SLIDELL MEMORIAL HOSPITAL

COMMUNITY HEALTH NEEDS ASSESSMENT

Prepared by:
Tripp Umbach

September 2013

Introduction

Slidell Memorial Hospital (SMH) is a 191-bed acute care community hospital located in the heart of Slidell, LA. In response to its community commitment, SMH contracted with Tripp Umbach to facilitate a comprehensive Community Health Needs Assessment (CHNA). The community health needs assessment was completed in September 2013. SMH collaborated with outside organizations in the Greater New Orleans region during the community health needs assessment process. The following is a list of organizations that participated in the community health needs assessment process by providing valuable input:

- President/North Shore Rotary Club
- Executive Director/St. Tammany Economic Development Foundation
- Executive Director/North Shore Healthcare Alliance
- Vice President/American Heart Association
- Development Administrator of Public Health/St. Tammany Parish Government[1]
- President/East St. Tammany Chamber
- Councilwomen and Mayor/City of Slidell
- Operations Manager/Acadian Ambulance
- Board Member/Ochsner North Shore

This project represents an important initiative to identify and explore the ever changing healthcare landscape. Also, this report fulfills the requirements of a new federal statute established within the Patient Protection and Affordable Care Act (PPACA) requiring that nonprofit hospitals conduct CHNA's every three years. The CHNA process undertaken by SMH, with project management and consultation by Tripp Umbach, included extensive input from persons who represent the broad interests of the communities served by the hospital facility, including those with special knowledge of public health issues. Tripp Umbach worked closely with senior leadership from the hospital to accomplish the assessment.

[1] John Tobin, CRC -- Previous: STP Government, St Tammany Parish Government, Premiere Rehab Hospital – Education: Louisiana State University Health Sciences Center.

Community Definition

While community can be defined in many ways, for the purposes of the CHNA, Tripp Umbach and SMH hospital leadership, have chosen to define the SMH community as six zip code areas in Pearl River County, MS and St. Tammany Parish, LA that hold a large majority (80%) of the inpatient discharges. (See Figure 1 & Table 1)

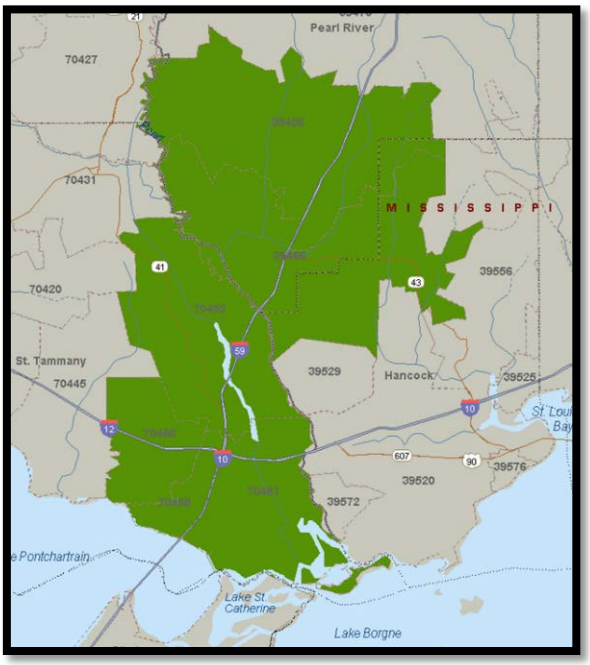
SMH Community Zip Codes

Table 1

County/Parish	Zip Code
Pearl River County	39426
Pearl River County	39466
St. Tammany Parish	70452
St. Tammany Parish	70458
St. Tammany Parish	70460
St. Tammany Parish	70461

SMH's Community Map

Figure 1



Consultant Qualifications

SMH contracted with Tripp Umbach, a private healthcare consulting firm headquartered in Pittsburgh, Pennsylvania to complete the community health needs assessment. Tripp Umbach is a recognized national leader in completing community health needs assessments, having conducted more than 200 community health needs assessments over the past 21 years. Today more than one in five Americans lives in a community where Tripp Umbach has completed a community health assessment.

Paul Umbach, founder and president of Tripp Umbach, is among the most experienced community health planners in the United States, having directed projects in every state and internationally. Tripp Umbach has written two national guide books[1] on the topic of community health and has presented at more than 50 state and national community health conferences.

[1] A Guide for Assessing and Improving Health Status Apple Book: http://www.haponline.org/downloads/HAP_A_Guide_for_Assessing_and_Improving_Health_Status_Apple_Book_1993.pdf AND

A Guide for Implementing Community Health Improvement Programs: http://www.haponline.org/downloads/HAP_A_Guide_for_Implementing_Community_Health_Improvement_Programs_Apple_2_Book_1997.pdf

Project Mission and Objectives

The mission of the SMH CHNA is to understand and plan for the current and future health needs of residents in its community. The goal of the process is to identify the health needs of the communities served by SMH, while developing a deeper understanding of community needs and identifying community health priorities. Important to the success of the community needs assessment process is meaningful engagement and input from a broad cross-section of community-based organizations, who were partners in the community health needs assessment.

