COMMUNITY HEALTH NEEDS ASSESSMENT

2023-2025

CHRISTUS Health®
Southwestern Louisiana

Ochsner

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EXECUTIVE SUMMARY

Executive Summary

CHRISTUS Ochsner Health Southwestern Louisiana (CHRISTUS SWLA) conducted a Community Health Needs Assessment (CHNA) to assess the greatest community health needs. The CHNA guides the hospital in selecting priority health areas and where to commit resources that can most effectively improve community members' health and wellness. To complete the 2023-2025 CHNA, CHRISTUS SWLA 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 Community Health Needs Assessment (CHNA) also 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.

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Health Need Priorities

Based on community input and analysis of a myriad of data, the priorities for the communities served by CHRISTUS SWLA for 2023-2025 are fall into two domains underneath an overarching goal of achieving health equity (Figure 1). The two domains and corresponding health needs are:

1. Advance health and wellbeing by addressing
    - Chronic illness
        - » Diabetes
        - » Heart disease
        - » Obesity
    - Behavioral health
        - » Mental health
        - » Substance abuse
2. Build resilient communities and improve social determinants by
    - Improving food access
    - Reducing smoking and vaping

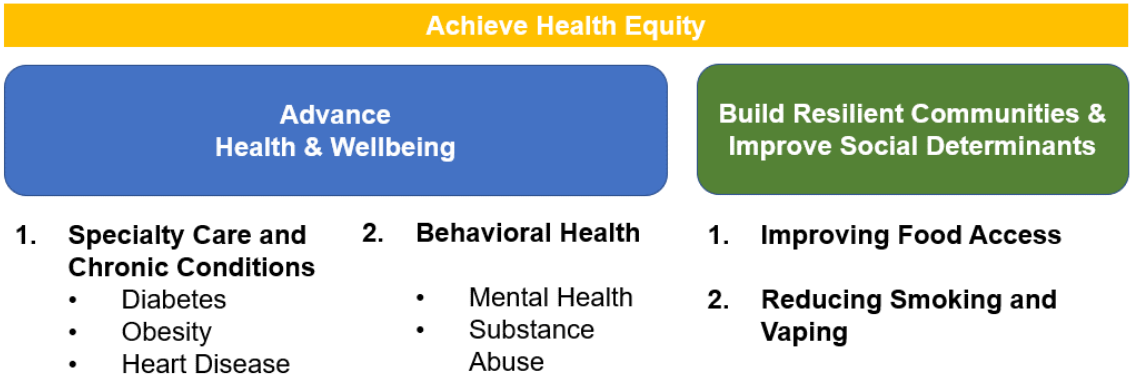


Figure 1. CHRISTUS SWLA Priority Areas

This report provides an overview of the CHRISTUS SWLA process involved in the CHNA, including data collection methods, sources, and CHRISTUS SWLA's service area. 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 is a systematic, data-driven approach to determine the health needs in the service area of the CHRISTUS SWLA. In this process, CHRISTUS SWLA directly engages community members and stakeholders to identify the issues of greatest need as well as the largest impediments to health. With this information, CHRISTUS SWLA can better allocate resources towards efforts to improve community health and wellness.

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

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

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

The following report provides an overview of the process used for this CHNA, including data collection methods and sources, results for CHRISTUS SWLA 's service area, historical inequities faced by the residents in the service area, 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.

The data from the CHNA is presented by CHRISTUS SWLA service area zip codes where it assessed the health needs for the entire service area. This method uses the granular data available by zip code and municipality and brings to light the differences and similarities within the communities in the CHRISTUS SWLA service area.

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

CHRISTUS SWLA Overview

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

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

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

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

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

Community Benefit

CHRISTUS SWLA implements strategies to promote health in the community and provide equitable care in the hospital. CHRISTUS SWLA builds on the assets that are already found in the community and mobilizes individuals and organizations to come together to work toward health equity.

CHRISTUS SWLA Service Area

Following IRS guidelines, 501(r) rules as required by the Affordable Care Act, CHRISTUS SWLA's CHNA service area includes 10 zip codes covering over 230,000 individuals. The zip codes included are:

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

Table 1. Primary Service Area (PSA) of CHRISTUS SWLA

The service areas for CHRISTUS Ochsner St. Patrick and CHRISTUS Ochsner Lake Area are unchanged from the 2020 - 2022 CHNA. The service area zip codes include the following parishes: Beauregard and Calcasieu (Figure 2).

While the hospitals are dedicated to providing exceptional care to all of the residents in the region, CHRISTUS SWLA 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.

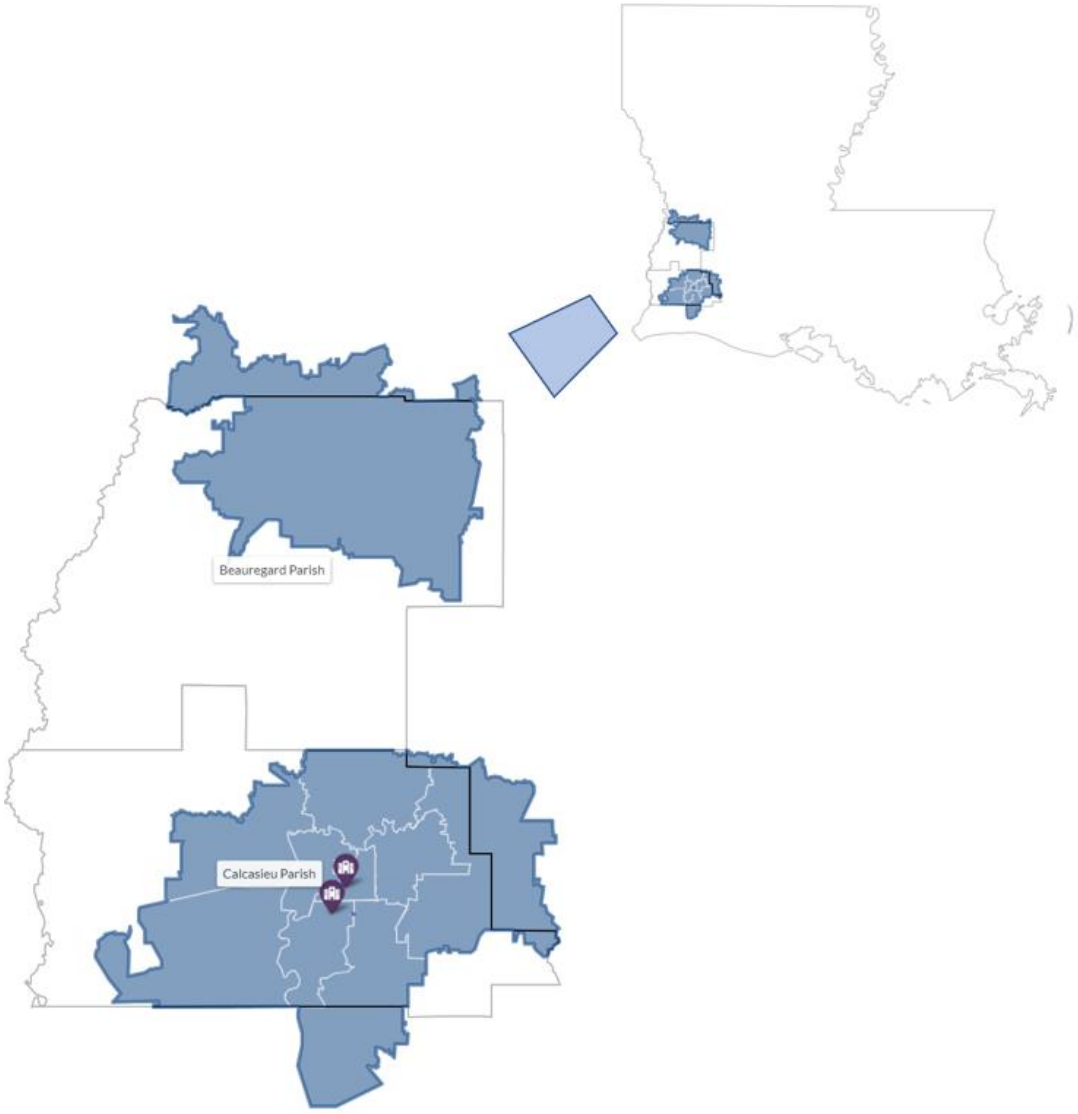


Figure 2. Primary Service Area (PSA) Map of CHRISTUS SWLA

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, CHRISTUS SWLA worked with Metopio, a software and services company that is grounded in the philosophy that communities are connected through places and people. Metopio's tools and visualizations use data to reveal valuable, interconnected factors that influence outcomes in different locations.

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

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

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

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

The CHRISTUS SWLA leadership team developed parameters for the 2022-2025 CHNA process that help drive the work. These parameters ensure that:

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

Data Collection

CHRISTUS SWLA conducted its CHNA process between September 2021 and March 2022 using an adapted process from the Mobilizing for Action through Planning and Partnerships (MAPP) framework. This planning framework is one of the most widely used for CHNAs. It focuses on community engagement, partnership development and seeking channels to engage people who have often are not part of decision-making processes. The MAPP framework was developed in 2001 by the National Association for Parish 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, 293 residents in the CHRISTUS SWLA PSA provided input to the CHNA process by completing a community resident survey. The survey was available online and in paper form in English and Spanish. Survey dissemination happened through multiple channels led by CHRISTUS SWLA and its community partners. The survey sought input from priority populations in the CHRISTUS SWLA PSA that are typically underrepresented in assessment processes, including communities of color, immigrants, persons with disabilities, and low-income residents. The survey was designed to collect information regarding:

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

The survey was based on a design used extensively for CHNAs and by public health agencies across the country. The final survey included 26 questions. The full community resident survey is included in Appendix 2. Table 2 summarizes the demographics of survey respondents in the CHRISTUS SWLA PSA.

DEMOGRAPHIC	%
Age (N=282)	
18-24 25-44	0.5 15.9
45-64	57.7
65 and older	25.8
Gender (N=282)	
Male	20.3
Female	77.5
Choose not to answer	2.1
Orientation (N=282)	
Straight or heterosexual	96.7
Lesbian or gay or homosexual Bisexual	0.5 0.5
Choose not to disclose	2.2
Race (N=292 (multiple answers allowed))	
American Indian or Alaska Native	1.7
Black or African American	16.7
White	75.9
Hispanic/Latino(a)	5.0
Choose to not disclose	6.9
Education (N=283)	
Less than high school	0.5
High school graduate or GED	6.0
Vocational or technical school	8.7
Some college, no degree	13.1
College graduate	38.3
Advanced degree	33.3
Current Living Arrangements (N=282)	
Own my home	86.3
Rent my home	6.6
Living in emergency or transitional shelter	0.5
Living with a friend or family	3.8
Other	2.7
Disability in Household (N=280)	30.6
Income (N=267)	
Less than $10,000	3.6

$10,000 to $19,999	3.6
$20,000 to $39,999	10.2
$40,000 to $59,999	14.4
$60,000 to $79,999	12.0
$80,000 to $99,999	15.6
Over $100,000	40.7
Average Number of Children in Home (#) (N=273)	0.5

Table 2. Demographics of Community Resident Survey Respondents in CHRISTUS SWLA Communities

Community Focus Groups and Key Informant Interviews

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

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

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

CHRISTUS SWLA conducted its 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
American Cancer Society	Associate Director, Development
Catholic Charities of SWLA	Director
Family & Youth Counseling Agency	Children's Advocacy Center Representative
Family & Youth Counseling Agency	Human Services Response Institute Representative
Family & Youth Counseling Agency	CEO
Healthy Blue	Community Relations Representative
Alzheimer's Association	Executive Director, Louisiana
Calcasieu Parish Police Jury	Disaster Housing Recovery Representative
Calcasieu Parish Police Jury	American Job Center Representative
Project Build a Future	Housing Representative

Project Build a Future	Housing Representative
Office of Public Health Region 5	Regional Medical Director
SWLA Center for Health Services	CEO

Table 3. Focus Group Participants

In addition to the focus groups, ten key informants were identified by CHRISTUS SWLA Management team 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 SWLA used a common set of health indicators to understand the prevalence of morbidity and mortality in the CHRISTUS SWLA PSA and compare them to benchmark regions at the state and the full CHRISTUS Health service area. Building on previous CHNA work, these measures have been adapted from the County Health Rankings MAPP framework (Figure 3). Where possible, CHRISTUS SWLA used data with stratifications so that health inequities could be explored and better articulated. Given the community input on economic conditions and community safety, CHRISTUS SWLA sought more granular datasets to illustrate hardship. A full list of data sources can be found in Appendix 3.

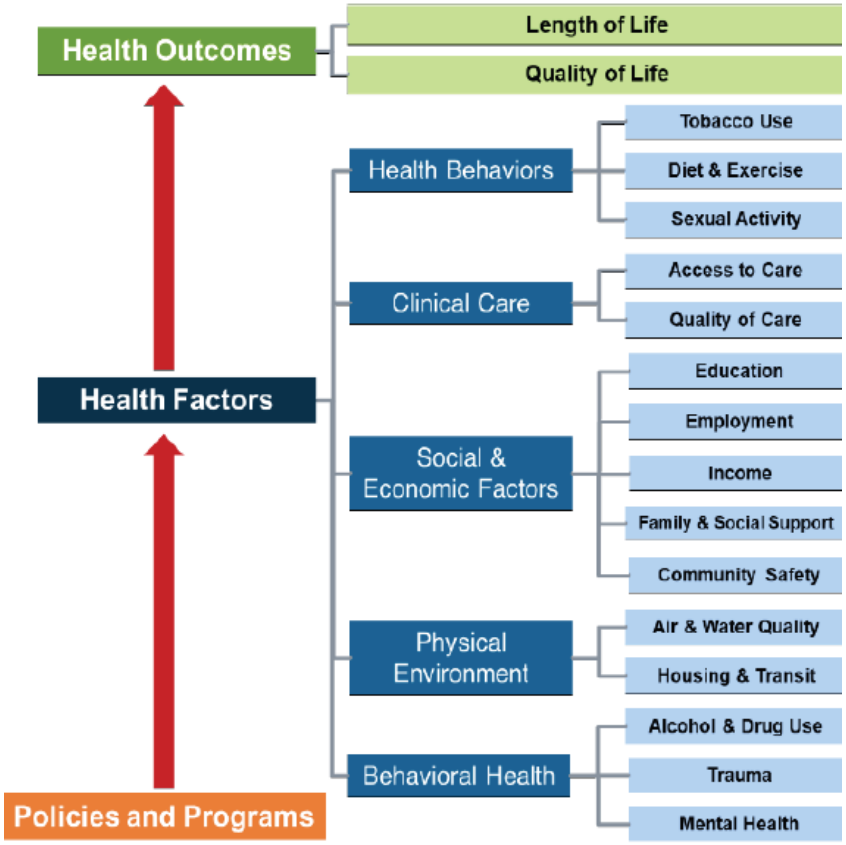


Figure 3. Illustration of County Health Rankings MAPP Framework

Data Needs and Limitations

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

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

With this in mind, CHRISTUS SWLA, Metopio, and all stakeholders were deliberate in discussing these limitations throughout the development of the CHNA and selection of the 2022-2025 health priority areas.

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 SWLA 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 SWLA 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

> "Our community has had to deal with COVID-19, back-to-back hurricanes, a flood, new virus strains, and the ever-growing inflation and financial burden that impacts us all."
>
> - Survey Respondent

As demonstrated in the survey results in Table 4, despite the impact of COVID-19 on the community, a majority of respondents saw natural disasters 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.

DURING THE PANDEMIC (MARCH 2020-PRESENT) HAVE YOU HAD ANY OF THE FOLLOWING (PLEASE CHECK ALL THAT APPLY):	% OF RESPONDENTS
Visited a physician for a routine checkup or physical	92.2
Dental exam	72.6
Mammogram	52.5
Pap test/Pap smear	45.3
Sigmoidoscopy or colonoscopy to test for colorectal cancer	19.6
Flu shot	61.5
Prostate screening	10.10
COVID-19 vaccine	78.2
BECAUSE OF THE PANDEMIC, DID YOU DELAY OR AVOID MEDICAL CARE?	
Yes	42.3
No	57.7
DURING THIS TIME PERIOD, HOW OFTEN HAVE YOU BEEN BOTHERED BY FEELING DOWN, DEPRESSED, OR HOPELESS?	
Not at all	39.4
Several days every month	45.0
More than half the days every month	10.6
Nearly every day	5.0
WHAT IS THE MOST DIFFICULT ISSUE YOUR COMMUNITY HAS FACED DURING THIS TIME PERIOD?	
COVID-19	5.5
Natural disasters (for example, hurricanes, flooding, tornadoes, fires)	90.7
Other:	3.8
	N=282

Table 4. Community Resident Survey Responses to COVID-19 Questions

CHNA RESULTS

CHNA Results

Demographic Characteristics

Over the past decade, the communities served by CHRISTUS SWLA have experienced an increase in population (Figure 4). Changes between the 2010 and 2020 Census show that the population in the SWLA PSA increased by 11.6%, a rate similar to that of the CHRISTUS Health service area (12.1%) and higher than Louisiana (2.7%). Based on the 2020 decennial Census, 230,331 people live in the CHRISTUS SWLA PSA.

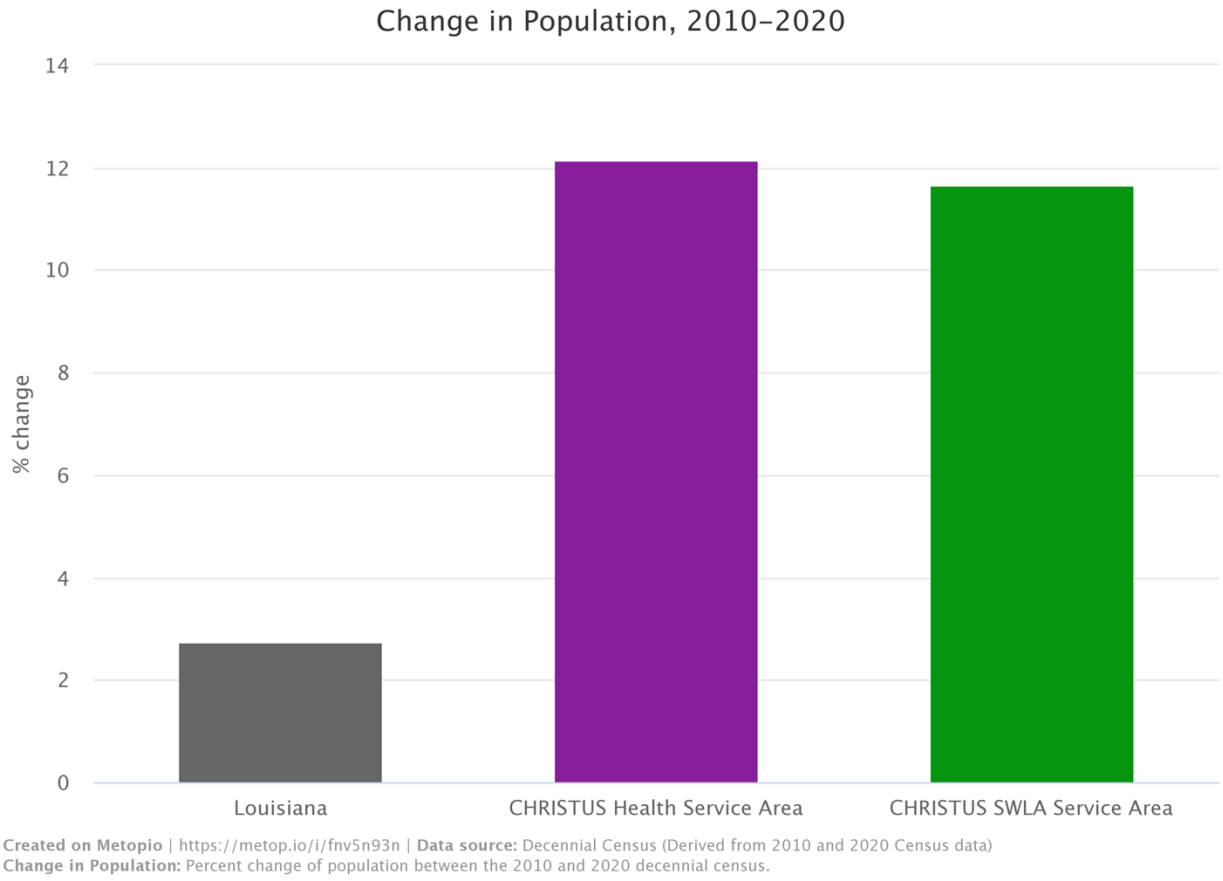
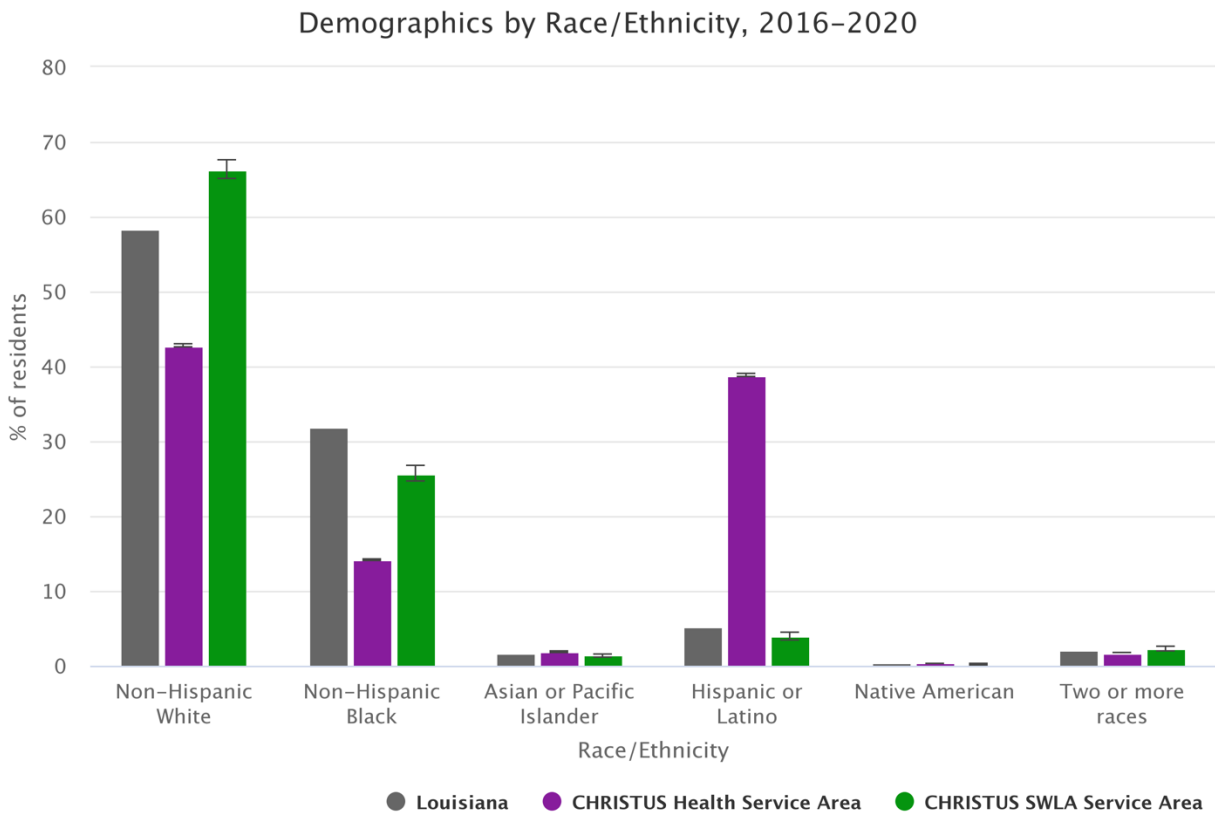


Figure 4. Change in Population in the CHRISTUS SWLA PSA

Figure 5 shows the demographics by race/ethnicity for the service areas. Non-Hispanic White individuals make up the majority of the CHRISTUS SWLA PSA population at 66.3%. 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 58.3% of the population, respectively. In the SWLA PSA, the second most prevalent racial/ethnic demographic is non-Hispanic Black people at 25.7% of the population. This is higher than the 14.2% of non-Hispanic Black residents in the CHRISTUS Health service area and the 32.9% of residents in Louisiana. The Hispanic/Latino populations in the service area (3.9%) and Louisiana (5.2%) are much lower than the overall CHRISTUS Health service area (38.8%). The remaining racial/ethnic demographics in the PSA are similar to those in the region. In the CHRISTUS SWLA PSA, Asian or Pacific Islander individuals make up 1.4%, compared to 1.9% of the CHRISTUS Health service area and 1.8% of the population of Louisiana. Native Americans account for 0.3% of the SWLA 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 2.3% of the CHRISTUS SWLA PSA, 1.8% of the CHRISTUS Health service area, and 2.0% of the Louisiana population. (Table 5 explores service area demographics by each parish.)



Created on Metopio | https://metop.io/i/n59zp8su | **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 5. Demographics by Race/Ethnicity in the CHRISTUS SWLA PSA

Topic	Beauregard Parish, LA	Calcasieu Parish, LA
Population residents, 2020	36,549	216,785
Demographics Non-Hispanic White % of residents, 2020	79.45	63.25
Demographics Non-Hispanic Black % of residents, 2020	11.17	25.29
Demographics Hispanic or Latino % of residents, 2020	3.48	5.25
Demographics Native American % of residents, 2020	0.75	0.42
Demographics Asian or Pacific Islander % of residents, 2020	0.68	1.81
Demographics Two or more races % of residents, 2020	4.22	3.59

Table 5. Demographics by Parish in the CHRISTUS SWLA PSA

Females represent 51.4% of the CHRISTUS SWLA PSA population and males represent 48.6% (Figure 6). The PSA has a slightly higher proportion of females than the broader population with 50.6% female and 49.4% male residents in the whole CHRISTUS Health service area 51.2% female and 48.8% male residents in Louisiana overall. The median age in the CHRISTUS SWLA PSA is 36.2 years old, which is slightly lower than the rest of the CHRISTUS Health service area (36.3 years old) and Louisiana overall (37.2 years old) (Figure 7).

