Lafayette General Health

Lafayette General Medical Center Community Health Needs Assessment Implementation Strategy

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Table of Contents

Evaluation of Impact

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Advancements related to the 2016 Implementation Strategy for Lafayette General Medical Center

Health Need - Cancer

- Recruited multiple oncologists
- Increased the capacity of the LGMC infusion center
- Increased access to cancer care in Opelousas, Eunice, New Iberia, and Abbeville

Health Need - Obesity

- Expanded the bariatric surgery program at LGMC and developed a new program at UHC
- Offered educational classes to the public related to nutrition and physical activity

Health Need - Heart Disease

- Improved the hospital's capacity to care for open heart surgery patients
- Increased the number of procedures offered within LGMC's cardiovascular service line
- Upgraded the cardiac catheterization laboratory at LGMC

Health Need - Access and Availability

- Increased the number of case managers and social workers on staff at the LGMC Emergency Department
- Opened a discharge clinic at LGMC to ensure continuity of care for inpatients

Introduction

Implementation Strategy Process for Lafayette General Medical Center

The most recent Community Health Needs Assessment (CHNA) for Lafayette General Medical Center was a collaborative joint CHNA including Our Lady of Lourdes Regional Medical Center, Heart Hospital of Lafayette, Park Place Surgical Hospital, and Our Lady of Lourdes Women's and Children's Hospital. Many of the strategies and goals presented within this implementation strategy reflect shared priorities between these facilities. The Implementation Strategy document will allow for ongoing assessment of relevant community health outcomes throughout Acadiana.

Current Health Priorities for Lafayette General Medical Center

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

1. Access to Care
2. Cancer
3. Health Literacy
4. Heart Disease & Stroke
5. Nutrition & Weight Status
6. Mental Health / Behavioral Health
7. Physical Activity
8. Maternal & Child Health
9. Diabetes

Implementation Strategy

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Health Priority	Target Population	Strategy/Action Plan	Goals	Existing Partners	Potential Partners	Rationale
Access to Care	Medicaid-eligible individuals	Increase the percentage of eligible individuals who are enrolled in the Medicaid program	A) Develop a process for identifying individuals who may meet eligibility criteria, but are not currently enrolled in the Medicaid program B) Utilize embedded Medicaid enrollment specialists within hospital registration departments to offer patients enrollment assistance C) Explore the development of rural health care clinics in Gueydan and Henderson/Cecelia	Region 4 Office of Public Health, University Hospital & Clinics, Southwest LA Area Health Education Center		Those without health insurance are more likely to go without care or treatment prescribed to them. They are more likely to undergo avoidable hospitalizations, and have higher mortality rates. A lack of health insurance can also lead to medical debt.
Access to Care	Service area population	Provide preventative healthcare services through telemedicine where individuals work or go to school, live, and play	Continue to provide telemedicine care at Ossun Elementary and within the St. Martin Parish School System in Stevensville	LSU providers, Urgent Care Facilities, Community-based primary care clinics		Community Leaders expressed concern over transportation barriers faced by many individuals across the service area.
Access to Care	Low-income populations	Provide assistance with basic needs	Continue to provide qualifying patients with free- or low-cost services at LGH facilities	University Hospital and Clinics	SMILE Community Access Agency, Acadiana Transit, Acadiana Coalition on Homelessness and Housing, Volunteers of America, Social Service Network, One Acadiana, 232 Help	Individuals are not able to address chronic disease risk factors or seek preventative care and screenings while they have unmet basic needs.
Access to Care	Medicaid Recipients	Increase access to primary and specialty care	A) Recruit additional family medicine, women's services and internal medicine providers to serve the Medicaid population B) Provide urgent care services with expanded hours of operation C) LGH will open a new Community Health Care Clinic on Jefferson Street in Summer 2020 that will accept Medicaid D) Continue to market the services available at University Hospital and Clinics	University Hospital and Clinics, LSU Medical School	Iberia Comprehensive Community Health Centers	A lack of providers serving the Medicaid population was cited as a concern by community leaders. Focus group participants described long wait times, especially to see specialists. A lack of access to dental care, rehabilitation services, and mental health services was also noted in the analysis.
Access to Care	Service area population	Research which specific risk factors and Social Determinants of Health (SDOH) are linked with poor health outcomes in Acadiana	Explore the potential for collaboration with technology partners in order to collect data related to barriers to care within the EMR		Socially Determinant	Monitoring and Research are essential public health services as defined by the CDC's Core Public Health Functions Steering Committee. Collecting this information will lead to more precise targeting of sub-populations, and the development of more effective public health interventions within the community.
Access to Care	Service area population	Increase the number of individuals with a regular source of care	A) Provide telehealth services B) LGMC and UHC will continue to screen for patients who have social needs that are complicating their health issues, and the Beacon Project's Community Care Navigators will connect those patients with community sources for food, housing, jobs and more	SCP Health, The Beacon Project, Acadiana Healthcare Alliance		Reduction in preventable hospital admissions and unnecessary ED usage.

