

# COMMUNITY HEALTH IMPROVEMENT PLAN



 **Ochsner**

 **CHRISTUS**  
Health<sup>®</sup>

# Table of contents

- Introduction..... 3**
- CHRISTUS SWLA Overview..... 4**
- Communities of Focus..... 5**
- Statement of Health Equity ..... 6**
- Community Health Needs Assessment ..... 7**
  - Stakeholder Engagement..... 8
  - Data Collection..... 8
  - Community Resident Surveys..... 9
  - Community Focus Groups and Key Informant Interviews..... 9
  - Secondary Data..... 10
- Health Issue Prioritization Process ..... 10**
- Data Needs and Limitations ..... 11**
- Health Priority Areas..... 12**
  - Approach to Community Health Improvement Plan..... 14
  - Community Benefit Report Communication..... 14
  - Health Priority Area 1: Advance Health & Wellbeing..... 15
  - Health Priority Area 2: Build Resilient Communities & Improve Social Determinants..... 18
- Appendix 1: Advance Health & Wellbeing..... 20**
  - Specialty Care and Chronic Conditions..... 20
  - Behavioral Health ..... 22
- Appendix 2: Build Resilient Communities & Improve Social Determinants..... 23**
  - Improving Food Access..... 23
  - Reducing Smoking and Vaping ..... 25



# INTRODUCTION



# Introduction

The Community Health Needs Assessment is a systematic, data-driven approach to determine the health needs in the service area of the CHRISTUS Ochsner Health Southwest Louisiana (CHRISTUS SWLA). In this process, CHRISTUS SWLA directly engages community members and stakeholders to identify the issues of greatest need as well as the largest impediments to health. With this information, CHRISTUS SWLA can better allocate resources towards efforts to improve community health and wellness.

Directing resources toward the greatest needs in the community is critical to CHRISTUS SWLA's work as a nonprofit hospital. The important work of CHNAs was codified in the Patient Protection and Affordable Care Act added Section 501(r) to the Internal Revenue Service Code, which requires nonprofit hospitals, including CHRISTUS SWLA, to conduct a CHNA every three years. CHRISTUS SWLA completed similar needs assessments in 2012, 2015 and 2018.

The process CHRISTUS SWLA used was designed to meet federal requirements and guidelines in Section 501(r), including:

- clearly defining the community served by the hospital, and ensuring that defined community does not exclude low-income, medically underserved, or minority populations in proximity to the hospital;
- providing a clear description of the CHNA process and methods; community health needs; collaboration, including with public health experts; and a description of existing facilities and resources in the community;
- receiving input from persons representing the broad needs of the community;
- documenting community comments on the CHNA and health needs in the community; and
- documenting the CHNA in a written report and making it widely available to the public.

The following report provides an overview of the process and approach used for this Community Health Improvement Plan, including communities of focus, community health needs assessment and health prioritization process and the health priorities areas.

When assessing the health needs for the entire CHRISTUS SWLA's area, the CHNA data is presented by zip code and county depending on the available data. Providing localized data brings to light the differences and similarities within the communities in the CHRISTUS SWLA's service area.

## CHRISTUS SWLA Overview

In the early 1900s, Lake Charles, LA was the center of a growing lumber industry, yet it had no hospitals. Seeing the need for a quality medical facility, John Greene Martin, M.D., president of the local medical society, and Rev. Hubert Cramers, rector of Immaculate Conception Church, set about to provide for one. They approached the Sisters of Charity of the Incarnate Word in Galveston, Texas, for help in setting up a hospital in Lake Charles like the one the sisters had established in Galveston. When the hospital was finished, Dr. Martin, a native of Ireland, insisted that it be named after St. Patrick, the patron saint of his homeland.

The new three-story hospital was dedicated on St. Patrick's Day in 1908 as St. Patrick Sanitarium, with 50 beds, an operating room and a sterilizing room. The name was later changed to St. Patrick Hospital which has continued its tradition of dedication and quality medical care for almost 100 years.

Since 2018 CHRISTUS Health and Ochsner Health System have operated a joint venture for the people of Southwest Louisiana. The joint venture includes two hospitals, a charitable foundation, an ambulatory surgery center, imaging centers, and clinics. CHRISTUS Health manages the hospitals, CHRISTUS Ochsner St. Patrick and CHRISTUS Ochsner Lake Area, while Ochsner manages all physician and clinic operations.

Over the years, CHRISTUS Ochsner Health has received many awards for excellence and earned The Joint Commission's Gold Seal of Approval and the American Heart Association/American Stroke Association's Heart-Check mark for Advanced Certification for Primary Stroke Centers.

