CHI St. Joseph Health

2019 Community Health Implementation Strategy

Adopted October 2019

CHI St. Joseph Health

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At-a-Glance Summary

Community Served

Our service area covers the Brazos Valley region including Brazos, Burleson, Grimes, Lee, Leon, Madison, Milam, Robertson and Washington counties.

Significant Community Health Needs Being Addressed

The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are:

- 1. Mental Health Services
- 2. Access to Health-Related Care
- 3. Risk Factors
- 4. Communication and Coordination

Strategies and Programs to Address Needs

The hospital intends to take actions and to dedicate resources to address these needs, including:

1) Mental Health Services
- Senior Renewal Program
- Telehealth Counseling Services
- Seek community partnerships for mental health services

2) Access to Health-Related Care
- ED Diversion and Patient Navigation Program
- Home Visit Program

3) Risk Factors
- Diabetes Education Program
- Chronic Disease Self-Management

4) Communication and Coordination
- Health Navigators
- Health Resource Centers

Anticipated Impact

Our anticipated impact for these strategies and programs is to continue to support our community's health needs through education and resource coordination, and identify new programming and partnership opportunities to better serve the health needs of our growing community.

Planned Collaboration

- Senior Renewal Program
- Texas A&M College of Medicine - Telehealth Counseling
- Texas A&M Center for Population Health & Aging – Diabetes Program
- Texas A&M Health Science Center
- Burleson Health Resource Center
- Grimes Health Resource Center
- Madison Health Resource Center
- Brazos Health Resource Center
- HealthPoint Clinics (FQHC)
- DSRIP (1115 Waiver)

This document is publicly available online at https://www.chistjoseph.org/about-us/community-benefit.

Written comments on this report can be submitted to the Healthy Communities Department; 2801 Franciscan Drive, Bryan, TX. 77802, Attn: Fawn Preuss, or by e-mail to HealthyCommunities@st-joseph.org.

Our Hospital and the Community Served

About CHI St. Joseph Health

Since 1936, CHI St. Joseph Health has been caring for the communities of the Brazos Valley. With the area's only Level II Trauma Center, the first Joint Commission certified Primary Stroke Center, and the first accredited Chest Pain Center in the Brazos Valley, CHI St. Joseph Health is a leader in critical care and the largest provider of cardiovascular care in the region, which is comprised of the counties of Brazos, Burleson, Grimes, Lee, Leon, Madison, Milam, Robertson and Washington.

As an integrated healthcare system, CHI St. Joseph Health includes a comprehensive network of over 100 employed providers including primary care physicians, specialists and advanced practice clinicians. Our network includes more than 50 ambulatory clinic settings featuring primary care, specialty care, Express Clinics, and imaging and diagnostic services. Earlier this year, CHI St. Joseph Health added College Station Hospital to its organization, bringing the number of hospital locations to five.

The CHI St. Joseph and Texas A&M Health Network is a primary care clinical and academic partnership with Texas A&M University Health Science Center. As an active member of the Brazos Valley, CHI St. Joseph Health is a leader in providing compassionate care as well as addressing the overall health of the community. It is part of Catholic Health Initiatives (CHI) which recently joined with Dignity Health to form CommonSpirit Health, a new nonprofit national health system committed to advancing the health of all people and dedicated to serving the common good.

"The Sisters of St. Francis, Sylvania, Ohio are sponsors of St. Joseph Health System. Our faith-based ministry is rooted in our belief that every life is sacred. Our employees and physicians minister as a team, guided by God's call to foster healing as we strive to transform hurt into hope." – Sr. Penny Dunn, Vice President, Mission Integration.

Our Mission

The mission of Catholic Health Initiatives and CHI St. Joseph Health is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we create healthier communities.

Financial Assistance for Medically Necessary Care

CHI St. Joseph Health delivers compassionate, high quality, affordable healthcare and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary healthcare services, and who otherwise may not be able to receive these services. The financial assistance policy and a plain language summary of the policy are on the hospital's website.

Description of the Community Served

CHI St. Joseph Health serves the Brazos Valley region including Brazos, Burleson, Grimes, Lee, Leon, Madison, Milam, Robertson and Washington counties. A summary description of the community is below. Additional details can be found in the CHNA report online.

Based on the U.S. Census Bureau's 2018 estimate, the population of the greater Brazos Valley region is 387,580 people, an increase of 11.4% since the 2010 Census. The median age for the region is 32.2 years, with variation by county from 44.7 years for Leon County to 25.8 years for Brazos County (the presence of Texas A&M University students can be assumed to contribute most substantially to this difference).

