TEXAS
Health and Human Services

# Critical Areas of Health Care: Chronic Care Management

# Panel participants

- Carol Huber, MBA, *Director, Regional Healthcare Partnership 6, University Health System*
- Michele Bosworth, MD, *CQO and Executive Director of The Center for Population Health, Analytics, and Quality Advancement, UTHSCT and UTHET North Campus*
- S. Kim Bush, MPA, *Program Director, University of Texas Health Science Center at Tyler*
- Mark Hernandez, MD, *Chief Medical Officer and Executive Vice President, Community Care Collaborative*
- Ann Rodriguez-McConnell, MSN, RN, *President/CEO and Administrator, TenderCare Home Health & Hospice*

# UTHSCT

## Center for Population Health, Analytics, and Quality Advancement

Michele Bosworth, MD & Kim Bush, MPA

UTHealth
The University of Texas
Health Science Center at Tyler

UTHSCT & Christus St. Michael

# Mobile Asthma Programs

Mobile Outreach vehicles equipped with intake, treatment, & private examination area lead by Nurse Practitioner Team

- 2500 unique patients served annually
- East Texas: 50 School Districts & 19 counties
- Asthma & Allergy management including spirometry, allergy testing, asthma care plans for patient and school nurse, asthma & medication education, follow-up care every 6 months

UTHealth
The University of Texas Health Science Center at Tyler

# Building CHWs into the Health System

Certified Community Health Workers are implemented into six (6) primary care clinics to provide patient navigation services for patients. Approximately 30% of patients are considered a part of the MLIU population. Majority have no coverage (self-pay).

- CHW Training
- CHW Roles and Responsibilities
- Pre-Visit Planning
- Impact on Community/Outcomes
- Home Visits

UTHealth
The University of Texas Health Science Center at Tyler

# HHSC Texas Healthcare Transformation and Quality Improvement Program

**HHSC DSRIP Statewide Learning Collaborative**

**Mark Hernandez MD, FACP**
**Chief Medical Officer and**
**Executive Vice President**

Community Care Collaborative

A Central Health and Seton partnership

# Ann Rodriguez-McConnell, MSN, RN

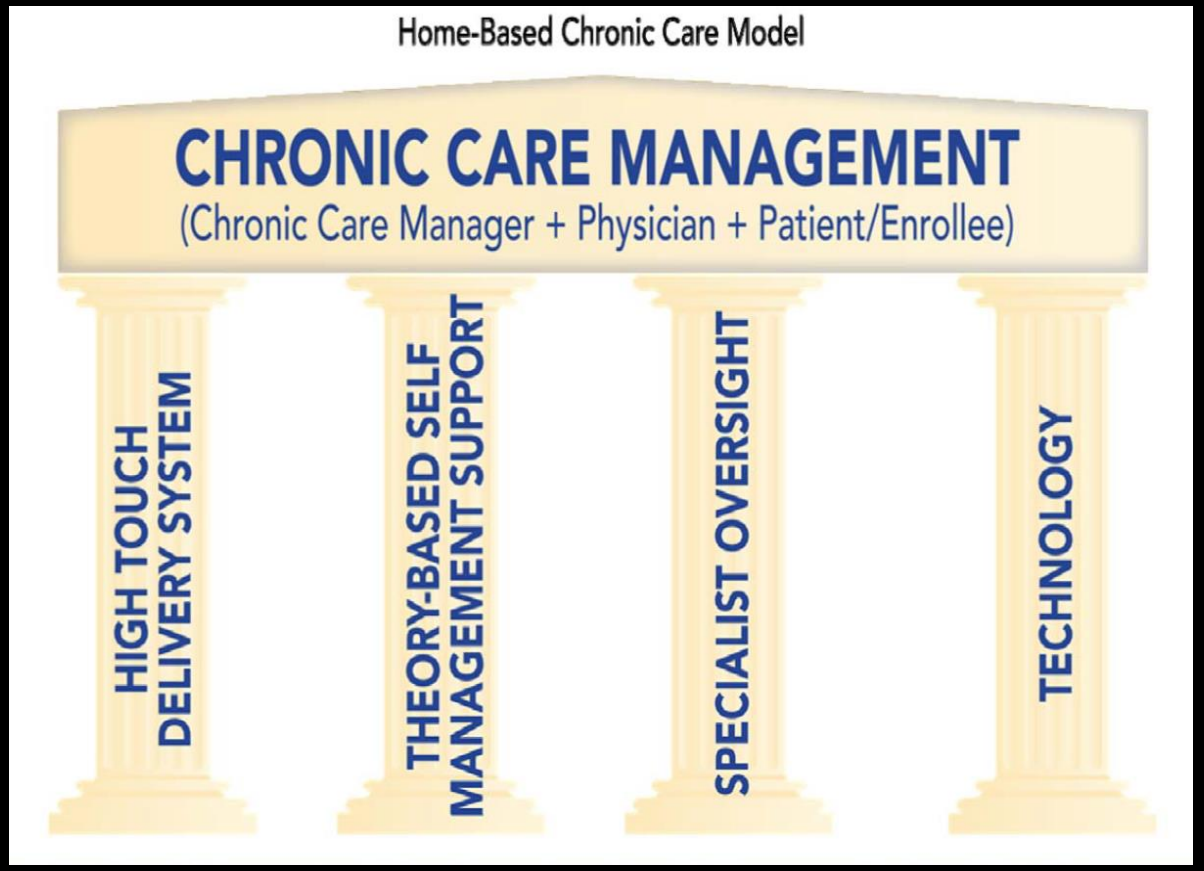
***President/CEO and Administrator***
***Tender Care Home Health & Hospice (TCHH&H)***
***El Paso, Texas and Las Cruces, New Mexico***

