# COMMUNITY HEALTH IMPROVEMENT PLAN

CHRISTUS® SANTA ROSA
Hospital
*San Marcos*

# Table of Contents


Introduction .... 4
CHRISTUS Santa Rosa – *San Marcos* .... 4
Communities of Focus .... 5
Statement of Health Equity .... 6
Community Health Needs Assessment .... 8
- Stakeholder Engagement .... 8
- Data Collection .... 8
- Community Resident Surveys .... 9
- Community Focus Groups and Key Informant Interviews .... 9
- Secondary Data .... 10

Health Issue Prioritization Process .... 11
Data Needs and Limitations .... 11
Health Priority Areas .... 14
- Approach to Community Health Improvement Plan .... 15
- Community Benefit Report Communication .... 15
- Health Priority Area 1: Advance Health & Wellbeing .... 16
- Health Priority Area 2: Build Resilient Communities & Improve Social Determinants .... 18

Appendix 1: Advance Health & Wellbeing .... 20
- Specialty Care and Chronic Illness .... 20
- Behavioral Health .... 24

Appendix 2: Build Resilient Communities & Improve Social Determinants .... 26
- Improving Food Access .... 26
- Reducing Smoking and Vaping .... 28

# 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 Santa Rosa Hospital – *San Marcos*. In this process, CHRISTUS Santa Rosa Hospital – *San Marcos* 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 Santa Rosa Hospital – *San Marcos* 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 Santa Rosa Hospital - *San Marcos* work as a nonprofit hospital. The important work of a CHNA 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 Santa Rosa Hospital – *San Marcos*, to conduct a CHNA every three years. CHRISTUS Santa Rosa Hospital – *San Marcos* completed similar needs assessments in 2013, 2016 and 2019.

The process CHRISTUS Santa Rosa Hospital – *San Marcos* 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 Santa Rosa Hospital – *San Marcos* 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 Santa Rosa Hospital – *San Marcos* 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.

# CHRISTUS Santa Rosa – *San Marcos*

CHRISTUS Santa Rosa Hospital - *San Marcos* is a non-profit hospital system serving *San Marcos*, Texas, and surrounding counties in southern Texas. CHRISTUS Santa Rosa Hospital - *San Marcos* is a 170-bed facility employing approximately 413 Associates and a medical staff of over 392 physicians. It offers comprehensive inpatient and outpatient services and is accredited by the Joint Commission. This CHNA covers the service areas for CHRISTUS Santa Rosa Hospital - *San Marcos*.

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 Charity of the Incarnate Word - Houston and Sisters of Charity of the Incarnate Word - San Antonio that began in 1866. In 2016, the Congregation of 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 Santa Rosa Hospital – *San Marcos* 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 Santa Rosa Hospital - *San Marcos* CHNA primary service area includes 7 zip codes covering over 286,000 individuals (Table 1). The primary service area (PSA) is the geographic region with 80% of hospital utilization. The primary service area zip codes are in the following counties: Caldwell and Hays (Figure 1).

While the hospital is dedicated to providing exceptional care to all of the residents in the region, CHRISTUS Santa Rosa Hospital - *San Marcos* 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 SANTA ROSA HOSPITAL – SAN MARCOS PSA | | |
|---|---|---|
| Hays & Caldwell Counties<br>*Kyle, TX* | Caldwell County<br>*Lockhart, Mustang Ridge and Niederwald, TX* | Caldwell, Gonzales, and Guadalupe Counties<br>*Luling, Texas* |
| 78130 | 78132 | 78133 |
| Caldwell and Guadalupe Counties<br>*Martindale, TX* | Hays County<br>*San Marcos and Austin, TX* | Hays and Blanco Counties<br>*Wimberley, TX* |
| 78655 | 78666 | 78676 |

