2023-2024
Grant Cycle

ENHANCE

Enhancing North Texas Health through Action, INnovation, & Community Evaluation

Texas Health Community Impact

Evaluation Report

UTHealth Houston
School of Public Health

Final Report

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Executive Summary

This section provides an overview of the THCI Initiative, the UTHealth Houston evaluation approach, and the impact of 2023-2024 projects.

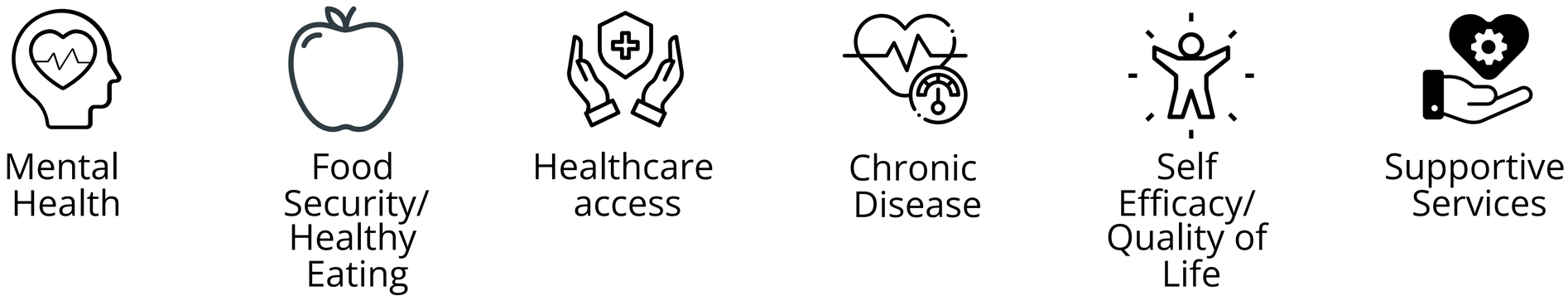
THCI OVERVIEW

Texas Health Community Impact (THCI) launched in 2019 with the goal of improving lives of North Texans by supporting cross-sector collaborations addressing local needs in innovative ways.

THCI projects leverage existing community relationships and use data to drive community health improvement at the local level. Projects focus on addressing priority areas identified by five unique regional Texas Health Community Impact Leadership Councils that represent counties in the Texas Health service area. The Councils are comprised of community leaders responsible for recommending outcome-driven programs and collaborations.

In the 2023-2024 grant cycle, twelve projects across five North Texas regions were funded.

UTHealth Houston served as the evaluator for nine of the projects in four regions. Two capacity building projects were not included in the evaluation and one project from the Dallas-Kaufman region had a separate evaluator. Projects addressed a variety of priority areas for their target communities.



Driving Equitable Health in Collin County

Collin
75074, 75442, 75407

RisingUP!

Collin
75074

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76082

The Railroad Project

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76104, 76105, 76119

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Tarrant
76010, 76011,76104, 76105, 76119

EVALUATION APPROACH

The Program Evaluation team at the UTHealth Houston School of Public Health in Dallas conducted an external evaluation of the THCI projects. This report summarizes the key learnings from the 2023-2024 THCI-funded projects.

A mixed-methods process and outcome evaluation was conducted to assess the impact of each project and generate findings across the initiative. The evaluation conducted in close collaboration with each grantee team and THCI staff to 1) develop a data collection plan that reflected the context, services, and goals of the project, 2) integrate quantitative and qualitative data to assess performance on three evaluation domains, and 4) synthesize data in real-time to share findings, monitor progress, troubleshoot issues, and adapt to changes.

The evaluation was guided by the RE-AIM framework.

