COMMUNITY HEALTH IMPROVEMENT PLAN

2023-2025

CHRISTUS® ST. MICHAEL
Health System

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INTRODUCTION

Introduction

The Community Health Needs Assessment (CHNA) is a systematic, data-driven approach to determine the health needs in the service area of the CHRISTUS St. Michael Health System. In this process, CHRISTUS St. Michael Health System 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 St. Michael Health System 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 St. Michael Health System'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 CHRISTUS St. Michael Health System, to conduct a CHNA every three years. CHRISTUS St. Michael Health System completed similar needs assessments in 2013, 2016 and 2019.

The process CHRISTUS St. Michael Health System 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 St. Michael Health System's 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 St. Michael Health System's 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 St. Michael Health System

CHRISTUS St. Michael Health System (CSMHS) is a non-profit hospital system serving the Upper East Texas and Southwest Arkansas regions and includes two medical centers along with a number of outpatient centers and medical homes. The CHRISTUS St. Michael Health System campus in Texarkana includes the main 311-bed acute-care hospital, a 50-bed rehabilitation hospital, an outpatient rehabilitation center and an outpatient imaging center. The campus was designed to also address the spiritual needs of our patients by providing a healing environment of streams, a 1-1/2 acre lake, wooded paths and water features. The CHRISTUS St. Michael Health System campus in Atlanta has a 43-bed, acute-care hospital providing general and medical care for inpatient, outpatient and emergency room patients. General and medical services include radiology, laboratory, respiratory, physical and speech therapy, rehabilitation, as well as wellness programs. This CHNA covers the service areas for both campuses in the CHRISTUS St. Michael Health System.

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 St. Michael 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, CHRISTUS St. Michael Health System's CHNA primary service area includes 16 zip codes covering over 190,000 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: Bowie and Cass in Texas; Hempstead, Howard, Little River, Miller and Sevier in Arkansas (Figure 1).

While the hospital is dedicated to providing exceptional care to all of the residents in East Texas and Southwest Arkansas, St. Michael Health System 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 ST. MICHAEL HEALTH SYSTEM PSA						
Hempstead County, AR	Howard County, AR	Little River County, AR	Miller County, AR	Sevier County, AR	Bowie County, TX	Cass County, TX
71801	71852	71822	71854	71832	75501, 75503	75551
			71837		75559, 75561	75563
					75567, 75569	75572
					75570	

