

 **CHRISTUS[®]
SOUTHEAST TEXAS**
Health System

**Community Health
Improvement Plan 2020-2022**



About Texas Health Institute:

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

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TABLE OF CONTENTS

TABLE OF CONTENTS	iii
MISSION FOR IMPLEMENTATION	1
TARGET POPULATION/AREA	2
COMMUNITY HEALTH PRIORITIES	3
SELECTED IMPLEMENTATION STRATEGIES	4

MISSION FOR IMPLEMENTATION

The CHRISTUS Southeast Texas Health System (CSETHS) serves the health needs of communities in and around the Beaumont-Port Arthur metropolitan statistical area. CSETHS defines the report area for the 2020-2022 Community Health Needs Assessment to include the following six Texas Counties: Hardin, Jasper, Jefferson, Newton, Orange, and Tyler. CSETHS serves this region with two non-profit hospitals. CHRISTUS Southeast Texas St. Elizabeth Hospital is located in downtown Beaumont. CHRISTUS Southeast Texas Jasper Memorial Hospital, located 70 miles north of Beaumont-Port Arthur, serves the northern portion of the CSETHS service area. CSETHS encompasses clinics and outpatient centers across the five report area counties and a number of physician partnerships. CSETHS also includes a Physician Hospital Organization, Management Services Organization, and the CHRISTUS Southeast Texas Foundation.¹

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," CSETHS strives to be, "a leader, a partner, and an advocate in the creation of innovative health and wellness solutions that improve the lives of individuals and communities so that all may experience God's healing presence and love."²

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

To produce the CHNA, CSETHS and THI analyzed data for over 40 different health indicators, spanning demographics, socioeconomic factors, health behaviors, clinical care, and health outcomes. The needs assessment process culminated in the 2020-2022 CSETHS Community Health Needs Assessment Report, finalized in June 2019. Report findings synthesize data from publicly available sources, internal hospital data, and input from those with close knowledge of the local public health and health care landscape to present a comprehensive view of unmet health needs in the region. Through an iterative process of analysis, stakeholder debriefing, and refinement, the collection of indicators presented for initial review was distilled into a final list of five priority health needs requiring a targeted community response in the coming triennium.

¹ In June 2019 CSETHS closed CHRISTUS Southeast Texas St. Mary Hospital in Port Arthur. CHRISTUS St Mary Hospital was included in the analysis of hospital admissions and emergency department visits as it provides insight about the health needs in the community.

² CHRISTUS Health. (2019). *Our mission, values, and vision*. Available at: <http://www.christushealth.org/OurMission>.

The CHIP presented in this document fulfills federal IRS 990H regulations for 501(c)(3) non-profit hospitals' community benefit requirements and will be made available to the public. The CHIP builds upon the CHNA findings by detailing how CSETHS intends to engage partner organizations and other local resources to respond to priority health needs identified in the CHNA. It identifies a set of actions to address prioritized health needs while clarifying benchmarks to monitor progress.

Also participating in this Community Health Needs Assessment (CHNA) is CHRISTUS Dubuis Hospital of Beaumont, a long-term acute care hospital (LTACH) located on the 4th floor of CHRISTUS Southeast Texas St. Elizabeth Hospital, and operated by the LHC Group of Lafayette, Louisiana. Currently the hospital has 33 beds. This CHIP includes actions to address a sixth priority health need associated with the patients and families who could be admitted to the hospital. CHRISTUS Dubuis Hospital of Beaumont, in coordination with community and other partners, will take the lead in implementing only actions to address this sixth health need. It will be uninvolved in implementation activities addressing the other five prioritized needs.

Specific community assets are identified and linked to needs they can address, a step toward fostering the collaboration and accountability necessary to ensure goals enumerated within the CHIP are pursued with the community's full available capacity.

TARGET POPULATION/AREA

CSETHS serves Hardin, Jasper, Jefferson, Newton, Orange, and Tyler Counties in Texas (the report area), consisting of a total population of 469,537 residents. Nearly 75% of the region's population resides in Jefferson County and Orange County. Eighty-eight percent of residents in the report area live in Hardin, Jefferson, Newton, and Orange Counties which are urban counties, while the remaining 12% live Jasper and Tyler Counties which are rural.³ The population increased for the report area by 1.6% from years 2010 to 2017. The highest population growth was in Hardin County at 4.6%.

