Lafayette General Health

Acadia General Hospital
Community Health Needs Assessment
Implementation Strategy

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Introduction

Implementation Strategy Process for Acadia General Hospital

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

Current Health Priorities for Acadia General Hospital

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

1. Heart Disease and Risk Factors
2. Social Determinants of Health
3. Access to Care
4. Mental Health and Substance Abuse
5. Weight Status

Implementation Strategy

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Health Priority	Target Population		Strategy/Action Plan	Goals	Existing Partners	Potential Partners	Rationale
Heart Disease and Risk Factors	Individuals with Diabetes	1	Reduce diabetes-related complications	A) Conduct regular diabetes education classes on campus and within the community B) Market classes to providers and community-based organizations		Diabetes Self-Management Education and Support (DSMES), Diabetes Self-Management Program (DSMP), SWLA Clinic, faith-based organizations	"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 life, and lower medical expenses." - CDC
Heart Disease and Risk Factors	Individuals with high blood pressure or heart conditions	2	Improve blood pressure self-management and cardiovascular treatment adherence. Reduce cardiovascular complications	Through the CIS Virtual Care Center, provide on-demand care consultations, telecardiology services	Cardiovascular Institute of the South	American Heart Association	"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
Heart Disease and Risk Factors	Individuals recently diagnosed with heart disease	3	Improve treatment adherence and medication compliance	Provide digital care management via "Get Well Loop" mobile apps and services			"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."
Social Determinants	Hospital inpatients	4	Address basic needs to reduce readmissions and improve treatment adherence	A) AGH will continue to screen patients for social needs through case management B) Beacon Project Community Care Navigators will connect identified patients with community resources for food, housing, jobs, and more	The Beacon Project		According to the CDC, the social determinants of health (SDOH) are defined as “conditions in the places where people live, learn, work, and play.” "A growing body of research shows that lifestyle has a major effect on a person’s well-being. As a result, hospitals have become revolving doors for patients who are struggling with multiple issues, like homelessness, chronic health conditions, or serious mental illnesses." - The Beacon Project
Social Determinants	Primary care and ED patients	5	Address basic needs to prevent chronic disease and other negative health outcomes	Explore the use of social workers within the emergency department		AAFP (EveryONE Project), SWLA Clinic (FQHC), Aunt Bertha, FamilyDoctor.org Neighborhood Navigator	"Non-medical social needs, or social determinants of health (SDOH), have a large influence on an individual’s health outcomes. For the medical community to have a significant and lasting impact on the health of their patients and communities, it must address the needs of patients outside the clinic walls." - American Academy of Family Physicians

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Health Priority	Target Population		Strategy/Action Plan	Goals	Existing Partners	Potential Partners	Rationale
Access to Care	Rural communities	6	Provide healthcare in rural or hard-to-reach areas	In partnership with the LGH system administration, explore the development of rural health care clinics to place physicians in underserved areas	LGH System		Acadia Parish is designated as a partially rural Medically Underserved Area by the Health Resources and Services Administration.
Access to Care	Older adults	7	Provide coordinated, quality emergency care for older adults	A) Complete the requirements to become an accredited geriatric emergency department B) Provide education for community providers and first responders related to geriatric emergency care	First responders	American College of Emergency Physicians	"Geriatric EDs embrace a variety of best practices including: a) Ensuring geriatric-focused education and interdisciplinary staffing b) Providing standardized approaches to care that address common geriatric issues c) Ensuring optimal transitions of care from the ED to other settings (inpatient, home, community-based care, rehabilitation, long-term care) d) Promoting geriatric-focused quality improvement and enhancements of the physical environment and supplies. Becoming a geriatric ED will improve the care provided to older people in the ED and ensure the resources to provide that care are available. It also signals to the public that the institution is focused on the highest standards of care for the community's older citizens." - American College of Emergency Physicians
Access to Care	Low-income and medically underserved populations	8	Improve medication affordability to encourage compliance	Continue to participate in the 340B Drug Pricing Program to provide discounted medications to patients	Local pharmacies		"The 340B Program enables covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." - Health Resources and Services Administration
Mental Health and Substance Abuse	Individuals at risk of suicide	9	Reduce suicide rates	Continue to utilize the Columbia Protocol (Columbia-Suicide Severity Rating Scale) to identify at-risk patients in need of psychiatric care		Compass Behavioral Health	"The Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS), supports suicide risk assessment through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs." - The Columbia Lighthouse Project
Mental Health and Substance Abuse	Community residents	10	Reduce stigma and increase the number of individuals who receive needed mental health and substance abuse treatment	A) Provide education for healthcare providers on how to identify patients in need of mental health or substance abuse support and resources B) Educate the general public on topics related to mental health and substance abuse C) Maintain local referral resources		Compass Behavioral Health	"Community education can help to reduce stigma surrounding mental health conditions and promote a positive mental health environment. Training sessions can be formal classes regarding constructive mental health promotion or informal conversations between community members. Change in the perception of mental health often starts with individuals; moves to families, the workplace, and schools; and ends with community leaders who are then equipped to maintain formal and informal community education efforts surrounding mental health." - Rural Health Information Hub