CHRISTUS Health is a Catholic health system formed in 1999 to strengthen the faith-based health care ministries of the Congregations of the Sisters of the Incarnate Word of Houston and San Antonio that began in 1866. In 2016, the Sisters of the Holy Family of Nazareth became the third sponsoring congregation to CHRISTUS Health. Today, CHRISTUS Health operates 25 acute care hospitals and 92 clinics in Texas. CHRISTUS Health facilities are also located in Louisiana, Arkansas, and New Mexico. It also has 12 international hospitals in Colombia, Mexico and Chile. As part of CHRISTUS Health's mission "to extend the healing ministry of Jesus Christ," CHRISTUS SWLA strives to be, "a leader, a partner, and an advocate in the creation of innovative health and wellness solutions that improve the lives of individuals and communities so that all may experience God's healing presence and love."

# Communities of Focus

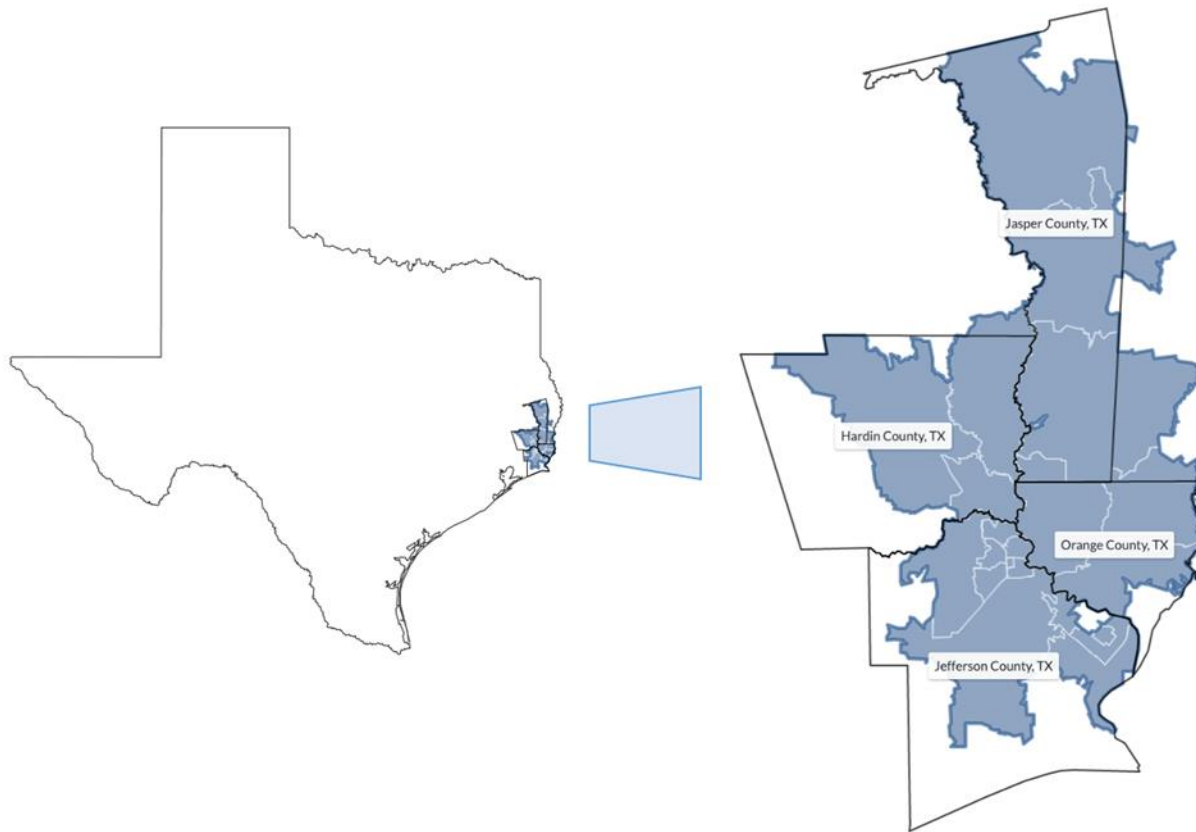
Following IRS guidelines, 501(r) rules as required by the Affordable Care Act, CHRISTUS SWLA's CHNA service area includes 10 zip codes covering over 230,000 individuals (Table 1). The primary service area (PSA) is the geographic region with 80% of hospital utilization. The primary service area zip codes are located in the following parishes: Beauregard and Calcasieu (Figure 1).

While the hospital is dedicated to providing exceptional care to all of the residents in South West Louisiana, CHRISTUS SWLA will use the information in this assessment to strategically establish priorities and commit resources to address the key health issues for the cities and municipalities that comprise the region.

