UNIVERSITY MEDICAL CENTER
NEIGHBORHOOD HEALTHCARE CENTERS

Chronic Care Model
Diabetes DSRIP Project

August 28, 2015

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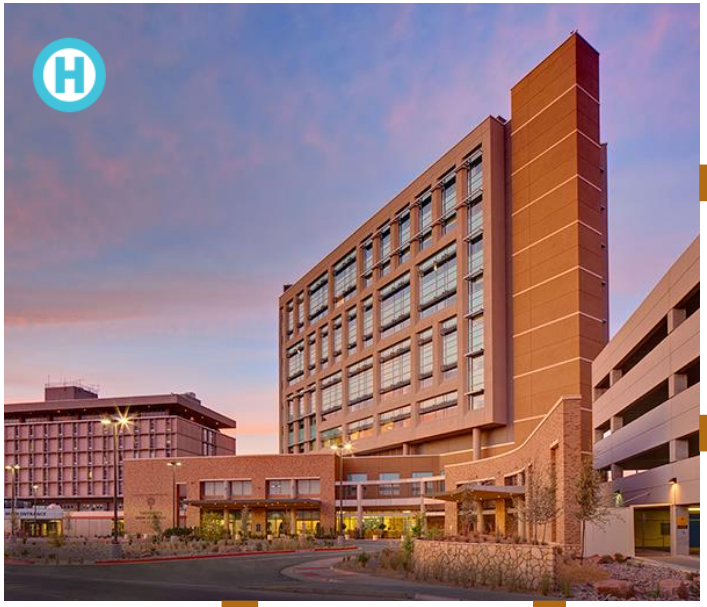
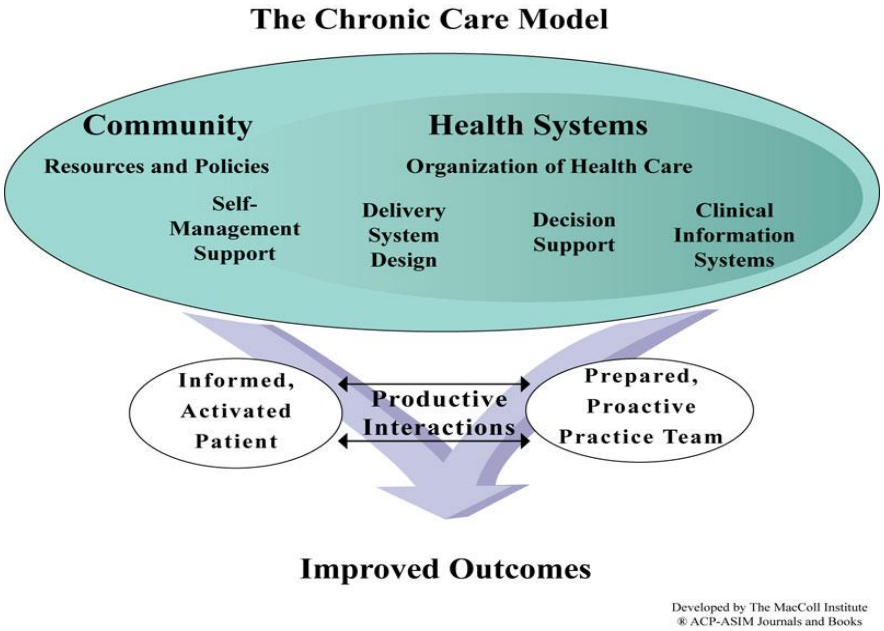
Project focus: Hospital Discharged Patients with Diabetes plus Existing & New Patients




N
El Paso
Northwest
Northeast
West
Central
East
Mission Valley
Fabens
375
10
601
Main Hospital
UMC – Ysleta
UMC – East II
UMC – Fabens
UMC – Northwest

Multiple Influences

Joint Commission Primary Care Medical Home
Wagner's Chronic Care Model
DSRIP Project Goals
latest ADA Clinical Guidelines