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Weight Status	Children and young adults	11	Provide opportunities for physical activity and nutrition education	A) Sponsor local events, clubs, or programs that promote physical activity and nutrition B) Educate parents of young children about physical fitness and nutrition through regular events like the Wacky Olympics and Halloween Giveaway	SWLA Clinic (FQHC)	Local food banks, Farm-To-Work programs, local farmers markets, community gardens, SNAP and WIC programs	"Children with obesity can be bullied and teased more than their normal weight peers. They are also more likely to suffer from social isolation, depression, and lower self-esteem. The effects of this can last into adulthood. Children with obesity are at higher risk for having other chronic health conditions and diseases, such as asthma, sleep apnea, bone and joint problems, and type 2 diabetes. Children with obesity also have more risk factors for heart disease like high blood pressure and high cholesterol than their normal weight peers. Children with obesity are more likely to have obesity as adults." - CDC
Cross Cutting: Weight Status, Heart Disease and Risk Factors	Hospital employees and their families	12	Improve nutrition knowledge, skills, and understanding	A) Offer a corporate wellness program to AGH employees and beneficiaries B) Include engaging health education sessions in regular employee health fairs C) Promote healthy eating with messaging and demonstrations at the hospital's cafeteria		CDC Workplace Health Resource Center	"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: Social Determinants and Access to Care	Uninsured and underinsured individuals	13	Increase the number of individuals with a regular source of primary care	A) Continue to provide qualifying patients with select free or low-cost services at AGH B) Educate patients about services offered at SWLA Clinic and make referrals C) Explore the potential for increased partnership with local FQHCs and clinics providing sliding fee scale services or free services	SWLA Clinic (FQHC)		"Primary care providers offer a usual source of care, early detection and treatment of disease, chronic disease management, and preventive care. Patients with a usual source of care are more likely to receive recommended preventive services such as flu shots, blood pressure screenings, and cancer screenings. However, disparities in access to primary health care exist, and many people face barriers that decrease access to services and increase the risk of poor health outcomes. Some of these obstacles include lack of health insurance, language-related barriers, disabilities, inability to take time off work to attend appointments, geographic and transportation-related barriers, and a shortage of primary care providers. These barriers may intersect to further reduce access to primary care. Primary care is critical for improving population health and reducing health disparities. ' - Healthy People 2020

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Cross Cutting: Social Determinants and Access to Care	School-aged children	14	Improve access to preventative and primary care services	Provide school-based telemedicine services through a grant program	LGH System Providers, Grantor		"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
Cross Cutting - All	Community residents	15	Engage stakeholders in collaborative problem solving and grassroots-level initiatives to achieve the goals contained within the implementation strategy	A) Conduct regular Community Advisory Meetings B) Conduct presentations at local civic organizations C) Gather feedback related to the CHNA and Implementation Strategy from community members and local stakeholders		Community-based organizations + local residents who have a passion for or are inquisitive about health-related topics	Community Advisory meetings serve as a platform for stakeholders to advise the hospital on issues of interest to the broader community. Through regular engagement with community members, the hospital can partner with individuals within the service area and local organizations to achieve the community benefit goals laid out within the Implementation Strategy.


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