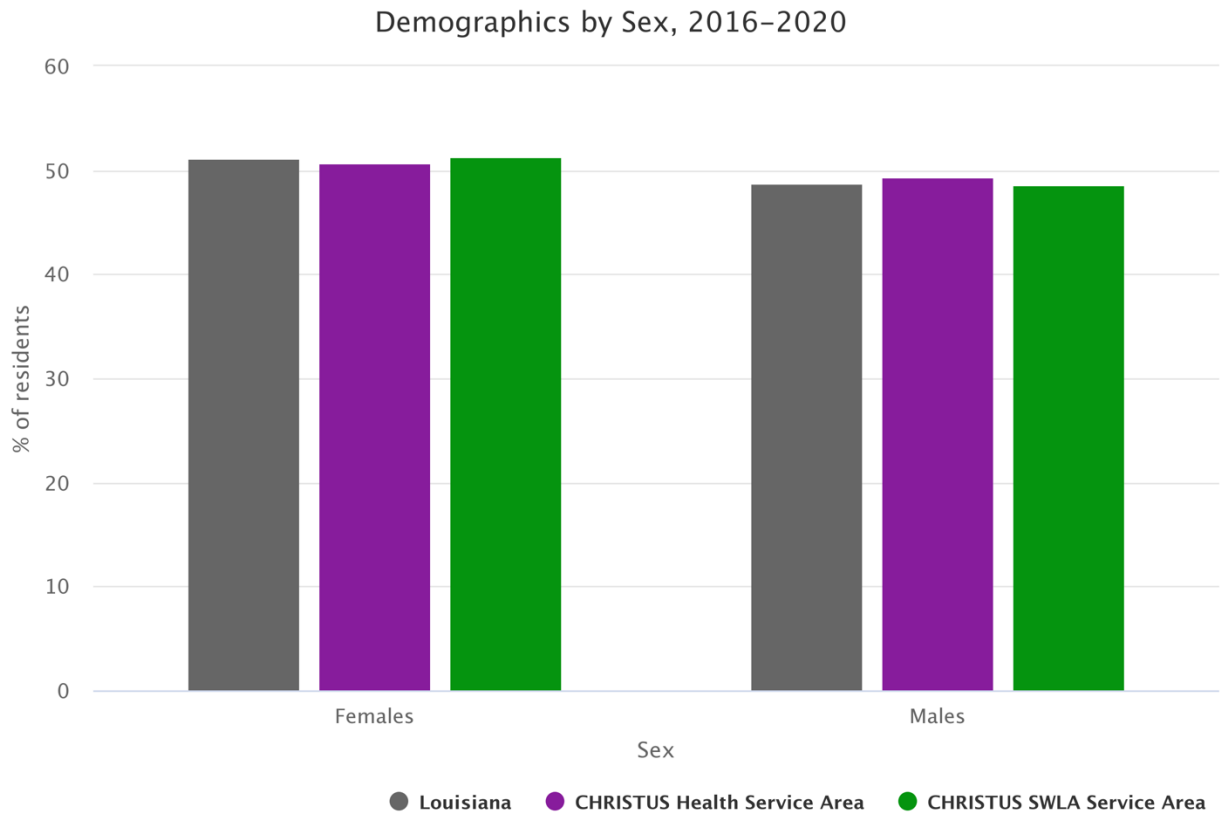
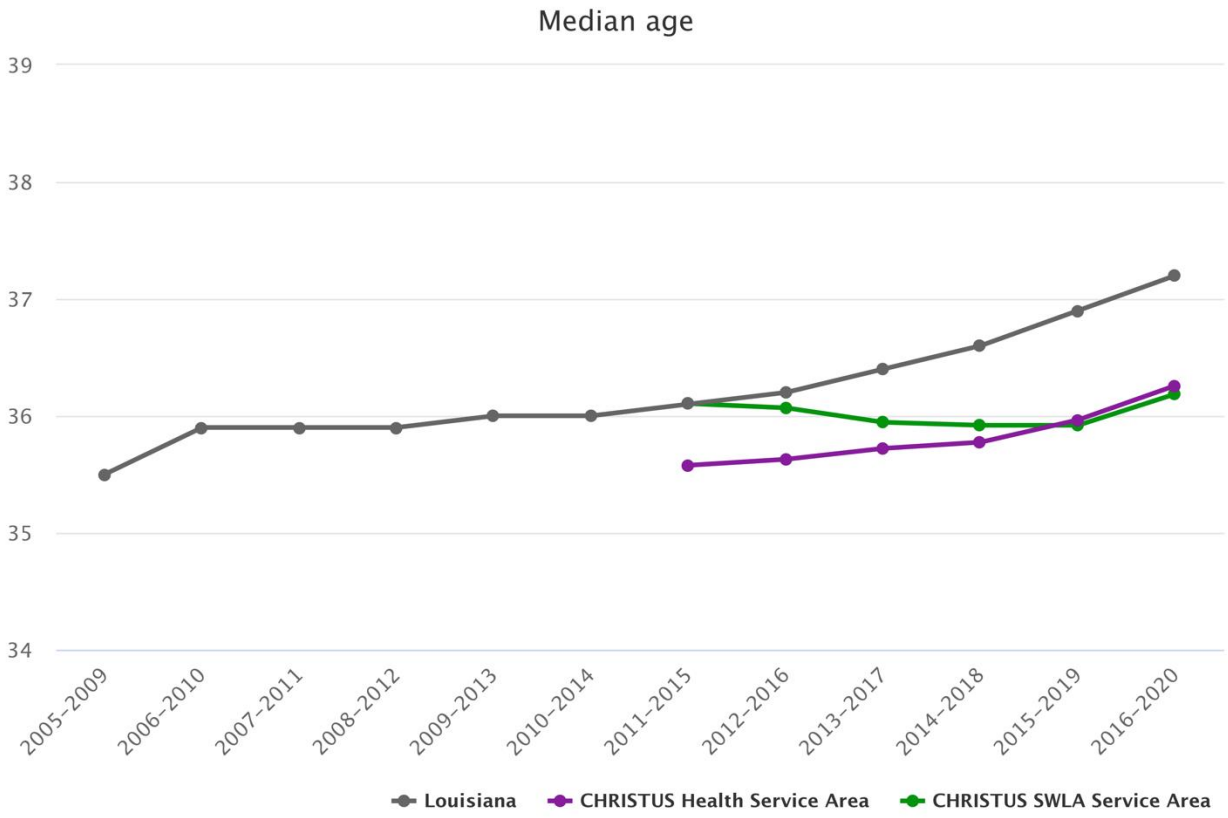


Figure 6. Demographics by Sex in the CHRISTUS SWLA PSA



Created on Metopio | https://metop.io/i/nhcor4x7 | **Data source:** American Community Survey (Table B01002)
Median age: The median age represents the age of the "middle" resident, if they were all lined up from youngest to oldest. (Half of all residents are older than this, and half are younger.)

Figure 7. Median Age in the CHRISTUS SWLA PSA

In the CHRISTUS SWLA PSA, only 0.6% of residents have limited English proficiency (Figure 8). This percentage is much lower than the CHRISTUS Health service area (4.0% of residents) and slightly lower than Louisiana overall (1.4%). The highest concentration of residents with limited English proficiency is in zip code 70607 (1.8%). 1.4% of households have limited English proficiency.

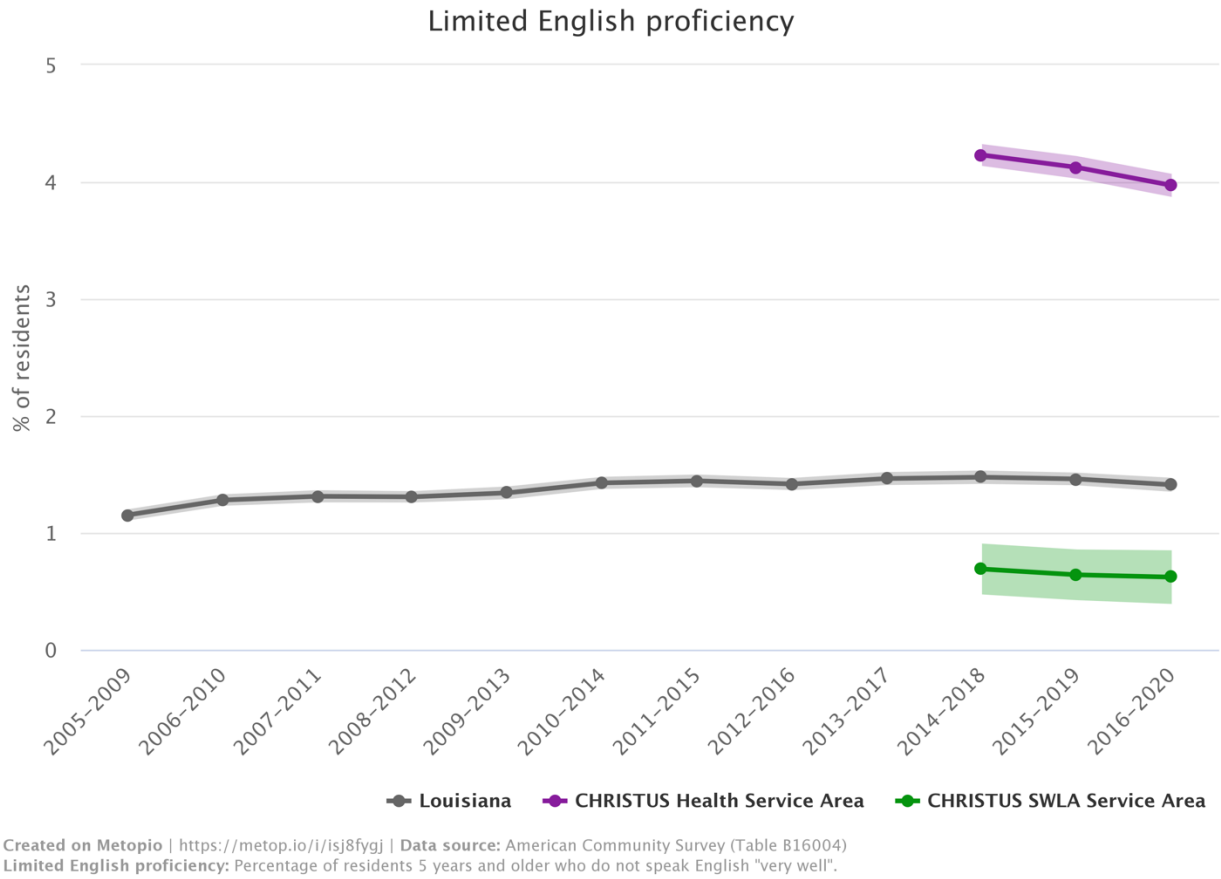


Figure 8. Limited English Proficiency in the CHRISTUS SWLA PSA

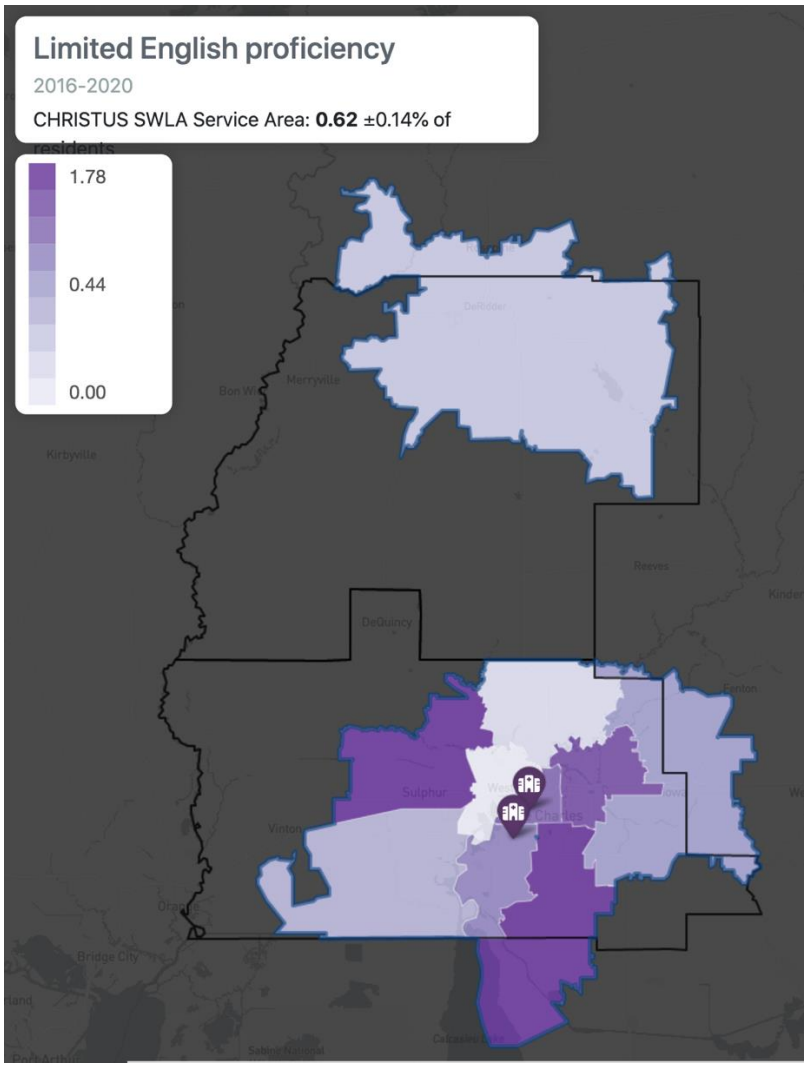
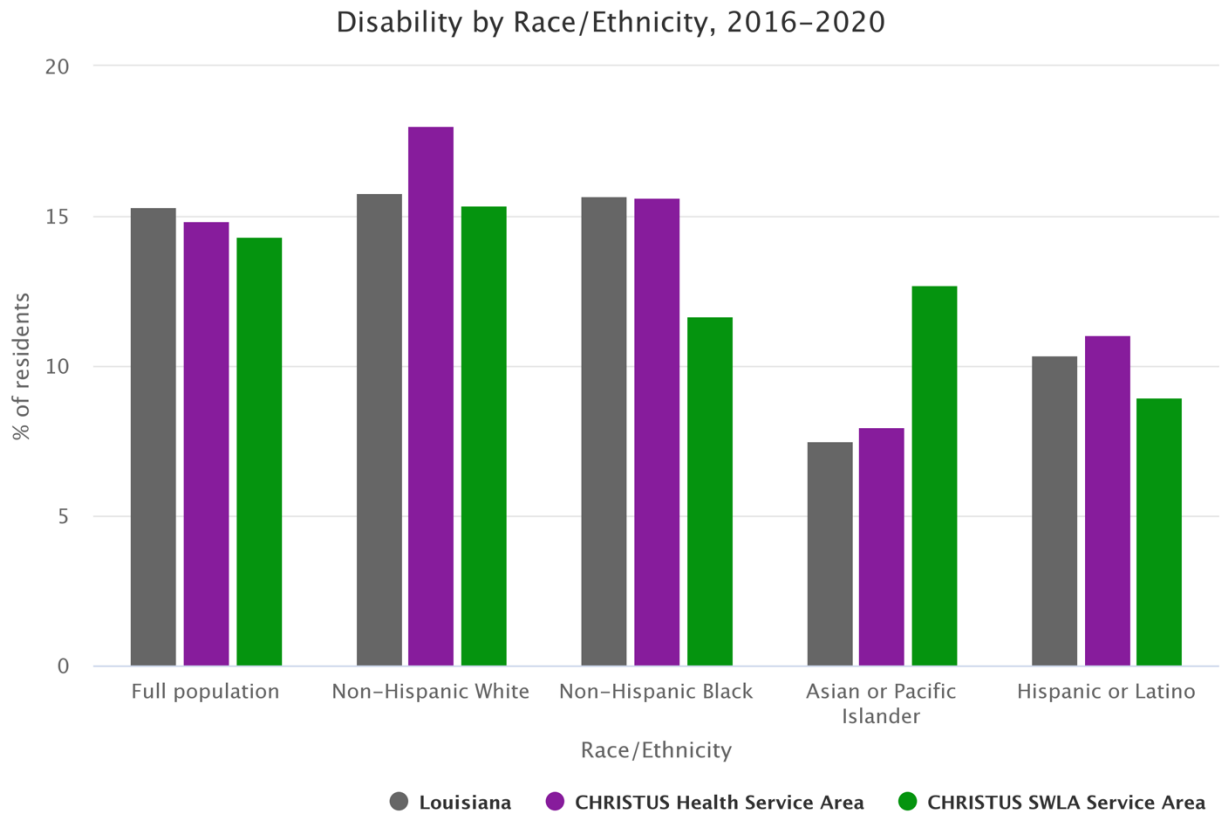


Figure 9. Map of Limited English Proficiency in the CHRISTUS SWLA PSA

The percentage of residents with a disability in the CHRISTUS SWLA PSA (14.3%) is slightly lower than the whole CHRISTUS Health service area (14.8%) and Louisiana overall (15.3%) (Figure 10). Within the PSA, non-Hispanic White people experience the highest rate of disability (15.6%), followed by Asian or Pacific Islanders (12.7%), Non-Hispanic Black people (11.7%), and Hispanic or Latino people (9.0%). Disability here is defined as one or more sensory disabilities or difficulties with everyday tasks.



Created on Metopio | https://metop.io/i/jrb78kpg | **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 10. Disability with Stratifications in the CHRISTUS SWLA PSA

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 among survey and focus group participants. There are few options for affordable dental care, dieticians, and specialists in the region. Residents must go to New Orleans or Houston to access specialists. Participants also highlighted limited resources for elderly, especially food, medication assistance, and in-home care options.
- Participants shared that there is a huge need for mental health care in the PSA, with few resources available, particularly for those who are uninsured or on Medicaid. They noted that domestic violence has become more prevalent since the pandemic began, resulting in post-traumatic stress throughout the community. Families who support those living with mental illness also could use more resources from local health systems.
- Economic opportunity and poverty came up as an area of need. Residents have difficulty paying for living expenses and that the thresholds for public benefits, such as SNAP, are too low. More resources are also needed for households during hurricane recovery.
- Survey respondents shared that elements of the built environment make it difficult to be healthy. Residents noted they feel unsafe in their communities because of increasing crime rates and feel that the police force is not staffed enough to respond to rising crime. Cost of childcare, food, and housing make it difficult to meet needs related to health, such as healthy eating. Finally, participants noted a need for supportive, low-income housing, particularly for disabled people.

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 6 shows the top 10 issues from the survey in descending order.

HEALTH ISSUE	% OF RESPONDENTS WHO RANKED EITHER 4 OR 5
Obesity	64.3%
Heart disease	58.3%
Cancer	55.4%
Diabetes	54.7%
Chronic pain	54.0%
Mental health	53.0%
Drug, alcohol, and substance abuse	50.2%
Smoking and vaping	45.6%
Arthritis	44.8%
Healthy eating	37.1%

Table 6. Ranking of Health Issues by Community Resident Survey Respondents

The primary data covered many health issues that community members see in the CHRISTUS SWLA 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 11). These represent the assets that community members can take advantage of to maintain their health.

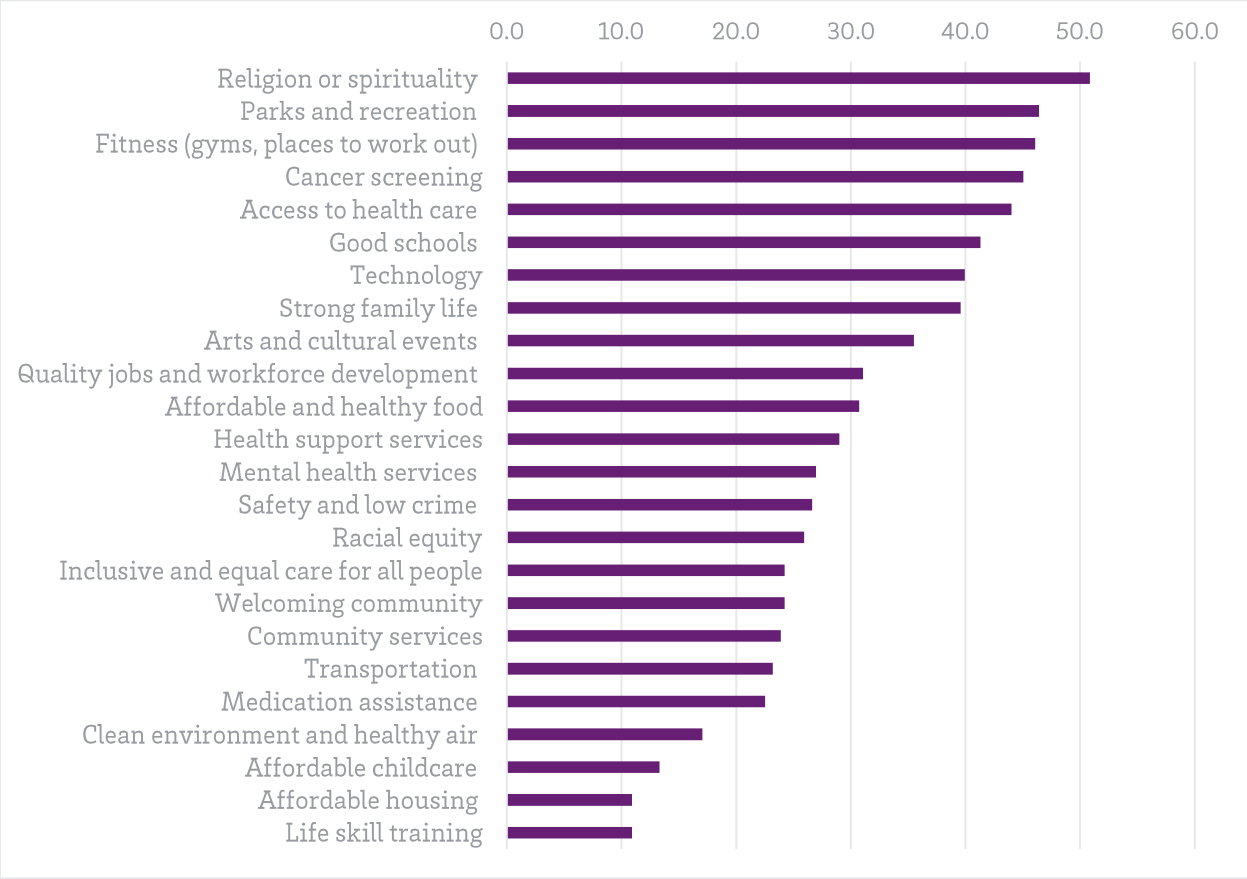


Figure 11. Survey Responses of Community Strengths that Support Health

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 12). 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 SWLA PSA is 56.8, which is slightly lower than the full CHRISTUS Health service area (60.6) and the state (59.5). Within the CHRISTUS SWLA PSA, hardship indicators are concentrated in zip code 70615 (79.0).

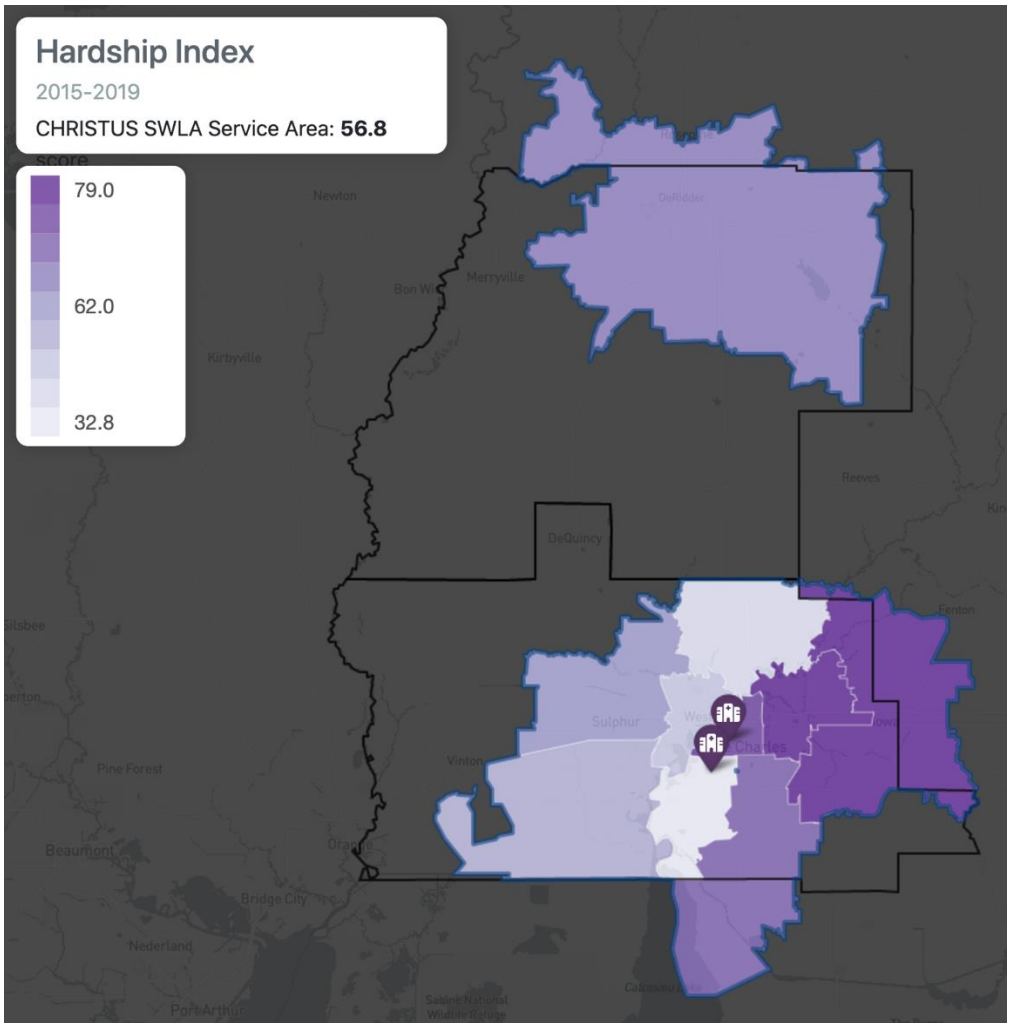


Figure 12. Map of Hardship Index in the CHRISTUS SWLA PSA

Poverty

> "The cost of living is higher than employment wages."
>
> – Survey respondent

Poverty and its corollary effects are present throughout the PSA. In the CHRISTUS SWLA PSA the poverty rate (Figure 13) is 16.1% and the median household income (Figure 14) is $58,027. 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 PSA is most pronounced for people of color, including non-Hispanic Black, Hispanic or Latino, and Asian or Pacific Islander residents (experiencing poverty at rates of 22.2%, 20.6%, and 18.2%, respectively). For comparison, 12.4% of non-Hispanic White residents live in poverty.

