

Community Health Implementation Plan

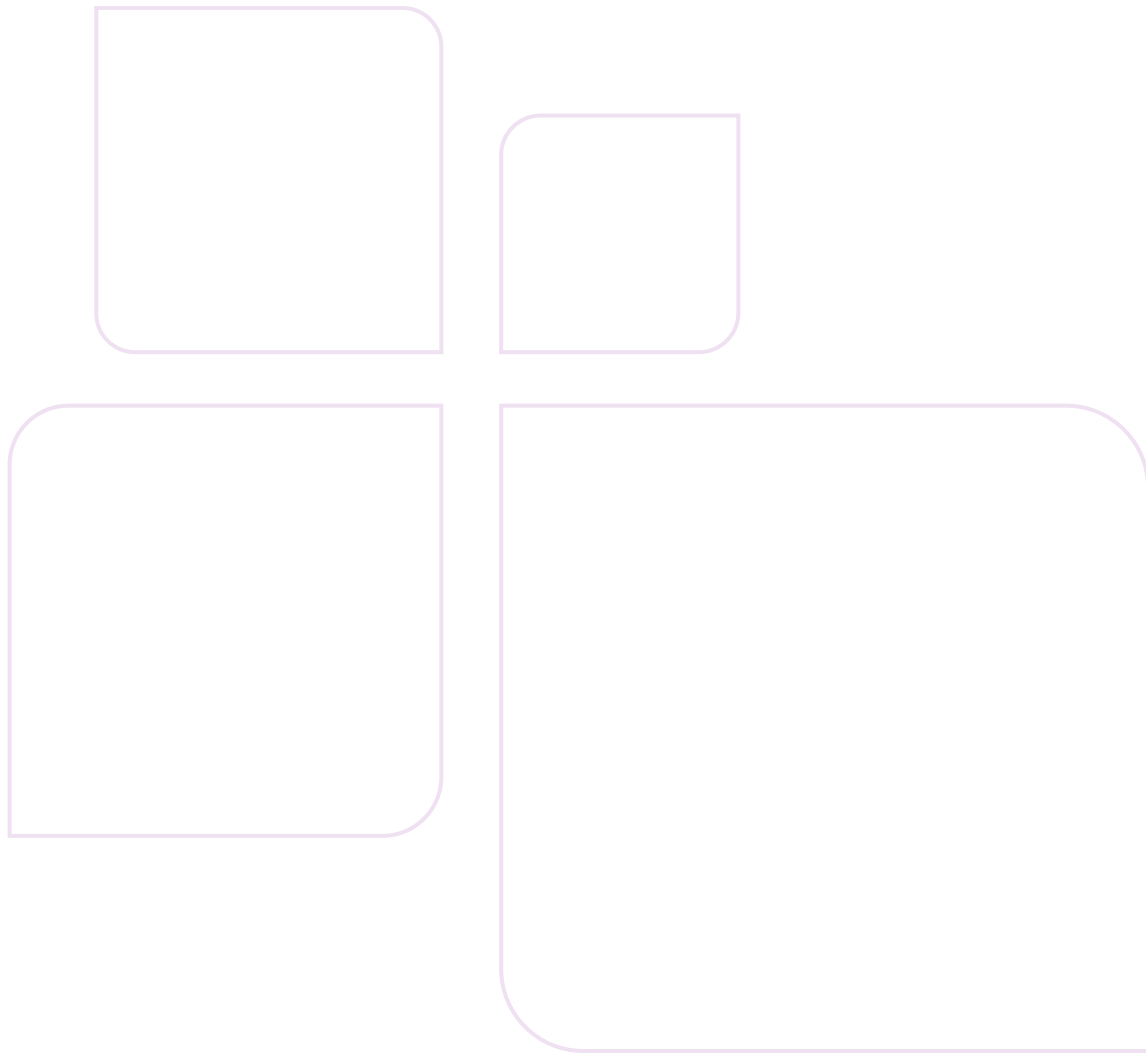
Strategies for responding to the prioritized needs in the community

2026 – 2028



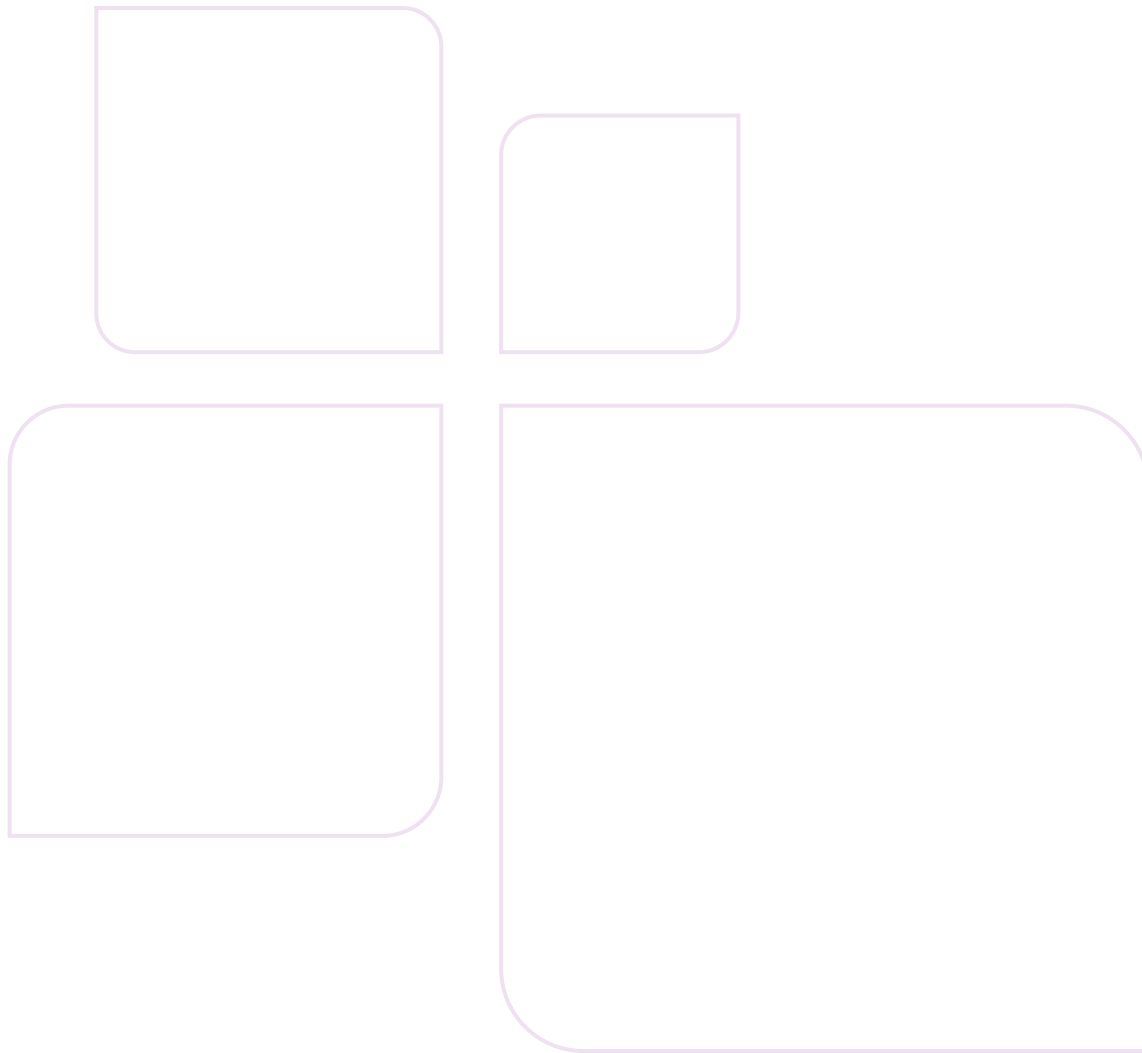
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Chapter 1: Introduction





Introduction

CHRISTUS St. Michael Health System has been identifying and addressing our community's health and well-being needs since our founding in 1916. We are called to be involved in our community, to contribute to the common good. Strengthening the overall health of our community involves serving individuals experiencing social and economic conditions that place them at society's margins. We recognize its role in serving its community beyond the physical walls of its hospital, urgent care and medical professional offices.

