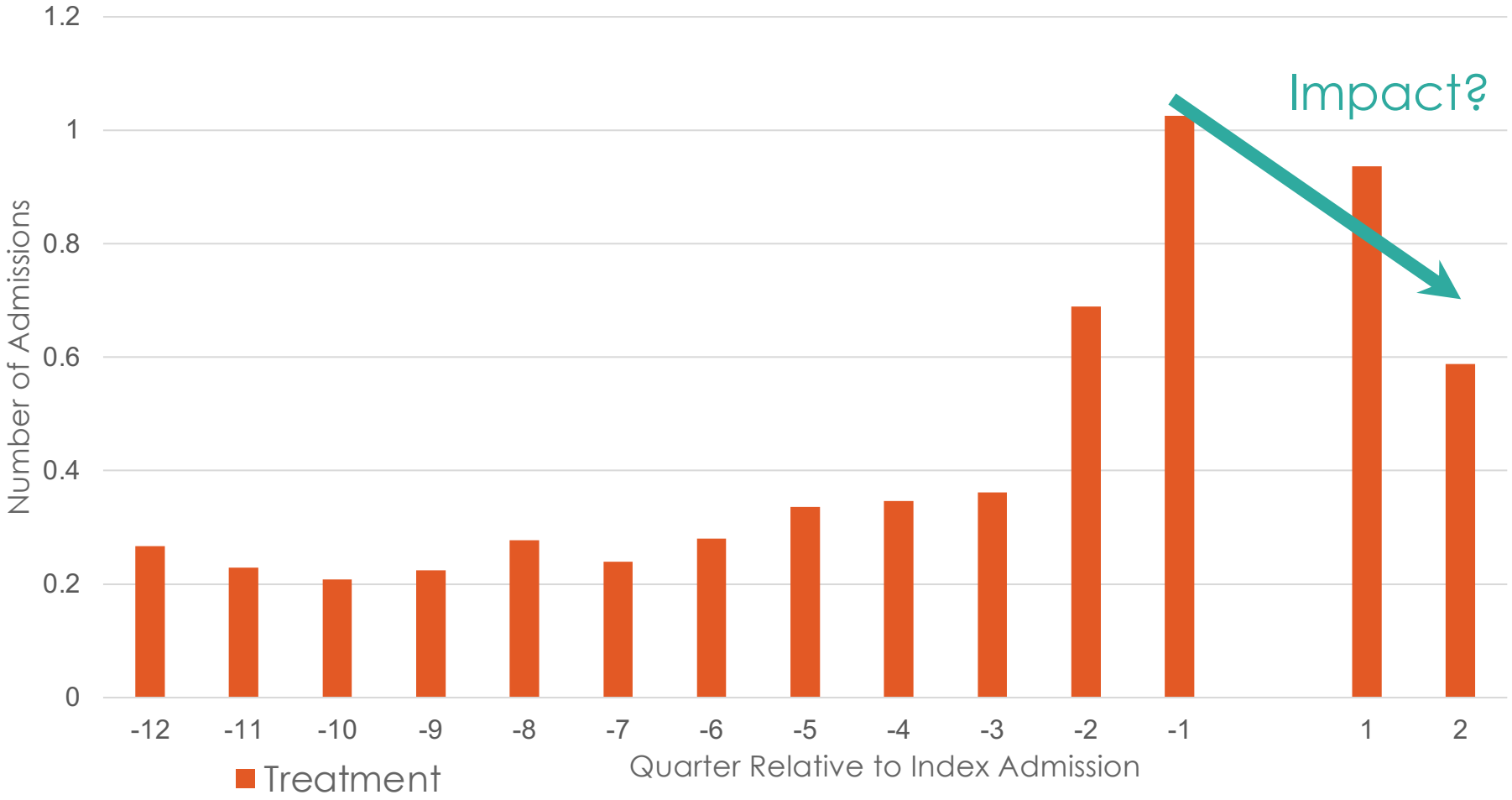
800 patients were enrolled while admitted to the hospital

