COMMUNITY HEALTH IMPROVEMENT PLAN

2023-2025

CHRISTUS®
ST. FRANCES CABRINI
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 St. Frances Cabrini Health System. In this process, they directly engage community members and stakeholders to identify the issues of greatest need as well as the largest impediments to health. With this information, CHRISTUS St. Frances Cabrini 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 St. Frances Cabrini Health System's work as a nonprofit healthcare provider. The critical 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 CHRISTUS St. Frances Cabrini Health System, to conduct a CHNA every three years. CHRISTUS St. Frances Cabrini Health System completed similar needs assessments in 2012, 2015, and 2018.

The process CHRISTUS St. Frances Cabrini 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 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 CHRISTUS St. Frances Cabrini Health System's 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 CHRISTUS St. Frances Cabrini Health System's service area.

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

CHRISTUS St. Frances Cabrini Health System Overview

CHRISTUS St. Frances Cabrini Hospital

CHRISTUS St. Frances Cabrini Hospital is a non-profit hospital system serving Alexandria, Louisiana and surrounding parishes in Central Louisiana. CHRISTUS St. Frances Cabrini Hospital, located in Alexandria Louisiana, is a 293-bed facility employing approximately 1,600 Associates and a medical staff of over 325 physicians. It offers comprehensive inpatient and outpatient services and is accredited by the Joint Commission.

CHRISTUS Dubuis Hospital of Alexandria

CHRISTUS Dubuis Hospital of Alexandria, LA is a long-term acute care hospital (LTAC) located within CHRISTUS St. Frances Cabrini Hospital. It is owned and operated by a joint venture between LHC Group of Lafayette, LA and CHRISTUS Health. Currently, the hospital is licensed for 25 LTACH beds and has the pleasure of serving approximately 280 patients annually (most are adults). It also provides employment for approximately 75 persons.

CHRISTUS Savoy Medical Center

Savoy Medical Center, managed under Christus St Frances Cabrini Hospital, is a 501-C3 Non-Profit, 60-Bed Acute Care facility located approximately 50 miles south of Alexandria in the town of Mamou in Evangeline Parish. The facility includes 6 beds designated for Intensive Care, a 24-Hour Emergency Department, 22 Acute Care Beds, 5 Private Physical Rehabilitation Beds, 24 beds for Beyond the Horizons a 28-day Residential Substance Abuse Program, and 27 Psychiatric & Medical DETOX Beds at NEW HORIZONS located on the SMC Campus. Additional services include SAVOY Cancer Center providing Chemotherapy, Radiation, and other Outpatient Infusions, a full-service Outpatient Laboratory, Respiratory Department, Radiology Department including MRIs and 3D Mammography, and 5 Rural Health Clinics located within a 30-mile radius in Mamou, Ville Platte, Eunice, Basile, and Elton.

CHRISTUS Coushatta Health Care Center

Compromised of a hospital, dental clinic and multiple rural health clinics, CHRISTUS Coushatta Health Care Center provides a network of services and facilities that collaborate to provide the medical, surgical and wellness needs of the communities. Specialty services such as general surgery, podiatry, cardiology, ophthalmology, cancer care and obstetrics & gynecology as well as a full-service emergency room. CHRISTUS Coushatta Health Care Center has been committed to improving health and serving the community so we may fulfill our mission to extend our healing ministry of Jesus Christ.

CHRISTUS Health

CHRISTUS Health is a Catholic health system formed in 1999 to strengthen the faith-based health care ministries of the Congregations of the Sisters of the Incarnate Word of Houston and San Antonio that began in 1866. In 2016, the Sisters of the Holy Family of Nazareth became the third sponsoring congregation to CHRISTUS Health. Today, CHRISTUS Health operates 25 acute care hospitals and 92 clinics in Texas. CHRISTUS Health facilities are also located in Louisiana, Arkansas, and New Mexico. It also has 12 international hospitals in Colombia, Mexico and Chile. As part of CHRISTUS Health's mission "to extend the healing ministry of Jesus Christ," CHRISTUS St. Frances Cabrini Hospital 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, CHRISTUS St. Frances Cabrini Health System's CHNA primary service area includes 32 zip codes (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:

Acadia, Allen, Avoyelles, Calcasieu, Catahoula, Concordia, Grant, LaSalle, Natchitoches, Rapides, St. Landry, Vernon and Winn. Figure 3 demonstrates the primary service area of CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Dubuis Hospital of Alexandria and CHRISTUS Savoy Medical Center and Figure 4 demonstrates the primary service are of CHRISTUS Coushatta Health Care Center

While the hospital is dedicated to providing exceptional care to all of the residents in the region, CHRISTUS St. Frances Cabrini Health System will use the information in this assessment to strategically establish priorities and commit resources to address the key health issues for the zip codes, parishes and municipalities that comprise the region.

CHRISTUS ST. FRANCES CABRINI HEALTH SYSTEM PSA			
Acadia Parish	Allen Parish	Avoyelles Parish	Calcausie Parish
70515	71463	71341	70601
	71303	71350	
	71322	71351	
Catahoula Parish	Concordia Parish	Evangeline Parish	Grant Parish
71343	71334	70554	71417
		70576	71423
		70586	71467
LaSalle Parish	Natchitoches Parish	Rapides Parish	St. Landry Parish
71342	71457	71301, 71302, 71328	70535
		71346, 71360, 71405	70570
		71409, 71433, 71485	
Vernon Parish	Winn Parish		
71403	71483		
71446			