CHRISTUS SWLA PSA	
Beauregard Parish	Calcasieu Parish
70634	70669, 70665, 70663
	70647, 70615, 70611
	70607, 70605, 70601

Table 1. Primary Service Area of CHRISTUS SWLA





*Figure 1. Map of Primary Service Area of CHRISTUS SWLA*

## Statement of Health Equity

While community health needs assessments (CHNA) and Improvement Plans are required by the IRS, CHRISTUS SWLA has historically conducted CHNAs and developed Improvement Plans as a way to meaningfully engage with our communities and plan our Community Health & Social Impact work. Community Health & Social Impact promotes optimal health for those who are experiencing poverty or other vulnerabilities in the communities we serve by connecting social and clinical care, addressing social needs, dismantling systemic racism, and reducing health inequities. CHRISTUS Health has adopted the Robert Wood Johnson Foundation's definition of Health Equity - "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

# COMMUNITY HEALTH NEEDS ASSESSMENT



# Community Health Needs Assessment

## Stakeholder Engagement

The CHNA process involved engagement with several internal and external stakeholders to collect, curate and interpret primary and secondary data. That data was then used to prioritize the health needs of the community. For this component, CHRISTUS SWLA worked with Metopio, a software and services company that is grounded in the philosophy that communities are connected through places and people. Metopio's tools and visualizations use data to reveal valuable, interconnected factors that influence outcomes in different locations.

Leaders from the CHRISTUS SWLA guided the strategic direction of Metopio through roles on various committees and workgroups.

CHRISTUS SWLA and Metopio relied on the expertise of community stakeholders throughout the CHNA process. The health system's partners and stakeholder groups provided insight and expertise around the indicators to be assessed, types of focus group questions to be asked, interpretation of results and prioritization of areas of highest need.

The Community Benefit Team is composed of key staff with expertise in areas necessary to capture and report CHRISTUS SWLA community benefit activities. This group discusses and validates identified community benefit programs and activities. Additionally, the team monitors key CHNA policies, provides input on the CHNA implementation strategies and strategic improvement plan, reviews and approves grant funding requests and provides feedback on community engagement activities.

Input from community stakeholders was also gathered from CHRISTUS SWLA's community partners. These partners played a key role in providing input to the survey questions, identifying community organizations for focus groups, survey dissemination and ensuring diverse community voices were heard throughout the process.

The CHRISTUS SWLA leadership team developed parameters for the 2023-2025 CHNA process that help drive the work. These parameters ensure that:

- the CHNA builds on the prior CHNA from 2020-2022 as well as other local assessments and plans;
- the CHNA will provide greater insight into community health needs and strategies for ongoing community health priorities;
- the CHNA leverages expertise of community residents and includes a broad range of sectors and voices that are disproportionately affected by health inequities;
- the CHNA provides an overview of community health status and highlights data related to health inequities;
- the CHNA informs strategies related to connections between community and clinical sectors, anchor institution efforts, policy change, and community partnerships; and
- health inequities and their underlying root causes are highlighted and discussed throughout the assessment.

## Data Collection

CHRISTUS SWLA conducted its CHNA process between September 2021 and March 2022 using an adapted process from the Mobilizing for Action through Planning and Partnerships (MAPP) framework. This planning framework is one of the most widely used for CHNAs. It focuses on community engagement, partnership development and seeking channels to engage people who have often not been part of decision-making processes. The MAPP framework was developed in 2001 by the National Association for County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC).



Primary data for the CHNA was collected through four channels:

- Community resident surveys
- Community resident focus groups
- Health care and social service provider focus groups
- Key informant interviews

Secondary data for the CHNA were aggregated on Metopio's data platform and included:

- Hospital utilization data
- Secondary sources including, but not limited to, the American Community Survey, the Decennial Census, the Centers for Disease Control, the Environmental Protection Agency, Housing and Urban Development and the Louisiana Department of Public Health.

## Community Resident Surveys

Between October and December of 2021, 337 residents in the CHRISTUS SWLA PSA provided input to the CHNA process by completing a community resident survey. The survey was available online and in paper form in English and Spanish. Survey dissemination happened through multiple channels led by CSETHS and its community partners. The survey sought input from priority populations in the CHRISTUS SWLA PSA that are typically underrepresented in assessment processes, including communities of color, immigrants, persons with disabilities, and low-income residents. The survey was designed to collect information regarding:

- Demographics of respondents
- Health needs of the community for different age groups
- Perception of community strengths
- Utilization and perception of local health services

The survey was based on a design used extensively for CHNAs and by public health agencies across the country. The final survey included 26 questions.