Implementation Strategy

Health Priority	Target Population	Strategy/Action Plan	Goals	Existing Partners	Potential Partners	Rationale
Cancer	Service Area Population	Increase the number of individuals screened for a variety of cancers	A) Provide patient and public education on screening recommendations B) Provide cancer screenings to the community	Miles Perret Cancer Services, Cancer Center of Acadiana, University Hospital and Clinics	Medical Laboratories	Early detection can lead to better outcomes for individuals with cancer. Community leaders and focus group participants expressed concern over low screening rates in sub-populations, and the affordability of screenings and diagnostic tests.
Cancer	Current Cancer Patients and Survivors	Provide support services for cancer patients and their family members	Provide or refer patients to programs offering peer-to-peer emotional support, health education, and assistance in navigating the healthcare system	Cancer Center of Acadiana Survivorship Program, Miles Perret Cancer Services, American Cancer Society, Komen Acadiana	Hospice of Acadiana	Cancer focus group participants expressed a need for additional one-on-one patient navigation and support services.
Cancer	Service Area Population	Provide high quality cancer care within the community	A) Recruit additional specialty providers to serve the community including through outreach locations B) Expand service line offerings C) Implement innovative team-based models of care		National associations, medical professional organizations	Community leaders discussed a need for additional cancer specialists within the service area.

Implementation Strategy

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Health Literacy	Individuals with low health literacy	Improve patient understanding of print and online resources	Provide clear communications that incorporate plain language in order to better engage individuals with lower levels of health literacy	University Hospital and Clinics	CDC Plain Language Resources and Clear Communication Initiative, MyChart	"Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions ... Plain language is a strategy for making written and oral information easier to understand. It is one important tool for improving health literacy." - NIH and HP2020

Implementation Strategy

Health Priority	Target Population	Strategy/Action Plan	Goals	Existing Partners	Potential Partners	Rationale
Heart Disease & Stroke	Individuals recently diagnosed with heart disease	Improve treatment adherence	Provide digital care management via "Get Well Loop" mobile apps and services		Cardiovascular Institute of the South	"The Community Preventive Services Task Force (CPSTF) recommends mobile health interventions to improve treatment adherence among patients recently diagnosed with cardiovascular disease. Sufficient evidence of effectiveness from included studies showed improvements in medication adherence, outpatient follow-up, and adherence to self-management goals."
Heart Disease & Stroke	Individuals at risk of heart disease	Improve early identification of heart disease	A) Screen individuals for cardiovascular disease and stroke risk factors and indicators B) Provide simultaneous health education C) Refer for treatment and follow up care	Cardiovascular Institute of the South, University Hospital and Clinics	School-based health centers, Emergency Departments	"A recent study showed that 40% of employees were not aware of the level of at least one of their cardiovascular disease (CVD) risk factors (high blood pressure, high cholesterol, and obesity). Furthermore, in another study, it is estimated that 36% of the US adult population with uncontrolled blood pressure (about 13 million people) are neither aware of their hypertension nor taking medications to control it." - CDC Workplace Health Resource Center
Heart Disease & Stroke	Individuals with high blood pressure	Improve blood pressure self-management	Through the CIS Virtual Care Center, provide on-demand care consultations, telecardiology services, Cardio@Home remote monitoring services, mobile communications regarding lab work or patient care, and the Chronic Care Management program	Cardiovascular Institute of the South		High blood pressure greatly increases your risk of heart disease and stroke. "Self-measured blood pressure monitoring can improve blood pressure outcomes in employees." - CDC Workplace Health Resource Center

