



OCHSNER MEDICAL CENTER

SEPTEMBER 2013

COMMUNITY HEALTH NEEDS ASSESSMENT

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Background

In April of 2012, Ochsner Health System joined with other members of the Metropolitan Hospital Council of New Orleans (MHCNO), a non-profit, regional membership and service organization representing hospitals and healthcare organizations in the Greater New Orleans Metropolitan Area, to initiate the process of conducting a comprehensive, regional Community Health Needs Assessment (CHNA). The 12 MHCNO member healthcare facilities included:

- Children's Hospital New Orleans
- East Jefferson General Hospital
- Ochsner Medical Center
- Ochsner Medical Center-Westbank
- Ochsner Medical Center-Kenner
- Ochsner Baptist Medical Center
- Ochsner Medical Center Northshore
- Slidell Memorial Hospital
- St. Tammany Parish Hospital
- Touro Infirmary
- Tulane Medical Center
- West Jefferson Medical Center

With mutual interest in the health and well-being of residents in the region served by the 12 facilities, a collaborative community health needs assessment was conducted to evaluate and understand the health needs across the Greater New Orleans Region.

The following is a list of organizations that participated in the regional community health needs assessment process by providing valuable input:

- Catholic Charities
- Kingsley House
- Delgado-Charity School of Nursing
- Blue Cross Blue Shield
- Acadian Ambulance
- United Way for the GNO Area
- Covenant House New Orleans
- Baptist Community Ministries
- LSU Health Science Center
- VOA - New Orleans
- Second Harvest Food Bank
- Jefferson Parish Public School System
- Louisiana Association of United Ways
- New Orleans Hornets (NBA team)
- United Healthcare Louisiana
- Humana Louisiana
- Prevention Research Center Tulane University
- St Thomas Community Health Center
- Louisiana Office of Public Health
- JEDCO
- West Jefferson Medical Center
- Entergy
- Gulf Coast Bank and Trust
- American Cancer Society
- NO/AIDS Task Force
- Louisiana Cancer Research Consortium
- American Heart Association
- Susan G. Komen, New Orleans
- New Orleans Health Dept.
- State of Louisiana Leadership
- Jefferson Parish Human Svcs. Authority
- Jefferson Parish Chamber of Commerce

- Hispanic Apostolate Community Services Catholic Charities Archdiocese of New Orleans
- Jefferson Parish Sheriff Dept.
- Neonatal Medical Group
- City of Slidell Leadership
- Acadian Ambulance Service
- STPH Community Wellness Center
- St. Tammany West Chamber of Commerce
- St. Tammany Parish Government
- St. Tammany Parish Government
- Greater New Orleans YMCA
- Seniors and Law Enforcement Together (SALT)
- STPH Parenting Center
- St. Tammany EDF
- St. Tammany Parish Fire District 4
- St. Tammany Parish Sheriff's Office
- City of Covington Leadership
- North Shore Healthcare Alliance
- New Orleans Health Dept.
- Ochsner Kenner
- Operations Vineyard Church
- Kenner Kiwanis Board Member
- The Dial Corporation
- City of Kenner Leadership
- St. Charles Community Health Center
- Dept. of Community Services, Archdiocese of New Orleans
- The Plaquemines Gazette
- Daul Insurance
- Algiers Economic Development
- Pickering and Cotogno
- City of New Orleans Leadership
- Institute of Mental Hygiene
- North Shore Rotary Club
- City of Slidell Leadership
- East St. Tammany Chamber of Commerce
- Ochsner North Shore
- Delgado Community College
- LSU Health Science Center, Allied Health
- LSU Health Science Center, Nursing
- Tulane University School of Medicine
- Xavier University, New Orleans
- LSU Health Science Center, Medical Students
- Tulane Medical Center
- Touro Infirmary

The regional CHNA played an important role in obtaining input by means of over 100 key stakeholder calls in the Greater New Orleans region as well as 14 focus groups with over 200 residents. The regional CHNA provided a foundation of data that was utilized to conduct the individual, hospital-level CHNAs (required by the IRS). Ochsner Medical Center (OMC) contracted with Tripp Umbach in March 2013 to complete the individual, hospital-level CHNA for the fiscal year ending in December 2013.

Introduction

In March of 2013, Ochsner Medical Center, a 473-bed hospital that includes 80 specialties and subspecialties, along with a team of more than 600 skilled physicians, conducted a comprehensive Community Health Needs Assessment (CHNA) in response to its community commitment. OMC contracted with Tripp Umbach to facilitate the CHNA.

This project represents an important initiative to identify and explore the ever changing healthcare landscape. Also, this report fulfills the requirements of a new federal statute established within the Patient Protection and Affordable Care Act (PPACA) requiring that nonprofit hospitals conduct CHNA's every three years. The CHNA process undertaken by OMC, with project management and consultation by Tripp Umbach, included extensive input from persons who represent the broad interests of the communities served by the hospital facility, including those with special knowledge of public health issues.

Community Definition

While community can be defined in many ways, for the purposes of this report, the OMC region has been defined to include 75 zip code areas across 17 of the 19 parishes in the study that hold a large majority (80%) of the inpatient discharges. (See Figure 1 & Table 1)

Ochsner Medical Center Community Zip Codes

Table 1

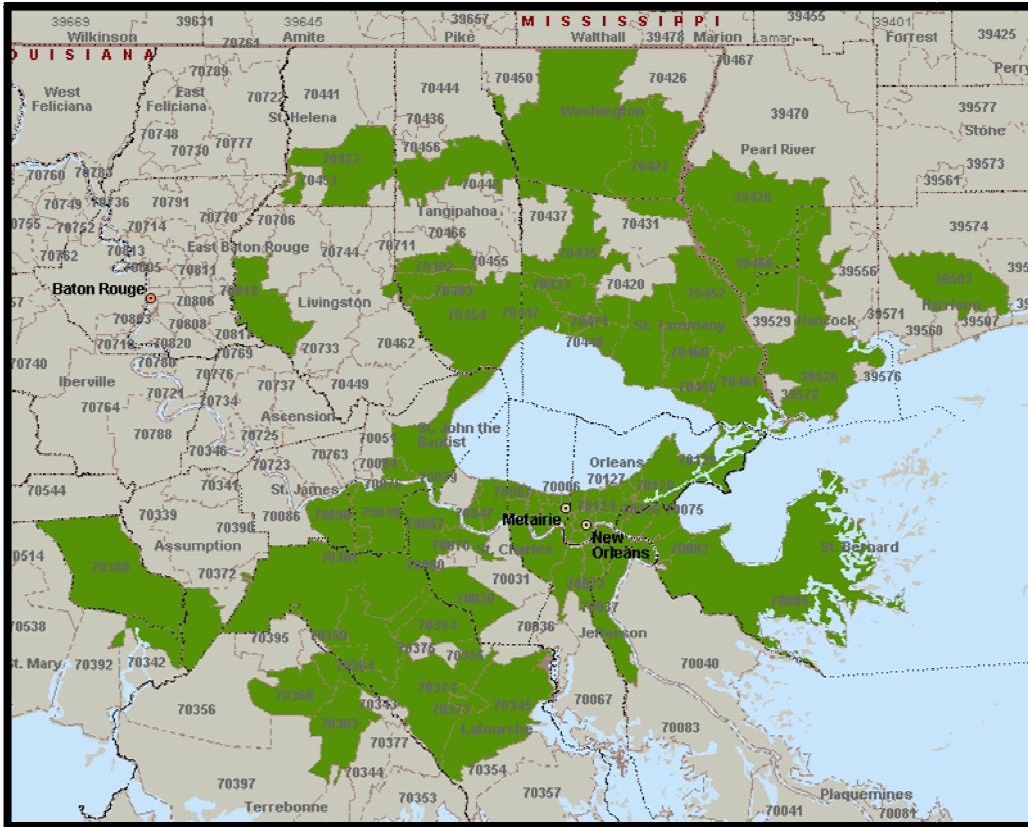
Zip Code	Parish	Zip Code	Parish
39520	Hancock County	70345	Lafourche Parish
39503	Harrison County	70373	Lafourche Parish
39426	Pearl River County	70374	Lafourche Parish
39466	Pearl River County	70394	Lafourche Parish
70001	Jefferson Parish	70726	Livingston Parish
70002	Jefferson Parish	70113	Orleans Parish
70003	Jefferson Parish	70114	Orleans Parish
70005	Jefferson Parish	70115	Orleans Parish
70006	Jefferson Parish	70116	Orleans Parish
70053	Jefferson Parish	70117	Orleans Parish
70056	Jefferson Parish	70118	Orleans Parish
70058	Jefferson Parish	70119	Orleans Parish
70062	Jefferson Parish	70122	Orleans Parish
70065	Jefferson Parish	70124	Orleans Parish
70072	Jefferson Parish	70125	Orleans Parish
70094	Jefferson Parish	70126	Orleans Parish
70121	Jefferson Parish	70127	Orleans Parish
70123	Jefferson Parish	70128	Orleans Parish
70301	Lafourche Parish	70129	Orleans Parish

