

COMMUNITY HEALTH NEEDS ASSESSMENT

2023-2025



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EXECUTIVE SUMMARY



Executive summary

CHRISTUS St. Frances Cabrini Health System, which includes CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Savoy Medical Center and CHRISTUS Coughatta Health Care Center, conducted a Community Health Needs Assessment (CHNA) to assess areas of greatest need, which guides the hospital on selecting priority health areas and where to commit resources that can most effectively improve community members' health and wellness. To complete the 2022-2025 CHNA, CHRISTUS St. Frances Cabrini Health System partnered with Metopio, health departments, and regional and community-based organizations. The CHNA process involved engagement with multiple stakeholders to prioritize health needs. Stakeholders also worked to collect, curate and interpret the data. Stakeholder groups provided insight and expertise around the indicators to be assessed, types of focus group questions to be asked to the community, interpretation of results, and prioritization of areas of highest need. Primary data for the CHNA was collected via community input surveys, resident focus groups, key informant interviews. The process also included an analysis of secondary data from federal sources, local and state health departments, and community-based organizations.

IRS Form 990, Schedule H Compliance

For non-profit hospitals, a CHNA serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Form 990 Schedule H, the following table cross-references related sections.

SECTION	DESCRIPTION	BEGINS ON PAGE
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Part V Section B Line 3i	The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	115

Health Need Priorities

Based on community input and analysis of a myriad of data, the priorities for the communities served by CHRISTUS St. Frances Cabrini Health System for Fiscal Years 2023–2025 fall into two domains underneath an overarching goal of achieving health equity (Figure 1; Figure 2). The two domains and corresponding health needs are:

CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Dubuis Hospital of Alexandria and CHRISTUS Savoy Medical Center

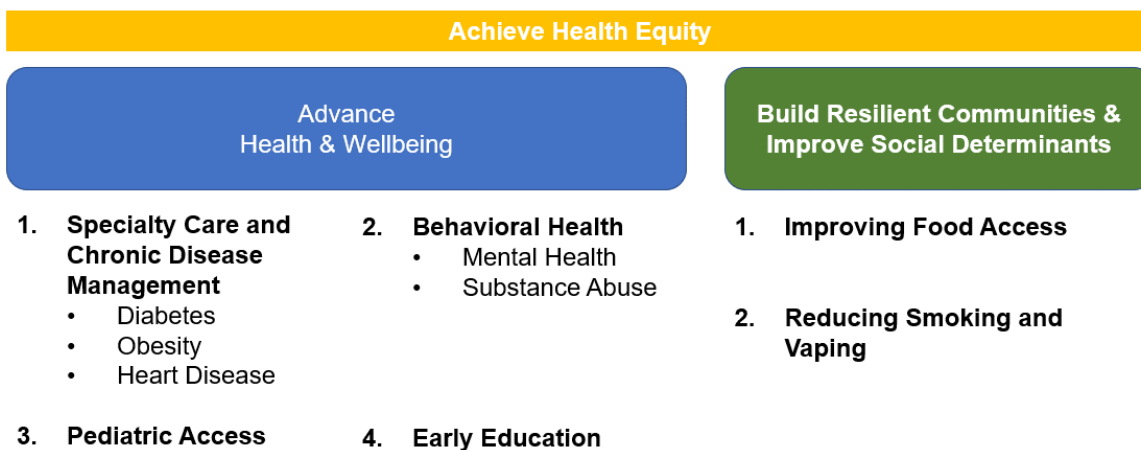


Figure 1. CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Dubuis Hospital of Alexandria and CHRISTUS Savoy Medical Center Priority Areas

CHRISTUS Coughatta Health Care Center

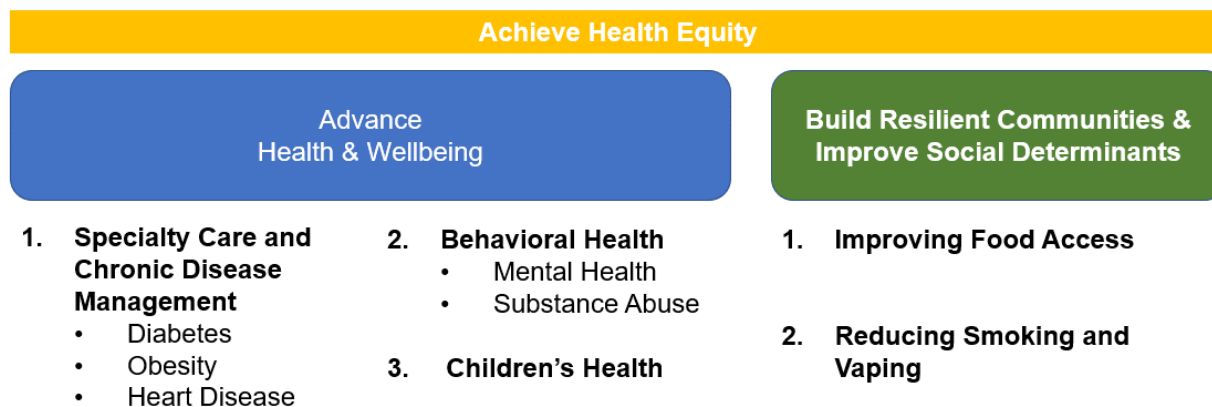


Figure 2. CHRISTUS Coughatta Health Care Center Priority Areas

This report provides an overview of the CHRISTUS St. Frances Cabrini Health System process involved in the CHNA, including data collection methods, sources, and the service areas. The body of the report contains results by service area zip codes, or parishes when zip code granularity is not possible, where health needs for the entire service area are assessed.

INTRODUCTION



Introduction: What is a Community Health Needs Assessment?

The Community Health Needs Assessment (CHNA) is a systematic, data-driven approach to determine the health needs in the service area of the CHRISTUS St. Frances Cabrini Health System. In this process, they directly engage community members and stakeholders to identify the issues of greatest need as well as the largest impediments to health. With this information, CHRISTUS St. Frances Cabrini Health System 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 St. Frances Cabrini Health System's work as a nonprofit healthcare provider. The critical 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 St. Frances Cabrini Health System, to conduct a CHNA every three years. CHRISTUS St. Frances Cabrini Health System completed similar needs assessments in 2012, 2015, and 2018.

The process CHRISTUS St. Frances Cabrini Health System 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 used for this CHNA, including data collection methods and sources, results for both service areas, historical inequities faced by the residents in the service areas, and considerations of how COVID-19 has impacted community needs. A subsequent strategic implementation plan will detail the strategies that will be employed to address the health needs identified in this CHNA.

When assessing the health needs for CHRISTUS St. Frances Cabrini Health System, 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 St. Frances Cabrini Health System service area.

Included in Appendix 1 is an evaluation of past efforts to address the community needs identified in the 2020 - 2022 CHNA.

CHRISTUS St. Frances Cabrini Health System Overview

CHRISTUS St. Frances Cabrini Hospital

CHRISTUS St. Frances Cabrini Hospital is a non-profit hospital system serving Alexandria, Louisiana and surrounding parishes in Central Louisiana. CHRISTUS St. Frances Cabrini Hospital, located in Alexandria Louisiana, is a 293-bed facility employing approximately 1,600 Associates and a medical staff of over 325 physicians. It offers comprehensive inpatient and outpatient services and is accredited by the Joint Commission.

CHRISTUS Dubuis Hospital of Alexandria

CHRISTUS Dubuis Hospital of Alexandria, LA is a long-term acute care hospital (LTAC) located within CHRISTUS St. Frances Cabrini Hospital. It is owned and operated by a joint venture between LHC Group of Lafayette, LA and CHRISTUS Health. Currently, the hospital is licensed for 25 LTACH beds and has the pleasure of serving approximately 280 patients annually (most are adults). It also provides employment for approximately 75 persons.

CHRISTUS Savoy Medical Center

Savoy Medical Center, managed under Christus St Frances Cabrini Hospital, is a 501-C3 Non-Profit, 60-Bed Acute Care facility located approximately 50 miles south of Alexandria in the town of Mamou in Evangeline Parish. The facility includes 6 beds designated for Intensive Care, a 24-Hour Emergency Department, 22 Acute Care Beds, 5 Private Physical Rehabilitation Beds, 24 beds for Beyond the Horizons a 28-day Residential Substance Abuse Program, and 27 Psychiatric & Medical DETOX Beds at NEW HORIZONS located on the SMC Campus. Additional services include SAVOY Cancer Center providing Chemotherapy, Radiation, and other Outpatient Infusions, a full-service Outpatient Laboratory, Respiratory Department, Radiology Department including MRIs and 3D Mammography, and 5 Rural Health Clinics located within a 30-mile radius in Mamou, Ville Platte, Eunice, Basile, and Elton.

CHRISTUS Coushatta Health Care Center

Comprised of a hospital, dental clinic and multiple rural health clinics, CHRISTUS Coushatta Health Care Center provides a network of services and facilities that collaborate to provide the medical, surgical and wellness needs of the communities. Specialty services such as general surgery, podiatry, cardiology, ophthalmology, cancer care and obstetrics & gynecology as well as a full-service emergency room. CHRISTUS Coushatta Health Care Center has been committed to improving health and serving the community so we may fulfill our mission to extend our healing ministry of Jesus Christ.

CHRISTUS Health

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 St. Frances Cabrini Hospital 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."

Community Benefit

CHRISTUS St. Frances Cabrini Hospital and CHRISTUS Coushatta Health Care Center implement strategies to promote health in the community and provide equitable care in the hospital. CHRISTUS St. Frances Cabrini Hospital and CHRISTUS Coushatta Health Care Center build on the assets that are already found in the community and mobilizes individuals and organizations to come together to work toward health equity.

CHRISTUS St. Frances Cabrini Health System Service Area

Following IRS guidelines, 501(r) rules as required by the Affordable Care Act, CHRISTUS St. Frances Cabrini Health System's CHNA primary service area includes 32 zip codes (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: Acadia, Allen, Avoyelles, Calcasieu, Catahoula, Concordia, Grant, LaSalle, Natchitoches, Rapides, St. Landry, Vernon and Winn. Figure 3 demonstrates the primary service area of CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Dubuis Hospital of Alexandria and CHRISTUS Savoy Medical Center and Figure 4 demonstrates the primary service area of CHRISTUS Coushatta Health Care Center

While the hospital is dedicated to providing exceptional care to all of the residents in the region, CHRISTUS St. Frances Cabrini Health System will use the information in this assessment to strategically establish priorities and commit resources to address the key health issues for the zip codes, parishes and municipalities that comprise the region.

CHRISTUS ST. FRANCES CABRINI HEALTH SYSTEM PSA			
Acadia Parish, LA	Allen Parish, LA	Avoyelles Parish, LA	Calcasieu Parish, LA
70515	71463	71341	70601
	71303	71350	
	71322	71351	
Catahoula Parish, LA	Concordia Parish, LA	Evangeline Parish, LA	Grant Parish, LA
71343	71334	70554	71417
		70576	71423
		70586	71467
LaSalle Parish, LA	Natchitoches Parish, LA	Rapides Parish, LA	St. Landry Parish, LA
71342	71457	71301, 71302, 71328	70535
		71346, 71360, 71405	70570
		71409, 71433, 71485	
Vernon Parish, LA	Winn Parish, LA		
71403, 71446	71483		

Table 1. Primary Service Area for CHRISTUS St. Frances Cabrini Health System

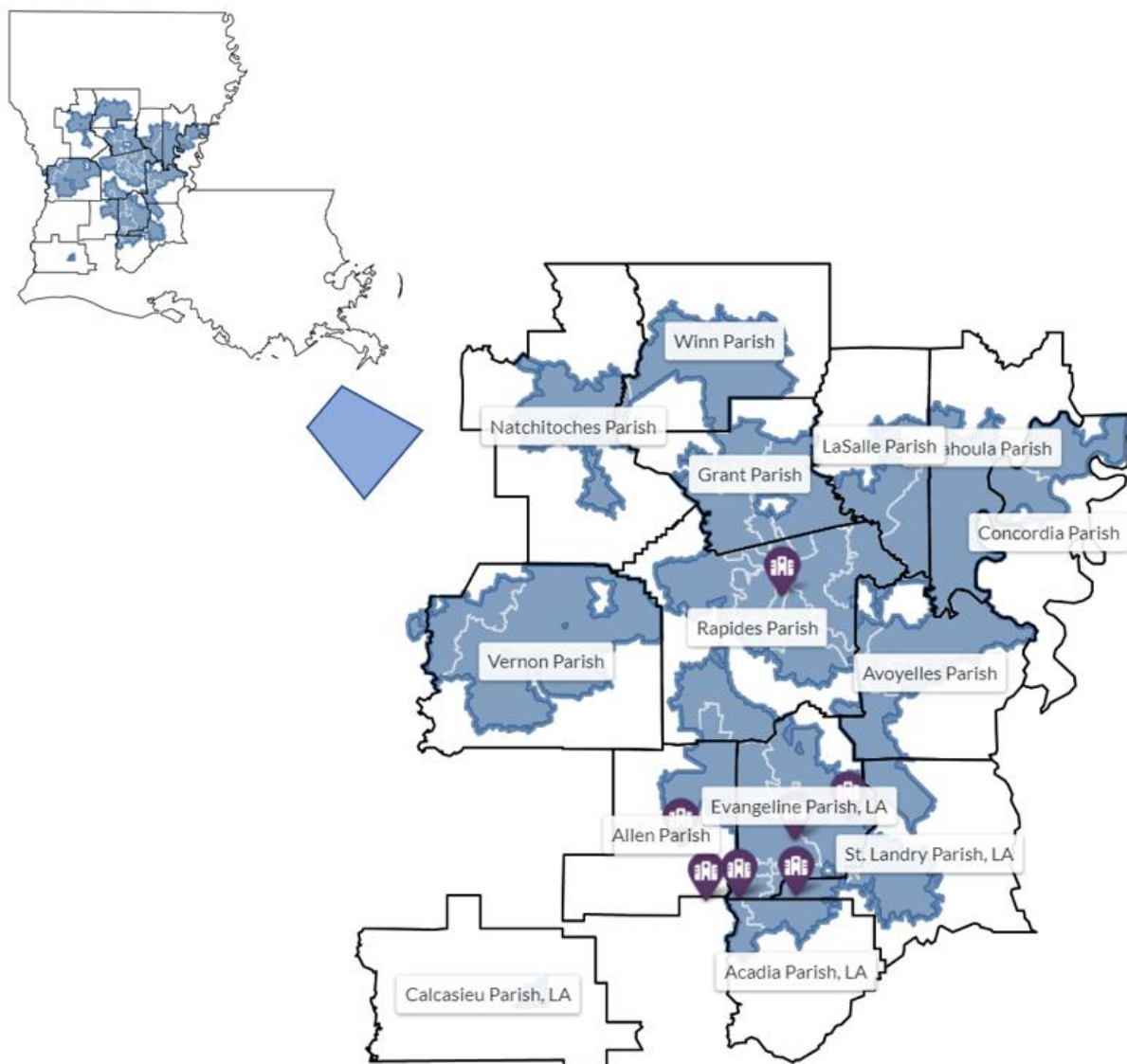


Figure 3. Map of St. Frances Cabrini Hospital, CHRISTUS Dubuis Hospital of Alexandria and CHRISTUS Savoy Medical Center PSA

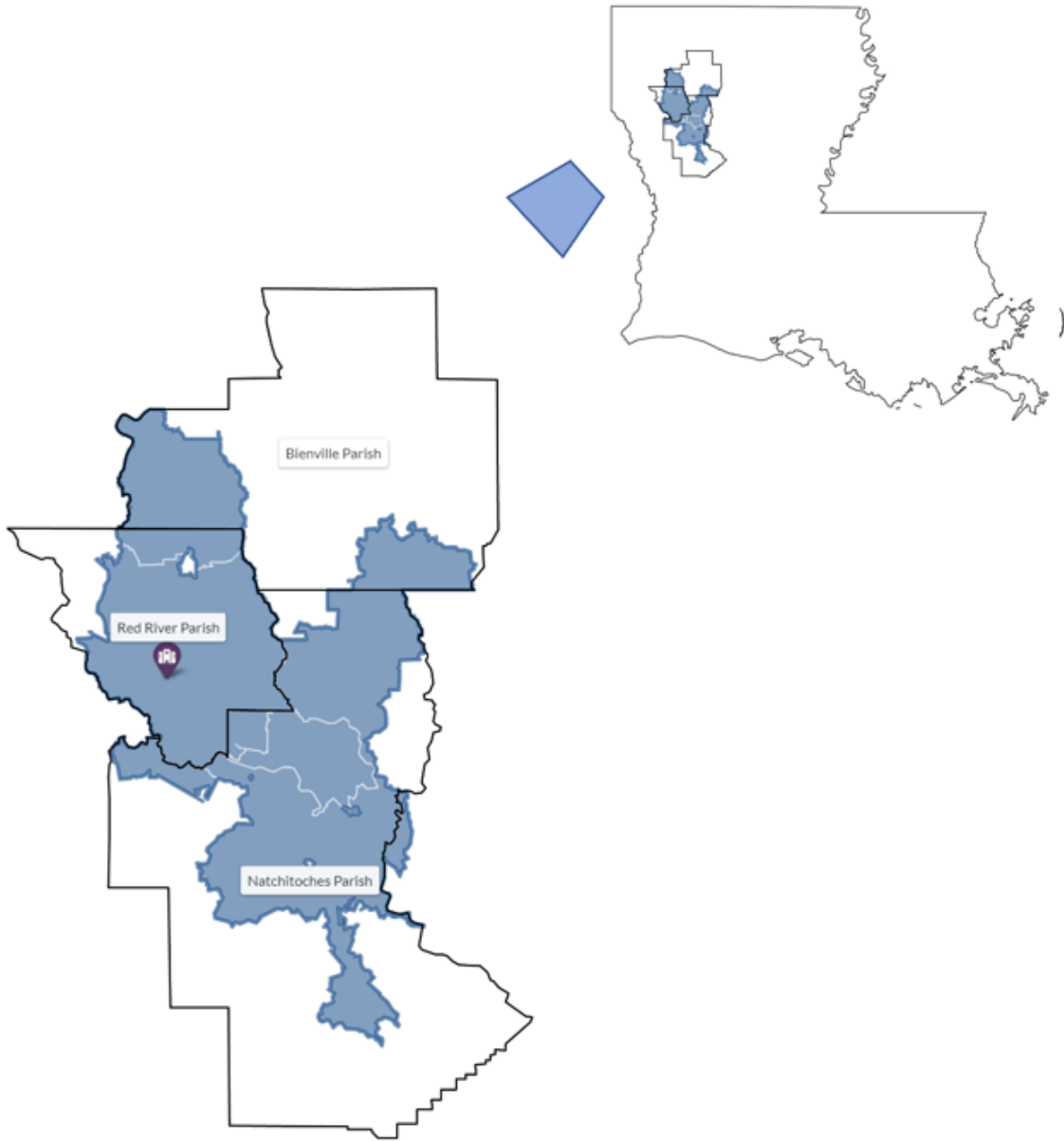


Figure 4. Map of CHRISTUS Coshatta Health Care Center PSA

CHNA PROCESS



CHNA Process

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, the health system 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 St. Frances Cabrini Health System guided the strategic direction of Metopio through roles on various committees and workgroups.

CHRISTUS St. Frances Cabrini Health System 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 teams are composed of key staff with expertise in areas necessary to capture and report CHRISTUS St. Frances Cabrini Health System's community benefit activities. These groups discuss and validate identified community benefit programs and activities. Additionally, the teams monitor key CHNA policies, provide input on the CHNA implementation strategies and strategic implementation plan, reviews and approves grant funding requests, provides feedback on community engagement activities

Input from community stakeholders was also gathered from CHRISTUS St. Frances Cabrini Health System'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 St. Frances Cabrini Health System 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 St. Frances Cabrini Health System 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, 351 residents in the two PSAs 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 CHRISTUS St. Frances Cabrini Health System and its community partners. The survey sought input from priority populations in the 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. The full community resident survey is included in Appendix 2. Table 2 summarizes the demographics of survey respondents in the PSAs.

DEMOGRAPHIC	%
Age (N=331)	
25-44	17.3
45-64	55.4
65 and older	27.3
Gender (N=332)	
Male	25.0
Female	73.3
Transgender	0.4
Choose not to answer	1.3
Orientation (N=331)	
Straight or heterosexual	93.9
Bisexual	1.7
Lesbian or gay or homosexual	1.7
Choose not to disclose	1.7
Other	0.9
Race (N=348 (multiple answers allowed))	
American Indian or Alaska Native	0.4
Asian	1.8
Black or African American	12.4
White	79.1
Hispanic/Latino(a)	1.3
Native Hawaiian or Pacific Islander	0.4
Choose to not disclose	7.1
Education (N=332)	
Less than high school	0.9
Some high school	1.7
High school graduate or GED	15.5
Vocational or technical school	16.8
Some college, no degree	7.8
College graduate	31.0
Advanced degree	26.3
Current Living Arrangements (N=330)	
Own my home	79.8
Rent my home	17.0
Living outside	0.4

Living with a friend or family	1.7
Other	1.3
Disability in Household (N=330)	34.3
Income (N=313)	
Less than \$10,000	3.3
\$10,000 to \$19,999	8.9
\$20,000 to \$39,999	16.0
\$40,000 to \$59,999	15.0
\$60,000 to \$79,999	15.5
\$80,000 to \$99,999	11.3
Over \$100,000	30.0
Average Number of Children in Home (#) (N=331)	0.6

Table 2. Demographics of Community Resident Surveys in the CHRISTUS St. Frances Cabrini Health System

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 St. Frances Cabrini Hospital PSA. This was done through focus groups and key informant interviews.

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

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

CHRISTUS St. Frances Cabrini Health System conducted their focus groups virtually. Focus groups lasted 90 minutes and had up to 15 community members participate in each group. The following community members participated in the focus groups:

ORGANIZATION	ROLE
CHRISTUS St. Frances Cabrini	Community Clinic Nurse
CHRISTUS St. Frances Cabrini	Administrative Director
CHRISTUS St. Frances Cabrini	Administrative Assistant
CHRISTUS St. Frances Cabrini	Director of Facilities
CHRISTUS St. Frances Cabrini	Director Care Management

CHRISTUS St. Frances Cabrini	Director Outpatient Services
CHRISTUS St. Frances Cabrini	Clinical Director
CHRISTUS St. Frances Cabrini	Clinical Educator
CHRISTUS St. Frances Cabrini	Social Worker
CHRISTUS St. Frances Cabrini	RN Diabetes Educator
CHRISTUS St. Frances Cabrini	Nurse Practitioner
CHRISTUS St. Frances Cabrini	RN
United Way of Central Louisiana	President/CEO
Hope House	Director
Louisiana Campaign Tobacco Free Living	Social Work
Central Louisiana Coalition to Prevent Homelessness	Population Representative
Cenla Pregnancy Center	Director
Red River Parish Public Schools	Director of Health/Nutrition

Table 3. Focus Group Participants

In addition to the focus groups, ten key informants were identified by the Hospital Management teams for one-on-one interviews. Key informants were chosen based on areas of expertise to further validate themes that emerged in the surveys and focus groups. Each interview was conducted virtually and lasted 30 minutes.

Secondary Data

CHRISTUS St. Frances Cabrini Health System used a common set of health indicators to understand the prevalence of morbidity and mortality in the PSAs 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 model (Figure 5). Where possible, the CHRISTUS St. Frances Cabrini Health System used data with stratifications so that health inequities could be explored and better articulated. Given the community input on economic conditions and community safety, the CHRISTUS St. Frances Cabrini Health System sought more granular datasets to illustrate hardship. A full list of data sources can be found in Appendix 3.

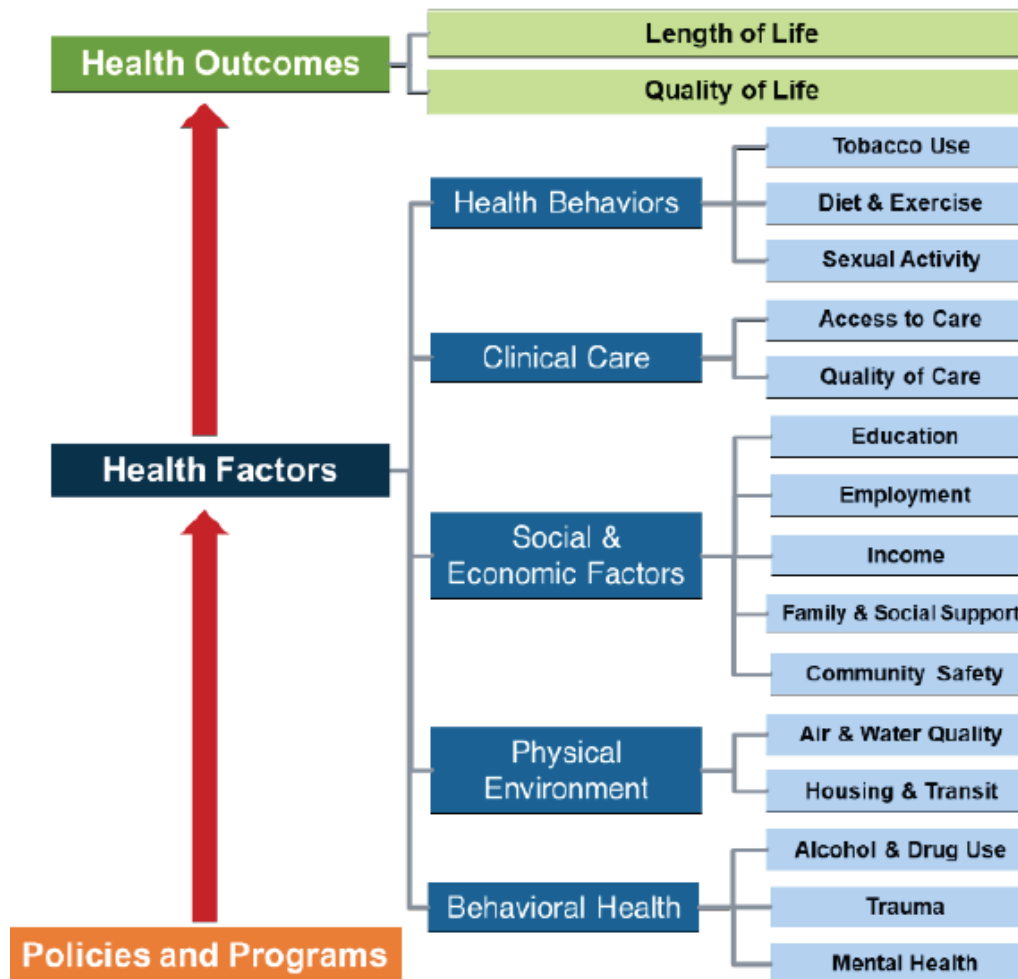


Figure 5. Illustration of the County Health Rankings MAPP Framework

Data Needs and Limitations

CSETHS 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, CSETHS, 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.

Overall Community Input

Community residents who participated in focus groups, key informant interviews, and the survey provided in-depth input about how specific health conditions impact community and individual health. Cross-cutting themes that emerged included:

- Access to care was a major issue that came up across the focus groups. Within the PSA, community members noted access needs for different groups in the region:
 - » Seniors and those on Medicaid need medication assistance and more providers in the area that accept their insurance.
 - » Pregnant people need more accessible prenatal care.
 - » Caregivers for relatives with co-morbidities need more support.
- Focus group participants shared that there is a need for mental health care in the PSA. Participants described an increase in the homelessness population, requiring more mental health and addiction services.
- Economic opportunity and poverty came up as an area of need. Overall, participants shared that people are leaving the community because of limited economic opportunity. There is a particular need for educational opportunities and affordable childcare for young mothers to provide for their families.
- Survey respondents shared that elements of the built environment make it difficult to be healthy. Limited access to healthy foods and limited safe green space in some communities make it difficult to live a healthy lifestyle. Additionally, respondents shared that limited transportation and internet options in rural areas create barriers to health.

Survey respondents were asked to rank a number of health issues on a scale of 1 to 5, with 1 being "not significant" and 5 being "very significant." Table 4 shows the top 10 issues from the survey in descending order.

HEALTH ISSUE	% OF RESPONDENTS WHO RANKED EITHER 4 OR 5
Obesity	63.7%
Diabetes	57.9%
Heart disease	57.4%
Mental health	55.6%
Drug, alcohol, and substance abuse	53.3%
Cancer(s)	52.0%
Smoking and vaping	49.1%
Chronic pain	46.7%
Arthritis	41.7%
Property Crime	41.6%

Table 4. Ranking of Health Issues by Survey Respondents

The primary data covered many health issues that community members see in the PSA, but data collection also included strengths that residents see in the community. Survey participants emphasized that community members look out for each other. They also highlighted the strength of local government services that listen to the needs of residents.

Additionally, survey respondents were asked to select all things which they thought contributed to health and were available in the community (Figure 6). These represent the assets that community members can take advantage of to maintain their health.

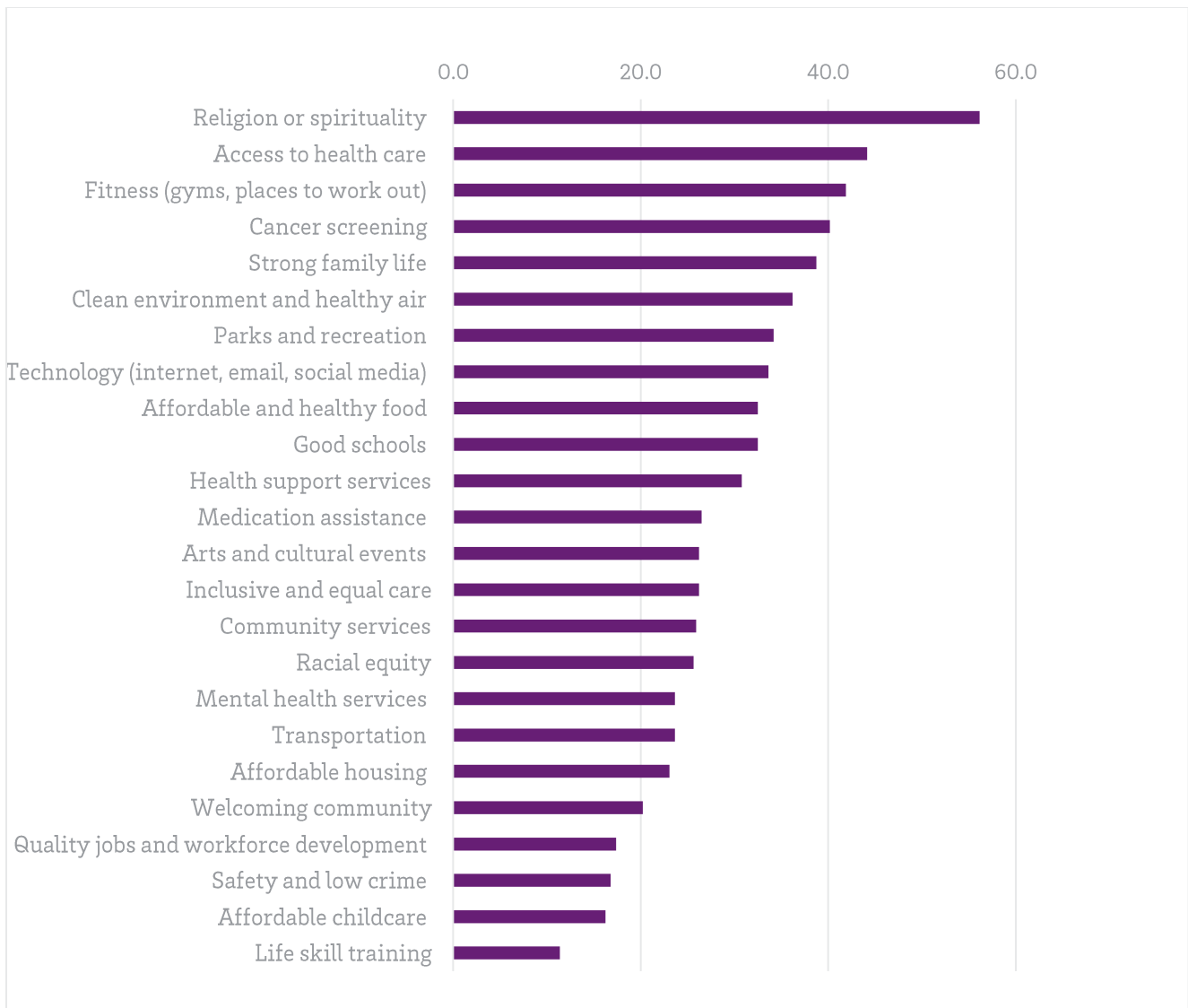


Figure 6. Survey Responses of Community Strengths that Support Health

Consideration of COVID-19

The COVID-19 pandemic touched all aspects of life for two of the last three years, which begs the question—should COVID-19 be considered its own health issue or did it merely expose existing health inequities in the community?

The CHRISTUS St. Frances Cabrini Health System PSA has experienced fluctuations in case rates and case fatality rates but was especially hard hit during the Delta surge in 2021. While causal factors are hard to pinpoint, several important determinants of health are more pronounced in the CHRISTUS St. Frances Cabrini Health System PSA including a lack of access to care, higher rates of chronic disease and a lack of transportation options. These vulnerabilities certainly exacerbated the spread and impact of COVID-19.

“This area was impacted by COVID-19, two hurricanes, a tornado, and a snowstorm all in one year. My husband’s workplace was destroyed by the tornado. He has had to work through having COVID twice and losing family members to COVID and Hurricane Laura, all while battling his long effects of COVID.”

– Survey Respondent

DURING THE PANDEMIC (MARCH 2020-PRESENT) HAVE YOU HAD ANY OF THE FOLLOWING (PLEASE CHECK ALL THAT APPLY):	% OF RESPONDENTS
Visited a doctor for a routine checkup or physical	91.4
Dental exam	66.8
Mammogram	48.2
Pap test/Pap smear	35.9
Sigmoidoscopy or colonoscopy to test for colorectal cancer	13.6
Flu shot	61.4
Prostate screening	6.8
COVID-19 vaccine	81.4
BECAUSE OF THE PANDEMIC, DID YOU DELAY OR AVOID MEDICAL CARE?	
Yes	34.4
No	65.6
DURING THIS TIME PERIOD, HOW OFTEN HAVE YOU BEEN BOTHERED BY FEELING DOWN, DEPRESSED, OR HOPELESS?	
Not at all	41.5
Several days every month	39.7
More than half the days every month	9.8
Nearly every day	8.9
WHAT IS THE MOST DIFFICULT ISSUE YOUR COMMUNITY HAS FACED DURING THIS TIME PERIOD?	
COVID-19	58.1
Natural disasters (for example, hurricanes, flooding, tornadoes, fires)	27.0
Extreme temperatures (for example, snowstorm of 2021)	3.7
Other:	11.2
	N=324

Table 5. Community Resident Survey Responses to COVID-19 Questions

As demonstrated in the survey results in Table 5, a majority of respondents saw the pandemic as the biggest issue their community faced over the last two years. And while many community members did not delay care, over half did experience challenges with feelings of hopelessness and depression. The community's major emphasis in focus groups and key informant interviews was on addressing the barriers to health equity, not necessarily the pandemic itself. Because of this, the CHNA will focus more on COVID-19's impact on existing health disparities.

CHRISTUS ST. FRANCES CABRINI CHNA RESULTS



CHRISTUS St. Frances Cabrini CHNA Results

Demographic Characteristics

Over the past decade, the primary service area of CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Dubuis Hospital of Alexandria and CHRISTUS Savoy Medical Center, which will now be referred to as the CHRISTUS St. Frances Cabrini PSA, has experienced a slight change in population (Figure 7). Changes between the 2010 and 2020 Census show that the population in the CHRISTUS St. Frances Cabrini PSA decreased by 1.9%. The CHRISTUS Health service area and Louisiana both experienced growth during this period, with a growth rate of 12.1% and 2.7%, respectively. In this report, the CHRISTUS Health service area refers to the geographic area that encompasses all primary service areas of CHRISTUS Health hospital systems in New Mexico, Texas, Louisiana, and Arkansas. Based on the 2020 decennial Census, 378,747 people live in the CHRISTUS St. Frances Cabrini PSA.

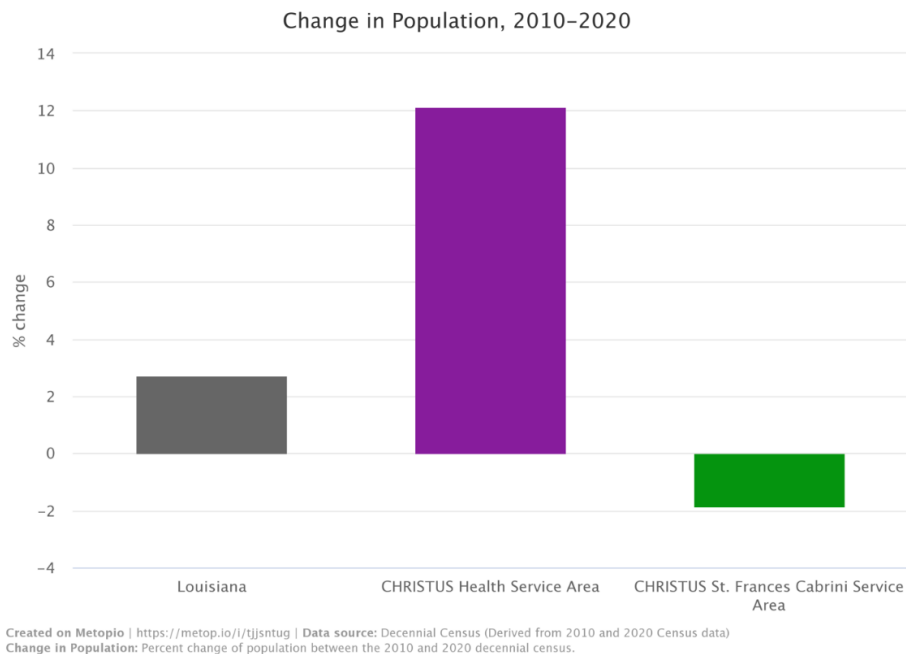
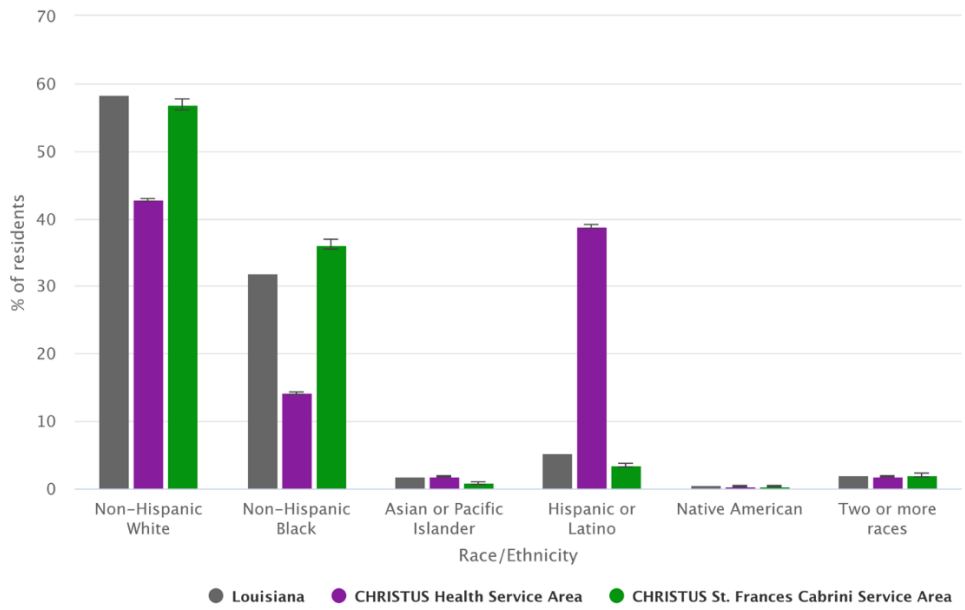


Figure 7. Change in Population in the CHRISTUS St. Frances Cabrini PSA

Figure 8 shows the demographics by race/ethnicity for the service areas. non-Hispanic White individuals make up the majority of the CHRISTUS St. Frances Cabrini PSA at 56.9%. This differs from the demographics of the CHRISTUS Health service area, but is similar to Louisiana as a whole, where non-Hispanic White people make up 42.8% and 58.9% of the population, respectively. In the CHRISTUS St. Frances Cabrini PSA, the second most prevalent racial/ethnic demographic is non-Hispanic Black people at 36.1% of the population. This is higher than the 14.2% of non-Hispanic Black residents in the CHRISTUS Health service area and similar to the 31.9% of residents in Louisiana. This Hispanic/Latino populations in the service area (3.4%) and Louisiana (5.2%) are much lower than the CHRISTUS Health service area (38.8%). In the CHRISTUS St. Frances Cabrini PSA, Asian or Pacific Islander individuals make up 0.8%, compared to 1.9% of the CHRISTUS Health service area and 1.8% of the population of Louisiana. Native Americans account for 0.4% of the CHRISTUS St. Frances Cabrini PSA, 0.4% of the CHRISTUS Health service area, and 0.5% of the population in Louisiana. People who report belonging to two or more races make up 2.0% of the CHRISTUS St. Frances Cabrini PSA, 1.8% of the CHRISTUS Health service area, and 2.0% of the Louisiana population. (Table 6 explores service area demographics by parish.)

Demographics by Race/Ethnicity, 2016–2020



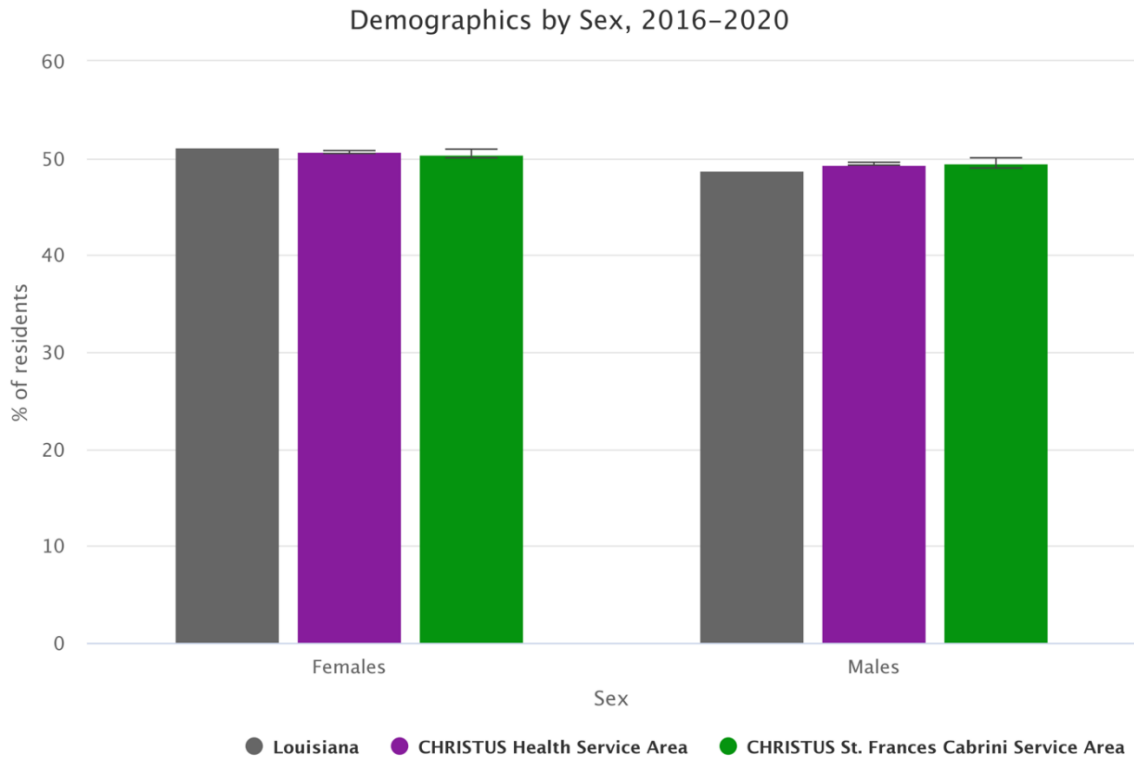
Created on Metopio | <https://metopio.io/vf/bxbnmv> | Data source: American Community Survey (Table B01001)
 Demographics: Percent of residents within each major demographic group. Use this topic to explore age, gender, and racial/ethnic breakdowns. This topic is expressed as a percent; to see a breakdown of all residents (pie or area chart), use Population (POP).

Figure 8. Demographics by Race/Ethnicity in the CHRISTUS St. Frances Cabrini PSA

Topic	Allen Parish, LA	Avoyelles Parish, LA	Catahoula Parish, LA	Concordia Parish, LA	Grant Parish, LA	LaSalle Parish, LA	Natchitoches Parish, LA	Rapides Parish, LA	Vernon Parish, LA	Winn Parish, LA
Change in Population % change, 2010-2020	-11.70	-5.66	-14.42	-10.25	-0.63	-0.66	-5.18	-1.21	-6.85	-10.17
Demographics Non-Hispanic White % of residents, 2020	66.58	63.58	64.43	54.35	75.23	76.15	50.37	58.70	68.92	61.78
Demographics Non-Hispanic Black % of residents, 2020	17.65	26.83	25.54	40.01	13.80	8.67	39.60	30.96	12.97	25.58
Demographics Asian or Pacific Islander % of residents, 2020	0.84	0.88	0.36	0.62	0.33	1.77	0.49	1.41	2.36	1.37
Demographics Hispanic or Latino % of residents, 2020	8.32	3.74	6.89	2.46	6.01	9.48	3.97	3.91	8.56	7.44
Demographics Native American % of residents, 2020	2.31	0.88	0.38	0.21	0.87	0.90	0.76	0.69	0.99	0.56
Demographics Two or more races % of residents, 2020	4.04	3.83	2.28	2.27	3.56	2.85	4.00	3.96	5.62	3.10

Table 6. Demographics by Parish in the CHRISTUS St. Frances Cabrini PSA

Females represent 50.5% of the CHRISTUS St. Frances Cabrini PSA and males represent 49.6% (Figure 9). The CHRISTUS St. Frances Cabrini PSA ratio is similar to the 50.6% female and 49.4% male population of the CHRISTUS Health service area and the 51.2% female and 48.8% male population of Louisiana overall. The median age in the CHRISTUS St. Frances Cabrini PSA is 37.1 years old, which is slightly higher than the rest of the CHRISTUS Health service area (36.3 years old) and Louisiana overall (37.2 years old) (Figure 10).



Created on Metopio | <https://metop.io/1/u1wiej5m> | Data source: American Community Survey (Table B01001)
 Demographics: Percent of residents within each major demographic group. Use this topic to explore age, gender, and racial/ethnic breakdowns. This topic is expressed as a percent; to see a breakdown of all residents (pie or area chart), use Population (POP).

Figure 9. Demographics by Sex in the CHRISTUS St. Frances Cabrini PSA

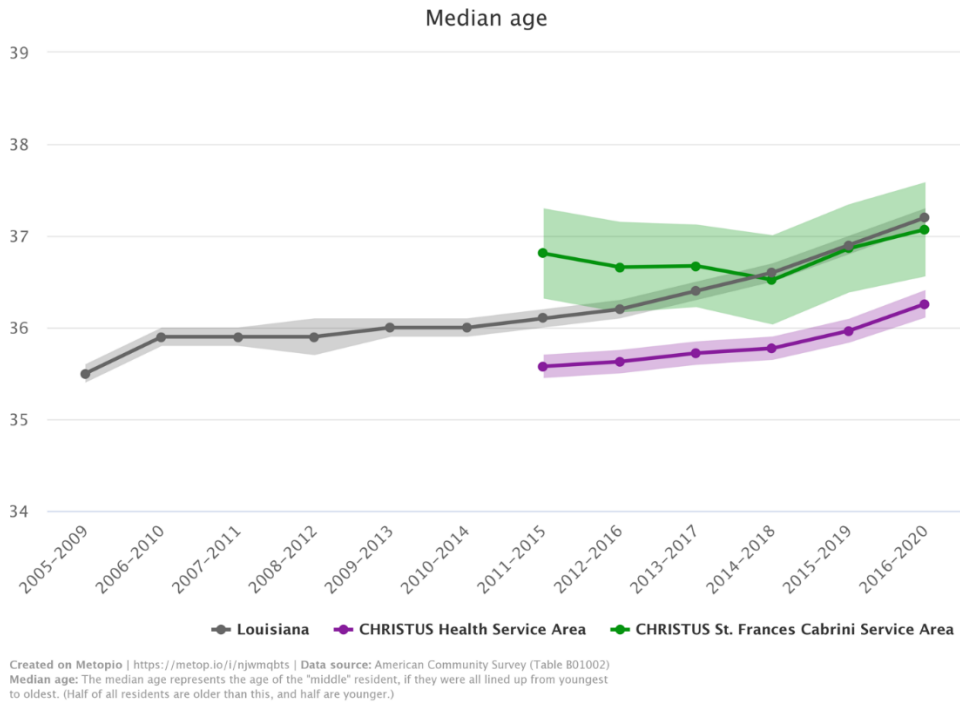


Figure 10. Median Age in the CHRISTUS St. Frances Cabrini PSA

In the CHRISTUS St. Frances Cabrini PSA, 0.9% of households have limited English proficiency (Figure 11). This percentage is much lower than the entire CHRISTUS Health service area (4.0%) and slightly lower than Louisiana overall (1.4%).

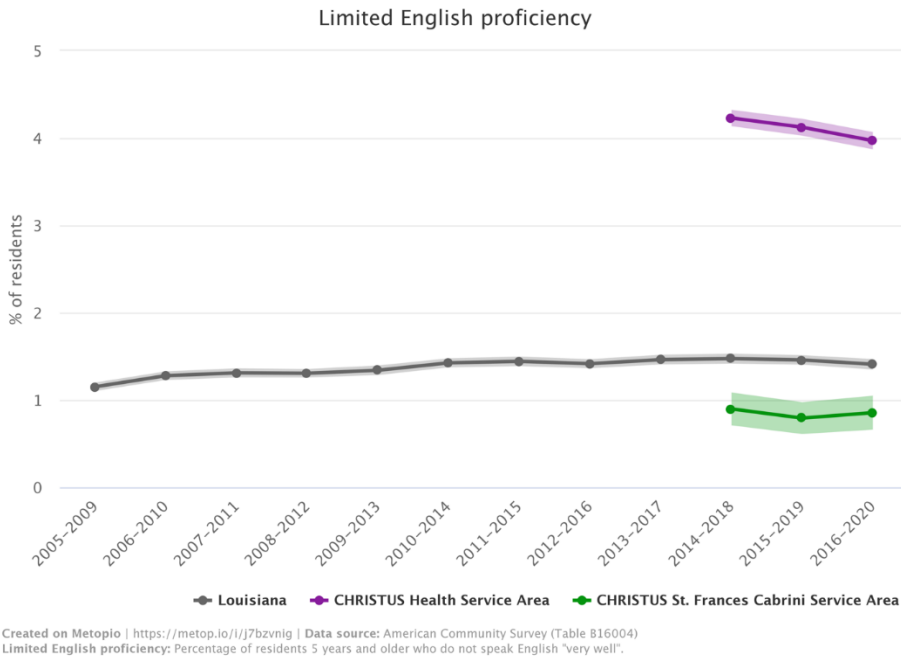
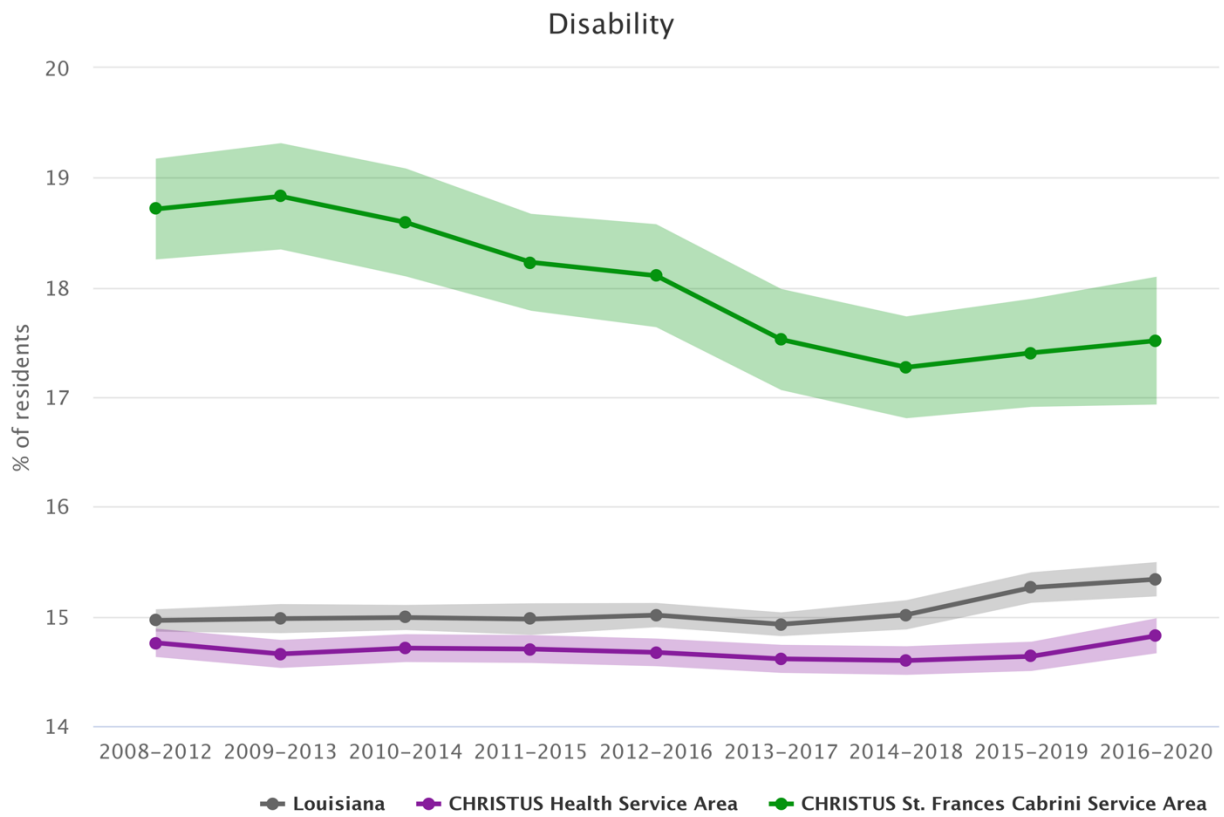


Figure 11. Limited English Proficiency in the CHRISTUS St. Frances Cabrini PSA

The percentage of residents with a disability in the CHRISTUS St. Frances Cabrini PSA (17.5%) is higher than the whole CHRISTUS Health service area (14.8%) and Louisiana (15.3%) (Figure 12). Since the 2014-2018 period, the rate of disability has been increasing in the CHRISTUS St. Frances Cabrini PSA. Disability here is defined as one or more sensory disabilities or difficulties with everyday tasks.



