CHRISTUS Spohn Health System

Community Health Improvement Plan

2020 - 2022

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Mission for Implementation

CHRISTUS Spohn Health System (CSHS) is a non-profit hospital system serving the Coastal Bend region. The CHRISTUS Spohn region offers comprehensive health care ranging from its primary care family health clinics, to its six acute care hospitals, the only Level II Trauma Center in the region, and the only inpatient behavioral medicine program that accepts the uninsured. In addition, a comprehensive Cancer Center, Palliative Care program, CHRISTUS Home Health, and CHRISTUS Hospice provide care for families and patients at the end of life.

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. 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," CSHS 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." In alignment with these values, all CHRISTUS Health hospitals work closely with the local 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 Community Health Improvement Plan (CHIP) for CSHS.

To produce the CHNA, CSHS 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 CSHS Community Health Needs Assessment (CHNA) Report, finalized in August 2019 (see separate document). 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 overview 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.

The CHIP presented in this document fulfills federal IRS 990H requirements 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 CSHS intends to engage partner organizations and other local resources to respond to priority health needs identified in the

CHNA. It identifies a clear set of goals, actions, and benchmarks to monitor progress. 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 Area/Population

While CSHS serves a wide swath of the coastal bend region, CSHS defines the report area to include the following four Texas counties: Nueces, Bee, Jim Wells and Kleberg. The demography and socioeconomic conditions of these counties are broadly representative of the CSHS service area. As such, they offer insight into the health needs of the patients of and communities surrounding the six hospitals. The service area consists of a total population of 465,734 residents.

Just over 75% of the report area's population resides in Nueces County. Seventy-eight percent of residents in the report area live in Nueces County which is the only urban county, while the remaining 22% live in the remaining report area rural counties. Sixty-one percent of the population in the report area are working-aged adults (age 18-64). Of the remaining population, 14% are ages 65 and older, 18% are school age children, and 7% are in infancy or early childhood.

The CSHS service area is home to a culturally, ethnically, and economically diverse population. Hispanic/Latino individuals comprise 64% of the area's population, while the NH-Asian, NH-Native Hawaiian/Pacific Islander and NH-Native American/Alaska Native categories each comprise less than 2% of the report area population. Over 4 in 10 service area residents live on an income at or below 200% of Federal Poverty Level.

With a lengthy history of serving poor and at-risk populations in the region, CSHS 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, people living with HIV/AIDS, the LGBTQ population, 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. CSHS's CHIP for the upcoming triennium reflects the organization's ongoing pursuit of regional health equity, promoting conditions that allow every person to attain the highest possible standard of health. While health equity and opportunity is not an explicit health need presented in this CHIP, actions aligned with driving health equity improvements are embedded throughout the plan. These may include diversity in recruitment and hiring of personnel, monitoring of cultural and

linguistic competence across different aspects of the clinical experience, pursuit of cross-sector partnerships with trusted community groups serving diverse populations, and outreach efforts targeted at harder-to-reach groups that may be chronically disengaged from health care resources.

Community Health Priorities

A committee of experts was tasked with reviewing the findings and distilling a broad list of ten indicators 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.

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, CSHS's organizational capacity to address the problem, impact of the problem on vulnerable populations, existing resources already addressing the problem, and potential risk associated with delaying intervention on the problem. The committee's final list of five priority needs is presented in rank order in the table below. This priority list of health needs lays the foundation for CSHS to remain an active, informed partner in population health in the region for years to come.

Rank	Health Need
1	Behavioral Health (Mental Health/Drug Abuse/Suicide)
2	Affordable Housing
3	Community & Family Violence
4	Lack of Trust in Community Resources & Systems
5	High Emergency Room Use

CSHS reviewed a draft CHNA report in July 2019. Following the needs prioritization committee meeting, convening of hospital staff and community stakeholders took place in to strategize planned responses to priority health needs, identify potential community partners for planned initiatives, and identify actions, sub-actions, and anticipated outcomes of improvement plan efforts.

Selected Implementation Strategy

Presented in this section are a series of implementation strategies containing the detailed goals and actions CSHS will undertake in the coming three year period to respond to each priority health need 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 and 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.

BEHAVIORAL HEALTH IMPROVEMENT STRATEGY

Major Action(s)	Sub-Actions
Support the Opioid Task Force Initiative	1) Participate in the diverse and collaborative county-wide task force initiated in October of 2019 to combat opioid addiction in our area 2) Contribute to the task force by providing personnel to the team, lending meeting space, and adjusting internal strategy to meet task force goals Anticipated outcomes: - Increased collaboration throughout Nueces county to combat opioid-related issues - Achieve a reduction among opioid prescriptions, dependence, and/or abuse
Sustain and enhance collaborations and referral relationships with local mental/behavioral health service providers	1) Continue to refer patients with mental health needs to community-based services when appropriate 2) Continue to build upon referral relationships with community-based resources 3) Continue to provide education and counseling in our family health clinics Anticipated outcomes: • Efficient referral relationships and responsive case management/follow-up will assist patients with finding a medical home • Increased networking and collaboration with providers in the community with drive reductions in duplicated services and improve continuity of care for populations who have traditionally experienced lower access
Sustain internal mental/behavioral health services	1) Continue to screen for mental health concerns including depression and unhealthy alcohol use in our family health clinics and create follow up plans and/or counseling plans 2) Continue to conduct behavioral risk assessment for pregnant women in our family health clinics

