Tulane Health System

Tulane Medical Center
Tulane Lakeside Hospital
Lakeview Regional Medical Center

2022-2024 COMMUNITY HEALTH IMPLEMENTATION PLAN

Adopted by hospital facility May 23, 2022

CHIP Background

This 2022-2024 Community Health Implementation Plan (CHIP) for Tulane Health System (THS) is a companion piece to their 2021 Community Health Needs Assessment (CHNA) adopted in December 2021. The CHNA identified significant health needs by reviewing data and soliciting input from people who represent the broad interests of the community. This CHIP builds upon the CHNA findings by detailing how THS intends to leverage resources and relationships with partner organizations to address the priority health needs identified in the CHNA over the next three years.

The CHNA and CHIP were conducted as part of a collaborative process with 19 hospital facilities across Southeast Louisiana. The Metropolitan Hospital Council of New Orleans (MHCNO), part of the Louisiana Health Association (LHA), contracted with the Louisiana Public Health Institute (LPHI) to develop joint CHNAs, as well as individual CHIP reports, for their member hospitals, including THS.

Community Served

The geographic region of focus for this CHIP is reflective of that described in the CHNA. This community includes seven Louisiana parishes: Jefferson, Orleans, St. Bernard, St. John the Baptist, St. Tammany, Tangipahoa, and Washington. These parishes are referred to as "the Greater New Orleans and Northshore (GNO-NS) area" for the purpose of the CHNA-CHIP process. This community includes medically underserved, low-income, and minority populations.

Priority Health Needs

Community input in the CHNA process drove the determination of significant health needs, which were then prioritized in the CHIP process. During the CHNA process, community input was gathered through interviews, focus groups, and an online survey, targeting participants with special knowledge of public health and representatives of vulnerable populations in the communities served by the hospitals. By triangulating community input from assessment participants with secondary data, six health needs were identified as significant drivers of poor health in the GNO-NS area CHNA. These include: access to and continuity of care, mental and behavioral health, education and health literacy, health equity and discrimination in healthcare, poverty and income inequality, and infrastructure. On September 28 and October 8, 2021, CHNA leads from the GNO and NS hospitals respectively gathered to review data from the assessment and conducted an initial prioritization activity of the six health needs. Participants rated each health need according to their perceptions of: 1) the impact that addressing the issue would have on community health and 2) the feasibility of the hospital's capacity to address the issue. After this initial prioritization activity, participants brought the health needs back to their hospital teams and leadership to discuss and finalize prioritization. THS prioritized and developed implementation strategies for the following four health needs: Access to and Continuity of Care, Behavioral Health, Discrimination & Inequities in Healthcare, and Health Literacy (Figure 1).

Figure 1.Health Needs Prioritized by THS

Priority Health Needs and Workplans

Below is a summary of findings for each priority health need along with Tulane Health System's corresponding CHIP workplan. Each table describes the workplan to address one of the four priority health needs chosen by THS leadership. While leadership chose four priorities to focus on, the workplan features multiple objectives housed under each priority to allow for a multi-pronged approach for improvement. Other elements of the plan include target populations, success measures, actions, objective leads and timeframes, and resources and partners. The activities outlined in these workplans are subject to change over time and should be updated on an ongoing basis.

Priority 1: Access to and Continuity of Care

Barriers to care in the THS community included insurance issues (limited options based on payor, uninsured rates), inadequate quality of care, and operational issues such as location and hours. Insurance was a barrier to care for participants, and data illustrates divides in who has access and who does not. In nearly every parish in the GNO area, a higher percentage of Black residents are uninsured compared to White residents, and a higher percentage of Hispanic residents are uninsured compared to non-Hispanic residents of any race. Barriers to care that related to location and hours were also an issue. This can be partially attributed to the fact that in most parishes, there are fewer primary care physicians per capita compared to the state rate.

Access to and continuity of care (Page 1 of 2)

Goal(s): Assist patients in living healthier and more productive lives.

General strategy: Improve access to medical services for the communities that Tulane Health System serves.