The objective of this assessment is to analyze traditional health-related indicators as well as social, demographic, economic, and environmental factors. Although the consulting team brings experience from similar communities, it is clearly understood that each community is unique. The overall objective of the CHNA is summarized by the following areas:

- Obtaining information on population health status as well as socio-economic and environmental factors,
- Assuring that community members, including underrepresented residents, were included in the needs assessment process,
- Identifying key community health needs within the hospital's community along with an inventory of available resources within the community that may provide programs and services to meet such needs, and
- Developing a CHNA document as required by the Patient Protection and Affordable Care Act (PPACA).

Methodology

Tripp Umbach facilitated and managed a comprehensive regional community health needs assessment on behalf of SMH — resulting in the identification of top community health needs. The assessment process included input from persons who represent the broad interests of the communities served by the hospital facilities, including those with special knowledge and expertise of public health issues and the underserved community[2].

Key data sources in the regional community health needs assessment included:

- **Community Health Assessment Planning:** A series of conference calls were facilitated by the consultants and the project team consisting of leadership from SMH.

- **Secondary Data:** The health of a community is largely related to the characteristics of its residents. An individual's age, race, gender, education and ethnicity often directly or indirectly impact health status and access to care. Tripp Umbach completed comprehensive analysis of health status and socio-economic environmental factors related to the health of residents of the defined project area from existing data sources such as state and county public health agencies, the Centers for Disease Control and Prevention, and other additional data sources. Data included in the secondary data analysis was collected and analyzed between April 2012 and August 2013. (Data profile available upon request)

- **Interviews with Key Community Stakeholders:** Tripp Umbach worked closely with hospital leadership to identify leaders from organizations that have special knowledge and or expertise in public health. Such persons were interviewed as part of the needs assessment planning process. A series of approximately 11 interviews were completed with key stakeholders in the Greater New Orleans metropolitan area between July and August 2012. (Key community stakeholder summary available upon request)

[2] In 2012, SMH joined with eleven members of the Metropolitan Hospital Council of New Orleans (MHCNO), a non-profit, regional membership and service organization representing hospitals and healthcare organizations in the Greater New Orleans Metropolitan Area to initiate the process of conducting a comprehensive regional Community Health Needs Assessment (CHNA). The collaborative study laid the foundation for individual hospital CHNA's (Individual-level CHNA reports required by the IRS), such as SMH's CHNA. Specifically, the collaborative effort played an important role with obtaining input through conducting over 100 key stakeholder calls in the Greater New Orleans region and facilitating 14 focus groups with over 200 residents.

- **Focus Groups with Community Residents:** Tripp Umbach worked closely with the CHNA oversight committee to assure that community members, including under-represented residents, were included in the needs assessment planning process via two focus groups conducted by Tripp Umbach in the Greater New Orleans community in October 2012. Focus group audiences were defined by the CHNA oversight committee utilizing secondary data to identify health needs and deficits in target populations. The focus group audience included: (Focus group summary available upon request)
    - Staff and Community Member Population
        - Conducted at the Slidell Founders Building in Slidell, LA

- **Identification of top regional community health needs:** Top community health needs were identified by analyzing secondary data, key stakeholder interviews and focus group input. The analysis process identified the health needs revealed in each data source. Tripp Umbach followed a process where the top needs identified in the assessment were supported by secondary data, where available and strong consensus provided by key community stakeholders and focus groups.

- **Inventory of Community Resources:** Tripp Umbach completed an inventory of community resources available in the service area using resources identified by the hospital facilities, internet research and resource databases. Using the zip codes which define the SMH community (refer to Table 1 presented on page 2) more than 28 community resources were identified with the capacity to meet the community health needs identified in the SMH CHNA. (External Inventory available upon request)

- **Final Regional Community Health Needs Assessment Report:** A final report was developed that summarizes key findings from the assessment process and an identification of top health needs as required by the IRS.

Key Terms:

- **Demographic Snapshots:** A snapshot of the SMH community definition compared to parishes and state benchmarks.

- **Community Need Index Analysis (CNI):** Because the CNI considers multiple factors that are known to limit health care access, the tool provides an accurate and useful assessment method at identifying and addressing the disproportionate unmet health-related needs of neighborhoods (zip code level). The five prominent socio-

economic barriers to community health quantified in CNI include: Income, Insurance, Education, Culture/Language and Housing. CNI quantifies the five socio-economic barriers to community health utilizing a 5 point index scale where a score of 5 indicates the greatest need and 1, the lowest need.

- **County Health Rankings:** Each parish receives a summary rank for 37 various health measures associated with health outcomes, health factors, health behaviors, clinical care, social and economic factors, and the physical environment.

