COMMUNITY HEALTH IMPROVEMENT PLAN

2023-2025

CHRISTUS®
TRINITY MOTHER FRANCES
Health System

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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 Trinity Mother Frances Health System (CTMFHS). In this process, CTMFHS directly engages community members and stakeholders to identify the issues of greatest need as well as the largest impediments to health. With this information, CTMFHS can better allocate resources towards efforts to improve community health and wellness.

Directing resources toward the greatest needs in the community is critical to CTMFHS's work as a nonprofit hospital. The important work of CHNAs was codified in the Patient Protection and Affordable Care Act added Section 501(r) to the Internal Revenue Service Code, which requires nonprofit hospitals, including CTMFHS, to conduct a CHNA every three years. CTMFHS completed similar needs assessments in 2013, 2016 and 2019.

The process CTMFHS 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 CTMFHS 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 CTMFHS' 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, community health needs assessment process, health needs prioritization process, and the strategies to address the health priorities.

CHRISTUS Trinity Mother Frances Health System

In 1937, the Sisters of the Holy Family of Nazareth came to Tyler from the Sacred Heart Province in Chicago to help open a new hospital. Mother Frances Hospital opened a day earlier than planned due to a major tragedy that struck a neighboring community – the New London gas explosion. The Sisters and staff at Mother Frances Hospital were able to care for the victims of the explosion and set the legacy of this Ministry in motion.

What began as a 60-bed not-for-profit hospital has grown to a health system comprised of eight hospitals with a total of 852 beds and over 4,681 Associates. Additionally, this health system includes 47 CHRISTUS Trinity Clinic locations, the largest multi-specialty medical group in the area with more than 470 providers.

In 2016, CHRISTUS Trinity Mother Frances Health System entered into a partnership with CHRISTUS Health to begin a period of extraordinary growth built on the values of dignity, integrity, excellence, compassion, and stewardship. In joining the CHRISTUS Health family, CHRISTUS Trinity Mother Frances Health System joined a legacy of caring and

compassion that goes back to the mid-19th century. The Sisters of the Holy Family of Nazareth joined the two founding congregations of the Sisters of Charity of the Incarnate Word of San Antonio and the Sisters of Charity of the Incarnate Word of Houston to continue the sacred mission of extending the healing ministry of Jesus Christ. This is the Mission of our founders; it remains unchanged.

In 2017, CHRISTUS Trinity Mother Frances – South Tyler opened to expand emergency care access to the residents of southern Tyler and surrounding areas.

In 2020, CHRISTUS Mother Frances Hospital – Tyler opened the Bradley-Thompson Tower, the massive new expansion increasing the Emergency and intensive care capabilities of the system.

In 2020, CHRISTUS Trinity Mother Frances Health System unveiled 24/7 emergency care center in Canton, Texas as an expansion of the CHRISTUS Trinity Mother Frances HealthPark.

In 2021, CHRISTUS Trinity Mother Frances Health System opened the Orthopedic and Sports Medicine Institute (OSMI)

Northeast Texas Cancer & Research Institute (in partnership with Texas Oncology) – Opening Fall 2022

24/7 Emergency Care Center in Lindale, TX as an expansion of CHRISTUS Trinity Mother Frances HealthPark – Opening Fall of 2022

24/7 Emergency Care Center in Athens, TX as an expansion of CHRISTUS Trinity Clinic – Opening Spring of 2023

CTMFHS exemplifies the founders' vision and mission in the everyday business and in collaborative community activities of the hospital, providers' offices, rural clinics, volunteers, and community leaders. The administration and staff of CHRISTUS Mother Frances Hospitals, CHRISTUS Trinity Clinics, and the founding congregations have a shared vision and a shared mission. The vision is that, as a Catholic health ministry, they will 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. Our Mission is to extend the healing ministry of Jesus Christ.

Representing the integrated health system, the executive team has vowed that CTMFHS will be a leading health care system throughout the region, state, and country in promoting the health and quality of life in the communities they serve. It is a part of the history and tradition of not-for-profit hospitals that they exist to serve community needs – that is their heritage. They work in partnership with the regional communities to address the most critical and difficult issues from early intervention programs for children, teenage health issues, community needs, rural health care issues, the plight of the elderly, and primary access issues.

CTMFHS makes targeted investments in programs, services and events that benefit all people throughout the communities, not just patients or members based on community needs. Innovative in finding solutions to difficult community issues, they do more than just make cash contributions and instead are involved in the community as a caring partner and participant. CTMFHS's community commitment is embodied in their mission and carried out by their family of employees.

CHRISTUS MOTHER FRANCES HOSPITAL – *Tyler*

Serving east Texas since March 18, 1937, CHRISTUS Mother Frances Hospital – *Tyler* (CMFH-T) is a 457-bed acute care facility located in the heart of Tyler, Texas, offering a wide range of services including emergency and trauma care, medical and surgical care, Tyler's ONLY Level III neonatal intensive care unit, Level III Maternal unit, pediatrics, advanced neurosurgical, orthopedic, and cardiac care. In 2012, the hospital expanded to add the CHRISTUS Trinity Mother Frances Louis and Peaches Owen Heart Hospital with a total bed count of 96 which features some of the most

innovative and advanced technology and healing concepts in the world. At CTMFHS our quality and safety efforts are evidence for the depth of work that is underway and ongoing, with the well-being of our patients as the ultimate goal. Our commitment to serving the east Texas region with compassion, excellence and efficiency has earned Mother Frances Hospital – Tyler national recognition.

We are a Level II Trauma Center, and the only Level III NICU and Level III Maternal Designation in Smith County. It is a distinguished honor to be the first hospital in the country to receive the American College of Cardiology HeartCARE Center of Excellence award, as well as numerous other distinctions, such as Blue Cross Blue Shield Blue Distinction Center+ for Hip and Knee Replacement, and the area's first Advanced Certification for Comprehensive Stroke Center by the Joint Commission. We are committed to delivering compassionate, quality care to our communities in which we serve.