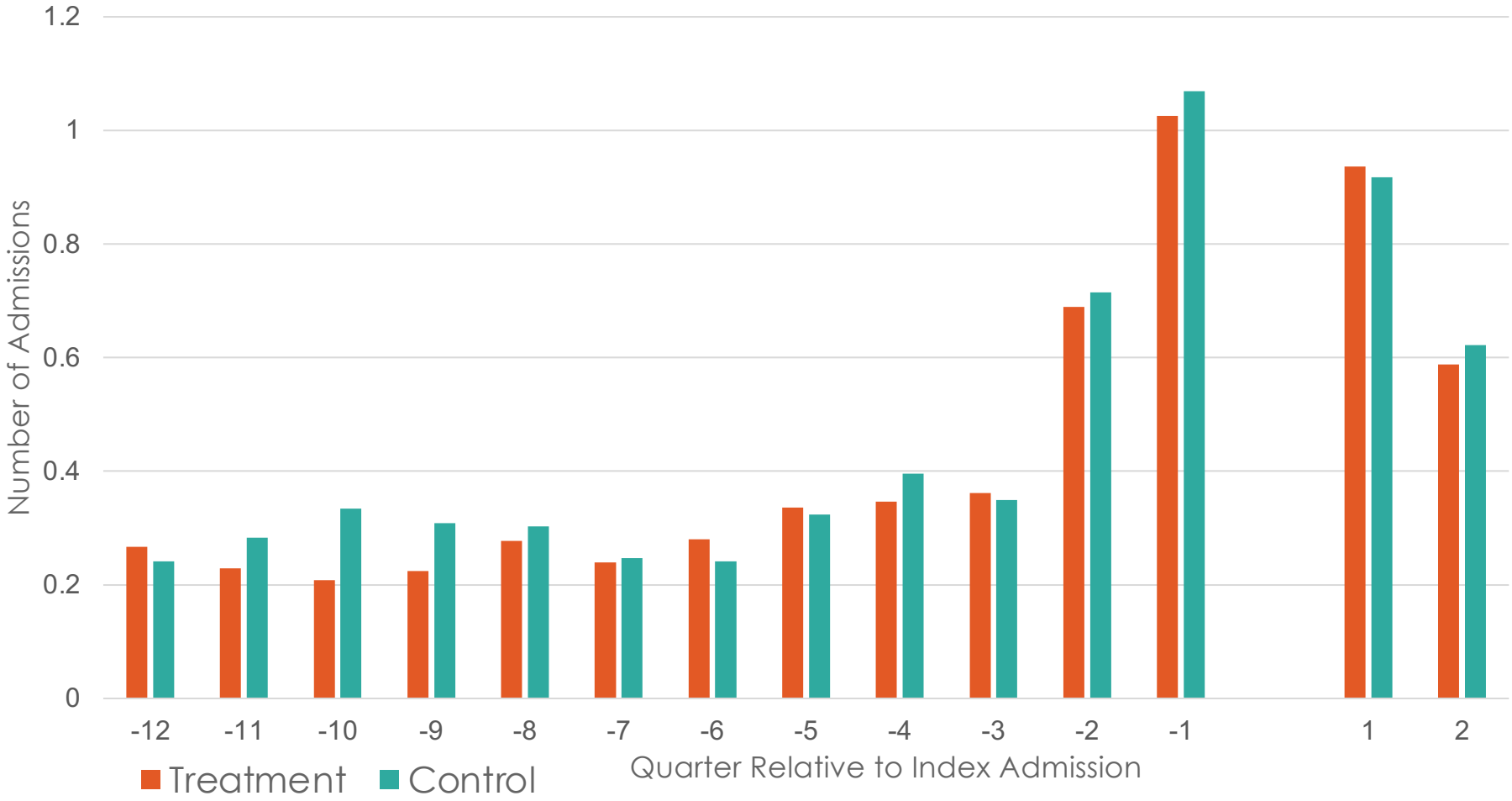
Primary outcome:

- Any readmission within 180 days of discharge

Program participants visited the hospital about 40% less in the six months post-intervention



But we saw the same decline in hospital use among those in the control group



Result: no impact on readmissions

These Patients Are Hard to Treat

A study examined a popular approach that coordinated care for the most expensive patients, and found that the project did not reduce hospital admissions.

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HEALTH REPORTING IN THE STATES

Reduce Health Costs By Nurturing The Sickest? A Much-Touted Idea Disappoints

JANUARY 8, 2020 · 5:00 PM ET

FROM KFF Health News

HEARD ON ALL THINGS CONSIDERED

By Dan Gorenstein, Leslie Walker

Unanswered questions generated debate

THE MILBANK QUARTERLY CURRENT ISSUE EARLY VIEW ARCHIVE NAVIGA

MARCH 2020 (VOLUME 98)
QUARTERLY ARTICLE

"Super-Utilizer" Interventions: What They Reveal About Evaluation Research, Wishful Thinking, and Health Equity

