A RESPONSE TO CARE COORDINATION

GINA PISTULKA
DEPARTMENT OF HEALTHCARE FINANCE
SEPTEMBER 29, 2015
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
- 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)

MCOs
- Trusted
- Amerihealth

Government Entities
- DC Health Care Finance
- DC Primary Care Association
Connectivity Among Health Care Entities

DCHCF
State Designated Entity

MD State Designated HIE, DCHIE ENS Service Provider

CCIN Sponsored eEHX eHub (Capital Partners in Care)

National Exchange Gateway

MediTec
Syntrane

Healtheway

eC W
eC W
eC W
eC W
eC W
eC W
eC W
eC W

PROVIDENCE HOSPITAL
PROVIDENCE HOSPITAL
UNITY HEALTH CARE
Mary's Center
LA CLINICA DEL PUEBLO

DCRCA
Community of Hope
Bread for the City

CRISP
Impact on System

• **Individual/Family**
  – Understand and act on health information → 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

- Claims data, referral from Transitional Care Services, CHCs, other
- ID target Population - Risk Assessment
- CCIN Consent
- Connect to Medical Home
- High touch Intervention
- Improve outcomes
- Behavior Modification
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 →
  – 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