



SMART MEDICINE | HEALING GRACE

# 2017-2019 Community Health Improvement Plan for CHRISTUS Health Central Louisiana

## MISSION FOR IMPLEMENTATION

CHRISTUS Health Central Louisiana is comprised of two non-profit hospitals in Central Louisiana, CHRISTUS St. Frances Cabrini Hospital located in Alexandria and CHRISTUS Coushatta Health Care Center located approximately 80 miles northwest of Alexandria in Coushatta, Louisiana. CHRISTUS Health Central Louisiana is part of CHRISTUS Health, formed in 1999 to strengthen the Catholic faith-based health care ministries of the Congregations of the Sisters of Charity of the Incarnate Word of Houston and San Antonio that began in 1866. 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 this effort and to meet [federal IRS 990H requirements](#), this document serves as a community health improvement plan (CHIP) report for CHRISTUS Health Central Louisiana. This report is the companion piece to the Community Health Needs Assessment (CHNA) report that was finalized June 2016 (see separate document), and based, in part, off of several needs identified in that document.

## TARGET AREA/ POPULATION

CHRISTUS Health Central Louisiana sees patients from the following five parishes in the Central Louisiana region. The target population for most of the implementation strategies discussed in this plan is dependent upon the priority area of focus, and will vary from patient groups to specific neighborhoods or communities within these parishes.

CHRISTUS Health Central Louisiana Parishes	
Avoyelles	Rapides
Bienville	Red River
Grant	

## PRIORITY HEALTH NEEDS

Leadership for CHRISTUS Health Central Louisiana was provided with a draft community health needs assessment report May 2016. The CHNA Advisory Committees for CHRISTUS St. Frances Cabrini Hospital and CHRISTUS Coushatta Health Care Center were tasked with reviewing the findings and determining which priority issues would be selected to address over the next three years as part of a community health implementation plan.

Each panel took a number of things into consideration when choosing priorities. Some priorities were selected based off of issue prevalence and severity according to parish and regional secondary data. Input provided by key informants, focus group participants, and other community stakeholders was also heavily considered, especially for priority areas where secondary data were less available. The official Community Health Needs Assessment report was finalized June 2016 (see separate document). Based

on the process described above, the priority health needs selected by CHRISTUS Health Central Louisiana are:

1. Access to Care
2. Chronic Diseases
3. Obesity
4. Lack of health literacy and accountability

**SELECTED IMPLEMENTATION STRATEGY**

The following implementation strategies outline actions CHRISTUS St. Frances Cabrini Hospital and CHRISTUS Coushatta Health Care Center will take over the next three years to address the four priority health needs listed above.

ACCESS TO CARE PRIORITY STRATEGY

Improve access to care by continuing to provide ample resources to the community in a variety of settings, including school-based health centers and community clinics, and by expanding services and facilities, improving physician recruitment (especially for specialty care), and facilitating Medicaid enrollment efforts in the area.

St. Frances Cabrini	
Major Actions	Sub-actions
<b>Increase Medicaid enrollment via Cardon Outreach</b>	<ol style="list-style-type: none"> <li>1. Perform screenings for patients eligible for health insurance</li> </ol> <p><i>Anticipated Outcome: Patients who are now eligible for Medicaid may seek primary care and preventative services now that they are insured.</i></p>
<b>Continue to provide care to school aged children through the School-Based Health Centers (SBHCs)</b>	<ol style="list-style-type: none"> <li>1. Continue to provide health screenings, immunizations and other primary care, preventative and mental services to the underserved youth serviced by SBHCs</li> </ol> <p><i>Anticipated Outcome: School-based health centers will improve the mental and physical health of school aged children and provide them with resources they would otherwise not be able to get.</i></p>
<b>Expand and enhance services available through CHRISTUS operated community clinics</b>	<ol style="list-style-type: none"> <li>1. Expand specialist involvement at Incarnate Word Community Clinic (IWCC)</li> </ol> <p><i>Anticipated Outcome: Uninsured patients will have increased access to specialty medical care that would otherwise not be available to them.</i></p> <ol style="list-style-type: none"> <li>2. Open two new community clinics in Alexandria and Pineville, LA</li> </ol> <p><i>Anticipated Outcome: An expansion of clinics throughout the surrounding area will provide patients with easier access to their medical needs and decrease the amount of patients not able to access care.</i></p>