This 2026-2028 Community Health Implementation Plan (CHIP) builds upon the findings of our most recent Community Health Needs Assessment (CHNA). It outlines how we will respond to the top health needs identified by the people and partners who live, work and serve in our region.

Our Vision

We envision a community where:

- Mothers and babies have access to the care and support needed for healthy pregnancies, childbirth, growth and development.
- Children are well-equipped with the care and support to grow up physically and mentally healthy.
- Adults have access to the care, support and opportunities needed to maintain physical and mental health throughout their lives.

- Older adults have accessible and empowering environments to ensure that every person can age with health and socioeconomic well-being.
- Community members receive compassionate, high-quality care that honors their dignity, life experiences and unique needs.

What This Plan Includes

CHIP identifies actionable strategies designed to improve health outcomes across the lifespan. These strategies fall into three categories:

- Hospital direct care strategies: programs led by CHRISTUS St. Michael Health System such as new service lines, mobile outreach or expanded screenings
- Community benefit funding strategies: investments through our CHRISTUS Fund and local benefit programs to strengthen the safety net and address social determinants of health
- Community partner strategies: collaborations with local nonprofits, schools, coalitions and agencies that advance shared goals through aligned services

Each strategy is aligned with one or more key priorities from the CHNA and is structured by life stage: maternal and early childhood, school age and adolescent, adult and older adult.

The Communities We Serve

As outlined in the CHRISTUS St. Michael Health System Community Health Needs Assessment (CHNA) and Community Health Implementation Plan (CHIP), the “community” is defined by the geographic areas that represent the primary service region for our ministry. This typically includes the county or counties where the hospital is located, as well as surrounding areas from which patients frequently seek care.

We serve as a vital access point for care in Smith, Cherokee, Henderson, Wood and Hopkins Counties. It extends its reach into neighboring counties such as Titus, Franklin, Rains, Van Zandt, Anderson and Delta, particularly in rural or underserved areas where health care options may be limited. Our ministry’s service area reflects both our commitment to addressing the most pressing health needs of our patients and our responsibility to support the well-being of the broader region.

Through the CHNA process, we have collaborated with community partners, local organizations and residents to better understand and address the unique health needs of the populations we serve. As we enter the 2026-2028 implementation cycle, we remain focused on enhancing access to high-quality, culturally responsive care and fostering stronger community connections to ensure that every person can live a healthier life, close to home.

Systems of Care Principle

CHRISTUS St. Michael Health System is part of a broader system of care that extends beyond the walls of any single organization. North and East Texas, a diverse network of health care providers, public agencies, community-based organizations, schools, faith communities and local leaders work in alignment to promote health and well-being.

This system of care is built on the understanding that health is shaped by more than medical care. It is influenced by stable housing, safe neighborhoods, transportation, food access, education, employment and social connection. No one institution can meet all these needs alone — but together, we can create a more coordinated, responsive and equitable approach to care.

The system of care model organizes services around key life domains, ensuring that people are supported holistically — not just as patients, but as whole individuals with interconnected needs. It also allows each partner to do what they do best — whether that’s delivering clinical care, offering counseling, preparing meals or advocating for policy change.

We embrace this model as part of our mission. By working collaboratively with our patients, neighbors, Associates, leaders and our strong community partners, we help reduce service gaps, improve outcomes and create a stronger safety net across our region.

Our Plan and Our Promise

The Community Health Implementation Plan (CHIP) is not just a requirement. It is a reflection of our CHRISTUS Health values in action.

Every three years, we conduct a Community Health Needs Assessment (CHNA) to better understand the health priorities, challenges and opportunities across our primary service area. The CHIP is our response to those findings — a forward-looking plan that outlines how we will work with communities to address the most pressing health needs over the next three years.

This plan was shaped through both data and dialogue. Using the Metopio platform and public health datasets, we analyzed dozens of indicators tied to health outcomes and social determinants. But we didn't stop at numbers — we listened deeply through focus groups, community surveys and direct conversations with local leaders, service providers and residents across the region. In particular, we made a focused effort to hear from those whose voices are too often left out: rural families, low-income residents, caregivers, youth and individuals with lived experience navigating health challenges.

What emerged from this process is a clear call to action — and a shared vision for a healthier East Texas.

The CHRISTUS St. Michael Health System CHIP includes strategies that fall into three categories. Each strategy, whether a hospital-led initiative, a community benefit investment, or a partnership effort, is rooted in lived experience, tied to measurable community needs and designed to advance health equity across the lifespan — from maternal and child health to chronic disease management and aging with dignity.

As we implement this plan, we remain deeply committed to:

- Centering community voice in every strategy
- Addressing root causes like poverty, access, housing and education
- Investing in trusted local solutions that build long-term resilience
- Connecting clinical care with community supports
- Working collaboratively across sectors to create lasting change

This plan is more than a list of programs; it is a shared commitment to healing, dignity and justice. Together with our partners, we will continue to build a region where every person, regardless of background, circumstance or ZIP code, has the opportunity to live a healthier, more dignified life.

