COMMUNITY HEALTH IMPROVEMENT PLAN

2023-2025

CHRISTUS® GOOD SHEPHERD 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 Good Shepherd Health System (CHRISTUS Good Shepherd). In this process, CHRISTUS Good Shepherd directly engages community members and stakeholders to identify the issues of greatest need as well as the largest impediments to health. With this information, CHRISTUS Good Shepherd 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 Good Shepherd's work as a nonprofit hospital. The important impact of CHNA was codified in the Patient Protection and Affordable Care Act added Section 501(r) to the Internal Revenue Service Code, requiring nonprofit hospitals, including CHRISTUS Good Shepherd, to conduct a CHNA every three years. CHRISTUS Good Shepherd completed similar needs assessments in 2013, 2016 and 2019.

The process CHRISTUS Good Shepherd 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 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 Good Shepherd service area, the CHNA data is presented by zip code and county depending on the available data. Providing localized data brings to light the differences and similarities within the communities in the CHRISTUS Good Shepherd service area.

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

Communities of Focus

Following IRS guidelines, 501(r) rules as required by the Affordable Care Act, CHRISTUS Good Shepherd's CHNA primary service area includes 15 zip codes covering over 240,000 individuals (Table 1). The primary service area (PSA) is the geographic region with 80% of hospital utilization. The primary service area zip codes are located in the following counties: Gregg, Harrison, Marion, Panola and Upshur (Figure 1).

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

CHRISTUS TRINITY MOTHER FRANCES HEALTH SYTEM PSA				
Gregg County	Harrison County	Marion County	Panola County	Upshur County
75601	75650	75657	75633	75644
75602	75670			75645
75603	75672			
75604				
75605				
75647				
75662				
75693				

