

CAPITAL CLINICAL INTEGRATED NETWORK





A RESPONSE TO CARE COORDINATION

GINA PISTULKA DEPARTMENT OF HEALTHCARE FINANCE SEPTEMBER 29, 2015

CCIN - Capital Clinical Integrated Network



Goals & Objectives

Funded by the Center for Medicare and Medicaid Services Innovation to Create an Integrated Care Coordination and Care Delivery System

- Improve access and coordination of care within the healthcare system within the District of Columbia. (key linkages, partnerships, technology)
- Improve the health of the CCIN participant population (HEDIS Measures)
- Reduce healthcare costs incurred by CCIN participants over 3 years



Our Partners and Subscribers

Clinics/Hospitals MCOs

- Bread for the City
- La Clinica del Pueblo
- Mary's Center
- So Others Might Eat
- Children's Medical Center
- Providence Hospital
- Core Service Agencies (Green Door, Life Stride)

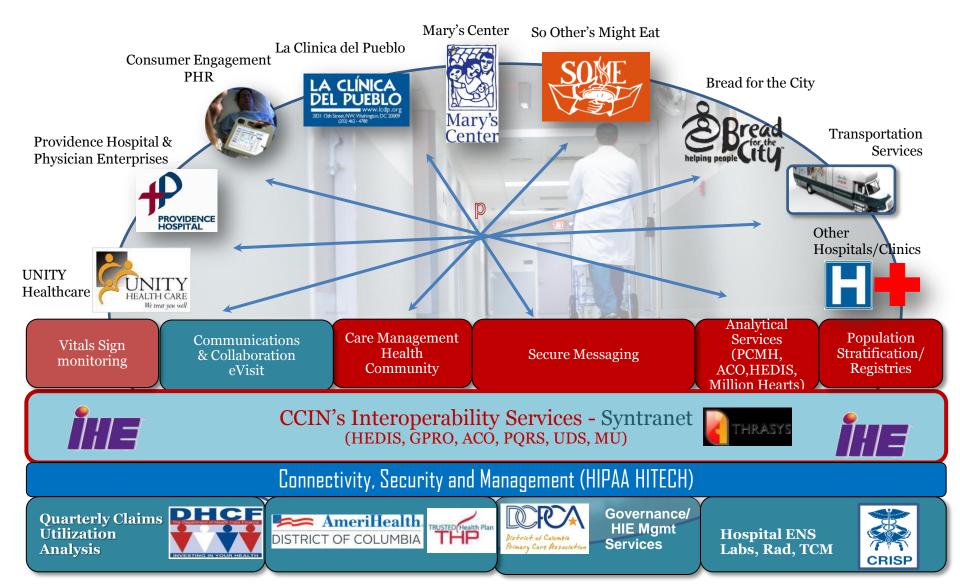
- Trusted
- Amerihealth

Government Entities

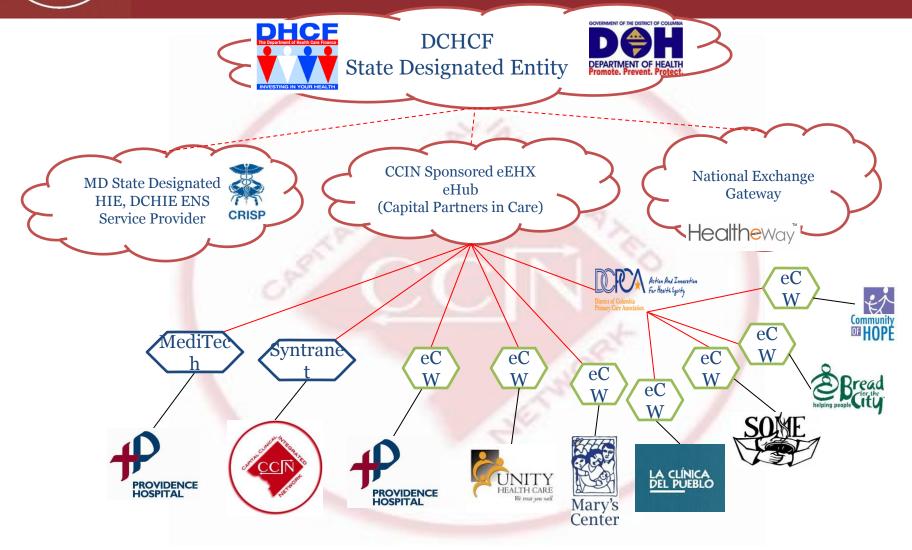
- DC Health Care Finance
- DC Primary Care Association



