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INTRODUCTION
Introduction

The Community Health Needs Assessment (CHNA) is a systematic, data-driven approach to determine the health needs in the service area of the CHRISTUS St. Frances Cabrini Health System. In this process, they directly engage community members and stakeholders to identify the issues of greatest need as well as the largest impediments to health. With this information, CHRISTUS St. Frances Cabrini Health System can better allocate resources towards efforts to improve community health and wellness.

Directing resources toward the greatest needs in the community is critical to CHRISTUS St. Frances Cabrini Health System’s work as a nonprofit healthcare provider. The critical work of CHNAs was codified in the Patient Protection, and Affordable Care Act, added Section 501(r) to the Internal Revenue Service Code, which requires nonprofit hospitals, including CHRISTUS St. Frances Cabrini Health System, to conduct a CHNA every three years. CHRISTUS St. Frances Cabrini Health System completed similar needs assessments in 2012, 2015, and 2018.

The process CHRISTUS St. Frances Cabrini Health System used was designed to meet federal requirements and guidelines in Section 501(r), including:

- clearly defining the community served by the hospital, and ensuring that defined community does not exclude low-income, medically underserved, or minority populations in proximity to the hospital;
- providing a clear description of the CHNA process and methods; community health needs; collaboration, including with public health experts; and a description of existing facilities and resources in the community;
- receiving input from persons representing the broad needs of the community;
- documenting community comments on the CHNA and health needs in the community; and
- documenting the CHNA in a written report and making it widely available to the public.

When assessing the health needs for the entire CHRISTUS St. Frances Cabrini Health System's area, the CHNA data is presented by zip code and county depending on the available data. Providing localized data brings to light the differences and similarities within the communities in the CHRISTUS St. Frances Cabrini Health System's service area.

The following report provides an overview of the process and approach used for this Community Health Improvement Plan, including communities of focus, community health needs assessment process, health needs prioritization process, and the strategies to address the health priorities.

CHRISTUS St. Frances Cabrini Health System Overview

CHRISTUS St. Frances Cabrini Hospital

CHRISTUS St. Frances Cabrini Hospital is a non-profit hospital system serving Alexandria, Louisiana and surrounding parishes in Central Louisiana. CHRISTUS St. Frances Cabrini Hospital, located in Alexandria Louisiana, is a 293-bed facility employing approximately 1,600 Associates and a medical staff of over 325 physicians. It offers comprehensive inpatient and outpatient services and is accredited by the Joint Commission.
CHRISTUS Dubuis Hospital of Alexandria

CHRISTUS Dubuis Hospital of Alexandria, LA is a long-term acute care hospital (LTAC) located within CHRISTUS St. Frances Cabrini Hospital. It is owned and operated by a joint venture between LHC Group of Lafayette, LA and CHRISTUS Health. Currently, the hospital is licensed for 25 LTACH beds and has the pleasure of serving approximately 280 patients annually (most are adults). It also provides employment for approximately 75 persons.

CHRISTUS Savoy Medical Center

Savoy Medical Center, managed under Christus St Frances Cabrini Hospital, is a 501-C3 Non-Profit, 60-Bed Acute Care facility located approximately 50 miles south of Alexandria in the town of Mamou in Evangeline Parish. The facility includes 6 beds designated for Intensive Care, a 24-Hour Emergency Department, 22 Acute Care Beds, 5 Private Physical Rehabilitation Beds, 24 beds for Beyond the Horizons a 28-day Residential Substance Abuse Program, and 27 Psychiatric & Medical DETOX Beds at NEW HORIZONS located on the SMC Campus. Additional services include SAVOY Cancer Center providing Chemotherapy, Radiation, and other Outpatient Infusions, a full-service Outpatient Laboratory, Respiratory Department, Radiology Department including MRIs and 3D Mammography, and 5 Rural Health Clinics located within a 30-mile radius in Mamou, Ville Platte, Eunice, Basile, and Elton.

CHRISTUS Coushatta Health Care Center

Compromised of a hospital, dental clinic and multiple rural health clinics, CHRISTUS Coushatta Health Care Center provides a network of services and facilities that collaborate to provide the medical, surgical and wellness needs of the communities. Specialty services such as general surgery, podiatry, cardiology, ophthalmology, cancer care and obstetrics & gynecology as well as a full-service emergency room. CHRISTUS Coushatta Health Care Center has been committed to improving health and serving the community so we may fulfill our mission to extend our healing ministry of Jesus Christ.

CHRISTUS Health

CHRISTUS Health is a Catholic health system formed in 1999 to strengthen the faith-based health care ministries of the Congregations of the Sisters of the Incarnate Word of Houston and San Antonio that began in 1866. In 2016, the Sisters of the Holy Family of Nazareth became the third sponsoring congregation to CHRISTUS Health. Today, CHRISTUS Health operates 25 acute care hospitals and 92 clinics in Texas. CHRISTUS Health facilities are also located in Louisiana, Arkansas, and New Mexico. It also has 12 international hospitals in Colombia, Mexico and Chile. As part of CHRISTUS Health’s mission “to extend the healing ministry of Jesus Christ,” CHRISTUS St. Frances Cabrini Hospital strives to be, “a leader, a partner, and an advocate in the creation of innovative health and wellness solutions that improve the lives of individuals and communities so that all may experience God’s healing presence and love.”

Communities of Focus

Following IRS guidelines, 501(r) rules as required by the Affordable Care Act, CHRISTUS St. Frances Cabrini Health System’s CHNA primary service area includes 32 zip codes (Table 1). The primary service area (PSA) is the geographic region with 80% of hospital utilization. The primary service area zip codes are located in the following parishes:
Acadia, Allen, Avoyelles, Calcasieu, Catahoula, Concordia, Grant, LaSalle, Natchitoches, Rapides, St. Landry, Vernon and Winn. Figure 3 demonstrates the primary service area of CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Dubuis Hospital of Alexandria and CHRISTUS Savoy Medical Center and Figure 4 demonstrates the primary service area of CHRISTUS Coushatta Health Care Center

While the hospital is dedicated to providing exceptional care to all of the residents in the region, CHRISTUS St. Frances Cabrini Health System will use the information in this assessment to strategically establish priorities and commit resources to address the key health issues for the zip codes, parishes and municipalities that comprise the region.

<table>
<thead>
<tr>
<th>CHRISTUS ST. FRANCES CABRINI HEALTH SYSTEM PSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acadia Parish</td>
</tr>
<tr>
<td>70515</td>
</tr>
<tr>
<td>71303</td>
</tr>
<tr>
<td>71322</td>
</tr>
<tr>
<td>Catahoula Parish</td>
</tr>
<tr>
<td>71343</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>LaSalle Parish</td>
</tr>
<tr>
<td>71342</td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Vernon Parish</td>
</tr>
<tr>
<td>71403</td>
</tr>
<tr>
<td>71446</td>
</tr>
</tbody>
</table>

*Table 1. Primary Service Area of CHRISTUS St. Frances Cabrini Health System*
Figure 1. Map of CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Dubuis Hospital of Alexandria and CHRISTUS Savoy Medical Center PSA
Statement of Health Equity

While community health needs assessments (CHNA) and Improvement Plans are required by the IRS, CHRISTUS St. Frances Cabrini Health System has historically conducted CHNAs and developed Improvement Plans as a way to meaningfully engage with our communities and plan our Community Health & Social Impact work. Community Health & Social Impact promotes optimal health for those who are experiencing poverty or other vulnerabilities in the communities we serve by connecting social and clinical care, addressing social needs, dismantling systemic racism, and reducing health inequities. CHRISTUS Health has adopted the Robert Wood Johnson Foundation’s definition of Health Equity - “Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”
COMMUNITY HEALTH NEEDS ASSESSMENT
Community Health Needs Assessment

Stakeholder Engagement

The CHNA process involved engagement with several internal and external stakeholders to collect, curate and interpret primary and secondary data. That data was then used to prioritize the health needs of the community. For this component, CHRISTUS St. Frances Cabrini Health System worked with Metopio, a software and services company that is grounded in the philosophy that communities are connected through places and people. Metopio's tools and visualizations use data to reveal valuable, interconnected factors that influence outcomes in different locations.