59% of the region are reported as White, Not-Hispanic, 13% reported as Black/African- American, Not Hispanic, 24% as Hispanic, Any Race, and 5% as All Other Races, Not Hispanic. Again, as in age distribution, the greater Brazos Valley region more closely reflects the racial/ethnic composition of the United States (60.7% White, Not Hispanic) than it does the rest of the State of Texas (42.0% White, Not Hispanic).

The greater Brazos Valley region has a higher proportion of residents with bachelor's degree or higher, at 30.9%, than either the State of Texas at 18.8% or the United States at 19.1%. Within the region that rate varies from a low of 13.0% in Madison County to a high of 40.0% in Brazos County. Washington County has the lowest percentage of population with less than a High School education at 6.0% and Austin and Madison County have the highest rate at 9.0%.

The 3.6% unemployment rate for the greater Brazos Valley region is equivalent to the rate for the entire State (3.7%) and only slightly lower than the nation (3.9%). Among Brazos Valley counties, the lowest unemployment rate was reported in Brazos County (2.8%), and the highest in Leon County where it was 5.0%. The estimated 2017 home ownership rate for the greater Brazos Valley region is 58.3%, lower than the State rate of 62.0% and the national rate of 63.8%.

The per capita income reported by the Census Bureau's 2017 estimate is $24,996 for the greater Brazos Valley region, varying among the counties from $17,436 in Madison County to $30,101 in Austin County. The greater Brazos Valley region has a higher rate of residents with incomes at 200% of the FPL or lower when compared to the State and nation (36.9%, 68.0%, and 72.0%, respectively).

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited to, conducting a Community Health Needs Assessment (CHNA) with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community health implementation strategy and programs were identified in the most recent CHNA report, which was adopted in May 2019. The CHNA contains several key elements, including:

- Description of the assessed communities served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at https://www.chistjoseph.org/about-us/community-benefit or upon request at the hospital's Healthy Communities office.

Significant Health Needs

The CHNA identified the following significant community health needs:

- Transportation
- Access to resources and services in rural communities
- Financial stability
- Lack of recreational activities
- Risk factors (obesity & chronic disease)
- Access to health-related care
- Increased crime rate
- Mental health services
- Alcohol & substance abuse
- Communication and coordination
- Illegal drug use
- Lack of jobs for unskilled workers
- Poverty
- Lack of affordable housing

Significant Needs the Hospital Does Not Intend to Address

CHI St. Joseph Health has chosen not to address the following significant health needs. These health needs do not fit within our scope of services, our mission, or other organizations in the community are working to address these needs.

- Transportation
- Financial stability
- Lack of recreational activities
- Increased crime rate
- Alcohol & substance abuse
- Illegal drug use
- Lack of jobs for unskilled workers
- Poverty
- Lack of affordable housing

2019 Implementation Strategy

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years. It summarizes planned activities with statements on anticipated impacts and planned collaboration. Program Digests provide additional detail on select programs.

This report specifies planned activities consistent with the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

The anticipated impacts of the hospital's activities on significant health needs are summarized below, and for select program initiatives are stated in Program Digests. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital works to evaluate impact and sets priorities for its community health programs in triennial Community Health Needs Assessments.

Creating the Implementation Strategy

CHI St. Joseph Health is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, physicians, clinicians and staff, and in collaboration with community partners.

In developing the implementation strategy, CHI St. Joseph Health formed a committee who work in each of the service areas, and work within programs that impact the issues identified by the CHNA. Individuals from the acute and ambulatory care setting, our clinically integrated network, and rural hospitals all participated in the discussion around programs and services that would have a great impact on the issues identified in the CHNA.

Programs that were selected for the implementation plan include those that showed evidence of success with assisting patients to access health and wellness services in rural communities, those that connected patients with resources and education and those that enhanced the services that we currently offer as a healthcare system. Additionally, all of these programs currently have metrics in place that are tracked consistently to allow us to measure our impact on these issues.

Strategy by Health Need

The tables below present strategies and program activities the hospital intends to deliver to help address significant health needs identified in the CHNA report.

They are organized by health need and include statements of the strategies' anticipated impact and any planned collaboration with other organizations in our community.

Health Need: Mental Health Services

Strategy or Program Name	Summary Description
Senior Renewal Program	Continue to support the Senior Renewal Program at each of the CHI St. Joseph Health rural hospitals: • CHI St. Joseph Health Burleson Hospital • CHI St. Joseph Health Grimes Hospital • CHI St. Joseph Health Madison Hospital
Telehealth Counseling Services	Support expanded Telehealth Counseling services through a partnership with Texas A&M College of Medicine - Telehealth Counseling in Grimes, Madison, Burleson, and Robertson Counties.

Anticipated Impact: The hospital's initiatives to address mental health services are anticipated to result in: expanded access to mental health services for our vulnerable populations (i.e., senior, rural, and low-income residents).

