Community Health Implementation Plan

Strategies for responding to the prioritized needs in the community

2026 – 2028

CHRISTUS ST. FRANCES CABRINI Health System

In partnership with CHRISTUS Coushatta Health Care Center and Savoy Medical Center

Table of Contents

Chapter 1: Introduction

Introduction

At CHRISTUS St. Frances Cabrini Health System—including Savoy Medical Center—and CHRISTUS Coushatta Health Care Center, our mission calls us to extend the healing ministry of Jesus Christ, especially to those who are most vulnerable. We recognize that true health begins not in hospitals, but in homes, schools, workplaces, and neighborhoods shaped by opportunity, dignity, and compassion.

That is why we are committed to working beyond our clinical walls—partnering with local organizations, faith communities, and public agencies to address the root causes of poor health across Central Louisiana and the surrounding rural parishes. Together, we strive to build a more just and healthy community where every person has the chance to thrive.

This 2026–2028 Community Health Implementation Plan (CHIP) builds upon the findings of our most recent Community Health Needs Assessment (CHNA). It outlines how our Ministries will respond to the top health priorities identified by the people who live, work, and serve in our region. Guided by community voice and data, this plan reflects our shared commitment to improving health outcomes and advancing equity for all.

Our Vision

At CHRISTUS St. Frances Cabrini Health System and CHRISTUS Coushatta Health Care Center, 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 St. Frances Cabrini Health System and CHRISTUS Coushatta Health Care Center, 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 St. Frances Cabrini Health System and CHRISTUS Coushatta Health Care Center serve as vital anchors for health and healing across Central Louisiana and the surrounding rural parishes. Our primary service area includes Rapides, Evangeline, Allen, Vernon, and Red River parishes—regions where our hospitals are located and where the majority of our patients live, work, and seek care.

While this defined area guides our formal planning and reporting, our mission-driven commitment extends far beyond. Through regional outreach, mobile health services, and deep-rooted community partnerships, our Ministries remain present in and accountable to neighboring communities—especially those that are rural, medically underserved, or historically marginalized.

Our service area encompasses a rich mix of small towns, agricultural communities, and growing regional hubs. These are the places that shaped our most recent Community Health Needs Assessment (CHNA), and the voices of their residents 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 St. Frances Cabrini Health System and CHRISTUS Coushatta Health Care Center are part of a broader system of care that reaches far beyond the walls of any single institution. Across Central Louisiana and the surrounding rural parishes, a diverse network of health care providers, public agencies, schools, faith communities, nonprofits, and local leaders work together to promote health and well-being.

This system of care is grounded in the understanding that health is shaped by more than clinical services. It is influenced by stable housing, safe neighborhoods, reliable transportation, nutritious food, quality education, meaningful employment, and strong social connections. No single organization can meet all these needs alone—but together, we can build a more coordinated, responsive, and equitable approach to care.

The system of care model organizes services around key life domains, ensuring that individuals are supported holistically—not just as patients, but as whole people with interconnected needs. It also empowers each partner to contribute their unique strengths—whether that's delivering medical care, providing counseling, preparing meals, or advocating for policy change.

Our Ministries embrace this model as part of our mission. By working collaboratively with patients, families, associates, community leaders, and trusted partners, we help reduce service gaps, improve health outcomes, and strengthen the safety net across the region.

Our Plan and Our Promise

The Community Health Implementation Plan (CHIP) is more than a regulatory requirement—it is a living expression of our CHRISTUS Health mission and values in action.

Every three years, CHRISTUS St. Frances Cabrini Health System and CHRISTUS Coushatta Health Care Center conduct a Community Health Needs Assessment (CHNA) to better understand the health priorities, challenges, and opportunities across our service area in Central Louisiana. The CHIP is our response to those findings—a forward-looking roadmap that outlines how we will work alongside our 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 publicly available health datasets, we analyzed dozens of indicators tied to health outcomes and social determinants. But we didn't stop at the numbers—we listened deeply through focus groups, community surveys, and direct conversations with local leaders, service providers, and residents. We made a focused effort to hear from those whose voices are often underrepresented: rural families, low-income residents, caregivers, youth, and individuals with lived experience navigating health challenges.

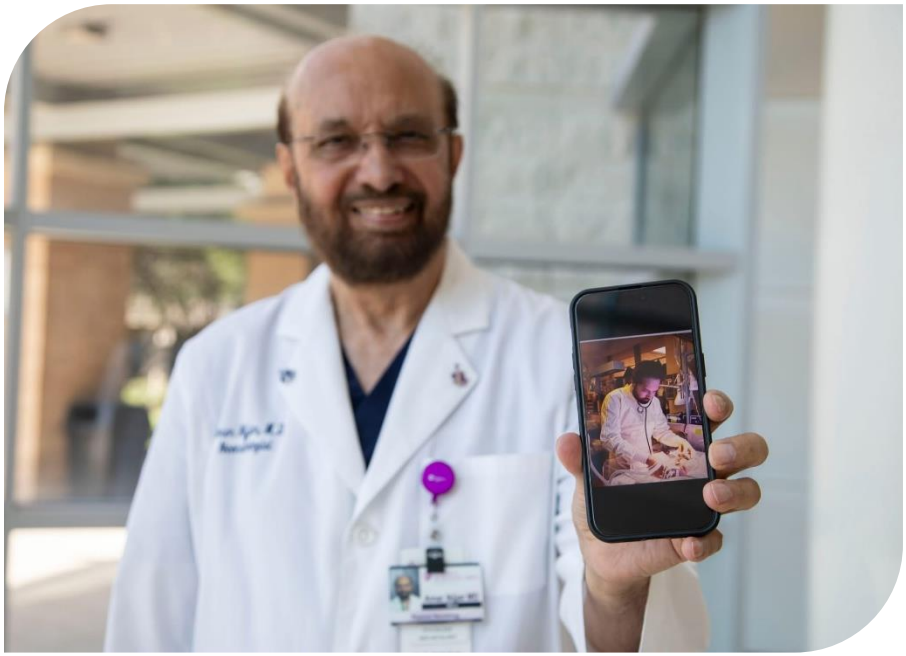
What emerged is a clear call to action—and a shared vision for a healthier Central Louisiana.

The CHRISTUS Cabrini and Coushatta CHIP includes strategies across three categories: hospital-led initiatives, community benefit investments, and collaborative partnerships. Each strategy 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, our Ministries remain deeply committed to:

- Centering community voice in every strategy
- Addressing root causes such as poverty, access barriers, 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 not just 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. Frances Cabrini Health System reviewed and approved the CHNA prior to June 30, 2025, with Board of Directors' ratification on September 9, 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 September 9, 2025.

