COMMUNITY HEALTH IMPROVEMENT PLAN

CHRISTUS®
SOUTHEAST TEXAS
Health System

Table of Contents

INTRODUCTION

Introduction

The Community Health Needs Assessment (CHNA) is a systematic, data-driven approach to determine the health needs in the service area of the CHRISTUS Southeast Texas Health System (CSETHS). In this process, CSETHS directly engages community members and stakeholders to identify the issues of greatest need as well as the largest impediments to health. With this information, CSETHS can better allocate resources towards efforts to improve community health and wellness.

Directing resources toward the greatest needs in the community is critical to CSETHS's work as a nonprofit hospital. The important work of CHNAs was codified in the Patient Protection and Affordable Care Act added Section 501(r) to the Internal Revenue Service Code, which requires nonprofit hospitals, including CSETHS, to conduct a CHNA every three years. CSETHS completed similar needs assessments in 2013, 2016 and 2019.

The process CSETHS used was designed to meet federal requirements and guidelines in Section 501(r), including:

- clearly defining the community served by the hospital, and ensuring that defined community does not exclude low-income, medically underserved, or minority populations in proximity to the hospital;
- providing a clear description of the CHNA process and methods; community health needs; collaboration, including with public health experts; and a description of existing facilities and resources in the community;
- receiving input from persons representing the broad needs of the community;
- documenting community comments on the CHNA and health needs in the community; and
- documenting the CHNA in a written report and making it widely available to the public.

When assessing the health needs for the entire CSETHS's service area, the CHNA data is presented by zip code and county depending on the available data. Providing localized data brings to light the differences and similarities within the communities in the CSETHS's service area.

The following report provides an overview of the process and approach used for this Community Health Improvement Plan (CHIP), including communities of focus, community health needs assessment process, health needs prioritization process, and the strategies to address the health priorities.

CHRISTUS Southeast Texas Health System

Setting the standard for progressive health care in Southeast Texas, CHRISTUS Southeast Texas Health System, is a Catholic, not-for-profit health care system and has been serving the needs of its communities for more than 120 years. The fully integrated healthcare delivery system including two inpatient hospitals, an outpatient surgery orthopedic hospital, and 40 additional points of access ranging from outpatient care to long term facilities, are recognized as the regional leader in outpatient services, cardiology, oncology, neurology, orthopedics, sports medicine, pediatrics, general surgery, robotic surgery, bariatrics, plastic and reconstructive surgery, birthing, neonatal care, cardiac rehabilitation, imaging, and emergency services, while CHRISTUS Southeast Texas - St. Elizabeth is designated as the area's only Level III Trauma Center. CHRISTUS Dubuis Hospital of Beaumont, a long-term acute care hospital operated by LHC Group of Lafayette, participated in the CHNA to better understand and address the unique needs of its patient population. The system continues to adapt and change to meet the needs of the community, following the values and mission of the founding Sisters of Charity of the Incarnate Word of Houston and San Antonio– to extend the healing ministry of Jesus Christ.

CHRISTUS Southeast Texas – St. Elizabeth

The 400+ bed acute care hospital is the regional leader in outpatient services, cardiology, oncology, neurology, orthopedics, sports medicine, pediatrics, general surgery, robotic surgery, bariatrics, plastic and reconstructive surgery, birthing, neonatal care, cardiac rehabilitation, imaging, and emergency services, and is designated as the area's only Level III Trauma Center.

CHRISTUS Southeast Texas – Orthopedic Specialty Center/Beaumont Bone & Joint Institute

The partnership between CHRISTUS Southeast Texas Orthopedic Specialty Center and the Beaumont Bone & Joint Institute means no more driving miles away to see an orthopedic specialist or waiting weeks for treatment. We now offer same day or next day appointments with one of our board certified, fellowship-trained orthopedists who are with you from the start of your care to the end of your care. Our orthopedic specialists provide a full range of exceptional care with access to most advanced imaging and surgical technology in the region. Why wait or drive long distances when the advanced orthopedic care you need is right here? Right now. Here, our surgeons treat a full range of orthopedic conditions and injuries. Our surgeons have trained at world-renowned centers, mastering the treatment of muscle and skeletal related injuries, and we bring that expertise to you here in Southeast Texas. Our Specialties include:

- General Orthopedics
- Knee Replacement
- Hip Replacement
- Shoulder Replacement
- Fracture Care
- Hand/Wrist Surgery
- Elbow/Shoulder Surgery
- Ankle/Foot Care
- Physical Therapy & Rehabilitation
- Trauma Care & Post Trauma Limb Reconstruction
- Joint Injections

CHRISTUS St. Mary Outpatient Center Mid County

CHRISTUS St. Mary Outpatient Center Mid County features a high-tech imaging center and in-house laboratories, a women's center and the area's only certified concussion center focused on sports rehabilitative therapy. With an emergency center that is open 24 hours, seven days a week, patients can be evaluated and treated quickly with the comfort of knowing they will receive the highest quality of care. The Hyperbaric and Wound Center at CHRISTUS St. Mary Outpatient Center Mid County offers advanced assessment and treatment options for wounds resulting from diabetic ulcers and slow-healing surgical wounds. The Susie Roebuck Mammography Center provides women with groundbreaking 3D digital mammography service, which allows South County residents to get the most advanced breast imaging techniques available, without having to travel. The center also provides a number of outpatient therapy services including speech, occupational and physical therapy, along with orthopedic surgical recovery.