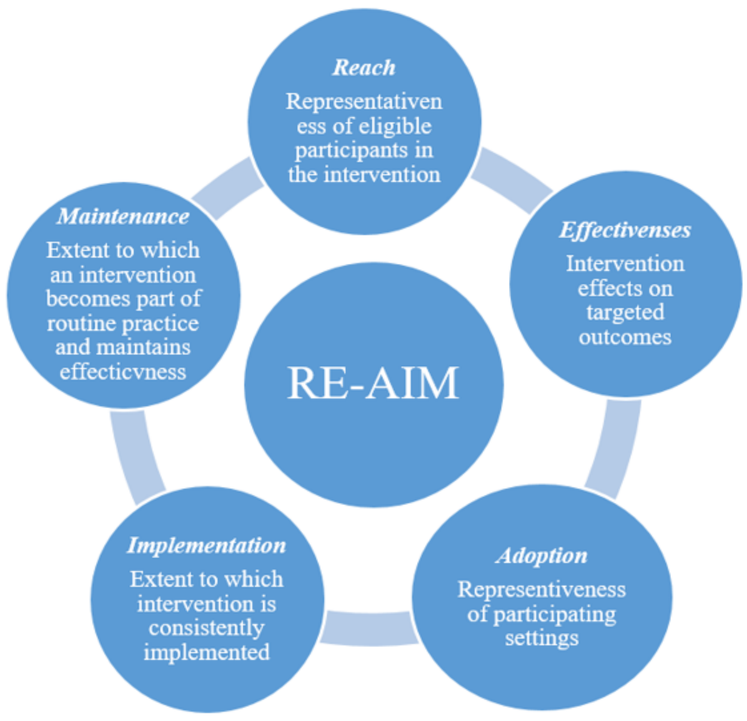
Reach (i.e., the number, proportion, and representativeness of individuals participating)

Effectiveness (i.e., the impact of each community project on specified outcomes)

Adoption (i.e.., the willingness of stakeholders and the target population to actively participate in each project)

Implementation (i.e.., the degree to which each project is implemented as intended)

Maintenance (i.e.., the sustainability of individual- and project-level effects and assesses the extent to which funded projects become institutionalized)



The Learning Evaluation approach was employed to:

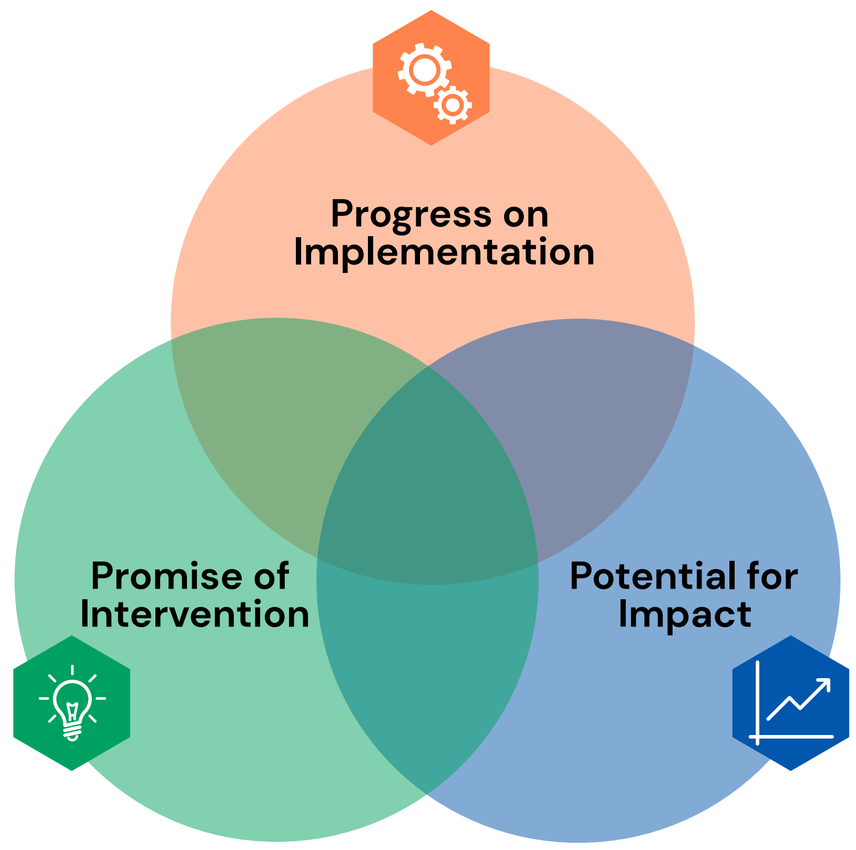
- Establish a detailed understanding of grantee projects, goals, and implementation plans.
- Provide ongoing training and technical assistance to grantees to support their evaluation design and help ensure the collection of timely, high-quality data.
- Conduct real-time assessment of implementation processes and rapid dissemination of findings with grantees and THR stakeholders.

