Community Health Improvement Plan (CHIP)

2026-2028

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Brazos County Health District

Table of Contents

Revision Records

(Month, Day, Year)	(Name)	(Signature)

BRAZOS COUNTY HEALTH DISTRICT

Brazos Valley Health Coalition

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Executive Summary

The Brazos County Health District (BCHD), in partnership with the Brazos Valley Health Coalition (BVHC), developed the 2026–2028 Brazos Valley Community Health Improvement Plan (CHIP) to provide a coordinated, data-driven framework for improving health outcomes and advancing health equity across the Brazos Valley Region. The CHIP reflects a shared commitment among public health agencies, healthcare providers, community-based organizations, educational institutions, and other partners to address priority health needs identified through a comprehensive Community Health Needs Assessment (CHNA).

BCHD has served the community since its establishment in 1939 and has evolved into a multi-division health district providing clinical services, environmental health protections, laboratory testing, emergency preparedness, and health promotion. In addition to serving Brazos County, BCHD functions as a regional leader and convener, operating as a clinical safety-net provider and coalition builder throughout the Brazos Valley. BVHC, established in 2016, was formed to address fragmentation across public health and healthcare systems in both rural and urban communities. With more than 40 member organizations, BVHC facilitates cross-sector collaboration, data sharing, and collective action to address community-identified health priorities. BCHD serves as the lead convening and coordinating agency for the coalition.

The CHIP is informed by both the 2025 Community Health Needs Assessment (CHNA) produced by Baylor Scott & White Health and the 2025 CHNA produced by CommonSpirit Health–St. Joseph. The Brazos Valley Health Coalition provided support and coordination assistance for both CHNAs. Both assessments utilized mixed-methods approaches that combined quantitative health and demographic data with extensive community engagement, including surveys, focus groups, and stakeholder interviews. Findings from these assessments identified persistent disparities related to access to care, maternal and child health, and chronic disease, particularly among low-income, Hispanic, rural, and uninsured populations. These findings highlighted the need for coordinated, equity-focused, and systems-level strategies that address both clinical care gaps and broader social drivers of health.

Following review of the CHNA findings, the BVHC Steering Committee and full coalition selected three priority areas for the 2026–2028 CHIP cycle: barriers to medical care, maternal and child health, and chronic disease and cancer. For each priority area, coalition partners collaboratively developed goals, measurable objectives, and evidence-based strategies designed to improve access to care, strengthen preventive services, and reduce disparities across the region. Subcommittees aligned with each priority area are being established to leverage partner expertise, coordinate implementation efforts, and support evaluation and continuous quality improvement.

Development of the 2026–2028 CHIP began in August 2025 and has continued through collaborative planning and refinement. The CHIP is intended to function as a living document that guides collective action, promotes accountability, and allows for adaptation as community needs evolve. BCHD and BVHC will jointly oversee implementation, monitor progress using defined performance measures, and provide regular updates to coalition partners and community stakeholders. Through this plan, BCHD and BVHC reaffirm their shared commitment to improving health outcomes, strengthening access to services, and advancing health equity throughout the Brazos Valley.

Background

On August 18th, 1939, the Bryan City Council members formally approved the proposal of the Health Unit. Thus, the Brazos County health unit was born period from 1939 to 1950, the Brazos County Health Unit continued to serve the public through venereal disease clinics, tuberculosis control eff orts, meat inspections, restaurant inspections, food handler classes, immunizations, health visits for children and adults, and communicable diseases-controlled methods. The Brazos County Health Unit was renamed to the Brazos County Health Department in 1964. During the 1960s, the department added the services of diabetic screening, pap smears for indigent women, and a ringworm clinic for indigent children. With this expansion of services came once again the need for additional space; Thus, the department relocated to 202 E 27th St. In October 1990, it moved to the newly renovated Safeway building at 201 N Texas Ave. where it is still located today. During the decades from 1970 to 2000, the Brazos County Health

Department continued to serve the citizens of Brazos County through programs and immunizations, sanitation, food and water safety, Child health, communicable Disease Control, tuberculosis treatment and control, disease prevention and health education. The events of September 11, 2001, ushered in new concerns for Brazos County citizens and for the Brazos County Health Department. While existing services continue to be provided, emergency preparedness became one of the focal points of the health department operations. Over the past decade, the health department has played a major role in planning and implementing measures to protect residents during natural and man-made disasters. Having transitioned from a department to a district, it now offers several programs across eight divisions. Seventy-five years after its inception, the health district continues to provide services that impact many aspects of public health. The services provided by the health district community health services division include immunizations, communicable disease control, tuberculosis elimination, adult health screenings for hepatitis C, HIV testing and counseling, and sexually transmitted disease diagnosis.

