Community Health Implementation Plan

Strategies for responding to the prioritized needs in the community

2026 – 2028

CHRISTUS SHREVEPORT-BOSSIER Health System

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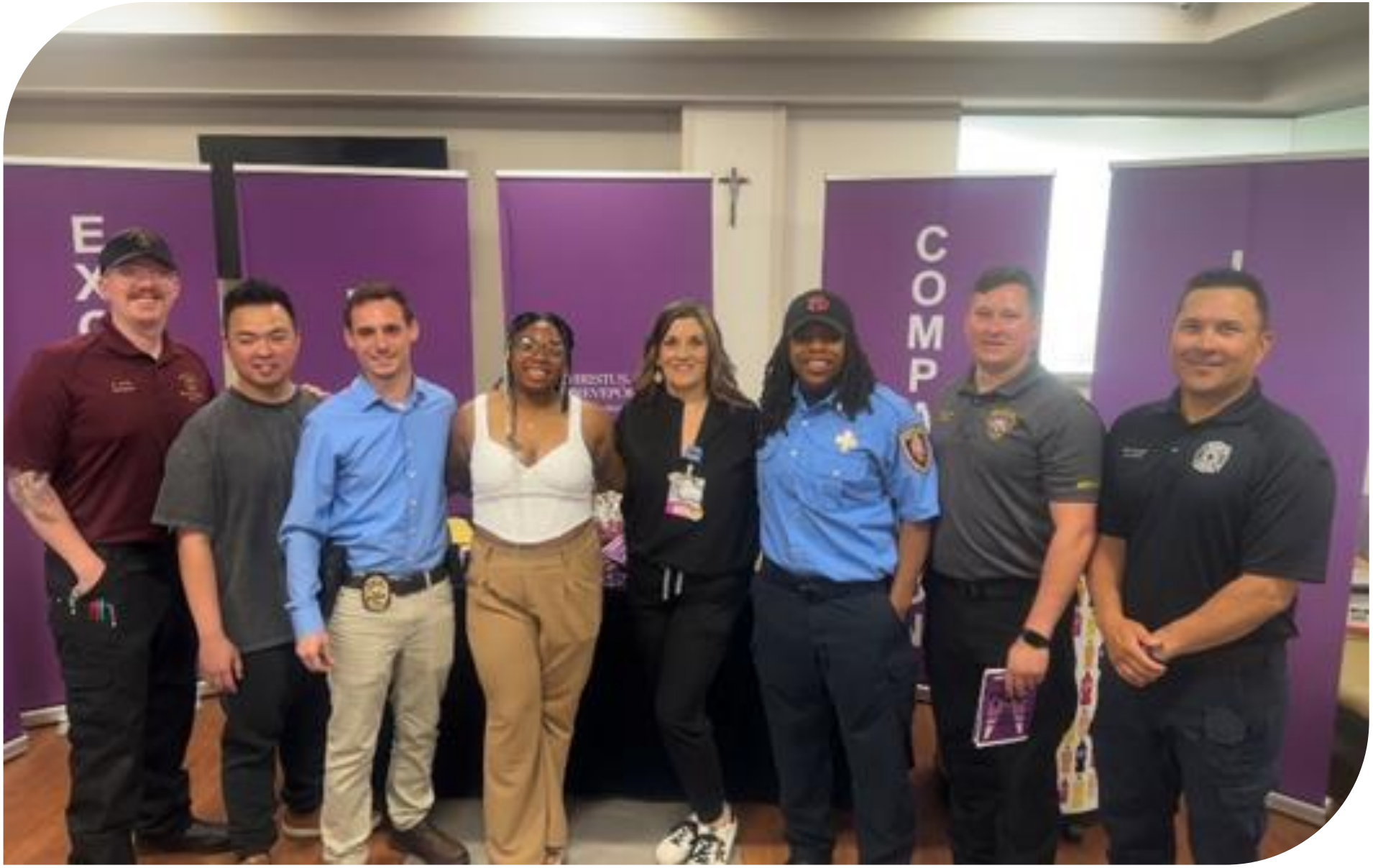
Chapter 1: Introduction



Introduction

CHRISTUS Shreveport-Bossier Health System has been identifying and addressing our community's health and well-being needs since our founding in 1894. We are called to be involved in our community and 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. CHRISTUS Shreveport-Bossier Health System recognizes 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 Shreveport-Bossier, 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 Shreveport-Bossier 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 parish or parishes where the hospital is located, along with surrounding areas from which patients frequently seek care.

We serve as a vital access point for care in Caddo and Bossier parishes and extend our reach into neighboring parishes, such as Webster, DeSoto and Red River, 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, we have worked with community partners, local organizations and residents to better understand and respond to the unique health needs of the populations we serve. As we move into the 2026-2028 implementation cycle, we remain focused on improving access to high-quality, culturally responsive care and building stronger community connections to ensure every person has the opportunity to live a healthier life — close to home.

Systems of Care Principle

CHRISTUS Shreveport-Bossier Health System is part of a broader system of care that extends beyond the walls of any single organization. Across Northern Louisiana, 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, CHRISTUS Shreveport-Bossier Health System conducts 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 community.

