Community Health Implementation Plan

Strategies for responding to the prioritized needs in the community

2026 – 2028

CHRISTUS SPOHN Health System

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Chapter 1: Introduction

Introduction

At CHRISTUS Spohn, our mission calls us to extend the healing ministry of Jesus Christ, especially to those who are most vulnerable. We know that health does not begin in a hospital. It begins in homes, neighborhoods and communities shaped by opportunity, support and care. That is why we work not only within our clinical walls, but also alongside community partners to address the root causes of poor health across the Coastal Bend.

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

Our Vision

At CHRISTUS Spohn, we envision a community where:

- Mothers and babies have access to the care and support needed for healthy pregnancies, childbirth and early development.
- Children are equipped with the care and resources to grow up physically and mentally healthy.
- Adults have access to the services, support and opportunities needed to maintain physical and mental health throughout life.
- Older adults live in environments that promote health, dignity and socioeconomic well-being as they age.
- Community members receive compassionate, high-quality care that honors their dignity, life experiences and unique needs.

What This Plan Includes

The 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 Spohn, 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

CHRISTUS Spohn Health System serves as a vital anchor for care across our primary service area, which includes Nueces, Aransas, Bee, Brooks, Jim Wells, Kleberg and San Patricio counties. This defined area represents the counties where our hospitals are located and where the majority of our patients live and seek care.

While the primary service area guides our formal planning and reporting, our commitment extends to the entire Coastal Bend. Through regional outreach, mobile services and mission-driven partnerships, CHRISTUS Spohn remains present in and accountable to communities beyond these core counties, especially those that are rural or medically underserved.

Our primary service area encompasses a diverse mix of coastal neighborhoods, agricultural towns and rapidly growing cities. These are the communities that shaped our most recent Community Health Needs Assessment (CHNA), and their lived experiences informed every strategy in this plan.

As we enter the 2026–2028 implementation cycle, we remain focused on expanding access to high-quality, culturally responsive care throughout the region. Through clinical outreach, local partnerships and targeted community investments, we aim to ensure that every person — regardless of zip code — has the opportunity to live a healthier life, close to home.

Systems of Care Principle

CHRISTUS Spohn is part of a broader system of care that extends beyond the walls of any single organization. Across the Coastal Bend, 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.

CHRISTUS Spohn embraces 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 Spohn 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 Coastal Bend.

The CHRISTUS Spohn 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, CHRISTUS Spohn remains 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

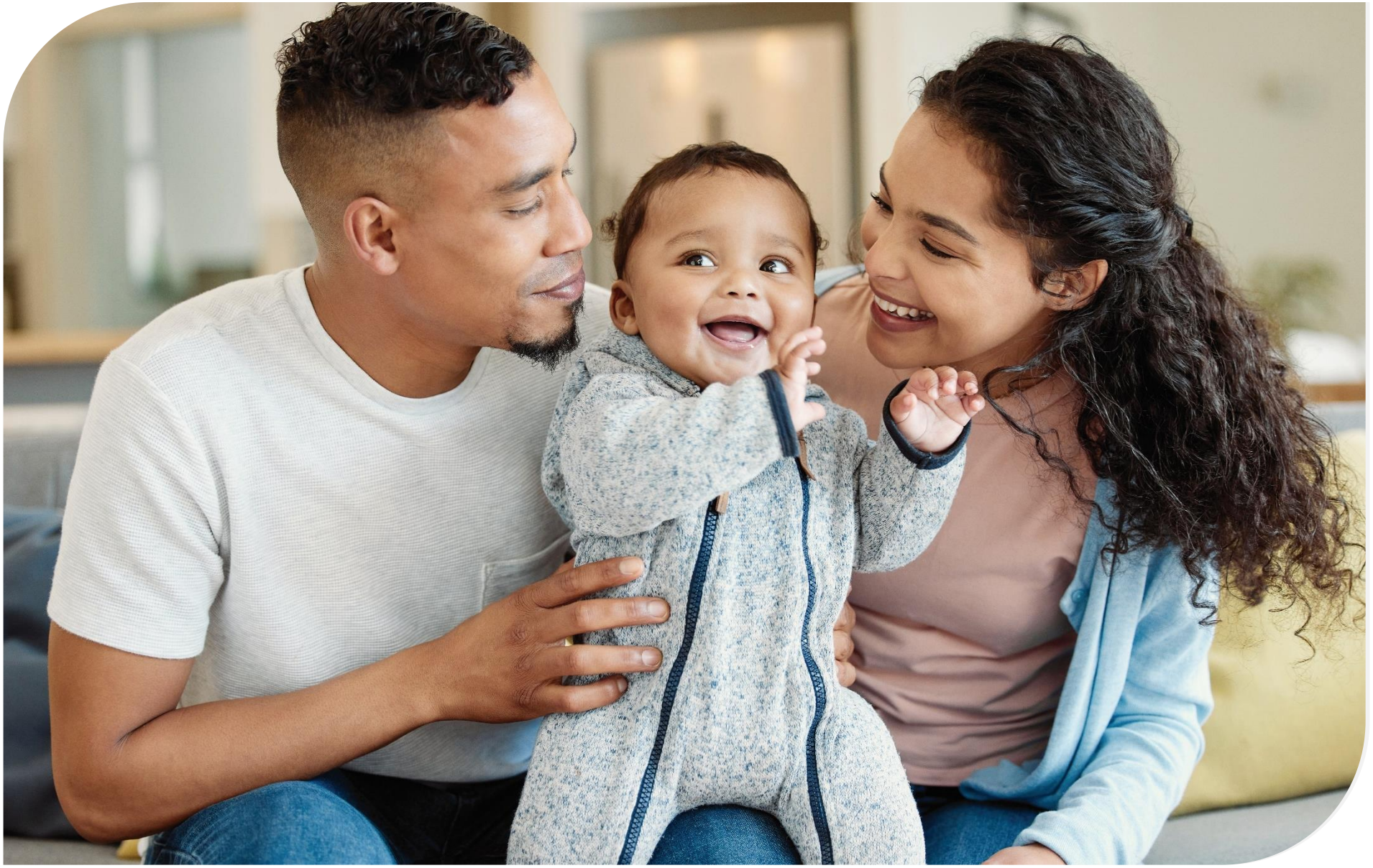
This plan is more than a list of programs; it is a shared commitment to healing, dignity and justice. Together with our partners, we will continue to build a region where every person, regardless of background, circumstance or zip code, has the opportunity to live a healthier, more dignified life.