Table 1. Primary Service Area of CHRISTUS St. Michael Health System

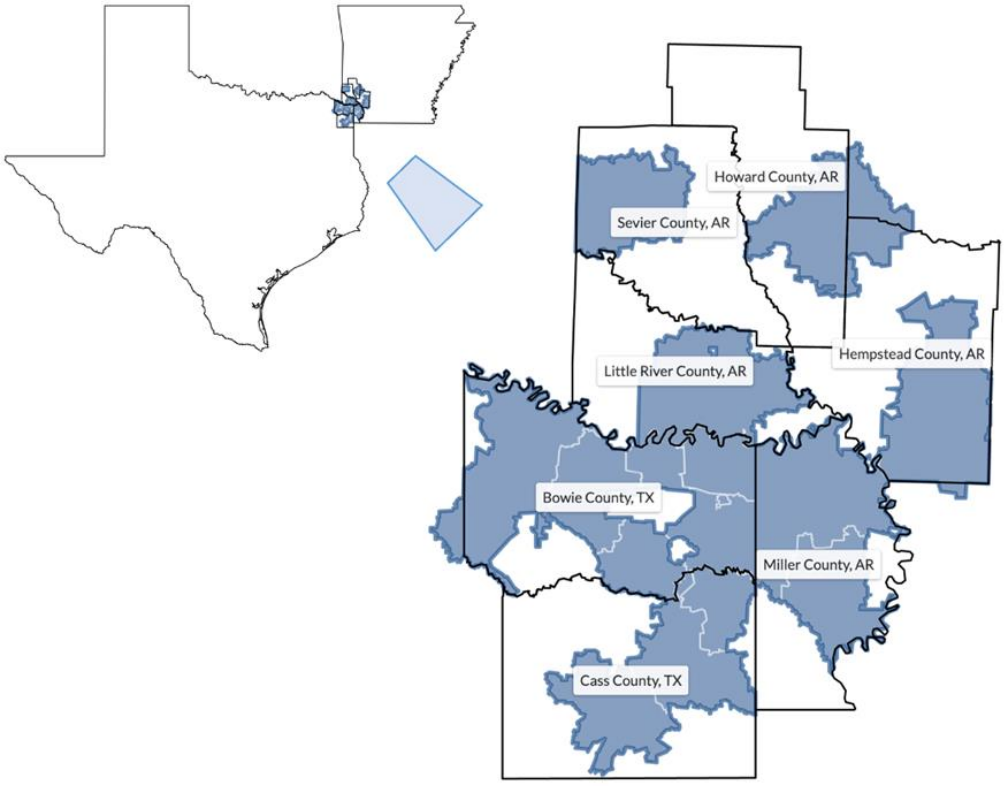

Figure 1. Primary Service Area of CHRISTUS St. Michael Health System

Statement of Health Equity

While community health needs assessments (CHNA) and Improvement Plans are required by the IRS, CHRISTUS St. Michael Health System 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 St. Michael Health System 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 St. Michael Health System guided the strategic direction of Metopio through roles on various committees and workgroups.

CHRISTUS St. Michael Health System 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 St. Michael Health System 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 improvement plan, reviews and approves grant funding requests, provides feedback on community engagement activities

Input from community stakeholders was also gathered from CHRISTUS St. Michael Health System'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 St. Michael Health System leadership team developed parameters for the 2023-2025 CHNA process that help drive the work. These parameters ensure that:

- the CHNA builds on the prior CHNA from 2020-2022 as well as other local assessments and plans;
- the CHNA will provide greater insight into community health needs and strategies for ongoing community health priorities;
- the CHNA leverages expertise of community residents and includes a broad range of sectors and voices that are disproportionately affected by health inequities;
- the CHNA provides an overview of community health status and highlights data related to health inequities;
- the CHNA informs strategies related to connections between community and clinical sectors, anchor institution efforts, policy change, and community partnerships; and
- health inequities and their underlying root causes are highlighted and discussed throughout the assessment.

Data Collection

CHRISTUS St. Michael Health System conducted its CHNA process between September 2021 and March 2022 using an adapted process from the Mobilizing for Action through Planning and Partnerships (MAPP) framework. This planning framework is one of the most widely used for CHNAs. It focuses on community engagement, partnership development and seeking channels to engage people who have often not been part of decision-making processes. The

MAPP framework was developed in 2001 by the National Association for County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC).

Primary data for the CHNA was collected through four channels:

- Community resident surveys
- Community resident focus groups
- Health care and social service provider focus groups
- Key informant interviews

Secondary data for the CHNA were aggregated on Metopio's data platform and included:

- Hospital utilization data
- Secondary sources including, but not limited to, the American Community Survey, the Decennial Census, the Centers for Disease Control, the Environmental Protection Agency, Housing and Urban Development and the Texas Department of State Health Services

Community Resident Surveys

Between October and December of 2021, 330 residents in the CHRISTUS St. Michael Health System 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 St. Michael Health System and its community partners. The survey sought input from priority populations in the CHRISTUS St. Michael Health System 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 St. Michael Health System PSA. This was done through focus groups and key informant interviews.

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

- Adult health

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

CHRISTUS St. Michael Health System conducted its focus groups in person. Focus groups lasted 90 minutes and had up to 15 community members participate in each group.

In addition to the focus groups, 10 key informants were identified by CHRISTUS St. Michael Health System Management team for one-on-one interviews. Key informants were chosen based on areas of expertise to further validate themes that emerged in the surveys and focus groups. Each interview was conducted virtually and lasted 30 minutes.

Secondary Data

CHRISTUS St. Michael Health System used a common set of health indicators to understand the prevalence of morbidity and mortality in the CHRISTUS St. Michael Health System 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 St. Michael Health System 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 St. Michael Health System sought more granular datasets to illustrate hardship.