A Tradition of Excellence

- American College of Cardiology Chest Pain Center Primary PCI with Resuscitation Accreditation
- American College of Cardiology Heart Failure Accreditation
- American College of Cardiology Cardiac Cath Lab Accreditation with PCI
- American Association of Cardiovascular and Pulmonary Rehabilitation Certified Program
- American College of Cardiology: HeartCARE Center of Excellence 2018-2021
- American College of College of Cardiology Certified Transcatheter Valve Accreditation
- U.S. News & World Report: Best Hospitals
- American College of Cardiology's NCDR Chest Pain – MI Registry Platinum Performance Achievement Award 2021
- American College of Cardiology's NCDR Chest Pain – MI Registry Gold Performance Achievement Award 2020
- Newsweek Best Maternity Hospitals
- Bishop Herzig Humanitarian Award
- Texas Department of State Health Services – Level III Maternal Care Facility
- NRC Health Top 100 Consumer Loyalty
- 5-Star Rating by Centers for Medicare & Medicaid Services
- American Heart Association/American Stroke Association's Get with the Guidelines Target: Stroke Honor Roll Silver Plus Quality Achievement Award – 2020
- Transcatheter Aortic Valve Replacement Accreditation

Previous Honors

- American College of Cardiology: First in U.S. HeartCARE Center of Excellence designation
- American Heart Association: First in Texas Cardiovascular Center of Excellence accreditation
- American College of Radiology Breast Imaging Center of Excellence
- American Medical Group Association (AMGA) Acclaim Award: #1 in Nation 2018 Acclaim Award
- Becker's Hospital Review: Recognized as "100 Great Community Hospitals" in the U.S. five years
- Blue Cross Blue Shield Distinction Center+: Cardiac Care, Bariatric Care, Spine Care
- CareChex: #1 in Texas for Clinical Excellence in Overall Hospital Care 2018; Recognized seven consecutive years
- CNOR® Strong for excellence in perioperative nursing – 2015
- Healthgrades: Recognized for 15 years in more than 40 categories for clinical excellence and safety
- Healthcare Financial Management Association: 2017 MAP Award for High Performance in Revenue Cycle
- The Joint Commission: 1st in Texas to achieve Gold Seal for "Advanced" Certification in Total Hip| Knee Replacement; 2018 Advanced Certification for Comprehensive Stroke Centers Designee
- LeapFrog Group: "A" Hospital Safety Ratings seven years; Twice named Top Hospital

- Magnet Designation: American Nurses Credentialing Center (ANCC) Magnet® facilities – Gold Standard in Nursing and Patient Care
- National Committee for Quality Assurance (NCQA) designation since 2014
- Studer Group: Excellence in Patient Care 2017
- Truven Health Analytics:100 Top Hospitals 2017; recognized seven times
- U.S. News & World Report: 2013-2018 Best Regional Hospitals Northeast Texas; Recognized in more than six specialties
- American College of Cardiology's NCDR Chest Pain - MI Registry Gold Performance Achievement Award
- American College of Cardiology Chest Pain Center Primary PCI with Resuscitation Accreditation
- American College of Cardiology Cardiac Cath Lab Accreditation with PCI
- American College of Cardiology Heart Failure Accreditation
- American Association of Cardiovascular and Pulmonary Rehabilitation Certified Program
- American Association of Critical – Care Nurses Beacon Award for Excellence

CHRISTUS Mother Frances Hospital is licensed by the Texas Department of Health and accredited by the Joint Commission of Healthcare Organizations.

CHRISTUS MOTHER FRANCES HOSPITAL – *Jacksonville*

Responding to community requests and identified needs for expanded health care services for the entire community in a not-for-profit environment, CHRISTUS Mother Frances Hospital – *Jacksonville* (CMFH-J) opened in 2001 as a critical access hospital with 25 beds. CMFH-J has expanded clinic access to physicians and provided them within the same medical complex as the hospital itself. This proximity provides better communication of medical information and offers patients more advanced care options.

Services at the hospital include a Level IV Trauma Center, bone densitometry, cardiology, gastroenterology, general surgery, mammography, gynecology, vascular, oncology, orthopedic and joint replacement capabilities, interventional pain management, podiatry, pulmonologist, sleep medicine, radiology, laboratory, and other diagnostic services. CHRISTUS Mother Frances Hospital – *Jacksonville* provides patients with primary care, urgent care, cardiac and pulmonary rehabilitation, dental surgery, urology, physical therapy, and a hospitalist program. Optometry services are now available in the CHRISTUS Trinity Optical Center.

CHRISTUS Mother Frances Hospital – *Jacksonville* is accredited by The Joint Commission.

CHRISTUS Mother Frances Hospital – *Jacksonville* 2014 – Hospital Quality Improvement Award – Gold Award

CHRISTUS Mother Frances Hospital receives 2021 Team DAISY award

CHRISTUS MOTHER FRANCES HOSPITAL – *Winnsboro*

Civic-minded citizens-built Winnsboro Memorial Hospital in 1960 to serve the people of Northeast Texas and particularly those in Wood, Franklin, and Camp counties. Over the years, the hospital has worked to bring rural clinics and physicians to the community to provide better access to medical services to the area.

In December 1983, the hospital merged with Presbyterian Medical Center, Dallas, and two years later a new facility opened and served the community for more than 20 years.

Winnsboro Hospital enjoyed a rich history of serving as the acute care hospital of choice for the residents of its surrounding area. In 2010, the hospital joined the CHRISTUS Trinity Mother Frances Health System and is now

known as CHRISTUS Mother Frances Hospital – *Winnsboro* (CMFH-W). CHRISTUS Mother Frances Hospital-*Winnsboro,* a 25-bed hospital, has received the status of a critical access hospital.

The primary service area for CHRISTUS Mother Frances Hospital – – *Winnsboro* is Wood County and the surrounding rural counties. The primary referral hospital for the patients in the service area is CHRISTUS Mother Frances Hospital-*Tyler.*

CHRISTUS Mother Frances Hospital – *Winnsboro* 2014 – Hospital Quality Improvement Award – Gold Award

CHRISTUS MOTHER FRANCES HOSPITAL – *Sulphur Springs*

We are proud to have served the residents of Hopkins County and surrounding areas since 1949. CHRISTUS Mother Frances Hospital – *Sulphur Springs* is a licensed 96-bed, Level IV Trauma and Primary Stroke Center with a full-service Emergency Department and 24/7 access to Intensivists, Hospitalists & a state-of-the-art Cath Lab.

