March 2019

Implementation Strategy Plan Report

University Medical Center New Orleans

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Our Mission

University Medical Center New Orleans will provide exceptional patient-centered care and a world-class academic experience through advanced research, leading technology, and innovation.

Our Vision

University Medical Center New Orleans will be a leading world-class academic medical center and the destination of choice for exceptional health care.

Introduction

LCMC Health is a Louisiana-based, not-for-profit healthcare system serving the needs of the people of Louisiana, the Gulf South and beyond. LCMC Health currently manages award-winning hospitals including Children's Hospital New Orleans, Touro Infirmary, New Orleans East Hospital (NOEH), University Medical Center New Orleans (UMCNO), and West Jefferson Medical Center (WJMC).

University Medical Center New Orleans, home of the Rev. Avery C. Alexander Academic Research Hospital, continues a rich legacy dating back nearly 300 years. From the beginnings of Charity Hospital to the state-of-the-art, $1.2 billion facility opened in August 2015, UMCNO fills a need no other hospital can. A public-private partnership with the State, UMCNO is Louisiana's largest training center for future healthcare professionals. As the region's only verified Level 1 Trauma Center, UMCNO has the highest-level response for the most seriously injured patients. UMCNO is committed to be a regional destination for compassionate and comprehensive care for all patients.

One of the most important contributions of UMC New Orleans is the unparalleled training given to thousands of medical, dentistry, nursing, and allied health students annually. As the state's largest teaching hospital and training facility for many of the state's physicians, UMC New Orleans plays an integral role in shaping the future of healthcare for the region.

The Patient Protection and Affordable Care Act (PPACA), which went into effect on March 23, 2010, requires tax-exempt hospitals to conduct community health needs assessments (CHNA) and implementation strategies in order to improve the health and well-being being of residents within the communities served by the hospital(s). These strategies created by hospitals and institutions consist of programs, activities, and plans that are specifically targeted towards populations within the community. The execution of the implementation strategy plan is designed to increase and track the impact of each hospitals' efforts.

Tripp Umbach was contracted by Metropolitan Hospital Council of New Orleans (MHCNO) to conduct a CHNA for East Jefferson General Hospital, LCMC Health, Ochsner Health System, HCA Healthcare (Tulane Medical Center), Slidell Memorial Hospital, and St. Tammany Parish Hospital. The overall CHNA involved multiple steps that are depicted in Chart 1.

The CHNA process undertaken by LCMC Health, along with East Jefferson General Hospital, HCA Healthcare (Tulane Medical Center), Ochsner Health System, Slidell Memorial Hospital, and St. Tammany Parish Hospital, with project management and consultation by Tripp Umbach, included input from representatives who represent the broad interests of the community served by the hospital facilities, including those with special knowledge of public health issues, data related to underserved, hard-to-reach, vulnerable populations, and representatives of vulnerable populations served by each hospital. Tripp Umbach worked closely with Working Group members to oversee and accomplish the assessment and its goals. This report fulfills the requirements of the Internal Revenue Code 501(r)(3), established within the Patient Protection and Affordable Care Act (PPACA) requiring that nonprofit hospitals conduct CHNAs every three years.

Data from government and social agencies provides a strong framework and a comprehensive piece to the overall CHNA. The information collected is a snapshot of the health of residents in Southern Louisiana, which encompassed socioeconomic information, health statistics, demographics, and mental health issues, etc.

The CHNA report is a summary of primary and secondary data collected for LCMC Health – UMCNO while the implementation strategy planning report is a plan for how LCMC Health – UMCNO will address the identified needs from the CHNA over the next 3 years.

The requirements imposed by the IRS for tax-exempt hospitals and health systems must include the following:

- Conduct a CHNA every three years.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how it is addressing the needs identified in the CHNA and a description of needs that are not being addressed, with the reasons why.

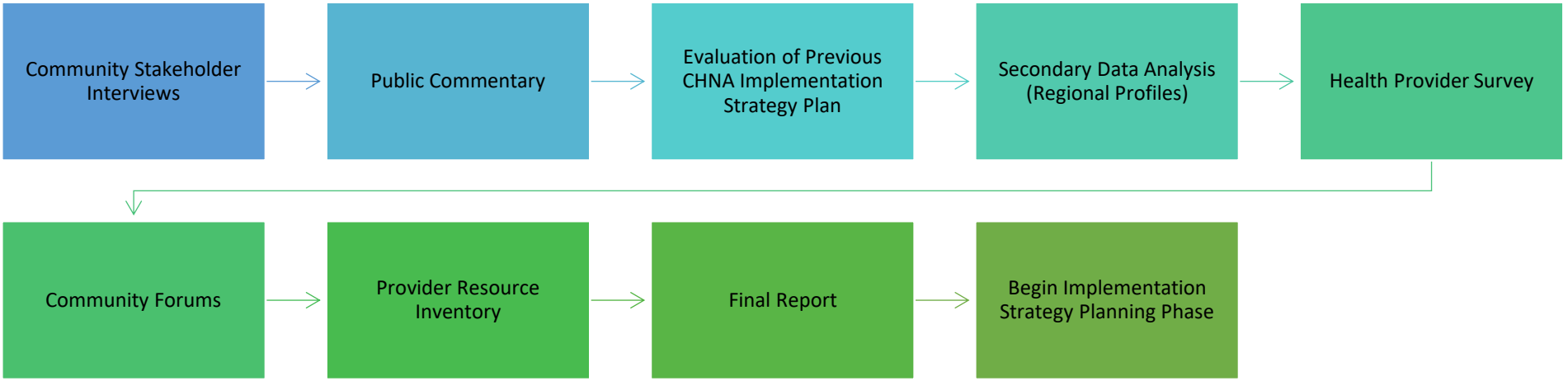
The Department of the Treasury and the IRS require a CHNA to include:

1. A description of the community served by the hospital facilities and how the description was determined.
2. A description of the process and methods used to conduct the assessment.
    - A description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs.
    - A description of information gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility.
    - Identification of organizations that collaborated with the hospital and an explanation of their qualifications.
3. A description of how the hospital organizations considered input from persons who represent the broad interests of the community served by the hospitals. In addition, the report must identify any individual providing input that has special knowledge of or expertise in public health. The report must also identify any individual providing input who is a "leader" or "representative" of populations.
4. A prioritized description of all of the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs.
5. A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.
6. A description of the needs identified that the hospital intends to address, the reasons those needs were selected, and the means by which the hospital will undertake to address the selected needs.

Addressing Community Health Needs

In 2018, UMCNO began a joint process of conducting a comprehensive Community Health Needs Assessment (CHNA) along with regional health care institutions and organizations in Southern Louisiana. The process connected public and private organizations, such as health and human service entities, government officials, faith-based organizations, and educational institutions to evaluate the needs of the community. The 2018 assessment included primary and secondary data collection and incorporated a multitude of phases as part of the assessment process. The overall CHNA involved multiple steps that are depicted in the below flow chart.

Chart 1: CHNA Process Chart



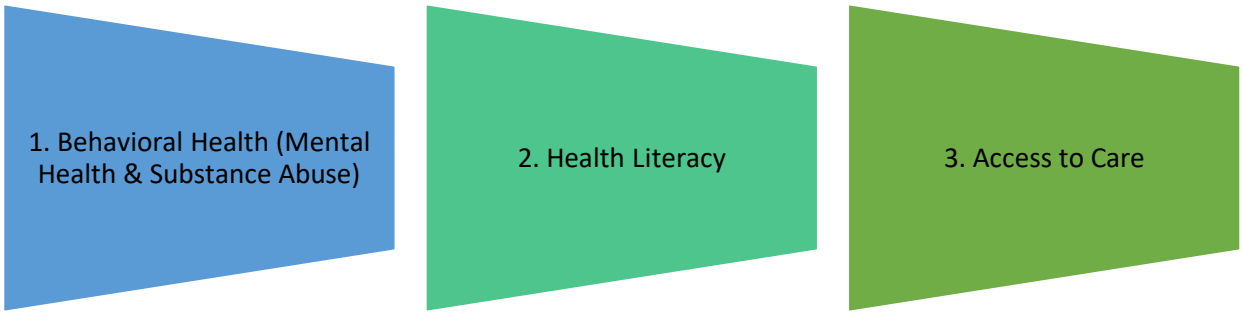
With the conclusion of the CHNA, a regional strategic planning phase was implemented and managed by Tripp Umbach with participation from representatives of LCMC Health, along with East Jefferson General Hospital, HCA Healthcare (Tulane Medical Center), Ochsner Health System, and Slidell Memorial Hospital. The developments and results from the implementation strategy report is to address the needs identified from UMCNO's community health needs assessment completed in 2018 (i.e., access to care, behavioral health (mental health and substance abuse), health education).

Tripp Umbach worked closely with administrative leadership from UMCNO to complete the implementation strategy planning phase through the review of previous strategies and planning actions. The identification of community health priorities helped hospital leaders align needs with best practice models and available resources, defined action steps, timelines, and potential partners for each need to develop the accompanying implementation strategy plan. Hospital strategies and subsequent action steps were recognized to address the health needs identified in the service area.

Prioritizing Community Health Needs

According to the Office of Disease Prevention and Health Promotion, a healthy community is "a community that is continuously creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential." This idyllic description is for a healthy community that also has access to health services, ample employment opportunities, high-quality education, affordable, clean housing options, and a safe physical environment. The reduction of poor health outcomes and poor health behaviors are essential in order to build a healthy community. Collaboration and teamwork from community groups, health care institutions, government leaders, and social and civic organizations can also improve the health status of a community. Healthy partnerships can lead to building a strong community infrastructure that addresses community health needs and provides services to prevent and stem preventable diseases.

Upon review of all data collected, with feedback from community leaders who were present at the community forum, and input from internal hospital leadership, the following needs were identified as the key community health needs in the UMCNO's community.



Community Definition

In 2018, a comprehensive CHNA was completed for UMCNO. Tripp Umbach has completed CHNAs and implementation strategy planning cycles for the hospital/health system proving benchmarking and or trending data to track and observe positive or negative movements in the primary and secondary data (where applicable).

The primary service area for UMCNO was defined by ZIP codes that contain a majority of inpatient discharges from the health care facility. In 2018, a total of 50 ZIP codes were identified for UMCNO's service area as containing a majority of inpatient discharges. The information collected from these specific ZIP codes will assist in future health care planning services, community benefit contributions, and programming efforts.