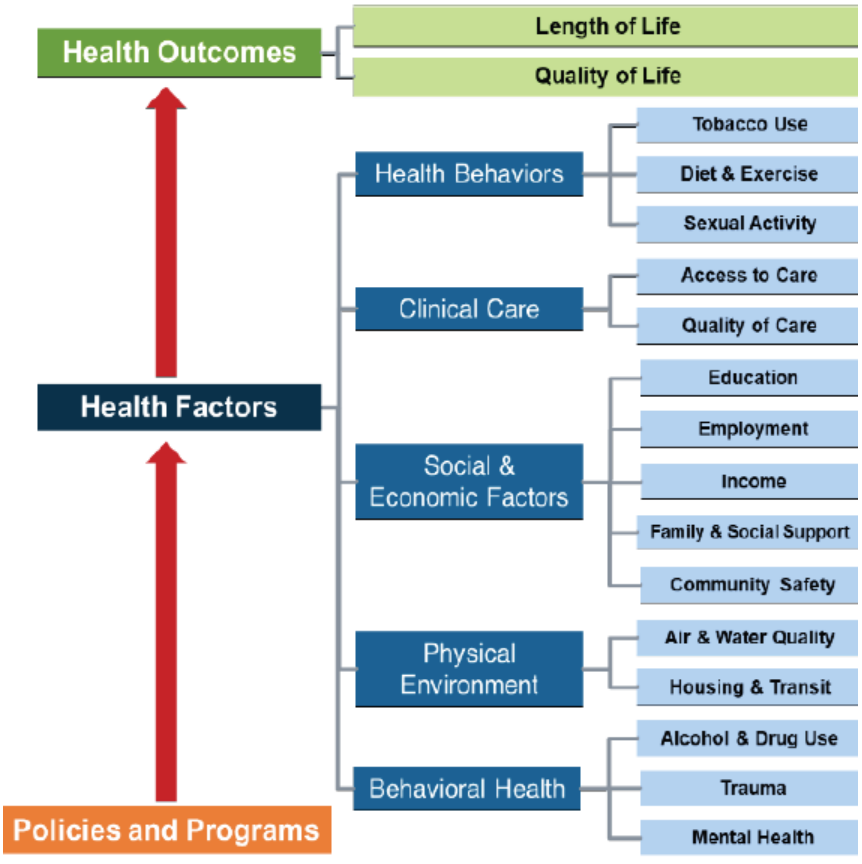

Figure 2. Illustration of the County Health Rankings MAPP Framework

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 St. Michael Health System and Metopio made substantial efforts to comprehensively collect, review and analyze primary and secondary data. However, there are limitations to consider when reviewing CHNA findings.

- Population health and demographic data are often delayed in their release, so data are presented for the most recent years available for any given data source.
- Variability in the geographic level at which data sets are available (ranging from census tract to statewide or national geographies) presents an issue, particularly when comparing similar indicators and collected at disparate geographic levels. Whenever possible, the most relevant localized data are reported.
- Due to variations in geographic boundaries, population sizes and data collection techniques for suburban and city communities, some datasets are not available for the same time spans or at the same level of localization throughout the county.

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

With this in mind, CHRISTUS St. Michael Health System, 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

For this cycle, CHRISTUS St. Michael Health System 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, CHRISTUS St. Michael Health System retained mental health as a priority issue from the 2020 – 2022 CHNA. In the previous CHNA, CHRISTUS St. Michael Health System identified chronic illness as a priority. In this cycle, CHRISTUS St. Michael Health System 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 CHRISTUS St. Michael Health System 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:

1. Advance Health and Wellbeing

- Chronic Illness
  - Cancer
  - Heart Disease
  - Diabetes
  - Obesity
- Behavioral Health
  - Mental Health
  - Substance Abuse
- Access to Care