## Community Focus Groups and Key Informant Interviews

A critical part of robust, primary data collection for the CHNA involved speaking directly to community members, partners and leaders that live in and/or work in the CHRISTUS SWLA PSA. This was done through focus groups and key informant interviews.

During this CHNA, CHRISTUS SWLA held two local focus groups, one covering Adult Health and the other Maternal and Child Health, and joined two system wide focus groups. All focus groups were coordinated by CHRISTUS SWLA and the CHRISTUS system office and facilitated by Metopio. CHRISTUS SWLA sought to ensure groups included a broad range of individuals from underrepresented, priority populations in the CHRISTUS SWLA. Focus group health topic areas are listed below:

- Adult health
- Maternal and child health
- Health care and social service providers
- Behavioral health

## Secondary Data

CHRISTUS SWLA used a common set of health indicators to understand the prevalence of morbidity and mortality in the CHRISTUS SWLA PSA and compare them to benchmark regions at the state and the full CHRISTUS Health service area. Building on previous CHNA work, these measures have been adapted from the County Health Rankings MAPP framework (Figure 2). Where possible, CHRISTUS SWLA used data with stratifications so that health inequities could be explored and better articulated. Given the community input on economic conditions and community safety, CHRISTUS SWLA sought more granular datasets to illustrate hardship.

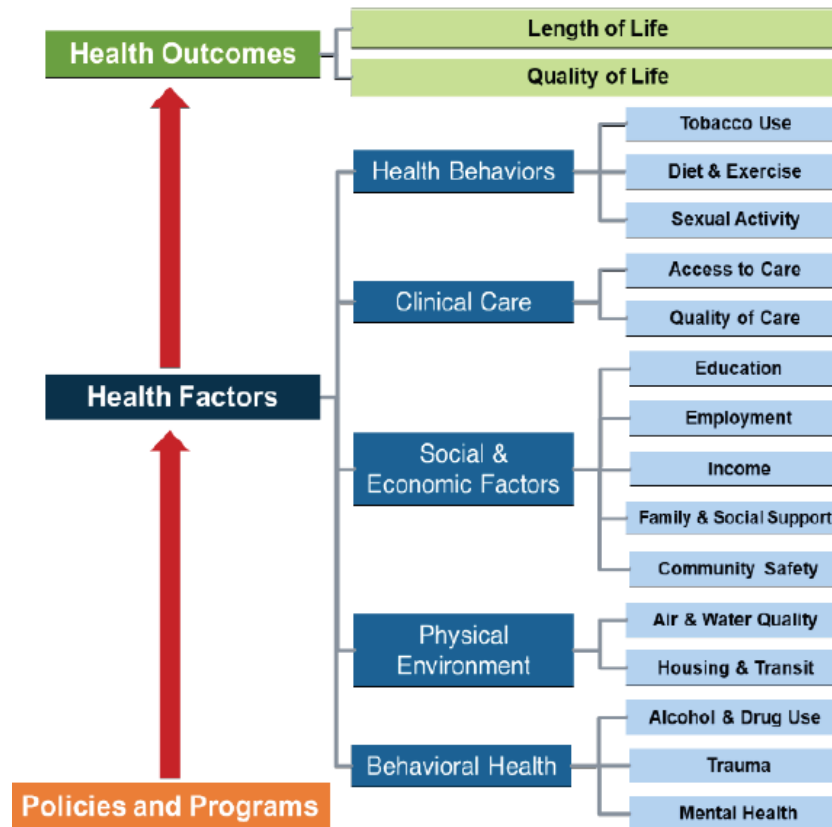


Figure 2. Illustration of County Health Rankings MAPP Framework

## Health Issue Prioritization Process

The Community Benefit team worked with the hospital leadership and community partners to prioritize the health issues of community benefit programming for fiscal years 2023-2025. These groups of internal and external stakeholders were selected for their knowledge and expertise of community needs. Using a prioritization framework guided by the MAPP framework, the process included a multi-pronged approach to determine health issue prioritization.

1. The team reviewed health issue data selected by the community survey respondents.
2. The team scored the most severe indicators by considering existing programs and resources.
3. The team assigned scores to the health issue based on the Prioritization Framework (Table 2). The highest-scoring health issues were reconciled with previous cycles' selected priorities for a final determination of priority health issues.
4. The team discussed the rankings and community conditions that led to the health issues.

