2019 Community Health Implementation Plan

CHRISTUS St. Frances Cabrini Hospital

CHRISTUS Coushatta Health Care Center

CHRISTUS Dubuis Hospital of Alexandria

Savoy Medical Center

CHRISTUS. ST. FRANCES CABRINI Hospital

18-0700

Contents

Mission for Implementation

CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Coushatta Health Care Center, and CHRISTUS Dubuis Hospital of Alexandria, along with Savoy Medical Center, a local governmental, non-profit hospital that is managed by CHRISTUS St. Frances Cabrini Health System, serve patients across Central Louisiana. Founded on the mission "to extend the healing ministry of Jesus Christ," CHRISTUS Health's vision is to be a leader, a partner, and an advocate in creating innovative health and wellness solutions that improve the lives of individuals and communities so that all may experience God's healing presence and love.

As part of their mission and to meet federal IRS 990H requirements, CHRISTUS Hospitals in Central Louisiana and Savoy Medical Center contracted with the Louisiana Public Health Institute (LPHI) to conduct and document the community health needs assessment (CHNA) and community health improvement plan (CHIP) reports, which is required every three years.[1] LPHI worked with CHRISTUS Hospitals across Central Louisiana and Savoy Medical Center using a mixed methods approach to conduct the CHNA approved by the board in April 2019 (see separate document). Data for this eight-parish footprint was compiled including indicators for demographics, socioeconomic factors, access to care, health outcomes, and other health factors, along with information gathered from persons who represent broad interests of the community served by the hospital facilities. Through an iterative process, three priorities were chosen for each facility requiring a targeted response with community partners, which is detailed in this implementation plan. IRS regulations define the implementation strategy as "a written plan that, with respect to each significant health need identified through the CHNA, either: (1) describes how the hospital facility plans to meet the health need, or (2) identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address the health need."[2]

This report is the companion piece to the 2019 Community Health Needs Assessment and serves as the 2019 Community Health Improvement Plan. The CHIP builds upon the CHNA findings by detailing how CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Coushatta Health Care Center, CHRISTUS Dubuis Hospital of Alexandria, and Savoy Medical Center intend to engage partner organizations and other local resources to respond to the priority health needs identified. This report identifies a clear set of strategies, actions, and anticipated outcomes.[3]

Target Area/ Population

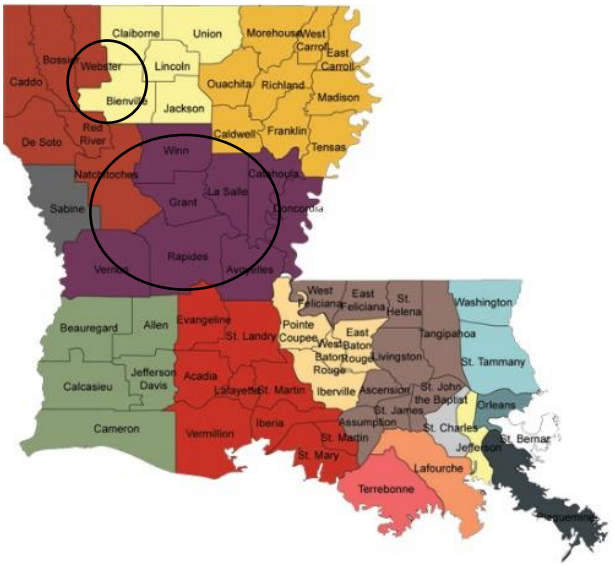
The geographic region of focus remains reflective of that described in the CHNA. CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Coushatta Health Care Center, CHRISTUS Dubuis Hospital of Alexandria, and Savoy Medical Center primarily serve patients across Central Louisiana including Allen, Avoyelles, Bienville, Evangeline, Grant, Rapides, Red River, and Vernon Parishes. Although CHRISTUS Coushatta is located further northwest, it is licensed under CHRISTUS St. Frances Cabrini Health System incorporating it into the central Louisiana service area. This eight-parish region will be referred to as Central Louisiana, CLA, or the Region throughout the report.

[1] All statements and opinions herein were expressed by key informants and focus group participants and do not necessarily represent the viewpoints and opinions of LPHI or its contractors.

