COMMUNITY HEALTH IMPROVEMENT PLAN

2023-2025

CHRISTUS® SHREVEPORT-BOSSIER
Health System

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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 Shreveport-Bossier Health System (CSBHS). In this process, CSBHS directly engages community members and stakeholders to identify the issues of greatest need as well as the largest impediments to health. With this information, CSBHS can better allocate resources towards efforts to improve community health and wellness.

Directing resources toward the greatest needs in the community is critical to CSBHS'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 CSBHS to conduct a CHNA every three years. CSBHS completed similar needs assessments in 2013, 2016 and 2019.

The process CSBHS 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 CSBHS'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 CSBHS'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 Shreveport-Bossier Health System

CHRISTUS Shreveport-Bossier Health System (CSBHS) is a Catholic, nonprofit system owned and operated by CHRISTUS Health. The system has provided high-quality, cost-effective care since 1894. CSBHS features CHRISTUS Highland Medical Center, a 211-bed hospital, with an additional 27 beds offsite at CHRISTUS Bossier Emergency Hospital and CHRISTUS Inpatient Rehabilitation. The staff includes more than 600 physicians, 1,100 employees, and 200 volunteers. For more than 100 years, CSBHS and the Sisters of Charity of the Incarnate Word have been committed to meeting the unanswered needs of the communities they serve.

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 Charity 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," CSBHS 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, CSBHS's total primary service area includes 22 zip codes covering over 406,000 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 parishes: Bossier, Caddo, De Soto, Natchitoches, Red River and Webster (Figure 1).

CHRISTUS SHREVEPORT-BOSSIER HEALTH SYSTEM PSA		
Bossier Parish, LA	**Caddo Parish, LA**	**De Soto Parish, LA**
71112	71129, 71119, 71118, 71115,	71078
71111	71109, 71108, 71107, 71106,	71052
71037	71105, 71104, 71103, 71101	
71006	71047	
Bossier Parish, LA	**Caddo Parish, LA**	**De Soto Parish, LA**
71411	71019	71055

