CHRISTUS®
SPOHN

Community Health Improvement Plan

2023 - 2025

Introduction

The Community Health Needs Assessment (CHNA) is a systematic, data-driven approach to determining the health needs of CHRISTUS Spohn Health System's service area. In this process, CHRISTUS Spohn Health System directly engages community members and stakeholders to identify issues of greatest need and the most significant impediments to health. With this information, CHRISTUS Spohn Health System can better allocate resources towards efforts to improve community health and wellness.

Directing resources toward the greatest needs in the community is critical to CHRISTUS Spohn Health System's work as a nonprofit hospital. The Patient Protection and Affordable Care Act added Section 501(r) to the Internal Revenue Service Code, which codified the CHNA for all nonprofit hospitals. The 501(r) addition requires nonprofit hospitals, including CHRISTUS Spohn Health System, to conduct a CHNA every three years. CHRISTUS Spohn Health System completed similar needs assessments in 2012, 2015, and 2018.

The process CHRISTUS Spohn Health System 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 the 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 people 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.

The following report provides an overview of the process used for this CHNA, including data collection methods and sources, results for CHRISTUS Spohn Health System's service area, historical inequities faced by the residents in the service area, and considerations of how COVID-19 has impacted community needs. A subsequent strategic implementation plan will detail the strategies developed and subsequentially employed to address the health needs identified in this CHNA.

To assess the health needs of the CHRISTUS Spohn Health System service area, the CHNA presented data by zip code and county (depending on the available data). Providing localized information highlights the differences and similarities of communities within the CHRISTUS Spohn Health System service area.

Communities of Focus (i.e., Zip Codes/Neighborhoods and Focused Population)

Following 501(r) IRS guidelines as required by the Affordable Care Act, CHRISTUS Spohn's CHNA primary service area includes 20 zip codes covering over 471,000 individuals (Table 1). The primary service area (PSA) is the geographic region that makes up 80% of total hospital utilization. The primary service area zip codes are in the following counties: Aransas, Bee, Brooks, Jim Wells, Kleberg, Nueces, and San Patricio (Figure 1).

While the hospital is dedicated to providing exceptional care to all residents in the region, CHRISTUS Spohn will use the information in this assessment to strategically establish priorities and commit resources to address the critical health issues for the zip codes, counties, and municipalities that comprise the region.

CHRISTUS Spohn Health System PSA			
Aransas County, TX	**Bee County, TX**	**Brooks County, TX**	**Jim Wells County, TX**
78382	78102	78355	78332
Kleberg County, TX	**Nueces County, TX**	**San Patricio County, TX**	
78363	78380, 78401, 78404	78368	
	78405, 78408, 78410	78374	
	78411, 78412, 78413		
	78414, 78415, 78416		
	78418		