Project impact was assessed on three domains:

Promise of Intervention
Assessment of project design. Does it have a strong evidence base or rooted in community expertise? Are there sufficient resources for successful implementation and measurement? Is it designed in a way that will successfully reach the target audience?

Progress on Implementation
Assessment of Implementation. Did the project reach the intended population at the level or rate planned? Are the project components successfully implemented and is there uptake of services?

Potential for Impact
Assessment of effectiveness in terms of outcome measures an overall impact. Is outcome change likely? Are services impactful? Is the project making a meaningful difference to those it serves?



Glasgow RE, Vogt TM, Boles SM. Evaluating the public health impact of health promotion interventions: the RE-AIM framework. Am J Public Health. (1999) 89:1322–7. 10.2105/AJPH.89.9.1322

Balasubramanian BA, Cohen DJ, Davis MM, Gunn R, Dickinson LM, Miller WL, Crabtree BF, Stange KC. Learning Evaluation: blending quality improvement and implementation research methods to study healthcare innovations. Implement Sci. 2015 Mar 10;10:31.

I would say that most of the problems, 99% of the problems, boil down to people sometimes are incapable of seeing their self-worth, and if you can't believe in yourself, you can't possibly believe that you can ever have better or do better.

And so sometimes, it's not necessarily just helping somebody get a job or helping somebody get counseling or things like that, but it's starting from square one, and you help them see that they're a human being and they're valued and they're worthy, and once they can see that for themselves, sometimes they can do things on their own without needing that assistance.

-Project HHH Team Member

Grantee Spotlights

This section, organized by region, provides key evaluation findings from each of the funded projects this grant cycle.

Collin

RisingUP!

Plano Independent School District

RisingUP! is a school-based mental health program aimed at removing traditional barriers to receiving mental health services. Students at four elementary and two middle schools in East Plano (75074) are screened for emotional and behavioral difficulties and students with elevated scores are connected with a Qualified Mental Health Professional (QMHP) for weekly life skills development sessions. Other project components include assistance with food insecurity, and mental health training and education for parents and staff.

RisingUP! delivered age-appropriate life skills services to students and provided valuable resources for parents and educators.

RisingUP! builds on the success of its predecessor PlanoUP! by delivering a comprehensive program designed to address the mental health needs of students on multiple levels. It provides 1:1 life skills counseling services to elementary and middle school students, district-wide food assistance to address food insecurity, and mental health education and consultation for caregivers and teachers.

> **When we [looked at] where are our mental health supports right now in PISD, we really are focusing on the reaction after something happened opposed to the prevention. I think it was just a consensus of we need more preventative services for our district, for our students, for our parents especially, and for our staff.**
> *– RisingUP! Team Member*

RisingUP! successfully screened and enrolled students into the program. Enrolled students received consistent services and were well engaged.

Students at participating schools were referred to RisingUP! for reasons including depression, anxiety, and trauma. Enrolled students received 1:1 weekly life skills development sessions with a QMHP and were reassessed for additional service needs after about 8 weeks. Life skills sessions helped students develop skills around emotional regulation, executive functioning, and building self-confidence with the ultimate goal of improving mental health and overall quality of life.

A total of 1,899 life skills sessions were conducted with students completed 11 (SD: 7.6, range: 1-41) 1:1 weekly life skills sessions on average.