Board Approval

The final Community Health Needs Assessment (CHNA) report was completed, and the Ministry CEO/President and Executive Leadership Team of CHRISTUS Spohn Health System reviewed and approved the CHNA prior to June 30, 2025, with Board of Directors' ratification on August 1, 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 August 1, 2025.

CHRISTUS Spohn 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 2023–2025 Community Health Needs Assessment (CHNA) and its corresponding Community Health Implementation Plan (CHIP). It highlights how CHRISTUS Spohn has translated strategy into meaningful action and how our collective efforts have improved lives across the Coastal Bend.

Guided by the priorities identified in the last CHNA, CHRISTUS Spohn has made strategic and mission-driven investments to improve health outcomes and promote equity, especially for those facing the greatest barriers to care. These efforts include targeted community benefit contributions in 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 limited access to behavioral health care.

This chapter also provides a closer look at the CHRISTUS Community Impact Fund, which allows us to support trusted nonprofit partners who are creating change at the local level. Summaries of our FY23 through FY25 investments illustrate how these organizations have delivered high-impact, culturally responsive programs that align with our mission, values and system goals.

As we prepare to launch the 2026–2028 CHIP, this chapter provides an opportunity to reflect on the progress we have made alongside our Coastal Bend community. It serves as a foundation for building upon, celebrating the lives we have touched, the partnerships we have formed and strengthened and the lessons we have learned that will inform our next chapter in community health.

Community Benefit Investment

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.

Each year, CHRISTUS Spohn Health System dedicates financial, physical, human, intellectual and informational resources to address the most pressing health and social needs identified in our Community Health Needs Assessment.