CHRISTUS St. Frances Cabrini 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 2023–2025 Community Health Needs Assessment (CHNA) and its corresponding Community Health Implementation Plan (CHIP). It highlights how CHRISTUS St. Frances Cabrini Health System—including Savoy Medical Center—and CHRISTUS Coushatta Health Care Center have translated strategy into meaningful action, improving lives across Central Louisiana and the surrounding rural communities.

Guided by the priorities identified in the last CHNA, our Ministries have made strategic, 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 enables 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 offers an opportunity to reflect on the progress we have made alongside our communities. It serves as a foundation for future growth—celebrating the lives we have touched, the partnerships we have formed and strengthened, and the lessons we have learned that will guide our next chapter in community health.

Community Benefit

Our Commitment in Action

As a Catholic, not-for-profit health system, CHRISTUS St. Frances Cabrini Health System—including Savoy Medical Center—and CHRISTUS Coushatta Health Care Center reinvest earnings into programs, partnerships, and services that improve health outcomes and advance equity for individuals and families across our Ministries.

Each year, we dedicate financial, physical, human, intellectual, and informational resources to address the most pressing health and social needs identified in our Community Health Needs Assessment (CHNA). Guided by Catholic social teaching, our community benefit activities aim to build healthier and more resilient communities by addressing both clinical and social determinants of health—bridging gaps that impact 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, our Ministries support programs that address upstream drivers of health—such as food insecurity, housing instability, and access to behavioral health services—through outreach, education, and strategic partnerships with local organizations.

At CHRISTUS St. Frances Cabrini and CHRISTUS Coushatta, community benefit is not just a responsibility—it is central to our identity and mission. These committed resources and investments reflect our dedication to equity, stewardship, and lasting community impact.

FY23 Community Benefit Landscape

Community services $14 million		Charity care $5 million		Total community benefits $19 million
$1.8 million Community health improvements and strategic partnerships	**$67 thousand** Health professionals' education and research	**$53 thousand** Subsidized health services	**$12.4 million** Cash and in-kind distributions	**$21 thousand** Community building activities

FY24 Community Benefit Landscape

Community services $4.4 million		Charity care $5.5 million		Total community benefits $9.9 million
$1.3 million Community health improvements and strategic partnerships	**$149 thousand** Health professionals' education and research	**$21 thousand** Subsidized health services	**$2.9 million** Cash and in-kind distributions	**$35 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 initiatives led by nonprofit community organizations 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 meaningful change.

Each year, the CHRISTUS Community Impact Fund provides grants to organizations that align with the priorities identified through our 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. Frances Cabrini Health System and CHRISTUS Coushatta Health Care Center awarded Community Impact Fund grants to trusted, mission-aligned partners across Central Louisiana and surrounding rural communities. 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
Catholic Charities of Central Louisiana	Build resilient communities and improve social determinants	Reducing smoking/vaping	Smoking/Vaping Cessation Program	To implement vaping education and cessation programs for youth and adults
Free the Youth	Advance health and well-being	Mental health and well-being	Free the Youth After-School Program	To create a safe and engaging environment for children while improving their academics, physical and mental health through the Free the Youth After-School program
The Food Bank of Central Louisiana	Build resilient communities and improve social determinants	Healthy food access	Warehouse Expansion with Demonstration/Learning Kitchen	To expand the food bank's permanent capacity to store and distribute food while creating a space for neighbors to learn about nutrition and how to prepare healthy food
Manna House	Build resilient communities and improve social determinants	Healthy food access	Manna House Meals Program	To provide hot, nutritious meals 365 days a year to all who are in need within Central Louisiana
Total CHRISTUS Community Impact Fund investment:				**$290,000.00**

FY24 Community Impact Fund

ORGANIZATION	DOMAIN	PRIORITY	PROGRAM NAME	PROGRAM DESCRIPTION
Cenla Pregnancy Centers Inc.	Build resilient communities and improve social determinants	Education	Cenla Pregnancy Center	To connect women experiencing an unplanned or crisis pregnancy to medical and social resources
Central Louisiana Homeless Coalition	Build resilient communities and improve social determinants	Safe housing	Providing Basic and Permanent Housing Services for Homeless Persons in Central Louisiana	To provide case management services to people experiencing homelessness and connect them to community programs and resources
The Food Bank of Central Louisiana	Build resilient communities and improve social determinants	Healthy food access	Warehouse Expansion with Demonstration/Learning Kitchen	To expand the food bank's permanent capacity to store and distribute food while creating a space to learn more about nutrition and how to prepare healthy food
Manna House	Build resilient communities and improve social determinants	Healthy food access	Manna House Meals Program	To improve food security by providing hot nutritious food 365 days a year in central Louisiana
Total CHRISTUS Community Impact Fund investment:				**$295,000.00**

FY25 Community Impact Fund

ORGANIZATION	DOMAIN	PRIORITY	PROGRAM NAME	PROGRAM DESCRIPTION
Catholic Charities of Central Louisiana	Build resilient communities and improve social determinants	Safe housing	Assist. Educate. Elevate.	To assist community members with financial help using a certified financial coach
Catholic Charities of Central Louisiana	Build resilient communities and improve social determinants	Healthy food access	Road to Healthy Living	To provide patients of St. Frances Cabrini with resources for transportation services and access to healthy food options
Central Louisiana Homeless Coalition	Build resilient communities and improve social determinants	Safe housing	Providing Basic and Permanent Housing Services for Homeless Persons in Central Louisiana	To provide referrals to services to available short-term shelters, physical and mental health services, substance misuse treatment and other supportive services to unhoused individuals
Children's Advocacy Network	Advance health and well-being	Mental health and well-being	Central Louisiana Trauma-Focused Therapy Enhancement Initiative	To provide trauma-focused therapy to children in Central Louisiana by hiring an additional therapist and providing further training to existing clinicians
Family Justice Center	Advance health and well-being	Mental health and well-being	Family Justice Center - Avoyelles	To provide counseling and additional social services to survivors of domestic violence and/or sexual assault
Food Bank of Central Louisiana	Build resilient communities and improve social determinants	Healthy food access	Warehouse Expansion with Demonstration/Learning Kitchen	To expand its permanent capacity to store and distribute food, while creating a space for neighbors to learn about nutrition and how to prepare healthy food
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, CHRISTUS St. Frances Cabrini Health System—including Savoy Medical Center—and CHRISTUS Coushatta Health Care Center have adopted a **Lifespan Approach** to guide both our Community Health Needs Assessment (CHNA) and Community Health Implementation Plan (CHIP). 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.

Our Ministries 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 influences infant outcomes, early trauma can shape lifelong well-being, and investments in one life stage often ripple into the next.