Caregiver and staff services included the creation of an online portal of mental health education videos and consultation opportunities on how to support the mental health needs of students in the classroom and at home.

RisingUP! also partnered with Minnie's Food Pantry to provide "VIP Hunger Bags" with non-perishable foods for East Plano students and their families.

242 Students screened for emotional and behavioral difficulties

163 Enrolled in RisingUP!

903 Parent and staff mental health support consultations

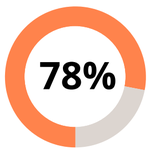
1899 Life skills sessions conducted

4782 VIP food bags distributed

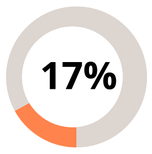
4648 Views of parent mental health education videos

RisingUP! reached students with diverse service needs.

Of 163 students enrolled into RisingUP!, 138 (85%) had at least one need or school support service and 45 (28%) students had more than one need or service. The majority (78%) identified as food insecure or economically disadvantaged.

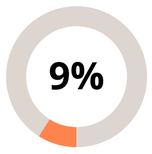


Economically disadvantaged



Special education

504 plan



Communities in Schools/social worker

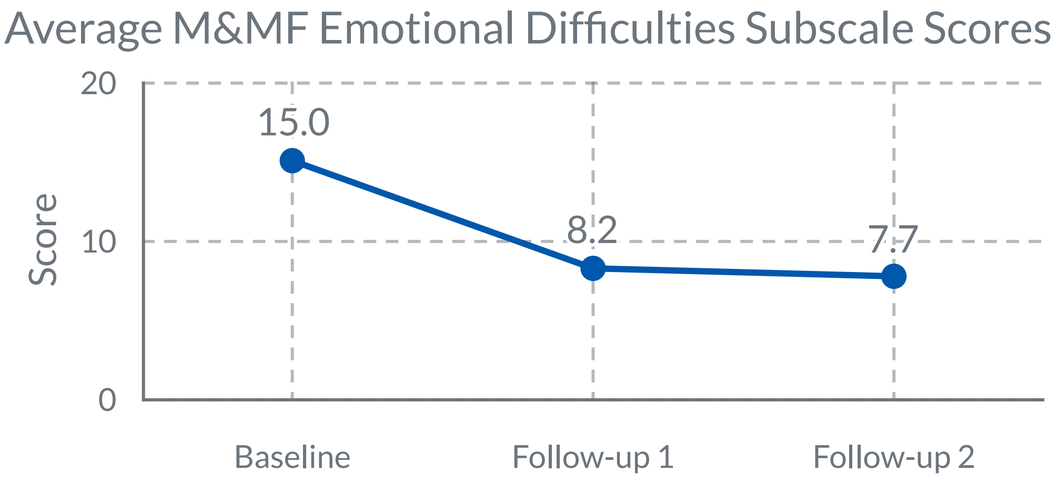
Participant Perspectives

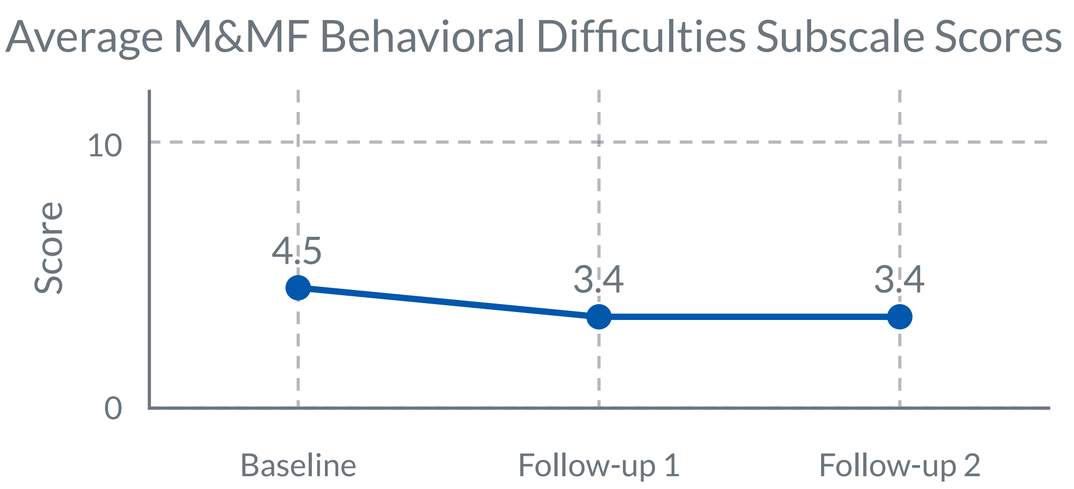
Participants reported that the program was well-structured and provided individualized support, supplementing students' learning beyond regular school hours. The program had a positive impact on students' academic performance, coping skills, and personal development, while also reducing parental stress by assisting with schoolwork. A lack of communication with parents was noted, with suggestions for more updates on children's progress and curriculum. Additional recommendations included expanding access to more schools and incorporating play therapy to enhance emotional and social development.