Planned Collaboration: The hospital will partner with Senior Renewal and Texas A&M College of Medicine to deliver this access to mental healthcare strategy. In addition, these services are all designed to be affordable to different incomes on a sliding scale basis if not free of charge.

Health Need: Access to Health-Related Care

Strategy or Program Name	Summary Description

ED Diversion and Patient Navigation Program (DSRIP)	Provide navigation care team services to patients that are high utilizers of the emergency department or utilize the emergency department (ED) for conditions that are more appropriately treated and managed in a primary care medical home. The navigation team within the ED will outreach to eligible patients at bedside and enroll them in the navigation program to establish the patient with primary care provider, and provide clinical and social services to reduce barriers to care.
Home Visit Program	Expand primary care services and team based healthcare, in partnership with Texas A&M Health Science Center. The expansion includes providing home visits to address patient access, unmanaged chronic conditions, and social determinants of health needs. The home visit care team will expand health-care services to those with transportation barriers, social barriers and/or those needing additional management of chronic disease states with a Home Visit Nurse Practitioner. Patients eligible for the Home Visits Program include high utilizers of the ED that have a chronic condition including Diabetes, Heart Failure, COPD, and Asthma.

Anticipated Impact: The navigation program and Home Visit program will reduce avoidable and preventable Emergency Department (ED) visits by establishing patients with a primary care provider. The impact will reduce ED visits for high utilizers, avoidable acute visits and help manage and control chronic conditions including Diabetes, Heart Failure, COPD, and Asthma. Overall, the program will reduce costs for the patient and healthcare system.

Planned Collaboration: The ED Diversion program with collaborate with local FQHC HealthPoint Clinic, Home Visit Program and the Brazos Health Resource Center for continued patient care and resource coordination. The Home Visit program will collaborate with the FQHC HealthPoint Clinic and ED Diversion program for resource assistance and providing the patient with a long term medical home. Home Visit Program will be staffed in partnership with Texas A&M Health Science Center with the potential team including a nurse practitioner, a multidisciplinary team of students specializing in nursing, pharmacy, medicine and rural health, working collaboratively with CHI St. Joseph Health's navigators.

Health Need: Risk Factors

Strategy or Program Name	Summary Description
Diabetes Education Program	Through collaboration, this program has been improved to provide a year's worth of support, resources and A1C testing.
Chronic Disease Self-Management	Evidence based, 6-week chronic disease self-management courses.

Anticipated Impact: Through a strengthened partnership with Texas A&M Center for Population Health and Aging, we will be able to provide quality diabetes education, improve A1C testing rates, and provide additional resources to our diabetic population. We will also collaborate with this group to provide evidence-based chronic disease self-management courses.

Planned Collaboration: We are partnering with the Texas A&M Center for Community Health Development to provide a more robust diabetes education program and chronic disease self-management courses.

Health Need: Communication and Coordination

Strategy or Program Name	Summary Description
Health Navigator(s)	A health navigator is a member of the healthcare team who helps patients "navigate" the healthcare system and get timely care. Our hospital has employed Patient Navigators in the following areas: Breast Health, Cardiac Services, Senior Advocate, and Population Healthcare Coach.
Health Resource Centers	Brazos, Grimes, and Madison Health Resource Centers will continue to receive direct support from the CHI St. Joseph Health Regional, Grimes, and Madison hospitals and act as a referral source for health-related care and resource identification for those in need.

Anticipated Impact: Navigators will help coordinate patient care, connect patients with resources, help patients understand the healthcare system, and patients in need of lifestyle behavior education and coaching. The Health Resource Center's impact goal is to improve communication and coordination for Madison, Grimes, and Brazos County residents through collaboration and coordination of services.

Planned Collaboration: The navigator(s) and Health Resource Centers coordinate with numerous service providers and gather resources from countless community partners to support these communication and coordination efforts.

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.

 **Mental Health Services**	
Significant Health Needs Addressed	The demand for qualified mental health specialists has increased significantly in recent years, thus increasing the lack of qualified mental health specialists, particularly in rural populations, such as the greater Brazos Valley region. The U.S. Top Performers have a ratio of 310:1; Texas has a ratio of 957:1 mental health provider.
Program Description	1) The Senior Renewal Program offers help in decreasing or resolving issues of life's challenges as we age including issues such as losing a spouse, family member, or friends, or experiencing a decrease in quality of health or mobility and also improving emotional health and physical well-being. 2) Telehealth Counseling Clinic services address disparities in access to high quality behavioral healthcare to diverse communities through collaborative partnerships and the application of scientific knowledge. The hospital provides space, network connections, and referrals to this program.
Community Benefit Category	C8. Behavioral Health Services
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	1) Senior Renewal: Through this program, individuals learn effective ways to cope with concerns through a combination of therapies, nursing care, and an individualized treatment plan that may include: • Referrals to community resources • Group therapy with other senior adults with similar concerns • Individual therapy • Family therapy • Continuous communication with your physician 2) Telehealth: CHI St. Joseph (CHI- STJ) will partner with the Texas A&M Tele-behavioral Care (TAMU-TBC) program to improve access to counseling for patients in the Brazos Valley. TAMU-TBC provides individual, couples, and group counseling via video and telephone. The partnership will increase access to behavioral health care for patients and community members and improve the mental health and quality of life of the individuals served.