The CHRISTUS Shreveport-Bossier Health System's 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

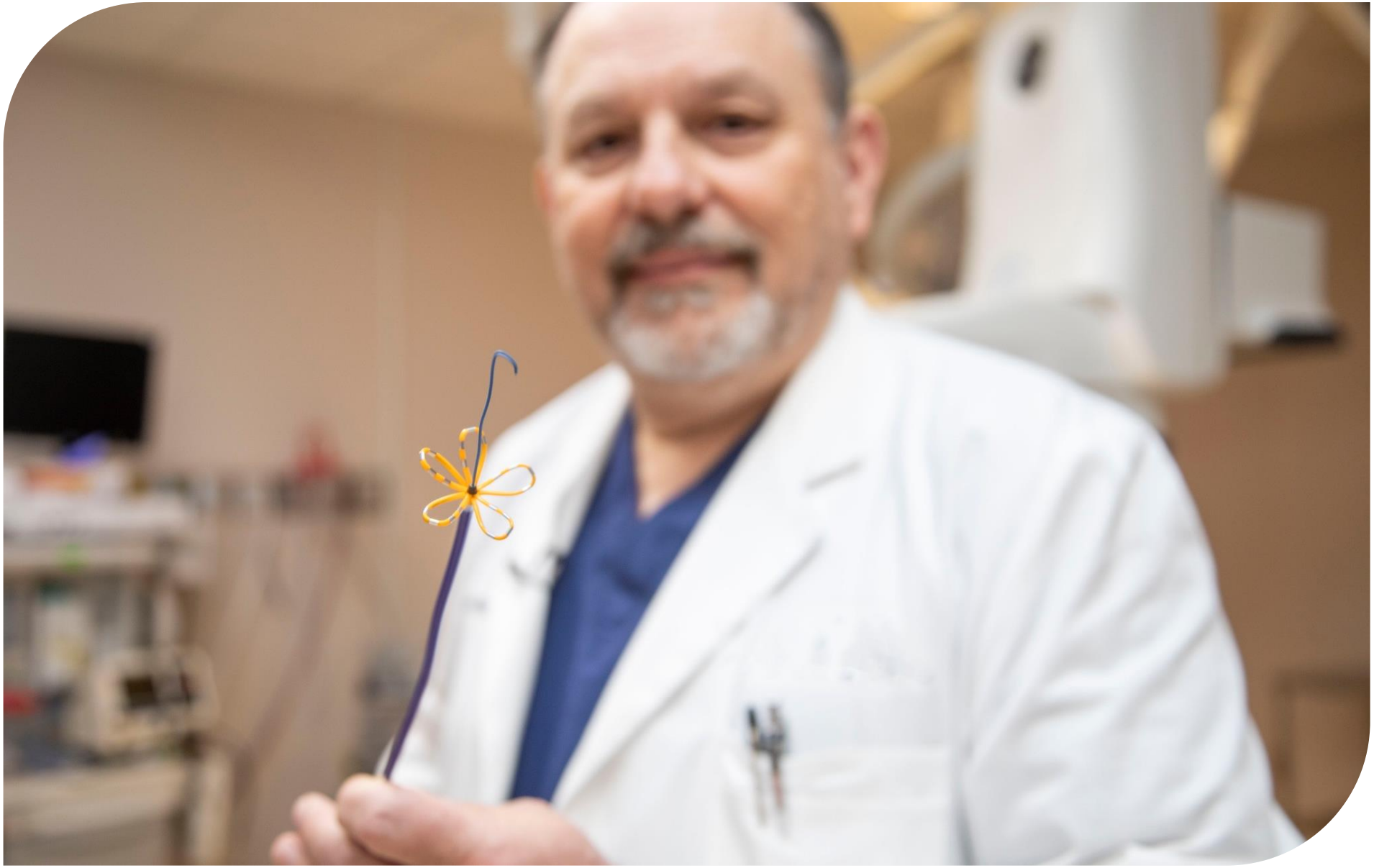
This plan is more than a list of programs; it is a shared commitment to healing, dignity and justice. Together with our partners, we will continue to build a region where every person, regardless of background, circumstance or ZIP code, has the opportunity to live a healthier, more dignified life.

Board Approval

The final Community Health Needs Assessment (CHNA) report was completed, and the ministry CEO/president and executive leadership team of CHRISTUS Shreveport Bossier 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.

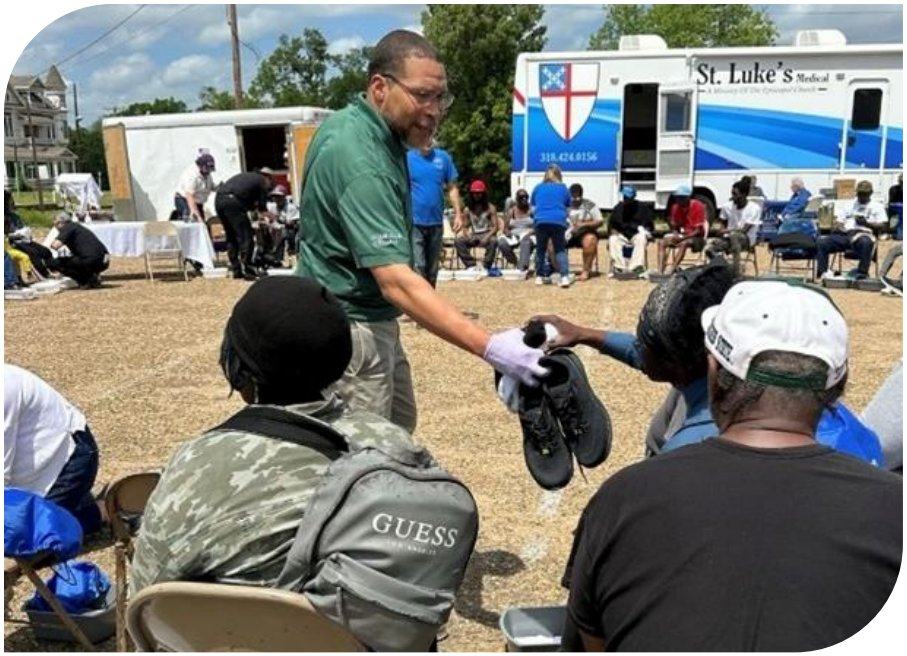
CHRISTUS Shreveport Bossier Health System will continue to monitor and evaluate the implementation of these strategies to ensure they are making a measurable, positive impact on the health and well-being of the community.

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 Shreveport-Bossier 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

Our Commitment in Action

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.