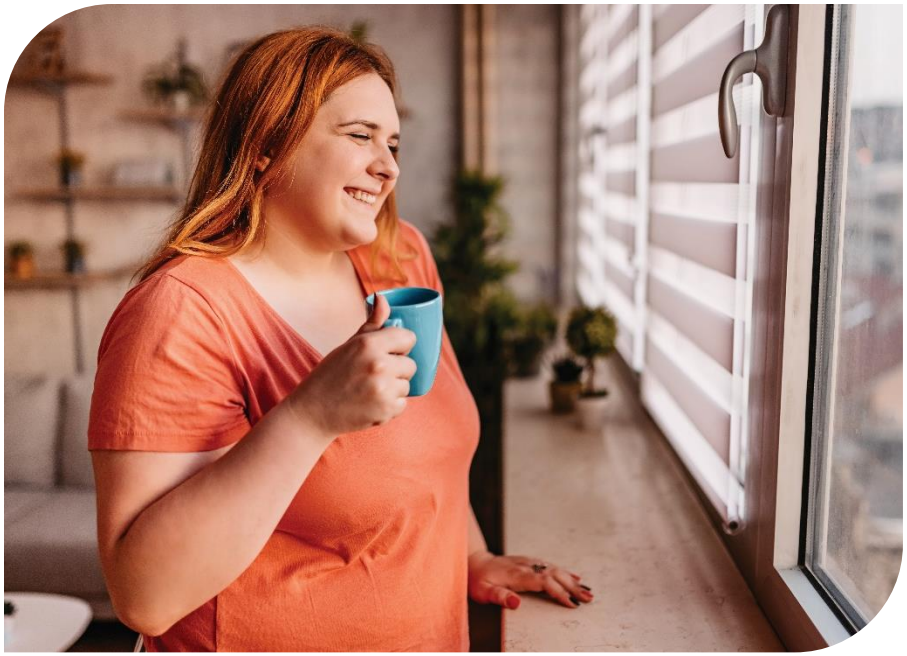
Guided by Catholic social teaching, these community benefit activities aim to create healthier and more resilient communities by addressing both clinical and broader social needs at the same time bridging gaps that affect long-term well-being.

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, CHRISTUS Spohn supports programs that focus on upstream drivers of health, such as food insecurity, housing instability and access to behavioral health services, through outreach, education and partnerships with local organizations.

At CHRISTUS Spohn, 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 $5.1 million	Charity care $115 million	Total community benefits $120.1 million
$2.2 million Community health improvements and strategic partnerships	**$2.9 million** Subsidized health services	**$41 thousand** Community building activities

FY24 Community Benefit Landscape

Community services $4.5 million	Charity care $114 million	Total community benefits 118.5 million	
$1.8 million Community health improvements and strategic partnerships	**$711 thousand** Health professionals' education and research	**$2 million** Subsidized health services	**$50 thousand** Community building activities

FY25 Community Benefit Landscape

At this time, 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 serves as the grantmaking arm of CHRISTUS Health. It was created to support nonprofit-led initiatives that improve the health and well-being of individuals and families across the communities we serve. Since its inception, the fund has become a catalyst for equity-focused, community-rooted innovation, amplifying the voices of those closest to the challenges and supporting those best positioned to create lasting 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 Spohn Health System awarded Community Impact Fund grants to trusted, mission-aligned partners across the region. These organizations embody our shared vision of healing and equity, delivering culturally responsive programs, building trust within communities and improving health outcomes where the need is greatest.

The following pages highlight the diverse partners and programs supported over the past three years, reflecting CHRISTUS Spohn's deep and ongoing commitment to collaborative, community-led solutions that extend our healing ministry beyond hospital walls.

FY23 Community Impact Fund

ORGANIZATION	DOMAIN	PRIORITY	PROGRAM NAME	PROGRAM DESCRIPTION
Catholic Charities of Corpus Christi	Build resilient communities and improve social determinants	Education	H.E.A.R.T. Initiative (Health, Education, Advocacy, Restore & Transform)	To utilize evidence-based strategies, curriculum and local community connections to increase human, social and physical capital, promote long-term poverty reduction and increase the financial health and well-being of the community
Coastal Bend Center for Independent Living	Advance health and well-being	Chronic diseases	Mobility Options Project (MOP)	To provide transportation services through the Mobility Options Program for low-income individuals with disabilities of all ages
Corpus Christi Metro Ministries	Build resilient communities and improve social determinants	Safe housing	Rustic House & Rainbow House	To provide a safe place for homeless people to live while they search for jobs, save and transition into stable housing.
Total CHRISTUS Community Impact Fund Investment:				**$275,000.00**