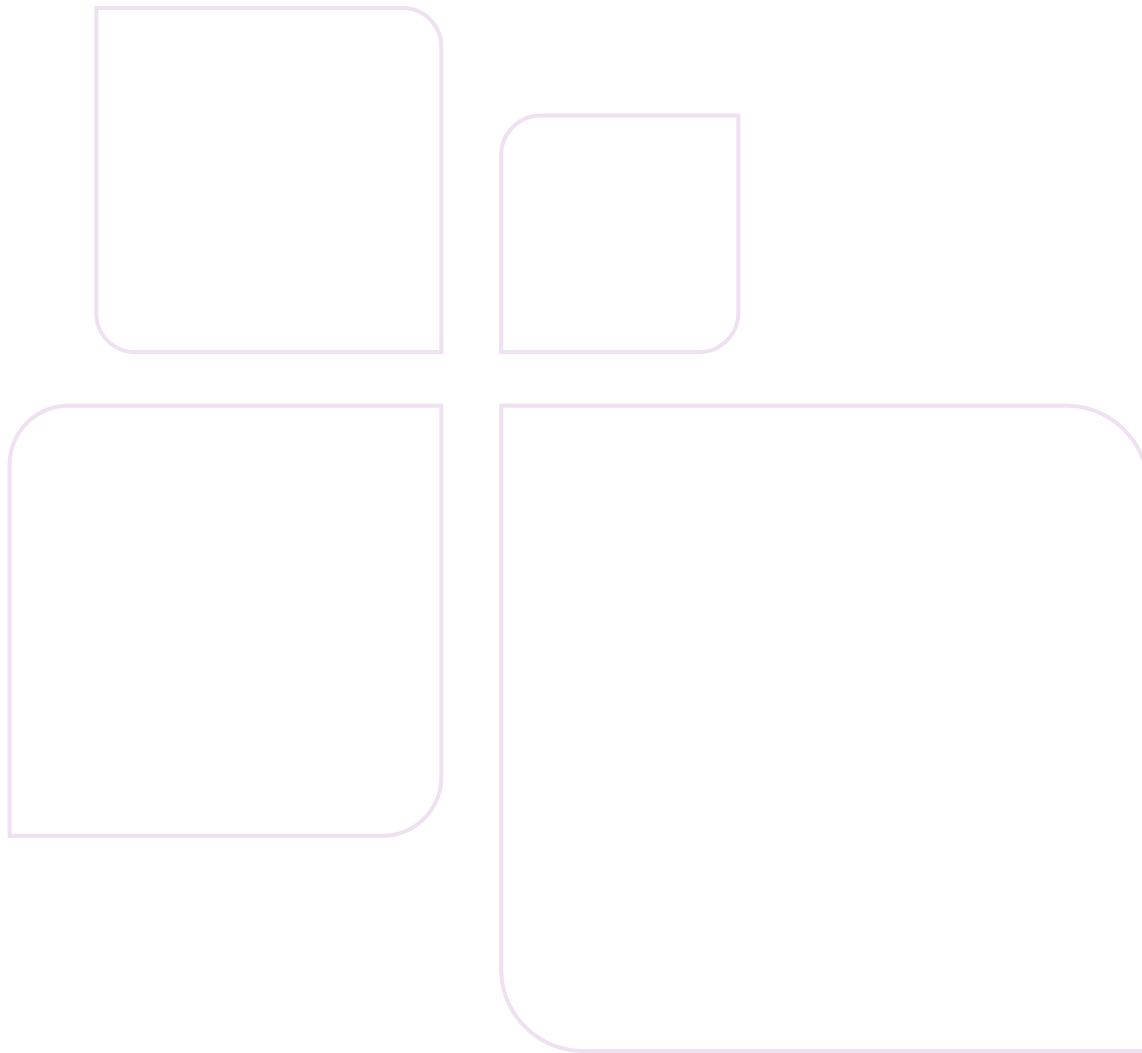
Board Approval

The final Community Health Needs Assessment (CHNA) report was completed, and the ministry CEO/president and executive leadership team of CHRISTUS St. Michael Health System reviewed and approved the CHNA prior to June 30, 2025, with the board of directors' ratification on July 31, 2025. Steps were also taken to begin implementation as of June 30, 2025, and the Community Health Implementation Plan (CHIP) was approved by the board of directors on July 31, 2025

CHRISTUS St. Michael Health System will continue to monitor and evaluate the implementation of these strategies to ensure they are making a measurable, positive impact on the health and well-being of the community.

Chapter 2: Impact





Reflecting on Our Impact

This chapter serves as both a reflection and a celebration of the progress made since the last Community Health Needs Assessment (CHNA) and the corresponding 2023-2025 Community Health Implementation Plan (CHIP). It highlights the measurable impact of our shared efforts to address the most urgent health and social needs identified by our communities and demonstrates how our ministry has turned strategy into action.

Guided by our CHNA priorities, CHRISTUS St. Michael Health System has made strategic investments to improve health outcomes and advance equity — especially for those who experience the greatest barriers to care. These efforts include targeted community benefit contributions across several key areas: charity care and financial assistance, subsidized health services and community-based programs that address the root causes of poor health, such as food insecurity, housing instability and access to behavioral health services.

This chapter also provides a closer look at the CHRISTUS Community Impact Fund, which enables us to support mission-aligned nonprofit partners who are creating change at the local level. The summaries of our FY23 through FY25 investments illustrate how these organizations have delivered high-impact, culturally responsive programs in alignment with our system's values and goals.

As we prepare to launch the 2026-2028 CHIP, this chapter allows us to pause and reflect on what we've been able to accomplish together. It offers a foundation of progress to build upon — celebrating the lives touched, partnerships strengthened and lessons learned that will guide our next phase of community health strategy.

Community Benefit Investments

As a Catholic, not-for-profit health system, we reinvest our earnings into programs, partnerships and services that improve health outcomes and advance equity for individuals and families across our ministries.

Every year, CHRISTUS St. Michael Health System makes strategic and intentional investments to address the most pressing health and social needs identified in our Community Health Needs Assessment. These community benefit activities are rooted in Catholic social teaching and focus on building healthier, more resilient communities by addressing both immediate clinical needs and long-term social influencers of health.

From FY23 through FY25, our community benefit contributions have supported three core categories:

- Charity care and financial assistance
- Unreimbursed Medicaid and means-tested government programs
- Community health improvement services and community-building activities

In addition to direct care and access, CHRISTUS invested in programs that address upstream drivers of health, such as food insecurity, housing instability and behavioral health access, through outreach, education and partnerships with local organizations. These investments reflect our commitment to equity, stewardship and sustained community impact.



FY23 Community Benefit Landscape

Community services \$15.4 million		Charity care \$19.4 million	Total community benefits \$34.8 million
\$1.2 million Community health improvements and strategic partnerships	\$963 thousand Health professionals' education and research	\$13.3 million Cash and in-kind distributions	\$22 thousand Community building activities

FY24 Community Benefit Landscape

Community services \$3.1 million		Charity care \$21.3 million	Total community benefits \$24.4 million
\$1.3 million Community health improvements and strategic partnerships	\$1.1 million Health professionals' education and research	\$701 thousand Cash and in-kind distributions	\$77 thousand Community building activities

FY25 Community Benefit Landscape

Currently, we are only including data from fiscal years 2023 and 2024 in our reporting on community benefit investments. We have chosen not to include FY2025 data as it remains unaudited and therefore subject to change. To ensure accuracy and maintain the integrity of our reporting, we only publish audited financial data. The audited data for FY2025 will be available in June 2026, at which point it will be incorporated into future reports and submissions.

Community Impact Fund

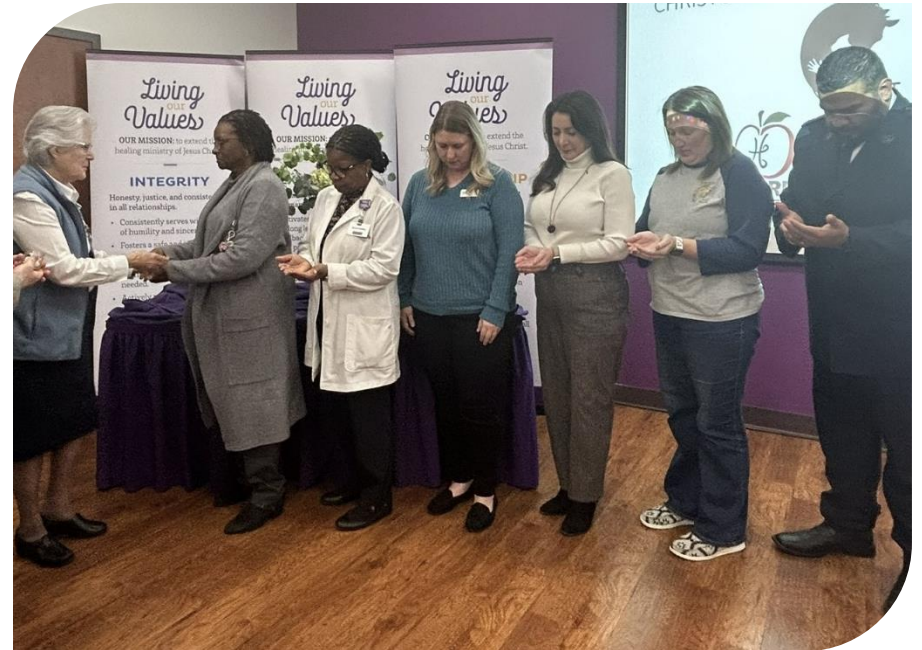
Established in January 2011, the CHRISTUS Community Impact Fund is the grantmaking arm of CHRISTUS Health. It was created to support initiatives led by nonprofit community agencies that improve the health and well-being of individuals and families across our ministries. Since its inception, the fund has become a catalyst for equity-driven, community-centered innovation — amplifying the voices of those closest to the challenges and investing in those best positioned to create change.