FIRST OPINION

Approaches to complex care innovation are 'naïve and insufficient.' We need systems and design thinking

Look Beyond Hotspotting To Focus On A Broader Population's Unmet Social Needs

Don't Throw Cold Water On Health Care's Hot Spotters

Shreya Kangovi, David Grande

FEBRUARY 11, 2020 10.1377/forefront.20200205.342657

TheUpshot

THE NEW HEALTH CARE

Disappointing Results of Major Study Point to Better Ways to Cut Health Care Waste

And inspired additional research

Dosage and outcomes in a complex care intervention (June 2023)

- Dawn Wiest, Qiang Yang, Teagan Kuruna, Mavis Asiedu-Frimpong (Camden Coalition)

THE AMERICAN JOURNAL OF MANAGED CARE

Hospital readmissions by variation in engagement in the healthcare hotspotting trial: A secondary analysis of a randomized clinical trial (Sep 2023)

-Qiang Yang, Dawn Wiest, Anna C. Davis, Aaron Truchil, John L. Adams (Camden Coalition, Kaiser Permanente)

JAMA Network | Open

The Camden Coalition care management program improved intermediate care coordination: A randomized controlled trial (Dec 2023)

-Amy Finkelstein, Joel C. Cantor, Jesse Gubb, Margaret Koller, Aaron Truchil, Annetta Zhou, Joseph Doyle (J-PAL North America, Camden Coalition, and Rutgers Center for State Health Policy)

Health Affairs

Understanding care coordination success

- Was the null result a failure of **implementation** or a failure of the program's **theory of change**?

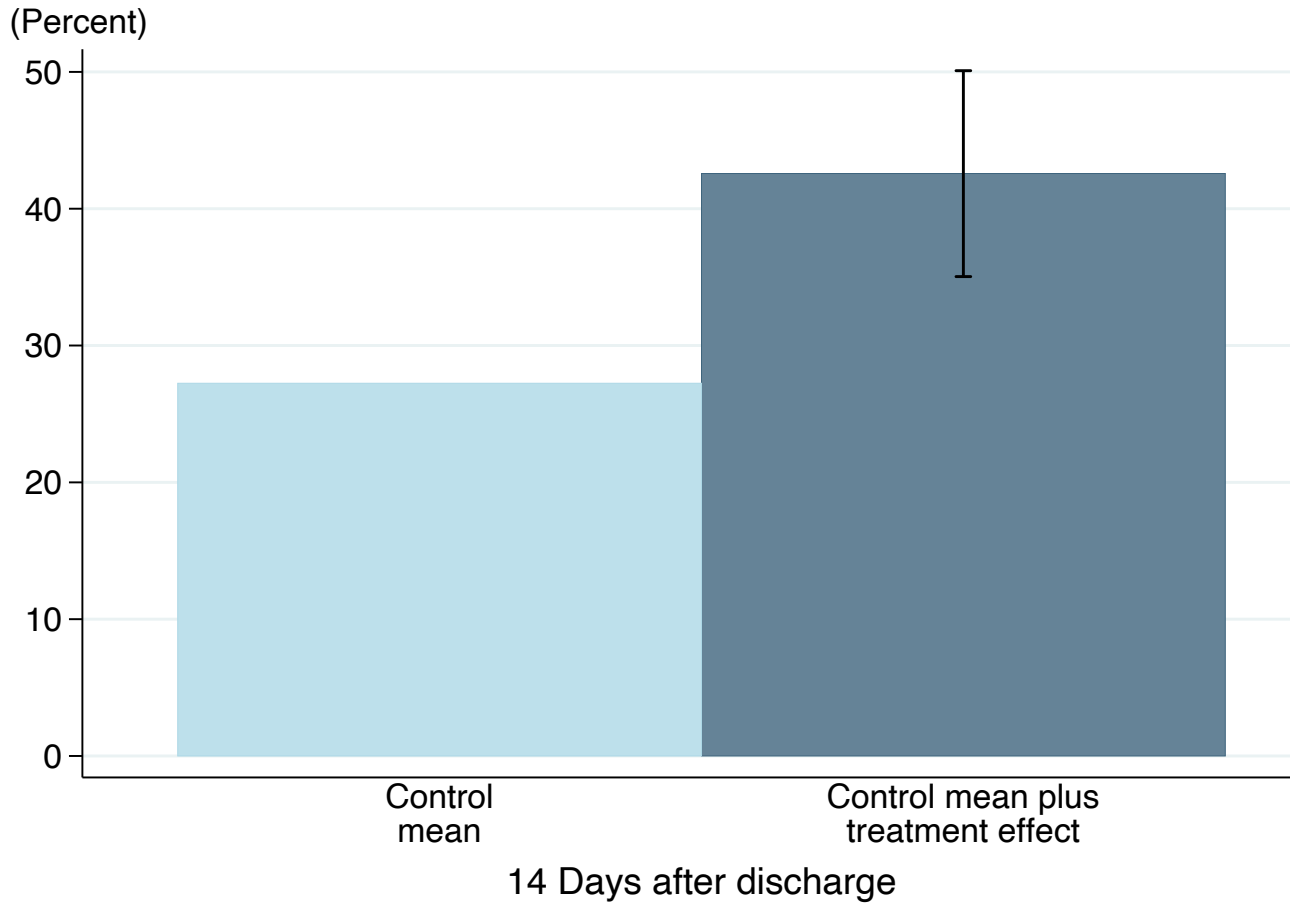
- Program was designed to connect patients to care in the community
  - *Did it?*
  - Mixed evidence in first paper (looking only at treatment group)