Table 1 Continued

Zip Code	Parish		Zip Code	Parish
70130	Orleans Parish		70435	St. Tammany Parish
70131	Orleans Parish		70445	St. Tammany Parish
70037	Plaquemines Parish		70447	St. Tammany Parish
70032	St. Bernard Parish		70448	St. Tammany Parish
70043	St. Bernard Parish		70452	St. Tammany Parish
70075	St. Bernard Parish		70458	St. Tammany Parish
70085	St. Bernard Parish		70460	St. Tammany Parish
70092	St. Bernard Parish		70461	St. Tammany Parish
70030	St. Charles Parish		70471	St. Tammany Parish
70047	St. Charles Parish		70401	Tangipahoa Parish
70057	St. Charles Parish		70403	Tangipahoa Parish
70070	St. Charles Parish		70422	Tangipahoa Parish
70087	St. Charles Parish		70454	Tangipahoa Parish
70090	St. James Parish		70360	Terrebonne Parish
70049	St. John the Baptist Parish		70363	Terrebonne Parish
70068	St. John the Baptist Parish		70364	Terrebonne Parish
70084	St. John the Baptist Parish		70427	Washington Parish
70380	St. Mary Parish		70438	Washington Parish
70433	St. Tammany Parish			

Ochsner Medical Center –Community Map

Figure 1



Consultant Qualifications

OMC contracted with Tripp Umbach, a private healthcare consulting firm headquartered in Pittsburgh, Pennsylvania to complete the community health needs assessment. Tripp Umbach is a recognized national leader in completing community health needs assessments, having conducted more than 200 community health needs assessments over the past 21 years. Today more than one in five Americans lives in a community where Tripp Umbach has completed a community health assessment.

Paul Umbach, founder and president of Tripp Umbach, is among the most experienced community health planners in the United States, having directed projects in every state and internationally. Tripp Umbach has written two national guide books^[1] on the topic of community health and has presented at more than 50 state and national community health conferences.

^[1] A Guide for Assessing and Improving Health Status Apple Book:

http://www.haponline.org/downloads/HAP_A_Guide_for_Assessing_and_Improving_Health_Status_Apple_Book_1993.pdf AND

A Guide for Implementing Community Health Improvement Programs:

http://www.haponline.org/downloads/HAP_A_Guide_for_Implementing_Community_Health_Improvement_Programs_Apple_2_Book_1997.pdf

Project Mission and Objectives

The mission of the OMC CHNA is to understand and plan for the current and future health needs of residents in its community. The goal of the process is to identify the health needs of the communities served by OMC, while developing a deeper understanding of community needs and identifying community health priorities. Important to the success of the community needs assessment process is meaningful engagement and input from a broad cross-section of community-based organizations, who were partners in the community health needs assessment.

The objective of this assessment is to analyze traditional health-related indicators as well as social, demographic, economic, and environmental factors. Although the consulting team brings experience from similar communities, it is clearly understood that each community is unique. The overall objective of the CHNA is summarized by the following areas:

- ❑ Obtaining information on population health status as well as socio-economic and environmental factors,
- ❑ Assuring that community members, including underrepresented residents, were included in the needs assessment process,
- ❑ Identifying key community health needs within the hospital's community along with an inventory of available resources within the community that may provide programs and services to meet such needs, and
- ❑ Developing a CHNA document as required by the Patient Protection and Affordable Care Act (PPACA).

Methodology

Tripp Umbach facilitated and managed a comprehensive regional community health needs assessment on behalf of Ochsner Medical Center resulting in the identification of community health needs. The assessment process included input from persons who represent the broad interests of the communities served by the hospital facilities, including those with special knowledge and expertise of public health issues. No information gaps were identified that impacted the hospital's ability to assess the health needs of the community served.

Key data sources in the regional community health needs assessment included:

- ❑ **Community Health Assessment Planning:** A series of conference calls were facilitated by the consultants and the project team consisting of leadership from Ochsner Medical Center.
- ❑ **Secondary Data:** The health of a community is largely related to the characteristics of its residents. An individual's age, race, gender, education and ethnicity often directly or indirectly impact health status and access to care. Tripp Umbach completed comprehensive analysis of health status and socio-economic environmental factors related to the health of residents of the defined project area from existing data sources such as state and county public health agencies, the Centers for Disease Control and Prevention, and other additional data sources. Data included in the secondary data analysis was collected and analyzed between April 2012 and August 2013. (Data profile available upon request)
- ❑ **Interviews with Key Community Stakeholders:** Tripp Umbach worked closely with hospital leadership to identify leaders from organizations that have special knowledge and or expertise in public health, agencies with information relative to the health needs of the community and representatives of medically underserved, low-income, minority populations and populations with chronic disease needs in the community. Such persons were interviewed as part of the needs assessment planning process. A series of approximately 100 interviews were completed in July and October of 2012 with key stakeholders in the Greater New Orleans metropolitan area. In order to maintain confidentiality of views expressed during the interviews, the names and titles of the individuals who participated will be reported to the IRS on form 990 Schedule H and made available upon request. (Regional key community stakeholder summary available upon request)

- ❑ **Focus Groups with Regional Community Residents:** Tripp Umbach worked closely with hospital leadership to assure that community members, including underrepresented residents were included in the needs assessment planning process via a series of fourteen focus groups in October 2012 involving 203 individuals conducted by Tripp Umbach in the Greater New Orleans metropolitan area. Focus group audiences were defined by hospital leadership utilizing secondary data to identify health needs and deficits in targeted populations. Several target populations were relevant to multiple geographical areas defined by hospital leadership, leading to the need to hold focus groups with the same target populations in multiple communities. Focus group audiences included: Senior Population (Independent Living), Vietnamese Senior Population, Senior Population (Assisted Living), Parents of Disabled Children/Young Adults, Healthcare Providers, Families Helping Families Staff and Members, General Patient Population, Hispanic Population, Mothers of Low Birth-Weight Babies, Heart Attack Survivors/Family Members of Survivors, and Women of Child-Bearing Age (including hospital volunteer staff). (Regional focus group summary available upon request)

- ❑ **Identification of top regional community health needs:** Top community health needs were identified by analyzing secondary data, key stakeholder interviews and focus group input. The analysis process identified the health needs revealed in each data source. Tripp Umbach followed a process where the top needs identified in the assessment were supported by secondary data, where available and strong consensus provided by key community stakeholders and focus group participants.