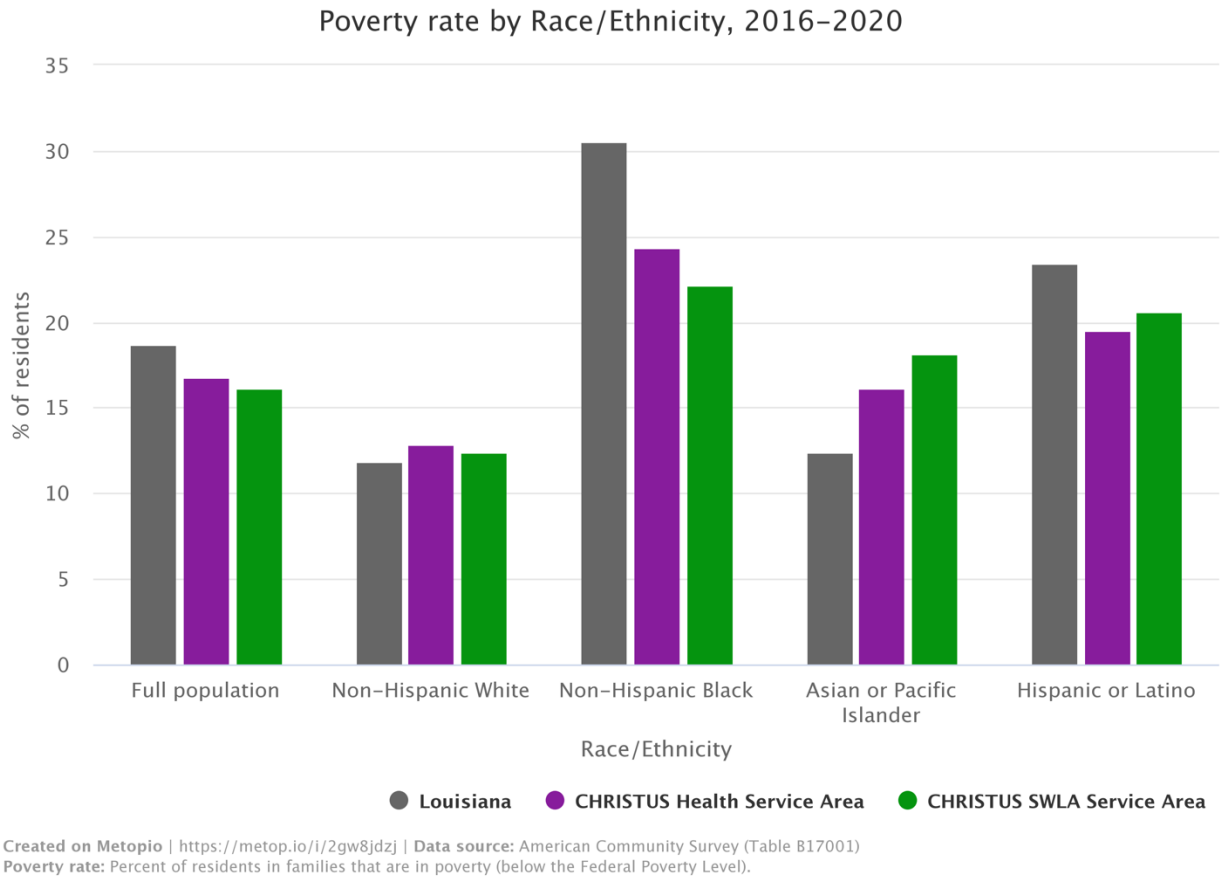


Figure 13. Poverty Rate in the CHRISTUS SWLA PSA

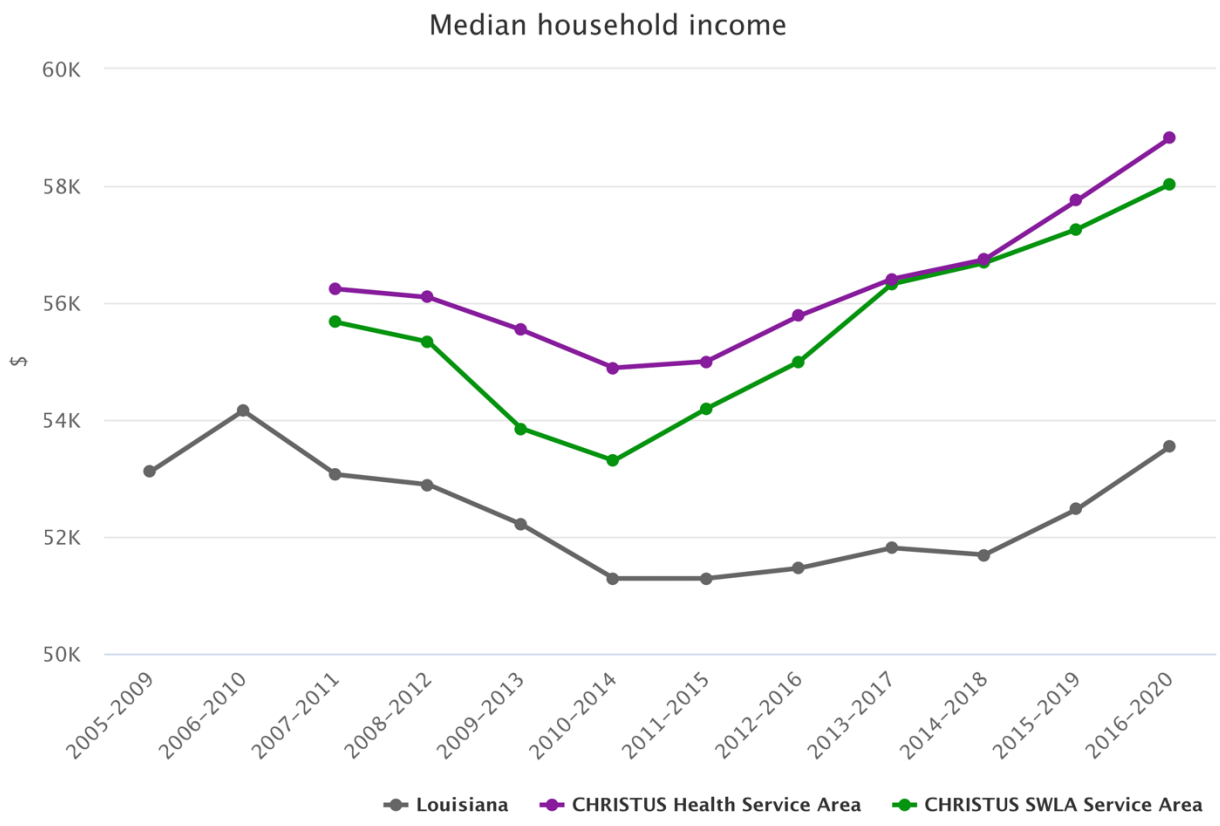


Figure 14. Median Household Income in the CHRISTUS SWLA PSA

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 15 shows that 19.8% of residents in rental housing units in the CHRISTUS SWLA PSA are severely rent-burdened, meaning they spend more than 50% of their income on housing. Zip code 70605, where the CHRISTUS Ochsner Lake Area Hospital is located, experiences the highest percentage of severely rent-burdened households (30.0%).

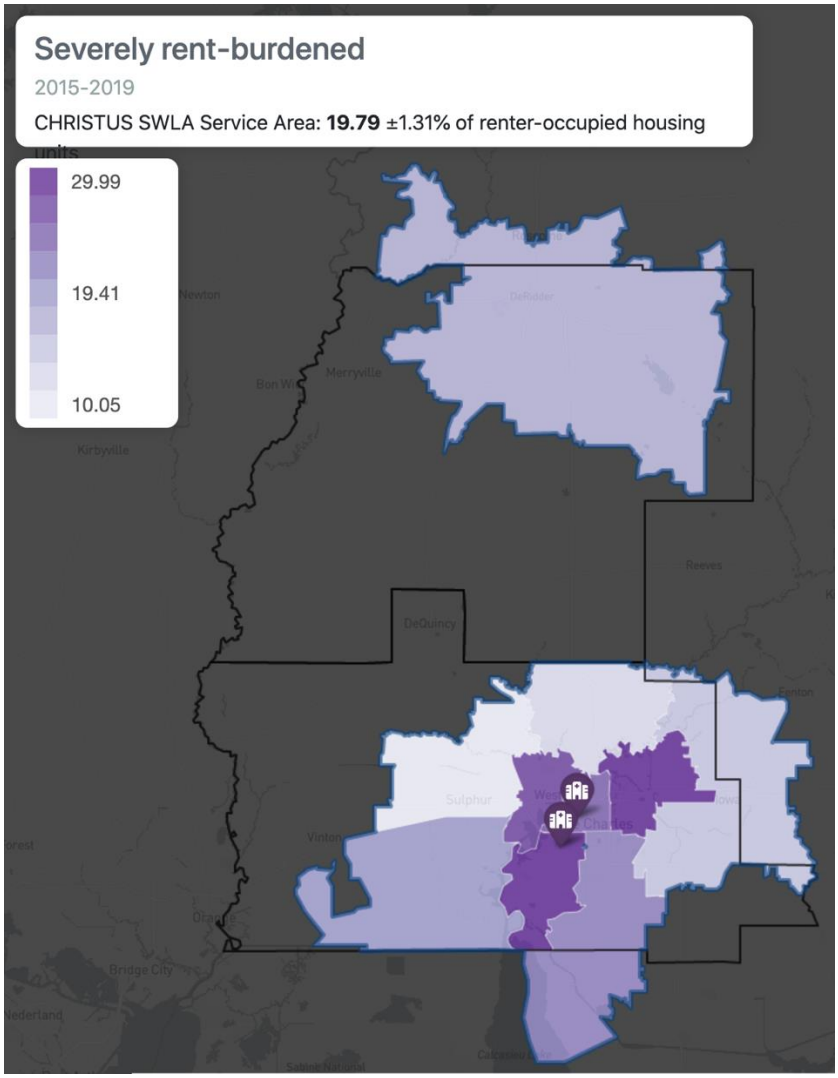


Figure 15. Housing Cost Burden in the CHRISTUS SWLA PSA

Unemployment

The overall unemployment rate in the CHRISTUS SWLA PSA (6.1%) is slightly higher than the rate of the CHRISTUS Health service area (5.9%) and slightly lower than Louisiana (6.6%) (Figure 16). Over the past decade, the region has generally seen a decline in the unemployment rate, up until the most recent reporting period. The recent increase is likely related to the COVID-19 pandemic. Table 7 explores each of these socio-economic indicators by parish for the service areas.

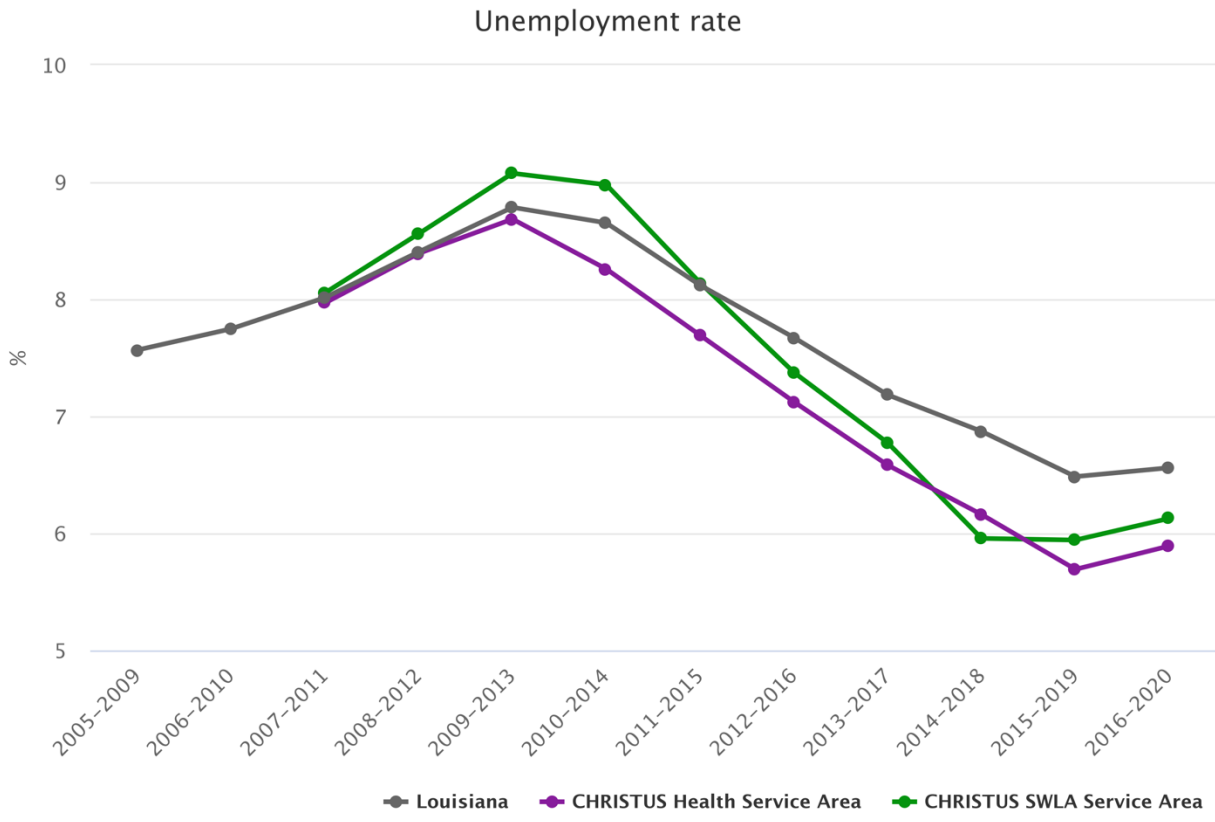


Figure 16. Unemployment Rate in the CHRISTUS SWLA PSA

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 SWLA PSA, the percentage is 9.0% compared to 10.3% in the whole CHRISTUS Health service area, and 9.8% in Louisiana (Figure 17).

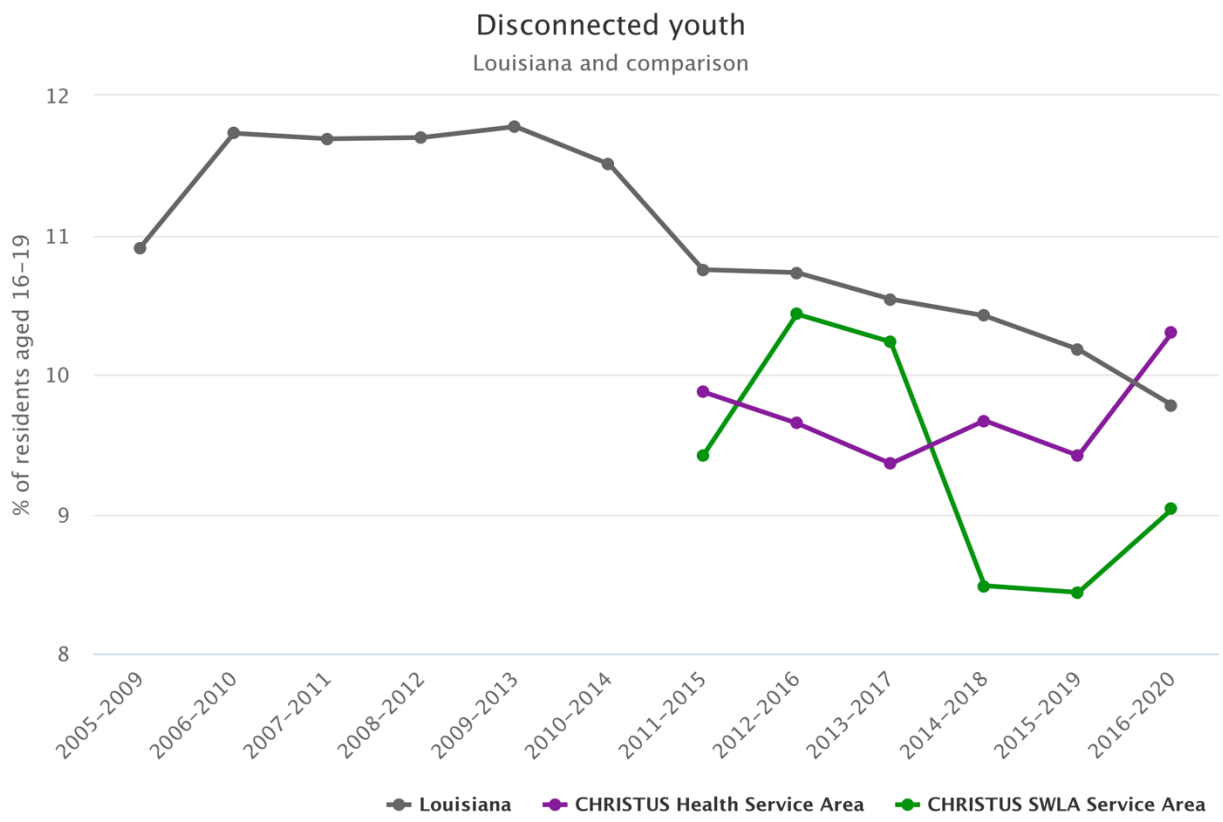


Figure 17. Disconnected Youth in the CHRISTUS SWLA PSA

Topic	Beauregard Parish, LA	Calcasieu Parish, LA
Hardship Index score, 2015 -2019	67.9	56.3
Poverty rate % of residents, 2016 -2020	13.81	16.74
Median household income 2016 -2020	$51,912	$55,716
Severely rent-burdened % of renter-occupied housing units, 2016 -2020	12.12	21.70
Unemployment rate %, 2016 -2020	7.85	5.85
Disconnected youth % of residentsaged 16-19, 2016 -2020	8.05	9.13

Table 7. Socio economic Indicators by Parish in the CHRISTUS SWLA PSA

Education

The high school graduation in the CHRISTUS SWLA PSA is 87.7%, which is slightly higher than the wider CHRISTUS Health service area and state averages (84.7% and 85.9%, respectively) (Figure 18). High school graduate rates have been on the rise in all benchmark regions since at least 2007.

Post-secondary education in the CHRISTUS SWLA PSA is about the same as the wider CHRISTUS service area and the state (Figure 19). For residents 25 or older with any post-secondary education, the higher degree graduation rate in the CHRISTUS SWLA PSA is 28.5% compared to 31.7% in the CHRISTUS Health service area and 28.1% in Louisiana. Table 8 provides additional education-related data for the service area parishes.

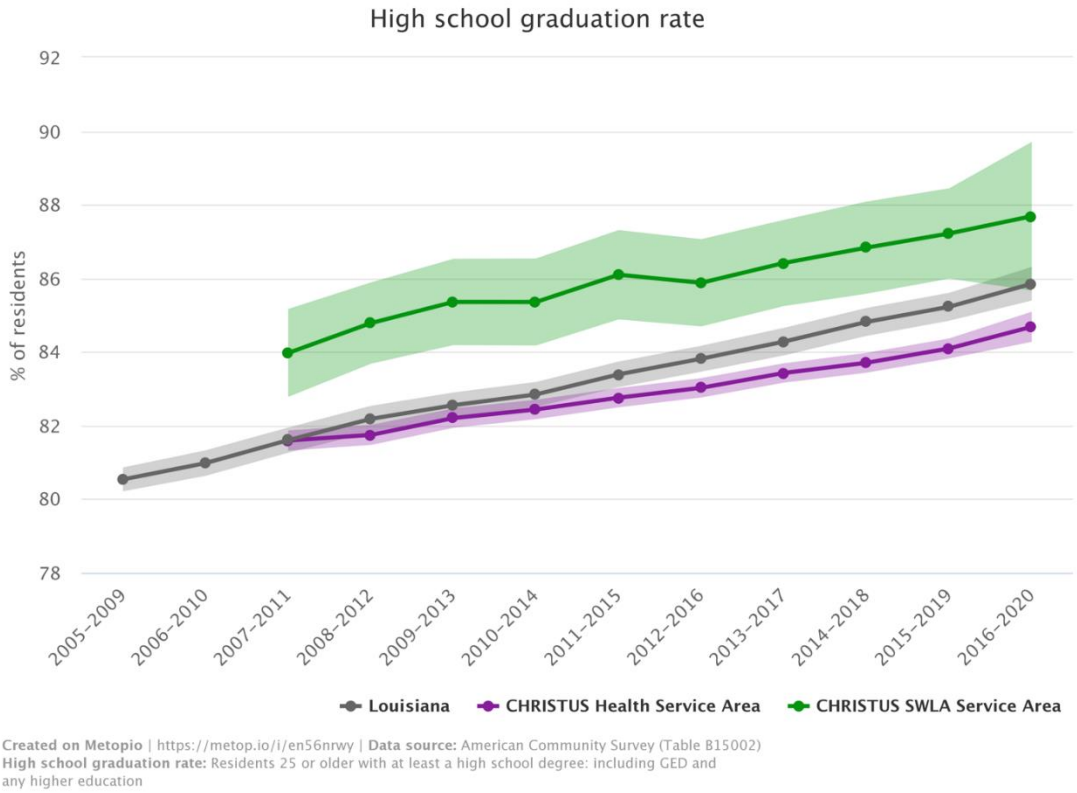


Figure 18. High School Graduation Rate in the CHRISTUS SWLA PSA

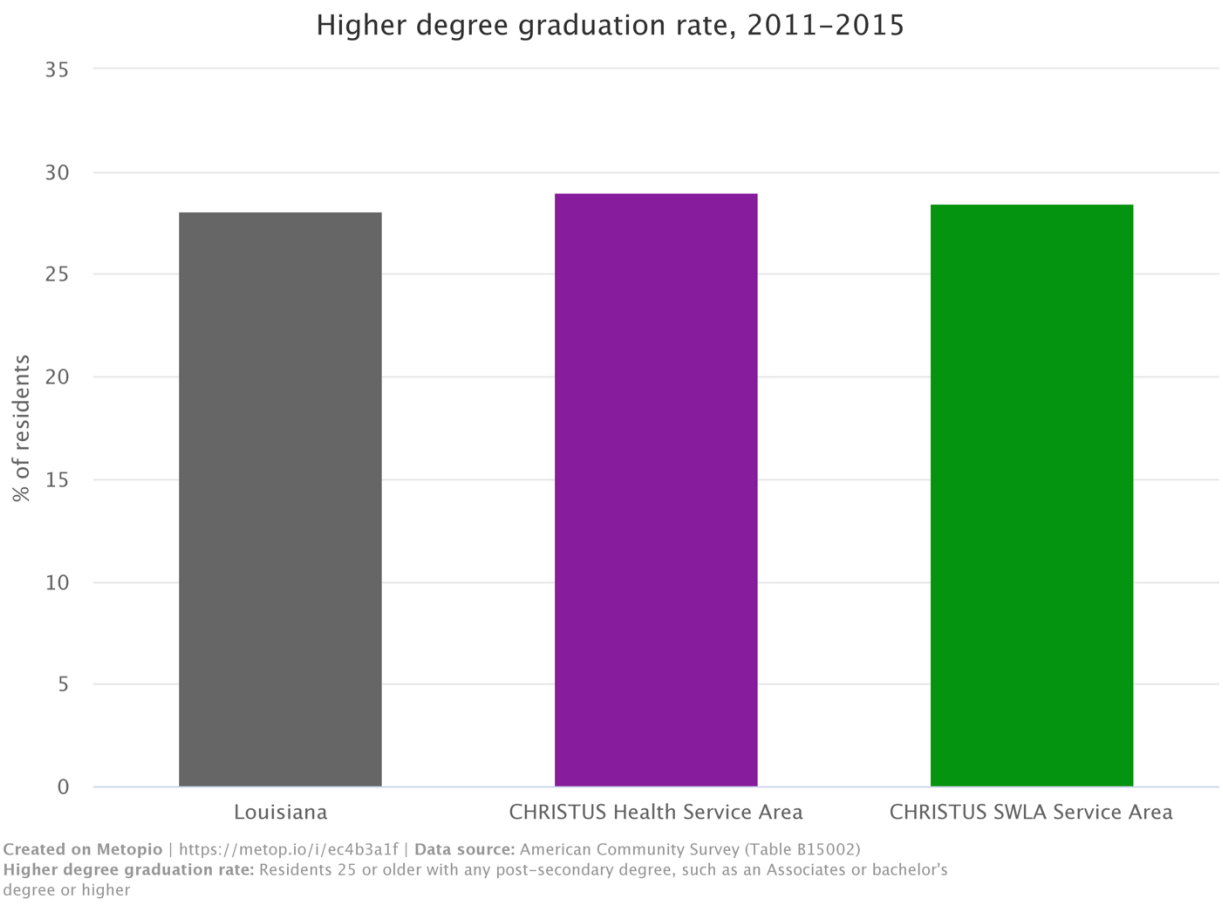


Figure 19. Higher Degree Graduation Rate in the CHRISTUS SWLA PSA

Topic	Beauregard Parish, LA	Calcasieu Parish, LA
Preschool enrollment Infants (0-4 years) % of toddlers, 2016-2020	37.06	44.56
Private school Juveniles (5-17 years) % of grade school students, 2016-2020	8.85	16.42
9th grade education rate % of residents, 2016-2020	95.66	96.58
High school graduation rate % of residents, 2016-2020	87.00	87.41
Higher degree graduation rate % of residents, 2016-2020	27.83	30.90
Graduate education rate % of residents, 2016-2020	6.17	7.38

Table 8. Education Indicators by Parish in the CHRISTUS SWLA 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 20). The uninsured rate in the CHRISTUS SWLA PSA (8.0%) and is much lower than the rate in the CHRISTUS Health service area (15.1%) and about the same as Louisiana (8.7%). Hispanic or Latino residents experience the highest uninsured rate of all racial/ethnic groups (21.2% in the PSA).

Many residents in the service area receive insurance through Medicaid programs. The percentage of residents covered by Medicaid in the CHRISTUS SWLA PSA (26.2%) is higher than full CHRISTUS Health service area (21.1%) and slightly lower than the state (27.2%) (Figure 21.)