By using a lifespan approach, CHRISTUS Cabrini, CHRISTUS Coushatta, and our community 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 St. Frances Cabrini Health System—including Savoy Medical Center—and CHRISTUS Coushatta Health Care Center used a **data-informed, 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 explore what good health looks like across the lifespan:

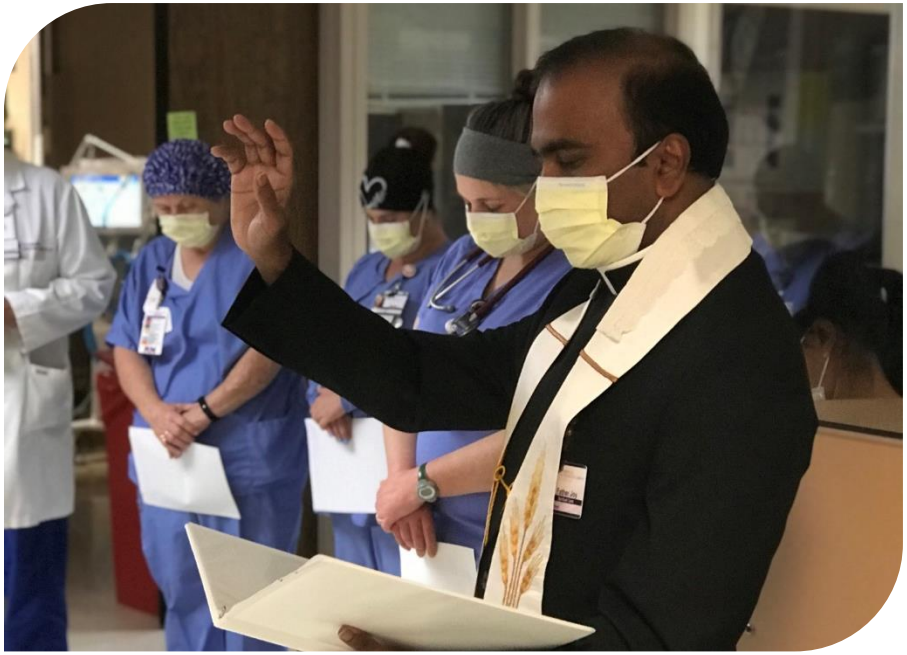
- **Maternal and early childhood**
- **School-age children and adolescents**
- **Adults**
- **Older adults**

During these sessions, participants reviewed CHNA data, discussed emerging health trends, and assessed indicators from the previous implementation cycle. They examined 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?

Using tools from the RBA model—including the concept of **"Turn the Curve"**—participants focused on trend data to assess whether community conditions are improving over time. Rather than reacting to short-term fluctuations, this approach emphasizes long-term progress and strategic impact.

Each workgroup identified **three to five leading health indicators** for their respective life stage. These indicators reflect the areas of greatest need, concern, and opportunity for impact. They now serve as a shared focus for CHRISTUS Cabrini and CHRISTUS Coushatta's strategies, investments, and partnerships over the next three years—ensuring that improvement efforts are targeted, measurable, and responsive to the communities we serve.



Lifespan Priority Indicators of 2026-2028

The following table summarizes the priority indicators selected through community indicator workgroups and approved by the CHRISTUS St. Frances Cabrini Health System and CHRISTUS Coushatta Health Care Center leadership. These indicators reflect the most urgent and actionable health and social needs across the lifespan—from early childhood to older adulthood—based on both community input and data analysis conducted during the Community Health Needs Assessment (CHNA) process.

These leading indicators will serve as the foundation for the **2026–2028 Community Health Implementation Plan (CHIP)**, guiding program strategies, resource investments, and collaborative partnerships that aim to "turn the curve" on health outcomes in Central Louisiana and surrounding rural communities.

For a detailed explanation of each indicator—including baseline data, trend analysis, and community context—please refer to the CHRISTUS 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
  ○ Prenatal care
  ○ Obstetric care
• Healthy births
• Behavioral health
  ○ Mental health
	• Access to care
	• Education
	• Housing instability
	• Crime
	  ○ Abuse and neglect
		• Chronic diseases
		  ○ Diabetes
		  ○ Heart disease
		  ○ Obesity
		• Behavioral health
		  ○ Mental health
		  ○ Substance use
		Poverty
			• Access to care
			  ○ Medication affordability
			• Behavioral health
			  ○ Mental health
			  ○ Substance use
			• Crime
			• Food insecurity
			• Housing instability
			Lack of broadband

Needs That Are Not Being Addressed

The CHRISTUS St. Frances Cabrini 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 St. Frances Cabrini, Savoy Medical Center, or CHRISTUS Coushatta Health Care Center can lead or sustain independently. Some community issues require 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:

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

Although CHRISTUS may 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 and multi-sector initiatives
- Supporting aligned programs and services
- Ensuring our strategies complement and enhance broader community efforts

The Strategies section that follows highlights where CHRISTUS is playing a supportive or collaborative role in addressing these issues, including 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 St. Frances Cabrini Health System and CHRISTUS Coushatta Health Care Center 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 St. Frances Cabrini Health System and CHRISTUS Coushatta Health Care Center, 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 St. Frances Cabrini Health System and CHRISTUS Coushatta Health Care Center 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 Central Louisiana 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
  - Prenatal care
  - Obstetric care
- Healthy births
- Behavioral health
  - Mental health

DATA MEASURES

- Prenatal care in first trimester
- Prevalence of stressful life events in mothers
- Prevalence of maternal postpartum depressive symptoms in Louisiana mothers
- Preterm births
- Maternity care deserts and access to maternity care
- Distribution of OBGYNs that accept Medicaid

MATERNAL AND EARLY CHILDHOOD HEALTH STRATEGIES CHRISTUS ST. FRANCES CABRINI		
Hospital direct care strategies	**Community funding strategies**	**Community partner strategies**
"We lead"	**"We fund"**	**"They lead"**
CSFCH will offer no charge education on: • prenatal education • birthing classes • lactation support through outpatient services • car seat safety checks and installation by certified technician • Prenatal lactation 1:1 education and preparedness • Education on Yomingo App which can be used from pregnancy to postpartum/newborn care. • Maternal Support Group • Expand access to women's care. • Provide web based maternal-child all-inclusive education, from prenatal to post-partum and newborn. • Evaluate standardization of social needs screening for new moms. • Evaluate standardization of social needs screening for all moms. • Initiate planning for a postpartum depression screening protocol.	Grant given to Rapides Early Childhood Network Evaluate continued funding of the Rapides Early Childhood Network through: • CHRISTUS Fund • CSFCH grants • CSFCH Foundation • Support of outside funding from other resources such as local foundations • Researching and reviewing best funding options for establishing: • A Hospital-Owned/Based transportation program • Transportation programs through local governmental and community organizations. Examples for transportation funding include: • CMS Innovation Grants • Hospital Foundation fundraising • Value-based care shared savings programs • Partnerships with FQHCs, ACOs, and local health departments	• Work with local organizations to break down barriers to care such as: » **CENLA Healthy Start** provides mental health clinicians, completes checkups with moms and connects moms with Nurse-Family Partnership » Family Tree » Support Nurse-Family Partnerships through local school boards and other non-profit organizations » Evaluate support of local Parish unit who distribute WIC for better outcomes • Transportation partnerships could include: » FQHCs » ACOs » local governmental agencies » Office of Public Health, » Atrans