- ❑ **Inventory of Community Resources:** Tripp Umbach completed an inventory of regional community resources available in the OMC service area using resources identified by the hospital facility, internet research and resource databases. Using the zip codes which define the OMC community (refer to Table 1/Figure 1 presented on pages 4-6) more than 365 community resources were identified with the capacity to meet the three community health needs identified in the OMC CHNA. (Regional Community Resource Inventory available at www.ochsner.org/assessment)

- ❑ **Final Regional Community Health Needs Assessment Report:** A final report was developed that summarizes key findings from the assessment process and an identification of top health needs as required by the IRS.

Key Terms:

- ❑ **Demographic Snapshots:** A snapshot of the OMC community definition compared to parishes and state benchmarks.

- ❑ **Community Need Index Analysis (CNI):** Because the CNI considers multiple factors that are known to limit health care access, the tool provides an accurate and useful assessment method at identifying and addressing the disproportionate unmet health-related needs of neighborhoods (zip code level). The five prominent socio-economic barriers to community health quantified in CNI include: Income, Insurance, Education, Culture/Language and Housing. CNI quantifies the five socio-economic barriers to community health utilizing a 5 point index scale where a score of 5 indicates the greatest need and 1, the lowest need.

- ❑ **County Health Rankings:** Each parish receives a summary rank for 37 various health measures associated with health outcomes, health factors, health behaviors, clinical care, social and economic factors, and the physical environment.

- ❑ **The Prevention Quality Indicators index (PQI)** was developed by the Agency for Healthcare Research and Quality (AHRQ). The AHRQ model was applied to quantify the PQI within the MHCNO region and Louisiana. The PQI index identifies potentially avoidable hospitalizations for the benefit of targeting priorities and overall community health. The quality indicator rates are derived from inpatient discharges by zip code using ICD diagnosis and procedure codes. There are 14 quality indicators. Lower index scores represent fewer admissions for each of the PQIs.

Key Community Health Needs

Tripp Umbach’s independent review of existing data and in-depth interviews with stakeholders representing a cross-section of agencies and focus group input resulted in the identification of three key health needs in the OMC service area that are supported by secondary and/or primary data. The stakeholder and focus group process gathers valuable qualitative and anecdotal data regarding the broad health interests of the communities served by the medical facilities within the service area of OMC. Key stakeholder and focus group input is subject to the limitations of the identified target populations (i.e., vocabulary, perspective, knowledge, etc.) and therefore is not factual and inherently subjective in nature. Key stakeholder and focus group participants were asked to identify and discuss what they perceived to be the top health issues and/or concerns in their communities. What follows is a collective summary of the substantial issues and concerns that were discussed by key stakeholder and focus group audiences and where relevant, supported by secondary data.

Needs identified include (not listed in any specific order):

- 1) Access to healthcare and medical services (i.e., primary, preventive, and mental)
- 2) Access to community/support services to sustain a healthy environment
- 3) Promotion of healthy lifestyles and behaviors (specific access barriers to healthy living options and resident accountability issues)

Tripp Umbach used CNI scores, the PQI index and County Health Rankings to identify barriers and potentially avoidable hospitalizations as part of the CHNA. These areas present the highest community health risk as they have the greatest barriers to health care and generally have the poorest health among the region. Also, for instance, factors such as educational attainment are a very important measure in community health analysis as it is related to many other health determinants; occupation, income, access to healthcare, access to healthy food and recreational options, and ability to make healthy decisions.

Below, is a general outlook of the OMC service area (e.g., as defined for the purposes of this CHNA report) based on secondary data analysis conducted during the CHNA process that includes, data on age, race, income, and educational attainments rates.

- ❑ The average CNI score for the OMC service area is 3.7; this score falls above the average for the scale (3.0), indicating a higher than average number of barriers to healthcare access for the OMC service area. 63 of the 75 zip code areas (84%) in the OMC study

area report CNI scores of 3.0 or higher indicating average or above average number of barriers to healthcare access.^{1,2}

❑ The OMC service area reports a slight majority of White, Non-Hispanic residents (57.8%). The next largest racial representation of the OMC service area's population is of Black, Non-Hispanic residents at 30.3%.

❑ The overall rates of the CNI measures for the OMC service area show:

- 16.6% of the population that is 65 and older are living in poverty
- 20.2% of children live in poverty
- 42.6% of single mothers with children live in poverty
- 1.3% of residents have limited English skills
- 41.1% of residents are a minority race/ethnicity
- 17.5% do not have a high school diploma
- 8.1% are unemployed
- 14.2% are uninsured
- 32.4% rent their homes

❑ 17.0% of households of the OMC service area report earning less than \$15,000 per year. This rate is lower than is seen for the state (19.1%).

A summary of the top needs in the OMC Main CHNA follows:

1. ACCESS TO HEALTHCARE AND MEDICAL SERVICES (E.G., PRIMARY, PREVENTIVE, AND MENTAL)

Underlying factors: The need for access to affordable healthcare services, including primary services mental health services, and health prevention services was identified by primary input from community stakeholders and focus group participants and supported by secondary data. The lack of receiving adequate levels of healthcare, which can be for various reasons, including a lack of health insurance due to affordability and navigation issues, cultural barriers and/or provider shortages, can lead to resident's lack of preventive care and eventually can lead to the need for expensive, advanced stage medical services.

✓ **Areas of specific focus** identified in the needs assessment include:

- *Access to care: including primary and preventive*
- *Health insurance coverage*

¹ CNI quantifies five socio-economic barriers to community health utilizing a 5 point index scale where 5 indicates the greatest need and 1 indicates the lowest need.

² The five prominent socio-economic barriers to community health quantified in CNI include: Income, Culture/Language, Education, Insurance, and Housing.