- **The Prevention Quality Indicators index (PQI)** was developed by the Agency for Healthcare Research and Quality (AHRQ). The AHRQ model was applied to quantify the PQI within the SMH region and Louisiana. The PQI index identifies potentially avoidable hospitalizations for the benefit of targeting priorities and overall community health. The quality indicator rates are derived from inpatient discharges by zip code using ICD9 diagnosis and procedure codes. There are 14 quality indicators. Lower index scores represent fewer admissions for each of the PQIs.

Key Community Health Needs

Tripp Umbach's independent review of existing data and in-depth interviews with stakeholders representing a cross-section of agencies and focus group input resulted in the identification of three key health needs in the SMH service area that are supported by secondary and/or primary data. The stakeholder and focus group process gathers valuable qualitative and anecdotal data regarding the broad health interests of the communities served by the medical facilities within the service area of SMH. Key stakeholder and focus group input is subject to the limitations of the identified target populations (i.e., vocabulary, perspective, knowledge, etc.) and therefore is not factual and inherently subjective in nature. Key stakeholder and focus group participants were asked to identify and discuss what they perceived to be the top health issues and/or concerns in their communities. What follows is a collective summary of the substantial issues and concerns that were discussed by key stakeholder and focus group audiences and where relevant, supported by secondary data.

Needs identified include (not listed in any specific order):

1) Access to healthcare and medical services (i.e., primary, specialty, preventive, and mental)
2) Access to community/support services to sustain a healthy environment
3) Promotion of healthy lifestyles and behaviors (specific focus on chronic and infectious disease)

Tripp Umbach used CNI scores, the PQI index and County Health Rankings to identify barriers and potentially avoidable hospitalizations as part of the CHNA. These areas present the highest community health risk as they have the greatest barriers to health care and generally have the poorest health among the region. Also, for instance, factors such as educational attainment are a very important measure in community health analysis as it is related to many other health determinants; occupation, income, access to healthcare, access to healthy food and recreational options, and ability to make healthy decisions.

Below, please find a general outlook of the SMH service area (e.g., as defined for the purposes of this CHNA report) based on secondary data analysis conducted during the CHNA process that includes, data on age, race, income, and educational attainments rates.

- ❑ The Slidell Memorial service area shows a projected population increase at a rate of 3.6% by 2017 (i.e., more than 5,000 more residents in five years).
    - ❑ Of the counties/parishes of interest, St. Tammany Parish projects the largest population rise in the next five years at a rate of 5.5% and more than 13,000 residents.

- The Slidell Memorial service area shows a relatively even distribution of ages from 0 to 65+ as compared with Louisiana and Mississippi.
    - 20.8% of the residents in the Slidell Memorial service area are aged 0-14 (approx. 30,174 youth).
    - 12.7% of the residents in the Slidell Memorial service area are aged 65 and older (approx. 18,424 older residents).
    - Louisiana and Mississippi show high rates of residents aged 34 and younger as compared with the parishes in the study area.

- The Slidell Memorial service area, along with all of the counties and parishes in the study area report a majority of the population as White, Non-Hispanic.
    - This finding differs from that of the State of Louisiana and the State of Mississippi that show only a slightly higher rate of White, Non-Hispanic residents over other racial categories.

- 14.6% of residents (approx. 21,180 residents) in the Slidell Memorial service area do not have a high school diploma. While this rate is lower than the rate seen across Louisiana or Mississippi, it is approximately one in every seven residents without a high school diploma.

- The Slidell Memorial service area shows an average annual household income level at $61,887; higher than Louisiana at $55,855 and Mississippi at $49,476.
    - However, 14.7% of households of the Slidell Memorial service area report earning less than $15,000 per year. This rate is lower than is seen for Louisiana (19.1%) or Mississippi (21.2%).

A summary of the top needs in the SMH CHNA follows:

1. **ACCESS TO HEALTHCARE AND MEDICAL SERVICES (I.E., PRIMARY, SPECIALITY, PREVENTIVE, AND MENTAL)**

   Underlying factors: The need for access to affordable healthcare services, including mental health and health prevention services was identified by primary input from community stakeholders and focus group participants and supported by secondary data. The lack of receiving adequate levels of healthcare, which can be for various reasons, including a lack of health insurance due to affordability and navigation issues, cultural barriers and/or provider shortages, can lead to resident's lack of preventive care and eventually can lead to the need for expensive, advanced stage medical services.

- ✓ **Areas of specific focus** identified in the needs assessment include:
  - *Access to care: including primary and preventive*
  - *Health insurance coverage*
  - *Physician shortage*
  - *Access to mental health services*

Below, please find the following data specific to the SMH region, including zip code/parish breakouts related to the identified need: 1) Access to healthcare and medical services (i.e., primary, specialty, preventive, and mental).

To determine the severity of barriers to healthcare access in a given community, the CNI gathers data about the community's socio-economy. It is important to note that the CNI scale range is from 1.0 (best) to 5.0 (worst) and the range of CNI scores for the Slidell Memorial service area is from 2.4 to 4.2 (i.e., middle of the scale range, 1.0-5.0). The Slidell Memorial service area has a weighted average CNI score of 3.2 indicating slightly more than the average number of barriers to healthcare access for the service area.