Table 1. Primary Service Area of CHRISTUS Good Shepherd

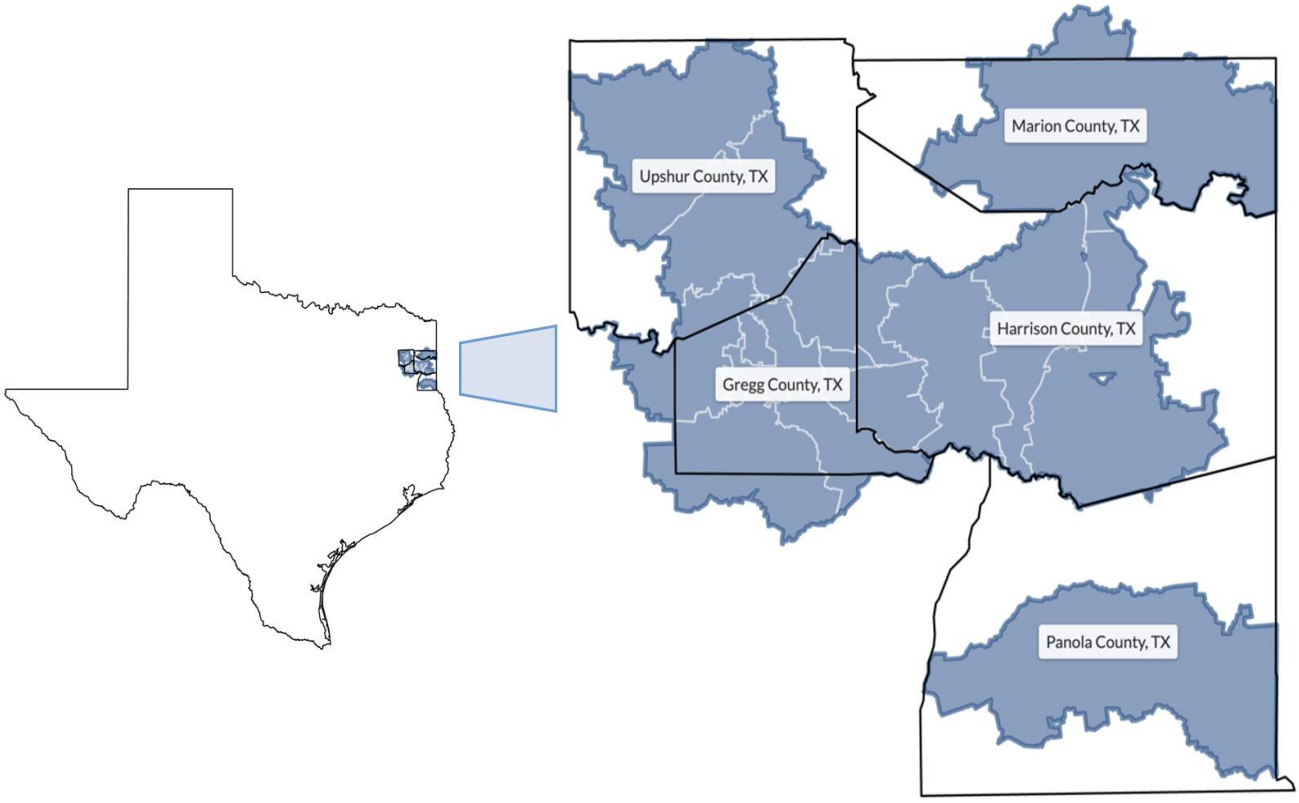

Figure 1. Map of Primary Service Area of CHRISTUS Good Shepherd

Statement of Health Equity

While community health needs assessments (CHNA) and Implementation Plans are required by the IRS, CHRISTUS Good Shepherd has historically conducted CHNAs and developed Implementation 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 Good Shepherd 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 CHRISTUS Good Shepherd guided the strategic direction of Metopio through roles on various committees and workgroups.

CHRISTUS Good Shepherd 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 Good Shepherd 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 Good Shepherd'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 Good Shepherd 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 Good Shepherd 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 Texas Department of State Health Services

Community Resident Surveys

Between October and December of 2021, 683 residents in the CHRISTUS Good Shepherd primary service area (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 Good Shepherd and its community partners. The survey sought input from priority populations in the CHRISTUS Good Shepherd 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 Good Shepherd PSA. This was done through focus groups and key informant interviews.

During this CHNA, CHRISTUS Good Shepherd 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 Good Shepherd and the CHRISTUS Health system office and facilitated by Metopio. CHRISTUS Good Shepherd sought

to ensure groups included a broad range of individuals from underrepresented, priority populations in the CHRISTUS Good Shepherd service area. Focus group health topic areas are listed below:

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

CHRISTUS Good Shepherd conducted its focus groups in person. Focus groups lasted 90 minutes and had up to 15 community members participate in each group. In addition to the focus groups, 10 key informants were identified by CHRISTUS Good Shepherd Management team for one-on-one interviews. Key informants were chosen based on areas of expertise to further validate themes that emerged in the surveys and focus groups. Each interview was conducted virtually and lasted 30 minutes.

Secondary Data

CHRISTUS Good Shepherd used a common set of health indicators to understand the prevalence of morbidity and mortality in the CHRISTUS Good Shepherd PSA and compared them to benchmark regions in the state and the full CHRISTUS Health service area. Building on previous CHNA work, these measures have been adapted from the County Health Rankings MAPP framework (Figure 2). Where possible, CHRISTUS Good Shepherd 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 Good Shepherd sought more granular datasets to illustrate hardship.