Table 1. Primary Service Area for CSBHS

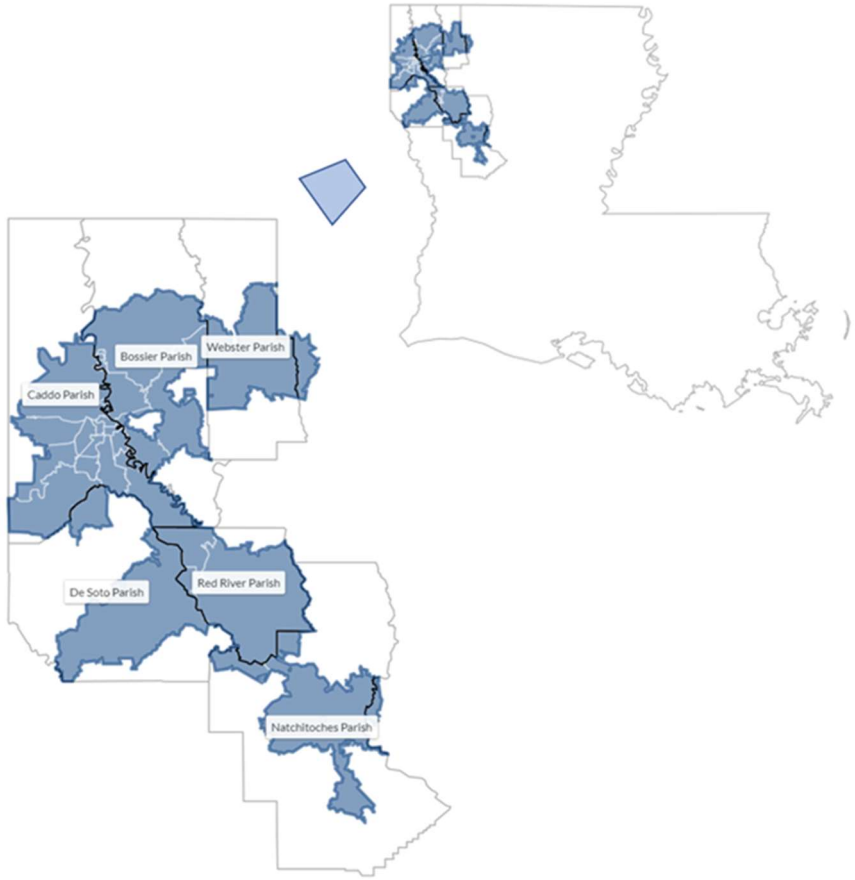

Figure 1. Primary Service Area for CSBHS

Statement of Health Equity

While Community Health Needs Assessments (CHNAs) and Improvement Plans are required by the IRS, CHRISTUS Shreveport-Bossier Health System (CSBHS) 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, CSBHS 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.

CSBHS 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 CSBHS 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 implementation plan, reviews and approves grant funding requests, provides feedback on community engagement activitiesInput 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.

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The CSBHS 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

CSBHS 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 Parish 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 Louisiana Department of Public Health

Community Resident Surveys

Between October and December of 2021, 359 residents in the CSBHS 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 CSBHS and its community partners. The survey sought input from priority populations in the CSBHS 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 CSBHS PSA. This was done through focus groups and key informant interviews.

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

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

In addition to the focus groups, ten key informants were identified by CSBHS's 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

CSBHS used a common set of health indicators to understand the prevalence of morbidity and mortality in the CSBHS PSA and compare them to benchmark regions at the state and the full CHRISTUS Health service area, which covers regions of Texas, Louisiana, Arkansas, and New Mexico. Building on previous CHNA work, these measures have been adapted from the County Health Rankings framework (Figure 3). Where possible, CSBHS used data with stratifications so that health inequities could be explored and better articulated. Given the community input on economic conditions and community safety, CSBHS 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 Shreveport-Bossier 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:

Advance Health and Wellbeing

- Chronic Illness
  - Heart Disease
  - Diabetes
  - Obesity
- Behavioral Health
  - Mental Health
  - Substance Abuse
- Children's Health