CHRISTUS Southeast Texas Jasper Memorial

CHRISTUS Southeast Texas Jasper Memorial is a 59-bed medical facility that serves approximately 45,000 East Texas residents. Located approximately 65 miles north of Beaumont and 60 miles south of Lufkin, Jasper Memorial is a general medical/surgical hospital with medical imaging, laboratory services, and outpatient services.

CHRISTUS Dubuis Hospital of Beaumont

CHRISTUS Dubuis Hospital of Beaumont is a long-term acute care hospital (LTACH) located on the 4th flood of CHRISTUS Southeast Texas St. Elizabeth Hospital, operated by the LHC Group of Lafayette, Louisiana.

CHRISTUS Health

CHRISTUS Health is a Catholic health system formed in 1999 to strengthen the faith-based health care ministries of the Congregations of the Sisters of the Incarnate Word of Houston and San Antonio that began in 1866. In 2016, the Sisters of the Holy Family of Nazareth became the third sponsoring congregation to CHRISTUS Health. Today, CHRISTUS Health operates 25 acute care hospitals and 92 clinics in Texas. CHRISTUS Health facilities are also located in Louisiana, Arkansas, and New Mexico. It also has 12 international hospitals in Colombia, Mexico, and Chile. As part of CHRISTUS Health's mission "to extend the healing ministry of Jesus Christ," CHRISTUS Southeast Texas Health System strives to be, "a leader, a partner, and an advocate in the creation of innovative health and wellness solutions that improve the lives of individuals and communities so that all may experience God's healing presence and love."

Communities of Focus

Following IRS guidelines, 501(r) rules as required by the Affordable Care Act, CSETHS's CHNA service area includes 21 zip codes covering almost 400,000 individuals (Table 1). The primary service area (PSA) is the geographic region with 80% of hospital utilization. The primary service area zip codes are located in the following counties: Hardin, Jasper, Jefferson and Orange (Figure 1).

While the hospital is dedicated to providing exceptional care to all of the residents in Southeast Texas, CSETHS will use the information in this assessment to strategically establish priorities and commit resources to address the key health issues for the cities and municipalities that comprise the region.

CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM PSA			
Hardin County, TX	Jasper County, TX	Jefferson County, TX	Orange County, TX
77625	75951	77619, 77627, 77640	77630
77656	75956	77642, 77701, 77702	77632
77657	77612	77703, 77705, 77706	77662
		77707, 77708, 77713	