- Therefore, we set out to study impacts on office-based care, home care, prescription drugs, and durable medical equipment using new data from NJ Medicaid and Rutgers CSHP

The Camden Coalition care management program improved intermediate care coordination

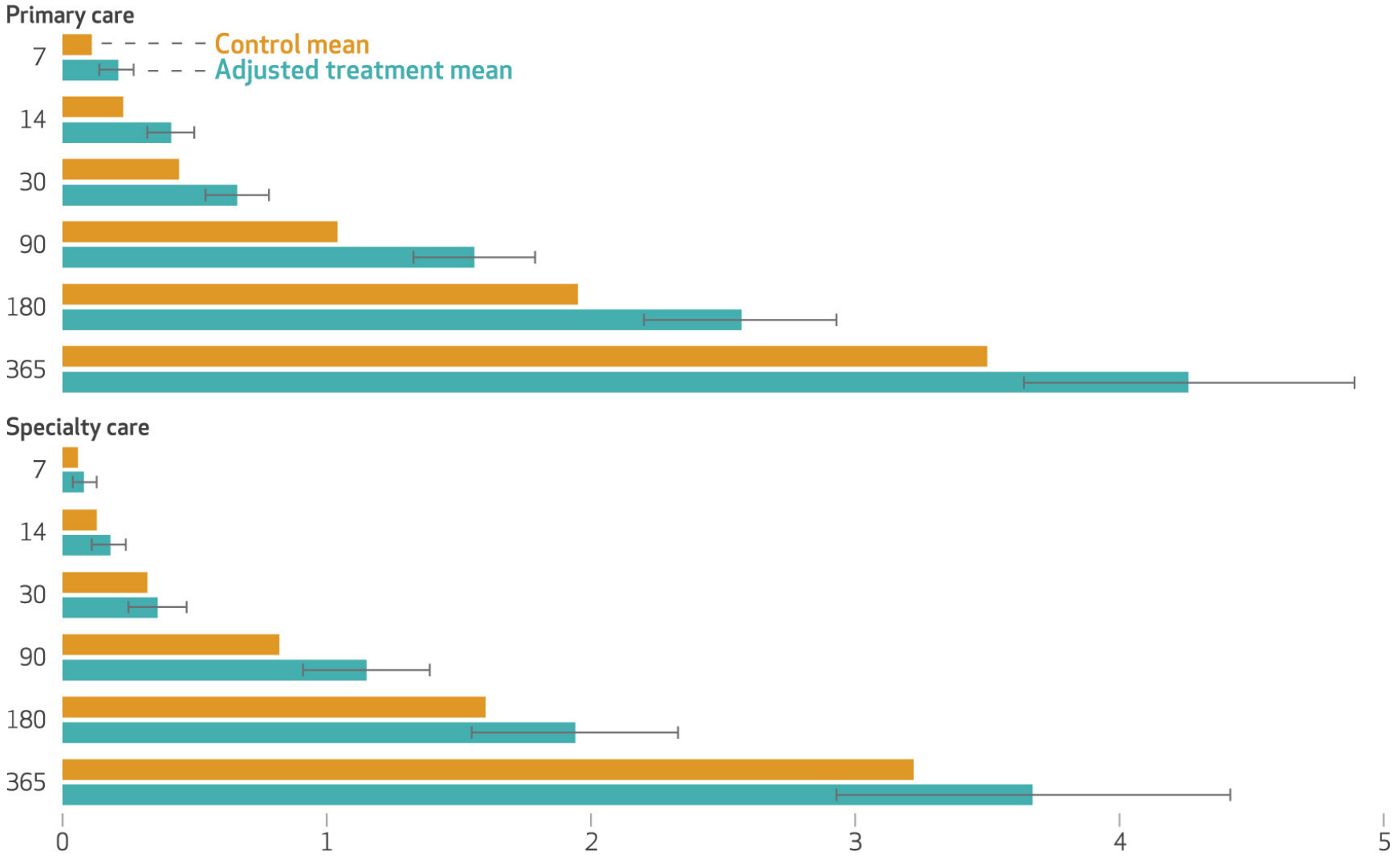
- Program caused an immediate and persistent increase in outpatient office care
  - Both primary care and specialty care increased
  - The increase in visits was similar to what other care coordination programs have achieved (10-15 percentage points)
  - In the absence of the program, very few patients received timely office care (27 percent after two weeks and <75% after 6 months)
- Program increased the proportion receiving any DME (but not the amount of DME)
- No effect on home health care use
- No effect on the quantity of prescriptions drugs