[2] https://lphi.sharepoint.com/Shared%20Services/s/e/CHRISTUS%20CHNA%20%20CHIP/2015cha_assesmentguide_edition2.pdf?CT=1563221225245&OR=ItemsView

[3] Hospital organizations use Form 990, Schedule H, Hospitals, to provide information on the activities and community benefit provided by its hospital facilities and other non-hospital health care facilities, which is separate from this report.

Central Louisiana Parishes	
Allen	Avoyelles
Bienville	Evangeline
Grant	Rapides
Red River	Vernon



Community Health Priorities

A validation meeting facilitated by LPHI in January 2019, provided over 60 facility staff and community partners an overview of the community's major concerns from the quantitative and qualitative findings described in the 2019 CHNA (see separate document). Major concerns included those that were (1) substantiated through the quantitative analysis and/or (2) brought up at least three times during interviews and focus group. These major concerns fell into eight priority areas. Participants then validated and ranked these health priorities in the region using polling software at the validation meeting. The ranking results are listed below:

1. Mental and behavioral health
2. Chronic disease and conditions
3. Access to care
4. Social determinants of health
5. Cancer
6. Sexual Health
7. Infant mortality
8. Quality of water (rural areas)

CHRISTUS Health St. Frances Cabrini Health System Vice President, Mission Integration, and the CHNA Advisory Committee used the information presented at the validation meeting, along with the ranking conducted by participants, to help determine the focal priorities the ministry will address over the next three years through the 2019-2022 Community Health Improvement Plan (CHIP). In addition, during the next three years, community benefit initiatives may be added as health-related issues arise that are identified community needs. To maximize and leverage resources, community benefit efforts in Central Louisiana will address the following priorities:

- Mental and Behavioral Health
- Chronic diseases and conditions
- Access to care
- Social determinants of health
- Cost of medications
- Substance abuse, alcoholism, and smoking

Selected Implementation Strategy

Presented in this section is a summary of the implementation strategies and actions CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Coushatta Health Care Center, CHRISTUS Dubuis Hospital of Alexandria, and Savoy Medical Center will each undertake in the upcoming three-year period to respond to the priority health issues:

CHRISTUS St. Frances Cabrini Hospital	• Mental and Behavioral Health • Chronic Diseases and Conditions (emphasis on diabetes) • Access to Care
CHRISTUS Coushatta Health Care Center	• Mental and Behavioral Health • Access to Care • Social Determinants of Health (emphasis on transportation & knowledge of community resources)
CHRISTUS Dubuis Hospital of Alexandria	• Chronic Diseases and Conditions • Access to Care • Cost of Medications
Savoy Medical Center	• Substance Abuse and Alcoholism • Smoking • Chronic Diseases and Conditions (emphasis on cardiovascular disease and diabetes)

Below are the details of the implementation plan addressing each of these health needs. A priority strategy statement describes each objective and introduces major actions that will be pursued to deliver improvements. Major actions are presented with sub-actions identifying specific partners and resources to be engaged in the improvement effort. Actions and sub-actions are linked with anticipated outcomes, which present a vision of how the status of each health need will change when the actions are completed.

CHRISTUS St. Frances Cabrini Hospital: Mental and Behavioral Health (MBH) Strategies

Mental health strategy: CHRISTUS St. Frances Cabrini Hospital will provide early identification, treatment at the least restrictive level of care possible, and supportive follow-up care for community individuals who suffer from anxiety, depression, Post Traumatic Stress Disorder (PTSD), and suicidal thoughts.

Major Actions	Sub-actions
Provide interdisciplinary care led by a Board-certified psychiatrist for community members regardless of ability to pay for services.	1. Community members who present MBH symptoms to the CHRISTUS St. Frances Cabrini Emergency Department will be assessed by an RN from the Behavioral Health Unit (BHU). 2. Those individuals who require inpatient treatment will be referred for the appropriate level of care. 3. Following treatment, the multi-disciplinary team works with patient to find the most appropriate, convenient and affordable continuing care. 4. Continuing Care plans are arranged for the patient with the first appointment within one week of discharge. 5. Cabrini Medical Staff educate Primary Care Physicians on integrated care for those patients who may have a Mental illness. ***Anticipated outcome:*** Improved mental health outcomes for high risk populations and fewer re-admissions to the BHU.

Substance abuse strategy: CHRISTUS St. Frances Cabrini Hospital will increase access to services for Substance Use Disorders (SUD), including Alcohol, Opioids, Cocaine, Methamphetamine and other street and prescription substances.