Leaders from the CHRISTUS St. Frances Cabrini Health System guided the strategic direction of Metopio through roles on various committees and workgroups.

CHRISTUS St. Frances Cabrini Health System and Metopio relied on the expertise of community stakeholders throughout the CHNA process. The health system's partners and stakeholder groups provided insight and expertise around the indicators to be assessed, types of focus group questions to be asked, interpretation of results and prioritization of areas of highest need.

The Community Benefit Team is composed of key staff with expertise in areas necessary to capture and report CHRISTUS St. Frances Cabrini Health System community benefit activities. This group discusses and validates identified community benefit programs and activities. Additionally, the team monitors key CHNA policies, provides input on the CHNA implementation strategies and strategic implementation plan, reviews and approves grant funding requests, provides feedback on community engagement activities.

Input from community stakeholders was also gathered from CHRISTUS St. Frances Cabrini Health System’s community partners. These partners played a key role in providing input to the survey questions, identifying community organizations for focus groups, survey dissemination and ensuring diverse community voices were heard throughout the process.

The CHRISTUS St. Frances Cabrini Health System leadership team developed parameters for the 2023–2025 CHNA process that help drive the work. These parameters ensure that:

- the CHNA builds on the prior CHNA from 2020–2022 as well as other local assessments and plans;
- the CHNA will provide greater insight into community health needs and strategies for ongoing community health priorities;
- the CHNA leverages expertise of community residents and includes a broad range of sectors and voices that are disproportionately affected by health inequities;
- the CHNA provides an overview of community health status and highlights data related to health inequities;
- the CHNA informs strategies related to connections between community and clinical sectors, anchor institution efforts, policy change, and community partnerships; and
- health inequities and their underlying root causes are highlighted and discussed throughout the assessment.

Data Collection

CHRISTUS St. Frances Cabrini Health System conducted its CHNA process between September 2021 and March 2022 using an adapted process from the Mobilizing for Action through Planning and Partnerships (MAPP) framework. This planning framework is one of the most widely used for CHNAs. It focuses on community engagement, partnership development and seeking channels to engage people who have often not been part of decision-making processes. The
MAPP framework was developed in 2001 by the National Association for County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC).

Primary data for the CHNA was collected through four channels:

- Community resident surveys
- Community resident focus groups
- Health care and social service provider focus groups
- Key informant interviews

Secondary data for the CHNA were aggregated on Metopio’s data platform and included:

- Hospital utilization data
- Secondary sources including, but not limited to, the American Community Survey, the Decennial Census, the Centers for Disease Control, the Environmental Protection Agency, Housing and Urban Development and the Louisiana Department of Public Health.

Community Resident Surveys

Between October and December of 2021, 351 residents in the CHRISTUS St. Frances Cabrini PSA provided input to the CHNA process by completing a community resident survey. The survey was available online and in paper form in English and Spanish. Survey dissemination happened through multiple channels led by CHRISTUS St. Frances Cabrini Health System and its community partners. The survey sought input from priority populations in the CHRISTUS St. Frances Cabrini Health System PSA that are typically underrepresented in assessment processes, including communities of color, immigrants, persons with disabilities and low-income residents. The survey was designed to collect information regarding:

- Demographics of respondents
- Health needs of the community for different age groups
- Perception of community strengths
- Utilization and perception of local health services

The survey was based on a design used extensively for CHNAs and by public health agencies across the country. The final survey included 26 questions.

Community Focus Groups and Key Informant Interviews

A critical part of robust, primary data collection for the CHNA involved speaking directly to community members, partners and leaders that live in and/or work in the CHRISTUS St. Frances Cabrini Health System PSA. This was done through focus groups and key informant interviews.

During this CHNA, CHRISTUS St. Frances Cabrini Health System held two local focus groups in CHRISTUS St. Frances Cabrini Health System, one covering Adult Health and the other Maternal and Child Health, and joined two systemwide focus groups. All focus groups were coordinated by CHRISTUS St. Frances Cabrini and the CHRISTUS Health system office and facilitated by Metopio. CHRISTUS St. Frances Cabrini Health System sought to ensure groups included a broad range of individuals from underrepresented, priority populations in the CHRISTUS St. Frances Cabrini Health System. Focus group health topic areas are listed below:
• Adult health
• Maternal and child health
• Health care and social service providers
• Behavioral health

Secondary Data

CHRISTUS St. Frances Cabrini Health System used a common set of health indicators to understand the prevalence of morbidity and mortality in the CHRISTUS St. Frances Cabrini Health System PSA and compare them to benchmark regions at the state and the full CHRISTUS Health service area. Building on previous CHNA work, these measures have been adapted from the County Health Rankings MAPP Framework (Figure 3). Where possible, CHRISTUS St. Frances Cabrini Health System used data with stratifications so that health inequities could be explored and better articulated. Given the community input on economic conditions and community safety, CHRISTUS St. Frances Cabrini Health System sought more granular datasets to illustrate hardship.

![Figure 3. Illustration of the County Health Rankings MAPP Framework](image)

Health Issue Prioritization Process

The Community Benefit team worked with the hospital leadership and community partners to prioritize the health issues of community benefit programming for fiscal years 2023–2025. These groups of internal and external stakeholders were selected for their knowledge and expertise of community needs. Using a prioritization framework guided by the MAPP framework, the process included a multi-pronged approach to determine health issue prioritization.

1. The team reviewed health issue data selected by the community survey respondents.
2. The team scored the most severe indicators by considering existing programs and resources.
3. The team assigned scores to the health issue based on the Prioritization Framework (Table 2). The highest-scoring health issues were reconciled with previous cycles’ selected priorities for a final determination of priority health issues.
4. The team discussed the rankings and community conditions that led to the health issues.

<table>
<thead>
<tr>
<th>SIZE</th>
<th>How many people are affected?</th>
<th>Secondary Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERIOUSNESS</td>
<td>Deaths, hospitalizations, disability</td>
<td>Secondary Data</td>
</tr>
<tr>
<td>EQUITY</td>
<td>Are some groups affected more?</td>
<td>Secondary Data</td>
</tr>
<tr>
<td>TRENDS</td>
<td>Is it getting better or worse?</td>
<td>Secondary Data</td>
</tr>
<tr>
<td>INTERVENTION</td>
<td>Is there a proven strategy?</td>
<td>Mission team</td>
</tr>
<tr>
<td>INFLUENCE</td>
<td>How much can CSETX affect change?</td>
<td>Mission team</td>
</tr>
<tr>
<td>VALUES</td>
<td>Does the community care about it?</td>
<td>Survey, Focus Groups, Key Informant Interviews</td>
</tr>
<tr>
<td>ROOT CAUSES</td>
<td>What are the community conditions?</td>
<td>Mission team</td>
</tr>
</tbody>
</table>

*Table 2. Prioritization Framework*

**Data Needs and Limitations**

CHRISTUS St. Frances Cabrini Health System and Metopio made substantial efforts to comprehensively collect, review and analyze primary and secondary data. However, there are limitations to consider when reviewing CHNA findings.