Table 1: Overall Study Area Profile

	ZIP Code	City	Parish
1.	70001	Metairie	Jefferson
2.	70002	Metairie	Jefferson
3.	70003	Metairie	Jefferson
4.	70005	Metairie	Jefferson
5.	70006	Metairie	Jefferson
6.	70032	Arabi	St. Bernard
7.	70043	Chalmette	St. Bernard
8.	70047	Destrehan	St. Charles
9.	70053	Gretna	Jefferson
10.	70056	Gretna	Jefferson
11.	70057	Hahnville	St. Charles
12.	70058	Harvey	Jefferson
13.	70062	Kenner	Jefferson
14.	70065	Kenner	Jefferson
15.	70068	LA Place	St. John the Baptist
16.	70072	Marrero	Jefferson
17.	70087	Saint Rose	St. Charles
18.	70092	Violet	St. Bernard

	ZIP Code	City	Parish
19.	70094	Westwego	Jefferson
20.	70112	New Orleans	Orleans
21.	70113	New Orleans	Orleans
22.	70114	New Orleans	Orleans
23.	70115	New Orleans	Orleans
24.	70116	New Orleans	Orleans
25.	70117	New Orleans	Orleans
26.	70118	New Orleans	Orleans
27.	70119	New Orleans	Orleans
28.	70121	New Orleans	Jefferson
29.	70122	New Orleans	Orleans
30.	70123	New Orleans	Jefferson
31.	70124	New Orleans	Orleans
32.	70125	New Orleans	Orleans
33.	70126	New Orleans	Orleans
34.	70127	New Orleans	Orleans
35.	70128	New Orleans	Orleans
36.	70129	New Orleans	Orleans

	ZIP Code	City	Parish
37.	70130	New Orleans	Orleans
38.	70131	New Orleans	Orleans
39.	70301	Thibodaux	Lafourche
40.	70360	Houma	Terrebonne
41.	70363	Houma	Terrebonne
42.	70427	Bogalusa	Washington
43.	70433	Covington	St. Tammany

	ZIP Code	City	Parish
44.	70438	Franklinton	Washington
45.	70454	Ponchatoula	Tangipahoa
46.	70458	Slidell	St. Tammany
47.	70460	Slidell	St. Tammany
48.	70712	Angola	West Feliciana
49.	70748	Jackson	East Feliciana
50.	70776	Saint Gabriel	Iberville

Methodology

A complete CHNA process performed for included the collection of primary and secondary data. Community organizations and leaders within the primary region were engaged to distinguish the needs of the community. Civic and social organizations, government agencies, educational systems, and health and human services entities were engaged throughout the CHNA. The comprehensive primary data collection phase resulted in the contribution of over 100 community stakeholders/leaders, organizations, and community groups.

The primary data collection consisted of several project component pieces. Community stakeholder interviews were conducted with individuals who represented a) broad interests of the community, b) populations of need or c) persons with specialized knowledge in public health. Health provider surveys were collected to capture thoughts and opinions regarding health providers' concerns about the care and services they provide. Community representatives and stakeholders attended a community forum facilitated by Tripp Umbach to prioritize health needs, which assisted in the implementation and planning phase. A resource inventory was generated to highlight available programs and services within the service area. The resource inventory identifies available organizations and agencies that serve the region within each of the priority needs.

A robust regional profile (secondary data profile) was analyzed. The regional profile contained local, state, and federal data/statistics providing invaluable information on a wide-array of health and social topics. Different socioeconomic characteristics, health outcomes, and health factors that affect residents' behaviors; specifically, the influential factors that impact the health of residents were reviewed and discussed with members of the Working Group and Tripp Umbach. In total, six regional health profiles were compiled based on the locations and service areas of the participating hospitals. For the overall assessment process, the regional profiles were: Baton Rouge, Jefferson, New Orleans, North Shore, West Bank, and St. Anne (Raceland)/Lafourche region.

LCMC Health – UMCNO continues to contribute towards regional programming efforts, educational initiatives, and high-quality patient care to improve the health and security of its community. UMCNO continues their obligation and devotion to their region not only with the completion of their CHNA but also with the implementation strategies and planning efforts involving strong partnerships with community organizations, health institutions, and regional partners through a comprehensive implementation strategy plan. UMCNO is a strong economic driver in Southern Louisiana with a strong focus on improving the health of the residents in their community and surrounding regions.

Note: The implementation planning strategy report identifies specific approaches and actions to address the community health needs from the 2018 CHNA. Specific timeframes and measures/metrics are tracked internally for reporting purposes. Hospital administration will utilize these measures/metrics to ensure benchmarking efforts are being tracked between each assessment cycle. LCMC Health also identified specific programs within each of their hospital locations as well as programs that are implemented from a systemwide approach. Systemwide strategies are marked with an asterisk in the following tables.

Key Community Health Priority 1: Behavioral Health

Mental disorders and substance use disorders affect people of all racial groups and socioeconomic backgrounds. Mental health is defined as a state of well-being in which every individual realizes their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to their community. Mental health affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Good mental health is freedom from depression, anxiety, and other psychological issues. It also refers to the overall coping mechanisms of an individual. Having a behavioral health condition is not the result of one event but rather multiple linking causes such as genetics, environment, and lifestyle.