Emotional and behavioral difficulties scores improved significantly with the majority of students exiting the program with normal scores.

RisingUP! used the Me & My Feelings (M&MF) questionnaire to assess the behavioral and emotional needs of students. 132 (81%) students completed at least one M&MF follow-up assessment.

69% of students exited the program with normal-range scores. Emotional difficulties and behavioral difficulties subscale scores decreased (improved) significantly, by an average of 7.2 (95% CI: 3.5-10.9) and 0.7 (95% CI: 0.4-1.0) points per follow-up respectively when clustered on school and controlled for gender, race, parent languages spoken, number of 1:1 sessions, and Communities in Schools services receipt.





> **[A student who moved away] messaged me and gave me a list of things that she felt had gotten better for her, like her self-esteem, and that she was more hopeful that her life would get better based on her time in the program. So even in that moment where her whole life was going to change, she still found hope in the idea that things could be better.**
> – RisingUP! Team Member

Overall Assessment

RisingUP! implemented a school-based program that significantly improved emotional and behavioral difficulties among a highly engaged group of enrolled students. The longstanding partnership with Minnie's Food Pantry allowed for reliable distribution of healthy foods to students and their families. By incorporating support and education for caregivers and teachers, RisingUP! took a holistic approach to addressing students' mental health needs both inside and outside the classroom. With strong leadership and committed partners, RisingUP! was able to ensure program components were effective and feasible for participants. Looking ahead, RisingUP! has an opportunity to expand its impact by implementing schoolwide screening to identify and support even more students in need.

Collin

Driving Equitable Health in Collin County

American Heart Association

Driving Equitable Health in Collin County (DEH) aims to improve health outcomes of residents of East Plano, Farmersville, and Princeton (75074, 75442, 75407) with high blood pressure by increasing opportunities to access quality healthcare, providing education on nutrition and chronic disease management, and offering a health coaching program to empower participants to adopt healthier lifestyle habits.

DEH aimed to empower residents with high blood pressure to self-manage chronic disease risks through an innovative health education program.

DEH allowed the American Heart Association to expand into a new service area through collaboration with established local organizations. Building on previous clinic-to-community programming, DEH placed a blood pressure kiosk in the partnering organizations and developed a custom health coaching program designed to support underserved residents of the target area in self-managing their chronic-disease risks through education, resources, and referrals.

> **We know that there are certain health disparities and certain neighborhoods that have trouble with access to healthcare. Our big thing is knowing your numbers and how before you're able to make any changes, you need to know what your numbers are.**
> *– DEH Team Member*

DEH faced startup challenges and employed several strategies to boost participation, but struggled with enrollment and retention in the program.

As a new project with new partners, DEH faced challenges with role definition, establishing workflows, and managing data sharing between partners. In total, 122 participants were enrolled across nine community partner sites. Enrolled participants received a baseline blood pressure measurement and completed a healthy lifestyle survey before being connected to the health coaching program. The health coaching program consisted of six sessions covering topics related to healthy living and chronic disease management. Participants received a home blood pressure monitor and training on how to self-monitor blood pressure.