The health promotion division does presentations and other educational events in the community. The environmental health services division provide food service establishment inspections, daycare facility inspections, food handler training and certification, on-site sewage facility permits and inspections and various environmental investigations. The laboratory service division conducts bacteriological analysis of public and private water, along with clinical lab testing for services previously mentioned. The health district continues to maintain an active role in emergency preparedness and health education within the community through its public health emergency preparedness division and its health promotion division. Today the Brazos County Health District is dedicated to preventing disease, protecting life and promoting a healthy lifestyle throughout the community period thanks to its work and eff ort over the years comma citizens of the Brazos County can now enjoy healthier lives in a cleaner and safer environment.

The Brazos County Health District is a, collaborator, and partner in improving health in the Brazos Valley Region. The BCHD serves Brazos County, located in the Brazos Valley Region. The Brazos Valley Region is a large rural-urban service area that includes the cities of Bryan-College Station and rural areas in counties like Robertson and Burleson. Brazos County Health District has operated as a clinical safety-net provider, policy leader, and coalition-builder in Brazos County and throughout the larger Brazos Valley Region's seven counties for decades

(Brazos County Health District, n.d.). BCHD services include immunizations, STI treatment, environmental health inspections, maternal-child outreach, case management, and more. As a result, the BCHD is well equipped to take on initiatives that respond to both medical and non-medical drivers of health.

The Brazos Valley Health Coalition (BVHC) was officially formed in January 2016 in order to address a growing concern among local public health departments and regional health care systems regarding the growing fragmentation of public health initiatives and clinical care access across rural and peri-urban counties in Central Texas. As health disparities continued to widen among low-income, Hispanic, and uninsured populations, a recognized need for cross-sectoral collaboration to streamline efforts, share data, and leverage resources existed. Rather than being a one-entity initiative, BVHC was conceptualized as a long-term regional public health partnership.

BVHC's membership includes 40+ organizations such as local public health departments, federally qualified health centers, nonprofit hospital systems, local mental health authorities, faith-based social service providers, school districts, housing authorities, and academic institutions like Texas A&M University's School of Public Health. These partners bring subject matter expertise, data insights, and frontline experience to the coalition in order to address community-identified priorities related to social determinants of health and clinical service gaps in the Brazos Valley.

BVHC has two main functions:

Performing cyclical Community Health Assessments (CHAs): A mixed-methods approach that includes primary (community input) and secondary (health and demographic) data collection to identify the most pressing needs, health disparities, and community strengths in the Brazos Valley. Quantitative data, such as health outcomes, social vulnerability, and access indicators, are triangulated with community input, including stakeholder interviews, focus groups, and resident surveys. The 2025 CHNAs were developed through this extensive, community-engaged process by Baylor Scott & White Health and CommonSpirit Health–St. Joseph, with support and coordination provided by the Brazos Valley Health Coalition.

Creating a Community Health Improvement Plan (CHIP): A strategic document that synthesizes CHA findings, defines priority health issues in the region, and details action steps to address them. Action steps are aligned with the CHA priority needs and defined with SMART criteria (specific, measurable, achievable, relevant, time-bound) along with lead agency, supporting resource partners, timelines, and evaluation measures. The current CHIP planning cycle has three identified priorities: barriers to care, maternal and child health, and prevention and management of chronic disease.

The Brazos County Health District (BCHD) is the lead convening and coordinating agency of the BVHC. BCHD leads coalition meeting logistics, maintains the region's collective datasets, and hosts community forums and health needs assessments to ensure BVHC efforts are community-engaged and informed. BCHD also works to align BVHC partner public health efforts, such as Narcan distribution, C4 STI Clinic, and BCCS outreach and education, with the CHIP priorities. In order to ensure regional collaboration and initiatives are health equity-driven, BCHD emphasizes cultural and linguistic appropriateness of services in all aspects of BVHC operations and works to elevate and prioritize the health needs of disproportionately impacted populations.

The BCHD partnership with Baylor Scott & White Health (BSWH) and CommonSpirit Health–St. Joseph to produce the 2025 Community Health Needs Assessment (CHNA) attests to BCHD's expertise in the region. BCHD partnered in the collection of primary data from the general population, including but not limited to focus groups, surveys, and key stakeholder interviews. These efforts prioritized representation of low-income residents, Spanish-speaking residents, and residents with the greatest burden of chronic health conditions (BSWH, 2025, p. 8). The variety of data collection sources—supported by the Metopio data platform—provides a clear understanding of the region's demographic trends, access barriers, and disparities in the state of health (BSWH, 2025, pp. 8–10).