People with serious mental and/or substance use disorders often face higher rates of cardiovascular disease, diabetes, respiratory disease, and infectious disease; elevated risk factors due to high rates of smoking, substance misuse, obesity, and unsafe sexual practices; increased vulnerability due to poverty, social isolation, trauma and violence, and incarceration; lack of coordination between mental and primary health care providers; prejudice and discrimination; side effects from psychotropic medications; and, an overall lack of access to health care, particularly preventive care.[i]

Providers are approaching patient health with an integrated care model because they realize the importance of treating the whole individual. Behavioral health impacts physical health and vice versa. With proper monitoring and treatment, individuals suffering from behavioral health issues can lead healthy, productive lives and be contributing members of the community. The difficulty lies in identifying these issues and linking these individuals with behavioral health services.

In addition to the growing behavioral health problem in the UMCNO study region, there is an increased use of drugs. Drug use and its consequences touches every sector of our society. Drug use effects our health and has a significant effect on the criminal justice system. Drug use also endangers the future of our youth. Addiction is a chronic disease, difficult to control as well as being difficult to break. Individuals who take drugs do so for many reasons including environmental influences, genetics, to escape reality, etc. An essential role the community can implement to stem its use is to provide programs towards prevention and reinforcement of keeping drugs and alcohol out of neighborhoods and schools; therefore, providing a safe and secure environment for all community residents. Prevention is a cost-effective approach to promoting safe and healthy communities.

Successful treatment of drug abuse is, most often, a life-long process. Treatment is intensive and expensive and requires a significant investment of time and effort on behalf of health professionals, social services, community-based organizations, the patient's support network, not to mention the patients themselves. Substance abuse treatment often requires multiple attempts to be deemed successful.

UMCNO provides programs and services to many in the parish and surrounding regions. Behavioral health was identified as a top need through the 2018 community health needs assessment. While UMCNO is not the only health care institution in the region, the following strategies were identified and revealed to address the growing issue. UMCNO in partnership and collaborating with other regional health care organizations will continue to capitalize on the communities' existing resources to tackle and confront the needs of the region.

Need: **Behavioral Health (Mental Health and Substance Abuse)**

WHAT IS THE GOAL? Provide in-patient and out-patient behavioral health services.

WHAT IS THE ANTICIPATED IMPACT? Increased numbers of behavioral health patients receiving services

Strategy -1	Target Population	Actions	Timeframe/Measures	Potential Resources/ Partners
Increase access to emergency behavioral health care and providers on outpatient services.	Community served	1. Provided there are resources available, UMCNO will provide increased access to emergency behavioral health care for patients that require acute episodic care services which may include: • Increase the number of hospital beds available • Referrals made to outside organizations • Information provided to the patient regarding available community-based resources	# of beds # of outpatient services # of inpatient services	Resources: Business Development and staff time Partners: Metropolitan Human Services District, Odyssey House, 504 Healthnet
		2. Improve ED BHERE patient length of stay by adding NP	# of visits conducted by the NP	Resources: Staff time Partners: Van Meter
		3. Addition of new OP BH services: Addiction Clinic, Medication Assistance Treatment Program (MAT), Addiction IOP (Intensive OP Treatment), Mental Health IOP	Targeted timelines for opening of the OP BH services are met: Addiction Clinic: 2/25/2019 MAT, Addiction Intensive OP treatment: 4/8/2019 Mental Health IOP: 4th qtr. 2019	Resources: Full clinical operations Partners: LSU, Louisiana Department of Health, City of New Orleans, Metropolitan Human Services District

Strategy -2	Target Population	Actions	Timeframe/Measures	Potential Resources/ Partners
Increase awareness of available behavioral health and social service resources.	Community served	1. Provide community resource sheet related to behavioral health services available in the community.	Track # of hits to Behavioral Health resource page Track use of the Companion App Behavioral Health Resource Page # of participation in community mental health events	Resources: UMC Website Partners: City of New Orleans, 504 Healthnet, Louisiana Department of Health (LDH), LSUHSC, Tulane, Metropolitan Human Services District.
		2. The resource list will be revised and updated regularly. To also include clinic embedded services (i.e. primary care, trauma, family medicine, oncology, OB, GI, bariatrics)	# of outpatient visits (clinic)	Resources: UMC Website Partners: City of New Orleans, 504 Healthnet, Louisiana Department of Health (LDH), LSUHSC, Tulane, Metropolitan Human Services District
Strategy -3	**Target Population**	**Actions**	**Timeframe/Measures**	**Potential Resources/ Partners**
Identify and partner to bring treatment opportunities to UMCNO whenever available.	Community served	1. Grant with the City of New Orleans Health Department; Opioid Survival Connection.	Addition of a treatment navigator based in the UMC Emergency Department to link people to treatment options, usually Medication Assisted Therapy.	Resources: Staff time Partners: City of New Orleans Health Department, New Orleans Civil District Court, Behavioral Health Council
		2. Work with the City of New Orleans Health Department on multiple endeavors such as Assistive Outpatient Treatment (AOT) - a judicial commitment program for outpatient treatment.	# of programs initiated with NOHD	Resources: Staff time Partners: City of New Orleans Health Department, New Orleans Civil District

