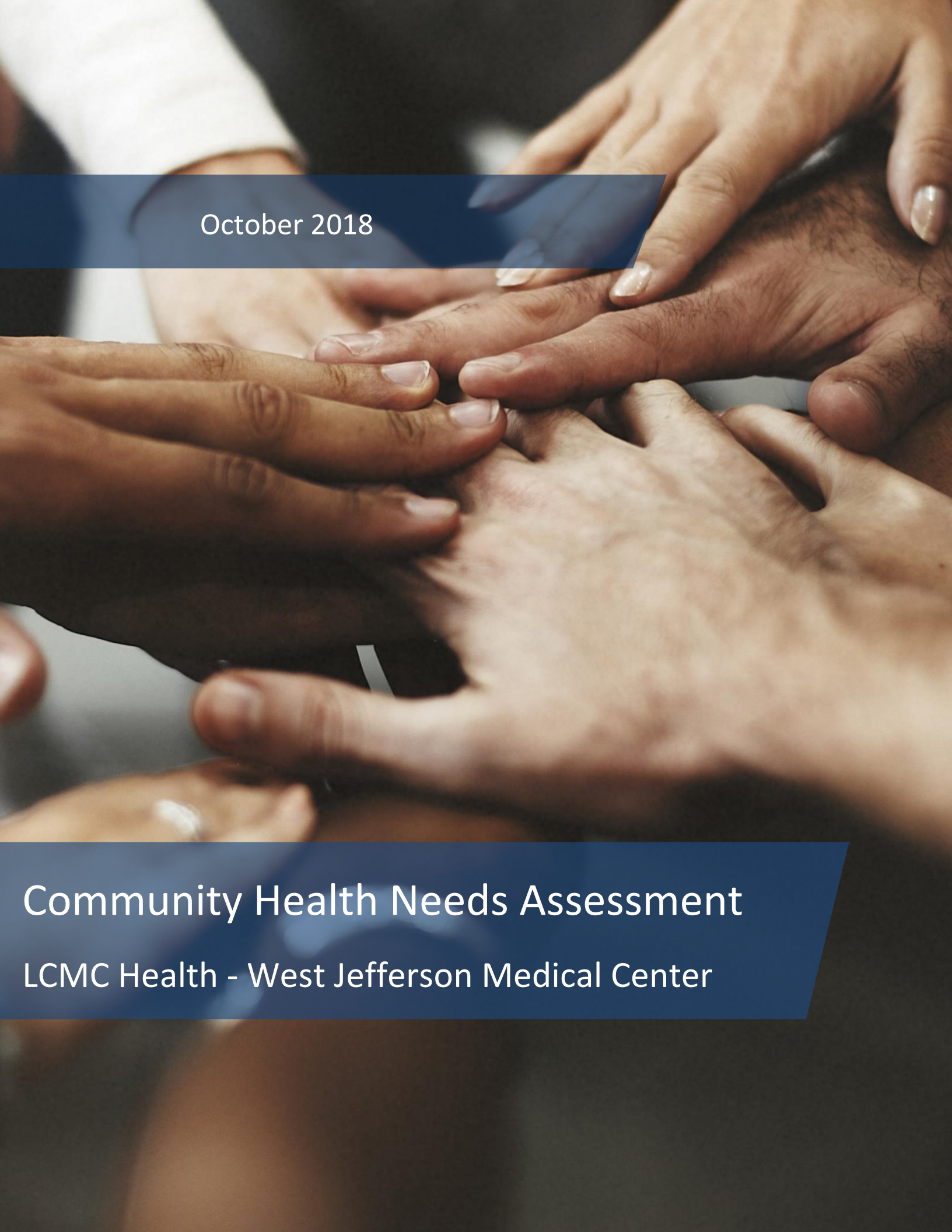

October 2018

Community Health Needs Assessment

LCMC Health - West Jefferson Medical Center

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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.

Founded in 1956, through the citizens of Jefferson Parish, West Jefferson Medical Center (WJMC) today is a 435-bed full-service community hospital. Located in the heart of the West Bank, West Jefferson Medical Center is dedicated to serving the people of the West Bank, including: Jefferson, Orleans, Plaquemines, St. Charles parishes, and beyond.

West Jefferson Medical Center opened its doors in April 1960. Throughout its distinguished history of caring for the community, the hospital has been nationally recognized for programs of excellence and for delivering high-quality care.

West Jefferson Medical Center offers comprehensive programs for preventive, emergency, acute, and rehabilitative care. Clinical excellence divisions include neurosciences, cardiovascular services, and an academic community cancer center. Located near vast industrial quarters, the medical center also serves business and industry across the Gulf South.

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 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.[1] The overall CHNA involved multiple steps that are depicted in Chart 1. Additional information regarding each component of the project, and the results, can be found in the Appendices section of this report. The MHCNO CHNA was spread among 15 Louisiana parishes and two Mississippi counties. This large geographic area was broken into six regional areas to aid comparison and analysis of primary and secondary data.

LCMC Health Hospitals were included in the Westbank Regional Profile and New Orleans Regional Profile. WJMC was included in the Westbank Regional Profile, while Children's Hospital, New Orleans East Hospital (NOEH), Touro Infirmary, and University Medical Center New Orleans (UMCNO) were included in the New Orleans Regional Profile.

[1] Tripp Umbach worked closely with Working Group members composed of hospital administration leaders from participating hospitals and health systems. A complete Working Group member listing can be found in Appendix F.

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 non-profit 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 - West Jefferson Medical Center.

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 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.

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.[2]

[2] The outcomes from the CHNA will be addressed through an implementation planning phase.

Methodology

A comprehensive CHNA process performed by WJMC included the collection of primary and secondary data. Community organizations and leaders within the three-parish 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' community regarding the care and services they provide. Community representatives and stakeholders attended a community forum facilitated by Tripp Umbach to prioritize health needs, which will assist 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.[3] 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, Westbank, and St. Anne (Raceland)/Lafourche region.

Additional data from Truven Health Analytics was supplied to gain a deeper understanding of community health care needs.[4] The Community Needs Index (CNI), jointly developed by Dignity Health and Truven Health, assists in the process of gathering vital socioeconomic factors in the community. CNI is a strong indicator of a community's demand for various health care services. The CNI data will be used to quantify the implementation strategy efforts and plans for LCMC Health.

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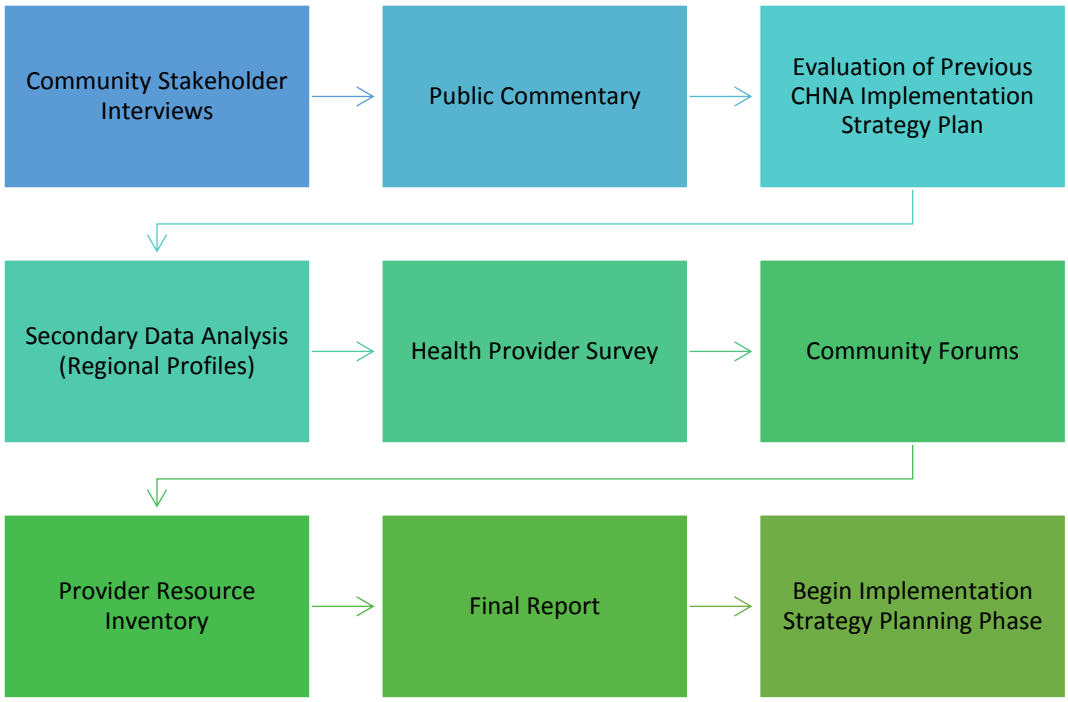
[3] For the regional profiles, Tripp Umbach cited the data years reflective of the year the CHNA was conducted. The data years from Community Commons vary for each data point. Some data points may be reflective of years prior to 2017. Tripp Umbach compiled and collected data that was currently available on the data sources' site. Tripp Umbach provided data on specific outcome factors and measures that had "fresh" information.

[4] Truven Health Analytics, formerly known as Thomson Reuters, is a multinational health care company that delivers information, analytic tools, benchmarks, research and services to a variety of organizations and companies. Truven Health Analytics uses: Demographic data, poverty data (from The Nielsen Company) and insurance coverage estimates (from Truven Health Analytics) to provide Community Needs Index (CNI) scores at the ZIP code level. Additional information on Truven Health Analytics can be found in the Appendices.

The overall CHNA involved multiple steps that are depicted in the below flow chart. Additional information regarding each component of the project, and the results, can be found in the Appendices section of this report.

Chart 1: CHNA Process Chart



Primary Service Area

A comprehensive CHNA was completed for LCMC Health - West Jefferson Medical Center. Tripp Umbach provided benchmarking or trending data to track and observe positive or negative movements in the primary and secondary data (where applicable).

The primary service area is defined by ZIP codes that contain a majority (80 percent) of inpatient discharges from the health facility. In 2018, a total of eight ZIP codes were identified for WJMC service area as containing a majority of inpatient discharges. (See Table 1.) For comparison purposes, the study area for WJMC's CHNA consisted of three parishes which held the majority of these ZIP codes. They included: Orleans, Plaquemines, and Jefferson parishes.

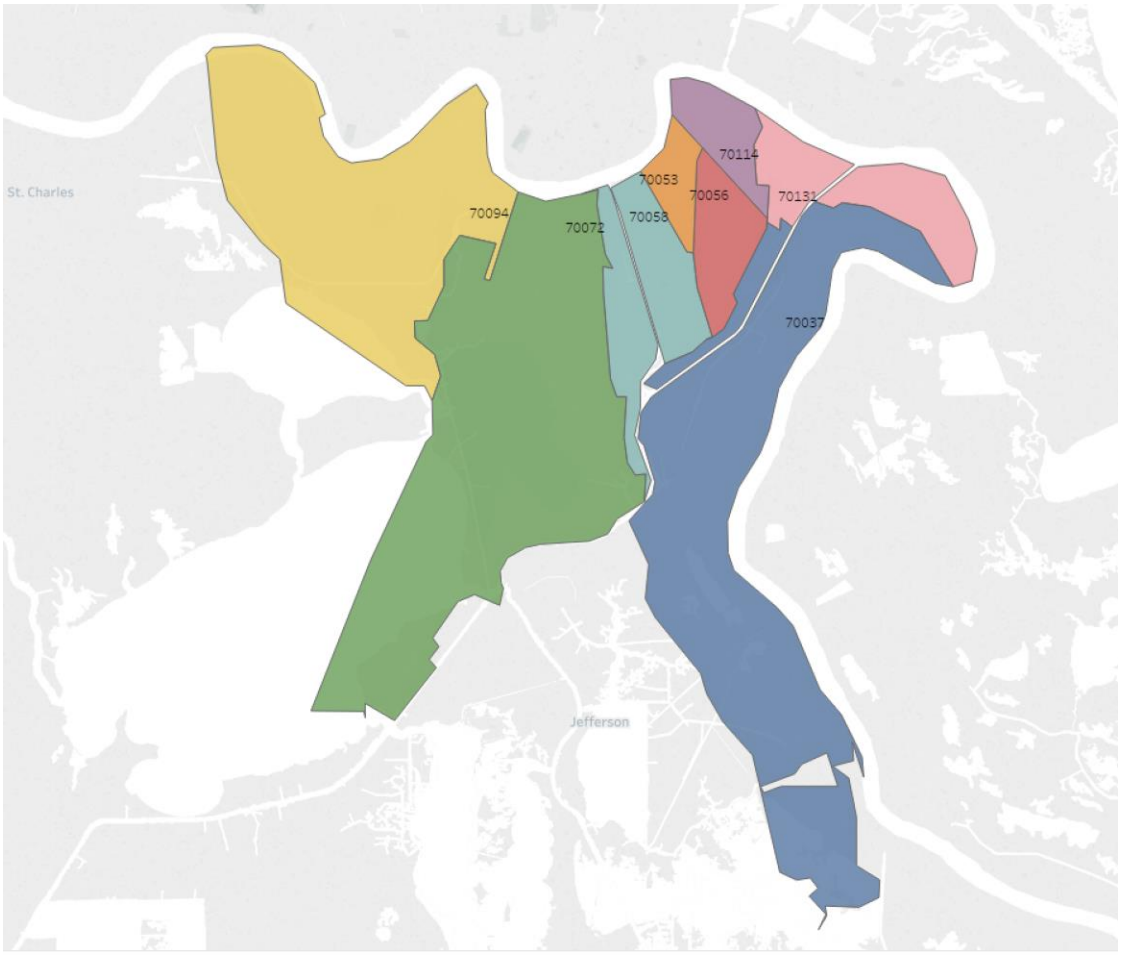
Thus, the CNI information compiled for analysis represented eight ZIP codes as part of the WJMC and reflected areas with the largest number of residents who utilize health care services from this health institution.

The information collected from these specific ZIP codes will assist in future health care planning services, community benefit contributions, and programming efforts. Map 1 represents the primary service area of West Jefferson Medical Center.

Table 1: Overall Study Area Profile

	ZIP Code	City	Parish
1.	70053	Gretna	Jefferson
2.	70056	Gretna	Jefferson
3.	70058	Harvey	Jefferson
4.	70072	Marrero	Jefferson
5.	70094	Westwego	Jefferson
6.	70114	New Orleans	Orleans
7.	70131	New Orleans	Orleans
8.	70037	Belle Chasse	Plaquemines

Map 1: **WJMC**- Study Area



Note: Map is not to scale.

Source: Truven Health Analytics

The study area for WJMC shows the three parishes are projected to have a population growth from 2017-2022; ranging from 400 to 28,089 residents.

Jefferson Parish encompasses 437,303 residents and is the largest parish in the study area, next to Orleans Parish with 399,567. (See Table 2.)

Orleans Parish is expected to have the largest population change at 7.03 percent or an increase of 28,089 residents.

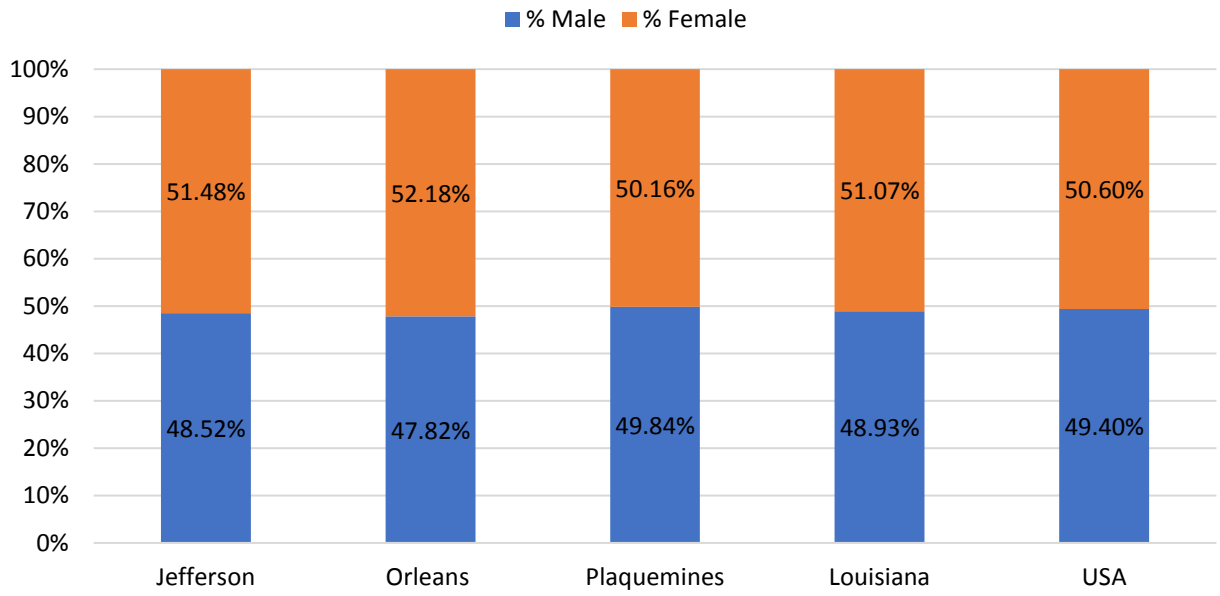
Table 2: WJMC Area Population Snapshot

	Jefferson Parish	Orleans Parish	Plaquemines Parish	Louisiana	USA
2017 Total Population	437,303	399,567	23,658	4,706,135	325,139,271
2022 Projected Population	444,708	427,656	24,058	4,839,118	337,393,057
# Change	7,405	28,089	400	132,983	12,253,786
% Change	1.69%	7.03%	1.69%	2.83%	3.77%

Source: Truven Health Analytics

The representation of males and females in the overall study area and the state are close (see Chart 2).

Chart 2: Gender



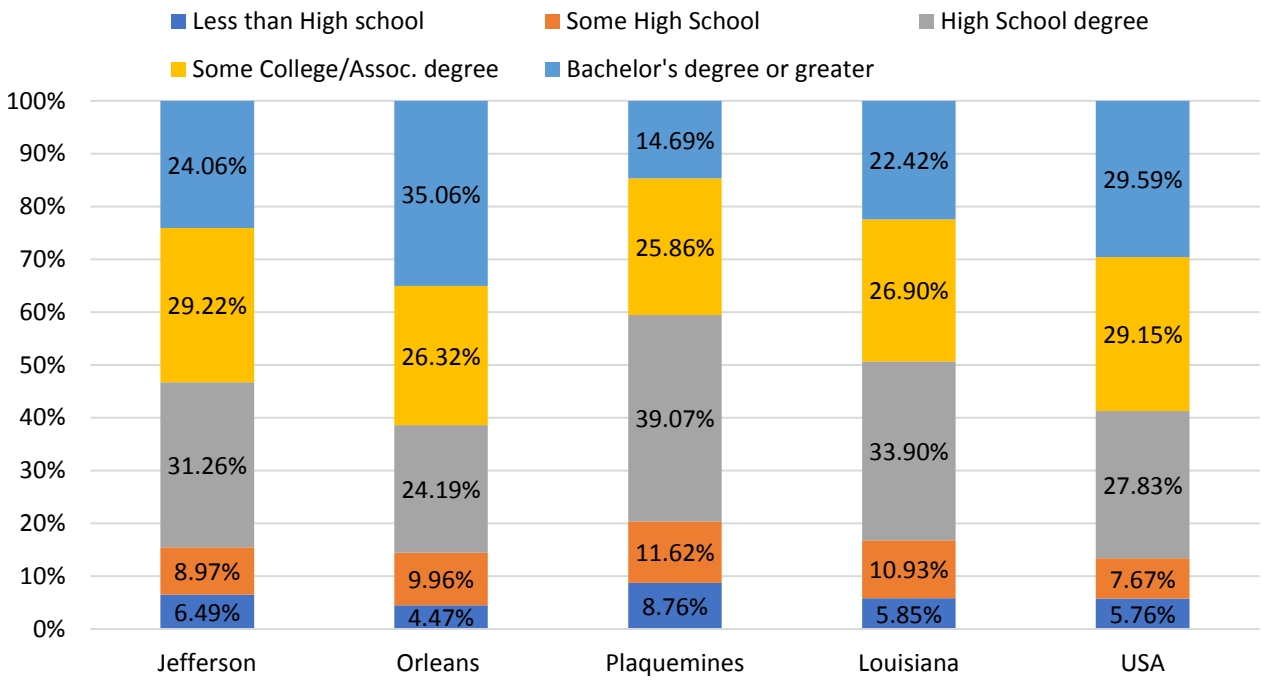
Source: Truven Health Analytics

Chart 3 illustrates the distribution of educational attainment among residents in the study area.

Plaquemines Parish reports the highest rate of residents with less than a high school education at 8.76 percent when compared to the remaining study area parishes.

Orleans Parish reports the highest rate of residents with a bachelor's degree or higher at 35.06 percent; while Plaquemines Parish reports the lowest rate of residents with a bachelor's degree or higher at 14.69 percent.

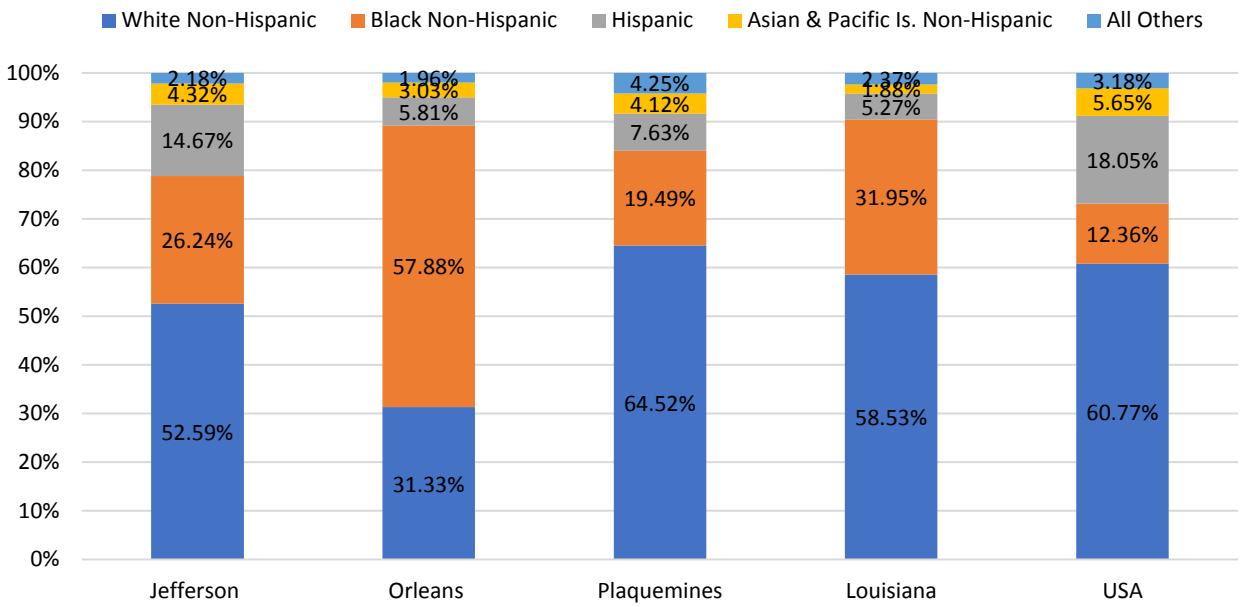
Chart 3: Education Level



Source: Truven Health Analytics

Chart 4 shows the diverse mixture of race/ethnicity represented in the study area. Orleans Parish reports the largest black, non-Hispanic population percentage for the study area (57.88 percent); while Plaquemines Parish reports the fewest (19.49 percent). Plaquemines Parish also reports the largest percentage of residents who are white/non-Hispanic (64.52 percent); higher than the state (58.53 percent) and nation (60.77 percent).