63% of enrolled participants completed the first health coaching session. The average number of sessions attended was 1.8 (SD: 1.3) with a maximum of 5 sessions. No participants completed the full six-session health coaching program.

DEH employed several strategies to increase engagement including adding community partner recruitment sites, offering virtual and pre-recorded heath coaching visits, and hiring a Spanish-speaking Community Health Worker. **Ultimately, these efforts did not translate to improved engagement and the grant was terminated in August 2024.**

- **122** Clients enrolled
- **77** Completed first health coaching session
- **74** Received home blood pressure monitor
- **37** Completed at least one follow-up session
- **0** Completed the health coaching program

> **I feel like [prospective participants] think it's going to be the same thing as a doctor's visit. I've had people say -- *well, I see my doctor, so they help me with my blood pressure*. They don't understand that it's going to be something different. It's going to be techniques that I teach them about. Different things that can help lower blood pressure alongside with what the doctor is telling them. I don't think people gave [it] a chance.**
> *– DEH Team Member*

DEH participants rated their health status positively at baseline. Change in lifestyle habits and blood pressure status could not be assessed due to lack of follow-up.

DEH developed a custom healthy lifestyle survey adapted from validated national surveys (BRFSS and NHANES). The survey included questions on physical activity, nutrition, and overall physical and mental health. At baseline, the majority of participants reported being in good, very good, or excellent health (61%).

Follow-up blood pressure readings and healthy lifestyle surveys were intended to be administered at the final health coaching visit. Since no participants completed the program, no follow-up assessments were completed.

Despite many challenges, DEH had the potential to enhance the traditional chronic disease management care provided in clinical settings through patient empowerment and education. The learnings from this abbreviated grant period offer valuable lessons that can inform future initiatives.

61%
reported good, very good, or excellent health status at baseline

2.44 Average days of moderate physical activity per week

0.87 Average days of vigorous physical activity per week

60% 3+ servings of fruit per week

65% 3+ servings of vegetables per week

> **You tell somebody they have hypertension, and they need to take this medicine, and they don't even know how to check their blood pressure. So that just that little bit of teaching that we were able to do here, those have been fun things just to see. Patients take [the information] and feel like --- *okay, I can do something*, [they] feel empowered.**
> *– DEH Team Member*

Overall Assessment

DEH proposed an innovative, holistic patient-centered program designed to improve the chronic disease self-management capacity of residents in the target area. However, the program encountered significant challenges that hindered its progress. Major obstacles included delays in startup, poorly defined partner roles, limited expertise and connection to the target area, and a lack of motivation for participants to stay engaged in the health coaching program. Despite implementing several thoughtful adaptations to address these issues, sufficient progress could not be made in the grant period. Nevertheless, partners remained committed to the program's mission, and the resources developed and lessons learned can shape future successful efforts.

Dallas Kaufman

Healthy Families, Healthy Communities

The Concilio

Healthy Families, Healthy Communities (HFHC) aims to provide access to culturally competent health education programming and household support to lower the rate of chronic diseases and improve the economic stability of households in the Vickery Meadow region of Dallas (75231 and 75243). HFHC offers an 11-week program featuring nutrition education, healthy cooking demonstrations, grocery store tours, fitness testing, physical activity education, financial literacy education, financial coaching, and wrap around case management support.

HFHC provided culturally-appropriate health education and support to improve behaviors that impact obesity and chronic disease in a hard-to-reach community.

HFHC allowed The Concilio to expand its existing education programming to a new area of Dallas (Vickery Meadow) by partnering with Vickery Meadow Youth Development Foundation (VMYDF), a well-established organization in the target region. This comprehensive, culturally relevant program includes tailored wrap-around case management services to address clients' needs holistically.

