



The Patient-Centered Primary Care Home — What Is It?

The Problem: Health care for New Yorkers is in crisis with spiraling health care costs, rising incidence of chronic illness, and appalling disparities in health and health status experienced by the State’s diverse patients.

Patient-Centered Primary Care Home Model of Care Addresses Problem: Extensive research indicates that a new model of care, the Patient-Centered Primary Care Home, can help New York to address its health care crisis. Essential to a quality health system, the Patient-Centered Primary Care Home model has been shown to produce positive health outcomes, improve patient experiences, and reduce costs of health care.

Patient-Centered Primary Care Home Defined: A patient-centered relationship between the patient and provider trained to provide first contact, continuous and comprehensive care in order to improve the patient’s health.

Patient-Centered Primary Care Home Elements: At a minimum, the following core services, functions and operating standards are necessary to operationalize a Patient-Centered Primary Care Home.

<p style="text-align: center;">Care Coordination</p> <ul style="list-style-type: none"> • Use evidence-based guidelines for at least three conditions • Actively support patient self-management • Manage patient care, including using care plans, assessing progress, and addressing barriers • Generate reminders about preventive services • Use appropriate staff to coordinate and assist in patient care • Coordinate care and follow-up for patients who receive care in other care settings, including inpatient and outpatient facilities and mental health and substance abuse services 	<p style="text-align: center;">Care Tracking and Registries</p> <ul style="list-style-type: none"> • Use a data system for basic patient information (mostly non-clinical data) • Use clinical data system(s), including: <ul style="list-style-type: none"> • Charting tools to organize clinical information • Data and processes to identify important diagnoses and conditions in practice • Processes to generate lists of patients and provide patient and provider reminders • Track tests and identify abnormal results systematically • Use electronic systems to order and retrieve tests and flag duplicate tests • Track referrals to other providers
<p style="text-align: center;">Access and Communication</p> <ul style="list-style-type: none"> • Provide 24 hour telephone access to clinical support and other options for communication (e.g. e-mail, group visits) • Ensure the availability of timely and appropriate appointments with patients’ personal provider • Ensure availability of language services for patients with limited English proficiency and other communication needs 	<p style="text-align: center;">Performance Reporting and Improvement</p> <ul style="list-style-type: none"> • Report clinical and/or service performance by physician or across the practice using standardized measures • Survey patients’ care experience and use the information for improvement • Establish performance improvement goals and implement improvements

Patient-Centered Primary Care Home Financing: An investment is necessary to enable providers to make changes in practice infrastructure consistent with this model of care and reimbursement changes are needed to reward outcomes consistent with higher quality and more efficient care. Evidence for the success of this model has been well documented in North Carolina and other states. A full, evidence-based review can be accessed at www.ahec.buffalo.edu.

Patient-Centered Primary Care Home Model Endorsement: Primary Care Coalition partners—Community Health Care Association of New York State; Primary Care Development Corporation; New York State Area Health Education Center System; New York Chapter, American College of Physicians; and New York State Academy of Family Physicians.