2026-2028 Joint CHIP Background: Ochsner Rush Health

CHIP Requirements (according to IRS)	A hospital facility's implementation strategy must be a written plan that, for each significant health need identified in the CHNA, either: 1) Describes how the hospital facility plans to address the health need, or 2) Identifies the health need as one the hospital facility does not intend to address and explains why it does not intend to address the health need.
	In describing **how a hospital facility plans to address a significant health need** identified through the CHNA, the implementation strategy must: - Describe the actions the hospital facility intends to take to address the health need and the anticipated impact of these actions, - Identify the resources the hospital facility plans to commit to address the health need, and - Describe any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need.
	If the hospital facility does not intend to address a significant health need, providing a brief explanation of its reason for not addressing the health need is sufficient. Reasons for not addressing a significant health need may include, but are not limited to: Resource constraints, Other facilities or organizations in the community are addressing the need, Relative lack of expertise or competencies to effectively address the need, A relatively low priority assigned to the need, and/or A lack of identified effective interventions to address the need.

Participating Ochsner Rush facilities included in this CHIP: Ochsner Choctaw General, Ochsner Rush Medical Center, Ochsner Watkins Hospital, Ochsner Specialty Hospital, Ochsner Laird Hospital, Ochsner Scott Regional and Ochnser Stennis Hospital

2026-2028 CHIP Priorities



Needs Not Being Addressed in this plan

All the health needs identified in the CHNA process are interconnected and impact one another as they drive health outcomes. For instance, implementing home visits and virtual visits are avenues to address transportation barrier and improving access to needed care.

Many Ochsner Rush facilities, especially in rural areas, do not currently have the resources and/ or expertise to directly address economic opportunities, k-12 education, and transportation needs in this .

- Many facilities serving rural communities continue attempting to partner and tap into programs, but transportation resources in the area are limited, at capacity, or have strict utilization guidelines.
- The workforce development initiative, Project SEARCH, is only active in Lauderdale County and active in at Ochsner Rush Medical Center.

Community Health Improvement Plan is a living document

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 2026 CHIP workplan will evolve as hospital facilities work with communities, and needs and resources shift. Those changes should be tracked and monitored at least annually. Ochsner Rush Health will monitor progress and revise the CHIP workplans as needed over the next three years.

Orientation to this 2026 CHIP	
Priorities	Many significant health needs identified fell into the following 5 domains, which align across the Ochsner System. 1. Access to Care, 2. Health Outcomes, 3. Education, 4. Community Economic Development, and 5. Community Partnerships to Address Social Drivers
Facility	Ochsner Rush developed a collaborative CHIP in 2026. Each hospital faclity is unique with the patients and communitites it serves, as well as different resources and assets available to address certain needs. So we expect facilites to have a few different strategies and activities to meet the needs. All hospitals are working on a strategy unless noted otherwise in this column.
Strategy	High level focus area of need tackling eg Cancer, Language, Access, Health Screenings, Virtual Care, etc
Objective	How the facility will achieve the goal. These should be specific, measurable, achievable, relevant, and time bound (SMART). One or more activites may be needed to reach an objective. Each objective should be measurable.
Activities	Steps need to achieve objective. May require different resources or partners.
Measurement	We are looking for one metric to track progress of objective. We do **not** need metrics for every activityy, but atleast for an objective. We recommend one high level number that is easily accessible on an an annual basis to measure progress toward meeting the objective.
Owner or metric source	Who holds the data for the baseline metric and targets or what is the source. As these metrics are collected annually we don't want to forget the source.
2025 baseline	If this is an ongoing program or inititative (or data we have), include the data for 2025 to set a baseline for progress and make sure you can easily gather data to track progress moving forward.
Targets	Etimate your target for the next 3 years to guide progress. We are aiming to meet 75% of objectives. Many external factor affect this important work We are not expecting perfection, but we are looking for progress and learning along the way.
Lead department	Who is accountable for the objective, acitivities, or data collection.
Partners & Resources	Collaboration is encouraged across departments, Ochsner system, and local community organizations and entities.

Ochsner Rush Health governing bodies adopt 2026 CHIP

5/7/2026	Ochsner Choctaw General Board Meeting
5/7/2026	Ochsner Rush Medical Center Exec Committee review and approval followed by full board review
5/7/2026	Ochsner Watkins Hospital Exec Committee review and approval followed by full board review
5/7/2026	Ochsner Specialty Hospital Exec Committee review and approval followed by full board review
5/11/2026	Ochsner Laird Hospital Board Meeting
5/12/2026	Ochsner Scott Regional Board Meeting
5/13/2026	Ochsner Stennis Hospital Board Meeting