- ❑ The zip code areas in the Slidell Memorial service area fall into the moderate number of barriers to healthcare access with the range of 4.2 to 2.4. Specifically:
  - o Zip code areas 39466 in Picayune, Pearl River County, MS reports the highest CNI score across the Slidell Memorial service area as well as a handful of the highest CNI measures; 26.1% of children living in poverty, 8.6% unemployment, 17.5% uninsured, and 26.5% residents renting their home.
    - ▪ Pearl River (70452) shows the highest rate of elderly residents living in poverty (26.5%). Additionally, Pearl River County, MS shows the highest rate of older individuals (e.g., 15.8% aged 65+); however St. Tammany shows the highest number of older residents due to a larger total population.
    - ▪ More than one quarter (25.4%) of the population of Pearl River (70452) does not have a high school diploma. Additionally, Pearl River County, MS shows the lowest rate of residents with a Bachelor's Degree or higher (14.5%) and the highest rate of residents with less than a high school diploma (18.7%).
    - ▪ Pearl River County displays the lowest average annual household income compared with the other counties/ parishes of interest at $48,605.

        - Pearl River County shows the highest rate of households earning below $15,000 per year (19.3%); however this rate is still lower than is seen across the state of Mississippi (21.2%).
    - Nearly two out of every three (64.9%) single mothers is living in poverty with their child in Carriere (39426).
    - However, zip code area 70461 in Slidell, LA shows the lowest CNI score for the Slidell Memorial service area (i.e., fewest barriers to healthcare access) at 2.4.

Specific health-related PQI data:

- The Slidell Memorial service area shows only two of the 14 PQI measures higher than is seen for the state; indicating conditions in which the zip code areas in the Slidell Memorial service area report more preventable hospitalizations than the state. These include: Chronic Obstructive Pulmonary Disease and Perforated Appendix.

- Specifically:
    - St. Tammany Parish shows the highest rates of preventable hospitalizations as compared with the other parishes in the study area, the states and the Slidell Memorial service area for:
        - Chronic Obstructive Pulmonary Disease (COPD)
        - Perforated Appendix
        - Bacterial Pneumonia
        - Urinary tract Infections

    - We see that COPD and Perforated Appendix for St. Tammany Parish aligns with the fact that the Slidell Memorial service area shows higher PQI rates for these measures than is seen for Louisiana.

- On the other hand, the Slidell Memorial service area shows 12 of the 14 PQI measures in which the hospital service area reports lower rates of preventable hospitalizations than the state.

Specific data breakouts for the study area's County Health Rankings follows:

Louisiana has 64 parishes. Therefore, a rank of 1 is considered to be the healthiest parish in the state and a rank of 64 is considered to be the unhealthiest parish in the state. The median rank for Louisiana is 32.

Mississippi has 81 counties. Therefore, a rank of 1 is considered to be the healthiest county in the state and a rank of 81 is considered to be the unhealthiest county in the state. The median rank is 40.5.

- Specifically:
    - St. Tammany Parish may be considered the healthiest parish with the most rankings in the top 10 healthiest for the state (16 of the 21 measures).
    - Pearl River County, MS: Ranks in the top 10 healthiest counties across the state for 3 of the 21 measures: Diet and Exercise, Environmental Quality, and Physical Environment.
        - Ranks in the **top 10 unhealthiest** counties across the state for 1 of the 21 measures: Tobacco Use.
        - Pearl River County shows a ranking above the median for Morbidity, Clinical Care, and Access to Care, Quality of Care, Health Behaviors, Alcohol Use, and Education.

Specific data breakouts from the CDC Health Trends follow:

- In 2009, St. Tammany showed 8.9% of the population with Diabetes.
- From 2004-2009, St. Tammany showed a slight increase in Obesity rates: 2004 (22.3%), 2005 (23.6%), 2006 (25.7%), 2007 (25.7%), 2008 (26.8%), and 2009 (27.2%).

2006 LA Health and Population Survey

- Survey results showed the most common place that residents go for healthcare is their doctor's office or HMO.
    - After the 2005 hurricanes, rates of residents going to their doctor declined across many of the parishes and rates of residents reporting that they go nowhere for healthcare increased for many of the parishes after the hurricanes.
- All of the parishes in the study area report at least 20% of their population aged 16 and older having been diagnosed with high blood pressure.
- Survey results showed, 18-44 year olds living in poverty in St. Tammany was at a rate of 33.1%.
- Survey results showed, 13.7% of resident in St. Tammany were uninsured.

The Louisiana Kids Count study for 2011-2012 was conducted by the Agenda for Children and contains data pertaining to childcare assistance, poverty levels, education, testing scores, and birth/neonatal matters. Specific data follows:

- St. Tammany Parish reports the highest rate of students deemed as gifted or talented (8.7%); higher than the state rate (3.7%).