SMART Objective (anticipated outcome)	Target Population(s)	Success Measures	Actions (can be multiple actions for one objective)	Lead & Timeframe	Resources & Partners
Connect underserved patients to appropriate health care services in region.	Community wide	# of patients served total dollars forgiven per drug	Partner with Walgreens retail pharmacy within Tulane Medical Center in their provision of financial assistance with prescription drugs	Lead: Walgreens leadership Timeframe: ongoing	Resources: vendor time Partners: Walgreens
Expand telemedicine efforts to additional spoke sites as well as within the Tulane clinics.	Regionwide	# of additional sites # of unique encounters	Continue to expand the Tulane Expert Teleconsulting network to hospitals in Louisiana and surrounding states. Expand telemedicine offerings for subspecialties that are generally only found at larger academic facilities (i.e., MFM, Oncology, etc)	Lead: Service line VPs Timeframe: ongoing	Resources: staff time, capital Partners: TU physicians, outlying facilities, PPR teams

SMART Objective (anticipated outcome)	Target Population(s)	Success Measures	Actions (can be multiple actions for one objective)	Lead & Timeframe	Resources & Partners
Continue to provide faculty physician led health screenings for various diseases	Community wide	# of events # of participants	Restart the Annual "Man-Up" prostate health screening; high-school pre-participation physicals and screening; diabetes. Add additional screenings.	Lead: Marketing Director Timeframe: ongoing	Resources: staff and hospital resources Partners: TU physicians, community, and health organizations
Promote and expand the navigation programs within Tulane Health System	Regionwide	# of navigation programs # of participants	Continue the Care Navigator online platform that includes contacts for appointments, emergency care, and telehealth options to connect patients to appropriate health care services in the region.	Lead: Navigation lead Timeframe: ongoing	Resources: marketing material, online content, staff time Partners: Care Navigation team
Provide Community Resource information via webpage	Community wide	# of resources # of website hits	Expand Tulane University's Student Clinic Council webpage that provides community resource information, including Aunt Bertha link to finding food, health, housing, and job training information.	Lead: TU Student Clinic Council Timeframe: ongoing	Resources: online content, marketing, volunteer time Partners: TU student clinic council

Priority 2: Behavioral Health

The CHNA revealed mental health conditions, substance abuse, addiction, excessive alcohol use, and trauma as major problems in GNO-NS communities. Qualitative participants expressed that behavioral health needs are immense, additive, and worsening due to the pandemic. In most parishes the drug overdose death rate is higher than the state rate, with St. Bernard rate at twice the state rate. A lack of availability of mental health providers is also an issue. In 6 of the 8 parishes in the GNO region there are fewer mental health providers per capita compared to the state rate.

Priority 2: Behavioral Health (Page 1 of 2)

Goal(s): To enhance behavioral health services and substance abuse resources in the population we serve.
General strategy: Increased community awareness and accessibility of mental health and alcohol and opioid abuse resources within the communities we serve.

SMART Objective (anticipated outcome)	Target Population(s)	Success Measures	Actions (can be multiple actions for one objective)	Lead & Timeframe	Resources & Partners
Continue to partner with community organizations to disseminate and provide information on behavioral health services to community residents.	Community partners	# of community partners # of active participants	Utilize community organizations to distribute information on available behavioral health services available to their population.	Lead: Case Management Director Timeframe: ongoing	Resources: staff time Partners: MH Jefferson Human Services Authority, Central City Behavioral Health, VA, and Metropolitan Human Health Services
			Promote the psychiatry resident clinic within Tulane Medical Center as a resource to community members who are in need of a psychiatric provider.	Lead: TU School of Medicine leadership Timeframe: ongoing	Resources: staff time Partners: TU Behavioral Health Clinic
ESR (Enhanced Surgical Recovery) participation with our surgical patients	Surgical patients at the three facilities	% of surgeons participating 100% eligible patients following ESR protocols	Expand to all surgical specialties other than Urology, Ophthalmology, and diagnostic procedures	Lead: Surgical Services leaders Timeframe: Q3 2022	Resources: current perioperative staff Partners: surgeons, anesthesiologists

