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About the Louisiana Public Health Institute:

Founded in 1997, Louisiana Public Health Institute (LPHI) is a 501(c)(3) nonprofit organization that serves as a partner and convener to improve population-level health outcomes. LPHI’s mission is to improve health and quality of life for all. This is achieved through the coordination and management of public health programs and initiatives in the areas of health information, public policy, applied research, and community capacity enhancement. Through these initiatives, LPHI provides an array of services to meet the needs of local, regional, and national partners and to develop community-oriented solutions that improve community health and well-being.
CHRISTUS Dubuis Hospital of Alexandria, LA is a long term acute care hospital located within CHRISTUS St. Frances Cabrini Hospital. CHRISTUS Dubuis Hospital of Alexandria is part of CHRISTUS Dubuis Health System, a non-profit long term acute care hospital (LTACH) system sponsored by CHRISTUS Health to provide care to patients who require acute care over an extended period of time. CHRISTUS Health was 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, CHRISTUS Health System Office contracted with the Louisiana Public Health Institute (LPHI) and the Texas Health Institute (THI) to develop a uniform, comprehensive CHNA process for its facilities in Texas and Louisiana.

LPHI was responsible for conducting the community health needs assessment (CHNA) and community health improvement plan (CHIP) reports for CHRISTUS Dubuis Hospital of Alexandria. This report serves as the CHRISTUS Dubuis Hospital of Alexandria CHNA report for 2017-2019, and meets the requirements set forth by the IRS in Notice 2011-52, 990 Requirements for non-profit hospitals’ CHNA.

The CHNA report contains secondary data from existing sources, such as the American Community Survey (ACS), Behavior Risk Factor Surveillance Survey (BRFSS), Louisiana Tumor Registry, and data from the Louisiana Department of Health and Hospitals, among others. This report also includes input from key informants in the region, particularly those with special knowledge of public health, the health of the communities served by the hospital, and/or vulnerable populations in the communities served by the hospital. This input was gathered through individual interviews, a focus group discussion, and meetings comprised of hospital leaders, staff, and community partners. As a result, four community health needs were identified as top priorities. These priorities were selected based off of issue prevalence and severity according to parish and regional secondary data in addition to the stakeholder input provided. The top needs identified through the process are as follows:

1. **Chronic Conditions**

   The CDC cites chronic diseases and conditions, such as heart disease, stroke, cancer, type 2 diabetes, obesity, and arthritis, as some of the most common, costly, and preventable of all health problems affecting the American public.\(^1\) According to the data, deaths in the Central LA region due to diseases of the heart are considerably higher than the state, with 280 deaths per 100,000 population versus 220. Additionally, diabetes Prevention Quality Indicators (PQIs) for long-term complications and uncontrolled diabetes are higher in this region compared to the state. Overall incidence and mortality rates for lung cancer are much higher in this region as well. Ultimately, staff at CHRISTUS Dubuis Hospital of Alexandria chose this issue as their #1 priority area because chronic conditions greatly impact the majority of their patients, either in terms of diagnosis-related group or

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2. **Access to care**

Access to health care, especially among the uninsured, was a common concern in the Central Louisiana region. Interview and focus group participants identified many barriers to accessing primary care including cost of services/lack of insurance, cost of medication, transportation, education on where to go, lack of awareness of available resources, insufficient amount of services, lack of providers that accept Medicaid, long wait times, and concentration of services in only certain areas. The panel at CHRISTUS Dubuis Hospital of Alexandria agreed that access to care is a great need in the community to access medical care. This is especially true for patients the hospital is able to accept for care, as proper insurance is essential to admission to CHRISTUS Dubuis Hospital of Alexandria.

3. **Cost of Medications**

Ensuring that patients who need life-saving or disease management medications are able to obtain them is complimentary to many of the issues already identified when tackling chronic conditions and access to care. Keeping the cost of medications affordable is key to this effort. Staff at Dubuis Hospital of Alexandria noted that many of their patients must be able to afford the medications they need to better manage their conditions and improve their health outcomes.

4. **Health Education/ Health Literacy**

Health education is an additional component that can be useful in addressing chronic conditions, or at least preventing them in the first place. Leaders and staff at CHRISTUS Dubuis Hospital of Alexandria felt that providing patient and prevention education is an important means to directly impact patients by giving them the tools and knowledge to improve the quality of their lives.