Services at the hospital include a Level III NICU (Neonatal Intensive Care Unit), Level II Maternal Designation, 10-bed ICU, 10-bed Inpatient Rehab, Ruth & Jack Gillis Women's Center, 2 Hyperbaric Chambers and Outpatient Therapy. EMS award Lifeline Gold Plus by AHA for excellent STEMI care, Primary Stroke Center recognized with the Joint Commission Gold Seal of Approval for Stroke.

CHRISTUS Mother Frances Hospital has a medical staff of more than 350 providers including most specialties and 10 CHRISTUS Trinity Clinic locations including Primary Care and Urgent care, plus several specialties.

CHRISTUS MOTHER FRANCES Rehabilitation Hospital

CHRISTUS Trinity Mother Frances Rehabilitation Hospital, a partner of Encompass Health, is committed to helping patients regain independence after a life-changing illness or injury. Located in Tyler and serving east Texas, this hospital is a leading provider of inpatient rehabilitation for stroke, hip fracture, and other complex neurological and orthopedic conditions.

This is a 94-bed inpatient rehabilitation hospital uses an interdisciplinary team approach that includes physical, speech and occupational therapists, rehabilitation physicians, rehabilitation nurses, case managers, dietitians and more, combined with advanced technology and expertise, to help patients achieve their goals.

Our rehabilitation hospital proudly displays the Joint Commission's Gold Seal of Approval for Disease-Specific Care Certification in stroke rehabilitation, cardiac rehabilitation, hip fracture rehabilitation and amputee rehabilitation, as well as the Stroke Center of Excellence award by Encompass Health.

CHRISTUS Health

CHRISTUS Health is a Catholic health system formed in 1999 to strengthen the faith-based health care ministries of the Congregations of the Sisters of the Incarnate Word of Houston and San Antonio that began in 1866. In 2016, the Sisters of the Holy Family of Nazareth became the third sponsoring congregation to CHRISTUS Health. Today, CHRISTUS Health operates 25 acute care hospitals and 92 clinics in Texas. CHRISTUS Health facilities are also located in Louisiana, Arkansas, and New Mexico. It also has 12 international hospitals in Colombia, Mexico, and Chile. As part of CHRISTUS Health's mission "to extend the healing ministry of Jesus Christ," CHRISTUS Trinity Mother Frances Health System 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, CTMFHS's total primary service area includes 38 zip codes covering over 475,000 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: Anderson, Cherokee, Delta, Franklin, Henderson, Hopkins, Rains, Rusk, Smith, Van Zandt, and Wood (Figure 1).

While the hospital is dedicated to providing exceptional care to all of the residents in East Texas, CTMFHS 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			
Anderson County, TX	Cherokee County, TX	Delta County, TX	Franklin County, TX
75763	75757	75432	75457
75801	75766		
75803	75785		
Henderson County, TX	Hopkins County, TX	Rains County, TX	Rusk County, TX
75751	75420, 75431, 75433	75440	75654
75758	75437, 75482		
Smith County, TX	Van Zandt County, TX	Wood County, TX	
75701, 75702, 75703	75103	75494, 75497	
75704, 75706, 75707	75140	75765, 75773	
75708, 75709, 75762	75754	75783	
75771, 75789, 75791	75790		

Table 1. Primary Service Area of CTMFHS
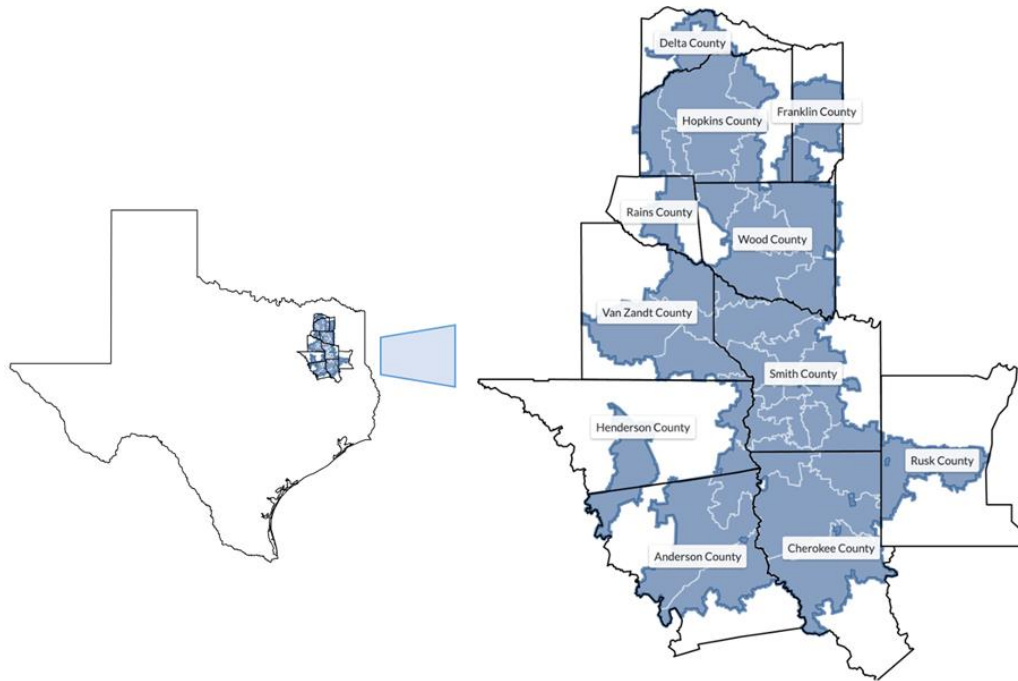
Figure 1. Primary Service Area of CTMFHS

Statement of Health Equity

While community health needs assessments (CHNA) and Improvement Plans are required by the IRS, CTMFHS 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

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, CTMFHS 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 CTMFHS guided the strategic direction of Metopio through roles on various committees and workgroups.

CTMFHS 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 CTMFHS 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 CTMFHS'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 CTMFHS leadership team developed parameters for the 2023–2025 CHNA/CHIP 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

CTMFHS 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, 1,365 residents in the CTMFHS service are 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 CTMFHS and its community partners. The survey sought input from priority populations in the CTMFHS 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 CTMFHS PSA. This was done through focus groups and key informant interviews.

