

Community Health Implementation Plan

Strategies for responding to the prioritized needs in the community

2026 – 2028

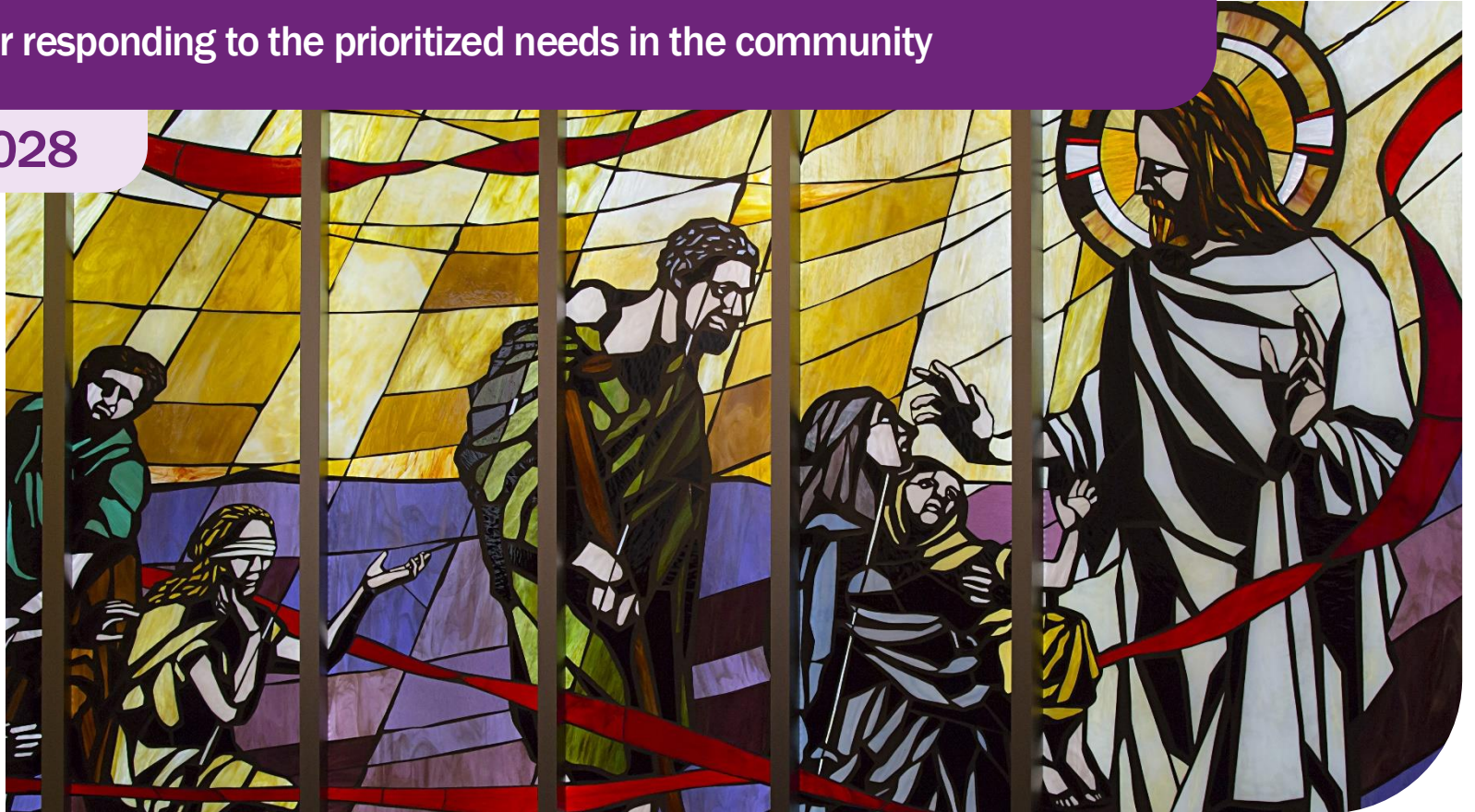
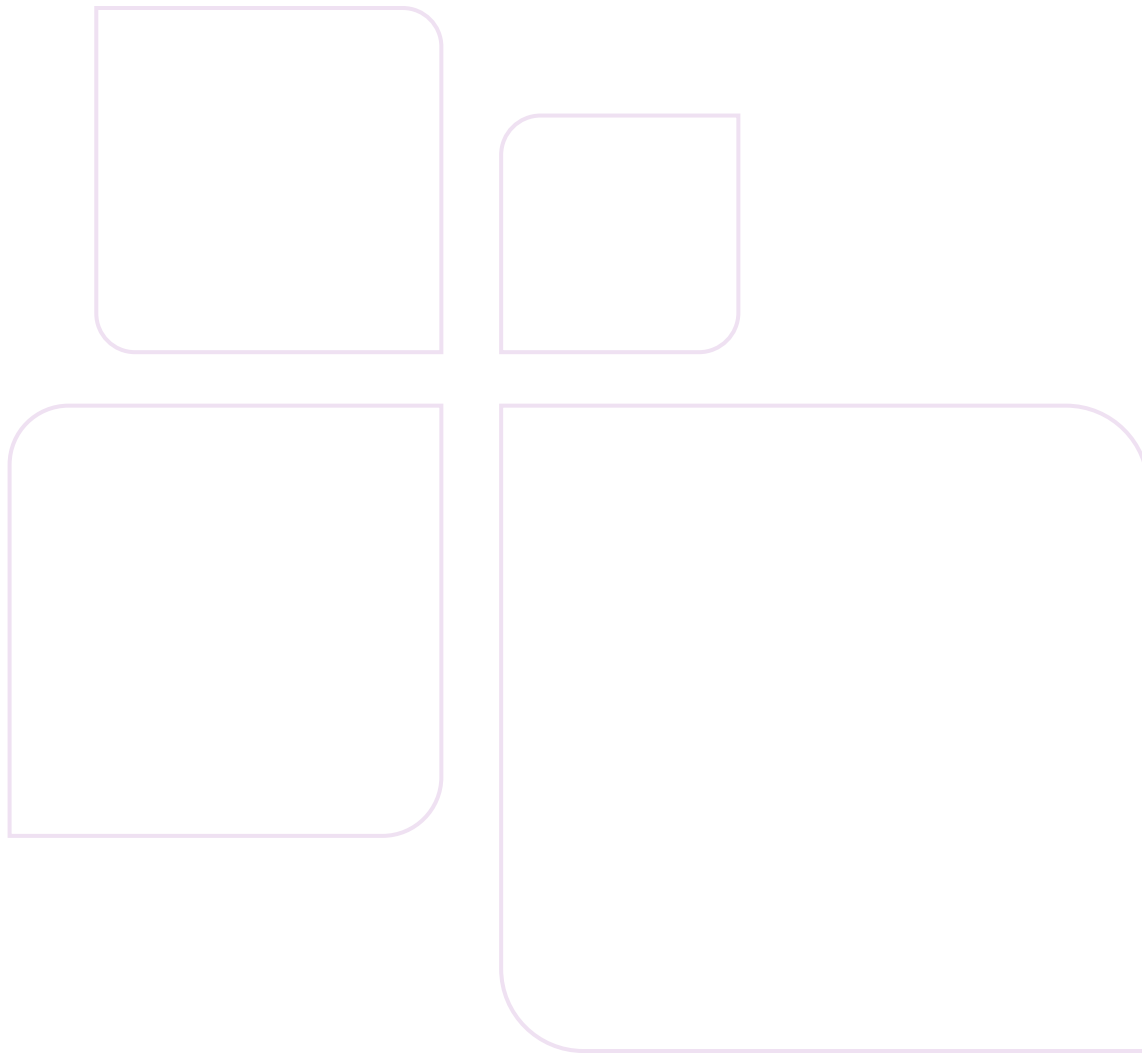