Each year, the CHRISTUS Community Impact Fund provides grants to organizations that align with the priorities identified through the Community Health Needs Assessment (CHNA). These investments support programs that:

- Expand access to care and essential social services
- Promote mental health and emotional well-being
- Prevent and manage chronic disease
- Address the root causes of poor health, including food insecurity, housing and transportation
- Strengthen community leadership, advocacy and capacity

From FY23 through FY25, CHRISTUS St. Michael Health System awarded Community Impact Fund grants to trusted, mission-aligned partners across the region. These organizations serve as the hands and feet of our shared vision — delivering culturally responsive programs, fostering community trust and driving measurable health improvements where they are needed most.

The following pages highlight the diverse grantees supported over the past three years, underscoring CHRISTUS Health's commitment to sustained and collaborative community impact.



FY23 Community Impact Fund

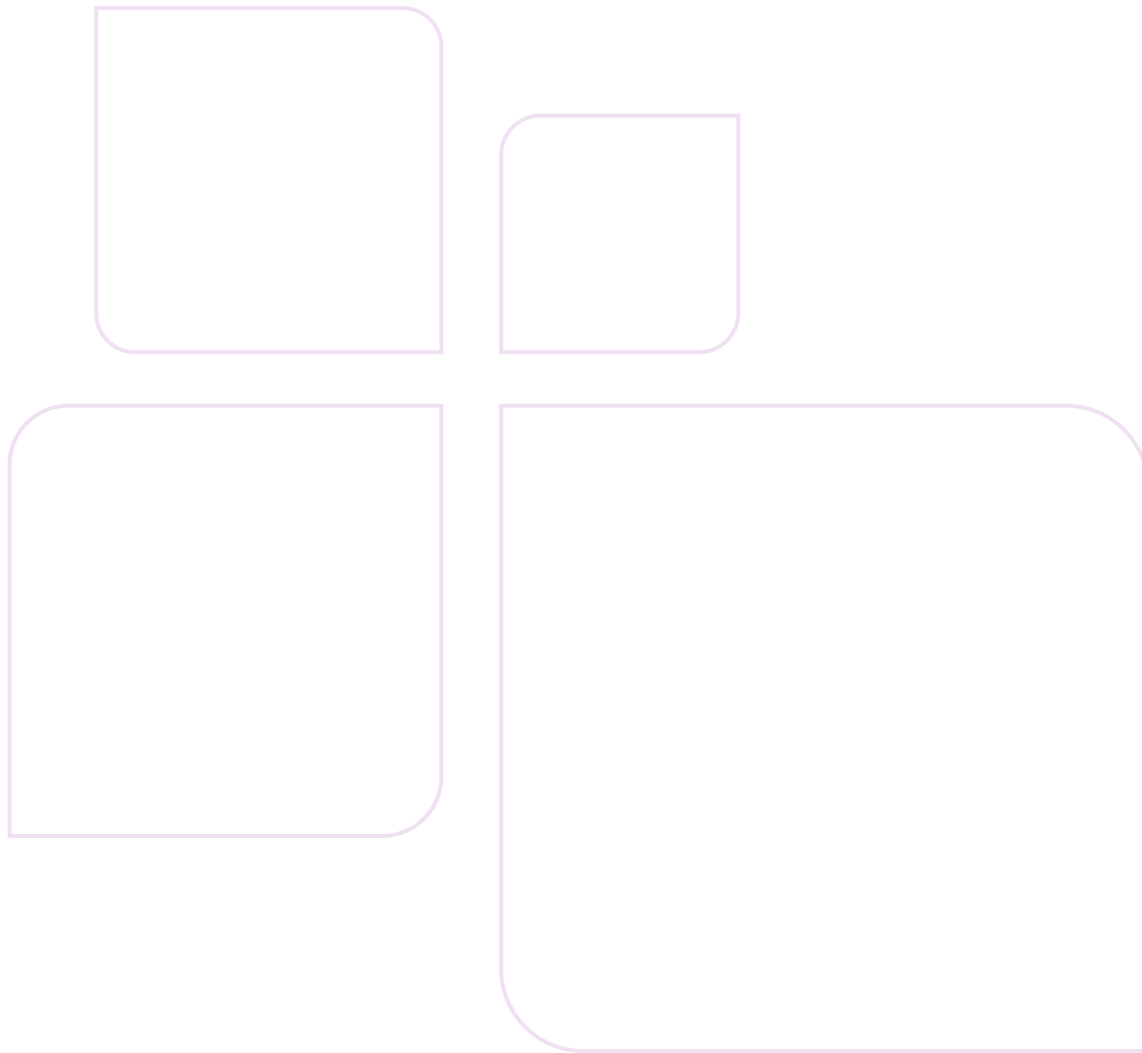
ORGANIZATION	DOMAIN	PRIORITY	PROGRAM NAME	PROGRAM DESCRIPTION
Community HealthCore	Advance health and well-being	Mental health and well-being	Behavioral health Triage RN	To provide an immediate response to individuals who present at the ER for behavioral health reasons
Harvest Regional Food Bank	Build resilient communities and improve social determinants	Healthy food access	Collaboration for Access to Healthy Foods for Low-Income Patients	To implement a Food Box Prescription program at CHRISTUS St. Michael for patients who are diabetic and/or hypertensive
Haven Homes	Advance health and well-being	Mental health and well-being	Haven Home for Women	To support the Haven Home for Women, a safe place for women in need of recovery and addiction support
Total CHRISTUS Community Impact Fund investment:				\$275,000.00

FY24 Community Impact Fund

ORGANIZATION	DOMAIN	PRIORITY	PROGRAM NAME	PROGRAM DESCRIPTION
Community Healthcore	Advance health and well-being	Mental health and well-being	Behavioral Health Triage RN	To provide an immediate response to individuals who present at the ER for behavioral health reasons
Harvest Regional Food Bank	Build resilient communities and improve social determinants	Healthy food access	Healthy Food Box Prescription	To implement a Food Box Prescription program at CHRISTUS St. Michael for patients who are diabetic and/or hypertensive
Runnin' WJ Therapeutic Riding Center, Inc.	Advance health and well-being	Mental health and well-being	Equine Assisted Mental Health Counseling	To aid individuals with mental health issues using alternative methods of counseling
Hands on Texarkana	Build resilient communities and improve social determinants	Healthy food access	Senior Transportation and Pantry	To improve access to essential health care services and nutritious food for senior citizens in Texas and Arkansas
The Salvation Army of Greater Texarkana	Build resilient communities and improve social determinants	Education	Boys & Girls Club	To provide young people with access to high-quality educational opportunities to help them success in school and life
Total CHRISTUS Community Impact Fund investment:				\$295,000.00