• Offer OT and PT screening for high-risk NICU graduates. • Offer lactation outpatient clinic services. • Promote Gestational Diabetes Self-Management Education/Support participation. • CSFCHS School Based Health Centers offer noninsured patients/families assistance in completing Medicaid applications. • CSFCHS School Based Health Centers provide community resources for pregnant teenagers identified at the schools served. • CSFCHS School Based Health Centers offer behavioral health services, including teen pregnancy support groups, at our high school clinics. • CSFCHS key leaders (Mission, CHRISTUS Community Clinics, OB/GYN Services, and Pedi Therapy to name a few) will evaluate, research and seek solutions for transportation needs of patients and families as well as the local community to ensure better outcomes by promoting: • Supporting discharge patients with no transportation	• Continue offering and supporting health fairs and health screenings throughout the CSFCHS PSA.	

• Ensuring prompt, safe transport home or to skilled nursing/rehab • Outpatient Appointments – including follow-ups, diagnostics, and therapy visits. • High-Risk Populations – such as dialysis patients, wound care, post-surgical follow-ups. • Continue offering and supporting health fairs and health screenings throughout the CSFCHS PSA for better health outcomes.		

MATERNAL AND EARLY CHILDHOOD HEALTH STRATEGIES CHRISTUS COUSHATTA		
Hospital direct care strategies	**Community funding strategies**	**Community partner strategies**
"We lead"	**"We fund"**	**"They lead"**
• OB/GYN Nurse Practitioner sees patients once per week for early OB care. • Established relationship with two OB physicians to continue follow-up care past the first trimester. • Hospital continues to accept Medicaid patients. • Explore alignment with CHRISTUS Health system initiatives to improve maternal health. • Explore options to increase OB clinic services for vulnerable women • Provide Lactation Services for underprivileged mothers. • Review options for providing access to lab services for vulnerable populations. • Offer transportation assistance for those in financial need.	• Work with local CMN partners to raise funds to expand service lines that benefit kids. • Explore funding crucial health services for infants and their caregivers. • Explore funding opportunities for scholarships to increase access to education and vocational training.	• Established telemedicine program in the local elementary school. • Explore alignment with CHRISTUS Health system initiatives to improve maternal health. • Explore options to increase OB clinic services for vulnerable women • Parish Health Unit distributes WIC • Collaborate with other non-profits to determine what education programs mothers and young families need. • Evaluate opportunities to offer community-based screening assessments and education on prevention and health maintenance. • Advocate locally for affordable insurance • Explore relationships with Federally Qualified Healthcare Centers (FQHCs) to expand PCP access.

MATERNAL AND EARLY CHILDHOOD HEALTH STRATEGIES SAVOY MEDICAL CENTER		
Hospital direct care strategies	**Community funding strategies**	**Community partner strategies**
"We lead"	**"We fund"**	**"They lead"**
Savoy Medical Center will continue its partnership with the New Life Pregnancy Center. • Savoy Medical Center will actively partner with the New Life Pregnancy Center, to ensure vital services for expectant mothers in need.	Savoy Medical Center will continue its partnership with the New Life Pregnancy Center. • Savoy Medical Center will continue to financially support the New Life Pregnancy Center, to ensure vital services for expectant mothers in need.	Savoy Medical Center will continue its partnership with the New Life Pregnancy Center. • The New Life Pregnancy offers support to expectant mothers in crisis with education, vital services and resource referrals for medical needs.

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
• Access to care • Education • Housing instability • Crime • Abuse and neglect	• Children under Louisiana Office of Juvenile Justice (OJJ) supervision on in OJJ custody • Distribution of pediatric providers that accept Medicaid • High school graduation rate • Students who met expectations on LEAP 2025 Assessment • Children confirmed as victims of abuse/neglect in 2021

SCHOOL-AGE CHILDREN AND ADOLESCENT HEALTH STRATEGIES CHRISTUS ST. FRANCES CABRINI		
Hospital direct care strategies	**Community funding strategies**	**Community partner strategies**
"We lead"	**"We fund"**	**"They lead"**

• **CSFCHS School-Based Health Centers** are located in 17 schools in Central LA. SBHC services are available to all students with a signed consent form and provided in a safe and convenient location during school hours.
  ○ All students enrolled in schools with CSFCHS SBHCs have access to medical and behavioral health services with no barriers regardless of their race, ethnicity, sexual orientation, religion, national origin, age, disability, health insurance status, or ability to pay.
  ○ Students registered in the CSFCHS SBHCs will be assessed for risks by medical and/or mental health providers on initial visits/yearly.
• At CSFCHS SBHCs behavioral health services are offered to all students identified as at-risk, including assessments, diagnosis, treatment, and referrals/resources.
• CSFCHS will partner with St. Mary's Residential Community to host a "Healthcare for Those with Disabilities" conference of local non-profit and governmental agencies to evaluate and execute plans to ensure greater access and best practices care for individuals with intellectual, physical, and developmental disabilities.
• Start a collaborative education initiative between CSFCH Pedi Therapy and LSUA's OT Program
• Provide a therapist-led, community-based developmental education and screening program
• Launch the CHRISTUS Cabrini Camp Lighthouse that provides Inclusive enrollment for children ages 5–18 with a variety of abilities, supported by peer
	• Evaluate continued funding of the School Age Children strategies through:
	  ○ CHRISTUS Fund
	  ○ CSFCH grants
	  ○ CSFCH Foundation
	• Support of outside funding from other resources such as local foundations
	  • Louisiana Clinical Services offers yearly contracts to help subsidize SBHC services.
	  • USDA funded a telehealth equipment grant to expand services in SBHC.
	  • Researching and reviewing best funding options for establishing:
	  • A Hospital-Owned/Based transportation program
	  • Transportation programs through local governmental and community organizations.
	Examples for transportation funding include:
	• CMS Innovation Grants
	• Hospital Foundation fundraising
		• Access Health LA now operates CHRISTUS SBHC centers as FQHC sites allowing for expansion and sustainability.
		• Avoyelles, LaSalle, Natchitoches, Grant, and Rapides parish school boards partner with CHRISTUS to house SBHC on site at 18 schools.
		• Central LA Human Service District partners with SBHC to provide crisis and prevention resources.
		• CSFCHS will work with St. Mary's Residential Community to continue offering sensory friendly and best practices for their residents
		• Partnership with Good Food Project to grow and maintain community gardens that allow community members to harvest fresh fruit and vegetables at no cost to them. Provides education on how to grow fresh food at home.
		• Good Food Project support in classroom and school campuses.
		• CMS