Table 1. Primary Service Area of CSETHS

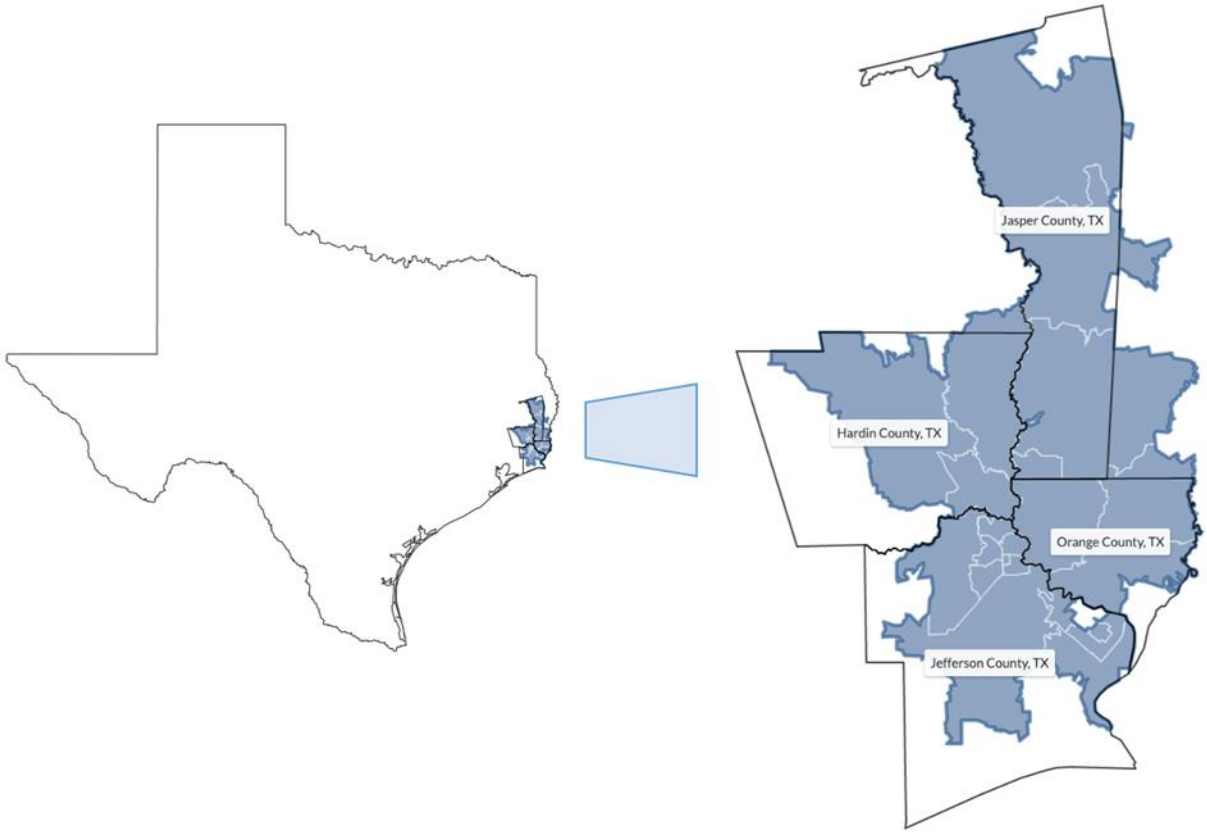

Figure 1. Primary Service Area of CSETHS

Statement of Health Equity

While community health needs assessments (CHNA) and Improvement Plans are required by the IRS, CHRISTUS Southeast Texas Health System has historically conducted CHNAs and developed Improvement Plans as a way to meaningfully engage with our communities and plan our Community Health & Social Impact work. Community Health & Social Impact promotes optimal health for those who are experiencing poverty or other vulnerabilities in the communities we serve by connecting social and clinical care, addressing social needs, dismantling systemic racism, and reducing health inequities. CHRISTUS Health has adopted the Robert Wood Johnson Foundation's definition of Health Equity - "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

COMMUNITY HEALTH NEEDS ASSESSMENT

Community Health Needs Assessment

Stakeholder Engagement

The CHNA process involved engagement with several internal and external stakeholders to collect, curate and interpret primary and secondary data. That data was then used to prioritize the health needs of the community. For this component, CSETHS worked with Metopio, a software and services company that is grounded in the philosophy that communities are connected through places and people. Metopio's tools and visualizations use data to reveal valuable, interconnected factors that influence outcomes in different locations.

Leaders from the CSETHS guided the strategic direction of Metopio through roles on various committees and workgroups.

CSETHS and Metopio relied on the expertise of community stakeholders throughout the CHNA process. The health system's partners and stakeholder groups provided insight and expertise around the indicators to be assessed, types of focus group questions to be asked, interpretation of results and prioritization of areas of highest need.

The Community Benefit Team is composed of key staff with expertise in areas necessary to capture and report CSETHS community benefit activities. This group discusses and validates identified community benefit programs and activities. Additionally, the team monitors key CHNA policies, provides input on the CHNA implementation strategies and strategic improvement plan, reviews and approves grant funding requests and provides feedback on community engagement activities.

Input from community stakeholders was also gathered from CSETHS's community partners. These partners played a key role in providing input to the survey questions, identifying community organizations for focus groups, survey dissemination and ensuring diverse community voices were heard throughout the process.

The CSETHS leadership team developed parameters for the 2023-2025 CHNA process that help drive the work. These parameters ensure that:

- the CHNA builds on the prior CHNA from 2020-2022 as well as other local assessments and plans;
- the CHNA will provide greater insight into community health needs and strategies for ongoing community health priorities;
- the CHNA leverages expertise of community residents and includes a broad range of sectors and voices that are disproportionately affected by health inequities;
- the CHNA provides an overview of community health status and highlights data related to health inequities;
- the CHNA informs strategies related to connections between community and clinical sectors, anchor institution efforts, policy change, and community partnerships; and
- health inequities and their underlying root causes are highlighted and discussed throughout the assessment.

Data Collection

CSETHS conducted its CHNA process between September 2021 and March 2022 using an adapted process from the Mobilizing for Action through Planning and Partnerships (MAPP) framework. This planning framework is one of the most widely used for CHNAs. It focuses on community engagement, partnership development and seeking channels to engage people who have often not been part of decision-making processes. The MAPP framework was developed in 2001 by the National Association for County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC).