Chart 4: Race/Ethnicity

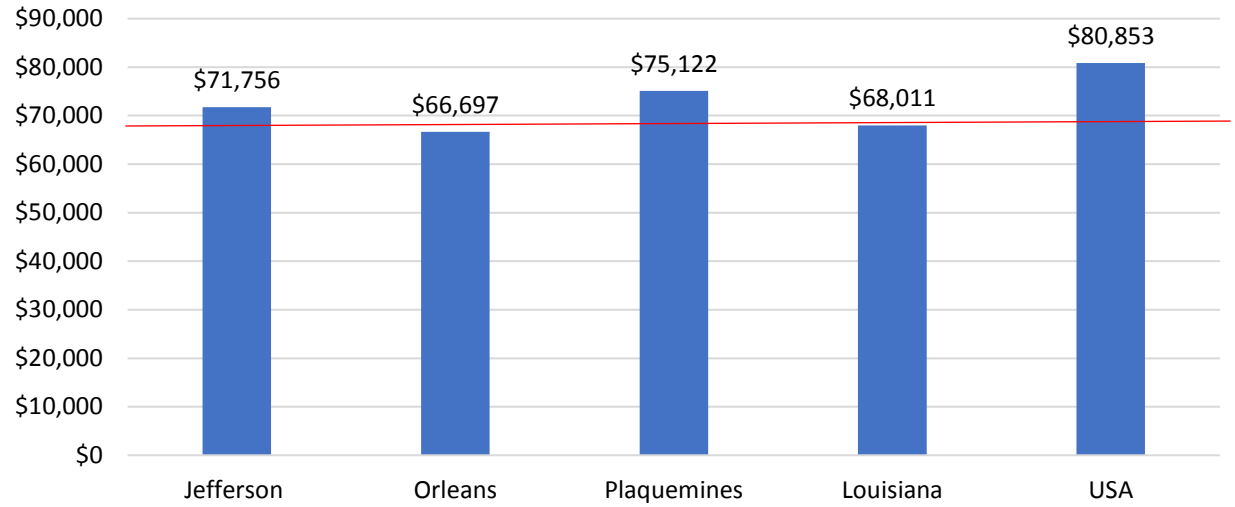


Source: Truven Health Analytics

Orleans Parish reports the lowest average household income of the entire study area at $66,697; this is also lower than state ($68,011) and national ($80,853) averages. Plaquemines Parish reports the highest average household income at $75,122. (See Chart 5.)

Note: The red line provides a visual of where the state income average lies.

Chart 5: Average Household Income



Source: Truven Health Analytics

CNI scores obtained by Truven Health Analytics were analyzed for the ZIP codes that make up the service area. This analysis is an important part of the study. The CNI ZIP code summary provides valuable background information to begin addressing and planning for the community's current and future needs. The CNI provides greater ability to diagnose community needs as it explores ZIP code areas with significant barriers to health care access.

A CNI score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with greatest need. It is important to note that a low score (e.g., 1.0) does not imply that attention should not be given to that neighborhood; rather, hospital leadership should explore and identify the specific strategies employed to ensure a low neighborhood score.

Examining the CNI scores of 2017, Chart 6 shows the average CNI score for each of the six study regions under the overall MHCNO scope. The Jefferson Study Area averaged 3.6; indicating that residents faced significant socioeconomic barriers to care. St. Anne had a CNI score in 2017 of 3.6; Baton Rouge had a 2017 CNI of 3.4.

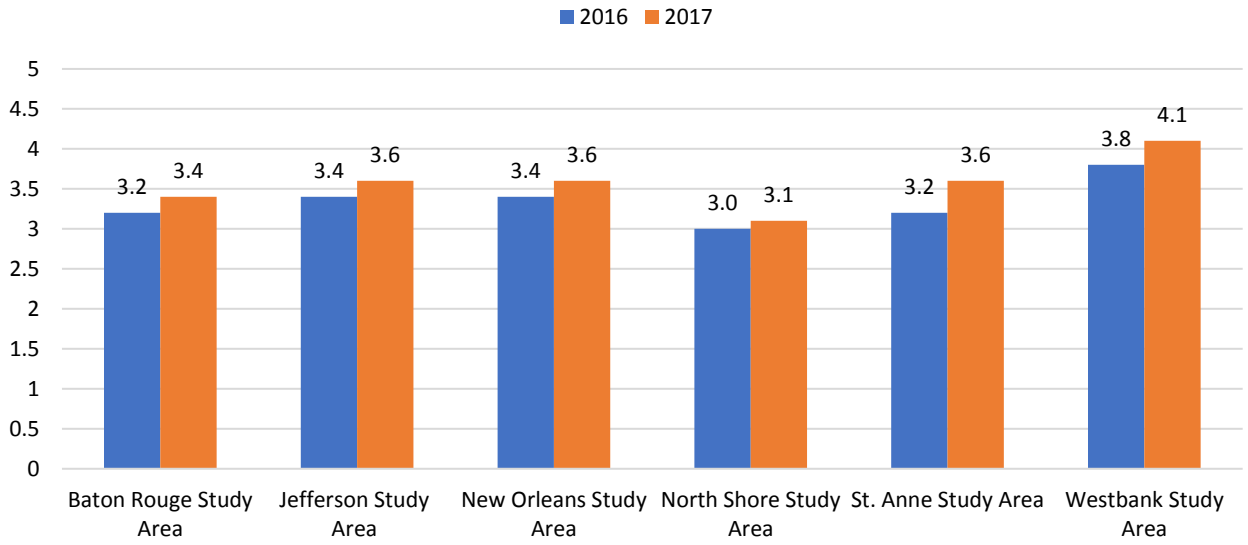
The New Orleans Study Area (which includes LCMC Health System facilities; Children's, New Orleans East (NOEH), Touro Infirmary, and University Medical Center) reported an average CNI score of 3.6. The West Bank Study Area (which includes West Jefferson Medical Center) reported the highest average CNI score

at 4.1; indicating that residents face the highest socioeconomic barriers to care when compared to the remaining study areas.

On the polar end, residents in the North Shore Study Area reported a lower score (3.1), indicating fewer socioeconomic barriers to care for residents.

Overall, all of the study regions increased their CNI scores from 2016 to 2017 and continue to report scores above the median for the CNI scale, with North Shore Study Area reporting the lowest score (3.1) and the West Bank Study Area reporting the highest (4.1).

Chart 6: Average CNI Scores of MHCNO Regional Profiles



Source: Truven Health Analytics

CNI Score

5.00 to 4.00 (High socioeconomic barriers)

3.99 to 3.00

1.99 to 1.00 (Low socioeconomic barriers)

Key Community 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."[5] This idyllic description of a healthy community 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 which addresses and provides services to impede preventable diseases.

With the implementation of the PPACA, the pathway to affordable and obtainable health insurance services has been made accessible to once uninsured residents in Southern Louisiana. Coordinating health services and reducing health care costs are components in the execution of the PPACA. Accessibility and better care coordination to health services can be delivered through health care institutions and regional partners. WJMC and their commitment to delivering high-quality health care services in collaboration with regional agencies and organizations can capitalize on existing resources to further expand community assets.

WJMC continues to contribute towards regional programming efforts, educational initiatives, and high-quality patient care to improve the health and security of its community. WJMC 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. WJMC 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.

WJMC is located in Jefferson Parish and the needs for the hospital and its surrounding communities was a result of the primary and secondary data collected. In the summer of 2018, key need areas were identified during the CHNA process through the gathering of primary and secondary data. The identified needs were:

A. Access to Care

B. Behavioral Health (Mental Health & Substance Abuse)

C. Health Education

[5] Office of Disease Prevention and Health Promotion: https://health.gov/news/blog-bayw/2010/10/healthy-communities-means-healthy-opportunities/

The identified community needs are depicted in order of priority in the chart below.

Chart 7: WJMC Community Health Needs 2018

Priority 1: Access to 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 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.

Across the U.S., a predicted shortage of as many as 120,000 physicians by 2030 will serve as an access issue according to the Association of American Medical Colleges (AAMC). By 2030, the study estimates a shortfall of between 14,800 and 49,300 primary care physicians. At the same time, there will be a shortage in non-primary care specialties of between 33,800 and 72,700 physicians.[6] In 2016, Louisiana had 11,737 active physicians with 3,873 primary care physicians.[7]

Orleans Parish ranks well in the state in terms of clinical care according to the 2018 County Health Rankings and Roadmaps report; Plaquemines Parish does not rank well compared to the other parishes in the study area. (See Table 3.) Clinical care ranking considers the availability of health services and the quality of those services, it also considers the preventive care measures that patients take to manage their health, including immunization rates, cancer screening rates, and percentage of the population that receives a yearly dental examination.

Table 3: 2018 County Health Rankings and Roadmaps Clinical Care

Louisiana (out of 64 parishes)	Ranking 2018
Jefferson	14
Orleans	7
Plaquemines	31

Source: County Health Rankings and Roadmaps

Closing the gaps of disparities, Louisiana's safety net providers play a vital role in delivering health care to the state's underserved and disenfranchised populations. Louisiana's community health centers provide access to primary and preventive services for low-income and underserved residents. Louisiana is home to 30 federally qualified health centers (FQHCs), which operate 162 sites throughout the state. Louisiana's FQHCs saw over 303,000 patients and provided nearly 1.1 million patient visits in 2014. Over one-third (37.0 percent) of their patients were uninsured and two-fifths (40.0 percent) had Medicaid coverage. Nearly all (93.0 percent) had incomes below 200 percent federal poverty line, including over three-quarters (77.0 percent) who had income below 100 percent federal poverty line.[8]

[6] Association of American Medical Colleges: https://news.aamc.org/press-releases /article/workforce_report_shortage_04112018
[7] Ibid.
[8] Henry J. Kaiser Family Foundation: www.kff.org/health-reform/fact-sheet/the-louisiana-health-care-landscape/

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. [9]

Most Americans underuse preventive services and vulnerable populations with social, economic, or environmental disadvantages are even less likely to use these services.[10] 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.

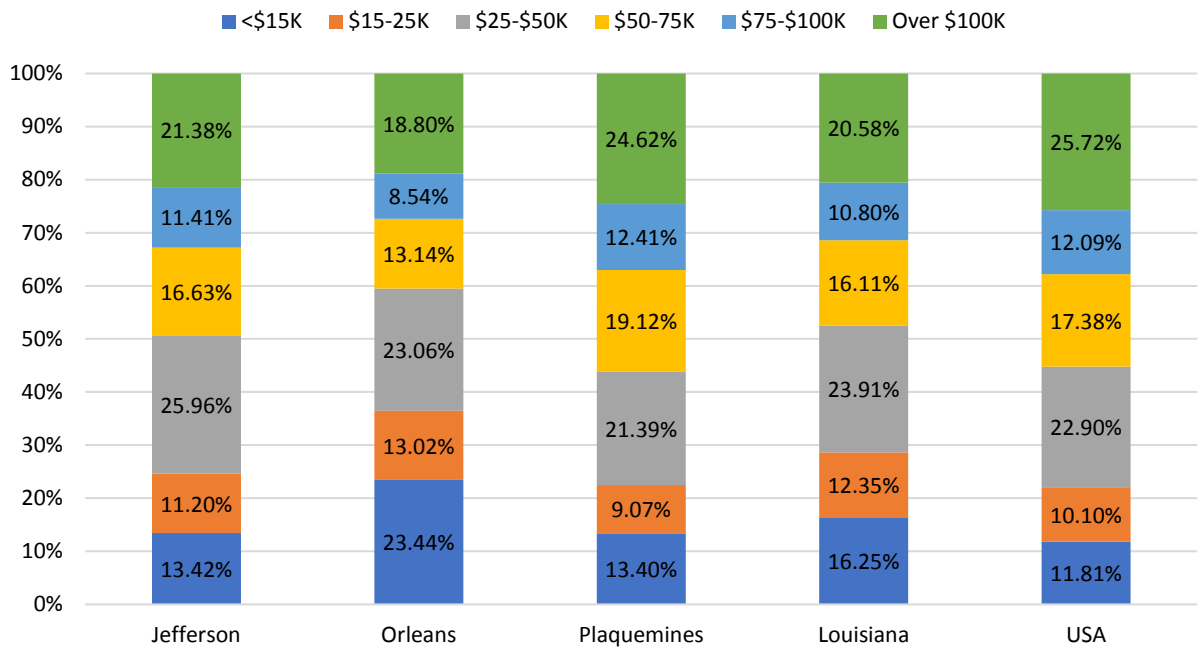
The level of access a community has to health care has a tremendous impact on the community's overall health. Several factors including, geography, economics, and culture, etc., contribute to how residents obtain care. Geography impacts the number of providers that are available to patients in a given area as transportation options are limited to some residents. Economically, health problems affect productivity resulting in 69 million workers reporting missed days due to illness each year.[11] Lack of job opportunities can reduce access to affordable health insurance. Both geographic and economic factors are impacting residents of the WJMC service area. While there are quality health care resources available to residents within the service area, many residents either cannot afford health services or are limited in transportation options to obtain the services they need.

According to demographic data obtained from Truven Health Analytics (see Chart 8), Orleans Parish (36.46 percent), reported higher levels of residents earning less than $25,000 per year when compared to the remaining parishes and the nation (21.91 percent).

The average household income for Orleans Parish ($66,697) is less than the household income for the State of Louisiana ($68,011) as well as the nation ($80,853); thereby, adding challenges for residents who seek health services. Jefferson ($71,756) and Plaquemines ($75,122) parishes average household income is lower than the nation ($80,853) but higher than the state ($68,011).

[9] Healthy People 2020: www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services
[10] Centers for Disease Control and Prevention: www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/PreventiveHealth.html
[11] Ibid.

Chart 8: WJMC Household Income



Source: Truven Health Analytics

A family's income level is a determining factor to many aspects of life such as where they live, what they eat, and how and when they access health care. As illustrated by data compiled by Community Commons, many residents in the WJMC service area experience issues with food insecurity, food access, substandard housing, and poverty.

Residents in Orleans Parish (23.71 percent) face higher food insecurity issues when compared to the other parishes in the study area, the state (17.30 percent), and the nation (14.91 percent). Orleans Parish (26.21 percent) has higher populations living 100 percent below the federal poverty line when compared to the state (19.70 percent) and the nation (15.11 percent).

Plaquemines (52.16 percent) residents face higher food access issues when compared to the remaining parishes, the state (19.70 percent), and the nation (15.11 percent). Jefferson Parish (14.18 percent) reports the lowest food access issue when compared to the remaining parishes.

Orleans (43.69 percent) and Jefferson (33.79 percent) parishes face higher occupied housing units with one or more substandard conditions. A family's household income is woven into how they are able to live, eat, and obtain safe, clean, and affordable housing. (See Table 4.)

Table 4: Social and Economic Factors 2018

	Jefferson	Orleans	Plaquemines	Louisiana	U.S.
Food Insecurity	14.08%	23.71%	12.78%	17.30%	14.91%
Population Below 100% FPL	16.09%	26.21%	17.16%	19.70%	15.11%
Food Access (Low Income & Low Food Access)	14.18%	20.05%	52.16%	26.32%	18.94%
Occupied Housing Units w/ one or more Substandard Conditions	33.79%	43.69%	28.01%	29.36%	33.75%

Source: Community Commons

Analyzing data from the regional study area, ZIP code 70114 (New Orleans) reported high percentages of residents who are seniors living in poverty, children living in poverty, single residents living in poverty with children, and who are unemployed. The CNI detailed data reported important factors related to barriers residents face when trying to obtain health care services.

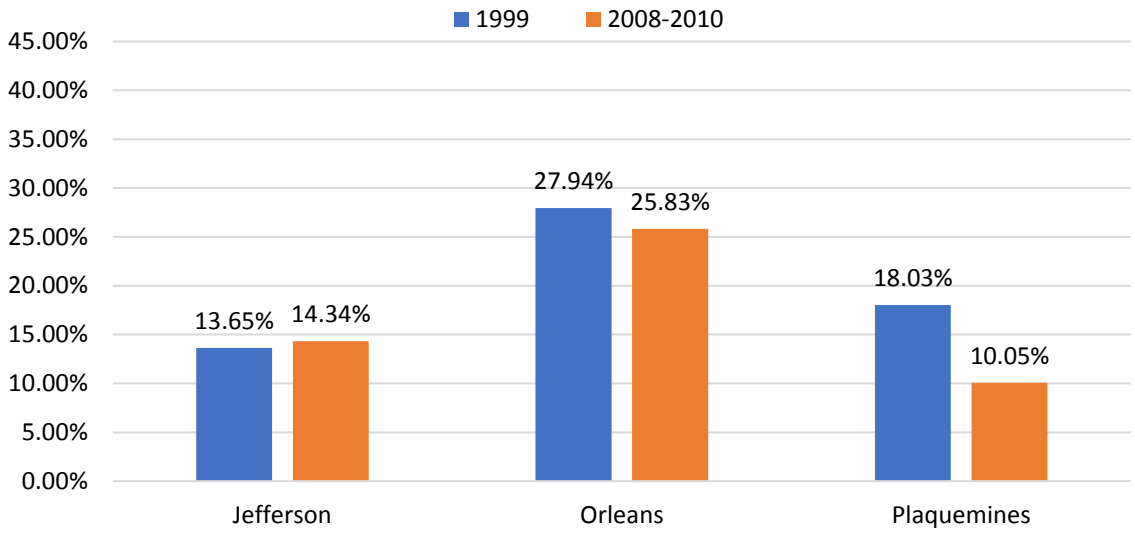
Social and economic factors significantly influence resident's health, clinical care options, and the environment where residents live. The inability to afford healthy food, the inability to obtain health care services, and the lack of educational attainment perpetuate the cyclic nature of poverty and poor health outcomes.

Education level determines employment choices, which, in turn, determines income level. These factors influence the probability of being able to afford to live in a health-supporting physical environment, such as housing without lead paint or other safety hazards, in a safe community, and at a sufficient distance from industrial polluting sites.

County Health Rankings and Roadmaps reported Jefferson (24;20) and Orleans (48;33) parishes improved their Social and Economic Factors ranking (gotten better) from 2015 to 2018. Plaquemines Parish (4;6) increased the rankings (gotten worse) between the years.

Additional data from the Greater New Orleans Community Data Center Report shows that poverty levels have improved in Orleans and Plaquemines parishes between 1999 and 2008-2010 (see Chart 9). Residents in Jefferson Parish rose in poverty rates from 13.65 percent to 14.34 percent.

Chart 9: Total Population in Poverty



Source: Greater New Orleans Community Data Center Report

Access to Health Screenings and Services

To obtain high-quality care, Americans must first gain entry into the health care system. 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.[12] Insurance coverage, health services, and timeliness of care are important components to access to care.

Access to care also includes access to health screening for prevention. Screenings for health and wellness help residents become and remain in a positive state of physical and mental well-being. Health screenings check for diseases and health conditions before there are any outward signs or symptoms. Screenings also help flag and signal issues; therefore, intervention programs from a health care professional can assist residents combat their disease/ailment more quickly and with greater ease. Screenings help ensure that residents stay in good physical and mental health. Maintaining healthy routines and management plans are examples of interventions for prevention, health, and wellness.

Recommended screening tests depends on age, sex, gender, history, etc. as these are important elements residents must remember in order to maintain a healthy status. Residents can be screened for certain diseases. They include: certain types of cancer, high blood pressure or high cholesterol,

[12] Healthy People 2010: www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

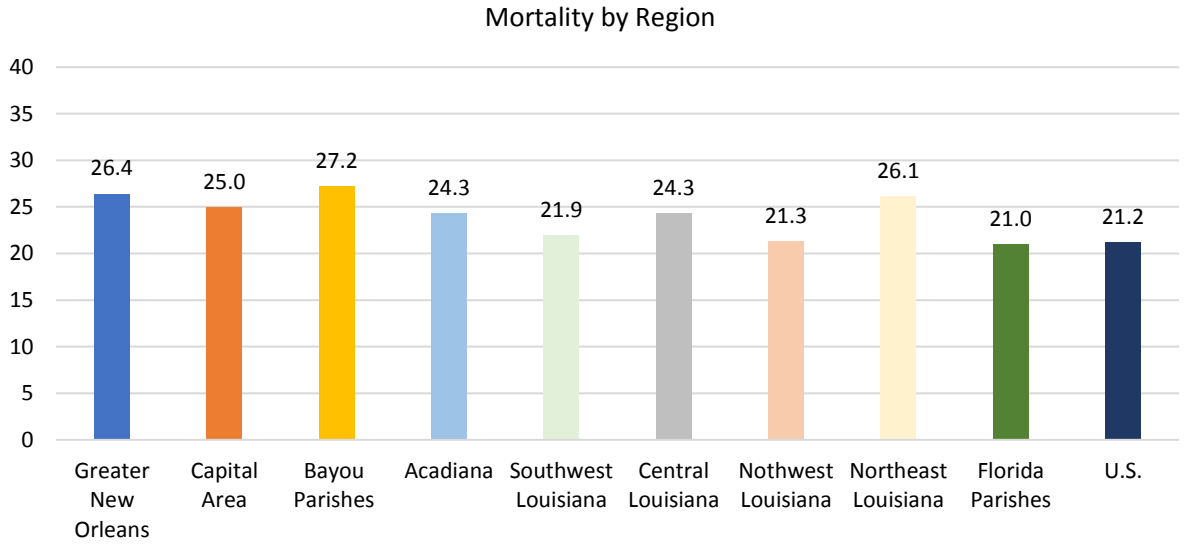
diabetes, osteoporosis, sexually transmitted diseases (STDs), and mental health conditions, like depression.[13]

The importance of screenings can be portrayed through examples related to cancer. The Louisiana Healthcare Connection recommends three specific screenings as of January 2018 for Louisianans (cervical, breast, and STDs) as they currently hold high mortality rates.