buddies. A professionally coordinated summer program that provides: • Inclusive Camp Enrollment – children ages 5–18 • Working with children with a variety of abilities, supported by peer buddies model modified for all abilities. • Offering Adaptive Programming – such as swimming, arts, recreation and crafts. • Volunteer Training – structured leadership development for teen counselors and adult 'Buddy Parents. • CSFCHS key leaders (Mission, CHRISTUS Community Clinics, SBHC, and Pedi Therapy to name a few) will evaluate, research and seek solutions for transportation needs of patients and families as well as the local community to ensure better outcomes by promoting: • Supporting discharge patients with no transportation • Ensuring prompt, safe transport home or to skilled nursing/rehab • Outpatient Appointments – including follow-ups, diagnostics, and therapy visits. • High-Risk Populations – such as dialysis patients, wound care, post-surgical follow-ups. • SBHCs provide community resources and Behavioral health services to teenage mothers • • SBHCs offer noninsured patients/families assistance in completing Medicaid applications. • • SBHCs provide Behavioral health services to students identified as at-risk including teen pregnancy support groups, at our high school clinics.	• Value-based care shared savings programs • Partnerships with FQHCs, ACOs, and local health departments Camp Lighthouse Funding includes: • Grant-funded supplies and adaptive equipment (sensory tools, accessible recreational gear). • Sponsorship of meals, snacks, and camp t-shirts through community fundraising. • Annual grant cycle support to cover staff training, safety, and insurance costs. • Continue offering and supporting health fairs and health screenings throughout the CSFCHS PSA.	• Transportation partnerships could include: • FQHCs • ACOs • local governmental agencies • Office of Public Health, • Atrans • Camp Lighthouse partnerships could include: • Local Churches and Faith Organizations – facility hosting and volunteer support. • Schools and Parent Networks – outreach and camper recruitment. • Community Businesses & Civic Groups – sponsorships and fundraising partnerships. • Healthcare and Therapy Partners – consulting to ensure adaptive programming and safety. • Local schools and school boards.

• Work with local schools and school boards to promote stronger graduation rates. • Continue offering and supporting health fairs and health screenings throughout the CSFCHS PSA for better health outcomes.		

SCHOOL-AGE CHILDREN AND ADOLESCENT HEALTH STRATEGIES CHRISTUS COUSHATTA		
Hospital direct care strategies	**Community funding strategies**	**Community partner strategies**
"We lead"	**"We fund"**	**"They lead"**
• Improved access to care by establishing telemed clinics in both the local Elementary School and JR High and High School. • Participate in local health education day at local schools passing out dental supplies and education. • Provide free/subsidized orthopedic and sports medicine services to schools serving vulnerable students, including on-site services, rehab, education, screening and follow-up care. • Evaluate proposals to provide support services for patients and families within the hospital or in the community who need behavioral health assistance. • Advocate locally for behavioral health access.	• Funding for the telemedicine equipment provided through state grants to improve healthcare access within a school setting. • Explore funding opportunities: • For scholarships to increase access to education and vocational training. • For afterschool programs providing safe space for academic, emotional and vocational support, for example, through Community Renewal's Friendship Houses. • To expand behavioral health services for adolescents, for example, with Community Renewal International.	• Explore partnerships to increase access to healthy foods by teaching nutrition, providing/growing healthier food, cooking with cultural appreciation: • Organizations could include: • Shreveport Green • LSU Ag Center. • Partner with the local school system to implement the tele clinics within the school and promote dental care with the CHRISTUS Coushatta dental clinic. • Work with the local school boards: • To offer CPR classes for adolescents. • To offer clinical education opportunities for healthcare students including nurses and allied health. • Provide shadowing opportunities for individuals considering a health care profession. ○ 3. Explore opportunities for underrepresented groups to consider a healthcare vocation.

SCHOOL-AGE CHILDREN AND ADOLESCENT HEALTH STRATEGIES SAVOY MEDICAL CENTER		
Hospital direct care strategies	**Community funding strategies**	**Community partner strategies**
"We lead"	"We fund"	"They lead"
Savoy Medical Center will provide High school physicals which includes: • Oberlin, Elton, Mamou, Pine Prairie, Sacred Heart and Ville Platte schools. Savoy Medical Center will continue to provide Flu shots for area schools • Both Initiatives above will enhance access to services needed for all students including those whose families have difficulties in getting basic healthcare due to the social determinants of health, such as poverty. Savoy Medical Center will continue providing substance abuse education to area school age children.	Savoy Medical Center will continue funding support of: • CASA of Evangeline St. Landry Spring Community Connect, supporting their belief that every child should be given the opportunity to thrive in a safe and loving home.	Savoy Medical Center will continue its partnership with the following non-profit organizations • Oberlin High School Athletics • CASA of Evangeline St. Landry CASA supports and promotes court-appointed volunteer advocacy for children and youth who have experienced abuse or neglect.

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

• Chronic diseases
  ○ Diabetes
  ○ Heart disease
  ○ Obesity
• Behavioral health
  ○ Mental health
  ○ Substance use
• Poverty
	• Obesity
	• Diabetes mortality
	• Heart disease mortality
	• Drug overdose mortality
	• Poverty rate
	• Households below ALICE Threshold

ADULT HEALTH STRATEGIES CHRISTUS ST. FRANCES CABRINI		
Hospital direct care strategies	**Community funding strategies**	**Community partner strategies**
"We lead"	**"We fund"**	**"They lead"**
• CSFCHS will partner with St. Mary's Residential Community to host a "Healthcare for Those with Disabilities" conference of local non-profit and governmental agencies to evaluate and execute plans to ensure greater access and best practices care for individuals with intellectual, physical, and developmental disabilities. • Christus Community Care Clinics to follow patients for: • Appointments for PCP • Appointments at Specialty Clinics • Support for affordable medications • Post-acute appointments • Support for affordable diabetic supplies • Transportation arrangements • Identification of Social Determinants of Health and connecting patients to resources to address those needs • Christus Community Care Clinics to offer and continue to offer for Chronic Disease: • Increased awareness and education around tobacco cessation	• State grant funded Opioid navigator Program in ED • Grants provided to Food Bank of Central Louisiana to help alleviate hunger and food insecurity, expansion of food bank warehouses, freezer, cooler, and establishment of community teaching kitchen. • Offering time, resources and grants to Manna House of Central Louisiana to help alleviate hunger and food insecurity. • Researching and reviewing best funding options for establishing: • A Hospital-Owned/Based transportation program • Transportation programs through local governmental and community organizations. Examples for transportation funding include: • CMS Innovation Grants • Hospital Foundation fundraising • Value-based care shared savings programs • Partnerships with FQHCs, ACOs, and local health departments	• Department of Health and Humans Services and the Opioid navigator program. • Partnership with Good Food Project to grow and maintain community gardens that allow community members to harvest fresh fruit and vegetables at no cost to them. Provides education on how to grow fresh food at home. • Partnership with LSU Ag to promote healthy eating strategies for diabetes, healthy weight, and heart health such as the Dining with Diabetes program and Healthy You at the Zoo. • Explore partnering with local governmental agencies and organizations to address transportation needs • Partner with LCU and Catholic Charities to bring on interns to work as Community Health Workers with a focus on: • Transportation needs • Food Insecurity