- Population health and demographic data are often delayed in their release, so data are presented for the most recent years available for any given data source.
- Variability in the geographic level at which data sets are available (ranging from census tract to statewide or national geographies) presents an issue, particularly when comparing similar indicators and collected at disparate geographic levels. Whenever possible, the most relevant localized data are reported.
- Due to variations in geographic boundaries, population sizes and data collection techniques for suburban and city communities, some datasets are not available for the same time spans or at the same level of localization throughout the parish.
- Gaps and limitations persist in data systems for certain community health issues such as mental health and substance use disorders (youth and adults), crime reporting, environmental health, and education outcomes. Additionally, these data are often collected and reported from a deficit-based framework that focuses on needs and problems in a community, rather than assets and strengths. A deficit-based framework contributes to systemic bias that presents a limited view on a community’s potential.

With this in mind, CHRISTUS St. Frances Cabrini Health System, Metopio and all stakeholders were deliberate in discussing these limitations throughout the development of the CHNA and selection of the 2023-2025 health priority areas.
HEALTH PRIORITY AREAS
Health Priority Areas

For this cycle, CHRISTUS St. Frances Cabrini and CHRISTUS Coushatta Health Care Center are using a new structure for the identified needs, categorizing them under two domains with the overarching goal of achieving health equity. While the prioritization structure is new, CHRISTUS St. Frances Cabrini and CHRISTUS Coushatta Health Care retained mental health as a priority issue from the previous CHNA. In this cycle, CHRISTUS St. Frances Cabrini and CHRISTUS Coushatta Health Care unpacked “chronic illness” and specifically call out diabetes, heart disease and obesity. Newly identified issues include substance abuse, food access, reducing smoking and vaping and childhood well-being.

CHRISTUS St. Frances Cabrini Health System Priority Areas

Based on community input and analysis of a myriad of data, the health needs of the communities served by CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Dubuis Hospital of Alexandria, and CHRISTUS Savoy Medical Center for Fiscal Years 2023-2025 fall into two domains underneath an overarching goal of achieving health equity. The two domains and corresponding health needs are:

Advance Health and Wellbeing

1. Specialty Care and Chronic Illness
   - Diabetes
   - Obesity
   - Heart Disease
2. Behavioral Health
   - Mental Health
   - Substance Abuse
3. Pediatric Access
4. Early Education

Build Resilient Communities and Improve Social Determinants

1. Improving Food Access
2. Reducing Smoking and Vaping

Achieve Health Equity

---

Figure 4. CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Dubuis Hospital of Alexandria and CHRISTUS Savoy Medical Center Priority Areas

2023-2025
CHRISTUS St. Frances Cabrini Health System acknowledges the wide range of priority health issues that emerged from the CHNA process and determined that it could effectively focus on only those health needs which are the most pressing, under-addressed and within its ability to influence. CHRISTUS St. Frances Cabrini Health System does not intend to address the following health needs at this time:

- Early Education
- Reducing Smoking and Vaping

This implementation plan specifies community health needs that the hospital, in collaboration with community partners, has determined to address. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During these three years, other organizations in the community may decide to address certain needs, indicating that the hospital then should refocus its limited resources to best serve the community.
CHRISTUS Coushatta Health Care Center

Based on community input and analysis of a myriad of data, the priorities for the communities served by CHRISTUS Coushatta Health Care Center for Fiscal Years 2023-2025 fall into two domains underneath an overarching goal of achieving health equity. The two domains and corresponding health needs are:

Advance Health and Wellbeing

1. Specialty Care and Chronic Illness
   - Diabetes
   - Obesity
   - Heart Disease
2. Behavioral Health
   - Mental Health
   - Substance Abuse
3. Children’s Health

Build Resilient Communities and Improve Social Determinants

1. Improving Food Access
2. Reducing Smoking and Vaping

Figure 5. CHRISTUS Savoy Medical Center Priority Areas

CHRISTUS Coushatta Health Care Center acknowledges the wide range of priority health issues that emerged from the CHNA process and determined that it could effectively focus on only those health needs which are the most pressing, under-addressed and within its ability to influence. CHRISTUS Coushatta Health Care Center does not intend to address the following health needs at this time:

- Behavioral Health
- Children’s Health
- Improving Food Access

This implementation plan specifies community health needs that the hospital, in collaboration with community partners, has determined to address. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During these three years, other organizations in the community may decide to address certain needs, indicating that the hospital then should refocus its limited resources to best serve the community.
Approach to Community Health Improvement Plan

All community benefit investments and programming are built on a framework that promotes health equity and is framed by the community benefit overarching goal: to enhance community health and wellness around CHNA priority health needs in the service area. To achieve this goal, CHRISTUS Health designs its interventions and programs through the following channels:

1. Care Delivery Innovations
2. Community Based Outreach
3. Grant Making
4. Medical Education
5. Partnerships
6. Public Policy

Outlined below are the specific strategies and initiatives corresponding to each of the selected health priority areas. See the appendices for a fully detailed evaluation framework relating to these strategies.

Community Benefit Report Communication

CHRISTUS St. Frances Cabrini Health System, CHRISTUS Dubuis Hospital of Alexandria and CHRISTUS Savoy Medical Center will make their CHNA and strategic improvement plan publicly available online via the CHRISTUS Health website once it is approved and adopted by the Board of Directors in 2022. In addition, CHRISTUS St. Frances Cabrini Health System, CHRISTUS Dubuis Hospital of Alexandria and CHRISTUS Savoy Medical Center will share the Community Health Improvement Plan (CHIP) to its advisors and partners (e.g., community members, local political representatives, faith leaders, healthcare providers, and community-based organizations), and make copies available upon request.

Throughout the 2023 – 2025 Improvement Strategy cycle, CHRISTUS Health will continue to monitor the evolving needs of our community, emerging resources made available through other organizations, and changing circumstances (such as COVID-19). While committed to providing the necessary people and financial resources to successfully implement the initiatives outlined above, CHRISTUS Health reserves the right to amend this improvement plan as circumstances warrant to best serve our community and allocate limited resources most effectively.
### Health Priority Area 1: Advance Health & Wellbeing

Addressing widespread chronic disease among adults is important to residents of all ages in the service area, as living with comorbidities is associated with poorer quality of life and lower life expectancy. It also contributes to financial instability and poor mental health. The first step to preventing chronic disease begins with establishing healthy behaviors. However, there are many impediments to living a healthy lifestyle.