Table 1. Primary Service Area (PSA) of CHRISTUS Spohn

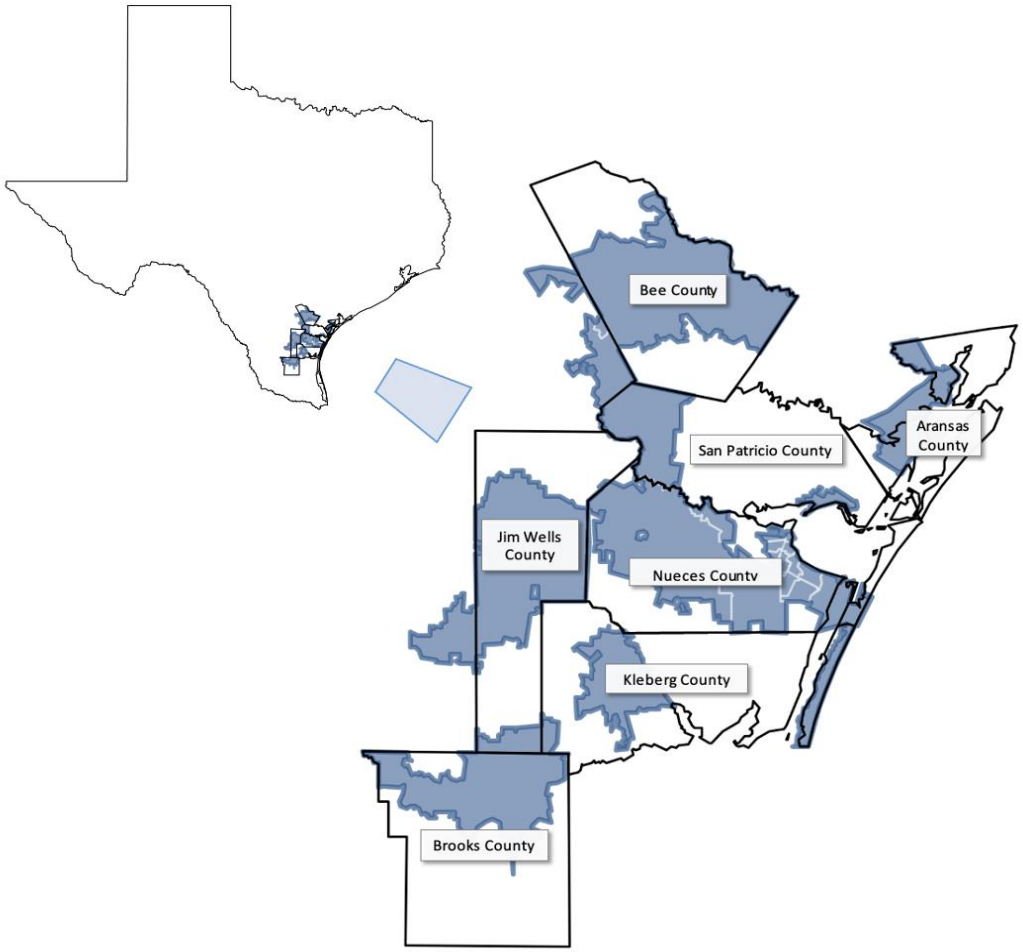

Figure 1. Primary Service Area (PSA) Map of CHRISTUS Spohn

Statement of Health Equity

CHRISTUS Spohn Health System will make its CHNA and strategic implementation plan publicly available online via the CHRISTUS Health website once approved and adopted by the Board of Directors in 2022. In addition, CHRISTUS Spohn Health System will

share the Community Health Implementation Plan with 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.

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, CHRISTUS Spohn worked with Metopio, a software and services company 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 various locations.

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

CHRISTUS Spohn 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 comprises key staff with expertise in areas necessary to capture and report CHRISTUS Spohn 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, and provides feedback on community engagement activities.

Input from community stakeholders was also gathered from CHRISTUS Spohn's community partners. These partners played a crucial 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 CHRISTUS Spohn 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 the 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

CHRISTUS Spohn Health System conducted its CHNA process between September 2021 and March 2022 using an adapted method 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 include, but are 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, 498 residents in the CHRISTUS Spohn 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 occurred through multiple channels led by CHRISTUS Spohn Health System and its community partners. The survey sought input from priority populations in the CHRISTUS Spohn PSA 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 the following:

- 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 or work in the CHRISTUS Spohn PSA. This was done through focus groups and key informant interviews.

During this CHNA, CHRISTUS Spohn 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 CHRISTUS Spohn and the CHRISTUS Health system office and facilitated by Metopio. CHRISTUS Spohn to ensure groups included a broad range of individuals from underrepresented, priority populations in the CHRISTUS Spohn. Focus group health topic areas are listed below:

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

CHRISTUS Spohn conducted its focus groups virtually. Focus groups lasted ninety (90) minutes and had up to fifteen (15) community members participate. In addition to the focus groups, ten (10) key informants were identified by CHRISTUS Spohn for one-on-one interviews. Key informants were chosen based on areas of expertise to validate themes from the surveys and focus groups. Each interview was conducted virtually and lasted thirty (30) minutes.

Secondary Data

CHRISTUS Spohn used a standard set of health indicators to understand the prevalence of morbidity and mortality in the CHRISTUS Spohn PSA and compare them to benchmark regions in the state and the entire 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, CHRISTUS Spohn used stratified data so that health inequities could be explored and better articulated. Given the community input on economic conditions and community safety, CHRISTUS Spohn sought more granular datasets to illustrate hardship.