Table 1. Primary Service Area of CHRISTUS St. Frances Cabrini Health System

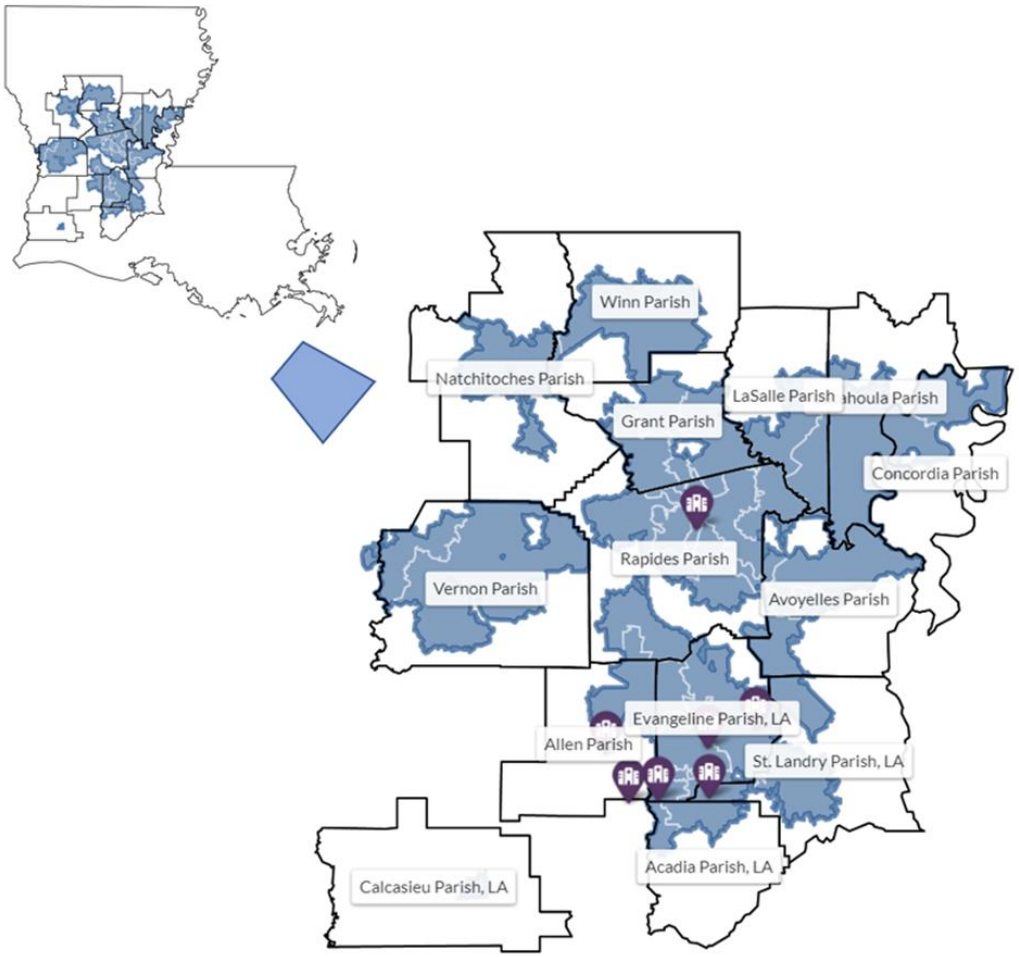

Figure 1. Map of CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Dubuis Hospital of Alexandria and CHRISTUS Savoy Medical Center PSA

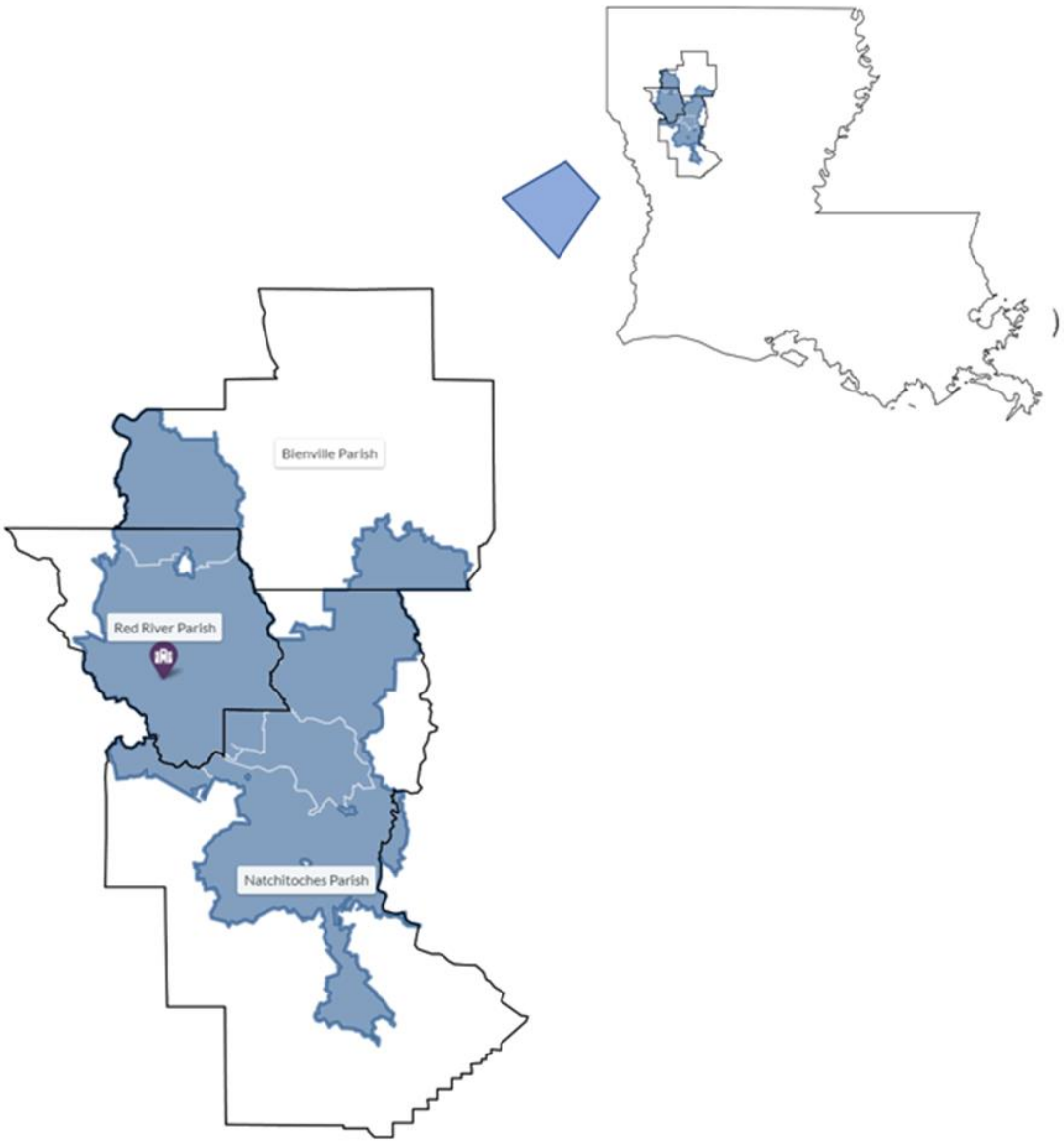

Figure 2. Map of CHRISTUS Coushatta Health Care Center PSA

Statement of Health Equity

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

COMMUNITY HEALTH NEEDS ASSESSMENT

Community Health Needs Assessment

Stakeholder Engagement

The CHNA process involved engagement with several internal and external stakeholders to collect, curate and interpret primary and secondary data. That data was then used to prioritize the health needs of the community. For this component, CHRISTUS St. Frances Cabrini Health System 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 CHRISTUS St. Frances Cabrini Health System guided the strategic direction of Metopio through roles on various committees and workgroups.