<p><b>Expand hospital services to reduce lengthier, unnecessary stays for patients when possible</b></p>	<ol style="list-style-type: none"> <li>1. Expand services provided in the hospital that are known to reduce unnecessary or lengthier visits, such as creating an infusion center.</li> </ol> <p><i>Anticipated Outcome: Increasing the services provided to patients will increase access to care and affect other key metrics such as length of stay. For example, an outpatient infusion center will eliminate the need to keep patients in the hospital longer than they need to be.</i></p>
<p><b>Achieve a 10% reduction in ED visits for the economically disadvantaged by improving access to appropriate care alternatives</b></p>	<ol style="list-style-type: none"> <li>1. Use of care coordination</li> <li>2. Collaborate with other community providers to promote alternate access points</li> <li>3. Collaborate with community entities to explore creation and/or expansion of a centralized information resource</li> <li>4. To be determined in consultation with Health, Equity, Diversity and Inclusion at the system level.</li> </ol> <p><i>Anticipated Outcome: Document the number of persons who receive appropriate care in the appropriate setting as a percentage that contributes toward the goal of a 10% reduction in the inappropriate use of the ED by the economically disadvantaged.</i></p>

CHRISTUS Coushatta	
Major Actions	Sub-actions
<p><b>Participate in activities to increase Medicaid enrollment</b></p>	<ol style="list-style-type: none"> <li>1. Per agreement with LA Department of Health, host a liaison onsite to deem Medicaid eligibility and enroll community members</li> <li>2. Actively promote enrollment activities via media outlets, including local newspaper and social media</li> </ol> <p><i>Anticipated Outcome: Hospital will assist in successfully enrolling a larger portion of our service area population in Medicaid Expansion plans, therefore, giving them greater access to healthcare.</i></p>
<p><b>Move towards expanding physical therapy services at the rural health clinic in Ringgold</b></p>	<ol style="list-style-type: none"> <li>1. Begin offering weekly physical therapy services to Bienville Parish communities surrounding Ringgold rural health clinic</li> <li>2. Establish a timeline to expand services to also include occupational and speech therapy</li> </ol> <p><i>Anticipated Outcome: By offering physical therapy to patients in Ringgold, the community will obtain access to these services minutes from home through the rural health clinic</i></p>
<p><b>Provide routine consultations and access to treatments typically not eligible in a rural setting through visiting doctor clinics</b></p>	<ol style="list-style-type: none"> <li>1. Offer weekly outpatient consultations and treatment for high level disease processes through the Dr. Troxclair Clinic</li> </ol> <p><i>Anticipated Outcome: Patients will be better able to honor their appointments by eliminating the need for long distance travel.</i></p>

<p><b>Establish school-based health services in schools to students in four area schools</b></p>	<p>1. Provide quality primary care and prevention services (e.g. wellness visits, immunizations/vaccinations, etc.) to youth through school-based health centers</p> <p><i>Anticipated Outcome:</i> 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.</p>
<p><b>Expand the number of rural health clinics</b></p>	<p>1. Move towards launching 2 new rural health clinics located in Stonewall and Boyce</p> <p><i>Anticipated Outcome:</i> Increased options for care will provide direct access to care in rural areas where healthcare services are not established.</p>

**CHRONIC DISEASES PRIORITY STRATEGY**

Improve prevention and management of chronic diseases in the community by increasing health/disease education offerings and providing chronic disease prevention and management services in a wide variety of settings, such as school-based health centers and community clinics.