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

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

CTMFHS 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, 20 key informants were identified by the CTMFHS Community Benefit 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

CTMFHS used a common set of health indicators to understand the prevalence of morbidity and mortality in the CTMFHS and Sulphur Spring Hospital PSAs and compare them to benchmarks—the state of Texas and the full CHRISTUS Health service area, which covers regions of Texas, Louisiana, Arkansas, and New Mexico. When available in the data, the United States is also used as a benchmark. Building on previous CHNA work, these measures have been adapted from the County Health Rankings MAPP framework (Figure 2). Where possible, CTMFHS used data with stratifications so that health inequities could be explored and better articulated. Given the community input on economic conditions and community safety, CTMFHS sought more granular datasets to illustrate hardship.
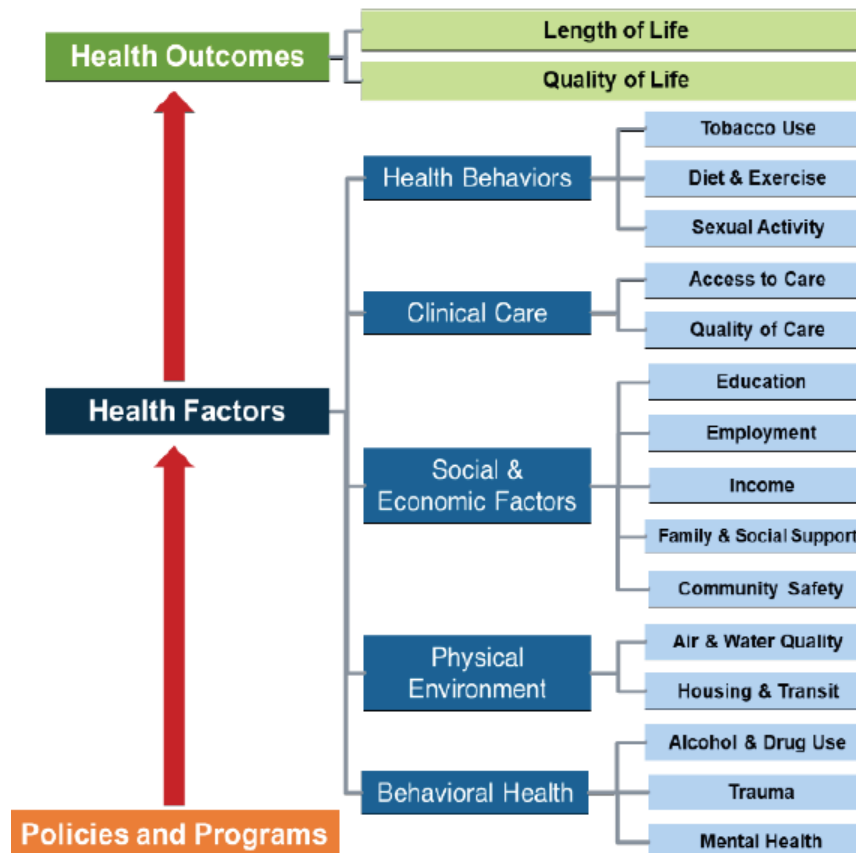

Figure 2. Illustration of the County Health Rankings MAPP Framework

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

CTMFHS 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, CTMFHS, 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

For this cycle, CTMFHS is using a new structure for its identified needs, categorizing them under two domains with the overarching goal of achieving health equity (Figure 3). While the prioritization structure is new, CTMFHS retained mental health as a priority issue from the 2020 – 2022 CHNA. In the previous CHNA, CTMFHS identified chronic illness as a priority. In this cycle, CTMFHS unpacked "chronic illness" and specifically calls out diabetes, heart disease, obesity and cancer. Newly identified issues include substance abuse, food access and smoking and vaping.

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

A. Advance Health and Wellbeing

1. Specialty Care and Chronic Disease Management
   - Obesity
   - Heart Disease
   - Diabetes
   - Cancer
2. Behavioral Health
   - Mental Health
   - Substance Abuse
3. Primary Care
4. Education

B. Build Resilient Communities and Improve Social Determinants

1. Improving food access
2. Reducing smoking and vaping
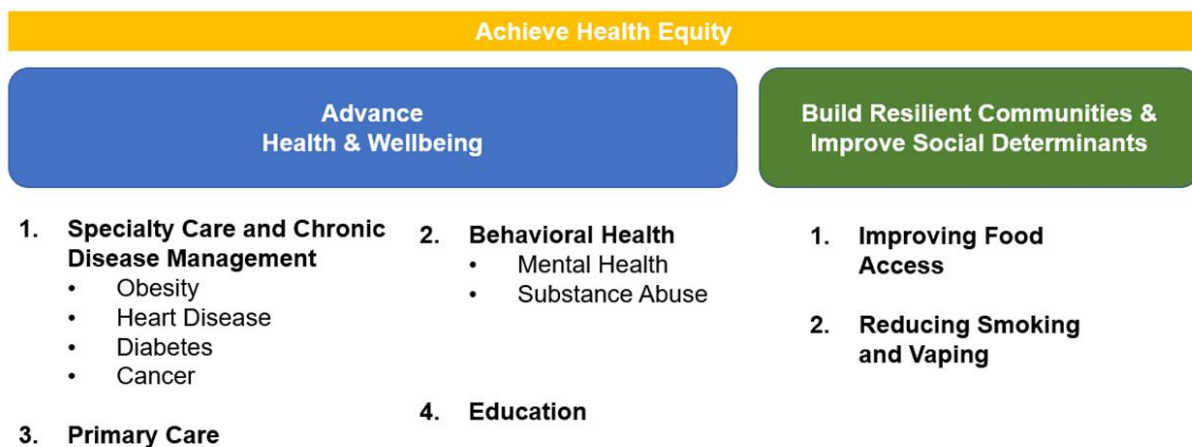
Figure 3. CHRISTUS Trinity Mother Frances Health System Priority Areas

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 Appendix 1 to a fully detailed evaluation framework relating to these strategies.