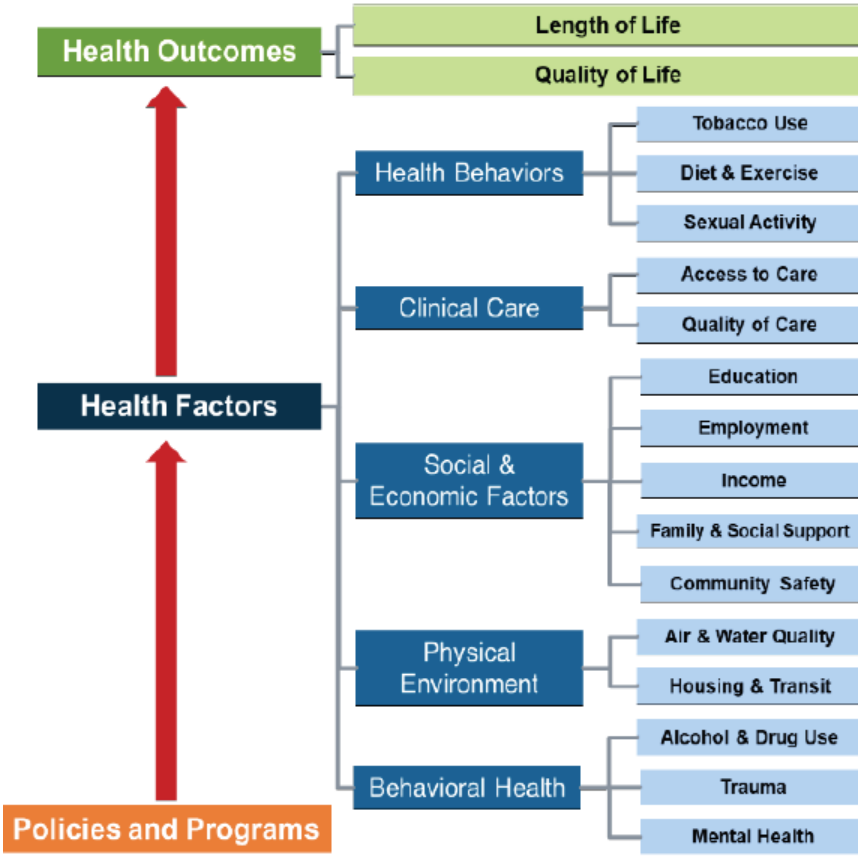

Figure 2. Illustration of the County Health Rankings MAPP Framework

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 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?	Community Benefit Team
INFLUENCE	How much can CGS 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 Good Shepherd 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 county.

- Gaps and limitations persist in data systems for certain community health issues such as mental health and substance use disorders (youth and adults), crime reporting, environmental health and education outcomes. Additionally, these data are often collected and reported from a deficit-based framework that focuses on needs and problems in a community, rather than assets and strengths. A deficit-based framework contributes to systemic bias that presents a limited view on a community's potential.

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

HEALTH PRIORITY AREAS

Health Priority Areas

Based on community input and analysis of a myriad of data, the health and social needs priorities for the communities served by CHRISTUS Good Shepherd for Fiscal Years 2023-2025 fall into two domains underneath an overarching goal of achieving health equity (Figure 3). The two domains and corresponding health needs are:

Advance Health and Wellbeing by addressing

1. Specialty Care Access and Chronic Disease Management (including Diabetes, Obesity, Heart Disease)
2. Behavioral Health (including Mental Health and Substance Abuse)
3. Primary Care Access
4. Education