#### ADVANCE HEALTH AND WELLBEING

<table>
<thead>
<tr>
<th>SPECIALTY CARE AND CHRONIC ILLNESS</th>
<th>SPECIALTY CARE AND CHRONIC ILLNESS</th>
<th>SPECIALTY CARE AND CHRONIC ILLNESS</th>
<th>SPECIALTY CARE AND CHRONIC ILLNESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide screening and education for heart disease, diabetes, and obesity</td>
<td>Empower community members to manage heart disease, diabetes, and obesity</td>
<td>Increase access to care</td>
<td>Reduce inequities caused by cultural barriers to care</td>
</tr>
<tr>
<td>• Expand free/subsidized screenings that include education components</td>
<td>• CSFCHS Sponsored Health Fairs with a Holistic Approach to better health including healthy eating, healthy lifestyle changes, and managing health</td>
<td>• Assist patients with healthcare navigation</td>
<td>• Train healthcare staff in cultural competency, shared decision-making and plain language</td>
</tr>
<tr>
<td>• Continue community education initiatives focused on chronic disease prevention</td>
<td></td>
<td>• Encourage patients to establish care with a primary care physician</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicaid list</td>
<td></td>
</tr>
</tbody>
</table>

#### BEHAVIORAL HEALTH

<table>
<thead>
<tr>
<th>PROVIDE EArLY IDENTIFICATION, RESOURCES, AND FOLLOW-UP CARE TO MENTAL HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide mental health risk screenings and referrals in School Based Health Centers (SBHCs)</td>
</tr>
<tr>
<td>Provide screenings and treatment for depression</td>
</tr>
<tr>
<td>All students enrolled in schools with School Based Health Centers (SBHCs) will have access to pediatric care, services and referrals needed.</td>
</tr>
<tr>
<td>All students enrolled in schools with School Based Health Centers (SBHCs) will have a signed consent to be seen in the SBHC.</td>
</tr>
<tr>
<td>All students having consent will be scheduled and seen in the SBHC (i.e. mental health screenings, chronic care, medical screenings, etc.)</td>
</tr>
</tbody>
</table>
CHRISTUS Health will continue to invest in care delivery innovations and expand programs that address prevention for heart disease, obesity and diabetes and improve access to care. Key programs that support these initiatives can be found in the appendices.
Health Priority Area 2: Build Resilient Communities & Improve Social Determinants

Many communities in the service area face structural barriers to healthy behaviors, including a lack of healthy food options and easy access to tobacco and vaping products. Several social determinants exist in the community, adding daily pressure to residents seeking a healthy life.

### BUILD RESILIENT COMMUNITIES & IMPROVE SOCIAL DETERMINANTS

<table>
<thead>
<tr>
<th>IMPROVE FOOD ACCESS</th>
<th>IMPROVE FOOD ACCESS</th>
<th>IMPROVE FOOD ACCESS</th>
<th>REDUCE SMOKING AND VAPING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultivate and maintain partnerships to improve access to healthy food in food deserts</td>
<td>Provide nutrition education for patients</td>
<td>Provide resources</td>
<td>Increase awareness of smoking and vaping effects</td>
</tr>
<tr>
<td>• Working with Local Organizations such as the Food Bank and Louisiana Central to ensure greater access to Healthy Choices Foods, through events such as CSFCH sponsored Health Fairs</td>
<td>• Through Diabetes Care &amp; Education, CHRISTUS Trinity Clinics and IWCC, patients will receive nutrition and healthy cooking education to improve social determinants.</td>
<td>• Promotion of Food Prescription, SNAP, Home Food Delivery and Community Garden (SBHCs) programs to patients throughout the CSFCHS PSA.</td>
<td>• Provide education</td>
</tr>
</tbody>
</table>

CHRISTUS Health will continue to invest in care delivery innovations and expand programs that address the social determinants of health. Key programs that support these initiatives can be found in the appendices.
## Appendix 1: CHRISTUS St. Frances Cabrini Hospital

**Specialty Care and Chronic Illness**

### Diabetes

**Goal:**

1. Improve prevention and management of diabetes and related health concerns in the community by increasing health/disease education offerings and provide chronic disease prevention, referral, and management services in a wide variety of settings, such as health fairs, hospital diabetes care and education and other departments, school-based health centers and community clinics.

2. Improve the quality of life of people with diabetes, people who are at risk of developing diabetes, and their families in our community through expansion of diabetes services, improved access to an endocrinologist, and improved social support.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Anticipated Impact</th>
<th>Programs, Services, Partnerships, Resources</th>
<th>Hospital’s Role</th>
<th>Timeframe</th>
<th>Community of Focus</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. School Based Health Center (SBHC) staff will conduct/coordinate health information presentations and screenings for school staff, students and families</td>
<td>Increase health literacy and community screening opportunities through partnerships and education</td>
<td>CTCLC nursing students, SBHC staff, Community health fair service providers</td>
<td>Leader and Collaborator</td>
<td>Begin: School Year 2022-2023</td>
<td>Students, parents, and staff of schools with a CHRISTUS SBHC site.</td>
<td>- Number of participants screened for diabetes/pre-diabetes</td>
</tr>
<tr>
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<tr>
<td>Resource materials such as informational brochures/fliers to school staff, parents, and students enrolled in centers</td>
<td>2a. Students enrolled in the SBHC will be screened for risk of diabetes/prediabetes and body mass index (BMI) will be assessed and recorded.</td>
<td>CHRISTUS Health Advocacy Office CSFCHS Leadership CHRISTUS Health HEDI office</td>
<td>Leader And Collaborator</td>
<td>Begin: School year 2022–23 End: School year 2024–25</td>
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<td></td>
<td>2b. A1C screenings will be completed on all students identified at risk and BMI will be recorded.</td>
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<td></td>
<td>Students enrolled in CHRISTUS CLA SBHC.</td>
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<td></td>
<td>2c. Any student identified with an abnormal or abnormal BMI will be educated on nutrition and physical activity and scheduled for a follow-up visit with SBHC.</td>
<td></td>
<td></td>
<td>• Number of students received BMI / A1C screenings.</td>
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<td></td>
<td>2d. Students showing no improvement will be referred to their PCP or dietician for a definitive diagnosis and treatment planning.</td>
<td>2a. Increase opportunities for wellness screenings to identify risk for diabetes/prediabetes.</td>
<td>2b. Decrease the number of students with abnormal A1C and abnormal BMI scores.</td>
<td>• Percentage of students seen in health center screened:</td>
<td>• Number of students whose A1C score and/or BMI showed improvement within 3 months.</td>
<td>• Percentage of students whose A1C score and/or BMI showed improvement within 3 months:</td>
</tr>
<tr>
<td>3a. Community Clinic patients will be screened for Diabetes per Hemoglobin A1C</td>
<td>Identify and treat those patients who have diabetes.</td>
<td>Community Clinic staff &amp; providers American Diabetes Association</td>
<td>Leader</td>
<td>Begin: FY23 Quarter 2 End: FY25 Quarter 4</td>
<td>Patients seen at Community Clinics in primary care between the ages of 18–75 years old with a diabetes documented history or active diagnosis of diabetes during the measurement period or year prior to the measurement period.</td>
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<tr>
<td>3b. Community clinic patients found to have abnormal Hemoglobin A1C will be educated on nutrition and physical activity</td>
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<tr>
<td>3c. Community clinic patients seen in Urgent Care that are found to have abnormal Hemoglobin A1c will be treated and referred to a Primary Care Provider.</td>
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<td>3d. Healthy Living Education with resources from the AMA</td>
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<tr>
<td>3e. Dr Zapatero provides a Primary clinic on Fridays treating Spanish speaking patients. This clinic treats but is not limited to Hypertensive and Diabetic patients.</td>
<td>3e. Increase compliance and disease management of patients with language barriers</td>
<td>3e. Spanish speaking physician Dr Zapatero. Education materials printed in Spanish.</td>
<td>Collaborator</td>
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<td></td>
<td>Spanish speaking patients with poorly controlled Diabetes</td>
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</tbody>
</table>