*Table 1. Primary Service Area of CHRISTUS Santa Rosa Hospital – San Marcos*

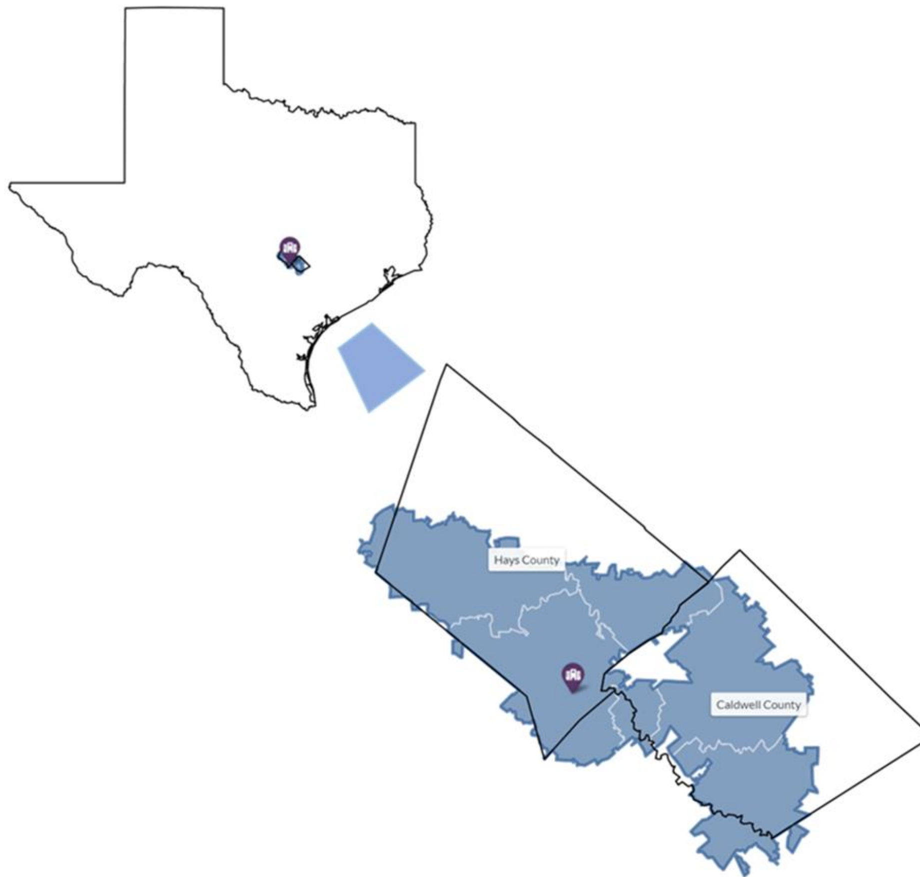


*Figure 1. Primary Service Area of CHRISTUS Santa Rosa Hospital – New Braunfels*

# Statement of Health Equity

While community health needs assessments (CHNA) and Improvement Plans are required by the IRS, CHRISTUS Santa Rosa Hospital – *San Marcos* 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 Santa Rosa Hospital - *San Marcos* 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 Santa Rosa Hospital - *San Marcos* guided the strategic direction of Metopio through roles on various committees and workgroups.

CHRISTUS Santa Rosa Hospital - *San Marcos* 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 Santa Rosa Hospital - *San Marcos* 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 Santa Rosa Hospital - *San Marcos* 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 Santa Rosa Hospital - *San Marcos* 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.
- provides greater insight into community health needs and strategies for ongoing community health priorities.
- leverages expertise of community residents and includes a broad range of sectors and voices that are disproportionately affected by health inequities.
- provides an overview of community health status and highlights data related to health inequities.
- informs strategies related to connections between community and clinical sectors, anchor institution efforts, policy change, and community partnerships.
- highlights and discuss health inequities and their underlying root causes throughout the assessment.

## Data Collection

CHRISTUS Santa Rosa Hospital - *San Marcos* 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 a CHNA. It focuses on community engagement, partnership development and seeking channels to engage people who have often not been part of the decision-making process.