Measurable Objective(s) with Indicator(s)	1) The CHI St. Joseph Health Burleson, CHI St. Joseph Health Grimes, and CHI St. Joseph Health Madison hospitals provide space, utilities, supplies, and pays the staff that run the Senior Renewal Programs in Burleson, Grimes, and Madison County. Impact will be measured by the number of people referred and treated. 2) Telehealth counseling services will be established in Hearne and Franklin locations. With additional locations, telehealth services will be available in the patient's community thus increasing referrals to the counseling services and increasing the number of patients served by telehealth. The resources will be announced and communicated within the communities including meeting with physician stakeholders and referral sources.
Intervention Actions for Achieving Goal	1) The Senior Renewal program at CHI St. Joseph Health offers help in decreasing or resolving many of the issues faced by seniors such as losing a spouse or family member, or experiencing a decrease in quality of health or mobility. They also assist in improving emotional health. The program's core principles include restoring quality of life, the value of your specific needs and the role of your family, and developing an ongoing plan for care and support. 2) CHI St Joseph will take necessary steps to ensure ease of referral to the services. The location sites will have installed telehealth and internet services to support the operations. Local staff will be trained and services will begin.
Planned Collaboration	1) Through Senior Renewal program, patients learn ways to cope with concerns through a combination of therapies, nursing care, and an individualized treatment plan that may include referrals to community resources such as group, individual or family therapy and continuous communication with your physician 2) CHI-STJ and TAMU-TBC are working together on HRSA award (G01RH32158-01-00) titled, Enhancing Patients Access to Telehealth by Engaging Rural Networks (e-PATTERN). The purpose of the award is to 1) increase access to services by establishing new counseling access points in Hearne and Franklin 2) conduct evaluation of the efforts to improve understanding of effectiveness and value of our partnership.

Access to Health-Related Care

Significant Health Needs Addressed	There are many reasons for delays in health-related care including for example, associated cost, lack of insurance, and not knowing where to get care. When survey respondents were asked about their ED utilization in the last 12 months, 7.2% used the emergency room because they *do not have a regular place to go for health care.*

Program Description	1) The ED Diversion and Patient Navigation Program was implemented as part of the Delivery System Reform Incentive Payment Program (1115 Waiver). This program focuses on the Medicaid, Dual Eligible, and uninsured population that utilizes our health system emergency departments for Ambulatory Care Sensitive Conditions (Chronic and Acute Avoidable Visits). The purpose of the program implemented in the Regional ED is to enroll eligible patients in our Navigation program educating them on available resources and proper healthcare system utilization; and establish them with a Medical Home with our local FQHC partner HealthPoint. 2) The Home Visit program is a resource for patients that have difficulty attending primary care appointments in a clinic or need close monitoring of their condition. This is accomplished by a Home Visit Nurse Practitioner with a team of medical, nursing, and public health students entering a patient's home to assess needs and provide care.
Community Benefit Category	A2. Community Based Clinical Services
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	1) Reduce avoidable ED utilization, improve patient access to health-related care, and management of chronic conditions. 2) The Nurse Practitioner (along with medical, nursing, and public health students) provide primary care to patients within their homes. When the patients are approached bedside in the ED, a patient enrolls in our program and if eligible, enroll in the Home Visits Program.
Measurable Objective(s) with Indicator(s)	1) The navigation care team enroll patients in the navigation services and assist in establishing a PCP. They meet eligible patients at the bedside while in the ED or IP, educate on proper health system utilization, assess their clinical and social needs/barriers, and offer to enroll them in a navigation program. Through enrollment in the program, the patients are scheduled with a primary care provider, at our local FQHC, or the Home Visit Program to provide necessary healthcare and education. This initiative is measured by the number of patients enrolled in services and the number of initial visits with the PCP or home visit program post enrollment. 2) The patients eligible for the Home Visits program include high utilizers of the ED that have a chronic condition including Diabetes, Heart Failure, COPD, and Asthma. The initiative is measured by tracking the number of patients enrolled in the home visit program and the reduction of ER visits for the avoidable chronic conditions.