	Anticipated outcomes: • Patients will be provided with proper resources and referrals to combat mental illness • Behavioral Health related ED visits will be reduced

AFFORDABLE HOUSING IMPROVEMENT STRATEGY

Major Action(s)	Sub-Actions
Support local organizations that are working towards affordable housing solutions	1) Support local organizations and efforts that advocate for affordable housing in our area 2) Support local organizations that advocate for revitalization of disadvantaged neighborhoods Anticipated outcomes: • Support for these efforts will lead to improved affordable housing solutions created by local government and/or local organizations • Efforts to revitalize disadvantaged neighborhoods will result in a decreased need for new/additional affordable housing solutions in our area
Support efforts and organizations that are working to provide affordable housing/shelter/resources to homeless in our area	1) Continue to participate in monthly meetings of the City Advisory Council on Homelessness and Substance Abuse Anticipated outcomes: • City of Corpus Christi will hire city positions to focus on homelessness and housing • Increased number of area homeless population accessing assistance from the organizations and programs within the City Advisory Council on Homelessness and Substance Abuse

COMMUNITY AND FAMILY VIOLENCE IMPROVEMENT STRATEGY

Major Action(s)	Sub-Actions
Sustain and enhance relationships with local organizations	1) Continue to build upon referral relationship to community-based organizations that offer services to victims of violence and abuse 2) Consider collaborating with local organizations to provide education and awareness Anticipated outcomes: • Efficient referral relationship will ensure patients in need receive swift assistance • Increasing education on community and family violence related resources will result in increased number of individuals obtaining appropriate aid and resources

LACK OF TRUST IN COMMUNITY RESOURCES AND SYSTEMS IMPROVEMENT STRATEGY

Major Action(s)	Sub-Actions
Continue to offer and expand outreach services throughout our community	1) Continue hosting a regional collaborative meeting that focuses on expansion of resources through collaboration and shared goals 2) Continue offering women's services throughout our service area through the Care Van and explore expanding Care Van services to include emergent care and outreach to rural areas 3) Expanded provision of vaccines to the homeless, poor, and/or underserved utilizing collaborative efforts to administer vaccines Anticipated outcomes: • Improve presence and trust within the community by partnering with other community-based organizations on shared community health initiatives and offering services in rural areas through the use of the Care Van • Expanded provision of vaccines will lead to increased trust by community and increased collaboration with community-based organizations
Continue to assist members of the community in increasing their understanding of health, awareness of resources, and how to navigate	1) Continue offering services of Community Health Workers, ED Navigator, and Nurse Navigators throughout our hospitals and clinics 2) Continue to open our educational auditorium at Hector P Garcia building to community partners to provide education to the public on important health topics Anticipated outcomes: • Continuation of these services will lead to increased levels of trust patients have for community resources and systems. This will also result in reduced inappropriate ED visits, increased awareness and use of resources and how to navigate them, increased health literacy, and better health outcomes

HIGH EMERGENCY ROOM USE IMPROVEMENT STRATEGY

Major Action(s)	Sub-Actions
Improve access to appropriate care alternatives	1) Use of Care Coordination 2) Continue to collaborate with community providers to promote and educate on alternate access points 3) Explore creation of a centralized information resource with community-based organizations

	Anticipated outcomes: • Will result in increased clinic visits or referrals to our community partners that provide primary care and lead to a decrease in preventable hospitalizations.
Continue offering expanded services at CHRISTUS Spohn Family Health Centers	1) Continue providing walk-in clinic with extended hours staffed by health care providers, community health workers, and nurse navigators 2) Continue assisting patients with enrollment and renewal of Nueces County Health District plan 3) Continue the triage and empanelment process for new Nueces County Health District plan members Anticipated outcomes: • Patients will receive appropriate level of care in the appropriate setting resulting in reduced preventable hospitalizations and reduced inappropriate ED visits.

Community Needs that Cannot Be Addressed

In an effort to maximize any resources available for the priority areas listed above, leaders and staff at CSHS determined that the following issues would not be explicitly included in their CHIP:

- Diabetes
- Obesity
- Physician Recruitment & Retention
- Transportation

While the needs prioritization committee stressed that these needs remain pressing, they were not ranked high enough for inclusion in the final priority list because committee members either (a) did not feel CSHS was optimally positioned to address the need in an impactful way or (b) perceived a relative abundance of capacity and resources already being directed at the need. We believe that through our continued community collaboration with a diverse group of providers, organizations, and engaged community leaders we will continue to identify areas where we can work together to improve the health and wellness of the Coastal Bend.