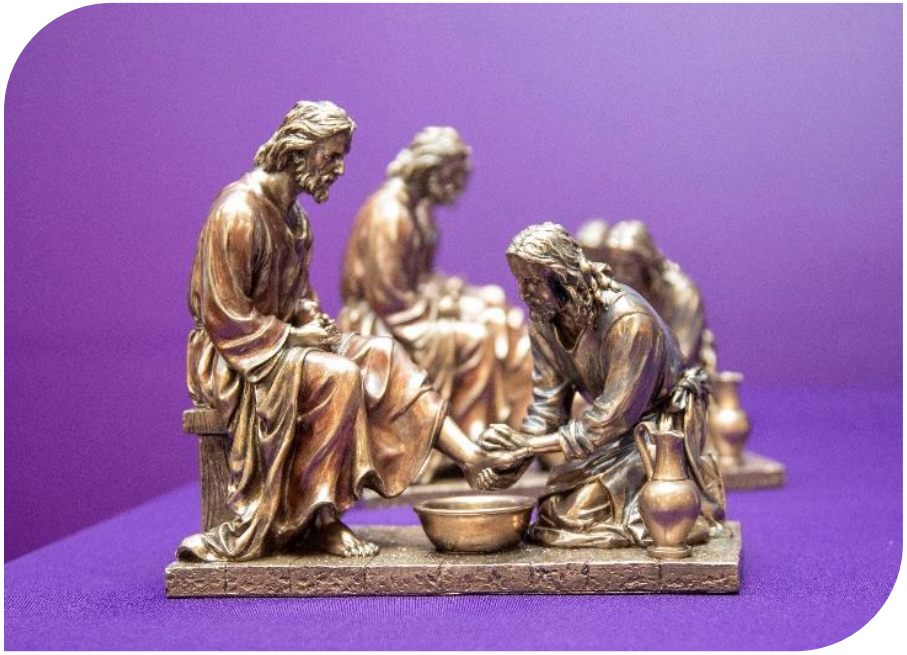
Every year, CHRISTUS Shreveport-Bossier Health System makes strategic and intentional investments to address the most pressing health and social needs identified in our Community Health Needs Assessment. These community benefit activities are rooted in Catholic social teaching and focus on building healthier, 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.

At CHRISTUS Shreveport-Bossier Health System, community benefit is fundamental to our identity and how we serve. These committed resources and investments reflect our dedication to equity, stewardship and ongoing community impact.



FY23 Community Benefit Landscape

Community services $7.5 million		Charity care $1.1 million		Total community benefits $8.6 million
$501 thousand Community health improvements and strategic partnerships	**$90 thousand** Health professionals' education and research	**$104** Subsidized health services	**$6.9 million** Cash and in-kind distributions	**$12 thousand** Community building activities

FY24 Community Benefit Landscape

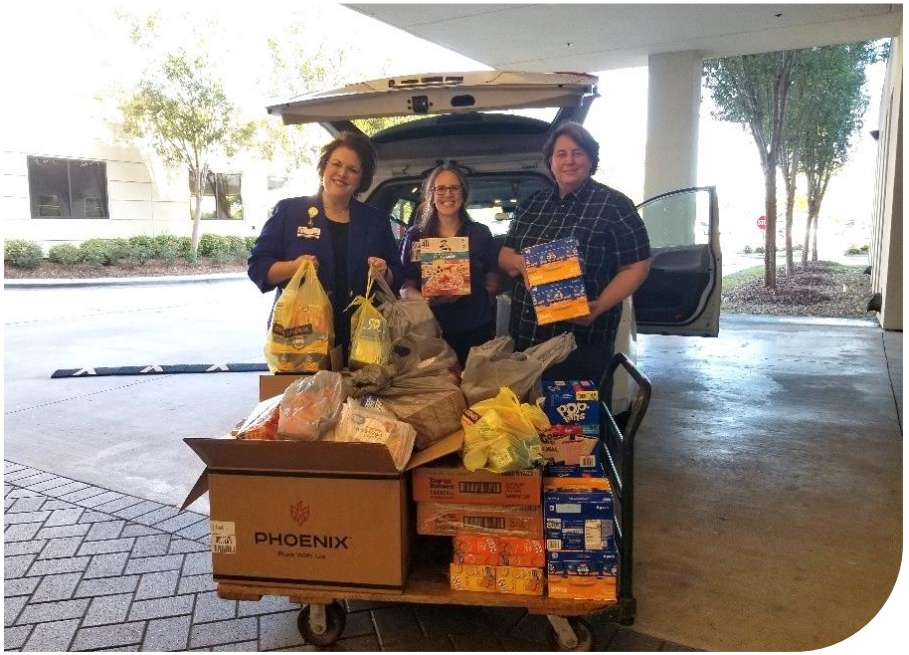
Community services $2 million		Charity care $1.4 million		Total community benefits $3.4 million
$755 thousand Community health improvements and strategic partnerships	**$131 thousand** Health professionals' education and research	**$104** Subsidized health services	**$1 million** Cash and in-kind distributions	**$17 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 Shreveport-Bossier 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 Renewal International	Build resilient communities and improve social determinants	Education	Community Renewal Highland Friendship House	To build positive relationships and networks in the community through the Highland Friendship House
Council on Alcoholism and Drug Abuse (CADA)	Advance health and well-being	Mental health and well-being	CADA Peer Recovery Support Specialist Program	To change the protocol of taking non-violent crises cases to local emergency rooms and educate law enforcement on the addiction problems in the community
Food Bank of Northwest Louisiana	Build resilient communities and improve social determinants	Healthy food access	Rural Mobile Food Pantry	To expand the food distribution sites to rural towns and areas in Northwest Louisiana that currently are not served by food pantries
Shreveport Green	Build resilient communities and improve social determinants	Healthy food access	Mobile Market Direct Impact Project	To provide bi-monthly deliveries of fresh produce to homebound individuals
St. Luke's Mobile Medical Ministry, Inc	Advance health and well-being	Chronic diseases	Street Outreach Providing Healthcare to the Underserved	To provide free basic health care to medically underserved individuals who are homeless and/or low-income
Total CHRISTUS Community Impact Fund investment:				**$300,000.00**