CHRISTUS St. Frances Cabrini Health System 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 CHRISTUS St. Frances Cabrini Health System 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 activities

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

The CHRISTUS St. Frances Cabrini Health System 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

CHRISTUS St. Frances Cabrini Health System conducted its CHNA process between September 2021 and March 2022 using an adapted process from the Mobilizing for Action through Planning and Partnerships (MAPP) framework. This planning framework is one of the most widely used for CHNAs. It focuses on community engagement, partnership development and seeking channels to engage people who have often not been part of decision-making processes. The

MAPP framework was developed in 2001 by the National Association for County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC).

Primary data for the CHNA was collected through four channels:

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

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

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

Community Resident Surveys

Between October and December of 2021, 351 residents in the CHRISTUS St. Frances Cabrini 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 CHRISTUS St. Frances Cabrini Health System and its community partners. The survey sought input from priority populations in the CHRISTUS St. Frances Cabrini Health System 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 CHRISTUS St. Frances Cabrini Health System PSA. This was done through focus groups and key informant interviews.

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

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

Secondary Data

CHRISTUS St. Frances Cabrini Health System used a common set of health indicators to understand the prevalence of morbidity and mortality in the CHRISTUS St. Frances Cabrini Health System PSA and compare them to benchmark regions at the state and the full CHRISTUS Health service area. Building on previous CHNA work, these measures have been adapted from the County Health Rankings MAPP Framework (Figure 3). Where possible, CHRISTUS St. Frances Cabrini Health System used data with stratifications so that health inequities could be explored and better articulated. Given the community input on economic conditions and community safety, CHRISTUS St. Frances Cabrini Health System sought more granular datasets to illustrate hardship.

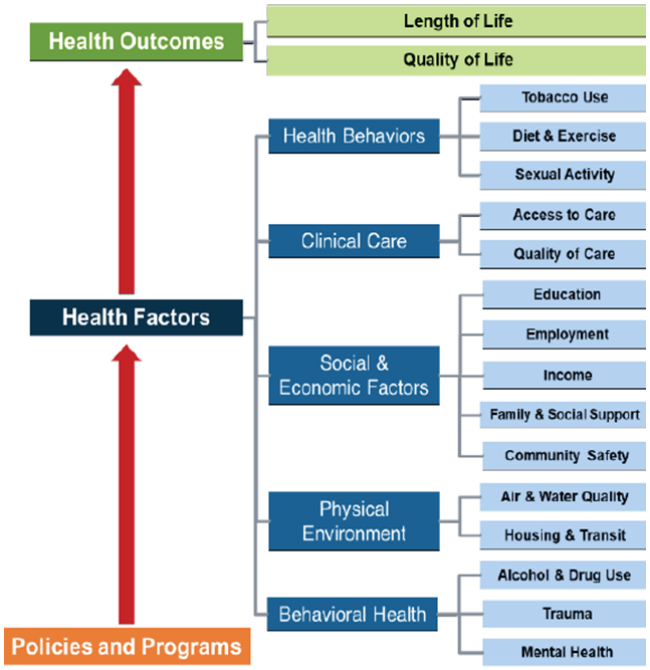

Figure 3. Illustation of the County Health Rankings MAPP Framework

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 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

CHRISTUS St. Frances Cabrini Health System 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 parish.
- 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, CHRISTUS St. Frances Cabrini Health System, 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

For this cycle, CHRISTUS St. Frances Cabrini and CHRISTUS Coushatta Health Care Center are using a new structure for the identified needs, categorizing them under two domains with the overarching goal of achieving health equity. While the prioritization structure is new, CHRISTUS St. Frances Cabrini and CHRISTUS Coushatta Health Care retained mental health as a priority issue from the previous CHNA. In this cycle, CHRISTUS St. Frances Cabrini and CHRISTUS Coushatta Health Care unpacked "chronic illness" and specifically call out diabetes, heart disease and obesity. Newly identified issues include substance abuse, food access, reducing smoking and vaping and childhood well-being.

CHRISTUS St. Frances Cabrini Health System Priority Areas

Based on community input and analysis of a myriad of data, the health needs of the communities served by CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Dubuis Hospital of Alexandria, and CHRISTUS Savoy Medical Center 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

1. Specialty Care and Chronic Illness
    - Diabetes
    - Obesity
    - Heart Disease
2. Behavioral Health
    - Mental Health
    - Substance Abuse
3. Pediatric Access
4. Early Education

Build Resilient Communities and Improve Social Determinants

1. Improving Food Access
2. Reducing Smoking and Vaping

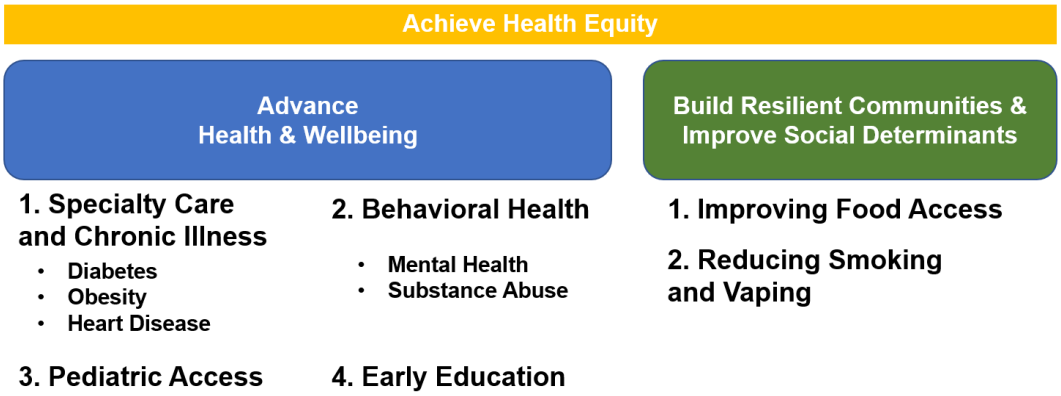

Figure 4. CHRISTUS St. Frances Cabrini Hospital, CHRISTUS Dubuis Hospital of Alexandria and CHRISTUS Savoy Medical Center Priority Areas

CHRISTUS St. Frances Cabrini Health System acknowledges the wide range of priority health issues that emerged from the CHNA process and determined that it could effectively focus on only those health needs which are the most pressing, under- addressed and within its ability to influence. CHRISTUS St. Frances Cabrini Health System does not intend to address the following health needs at this time:

- Early Education
- Reducing Smoking and Vaping

This implementation plan specifies community health needs that the hospital, in collaboration with community partners, has determined to address. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During these three years, other organizations in the community may decide to address certain needs, indicating that the hospital then should refocus its limited resources to best serve the community.