Created on Metopio | <https://metop.io/i/ns1gsx44> | Data source: American Community Survey (Table S1810)
 Disability: Percent of residents with a disability, defined as one or more sensory disabilities or difficulties with everyday tasks.

Figure 12. Disability in the CHRISTUS St. Frances Cabrini PSA

Social and Structural Determinants of Health

Community residents who participated in focus groups and the community resident surveys also provided in-depth input about how social and structural determinants of health – such as education, economic inequities, housing, food access, access to community services and resources, and community safety and violence – impact community and individual health. The following sections review secondary data insights that measure the social and structural determinants of health.

Hardship

One way to measure overall economic distress in a place is with the Hardship Index (Figure 13). This is a composite score reflecting hardship in the community, where the higher values indicate greater hardship. It incorporates unemployment, age dependency, education, per capita income, crowded housing, and poverty into a single score. The Hardship Index score for the CHRISTUS St. Frances Cabrini PSA is 70.0, which is higher than the measure of the full CHRISTUS Health service area (60.6) and the state (59.5). Within the CHRISTUS St. Frances Cabrini PSA, hardship indicators are concentrated in the following zip codes: 70506 (88.7), 70554 (87.6), 70586 (85.1), and 70515 (84.9).

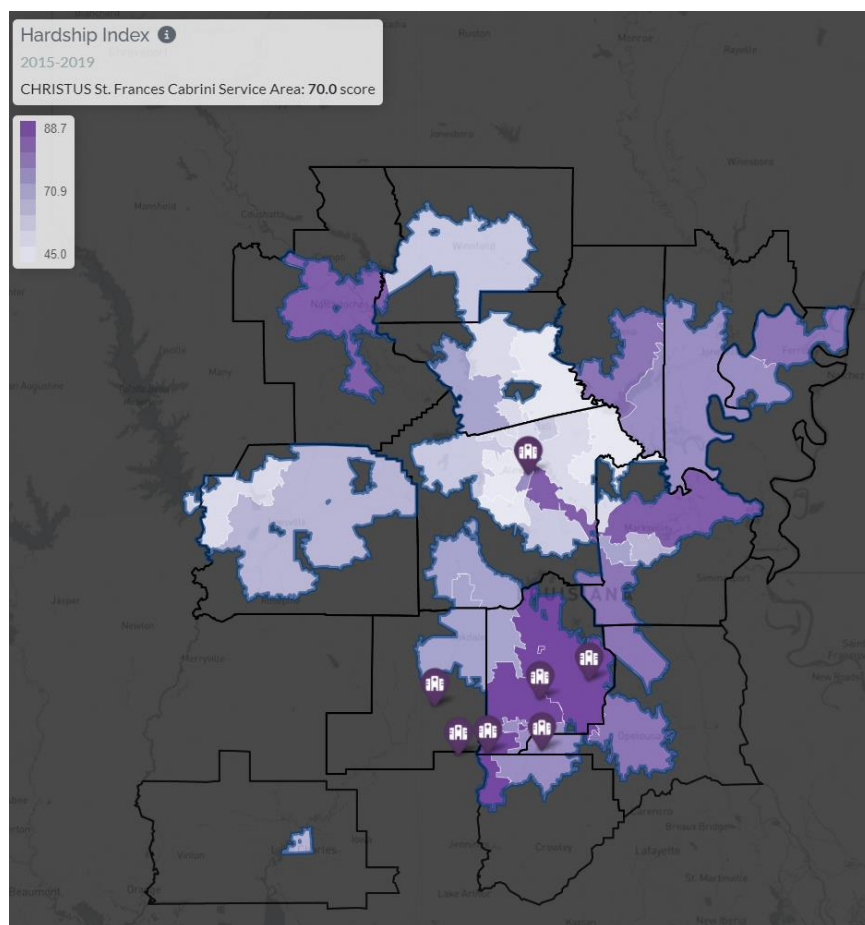
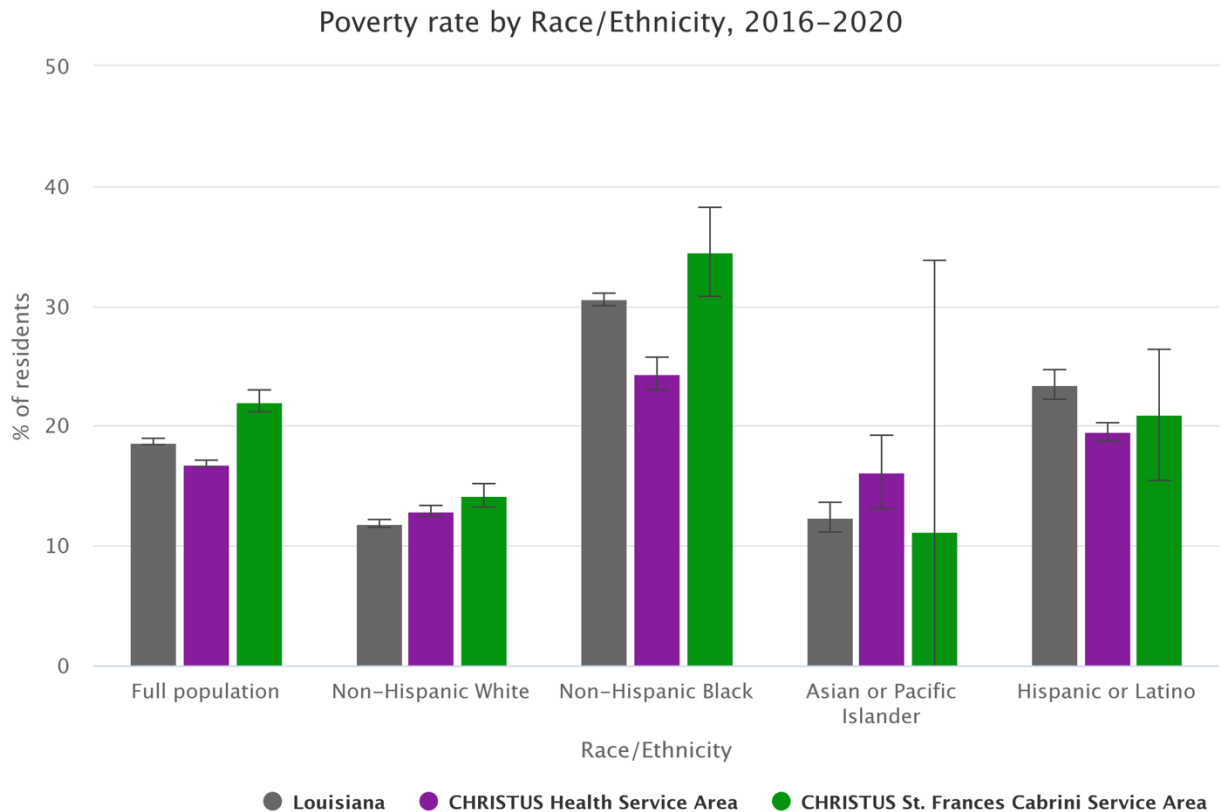


Figure 13. Map of Hardship Index in the CHRISTUS St. Frances Cabrini PSA

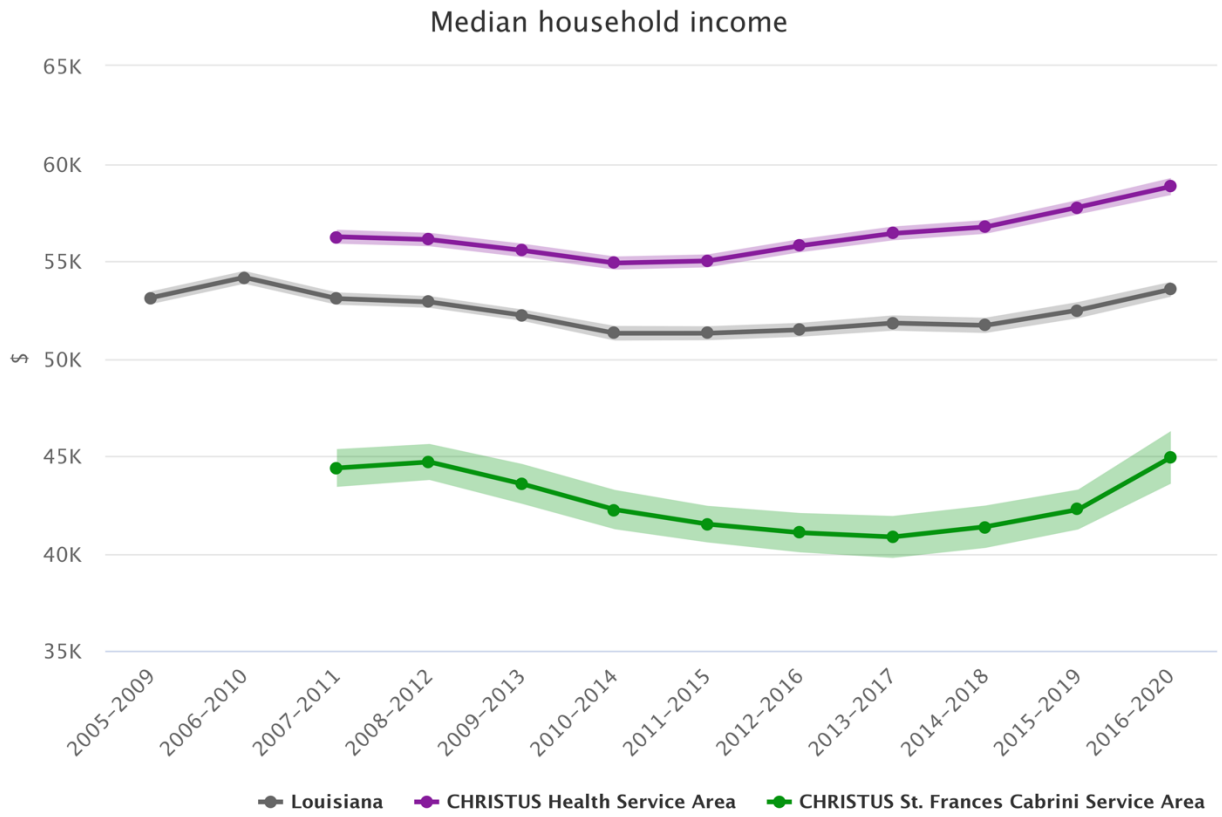
Poverty

Poverty and its corollary effects are present throughout the CHRISTUS St. Frances Cabrini PSA. In the CHRISTUS St. Frances Cabrini PSA the poverty rate (Figure 14) is 22.1% and the median household income (Figure 15) is \$44,951. In comparison, the CHRISTUS Health service area has a median household income of \$58,813 and 16.8% of residents living in poverty, and Louisiana, \$53,539 and 18.7%, respectively. The poverty rate in the CHRISTUS St. Frances Cabrini PSA is even more pronounced for non-Hispanic Black residents (34.5%). For comparison, 14.2% of non-Hispanic White residents live in poverty, 11.3% of Asian or Pacific Islanders, and 20.9% of Hispanic or Latinos.



Created on Metopio | <https://metop.io/i/9prezi3n> | Data source: American Community Survey (Table B17001)
 Poverty rate: Percent of residents in families that are in poverty (below the Federal Poverty Level).

Figure 14. Poverty Rate with Stratifications in the CHRISTUS St. Frances Cabrini PSA



Created on Metopio | <https://metop.io/i/eoit9gp> | Data source: American Community Survey (Table B19013)
 Median household income: Income in the past 12 months.

Figure 15. Median Household Income in the CHRISTUS St. Frances Cabrini PSA

Housing

In the focus groups, community members shared disparities in resources limit the ability of all people to be healthy. Participants also shared that the expensive cost of childcare also puts a burden on working families, making them feel like they can't get ahead. Figure 16 shows that more than 1-in-5 residents in rental housing units are severely rent-burdened, meaning they spend more than 50% of their income on housing. Zip code 71322 experiences the highest percentage of severely rent-burdened households at 41.1%.

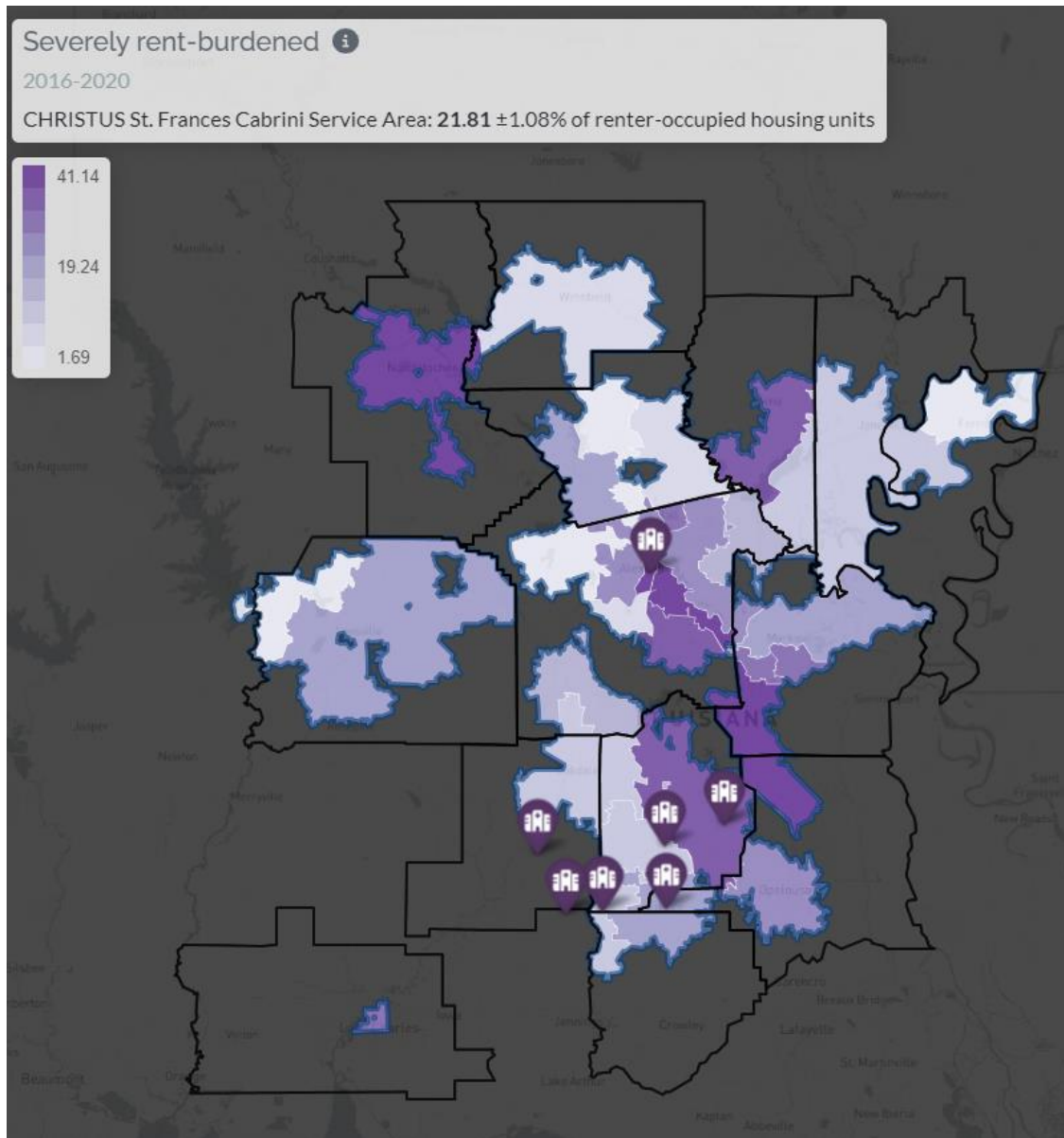
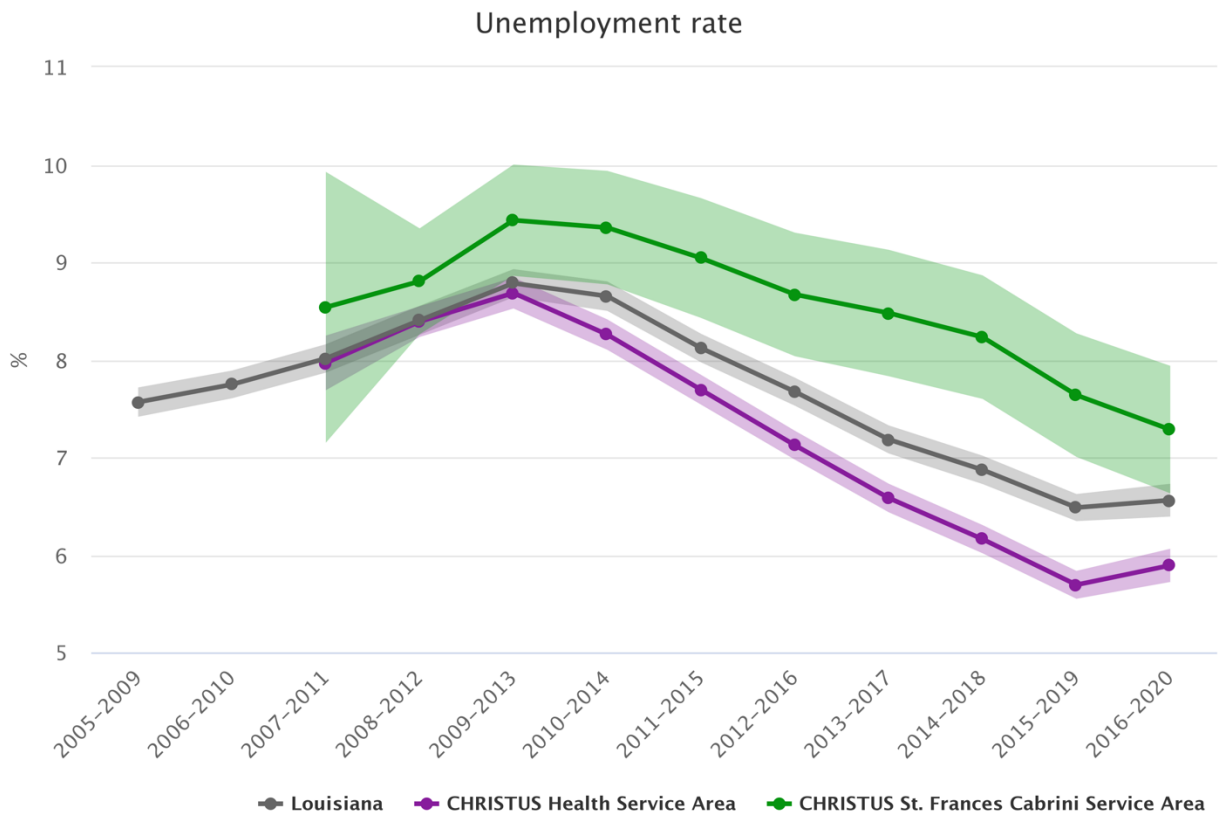


Figure 16. Housing Cost Burden in the CHRISTUS St. Frances Cabrini PSA

Unemployment

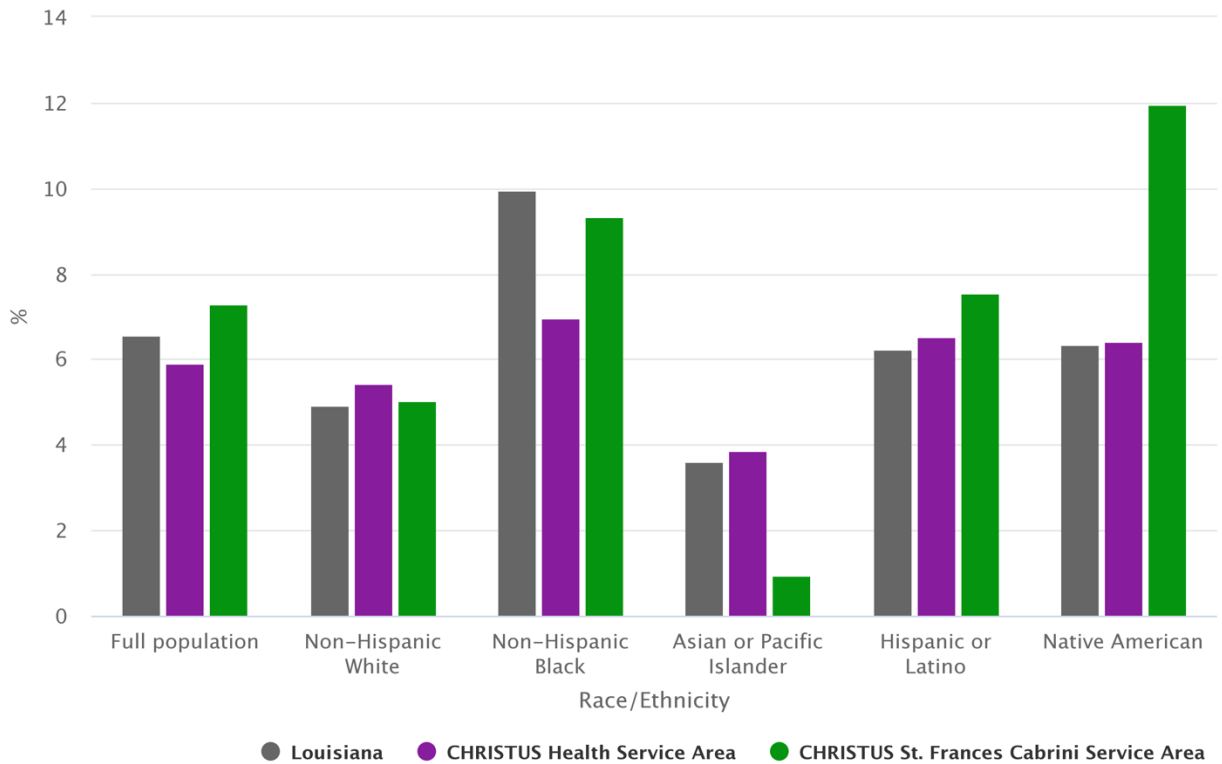
The overall unemployment rate in the CHRISTUS St. Frances Cabrini PSA (7.3%) is slightly higher than the rate of the CHRISTUS Health service area (5.9%), and Louisiana (6.6%) (Figure 17). When this data is stratified by race/ethnicity (Figure 18), there are disparities in unemployment rates. In particular, non-Hispanic Blacks (9.3%), Hispanic or Latinos (7.5%), and Native Americans (12.0%) experience the highest unemployment rates. Because of the small number of Native Americans and Hispanic/Latino people in the service area, there is error in this data, which means the actual unemployment rate for these populations may be higher or lower than the collected average. Over the past decade, the region has generally seen a decline in the unemployment rate, even though the 2016-2020 period, when the COVID-19 pandemic began. Future data will better illustrate the effects of the pandemic on unemployment rates.



Created on Metopio | <https://metop.io/i/yzidu57n> | Data source: American Community Survey (Tables B23025, B23001, and C23002)
Unemployment rate: Percent of residents 16 and older in the civilian labor force who are actively seeking employment.

Figure 17. Unemployment Rate in the CHRISTUS St. Frances Cabrini PSA

Unemployment rate by Race/Ethnicity, 2016–2020

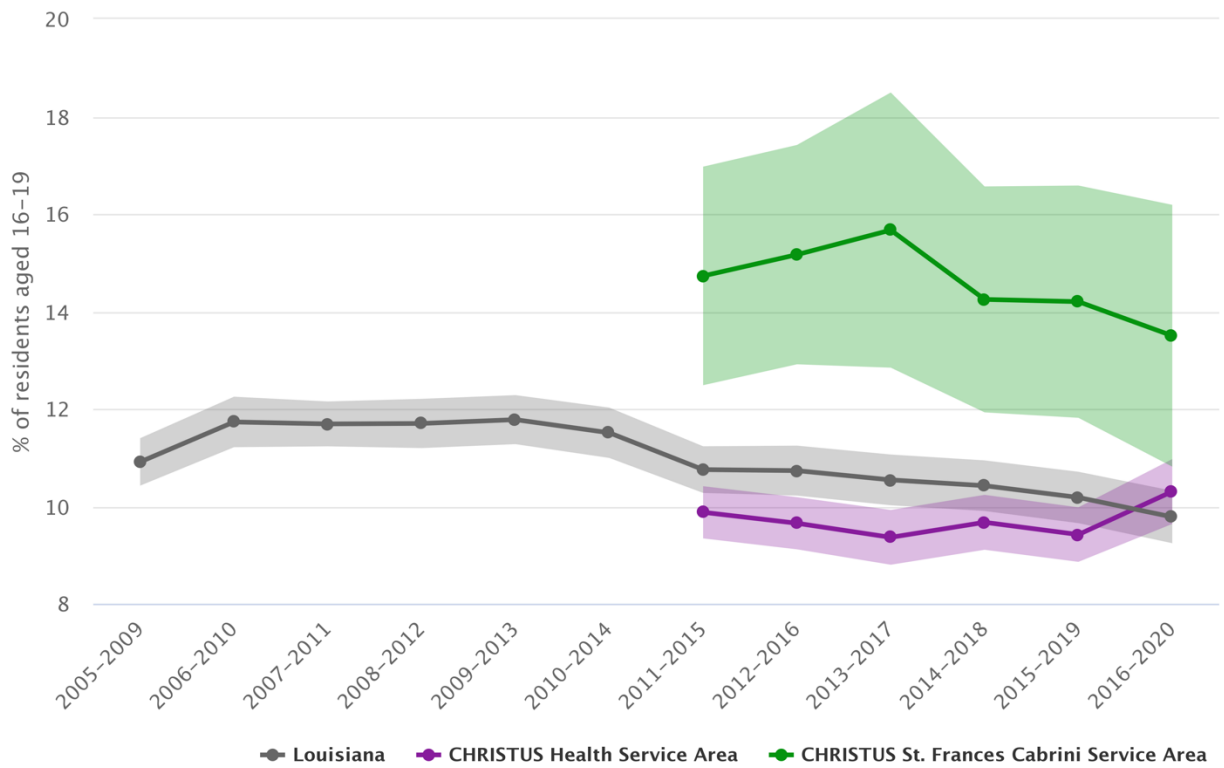


Created on Metopio | <https://metop.io/i/92b7wysz> | Data source: American Community Survey (Tables B23025, B23001, and C23002)
 Unemployment rate: Percent of residents 16 and older in the civilian labor force who are actively seeking employment.

Figure 18. Unemployment Rate with Stratifications in the CHRISTUS St. Frances Cabrini PSA

Another measure of potential economic stress is disconnected youth, defined as residents aged 16–19 who are neither in school nor employed. For the CHRISTUS St. Frances Cabrini PSA, the percentage is 13.5% compared to 10.3% in the whole CHRISTUS Health service area, and 9.8% in Louisiana (Figure 19). Focus group participants shared that many young people, particularly in immigrant communities, drop out of high school to help care for their families. This may account for some of this measure in the CHRISTUS St. Frances Cabrini PSA.

Disconnected youth



Created on Metopio | <https://metop.io/i/1/6sqdfqqw> | Data source: American Community Survey (Table B14005)
 Disconnected youth: Percent of residents aged 16-19 who are neither working nor enrolled in school.

Figure 19. Disconnected Youth in the CHRISTUS St. Frances Cabrini PSA

Table 7 explores each of these socio-economic indicators by parish for the service areas.

Topic	Allen Parish, LA	Avoyelles Parish, LA	Catahoula Parish, LA	Concordia Parish, LA	Grant Parish, LA	LaSalle Parish, LA	Natchitoches Parish, LA
Hardship Index score, 2015-2019	74.3	76.9	72.2	72.9	59.9	74.2	79.9
Poverty rate % of residents, 2016-2020	15.38	23.69	26.66	28.64	15.89	17.79	30.09
Median household income 2016-2020	\$50,934	\$37,446	\$43,182	\$38,251	\$54,223	\$53,898	\$32,276
Severely rent-burdened % of renter-occupied housing units, 2016-2020	10.57	24.45	15.20	18.51	15.78	17.28	26.94
Unemployment rate %, 2016-2020	8.74	6.35	7.74	9.18	4.10	4.43	13.09
Disconnected youth % of residents aged 16-19, 2016-2020	10.96	15.35	20.16	17.22	22.33	7.61	9.72

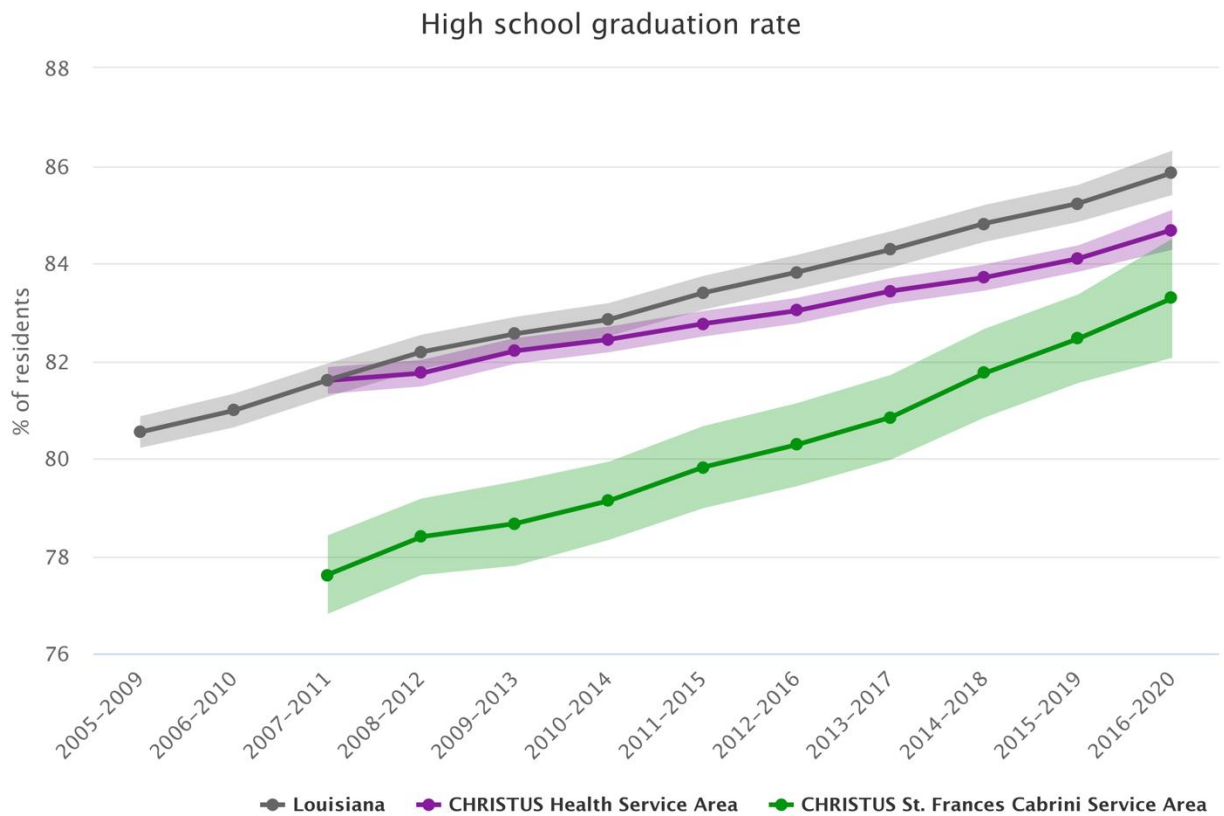
Table 7. Socioeconomic Indicators by Parish in the CHRISTUS St. Frances Cabrini PSA

Education

The high school graduation in the CHRISTUS St. Frances Cabrini PSA is 83.3%, which is in line with the wider CHRISTUS Health service area and state averages (84.7% and 85.9% respectively) (Figure 20). High school graduate rates have been on the rise in all benchmark regions since at least 2007.

Post-secondary education in the CHRISTUS St. Frances Cabrini PSA is lower than in both the wider CHRISTUS service area and the state (Figure 21). For residents 25 or older with any post-secondary education, the higher degree graduation rate in the CHRISTUS St. Frances Cabrini PSA is 26.4% compared to 31.7% in the CHRISTUS Health service area and 31.4% in Louisiana. Table 8 provides additional education-related data for the service area parishes.

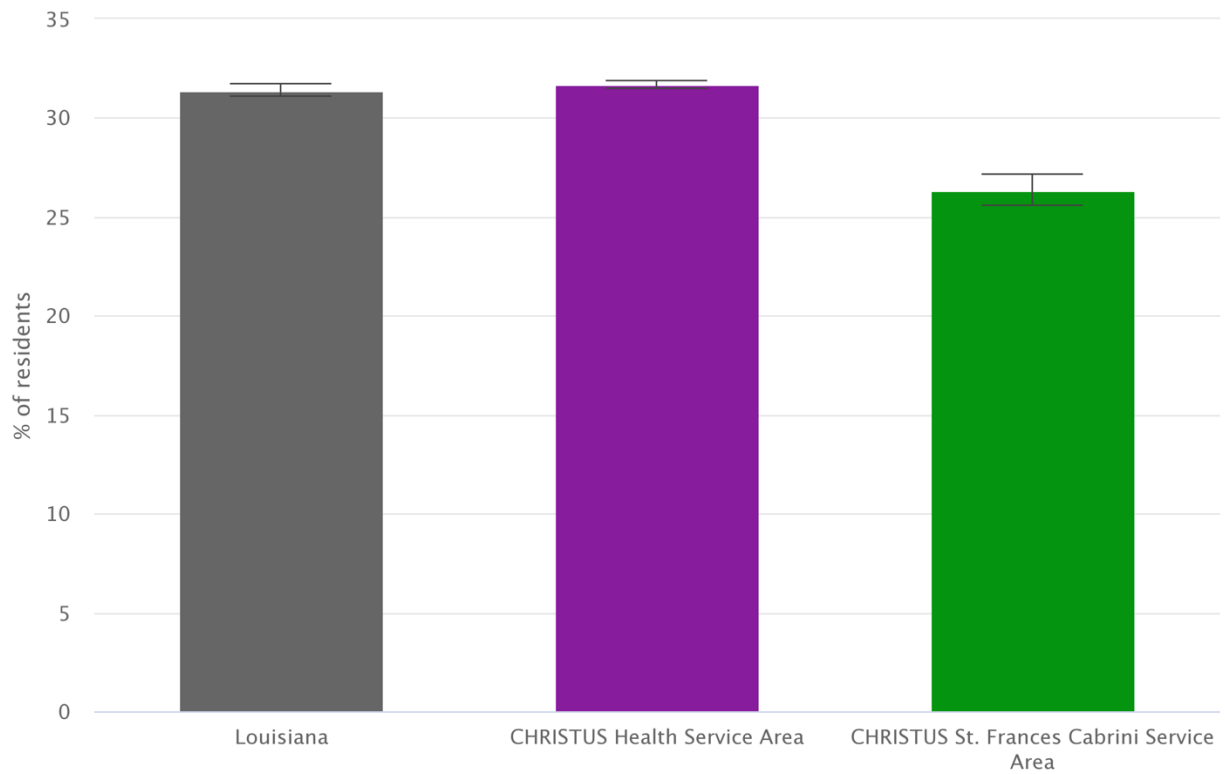
Education came up as an issue in the focus groups. Participants shared that community members, young mothers and disadvantaged youth in particular, need more education to qualify for the jobs that are available. They also shared that limited childcare in the area makes it difficult for parents to pursue higher education.



Created on Metopio | <https://metop.io/i/t33g4tq7> | Data source: American Community Survey (Table B15002)
High school graduation rate: Residents 25 or older with at least a high school degree: including GED and any higher education

Figure 20. High School Graduation Rate in the CHRISTUS St. Frances Cabrini PSA

Higher degree graduation rate, 2016–2020



Created on Metopio | <https://metop.io/i/5in3jhfW> | Data source: American Community Survey (Table B15002)
Higher degree graduation rate: Residents 25 or older with any post-secondary degree, such as an Associates or bachelor's degree or higher

Figure 21. Higher Degree Graduation Rate in the CHRISTUS St. Frances Cabrini PSA

Topic	Allen Parish, LA	Avoyelles Parish, LA	Catahoula Parish, LA	Concordia Parish, LA	Grant Parish, LA	LaSalle Parish, LA	Natchitoches Parish, LA	Rapides Parish, LA	Vernon Parish, LA	Winn Parish, LA
Preschool enrollment Infants (0-4 years) % of toddlers, 2016-2020	58.27	69.80	55.84	54.02	60.92	44.97	43.93	47.89	30.72	61.22
Private school Juveniles (5-17 years) % of grade school students, 2016-2020	10.05	19.39	8.18	1.91	7.99	11.59	8.93	13.17	6.91	14.27
9th grade education rate % of residents, 2016-2020	93.92	93.91	91.84	92.72	95.38	94.41	97.13	95.15	96.79	93.59
High school graduation rate % of residents, 2016-2020	81.82	79.26	74.87	80.62	83.84	80.12	87.91	86.52	87.63	80.68
Any higher education rate % of residents, 2016-2020	38.42	41.41	35.72	40.52	40.78	36.31	49.88	50.21	48.72	39.35
Graduate education rate % of residents, 2016-2020	4.05	3.88	4.91	4.35	2.32	3.26	7.95	8.38	4.83	4.10

Table 8. Education Indicators by Parish in the CHRISTUS St. Frances Cabrini PSA

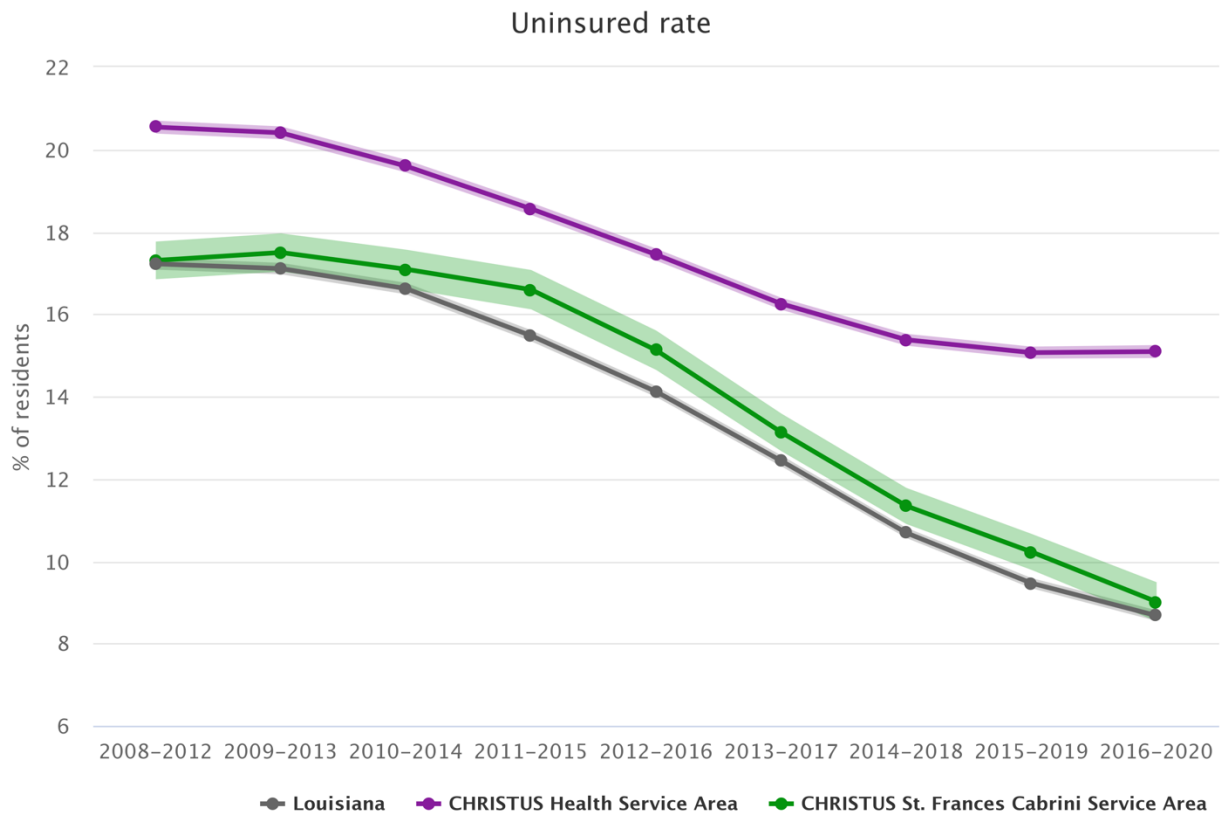
Access to Care

Being able to reliably access the health system, whether for primary care, mental health, or specialists, is often dependent on one's insurance (Figure 22). The uninsured rate in the CHRISTUS St. Frances Cabrini PSA (9.0%) and is similar to the rate in Louisiana (8.7%), but much lower than the rest of the CHRISTUS Health service area (15.1%).

Many residents in the service area receive insurance through Medicaid programs. The percentage of residents covered by Medicaid in the CHRISTUS St. Frances Cabrini PSA (32.9%) is higher than both the full CHRISTUS Health service area (21.1%) and Louisiana (27.7%) (Figure 23).

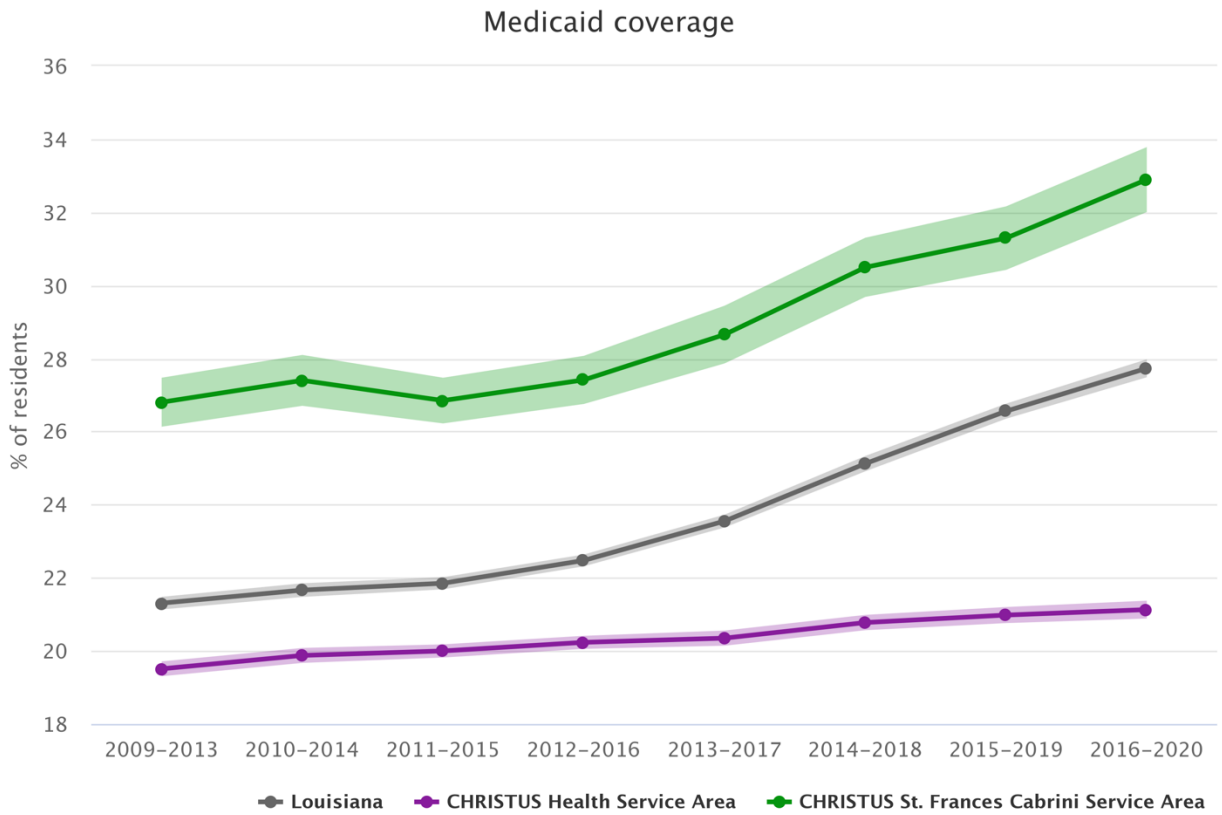
"Close access to quality medical care. We travel about 47 miles to get to Cabrini. In an emergency the time counts... This is a huge issue in our community."

- Survey respondent



Created on Metopio | <https://metop.io/i/jps79iks> | Data source: American Community Survey (Tables B27001/C27001)
 Uninsured rate: Percent of residents without health insurance (at the time of the survey).

Figure 22. Uninsured Rate in the CHRISTUS St. Frances Cabrini PSA

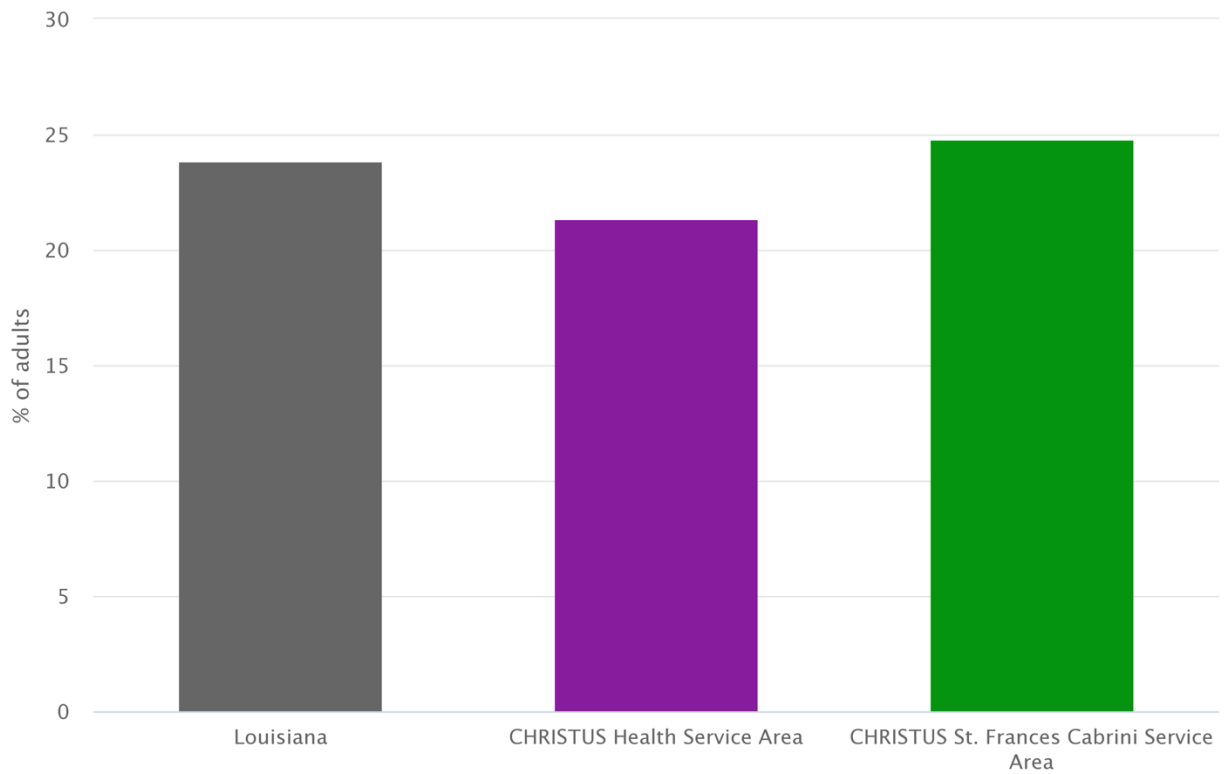


Created on Metopio | <https://metop.io/i/xmmvh1nt> | Data source: American Community Survey (Tables S2704, S2701, and B27010)
Medicaid coverage: Percent of residents covered by Medicaid, a state-administered health insurance program for residents meeting certain income limits and other eligibility standards that vary by state.

Figure 23. Medicaid Coverage in the CHRISTUS St. Frances Cabrini PSA

Mental health was raised as an issue through all channels of primary data collection. Figure 24 shows the percentage of adults in the CHRISTUS St. Frances Cabrini PSA experiencing depression, which is over one-in-five for the CHRISTUS St. Frances Cabrini PSA, the whole CHRISTUS Health service area, and the United States. Of the three areas, the CHRISTUS St. Frances Cabrini PSA has the highest percentage of adults who experience depression (24.8%). Many residents noted a lack of access to providers, regardless of a person's insurance. Table 9 shows the per capita rate for types of mental health providers in each of the service area parishes, as well as other behavioral health indicators for comparison.

Depression, 2019



Created on Metopio | <https://metop.io/i/zrgthqop> | Data source: PLACES
 Depression: Prevalence of depression among adults 18 years and older

Figure 24. Depression in the CHRISTUS St. Frances Cabrini PSA

Topic	Allen Parish, LA	Avoyelles Parish, LA	Catahoula Parish, LA	Concordia Parish, LA	Grant Parish, LA	LaSalle Parish, LA	Natchitoches Parish, LA	Rapides Parish, LA	Vernon Parish, LA	Winn Parish, LA
Poor self-reported mental health % of adults, 2019	18.40	20.60	19.60	20.80	18.60	19.60	20.00	18.70	17.80	19.10
Poor mental health days days per month, 2018	5.3	5.8	5.4	5.7	5.3	5.5	5.4	5.3	4.9	5.3
Psychiatry physicians per capita physicians per 100,000 residents, 2021	0	3	0	0	0	10	20	27	3	3
Mental health providers per capita providers per 100,000 residents, 2021	115.5	226.2	20.3	595.4	95.8	101.9	490.5	594.9	219.0	60.1
Depression % of adults, 2019	24.10	25.80	25.00	25.10	24.60	26.50	24.20	24.60	24.00	24.50
Drug overdose mortality deaths per 100,000, 2016-2020	21.41	22.39	23.05	12.89	15.20	17.38	12.67	33.50	14.59	17.01

Table 9. Mental Health Access Indicators by Parish in the CHRISTUS St. Frances Cabrini PSA

Many low-income residents in the PSAs rely on Federally Qualified Health Centers (FQHCs) for their care in addition to hospitals, outpatient centers and primary care offices (Figure 25). Table 10 includes other indicators that measure access to primary care including the per capita number of primary care physicians and nurse practitioners.

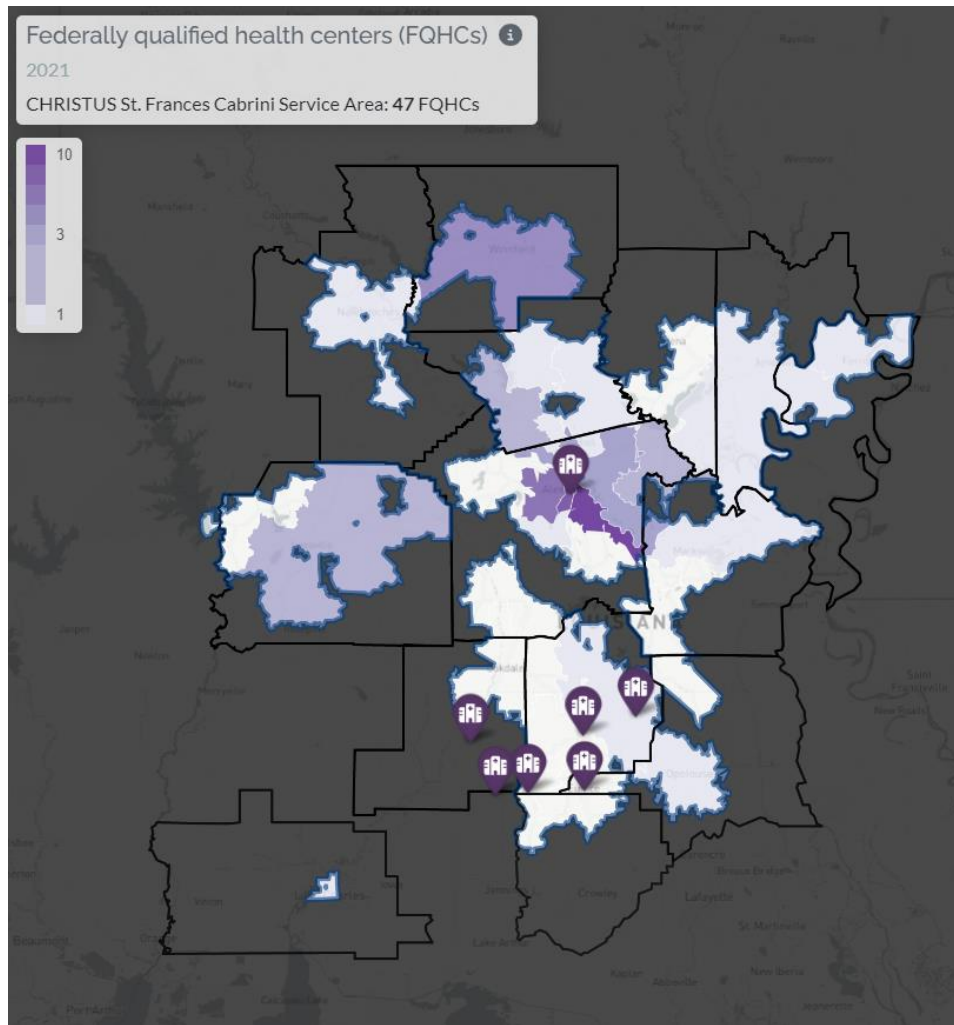


Figure 25. Heat Map of FQHC locations in the CHRISTUS St. Frances Cabrini PSA

Topic	Allen Parish, LA	Avoyelles Parish, LA	Catahoula Parish, LA	Concordia Parish, LA	Grant Parish, LA	LaSalle Parish, LA	Natchitoches Parish, LA	Rapides Parish, LA	Vernon Parish, LA	Winn Parish, LA
Visited doctor for routine checkup % of adults, 2019	78.30	80.00	79.00	80.00	77.70	77.50	80.90	81.10	78.60	79.00
Primary care providers (PCP) per capita physicians per 100,000 residents, 2018	11.7	29.0	9.8	24.5	8.9	60.4	55.9	94.5	34.3	53.9
Nurse practitioners per capita nurses per 100,000 residents, 2019	85.76	53.15	78.07	48.90	26.83	60.41	53.39	156.55	57.17	53.85

Table 10. Primary Care Access Indicators in the CHRISTUS St. Frances Cabrini PSA

Food Access

Both obesity and healthy eating were raised as top health issues by survey respondents. Often obesity is correlated with poor food access and about 11.4% of residents in the CHRISTUS St. Frances Cabrini PSA live in a food desert, meaning there isn't a grocery store with one mile for urban residents and five miles for rural residents. Without easy access to fresh, healthy foods, people sometimes rely on fast food and other unhealthy options. Figure 26 shows that food desert areas are spread across the CHRISTUS St. Frances Cabrini PSA, but the highest concentration is found in zip code 71302 (37.2% of residents). In addition to food deserts, 15.5% of residents are considered food insecure which is an indicator that incorporates both economic and social barriers to food access (Figure 27). Table 11 breaks out various indicators of food access by parishes in the service areas.