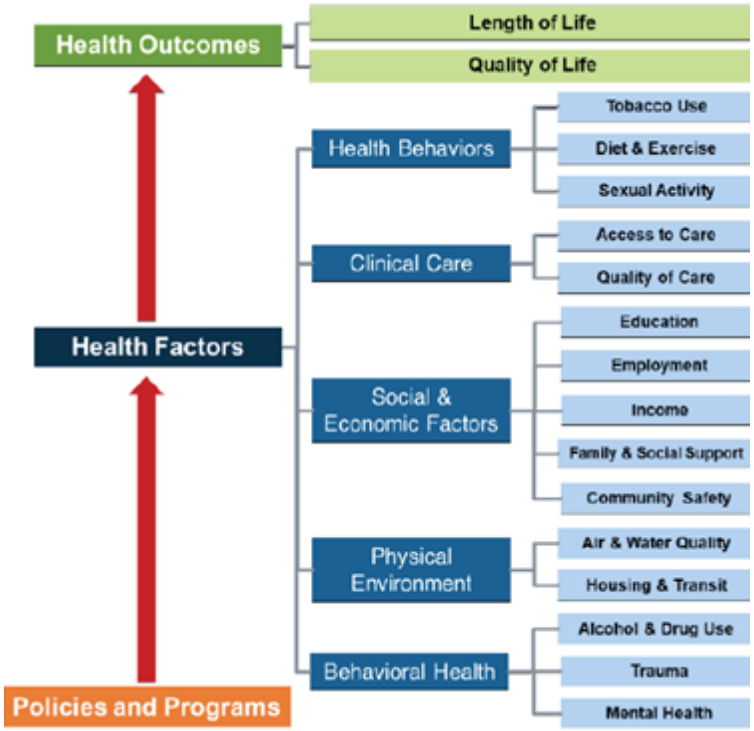

Figure 2. Illustration of the County Health Rankings MAPP Framework

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 in 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 to determine 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?	Community Benefit team
Influence	How much can CHRISTUS Spohn Health System affect change?	Community Benefit team
Values	Does the community care about it?	Survey, Focus Groups, Key Informant Interviews
Root Causes	What are the community conditions?	Community Benefit team

Table 2. Prioritization Framework

Data Needs and Limitations

CHRISTUS Spohn 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; such as:

- 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 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 similar periods or at the same level of localization throughout the county.
- Gaps and limitations persist in data systems for specific 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, presenting a limited view of a community's potential.

With this in mind, CHRISTUS Spohn, Metopio, and all stakeholders deliberately discussed these limitations throughout the development of the CHNA and the selection of the 2023-2025 health priority areas.

Health Priority Areas

For this cycle, CHRISTUS Spohn Health System is using a new structure for its identified needs, categorizing them under two domains with the overarching goal of achieving health equity. While the prioritization structure is new, CHRISTUS Spohn retained mental health as a priority issue from the previous CHNA. In the last iteration of the CHNA, CHRISTUS Spohn identified chronic illness as a priority. In this cycle, CHRISTUS Spohn unpacked "chronic illness" and specifically called out diabetes, heart disease, and obesity. Newly identified issues include substance abuse, housing access, and job training.

Based on community input and analysis of a myriad of data, the priorities for the communities served by CHRISTUS Spohn Health System for 2023-2025 fall into two domains underneath an overarching goal of achieving health equity (Figure 1). The two domains and corresponding health needs are:

1. Advance Health and Wellbeing by addressing
    - Chronic Illness
        - Heart Disease

    - Diabetes
    - Obesity
- Behavioral Health
    - Mental Health
    - Substance Abuse
- Access to Care

2. Build Resilient Communities and Improve Social Determinants by
    - Improving employment by building education and training opportunities
    - Increasing access to housing and wrap-around services