Intervention Actions for Achieving Goal	1) Once a patient is enrolled and scheduled with the medical home or Home Visit Program, our navigation team financially assists with assessed barriers including co-pays, transportation, DMEs, medication, and specialty referrals (as needed). During their enrollment we provide consistent follow up calls (both social and clinical if applicable) and reminder calls for appointments. Eligible patients are stratified based on clinical needs and historical ED utilization. When patients are nearing the end of their enrollment period with DRSIP Navigation, we refer patients to the Brazos Health Resource Center for continued resources in the future. 2) Patients that are enrolled in the home visit program will receive at home visits by the care team including the Nurse Practitioner. The care team will help with education on health processes as well as community resources available to address social needs. The patient will then be assessed for graduation of the program and care will be transitioned to a HealthPoint Clinic provider.
Planned Collaboration	• The Home Visits Program is in partnership with Texas A&M Health Science Center. • Brazos County Health Resource Center • FQHC – HealthPoint Clinics • DSRIP (1115 Waiver)

Risk Factors

Significant Health Needs Addressed	Overall health status is driven by both individual and social factors. Risk factors are health-related behaviors among the individual factors which contribute to the development of chronic diseases. Examples include smoking, obesity (as related to healthy eating and physical activity), and preventive screening participation, among others.
Program Description	1) Making Moves with Diabetes (MMWD), is an American Diabetes Association (ADA) recognized program designed to help individuals manage their diabetes with minimal impact to their current lifestyle. With the guidance of a diabetes care team, participants will have access to a Registered Nurse and Certified Community Health Worker who will connect them with community resources within the greater Brazos Valley area to help manage their diabetes. The hospital provides an RN educator, Registered Dietician, and direct referrals from physicians, materials, location, etc.

	2) Chronic Disease Self-Management Program (CDSMP): CDSMP was developed by a team of researchers at Stanford University. It's a self-management education workshop attended by people with a variety of chronic health conditions. It aims to build participants' confidence in managing their health and keep them active and engaged in their lives. Participants attend a 2½-hour interactive workshop once a week for 6 weeks to learn problem-solving, decision-making, and other techniques for managing problems common to people with chronic diseases. In a typical workshop, participants set a realistic goal for the upcoming week and develop an action plan for meeting that goal. They report on their progress at the following workshop, and solicit feedback from the group to help address any challenges. The hospital provides the educator, course materials and facility for these programs.
Community Benefit Category	A1. Community health education
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	1) Increase participation numbers and education opportunities for residents of the Brazos Valley. Provide direct physician referrals, increase A1C testing for diabetic patient population, and assist hospital efforts to reduce readmission rates. 2) Among the most studied evidence-based programs, the Chronic Disease Self-Management Program (CDSMP) has been shown to help participants improve their health behaviors, health outcomes, and reduce healthcare utilization.
Measurable Objective(s) with Indicator(s)	1) Increase diabetic monitoring rates. Report test results in eCW for all SJMG patients (Goal 75% of all MMWD participants that are SJMG patients) 2) An accountability support group will be formed to follow-up with past participants of these programs to ensure they are meeting their goals and objectives. This support group will have networking support from other hospital departments to provide ongoing support and resource connection.
Intervention Actions for Achieving Goal	1) Making Moves with Diabetes Program • RN reporting • physician referral • community networking 2) Chronic Disease Self-Management Programs held at MatureWell Lifestyle Center • Accountability support group • Increase physician referrals

	• Community networking
Planned Collaboration	Texas A&M University - Center for Population Health & Aging

Communication and Coordination

Significant Health Needs Addressed	When surveyed, residents in every community expressed concern with communication and its impact on access to services. Specific issues raised include how to inform residents of the resources available to them, the need for outreach to a growing Hispanic community, and how to improve communication and coordination among/between service providers.
Program Description	1) Health Navigator(s) – Senior Advocate, Health Coach, Breast Health, Cardiac a. Senior Advocate: multi-disciplinary expertise to connect individuals with services, resources, providers, and care coordinators, effectively eliminating barriers to healthcare and promoting health management outside of the acute care setting for those aged 55 and older. The Advocate provides educational and social opportunities for learning and support, promoting the highest level of lifestyle change and self-advocacy. As a Certified Senior Advisor®, the advocate offers knowledge in the multiple processes of aging, adhering to the goal of benefiting and protecting the health and welfare of older adults. b. Health Coach: Our health coach offers a highly personalized service that aims to improve the health of the patient by working on healthy lifestyle behaviors, like diet and exercise. Our health coach works one-on-one with the patient to develop a personalized wellness plan that fits their specific health needs by setting wellness goals and providing resources needed to live a healthier life. c. Breast Health: multi-disciplinary expertise to connect individuals with services, resources, providers, and care coordinators, effectively eliminating barriers to healthcare and promoting health management for those going through breast cancer treatment. The navigator serves as a central point of timely and precise communication between the patient, treatment team, and the referring physician. They ensure the patient and their family has a clear understanding of their disease process and options. d. Cardiac: multi-disciplinary expertise to connect individuals with services, resources, providers, and care coordinators, effectively eliminating barriers to healthcare and promoting health