- *Cultural barriers*
 - *Physician shortage*
 - *Access to mental health services*
- It is important to note that the CNI scale range is from 1.0 to 5.0 and the OMC-Main service area CNI score range is 1.6 to 5.0 (no score of 1.0).
- The zip code area 70113 in New Orleans, LA reports the highest CNI score (along with 3 other zip code areas) in the OMC service area at 5.0 (e.g., worst possible for the scale); as well as reporting many of the highest CNI measures of the CNI score (i.e., New Orleans (70113) shows many of the highest rates in the study area for the CNI measures: poverty 65+ (41.8%), childhood poverty (55.2%), no high school diploma (37.5%), unemployment (27.4%), uninsured (40.8%) and renting (78.5%). These areas present the highest community health risk as they have the greatest barriers to health care and generally have the poorest health among the region.
- Specifically:
- 70119 is the largest population in zip code area and this area has the highest number of residents in need.
 - Zip code area 70049 shows the highest minority rate at 97.6%.
 - Zip code area 70129 shows the highest rate of residents with limited English at 9.1%.
 - Only zip code area 70726 in Denham Springs, LA showed a rise in CNI score in the range of scores from 3.4 to 3.0 with a rise from 2.8 in 2010 to 3.0 in 2011.
 - Zip code area 70057 has an overall CNI score of 4.4 (e.g., moderate number of barriers); however it shows the highest rate of single mothers living with children in poverty (76%) compared to all of the other zip code areas in the study area.
 - Zip code area 70448, in Mandeville, LA shows the lowest CNI score (e.g., fewest barriers to healthcare access) at 1.6.
- The highest uninsured rate across the OMC service area is 40.8% in New Orleans (70113), which also includes the highest unemployment rate of 27.4%.
- St. Bernard and Terrebonne parishes show high rates of uninsured residents across the study area parishes (21.4% and 20.4% respectively).

- ❑ Jefferson Parish shows the highest rate for Medicare coverage (9.5%) and Washington Parish shows the highest rate of Medicaid coverage (14.5%) across the study area parishes.
 - Nearly one in every three (32.3%) residents of St. Bernard Parish reports a lack of health insurance coverage as a result of the 2005 hurricanes.

- ❑ Specifically, Washington Parish shows the highest rate of households earning less than \$15,000 per year at 25.7%.
 - Orleans, Washington, and Tangipahoa parishes all show a ranking above the median for Income.
 - Orleans Parish shows the highest ranking (i.e., unhealthiest) across the LA parishes of 60 for income (fifth worst in the state).

- ❑ Specifically:
 - Orleans Parish reports the largest majority of Black, Non-White residents at 58.4%. St. John the Baptist and St. James parishes join Orleans Parish in having a majority of their population as Black, Non-Hispanic.
 - Jefferson Parish shows the highest rate of Hispanic residents at 13.3% as well as the highest rate of Asian and Pacific Islander residents at 4%.
 - Hancock and Pearl River counties in Mississippi show similar racial breakdowns as Livingston Parish with a very large majority of the population as White, Non-Hispanic.

- ❑ Congestive heart failure and diabetes are examples of diseases where preventive treatment and education play a vital role in maintaining health.
 - The OMC service area shows a majority (i.e., 11 of the 14, 78.6%) of the PQI measures lower than is seen for the state; indicating conditions in which the zip code areas in the OMC service area report fewer preventable hospitalizations than the state.
 - On the other hand, there are two PQI measures in which the hospital service area reports higher rates of preventable hospitalizations than the state, these include short-term complications of diabetes and perforated appendix.
 - Congestive heart failure showed the highest rate of preventable hospital admissions for the study area across all of the measures, followed by low birth-weight.
 - Washington Parish reports the highest PQI rates compared to the other parishes for the most measures (i.e., 4 of the 14), they include:

- chronic obstructive pulmonary disease
 - congestive heart failure
 - angina without procedure (nearly 4 times higher than the state)
 - bacterial pneumonia
 - St. Mary Parish reports higher PQI rates than the other parishes for 4 of the 14 measures; Hypertension (i.e., nearly three times higher than the state), lower extremity amputation, dehydration, and urinary tract infections.
 - St. John the Baptist Parish reports the highest PQI rates compared to the other parishes for long-term complications of diabetes.
 - Orleans Parish reports the highest PQI values for 2 of the 4 diabetes measures; short-term complications of diabetes and adult asthma.
 - St. James Parish shows the highest PQI rates compared to the other parishes for:
 - uncontrolled diabetes (i.e., more than double the state rate)
 - low birth-weight babies (i.e., nearly 4 times higher than the state)
- ❑ Louisiana has 64 parishes. Therefore, a rank of 1 is considered to be the healthiest parish in the state and a rank of 64 is considered to be the unhealthiest parish in the state. The median rank for Louisiana is 32.
- ❑ Mississippi has 81 counties. Therefore, a rank of 1 is considered to be the healthiest county in the state and a rank of 81 is considered to be the unhealthiest county in the state. The median rank is 40.5.
- Specifically:
 - St. Tammany Parish may be considered the healthiest parish with the most rankings in the top 10 healthiest for the state (e.g., 16 of the 21 measures)
 - Washington Parish may be considered the unhealthiest parish with the most rankings in the top 10 unhealthiest for the state (e.g., 8 of the 21 measures)
 - St. Bernard Parish ranks in the top 10 healthiest counties across the state for none of the measures. However, ranks in the top 10 unhealthiest counties across the state for 6 of the 21 measures: health outcomes, morbidity, clinical care, and access to care, environmental quality, and physical environment.

- Hancock, Pearl River, St. Bernard, Plaquemines, Washington, St. Mary, Lafourche, and Livingston parishes and counties all show a ranking above the median for access to care.
 - St. Bernard Parish shows the highest ranking (i.e., unhealthiest) of 64 for access to care (the worst in the state).
- ❑ Region 3 (i.e., Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary, Terrebonne) reports the highest rates of serious psychological distress in the past year (10.07%).
- Livingston Parish shows the highest suicide rate at 15.5 per 100,000 deaths.
 - 11 of the 16 parishes report a higher suicide rate than the state. 7 of the 16 parishes report a suicide rate higher than the national rate.

The more than 100 community stakeholders specifically mentioned the following regarding perceived problems and/or barriers for residents in the service area:

- ❑ Stakeholder interview findings support secondary data that residents' access to healthcare and medical services, including preventive services, are important community health priorities.
- ❑ Community stakeholders perceived mental health and an increase in chronic disease such as hypertension, diabetes and obesity as the top trending health needs regional. Some of the other health needs mentioned often by stakeholders were a lack of healthy lifestyles, accessible healthcare for the under/uninsured, and perinatal issues (i.e., the rate of pre-mature births and infant mortality). Additional health needs mentioned included a lack of prevention education/preventive care, heart disease, drug and alcohol abuse, and cancer rates.

Access to care: including primary, specialty, and preventive

- ❑ Stakeholders believed the healthcare system is still somewhat fractured and there is a lack of consistent information available and human resources to help with navigation of the system. Overall, stakeholders perceived, there isn't a system that is easily universal and easily accessible to help navigate through all the ways to obtain healthcare and mental health care. Also, stakeholders felt not all medical records are computerized throughout the region, which can create future issues for systems and patients.

- ❑ Stakeholders stated there is a lack of service and lack of appropriate match of services to specific populations due to language/cultural barriers. Additionally, stakeholders believed Asian, Vietnamese and Latino populations are increasing through the region.
- ❑ Stakeholders stated the closure of the charity-based hospital system is causing concern for patients that relied on their services. Stakeholders stated there needs to be an increase in access to quality, affordable care. Specifically, stakeholders perceived there is a lack of access to quality primary care (i.e., 24 hr. clinics) throughout the region. Stakeholders mentioned, eventually, clinical needs and mental needs can arise that require more intensive care. Ultimately, stakeholders perceived with a lack of care in a preventative way it soon becomes a really expensive care model.
- ❑ Stakeholder's perceived access is becoming increasingly more difficult, especially among the mental health and indigent population. Stakeholders stated primary care services should continue to develop in every "neighborhood" to prevent the costlier visits to the ER.
- ❑ Stakeholders believed there is an overall lack funding and resources that is geared toward prevention education. Stakeholders stated preventive education and general access to healthcare go hand and hand.
- ❑ Stakeholders believed hospital competition creates barriers to coordination of care throughout the region.
- ❑ Stakeholders stated the amount of time it takes to secure healthcare can create access barriers to residents.
- ❑ Specifically, regarding women's healthcare services, stakeholders perceived there are perinatal issues (i.e., the rate of pre-mature births and infant mortality). Stakeholders perceived premature delivers as an issue in the area, which they believed are linked with special needs children.