Community Benefit Report Communication

CTMFHS 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, CTMFHS 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.

SECTION A: SPECIALITY CARE AND CHRONIC DISEASE MANAGEMENT

There is a lack of specialty care, particularly for those with chronic illness including heart disease and diabetes. The strategy to address this priority is twofold. First, CTMFHS will continue collaborative efforts at chronic disease prevention. This includes prevention, screening, and health education in the community. We will collaborate with community partners to offer more community health events in our community. We will target the youth in our communities to support the adoption of healthy lifestyle behaviors and the elderly as they are most adversely affected by chronic illness. Second, CTMFHS will support efforts to deliver of at least two types of specialty care: orthopedics for youth in low-income schools and breast cancer screening and referrals for women, and other outreach programs may be added.

ADVANCE HEALTH AND WELLBEING		
SPECIALTY CARE AND CHRONIC DISEASE MANAGEMENT (SC)	SPECIALTY CARE AND CHRONIC DISEASE MANAGEMENT (SC)	SPECIALTY CARE AND CHRONIC DISEASE MANAGEMENT (SC)
1)Provide screening and education opportunities about heart disease, diabetes, and obesity	2)Provide specialty care in conjunction with schools, events, and community requests for support	3)Provide education, screenings, and care for cancer diseases
a) Expand free/subsidized screenings that include education components b) Continue community education initiatives focused on chronic disease prevention as well as supporting health promotion portions of community events/programs c) Develop an education program for faculty and students on healthy eating	a) Provide free/subsidized orthopedic and sports medicine professional volunteers as needed b) Educate and support improvements on comorbidities like hypertension and obesity	a) Establish a cancer awareness education program for the priority service area b) Collaborate with governmental and community groups on impacting access for mammograms and other screenings c) Monitor and collaborate on cancer public policy issues

CHRISTUS Health will continue to invest in care delivery innovations and expand programs that address prevention for chronic diseases and improve access to care. Key programs that support these initiatives are mobile mammography and community screenings, Sports Medicine and Physician Volunteer hours and Saturday Morning Clinics. Partnerships include: the American Cancer Society, Susan G. Komen and Cancer Foundation for Life.

SECTION B: BEHAVIORAL HEALTH

We have worked in our ministries to expand and support behavioral health services for our individuals and families. We work to address social and environmental determinants of health with our patients being treated in our Emergency Departments. We coordinate and partner with our local behavioral health entities in each of our ministries to better meet the needs of those with behavioral health issue.

ADVANCE HEALTH AND WELLBEING		
BEHAVIORAL HEALTH (BH)	BEHAVIORAL HEALTH (BH)	BEHAVIORAL HEALTH (BH)
1)Expand and support behavioral health services in the communities served for individuals and families	2)Create community connections for mental health services	3)Develop a community workgroup to collect information on substance abuse in both adolescences and adults
a) Improve access to care, information, and support services for people with or at risk of behavioral health in collaboration with local providers b) Improve stability and effectiveness of behavioral health organizations c) Improve collaboration efforts to improve services and education with local, state, and governmental organizations.	a) Offer financial and in-kind support to community organizations involved in the delivery of behavioral health services b) Support the development of a listing of behavioral health services in the priority service area	a) Review and develop a resource listing of groups working on substance abuse b) Review and monitor efforts by the legislature to address substance abuse c) Reach out to the public schools to see what their policies and data is on substance abuse

CHRISTUS Health will focus on building a coalition to address Behavioral Health issues in the service area. Partners include: Alzheimer's Alliance, American Suicide Prevention Programs, Mosaic Counseling of East Texas, Women in Tyler, Smith County Behavioral Leadership Council, Women's Abuse Programs, Veteran's Programs, Leadership Development Programs in Communities, and others. For the northern area of CTMFHS we are considering working with some of the following entities: Glen Oaks Hospital, Lakes Regional MHMH, Prestonwood Counseling, SS Christian Counseling and Bright Star Counseling.

SECTION C: PRIMARY CARE

We work to add primary care physicians to CHRISTUS Trinity Clinic to meet the needs of our growing population, additionally we coordinate with local FQHC's in our ministries to expand services. In our ministries we work to provide community-based screenings, assessment and education to low income, uninsured and special needs populations.

ADVANCE HEALTH AND WELLBEING		
PRIMARY CARE (PC)	PRIMARY CARE (PC)	PRIMARY CARE (PC)
1)Increase access to primary care	2)Reduce inequities caused by cultural barriers to care	3)Develop, participate, and expand community collaboration to increase access and follow-up care
a) Collaborate with FQHCs to expand access and improve outcomes b) Provide community-based screening, assessments, and education to low-income, uninsured, and special request populations	a) Conduct preliminary analysis and planning to secure vaccines/screenings for low-income patients and participate in community public health issues focusing on health disparities, hypertension, diabetes, etc., and provide leadership training as requested. b) Provide free orthopedic services to low-income schools, including on-site services, rehab, education, and screenings	a) Expand opportunities with other not-for-profit organizations and governmental entities to provide primary care b) Work with school districts to provide training, screenings, education, and follow-up care at reduced rate or free

CHRISTUS Health will continue to invest in care delivery innovations and expand programs that improve access to care. Key programs that support these initiatives are partnerships with the local FQHCs, community health fairs, blood drives and in-kind support to local non-profits.

SECTION D: EDUCATION

We work to maintain and increase education and training opportunities for our health professionals through high school programs and work with local colleges for clinical rotations of various specialties in all our ministries.

ADVANCE HEALTH AND WELLBEING		
EDUCATION (ED)	EDUCATION (ED)	EDUCATION (ED)
1)Collaborate with community health education access points	2)Collaborate with community groups to enhance funding for student scholarships	3)Collaborate on community leadership building programs
a) Offer a job shadowing program for junior high, high school, and college students within the health care programs/jobs offered as needed b) Support a summer program for students to learn more about healthcare job opportunities c) Provide mentoring staff, faculty assistance as requested for students in health care programs and investigate developing job training programs in conjunctions with higher education including all aspects of health care for student internships	a) Identify programs that help to fund k-12 scholarships b) Identify programs that help to fund higher education scholarships	a) Research and identify programs that help to develop leadership programs for students and community members b) Research and identify programs that help to support diversity programs and educational projects

CHRISTUS Health will continue to invest in care delivery innovations and expand programs that educate the community. Key programs that support these initiatives are nursing and ancillary education, job shadowing and in-kind support. Some of the community partners might include: Greater East Texas Black Nursing Association (GETBNA), Jacksonville Leadership & Education Advancement, Junior Achievement, Junior League, Leadership Tyler, Mentoring Alliance, Tyler Hispanic Business Alliance, CAN Help, Hopkins County Leadership Program.

