Texas Health Resources

System Report

2023-2025 Implementation Strategy

Texas Health Resources®

Introduction

As required by the 2010 Patient Protection and Affordable Care Act, the IRS requires all non-profit hospitals to complete a Community Health Needs Assessment (CHNA) and adopt an Implementation Strategy (IS) to meet identified needs every three years. This system report outlines the 2023-2025 IS for the 27 Texas Health Resources wholly owned, non-profit and joint venture hospitals in response to the 2022 CHNA.

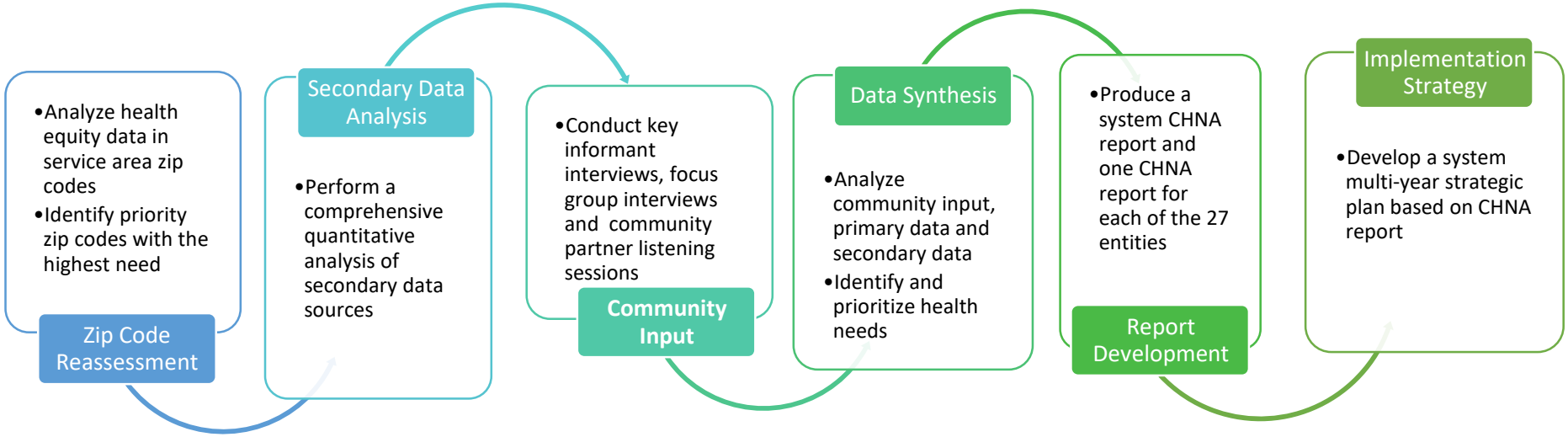
Texas Health Resources developed a system wide IS to leverage a larger network of internal and external resources and therefore increase its ability to impact community health needs. The strategy reaches Texas Health Resource's **16 county service area with a focus on the 56 high needs zip codes** identified in the CHNA. Strategies will be addressed through the IS for the **top three prioritized community health areas:**

1. **Behavioral health**
2. **Chronic disease**
3. **Awareness, health literacy and navigation**

In addition to these top priority areas, the CHNA specifically highlighted additional gaps for transportation, substance abuse and childcare. These gaps will be analyzed further for strategy development. Based on strategy development, new programs/partnerships may be added to this plan or will be incorporated in the next CHNA cycle.

Texas Health's 2022 CHNA & 2023-2025 IS Planning Overview

An outline of the CHNA and IS project steps that were undertaken for the 27 facilities can be seen in the figure below:



Implementation Strategy Highlights

- Expanding and replicating existing successful and impactful community health programs to address health needs in additional zip codes.
- Developing innovative relationships with community partners to better leverage resources for community health needs.
- Utilizing education events and trainings to increase health literacy.
- Increasing the number of program access points to aide in health prevention.
- Establishing programs addressing social determinants of health leading to improved health, well-being, and quality of life.

Implementation Strategy

The chart on the following pages reflects the strategic goals and measurements for the Texas Health System Implementation Strategy.