CHRISTUS Southeast Texas Health System Report Area Counties
Hardin County, TX
Jasper County, TX
Jefferson County, TX
Newton County, TX
Orange County, TX
Tyler County, TX

Individuals between ages 18 and 64 (working-aged adults) constitute 60% of total population. Of the remaining population, 16% are ages 65 and older, 17% are school age children, and 7% are in infancy or early childhood. Overall, the population ages 65 and older are slightly higher than

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

that of the population of Texas (12%). Newton (20%) and Tyler (22%) Counties have an even higher population 65 and older.

Compared to Texas, the population in the report area have a lower proportion of Hispanic residents. The Hispanic/Latino population in the report area more closely resembles that of the US than that of Texas — just over 13% of the report area is Hispanic/Latino, compared to 39% of Texans. The Non-Hispanic (NH) African American population in the report area are a higher proportion of residents at 23% compared to Texas at 12%. The NH-Asian, NH-Native Hawaiian/Pacific Islander and NH-Native American/Alaska Native categories each comprise less than 4% of the report area population. Gender is virtually evenly distributed by gender (51% male, 49% female) in the report area, mirroring the gender distribution of Texas and the US.

Poverty is fairly widespread in the report area, with 38% of report area residents earning annual incomes at or below 200% FPL. This is on par with the poverty for the state of Texas at 37%. Newton County has the highest poverty at 42%. According to 2019 federal guidelines, 200% FPL corresponds to an income of \$51,500 per year for a family of four.⁴

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

COMMUNITY HEALTH PRIORITIES

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

Priorities were evaluated according to issue prevalence and severity, based on county and regional secondary data. Input provided by key informants, focus group participants, and other community stakeholders was also heavily considered, especially for priority areas where secondary data are less available. The committee considered a number of criteria in distilling top priorities, including magnitude and severity of each problem, CSETHS organizational capacity to address the problem, impact of the problem on vulnerable populations, existing resources already

⁴ Office of the Assistant Secretary for Planning and Evaluation. (2019). US Poverty Guidelines Used to Determine Financial Eligibility for Certain Government Programs. Available at <https://aspe.hhs.gov/poverty-guidelines>

addressing the problem, and potential risk associated with delaying intervention on the problem. Finally, in recognition of the unique needs of the patient population in CHRISTUS Dubuis Hospital, one additional prioritized need was developed. Identifying this need was supplemented by reports from informants rooted in the community and with broad knowledge about the needs of the LTACH patients and families. The committee’s final list of six prioritized health needs presented in rank order in the above table above. This priority list of health needs lays the foundation for CSETHS to remain an active, informed partner in population health in the region for years to come.

CHRISTUS Southeast Texas Prioritized Health Needs 2020-2022	
1	Access to Mental and Behavioral Health
2	Access to Primary Care
3	Transportation
4	Healthcare Disparities
5	Food Insecurity
6	Improved End-of-Life Resources and Supports

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

SELECTED IMPLEMENTATION STRATEGIES

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

1. Increase Access to Mental and Behavioral Health

Access to mental and behavioral health care is considered the number one community health need in southeast Texas, much like the rest of the State of Texas. Patients and their families face limited inpatient care availability, encounter long wait times for appointments, and struggle with a scarcity of behavioral health professionals. CSETHS will work collaboratively with other organizations to increase access to mental and behavioral health in the region.

The need for mental and behavioral healthcare is exacerbated by high rates of violence and the after effects of Hurricane Harvey. Medical providers are often challenged when persons seeking healthcare display behaviors associated with mental illness or substance abuse. CSETHS will strengthen awareness and training about mental and behavioral health to improve their ability to serve patients with behavioral and mental health diagnoses and protect patients from other patients displaying behaviors associated with substance abuse or mental/behavioral health disorders.