Major Actions	Sub-actions
Provide early identification and appropriate care for individuals who have a Substance Use Disorder.	1. The BHU Intake RN, in cooperation with the Cabrini ER staff, will identify those individuals who exhibit signs and symptoms of a Substance Use Disorder. 2. Provide appropriate treatment recommendations to those individuals who may have a SUD and recommendations for their family members. 3. Through the Cabrini Medical Staff educate, Primary Care Physicians on early identification of SUDs for their patients in the community. They may employ tools such as TAP-1 and TAPS-2. 4. Patients admitted to the BHU will be detoxed, when needed, receive basic education on SUD, and be referred for appropriate follow-up care such as inpatient SUD treatment, SA-IOP, or community programs such as AA/NA. Anticipated Outcomes: Earlier detection and treatment for community members suffering with a Substance Use Disorder. Fewer uses of tertiary agents such as NARCAN being required.

Smoking cessation strategy: CHRISTUS St. Frances Cabrini Hospital will make smoking cessation resources accessible to all community members who encounter CHRISTUS St. Frances Cabrini services.

Major Actions	Sub-actions
Identify and offer cessation support to all patients seen in CHRISTUS St. Frances Cabrini clinics as well as the Emergency Department	1. Identify those who are seen by the Emergency Department and all Cabrini clinics who use Nicotine products regularly. 2. Refer patients to affordable or zero cost treatment services to those individuals who express an interest. 3. Offer prescriptions for smoking cessation medication, wherever possible. *Anticipated Outcomes:* Improved overall health for community members. Fewer Emergency Department visits for respiratory infections.
Identify and provide resources to help BHU patients stop smoking and/or using nicotine products.	1. The BHU will screen patients admitted who use Nicotine on a regular basis. 2. Referral to affordable or zero cost treatment services will be provided at the time of discharge. 3. Prescription for smoking cessation medications will be offered/provided at the time of discharge. *Anticipated Outcomes:* Improved overall health patients discharged from BHU.

CHRISTUS St. Frances Cabrini: Chronic Diseases and Conditions – Diabetes Strategy

CHRISTUS St. Frances Cabrini Hospital will partner with local faith communities and food organizations to increase access to diabetes/ cardiovascular health screenings, medications, glucose testing supplies, primary care providers, and other prevention and disease management activities.

Major Actions	Sub-actions
Partner with churches and community leaders during health fairs in the most vulnerable communities (African American and Hispanic communities) to screen and identify those in need of services.	1. Participate in church/ community-lead health fairs to provide blood glucose, cholesterol, hemoglobin A1c, and blood pressure testing on a routine basis (at least biannually if not quarterly). 2. Provide opportunities for community members to be established with primary care providers for management of diabetes 3. Provide opportunities for participation group/ individual in Diabetes Self-Management Education (DSME) ***Anticipated outcomes:*** Participation in community events and partnering with our local churches and community leaders will help establish a trust and allow us to better understand the needs of the population. By better understanding the communities served, we can better address the barriers and better serve the communities. Those in need of primary care providers will get established with a primary care provider. Routine screenings will allow us to monitor the prevention and management of diabetes.
Work with the Food Bank to assist with enrollment of those in need of food services and provide food preparation education to those receiving food services.	1. Invite the Food Bank to participate in the church/ community-lead health fairs raise community awareness of their services. 2. Assist with on-line registration for food stamps and/or Food Bank boxes 3. Provide healthy food demonstrations and samples using the food that is typically included in the boxes from the Food Bank. ***Anticipated outcomes:*** Community members who are eligible for services from the Food Bank will be registered for services. Those receiving food supplies will gain knowledge and skills necessary to prepare the foods they receive from the Food Bank in a healthy way to prevent and/or manage chronic disease.
Diabetes Self-Management Education (DSME)	1. Partner with churches/community leaders to provide economical DSME in the locations/times most convenient for participation. 2. Partner with the parish school nurses and CHRISTUS School-based health centers to screen for diabetes, hemoglobin A1c, blood pressure, and provide DSME to the school-aged members of the communities who are at risk or who have already developed Type 2 Diabetes. ***Anticipated outcomes:*** Those at risk for development of Type 2 Diabetes and their caregivers will gain the knowledge and skills to help prevent the development of Type 2 Diabetes. Those that already have a diagnosis of Type 2 Diabetes will gain the knowledge and skills to better manage their diabetes as evidenced by lower or maintained hemoglobin A1c results.

