Lafayette General Health

St. Martin Hospital
Community Health Needs Assessment
Implementation Strategy

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Introduction

Implementation Strategy Process for St. Martin Hospital

The most recent Community Health Needs Assessment (CHNA) for St. Martin Hospital was adopted on September 17, 2019. The Implementation Strategy document will allow for ongoing assessment of relevant community health outcomes throughout St. Martin Parish.

Current Health Priorities for St. Martin Hospital

The six health needs identified through the CHNA will be addressed within the Implementation Strategy.

1. Weight Status and Nutrition
2. Mental Health and Substance Abuse
3. Access to Care
4. Cancer
5. Heart Disease and Risk Factors
6. Health Literacy

Implementation Strategy

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Community Health Need	Target Population		Strategy / Action Plan	Goals	Existing Partners	Potential Partners	Rationale
Weight Status and Nutrition	Whole Community	1	Promote increased physical activity	A) Have providers administer "prescriptions" for physical activity B) Support local walking clubs C) Provide free or low-cost gym memberships to certain patients			"There is strong evidence that medical prescriptions for physical activity increase physical activity and physical fitness (Muller-Riemenschneider 2008, Senter 2013). Prescriptions for physical activity, especially aerobic exercise and resistance training, have been shown to maintain mobility among older adults (Yeom 2009)." -County Health Rankings
Weight Status and Nutrition	Diabetics or individuals with pre-diabetes	2	Promote knowledge and understanding of nutrition	A) Continue to provide "Cajun Delights" nutrition classes B) Market the classes to diabetic patients and monitor participation rates	Council on Aging, local newspapers and media outlets		"Participating in a self-management education (SME) program can help individuals learn skills to manage their diabetes more effectively by checking blood sugar regularly, eating healthy food, being active, taking medicines as prescribed, and handling stress. SME programs have been shown to lower A1C levels, prevent or reduce diabetes complications, improve quality of live, and lower medical expenses." -CDC
Weight Status and Nutrition	Whole Community	3	Increase access to healthy foods and healthy menu options	A) SMH to continue to participate in the "Eat Fit" program B) SMH will explore partnerships to expand community members' access to healthy foods		Meal delivery programs, LSU AgCenter, summer feeding programs for school-aged children	"Access to foods that support healthy eating patterns contributes to an individual's health throughout his or her life. Healthy eating habits include controlling calories; eating a variety of foods and beverages from all of the food groups; and limiting intake of saturated and trans fats, added sugars, and sodium. Healthy eating can help lower the risk for chronic disease. Evidence also shows that poor nutrition and an unhealthy diet are risk factors for high blood pressure, diabetes, and cancer." -Healthy People 2020 "Ochsner Eat Fit encourages chefs to offer nutritious, delicious meals for those who want to eat clean, watch their weight, and manage diabetes, blood pressure and cholesterol. The program's goal is to empower the community to live their strongest, healthiest lives possible by providing easy-to-access real-world education, inspiration and resources on wellness and nutrition." -Ochsner Eat Fit

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Mental Health and Substance Abuse	Healthcare providers	4	Increase provider understanding of the negative effects of trauma on health and wellbeing	Host trauma-informed care trainings for healthcare providers		Trauma-Informed Care Implementation Resource Center (national)	"Trauma-informed care seeks to: Realize the widespread impact of trauma and understand paths for recovery; Recognize the signs and symptoms of trauma in patients, families, and staff; Integrate knowledge about trauma into policies, procedures, and practices; and Actively avoid re-traumatization." -Trauma Informed Care Implementation Resource Center
Mental Health and Substance Abuse	Whole Community	5	Ensure access to the appropriate level of psychiatric care	A) Collaborate with partners to streamline referrals to needed inpatient and outpatient services B) Facilitate access to psychiatric services through telemedicine	University Hospital and Clinics, Lafayette General Medical Center		"Although rates of mental health conditions are similar in urban and rural areas across the United States, rural communities have less availability of screening, treatment, and recovery services due to unique issues, such as workforce shortages and transportation obstacles." -Rural Health Information Hub
Mental Health and Substance Abuse	Individuals impacted by opioid use disorders	6	Increase access to opioid use disorder treatments	Partner with LSU Health Sciences to become an Office-Based Opioid Treatment site	LSU Health Sciences		"Researchers, federal health agencies, and pharmaceutical manufacturers have focused on developing medications that can be used to treat opioid addiction in medical office settings, rather than being limited to use only in specialized Opioid Treatment Programs (OTPs). As a result of those efforts, two major products are now available for use in office settings: buprenorphine (alone and in combination with naloxone) and naltrexone (in an oral formulation and an extended-release injectable formulation). These medications have been shown to be effective when used in office-based settings and thus to increase access to treatment for many patients who would not or cannot obtain care in OTPs." -Federation of State Medical Boards