Major Action(s)	Sub-Actions
<p>1. Collaborate with Local Mental and Behavioral Health Providers to Reduce Barriers to Care.</p>	<ol style="list-style-type: none"> 1. Emergency Department staff and leadership to attend Spindletop ER Advisory Committee. 2. Increase collaboration with Spindletop Mental Health Services for patient care and screening. <p><i>Anticipated Outcome: Hospital will be able to work better with local mental health providers and law enforcement to address needs and resolve problems that arise; improve networking. Mental and Behavioral Health patient care quality to improve.</i></p>
<p>2. Increase Emergency Room resources to be better equipped for Mental and Behavioral Health.</p>	<ol style="list-style-type: none"> 1. Provide safe rooms for securing patients in care when violent or unpredictable. 2. Provide specially trained and certified Psychiatric Registered Nurse to lead efforts. <p><i>Anticipated Outcomes: Staff will attend to patient needs with greater effectiveness. Both staff and patients will be safer. Quality of patient care to improve as well as safety.</i></p>
<p>3. Provide education to Emergency Room and other departments' staff for Mental and Behavioral Health.</p>	<ol style="list-style-type: none"> 1. Training with use of Flow Chart so staff knows what the process is for Mental and Behavioral Health patients upon arriving in the Emergency Room. 2. All staff in the Emergency Room to go through SOMA training on how to de-escalate violence. <p><i>Anticipated Outcomes: Improved safety and quality of care. Staff work satisfaction increases. Improved patient medical outcomes along with patient and staff safety.</i></p>

2. Access to Primary Care

Several factors limit access to primary care in the service area. In addition to lacking insurance, many need navigation assistance to find appropriate care and could benefit from health education. The lack of sufficient numbers of providers has led to the extraordinary practice whereby some physicians require prospective patients to undergo an application process. The imbalance between physician requirements and supplies is likely to get worse as a large number of physicians are over 60 and set to retire.

CSETHS has a three-prong strategy to improve access to primary care. This includes collaboration with federally qualified health centers to ensure patients have a medical home,

greater use of bilingual outreach workers to help patients avoid hospitalization through prevention and disease management, and efforts to recruit more providers in its own physician group.

Major Action(s)	Sub-actions
<p>1. Collaborate with Local Providers to Reduce Barriers to Care.</p>	<p>1. Continue to build upon referral relationships with the Legacy Community Health Services and Gulf Coast Health Center federally qualified health centers (FQHCs).</p> <p><i>Anticipated Outcomes: Frequent users of Emergency Room and Frequent Readmissions to decrease as patients are able to find a medical home and get better follow-up.</i></p>
<p>2. Increased use of Bilingual Community Outreach Worker with potential for more added.</p>	<p>1. Develop Contractual Relationship with FQHCs for Better Patient Access for Referrals.</p> <p>2. Assessment of targeted chronic diseases presenting in Emergency Room for follow up.</p> <p><i>Anticipated Outcomes: Patients referred will gain access in a more timely way. Selected diseases that result in readmissions will have better follow up.</i></p>
<p>3. CHRISTUS Physicians Group (CPG) Medical Centers to Expand</p>	<p>1. Recruit more physicians and nurse practitioners into CPG.</p> <p>2. Develop pediatrics patient medicine with increased referrals to hospital.</p> <p><i>Anticipated Outcomes: Increased patient census for in and out patient care. Community will have better access for pediatric care.</i></p>

3. Transportation

The lack of transportation reduces access to healthcare, increases health disparities, and leads to missed appointments that further increase inefficiencies in the health system. Like many health systems throughout the country, CSETHS recognizes the cost effectiveness of directly investing in efforts to reduce patient transportation barriers.

Major Action(s)	Sub-actions
<p>1. Publish a Brochure Available to Patients and Families to Access Various Forms of Transportation.</p>	<ol style="list-style-type: none"> 1. Explain use of and access of Medicaid Transportation Services, Southeast Texas Transit, Gulf Coast FQHC and other services. 2. Research potential of contracting with Uber or Lyft for patient transportation. <p>Anticipated Outcomes: <i>Patients will better be able to access transportation. Increased access for patients and providers not on a public transportation designated route.</i></p>
<p>2. Make use of Healthy Beaumont website to provide information on transportation available.</p>	<ol style="list-style-type: none"> 1. Develop links to resources. 2. Develop website page listing all services. <p>Anticipated Outcomes: <i>Increased transportation access. Avoid duplication of transportation services.</i></p>
<p>3. Do an Analysis of a Financial Agreement to Provide a Van Between FQHCs and other Providers.</p>	<ol style="list-style-type: none"> 1. Assess need for a designated route and schedule. 2. Assess potential for funding a transportation program with collaboration among providers. <p>Anticipated Outcomes: <i>Better understand financial viability of a transportation service. The underserved will have transportation to their appointments.</i></p>