Health insurance coverage

- ❑ Stakeholders felt increased healthcare navigation is needed (i.e., helping people understand what is available to them and how to access resources); this is for everyone, employed and unemployed).
- ❑ Stakeholders perceived there is a lack of insurance coupled with increased poverty rates.
- ❑ A majority of stakeholders felt services seem to be so scattered and it also takes a long time to get through the process to ultimately obtain the required health-related services.
- ❑ Stakeholders felt there is a lack of access to affordable medication. Stakeholders shared some residents can't control chronic illness because they can't afford their prescriptions.

Cultural barriers

- ❑ Stakeholders believed it is a diverse community so healthcare needs to be provided in a culturally sensitive way. Overall, stakeholders felt there are a lack of resources to address cultural barriers when dealing with the navigation of healthcare services

Physician shortage

- ❑ Stakeholders felt there are a lack of access to healthcare providers that's timely, and a lack of access to specialty services/providers. Overall, stakeholders felt there is a shortage of healthcare providers throughout the region.
- ❑ Stakeholders felt primary care in the Greater New Orleans area is a consistent issue. Stakeholders also stated there is a huge case load and not enough physicians to see them and then they are not coordinating services.

Access to mental health services

- ❑ Stakeholders felt negative effects exist due to the closure of mental health clinics and hospitals throughout the communities.
- ❑ Stakeholders perceived mental health issues exist that are coupled with homelessness and substance abuse. Stakeholders stated, violence, drugs and mental health all go hand and hand throughout the region.
- ❑ Some stakeholders felt in rural areas access to mental and physical care is a huge problem. Post Katrina has also affected suburban areas with the same problem as traditional rural areas have had. Stakeholders also believed the state continues to make cuts to health and human service budgets, while these problems increase.
- ❑ Stakeholders stated there is a spike of mental health issues in children health and multiple health needs regarding mental health issues are increasing. Stakeholders believed there is a considerable need in the Greater New Orleans area with children and families at large. Specifically, domestic violence has increased which creates an environment prone to mental health issues for the entire family.
- ❑ Stakeholders agreed that psychiatric/mental health services are currently having funding/budget cuts that are creating negative impacts on the population. For instance, facilities are closing and access to an appropriate facility for mental health services is almost impossible and usually residents in need end up in jail or the emergency department rooms at community hospitals.
- ❑ Stakeholders identified the target populations they felt had the greatest risk of having increased health needs. Stakeholders identified (in order of most mentioned) residents that are: low-income, working poor, children, those in need of mental health services, senior citizens, homeless, uninsured, single parent households, minority population, at-risk female youth, women, and/or unemployed.

Focus group participants specifically mentioned the following regarding perceived problems and/or barriers for residents in the service area:

- ❑ Focus group participants from all 14 discussion groups felt barriers to access of healthcare and medical services, specifically, primary, preventative and mental health services, existed within the Greater New Orleans metropolitan area. Specifically mentioned were the following:

Access to care: including primary, preventive, and specialty

- ❑ Overall, many group participants felt that healthcare may be difficult to secure for some residents due to limited outreach programs, costly procedures and a lack of health insurance coverage. Specifically, focus group participants felt the cost of medical care, including medical prescriptions, can be unaffordable for some residents due to costly procedures and the impression that Medicare/Medicaid is not comprehensive enough to cover necessary services.
- ❑ Many focus group participants perceived that access to preventive care in their communities is limited due to not enough programs offering preventive services such as health screenings and fitness activities.
- ❑ Participants gave the impression they are concerned with the current level of coordination of medical care offered by local medical providers. Participants implied there may be limited communication between the patient and some local healthcare providers, specifically with bi-lingual services. Participants also gave the impression there may be times when residents have had pre-authorization issues with the medical billing process of some local hospitals. Participants believed it can be difficult at times for residents to manage medical billing errors and the process related to resolving inaccuracies they have encountered.
- ❑ Focus group participants were under the impression their access to medical care is limited due to transportation issues. Participants felt public transportation is not always readily accessible or convenient due to a decrease in public bus routes that serve many communities throughout the region. Overall, the absence of readily, accessible, convenient transportation causes limited access to medical care for some residents because they cannot get to and from their medical appointments. Many participants felt the result of limited public transportation is that residents require the use of emergency medical

transportation (EMT) services more often, which may increase the cost of medical care and possibly over-utilization of emergency rooms for non-emergency related issues.

- ❑ Some focus group participants were under the impression pediatric and under/uninsured medical services can be difficult to access due to the perception that there is no local medical clinic that offers free/affordable under/uninsured medical care, a limited number of local specialized pediatricians, and the perception that pediatric emergency medical care at local medical facilities can be problematic at times when treating disabled children/youth.

Health insurance coverage

- ❑ Group participants felt health insurance can be difficult for some residents to afford due to costly premiums and higher co-pays for medical care. Participants felt Medicare and supplemental insurance are costly and can be unaffordable for some residents that may be on a fixed income. Additionally, participants felt some residents may not be able to afford health insurance due to limited financial resources and the need to pay for basic necessities.
- ❑ Participants also shared that there is limited financial resources provided for under/uninsured medical care that is coupled with new regulations regarding reimbursements. Also, participants stated acceptance issues of certain insurance coverage by some facilities/private providers causes issues for some residents when obtaining services. Some participants felt that many preventive services are not covered by some health insurance providers, which causes preventive health services to be unaffordable for some residents, and therefore inaccessible.
- ❑ Specifically, some focus group participants perceived Medicare/Medicaid is not comprehensive enough to cover the cost of medical care because they receive medical bills for the cost of services that are not covered by Medicare/Medicaid. Participants believed patients may, at times, resist care due to costly fees/co-pays and uninsured patients are less likely to seek medical care, which participants believed may result in untreated illness and a poorer health status.

Cultural barriers

- ❑ Group participants felt health care can be difficult for some residents to secure due to cumbersome approval processes for financial assistance and costly fees for under/uninsured health care. Specifically, participants for whom English is a second language believed due to cultural and language barriers they feel uncomfortable obtaining healthcare services and obtaining healthcare coverage and ultimately are uninsured.

Physician shortage

- ❑ Many focus group participants were under the impression there may be a shortage of physicians, both in primary care and specialty care. Specifically, some participants believed that there is an out flux of local physicians from their communities. Participants perceived shortages in physicians may be the underlying cause of lengthy waiting periods for medical appointments and increased use of emergency medical care for non-emergent issues.
- ❑ Additionally, participants were under the impression there are not enough healthcare professionals or clinics to meet the demand for under/uninsured medical care. Participants believed medical appointments scheduled with some physicians are poorly timed due to lengthy waiting periods for previously scheduled appointments, resulting in rushed services provided by some physicians.
- ❑ Many group participants were under the impression, due to lack of resources, follow-up care and/or in-home care is not being provided to some residents upon discharge from an inpatient stay at local hospitals.
- ❑ Some participants believed overall there were a limited number of pediatricians practicing in the community. Participants believed many residents are seeking pediatric medical care outside of their community. Participants felt residents would prefer to seek pediatric medical care in their community rather than outside of their community if available.