<p><b>St. Frances Cabrini</b></p>	
<p><b>Major Actions</b></p>	<p><b>Sub-actions</b></p>
<p><b>Provide patient education and chronic disease programs for an expanded list of chronic conditions</b></p>	<p>1. Continue providing education for diabetes and congestive heart failure patients.</p> <p>2. If possible, consider sponsoring diabetes self-management education (DSME) for up to 2 uninsured patients a month</p> <p>3. Explore expanding education services for patients with other chronic diseases.</p> <p><i>Anticipated Outcome:</i> Providing education to those suffering from chronic conditions can teach patients how to manage their disease and equip them with the necessary tools to live a healthy lifestyle. This is likely to decrease readmissions and result in a healthier patient overall.</p> <p>4. Grow the chronic disease programs that are currently being utilized at the hospital</p> <p>5. Research creating other programs for other chronic diseases that are prevalent in our community</p> <p><i>Anticipated Outcome:</i> Programs provide patients with greater access to the resources that will aid in managing chronic disease or preventing the disease.</p>
<p><b>Provide chronic disease management through the IWCC Coumadin Clinic</b></p>	<p>1. Continue ongoing support of the Coumadin clinic, which provides services and care 1.5 days a week</p> <p>2. Explore expanding the number of days services are provided at clinic –</p>

	<p><i>Anticipated Outcome:</i> Patients are able to get their blood drawn and monitor their blood flow to ensure there is no clotting, which will result in fewer complications for these patients when managing their diseases.</p>
<p><b>Continue to provide coordinated chronic disease management and care to school aged children through the School-Based Health Centers (SBHCs)</b></p>	<ol style="list-style-type: none"> <li>1. Monitor and provide treatment at school for children with chronic diseases</li> <li>2. Health center coordinates with child’s primary care physician (PCP)</li> </ol> <p><i>Anticipated Outcome:</i> SBHCs monitor the health of all children with existing chronic conditions and can provide treatment if needed. Additionally, the SHBCs coordinate with the children’s physician to provide seamless care in the event there is an incident while at school. Prompt, coordinated care can result in better health outcomes for these kids.</p>
	<ol style="list-style-type: none"> <li>3. Provide preventative tests such as pre-diabetic and blood pressure screenings and EKGs</li> </ol> <p><i>Anticipated Outcome:</i> Screening provides an opportunity for early diagnosis and/or prevention of chronic diseases in youth participating in the SBHC.</p>

<b>CHRISTUS Coushatta</b>	
<b>Major Actions</b>	<b>Sub-actions</b>
<p><b>Enhance existing Diabetes Education Program to expand reach and impact</b></p>	<ol style="list-style-type: none"> <li>1. Expand program to include collaborative efforts with dietician and Dr. Troxclair (Board Certified Nutritionist)</li> <li>2. Engage in collaborative discussions with local schools to provide the program in all current school-based health centers</li> </ol> <p><i>Anticipated Outcome:</i> By enhancing certain elements of the Diabetes Education program and providing it in a variety of settings, the program will benefit others besides hospitalized patients—hopefully resulting in improved diabetes prevention and management among this expanded group of participants. 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.</p>
<p><b>In conjunction with Diamond Health continue to ensure that cardio-pulmonary rehab is an accessible resource to those in need or can most benefit</b></p>	<ol style="list-style-type: none"> <li>1. Conduct outreach and provide transportation to populations utilizing Home Health agencies or residing in nursing homes, etc.</li> <li>2. Actively promote the program to primary care physicians, who can refer directly to the program</li> </ol> <p><i>Anticipated Outcome:</i> Primary care physicians will refer directly to the program allowing their patients to receive care without the need for travel, thus leading to greater compliance to treatment regimens.</p>

<p><b>Provide education, diet, and medication management to attendees of Dr. Troxclair Clinic</b></p>	<p>1. Offer weekly outpatient consultations and treatment for high level disease processes by Dr. Troxclair</p> <p><i>Anticipated Outcome:</i> Ensure those with severe and multiple chronic diseases receive the education, diet and medication management support to mitigate poorer health outcomes that can occur as a result of these conditions.</p>
<p><b>Explore opportunities to expand mobile health care services offered to area employers</b></p>	<p>1. Develop the means to provide services in addition to onsite drug screenings and physicals for area businesses</p> <p>2. Employment care/Mobile Health Initiative is intended to provide onsite care to local businesses by reducing the requirement of employees of those businesses to travel and lose labor hours.</p> <p><i>Anticipated Outcome:</i> Preventative care will be provided to members of working population onsite at job location – need for travel and loss of labor hours will be decreased.</p>

**OBESITY PRIORITY STRATEGY**

Decrease obesity in the community by collaborating with community partners, nutrition experts, and others to provide the public with information and tips via different mediums (e.g. newsletters, social media) and settings (e.g. schools, community events, etc.) to encourage healthier eating and increased physical activity.