In 2010-2014, data reveal Louisiana's breast cancer mortality rate is higher than the rest of the country. 123.2 people per 100,000 were diagnosed with breast cancer, while the national average was 123.5 per 100,000. An average of 24.2 Louisiana residents per 100,000 died each year from this disease, while the national average was 21.2 deaths per 100,000.

The Greater New Orleans Area, Capital Area, Bayou Parishes, Acadiana, Central Louisiana, and Northeast Louisiana have the highest breast cancer death rates in the state (see Chart 10). Breast cancer does not discriminate as black women are significantly higher to die from breast cancer than the rest of the country.[14]

Chart 10: Average Annual Breast Cancer Mortality by Region 2010-2014 (per 100,000 population)[15]



Source: Louisiana Cancer Prevention

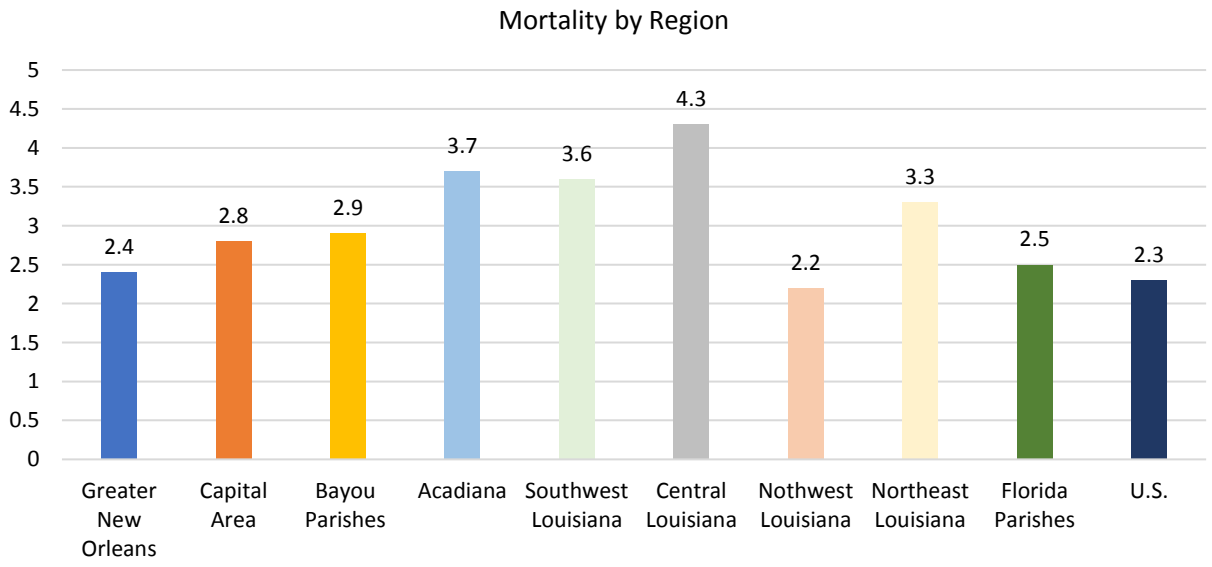
[13] Office of Disease Prevention and Health Promotion: https://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-screened
[14] Louisiana Cancer Prevention: http://louisianacancer.org/cervical-cancer/
[15] Ibid.

Examining additional data, Louisiana has the sixth highest rate of cervical cancer in the U.S. Data from 2010-2014 reported that 8.9 residents per 100,000 were diagnosed with cervical cancer, while the national average was 7.5 per 100,000. Unfortunately, an average of 2.9 Louisiana residents per 100,000 died each year from this disease, while the national average was 2.3 deaths per 100,000. Cervical cancer is a killer of women in all races; as Louisiana black women have significantly higher cervical cancer incidence and death rates than the rest of the country. White females in the state have a 7.9 incidence rate and 2.5 mortality rate vs. 11.5 incidence and 4.2 per 100,000 for black women in Louisiana.

Screenings for cervical cancer are fairly simple and require no down time. However, a multitude of reasons contribute to why these screenings are not obtained. Some reasons include: insurance coverage, fear, lack of screening information (knowledge), apathy, having a physician, and traveling for health services. Cervical cancer can be easier to treat when it is found early. It was also reported that cervical cancer is an expensive cancer to treat. Despite having insurance coverage, residents still pay higher health insurance premiums for treatment and follow-up care. Therefore, it is important for women between the ages of 21 and 64 to have a cervical cancer screening each year.

Chart 11 provides a mortality snapshot of cervical cancer patents. The chart depicts residents in Central Louisiana (4.3 per 100,000 population) and Acadiana (3.7 per 100,000 population) reporting the highest rates of those who passed from cervical cancer between 2010-2014.

Chart 11: Average Annual Cervical Cancer Mortality by Region 2010-2014 (per 100,000 population)[16]



Source: Louisiana Cancer Prevention

[16] Ibid.

Prevention measures related to exercising, eating well, avoiding tobacco and excessive alcohol use, as well as obtaining regular health screenings from a health care provider can prevent diseases and improve the quality of life for an individual.

Preventive screenings assess and reduce patients' risk for diseases and conditions. Overall, screenings related to the above aforementioned diseases reduce risk factors in residents. Health screenings reduce disease and improve health at a national level. Community programs aimed at offering preventive screenings and prevention measures at a grassroots approach can help reduce the community's health problems.

Seeking and obtaining information related to screenings is vital in order to maintain and preserve a healthy life. Health screenings can help build relationships between healthy behaviors and health outcomes as community residents have an increased desire to be proactive and take charge of their health status.

Access to health care is a culmination of many factors including, geographic, economic, cultural, and social.[17] Economic, cultural, and social factors can reduce and, in some cases, eliminate access to needed medical services, despite an existing adequate ratio of providers and transportation to those providers.

For patients to get timely, appropriate, affordable, and quality care, they must be able to navigate the health care system. When the system is too burdensome, patients may delay or neglect to schedule needed care or will seek care in inappropriate but more easily accessible settings, such as emergency departments. Certain populations may experience greater challenges when navigating the health care system which leads to increased health disparities and decreased access to necessary healthcare services.

Health care systems have become laden with complexity. While patients are dealing with unexpected medical diagnoses requiring the expertise of multiple healthcare professionals, procedures, and doctor visits, they must also address barriers such as transportation, financial and insurance issues, cultural beliefs, and language barriers. Trying to address all these factors may present insurmountable barriers to accessing services appropriately.

Lack of Health Providers

The Health Resources and Services Administration (HRSA), as an agency of the U.S. Department of Health and Human Services (HHS), is the primary federal agency for improving access to health care for the tens of millions of Americans who are medically underserved or face barriers to needed care.[18] According to recent Community Commons data, Jefferson Parish has a total Health Professional Shortage Areas (HPSAs) facility designation of 12, Orleans Parish has a total of 25 HPSAs, and Plaquemines Parish is set at zero. This Community Commons indicator reports the number and location of health care facilities designated as "Health Professional Shortage Areas" (HPSAs), defined as having

[17] Rand Corporation: www.rand.org/topics/health-care-access.html
[18] Health Resources & Services Administration: www.hrsa.gov/about/strategic-plan/introduction.html

shortages of primary medical care, dental or mental health providers. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Community leaders and health professionals surveyed during the CHNA process still observe residents having difficulty finding care; specifically, around behavioral and oral care. More than half of survey respondents disagreed (37.7 percent) and strongly disagreed (29.1 percent) that residents have access to mental/behavioral health providers. Close to one-third of survey respondents disagreed (21.4 percent) and strongly disagreed (9.2 percent) that residents have access to dental care.

Table 5: Clinical Care

	Primary Care Physicians	Dentists	Mental Health Providers	Preventable Hospital Stay
Jefferson 2015	1,132:1	1,264:1	790:1	65
Jefferson 2018	1,130:1	1,200:1	470:1	49
Orleans 2015	1,143:1	1,591:1	492:1	47
Orleans 2018	1,110:1	1,470:1	240:1	43
Plaquemines 2015	3,417:1	3,925:1	1,812	73
Plaquemines 2018	5,870:1	4,690:1	1,380	39
Louisiana 2015	1,555:1	1,976:1	977:1	80
Louisiana 2018	1,530:1	1,880:1	420:1	66

Source: County Health Rankings and Roadmaps

When comparing years 2015 and 2018, County Health Rankings and Roadmaps data shows decreased rates of dental providers and primary care physicians per 100,000 population in Jefferson and Orleans parishes. Plaquemines Parish showed a significant increase in primary care physicians (going from 3,417 to 5,870) and dentists (going from (3,925:1 to 4,690:1) in 2018.

Jefferson and Orleans parishes reported lower rates of primary care physicians and dentists when compared to the state. Both parishes also reported low rates of mental healthcare providers lower than the nation in 2018. (See Table 5.)

According to data compiled by the Louisiana Department of Health, the demand for such services has dramatically increased since 2016 and continues to outpace the supply of providers.

It is also important to note the decrease in the number of preventable hospital stays within all the parishes and state. The preventable hospital stay indicator measures the hospital discharge rate for ambulatory care-sensitive conditions per 1,000 fee-for-service Medicare enrollees. The measure looks at people who were discharged from the hospital for conditions that, with appropriate care, can normally be treated without the need for a hospital stay. Examples of these conditions include convulsions, chronic obstructive pulmonary disease, bacterial pneumonia, asthma, congestive heart failure,

hypertension, angina, cellulitis, diabetes, gastroenteritis, kidney/urinary infection, and dehydration.[19] Proper diagnosis, along with primary care treatment from a health professional, and addressing the needs of the patient population who are at risk of readmissions have played a role in the reduction of hospital stays. (See Table 6).

Hospitals and individual providers will need to continuously assess and populate the region with an adequate supply and number of health providers in order to serve the residents of LCMC's service area.

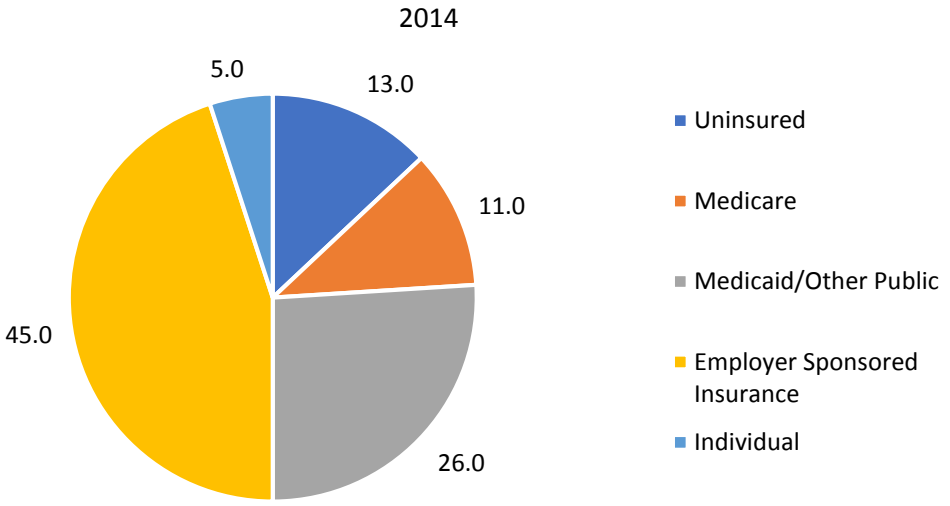
Health Insurance Coverage

While not the only barrier to obtaining health care, being uninsured is by all indications the most significant one. Having health insurance is a prerequisite for routine access to health care. It is associated with better health outcomes for adults and improves the likelihood of disease screening and early detection, the management of chronic illness, and the effective treatment of acute conditions. Those without health insurance or without insurance for particular types of services face serious, sometimes insurmountable barriers to necessary and appropriate care.[20]

Louisiana had the one of the highest uninsured rates (13.0 percent) in 2014. Half of Louisianans were covered under private health insurance, with 45.0 percent of Louisianans covered by employer-sponsored insurance and the remaining 5.0 percent covered by individual coverage. Over one quarter (26.0 percent) were covered by Medicaid/other public coverage and 11.0 percent were covered by Medicare.[21] (See Chart 12.)

[19] County Health Rankings and Roadmaps: www.countyhealthrankings.org/learn/explore-health-rankings/what-and-why-we-rank/health-factors/clinical-care/quality-of-care/preventable-hospital-stays
[20] National Center for Biotechnology Information: www.ncbi.nlm.nih.gov/books/NBK221227/
[21] Henry J. Kaiser Family Foundation: www.kff.org/health-reform/fact-sheet/the-louisiana-health-care-landscape/

Chart 12: Health Insurance Coverage of the Total Population in Louisiana



Source: Henry J. Kaiser Family Foundation

Of the over half million beneficiaries enrolled in Medicare, nearly a third (30.0 percent) were enrolled in Medicare Advantage plans in 2015. Individuals who were uninsured in 2014 were primarily low-income, in working families, and white non-Hispanic. Because most elderly Louisianans are covered by Medicare, most uninsured are nonelderly (under age 65). The majority of nonelderly, uninsured Louisianans in 2014 had at least one full-time worker in their household (65.0 percent) and had income below 400 percent of the federal poverty level (FPL, 85.0 percent).[22]

According Community Commons data in 2018, Orleans (31.94 percent), Jefferson (24.57 percent), and Plaquemines (19.93 percent) residents receive Medicaid; Orleans Parish reported rates higher than the state (26.17%). Medicaid expansion in Louisiana has improved access to affordable health insurance and prescription coverage for many residents in the LCMA West Jefferson Medical Center service area.

Community Commons data also reported high percentages of uninsured residents in 2018 in Jefferson and Orleans parishes (14.97 percent and 14.18 percent respectively); these percentages are higher than the state (14.12 percent) and the nation (11.70 percent). These percentages also decreased between 2015 and 2018.

Per 100,000 population, Community Commons reported that Jefferson (3.5), and Plaquemines (4.3) parishes had low rates of FQHCs when compared to Louisiana (3.6). FQHCs encourage populations without insurance or the means to pay out of pocket to access health services. Improving access to

[22] Ibid.

affordable health insurance is vital to the health and wellness of residents in the West Jefferson Medical Center.

As part of the CHNA process, Tripp Umbach worked with members of the Working Group to develop a survey for health providers in the service area to offer valuable input regarding the changing community health needs. The provider health survey was created to collect thoughts and opinions about the health providers' community regarding the care and services through the eyes of the provider.

For the 2018 study, when asked to rate the health of the community where they provide care or services, only 11.6 percent of health professional survey respondents felt their community was healthy; 37.8 percent felt the community was unhealthy and 11.0 percent felt the community was very unhealthy. In the same survey, 17.7 percent of health professionals named access to health care as one of their top five health concerns affecting residents in the community and 14.1 percent identified access to care as one of the top five factors contributing to health concerns affecting residents.

Community leaders from WJMC stated that the community is well-served by many health care facilities focusing on primary care services. The region was impacted by Katrina and as a result clinics and health care facilities have an increased presence in the area. Residents who are unable to obtain insurance and or do not have the ability to afford health services obtain care from clinics and FQHCs. In many cases, residents who do not have a medical home are also more willing to obtain services that are conveniently located. The notion or thought of having or needing a primary care physician is something many think is not necessary, as many only seek care when medically needed. The disenfranchised do not maintain preventive health as they are often plagued with multiple environmental issues that need to be addressed daily; therefore, community-based organizations have a noteworthy role to assist residents in obtaining and understanding the importance of accessible health and social programs and services. Health clinics are also able to disseminate health information and reinforce the importance of patient's health practices that would ensure healthy living.

The ACA has created a strong framework where health care is available to everyone. Unfortunately, current policies may reduce and or eliminate the degree in which they are covered. While insurance is fundamentally available overall, the affordability of the program may not be obtainable for the underserved. Potential restrictions and coverage in the program would steer residents back to utilizing the emergency room as options for health care services would be limited. Increased hospital costs would fundamentally be problematic for all in the region. Stakeholders reported that with these restrictions, hospital rates may increase for those who are uninsured and/or for those who have limited insurance resources. Congress needs to work together to provide a plan that includes and amply provides what the ACA is currently addressing, only better.

The community is very receptive to West Jefferson and the impact the hospital is making in the region. While the region is a close-knit community, West Jefferson is seen as the local community hospital providing needed care to their residents.

Cost of Health Services

Residents are often concerned about the increasing out-of-pocket costs oftentimes associated with obtaining health care services. This barrier can limit patient's access and ability to pay for quality care. High out-of-pocket costs can affect patient treatment utilization and impact how patients can access overall health.

Health care organizations can assist patients by alleviating cost burdens and help them take advantage of opportunities to become proactive in their own preventive health care. There are connections related to high patient cost for services and health service utilization, indicating that when patients pay more for their health care they are less likely to access treatment. Unfortunately, when patients do not seek regular health care services their overall health suffers.

As a result of the ACA, the uninsured rate in the U.S. has fallen. Unfortunately, about 28.9 million people remain uninsured in 2015 (a recent Kaiser Family Foundation analysis found that 43.0 percent of the remaining uninsured could qualify for assistance to purchase health insurance or enroll in Medicaid, but many have not taken advantage of this assistance). Analysis of NHIS data, the Health System Tracker, revealed that half of uninsured adults (50.0 percent) reported having no usual source of care, while 10.0 percent of those with insurance say the same. Similarly, of uninsured adults who did not report having a usual source of care, the majority (70.0 percent) also said they went without preventive health care services.[23]

Data from Kaiser Family Foundation revealed that 1 in 10 adults reported that they delayed or did not get care due to cost. Additional data reported that one in five adults in worse health (19.0 percent) said they delayed or did not receive medical care due to cost barriers, while 7.0 percent of respondents in better health reported the same. Overall, more than 1 in 4 uninsured adults (27.0 percent) said they delayed or went without healthcare because of cost reasons. Meanwhile, 7.0 of adults who have health insurance reported encountering cost-related access barriers to care. Data related to resident and patient accessibility are similar at the local and national level.

The future of the ACA is uncertain. One of the main objectives of the recent health care reform legislation was to improve access to care through increased affordability. In the years since its implementation, data suggested that rates of cost-related access barriers have fallen, particularly for lower-income people and those in worse health, but access remains a challenge for many Americans in the early years of the health reform law.[24]

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[23] Peterson-Kaiser Health System Tracker: www.healthsystemtracker.org/brief/despite-lower-rates-of-access-barriers-for-some-groups-health-costs-remain-a-concern-for-many-americans/#item-start
[24] Ibid.

Priority 2: Behavioral Health (Mental Health and Substance Abuse)

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.[25] 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.

Having a behavioral health condition is not the result of one event. Research suggests multiple, linking causes. Genetics, environment, and lifestyle influence whether someone develops a mental health condition. A stressful job or home life makes some people more susceptible, as do traumatic life events like being the victim of a crime. Biochemical processes and circuits and basic brain structure may play a role, too.[26]

Mental health is important at every stage of life, from childhood and adolescence through adulthood.[27] Families and individuals throughout the United States, and Southern Louisiana in particular, are susceptible to the rise of mental illness and substance abuse. In 2014, according to SAMHSA's National Survey on Drug Use and Health, an estimated 43.6 million (18.1 percent) Americans ages 18 and up experienced some form of mental illness. In the past year, 20.2 million adults (8.4 percent) had a substance use disorder. Of these, 7.9 million people had both a mental disorder and substance use disorder, also known as co-occurring mental and substance use disorders.[28]

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.[29]

More and more providers are approaching patient health with an integrated care model because they realize the importance of treating the whole individual. Behavioral health affects 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.

Data obtained from the Louisiana Department of Health (LDH) showed that in May 2018, 57,289 adults obtained outpatient mental health services in the state. The number of adults obtaining care has increased significantly over the years. From 2016 to 2017, there was a roughly 50 percent increase in the

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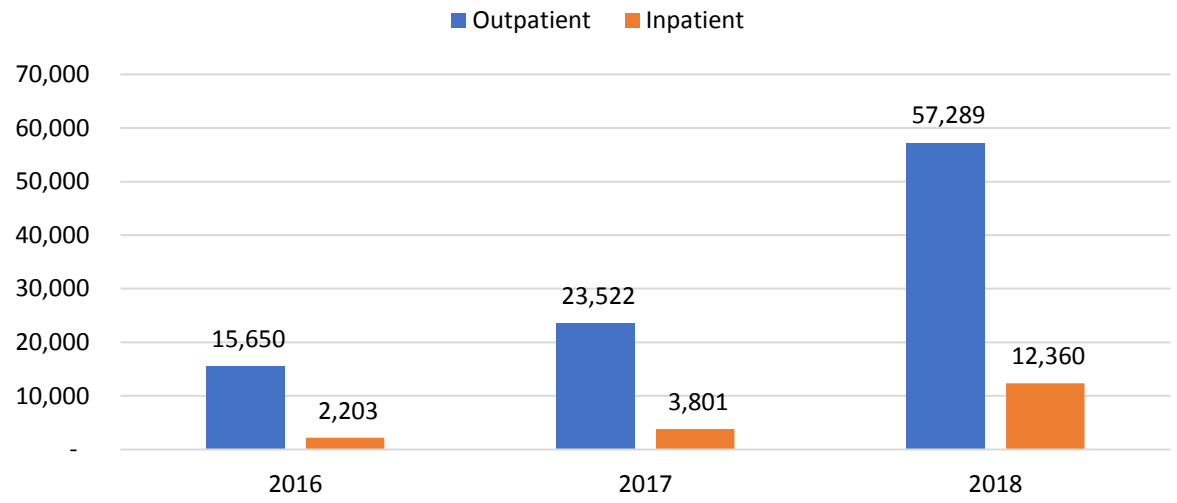
[25] World Health Organization: www.who.int/features/factfiles/mental_health/en/
[26] National Alliance on Mental Illness: www.nami.org/Learn-More/Mental-Health-Conditions
[27] U.S. Department of Health and Human Services: www.mentalhealth.gov/basics/what-is-mental-health
[28] Substance Abuse and Mental Health Services Administration: www.samhsa.gov/disorders
[29] Substance Abuse and Mental Health Services Administration: www.samhsa.gov/wellness-initiative

number of adults obtaining outpatient mental health services (from 15,650 to 23,522); while from 2017 to 2018, there was a 140 percent increase in the number of adults seen for outpatient services (from 23,522 to 57,289). (See Chart 13.)