Primary data for the CHNA was collected through four channels:

- Community resident surveys
- Community resident focus groups
- Health care and social service provider focus groups
- Key informant interviews

Secondary data for the CHNA were aggregated on Metopio's data platform and included:

- Hospital utilization data
- Secondary sources including, but not limited to, the American Community Survey, the Decennial Census, the Centers for Disease Control, the Environmental Protection Agency, Housing and Urban Development and the Texas Department of State Health Services

Community Resident Surveys

Between October and December of 2021, 337 residents in the CSETHS PSA provided input to the CHNA process by completing a community resident survey. The survey was available online and in paper form in English and Spanish. Survey dissemination happened through multiple channels led by CSETHS and its community partners. The survey sought input from priority populations in the CSETHS PSA that are typically underrepresented in assessment processes, including communities of color, immigrants, persons with disabilities, and low-income residents. The survey was designed to collect information regarding:

- Demographics of respondents
- Health needs of the community for different age groups
- Perception of community strengths
- Utilization and perception of local health services

The survey was based on a design used extensively for CHNAs and by public health agencies across the country. The final survey included 26 questions.

Community Focus Groups and Key Informant Interviews

A critical part of robust, primary data collection for the CHNA involved speaking directly to community members, partners and leaders that live in and/or work in the CSETHS PSA. This was done through focus groups and key informant interviews.

During this CHNA, CSETHS held two local focus groups, one covering Adult Health and the other Maternal and Child Health, and joined two system wide focus groups. All focus groups were coordinated by CSETHS and the CHRISTUS system office and facilitated by Metopio. CSETHS sought to ensure groups included a broad range of individuals from underrepresented, priority populations in the CSETHS. Focus group health topic areas are listed below:

- Adult health
- Maternal and child health
- Health care and social service providers
- Behavioral health

Due to the COVID-19 pandemic, CSETHS conducted its focus groups virtually over Zoom. Focus groups lasted 90 minutes and had up to 12 community members participate in each group. In addition to the focus groups, 10 key informants were identified by CSETHS Management team for one-on-one interviews. Key informants were chosen based on areas of expertise to further validate themes that emerged in the surveys and focus groups. Each interview was conducted virtually and lasted 30 minutes.

Secondary Data

CSETHS used a common set of health indicators to understand the prevalence of morbidity and mortality in the CSETHS PSA and compare them to benchmark regions at the state and the full CHRISTUS Health service area. Building on previous CHNA work, these measures have been adapted from the County Health Rankings MAPP framework (Figure 2). Where possible, CSETHS used data with stratifications so that health inequities could be explored and better articulated. Given the community input on economic conditions and community safety, CSETHS sought more granular datasets to illustrate hardship.

Health Issue Prioritization Process

The Community Benefit team worked with the hospital leadership and community partners to prioritize the health issues of community benefit programming for fiscal years 2023-2025. These groups of internal and external stakeholders were selected for their knowledge and expertise of community needs. Using a prioritization framework guided by the MAPP framework, the process included a multi-pronged approach to determine health issue prioritization.

1. The team reviewed health issue data selected by the community survey respondents.
2. The team scored the most severe indicators by considering existing programs and resources.
3. The team assigned scores to the health issue based on the Prioritization Framework (Table 2). The highest-scoring health issues were reconciled with previous cycles' selected priorities for a final determination of priority health issues.
4. The team discussed the rankings and community conditions that led to the health issues.

SIZE	How many people are affected?	Secondary Data
SERIOUSNESS	Deaths, hospitalizations, disability	Secondary Data
EQUITY	Are some groups affected more?	Secondary Data
TRENDS	Is it getting better or worse?	Secondary Data
INTERVENTION	Is there a proven strategy?	Mission team
INFLUENCE	How much can CSETX affect change?	Mission team
VALUES	Does the community care about it?	Survey, Focus Groups, Key Informant Interviews
ROOT CAUSES	What are the community conditions?	Mission team

Table 2. Prioritization Framework

Data Needs And Limitations

CSETHS and Metopio made substantial efforts to comprehensively collect, review, and analyze primary and secondary data. However, there are limitations to consider when reviewing CHNA findings.

- Population health and demographic data are often delayed in their release, so data are presented for the most recent years available for any given data source.
- Variability in the geographic level at which data sets are available (ranging from census tract to statewide or national geographies) presents an issue, particularly when comparing similar indicators and collected at disparate geographic levels. Whenever possible, the most relevant localized data are reported.
- Due to variations in geographic boundaries, population sizes, and data collection techniques for suburban and city communities, some datasets are not available for the same time spans or at the same level of localization throughout the county.
- Gaps and limitations persist in data systems for certain community health issues such as mental health and substance use disorders (youth and adults), crime reporting, environmental health, and education outcomes. Additionally, these data are often collected and reported from a deficit-based framework that focuses on needs and problems in a community, rather than assets and strengths. A deficit-based framework contributes to systemic bias that presents a limited view on a community's potential.

With this in mind, CSETHS, Metopio, and all stakeholders were deliberate in discussing these limitations throughout the development of the CHNA and selection of the 2023-2025 health priority areas.