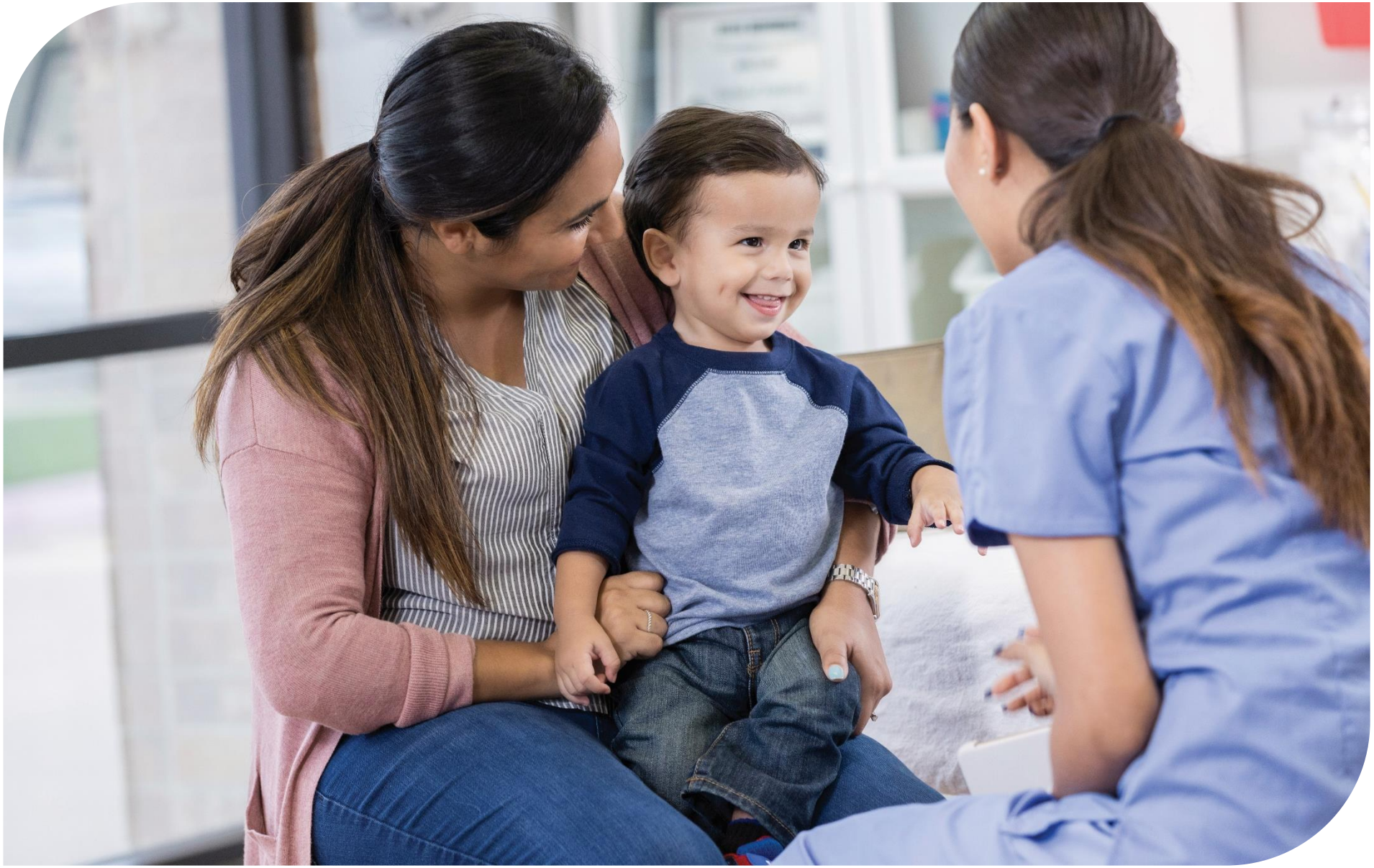
FY24 Community Impact Fund

ORGANIZATION	DOMAIN	PRIORITY	PROGRAM NAME	PROGRAM DESCRIPTION
Coastal Bend Center for Independent Living	Advance health and well-being	Chronic diseases	Mobility Options Program (MOP)	To provide transportation services to health-related services and community activities for individuals with disabilities and older adults
Rural Economic Assistance League, Inc.	Advance health and well-being	Mental health and well-being	Consumer Navigation	To provide a space for adults living with severe mental illnesses to learn, volunteer and grow
Texas A&M-Corpus Christi Foundation	Advance health and well-being	Mental health and well-being	Building Resilient Adult Voices through Engagement in Simulation (BRAVES) Mental Health Initiative	To provide young adults with culturally and developmentally appropriate resources to help them identify and proactively address behavioral health issues
The Purple Door	Build resilient communities and improve social determinants	Safe housing	Shelter and Supportive Services Program	To expand culturally competent, specialized, supportive services to survivors of domestic and sexual violence and their families
Total CHRISTUS Community Impact Fund Investment:				**$295,000.00**