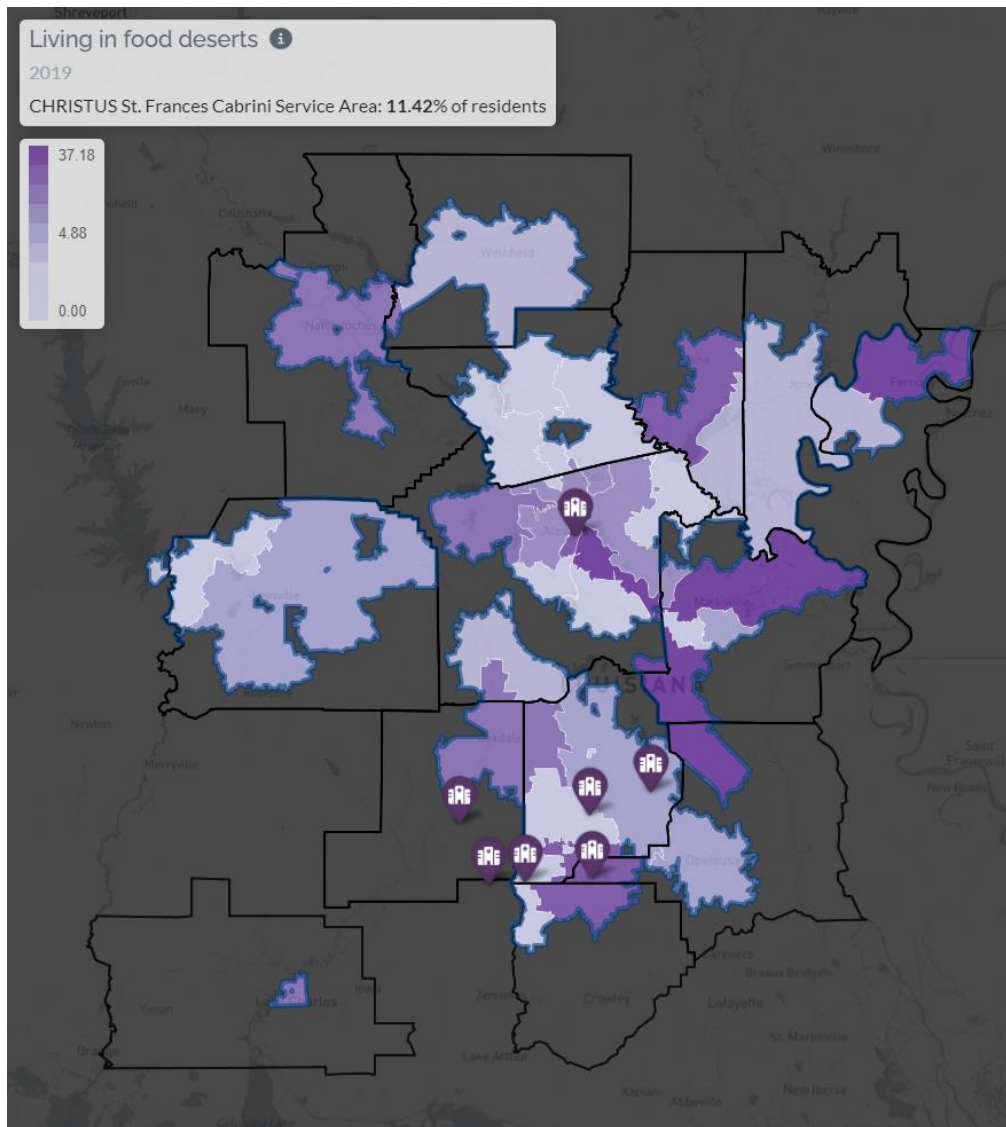
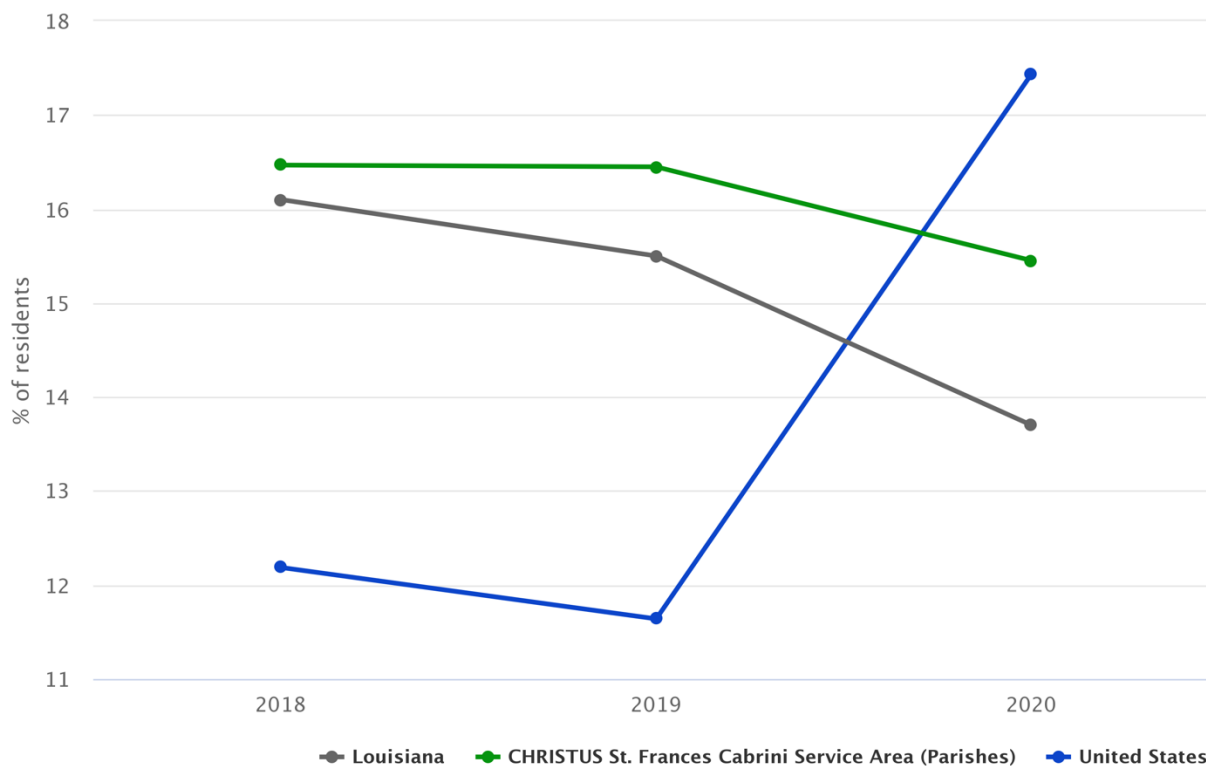


Figure 26. Map of Residents Living in Food Deserts in the CHRISTUS St. Frances Cabrini PSA

Food insecurity



Created on Metopio | <https://metop.io/i/7qykjdbn> | Data source: Feeding America (Map the Meal Gap 2020)
Food insecurity: Percentage of the population experiencing food insecurity at some point. Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food, as represented in USDA food-security reports. 2020 data is a projection based on 11.5% national unemployment and 16.5% national poverty rate.

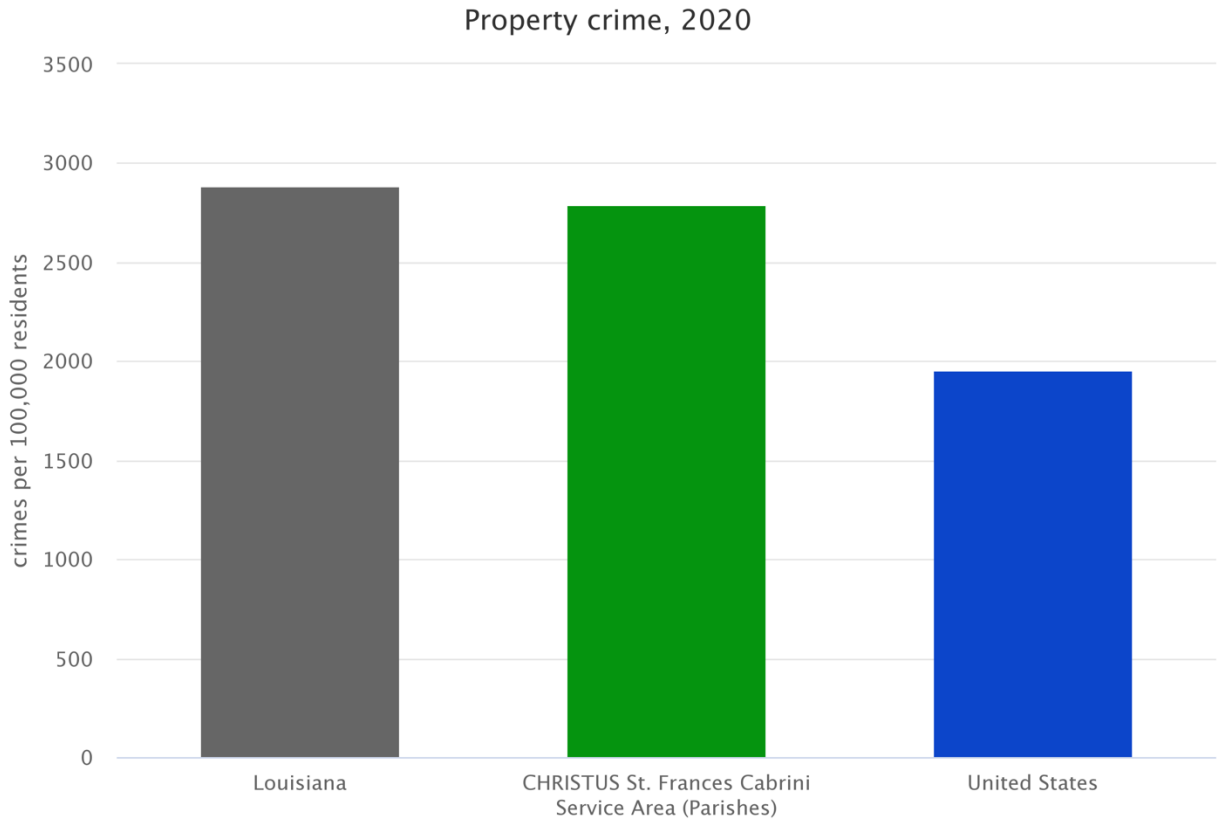
Figure 27. Percent of Residents who are Food Insecure in the CHRISTUS St. Frances Cabrini PSA

Topic	Allen Parish, LA	Avoyelles Parish, LA	Catahoula Parish, LA	Concordia Parish, LA	Grant Parish, LA	LaSalle Parish, LA	Natchitoches Parish, LA	Rapides Parish, LA	Vernon Parish, LA	Winn Parish, LA
Food insecurity % of residents, 2020	22.5	23.9	22.0	24.3	21.8	20.6	25.5	21.6	22.3	24.0
Low food access % of residents, 2019	37.30	30.34	38.11	48.39	18.44	38.07	43.33	55.32	56.95	24.15
Very low food access % of residents, 2019	17.42	16.64	0.00	26.10	0.00	17.67	12.67	23.63	32.12	0.23
Living in food deserts % of residents, 2019	6.17	10.19	0.00	15.90	0.00	10.05	8.78	12.85	14.79	0.09
Average cost per meal 2019	\$3.08	\$3.10	\$2.99	\$2.99	\$3.02	\$2.96	\$3.11	\$2.97	\$3.24	\$3.13

Table 11. Food Access Indicators by Parish in the CHRISTUS St. Frances Cabrini PSA

Violence and Community Safety

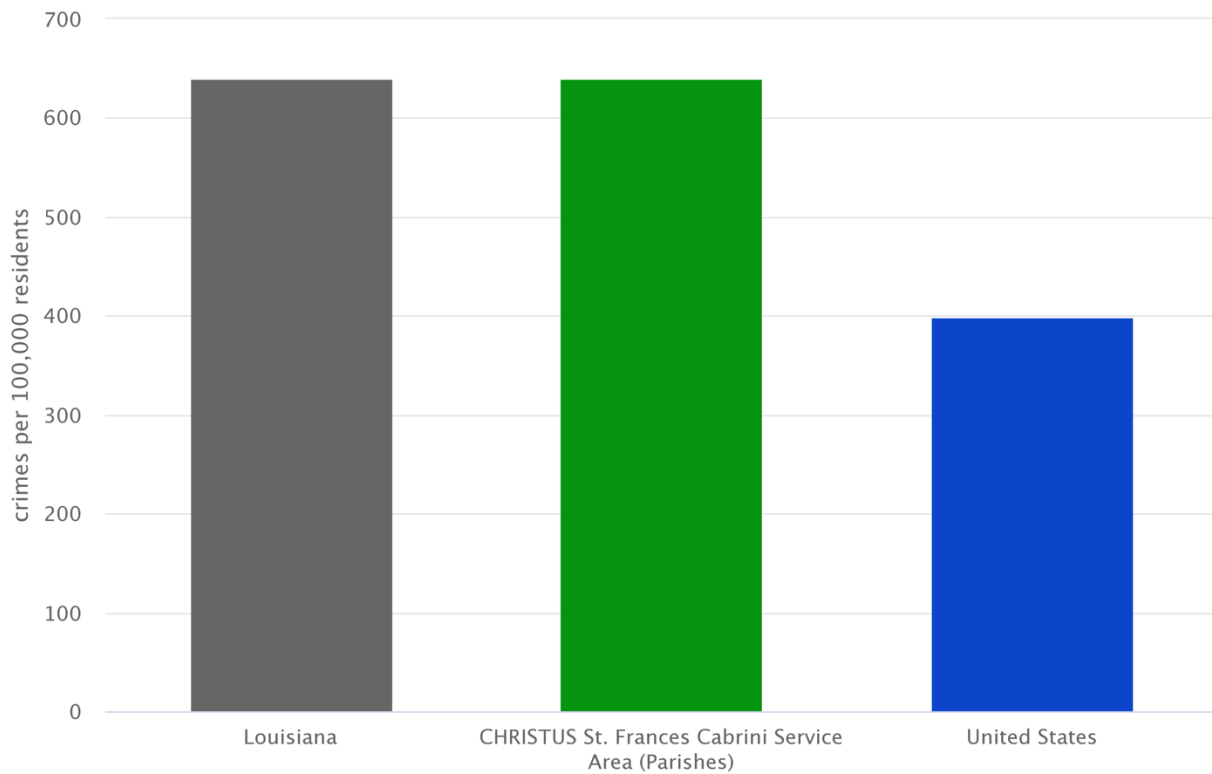
The rate of property crimes, which includes burglary, larceny, motor vehicle theft, and arson crimes is lower in CHRISTUS St. Frances Cabrini PSA than the rate in Louisiana, but it is higher than the rate in the United States overall (Figure 28). The same can be said for crimes related to violence, including homicide, criminal sexual assault, robbery, aggravated assault, and aggravated battery (Figure 29). Table 12 shows specific crimes for each parish in the service areas.



Created on Metopio | <https://metop.io/i/gcgt2bp> | Data sources: FBI Crime Data Explorer (County, state, and city level data), Chicago crime data portal (Data v
Property crime: Property crimes (yearly rate). Includes burglary, larceny, motor vehicle theft, and arson crimes.

Figure 28. Property Crime in the CHRISTUS St. Frances Cabrini PSA

Violent crime, 2020



Created on Metopio | <https://metop.io/i/wkokei5f> | Data sources: Chicago crime data portal (Data within Chicago), New York City Police Department (NYPD) (Data within New York City)
Violent crime: Crimes related to violence (yearly rate). Includes homicide, criminal sexual assault, robbery, aggravated assault, and aggravated battery.

Figure 29. Violent Crime Rate in the CHRISTUS St. Frances Cabrini PSA

Topic	Allen Parish, LA	Avoyelles Parish, LA	Catahoula Parish, LA	Concordia Parish, LA	Grant Parish, LA	LaSalle Parish, LA	Natchitoches Parish, LA	Rapides Parish, LA	Vernon Parish, LA	Winn Parish, LA
Property crime crimes per 100,000 residents, 2020	2,015.4	1,014.8	702.6	1,814.3	4.5	234.9	3,757.9	4,184.5	1,351.1	1,265.6
Violent crime crimes per 100,000 residents, 2020	132.5	229.5	351.3	577.0	0.0	268.5	638.2	1,030.8	261.1	464.5
Arson crimes per 100,000 residents, 2020	0.0	0.0	39.0	9.8	0.0	0.0	17.8	7.6	7.6	0.0
Burglary crimes per 100,000 residents, 2020	233.9	236.8	273.3	396.1	4.5	107.4	945.8	1,099.6	240.1	215.4
Homicide crimes per 100,000 residents, 2020	0.0	14.5	9.8	0.0	0.0	6.7	17.8	15.9	1.9	20.2

Table 12. Types of Crime by County in the CHRISTUS St. Frances Cabrini PSA

CHRISTUS ST. FRANCES CABRINI HEALTH DATA ANALYSIS

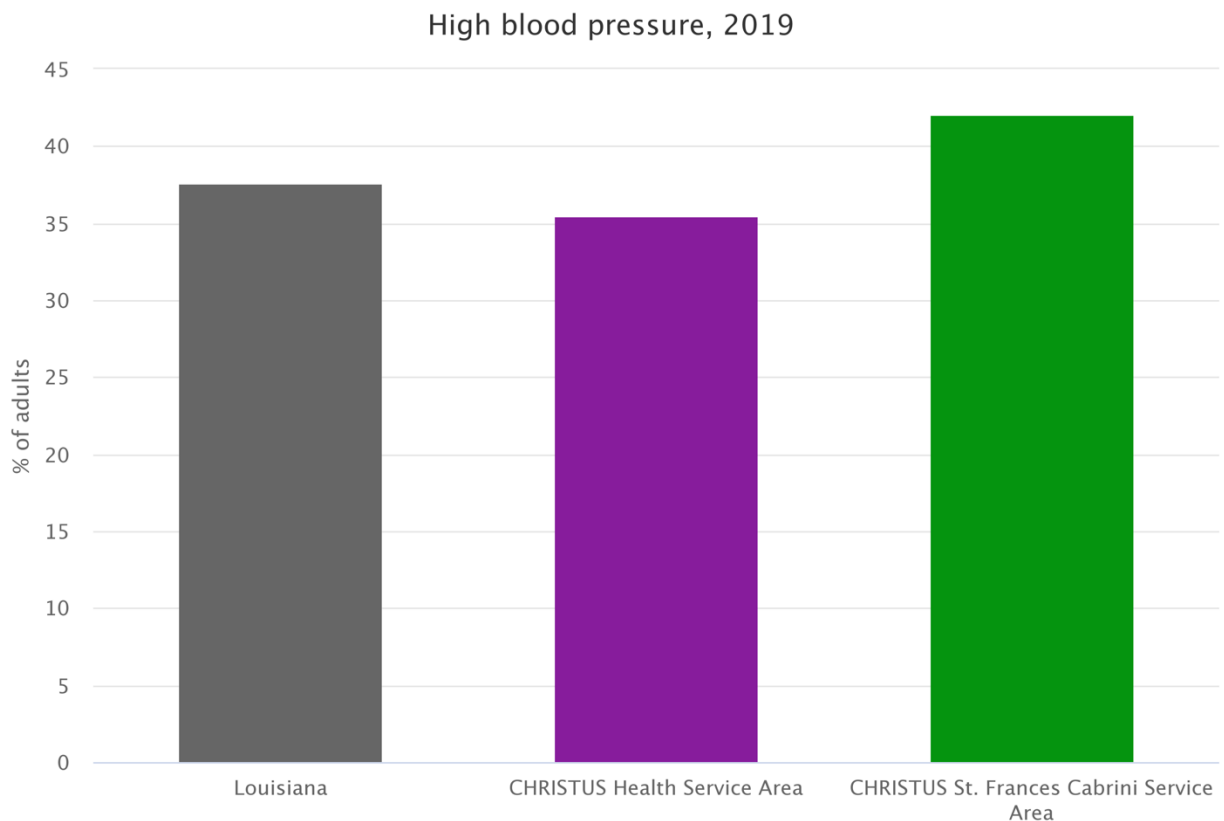


CHRISTUS St. Frances Cabrini CHNA Health Data Analysis

Health Outcomes: Morbidity and Mortality

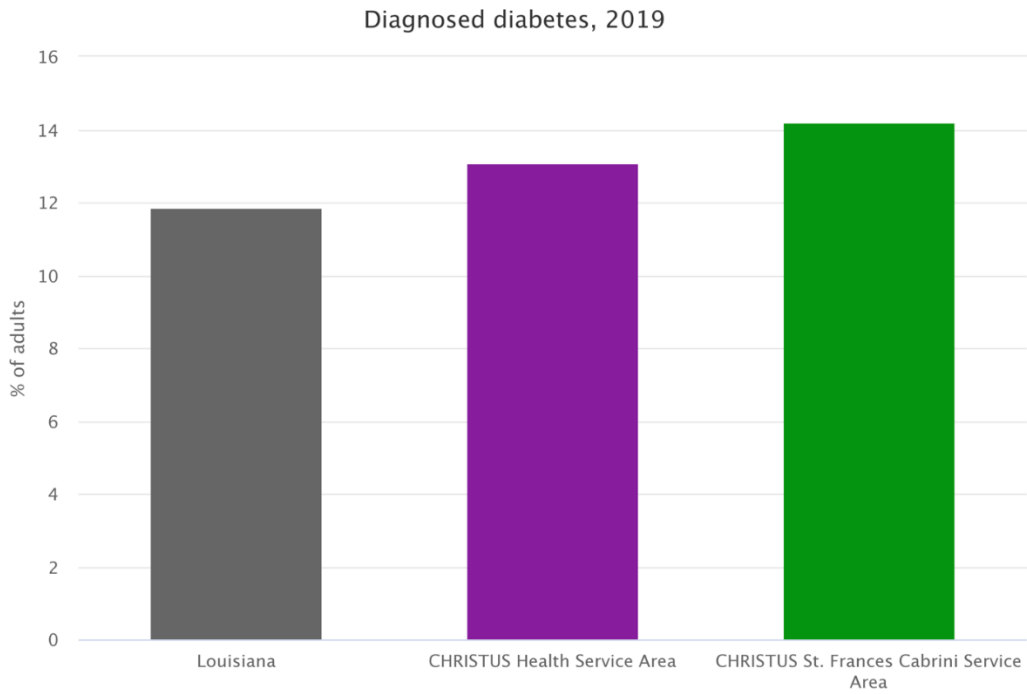
Chronic Disease

Community members noted that chronic conditions, especially heart disease and diabetes, had an outsized impact on the community. The rate of high blood pressure is higher in the CHRISTUS St. Frances Cabrini PSA than in the full CHRISTUS Health service area and Louisiana as illustrated below in Figure 30. And more than 1 in 10 adults has diabetes in the CHRISTUS St. Frances Cabrini PSA (Figure 31). The rate of diabetes is slightly higher rate in Louisiana and the full CHRISTUS Health service area (Figure 31). Chronic kidney disease affects 3.8% in the CHRISTUS St. Frances Cabrini PSA, which is slightly above both benchmarks (Figure 32). Lastly, about 10.5% of the population lives with asthma in CHRISTUS St. Frances Cabrini PSA (Figure 33), which is just above the average in the CHRISTUS Health service area and the state. The following charts and line graphs illustrate these disease conditions.



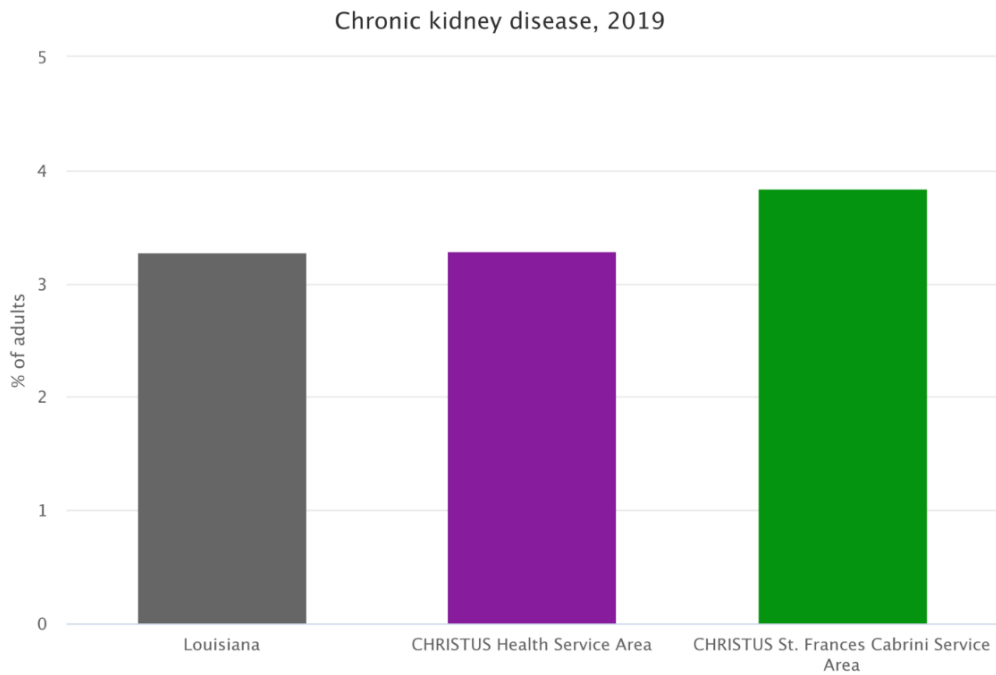
Created on Metopio | <https://metop.io/i/v5avg7h3> | Data sources: PLACES (Sub-county data (zip codes, tracts)), Behavioral Risk Factor Surveillance System (BRFSS) (County and state level data)
High blood pressure: Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have high blood pressure (hypertension). Women who were told high blood pressure only during pregnancy and those who were told they had borderline hypertension were not included.

Figure 30. High Blood Pressure in the CHRISTUS St. Frances Cabrini PSA



Created on Metopio | <https://metop.io/i/k2tr6eoj> | Data sources: Diabetes Atlas (County and state level data), PLACES
 Diagnosed diabetes: Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have diabetes, other than diabetes during pregnancy.

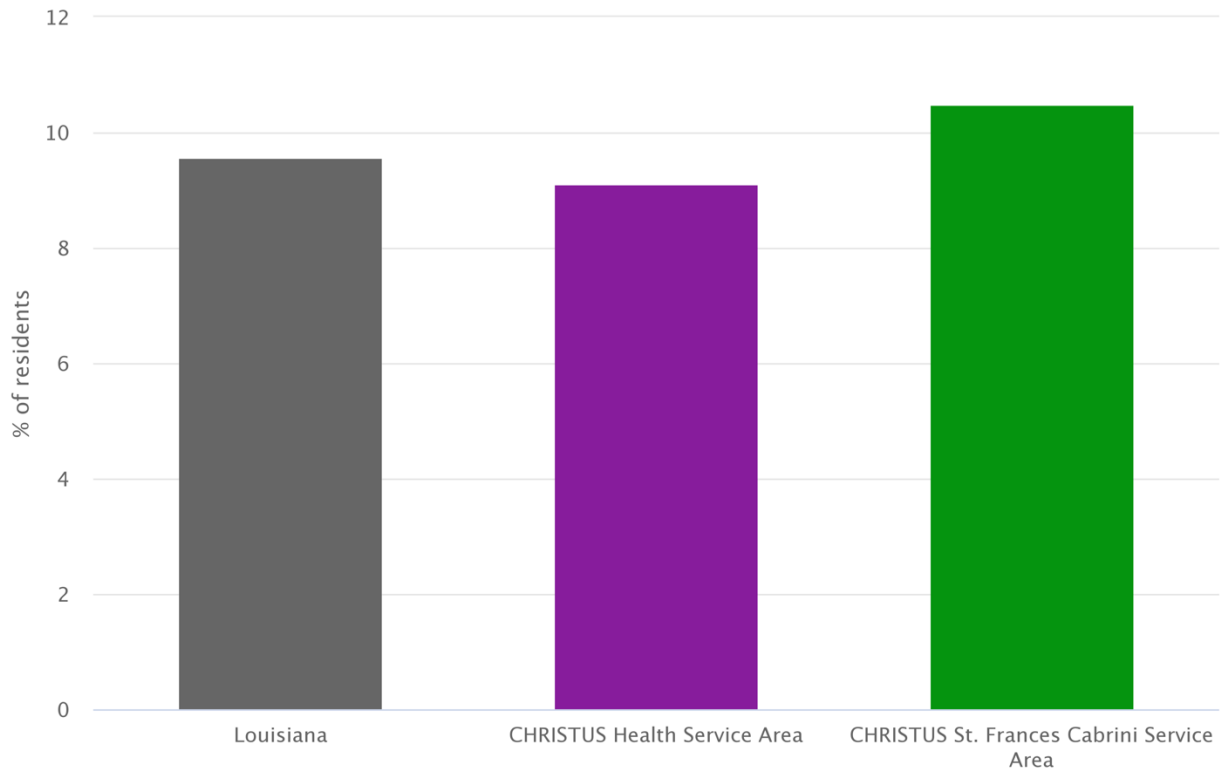
Figure 31. Diagnosed Diabetes in the CHRISTUS St. Frances Cabrini PSA



Created on Metopio | <https://metop.io/i/g4s3y8ye> | Data sources: PLACES (Sub-county data (zip codes, tracts)), Razzaghi, Wang, et al. (MMWR Morb Mortal Wkly Rep 2020) (county
 Chronic kidney disease: Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have kidney disease.

Figure 32. Chronic Kidney Disease in the CHRISTUS St. Frances Cabrini PSA

Current asthma, 2019



Created on Metopio | <https://metop.io/i/4fi4gy2w> | Data sources: PLACES (Sub-county data (zip codes, tracts)), Behavioral Risk Factor Surveillance System (BRFSS) (County and state
Current asthma: Percent of residents (civilian, non-institutionalized population) who answer "yes" both to both of the following questions: "Have you ever been told by a doctor, nurse, or other health professional that you have asthma?" and the question "Do you still have asthma?"

Figure 33. Residents with Asthma in the CHRISTUS St. Frances Cabrini PSA

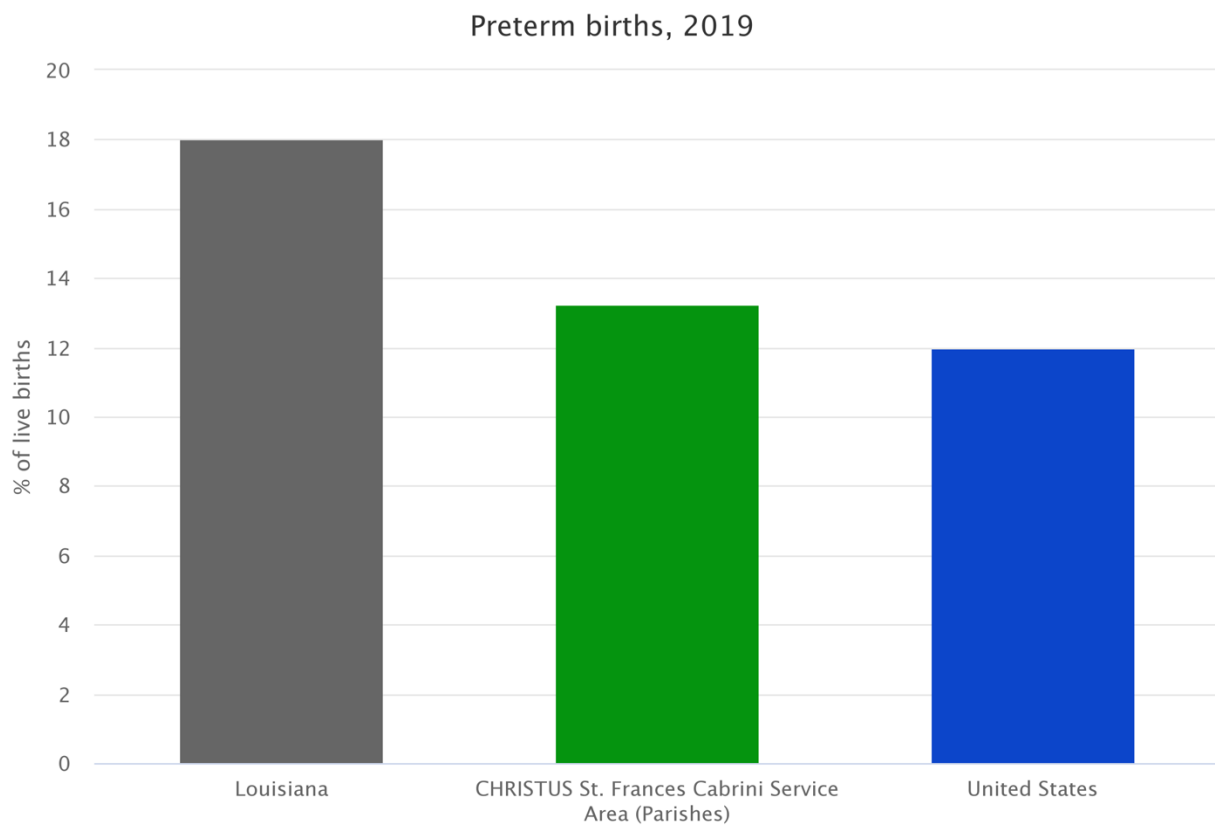
Table 13 provides additional insight into the burden of chronic diseases by each parish in the Cabrini service areas.

Topic	Allen Parish, LA	Avoyelles Parish, LA	Catahoula Parish, LA	Concordia Parish, LA	Grant Parish, LA	LaSalle Parish, LA	Natchitoches Parish, LA	Rapides Parish, LA	Vernon Parish, LA	Winn Parish, LA
High blood pressure % of adults, 2019	37.40	40.20	39.90	41.90	37.50	37.10	41.30	38.40	37.20	40.40
Diagnosed diabetes % of adults, 2019	11.6	13.3	12.6	14.5	11.7	11.6	14.0	12.2	11.4	12.5
Coronary heart disease % of adults, 2019	6.80	7.70	7.40	8.00	7.10	7.30	7.60	6.70	6.70	7.30
Chronic kidney disease % of adults, 2019	3.1	3.6	3.5	3.9	3.2	3.2	3.8	3.3	3.1	3.4
Current asthma % of residents, 2019	9.40	10.30	10.10	10.70	9.20	9.70	10.80	9.90	9.10	9.80
Obesity % of adults, 2019	37.1	42.8	38.0	42.4	38.2	36.8	42.0	39.8	37.9	38.8

Table 13. Chronic Disease Indicators by Parish in the CHRISTUS St. Frances Cabrini PSA

Maternal Health

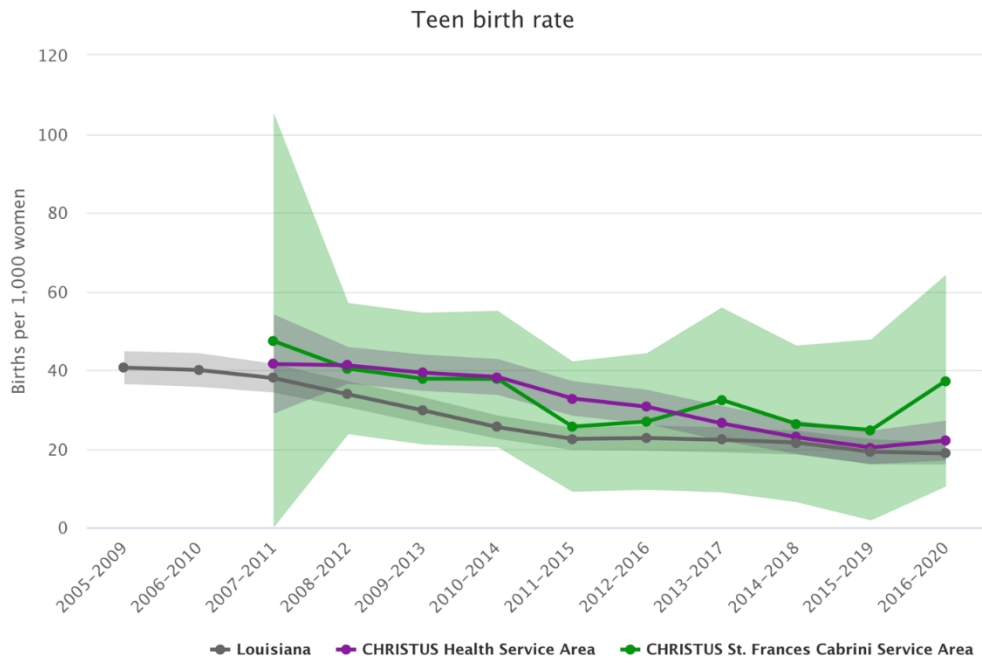
Preterm births are a challenge within the CHRISTUS St. Frances Cabrini PSA. The rate of preterm births in the service area (13.3%) is significantly higher than that in the state (18.0%) or the United States (12.0%) (Figure 34).



Created on Metopio | <https://metop.io/i/emakfkqa> | Data sources: National Vital Statistics System–Nativity (NVSS–N) (via CDC wonder (2016–2020 data average)
Preterm births: Percent of live births that are preterm (<37 completed weeks of gestation). Different states are available for different time periods.

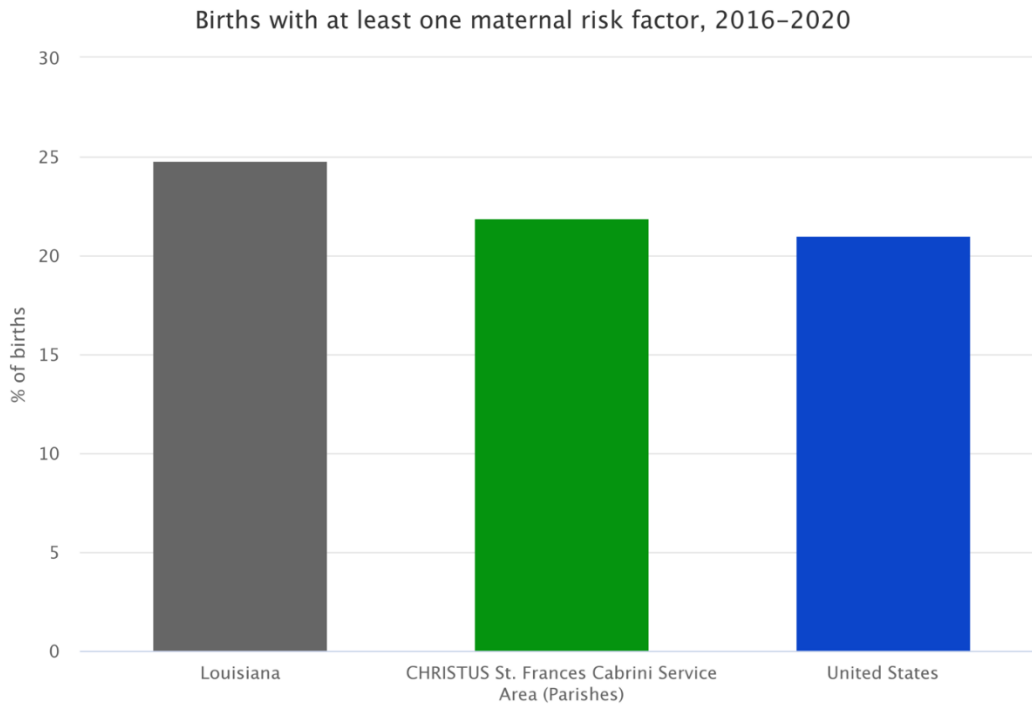
Figure 34. Percent of Preterm Births in the CHRISTUS St. Frances Cabrini PSA

The teen birth rate has been declining over the last decade in all benchmark regions. The rate within the CHRISTUS St. Frances Cabrini PSA (37.3 births per 1,000) is similar to that of the whole CHRISTUS Health service area (22.1 births) and Louisiana (18.8 births) (Figure 35). Within the CHRISTUS St. Frances Cabrini PSA, the rate of births with at least one maternal risk factor about the same as the rate in Louisiana (21.9% of births versus 24.8%). Both of these are higher than the rate in the United States (21.0%) (Figure 36).



Created on Metopio | <https://metop.io/i/mabrrt3c> | Data source: American Community Survey (Table B13002)
 Teen birth rate: Women age 15-19 with a birth in the past year, per 1,000 women age 15-19. Does not include births to women below age 15.

Figure 35. Teen Birth Rate in the CHRISTUS St. Frances Cabrini PSA



Created on Metopio | <https://metop.io/i/1953er4sk> | Data source: National Vital Statistics System-Nativity (NVSS-N) (via CDC Wonder, 5 year data)
 Births with at least one maternal risk factor: Births where the mother has at least one of the following conditions: Chronic Hypertension, Eclampsia, Diabetes, Tobacco use, or Pregnancy-associated hypertension

Figure 36. Percent of Births with At Least One Maternal Risk Factor in the CHRISTUS St. Frances Cabrini PSA

Leading Causes of Death

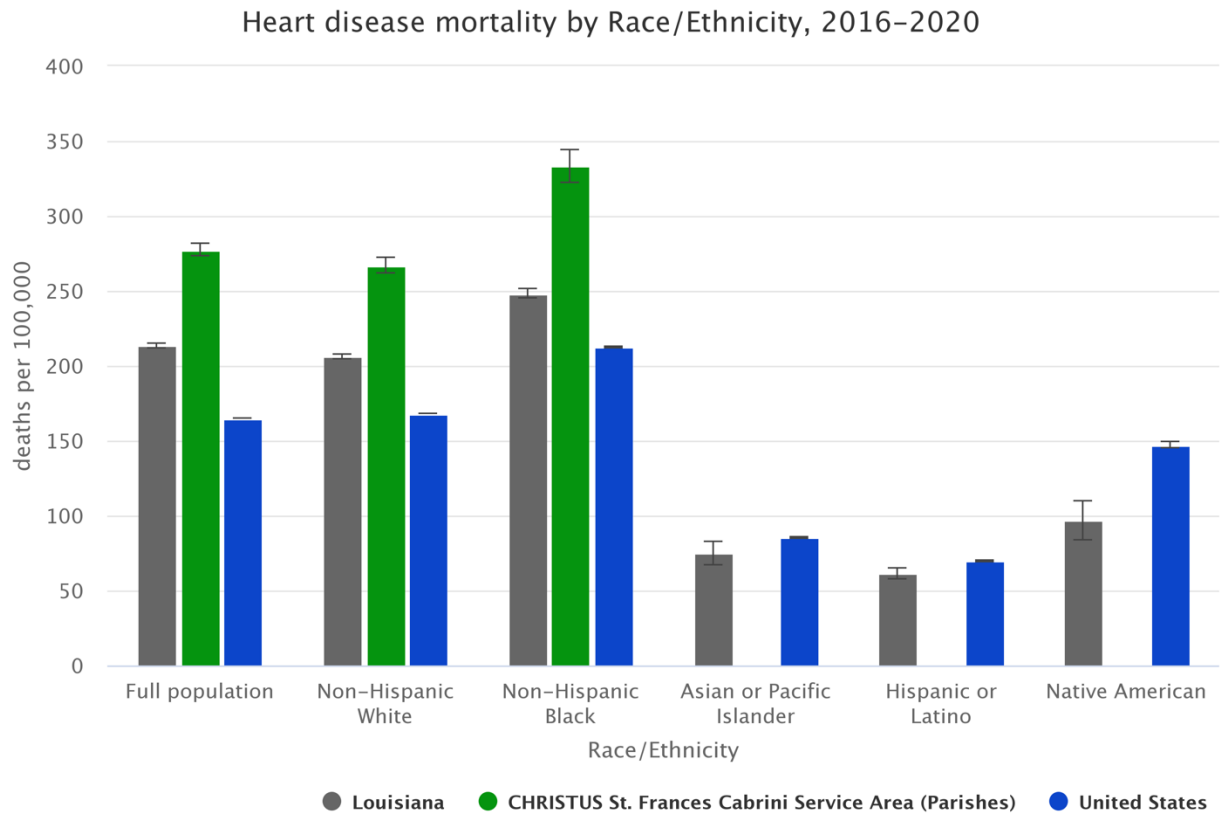
The top causes of death for the CHRISTUS St. Frances Cabrini PSA as a whole can be found in Table 14. The leading causes of death will be explored further for the service area in the following section. Parish level mortality rates will be explored at the end of this section (Table 16).

Topic	CHRISTUS St. Frances Cabrini (Counties)	Louisiana	United States
Heart disease mortality deaths per 100,000 , 2016 -2020	277.6	213.8	164.8
Cancer mortality deaths per 100,000 , 2016 -2020	185.2	168.7	149.4
Injury mortality deaths per 100,000 , 2016 -2020	94.9	95.8	72.6
Stroke mortality deaths per 100,000 , 2016 -2020	56.2	46.2	37.6
Chronic lower respiratory disease mortality deaths per 100,000 , 2016 -2020	47.6	42.5	39.1
Alzheimer's disease mortality deaths per 100,000 , 2016 -2020	46.6	43.6	30.8
Septicemia (sepsis) mortality deaths per 100,000 , 2016 -2020	23.8	20.0	10.1
Diabetes mortality deaths per 100,000 , 2016 -2020	21.4	27.2	22.1
Drug overdose mortality deaths per 100,000 , 2016 -2020	21.23	28.51	22.43
Influenza and pneumonia mortality deaths per 100,000 , 2016 -2020	20.9	14.2	13.6

Table 14. Leading Causes of Death in the CHRISTUS St. Frances Cabrini PSA

Heart disease

Coronary heart disease makes up the largest contributor to the heart disease mortality rate, accounting for 126.0 deaths per 100,000 out of the total 277.6 per 100,000 deaths for heart disease overall in the CHRISTUS St. Frances Cabrini PSA. Heart disease mortality has a disparate impact on the Black community in the CHRISTUS St. Frances Cabrini PSA. The mortality rate for non-Hispanic Black people is 333.4 deaths per 100,000 deaths in the PSA, compared to 267.1 deaths for non-Hispanic White people. There is insufficient data for the Hispanic or Latino, Asian or Pacific Islander, or Native American populations in the CHRISTUS St. Frances Cabrini PSA (Figure 37).



Created on Metopio | <https://metop.io/i/vmwemeip> | Data sources: National Vital Statistics System–Mortality (NVSS–M) (Via <http://healthindicators.gov>), Chicago Heart disease mortality: Deaths per 100,000 residents with an underlying cause of heart disease (ICD–10 codes I00–I09, I11, I13, I20–I51).

Figure 37. Heart Disease Mortality with Stratifications in the CHRISTUS St. Frances Cabrini PSA

Cancer

Cancer represents the second leading cause of death the CHRISTUS St. Frances Cabrini PSA. Lung, trachea, and bronchus cancer, in particular, make up a large portion of cancer deaths, causing 185.2 deaths per 100,000 deaths in the CHRISTUS St. Frances Cabrini PSA (Figure 38). Table 15 breaks out the mortality rate for some cancers.

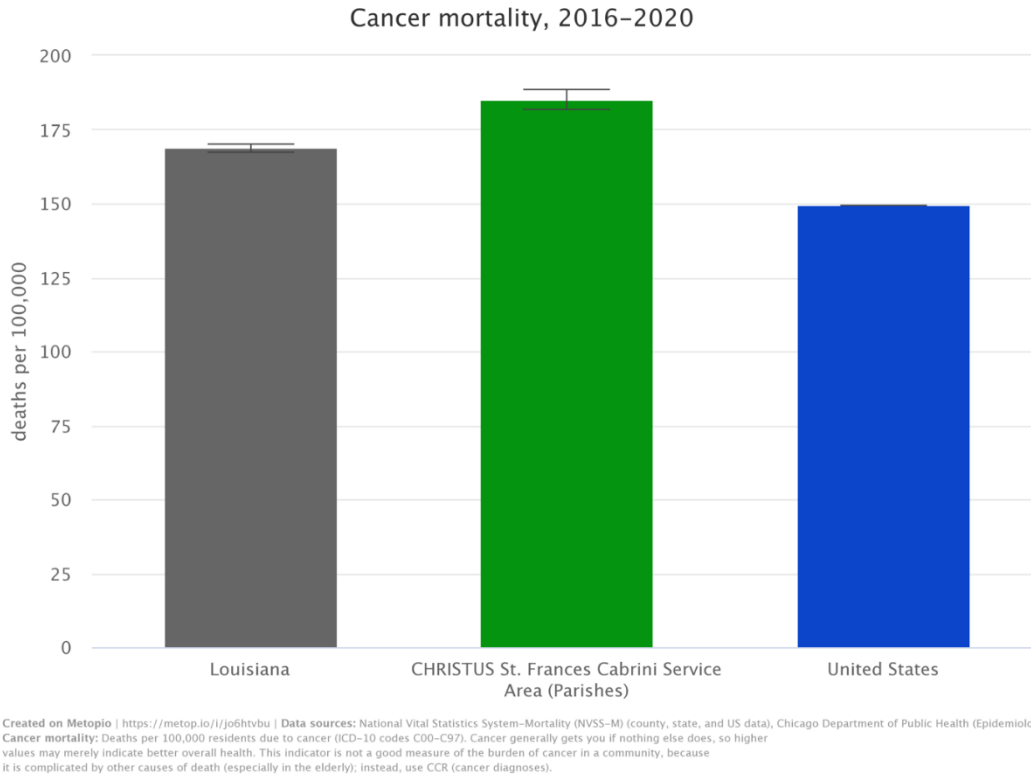


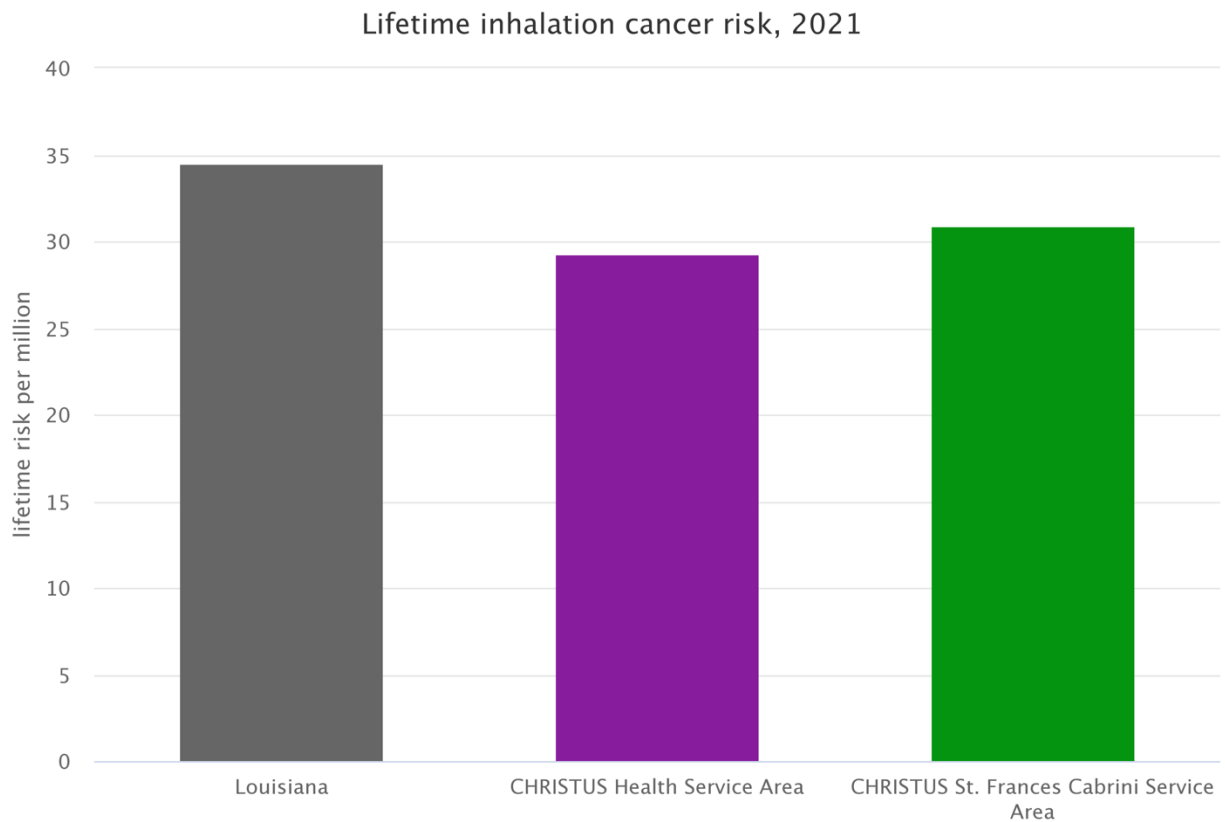
Figure 38. Cancer Mortality in the CHRISTUS St. Frances Cabrini PSA

Topic	Allen Parish, LA	Avoyelles Parish, LA	Catahoula Parish, LA	Concordia Parish, LA	Grant Parish, LA	LaSalle Parish, LA	Natchitoches Parish, LA	Rapides Parish, LA	Vernon Parish, LA	Winn Parish, LA
Lung, trachea, and bronchus cancer mortality deaths per 100,000, 2016–2020	56.7	57.9	38.9	49.3	46.6	46.4	43.9	42.1	66.9	51.7
Colorectal cancer mortality deaths per 100,000, 2016–2020	14.3	22.6	35.3	26.8	22.0	25.4	20.2	19.8	22.6	22.7
Breast cancer mortality deaths per 100,000, 2016–2020	13.3	10.0	23.5	18.2	13.4	14.7	16.1	14.6	14.1	17.0

Table 15. Cancer Mortality Indicators by Type in the CHRISTUS St. Frances Cabrini PSA

Environmental factors may contribute to the lung cancer burden in the service areas. The Lifetime Inhalation Cancer Risk of the Environmental Protection Agency’s Environmental Justice Index is a weighted index of vulnerability to lifetime inhalation cancer risk. It measures estimated lifetime risk of developing cancer as a result of inhaling carcinogenic compounds in the environment, per million people. The Lifetime Inhalation Cancer Risk in the CHRISTUS St. Frances Cabrini PSA (30.9 lifetime risk per million) is higher than the CHRISTUS Health service area (29.2) but lower than the overall risk in Louisiana (34.5) (Figure 39).