CHRISTUS St. Frances Cabrini Hospital: Access to Care Improvement Strategy

CHRISTUS St. Frances Cabrini Hospital will ensure patients have access to appropriate care by collaborating with local providers, clinics, community resources, and school-based health centers.

Major Actions	Sub-actions
Ensure patients have access to the appropriate medicines to meet their medical needs.	1. Advertise the discount pharmacy at Christus Community Clinic. 2. Work out a process so patients discharged from Cabrini can have their meds filled at our 340B pharmacy. 3. Get Pineville listed as a 340B pharmacy site. ***Anticipated outcome:*** Patients who cannot afford their medicines will have access to affordable medications.
Increase Health Literacy through partnerships and education	1. Visit churches to educate the community about different services offered. 2. Place bulletin boards around the hospital and clinics with Health Literacy information. 3. Addition of Case manager/ Social worker to the clinics who does 1:1 Education with our patients. 4. Work with School Based Health Center to educate students and parents. ***Anticipated outcomes:*** Patients in the region will become more educated about general health and what resources are available.
Expand specialty care to the Medicaid and uninsured Population	1. Hire a new Case Manager to help with referrals 2. Provide GYN care on Saturdays for patients who cannot attend appointment during the week 3. Add another Neurology and Cardiology clinic. 4. Hospital recruiting specialist. ***Anticipated outcomes:*** Expanded specialized care provided for Medicaid and uninsured patients.
Address the Cost of Care for patients in our area.	1. Increase the charity care threshold to 300% of the poverty level. 2. Hire a Medicaid person at the clinics that helps facilitate the signup for new members. 3. Allow patients who have insurance to use our charity as secondary to cover copays and deductibles. ***Anticipated outcomes:*** More patients will be able to afford the care they need.
Address transportation needs for patients.	1. Work with city to add bus stop at CHRISTUS Community Clinic Alexandria 2. Add a primary care person in Pineville for patients who live on that side of the river. ***Anticipated outcomes:*** Increased transportation options for patients will decrease no-show rates and increase access to care.

Increase coordination of care between multiple providers	1. New Case Manager at clinics to help coordinate care for our patients. 2. Work with Dr. Holcombe to schedule quarterly meeting between clinics providing care to the uninsured and Medicaid patients. 3. Meet with Health unit once a month to monitor and address the STD epidemic in Central LA. ***Anticipated outcomes:*** Increased coordination of care between providers and clinics.
Coordination of Care between the ER and Primary Care	1. New system where the ER staff can fax referrals straight to an RN at the clinic to facilitate faster scheduling of appointments. 2. Hire an ER navigator to help coordinate care. ***Anticipated outcomes:*** Less patients will need to use the ER for Primary Care.

CHRISTUS Coushatta Health Care Center: Access to Care Improvement Strategy

CHRISTUS Coushatta Health Care Center will increase access to health and preventative care services by targeting outpatient specialty services not currently offered in the local ministry service area.

Major Actions	Sub-actions
Establish chemotherapy outpatient IV infusion center at CHRISTUS Coushatta.	1. Identify local patients in need of chemo treatment who currently travel over 35 miles one way to receive chemo multiple times per week. ***Anticipated outcome:*** Local cancer patients will have increased and easier access to chemo treatment.
ENT services	1. Looking to recruit an ENT provider for our area. ***Anticipated outcome:*** Increased access to ENT services in our service area.
Transportation	1. Explore possibilities of transporting patients to and from appointments. 2. Seek sponsorship for transportation services ***Anticipated outcome:*** Transportation provides increased access to patient care and decreases no show rates, which will improve overall health outcomes.
340B Pharmacy contract - Boyce	1. Expand 340b discounts on prescriptions for eligible patients. ***Anticipated outcome***: Increased access to underserved population for prescription drugs.
School-based telemedicine program and School-based Health Centers	1. Explore partnership with Red River Parish School board to establish telehealth services for students & faculty. 2. Provide quality primary care and prevention services (e.g. wellness visits, immunizations/vaccinations, etc.) to youth through School-based Health Centers. ***Anticipated Outcome:*** Parents of children in participating schools will have the ease of knowing healthcare will be provided to their children during school hours, eliminating loss of labor hours for the parents. This, in turn, increases the likelihood of children being examined and treated appropriately.
Enhance existing Diabetes Education Program to expand reach and impact	1. Partner with MLK Community Health Center to provide Diabetes education in our service area. ***Anticipated Outcome:*** Improved diabetes prevention and management by enhancing certain elements of the Diabetes Education Program and providing it in a variety of settings to expand group of participants beyond hospitalized patients. SBHCs will address the needs of the pediatric population. The program will enable positive lifestyle changes for those living with or at risk of complications from diabetes.