The CHNA report presents data for a number of needs for the Central Louisiana region, as well as additional information specific to the above prioritized community health needs. This report will be used by CHRISTUS Dubuis Hospital of Alexandria as a resource to developing implementation strategies to improve community health over the next three years.
Introduction

CHRISTUS Dubuis Hospital of Alexandria, LA is a long term acute care hospital located within CHRISTUS St. Frances Cabrini Hospital. Opened in December 1993, CHRISTUS Dubuis currently has total of 33 long-term acute care beds to provide care to medically complex patients—patients who require extended acute care hospitalization with specialty programs focusing on ventilator dependency, wound care, and rehabilitation. As part of the larger CHRISTUS Health system, CHRISTUS Dubuis Hospital of Alexandria is one of several facilities striving to serve as “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.”\(^2\) As part of this effort and to meet federal IRS 990H requirements, CHRISTUS Health contracted with the Louisiana Public Health Institute (LPHI) to conduct the community health needs assessment (CHNA) and community health improvement plan (CHIP) reports for several CHRISTUS Dubuis hospitals, of which the Dubuis facility in Alexandria is one.

This document serves as the CHRISTUS Dubuis Hospital of Alexandria CHNA report for 2017-2019, and will be made publically available on the CHRISTUS Health website for future reference. The purpose of the CHNA is to identify needs, assets, and opportunities to answer the following research questions:

1. What constitutes the community/communities which CHRISTUS Dubuis Hospital of Alexandria serve(s)?
2. What are the community’s attributes (i.e., demographics, health status, etc.)?
3. What are the community’s health needs?
4. What are the community’s assets and opportunities?
5. What action can CHRISTUS Dubuis Hospital of Alexandria feasibly take to meet identified health needs?

These questions were answered using a mixed-methods approach (described in further detail below), and the report presented here describes the methods used for data collection and a summation of findings based on hospital data, publically available secondary data, key informant interviews and focus group discussions.\(^3\) This summation was further discussed and analyzed by a panel of experts comprised of both CHRISTUS staff and external partners representing various community organizations, and with guidance from LPHI. The panel met on May 19, 2016 to prioritize and select needs, and began to chart the next steps for their community health implementation plan (CHIP). The CHIP is provided in a separate document.

Methodology

The mixed-methods approach conducted for this report was based off methodology used by LPHI when contracted in 2012 to complete the CHNA report for CHRISTUS Health Shreveport-Bossier. Originally informed by assessment materials developed by national organizations such as the Association for Community Health Improvement (ACHI), the Catholic Health Association (CHA), and the National

\(^2\) [http://www.christusadvocacy.org/](http://www.christusadvocacy.org/)

\(^3\) All statements and opinions herein were expressed by key informants and focus group respondents and do not necessarily represent the opinions or viewpoints of LPHI or its contractors.
CHRISTUS Dubuis Hospital of Alexandria 2017-2019 CHNA

Association of County and City Health Officials (NACCHO), this approach was further refined through discussions with Texas Health Institute (THI) and the CHRISTUS Health corporate office. Representatives from the CHRISTUS Health corporate office were especially interested in formulating a process for CHNA report development that could serve as a template to all hospitals within its southeastern footprint in the U.S., including but not limited to its facilities in Louisiana, New Mexico, and Texas. As a result, both LPHI and THI agreed to conduct a combination of key informant interviews, focus groups, and other validation meetings to provide CHRISTUS Health with critical input from various community representatives to assist each CHRISTUS facility with determining what priorities will be addressed over the next three years. This feedback was used to supplement the quantitative data provided by each hospital and available from secondary sources, such as the American Community Survey (ACS) and the State of Louisiana Department of Health and Hospitals. A full list of data sources referenced in this report is listed in Appendix A.

Each step of the CHNA process essential to this methodology is explained in detail below.

**Quantitative Indicators**
LPHI and THI worked with CHRISTUS Health to adapt a list of potential indicators for analysis based off of prior CHNA reports completed by both public health institutes and a list of recommended indicators provided by the Catholic Health Association. In most cases, indicators were chosen based on availability. For topics in which secondary data was not readily available, these topics were representatively addressed in the qualitative instruments developed by LPHI.

The geographic region of focus was determined in collaboration with the CHRISTUS Health System Office. Given that CHRISTUS Dubuis Hospital of Alexandria, LA serves patients from the same parishes included in the CHRISTUS Health Central Louisiana region, it made the most sense to define the community assessed in this report by the population residing in the following parishes.

<table>
<thead>
<tr>
<th>CHRISTUS Health Central Louisiana Parishes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoyelles</td>
</tr>
<tr>
<td>Bienville</td>
</tr>
<tr>
<td>Grant</td>
</tr>
</tbody>
</table>

Existing data for this five-parish footprint was compiled from local and national sources by an experienced biostatistics epidemiologist. Data was compiled and analyzed using SPSS. A full list of indicators provided in this report can be viewed in the list of Figures on page 3. As previously mentioned, all data sources referenced in this report are listed in Appendix A. For benchmarking, data at the zip code level were compared to parish level and state level data, where applicable. This data is presented in the Findings section starting on page 11.

