

Care Coordination - Best Practices

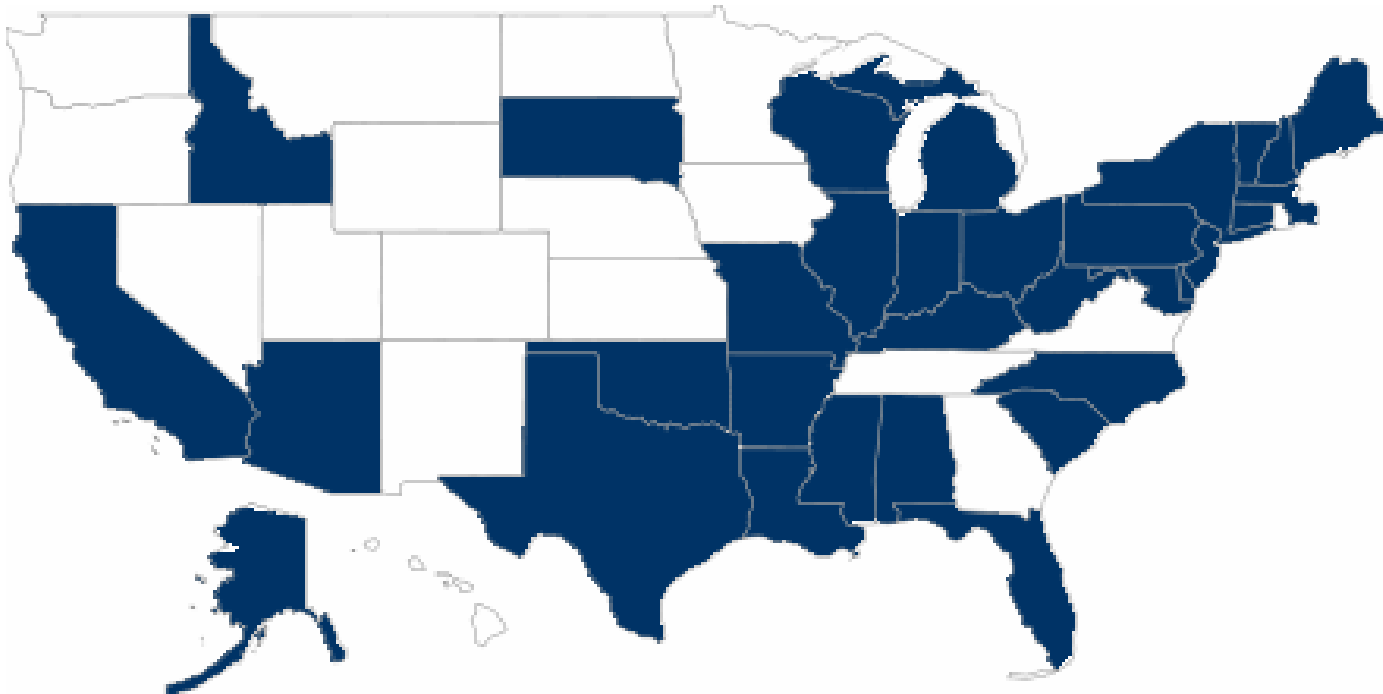
Vanessa Rudin, Primary Care Development Corporation (PCDC)
Ryan Wilcoxon, Community Healthcare Network

About PCDC

- Founded in 1993
- Nonprofit organization dedicated to transforming and expanding primary care in underserved communities to:
 - Improve health outcomes
 - Reduce healthcare costs and disparities.
- PCDC's programs enhance access to primary care by offering:
 - **Capital Investment:** Flexible financing to build and modernize facilities
 - **Performance Improvement:** Coaching and training to strengthen care delivery
 - **Policy & Advocacy:** Leading policy initiatives to strengthen primary care policy

PCDC Clients

PCDC has partnered with more than 500 organizations in 33 states to deliver its capital financing and performance improvement services.