Every state is parceled into regions defined by Substance Abuse and Mental Health Services (SAMHSA). The regions are defined in the 'Sub-state Estimates from the 2002-2004 National Surveys on Drug Use and Health'. (i.e., Regions 2 and 9: Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, **St. Tammany**, Tangipahoa, Washington, West Baton Rouge, West Feliciana)

- Regions 2 and 9 reported the highest rate of binge drinking for the study area (i.e., 25.73% in the past month).

- Residents of Regions 2 and 9 reported the highest rate of needing but not receiving treatment for alcohol use (i.e., 8.6% of the pop reported this).

Community stakeholders specifically mentioned the following regarding perceived problems and/or barriers for residents in the service area:

Access to Care: including primary, specialty, and preventive

- Overall, stakeholders were under the impression there is a lack of access to primary care services. Stakeholders felt a need for affordable clinics in neighborhoods throughout communities exist. Stakeholders believed clinics will help make healthcare more accessible and affordable to all. Stakeholders expressed clinics will provide more facilities for people to go without wait times. Stakeholders also believed due to the changing face of clients (i.e., those once considered middle class are now lower class), more options need to be available to this translation population.

Health Insurance Coverage

- Stakeholders believed some residents are financially challenged. Stakeholders believed those residents that are just above the poverty line can't afford healthcare and/or insurance and hope proposed governmental initiatives will help to serve this group.

Physician Shortage

- Stakeholders perceived a shortage of certified nursing assistants and physicians. Specifically, stakeholders believed there is a need for more mental health specialist, including neurosurgeons (stakeholders mentioned neurosurgery covers an entire array of mental health needs, specifically psychiatry). Stakeholders stated residents with mental health related needs can't afford to find a physician, nor do they have the appropriate resources to help them navigate the system. One stakeholder stated there are only six or seven psychiatrists in parish of 240,000 residents.

- Stakeholders believed since Katrina, many hospitals are gone, and are in the process of either rebuilding or aren't coming back. Ultimately stakeholders believed this leads to a lack of healthcare providers.

Access to Mental Health Services

- Stakeholders believed mental health has recently moved to the forefront as an important issue. Stakeholders perceived mental health is a tremendous issue and the region has a shortage of mental health doctors and support staff. Additionally, stakeholders felt there is a dire need for mental health facilities because the ER's are overloaded. Some stakeholders felt mental health is sometimes coupled with addictive disorders.

- Specifically, one stakeholder stated there have been some programs implemented to address suicide prevention, as there is a very high rate of suicide throughout the community, but this is only counseling available through a private circuit (e.g., stakeholder stated: 543 suicide attempts; 36 killed themselves; and at least once a day they are receiving a call through the private circuit).

- **Stakeholders identified the target populations** they felt had the greatest risk of having increased health needs. Stakeholders identified (in order of most mentioned) residents that are: all sectors have health needs and that health needs cross all boundaries. Specific populations mentioned by stakeholders include the lower and middle income, uninsured, children, adult males, elderly, and those in the age range of 38-56 years old.

Focus group participants specifically mentioned the following regarding perceived problems and/or barriers for residents in the service area:

Access to Care: including primary, specialty, and preventive

- Overall, focus group participants perceived access issues to healthcare services (i.e. hospitals, private practitioners, specialists, mental health etc.) in their communities to be limited in the areas of affordability, and insurance coverage. Specifically, participants believed the cost of medication is very expensive and some residents are unable to afford the medicine necessary to care for them, which they stated can lead to more intense health-related issues.

Health Insurance Coverage

- Participants believed healthcare can be unaffordable for some residents due to Medicaid/Medicare not being comprehensive enough and the perceived high-cost of under/uninsured medical care. Additionally, participants perceived residents are frustrated because some healthcare providers are not accepting Medicare/Medicaid, which is inhibiting these residents to receive necessary care.

Physician/Provider Shortage

- Participants perceived the community is having trouble recruiting necessary medical staff. Participants shared they believe physicians are leaving the community, which is causing a lack of physicians and specialist throughout the region.

2. ACCESS TO COMMUNITY/SUPPORT SERVICES TO SUSTAIN A HEALTHY ENVIRONMENT

Underlying factors: Underlying factors identified by primary input from key stakeholders and focus group participants: Need for access to community/support services. There is a need for programs and services to support healthy lifestyles. While community services supporting residents are available, stakeholders and focus group participants indicated there may be a gap between the availability of services and access to these services due to various factors, including lack of public transportation, financial barriers, lack of adequate dissemination of information, etc. Specifically, they perceived these services to be limited in the areas of transportation, technology, walkable areas, educational opportunities, safety, employment opportunities, and collaboration. The number of community services can be further ascertained through existing directories and the development of a provider

inventory, while access to these services by community members is not always quantified by secondary data.

Areas of specific focus identified in the needs assessment include:

- *Community Support Infrastructure*
  - *Access to Public Transportation*
  - *Safety*

Below, please find the following data specific to the SMH region, including zip code/parish breakouts related to the identified need, 2) Access to community/support services to sustain a healthy environment:

- ❑ The Slidell Memorial service area shows a projected population increase at a rate of 3.6% by 2017 (i.e., more than 5,000 more residents in five years). Of the counties/parishes of interest, St. Tammany Parish projects the largest population rise in the next five years at a rate of 5.5% and more than 13,000 residents. An increase in population can create a higher demand on community services.

