Mission and Vision

It is the mission of Ammonoosuc Community Health Services to provide a stable network of comprehensive primary health care services to individuals and families throughout the communities we serve.

In support of this mission, ACHS provides evidence based outcome specific, systematic care that is:

- Patient centered
- Focused on prevention
- Accessible and affordable to all

ACHS – Origins and History

- 1975 Incorporated with initial funding from Title X Family Planning Program, had a staff of two, and a budget of $12,000
- 1994 Funded as a new start FQHC at ACHS – Littleton and ACHS – Warren
- 1996 Implemented GE – Centricity EHR/PMS
- 1997 ACHS – Whitefield added to scope of project
- 1998 Joined HRSA Chronic Disease Collaborative now encompassing Depression, Diabetes, Asthma, Coronary Artery Disease, Patient Safety & Clinical Pharmacy
- 2002 ACHS – Franconia added to scope of project
- 2002 ACHS Awarded a Medical Capacity Expansion Grant for ACHS - Littleton
- 2005 – 2006 Implemented Patient Centered Redesign
ACHS – Origins and History

- 2007 Expanded Medical Capacity at ACHS-Woodsville
- 2009 Recognized by HRSA & NIH as 1 of 26 other “High Performing FQHC’s in the country out of 1,086.
- 2009 Recognized by NCQA as a Level 3 Patient Centered Medical Home
- 2009 Awarded 1 of 85 competitive Facility Improvement Program Grants from over 600 applicants. Funds will renovate and expand the ACHS – Littleton care delivery site.
- 2009 Calendar Year Uniform Data System (UDS) Report
  - 5 Care Delivery Sites
  - 72.16 Full Time Equivalents
    - 6.85 Physician FTE
    - 8.72 APRN / PA FTE
    - 30.01 Clinical Support Staff FTE
  - 8,171 Unduplicated Patients
  - 33,199 Medical Encounters

ACHS Service Delivery Area

- 26 town, ~31,000 residents
ACHS - Franconia

ACHS – Warren (Mt. Mooselaukee Health Center)
Elements of Patient Centered Medical Home

The TransformED Patient-Centered Model & Medical Home for all

Access to Care and Information
- Electronic referrals
- Electronic appointment scheduling
- Portable electronic records
- Patient portals
- Health information exchange

Practice Based Services
- Board-certified providers
- Team-based care
- Patient-focused care
- Care transitions
- Patient educational programs

Care Management
- Fast track to care
- Care coordination
- Nursing home care
- Case management

Health Information Technology
- Electronic health records
- Electronic health information exchange
- Electronic health management
- Clinical decision support
- Patient education

Quality Improvement
- Quality data collection
- Quality improvement committee
- Quality analysis
- Patient surveys

"A patient-centered approach to medical care that coordinares care for both services and illness."
Ammonoosuc Community Health Services, Inc

Practice Management Leadership; a patient driven culture

- Financial Sustainability
- 2005 Patient Centered Redesign
- Realign staffing; flatten organization
- Develop Key Result Areas reported weekly as precursors to monthly financials
- Five year trend
  - 549% ↑ in Unrestricted Net Assets
  - 88% ↑ in Debt/Equity Ratio
  - 196% ↑ in Working Capital
  - 1,176% ↑ Debt Service Ratio
  - 45% ↑ Days in AR
  - 70% ↑ Days in AP
- "No Margin; No Mission!"
ACHS Practice Philosophy

- We care most about the quality of health for our patients.
- We are innovative, systems oriented focusing on populations, holistic in approach.
- We are cost effective and use evidence based approaches which empower our patients and avoid dependency.
- We are collaborative, with a team-based approach to care that uses our whole staff to support the patient.
- We believe in prevention and preventing disease.
- We believe patient self care should be an integral part of each visit.
- We believe caring for self is essential and emulating good health is good medicine.

Patient Story: Starting at the picnic table engages patient in care

- 48 is a year old female who established care at ACHS in 2001.
- A smoker on birth control with a history of an abnormal pap smear.
- Patient had one abnormal pap smear and was avoiding a repeat pap smear due to severe Post Traumatic Stress Disorder and a treatment resistant form Panic Disorder with Agoraphobia.
- At the outset of counseling the patient could not tolerate being in the office so Behavioral Health Specialist met with her at the picnic table outside the practice.
- In a few weeks a plan was established with her provider to schedule the exam at a time when the exam room door could be left open, give her a mild sedative prior the procedure and had her significant other accompany her to the exam.
- The intervention was successful, with continued care the patient now functions more comfortably outside her home, has resumed a relationship with her family and has returned to participating in her church. The patient continues with maintenance therapy about once per month.
Patient Story: Bartering a way to better health one plowed lot at a time