Program caused an immediate and persistent increase in ambulatory office-based care



- 15 percentage point increase in proportion with an office visit 14 days after discharge
- This effect persists through 365 days
- Equates to about 1.25 additional visits over 365 days

The difference in the number of visits was immediate and increased over time, driven by an increase in primary care



“Care coordination alone, even when implemented well, is insufficient to reduce hospitalizations for this complex population of high-need patients.”

RCT RESULTS

Healthcare hotspotting: A randomized, controlled trial (2020)

Dosage and outcomes in a complex care intervention (June 2023)

Hospital readmissions by variation in engagement in the healthcare hotspotting trial: A secondary analysis of a randomized clinical trial (Sep 2023)

The Camden Coalition care management program improved intermediate care coordination: A randomized controlled trial (Dec 2023)

NEW ENGLAND JOURNAL OF MEDICINE 1812 1823 1828 1928

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Health Affairs

Effects observed

- Connection to SNAP
- Connection to primary care
- Connection to specialty care
- Connection to durable medical equipment

Null results

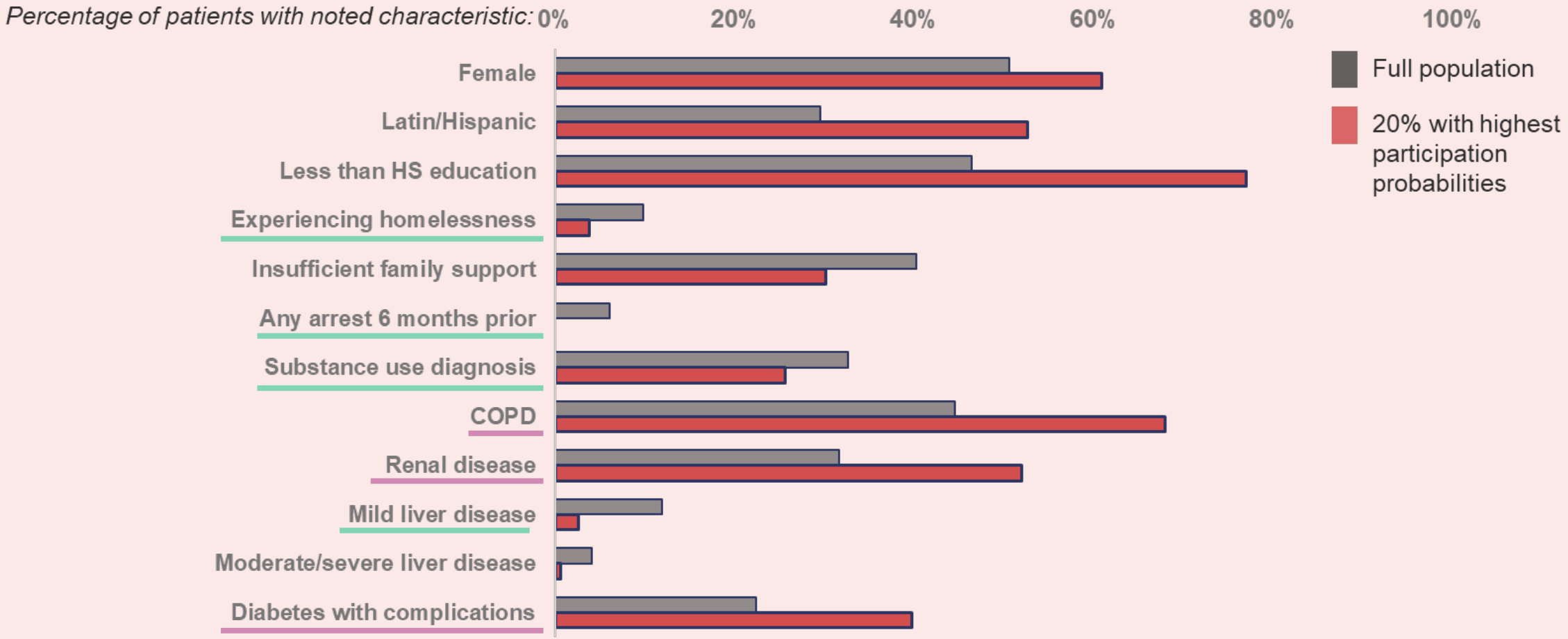
- Hospital readmissions
- Emergency Department visits
- Access to prescriptions
- Home health outcomes