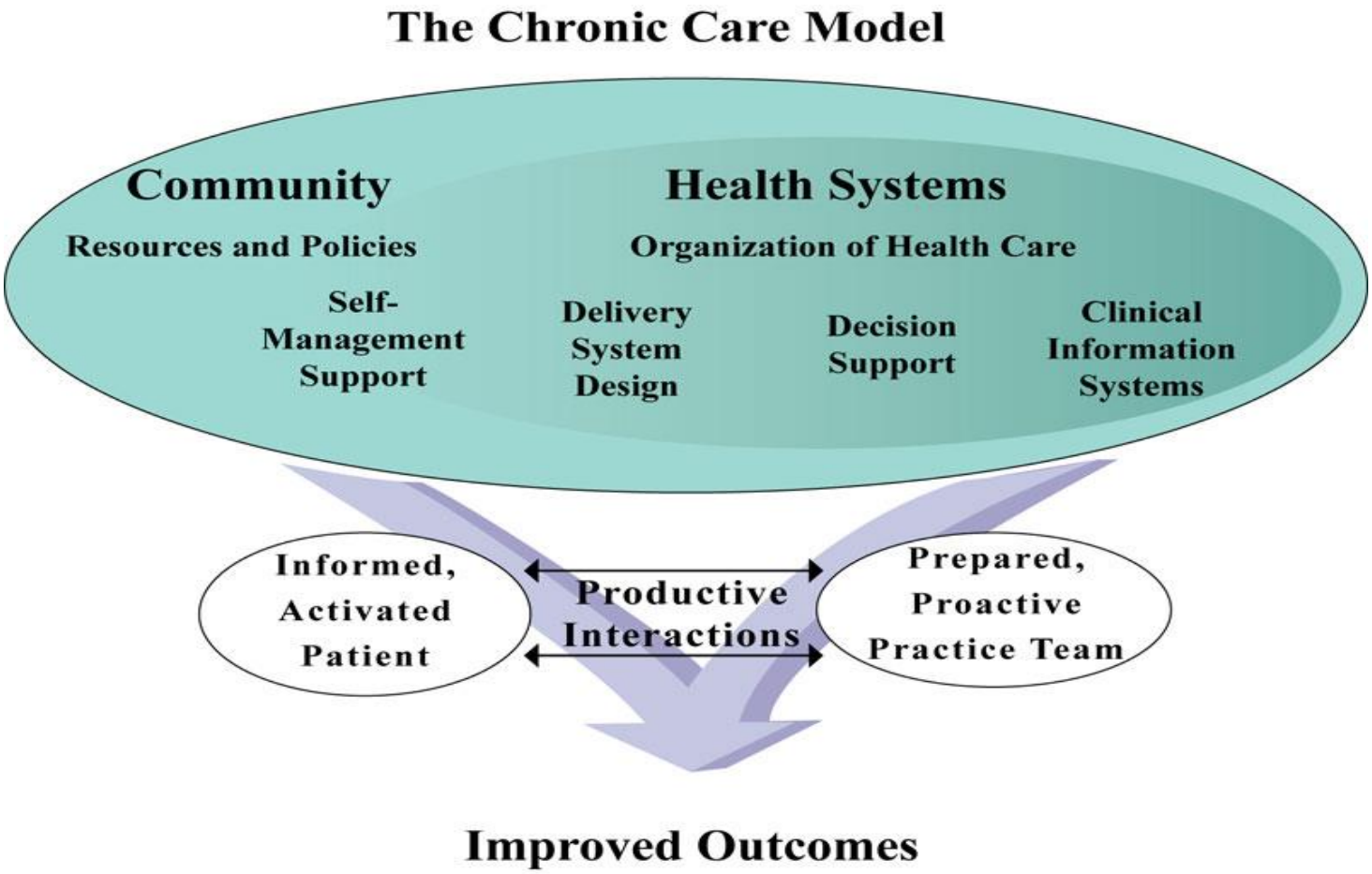


American Diabetes Association®

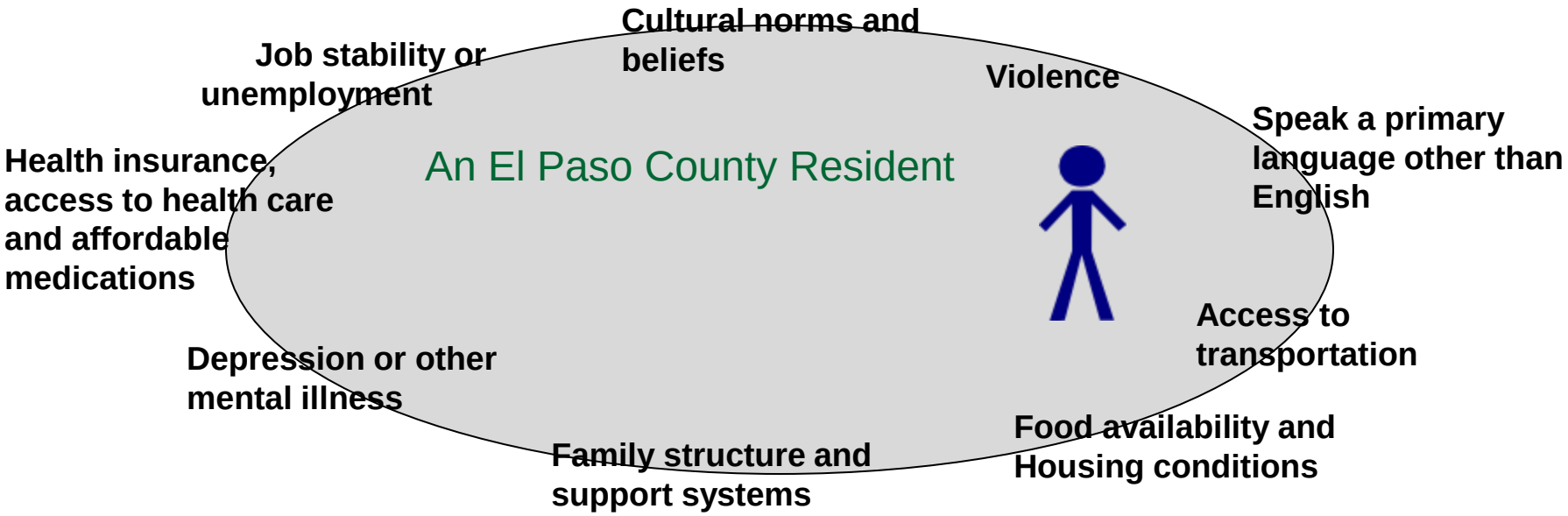
THE JOINT COMMISSION
NATIONAL QUALITY APPROVAL

Accredited by
The Joint Commission as a
Primary Care Medical Home

Chronic Care Model



COMMUNITY: What affects the ability of a patient to manage his or her health?



NHC Multidisciplinary Team

- MD
- FNP/PA
- Medical Assistants
- Clinic Nurse Supervisor – Hospital Liaison
- Clinical Pharmacist with specialized training in Diabetes
- Registered Dietitian
- Exercise Physiologist
- Social Worker
- Financial Counselor
- Scheduling
- Coder
- Front Desk
- Data Specialist

It Takes The Village: Honorary Members of the Team

- Medical Director and Management Team
- Pharmacy Director/Staff
- UMC Hospitalists
- Texas Tech Residents/Attending Physicians
- ED Staff
- UMC and other Hospital Discharge Planners
- Wound Care Staff
- IT Staff
- Marketing Staff
- COO
- CEO and Board of Managers

Program Growth

- DY 2 One Provider Team and supporting staff at Ysleta
- DY 3 Added a Provider Team at Ysleta and 2 Part time provider teams at Fabens. Moved the Ysleta team into a brand new site better designed to handle group visits in between Ysleta and East clinic sites and because we were out of space at those two sites.
- DY4 Continued to increase referrals from other hospitals, streamlined phone referral system, started group nutrition counseling, worked with a Medicaid health insurance program to accept their high risk patients
- DY5 Opened a new site in NW (The third location) with two provider teams and support staff

Target Market

- 77 % Uninsured
- 3 % Medicaid

- DY3 Data

Program Goals, Statistics

- DY3 Goal 520 New Patients - 602
- DY4 Goal 700 New Patients – over 975*
- DY5 Goal 1040 New Patients

- Foot exams 98%*
- LDL Screen 94% with 58% less than 100*
- Pain Assessments 100%*

- HbA1C (Medical Home Goal) 67% under 9*

- * Year to date

and Success Stories

- Readmissions Down
- ED Visits Down
- Our Patients Feel Better