CHRISTUS Trinity Mother Frances Health System

Community Health Improvement Plan 2020-2022

About Texas Health Institute:

Texas Health Institute (THI) is a non-profit, non-partisan public health institute. Since 1964, THI has served as a trusted, leading voice on public health and healthcare issues in Texas and the nation. THI's expertise, strategies, and nimble approach makes it an integral and essential partner in driving systems change efforts. THI works across and within sectors to lead collaborative efforts and facilitate connections to foster systems that provide the opportunity for everyone to lead a healthy life.

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MISSION FOR IMPLEMENTATION

CHRISTUS Trinity Mother Frances Health System (CTMFHS) is a non-profit hospital system serving the Upper East Texas region. In addition to the 402-bed CHRISTUS Mother Frances Hospital and 51-bed Louis and Peaches Owen Heart Hospital in Tyler, Texas, CTMFHS includes acute hospitals and inpatient facilities in Jacksonville, South Tyler, Sulphur Springs, and Winnsboro. CTMFHS also includes a long-term acute care hospital in Tyler; clinics and outpatient centers spread across Tyler, Jacksonville, Canton, Lindale, and Flint; physician partnerships, PHOs, and MSOs; several collaborative ventures and affiliations; and the CHRISTUS Trinity Mother Frances Foundation.[1]

While CTMFHS serves a wide swath of Upper East Texas, CTMFHS defines the report area for its 2020-2022 Community Health Needs Assessment (CHNA) to include the following seven Texas counties: Delta, Franklin, Hopkins, Rains, Wood, Smith, and Cherokee. The demography and socioeconomic conditions of these counties are broadly representative of the CTMFHS service area. As such, they offer insight into the health needs of the patients of and communities surrounding the seven hospitals for which this CHNA is conducted.

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," CTMFHS 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."[2]

In alignment with these values, all CHRISTUS Health hospitals work closely with the community to ensure regional health needs are identified and incorporated into system-wide planning and strategy. To this end, CHRISTUS Health commissioned Texas Health Institute (THI) to produce the 2020-2022 CHNA and this Community Health Improvement Plan (CHIP) for CTMFHS.

To produce the CHNA, CTMFHS and THI analyzed data for over 40 different health indicators, spanning demographics, socioeconomic factors, health behaviors, clinical care, and health outcomes. The needs assessment process culminated in the 2020-2022 CTMFHS Community Health Needs Assessment (CHNA) Report, finalized in May 2019. Report findings synthesize data from publicly available sources, internal hospital data, and input from those with close knowledge of the local public health and health care landscape to present a comprehensive

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[1] CHRISTUS Health. (2018). *System Profile 2018*. Available at: https://www.christushealth.org/-/media/files/Homepage/About/2018_SysProfile.ashx.
[2] CHRISTUS Health. (2019). *Our mission, values, and vision*. Available at: http://www.christushealth.org/OurMission.

view of unmet health needs in the region. Through an iterative process of analysis, stakeholder debriefing, and refinement, the collection of indicators presented for initial review was distilled into a final list of five priority health needs requiring a targeted community response in the coming triennium.

The CHIP presented in this document fulfills federal IRS 990H regulations for 501(c)(3) non-profit hospitals' community benefit requirements and will be made available to the public. The CHIP builds upon the CHNA findings by detailing how CTMFHS intends to engage partner organizations and other local resources to respond to priority health needs identified in the CHNA. It identifies a set of actions to address prioritized health needs while clarifying benchmarks to monitor progress. Specific community assets are identified and linked to needs they can address, a step toward fostering the collaboration and accountability necessary to ensure goals enumerated within the CHIP are pursued with the community's full available capacity.

TARGET POPULATION/AREA

While CTMFHS receives patients from a very broad region of North East Texas, the report area includes the following seven counties: Cherokee, Delta, Franklin, Hopkins, Rains, Smith and Wood Counties. Consisting of a total population of 388,604 residents the report area reflects the diverse communities in North East Texas from which CTMFHS patients could live while representing the bulk of individuals using CTMFHS services. Nearly 75% of the report area's population resides in Smith and Cherokee County. Fifty-nine percent of residents in the report area live in Smith County, the only urban county, while the remaining 41% live in the rest of the report area rural counties.[3] This also mirrors the urban-rural breakdown of the Texas population statewide.