CHRISTUS Coushatta Health Care Center

Based on community input and analysis of a myriad of data, the priorities for the communities served by CHRISTUS Coushatta Health Care Center 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

1. Specialty Care and Chronic Illness
    - Diabetes
    - Obesity
    - Heart Disease
2. Behavioral Health
    - Mental Health
    - Substance Abuse
3. Children's Health

Build Resilient Communities and Improve Social Determinants

1. Improving Food Access
2. Reducing Smoking and Vaping

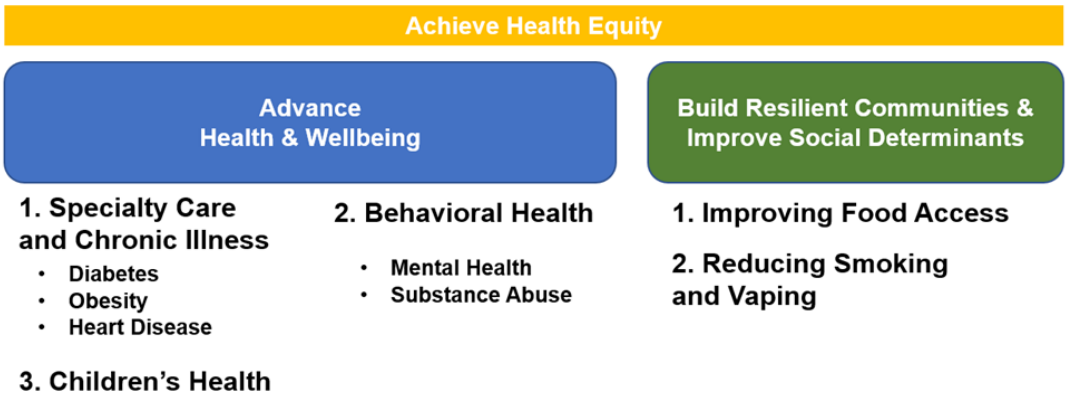

Figure 5. CHRISTUS Savoy Medical Center Priority Areas

CHRISTUS Coushatta Health Care Center acknowledges the wide range of priority health issues that emerged from the CHNA process and determined that it could effectively focus on only those health needs which are the most pressing, under- addressed and within its ability to influence. CHRISTUS Coushatta Health Care Center does not intend to address the following health needs at this time:

- Behavioral Health
- Children's Health
- Improving Food Access

This implementation plan specifies community health needs that the hospital, in collaboration with community partners, has determined to address. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During these three years, other organizations in the community may decide to address certain needs, indicating that the hospital then should refocus its limited resources to best serve the community.

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 the appendices for a fully detailed evaluation framework relating to these strategies.

Community Benefit Report Communication

CHRISTUS St. Frances Cabrini Health System, CHRISTUS Dubuis Hospital of Alexandria and CHRISTUS Savoy Medical Center will make their CHNA and strategic improvement plan publicly available online via the CHRISTUS Health website once it is approved and adopted by the Board of Directors in 2022. In addition, CHRISTUS St. Frances Cabrini Health System, CHRISTUS Dubuis Hospital of Alexandria and CHRISTUS Savoy Medical Center 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	SPECIALTY CARE AND CHRONIC ILLNESS	SPECIALTY CARE AND CHRONIC ILLNESS
Provide screening and education for heart disease, diabetes, and obesity	Empower community members to manage heart disease, diabetes, and obesity	Increase access to care	Reduce inequities caused by cultural barriers to care
• Expand free/subsidized screenings that include education components • Continue community education initiatives focused on chronic disease prevention	• CSFCHS Sponsored Health Fairs with a Holistic Approach to better health including healthy eating, healthy lifestyle changes, and managing health	• Assist patients with healthcare navigation • Encourage patients to establish care with a primary care physician • Medicaition list	• Train healthcare staff in cultural competency, shared decision-making and plain language
BEHAVIORAL HEALTH	PEDIATRIC ACCESS		
Provide early identification, resources, and follow-up care to mental health	All students enrolled in schools with School Based Health Centers (SBHCs) will have access to pediatric care, services and referrals needed.		
• Provide mental health risk screenings and referrals in School Based Health Centers (SBHCs) • Provide screenings and treatment for depression	• All students enrolled in schools with School Based Health Centers (SBHCs) will have a signed consent to be seen in the SBHC. • All students having consent will be scheduled and seen in the SBHC (i.e. mental health screenings, chronic care, medical screenings, etc.)		

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 appendices.

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

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

BUILD RESILIENT COMMUNITIES & IMPROVE SOCIAL DETERMINANTS			
IMPROVE FOOD ACCESS	IMPROVE FOOD ACCESS	IMPROVE FOOD ACCESS	REDUCE SMOKING AND VAPING
Cultivate and maintain partnerships to improve access to healthy food in food deserts	Provide nutrition education for patients	Provide resources	Increase awareness of smoking and vaping effects
• Working with Local Organizations such as the Food Bank and Louisiana Central to ensure greater access to Healthy Choices Foods, through events such as CSFCH sponsored Health Fairs	• Through Diabetes Care & Education, CHRISTUS Trinity Clinics and IWCC, patients will receive nutrition and healthy cooking education to improve social determinants.	• Promotion of Food Prescription, SNAP, Home Food Delivery and Community Garden (SBHCs) programs to patients throughout the CSFCHS PSA.	• Provide education

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 the appendices.