SIZE	How many people are affected?	Secondary Data
SERIOUSNESS	Deaths, hospitalizations, disability	Secondary Data
EQUITY	Are some groups affected more?	Secondary Data
TRENDS	Is it getting better or worse?	Secondary Data
INTERVENTION	Is there a proven strategy?	Mission team
INFLUENCE	How much can CSETX affect change?	Mission team
VALUES	Does the community care about it?	Survey, Focus Groups, Key Informant Interviews
ROOT CAUSES	What are the community conditions?	Mission team

*Table 2. Prioritization Framework*

## Data Needs and Limitations

CHRISTUS SWLA and Metopio made substantial efforts to comprehensively collect, review, and analyze primary and secondary data. However, there are limitations to consider when reviewing CHNA findings.

- Population health and demographic data are often delayed in their release, so data are presented for the most recent years available for any given data source.
- Variability in the geographic level at which data sets are available (ranging from census tract to statewide or national geographies) presents an issue, particularly when comparing similar indicators and collected at disparate geographic levels. Whenever possible, the most relevant localized data are reported.
- Due to variations in geographic boundaries, population sizes, and data collection techniques for suburban and city communities, some datasets are not available for the same time spans or at the same level of localization throughout the county.
- Gaps and limitations persist in data systems for certain community health issues such as mental health and substance use disorders (youth and adults), crime reporting, environmental health, and education outcomes. Additionally, these data are often collected and reported from a deficit-based framework that focuses on needs and problems in a community, rather than assets and strengths. A deficit-based framework contributes to systemic bias that presents a limited view on a community's potential.

With this in mind, CHRISTUS SWLA, Metopio, and all stakeholders were deliberate in discussing these limitations throughout the development of the CHNA and selection of the 2023-2025 health priority areas.



# HEALTH PRIORITY AREAS



# Health Priority Areas

Based on community input and analysis of a myriad of data, the priorities for the communities served by CHRISTUS SWLA Fiscal Years 2023-2025 fall into two domains underneath an overarching goal of achieving health equity. The two domains and corresponding health needs are:

## 1. Advance Health and Wellbeing

- Specialty Care and Chronic Conditions
  - Diabetes
  - Obesity
  - Heart Disease
- Behavioral Health
  - Mental Health
  - Substance Abuse

## 2. Build Resilient Communities and Improve Social Determinants

- Increasing Stable Housing
- Reducing smoking and vaping

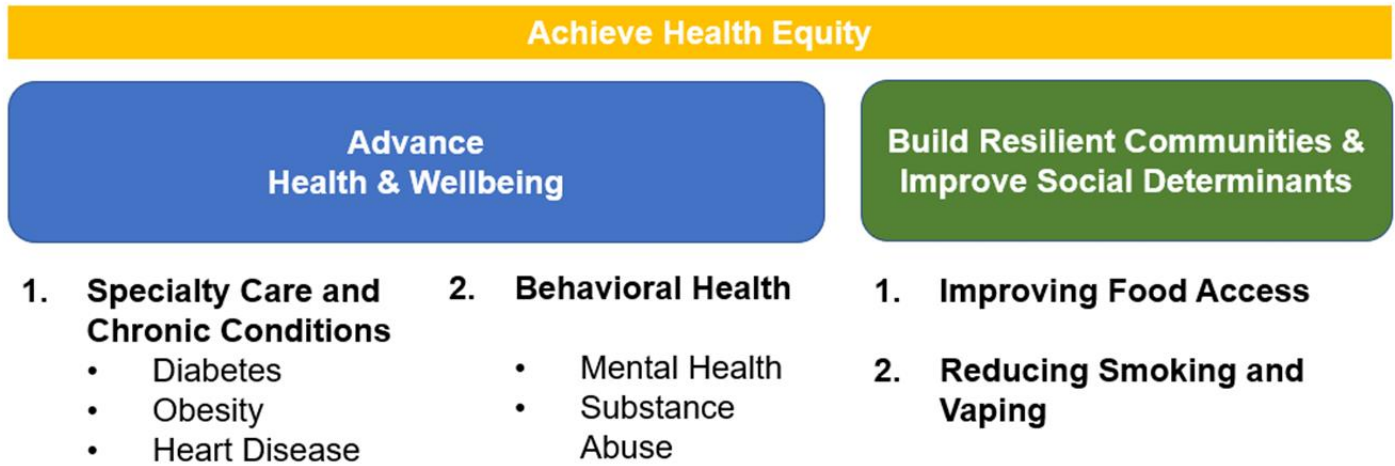


Figure 3. CHRISTUS SWLA System Priority Areas

## Approach to Community Health Improvement Plan

All community benefit investments and programming are built on a framework that promotes health equity and is framed by the community benefit overarching goal: to enhance community health and wellness around CHNA priority health needs in the service area. To achieve this goal, CHRISTUS Health designs its interventions and programs through the following channels:

1. Care Delivery Innovations
2. Community Based Outreach
3. Grant Making
4. Medical Education
5. Partnerships
6. Public Policy

Outlined below are the specific strategies and initiatives corresponding to each of the selected health priority areas. See Appendix 1 to a fully detailed evaluation framework relating to these strategies.