PRIORITY AREA 1: BEHAVIORAL HEALTH

Need Statement	Mental Health can be affected by a variety of factors including, education, employment, economic stability, food insecurity, housing and built environment, and discrimination, including racism and gender identity. The Healthy People 2030 goal is to improve mental health and reduce substance abuse through prevention and by ensuring access to appropriate, quality behavioral health services. The Statewide Behavioral Health Coordinating Council recently released a five-year Texas Statewide Behavioral Health Strategic Plan for 2023 - 2025, which identified gaps and challenges related to coordination, access, and service provision within the behavioral health system in Texas. *Source: Gnanapragasam, S., Astill Wright, L., Pemberton, M., & Bhugra, D. (2021). Outside/inside: Social determinants of mental health. U.S. Surgeon General, Texas Health and Human Services Commission, Healthy People 2030, Texas Statewide Behavioral Health Strategic Plan, Texas Health System-Wide CHNA Report*
Goals	Improve quality of life through awareness, detection, treatment, and management of behavioral health conditions; address social determinants of health by partnering with community organizations.
Strategic Alignment	Consumer Focus
Resources	• Community Health Improvement staff, advocates, educators, community health workers (system and entity-level) • Partner and community-based organizations • Internal channels, capabilities and service lines • Revenue: Community Health Improvement & Community Benefit budgets (system and entity-level); In collaboration with Texas Health Resources Foundation funding secured grants and sponsorships

PRIORITY AREA FRAMEWORK: BEHAVIORAL HEALTH

Community Health Need	Strategic Partnerships	Target Population	Objectives	Anticipated Impact		
				Year 1	Year 2	Year 3
1.1 Explore opportunities for new system-wide behavioral health community program(s). 1.2 Increase accessibility to available services. 1.3 Improve quality of life in older adults. 1.4 Reduce effects from adverse childhood experiences through resiliency training.	Communities Foundation of Texas Fort Worth Independent School district Dallas Independent School District Terrell Independent School District A+ Charter Schools Cleburne Independent School District Lewisville Independent School District Dr. Matthew Smith, MD (MLS Health, LLC) Mission Metroplex, Inc. Carevide	**Collin County High Needs Zip Codes:** 75069, 75074, 75407, 75442 **Denton/Wise Counties High Needs Zip Codes:** 76201, 75057, 76205, 76209, 76266, 76431, 76426 **Dallas/Rockwall Counties High Needs Zip Codes:** 75212, 75216, 75217 75224, 75211, 75203 75227, 75042, 75220 75233, 75180, 75051 75231, 75116, 75150 75032, 75189	Embed resiliency training in schools to improve resiliency skills among youth overcoming adverse childhood experiences.	Replicate Together Harnessing Resources to Give Individual Voice and Empowerment (THRIVE) program at three schools.	Replicate THRIVE program at two schools.	Informed by community readiness and philanthropic interest, assess further expansion opportunities for THRIVE program.
			Reduce isolation and improve quality of life in adults 50+.	72% of participants in Reduce Social Isolation and Lift Outcomes for Seniors (SILOS) program will show as least 10% improvement in social connectedness as measured by Duke Social Support Index (DSSI). Sustain and expand Reduce SILOS program into additional service lines.	Define improvement goals based on year one baseline. Secure sustainability of Reduce SILOS program and analyze baseline data to understand need for additional expansion.	Define improvement goals based on year two metrics. Informed by new CHNA, establish strategic plan for Reduce SILOS program.

1.5 Reduce depression and mental distress among minority populations by increasing access to providers and resources for mental health and substance use disorder treatment.	North Texas Area Community Health Centers, Inc. Brother Bill's Helping Hand Health Services of North Texas, Inc. (Denton/Wise) Children & Community Health Center University of Texas - Dallas	**Southern Counties High Needs Zip Codes:** 76402, 76401, 76446, 75143, 75119, 76031 76093, 76059, 76033, 75161, 75147, 75160 **Tarrant/Parker Counties High Needs Zip Codes:** 76105, 76164, 76106, 76115, 76010, 76119, 76104, 76103, 76111, 76011 76110, 76116, 76117, 76112, 76134, 76082	Increase number and quality of funded programs addressing behavioral health initiatives.	Establish an innovative collaborative framework for strategic partnership and community-based program alliances.	Leverage year one framework to increase the quality of applicants that apply to the Texas Health Community Impact (THCI) 2024 RFP – focused on applications that are innovative, collaborative and have strong potential for long term impact.	Implement cycle four THCI grants, focusing on strong evaluation to demonstrate behavioral health impact.