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 Public Health Services

## Community Resident Surveys

Between October and December of 2021, 271 residents in the CHRISTUS Santa Rosa - *San Marcos* 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 Santa Rosa - *San Marcos* and its community partners. The survey sought input from priority populations in the CHRISTUS Santa Rosa - *San Marcos* 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 Santa Rosa Hospital - *San Marcos* PSA. This was done through focus groups and key informant interviews.

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

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

In addition to the focus groups, ten key informants were identified by CHRISTUS Santa Rosa Hospital - *San Marcos* Management team for one-on-one interviews and two participated in the 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 Santa Rosa Hospital - *San Marcos* used a common set of health indicators to understand the prevalence of morbidity and mortality in the CHRISTUS Santa Rosa Hospital - *San Marcos* 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 2). Where possible, CHRISTUS Santa Rosa Hospital - *San Marcos* 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 Santa Rosa Hospital - *San Marcos* sought more granular datasets to illustrate hardship.

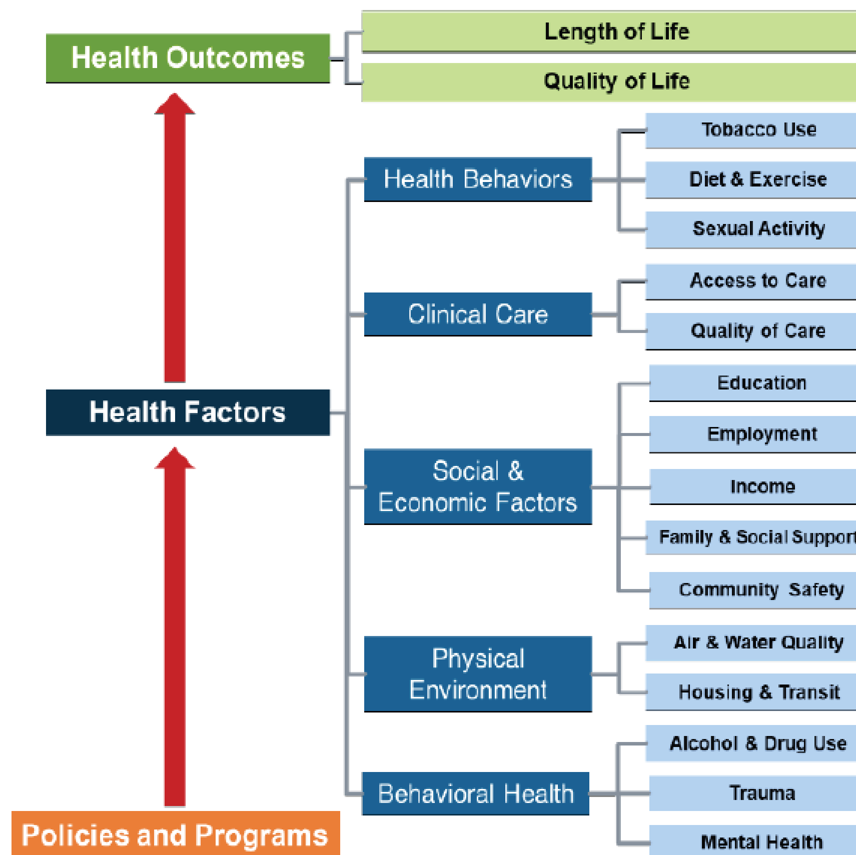


*Figure 2. Illustration of the County Health Rankings MAPP Framework*

# 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? | 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 Santa Rosa Hospital - *San Marcos* 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 is 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 Santa Rosa Hospital - *San Marcos*, 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 priorities for the communities served by CHRISTUS Santa Rosa Hospital - *San Marcos* for 2023-2025 are 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

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

Build Resilient Communities and Improve Social Determinants

1. Improving food access
2. Reducing smoking and vaping

*Figure 3. CHRISTUS Santa Rosa Hospital – San Marcos 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:

Care Delivery Innovations

Community Based Outreach

Grant Making

Medical Education

Partnerships

Public Policy

Outlined below are the specific strategies and initiatives corresponding to each of the selected health priority areas. See Appendix 1 to a fully detailed evaluation framework relating to these strategies.