“Water quality is poor. We are constantly on a water boil alert. I had to boil water for a month. People seem to take it for granted that everyone boils water, even to bathe. I am senior citizen and can't afford to be buying water.”
 – Survey respondent

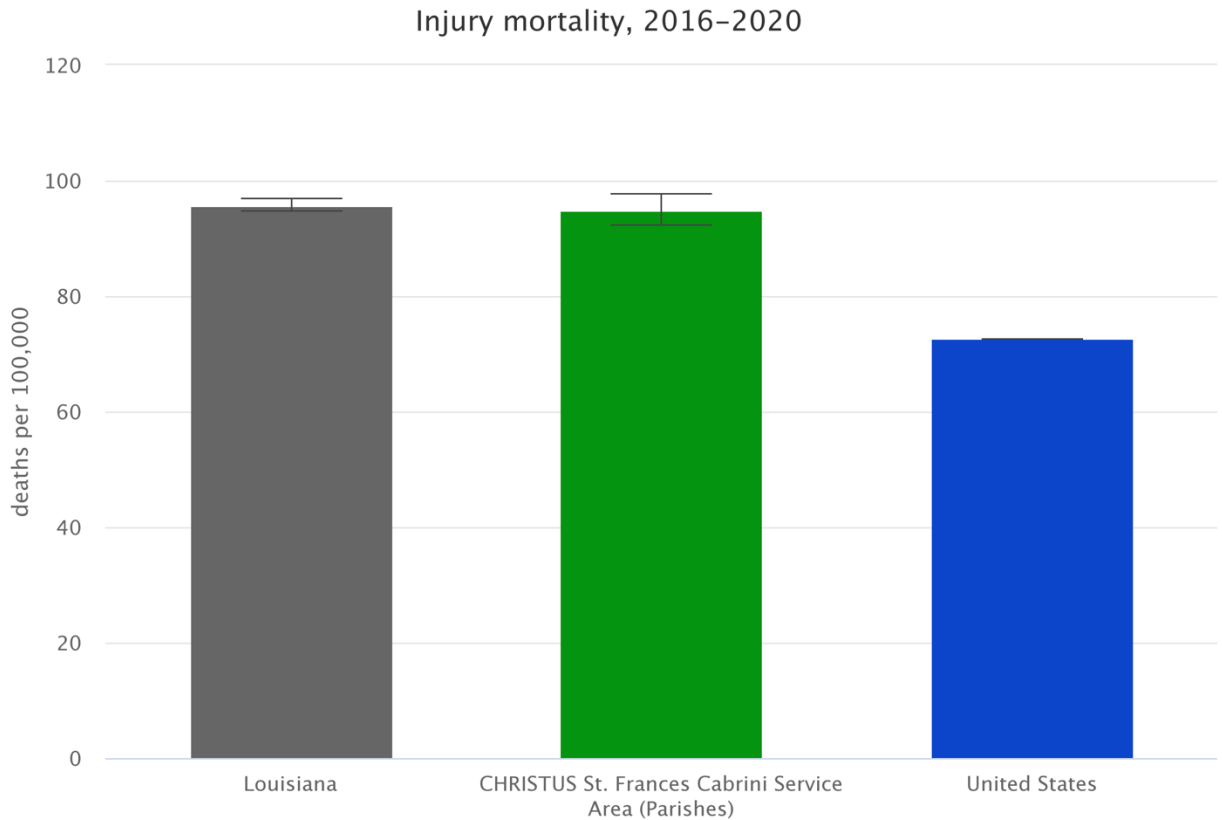


Created on Metopio | <https://metop.io/i/7v3aeuo2> | Data source: EJScreen: Environmental Justice Screening (EJSCREEN, via National-Scale Air Toxics Assessment) Lifetime inhalation cancer risk: Estimated lifetime risk of developing cancer as a result of inhaling carcinogenic compounds in the environment, per million people.

Figure 39. Lifetime Inhalation Cancer Risk in the CHRISTUS St. Frances Cabrini PSA

Injury

Injuries account for the fourth highest cause of death in the CHRISTUS St. Frances Cabrini PSA. This is, in part, because this category includes many kinds of injury including unintentional injury mortality and motor vehicle traffic mortality and workplace mortality. This topic does not include homicide or suicide mortality. The rate for the in the CHRISTUS St. Frances Cabrini PSA (94.9 deaths per 100,000) is about the same as rate in Louisiana (95.8), but both benchmarks are much higher than the average across the United States (72.6) (Figure 40).

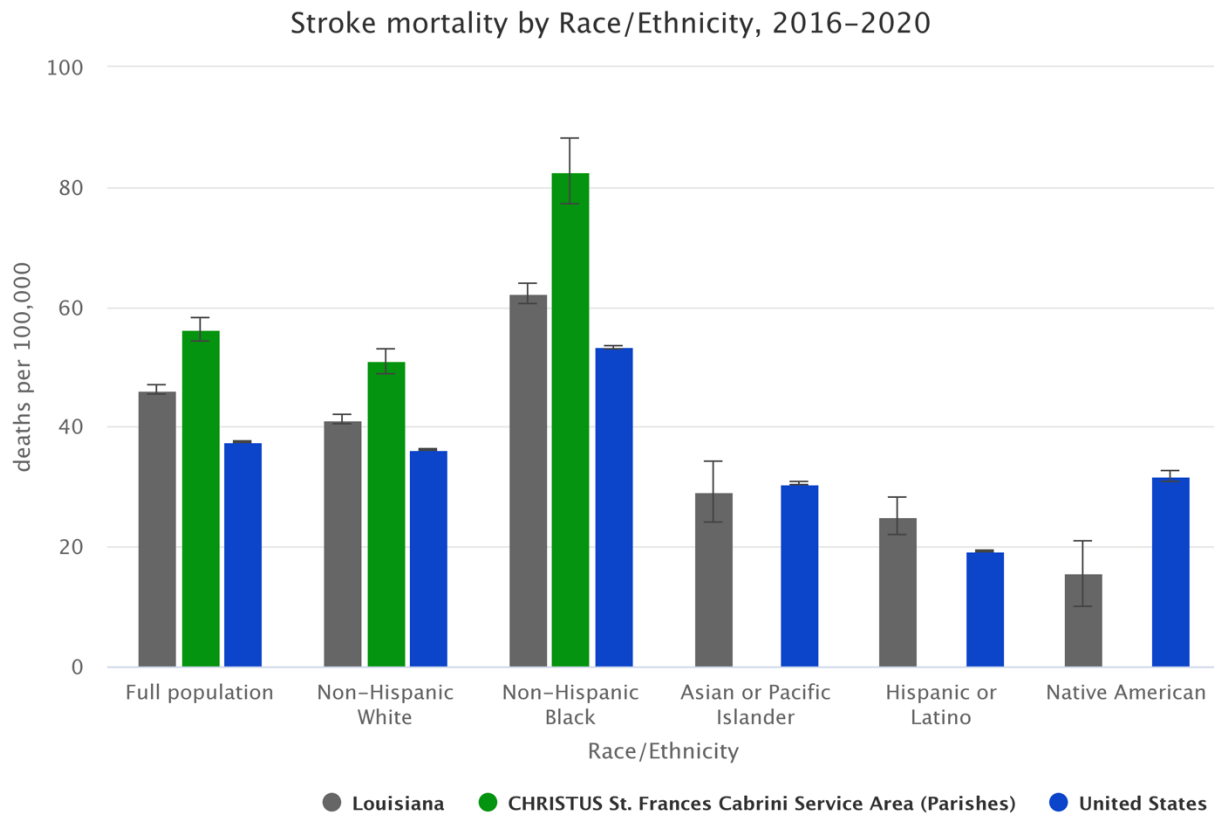


Created on Metopio | <https://metop.io/i/f5qo3ba1> | Data sources: National Vital Statistics System–Mortality (NVSS–M) (Via <http://healthindicators.gov>), Chicago Injury mortality: Deaths per 100,000 residents with an underlying cause of injury (ICD–10 codes *U01–*U03, V01–Y36, Y85–Y87, Y89).

Figure 40. Injury Mortality in the CHRISTUS St. Frances Cabrini PSA

Stroke

The mortality rate for stroke is higher than both benchmarks for the full population the CHRISTUS St. Frances Cabrini PSA (56.2 deaths per 100,000) (Figure 41). When this data is stratified by race, non-Hispanic Black residents experience a much greater stroke mortality rate (82.7) than non-Hispanic White residents (40.9). There is insufficient data for the Hispanic and Latino, Asian or Pacific Islander, or Native American populations.

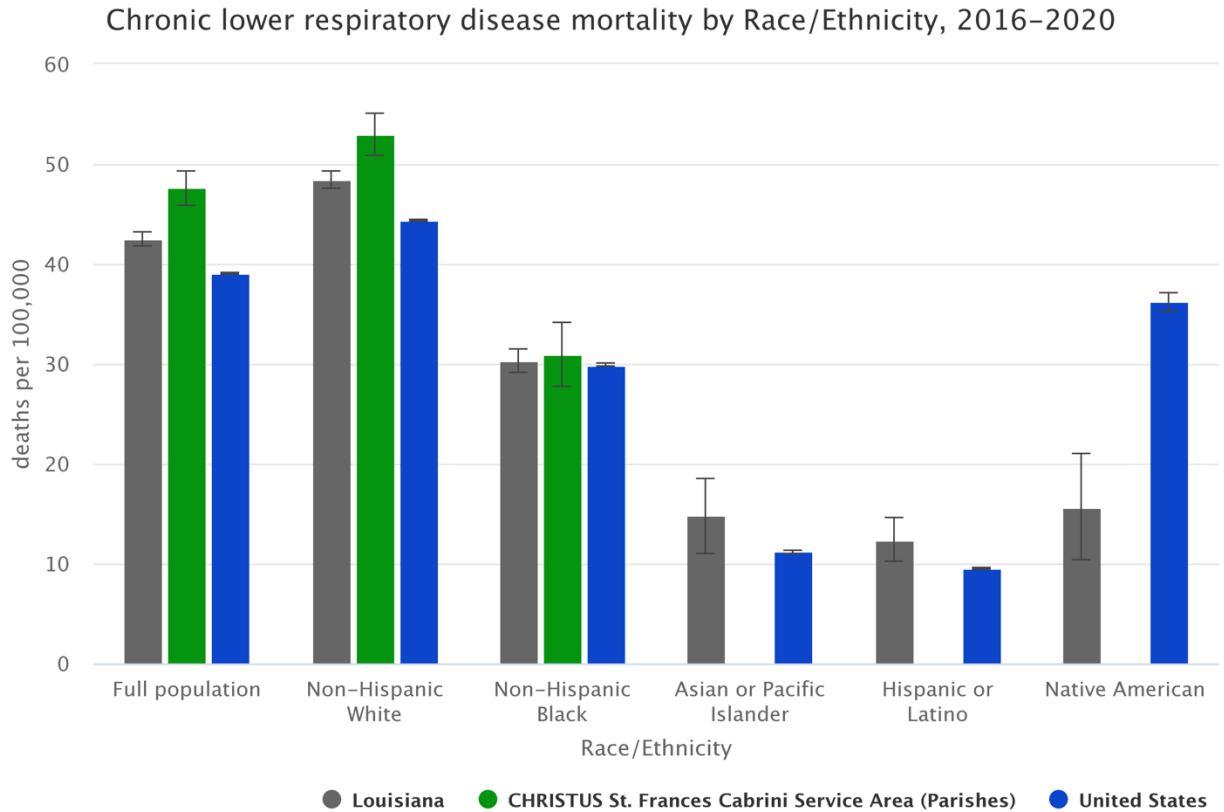


Created on Metopio | <https://metop.io/i/rzcjbpqu> | Data sources: National Vital Statistics System–Mortality (NVSS–M) (Via <http://healthindicators.gov>), Chicago Stroke mortality: Deaths per 100,000 residents due to stroke (ICD–10 codes I60–I69).

Figure 41. Stroke Mortality with Stratifications in the CHRISTUS St. Frances Cabrini PSA

Chronic Lower Respiratory Disease

This is a roll up of four major respiratory diseases—chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, and asthma. There appears to be a disparity with this cause of mortality when comparing the service areas to the state and the U.S for the full population, non-Hispanic Whites and non-Hispanic Black. The rate in the CHRISTUS St. Frances Cabrini PSA is 47.6 deaths per 100,000 for the full population, 53.0 for non-Hispanic Whites and 31.0 for non-Hispanic Blacks. There is insufficient data for the Hispanic and Latino, Asian or Pacific Islander, or Native American populations (Figure 42).

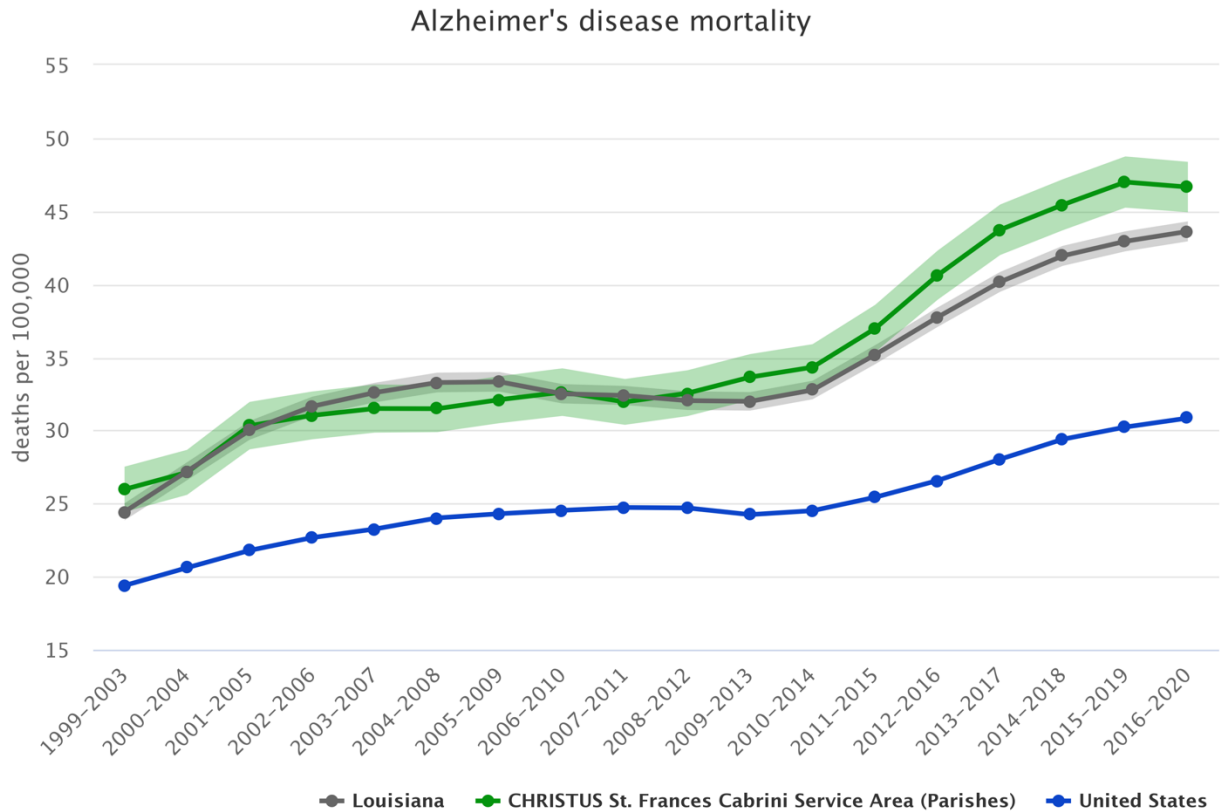


Created on Metopio | <https://metopio.io/i/jr7b54pm> | Data sources: National Vital Statistics System–Mortality (NVSS–M) (Via <http://healthindicators.gov>), Chicago Department of Public Health
Chronic lower respiratory disease mortality: Deaths per 100,000 residents due to chronic lower respiratory disease (ICD–10 codes J40–J47). The primary disease in this category is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Also includes asthma and bronchiectasis.

Figure 42. Chronic Lower Respiratory Disease Mortality in the CHRISTUS St. Frances Cabrini PSA

Alzheimer's Disease

The mortality rate for Alzheimer's has been rapidly increasing throughout all regions over the reporting period (Figure 43). In the CHRISTUS St. Frances Cabrini PSA, Alzheimer's disease accounts for 46.6 deaths per 100,000. The rates in the state (43.6) and country (30.8) are slightly lower, but still increasing over time.

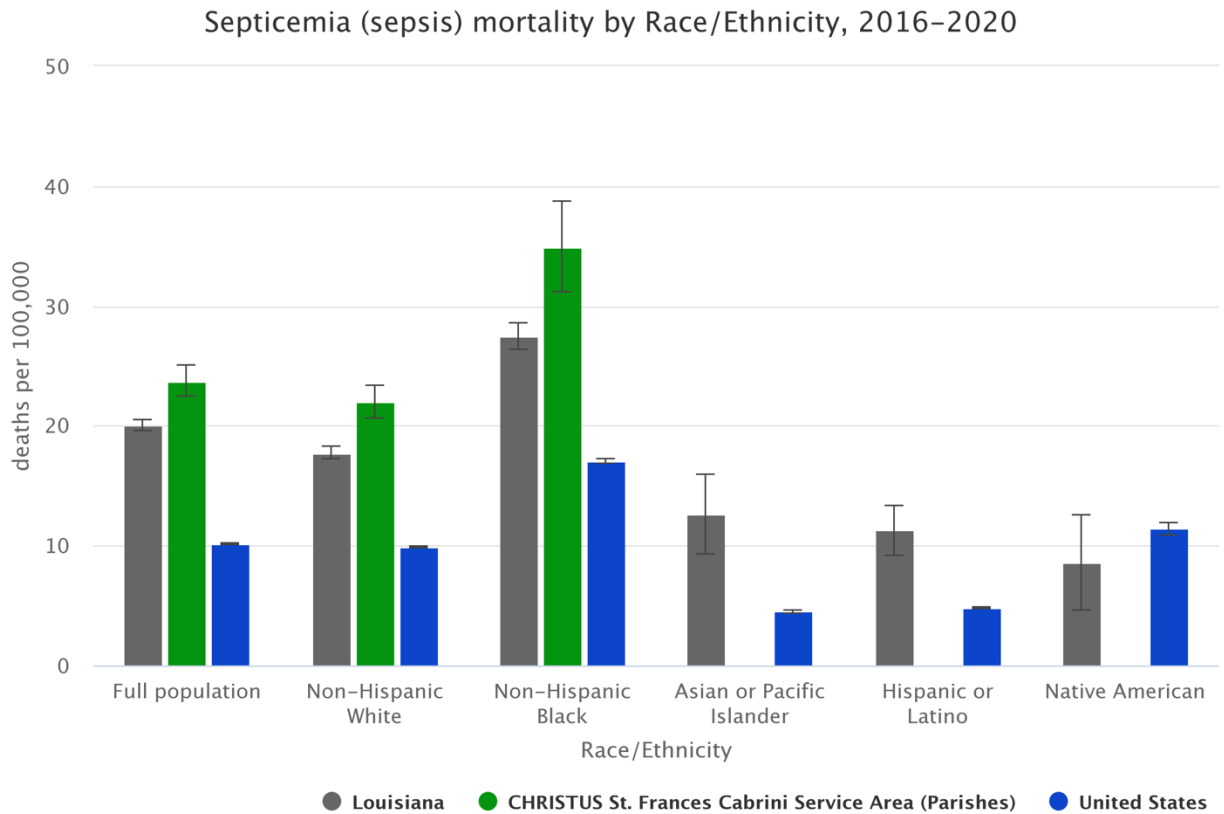


Created on Metopio | <https://metop.io/i/jjwa4gcz> | Data sources: National Vital Statistics System-Mortality (NVSS-M) (Via <http://healthindicators.gov>), Chicago Alzheimer's disease mortality: Deaths per 100,000 residents due to Alzheimer's disease (ICD-10 code G30).

Figure 43. Alzheimer's Disease Mortality in the CHRISTUS St. Frances Cabrini PSA

Sepsis

Sepsis mortality is the 7th leading cause of death in the CHRISTUS St. Frances Cabrini PSA. This disease is caused by untreated bacterial, fungal, parasitic, or viral infections and is preventable through prompt access to health services. As shown in Figure 44, sepsis mortality rates in the PSA (23.8 deaths per 100,000) are more common than in the state (20.0 deaths) or country (10.1). Within the CHRISTUS St. Frances Cabrini PSA, non-Hispanic Black people experience the highest sepsis mortality rate (34.9 deaths).

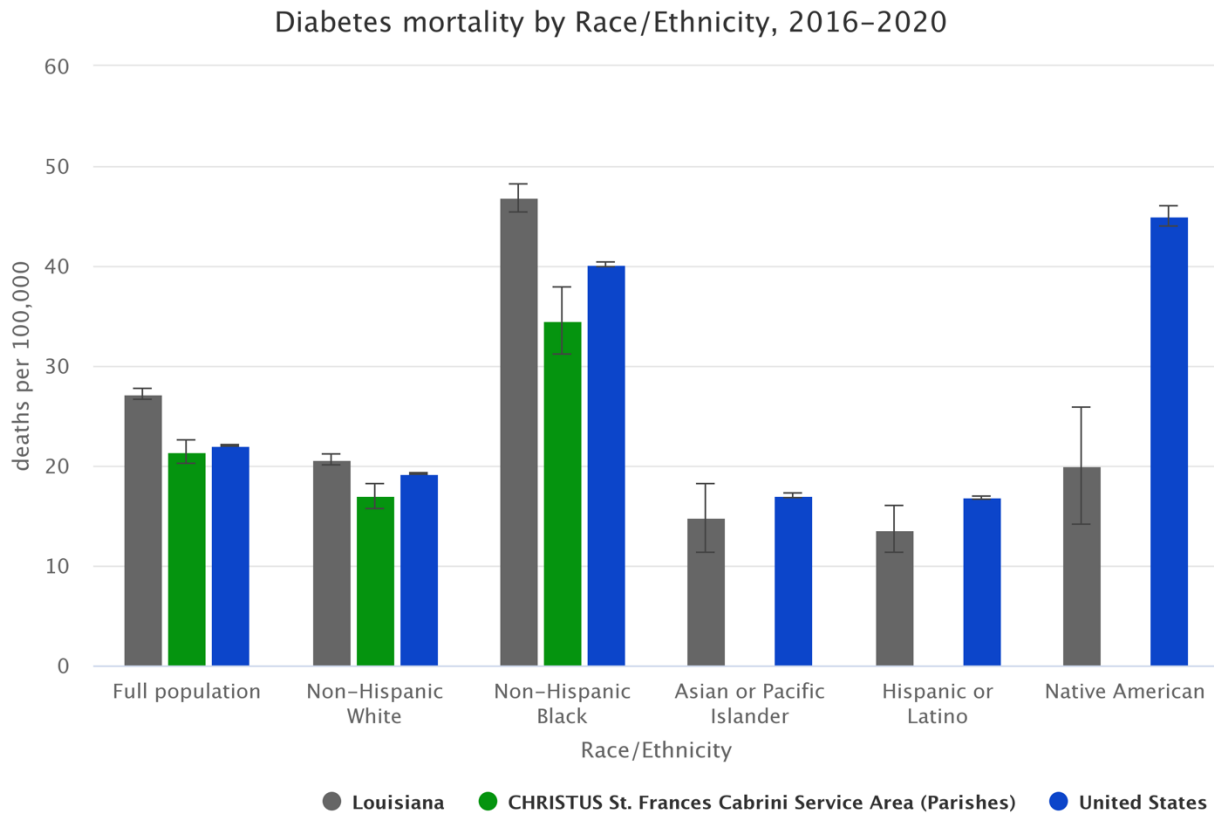


Created on Metopio | <https://metop.io/i/q7qrxovp> | Data source: National Vital Statistics System–Mortality (NVSS–M) (Via <http://healthindicators.gov>)
 Septicemia (sepsis) mortality: Deaths per 100,000 residents due to septicemia or sepsis (blood poisoning) (ICD–10 codes A40–A41).

Figure 44. Sepsis Mortality with Stratifications in the CHRISTUS St. Frances Cabrini PSA

Diabetes

The diabetes mortality rate for the CHRISTUS St. Frances Cabrini PSA is in line with the state and national rates for the full population (Figure 45). There is a racial disparity among diabetes mortality. Black residents die from diabetes at a much higher rate than non-Hispanic White residents (34.6 deaths per 100,000 versus 17.0). This disparity in the CHRISTUS St. Frances Cabrini PSA is not as large as the statewide disparity, but it is still a significant difference. There is insufficient data for the Hispanic and Latino, Asian or Pacific Islander, or Native American populations.

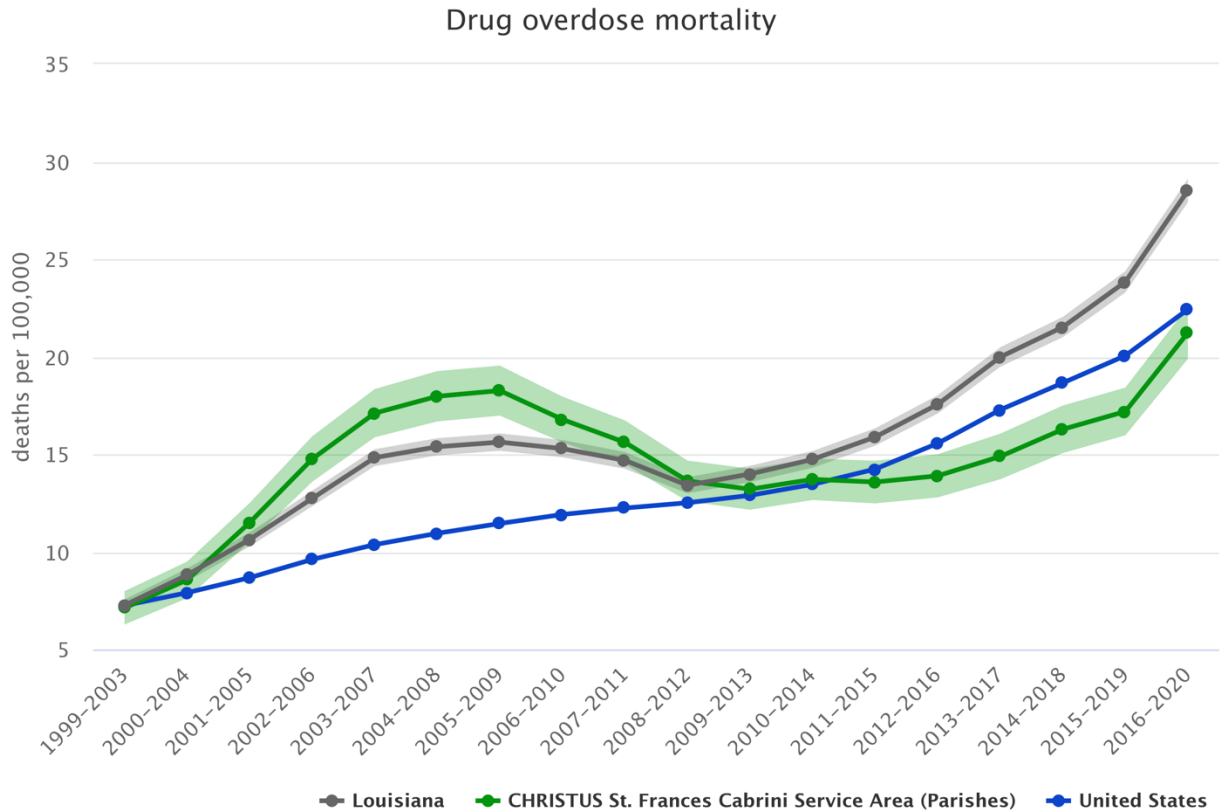


Created on Metopio | <https://metop.io/i/3y8985dw> | Data sources: National Vital Statistics System–Mortality (NVSS–M) (CDC Wonder), Chicago Department of P
Diabetes mortality: Deaths per 100,000 residents with an underlying cause of diabetes (ICD–10 codes E10–E14).

Figure 45. Diabetes Mortality with Stratifications in the CHRISTUS St. Frances Cabrini PSA

Drug Overdose

Deaths from drug overdoses has been a national story for several years. The drastic increase in drug overdose mortality rates in the Louisiana mirrors the national increase. Of the three regions presented in Figure 46, Louisiana has the highest overdose mortality rate (28.5 deaths per 100,000), followed by the United States (22.4), and the CHRISTUS St. Frances Cabrini PSA (21.2).

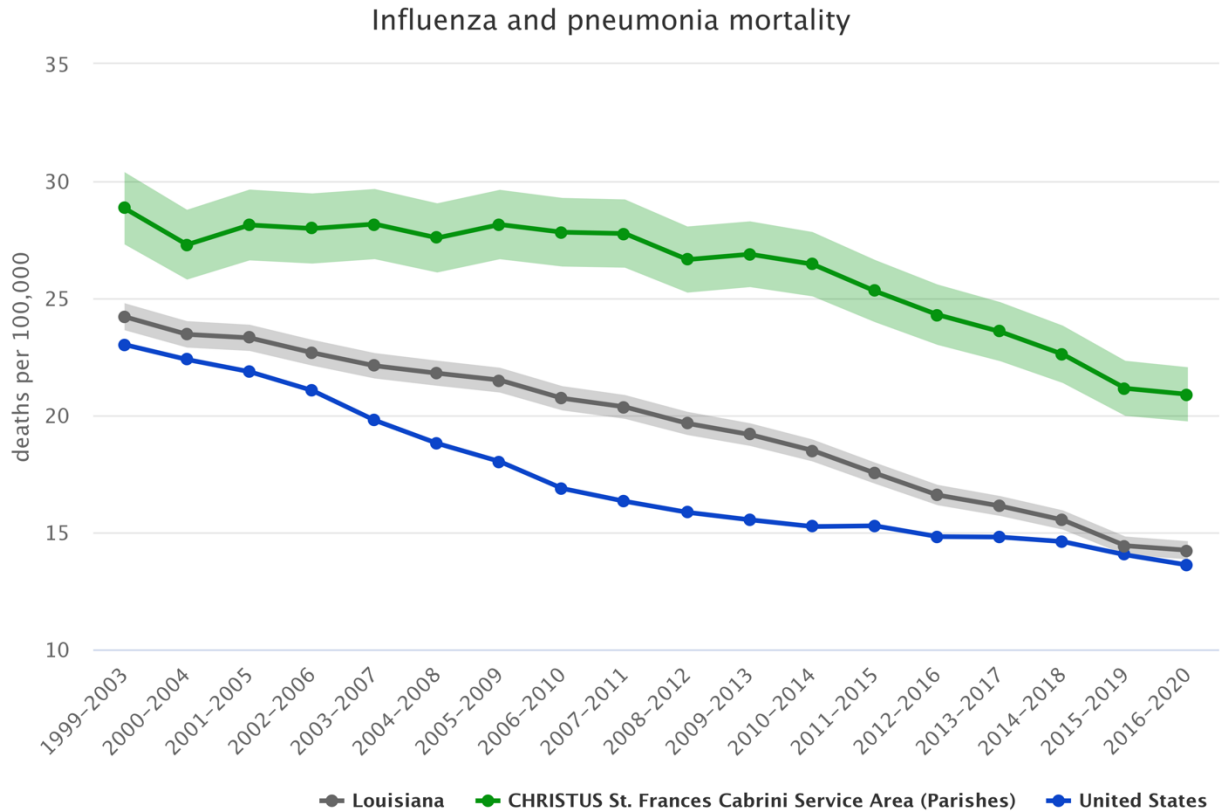


Created on Metopio | <https://metop.io/i/xum24ntv> | Data sources: National Vital Statistics System–Mortality (NVSS–M) (CDC Wonder), Chicago Department of Public Health (Epidem Drug overdose mortality: Deaths per 100,000 residents due to drug poisoning (such as overdose), whether accidental or intentional. The increase during the 2010s is largely due to the opioid overdose epidemic, but other drugs are also included here. Age-adjusted.

Figure 46. Drug Overdose Mortality in the CHRISTUS St. Frances Cabrini PSA

Influenza and Pneumonia

Death from influenza and pneumonia had been on a steady decline across all benchmark regions over time, but it remains a top cause of mortality in the CHRISTUS St. Frances Cabrini PSA, accounting for 20.9 deaths per 100,000 (Figure 47). This is much higher than the influenza and pneumonia mortality rates in Louisiana overall (14.2) and the country (13.6).



Created on Metopio | <https://metop.io/i/yn44qok8> | Data source: National Vital Statistics System–Mortality (NVSS–M) (CDC Wonder)
Influenza and pneumonia mortality: Deaths per 100,000 residents due to influenza and pneumonia. These diseases are frequent causes of death especially among the elderly because they spread widely and tend to be complications from other conditions. The flu can change quite a bit from one year to another, affecting which populations are most vulnerable to it. Age-adjusted.

Figure 47. Influenza and Pneumonia Mortality in the CHRISTUS St. Frances Cabrini PSA

Topic		Allen Parish, LA	Avoyelles Parish, LA	Catahoula Parish, LA	Concordia Parish, LA	Grant Parish, LA	LaSalle Parish, LA	Natchitoches Parish, LA	Rapides Parish, LA	Vernon Parish, LA	Winn Parish, LA
Heart disease mortality <i>deaths per 100,000, 2016-2020</i>	i	227.0	268.5	337.3	291.5	210.7	178.5	215.9	295.1	291.8	297.5
Cancer mortality <i>deaths per 100,000, 2016-2020</i>	i	187.1	197.0	197.8	205.2	173.6	164.2	194.1	164.8	217.7	186.5
Injury mortality <i>deaths per 100,000, 2016-2020</i>	i	99.5	101.8	77.9	91.7	79.0	84.8	99.5	108.3	79.7	89.5
Chronic lower respiratory disease mortality <i>deaths per 100,000, 2016-2020</i>	i	42.0	71.3	47.5	51.9	93.5	84.1	59.8	56.6	70.2	49.7
Alzheimer's disease mortality <i>deaths per 100,000, 2016-2020</i>	i	36.6	60.6	67.0	53.3	62.6	55.9	48.9	64.4	35.0	43.2
Stroke mortality <i>deaths per 100,000, 2016-2020</i>	i	46.9	61.1	38.4	33.1	58.1	45.9	64.6	53.7	46.9	51.7
Influenza and pneumonia mortality <i>deaths per 100,000, 2016-2020</i>	i	19.6	17.7	39.5	28.2	21.4	34.6	14.2	31.4	18.7	20.8
Drug overdose mortality <i>deaths per 100,000, 2016-2020</i>	i	21.41	22.39	23.05 📅	12.89 📅	15.20	17.38	12.67	33.50	14.59	17.01
Diabetes mortality <i>deaths per 100,000, 2016-2020</i>	i	32.9	25.4	31.2	48.4	33.2	31.8	22.8	9.1	31.0	19.8
Septicemia (sepsis) mortality <i>deaths per 100,000, 2016-2020</i>	i	16.9	18.6	34.6	36.3	19.4	22.2	14.2	23.2	23.9	21.3

Table 16. Mortality Rates by Parish in the CHRISTUS St. Frances Cabrini PSA

Hospital Utilization

For this CHNA, CHRISTUS St. Frances Cabrini PSA looked at three years of utilization data (2019-2021). During the course of the COVID-19 pandemic, the health system saw Emergency Department utilization decline year over year (Figure 48), including a 9% drop from 2020 to 2021. This follows national trends where people avoided or delayed care due to restrictions caused by the COVID-19 pandemic.

Inpatient cases (Figure 49) also saw a year-over-year decline during the study period, most notably with a 5% reduction between 2020 and 2021. Regarding inpatient utilization (Table 17), the top cause for inpatient admission was sepsis followed by labor and delivery. Interestingly, COVID-19 was only the seventh most common cause for admissions. For almost every other CHRISTUS ministry, COVID-19 was a top ten cause for inpatient admission.

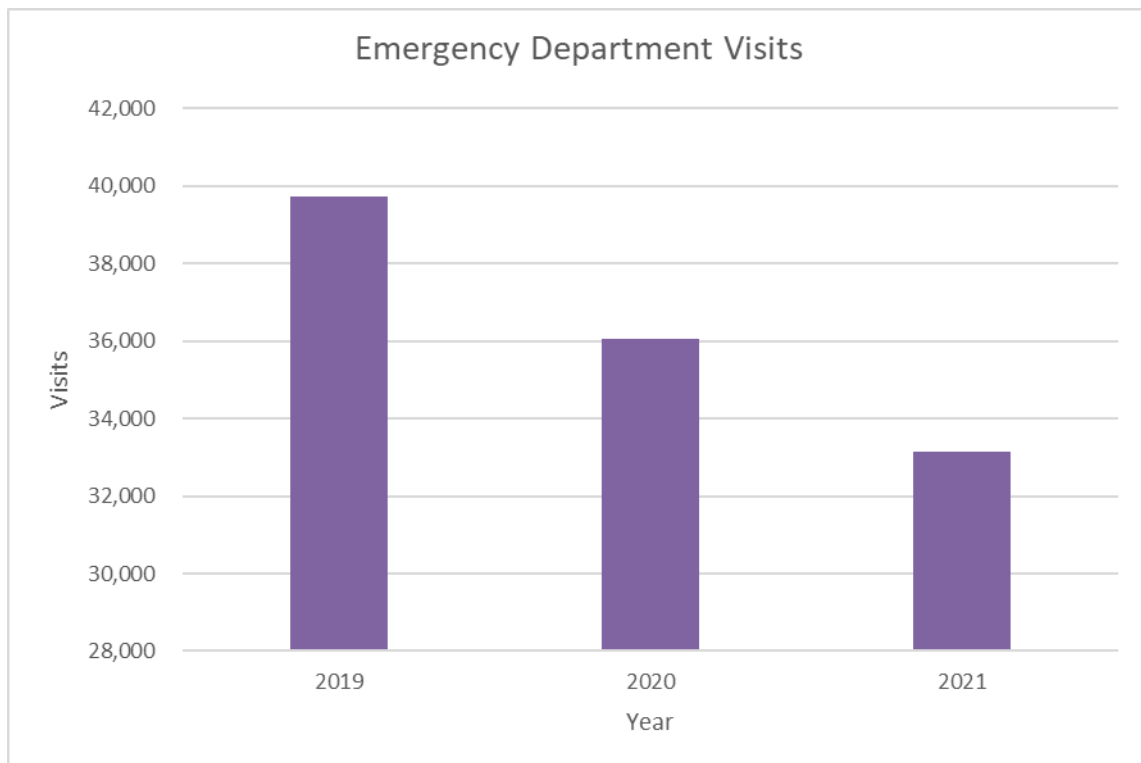


Figure 48. Emergency Department Utilization at CHRISTUS St. Frances Cabrini

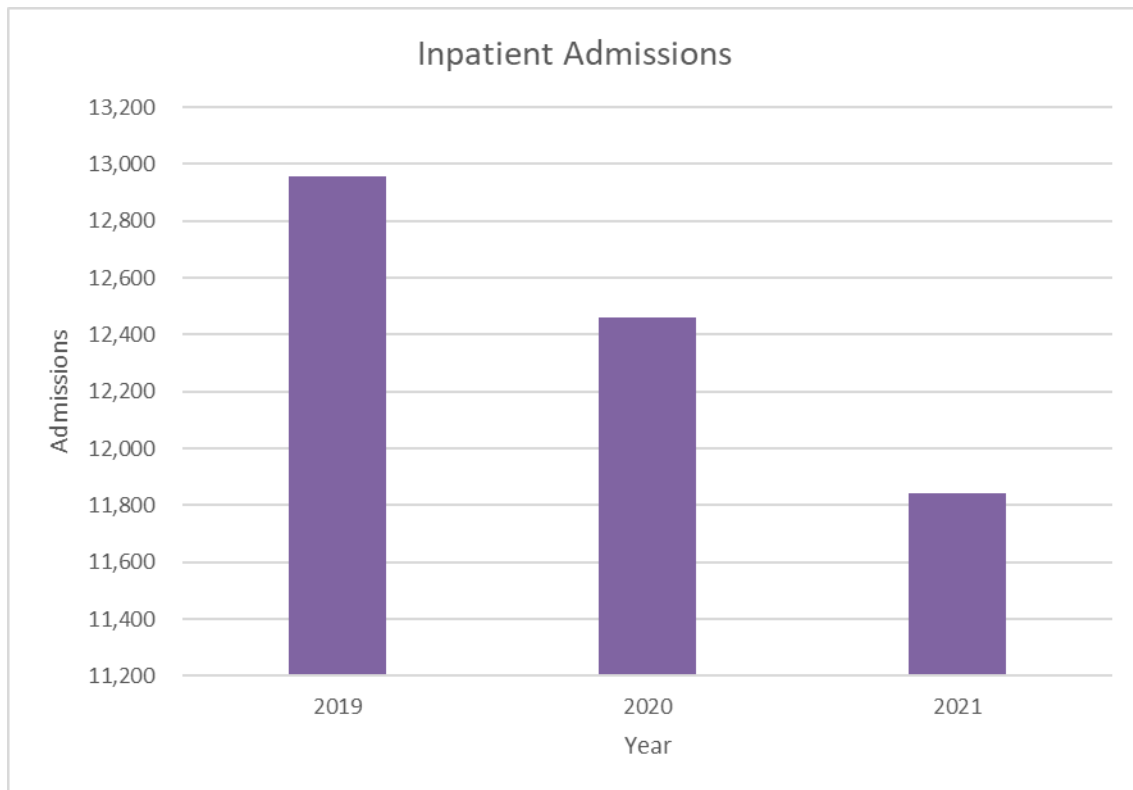


Figure 49. Inpatient Admissions at CHRISTUS St. Frances Cabrini

TOP INPATIENT PRIMARY DIAGNOSES

1. Sepsis
2. Single liveborn infant delivered
3. Non-ST elevation (NSTEMI) myocardial infarction
4. Hypertensive heart disease with heart failure
5. Acute kidney failure
6. Hypertensive heart and chronic kidney disease with heart failure
7. COVID-19
8. Morbid obesity
9. Maternal care for low transverse scar from previous cesarean delivery
10. Pneumonia

Table 17. Top Inpatient Primary Diagnoses at CHRISTUS St. Frances Cabrini

CHRISTUS COUSHATTA HEALTH CARE CENTER CHNA RESULTS



CHRISTUS Coushatta Health Care Center CHNA Results

Demographic Characteristics

Over the past decade, the CHRISTUS Coushatta Health Care Center (CHRISTUS Coushatta) PSA has experienced a slight change in population (Figure 50). Changes between the 2010 and 2020 Census show that the population in the CHRISTUS Coushatta PSA decreased by 10.2%. The CHRISTUS Health service area and Louisiana both experienced growth during this period, with a growth rate of 12.1% and 2.7%, respectively. Based on the 2020 decennial Census, 40,054 people live in the CHRISTUS Coushatta PSA.

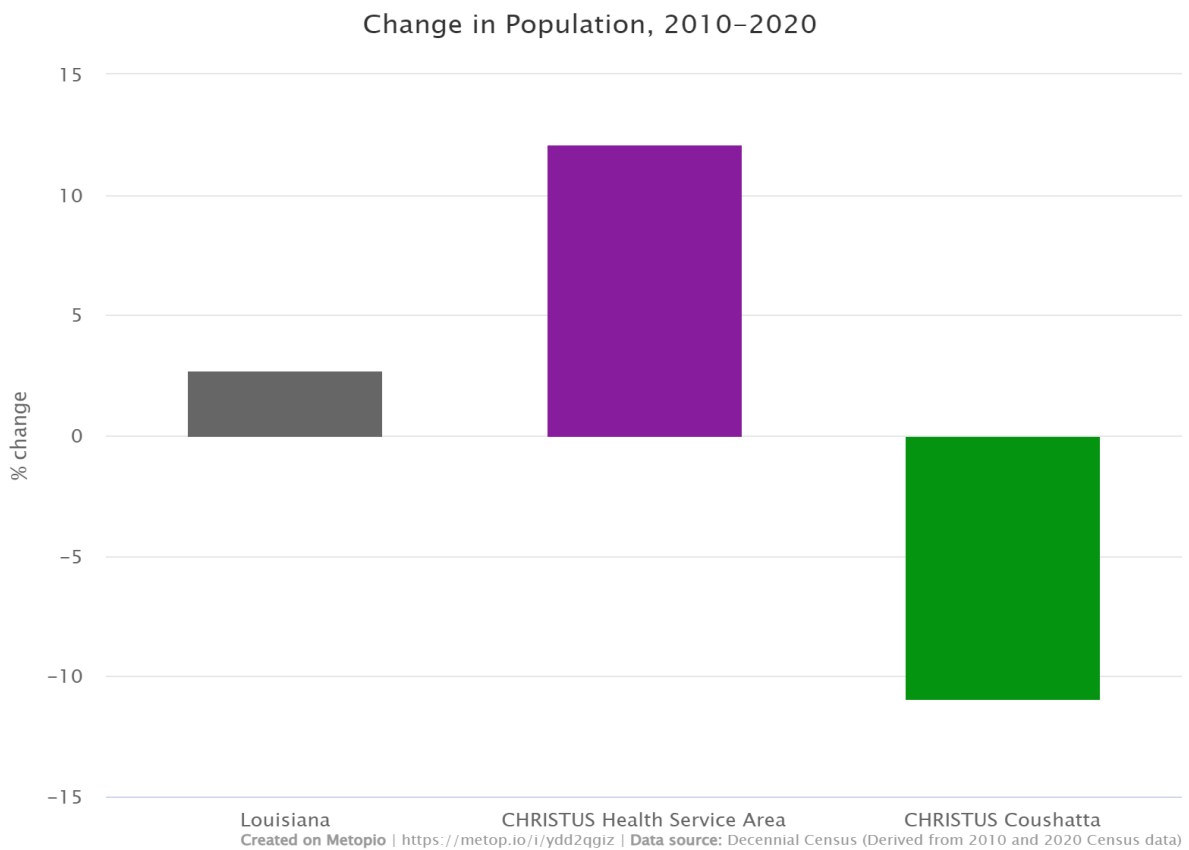


Figure 50. Change in Population in the CHRISTUS Coushatta PSA

Figure 51 shows the demographics by race/ethnicity for the service areas. non-Hispanic White individuals make up the majority of the CHRISTUS Coushatta PSA population at 48.6%. This differs from the demographics of the CHRISTUS Health service area but is similar to Louisiana as a whole, where non-Hispanic White people make up 42.8% of the population. In the CHRISTUS Coushatta PSA, the second most prevalent racial/ethnic demographic is non-Hispanic Black people at 45.6% of the population. This is higher than the 14.2% of non-Hispanic Black residents in the CHRISTUS Health service area and to the 31.9% of residents in Louisiana. This Hispanic/Latino populations in

the service area (2.3%) and Louisiana (5.2%) are much lower than the overall CHRISTUS Health service area (38.8%). The remaining racial/ethnic demographics in the CHRISTUS Coushatta PSA are similar to those in the region. In the CHRISTUS Coushatta PSA, Asian or Pacific Islander individuals make up 0.1%, compared to 1.9% of the CHRISTUS Health service area and 1.8% of the population of Louisiana. Native Americans account for 0.4% of the CHRISTUS Coushatta PSA, 0.4% of the CHRISTUS Health service area, and 0.5% of the population in Louisiana. People who report belonging to two or more races make up 1.5% of the CHRISTUS Coushatta PSA, 1.8% of the CHRISTUS Health service area, and 2.0% of the Louisiana population. (Table 18 explores service area demographics by each parish.)

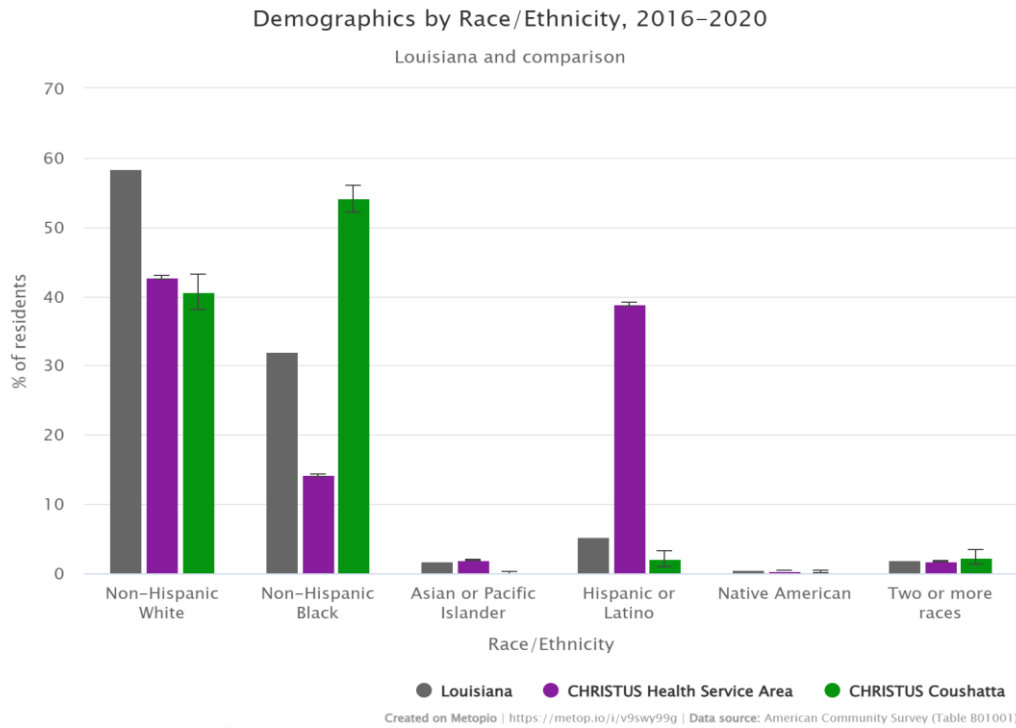


Figure 51. Demographics by Race/Ethnicity in the CHRISTUS Coushatta PSA

Topic	Bienville Parish, LA	Natchitoches Parish, LA	Red River Parish, LA
Change in Population % change, 2010-2020	① -9.56	-5.18	-16.18
Demographics Non-Hispanic White % of residents, 2020	① 53.16	50.37	54.46
Demographics Non-Hispanic Black % of residents, 2020	① 40.62	39.60	38.74
Demographics Asian or Pacific Islander % of residents, 2020	① 0.20	0.49	0.00
Demographics Hispanic or Latino % of residents, 2020	① 1.63	3.97	2.47
Demographics Native American % of residents, 2020	① 0.47	0.76	0.54
Demographics Two or more races % of residents, 2020	① 3.84	4.00	3.53

Table 18. Demographics by Parish in the CHRISTUS Coushatta PSA

Females represent 52.6% of the CHRISTUS Coughatta PSA population and males represent 47.4% (Figure 52). The CHRISTUS Coughatta PSA has a ratio similar to the CHRISTUS Health service area with 50.6% female and 49.4% male residents and Louisiana overall with 51.2% female and 48.8% male residents. The median age in the CHRISTUS Coughatta PSA is 33.5 years old, which is more than two years younger than the rest of the CHRISTUS Health service area (36.3 years old) and 5 years younger than Louisiana (37.2 years old) (Figure 53).

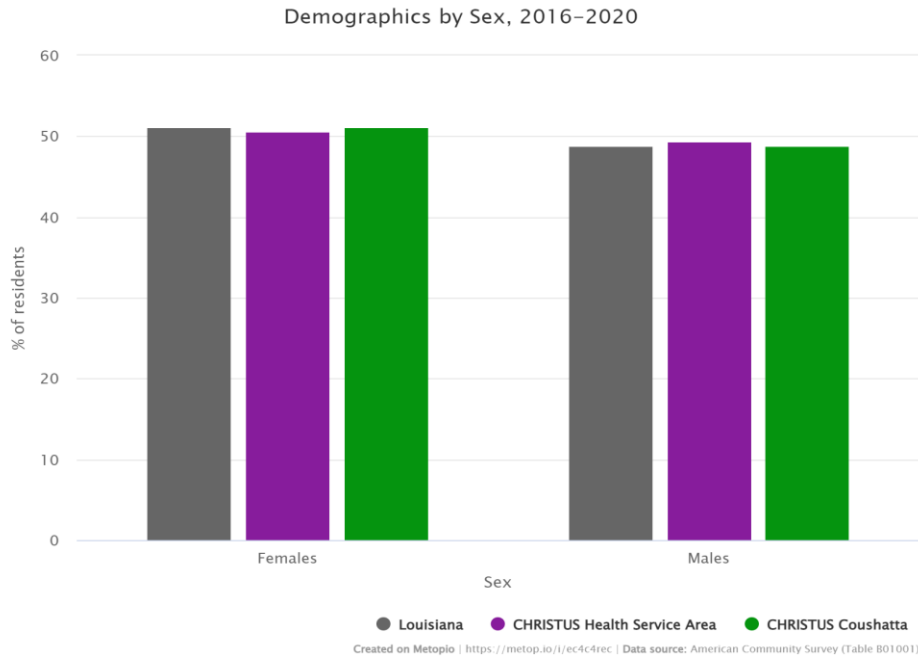


Figure 52. Demographics by Sex in the CHRISTUS Coughatta PSA

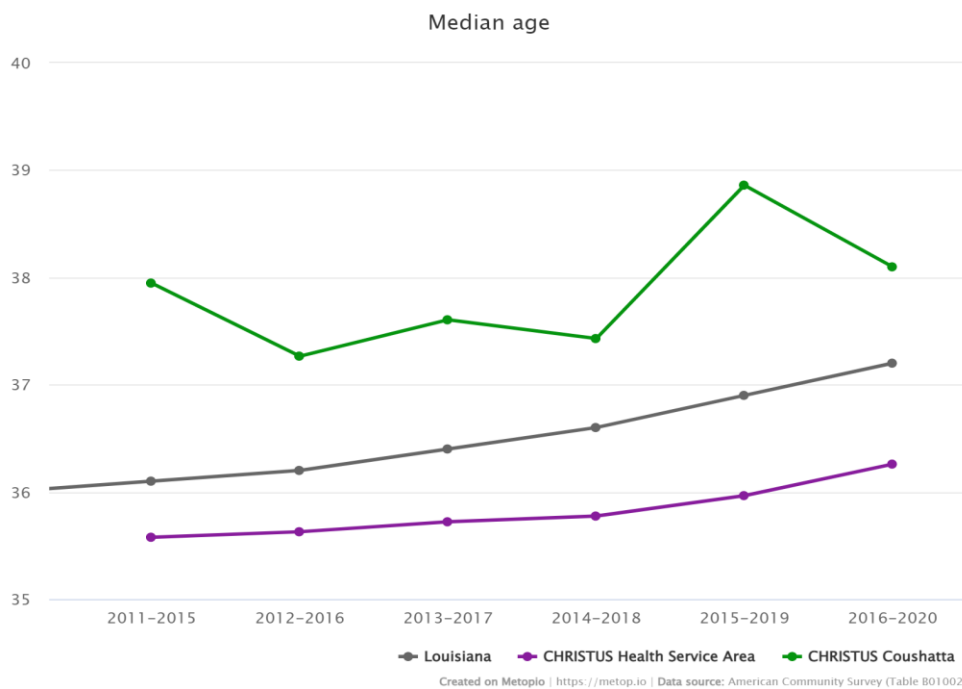


Figure 53. Median Age in the CHRISTUS Coughatta PSA

In the CHRISTUS Coughatta PSA, 0.1% of households have limited English proficiency (Figure 54). This percentage is much lower than the CHRISTUS Health service area (4.0%) and Louisiana overall (1.4%).