<p><b>St. Frances Cabrini</b></p>	
<p><b>Major Actions</b></p>	<p><b>Sub-actions</b></p>
<p><b>Collaborate with community partners to extend services and programs for healthy eating and physical activity</b></p>	<p>1. Establish partnerships with agencies and individuals in the community in order to coordinate, co-develop, or enhance programs and services to improve healthy lifestyles</p> <p>2. Explore opportunities to seek funding to create needed services and programs to improve healthy eating and physical activity</p> <p><i>Anticipated Outcome:</i> Programs and services developed will help lower rates of obesity.</p>
<p><b>Utilize community events to reach larger number of people when promoting healthy eating and physical activity</b></p>	<p>1. Have events in the community where the public can receive screenings and participate in various assessments and learn relevant information pertaining to their health</p> <p><i>Anticipated Outcome:</i> Public will learn about their current health state and participate in activities on how to live a healthy lifestyle.</p> <p>2. Provide healthy cooking simulations for the public at these events</p> <p><i>Anticipated Outcome:</i> People will learn how to prepare and cook healthy dishes.</p>

<p><b>Provide obesity prevention services and activities to school aged children through the School-Based Health Centers (SBHCs)</b></p>	<ol style="list-style-type: none"> <li>1. Continue to monitor BMI of children and provide counseling to help educate them how to achieve and maintain a healthy BMI</li> <li>2. Continue to encourage healthy eating and providing children with dieticians if needed</li> <li>3. If possible, explore reviving before-school obesity camps to promote healthy weights</li> </ol> <p><i>Anticipated Outcome:</i> BMI monitoring and the promotion of healthy eating and physical activity provides an opportunity for early diagnosis and/or prevention of obesity in youth participating in the SBHC.</p>
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CHRISTUS Coushatta	
Major Actions	Sub-actions
<p><b>Incorporate obesity prevention education and activities in all school-based programs</b></p>	<ol style="list-style-type: none"> <li>1. Provide obesity prevention education and activities at health fairs, KidMed visits, etc.</li> <li>2. Engage in collaborative discussions with local schools to provide obesity prevention education and activities in current school-based health agendas</li> </ol> <p><i>Anticipated Outcome:</i> School based health centers will address pediatric population obesity needs thus positively influencing lifestyle adjustments and reducing risk for acute and chronic complications of obesity.</p>
<p><b>Enhance H.E.A.L. Events offerings to address healthy eating and nutrition</b></p>	<ol style="list-style-type: none"> <li>1. Provide access to Dr. Troxclair and a dietician to answer questions and provide valuable lifestyle tips to improve current weight or prevent weight control issues</li> <li>2. Offer healthy food preparation simulations</li> <li>3. Utilize different venues for events to broaden reach in the community</li> </ol> <p><i>Anticipated Outcome:</i> At risk population will gain better understanding of possible complications and need for lifestyle adjustments. Support and access to skilled personnel will offer true opportunity for change and prevention of complications caused by obesity.</p>
<p><b>Provide nutrition services through the Dr. Troxclair Clinic</b></p>	<ol style="list-style-type: none"> <li>1. Offer individualized meal planning, in concordance with dietician assessment to clinic patients</li> </ol> <p><i>Anticipated Outcome:</i> Patients both hospitalized and on an outpatient basis will receive individualized mean plans and lifestyle changing tips that will lead to decrease of current or future risk of complications caused by obesity.</p>



LACK OF HEALTH LITERACY AND ACCOUNTABILITY PRIORITY STRATEGY

Improve lack of health literacy and accountability by educating patients, school-based health center users, and the general public about ways they can improve their health and access the services and resources needed to do this successfully (e.g. Medicaid enrollment, case management, nutrition planning, etc.).