FY25 Community Impact Fund

ORGANIZATION	DOMAIN	PRIORITY	PROGRAM NAME	PROGRAM DESCRIPTION
Amistad Community Health Center	Advance health and well-being	Chronic diseases	Pathways to Healthcare	To provide patient navigator services, monthly health education workshops, expand preventative screenings and expand telehealth services to the community
Coastal Bend Center for Independent Living	Advance health and well-being	Chronic diseases	Mobility Options Program	To provide transportation to health-related activities to individuals with disabilities and older adults
Coastal Bend Wellness Foundation	Build resilient communities and improve social determinants	Safe housing	Red Cord Initiative	To provide trafficking survivors with safe, stable housing and case management services
Family Counseling Service	Advance health and well-being	Mental health and well-being	Equitable Access to Mental Health	To provide equitable access to mental health counseling for uninsured and underinsured individuals
The Purple Door	Build resilient communities and improve social determinants	Safe housing	Shelter and Supportive Services Program	To provide safe shelter and supportive services such as advocacy, counseling and legal advocacy to survivors of domestic and sexual violence
Total CHRISTUS Community Impact Fund Investment:				**$305,000.00**

Chapter 3: Priorities



Priorities & Focus

The Lifespan Approach

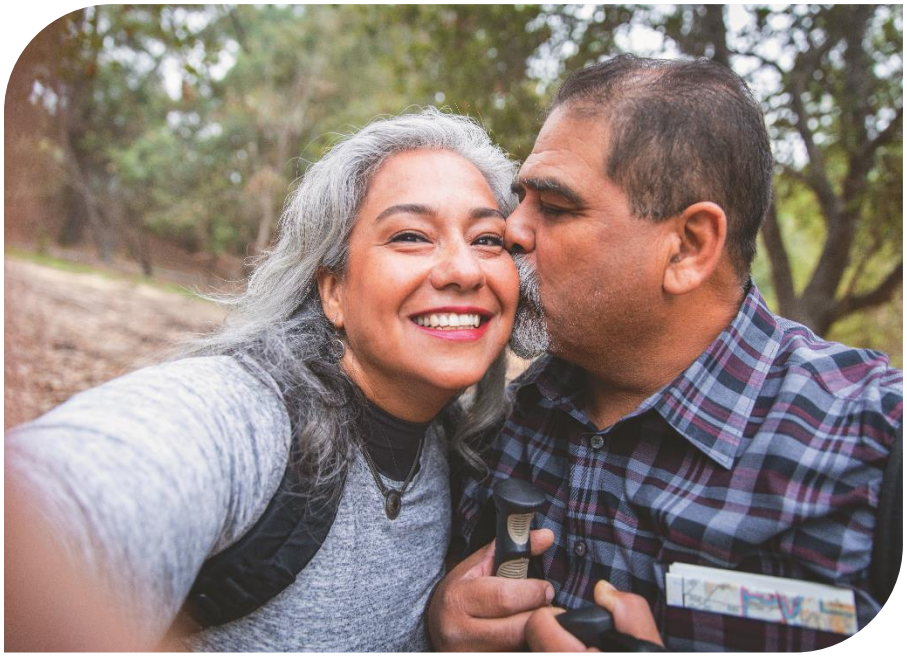
To understand and respond to the evolving needs of the communities we serve, CHRISTUS Spohn structured its Community Health Needs Assessment (CHNA) and Community Health Implementation Plan (CHIP) using a Lifespan Approach more effectively. This framework organizes data, priorities and strategies by key stages of life, recognizing that health needs and the factors that shape them change as individuals grow, age and move through different phases of life.

CHRISTUS Spohn identified three to five leading health indicators within each of the following four life stages:

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

Segmenting our work in this way ensures that interventions are age-appropriate, culturally responsive and aligned with the unique developmental, social and health needs of each phase of life. At the same time, we recognize that health is deeply interconnected — maternal health affects infant outcomes, early trauma can influence long-term well-being and investments in one life stage often ripple into the next.

By using a lifespan approach, CHRISTUS Spohn and its partners can deliver more precise, equitable and coordinated responses across the continuum of care, laying stronger foundations for health 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 Spohn 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 this indicator easy to explain and understand?
- Does this 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 CHRISTUS Spohn's 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 Spohn 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 Spohn 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.*

• Access to care
  ○ OBGYNs
• Healthy births
• Neonatal abstinence syndrome
• Chronic diseases
  ○ Heart disease
  ○ Diabetes
  ○ Obesity
• Poverty
	• Chronic diseases
	  ○ Obesity
	  ○ Diabetes
	  ○ Fatty liver
	• Behavioral health
	  ○ Suicide
	• Neurodevelopmental disorders (autism and ADHD)
	• Teen pregnancy
	• Food insecurity
	• Poverty
		• Access to care
		  ○ Provider shortage
		  ○ Insurance
		• Chronic diseases
		  ○ Heart disease
		  ○ Diabetes
		  ○ Obesity
		• Behavioral health
		  ○ Mental health
		  ○ Substance abuse
			• Chronic diseases
			  ○ Heart disease
			  ○ Diabetes
			  ○ Obesity
			• Behavioral health
			  ○ Mental health
			  ○ Substance abuse
			• Poverty
			• Housing insecurity