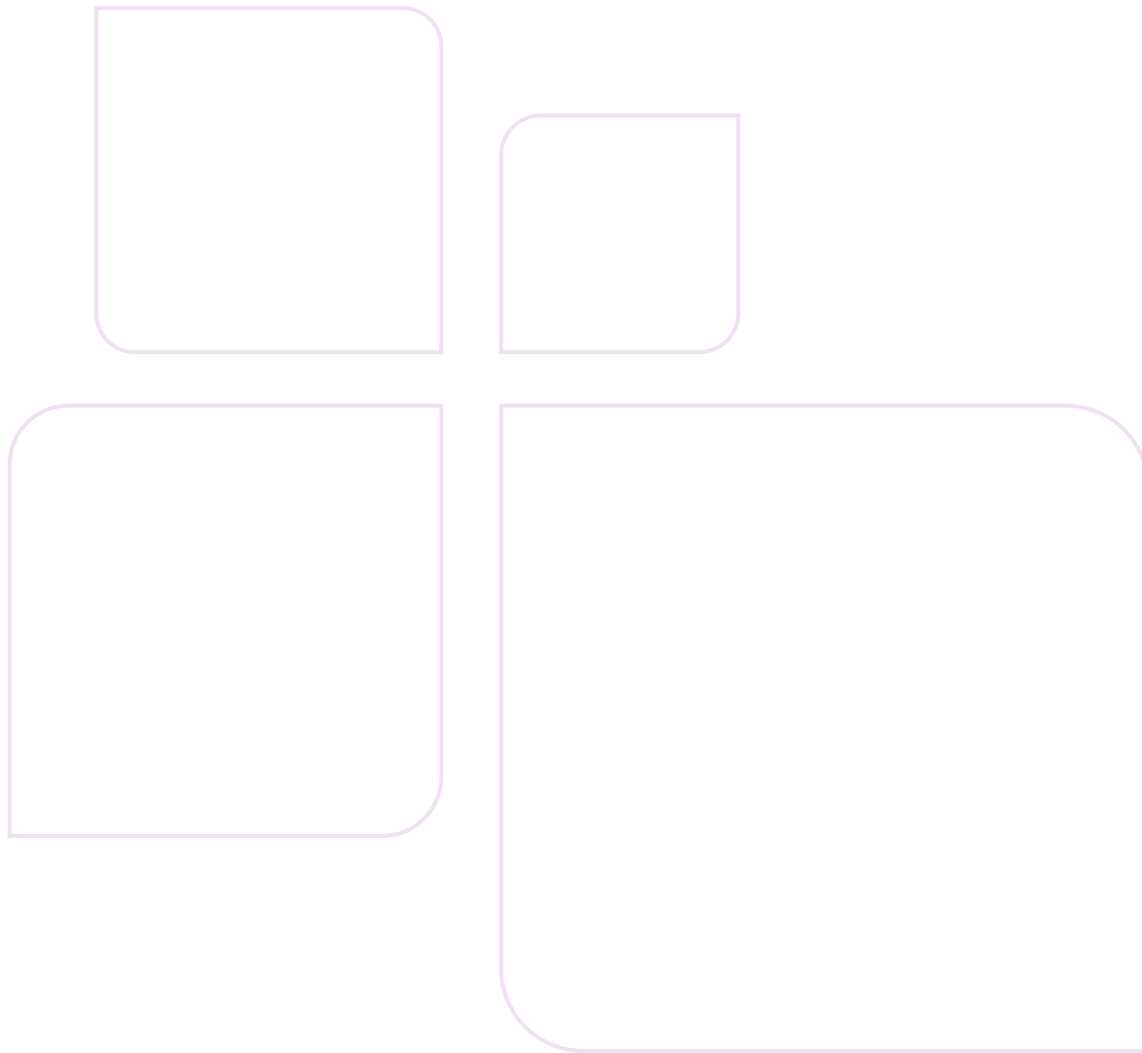
FY25 Community Impact Fund

ORGANIZATION	DOMAIN	PRIORITY	PROGRAM NAME	PROGRAM DESCRIPTION
Community Healthcore	Advance health and well-being	Mental health and well-being	Behavioral Health Triage RN	To embed a Behavioral Triage RN at the CHRISTUS St. Michael ER to support individuals who present to the ER for behavioral health reasons
HandsOn Texarkana	Build resilient communities and improve social determinants	Healthy food access	Senior Transportation and Pantry	To provide transportation to medical appointments and provide monthly food box deliveries to older adults
Harvest Regional Food Bank	Build resilient communities and improve social determinants	Healthy food access	Healthy Food Box Prescription	To provide two healthy food boxes a month to patients who are hypertensive and/or diabetic
Southwest Arkansas Counseling and Mental Health Center	Advance health and well-being	Mental health and well-being	Southwest Arkansas Mental Health and Counseling Center.	To prevent, treat and cure mental illnesses and related disorders regardless of the individual's ability to pay
Texarkana Children's Advocacy Center	Advance health and well-being	Mental health and well-being	Texarkana Children's Advocacy Center (TCAC)	To provide trauma-informed, evidence based mental health services to children impacted by abuse and neglect
The Salvation Army of Greater Texarkana	Build resilient communities and improve social determinants	Education	Red Shield Youth Center	To empower and equip underserved youth with the academic, social, emotional and life-skills necessary to break the cycle of poverty and achieve long-term success
Total CHRISTUS Community Impact Fund investment:				\$305,000.00



Chapter 3: Priorities





Priorities and Focus

The Lifespan Approach

To better understand and respond to the evolving needs of the communities we serve, CHRISUTS St. Michael Health System structured its Community Health Needs Assessment (CHNA) and Community Health Implementation Plan (CHIP) using a lifespan approach. This framework organizes data, priorities and strategies by key stages of life, recognizing that health needs — and the factors that influence them — shift as individuals grow, age and move through different phases of life.

We identify three to five leading health indicators within each of the following four life stages:

- Maternal and early childhood (pregnancy through age 4)
- School-age children and adolescents (ages 5–17)
- Adults (ages 18–64)
- Older adults (ages 65 and up)

By segmenting our focus in this way, we can ensure that interventions are age-appropriate, culturally relevant and responsive to developmental and social needs unique to each stage. At the same time, we acknowledge that the health and well-being of one life stage can influence and be influenced by another — for example, how maternal health affects infant outcomes, or how early trauma can impact chronic disease in adulthood.

Using this life course perspective allows us and our partners to deliver more precise, equitable and coordinated responses across the continuum of care — ultimately creating healthier communities today and for generations to come.



Prioritization Process

To determine the most pressing community health needs for the 2026-2028 Community Health Implementation Plan (CHIP), CHRISTUS St. Michael Health System used a data-informed and community-driven approach grounded in the Results-Based Accountability (RBA) framework. This method ensures that decisions are rooted in both quantitative data and the lived experiences of community members.

A series of community indicator workgroups organized by life stage brought together residents, partners and subject matter experts to discuss what good health looks like across the lifespan:

- Maternal and early childhood
- School-age children and adolescents
- Adults
- Older adults

During these workgroups, participants reviewed existing CHNA data, discussed emerging health trends and assessed indicators from the prior implementation cycle. They explored local conditions and asked key questions to guide prioritization:

- Can we trust the data?
- Is the indicator easy to explain and understand?
- Does it represent a larger community condition?

This process included tools from the RBA model, including the concept of “turn the curve,” which focuses on using trend data to understand whether community conditions are improving over time. Rather than focusing on year-to-year fluctuations, this model assesses progress

based on whether strategies are starting to shift long-term trends in the right direction.