➢ Addition of more cardiologists to meet the needs of the community. ➢ Hospital push to increase the number of LDCT's. ➢ Push to get patients scheduled and followed by Primary Care Providers. • Christus Community Care Clinics to offer and continue to offer for Those in Poverty: ➢ 340B discounted med pharmacy for those with Medicaid and uninsured. ➢ Food Pantry ➢ Financial Counselor and Medicaid representative in clinic. The CSFCH BHU department will work: ➢ Short-term stabilization in BHU and BCDU Continue to reduce ED boarding and improve patient throughput. ➢ Update exclusionary criteria to ensure safe and appropriate placement for patients in crisis. ➢ Automatic referrals to community providers prior to discharge from BHU. ➢ Social workers coordinate discharge planning and ensure follow-up care with appropriate resources. To support Education and improve access to behavioral health services, the CSFCH BHU department will: ➢ Work with Ongoing CPI and certification training for staff. ➢ Provide recruitment, mentorship, and collaboration with ED leadership to	• Explore funding opportunities to partner with local governmental agencies and organizations to address transportation needs. • Catholic Charities has received a grant from the CHRISTUS Fund to address: • Transportation needs • Food Insecurity • Mission Department is allocating resources to start an intern program with LCU from their MSW program to assist in the community health worker role to help with: • Transportation needs • Food Insecurity • Use of 411, VA Benefits • Aging & Disability Resources • CSFCHS for better access for behavioral health will research funding to support transportation needs for the homeless population, including bus passes to aid in discharge planning for both ED and behavioral health patients. This would significantly reduce	• Transportation partnerships could include: • FQHCs • ACOs • local governmental agencies • Office of Public Health, • Atrans • CSFCHS will work with St. Mary's Residential Community to continue offering sensory friendly and best practices for their residents • Explore new and continued partnership opportunities with local organizations such as: • Catholic Charities • CLHSD Mobile Crisis Team • Homeless Coalition • Food Bank of Central Louisiana • Children's Advocacy Network • Manna House • Central Louisiana Crisis Pregnancy Center • LSUA • NSU • LCU • Long Term Recovery Group • CLASS • Healthy Living for All • Main St. Baptist Mission Pineville • Save Cenla Suicide Prevention • Mental Health Agencies

strengthen continuity of care and response to behavioral health needs. • American Diabetes Association recognized Healthy Eating Active Living (HEAL) Diabetes self-management education & support program offers group and individual sessions to provide comprehensive training and collaboration with Certified Diabetes Care & Education Specialists and Registered Dietitians in the Healthy Learning Center. • Food Drive with emphasis on donation of nutrient dense, health foods to support the partnership with the Food Bank of Central Louisiana for patients who are food insecure. • Provide access to nutritional counseling and medical nutrition therapy with a Registered Dietitian for chronic diseases such as diabetes, renal failure, fatty liver, congestive heart failure, cancer, and obesity. • Maintain Bariatric Center for Excellence for obesity management. • Provide Registered Dietitian and Exercise Physiologist-led monthly, in person, and virtual bariatric support groups. • CSFCHS key leaders (Mission, CHRISTUS Community Clinics, Case Management, BHU and Pedi Therapy to name a few) will evaluate, research and seek solutions for transportation needs of patients and families as well as	barriers to outpatient follow-up and community reintegration. • The CSFCH BHU Department is actively seeking funding to support transportation needs for the homeless population, including bus passes to aid in discharge planning for both ED and behavioral health patients. This would significantly reduce barriers to outpatient follow-up and community reintegration. Provide Voluntary Free Care • Assist with Medicaid Applications • Provide medications from Incarnate Word Community Care Pharmacy for Behavioral Health and Indigent Population • Continue offering and supporting health fairs and health screenings throughout the CSFCHS PSA.	• United Way • Salvation Army • Healthworx • Interfaith • Office of Public Health • MOED • Continuing partnerships with local colleges, universities, and technical colleges to support education efforts in the different degrees within healthcare to support staffing, clinical education, and internship opportunities to ensure a stronger healthcare workforce, supporting better access to care which may include behavioral health.

the local community to ensure better outcomes by promoting: • Supporting discharge patients with no transportation • Ensuring prompt, safe transport home or to skilled nursing/rehab • Outpatient Appointments – including follow-ups, diagnostics, and therapy visits. • High-Risk Populations – such as dialysis patients, wound care, post-surgical follow-ups. • CSFCHS, for better access for behavioral health patients, will also research transportation needs for the homeless population, including bus passes to aid in discharge planning for both ED and behavioral health patients. This would significantly reduce barriers to outpatient follow-up and community reintegration. • Increased awareness and education around tobacco cessation • Accepting self-pay and Medicaid patients • Identify and set up follow-up appointments for PCP in the Community Care Clinics. ED Navigator identifies SDOH and resources needed:		

• outpatient to manage home care • Transportation • Legal • safety concerns • Housing • Assistance with communication between patients and agencies. • Partner with Louisiana Christian University and the MSW program to bring on Interns to work as Community Health workers to assist with SFOH needs of patients throughout CHRISTUS CLA. • Push to get patients scheduled and followed by a Primary Care Provider • 340B discounted med pharmacy for those with Medicaid and uninsured. • Continue offering and supporting health fairs and health screenings throughout the CSFCHS PSA for better health outcomes.		

