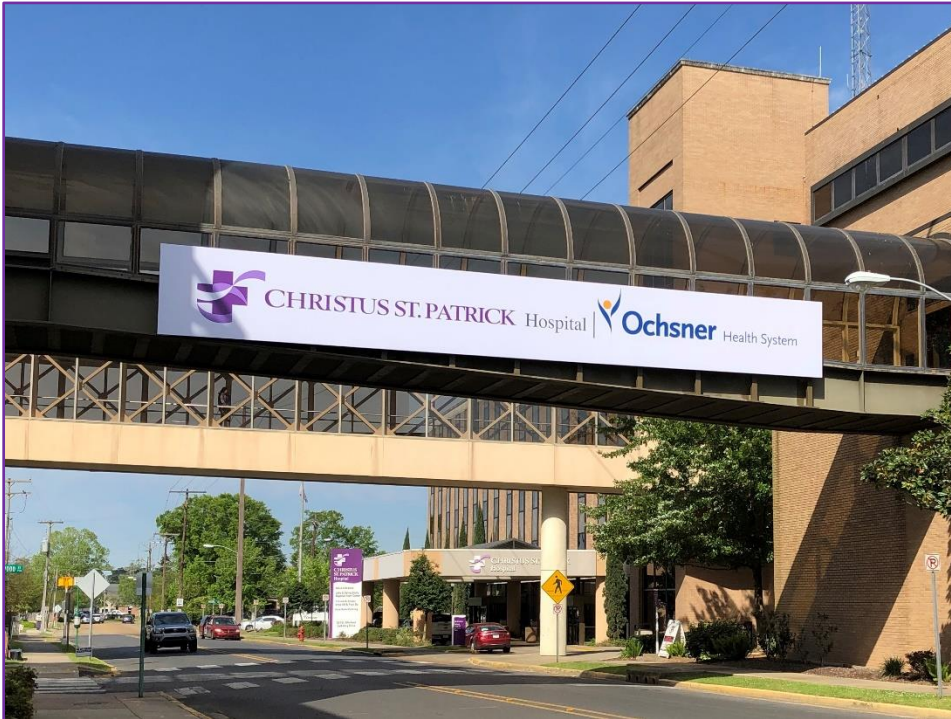


2019 Community Health Improvement Plan

CHRISTUS Ochsner Health Southwestern Louisiana



Contents

Mission for Implementation	3
Target Area/ Population	3
Community Health Priorities	3
Selected Implementation Strategy	4
Access to Care Improvement Strategy	5
Cancer Strategy	6
Mental and Behavioral Health Strategy.....	7
Chronic Disease Management Strategy	8
Issues not selected for prioritization	9
Appendix A: 2019-2022 Community Health Action Snapshot	10

About the Louisiana Public Health Institute (LPHI)

LPHI, founded in 1997, is a statewide 501(c)(3) nonprofit and public health institute that translates evidence into strategy to optimize health ecosystems. Our work focuses on uncovering complementary connections across sectors to combine the social, economic, and human capital needed to align action for health. We champion health for people, within systems, and throughout communities, because we envision a world where everyone has the opportunity to be healthy. For more information, visit www.lphi.org.

Mission for Implementation

CHRISTUS Ochsner Health Southwestern Louisiana currently manages two non-profit hospitals: CHRISTUS Ochsner St. Patrick Hospital and CHRISTUS Ochsner Lake Area Hospital. 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 Health 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.¹ The requirements imposed by the IRS for tax-exempt hospitals includes conducting a CHNA every three years and to adopt an implementation strategy to meet the community health needs identified through the assessment.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 Ochsner Southwest Louisiana intends to engage partner organizations and other local resources to respond to the priority health needs identified in the CHNA. It identifies a clear set of goals, actions, and interim benchmarks to monitor progress.

Target Area/ Population

Given that the CHRISTUS Health Southwestern Louisiana region serves patients primarily from the following 5-parish region, it made the most sense to define the community assessed in this process by the same region. Both CHRISTUS Ochsner St. Patrick Hospital and CHRISTUS Ochsner Lake Area Hospital are located in Lake Charles, LA and serve patients from the following 5-parishes.