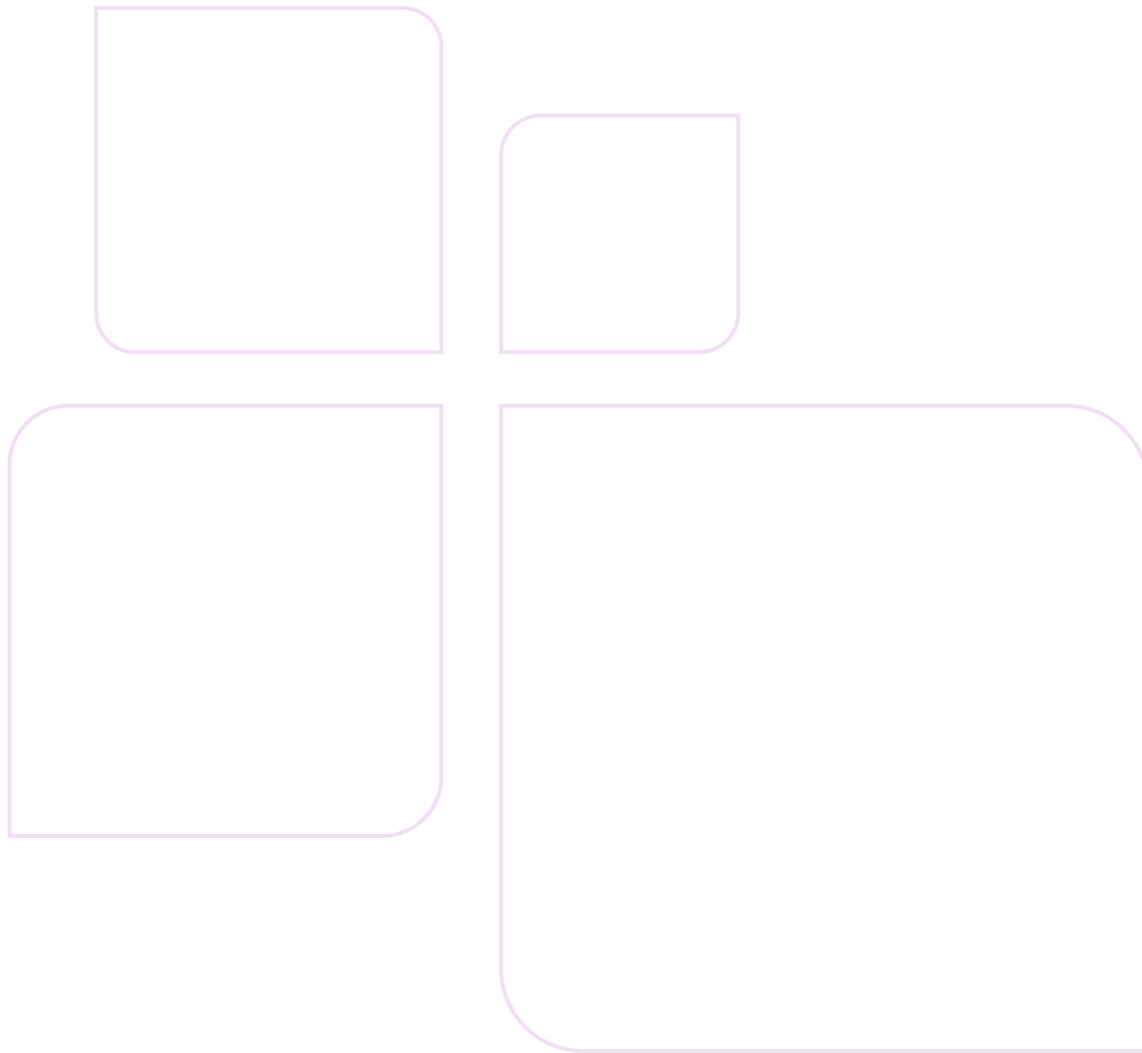
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Chapter 1: Introduction





Introduction

CHRISTUS Trinity Mother Frances Health System (CTMFHS) has been identifying and addressing our community's health and well-being needs since its founding in 1937. CHRISTUS Trinity Mother Frances Health System and the four hospitals within this ministry are called to be involved in our community, contributing to the common good. Strengthening the overall health of our community involves serving individuals who face social and economic conditions that place them at the margins of society. CTMFHS recognizes its role in serving the community beyond the physical walls of its hospitals, urgent care centers and medical professional offices. This 2026-2028 Community Health Implementation Plan (CHIP) builds upon the findings of our most recent Community Health Needs Assessment (CHNA). It outlines how CHRISTUS Trinity Mother Frances Health System 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 Trinity Mother Frances Health System, we envision a community where:

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

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

What This Plan Includes

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

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

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

The Communities We Serve

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

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

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

Systems of Care Principle

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

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

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

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

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

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

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

As we implement this plan, CHRISTUS Trinity Mother Frances Health System 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

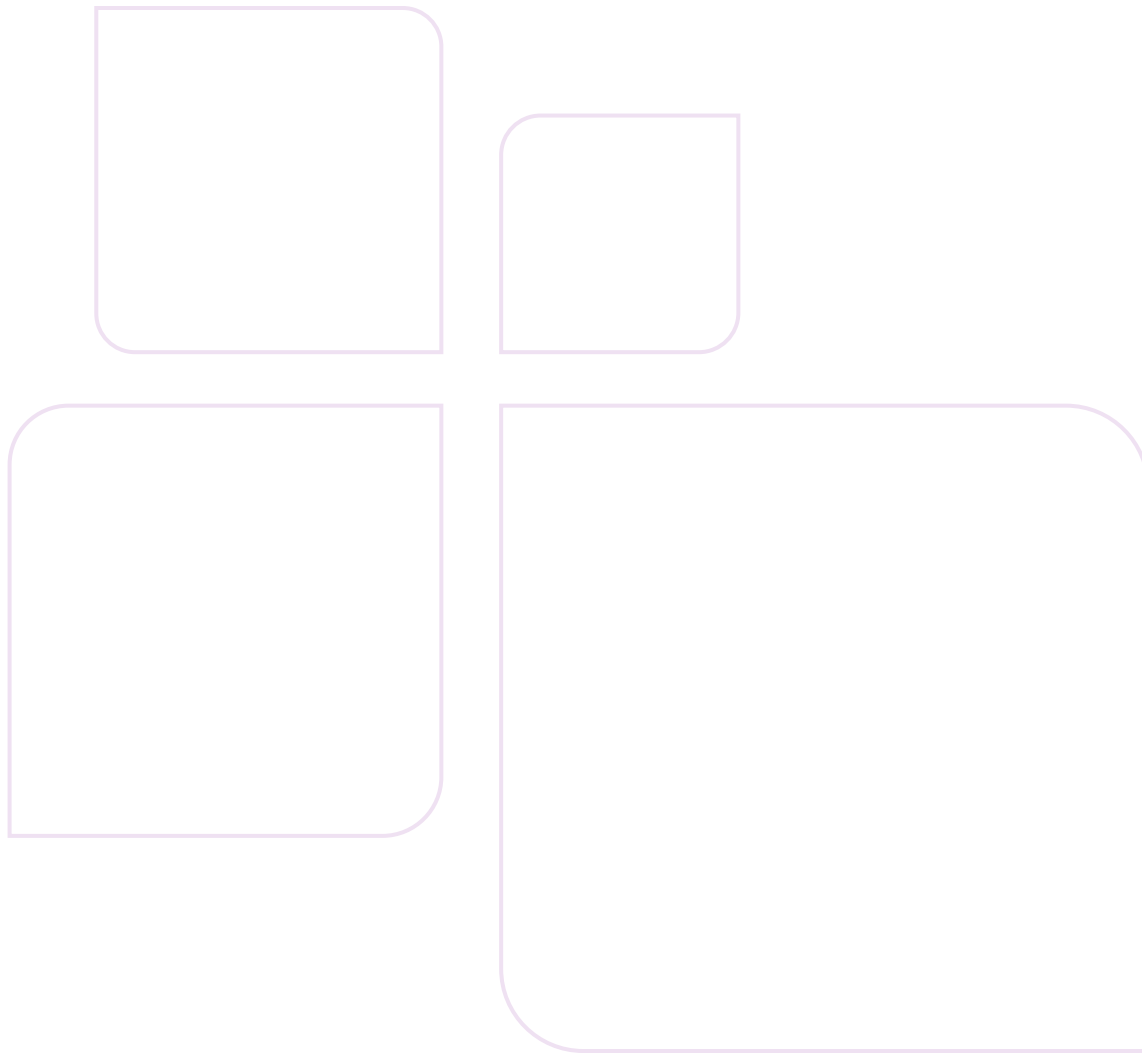
The final Community Health Needs Assessment (CHNA) report was completed, and the Ministry CEO/President and Executive Leadership Team of CHRISTUS Trinity Mother Frances Health System, including CHRISTUS Mother Frances Hospital - Jacksonville, CHRISTUS Mother Frances Hospital - Winnsboro, CHRISTUS Mother Frances Hospital - Sulphur Springs and CHRISTUS Mother Frances Hospital - Tyler, reviewed and approved the CHNA prior to June 30, 2025, with Board of Directors' ratification on July 31, 2025. Steps were also taken to begin implementation as of June 30, 2025, and the Community Health Implementation Plan (CHIP) was approved by the Board of Directors on July 31, 2025.