St. Frances Cabrini	
Major Actions	Sub-actions
<b>Educate community about Medicaid Expansion</b>	<p>1. Partner with entities where people spend time (church, school, work) to disseminate health information and education</p> <p><i>Anticipated Outcome:</i> Increase patient understanding and commitment to health and wellness through one on one and group sessions that motivate and emphasize health disease management activities.</p>
<b>Continue to provide community clinic patients with individualized education for a variety of disease and prevention topics</b>	<p>1. Provide comprehensive, one-on-one education to patients at Incarnate Word Community Clinic (IWCC)</p> <p><i>Anticipated Outcome:</i> Patient will have one-on-one communication with provider and have opportunity to ask questions pertaining to their care, which may increase disease management adherence and mitigate poor health outcomes.</p>
	<p>2. Provide nutrition education to Coumadin Clinic patients</p> <p><i>Anticipated Outcome:</i> Coumadin patients will be better equipped to engage in a healthy lifestyle and proper diet, and may reduce their risk of chronic diseases associated with poor diet and exercise.</p>
<b>Identify patients that are more likely to make lifestyle changes to accommodate their healthcare needs</b>	<p>1. Case managers can use Patient Activation Measure (PAM) to assess whether patients are able to manage one’s own health</p> <p><i>Anticipated Outcome:</i> Case managers will know which patients can be educated about their health care needs and be able to manage themselves and those who are not capable and therefore need a different approach to education.</p>
<b>Continue to utilize the school-based health center model to educate students and their families on a variety of disease and prevention topics</b>	<p>1. Provide education to individual students</p> <p>2. Look into opportunities to conduct classroom education/prevention activities (can sometimes do these in PE classes or bring in guest speakers)</p> <p>3. Host health fairs at schools</p> <p><i>Anticipated Outcome:</i> Students and their families will learn about their current health and can participate in activities on how to live a healthy lifestyle, which may prevent future chronic diseases and mitigate poor health outcomes in this population.</p>

CHRISTUS Coushatta	
Major Actions	Sub-actions
<p><b>Offer medication information and adherence education through the Med to Bed Program</b></p>	<p>1. By establishing partnership with local pharmacy hospital will provide patients with medication information and filled prescriptions prior to discharge and in preparation for continued disease management at home</p> <p><i>Anticipated Outcome:</i> Offering medication information and adherence education through the Med to Bed program could improve medication adherence, resulting in increased odds of a fuller, quicker recovery post-release and reducing need for further hospitalization.</p>
<p><b>Develop an “Ask a Nurse, Pharmacist, Doctor” Q&amp;A series</b></p>	<p>1. Expand current model (with dental hygienist) to include nurses, pharmacists, and other clinicians. With this format, community members ask these professionals questions and receive answers in a series of newsletter articles or through social media posts</p> <p><i>Anticipated Outcome:</i> Broader population will gain ease of access to information provided by expert personnel without the need for a visit. Increased understanding of healthcare needs and risks will encourage population to seek appropriate preventative measures to maintain health.</p>

## **OTHER COMMUNITY NEEDS THAT CANNOT NOT BE ADDRESSED**

In an effort to maximize any resources available for the priority areas listed above, the CHNA Advisory Committees for both CHRISTUS St. Frances Cabrini Hospital and CHRISTUS Coushatta Health Care Center determined that the following issues would not be explicitly included in their community health improvement plan (CHIP):

- Mental health
- Economic Issues (e.g. homelessness, low educational attainment, joblessness)
- STIs
- Environmental health

Committed to focusing on key issues where they could serve as a leader and driver of change in the community, CHRISTUS Health Central Louisiana leadership determined that for the issues listed above there are others in the region already addressing these needs or have more specialized resources at their disposal. This is especially true for issues like environmental health and economic opportunity and development, the latter of which is an area of expertise for the Central Louisiana Economic Development Alliance (CLEDA).

Other issues, like the rates of STI, did not rise to top of the list of concerns when looking at all of the data available.