STRATEGIES

Appendix 1: CHRISTUS St. Frances Cabrini Hospital

Specialty Care and Chronic Illness

Diabetes

Goal:

1. Improve prevention and management of diabetes and related health concerns in the community by increasing health/disease education offerings and provide chronic disease prevention, referral, and management services in a wide variety of settings, such as health fairs, hospital diabetes care and education and other departments, school-based health centers and community clinics.
2. Improve the quality of life of people with diabetes, people who are at risk of developing diabetes, and their families in our community through expansion of diabetes services, improved access to an endocrinologist, and improved social support.

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?*
1a. School Based Health Center (SBHC) staff will conduct/coordinate health information presentations and screenings for school staff, students and families 1b. SBHC staff will disseminate educational and	Increase health literacy and community screening opportunities through partnerships and education	CTCLC nursing students SBHC staff Community health fair service providers	Leader and Collaborator	**Begin:** School Year 2022-2023 **End:** School Year 2024-2025	Students, parents, and staff of schools with a CHRISTUS SBHC site.	• Number of participants screened for diabetes/pre-diabetes • Percentage of participants in SBHC services were screened • Number of participants referred for follow-up due to abnormal results • Percentage of participants with abnormal results

	resource materials such as informational brochures/ fliers to school staff, parents, and students enrolled in centers						receiving follow-up services
	2a. Students enrolled in the SBHC will be screened for risk of diabetes/prediabetes and body mass index (BMI) will be assessed and recorded. 2b. A1C screenings will be completed on all students identified at risk and BMI will be recorded. 2c. Any student identified with an abnormal or abnormal BMI will be educated on nutrition and physical activity and scheduled for a follow-up visit with SBHC. 2d. Students showing no improvement will be referred to their PCP or dietician for a definitive diagnosis and treatment planning.	2a. Increase opportunities for wellness screenings to identify risk for diabetes/prediabetes . 2b. Decrease the number of students with abnormal A1C and abnormal BMI scores. 2c. Increase % of students receiving education and follow-up visits. 2d. Show improvement based on the decrease % of students needing referral for additional services.	CHRISTUS Health Advocacy Office CSFCHS Leadership CHRISTUS Health HEDI office	Leader And Collaborator	**Begin: School year 2022-23** **End: School year 2024-25**	Students enrolled in CHRISTUS CLA SBHC.	• Number of students received BMI / A1C screenings. • Percentage of students seen in health center screened: • Number of students whose A1C score and/or BMI showed improvement within 3 months. • Percentage of students whose A1C score and/or BMI showed improvement within 3 months:

	3a. Community Clinic patients will be screened for Diabetes per Hemoglobin A1C 3b. Community clinic patients found to have abnormal Hemoglobin A1C will be educated on nutrition and physical activity 3c. Community clinic patients seen in Urgent Care that are found to have abnormal Hemoglobin A1c will be treated and referred to a Primary Care Provider. 3d. Healthy Living Education with resources from the AMA	Identify and treat those patients who have diabetes.	Community Clinic staff & providers American Diabetes Association	Leader	Begin: FY23 Quarter 2 End: FY25 Quarter 4	Patients seen at Community Clinics in primary care between the ages of 18-75 years old with a diabetes documented history or active diagnosis of diabetes during the measurement period or year prior to the measurement period.	• Number of Hemoglobin A1c screenings done in primary care • Percentage of patients who have Hemoglobin A1c equal to or below 9 • 3e. Number of patients seen by Dr. Zapatero.
	3e. Dr Zapatero provides a Primary clinic on Fridays treating Spanish speaking patients. This clinic treats but is not limited to Hypertensive and Diabetic patients.	3e. Increase compliance and disease management of patients with language barriers	3e. Spanish speaking physician Dr Zapatero. Education materials printed in Spanish.	Collaborator		Spanish speaking patients with poorly controlled Diabetes	

	4a. Expand services at the Healthy learning Center to reach a greater number of people, including the Hispanic and African American populations through marketing and referrals 4b. Host, collaborate and participate in health fairs to include and provide health education, resources, and screenings when possible 4c. Project Power Community Partner for the ADA's Project Power Youth for kids aged 5-12 and Project Power Adult for diabetes and obesity prevention. *see description under priority # Obesity.	To promote education among our SBHCs, diabetes and heart patients, and the community at large at Health Fairs. To break down barriers to food access and healthier food choices for better health outcomes.	Local food banks Louisiana Central CSFCH Clinics CHRISTUS Trinity Clinics CSFCH Staff SBHCs	Leader, Collaborator and Supporter (Depending on what is needed to promote any said program.)	Begin: Calendar Year 2023 End: Calendar Year 2025	Adult Participants referred for Diabetes Self-Management Education & Support services	• Number of HEAL participants - (Group participants) - (Individual participants) • Number of Hispanic participants • Number of African American participants • Number of people screened and/or educated at health fair events • Number of kids aged 5-12 enrolled in Project Power • % Increase in total number of participants • % Increase in Hispanic participants • % Increase in African Americans participants • %Increase in number of people screened and/or educated at health fair events • % Increase in number of kids aged 5-12 enrolled in Project Power • Number of participants who completed the HEAL program • Number of Hispanic participants who completed the HEAL program • Number of African American participants who completed the HEAL program • Number of people who report better health or increased knowledge because of screenings

							and/or education at health fair events • Number kids aged 5-12 who complete Project Power • % Of HEAL participants whose hemoglobin A1c lowered compared to initial hemoglobin A1c levels • % Of Hispanic HEAL participants whose hemoglobin A1c lowered compared to initial hemoglobin A1c levels • % Of African American HEAL participants whose hemoglobin A1c lowered compared to initial hemoglobin A1c levels • % Of increase in people who report better health or increased knowledge because of screenings and/or education at health fair events

Heart Disease

Goal:

1. Improve prevention and management of diabetes and related health concerns in the community by increasing health/disease education offerings and provide chronic disease prevention, referral, and management services in a wide variety of settings, such as health fairs, hospital diabetes care and education and other departments, school-based health centers and community clinics.
2. Improve the quality of life of people with diabetes, people who are at risk of developing diabetes, and their families in our community through expansion of diabetes services, improved access to an endocrinologist, and improved social support.