Needs That Are Not Being Addressed

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

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

- Youth suicide
- Teen pregnancy
- Youth chronic diseases
- Youth neurodevelopmental disorders
- Housing insecurity
- Food insecurity
- Poverty

Although CHRISTUS Spohn 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 highlights where CHRISTUS Spohn is playing a supportive or collaborative role in addressing these issues, including our coordination with trusted organizations and multi-sector partners. These collaborative efforts are essential in developing a more comprehensive, equitable and effective system of care across our region.

Chapter 4: Strategies

Strategies

The implementation strategies 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 that CHRISTUS Spohn will use to address priority health indicators, which are clearly categorized into three distinct strategy types: hospital direct care strategies, community funding strategies and community partner strategies.

As you review the leading health indicators across each life stage, identify existing or planned programs and strategies that address these specific community needs. These interventions will fall within one of three categories:

Hospital Direct Care Strategies ("We Lead"): Initiatives led directly by CHRISTUS Spohn Health System, typically aligned with hospital and clinical operations; examples include implementing cardiovascular clinic programs and expanding sports medicine offerings.

Community Funding Strategies ("We Fund"): Efforts supported financially by CHRISTUS through grants and community benefit funds; this includes grant-making programs, such as the CHRISTUS Fund, or local community benefit investments, designed to address community needs and fill gaps in care.

Community Partner Strategies ("They Lead"): Collaborative efforts where community organizations take the lead, with CHRISTUS playing a supportive role through active participation, advisory board membership or joint initiatives; examples include involvement in community health collaboratives, United Way boards and other strategic partnerships.

Through these coordinated strategies, CHRISTUS Spohn Health System commits to community benefit initiatives annually. These include supporting treatment services, safety net programs, addressing social determinants of health and offering direct community benefits such as free flu vaccinations and health screenings. Additionally, ongoing collaboration with community partners ensures aligned efforts to improve public policy, coordinate programs, expand outreach and develop new initiatives aimed at addressing the priority health needs of the Coastal Bend communities served.

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
• Access to care
  ○ OBGYNs
• Healthy births
• Neonatal abstinence syndrome
• Chronic diseases
  ○ Heart disease
  ○ Diabetes
  ○ Obesity
• Poverty
	DATA MEASURES
	• Prenatal care in first trimester
	• Low birth weight
	• Neonatal abstinence syndrome trends
	• Births with at least one maternal risk factor
	• Poverty rate
	• Low birth weight

MATERNAL AND EARLY CHILDHOOD HEALTH STRATEGIES		
Hospital Direct Care Strategies	**Community Funding Strategies**	**Community Partner Strategies**
"We Lead"	**"We Fund"**	**"They Lead"**
• **Expand Access to Women's Care** Add physicians and advanced practice clinicians to staff clinics and increase patient capacity in underserved and rural communities • **Mobilize the Care Van for Women's Health Needs** Deploy the Care Van to provide prenatal care, well-woman visits, screenings, and health education in areas with limited access to women's services • **Evaluate Standardization of Social Needs Screening for New Moms** Incorporate questions on food, housing, and safety during inpatient stay or pediatric follow-up visits • **Continue Prenatal Education, Birthing Classes, and Lactation Support at Spohn South** Offer in-person classes on pregnancy, childbirth, and breastfeeding to promote maternal and infant health for Spohn patients	• **Fund Parenting Education Programs** Support organizations that deliver evidence-based parenting programs like Triple P or Nurturing Parenting • **Support Home Visiting Programs** Fund Nurse-Family Partnership, Early Head Start, or CHW-led visits for at-risk families • **Fund Breastfeeding Peer Counselor Networks** Support culturally relevant, community-based breastfeeding support, especially for low-income and minority families	• **Continue NICU Partnership with Driscoll Children's Hospital** Maintain collaboration to ensure access to high-quality neonatal intensive care at Spohn South for preterm and medically fragile newborns, supporting positive outcomes for families across the region • **Support Faith-Based and Nonprofit Diaper and Infant Supply Drives** Engage parishes and mission partners in collecting and distributing essential infant items