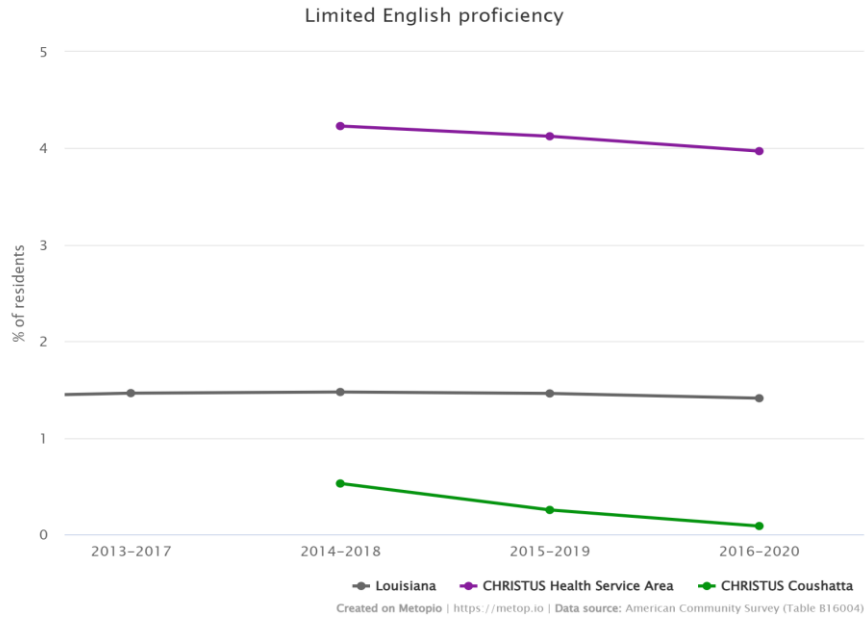
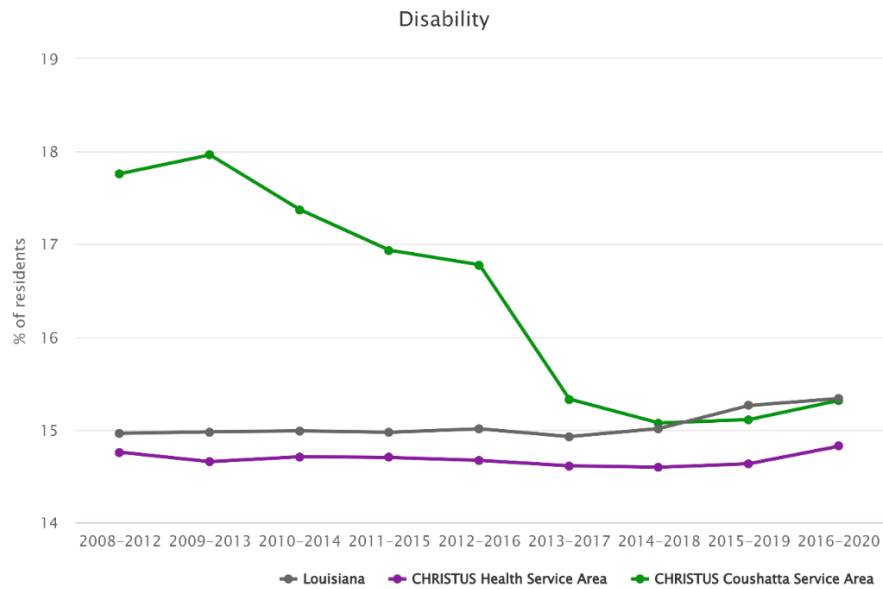


Figure 54. Limited English Proficiency in the CHRISTUS Coughatta PSA

The percentage of residents with a disability in the CHRISTUS Coughatta PSA (15.3%) is higher than the whole CHRISTUS Health service area (14.8%) but identical to Louisiana (15.3%) (Figure 55). Disability here is defined as one or more sensory disabilities or difficulties with everyday tasks.



Created on Metopio | <https://metop.io/i/1/mz72wqa> | Data source: American Community Survey (Table S1810)
 Disability: Percent of residents with a disability, defined as one or more sensory disabilities or difficulties with everyday tasks.

Figure 55. Disability in the CHRISTUS Coughatta PSA

Social and Structural Determinants of Health

Community residents who participated in focus groups and the community resident surveys also provided in-depth input about how social and structural determinants of health – such as education, economic inequities, housing, food access, access to community services and resources, and community safety and violence – impact community and individual health. The following sections review secondary data insights that measure the social and structural determinants of health.

Hardship

One way to measure overall economic distress in a place is with the Hardship Index (Figure 56). This is a composite score reflecting hardship in the community, where the higher values indicate greater hardship. It incorporates unemployment, age dependency, education, per capita income, crowded housing, and poverty into a single score. The Hardship Index score for the CHRISTUS Coughatta PSA is 81.2, which is significantly higher than the measure of the full CHRISTUS Health service area (60.6) and the state (59.5).

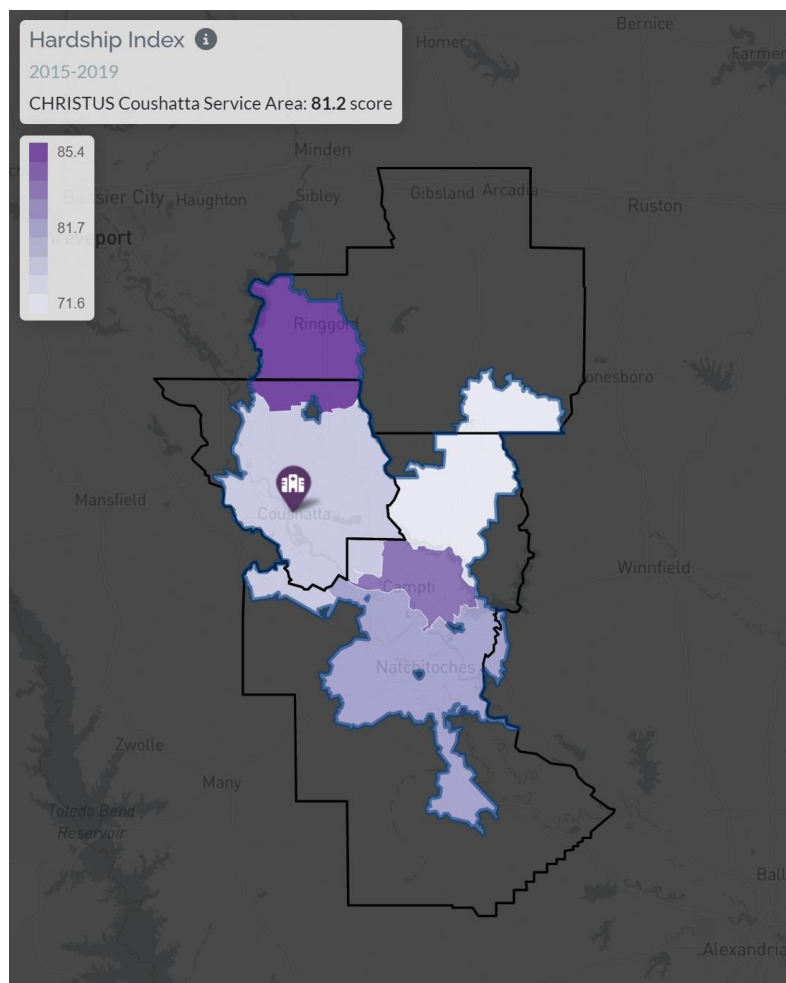
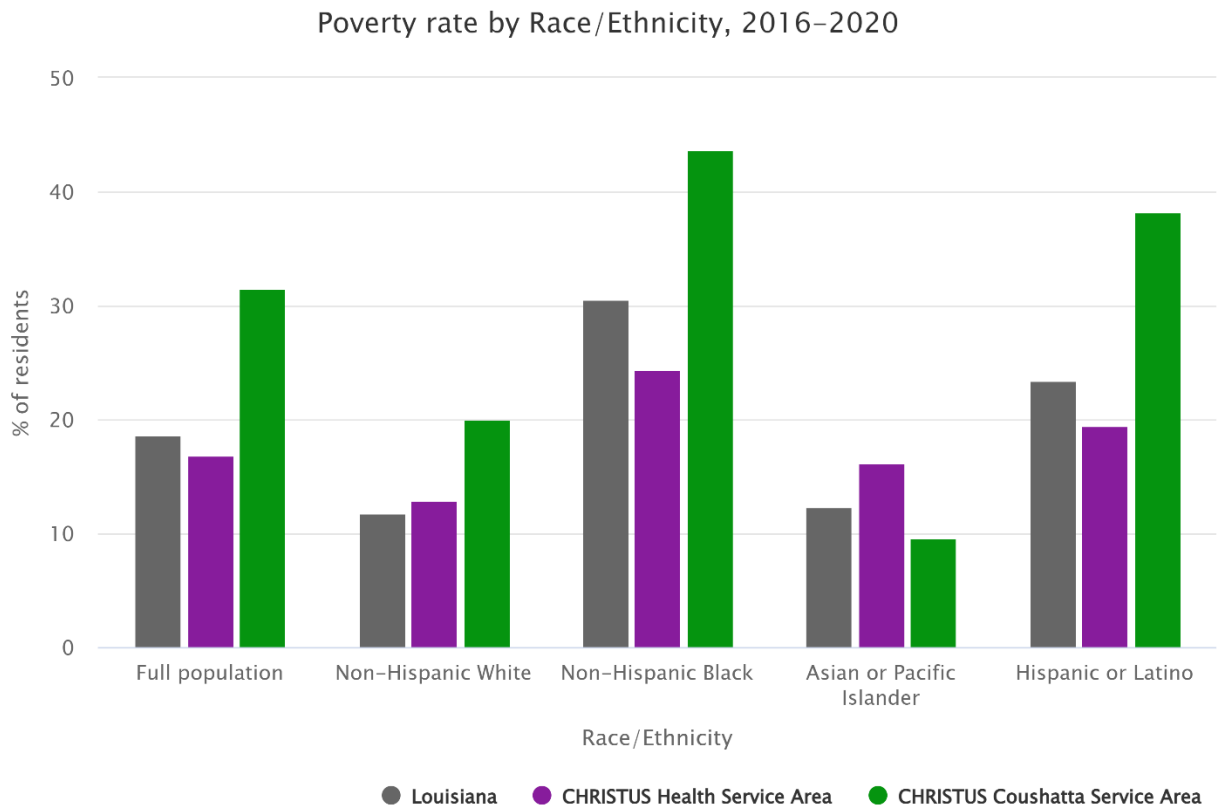


Figure 56. Map of Hardship Index in the CHRISTUS Coughatta PSA

Poverty

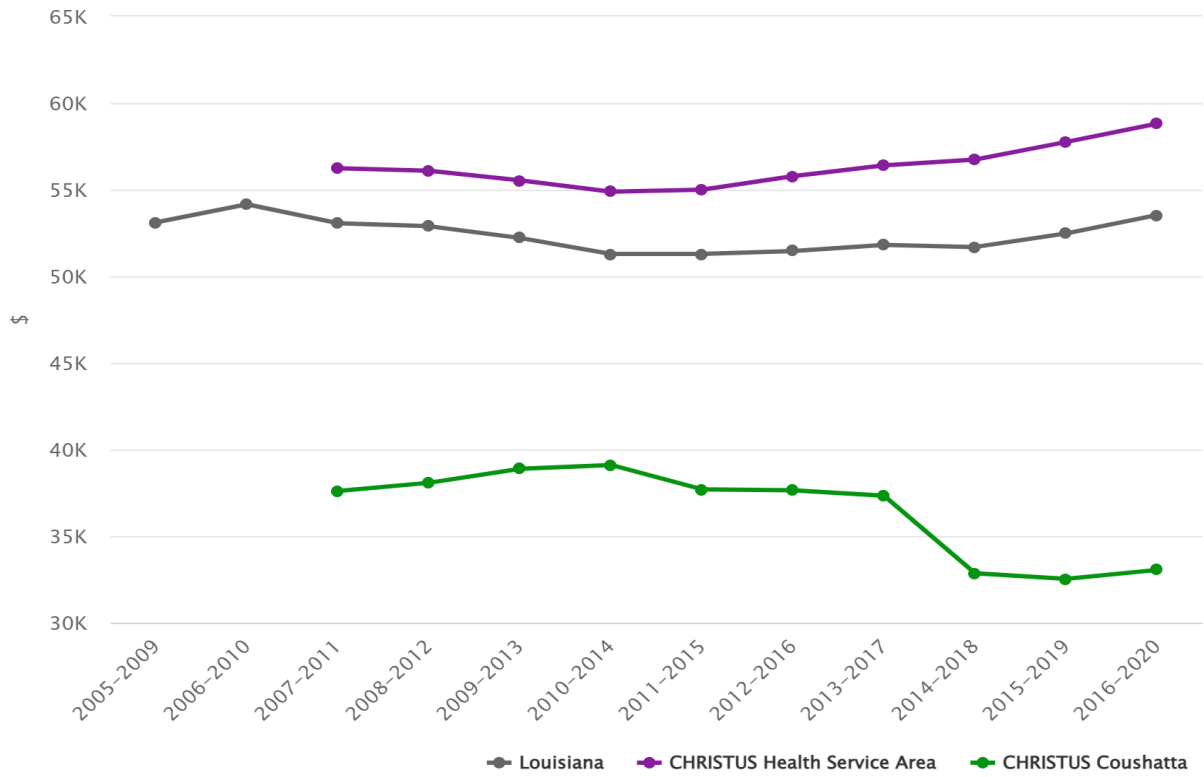
Poverty and its corollary effects are significantly higher in the CHRISTUS Coushatta PSA across most race/ethnic stratifications. In the CHRISTUS Coushatta PSA, the poverty rate is 31.4% (Figure 57) and the median household income is \$33,203 (Figure 58). In comparison, the CHRISTUS Health service area overall has a median household income of \$58,813 and 16.8% of residents living in poverty, and Louisiana, \$53,539 and 18.7%, respectively. The poverty rate in the CHRISTUS Coushatta PSA is even more pronounced for non-Hispanic Black residents (43.7%). For comparison, 19.9% of non-Hispanic White residents live in poverty, 9.6% of Asian or Pacific Islanders, and 38.2% of Hispanic or Latinos.



Created on Metopio | <https://metop.io/1/tgniidcm> | Data source: American Community Survey (Table B17001)
Poverty rate: Percent of residents in families that are in poverty (below the Federal Poverty Level).

Figure 57. Poverty Rate with Stratifications in the CHRISTUS Coushatta PSA

Median household income



Created on Metopio | <https://metop.io/i/haqeq1at> | Data source: American Community Survey (Table B19013)

Figure 58. Median Household Income in the CHRISTUS Coughatta PSA

Housing

In the focus groups, community members shared disparities in resources limit the ability of all people to be healthy. Participants also shared that the expensive cost of childcare also puts a burden on working families, making them feel like they can't get ahead. Figure 59 shows that almost a quarter of residents in rental housing units are severely rent-burdened, meaning they spend more than 50% of their income on housing. Zip code 71457 experiences the highest percentage of severely rent-burdened households at 29.5%.

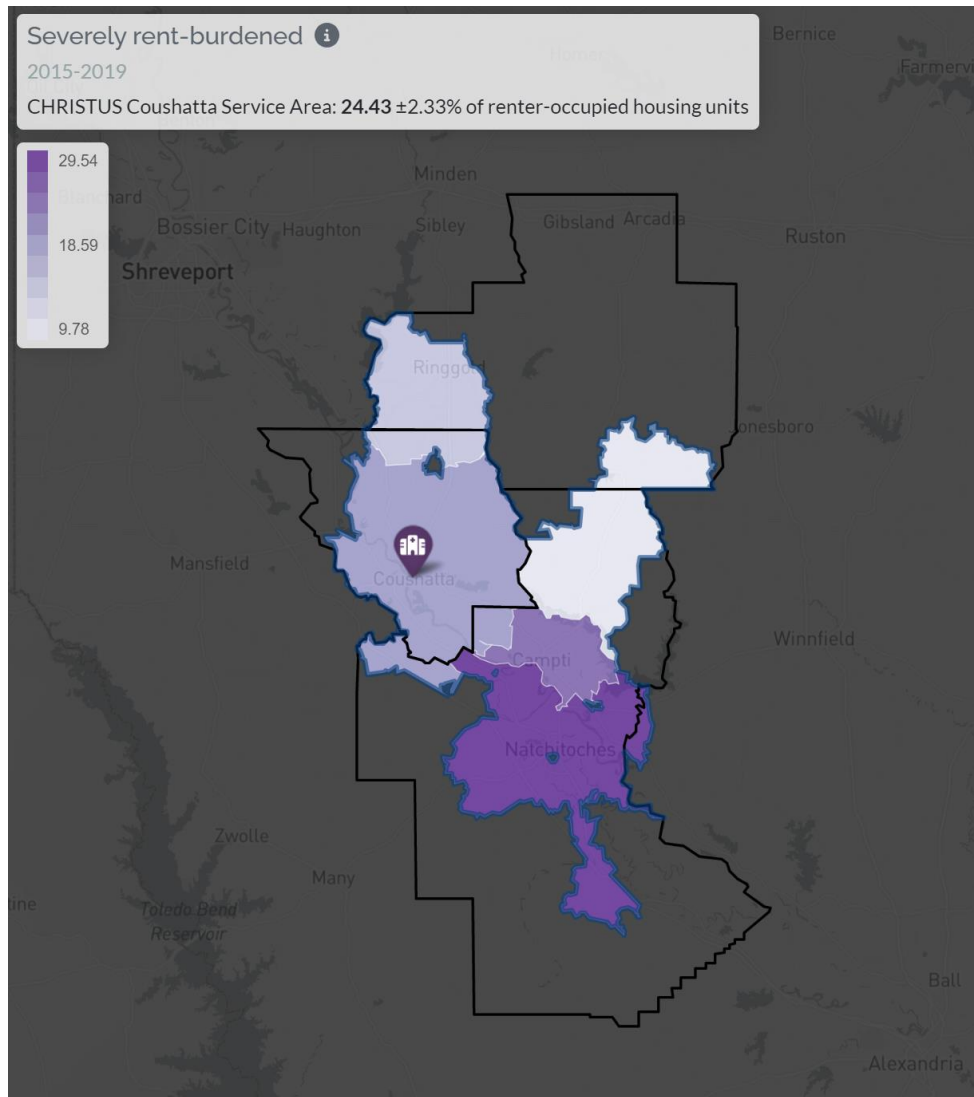
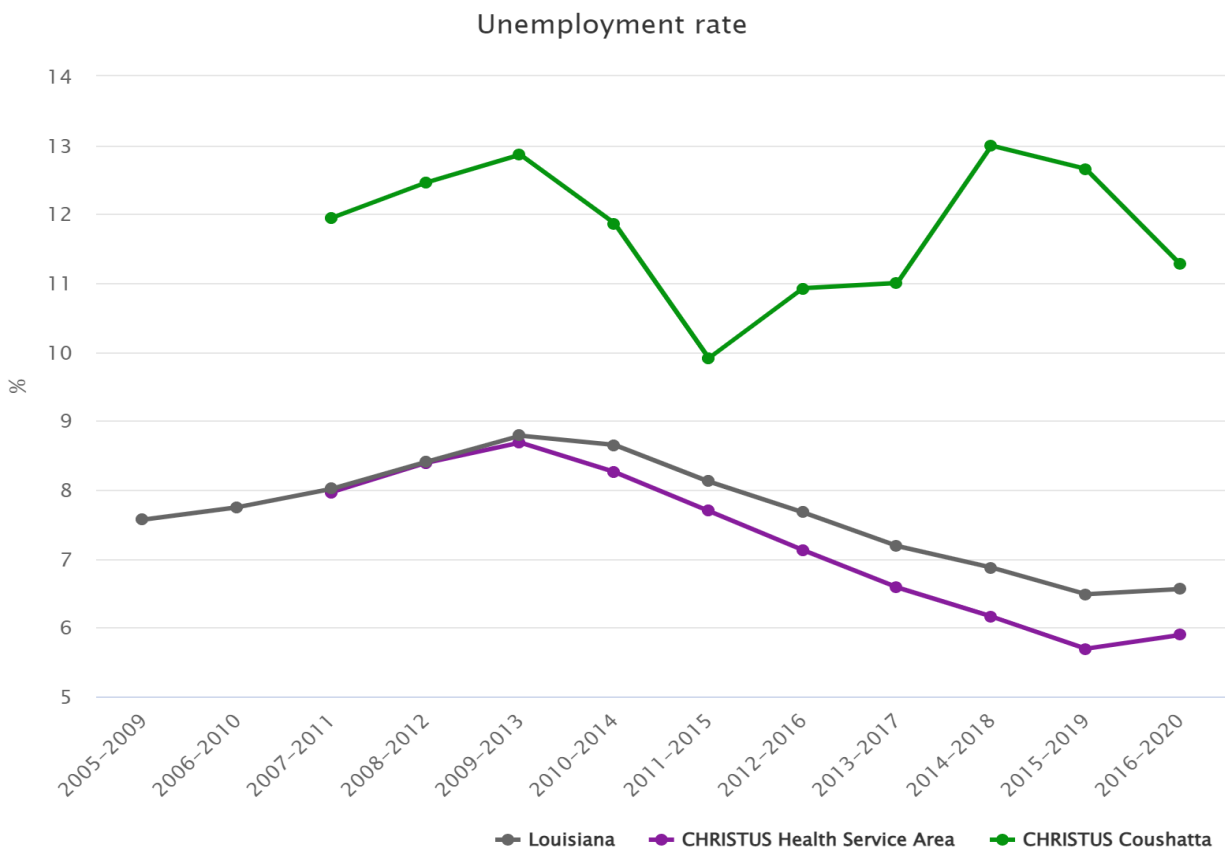


Figure 59. Housing Cost Burden in the CHRISTUS Coushatta PSA

Unemployment

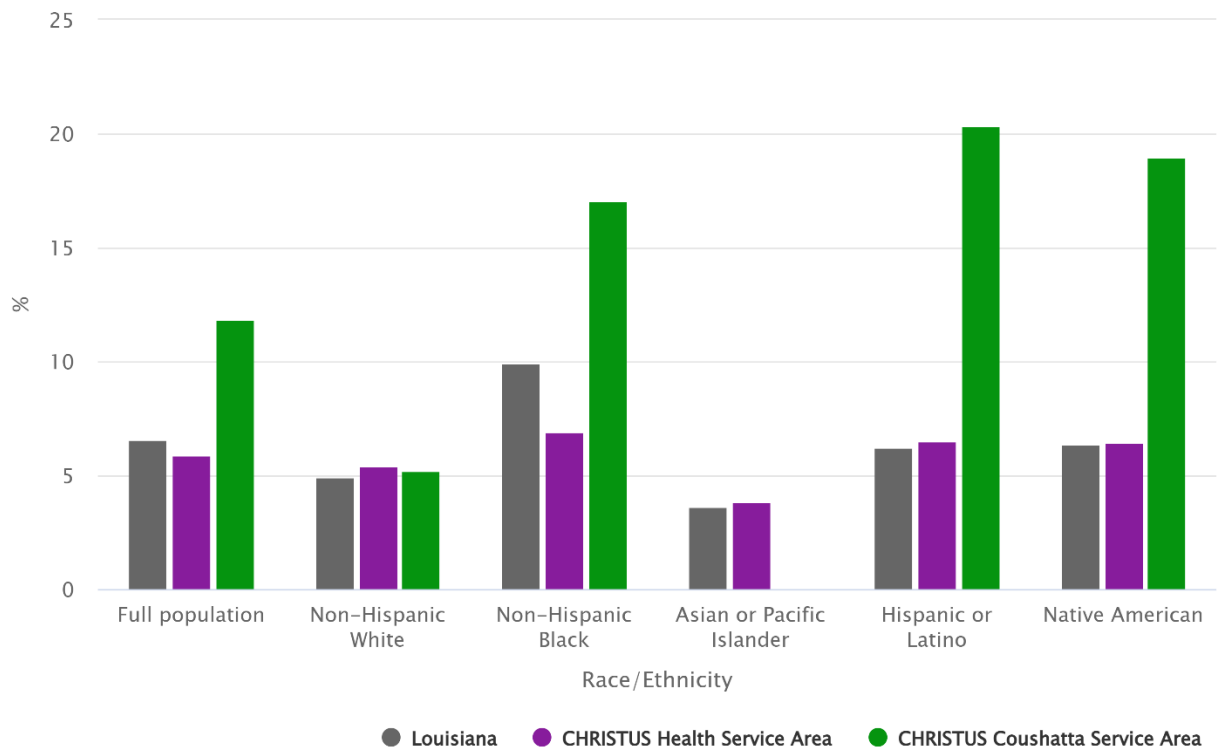
The overall unemployment rate in the CHRISTUS Coughatta PSA (11.3%) is higher than the rate of the CHRISTUS system (5.9%), and Louisiana (6.6%) (Figure 60). When this data is stratified by race/ethnicity (Figure 61), there are disparities in unemployment rates. In particular, non-Hispanic Blacks (16.8%), Hispanic or Latinos (20.1%), and Native Americans (18.9%) experience the highest unemployment rates. Because of the small number of Native Americans and Hispanic/Latino people in the CHRISTUS Coughatta PSA, there is error in this data, which means the actual unemployment rate for these populations may be higher or lower than the collected average. Over the past decade, the CHRISTUS Coughatta PSA has generally seen fluctuations in the unemployment rate, even through the 2016-2020 period, when the COVID-19 pandemic began. Future data will better illustrate the effects of the pandemic on unemployment rates.



Created on Metopio | <https://metop.io> | Data source: American Community Survey (Tables B23025, B23001, and C23002)

Figure 60. Unemployment Rate in the CHRISTUS Coughatta PSA

Unemployment rate by Race/Ethnicity, 2016–2020

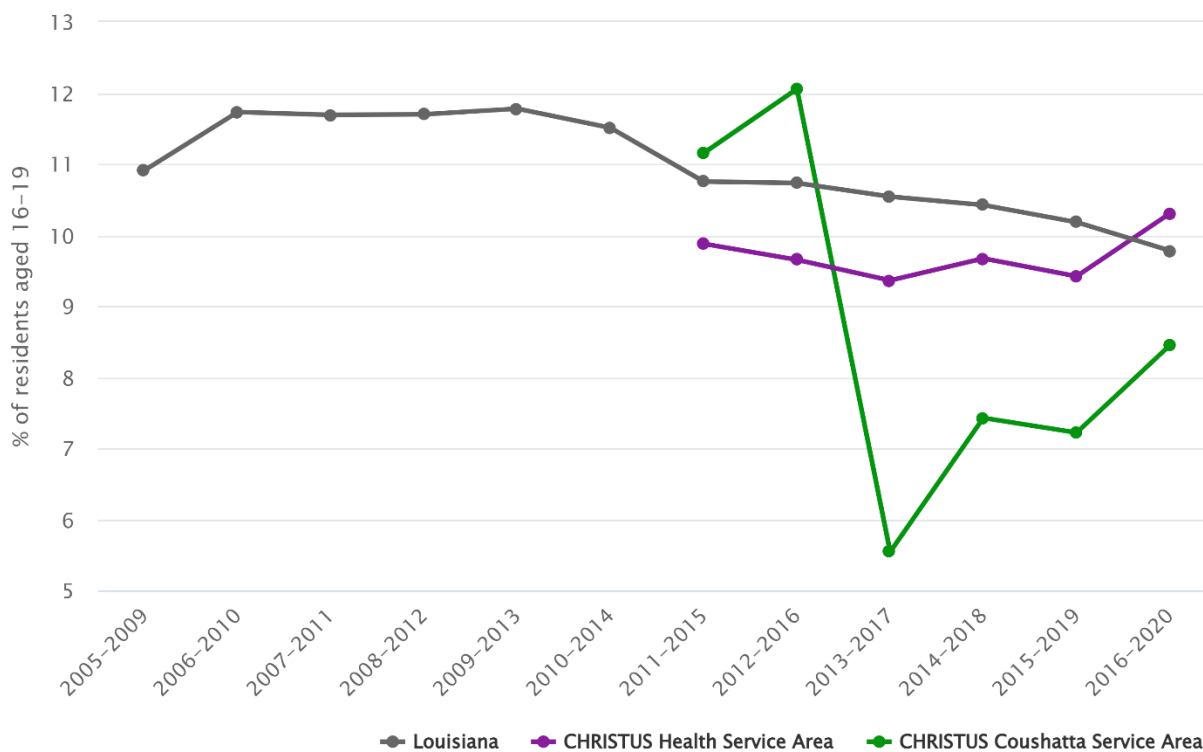


Created on Metopio | <https://metop.io/1/tgniidcm> | Data source: American Community Survey (Tables B23025, B23001, and C23002)
 Unemployment rate: Percent of residents 16 and older in the civilian labor force who are actively seeking employment.

Figure 61. Unemployment Rate with Stratifications in the CHRISTUS Coughatta PSA

Another measure of potential economic stress is disconnected youth, defined as residents aged 16–19 who are neither in school nor employed. For the CHRISTUS Coughatta PSA, the percentage is 8.4% compared to 10.3% in the entire CHRISTUS Health service area, and 9.8% in Louisiana (Figure 62). Focus group participants shared that many young people drop out of high school to help care for their families. This may account for some of this measure in the CHRISTUS Coughatta PSA.

Disconnected youth



Created on Metopio | <https://metop.io/1/81r3nune> | Data source: American Community Survey (Table B14005)
 Disconnected youth: Percent of residents aged 16-19 who are neither working nor enrolled in school.

Figure 62. Disconnected Youth in the CHRISTUS Coughatta PSA

Table 19 explores each of these socio-economic indicators by parish for the service areas.

Topic	Bienville Parish, LA	Natchitoches Parish, LA	Red River Parish, LA
Hardship Index score, 2015-2019	74.4	79.9	75.3
Poverty rate % of residents, 2016-2020	29.52	30.09	26.61
Median household income 2016-2020	\$29,315	\$32,276	\$35,640
Severely rent-burdened % of renter-occupied housing units, 2016-2020	11.59	26.94	19.16
Unemployment rate %, 2016-2020	5.31	13.09	4.21
Disconnected youth % of residents aged 16-19, 2016-2020	7.58	9.72	4.70

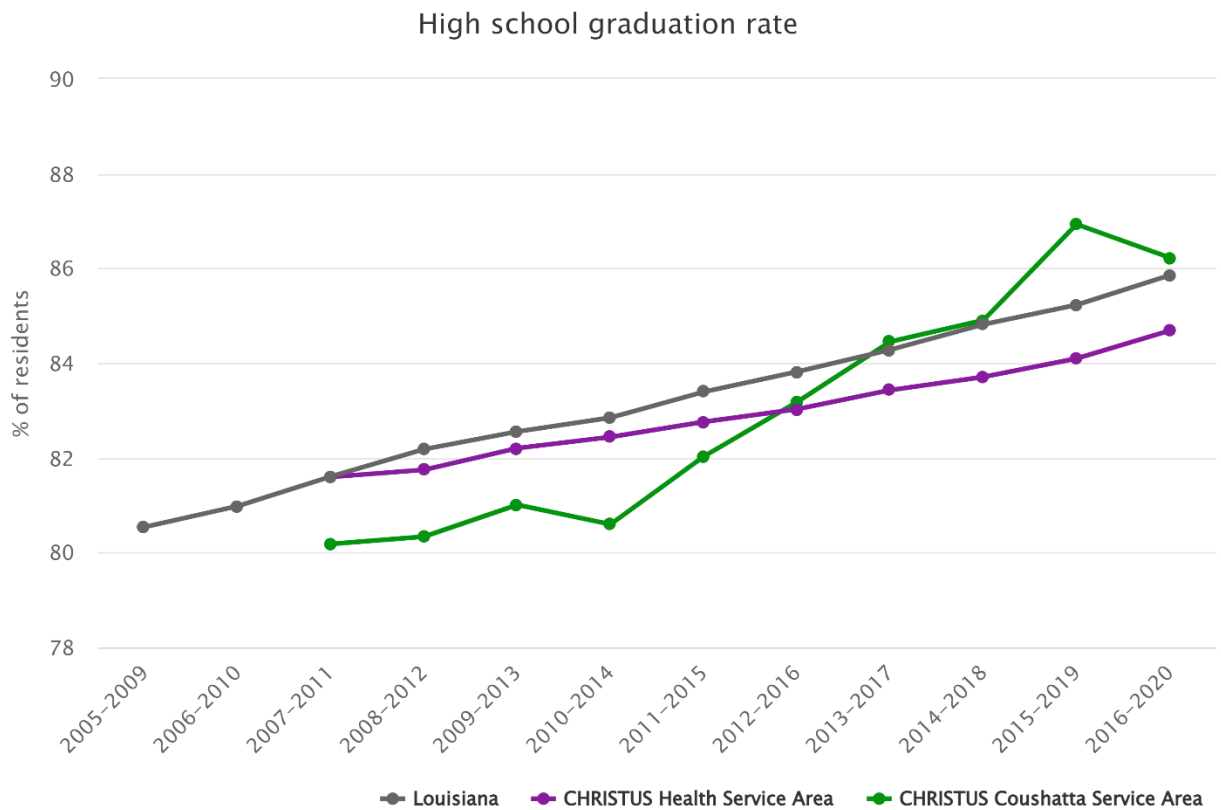
Table 19. Socioeconomic Indicators by Parish in the CHRISTUS Coughatta PSA

Education

The high school graduation in the CHRISTUS Coushatta PSA is 86.1%, which is higher than the wider CHRISTUS Health service area and state averages (84.7% and 85.9% respectively) (Figure 63). High school graduate rates have been on the rise in all benchmark regions since at least 2007.

Post-secondary education in the CHRISTUS Coushatta PSA is substantially lower than in both the wider CHRISTUS Health service area and the state (Figure 64). For residents 25 or older with any post-secondary education, the higher degree graduation rate in the CHRISTUS Coushatta PSA is 15.9% compared to 31.7% in the CHRISTUS Health service area and 31.4% in Louisiana. Table 20 provides additional education-related data for the service area parishes.

Education came up as an issue in the focus groups. Participants shared that community members, young mothers and disadvantaged youth in particular, need more education to qualify for the jobs that are available. They also shared that limited childcare in the area makes it difficult for parents to pursue higher education.



Created on Metopio | <https://metop.io/i/w8bour4d> | Data source: American Community Survey (Table B15002)
High school graduation rate: Residents 25 or older with at least a high school degree: including GED and any higher education

Figure 63. High School Graduation Rate in the CHRISTUS Coushatta PSA

Higher degree graduation rate, 2016–2020

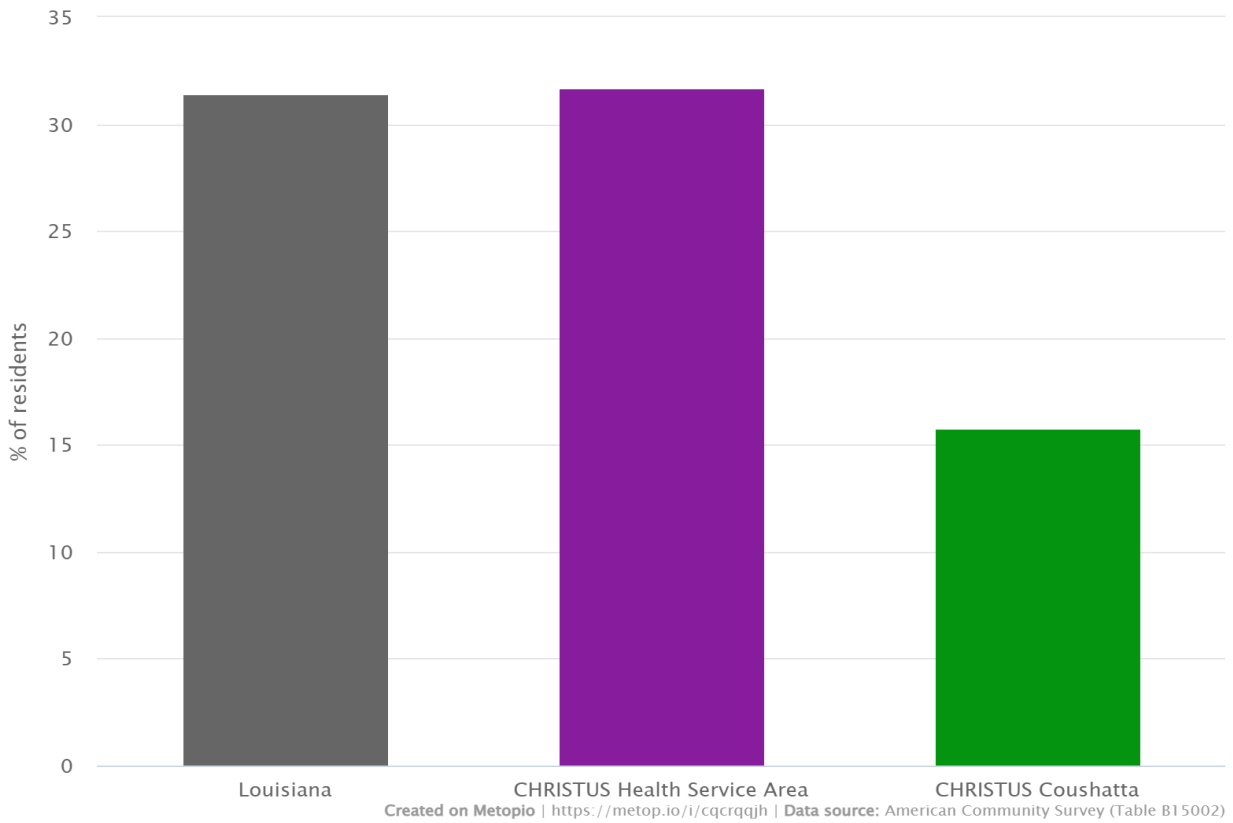


Figure 64. Higher Degree Graduation Rate in the CHRISTUS Coushatta PSA

Topic	Bienville Parish, LA	Natchitoches Parish, LA	Red River Parish, LA
Preschool enrollment <i>Infants (0-4 years)</i> % of toddlers, 2016-2020	49.11	43.93	74.79
Private school <i>Juveniles (5-17 years)</i> % of grade school students, 2016-2020	12.79	8.93	10.37
9th grade education rate % of residents, 2016-2020	95.45	97.13	93.96
High school graduation rate % of residents, 2016-2020	83.95	87.91	79.09
Any higher education rate % of residents, 2016-2020	39.67	49.88	33.40
Graduate education rate % of residents, 2016-2020	4.20	7.95	6.63

Table 20. Education Indicators by Parish in the CHRISTUS Coushatta PSA

Access to Care

Being able to reliably access the health system, whether for primary care, mental health, or specialists, is often dependent on one's insurance (Figure 65). The uninsured rate in the CHRISTUS Coughatta PSA (9.9%) and is slightly higher to the rate in Louisiana (8.7%), but much lower than the rest of the CHRISTUS Health service area (15.1%).

Many residents in the service area receive insurance through Medicaid programs. The percentage of residents covered by Medicaid in the CHRISTUS Coughatta PSA (44.8%) is higher than both the full CHRISTUS Health service area (21.1%) and Louisiana (27.7%) (Figure 66).

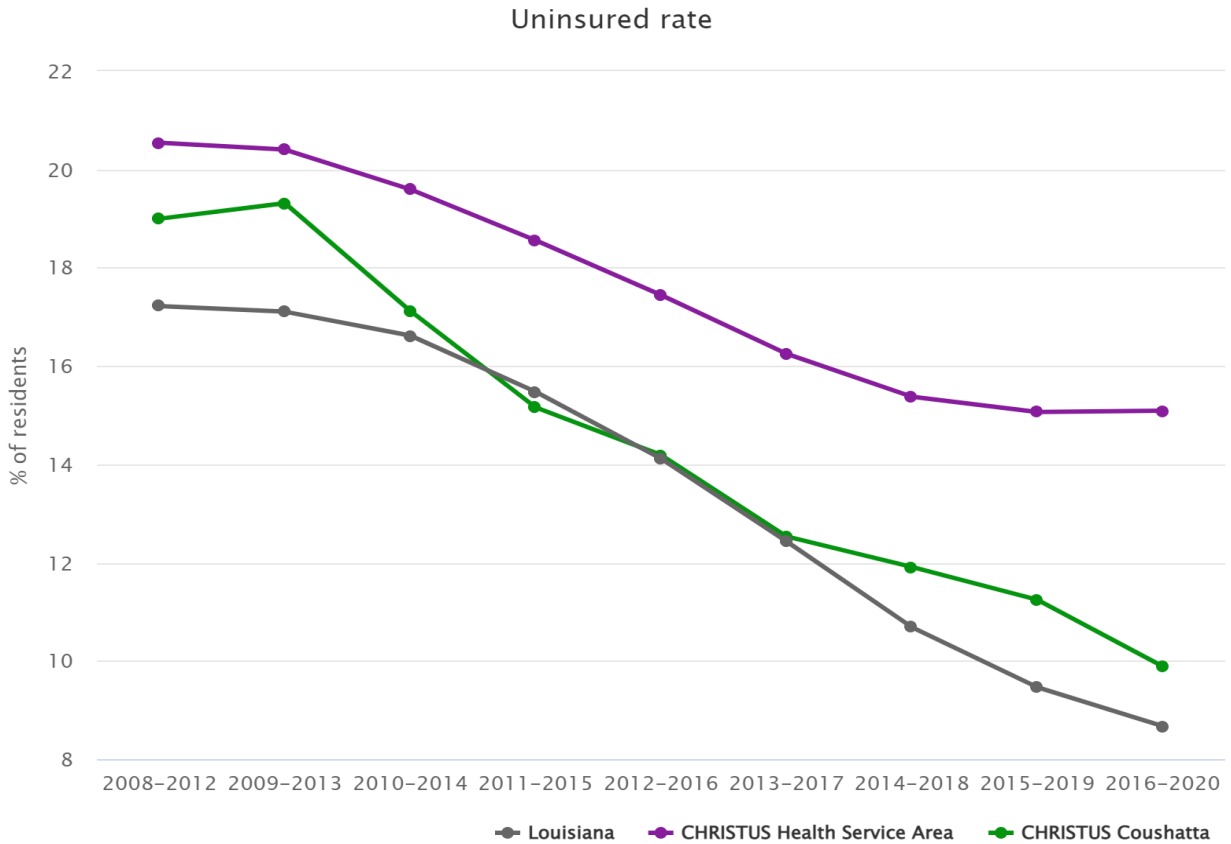


Figure 65. Uninsured Rate in the CHRISTUS Coughatta PSA

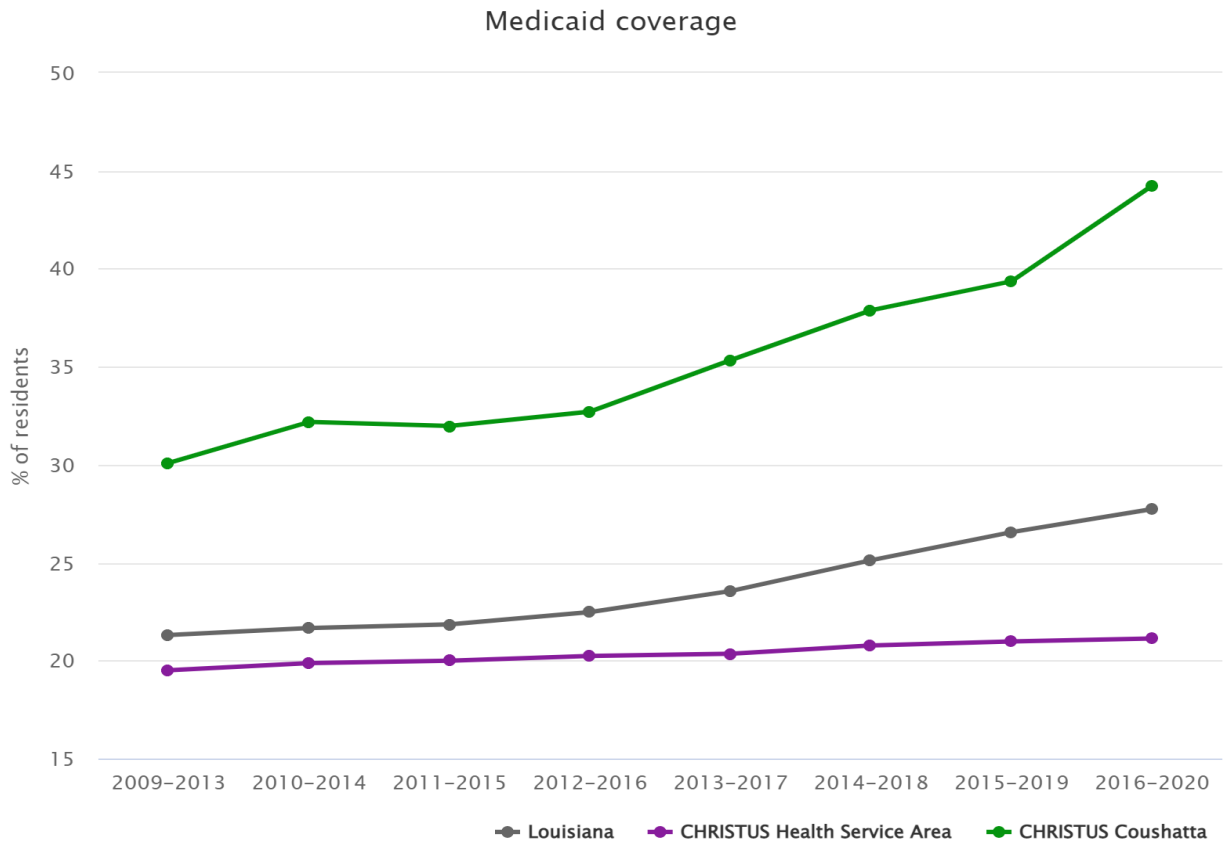


Figure 66. Medicaid Coverage in the CHRISTUS Coushatta PSA

Mental health was raised as an issue through all channels of primary data collection. Figure 67 shows the percentage of adults in the CHRISTUS Coushatta PSA experiencing depression, which is almost a quarter of adult residents for the CHRISTUS Coushatta PSA, and over 1-in-5 adults the whole CHRISTUS Health service area, and the United States. Of the three areas, the CHRISTUS Coushatta PSA has the highest percentage of adults who experience depression (24.8%). Many residents noted a lack of access to providers, regardless of a person's insurance. The table below shows the per capita rate for types of mental health providers in each of the service area parishes, as well as other behavioral health indicators for comparison (Table 21).

Depression, 2019

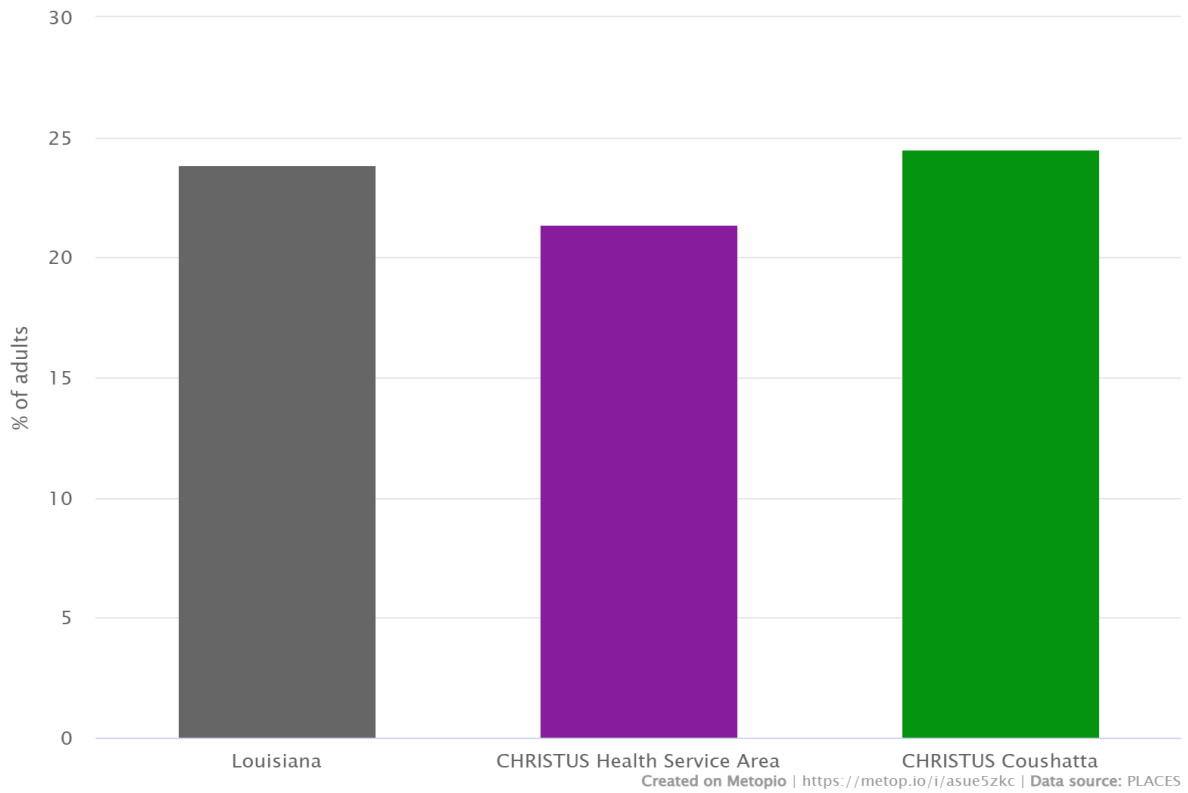


Figure 67. Depression in the CHRISTUS Coushatta PSA

Topic	Bienville Parish, LA	Natchitoches Parish, LA	Red River Parish, LA
Poor self-reported mental health <i>% of adults, 2019</i>	i 20.90	20.00	20.30
Poor mental health days <i>days per month, 2018</i>	i 5.5	5.4	5.4
Psychiatry physicians per capita <i>physicians per 100,000 residents, 2022</i>	i 0	20	1
Mental health providers per capita <i>providers per 100,000 residents, 2021</i>	i 299.6	490.5	123.3
Depression <i>% of adults, 2019</i>	i 24.70	24.20	24.60
Drug overdose mortality <i>deaths per 100,000, 2016-2020</i>	i —	12.67	—

Table 21. Mental Health Access Indicators in the CHRISTUS Coushatta PSA

Many low-income residents in the CHRISTUS Coushatta PSA rely on Federally Qualified Health Centers (FQHCs) for their care in addition to hospitals, outpatient centers and primary care offices (Figure 68). Table 22 includes other indicators that measure access to primary care including the per capita number of primary care physicians and nurse practitioners by parish.

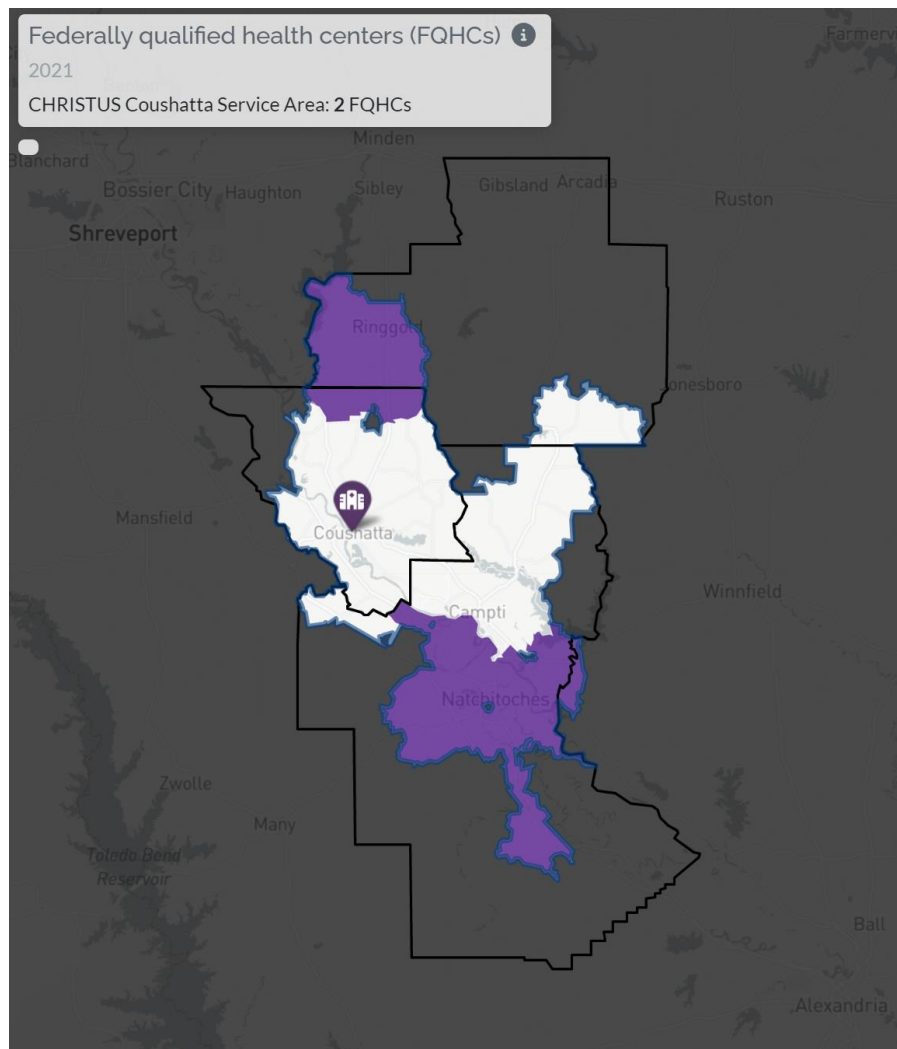


Figure 68. Heat Map of FQHC locations in the CHRISTUS Coushatta PSA

Topic	Bienville Parish, LA	Natchitoches Parish, LA	Red River Parish, LA
Visited doctor for routine checkup % of adults, 2019	80.50	80.90	80.00
Primary care providers (PCP) per capita physicians per 100,000 residents, 2018	14.3	55.9	22.6
Nurse practitioners per capita nurses per 100,000 residents, 2019	50.08	53.39	79.20

Table 22. Primary Care Access Indicators by Parish in the CHRISTUS Coushatta PSA

Food Access

Both obesity and healthy eating were raised as top health issues by survey respondents. Often obesity is correlated with poor food access and 8.1% of residents in the CHRISTUS Coughatta PSA live in a food desert, meaning there isn't a grocery store with one mile for urban residents and five miles for rural residents (Figure 69). Without easy access to fresh, healthy foods, people sometimes rely on fast food and other unhealthy options. In addition to food deserts, 25.1% of residents are considered food insecure (Figure 70) which is an indicator that incorporates both economic and social barriers to food access. Table 23 breaks out various indicators of food access by parishes in the service area.