**Key Informant Interview Protocol**
The key informant semi-structured interview guide was designed to illicit responses about both the direct and indirect factors that influence the health of community members. Major areas of focus of the guide included: community health and wellness, behavioral risk factors, health care utilization, and access to care. Additional probes and follow up questions were designed to ensure the participant provided detailed responses, including opportunities to share information on assets in the community.
that could be tapped for future implementation planning. The guide was reviewed and approved by CHRISTUS Health Central Louisiana representatives in January 2016.

Per IRS regulations (Section 3.06 of Notice 2011-52), each facility must get input from people who fall into each of these three categories:

“(1) Persons with special knowledge of or expertise in public health;
(2) Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility; and
(3) Leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility.

Treasury and the IRS expect that certain persons may fall into more than one of the categories listed above in paragraphs (1) through (3). For example, taking into account input from certain government officials with special knowledge of or expertise in public health may allow a hospital organization to satisfy the requirements described in both paragraphs (1) and (2).”

In order to satisfy these requirements, the Community Benefit Director and/ or Hospital Administrator from each CHRISTUS facility, with input from CHRISTUS Health System Office, provided LPHI with a list of potential key informants, many of whom met one or more of these requirements and were able to speak to the geographic region served by CHRISTUS Dubuis Hospital of Alexandria, LA. A matrix detailing key informant affiliation in compliance with these requirements can be viewed in Appendix B.

Key informants were contacted by phone or email to initiate the scheduling of the interview. The interviewer provided a brief introduction to the project and explained the purpose of the interview, including how the data will be used and the time commitment to complete the interview. All key informants were ensured that no names would be associated with responses in any way and that all results would be reported in aggregate. If the key informant agreed to participate, phone interviews were scheduled depending on interviewer and respondent availability.

At the beginning of the scheduled interview, consent was obtained to record the phone call. All interviews were recorded using an audio recorder. Recording did not begin until all instructions were provided and agreed upon. The interviewer assigned a study number to the participant and no identifiers were captured on the recording. Participants were only asked about their names, job titles, and affiliation with CHRISTUS to determine if they met one of the three IRS requirements listed above.

On average, most Interviews took around 45 minutes. Detailed notes comprised of quotes, key themes, and the interviewer’s general comments regarding each interview were typed up and synthesized into a larger master notes document for each facility or hospital region. For CHRISTUS Dubuis Hospital of Alexandria, LA, a total of 4 interviews were conducted.

**Focus Group Protocol**
Focus groups were also selected as an additional mechanism to obtain community input. Like the key informant interview guide, the focus group guide was also designed to encourage participants to think about the behavioral, environmental, and social factors that influence a person’s health status within the geographic area of focus. Questions inquiring about existing community assets and ways CHRISTUS
could partner with others, to address some of the factors discussed, were included in the guide. The guide was reviewed and approved by CHRISTUS Health representatives in January, 2016.

As part of the protocol, one of LPHI’s qualitative experts provided all community benefit directors with a one hour virtual focus group facilitation training. All directors were responsible for conducting a 90-minute focus group with participants, who were recruited to represent CHRISTUS patients and/or other community stakeholders with knowledge and awareness of health issues impacting the region. Individuals who participated in a key informant interview were not recruited for these groups.

All focus groups were audio recorded to accurately capture responses. Additionally, at least one note taker was assigned to take notes in person and, within the notes, each participant was assigned and referred to by a corresponding number to provide anonymity. Staff from LPHI also listened in via phone or Skype to observe conversation and take their own notes. The notes taken onsite and the audio recording were then provided to LPHI, who combined all notes for a given facility within one master document.

The focus group for CHRISTUS Dubuis Hospital of Alexandria occurred on March 9, 2016. Information provided during this session is incorporated into the findings shared in the following pages.
Findings
The quantitative data and qualitative data were analyzed independently and then cross-walked together to identify areas of agreement and areas of disconnect. Notes from both the interviews and focus groups were carefully read through to identify major themes, which are summarized below. For the purposes of this report, “participant” refers to key informant interview participants and focus group participants, unless specified.

Demographics and Socio-Economic Measures
The geographic area for CHRISTUS Dubuis Hospital of Alexandria, LA includes the following 5 parishes in Louisiana: Avoyelles, Bienville, Grant, Rapides and Red River. The total population of these parishes is 219,169, comprising 71% of the total population for Louisiana Department of Health and Hospitals (LA-DHH) Administrative Region 6 from the US Census American Community Survey 2013. This region is the most rural of the three regions in Louisiana analyzed for CHRISTUS Health, with a population density of only 44 people per square mile compared to the overall density of 106 in the state. In comparison, more urban regions, such as LA-DHH Region 1, have a population density of 528 people per square mile.

Age distributions in this area are similar to the state with about 25% under 18 years of age, 60% between 18 and 64 years, and 15% over 65 years (Figure 1). Race and ethnicity shows a larger Caucasian population and lower African American, Asian, and Hispanic/Latino populations compared to the state (Figure 2).