Performance Improvement Impact

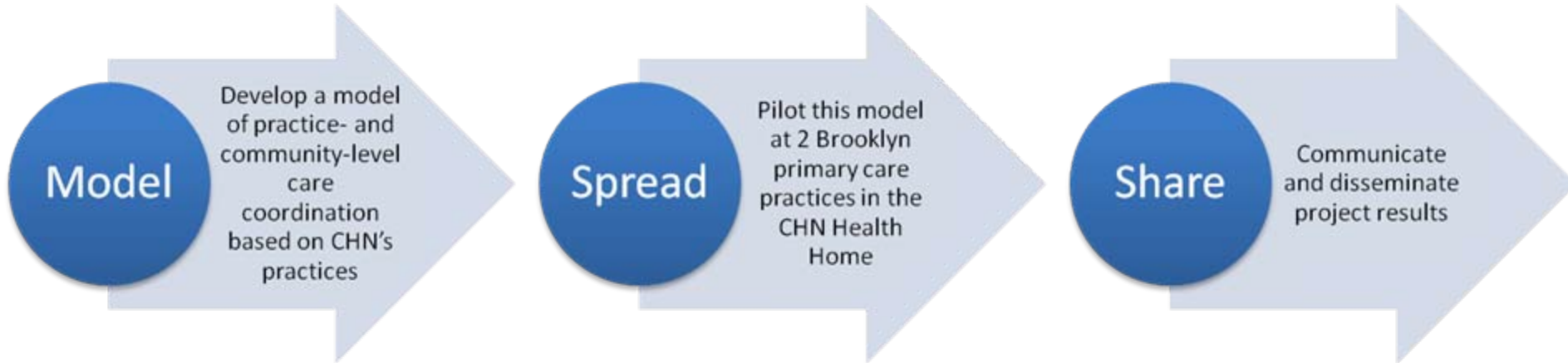
We have partnered with more than 500 primary care organizations throughout the U.S. to adopt a patient-centered model of care, including:

- **5,000 health workers trained** to expand access, adopt new technologies and prepare for emergencies
- **10,000 providers, policymakers and insurers** using our [medical home toolkit](#)
- **10 state primary care associations** equipped to provide meaningful use and medical home training to their members
- **5 million patients** impacted by expanded access to primary care

