Natchitoches Regional Medical Center
NATCHITOCHES, LOUISIANA
Natchitoches Regional Medical Center

- Mission – Excellence Everyday
- Vision – Natchitoches Regional Medical Center, Your first choice for care!
- Values – iEXCEL
- Core Purpose – Care for the Community
Hospital/Clinic Sharing: Key Recommendations and Current Action Steps

**CARE COORDINATION**

- **Reduce avoidable ED visits**
  - Create ED redirect program – Patient Navigator
  - Walk-in Clinic expansion

- **Readmission reduction**
  - Home health participation prior to DC
  - Community partnership
  - Retail DC pharmacy
  - Swing Bed growth

- **Patient Satisfaction**
  - Discharge letter from CEO
  - Follow up phone calls with survey indication
  - Quality Impact Teams – HACAPHS, OAS CAHPS, ED CAHPS
    - Begin CG CAHPS

- **Quality Improvement**
  - Top Decile Performance
    - Realign goals & benchmarks
    - Add front line staff / board member to quality council
    - Educate staff on QAPI
Embrace & drive patient value & sustainable profitability

- **Financial Status**
  - Rev Cycle optimization
  - Optix labor management
  - 340B program

- **Growth**
  - Market Share expansion – inpatient
  - Claims analysis opportunities for population health management
    - Chronic care registry, Chronic Care Management
  - Increase IP & OP psych services

**Be a Team of Champions**

- Associate Engagement Survey
- Physician recruitment / alignment
- Leadership Development
- Associate Rounding
Problem
➢ Lack of sufficient Primary care Provider for Medicaid Patients in Natchitoches.
➢ Frequent Preventable Emergency Room visits.

Goal
➢ Improve the health of our community
➢ Reduce the percentage of our preventable ED visits from 69.3% by 18% over a period of 3 years.
➢ Ensure appropriate use of the Emergency Room by Medicaid patients.

Target Population
➢ Medicaid Patients 18yrs and older with a primary or secondary diagnosis of diabetes, or a primary or secondary diagnosis of COPD that utilize the emergency room 3 or more times in a 6 month period.

Implementation Strategies
➢ Community partnerships (Home health,
➢ Council of Aging, Hospice, etc.)
➢ Identification of Target population
➢ Communication and Engagement
➢ Utilize Patient Navigator
Communication and Engagement Method

Patient Navigator / Community Champion:

- Meet with Patient in the Emergency room
- Assess patients need and understanding of discharge instruction/ care plan
- Provide and explain discharge education and care plan using the teach back method
- Schedule follow up appointment for patient with their established PCP or a PCP at NRMC Medicaid Clinic if patient has no PCP
- Educate patient on available hospital/community services and resources.
- Encourage patient to attend NRMC diabetes class or Smoking cessation class
- Work with Pulmonologist to Develop individualized care plan for COPD patients.
- Assist patients in setting and achieving short term and long term health goals.
- Weekly or bi-weekly follow up phone call