Figure 1: Population age distributions (ACS 2013)

All demographic indicators were compiled from the ACS 5 Year average file (2009-2013) in order to include all parishes with small populations (Only the 5 year file includes all parishes regardless of population). This was the most recent file available from the Census at the time of this analysis.
When looking at the data for educational status, the population in the central region of the state is less educated compared to the state, with a higher percentage of people with less than a high school education (24% vs. 21%), and a lower percentage with college or graduate degrees (15% vs. 22%) (Figure 3). This is significant given that research provided by the National Bureau of Economic Research have found an inverse relationship between additional levels of education and a decrease in five-year mortality, as well as a decreased risk of morbidity for certain diseases, such as heart disease and diabetes.⁵

If one examines three measures of socio-economic status side-by-side (Figure 4), Central Louisiana is quite similar overall to the state, with the largest gaps in poor education.

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Unemployment and a lack of jobs were mentioned by several interview participants. Participants specified that rural areas especially suffer from a lack of jobs, but that jobs even in non-rural areas tend to be minimum wage and not provide benefits. They also explained that many people do not have the skills to advance to better jobs. The closure of some large employers and corporations, including Huey P. Long Medical Center, was also mentioned. Homelessness and a lack of appropriate housing were also issues brought up in interviews and focus groups. At least one participant believed homelessness was on the rise. Participants also discussed how many seniors are caring for their grandchildren.

Figure 4: Three measures of poor socio-economic status (ACS 2013)

Access to Healthcare
Access to healthcare is an indisputable determinant of health. In 1993, The Institute of Medicine defined access as the “timely use of personal health services to achieve the best health outcomes.” Healthy People 2020 adds to this definition to state that “access to comprehensive quality health care services is important to the achievement of health equity,” and asserts that access encompasses not only health insurance coverage, but availability and quality of services, timeliness, and sufficient numbers of health care providers within the workforce.

Central Louisiana has a similar percentage of the population who are uninsured compared to the state, 17.5% vs. 17.1% (Figure 5). The largest group, private insurance, is lower in Central Louisiana by 8%, however the percentage for ‘other’ types of insurance is higher by 7% compared to the state. Other includes military insurance, such as TRICARE.

According to the participants, lack of insurance and financial resources are some of the most common barriers to accessing care. Participants discussed how many uninsured individuals go without care

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because they cannot afford it. Affordability of medication was also a large barrier. One focus group participant elaborated, “too many take the chance of going without insurance even if they are working because they don’t want to spend limited resources on health insurance.” One participant also talked about seniors falling into the Medicare gap.

![Figure 5: Types of healthcare insurance (ACS 2013)](image)

The parishes within the CHRISTUS Dubuis Hospital of Alexandria region in Central Louisiana have fewer primary care physicians per capita compared to the state (5.5 vs. 6.4), but consistent with the higher percentage of these parishes in this LA-DHH Administrative Region designated as Health Provider Shortage Areas (HPSA) for physicians (Figures 6 & 7). In addition, both dental and mental health providers are in shorter supply in these parishes compared to the state.

The closure of Huey P. Long Medical Center was mentioned by several participants. One participant explained, “the closure of Huey P. Long Hospital has taken a toll. Now people have to go two or three places to get the services they used to get in one place.” Another participant elaborated, “Huey P. Long was a safety net so the general public was not aware of all the problems until it closed.” Several participants suggested that the other local hospitals have tried to “make up the difference,” but gaps still remain, especially for the uninsured and underinsured.
Participants also discussed a lack of primary care providers and mental health facilities and providers. One participant mentioned challenges recruiting medical professionals to the area. There were conflicting reports of Central State Hospital among participants—some reported that Central State had closed, while others stated that the future of mental health services is uncertain and the number of in-patient and out-patient mental health beds are limited.
**Health Outcomes**

**Physical health**

The rate of mortality for the top 5 causes of death in Louisiana are higher in parishes throughout the Central Louisiana region, except for accidents (Figure 8). Deaths due to diseases of the heart are considerably higher than the state, with 280 deaths per 100,000 population versus 220.

Likewise, in the interviews and focus group, cancer, heart conditions, and asthma were reported as being large health issues.

![Figure 8: Top 5 cause of mortality (Louisiana Department of Health and Hospitals, Vital Statistics 2013)](image)

The death rate due to suicide in this region is much higher than the state, with 15 deaths per 100,000 population versus 12. The rate of homicide is lower. In the interviews, one respondent specifically referred to a high suicide rate among teenagers, and focus group participants knew of suicides in their communities.
Prevention Quality Indicators (PQIs) are hospital admission rates for conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. The Agency for Healthcare Research and Quality (AHRQ) promote the use of PQIs as a “screening tool” to help identify unmet community health care needs such as access to, and quality of, outpatient care. PQIs do not include all hospital admissions but only those referred to as “ambulatory care sensitive conditions.”