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



Chapter 2: Impact





Reflecting on Our Impact

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

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

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

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



Community Benefit

Our Commitment in Action

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

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

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

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

In addition to direct care and access, CHRISTUS invested in programs that address upstream drivers of health, such as food insecurity, housing instability and behavioral health access, through outreach, education and partnerships with local organizations.

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



So, what does the Community Benefit program driven by the CHNA and CHIP look like for CHRISTUS Trinity Mother Frances Health System by ministry? Here's a summary:

CHRISTUS Trinity Mother Frances Health System (Jacksonville, Sulphur Springs, Tyler and Winnsboro)

The Tyler ministry, including Jacksonville, Tyler and Winnsboro, averaged over \$6.86 million a year over the five-year period from 2021-2025 in expenditures totaling over \$34 million. Their focus areas included specialty care, behavioral health, primary care access, education, improving food insecurity, smoking and vaping. As a rule, the top areas were primary care access (support for FQHCs, EPIC access and pediatric services to low-income and underinsured); education (preceptorships for health care areas, public school foundations for scholarships and teacher support, health fairs and support programs), and behavioral health (community education, support for local services and conferences). Food insecurity was a fast-growing focus area, and in response to this need, our Winnsboro ministry provided an expansion opportunity for the food bank and Associates as volunteers. These types of volunteer programs are found in all CHRISTUS facilities to help address support for food banks and local community pantries, as well as support for local school programs that need volunteers. Educational support for nurses to get advanced training with local seminars and conference offerings in their local area was provided across the NETX region. Finally, a significant level of support for chronic diseases through education, health fairs and direct patient support was provided. Funding in grants, donations, volunteer time and in-kind donations supports 140 projects per year.

Sulphur Springs, which is part of the Tyler ministry, is an outstanding example of a hospital district that moved into the not-for-profit status and became fully engaged in the community benefit requirements for non-profit hospitals. Prior to joining CHRISTUS Health in 2016, the Sulphur Springs Hospital was not required to account for funding community programs and did not have an allocation for those programs. Today, nine years later, for FY2025, CHRISTUS Trinity Mother Frances Hospital - Sulphur Springs will report nearly \$1.5 million in community benefits. For the last five years, the total commitment was \$3.9 million. Major funding includes support for the local FQHC, CAREVIDE, including EPIC services and support for program opportunities and providers. They also have a monthly food security project with the First United Methodist Church, providing funding assistance for food costs for lunch monthly. And once a quarter, Associates volunteer to cook, serve and clean up for the weekly meal. They are also highly engaged in medical education with medical schools, colleges and universities, community colleges, EMS and high school programs. Community program support is extensive and meets the focus areas as designated by the community through the CHNA/CHIP process, supporting 48 projects per year.

FY23 Community Benefit Landscape - Tyler

Community services \$6.6 million		Charity care \$52 million	Total community benefits \$58.6 million	
\$3 million Community health improvements and strategic partnerships		\$811 thousand Health professionals' education and research	\$2 million Cash and in-kind distributions	\$825 thousand Community building activities

FY24 Community Benefit Landscape – Tyler

Community services \$9.3 million		Charity care \$47 million	Total community benefits \$56.3 million	
\$3.7 million Community health improvements and strategic partnerships		\$51 thousand Health professionals' education and research	\$3 million Subsidized health services	\$1.7 million Cash and in-kind distributions
				\$876 thousand Community building activities

FY25 Community Benefit Landscape - Tyler

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

FY23 Community Benefit Landscape – Jacksonville

Community services \$207 thousand		Charity care \$5 million	Total community benefits \$5.2 million
\$56 thousand Community health improvements and strategic partnerships		\$107 thousand Cash and in-kind distributions	\$44 thousand Community building activities

FY24 Community Benefit Landscape - Jacksonville

Community services \$147 thousand		Charity care \$3.8 million	Total community benefits \$5.2 million
\$10 thousand Community health improvements and strategic partnerships	\$4 thousand Subsidized health services	\$126 thousand Cash and in-kind distributions	\$73 thousand Community building activities

FY25 Community Benefit Landscape – Jacksonville

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

FY23 Community Benefit Landscape - Winnsboro

Community services \$62 thousand		Charity care \$2 million		Total community benefits \$2 million	
\$19 thousand Community health improvements and strategic partnerships		\$4 thousand Health professionals' education and research		\$29 thousand Cash and in-kind distributions	
				\$10 thousand Community building activities	

FY24 Community Benefit Landscape - Winnsboro

Community services \$105 thousand		Charity care \$1.6 million		Total community benefits \$1.7 million	
\$15 thousand Community health improvements and strategic partnerships		\$9 thousand Health professionals' education and research		\$4 thousand Subsidized health services	
				\$62 thousand Cash and in-kind distributions	
				\$15 thousand Community building activities	

FY25 Community Benefit Landscape - Winnsboro

At this point, 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.

FY23 Community Benefit Landscape - Sulphur Springs

Community services \$1.1 million		Charity care \$8.5 million		Total community benefits \$9.6 million	
\$440 thousand Community health improvements and strategic partnerships	\$29 thousand Health professionals' education and research	\$107 thousand Subsidized health services	\$495 thousand Cash and in-kind distributions	\$39 thousand Community building activities	

FY24 Community Benefit Landscape - Sulphur Springs

Community services \$1.1 million		Charity care \$9.3 million		Total community benefits \$10.4 million	
\$415 thousand Community health improvements and strategic partnerships	\$32 thousand Health professionals' education and research	\$244 thousand Subsidized health services	\$320 thousand Cash and in-kind distributions	\$85 thousand Community building activities	