2. Build Resilient Communities and Improve Social Determinants

- Reducing smoking and vaping
- Improving employment
- Improving Food Access

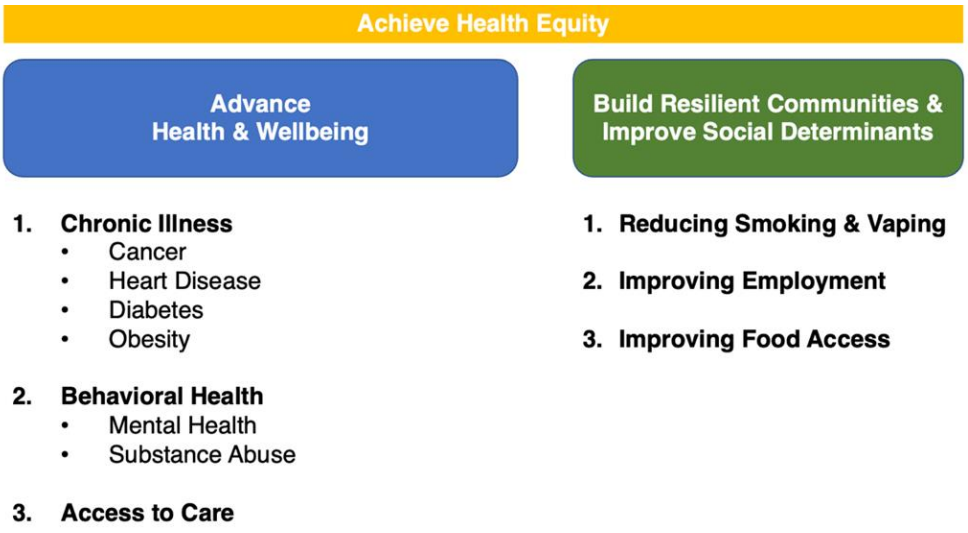

Figure 3. CHRISTUS St. Michael Health System Priority Areas

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 appendices to a fully detailed evaluation framework relating to these strategies.

Community Benefit Report Communication

CHRISTUS St. Michael Health System 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 St. Michael Health System 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		
CHRONIC ILLNESS (CI)	CHRONIC ILLNESS (CI)	BEHAVIORAL HEALTH (BH)
Provide screening and education opportunities about heart disease, cancer, diabetes, and obesity	Provide specialty care in conjunction with schools, events, and community requests for support	Enhance collaborations with local behavioral health service agencies
• Expand free/subsidized screenings that include education components • Continue community education initiatives focused on chronic disease prevention as well as supporting health promotion portions of community events/programs • Continue to provide and support cancer care services collaborating with other providers/agencies to impact access for treatment/care and educational activities	• Continue to collaborate with local school districts to promote healthy behaviors and physical activity • Work with school districts through sports medicine program to provide training, screenings, education and follow-up care	• Participate with area community agencies to improve access to care, information and support services for people with behavioral health needs. • Offer financial and in-kind support to community organizations involved in the delivery of behavioral health services.
BEHAVIORAL HEALTH (BH)	ACCESS TO CARE (AC)	ACCESS TO CARE (AC)
Enhance collaborations with local behavioral health service agencies	Develop, participate and expand community collaboration to increase access to care and follow-up care	Provide access to care in area schools

• Review and support development of resource guide for behavioral health services in service areas • Collaborate with community agencies to improve continuity of care.	• Collaborate with local FQHC to expand access and improve outcomes • Provide community-based screening assessments and education to low-income, uninsured and special request populations. • Continue partnership with parish nurse program to provide access to services for screening, education and follow-up	• Conduct asthma screening and assessments, and education to students at area schools

CHRISTUS St. Michael Health System will continue to invest in care delivery innovations and expand programs that address prevention for heart disease, obesity and diabetes and improve access to care. Key programs that support these initiatives are service area health screenings and education in numerous venues, i.e. senior community centers, churches; area school mobile pediatric asthma clinics; support of Go Noodle activities in area schools, providing resources to local community agencies and partners, i.e. Partner for the Pathways, Catholic Charities, American Heart Association,

And CHRISTUS St. Michael Health System will focus on building a coalition to address Behavioral Health issues in the service area. Partners include local behavioral health agencies in both Arkansas and Texas and other local support mental health centers and local law enforcement.

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		
REDUCE SMOKING AND VAPING (RS)	IMPROVE EMPLOYMENT (IE)	IMPROVE FOOD ACCESS (FA)
Develop a community-based smoking/vaping cessation program	Collaborate and partner with the community to improve employment	Cultivate and maintain partnerships to improve access to health food in food deserts
• Partner with local agencies for smoking cessation community programs • Work with local schools to access current activities to reduce vaping and smoking	• Provide mentoring staff as requested for students in health care • Support financial assistance to local nursing programs for faculty assistance • Provide financial support and participate in area agency activities with AR-TX REDI to assist in job creation/development opportunities • Collaborate with local school district to provide resources for technical skills/trades development	• Collaborate with community agencies and others who provide food distribution, pantries and support food drives • Support financial assistance to area food bank to expand access to services

CHRISTUS St. Michael Health System 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 area school districts, local employers, AR-TX Regional Economic Development Inc, Texarkana College, and local school districts

STRATEGIES

Appendix 1: Advance Health & Wellbeing

Chronic Illness

Goal:

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

Strategy	Anticipated Impact	Programs, Services, Partnerships, Resources	Hospital's Role	Timeframe	Community of Focus	Metrics
What actions or activities will we do to help to improve the conditions/	*What are the expected outcomes of the population?*	*Who are the partners who have a role to play in doing better?*	*What is our role?* *Leader, Collaborator, Supporter*	*When do you expect this activity to begin/end?*	*Who are our customers/the population?*	*How much? How well? Is anyone better off?*
CI1a. Expand free/subsidized chronic disease screenings that include education components.	Provide screening and education opportunities about heart disease, cancer, diabetes and obesity to improve morbidity and mortality rates for chronic disease	Local churches, American Heart Association Local senior community centers Area on Aging Local community agencies Tough Cookie	Leader, Collaborator, Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Number of events held • Number of event participants • Number of cancer patients assisted with Tough Cookie resources

	CI1b.Continue community education initiatives focused on chronic disease prevention as well as supporting health promotion portions of community events/programs	Provide screening and education opportunities about heart disease, cancer, diabetes and obesity	Local churches, American Heart Association Local senior community centers Area on Aging Local community agencies Tough Cookie	Leader, Collaborator, Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Number of events held • Number of event participants • Number of patients assisted with Tough Cookie resources
	CI1c.Continue to provide and support cancer care services collaborating with other providers/ agencies to impact access for treatment/care and educational activities	Provide screening and education opportunities about heart disease, cancer, diabetes and obesity.	Local churches, American Heart Association Local senior community centers Area on Aging Local community agencies Tough Cookie	Leader, Collaborator, Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Number of event participants • Number of participants receiving cancer education • Number of cancer patients assisted with Tough Cookie resources

	CI1d.Continue to collaborate with local school districts to promote healthy behaviors and physical activity.	Provide specialty care in conjunction with schools, events, and community requests for support	Local school districts Local colleges	Leader, Collaborator, Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Increased rates of on-site services, screenings and education • Increased minutes of physical activity in Go Noodle program • Number of events held • Number of school districts
	CI1e.Provide free sports medicine services to area schools including on-site services and screenings	Provide specialty care in conjunction with schools, events, and community requests for support	Local school districts Local colleges	Leader, Collaborator, Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Increased rates of on-site services, screenings and education • Number of events held • Number of school districts

Behavioral Health

Goal:

1. Enhance and improve access to 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.Participate with area community agencies to improve access to care, information and support services for people with behavioral health needs.	Enhance collaborations with local behavioral health service agencies	Community Health Core Area agencies working with substance abuse and mental health County Judges Law enforcement EMS FQHC	Collaborator Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Number of organizations we support/collaborate with • Number of programs offered with information to participants

	BH1b.Offer financial and in-kind support to community organizations involved in the delivery of substance abuse and mental health services	Enhance collaborations with local behavioral health service agencies	Community Health Core Area agencies working with substance abuse and mental health County Judges Law enforcement EMS FQHC	Collaborator Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Number of organizations we support/collaborate with • Number of persons with behavioral health needs transported and financial support • Number of programs offered with information to participants
	BH1c.Review and support development of resource guide for behavioral health services in service areas	Create community connections for behavioral health services	Community Health Core Area agencies working with substance abuse and mental health County Judges Law enforcement EMS FQHC	Collaborator Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Number of collaborators to create resource guide • Number of distribution points • Number of education messages to community members

	BH1d.Collaborate with community agencies to improve continuity of care.	Create community connections for behavioral health services	Community Health Core Area agencies working with substance abuse and mental health County Judges Law enforcement EMS FQHC	Collaborator Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Number of collaborators to create resource guide • Number of distribution points • Number of education messages to community members

Access to Care

Goal:

1. Improve access to comprehensive high-quality health care services

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?*
AC1a. Collaborate with local FQHC to expand access and improve outcomes	Develop, participate and expand community collaboration to increase access to care and follow-up care	FQHC Catholic Charities of East TX Non-profit agencies in community Area Churches	Leader, Collaborator, Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Number of patients receiving services in FQHC • Number patients referred to FQHC