	management outside of the acute care setting for those patients with heart related issues. The navigator serves as a central point of timely and precise communication between the patient, treatment team, and the referring physician. They ensure the patient and their family has a clear understanding of their disease process and options. 2) Health Resource Centers – Resource Coordination--medically necessary items only --30 days of medication needed at discharge (medical necessity to treat chronic or acute condition); low cost assistive equipment or DME (nebulizer, glucometer, walker, etc.); transportation home (if NO OTHER means available); follow up visit with cardiologist or heart failure clinic. Other social needs may be able to be helped with for those living in Brazos County. Referral to appropriate resources in area of residence also done (including Brazos County). Referrals graduating from patient navigation (DSRIP) program are covered for primary visits, medication, and/or transportation if needed, for up to 1 year (from initial intake date at DSRIP).
Community Benefit Category	F7. Community Health Improvement Advocacy
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	• Improve communication and coordination • Improve outcomes • Reduce readmissions
Measurable Objective(s) with Indicator(s)	Utilization of these resources is monitored by the number of patients and referrals by navigator resources.
Intervention Actions for Achieving Goal	The navigators receive referrals from providers and other care team members. These services are offered to the community members. Improve communication of the services offered thereby increasing referrals to the navigators.
Planned Collaboration	Community resources

Hospital Board and Committee Rosters

James E. Blair III, Chairman of the Board
James Blair is a graduate of Texas A&M University. He is the Vice President of J&B Propane in Madisonville, Texas. James is an active member of First Baptist Church of Madisonville and also serves on the Madison County Appraisal Board.

Tony Morelos, Vice-Chair, Board of Directors
Prior to joining the W.E. Gibson Agency in 2002, Tony was a successful independent agent in Houston for over 25 years. He is a past president of the Independent Insurance Agents of Houston, as well as a past director and regional vice president of the Independent Insurance Agents of Texas. Tony currently serves as the Vice Chair of the Board of Trustees for CHI St. Joseph Health. He is a past president of the Navasota/Grimes County Chamber of Commerce. Tony and his wife Cheryl are members of the First Baptist Church of Navasota.

Robert Upchurch, Secretary, Board of Directors
Robert Upchurch is a graduate of Texas A&M University '84. Robert serves as President, CEO, & Chairman of First State Bank of Bedias. He is also Mayor Pro-Tem of the City of Bedias. He is a former director of the Texas Bankers Association and has served on the Community Bankers Council of the American Bankers Association. Since 2000, Robert has held several governance roles at CHI St. Joseph Health, including chairman of the Governance Council of the Grimes Hospital and later as chairman of the Governance Council of the Regional Hospital in Bryan.

Antonio Arreola-Risa, PhD., Board Member
Dr. Arreola-Risa is a faculty member in the Information and Operations Management Department at Mays Business School, Texas A&M University. He received his B.S. from Monterrey Institute of Technology (ITESM) in Mexico, his M.S. from the Georgia Institute of Technology and his Ph.D. from Stanford University. Prior to joining Texas A&M he was on the faculty in the Foster School of Business, University of Washington. He is a member of the Decision Sciences Institute for Operations Research and the Management Sciences.

Michael Cohen, M.D., Board Member
Dr. Cohen obtained his medical degree from Texas A&M University Health Science Center, College of Medicine in College Station, Texas. He completed an internship in Pathology at the University of Texas Southwestern Medical Center in Dallas, Texas, and a residency in Anatomic and Clinical Pathology at Scott & White Memorial Hospital in Temple, Texas. As a founding member of Brazos Valley Pathology, he has served as Medical Director of Laboratories and Department of Pathology chairman at CHI St. Joseph Health since 1999. Dr. Cohen is also a past president of the CHI St. Joseph Health medical staff. He is a Clinical Assistant Professor in Pathology and Laboratory Medicine at Texas A&M Health Science Center College of Medicine. Dr. Cohen is a member of the College of American Pathologists, American College of Physician Executives and Brazos Valley Pathology Physicians Organization.

Chuck Ellison, Board Member
Chuck, a 1976 graduate of A&M has practiced law in the Brazos Valley since his discharge from the U.S. Army in 1983. He has served the community in many volunteer capacities, including as a founding member of the Ethics Committee of Hospice Brazos Valley since 2001 and a member of the Corporate Integrity Committee of St. Joseph Regional Health System since 2010. He currently serves on the boards of CHI St. Joseph Health System and CHI Texas Division in Houston. He chairs the audit and compliance committee of the Texas Division.