A selection of PQI measures are shown for the 5-parish Central Louisiana region and the state in Figure 10. The greatest differences show the Central Louisiana region has much higher admissions for chronic obstructive pulmonary disease (COPD), congestive heart failure, bacterial pneumonia and urinary tract infection compared to the entire state. This indicates a need for improved primary care for these conditions.

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Figure 10: Prevention Quality Indicators observed rates (Louisiana Department of Health and Hospitals, Hospital Inpatient Discharge Data - LAHIDD 2012)

NOTE: These rates include all hospitals serving Region 6.

Diabetes PQIs for long-term complications and uncontrolled diabetes are higher in this region compared to the state (Figure 11). These findings suggest a need to focus on improving monitoring and managing diabetes in this population. One focus group participant believed that individuals’ challenges controlling their diabetes in particular is tied into low levels of health literacy. Another participant explained how diabetes is seen by many as being an inevitable health condition; “too many kids just accept that if their grandmother had diabetes and their mother has diabetes that I am going to have diabetes and there is nothing I can do. [They think] it’s just a part of life.”

Figure 11: Diabetes Prevention Quality Indicators observed rates (Louisiana Department of Health and Hospitals, Hospital Inpatient Discharge Data - LAHIDD 2012)
The Louisiana Tumor Registry collects information from the entire state on the incidence of cancer. The top four cancers commonly reported include: lung, breast, colorectal, and prostate cancer. Figures 12 and 13 look at reported incidence and mortality rates over a combined five-year period (2008 – 2012) for lung cancer and prostate cancer, respectively. For the 5-parish Central Louisiana region, the greatest difference from the state is for lung cancer incidence and mortality rates among Caucasians in particular (Figure 12). Overall incidence rates for lung cancer are much higher than the state (81 vs. 73 per 100,000 population), and mortality is also higher, at 62 vs. 58 per 100,000 population. This gap applies to Caucasians but not African Americans which show similar rates to the state.

Breast cancer rates are lower in this region than in the state for both races (not shown), colorectal cancers are very slightly elevated in Central Louisiana (not shown), and the incidence rate for prostate cancer is slightly lower except for African American males, whose incidence rate is much higher than African American men for the entire state (Figure 13).
Mental health

The Louisiana Office of Behavioral Health reports mental health diagnosis rates by parish in Louisiana for ten categories: Figure 14 shows the distributions for substance and alcohol dependence and abuse for LA-DHH Administrative Region 6, which corresponds with the 5-parish region considered for this report. In this region, the population suffers from higher substance and alcohol dependence rates with rates more than double those for the entire state (459 vs. 196 and 152 vs. 67, respectively). These findings may be related to the higher suicide rate shown in Figure 9 (above).

Participants identified substance abuse as being a large concern. They stated that crystal meth is an issue, and that many individuals in rural areas are making it in their homes. Participants also mentioned heroin being on the rise because of tighter restrictions on prescription opiates, and the high use of crack among low-income individuals and cocaine among upper-income individuals. One participant described, “it’s really whatever the drug of choice is coming down the interstate.” Participants also identified jails as being full of drug problems and “not getting to the root [of the problem],” and emphasized a need for addiction resources.

![Figure 14: Substance dependence and abuse rates (Louisiana Office of Behavioral Health 2013-2014)](image)

The U.S. Centers for Disease Control and Prevention (CDC) carries out a Behavioral Risk Factor Surveillance Survey (BRFSS) annually in every state. It is a phone-based survey which covers the adult population only, and is carefully weighted based on a rigid sampling procedure incorporating both landlines and cell phones. Among its many goals is to assess health risk behaviors in the population, such as exercise frequency, alcohol consumption, and use of preventative services, such as cancer screenings. BRFSS is the second largest survey done in the U.S. (after the American Community Survey), and as such measures can be reported at the county/ parish level.

Findings on serious mental illness from the 2014 LA BRFSS show a higher percentage of adults reporting both major depression and serious mental illness in the 5-parish Central Louisiana region (Figure 15).
Again, these findings are consistent with those previously reported, indicating mental health may be a critical area of focus in this region.

Participants described a number of mental health issues and concerns including: bipolar disorder, attention deficit hyperactivity disorder (ADHD), suicide, growing rates of depression (specifically among the elderly), individuals not seeking care or not being able to access services, and parents not being able to help their children when depression and suicidal thoughts surface. One participant reported a high concentration of post-traumatic stress disorder, especially because of the high number of military members and veterans in the area. Several participants believed that mental health is stigmatized—“it is a label, so people don’t want to go there.” Participants also mentioned a need for more services to increase access, as many individuals in crisis end up in the emergency room.