Implementation Strategy

Health Priority	Target Population	Strategy/Action Plan	Goals	Existing Partners	Potential Partners	Rationale
Nutrition & Weight Status	Service Area Population	Increase access to healthy foods and healthy menu options	A) Provide healthy meals in LGH cafeteria locations B) Provide healthy options within hospital vending machines	EatFit Acadiana	Farm-To-Work programs, local farmers markets, community gardens, SNAP and WIC programs	Exposure to healthy options, in conjunction with marketing of healthy foods, can enable individuals to make more nutritious choices.
Nutrition & Weight Status	Individuals with obese weight status	Provide medical weight loss interventions	A) Continue to provide bariatric surgical care B) Expand support service referrals for patients who undergo bariatric procedures	LGH providers, University Hospital and Clinics		Bariatric surgery can assist patients in losing excess weight and reduce their risk of complications associated with an obese weight status.
Nutrition & Weight Status	Low-income populations	Reduce food insecurity	A) Through the Beacon Project, identify patients experiencing food insecurity and refer them to local resources B) LGH regularly places volunteers at local food banks	Local food banks	Acadiana Food Alliance, Farm-To-Work programs, local farmers markets, community gardens, SNAP and WIC programs	Local food insecurity rates have been relatively stable over the past 10 years. Those experiencing food insecurity may not be able to comply with treatment plans. Poor nutrition is a risk factor for chronic disease and can disrupt recovery or treatment for a variety of health conditions.

Implementation Strategy

Health Priority	Target Population	Strategy/Action Plan	Goals	Existing Partners	Potential Partners	Rationale
Mental Health / Behavioral Health	Youth and young adults	Screen for mental health conditions or risk factors	A) Utilize evidence-based screeners such as the ASQ (Ask Suicide-Screening Questions) in primary care, emergency, inpatient, and outpatient clinical care settings B) Refer patients for mental / behavioral health services		The Extra Mile, The Family Tree	The Ask Suicide-Screening Questions (ASQ) Toolkit is a free resource for medical settings (emergency department, inpatient medical/surgical units, outpatient clinics/primary care) that can help nurses or physicians successfully identify youth at risk for suicide.
Mental Health / Behavioral Health	Healthcare providers	Increase provider understanding of the negative effects of trauma on health and wellbeing	Provide trainings for healthcare providers to encourage self-efficacy related to identifying and addressing mental health concerns		Trauma-Informed Care Implementation Resource Center, Justice & Health Collaboration	Exposure to trauma — including abuse, neglect, systemic discrimination, and violence — increases an individual's risk for serious health issues and poor health outcomes throughout life. Trauma-informed care can improve patient outcomes, increase patient and staff resilience, and reduce avoidable healthcare service use and costs.
Mental Health / Behavioral Health	Caregivers	Support those caring for older adults or individuals with disabilities	Provide evidence-based education and support programs at the Neuroscience Center of Acadiana	Alzheimer's Association of Acadiana	Nursing homes, Local Area Agencies on Aging	Community leaders described the chronic stress that many personal caregivers face. National and state programs have limited funding and years long waitlists. Caregivers throughout the community need additional resources to promote their own mental health and wellbeing.