> **We've been doing our Healthy Kids Healthy Families program for a very long time and our focus has been on serving primarily Hispanic families. But the program has done very well. And so, we wanted to be able to expand our reach outside of the area...and Vickery Meadow was an area that we knew we wanted to target.**
> *– HFHC Team Member*

HFHC successfully reached diverse, high-needs families in the target region and expanded services to a new demographic group.

HFHC enrolled 196 families over 8 cohorts, encompassing 905 total family members. Only 1 adult parent enrolls in HFHC and 96% of families were represented by a female parent. The Concilio has historically served Hispanic communities and aimed to reach new underserved populations in the Vickery Meadow area. One cohort was offered in Dari (an Indo-Iranian language), expanding HFHCs reach into the refugee community. Participants were also largely low-income and uninsured indicating reach into a high-needs group.

Completion of the HFHC program requires attending 8 of the 11 weekly sessions. 155 families (79%) completed the program, and 67 families attended all sessions, indicating strong participant engagement.

Wrap-around services offered through HFHC including grocery store tours, cooking demonstrations, and SNAP and Medicaid enrollment were well utilized. Financial coaching started in Spring 2024 and was offered only in Burmese and Dari, limiting participation.

106 Grocery store tours

94 Medicaid enrollments

126 Cooking demonstrations

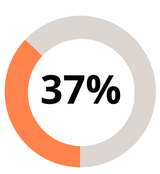
24 Rent/utility assistance

129 SNAP enrollments

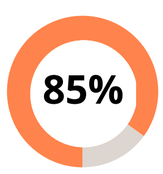
7 Financial coaching calls

196 families enrolled in 11-week program

79% completed the program



SNAP Recipient



Asian race

Household income less than $26,700

Medicaid or Uninsured

The HFHC program successfully improved participants' healthy behaviors. Downstream impacts of behavior change like BMI improvement may take more time.

HFHC significantly improved 3 out of their 4 main outcome measures: guideline-concordant fruit and vegetable intake, number of physical activity days, and waist circumference.

Healthy behaviors such as improving healthy eating habits and number of physical activity days are more immediately measurable for change. BMI change due to improvement in healthy behaviors likely takes more time than the 11-week program; however the improvement in waist circumference over the study period adds promise for the potential future improvement of BMI.

Longer term follow-up would be beneficial to determine sustained healthy behavior change and if these translate into long-term BMI improvements.

A **significantly higher** percentage of families reported **following fruit and vegetable intake guidelines** at follow-up compared to baseline in 2023 (96% vs 69%, $p<0.001$) and 2024 (76 vs 40%, $p<0.001$).

The **average number of physical activity days for children significantly increased** from 3.7 to 4.8 days ($t=7.1$, $p<0.001$). 130 children increased their number of physical activity days by at least one day.

The **average waist circumference significantly decreased** from 38.7 to 37.9 inches ($t=4.2$ $p<0.001$). 60 adults decreased their waist circumference by at least one inch.

The average **BMI remained consistent** throughout the program at 31.7. One participant had an improvement in BMI from overweight to normal.

Participant Perspectives

The program promoted community engagement, personal growth, and self-empowerment, offering participants opportunities to share experiences and develop essential life skills. It supported mental well-being by reducing isolation and providing a welcoming space for learning and connection. Education on nutrition, exercise, and healthier lifestyles for families was perceived as valuable, with some participants using their program diplomas for career and personal advancement.

Despite overall satisfaction, challenges include scheduling conflicts, outreach gaps, and communication issues that impact accessibility. Participants also recommended more physical activity, greater support for young mothers, and better staff communication to recognize program staff/new staff and understand program expectations.

> **For me, a success story is seeing moms' joy, that they come here knowing that there's something else they're learning that day, to see that they're making that change...this program brought moms together...They come from remote places, they've just arrived with thousands of problems...The families come happy, they feel motivated. That's something that can be transmitted at home.**
> *- HFHC Team Member*

Overall Assessment

HFHC successfully implemented a culturally sensitive, comprehensive, multi-level education program to a diverse group of families in the target area. Families were highly engaged in both core program components and wrap-around support services offered. The well-defined partnership with VMYDF allowed HFHC to expand services to a new language group. By adopting a thoughtful approach to data collection and assessment design, HFHC achieved significant improvements on all outcome measures appropriate for the design of the program. Looking ahead, HFHC has the opportunity to expand its work with the refugee community and incorporating long-term follow-up with participants could help demonstrate the program's lasting impact.