PRIORITY AREA 2: CHRONIC DISEASE

Need Statement	Chronic conditions are a significant public health issue that pose a great societal cost. Sixty-six percent of healthcare spending is directed toward people with multiple chronic conditions. However, regular physical activity, a healthy diet, and the maintenance of a healthy body weight can lower a person's risk of several chronic conditions and improve health and quality of life for those already diagnosed with a chronic disease. Common themes from the system wide CHNA report include issues related to the availability of healthy foods, the built environment, and obesity. *Source: Dallas County Health & Human Services, Texas Health System-Wide CHNA Report*
Goals	Improve quality of life and preventable, healthcare utilization through the continued prevention and management of chronic conditions; address social determinants of health by partnering with community organizations
Strategic Alignment	Consumer Focus, Exceptional Care, Value Creation, Culture of Excellence
Resources	• Community Health Improvement staff, advocates, educators, community health workers (system and entity-level) • Partner and community-based organizations • Internal channels, capabilities and service lines • Revenue: Community Health Improvement & Community Benefit budgets (system and entity-level); In collaboration with Texas Health Resources Foundation funding secured grants and sponsorships

PRIORITY AREA FRAMEWORK: CHRONIC DISEASE

Community Health Need	Strategic Partnerships	Target Population	Objectives	Anticipated Impact		
				Year 1	Year 2	Year 3
2.1 Reduce malnutrition by supporting healthy eating lifestyles. 2.2 Provide education and screening to address healthy lifestyle changes. 2.3 Reduce the number of those with diabetes and high blood pressure, especially within minority and obese populations.	Mission Metroplex, Inc. Carevide North Texas Area Community Health Centers, Inc. Brother Bill's Helping Hand Health Services of North Texas, Inc. (Denton/Wise) Children & Community Health Center Mobile Healthy Education Lifestyle Program (HELP) Austin Street Center Mobile Partners • Grocery Stores • School districts • Colleges • Community Centers • Community Based Organizations • Churches • Federally Qualified Health Clinics • Clinics serving uninsured/ underinsured • Homeless Shelters • Food Pantries	**Collin County High Needs Zip Codes:** 75069, 75074, 75407, 75442 **Denton/Wise County High Needs Zip Codes:** 76201, 75057, 76205, 76209, 76266, 76431, 76426 **Dallas/Rockwall County High Needs Zip Codes:** 75212, 75216, 75217 75224, 75211, 75203 75227, 75042, 75220 75233, 75180, 75051 75231, 75116, 75150 75032, 75189 **Southern High Needs Zip Codes:** 76402, 76401, 76446, 75143, 75119, 76031 76093, 76059, 76033, 75161, 75147, 75160	Increase community -level access points, resources and referral streams to preventive chronic disease management programs and community initiatives.	Increase Wellness for Life access points for cancer screenings (ie. breast, cervical, colon) by 30%. Increase number of patients served for Mobile HELP by at least 50%.	Based on year one performance determine growth measures based on capacity and available funding. Based on year one baseline determine growth rate for Mobile HELP.	Informed by new CHNA report redefine Mobile footprint and establish new strategic plan. Informed by new CHNA report redefine Mobile footprint and establish new strategic plan for Mobile HELP to strengthen capacity and support growth of Mobile HELP.
			Increase number of grantee programs addressing chronic disease initiatives.	Establish an innovative collaborative framework for strategic partnership and community-based program alliances.	Leverage year one framework to increase the quality of applicants that apply to the THCI 2024 RFP – focused on applications that are innovative, collaborative and have strong potential of impact.	Implement cycle four THCI grants, focusing on strong evaluation to demonstrate chronic disease related impact.

		Tarrant/Parker County High Needs Zip Codes: 76105, 76164, 76106, 76115, 76010, 76119 76104, 76103, 76111, 76011,76110, 76116, 76117, 76112, 76134, 76082	Improve health outcomes, readmission rates and cost savings among homeless individuals served.	Increase the number of neighbors enrolled and graduating from Health to Home in Dallas County. Demonstrate improved readmissions and cost savings for neighbors that graduate from Health to Home in Dallas County.	Based on year one metrics, set goals for identification and enrollment of Health to Home participants across open sites.	Establish strategic plan for sustainability and growth for Health to Home.
			Improve access to medical care and services among homelessness individuals through medical respite care.	Assess environment for implementing a medical respite in additional counties.	Establish new partnership agreements in additional county and implement program.	Establish baseline data for readmissions among participants completing medical respite care and identify opportunities for improvement.

PRIORITY AREA 3: AWARENESS, HEALTH LITERACY, & NAVIGATION

Need Statement	Low health literacy--an individual's ability to obtain, process, and understand basic health information--has been linked to poor health outcomes such as higher rates of hospitalization and less frequent use of preventive services. Increased access to comprehensive, quality health care services and improved health literacy are part of the Healthy People 2030 goals and objectives. These measures are important for improving health equity and quality of life. Access to health services and health literacy and navigation were the third most prioritized needs across 25 Texas Health facilities. Common themes from the system wide CHNA report include issues related to low health insurance coverage, healthcare provider shortage, health literacy, language and cultural barriers, and resource navigation. *Source: The Henry J. Kaiser Family Foundation, U.S. Department of Health and Human Services, Healthy People 2030, Texas Health System-Wide CHNA Report*
Goals	Increase individual awareness of health information and services that are accurate, accessible and actionable; address social determinants of health by partnering with community organizations
Strategic Alignment	Consumer Focus
Resources	• Community Health Improvement staff, advocates, educators, community health workers (system and entity-level) • Partner and community-based organizations • Internal channels, capabilities and service lines • Revenue: Community Health Improvement & Community Benefit budgets (system and entity-level); In collaboration with Texas Health Resources Foundation funding secured grants and sponsorships