FY24 Community Impact Fund

ORGANIZATION	DOMAIN	PRIORITY	PROGRAM NAME	PROGRAM DESCRIPTION
Community Renewal International	Build resilient communities and improve social determinants	Education	Community Renewal Highland Friendship House	To build and grow positive caring relationships between and amongst the Highland neighborhood residents through the Friendship House strategy
Council on Alcoholism and Drug Abuse (CADA)	Advance health and well-being	Mental health and well-being	CADA Crisis Response Program	To provide assistance to police and other first responders to help individuals experiencing a mental health crisis
Food Bank of Northwest Louisiana	Build resilient communities and improve social determinants	Healthy food access	Rural Mobile Food Pantry	To increase food access to low-income, rural areas through mobile food pantry deliveries
Shreveport Green	Build resilient communities and improve social determinants	Healthy food access	Mobile Market Produce Capacity Project	To provide fresh, locally sourced produce along with educational initiatives to individuals experiencing cardiovascular disease
St. Luke's Mobile Medical Ministry, Inc	Advance health and well-being	Chronic diseases	Street Outreach Providing Healthcare to the Underserved	To provide free health services to the underserved residents of northwest Louisiana with a focus on individuals who are homeless and/or low-income
Total CHRISTUS Community Impact Fund investment:				**$295,000.00**

FY25 Community Impact Fund

ORGANIZATION	DOMAIN	PRIORITY	PROGRAM NAME	PROGRAM DESCRIPTION
Community Renewal International	Build resilient communities and improve social determinants	Education	Community Renewal Highland Friendship House	To build and grow positive caring relationships between and amongst the Highland neighborhood residents through the Friendship House strategy
Council on Alcoholism and Drug Abuse (CADA)	Advance health and well-being	Mental health and well-being	CADA Mobile Response Team	To respond to crisis calls by deploying the CADA Mobile Response Team to the location, deescalating the crisis, determining appropriate services and doing follow-up
Food Bank of Northwest Louisiana	Build resilient communities and improve social determinants	Healthy food access	Rural Mobile Food Pantry	To increase food access to low-income, rural areas through mobile food pantry deliveries
LSU Ag Center	Build resilient communities and improve social determinants	Healthy food access	Health Beyond Boundaries: A Tri-Parish Wellness Alliance	To empower individuals to grow their own food, increase their food and vegetable consumption and promote sustainable food practices
Shreveport Green	Build resilient communities and improve social determinants	Healthy food access	Mobile Market: Food for All Project	To host farm-to-table markets, support local farmers and provide nutritional education to empower residents to make healthier lifestyle choices
St. Luke's Mobile Medical Ministry, Inc	Advance health and well-being	Chronic diseases	Street Outreach Providing Healthcare to NWLA	To improve the health of underserved individuals through preventative health screenings, basic health services, patient education and onward referrals
Total CHRISTUS Community Impact Fund investment:				**$305,000.00**

Chapter 3: Priorities

Priorities and Focus

The Lifespan Approach

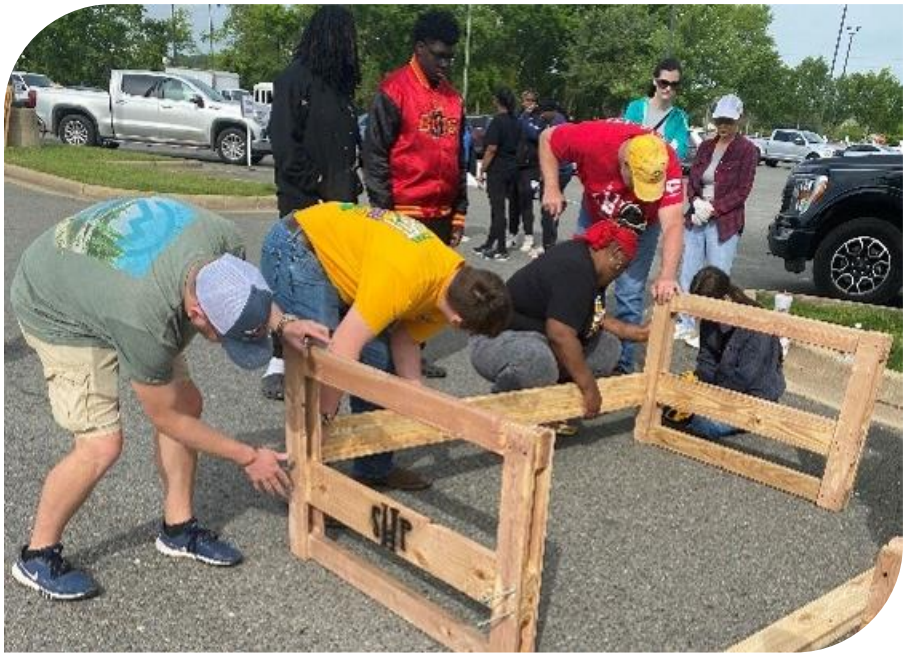
To better understand and respond to the evolving needs of the communities we serve, we structured our Community Health Needs Assessment (CHNA) and Community Health Implementation Plan (CHIP) using a *lifespan approach*. This framework organizes data, priorities and strategies by key stages of life, recognizing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

CHRISTUS Shreveport-Bossier identifies 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 Shreveport-Bossier 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 CHRISTUS Shreveport-Bossier'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 Shreveport-Bossier Community Health Needs Assessment, available at: CHRISTUShealth.org/connect/community/community-needs

LEADING INDICATORS			
Maternal Health and Early Childhood Health	**School-Age Children and Adolescent Health**	**Adult Health**	**Older Adult Health**
Mothers and babies will have access to the care and support needed for healthy pregnancies, childbirth, growth and development.	*Children will be well-equipped with the care and support to grow up physically and mentally healthy.*	*Adults will have access to the care, support and opportunities needed to maintain physical and mental health throughout their lives.*	*Older adults will have accessible and empowering environments to ensure that every person can age with health and socioeconomic well-being.*
• Early childhood education • Health care literacy • Affordable insurance • Affordable health care • Affordable housing	• Poverty • Unhealthy diet (food desert, accessibility) • Literacy • Mental health • Access to primary care	• Chronic diseases (diabetes, obesity, cardiovascular) • Affordable housing • Mental health • Crime • Food insecurity	• Isolation/loneliness • Alzheimer's • Health literacy • Access to nutritious food

Needs That Are Not Being Addressed

The CHRISTUS Shreveport-Bossier 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 needs fall within the direct scope of services or resources that we can lead or sustain independently. Some community issues require specialized focus, infrastructure or mission alignment of other organizations, agencies or collaborative groups better positioned to lead efforts in those areas.