				Court, Behavioral Health Council
Strategy -4	**Target Population**	**Actions**	**Timeframe/Measures**	**Potential Resources/ Partners**
Increase screening and referral for behavioral health and substance abuse.	Community served	1. Provided resources remain available, UMCNO will provide screening for PTSD and toxicology screening for inpatient trauma patients.	# of screenings provided	Resources: Staff time Partners: Baptist Community Ministries (BCM)
		2. Provide suicide screenings at each provider visit.	# of screenings provided	Resources: Staff time Partners: TBD
		3. Provide screening results for those in need of treatment and referrals to outpatient community-based settings.	# of screenings provided	Resources: Staff time Partners: TBD
Strategy -5 *	**Target Population**	**Actions**	**Timeframe/Measures**	**Potential Resources/ Partners**
Actively engage as members of the City of New Orleans Behavioral Health Council.[ii]	Health system employees	1. Attend and participate in the relevant sector work group meetings that are held 9-10 times per year.	# of meeting attended # of participants in attendance	Resources: Staff time Partners: City of New Orleans Behavioral Health Council
		2. Attend, participate, and sponsor the annual health forum that is open to the public when held.	# of attendees	Resources: Staff time Partners: City of New Orleans Behavioral Health Council

Strategy -6 *	Target Population	Actions	Timeframe/Measures	Potential Resources/ Partners
Actively engage as members of the City of New Orleans Opioid Task Force. [iii]	Health system employees	1. Attend and participate in task force meetings as scheduled. Anticipated cadence of meetings will be every 3 months.	# of meetings attended # of participants in attendance	Resources: Staff time Partners: City of New Orleans Opioid Task Force
		2. Share de-identified data and trending information to the task force when available and requested.	Reports pulled together	Resources: Staff time Partners: City of New Orleans Opioid Task Force

Key Community Health Priority 2: Health Literacy

Education plays a critical role in overall public health. Individuals without basic education and life skills are more likely to experience lifelong disadvantages such as lack of job opportunities, poor health outcomes, increased likelihood to engage in risky health behaviors, and a general inability to be self-supporting/productive and or to be a contributing member of society. Reading and reading comprehension skills are important to helping us understand and interact with the world around us.

Education and knowledge are crucial to successfully managing all aspects of life including health care needs, nutrition and food preparation, financial health needs, and basic life skills. Education provides the necessary tools to make informed decisions; where to look for information, determine its validity, and how to interpret and best apply it to the decision at hand.

Health Education/literacy is instrumental to laying a foundation of basic health knowledge and life skills to improve overall public health. The Nation's Report Card is the largest continuing and nationally representative assessment of what our nation's students know and can do in subjects such as mathematics, reading, science, and writing. Standard administration practices are implemented to provide a common measure of student achievement. The National Assessment of Educational Progress (NAEP) is a congressionally mandated project administered by the National Center for Education Statistics (NCES), within the U.S. Department of Education and the Institute of Education Sciences (IES). The NAEP reading scale ranges from zero to 500.

The 2017 Reading State Snapshot Report revealed that the average reading score of Louisiana eighth grade students was 257; lower than the national average score of 265. When compared to the rest of the United States, Louisiana's average reading score was lower than 41 other states/jurisdictions, not significantly different than nine, and only higher than the District of Columbia. The 2017 report also indicated score gaps among different student groups. Black students had an average score that was 27 points lower than white students. Hispanic students had an average score that was 16 points lower than that of white students. Students who were eligible for free/reduced-price school lunch, an indicator of low family income, had an average score that was 24 points lower than students who were not eligible. This performance gap was not significantly different from that in 1998 (20 points).

Education about health in schools is instrumental to laying a foundation of basic health knowledge and life skills to improve overall public health. In recognition of the serious lack of educational performance among students in Louisiana school districts, the Louisiana Department of Education created and implemented the Louisiana Believes initiative. Louisiana Believes is a cohesive academic plan that raises expectations and educational outcomes for students through five priority areas: access to quality early childhood education, academic alignment in every school and classroom, teacher and leader preparation, pathways to college or a career, and supporting struggling schools. As a result of this focus, over the past five years, Louisiana has seen an increase in student performance in every measure both locally and nationally.

NEED: **Health Education**

WHAT IS THE GOAL? **Expand capability to provide culturally and linguistically appropriate health care.**

WHAT IS THE ANTICIPATED IMPACT? **Increased ability to meet patient care needs of limited English-speaking patients.**

Strategy -1	Target Population	Actions	Timeframe/Measures	Potential Resources/ Partners
Increase the information that is available about what services are offered by UMCNO including medical services, outreach /education, etc.	Community served	1. Increase the outreach offered to underserved populations (including residents with limited English-speaking skills) regarding the service offered at UMCNO.	# of presentations made # of social media campaigns launched and the focus of each	Resources: Staff time Partners: 504 Healthnet
		2. Increase outreach through social media and applications regarding the services offered at UMCNO.	# of applications	Resources: Staff time Partners: 504 Healthnet
Strategy -2	**Target Population**	**Actions**	**Timeframe/Measures**	**Potential Resources/ Partners**
Increased the information available to community residents and patients at UMC regarding financial literacy and healthcare.	Community served	1. Seek out community partners to communicate financial literacy and health services and various ways to pay for healthcare.	# of presentations # in attendance	Resources: Staff time Partners: Total Community Action, United Way