Build Resilient Communities and Improve Social Determinants by

1. Improving Food Access
2. Reducing Smoking and Vaping

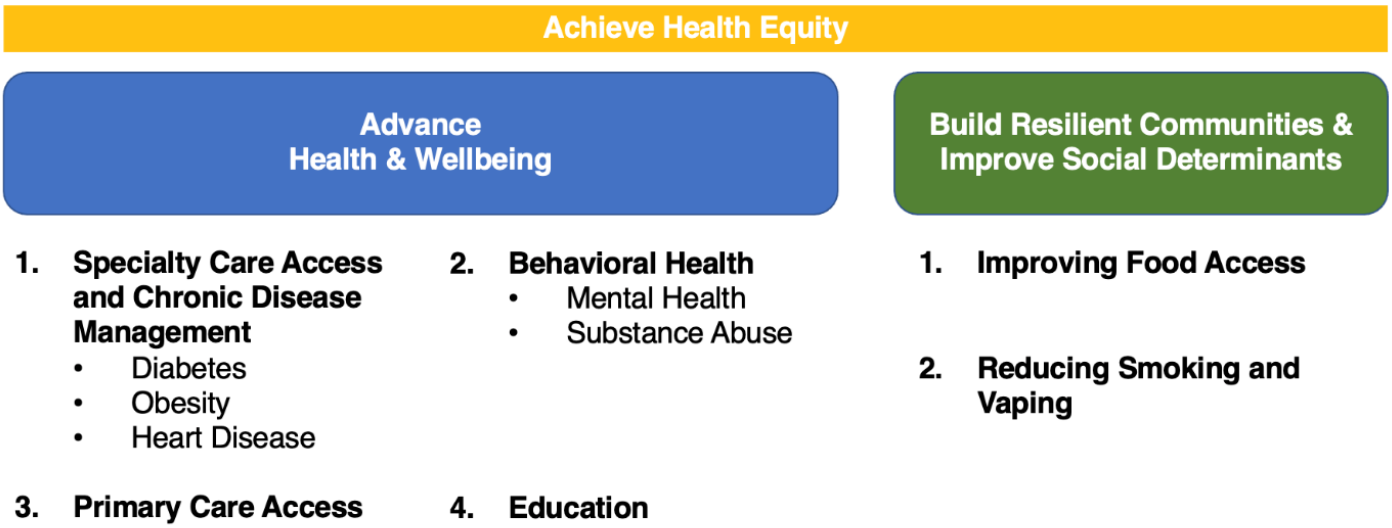

Figure 1. CHRISTUS Good Shepherd Health System Priority Areas

Approach to Community Health Improvement Plan

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

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

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

Community Benefit Report Communication

CHRISTUS Good Shepherd will make its CHNA and strategic improvement plan publicly available online via the CHRISTUS Health website once it is approved and adopted by the Board of Directors in 2022. In addition, CHRISTUS Good Shepherd will share the Community Health Implementation 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 implementation strategy 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 DISEASE MANAGEMENT (SC)		PRIMARY CARE (PC)	
1. Provide screening and education opportunities about heart disease, diabetes, and obesity	2. Empower community members to manage their heart disease, diabetes, and/or obesity	1. Increase access to primary care	2. Reduce inequities caused by cultural barriers to care or Social Determinants of Health
a) Expand free/subsidized screenings that include education components b) Continue community education initiatives focused on chronic disease prevention c) Develop educational programs for healthy eating	a) Manage comorbidities like hypertension and obesity b) Investigate options/partners for supporting Transitional Care of patients c) Promote Institute for Health Living scholarships and assessment for individuals in financial need requiring fitness access	a) Encourage patients to establish care with a primary care physician; explore relationships with FQHCs b) Provide free/subsidized orthopedic and sports medicine services to low-income schools, including on-site services, rehab, education, screening and follow-up care c) Explore feasibility of CHRISTUS Health Equity of Care initiatives to increase PCP access for select ED users	a) Train healthcare staff in cultural competency, shared decision-making and plain language b) Expand screening for Social Determinants of Health (SDoH) c) Offer transportation assistance home for those in financial need

BEHAVIORAL HEALTH (BH)			EDUCATION (ED)
1. Increase access to mental health resources	2. Develop community connections for mental health services	3. Increase access to Substance Abuse treatment	1. Provide education opportunities for current and potential healthcare students
a) Reduce preventable Emergency Department usage for mental health b) Provide transport for uninsured individuals requiring in-patient Behavioral Health care out of region c) Explore options for increasing mental health resources & capacity in CTC clinics and/or telehealth.	a) Gather key stakeholders in local government, healthcare and community organizations to identify, prioritize and address Behavioral Health needs for our region. b) Collaborate with key stakeholders to address needs	a) Review and develop a resource listing of groups/programs addressing substance abuse b) Explore possible means to expand substance abuse treatment in our region	a) Offer clinical education opportunities for health care students including nurses and allied health b) Provide shadowing opportunities for individuals considering a health care profession c) Explore opportunities for underrepresented groups to consider a healthcare vocation

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 may support these initiatives are Wellness Pointe, Genesis PrimeCare, area colleges and universities with healthcare programs, Chambers of Commerce, our CHRISTUS Trinity Clinics and CHRISTUS Health dieticians and educators, Catholic Charities parish nurses, and event sponsors who may support public health education.

And CHRISTUS Health will focus on building a coalition to address Behavioral Health issues in the service area. Partners could potentially include Gregg and Harrison Counties, Cities of Longview and Marshall, Community Healthcore, Oceans, Greater Longview Optimal Wellness, Twelve Way, behavioral health partner agencies of the Greater Longview United Way.