PRIORITY AREA FRAMEWORK: AWARENESS, HEALTH LITERACY, & NAVIGATION

Community Health Need	Strategic Partnerships	Target Population	Objectives	Anticipated Impact		
				Year 1	Year 2	Year 3
3.1 Increase access to low-cost or free healthcare resources and transportation systems. 3.2 Address affordability due to lack of insurance and geographic availability. 3.3 Reduce language barriers causing gaps in navigation (CHW/SW) and understanding. 3.4 Identify opportunities for transportation barriers. 3.5 Reduce food insecurity by improving access to healthy foods.	Mission Metroplex, Inc. Carevide North Texas Area Community Health Centers, Inc. Brother Bill's Helping Hand Health Services of North Texas, Inc. (Denton/Wise) Children & Community Health Center Austin Street Center Faith Communities Faith Community Partners • Community-based organizations • Food pantries • School districts	**Collin County High Needs Zip Codes:** 75069, 75074, 75407, 75442 **Denton/Wise Counties High Needs Zip Codes:** 76201, 75057, 76205, 76209, 76266, 76431, 76426 **Dallas/Rockwall Counties High Needs Zip Codes:** 75212, 75216, 75217 75224, 75211, 75203 75227, 75042, 75220 75233, 75180, 75051 75231, 75116, 75150 75032, 75189	Increase and align vaccination rates to Healthy People 2030 across existing and integrated Texas Health networks.	Develop and deploy curriculum for vaccine education that supports Healthy People 2030 vaccine goals.	Assess and deploy vaccine education at aligned pilot organizations. Evaluate effectiveness of education, determine reach potential and deploy across CHNA communities.	Informed by new CHNA report, establish strategic plan that strengthens education offerings and targets communities at highest risk.
			Increase community-level access points, resources and referral streams to disease management programs and community initiatives.	Establish an innovative collaborative framework for strategic partnership and community-based program alliances.	Leverage year one framework to increase the quality of applicants that apply to the THCI 2024 RFP – focused on applications that are innovative, collaborative and have strong potential for long term impact.	Implement cycle four THCI grants, focusing on strong evaluation to demonstrate behavioral health impact.
			Convene multiple congregations/faith-based organizations for activities and/or programs that provide resources/services addressing community needs.	Establish and implement strategic plan, define measures of success and define baseline.	Based on year one measures, establish process improvement and growth measures.	Based on new CHNA report and year one and two data, establish strategic plan.

		Southern Counties High Needs Zip Codes: 76402, 76401, 76446, 75143, 75119, 76031 76093, 76059, 76033, 75161, 75147, 75160 **Tarrant/Parker Counties High Needs Zip Codes:** 76105, 76164, 76106, 76115, 76010, 76119, 76104, 76103, 76111, 76011 76110, 76116, 76117, 76112, 76134, 76082	Improve health outcomes and readmission rates among uninsured and underinsured populations.	Establish Continuum of Care program baseline data for medical home connection and readmission rates across four pilot sites. Create sustainability plan for grant-based sites. Create referral channels across service lines and at community level.	Improve key Continuum of Care measures for existing sites based on previous year's performance. Implement new sites based on operational model that leverages existing resources for efficiencies.	Based on new CHNA report and alignment with system strategies, create a strategic plan that focuses on strengthening operations and sustainability.
			Coordinate and provide comprehensive care to patients with the complaint of sexual assault. Establish plan that increases capacity for the Sexual Assault Nurse Examiner (SANE) program-related outreach and education.	Increase SANE referrals to local rape crisis advocacy services by 10%. Create a sexual violence/human trafficking curriculum and train all Community Health Workers (CHW), Faith Community Nurses (FCN) and Promoters on content. Assess community partner interest for train the trainer opportunities and for implementation of curriculum and deploy pilot.	Define growth measures for SANE increased referrals to local rape crisis advocacy from previous year. Based on year one performance define process improvement, metrics for reach and impact.	Define growth measures for SANE increased referrals to local rape crisis advocacy services from previous year. Define progress measures based on year two performance. Based on new CHNA report, establish strategic plan for expansion and growth.