ADULT HEALTH STRATEGIES CHRISTUS COUSHATTA		
Hospital direct care strategies	**Community funding strategies**	**Community partner strategies**
"We lead"	**"We fund"**	**"They lead"**
• Continue to accept all payors and self-pay • Continue to realign behavioral health NP clinic to telemedicine to allow for easier access to mental health care. • Advocate locally for behavioral health access. • Review options for providing access to lab services for vulnerable populations. • Encourage patients to establish routine primary care visits with local rural health clinics to manage chronic diseases. • Encourage patient population to establish care with CHRISTUS Coushatta Rural Health Clinics (Coushatta, Ringgold, Boyce and Stonewall) to increase primary and specialty care access through provider recruitment and expansion. • Improve screening and referral for Social Determinants of Health (SDoH), particularly food insecurity.	• Explore offering transportation assistance for those in financial need. • Explore continued funding for crime prevention initiatives, for example, with Caddo Parish Sheriff Office and Community Renewal International. • Explore funding opportunities to expand behavioral health services for adults, for example, with the Council on Alcoholism & Drug Abuse of Northwest Louisiana (CADA). • Explore funding partnerships to increase access to healthy foods by teaching nutrition, providing/growing healthier food, cooking with cultural appreciation	• Explore partnerships to increase access to healthy foods by teaching nutrition, providing/growing healthier food, cooking with cultural appreciation: • Organizations could include: • Shreveport Green • LSU Ag Center. • Partner with Elevate to screen patients for Medicaid funding and assist with enrollment. • Partner with LDH to provide space within the hospital for a LA Medicaid enrollment specialist to assist patients • Explore relationships with Federally Qualified Healthcare Centers (FQHCs) to expand PCP access.

• Evaluate proposals to provide support services for patients and families within the hospital or in the community who need behavioral health assistance. • Evaluate offering emotional and spiritual support to patients experiencing chronic disease, including support groups, pastoral care.		

ADULT HEALTH STRATEGIES SAVOY MEDICAL CENTER		
Hospital direct care strategies	**Community funding strategies**	**Community partner strategies**
"We lead"	"We fund"	"They lead"
Savoy Medical Center will work to bridge the gap that barriers within the social determinants of health with a focus on its work around rural clinics: • By continuing its work of rural clinics to expand services to rural areas. • Adding two clinics will bring the number of clinics they are operating to ten. • Ensuring all ten clinics are classified as rural health clinics, by completing the certification process of the two newest clinics. • These clinics primarily serve Medicaid patients. • Increasing awareness about chronic disease management and prevention to elevate the health of the community. **Savoy Medical Center will work to bridge the gap concerning Behavioral Health Services for adults within their PSA.**	**Savoy Medical Center will continue funding support of:** • Savoy Indigent Patient Support (SIPS) who work with cancer patients and offer resources needed. • Race 2 Cure Breast Cancer Walk • Vietnam Veterans of America • REC Foundation (Respite Care) • Gold Club Alumni (Sober Living organization) • Kevin Naquin for Pancreatic Cancer Research • Turkey to feed the Homeless in Ville Platte with Catholic Daughters	**Savoy Medical Center will be working with a new Respite Care Center located within its PSA.** **Savoy Medical Center will continue seeking avenues of partnership with these organizations and events:** • Race 2 Cure Breast Cancer Walk • Vietnam Veterans of America • Gold Club Alumni (Sober Living organization) • Kevin Naquin for Pancreatic Cancer Research • Turkey to feed the Homeless in Ville Platte with Catholic Daughters • Oberlin Health Fair • Council on Aging Health Fair

• By increasing services and addressing barriers to promote better mental health outcomes for the community. • Improving efficiency, effectiveness, and access to an ever-widening range of care options. **Savoy Medical Center will continue to support the local communities through its leaders serving with the organizations below:** • The Evangeline Parish Chamber of Commerce • The Mamou Rotary Club • The Ville Platte Rotary Club **Savoy Medical Center will continue to research new avenues for Community support opportunities and get involved where they are needed.**		

Older Adult Health

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

LEAD INDICATORS

- Access to care
  - Medication affordability
- Behavioral health
  - Mental health
  - Substance use
- Crime
- Food insecurity
- Housing instability
- Lack of broadband

DATA MEASURES

- Food insecurity among seniors in Louisiana
- ALICE 65+ survival budget
- Long-term care facilities that accept Medicaid
- Medication cost for adults
- Ways that patients that delayed or went without health care due to cost
- No internet
- Drug-involved deaths
- Drug-poisoning-related hospital admissions
- Drug-poisoning-related ER visits
- Distribution of elderly protective services reports in 2024

OLDER ADULT HEALTH STRATEGIES CHRISTUS ST. FRANCES CABRINI		
Hospital direct care strategies	**Community funding strategies**	**Community partner strategies**
"We lead"	**"We fund"**	**"They lead"**
• Christus Community Clinics to offer and continue to offer for Chronic Disease: • Increased awareness and education around tobacco cessation ➢ Addition of more cardiologists to meet the needs of the community. ➢ Hospital will push to increase the number of LDCT's. ➢ Push to get patients scheduled and followed by Primary Care Providers. • Christus Community Clinics to offer and continue to offer for Those in Poverty: ➢ 340B discounted med pharmacy for those with Medicaid and uninsured. ➢ Food Pantry ➢ Financial Counselor and Medicaid representative in clinic. • Christus Community Care Clinics to follow patients for: • Appointments for PCP • Appointments at Specialty Clinics	• Grants provided to Food Bank of Central Louisiana to help alleviate hunger and food insecurity, expansion of food bank warehouses, freezer, cooler, and establishment of community teaching kitchen. • Offering time, resources and grants to Manna House of Central Louisiana to help alleviate hunger and food insecurity. • Researching and reviewing best funding options for establishing: • A Hospital-Owned/Based transportation program • Transportation programs through local governmental and community organizations. Examples for transportation funding include: • CMS Innovation Grants • Hospital Foundation fundraising • Value-based care shared savings programs • Partnerships with FQHCs, ACOs, and local health departments • Explore funding opportunities to partnering with local governmental agencies and organizations to address transportation needs	• Partnership with **Good Food Project** to grow and maintain community gardens that allow community members to harvest fresh fruit and vegetables at no cost to them. Provides education on how to grow fresh food at home. • Explore partnering with local governmental agencies and organizations to address transportation needs • CSFCHS will work with St. Mary's Residential Community to continue offering sensory friendly and best practices for their residents • Transportation partnerships could include: • FQHCs • ACOs • local governmental agencies • Office of Public Health, • Atrans • Explore new and continued partnership opportunities with local organizations such as: • Catholic Charities • CLHSD Mobile Crisis Team • Homeless Coalition

• Support for affordable medications • Post-acute appointments • Support for affordable diabetic supplies • Transportation arrangements • Identification of Social Determinants of Health and connecting patients to resources to address those needs • Provide Voluntary Free Care Assist with Medicaid Applications • Provide medications from CHRISTUS Community Clinic 340B pharmacy. • Pharmacy for Behavioral Health and Indigent Population • Food Drive with emphasis on donation of nutrient dense, health foods to support the partnership with the Food Bank of Central Louisiana for patients who are food insecure. • Operate Food Pantries at Clinics and continue partnership with Cenla Food Bank for patients who are food insecure.	Provide Voluntary Free Care • Assist with Medicaid Applications • Provide medications from Incarnate Word Community Care Pharmacy for Behavioral Health and Indigent Population • The CSFCH BHU Department is actively seeking funding to support transportation needs for the homeless population, including bus passes to aid in discharge planning for both ED and behavioral health patients. This would significantly reduce barriers to outpatient follow-up and community reintegration. • Continue offering and supporting health fairs and health screenings throughout the CSFCHS PSA.	• Food Bank of Central Louisiana • Children's Advocacy Network • Manna House • Central Louisiana Crisis Pregnancy Center • LSUA • NSU • LCU • Long Term Recovery Group • CLASS • Healthy Living for All • Main St. Baptist Mission Pineville • Save Cenla Suicide Prevention • Mental Health Agencies • United Way • Salvation Army • Healthworx • Interfaith • Office of Public Health • Continuing partnerships with local colleges, universities, and technical colleges to support education efforts in the different degrees within healthcare to support staffing, clinical education, and internship opportunities to ensure a stronger healthcare workforce, supporting better access to care which may include behavioral health.