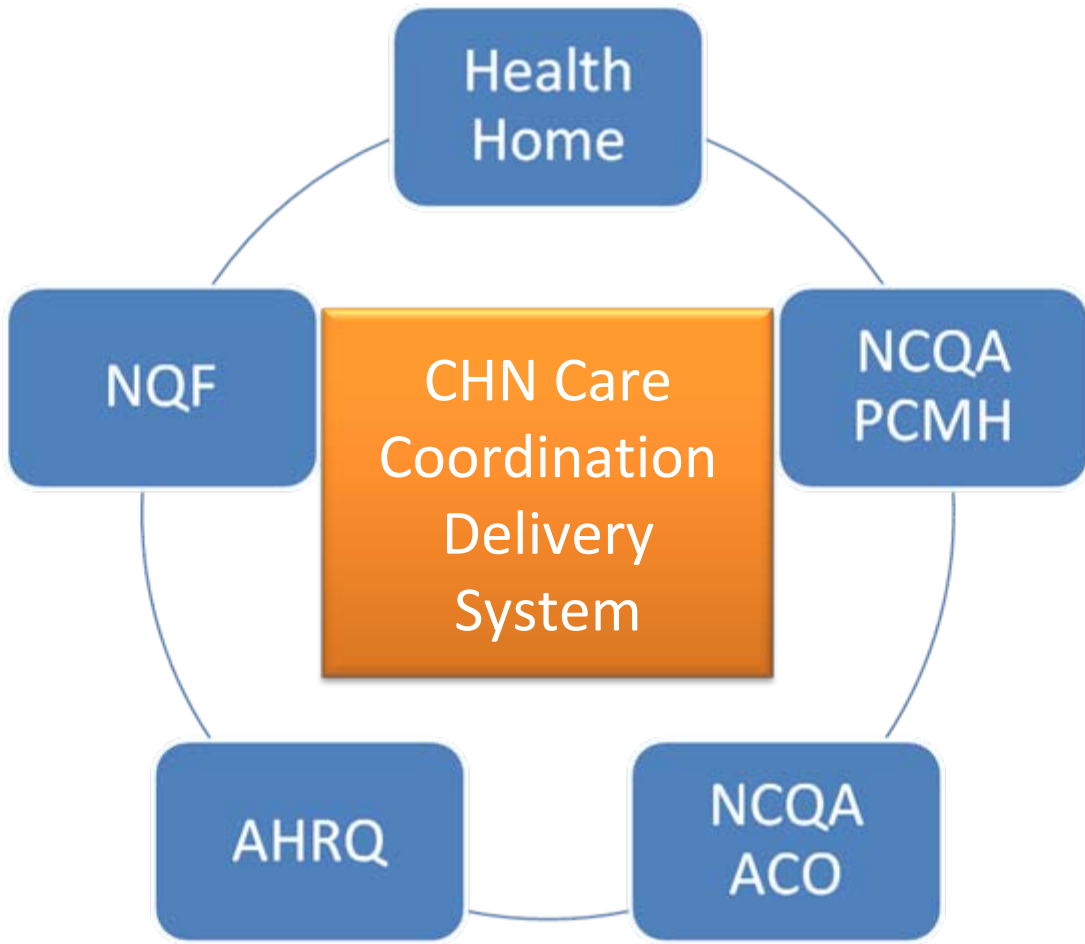
Performance Improvement Services

- **Medical Home Transformation:** enhance current PCMH capabilities, including open access, care coordination/management, care team development, patient experience, and health IT adoption.
- **Medical Home Recognition:** assess current operations against medical home standards, provide gap analyses, workplans and recommendations, and manage PCMH survey submissions.
- **Health IT & Meaningful Use:** support to adopt technology and health IT innovations.
- **Emergency Preparedness:** support and training for emergency management and business continuity, including planning, training, drills and exercises, and evaluations.

Care Coordination Model Project Funded by the Altman Foundation



From Standards to Delivery Model



Crosswalk of Standards for Care Plan

Health Home The individual's plan of care integrates the continuum of medical, behavioral health services, rehabilitative, long term care and social service needs and clearly identifies the primary physician/nurse practitioner, specialists, behavioral health care providers, care manager and other providers directly involved in the individual's care.

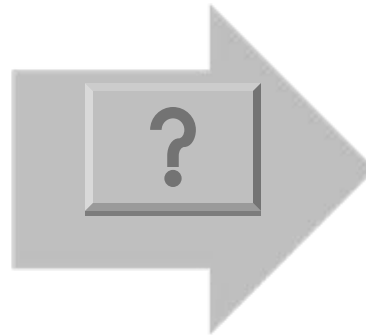
NCQA PCMH 2011 individual care plan: for at least 75% of patients with at least one of the three clinically important conditions. Includes treatment goals that are reviewed and updated at each relevant visit

NQF Healthcare providers and entities should have structured and effective systems, policies, procedures, and practices to create, document, execute, and update a plan of care with every patient.