CHRISTUS Trinity Mother Frances Health System Report Area Counties
Cherokee County, TX
Delta County, TX
Franklin County, TX
Hopkins County, TX
Rains County, TX
Smith County, TX
Wood County, TX

Individuals between ages 18 and 64 (working-aged adults) constitute 59% of total population. Of the remaining population, 18% are ages 65 and older, 17% are school age children, and 6% are in infancy or early childhood. Overall, the population ages 65 and older are slightly higher than that of the population of Texas (12%). Rains (24%) and Wood (27%) Counties have an even higher population 65 and older.

[3] Health Services and Resources Administration. (2016). List of Rural Counties and Designated Eligible Census Tracks in Metropolitan Counties. Available at https://www.hrsa.gov/sites/default/files/ruralhealth/resources/forhpeligibleareas.pdf

Compared to Texas, the population in the report area has a lower proportion of Hispanic residents. The Hispanic/Latino proportion in the report area more closely resembles that of the US than that of Texas — just over 17% of the report area is Hispanic/Latino, compared to 39% of Texans. African Americans constitute 14% of the report area, while the NH-Asian, NH-Native Hawaiian/Pacific Islander and NH-Native American/Alaska Native categories each comprise less than 4% of the report area population.

Poverty is widespread in the report area, with 41% of report area residents earning annual incomes at or below 200% FPL. Cherokee County has even higher poverty at 49%. Compared to Texas, the report area's unemployment is similar while food insecurity is slightly higher.

With a lengthy history of serving poor and at-risk populations in the region, CTMFHS remains committed to planning proactively for the needs of those who may be medically vulnerable. Race/ethnicity, income, employment, and education are known to predict health risk and health outcomes, ultimately contributing to disparities in well-being across lines of social and economic opportunity. In addition, persons experiencing homelessness, veterans, pregnant or parenting teens, new immigrant families, people living with HIV/AIDS and other hard-to-reach individuals experience unique medical challenges and vulnerabilities to which the health systems that receive them must be prepared to respond. CTMFHS's CHIP for the upcoming triennium reflects the organization's ongoing pursuit of regional health equity and commitment to promote conditions that allow every person to attain the highest possible standard of health.

COMMUNITY HEALTH PRIORITIES

A needs prioritization committee of experts was tasked with reviewing the findings and distilling a broad list of ten indicators (from an even broader list) into a list of five priority health needs for targeted, near-term action. This committee was comprised of both hospital staff and external community health partners who participated in the CHNA formulation. External partners included representatives from the local health department as well as a variety of community-based organizations serving clients in the report area.

Rank	CTMFHS Prioritized Health Needs 2020-2022
1	Behavioral Health
2	High Emergency Department Use
3	Specialty Care and Chronic Illness
4	Primary Care and Elderly Needs
5	Education

Priorities were evaluated according to issue prevalence and severity, based on county and regional secondary data. Input provided by key informants, focus group participants, and other community stakeholders was also heavily considered, especially for priority areas where secondary data are less available. The committee considered a number of criteria in distilling top priorities, including magnitude and severity of each problem, CTMFHS's organizational capacity to address the problem, impact of the problem on vulnerable populations, existing resources already addressing the problem, and potential risk associated with delaying intervention on the problem. The committee's final list of five priority needs is presented in rank order in the above table. This priority list of health needs lays the foundation for CSMHS to remain an active, informed partner in population health in the region for years to come.

Following the needs prioritization committee meeting, hospital staff convened to strategize planned responses to priority health needs, identify potential community partners for planned initiatives, and specifying major actions, sub-actions, and anticipated outcomes of improvement plan efforts. These actions and sub-actions form the basis of a targeted implementation strategy to address the health needs identified in the Community Health Needs Assessment report.