CHRISTUS Ochsner Health Southwestern Louisiana Parishes				
Allen	Beauregard	Calcasieu	Cameron	Jefferson Davis



The target population for many of the implementation strategies discussed in this report are dependent upon the priority areas of focus and will vary from patient groups to specific neighborhoods and communities within these parishes.

Community Health Priorities

A validation meeting, facilitated by LPHI in January 2019, provided facility staff and community partners an overview of the community’s major concerns from the quantitative and qualitative findings described in the 2019 Community Health Needs Assessment (see separate document). Major concerns included those that were 1) substantiated through the quantitative analysis and/ or 2) brought up at least 3 times during interviews and/ or the focus group. These specific concerns were bucketed into 8 priority areas. Over 20 participants, including key CHRISTUS Ochsner SWLA staff and external community partners, validated and ranked health priorities in the region using a polling software at the validation meeting. The ranking results are listed below:

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 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.

1. Mental and behavioral health
2. Social determinants
3. Access to care
4. Chronic disease
5. Cancer
6. Stroke
7. Sexually transmitted infections
8. Infant death

CHRISTUS Ochsner Health Southwestern Louisiana leadership and their community benefit team used the information presented at the validation meeting, along with the ranking conducted by participants, to determine the four focal priorities the ministry will address over the next three years through the upcoming 2019 Community Health Improvement Plan (CHIP). To maximize and leverage resources, community benefit efforts will focus on the following:



Selected Implementation Strategy

Presented in this section are a series of implementation strategies containing the actions and anticipated outcomes CHRISTUS Ochsner St. Patrick Hospital and CHRISTUS Ochsner Lake Area Hospital will undertake in the upcoming three-year period to respond to the four priority health issues:

- Access to Care
- Cancer
- Chronic Disease
- Mental and Behavioral Health

Appendix A depicts a detailed snapshot of the implementation strategy for each facility including resources, partners, and measurements for change.

Access to Care Improvement Strategy	
<p>CHRISTUS Ochsner Southwestern Louisiana will increase access to care in the region by collaborating with local providers, utilizing community health worker model, focus on recruitment, and continuing to support five School Based Health Centers (SBHCs).</p>	
Major Actions	Sub-actions
<p>Ensure people have access to appropriate level of care that meets their needs</p>	<ol style="list-style-type: none"> Expand referral relationships with SWLA Center for Health Services and others through coordination meetings, utilizing CHW model, and other means as necessary <p>Anticipated outcome: Establishing strong referral relationships and processes will improve care coordination and patients’ access to appropriate services in their community, regardless of their ability to pay.</p>
<p>Reduce frequent non-emergent emergency department (ED) revisits for 5% of hypertension patients among low-income populations by improving access to appropriate care alternatives</p>	<ol style="list-style-type: none"> CHWs will contact and assist all discharged patients that do not have medical home Hospital facilities (starting with St. Patrick) will institute IT platform for CHW follow-up to track whether patient referrals were completed <p>Anticipated outcomes: Utilizing a CHW model and new IT platform will improve effectiveness of care coordination between service providers. By placing patients with a local Medical Home and improving care coordination patients will be more aware of where and how to seek appropriate care reducing number of non-emergent ED revisits for the cohort of hypertensive patients.</p>
<p>Address physician and other provider shortages as defined by needs assessment to overcome gaps in service</p>	<ol style="list-style-type: none"> Develop a timeline and recruitment strategy for open positions Onboard physicians and other providers <p>Anticipated outcomes: Addressing provider shortages, as identified in the needs assessment, will increase the number of services available to more patients.</p>
<p>Five School Based Health Centers (SBHCs) will provide health services to at-risk/low income/underserved students enrolled in health centers.</p>	<ol style="list-style-type: none"> Each SBHC will meet identified productivity goals for serving low-income/underserved students. <p>Anticipated outcomes: Students who do not have routine access to care will receive needed physical and mental health care in SBHCs.</p>