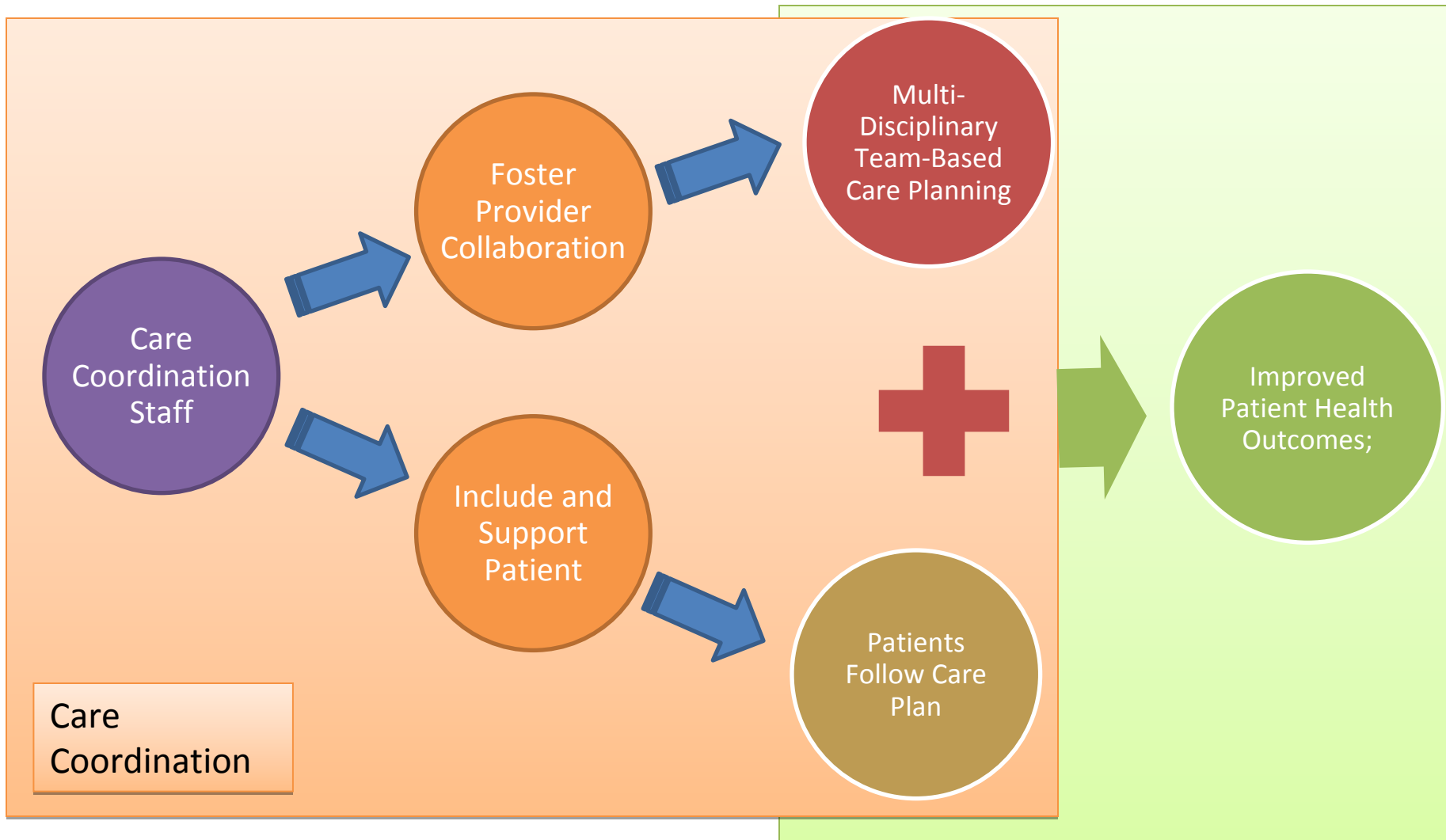
NCQA ACO The care team collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit.

AHRQ Create a Proactive Plan of Care: Establish and maintain a plan of care, jointly created and managed by the patient/family and health care team, which outlines the patient's current and longstanding needs and goals for care and/or identifies coordination gaps. The plan is designed to fill gaps in coordination, establish patient goals for care and, in some cases, set goals for the patient's providers. Ideally, the care plan anticipates routine needs and tracks current progress toward patient goals.