The 2025 CHNA report itself is a roadmap for a collective impact approach in improving health in Brazos Valley. The report and its development process established the top two health priorities for the region based on qualitative community feedback and quantitative analysis of demographic and health trends. This CHNA process empowers BCHD and other partners to

continue making decisions about how to align programming with the community's most pressing needs (BSWH, 2025, pp. 6–7). The CHNA findings also inform the CHIP process in an effort to prioritize equity-focused, systemic change strategies (BSWH, 2025, pp. 6–7).

It is useful to note the area's overall demographic characteristics and demographic needs to contextualize the BCHD's response. The overall regional population is over 244,000 people, with an average median age of 31.9, the latter being a reflection of the region's high population of young adults and Texas A&M University (BSWH, 2025, p. 11). Approximately 31.9% of the population reported Spanish as the main language spoken at home. Nearly 38% of the population is at or below 200% of the federal poverty level (FPL) (BSWH, 2025, pp. 11, 20). The regional prevalence of health-related factors that need more equitable access to bilingual, culturally responsive, and otherwise accessible health and social services points to the BCHD's importance to the community.

Significantly, access issues that align with the CHNA's findings about the top two priority areas are found in both the urban and rural contexts of the Brazos Valley. Brazos County, home to BCDH's service, and Washington, Burleson, and Robertson counties are characterized by long travel times to care, provider shortages, and digital literacy levels among residents that negatively impact telemedicine usage (BSWH, 2025, p. 23). This is despite there being two BSWH hospitals with medical staff in the regional service area and provider-based clinics (BSWH, 2025, p. 13). Given BCHD's existing presence in the Brazos Valley as a clinical service provider and community resource, the BCHD is well-positioned to leverage its service delivery to meet these specific access needs.

Notably, BCHD's existing service areas and programs align with the CHNA's top priority needs. Some of BCHD's major programs are C4 Clinic for STI and HIV services, mobile screening for infectious diseases and women's health, and maternal health navigation services. These programs are already working to dismantle systemic and situational access barriers to care and have potential to continue doing so in response to CHIP. On its own, the BCHD staff are referred to as "community voices" in the report, citing concerns about barriers to access and the need for localized and culturally relevant care that BCHD is already operationalizing (BSWH, 2025, p. 8). BCHD collaborates with organizations such as the Brazos Valley Health Coalition,

Project Unity, and the Bryan-College Station Prenatal Clinic to be responsive to the Brazos Valley's unique needs.

In sum, BCHD's alignment with the CHNA's goals and findings—and its own partnership role in co-producing local solutions—renders it an essential institution to support and improve health equity and outcomes for Brazos Valley residents.

Community Health Improvement Plan (CHIP) Process

Community Health Needs Assessment

The Brazos County Health District (BCHD) serves as the lead agency for the Brazos Valley Health Coalition (BVHC), providing overall coordination and administrative support for the Coalition's work. Multiple BCHD employees serve on the BVHC Steering Committee, offering leadership and subject-matter expertise to guide regional planning efforts. In 2025, Baylor Scott & White Health and CommonSpirit Health–St. Joseph conducted the most recent Community Health Needs Assessments (CHNAs), with the Steering Committee contributing to both the planning and implementation phases. The CHNAs incorporated primary data collected through the assessment process as well as secondary data from existing sources relevant to the Brazos Valley. They identified key health needs across the region, which includes the counties of Brazos, Burleson, Grimes, Lee, Leon, Madison, Milam, Robertson, and Washington. The complete CHNAs are available at: https://health.brazoscountytx.gov/brazos-valley-health-coalition/

Priority Issues

The BCHD reviewed the insights and findings from the CHNA and proposed plausible priority areas. The Steering Committee brought these recommendations to the full BVHC body, which then voted to select the three final priority areas for the region.

- **Priority Issue 1: Barriers to Medical Care**
- **Priority Issue 2: Child Health**
- **Priority Issue 3: Chronic Disease/Cancer**

Impact to Residents

Through the coordinated efforts of the Brazos County Health District (BCHD) and the Brazos Valley Health Coalition (BVHC) partners, residents of the Brazos Valley can expect improvements in community health. By focusing on these priority areas, the Coalition aims to enhance access to medical care, promote child health and well-being, and reduce the burden of chronic disease and cancer across the region.

Subcommittees are being established for each of the three priority areas to leverage the expertise of BVHC partners more effectively. These subcommittees will facilitate a coordinated, focused approach to addressing barriers to medical care, child health, and chronic disease/cancer, ensuring that each partner's skills and resources are used to maximize impact across the region.

The 2026–2028 Brazos Valley Community Health Improvement Plan (CHIP) began development in August 2025 and has continued to be actively refined and implemented to the present.

Developing the Community Health Improvement Plan

Once the Brazos Valley Health Coalition selected the three priority issues that were the most important for the region, in their opinion, goals, objectives, and activities were developed to target each of these issues. Through a series of meetings and focused discussions, the CHIP Subcommittee finalized the goals, objectives, and activities found in this plan (Figure 1.)