Figure 15: Percent of adult population with serious mental illness (Louisiana BRFSS 2014)

Maternal and Child Health

Births to mothers aged 15 to 19 years are much higher in the 5-parish Central Louisiana region than the entire state as seen in Figure 16. A focus on reducing teenage pregnancy could lessen this gap and prevent some of the many costs associated with early pregnancy. According to the U.S. Centers for Disease Control and Prevention, teen pregnancy and births are “significant contributors to high school dropout rates among girls,” with only about 50% of teen mothers receiving a high school diploma by the age of 22.9

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The infant mortality rate (IMR) and percentage of the low birth weight (LBW) in the CHRISTUS Health Central Louisiana region are similar to the state, with the exception of African American mothers and mothers of ‘other’ races who have a slightly higher percent of births with LBW (Figure 17).

**Health Behaviors and Screening**

The BRFSS, described above, collects information on screening and health risk behaviors. Figure 18 reports four of these, of which the largest difference from the state is with the percent of adults currently smoking –28% of adults in the 5-parish Central Louisiana region smoke compared to 24% throughout the entire state. This is consistent with the higher incidence rate for lung cancer in this region. Smoking was also mentioned in interviews.
Participants reported that there are a large amount of screenings (prostate, breast, and colon), health fairs, and workplace wellness initiatives happening around the region.

Figure 18: Health-related risk factors in the adult population (Louisiana BRFSS 2014)

Also collected by the BRFSS are the percent of adults who’ve ever had a screening procedure done (Figure 19). Except for diabetes, the percent of adults who ever had a screening test for three types of cancer is lower in the 5-parish Central Louisiana region than the state.

Figure 19: Screening for health conditions in the adult population (Louisiana BRFSS 2014)

Poor nutrition was mentioned by a number of participants, especially as a result of “a culture of cooking,” lack of education about good nutrition, and few sources of fresh and healthy food. Participants tied poor nutrition into obesity and diabetes. Other health-related risk factors mentioned by
participants included: hypertension and nonadherence to medications (both relating to mental health issues and challenges affording medications).

**Hospital Data**

All findings in this section refer to primary data provided by the two short-term acute care CHRISTUS facilities serving patients residing in the 5-parish Central Louisiana region: CHRISTUS St. Frances Cabrini Hospital, which is the host hospital for CHRISTUS Dubuis Hospital of Alexandria, and CHRISTUS Coushatta Health Care Center. Comparable data from all hospitals in the State of Louisiana is not available, so this information only provides info on internal use.

![Figure 20: Top causes of admission (Coushatta & Cabrini Hospital admissions data 2013-2014)](image)

![Figure 21: Insurance types for hospital admissions (Coushatta & Cabrini Hospital admissions data 2013-2014)](image)
Participants described a lack of preventive care, and that many individuals use the ER and urgent care as primary care. One participant described how many uninsured individuals go to the ER because they cannot afford a regular doctor.
Figure 24: Emergency room visits by the top 20 zip-codes (Coushatta & Cabrini Hospital admissions data 2013-2014)
Other Issues Highlighted by Qualitative Data: Contributing Factors & Community Perspective

Other health issues mentioned included: sexually transmitted infections and air and water quality issues due to plants and factories.

Participants also discussed a need for elderly daycare, patient navigators, “walk-in options” for the uninsured and underinsured, community-based supports and group counseling for mental health, volunteer opportunities for medical professionals and students, caregivers for people without families, parks (especially in rural areas), community education and involvement, more health fairs, community gardening, and bicycle routes. One participant discussed how too many individuals live in areas where it is not safe to let children go outside to play, further leading to inactivity and diabetes.

Participants described a lack of coordinated care and follow-up, especially as individuals see multiple doctors when they go to the hospital. One participant shared how there is a lack of communication—“Everyone is tired of hearing Huey is gone. It’s gone. We are trying to get open communication about who will see people.”

Veterans were one area of particular focus of the interviews and focus groups. Some participants stated that homeless veterans receive help and services from the VA, while homeless individuals in the general population do not qualify for services. On the other hand, two participants talked about the VA cutting services and moving from a hospital to clinics.

Barriers to accessing primary care included: cost of services/lack of insurance, cost of medication, transportation (especially in more rural areas), education on where to go, lack of education on well-being, lack of awareness of available resources, insufficient amount of services, lack of providers that accept Medicaid, long wait times, and concentration of services in certain areas.

Barriers to accessing mental health services included: not enough inpatient and outpatient services, (especially psychiatrists), services not easily accessible due to location, services not being affordable, lack of outreach, lack of support at home, and stigma.