## Community Benefit Report Communication

CHRISTUS Santa Rosa – *San Marcos* 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 Santa Rosa – *San Marcos* 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 | BEHAVIORAL HEALTH | BEHAVIORAL HEALTH |
| Provide screening and education opportunities about diabetes, obesity, and heart disease | Empower community members to manage diabetes, obesity, and heart disease | Reduce preventable Emergency Department usage for mental health | Create community connections for mental health services |
| • Expand free/subsidized basic health screenings that provide a baseline for making healthy choices and distribute supporting chronic condition(s) educational material.<br>• Together with community partners, continue promoting the ideals of healthy living by addressing management of comorbidities through community education initiatives focused on chronic condition(s). | • Provide supporting chronic condition(s) educational material on managing comorbidities to community members.<br>• Create a forum to Increase awareness and early detection by collaborating with community partners to demonstrate the importance of eating a well-balanced diet, maintaining healthy body weight, and regular exercise, thus addressing obesity. | • Continue care screening for social determinants of health identifying signs of mental health illness.<br>• Provide well-trained sitters to keep at-risk patients safe. | • Establish personalized intervention community resources responding to individual needs that otherwise go untreated.<br>• Create community partnerships and resources addressing mental health services. |
| BEHAVIORAL HEALTH | PRIMARY CARE | PRIMARY CARE | EDUCATION |
| Increase access to substance abuse treatment | Increase access to primary care | Reduce inequities caused by cultural barriers to care | Establish community health education access points |

| | | | |
|---|---|---|---|
| • Identify community substance abuse treatment resources student internships | • Navigate the uninsured and underinsured to "Enroll SA" coalition of healthcare/community enrollment, faith-based & community organizations with the sole goal of increasing health insurance enrollment<br>• Provide safety-net of affordable medical resources highlighting FQHCs and free community clinics<br>• Encourage patients to establish care with a primary care physician | • Train healthcare staff in cultural competency, shared decision-making, and plain language<br>• Utilize Language Line to limit communication barriers | • Advance partnerships with public health, social services, and community stakeholders to identify access points of information, services, resources, and community-based initiatives<br>• Train, but not limited to, Case Managers, Social Workers and Community Health Workers on subject matter, resources, and community initiatives |

CHRISTUS Santa Rosa Hospital – *San Marcos* will continue to invest in care delivery innovations and expand programs that address prevention for **diabetes, obesity and heart disease** and improve access to care. ***Key programs*** that support these initiatives are:

- CHRISTUS Santa Rosa Hospital – *San Marcos* Nursing and Clinical Education
- CHRISTUS Santa Rosa Hospital – *San Marcos* Mammography Education Program & Mobile
- CHRISTUS Santa Rosa Hospital – *San Marcos* Stroke Education Program
- CHRISTUS Santa Rosa Hospital – *San Marcos* Diabetes Education Program
- CHRISTUS Santa Rosa Hospital – Community Health Worker Program

And CHRISTUS Santa Rosa Hospital – *San Marcos* will focus on building a coalition to address **Behavioral Health issues** in the service area. ***Partners*** include:

- Southwest Texas Regional Advisory Council (STRAC)
- CHRISTUS – Behavioral Sitter Program
- Clarity Child Guidance Center – Community Behavioral & Mental Health Well-Being
- Alpha Home & Rise Recovery – Community Behavioral & Mental Health Well-Being
- Hays-Caldwell Women's Center