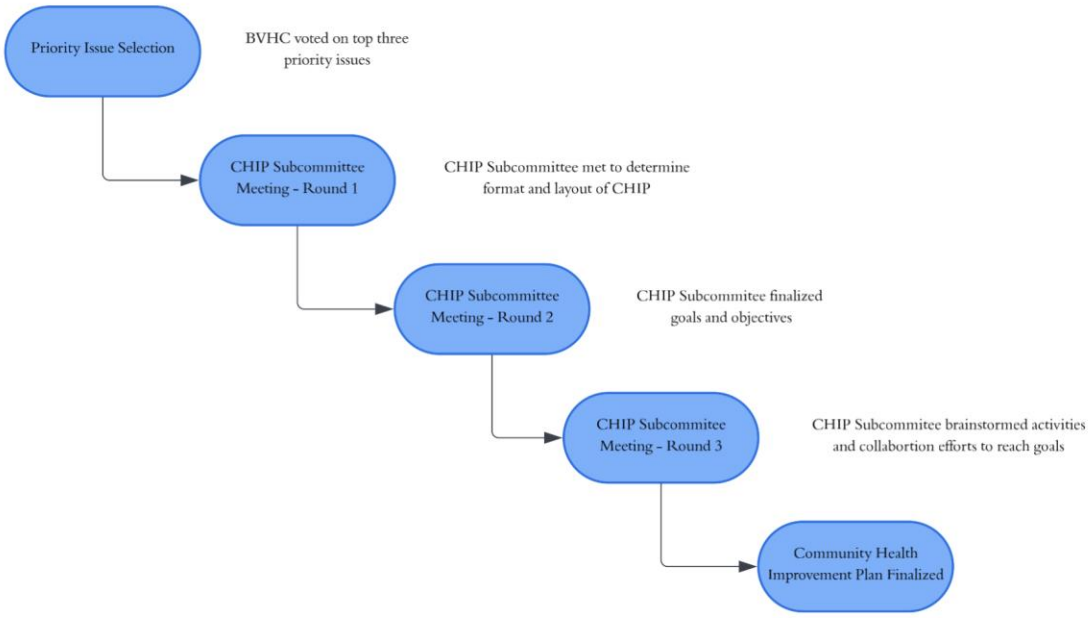
The 2026–2028 Brazos Valley Community Health Improvement Plan (CHIP) was developed by the Brazos County Health District (BCHD) in its role as the lead convening and coordinating agency for the Brazos Valley Health Coalition (BVHC). BCHD led the review of Community Health Needs Assessment (CHNA) findings, facilitated priority selection through the BVHC Steering Committee and full coalition, and drafted the CHIP document. While no external organizations directly authored the CHIP, the development process was informed by extensive community input and data gathered through the CHNA, including surveys, focus groups, and stakeholder interviews that engaged residents and organizations representing populations disproportionately affected by health inequities.

BVHC member organizations—representing sectors such as healthcare, education, social services, housing, transportation, faith-based organizations, and academic institutions—will serve as key partners in the implementation of CHIP strategies. These partners bring subject-

matter expertise, resources, and community connections that will support execution of activities, policy advocacy efforts, and evaluation aligned with CHIP priorities.

Implementation of the CHIP strategies will be coordinated by BCHD as the lead agency, with support from BVHC partner organizations. For each priority area, BCHD will serve as the primary coordinating entity responsible for convening partners, monitoring timelines, and facilitating data collection and reporting. Supporting partners—including healthcare providers, community-based organizations, academic institutions, and social service agencies—have accepted responsibility for implementing specific activities aligned with their expertise and capacity. Subcommittees established for each priority area will meet regularly to coordinate implementation efforts, review progress toward objectives, address challenges, and ensure alignment with equity-focused goals.

Figure 1. CHIP Development Process



Priority Issue One: Addressing Barriers to Care – Transportation

Access to care is among the top barriers cited by Brazos Valley residents. Multiple factors contribute to this issue, including geographic distance, lack of transportation, shortage in

the health workforce, unaffordability, and lack of culturally appropriate or linguistically sensitive care (BSWH, 2025, pp. 14, 23). In particular, several rural counties in the region are underserved in terms of primary care and specialty care; some local communities are so severely impacted that they have been classified as "medical deserts" due to provider scarcity and/or hospital closures (Wolfe et al., 2020; HRSA, 2023).