FY25 Community Benefit Landscape - Sulphur Springs

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

Community Impact Fund

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

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

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

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

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



FY23 Community Impact Fund

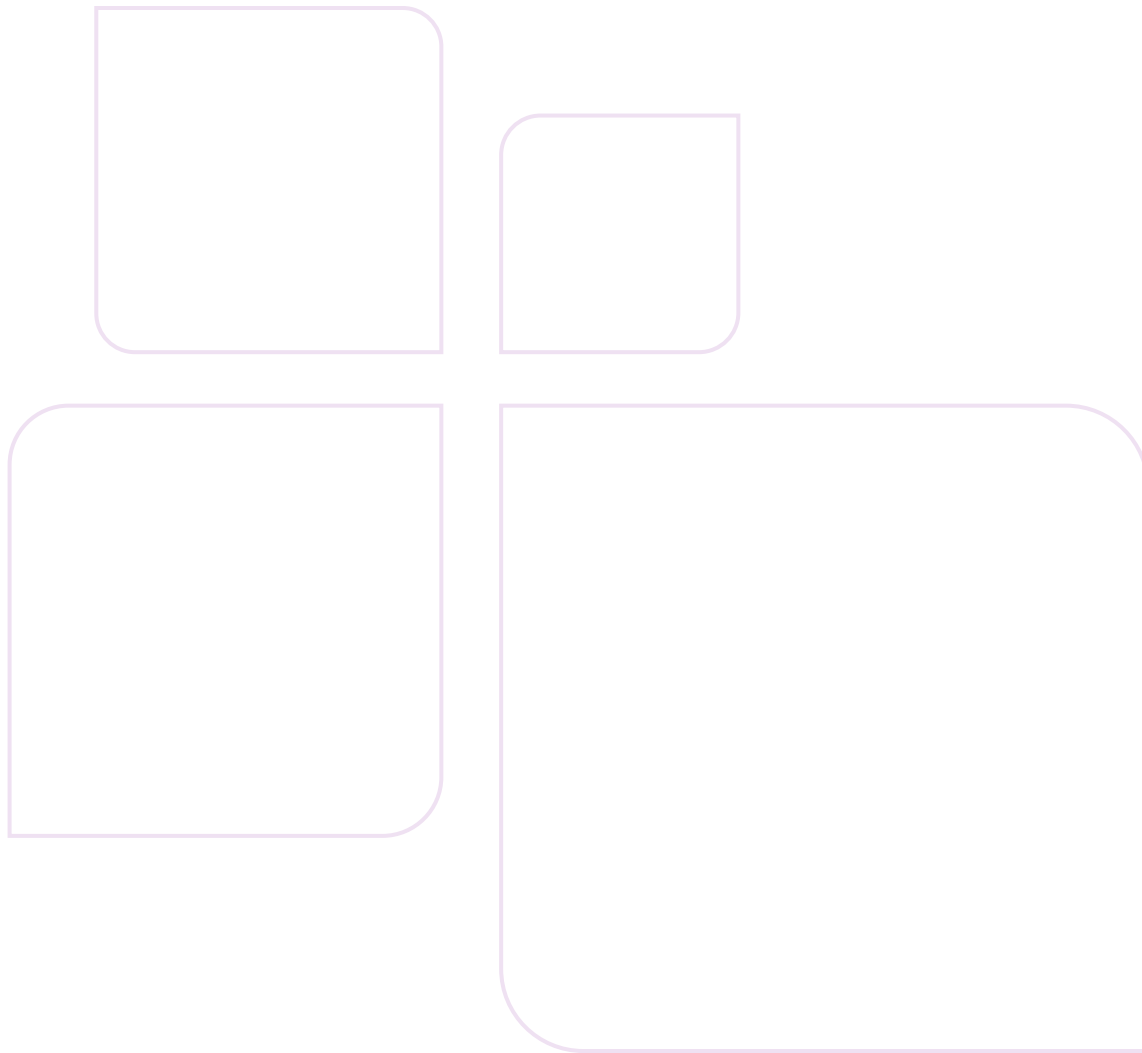
ORGANIZATION	DOMAIN	PRIORITY	PROGRAM NAME	PROGRAM DESCRIPTION
Children's Advocacy Center of Smith County	Advance health and well-being	Mental health and well-being	Trauma Informed Schools	To establish trauma-informed schools in Smith County that offer children learning environments that reduce trauma
For the Silent	Advance health and well-being	Mental health and well-being	Evidence-Based Mental Health Care for Trafficked Youth	To provide evidence-based mental health care and support services to high-risk and trafficked youth and young adults
PATH (People Attempting to Help)	Build resilient communities and improve social determinants	Education	A PATH Home from School	To provide financial assistance to families with elementary-aged students who are economically disadvantaged or experiencing homelessness to address student mobility rates and educational outcomes
Total CHRISTUS Community Impact Fund investment:				\$250,000.00

FY24 Community Impact Fund

ORGANIZATION	DOMAIN	PRIORITY	PROGRAM NAME	PROGRAM DESCRIPTION
Carevide	Advance health and well-being	Chronic diseases	Increasing Quality Through Care Coordination	To advance the health and well-being of Hopkins County by supporting the health care center's engagement in a value-based health care delivery model
Children's Advocacy Center of Smith County	Advance health and well-being	Mental health and well-being	Trauma Informed Schools	To establish trauma-informed schools in Smith County that offer children learning environments that reduce trauma
PATH (People Attempting to Help)	Build resilient communities and improve social determinants	Safe housing	A PATH Home from School	To provide financial assistance to families with elementary-aged students who are economically disadvantaged or experiencing homelessness to address student mobility rates and educational outcomes
St. Vincent de Paul	Build resilient communities and improve social determinants	Healthy food access	Feeding the Hungry	To improve food security by being a reliable and sustainable supplemental source of food
Total CHRISTUS Community Impact Fund investment:				\$300,000.00

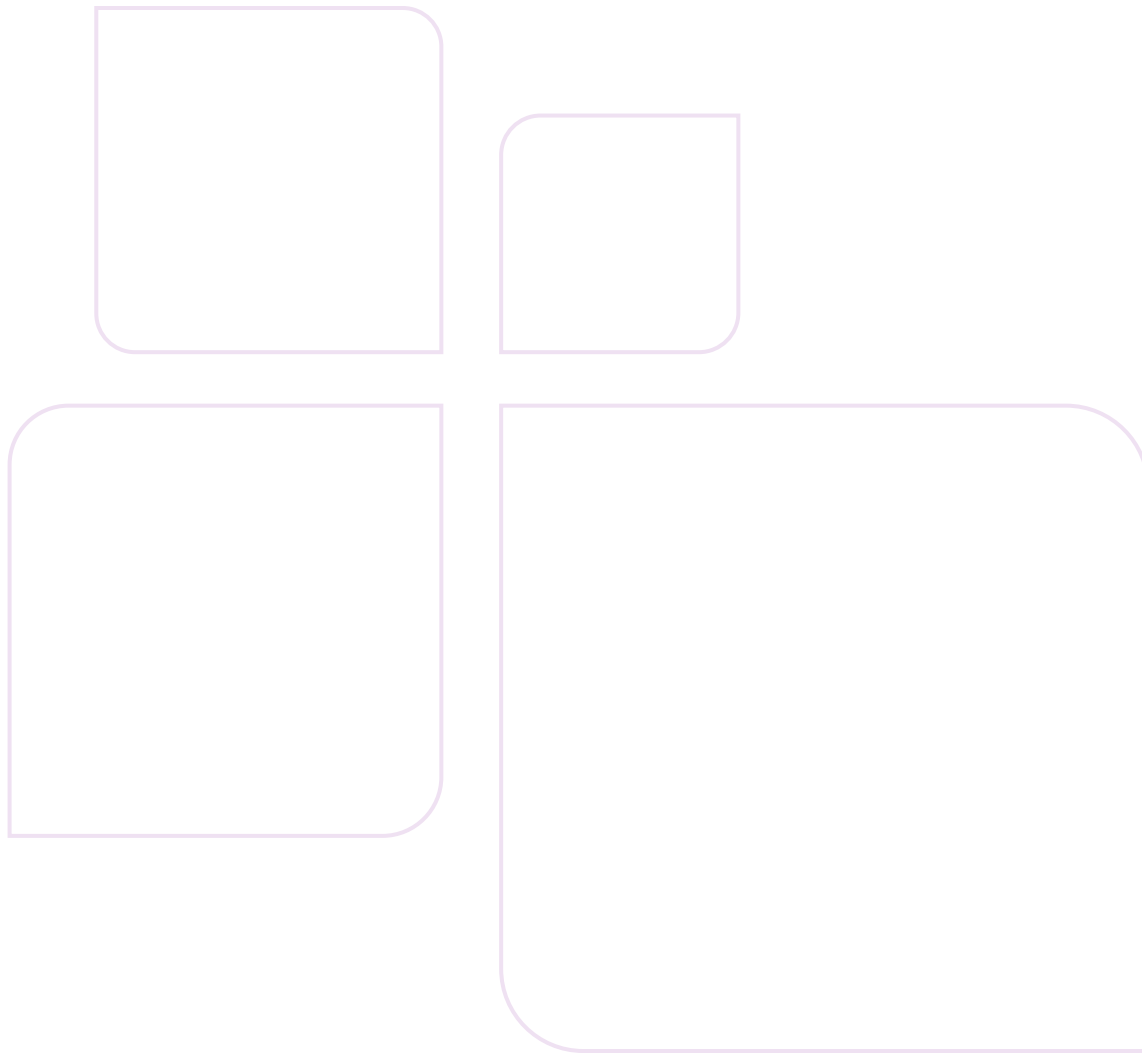
FY25 Community Impact Fund

ORGANIZATION	DOMAIN	PRIORITY	PROGRAM NAME	PROGRAM DESCRIPTION
Carevide	Advance health and well-being	Chronic diseases	Increasing Quality Through Care Coordination	To employ nurse care coordinators to help coordinate care between providers, provide patient education and make referrals to social services for patients
Children's Advocacy Center of Smith County	Advance health and well-being	Mental health and well-being	Trauma Informed Schools	To identify, understand and address the needs of children by training adults who work with children in trauma-informed care
East Texas Food Bank	Build resilient communities and improve social determinants	Healthy food access	Tyler Resource Center	To increase food distribution and expand services to low-income households in Smith County through the Tyler Resource Center
PATH (People Attempting to Help)	Build resilient communities and improve social determinants	Safe housing	A PATH Home from School	To reduce mobility rates, support academic success and strengthen family stability by providing housing financial assistance to families in the Tyler Independent School District
St. Vincent de Paul	Build resilient communities and improve social determinants	Healthy food access	Feeding the Hungry	To increase food security to neighbors by offering pantry sessions every Monday night
Total CHRISTUS Community Impact Fund investment:				\$315,000.00