Based on these discussions, each workgroup identified three to five leading health indicators for their respective life stage. These indicators highlight the areas of greatest need, concern and opportunity for impact. They now serve as a shared focus for our strategies, investments and partnerships over the next three years, ensuring that improvement efforts are both targeted and measurable.



Lifespan Priority Indicators of 2026-2028

The following table summarizes the priority indicators selected through the community indicator workgroups and approved by the CHRISTUS St. Michael Health System's board of directors. These indicators represent the most urgent and actionable health and social needs for each stage of life, based on both community input and data analysis conducted during the Community Health Needs Assessment (CHNA) process.

These leading indicators will serve as a foundation for the 2026-2028 Community Health Implementation Plan (CHIP), guiding program strategies, investments and partnerships that aim to “turn the curve” on health outcomes across the lifespan.

For a detailed explanation of each indicator, including baseline data, trend analysis and community context, please refer to the CHRISTUS St. Michael's Community Health Needs Assessment, available at: CHRISTUShealth.org/connect/community/community-needs

COMMUNITY LEADING INDICATORS			
Maternal Health and Early Childhood Health	School-Age Children and Adolescent Health	Adult Health	Older Adult Health
<i>Mothers and babies will have access to the care and support needed for healthy pregnancies, childbirth, growth and development.</i>	<i>Children will be well-equipped with care and support to grow up physically and mentally healthy.</i>	<i>Adults will have access to the care, support and opportunities needed to maintain physical and mental health throughout their lives.</i>	<i>Older adults will have accessible and empowering environments to ensure that every person can age with health and socioeconomic well-being.</i>
A. Healthy births B. Trauma C. Poverty D. Awareness of resources	A. Behavioral health 1. Suicide B. Abuse and neglect C. Poverty D. Food insecurity	A. Behavioral health 1. Mental health B. Heart disease C. Continuity of care/treatment across state lines D. Food insecurity	A. Chronic diseases 1. Heart disease 2. Diabetes 3. Cancer • Alzheimer's/dementia B. Overutilization of the ER C. Poverty

Needs That Are Not Being Addressed

The CHRISTUS St. Michael Health System 2026-2028 Community Health Needs Assessment (CHNA) identified a broad range of important health and social needs across our service area. However, not all these needs fall within the direct scope of services or resources that we can lead or sustain independently. Some community issues require the specialized focus, infrastructure or mission alignment of other organizations, agencies or collaborative groups better positioned to lead efforts in those areas.

Examples of these needs may include, but are not limited to:

- Housing and homelessness
- Transportation barriers
- Food insecurity
- Family support for individuals with disabilities or special needs

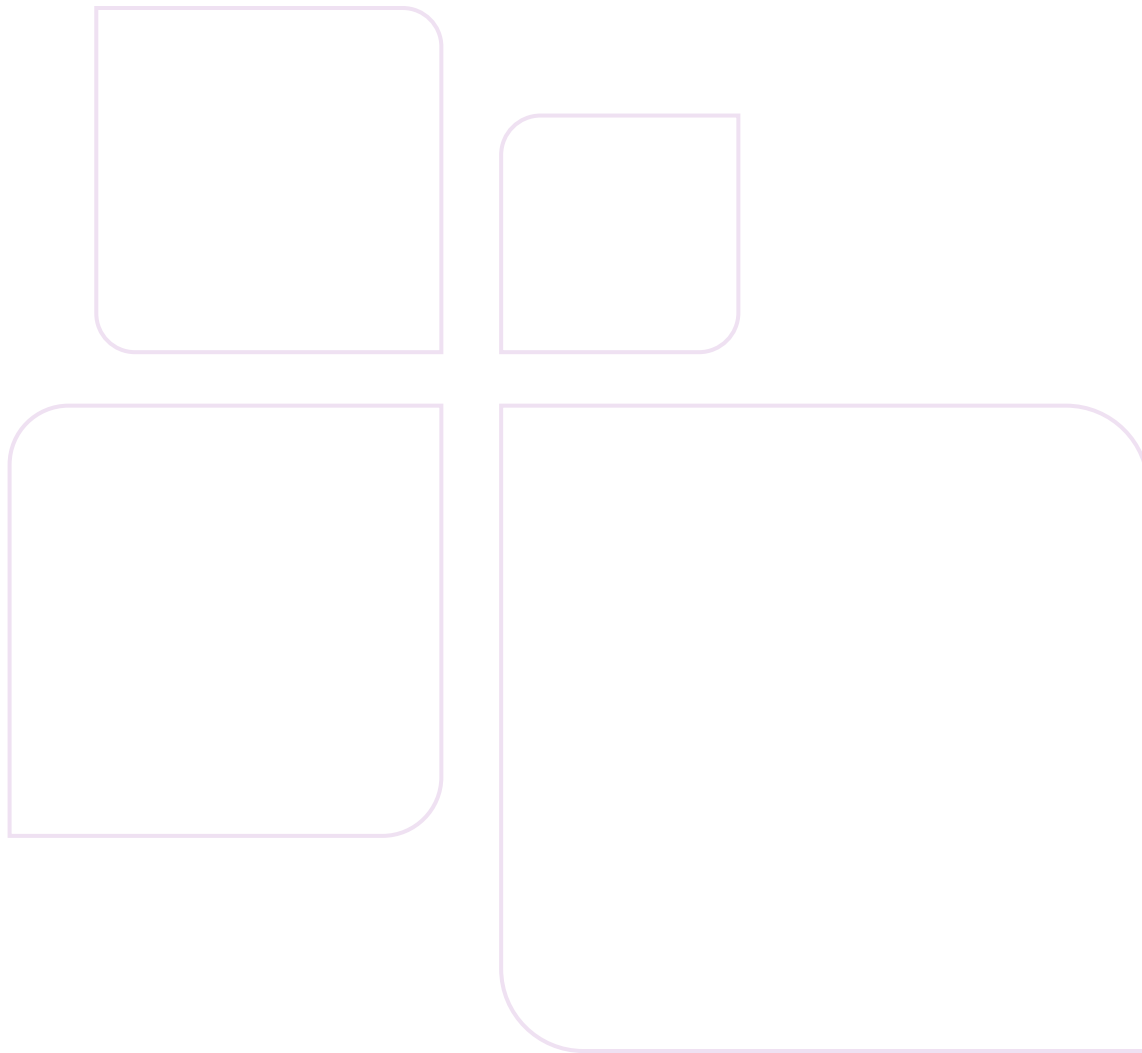
Although we will not serve as the primary lead on these issues, we recognize their direct impact on health outcomes and the overall well-being of our patients and communities. For this reason, we remain deeply committed to collaborating with community partners who address these needs, participating in coalitions, supporting aligned initiatives and ensuring that our strategies complement and enhance their work.

The strategies section that follows will highlight where CHRISTUS St. Michael Health System is playing a supportive or collaborative role on these issues, including how we are coordinating with trusted organizations and multi-sector partners. These collaborative efforts are essential to building a more comprehensive, equitable and effective system of care across our region.



Chapter 4: Strategies





Strategies

The implementation strategies outlined in the following sections are organized according to the lifespan stages identified in the 2026–2028 Community Health Needs Assessment. Each section details the approaches CHRISTUS St. Michael Health System (CSMHS) will use to address priority health indicators, categorized into three distinct strategy types:

- **Hospital Direct Care Strategies ("We lead")**

Initiatives led directly by CHRISTUS St. Michael, typically aligned with hospital and clinical operations. Examples include expanding access to cardiovascular care, enhancing cancer screening programs, and strengthening maternal and child health services.