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

• Chronic diseases
  ○ Obesity
  ○ Diabetes
  ○ Fatty liver
• Behavioral health
  ○ Suicide
• Neurodevelopmental disorders (Autism and ADHD)
• Teen pregnancy
• Food insecurity
• Poverty
	• Suicide mortality
	• Youth suicide
	• BMI Of high school students
	• Neurodevelopmental disorders: ADHD, Autism
	• Teen birth rate
	• Poverty rate
	• Poverty rate
	• Food insecurity

SCHOOL-AGE CHILDREN AND ADOLESCENT HEALTH STRATEGIES		
Hospital Direct Care Strategies	**Community Funding Strategies**	**Community Partner Strategies**
"We Lead"	**"We Fund"**	**"They Lead"**
• **Continue Providing Free Sports Physicals and Immunizations at School Events.** Reduce access barriers to basic preventive care	• **Fund School Pantry and Backpack Programs** Provide weekend and holiday food support to reduce child hunger • **Fund School-Based Counseling Services** Support embedded LCSWs or LPCs to meet student behavioral health needs • **Support Wraparound Services on School Campuses** Grant funding for hygiene closets, food pantries, and clothing banks • **Partner with Caregiver Support and Respite Programs** Fund services that provide tools and time for unpaid caregivers	• **Join Local School Health Advisory Councils** Participate in shaping school wellness policies and programs • **Deepen Collaboration with Driscoll Children's Hospital** Work to expand and enhance coordinated efforts in wellness, prevention, and outreach

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	DATA MEASURES

• Access to care
  ○ Provider shortage
  ○ Insurance
• Chronic diseases
  ○ Heart disease
  ○ Diabetes
  ○ Obesity
• Behavioral health
  ○ Mental health
  ○ Substance abuse
	• Obesity
	• Diabetes mortality
	• Heart disease mortality
	• Primary care providers (PCP) per capita
	• Depression
	• Suicide mortality
	• Drug overdose mortality
	• Uninsured rate

ADULT HEALTH STRATEGIES		
Hospital Direct Care Strategies	**Community Funding Strategies**	**Community Partner Strategies**
"We Lead"	**"We Fund"**	**"They Lead"**
• **Consider Embedding CHWs in Primary Care Clinics** Support patients in navigating insurance, transportation, housing, and social needs • **Offer Screening Events in High-Need Areas** Partner with churches, businesses, and community partners to provide screenings for men's health issues, blood pressure, cholesterol, and diabetes • **Initiate Trauma-Informed Care and Motivational Interviewing Training for Clinic Staff** Equip providers with skills to build trust, recognize trauma, and support patient-centered behavior change • **Evaluate Opportunities to Expand Access Points for Uninsured Adults** Explore the expansion of same-day clinic appointments and urgent care centers • **Study the Feasibility of Using the Care Van for Chronic Disease Follow-Ups** Deploy to rural areas for A1C and BP checks, medication reviews, and care coordination	• **Fund Local Food Banks, Housing, and Transportation Programs** Use community benefit grants to address key social drivers of health • **Support Community-Based Behavioral Health Initiatives** Fund nonprofit therapy services, peer groups, or mobile crisis response teams • **Fund Health Educators to Deliver Chronic Disease Workshops** Target ZIP codes with high burdens of obesity, diabetes, or heart disease\ • **Fund Health Literacy Workshops and Health Fairs** Support organizations that provide education on wellness, prevention, and system navigation • **Support Food-as-Medicine Programs** Fund diabetic-friendly, heart-healthy food box initiatives paired with nutrition education	• **Support Community Walking or Exercise Groups** Assist organizations offering accessible fitness and peer support programs • **Partner with Free & Charitable Clinics for Referral Pipelines** Strengthen handoffs and reduce fragmentation for uninsured and underinsured patients • **Support Faith-Based Health Ministries** Recognize churches that offer BP checks, health fairs, grief groups, or wellness classes

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	DATA MEASURES

• Chronic diseases
  ○ Heart disease
  ○ Diabetes
  ○ Obesity
• Behavioral health
  ○ Mental health
  ○ Substance abuse
• Poverty
• Housing insecurity
	• Diabetes mortality
	• Heart disease mortality
	• Alzheimer's Disease mortality
	• Drug overdose mortality
	• Opioid dispensing rate
	• Poverty rate
	• Housing cost burden