Chapter 3: Priorities





Priorities and Focus

The Lifespan Approach

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

CHRISTUS Trinity Mother Frances Health System identifies three to five leading health indicators within each of the following four life stages:

- **Maternal and early childhood (pregnancy through Age 4)**
- **School-age children and adolescents (ages 5-17)**
- **Adults (ages 18-64)**
- **Older adults (ages 65-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 Trinity Mother Frances Health System 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 Trinity Mother Frances Health System used a data-informed and community-driven approach grounded in the Results-Based Accountability (RBA) framework. This method ensures that decisions are rooted in both quantitative data and the lived experiences of community members.

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

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

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

- Can we trust the data?
- Is the indicator easy to explain and understand?
- Does it represent a larger community's 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 stages. These indicators highlight the areas of greatest need, concern and opportunity for impact. They now serve as a shared focus for CHRISTUS Trinity Mother Frances Health System’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 CHRISTUS Trinity Mother Frances 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 Trinity Mother Frances Health System Community Health Needs Assessment, available at CHRISTUS Health's website:

CHRISTUShealth.org/connect/community/community-needs



CHRISTUS Mother Frances Hospital - Tyler and CHRISTUS Mother Frances Hospital - Jacksonville

COMMUNITY LEADING INDICATORS			
Maternal Health and Early childhood Health	School-Age Children and Adolescent Health	Adult Health	Older Adult Health
<i>Mothers and babies will have access to the care and support needed for healthy pregnancies, childbirth, growth and development.</i>	<i>Children will be well-equipped with the care and support to grow up physically and mentally healthy.</i>	<i>Adults will have access to the care, support and opportunities needed to maintain physical and mental health throughout their lives.</i>	<i>Older adults will have accessible and empowering environments to ensure that every person can age with health and socioeconomic well-being.</i>
• Access to care ◦ Prenatal care ◦ OBGYNs ◦ Continuity of care* • Chronic diseases ◦ Obesity ◦ Diabetes • Health literacy • Child care • Behavioral health* ◦ Mental health* ◦ Substance abuse* • Poverty*	• Behavioral health ◦ Mental health ◦ Substance abuse • Obesity • Food insecurity • Abuse • Poverty* • Workforce Development/employment*	• Access to care/primary care ◦ Preventative care* ◦ Insurance* • Chronic conditions ◦ Diabetes ◦ Cancer ◦ Heart disease ◦ Obesity • Food insecurity • Behavioral health* ◦ Mental health* ◦ Substance abuse* • Housing instability*	• Access to care/primary care ◦ Long-term care cost* ◦ Medication cost* • Behavioral health ◦ Alzheimer's and dementia ◦ Depression ◦ Social isolation* • Health education • Food insecurity ◦ Inability to perform tasks of daily living*

CHRISTUS Mother Frances Hospital - Winnsboro and CHRISTUS Mother Frances Hospital - Sulphur Springs

COMMUNITY LEADING INDICATORS			
Maternal Health and Early Childhood Health	School-Age Children and Adolescent Health	Adult Health	Older Adult Health
<i>Mothers and babies will have access to the care and support needed for healthy pregnancies, childbirth, growth and development.</i>	<i>Children will be well-equipped with the care and support to grow up physically and mentally healthy.</i>	<i>Adults will have access to the care, support and opportunities needed to maintain physical and mental health throughout their lives.</i>	<i>Older adults will have accessible and empowering environments to ensure that every person can age with health and socioeconomic well-being.</i>
• Access to care ◦ Prenatal care • Behavioral health ◦ Mental health ◦ Social media • Food insecurity • Poverty ◦ High cost of living • Children in foster care	• Access to primary care • Behavioral health ◦ Mental health ◦ Social media, screen time, phone addiction ◦ Anxiety ◦ Depression • Food insecurity • Education/workforce development • English as second language • Poverty	• Access to primary care • Chronic diseases ◦ Diabetes ◦ Cancer • Food insecurity • Behavioral health ◦ Mental health ◦ Substance abuse	• Mobility • Falls • Behavioral health ◦ Alzheimer's and dementia ◦ Social isolation • Access to care ◦ Medication cost • Poverty • Food insecurity • Housing instability

Needs That Are Not Being Addressed

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

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

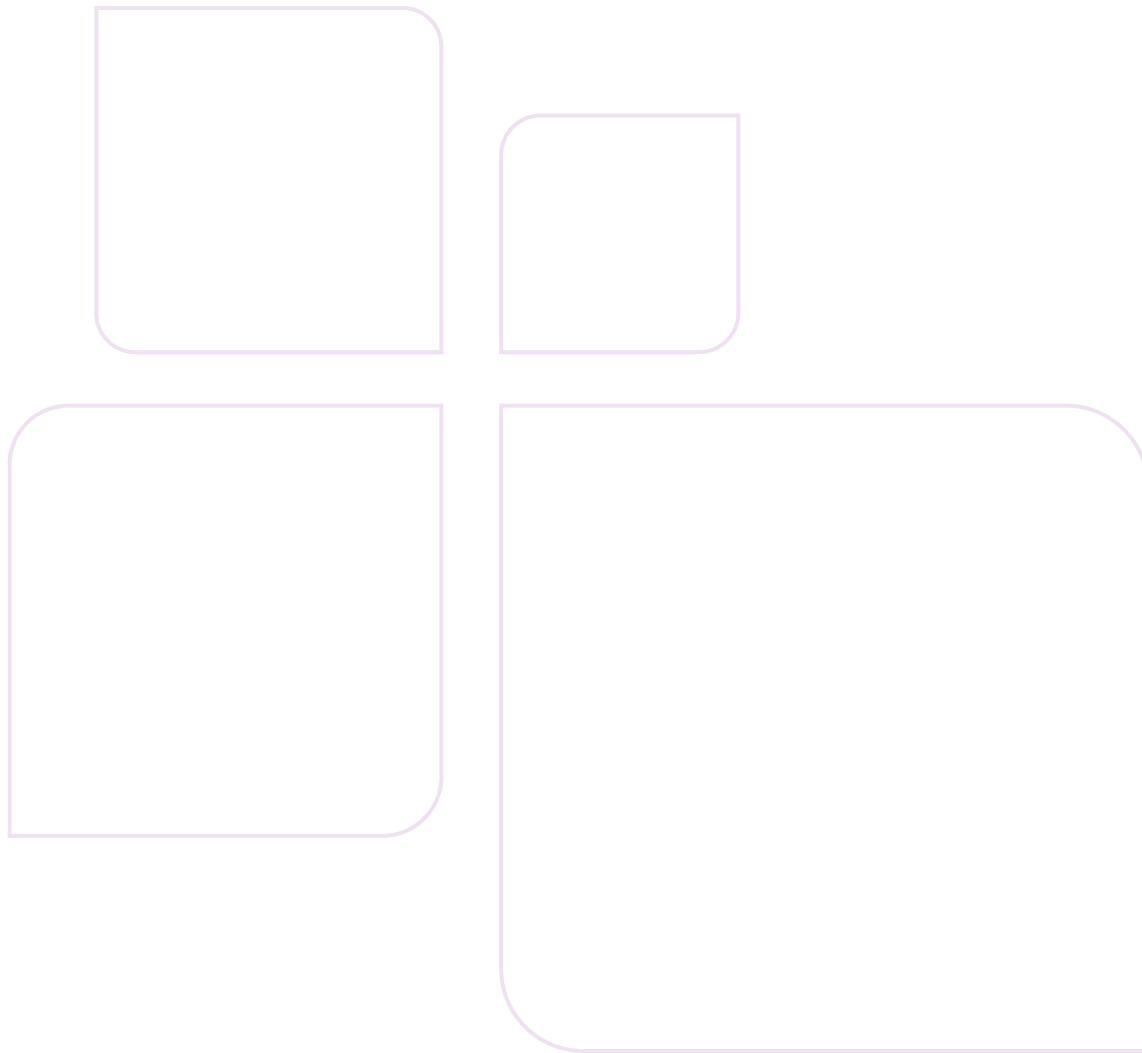
- Social media and social isolation
- Inability to perform activities of daily living
- Long-term care cost
- Phone addiction
- Screen time

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

The section that follows will highlight where CHRISTUS Trinity Mother Frances Health System is playing a supportive or collaborative role on these issues, including how we are coordinating with trusted organizations and multi-sector partners. These collaborative efforts are crucial to developing a more comprehensive, equitable and effective system of care throughout our region.