For example, while about 73% of adults in the region report receiving a routine check-up in the past 12 months (just below Healthy People 2030 targets), Brazos Valley's provider-to-patient ratios are well below the national average for certain types of care, particularly dental and mental health. The community has only 71.3 dentists and 212.8 mental health providers per 100,000 residents, compared to 105.2 and 602.7 nationally (BSWH, 2025, p. 24). This echoes national shortages in the rural health workforce: Primary and specialty care providers in rural communities are declining at alarming rates, and over 100 rural hospital closures have occurred nationwide between 2013 and 2020 alone (U.S. GAO, 2021; The Commonwealth Fund, 2025).

Patients often experience long wait times for appointments, gaps in Medicaid enrollment, or find care unaffordable. Furthermore, just 13.47% of Brazos Valley residents are enrolled in Medicaid, well below the national average of 20.4%, indicating that there may be an insurance gap for low-income residents (BSWH, 2025, p. 25). Structural access issues are more pronounced for certain populations, such as elderly adults who live alone, those with mobility challenges or disabilities, and the digitally or transportation ill-equipped (Syed et al., 2013; Butzner & Meister, 2021; Atlanta Fed, 2024).

Local stakeholder quotes in the CHNA reinforce these structural access issues: "It's hard anywhere to find affordable mental healthcare," "Transportation, lack thereof, of getting people to medical appointments" were among several factors identified in a series of community interviews and roundtables (BSWH, 2025, p. 23). These statements reflect similar findings from other rural areas: Up to 1 in 5 rural residents report delaying or foregoing medical care because of transportation issues, travel distance, or lack of available providers (Rural Health Information Hub, 2024; Fontenot et al., 2024).

Increasing access to healthcare in underserved communities has been the focus of several emerging care delivery models, like mobile health and telehealth. Virtual care has shown efficacy in improving access to both general and behavioral health services, particularly in the

context of COVID-19 and other emergent care needs (Kolluri, 2022; Butzner & Meister, 2021). The availability of telehealth for mental health care can be especially useful in Brazos County, as both primary and behavioral health providers are well below national averages. However, digital equity remains a pervasive challenge for rural populations who have less broadband internet access and/or basic digital literacy (Maita et al., 2024; Atlanta Fed, 2024).

Increasing access to healthcare in rural and underserved communities is a complex issue that requires an integrated, equity-driven approach to both upstream (provider recruitment) and local, grassroots (mobile services expansion, digital health, outreach, etc.) solutions. Academic research has shown that the most cost-effective and impactful upstream interventions for increasing healthcare access in low-resource populations are those that are community-directed, like mobile health units, CHWs, and health navigators (Gizaw et al., 2022; NRHA, 2024). This evidence closely aligns with the CHNA's community recommendations for addressing access to care, which also favor locally rooted, culturally appropriate solutions (BSWH, 2025, p. 23).

Goal and Objectives – Barriers to Care

Goal 1: Improve access to preventive and specialty healthcare services in underserved and rural areas of the Brazos Valley	
Objective 1.1	By 2026, increase the number of mobile clinic visits to rural communities by 30%.
Strategy: Partner with local health organizations, who have the capability and/or desire to run mobile health clinics, and Texas A&M School of Nursing to schedule and implement rural community health days with mobile clinics. Evidence: Mobile health clinics improve access to health care for rural communities, as well as overall health outcomes (Coaston, 2022).	
Objective 1.2	Launch a digital equity initiative by 2025 that provides telehealth navigation and internet access support to 500+ residents annually.
Strategy: Partner with health organizations and digital partners to develop and implement the digital health initiative.	

Evidence: Access to and utilization of telehealth is associated with improvements in patient outcomes and satisfaction for health care (Ezeamii, 2024).	
Objective 1.3	Partner with regional academic institutions to recruit five new primary care, dental, and behavioral health providers for underserved ZIP codes by 2027.
Strategy: Connect and collaborate with local academic institutions, like Blinn College and Texas A&M University, to recruit new health providers. Evidence: Increasing access to providers improves health outcomes, decreases overall health care costs, and betters health equity (Cha, 2025; Glass, 2017).	
Objective 1.4	Establish a Community Health Worker training and deployment program focused on Medicaid navigation, preventive screening outreach, and culturally competent engagement by Q4 2026.
Strategy: Partner with local health organizations and Texas A&M University to enroll, train, and deploy the newly educated community health workers into the community to assist with patient navigation and engagement. Evidence: Community health workers can advance health equity, improve patients' satisfaction with care, decrease the costs associated with healthcare, and decrease barriers to preventative care (Knowles, 2023).	

Priority Issue Two: Maternal and Child Health

Maternal and child health (MCH) is a priority for a wide array of subpopulations across Brazos Valley, especially Hispanic, Native American, and rural-residing residents. Access to quality prenatal care, postpartum support, and obstetric services can be limited by structural barriers such as transportation, provider availability, income status, and cultural dynamics. Barriers in prenatal and maternal care are known to contribute to poor birth outcomes and ongoing health inequities.