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 (FA)		REDUCE SMOKING AND VAPING (SV)	
1. Cultivate and maintain partnerships to improve access to healthy food in food deserts	2. Provide nutrition education for individuals, patients, and families	1. Contribute to community-based smoking cessation efforts	2. Partner with schools to reduce vaping among students
a) Collaborate with non-profits who provide food distribution, pantries, and support food drives in the service area.	a) Determine current nutrition and food preparation education currently in healthcare and school settings. b) Evaluate if a special education program for food insecurity should be established for a targeted population.	a) Research and evaluate types of smoking cessation programs currently offered in community. b) Work with local groups on providing smoking cessation programs	a) Assess current initiatives to reduce vaping among students b) Explore feasibility of offering education on dangers of vaping to students via athletic training partnerships

CHRISTUS Health will continue to invest in care delivery innovations and expand programs that address the social determinants of health. Key programs that support these initiatives are Greater Longview Optimal Wellness, Longview Community Ministries and other Greater Longview United Way agencies, East Texas Food Bank, Catholic Charities and parish nurses, area Independent School Districts, Mission Marshall.

STRATEGIES

Appendix 1: Advance Health & Wellbeing

Specialty Care and Chronic Disease Management (SC)

Goal:

Prevent and manage risk factors known to worsen morbidity and mortality due to chronic disease.

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?*
SC1a. Expand free/subsidized screenings that include education components	Provide screening and educational opportunities about heart disease, diabetes, obesity.	CGS departments, Local Chambers of Commerce Local community event sponsors Parish nurses Other non-profits in community	Leader Collaborator Supporter	**Begin:** FY23 Q2 **End:** FY25 Q4	Inhabitants of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	# of screening events # of participants screened

	SC1b. Continue community education initiatives focused on chronic disease prevention	Provide screening and education opportunities about heart disease, diabetes, and obesity	CGS departments, Local Chambers of Commerce, Local community event sponsors, Parish nurses, Other non-profits in community	Leader Collaborator Supporter	**Begin:** FY23 Q2 **End:** FY25 Q4	Inhabitants of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	# of health education events # of participants
	SC1c. Develop educational programs for healthy eating.	Provide screening and education opportunities about heart disease, diabetes, and obesity	East Texas Food Bank, NETX ministries, CGS dieticians, Local schools	Leader Collaborator	Evaluate opportunity to implement collaborative project in FY23. Implement and grow data in FY24 and FY25.	Inhabitants and students of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	Year 1: Program content/proposal complete
	SC2a. Manage comorbidities like hypertension and obesity	Empower community members to manage their heart disease, diabetes, and/or obesity	CTC clinics CTC quality CTC population health Parish nurses	Collaborator Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	CTC clinic patients	Year 1: establish baseline values for select health markers for participants

	SC2b. Explore options/partners for supporting Transitional Care of patients.	Empower community members to manage their heart disease, diabetes, and/or obesity	Transition Care providers CSM TC pilot ED physicians CTC clinicians CMO	Leader Collaborator	Investigate options in FY23 for possible implementation in FY24 & 25	Targeting frequent re-users of EDs or poor follow up with PCP	Year 1: evaluation & proposal complete
	SC2c. Promote Institute for Health Living scholarships and assessment for individuals in financial need requiring fitness access.	Empower community members to manage their heart disease, diabetes, and/or obesity	IHL Trainers, CTC clinics	Leader collaborator	**Begin:** FY23 Q1 **End:** FY25 Q4	Focusing on Gregg and Harrison Counties, but open to all in PSA	# of participants % of participants improving on targeted health measures

Behavioral Health (BH)

Goal:

Strengthen network of behavioral health resources in service area.

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?*
BH1a. Reduce preventable Emergency Department usage for mental health	Increase access to mental health resources. Patients will be connected to appropriate mental health resources. Emergency resources will be better stewarded.	GLOW, BH providers and organizations, ED team	Leader Collaborator	**Begin:** FY23 Q1 **End:** FY25 Q4	Targeting frequent users of EDs in Gregg County	Identify baseline of high ED users # of ED visits by these users