"I am sure there are many organizations that provide assistance but how do I find them? Where do I go to get my elderly parents a ride to their doctor? They both use a walker but I can only fit one walker in my car. We need better coordination."

- Survey respondent

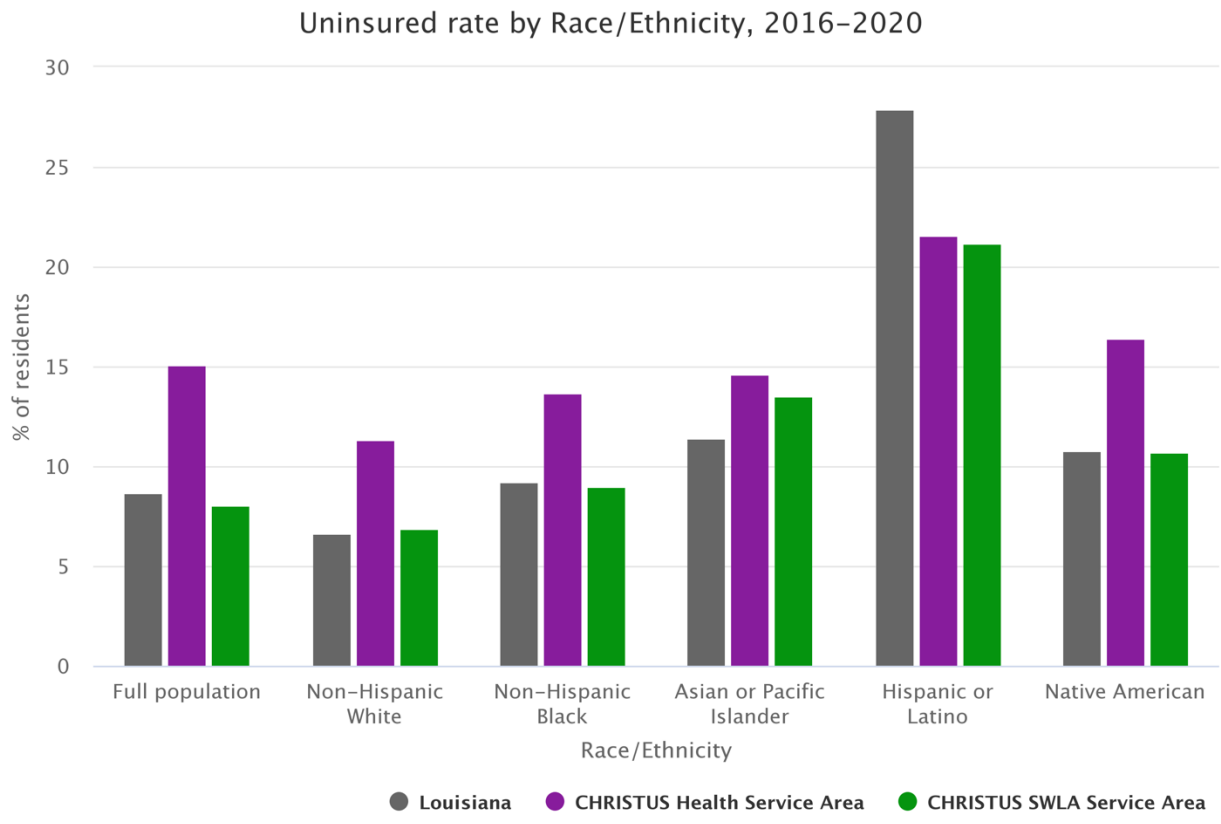


Figure 20. Uninsured Rate with Stratifications in the CHRISTUS SWLA PSA

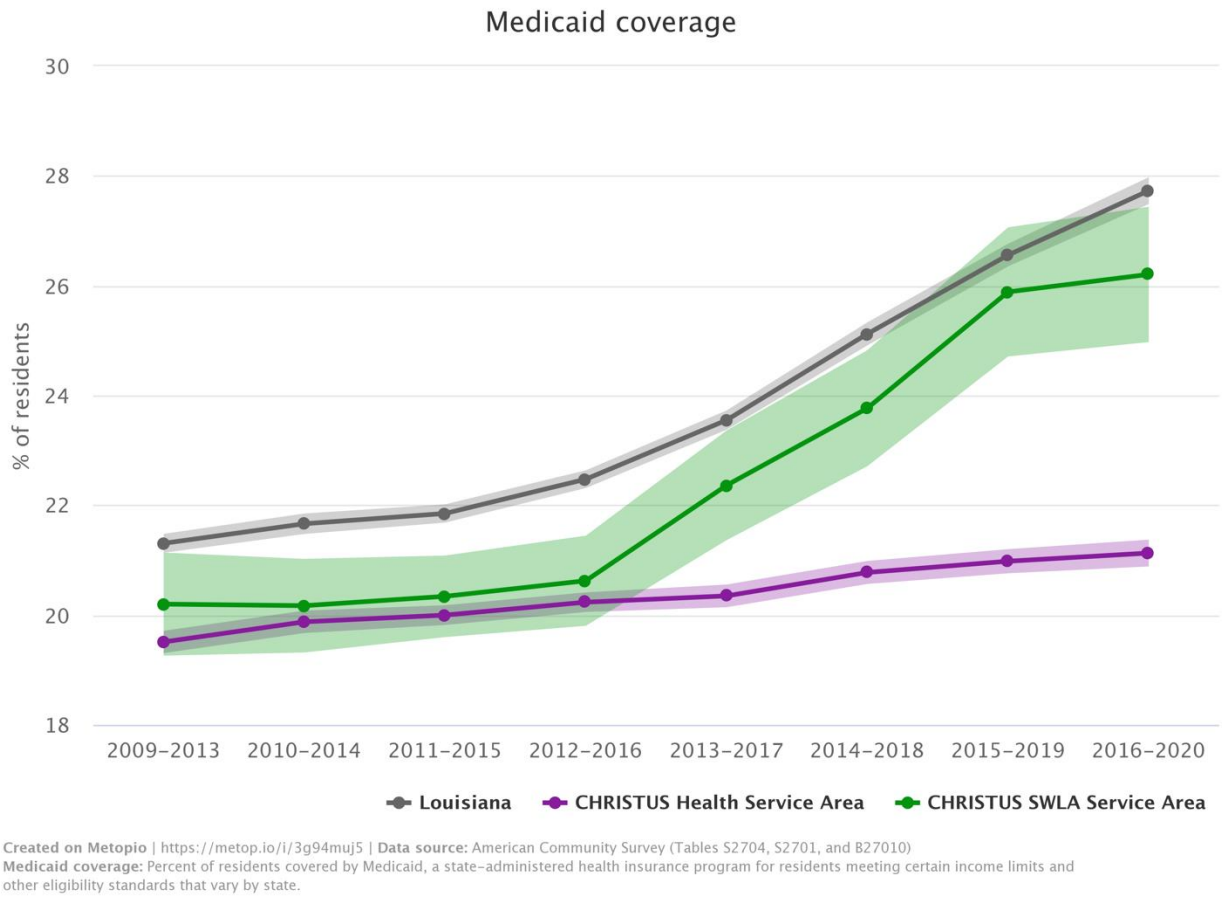


Figure 21. Medicaid Coverage in the CHRISTUS SWLA PSA

Mental health was raised as an issue through all channels of primary data collection. Figure 22 shows the percentage of adults in the PSA experiencing depression, which is over one-in-five for all benchmark regions. 24.8% of residents in the CHRISTUS SWLA PSA experiences depression. Survey participants noted a lack of access to providers, regardless of a person's insurance. The table below (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.

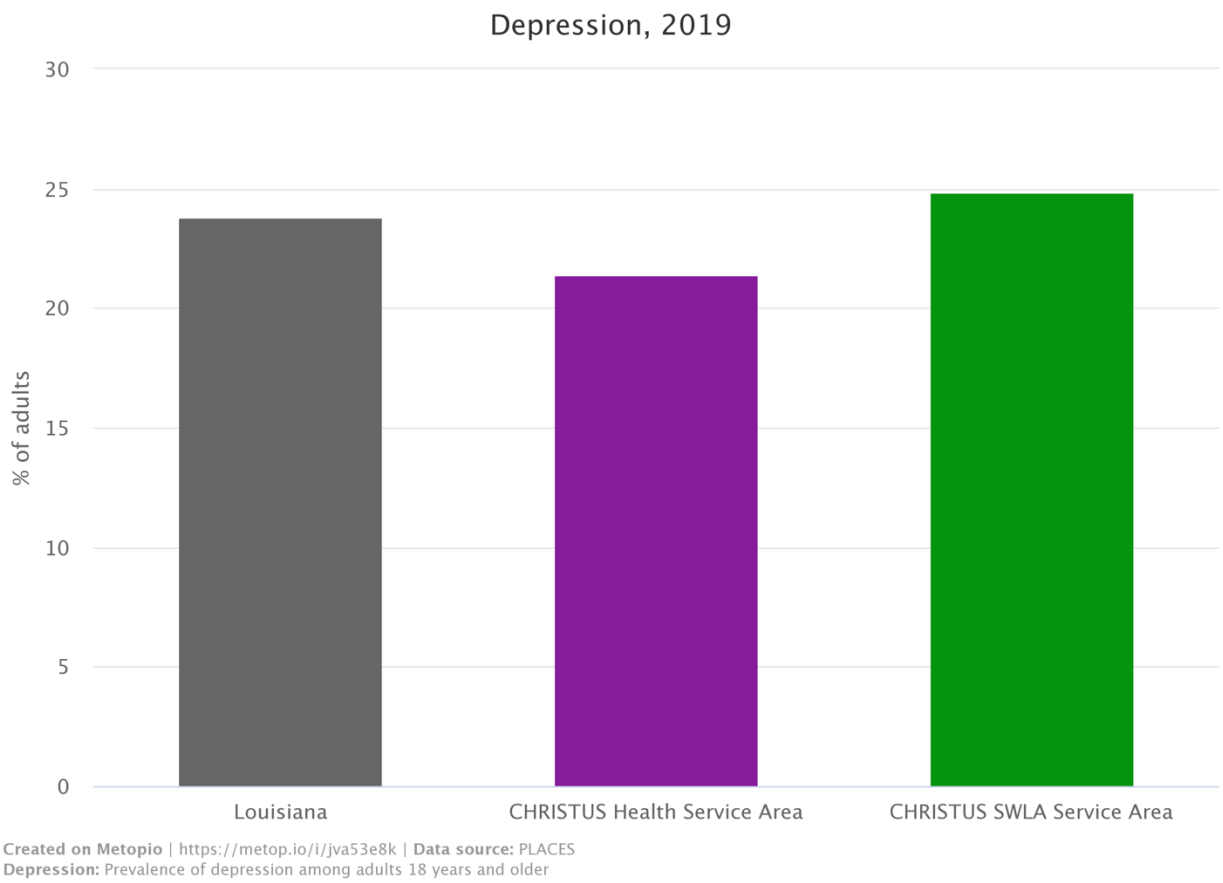


Figure 22. Percent of Adults with Depression in the CHRISTUS SWLA PSA

Topic	Beauregard Parish, LA	Calcasieu Parish, LA
Mental health providers per capita providersper 100,000 residents, 2021	69.0	331.0
Clinical social workers per capita physicians per 100,000 residents, 2021	7.92	36.16
Psychiatry physicians per capita physicians per 100,000 residents, 2021	0	14
Depression % of adults, 2019	25.50	24.20
Poor mental health days days per month, 2018	5.1	5.0
Drug overdose mortality deaths per 100,000 , 2016-2020	8.58	18.62
Poor self-reported mental health % of adults, 2019	18.60	18.30

Table 9. Access to Mental Health Providers in the CHRISTUS SWLA 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 23). Table 9 includes the number of FQHC locations/offices by parish along with other indicators that measure access to primary care including the per capita number of primary care physicians and nurse practitioners.

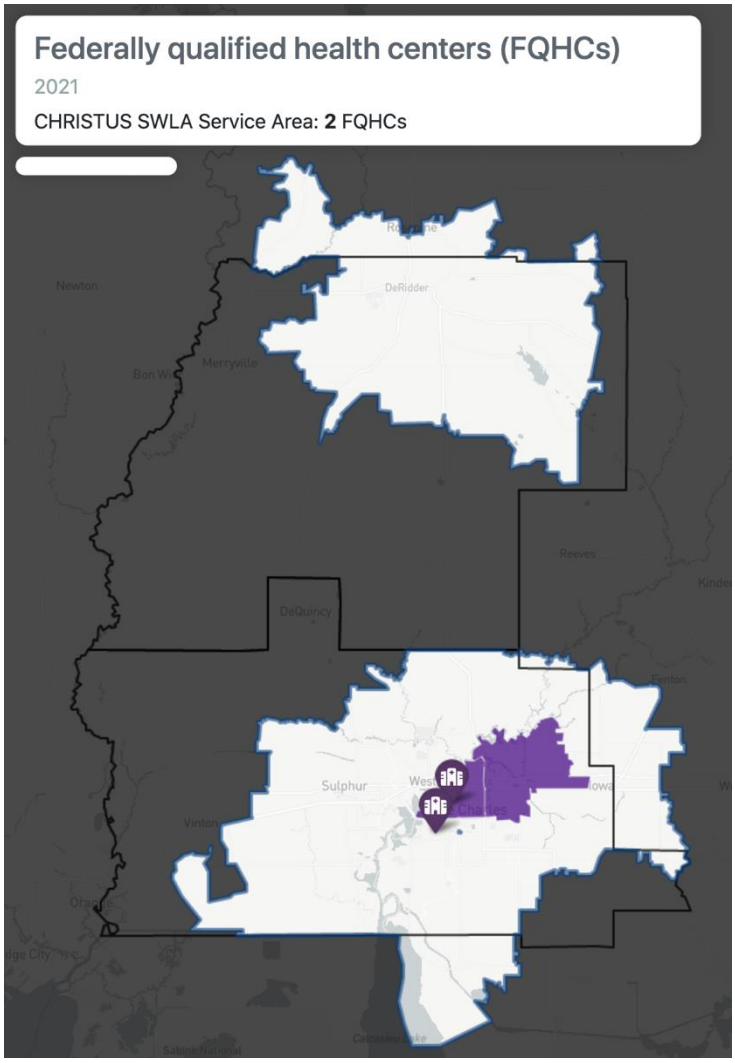


Figure 23. Map of FQHC locations in the CHRISTUS SWLA PSA

Topic	Beauregard Parish, LA	Calcasieu Parish, LA
Visited doctor for routine checkup % of adults, 2019	78.60	77.60
Primary care providers (PCP) per capita physicians per 100,000 residents, 2018	41.4	87.8
Nurse practitioner FTEs full-time equivalent, 2012	2.15	28.93
Federally qualified health centers (FQHCs)	1	2

Table 10. Primary Care Access Indicators by Parish in the CHRISTUS SWLA 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 12.6% of residents in the CHRISTUS SWLA service area 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 24 shows that the highest concentration of food desserts in the PSA are found in zip codes 70607 (24.6% of residents). In addition to food deserts, 20.0% of residents are considered food insecure (Figure 25) which is an indicator that incorporates both economic and social barriers to food access. Table 11 breaks out various indicators of food access by parishes in the service areas.

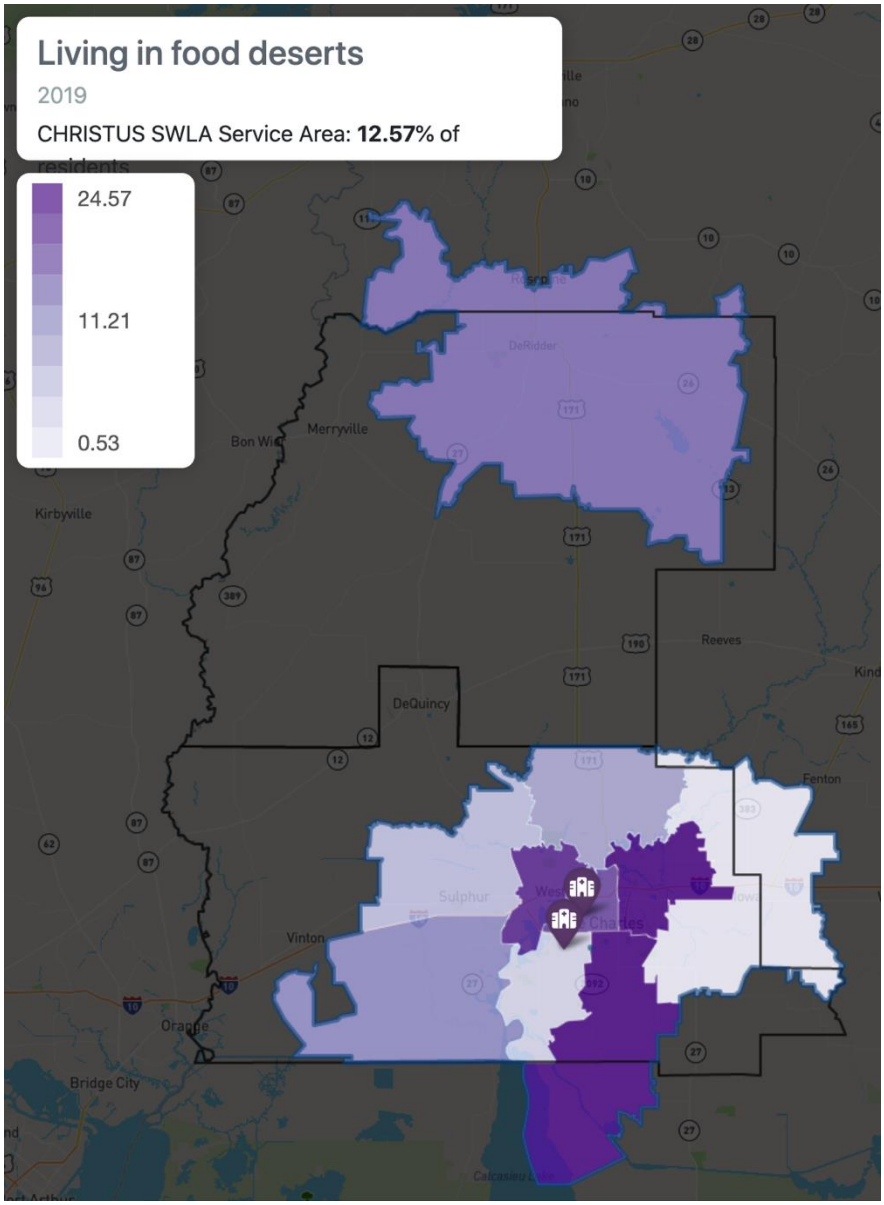
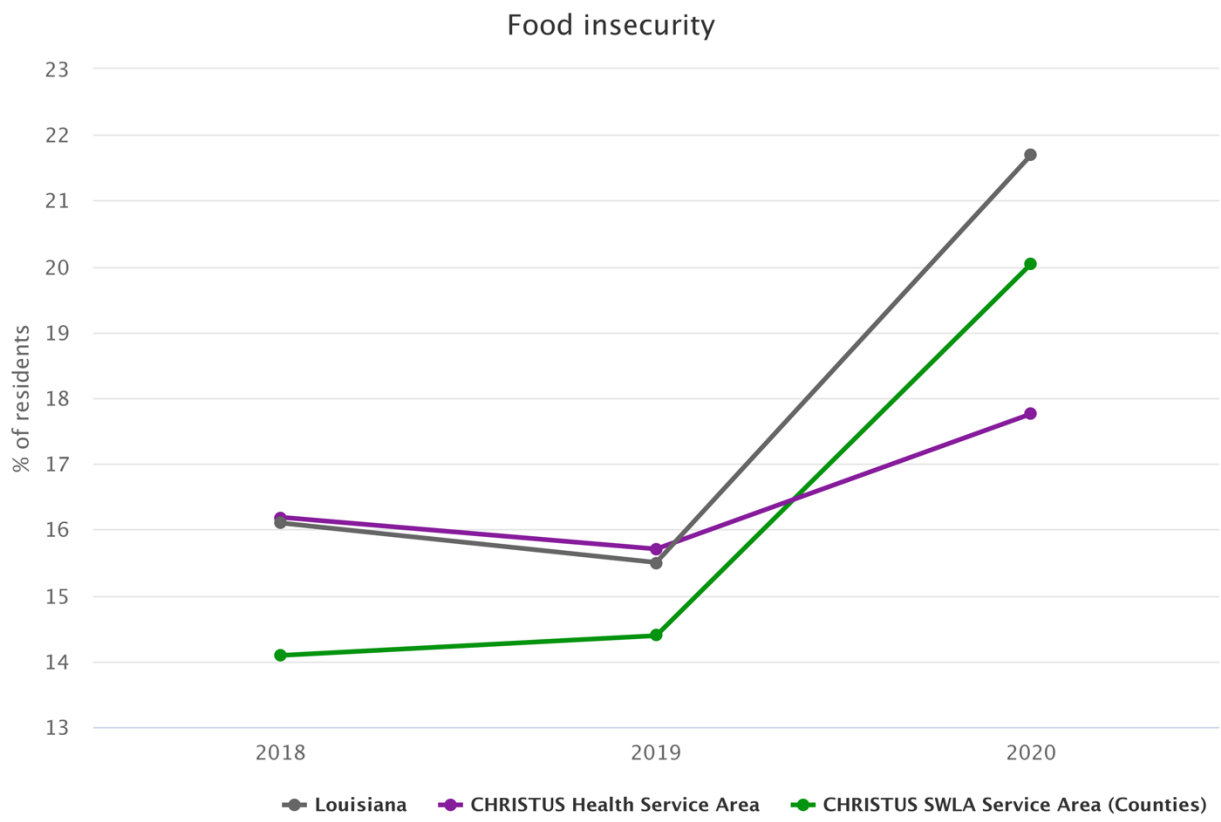


Figure 24. Map of Residents Living in Food Deserts in the CHRISTUS SWLA PSA



Created on Metopio | https://metop.io/i/y3nexq8i | **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 25. Percent of Residents who are Food Insecure in the CHRISTUS SWLA PSA

Topic	Beauregard Parish, LA	Calcasieu Parish, LA
Food insecurity % of residents, 2020	20.9	19.9
Low food access % of residents, 2019	72.37	66.48
Very low food access % of residents, 2019	26.76	33.54
Living in food deserts % of residents, 2019	9.14	12.86
Average cost per meal 2019	$3.10	$3.40

Table 11. Food Access Indicators by Parish in the CHRISTUS SWLA PSA

Violence and Community Safety

The rate of property crimes, which includes burglary, larceny, motor vehicle theft, and arson crimes is higher in CHRISTUS SWLA PSA than the rate in Louisiana and the United States overall (Figure 26). The rate of violent crime in the PSA is about the same as Louisiana, but still higher than the United States. Violent crime includes homicide, criminal sexual assault, robbery, aggravated assault, and aggravated battery (Figure 27). Table 12 shows specific crimes for each parish in the service areas.

