2023-2025 Community Health Implementation Plan

West Calcasieu Cameron Hospital (WCCH)

Adopted by hospital facility: June 2023

CHIP Overview

The 2023-2025 Community Health Implementation Plan (CHIP) for West Calcasieu Cameron Hospital (WCCH) is a companion piece to the WCCH's 2023 Community Health Needs Assessment (CHNA). The CHNA identified significant health needs in Calcasieu and Cameron Parishes by synthesizing data and soliciting input from people who represent the broad interests of the community. This CHIP builds upon the CHNA findings by detailing how WCCH intends to leverage resources and relationships with partner organizations to address the priority health needs identified in the CHNA over the next three years.

WCCH prioritized and developed implementation strategies for the following three health needs:

Access to Care

Concerns about access to care were evident among CHNA participants. The main barriers to care that arose include insurance issues, lack of providers, and lack of local services (especially for those in rural areas, the aging population, and those without reliable transportation).

Mental & Behavioral Health

All CHNA participants expressed mental and behavioral health as the most important health concern. The percentage of adults reporting frequent mental health distress in the Community increased by over 50% since the previous CHNA representing data from 2016. Teens also experienced higher rates of depression and other mental distress during this time. The rates of drug overdose deaths have also increased, notably with the rise of Fentanyl.

Chronic Disease Prevention & Management

Chronic diseases continue to be a significant health concern in the community. Although the percentage of people with access to exercise opportunities is higher in Calcasieu and Cameron Parishes compared to Louisiana, the percentage who are physically inactive is also higher. According to participants, many resources are available to help increase physical activity and improve diet, but they are not used as they should be.

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. To maximize the resources and strengths of WCCH, some significant needs will not be explicitly included in the CHIP. Tobacco & vaping cessation and lack of transportation were community health concerns not prioritized. Still, WCCH will continue to view these concerns as significant and support ongoing efforts in these areas.

Priority 1: Access to Care

Goal(s): Improve access to care for ALL patients in WCCH Service District

General strategy: Promote and utilize coordinated care measures and programs to ensure health equity

SMART Objectives *(anticipated outcome)*	Target Population(s)	Success Measures	Actions	Lead & Timeframe	Resources & Partners
Increase the # of non-emergent services for the underinsured and uninsured adult population through the Community Health Center of WCCH	18 +	Clinic patient metrics	Utilize CHC to offer primary care, general surgery, wound care and gynecological services	**Lead:** Tressie Brunson **Timeframe:** Year 1 - 3	**Resources:** Staff time, operational costs, clinic space **Partners:** Primary Care Providers
	Childbearing-age patient population	Metrics provided by OPH	Collaborate with OPH to offer community clinic services: RH (Reproductive Health), WIC (Women, Infants, Children), & Immunization programs within the CHC	**Lead:** Tressie Brunson **Timeframe:** Year 1 - 3	**Resources:** Clinic space **Partners:** Office of Public Health (OPH)
Focus on health equity initiatives to reduce health disparities within the community	All patient populations	Document # of health disparities identified Document # of health disparities process improvements completed	Develop a health equity task force in Q3 2023 to stratify data through disaggregation to identify and address health disparities. Implement new screening processes to identify social determinants of health during year 2.	**Lead:** Matthew Welsh/Leadership **Timeframe:** Year 1 - 3	**Resources:** Staff time, reporting mechanisms **Partners:** Vizient Southern States, Clinic partners
Improve digital healthcare infrastructure	N/A	Patient satisfaction scores	Audit current digital healthcare infrastructure Explore at least three (3) options to improve digital healthcare infrastructure	**Lead:** Mike Klenke **Timeframe:** Year 2 - 3	**Resources:** Staff time, implementation and equipment costs, maintenance costs **Partners:** IT Vendors/Partners
Host community health fairs in rural areas of our service district	Residents of selected rural areas *(i.e., Starks/Cameron Parish, etc.)*	# of participants for each	Partner with local officials in rural areas of our service district to execute two (2) community health fairs per year.	**Lead:** Matthew Welsh **Timeframe:** Year 1 - 3	**Resources:** Staff time, health fair materials and supplies, marketing resources **Partners:** Local community officials, Imperial Calcasieu Human Services District (IMCAL), OPH, Community Partnerships, Local health coalitions

Priority 2: Mental/Behavioral Health & Substance Abuse

Goal(s): Increase access to mental/behavioral health and substance use resources and services to members of our community

General strategy: Expand the reach of mental health and substance use prevention programs and resources