Cancer Strategy	
<p>CHRISTUS Ochsner Southwestern Louisiana will increase access to and enhance existing oncological services and prevention activities in SWLA region specifically targeting colorectal, breast, lung and prostate cancers.</p>	
Major Actions	Sub-actions
<p>Provide nurse navigation and support groups for oncological patients</p>	<ol style="list-style-type: none"> 1. Conduct weekly multi-disciplinary huddles to address barriers to care 2. Provide nurse navigation for oncological patients 3. Provide support groups <p>Anticipated outcome: Increasing services and addressing barriers will promote better physical and mental outcomes for oncological patients.</p>
<p>Work with American Cancer Society, clinicians, and programs supported by Louisiana Smoking Cessation Trust to advance cancer prevention efforts within the community</p>	<ol style="list-style-type: none"> 1. Coordinate with organizations, community coalition and/or others to support the passage of a local smoke-free ordinance and cancer prevention community activities 2. Conduct screenings <p>Anticipated outcomes: Expanding CHRISTUS Ochsner Southwestern Louisiana’s role in cancer prevention activities through increased partnerships, screenings, and the support of smoke-free initiatives will contribute to the collective capacity in Southwest Louisiana to promote cancer prevention.</p>
<p>Connect with area businesses and community organizations to provide cancer screening and prevention education materials</p>	<ol style="list-style-type: none"> 1. Offer three cancer screenings annually (such as for prostate, lung and skin cancer) along with navigation for appropriate follow-up <p>Anticipated outcomes: Providing more cancer screenings with navigation will increase early detection and support patients needing follow-up.</p>
<p>Increase patient access to clinical trials, counseling, and education</p>	<ol style="list-style-type: none"> 1. Offer health risk assessments to broad community. Fifteen percent (15%) of patients identified as moderate to high-risk will be referred for further genetic counseling/ testing. 2. Provide counseling and education to approximately 230 high risk patients annually <p>Anticipated outcomes: Increased referrals for genetic counseling and testing for moderate to high-risk patients. Increased counseling and education for high-risk patients. Increased testing, counseling, and education will result in increased detection and improved access to treatment, ultimately contributing to a reduction in cancer mortality rates.</p>

Mental and Behavioral Health Strategy	
<p>CHRISTUS Ochsner Southwestern Louisiana will explore partnerships and strategies to improve the accessibility of mental and behavioral health services and resources. St. Patrick Hospital will continue to provide 24-hour emergency access center and interdisciplinary mental health care.</p>	
Major Actions	Sub-actions
<p>Provide interdisciplinary care led by nursing staff specifically designed for the adult population between ages of 21-64</p>	<p>1. Utilize 15-bed adult in-patient unit for the uninsured and underinsured designed for mental health as well as dual diagnoses</p> <p>Anticipated outcome: Un/underinsured adults will receive mental and behavioral health care on site.</p>
<p>Provide interdisciplinary care led by nursing staff specially designed to deliver care to those over age 65</p>	<p>1. Utilize 10-bed inpatient unit designed to deliver interdisciplinary care to those over the age of 65</p> <p>Anticipated outcomes: Appropriate mental health care is provided to the elderly population.</p>
<p>Provide 24-hour access center located in the Emergency Department for patients that present with psychiatric diagnosis</p>	<p>1. Each patient with a psychiatric diagnosis or problem is assessed for appropriate placement</p> <p>Anticipated outcomes: Patients suffering with mental health issues can remain in access center under care of providers until they are placed in appropriate longer-term care.</p>
<p>The five SBHCs will conduct mental health screenings provided by LCSW and/or LPC</p>	<p>1. LCSW evaluates 100% of students seen that are identified with behavioral concerns</p> <p>2. Students are counseled on site and/or referred as needed</p> <p>Anticipated outcomes: Students suffering with mental health issues will be assessed and provided counseling (and/or referrals) as appropriate.</p>
<p>In coordination with community partners, develop a plan addressing lack of access to substance abuse treatment and services</p>	<p>1. Form committee (5-8 people) to develop plan.</p> <p>2. Facilitate meetings as needed (bi-monthly or quarterly)</p> <p>3. Identify current community resources that address substance abuse and gaps</p> <p>Anticipated outcomes: The ministry will have a baseline understanding of the existing substance abuse services in the region allowing them to realistically plan with partners, leverage resources to fill gaps, and better meet the growing need for substance abuse treatment.</p>