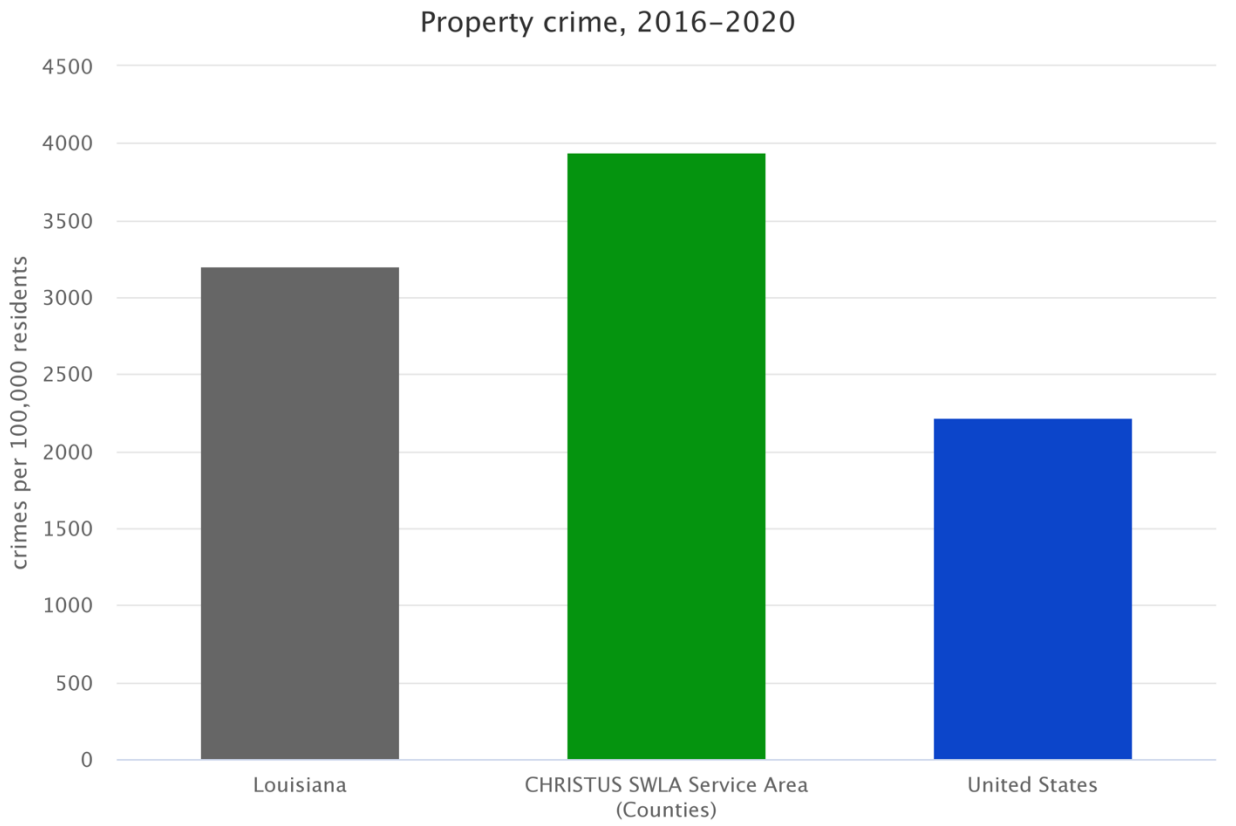


Figure 26. Property Crime Rate in the CHRISTUS SWLA PSA

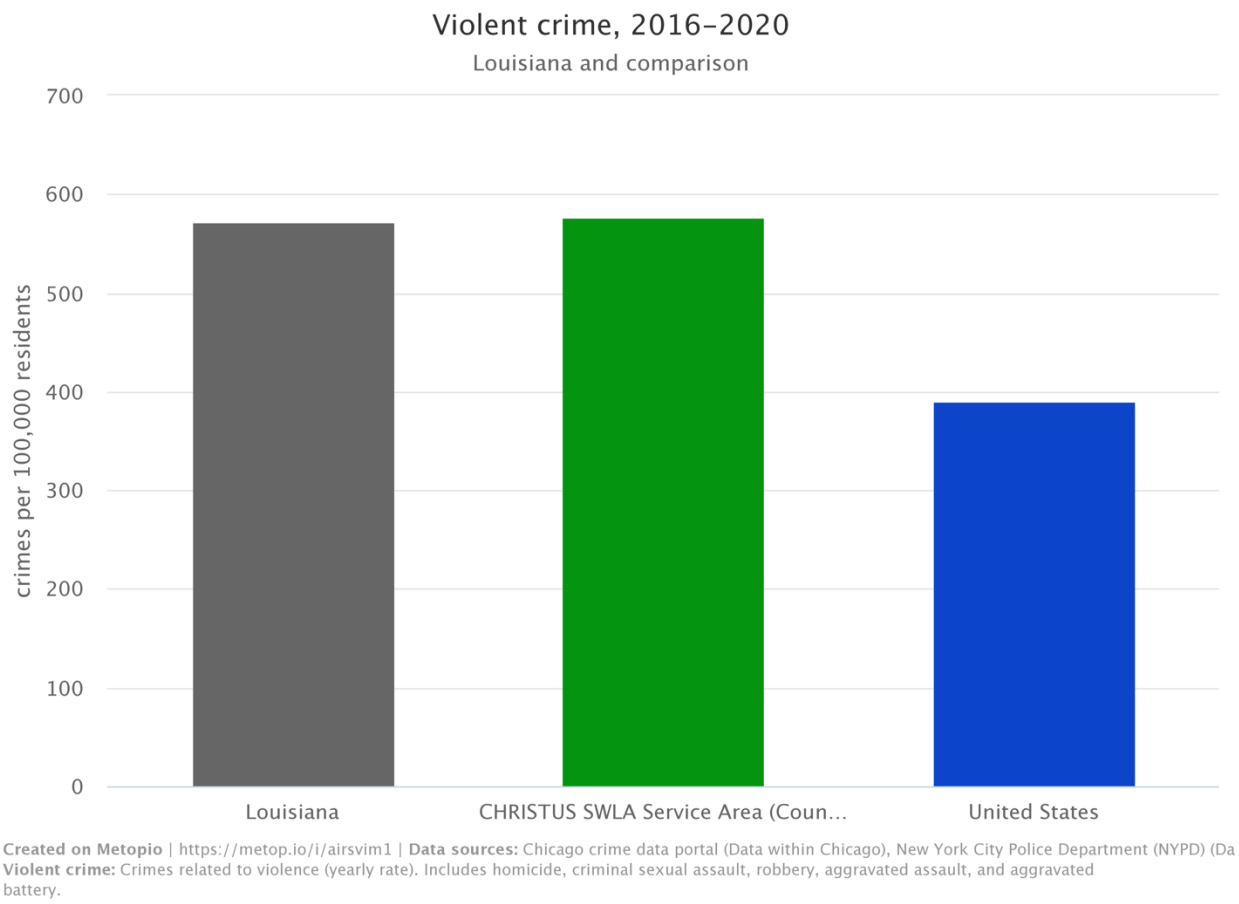


Figure 27. Violent Crime Rate in the CHRISTUS SWLA PSA

Topic	Beauregard Parish, LA	Calcasieu Parish, LA
Burglary crimes per 100,000 residents, 2020	275.8	1,130.8
Homicide crimes per 100,000 residents, 2020	8.3	9.7
Arson crimes per 100,000 residents, 2020	13.8	6.6
Property crime crimes per 100,000 residents, 2020	1,185.9	4,001.8
Violent crime crimes per 100,000 residents, 2020	179.3	829.6

Table 12. Types of Crime by Parish in the CHRISTUS SWLA PSA

HEALTH DATA ANALYSIS

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 SWLA PSA than in the full CHRISTUS Health service area and Louisiana as illustrated below in Figure 28. Additionally, more than 1 in 10 adults has diabetes in the CHRISTUS SWLA service area (Figure 29). The rate of diabetes in the PSA is the same as the roll up of all CHRISTUS Health service areas and slightly higher than the rate in Louisiana. Chronic kidney disease affects 3.1% of adults in the CHRISTUS SWLA PSA, which is below both benchmarks (Figure 30). Lastly, about 10.0% of the population lives with asthma in the CHRISTUS SWLA PSA, which is just above the average in the CHRISTUS Health service area and in the state (Figure 31). The following charts and line graphs illustrate these disease conditions.

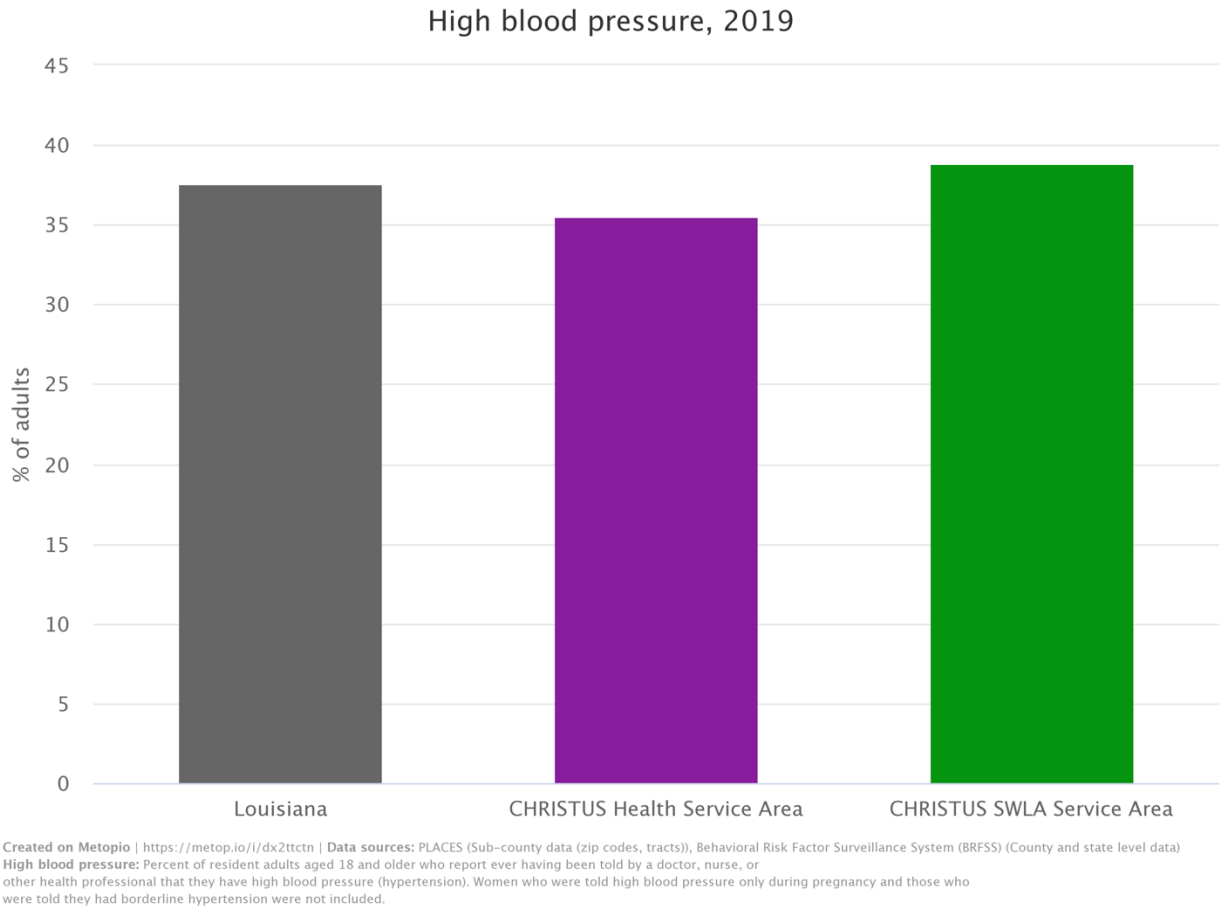


Figure 28. High Blood Pressure in the CHRISTUS SWLA PSA

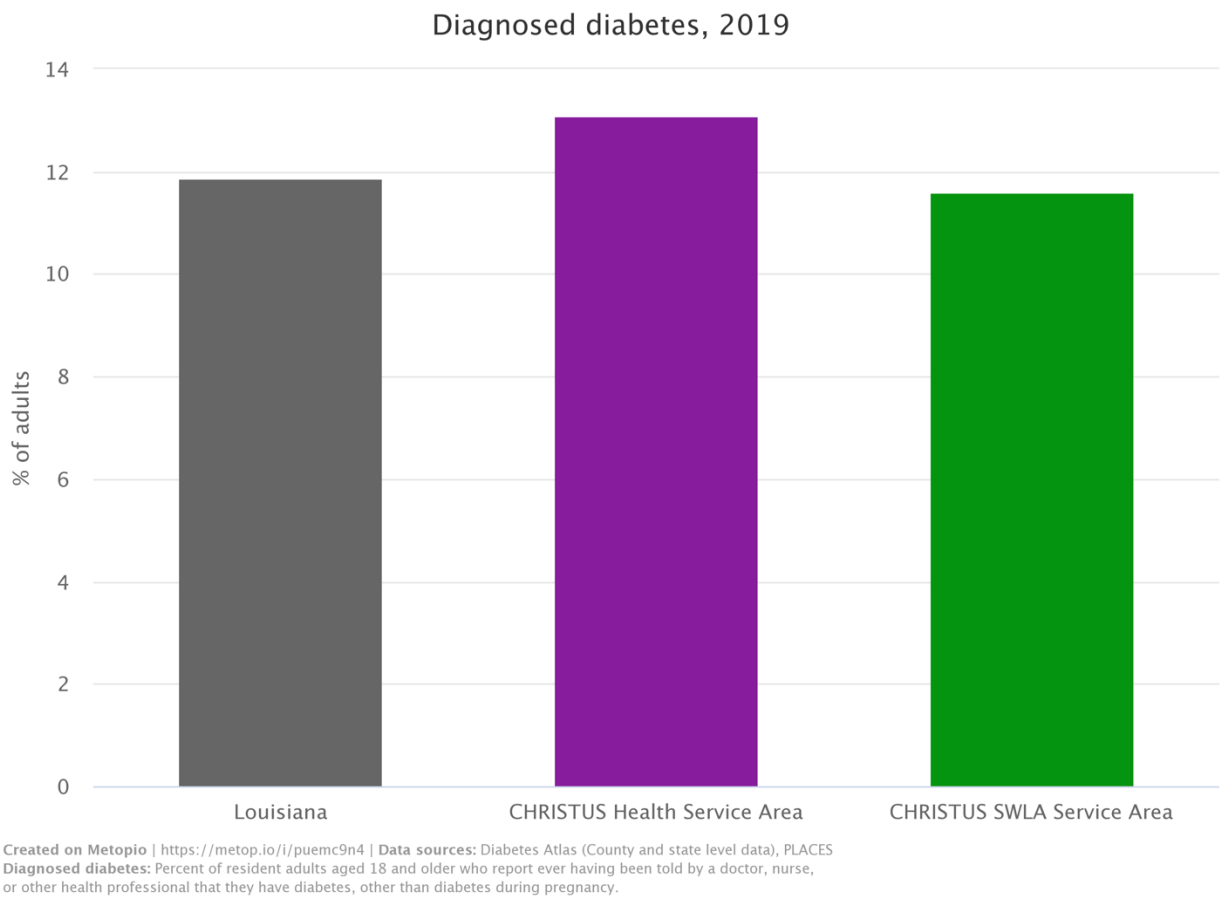


Figure 29. Diagnosed Diabetes in the CHRISTUS SWLA PSA

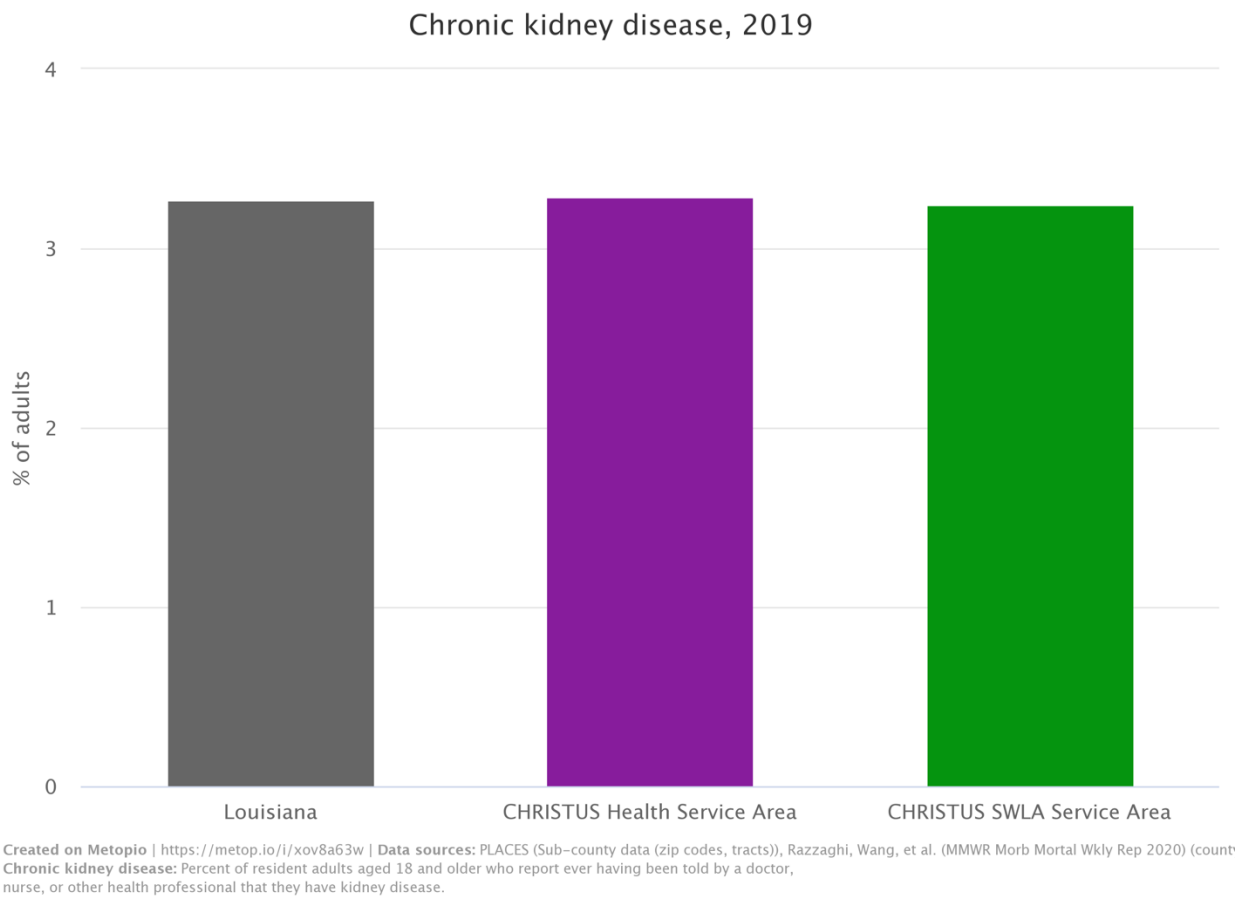


Figure 30. Chronic Kidney Disease in the CHRISTUS SWLA PSA

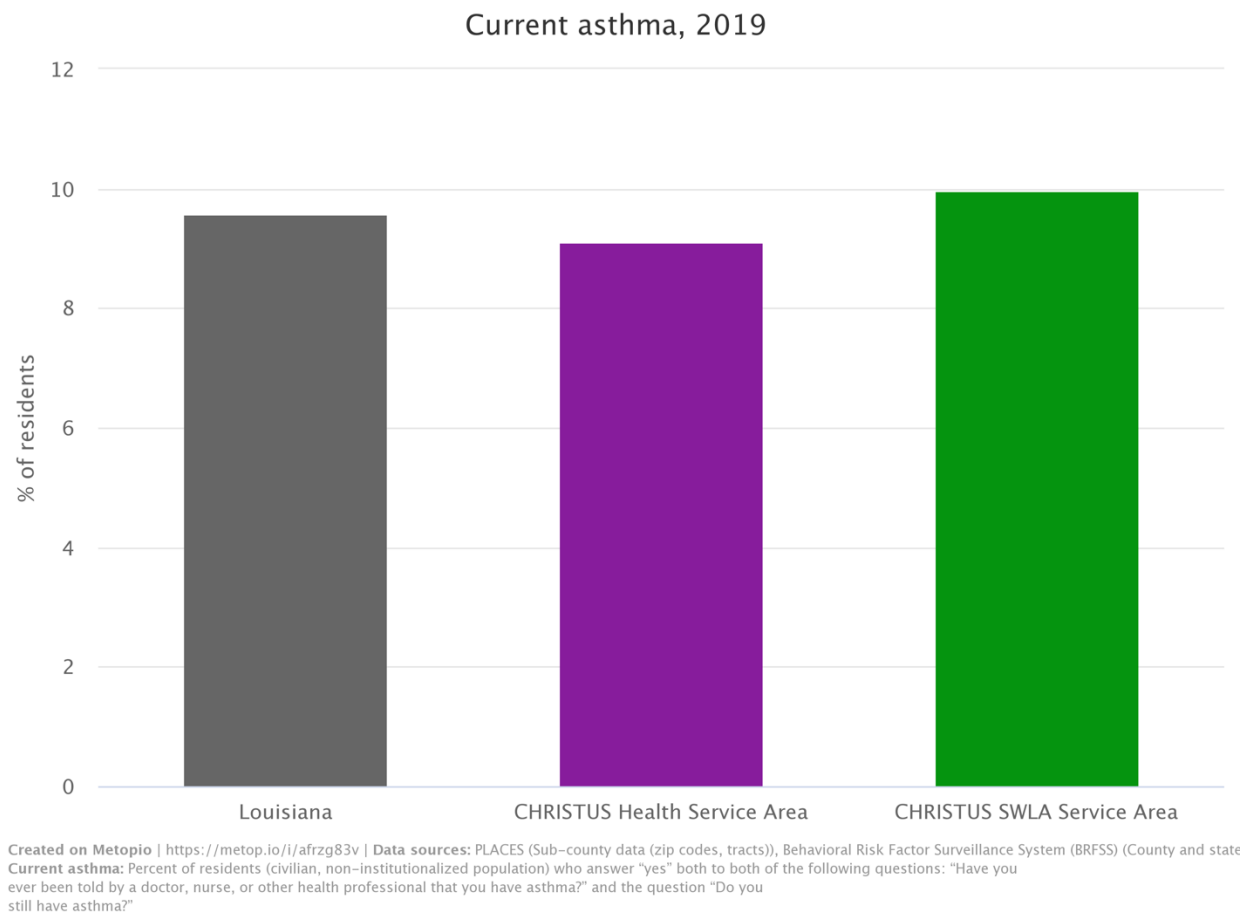


Figure 31. Residents with Asthma in the CHRISTUS SWLA PSA

Table 13 provides additional insight into the burden of chronic diseases by each parish in the CHRISTUS SWLA PSA.

Topic	Beauregard Parish, LA	Calcasieu Parish, LA
High blood pressure % of adults, 2019	35.70	38.10
Diagnosed diabetes % of adults, 2019	10.7	11.1
Coronary heart disease % of adults, 2019	6.50	6.20
Chronic kidney disease % of adults, 2019	3.0	3.1
Current asthma % of residents, 2019	9.40	9.80
Obesity % of adults, 2019	37.5	37.5

Table 13. Chronic Disease indicators by Parish in the CHRISTUS SWLA PSA

Maternal Health

The rate of preterm births in the service area (16.8% of live births) is lower than that in the state (17.4%) and higher than the rate in the United States (11.7%) (Figure 32). Within the PSA, there is some disparity among racial and ethnic groups. Non-Hispanic Black People experience higher preterm birth rates (20.6%) than any other group.

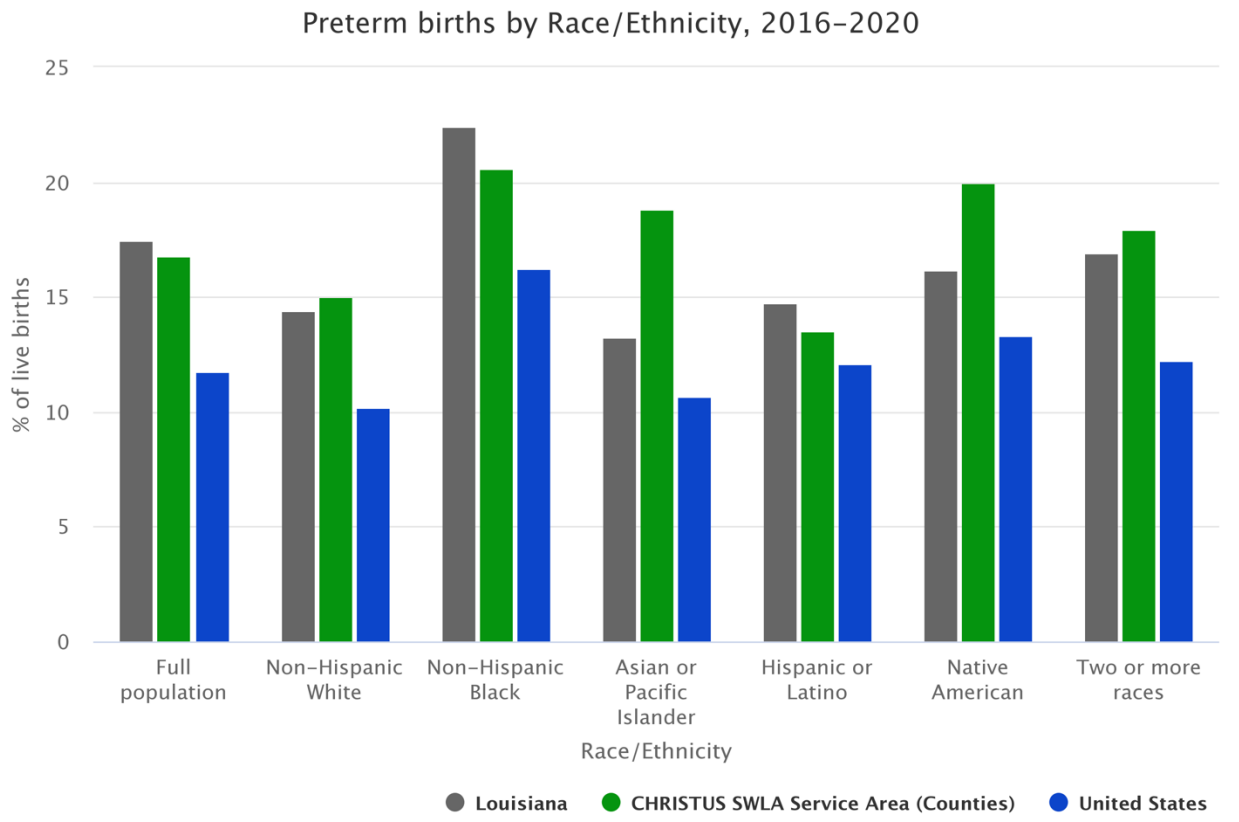
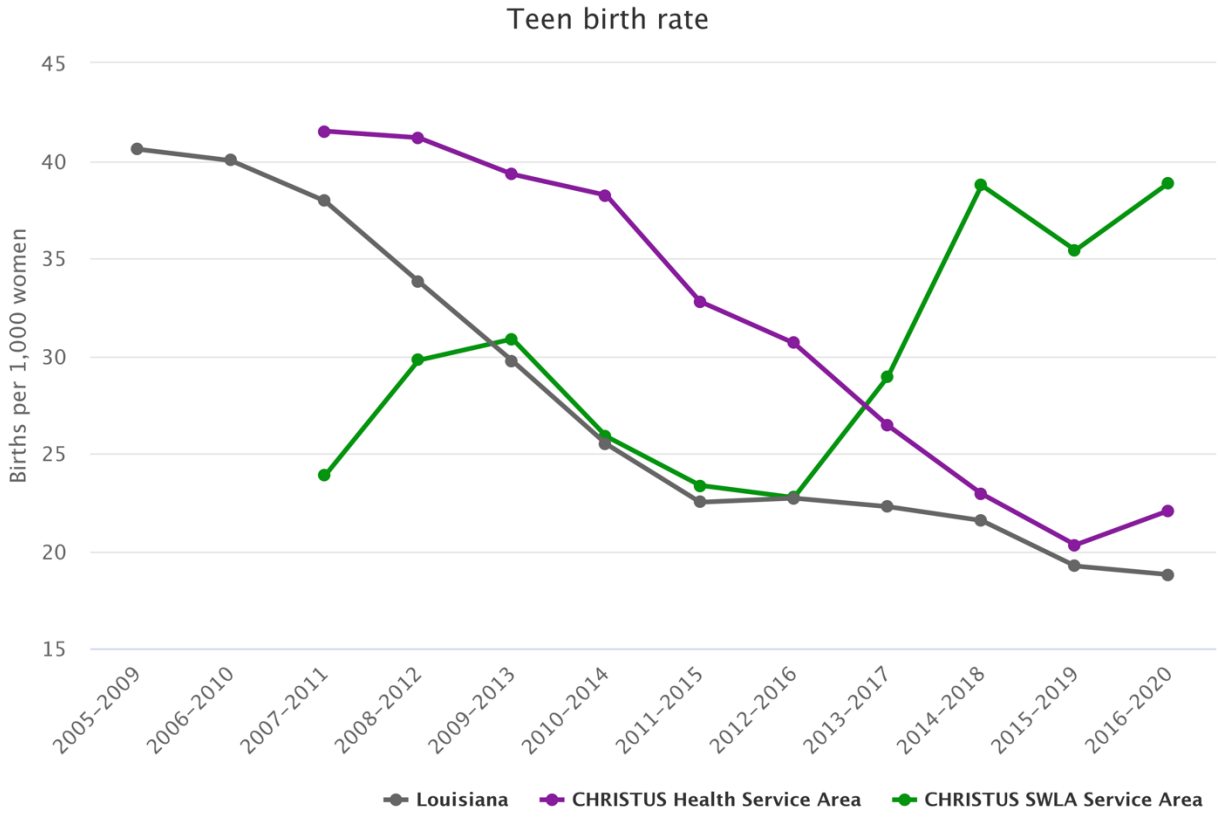


Figure 32. Percent of Births that are Preterm in the CHRISTUS SWLA PSA

The teen birth rate has generally been declining over the last decade in the CHRISTUS Health service area and the state, but in the most recent reporting periods, the teen birth rate has increased in the whole CHRISTUS Health service area and the CHRISTUS SWLA Service Area. The most recent reported data shows that the current teen birth rate in the CHRISTUS SWLA PSA (38.9 births per 1,000 women) is much higher than both the whole CHRISTUS Health service area (22.1 births) and Louisiana (18.8 births) (Figure 33). Within the PSA, the rate of births with at least one maternal risk factor (20.3% of births) is lower than the rate in both Louisiana (24.8%) and the United States (21.0%) (Figure 34).