4. Health Inequities / Healthcare Disparities

Individuals from minority communities are disproportionately impacted by ambulatory care sensitive conditions such hypertension. By investing in education, detection and management in hypertension, CSETHS can address a key health disparities in the community.

Major Action(s)	Sub-actions
<p>1. Patients presenting in the emergency room with primary diagnosis of hypertension to be targeted.</p>	<ol style="list-style-type: none"> 1. At least 35% of patients with hypertension as primary presenting in Emergency Room will be followed up on. 2. Follow up care will provide patient education, lifestyle changes and a medical home. <p>Anticipated Outcomes: <i>Underserved patients with Hypertension will receive follow up care. As patients receive follow up care, health improves and they have less Emergency Room use.</i></p>
<p>2. Community Health Worker will call and sometimes visit with patients in need of follow up care.</p>	<ol style="list-style-type: none"> 1. Medications can be explained and appointments set for patients in need. <p>Anticipated Outcomes: <i>Better health outcomes with lower hypertension rates.</i></p>
<p>3. When sufficient data is obtained, an analysis will be done to determine needs of underserved patients.</p>	<ol style="list-style-type: none"> 1. Demographics will be analyzed to determine inequities and how to address them. 2. Plan for the future with learnings from the program for equity of care. <p>Anticipated Outcomes: <i>Better alignment with Mission to serve the underserved. Readmissions lower with patient health improved.</i></p>

5. Food Insecurity

Food insecurity, defined as the lack of consistent access to adequate food due to a lack of money and other resources at times during the year, is a social determinant of health that stakeholders and community identified as a top health need. CSETHS will continue to address this by mobilizing staff and collaborating with food banks, pantries, and other community-based organizations.

Major Action(s)	Sub-actions
<p>1. Partner with Southeast Texas Food Bank to Provide Food for Discharged Patients.</p>	<p>1. A satellite food bank will be established on the hospital campus to serve patients going home.</p> <p><i>Anticipated Outcomes:</i> <i>Discharge home situations will be safer and provide nutrition for healing.</i></p>
<p>2. Provide Diabetic Appropriate Food Boxes to Discharged Patients; Collaborate with Senior Nutrition Services.</p>	<p>1. Referrals will be provided for not only food but an appropriate diet for health.</p> <p>2. Patients receiving food packages will also receive a follow up call to check on them.</p> <p><i>Anticipated Outcomes:</i> <i>Safer discharge for Diabetics and less readmissions. Those patients most in need will be cared for like a family member, resulting in better health improvements.</i></p>
<p>3. Outpatients and Family Members at Anayat House will Receive Cafeteria Vouchers.</p>	<p>1. Up to 100 Vouchers per month will be provided to patients in need.</p> <p>2. Do an analysis to determine the patients most in need of the vouchers.</p> <p><i>Anticipated Outcomes:</i> <i>Less Food Insecurity stress, resulting in better health outcomes. Better follow up on patients' families and discharged patients for Food Insecurity needs in the future.</i></p>

6. Resources and Supports for End-of Life Care

The needs assessment uncovered the need for families to be better prepared when their loved one admitted to CHRISTUS Dubuis Hospital of Beaumont reaches the end of life. CHRISTUS Dubuis Hospital will be responsible for leading actions to address this need.

Major Action(s)	Sub-actions
1. Improve resources and support for end-of-life care.	<ol style="list-style-type: none">1. Provide end of life care to patient and family through spiritual care department sooner in the discharge process if considered high risk.2. Provide end of life training to all direct patient care providers. <p>Anticipated Outcome(s): Ease transitioning patients to appropriate level of care at time of discharge. Increase support services to patients and staff.</p>

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