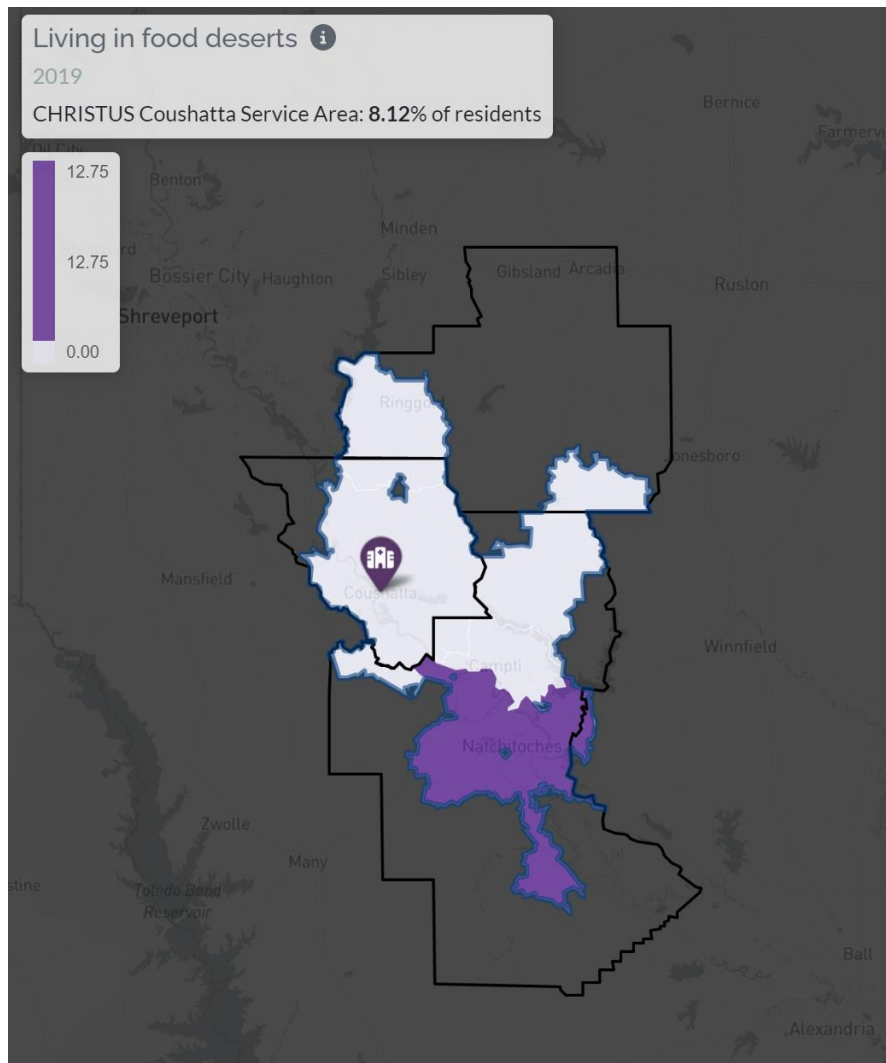


Figure 69. Map of Residents Living in Food Deserts in the CHRISTUS Coughatta PSA

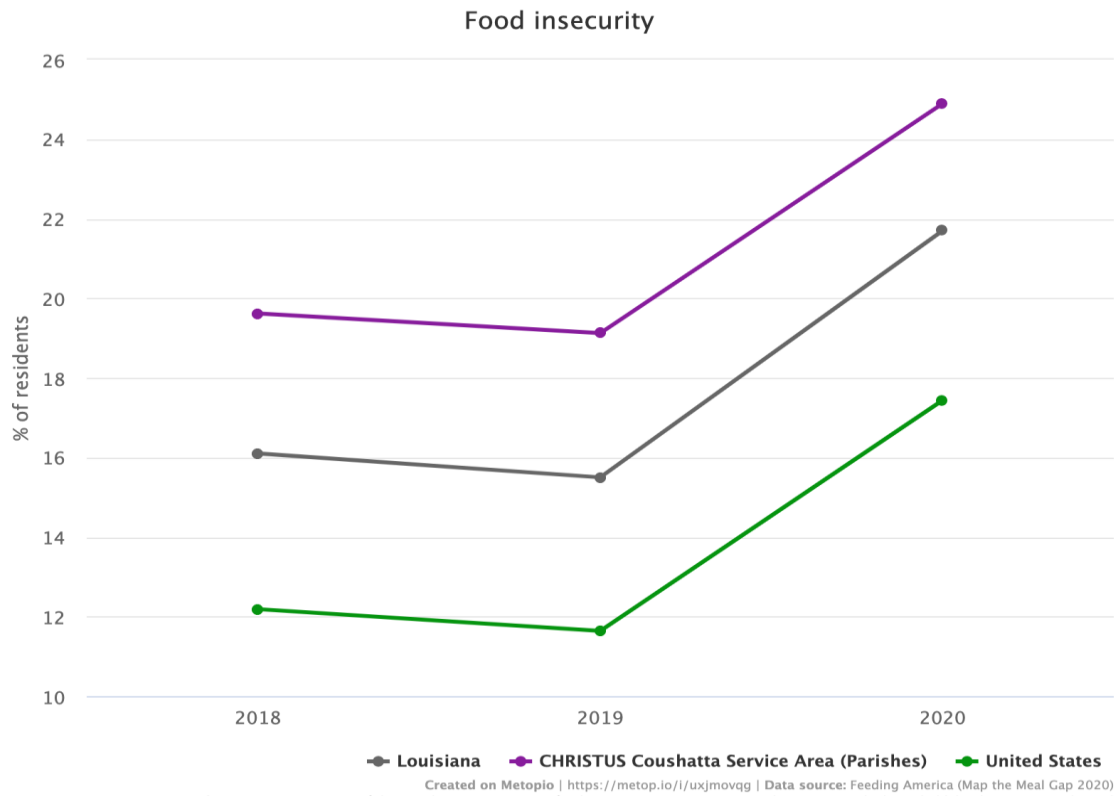


Figure 70. Percent of Residents who are Food Insecure in the CHRISTUS Coushatta PSA

Topic	Bienville Parish, LA	Natchitoches Parish, LA	Red River Parish, LA
Food insecurity <i>% of residents, 2020</i>	i 19.2	16.5	16.8
Low food access <i>% of residents, 2019</i>	i 45.92	43.33	11.44
Very low food access <i>% of residents, 2019</i>	i 16.97	12.67	0.00
Living in food deserts <i>% of residents, 2019</i>	i 11.67	8.78	0.00
Average cost per meal <i>2020</i>	i \$3.43	\$3.25	\$3.27

Table 23. Food Access Indicators by Parish in the CHRISTUS Coushatta PSA

Violence and Community Safety

The rate of property crimes, which includes burglary, larceny, motor vehicle theft, and arson crimes is lower in CHRISTUS Coushatta PSA than the rate in Louisiana, but it is higher than the rate in the United States overall (Figure 71). The same can be said for crimes related to violence, including homicide, criminal sexual assault, robbery, aggravated assault, and aggravated battery (Figure 72). Table 24 shows specific crimes for each parish in the service area.

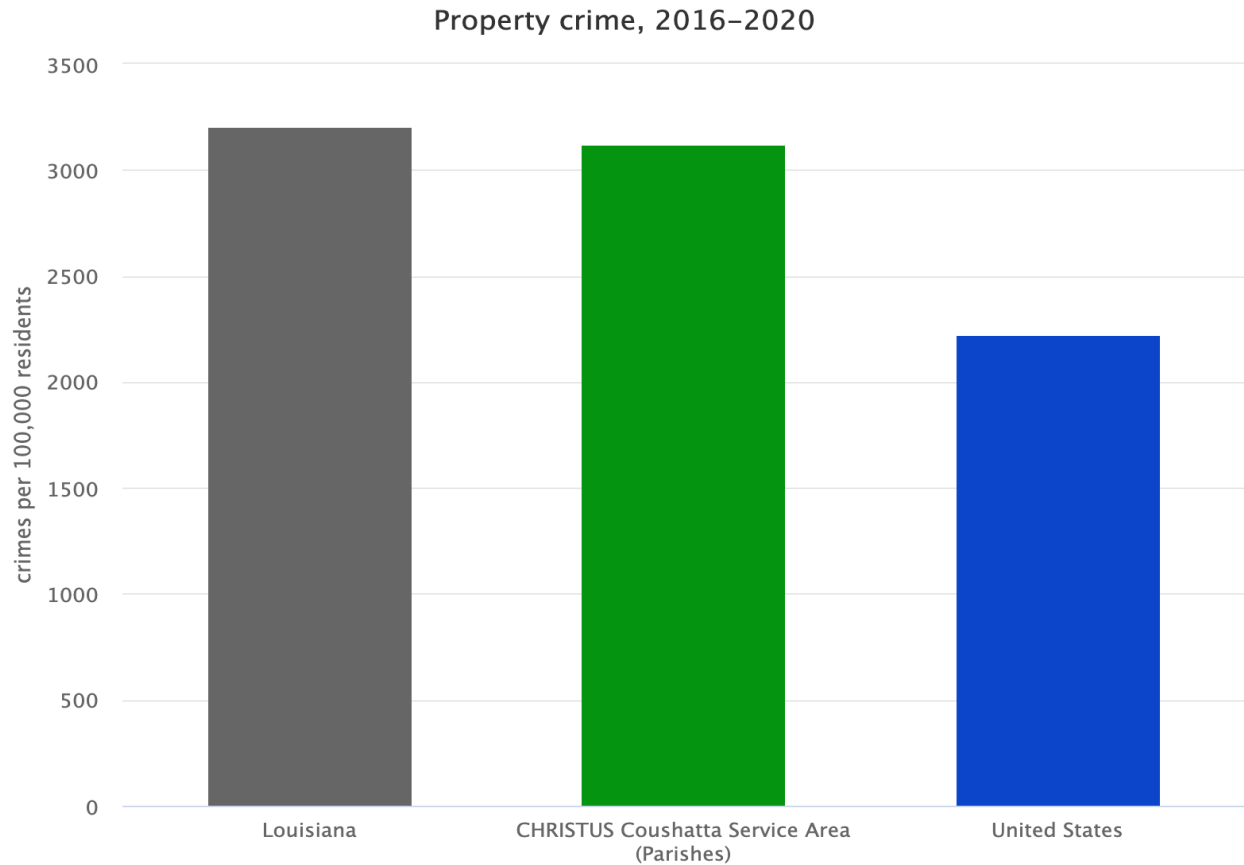
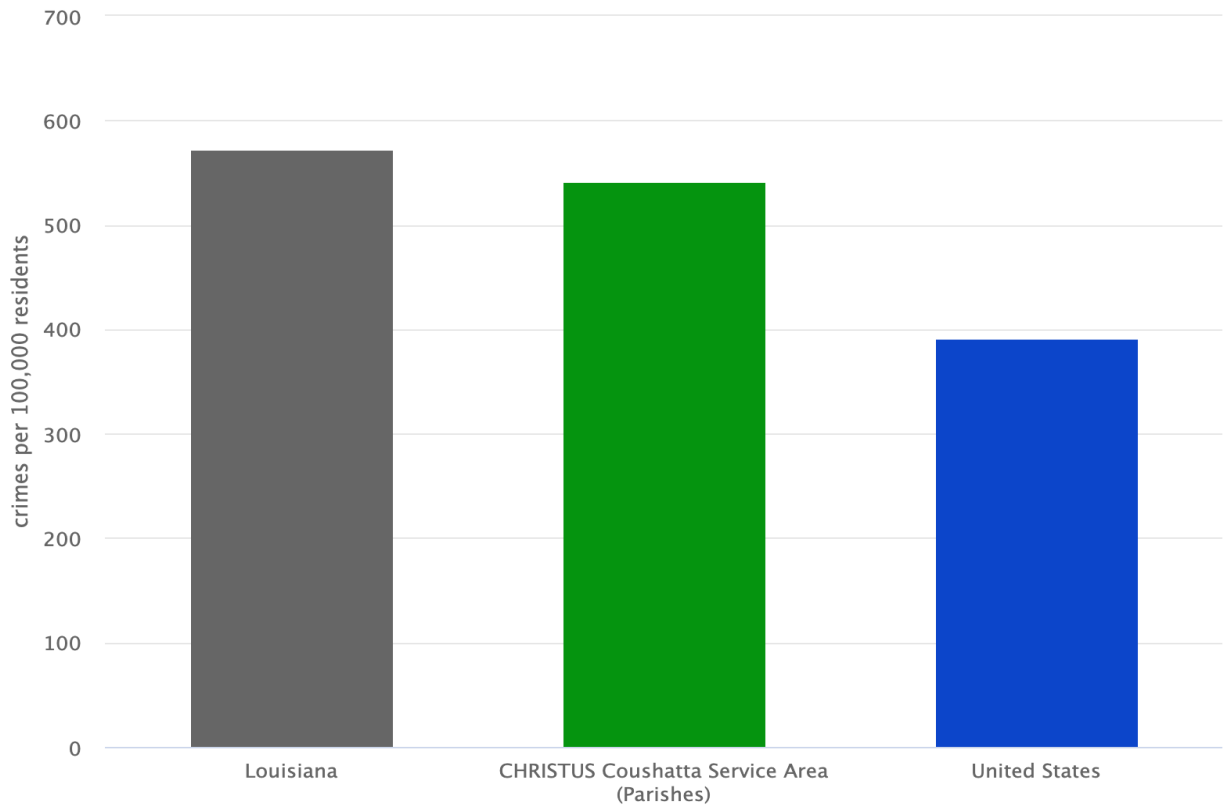


Figure 71. Property Crime Rate in the CHRISTUS Coushatta PSA

Violent crime, 2016–2020



ago crime data portal (Data within Chicago), New York City Police Department (NYPD) (Data within NYC), FBI Crime Data Explorer (County, state, and city level data)

Figure 72. Violence Crime Rate in the CHRISTUS Coughatta PSA

Topic	Bienville Parish, LA	Natchitoches Parish, LA	Red River Parish, LA
Property crime <i>crimes per 100,000 residents, 2020</i>	i 944.4	3,757.9	1,595.4
Violent crime <i>crimes per 100,000 residents, 2020</i>	i 250.4	638.2	305.5
Arson <i>crimes per 100,000 residents, 2020</i>	i 0.0	17.8	0.0
Burglary <i>crimes per 100,000 residents, 2020</i>	i 364.9	945.8	407.3
Homicide <i>crimes per 100,000 residents, 2020</i>	i 7.2	17.8	0.0

Table 24. Types of Crime by Parish in the CHRISTUS Coughatta PSA

CHRISTUS COUSHATTA HEALTH CARE CENTER HEALTH DATA ANALYSIS



CHRISTUS Coushatta Health Care Center CHNA Health Data Analysis

Health Outcomes: Morbidity and Mortality

Chronic Disease

Community members noted that chronic conditions, especially heart disease and diabetes, had an outsized impact on the community. The rate of high blood pressure is higher in the CHRISTUS Coushatta PSA than in the full CHRISTUS Health service area and Louisiana as illustrated below in Figure 73. And more than 17% of adults have diabetes in the CHRISTUS Coushatta PSA (Figure 74). The rate of diabetes is slightly higher rate in Louisiana and full CHRISTUS Health service area. Chronic kidney disease affects 4.4% in CHRISTUS Coushatta PSA, which is above both benchmarks (Figure 75). Lastly, about 11.2% of the population lives with asthma in CHRISTUS Coushatta PSA (Figure 76), which is just above the average in the CHRISTUS Health service area and the state. The following charts and line graphs illustrate these disease conditions.

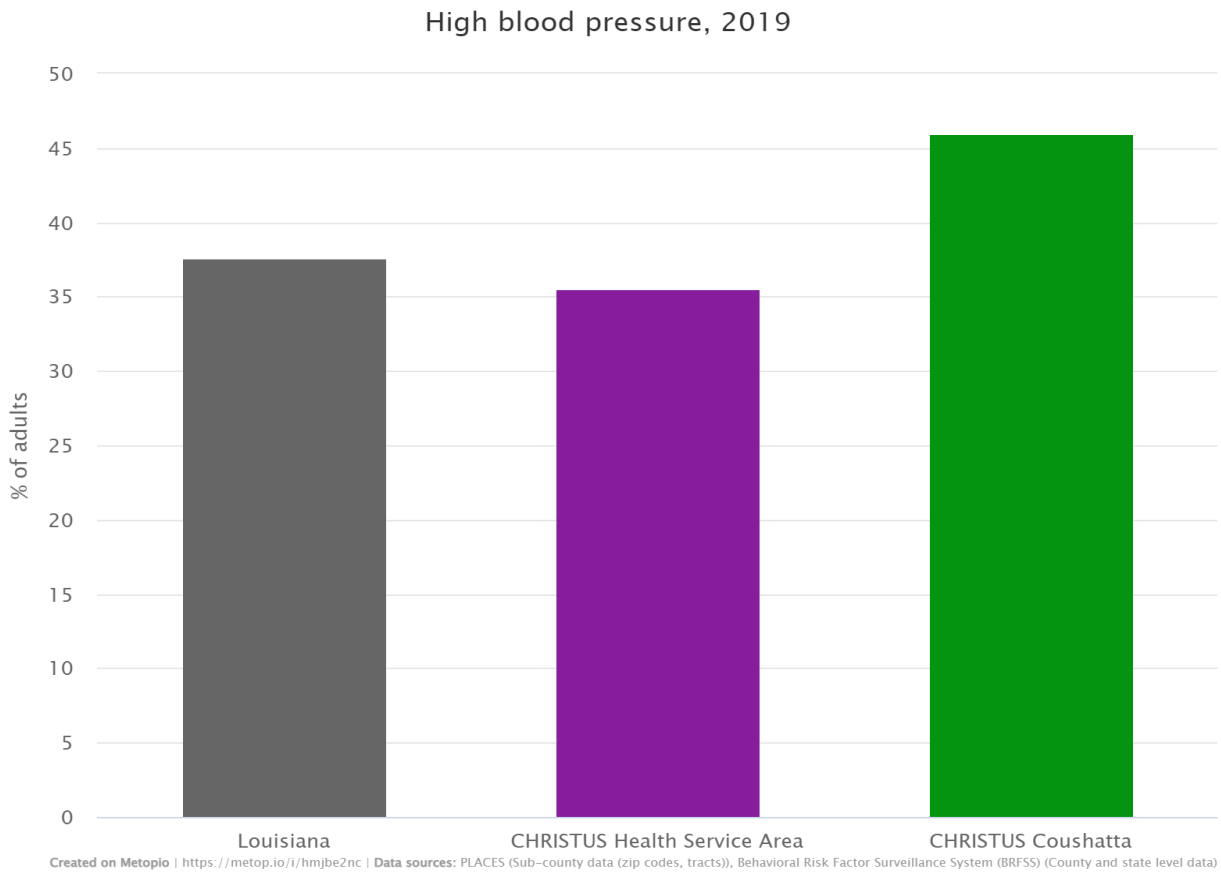


Figure 73. High Blood Pressure in the CHRISTUS Coushatta PSA

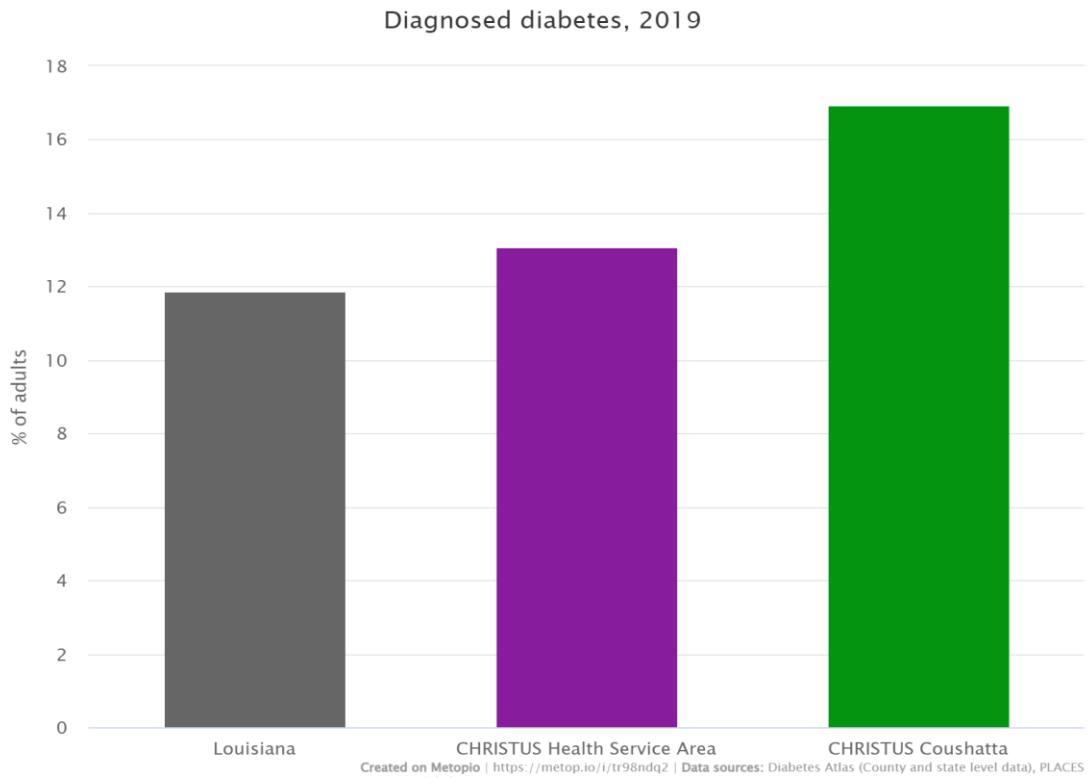


Figure 74. Diagnosed Diabetes in the CHRISTUS Coushatta PSA

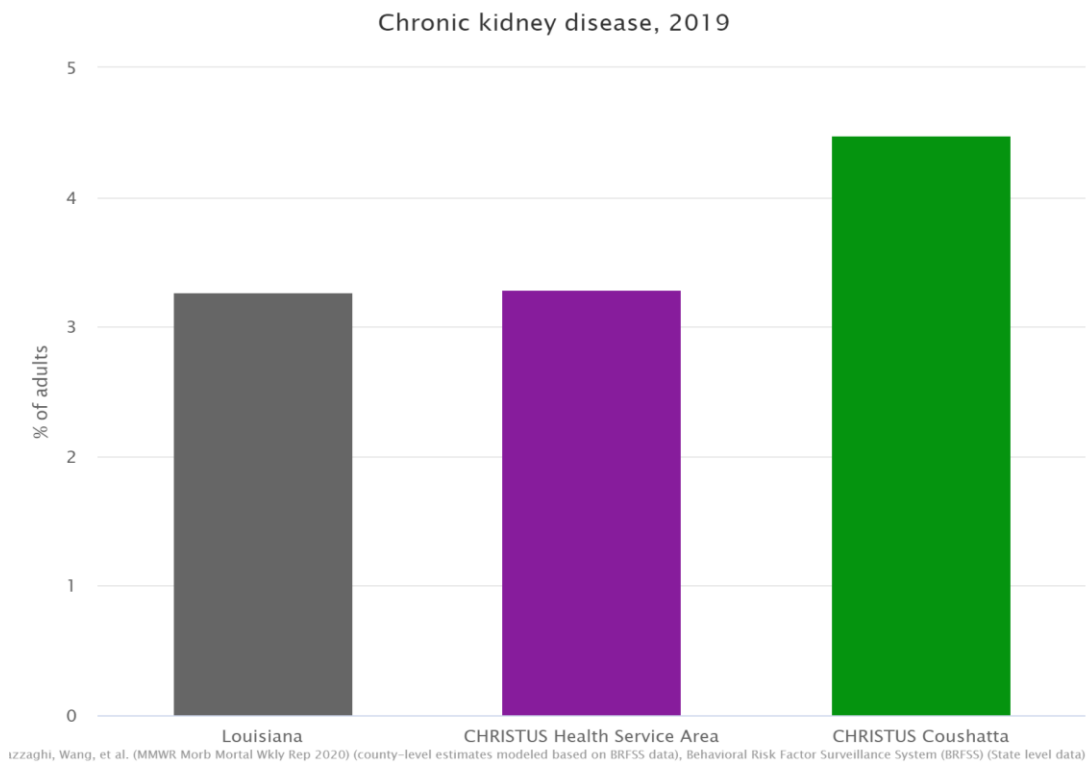


Figure 75. Chronic Kidney Disease in the CHRISTUS Coushatta PSA

Current asthma, 2019

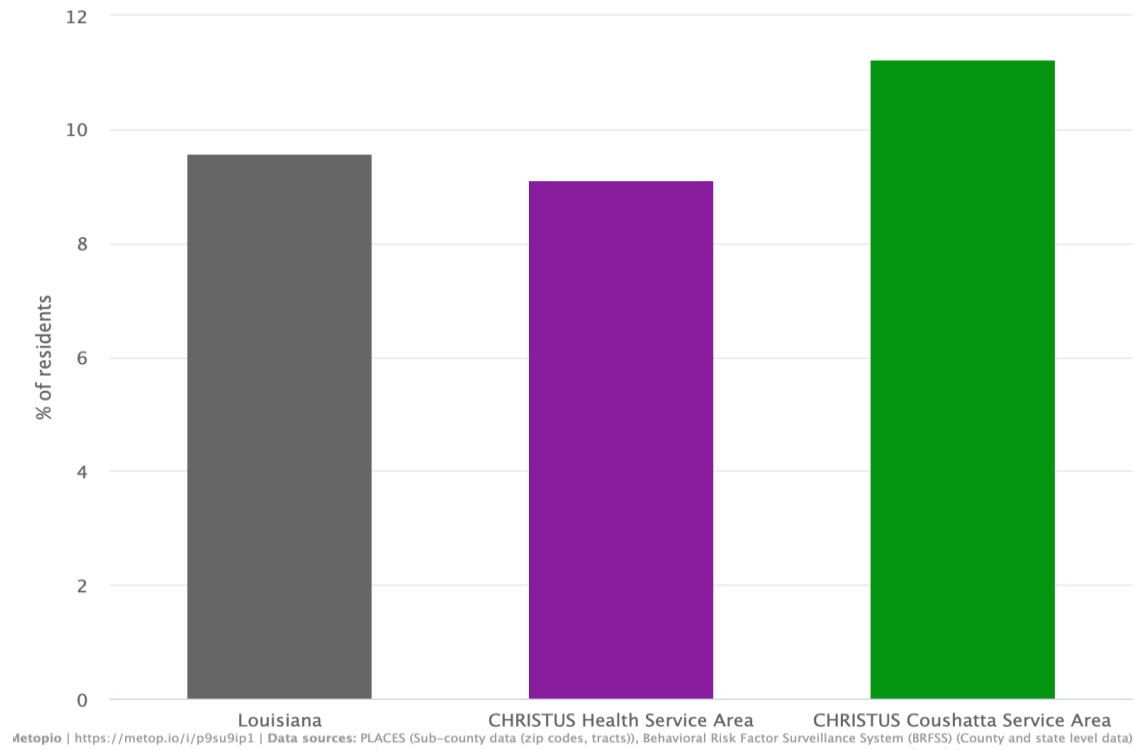


Figure 76. Residents with Asthma in the CHRISTUS Coughatta PSA

Table 25 provides additional insight into the burden of chronic diseases by each parish in the CHRISTUS Coughatta PSA.

Topic	Bienville Parish, LA	Natchitoches Parish, LA	Red River Parish, LA
High blood pressure % of adults, 2019	42.80	41.30	41.20
Diagnosed diabetes % of adults, 2019	14.8	14.0	14.0
Coronary heart disease % of adults, 2019	7.90	7.60	7.60
Chronic kidney disease % of adults, 2019	4.0	3.8	3.8
Current asthma % of residents, 2019	10.90	10.80	10.60
Obesity % of adults, 2019	42.6	42.0	43.0

Table 25. Chronic Disease Indicators by Parish in the CHRISTUS Coughatta PSA

Maternal Health

Preterm births are a challenge within the CHRISTUS Coushatta PSA. The rate of preterm births in the CHRISTUS Coushatta PSA (15.7%) is lower than that in the state (18.0%) but above the United States (12.0%) (Figure 77).

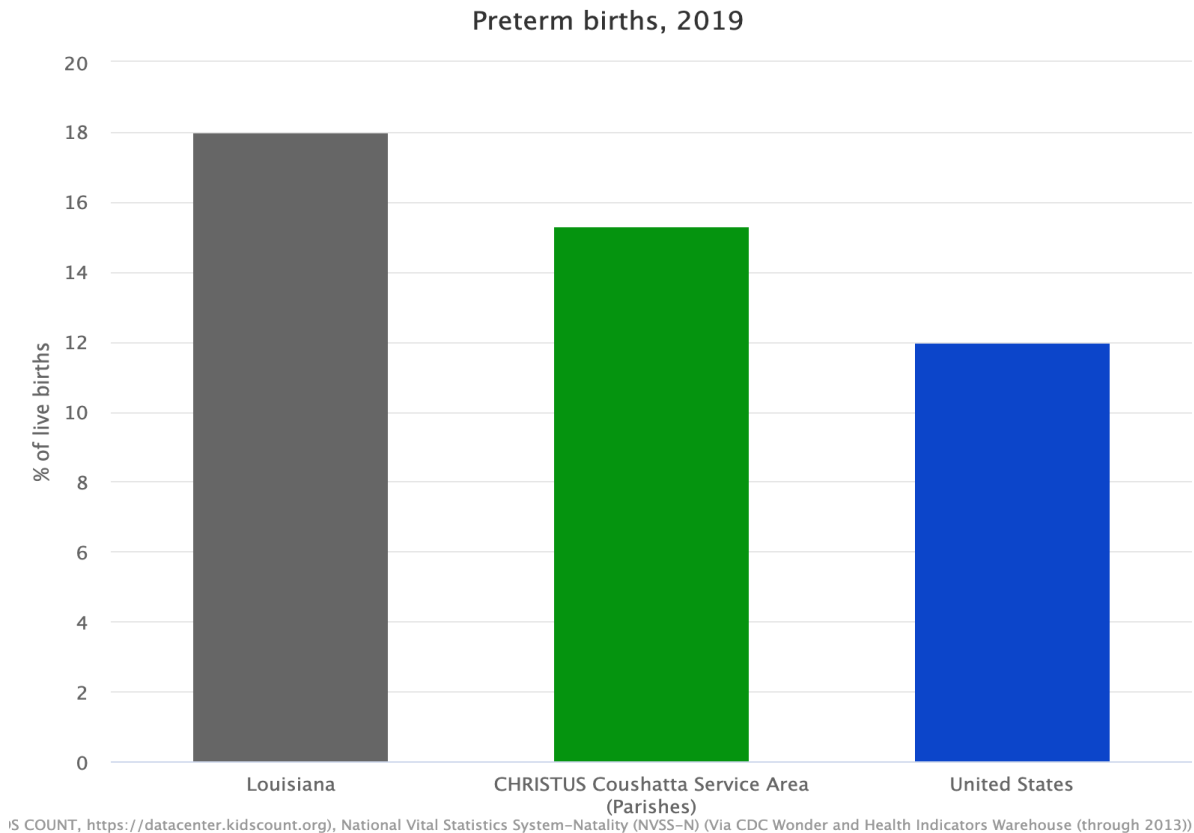


Figure 77. Percent of Preterm Births in the CHRISTUS Coushatta PSA

The teen birth rate has fluctuated over the last decade. The rate within the CHRISTUS Coushatta PSA (25.1 births per 1,000) is above that of the whole CHRISTUS Health service area (22.1 births) and Louisiana (18.8 births) (Figure 78). Within the CHRISTUS Coushatta PSA, the percentage of births to women without partners present is over 50%, which is higher than Louisiana (38.5%) and the United States (27.2%) (Figure 79).

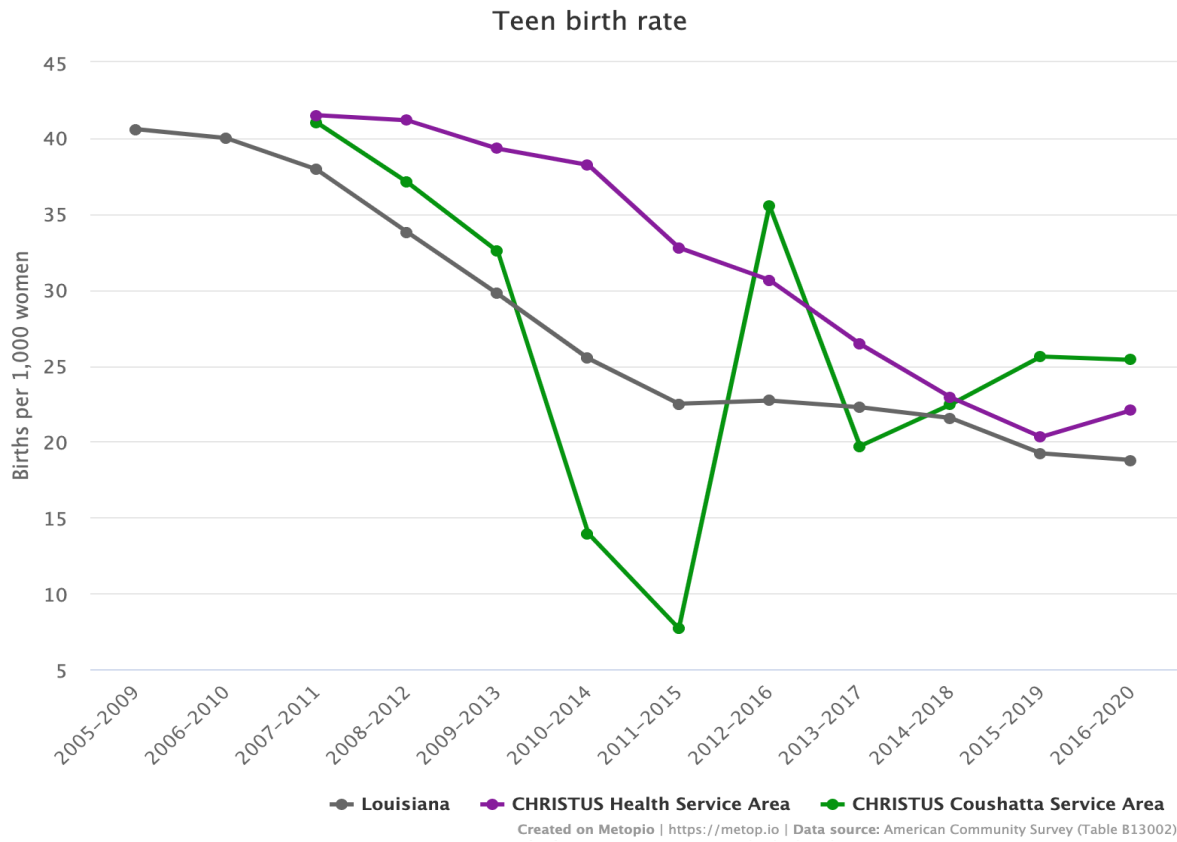


Figure 78. Teen Birth Rate in the CHRISTUS Coughatta PSA

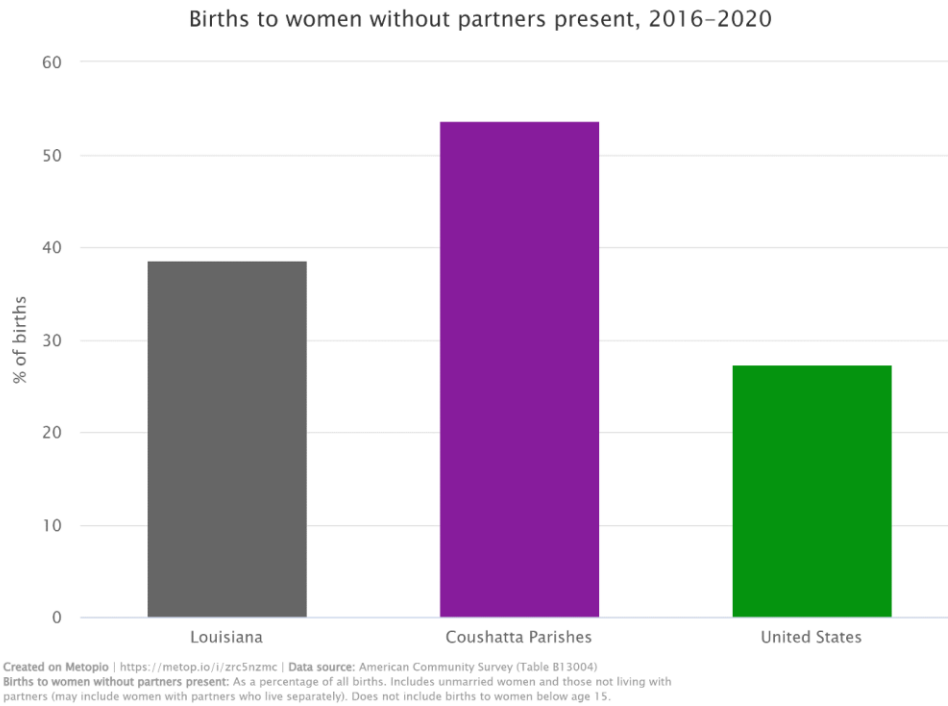


Figure 79. Percent of Births to Women Without Partners in the CHRISTUS Coughatta PSA

Leading Causes of Death

The top causes of death for service area as a whole can be found in Table 26. The leading causes of death will be explored further for the service area in the following section. Parish level mortality rates will be explored at the end of this section (Table 28).











Topic		Coushatta Parishes	Louisiana	United States
Heart disease mortality <i>deaths per 100,000, 2016-2020</i>		204.3	213.8	164.8
Cancer mortality <i>deaths per 100,000, 2016-2020</i>		181.7	168.7	149.4
Injury mortality <i>deaths per 100,000, 2016-2020</i>		82.4	95.8	72.6
Chronic lower respiratory disease mortality <i>deaths per 100,000, 2016-2020</i>		63.6	42.5	39.1
Alzheimer's disease mortality <i>deaths per 100,000, 2016-2020</i>		49.9	43.6	30.8
Stroke mortality <i>deaths per 100,000, 2016-2020</i>		48.6	46.2	37.6
Influenza and pneumonia mortality <i>deaths per 100,000, 2016-2020</i>		14.0	14.2	13.6
Drug overdose mortality <i>deaths per 100,000, 2016-2020</i>		16.40	28.51	22.43
Diabetes mortality <i>deaths per 100,000, 2016-2020</i>		33.1	27.2	22.1
Septicemia (sepsis) mortality <i>deaths per 100,000, 2016-2020</i>		23.2	20.0	10.1

Table 26. Leading Causes of Death in the CHRISTUS Coushatta PSA

Heart Disease

Coronary heart disease makes up the largest contributor to the heart disease mortality rate, accounting for 110.0 deaths per 100,000 out of the total 218.6 per 100,000 deaths for heart disease overall in the CHRISTUS Coushatta PSA. Heart disease mortality has a disparate impact on the Black community in the CHRISTUS Coushatta PSA. The mortality rate for non-Hispanic Black people is 245.4 deaths per 100,000 deaths in the CHRISTUS Coushatta PSA, compared to 205.1 deaths for non-Hispanic White people. There is insufficient data for the Hispanic or Latino, Asian or Pacific Islander, or Native American populations in the CHRISTUS Coushatta PSA (Figure 80).

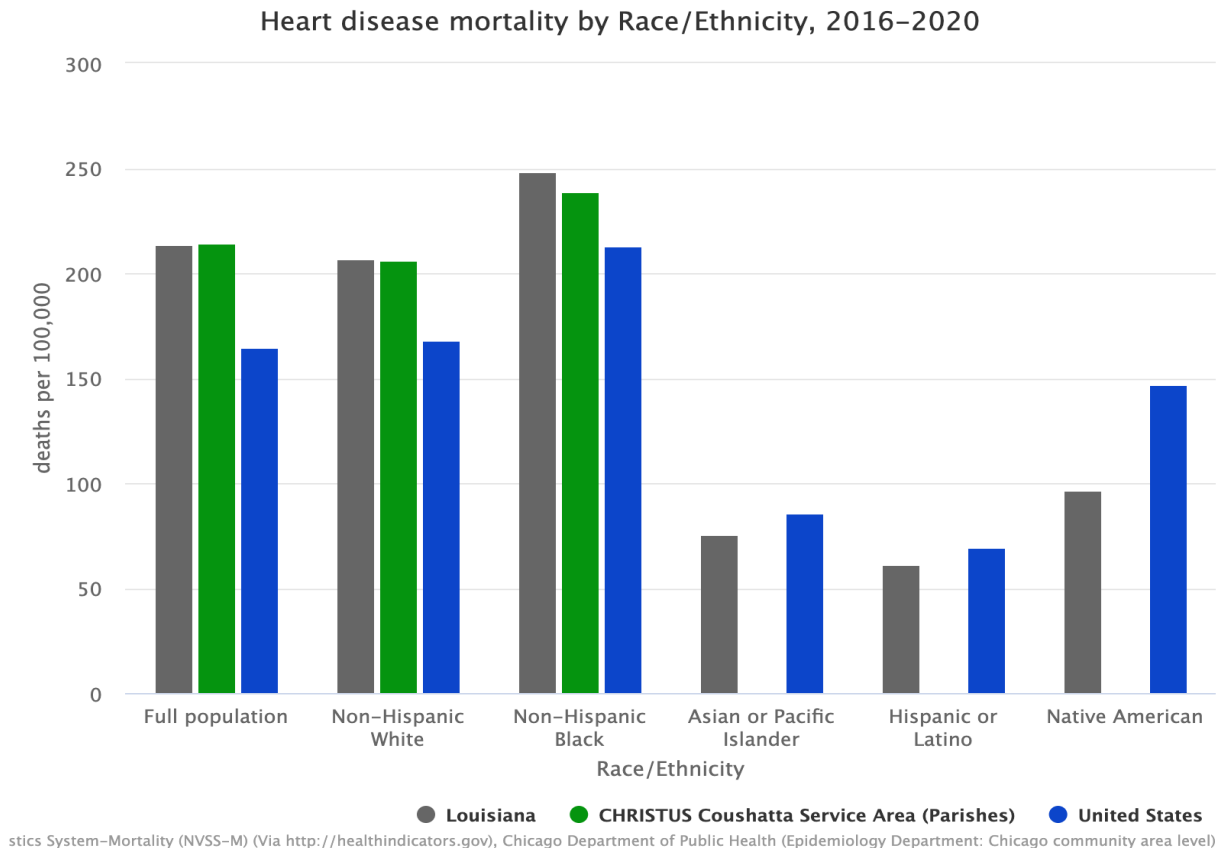


Figure 80. Heart Disease Mortality with Stratifications in the CHRISTUS Coushatta PSA

Cancer

Cancer represents the second leading cause of death in the CHRISTUS Coughatta PSA. Lung, trachea, and bronchus cancer, in particular, make up a large portion of cancer deaths. The overall mortality rate for cancer mortality is 195.2 deaths per 100,000 deaths in the CHRISTUS Coughatta PSA (Figure 81). Table 27 breaks out the mortality rate for some cancers.

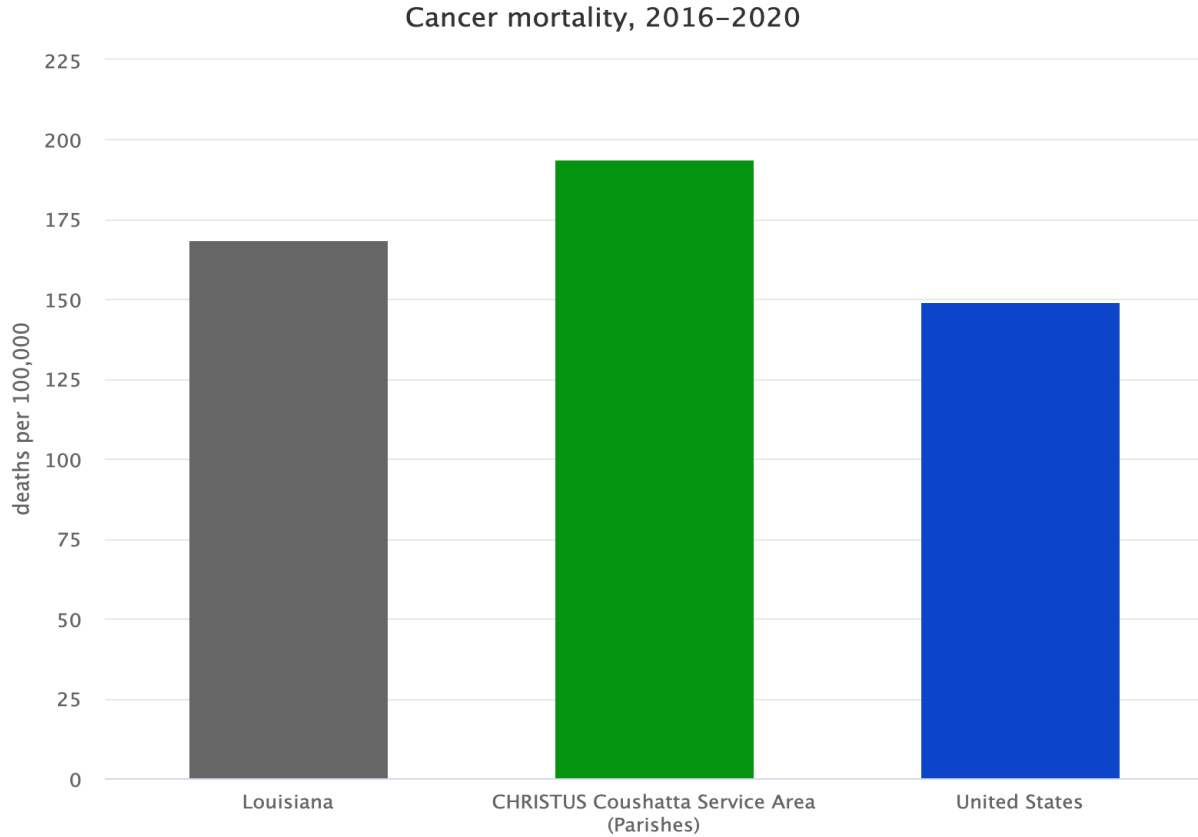
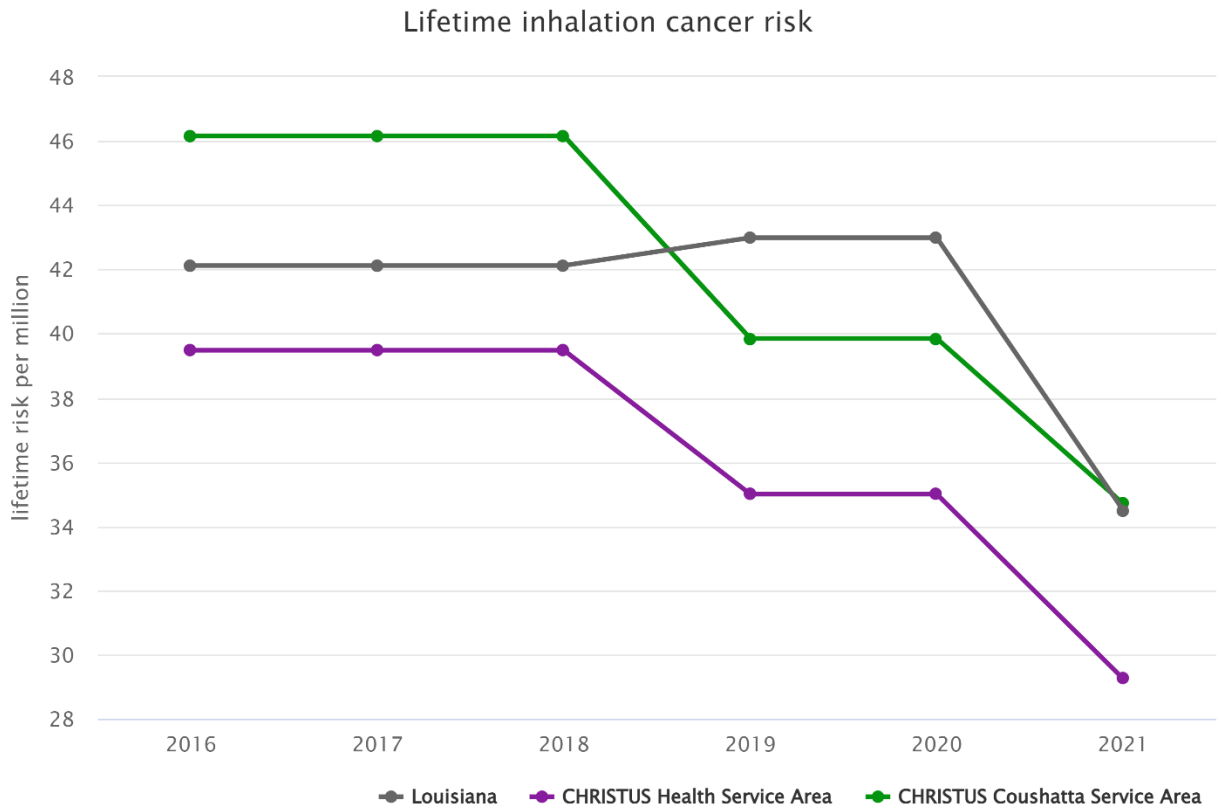


Figure 81. Cancer Mortality Rate in the CHRISTUS Coughatta PSA

Topic	Bienville Parish, LA	Natchitoches Parish, LA	Red River Parish, LA
Lung, trachea, and bronchus cancer mortality <small>deaths per 100,000, 2016-2020</small>	42.7	43.9	60.1
Colorectal cancer mortality <small>deaths per 100,000, 2016-2020</small>	24.2	20.2	42.6
Breast cancer mortality <small>deaths per 100,000, 2016-2020</small>	17.9	16.1	25.4

Table 27. Cancer Mortality by Type in the CHRISTUS Coughatta PSA

Environmental factors may contribute to the lung cancer burden in the service areas. The Lifetime Inhalation Cancer Risk of the Environmental Protection Agency's Environmental Justice Index is a weighted index of vulnerability to lifetime inhalation cancer risk. It measures estimated lifetime risk of developing cancer as a result of inhaling carcinogenic compounds in the environment, per million people. The Lifetime Inhalation Cancer Risk in the CHRISTUS Coughatta PSA (34.6 lifetime risk per million) is higher than the CHRISTUS Health service area (29.2) and almost identical to the overall risk in Louisiana (34.5) (Figure 82). All three places have seen a decline in recent years.

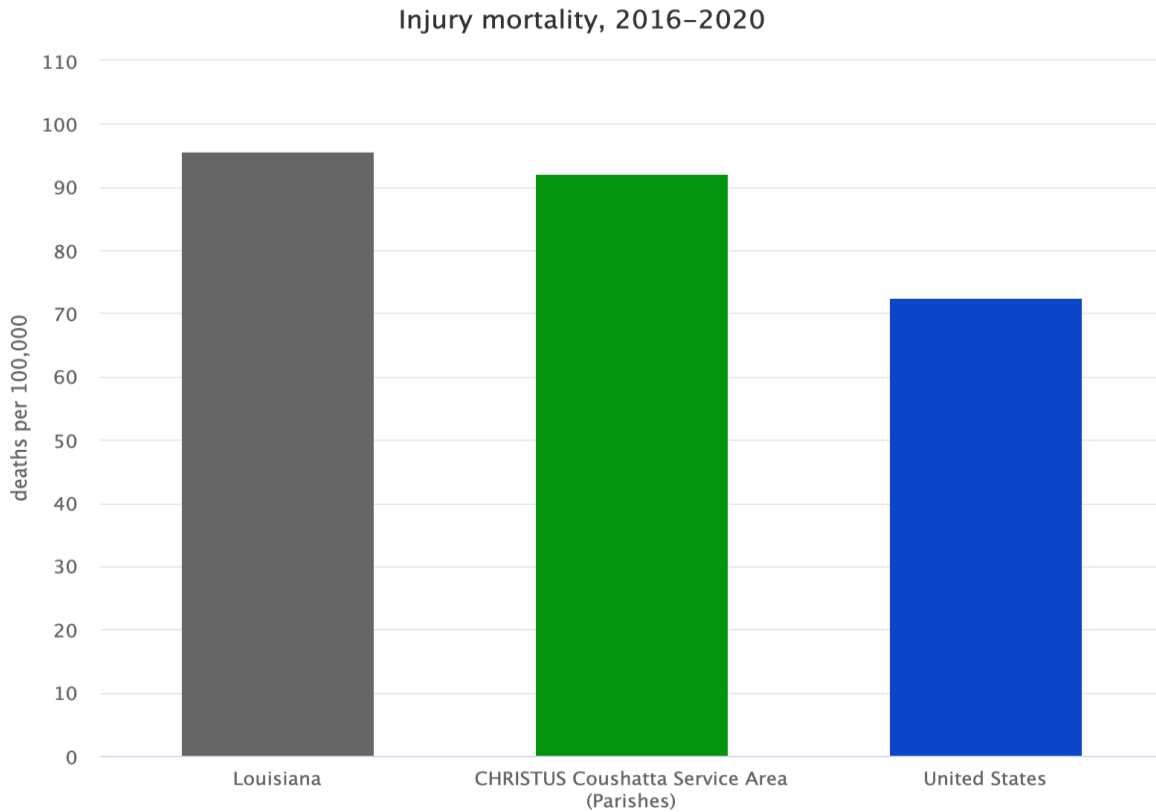


Created on Metopio | <https://metop.io/i/qgu56e76> | Data source: EJScreen: Environmental Justice Screening (EJSCREEN, via National-Scale Air Toxics Assessment (NSA-TA)) | Lifetime inhalation cancer risk: Estimated lifetime risk of developing cancer as a result of inhaling carcinogenic compounds in the environment, per million people.

Figure 82. Lifetime Inhalation Cancer Risk in the CHRISTUS Coughatta PSA

Injury

Injuries account for the fourth highest cause of death in the CHRISTUS Coushatta PSA. This is, in part, because this category includes many kinds of injury including unintentional injury mortality and motor vehicle traffic mortality and workplace mortality. This topic does not include homicide or suicide mortality. The rate for the in the CHRISTUS Coushatta PSA (92.6 deaths per 100,000) is close to the rate in Louisiana overall (95.8), but both benchmarks are much higher than the average across the United States (72.6) (Figure 83).