The Brazos Valley is an area with high teen birth rates, low prenatal care engagement in rural ZIP codes, and substantial disparities by race and income. Many residents have reported that they have to travel long distances or that they are unable to access prenatal or OB services due to a lack of local providers (BSWH, 2025, pp. 23, 56).

Low rates of early prenatal care can lead to poor birth outcomes, and vice versa. On a positive note, the Brazos Valley CHIP states that 94.7% of pregnant individuals in the area report receiving some form of prenatal care (BSWH, 2025, p. 56). However, a sub-population of high-risk residents may not receive care in the first trimester due to these access barriers, as recommended by Healthy People 2030. Hispanic mothers and mothers living below the poverty level experience the lowest prenatal care utilization in the Brazos Valley.

High poverty rates and low wages are likely contributing factors to these disparities (BSWH, 2025, p. 20). 36.12% of the population lives below 200% of the federal poverty level. This low economic security, coupled with low Medicaid enrollment (13.47%) and a limited maternal health infrastructure, may be having a large impact on women of childbearing age who live in rural communities in particular (BSWH, 2025, pp. 20, 25, 56). Community members shared that "We don't have OBs in this area anymore, so they're driving over an hour" (BSWH, 2025, p. 56).

Access to prenatal care and maternal health services is not only a challenge for the Brazos Valley; it is also a national issue. A 2022 report from March of Dimes found that over 2.2 million U.S. women of reproductive age are living in maternity care deserts, where they have limited or no access to OB/GYNs or birthing facilities (March of Dimes, 2023). In Texas, over 50 counties have no OB provider or birthing hospital (Texas Maternal Mortality Review Committee, 2020). Travel distance to prenatal care has been found to significantly decrease utilization and increase the risk of adverse birth outcomes, with rural women traveling significantly farther for maternal care, leading to reduced visit frequency and poorer outcomes (Evans et al., 2022; Hung et al., 2017; Kozhimannil et al., 2018).

Goals and Objectives – Maternal and Child Health

Goal 2.1: Increase early prenatal care by reducing first trimester delays	
Objective 2.1.1	By 2028, increase the rate of first trimester prenatal care to 85% among pregnant persons in Brazos Valley.
Strategy: Coordinate with local maternal and child health organizations to increase access to prenatal care for their clients.	

Evidence: High-quality prenatal care is associated with a reduction in maternal and infant mortality (Albarqi, 2025).	
Goal 2.2: Expand availability of culturally responsive maternal care	
Objective 2.2.1	By 2027, ensure all public maternal health programs offer bilingual education and services.
Strategy: Work with Texas A&M public health students and promotores de salud to co-develop culturally and linguistically relevant health materials to local maternal and child health organizations. Evidence: Culturally and linguistically competent care improves maternal and child health outcomes and improves quality of care for patients, specifically among Hispanic and African American populations (Dehlendorf et al., 2016; Jones, 2017).	
Goal 2.3: Reduce rural maternity care gaps	
Objective 2.3.1	By 2029, pilot at least one mobile prenatal/postnatal clinic serving rural counties in the Brazos Valley.
Strategy: Partner with local maternal and child health organizations and clinics, as well as Texas A&M Schools of Public Health and Nursing to plan and implement the mobile clinic. Evidence: Increased access to prenatal care for rural areas is associated with an increase in prenatal care utilization and a decrease in maternal and child morbidity and mortality (Hung et al., 2017; Kozhimannil et al., 2018).	

Priority Issue Three: Chronic Health Conditions

Priority Issue #3 is chronic health conditions, which have been selected due to their high burden and the degree to which they overlap with other issues discussed above, including access to care, socioeconomic status, and healthcare infrastructure. Chronic diseases, such as diabetes, cardiovascular disease, asthma, chronic obstructive pulmonary disease, and obesity, place long-term demands on healthcare systems, require access to consistent preventive care and primary care services, and often necessitate long-term management and specialty care. In rural and semi-urban settings like those found in the Brazos Valley, care access and provider shortage

issues have been shown to worsen disease severity and create barriers to effective disease management (BSWH, 2025, pp. 35–36).

The CHNA reveals that the Brazos Valley has chronic disease prevalence rates that are on par with or above state and national benchmarks across several metrics. Rates of diagnosed diabetes and coronary heart disease are 12.6% and 6.47%, respectively, two of the most common contributors to morbidity and long-term healthcare use (BSWH, 2025, pp. 36–37). Chronic respiratory diseases are also common; 9.77% of adults reported having current asthma and 6.91% of adults reported having chronic obstructive pulmonary disease (BSWH, 2025, p. 36). Not only do chronic diseases represent common causes of death and preventable complications, but they also cause sustained demands on healthcare systems and place disproportionate burden on low-income, older, and rural populations.