Created on Metopio | https://metop.io/i/5iu45mv8 | **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 33. Teen Birth Rate in the CHRISTUS SWLA PSA

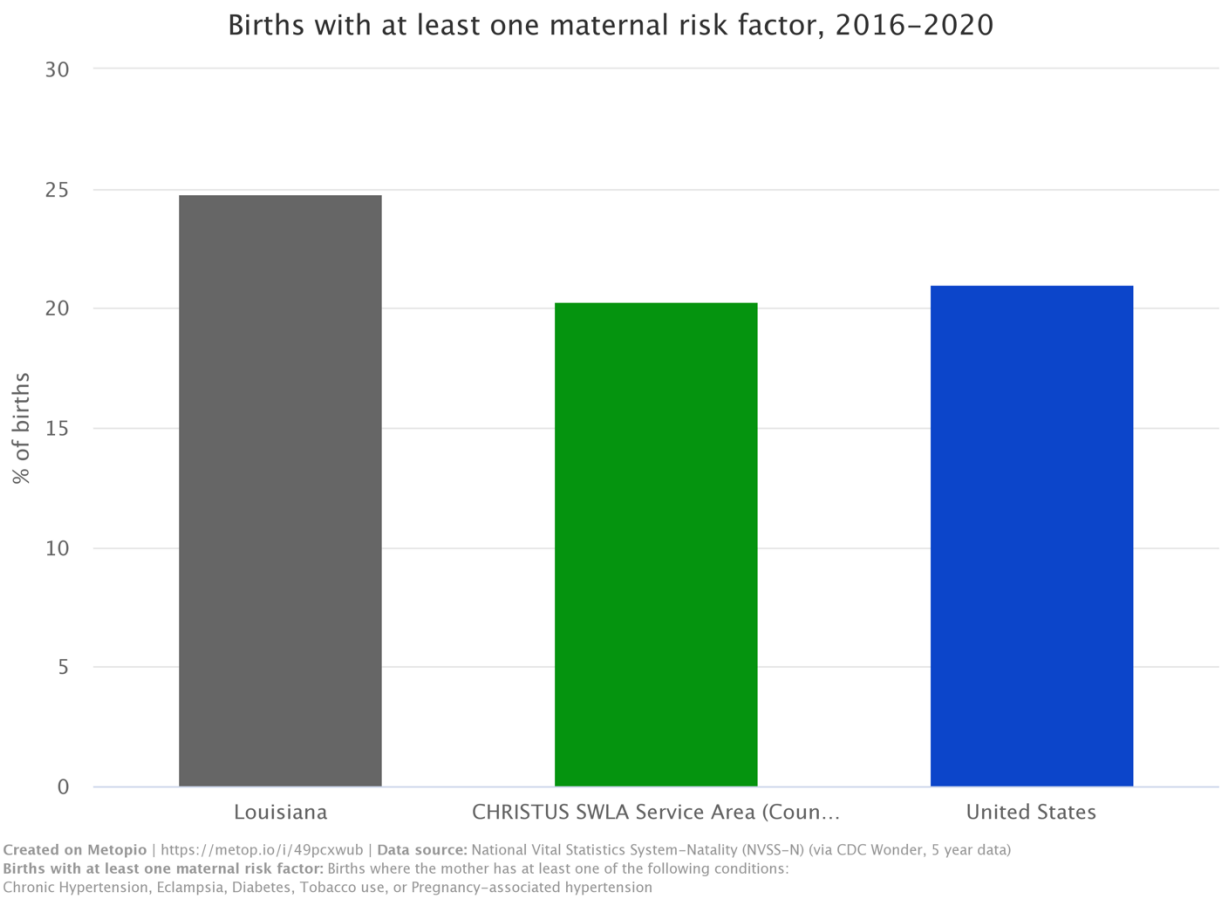


Figure 34. Births with At Least One Maternal Risk Factor in CHRISTUS SWLA PSA

Leading Causes of Death

The top causes of death for service area as a whole can be found in Table 13. 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 SWLA Service Area (Counties)	Louisiana	United States
Heart disease mortality deaths per 100,000 , 2016-2020	297.1	213.8	164.8
Cancer mortality deaths per 100,000 , 2016-2020	182.9	168.7	149.4
Injury mortality deaths per 100,000 , 2016-2020	84.7	95.8	72.6
Stroke mortality deaths per 100,000 , 2016-2020	62.8	46.2	37.6
Septicemia (sepsis) mortality deaths per 100,000 , 2016-2020	26.7	20.0	10.1
Alzheimer's disease mortality deaths per 100,000 , 2016-2020	22.8	43.6	30.8
Chronic lower respiratory disease mortality deaths per 100,000 , 2016-2020	20.2	42.5	39.1
Drug overdose mortality deaths per 100,000 , 2016-2020	17.17	28.51	22.43
Diabetes mortality deaths per 100,000 , 2016-2020	13.9	27.2	22.1
Influenza and pneumonia mortality deaths per 100,000 , 2016-2020	12.8	14.2	13.6

Table 14. Leading Causes of Death in the CHRISTUS SWLA PSA

Heart Disease

Coronary heart disease makes up the largest contributor to the heart disease mortality rate, accounting for 121.1 deaths per 100,000 out of the total 297.1 per 100,000 deaths for heart disease overall in the CHRISTUS SWLA PSA. Heart disease does not impact each racial/ethnic group equally. Non-Hispanic Black people experience the highest rates of heart disease mortality (355.7 deaths per 100,000 deaths). This rate is significantly higher than all other racial groups and all other regions. There is insufficient data for the Hispanic or Latino, Asian or Pacific Islander, and Native American populations in the CHRISTUS SWLA PSA to present here (Figure 35).

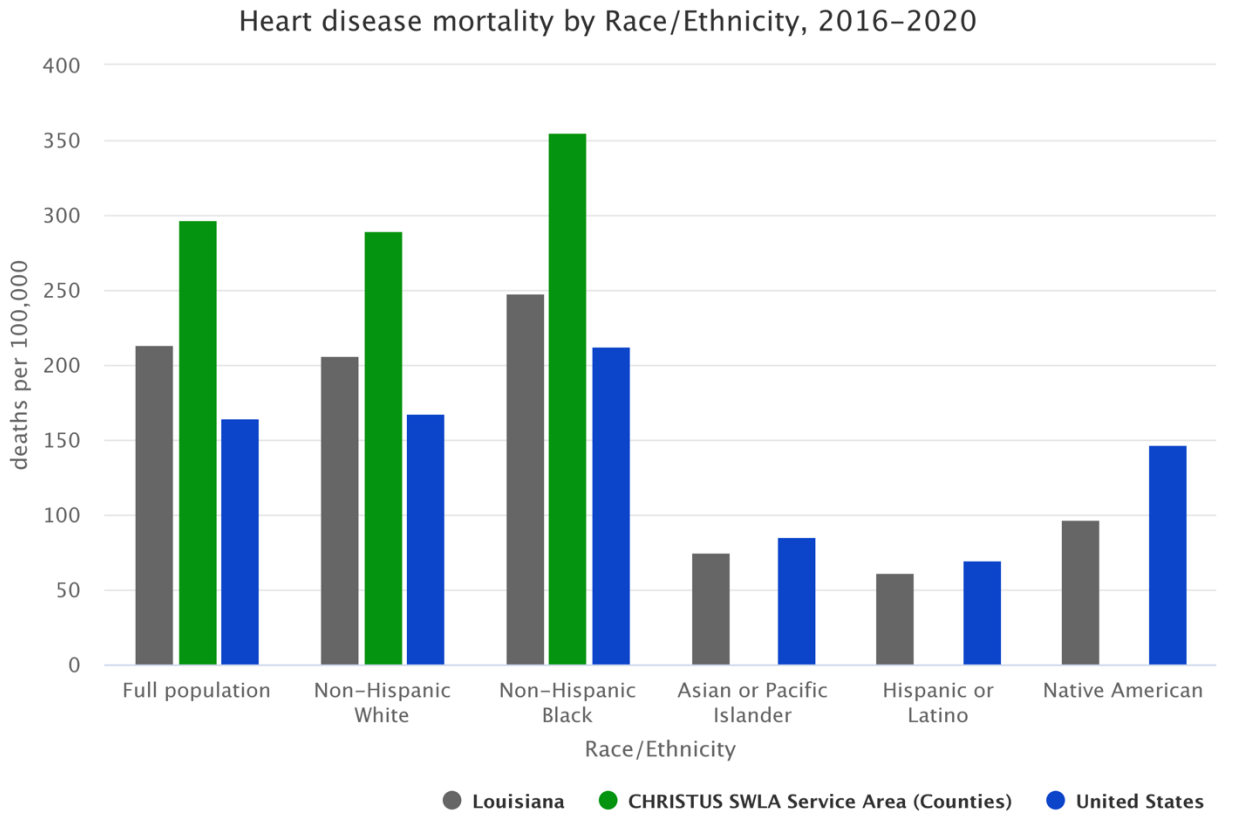


Figure 35. Heart Disease Mortality with Stratifications in the CHRISTUS SWLA PSA

Cancer

Cancer represents the second leading cause of death in the PSAs, causing 182.9 deaths per 100,000 in the PSA. This rate is higher than both the state and country (Figure 36). Lung, trachea, and bronchus cancer, in particular, make up a large portion of cancer deaths, causing 49.6 deaths per 100,000 deaths in the CHRISTUS SWLA PSA. Table 15 breaks out the mortality rate for some cancers.

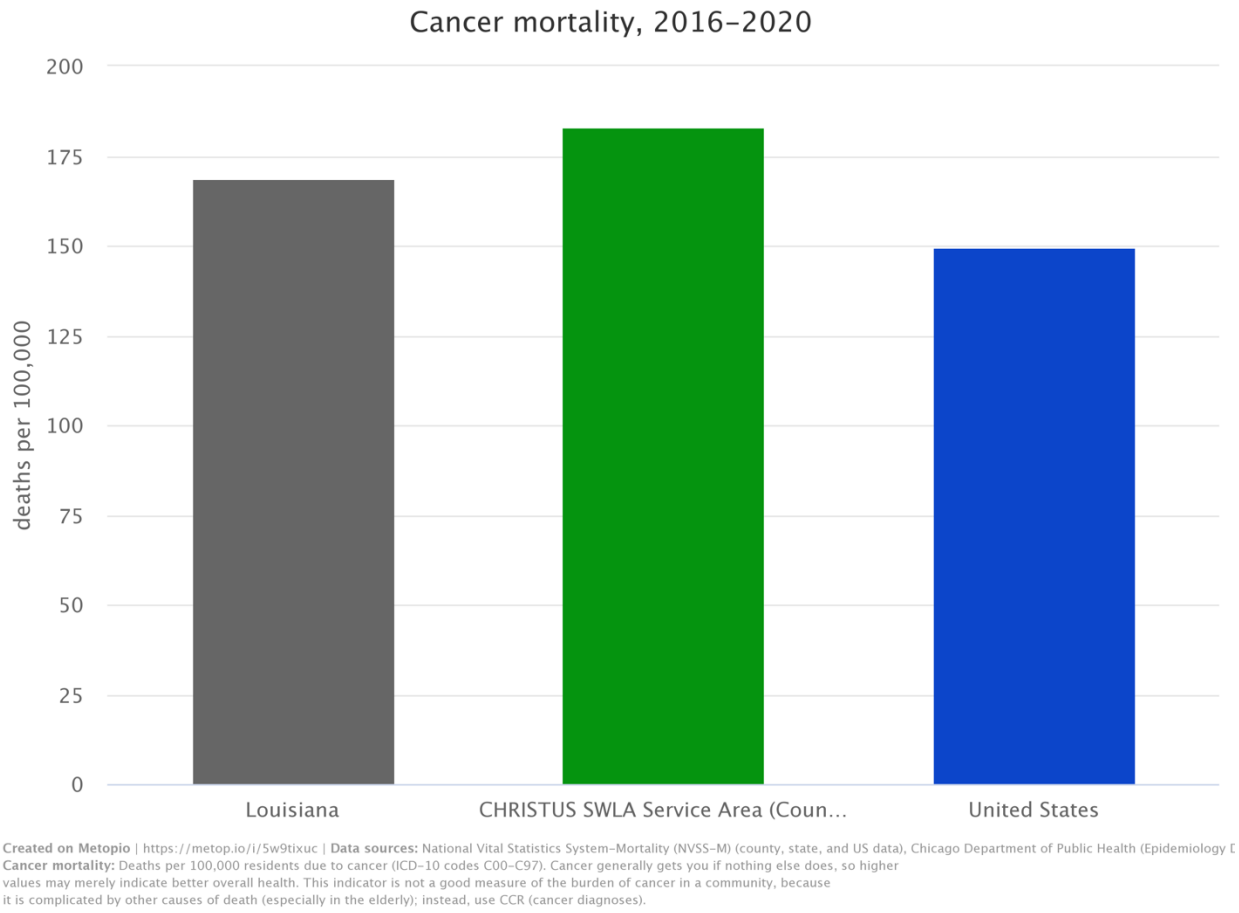


Figure 36. Cancer Mortality Rate with Stratifications in CHRISTUS SWLA PSA

Topic	Beauregard Parish, LA	Calcasieu Parish, LA
Breast cancer mortality deaths per 100,000 , 2016 -2020	12.0	13.0
Colorectal cancer mortality deaths per 100,000 , 2016 -2020	19.4	16.8
Lung, trachea, and bronchus cancer mortality deaths per 100,000 , 2016 -2020	66.8	46.7

Table 15. Cancer Indicators by Parish in the CHRISTUS SWLA PSA

Environmental factors may contribute to the lung cancer burden in the service area. 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 because of inhaling carcinogenic compounds in the environment, per million people. The Lifetime Inhalation Cancer Risk in the CHRISTUS SWLA PSA (49.8 lifetime risk per million) is higher than both the CHRISTUS Health service area (35.0) and the overall risk in Louisiana (43.0) (Figure 37).

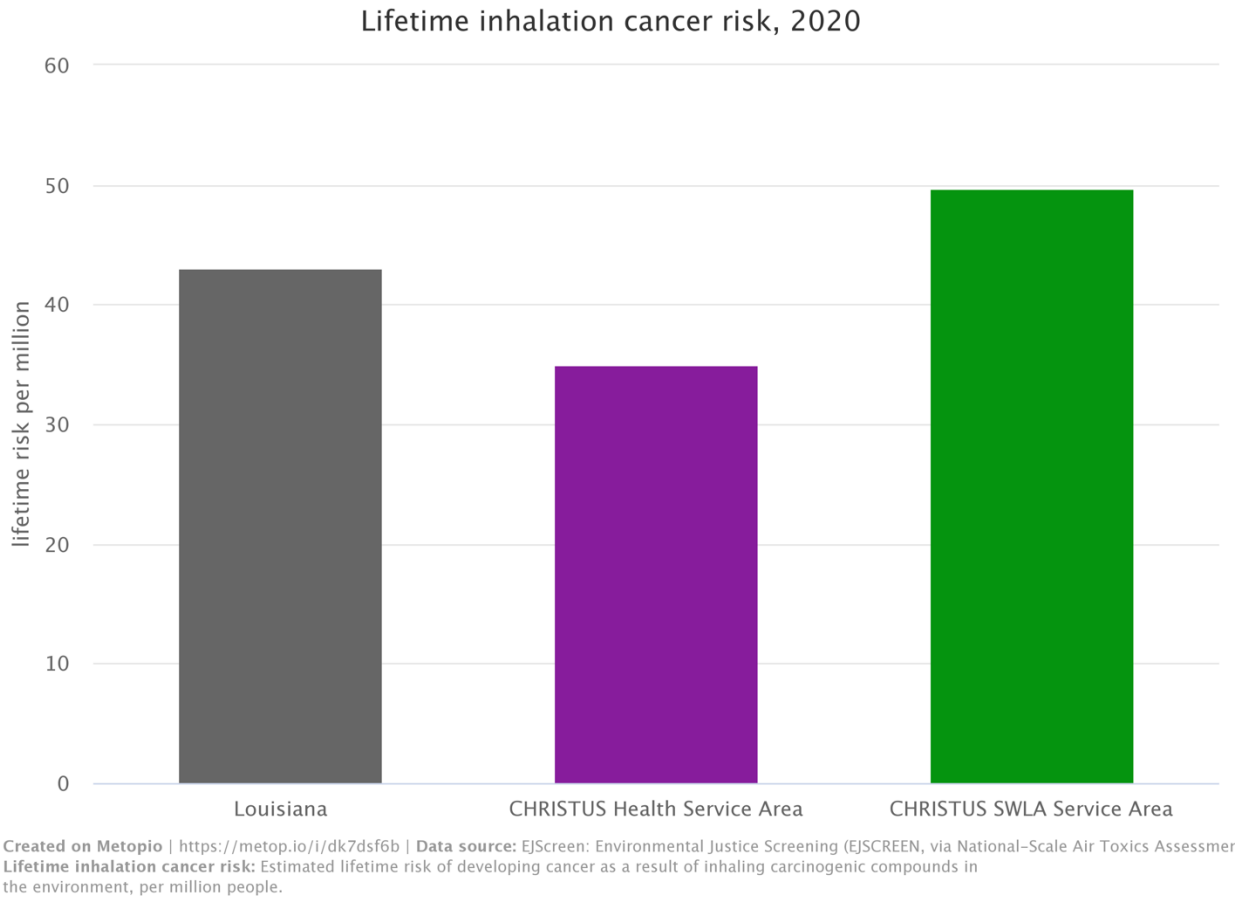


Figure 37. Lifetime Inhalation Cancer Risk in CHRISTUS SWLA PSA

Injury

Injuries account for the third highest cause of death in the 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 in the CHRISTUS SWLA PSA (84.7 deaths per 100,000) is lower than the rate in Louisiana overall (95.8) and higher than the rate in the United States (72.6) (Figure 38).

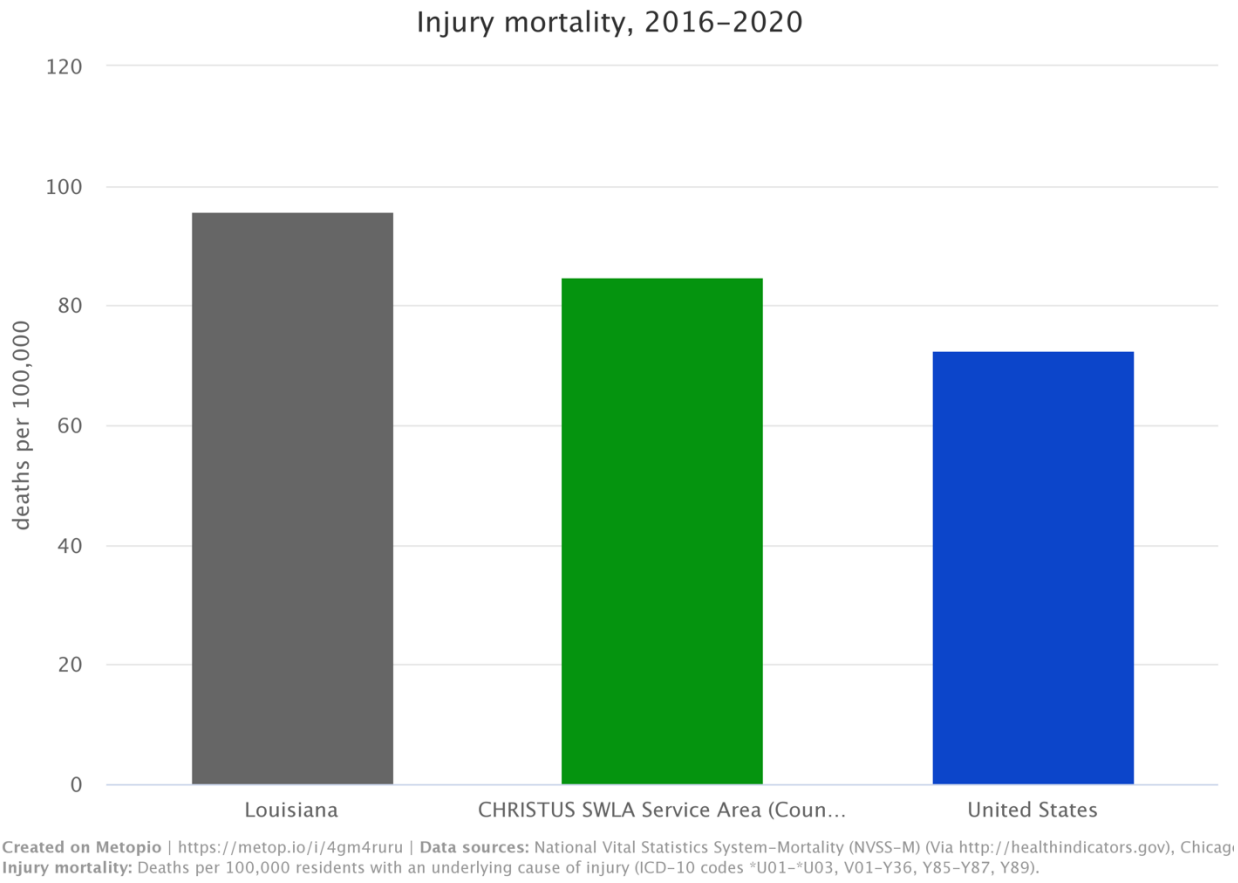


Figure 38. Injury Mortality Rate with Stratifications in the CHRISTUS SWLA PSA

Stroke

The mortality rate for stroke is higher than both benchmarks for the full population the CHRISTUS SWLA PSA (62.8 deaths per 100,000) (Figure 39). When this data is stratified by race, non-Hispanic Black residents experience a much greater stroke mortality rate (98.8) than any other racial/ethnic group or region. There is insufficient data for the Asian or Pacific Islander, Hispanic or Latino, or Native American populations.

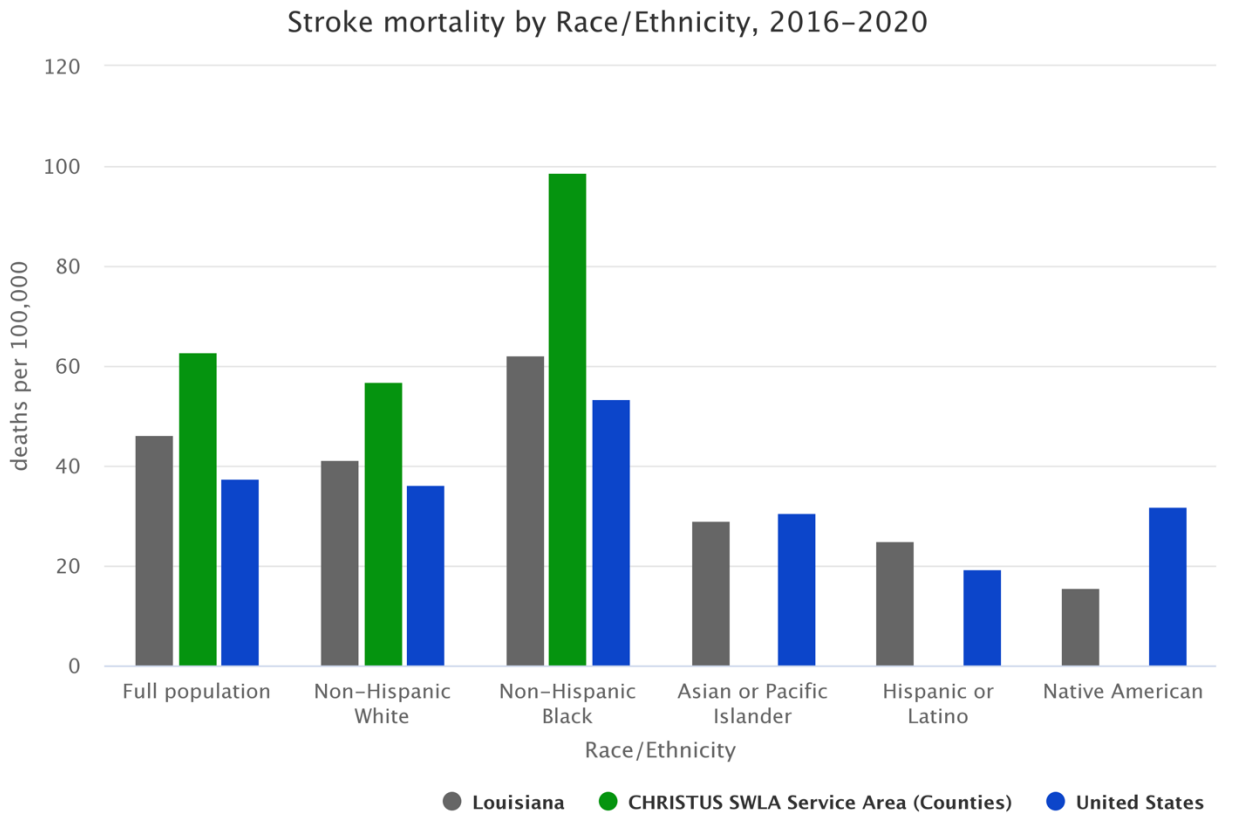


Figure 39. Stroke Mortality Rate with Stratifications in the CHRISTUS SWLA PSA

Sepsis

Sepsis mortality is the 5th leading cause of death in the CHRISTUS SWLA PSA. This disease is caused by untreated bacterial, fungal, parasitic, or viral infections and is preventable through prompt access to health services. The sepsis mortality rate in the PSA (26.7 deaths per 100,000) is much higher than that of the state (20.0 deaths) and the country overall (10.1 deaths). As shown in Figure 40, Non-Hispanic Black people experience the highest sepsis mortality rate (34.4 deaths). There is insufficient data for the Asian or Pacific Islander, Hispanic or Latino, or Native American populations to report mortality rates in the PSA.