Caroline McDonald, Board Member
A board member for more than 30 years, Caroline McDonald has faithfully served CHI St. Joseph Health. Caroline is a native of Brownsville, Texas, and attended the University of Texas at Austin. Caroline's extensive community volunteer service and leadership have been acknowledged with the presentation of the "Women of Distinction Award" by the Bluebonnet Girl Scout Council and "You Are Tops" by the Prenatal Clinic.

Mark Scarmardo, Board Member
Mark Scarmardo attended Sam Houston State University and Texas A&M University. A resident of Bryan, Scarmardo owns The Farm Patch and Scarmardo Food service. He also serves on the boards for the Bryan-College Station Chamber of Commerce and the Brazos Valley Museum of Natural History.

Michael Steines, M.D., Board Member
Dr. Michael W. Steines earned his medical degree from the Baylor College of Medicine. He then completed his residency and internship at the University of Kansas Medical Center. Dr. Steines relocated to the Bryan/College Station to start his practice. Dr. Steines obtained board certification from the American Board of Surgery in 1997 and became a Fellow of the American College of Surgery in 1999.

Gina Flores, Board Member
Gina Flores received her Bachelor of Arts in teaching from Sam Houston State in 1979. Her teaching career includes three years in public school and fourteen years in Christian education. Since moving to B/CS in 2006, Gina has served on several community boards. Currently she serves on the Board of CHI St. Joseph's Hospital and Allen Academy Board of Trustees. She is also involved in Woman's Club and Republican Women. Gina and her husband Bill attend Central Baptist Church. They have two grown sons, and four grandchildren.

Bryan Cole, PhD., Board Member
Dr. Bryan R. Cole previously served on the Board of Directors from 2007-2013. He is Professor Emeritus of Educational Administration in the Department of Educational Administration and Human Resource Development at Texas A&M University. During his 41-year career at Texas A&M, Dr. Cole served in numerous administrative and professorial capacities in the College of Education and Human Development and at the University level. A retired Colonel from active duty and the U.S. Army Reserve, Dr. Cole holds his Master's and Doctoral degrees in Educational Administration from Texas A&M and his Bachelor's from the U.S. Military Academy at West Point. He is married to Wanda Kay Cole and has two adult children, Keith and Allison, and four grandchildren. He has served as a Deacon at First Baptist Church in Bryan since 1983.

Karen Boone, R.N., Board Member
Karen Boone retired from CHI St. Joseph Health in 2017 after nearly 40 years of service. Beginning her career as a graduate/registered nurse in the Regional Hospital Labor and Delivery department. Karen went on to lead the team as Director of Maternity Services. As a director, Karen served on the CHI St. Joseph Health Ethics Committee and was active in a number of internal leadership initiatives and team events. Karen has a Bachelor's degree in Nursing from Texas Women's University. She is also a past member of the Ronald McDonald Advisory Board and Association of Women's Health, Obstetric and Neonatal Nurses, a Certified Weather Watcher and a member of St. Joseph Catholic Church. Karen has been married for over 40 years to her husband Glenn, and they have three children and four grandchildren.

John Smith, Board Member
A Loan Officer at Citizens State Bank in Caldwell for 18 years, John Smith has been a member of both the Burleson St. Joseph Healthcare Council and Skilled Nursing and Rehab Burleson Governance Council. Involved in his local community, he is also an alumnus of the Texas Agriculture Lifetime Leadership Program and served as part of the Deanville Heritage Foundation, Caldwell's Main Street Program and St. John's Lutheran Church Council. He has a Bachelor's degree from Texas A&M University.

Brad White, M.D., Board Member
Dr. Brad White is a Neurosurgeon in the Texas Brain & Spine Institute and Vice President of Medical Affairs for CHI St. Joseph Health. Part of the team since 2008, Dr. White is a past president of CHI St. Joseph Health medical staff and former chair and vice-chair in the Department of Surgery. He holds both his Medical and Doctoral degrees from the University of Alabama at Birmingham and a Bachelor's degree from Birmingham-Southern College, as well as a Master's degree in Business Administration and a Master's in Finance. Dr. White has also served on the Board of Directors for the Texas Medical Association Insurance Trust and both the CHI St. Joseph Health Affordable Care Organization and Clinically Integrated Network.

Marcia Ory, PhD., MPH, Board Member
Dr. Marcia Ory is Regents and Distinguished Professor in the Department of Environmental and Occupational Health at the Texas A&M School of Public Health. She also serves as Associate Vice President for Strategic Partnerships and Initiatives at the Health Sciences Center and is Founding Director of the Texas A&M Board of Regents Center for Population Health and Aging. Dr. Ory holds a Doctoral degree in Family Studies and Sociology from Purdue University, Masters' degrees from Indiana University and the Johns Hopkins University and a Bachelor's degree from the University of Texas - Austin. She completed her postdoctoral fellowship in Chronic Disease Epidemiology at the Johns Hopkins Bloomberg School of Public Health.