Strategy -3	Target Population	Actions	Timeframe/Measures	Potential Resources/ Partners
Increase the information that is offered to residents about preventive practices and health management.	Community served	1. UMCNO Resource and education department will offer outreach education related to HIV, Hep-C, diabetes, trauma, cancer, and stroke prevention. • Diabetes education will include disease Mgmt. and medication mgmt. • Trauma Program Outreach related to trauma topics will include the Sudden Impact Teen Program (hospital based). Child Passenger Safety Program (community based), STOP Program (elementary school based). • Stroke Program will provide prevention efforts to the community by means of Health Fairs, Community Meetings, Hospital based prevention programs on Stroke Awareness, Stroke • Conferences for medical community. The Stroke Program Coordinator leads these efforts and it is required by the TJC. Cancer Program provides the following: Monthly Breast Cancer Support group (Team Survivors), Massage, Art Therapy, and Yoga. Cancer Community Outreach: Monthly lunch and learn lectures on breast health and Oncology (average 40-60 participants), Quarterly community outreach with faith-based communities, local high schools, or cancer associations. Members of the Breast care team involved on statewide committees (i.e. Taking aim at Cancer community engagement, Cancer Crusaders, American Cancer Society).	# in attendance	Resources: Internal Resources, departmental and administrative Partners: TBD

Strategy -4	Target Population	Actions	Timeframe/Measures	Potential Resources/ Partners
Increase the information that is offered to residents about healthy options and healthy behaviors.	Community served	1. UMCNO Resource and education department will offer outreach education related to smoking cessation, healthy weight/nutrition, and accident safety. • Tobacco Control Initiative to reduce the prevalence of tobacco use through behavioral counseling and pharmacotherapy. • Healthy weight educators • The Nutrition Committee provides oversight of the nutritional care of hospital patients to assure adequate nutrition for all, including visitors, patient's family members and hospital staff. The committee follows guidelines established by national dietetic standards. • The Sudden Impact Teen Program is a 7-hour hospital-based program that promotes good decision making as a driver or passenger in a motor vehicle. The class consist of 30 teens from area high schools who interact the Trauma Team, Law Enforcement, LOPA and a Trauma Victim.	# of presentations # in attendance # of NicoDerm patches	Resources: Staff time, patient materials available in English and Spanish Partners: Refresh Project, Tobacco Free Living (TFL) Project with LPHI
Strategy -5	**Target Population**	**Actions**	**Timeframe/Measures**	**Potential Resources/ Partners**
Increase early detection of HIV and HepC infection in order to reduce the spread and improve treatment outcomes.	Community served	1. Continue opt out screening for HepC and HIV in the emergency department. All patients seeking care in the emergency department will be screened for HepC and HIV unless they choose not to be tested. Increase appropriate immunizations.	Document the number of HepC and HIV tests are administered in the emergency department Document the number of positive new cases	Resources: Staff time Partners: Potential partnership with Gilead

Key Community Health Priority 3: Access to Care

Access to comprehensive, high-quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all Americans. The Patient Protection and Affordable Care Act (PPACA) of 2010 improved access to health care by providing health insurance for 20 million adults. Despite this increase, significant disparities still exist with all levels of access to care by sex, age, race, ethnicity, education, and family income.[iv]

Most Americans underuse preventive services and vulnerable populations with social, economic, or environmental disadvantages are even less likely to use these services.[v] Both routine preventive and regular primary care are essential to good health; providers are able to detect and treat health issues early; preventing complications, chronic conditions, and hospitalizations. Individuals without insurance or the financial means to pay out of pocket are less likely to take advantage of routine preventive and primary care. These individuals consume more public health dollars and strain the resources of already overburdened facilities dedicated to free and low-cost care.

The level of access a community has to health care has a tremendous impact on the community's overall health. Several factors including, geography, economics, and culture, etc., contribute to how residents obtain care. Geography impacts the number of providers that are available to patients in a given area as transportation options are limited to some residents. Health problems affect productivity resulting in 69 million workers reporting missed days due to illness each year.[vi] Lack of job opportunities can reduce access to affordable health insurance. Both geographic and economic factors are impacting residents of the UMCNO service area. While there are quality health care resources available to residents within the service area, many residents either cannot afford health services or have additional access issues which affect their ability to obtain and receive care

Characteristically, access to care refers to the utilization of health care services or the ability in which people can obtain health care services. Disparities in health service access can negatively impact and affect an individual's quality of life. High cost of services, transportation issues, and availability of providers are some of the top barriers or problems to accessing health care services. Identifying access to care was a top community need in the UMCNO community; as this community need was a top community concern in the 2015 community health needs assessment.

As part of LCMC Health, UMCNO provides access to health care to many in the parish and surrounding regions. Access to care was identified as a top need through the 2018 community health needs assessment. While UMCNO is not the only health care institution in the region, the following strategies were identified and revealed to address the growing issues. UMCNO working in partnership and collaborating with other regional health care organizations, will continue to capitalize on the communities' existing resources to tackle and confront the needs of the region.