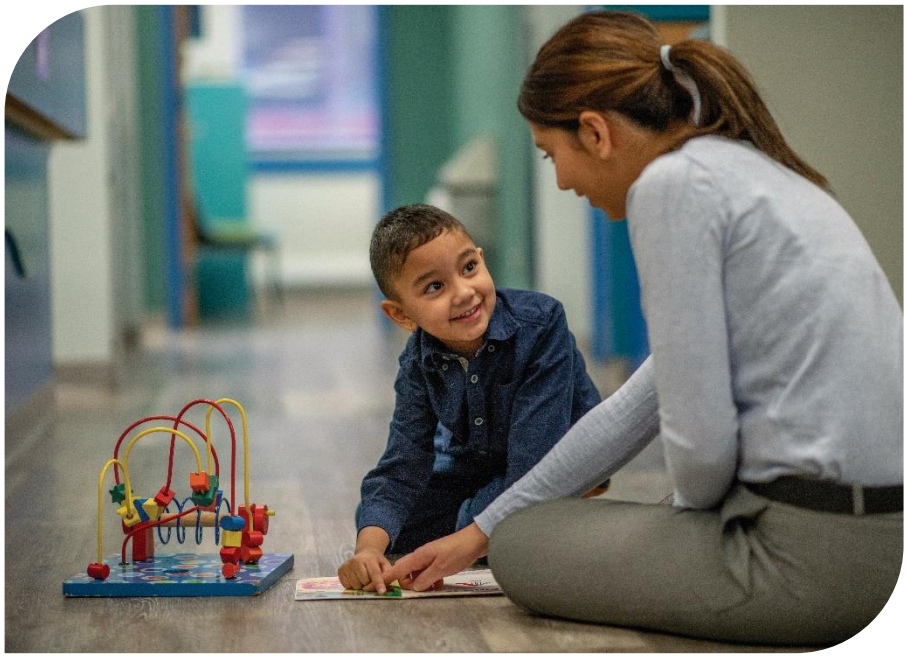
OLDER ADULT HEALTH STRATEGIES		
Hospital Direct Care Strategies	**Community Funding Strategies**	**Community Partner Strategies**
"We Lead"	**"We Fund"**	**"They Lead"**
• **Assess Need for Healthcare Navigation for Aging Adults** Assist with Medicare, SNAP, transportation, and healthcare navigation • **Evaluate Dementia-Friendly Clinic Practices** Assess training, signage, and environmental adaptations to support patients with cognitive decline • **Develop Elder Health Programs for Seniors** Create education on prevention of falls, elder abuse, cognitive impairment, and Senior wellness • **Expand Advance Care Planning** Education Broadly into the Community Provide ACP forms and education in collaboration with churches and other local organizations • **Promote Hospital Volunteerism as a Health Strategy** Connect older adults with meaningful service roles at Spohn and in the community	• **Fund Transportation and Ride Voucher Programs** Help older adults access care through partnerships with transit agencies and nonprofits • **Fund Caregiver Support and Respite Services** Provide relief and training to unpaid caregivers, supporting both caregiver and patient wellbeing • **Fund Local Food, Housing, and Transportation Programs** Support core social needs through community benefit funding	• **Partner with Area Agency on Aging** Coordinate on transportation, caregiver referrals, and long-term care support • **Support Faith-Based Senior Ministries** Collaborate with churches offering senior groups, luncheons, or support sessions • **Join Elder Abuse Prevention Task Forces** Work with APS, legal aid, and law enforcement to protect vulnerable adults

Chapter 5: Conclusion

Conclusion

The CHRISTUS Spohn 2026–2028 Community Health Implementation Plan (CHIP) will guide the system's strategies over the next three years, aligning the health priorities identified in the Community Health Needs Assessment (CHNA) with targeted efforts in direct care, community benefit funding and community-based partnerships.

Together with the triennial CHNA, the CHIP offers a structured opportunity for CHRISTUS Spohn and its partners to assess the region's most urgent health challenges and determine how we will respond collectively and with purpose.



Improving the health and well-being of an entire community is not the work of one organization alone. It requires deep collaboration, shared accountability and long-term investment in relationships and systems that extend beyond traditional health care. Through this plan, CHRISTUS Spohn reaffirms its commitment to working with residents, local leaders and mission-aligned partners to advance equity and create the conditions where all people can thrive.

This work is guided by a shared vision of a healthier Coastal Bend, 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.

As we move forward, this CHIP will serve as a roadmap and a promise. A roadmap for focused, measurable action. And a promise to listen, to adapt and to continue showing up in partnership with our community.

Contact Information

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

Deacon Peter McCourt
Vice President of Mission Integration
CHRISTUS Spohn Health System

Peter.McCourt@christushealth.org

Valerie Gutierrez
Director of Mission Integration
CHRISTUS Spohn Health System

Valerie.Gutierrez@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® SPOHN Health System