NEW YORK eHEALTH COLLABORATIVE

New York State Patient-Centered Medical Home (NYS PCMH)

About the Program

The New York State Patient-Centered Medical Home (NYS PCMH) model is designed to provide direct technical assistance for small and medium-sized primary care practices to achieve NYS PCMH recognition and thrive under value-based payment arrangements. New York eHealth Collaborative (NYeC)'s NYS PCMH services help practices meet program aims and milestones to transform healthcare delivery.

Free Technical Assistance

NYS PCMH services include assessment tools to develop a customized work plan, practice transformation services, and support to prepare for value-based payment arrangements and engagement with payers to develop supporting payment approaches.

NYS PCMH Concept Areas

- **Team-Based Care and Practice Organization**
- **Knowing and Managing Your Patients**
- **Patient-Centered Access and Continuity**
- **Care Management and Support**
- **Care Coordination and Care Transitions**
- **Performance Measurement & Quality Improvement**

Paths to PCMH

NYeC and our skilled technical assistants throughout New York State will support practices to truly transform their practices and achieve recognition status. Practices will pursue one of 3 NYS PCMH Pathways:

New to PCMH: Up to 18 months to achieve recognition over 3 virtual check-ins

PCMH 2011 or 2014 Level 1 or 2 Practices: Accelerated Renewal

PCMH 2014 Level 3 Practices: Meet the 12 NYS PCMH Core Criteria during Annual Reporting

Eligibility Criteria

Practices with sites that provide primary care services including internal, family, and pediatric medicine are eligible to participate in the program.

Practices currently receiving federally-funded transformation technical assistance (e.g. TCPI, DSRIP-supported PCMH) are not eligible to participate.

strategic interests
strategic vision + thinking + relationships

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