Access to mental health services

- Focus group participants were under the impression mental health services are limited in the areas of capacity to meet the demand for services due to recent closures and funding cuts. Specifically, participants believed mental health services throughout the region are disjointed and at times difficult to navigate. Participants gave the impression some residents in the region may not be aware of available mental health services and believed that as a result of these issues, patients who suffer from mental illnesses may not always be getting their needs met, which is not safe for the individual within communities. Participants felt rates of violence, crime, and drug activity are in some ways bound to increase due to the closing of mental health facilities.
- Some participants believed there is disconnect in the communication between mental health providers and/or physicians and the school system. Participants believed the lack of communication is causing academic difficulties for students with disabilities.

2. ACCESS BARRIERS TO COMMUNITY/SUPPORT SERVICES TO SUSTAIN A HEALTHY AND SAFE ENVIRONMENT

Underlying factors: Underlying factors identified by primary input from key stakeholders and focus group participants: Need for access to community/support services. Stakeholders and focus group participants believed there is a need for programs and services to support healthy lifestyles. While community services exist that are supporting residents, stakeholders and focus group participants indicated there may be a gap between the availability of services and access to these services due to various factors, including lack of public transportation, financial barriers, lack of adequate dissemination of information, etc. The number of community services can be further ascertained through existing directories and the development of a provider inventory, while access to these services by community members is not always quantified by secondary data.

Areas of specific focus identified in the needs assessment include:

- *Prevention education and awareness*
- *Community support infrastructure*
 - *Access to public transportation*
- *Economic challenges*

Below, is the following data specific to the OMC region, including zip code/parish breakouts related to the identified need: 2) Access to community/support services to sustain a healthy and safe environment:

- ❑ The OMC service area shows a projected population increase at a rate of 5.1% by 2017 (i.e., more than 83,000 residents in five years). Often, population growth will necessitate future development of the infrastructure of a community (i.e., public utilities, public transit system and housing).
- ❑ 20.2% of the residents in the OMC service area are aged 0-14 (approx. 328,755 youth).
- ❑ 12.1% of the residents in the OMC service area are aged 65 and older (approx. 196,939 older residents).
- ❑ The zip code area 70113 in New Orleans, LA reports the highest CNI score (along with 3 other zip code areas) in the OMC service area at 5.0 (worst possible for the scale); as well as reporting many of the highest CNI measures of the CNI score (poverty 65+, childhood poverty, no high school diploma, unemployment, uninsured, and renting).
 - St. James Parish is in the top 10 unhealthiest counties across the state for 4 of the 21 measures: alcohol use, employment, family and social support, and community safety.
 - Washington Parish is in the top 10 unhealthiest counties across the state for 8 of the 21 measures: health outcomes, health factors, mortality, morbidity, health behaviors, tobacco use, income, and family and social support.

The more than 100 community stakeholders specifically mentioned the following regarding perceived problems and/or barriers for residents in the service area:

- ❑ Stakeholder interview findings display residents' access to community/support services is an important community health priority.

Community support infrastructure

- ❑ Stakeholders felt homelessness and homicide by firearm are regional issues. Specifically, stakeholders felt there are youth issues involving violence, etc.

- ❑ Stakeholders were under the impression there is limited access to recreation/fitness facilities in some communities. Also, stakeholders felt there is a lack of quality, affordable housing options in some communities.
- ❑ Stakeholders perceived some parks and playgrounds are unsafe due to crime and equipment in areas throughout the region.
- ❑ Stakeholders believed there is a lack of nurturing and family support in some areas throughout the region.

Access to public transportation

- ❑ Stakeholders believed a major problem is active public transportation, as there is less and less available.
- ❑ Some stakeholders perceived transportation is a statewide issue. Specifically, regarding a reliable, public transportation system that can be used for everyday uses, such as healthcare access.

Economic challenges

- ❑ Stakeholders felt there is a lack of jobs throughout the region and there is a lack of financial well-being throughout some communities. Overall, stakeholders believed the state of Louisiana is a financially poor state.
- ❑ Stakeholders perceived there are a combination of issues, such as poverty, illiteracy and unemployment in some communities.
- ❑ Stakeholders identified the target populations they felt had the greatest risk of access to community/support services. Stakeholders identified (in order of most mentioned) residents that are: children living in inner city areas, single parent households (e.g., mother working more than one job), the homeless population whom often have mental illness, are veterans, or have dual diagnosis of health related conditions, elderly, the working poor population, unemployed, and uninsured.

Focus group participants specifically mentioned the following regarding perceived problems and/or barriers for residents in the service area:

- ❑ Focus group participants from all 14 discussion groups felt access barriers to community/support services existed within the Greater New Orleans metropolitan area. Specifically mentioned were the following:

Prevention education and awareness

- ❑ Many focus group participants felt residents are unaware of meetings, events, programs and services in their communities due to ineffective dissemination of information. Specifically, participants felt that information about meetings, events, programs and services is not always publicized in their communities causing a lack of awareness and limited participation among residents. Participants felt the development of information sharing groups and increased publicity using flyers, billboards, advertisements in neighborhood publications and on public transportation could improve information dissemination, resident awareness and resident participation regarding meetings, events, programs and services in their communities. Some participants felt there is a lack of bi-lingual information publicized. Some participants stated there are limited social services in the community for parents of disabled children and young adults with disabilities to receive guidance and or information.

Community support infrastructure

- ❑ Many focus group participants felt local businesses; hospitals and communities could collaborate and pool resources to meet the needs of residents in their communities. Participants did not perceive collaboration to be taking place in their communities at a level that ensured the needs of residents were being met on a consistent basis.
- ❑ Many focus group participants gave the impression there are limited recreational and physical activities available to residents, particularly young people and children/youth with disabilities, due to limited resources, space, safety and costly fees that may be unaffordable for some residents. Additionally, focus group participants believed the absence of recreational and educational activities may lead young people in their communities to engage in criminal activities due to having too much unsupervised free time.

Access to public transportation

- ❑ Focus group participants believed that public transportation provided in some of their communities has restrictive regulations such as limited weekday hours, no weekend service, limited circulation and 48-hour advanced scheduling. Participants felt these restrictions limit the convenience and availability of public transportation which ultimately affects their ability to access services.

Economic challenges

- ❑ Participants felt that poverty is prevalent in their community.
- ❑ Participants believed there is a lack of jobs throughout the region, which they perceived brings a lack of hope to the residents.

3. ACCESS BARRIERS TO HEALTHLY LIVING OPTIONS AND RESIDENT ACCOUNTIBILITY ISSUES

Underlying factors: identified by secondary data and primary input from community stakeholders: Need for improved promotion of healthy lifestyles and behaviors (specific to chronic and infectious diseases) and accountability issues. Stakeholders perceived the health status of many residents to be poor due to various factors such as, limited education on how to promote healthy living. Specifically, stakeholders referenced the increase of chronic and infectious diseases (i.e., obesity, diabetes, and HIV/AIDS). Stakeholders and focus group participants discussed accountability issues that are coupled with lack of awareness and education. Stakeholders and focus group participants focused their discussion on target populations such as the underserved/uninsured, children and elderly, and the working poor.