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?*
1a. SBHC staff will conduct/coordinate health information presentations and screenings for school staff, students and families. 1b. SBHC staff will disseminate educational and resource materials	Increase health literacy through partnerships and education.	CTCLC- nursing students SBHC staff Community Health Fair service providers	Leader and Collaborator	**Begin:** School year 2022-23 **End:** School year 2024-25	Students, parents, and staff of schools with a CHRISTUS CLA SBHC site.	• Number of participants screened for hypertension • Percentage of school population screened: • Number of participants referred for follow-up to PCP.

	such as informational brochures/ fliers to school staff, parents, and students enrolled in centers.						
	2a. Students enrolled in the SBHC will be screened for risk of heart disease. 2b. Hypertension screenings will be completed on all students at risk and blood pressure (BP) will be recorded. 2c. BMI screenings will be completed on all students and recorded. 2d. Any student identified with an elevated BP or obesity will be educated on nutrition and physical activity and scheduled for a follow-up visit with SBHC. 2e. Students showing no improvement will be referred to their PCP or dietician for a definitive diagnosis and treatment planning.	2a. Increase opportunities for wellness screenings to identify risk for heart disease. 2b. Decrease % of students at risk for heart disease. 2c. Increase BMI and hypertension screenings to be conducted in SBHC 2d. Improve follow up procedures for elevated BMIs and BP. 2e. Improve referral documentation and process.	PCPs SBHC medical staff Local dieticians	Leader and Collaborator	**Begin:** School year 2022-23 **End:** School year 2024-25	Students enrolled in CHRISTUS CLA SBHC.	• Number of students received BMI / Hypertension screenings • Percentage of student population screened • Number of students whose BP and/or BMI showed improvement within 3 months

	3a. Community Clinic patients will be screened for Hypertension. 3b. Community clinic patients found to have Hypertension will be treated and educated on Hypertension. 3c. Community clinic patients seen in Urgent Care that are found to be Hypertensive will be treated and referred to a Primary Care Provider. 3d. Healthy Living Education with resources from the AMA 3e. Resources to support healthy living?	Identify and treat those patients who are hypertensive. Blood pressure maintained <140/90	Community Clinic staff and providers American Heart Association	Leader and Collaborator	Begin: FY 2023 Quarter 1 End: FY 25 Quarter 4	Community Clinic Patients 18 - 85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (< 140/90 mmHg) during the most recent encounter of the measurement period.	• Number of patients screened in Primary care for hypertension • Average Percentage of patients who have a BP <140/90 • Percentage baseline currently is 66% Target >78 • 3f. Number of Trained Staff • 3g. Number of patients seen by Dr. Zapatero.
	3f. Train healthcare staff in cultural competency, shared decision-making and plain language	3f. Reduce inequities caused by cultural barriers to care	3f. CHRISTUS Health HEDI System Office, CSFCHS Leadership	Leader		3f. Patients who face inequities caused by cultural barriers and the CSFCHS staff who care for them.	
	3g. Dr Zapatero provides a Primary clinic on Fridays treating Spanish speaking patients. This clinic treats but	3g. Increase compliance and disease management of patients with language barriers.	3g. Spanish speaking physician Dr Zapatero. Education	Collaborator		Spanish speaking patients with poorly controlled Hypertension.	

	is not limited to Hypertensive and Diabetic patients.		materials printed in Spanish.				

Obesity

Goal:

1. Improve prevention and management of diabetes and related health concerns in the community by increasing health/disease education offerings and provide chronic disease prevention, referral, and management services in a wide variety of settings, such as health fairs, hospital diabetes care and education and other departments, school-based health centers and community clinics.
2. Improve the quality of life of people with diabetes, people who are at risk of developing diabetes, and their families in our community through expansion of diabetes services, improved access to an endocrinologist, and improved social support.

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?*
1a. BMI screenings will be completed on all students being seen in the health centers. 1b. Any student identified with an elevated BMI will be	1a. Increase opportunities for wellness screenings to identify risk for chronic disease.	PCPs SBHC medical staff Local dietitians	Leader and Collaborator	Begin: School year 2022-23 End:	Students enrolled in CHRISTUS CLA SBHC.	• Number of students who received BMI screenings • Percentage of student population screened • Number of students whose BMI showed improvement within 3 months • Percentage of students whose BMI showed

	educated on nutrition and physical activity and scheduled for a follow-up visit with SBHC. 1c. Students showing no improvement within 3 months will be referred to their PCP or dietician for a nutritional consult and treatment planning.	1b. Decrease % of students with abnormal BMI. 1c. Improve follow up procedures for elevated BMIs. 1d. Improve referral documentation and process.			School year 2024-25		improvement within 3 months
	2. Project Power Community Partner: Project Power Youth is an obesity prevention program that tackles childhood obesity and helps reduce its consequences.	Prevent childhood obesity and pre-diabetes Promotion of making healthy food choices, increased physical activity, and building family and peer support	ADA	Leader Collaborator Supporter	Begin: School year 2022-2023 End: School Year 2024-2025	Elementary/Middle School Districts in Acadia, Allen, Avoyelles, Calcasieu, Catahoula, Concordia, Grant, LaSalle, Natchitoches, Rapides, St. Landry, Vernon, and Winn Parishes	• Number of kids aged 5-12 enrolled in Project Power • % Increase in number of kids aged 5-12 enrolled in Project Power • Number of kids aged 5-12 who complete Project Power • % Of increase of kids aged 5-12 who complete Project Power
	3.Promotion of and increased access to Medical Nutrition Therapy (MNT) and	People will have access to registered dietitians to address nutritional	PCPs	Leader Collaborator	**Begin:** **FY 2023**	SCHC patients and patients of	• Number of people referred to outpatient dietitian services

	Healthy Eating Active Living classes for obesity with Registered dietitians by encouraging referrals from primary providers.	challenges related to pathophysiology and weight loss	Specialty HCPs (healthcare providers) Registered Dietitians		End: FY2025	local Region 6 HCPs	• % Increase in Number of people referred to outpatient services compared to previous years • Number of people who participate in outpatient MNT with Registered Dietitians • % Increase in number of people who participated in MNT compared to previous years
	4.BMI screenings for all Christus Community Clinic Patients. Patients with a BMI >30 educated on diet and exercise program. Referred as needed to dietician, surgeon for bariatric surgery, Rapides foundation for exercise program.	1a. Increase opportunities for wellness screenings to identify risk for chronic disease. 1b. Decrease % of people with abnormal BMI. 1c. Improve referral documentation and process.	PCPs Specialty HCPs (healthcare providers) Registered Dietitians Rapides Foundation Surgeon	Leader Collaborator	Begin: FY 2023 End: FY2025	All CCC patients.	• Percentage of patients whose BMI < 30 • Number of patients Whose BMI <30

Behavioral Health

Goal:

1. Provide early identification, treatment at the least restrictive level of care possible, resources, and supportive follow-up care of those individuals who suffer from anxiety and/or depression.