Chapter 4: Strategies





Strategies

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

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

Initiatives led directly by CTMFHS, typically aligned with hospital and clinical operations. Examples include expanding access to specialty care, implementing chronic disease management programs, and enhancing maternal and child health services.

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

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

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

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

As a first step in developing these strategies, the leading health indicators were categorized using common language and mapped across lifespan stages. This approach helps align local and system-level strategies with health data, community survey responses, and feedback

from focus groups. Each strategy is then evaluated against available hospital, community, and system resources to ensure feasibility and impact.

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

To improve how we capture and evaluate community health activities, we have renamed and reformatted the *Community Leading Indicators*, which can be found on the next page. While the indicators themselves remain the same, the updated format aligns more closely with our internal tracking systems and reporting needs.

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

LEADING INDICATORS

Maternal Health and Early Childhood Health	School-Age Children and Adolescent Health	Adult Health	Older Adult Health
<i>Mothers and babies will have access to the care and support needed for healthy pregnancies, childbirth, growth and development.</i>	<i>Children will be well-equipped with the care and support to grow up physically and mentally healthy.</i>	<i>Adults will have access to the care, support and opportunities needed to maintain physical and mental health throughout their lives.</i>	<i>Older adults will have accessible and empowering environments to ensure that every person can age with health and socioeconomic well-being.</i>
A. Primary care 1. Access 2. Prenatal care 3. OBGYNs 4. Continuity of care B. Specialty care and chronic diseases 1. Obesity 2. Diabetes 3. Heart disease 4. Cancer C. Behavioral health 1. Mental health 2. Substance abuse 3. Social media (as it relates to mental health) 4. Children in foster care D. Education and workforce development 1. Health literacy 2. Poverty 3. High cost of living E. Food insecurity F. Child care	A. Primary care 1. Access B. Specialty care and chronic diseases 1. Obesity 2. Diabetes 3. Heart disease 4. Cancer 5. Ortho C. Behavioral health 1. Mental health 2. Substance abuse 3. Social media 4. Screen time 5. Phone addiction 6. Anxiety 7. Depression 8. Abuse D. Education and workforce development 1. Health literacy* 2. Poverty* 3. Employment* E. Food insecurity F. Language barriers 1. English as a second language	A. Primary care 1. Access 2. Preventive care* 3. Insurance 4. Primary care B. Specialty care and chronic diseases 1. Obesity 2. Diabetes 3. Heart disease 4. Cancer 5. Ortho C. Behavioral health 1. Mental health 2. Substance abuse D. Education and workforce development 1. Health literacy E. Food insecurity F. Housing instability	A. Primary care 1. Access 2. Long-term care cost 3. Medication cost B. Specialty care and chronic disease 1. Obesity 2. Diabetes 3. Heart disease 4. Cancer 5. Ortho C. Behavioral health 1. Alzheimer's and dementia 2. Depression 3. Social isolation 4. Abuse D. Education and workforce development 1. Health literacy 2. Poverty E. Food insecurity F. Housing instability G. Activities of daily living 1. Inability to perform tasks of daily living 2. Mobility 3. Falls

Maternal and Early Childhood Health

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

LEAD INDICATORS

A. Primary care

1. Access
2. Prenatal care
3. OBGYNs
4. Continuity of care

B. Specialty care and chronic diseases

1. Obesity
2. Diabetes
3. Heart disease
4. Cancer

C. Behavioral health

1. Mental health
2. Substance abuse
3. Social media (as it relates to mental health)
4. Children in foster care

D. Education and workforce development

1. Health literacy
2. Poverty
3. High cost of living

E. Food insecurity

F. Child care

DATA MEASURES

- Postpartum depression
- Uninsured rate
- Smoking during pregnancy
- Births to mothers with obesity
- Poor literacy and functionally illiterate
- Preterm births
- Vaccine coverage estimate
- Neonatal abstinence syndrome rate
- Food insecurity
- Poverty rate
- Prenatal care in first trimester
- Households below ALICE threshold

MATERNAL AND EARLY CHILDHOOD HEALTH STRATEGIES		
Hospital direct care strategies	Community funding strategies	Community partners strategies
"We lead"	"We fund"	"They lead"
A1. Encourage patients to establish a primary care medical home. A2. Research and consideration of developing expanded access points for prenatal, mother/baby and pre-k patients. B1. Education and screening for chronic diseases C1. Improve access to care, information and support services for people with or at risk of behavioral health needs. D1. Provide educational classes for new moms and families. E1. Hold an internal collaborative meeting of department and providers to determine key issues contributing to food insecurity and potential actions (EOC). E2. Improve screening and referral for social determinants of health (SDoH), particularly food insecurity.	A1. Fund Community Connect/Epic services to FQHCs and non-profits. A2. Expand opportunities with other local non-profit organizations and governmental entities to provide primary care. B1. Ensure patient services for high-risk pregnancies; NICU and pediatric services meet community needs. C1. Offer financial and in-kind support to community organizations involved in the delivery of behavioral health services (see C1 community partners). D1. Provide support to local non-profit organizations who provide educational programs for young families. E1. Support non-profit programs for food insecurity. F1. Support non-profit programs for child care.	A1. Collaborate with local FQHCs, public health departments and Bethesda health to expand and improve access, education and information sharing. B1. Education and screening for chronic diseases C1. We will focus on supporting a coalition to address behavioral health issues in the service area. Partners include American Suicide Prevention Programs, Mosaic Counseling of East Texas, Women in Tyler, Smith County Behavioral Leadership Council, Women's Abuse Programs, women support groups in communities, children in foster care and others. Support development of coalition to address social media issues. D1. Support "Healthy Me/Healthy Baby" collaboration. E1. Collaborate with non-profits who provide food distribution, pantries and support food drives in the priority service area.

School-Age Children and Adolescent Health

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

LEAD INDICATORS

- A. Primary care**
 - 1. Access
- B. Specialty care and chronic diseases**
 - 1. Obesity
 - 2. Diabetes
 - 3. Heart disease
 - 4. Cancer
 - 5. Ortho
- C. Behavioral health**
 - 1. Mental health
 - 2. Substance abuse
 - 3. Social media
 - 4. Screen time
 - 5. Phone addiction
 - 6. Anxiety
 - 7. Depression
 - 8. Abuse
- D. Education and workforce development**
 - 1. Health literacy*
 - 2. Poverty
 - 3. Employment*
- E. Food insecurity**
- F. Language barriers**
 - 1. English as a second language

DATA MEASURES

- Poverty rate
- Food insecurity
- High school graduation rate
- Higher degree graduation rate
- Screentime impact on mental health
- Poverty rate
- High school graduation rate
- Food insecurity
- Uninsured rate
- Mental health among teens in Texas
- Substance use among Texas students
- Obesity
- Feeling sad or hopeless
- Higher degree graduation rate