HEALTH PRIORITY AREAS

Health Priority Areas

Based on community input and analysis of a myriad of data, the priorities for the communities served by CHRISTUS Southeast Texas Health System for Fiscal Years 2023-2025 fall into two domains underneath an overarching goal of achieving health equity. The two domains and corresponding health needs are:

1. Advance Health and Wellbeing

- Specialty Care and Chronic Conditions
  - Diabetes
  - Heart Disease
  - Obesity
- Behavioral Health
  - Mental Health
  - Substance Abuse

2. Build Resilient Communities and Improve Social Determinants

- Improving food access
- Increasing physical activity
- Reducing smoking and vaping

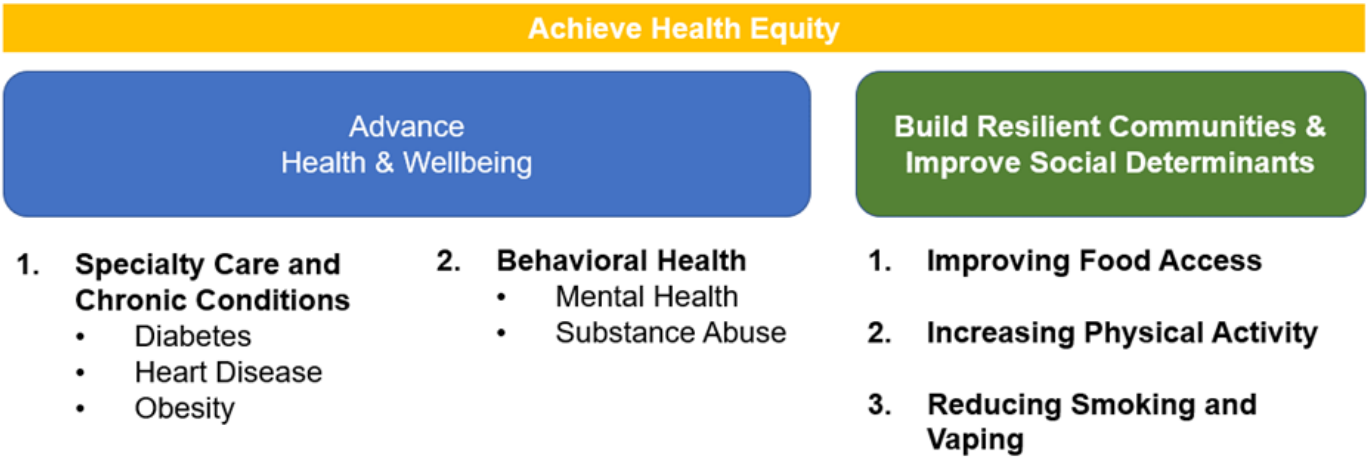

Figure 3. CHRISTUS Southeast Texas Health System and CHRISTUS Dubuis Hospital of Beaumont Priority Areas

Approach to Community Health Improvement Plan

All community benefit investments and programming are built on a framework that promotes health equity and is framed by the community benefit overarching goal: to enhance community health and wellness around CHNA priority health needs in the service area. To achieve this goal, CHRISTUS Health designs its interventions and programs through the following channels:

1. Care Delivery Innovations
2. Community Based Outreach
3. Grant Making
4. Medical Education
5. Partnerships
6. Public Policy

Outlined below are the specific strategies and initiatives corresponding to each of the selected health priority areas. See Appendix 1 to a fully detailed evaluation framework relating to these strategies.

Community Benefit Report Communication

CHRISTUS Southeast Texas Health System will make its CHNA and strategic improvement plan publicly available online via the CHRISTUS Health website once it is approved and adopted by the Board of Directors in 2022. In addition, CHRISTUS Southeast Texas Health System will share the Community Health Improvement Plan (CHIP) to its advisors and partners (e.g., community members, local political representatives, faith leaders, healthcare providers, and community-based organizations), and make copies available upon request.

Throughout the 2023 - 2025 Improvement Strategy cycle, CHRISTUS Health will continue to monitor the evolving needs of our community, emerging resources made available through other organizations, and changing circumstances (such as COVID-19). While committed to providing the necessary people and financial resources to successfully implement the initiatives outlined above, CHRISTUS Health reserves the right to amend this improvement plan as circumstances warrant to best serve our community and allocate limited resources most effectively.

Health Priority Area 1: Advance Health & Wellbeing

Addressing widespread chronic disease among adults is important to residents of all ages in the service area, as living with comorbidities is associated with poorer quality of life and lower life expectancy. It also contributes to financial instability and poor mental health. The first step to preventing chronic disease begins with establishing healthy behaviors. However, there are many impediments to living a healthy lifestyle.