Chronic illness can also be made worse by socioeconomic status and structural inequities, or as one CHNA participant put it, "housing, food insecurity, and chronic disease go hand in hand" (BSWH, 2025, p. 38). More than 36% of the Brazos Valley population live at 200% below the federal poverty line or below, which has been linked to higher prevalence of chronic diseases and poorer disease management outcomes (BSWH, 2025, p. 20; CDC, 2023). High rates of financial insecurity, inadequate insurance, and transportation insecurity lead to higher odds of delayed care seeking, missed follow-up appointments, and preventable hospitalizations for those with chronic conditions (BSWH, 2025, pp. 23, 35).

The CHNA includes several statements by community members that support these trends. Respondents reported challenges of long wait times, lack of specialty care, and difficulty accessing regular or ongoing treatment for chronic conditions, especially in the most rural parts of the Valley. One resident reported the shared frustrations for both patients and care providers when these types of care are unobtainable or delayed: "It's really frustrating for the medical professionals as well to tell us these things" (BSWH, 2025, p. 35). Another stated that older adults living with chronic conditions often face significant barriers when seeking care, with some patients struggling with virtual care options and lacking support for appointments and treatments (BSWH, 2025, pp. 23, 35).

These difficulties are also reflected in national data. In rural areas, chronic disease is associated with higher mortality rates and worse health outcomes when compared to patients in more urban settings, often due to reduced access to both preventive care and specialty services (CDC, 2023; NRHA, 2024). In one study, patients with multiple chronic conditions were at higher risk of adverse health outcomes if they lived in rural areas, and researchers suggest that limited availability of providers and lack of integrated, coordinated care among the care systems frequented by these patients lead to reduced opportunities for preventive care and early detection of health conditions (Hing & Hsiao, 2018). Another study found that rural patients with multiple chronic conditions visited fewer preventive care providers than primary care providers, suggesting decreased opportunity for preventive care that might otherwise help prevent or manage chronic illness (Moy et al., 2017).

Public health approaches to chronic health conditions and disease management in the Brazos Valley and other rural communities, therefore, center on not only efforts to provide consistent preventive and primary care services, but also efforts to support self-management of chronic disease, expand access to specialty care providers, and account for social determinants of health in health care planning. As noted in the CHNA, focus on these areas in the CHIP will likely help to decrease preventable complications of chronic disease and improve quality of life while decreasing the cost burden of long-term unmanaged chronic illness (BSWH, 2025, pp. 35–37).

Goals and Objectives – Chronic Care Conditions

Goal 3.1: Increase access to screening and diagnosis resources for chronic illnesses in the Brazos Valley	
Objective 3.1.1	By December 2027, increase the percentage of adults with diagnosed diabetes who report receiving diabetes self-management education (DSME) from 18% to 30%, as measured by local health department surveys and clinic reporting.
Strategy: Partner with Federally Qualified Health Centers (FQHCs), BCHD's Narcan Team, and local community health workers to offer free DSME classes quarterly, especially in rural counties.	

Evidence: DSME participation improves glycemic control and reduces complications (Powers et al., 2015).	
Objective 3.1.2	By December 2026, implement two new mobile screening events per quarter in underserved counties (e.g., Burleson, Madison, Grimes) to monitor blood pressure, blood glucose, and BMI.
Strategy: Coordinate with local fire departments and schools for venue access and integrate with BCHD community events. Evidence: Mobile screenings improve early detection in rural communities (Probst et al., 2019).	
Goal 3.2: Increase access to coordinated care for residents living with multiple chronic conditions	
Objective 3.2.1	By 2026, establish a chronic care navigation pilot program at BCHD targeting 200 adults per year with two or more chronic conditions.
Strategy: Train bilingual community health workers (CHWs) to provide care navigation, schedule follow-ups, and connect clients with medical homes. Evidence: CHW-led navigation programs improve outcomes for complex patients (Viswanathan et al., 2010).	
Objective 3.2.2	Reduce emergency room visits for unmanaged chronic disease (e.g., uncontrolled asthma, CHF exacerbations) by 10% by end of 2027, using aggregated regional ER data.
Strategy: Implement a telehealth check-in program for patients post-ER discharge, especially targeting those without primary care providers. Evidence: Telehealth reduces rural disparities and readmission rates (Batsis et al., 2019; KRHA, 2023).	
Goal 3.3: Address disparities in chronic disease outcomes among Hispanic, African American, and older adult populations	
Objective 3.3.1	By end of 2027, reduce self-reported uncontrolled high blood pressure in Black adults by 15%, as measured by BRFSS and CHNA metrics.
Strategy: Collaborate with churches, barbershops, and trusted community partners to launch "Know Your Numbers" BP campaigns.	