Chronic Disease Management Strategy	
<p>CHRISTUS Ochsner Southwestern Louisiana will provide opportunities in the community for prevention activities, education, and direct services through the five SBHCs, the Cardiac Rehabilitation program, and Live Well seminars.</p>	
Major Actions	Sub-actions
<p>The five SBHCs provide education designed to address obesity through encouraging exercise and healthy eating habits</p>	<p>1. Provide individualized diet and exercise education to all students with a BMI score of 35 or greater at the SBHCs</p> <p>Anticipated outcome: Through increased education and guidance, students with high BMI will better understand how to lead a healthy lifestyle.</p>
<p>Cardiac Rehabilitation Program will continue to focus on healthy lifestyles to reduce possibility of reoccurrence of heart issues</p>	<p>1. Maintain Cardiac Rehabilitation Program at St. Patrick Hospital</p> <p>Anticipated outcomes: Increase knowledge and promote behavior change to reduce reoccurrence of heart issues.</p>
<p>Increase appropriate prevention activities for students</p>	<p>1. The five SBHCs provide screenings (blood pressure, STD, vision/hearing, diabetes, obesity, and depression), comprehensive physicals, immunizations, and education to 70% of students enrolled in school as defined by Louisiana Office of Public Health's Adolescent School Health Program (ASHP).</p> <p>Anticipated outcomes: Ninety percent (90%) of students served will receive a screening. Twenty percent (20%) of students served will have a comprehensive physical. Eighty percent (80%) of students served are meeting required immunizations. One hundred percent (100%) of students served will be referred to an appropriate provider as needed.</p>
<p>Continue Live Well Seminars focused on women's health</p>	<p>1. Deliver four health workshops, featuring popular keynote speakers and including education materials and free screenings, to women in the community through Lake Area Hospital</p> <p>2. Use contact information collected from seminar attendees to conduct ongoing outreach to women, promoting improved health behaviors year-round</p> <p>Anticipated outcomes: Increase education and activities encouraging healthy lifestyle with over 800 female participants.</p>

Issues not selected for prioritization

To maximize any resources available for the priority areas listed above, the Community Benefit Team determined that the following issues would not be explicitly included in their community health improvement plan (CHIP):

- Social Determinants
- Sexually Transmitted Infections
- Stroke
- Infant Death

While all four areas are community concerns, it was determined that there are other health care facilities and organizations in the region who are better equipped to lead efforts to address these needs or have designated resources at their disposal to specifically address these needs in the immediate future.

In the case of the social determinants, the stakeholders feel other entities are in better position to lead the work. The Region V Office of Public Health (OPH) has a task force of Community Leaders addressing sexually transmitted diseases of which the SWLA Ministry participates. In December 2018, CHRISTUS Ochsner St. Patrick Hospital received Advanced Certification as a Primary Stroke Center from The Joint Commission. CHRISTUS Ochsner Lake Area Hospital has a Level III Neonatal Unit and works in collaboration with OPH and other providers in addressing infant death. These collaborations will continue as an ongoing strategy.

Appendix A: 2019-2022 Community Health Action Snapshot

CHRISTUS Ochsner Southwest Louisiana

CHRISTUS Ochsner St. Patrick Hospital & CHRISTUS Ochsner Lake Area Hospital

Health Need 1: Access to Care

Priority Strategy: Increase access to appropriate care in the region by collaborating with local providers, utilizing community health worker model, focus on recruitment, and continue to support five School Based Health Centers (SBHCs).

Anticipated Outcomes:

1. Increased access to appropriate care, services, and follow-up.
2. Improved care coordination.
3. Reduction in non-emergent ED visits for hypertension patients.