SCHOOL-AGE CHILDREN AND ADOLESCENT HEALTH STRATEGIES		
Hospital direct care strategies	Community funding strategies	Community partners strategies
"We lead"	"We fund"	"They lead"
A1. Encourage patients to establish a primary care medical home. A2. Provide community-based screening assessments and education to low-income, uninsured and special request populations. B1. Provide pediatrics diabetes educator and pediatric diabetes education within clinics. B2. Offer diabetes education within local elementary and high schools. C1. Improve access to care, information and support services for people with or at risk of behavioral health needs. D1. Provide mentoring staff, faculty assistance as requested for students in health care programs and investigate developing job training programs in conjunction with higher education including all aspects of health care for student internships.	A1. Expand opportunities with other not-for profit organizations and governmental entities to provide primary care. B1. Continue community education initiatives focused on chronic disease prevention, as well as support health promotion portions of community events/programs. B2. Provide free orthopedic services to low-income schools, including on-site services, rehab, education and screenings. C1. Offer financial and in-kind support to community organizations involved in the delivery of behavioral health services (see C1 community partners). D1. Identify programs that help to support and fund k-12 and higher education scholarships.	A1. Collaborate with local FQHCs, public health departments and Bethesda health to expand and improve access, education and information sharing. B1. Develop education programs for faculty and students based on request. B2. Work with school districts and community colleges to provide training, screenings, education and follow-up care at reduced or free rates. C1. We will focus on supporting a coalition to address behavioral health issues in the service area. Partners include American Suicide Prevention Programs, Mosaic Counseling of East Texas, Women's Fund, Smith County Behavioral Leadership Council, Women's Abuse Programs, women support groups in communities, children in foster care and others. Support development of coalition to address social media issues. D1. Research and identify programs that help to support diversity programs and educational projects.

SCHOOL-AGE CHILDREN AND ADOLESCENT HEALTH STRATEGIES		
Hospital direct care strategies	Community funding strategies	Community partners strategies
"We lead"	"We fund"	"They lead"
D2. Deliver women with heart program which includes education, scholarships and screenings. D3. Offer job shadowing programs for junior high, high school and college students within the health care programs/ jobs offered as needed. E1. Hold a collaborative meeting to determine key issues contributing to food insecurity and potential actions. E2. Improve screening and referral for social determinants of health (SDoH), particularly food insecurity.	E1. Fund The Backpack Program to provide healthy food to children and families throughout the school year and summer months and other programs as identified.	E1. Collaborate with non-profits who provide food distribution, pantries and support food drives in the priority service area.

Adult Health

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

LEAD INDICATORS

- A. Primary care
 - 1. Access
 - 2. Preventative care
 - 3. Insurance
 - 4. Primary care
- B. Specialty care and chronic diseases
 - 1. Obesity
 - 2. Diabetes
 - 3. Heart disease
 - 4. Cancer
 - 5. Ortho
- C. Behavioral health
 - 1. Mental health
 - 2. Substance abuse
- D. Education and workforce development
 - 1. Health literacy
- E. Food insecurity
- F. Housing instability

DATA MEASURES

- Poor self-reported mental health
- Suicide mortality
- Cancer mortality
- Diabetes mortality
- Drug overdose mortality
- Diabetes mortality
- Food insecurity
- Cancer diagnosis rate
- Visited doctor for routine checkup
- Drug overdose mortality
- Households below ALICE threshold
- Uninsured rate by age group
- Coronary heart disease mortality
- Obesity
- Depression
- Poor self-reported mental health
- Food insecurity
- Physician use delayed due to cost

ADULT HEALTH STRATEGIES		
Hospital direct care strategies	Community funding strategies	Community partners strategies
"We lead"	"We fund"	"They lead"
A1. Encourage patients to establish a primary care medical home. A2. Provide community-based screening assessments and education to low-income, uninsured and special request populations. B1. Work on improving access to providers in all areas. C1. Improve access to care, information and support services for people with or at risk of behavioral health needs. D1. Provide mentoring staff, faculty assistance as requested for students in health care programs and investigate developing job training programs in conjunction with higher education including all aspects of health care for student internships. E1. Hold a collaborative meeting to determine key issues contributing to food insecurity and potential actions. E2. Improve screening and referral for social determinants of health (SDoH), particularly food insecurity.	A1. Expand opportunities with other not-for-profit organizations and governmental entities to provide primary care. B1. Continue community education initiatives focused on chronic disease prevention, as well as support health promotion portions of community events/programs. C1. Offer financial and in-kind support to community organizations involved in the delivery of behavioral health services (see C1 community partners). D1. Continue to invest in care delivery innovations and expand programs that educate the community including scholarships, and training programs. E1. Support non-profit programs for food insecurity.	A1. Collaborate with local FQHCs, public health departments and Bethesda health to expand and improve access, education and information sharing. B1. Collaborate with governmental and community groups on impacting access to mammograms and other screenings. C1. We will focus on supporting a coalition to address behavioral health issues in the service area. Partners include Alzheimer's Alliance, American Suicide Prevention Programs, Mosaic Counseling of East Texas, Women in Tyler, Smith County Behavioral Leadership Council, Women's Abuse Programs, women support groups in communities, children in foster care and others. Support development of coalition to address social media issues. D1. Research and identify programs that help to develop leadership programs for students and community members.. E1. Collaborate with non-profits who provide food distribution, pantries and support food drives in the priority service area.