Frank B. Ashley III, Ed.D., Board Member
Dr. Ashley received his degrees from Louisiana College and The University of Alabama. Before assuming his current position at the Bush School he served as a Senior VP for the College Board Corporation in New York where he worked on initiatives to increase college participation for underprivileged students. In his 35+ years in education, Ashley has served in a variety of roles, including teacher, coach and administrator. Ashley also served as a faculty member, and administrator at Texas A&M University-Commerce, as the dean of the college of education, and he also served on the Commerce ISD School Board. During this tenure he received "The Citizen of the Year Award" and the "Distinguished Service Award". After three years in Commerce, Ashley returned to College Station as vice chancellor of academic affairs for the A&M System. Dr. Ashley has numerous publications and presentations and has been invited to present nationally and internationally, however what he enjoys most is speaking to K-12 students, teachers and parents about the importance of education. Ashley is an Ordained Deacon serving at St. Thomas Aquinas Catholic Church, and has also served as a Chaplain for the Texas A&M Football team for several years. He and his wife Janice have two children, Frank IV and Elizabeth.

Sr. Nancy Surma, OSF, Ph.D.
Sister Nancy Surma came on as a board member in July 2019. Sister Nancy currently serves as the Vice President, Mission Integration for CHI Living Communities in Toledo, Ohio. She is responsible for leading mission integration, pastoral care and ethical activities throughout the 13-campus ministry and also serves on the Executive Leadership Team. In 2006, Sister Nancy joined Sylvania Franciscan Health (Franciscan Services Corporation) as the Vice President, Mission Integration. Prior to this role, Sister Nancy served in numerous leadership roles for the University of Detroit Mercy in Detroit, Michigan,

Briar Cliff University in Sioux City, Iowa, Lourdes University in Sylvania, Ohio, Marywood University in Scranton, Pennsylvania and Cardinal Stritch Catholic High School and Central Catholic High School, in Toledo, Ohio. Sister Nancy Surma received her Doctor of Philosophy at Boston College in Boston, Massachusetts, a Masters in Art and Education from the University of Toledo in Ohio, and a Bachelor of Arts from Mary Manse College in Toledo, Ohio. She has also received numerous professional certifications and recognition and currently serves on the Mission Leader Advisory Committee of Catholic Health Association.

Theron Park
Theron Park was named CHI St. Joseph Health's President and Chief Executive Officer in July, 2018. As CEO, Theron is responsible for operational leadership of CHI St. Joseph Health, as well as advancement of our market's strategic initiatives, working in close collaboration with Texas Division and National Leadership. Prior to joining CHI St. Joseph Health, Theron served as Chief Executive, Delivery System for Providence St. Joseph Health in Oregon, where he led more than 10,000 caregivers across eight hospitals, 14 joint ventures, a large reference lab and 60 outpatient sites. Theron also served as Chief Executive for Providence Portland Medical Center and Providence Milwaukie Hospital, in addition to rural hospitals and health systems throughout Texas and Montana in roles of increasing responsibility. Originally from Texas, Theron received a Master of Science in Health Care Administration from Trinity University and a Bachelor of Business Administration Degree in Accounting from Texas A&M University.

T. Douglas Lawson, Ph.D.
Doug Lawson currently serves as CEO of the CHI Texas Division, a $2 billion+ regional health system with 17 hospitals that stretches across the southeastern section of the state and includes CHI St. Luke's Health in Houston, CHI St. Luke's Health Memorial in the Lufkin-East Texas area, and CHI St. Joseph Health in Bryan/College Station and Brazos Valley region. He also serves as Senior Vice President for Catholic Health Initiatives, the Englewood, Colorado based parent company of the CHI Texas Division. Lawson began his healthcare career at Scott & White Memorial Hospital and Clinic in Temple, Texas, and served in Kansas City with the Saint Luke's Health System and later in Huntington, West Virginia, for Cabell-Huntington Hospital. Following these leadership roles, Lawson returned to Texas and became president of Baylor Scott & White Medical Center – Grapevine and was asked to serve as President of the organization's North Texas Central Region and Baylor University Medical Center in 2015. Lawson is a graduate of Texas A&M University where he earned a Bachelor of Science degree in political science. He went on to complete a Master of Science degree in healthcare administration from Trinity University, San Antonio, Texas, and a doctorate in philosophy from Dallas Baptist University. Lawson is also a Fellow of the American College of Healthcare Executives.