Access to Care					
Objectives	Actions	Partners/ Resources	Lead	Time frame	How will it be measured?
1. Ensure people have access to appropriate level of care that meets their needs <i>Facilities: Both</i>	Expand referral relationships with SWLA Center for Health Services and others through coordination meetings, utilizing CHWs, and other mean as necessary	Ochsner CHRISTUS Physician Network; SWLA Center for Health Service; CHRISTUS Health CHW Model; Care Mgmt Team	Joy Huff-Martin	On-going	<ul style="list-style-type: none"> • # monthly meetings held with SWLA Center for Health Services • # of referrals made to SWLA Center for Health Services • # of patients with CHW assists • # placed with care alternatives
2. Reduce frequent non-emergent emergency department (ED) revisits for 5% of hypertension patients among low-income populations by improving access to appropriate care alternatives <i>Facilities: Initially St. Patrick</i>	CHW will contact and assist all discharged patients who do not have medical home	Ochsner CHRISTUS Physician Network; SWLA Center for Health Service; CHRISTUS Health CHW Model; Care Mgmt Team	Joy Huff-Martin & Care Mgmt Team	Ongoing	<ul style="list-style-type: none"> • Reduction in % of unnecessary ED revisits for identified population with hypertension
	Institute IT platform of CHWs follow-up to whether referral was complete	Ochsner CHRISTUS Physician Network; SWLA Center for Health Service; CHRISTUS Health CHW Model; Care Mgmt Team	Joy Huff-Martin & Care Mgmt Team	Assessment period – 36 months	<ul style="list-style-type: none"> • IT platforms assessed and instituted • Both facilities are connected to IT platform • Data sharing agreement signed with FQHC • % of hypertension patient cohort with completed referrals
3. Hospitals will address physician and other provider shortages as defined by needs	Develop a timeline to execute recruitment strategy for open positions	Ochsner Health System	Kevin Holland	2019-2021	<ul style="list-style-type: none"> • Timeline and recruitment/ retention strategy developed

assessment to overcome gaps in service <i>Facilities: Both</i>	On-board physicians and/ or other providers	Ochsner Health System	Kevin Holland	2020-2021	<ul style="list-style-type: none"> # Physicians and other providers recruited and on-boarded
4. Five School Based Health Centers (SBHCs) will provide health services to at-risk/low income/underserved students enrolled in health centers. <i>SWLA Ministry: SBHCs</i>	Each SBHC will meet identified productivity goals for seeing students.	Adolescent School Health Program SBHC associates	Joy Huff-Martin	Annually by school year	<ul style="list-style-type: none"> # students seen by NP or RN # students seen by LCSW/LPC % of productivity goals met by each SBHC

Health Need 2: Cancer

Priority Strategy: Increase access to and enhance existing oncological services and screening activities in SWLA region, specifically targeting colorectal, breast, lung, and prostate cancers.

Anticipated Outcomes:

1. Increased access to cancer screenings and services, including nurse navigation and genetic testing.
2. Increased involvement in cancer prevention efforts in SWLA communities.
3. Long-term reduction in cancer morbidity and mortality rates in SWLA region targeting colorectal, breast, lung, and prostate cancers.

Cancer					
Objectives	Actions	Partners/ Resources	Lead	Time frame	How will it be measured?
1. Provide nurse navigation and support groups to oncological patients <i>Facilities: Both</i>	Weekly multi-disciplinary huddles to address barriers to care	Navigators	Dawn Matte	On-going	<ul style="list-style-type: none"> # of multidisciplinary huddles to address barriers to care
	Provide nurse navigation for oncological patients	Navigators	Dawn Matte	On-going	<ul style="list-style-type: none"> # of patients navigated # of patients assisted by navigator that need it
	Provide support groups	Navigators	Dawn Matte	On-going	<ul style="list-style-type: none"> # of support groups held # of attendees
2. Work with American Cancer Society, clinicians, and programs supported by Louisiana Smoking Cessation Trust to advance efforts within community <i>Facilities: Both</i>	Coordinate with TFL, healthy community coalition, or others to support passing of a local smoke-free ordinance and community activities	City of Lake Charles Cancer Committee Imperial Health	Joy & David Boudreaux	2019-2020	<ul style="list-style-type: none"> # of new partnerships developed (or activities supported) as result of smoke-free effort
	Conduct screenings	Imperial Health	David Boudreaux	2019-2020	<ul style="list-style-type: none"> # of screenings developed as result of smoke-free effort

