THE ROAD TO A PCMH

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Two Interlocked Components

PCMH

- Personal Physician/Team
- Physician Directed
- Patient Centered/Whole Person Orientation
- Coordinated/Integrated Care
- Quality and Safety
- Enhanced Access to Care

Chronic Disease Model of Care

- Visible Clinical Leaders
- Regular Proactive Planned Visits
- Evidence-Based Guidelines
- Clincal Information Systems
- Patient Self-Management
- Community Resources

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Contributing Factors

- Providers in clinic at limited times
- High rate of walk-ins and no shows
- Limited and inconsistent access beyond clinic hours
- Limited pt. information esp. regarding health maintenance
- Limited coordination outside of CCHHS

Innovations

- Reminder calls/Same day appointments
- Charge nurse available by phone during clinic hours /Answering service
- Medical Assistant
- Pre-clinic triage
- Pre-discharge appointments
- Time-framed registration
- Health educators in clinic session

Results

- Clinic flow/patient experience improved
- 90+% of pts. leave with follow-up appointment
- Fewer provider interruptions
- Improved management of walk ins
- Decreased no-show rate
- Patient survey currently being conducted

Impact

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Future Directions

- Improve monitoring of health maintenance
- Implementation of after hours answering service
- On-going evaluation
- Certification

Certification Options

- Accreditation Association for Ambulatory Health Care (AAAHC)
- The Joint Commission (TJC)
- National Committee for Quality Assurance (NCQA)