- Number of Hemoglobin A1c screenings done in primary care
- Percentage of patients who have Hemoglobin A1c equal to or below 9
- 3e. Number of patients seen by Dr. Zapatero.
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<tbody>
<tr>
<td>4a. Expand services at the Healthy Learning Center to reach a greater number of people, including the Hispanic and African American populations through marketing and referrals.</td>
<td>To promote education among our SBHCs, diabetes and heart patients, and the community at large at Health Fairs. To break down barriers to food access and healthier food choices for better health outcomes.</td>
<td>Local food banks, Louisiana Central, CSFCH Clinics, CHRISTUS Trinity Clinics, CSFCH Staff, SBHCs</td>
<td>Leader, Collaborator and Supporter (Depending on what is needed to promote any said program.)</td>
<td>Begin: Calendar Year 2023&lt;br&gt;End: Calendar Year 2025</td>
</tr>
</tbody>
</table>

- Number of HEAL participants - (Group participants) - (Individual participants)
- Number of Hispanic participants
- Number of African American participants
- Number of people screened and/or educated at health fair events
- Number of kids aged 5–12 enrolled in Project Power
- % Increase in total number of participants
- % Increase in Hispanic participants
- % Increase in African Americans participants
- % Increase in number of people screened and/or educated at health fair events
- % Increase in number of kids aged 5–12 enrolled in Project Power
- Number of participants who completed the HEAL program
- Number of Hispanic participants who completed the HEAL program
- Number of African American participants who completed the HEAL program
- Number of people who report better health or increased knowledge because of screenings

*See description under priority # Obesity.*
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<td></td>
<td></td>
<td></td>
<td>and/or education at health fair events</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>• Number kids aged 5-12 who complete Project Power</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>• % Of HEAL participants whose hemoglobin A1c lowered compared to initial hemoglobin A1c levels</td>
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<td></td>
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<td></td>
<td>• % Of Hispanic HEAL participants whose hemoglobin A1c lowered compared to initial hemoglobin A1c levels</td>
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<td></td>
<td></td>
<td></td>
<td>• % Of African American HEAL participants whose hemoglobin A1c lowered compared to initial hemoglobin A1c levels</td>
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<td></td>
<td></td>
<td></td>
<td>• % Of increase in people who report better health or increased knowledge because of screenings and/or education at health fair events</td>
</tr>
</tbody>
</table>
## Heart Disease

### Goal:

1. Improve prevention and management of diabetes and related health concerns in the community by increasing health/disease education offerings and provide chronic disease prevention, referral, and management services in a wide variety of settings, such as health fairs, hospital diabetes care and education and other departments, school-based health centers and community clinics.

2. Improve the quality of life of people with diabetes, people who are at risk of developing diabetes, and their families in our community through expansion of diabetes services, improved access to an endocrinologist, and improved social support.

### Strategy Table

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<th>Programs, Services, Partnerships, Resources</th>
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<tbody>
<tr>
<td>What actions or activities will we do to help to improve the conditions?</td>
<td>What are the expected outcomes of the population?</td>
<td>Who are the partners who have a role to play in doing better?</td>
<td>What is our role?</td>
<td>When do you expect this activity to begin/end?</td>
<td>Who are our customers/the population?</td>
<td>How much? How well? Is anyone better off?</td>
</tr>
<tr>
<td>1a. SBHC staff will conduct/coordinate health information presentations and screenings for school staff, students and families.</td>
<td>Increase health literacy through partnerships and education.</td>
<td>CTCLC- nursing students, SBHC staff, Community Health Fair service providers</td>
<td>Leader and Collaborator</td>
<td>Begin: School year 2022-23</td>
<td>Students, parents, and staff of schools with a CHRISTUS CLA SBHC site.</td>
<td>- Number of participants screened for hypertension - Percentage of school population screened: - Number of participants referred for follow-up to PCP.</td>
</tr>
<tr>
<td>1b. SBHC staff will disseminate educational and resource materials</td>
<td></td>
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<td>End: School year 2024-25</td>
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<tr>
<td>such as informational brochures/ flyers to school staff, parents, and students enrolled in centers.</td>
<td>2a. Students enrolled in the SBHC will be screened for risk of heart disease.</td>
<td>PCPs SBHC medical staff Local dieticians</td>
<td>Leader and Collaborator</td>
<td>Begin: School year 2022–23 End: School year 2024–25</td>
<td>Students enrolled in CHRISTUS CLA SBHC.</td>
<td></td>
</tr>
<tr>
<td>2b. Hypertension screenings will be completed on all students at risk and blood pressure (BP) will be recorded.</td>
<td>2c. BMI screenings will be completed on all students and recorded.</td>
<td>2d. Any student identified with an elevated BP or obesity will be educated on nutrition and physical activity and scheduled for a follow-up visit with SBHC.</td>
<td>2e. Students showing no improvement will be referred to their PCP or dietician for a definitive diagnosis and treatment planning.</td>
<td>- Number of students received BMI / Hypertension screenings - Percentage of student population screened - Number of students whose BP and/or BMI showed improvement within 3 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Clinic patients will be screened for Hypertension.</td>
<td>Identify and treat those patients who are hypertensive. Blood pressure maintained &lt;140/90</td>
<td>Community Clinic staff and providers American Heart Association</td>
<td>Leader and Collaborator</td>
<td>Begin: FY 2023 Quarter 1 End: FY 25 Quarter 4</td>
<td>Community Clinic Patients 18 – 85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (&lt;140/90 mmHg) during the most recent encounter of the measurement period.</td>
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<tr>
<td>Community Clinic patients found to have Hypertension will be treated and educated on Hypertension.</td>
<td>3f. Reduce inequities caused by cultural barriers to care</td>
<td>3f. CHRISTUS Health HEDI System Office, CSFCHS Leadership</td>
<td>Leader</td>
<td>3f. Patients who face inequities caused by cultural barriers and the CSFCHS staff who care for them.</td>
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</tr>
<tr>
<td>Community Clinic patients seen in Urgent Care that are found to be Hypertensive will be treated and referred to a Primary Care Provider.</td>
<td>3g. Increase compliance and disease management of patients with language barriers.</td>
<td>3g. Spanish speaking physician Dr Zapatero. Education</td>
<td>Collaborator</td>
<td>Spanish speaking patients with poorly controlled Hypertension.</td>
<td></td>
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</tr>
<tr>
<td>Healthy Living Education with resources from the AMA</td>
<td>3d. Resources to support healthy living?</td>
<td></td>
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</tr>
<tr>
<td>Train healthcare staff in cultural competency, shared decision-making and plain language</td>
<td>Dr Zapatero provides a Primary clinic on Fridays treating Spanish speaking patients. This clinic treats but</td>
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</tbody>
</table>

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<p>| Number of patients screened in Primary care for hypertension |
| Average Percentage of patients who have a BP &lt;140/90 |
| Percentage baseline currently is 66% Target &gt;78 |
| 3f. Number of Trained Staff |
| 3g. Number of patients seen by Dr. Zapatero. |</p>
<table>
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<tr>
<td>is not limited to Hypertensive and Diabetic patients.</td>
<td>materials printed in Spanish.</td>
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</table>
**Goal:**

1. Improve prevention and management of diabetes and related health concerns in the community by increasing health/disease education offerings and provide chronic disease prevention, referral, and management services in a wide variety of settings, such as health fairs, hospital diabetes care and education and other departments, school-based health centers and community clinics.