2026-2028 Joint Community Health Improvement Plan: Ochnser Rush Health

Priority	Facility	Strategy	Objective	Activities	Measurement	Owner or metric source	2025 baseline	2026 target	2027 target	Partner & resources
Access to Care	ALL	Pediatric & Adolescent care	Expand Pediatric and Adolescent Behavioral Health Services	Continue to recruit qualified providers to address the needs of our pediatric patients. Streamlining of pediatric services in a unified location. Availability of virtual visits within our region and health system. Availability to offer referrals to pediatric specialists within in the Ochsner Health Network. Will use a variety of platforms to highlight and promote awareness of services.	The successful recruitment of new pediatric providers, an increase in regional growth of our pediatric clientele, the establishment of new services, and growth in virtual pediatric visits will demonstrate growth.	Brittany Ladd, Melissa Martin	Not applicable	2 providers	+2 providers	Physician Recruitment/Rural Health Clinics
Access to Care	ALL	Behavioral Health	Behavioral Health Expansion services in Rural Health Clinics	Continue to recruit qualified clinicians to address the needs of our patients. A variety of platforms/avenues will be utilized to share program awareness to providers and the community.	The successful maintenance and growth of clients for this service each year will be the measure to ascertain success of this goal.	Angie Coleman/ Susan Campbell	BH services currently available in 4 clinics	Increase BH to 40% of clinics (8 clinics)	Increase BH to 80% of clinics (16 clinics)	IOP/Rural Health Clinics
Access to Care	ALL	Virtual Care	Expand use Virtual Visits, Focus on retirement community and aging population use MyOchsner	Outline a campaign promoting MyOchsner. Utilize a variety of platforms to communicate virtual/electronic services available. Offer user-friendly instructions on scheduling or completing virtual visits.	Number of Patients	Angela Shirley?				Patient Access
Access to Care	ALL	Patient Engagement with MyOchsner	Increase patient engagement with online tools and resources eg online scheduling	Support/Promote Patient Engagement through increasing Online Scheduling. Outline a campaign promoting MyOchsner. Utilize a variety of platforms to communicate virtual/electronic services available. Offer user-friendly instructions for online scheduling or services.	Percent of patients scheduled through MyOchsner or through website quarterly.	Angela Shirley	12.14% from IS, primary acces to care (epic)	increase by 2%	Increase by 2%	Patient Access
Access to Care	ALL	Specialists	Improve Access to Specialties: GI, Cardiology, Neurology, Urology, Infusion	Active recruitment of providers to address the speciality needs of our patient populations. Will use a variety of platforms to promote awareness of services. Outline a workflow that easily connects patients to specialities with our health system. Focus on new patients to be seen by their desired provider (across all specialties, including Family Practice)	Percent of New Patients to see their desired provider within two weeks	Angela Shirley	65.94%	70%	71%	Patient Access
Access to Care	ALL	Home Visits	Increase Home Visits in Rural Health Clinics/EC Healthnet Clinic	Provide home visits to patients with transporation difficulties and homebound patients	Number of visits per quarter	Susan Campbell	20 visits	25	30	EC Healthnet Family Medicine Residency Program
Access to Care	ALL	Community outreach & screenings	Community health screenings	Provide health screenings, referrals, and education in a community setting	Number preventative screenings done in a community setting	Population health	(see 990 data when availble)			Community Benefit

Priority	Facility	Strategy	Objective	Activities	Measurement	Owner or metric source	2025 baseline	2026 target	2027 target	Partner & resources
Health Outcomes	ALL	Cancer Screenings	Breast Cancer Screenings	Ochsner Rush Health independently and/or collaboratively will offer educational campaigns and preventative screenings to clients.	Number of Screenings/referrals per quarter	Kim Lee (Director Population Health)	75%	78%	79%	Population Health
Health Outcomes	ALL	Cancer Screenings	Colorectal Cancer Screenings	Ochsner Rush Health independently and/or collaboratively will offer educational campaigns and preventative screenings to clients.	Number of Screenings/referrals per quarter	Kim Lee (Director Population Health)	72%	78%	80%	Population Health
Health Outcomes	ALL	Cancer Screenings	Cervical Cancer Screening	Ochsner Rush Health independently and/or collaboratively will offer educational campaigns and preventative screenings to clients.	Number of Screenings/referrals per quarter	Kim Lee (Director Population Health)	70%	86%	88%	Population Health
Health Outcomes	ALL	BP screenings & control	Blood Pressure Control	Provide education regarding and monitoring of blood pressure levels to prevent hypertension complications	Number of Screenings/referrals per quarter	Kim Lee (Director Population Health)	84%	85%	86%	Population Health, Care Harmony
Health Outcomes	ALL	Screenings: Cholesterol	Statin Therapy for Prevention and Treatment of CVD	Provide community education regarding and monitoring of triglyceride levels to prevent complications or exacerbated heart disease symptoms	Number of Screenings in community and clinic/referrals per quarter	Kim Lee (Director Population Health)	88%	88%	88%	Population Health
Health Outcomes	ALL	Smoking cessation	One Year Smoking Quit Rate	Smoking cessation promotion to improve health	# of referals and calls, or quit rate	Kim Lee (Director Population Health)	12%	10%	10%	Population Health
Health Outcomes	ALL	Nutrition	Eat Fit Program	Increase percentage of Eat Fit-approved items offered at 50% off/ or at cost. Promoting Healthier Food choices and discounts on Healthy options in the retail area	Percentage of items offered by Morrison that meet the Eat Fit requirements.	Hospital Administrators/ Lindsey Vasquez	30% of offerings	40%of offerings	50% of offerings	Morrisons
Health Outcomes	ALL	Screenings: diabetes	Diabetic Eye Exam Completion	Promotion of preventative eye exam to reduce the complications of diabetes.	Number of referrals per quarter	Kim Lee (Director Population Health)	65%	76%	76%	Population Health
Health Outcomes	ALL	Diabetes Control	Diabetes control	Increase diabetes compliance among the African American pop by 5%. Promote sliding scale and pt assistance programs. Provide education. Increase diabetes education, clinic, and digital medicine referrals	Percent compliant patients (2026 focus on African American population)	Kim Lee (Director Population Health)	74%	76%	78%	Population Health, Care Harmony