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Access to Care	School-aged children	7	Improve access to preventative and primary care services	A) Continue to provide school-based telemedicine services B) Explore the implementation of behavioral health services via telemedicine	St. Martin Parish School District		"Utilization of telehealth technology may be a valuable tool to assist registered professional school nurses (herein referred to as a school nurse) to provide school health services. The health of many students is impacted by lack of access to primary care and specialty services due to health disparities caused by poverty and other social determinants of health. Technology and telehealth can assist the school nurse in addressing these issues." -National Association of School Nurses
Access to Care	Whole Community	8	Link community members to supportive services that impact social determinants of health	A) Explore referral technologies like the "Aunt Bertha" web-based platform B) Continue to share educational articles via local media outlets			"Aunt Bertha is free, open to the public, and easy to use so anyone can find help and connect with programs in just a few clicks. The company supports nonprofits with the Open Toolkit, a free dashboard of intake, referral, and analytics tools that empower them to help people in their communities more effectively." -Aunt Bertha
Access to Care	Medicaid enrollees, individuals without health insurance	9	Provide access to care facilities outside of the hospital's Emergency Department	The hospital's Community Health Clinic will begin to offer extended nighttime hours of operation in 2020			"The Community Health Clinic is a great place to visit for medical needs that cannot wait for an appointment. The Community Health Clinic sees patients on a “first come first served” basis, with limited wait time. Appointments are available but not necessary. The clinic currently accepts all Medicaid plans." -Lafayette General Health
Access to Care	Whole Community	10	Increase the number of individuals with a regular source of care	A) Connect inpatients and those seen through the Community Health Clinic with primary care providers B) Provide Medicaid enrollment assistance		Louisiana Department of Health	"According to the 20th report of the Council on Graduate Medical Education on Advancing Primary Care (www.hrsa.gov), research shows that health care outcomes and costs in the United States are strongly linked to the availability of primary care physicians. Patients with access to a regular primary care physician have lower overall health care costs than those without one, and health outcomes improve." -American Academy of Family Physicians

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Cancer	Individuals over the age of 45	11	Decrease colorectal cancer mortality rate	A) Provide free colorectal cancer screening kits B) Educate the public about colorectal cancer screening guidelines and risk factors		American Cancer Society, Miles Perret Cancer Services, Cancer Center of Acadiana	"Colorectal cancer almost always develops from precancerous polyps (abnormal growths) in the colon or rectum. Screening tests can find precancerous polyps, so that they can be removed before they turn into cancer. Screening tests can also find colorectal cancer early, when treatment works best." -CDC
Cancer	Whole Community	12	Provide high quality cancer care within the community	Expand the number of oncology services available in Breaux Bridge	LGH Oncology Services Department		"While 19% of the US population resides in rural areas, just 6% to 7% of oncology practices have a practice that includes a rural area, creating an access to care issue among older, sicker, and poorer populations... Patients in rural areas also often lack the resources needed to get to the appointment, including transportation. As a result, people in rural areas are diagnosed with cancer in later stages and, consequently, have higher mortality rates despite cancer incidence being comparable between rural and urban settings. " -American Journal of Managed Care 2019