“There is no support for those leaving jail after a drug offense. It’s hard to get a job with a drug offense, but if you have someone to advocate for you or if you have family support you are more likely to get a job. Those without this support tend to be disproportionately African American. It becomes a cycle of drugs-jail-drugs-jail if there is no intervention.”
Summary and Discussion of Prioritized Community Health Needs

Prioritization Process

Once the quantitative and qualitative data were analyzed and gathered into an initial draft CHNA report, the draft report was shared with CHRISTUS Health leadership for CHRISTUS Dubuis Hospital of Alexandria. A panel of experts comprised of both CHRISTUS staff and external partners representing various members of the community was tasked with reviewing the initial findings and determining which priority issues would be selected to address over the next three years as part of a community health implementation plan.

The 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 is less available. Detailed rationale regarding these top priorities is provided below.

1. Chronic Conditions

The CDC cites chronic diseases and conditions, such as heart disease, stroke, cancer, type 2 diabetes, obesity, and arthritis, as some of the most common, costly, and preventable of all health problems affecting the American public. According to the data, deaths in the Central LA region due to diseases of the heart are considerably higher than the state, with 280 deaths per 100,000 population versus 220. Additionally, diabetes PQIs for long-term complications and uncontrolled diabetes are higher in this region compared to the state. Overall incidence and mortality rates for lung cancer are much higher in this region as well. Ultimately, staff at CHRISTUS Dubuis Hospital of Alexandria chose this issue as their #1 priority area because chronic conditions greatly impact the majority of their patients, either in terms of diagnosis-related group or co-morbidity.

2. Access to care

Access to health care, especially among the uninsured, was a common concern in the Central Louisiana region. Interview and focus group participants identified many barriers to accessing primary care including cost of services/lack of insurance, cost of medication, transportation, education on where to go, lack of awareness of available resources, insufficient amount of services, lack of providers that accept Medicaid, long wait times, and concentration of services in only certain areas. The panel at CHRISTUS Dubuis Hospital of Alexandria agreed that access to care is a great need in the community to access medical care. This is especially true for patients the hospital is able to accept for care, as proper insurance is essential to admission to Dubuis Hospital of Alexandria.

3. Cost of Medications

Ensuring that patients who need life-saving or disease management medications are able to obtain them is complimentary to many of the issues already identified when tackling chronic conditions and access to care. Keeping the cost of medications affordable is key to this effort. Staff at Dubuis Hospital of Alexandria noted that many of their patients must be able to afford the medications they need to better manage their conditions and improve their health outcomes.

4. Health Education/ Health Literacy

Health education is an additional component that can be useful in addressing chronic conditions, or at least preventing them in the first place. Leaders and staff at Dubuis Hospital of Alexandria felt that providing patient and prevention education is an important means to directly impact patients by giving them the tools and knowledge to improve the quality of their lives.

Issues Not Selected for Prioritization

In an effort to maximize any resources available for the priority areas listed above, leaders and staff at Dubuis Hospital of Alexandria determined that the following issues would not be explicitly included in their community health improvement plan (CHIP):

- Mental health/ behavioral issues
- Transportation
- Nutrition

While mental health was acknowledged as a critical community issue, current hospital policy/ procedures disallow admission to CHRISTUS Dubuis Hospital of Alexandria for those with diagnosed mental health issues.

The issue of transportation was not selected as patients admitted to Dubuis Hospital of Alexandria are already hospitalized prior to arriving.

While Dubuis Hospital of Alexandria occasionally works on nutritional issues with patients and behavioral issues sometimes addressed in scope of care for some patients, neither issue is considered to be a pressing issue that falls within the usual scope of what a long term acute care facility should provide.

Available Resources and Opportunities for Action

As previously mentioned, participants involved in each step of the CHNA process were encouraged to offer ideas for implementation or provide examples of other organizations or local assets in the community that CHRISTUS Dubuis Hospital of Alexandria could possibly engage or utilize when tackling the priority issues listed above. A list of recommendations provided by interview and focus group participants is provided in Appendix C. The various organizations working on some of these issues that
were mentioned by participants are also included in Appendix D. Leaders, partners, and staff at CHRISTUS Dubuis Hospital of Alexandria noted several ways the hospital could take action on each priority. These items include:

1. **Chronic Conditions**
   - Provide education on disease management and prevention
   - Continue scheduling follow-up appointments prior to discharge
   - Continue providing follow-up telephone calls after discharge

2. **Access to care / Cost of Medications**
   - Continue to provide referrals for assistance when possible (e.g. Community HealthWorx)
   - Continue to pay annual fee for Dispensary of Hope for Community HealthWorx so that medication assistance is available to as many people as possible who qualify
   - Obtain drug company involvement for indigent patients when possible
   - Arrange for samples from physician offices when available
   - Continue providing follow-up telephone calls after discharge

3. **Health Education / Health Literacy**
   - Ensure that education materials are available at a reading level most patients can understand
   - Ensure interdisciplinary involvement in education
   - Provide patient discharge education online and encourage staff to access and provide routinely

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**Community Impact Thus Far**