## 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 | REDUCE SMOKING | REDUCE VAPING |
| Cultivate and maintain partnerships to improve access to healthy food in food deserts | Provide nutrition education for patients | Develop a community-based smoking cessation program | Partner with schools to reduce vaping among students |
| • Increase collaboration among community organizations with services/programs such as mobile pantries, home delivery, School Meals Map, mega food distributions, as well as Special supplemental Nutrition Program for Women, Infants, and Children (WIC) and Supplemental Nutrition Assistance Program (SNAP) | • Increase awareness of the importance of eating a well-balanced diet, maintaining healthy body weight, and regular exercise to improve social determinants.<br>• Promote Food Prescription, SNAP, WIC, etc... and healthy cooking education. | • Develop community-based initiatives focused on promoting smoking cessation / health intervention initiatives | • Collaborate with student organizations and substance abuse counselors in school districts to service primary low income and minority students. |

CHRISTUS Santa Rosa Hospital – *San Marcos* 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:

- San Antonio Food Bank (Bexar, Comal, Guadalupe)
- Alcoholics Anonymous – San Marcos
- San Marcos Youth Services
- Hays County Food Bank
- St. Vincent De Paul Society
- Nicotine Anonymous

# STRATEGIES

# Appendix 1: Advance Health & Wellbeing

## Specialty Care and Chronic Illness

**Goal:**

1. Provide screening and education opportunities about heart disease, obesity, and diabetes.
2. Empower community members to manage their heart disease, obesity, and diabetes.
3. Increase access to primary care.
4. Reduce inequities by cultural barriers to 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?* |

| | | | | | | |
|---|---|---|---|---|---|---|
| Provide health education and screening for diabetes, obesity, and heart disease | Reduce the risk of developing a chronic disease by increasing health access to preventative screenings and awareness of contributing factors by providing educational material through partnerships. | American Heart Association<br><br>New Braunfels Food Bank<br><br>American Diabetes Association<br><br>YMCA – New Braunfels<br><br>CHRISTUS – Children's Mobile Unit<br><br>CHRISTUS – Mammography Unit<br>CHRISTUS – Physician Recruitment<br><br>CHRISTUS - Community Health Worker Program<br><br>CHRISTUS - Stroke | Leader / Collaborator | Begin: FY23 Q1<br><br>End: FY25 Q4 | Hays, Caldwell 78640<br><br>Caldwell 78644<br><br>Caldwell, Gonzales, Guadalupe 78648<br><br>Caldwell, Guadalupe 78655<br><br>Hays 78666<br><br>Hays, Blanco 78676 | • # of program participants<br>• % of participants who were satisfied with the program<br>• # of individuals whose blood pressure improved within 6 months<br>• % of individuals whose blood pressure improved within 6 months |

| | | | | | | |
|---|---|---|---|---|---|---|
| Empower community members to manage their heart disease, obesity, and diabetes. | Increase community awareness regarding preventative and detection of chronic disease to help in early and timely intervention that encourages a change in lifestyle habits by participating in health fairs and presentations. | American Heart Association<br><br>New Braunfels Food Bank<br><br>American Diabetes Association<br><br>YMCA – New Braunfels<br><br>CHRISTUS Children's Mobile Unit<br><br>CHRISTUS - Community Health Worker Program<br><br>CHRISTUS - Stroke | Leader / Collaborator | Begin:<br><br>FY23 Q1<br><br>End:<br><br>FY25 Q4 | Hays, Caldwell 78640<br><br>Caldwell 78644<br><br>Caldwell, Gonzales, Guadalupe 78648<br><br>Caldwell, Guadalupe 78655<br><br>Hays 78666<br><br>Hays, Blanco 78676 | • # of program participants<br>• % of participants who were satisfied with the program<br>• # of individuals whose blood pressure improved within 6 months<br>• % of individuals whose blood pressure improved within 6 months |
| Increase access to primary care. | Increase enrollment into health insurance through community partnership efforts. | CHRISTUS - Community Health Worker Program | Leader / Collaborator | Begin:<br>FY23 Q1<br><br>End:<br>FY25 Q4 | Hays, Caldwell 78640<br><br>Caldwell 78644<br><br>Caldwell, Gonzales, Guadalupe 78648<br><br>Caldwell, Guadalupe 78655<br><br>Hays 78666<br><br>Hays, Blanco 78676 | • # of program participants<br>• % of participants who were satisfied with the program<br>• # of individuals whose blood pressure improved within 6 months<br>• # of individuals whose blood pressure improved within 6 months |