Capital Clinic Integrated Network (CCIN) VISION



Connectivity Among Health Care Entities





Impact on System

• Individual/Family

- Understand and act on health information \rightarrow self management of chronic illness
- Connect to Primary Care and Health Homes: Understanding of the role of primary care
- Emergency Room vs. Urgent Care vs. Walk-in Clinic
- Prescription Adherence
- Lifestyle Issues
- Find solutions to barriers: Transportation Options, Substance abuse/Mental health support
- Advocacy
- Receive improved quality of care
- Interpersonal
 - Enhanced relationship/advocacy with healthcare team
- Organizational
 - Improved quality of care, Improve clinic workflows to support participants
- Community
 - Efficient communication, reduction of duplication, higher sense of collaboration
- Policy
 - Advocacy (Quality of Care Delivery, Care Coordination, Improved healthcare system, decreased costs)

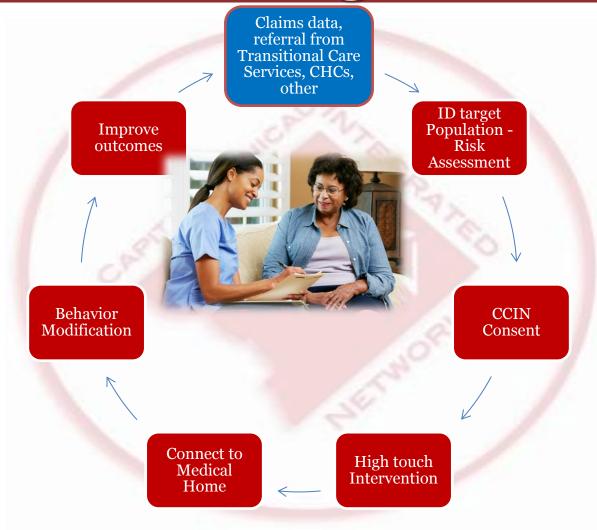


Hi-Tech Arm

- Capital Partners in Care Health Information Exchange
- Care Coordination System
 - Integrated health records
 - Population health management
 - Identify high-risk patients and stratify populations based on disease, condition markers, key cost drivers and other ad-hoc criteria
 - Claims data- monitor and evaluate impact
- Data analytics & reporting on quality, performance, outcomes, and cost savings
- Tele-health



Population Health Management





CCIN CARE COORDINATION SERVICES

- View integrated health records for patients with demographic, clinical and financial data
- Identify high-risk patients and stratify populations based on disease, condition markers and other ad-hoc criteria
- Collaboratively develop individualized care plans, monitor compliance and view status of interventions
- Analyze and report on quality, performance, outcomes, and cost savings
- Vision was to send to clinicians via CPC-HIE, CCIN effort, enrollment status, care plans and other secure messaging regarding participant as it happened.
- Universal care plan



Hi-Touch Arm RN led-CHW teams

Community Health Worker

- Boots on the ground
- Face-to-face participant centered care \rightarrow
 - Create care plans
 - Document activities
 - Capturing structured data
- Coach, navigate, empower, educate and support

RN Care Coordinator

- Clinical triage, case management, med adherence support/reconciliation
- Tele-health
- Quality Improvement: CHW guidance, supervision, training



Thank you!

Contact Information:

Gina Pistulka CCIN Chief Nursing Officer gpistulka@ccin-dc.org gpistulka@yahoo.com Cell: 410-404-3905