	AC1b. Provide community-based screening assessments and education to low-income, uninsured and special request populations.	Develop, participate and expand community collaboration to increase access to care and follow-up care	FQHC Catholic Charities of East TX Non-profit agencies in community Area Churches	Leader, Collaborator, Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	Arkansas: Hempstead County Howard County Little River County Miller County Sevier County Texas: Bowie County Cass County	• Number of community-based screenings with community partners • Number of screening assessments
	AC1c. Continue partnership with parish nurse program to provide access to services for screening, education and follow-up	Develop, participate and expand community collaboration to increase access to care and follow-up care	FQHC Catholic Charities of East TX Non-profit agencies in community Area Churches	Leader, Collaborator, Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	Arkansas: Hempstead County Howard County Little River County Miller County Sevier County Texas: Bowie County Cass County	• Number of clients served by the parish nursing program
	AC1d. Conduct asthma screening and assessments, and education to students at area schools	Provide access to care in area schools	Area school districts FQHC	Leader, Collaborator, Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	Arkansas: Hempstead County Howard County Little River County Miller County Sevier County Texas: Bowie County Cass County	• Number of participating school districts • Number of children served in the pediatric asthma program

Appendix 2: Build Resilient Communities & Improve Social Determinants

Reducing Smoking and Vaping

Goal:

1. Evaluate and expand education of health risks related to smoking and vaping

Strategy	Anticipated Impact	Programs, Services, Partnerships, Resources	Hospital's Role	Timeframe	Community of Focus	Metrics
What actions or activities will we do to help to improve the conditions/	*What are the expected outcomes of the population?*	*Who are the partners who have a role to play in doing better?*	*What is our role?* *Leader, Collaborator, Supporter*	*When do you expect this activity to begin/end?*	*Who are our customers/the population?*	*How much? How well? Is anyone better off?*
RS1a. Collaborate with local agencies for smoking cessation community programs	Develop a community-based smoking/vaping cessation program	Community partners and employers Area School districts	Collaborator, Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Number of community programs offered • Number of community program participants

	RS1b. Work with area schools to access current activities to reduce vaping and smoking	Develop a community-based smoking/vaping cessation program	Community partners and employers Area School districts	Collaborator, Supporter	Begin: FY23 Q1 End: FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Number of community program participants • Number of school programs

Improving Employment

Goal:

1. Relieve and reduce unemployment, achieve economic stability, and increase the standard of living for all citizens

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?*
IE1a. Provide mentoring staff as requested for students in health care.	Collaborate and partner with the community to improve employment	ARTX REDI Texarkana College Area school districts	Leader, Collaborator, Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Number of students participating in clinical rotations in multiple disciplines • Number of high school students participating in job shadowing program • Number of student participants in program

	IE1b. Support financial assistance to local nursing programs for faculty assistance.	Collaborate and partner with the community to improve employment	ARTX REDI Texarkana College Area school districts	Leader, Collaborator, Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Financial support provided to local nursing programs
	IE1c. Provide financial support and participate in area agency activities with AR-TX REDI to assist in job creation/development opportunities.	Collaborate and partner with the community to improve employment	ARTX REDI Texarkana College Area school districts	Leader, Collaborator, Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Number of jobs increased in community through AR-TX REDI •
	IE1d. Collaborate with local school district to provide resources for technical skills/trades development	Collaborate and partner with the community to improve employment	ARTX REDI Texarkana College Area school districts	Leader, Collaborator, Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Program creation for technical skills/trade in local school district • Number of student participants in program

Improving Food Access

Goal:

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

Strategy	Anticipated Impact	Programs, Services, Partnerships, Resources	Hospital's Role	Timeframe	Community of Focus	Metrics
What actions or activities will we do to help to improve the conditions/	*What are the expected outcomes of the population?*	*Who are the partners who have a role to play in doing better?*	*What is our role?* *Leader, Collaborator, Supporter*	*When do you expect this activity to begin/end?*	*Who are our customers/the population?*	*How much? How well? Is anyone better off?*
FA1a. Collaborate with community agencies and others who provide food distribution, pantries and support food drives.	Cultivate and maintain partnerships to improve access to healthy food in food deserts	Regional Food Bank Area church pantries Area school districts Area community garden Other non-profits	Collaborator Supporter	**Begin:** FY23 Q1 **End:** FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Number of community partner collaborators • Number of clients receiving services • Creation of community garden

	FA1b. Support financial assistance to area food bank to expand access to services.	Cultivate and maintain partnerships to improve access to healthy food in food deserts	Regional Food Bank	Cultivate and maintain partnerships to improve access to healthy food in food deserts	**Begin:** FY23 Q1 **End:** FY25 Q4	<u>Arkansas:</u> Hempstead County Howard County Little River County Miller County Sevier County <u>Texas:</u> Bowie County Cass County	• Financial support provided to regional food bank