<p>3. Connect with area businesses and community organizations to provide cancer screening and prevention education materials.</p> <p><i>Facilities: Both</i></p>	<p>Three (3) different cancer screenings offered annually (such as prostate, lung, and skin cancer screenings) along with navigation for appropriate follow-up</p>	<p>Workplace Wellness Service Line Leaders</p>	<p>Louise McDaniel</p>	<p>Annually through 2021</p>	<ul style="list-style-type: none"> • # of screenings by type • # of patients provided navigation for additional follow-up
<p>4. Increase patient access to clinical trials, counseling and education</p> <p><i>Facilities: Lake Area</i></p>	<p>Offer health risk assessments to the broad community. Fifteen (15%) of patients identified as moderate to High-risk will be referred for further genetic counseling/testing.</p>	<p>Navigators/educators Breast Program Medical Director Myriad</p>	<p>Leah Marcantel</p>	<p>Annually through 2021</p>	<ul style="list-style-type: none"> • # of assessments done • % of target population referred for genetic testing • # of patients who obtained genetic testing and follow-up as needed
	<p>Provide counseling and education to approximately 230 high-risk patients annually</p>	<p>Navigators/educators Breast Program Medical Director Myriad</p>	<p>Leah Marcantel</p>	<p>Annually through 2021</p>	<ul style="list-style-type: none"> • # high risk patients that receive counseling and education

Health Need 3: Mental and Behavioral Health

Priority Strategy: Explore partnerships and strategies to improve the accessibility of mental and behavioral health services and resources.

Anticipated Outcomes:

1. Improved accessibility of mental health services and resources for populations at risk in SWLA.
2. Long-term reduction in poor mental health outcomes for populations at risk.

Mental and Behavioral Health					
Objectives	Actions	Partners/ Resources	Lead	Time frame	How will it be measured?
<p>1. Provide interdisciplinary care led by nursing staff and specifically designed for the adult population between ages of 21-64.</p> <p><i>Facilities: St. Patrick</i></p>	<p>Utilize 15-bed adult in-patient unit for the uninsured and underinsured designed for mental health as well as dual diagnoses</p>	<p>Internal Interdisciplinary team</p>	<p>Christin Bennett</p>	<p>Ongoing</p>	<ul style="list-style-type: none"> • # Patients Admitted (by payer) • Avg daily census
<p>2. Provide interdisciplinary care led by nursing staff and specially designed to deliver geriatric care</p>	<p>Utilize 10-bed inpatient unit designed to meet the needs of patients over age 65.</p>	<p>Internal Interdisciplinary Team</p>	<p>Christin Bennett</p>	<p>Ongoing</p>	<ul style="list-style-type: none"> • # of Patients Admitted • Avg daily census