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)	**IMPROVE FOOD ACCESS (FA)**	**REDUCE SMOKING (RS)**	**REDUCE VAPING (RV)**
1)Cultivate and maintain partnerships to improve access to healthy food	2)1Provide nutrition education for individuals and families	1)Develop a community-based smoking cessation program	1)Partner with schools to reduce vaping among students
a) Hold a collaborative meeting to determine key issues contributing to food insecurity and potential actions b) Collaborate with non-profits who provide food distribution, pantries, and support food drives in the priority service area	a) Determine what education is currently being done in the care settings, schools, and health district b) Evaluate if a special education program for a food insecurity should be established for a targeted population	a) Research and evaluate the types of smoking cessation programs currently being offered in the community b) Work with local groups on providing smoking cessation programs.	a) Organize a small workgroup on vaping to address gathering information on vaping among teenagers to determine programs and messaging that are currently underway b) Determine if the programs need volunteers or financial support or what the key issues are contributing to vaping among students that still need to be addressed.

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 Nazarene Church Food Pantry, Catholic Charities Feed My Lamb, St. Vincent Food Pantry and First Methodist Church – Dinner Bell, and other food pantries across our service area.

Appendix 1: Advance Health & Wellbeing

Specialty Care and Chronic Disease Management

SPECIALTY CARE AND CHRONIC DISEASE MANAGEMENT (SC)						
Goal: Identify and educate on the 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 –Evaluate and then implement if possible free-subsidized screenings for key health issues for individuals, and the electronic survey would be pushed to all care givers and share the site with other non-profits for FY23. Baseline will be FY24.	Provide screening and education opportunities about heart diseases, diabetes, and obesity.	Potential Partners Include: American Heart Association (AHA) Local Chamber of Commerce's NETX Public Health District Other non-profit in the community	Leader Collaborator Supporter	FY23 – evaluate the opportunity to implement a collaborative project. Implement and grow data in FY 24, and 25	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. How many programs did we offer with the information or screenings to participants? 2. How many people participate in the screenings? 3. Percentage of programs where we offered 2 or more screenings. 4. Percentage of individuals who had a higher-than-average result.

SC1b.Continue community education initiatives focused on chronic disease prevention as well as supporting health promotions of community events/ programs.	Provide education opportunities about heart disease, diabetes, and obesity.	Potential Partners Include: Local Chamber of Commerce	Leader Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. How many programs did we offer with the information or screenings to participants? 2. How many people attended 2 or more educational programs? 3. How many programs had multiple entities offering information?
SC1c.Develop an education program for faculty and students on healthy eating.	Provide education opportunities about heart disease, diabetes, and obesity.	Potential Partners Include: Local ISDs	Leader Supporter	FY23 – evaluate the opportunity to implement a collaborative project. Implement and grow data in FY 24, and 25	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. How many programs did we offer with the information or screenings to participants? 2. How many people attended 2 or more educational programs? 3. How many programs had multiple entities offering information?

SPECIALTY CARE AND CHRONIC DISEASE MANAGEMENT (SC)

Goal:

Identify, provide services, and minimize the risk to life-long injuries by monitoring healing for orthopedic 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?*
SC2a. Provide free/subsidized orthopedic and sports medicine professionals volunteer as needed.	Provide specialty care in conjunction with schools, events, and community requests for support.	Potential Partners Include: Local ISDs Community Health Fairs/5Ks	Leader Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. How many requests did we receive? 2. How many did we provide services too? 3. How many people could have received services?

| SC2b. Educate and support improvements on comorbidities like hypertension and obesity. | Provide specialty care in conjunction with schools, events, and community requests for support. | Provide specialty care in conjunction with schools, events, and community requests for support. | Leader Collaborator Supporter | FY23 – Q1 through FY25 _ Q4 | Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County | Metrics/Indicators will be selected from the following: 1. How many programs did we offer with the information or screenings to participants? 2. How many people participate in the screenings? 3. Percentage of programs where we offered 2 or more screenings. |

SPECIALTY CARE AND CHRONIC DISEASE MANAGEMENT (SC)

Goal:

Educate, prevent, and identify risk factors known for cancer.

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?*
SC3a. Establish a cancer awareness education program for the priority service area.	Provide education, screenings, and care for cancer disease.	Potential Partners Include: American Cancer Society (ACS) Susan G. Komen	Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. How many programs did we offer with the information or screenings to participants? 2. How many people participate in the screenings? 3. Percentage of programs where we offered 2 or more screenings.

SC3b. Collaborate with governmental and community groups on impacting access for mammograms and other screenings.	Provide education, screenings, and care for cancer disease.	Potential Partners Include: RBC Mobile Mammography Unit in the community Ruth and Jack Gillis Women's Center	Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. How many programs did we offer with the information or screenings to participants? 2. How many people participated in the screenings? 3. Percentage of programs where we offered 2 or more screenings. 4. Percentage of individuals who had a larger than average result. 5. How many people attended 2 or more educational programs? 6. How many organizations did we support/collaborate with?
SC3c. Monitor and collaborate on cancer public policy issues.	Provide education, screenings, and care for cancer disease.	Potential Partners Include: American Cancer Society (ACS) Texas Medical Society (TMS) Texas Hospital Association (THA) NET Health	Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. How many programs had multiple entities offering information? 2. Establish and/or community disease support groups. 3. How many organizations did we support/collaborate with?

Behavioral Health

BEHAVIORAL HEALTH (BH)							
Goal: Improve and stabilize behavioral health services in the 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. Improve access to care, information, and support services for people with or at risk of behavioral health in collaboration with local providers.	Expand and support behavioral health services in the communities served for individuals and families.	Potential Partners Include: Alzheimer's Alliance of Smith County Mosaic Counseling of East Texas Andrews Center	Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. How many programs did we offer with the information or screenings to participants? 2. Percentage of programs where we offered 2 or more screenings? 3. How many organizations did we support/ collaborate with?