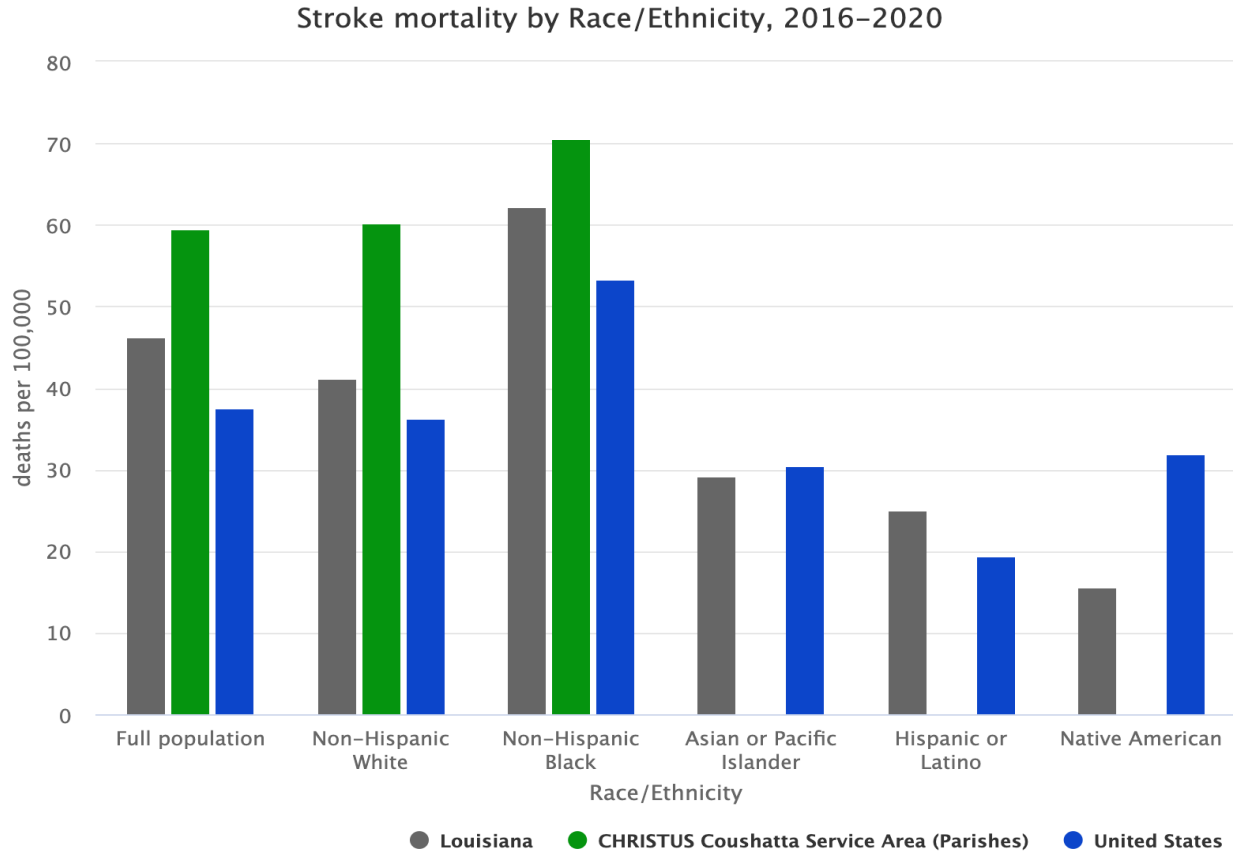


astics System–Mortality (NVSS–M) (Via <http://healthindicators.gov>), Chicago Department of Public Health (Epidemiology Department: Chicago community area level)

Figure 83. Injury Mortality in the CHRISTUS Coushatta PSA

Stroke

The mortality rate for stroke is higher than both benchmarks for the full population in the CHRISTUS Coughatta PSA (59.8 deaths per 100,000) (Figure 84). When this data is stratified by race, non-Hispanic Black residents experience a much greater stroke mortality rate (70.1) than non-Hispanic White residents (60.0). There is insufficient data for the Hispanic and Latino, Asian or Pacific Islander, or Native American populations.

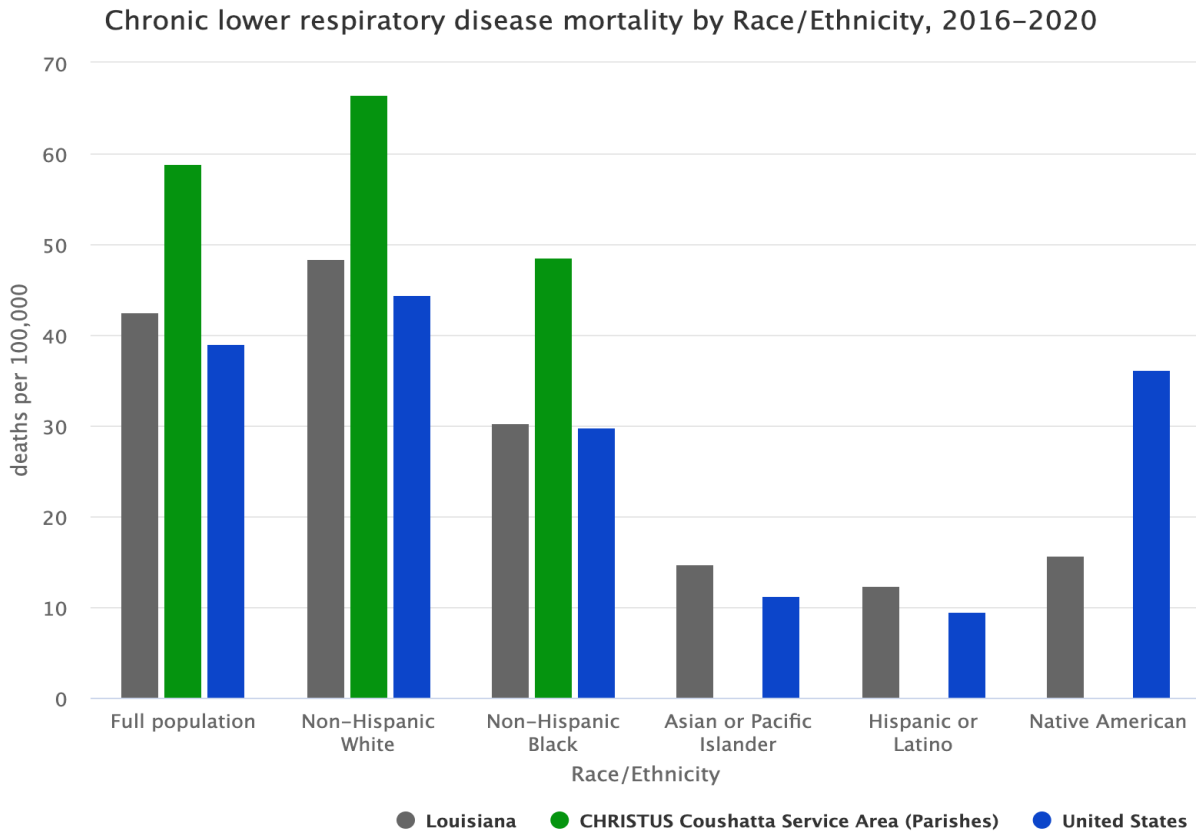


stics System–Mortality (NVSS–M) (Via <http://healthindicators.gov>), Chicago Department of Public Health (Epidemiology Department: Chicago community area level)

Figure 84. Stroke Mortality with Stratifications in the CHRISTUS Coughatta PSA

Chronic Lower Respiratory Disease

This is a roll up of four major respiratory diseases—chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, and asthma. There appears to be a disparity with this cause of mortality when comparing the CHRISTUS Coshatta PSA to the state and the U.S. The rate in the Coshatta PSA is 59.2 deaths per 100,000 for the full population, 66.3 for non-Hispanic Whites and 48.7 for non-Hispanic Blacks. There is insufficient data for the Hispanic and Latino, Asian or Pacific Islander, or Native American populations (Figure 85).



National Vital Statistics System–Mortality (NVSS–M) (Via <http://healthindicators.gov>), Chicago Department of Public Health (Epidemiology Department: Chicago community area level)

Figure 85. Chronic Lower Respiratory Disease with Stratifications in the CHRISTUS Coshatta PSA

Alzheimer's Disease

The mortality rate for Alzheimer's has been rapidly increasing throughout all regions over the reporting period (Figure 86). In the CHRISTUS Coughatta PSA, Alzheimer's disease accounts for 50.6 deaths per 100,000. The rates in the state (43.6) and country (30.8) are slightly lower, but still increasing over time.

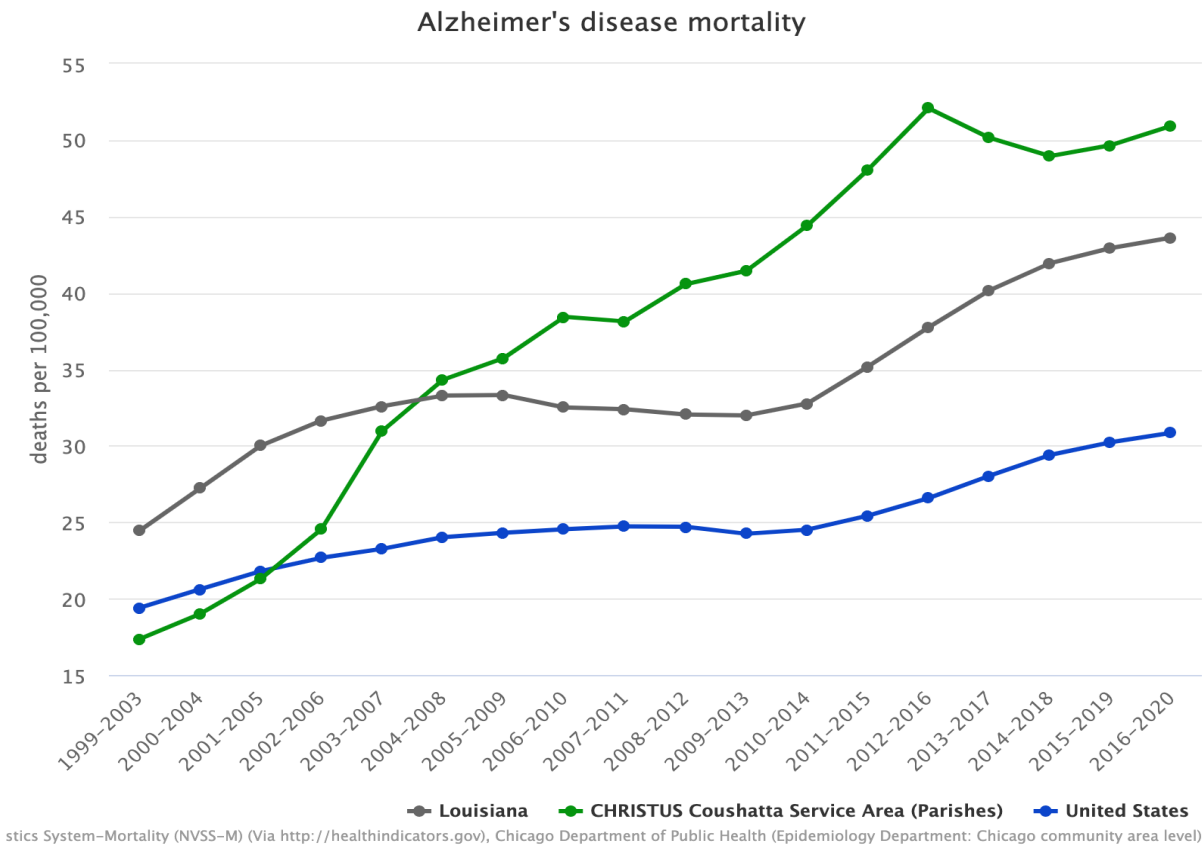
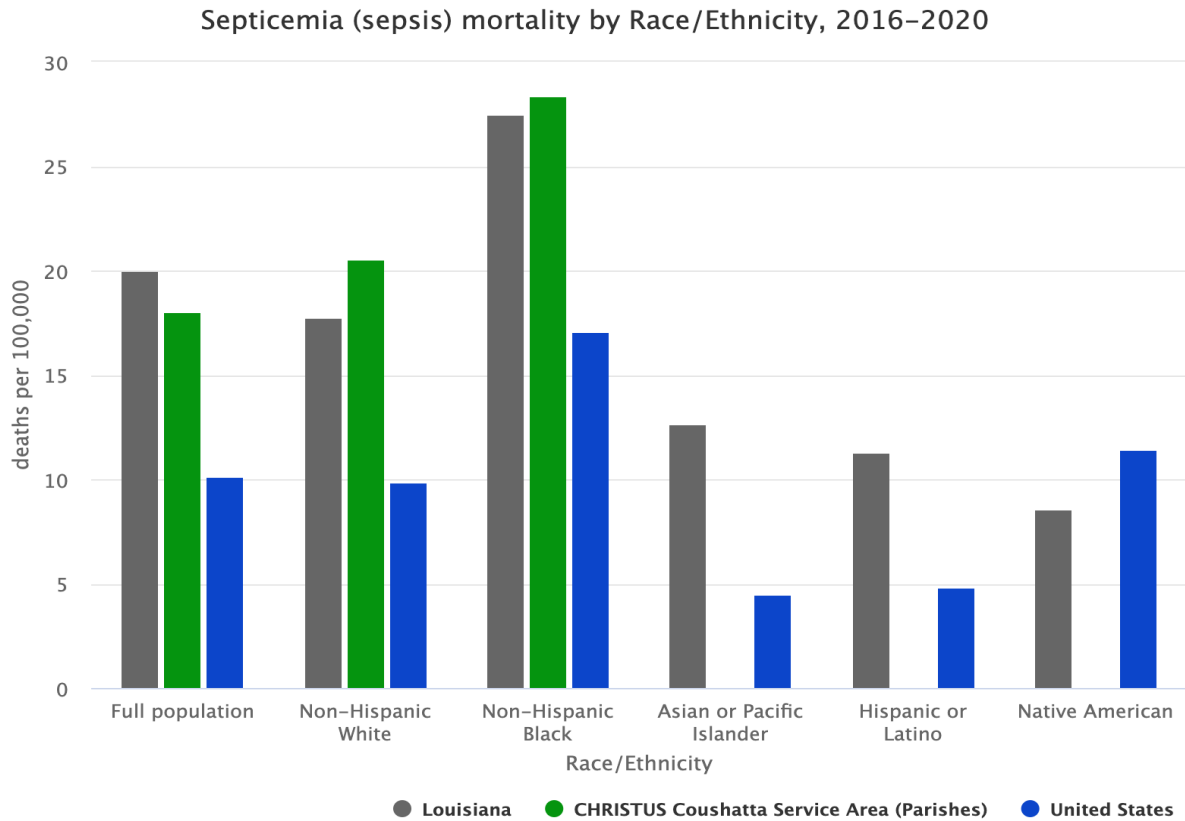


Figure 86. Alzheimer's Disease Mortality in the CHRISTUS Coughatta PSA

Sepsis

Sepsis mortality is the 7th leading cause of death in the CHRISTUS Coughatta PSA. This disease is caused by untreated bacterial, fungal, parasitic, or viral infections and is preventable through prompt access to health services. As shown in Figure 87, sepsis mortality rates in the CHRISTUS Coughatta PSA (18.3 deaths per 100,000) are less common than in the state (20.0 deaths) but more prevalent than the country (10.1). Within the CHRISTUS Coughatta PSA, non-Hispanic Black people experience the highest sepsis mortality rate (27.1 deaths).



Created on Metopio | <https://metop.io/i/9v68fw6o> | Data source: National Vital Statistics System–Mortality (NVSS–M) (Via <http://healthindicators.gov>)

Figure 87. Sepsis Mortality with Stratifications in the CHRISTUS Coughatta PSA

Diabetes

The diabetes mortality rate for the service area is higher than the state and national rates for the full population (Figure 88). There is a racial disparity among diabetes mortality. non-Hispanic Black residents die from diabetes at a much higher rate than non-Hispanic White residents (47.6 deaths per 100,000 versus 30.2). There is insufficient data for the Hispanic and Latino, Asian or Pacific Islander, or Native American populations.

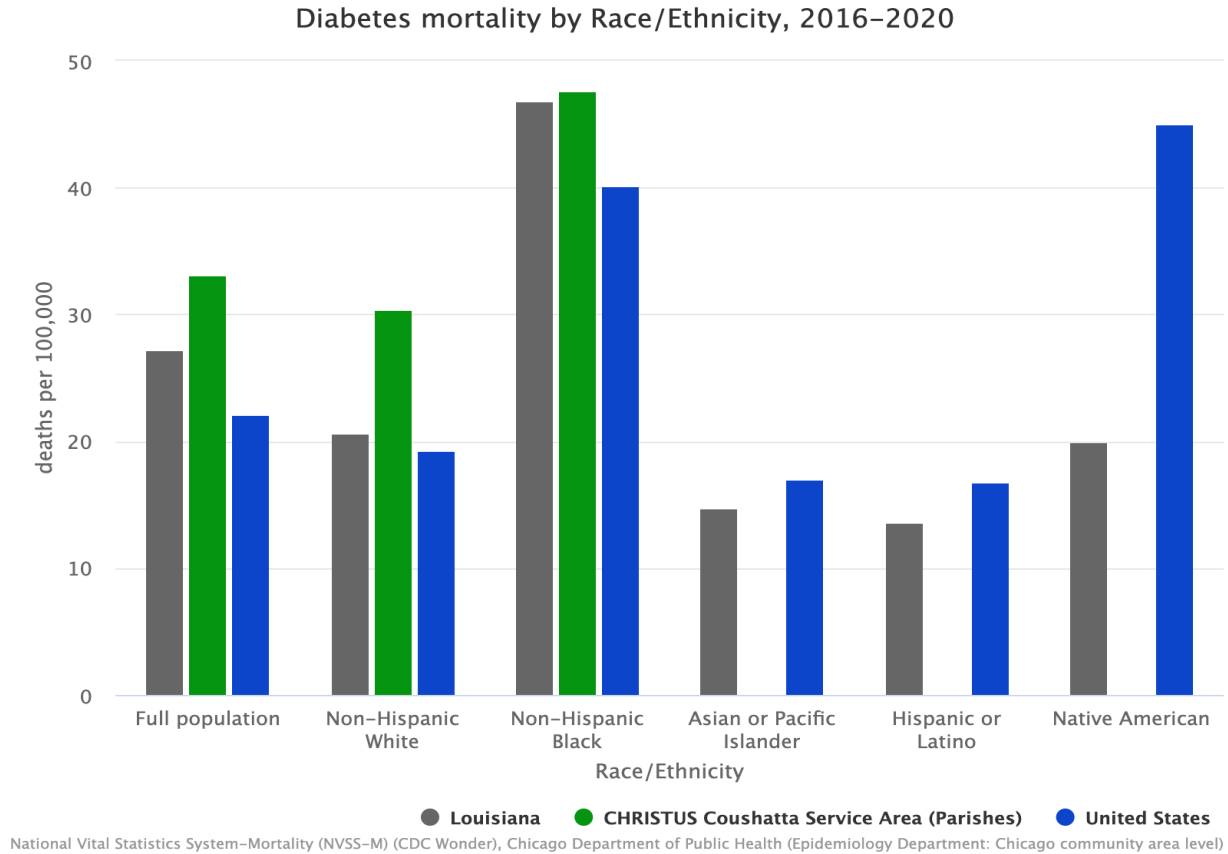
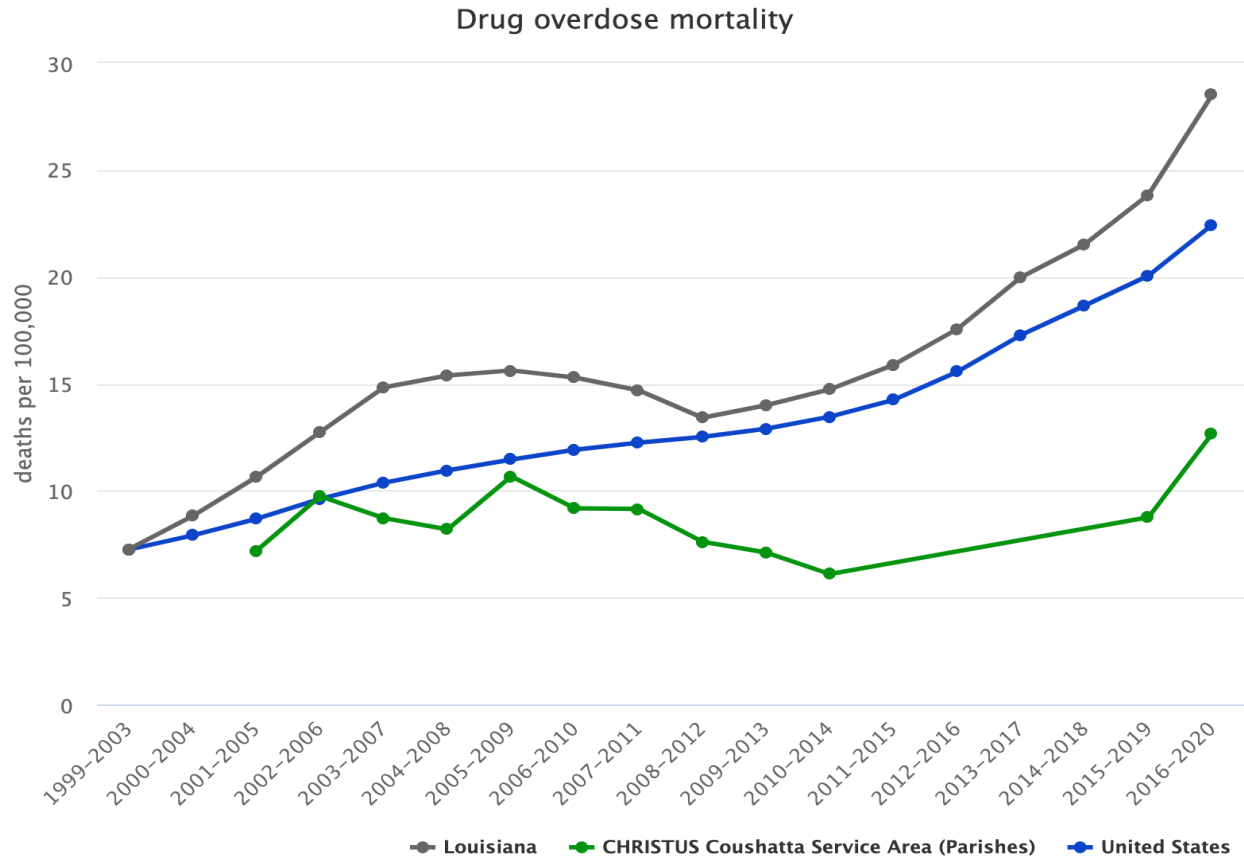


Figure 88. Diabetes Mortality with Stratifications in the CHRISTUS Coughatta PSA

Drug Overdose

Deaths from drug overdoses has been a national story for several years. The drastic increase in drug overdose mortality rates in the Louisiana mirrors the national increase. Of the three regions presented in Figure 89, Louisiana has the highest overdose mortality rate (28.5 deaths per 100,000), followed by the United States (22.4), and the CHRISTUS Coughatta PSA (13.2).



1 | Data sources: National Vital Statistics System–Mortality (NVSS–M) (CDC Wonder), Chicago Department of Public Health (Epidemiology Department: Chicago community area level)

Figure 89. Drug Overdose Mortality in the CHRISTUS Coughatta PSA

Influenza and Pneumonia

Death from influenza and pneumonia had been on a steady decline across all benchmark regions over time, but it remains a top cause of mortality in the CHRISTUS Coughatta PSA, accounting for 20.9 deaths per 100,000 (Figure 90). This is much higher than the influenza and pneumonia mortality rates in Louisiana overall (14.2) and the country (13.6).

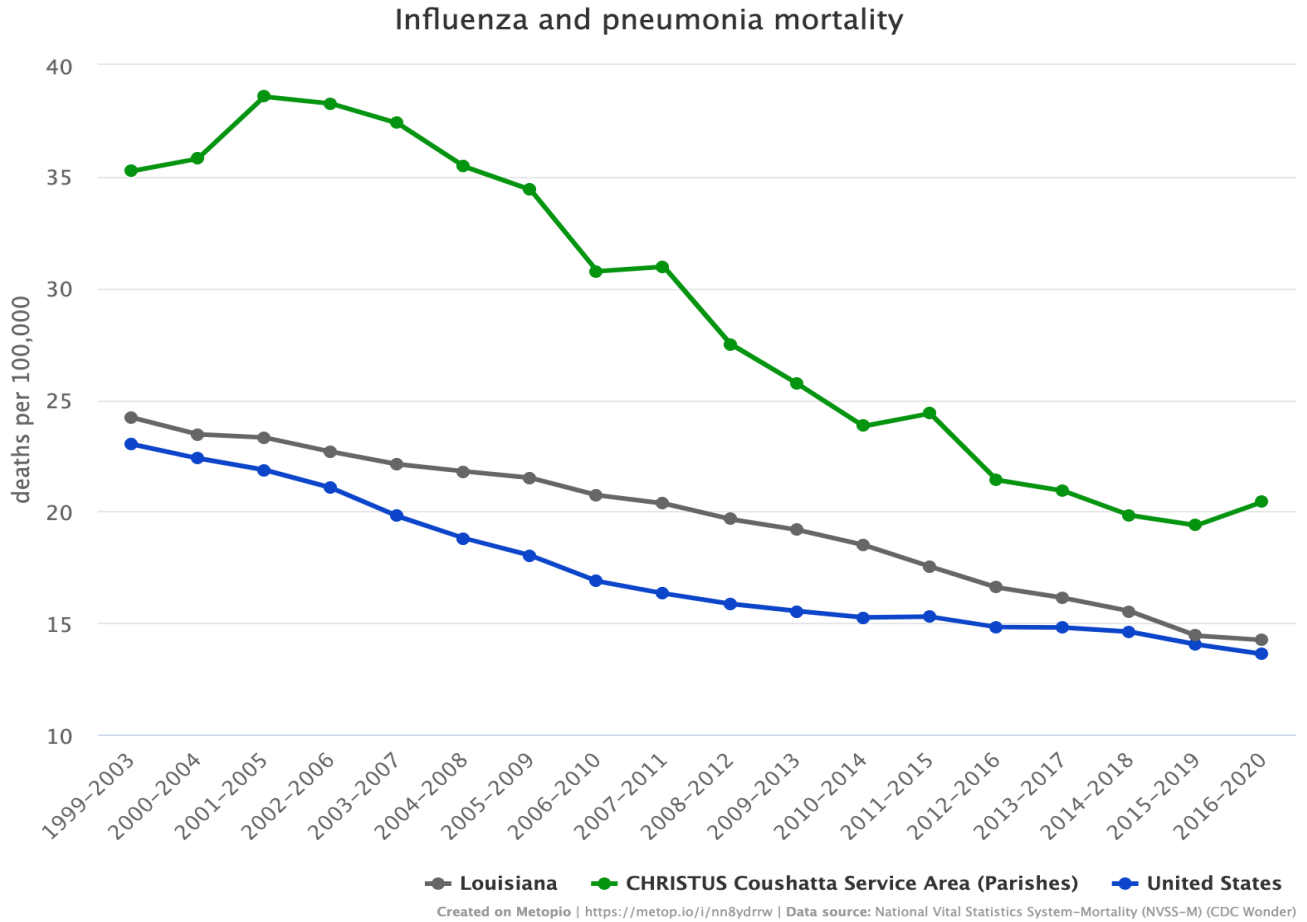


Figure 90. Influenza and Pneumonia Mortality in the CHRISTUS Coughatta PSA












Topic		Bienville Parish, LA	Natchitoches Parish, LA	Red River Parish, LA
Heart disease mortality <i>deaths per 100,000, 2016-2020</i>		216.3	215.9	203.2
Cancer mortality <i>deaths per 100,000, 2016-2020</i>		188.0	194.1	202.3
Injury mortality <i>deaths per 100,000, 2016-2020</i>		66.5	99.5	99.3
Chronic lower respiratory disease mortality <i>deaths per 100,000, 2016-2020</i>		58.1	59.8	55.6
Alzheimer's disease mortality <i>deaths per 100,000, 2016-2020</i>		63.5	48.9	39.6
Stroke mortality <i>deaths per 100,000, 2016-2020</i>		50.9	64.6	48.2
Influenza and pneumonia mortality <i>deaths per 100,000, 2016-2020</i>		38.4	14.2	25.4 
Drug overdose mortality <i>deaths per 100,000, 2016-2020</i>		—	12.67	—
Diabetes mortality <i>deaths per 100,000, 2016-2020</i>		42.4	22.8	68.5
Septicemia (sepsis) mortality <i>deaths per 100,000, 2016-2020</i>		25.9	14.2	23.6

Table 28. Mortality Rates by Parish in the CHRISTUS Coushatta PSA

Hospital Utilization

For this CHNA, CHRISTUS Coughatta Health Care Center looked at three years of utilization data (2019-2021). During the course of the COVID-19 pandemic, the health system saw Emergency Department utilization decline year over year (Figure 91), including a 17% drop from 2020 to 2021. This follows national trends where people avoided or delayed care due to restrictions caused by the COVID-19 pandemic.

Inpatient cases (Figure 92) also saw a year-over-year decline during the study period, most notably with a 21% reduction between 2020 and 2021. Regarding inpatient utilization (Table 29), the top cause for inpatient admission was sepsis followed by respiratory conditions, namely COPD and pneumonia. COVID-19 was the fourth most common cause for admissions. This is in line with almost every other CHRISTUS ministry, where COVID-19 was a top five cause for inpatient admission.

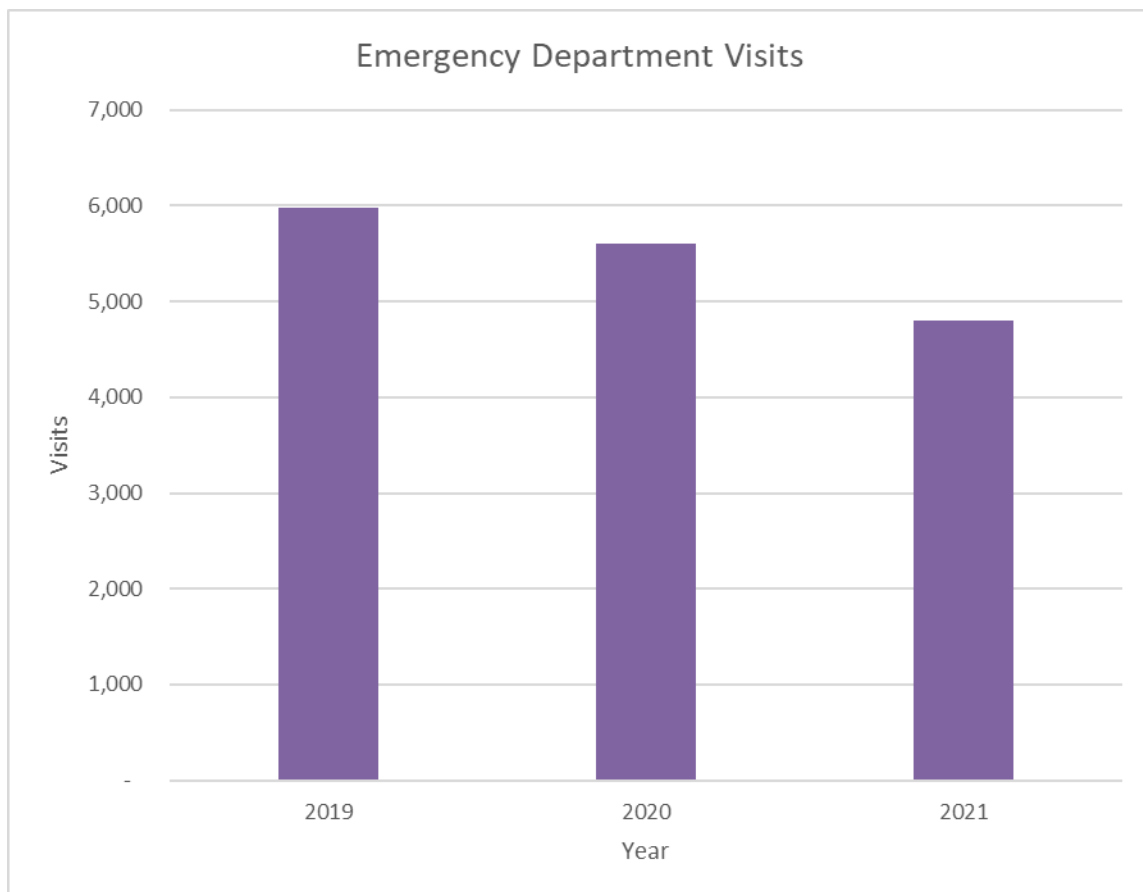


Figure 91. Emergency Department Utilization at CHRISTUS Coughatta Health Care Center

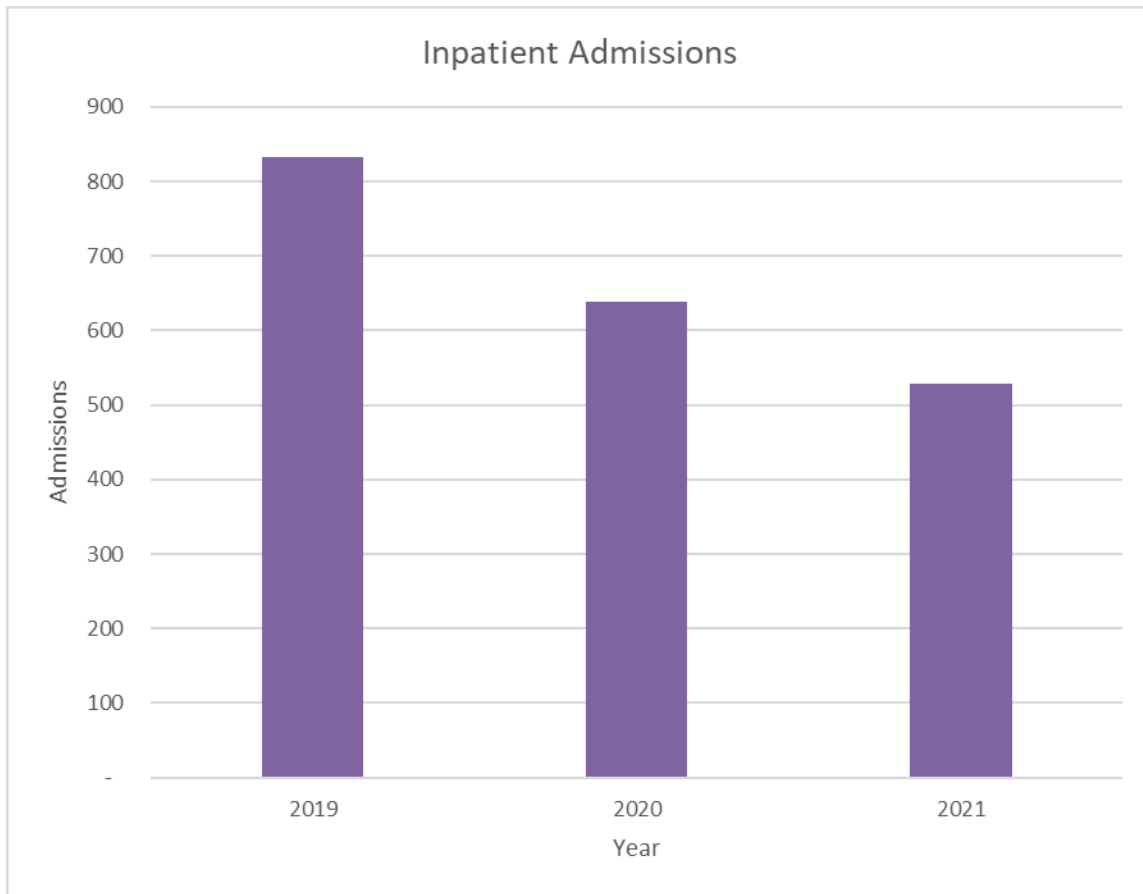


Figure 92. Inpatient Admissions at CHRISTUS Coughatta PSA

TOP INPATIENT PRIMARY DIAGNOSES

1. Sepsis
2. Chronic obstructive pulmonary disease
3. Pneumonia
4. COVID-19
5. Hypertensive heart disease with heart failure
6. Urinary tract infection
7. Acute kidney failure unspecified
8. Hypertensive heart and chronic kidney disease with heart failure
9. Cellulitis
10. Cerebral infarction

Table 29. Top Inpatient Primary Diagnoses at CHRISTUS Coughatta Health Care Center

CONCLUSION



Conclusion

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. The team scored the most severe indicators by considering existing programs and resources.
2. The team assigned scores to the health issue based on the Prioritization Framework (Table 30). The highest-scoring health issues were reconciled with previous cycles' selected priorities for a final determination of priority health issues.
3. 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?	Community Benefit team
INFLUENCE	How much can CHRISTUS St. Frances Cabrini Hospital affect change?	Community Benefit team
VALUES	Does the community care about it?	Survey, Focus Groups, Key Informant Interviews
ROOT CAUSES	What are the community conditions?	Community Benefit team

Table 30. Prioritization Framework

CHRISTUS St. Frances Cabrini Health System Selected FY 2023 - 2025 Health Priority Areas

For this cycle, CHRISTUS St. Frances Cabrini and CHRISTUS Coughatta Health Care Center are using a new structure for the identified needs, categorizing them under two domains with the overarching goal of achieving health equity. While the prioritization structure is new, CHRISTUS St. Frances Cabrini and CHRISTUS Coughatta Health Care retained mental health as a priority issue from the previous CHNA. In this cycle, CHRISTUS St. Frances Cabrini and CHRISTUS Coughatta Health Care unpacked "chronic illness" and specifically call out diabetes, heart disease and obesity. Newly identified issues include substance abuse, food access, reducing smoking and vaping and childhood well-being.

CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Dubuis Hospital of Alexandria and CHRISTUS Savoy Medical Center

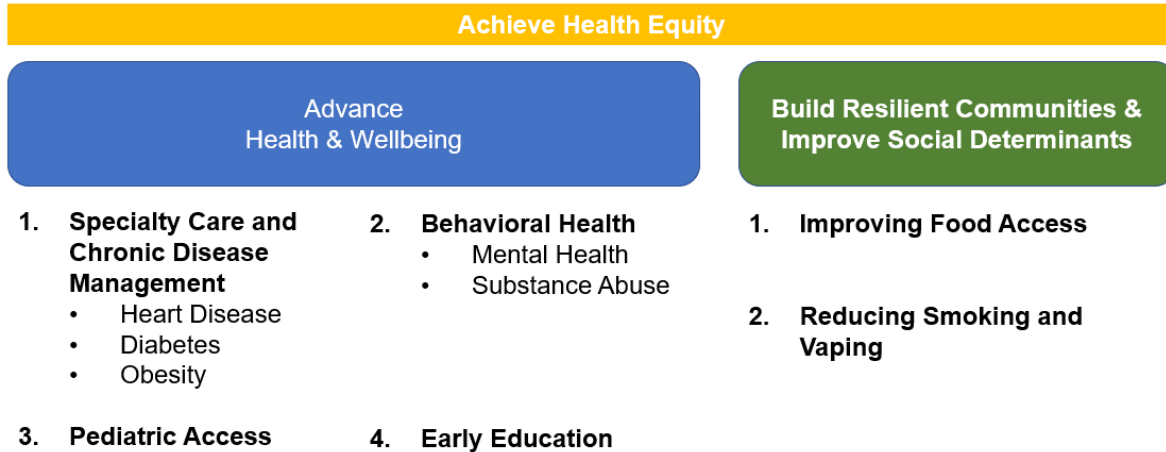


Figure 93. CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Dubuis Hospital of Alexandria and CHRISTUS Savoy Medical Center Priority Areas

CHRISTUS Coushatta Health Care Center

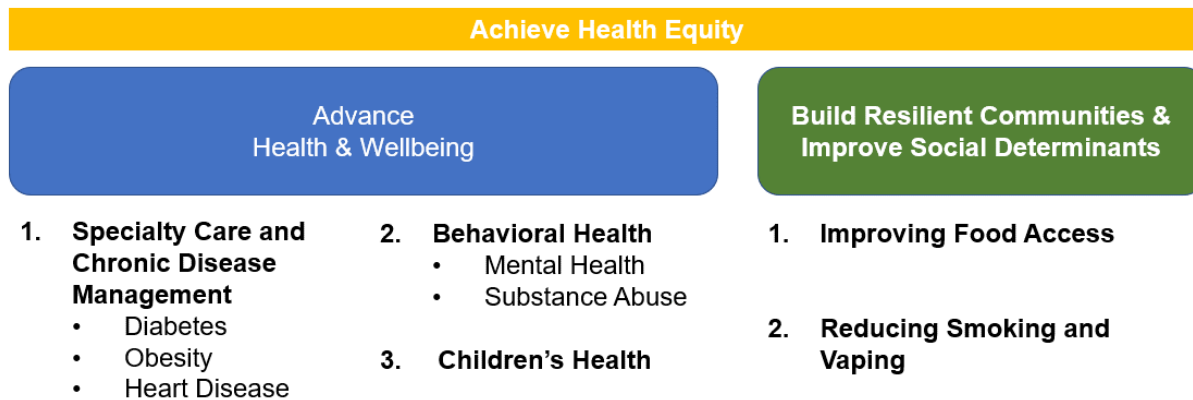


Figure 94. CHRISTUS Coushatta Health Care Center Priority Areas

These domains and corresponding issues will serve as the designated issue areas for official reporting and are the principal health concerns that CHRISTUS St. Frances Cabrini Health System community efforts will target.

Adoption by the Board

The Board of Directors received the 2023-2025 CHNA report for review and formally approved the documents on September 29, 2022.

APPENDIX



Appendix 1: Evaluation of Community Health Improvement Plan (CHIP) Activities

This evaluation is meant to capture the programmatic efforts undertaken by CHRISTUS St. Frances Cabrini Health System to meet priority health area goals and intended outcomes as outlined in the 2020-2022 Community Health Improvement Plan (CHIP).

Identified programs and services will share specific process and outcome metrics that demonstrate impact on the priority health areas and foals outlined below.

CHRISTUS St. Frances Cabrini Health System Community Benefit Priority Health Area Goals (2020-2022)

There are three areas of health-related priorities that the CHRISTUS St. Frances Cabrini adopted for the 2019-2022 CHIP, which was based upon the significant health-related needs identified in the CHRISTUS St. Frances Cabrini 2019 Community Health Needs Assessment:

1. Access to care
2. Chronic diseases and conditions (emphasis on diabetes)
3. Mental and behavioral health

There are three areas of health-related priorities that the CHRISTUS Coughatta Health Care Center adopted for the 2019-2022 CHIP, which was based upon the significant health-related needs identified in the CHRISTUS Coughatta Health Care Center 2019 Community Health Needs Assessment:

1. Access to care
2. Social determinants of health (emphasis on transportation & knowledge of community resources)
3. Mental and behavioral health

CHRISTUS St. Frances Cabrini Health System

Health Need: Access to Care

ACCESS TO CARE STRATEGY	
To ensure patients have access to appropriate care by collaborating with local providers, clinics, community resources, and school-based health centers.	
Major actions	Sub-actions
Ensure patients have access to the appropriate medicines to meet their medical needs.	<ol style="list-style-type: none"> 1. Advertise the discount pharmacy at CHRISTUS Community Clinic. 2. Work out a process so patients discharged from Cabrini can have their meds filled at our 340B pharmacy. 3. Get Pineville listed as a 340B pharmacy site. <p>Anticipated outcome: Patients who cannot afford their medicines will have access to affordable medications.</p>
Increase health literacy through partnerships and education	<ol style="list-style-type: none"> 1. Visit churches to educate the community about different services offered. 2. Place bulletin boards around the hospital and clinics with Health Literacy information. 3. Addition of case manager/ social worker to the clinics who does 1:1 Education with our patients. 4. Work with school based health center to educate students and parents. <p>Anticipated outcomes: Patients in the region will become more educated about general health and what resources are available.</p>
Expand specialty care to the Medicaid and uninsured Population	<ol style="list-style-type: none"> 1. Hire a new case manager to help with referrals 2. Provide GYN care on Saturdays for patients who cannot attend appointment during the week 3. Add another neurology and cardiology clinic. 4. Hospital recruiting specialist. <p>Anticipated outcomes: Expanded specialized care provided for Medicaid and uninsured patients.</p>
Address the cost of care for patients in our area.	<ol style="list-style-type: none"> 1. Increase the charity care threshold to 300% of the poverty level. 2. Hire a Medicaid person at the clinics that helps facilitate the signup for new members. 3. Allow patients who have insurance to use our charity as secondary to cover copays and deductibles. <p>Anticipated outcomes: More patients will be able to afford the care they need.</p>

Address transportation needs for patients.	<ol style="list-style-type: none"> 1. Work with city to add bus stop at CHRISTUS Community Clinic Alexandria 2. Add a primary care person in Pineville for patients who live on that side of the river. <p>Anticipated outcomes: Increased transportation options for patients will decrease no-show rates and increase access to care.</p>
Increase coordination of care between multiple providers.	<ol style="list-style-type: none"> 1. New case manager at clinics to help coordinate care for our patients. 2. Work with Dr. Holcombe to schedule quarterly meeting between clinics providing care to the uninsured and Medicaid patients. 3. Meet with health unit once a month to monitor and address the STD epidemic in Central LA. <p>Anticipated outcomes: Increased coordination of care between providers and clinics.</p>
Coordination of care between the ER and primary care.	<ol style="list-style-type: none"> 1. New system where the ER staff can fax referrals straight to an RN at the clinic to facilitate faster scheduling of appointments. 2. Hire an ER navigator to help coordinate care. <p>Anticipated outcomes: Less patients will need to use the ER for primary care.</p>

Ensure Patients Have Access to the Appropriate Medicines to Meet Their Medical Needs

To ensure patients have access to the medicines they need, CHRISTUS St. Frances Cabrini Health System (CSFCHS) has worked hard to promote the 340B retail pharmacy. The 340B program mandates that pharmaceutical manufacturers provide outpatient drugs to certain healthcare entities—known as eligible covered entities—at significant discounts. Through advertising the pharmacy within the hospital and with the case managers, CHRISTUS Community Health Clinic in Alexandria increased prescriptions filled from an average of 5149 a month to 5446 a month in the fiscal year 2020, fiscal year 2021, the clinic has filled an average of 5300 a month. We were also able to get our CHRISTUS Community Clinic Pineville site approved as a 340B site, which will make prescriptions written there more affordable.

Increase Health Literacy Through Partnerships and Education

In June of 2019 CSFCHS hired a case manager at the CHRISTUS Community Clinics to help increase health literacy in our community. The case manager is able to work 1:1 with patients and families to educate them on topics such as smoking cessation, diabetes management, hypertension and other chronic diseases, averaging 30 patients a month. The case manager also helps with referrals to specialist for underinsured patients who otherwise have very limited options due to their insurance status.

The School Based Healthcare Centers (SBHCs) provided education to individual students and their families by providing printed materials on information regarding the student's visit to the center. The SBHCs also prepared quarterly newsletters that were sent home to parents on information concerning medical and behavioral health. The topics included COVID precautions, importance of screenings, flu prevention, sleep concerns, nutrition, and activities for youth in the community, communication tips, and signs of depression/suicide and suicide prevention as well as other areas particular to each population/school. Nutrition education was also provided by staff during student visits to the health center in addition to referral to the Dietician as needed. Height, weight, B/P, and BMI were performed on each student who visited the SBHCs annually. Referrals to physicians were given as needed as well as follow up.

The SBHCs also presented classroom education and prevention activities which included Health Fairs for students in the school year 2019-2020. A total of 56 sessions were accomplished before COVID-19 restrictions prohibited

further activities at the schools. Topics included: Suicide Prevention, Breast health Education, Substance Abuse Prevention, Flu Prevention, Bullying Prevention, Handwashing, Hygiene/ Puberty, Vehicle Safety, STI/ Abstinence, Social Media Dangers, Self Esteem, HPV Vaccine, Bicycle Safety, Cyberbullying, Sexting Consequences, CPR/ AED Training, Child Abuse Awareness, Pre-Diabetes Prevention, Grief Processing, Mock Crash Demonstrations, Sunscreen Protection, and Testicular Self-Exam.

The SBHCs presented classroom education and prevention activities on a very restricted basis during the 20-21 school year due to COVID guidelines set by the LA Dept of Education. Topics included: Suicide Prevention, Breast health Education, Substance Abuse Prevention, Flu Prevention, Bullying Prevention, Handwashing, Hygiene/ Puberty, Vehicle Safety, STI/ Abstinence, Social Media Dangers, Self Esteem, HPV Vaccine, Bicycle Safety, Cyberbullying, Sexting Consequences, CPR/ AED Training, Child Abuse Awareness, Pre-Diabetes Prevention, and Grief Processing.

In school year 21-22 classroom presentations were limited due to ongoing COVID restrictions. Small group and classroom education were conducted to address such as suicide prevention, breast health, substance abuse awareness, hygiene, bullying prevention, social media dangers, social skills training, HPV vaccine education, CPR training, child abuse awareness, Pre-diabetes prevention, grief groups, and self-esteem.

The SBHCs engaged in teacher education concerning the topics of Mandatory Reporting on Child Abuse situations, heimlich maneuver proper technique and Staff Wellness Fairs with blood pressure, height, weight and blood sugar checks.

Expand Specialty Care to the Medicaid and Uninsured Population

One of the issues underinsured patients face is access to specialist. In 2019 CSFCHS expanded its specialty care clinics by 140 appointments. To make it easier for working patients the CHRISTUS Community Clinic of Alexandria added gynecological appointments every other Saturday. Increases of appointments occurred in Neurology adding 40 appointment slots per month on Mondays, Cardiology adding 60 appointment slots per month, and Gynecology seeing an increase in 40 appointment slots per month. In fiscal year 2021, the clinic added Pulmonology as a specialty as well as another orthopedic clinic day. With the addition of Dr Slatkin, the clinic has opened up 40 Pulmonology appointments per month. With the addition of another orthopedic day, the clinic was able to open up an additional 30 appointments per month.

Address the Cost of Care for Patients in Our Area

To address the cost of access to care for patients CHRISTUS Health made changes to its charity policies and procedures. The charity threshold increased to 300% of the poverty level so for example a family of 4 making less than \$76,600 can receive 100% free care. CHRISTUS Health also contracted with a Medicaid rep who works at the CHRISTUS Community Clinic in Alexandria to facilitate signing up new members. If a patient without insurance presents to our clinics, they can meet directly with the rep who helps speed up the application and approval process. Patients who have insurance but still qualify under CHRISTUS Health charity guidelines are able to qualify for help to pay for copays and deductibles. An average of 17% uninsured in 2019 has decreased to 13% in 2020, reflecting the positive outcomes of these efforts. For the month of July 2021, the clinics are now averaging only 7 % self-pay which means 93% of our patients have some type of payer source.

Address Transportation Needs for Patients

Transportation is a barrier to many of the patients who use our clinics. In partnership with the city, we were able to secure a bus stop directly in front of the CHRISTUS Community Clinic in Alexandria. Prior to this bus stop being added our patients were forced to walk 3 plus blocks to the closest stop. This added undue burden to many of the sick and limited mobility patients. We currently average 170 bus riders to the clinic a month now. As a help to patients

who reside in Pineville and are not able to utilize transportation to the CHRISTUS Community Clinic in Alexandria, a Primary Care Provider was added at the CHRISTUS Community Clinic in Pineville.

Increase Coordination of Care Between Multiple Providers

A new Case Manager was hired to work on efforts of increasing coordination of care between multiple providers. This case manager is able to help our patients navigate through diagnostic testing, appointments with specialists, and arrange transportation when needed. CHRISTUS Community Clinic of Alexandria also added a breast navigator who helps get their female patients scheduled for their mammograms. The navigator then follows up with the patient on the results and schedules them for further diagnostic testing if needed. This navigator walks with them through the process including the treatment step if needed.

Coordination of Care Between the ER And Primary Care

Many underinsured patients utilize the CHRISTUS St. Frances Cabrini Emergency room due to lack of Primary Care. CHRISTUS St. Frances Cabrini Hospital has coordinated the efforts of the ER with the CHRISTUS Community Clinics of Alexandria and Pineville to help address this issue. When patients without primary care present to the Emergency room they are referred to the CHRISTUS Community Clinics for follow up. The Emergency room has hired an ED navigator who works with the Managed Care Incentive Program (MCIP) (See more details on the next page concerning the MCIP program) to facilitate these referrals. Patients are educated on Emergency room utilization, and a primary care doctor is found for each enrollee. A Primary care doctor appointment is scheduled, and a call is made to remind them of their appointment and a follow up call occurs after their primary care appointment as well. Through proper primary care, we are able to decrease Emergency room visits for episodic care and improve the health of those with chronic issues. In the calendar year 2020, on average 36 patients were referred a month from the Emergency room to the clinics with a 68% response attending their appointments. In calendar year 2021, CSFCHS, enrolled 313 members who participated in activities designed to address avoidable ED utilization and lack of annual or preventative care visits. In 2022 (through July), CSFCHS has already enrolled and additional 88 members.

Other Initiatives

Refer Uninsured Patients for Possible Medicaid Enrollment at CHRISTUS St. Frances Cabrini Hospital

From August 1, 2019 to July 31, 2020, CSFCHS referred 1503 uninsured patients for possible Medicaid enrollment. Of those referred, 1246 were approved for Medicaid and 257 denied. The approval percentage rate was eighty-three percent. For fiscal year 2021, CSFCHS referred 1306 uninsured patients for possible Medicaid enrollment. Of those referred, 1032 were approved for Medicaid and 246 denied with 28 pending. The approval percentage rate was seventy-nine percent. Those who were denied Medicaid enrollment then qualified for a discounted cost per our Financial Assistance Program. For fiscal year 2022, CSFCHS referred 4,975 uninsured patients for possible Medicaid enrollment. Of those referred, 1246 were approved for Medicaid, and 2,366 determined not eligible. Of the applications determined to be eligible, the conversion rate was 57%.

MCIP

Starting January 1, 2020, CHRISTUS St Frances Cabrini Health System began its participation in MCIP (Managed Care Incentive Program). MCIP is a quality incentive program established by the Louisiana Department of Health ("LDH") with the goal of improving healthcare outcomes across different Louisiana Medicaid managed care populations. The original focus 5 areas for improvement were ED Utilization, Diabetes, Hypertension, Pediatric Prevention Care, and Maternal Care. Newly added focus areas in 2022 are Tobacco Cessation and Lung Cancer Screenings. Qualifying patients are enrolled in a registry and data is extracted to support quality goal achievements.