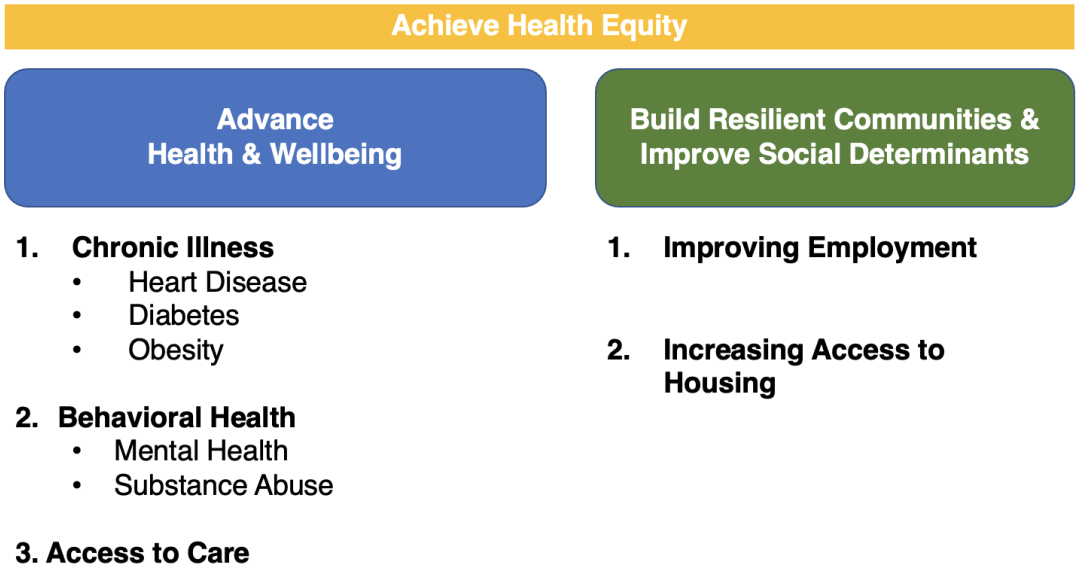

Figure 3. CHRISTUS Spohn Health System Priority Areas

The two domains and their respective health needs will be the principal health concerns CHRISTUS Spohn Health System's Community Health Improvement Plan (CHIP) efforts will target.

Approach to Community Health Improvement Plan

All community benefit investments and programming throughout CHRISTUS Health are built on a framework that promotes health equity and outlined 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 selected health priority area. See Appendix 1 for a fully detailed evaluation framework relating to these strategies.

Health Priority Area 1: Advance Health and Wellbeing

Addressing widespread chronic disease among adults is essential 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.

I. Advance Health and Wellbeing		
Strategies		
CHRONIC ILLNESS	**BEHAVIORAL HEALTH**	**ACCESS TO CARE**
Provide opportunities for education and resource assistance related to heart disease, diabetes, and obesity	**Empower patients by providing resources to combat mental illness or substance abuse**	**Increase access to primary care**
• Continue to utilize our community health workers and nurse navigators to educate, provide resources, and provide case management • Continue community education initiatives focused on diabetes education	• Provide free depression screenings to all Spohn clinic patients • Provide free counseling to all Spohn clinic patients • Expand in-patient behavioral health services	• Offer extended hours at the Quick Care clinic six days a week with no appointment necessary

CHRISTUS Health will continue to invest in care delivery innovations, expand programs that address heart disease, obesity, and diabetes prevention, and improve access to care. Key programs that support these initiatives can be found in appendix 1.

And CHRISTUS Health will focus on building a coalition to address Behavioral Health issues in the service area. Partners include Oceans Healthcare, Nueces Center for Mental Health & Intellectual Disabilities, and Cenikor.

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 on residents seeking a healthy life.

II. Build Resilient Communities & Improve Social Determinants	
Strategies	
IMPROVING EMPLOYMENT	**INCREASING ACCESS TO HOUSING AND WRAP-AROUND SERVICES**
Cultivate and maintain partnerships with clinical education programs	**Support local organizations that focus on providing access to affordable housing or wrap-around services**
• Partner with clinical education programs in the area to provide on-site clinical training to students within CHRISTUS Spohn facilities	• Support the work these organizations are doing by inviting applications for CHRISTUS Fund grants • Sustain and expand the Homeless Leaders' collaborative, who are working to facilitate a results-based accountability approach to mitigate and eliminate homelessness in select Coastal Bend communities

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 can be found in appendix 2.

Throughout the 2023 - 2025 CHIP 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 strategy as circumstances warrant to best serve our community and allocate resources most effectively.

Community Benefit Report Communication

CHRISTUS Spohn Health System will make its CHNA and strategic improvement plan publicly available online via the CHRISTUS Health website once approved and adopted by the Board of Directors in 2022. In addition, CHRISTUS Spohn Health System will

share the Community Health Improvement Plan with 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.

