Changing the Healthcare Landscape in Louisiana

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Our Lady of the Lake Regional Medical Center | Baton Rouge, Louisiana
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FMOLHS’ service area includes almost 50% of the population of Louisiana and parts of Mississippi with recent acquisition of St. Dominic
Community Health Needs Assessment

- HIV and other STDs
- Mental Health and Substance Abuse
- Obesity
- Overuse of Emergency Departments
- Barriers to Healthcare
- Cancer
- Diabetes
- Heart Disease and Stroke
- Negative Lifestyle/Behaviors
- Vulnerable Population
Cost Per Patient Day Decreases 58%

<table>
<thead>
<tr>
<th></th>
<th>Base Year</th>
<th>Year One</th>
<th>Year Two</th>
<th>Year Three</th>
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<tbody>
<tr>
<td></td>
<td>$4,137</td>
<td>$1,819</td>
<td>$1,690</td>
<td>$1,750</td>
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Able to leverage the existing operations and efficient systems without many new fixed costs.

Care Coordination and Navigation
AONN+ Knowledge Domains

- Community Outreach and Prevention
- Coordination of Care/Care Transitions
- Patient Advocacy/Patient Empowerment
- Psychological Support Services/Assessment
- Survivorship/End of Life
- Professional Roles and Responsibilities
- Operations Management/Organizational Development/Healthcare Economics
- Research/Quality/Performance Improvement

AONN+ Metrics Initiative

**AIM**
- Improve health, health outcomes and lower cost of oncology care through improvements in patient-centered comprehensive care

**PRIMARY DRIVERS**
- Comprehensive Coordinated Cancer Care
- Enhanced Payment
- Continuous Improvement Driven by Data

**SECONDARY DRIVERS**
- Access to Care
- Planned Care for Cancer Treatment and Management
- Patient and Caregiver Engagement
- Care Coordination
- Care Management Payment (PBPM)
- Application of Meaningful and Timely Data
- Performance-Based Payment (for Episode of Care)

**CHANGE CONCEPTS**
1. Optimize use of HIT to support care.
2. Use available data to drive improvement.
3. Use risk-stratified approaches.

**PAYER**
1. Use a list of quality measures.
2. Use model participant of national benchmarks.
3. Use risk-adjusted factors.
Registered Nurses working to top of license is essential to care redesign

<table>
<thead>
<tr>
<th>UR/UM Care Coordination</th>
<th>Chronic/Complex Disease Management</th>
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<tbody>
<tr>
<td><strong>RN Case Manager</strong></td>
<td><strong>RN Navigator</strong></td>
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<tr>
<td>• Care Coordination</td>
<td>• Community Outreach and Advocacy</td>
</tr>
<tr>
<td>• Screens for SDOH</td>
<td>• Treatment Compliance/Intervention/Education</td>
</tr>
<tr>
<td>• Supports transportation and home care needs</td>
<td>• Self Management Optimization</td>
</tr>
<tr>
<td>• Manages Transition</td>
<td>• Psychosocial Support</td>
</tr>
<tr>
<td></td>
<td>• Patient Empowerment and Advocacy</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Registered Nurses</th>
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<tbody>
<tr>
<td><strong>Ambulatory Care</strong></td>
<td><strong>Acute/Post Acute Care</strong></td>
</tr>
<tr>
<td>• Wellness and Prevention</td>
<td>• Person Centric</td>
</tr>
<tr>
<td>• Coaching and Counseling</td>
<td>• Prevent Harm</td>
</tr>
<tr>
<td>• Adherence Monitoring</td>
<td>• Engage and Educate</td>
</tr>
<tr>
<td>• Continuity of Care</td>
<td>• Manage Barriers to Care and Discharge</td>
</tr>
</tbody>
</table>
Drivers

Access

Team Based Care

Metrics & Incentives

Partnerships
References

1. Haas, S., PhD, RN, FAAN, Conway-Phillips, R., PhD, RN, Swan, B., PhD, CRNP, FAAN, De La Penta, L., MSN, RNC, C-EFM, Start, R., MSN, RN, NE-BC, & Brown, D. S., PhD, RN, CPHQ, FNAHQ, FAAN. (2019, May). Developing a Business Case for the Care Coordination and Transition Management Model: Need, Methods, and Measures. Nursing Economics, 37(3), 118-125.


Contact Information

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