## Community Benefit Report Communication

CHRISTUS SWLA System will make its CHNA and strategic improvement plan publicly available online via the CHRISTUS Health website once it is approved and adopted by the Board of Directors in 2022. In addition, CHRISTUS SWLA will share the Community Health Improvement Plan (CHIP) to its advisors and partners (e.g., community members, local political representatives, faith leaders, healthcare providers, and community-based organizations), and make copies available upon request.

Throughout the 2023 - 2025 Improvement Strategy cycle, CHRISTUS Health will continue to monitor the evolving needs of our community, emerging resources made available through other organizations, and changing circumstances (such as COVID-19). While committed to providing the necessary people and financial resources to successfully implement the initiatives outlined above, CHRISTUS Health reserves the right to amend this improvement plan as circumstances warrant to best serve our community and allocate limited resources most effectively.



# Health Priority Area 1: Advance Health & Wellbeing

Addressing widespread chronic disease among adults is important to residents of all ages in the service area, as living with comorbidities is associated with poorer quality of life and lower life expectancy. It also contributes to financial instability and poor mental health. The first step to preventing chronic disease begins with establishing healthy behaviors. However, there are many impediments to living a healthy lifestyle.

ADVANCE HEALTH AND WELLBEING			
BEHAVIORAL HEALTH	BEHAVIORAL HEALTH	BEHAVIORAL HEALTH	BEHAVIORAL HEALTH
<p>Goal:</p> <ul style="list-style-type: none"> <li>In coordination with community partners, develop a plan expanding training and community knowledge involving risk factors and concerns of Suicide among our youth along with adult and elderly people with mental health diagnoses in our community.</li> </ul>	<p>Strategy:</p> <ul style="list-style-type: none"> <li>Identify current community resources that address Suicide and work with community partners to narrow the gaps in community education of Suicide and people who are at risk.</li> </ul>	<p>Partners and Hospital Role:</p> <ul style="list-style-type: none"> <li>Workplace Wellness, Community Wellness Partner, Calcasieu Parish School Board, Diocese of Lake Charles</li> <li>CHRISTUS St. Pats Hospital will provide a power point presentation and in-person discussion seminars to community partners.</li> </ul>	<p>Measures:</p> <ul style="list-style-type: none"> <li>The ministry will have a baseline understanding of the existing Suicide Risk programs and services in the region allowing them to plan education with partners, leverage resources to fill gaps, and better meet the growing need of education for Suicide Prevention in our community.</li> </ul>

## ADVANCE HEALTH AND WELLBEING

SPECIALTY CARE AND CHRONIC CONDITIONS	SPECIALTY CARE AND CHRONIC CONDITIONS	SPECIALTY CARE AND CHRONIC CONDITIONS	SPECIALTY CARE AND CHRONIC CONDITIONS
<p><b>Education:</b></p> <ul style="list-style-type: none"> <li>• Provide continual community education via various delivery methods, promoting overall cardiac health, with special emphasis on optimal control of blood pressure, weight, and blood sugar. Endorse method to measure and track teaching response.</li> </ul>	<p><b>Screening:</b></p> <ul style="list-style-type: none"> <li>• Include all ED patients as opportunity to screen for deviations of blood pressure, weight, and blood sugar metrics; provide education, referral, or follow-up guidance as needed.</li> <li>• Host or participate in quarterly community screenings for blood pressures, weight, and blood sugar metrics. Identify at risk and refer further as needed via nurse navigation or by self-referred medical provider referral.</li> <li>• Host bi-annual screenings for uninsured and underserved with focus on blood pressure, weight, and blood sugar. Interchange attraction for attending as assessment for undiagnosed heart failure, atrial fibrillation, or peripheral vascular disease.</li> <li>• Offer free virtual risk assessments.</li> <li>• Secure method to track and monitor metrics, follow-through with referrals, and impact on health change.</li> </ul>	<p><b>Support:</b></p> <ul style="list-style-type: none"> <li>• Explore resuming or initiating support groups for heart patients, weight management, and diabetics.</li> <li>• Utilize nurse navigation as appropriate.</li> <li>• Provide valid websites or other organizational references as further resources.</li> <li>• Select method to track efficacy of these interventions</li> </ul>	<p><b>Resources:</b></p> <ul style="list-style-type: none"> <li>• Drill down process to assist morbid obese patient population with resources for medical issues and financials limitations.</li> <li>• Collaborate with various organizations, community coalition and/or others for support and innovation.</li> <li>• Seek and maintain appropriate accreditations and certifications</li> </ul>

CHRISTUS Health will continue to invest in care delivery innovations and expand programs that address prevention for heart disease, obesity and diabetes and improve access to care. Key programs that support these initiatives are women's health services, five SBHCs, Cardiac Rehabilitation, Bariatric Program, ACC accreditation, AACVPR certification, Partnership with local Endocrinology physicians.