2. Build Resilient Communities and Improve Social Determinants

- Improving food access
- Reducing smoking and vaping

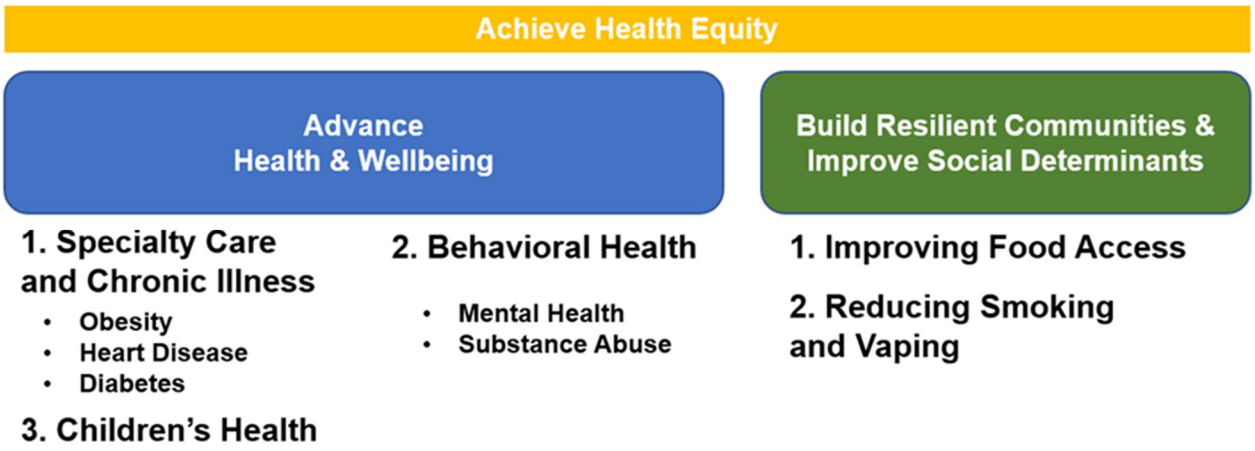

Figure 3. CHRISTUS Shreveport-Bossier Health System Priority Areas

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 Shreveport-Bossier Health System (CSBHS) 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, CSBHS 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 ILLNESS	SPECIALTY CARE AND CHRONIC ILLNESS	BEHAVIORAL HEALTH	CHILDREN'S HEALTH
Prevent and manage risk factors known to worsen morbidity and mortality due to chronic diseases.	Increase access to and enhance oncologic services, education, and prevention activities in the North Louisiana region.	To decrease mental health and substance abuse rates in the community	CHRISTUS Health Shreveport-Bossier will enhance collaboration with local community partners to support regional strategies to ensure child safety and wellbeing

• Expand free/subsidized screenings that include education components • CR Healing Hearts Maintenance Program • Pilot Remote Patient Monitoring for Congestive Heart Failure (CHF) and Congestive Obstructive Pulmonary Disorder (COPD) • Increase access to care • Increase equity of care • MCIP Program • Monthly Health Education Topics Meetings • Partner with MLK Community Center to provide lab testing to patients, increase access to care, and help improve cardiovascular health	• Provide lung cancer screenings with referrals to Lung Nodule Clinic • Provide annual free skin cancer screenings at the Cancer Center • Provide monthly support groups for breast cancer • Provide education to patients in Breast Venter regarding high-risk benign findings • Provide clinical drug trials for different types of cancer • Provide colorectal cancer screenings	• Educate providers on Outpatient Mental Health/Substance Abuse clinics in our community. • Attend quarterly Community Advisory Council meetings at Brentwood Hospital	• Distribute and explain age-appropriate informational folders regarding safety measures to each child and/or parent who is referred for evaluation • Distribute informational folders to the guardians of children seen in the clinic for suspected physical abuse and/or neglect. The folders will contain information regarding how to prevent child physical abuse and how to recognize neglect • Provide the Edinburgh Post-Natal Depression Scale (EPDS) to each patient after delivery to screen for post-partum depression • Provide prenatal classes including prepared childbirth, newborn care, and breast-feeding basics to the community • Partner with Heart of Hope and local HCP to identify young mothers in need of mentoring

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 can be found in the appendix.

And CHRISTUS Health will focus on building a coalition to address Behavioral Health issues in the service area. Partners can be found in the appendix.

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	
IMPROVING FOOD ACCESS	REDUCING SMOKING AND VAPING
Build more resilient communities by improving access to food	Reduce smoking and vaping in the community by providing education to patients and community
• Screen patients for food insecurity and partner with community organizations to offer programs and resources that increase access to healthy foods and raise awareness in the community. Identify food-insecure individuals and households.	• Develop a Tobacco Cessation package to give to patients and educate them on the dangers of tobacco use in any form, as well as provide access to community-based cessation programs • Identify patients who smoke or vape and provide brochures on quitting smoking

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 found in the appendix.

STRATEGIES

Appendix 1: Advance Health & Wellbeing

Specialty Care and Chronic Illness

Goal:

1. Prevent and manage risk factors known to worsen morbidity and mortality due to chronic disease.
2. Increase access to and enhance oncologic services, education, and prevention activities in the North Louisiana region, specifically targeting breast, lung, skin, and colon cancer.

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?* *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?*
Expand free/subsidized screenings that include education components	Provide screening and education opportunities about heart disease. Community members will have increased access to heart disease screening and educational tools, with access to	American Heart Association NSU School of Nursing	Leader/ Collaborator	**Begin:** FY23 Q1 **End:** FY25 Q4		# of people served