- ❑ 20.8% of the residents in the Slidell Memorial service area are aged 0-14 (approx. 30,174 youth) and 12.7% of the residents in the Slidell Memorial service area are aged 65 and older (approx. 18,424 older residents).

- ❑ More than one quarter (25.4%) of the population of Pearl River (70452) does not have a high school diploma. Additionally, Pearl River County, MS shows the lowest rate of residents with a Bachelor's Degree or higher (14.5%) and the highest rate of residents with less than a high school diploma (18.7%).

To determine the severity of barriers to healthcare access in a given community, the CNI gathers data about the community's socio-economy. It is important to note that the CNI scale range is from 1.0 (best) to 5.0 (worst).

- ❑ Zip code areas 39466 in Picayune, Pearl River County, MS reports the highest CNI score across the Slidell Memorial service area as well as a handful of the highest CNI measures; 26.1% of children living in poverty, 8.6% unemployment, 17.5% uninsured, and 26.5% residents renting their home.

- ❑ Nearly two out of every three (64.9%) single mothers is living in poverty with their child in Carriere (39426).

Community stakeholders specifically mentioned the following regarding perceived problems and/or barriers for residents in the service area:

Community Support Infrastructure

- Stakeholders believed there is a need to educate the voting public about services that are available and make sure that they are utilizing them so that these programs remain viable.

Access to Public Transportation

- Stakeholders perceived there are limited public transportation options offered throughout the region. Specifically, some stakeholders felt transportation is a huge problem for the elderly population because some can't drive and the services that are available to this population are limited and unreliable. Stakeholders did mention they believed this is trying to be addressed at the parish level.

Safety

- Stakeholders perceived the lack of mental health facilities is affecting crime rates and the safety of the community. Some stakeholders believed violence, drugs and mental health all go hand and hand, when issues aren't properly being addressed due to lack of resources.

- Stakeholders also felt there is a need for more safe parks and playgrounds (i.e., crime-free areas and safe equipment).

Focus group participants specifically mentioned the following regarding perceived problems and/or barriers for residents in the service area:

Community Support Infrastructure

- While participants acknowledged there are service coordinators in their communities; participants did perceive a lack of available community programs. Additionally, participants perceived some residents are unaware of regional resources that do exist. Participants felt chamber websites throughout the region should be continuously updated to provide a list of available resources/programs within the region. Participants believed continuous

updating of the most available and current regional resources/programs can help improve awareness.

- Participants perceived a lack of visible collaboration in their communities. Participants believed that some residents that require assistance do not always receive help or compassion from the community, as they believed some residents do not embrace different cultures. Participants also perceived a lack of philanthropy and public services throughout the community. Participants believed hospitals could collaborate with regional radio stations to gain sponsored air time to share the same information. Lastly, participants felt hospitals could coordinate and collaborate with regional churches to increase awareness amongst residents.

- Participants believed there is a lack of jobs throughout the region, which they perceived brings a lack of hope to the residents. Participants shared some residents are commuting over 100 miles a day to available jobs outside the region. Participants perceived the jobs that are available within the region are low paying and hospital budgets and positions are being cut. Additionally, participants perceived there is a lack of trade schools in the region available for residents to continue their education and gain a skill. Participants shared the one trade school that existed was destroyed by Hurricane Katrina and was never reopened. Participants added they believed there are very minimal job training opportunities in the region.

Access to Public Transportation

- Participants perceived a lack of transportation, specifically for handicap and/or disabled residents in their communities. Participants added there are limited public transit routes/times. Participants also felt some areas throughout the community aren't pedestrian friendly, specifically; there is a lack of sidewalks, which makes it unsafe for residents to walk.

Safety

- Participants perceived crime and violence to be a huge concern within some communities, where an unstable environment with substance abuse exists. Specifically, participants perceived artificial marijuana is being abused by some

residents throughout the region, which can create the brain to melt down and cause violent reactions.

3. **PROMOTION OF HEALTHY LIFESTYLES AND BEHAVIORS (SPECIFIC FOCUS ON CHRONIC AND INFECTIOUS DISEASE)**

Underlying factors: identified by secondary data and primary input from community stakeholders: Need for improved promotion of healthy lifestyles and behaviors (specific to chronic and infectious diseases). Stakeholders perceived the health status of many residents to be poor due to various factors such as, limited education on how to promote healthy living. Specifically, stakeholders referenced the increase of chronic diseases (i.e., Obesity, Diabetes, and High Blood Pressure, etc.). Stakeholders and focus group participants also felt there are issues regarding the increased HIV/AIDS population. Stakeholders and focus group participants focused their discussion on target populations such as the underserved/uninsured, children/youth and elderly, parents and the working poor.