Upon reviewing additional data, the number of adults receiving inpatient mental health services at a psychiatric facility as of May 2018 also rose steadily through the years. The number of adults obtaining mental health care services tripled in 2018 (12,360) from 2017 (3,801). (See Chart 13.)

Chart 13: Mental Health: Adults receiving Mental Health Services as of May 2018

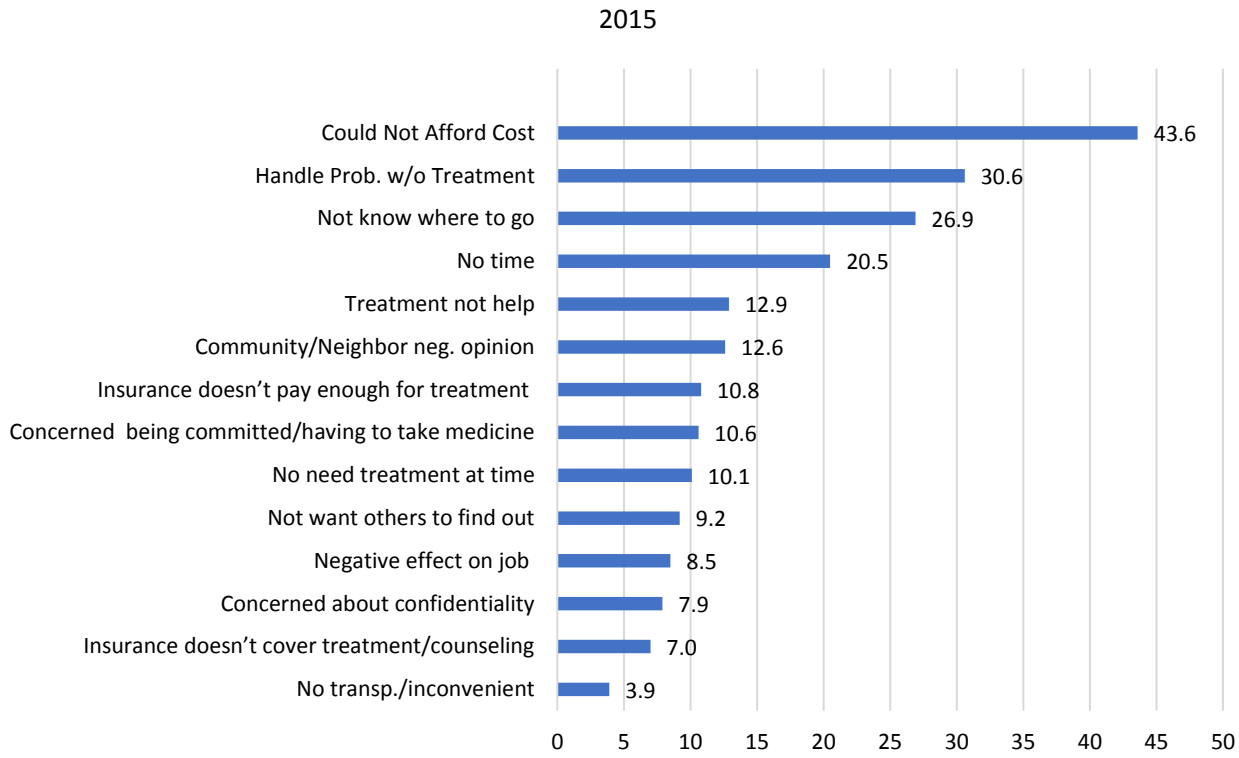


Source: Louisiana Department of Health

SAMHSA's 2016 National Survey on Drug Use and Health revealed the reasons for not receiving mental health services for adults 18 and older included cost (43.6 percent)(this was their main reason), followed by "can handle problem without treatment" (30.6 percent), and "did not know where to go for services" (26.9 percent).[30] (See Chart 14.)

[30] Substance Abuse and Mental Health Services Administration: www.samhsa.gov/data/sites/default/files/NSDUH-ServiceUseAdult-2015/NSDUH-ServiceUseAdult-2015/NSDUH-ServiceUseAdult-2015.htm

Chart 14: Reasons Not Receiving Mental Health Services (Adults Aged 18 or Older)



Source: Substance Abuse and Mental Health Services Administration

Data from the provider health surveys revealed mental health and substance abuse services were the top two responses that were missing that would improve the health of residents in the community (14.4 percent and 11.2 percent respectively). More than one-third (37.7 percent) disagreed and 29.1 percent strongly disagreed that residents had access to mental/behavioral health providers in their region.

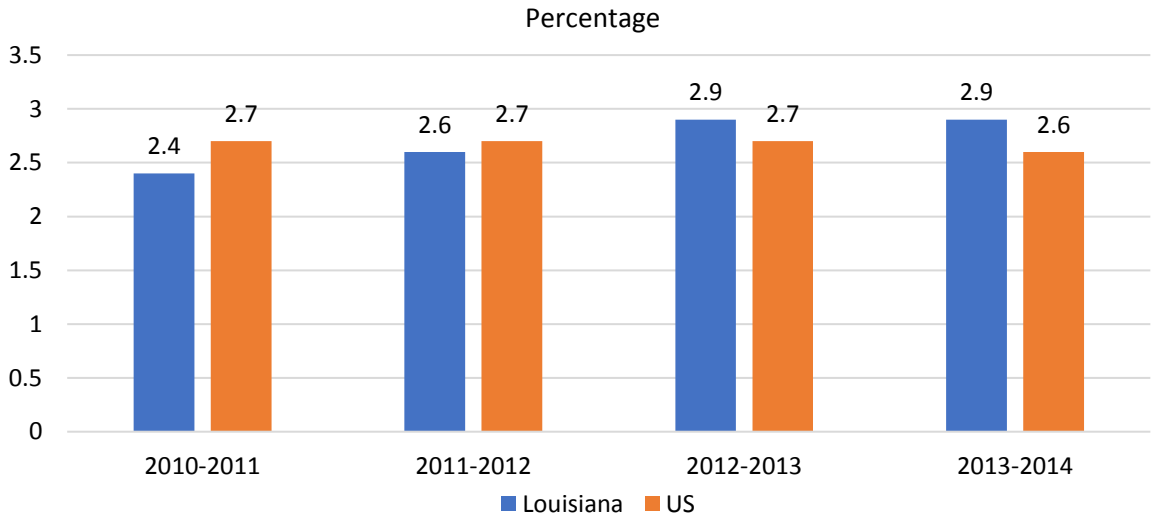
Drug Use and Abuse

In addition to the growing behavioral health problem in the study region, there is an increased use of drugs. Drug use and its consequences touch every sector of our society. Drug use affects 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 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 to encourage 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.

SAMHSA reported in its 2016 National Drug Use and Health Survey that 28.6 million residents 12 years or older were current illicit drug users. Marijuana is the most commonly used drug in the U.S. with 24 million users in 2013, followed by 3.3 million people misusing prescription pain relievers. In addition, 20.1 million Americans aged 12 or older had a substance abuse disorder, with 15.1 million abusing alcohol specifically. In 2016, 1.4 percent aged 12 or older (3,755) received substance use treatment in the past year. Only 1.4 percent aged 26 or older (2,950) received treatment.[31]

Louisiana's percentage of illicit drug dependence or abuse among individuals aged 12 or older was similar to the national percentage in 2013–2014. In Louisiana, about 112,000 individuals aged 12 or older (2.9% of all individuals in this age group) per year in 2013–2014 were dependent on or abused illicit drugs within the year prior to being surveyed. The percentage did not change significantly from 2010–2011 to 2013–2014.[32] (See Chart 15.)

Chart 15: Substance Use – Illicit Drug Dependence or Abuse



Source: Substance Abuse and Mental Health Services Administration

Data reveal that Louisiana is experiencing a high number of drug overdose deaths. The CDC reported the age-adjusted rate of drug overdose deaths in Louisiana in 2014 was 16.9 per 100,000, higher than the national rate of 14.7 per 100,000. Unlike the 6.5 percent national increase in drug overdose–related deaths between 2013 and 2014, the rate in Louisiana decreased 5.1 percent over that same period.[33]

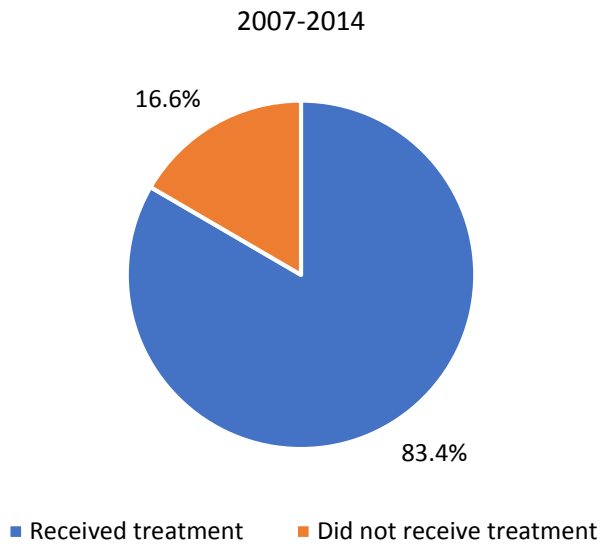
[31] Substance Abuse and Mental Health Services Administration: www.samhsa.gov/data/sites/default/files/2016_ffr_1_slideshow_v5.pdf
[32] Substance Abuse and Mental Health Services Administration: www.samhsa.gov/data/sites/default/files/2015_Louisiana_BHBarometer.pdf
[33] Henry J. Kaiser Family Foundation: www.kff.org/health-reform/fact-sheet/the-louisiana-health-care-landscape/

Substance abuse has reached epidemic levels in communities across the nation; especially within vulnerable populations. Drug abuse can alter a person's thinking and judgment, leading to health risks including addiction, drugged driving, infectious disease, and potential harm of unborn babies.[34] Drug abuse often co-occurs with mental health issues, with one exacerbating the other. Due to the complex nature of co-occurring disorders, providers have difficulty diagnosing and treating both disorders effectively. Further compounding the issue, patients often also present with physical health issues.

Successful treatment of drug abuse is, most often, a lifelong 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, and the patient's support network, not to mention the patients themselves. Oftentimes, people around the individual require mental health and social services as well. Additionally, substance abuse treatment often requires multiple attempts to be deemed successful.

In Louisiana, in the past year treatment for illicit drug use among individuals aged 12 or older with illicit drug dependence or abuse, about 17,000 individuals (16.6 percent) per year from 2007 to 2014 did not received treatment for their illicit drug use. (See Chart 16.)[35]

Chart 16: Past Year Treatment for Illicit Drug Use Among Individuals Aged 12 or Older with Illicit Drug Dependence or Abuse in Louisiana (Annual Average, 2007–2014)



Source: National Institute on Drug Abuse

[34] National Institute on Drug Abuse: www.drugabuse.gov/drugs-abuse/commonly-abused-drugs-charts
[35] Ibid.

Among individuals needing substance use treatment who unsuccessfully sought it, the lack of adequate health insurance or an inability to afford the cost of treatment was the most often cited reason for not getting it.[36] Many agencies struggle with funding sources to meet the needs of the ever-increasing population requiring assistance with substance abuse. This problem requires a concerted effort on behalf of the entire community of service providers to support individuals with substance abuse issues by coordinating resources and increasing community outreach.

Drug addiction is treatable and can be successfully managed. Parents, teachers, community leaders, social and civic organizations, and health care institutions all play a vital role in educating residents and preventing drug use and addiction.

Suicide Rates

Suicide is a major issue across the country and it is continuing to grow. Much of the increase is driven by suicides occurring in mid-life and are mostly committed by men. Typically, having a mental health condition contributes to suicide; however, suicide is rarely caused by a single factor. Additional environmental factors can contribute to suicide such as unemployment, relationships, money issues, substance abuse, housing problems, etc.

According to SAMHSA, in 2013, the highest number of suicides among both men and women occurred among those aged 45 to 54. The highest rates of suicide (suicides per 100,000) occurred among men aged 75 and up and among women aged 45 to 54. Suicide was the second leading cause of death for young people ages 15 to 24 and for those aged 25 to 34.[37]

Having suicidal thoughts is a significant concern; however, having severe suicidal thoughts increases the risk of an individual attempting suicide. In 2014, an estimated 9.4 million adults in the U.S. (3.9 percent) aged 18 or older had serious thoughts of suicide in the past year. People aged 18 to 25 reported the highest percentage, followed by people aged 26 to 49, then by people aged 50 or older. Among high school students, more than 17 percent (approximately 2.5 million ninth through 12th graders) have seriously considered suicide, more than 13 percent have made a suicide plan, and more than 8 percent have attempted suicide.[38]

According to the Centers for Disease Control and Prevention (CDC), suicide is a leading cause of death as rates have steadily increased in nearly every state from 1999 through 2016. Louisiana saw an increase of 29.3 percent from 1999 to 2016.[39] (See Map 2.)

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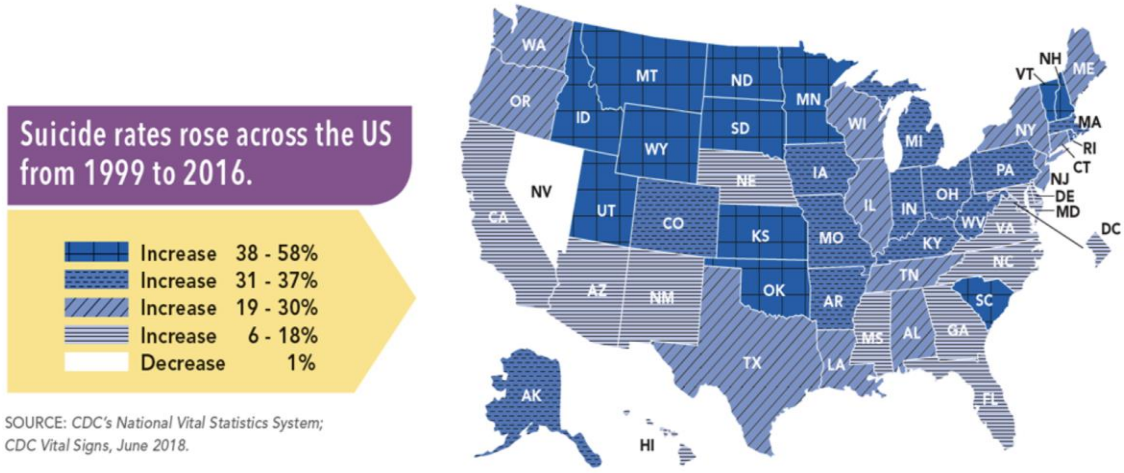
[36] Substance Abuse and Mental Health Services Administration: www.samhsa.gov/newsroom/press-announcements/201509170900
[37] Substance Abuse and Mental Health Services Administration: www.samhsa.gov/suicide-prevention
[38] Ibid.
[39] Centers for Disease Control and Prevention: www.cdc.gov/vitalsigns/suicide/infographic.html#graphic1

Map 2: Suicide in the U.S.



Source: Centers for Disease Control and Prevention

Community Commons data demonstrates the impact unmet mental health and substance abuse needs has had on residents of the LCMC Jefferson Medical Center service area service area by reporting high rates for several key health outcome measures: drug overdose deaths, homicide deaths, premature deaths, suicides, and lack of emotional support. Data from Orleans (38.2 per 100,000 population) and Jefferson (13.5 per 100,000 population) parishes reveal the homicide rates are significantly higher when compared to the state (6.0) and nation (5.5). (See Table 6.)

Jefferson (27.4), Orleans (27.3), and Plaquemines (26.2) parishes report high drug overdose rates when compared to the state (17.6) and nation (15.6). (See Table 6.)

Data from Community Commons also revealed high suicide rates in Jefferson (12.4 per 100,000 population) and Orleans (9.9 per 100,000 population) parishes when compared to the state (5.8). (See Table 6.) The Healthy People 2020 goal is to be under or equal to 10.2 per 100,000 population.

Both Jefferson (23.6 percent) and Orleans (24.5 percent) parishes report higher rates of residents who lack social or emotional support when compared to the state (21.7 percent) and the nation (20.7 percent).

This indicator reports adults 18 and older who self-report that they receive insufficient social and emotional support all or most of the time. This indicator is relevant because social and emotional support is critical for navigating the challenges of daily life as well as for good mental health. Social and emotional support is also linked to educational achievement and economic stability. (See Table 6.)

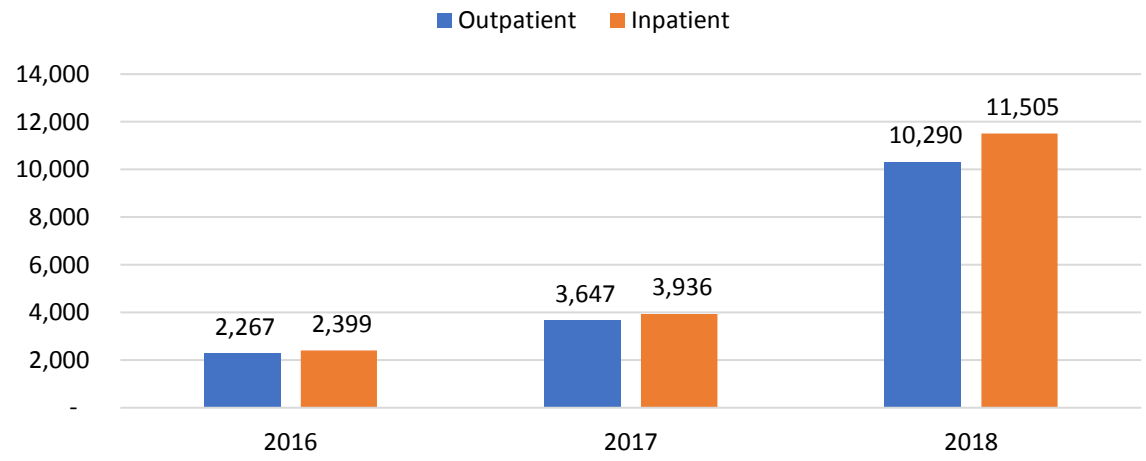
Table 6: Health Outcomes & Social and Economic Support[40]

2018	Jefferson	Orleans	Plaquemines	Louisiana	USA
Drug Overdose Death Rate (per 100,000 pop.)	27.4	27.3	26.2	17.6	15.6
Homicide Death Rate (per 100,000 pop.)	13.5	38.2	--	6.0	5.5
Premature Death Rate (per 100,000 pop.)	8,410	10,297	8,245	9,587	7,222
Suicide Rate (per 100,000 pop.)	12.4	9.9	--	5.8	13.0
Lack of Social or Emotional Support	23.6%	24.5%	21.5%	21.7%	20.7%

Source: Community Commons

The LDH metrics related to substance abuse show the number of adults receiving substance abuse services, both inpatient and outpatient, has increased exponentially since 2016. In May 2018, 10,290 adults obtained outpatient substance abuse services in the state. The number of adults obtaining care has increased significantly over the years. Between 2016 and 2017, there was an increase in the number of adults obtaining outpatient substance abuse services (from 2,267 to 3,647); while in 2017 to 2018, there was a 2.8 percent increase in the number of adults seen for outpatient services (from 3,647 to 10,290). (See Chart 17.)

Chart 17: Substance Abuse: Adults Using Service as of May 2018



Source: The Louisiana Department of Health

[40] Community Commons: www.communitycommons.org

The consequences of undiagnosed, untreated, or undertreated co-occurring disorders can lead to a higher likelihood of experiencing homelessness, incarceration, medical illnesses, suicide, or even early death.[41] Individuals with unmet behavioral health needs are not always capable of recognizing they have a problem or seeking care. Oftentimes, this responsibility falls on the patient's support network or points of contact within the health care system or other community-based organizations. Better coordination of services and collaborative efforts among all members of the medical community and county and community service organizations would improve the disconnect occurring in identifying mental health and substance abuse needs and linking residents with services.

Residents who try to seek assistance for their conditions often face barriers related to finding a health professional, long waiting periods to be seen by a professional, traveling long distances for care, financial burden, overall health system navigation, and stigma related to having a mental health issue. Education and awareness can impact and remove some stereotypes in order to limit these barriers to care.

According to community leaders from WJMC, mental health providers and health institutions are not abundant in the region and seeking care for those that are diagnosed require many to travel out of the area for treatment. Again, residents who are underserved and vulnerable are the most afflicted.

Post Katrina, there has been an emphasis to increase the number of providers in the community knowing that many would be suffering as a result of the environmental devastation. Health workers worked in collaboration and in cooperation to educate the community and provide information related to resources. Post Katrina there has been an upsurge of residents faced with mental health issues such as depression and anxiety. Many of their mental health issues stem from their socioeconomic problems; meeting the financial needs of their families. This in turn increases health problems and turns into health-related issues such as high blood pressure, depression, and the potential to use/abuse drugs and alcohol. According to stakeholders, these conditions have become more prevalent causing great concern as mental health has been affecting families throughout the region.

Community leaders also reported an increase in the homeless population. Again, post Katrina, with the lack of available and affordable housing, many have been forced to live (stay) in shelters. The number of available shelters does not sufficiently represent what is needed in the region. Many in the homeless population have existing chronic illnesses and mental health problems. Unfortunately, being homeless, they are exposed to the environmental elements; increasing and exacerbating current health conditions; thus, adding to their health crisis. The economically vulnerable population is facing much uncertainty with health care in the wake of modifications and actions to repeal the ACA. It is important for government leaders at the state and national level with support from the area's health systems to address the growing health care concerns for all within the service area.

[41] Substance Abuse and Mental Health Services Administration: www.samhsa.gov/disorders/co-occurring

In 2015, former LDH Secretary Kathy H. Kliebert stated that "being there and showing care and concern for someone who is vulnerable to suicide is invaluable. We should all reserve judgment and understand that suicide is often caused by a disease we can't see, but we can look for the warning signs. Louisiana Department of Health is aware of the significant problem related to suicide. As such, the department implemented a proactive approach in preventing suicide by urging residents to look for warning signs so that they may connect those individuals with prevention resources."[42]

Mental disorders are risk factors for suicide. Additional experiences with violence, abuse, bereavement, isolation, etc., are also associated with suicidal behavior. A proactive approach by offering a sympathetic, non-judgmental ear can be effective. Active listening and positive engagement are important parts of reaching out, as well as linking the individual to receiving professional services for appropriate intervention and follow-up care.

There is strong evidence that a comprehensive public health approach is effective in reducing suicide rates. Released by the U.S. Surgeon General in 2012, the National Strategy for Suicide Prevention is intended to guide suicide prevention actions in the United States. The strategy provides guidance for schools, businesses, health systems, clinicians, and others, and emphasizes the role every American can play in protecting their friends, family members, and colleagues from suicide.[43]

Community partnerships with government, public health, health care, employers, education, and community organizations can assist in the prevention of suicide with continued measures, efforts, and initiatives.