SMART Objective (anticipated outcome)	Target Population(s)	Success Measures	Actions (can be multiple actions for one objective)	Lead & Timeframe	Resources & Partners
Expand initiatives to improve staff wellbeing	Hospital staff, contractors, and physicians	# of active participants % Very Satisfied and Satisfied recorded in employee engagement surveys	Remind colleagues of the EAP resources available to them on a monthly basis and seek feedback through employee surveys on additional services that would be helpful.	Lead: HR VP Timeframe: ongoing	Resources: marketing and HR support Partners: Optum
			Seek opportunities to be included in Tulane University's School of Social Work's "Project RETAIN" – three-year project developing self-care models contributing to the overall wellbeing and resiliency of health care workers	Lead: HR VP Timeframe: late 2022	Resources: staff time Partners: TU School of Social Work
			Continue to promote Tulane's Living Well healthcare clinic which offers cognitive behavioral therapy for Tulane employees	Lead: TU admin Timeframe: ongoing	Resources: staff time Partners: Tulane University

Priority 3: Health Equity and Discrimination in Healthcare

Discrimination in healthcare affects patient engagement, access to care, and quality of care. Survey participants shared examples of healthcare entities discriminating based on race, language, immigration status, age, sexual orientation, and gender identity/expression. The percent of the population who speak a language other than English, and with limited English proficiency are highest in Jefferson, St. Bernard, and Orleans. Qualitative participants reported that LGBTQ people, the aging population, the undocumented population, and people perceived as low-income or uneducated experience discrimination in the healthcare system.

Priority 3: Health Equity and Discrimination in Health Care (Page 1 of 2)

Goal(s): Support deployment of key Diversity, Equity and Inclusion strategies and programs identified by our facility-based DEI councils and supported by the corporate DEI council.

General strategy: Ensure equitable access to high quality care for our patients, fostering a diverse and inclusive workplace for our colleagues and cultivating and sustain relationships with suppliers and community partners that broaden our reach and deepen our understanding of the communities we serve.

SMART Objective (anticipated outcome)	Target Population(s)	Success Measures	Actions (can be multiple actions for one objective)	Lead & Timeframe	Resources & Partners
Increase recruitment and retention efforts at THS with a focus on matching our % of POC in the workforce (frontline and leadership) to match the communities that we serve.	POC w/ appropriate credentials for posted positions	Improve recruitment, retention, and engagement of POC improved % of POC in workforce and leadership	Increase hiring of POC by 10% YOY	Lead: HR VP Timeframe: ongoing	Resources: staff time Partners: DEI council
			Reduce turnover amongst POC by 10%	Lead: HR VP Timeframe: ongoing	Resources: staff time Partners: DEI council
			Reduce turnover amongst POC in leadership positions by 10%	Lead: HR VP Timeframe: ongoing	Resources: staff time Partners: DEI council
Provide education to all THS leaders on Conscious Inclusion training	Current and future leaders at THS	Establish in-person and virtual training 100% trained	Develop training program in collaboration with the Division and Corporate DEI councils	Lead: THS educator Timeframe: Q1 2022	Resources: staff time Partners: education department, DEI council
			Ensure that current leaders have received training	Lead: THS educator Timeframe: Q2 2022	Resources: staff time Partners: education department, DEI council
			Incorporate training with new leaders during their onboarding	Lead: THS educator Timeframe: ongoing	Resources: staff time Partners: education department, DEI council

SMART Objective (anticipated outcome)	Target Population(s)	Success Measures	Actions (can be multiple actions for one objective)	Lead & Timeframe	Resources & Partners
Strengthen culturally competent education for patients and clinicians	Patients and clinicians at THS facilities	Publish education materials for targeted population # of targeted population educated	Publish education material for patients and clinicians to ensure that all patients served have access to the highest quality, culturally competent care	Lead: Corporate DEI council Timeframe: ongoing	Resources: publications Partners: Corporate, Division, and local DEI councils
			Operationalize the commitment to culturally competent care through standardized education, involvement of the Equity Compliance Coordinator network, and professional development	Lead: FECC Timeframe: ongoing	Resources: publications Partners: Corporate, Division, and local DEI councils, FECC
Collaborate with Tulane School of Medicine on initiatives to engage underrepresented populations in pursuing careers in medicine.	Current students enrolled at local HBCUs and students involved in minority-based organizations at local non-HBCU schools	Enroll 15 eligible students per year # of students participating	Initiate the IMPRESS (**I**ntroduction to the **M**edical **P**rofession: a **R**otation to **E**mpower **S**tudent**s**) program at Tulane Medical Center	Lead: Dr. Jacqueline Turner Timeframe: starting in Summer 2023	Resources: TMC OR, robot simulator, SIM Center time, staff time Partners: TMC, TU School of Medicine, SIMCENTER