Area of specific focus identified in the needs assessment includes:

- *Prevention and Health Education with a focus on Prevention of Chronic and Infectious Diseases*

Below, please find the following data specific to the SMH region, including zip code/parish breakouts related to the identified need, 3) improved promotion of healthy lifestyles and behaviors (specific to chronic and infectious diseases).

- ❑ 14.6% of residents (approx. 21,180 residents) in the Slidell Memorial service area do not have a high school degree. While this rate is lower than the rate seen across Louisiana or Mississippi, it is approximately one in every seven residents without a HS degree.

County Health Rankings data:

- ❑ Pearl River County, MS:
  - o Ranks in the top **10 unhealthiest counties** across the state for 1 of the 21 measures: Tobacco Use.

Health Survey 2006

- All of the parishes in the study area reported at least 20% of their population aged 16 and older having been diagnosed with high blood pressure.

CDC Health Trends

- In 2009, St. Tammany showed 8.9% of the population with Diabetes.

- From 2004-2009, St. Tammany showed a slight increase in Obesity rates: 2004 (22.3%), 2005 (23.6%), 2006 (25.7%), 2007 (25.7%), 2008 (26.8%), and 2009 (27.2%).

Every state is parceled into regions defined by Substance Abuse and Mental Health Services (SAMHSA). The regions are defined in the 'Sub-state Estimates from the 2002-2004 National Surveys on Drug Use and Health'. (i.e., Regions 2 and 9: Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, **St. Tammany**, Tangipahoa, Washington, West Baton Rouge, West Feliciana)

- Regions 2 and 9 reported the highest rate of binge drinking for the study area (i.e., 25.73% in the past month).

- Residents of Regions 2 and 9 reported the highest rate of needing but not receiving treatment for alcohol use (i.e., 8.6% of the pop reported this).

Community stakeholders specifically mentioned the following regarding perceived problems and/or barriers for residents in the service area:

Prevention and Health Education focused on Prevention of Chronic and Infectious Diseases

- Overall, stakeholders perceived some residents are making poor lifestyle choices (i.e., smoking, alcohol and drug abuse, lack of physical activity, poor eating habits, risky sexual behavior, etc.), which lead to obesity, diabetes, heart disease, etc. Stakeholders believed a pressing health need is controlling obesity issues and creating good nutritional habits for the younger population. Stakeholders felt by extending this education at a young age, it would instill a healthy lifestyle throughout their lives. Specifically, stakeholders mentioned 66% of the population is overweight and/or obese, heart disease is the #1 killer and stroke is the #4 killer. Stakeholders felt the main risk factor that is controllable is obesity.

However, stakeholders perceived there is a limited amount of health literacy outreach and education to residents, and the need to promote healthy nutrition and lifestyle choices is very important and needed.

Focus group participants specifically mentioned the following regarding perceived problems and/or barriers for residents in the service area:

- Overall, participants perceived a lack of awareness amongst the community of healthy living/healthy eating habits. Participants felt regional hospitals could increase educational efforts, such as healthy eating literacy materials offered to residents. Participants believed preventative educational outreach, such as health literacy is crucial to creating an overall healthy community. Participants believed increasing awareness will lead to increasing accountability.

- Specifically, participants felt obesity among children is a concern. Participants felt regional pediatricians could collaborate to identify regional system-wide programs for children/parents once they acknowledge they are overweight. Participants believed if regional pediatricians identify and promote available regional programs, specific to obesity and healthy eating options, awareness of parents and children will increase. Additionally participants felt there could be increased coordination and collaboration among hospitals and schools to create and send fliers home to families that provides an overview of available regional resources/programs offered regarding healthy eating literacy and activities.

Conclusions and Recommended Next Steps

The majority of community needs identified through the SMH community health needs assessment process are not directly related to the provision of traditional medical services provided by community hospitals. However, the top needs identified in this assessment do "translate" into a wide variety of health related issues that may ultimately require hospital services.

Common themes throughout the assessment speak to the need to increase access to affordable healthcare services, while simultaneously building a culture that supports healthy behaviors both at the individual, cultural and community levels. Larger scale issues like healthcare funding and the organization of public service agencies has been found to have a trickledown effect on neighborhoods and individuals.

For example, the range of CNI scores for the Slidell Memorial service area is from 2.4 to 4.2 (i.e., middle of the scale range, 1.0-5.0). The Slidell Memorial service area has a weighted average CNI score of 3.2 indicating slightly more than the average number of barriers to healthcare access for the service area. These areas present the highest community health risk as they have the greatest barriers to health care and generally have the poorest health among the region. Additionally, an increase in residents who are under/unemployed ultimately causes a decrease in their purchasing power. Individuals and families, including children, living in poverty is a large concern for certain areas of the region, along with a diverse population of residents for who English is a second language. Economic and cultural barriers often lead to the lack of preventive care, resulting in the need for more serious hospital services when care is ultimately provided.