| | | | | | | |
|---|---|---|---|---|---|---|
| Reduce inequities by cultural barriers to care. | Increase use of interpreter service, knowledge, and skills to address a patient's beliefs and religious beliefs. | CHRISTUS – HR Department<br>CHRISTUS – Interpreter Services<br>CHRISTUS – Pastoral Care / Chaplains | Leader / Collaborator | Begin:<br><br>FY23 Q1<br><br>End:<br><br>FY25 Q4 | Hays, Caldwell 78640<br><br>Caldwell 78644<br><br>Caldwell, Gonzales, Guadalupe 78648<br><br>Caldwell, Guadalupe 78655<br><br>Hays 78666<br><br>Hays, Blanco 78676 | • # of program participants<br>• % of participants who were satisfied with the program<br>• # of individuals whose blood pressure improved within 6 months<br>• % of individuals whose blood pressure improved within 6 months |

# Behavioral Health

**Goal:**

1. Reduce preventable Emergency Department usage for mental health.
2. Create community connections for mental health services.
3. Increase access to substance abuse treatment.
4. Establish community health education access points.

| 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 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?* |
| Reduce preventable Emergency Department usage for mental health. | Increased collaboration with primary care clinicians to integrate and improve care and communications.<br><br>Connect patients and families to alternative resources and providing education on the | The Southwest Texas Regional Advisory Council (STRAC) – Southwest Texas Crises Collaboration (STCC)<br><br>CHRISTUS Community Health Worker program<br><br>CHRISTUS – Case Management<br><br>CHRISTUS – Center for Miracles | Leader / Collaborator | Begin: FY23 Q1<br><br>End: FY25 Q4 | Hays, Caldwell 78640<br><br>Caldwell 78644<br><br>Caldwell, Gonzales, Guadalupe 78648<br><br>Caldwell, Guadalupe 78655 | • # of program participants<br>• % of participants who were satisfied with the program<br>• # of individuals whose blood pressure improved within 6 months<br>• % of individuals whose blood pressure improved within 6 months |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | appropriate use of the ED | | | | Hays<br>78666<br><br>Hays, Blanco<br>78676 | |
| | Create community connections for mental health services. | Participate in a safe shared space to interact and foster collaboration to provide behavioral health awareness and community resources for individuals coping with mental illness, addiction, and the aftermath of trauma and abuse. | The Southwest Texas Regional Advisory Council (STRAC) – Southwest Texas Crises Collaboration (STCC)<br><br>CHRISTUS –Community Health Worker program<br><br>CHRISTUS – Case Management | Leader / Collaborator | Begin:<br>FY23 Q1<br><br>End:<br>FY25 Q4 | Hays, Caldwell<br>78640<br><br>Caldwell<br>78644<br><br>Caldwell, Gonzales, Guadalupe<br>78648<br><br>Caldwell, Guadalupe<br>78655<br><br>Hays<br>78666<br><br>Hays, Blanco<br>78676 | • # of program participants<br>• % of participants who were satisfied with the program<br>• # of individuals whose blood pressure improved within 6 months<br>• % of individuals whose blood pressure improved withn 6 months |
| | Increase access to substance abuse treatment. | Provide a list of substance abuse treatment resources | CHRISTUS –Community Health Worker program<br><br>CHRISTUS – Case Management<br><br>Alcoholics Anonymous | Leader/ Collaborator | Begin:<br>FY23 Q1<br><br>End:<br>FY25 Q4 | Hays, Caldwell<br>78640<br><br>Caldwell 78644<br><br>Caldwell, Gonzales, Guadalupe 78648<br><br>Caldwell, Guadalupe 78655<br><br>Hays 78666 | • # of program participants<br>• % of participants who were satisfied with the program<br>• # of individuals whose blood pressure improved within 6 months<br>• % of individuals whose blood pressure |