		clinical care when necessary					
	CR Healing Hearts Maintenance Program	Provide a program for Phase 2 graduates to continue their exercise program Improve productivity and increase revenue for Cardiac Rehab	Cardiac Rehab Staff (RNs, Exercise Physiologists, and Registered Dieticians	Leader	**Begin:** FY23 Q1 **End:** FY25 Q4		# of participants
	Implementing a pilot program for Remote Patient Monitoring of Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD)	Provide remote monitoring of patients going home with chronic illness (CHF, COPD) to provide monitoring and resources. The anticipated impact is the reduction in readmissions for this population.	Remote Monitoring Package provided to pts. CHF: Blood Pressure Cuff, Scales, O2 Saturation Monitor COPD: Blood Pressure Cuff, O2 Saturation Monitor	Leader	**Begin:** FY23 Q1 **End:** FY25 Q4	Patients in ED or admitted with acute exacerbations of CHF or COPD that do not discharge with services such as HH or facility placement	# of people served
	Increasing Access to Care	Identify and remedy barriers to access for transfers and direct admits. Mainstream direct admit and transfers through CHRISTUS Transfer Center promotion.	EMS Stations Referring providers Facilities	Leader/ Collaborator	**Begin:** FY23 Q1 **End:** FY25 Q4	Rural areas with limited access to healthcare	# of people served

	Increasing Equity of Care	Identify patients with primary diagnosis of hypertension in the Emergency Department.		Leader/ Collaborator	**Begin:** FY23 Q1 **End:** FY25 Q4	All PSA zip codes	# of people served
	MCIP Program	Contact discharged Medicaid Emergency Room Patients who have more than 2 visits in a month or 4 visits in a year			**Begin:** FY23 Q1 **End:** FY25 Q4	All PSA zip codes	# of patient contacted
	Partner with MLK Community Center to provide lab testing to patients, increase access to care, and help improve cardiovascular health	Provide lab testing to help the MLK Community Center serve the underserved	MLK Community Center	Collaborator	**Begin:** FY23 Q1 **End:** FY25 Q4	Uninsured and underinsured in the Shreveport-Bossier PSA.	# of people served

	Monthly Health Education Topics Meetings	Educate the community of Shreveport/Bossier on health initiatives in our area to reduce heart disease, diabetes, and obesity rates in the community.			**Begin:** FY23 Q1 **End:** FY25 Q4	All PSA zip codes	# of participants
	Provide Lung Cancer Screening with Referrals to Lung Nodule Clinic	Increase early detection and provide support and follow up for those patients at risk decreasing comorbidity from these types of cancer	Cancer Treatment Center Nurse Navigator Radiology Dept. Surgeons Primary Care Providers		**Begin:** FY23 Q1 **End:** FY25 Q4	All PSA zip codes	# of people served
	Provide annual free skin cancer screenings at the Cancer Center for early detection of skin cancers	Increase access to skin cancer screenings and education to increase early detection and provide support and follow up for those patients at higher risk. Long term outcomes will decrease morbidity from these types of cancers	Cancer Treatment Center Dermatologists		**Begin:** FY23 Q1 **End:** FY25 Q4	All PSA zip codes	# of people served

	Provide monthly support groups for breast cancer	Promote better outcomes by addressing barriers and increasing emotional support for breast cancer patients	Cancer Treatment Community Outreach Coordinators Breast Cancer Navigator		**Begin:** FY23 Q1 **End:** FY25 Q4	All PSA zip codes	# of particpants
	Provide drug trials for many different types of cancers	Provide access to clinical trial treatment when patients have exhausted other recommended treatments will help extend survival rates in the long run and decrease morbidity	Cancer Center Clinical Research Department Oncologists		**Begin:** FY23 Q1 **End:** FY25 Q4	All PSA zip codes	# of participants
	Provide colorectal screenings for the community	Provide a colorectal screening program to the community for early detection and to decrease morbidity	Cancer Treatment Community Coordinator Lab Physicians		**Begin:** FY23 Q1 **End:** FY25 Q4	All PSA zip codes	# of people served

Behavioral Health

Goal:

To decrease mental health and substance abuse rates in the community.