- **Community Funding Strategies ("We fund")**

Efforts financially supported by CHRISTUS through grants and community benefit funds. These include programs such as the CHRISTUS Fund and local community benefit investments designed to address unmet needs and fill gaps in care.

- **Community Partner Strategies ("They lead")**

Collaborative efforts led by community organizations, with CHRISTUS serving in a supportive role through participation, advisory board membership, or joint initiatives. Examples include involvement in regional health coalitions, school-based health initiatives, and strategic partnerships with organizations like United Way.

As a first step in developing these strategies, the leading health indicators were categorized using common language and mapped across lifespan stages. This approach helps align local and system-level strategies with health data, community survey responses, and feedback from focus groups. Each strategy is then evaluated against available hospital, community, and system resources to ensure feasibility and impact.

The investments CSMHS commits to support treatment services, safety net programs, efforts to address social determinants of health, and direct community benefits such as free flu vaccinations, health screenings, and health education events. Ongoing collaboration with community partners ensures coordinated efforts to improve public policy, expand outreach, and develop new initiatives that respond to the priority health needs of the communities we serve

To improve how we capture and evaluate community health activities, we have categorized the *Community Leading Indicators* for better partnership and alignment. While the indicators themselves remain the same, the updated format aligns more closely with our internal tracking systems and reporting needs.

This refinement enhances our ability to demonstrate the impact of our work and ensures that our activities are accurately reflected for community benefit purposes. The new format provides a more structured and evaluative framework, supporting consistency and clarity across our reporting processes.

LEADING INDICATORS			
Maternal Health and Early Childhood Health	School-Age Children and Adolescent Health	Adult Health	Older Adult Health
<i>Mothers and babies will have access to the care and support needed for healthy pregnancies, childbirth, growth and development.</i>	<i>Children will be well-equipped with care and support to grow up physically and mentally healthy.</i>	<i>Adults will have access to the care, support and opportunities needed to maintain physical and mental health throughout their lives.</i>	<i>Older adults will have accessible and empowering environments to ensure that every person can age with health and socioeconomic well-being.</i>
A. Primary Care Access 1. Access to providers B. Specialty Care/Chronic Illness 1. Healthy Births C. Behavioral Health 1. Trauma D. Education/Employment Opportunities Development 1. Awareness of Resources E. Social Determinants / Food Insecurity 1. Poverty	A. Primary Care Access 1. Access to providers B. Specialty Care/Chronic Illness 1. Access to providers C. Behavioral Health 1. Suicide 2. Abuse and Neglect D. Education/Employment Opportunities Development 1. Poverty E. Social Determinants / Food Insecurity 1. Food Insecurity	A) Primary Care Access 2. Access to providers B) Specialty Care/Chronic Illness 3. Access to providers C) Behavioral Health 4. Suicide 5. Abuse and Neglect D) Education/Employment Opportunities Development 6. Poverty E) Social Determinants / Food Insecurity 7. Food Insecurity	A) Primary Care Access 8. Overutilization of the ER B) Specialty Care/Chronic Illness 9. Heart Disease 10. Diabetes 11. Cancer C) Behavioral Health 12. Alzheimer's Disease / Dementia D) Education/Employment Opportunities Development 13. Awareness of Resources E) Social Determinants / Food Insecurity 14. Poverty

Maternal and Early Childhood Health

RESULT: Mothers and babies will have access to the care and support needed for healthy pregnancies, childbirth, growth and development.

LEAD INDICATORS:

- A. Healthy births
- B. Trauma
- C. Poverty
- D. Awareness of resources

DATA MEASURES

- Poverty rate
- Households in poverty not receiving food stamps (SNAP)
- Prenatal care in first trimester

MATERNAL AND EARLY CHILDHOOD STRATEGIES

Hospital direct care strategies	Community funding strategies	Community partner strategies
"We lead"	"We fund"	"They lead"
A1. Improve access to care, information and support services for prenatal and perinatal care. A2. Hold regular internal perinatal interdisciplinary collaborative meetings to better serve high-risk patients. B1. Provide trauma preventative education to pediatric providers, families and emergency clinicians. B2. Provide infant car seat education and installation. D1. Provide community resource guides for patients and their families.	A1. Support non-profit programs for food insecurity. A2. Provide support to local non-profit organizations to provide educational and other programs for expecting families. C1. Support local non-profits that focus on reducing the challenges related to poverty.	A1. Collaborate with local non-profits and health departments to improve care access and information sharing for expecting mothers and young families. A2. Collaborate with organizations that address healthy births and families, such as Bridging the Gaps, Fearfully and Wonderfully Made, etc. C1. Collaborate with non-profits who provide food distribution, pantries and support food drives in the priority service area.

School-Age Children and Adolescent Health

RESULT: More children will be well-equipped with the care and support to grow up physically and mentally healthy.

LEAD INDICATORS:

- A. Behavioral health
 - 1. Suicide
- B. Abuse and neglect
- C. Poverty
- D. Food insecurity

DATA MEASURES

- Poverty rate
- Adverse childhood experiences
- Teen suicide by rate
- Child psychologists per capita
- Suicide mortality

SCHOOL-AGE CHILDREN AND ADOLESCENT HEALTH STRATEGIES

Hospital direct care strategies	Community funding strategies	Community partner strategies
"We lead"	"We fund"	"They lead"
C1. Provide opportunities to students for job shadowing, preceptorships, etc. C2. Provide community-based screening assessments and education to low-income, uninsured and special request populations. D1. Hold a collaborative meeting to determine key issues contributing to food insecurity and potential actions.	A1. Provide access to programming for service area schools focusing on mental health and social/emotional learning. A2. Offer financial and in-kind support to community organizations involved in the delivery of behavioral health services. B1. Offer financial support to community organizations involved in the delivery of services to support and advocate for vulnerable children.	A1. Collaborate with organizations that address behavioral health issues, such as Community Health Core, Salvation Army, Domestic Violence Prevention, Opportunities Inc., Water Springs Ranch, Casa, Runnin WJ Ranch, etc. D1. Collaborate with non-profits who provide food distribution, pantries and support food drives in the priority service area.

Adult Health

RESULT: More adults will have access to the care, support and opportunities needed to maintain physical and mental health throughout their lives.

LEAD INDICATORS

- A. Behavioral health
 - 1. Mental health
- B. Heart disease
- C. Continuity of care/treatment across state lines
- D. Food insecurity

DATA MEASURES

- Poor self-reported mental health
- Suicide mortality
- Heart disease mortality
- High blood pressure
- Specialist physicians per capita
- Food insecurity

ADULT HEALTH STRATEGIES		
Hospital direct care strategies	Community funding strategies	Community partner strategies
"We lead"	"We fund"	"They lead"
B1. Provide screenings and education around prevention and early detection of heart disease. B2. Improve access to care, information and support services for cardiac patients. C1. Increase access to primary and specialty care across our service area. C2. Provide mentoring staff, faculty assistance and training opportunities for students in health care programs across state lines. D 1. Identify patients experiencing food insecurity and provide education on available resources.	A1. Offer financial and in-kind support to community organizations involved in the delivery of behavioral health services. B1. Provide education and funding for heart-healthy nutrition for patients identified through social determinants of health screening. B2. Continue community education initiatives focused on chronic disease prevention, as well as support health promotion portions of community events/programs. D 1. Provide funding for non-profits who are focused on addressing food insecurity challenges in our service area.	A1. Collaborate with organizations that address behavioral health issues, such as Community Health Core, Alzheimer's Alliance, Restoration of Hope, Domestic Violence Prevention, Opportunities Inc., etc. C1. Evaluate opportunities for collaboration with FQHC's to expand access to care across state lines. D1. Collaborate with non-profits who provide food distribution, pantries and support food drives in the priority service area.