## Results thru Partnerships
## DSRIP Region 15

# DSRIP & Post Acute Results…

**2012, TCHH&H presented the Home-Based Chronic Care Model to University Medical Center of El Paso (UMC) as a potential DSRIP project**

- **What is the Home-Based Chronic Care Model?**



# Home-Based Chronic Care Model

- Collaboration with Primary Care Physician, or establishing a Primary Care Physician
- Utilization of a nurse-case management model for care coordination
- Work with patients over time to provide self management education, to set an action plan that includes smart goals
- The home health nurse has a unique view of the patient's environment which better illuminates' barriers to care that need to be addressed
- Satisfies a patient preference for home care over institutional care if requiring medical services
- Post-Acute interdisciplinary meetings with UMC, where we discuss improving our process for better outcomes
- Incorporates elements of Motivational Interviewing

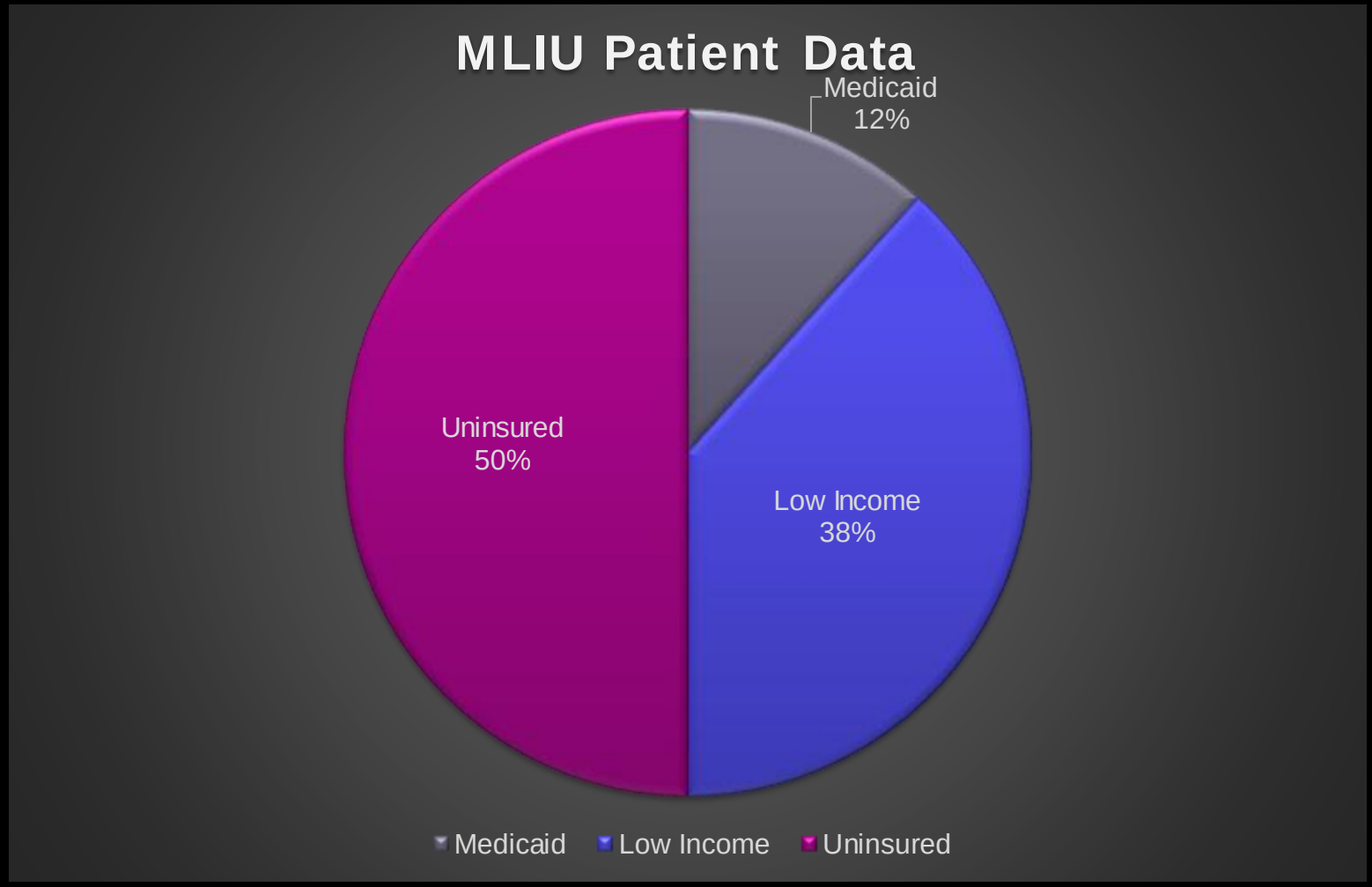
# DSRIP & Post Acute Results…

- **Motivational Interviewing (MI)** is a scientific patient-centered approach for building motivation and helping patients resolve ambivalence about change.
  - MI is effective in building engagement, readiness and motivation to change, such as for increased medication adherence. MI is effective with patients labeled as "non-compliant" or "resistant"

- **TCHH&H Care Transition Nurse**
  - Care Transition /Navigation Nurse works within UMC Units and assists in the discharge process and works with patients and nurses to ensure they are getting what they need upon discharge:
    - Identify patient equipment needs
    - 30-day supply of High-Risk Medications
    - Identifying patients that are High Risk for Readmission coordinating care with HHA
    - Post acute dc follow - up tuck in phone calls