Evidence: Community-based interventions are effective in improving hypertension management among Black adults (Victor et al., 2018).	
Objective 3.3.2	By 2026, translate and distribute chronic disease prevention materials in Spanish and Vietnamese across all nine Brazos Valley counties.
Strategy: Work with Texas A&M public health students and promotores de salud to co-develop culturally relevant health literacy materials. Evidence: Language-access materials increase health knowledge and disease control in LEP (limited English proficient) groups (Andrulis et al., 2007).	

Looking Ahead

Next Steps

All elements included in this plan represent the strategic framework for an evidence-based, data-driven, and community-informed CHIP. The BVHC Community Improvement Plan team, including the coalition partners and stakeholders, will continue with these next steps:

- **Cultivate CHIP subcommittees.** Expand the list of community partners who are involved in priority area subcommittees and in the CHIP process.
- **Identify resources.** Continue to identify resources and potential partners within the priority areas and assign these resources to subcommittees.
- **Improve Collaboration.** Host community-wide public engagement opportunities for involvement with the CHIP will be held through public meetings and continue to grow the BVHC through adding new community partners.
- **Improve the focus on equity.** Utilize equity and Social Determinants of Health (SDoH) lenses to prioritize efforts that reduce unfair and inequitable differences in outcomes among underprivileged and vulnerable populations in the community.
- **Policy and Systems Change Strategies.** In addition to programmatic strategies, the CHIP includes policy-oriented approaches to address systemic barriers and advance health equity. Coalition partners will collaborate to advocate for policies that expand access to care for underserved populations, including policies that support transportation

access for medical appointments, strengthen language access requirements for publicly funded health services, and improve Medicaid enrollment outreach and navigation. At least one policy strategy will explicitly focus on reducing health inequities by addressing structural barriers that disproportionately impact low-income, rural, Hispanic, and uninsured populations. BCHD and BVHC partners will engage local decision-makers, provide data-informed recommendations, and support policy education efforts that align with CHIP priorities and CHNA findings.

- **Provide CHIP updates.** An annual CHIP progress report will be disseminated to BVHC and community members and will include updates on the implementation and evaluation of the priority areas.

Sustainability

Progress toward CHIP objectives will be monitored through a structured evaluation and reporting process. Priority-area subcommittees will provide quarterly updates to the BVHC Steering Committee on strategy implementation, performance measures, and emerging challenges. BCHD and BVHC will compile an annual CHIP progress report that documents activities completed, progress toward measurable objectives, and lessons learned. Evaluation findings will be used to inform continuous quality improvement, adjust strategies as needed, and ensure accountability to coalition partners and community stakeholders.

As part of the planning process for this Community Health Implementation Plan, all BVHC partners and resources have committed to sustaining this plan and all steps needed to ensure the health of those in the Brazos Valley. BVHC leadership will provide oversight of all CHIP progress and processes through meetings and workshops focusing on the three priority areas, as well as quarterly meetings with the subcommittees. Community input sessions will be held to allow for residents' engagement in the implementation and evaluation of the CHIP, as well as allowing for feedback to strengthen the CHIP. Regular communication with community members and coalition partners will occur throughout the implementation phase, to ensure continual community buy-in.

How to Get Involved

As a Resident

Area of Expertise

Figure out which priority issue you feel most closely aligns with your area of expertise or interest, whether that be professionally or personally. You can become involved in improving the health of the community and CHIP efforts through joining one of the coalition's partner organizations, attending community meetings, or by having your organization join the coalition. To see what partner organizations you may want to engage with, you can see the list of BVHC members on the BVHC website: https://health.brazoscountytx.gov/brazos-valley-health-coalition/.

Advocate

All community members have different levels of investment and opportunities for educating those in the community about public health topics. You can become an advocate by staying informed on the most up-to-date public health information and sharing evidence-based practices. You can become an advocate by staying informed of and engaging with the public health information that is available to you. Helping to then share this information helps to combat any misconceptions you, and those around you, may encounter with evidence-based public health information.

As a Public Health Partner

Strategize

As a public health partner, you can utilize the CHIP when undergoing strategic planning and program planning. This utilization can assist you in accessing the priorities of community members that have been identified by other public health and service organizations.

Engage

Your organization is likely already engaged in programs that influence the objectives that are identified in this CHIP. Consider becoming involved in the BVHC, meeting with the Brazos County Health District, or joining a CHIP priority issue subcommittee to make an impact on the health issues of concern.

Advocate

You can actively engage in advocacy for legislation that improves the health and well-being of Brazos Valley residents. You can remain aware of current legislation, the role that our local legislators play, and how your expertise can be utilized to inform policy makers. Advocating can range from simply calling your representative to writing position statements on recent legislation.

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