2. Improve the quality of life of people with diabetes, people who are at risk of developing diabetes, and their families in our community through expansion of diabetes services, improved access to an endocrinologist, and improved social support.

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<th>Metrics</th>
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<tr>
<td>What actions or activities will we do to help to improve the conditions/</td>
<td>What are the expected outcomes of the population?</td>
<td>Who are the partners who have a role to play in doing better?</td>
<td>What is our role?</td>
<td>When do you expect this activity to begin/end?</td>
<td>Who are our customers/the population?</td>
<td>How much? How well? Is anyone better off?</td>
</tr>
</tbody>
</table>
| 1a. BMI screenings will be completed on all students being seen in the health centers. | 1a. Increase opportunities for wellness screenings to identify risk for chronic disease. | PCPs SBHC medical staff Local dietitians | Leader and Collaborator                  | Begin: School year 2022-23 | Students enrolled in CHRISTUS CLA SBHC. | • Number of students who received BMI screenings  
• Percentage of student population screened  
• Number of students whose BMI showed improvement within 3 months  
• Percentage of students whose BMI showed |
| 1. | Educated on nutrition and physical activity and scheduled for a follow-up visit with SBHC.  
1c. Students showing no improvement within 3 months will be referred to their PCP or dietician for a nutritional consultation and treatment planning. | School year 2024–25 | Improvement within 3 months |
| --- | --- | --- | --- |
| 1b. Decrease % of students with abnormal BMI.  
1c. Improve follow up procedures for elevated BMIs.  
1d. Improve referral documentation and process. | | | |

2. Project Power Community Partner:  
Project Power Youth is an obesity prevention program that tackles childhood obesity and helps reduce its consequences.  
Prevent childhood obesity and pre-diabetes  
Promotion of making healthy food choices, increased physical activity, and building family and peer support  
ADA  
Leader  
Collaborator Supporter  
Begin: School year 2022–2023  
End: School Year 2024–2025  
Elementary/Middle School Districts in Acadia, Allen, Avoyelles, Calcasieu, Catahoula, Concordia, Grant, LaSalle, Natchitoches, Rapides, St. Landry, Vernon, and Winn Parishes  
- Number of kids aged 5–12 enrolled in Project Power  
- % Increase in number of kids aged 5–12 enrolled in Project Power  
- Number of kids aged 5–12 who complete Project Power  
- % Of increase of kids aged 5–12 who complete Project Power |

3. Promotion of and increased access to Medical Nutrition Therapy (MNT) and PCPs  
People will have access to registered dietitians to address nutritional needs  
PCPs  
Leader  
Collaborator  
Begin: FY 2023  
SCHC patients and patients of  
- Number of people referred to outpatient dietitian services |
<table>
<thead>
<tr>
<th>Healthy Eating Active Living classes for obesity with Registered dietitians by encouraging referrals from primary providers.</th>
<th>challenges related to pathophysiology and weight loss</th>
<th>Specialty HCPs (healthcare providers) Registered Dietitians</th>
<th>End: FY2025</th>
<th>local Region 6 HCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. BMI screenings for all Christus Community Clinic Patients. Patients with a BMI &gt;30 educated on diet and exercise program. Referred as needed to dietician, surgeon for bariatric surgery, Rapides Foundation for exercise program.</td>
<td>1a. Increase opportunities for wellness screenings to identify risk for chronic disease. 1b. Decrease % of people with abnormal BMI. 1c. Improve referral documentation and process.</td>
<td>PCPs Specialty HCPs (healthcare providers) Registered Dietitians Rapides Foundation Surgeon</td>
<td>Leader Collaborator Begin: FY 2023 End: FY2025</td>
<td>All CCC patients.</td>
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<td>• % Increase in Number of people referred to outpatient services compared to previous years • Number of people who participate in outpatient MNT with Registered Dietitians • % Increase in number of people who participated in MNT compared to previous years • Percentage of patients whose BMI &lt; 30 • Number of patients Whose BMI &lt;30</td>
</tr>
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## Behavioral Health

### Goal:
1. Provide early identification, treatment at the least restrictive level of care possible, resources, and supportive follow-up care of those individuals who suffer from anxiety and/or depression.

<table>
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<tr>
<td>What actions or activities will we do to help to improve the conditions?</td>
<td>What are the expected outcomes of the population?</td>
<td>Who are the partners who have a role to play in doing better?</td>
<td>What is our role? Leader Collaborator Supporter</td>
<td>When do you expect this activity to begin/end?</td>
<td>Who are our customers/the population?</td>
<td>How much? How well? Is anyone better off?</td>
</tr>
<tr>
<td>All students enrolled in School Based Health Centers (SBHCs) will have access to risk screenings conducted by SBHC staff</td>
<td>Increase the number of students that receive screenings to identify risks for depression and anxiety.</td>
<td>SBHCs Mental Health Staff Medical Staff Primary Care Providers (PCPs) Outpatient and inpatient resources</td>
<td>Leader and Collaborator</td>
<td>Begin: School Year 2022-2023</td>
<td>Students enrolled in CHRISTUS SFCHS SBHCs</td>
<td>• Number of students completing a risk screening • Number of students referred for psychosocial assessment • Number of students referred for follow-up with an off-site provider • Number of students who received mental health services in the SBHCs</td>
</tr>
</tbody>
</table>
| All students identified at-risk will be referred to mental health staff for a psychosocial assessment or follow-up with an off-site provider | Increase the number of students identified at-risk, will have access to follow-up care | SBHCs, Mental Health Staff, Medical Staff, Primary Care Providers (PCPs), Outpatient and inpatient resources | Leader and Collaborator | Begin: School Year 2022-2023 | End: School Year 2024-2025 | Students enrolled in CHRISTUS SFCHS SBHCs | - Number of students completing a risk screening  
- Number of students referred for psychosocial assessment  
- Number of students referred for follow-up with an off-site provider  
- Number of students who received mental health services in the SBHCs |
| All CHRISTUS Community Clinic patients are screened for depression on every visit with a PHQ9 questionnaire | To identify depressed patients at risk of suicide | Nurses and practitioners | Leader and collaborator | Begin: Calendar Year 2023 | End: Calendar Year 2025 | CHRISTUS Community Clinic patients with depression who are at risk of suicide | - Number of patients screened  
- Number of patients who scored a 10 or above |
| Patients identified at risk for severe depression and/or suicide are screened by a provider and treated | To provide treatment to depressed patients at risk of suicide | Nurses and practitioners | Leader and collaborator | Begin: Calendar Year 2023 | End: Calendar Year 2025 | CHRISTUS Community Clinic patients with depression who are at risk of suicide | - Number of patients screened  
- Number of patients who scored a 10 or above  
- Number of patients treated |
### Pediatric Access

#### Goal:

1. All students enrolled in schools with School Based Health Centers (SBHCs) will have access to pediatric care, services and referrals needed.