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?* *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?*
Educate providers on Outpatient Mental Health/Substance Abuse clinics in our community.	Provide resources for providers to refer to their patient base. To decrease mental health and substance abuse rates in the community.	CHRISTUS Community Health Workers	Leader	**Begin:** FY23 Q1 **End:** FY25 Q4	All PSA Zip codes	# of people served
Attend quarterly Community Advisory Council meetings at Brentwood Hospital	Decrease the number of community members who will die from suicide or drug overdose daily in the community.	Brentwood Hospital Community Health Workers ED Managers	Collaborator	**Begin:** FY23 Q1 **End:** FY25 Q4	All PSA Zip codes	# of participants

Children's Health

Goal:

Enhance collaboration with local community partners to support regional strategies to ensure child safety and well-being in CHRISTUS Health North Louisiana Region

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?* *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?*
Distribute and explain age-appropriate informational folders regarding safety measures to each child and/or parent who is referred for evaluation	The children will: • learn about personal body safety • be able to identify trusted adults to tell if something bad has happened or if something/someone is making them uncomfortable • learn the difference between a secret and a surprise	Cara Center	Leader	**Begin:** FY23 Q1 **End:** FY25 Q4	Children ages 4-17 years of age in the PSA parishes, who are suspected to be victims of abuse	# of participants

	Distribute informational folders to the guardians of children seen in the clinic for suspected physical abuse and/or neglect. The folders will contain information regarding how to prevent child physical abuse and how to recognize neglect	Guardians will: • learn about de-escalating emotions before correcting a child's behavior • be able to identify what is considered abuse in the eyes of the law • learn about the negative impacts that child abuse can have later in life	Cara Center	Leader	**Begin:** FY23 Q1 **End:** FY25 Q4	The parents or guardians of children who are referred to Cara Center	# of participants
	Provide the Edinburgh Post-Natal Depression Scale (EPDS) to each patient after delivery to screen for post-partum depression	To identify risk of post-partum depression prior to leaving the hospital	Birthplace Nurses Social Workers OB Physicians Telehealth	Leader	**Begin:** FY23 Q1 **End:** FY25 Q4		# of surveys given
	Provide prenatal classes including prepared childbirth, newborn care, and breast-feeding basics to the community .	Provide education for parents expecting increase participation in collaborative decision-making during hospital stays.	InJoy virtual classes with an in-person follow-up Q&A and Birthplace Tour	Leader	**Begin:** FY23 Q1 **End:** FY25 Q4	Expecting parents in the PSA zip codes	# of participants

	Partner with Heart of Hope and local HCP to identify young mothers in need of mentoring	Provide education on positive parenting, child safety and goal setting to all participants	CHRISTUS Teen Mom Heart of Hope Young Life	Leader/ Collaborator	**Begin:** FY23 Q1 **End:** FY25 Q4	Teen moms and children in the Shreveport-Bossier Area	# of participants

Appendix 2: Build Resilient Communities & Improve Social Determinants

Improving Food Access

Goal:

Build more resilient communities by improving food access.

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?* *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?*

	Screen patients for food insecurity and partner with community organizations to offer programs and resources that increase access to healthy foods and raise awareness in the community. Identify food-insecure individuals and households.	Provide resources for providers to refer their patients with food insecurity.	Community Health Workers Local food banks Providers	Leader	**Begin:** FY23 Q1 **End:** FY25 Q4	Patients with food insecurity Uninsured and underinsured populations in the PSA zip codes	# of people served

Reducing Smoking and Vaping

Goal:

To reduce smoking and vaping by providing education to patients and community

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?* *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?*
Develop a Tobacco Cessation package to give to patients and educate them on the dangers of tobacco use in any form, as well as provide access to community-based cessation programs	Increase awareness of the dangers of tobacco use in any form, including vaping/e-cigarettes. Decrease tobacco use in the community	American Lung Association American Heart Association	Leader	**Begin:** FY23 Q1 **End:** FY25 Q4	All PSA Zip codes	# of participants
Identify patients who smoke or vape and provide brochures on quitting smoking	Increase awareness of the dangers of tobacco use in any form, including vaping/e-cigarettes. Decrease tobacco use in the community	American Lung Association American Heart Association Physicians Clinical Staff	Leader	**Begin:** FY23 Q1 **End:** FY25 Q4	All PSA Zip codes	# of people served