Priority 4: Education and Health Literacy

The CHNA illustrates that low health literacy is a key factor contributing to poor health outcomes in the GNO-NS community. Low levels of educational attainment and poor quality of primary and secondary schools are seen as contributing factors to low health literacy in the community. In most parishes, except St. Tammany, Orleans, and Jefferson, higher educational attainments lag behind state averages. Participants have noted the impacts of this on health literacy in the community.

Priority 4: Health Literacy

Goal(s): Support and implement initiatives to promote healthy behaviors, health awareness, and education
General strategy: Increased public health awareness and education to improve positive health behaviors within the population we serve.

SMART Objective (anticipated outcome)	Target Population(s)	Success Measures	Actions (can be multiple actions for one objective)	Lead & Timeframe	Resources & Partners
Increase education, health literacy, outreach opportunities and participation in regional programs	Communitywide	# of unique opportunities to education # of participants	Continue tobacco cessation and smoking prevention programs with the addition of the Louisiana MCIP Tobacco Cessation Program.	Lead: Respiratory Director Timeframe: ongoing	Resources: staff time and resources Partners: community and health organizations
			Continue with community outreach at all three THS campuses including community classes	Lead: Marketing Director Timeframe: ongoing	Resources: staff, provider time, equipment Partners: local schools, local businesses
			Continue participation with health fairs and community education on all aspects of chronic diseases (heart disease, stroke, cancer, etc.)	Lead: Marketing Director Timeframe: ongoing	Resources: staff, provider time, equipment Partners: local schools and community/healthcare partners
Continue to provide patients financial assistance information and links to further follow-up information	Communitywide	# of unique opportunities # of participants	Provide financial assistance and insurance coverage at all hospitals	Lead: Registration Director Timeframe: ongoing	Resources: staff time Partners: TBD
Continue to offer outreach education on life skills	Communitywide	# of unique opportunities # of participants	Continue to offer monthly education opportunities (i.e., car seat safety check, “birth and beyond”, breastfeeding basics, “safe and sound”, “what to expect for dads”, etc)	Lead: Marketing Director Timeframe: ongoing	Resources: staff time Partners: TBD

Health Needs Not Selected for Prioritization

While all health needs identified in the CHNA process are of concern and importance, THS commits to focusing on key issues where they can be most impactful. To maximize resources available for the priority health needs listed above, the THS leadership determined that the following issues would not be explicitly prioritized and addressed in this CHIP:

- Crime and Violence
- Environmental Factors
- Infrastructure (transportation, housing)
- Poverty and income inequality

All the health needs identified in the CHNA process are interconnected and impact one another as they drive health outcomes. Thus, progress on the priority health needs should positively impact the health needs not selected for prioritization. Furthermore, there are community organizations and leaders working to address these health needs. The CHNA-CHIP process creates an opportunity for additional partnerships between hospital facilities and community organizations to improve all aspects of community health.

Next steps

Improving the health of communities is a long-term, continuous process that occurs in a constantly changing environment and requires ongoing partnership and trust building. Rather than remain a static document, the CHIP workplans should evolve as hospital facilities work with community, and those changes should be tracked and evaluated. THS will monitor progress and revise the CHIP workplans as needed over the next three years. Progress will be reported in the next CHNA. For additional information on Tulane Health System's CHIP, please contact Sarah Balyeat, Director of Marketing and Public Relations, at Sarah.Balyeat@hcahealthcare.com.