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?*
All students enrolled in School Based Health Centers (SBHCs) will have access to risk screenings conducted by SBHC staff	Increase the number of students that receive screenings to identifyrisks for depression and anxiety.	SBHCs Mental Health Staff Medical Staff Primary Care Providers (PCPs) Outpatient and inpatient resources	Leader and Collaborator	**Begin:** School Year 2022-2023 **End:** School Year 2024-2025	Students enrolled in CHRISTUS SFCHS SBHCs	• Number of students completing a risk screening • Number of students referred for psychosocial assessment • Number of students referred for follow-up with an off-site provider • Number of students who received mental health services in the SBHCs

	All students identified at-risk will be referred to mental health staff for a psychosocial assessment or follow-up with an off-site provider	Increase the number of students identified at-risk, will have acces to follow-up care	SBHCs Mental Health Staff Medical Staff Primary Care Providers (PCPs) Outpatient and inpatient resources	Leader and Collaborator	**Begin:** School Year 2022-2023 **End:** School Year 2024-2025	Students enrolled in CHRISTUS SFCHS SBHCs	• Number of students completing a risk screening • Number of students referred for psychosocial assessment • Number of students referred for follow-up with an off-site provider • Number of students who received mental health services in the SBHCs
	All CHRISTUS Community Clinic patients are screenied for depression on every visit with a PHQ9 questionnaire	To identify depressed patients at risk of suicide	Nurses and practitioners	Leader and collaborator	**Begin:** Calendar Year 2023 **End:** Calendar Year 2025	CHRISTUS Community Clinic patients with depression who are at risk of suicide	• Number of patients screened • Number of patients who scored a 10 or above
	Patients identified at risk for severe depression and/or suicide are screened by a provider and treated	To provide treatment to depressed patients at risk of suicide	Nurses and practitioners	Leader and collaborator	**Begin:** Calendar Year 2023 **End:** Calendar Year 2025	CHRISTUS Community Clinic patients with depression who are at risk of suicide	• Number of patients screened • Number of patients who scored a 10 or above • Number of patients treated

Pediatric Access

Goal:

1. All students enrolled in schools with School Based Health Centers (SBHCs) will have access to pediatric care, services and referrals needed.

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?*
All students enrolled in schools with School Based Health Centers (SBHCs) will have a signed consent to be seen in the SBHC.	Increase the number of students receiving services at the SBHC	SBHC staff School administrators	Leader and Collaborator	**Begin:** School Year 2022-2023 **End:** School Year 2024-2025	Students enrolled in schools with a CHRISTUS SFCHS SBHC	• Number of students enrolled in the SBHC • Number of students who received pediatric services in the SBHC
All students having consent will be scheduled and seen in the SBHC (i.e. mental health screenings, chronic care, medical screenings, etc.)	Increase the number of students receiving services at the SBHC	SBHC staff School administrators	Leader and Collaborator	**Begin:** School Year 2022-2023 **End:** School Year 2024-2025	Students enrolled in schools with a CHRISTUS SFCHS SBHC	• Number of students enrolled in the SBHC • Number of students who received pediatric services in the SBHC

Food Access

Goal:

1. Work with partnerships in collaboration, education and support of programs that assist in healthier food access, particularly for neighborhoods and communities facing difficulties in food acces.

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?*
Participate in bi-annual health fairs with a holistic approach to better health outcomes, including health eating and food access	The Health Fairs are to include health screenings, farmer's market access, food access program education, cooking demonstrations as examples, which will promote healthier lifestyles and increase health literacy as well as sharing resources for better healthy food access for better health outcomes.	CSFCHS associates Aramark CMAP Louisiana Central CSFCH Clinics CSFCH Staff SBHCs Community Leaders Local Churches	Leader, Collaborator, Suporter	**Begin:** Calendar Year 2023 **End:** Calendar Year 2025	CHRISTUS St. Frances Cabrini PSA	• Number of health fair participants • Number of individuals helped through food access resources and healthy living education • Percentage of participants who found the health fairs useful • Percentage of participants who report greater access to healthy food options

	Commitment to advocacy on the state and local levels concerning legislation that impacts food access within the CSFCHS PSA	To impact our region on a legislative level, supporting laws and programs that break down barriers to food access and expand healthy food choices for the community.	CHRISTUS Health Advocacy Office CSFCHS Leadership CHRISTUS Health HEDI Office	Collaborator and Supporter	**Begin:** Calendar Year 2023 **End:** Calendar Year 2025	CHRISTUS St. Frances Cabrini PSA	• Based on what Legislation needs support, the time needed to support state and local level initiatives • Active support of CSFCHS leadership of said legislation • Number of communities impacted by positive change brought on by the supported legislation • Percentage of communities reporting greater access to healthy foods and less food insecurity
	Promote food prescription, home delivery, community gardens, and SNAP programs	To break down barriers to food access and healthier food choices for better health outcomes	Food bank Louisiana Central CSFCH Clinics CHRISTUS Trinity Clincs CSFCH Staff School Based Health Centers (SBHCs)	Leader, Collaborator, Supporter	**Begin:** Calendar Year 2023 **End:** Calendar Year 2025	Students and families that participate in SBHCs Diabetes patients Heart disease patients Visitors of CSFCH health fairs	• Number of participants in the education and promotion of these programs • Number of individuals who were helped by these programs • Percentage of participants who report greater access to food and healthier food choices

Appendix 2: CHRISTUS Dubuis Hospital of Alexandria

Specialty Care and Chronic Illness

Goal:

1. Improve outcomes associated with chronic illnesses.
2. Improve access to care for chronic illnesses.
3. Improve access to more affordable medication options.