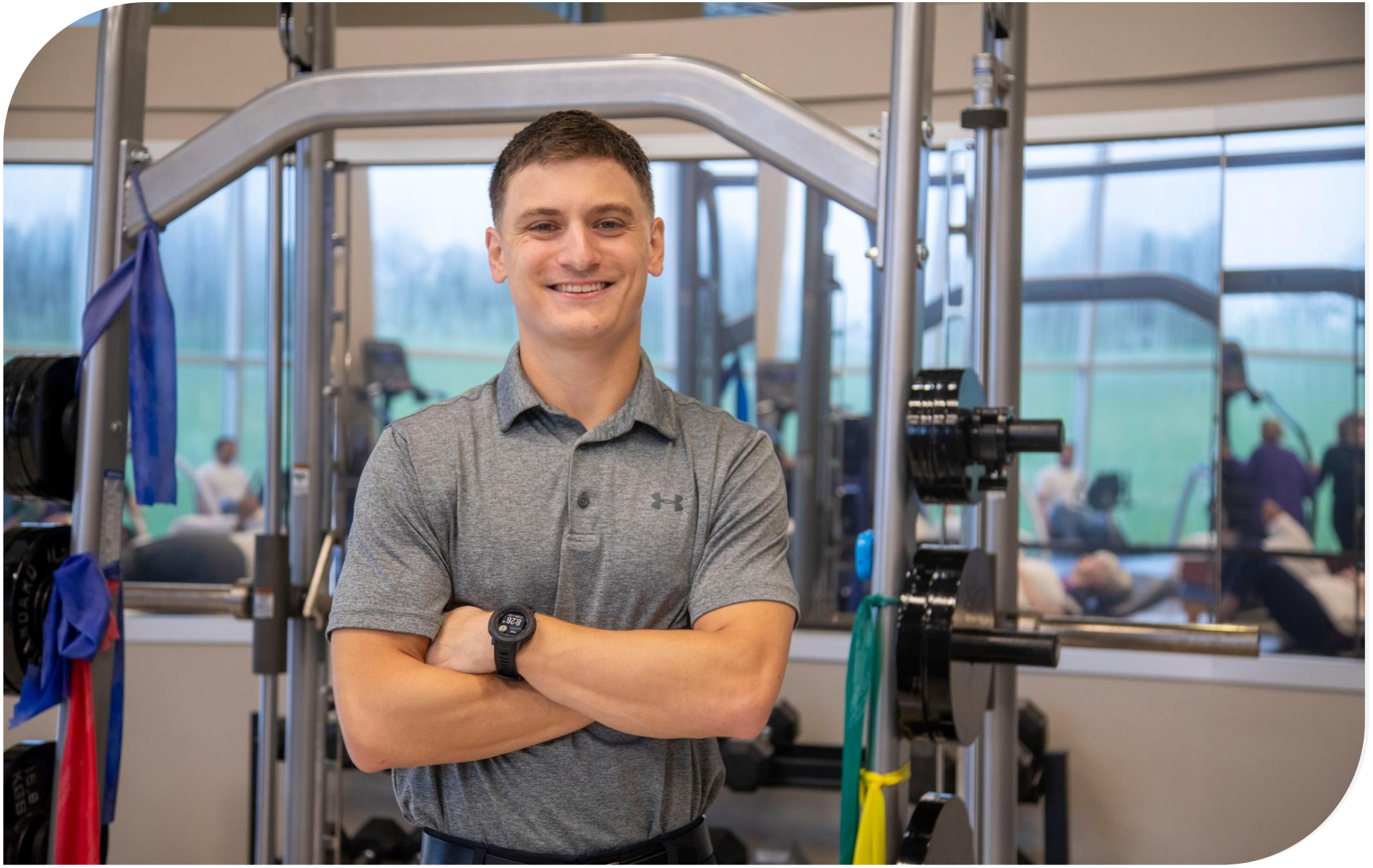
Examples of these needs may include, but are not limited to:

- Housing and homelessness
- Transportation barriers
- Early childhood education
- Poverty and crime
- Family support for individuals with disabilities or special needs

Although CHRISTUS Shreveport-Bossier Health System 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 we are 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 Shreveport-Bossier Health System will use to address priority health indicators, categorized into three distinct strategy types:

- **Hospital Direct Care Strategies ("We lead")**
  Initiatives led directly by CHRISTUS Shreveport-Bossier, typically aligned with hospital and clinical operations. Examples include implementing cardiovascular clinic programs and expanding sports medicine offerings.
- **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 community health collaboratives 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.