CHRISTUS Coushatta Health Care Center: Social Determinants of Health (SDoH) Strategy

CHRISTUS Coushatta Health Care Center plans to incorporate increasing transportation options and increasing awareness of resources throughout their other strategies.

Major Actions	Sub-actions
Improve Transportation options	1. Explore possibilities of transporting patients to and from appointments. 2. Seek sponsorship for transportation services ***Anticipated outcome:*** Transportation provides increased access to patient care & decreases no show rates, which will improve overall health outcomes.
Identify Community Resources	1. Compile a list of services to distribute to community stakeholders. ***Anticipated outcome:*** This will identify resources in our community that we can assist/partner with to reach patients that we may not otherwise have access to.

CHRISTUS Coushatta Health Care Center: Mental and Behavioral Health Strategy

CHRISTUS Coushatta Health Care Center will increase access to mental and behavioral health services in the ministry's service area for adult age patients. CHRISTUS Coushatta currently offers geriatric behavioral health services.

Major Actions	Sub-actions
Recruit a mental health nurse practitioner for the Rural Health Clinic located in Coushatta to expand mental health services.	1. Begin with one mental health clinic day per week 2. Provide medication management for adult mental health patients ***Anticipated outcome:*** Providing a mental health nurse practitioner will provide mental health services and medication management not currently available in the Coushatta area.
Work with the Geri-Psych management company to identify potential patients who do not meet their age limits and requirements.	1. Identify patients who need mental health services that do not meet the requirements for the geri-psych program currently offered. ***Anticipated outcomes:*** Will increase access to mental health services to an underserved age population in the ministries' service area.
Improve Transportation options	1. Explore possibilities of transporting mental/behavioral health patients to and from appointments. 2. Seek sponsorship for transportation services ***Anticipated outcome:*** Transportation increases access to patient care and decreases no show rates, which will improve overall health outcomes.

CHRISTUS Dubuis Hospital of Alexandria: Chronic Diseases and Conditions Strategy

CHRISTUS Dubuis Hospital of Alexandria will provide individualized education plans and follow-up for patients suffering with chronic disease to improve care compliance and reduction in re-admissions.

Major Actions	Sub-actions
Provide individualized education and instruction on managing chronic disease	1. Provide individualized education plan focusing on patient and caregivers 2. Provide thorough follow up care including arranging appointments with providers *Anticipated outcomes:* Enhanced care compliance resulting in improved disease management. Long-term reduction in both visits to the ED and hospital admissions.

CHRISTUS Dubuis Hospital of Alexandria: Access to Care Improvement Strategy

CHRISTUS Dubuis Hospital of Alexandria will assist patients with referrals and explore alternative care options, such as telehealth, to increase access to care.

Major Actions	Sub-actions
Provide thorough, appropriate follow up care	1. Provide referrals and help set appointments to Primary Care physician, specialty care and home health providers 2. Research availability of Telehealth for people who live in more remote areas with limited ability to meet with providers in-person and make local referrals when possible *Anticipated outcome:* Improved disease management will result in reduction of repeat visits to ED and hospital admissions.

CHRISTUS Dubuis Hospital of Alexandria: Cost of Medications Strategy

CHRISTUS Dubuis Hospital of Alexandria will improve medication management for chronic disease patients by addressing cost of medications.

Major Actions	Sub-actions
Ensure access to affordable medications necessary to treat chronic conditions	1. Research Prescription Assistance Programs (PAP) and assist filling out and submitting applications 2. Network locally to provide medication assistance (medication samples from physicians, referrals to Community Healthworx, price compare local pharmacies) 3. To the extent possible, prescribe generic medications for disease management *Anticipated outcome:* Improved disease management due to increased accessibility of needed medications

Savoy Medical Center: Substance Abuse and Alcoholism Strategy

Provide increased and varied access to healthcare opportunities that are tailored to the needs of the community served by Savoy Medical Center (SMC).