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Community Health Need	Target Population		Strategy / Action Plan	Goals	Existing Partners	Potential Partners	Rationale
Heart Disease and Risk Factors	Whole Community	13	Prevent cardiovascular disease and diabetes, and promote chronic disease self-management	A) Screen individuals for cardiovascular disease and diabetes risk factors and indicators of disease for free or at a reduced cost B) Provide education to the public on the signs and symptoms of heart disease	Cardiovascular Institute of the South	American Heart Association	"Heart disease is the leading cause of death in men and women in the United States. Together, heart disease, stroke, and other vascular diseases claim over 800,000 lives each year. An estimated one in every seven US dollars spent on health care goes toward cardiovascular disease (CVD), totaling over $300 billion in annual health care costs and lost productivity from premature death each year. Several modifiable risk factors for CVD are well known, including hypertension, hyperlipidemia, smoking, being overweight, being inactive, and eating an unhealthy diet. Although treatments for hypertension and hyperlipidemia are very effective and relatively inexpensive, most people with these conditions do not have them under control." -CDC Division for Heart Disease and Stroke Prevention
Heart Disease and Risk Factors	Individuals at risk of developing heart disease or those with heart conditions	14	Reduce morbidity and mortality rates for cardiovascular disease	A) Via the new cath lab, provide diagnostics and treatments by Spring 2021 B) Continue to partner with CIS to provide 24/7 cardio coverage	Cardiovascular Institute of the South		"In 2014, many deaths among rural Americans were potentially preventable, including 25,000 from heart disease…and 4,000 from stroke. The percentages of deaths that were potentially preventable were higher in rural areas than in urban areas." -CDC
Heart Disease and Risk Factors	Smoking cessation program participants	15	Promote cardiovascular health	A) Encourage smoking cessation program enrollees to participate in the cardiovascular rehabilitation program B) Track participant crossover	Cardiovascular Institute of the South		"Smoking is a major cause of CVD and causes one of every three deaths from CVD. Smoking can: raise triglycerides, lower “good” cholesterol (HDL), make blood sticky and more likely to clot, which can block blood flow to the heart and brain, damage cells that line the blood vessels, increase the buildup of plaque in blood vessels, and cause thickening and narrowing of blood vessels." -CDC
Health Literacy	Older adults	16	Improve computer-based skills and health literacy	A) Educate providers to improve their ability to treat patients with low health literacy B) Collaborate with local nursing homes and assisted living facilities to provide education to older adults on how to navigate the healthcare system and how to utilize online health resources	Local nursing homes	CDC Train Health Literacy Training materials	The Patient Protection and Affordable Care Act of 2010, Title V, defines health literacy as the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions.

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Cross-Cutting - Cancer, Heart Disease and Risk Factors	Individuals who smoke	17	Decrease the number of parish residents who smoke	Counsel patients who smoke and encourage participation in a tobacco cessation program	Cardiovascular Institute of the South	LA Campaign for Tobacco-Free Living, 1-800-QUIT-NOW	"Tobacco use increases the risk for heart disease and heart attack: Cigarette smoking can damage the heart and blood vessels, which increases your risk for heart conditions such as atherosclerosis and heart attack. Nicotine raises blood pressure. Carbon monoxide from cigarette smoke reduces the amount of oxygen that your blood can carry. Exposure to secondhand smoke can also increase the risk for heart disease, even for nonsmokers." -CDC
Cross-Cutting - Health Literacy, Heart Disease and Risk Factors, Weight Status and Nutrition	Individuals at risk of negative chronic disease outcomes	18	Reduce chronic disease prevalence and the rate of complications	Continue to facilitate the "Road to Good Health" program, which includes education about behavioral risk factors, chronic disease, and healthy living		Diabetes Self-Management Program (DSMP)	One of the Healthy People 2020 Objectives is to "Increase the proportion of persons with diagnosed diabetes who received formal diabetes education."
Cross-Cutting - Access to Care, Mental Health and Substance Abuse	Incarcerated individuals	19	Improve access to integrated mental health services	Partner with the Parish jail system to provide on-site care including tele-psych services		NAMI	"In a mental health crisis, people are more likely to encounter police than get medical help. As a result, 2 million people with mental illness are booked into jails each year. Nearly 15% of men and 30% of women booked into jails have a serious mental health condition. The vast majority of the individuals are not violent criminals—most people in jails have not yet gone to trial, so they are not yet convicted of a crime. The rest are serving short sentences for minor crimes. Once in jail, many individuals don't receive the treatment they need and end up getting worse, not better. They stay longer than their counterparts without mental illness. They are at risk of victimization and often their mental health conditions get worse." -National Alliance on Mental Illness
Cross-Cutting - All	Whole Community	20	Improve knowledge and understanding through health communication	Publish weekly articles on various topics within the Teche News and via other local media outlets		Local social media campaigns	"Health communication includes verbal and written strategies to influence and empower individuals, populations, and communities to make healthier choices. Health communication often integrates components of multiple theories and models to promote positive changes in attitudes and behaviors. Health communication is related to social marketing, which involves the development of activities and interventions designed to positively change behaviors." -Rural Health Information Hub


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