These investments CHRISTUS Shreveport Bossier commits to supports treatment services, safety net programs, efforts to address social determinants of health, and direct community benefits such as free flu vaccinations and health screenings. 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 renamed and reformatted the *Community Leading Indicators*. 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**
Mothers and babies will have access to the care and support needed for healthy pregnancies, childbirth, growth and development.	*Children will be well-equipped with the care and support to grow up physically and mentally healthy.*	*Adults will have access to the care, support and opportunities needed to maintain physical and mental health throughout their lives.*	*Older adults will have accessible and empowering environments to ensure that every person can age with health and socioeconomic well-being.*
A. Primary care 1. Access to affordable care 2. Affordable health insurance B. Specialty care 1. Access to affordable care 2. OB-GYN C. Education/Workforce Development 1. Early childhood 2. Health care literacy 3. Affordable housing	A. Primary care B. Behavioral/Mental health C. Education/Workforce Development 1. Literacy 2. Poverty D. Food insecurity 1. Unhealthy diet 2. Food desert	A. Primary care B. Specialty care 1. Diabetes 2. Obesity 3. Cardiovascular 4. Cancer C. Behavioral/mental health D. Education/Workforce Development E. Food insecurity F. Affordable housing G. Crime	A. Primary care B. Specialty care C. Behavioral/mental health 1. Isolation/loneliness 2. Alzheimer's D. Education/Workforce Development 1. Health literacy E. Food insecurity

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. Primary care
   1. Access to affordable care
   2. Affordable health insurance

B. Specialty care
   1. Access to affordable care
   2. OB-GYN

C. Education/Workforce Development
   1. Early childhood
   2. Health care literacy

D. Affordable housing

DATA MEASURES

- Preschool enrollment
- Health care literacy survey
- Poor literacy and functionally illiterate
- Uninsured rate
- Households below ALICE threshold
- Housing cost burden
- Severe housing cost burden

MATERNAL AND EARLY CHILDHOOD HEALTH STRATEGIES		
Hospital direct care strategies	**Community funding strategies**	**Community partner strategies**
"We lead"	**"We fund"**	**"They lead"**
A1a. Encourage patients to establish a primary care medical home. A1b. Offer transportation assistance for those in financial need. A1c. Review options for providing access to lab services for vulnerable populations. A1d. Collaborate with CHRISTUS Trinity Clinic (CTC) to increase primary and specialty care access through provider recruitment and expansion. A1e. Explore alignment with CHRISTUS Health system initiatives to improve maternal health. B2a. Collaborate with CHRISTUS Trinity Clinic (CTC) to increase primary and specialty care access through provider recruitment and expansion. B2b. Explore alignment with CHRISTUS Health system initiatives to improve maternal health. B2c. Explore options to increase OB clinic services for vulnerable women. B2d. Provide lactation services for underprivileged mothers. C2b. Explore alignment with CHRISTUS Health system initiatives to improve maternal health.	A0a. Explore funding crucial health services for infants and their caregivers. B0a. Explore funding crucial health services for infants and their caregivers. C0a. Explore funding opportunities for scholarships to increase access to education and vocational training.	A1a. Explore relationships with Federally Qualified Healthcare Centers (FQHCs) to expand PCP access. A2a. Advocate locally for affordable insurance. B0a. Evaluate opportunities to offer community-based screening assessments and education on prevention and health maintenance. C0a. Offer clinical education opportunities for health care students, including nurses and allied health. C0b. Provide shadowing opportunities for individuals considering a health care profession. C0c. Explore opportunities for underrepresented groups to consider a health care vocation. C2a. Collaborate with other non-profits to determine what education programs mothers and young families need. C2b. Evaluate opportunities to offer community-based screening assessments and education on prevention and health maintenance.

School-Age Children and Adolescent Health

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

LEAD INDICATORS	DATA MEASURES
A. Primary care B. Behavioral/mental health C. Education/workforce development 1. Literacy 2. Poverty D. Food insecurity 1. Unhealthy diet 2. Food desert	• Poverty rate • Households below ALICE threshold • Food insecurity • Other • Child psychologists per capita • Other • Poor literacy and functionally illiterate • Pediatricians per capita

SCHOOL-AGE CHILDREN AND ADOLESCENT HEALTH STRATEGIES		
Hospital direct care strategies	**Community funding strategies**	**Community partner strategies**
"We lead"	**"We fund"**	**"They lead"**
A0a. Encourage patients to establish a primary care medical home. A0b. Review options for providing access to lab services for vulnerable populations. A0c. Provide free/subsidized orthopedic and sports medicine services to schools serving vulnerable students, including on-site services, rehab, education screening and follow-up care. A0d. Collaborate with CHRISTUS Trinity Clinic (CTC) to increase primary and specialty care access through provider recruitment and expansion. B0a. Evaluate proposals to provide support services for patients and families within the hospital or in the community who need behavioral health assistance. B0b. Collaborate with CHRISTUS Trinity Clinic (CTC) to increase primary and specialty care access through provider recruitment and expansion.	B0a. Explore funding opportunities to expand behavioral health services for adolescents, for example, with Community Renewal International. B0b. Fund afterschool programs providing safe space for academic, emotional and vocational support, for example, through Community Renewal's Friendship Houses. C0a. Explore funding opportunities for scholarships to increase access to education and vocational training. C0b. Fund afterschool programs providing safe space for academic, emotional and vocational support, for example, through Community Renewal's Friendship Houses. D0a. Explore funding partnerships to increase access to healthy foods by teaching nutrition, providing/growing healthier food and cooking with cultural appreciation, for example, with Shreveport Green and Northwest Louisiana Foodbank.	A0a. Explore relationships with Federally Qualified Healthcare Centers (FQHCs) to expand PCP access. A0b.Offer CPR classes for adolescents. A0c. Evaluate opportunities to offer community-based screening assessments and education on prevention and health maintenance. B0a. Participate in domestic abuse prevention programs, for example, with Gingerbread House Children's Advocacy Center (CAC). B0b. Advocate locally for behavioral health access. B0c. Evaluate opportunities to offer community-based screening assessments and education on prevention and health maintenance. C0a.Offer clinical education opportunities for health care students including nurses and allied health. C0b. Provide shadowing opportunities for individuals considering a health care profession. C0c. Explore opportunities for underrepresented groups to consider a health care vocation. D0a. Explore partnerships to increase access to healthy foods by teaching nutrition, providing/growing healthier food and cooking with cultural appreciation, for example, with Shreveport Green and LSU Ag Center.

		D1a. Evaluate opportunities to offer community-based screening assessments and education on prevention and health maintenance.