CHRISTUS St Frances Cabrini Health System has over twenty provider sites participating in the initiative: CHRISTUS St Frances Cabrini hospital, CHRISTUS Community Specialty Clinic, CHRISTUS Community Clinic, Pineville and Alexandria – Primary & Urgent Care, CHRISTUS Primary Care – Versailles, CHRISTUS Family Medicine Center and seventeen school-based health centers. From the program's launch on January 1, 2020, CSFCHS has enrolled over 4000 patients in our hypertensive registry, and over 1600 in our diabetic registry.

Hypertension

From the program's launch through calendar year 2020 CSFCHS enrolled over 4000 patients in the hypertensive registry. In calendar year 2021, CSFCHS, enrolled 4,661 members in the hypertension registry with 4,491 members participating in activities designed to address poor blood pressure control. In 2022 (through July), CSFCHS has already enrolled an additional 3,875 members.

Pediatrics

This improvement activity aims to improve pediatric preventative care services by incorporating tips from the AAP for implementing the Bright Futures Guideline in Clinical Practices. As part of the improvement activity, in 2021, School-Based Health Clinics ("SBHC") began providing BMI screenings with nutritional education and physical activity counseling consistent with the anticipatory guidance from the AAP Bright Futures Periodicity Schedule. In 2022, the SBHCs expanded this activity by implementing We Can! (Ways to Enhance Children's Activity & Nutrition), a new public education out-reach program designed to help children stay at a healthy weight through improving food choices, increasing physical activity and reducing screen time. We Can! Families Finding the Balance: A Parent Handbook is provided to parents in both English and Spanish as well as "parent tips" regarding nutritional education and physical activity.

Maternal Care

The improvement activity for this project aims to decrease the percentage of members with live birth that weighed less than 2,500 grams; decrease the percentage of members with elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks of gestation completed, and decrease number of nulliparous enrollees with a term, singleton baby in a vertex position delivered by c-section. New in 2022, CSFCH has elected to utilize ED Navigators to connect expecting mother with primary care providers for prenatal visits in order to assist with meeting the decrease percentage goals mentioned above.

SBHCs

School Based Healthcare Center's areas of impact for the last 2 years include:

School Year 19-20

1. Total school enrollment = 11,134
2. Health Center enrollment = 10,299
3. Mental health visits = 8,842
4. Wellness checks = 1,601
5. Immunizations = 6,923
6. Asthmatic visits = 411
7. BMI/obesity screenings = 11,010
8. Hypertension screenings = 3,477
9. Students identified in need of coordinated care with students receiving this care = 1606/365

School Year 20-21

1. Total school enrollment = 10,852
2. Health Center enrollment = 9,680

3. Mental health visits = 9,553
4. Wellness checks = 2,022
5. Immunizations = 4,639
6. Asthmatic visits = 354
7. BMI/obesity screenings = 5,325
8. Hypertension screenings = 4,416
9. Students identified in need of coordinated care with students receiving this care = 3854/645

School Year 21-22

1. Total school enrollment = 10,585
2. Health Center enrollment = 9,868
3. Mental health visits = 11,469
4. Wellness checks = 2,118
5. Immunizations = 3,537
6. Asthmatic visits = 484
7. BMI/obesity screenings = 5,347
8. Hypertension screenings = 4,779
9. Students identified in need of coordinated care with students receiving this care = 2927/108

CHRISTUS St. Frances Cabrini Health System

Health Need: Chronic Diseases and Conditions (Emphasis on Diabetes)

CHRONIC DISEASES AND CONDITIONS – DIABETES STRATEGY	
To collaborate with local faith communities, food organizations, community health providers, educational/academic entities, and civic clubs/organizations to promote diabetes awareness, increase access to diabetes/ diabetes complications screenings, Diabetes Self-Management Education/Support and healthy-lifestyle education and resources.	
Major actions	Sub-actions
Increase the number and availability of diabetes screenings	<ol style="list-style-type: none"> 1. Purchase more Hemoglobin A1c test machines to be available to school-based health clinics, the Healthy Learning Center and health fairs. 2. Provide Hemoglobin A1c screenings and monitoring at the CHRISTUS School Based Health Centers. 3. Participate in church/ community-lead health fairs and in-house to provide blood glucose, cholesterol, hemoglobin A1c, and blood pressure testing on a routine basis (at least biannually if not quarterly). <p><i>Anticipated outcomes:</i> By increasing the number and availability of diabetes screenings and monitoring, we hope to raise awareness of the growing epidemic of diabetes and promote diabetes self-management.</p>

<p>Increase number and availability of diabetes complications screenings</p>	<ol style="list-style-type: none"> 1. Collaborate with Louisiana Eye and Laser to provide complimentary eye/retina screening 2. Provide foot screening as part of individual DSME/S sessions. 3. Collaborate with Dr. Jones to provide Autonomic Nervous System (ANS) complication screening <p>Anticipated outcomes: Those who are living with diabetes will have the opportunity to receive screening for the most common complications associated with diabetes in order to identify existing complications as well as raise awareness and increase education on how to prevent diabetes complications.</p>
<p>Raise awareness of and Increase availability of Diabetes Self-Management Education/Support (DSMES) and healthy lifestyle education</p>	<ol style="list-style-type: none"> 1. Provide DSMES and Medical Nutrition Therapy outpatient 2. Provide Healthy Cooking/ Diabetes Education segment on local news station 3. Provide Healthy Eating Active Living class for weight-loss and healthy diet while promoting other area resources that offer healthy lifestyle classes 4. Partner with local entities and provide diabetes/ nutrition talks as opportunities arise <p>Anticipated outcomes: The community will have access and multiple opportunities to learn how to prevent and/or manage diabetes and gain support in their efforts for living a healthy lifestyle.</p>

Increase the Number and Availability of Diabetes Screenings

During fiscal year 2020, CSFCHS efforts to increase the number and availability of screenings for diabetes (elevated blood glucose) was successful through some key outreach events. One large-scale, on-campus screening for blood glucose was highly successful in that we were able to screen approximately 250 people. One person was found to have an extremely high glucose level and was sent to the emergency room for immediate care. Those that had elevated blood glucose levels were provided information for primary care providers if they did not already have one as well as a referral sheet for Diabetes Self-Management Education/ Support Services. Another large-scale screening served between 250-300 people predominantly in the Hispanic community. Those who did not already have primary care providers were assisted in obtaining one, and those with elevated glucose levels received a referral sheet to access formal Diabetes Self-Management Education/Support services. In both of the large-scale events totaling screenings for over 500 people, each of the people who were screened were provided a complimentary glucose meter kit and received education on how to use it. Other, smaller-scale screenings for diabetes were held in more private venues such as church events or health fairs. Those that were found to have elevated glucose levels received a complimentary glucose meter kit as well.

During fiscal year 2021, efforts to increase the number and availability of screenings for diabetes (elevated blood glucose) was unfeasible because of the constraints that the public health mandates in response to COVID-19. Social distancing efforts, visitation restrictions to the hospital, and precautions taken to reduce the spread of COVID-19 did not allow traditional health screenings as performed in years before. Likewise, because of the shift in priority towards treating patients with COVID-19 and efforts to prevent the spread of COVID-19, plans to purchase hemoglobin A1c machines and glucometers were postponed. However, as funds have become available, a purchase of hemoglobin A1c machines, glucometers, and various educational tools to screen and provide resources to those vulnerable in our community. During Fiscal Year 2022, 400 Hemoglobin A1c test machines were distributed to SBHCs.

In the aftermath and recovery efforts of Hurricane Laura in August of 2020, CSFCHS operated as a hub for diabetes medications and supplies distribution. More than 105 people directly affected by Hurricane Laura received glucometers, glucose testing strips, alcohol swabs, insulin pump supplies, syringes, pen needles, glucose tablets, hand sanitizer, masks, continuous glucose monitoring supplies and life-saving insulin.

Also, the School-Based Health Centers (SBHCs) were able to offer pre-diabetic screenings to 967 students who met criteria, perform 2319 glucose checks, refer 23 students to a dietician and offer 500 visits for endocrine/diabetic medical care while identifying 121 students as at risk for diabetes before COVID-19 restrictions closed the schools in the 2019-2020 school year. In the 2020-2021 school year, the SBHCs were able to offer pre-diabetic screenings to 914 students who met criteria, perform 1973 glucose checks, refer 23 students to a dietician and offer 1591 visits for endocrine/diabetic medical care while identifying 112 students as at risk for diabetes before COVID-19 restrictions closed the schools. In 21-22 school year, the SBHCs were able to offer pre-diabetic screenings to 722 students who met criteria for the pre-diabetic program, 5,347 BMI/obesity screenings with physical activity education and nutritional counseling, performed 6595 glucose checks, referred 4 students to a dietician for education. The SBHCs clinics completed 2558 visits for endocrine/diabetic medical care while identifying 44 students as at risk for diabetes.

Increase Number Availability of Diabetes Complications Screenings

Diabetic retinopathy: The CSFCHS Diabetes Care and Education specialists worked to increase the availability of diabetes complications. CSFCHS partnered with Louisiana Eye and Laser and were able to provide two large-scale eye screenings where over 100 people were screened for diabetic retinopathy. Of those screened, 39 people were found to have poor vision or early diseases of the eye and required follow-up. Six people had eye injuries with prolonged vision loss requiring follow-up. Ten people who were screened needed corrective eyewear. Fiscal year 2022, Diabetes Education worked with Dr. Jones office for DSMES for diabetes patients in need. Diabetes relief provides treatment for DM complications. They also collaborated in wound care, dietician support, Ob care and renal care.

Diabetic foot screenings: Beginning in January, the CSFCHS Diabetes Care and Education Specialists began performing diabetic foot screenings during individual education sessions. Over 10 screenings were performed before the COVID19 precautions were mandated. Two patients who were screened were referred to the Wound Care Clinic for follow-up.

Diabetic autonomic nervous system screenings: The CSFCHS Diabetes Care and Education Specialists were able to partner with a local cardiovascular surgeon's office who has the equipment to screen for autonomic nervous system problems. This is highly important for those with diabetes, who are at a significantly increased risk for developing neuropathy. Of the 50 people screened, less than a quarter were required follow-up. While the COVID19 precaution mandates have become a challenge in offering these screenings, we are working to come up with a solution to meet these challenges so we can continue to offer this service.

Unfortunately, the pandemic has prevented plans of performing diabetes and diabetes complications screenings. The team is actively looking for opportunities and methods to carry out safe screenings.

Raise Awareness of and Increase Availability of Diabetes Self-Management Education/Support (DSMES) and Healthy Lifestyle Education

CHRISTUS St. Frances Cabrini Hospital has earned the honor of being recognized by the American Diabetes Association (ADA) for adhering to the Ten National Standards for Diabetes Self-Management Education/ Support which is the only ADA recognized program in roughly 80 miles. The ADA recognized program is comprehensive and patient centered. The Diabetes Care and Education Specialists receive referrals for patients from health care providers across the state. Depending on the patient's needs, limitations, and/or barriers, we offer group classes for DSMES

called *Healthy Eating Active Living (HEAL) Diabetes*, at least twice a month. During the six hours of class, the educators provide healthy morning refreshments, lunch, and afternoon snacks that are chosen by the Registered Dietitian. The patients, who are allowed to bring a support person along with them, learn from both Diabetes Care and Education Specialist nurses and a dietitian using a curriculum that is tailored to the local population and approved by the ADA. The patients and support persons receive training using video, group discussion, a variety of literature and handouts, a complimentary glucometer for hands-on learning, complimentary measuring cups and spoons, and an opportunity to meet individually with one of the nurses or dietitians for an individualized follow-up appointment with personalized goal setting. For those who have barriers for attending a group class, we offer individual sessions as well. Most of the expectant mothers who have gestational diabetes take advantage of the individual appointments. During fiscal year 2020, a total of 78 people participated in the *HEAL Diabetes* classes along with 24 support persons. Approximately 82 individual sessions were provided. During the month of March when COVID19 precautions were mandated, our Diabetes Care and Education Specialists as well as Registered Dietitians began offering telehealth appointments. A total of 13 telehealth appointments were conducted. Telehealth will continue to be offered as people with diabetes are at an increased risk for complications with COVID19. Eighty-five people participated in the *HEAL Diabetes* classes during fiscal year 2021. Approximately 218 individual sessions were conducted for individual education, pump training, continuous glucose monitor training, diabetes regimen review and troubleshooting.

Participants in the HEAL Diabetes Education Outpatient Program in Fiscal Year 2021 – 2022

- HEAL Group classes: 82 (includes patients and their support persons)
- HEAL Individualized sessions: 59 (alternate for those who can't do all-day class)
- 1:1/Follow-up/All types: 178 (includes calls and texts on evenings and weekends)
- Insulin pump/CGMs: 150 (includes training, troubleshooting, downloads, support)
- Sugar Babies: 26 (Pregnant women with diabetes)
- Diabetes Relief Consultations : 5 (Dr. Jones Insulin Infusion Clinic)
- Free Care: 39 (Remedios Clinic classes, areas affected by last year's hurricanes, and uninsured)
- Misc./other: 11 (Stakeholder and product representative visits)

CSFCHS Diabetes Care and Education Specialists have also been in communication with the surrounding communities via television and radio. They were featured in a local TV program called *Good Day CENLA* throughout the year and provided five healthy recipe demonstrations, and three segments focusing on diabetes awareness and education. On Talk Radio/ TV with Carlette Christmas hosted three segments featuring our Diabetes Care and Education Specialists who shared about diabetes awareness and education. Additionally, the Diabetes Educators from SFCH hosed 8 presentations at local churches, 1 with the local Boys & Girls Club, 1 with the Rotary Club, 1 with the Daughters of the Revolution, and 2 presentations with the Lions Club. Throughout the year, SFCH hosted at three students majoring in either nursing or dietetics. We have also partnered with the LSU Ag Center and hosted Dining for Diabetics workshops and Healthy Cooking workshops to the public. CSFCHS will continue to partner with them as well as the Food Bank of Central Louisiana to provide education on healthy eating.

In effort to address the diabetes needs of the vulnerable Hispanic community, in March 2021, CSFCHS began providing community service hours to no fewer than 40 Spanish-speaking individuals at a local clinic with the aid of a Spanish interpreter. Participants include migrant workers who have no other health resources available.

Fiscal Year 2022 approximately 180 lipid/glucose and 100 A1c test were administered at the Alexandria Farmer's Market Health Fair.

Other Initiatives

Since both of the Diabetes Care and Education specialists at CSFCHS are also Certified Insulin Pump/ Continuous Glucose Monitor Trainers, CSFCHS was able to provide training services to 123 people in need of training during fiscal year 2020.

Often the Diabetes Care and Education specialists will receive consults to see inpatients who have diabetes to offer education at the bedside. The inpatients are offered a complimentary glucometer as needed and when available, a diabetes survival-skills packet, individualized diabetes education related to admission, and offered a complimentary post-discharge appointment with the Diabetes Care and Education Specialist. When needed, a Registered Dietitian also visits the patient at bedside for individualized care. During fiscal year 2020, CSFCHS Diabetes Care and Education Specialists provided services to 247 inpatients. During fiscal year 2021, these Diabetes Care and Education Specialists provided services to 225 inpatients.

MCIP

From the program's launch through calendar year 2020 CSFCHS enrolled over 1600 in the diabetic registry. In calendar year 2021, CSFCHS, enrolled 2,002 members in the diabetic registry with 599 members participating in activities designed to reduce HbA1c poor control, and 1,673 members participating in activities designed to address poor blood pressure control. In 2022 (through July), CSFCHS has already enrolled an additional 1,657 members.

New Physician Onboarded

Dr. Sablaa Ali, endocrinologist, is starting a practice within the calendar year 2022. This will support more ease of access of care for diabetes patients who were having to travel at least two hours away for care.

CHRISTUS St. Frances Cabrini Health System

Health Need: Mental and Behavioral Health

MENTAL AND BEHAVIORAL HEALTH (MBH) STRATEGIES

Mental health strategy: To provide early identification, treatment at the least restrictive level of care possible, and supportive follow-up care for community individuals who suffer from anxiety, depression, Post Traumatic Stress Disorder (PTSD), and suicidal thoughts.

Major actions	Sub-actions
Provide interdisciplinary care led by a board-certified psychiatrist for community members regardless of ability to pay for services.	<ol style="list-style-type: none"> 1. Community members who present to the CHRISTUS St. Frances Cabrini Emergency Department with MBH symptoms requiring acute hospitalization will be case reviewed, triaged, or assessed by an RN from the Behavioral Health Unit (BHU). The BHU RN will notify the psychiatrist on call of patients who meet preliminary criteria for admission to the BHU. The psychiatrist on call will determine if placement at the BHU is clinically appropriate and provide admission orders if accepting the patient. 2. Those individuals who require inpatient treatment will be referred for the appropriate level of care. 3. Following treatment, the multi-disciplinary team works with patient to find the most appropriate, convenient and affordable continuing care. 4. Continuing Care plans are arranged for the patient with the first appointment within one week of discharge. <p>Anticipated outcome: Improved mental health outcomes for high risk populations and fewer re-admissions to the BHU.</p>

Substance abuse strategy: To increase access to services for Substance Use Disorders (SUD), including Alcohol, Opioids, Cocaine, Methamphetamine and other street and prescription substances.

Major Actions	Sub-actions
Provide early identification and appropriate care for individuals who have a substance use disorder.	<ol style="list-style-type: none"> 1. The BHU Intake RN, in cooperation with the Cabrini ER staff, will identify those individuals who exhibit signs and symptoms of a substance use disorder. 2. Provide appropriate treatment recommendations to those individuals who may have a SUD and recommendations for their family members. 3. Patients admitted to the BHU for acute psychiatric illness, with co-occurring/dual diagnosis substance abuse disorders, will be detoxed, when needed, receive basic education on SUD, and be referred for appropriate follow-up care such as inpatient SUD treatment, SA-IOP, or community programs such as AA/NA. <p>Anticipated Outcomes: Earlier detection and treatment for community members suffering with a Substance Use Disorder. Fewer uses of tertiary agents such as NARCAN being required.</p>

Smoking cessation strategy: To make smoking cessation resources accessible to all community members who encounter CHRISTUS St. Frances Cabrini services.	
Major actions	Sub-actions
Identify and offer smoking cessation support to all patients seen in CHRISTUS St. Frances Cabrini clinics as well as the Emergency Department.	<ol style="list-style-type: none"> 1. Identify those who are seen by the Emergency Department and all Cabrini clinics who use nicotine products regularly. 2. Refer patients to affordable or zero cost treatment services to those individuals who express an interest. 3. Offer prescriptions for smoking cessation medication, wherever possible. <p>Anticipated Outcomes: Improved overall health for community members. Fewer Emergency Department visits for respiratory infections.</p>
Identify and provide resources to help BHU patients stop smoking and/or using nicotine products.	<ol style="list-style-type: none"> 1. The BHU will screen patients admitted who use nicotine on a regular basis. 2. Referral to affordable or zero cost treatment services will be provided at the time of discharge. 3. Prescription for smoking cessation medications will be offered/provided at the time of discharge. <p>Anticipated Outcomes: Improved overall health patients discharged from BHU.</p>

Provide Interdisciplinary Care Led by a Board-Certified Psychiatrist for Community Members Regardless of Ability to Pay for Services

The CSFCH Behavioral Health Unit's experienced psychiatric intake registered nurses provide assessments for patients who present to the Emergency Department with MBH symptoms. The intake nurses are being relocated to the Emergency Department to improve access and expedite assessment of patients with MBH symptoms. Patients with acute psychiatric needs are referred to the appropriate level of care. Patients who meet admission criteria are evaluated for acceptance to Cabrini's behavioral health unit, regardless of ability to pay. Prior to patient discharge, the treatment team coordinates with the patient, their family, and community resources to secure an aftercare plan that financially and geographically meets the psychiatric needs of the patient. The BHU Director meet with emergency room directors throughout the region to educate on the services provided at CSFCH BHU for any patient needing care, but also supporting efforts to break down barriers to access to care.

Provide Early Identification and Appropriate Care for Individuals Who Have a Substance Use Disorder

The CSFCH Behavioral Health Unit's experienced psychiatric intake registered nurses provide assessments for patients who present to the Emergency Department with substance use disorder symptoms. The ER staff and BHU intake RN provide appropriate treatment recommendations and referrals to community resources for inpatient and/or outpatient detoxification or rehabilitation, as appropriate. Patients who present with acute psychiatric illness and co-occurring alcohol detoxification symptoms are evaluated for acceptance to Cabrini's behavioral health unit, regardless of ability to pay. Prior to patient discharge, the treatment team coordinates with the patient, their family, and community resources to secure an aftercare plan that financially and geographically meets the psychiatric and substance use rehabilitation needs of the patient.

Identify and Provide Resources to Help BHU Patients Stop Smoking and/or Using Nicotine Products

A new patient handbook was developed and is now distributed that provides additional community resources for smoking cessation within the community.

Other Initiatives

MCIP

Tobacco Cessation and Lung Cancer Screening

In 2022, the Tobacco Cessation and Lung Cancer Screening projects were added to the MCIP program. CSFCHS has conducted education and training regarding tobacco cessation, including assessing tobacco use status of members and tobacco cessation counseling. CSFCHS also created materials to educate members regarding the importance of lifestyle decisions in cancer prevention, including tobacco use and other factors that could lead to increased risk of cancer; as well as educational materials regarding low dose CT scans and the importance of lung cancer screening.

SBHCs

In the school year 2019-2020, School Based Healthcare Centers provided 310 depression/suicide screenings for students with 11 students being referred for follow-up. 1803 students were given at-risk screenings by mental health staff with 473 of these students being referred for further psychosocial assessment. A total of 3135 students received mental health services in the fiscal year before COVID-19 restrictions closed the schools. In the school year 2020-2021 they also provided 2754 mental health risk screenings to students. 975 students were identified with a mental illness. A total of 3345 students received mental health services during the 20-21 school year with 651 of those students receiving on-going follow-up MH services by our SBHC staff and approximately 80 students referred to off-site providers. In school year 21-22, SBHC clinics completed 11,469 mental health visits with students enrolled. Risk screenings were conducted on 2,935 students. 571 students had follow-up visits after positive risk screenings. 2,675 students 226 students were referred for off-site interventions.

CHRISTUS Coushatta Health Care Center

Health Need: Access to Care

ACCESS TO CARE STRATEGY	
To increase access to health and preventative care services by targeting outpatient specialty services not currently offered in the local ministry service area.	
Major actions	Sub-actions
Establish chemotherapy outpatient IV infusion center at CHRISTUS Coushatta.	<ol style="list-style-type: none"> 1. Identify local patients in need of chemo treatment who currently travel over 35 miles one way to receive chemo multiple times per week. <p>Anticipated outcome: Local cancer patients will have increased and easier access to chemo treatment.</p>
ENT services	<ol style="list-style-type: none"> 1. Looking to recruit an ENT provider for our area. <p>Anticipated outcome: Increased access to ENT services in our service area.</p>
Transportation	<p>Explore possibilities of transporting patients to and from appointments. Seek sponsorship for transportation services.</p> <p>Anticipated outcome: Transportation provides increased access to patient care and decreases no show rates, which will improve overall health outcomes.</p>
340B Pharmacy contract - Boyce	<ol style="list-style-type: none"> 1. Expand 340b discounts on prescriptions for eligible patients. <p>Anticipated outcome: Increased access to underserved population for prescription drugs.</p>
School-based telemedicine program and School-based Health Centers	<ol style="list-style-type: none"> 1. Explore partnership with Red River Parish School board to establish telehealth services for students & faculty. 2. Provide quality primary care and prevention services (e.g. wellness visits, immunizations/vaccinations, etc.) to youth through School-based Health Centers. <p>Anticipated Outcome: Parents of children in participating schools will have the ease of knowing healthcare will be provided to their children during school hours, eliminating loss of labor hours for the parents. This, in turn, increases the likelihood of children being examined and treated appropriately.</p>

<p>Enhance existing diabetes education program to expand reach and impact</p>	<p>Partner with MLK Community Health Center to provide Diabetes education in our service area. Anticipated Outcome: Improved diabetes prevention and management by enhancing certain elements of the Diabetes Education Program and providing it in a variety of settings to expand group of participants beyond hospitalized patients. SBHCs will address the needs of the pediatric population. The program will enable positive lifestyle changes for those living with or at risk of complications from diabetes.</p>
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Establish Chemotherapy Outpatient IV Infusion Center at CHRISTUS Coushatta

CHRISTUS Coushatta Healthcare Center (CHCC) Explored options to mix chemo on site or have compounded off-site. Due to cost and regulatory restraints this initiative will not be pursued.

ENT Services

CHRISTUS Coushatta Healthcare Center recruited an Ear Nose and Throat Provider and opened the ENT clinic in November of 2019. Over 30 patients were seen until COVID-19 restrictions delayed the clinic's progress. In the short period of patient access the response was very positive from the community, recognizing the need for an ENT in this rural area. The ENT Clinic reopened on July 17, 2021. In FY22 (July 1, 2021- June 30, 2022) CHRISTUS Coushatta Health Care Center completed 474 RHC ENT visits and 24 ENT procedures in the OR.

Transportation

Update for FY21; Sponsorship has been sought but denied. Other funding avenues are being pursued.

Update for FY22; Unable to secure funding. Multiple independent transport companies are now servicing the area.

340B Pharmacy Contract – Boyce

The CHRISTUS Community Health Clinic in Boyce received 340B certification in July 2019 and went live during the third quarter 2019.

School Based Telemedicine Program and School Based Health Centers

CHRISTUS Coushatta Healthcare Center began conversations with the Red River School System prior to COVID-19 restrictions being in place. With students and teachers not being on-site since March we have been on hold. With school beginning and students and teachers returning to the classroom CHRISTUS Coushatta Healthcare Center will resume conversations with school system concerning the telemedicine program. Update: The telemedicine program started with Red River Schools on August 1, 2021. CHRISTUS Coushatta Health Care Center completed 546 RHC telehealth visits during the 2021-2022 school year.

Enhance Existing Diabetes Education Program to Expand Reach and Impact

Unfortunately, after some discussions and review of their ability to offer diabetes education in the CHRISTUS Coughatta Healthcare Center's region it was determined that the Martin Luther King Jr. Community Health Center will not be able to help provide the diabetes education service as first discussed. Because of this CHRISTUS Coughatta Healthcare Center leadership is exploring other possible partners as well as internal options with associates who offer diabetes education. (The program at SFCH is one example of internal education) CHRISTUS Coughatta Health Care Center is currently utilizing the in-house dietician for Diabetes Education.

Other Initiatives

MCIP and The Community Health Worker

The CHRISTUS Coughatta Community Health Worker position continues to serve patients who lack resources including the uninsured or underinsured. CHRISTUS Health defines an underinsured patient as one who has Medicaid Primary Insurance, a patient who has Medicare but is under the age of 65, or who has another type of insurance that does not meet their health care needs. Below are outcomes of the program.

Starting January 1, 2020, the Managed Care Incentive Program (MCIP) began. The MCIP Identifies Managed Care Medicaid patients who have had more than 2 emergency room visits in a month or more than four emergency room visits in a year. Between January 1, 2020 to July 31, 2020, 188 patients were contacted to enroll in the MCIP program and 13 were successfully enrolled. Between August 1, 2020 to July 31, 2021, 286 patients were called, and 57 patients were successfully enrolled in the program.

As a part of the MCIP program, patients are educated on Emergency Room utilization. A primary care doctor is found for each enrollee. A Primary care doctor appointment is scheduled and a call is made to remind them of their appointment and a follow up call occurs after their primary care appointment as well.

From January 1, 2020 to July 31, 2020, 14 frequent ED utilizers who have Medicaid were referred to their Managed Care Organization Case Management department for further education. From August 1, 2020 to July 31, 2021, eight patients were referred.

Below is the remaining calendar year 2021 data as well as new 2022 achievements and goals.

ED Utilization

In calendar year 2021, Coughatta's ED Navigator assisted 232 members with scheduling primary or specialty care appointments for high-ED utilizers.

Diabetes

In calendar year 2021, Coughatta, enrolled 332 members in the diabetic registry with 164 members participating in activities designed to reduce HbA1c poor control, and 321 members participating in activities designed to address poor blood pressure control. In 2022 (through July), Coughatta has already enrolled an additional 120 members.

Hypertension

In calendar year 2021, Coughatta, enrolled 1,094 members in the hypertension registry with 1,076 members participating in activities designed to address poor blood pressure control. In 2022 (through July), Coughatta has already enrolled and additional 330 members.

Pediatrics

The pediatric goal is to improve pediatric preventative care by measuring and increasing compliance and performance rates related to the recommendations set forth by the AAP. As part of the improvement activity, in

2022, Coushatta has provided training and education to the providers regarding the AAP's recommendations for Well-Child Care visits.

Maternal Care

The improvement activity for this project aims to decrease the percentage of members with live birth that weighed less than 2,500 grams; decrease the percentage of members with elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks of gestation completed, and decrease number of nulliparous enrollees with a term, singleton baby in a vertex position delivered by c-section. New in 2022, Coushatta also elected to utilize ED Navigators to connect expecting mother with primary care providers for prenatal visits in order to assist with meeting the decrease percentage goals mentioned above.

Tobacco Cessation and Lung Cancer Screening

In 2022, the Tobacco Cessation and Lung Cancer Screening projects were added to the MCIP program. Coushatta has conducted education and training regarding tobacco cessation, including assessing tobacco use status of members and tobacco cessation counseling. Coushatta also created materials to educate members regarding the importance of lifestyle decisions in cancer prevention, including tobacco use and other factors that could lead to increased risk of cancer; as well as educational materials regarding low dose CT scans and the importance of lung cancer screening.

Equity of Care Initiative - Cardiovascular Health

During August 1, 2019 to July 31, 2020, 52 Emergency Room patients were enrolled in the Equity of Care Program, and during August 1, 2020 to July 31, 2021, 22 ER patients were enrolled. The Equity of Care Program targets patients who have a primary care diagnosis of hypertension. Through the Equity of Care Program, a Community Health Worker spoke to each patient within 24 hours of their Emergency Room visit and then followed up with each patient at the two-week, two-month, and six-month mark. The Community Health Worker closely followed any participant that had a readmission within 30 days of their initial Emergency Room visit. Ninety-eight percent (98%) of Equity of Care participants did not have a readmission within 30 days.

CHRISTUS Coushatta Health Care Center

Health Need: Social Determinants of Health (Emphasis On Transportation and Knowledge of Community Resources)

SOCIAL DETERMINANTS OF HEALTH STRATEGY	
To incorporate increasing transportation options and increasing awareness of resources throughout their other strategies.	
Major actions	Sub-actions
Improve transportation options	1. Explore possibilities of transporting patients to and from appointments. Seek sponsorship for transportation services <i>Anticipated outcome:</i> Transportation provides increased access to patient care & decreases no show rates, which will improve overall health outcomes.
Identify Community Resources	1. Compile a list of services to distribute to community stakeholders. <i>Anticipated outcome:</i> This will identify resources in our community that we can assist/partner with to reach patients that we may not otherwise have access to.

Improve Transportation Options

Update for FY21; Sponsorship has been sought but denied. Other funding avenues are being pursued.

Update for FY22; Coushatta was unable to secure funding. Multiple independent transport companies are now servicing the area.

Identify Community Resources

An identified need for the CHCC area was a more readily available resource list to help the local community members find services at times of need. During the beginning of the pandemic and institution of COVID-19 restrictions, CHRISTUS Coushatta Healthcare Center met with local agencies including nursing homes, home healths, inpatient rehab, the District Attorney’s office, the Sheriff’s office, The Council on Aging, and EMS/Fire Services. This need became particularly crucial in the pandemic to ensure the community was aware of the resources available to them. Available resources by all agencies were discussed and a list of services was compiled for distribution to community stakeholders. This was completed in March 2020.

Other Initiatives

From August 1, 2019 to July 31, 2020, CHCC referred 60 uninsured patients for possible Medicaid enrollment. Of those referred, 29 were approved for Medicaid and 31 denied. The approval percentage rate was forty-eight percent (48%). From August 1, 2020 to July 31, 2021, CHCC referred 41 uninsured patients, 22 were approved, 3 are pending, and 16 were denied. The approval percentage rate was fifty-four percent (54%). Those who were denied Medicaid enrollment then qualified for a discounted cost per the CHRISTUS Health Financial Assistance Program.

CHRISTUS Coushatta Health Care Center

Health Need: Mental and Behavioral Health

MENTAL AND BEHAVIORAL HEALTH STRATEGY	
CHRISTUS Coushatta Health Care Center will increase access to mental and behavioral health services in the ministry's service area for adult age patients. CHRISTUS Coushatta currently offers geriatric behavioral health services.	
Major actions	Sub-actions
Recruit a mental health nurse practitioner for the Rural Health Clinic located in Coushatta to expand mental health services.	<ol style="list-style-type: none"> 1. Begin with one mental health clinic day per week 2. Provide medication management for adult mental health patients <p>Anticipated outcome: Providing a mental health nurse practitioner will provide mental health services and medication management not currently available in the Coushatta area.</p>
Work with the Geri-Psych management company to identify potential patients who do not meet their age limits and requirements.	<ol style="list-style-type: none"> 1. Identify patients who need mental health services that do not meet the requirements for the geri-psych program currently offered. <p>Anticipated outcomes: Will increase access to mental health services to an underserved age population in the ministries' service area.</p>
Improve transportation options	<ol style="list-style-type: none"> 1. Explore possibilities of transporting mental/behavioral health patients to and from appointments. 2. Seek sponsorship for transportation services <p>Anticipated outcome: Transportation increases access to patient care and decreases no show rates, which will improve overall health outcomes.</p>

Recruit a Mental Health Nurse Practitioner for the Rural Health Clinic Located in Coushatta to Expand Mental Health Services

CHRISTUS Coushatta Health Care Center hired a Nurse Practitioner with a specialization in mental health to offer care at the Coushatta Rural Health Clinic and the CHRISTUS Community Clinic in Boyce. Patients seeking mental health services had the opportunity to make appointments starting in May of 2020 at Coushatta and June 2020 in Boyce, one day every other week at each clinic. Over 140 patients have been seen in both clinics by August 1, 2020, shows the high need of these services for the underserved population in those communities as no other mental health services were provided for the age groups outside of Geri-Psych. Medication management is part of the services offered.

In FY22 1,109 RHC visits were completed by the Behavioral Health Nurse Practitioner proving the need for these services in the communities served by CHRISTUS Coushatta Health Care Center.

Work With the Geri-Psych Management Company to Identify Potential Patients Who Do Not Meet Their Age Limits and Requirements

Diamond is the vendor who has worked with CHRISTUS Coughatta Health Care Center for some time. They specialize and have expertise in Geri-Psych care but do not service other age group populations. With the new mental health services being offered at Coughatta Rural Health Clinic and the CHRISTUS Community Clinic in Boyce, patients not meeting Geri-Psych age requirements at Diamond are referred to the new outpatient clinic services at Coughatta and Boyce, for appointments with the Nurse Practitioner offering mental health services.

Improve Transportation Options

Update for FY21; Sponsorship has been sought but denied. Other funding avenues are being pursued.

Update for FY22; Coughatta was unable to secure funding. Multiple independent transport companies are now servicing the area.

Appendix 2: Primary Data Tools

Primary data was collected through the main channels—community surveys, focus groups and key informant interviews. The instruments used for each are included in this appendix.

Community Survey

Community Health Needs Assessment Survey	
<p>Welcome to the CHRISTUS Health Community Health Needs Assessment Survey.</p> <p>This survey will only take about 10 minutes. We will ask you questions about the health needs of your community. The information we get from the survey will help us:</p> <ul style="list-style-type: none">• Identify health problems that affect the people in your community.• Understand the needs of your community.• Work together to find a solution. <p>The survey is voluntary and you do not have to participate. You can also skip any questions you do not want to answer or end the survey at any time.</p> <p>The answers you give are very important to us. Your answers will be private (we will not know who gave the answers) and we will protect the information you are giving. We will not share your personal information or survey answers to anyone outside of CHRISTUS Health.</p> <p>We thank you for your help.</p>	
Your Information	
Your home zip code: _____	How many years have you lived here? _____

Community Health Needs Assessment Survey

Community Health Questions

Thinking about where you live (zip code, neighborhood, town), on a scale of 1 - 5 (with 1 - being not at all and 5- being serious), how much of a problem are each of the following health concerns?

Please consider how any of these issues affect you or a family member personally, impact others you know, or deal with in your profession. If you don't know, please leave blank/skip.

HEALTH CONCERN	RATING (1-5)
Abuse (child, emotional or physical abuse; neglect, sexual assault, domestic violence)	
Access to healthy food items	
Access to prenatal care (including insurance, medical provider, transportation)	
Alzheimer's and Dementia	
Arthritis	
Cancer (s)	
Chronic pain	
Dental disease (Dental Problems)	
Diabetes (high blood sugar)	
Drug, Alcohol and Substance Abuse (Prescription, Illegal Drugs)	
Healthy Eating (including preparing meals and cooking)	
Exercise and physical activity	
Hearing and vision loss	
Heart disease (hypertension, high blood pressure, heart attack, stroke)	
Infectious diseases (hepatitis, tuberculosis or TB, flu, COVID-19)	
Lung disease (asthma, chronic obstructive pulmonary disease or COPD)	
Maternal and child health (preterm birth, gestational diabetes, maternal hypertension, preeclampsia, maternal death, infant mortality)	
Mental health (ADHD, depression, anxiety, post-traumatic stress disorder or	
Motor vehicle crash injuries	
Obesity (Overweight)	
Property crime (theft, burglary and robbery, motor vehicle theft)	
Sexually Transmitted Infections (STIs and STDs), including Human Immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS)	
Smoking and vaping	
Teen Pregnancy	

Other than those included in the previous question, are there any additional concerns that you feel affect the health of our community?

If you, family members or others who you are in frequent contact with are impacted by any of these health concerns, please share the age group and the impact. (e.g., I am the primary caregiver for my aging parent who has Alzheimer's)

Community Health Needs Assessment Survey

Community Resources Questions

What strengths and/or resources do you believe are available in your community? Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Community services, such as resources for housing | <input type="checkbox"/> Inclusive and equal care for all people whatever race, gender identity or sexual orientation (LGBTQ) |
| <input type="checkbox"/> Access to health care | <input type="checkbox"/> Life skill training (cooking, how to budget) |
| <input type="checkbox"/> Medication Assistance | <input type="checkbox"/> Parks and recreation |
| <input type="checkbox"/> Health support services (diabetes, cancer, diet, nutrition, weight management, quit smoking, end of life care) | <input type="checkbox"/> Cancer Screening (mammograms, colon cancer, HPV vaccine/Pap smear, prostate cancer) |
| <input type="checkbox"/> Affordable and healthy food (fresh fruits and vegetables) | <input type="checkbox"/> Quality Job Opportunities and Workforce Development |
| <input type="checkbox"/> Mental health services | <input type="checkbox"/> Racial Equity (The elimination of policies, practices, attitudes, and cultural messages that reinforce differential outcomes by race) |
| <input type="checkbox"/> Technology (internet, email, social media) | <input type="checkbox"/> Religion or spirituality |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Safety and low crime |
| <input type="checkbox"/> Affordable childcare | <input type="checkbox"/> Strong community cohesion and social network opportunities (reword – Welcoming community and opportunities to join support groups) |
| <input type="checkbox"/> Affordable housing | <input type="checkbox"/> Strong family life |
| <input type="checkbox"/> Arts and cultural events | <input type="checkbox"/> Other, please specify: _____ |
| <input type="checkbox"/> Clean environment and healthy air | |
| <input type="checkbox"/> Fitness (gyms place to work out) | |
| <input type="checkbox"/> Good schools | |

Are there any additional services or resources that you would like to see in our community that would help residents maintain or improve their health?

Community Health Needs Assessment Survey

Questions About You

What is your age?

- | | | | |
|--------------------------------|--------------------------------|--------------------------------|---------------------------------------|
| <input type="checkbox"/> 18-24 | <input type="checkbox"/> 35-44 | <input type="checkbox"/> 55-64 | <input type="checkbox"/> 75-84 |
| <input type="checkbox"/> 25-34 | <input type="checkbox"/> 45-54 | <input type="checkbox"/> 65-74 | <input type="checkbox"/> 85 and older |

What is your current gender identity?

- | | | |
|--|---|--|
| <input type="checkbox"/> Female | <input type="checkbox"/> Transgender Female
(Male to Female) | <input type="checkbox"/> Choose not to disclose |
| <input type="checkbox"/> Male | <input type="checkbox"/> Transgender Male
(Female to Male) | <input type="checkbox"/> Other, please specify:
_____ |
| <input type="checkbox"/> Non-Binary (Do Not
Strictly Identify as Female
or Male) | | |

Do you think of yourself as?

- | | |
|--|--|
| <input type="checkbox"/> Straight or heterosexual | <input type="checkbox"/> Choose not to disclose |
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> Other, please specify:
_____ |
| <input type="checkbox"/> Lesbian or gay or
homosexual | |

Do you consider yourself Hispanic or Latino?

- Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Not Hispanic or Latino: A person is not of Hispanic or Latino ethnicity.
- Decline to answer: A person who is unwilling to choose/provide from the categories available

Which category best describes your race? (check all that apply)

- American Indian or Alaska Native: *A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.*
- Asian: *A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.*
- Black or African American: *A person having origins in any of the black racial groups of Africa.*
- Native Hawaiian or Other Pacific Islander: *A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.*
- White: *A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.*
- Decline to answer

Is a language other than English spoken in your home?

- Yes No

If Yes: What language(s) other than English are spoken in your home?

- Spanish Vietnamese Mandarin Other, please specify: _____

What is the highest level of education you have completed?

- | | |
|--|---|
| <input type="checkbox"/> Less than high school | <input type="checkbox"/> Vocational or technical school |
| <input type="checkbox"/> Some high school | <input type="checkbox"/> College graduate (such as AA, AS, BA, BS, etc.) |
| <input type="checkbox"/> High school graduate or graduate equivalency degree (GED) | <input type="checkbox"/> Advanced degree (such as MS, MA, MBA, MD, PhD, JD, etc.) |
| <input type="checkbox"/> Some college, no degree | |

Community Health Needs Assessment Survey

Household Questions

What are your current living arrangements?

- | | |
|--|--|
| <input type="checkbox"/> Own my home | <input type="checkbox"/> Living with a friend or family |
| <input type="checkbox"/> Rent my home | <input type="checkbox"/> Living outside (e.g., unsheltered, car, tent, abandoned building) |
| <input type="checkbox"/> Living in emergency or transitional shelter | <input type="checkbox"/> Other: _____ |

How many people live in your household? _____

How many children (less than 18 years old) live with you in your home? _____

How often do you have access to a computer or other digital device with the internet?

- Always Often Sometimes Very Rare Never

Do you or anyone in your household have a disability?

- Yes No

What is the yearly household income? (The total income before taxes are deducted, of every person in the home who financially helps)

- | | |
|---|---|
| <input type="checkbox"/> Less than \$10,000 | <input type="checkbox"/> \$60,000 to \$79,999 |
| <input type="checkbox"/> \$10,000 - \$19,999 | <input type="checkbox"/> \$80,000 to \$99,999 |
| <input type="checkbox"/> \$20,000 to \$39,999 | <input type="checkbox"/> Over \$100,000 |
| <input type="checkbox"/> \$40,000 to \$59,999 | |

Community Health Needs Assessment Survey

Questions about Your Health

Are you currently covered by health insurance?

- Yes No

Do you have a medical or healthcare professional that you see regularly (primary care provider/doctor/pediatrician/cardiologist, etc.)?

- Yes No

The following questions concern the time since the start of the pandemic (March 2020):

During this time period have you had any of the following (please check all that apply):

- Visited a doctor for a routine checkup or physical? (not an exam for a specific injury, illness or condition)?
- Dental exam
- Mammogram
- Pap test/pap smear
- Sigmoidoscopy or colonoscopy to test for colorectal cancer
- Flu shot
- Prostate screening
- COVID-19 vaccine

Because of the pandemic did you delay or avoid medical care?

- Yes No

During this time period, how often have you been bothered by feeling down, depressed, or hopeless? (Check only one answer).

- Not at all
- Several days every month
- More than half the days every month
- Nearly every day

What is the most difficult issue your community has faced during this time period?

- COVID-19
- Natural disasters (for example, hurricanes, flooding, tornadoes, fires)
- Extreme temperatures (for example, snowstorm of 2021)
- Other: _____

Other than those concerns included in the previous question, are there additional concerns that affected your community during this time period?

CHNA Focus Group Guide

Population:

Date and Time:

Location:

RSVPs:

FACILITATION PROTOCOLS

1. Establishing ground rules

- Establish purpose of the focus group.
 - We are meeting today to learn about your community. Specifically, we want to understand what you like about where you live and what you would like to see changed. We also want to understand the biggest health challenges your friends and families face.
 - You were selected to participate in this focus group because of the valuable insight you can provide.
 - We would like to understand how the hospital can partner to make improvements in your neighborhood.
- Establish confidentiality of participants' responses.
 - Our team will be taking notes about what is discussed, but individual names or identifying information will not be used.
- Establish guidelines for the conversation.
 - Keep personal stories "in the room".
 - Everyone's ideas will be respected.
 - One person talks at a time.
 - It's okay to take a break if needed or help yourself to food or drink (if provided).
 - Everyone has the right to talk.
 - Everyone has the right to pass a question.
 - There are no right or wrong answers.
- Explain to participants how their input will be used.
 - Your input will be part of the Community Health Needs Assessment process.
- Give participants estimated timeline of when results will be shared.
 - We expect to make the report available in 2022.
- Establish realistic expectations for what the hospitals and partners can do to address community needs.

2. Introductions

- When we speak about community, it can have different meanings. For example, it can mean your family, the people you live or go to school with, the neighborhood you live in, a group of people you belong to. We are interested in hearing about your community, no matter how you define it.
- The facilitator will go around the room and ask each participant:
 - Name?
 - How long have you lived in the community?
 - What one word would you use to describe your community?

3. Community Descriptions

- Can you describe your community?
 - What are things like?
 - What are things you would like to see changed?
 - Probe: Do you have ideas for how those things can be changed?

4. Health Questions

- What do you think are the biggest health challenges in your community?
 - Follow up on specifics – diabetes, heart disease, asthma/COPD, cancer, sickle cell, substance abuse
 - With chronic diseases answers probe on what are the specific challenges (i.e., managing diabetes, accessing medicine, getting screened, etc.)
 - If substance abuse comes up, follow up on types – alcohol, marijuana, opioids, other?
- What do you think could prevent these issues from being so challenging?
 - Follow up on specific ideas – access to preventative care? Education?
- How has COVID-19 impacted you and your community?
 - Follow up on specifics – job loss, homeschooling, severe illness, mental health, ability to access the internet and health information at home

5. Access and Education Questions

- How easy is it in your community to access health services?
 - Do they have a primary care provider?
 - Can they access Behavioral Health services?
 - Are they able to get cancer screenings and vaccinations?
 - Is telehealth an option? Why or why not?
 - Is transportation a barrier?
- How easy is it for adults in your community to maintain a healthy lifestyle?
 - Is there access to healthy foods?
 - Are there places to exercise?
 - Do you feel a sense of cohesion in your community?

6. Solutions and Strategies Questions

- What do you think a community needs to be healthy?
 - Depending on responses, follow up on specifics – jobs, housing, access to care, schools, parks, food access, etc.
- Who do you think can contribute to make a community healthy?
 - Probe: neighbors, doctors, hospitals, social service agencies, politicians, etc.

7. Final Questions

- What do you think CHRISTUS Health can do to help your community?
- Where do you get your health information now?
- What is the best way to communicate with you about health information?

8. Closing and Next Steps

- Explain how the notes will be synthesized and shared.
- Ask whether participants would like to be involved in future stages of the CHNA and set the process for continued engagement.
- Thank everyone for their participation

CHNA Key Informant Interview Guide

FACILITATION PROTOCOLS

1. Establishing ground rules

- Establish purpose of the interview
 - CHRISTUS Health is conducting a Community Health Needs Assessment and your input is an important part of the work.
 - We have collected thousands of surveys and held over two dozen focus groups. Now we are interviewing key informants like yourself.
 - You were selected to participate in this interview because of the valuable insight you can provide.
 - We would like to understand how the hospital can partner to improve the health of the community.
- Establish confidentiality of the conversation
 - I will be taking notes about what is discussed, but your name and identifying information will not be used.
- Give participants an estimated timeline of when results will be shared.
 - We expect to make the report available later this year.

2. Introductions

- During our time together, I'm interested in learning about your work and the needs of the people you serve.
- What is your:
 - Name?
 - Organization?
 - Work you do for that organization and/or the community?

3. Survey-alignment questions

- What are strengths you see with your patients/community members right now?
- What are the challenges they face?
 - How do you think those challenges can be addressed?
- What programs or partnerships have worked well? Why?

4. Health questions

- What do you think are the biggest health challenges your patients/constituents/community members face?
 - Follow up on specifics—diabetes, heart disease, asthma/COPD, cancer, sickle cell, substance abuse, mental health
 - With chronic disease answers probe on what are the specific challenges (i.e., managing diabetes, accessing medicine, getting screened, etc.)
 - For cancer ask about specifics
 - For substance abuse follow up on types—alcohol, marijuana, opioids, other?
- How has COVID-19 impacted you and your work?

5. Social Determinant questions

- What elements in the community make it hard for people to be healthy?
 - Follow up on food access, affordable housing, childcare, crime, access to care, etc.
- How can Christus help address these issues?

6. Next Steps

- Explain how the notes will be synthesized and shared.
- Thank them for their participation.

Appendix 3: Data Sources

Secondary data that was used throughout this report was compiled from Metopio's data platform. Underneath each graphic in this report, there is a label that cites the data source for that visual. Primary sources of this data come from:

- American Community Survey
- Behavioral Risk Factor Surveillance System
- Centers for Disease Control PLACES data
- Centers for Disease Control WONDER database
- Centers for Medicare and Medicaid Services: Provider of Services Files, National Provider Identifier
- Decennial Census (2010 and 2020 census data)
- Diabetes Atlas
- Environmental Protection Agency
- FBI Crime Data Explorer
- National Vital Statistics System
- The New York Times
- State health department COVID dashboards
- Louisiana Department of Public Health
- United States Department of Agriculture: Food Access Research Atlas

Appendix 4: Community Resources

An inventory of community resources was compiled based on key informant interviews, focus group discussions, and an internet-based review of health services in the CHRISTUS St. Frances Cabrini Health System service area. The list below is not meant to be exhaustive but represents a broad sampling of feedback received from the stakeholder engagement process. The list of community resources is restricted to only those that are physically located within the report area. Several additional organizations located outside the report area may provide services to report area residents but fall outside the scope of inclusion in this needs assessment. Similarly, many of the organizations identified in this resource compilation serve a population broader than the report area but are included here in the context of the services they offer to report area residents.

NAME	DESCRIPTION
CHRISTUS St. Frances Cabrini Hospital	CHRISTUS St. Frances Cabrini Hospital, located in Alexandria Louisiana, is a 293-bed facility. It offers comprehensive inpatient and outpatient services and is accredited by the Joint Commission.
CHRISTUS Dubuis Hospital of Alexandria	CHRISTUS Dubuis Hospital of Alexandria, LA is a long-term acute care hospital (LTAC) that is currently licensed for 25 LTACH beds. It also provides employment for approximately 75 persons.
CHRISTUS Savoy Medical Center	Savoy Medical Center is a 60-bed acute care facility. The facility includes 6 beds designated for intensive care, a 24-hour Emergency Department, 22 acute care beds, 5 private physical rehabilitation beds, 24 beds for Beyond the Horizons a 28-day residential substance abuse program, and 27 psychiatric & medical DETOX Beds at NEW HORIZONS. Additional services include SAVOY Cancer Center providing chemotherapy, radiation, and other outpatient infusions, a full-service outpatient laboratory, respiratory department, radiology department including MRIs and 3D mammography and 5 rural health clinics.
CHRISTUS Coushatta Health Care Center	Comprised of a hospital, dental clinic and multiple rural health clinics, CHRISTUS Coushatta Health Care Center provides a network of services and facilities that collaborate to provide the medical, surgical and wellness needs of the communities.
Louisiana Public Health Institute	The Louisiana Public Health Institute is a statewide, non-profit organization that has been promoting the health and well-being of Louisianans since 1997. They accomplish their goals alongside their over 500 partner organizations, which include communities, community-based organizations, foundations, healthcare systems, academic institutions,

	government agencies, and a diverse group of additional stakeholders.
Central Louisiana Coalition to Prevent Homelessness	Their mission is to identify, advocate, and mobilize community resources to ensure all people in central Louisiana have access to stable homes.
Louisiana Central	Louisiana Central successfully recruits staff from across the nation and across town to support and grow regional prosperity.
The Food Bank of Central Louisiana	The Food Bank of Central Louisiana is able to serve more than 22,400 people every month in the community. For every dollar donated, the food bank can provide five meals to families in need. Each year, the Feeding America network of food banks and food-rescue organizations distributes more than two billion pounds of food and grocery products to support feeding programs at approximately 50,000 local charitable agencies, including food pantries, soup kitchens, emergency shelters, after-school programs, and Kids Cafes.
Save CenLa	Their mission is to promote mental health awareness and suicide prevention through education, media, and events. Our hope is to break the stigma and equate it with all other life-threatening illnesses, so that people are not afraid to come into the light and learn how to seek help through local mental health resources
Fostering Community	Fostering Community works to improve the lives of children impacted by foster care through advocacy, resources, and support. They aim to provide a holistic approach to supporting foster care from the initial entry of children into foster care to those exiting the system. They recruit new foster parents and pair them with experienced foster parents who are trained mentors. Mentors support new foster parents on their foster care journey by providing information, resources, and ongoing support through their first placement.
Louisiana Campaign Tobacco Free Living	The Louisiana Campaign for Tobacco-Free Living (TFL) engages in local and statewide tobacco control policy efforts that focus on tobacco prevention, eliminate exposure to secondhand smoke, promote cessation services, and identify and eliminate tobacco-related disparities.
Hope House	Provide safe shelter and essential services to homeless families, empowering them to independence. Everyone served by Hope House will become actively engaged

	role models demonstrating self-determination, responsibility, and citizenship.
Ministers of Economic Development	Ministers of Economic Development (MOED) is a not-for-profit organization that provide clergy to minister patients being served in Emergency Room.
United Way of Central Louisiana (UWCL)	The United Way of Central Louisiana empowers members of the community through access and improvement in education, health and financial stability.
Catholic Charities of Central Louisiana	Catholic Charities of Central Louisiana strives to be good stewards of life by empowering individuals, families, and communities to become self-sustainable, recognizing the dignity of all people.
LHC Group	LHC Group, Inc. is a national provider of in-home healthcare services and innovations for communities around the nation, offering quality, value-based healthcare to patients primarily within the comfort and privacy of their home or place of residence. The company's employees deliver home health, hospice, home- and community-based services, and facility-based care.