ADVANCE HEALTH AND WELLBEING			
SPECIALTY CARE AND CHRONIC CONDITIONS	SPECIALTY CARE AND CHRONIC CONDITIONS	HELPING PATIENTS TO A MEDICAL HOME	HELPING PATIENTS TO A MEDICAL HOME
Accredited programs in heart disease, diabetes, and obesity	Empower community members to manage their heart disease, diabetes, and/or obesity	Increase access to primary care	Reduce inequities caused by cultural barriers to care
• Accredited ADA program consults with outpatients and inpatients on diabetes, heart disease and obesity comorbidities. Personal patient goals set and progress measured. Underserved patients qualified for financial assistance. Discharge counseling and education with referrals provided free of charge. • Continue community education initiatives focused on chronic disease prevention.	• Manage comorbidities such as hypertension, obesity, diabetes, and heart disease. • Continue community education focused on chronic disease prevention. • Increase easy access to Qualified Bilingual Language Interpreters	• Assist patients with healthcare referrals to cooperating FQHCs to enable them with a medical home. • Expand the physician network within CSETHS. • Establish new outpatient healthcare facilities in Orange, TX.	• Train healthcare staff in cultural competency, shared decision-making and plain language. • Refresh training for all leaders on "unconscious bias." • Establish a HEDI Council of leaders in the CSETHS ministry. • Provide training for the Ethics Consult Team on cultural competency for families of minority patients.
BEHAVIORAL HEALTH	BEHAVIORAL HEALTH	BEHAVIORAL HEALTH	BEHAVIORAL HEALTH
Reduce preventable Emergency Department usage for mental health	Create community connections for mental health services	Increase access to substance abuse treatments	Increase access to substance abuse treatement

• Continue to work with Spindletop Mental Health Center. Plan use of their Sprint Mental Health Mobile Unit for interventions, screenings and referrals. So, screenings for inpatients, at discharge or refer for follow up. • Refer also to newly leased on campus "C.A.R.E." for Counseling and Relief Everyday, LLC. • Refer unfunded patients, including Spanish speaking, to Catholic Charities Counseling Services.	• Refer unfunded patients, including Spanish speaking, to Catholic Charities Counseling Services with bilingual support. Use sliding fee and income based, household size qualifications to overcome financial resistance to needed counseling services. • Continue to support S.A.N.E. Forensic Nursing program's collaboration to train law enforcement and emergency services staff.	• In Jasper, the Burke Mental Health Center is in front of the hospital. Make use of their on-call and evaluate process for potential patients or higher level of care. • Use Telemed with Telepsyche to work closely with ER physicians on referrals. Work with county judge for commitment when needed.	• Collaborate with substance abuse services in SETX to improve continuity of care. • Provide access on campus for 12-Step programs. • Establish literature library rack in ER for patients, families and staff. • Partner with local Salvation Army shelter for clients in need of care and substance abuse interventions.

CHRISTUS Health will continue to invest in care delivery innovations and expand programs that address prevention for heart disease, obesity and diabetes and improve access to care. Key programs that support these initiatives are accredited ADA medical care, free of charge discharge counseling and follow up, education in self-care, helping the uninsured to get insured in the ACA programs, qualifying low-income and the uninsured for financial assistance, increasing access to care by helping patients find a medical home, providing Qualified Bilingual Staff and increasing facilities in the physician network.

And CHRISTUS Health will focus on building a coalition to address Behavioral Health issues in the service area. Partners include Spindletop Mental Health Center and the Sprint Mental Health Mobile Unit, CARE for Counseling Relief Every Day, Catholic Charities Counseling, and the Burke Center.

Health Priority Area 2: Build Resilient Communities & Improve Social Determinants

Many communities in the service area face structural barriers to healthy behaviors, including a lack of healthy food options and easy access to tobacco and vaping products. Several social determinants exist in the community, adding daily pressure to residents seeking a healthy life.

BUILD RESILIENT COMMUNITIES & IMPROVE SOCIAL DETERMINANTS			
IMPROVE FOOD ACCESS	IMPROVE FOOD ACCESS	REDUCE SMOKING	REDUCE VAPING
Cultivate and maintain partnerships to improve access to healthy food in food deserts	Provide nutrition education for patients	Develop a community-based smoking cessation program	Partner with schools to reduce vaping among students
• Maintain partnership (financial and volunteers) with Catholic Charities Helping Other People Eat (HOPE). • Develop Satellite Food Banks in health facilities through partnership with Food Bank of Southeast Texas. • Provide discharge food boxes that are diet appropriate for patients upon discharge.	• Provide nutrition education for patients within discharge planning. • Continue Diabetic Cooking Classes • Educate physicians on the value of "diet prescriptions" that are culturally appropriate to increase patient compliance.	• Leverage discounted membership in the Wellness Center to combine with smoking cessation classes for the community. • Encourage physicians to educate and guide patients in smoking cessation. • Collaborate with local employers for No Smoking programs. • Continue No Smoking discount in CHRISTUS insurance plans.	• Collaborate with local schools to develop an anti-vaping message. • Establish an ad-hoc task committee to find ways to attack the vaping problem in schools, including some teachers and health professionals. • Advocate locally to reduce the growth of vaping supply stores in the community.
INCREASE PHYSICAL ACTIVITY	INCREASE PHYSICAL ACTIVITY		
Cultivate and maintain partnerships to improve access to healthy food in food deserts	Provide nutrition education for patients		