Priority	Facility	Strategy	Objective	Activities	Measurement	Owner or metric source	2025 baseline	2026 target	2027 target	Partner & resources
Partnerships to address social drivers	ORMC	Food Insecurity	Meals On Wheels	Currently working with East MS Coalition to provide Meals to Families/Older Community in Need	Number of Meals provided per Quarter.	Allen Tyra	0	50 Start program in 2026	150	Morrisons/East MS Coalition
Partnerships to address social drivers	Ochsner Scott Regional	Food Insecurity	Meals On Wheels	Provide Meals to Families in Community	Number of Meals provided Weekly	Heather Davis	3900/ wk in 2025	3900	3900	Morrisons/Meals on Wheels
Partnerships to address social drivers	Ochsner Choctaw General	Food Insecurity	Partnering with a Local Food Truck/Faith Groceries	Address the area's food insecurity by partnering locally to provide Meals to Families in Community. This partnership begins in the summer; this is an 18 wheeler full of groceries and provides food for families in need.	Number of Meals provided Annually	Kawanda Johnson	0			Faith Groceries
Partnerships to address social drivers	ALL	Youth violence/ Project Inspire	Ochsner Project Inspire	Through an ongoing partnership with Meridian Youth Court, local juvenile offenders gain unique insight into the consequences of gun violence through tours of our Trauma system.	Number of students that graduate each quarter	Dr. Jason DeFatta	8 Students	10 students	12 students	Meridian Youth Court/East MS Business Development Corporation
Partnerships to address social drivers	ALL	Employee volunteerism	Collaborate with MyOchsner and community partners	Increase number of volunteer opportunities and partnerships in Rush community addressing social drivers.	Number of Ochnser Serves opportunities in Rush communities.	Vanessa Cave Herazo	2 events, 384 Rush volunteers	5 events, 500 participants in 2026	5	OchsnerServes, Community partners

Priority	Facility	Strategy	Objective	Activities	Measurement	Owner or metric source	2025 baseline	2026 target	2027 target	Partner & resources
Education & Health Literacy	ALL	Education/ Screenings	Provide Hope and Healing and Raise Awareness of Suicide	Ochsner Rush Health partners with Lean on Me Jubilee, The Stronger Foundation, and The Spot for an Event downtown during the month of October. Provide screenings, volunteers, and meeting place for event planning.	Number of meetings/events held during the year.	Rhonda Blanks/Lynn Holifield	50	55	60	The Stronger Than Us Foundation, The Spot, Lean on Me Jubilee
Education & Health Literacy	ALL	Women's Health	Women's Health Services Outreach	Health Fairs promoting Women's Services and partnering with local vendors to Educate and provide women with screenings on Women's Issues concerning Cardiac warning signs, Importance of Health screenings, GYN Issues, etc.	Number of Outreach events per quarter	Stephanie Wilkerson/Paige King	2	3	4	Women's Services
Education & Health Literacy	ALL	Chronic disease education	Chronic Disease Management Programs and Education	Promote and train patients on managing: hypertension, diabetes, and otehr chronic disease	Number of health education referrals	Kim Lee (Director Population Health)	N/A			Population Health
Education & Health Literacy	ALL	Education and partnerships	CHIN Lunch & Learns and Community Education	Ochsner Rush Health partners with the Community Health Improvement Network to address key community health needs. An assortment of resources and educational strategies are employed to bring awareness and management of disparities. Such sevices include a variety of community health tips or lunch and learns conducted by providers, clinicians or other subject matter experts. Topics include heart health, diabetes, hypertension, alzheimer's, and many others.	Number of Lunch and Learns provided quarterly	Jeremy Hill/Lance Brent/Brittany Ladd	3 annually	5	6	Community Health Improvement Network
Education & Health Literacy	ALL	Heart Health Education	"Coffee with a Cardiologist" event	Physicians hold a Q&A and share the importantance of cardiovasculare care, prevention strategies and the benefits of a heart healthy lifestyle.	Number of events	Jeremy Hill/Lance Brent/Brittany Ladd	2	4	4	Local Coffee Shops in the area
Economic opportunity	ORMC	Workforce development	Project SEARCH in Lauderdale County	Enables Young adults with disabilities to gain and maintain employment through training and career exploration	Number of interns employed after 10 month period	Derek Lasher	1			Lauderdale County School District