Need: **Access to care**

What is the Goal? **Reduce barriers to care and ensure access to primary care services for the underserved populations continue.**

Anticipated Impact: **Improve on the number of low-income, vulnerable patients are receiving and linking them to patient care providers, services, and resources.**

Strategy -1	Target Population	Actions	Timeframe/Measures	Potential Resources/ Partners
Increase access to advanced diagnostic and specialty care for residents that would not otherwise receive these types of services.	Community served	1. Provided resources remain available, UMCNO will continue to receive referrals from any of the Community Health Centers to assist patients with getting the appropriate appointments and provide access to advanced diagnostics and specialty care for populations that would not otherwise receive these types of services • Residents currently incarcerated • Homeless individuals Types of Services • Primary Care • Burn • Outpatient Behavioral Health • Bariatrics	Develop a measure of services provided such as number of individuals, types and number of services • #504 Healthnet referrals • # offender clinic visits	Resources: Operations and Funding of the clinic services, outreach to the 504 Healthnet and Department of Corrections. Partners: 504 HealthNet; Department of Corrections, other healthcare providers in the service area.
Strategy -2	**Target Population**	**Actions**	**Timeframe/Measures**	**Potential Resources/ Partners**
Provide culturally competent care.	Community served	1. Continue to provide culturally competent care in the following ways: • Provide translation options for relevant areas on the hospital website. • Continue to offer a variety of language translations for the onsite check in kiosks. • Continue to offer translation services through the language line • Addition of translated patient education materials and wayfinding maps.	Document the language translation option available for the website and on-site kiosks. # of times the language line is used # of times sign language video interpretation used	Resources: Hospital funded Partners: 504 Healthnet

		2. Partnership with LSUHSC to perform an Environmental Health Literacy Assessment.	Receipt and review of the assessment. Develop timeframe to develop plan based on the assessment findings.	Resources: Hospital funded Partners: LSUHSC School of Nursing (SON)
Strategy -3	**Target Population**	**Actions**	**Timeframe/Measures**	**Potential Resources/ Partners**
Provide care coordination.	Community served	1. Continue to provide care coordination following specialty care. Specialist providers will continue to identify follow-up providers and schedule follow-up appointments after specialty care is provided. • Complete assessment of clinic throughput and develop plan for reduction of barriers to scheduling and coordination of appointments.	Track wait time for clinic appointments Develop measures based on throughput assessment and developed strategy. Develop and implement tracking mechanism for patient portal access that is HIPAA compliant Develop and implement tracking mechanism for follow-up appointments scheduled.	Resources: Clinic departmental funding, staff and administrative time, throughput assessment. Partners: LSUHSC physicians, Tulane Physicians, 504 Healthnet, other provider partners to educate patients to use of the patient access portal.
		2. Continue to provide a patient portal that allows patients to access their medical records in order to provide them to their primary care physician.	Implementation of patient access portal in late 2019. Once implemented, # of patients accessing medical records	Resources: Clinic departmental funding, staff and administrative time, throughput assessment. Partners: LSUHSC physicians, Tulane Physicians, 504 Healthnet, other provider partners to educate patients to use of the patient access portal.
		3. Follow-up appointment will be scheduled for patients after inpatient stays and clinic visits.	Track follow-up appointments with patients	Resources: Clinic departmental funding, staff and administrative time, throughput assessment.

				Partners: LSUHSC physicians, Tulane Physicians, 504 Healthnet, other provider partners to educate patients to use of the patient access portal.
Strategy -4	**Target Population**	**Actions**	**Timeframe/Measures**	**Potential Resources/ Partners**
Develop specialty care services to meet specific demands.	Community served	1. Further develop specialty care services to meet specific demands (e.g., cardiovascular, oncology, head and neck, neurosciences)	Track the number and type of additional services provided	Resources: Business Development Partners: LSUHSC physicians, Tulane physicians
		2. Providing radiation therapy program for indigent population who otherwise not have access to this treatment option	Track the number of indigent residents receiving radiation therapy	Resources: Staff time Partners: Physicians
		3. Walk-in Mammogram screenings will provide mammogram screening without appointments or referrals required	Track the number of mammograms provided.	Resources: Staff time Partners: Physicians, LA Breast & Cervical cancer program
Strategy -5	**Target Population**	**Actions**	**Timeframe/Measures**	**Potential Resources/ Partners**
Provide financial counseling for cost of medical care.	Community served, medically underinsured populations and undocumented population.	1. Staff in the financial department will offer assistance and financial counseling to residents that may be under/uninsured • Assistance filing Medicaid applications; • Assistance filing charity care eligibility application • Help set up payment plan options provide access to financial navigators to help patients understand potential cost of care prior to services if requested.	metrics to include # of patients accessing services of navigators # of patients accessing website to view chargemaster	Resources: Staff time/patient finance Partners: 504 Healthnet,