SELECTED IMPLEMENTATION STRATEGIES

Presented in this section are a series of implementation strategies containing the detailed goals and actions CTMFHS will undertake in the coming three-year period to respond to each of the five priority health needs listed above. A priority strategy statement describes each objective and introduces major actions that will be pursued to deliver improvements. Major actions are presented with sub-actions identifying specific partners or resources to be engaged in the improvement effort. Actions and sub-actions are linked with anticipated outcomes, which present a vision of how the status of each health need will change when the actions are completed.

1. Behavioral Health

Behavioral Health is considered the number one community health need in northeast Texas, much like the rest of the State of Texas. Services for patients and their families have long wait times for appointments, little inpatient care availability, and few professionals in the region. The report area also has a growing number of young people and aging adults who need services with very little access or availability. Within the rural communities there is a recurring theme of drug abuse, particularly with meth and opioids.

CTMFHS will work collaboratively with behavioral health providers and community organizations to inform the public about behavioral health and refer patients to existing behavioral health programs and services. CHRISTUS Mother Frances Hospital will continue to provide current support and assistance to these programs and will work to increase access and expand services. As many social factors determine the need for behavioral health services and the ability to comply with treatment, CTMFHS will partner with community-based organizations to address the social and environmental determinants of health.

Major Action(s)	Sub-Actions
1. Expand and support behavioral health services in the community for individuals and families.	1. Support local behavioral health providers (e.g., Alzheimer's Alliance, Samaritan Counseling, Andrews Center, Behavioral Health Leadership Council) to improve access to behavioral health services, including education, counseling, direct patient care, etc. 2. Encourage joint collaborative action among associates, local and state organizations, and government units to improve access to behavioral

Major Action(s)	Sub-Actions
	health services for low income, vulnerable, and the underserved. 3. Offer financial and in-kind support to community organizations involved in the delivery of behavioral health services ***Anticipated Outcome**: Improved access to care, information, and support services for people with or at risk of behavioral health problems; improved stability and effectiveness of behavioral health organizations; more collaborative efforts to improve access to behavioral health services.*
2. Address social & environmental determinants of health	1. Partner with community-based organizations to address the social and environmental determinants of health in order to improve the physical, mental, social, and spiritual well-being of individuals and families. 2. Offer cash, in-kind, and other support to community-based organizations partnering to effect change in the social and environmental determinants of health. ***Anticipated Outcome**: Improved capacity of community-based organizations to address social and environmental determinants of health; new collaborative efforts to address the root causes of ill health, improved community health; improved compliance with behavioral health treatments.*

2. High Emergency Department Use

Care coordination among a team of providers is the most effective way to treat patients with clinically complex care. Such treatment unfolds in time and is beyond the scope of an emergency department. The high costs of emergency department treatment and the lack of a continuum of care make the emergency department the least effective place to receive care. Yet, across America, Texas, and East Texas, emergency rooms are flooded with patients seeking care without addressing the underlying conditions that led to an emergency department visit in the first place.

CTMFHS will work collaboratively with federally qualified health centers (FQHCs) to implement an initiative to reduce inappropriate emergency department use. This will involve a three-pronged strategy consisting of public education, referrals to FQHCs, and continual monitoring to measure impact and hone strategy. CTMFHS will support and work in collaboration with community organizations and not-for-profits to expand services and access with a focus on families living in poverty, people at high risk of disease, and those with ongoing challenges managing existing health conditions.