Suicide does not discriminate, as it effects people from all ethnic, race, and socioeconomic groups. Identifying those who are at risk, reducing their environmental problems, promoting factors that improve their coping skills, and providing professional help are measures that can reduce suicide rates in the region.

Lack of Mental Health Services

There is unmet need for health care providers in Louisiana. As of April 2014, Louisiana had 118 primary care Health Professional Shortage Areas (HPSA), 102 dental HPSAs, and 109 mental health HPSAs. Louisiana has less than half (42 percent) of the number of mental health care providers needed to adequately serve the population, compared to just over half (51 percent) for the nation as a whole.[44]

Table 7 depicts the ratio of available mental health providers to residents within the area. Jefferson, Orleans, and Plaquemines parishes report improved mental health provider rates from 2015 to 2018. In 2018, all of the parishes reported low mental health provider figures when compared to the state; which indicates increased accessibility for residents. Orleans (240:1) Parish is a top U.S. performers, having mental health provider rates lower than 412:1.

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[42] Louisiana Department of Health: http://ldh.la.gov/index.cfm/newsroom/detail/3515
[43] Substance Abuse and Mental Health Services Administration: www.samhsa.gov/suicide-prevention0
[44] Henry J. Kaiser Family Foundation: www.kff.org/health-reform/fact-sheet/the-louisiana-health-care-landscape/

Mental health provider shortages highlight what residents currently face and will continue to face without intervention. The ability to secure treatment and services is affected by the shortfall of mental health providers in the WJMC service area.[45]

Table 7: Mental Health Providers at Parish Level

	Jefferson	Orleans	Plaquemines	Louisiana	Top U.S. Performers
2015	790:1	492:1	1,812:1	977:1	412:1
2018	470:1	240:1	1,380:1	420:1	330:1

Source: County Health Rankings and Roadmaps

Collaborative efforts among providers and the rest of the community is needed to maximize the impact of the work being done in the community to stretch funding dollars. Innovative approaches with community collaboration and partnerships is essential to continue to establish mental health prevention and early intervention programs for those in need.

Priority 3: Health Education

Education is essential 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. Typically, this knowledge is attained through a combination of trusted sources (e.g., home, school, and community) and continues to evolve as we live through experiences and increased exposure to the world. Today, copious amounts of information are just a click away. Sifting through and deciphering what is true is a daunting task, especially when experiencing a crisis.

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 a contributing member of society.

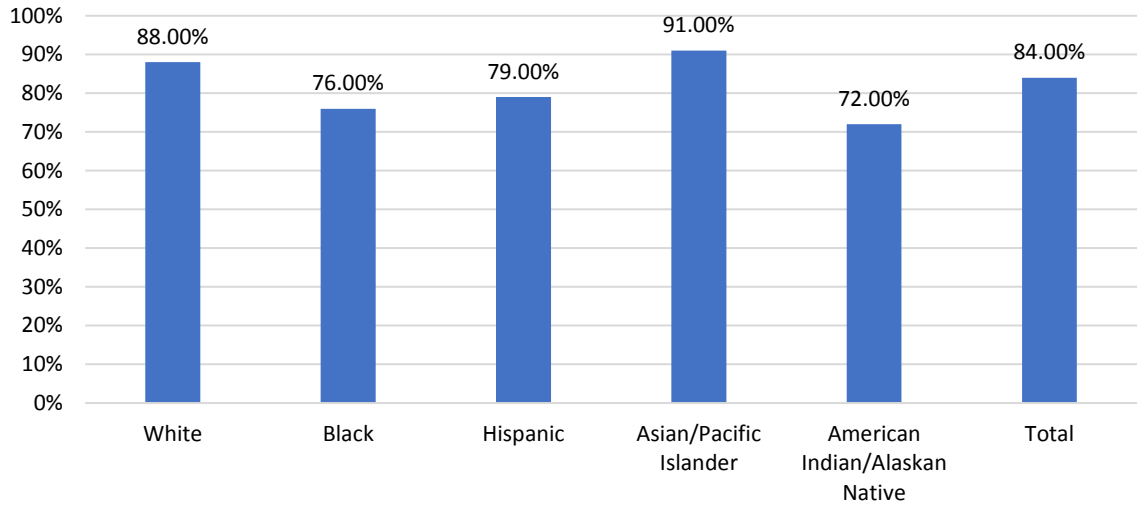
Education about health in schools is instrumental to laying a foundation of basic health knowledge and life skills to improve overall public health. Hungry or sick children do not perform well in classrooms compared to their healthy counterparts. Public health policies like the free/reduced-price lunch and free/low-cost health programs help to close these gaps. Physical education as part of a school's

[45] County Health Rankings and Roadmaps: www.countyhealthrankings.org

curriculum provides valuable knowledge regarding the importance of physical activity and other healthy behaviors to stay healthy.[46]

Nationally, 84 percent of students graduated from high school on time in 2016, and this percentage varies by race/ethnicity. (See Chart 18.) At the state level, 79 percent of students in Louisiana graduated from high school on time in 2016.[47]

Chart 18: Adjusted Cohort Graduation Rate (ACGR) for Public High School Students, by Race/Ethnicity: 2015–16.



Source: U.S. Department of Education, Office of Elementary and Secondary Education, Consolidated State Performance Report, 2015–16.

Reading and comprehension skills are important for helping us understand and interact with the world around us. 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).[48] The NAEP reading scale ranges from zero to 500.

The 2017 Reading State Snapshot Report revealed that the average reading score of eighth grade students in Louisiana was 257; lower than the national average score of 265. When compared to the

[46] National Center for Biotechnology Information: www.ncbi.nlm.nih.gov/pmc/articles/PMC4691207/#R9
[47] National Center for Education Statistics: https://nces.ed.gov/programs/coe/indicator_coi.asp
[48] US Department of Education: www.nationsreportcard.gov/about.aspx

rest of the United States, Louisiana's average reading score was lower than 41 other states/jurisdictions, not significantly different from nine, and only higher than the District of Columbia. The 2017 report also indicated score gaps among different student groups as well. Black students had an average score that was 27 points lower than white students' scores. Hispanic students had an average score that was 16 points lower than 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).[49]

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.[50]

Focusing on the WJMC service area, secondary data related to education from Truven Health Analytics show that statistics vary widely from parish to parish and neighborhood to neighborhood. For example, Jefferson Parish reports the highest percentage of residents without a high school diploma (in ZIP code 70053 – Gretna) at 24.37 percent and the lowest percentage is located in 70131 (Orleans Parish)– New Orleans. CNI rankings in the study area for education range from three (best ranking) to five (worst ranking).

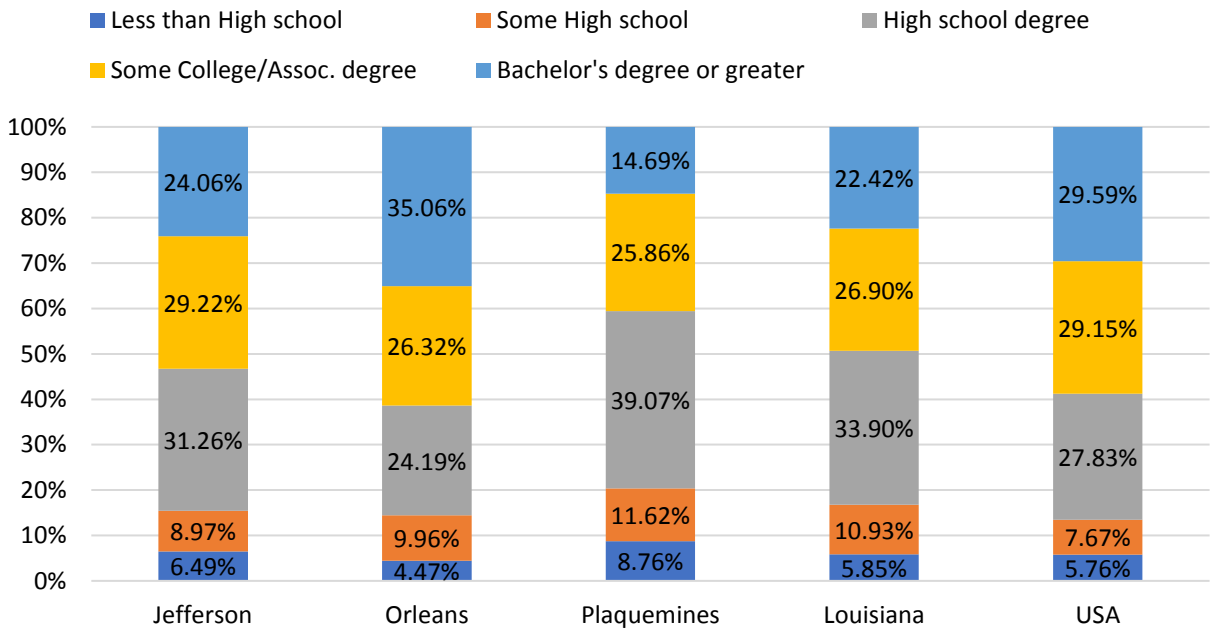
Of the eight ZIP codes that make up the WJMC service area, seven ZIP codes scored above a three or higher for education; indicating that education is a socioeconomic barrier in the region. Only ZIP code 70131 (New Orleans) had a CNI score of three. CNI data illustrated a significant number of residents in the service area that do not have or have not followed a path to education.

Chart 19 also illustrates marked differences in resident education among the three parishes included in the study area. For instance, more than one-third (35.06 percent) of residents in Orleans Parish have a bachelor's degree or greater verses 14.69 percent in Plaquemines Parish. Overall, 16.78 percent of Louisiana residents do not have a high school diploma.

Plaquemines (20.83 percent) fares worse than the overall state of Louisiana (16.78 percent) and the nation (13.43 percent) with respect to residents without a high school diploma. Two parishes in the study area, Jefferson (15.46 percent) and Orleans (11.49 percent), have fewer residents without a high school diploma than Louisiana (16.78 percent).

[49] The Nation's Report Card:
https://nces.ed.gov/nationsreportcard/subject/publications/stt2017/pdf/2018039LA8.pdf
[50] Louisiana Department of Education: www.louisianabelieves.com/resources/about-us

Chart 19: Education



Source: Truven Health Analytics

Education is a crucial component in overcoming social determinates of health. Continuing to increase pathways to higher education and opportunities to develop skills valued by business and industry is important to mitigate the effects that social determinants of health have on residents of the WJMC service area.

Health Education/Literacy

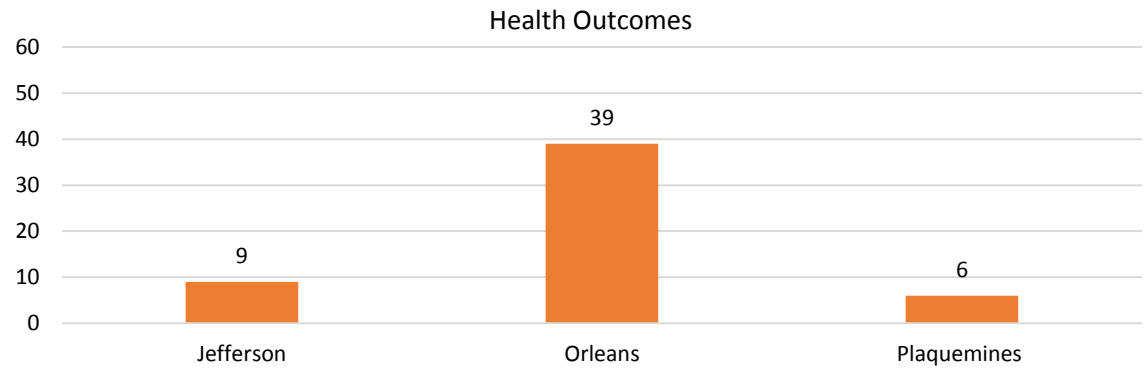
Health education information related to chronic diseases can help reduce mortality and morbidity rates if lifestyles changes were also applied. Providing information to residents could motivate and encourage citizens to improve and maintain their health, prevent disease, and reduce risky behaviors. Information related to diet, exercise, and disease prevention can help individuals make positive, healthy, long-term decisions.

County Health Rankings and Roadmaps reports in 2018 a ranking of nine for Jefferson Parish, 39 for Orleans Parish, and a six for Plaquemines for health outcomes. (See Chart 20.)[51]

[51] County Health Rankings are out of 65 parishes in Louisiana. By ranking the health of nearly-every county in the nation, the County Health Rankings and Roadmaps help communities understand what influences how healthy residents are and how long they will live. The comparisons provide context and demonstrate that where you live, and many other factors including race/ethnicity, can deeply impact one's ability to live a healthy life. The Rankings

The overall rankings in health outcomes represent how healthy counties (parishes) are within the state. The ranks are based on two types of measures: how long people live and how healthy people feel while alive. If rankings are to improve, health education, specifically concerning diet, exercise, and disease management, is vital to managing health conditions and practicing healthy behaviors. Changing health behaviors requires community residents to be committed and armed with adequate information in order to modify their current living habits.

Chart 20: 2018 County Health Rankings and Roadmaps Health Outcomes



Source: County Health Rankings and Roadmaps

Easy-to-understand programs designed around nutrition and healthy living could assist residents in understanding the long-term benefits of healthy living, as the goal of health programs is to modify and establish healthy behaviors. Overall, education plays a significantly large role in how residents can improve health outcomes in that by attaining even a basic education (i.e., a high school diploma), residents are better able to grasp the concepts of health education and the benefits of incorporating healthy behaviors into daily life.

Community stakeholders reported that health education and awareness would be able to provide a landscape of information to many, in particular, to youths who need information associated to living a healthy and productively lifestyle.

The socioeconomic determinants of health in the community are very poor; therefore, the issues related to the underserved and disenfranchised population require additional attention and consideration. Families are under constant stress and pressure to be economically stable; forcing many to work multiple jobs to afford basic necessities. Providing a framework of information through community

provide a snapshot of the parishes' health. A low-ranking score signifies a parish that does well in specific measures when compared to the remaining parishes in the state.

organizations and groups would raise awareness of residents who require additional attention related to health and health services.

The use of social media to promote and maintain awareness is a good avenue for many; however, families who are underserved typically require guidance navigating the plethora of information on the worldwide web. While a surplus of information is broadcast via the internet, seniors do not have computers, utilize one and/or the desire to learn how to use them; thus, this hinders awareness efforts for those in this community group. These issues are the predominate barriers to care for some in the region.

Involvement, partnerships and collaboration with community groups is crucial for success. The dissemination of information on outreach programs can increase awareness of available health services, community amenities, and help provide feedback on which programs are popular in the region. Feedback on specific programs can, in turn, create additional programs placed strategically throughout the community to yield the best results. Stakeholders reported that West Jefferson is seen as the region's community hospital, as they are actively involved with providing community outreach programs and are in tune with the many growing minority populations such as the Vietnamese and Latino communities.

Sexually Transmitted Infections (STIs)/Diseases (STDs) Education

Education related to STI's is the delivery of information about body development, sex, sexuality, and relationships, along with skills-building to help educate, inform, and communicate about making informed decisions regarding sex, sexual health, and its outcomes. Sex education should begin and occur throughout a student's grade levels, with information appropriate to students' development and cultural background. It should include information about puberty and reproduction, abstinence, contraception and condoms, relationships, sexual violence prevention, body image, gender identity, and sexual orientation. Sex education should be informed by evidence of what works best to prevent unintended pregnancy and sexually transmitted infections. Sexual education should provide people with information necessary to help take personal responsibility for one's health and overall well-being.

A lack of high-quality, age appropriate sexual and relationship education may leave youths vulnerable to harmful sexual behaviors and sexual exploitation; therefore, it is important to provide educational pathways for children and young adults.

The World Health Organization (WHO) defines sexual health as a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence.[52]

Sexual health is important to individual health, both physical and mental, and a component of the broader, national public health conversation. In 2001, the United States Surgeon General released The

[52] World Health Organization: www.who.int/topics/sexual_health/en/

Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior (Call to Action). This report formally recognized the importance of a sexual health framework to enhance population health in the United States. Ten years after the Surgeon General's Call to Action, many measures of adverse health outcomes of sexual behavior (e.g., unplanned pregnancy and sexually transmitted infections) had not improved; they had, in fact, gotten worse. In response, in April 2010, the CDC held a consultation including 67 experts in the field of sexual health to discuss a health-based approach addressing sexual behavior to serve as a potential framework for public health action to advance the Surgeons General's 2001 Call to Action.[53]

Sexually transmitted infections (STIs) have long been an underestimated opponent in the public health battle. A 1997 Institute of Medicine (IOM) report described STDs as, "hidden epidemics of tremendous health and economic consequence in the United States," and stated that the "scope, impact, and consequences of STDs are under-recognized by the public and healthcare professionals."[54] Nearly-two decades later, those facts remain unchanged.

As recently as August 2018, researchers at the Center for Disease Control and Prevention (CDC) reported that sexually transmitted diseases are on the rise in America. It is noted that nearly 2.3 million cases of chlamydia, gonorrhea and syphilis were diagnosed in the U.S. in 2017, surpassing the record set in 2016 by more than 200,000. (See Table 8.)

CDC researchers found that gonorrhea diagnoses increased by 67 percent — from 333,004 to 555,608 — in just five years. The sharpest increase was in men, in whom cases nearly doubled, going from 169,130 in 2013 to 322,169 in 2017. Though increases were also seen in women, they weren't quite as dramatic, rising 18 percent over the same period of time[55]. Syphilis diagnoses, which rose by 76 percent, from 17,375 to 30,644, were mostly in men. Syphilis in women is of great concern because of the effects it can have on developing fetuses.

The chlamydia rate held steady with more than 1.7 million cases diagnosed in 2017, just a few percentage points above where it was in 2013. Nevertheless, the chlamydia rate continues to be of concern because the disease can scar a woman's reproductive organs, leaving her infertile. The largest group of infections were in women and girls ages 15 to 24.

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[53] Centers for Disease Control and Prevention: www.cdc.gov/sexualhealth/docs/SexualHealthReport-2011-508s.pdf

[54] Eng TR, Butler WT, editors; Institute of Medicine (US). Summary: The hidden epidemic: confronting sexually transmitted diseases. Washington (DC): National Academy Press; 1997. www.cdc.gov/std/stats15/foreword.htm

[55] National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. www.cdc.gov/nchhstp/newsroom/2018/press-release-2018-std-prevention-conference.html

Table 8: STD Diagnoses among Key U.S. Populations, 5-Year Trends

	2013	2014	2015	2016	2017*
Chlamydia	1,401,906	1,441,789	1,526,658	1,598,354	1,708,569
Young women (Ages 15-24)	715,983	709,170	724,709	735,027	771,340
Gonorrhea	333,004	350,062	395,216	468,514	555,608
Among women	163,208	16,2608	173,514	197,499	232,587
Among men	169,130	186,943	221,070	270,033	322,169
Primary & Secondary Syphilis	17,375	19,999	23,872	27,814	30,644
Among men who have sex with men	10,451	12,226	14,229	16,149	17,736
Combined cases	1,752,285	1,811,850	1,945,746	2,094,682	2,294,821

*Preliminary Data

Source: Centers for Disease Control and Prevention

Annual HIV infections and diagnoses are declining in the United States. The declines may be due to targeted HIV prevention efforts. However, progress has been uneven, and annual infections and diagnoses have increased among some groups. There were an estimated 38,500 new HIV infections in 2015. Among all populations in the United States, the estimated number of annual infections declined 8 percent from 2010 (41,800) to 2015 (38,500).[56]

Studies have shown that all of these infections can lead to long-term health consequences, including infertility and the transmission of HIV. Another unfortunate outcome of these infections is the stigmatization of entire subgroups across the country.

In the United States, HIV diagnoses are not evenly distributed across states and regions. Southern states accounted for more than half of new HIV diagnoses in 2016, while making up 38 percent of the national population.[57] In all regions of the United States, the majority of people who receive an HIV diagnosis live in urban areas. But in the South, 23 percent of new HIV diagnoses are in suburban and rural areas, and in the Midwest, 21 percent are suburban or rural—higher proportions than in the North and West. The

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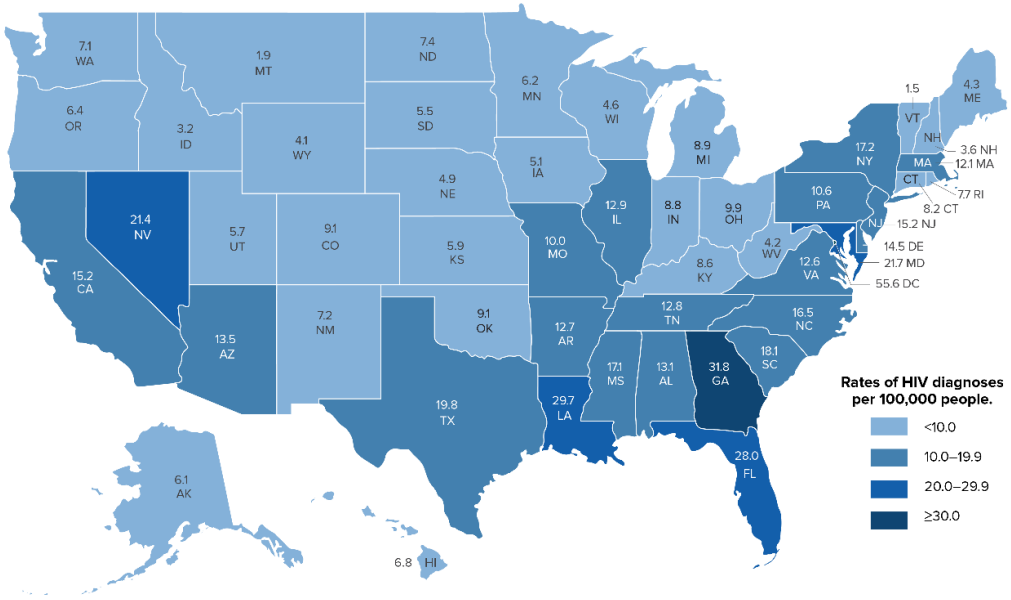
[56] Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2010-2015. HIV Surveillance Supplemental Report 2018;23(1).
https://www.cdc.gov/hiv/statistics/overview/ataglance.html

[57] [a] Regions defined by the US Census Bureau and used in CDC's National HIV Surveillance System:
Northeast: CT, ME, MA, NH, NJ, NY, PA, RI, VT
Midwest: IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, SD, WI
South: AL, AR, DE, DC, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV
West: AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY.
www.cdc.gov/hiv/statistics/overview/geographicdistribution.html

South's larger and more geographically dispersed population of people living with HIV creates unique challenges for prevention and treatment. (See Map 3.)