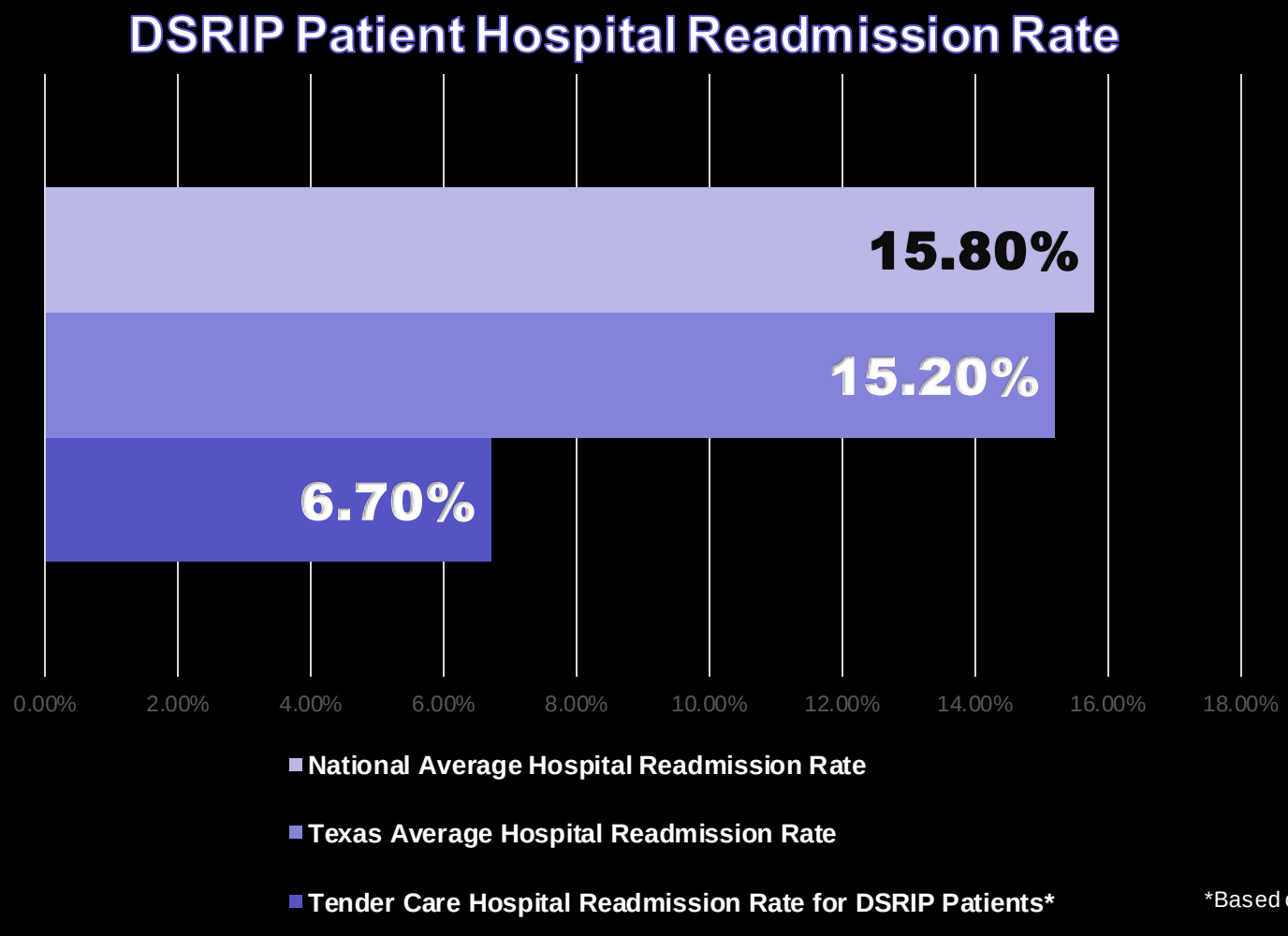
# DSRIP & Post Acute Patient Data

## Who receives the care…



# DSRIP & Post Acute Results…

Since 2012, TCHH&H has been an active partner co-managing and improving the readmission rate for DSRIP participants.




*Based on July 2019 DSRIP Data

# Innovative Healthcare Programs with DSRIP Partners

## ❑ El Paso Shelter Nurse Program

- 2012: TCHH&H took over the Shelter Nurse Programs at the Rescue Mission of El Paso and the Salvation Army of El Paso.
- 2012 – Present: TCHH&H restructured the projects to include:
  - Medical Director oversight
  - Creation of treating protocols to ensure positive project metric outcomes
  - The Shelter Projects have served over 10,000 encounters for El Paso homeless community, since inception.

## ❑ TMF Health Quality Institute - Hand-off Reporting Initiative

- Improving Hand-off report in the El Paso region since 2018

# Innovative Healthcare Programs with DSRIP Partners

- **Texas Tech University Health Sciences Center El Paso (TTUHSC)**
  - **Blood Pressure Initiative**
    - 2016 TCHH&H Assisted TTUHSC in reducing patient blood pressures to <140/90 using the Home-Based Chronic Care Model– avoiding adverse patient outcomes

- **City of El Paso Department of Public Health**
  - Mobile Dental Clinic
  - Immunization Clinic
  - Colorectal & Breast Cancer Screening