Appendix 1: Advance Health and Wellbeing

Priority Area #1: Chronic Illness							
Population Accountability	**Goal:** *What is our end-result? Desired condition of well-being for a whole population.* Prevent and successfully manage risk factors that worsen morbidity and mortality due to chronic disease(s).						
Program Accountability	**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?* *Leader* *Collaborator* *Supporter*	*When do you expect this activity to begin/end?*	*Who are our customers/the population?* *Zip Code + Demographics* *Equitable Data Infrastructure*	*How much? How well? Is anyone better off?* *Be specific (i.e. # of participants, frequency and duration of intervention, target % behavior change on pre/post tests, pounds of produce, etc.).*
	Continue to provide access to education and free resources related to Heart Disease and Hypertension through Community Health Workers and Nurse Navigators	Community members have increased access to education, organizations, resources, and clinical care related to heart disease.	CHRISTUS Spohn Health System, CHRISTUS Spohn Community Health Development Department, American Heart Association	Leader	**Begin:** FY23 **End:** FY25	The broader Coastal Bend region	# of individuals seen by the Community Health Development department seeking heart disease-related assistance % of individuals that were satisfied with the assistance provided # of individuals that were provided with blood pressure monitors % of individuals that report using the monitor regularly

	Continue to provide access to education, free resources, and in extreme cases, case management related to diabetes through Community Health Workers and Nurse Navigators	Community members have increased access to education, organizations, resources, and clinical care related to diabetes	CHRISTUS Spohn Health System, CHRISTUS Spohn Community Health Development Department	Leader	**Begin:** FY23 **End:** FY25	The broader Coastal Bend region	# of individuals seeking diabetes-related assistance that were seen by the Community Health Development department % of individuals that were satisfied with the assistance provided # of individuals with A1c's 9 or above that are in the case management program % of individuals that reduce their A1c % of individuals that reduce their A1c to less than 7
	Continue to offer diabetic education classes at the Dr. Hector P. Garcia Memorial Family Health Center	Provide individuals with an overview of diabetes and educate them on blood glucose monitoring, carbohydrate counting, meal planning, medication and insulin administration, the benefits of exercising, and the importance of preventing diabetes complications.	CHRISTUS Spohn Health System, Dr. Hector P. Garcia Family Health Center, Texas A&M University Coastal Bend Health Education Center	Collaborator	**Begin:** FY23 **End:** FY25	The broader Coastal Bend region	# of participants registered % of participants that attend # of participants return for follow-up lab work every three months for one year % of participants that show improvements in lab work

Priority Area #1: Behavioral Health

Population Accountability

Goal:

What is our end-result? Desired condition of well-being for a whole population.

Patients will have access to resources that support mental health and/or eliminate substance abuse.

Program Accountability

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?* *Leader* *Collaborator* *Supporter*	*When do you expect this activity to begin/end?*	*Who are our customers/the population?* *Zip Code + Demographics* *Equitable Data Infrastructure*	*How much? How well? Is anyone better off?* *Be specific (i.e. # of participants, frequency and duration of intervention, target % behavior change on pre/post tests, pounds of produce, etc.).*
Continue to provide free depression screenings to all patients at every CHRISTUS Spohn Family Health Center clinic and the Quick Care Clinic	Patients who meet the criteria for a depressive disorder are reviewed by their physician during their visit; if diagnosed with depression, the patient and their physician will create a treatment plan	CHRISTUS Spohn Family Health Centers, CHRISTUS Spohn Quick Care Clinic, CHRISTUS Spohn Community Health Development Department	Leader	**Begin:** FY23 **End:** FY25	Family Health Center Patients and Quick Care Clinic Patients	# of PHQ-2 screenings done % of PHQ-2 screenings positive # of PHQ-9 screenings done % of PHQ-9 screenings positive # of patients being treated for depression in clinics % of patients who believe the treatment has led to an improvement in their symptoms (improved daily function and reduction in relapses)

	Continue to provide free counseling to patients of our Family Health Center Clinics	Patients have access to free counseling through Licensed Professional Counselors and a Licensed Chemical Dependency Counselor to help clients identify goals and potential solutions to problems that cause emotional turmoil; seek to improve communication and coping skills; strengthen self-esteem; and promote behavior change and optimal mental and physical health.	CHRISTUS Spohn Family Health Centers, CHRISTUS Spohn Quick Care Clinic, CHRISTUS Spohn Community Health Development Department	Leader	**Begin:** FY23 **End:** FY25	Family Health Center Patients and Quick Care Clinic Patients	# of patients utilizing counseling services in clinics % of patients utilizing counseling services in clinics # of patients discharged from counseling services % of patients who were satisfied with the services
	Expand behavioral health services in the Coastal Bend region by providing the community with new resources and bridging existing gaps in care.	Increase the hospital's inpatient capacity for adult behavioral health services & ensure access to a full continuum of behavioral health care.	CHRISTUS Spohn Health System, CHRISTUS Spohn Shoreline Hospital, Oceans Healthcare	Collaborator	**Begin:** FY21 **End:** FY23	The broader Coastal Bend region	# of patients treated prior to expansion (FY22) compared to # of patients treated following expansion (FY23)

Priority Area #1: Access to Care

Population Accountability

Goal:

What is our end-result? Desired condition of well-being for a whole population.

