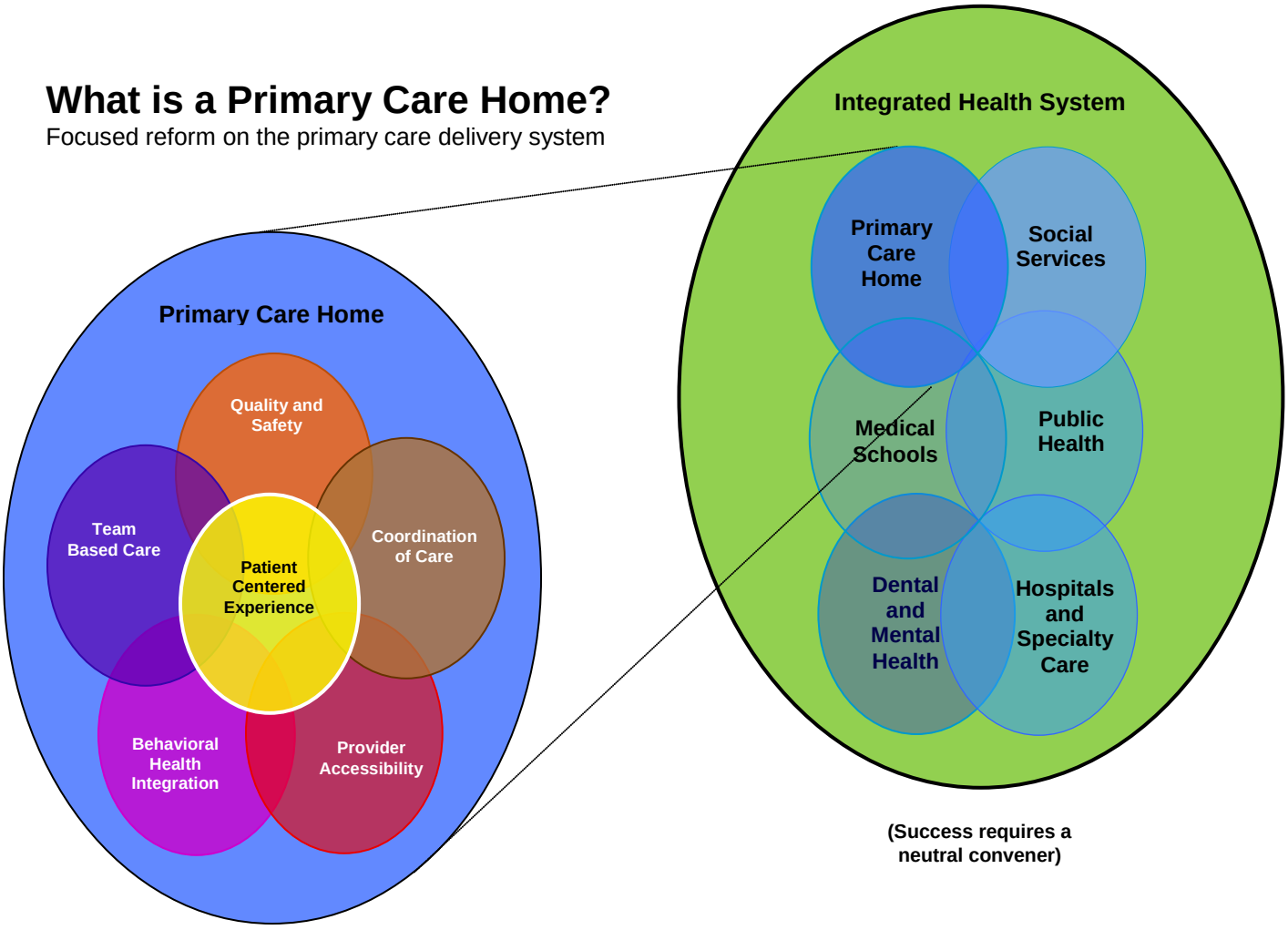
What is a Primary Care Home?

Focused reform on the primary care delivery system



(Success requires a neutral convener)

(Sustainability requires payment reform)

Patient-Centered Experience

- Time for patient care.
- Sustained relationship with culturally and linguistically competent provider team.
- Patient-driven goals.

Quality and Safety

- Evidence-based practices used.
- Use data to measure and report on quality and safety performance.

Behavioral Health Integration

- Behavioral health, and sometimes mental, deeply integrated (Access 1 mental health needs are usually met through mental health clinics).

Provider Team Accessibility

- Removes barriers to health care, e.g., transportation, language, etc.
- Visits, phone, or email, etc.
- Timely.

Nested in Community Collaborations

- All health-related interests and community services are closely coordinated.
- Psycho-social services are strongly incorporated.
- Resources are leveraged & maximized.
- Assessments are conducted on health status, equities, & effectiveness of services.

Team-Based Care

- Prevention and chronic disease care management
- Proactive and planned care for all patients assigned to the provider team– not only those who make appointments.
- Culturally and linguistically competent, co-located team, each serving the client from his/her highest ability/license.
- Supports family with end of life decisions and navigating that system, if necessary.
- Maximizes services during each visit.

Coordination of Care

- In most cases, manages entire health care process.
- Links patient to community services, as needed, (e.g., housing, etc.) or coordinates with community agency that has on-going relationship with patient.