Stakeholders and focus group participants believed there is a high population of those afflicted by drug and alcohol addictions and addictive disorders and there is a lack of nurturing and family/community support. Stakeholders and focus group participants believed there is an overall lack of health literacy offered throughout the communities. Furthermore, stakeholders and focus group participants mentioned they felt there is a lack of public transportation and healthy living options which can ultimately lead to inadequate diets contributing to chronic health conditions.

Needs identified include (not listed in any specific order):

1) Access to healthcare and medical services (i.e., primary, specialty, preventive, and mental)

✓ **Areas of specific focus** identified in the needs assessment include:

- *Access to Care: including primary, specialty, and preventive*
- *Health Insurance Coverage*
- *Physician Shortage*
- *Access to Mental Health Services*

2) Access to community/support services to sustain a healthy and safe environment

✓ **Areas of specific focus identified in the needs assessment include:**

- *Community Support Infrastructure*
- *Access to Public Transportation*
- *Safety*

3) Promotion of healthy lifestyles and behaviors (specific focus on chronic and infectious disease)

✓ **Areas of specific focus** identified in the needs assessment include:

- *Prevention and Health Education focused on Prevention of Chronic and Infectious Disease*

SMH, working closely with community partners, understands that the community health needs assessment document is only a first step in an ongoing process. SMH currently provides numerous services throughout the study area, but they also recognize it is vital that ongoing communication and a strategic process follow this assessment. Collaboration and partnership exists in the region and SMH understands it is important to expand existing partnerships and build additional partnerships with multiple regional organizations and the State to develop strategies to create a plan to address the top identified needs. There are consistent areas of focus in the region as it relates to improved access to healthcare, behaviors that impact health, cultural barriers and community support services. The area is faced with poverty, chronic illness, limited educational attainment in some areas, mental health issues and substance abuse. Strategic discussions among hospital leadership as well as regional leadership will need to consider the interrelationship of the chronic and infectious issues facing the area, specifically obesity and HIV/AIDS. It will be important to determine the cost effectiveness, future impact and limitations of any best practices methods. Implementation plans will have to give top priority to those strategies that will have the greatest influence in more than one need area to effectively address the needs of residents. Tripp Umbach recommends the following actions be taken by SMH, in close partnership with community organizations, over the next four to six months.

(Additional data and greater detail related to an inventory of available resources within the community that may provide programs and services to meet such needs are available upon request.)

Recommended Action Steps:

- ❑ Results are presented widely to community residents (i.e., made available via the internet through the hospital website).
- ❑ Take an inventory of available resources in the communities that are available to help address the top community health needs identified by the community health needs assessment.

- Implement a comprehensive “grass roots” engagement strategy to build upon the resources that already exist in the communities and the energy of and commitment of community leaders that have been engaged in the community health needs assessment process.
- Develop “Working Groups” to focus on specific strategies to address the identified needs in the community health needs assessment.
- Attraction of outside funding and implementation of actions to address the top health needs on a regional level.
- Work at the hospital level and with local participating organizations to translate the top identified community health issues into individual hospital and community level strategic planning and community benefits programs.
- Within three years’ time conduct an updated community health needs assessment to evaluate community effectiveness on addressing top needs and to identify new community needs.

RESOLUTION OF THE
BOARD OF COMMISSIONERS OF
ST. TAMMANY PARISH HOSPITAL SERVICE DISTRICT NO. 2
doing business as
SLIDELL MEMORIAL HOSPITAL

A regular meeting of the Board of Commissioners of St. Tammany Parish Hospital Service District No. 2, doing business as Slidell Memorial Hospital, was held on September 30, 2013 at which meeting a quorum was present and voting.

RECITALS,

As part of its commitment to the community, Slidell Memorial Hospital contracted with Tripp Umbach, a nationally recognized healthcare consulting firm, to prepare a comprehensive Community Health Needs Assessment, which assessment was completed in September 2013.

As a component of its contractual engagement and in cooperation with Slidell Memorial Hospital personnel, Tripp Umbach prepared a Community Health Needs Assessment Implementation Plan, also completed in September 2013.

RESOLVED,

That the Slidell Memorial Hospital Board of Commissioners hereby accepts the Community Health Needs Assessment dated September 2013 as prepared by Tripp Umbach.

That the Slidell Memorial Hospital Board of Commissioners hereby adopts the Community Health Needs Assessment Implementation Plan dated September 2013 as prepared by Tripp Umbach in cooperation with Slidell Memorial Hospital personnel.

That the Chairman of the Board of Commissioners and the Chief Executive Officer, are each hereby authorized to have such additional authority as necessary and appropriate to accomplish the intent of this resolution.

CERTIFICATE

I, Larry P. Englande, Secretary of St. Tammany Parish Hospital Service District No. 2, doing business as Slidell Memorial Hospital, certify that the foregoing is a true, accurate and correct excerpt from the minutes of the regular meeting of the Board of Commissioners held September 30, 2013, at which meeting was duly called and convened and at which meeting a quorum was present and voting.

Slidell, Louisiana this 30th day of September, 2013.

LARRY P. ENGLANDE, Secretary