• Continue to provide free memberships to the Hebert Wellness Center upon needs based qualification. • Continue to collaborate with 5K and 10K runs in the community to provide warm-ups to prevent sports injuries. • Water aerobics continue to be available for safe workouts for weight loss.	• Memberships are provided free upon physician referral for bariatric and oncology patients to enhance wellness, build new healthy habits and lifestyle and build self-esteem through self-management of their disease. • Keep outside track open to the public to encourage physical activity of walking or running.		

CHRISTUS Health will continue to invest in care delivery innovations and expand programs that address the social determinants of health. Key programs that support these initiatives are Catholic Charities, Food Bank of Southeast Texas, Hebert Wellness Center, and local public and private schools.

STRATEGIES

Appendix 1: Advance Health & Wellbeing

Specialty Care and Chronic Disease

Goal:

1. Implement Accredited Programs in heart disease, diabetes, and obesity
2. Empower community members to manage their heart disease, diabetes, and/or obesity

Strategy	Anticipated Impact	Programs, Services, Partnerships, Resources	Hospital's Role	Timeframe	Community of Focus	Metrics
What actions or activities will we do to help to improve the conditions/	*What are the expected outcomes of the population?*	*Who are the partners who have a role to play in doing better?*	*What is our role? (i.e. Leader, Collaborator, Supporter)*	*When do you expect this activity to begin/end?*	*Who are our customers/the population?*	*How much? How well? Is anyone better off?*
Accredited ADA program consults with outpatients and inpatients on diabetes, heart disease and obesity comorbidities. Personal patient goals set and progress measured. Underserved patients qualified for financial assistance. Discharge counseling and education with referrals provided free of charge	Improved health and wellbeing	Physicians, case management and patients	Leader	Begin: FY23 End: FY25	Primary Service Area Zip Codes	# of People Served
Continue community education initiatives focused on chronic disease prevention.		Physicians, instructors and patients	Leader			# of People Served

	Manage comorbidities such as hypertension, obesity, diabetes, and heart disease.		Physicians, their teams and patients	Leader			# of People Served
	Continue community education focused on chronic disease prevention.		Physicians, instructors and patients	Leader			# of People Served
	Increase easy access to Qualified Bilingual Language Interpreters		Staff and patients and families	Leader			# of People Served

Behavioral Health

POPULATION ACCOUNTABILITY

Goal:

1. Reduce preventable Emergency Department usage for mental health
2. Create community connections for mental health services
3. Increase access to Substance Abuse treatment

PROGRAM ACCOUNTABILITY

Strategy	Anticipated Impact	Programs, Services, Partnerships, Resources	Hospital's Role	Timeframe	Community of Focus	Metrics
What actions or activities will we do to help to improve the conditions/	*What are the expected outcomes of the population?*	*Who are the partners who have a role to play in doing better?*	*What is our role? (i.e. Leader, Collaborator, Supporter)*	*When do you expect this activity to begin/end?*	*Who are our customers/the population?*	*How much? How well? Is anyone better off?*
Continue to work with Spindletop Mental Health Center. Plan use of their Sprint Mental Health Mobile Unit for interventions, screenings and referrals. So, screenings for inpatients, at discharge or refer for follow up.	Improved health and wellbeing	SMHC	Collaborator	Begin: FY23 End: FY25	Primary Service Area Zip Codes	# of People Served
Refer also to newly leased on campus "C.A.R.E." for Counseling and Relief Everyday, LLC.		C.A.R.E	Collaborator			# of People Served
Refer unfunded patients, including Spanish speaking, to Catholic Charities Counseling Services.		Catholic Charities	Supporter			# of People Served

	Refer unfunded patients, including Spanish speaking, to Catholic Charities Counseling Services with bilingual support. Use sliding fee and income based, household size qualifications to overcome financial resistance to needed counseling services		Financial counselors and Catholic Charities	Supporter			# of People Served
	Continue to support S.A.N.E. Forensic Nursing program's collaboration to train law enforcement and emergency services staff.		S.A.N.E.	Leader			# of People Served
	In Jasper, the Burke Mental Health Center is in front of the hospital. Make use of their on-call and evaluate process for potential patients or higher level of care.		Burke Mental Health Center	Collaborator			# of People Served
	Use Telemed with Telepsyche to work closely with ER physicians on referrals. Work with county judge for commitment when needed.		CHRISTUS, other providers and the court system	Leader			# of People Served
	Collaborate with substance abuse services in SETX to improve continuity of care.		Community services for substance abuse treatment	Collaborator			# of People Served
	Provide access on campus for 12-Step programs.		CHRISTUS	Supporter			# of People Served
	Establish literature library rack in ER for patients, families and staff.		CHRISTUS	Leader			# of People Served
	Partner with local Salvation Army shelter for clients in need of care and substance abuse interventions.		Salvation Army	Collaborator			# of People Served