Adult Health

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

LEAD INDICATORS

A. Primary care
B. Specialty care
    1. Diabetes
    2. Obesity
    3. Cardiovascular
    4. Cancer
C. Behavioral/mental health
D. Education/Workforce Development
E. Food insecurity
F. Affordable housing
G. Crime

DATA MEASURES

- Coronary heart disease
- Heart disease mortality
- Diagnosed diabetes
- Diabetes mortality
- Obesity
- Housing cost burden
- Poor self-reported mental health
- Suicide mortality
- Violent crime
- Property crime
- Aggravated assault/battery
- Firearm-related mortality
- Mental health providers per capita

ADULT HEALTH STRATEGIES		
Hospital direct care strategies	**Community funding strategies**	**Community partner strategies**
"We lead"	**"We fund"**	**"They lead"**
A0a. Encourage patients to establish a primary care medical home. A0b. Offer transportation assistance for those in financial need. A0c. Review options for providing access to lab services for vulnerable populations. A0d. Offer patient navigation for post-hospital discharge through a community health worker. A0e. Collaborate with CHRISTUS Trinity Clinic (CTC) to increase primary and specialty care access through provider recruitment and expansion. B0a. Offer emotional and spiritual support to patients experiencing chronic disease, including support groups and pastoral care. B0b. Collaborate with CHRISTUS Trinity Clinic (CTC) to increase primary and specialty care access through provider recruitment and expansion. C0a. Evaluate proposals to provide support services for patients and families within the hospital or in the community who need behavioral health assistance. C0b. Offer emotional and spiritual support to patients experiencing chronic disease, including support groups and pastoral care E0a. Improve screening and referral for social determinants of health (SDoH), particularly food insecurity.	C0a. Explore funding opportunities to expand behavioral health services for adults, for example, with the Council on Alcoholism & Drug Abuse of Northwest Louisiana (CADA). E0a. Explore funding partnerships to increase access to healthy foods by teaching nutrition, providing/growing healthier food and cooking with cultural appreciation, for example, with Shreveport Green and Northwest Louisiana Foodbank. G0a. Explore continued funding for crime prevention initiatives, for example, with Caddo Parish Sheriff Office and Community Renewal International.	A0a. Explore relationships with Federally Qualified Healthcare Centers (FQHCs) to expand PCP access. A0b. Offer CPR classes for adults. B0a. Evaluate opportunities to offer community-based screening assessments and education on prevention and health maintenance. B0a. Explore collaboration with non-profits focused on addressing chronic disease. C0a. Advocate locally for behavioral health access. D0a.Offer clinical education opportunities for health care students including nurses and allied health. D0b. Provide shadowing opportunities for individuals considering a health care profession. D0c. Explore opportunities for underrepresented groups to consider a health care vocation. G0a. Explore partnerships to increase access to healthy foods by teaching nutrition, providing/growing healthier food and cooking with cultural appreciation, for example, with Shreveport Green and LSU Ag Center.

Older Adult Health

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

LEAD INDICATORS

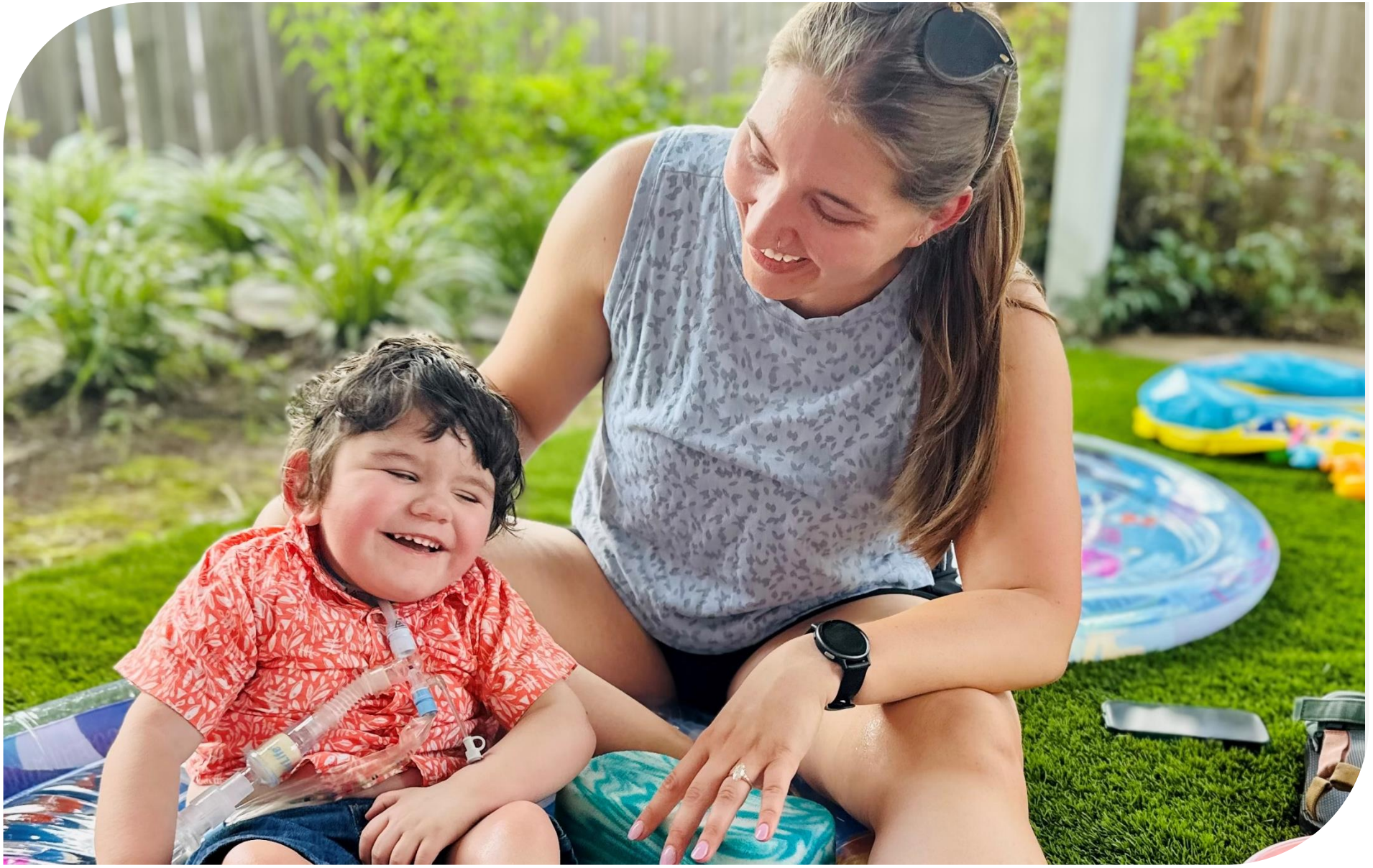
A. Primary care
B. Specialty care
C. Behavioral/mental health
    1. Isolation/loneliness
    2. Alzheimer's
D. Education/Workforce Development
    1. Health literacy
E. Food insecurity