Older Adult Health

RESULT: More older adults will have accessible and empowering environments to ensure that every person can age with health and socioeconomic well-being.

LEAD INDICATORS

- A. Chronic diseases
 - 1. Heart disease
 - 2. Diabetes
 - 3. Cancer
- B. Alzheimer's/dementia
- C. Overutilization of the emergency room
- D. Poverty

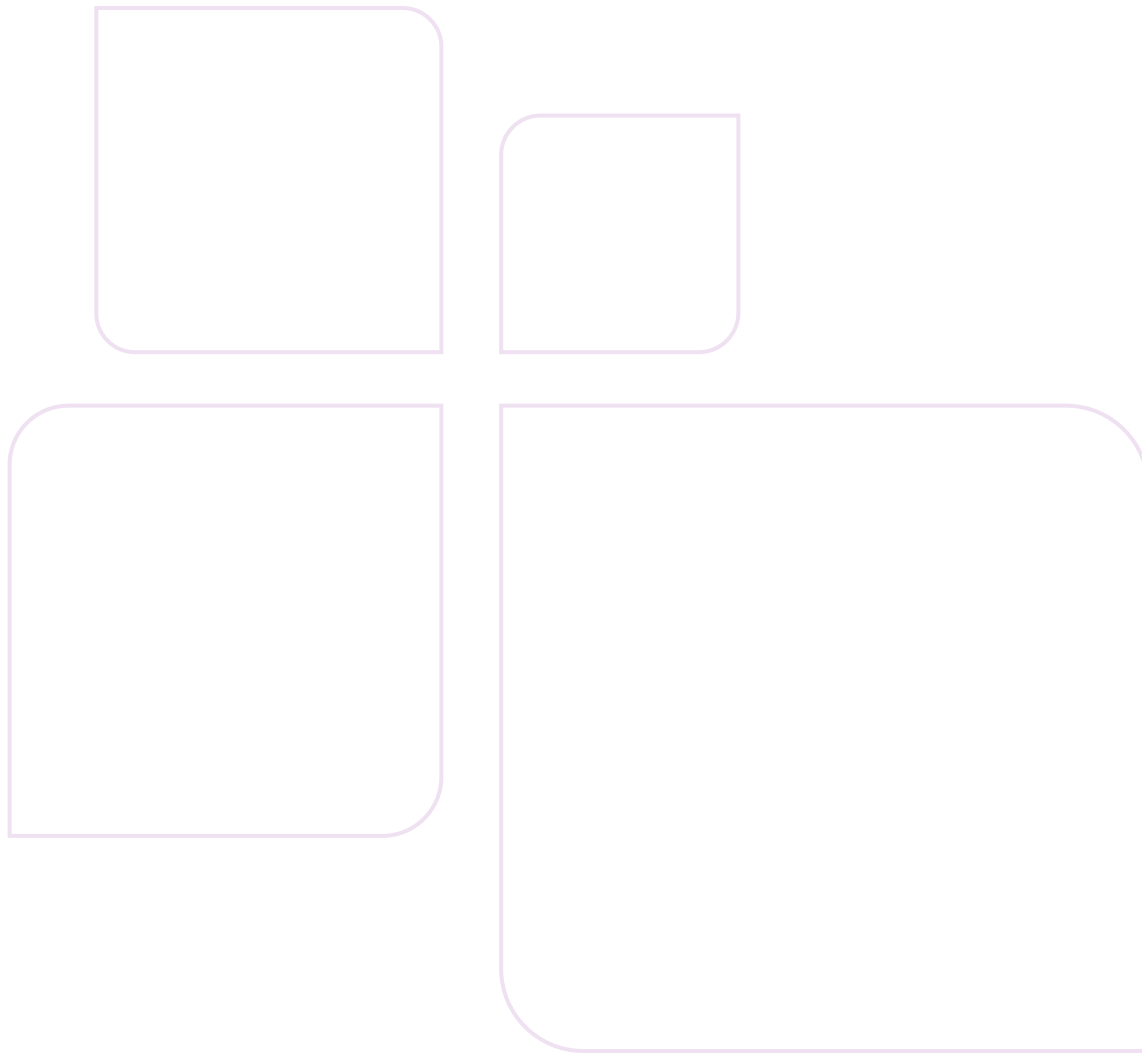
DATA MEASURES

- Diabetes mortality
- Heart disease mortality
- Cancer mortality
- Mean retirement income
- Medicare emergency department visit rate
- Alzheimer's disease mortality

OLDER ADULT HEALTH STRATEGIES		
Hospital direct care strategies	Community funding strategies	Community partner strategies
"We lead"	"We fund"	"They lead"
A1. Provide screenings and education around prevention and early detection of chronic diseases. A2. Improve access to care, information and support services for older adults. C1. Increase access to primary and specialty care across our service area. C2. Provide mentoring staff, faculty assistance and training opportunities for students in health care programs serving our community. D1. Identify patients experiencing food insecurity and provide education on available resources.	A1 & B1. Offer financial and in-kind support to community organizations involved in addressing challenges stemming from chronic disease, such as Alzheimer's, heart disease, diabetes and cancer. C1. Continue community education initiatives focused on chronic disease prevention, as well as support health promotion portions of community events/programs. D1. Provide education and funding for heart-healthy nutrition for patients identified through social determinates of health screening to live with cardiovascular disease and/or diabetes. D2. Provide funding for non-profits who are focused on addressing challenges stemming from poverty.	A1. Collaborate with organizations that address chronic disease, such as Community Alzheimer's Alliance, Area Agency on Aging, Tough Kookie Foundation, Harvest Texarkana, etc. C1. Evaluate opportunities for collaboration with FQHC's to expand access to care across our service area. D1. Collaborate with non-profits who provide food distribution, transportation, housing and other challenges stemming from poverty in the priority service area.

Chapter 5: Conclusion





Conclusion

The CHRISTUS St. Michael Health System 2026-2028 Community Health Implementation Plan will guide our strategies over the next three years. The CHIP aligns the health priorities identified in the CHNA with us focusing on direct care, community benefit funding and community partnerships and collaborations. The triannual Community Health Needs Assessment and Community Health Implementation Plan provide a routine opportunity for us and our community partners to assess community health needs and how we are going to address them together.



Improving the overall health and wellness of a community requires a range of partnerships, both deep and wide. Community partnerships ensure that multiple perspectives are represented and that varied needs are met. Each entity has a role to play in meeting our vision of a community where:

- Mothers and babies have access to the care and support needed for healthy pregnancies, childbirth, growth and development.
- Children are well-equipped with the care and support to grow up physically and mentally healthy.
- Adults have access to the care, support and opportunities needed to maintain physical and mental health throughout their lives.
- Older adults have accessible and empowering environments to ensure that every person can age with health and socioeconomic well-being.
- Community members receive compassionate, high-quality care that honors their dignity, life experiences and unique needs.

Contact Information

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An electronic version of this Community Health Implementation Plan is publicly available at:

CHRISTUS Health's website:

CHRISTUShealth.org/connect/community/community-needs