Map 3: Rates of HIV Diagnoses Among Adults and Adolescents in the U.S. by State, 2016



Source: Centers for Disease Control and Prevention

STDs are a substantial health challenge facing the United States. CDC estimates that nearly 20 million new sexually transmitted infections occur every year, accounting for almost $16 billion in health care costs annually. Many cases of chlamydia, gonorrhea, and syphilis continue to go undiagnosed and unreported, and data on several additional STDs – such as human papillomavirus and herpes simplex virus, are not routinely reported to CDC. As a result, national surveillance data captures only a fraction of America's STD burden. However, the data presented in the 2016 STD Surveillance Report provide important insight into the scope, distribution, and trends in STD diagnoses in the country.

STI prevention and control has widespread public health benefits. Left untreated, STIs increase the risk of HIV transmission during unprotected sexual contact and lead to complications, such as pelvic inflammatory disease (PID), infertility, ectopic pregnancy, miscarriage, fetal death, and congenital infection.

As previously noted, while most of these STIs will not cause harm, some have the potential to cause serious health problems, especially if not diagnosed and treated early. Young people (ages 15-24) are particularly affected, accounting for half (50 percent) of all new STIs, although they represent just 25 percent of the sexually experienced population.

Beyond the impact on an individual's health, STDs are also an economic drain on the U.S. health care system. Data suggest the direct cost of treating STDs in the U.S. is nearly $16 billion annually.[58] STD public health programs are increasingly facing challenges and barriers in achieving their mission. In 2012, 52 percent of state and local STD programs experienced budget cuts.

In addition, CDC conservatively estimates that the lifetime cost of treating eight of the most common STIs contracted in just one year is $15.6 billion. Because some STIs – especially HIV – require lifelong treatment and care, they are by far the costliest. In addition, HPV is particularly costly due to the expense of treating HPV-related cancers. However, the annual cost of curable STIs is also significant ($742 million). Among these, chlamydia is most common and therefore the costliest.[59]

State of Louisiana

The CDC's 2016 Sexually Transmitted Diseases Surveillance Report, which was released in late September 2017, STDs increased across the United States for the third year in a row, and Louisiana ranked second-highest for each of the three diseases measured. Louisiana was also named the state with the second-highest rate of HIV diagnoses. According to Louisiana Department of Health Office of Public Health STD/HIV Program report, in September 2017:

Chlamydia

- Louisiana had the 2nd highest chlamydia rate in the United States in 2016 and 31,727 persons were diagnosed with chlamydia for a rate of 677.7 per 100,000, a 2 percent decrease from 2015. The national rate of chlamydia was 497.3 per 100,000.

Syphilis

- Louisiana had the second-highest number of syphilis cases reported in 2016, with a rate of 16.1 cases per 100,000. The national rates for syphilis in 2016 were 8.7 cases per 100,000 people.

Gonorrhea

- Louisiana came in second for its gonorrhea rate, with 230.8 cases per 100,000 people. The 2016 national rate was 145.8 cases per 100,000 people.

HIV/AIDS

- HIV data was not included in the 2016 Sexually Transmitted Diseases Surveillance Report, but the 2015 data put Louisiana again at number two for most HIV diagnoses per capita, reporting

[58] Owusu-Edusei K Jr, Chesson HW, Gift TL, et al. The estimated direct medical cost of selected sexually transmitted infections in the United States, 2008. Sex Transm Dis. 2013 Mar;40(3):197–201. doi: 10.1097/OLQ.0b013e318285c6d2.https://journals.lww.com/stdjournal/fulltext/2013/03000/The_Estimated_Direct_Medical_Cost_of_Selected.3.aspx

[59] Centers for Disease Control and Prevention: www.cdc.gov/std/stats/sti-estimates-fact-sheet-feb-2013.pdf

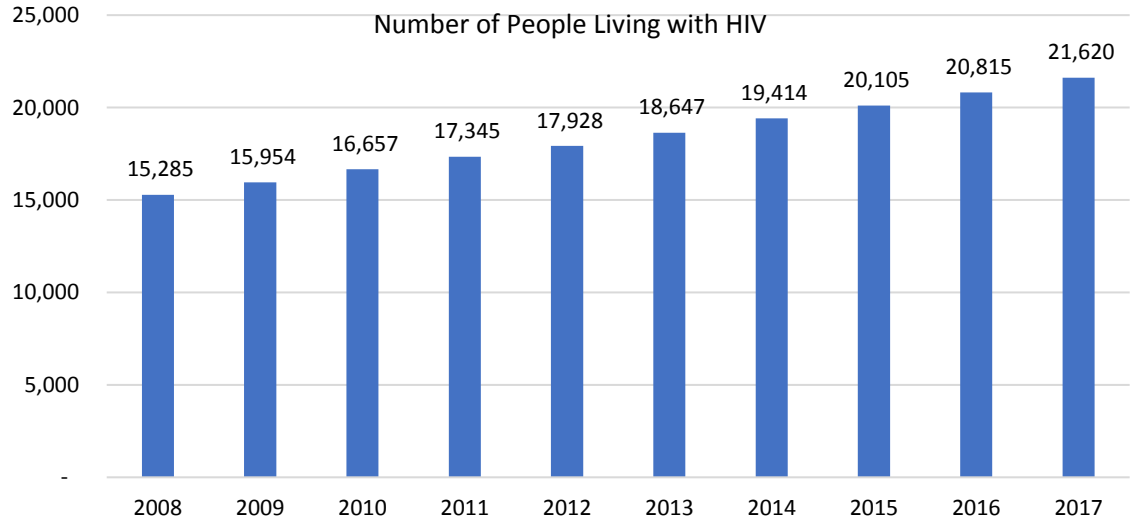
29.2 per 100,000 people. Washington, D.C., is home to the highest rate of HIV diagnoses with a rate of 66.1.

STDs continue to pose a significant impact to the health of the population of Louisiana. Louisiana consistently ranks in the five states with the highest rates of sexually transmitted diseases (STDs). STD rates in Louisiana are much higher than rates in other southern states as well. The reported rates and increasing trends of these three conditions highlight a growing problem for the health of many Louisianans that increases the risk for contracting other infections, such as HIV.

According to the Louisiana HIV, AIDS, and Early Syphilis Surveillance Report Quarterly Report published as recently as March 31, 2018, there is a steady increase in the number of people living with HIV in Louisiana. (See Chart 21):

- In 2016, Louisiana ranked 3rd in the nation for HIV case rates (24.6 per 100,000 population).
- In 2017, 1,056 new HIV cases were diagnosed in Louisiana.
- As of March 31, 2018, a total of 21,910 persons were living with HIV infection (PLWH) in Louisiana.

Chart 21: 10-Year Trends in Persons Living with HIV Infection Louisiana, 2008-2017



Source: Louisiana HIV, AIDS and Early Syphilis Surveillance

It is essential to lower the rates of STIs/STDs and teen pregnancy through the dissemination of education and information using partnerships and collaborations with community organizations, health care facilities, and government entities to combat this public health concern.

Conclusion

WJMC will continue to work to close the gaps in health disparities and continue to improve health services for residents by leveraging the region's resources and assets; while existing and newly developed strategies can be successfully developed. Results from the CHNA in conjunction with the final Implementation Strategy Plan will build upon an existing infrastructure of previous community health improvement efforts as these plans will enhance new developments.

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 factor towards future strategies that will improve the health and well-being of residents in their region. WJMC will work closely with community organizations and regional partners to effectively address and resolve the identified needs. As the completion of the 2018 CHNA is finalized, an internal planning team from WJMC will begin the framework for the implementation strategy phase and its ongoing evaluation.

Community stakeholders and health providers are specific groups who have knowledge of, relationships with, and treat the underserved, disenfranchised, and hard-to-reach populations. Data from these specific groups have and will continue to assist WJMC's leadership in reducing the challenges residents often face when seeking services.

WJMC took into consideration the ability to address the regions identified needs and viewed the overall short and long-term effects of undertaking the task. WJMC will address the identified needs and view them as positive and encouraging changes. WJMC 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 WJMC to meet the region's need. Tackling the region's needs is a central focus hospital leadership will continue to measure throughout the years. WJMC will continue to work closely with community partners as the CHNA report is the first step to an ongoing process to reducing the gaps of health disparities.

APPENDICES

West Jefferson Medical Center

Appendix A: General Description of LCMC Health & West Jefferson Medical Center

About LCMC Health

LCMC Health is a Louisiana-based, non-profit healthcare system serving the needs of the people of Louisiana, the Gulf South and beyond. Our mission is to enhance the health of the communities we serve by delivering high quality healthcare services to all patients through a commitment to clinical excellence, education, technology and research.

LCMC Health was founded by Louisiana's only freestanding children's hospital, and currently consists of Children's Hospital, Touro, 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.

"We proudly provide high-quality medical care at each of our hospitals and clinics, but our goal is to transform our community to be healthier and more resilient. Every day, more than 8,600 employees of LCMC Health reaffirm that commitment to our patients."

GREGORY C. FEIRN
LCMC Health, Chief Executive Officer

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.

OUR UNIQUE HISTORY & GROWTH

2009

LCMC Health is formed out of Children's Hospital to partner with Touro Infirmary, preserving the hospital's legacy of providing healthcare to New Orleans for more than 160 years.

2012-13

LCMC Health partners with the State of Louisiana to operate the Interim LSU Hospital (ILH), preserving services and access in New Orleans and averting a significant disruption in university teaching programs.

2013

LCMC Health finalizes partnership with the State of Louisiana to operate ILH and the future University Medical Center New Orleans.

2014

LCMC Health partners with the City of New Orleans and assumes management of New Orleans East Hospital, returning a full-service hospital to the area for the first time since Hurricane Katrina.

2015-17

West Jefferson Medical Center joins LCMC Health after agreement is reached with Jefferson Parish.

Health Leaders Network

LCMC Health expands reach with partnerships throughout Greater New Orleans and at state level through joining Healthcare Leaders Alliance.

2018

LCMC Health introduces LCMC Healthcare Partners, LLC, a clinically integrated network focused on improving care in the Greater New Orleans community.

LCMC HEALTH

BY THE NUMBERS

5 HOSPITALS

8,960 EMPLOYEES FULL & PART TIME

Total represents employees of the LCMC Health system as well as its five member hospitals.

1,849 PHYSICIANS

Some physicians are represented more than once due to having admitting privileges at more than one hospital.

3,019 ACTIVE VOLUNTEERS

255,876 TOTAL EMERGENCY DEPARTMENT VISITS

685,522 TOTAL PRIMARY & SPECIALTY CARE CLINIC VISITS

1,525 INPATIENT BEDS

PATIENTS COME FROM THE GULF SOUTH & BEYOND

LCMC Health Hospitals

Children's Hospital is a 224-bed, non-profit academic pediatric medical center offering a comprehensive range of healthcare services for children from birth to 21 years. With 43 pediatric specialties, it is the only full-service hospital exclusively for children in Louisiana and the Gulf South. Children's Hospital cares for children from all 64 parishes in Louisiana, 43 states and 4 countries.

Founded in 1852, Touro Infirmary is New Orleans' only community based, non-profit, faith-based hospital. For more than 165 years, Touro has had a special place in the heart of the community, providing high quality, compassionate healthcare to the New Orleans community. As a full-service hospital, Touro offers medical, surgical, intensive care, obstetric, skilled nursing inpatient services, inpatient and outpatient rehabilitation services and a 24-hour Emergency Department.

University Medical Center New Orleans, home of the Rev. Avery C. Alexander Academic Research Hospital, fulfills a 275-year legacy of serving the people of New Orleans and Gulf South. With our academic partners, UMC is training the next generation of healthcare professionals and leading research to find tomorrow's cures and treatments. As the region's only Level 1 Trauma Center, UMC plays a vital role in treating south Louisiana's most critically injured patients.

As a hospital service district of the City of New Orleans, New Orleans East Hospital opened in summer 2014, bringing a full-service hospital to the area for the first time since Hurricane Katrina. The 80-bed (60 inpatient; 20 leased to community organization) facility provides complete surgical services, diagnostic imaging, laboratory and emergency services in both inpatient and outpatient settings.

Founded April 11, 1956, through the citizens of Jefferson Parish, West Jefferson Medical Center is a 435-bed, full-service community hospital. Frequently recognized with national Patient Safety and Stroke Care accolades, West Jefferson Medical Center provides quality and compassionate healthcare to the people of West Bank, Gretna, Harvey, New Orleans and surrounding areas.

Our Academic Partners

LCMC Health plays a vital role in training the next generation of healthcare professionals and education is a key component of our mission. Through our successful partnerships with local universities, thousands of medical, dentistry, nursing and allied health students train in our hospitals every year.

Source: information annualized based on June 30, 2018 data available.

West Jefferson Medical Center

Our *Family* Caring For Your *Family.*

Founded in 1956, through the citizens of Jefferson Parish, West Jefferson Medical Center (WJMC) today is a 435-bed full-service community hospital. Located in the heart of the West Bank, West Jefferson Medical Center is dedicated to serving the people of the West Bank, including: Jefferson, Orleans, Plaquemines, St. Charles parishes, and beyond.

West Jefferson Medical Center opened its doors in April 1960. Throughout its distinguished history of caring for the community, the hospital has been nationally recognized for programs of excellence and for delivering high-quality care.

West Jefferson Medical Center offers comprehensive programs for preventive, emergency, acute, and rehabilitative care. Clinical excellence divisions include neurosciences, cardiovascular services, and an academic community cancer center. Located near vast industrial quarters, the medical center also serves business and industry across the Gulf South.

BY THE NUMBERS

- 1,364 EMPLOYEES
- 436 PHYSICIANS
- 116 ACTIVE VOLUNTEERS
- 435 INPATIENT BEDS
- 1,052 THE FAMILY BIRTH PLACE DELIVERIES
- 172,748 TOTAL PRIMARY AND SPECIALITY CARE CLINIC VISITS
- 53,424 TOTAL EMERGENCY DEPARTMENT VISITS

EXECUTIVE LEADERSHIP

"West Jefferson often appears on national 'best of' lists for quality. Our hospital family is also proud of its consistently high rankings for overall patient satisfaction. Our best-in-the-region ratings are a testimony to our hospital family and its motto: *Our Family, Caring for Your Family.*"

NANCY R. CASSAGNE
West Jefferson Medical Center (WJMC), President and CEO

WEST JEFFERSON MEDICAL CENTER SERVICES

- Cancer Center
- Cardiac & Vascular Services
- Comprehensive Stroke Center
- Family Birth Place
- Family Doctors Primary Care
- Neurosurgery
- Only Pediatric ER on the West Bank
- Only Radiation Therapy Department on West Bank
- Sleep Disorders Center
- West Jefferson Cardiology Center
- West Jefferson ENT
- West Jefferson Heart Clinic of LA
- West Jefferson Pulmonary Associates
- West Jefferson Urology Specialists
- West Jefferson's Women's Health

PROUD MEMBER OF LCMC HEALTH

LOCATION

MAIN CAMPUS: West Bank of Jefferson Parish (Marrero)

SUBSIDIARIES

THE FAMILY DOCTORS

At The Family Doctors clinics, the level of care offered to its patient population ranges from treating acute to chronic conditions. Its medical staff consists of Board Certified and Board Eligible physicians concentrating in specialties such as family practice, internal medicine, and pediatrics. To meet the primary care needs of its community, there are 17 physicians and 6 nurse practitioners at 6 convenient locations across the West Bank.

WEST JEFF FITNESS CENTER

As part of its vision to keep the community well with a focus on prevention, West Jeff has a 46,000 sq. ft. wellness complex on the main campus as well as a satellite location near Oakwood Shopping Center in Terrytown. In addition to family-focused fitness and exercise programs, the West Jeff Fitness Center at Oakwood also houses a Family Doctors primary care practice and outpatient rehabilitation services.

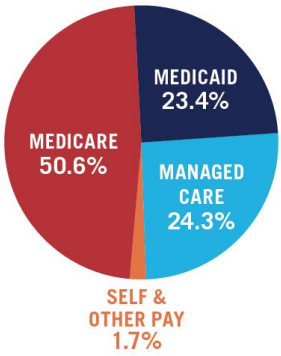
EMERGENCY MEDICAL SERVICES

WJMC operates the EMS service for the West Bank of Jefferson Parish, excluding municipalities, having their own ambulance services. The oldest EMS 9-1-1 responder on the West Bank, WJMC EMS recently celebrated 35 years of distinguished service by being recognized as the only EMS provider in Louisiana to earn the AHA Mission: Lifeline® Gold Achievement Award for excellence in treating severe heart attacks.

With its own EMS fleet in place, WJMC also offers in-field care including the LUCAS™ Chest Compression System and state-of-the-art EKG transmissions to the WJMC Emergency Room prior to a patient's arrival and early identification of potential heart and brain (stroke) attacks.

AWARDS & ACCREDITATIONS

- Patient Safety Excellence Award for three consecutive years by Healthgrades
- Advanced Certification for Comprehensive Stroke Centers by The Joint Commission
- 2018 America's 100 Best for Stroke Care by Healthgrades
- 2018 Stroke Care Excellence Award by Healthgrades
- 2017 Top 10% in the Nation for Treatment of Stroke by Healthgrades
- 2017 America's Best Stroke Centers by Women's Choice Awards



PAYER MIX

West Jefferson Medical Center

1101 Medical Center Blvd.
Marrero, LA 70072
(504) 347-5511

WJMC.ORG

1960

West Jefferson Medical Center opens its doors in April 1960 to serve the healthcare needs of the citizens on the West Bank of Jefferson Parish.

2012

Neurosurgery at West Jefferson Medical Center receives Excellence Award and Top 10% in the Nation by Healthgrades.

2015

After an agreement with Jefferson Parish is finalized, WJMC joins LCMC Health in October 2015.

LCMC HEALTH

2016

Opens Pediatric Emergency Room with Children's Hospital

Source: information annualized based on June 30, 2018 data available.

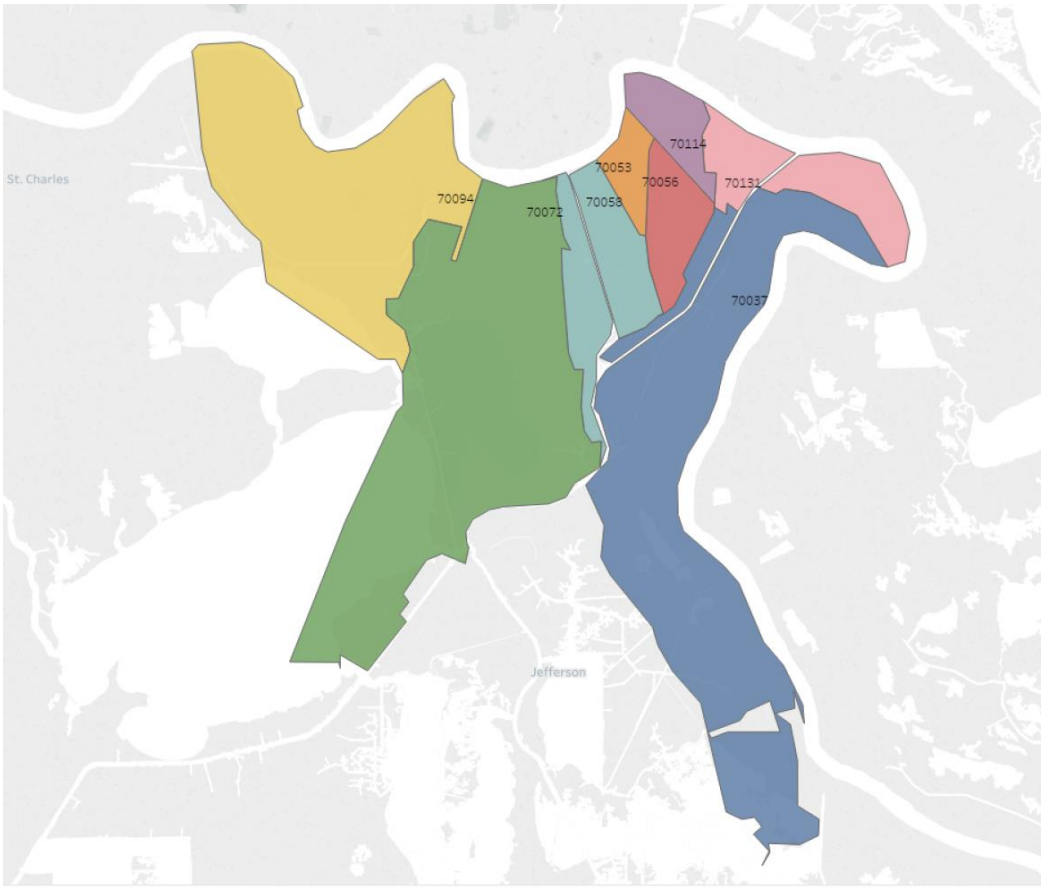
Appendix B: WJMC Community Definition

A community can be defined in many different ways and in 2018, the community served by WJMC represents a total of eight ZIP codes which represents 80 percent of the inpatient discharges for the hospital. The ZIP codes fall into three parishes. For comparison purposes the WJMC compares Jefferson, Orleans, and Plaquemines parishes (the parishes with the largest number of ZIP codes that make up the study). (See Table 9.)

Table 9: WJMC- ZIP codes

	ZIP Code	City	Parish
1.	70053	Gretna	Jefferson
2.	70056	Gretna	Jefferson
3.	70058	Harvey	Jefferson
4.	70072	Marrero	Jefferson
5.	70094	Westwego	Jefferson
6.	70114	New Orleans	Orleans
7.	70131	New Orleans	Orleans
8.	70037	Belle Chasse	Plaquemines

Map 4: WJMC– Study Area Map



Note: Map not to scale.

Source: Truven Health Analytics

WJMC Population and Demographics Snapshot:

- The West Bank Regional Profile encompass 860,528 residents. Orleans Parish is expected to have the highest population growth with 28,089 residents.
- From 2017 to 2022 the West Bank study area is projected to experience a 4.17% increase in population (35,894 people). The entire West Bank study area is projected to have population growth in 2022.
- Plaquemines Parish reports the highest rate of residents with less than a high school education at 8.76 percent when compared to the remaining study area parishes.
- Orleans Parish reports the highest rate of residents with a bachelor's degree or higher at 35.06 percent; while Plaquemines Parish reports the lowest rate of residents with a bachelor's degree or higher at 14.69 percent.
- Orleans Parish reports the largest black, non-Hispanic population percentage for the study area (57.88 percent); while Plaquemines Parish reports the fewest (19.49 percent). Plaquemines Parish also reports the largest percentage of residents who are white/non-Hispanic (64.52 percent); higher than the state (58.53 percent) and nation (60.77 percent).
- Orleans Parish reports the lowest average household income of the entire study area at $66,697; this is also lower than state ($68,011) and national ($80,853) averages. Plaquemines Parish reports the highest average household income at $75,122.