Implementation Strategy

Health Priority	Target Population	Strategy/Action Plan	Goals	Existing Partners	Potential Partners	Rationale
Physical Activity	Children	Increase access to physical activity opportunities	A) Support school-based physical fitness and health education B) Support extra-curricular activities through the LGMC Employee Community Service Program C) Advocate for "shared use" or "joint use" agreements across the service area D) Support St. Martin Hospital's "Road to Good Health" Program	One Acadiana, Boys and Girls Club of Acadiana	Local governments (complete street initiatives), Kiwanis Club of Lafayette	"Shared use is seen as a promising strategy to address issues of physical inactivity and obesity across the country. In addition, shared use has been recommended by leading public health authorities, including the Centers for Disease Control Prevention, the U.S. Department of Health and Human Services and the American Academy of Pediatrics. These organizations recommend sharing existing school and community recreational facilities to promote opportunities for Physical Activity." - Safe Routes to School National Partnership
Physical Activity	Service area population	Increased physical activity and physical fitness	A) Conduct community-wide physical activity campaigns and events B) Continue to participate in Healthy Acadiana initiatives including those related to physical activity	Region 4 Office of Public Health, Acadiana Health Coalition, Healthy Acadiana, University Hospital and Clinics		"There is strong evidence that community-based social support interventions for physical activity increase physical activity and physical fitness among adults. Such interventions have also been shown to provide health benefits such as reductions in indicators of cardiovascular risk, including reduced blood pressure, body mass index (BMI), and total cholesterol, and depression symptoms." - County Health Rankings, What Works for Health

Implementation Strategy

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Maternal and Child Health	Pregnant women and infants	Increase breastfeeding rates	A) Facilitate breastfeeding promotion programs B) Encourage workplace supports for breastfeeding as a designated Baby-Friendly Facility C) Offer outpatient lactation consults D) Provide a milk bank depot where approved donors can bring their frozen breast milk to donate to recipients across the country	Mother's Milk Bank in Austin, TX	Local corporations and businesses, WIC, La Leche League, Maternal and Child Health Taskforce (ULL partnership)	"There is strong evidence that breastfeeding promotion programs increase initiation, duration, and exclusivity of breastfeeding. Support from health professionals, lay health workers, and peers have demonstrated positive effects, including increases in initiation, duration, and exclusivity of breastfeeding. For employed mothers, supportive work environments also increase the duration of breastfeeding." - County Health Rankings
Maternal and Child Health	Pregnant women	Improve prenatal care and knowledge, attitudes, and skills	A) Provide childbirth, breastfeeding, and infant care education classes at LGMC B) Support programs and technologies that provide health education for pregnant women	LGH Obstetrics Service Line	Text4baby, WIC	"On four critical topics – safe sleep, infant feeding, best time to deliver in a healthy pregnancy, and the meaning of full-term – Text4baby participants in the HRSA evaluation demonstrated a significantly higher level of health knowledge than comparison groups. The program also improves access to health services, promotes conversations with healthcare providers, and helps pregnant women prepare for motherhood. " - Text4baby
Maternal and Child Health	Infants and children	Promote literacy and learning	Refer parents to the United Way's Dolly Parton's Imagination Library Program that donates children's books to eligible families	United Way of Acadiana	AAP Books Build Connections Toolkit, Local public libraries, Early Start, Kiwanis Club of Lafayette	"Pediatricians can translate the science of Early Brain and Child Development into their clinical practice by focusing on fostering safe, stable, nurturing early relationships. By promoting early literacy, pediatric professionals can help support optimal early brain and child development." - AAP Literacy Resources

Implementation Strategy

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Diabetes	Individuals with type 2 diabetes	Improve health outcomes and reduce diabetes-related complications	A) Implement team-based care for treatment of patients with diabetes B) Offer retinal screenings, self-management classes and educational programs at the LGMC Diabetes Clinic			"The Community Preventive Services Task Force recommends team-based care to control type 2 diabetes by improving patients' blood glucose (measured using A1c levels), blood pressure, and lipid levels. The Task Force recommendation is based on evidence from a systematic review of 35 studies (search period 1960– October 2015) that evaluated the impact of team-based care on blood glucose, blood pressure, and lipids." - Community Preventive Services Task Force