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<tr>
<td>What actions or activities will we do to help to improve the conditions?</td>
<td>What are the expected outcomes of the population?</td>
<td>Who are the partners who have a role to play in doing better?</td>
<td>What is our role? Leader Collaborator Supporter</td>
<td>When do you expect this activity to begin/end?</td>
<td>Who are our customers/the population?</td>
<td>How much? How well? Is anyone better off?</td>
</tr>
<tr>
<td>All students enrolled in schools with School Based Health Centers (SBHCs) will have a signed consent to be seen in the SBHC.</td>
<td>Increase the number of students receiving services at the SBHC</td>
<td>SBHC staff</td>
<td>School administrators</td>
<td>Begin: School Year 2022-2023 End: School Year 2024-2025</td>
<td>Students enrolled in schools with a CHRISTUS SFCHS SBHC</td>
<td>- Number of students enrolled in the SBHC - Number of students who received pediatric services in the SBHC</td>
</tr>
<tr>
<td>All students having consent will be scheduled and seen in the SBHC (i.e. mental health screenings, chronic care, medical screenings, etc.)</td>
<td>Increase the number of students receiving services at the SBHC</td>
<td>SBHC staff</td>
<td>School administrators</td>
<td>Begin: School Year 2022-2023 End: School Year 2024-2025</td>
<td>Students enrolled in schools with a CHRISTUS SFCHS SBHC</td>
<td>- Number of students enrolled in the SBHC - Number of students who received pediatric services in the SBHC</td>
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## Food Access

### Goal:

1. Work with partnerships in collaboration, education and support of programs that assist in healthier food access, particularly for neighborhoods and communities facing difficulties in food access.

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</thead>
</table>
| Participate in bi-annual health fairs with a holistic approach to better health outcomes, including health eating and food access | What are the expected outcomes of the population?                                | CSFCHS associates, Aramark, CMAP           | Leader, Collaborator, Supporter | Begin: Calendar Year 2023 | CHRISTUS St. Frances Cabrini PSA                     | • Number of health fair participants  
• Number of individuals helped through food access resources and healthy living education  
• Percentage of participants who found the health fairs useful  
• Percentage of participants who report greater access to healthy food options |
| Commitment to advocacy on the state and local levels concerning legislation that impacts food access within the CSFCHS PSA | To impact our region on a legislative level, supporting laws and programs that break down barriers to food access and expand healthy food choices for the community. | CHRISTUS Health Advocacy Office CSFCHS Leadership CHRISTUS Health HEDI Office | Collaborator and Supporter | Begin: Calendar Year 2023 End: Calendar Year 2025 | CHRISTUS St. Frances Cabrini PSA |

- Based on what Legislation needs support, the time needed to support state and local level initiatives
- Active support of CSFCHS leadership of said legislation
- Number of communities impacted by positive change brought on by the supported legislation
- Percentage of communities reporting greater access to healthy foods and less food insecurity

| Promote food prescription, home delivery, community gardens, and SNAP programs | To break down barriers to food access and healthier food choices for better health outcomes | Food bank Louisiana Central CSFCH Clinics CHRISTUS Trinity Clinics CSFCH Staff School Based Health Centers (SBHCs) | Leader, Collaborator, Supporter | Begin: Calendar Year 2023 End: Calendar Year 2025 | Students and families that participate in SBHCs Diabetes patients Heart disease patients Visitors of CSFCH health fairs |

- Number of participants in the education and promotion of these programs
- Number of individuals who were helped by these programs
- Percentage of participants who report greater access to food and healthier food choices

2023-2025
# Appendix 2: CHRISTUS Dubuis Hospital of Alexandria

## Specialty Care and Chronic Illness

**Goal:**

1. Improve outcomes associated with chronic illnesses.
2. Improve access to care for chronic illnesses.
3. Improve access to more affordable medication options.

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<tr>
<td>What actions or activities will we do to help to improve the conditions/expected outcomes of the population?</td>
<td>What are the expected outcomes of the population?</td>
<td>Who are the partners who have a role to play in doing better?</td>
<td>What is our role? Leader Collaborator Supporter</td>
<td>When do you expect this activity to begin/end?</td>
<td>Who are our customers/the population?</td>
<td>How much? How well? Is anyone better off?</td>
</tr>
<tr>
<td>Maximize opportunities to provide disease management and prevention through education and arranging follow-up care</td>
<td>Reduce poor outcomes associated with chronic conditions</td>
<td>Post-acute providers Local home health care agencies Community Clinics Support groups such as CHF clinics</td>
<td>Leader</td>
<td>Begin: Calendar Year 2023 End: Calendar Year 2025</td>
<td>71346, 71341, 71350, 71322, 71417, 71343, 71342, 71423, 71405, 71433, 71467, 71463, 71457, 71328, 71409, 71446, 71351, 71019, 71302, 71303, 71301, 71360</td>
<td>• Review of readmission rates • Post discharge telephone calls</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>Introduction</td>
<td>CHNA</td>
<td>Health Priority Areas</td>
<td>Strategies</td>
<td></td>
<td></td>
</tr>
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</tr>
</tbody>
</table>
| Develop a list of agencies and organizations that may be able to provide services | Introducing patients to the resource list to improve opportunities for the patients to access appropriate levels of care | Local hospitals | Leader | \(\text{Begin: Calendar Year 2023} \)  
\(\text{End: Calendar Year 2025} \) | 71346, 71341, 71350, 71322, 71417, 71343, 71342, 71423, 71405, 71433, 71467, 71463, 71457, 71328, 71409, 71446, 71351, 71019, 71302, 71303, 71301, 71360 |
| Research and provide options to patients for more affordable medications | To obtain medications to control chronic conditions and improve health by controlling chronic conditions | Community Health Workers | Leader | \(\text{Begin: Calendar Year 2023} \)  
\(\text{End: Calendar Year 2025} \) | Patients with no health insurance  
Indigent patients  
71346, 71341, 71350, 71322, 71417, 71343, 71342, 71423, 71405, 71433, 71467, 71463, 71457, 71328, 71409, 71446, 71351, 71019, 71302, 71303, 71301, 71360 |

- Completed list of referrals  
- Number of patients who received the resource list  
- Percentage of patients who found the resource list useful  
- List of options for affordable medication  
- Number of patients who received the medication list  
- Percentage of patients who found the medication list useful
# Appendix 3: CHRISTUS Savoy Medical Center