- Patient is 46-year-old male with a history of severe agoraphobia the onset beginning in late adolescence complicated by a severe history of alcohol dependence, intensified panic disorder especially without structured activities. For many years now he has been unable to travel outside of the town in which he resides.
- Patient had worked in his town and held an elected position. After losing his job his alcoholism which had been in remission for many years returned and he resumed active drinking. This further complicated and in the process of treating him for the panic disorder/alcoholism patient had accrued a balance and had no ability to repay as he awaited disability.
- An IRS compliant plan was proposed by the senior leadership team that allowed the patient to work off the debt.
- The patient stated to his provider that he felt good about working off the debt and it gave him a sense of purpose and contribution to his community.
- Patient returned to a period of abstinence, acquired disability, and also for the first time in many years with the assistance per need medications was able to travel outside the immediate area for much needed dental work and he started a small salvage business to supplement his disability income.

Patient Story: Interdisciplinary teamwork exemplifies patient centeredness

- Patient is an individual with a severe blood clotting disorder, unresponsive to oral medication. He requires a very expensive type of anticoagulant but, facing a financial barrier to care, was going to run out. His clotting disorder is so severe that missing one dose of the drug could have significant untoward outcomes including those that are life threatening.
- Certified Medical Assistant / Pharmacy Technician called me at home Friday AM to report the barrier to care.
- Certified Medical Assistant / Pharmacy Technician and Patient Navigator / Pharmacy Technician then spent about 5 hours Friday obtaining an emergency supply of medication for this patient.
- Patient Navigator / Pharmacy Technician further secured a supply from the drug company for Monday.
- The excellent work on this, by these two individuals quite possibly saving this patient's life.
Patient Story: Office Manager mother & child centered care

- Patient is a Medicaid eligible child in need of a prescription.
- Due to a delay in the Medicaid application process, the child was unable to get a needed prescription for a medical issue.
- The Medical Provider reached out to Office Manager and asked if there was anything that could be done to speed this along.
- Next thing the Medical Provider knew, the issue was solved, the Office Manager linked the mother to available resource that solved the problem.
- The Office Manager also took great personal interest in the fact that the mother did not drive, had walked with a newborn twice to the pharmacy to try and get the prescription, unsuccessfully.
- Office Manager was empowered to call, coordinate and pick up voucher from the Community Action Program Office which she brought to the pharmacy, waited for the prescription to be filled and dropped off at mothers home.

Patient Story: Patient in dire need obtains much needed prescription

- Patient in need of RX with approximate cost of $3,600/mos. No time to get external measures in place for immediate use.
- Conventional methods of funding for an ASAP prescription unavailable due to cost.
- Certified Medical Assistant / Pharmacy Technician contacted Collaborating Critical Access Hospital and was able to negotiate a few days supply donated by pharmacy.
- Patient Navigator / Pharmacy Technician & patient completed application process for Patient Assistance Program, fully knowing the first application would be denied and a patient appeal would be needed. While submitting the application Patient Navigator / Pharmacy Technician also assisted the patient to file an immediate appeal. Again, there were errors on the appeal and Patient Navigator / Pharmacy Technician assisted. The application was denied but the appeal accepted and the patient is now receiving regular refills of his medication.
Patient Story: Back taxes & potential loss of home impacts health

- Patients are Husband and Wife who were alerted that the town was filing to take home for back taxes.
- Patients unable to obtain loan due to no homeowners insurance and need for new roof. Can’t afford increased cost of homeowners insurance without new roof.
- Patient Navigator worked with the Town, Consumer Credit Counsel, Local Bank to obtain a loan for back taxes, new roof and insurance.
- Patient Navigator was able to manage a decrease in the back property taxes by having the interest accrual written off, Consumer Credit Counsel worked with the couple to achieve monthly payments and stability, a loan was secured with the stipulations back taxes were paid to date, new roof was put on and home owners insurance obtained.
- All parties happy and the couple has decreased stress which had been impacting their general health and well-being.

Patient Centered Medical Home Solution After Next

- Further Integration of Behavioral Health with local community mental health partners
- Integration of Pharmacist into the Multi-Disciplinary Care Team
  - Phase I on-site pharmacy at ACHS-Littleton
  - Phase II Tele-pharmacy at remote sites.
- Integration of Oral Health
  - Phase I integration of a Dental Hygienist for screenings, cleanings, prophylaxis
  - Phase II integration of a full dental program with Dentist, Hygienist, etc.
- Exploration and integration of tele-medicine as appropriate.
- Expansion of Medical Home Pilot Effort toward Accountable Care Organization through collaboration with local and regional partners.