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Cross Cutting - All Priorities	Service Area Population	Improve quality of life and health outcomes	1) Utilize tools embedded within the EMR to identify patients in need of care management services 2) Provide chronic care management services for patients meeting CMS criteria and those who have been identified as high risk		Healthy Acadiana	"Care management has emerged as a primary means of managing the health of a defined population. Unlike case management, which tends to be disease-centric and administered by health plans, CM is organized around the precept that appropriate interventions for individuals within a given population will reduce health risks and decrease the cost of care." - AHRQ
Cross-Cutting: Access to Care, Heart Disease, Maternal & Child Health	Rural or medically underserved populations	Provide healthcare in rural or hard-to-reach areas	A) Increase the utilization of telemedicine technologies to provide care in a variety of settings B) Explore the development of rural health care clinics in Gueydan and Henderson/Cecelia	LGH partnerships with Cardiovascular Institute of the South and local school districts	Worksites, FQHCs	Reduce poor health outcomes associated with long transportation times (ex. stroke outcomes) and provide care to those who lack adequate transportation
Cross-Cutting: Access to Care, Heart Disease, Diabetes	Service Area Population	Provide free or low-cost medications	A) Continue to administer a retail pharmacy at UHC for qualifying patients B) Refer patients to partner organizations and external programs that may lower the cost of prescriptions C) Consider the use of alternate treatments in individuals at risk of non-compliance	University Hospital and Clinics	Payors, pharmaceutical companies, Seniors program	Community leaders expressed concern over the high costs of certain prescription medications. Research shows eliminating copayment for medications and concurrent disease management support can lead to increased patient compliance.
Cross Cutting - Nutrition & Weight Status, Physical Activity	Healthcare providers	Coach patients to encourage healthy behavior change	A) Increase provider self-efficacy to coach patients to make behavior changes B) Utilize telehealth and technological interventions C) Implement "healthy food prescription" and "exercise prescription" programming		FQHCs	Providers could utilize skills like motivational interviewing during patient interactions to effectively encourage positive behavior change. Telehealth programs coaching chronic disease patients to decrease sodium and fat intake and to increase fruit and vegetable intake have been proven effective. The utilization of "Healthy Food Prescriptions" or "Food Pharmacies" are emerging best practices.
Cross Cutting - Physical Activity, Nutrition, Access to Care, Cancer, Heart Disease	Employers	Improve chronic disease rates	Promote robust healthy workplace initiatives		CDC Workplace Health Resource Center, Corporations (ex. Abreco)	"On average, an employee with CVD costs his or her employer over a week in absences and $1,100 more on lost productivity each year than an employee without CVD. Conducting health screenings and referrals in the workplace is a promising strategy for early detection of CVD risk factors, with the goal of preventing the onset of CVD, or managing CVD for those who have been diagnosed. In particular, screenings may motivate employees to seek healthcare if they were previously unaware of their risk factors. Employer healthcare costs can be avoided through worksite-based health screening. Employers can achieve a positive return on investment when employee health screening is offered with a well-designed comprehensive health and wellness program, estimated at approximately $2.50 – $10.00 saved due to reduced absenteeism and medical costs per $1 invested in wellness activities." - CDC Workplace Health Resource Center
Cross Cutting - Heart Disease, Cancer	Individuals who smoke	Promote smoking cessation	A) Counsel patients who smoke B) Refer patients who smoke to supportive services including those offered by Cardiovascular Institute of the South	Cardiovascular Institute of the South, LA Campaign for Tobacco-Free Living, 1-800-QUIT-NOW	Local governments (smoke free ordinances)	Smoking is a modifiable risk factor for cancer and heart disease.


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