**ABSTRACT**

**Goals:** The Camden Coalition of Healthcare Providers’ (CCHP) ultimate aim is the reduction of health care costs through improved care coordination. It targets patients with specific goals:

1. Identify patients suitable for enrollment through the Camden Health Information Exchange (HIE).
2. Case of Care Transition outreach team for them to achieve both their specific and broader goals.
3. Improve clinical outcomes and process measures such as attendance to DSME classes and improved adherence to primary care visits.
4. Decreased rates of ER and hospital use.

**Method:**

Patients with excess ER and hospital admissions were identified for the program through the Camden Health Information Exchange (HIE). Patients who meet the criteria are enrolled at bedside for a 30-90 day intensive care coordination intervention.

**Target Population:**

Camden City residents with at least two ER visits or hospital admissions within 6 months and chronic co-morbidities.

**Outcome Measures:**

Measuring clinical outcomes such as HbA1c, lipids, blood pressure, number of patients attending DSME, and cost savings associated with the Care Transitions Program, borne out of the Care Management Project, was created.

**Evaluation Results:**

- **1,550,429,036.37** receipts of $203,716,769.83. Among several patients, there was a dramatic decline of ER and hospitalizations from pre-enrollment to post-enrollment, some without any utilization.

**Preliminary Analysis:**

- There was a 57% decrease in both ER and hospital utilization post-enrollment across all patients.
- ER utilizations decreased from an average of 82.25% per month of charges to 69% per month after enrollment.
- Inpatient admissions decreased from an average of $22,225 per month of charges to $0 per month after enrollment.

**RESULTS**

**Goal:** To improve diabetes outcomes for high-utilizing patients in Camden.

**Target Population:**

Camden City residents with at least two ER visits or hospital admissions within 6 months and diabetes as a comorbidity.

**Outreach Team Composition:**

- High Risk Outreach Team
- Intermediate Risk Outreach Team
- RN
- MA
- LPN
- Health Coaches

**Transitions of Care Guiding Principles:**

- *Rule-out criteria* are used to graphically represent patient ER and in-patient hospitalization.

**CONCLUSION**

The Care Transitions Program has been successful in reducing both ER visits and hospitalizations. The Care Transitions Program has been successful in reducing both ER visits and hospitalizations. The Care Transitions Program has been successful in reducing both ER visits and hospitalizations. The Care Transitions Program has been successful in reducing both ER visits and hospitalizations. The Care Transitions Program has been successful in reducing both ER visits and hospitalizations. The Care Transitions Program has been successful in reducing both ER visits and hospitalizations. The Care Transitions Program has been successful in reducing both ER visits and hospitalizations. The Care Transitions Program has been successful in reducing both ER visits and hospitalizations. The Care Transitions Program has been successful in reducing both ER visits and hospitalizations. The Care Transitions Program has been successful in reducing both ER visits and hospitalizations. The Care Transitions Program has been successful in reducing both ER visits and hospitalizations. The Care Transitions Program has been successful in reducing both ER visits and hospitalizations.