And CHRISTUS Health will focus on building a coalition to address Behavioral Health issues in the service area. Partners include the Suicide Coalition.



## Health Priority Area 2: Build Resilient Communities & Improve Social Determinants

Many communities in the service area face structural barriers to healthy behaviors, including a lack of healthy food options and easy access to tobacco and vaping products. Several social determinants exist in the community, adding daily pressure to residents seeking a healthy life.

BUILD RESILIENT COMMUNITIES & IMPROVE SOCIAL DETERMINANTS		
IMPROVE FOOD ACCESS	IMPROVE FOOD ACCESS	REDUCE SMOKING AND VAPING
<ul style="list-style-type: none"> <li>Reduction of food insecurity in SWLA by partnering with other local organizations who work on alleviating food insecurity in our SWLA parishes.</li> <li>Starting food pantry at some of our four School-Based Health Centers that will benefit school children.</li> <li>Education on the importance of healthy eating and physical activity.</li> </ul>	<ul style="list-style-type: none"> <li>We will work with Food Harvest Bank, Catholic Charities of SWLA, Calcasieu Parish Police Jury (Senior Food Program), City of Lake Charles (Summer Feeding Program), Water's Edge Pantry (general public distribution and homeless ministry), Pantry of Hope/Word of Hope Family Worship Center</li> </ul>	<p>Reduction in smoking and vaping rates among young people.</p> <ul style="list-style-type: none"> <li>Increase awareness.</li> <li>Increase the number of people who do not start at all/prevention.</li> <li>Get people to quit. Increase the number of partnerships we have.</li> <li>Tobacco cessation education provided by CHRISTUS Ochsner Smoking Treatment</li> </ul>

CHRISTUS Health will continue to invest in care delivery innovations and expand programs that address the social determinants of health. Key programs that support these initiatives are are Tobacco cessation education provided by hospital, Free program - Ochsner Smoking Treatment.

# STRATEGIES



# Appendix 1: Advance Health & Wellbeing

## Specialty Care and Chronic Conditions

Goal:						
<ol style="list-style-type: none"> <li>1. Increase knowledge to prevent and reduce reoccurrence of heart disease</li> <li>2. Promote behavior change and optimal management for the direct contributing heart disease risk factors of blood pressure, weight, and blood sugar levels</li> </ol>						
Strategy	Anticipated Impact	Programs, Services, Partnerships, Resources	Hospital's Role	Timeframe	Community of Focus	Metrics
<i>What actions or activities will we do to help to improve the conditions/</i>	<i>What are the expected outcomes of the population?</i>	<i>Who are the partners who have a role to play in doing better?</i>	<i>What is our role?</i> <i>Leader</i> <i>Collaborator</i> <i>Supporter</i>	<i>When do you expect this activity to begin/end?</i>	<i>Who are our customers/the population?</i>	<i>How much? How well? Is anyone better off?</i>
Target women and students to improve cardiac health with emphasis on optimal blood pressure, weight, and blood sugar control.	Provide education and screening events. Identify those at high-risk and refer further as appropriate.	CHRISTUS EDs CHRISTUS Live Well Network CHRISTUS SBHCs, Local Secondary Education	Heather Hidalgo Louise McDaniel	<b>Begin:</b> Annually and by school year <b>End:</b>	Women, students of all ages, men. Zip codes in Lake Charles, DeRidder, Iowa, Westlake, Sulphur	# of participants

		Institutions and Programs SWLA Women's Commission Other local hospitals				
Foster Cardiac Rehab Program and Bariatric Program.	Offer education and promote behavior modification strategies, provide support, perform bariatric surgical intervention as appropriate.	Cardiologists, Bariatric Surgeons, and other medical providers Case Management Dieticians Physical Therapy Behavioral Specialists AACVPR	Kelly Cornwell Tracy Mayeux Kaitlyn Blackmer	<b>Begin:</b> ongoing  <b>End:</b>	Adults.  Zip codes in Lake Charles, DeRidder, Iowa, Westlake, Sulphur	# of people served
Forward collaboration with local Endocrinologist office.	Identify patients at risk, with abnormal or uncontrolled blood sugar. Educate. Refer further as appropriate.	CHRISTUS EDs American Diabetes Association Dr. Gilbert and office personnel CHRISTUS nurse educators	Dr. Gilbert Samantha Ryder Kaitlyn Blackmer Nurse educators	<b>Begin:</b> Ongoing  <b>End:</b>	Children and adults.  Zip codes in Lake Charles, DeRidder, Iowa, Westlake, Sulphur	# of people served



## Behavioral Health

### Goal:

1. In coordination with community partners, develop a plan expanding training and community knowledge involving risk factors and concerns of suicide among our youth along with adult and elderly people with mental health diagnoses in our community.