BH1b. Improve stability and effectiveness of behavioral health organizations.	Expand and support behavioral health services in the communities served for individuals and families.	Potential Partners Include: Alzheimer's Alliance of Smith County Mosaic Counseling of East Texas Andrews Center	Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. How many organizations did we support/ collaborate with?
BH1c.Improve collaboration efforts to improve services and education with local, state, and governmental organization.	Expand and support behavioral health services in the communities served for individuals and families.	Potential Partners Include: Local Chamber of Commerce Local non-profits Behavioral Health Leadership Council Glen Oaks Lakes Regional MHMR SS Counseling Center Prestonwood Counseling Bright Star Counseling	Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. How many programs did we offer with the information or screenings to participants? 2. Establish and/or support community disease support groups. 3. How many organizations did we support/ collaborate with?

BEHAVIORAL HEALTH (BH)

Goal:
Encourage communities to work together to educate and provide services to build pathways for 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?*
BH2a. Offer financial and in-kind support to community organizations involved in the delivery of behavioral health services.	Create community connections for mental health services.	Potential Partners Include: Alzheimer's Alliance of Smith County Mosaic Counseling of East Texas Andrews Center For the Silent	Leader Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. How many programs had multiple entities offering information? 2. Establish and/or support community disease support groups. 3. How many organizations did we support/ collaborate with?

BH2b. Support the development of a listing of behavioral health services in the priority service area.	Create community services for mental health services.	Potential Partners Include: Glen Oaks Lakes Regional MHMR SS Counseling Center Prestonwood Counseling Bright Star Counseling	Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Established and/or supported community disease groups. 2. How many organizations did we collaborate with?

BEHAVIORAL HEALTH (BH)

Goal:
To share information of target areas of concern, needs and key programs on substance abuse to improve 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?*
BH3a.Review and develop a resource listing of local groups working on substance abuse.	Develop a community workgroup to collect information on substance abuse in both adolescents and adults.	Potential Partners Include: Local non-profits Smith County Behavioral Health Leadership Council Andrews Center Glen Oaks Lakes Regional MHMR SS Counseling Center Prestonwood Counseling Bright Star Counseling	Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. How many programs had multiple entities offering information? 2. Establish and/or support community disease groups. 3. How many organizations did we support/ collaborate with?

BH3b.Review and monitor efforts by the legislature to address substance abuse.	Develop a community workgroup to collect information on substance abuse in both adolescents and adults.	Potential Partners Include: Texas Hospital Association (THA) Texas Medical Assocation (TMA)	Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Established and/or supported community disease groups. 2. How many organizations did we collaborate with?
BH3c.Reach out to the public schools to see what their policies and data is on substance abuse.	Develop a community workgroup to collect information on substance abuse in both adolescents and adults.	Potential Partners Include: Local ISDs	Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. How many programs did we offer with the information or screenings to participants? 2. Establish and/or support community disease support groups. 3. How many organizations did we support/ collaborate with?

Primary Care

PRIMARY CARE (PC)						
Goal: Impact knowledge and access for primary care and early detection of health risk factors.						

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. Collaborate with FQHCs to expand access and improve outcomes.	Increase access to primary care.	Potential Partners Include: Tyler Family Circle of Care St. Paul Children's Foundation Carevide	Leader Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Establish a standing meeting to discuss FQHC needs. 2. Evaluate options and present to leadership for potential funding. 3. How many projects were funded in a year?

| PC1b.Provide community-based screening assessments, and education to low-income, uninsured, and special request populations. | Increase access to primary care. | Potential Partners Include:

Tyler Family Circle of Care

St, Paul Children's Foundation

Carevide | Collaborator Supporter | FY23 – Q1 through FY25 – Q4 | Selected from the following counties:
Anderson County
Cherokee County
Delta County
Franklin County
Henderson County
Hopkins County
Rains County
Rusk County
Smith County
Van Zandt County
Wood County | Metrics/Indicators will be selected from the following:
1. Determine which community efforts are being offered for screening.
2. How many did we provide services too?
3. How many people could have received services? |

PRIMARY CARE (PC)

Goal:

To improve knowledge and resources directed to populations who are affected by health inequities.

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?*
PC2a.Conduct preliminary analysis and planning to secure vaccines/screenings for low-income patients and participate in community public health issues focusing on health disparities, hypertension, diabetes, etc., and provide leadership training as requested.	Reduce inequities caused by cultural barriers to care.	Potential Partners Include: Community Collaborative	Collaborator Supporter	FY23 – through FY25	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Determine offerings currently in place. 2. Number of programs CTMFHS participated in.

PC2b.Provide free orthopedic services to low-income schools, including on-site services, rehab, education, and screenings.	Reduce inequities caused by cultural barriers to care.	Potential Partners Include: Local ISDs	Leader Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Total number of school districts listed by county with services provided. 2. Number of events held in a fiscal year.

PRIMARY CARE (PC)

Goal:

To improve knowledge and resources directed to populations who are affected by health inequities.

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?*
PC3a.Expand opportunities with other not-for-profit organizations and governmental entities to provide primary care.	Develop, participate, and expand community collaboration to increase access and follow-up care.	Potential Partners Include: CareVide Hopkins County Jail	Collaborator Supporter	FY23 – Q1 through FY25 - Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Number of patients seen per month. 2. Frequency of clinics. 3. Number of partnerships recruited per month? Or contacts made to recruit?

PC3b. Work with school districts to provide training, screenings, education, and follow-up care at reduced rate or free.	Develop, participate, and expand community collaboration to increase access and follow-up care.	Potential Partners Include: Local ISDs	Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Total number of schools district listed by county with services provided. 2. Total number of districts collaborated with per fiscal year. 3. Total number of students per ISD and total number screened. 4. Number of students listed by county and school district what services were provided semi-annually.

Education

EDUCATION (ED)

Goal:

Maximize early education on potential careers in health care and fully support all training programs for students at all education levels.