Areas of specific focus identified in the needs assessment include:

- *Prevention and health education with a focus on prevention of chronic diseases – especially diabetes and obesity*
- *Resident accountability*

Below, is the following data specific to the OMC region, including zip code/parish breakouts related to the identified need: 3) improved promotion of healthy lifestyles and behaviors (specific to chronic and infectious diseases) and accountability issues.

- ❑ In terms of rankings, data provided displays:
 - Washington, Terrebonne, St. Mary, Pearl River, Harrison, St. James, St. John the Baptist, and Tangipahoa parishes and counties all show a ranking above the median for health behaviors.
 - Washington Parish shows the highest ranking (i.e., unhealthiest) of 59 for health behaviors (sixth worst in the state).
 - St. Bernard, Washington, Orleans, Pearl River, Tangipahoa, St. John the Baptist and St. Mary parishes and counties all show a ranking above the median for morbidity.
 - St. Bernard Parish shows the highest ranking (i.e., unhealthiest) of 62 for morbidity (third worst in the state).
 - Terrebonne, St. John the Baptist, St. Mary, St. James, Lafourche, Washington, Tangipahoa, and Plaquemines parishes all show a ranking above the median for diet and exercise.
 - Terrebonne Parish shows the highest ranking (i.e., unhealthiest) of 64 for diet and exercise (the worst in the state).
 - Pearl River, St. James, Terrebonne, Harrison, St. Bernard, Livingston, Tangipahoa, St. Tammany, Hancock, Washington, and Lafourche parishes and counties all show a ranking above the median for alcohol use.
 - St. James Parish shows the highest ranking (i.e., unhealthiest) across the LA parishes of 64 for alcohol use (the worst in the state).
 - Orleans Parish shows the highest ranking (i.e., unhealthiest) across the LA parishes of 62 for family and social support (third worst in the state).
- ❑ In 2007 and 2008, St. John the Baptist Parish showed the highest rates, compared to the other study area parishes, for obesity.
 - However, Terrebonne Parish has shown rising obesity rates, to where, by 2009, Terrebonne Parish reports the highest obesity rate of 38.9% and the obesity rate for St. John the Baptist Parish declined from 38.9% in 2008 to 38.5% in 2009.
- ❑ Washington Parish reports the highest rate of residents aged 16 and older across the study area that have ever been diagnosed with: high blood pressure (35.8%),

diabetes (13.9%), asthma (11.2%), coronary heart disease (10.3%), heart attack or myocardial infarction (6.7%) and a stroke (4.8%).

- ❑ Lafourche Parish shows the highest rate of children aged 0-4 living in poverty compared to the other parishes in the study area.
 - Plaquemines Parish reports the highest rate of elderly (aged 65+) living in poverty compared with the other parishes in the study area.

- ❑ After the 2005 hurricanes, rates of residents going to their doctor declined across many of the parishes and rates of residents reporting that they go nowhere for healthcare increased for many of the parishes after the hurricanes.

- ❑ Specifically, regarding alcohol and drug use ratings, data provided displays:
 - St. Bernard Parish shows the highest rate of head of households reporting a serious mental health condition (17.8%).
 - Residents of Region 1 (Orleans, Plaquemines, and St. Bernard) report the highest rate of alcohol dependence as compared with the other regions in the study area (4.56% reporting in the past year).
 - Residents of Regions 2 and 9 (Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, St. Tammany, Tangipahoa, Washington, West Baton Rouge, and West Feliciana) report the highest rate of needing but not receiving treatment for alcohol use (8.6% of the pop reports this).

- ❑ St. James Parish reported the highest crime rates for aggravated assault from 2001 to 2003 but this rate was steadily declining. Tangipahoa Parish, on the other hand, has shown a rise in the rate of aggravated assault to see the highest rates for the service area in 2004 and 2005.
 - Tangipahoa Parish reports the highest rates as well as rising rates for burglary from 2002 to 2005.

The more than 100 community stakeholders specifically mentioned the following regarding perceived problems and/or barriers for residents in the service area:

- ❑ Stakeholder interview findings display residents' access to community/support services is an important community health priority.

- ❑ Community stakeholders perceived an increase in chronic disease such as hypertension, diabetes and obesity as the top trending health needs regionally,

along with a lack of healthy lifestyles and accessible healthcare for the under/uninsured.

Prevention and health education focused on prevention of chronic diseases – especially diabetes and obesity

- ❑ Stakeholders perceived the health status of many residents to be poor due to the limited education available and/or received on how to promote healthy living, specifically regarding chronic diseases. According to national data provided by the Centers for Disease Control and Prevention (CDC), diabetes is becoming more common in the United States. From 1980 through 2011, the number of Americans diagnosed with diabetes has more than tripled (from 5.6 million to 20.9 million).
- ❑ Stakeholder's perceived obesity and diseases associated with obesity (i.e., diabetes, cardiovascular disease, and high blood pressure) are leading health issues in the area, especially amongst the African American population.
- ❑ Stakeholders felt an increase in chronic disease such as hypertension; diabetes and obesity are all top trending health needs regionally. Some of the other health needs mentioned often by stakeholders were a lack of healthy lifestyles. Stakeholders stated they believed some residents are living unhealthy lifestyles and do not have an appropriate diet, nor are aware of what a healthy diet consists of. Overall, stakeholders believed there is a lack of knowledge of primary prevention and good health behaviors. Ultimately, stakeholders felt there is a lack of information/outreach on what resources are available in the community to help residents live healthy.
- ❑ Stakeholders believed Louisiana is #1 in obesity rankings and all related diseases caused by obesity issues, specifically within the youth population. Stakeholders shared there are heart disease issues, which is also part of the existing obesity problem.
- ❑ Stakeholders perceived more and more residents are accessing healthcare and they have disease states that are actually preventable. Stakeholders added, patient/consumer accountability is something that needs to be promoted more by all key leaders within the communities.

- ❑ Stakeholders believed the community as a whole (i.e., all age groups and socioeconomic levels) needs more education regarding preventive measures, such as healthy nutritional options and physical activity benefits/options.
- ❑ Overall, stakeholders believed there is a lack of preventive education regarding diet and exercise, specifically regarding how to control chronic illness due to lack of funding and resources.
- ❑ Stakeholders perceived certain populations, including minority populations and non-English speaking populations, do not seek services due to displacement and feeling that they are treated unfairly due to lack of understanding their cultural needs.
- ❑ Stakeholders perceived the health status of many residents to be poor due to the limited education available and/or received on how to promote healthy living. Specifically, stakeholders mentioned HIV/AIDS issues. The NO/AIDS Task Force released the numbers from the CDC's HIV Surveillance Report for 2010. The report defines the AIDS rate for cities and metro areas according to the number of cases per 100,000 population. In 2010, Baton Rouge, LA had the highest rate in the country, with 33.7 cases per 100,000 people. Among cities, Baton Rouge, LA and New Orleans, LA ranked second and third in rates of HIV infection per 100,000 people, with 43 and 36.9, respectively.