Strategy	Anticipated Impact	Programs, Services, Partnerships, Resources	Hospital's Role	Timeframe	Community of Focus	Metrics
<i>What actions or activities will we do to help to improve the conditions/</i>	<i>What are the expected outcomes of the population?</i>	<i>Who are the partners who have a role to play in doing better?</i>	<i>What is our role?</i> <i>Leader</i> <i>Collaborator</i> <i>Supporter</i>	<i>When do you expect this activity to begin/end?</i>	<i>Who are our customers/the population?</i>	<i>How much? How well? Is anyone better off?</i>
Identify current community resources that address suicide and work with community partners to narrow the gaps in community education of Suicide and people who are at risk.		Workplace Wellness, Community Wellness Partner, Calcasieu Parish School Board, Diocese of Lake Charles	CHRISTUS St. Pats Hospital will provide a power point presentation and in-person discussion seminars to community partners.	<b>Begin:</b> ongoing  <b>End:</b>	Youth, students of all ages.  Zip codes in Lake Charles, DeRidder, Iowa, Westlake, Sulphur	# of people served

# Appendix 2: Build Resilient Communities & Improve Social Determinants

## Improving Food Access

Goal:						
1. Reduction of food insecurity in SWLA by partnering with other local organizations who work on alleviating food insecurity in our SWLA parishes.						
Strategy	Anticipated Impact	Programs, Services, Partnerships, Resources	Hospital's Role	Timeframe	Community of Focus	Metrics
<i>What actions or activities will we do to help to improve the conditions/</i>	<i>What are the expected outcomes of the population?</i>	<i>Who are the partners who have a role to play in doing better?</i>	<i>What is our role?</i> <i>Leader</i> <i>Collaborator</i> <i>Supporter</i>	<i>When do you expect this activity to begin/end?</i>	<i>Who are our customers/the population?</i>	<i>How much? How well? Is anyone better off?</i>

Improving food access by partnering with local organizations		<p>Food Harvest Bank</p> <p>Catholic Charities of SWLA</p> <p>Calcasieu Parish Police Jury (Senior Food Program)</p> <p>City of Lake Charles (Summer Feeding Program)</p> <p>Water's Edge Pantry (general public distribution and homeless ministry)</p> <p>Pantry of Hope/Word of Hope Family Worship Center</p>		<p><b>Begin:</b> ongoing</p> <p><b>End:</b></p>	Zip codes in Lake Charles, DeRidder, Iowa, Westlake, Sulphur	# of community organizations partnered
Provide discharge food boxes that are diet appropriate for patients upon discharge.				<p><b>Begin:</b> ongoing</p> <p><b>End:</b></p>	Zip codes in Lake Charles, DeRidder, Iowa, Westlake, Sulphur	# of people served

## Reducing Smoking and Vaping

### Goal:

1. Reduction in smoking and vaping rates among young people.
2. Increase awareness.
3. Increase the number of people who do not start at all/prevention.
4. Get people to quit.
5. Increase the number of partnerships we have.

Strategy	Anticipated Impact	Programs, Services, Partnerships, Resources	Hospital's Role	Timeframe	Community of Focus	Metrics
<i>What actions or activities will we do to help to improve the conditions/</i>	<i>What are the expected outcomes of the population?</i>	<i>Who are the partners who have a role to play in doing better?</i>	<i>What is our role?</i>  <i>Leader</i> <i>Collaborator</i> <i>Supporter</i>	<i>When do you expect this activity to begin/end?</i>	<i>Who are our customers/the population?</i>	<i>How much? How well? Is anyone better off?</i>
Tobacco cessation education provided by CHRISTUS Ochsner Smoking Treatment  More education around harms of vaping. Work with Government entities to restrict access to vaping devices.	Awareness campaign – to encourage businesses to ban smoking/vaping on their campus.	American Cancer Society. American Heart Association, health departments, schools, mayors, and city council members from chamber of commerce	Leader	<b>Begin:</b>  Annually and by school year  <b>End:</b>	Young people, students  Zip codes: Lake Charles, DeRidder, Iowa, Westlake, Sulphur	# of participants