Appendix 2: Build Resilient Communities & Improve Social Determinants

Improving Food Access

Goal:

1. Cultivate and maintain partnerships to improve access to healthy food in food deserts
2. Provide nutrition education

Strategy	Anticipated Impact	Programs, Services, Partnerships, Resources	Hospital's Role	Timeframe	Community of Focus	Metrics
What actions or activities will we do to help to improve the conditions/	*What are the expected outcomes of the population?*	*Who are the partners who have a role to play in doing better?*	*What is our role? (i.e. Leader, Collaborator, Supporter)*	*When do you expect this activity to begin/end?*	*Who are our customers/the population?*	*How much? How well? Is anyone better off?*
Maintain partnership (financial and volunteers) with Catholic Charities Helping Other People Eat (HOPE).	Build resilient communities and improve social determinants	H.O.P.E.	Supporter	**Begin:** FY23 **End:** FY25	Primary Service Area Zip Codes	# of People Served
Develop Satellite Food Banks in health facilities through partnership with Food Bank of Southeast Texas.		Food Bank of SETX	Collaborator			# of People Served

	Provide discharge food boxes that are diet appropriate for patients upon discharge.		CHRISTUS and Food Bank	Collaborator			# of People Served
	Provide nutrition education for patients within discharge planning.		CHRISTUS	Leader			# of People Served
	Continue Diabetic Cooking Classes.		CHRISTUS	Leader			# of People Served
	Educate physicians on the value of "diet prescriptions" that are culturally appropriate to increase patient compliance.		CHRISTUS	Leader			# of People Served

Increasing Physical Activity

Goal:

1. Engage with the community to promote healthy physical activity.
2. Provide physicians options for their patients to improve health through physical activity.

Strategy	Objectives / Anticipated Impact	Programs, Services, Partnerships, Resources	Hospital's Role	Timeframe	Community of Focus	Metrics
What actions or activities will we do to help to improve the conditions/	*What is the objective/goal of the activity? What are the expected outcomes of the population?*	*Who are the partners who have a role to play in doing better?*	*What is our role? (i.e. Leader, Collaborator, Supporter)*	*When do you expect this activity to begin/end?*	*Who are our customers/the population?*	*How much? How well? Is anyone better off?*
Continue to provide a limited number of free memberships to the Wellness Center for upon request. Memberships are provided free upon physician referral for bariatric and oncology patients to enhance wellness, build new healthy habits and lifestyle and build self-esteem through self-management of their disease.	Build resilient communities and improve social determinants	CHRISTUS	Leader	**Begin:** FY23 **End:** FY25	Primary Service Area Zip Codes	# of People Served
Continue to collaborate with 5K and 10K runs in the	Build resilient communities and	CHRISTUS	Collaborator			# of People Served

	community to provide warm-ups to prevent sports injuries.	improve social determinants					
	Water aerobics continue to be available for safe workouts for weight loss. Keep outside track open to the public to encourage physical activity of walking or running.	Build resilient communities and improve social determinants	CHRISTUS	Leader			# of People Served

Reducing Smoking and Vaping

Goal:

1. Develop a community-based smoking cessation program
2. Partner with schools to reduce vaping among students

Strategy	Anticipated Impact	Programs, Services, Partnerships, Resources	Hospital's Role	Timeframe	Community of Focus	Metrics
What actions or activities will we do to help to improve the conditions/	*What are the expected outcomes of the population?*	*Who are the partners who have a role to play in doing better?*	*What is our role? (i.e. Leader, Collaborator, Supporter)*	*When do you expect this activity to begin/end?*	*Who are our customers/the population?*	*How much? How well? Is anyone better off?*
Leverage discounted membership in the Wellness Center to combine with smoking cessation classes for the community	Build resilient communities and improve social determinants	CHRISTUS	Leader	Begin: FY23 End: FY25	Primary Service Area Zip Codes	# of People Served
Encourage physicians to educate and guide patients in smoking cessation.		CHRISTUS	Leader			# of People Served
Collaborate with local employers for No Smoking programs.		CHRISTUS and local employers	Collaborator			# of People Served
Continue No Smoking discount in CHRISTUS insurance plans		CHRISTUS and BCBS Insurance	Leader			# of People Served
Collaborate with local schools to develop an anti-vaping message		CHRISTUS and local school system	Collaborator			# of People Served

	Establish an ad-hoc task committee to find ways to attack the vaping problem in schools, including some teachers and health professionals.		CHRISTUS and local schools	Collaborator			# of People Served
	Advocate locally to reduce the growth of vaping supply stores in the community.		CHRISTUS and the community and local leaders	Leader			# of People Served