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?*
Maximize opportunities to provide disease management and prevention through education and arranging follow-up care	Reduce poor outcomes associated with chronic conditions	Post-acute providers Local home health care agencies Community Clinics Support groups such as CHF clinics	Leader	**Begin:** Calendar Year 2023 **End:** Calendar Year 2025	71346, 71341, 71350, 71322, 71417, 71343, 71342, 71423, 71405, 71433, 71467, 71463, 71457, 71328, 71409, 71446, 71351, 71019, 71302, 71303, 71301, 71360	• Review of readmission rates • Post discharge telephone calls

	Develop a list of agencies and organizations that may be able to provide services	Introducing patients to the resource list to improve opportunities for the patients to access appropriate levels of care	Local hospitals Local clinics	Leader	**Begin:** Calendar Year 2023 **End:** Calendar Year 2025	71346, 71341, 71350, 71322, 71417, 71343, 71342, 71423, 71405, 71433, 71467, 71463, 71457, 71328, 71409, 71446, 71351, 71019, 71302, 71303, 71301, 71360	• Completed list of referrals • Number of patients who received the resource list • Percentage of patients who found the resource list useful
	Research and provide options to patients for more affordable medications	To obtain medications to control chronic conditions and improve health by controlling chronic conditions	Community Health Workers Drug companies Physicians	Leader	**Begin:** Calendar Year 2023 **End:** Calendar Year 2025	Patients with no health insurance Indigent patients 71346, 71341, 71350, 71322, 71417, 71343, 71342, 71423, 71405, 71433, 71467, 71463, 71457, 71328, 71409, 71446, 71351, 71019, 71302, 71303, 71301, 71360	• List of options for affordable medication • Number of patients who received the medication list • Percentage of patients who found the medication list useful

Appendix 3: CHRISTUS Savoy Medical Center

Specialty Care and Chronic Illness

Goal:

1. Prevent and manage risk factors that worsen morbidity and mortality rates related to obesity.
2. Implement a diabetes prevention program, including conducting community education and outreach, screenings, and increasing access to resources.

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?*
Offer nutritional counseling by the hospitals education/nutrition directors	Provide screening and education opportunities to decrease obesity rates	Mamou Health Resources Savoy Medical Center education departments	Leader	**Begin:** Fiscal Year 2023 **End:** Fiscal Year 2024	CHRISTUS St. Frances Cabrini PSA	• Number of participants attending our events • % of those attending who received education • Number of participants identified as needing additional help • % of participants receiving additional help

	Offer free/subsidized screenings	Community members will have increased access to health screening and educational tools, with accesss to clinical care when necessary	Mamou Health Resources Savoy Medical Center education departments	Leader	**Begin:** Fiscal Year 2023 **End:** Fiscal Year 2024	CHRISTUS St. Frances Cabrini PSA	• Number of participants attending our screenings • % of participants receiving screenings and education • Number of participants requiring follow-up • % of participants receiving follow-up
	Implement community education and outreach activities promoting diabetes education	Through community education outreach, we will increase awareness about diabetes management, with the goal of elevating the health of those in the community we serve.	Savoy Medical Center Dietary Savoy Medical Center Education Department	Leader	**Begin:** Fiscal Year 2023 **End:** Fiscal Year 2024	CHRISTUS St. Frances Cabrini PSA	• Number of participants attending our events • % of participants attending our events • Request review and evaluations after our activities • Results of evaluations of our activites
	Increase access to education, screenings, and testing for those suffering with pre-diabetes and diabetes	Increased awareness about chronic disease management and prevention with the goal of elevating the health in the community. We anticipate seeing a reduction of diabetes complications.	Savoy Medical Center Dietary Savoy Medical Center Education Department	Leader	**Begin:** Fiscal Year 2023 **End:** Fiscal Year 2024	CHRISTUS St. Frances Cabrini PSA	• Number of participants attending our screening and testing events • Number of screenings and tests performed • Review the participation and future demand of services • Measure requests for additional access to the information provided

Behavioral Health

Goal:

1. Provide increased and caried access to healthcare opportunities that are tailored to the needs of the community served by Savoy Medical Center.

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?*
Provide behavioral health services for adults in the surrounding parishes	Increasing services and addressing barriers will promote better physical and mental health outcomes for the community	Law enforcement agencies Local churches Savoy Medical center	Leader	**Begin:** Fiscal Year 2023 **End:** Fiscal Year 2024	PSA	• Number of patients requesting/seeking our services • Number of patients who received our services • Percentage of patients receiving our services • Percentage of patients who completed treatment
Provide substance abuse education to area school children	Improving the efficiency, effectiveness, and access to an ever-widening range of care options to the community that SMC services	Local schools Savoy Medical Center	Leader	**Begin:** Fiscal Year 2023 **End:** Fiscal Year 2024	PSA	• Number of students attending our events • Number of events provided • Percentage of students attending our events

Appendix 4: CHRISTUS Coushatta Health Care Center

Specialty Care and Chronic Illness

Goal:

1. To collaborate with community health providers and dieticians to promote diabetes awareness, increase access to diabetes screenings, increase access to diabetes self-management education/support, and increase healthy-lifestyle education and resources.
2. To increase the availability and amount of diabetics receiving annual food exams.
3. Improve prevention and management of heart disease in the community by increasing heart disease education at local health fairs, hospital departments, school telehealth visits, and rural health clinics.

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?*
Increase the number and availability of diabetes screenings	By increasing the number and availability of diabetes screenings, we hope to raise awareness of the growing epidemic of diabetes and promote diabetes self-management	Local churches Community Clinics Community Centers	Collaborator	**Begin:** Calendar Year 2023 **End:** Calendar Year 2025	PSA	• Number of participants attending health fairs • Number of participants educated or utilizing testing during health fairs • Percentage of participants that received education or testing

	Provide discharge food boxes that are diet appropriate for patients upon discharge.		Podiatrist/RHC	Leader	**Begin:** Calendar Year 2023 **End:** Calendar Year 2025	PSA	• Number of patients receiving annual diabetic foot exams • Increased percentage of patients receiving diabetic food exams
	To improve prevention and management of heart disease by: -increasing education -obtaining and recording blood pressures at each visit -completing BMI screenings	To improve prevention and management of heart disease	Clinic and hospital staff American Heart Association (AHA)	Leader	**Begin:** Calendar Year 2023 **End:** Calendar Year 2025	PSA	• Number of patients receiving hypertension screenings • Number of patients receiving BMI screenings • Number of patients receiving heart disease education

Reducing Smoking and Vaping

Goal:

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

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?*	*How much? How well? Is anyone better off?*
Provide education to patients who smoke/vape through our clinics and school telehealth program	Increasing awareness and smoking and vaping in efforts to reduce smoking and vaping in patients.	Providers and staff	Leader	**Begin:** Calendar Year 2023 **End:** Calendar Year 2025	PSA	• Number of patients receiving education on smoking and vaping