Appendix C: Primary and Secondary Data Overview

Process Overview

WJMC completed a wide-scale comprehensive community-focused CHNA to better serve the residents of Southern Louisiana. WJMC with other health care systems and hospitals within the Metropolitan Hospital Council of New Orleans participated in the assessment process.

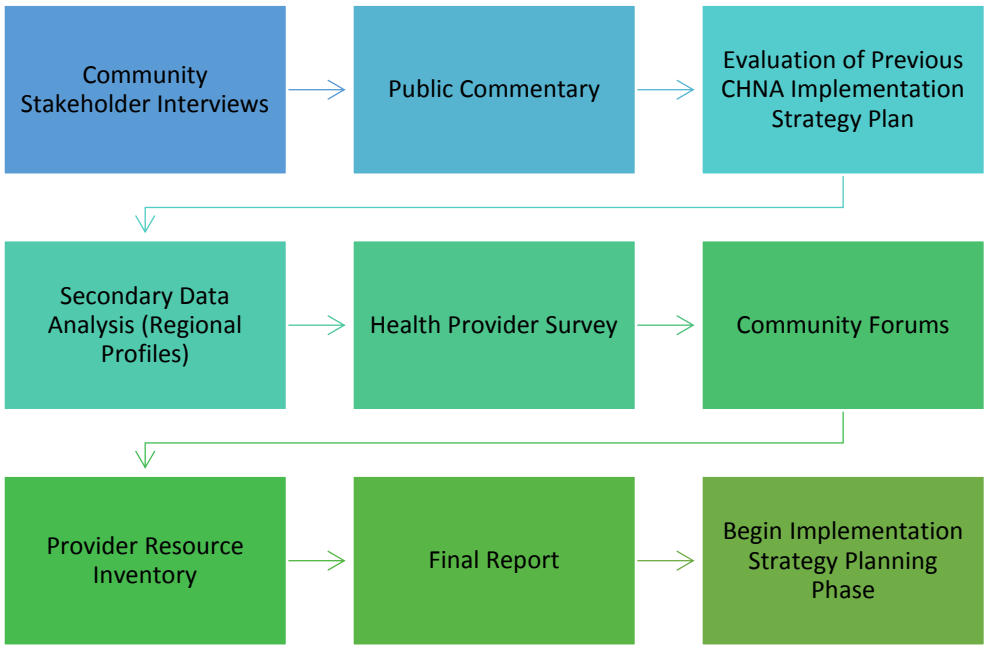
Civic and social organizations, government officials, educational institutions, and community-based organizations participated in the assessment to assist WJMC evaluate the needs of the community. The 2018 assessment included primary and secondary data collection that incorporated public comments, community stakeholder interviews, a health provider survey, and community forums.

Tripp Umbach collected primary and secondary data through the identification of key community health needs in the region. WJMC will develop an Implementation Strategy Plan that will highlight and identify ways the hospital will meet the needs of the community it serves.

WJMC and Tripp Umbach worked diligently to collect, analyze, review, and discuss the results of the CHNA, concluding in the identification and prioritization of the community's needs for LCMC Health - West Jefferson Medical Center.

The overall process and the project components in the CHNA are depicted in the flow chart below.

Chart 22: CHNA Process



Community Stakeholder Interviews

As part of the CHNA phase, telephone interviews were completed with community stakeholders in the service area to better understand the changing community health environment. The interviews offered community leaders an opportunity to provide feedback on the needs of the community, suggestions on secondary data resources to review and examine, and other information relevant to the study.

As part of the CHNA project, telephone interviews were completed with community stakeholders to better understand the changing community health environment. Community stakeholder interviews were conducted during February 2018 and continued through April 2018. Community stakeholders targeted for interviews encompassed a wide variety of professional backgrounds including: 1) public health experts; 2) professionals with access to community health related data; 3) representatives of underserved populations; 4) government leaders; and 5) religious leaders.

In total, 91 interviews were conducted with community leaders and stakeholders within the MHCNO project; 27 key stakeholders were interviewed as part of LCMC Health; six key stakeholders were identified and represented WJMC.

The qualitative data collected from community stakeholders are the opinions, perceptions, and insights of those who were interviewed as part of the CHNA process. The information provided insight and added great depth to the qualitative data.

Within the interview and discussion process, overall health needs, themes, and concerns were presented. Within each of the overarching themes, additional topics fell under each category. Below are key themes community stakeholders communicated from the most discussed to the least discussed (in descending order).

1. Health Education and Information
2. Mental Health
3. Access to Care
4. Nutrition and Chronic Diseases

Public Commentary Collection

As part of the CHNA Tripp Umbach solicited comments related to the 2015 CHNA and Implementation Strategy Plan (ISP) on behalf of WJMC. The solicitation of feedback was obtained from community stakeholders identified by the Working Group. Observations offered community representatives the opportunity to react to the methods, findings, and subsequent actions taken as a result of the previous 2015 CHNA and implementation planning process. Stakeholders were posed questions developed by Tripp Umbach and reviewed by the Working Group. Feedback was collected from six community stakeholders related to the public commentary survey. The comments below are a summary of stakeholder's feedback regarding the former documents.

The collection period for the survey began late February 2018 and continued through April 2018.

When asked if the assessment "included input from community members or organizations," five survey respondents reported that it did include input from community members or organizations and one stakeholder did not have the opportunity to review the documents in order to respond.

In response to the question, "Are there needs in the community related to health (e.g., physical health, mental health, medical services, dental services, etc.) that were not represented in the CHNA," three respondents agreed the needs identified in the 2015 CHNA represented the needs of the community; and two reported it did not. It was reported that dental needs were not covered in the CHNA.

Five of the survey respondents indicated that the ISP was directly related to the needs identified in the CHNA; one did not review the documents in order to respond.

Evaluation of Previous Planning Efforts

WJMC submitted an evaluation matrix to highlight and measure specific strategies that were developed. The Implementation Strategy Plan is a roadmap for how hospitals and communities are addressing the community health needs identified in the CHNA.

The purpose of the implementation strategy evaluation is for hospitals and community leaders to review and assess progress on the strategies and goals identified in the 2016 Implementation Strategy Plan to address community health needs.

A. Access to Health Services

Outcomes/Results

- Provided emergent care to all patients regardless of their ability to pay through the WJMC emergency medical care offering care 24 hours each day, 7 days every week.
    - Provided referrals for ongoing outpatient primary care to patients as needed.
- Assisted with the cost of health services received at WJMC to residents that qualify through grants and discount pricing.
- Provided care coordination for residents seeking care at WJMC.
    - ER Rapid follow-up reports to WJMC primary care physicians when patients have been hospitalized.
    - Provided nurse navigators where there are resources to do so.
    - WJMC primary care physicians made necessary referrals to specialty/subspecialty providers.
- Provided educational information about what services are available in the community, including transportation services, by posting the resource inventory (a component of the CHNA) on the hospital website and updating the information at regular intervals.
- Provided preventative care and/or resource information related to community-based preventive care to improve the outcomes of treatment options and potentially increasing effectiveness.

- Provided access to behavioral health care (outpatient/Inpatient) through referrals and contracting and/or information on available community resources.

B. Resource Awareness and Health Literacy

Outcomes/Results

- WJMC offers outreach education and information dissemination.
    - Hosted local civic groups providing 1) space for meetings and 2) information about health services available at the hospital.
    - Participated in community events with screening programs and health education.
    - Provided information and education regarding healthy behaviors.
- Increased the outreach offered to underserved populations (including residents with limited English-speaking skills regarding services that are available in communities served by WJMC).
    - Disseminated resource inventory (a component of the CHNA process) to organizations serving vulnerable populations, including: low income, seniors, and residents with limited English-speaking skills.
    - Provided the resource inventory in a format that can be translated.
    - Shared information via annual community venues: health fair and/or health forums collaborating with local Vietnamese and Hispanic communities and other vulnerable populations.
- WJMC provided appropriate translation services for patients that prefer a language other than English.
    - Offered a language line service for translation.
    - Based on resources and availability, offered bi-lingual staff to assist with translation.
    - Following applicable processes, ensured comprehension of medical documents for patients with limited English-speaking skills.

C. Access to Healthy Options and Behaviors that Impact Health

Outcomes/Results

- WJMC community relations department offered outreach education related to smoking cessation and healthy weight in conjunction with other departments on the Medical Center.
    - Smoking Cessation
    - Offered health and wellness classes through 1) Fitness Centers; 2) onsite at WJMC, and 3) in the community at local venues.
    - Provided onsite and community-based screenings and related activities to raise awareness and offered early detection of health issues.

- Provided continuing in medical education classes and/or relevant information to providers.

Secondary Data Collection

Tripp Umbach collected and analyzed secondary data from multiple sources, including Community Need Index (CNI), Community Commons Data, County Health Rankings and Roadmaps, Greater New Orleans Community Data Center's Report, and the Louisiana Department of Health. The regional data profile includes information from multiple health, social, and demographics sources. ZIP code analysis was also completed to illustrate community health needs at the local level. Tripp Umbach used secondary data sources to compile information related to disease prevalence, socioeconomic factors, and behavioral habits. Data were benchmarked against state and national trends, where applicable.

The information provided in the secondary data profile does not replace existing local, regional, and national sites but provides a comprehensive (but not all-inclusive) overview that complements and highlights existing and changing health and social behaviors of community residents for the health system, social, and community health organizations involved in the CHNA. A robust secondary data report was compiled for -WJMC; select information collected from the report has been presented throughout the CHNA. Data specifically related to the identified needs were used to support the key health needs.

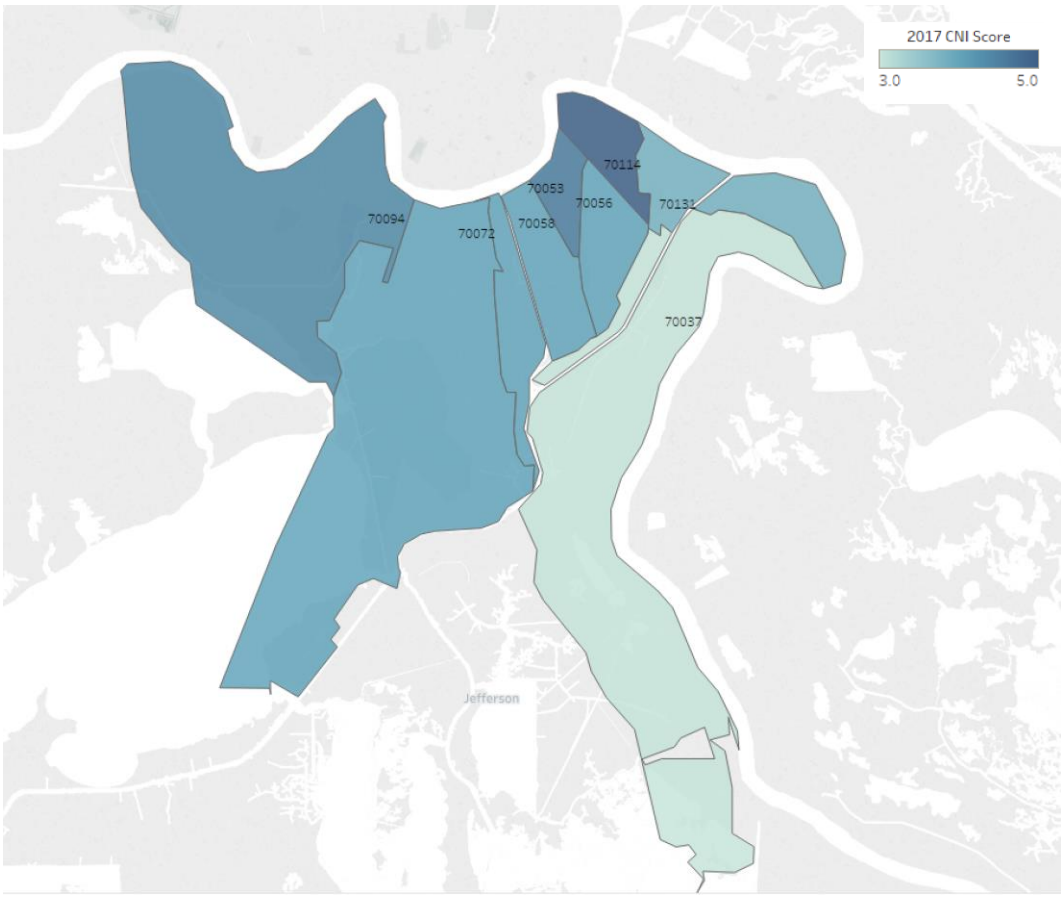
Tripp Umbach obtained data through Truven Health Analytics to quantify the severity of health disparities for ZIP codes in WJMC's service area. Truven Health Analytics provides data and analytics to hospitals, health systems, and health-supported agencies.

The Community Need Index (CNI) data source was also used in the health assessment. CNI considers multiple factors that are known to limit health care access; the tool is useful in identifying and addressing the disproportionate and unmet health-related needs of neighborhoods. The five prominent socioeconomic barriers to community health quantified in the CNI are Income Barriers, Cultural/Language Barriers, Educational Barriers, Insurance Barriers, and Housing Barriers. Additional information related to CNI can be found in Appendix G.

WJMC's community is defined as eight ZIP codes across three parishes that hold a large majority (80 percent) of the inpatient discharges. These ZIP codes represent the community served by WJMC as portions of the hospital's service areas falls into three parishes: Jefferson, Orleans, and Plaquemines parishes. WJMC provides services to communities throughout Southern Louisiana. The following map geographically depicts the service area.

Map 5 is the primary service area (study area) for LCMC Health - West Jefferson Medical Center.

Map 5: WJMC– CNI Scores



Note: Map is not to scale.

Source: Truven Health Analytics

In 2017, ZIP codes 70114 (New Orleans) and 70053 (Gretna) reported the highest CNI score of 5.0 and 4.6 respectively out of the eight ZIP codes in the study area.

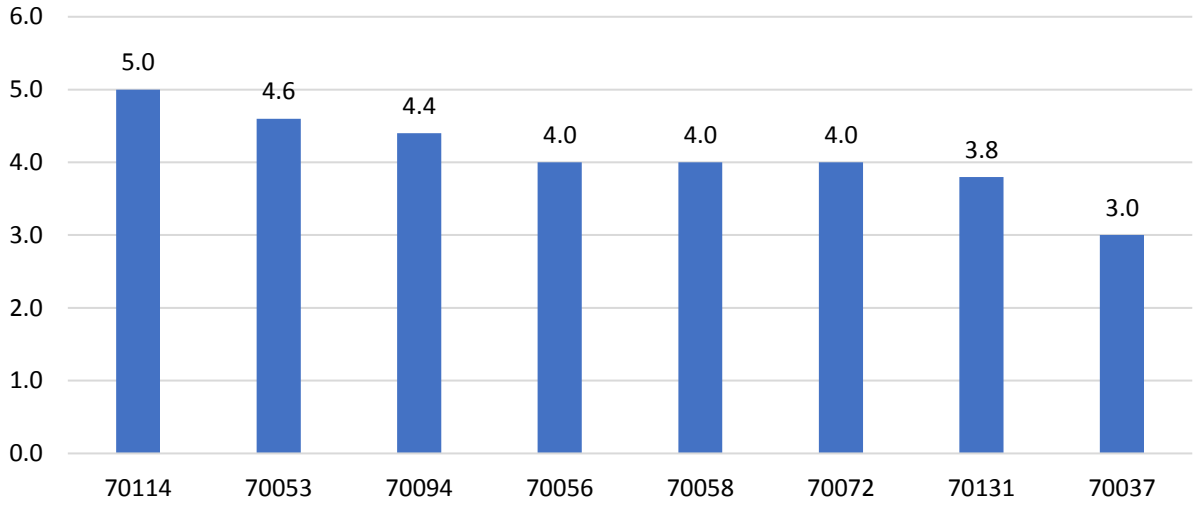
On the polar end, ZIP code 70037 in Belle Chasse in Plaquemines Parish reported a lower CNI score of 3.0 which indicates that residents within these ZIP code face lower socioeconomic barriers to care. It is important to note that this CNI score is still relatively high.

CNI data also revealed that the range in the West Bank region was 5.0 – 3.0.

Table 10: WJMC (CNI Score Breakouts)

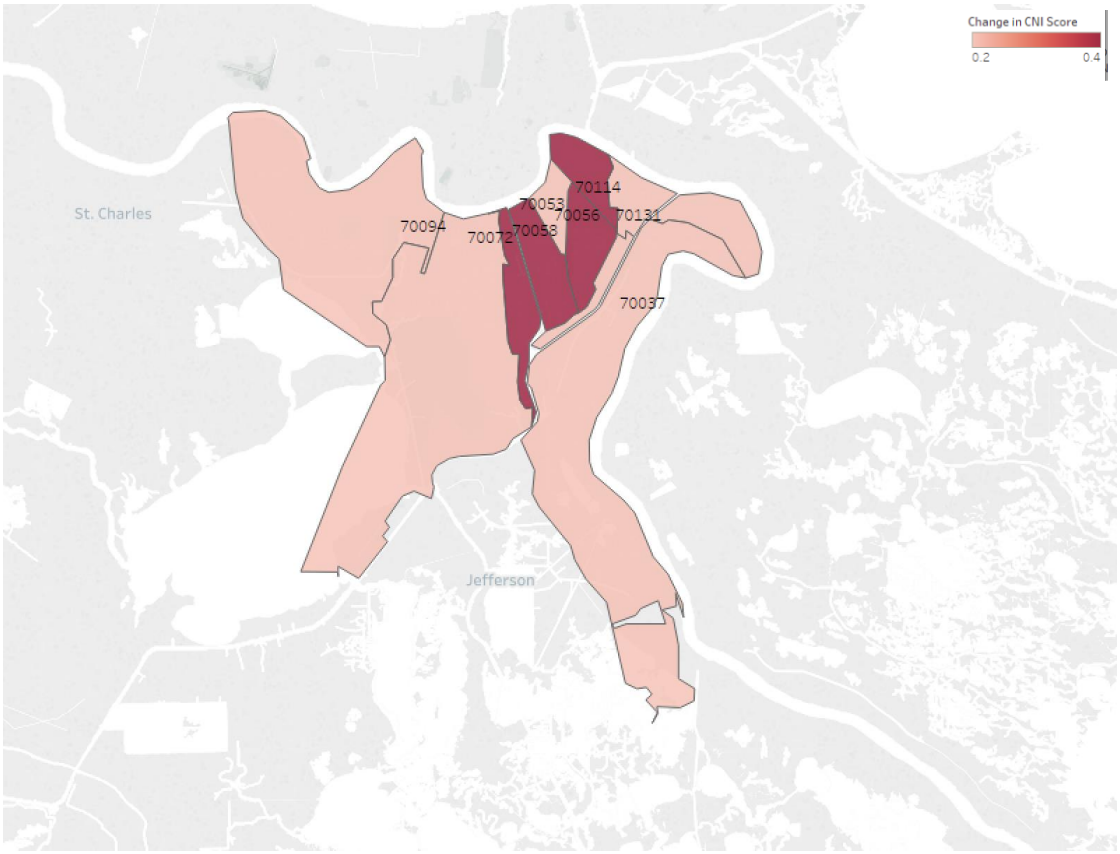
ZIP	City	County	Pov. 65+	Pov. Children	Pov. Single w/kids	Limit English	Minority	No HS Diploma	Un-employed	Un-insured	Rent	Income	Culture	Education	Housing	Insurance	2017 CNI Score
70114	New Orleans	Orleans	28.57%	42.40%	64.06%	1.46%	81.22%	20.36%	13.33%	12.30%	56.53%	5	5	5	5	5	5.0
70053	Gretna	Jefferson	14.41%	35.04%	51.14%	6.59%	56.06%	24.37%	9.00%	8.45%	52.51%	4	5	5	5	4	4.6
70094	Westwego	Jefferson	14.81%	30.69%	47.97%	2.48%	58.35%	22.51%	11.64%	7.26%	30.95%	4	5	5	4	4	4.4
70056	Gretna	Jefferson	9.32%	22.68%	45.59%	5.82%	63.48%	13.91%	5.95%	5.08%	40.17%	4	5	4	5	2	4.0
70072	Marrero	Jefferson	20.31%	25.43%	51.58%	2.53%	55.34%	21.84%	5.70%	6.78%	24.34%	4	5	5	3	3	4.0
70058	Harvey	Jefferson	18.54%	24.38%	41.83%	5.47%	75.52%	19.97%	5.32%	6.98%	30.69%	3	5	5	4	3	4.0
70131	New Orleans	Orleans	10.37%	19.09%	40.51%	2.68%	74.44%	10.37%	8.64%	6.63%	42.45%	3	5	3	5	3	3.8
70037	Belle Chasse	Plaquemines	13.61%	10.39%	23.90%	1.30%	26.64%	14.54%	3.80%	3.45%	32.94%	2	4	4	4	1	3.0

Chart 23: WJMC– Study Area Overview



Source: Truven Health Analytics

Map 6: WJMC- Study Area (Trending Scores)



Note: Map is not to scale.

Source: Truven Health Analytics

2017 CNI Score

5.00 to 4.00 (High socioeconomic barriers)

3.99 to 3.00

1.99 to 1.00 (Low socioeconomic barriers)

Across the eight West Bank study area ZIP codes, all eight ZIP codes experienced a rise in their CNI score from 2016 to 2017, indicating a shift to more barriers to health care access. None remained the same from 2016 to 2017.

ZIP code areas 70056, 70058, and 70114 – Gretna, Harvey, and New Orleans experienced the largest rises in CNI score (going from 3.6 to 4.0 in Gretna and Harvey; going from 4.6 to 5.0 in New Orleans).

In reviewing scores from 2016 and 2017, the map provides a geographic trending visual of the service area between the years. As the color changes from lighter red to dark red all eight ZIP codes face higher (got worse) socioeconomic barriers. (See Map 6.)

ZIP code 70056 (Gretna), 70058 (Harvey), and 70114 (New Orleans) reported the largest move with a 0.40 score change indicating factors that contributed to residents facing more socioeconomic barriers to health care.

