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

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

Accredited by
The Joint Commission as a Primary Care Medical Home
Chronic Care Model

The Chronic Care Model

Community
- Resources and Policies
  - Self-Management Support
Health Systems
- Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes

Developed by The MacColl Institute
® ACP-ASIM Journals and Books
COMMUNITY: What affects the ability of a patient to manage his or her health?

- Cultural norms and beliefs
- Violence
- Job stability or unemployment
- Health insurance, access to health care and affordable medications
- Depression or other mental illness
- Family structure and support systems
- Speak a primary language other than English
- Access to transportation
- Food availability and Housing conditions
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