	BH1b. Provide transport for uninsured individuals requiring in-patient Behavioral Health care out of region	Increase access to mental health resources	CGS BH leads, Community Healthcore, In-patient mental health facilities	Collaborator	**Begin:** FY23 Q1 **End:** FY25 Q4	Unfunded persons requiring in-patient BH care	# of persons transported
	BH1c. Explore options for increasing mental health resources & capacity in CTC clinics and/or telehealth	Increase access to mental health resources	CTC, Area colleges with BH programs	Collaborator	FY23 – evaluate options Possible implementation in FY24 or FY25.	Inhabitants of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	Year 1: evaluation and proposal complete
	BH2a. Gather key stakeholders in local government, healthcare and community organizations to identify, prioritize and address Behavioral Health needs for our region.	Develop community connections for mental health services	PSA Counties; PSA municipalities, including police and EMS; GLOW partners; CGS BH leads; BH providers and organizations	Leader Collaborator Supporter	Hold meeting in FY23 to develop strategies for implementation in FY24 & 25	Initial focus on Gregg and Harrison Counties	Convening of the group

	BH2b. Collaborate with key stakeholders to address needs.	Develop community connections for mental health services	Same as above	Collaborator Supporter	**Begin:** FY24Q1 **End:** FY25 Q5	Initial focus on Gregg and Harrison Counties	# of obstacles reduced and/or resources gained for BH
	BH3a. Review, develop, promote a resource listing of groups/programs addressing substance abuse	Increase access to Substance Abuse treatment	GLUW, GLOW, BH providers and organizations, County Health Department Twelve Way, Local ISDs & higher ed	Collaborator Supporter	**Begin:** FY23 Q3 **End:** FY24 Q2	Inhabitants of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	# of collaborators to create resource # of resources/programs listed # of distribution points
	BH3b. Explore possible means to expand substance abuse treatment in our region.	Increase access to Substance Abuse treatment	Same as above	Supporter	In FY23 Q3 begin assessment with area partners, for possible implementation in FY24 & FY25	Inhabitants of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	Year 1: evaluation and proposal complete

Primary Care Access (PC)

Goal:

Increase access and reduce barriers to primary care.

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?*
PC1a. Encourage patients to establish care with a primary care physician; explore relationships with FQHCs	Increase access to primary care	CTC clinics, ED teams, Area FQHCs	Leader Collaborator	Research best means to promote in FY23 for implementation in FY24 & 25	Inhabitants of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	# of repeat ED users who establish with a PCP % reduction in repeat non-emergent ED visits

	PC1b. Provide free/subsidized orthopedic and sports medicine services to low-income schools, including on-site services, rehab, education, screening and follow-up care.	Increase access to primary care	Local schools; Community Health Fairs/5Ks; CGS Athletic Trainers; CGS orthopedic, sports med, pain providers	Leader, Collaborator Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	Inhabitants of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	# of schools with services provided # of events held in FY # of people served
	PC1c. Explore feasibility of CHRISTUS Health Equity of Care initiatives to increase PCP access for select ED users.	Increase access to primary care	CHRISTUS Health system office, CTC clinics, ED physicians, local pharmacies	Leader	**Begin:** Explore options in FY23 for implementation in FY24 & 25	ED users with select comorbidities	Year 1: evaluation and proposal complete
	PC2a. Train healthcare staff in cultural competency, shared decision-making, and plain language	Reduce inequities caused by cultural barriers to care or Social Determinants of Health	HealthStream CGS Education	Leader	**Begin:** FY23 Q2 **End:** FY25 Q4	Inhabitants of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	# of courses offered yearly % completion by Associates

	PC2b. Expand screening for Social Determinants of Health (SDoH)	Reduce inequities caused by cultural barriers to care or Social Determinants of Health	CGS nursing, CGS care management, CH system community benefit & HEDI	Leader	**Begin:** FY23 Q2 **End:** FY23 Q4 Possibly continue	Inhabitants of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	% increase capture rate of SDoH Z-codes
	PC2c. Offer transportation assistance home for patients in financial need.	Reduce inequities caused by cultural barriers to care or Social Determinants of Health	ED staff, House Supervisor, Local transportation vendors	Leader	**Begin:** FY23 Q1 **End:** FY25 Q4	Inhabitants of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	# of eligible patients assisted

Education (ED)

Goal:

The next generation of healthcare professionals may participate in excellent, mission-grounded clinical education and healthcare experiences.