Major Action(s)	Sub-actions
1. Educate the public on the appropriate use of the Emergency Department and alternative community resources	1. Convene a new or work with an existing collaborative to place appropriate ED use as a collective action item. 2. Develop educational materials about appropriate options for different categories of care. This can include, for example, a "meeting-in-a-box" about inappropriate ED usage and resources for effective prevention and care.[4] 3. Develop a brochure listing resources in the community with assistance from the collaborative. 4. Disseminate educational materials and brochure in coordination with the collaborative at health fairs and other venues. 5. Present using the meeting-in-a-box at multiple venues throughout the community. ***Anticipated Outcome****: The public is better educated about the appropriate use of the ER and community resources available for prevention and care*.
2. Support and expand access to FQHC services as a substitute for inappropriate ER use.[5]	1. Collaborate with FQHCs to develop and implement direct referrals of appropriate patients to FQHCs. 2. Communicate through education (see above), social media, and direct advertising the services and programs offered at FQHCs—in collaboration with the FQHCs and other community partners. ***Anticipated Outcome****: More residents, particularly low income, uninsured, or those with high health needs, will be referred to an FQHC, which will become their medical home. Patients who otherwise would have visited the ER will receive needed care through their primary care provider. Patients who initially visit an ER will be less likely to visit the ER in the future because they will have a medical home.*

[4] A "meeting-in-a-box" is a Power Point template (along with handouts, brochures, etc.) that can be modified for multiple presenters at different community meetings.
[5] Note: This major action also addresses Priority 4: Access to Primary Care and Elderly Needs.

Major Action(s)	Sub-actions
3. Track referrals to FQHCs and inappropriate use of the ED.	1. Provide financial and other support to support an electronic health record (EHR) services to all locations of Tyler Family Circle of Care. 2. Track referrals and patient follow-up for care to FQHC. 3. Monitor the impact of community events and education on uptake of new patients at FQHC. ***Anticipated Outcome**: Improved understanding of the impact of the education and referrals on FQHC enrollment. Improved strategies for increasing referrals and enrollment.*

3. Specialty Care and Chronic Illness

The lack of specialty care, particularly for those with chronic illness was ranked as the third highest priority in the report area. The strategy to address this priority is twofold. First, CTMFHS will continue collaborative efforts at chronic disease prevention. This includes prevention, screening, and health education in the community. These efforts will be targeted to youth to support the adoption of healthy lifestyle behaviors and the elderly as they are most adversely affected by chronic illness. Second, CTMFHS will support efforts to deliver of at least two types of specialty care: orthopedics for youth in low income schools and breast cancer screening and referrals for women, and other outreach programs may be added.

Major Action(s)	Sub-actions
1. Support ongoing and new chronic disease prevention and health promotion programs	1. Provide financial support and work collaboratively with local non-profits on chronic disease prevention, management, and education. 2. Participate in health workshops, special events, and health fairs. ***Anticipated Outcome**: Improved opportunities for people with targeted health needs. Increased knowledge and awareness in the community about how to prevent disease, stay healthy, and seek care. Increase in the number of health promotion events mentioned in local and social media*.

Major Action(s)	Sub-actions
2. Provide free orthopedic services to low income schools, including (1) on-site services and screenings, and (2) free/subsidized orthopedic and sports medicine professionals as needed.	1. Provide sports training to low income school(s) including free pre-participation physicals in collaboration with school-based organizations. 2. Provide on-site support services for potential injuries as requested. 3. Provide areas of care regardless of the student's ability to pay. ***Anticipated Outcome**: Reduction in absenteeism and presenteeism. Early detection and treatment of injuries common in school age children: head injuries, spinal cord conditions, broken bones, etc. Improved overall health.*
3. Provide mammogram programs to low-income women in need of screening in the community through the mobile mammography unit or clinics.	1. Work collaboratively with event organizers, churches, and community based organizations to site mobile unit in locations amenable to use by low income patients. 2. Site mobile unit facilitate walk-ins option in rural clinics and special events. 3. Track the number of low-income mammograms provided in the service area and refer patients as needed. ***Anticipated Outcome**: Early detection and treatment. Increased breast cancer education and awareness. Increased access to screenings at rural locations. Reduced breast cancer screening disparities*.

4. Access to Primary Care and Elderly Needs

This priority is based on the observation that even insured in the report area lack a medical home, a continuum of care, routine preventative care, and care coordination. In addition, many newly eligible Medicare patients in the report area find themselves without a medical home after turning 65, as their provider does not accept Medicare-covered patients. This is concerning, as Medicare patients often have clinically complex care and most benefit from a continuum of care.