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 a job shadowing program for junior high, high school, and college students within the health care programs/jobs offered as needed.	Collaborate with community health education access points.	Potential Partners Include: Local ISDs	Leader Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Number of students participating. 2. Total number of hours worked per month. 3. What school districts have we partnered with?

ED1b. Support a summer program for students to learn about health care job opportunities.	Collaborate with community health education access points.	Potential Partners Include: Local ISDs Local colleges and universities in our primary service area.	Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Number of students participating. 2. Total number of hours worked per month. 3. What school districts have we partnered with?
ED1c.Provide mentoring staff, faculty assistance for students in health care programs while developing job training programs in conjunction with higher education including all aspects of health care for internships.	Collaborate with community health education access points.	Potential Partners Include: Local ISDs Local colleges and universities in our primary service area.	Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Number of students participating. 2. Total number of hours worked per month. 3. What school districts have we partnered with?

EDUCATION (ED)

Goal:

Improve opportunities and education on financial assistance to 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?* *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?*
ED2a.Identify programs that help to fund K–12 scholarships.	Collaborate with community groups to enhance funding for student scholarships.	Potential Partners Include: Lindale Chamber of Commerce East Texas Boy Scouts of America Mentoring Alliance Hideaway Lake Kiwanis	Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Number of programs receiving funding. 2. Number of students receiving support.

ED2b. Identify programs that help to fund higher education scholarships.	Collaborate with community groups to enhance funding for student scholarships.	Potential Partners Include: ACHE GETBNA	Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Number of research scholarship opportunities. 2. Number of entities offering scholarships.

Goal:

Increase opportunities for leadership, diversity, and equity/training information in the communities.

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?*
ED3a.Research and identify programs that help to develop leadership programs for students and community members.	Collaborate on community leadership building programs.	Potential Partners Include: Leadership Tyler Jacksonville Leadership Education Advancement and Development (JLEAD) Canton Chamber – Leadership Van Zandt	Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Number of programs currently. 2. Number of program participants and ethnicity of participants

ED3b.Research and identify programs that help to support diversity programs and educational projects.	Collaborate on community leadership building programs.	Potential Partners Include: Junior League	Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Number of programs identified. 2. Listing of supporting/ sponsoring agencies.

Appendix 2: Build Resilient Communities & Improve Social Determinants

Improving Food Access

IMPROVING FOOD ACCESS (FA)						
Goal: Expand and share information on food insecurities to better serve targeted populations.						
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.Hold a collaborative meeting to determine key issues contributing to food insecurity and potential actions.	Cultivate and maintain partnerships to improve access to healthy food.	Potential Partners Include: PATH East Texas Food Bank Church Food Banks Local ISDs	Leader Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. How many groups participated? 2. Percentage of those who have a new or established program. 3. Percentage of new potential partners who participated in 2 or more meetings in projects.
FA1b.Collaborate with non-profits who provide food distribution, pantries, and support food drives in the priority service area.	Cultivate and maintain partnerships to improve access to healthy food.	Potential Partners Include: NET Health East Texas ISDs/ school nurses Hopkins County area Food Banks	Collaborator	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. How many food drive requests did CTMFHS receive? 2. How many food drives did CTMFHS participate in?

IMPROVING FOOD ACCESS (FA)

Goal:

Improve/expand education on the importance of healthy eating and resources.

Strategy	Anticipated Impact	Programs, Services, Partnerships, Resources	Hospital's Role	Timeframe	Community of Focus	Metrics
What actions or activities will we do to help to improve the conditions?	*What are the expected outcomes of the population?*	*Who are the partners who have a role to play in doing better?*	*What is our role?* *Leader, Collaborator, Supporter*	*When do you expect this activity to begin/end?*	*Who are our customers/the population?*	*How much? How well? Is anyone better off?*
FA2a. Determine what education on food insecurity is currently being done in the care settings, schools, and health district.	Provide nutrition education for individuals, patients, and families.	Potential Partners Include: PATH East Texas Food Bank Church Food Banks Local ISDs	Leader Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Request information on education currently being offered. 2. Number of new offerings for each year.

FA2b. Evaluate if a special education program on food insecurity should be established for a targeted population.	Provide nutrition education for individuals, patients, and families.	Potential Partners Include: NET Health East Texas ISD/school nurses Hopkins County Area food banks	Collaborator	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Request information on education currently being offered. 2. Number of new offerings for each year for FY24 and FY25.

Reducing Smoking and Vaping

REDUCING SMOKING (RS)							
Goal: Evaluate and expand smoking cessation program to prevent risk of diseases.							

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?*
RS1a.Research and evaluate the types of smoking cessation programs currently being offered in the community.	Develop a community-based smoking cessation program.	Potential Partners Include: NET Health	Collaborator	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Number of groups participating in research. 2. Number of groups offering 2 or more sessions.

| RS1b. Work with local groups on providing smoking cessation programs. | Develop a community-based smoking cessation program. | Potential Partners Include:

Community Collaborator | Collaborator | FY23 – Q1 through FY25 – Q4 | Selected from the following counties:
Anderson County
Cherokee County
Delta County
Franklin County
Henderson County
Hopkins County
Rains County
Rusk County
Smith County
Van Zandt County
Wood County | Metrics/Indicators will be selected from the following:
1. Number of programs offered.
2. Number of people attending.
3. Number of people attending 2 or more sessions. |

Goal:

Evaluate and expand smoking cessation program to prevent risk of diseases.

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?*
RV1a. Organize a small workgroup on vaping to address gathering information on vaping among teenagers to determine programs and messaging that are currently underway.	Partner with schools to reduce vaping among students.	Potential Partners Include: Local ISDs	Collaborator Supporter	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Number of agencies attending. 2. Number of people attending. 3. Number of people attending 2 or more meetings.

RV1b. Determine if the programs need volunteers or financial support or what the key issues are contributing to vaping among students that still need to be addressed.	Partner with schools to reduce vaping among students.	Potential Partners Include: Community Collaborator	Collaborator	FY23 – Q1 through FY25 – Q4	Selected from the following counties: Anderson County Cherokee County Delta County Franklin County Henderson County Hopkins County Rains County Rusk County Smith County Van Zandt County Wood County	Metrics/Indicators will be selected from the following: 1. Number of programs offered. 2. Number of people attending. 3. Number of people attending 2 or more sessions.