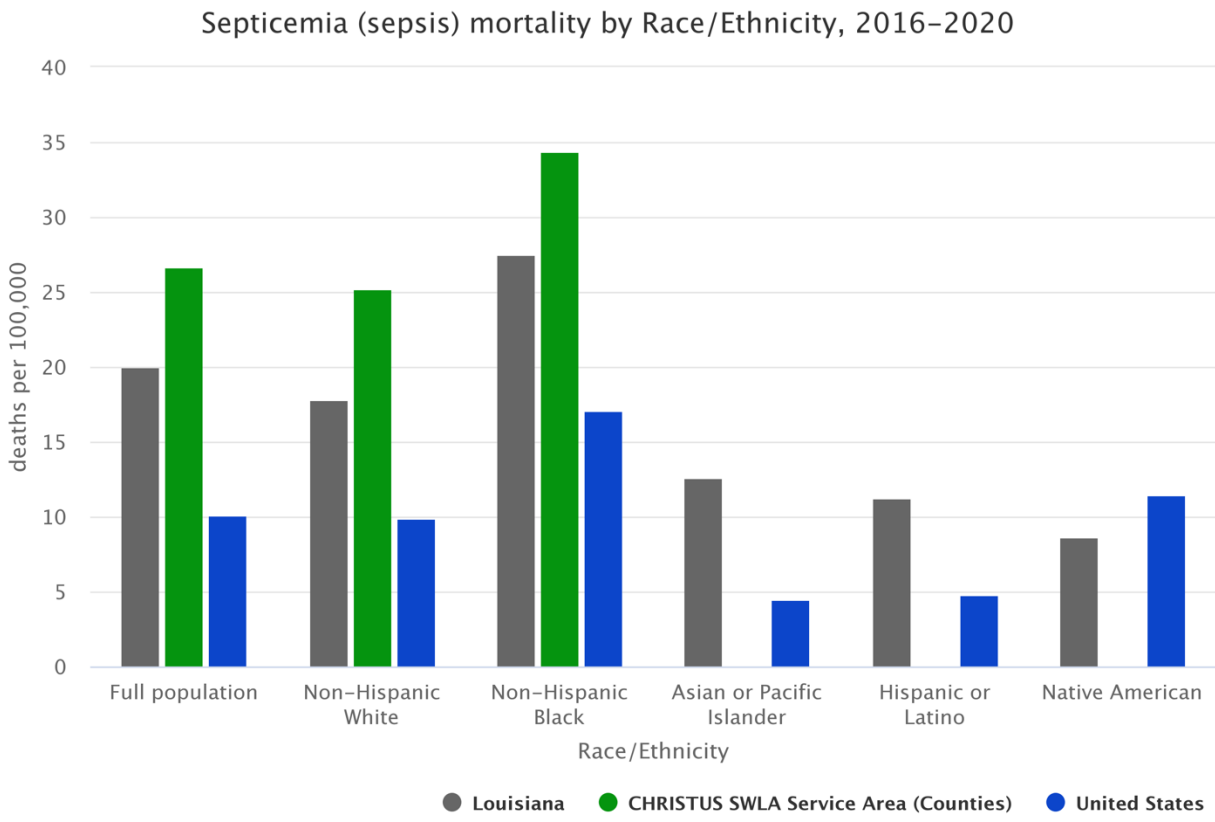


Figure 40. Sepsis Mortality Rate in the CHRISTUS SWLA PSA

Alzheimer's Disease

Until the most recent reporting period, mortality rates for Alzheimer's had been increasing throughout all regions (Figure 41). Since the 2014-2018 reporting period, this mortality rate has been declining in the PSA, currently accounting for 22.8 deaths per 100,000. The rates in the state (43.6) and country (30.8) are similar, but still increasing over time.

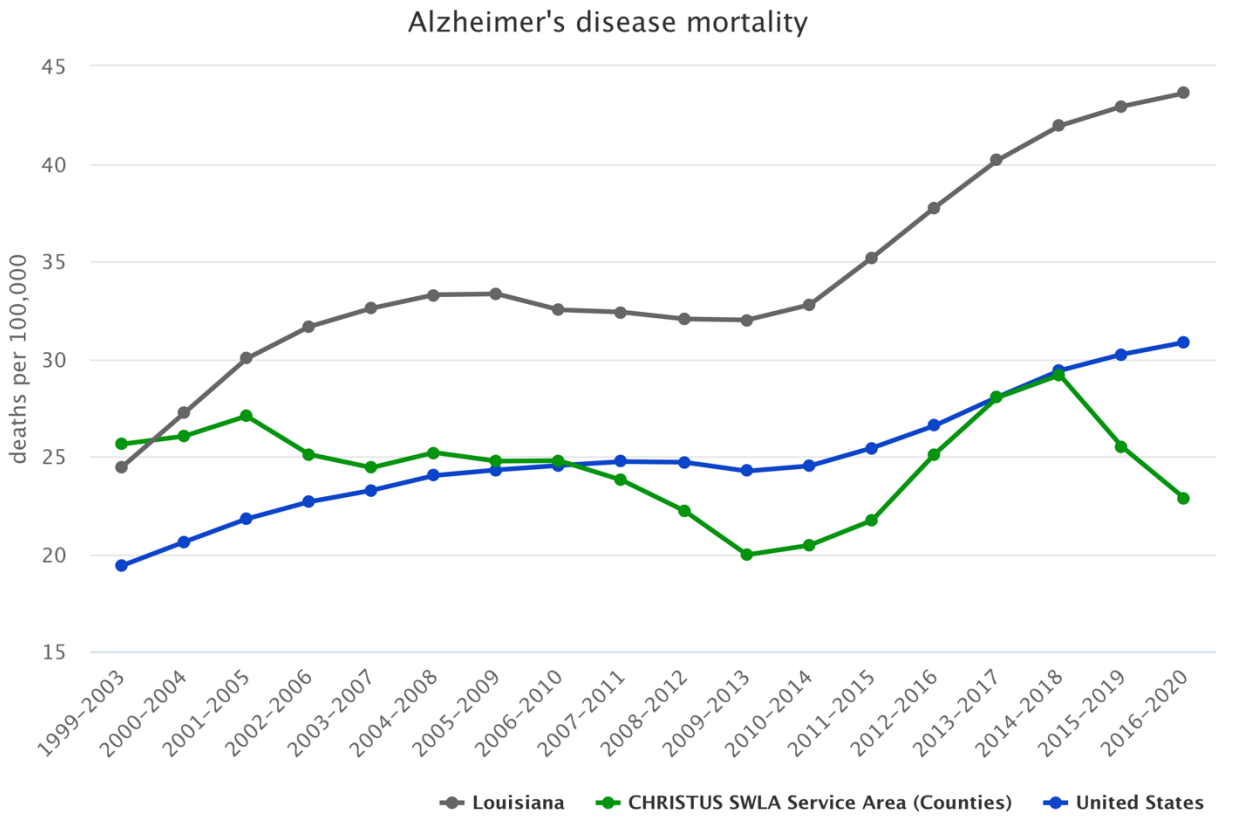


Figure 41. Alzheimer's Disease Mortality Rate in the CHRISTUS SWLA PSA

Chronic Lower Respiratory Disease

This is a roll up of four major respiratory diseases—chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, and asthma. The chronic lower respiratory disease mortality rate in the PSA (20.2 deaths per 100,000) is much lower than the state (42.5 deaths) and the country (39.1 deaths) (Figure 42).

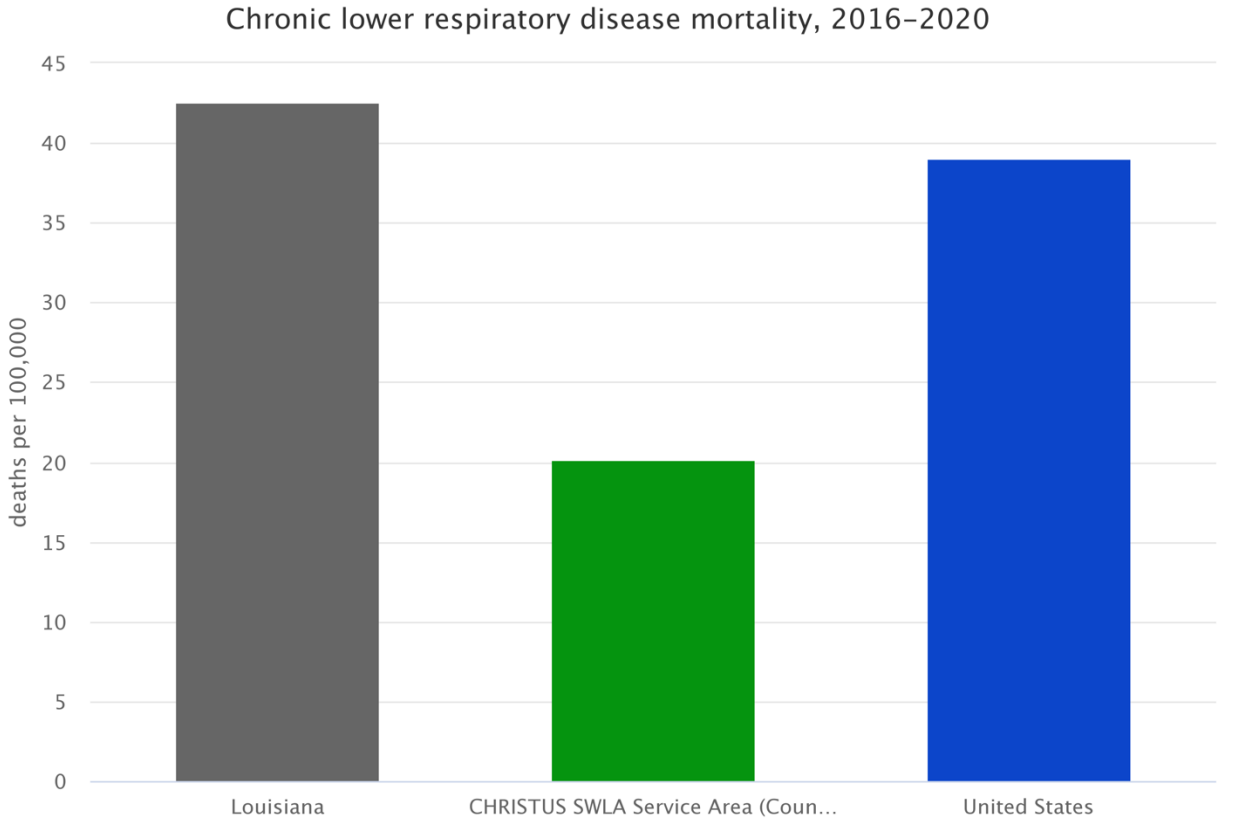


Figure 42. Chronic Lower Respiratory Disease Mortality Rate in the CHRISTUS SWLA PSA

Drug Overdose

Death from drug overdoses has been a national story for several years. The CHRISTUS SWLA PSA experienced a peak of drug overdose mortality in the 2005-2009 reporting period (25.4 deaths per 100,000) before declining (Figure 43). Though the current rate (17.2 deaths) is much lower than the peak, it has been slowly increasing since 2009-2013. The current rate in the PSA is lower than that of the state (28.5) and country (22.4).

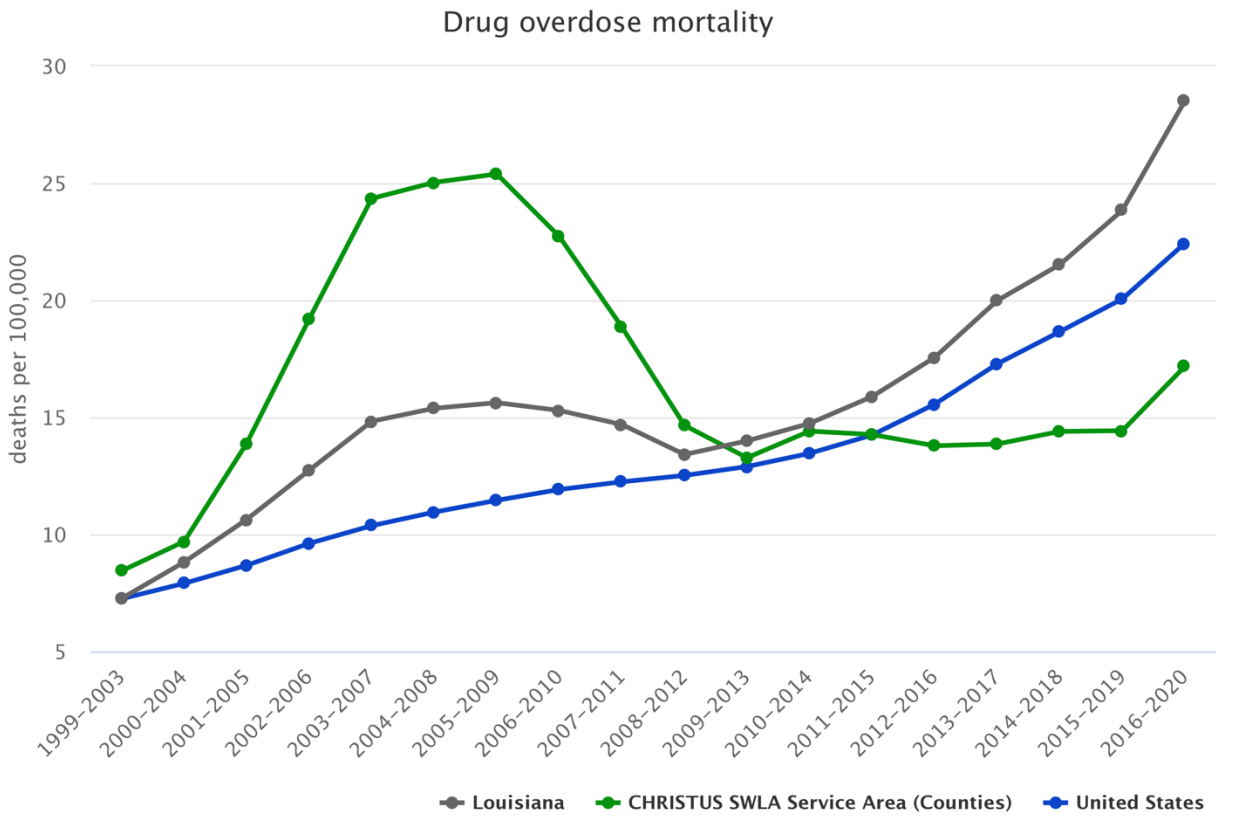


Figure 43. Drug overdose Mortality Rate in the CHRISTUS SWLA PSA

Diabetes

The diabetes mortality rate for the service area is much lower than the state and national rates across all reported population groups (Figure 44). There is a racial disparity among diabetes mortality. Non-Hispanic Black residents of the CHRISTUS SWLA PSA die from diabetes at a much higher than the average of the PSA, state, and country (26.0 deaths per 100,000). There is insufficient data for the Asian or Pacific Islander, Hispanic or Latino, or Native American populations to report mortality rates in the PSA.

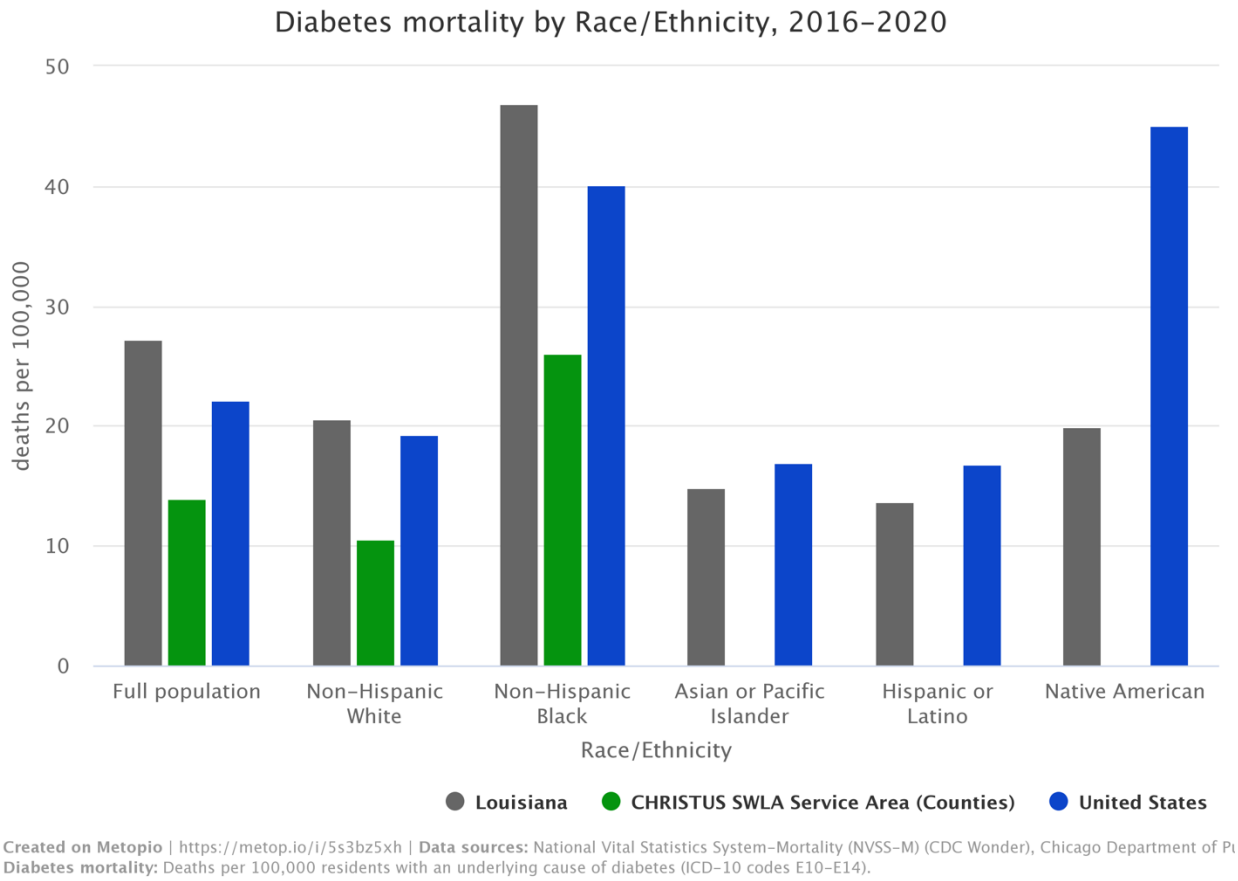


Figure 44. Diabetes Mortality Rate in the CHRISTUS SWLA PSA

Influenza and Pneumonia

Death from influenza and pneumonia had been on a steady decline across all benchmark regions over time, but it remains one of the top ten causes of mortality in the CHRISTUS SWLA PSA, accounting for 12.8 deaths per 100,000 (Figure 45). This is lower than the influenza and pneumonia mortality rates in Louisiana overall (14.2) and the country (13.6).

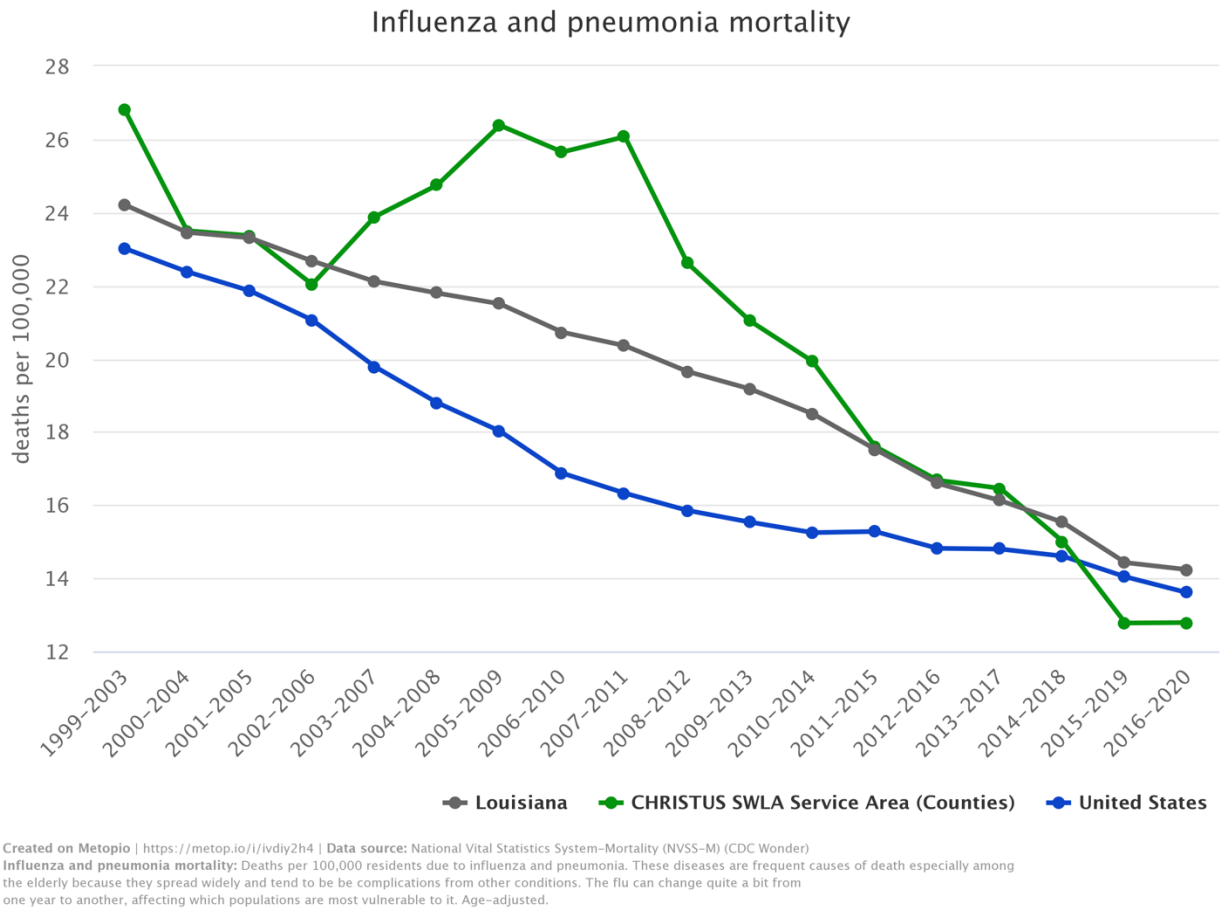


Figure 45. Influenza and Pneumonia Mortality Rate in the CHRISTUS SWLA PSA

Topic	Calcasieu Parish, LA	Beauregard Parish, LA
Heart disease mortality deaths per 100,000 , 2016 -2020	302.2	266.4
Cancer mortality deaths per 100,000 , 2016 -2020	178.7	207.9
Injury mortality deaths per 100,000 , 2016 -2020	85.7	78.5
Stroke mortality deaths per 100,000 , 2016 -2020	65.5	47.2
Septicemia (sepsis) mortality deaths per 100,000 , 2016 -2020	24.9	37.5
Alzheimer's disease mortality deaths per 100,000 , 2016 -2020	20.8	35.0
Chronic lower respiratory disease mortality deaths per 100,000 , 2016 -2020	13.2	61.4
Drug overdose mortality deaths per 100,000 , 2016 -2020	18.62	8.58
Diabetes mortality deaths per 100,000 , 2016 -2020	13.9	5.9 (2015 -2019 data)
Influenza and pneumonia mortality deaths per 100,000 , 2016 -2020	12.7	13.4

Table 16. Mortality Rates by Parishes in CHRISTUS SWLA PSA

Hospital Utilization

For this CHNA, CHRISTUS SWLA looked at three years of utilization data (2019-2021). During the course of the COVID-19 pandemic, the two hospitals saw Emergency Department utilization decline significantly year over year (Figure 46), including a 16.8% drop from 2019 to 2020 and a 41.2% drop from 2020 to 2021 at CHRISTUS Lake Area Hospital. The decline at CHRISTUS St. Patrick Hospital was 13.0% and 20.6% respectively. This follows national trends where people avoided or delayed care due to restrictions caused by the COVID-19 pandemic.

Inpatient admissions (Figure 47) also saw a year-over-year decline during the study period, most notably with a 19% reduction between 2020 and 2021 at CHRISTUS Lake Area Hospital and a 15.7% decline during the same period at CHRISTUS St. Patrick Hospital.

Because CHRISTUS Lake Area Hospital specializes in women's and children's services, inpatient diagnoses didn't change much during the study period (Table 17). The majority of the diagnoses are related to labor and delivery as well as complications during pregnancy. At CHRISTUS St. Patrick's Hospital saw COVID-19 become the number four reason for inpatient admissions. In addition to COVID-19, sepsis, chronic conditions including Chronic Kidney Disease and behavioral health make up the top 10.