CTMFHS will tackle these and other barriers to primary care by (1) support and expand access to FQHCs, (2) enrolling Medicare patients at the most appropriate level of care; and (3) targeting community-based screenings, assessments, and education to low income and the uninsured. In addition, CTMFHS will lay the groundwork for an initiative to ensure that everyone receives needed vaccinations to prevent disease.

Major Action(s)	Sub-actions
1. Support and expand access to FQHC services.	1. Collaborate with FQHCs to develop and implement direct referrals of appropriate patients to FQHCs. 2. Communicate through education (see above), social media, and direct advertising the services and programs offered at FQHCs—in collaboration with the FQHCs and other community partners. 3. Encourage providers to participate with enrolling Medicare patients at the appropriate level. ***Anticipated Outcome**: More providers will accept Medicare patients. Newly eligible Medicare patients will have a medical home with an FQHC or at an appropriate level.*
2. Provide community-based screening, assessments, and education to low income, uninsured, and special request populations.	1. Offer primary care assessments, education, and evaluation to adults (e.g., parents and coaches) and youth at schools using a trainer program and assistance from other professionals. 2. Provide education about safety and injury prevention at schools using a trainer program and with assistance from other voluntary professionals. ***Anticipated Outcome**: Lower critical care issues for students from low income schools*. *Faculty and staff support for CPR and Stop the Bleed programs*.
3. Conduct preliminary analysis and planning to secure vaccines for low income patients and participate in community public health issues focusing on health disparities, hypertension, diabetes, etc. and provide leadership as requested.	1. Review data to estimate vaccine requirements and needed supplies. 2. Engage community to organize a collaborative to support future vaccination promotions and improve knowledge of patient needs and outcomes for other health issues. ***Anticipated Outcome**: New community collaborative. Greater public awareness of importance of vaccinations.*

5. Education

Although one of every four jobs in East Texas is healthcare related, there is a need to attract and maintain health professionals and paraprofessionals. While local universities offer certification and degrees for health professionals and paraprofessionals, there is still a mismatch between the requirements and supplies of various health professionals, particularly in

rural areas. Newly educated health professionals and paraprofessionals often relocate to the larger Texas metropolitan areas. Moreover, the aging of the health professionals and their prospective retirement threaten to open new or exacerbate existing health professional shortages.

Supporting health professional education was identified as a top need to address the attrition of health professionals through retirement or migration. The goals are to (1) support encourage entry into the health professions by young adults and seasoned workers seeking a mid-level career change, and (2) offer training opportunities for health professions through internships and residencies.

CTMFHS is already the provider of choice by local universities offering health professional training programs. Major actions to address this goal would build on, modify, or expand CTMFHS's track record of offering internships, job shadow programs, internships, and other opportunities to introduce the public to careers in the health professions.

Major Action(s)	Sub-actions
1. Maintain and increase education and training opportunities for health professionals while encouraging youth and young adults to enter careers as health professionals or paraprofessionals.	1. Support programs for nursing, pharmacy, allied health professions, and provider continuing education 2. Provide financial and other support for mentoring chaplain/pastoral care program 3. Provide financial and other support to improve fund-raising success for scholarship program 4. Offer job shadowing programs for youth and young adults 5. Support community programs to strengthen K-12 education 6. Support programs and projects in the region that help raise money for scholarships. 7. Provide mentoring opportunities for Associates or programs that provide support to at-risk students. 8. Support Associates to volunteer leadership time for educational programs in all areas. ***Anticipated Outcome****: Increase in number of youths entering job shadowing programs in the health profession. Greater school preparedness and increased financial support for students entering health fields. A greater number of health providers in the area. To provide a more diverse and well-educated community and the ability to help support the needs of the East Texas Region in HealthCare. Ability to support volunteer opportunities with Associates and local non-profits.*

CHRISTUS Trinity Mother Frances Health System would like to thank residents and stakeholders who participated in the focus group to prioritize health needs in the community.