Patients will receive the appropriate level of care in the appropriate setting at the appropriate time.

Program Accountability

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?* *Leader* *Collaborator* *Supporter*	*When do you expect this activity to begin/end?*	*Who are our customers/the population?* *Zip Code +* *Demographics* *Equitable Data* *Infrastructure*	*How much? How well? Is anyone better off?* *Be specific (i.e. # of participants, frequency and duration of intervention, target % behavior change on pre/post tests, pounds of produce, etc.).*
Continue operating the Quick Care clinic with extended hours; Offer walk-in access to primary care 6 days a week from 9 am-8 pm with no appointment necessary.	Patients have improved access to primary care services outside of normal operating hours;	CHRISTUS Spohn Health System, Dr. Hector P. Garcia Memorial Family Health Center Quick Care Clinic	Leader	**Begin:** FY23 **End:** TBD	The broader Corpus Christi community	# of patients seeking care at the clinic % of patients seeking care after 5 pm % of patients that report their needs were addressed at the visit

Appendix 2: Build Resilient Communities & Improve Social Determinants

Priority Area #2: Improving Employment							
Population Accountability	**Goal:** *What is our end-result? Desired condition of well-being for a whole population.* Increase professional healthcare knowledge of Coastal Bend residents through various clinical preceptorships.						
Program Accountability	**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?* *Leader* *Collaborator* *Supporter*	*When do you expect this activity to begin/end?*	*Who are our customers/the population?* *Zip Code + Demographics* *Equitable Data Infrastructure*	**Expected Measurable Outcome(s) / Expected Results** *Be specific (i.e. # of participants, frequency and duration of intervention, target % behavior change on pre/post tests, pounds of produce, etc.).*
	Partner with clinical education programs in the area to provide on-site clinical training to students within our facilities	Students enrolled in clinical education programs will gain experience through supervised clinical rotations in various locations throughout the Spohn system.	CHRISTUS Spohn Health System, Texas A&M – Corpus Christi, Texas A&M University, Del Mar College, Coastal Bend College	Collaborator	**Begin:** FY23 **End:** FY25	The broader Coastal Bend region	# of clinical education programs supported by Spohn # of clinical students hosted per semester % of students that apply to Spohn per semester

Priority Area #2: Increasing Access to Housing & Wrap-Around Services

Population Accountability

Goal:

What is our end-result? Desired condition of well-being for a whole population.

All Coastal Bend residents will have access to safe and affordable housing.

Program Accountability

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?* *Leader* *Collaborator* *Supporter*	*When do you expect this activity to begin/end?*	*Who are our customers/the population?* *Zip Code + Demographics* *Equitable Data Infrastructure*	**Expected Measurable Outcome(s) / Expected Results** *Be specific (i.e. # of participants, frequency and duration of intervention, target % behavior change on pre/post tests, pounds of produce, etc.).*
Support local organizations and efforts that advocate for affordable housing and provide wrap-around services in our area by inviting them to apply for a CHRISTUS Fund grant	Improved education and access to housing & housing-related services created by local government and/or local organizations	CHRISTUS Spohn Health System, City of Corpus Christi, Local Shelters	Supporter	**Begin:** FY23 **End:** FY25	The City of Corpus Christi	One or more local organization(s) will receive a CHRISTUS fund grant to improve education or access to housing or housing-related services.

	Sustain the Homeless Leader's collaborative	Create and implement a multi-faceted collaborative approach to combat and eliminate homelessness in the Coastal Bend.	CHRISTUS Spohn, Metro Ministries, Catholic Charities, Diocese of Corpus Christi, Coastal Bend Center for Independent Living, The Purple Door, Coastal Bend Wellness Foundation, and The Salvation Army	Leader Collaborator	**Begin:** September 2022 **End:** TBD	The homeless population of the Coastal Bend	# of organizations participating % of organizations who believe collaboration and shared responsibility are beneficial # of homeless individuals in the Coastal Bend in 2022 vs. # of homeless individuals in 2025 (as counted by the point in time count)