CHRISTUS Dubuis Hospital of Alexandria, a long term acute care hospital located in Central Louisiana, serves a population of medically complex, acutely ill patients for extended periods of time. Due to the nature of the long term acute care industry and the regulatory bodies that oversee and govern the types of services that are provided, the hospital has a limited scope of service and is subject to penalties if serving patients that do not meet the strict requirements for admission. The hospital only provides inpatient acute care services to patients whose length of stay exceeds 25 days and fall into a limited number of diagnoses. Low profit margins further restrict the scope of community health activities the hospital undertakes.
A few areas Dubuis Hospital of Alexandria had an impact on the community include:

- Partnering with the American Heart Association and providing education on heart disease and prevention to area churches and women’s shelter
- Providing a dietician, as part of American Heart Association’s label education program, to conduct several grocery tours on shopping, aimed at congestive heart failure and diabetic patients.
- Partnering with a local Federally Qualified Health Care clinic by purchasing them a subscription to participate in the Dispensary of Hope medication assistance program, providing access to medications for the poor and uninsured.

Providing on-site training and experience for nursing students which improves access of medical providers in the community.
Appendix A: Source List

Quantitative data utilized in this report were obtained through the following sources:

- United States Census Bureau American Community Survey (ACS) 2013
- U.S. Department of Health and Human Services Health Resources and Services Administration Area Health Resource Files (AHRF) 2014
- Louisiana Department of Health and Hospitals Vital Statistics 2013
- Louisiana Department of Health and Hospitals Hospital Inpatient Discharge Data (LAHIDD) 2012
- Louisiana Tumor Registry 2008-2012
- Louisiana Department of Health and Hospitals Office of Behavioral Health data 2013-2014
- Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (BRFSS) data for Louisiana 2014
- CHRISTUS St. Frances Cabrini Hospital Admissions data 2013-2014
- CHRISTUS Coushatta Health Care Center Admissions data 2013-2014
Appendix B: Matrix of Key Informants Meeting IRS Requirement Guidelines

Per IRS regulations (Section 3.06 of Notice 2011-52), each facility must get input from people who fall into each category. It should be noted that several respondents fall into more than one category, which is reflected in the counts below.

<table>
<thead>
<tr>
<th>Key Informant Affiliations Required by the IRS</th>
<th>Number of Key Informants Meeting Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Persons with special knowledge of or expertise in public health</td>
<td>3</td>
</tr>
<tr>
<td>2) Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility</td>
<td>1</td>
</tr>
<tr>
<td>3) Leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility</td>
<td>3</td>
</tr>
</tbody>
</table>
Appendix C: Recommendations Provided by Interview and Focus Group Respondents

- Help patients get more information about what is available and resources they can access. It’s easy to discharge someone and say that they should get home health care, but there are a lot of details that fall through the cracks. People need more help. “People only got to ER when they are sick already, but they need to understand what they can do in between those times. If they knew screening didn’t cost anything and it came to their neighborhoods, maybe they would do it.”
- Have clinics where poor people without transportation can access them
- Need for health coach/navigator, especially for individuals without insurance
- Day treatment options for mental health/extension of the in-patient unit; continue van program for people without transportation
- Improve communication and partner more with Community HealthWorx, promote them
- Need to get front line people together to talk about how to partner; when discussing implementation plans, include stakeholders and people doing the work in the conversations
- More opportunities for medical communities to serve as volunteers
- Need a central person from the hospital to consistently represent CHRISTUS at community meetings with other organizations
- Provide health education through the churches
- Provide nutrition education and demonstrations (label reading, speakers, etc.) and partner with churches
- Partner with area businesses on employee health education
- Pull together community resources to not only “stop the bleeding” (short term efforts), but also have commitment to long term plans that will challenge the status quo – a change in culture comes over time – CHRISTUS must be invested over the long haul
Appendix D: Local Organizations / Community Assets Mentioned by Respondents

- Veteran’s Affairs - shelter for veterans
- New community college - skills training
- Salvation Army - tackle homeless
- Grace House/ Pentecostal Church - tackle homeless
- Olive House - homeless
- Hope House - homeless
- Workforce Commission
- Homeless Coalition - provide services once a month downtown
- Reentry Solutions - helping formerly incarcerated with housing and jobs
- School-based health centers - counselors
- Neighborhood watch programs
- Police - address domestic violence
- Tobacco-Free Living
- Rapides Foundation - bring non-profit organizations together once a year
- Community HealthWorx - provide dental to veterans
- Meals on Wheels
- YMCA
- Food Project with the Food Bank - healthy gardening and eating
- Health Unit - immunization and flu shots
- Incarnate Word
- Rapides Clinic
- YWCA
- Churches, ministerial associations - health fairs, sports
- Healthy Food Coalition
- CASA
- Business Incubator
- Volunteers of America - services for homeless