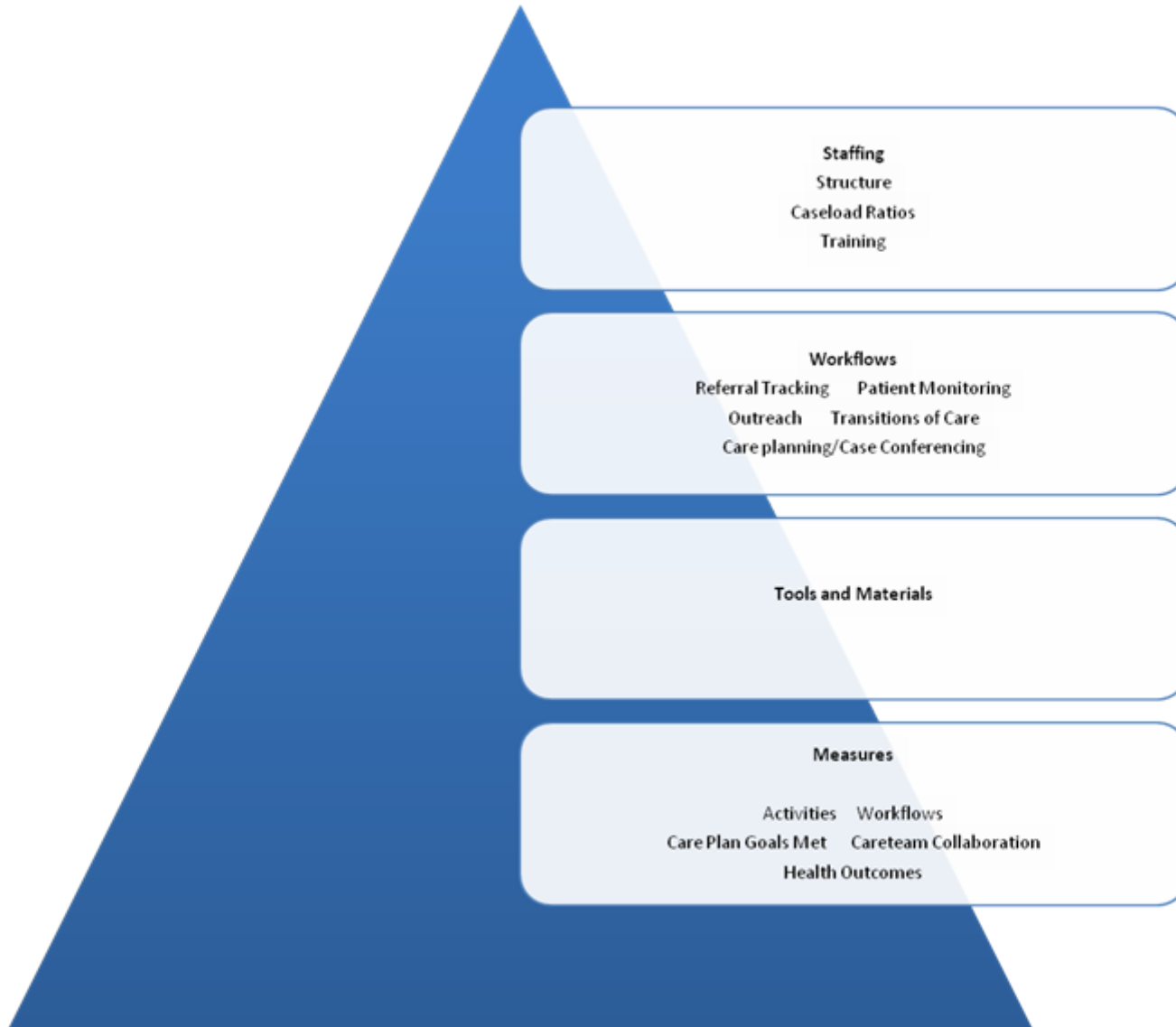
Measures in the Care Coordination Standards



Relationship between Care Coordination and Health Outcomes VERSION 2



Care Coordination Delivery Model





PRIMARY CARE
DEVELOPMENT
CORPORATION

Contact:

Vanessa Rudin

212-437-3928

vrudin@pcdc.org

www.pcdc.org