Older Adult Health

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

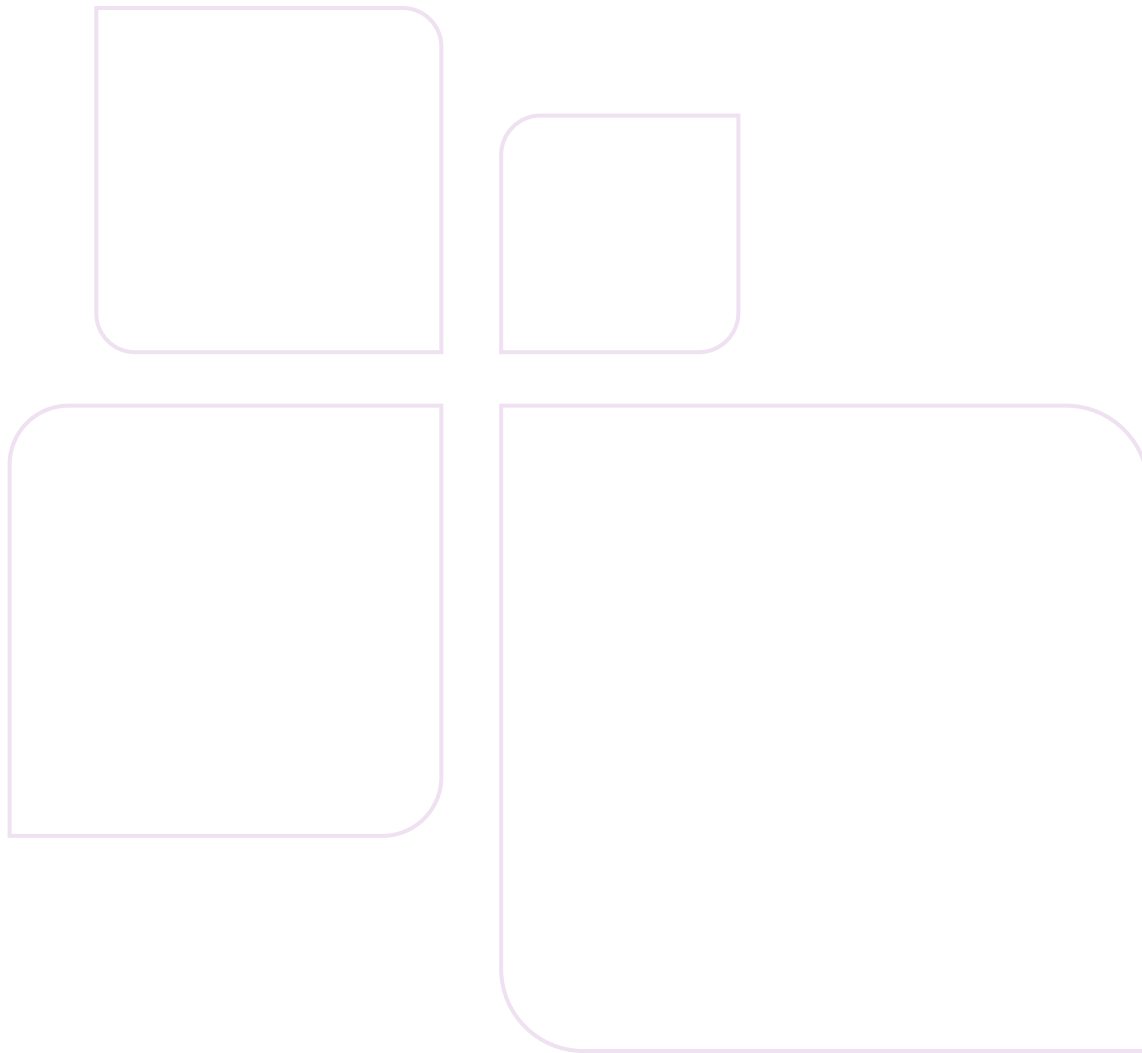
LEAD INDICATORS

- A. Primary care
 - 1. Access
 - 2. Long-term care cost
 - 3. Medication cost
- B. Specialty care and chronic disease
 - 1. Obesity
 - 2. Diabetes
 - 3. Heart disease
 - 4. Cancer
 - 5. Ortho
- C. Behavioral health
 - 1. Alzheimer's and dementia
 - 2. Depression
 - 3. Social isolation
 - 4. Abuse
- D. Education and workforce development
 - 1. Health literacy
 - 2. Poverty
- E. Food insecurity
- F. Housing instability
- G. Activities of daily living
 - 1. Inability to perform tasks of daily living
 - 2. Mobility
 - 3. Falls

DATA MEASURES

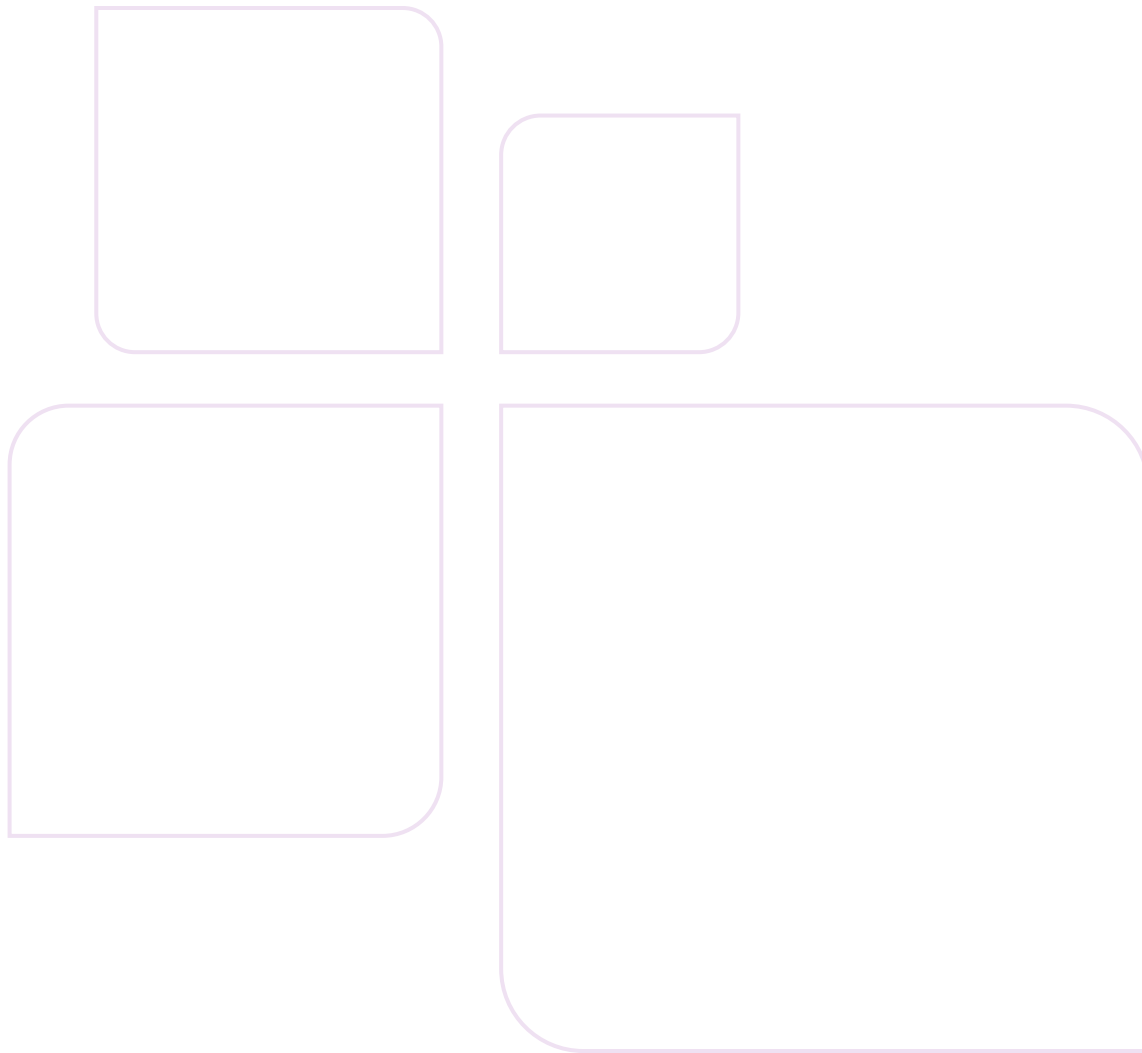
- Alzheimer's disease mortality
- Seniors living alone
- Medicare Part B drugs per capita costs
- Poverty rate
- Housing insecurity
- Fall mortality
- Food insecurity
- Independent living difficulty
- Medicare LTACH per user costs
- Depression in Medicare beneficiaries
- Very low food access
- ALICE 65+ survival budget
- Poor literacy and functionally illiterate
- Family care burden
- Caregiver support

OLDER ADULT HEALTH STRATEGIES		
Hospital direct care strategies	Community funding strategies	Community partners strategies
"We lead"	"We fund"	"They lead"
A1. Encourage patients to establish a primary care medical home. A2. Provide community-based screening assessments and education to low-income, uninsured and special request populations. B1. Work on improving access to providers in all areas. C1. Improve access to care, information and support services for people with or at risk of behavioral health needs. D1. Support development of health-related education programs and opportunities for older adults. E1. Hold a collaborative meeting to determine key issues contributing to food insecurity and potential actions. E2. Improve screening and referral for social determinants of health (SDoH), particularly food insecurity.	A1. Provide community-based screening assessments and education to low-income, uninsured and special request populations. B1. Continue community education initiatives focused on chronic disease prevention, as well as support health promotion portions of community events/programs. C1. Offer financial and in-kind support to community organizations involved in the delivery of behavioral health services (see C1 community partners). D1. Continue to invest in care delivery innovations and expand programs that educate the community including scholarships, health education and training programs. E1. Support non-profit programs for food insecurity.	A1. Collaborate with local FQHCs, public health departments and Bethesda health to expand and improve access, education and information sharing. B1. Collaborate with governmental and community groups on impacting access to mammograms and other screenings. C1. We will focus on supporting a coalition to address behavioral health issues in the service area. Partners include Alzheimer's Alliance, American Suicide Prevention Programs, Mosaic Counseling of East Texas, Women in Tyler, Smith County Behavioral Leadership Council, Women's Abuse Programs, women support groups in communities, children in foster care and others. Support development of coalition to address social media issues. D1. Research and identify programs that help to develop leadership programs for students and community members. E1. Collaborate with non-profits who provide food distribution, pantries and support food drives in the priority service area.



Chapter 5: Conclusion





Conclusion

The CHRISTUS Trinity Mother Frances Health System's 2026-2028 Community Health Implementation Plan will guide the system's strategies over the next three years. The CHIP aligns the health priorities identified in the CHNA with those of CTMFHS focusing on direct care, community benefit funding and community partnerships and collaborations. The triannual Community Health Needs Assessment and Community Health Implementation Plan provide a routine opportunity for CTMFHS and its community partners to assess community health needs and outline how they will be addressed together.



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

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

Contact Information

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

CHRISTUS Health's website:

CHRISTUShealth.org/connect/community/community-needs