Table 11: WJMC- Study Area (Trending Scores)

Zip	City	County	2017 CNI Score	2016 CNI Score	Difference
70056	Gretna	Jefferson Parish, LA	4.0	3.6	0.40
70058	Harvey	Jefferson Parish, LA	4.0	3.6	0.40
70114	New Orleans	Orleans Parish, LA	5.0	4.6	0.40
70072	Marrero	Jefferson Parish, LA	4.0	3.8	0.20
70053	Gretna	Jefferson Parish, LA	4.6	4.4	0.20
70094	Westwego	Jefferson Parish, LA	4.4	4.2	0.20
70131	New Orleans	Orleans Parish, LA	3.8	3.6	0.20
70037	Belle Chasse	Plaquemines Parish, LA	3.0	2.8	0.20

Health Provider Survey

Tripp Umbach employed a health provider survey methodology to survey providers within the region. A provider health survey was created to collect thoughts and opinions regarding health providers' community regarding the care and services they provide. Each hospital organization within the MHCNO collaboration sent emails to their health providers requesting survey participation. A survey link was also posted in an internal company newsletter to increase response rates. The survey data collection period ran on Survey Monkey from March thru May 2018. In total, a sample size of 176 surveys were collected.

Key Points:

- Jefferson (13.5 percent), Orleans (13.4 percent), St. Tammany (11.5 percent), St. Charles (6.2 percent), and St. Bernard (5.6 percent) parishes were the top five parishes where survey respondents reported they serve.
- A majority of survey respondents identified themselves as being a physician specialist (30.6 percent), 26.6 percent were primary care physicians, 19.1 percent were nurses.

- Hospital facility (39.3 percent) or doctor's office (26.6 percent) were the top two types of facilities where survey respondents provided care.
- The top three specific population's survey respondents that have focused care are: all populations (14.9 percent), seniors/elderly (9.5 percent), and low income/poor (8.4 percent).
- Overall, close to one-half of survey respondents reported the community in which they provide care or services as being unhealthy (37.8 percent)/very unhealthy (11 percent).
- More than half of survey respondents strongly agreed (30.3 percent) and agreed (37.7 percent) that residents have access to high-quality primary care providers.
- More than half of survey respondents strongly agreed (26.3 percent) and agreed (37.7 percent) that residents have access to specialists.
- More than half of survey respondents disagreed (37.7 percent) and strongly disagreed (29.1 percent) that residents have access to mental/behavioral health providers.
- Close to one-third of survey respondents disagree (21.4 percent) and strongly disagree (9.2 percent) that residents have access to dental care.
- More than half of survey respondents strongly agree (17.1 percent) and agree (36.6 percent) that residents have access to vision care.
- More than one-third of respondents disagreed (26.4 percent) and strongly disagreed (14.4 percent) that residents have available transportation options for medical appointments and other services.
- There was strong agreement (22.9 percent) and agreement (38.3 percent) that residents have access to health facilities where interpreter services/bilingual providers are available (61.3 percent).
- More than half of survey respondents strongly agree (12 percent) and agree (39.4 percent) that there are ample employment opportunities in the community where they practice.
- More than half of survey respondents strongly agreed (17.1 percent) and agreed (35.4 percent) the community where they practice is a safe place to live.
- 50.9 percent of survey respondents reported that there are safe, clean, and affordable housing options in the community.
- Close to one quarter of respondents (24.9 percent) disagreed that quality public education is available in the community.
- The top five health concerns affecting residents in the community according to health providers are: chronic diseases (19.9 percent), access to health care (17.7 percent), obesity/poor diet/lack of exercise (14.1 percent), mental health (12.2 percent) and substance abuse (6.4 percent).
- The top five reported health factors that contribute to the health concerns are: Health literacy/overall education (16.2 percent), obesity/poor diet/lack of exercise (11 percent), access

to health care (14.1 percent), unemployment/poverty (10.8 percent), and mental health/lack of mental health services (5.6 percent).

- Mental health services (14.4 percent) and substance abuse services (11.2 percent) were the top two resources/services that are missing from the community that would improve the health of residents.
- Conversely, vision care (1.7 percent) and emergency care (0.7 percent) were not seen as important resources/services that are missing from that community that would improve the health of residents.
- More than half of survey respondents (55.7 percent) were female, while 41.4 percent were male.
- Close to one-third of survey respondents (29.1 percent) are 55 and older.
- More than one-third of survey respondents plan to retire in 15 or more years (44 percent).
- A majority of survey respondents are white/Caucasian (83.1 percent).
- More than half of survey respondents have a medical degree (55.7 percent) followed by a college or master's degree (16.7 percent).

Community Forum

On July 10, 2018, Tripp Umbach facilitated a public input session (community forum) with leaders from community, government, civic, and social organizations, and other key community leaders at the Woodmere Community Center. The purpose of the community forum was to present the CHNA findings, which included existing data, in-depth community stakeholder interviews results, and results from the health provider survey, and to obtain input regarding the needs and concerns of the community overall. Community leaders discussed the data, shared their visions and plans for community health improvement in their communities, identified and prioritized the top community health needs in their region. With input received from forum participants, community stakeholders prioritized and identified top priority areas.

A. Access to Care
    a. Access to health screenings and services
    b. Lack of health providers
    c. Cost of health services
B. Behavioral Health (Mental Health & Substance Abuse)
    a. Drug use & abuse
    b. Suicide rates
    c. Lack of mental health services

C. Health Education

   a. Health education/literacy

   b. Sexually transmitted infections/diseases education

Provider Resource Inventory

An inventory of programs and services specifically related to the key prioritized needs was cataloged by Tripp Umbach. The inventory highlights programs and services within the focus area. The inventory identifies the range of organizations and agencies in the community that are serving the various target populations within each of the prioritized needs. It provides program descriptions, contact information, and the potential for coordinating community activities by creating linkages among agencies. The provider inventory was provided as a separate document due to its interactive nature, and is available on LCMC Health's website.

Final Report

A final report was developed that summarized key findings from the assessment process including the final prioritized community needs. Top community health needs were identified by analyzing secondary data, primary data collected from key stakeholder interviews, a health provider survey, and a community forum. Tripp Umbach provided support to the prioritized needs with secondary data (where available), and consensus with community stakeholders results, and surveys results.

Implementation Planning

With the completion of the community health needs assessment, an implementation phase will begin with the onset of work sessions facilitated by Tripp Umbach. The work sessions will maximize system cohesion and synergies, during which leaders from LCMC Health will be guided through a series of identified processes. The planning process will result in the development of an implementation plan that will meet system and IRS standards.

Appendix D: Community Stakeholder Interviewees

Tripp Umbach completed six interviews with community stakeholders representing WJMC to gain a deeper understanding of community health needs from organizations, agencies and government officials that have day-to-day interactions with populations in greatest need. Interviews provide information about the community's health status, risk factors, service utilizations and community resource needs, as well as gaps and service suggestions.

Listed below in alphabetic order by last name are the community stakeholders interviewed for the community needs assessment.

Table 12: Community Stakeholders for WJMC (Listed alphabetically by last name)

Name	Organizations
Jennifer Steel-Bourgeois	West Jefferson Medical Center
Dr. Clara Byes	Martin Luther King Task Force & West Bank African American Churches
Althea LaCour	West Jefferson Medical Center Auxiliary
Oscar Pipkins	Civic Coalition West Bank
Susan Trantham	West Jefferson Medical Center Foundation
Jeanne Tripoli	Jefferson Council on Aging

Listed below in alphabetic order by last name are the community stakeholders who were interviewed overall for LCMC Health.

Table 13: Overall Community Stakeholders for LCMC Health (Listed alphabetically by last name)

Name	Organizations Representing LCMC Health
Kate Andrus, MPH, RDN, LDN	Louisiana Department of Health Bureau of Chronic Disease Prevention and Health Promotion
Mike Andry	Excelth Health Center
Jennifer Avegno, MD	UMCNO Forensics
Jennifer Steel-Bourgeois	Community Stakeholder
Matthew Broussard	The Louisiana Campaign for Tobacco-Free Living
Dr. Clara Byes	Martin Luther King Task Force & West Bank African American Churches
Paulette Carter	Children's Bureau New Orleans
Sandy Denapolis	Jefferson Parish Public School System
Jeff Elder, MD	EMS New Orleans
Martha Kegel	Unity of Greater New Orleans
Joseph D. Kimbrell, MA, MSW	Louisiana Public Health Institute
Althea LaCour	West Jefferson Medical Center; Auxiliary
Coretta LaGarde	American Heart Association/American Stroke Association
Lang Le	VIET

Name	Organizations Representing LCMC Health
Lisa Plunkett	Susan G. Komen
Oscar Pipkins	Civic Coalition West Bank
Chioma Ogbuefi, MD	Excelth Health Center
Howard Rodgers	New Orleans Council on Aging
Melanie Thompson	United Healthcare
Susan Todd	504 HealthNet
Susan Trantham	WJMC Foundation Director
Jeanne Tripoli	Jefferson Parish Council on Aging
Charlotte Weil, M.A., CWWS	HUB International Gulf South
Amy Williams	American Cancer Society
Rosalind Woodfox	The Blood Center
Stephanie Young	Louisiana Organ Procurement Agency
Amy Zapata	Bureau of Family Health

Appendix E: Community Organizations and Partners

Metropolitan Hospital Council of New Orleans along with its hospital partners, East Jefferson General Hospital, HCA Healthcare (Tulane Medical Center), LCMC Health, Ochsner Health System, Slidell Memorial Hospital, and St. Tammany Parish Hospital came together to gain a better understanding of the health needs of the community they serve.

LCMC Health is a leading health care provider dedicated to understanding community needs, offering high quality programs to address the region's needs, and promoting population wellness. The primary data collected in the CHNA provided valuable input and ongoing dedication to assisting LCMC Health and its health care partners in identifying community health priorities; building on a foundation to develop strategies that will address the needs of residents in Southern Louisiana.

The table below lists community organizations that assisted LCMC Health and its hospital partners with the primary data collection through community stakeholder interviews, completing a health provider survey, and or attending a regional forum.

Table 14: Community Organizations and Partners

	Organization Name
1.	504HealthNet
2.	Acadian Ambulance Service
3.	Access Health Louisiana
4.	Agenda for Children
5.	American Cancer Society
6.	American Heart Association/American Stroke Association
7.	Andrea's Restaurant
8.	Backyard Gardeners Network
9.	Baton Rouge Health District
10.	Belle Chasse YMCA
11.	Boys & Girls Clubs West Bank
12.	Broad Community Connections
13.	Bryan Bell Metropolitan Leadership Forum
14.	Bureau of Chronic Disease Prevention and Health Promotion
15.	Bureau of Family Health
16.	Café Hope
17.	Caffin Avenue SDA Church
18.	Capital Area Human Services
19.	CCOSJ
20.	Central Chamber of Commerce

	Organization Name
21.	Central Lafayette High School
22.	Children's Bureau New Orleans
23.	City of Baton Rouge
24.	City of Covington
25.	City of Kenner
26.	City of Mandeville
27.	City of New Orleans Emergency Medical Services
28.	City of Slidell
29.	Civic Coalition West Bank
30.	Council on Aging of St. Tammany
31.	Covenant House New Orleans
32.	Covington Food Bank
33.	Crescent Dental
34.	Daughters of Charity
35.	East Jefferson General Hospital
36.	East St. Tammany Chamber of Commerce
37.	EXCELth Family Health Center
38.	Fifth District Savings Bank
39.	Friends of Lafitte Greenway
40.	Gheens Needy Family
41.	Gin Wealth Management Partners
42.	Good Samaritan Food Bank
43.	Gulf Coast Bank & Trust Company
44.	Health Guardians of Catholic Charities Archdiocese of New Orleans
45.	Hospital Service District
46.	HUB International Gulf South
47.	Humana
48.	Humana Bold Goal
49.	JEFFCAP
50.	Jefferson Chamber of Commerce
51.	Jefferson Parish Council on Aging
52.	Jefferson Parish Public School System
53.	Jewish Family Services
54.	John J. Hainkel, Jr. Home & Rehabilitation Center

	Organization Name
55.	Junior League of New Orleans
56.	Kenner Discovery Health Sciences Academy
57.	Kingsley House
58.	Lafourche Behavioral Health Center
59.	Lafourche Fire Department District #1
60.	Lafourche Hospital Service District #2
61.	Lafourche Parish Government
62.	Lafourche Parish School Board
63.	Lafourche Parish Sheriff's Office
64.	Lakeview Regional Medical Center
65.	LCMC Health
66.	LCMC Health – Children's Hospital
67.	LCMC Health – New Orleans East Hospital
68.	LCMC Health – Touro Infirmary
69.	LCMC Health – University Medical Center
70.	LCMC Health – West Jefferson Medical Center
71.	Limb Up
72.	Lockport City Council
73.	Louisiana Children's Research Center for Development and Learning
74.	Louisiana Department of Health
75.	Louisiana Organ Procurement Agency
76.	Louisiana Policy Institute for Children
77.	Louisiana Public Health Institute
78.	Louisiana Public Health Institute
79.	Louisiana State University Agricultural Center
80.	Louisiana State University Health Sciences Center
81.	Louisiana State University/University Medical Center
82.	Market Umbrella
83.	Martin Luther King, Jr. Task Force & West Bank African American Churches
84.	Methodist Health System Foundation, Inc.
85.	Metropolitan Human Services District
86.	New Orleans Chamber of Commerce
87.	New Orleans Council on Aging
88.	New Orleans Emergency Medicine

	Organization Name
89.	New Orleans Health Department
90.	New Orleans Mission/Giving Hope Retreat
91.	New Pathways New Orleans
92.	Newman, Mathis, Brady & Spedale
93.	NOLA Business Alliance
94.	Northshore Community Foundation
95.	Northshore Healthcare Alliance
96.	Nurse Family Partnership
97.	Ochsner Baptist Medical Center
98.	Ochsner Health System
99.	Ochsner Health System Board of Trustees
100.	Ochsner Medical Center – Baton Rouge
101.	Ochsner Medical Center – Kenner
102.	Ochsner Medical Center – Kenner Hospital Board
103.	Ochsner Medical Center – North Shore
104.	Ochsner Medical Center – West Bank
105.	Ochsner Rehabilitation Hospital in partnership with Select Medical
106.	Ochsner St. Anne Hospital
107.	One Haven Inc.
108.	People's Health
109.	Rainbow Child Care Center, Inc.
110.	Ready Responders
111.	Regina Coeli Child Development Center
112.	River Parish Behavioral Center
113.	River Place Behavioral Health a service of Ochsner Health System
114.	SAIRP
115.	Salvation Christian Fellowship
116.	Second Baptist Church
117.	Second Harvest Food Bank
118.	Slidell Memorial Hospital
119.	South Central Planning & Development Commission (SCPDC)
120.	St. John Council
121.	St. John Volunteer Citizen
122.	St. Tammany Coroner's Office

	Organization Name
123.	St. Tammany Department of Health & Human Services
124.	St. Tammany Parish Clerk of Court; 22nd Judicial District Court
125.	St. Tammany Parish Government Health & Human Services
126.	St. Tammany Parish Hospital
127.	St. Thomas Health Center
128.	Susan G. Komen
129.	The Blood Center
130.	The Haven
131.	The Louisiana Campaign for Tobacco-Free Living
132.	The Metropolitan Hospital Council of New Orleans
133.	The National Alliance on Mental Illness
134.	TPRC
135.	Tulane Lakeside Hospital for Women and Children
136.	Tulane Medical Center
137.	U.S. House of Representatives
138.	UMCNO Forensics
139.	United Healthcare
140.	United Way
141.	United Way for Greater New Orleans
142.	United Way of Southeast Louisiana
143.	UNITY of Greater New Orleans
144.	Vacherie-Gheens Community Center
145.	VIET
146.	Volunteers of America
147.	Well-Ahead Louisiana Region 9
148.	West Jefferson Medical Center
149.	West Jefferson Medical Center Foundation Director
150.	West Jefferson Medical Center; Auxiliary

Appendix F: Working Group Members

The CHNA was overseen by a committee of representatives from the sponsoring organizations. Members of the Working Group and the organizations they represent are listed in alphabetical order by last name.

Table 15: Working Group Members (Listed aphabetically by last name)

Name	Organization
Jennifer Berger, MBA	Manager, Marketing & Communications Business Development Slidell Memorial Hospital
Avery Corenswet, MHA, BSN, RN	Vice President of Community Outreach Ochsner Health System
Melissa Hodgson, ABC, APR	Director of Communication St. Tammany Parish Hospital
Jennifer E. McMahon	Executive Director The Metropolitan Hospital Council of New Orleans
Charlotte Parent, RN, MHCM	Assistant Vice President Community Affairs Network Navigation LCMC Health
Tom Patrias, FACHE	Chief Operating Officer Tulane Health System
Megan Perry	Marketing & Communications Coordinator Business Development Slidell Memorial Hospital
John Sartori	Director of Marketing Communications East Jefferson General Hospital
Ha T. Pham	Principal Tripp Umbach
Barbara Terry	Senior Advisor Tripp Umbach

Appendix G: Truven Health Analytics

Community Needs Index (CNI) Overview

Not-for-profit and community-based health systems have long considered a community's needs to be a core component of their mission of service to local communities. While specific initiatives designed to address health disparities vary across local communities (outreach to migrant farm workers, asthma programs for inner city children, etc.), the need to prioritize and effectively distribute hospital resources is a common thread among all providers.

Given the increased transparency of hospital operations (quality report cards, financial disclosures, etc.), community benefit efforts need to become increasingly strategic and targeted in order to illustrate to a variety of audiences how specific programs have been designed and developed. While local community needs assessments will always play a central role in this process, they are often voluminous, difficult to communicate, and may lack necessary qualitative and statistical justification for choosing specific communities as having the "greatest need."

Because of such challenges, Dignity Health and Truven Health Analytics jointly developed a Community Need Index (CNI) in 2004 to assist in the process of gathering vital socioeconomic factors in the community. The CNI is strongly linked to variations in community health care needs and is a strong indicator of a community's demand for various health care services.

Based on a wide-array of demographic and economic statistics, the CNI provides a score for every populated ZIP code in the United States on a scale of 1.0 to 5.0. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need. The CNI should be used as part of a larger community need assessment and can help pinpoint specific areas that have greater need than others. The CNI should be shared with community partners and used to justify grants or resource allocations for community initiatives.

Methodology

The CNI score is an average of five different barrier scores that measure various socioeconomic indicators of each community using the source data. The five barriers are listed below, along with the individual statistics that are analyzed for each barrier. The following barriers, and the statistics that comprise them, were carefully chosen and tested individually by both Dignity Health and Truven Health:

1. Income Barrier

- Percentage of households below poverty line, with head of household age 65 or older.
- Percentage of families, with children under age 18, below poverty line.
- Percentage of single female-headed families, with children under age 18, below poverty line.

2. Cultural Barrier

- Percentage of population that is a minority (including Hispanic ethnicity).
- Percentage of population, over age five, which speaks English poorly or not at all.

3. Education Barrier

- Percentage of population, over age 25, without a high school diploma.

4. Insurance Barrier

- Percentage of population in the labor force, age 16 or older, without employment.
- Percentage of population without health insurance.

5. Housing Barrier

- Percentage of households renting their home.

Every populated ZIP code in the United States is assigned a barrier score of 1,2,3,4, or 5 depending upon the ZIP national rank (quintile). A score of 1 represents the lowest rank nationally for the statistics listed, while a score of 5 indicates the highest rank nationally. For example, ZIP codes that score a 1 for the Education Barrier contain highly educated populations; ZIP codes with a score of 5 have a very small percentage of high school graduates.

For the two barriers with only one statistic each (education and housing), Truven Health used only the single statistic listed to calculate the barrier score. For the three barriers with more than one component statistic (income, cultural, and insurance), Truven Health analyzed the variation and contribution of each statistic for its barrier; Truven Health then weighted each component statistic appropriately when calculating the barrier score.

Once each ZIP code is assigned its barrier scores from 1 to 5, all five barrier scores for each ZIP code are averaged together to yield the CNI score. Each of the five barrier scores receives equal weight (20.0 percent each) in the CNI score. An overall score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need.

Data Sources

- Demographic Data, The Nielsen Company
- Poverty Data, The Nielsen Company
- Insurance Coverage Estimates, Truven Health Analytics

Applications and Caveats

- CNI scores are not calculated for non-populated ZIP codes. These include such areas as national parks, public spaces, post office boxes, and large unoccupied buildings.
- CNI scores for ZIP codes with small populations (especially less than 100 people) may be less accurate. This is due to the fact that the sample of respondents to the 2010 census is too small to provide accurate statistics for such ZIP codes.

Appendix H: Regional Groupings

The table below represents the areas that were representative of each hospital within the MHCNO project.

Table 19: Regional Groupings

Region	Hospital/Health Care Institution
West Bank	LCMC Health – West Jefferson Medical Center Ochsner Medical Center – West Bank
North Shore	Ochsner Medical Center – North Shore Slidell Memorial Hospital St. Tammany Parish Hospital Tulane Lakeview Regional Medical Center
New Orleans	LCMC Health – Children's Hospital LCMC Health – New Orleans East Hospital (NOEH) LCMC Health – Touro Infirmary LCMC Health – University Medical Center (UMC) Ochsner Medical Center – Baptist
Jefferson	East Jefferson General Hospital Ochsner Medical Center – Kenner Ochsner Medical Center – Main Ochsner Rehabilitation Hospital River Place Behavioral Health – Ochsner Medical Center Tulane Lakeside Hospital
St. Anne (Raceland/Lafourche)	Ochsner Medical Center – St. Anne
Baton Rouge	Ochsner Medical Center – Baton Rouge

Appendix I: Tripp Umbach

Consultants

The Metropolitan Hospital Council of New Orleans (MHCNO) along with its partners, East Jefferson General Hospital, LCMC Health, Ochsner Health System, HCA Healthcare (Tulane Medical Center), Slidell Memorial Hospital, and St. Tammany Parish Hospital, contracted with Tripp Umbach, a private health care consulting firm with offices throughout the United States, to complete a community health needs assessment (CHNA) and implementation strategy planning phase. Tripp Umbach has worked with more than 300 communities in all 50 states. In fact, more than one in five Americans lives in a community where our firm has worked.

From community needs assessment protocols to fulfilling the new Patient Protection and Affordable Care Act (PPACA) IRS 990 requirements, Tripp Umbach has turned needs assessments into practical action plans with sound implementation strategies, evaluation processes, and funding recommendations for hundreds of communities. Tripp Umbach has conducted more than 400 community health needs assessments and has worked with over 800 hospitals.

Changes introduced as a result of the PPACA have placed an increased level of importance on population health and well-being and on collaborative efforts between providers, public health agencies, and community organizations to improve the overall health of communities.

Tripp Umbach