## Specialty Care and Chronic Illness

### Goal:

1. Prevent and manage risk factors that worsen morbidity and mortality rates related to obesity.
2. Implement a diabetes prevention program, including conducting community education and outreach, screenings, and increasing access to resources.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Anticipated Impact</th>
<th>Programs, Services, Partnerships, Resources</th>
<th>Hospital's Role</th>
<th>Timeframe</th>
<th>Community of Focus</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>What actions or activities will we do to help to improve the conditions?</td>
<td>What are the expected outcomes of the population?</td>
<td>Who are the partners who have a role to play in doing better?</td>
<td>What is our role? Leader Collaborator Supporter</td>
<td>When do you expect this activity to begin/end?</td>
<td>Who are our customers/the population?</td>
<td>How much? How well? Is anyone better off?</td>
</tr>
<tr>
<td>Offer nutritional counseling by the hospitals education/nutrition directors</td>
<td>Provide screening and education opportunities to decrease obesity rates</td>
<td>Mamou Health Resources Savoy Medical Center education departments</td>
<td>Leader</td>
<td>Begin: Fiscal Year 2023 End: Fiscal Year 2024</td>
<td>CHRISTUS St. Frances Cabrini PSA</td>
<td>• Number of participants attending our events • % of those attending who received education • Number of participants identified as needing additional help • % of participants receiving additional help</td>
</tr>
</tbody>
</table>
| Offer free/subsidized screenings | Community members will have increased access to health screening and educational tools, with access to clinical care when necessary | Mamou Health Resources | Savoy Medical Center education departments | Leader | Begin: Fiscal Year 2023 | End: Fiscal Year 2024 | CHRISTUS St. Frances Cabrini PSA | • Number of participants attending our screenings  
• % of participants receiving screenings and education  
• Number of participants requiring follow-up  
• % of participants receiving follow-up |
| Implement community education and outreach activities promoting diabetes education | Through community education outreach, we will increase awareness about diabetes management, with the goal of elevating the health of those in the community we serve. | Savoy Medical Center Dietary | Savoy Medical Center Education Department | Leader | Begin: Fiscal Year 2023 | End: Fiscal Year 2024 | CHRISTUS St. Frances Cabrini PSA | • Number of participants attending our events  
• % of participants attending our events  
• Request review and evaluations after our activities  
• Results of evaluations of our activities |
| Increase access to education, screenings, and testing for those suffering with pre-diabetes and diabetes | Increased awareness about chronic disease management and prevention with the goal of elevating the health in the community. We anticipate seeing a reduction of diabetes complications. | Savoy Medical Center Dietary | Savoy Medical Center Education Department | Leader | Begin: Fiscal Year 2023 | End: Fiscal Year 2024 | CHRISTUS St. Frances Cabrini PSA | • Number of participants attending our screening and testing events  
• Number of screenings and tests performed  
• Review the participation and future demand of services  
• Measure requests for additional access to the information provided |
### Behavioral Health

**Goal:**
1. Provide increased and carried access to healthcare opportunities that are tailored to the needs of the community served by Savoy Medical Center.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Anticipated Impact</th>
<th>Programs, Services, Partnerships, Resources</th>
<th>Hospital’s Role</th>
<th>Timeframe</th>
<th>Community of Focus</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>What actions or activities will we do to help to improve the conditions?</td>
<td>What are the expected outcomes of the population?</td>
<td>Who are the partners who have a role to play in doing better?</td>
<td>What is our role? Leader Collaborator Supporter</td>
<td>When do you expect this activity to begin/end?</td>
<td>Who are our customers/the population?</td>
<td>How much? How well? Is anyone better off?</td>
</tr>
<tr>
<td>Provide behavioral health services for adults in the surrounding parishes</td>
<td>Increasing services and addressing barriers will promote better physical and mental health outcomes for the community</td>
<td>Law enforcement agencies Local churches Savoy Medical center</td>
<td>Leader</td>
<td>Begin: Fiscal Year 2023 End: Fiscal Year 2024</td>
<td>PSA</td>
<td>- Number of patients requesting/seeking our services - Number of patients who received our services - Percentage of patients receiving our services - Percentage of patients who completed treatment</td>
</tr>
<tr>
<td>Provide substance abuse education to area school children</td>
<td>Improving the efficiency, effectiveness, and access to an ever-widening range of care options to the community that SMC services</td>
<td>Local schools Savoy Medical Center</td>
<td>Leader</td>
<td>Begin: Fiscal Year 2023 End: Fiscal Year 2024</td>
<td>PSA</td>
<td>- Number of students attending our events - Number of events provided - Percentage of students attending our events</td>
</tr>
</tbody>
</table>
Appendix 4: CHRISTUS Coushatta Health Care Center

Specialty Care and Chronic Illness

**Goal:**

1. To collaborate with community health providers and dieticians to promote diabetes awareness, increase access to diabetes screenings, increase access to diabetes self-management education/support, and increase healthy-lifestyle education and resources.

2. To increase the availability and amount of diabetics receiving annual food exams.

3. Improve prevention and management of heart disease in the community by increasing heart disease education at local health fairs, hospital departments, school telehealth visits, and rural health clinics.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Anticipated Impact</th>
<th>Programs, Services, Partnerships, Resources</th>
<th>Hospital’s Role</th>
<th>Timeframe</th>
<th>Community of Focus</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>What actions or activities will we do to help to improve the conditions/</td>
<td>What are the expected outcomes of the population?</td>
<td>Who are the partners who have a role to play in doing better?</td>
<td>What is our role? Leader, Collaborator, Supporter</td>
<td>When do you expect this activity to begin/end?</td>
<td>Who are our customers/the population?</td>
<td>How much? How well? Is anyone better off?</td>
</tr>
<tr>
<td>Increase the number and availability of diabetes screenings</td>
<td>By increasing the number and availability of diabetes screenings, we hope to raise awareness of the growing epidemic of diabetes and promote diabetes self-management</td>
<td>Local churches Community Clinics Community Centers</td>
<td>Collaborator</td>
<td>Begin: Calendar Year 2023 End: Calendar Year 2025</td>
<td>PSA</td>
<td>• Number of participants attending health fairs • Number of participants educated or utilizing testing during health fairs • Percentage of participants that received education or testing</td>
</tr>
</tbody>
</table>
| To improve prevention and management of heart disease by: | Podiatrist/RHC | Leader | Begin: Calendar Year 2023 | End: Calendar Year 2025 | PSA | • Number of patients receiving annual diabetc foot exams  
• Increased percentage of patients receiving diabetic food exams  
• Number of patients receiving hypertension screenings  
• Number of patients receiving BMI screenings  
• Number of patients receiving heart disease education |
|----------------------------------------------------------|----------------|--------|---------------------------|-------------------------|-----|--------------------------------------------------------------------------------------------------------|
| - increasing education  
- obtaining and recording blood pressures at each visit  
- completing BMI screenings | To improve prevention and management of heart disease | Clinic and hospital staff  
American Heart Association (AHA) | Leader | Begin: Calendar Year 2023 | End: Calendar Year 2025 | PSA |--------------------------------------------------------------------------------------------------------|
| Provide discharge food boxes that are diet appropriate for patients upon discharge. | Podiatrist/RHC | Leader | Begin: Calendar Year 2023 | End: Calendar Year 2025 | PSA |--------------------------------------------------------------------------------------------------------|
## Reducing Smoking and Vaping

**Goal:**

1. To reduce smoking and vaping by providing education to patients and community.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Objectives / Anticipated Impact</th>
<th>Programs, Services, Partnerships, Resources</th>
<th>Hospital’s Role</th>
<th>Timeframe</th>
<th>Community of Focus</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>What actions or activities will we do to help to improve the conditions?</td>
<td>What is the objective/goal of the activity? What are the expected outcomes of the population?</td>
<td>Who are the partners who have a role to play in doing better?</td>
<td>What is our role? Leader Collaborator Supporter</td>
<td>When do you expect this activity to begin/end?</td>
<td>Who are our customers/the population?</td>
<td>How much? How well? Is anyone better off?</td>
</tr>
<tr>
<td>Provide education to patients who smoke/vape through our clinics and school telehealth program</td>
<td>Increasing awareness and smoking and vaping in efforts to reduce smoking and vaping in patients.</td>
<td>Providers and staff</td>
<td>Leader</td>
<td>Begin: Calendar Year 2023  End: Calendar Year 2025</td>
<td>PSA</td>
<td>• Number of patients receiving education on smoking and vaping</td>
</tr>
</tbody>
</table>