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?*
ED1a. Offer clinical education opportunities for health care students including nursing and allied health.	Provide education opportunities for current and potential healthcare students	CGS nursing and allied health Associates and Leads, CGS education, Regional higher education institutions with nursing and allied health programs	Leader Collaborator	**Begin:** FY23 Q1 **End:** FY25 Q4	Healthcare students enrolled in regional programs	# of healthcare professions offered clinical education # of higher ed collaborators # of student participants $ value of clinical education

	ED1b. Provide shadowing opportunities for individuals considering a health care profession.	Provide education opportunities for current and potential healthcare students	CGS physicians, nurses, and allied health Associates, CGS education, Local high schools	Leader Collaborator	**Begin:** FY23 Q1 **End:** FY25 Q4	High school students enrolled in service area	# of school collaborators # of student participants $ value of shadowing
	ED1c. Explore opportunities for underrepresented groups to consider a healthcare vocation.	Provide education opportunities for current and potential healthcare students	CGS Diversity Committee, CGS physicians, nurses and allied health Associates CGS education, Local schools, CGS videography	Leader Collaborator	**Begin:** FY23 Q2 **End:** FY25 Q4	Middle school and high school students in our service area of races/ethnicities underrepresented in healthcare professions	# of speakers/mentors # of presentations/schools # of students participating

Appendix 2: Build Resilient Communities & Improve Social Determinants

Improving Food Access (FA)

Goal:

Improve access to healthy food and understanding of benefits of healthy eating.

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?*
FA1a. Collaborate with non-profits who provide food distribution, pantries, and support food drives in the service area.	Cultivate and maintain partnerships to improve access to healthy food in food deserts	East Texas Food Bank, Longview Community Ministries, Mission Marshall, Catholic Charities, Other non-profits	Collaborator Supporter	In FY23 explore possible role for partnership in FY24 & 25	Inhabitants of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	# of community partner collaborators

	FA2a. Determine current nutrition and food preparation education currently in healthcare and school settings.	Provide nutrition education for individuals, patients, and families	Local ISDs, CGS nutritionist, East Texas Food Bank, Parish nurses, Area non-profits	Collaborator Supporter	Evaluate in late FY23	Patients and students of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	Data gathered, evaluated, and proposal made
	FA2b. Evaluate if a special education program for food insecurity should be established for a targeted population.	Provide nutrition education for individuals, patients, and families	Local schools, CGS dieticians, Catholic Charities, Other area non-profits, CGS athletic trainers	Collaborator	Evaluate in FY23 for offerings in late 23 and through FY25	Inhabitants of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	Establish a team to review the data and make recommendations

Reducing Smoking and Vaping (SV)

Goal:

Improve understanding of health risks of smoking and vaping.

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?*
SV1a. Research and evaluate types of smoking cessation programs currently offered in community.	Contribute to community-based smoking cessation efforts	County Health Departments, Lung Cancer Association Local schools, Parish Nurses	Collaborator	Begin: Research FY23 For possible support of programs in FY24&25	Inhabitants at high risk of smoking of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	# of schools participating in research # of organizations participating in research

	SV1b. Work with local groups on providing smoking cessation programs	Contribute to community-based smoking cessation efforts	County Health Departments, Lung Cancer Association Area schools, Parish Nurses, Other non-profits	Supporter	Begin: FY24 End: **FY25**	Inhabitants at high risk of smoking of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	# of programs offered # of people attending
	SV2a. Assess current initiatives to reduce vaping among students.	Partner with schools to reduce vaping among students	County Health Departments, American Lung Association, Parish Nurses, Other non-profits	Collaborator	Begin: Research FY23 For possible support of programs in FY24&25	Youth at high risk of vaping of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	# of schools participating in research # of organizations participating in research
	SV2b. Explore feasibility of offering education on dangers of vaping to students via athletic training partnerships.	Partner with schools to reduce vaping among students	County Health Departments, American Lung Association, Other non-profits, Area schools, CGS Athletic Trainers	Supporter	Begin: FY24 End: FY25	Youth at high risk of vaping of the following counties: -Gregg -Harrison -Marion -Panola -Upshur	# of programs offered # of people attending