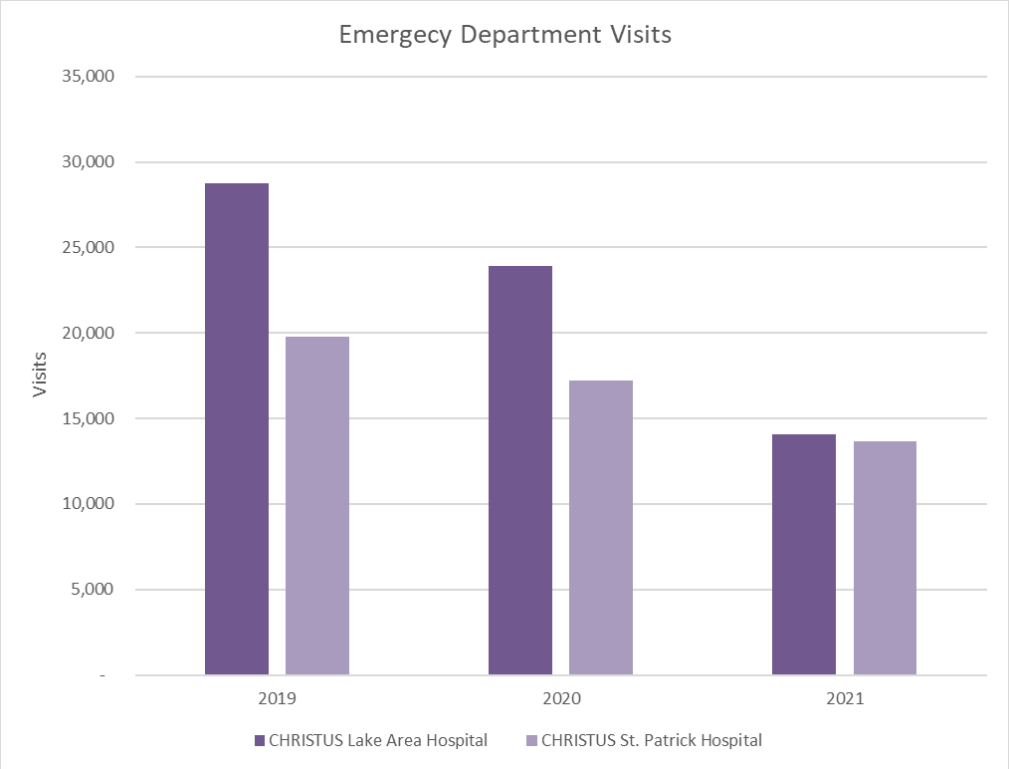


Figure 46. Emergency Department Utilization at CHRISTUS SWLA PSA

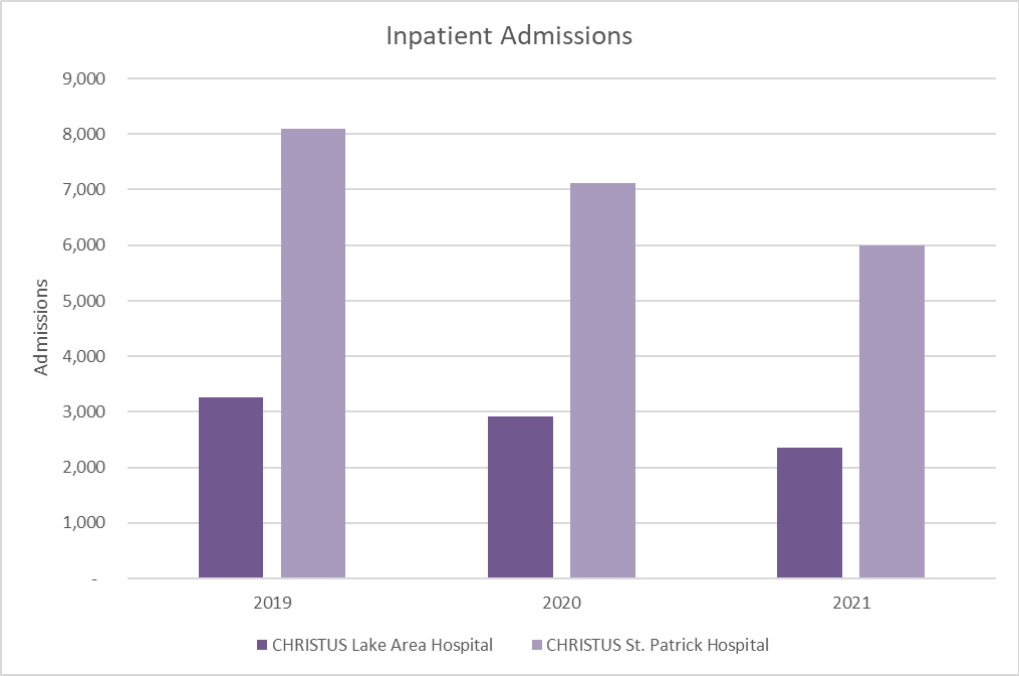


Figure 47. Inpatient Admissions at CHRISTUS SWLA PSA

TOP INPATIENT PRIMARY DIAGNOSES—CHRISTUS LAKE AREA HOSPITAL
1. Single liveborn infant delivered
2. Maternal care for low transverse scar from previous cesarean delivery
3. Gestational [pregnancy-induced] hypertension
4. Encounter for full-term uncomplicated delivery
5. Labor and delivery complicated by cord around neck
6. Abnormality in fetal heart rate and rhythm complicating labor and delivery
7. First degree perineal laceration during delivery
8. Streptococcus B carrier state complicating childbirth
9. Second degree perineal laceration during delivery
10. Sepsis

Table 17. Top Inpatient Primary Diagnoses at CHRISTUS SWLA– Lake Area

TOP INPATIENT PRIMARY DIAGNOSES—CHRISTUS ST. PATRICK HOSPITAL
1. Sepsis
2. Acute kidney failure
3. Hypertensive heart and chronic kidney disease with heart failure
4. COVID-19
5. Major depressive disorder
6. Hypertensive heart disease with heart failure
7. Non-ST elevation (NSTEMI) myocardial infarction
8. Cerebral infarction
9. Schizoaffective disorder bipolar type
10. Other malaise

Table 18. Mortality Top Inpatient Primary Diagnoses at CHRISTUS SWLA- St. Patrick

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 19). 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 Health Shreveport-Bossier 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 19. Prioritization Framework

CHRISTUS SWLA Selected FY 2023 - 2025 Health Priority Areas

For this cycle, CHRISTUS SWLA is using a new structure for its identified needs, categorizing them under two domains with the overarching goal of achieving health equity. While the prioritization structure is new, CHRISTUS SWLA retained mental health as a priority issue from the previous CHNA. In the previous CHNA, CHRISTUS SWLA identified chronic illness as a priority. In this cycle, CHRISTUS SWLA unpacked "chronic illness" and specifically calls out diabetes, heart disease and obesity. Newly identified issues include substance abuse, children's health and smoking and vaping.

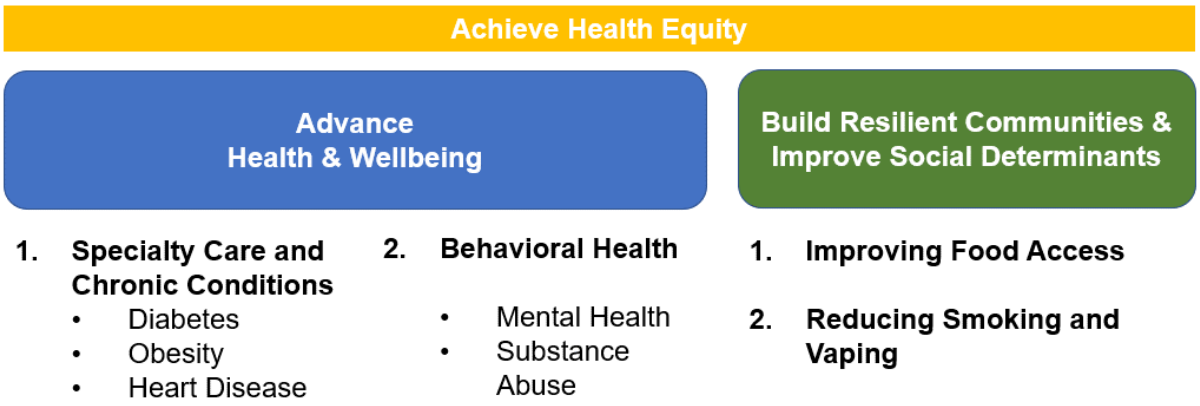


Figure 48. CHRISTUS SWLA Priority Areas

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

Adoption by the Board

The Board of Directors received the 2023-2025 CHNA report for review and are expected to formally approve the documents by November 15th, 2022.

APPENDIX

W

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

This evaluation is meant to capture the programmatic efforts undertaken by CHRISTUS SWLA 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 goals outlined in the table below.

CHRISTUS SWLA Community Benefit Priority Area Health Area Goals (2020-2022)

PRIORITY	Access to Care
PRIORITY	Mental and Behavioral Health
PRIORITY	Chronic Disease Management
PRIORITY	Disease Prevention and Management

Because of the varied program structures and approaches, it is recommended that the community benefits team to use three overarching areas to organize data sources and reporting mechanisms. These include:

Community Based Program Data

- Data includes process and outcome level measures, often captured through activity logs, standard or customized designed reporting templates, surveys, and qualitative reports.

CHRISTUS Captured Data

- CHRISTUS staff utilize databases and internal tracking templates to document and report programs and services. These include CBISA, EMRs and other a program dashboards.

Engagement Data

- Engagement data are largely qualitative including Board presentations, community reports, participant interviews and program manager feedback sessions.

Access to Care

GOAL	CHRISTUS Ochsner Southwestern Louisiana will increase access to care in the region by collaborating with local providers, utilizing Community Health Worker model, focus on recruitment, and continuing to support five School Based Health Centers (SBHCs).
OBJECTIVES	1. Ensure people have access to appropriate level of care that meets their needs by expanding referral relationships with SWLA Center for Health Services and others through coordination meetings, utilizing CHW model, and other means as necessary. 2. Reduce frequent nonemergent emergency department (ED) revisits for 5% of hypertension patients among low-income populations by improving access to appropriate care alternatives. Community Health Workers (CHWs) will contact and assist all discharged patients that do not have medical home. Hospital facilities (starting with St. Patrick) will institute IT platform for CHW follow-up to track whether patient referrals were completed. 3. Address physician and other provider shortages as defined by needs assessment to overcome gaps in service. Develop a timeline and recruitment strategy for open positions and onboard physicians 4. Five School Based Health Centers (SBHCs) will provide health services to at-risk/low income/underserved students enrolled in health centers.
IMPACT	***Anticipated outcome:*** (i). Establishing strong referral relationships and processes will improve care coordination and patients' access to appropriate services in their community, regardless of their ability to pay. (ii). Utilizing a CHW model and new IT platform will improve effectiveness of care coordination between service providers. By placing patients with a local Medical Home and improving care coordination patients will be more aware of where and how to seek appropriate care reducing number of non-emergent ED revisits for the cohort of hypertensive patients. (iii). Addressing provider shortages, as identified in the needs assessment, will increase the number of services available to more patients. (iv). Students who do not have routine access to care will receive needed physical and mental health care in SBHCs. In these years, we continued to increase Medicaid enrollment by performing screenings to assess patient eligibility. We continued the Equity of Care Program for uninsured and underinsured ED patients who do not have PCP and recruited physicians to SWLA service area. SBHCs have continued to offer a variety of health care services such as immunizations, chronic care, counseling, vision, hearing, and depression screening as well as wellness physicals from kindergarten to 12th grade. For the abbreviated period from August, 2019 – June 30, 2021, the number of student encounters was 19,800. These services have continued to be provided in 2022. All these programs and expenditures were documented in the CBISA platform. The programs were also discussed in the quarterly committee meetings to the stakeholders and internal leaders.

Mental and Behavioral Health

GOAL	CHRISTUS Ochsner Southwestern Louisiana will explore partnerships and strategies to improve the accessibility of mental and behavioral health services and resources. St. Patrick Hospital will continue to provide 24-hour emergency access center and interdisciplinary mental health care.
OBJECTIVES	1. Provide interdisciplinary care led by nursing staff specifically designed for the adult population between ages of 21-64 - Utilize 15-bed adult in-patient unit for the uninsured and underinsured designed for mental health as well as dual diagnoses. 2. Provide interdisciplinary care led by nursing staff specially designed to deliver care to those over age 65 - Utilize 10-bed inpatient unit designed to deliver interdisciplinary care to those over the age of 65 3. Provide 24-hour access center located in the ED for patients that present with psychiatric diagnosis - Each patient with a psychiatric diagnosis or problem is assessed for appropriate placement. The five SBHCs will conduct mental health screenings provided by LCSW and/or LPC - LCSW evaluates 100% of students seen that are identified with behavioral concerns 4. In coordination with community partners, develop a plan addressing lack of access to substance abuse treatment and services - Form committee (5-8 people) to develop plan. Facilitate meetings as needed. Identify current community resources that address substance abuse and gaps.
IMPACT	***Anticipated outcome:*** Un/underinsured adults will receive mental and behavioral health care on site. Appropriate mental health care is provided to the elderly population. Patients suffering with mental health issues can remain in access center under care of providers until they are placed in appropriate longer-term care. Students suffering with mental health issues will be assessed and provided counseling (and/or referrals) as appropriate. The ministry will have a baseline understanding of the existing substance abuse services in the region allowing them to realistically plan with partners, leverage resources to fill gaps, and better meet the growing need for substance abuse treatment. Unit 54 provided interdisciplinary care for adults age 18+ to 2012 patient during the time period of July 2019 through June 2021. With the onset of the COVID-19 pandemic, the SBHCs were forced to close operations on March 3, 2020. Prior to opening the 2020-2021 school year, the SBHCs were affected by the Hurricanes due to structural damage. The centers in Calcasieu Parish opened on October 18, 2020; the center in Cameron parish opened Dec. 7, 2020. The SBCH offer onsite prevention to address environmental influencers like alcohol, drug, tobacco use along with bully prevention and suicide warning identification. Through these centers we have been able to reduce absenteeism, suspensions, dropout rates and violence. For the time period of August 2019 – June 30, 2021 SBHCs provided 3198 encounters for mental health services. *These services continued to be provided in 2022. All these programs and expenditures were documented in the CBISA platform.

Chronic Disease Management

GOAL	CHRISTUS Ochsner Southwestern Louisiana will provide opportunities in the community for prevention activities, education, and direct services through the five SBHCs, the Cardiac Rehabilitation program, and Live Well seminars.
OBJECTIVES	1. The five SBHCs provide education designed to address obesity through encouraging exercise and healthy eating habits - Provide individualized diet and exercise education to all students with a BMI score of 35 or greater at the SBHCs 2. Cardiac Rehabilitation Program will continue to focus on healthy lifestyles to reduce possibility of reoccurrence of heart issues - Maintain Cardiac Rehabilitation Program at CHRISTUS Ochsner St. Patrick Hospital 3. Increase appropriate prevention activities for students - The five SBHCs provide screenings (blood pressure, STD, vision/hearing, diabetes, obesity, and depression), comprehensive physicals, immunizations, and education to 70% of students enrolled in school as defined by Louisiana Office of Public Health's Adolescent School Health Program (ASHP). 4. Continue Live Well Seminars focused on women's health - Deliver four health workshops, featuring popular keynote speakers and including education materials and free screenings, to women in the community through Lake Area Hospital Use contact information collected from seminar attendees to conduct ongoing outreach to women, promoting improved health behaviors year-round
IMPACT	***Anticipated outcome:*** (i). Through increased education and guidance, students with high BMI will better understand how to lead a healthy lifestyle. (ii). Increase knowledge and promote behavior change to reduce reoccurrence of heart issues. (iii). Ninety percent (90%) of students served will receive a screening. Twenty percent (20%) of students served will have a comprehensive physical. Eighty percent (80%) of students served are meeting required immunizations. One hundred percent (100%) of students served will be referred to an appropriate provider as needed. (iv). Increase education and activities encouraging healthy lifestyle with over 800 female participants. Cardiac Rehab also was affected by COVID pandemic and Hurricanes Laura and Delta and was forced to close operations for 6 months during this time period. The 4 SBHC provided 709 wellness check ups, 816 immunizations, 1095 Obesity screenings, and 557 Hypertension Screenings. The percentage of students with BMIs of over 85 is 90%. These services continued to be provided in 2022. All these programs and expenditures were documented in the CBISA platform. The programs were also discussed in the quarterly committee meetings to the stakeholders and internal leaders.

Disease Prevention and Management

GOAL	CHRISTUS Ochsner Southwestern Louisiana will increase access to and enhance existing oncological services and prevention activities in SWLA region specifically targeting colorectal, breast, lung and prostate cancers.
OBJECTIVES	1. Provide nurse navigation and support groups for oncological patients by conducting weekly multi-disciplinary huddles to address barriers to care and by providing nurse navigation for oncological patients. 2. Work with American Cancer Society, clinicians, and programs supported by Louisiana Smoking Cessation Trust to advance cancer prevention efforts within the community by coordinating with organizations, community coalition and/or others to support the passage of a local smoke-free ordinance and cancer prevention community activities as well as screenings 3. Connect with area businesses and community organizations to provide cancer screening and prevention education materials - Offer three cancer screenings annually (such as for prostate, lung and skin cancer) along with navigation for appropriate follow-up 4. Increase patient access to clinical trials, counseling, and education by offering health risk assessments to broad community. Fifteen percent (15%) of patients identified as moderate to high-risk will be referred for further genetic counseling/ testing. Provide counseling and education to approximately 230 high risk patients annually
IMPACT	***Anticipated outcome:*** (i). Increasing services and addressing barriers will promote better physical and mental outcomes for oncological patients. (ii). Expanding CHRISTUS Ochsner Southwestern Louisiana's role in cancer prevention activities through increased partnerships, screenings, and the support of smoke-free initiatives will contribute to the collective capacity in Southwest Louisiana to promote cancer prevention. (iii). Providing more cancer screenings with navigation will increase early detection and support patients needing follow-up. (iv). increased referrals for genetic counseling and testing for moderate to high-risk patients. Increased counseling and education for high-risk patients. Increased testing, counseling, and education will result in increased detection and improved access to treatment, ultimately contributing to a reduction in cancer mortality rates. Provided colon, prostate, lung and skin cancer education via health fairs, social media and direct mail. Out of those educated, 47 were identified as high-risk and 8 needed immediate follow-up. Provided oncology nurse navigation to 3800 encounters with patients with family history of cancer. Identified and assisted patients for additional testing. Monthly support group sessions for breast cancer patients and families were provided. They were postponed during COVID and hurricanes, then moved to virtual platform. We worked in collaboration with Louisiana Smoking Cessation Trust to provide smoking cessation and prevention materials to community to over 2300 individuals. These services continued to be provided in 2022. All these programs and expenditures were documented in the CBISA platform. The programs were also discussed in the quarterly committee meetings to the stakeholders and internal leaders.

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

Welcome to the CHRISTUS Health Community Health Needs Assessment Survey.

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:

- Identify health problems that affect the people in your community.
- Understand the needs of your community.
- Work together to find a solution.

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.

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.

We thank you for your help.

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.

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

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?

- ☐ 18-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65-74
- ☐ 75-84
- ☐ 85 and older

What is your current gender identity?

- ☐ Female
- ☐ Male
- ☐ Non-Binary (Do Not Strictly Identify as Female or Male)
- ☐ Transgender Female (Male to Female)
- ☐ Transgender Male (Female to Male)
- ☐ Choose not to disclose
- ☐ Other, please specify: _____

Do you think of yourself as?

- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Lesbian or gay or homosexual
- ☐ Choose not to disclose
- ☐ Other, please specify: _____

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?

- ☐ Less than high school
- ☐ Some high school
- ☐ High school graduate or graduate equivalency degree (GED)
- ☐ Some college, no degree
- ☐ Vocational or technical school
- ☐ College graduate (such as AA, AS, BA, BS, etc.)
- ☐ Advanced degree (such as MS, MA, MBA, MD, PhD, JD, etc.)

Community Health Needs Assessment Survey

Household Questions

What are your current living arrangements?

- ☐ Own my home
- ☐ Rent my home
- ☐ Living in emergency or transitional shelter
- ☐ Living with a friend or family
- ☐ Living outside (e.g., unsheltered, car, tent, abandoned building)
- ☐ 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)

- ☐ Less than $10,000
- ☐ $10,000 - $19,999
- ☐ $20,000 to $39,999
- ☐ $40,000 to $59,999
- ☐ $60,000 to $79,999
- ☐ $80,000 to $99,999
- ☐ Over $100,000

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?

Focus Group Protocols

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 prove 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

Key Informant Interview Protocols

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
- Louisiana Department of Public Health
- National Vital Statistics System
- The New York Times
- State health department COVID dashboards
- 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 SWLA 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 SWLA	Two hospitals, a charitable foundation, an ambulatory surgery center, imaging centers, and clinics.
Children's Miracle Network	To provide the best care for kids, children's hospitals rely on donations and community support, as Medicaid and insurance programs do not fully cover the cost of care. Its various fundraising partners and programs support the nonprofit's mission to save and improve the lives of as many children as possible.
United Way of Southwest Louisiana	United Way of Southwest Louisiana is an authority recognizing, measuring and mobilizing the resources to target community needs in Southwest Louisiana with a focus on Education, Economic Mobility, Health, and Basic Needs.
Salvation Army	Provides the following services: Center of Hope Shelter, Social Service Office Assistance, Youth Programs, Disaster Services, Red Kettle Campaign, Holiday Assistance.
American Red Cross of Southwest Louisiana	Provides emergency services during fires and man made or natural disasters, 24-hours emergency communication for military personnel and their immediate families, and community education presentations.
Calcasieu Parish Sheriff's Office	To provide the highest professional level of law enforcement response to the citizens of Calcasieu Parish. To earn the respect and trust of both the community and of one another.
Catholic Charities of Southwest Louisiana	Provides the following services: Emergency Rental Assistance, Medical Transportation, Utilities Assistance, Funeral Expenses, Prescription Medications, TWIC Assistance, Identification Card and

	Birth Certificate Help, Disaster Operations, Pastoral Services and Social Ministry, Food Bank.
Louisiana Campaign for Tobacco-Free Living (TFL)	TFL engages in local and statewide tobacco control policy efforts that focus on tobacco prevention, eliminate exposure to second hand smoke, promote cessation services, and identify and eliminate tobacco-related disparities.
Region 5 Office of Public Health	The mission of the Department of Health (LDH) Office of Public Health (OPH) is to protect and promote the health and wellness of all individuals and communities in Louisiana. They accomplish this through education, promotion of healthy lifestyles, preventing disease and injury, enforcing regulations that protect the environment, sharing vital information and assuring preventive services to uninsured and underserved individuals and families.
American Heart Association	Provides services related to heart disease and blood pressure.
Lake Charles Recreation System	The City of Lake Charles Department of Recreation & Parks strives to offer the people of Lake Charles a wide variety of activities through team and individual athletic programs, classes and activities, as well as the individual and family enjoyment of playgrounds, picnics and nature. The Department of Recreation & Parks is pleased to announce that the community centers are open for private event rentals, civic organization meetings, senior activities, public community meetings, health screenings and structured activity classes for the general public.
Sulphur Parks and Recreation	SPAR offers a comprehensive park experience that includes everything for those who love the outdoors. Providing venues for community and regional activities including golf at the historic Frasch Golf Course and walking paths at our unique parks. Facilities for other active sports include softball, tennis, volleyball, and there are many soccer and baseball fields. Picnic pavilions and playgrounds are available at various parks.
Family and Youth Counseling Agency	Provides affordable and professional support through programs and services dedicated to advocacy, counseling and education for the people of Southwest Louisiana.

Habitat for Humanity	The Lake Charles Area Habitat for Humanity ReStore offers new and gently used items up to 90% less than traditional prices. Our Restore offers shoppers the opportunity to purchase brand name furniture, household goods and much more at bargain prices.
Rotary Club	The Object of Rotary is to encourage and foster the ideal of service as a basis of worthy enterprise and, in particular, to encourage and foster: • First: The development of acquaintance as an opportunity for service; • Second: High ethical standards in business and professions; the recognition of the worthiness of all useful occupations; and the dignifying of each Rotarian's occupation as an opportunity to serve society; • Third: The application of the ideal of service in each Rotarian's personal, business, and community life; • Fourth: The advancement of international understanding, goodwill, and peace through a world fellowship of business and professional persons united in the ideal of service
Healthy Communities Coalition of Southwest LA	Provides a network that helps untie, train, support and leverage communities work through: • Statewide Leadership + Connection • Communication Support • Community Grants • Hosting the Annual Summit
Louisiana Workforce Commission	The Louisiana Workforce Commission's vision is to make Louisiana the best place in the country to get a job or grow a business, and our goal is to be the country's best workforce agency. Their mission is to put people to work.
Project Build a Future	Project Build a Future builds homes that provide hope and opportunity for people dreaming of homeownership. While affordability is a cornerstone of PBAF's program, it is not what defines our work... quality is what defines our work. We strive to build a home that is a beautiful fixture in our community providing a source of pride and hope for our homebuyers, as well as an opportunity for permanent financial stability.

SWLA Economic Development Alliance	The Southwest Louisiana Economic Development Alliance is the umbrella organization of the Chamber SWLA, the SWLA Alliance Foundation, and the Southwest Louisiana Partnership for Economic Development. These regional economic development organizations, each with its own Board of Directors, have combined resources to strengthen the business recruiting and retention efforts for Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis Parishes. The Alliance combines the staff and resources of the three organizations on the third floor of the SEED Center at 4310 Ryan Street, Lake Charles.
211	By maintaining an accurate database of public and community-based resources, 211 is able to connect you to basic services - 24 hours a day, seven days a week, and even during a disaster.
Lake Charles Memorial Health System	Provides services related to Behavioral Health, Cancer, Cardiology, OB/Gyn, Orthopedics, and Pulmonary health.
Calcasieu Community Clinic	Calcasieu Community Clinic is a not-for-profit, free health care clinic located at McNeese State University's Juliet Hardtner Hall College of Nursing. The clinic provides free ambulatory medical care and pharmaceuticals to the low-income, working uninsured in the five-parish area of Imperial Calcasieu including Allen, Beauregard, Calcasieu, Cameron and Jefferson Davis.
SWLA Center for Health Services	SWLA Center for Health Services provides quality, cost-effective and comprehensive primary health care and support services in an environment that embraces respect and dignity.
Kingdom Expressions	A multidisciplinary clinic providing a full range of quality outpatient behavioral health services to adults seeking change, healing, and care within a collaborative and safe setting.
Oceans Behavioral Hospital Lake Charles	Help individuals experiencing depression; anxiety; schizophrenia; behavioral changes related to Alzheimer's disease or other dementias, medication management or substance abuse; and other mental health issues. Utilize proven innovative and progressive therapies, Oceans' qualified professionals strive to promote long-term wellness in an environment of dignity, honesty and compassion.