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Community Health Centers: Patient-Centered Medical Homes

COMMUNITY HEALTH NETWORK OF WASHINGTON

Washington Association of COMMUNITY & MIGRANT HEALTH CENTERS

Washington's community health centers (CHCs) are undertaking an innovative delivery system redesign that leverages decades of experience providing comprehensive, integrated health care. At their core, **Patient-Centered Medical Homes (PCMH)** build essential partnerships between the individual, their personal physicians, and their families to optimize patient's health. The ultimate goal of PCMH is to achieve the Triple Aim – improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

Patient-Centered Medical Homes optimize patient health and quality of care by:

- **Coordinating care through a health care team** to ensure patients get preventive and chronic disease care that is best suited to their current health needs. The team includes providers, medical assistants, and care managers, each of whom has a role in engaging patients in their care. The team supports self-management goal setting; referral follow-up; and preventive screenings.
- **Utilizing information technology to ensure** that patients get care and preventive screenings when and where they need them, and to track data to measure patient outcomes and clinic performance;
- **Integrating behavioral and oral health** as a part of **whole-patient care;**
- **Providing same-day appointments** and after-hours access to care to avoid unnecessary emergency room visits; and
- **Assessing patient cultural and language needs** to provide care and coordination in a culturally and linguistically appropriate manner.

Already serving more than one in 10 Washington residents, Washington's CHCs have committed to achieving national PCMH recognition by the end of 2014. Eight CHCs have already achieved national PCMH recognition and many more are on their way. The recognition assures that the community health centers meet national PCMH standards and signals to patients that they are receiving high quality patient-centered care. This effort will enhance investments in electronic health records and longstanding efforts to integrate behavioral and oral health, coordinate patient care, and go beyond the patient's symptoms and diagnosis to focus on wellness.

Patient-Centered Medical Home reforms save money:

Implementing Patient-Centered Medical Homes helps patients get care when they need it and serves to avoid hospitalizations and ER visits for health problems that can be managed in a primary care setting.

- By working together, community health centers and Community Health Plan have already generated millions in savings for the state by implementing some aspects of the patient-centered medical home model for the Disability Lifeline population. After expanding the managed care model to Disability Lifeline enrollees statewide and ensuring access to integrated mental health care and a care coordinator, the state experienced $10.7M in hospital savings in the program. Utilizing the PCMH model for all CHC patients will lead to reduced costs in the health care system and the state budget.

Community health centers are committed to becoming patient-centered medical homes for the benefit of all of their patients.

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