		Chargemaster posted to hospital website for transparency. • Educate patient access staff and navigators on ways to connect patients to financial counseling when needed.		
Strategy -6	**Target Population**	**Actions**	**Timeframe/Measures**	**Potential Resources/ Partners**
Provide prescription assistance to patients that are eligible.	Underinsured and uninsured populations	1. Provided resources are available, staff will offer assistance to patients to find and secure resources to secure prescription medications.	# of patients assisted # of patients participating in the medication bridge program	Resources: Staff time/Patient finance Partners: TBD
		2. Provided resources are available, UMCNO hospital foundation will continue to administer the medication bridge program (set amount of funds in one year to secure prescription medications) to UMCNO patients that qualify for charity care. Medication Bridge Program sponsored by the Spirit of Charity Foundation: • Medications and durable medical equipment for patients who financially qualify and to Medicaid pending patients • Cab and transport vouchers to clinic, infusion and home • Oxygen, noninvasive positive pressure ventilators CPAP/BIPAP to qualified patients		Resources: Staff time Partners: Spirit of Charity Foundation, potential funders to include Baptist Community Ministries, Cancer Society

		3. Identify other organizations who may donate patient assistance to decrease barriers to services.	# of organizations participating	Resources: Staff time Partners: Spirit of Charity Foundation, potential funders to include Baptist Community Ministries, Cancer Society
Strategy -7	**Target Population**	**Actions**	**Timeframe/Measures**	**Potential Resources/ Partners**
Provide Health System Navigation to residents	Community served	1. Hospital Liaison Program for Homeless: State-trial completed with volunteer advisors. First 10 months showed: • Decrease in ED visits (-16 visits) • Decrease in 30-day admissions (-29 visits), • Decrease in hospital days (-17%) among enrolled patients	# of visits	Resources: Staff time Partners: LSUHSC physicians, City of New Orleans Health Department Healthcare for the Homeless program, Unity
		2. Decrease in ED visits (-16 visits)	# of ED visits with timeframe	Resources: Staff time Partners: LSUHSC physicians, City of New Orleans Health Department Healthcare for the Homeless program, Unity
		3. Decrease in 30-day admissions (-29 visits),	Measures based on enrolled patients to include: decrease in ED visits, decrease in 30-day admissions and decrease in hospital days.	Resources: Staff time Partners: LSUHSC physicians, City of New Orleans Health Department Healthcare for the Homeless program, Unity

		4. Decrease in hospital days (-17%) among enrolled patients	# of hospital stays	Resources: Staff time Partners: LSUHSC physicians, City of New Orleans Health Department Healthcare for the Homeless program, Unity

Conclusion

LCMC Health was founded by Louisiana's only freestanding children's hospital, and currently consists of Children's Hospital, Touro Infirmary, University Medical Center New Orleans, New Orleans East Hospital and West Jefferson Medical Center. In addition to its five hospitals, LCMC Health significantly expanded its footprint and scope in the past several years through a joint ownership agreement with Crescent City Surgical Centre, an urgent care partnership with Premier Health, and a joint ownership agreement with Fairway Medical Center. In 2017, LCMC Health joined the Health Leaders Alliance clinically integrated statewide network, and in 2018 introduced its own clinically integrated network, LCMC Healthcare Partners, LLC. As a large health system in Louisiana, LCMC Health is uniquely positioned to adapt to the rapidly changing healthcare environment through its size, scale and leadership, and is committed to providing the best care possible for its community.

UMCNO will continue to improve health services for residents by leveraging the region's resources and assets; while existing and newly developed strategies can be successfully employed. The collection and analysis of primary and secondary data armed the Working Group with sufficient data and resources to identify key health needs. Local, regional, and statewide partners understand the CHNA is an important building block towards future strategies that will improve the health and well-being of residents in their region. UMCNO will work closely with community organizations and regional partners to effectively address and resolve the identified needs.

UMCNO took into consideration the ability to address the region's identified needs and viewed the overall short and long-term effects of undertaking the task. UMCNO will address the identified needs and view them as positive and encouraging changes. UMCNO will complete the necessary action and implementation steps of newly formed activities or revise strategies to assist the community's underserved and disenfranchised residents. Future community partnerships and collaboration with other health institutions, organizations, involvement from government leaders, civic organizations, and stakeholders are imperative to the success of addressing the region's needs. The available resources and the ability to track progress related to the implementation strategies will be managed by the health system along with other hospital departments at UMCNO to meet the region's need. Tackling the region's needs is a central focus hospital leadership will continue to measure throughout the years. UMCNO will continue to work closely with community partners, as this implementation strategy planning report is the first step to an ongoing process to reducing the gaps of health disparities and ensuring all residents have access to the high-quality health care resources available in the region.

Endnotes

[i] Substance Abuse and Mental Health Services Administration: www.samhsa.gov/wellness-initiative

[ii] The council is co-led by the New Orleans Health Department and Metropolitan Human Services District. It focuses on four sectors to coordinate and implement community wide strategies to integrate behavioral health; health and hospitals, education, housing and criminal justice.

[iii] Since December 2017, the New Orleans Health Department has convened four meetings of the Opioid Task Force, which is comprised of treatment providers, first responders, law enforcement agencies, and policy advocates. There are four subcommittees: Data collection and consolidation, harm reduction efforts and coordination, outreach and care coordination and direct service providers.

[iv] Healthy People 2020: www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

[v] Centers for Disease Control and Prevention: www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/PreventiveHealth.html

[vi] Ibid.

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