Major Actions	Sub-actions
Provide behavioral health services for adults in the surrounding parishes	1. Market SMC Behavioral Health Services to the surrounding parishes 2. Meet with law enforcement agencies regarding substance abuse and alcoholism 3. Distribute handouts to families and caretakers about services offered **Anticipated outcome*:*** Increasing services and addressing barriers will promote better physical and mental outcomes for community.
Provide Substance Abuse Education to area school children.	1. Coordinate with schools, and/or others to have SMC Behavioral Health Team provide onsite Alcoholism/Substance Abuse education to middle school children in the community **Anticipated outcomes:** Improving the efficiency, effectiveness, and access to an ever-widening range of care options to the community that SMC serves.

Savoy Medical Center: Smoking Strategy

Savoy Medical Center will lead efforts to decrease number of people who smoke in the community.

Major Actions	Sub-actions
In collaboration with partners, provide smoking cessation education classes and resources	1. Conduct bi-annual smoking cessation classes in hospital 2. Provide smoking cessation support groups 3. Provide a booth at the SMC annual breast walk to promote quitting smoking and nicotine products 4. Promote the State of Louisiana Quit Line for patients that smoke **Anticipated outcome:** Increasing services and addressing barriers will promote better physical and mental outcomes for community.
Provide Substance Abuse Education to area school children.	1. Coordinate with schools, and/or others to have the SMC Behavioral Health Team provide onsite Alcoholism/Substance Abuse education to middle school children in the community **Anticipated outcomes:** Raising community awareness regarding the complications and impact of smoking will promote decreasing the rate of smoking in the community.

Savoy Medical Center: Chronic Diseases and Conditions Strategy

Savoy Medical Center will implement Cardiovascular Disease/Diabetes Prevention Program, including conducting community education and outreach, screenings, and increasing access to resources.

Major Actions	Sub-actions
Implement Community Education and Outreach activities promoting heart health.	1. Offer one free Wellness health screening to employees yearly 2. Offer lunch – and – learn to the community with expanded topics tailored to the needs and requests of area businesses 3. Provide semi-annual support groups 4. Continue annual Breast Walk to encourage family exercise 5. Develop wellness program for both hospital and area businesses **Anticipated outcome:** Through our Community Education outreach, we will increase awareness about chronic disease management and prevention with the goal of elevating the health of those in the community that we serve. We anticipate seeing a reduction in the complications of heart disease, and obesity.
Increase access to education, screenings, and testing for those suffering with pre-diabetes and diabetes.	1. Offer A1C testing at a reduced cost 2. Continue to offer blood glucose screenings and quickly link newly found diabetic patients to a Primary Care Provider (PCP) for follow-up care 3. Provide healthy lifestyle education and awareness for those with prediabetes **Anticipated outcome:** Increased awareness about chronic disease management and prevention with the goal of elevating the health of those in the community that we serve. We anticipate seeing a reduction in the complications of diabetes.

Issues not selected for prioritization

To maximize resources available for the priority areas listed above, the CHNA Advisory Committee and executive leaders of the facilities determined that the following issues would not be explicitly included in their community health improvement plan (CHIP):

CHRISTUS St. Frances Cabrini Hospital	CHRISTUS Coushatta Health Care Center	CHRISTUS Dubuis Hospital of Alexandria	Savoy Medical Center
Social determinants of Health	Cancers	Mental and Behavioral Health	Access to Care
Cancers	Stroke	Social Determinants of Health	Social Determinants of Health
Stroke	Chronic Disease	Cancers	Cancer
Water Quality	Quality of Water	Stroke	Stroke
Infant Mortality	Infant Mortality	Quality of Water	Quality of Water
Sexual Health	Sexual Health	Infant Mortality	Infant Mortality
		Sexual Health	Sexual Health

While all priority areas are of community concern and important issues, CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Coushatta Health Care Center, CHRISTUS Dubuis Hospital of Alexandria, and Savoy Medical Center determined there are others in the region already addressing or possess more specialized resources to better address these excluded priorities. View Appendix C in the separate 2019 Community Health Needs Assessment document for a list of local organizations and community assets mentioned by stakeholders.