Focus group participants specifically mentioned the following regarding perceived problems and/or barriers for residents in the service area:

- ❑ Focus group participants from all 14 discussion groups felt barriers to access of healthy living options along with resident accountability existed within Greater New Orleans metropolitan area. Specifically mentioned were the following:

Prevention and health education with a focus on prevention of chronic diseases – especially diabetes and obesity

- ❑ Many focus group participants gave the impression healthy nutrition is limited. Focus group participants felt the prevalence of obesity is on the rise nationally for all people including children, which participants felt may be the result of cultural changes to a more sedentary behavior and generational traditions/behaviors. Additionally, participants gave the impression unhealthy behavior at times may be motivated by a variety of factors that are not always directly related to the behavior itself (e.g., overeating as a result of feeling

lonely). Furthermore, participants believed ultimately residents were largely responsible for their own health outcomes. Participants believed increasing availability of specific resources could ultimately increase individual accountability for personal health status and could improve the health status of residents.

- ❑ Participants were under the impression some residents do not have access to affordable healthy food options. Additionally, participants were under the impression unhealthy options may be more affordable than healthy options.
- ❑ Participants from all groups felt health education could be increased to residents of all ages. Many participants felt increasing health education could improve the accuracy of information that residents receive about medical care, which in turn could improve patient care.
- ❑ Some participants believed at times residents may have a limited awareness of the cause and effect of healthy and unhealthy options. Participants believed there has been a rise in lifestyle driven diseases (i.e., diabetes, hypertension, etc.), some of which may be controllable if residents are aware of and implement healthy behaviors (i.e., healthy eating habits, stress management, etc.).
- ❑ Participants believed the community could increase the awareness of available community services by increasing outreach efforts through television, community newspapers, internet, churches and schools. Participants believed increasing awareness of available community services could increase resident participation in the programs and services that are available.

Resident accountability

- ❑ Focus group participants felt some parents do not supervise their children adequately due to lengthy work hours. Some focus group participants felt unsupervised young people in their communities are more likely to participate in criminal activity. Participants were under the impression recreational programs for adolescents are limited in their community due to program closures, limited adult-supervision, and fees that can be unaffordable for some residents.

- Focus group participants felt some residents are not participating in available outreach/prevention programs or informing themselves about their own health status at the level participants felt they should. Some participants perceived residents may not participate in preventive outreach programs due to a perception that the information provided is not relevant and/or necessary. Additionally, some participants felt residents may not be informing themselves about their own health status enough to effectively interact with their primary care physicians during medical appointments. Participants felt on some level, residents are responsible for improving their own health status and that they may need to increase their participation in outreach/prevention programs and their efforts to inform themselves about their own health status.

Conclusions and Recommended Next Steps

The majority of community needs identified through the OMC community health needs assessment process are not directly related to the provision of traditional medical services provided by community hospitals. However, the top needs identified in this assessment do “translate” into a wide variety of health related issues that may ultimately require hospital services.

Common themes throughout the assessment speak to the need to increase access to affordable healthcare services, while simultaneously building a culture that supports healthy behaviors both at the individual and community levels. Larger scale issues like healthcare funding and the organization of public service agencies has been found to have a trickledown effect on neighborhoods and individuals.

For example, the average CNI score for the OMC service area is 3.7; this score falls above the average for the scale (3.0), indicating a higher than average number of barriers to healthcare access for the OMC service area. 63 of the 75 zip code areas (84%) in the OMC study area report CNI scores of 3.0 or higher indicating average or above average number of barriers to healthcare access. Specifically, the zip code area 70113 in New Orleans, LA reports the highest CNI score (along with 3 other zip code areas) in the OMC service area at 5.0 (e.g., worst possible for the scale); as well as reporting many of the highest CNI measures of the CNI score (i.e., New Orleans, LA (70113) shows many of the highest rates in the study area for the CNI measures: poverty 65+ (41.8%), childhood poverty (55.2%), no high school diploma (37.5%), unemployment (27.4%), uninsured (40.8%) and renting (78.5%). These areas present the highest community health risk as they have the greatest barriers to health care and generally have the poorest health among the region. Additionally, an increase in residents who are under/unemployed ultimately causes a decrease in their purchasing power. Individuals and families, including children, living in poverty is a large concern for certain areas of the region. Economic barriers often lead to the lack of preventive care, resulting in the need for more serious hospital services when care is ultimately provided.

Stakeholders and focus group participants perceive a decrease in available community services (i.e., public transportation, support services, such as preventive education outreach, etc.) potentially due to funding cuts. Furthermore, stakeholders and focus group participants mentioned they felt there is a lack of public transportation and healthy living options which can ultimately lead to inadequate diets contributing to chronic health conditions.

Needs identified include (not listed in any specific order):

- 1) Access to healthcare and medical services (i.e., primary, specialty, preventive, and mental)

- ✓ **Areas of specific focus** identified in the needs assessment include:
 - *Access to care: including primary, specialty, and preventive*
 - *Health insurance coverage*
 - *Cultural barriers*
 - *Physician shortage*
 - *Access to mental health services*

- 2) Access to community/support services to sustain a healthy and safe environment
 - ✓ **Areas of specific focus identified in the needs assessment include:**
 - *Prevention education and awareness*
 - *Community support infrastructure*
 - *Access to public transportation*
 - *Economic challenges*

- 3) Promotion of healthy lifestyles and behaviors (specific focus on chronic disease)
 - ✓ **Areas of specific focus** identified in the needs assessment include:
 - *Prevention and health education focused on prevention of chronic diseases – Especially diabetes and obesity*
 - *Resident accountability*

OMC, working closely with community partners, understands that the community health needs assessment document is only a first step in an ongoing process. OMC currently provides numerous services throughout the study area, but they also recognize it is vital that ongoing communication and a strategic process follow this assessment. Collaboration and partnerships are strong in the region and OMC understands it is important to expand existing partnerships and build additional partnerships with multiple regional organizations to develop strategies to create a plan to address the top identified needs. There are consistent areas of focus in the region as it relates to improved access to healthcare, behaviors that impact health, and community support services. The area is faced with poverty, chronic illness, limited educational attainment in some areas, mental health issues and substance abuse. Strategic discussions among hospital leadership as well as regional leadership will need to consider the interrelationship of the chronic issues facing the area, specifically obesity. It will be important to determine the cost effectiveness, future impact and limitations of any best practices methods. Implementation plans will give top priority to those strategies that will have the greatest influence in more than one need area to effectively address the needs of residents. Tripp Umbach recommends the following actions be taken by OMC in close partnership with community organizations over the next four to six months.

Additional data and greater detail related to an external inventory of available resources within the OMC community, that may provide programs and services to meet such needs is available upon request.

Recommended Action Steps:

- ❑ Results are presented widely to community residents (i.e., made available via the internet through the hospital website).
- ❑ Take an inventory of available resources in the communities that are available to help address the top community health needs identified by the community health needs assessment.
- ❑ Implement a comprehensive “grass roots” engagement strategy to build upon the resources that already exist in the communities and the energy of and commitment of community leaders that have been engaged in the community health needs assessment process.
- ❑ Develop “Working Groups” to focus on specific strategies to address the identified needs in the community health needs assessment.
- ❑ Attraction of outside funding and implementation of actions to address the top health needs on a regional level.
- ❑ Work at the hospital level and with local participating organizations to translate the top identified community health issues into individual hospital and community level strategic planning and community benefits programs.
- ❑ Within three years’ time conduct an updated community health needs assessment to evaluate community effectiveness on addressing top needs and to identify new community needs.