Caveat when analyzing the full RCT population

Not everyone in the intervention group:

1. Engaged in the program
2. Received the same “dosage” of care management

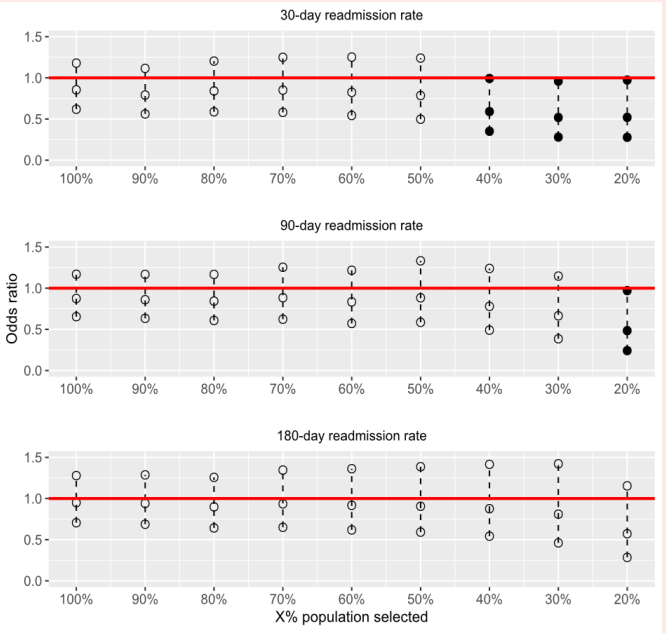
Based on baseline characteristics, who was most and least likely to engage in care management?

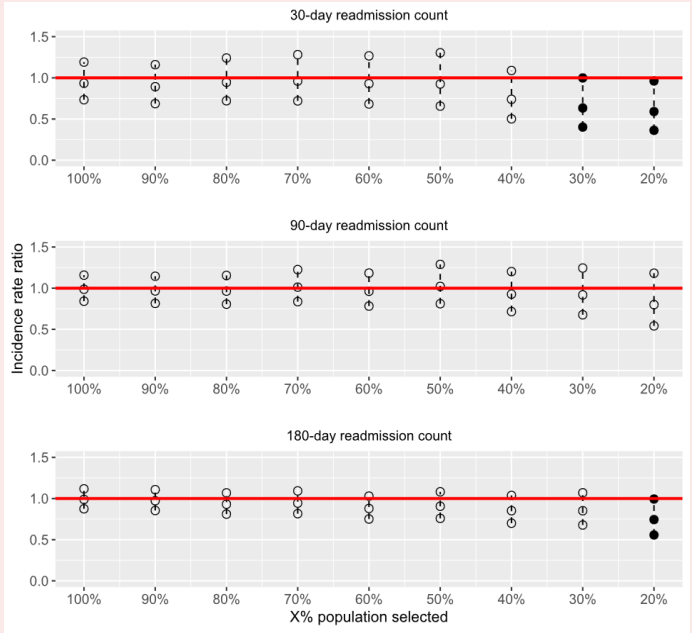


Engagement matters

Greater intervention participation was associated with:

- significantly **lower readmission rates** 30 and 90 days after hospital discharge
- significantly **lower numbers of** 30- and 180-day **readmissions**





95% confidence interval of the odds ratio and incidence rate ratio for readmission rates between intervention and control group patients within increasingly distilled samples

NEW ADVANCES

Expanded internal teams and supports

Housing First

Medical Legal Partnership

Deeper partnerships with addiction medicine (including partnership with local jail)