DATA MEASURES

- Seniors living alone
- Alzheimer's disease mortality
- Limited English proficiency
- Poor literacy and functionally illiterate
- Food insecurity
- Independent living difficulty

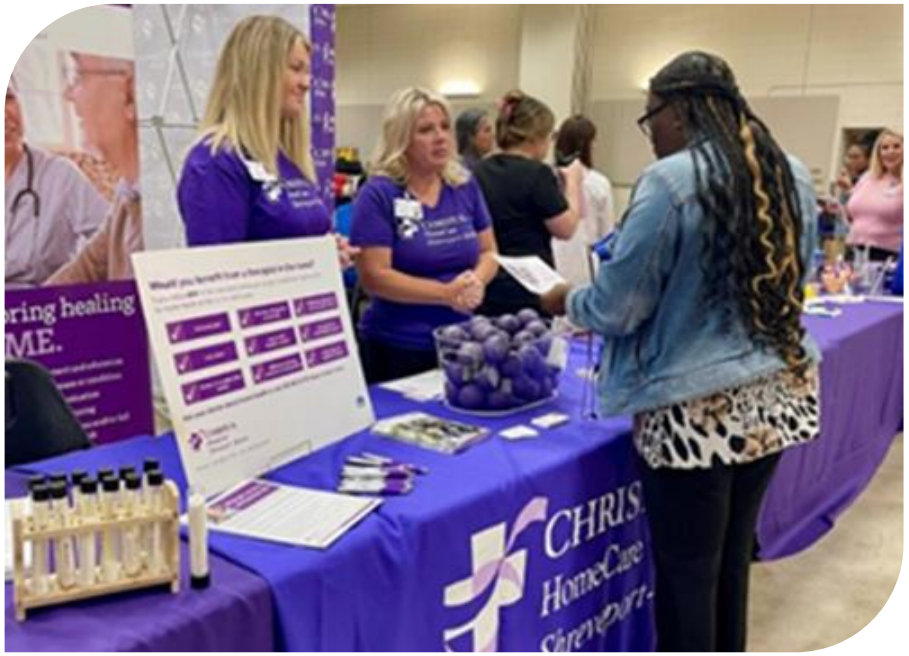
OLDER ADULT HEALTH STRATEGIES		
Hospital direct care strategies	**Community funding strategies**	**Community partner strategies**
"We lead"	**"We fund"**	**"They lead"**
A0a. Encourage patients to establish a primary care medical home. A0b. Offer transportation assistance for those in financial need. A0c. Review options for providing access to lab services for vulnerable populations. A0d. Offer patient navigation for post-hospital discharge through a community health worker. A0e. Collaborate with CHRISTUS Trinity Clinic (CTC) to increase primary and specialty care access through provider recruitment and expansion. B0a. Offer emotional and spiritual support to patients experiencing chronic disease, including support groups and pastoral care. B0b. Collaborate with CHRISTUS Trinity Clinic (CTC) to increase primary and specialty care access through provider recruitment and expansion. C0a. Evaluate proposals to provide support services for patients and families within the hospital or in community who need behavioral health assistance. C0b. Offer emotional and spiritual support to patients experiencing chronic disease, including support groups and pastoral care E0a. Improve screening and referral for social determinants of health (SDoH), particularly food insecurity.	C0a. Explore funding opportunities to expand behavioral health services for adults, for example, with the Council on Alcoholism & Drug Abuse of Northwest Louisiana (CADA). D0a. Explore funding partnerships to increase access to healthy foods by teaching nutrition, providing/growing healthier food and cooking with cultural appreciation, for example, with Shreveport Green and Northwest Louisiana Foodbank.	A0a. Explore relationships with Federally Qualified Healthcare Centers (FQHCs) to expand PCP access. A0b. Offer CPR classes for older adults. B0a. Evaluate opportunities to offer community-based screening assessments and education on prevention and health maintenance. C0a. Advocate locally for behavioral health access. D0a.Offer clinical education opportunities for health care students including nurses and allied health. D0b. Provide shadowing opportunities for individuals considering a health care profession. D0c. Explore opportunities for underrepresented groups to consider a health care vocation. E0a. Explore partnerships to increase access to healthy foods by teaching nutrition, providing/growing healthier food and cooking with cultural appreciation, for example, with Shreveport Green and LSU Ag Center.

Chapter 5: Conclusion



Conclusion

The CHRISTUS Shreveport-Bossier 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 our 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 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.
- All adults are physically, mentally and emotionally 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

To request a print copy of this report, or to submit your comment, please contact:

Jamey Brogan, Interim VP of Mission Integration

Jamey.Brogan@christushealth.org

Aliyah Hollins, Community Health Lead for the Ministry

aliyah.hollins@christushealth.org

CHRISTUS Health's Community Health Team

communityhealth@christushealth.org

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

CHRISTUS Health's website
CHRISTUShealth.org/connect/community/community-needs

CHRISTUS SHREVEPORT-BOSSIER Health System