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
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
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
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
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
**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
Who receives the care...

MLIU Patient Data

- Medicaid: 12%
- Low Income: 38%
- Uninsured: 50%
Since 2012, TCHH&H has been an active partner co-managing and improving the readmission rate for DSRIP participants.

**DSRIP Patient Hospital Readmission Rate**

- National Average Hospital Readmission Rate: 6.70%
- Texas Average Hospital Readmission Rate: 15.20%
- Tender Care Hospital Readmission Rate for DSRIP Patients*: 15.80%

*Based on July 2019 DSRIP Data
El Paso Shelter Nurse Program

- 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
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