# Appendix 2: Build Resilient Communities & Improve Social Determinants

## Improving Food Access

**Goal:**

1. Cultivate and maintain partnerships to improve access to healthy food in food deserts.
2. Provide nutrition education for patients.

| 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?* |
| Cultivate and maintain partnerships to improve access to healthy food in food deserts | Increase limited access to food resources, particularly healthy and culturally appropriate food | Women, Infant, and Children (WIC) Program<br><br>New Braunfels Food Bank<br><br>San Antonio Food Bank | Leader / Collaborator | Begin: FY23 Q1<br><br>End: FY25 – Q4 | Hays, Caldwell 78640<br><br>Caldwell 78644<br><br>Caldwell, Gonzales, Guadalupe 78648 | • # of program participants<br>• % of participants who were satisfied with the program<br>• # of individuals whose blood pressure improved within 6 months |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | S.O.S. Food Bank (Spirit of Sharing Food Bank) | | | Caldwell, Guadalupe 78655<br><br>Hays 78666<br><br>Hays, Blanco 78676 | • % of individuals whose blood pressure improved within 6 months |
| Provide nutrition education for patients | Offer a set of learning experiences designed to assist in healthy eating choices and other nutrition-related behavior | Women, Infant, and Children (WIC) Program<br><br>New Braunfels Food Bank<br><br>San Antonio Food Bank<br><br>S.O.S. Food Bank (Spirit of Sharing Food Bank) | Leader | Begin: FY23 Q1<br><br>End: FY25 – Q4 | Hays, Caldwell 78640<br><br>Caldwell 78644<br><br>Caldwell, Gonzales, Guadalupe 78648<br><br>Caldwell, Guadalupe 78655<br><br>Hays 78666<br><br>Hays, Blanco 78676 | • # of program participants<br>• % of participants who were satisfied with the program<br>• # of individuals whose blood pressure improved within 6 months<br>• % of individuals whose blood pressure improved within 6 months |

# Reducing Smoking and Vaping

**Goal:**

1. Develop a community-based smoking cessation program
2. Partner with schools to reduce vaping among students

| 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?*<br><br>*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?* |

| | | | | | | |
|---|---|---|---|---|---|---|
| Develop a community-based smoking cessation program | To increase awareness of the negative consequences of smoking | Alcoholics Anonymous –San Marcos | Leader / Collaborator | Begin: FY23 Q1<br><br>End: FY25 Q4 | Hays, Caldwell 78640<br><br>Caldwell 78644<br><br>Caldwell, Gonzales, Guadalupe 78648<br><br>Caldwell, Guadalupe 78655<br><br>Hays 78666<br><br>Hays, Blanco 78676 | • # of program participants<br>• % of participants who were satisfied with the program<br>• # of individuals whose blood pressure improved within 6 months<br>• % of individuals whose blood pressure improved within 6 months |
| Partner with schools to reduce vaping among students | To develop an alliance with schools for a healthier generation awareness campaign | Alcoholics Anonymous –San Marcos<br><br>American Heart Association | Leader / Collaborator | Begin: FY23 Q1<br><br>End: FY25 Q4 | Hays, Caldwell 78640<br><br>Caldwell 78644<br><br>Caldwell, Gonzales, Guadalupe 78648<br><br>Caldwell, Guadalupe 78655<br><br>Hays 78666<br><br>Hays, Blanco 78676 | • # of program participants<br>• % of participants who were satisfied with the program<br>• # of individuals whose blood pressure improved within 6 months<br>• % of individuals whose blood pressure improved within 6 months |