<i>Facilities: St. Patrick</i>					
3. Provide 24-hour access center located in the Emergency Department for patients that present with psychiatric diagnosis <i>Facilities: St. Patrick</i>	At request of ED physician, each patient with psychiatric diagnosis or problem is assessed for placement	Police/ sheriff's office Sound Physicians Referral Sources	Christin Bennett	Ongoing	<ul style="list-style-type: none"> • # of ED visits that present with psychiatric diagnosis or problem • # of placements made
4. At the five SBHCs, mental health screenings provided by LCSW and/or LPC <i>SWLA Ministry: SBHCs</i>	LCSW evaluate 100% of students seen that are identified with behavioral concerns	Screening tool LCSW Referral Resources	Joy Huff-Martin	Ongoing	<ul style="list-style-type: none"> • # of students screened • # of students IDed in need of additional services
	Students are counseled on site and/ or referred as needed	LCSW/ LPC provided onsite	Joy Huff-Martin	Ongoing	<ul style="list-style-type: none"> • # of referrals made • # of students provided counseling by LCSW
5. Develop a plan to address lack of access to treatment for individuals that suffer from substance abuse in SWLA. <i>Facilities: St. Patrick</i>	Form committee (5-8 people) to develop plan. Facilitate meetings as needed (bi-monthly or quarterly) Identify current community resources that address substance abuse and gaps	Internal Behavioral Health team Community Resources	Ginger Disante	12 months to develop plan	<ul style="list-style-type: none"> • Committee formed • # Meetings held • List of Resources identified • Plan developed

*Note: Mental and Behavioral Health (MBH) services are not currently offered at Lake Area Hospital.

Health Need 4: Chronic Disease Management

Priority Strategy: Provide opportunities for prevention, education, and direct services through the five SBHCs, the Cardiac Rehabilitation program, and Live Well seminars.

Anticipated Outcomes:

1. Increase in prevention activities.
2. Long-term reduction in prevalence of chronic conditions and unhealthy lifestyles in the community.

Chronic Disease Management					
Objectives	Actions	Partners/ Resources	Lead	Time frame	How will it be measured?
1. The five SBHCs provide programs / education specifically designed to address obesity through encouraging exercise and healthy eating habits <i>SWLA Ministry: SBHC</i>	SBHCs provide individualized diet and exercise education to all students with a BMI score of 35 or greater	Cameron School Board Calcasieu School Board SBHC Associates Louisiana Office of Public Health Adolescent	Joy Huff Martin	Annually by school year	<ul style="list-style-type: none"> • # of students participating in obesity education • % of students with lower BMI after education

2019 CHIP: CHRISTUS Ochsner Health Southwestern Louisiana

		School Health Program (ASHP)			
<p>2. Cardiac Rehabilitation program will continue to focus on healthy lifestyles to reduce possibility of reoccurrence of heart issues.</p> <p><i>Facilities: St. Patrick</i></p>	Maintain Cardiac Rehabilitation program	<p>Cardiologists and other medical providers</p> <p>Dieticians</p> <p>Social workers</p> <p>Spiritual Care</p>	Kelly Cornwell	Ongoing	<ul style="list-style-type: none"> • # of patients enrolled in program • # of patients that complete program
<p>3. Increase prevention activities for students:</p> <p>-90% of students served will receive a screening</p> <p>-20% of students served will have a comprehensive physical</p> <p>-80% of students served have received required immunizations</p> <p>-100% of students served are referred to an appropriate provider as needed</p> <p><i>SWLA Ministry: SBHC</i></p>	<p>The five SBHCs provide screenings (blood pressure, STD, vision/hearing, diabetes, obesity, and depression), comprehensive physicals, immunizations, and education to 70% of students enrolled in school as defined by LDH-OPH ASHP.</p>	<p>ASHP</p> <p>Local School Administrations</p>	Troy Hidalgo, DNP	Annually by school year	<ul style="list-style-type: none"> • # of students screened • # of comprehensive physicals given • # of referrals • # of students not meeting immunization requirements • # of immunizations administered
<p>4. Continue Live Well Seminars providing education and activities encouraging healthy lifestyle with over 800 female participants</p> <p><i>Facilities: Lake Area</i></p>	<p>Deliver 4 health workshops, featuring popular keynote speakers, education, and free screenings to women in the community</p> <p>Use contact information collected from seminar attendees to conduct ongoing outreach to women, promoting improved health behaviors year-round</p>	<p>Live Well Advisory Board</p> <p>Community Organizations</p> <p>Marketing Team</p>	Heather Hidalgo	Seminars held annually	<ul style="list-style-type: none"> • # of seminars • # of participants • Evaluate seminars, including knowledge gained • # of participants targeted to promote continued engagement with CHRISTUS Ochsner for health care needs