• Work to increase the number of LDCT's • CSFCHS will partner with St. Mary's Residential Community to host a "Healthcare for Those with Disabilities" conference of local non-profit and governmental agencies to evaluate and execute plans to ensure greater access and best practices care for individuals with intellectual, physical, and developmental disabilities. • CSFCHS key leaders (Mission, CHRISTUS Community Clinics, BHU, Case Management, and Pedi Therapy to name a few) will evaluate, research and seek solutions for transportation needs of patients and families as well as the local community to ensure better outcomes by promoting: • Supporting discharge patients with no transportation • CSFCHS, for better access for behavioral health patients, will also research transportation needs for the homeless population, including bus passes to aid in discharge		

planning for both ED and behavioral health patients. This would significantly reduce barriers to outpatient follow-up and community reintegration. • Ensuring prompt, safe transport home or to skilled nursing/rehab • Outpatient Appointments – including follow-ups, diagnostics, and therapy visits. • High-Risk Populations – such as dialysis patients, wound care, post-surgical follow-ups. • Increased awareness and education around tobacco cessation • Accepting self-pay and Medicaid patients • Identify and set up follow-up appointments for PCP in the Community Care Clinics. ED Navigator identifies SDOH and resources needed: • outpatient to manage home care • Transportation • Legal • safety concerns • Housing • Assistance with communication between patient and agencies.		

• Partner with Louisiana Christian University and the MSW program to bring on Interns to work as Community Health workers to assist with SFOH needs of patients throughout CHRISTUS CLA. • Push to get patients scheduled and followed by a Primary Care Provider • 340B discounted med pharmacy for those with Medicaid and uninsured The CSFCH BHU department will work: ➢ Short-term stabilization in BHU and BCDU Continue to reduce ED boarding and improve patient throughput. ➢ Update exclusionary criteria to ensure safe and appropriate placement for patients in crisis. ➢ Automatic referrals to community providers prior to discharge from BHU. ➢ Social workers coordinate discharge planning and ensure follow-up care with appropriate resources. To support Education and improve access to behavioral health services, the CSFCH BHU department will: ➢ Work with Ongoing CPI and certification training for staff.		

➢ Provide recruitment, mentorship, and collaboration with ED leadership to strengthen continuity of care and response to behavioral health needs. • Continue offering and supporting health fairs and health screenings throughout the CSFCHS PSA for better health outcomes.		

OLDER ADULT HEALTH STRATEGIES CHRISTUS COUSHATTA		
Hospital direct care strategies	**Community funding strategies**	**Community partner strategies**
"We lead"	**"We fund"**	**"They lead"**
• Provide 340b program for lower drug costs. • Offer mental health nurse practitioner clinic through telemedicine. • Advocate locally for behavioral health access. • Encourage patients to establish a primary care medical home. • Encourage patient population to establish care with CHRISTUS Coushatta Rural Health Clinics (Coushatta, Ringgold, Boyce and Stonewall) to increase primary and specialty care access through provider recruitment and expansion. • Improve screening and referral for Social Determinants of Health (SDoH), particularly food insecurity. • Review options for providing access to lab services for vulnerable populations. • Evaluate proposals to provide support services for patients and families within	• Assist or partner with the Northwest LA Food Bank. • Explore offering transportation assistance for those in financial need. • Explore funding opportunities to expand behavioral health services for adults, for example, with the Council on Alcoholism & Drug Abuse of Northwest Louisiana (CADA). • Explore funding partnerships to increase access to healthy foods by teaching nutrition, providing/growing healthier food, cooking with cultural appreciation	• Explore partnerships to increase access to healthy foods by teaching nutrition, providing/growing healthier food, cooking with cultural appreciation: » Organizations could include: » Shreveport Green » LSU Ag Center. • Work with Red River Parish Council on Aging to identify care gaps and connect them with local resources. • Partner with local pharmacy in 340b program participation. • Explore relationships with Federally Qualified Healthcare Centers (FQHCs) to expand PCP access. • Work with organizations such as Council on Aging or Church organizations to: • Offer CPR classes for older adults. • Offer community-based screening assessments and education on prevention and health maintenance.

the hospital or in the community who need behavioral health assistance. • Evaluate offering emotional and spiritual support to patients experiencing chronic disease, including support groups and pastoral care. • Explore patient navigation for post hospital discharge by a Community Health Worker.		

OLDER ADULT HEALTH STRATEGIES SAVOY MEDICAL CENTER		
Hospital direct care strategies	**Community funding strategies**	**Community partner strategies**
"We lead"	**"We fund"**	**"They lead"**
Savoy Medical Center will work to bridge the gaps that are barriers within the social determinants of health for elderly through its work in their rural health clinics: • The clinics primarily serve Medicaid patients, to ensure access to the older adult population. **Savoy Medical Center will continue its work through these programs and services:** • Offer nutritional counseling to provide screening and education to decrease obesity rates. • Through its clinics, community members will have increased access to health screenings and educational tools • Continue to implement community education and outreach activities promoting diabetes education • Increase access to screenings and testing for those suffering with pre-diabetes and diabetes.	**Savoy Medical Center supports Savoy Indigent Patient Support (SIPS) who work with cancer patients and offer resources needed.** **Savoy Medical Center will continue to research new avenues for Community support funding opportunities and work to fill the gaps of social determinants of health.**	**Savoy Medical Center will continue seeking avenues of partnership with these organizations and events:** • REC Foundation (Respite Care) • Gold Club Alumni (Sober Living organization) • Turkey to feed the Homeless in Ville Platte with Catholic Daughters • Council on Aging Health Fair

Chapter 5: Conclusion

Conclusion

The CHRISTUS St. Frances Cabrini Health System and CHRISTUS Coushatta Health Care Center 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 St. Frances Cabrini Health System and CHRISTUS Coushatta Health Care Center reaffirm 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:

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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

CHRISTUS®
ST. FRANCES CABRINI
Health System

In partnership with CHRISTUS Coushatta Health Care Center and Savoy Medical Center