SMART Objectives *(anticipated outcome)*	Target Population(s)	Success Measures	Actions	Lead & Timeframe	Resources & Partners
Improve access to mental health resources for patients in the WCCH Service District	Adolescent/Teen populations	# of outreach programming/education events	Address the increase in mental distress among the high school population (particularly teen girls)	**Lead:** Shawna Carlson **Timeframe:** Year 2 - 3	**Resources:** Staff time, training **Partners:** IMCAL, OPH, Calcasieu & Cameron Parish School Boards
	16+	# of patients utilizing IMCAL Service	Partner with IMCAL - Sulphur to facilitate mental health referrals	**Lead:** Tressie Brunson **Timeframe:** Year 2 - 3	**Resources:** Staff time, referral mechanisms **Partners:** IMCAL, Psych Providers
	Adults	# of patients utilizing telehealth or in-person psych services	Provide mental health care services (e.g., psychotherapy or counseling) via telephone, videoconference or in-person	**Lead:** Tressie Brunson **Timeframe:** Year 2 -3	**Resources:** Staff time, contract fees **Partners:** Psych provider(s)
Expand substance abuse services and resources	Substance-abuse patient population	Document the # of patients served	Provide substance abuse navigators to assist patients that present with overdose or substance abuse dependency in the ER.	**Lead:** Kenny Adamson/Brenna Davis **Timeframe:** Year 1 - 3	**Resources:** Staff time, contract fees, inventory management **Partners:** IMCAL, Bridge Network
	Substance-abuse patient population	# of Narcan prescriptions administered	Medication-assisted treatment (MAT) for opioid dependence through ER and outpatient clinics	**Lead:** Kenny Adamson/Glyn Foreman **Timeframe:** Year 1 - 3	**Resources:** Staff time, contract fees, drug costs **Partners:** IMCAL, Bridge Network

Priority 3: **Chronic Disease Prevention & Management (Healthy Living)**

Goal(s): Address factors and barriers that contribute to chronic conditions and inhibit healthy lifestyles in WCCH Service District

General strategy: Promote and educate the community about the importance of chronic disease management and prevention through physical activity and healthy lifestyle choices.

SMART Objectives ***(anticipated outcome)***	**Target Population(s)**	**Success Measures**	**Actions**	**Lead & Timeframe**	**Resources & Partners**
Increase programming that addresses Chronic Disease Prevention + Awareness	Patients with chronic diseases/General public	# of screenings	Communicate and promote the importance of annual wellness exams and screenings (mammograms, lung and colon screenings)	**Lead:** Matthew Welsh **Timeframe:** Year 1 - 3	**Resources:** Staff time, operational and marketing costs **Partners:** Community businesses, Sulphur Surgical Center, Clinic partners Dynamic Dimensions, OPH, Food banks, Community Partnerships, Local healthcare coalitions, Faith-based partners/organizations
		# of individuals that receive financial assistance # of participants at the annual Ethel Precht Breast Cancer Walk	Continue the Ethel Precht Breast Cancer Program of WCCH to provide financial assistance to breast cancer patients in Calcasieu & Cameron parishes.		
Implement Healthy Lifestyle programming and resources for community and area businesses	General public	Number of individuals who participate in various programs	Promote educational and community outreach programming available to the community	**Lead:** Vanessa Hardy/Suzy Trahan **Timeframe:** Year 1 - 3	**Resources:** Staff time, marketing & communication resources, supplies & materials **Partners:** Nutrition Services, Dynamic Dimensions, Speakers Bureau, Marketing, Business Relations, Food banks, OPH
Focus on Cardiovascular disease and at-risk congestive heart failure (CHF) patients	CHF/At-risk CHF patient population	# of patients that participate	Implement a CHF clinic for at-risk CV patients	**Lead:** Tressie Brunson/Cathy Patton **Timeframe:** Year 2 or 3	**Resources:** Staff time, operational costs, implementation and maintenance costs **Partners:** Cardiologists, Hospital Medicine providers
Continue Chronic Care Management Program at Community Clinic to manage Medicaid/Medicare population	Medicaid/Medicare patient populations	MCIP and Medicare ACO (Aledade) measures	Use of evidence-based medicine with proven treatments and techniques	**Lead:** Tressie Brunson/Thea Tran **Timeframe:** Year 2 or 3	**Resources:** Staff time **Partners:** Aledade, Louisiana Quality Network (LQN)

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. WCCH 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 WCCH's CHNA or CHIP, please contact Matthew Welsh, Chief Marketing + Community Impact Officer, at mwelsh@wcch.com.