Denton Wise Parker

Healthcare and Support Services for Denton County Residents Experiencing Homelessness

Health Services of North Texas

Healthcare and Support Services (HCSS) aims to connect individuals experiencing homelessness in Denton County with primary medical care and other supportive services. Health care services connection pathways included the establishment of a Licensed Vocational Nurse services on-site at Our Daily Bread as well as developing a referral pathway for primary care services at Health Services of North Texas. Through better primary care connection, HCSS hopes to lessen reliance on 911 systems and improve management of chronic health conditions for their guests.

HCSS developed a robust care coordination and healthcare service program to deliver healthcare and wrap-around support to a population facing many service barriers.

A key component of the HCSS program was the addition of a grant-funded care coordinator and Licensed Vocational Nurse (LVN) to provide healthcare and other supportive services on-site at the Our Daily Bread (ODB) homeless shelter. These staff members were able to provide referrals and assist with scheduling appointments that allowed guests to receive primary care at Health Services of North Texas (HSNT), including the management of chronic health conditions. A new partnership, HCSS spent significant time establishing trust with the ODB guest.

> **The guests at Our Daily Bread were a little bit leery. You know, they don't just immediately trust. They were like, 'What are you doing here?' But now the feedback that I've received from our team – like our senior clinical nurse manager, for example – is that they know who we are.**
> *– HCSS Team Member*

HCSS components worked effectively both independently and in unison to provide vital health services to a large number of guests in need of medical care.

Guests could receive services from any combination of the care coordinator, LVN, and HSNT. Receipt of services from one source was not dependent on the other. However, both the LVN and care coordinator referred guests to HSNT. In total across the three service types, there were 1,557 encounters with ODB guests. Due to challenges with collecting guest ID number, there are many encounters that are not included in this total and thus true service administration is likely higher.

Health care services provided by the program components include vaccinations, entry into a vaccine tracking system (ImmTrac2), sexually transmitted disease tests, healthcare referrals, and healthcare education. Participation in vaccination and ImmTrac2 registration was lower than anticipated for the program, but there is opportunity to improve upon these numbers by supplementing these services on-site at ODB.

468 Unique guests seen by care coordinator (897 total encounters)

207 Unique guests seen by LVN (387 total encounters)

233 Unique guests receiving medical care by either LVN or at HSNT

170 Days LVN was on-site at ODB clinic

144 Vaccinations provided (COVID-19, flu, other)

A total of 144 total vaccinations were provided. COVID-19 vaccines were the most provided vaccines (78%), followed by flu (15%). 63 participants also received STI tests, 20 were registered in ImmTrac2, and health education was provided to 16 guests. The care coordinator met with guests to understand their needs and provide referrals and other supportive services. 33 referrals for services including eye exams, prescription assistance, and specialist services were provided.

The number of 911 calls originating from ODB decreased after LVN services began.

HCSS identified two main outcome measures: 1) reduction in 911 calls originating from the ODB campus and 2) improvement in blood pressure and HbA1c in guests with hypertension or diabetes seen by HSNT at least four times.

Reduction in 911 calls from pre-grant period of 2022 is not assessable because the shelter capacity expanded in December 2022 due to a building addition. However, 911 calls pre- and post-the start of on-site LVN services (May 2025) are comparable. **The proportion of 911 calls to guests in June 2023 to December 2024 was significantly lower by 1.1% (7.5 vs 6.4%, *p*=0.038) compared to January to April 2023.**

Few guests served by the program had diabetes (n=9) or hypertension (n=23) and even fewer received the target of at least four visits at HSNT. As a result, assessing improvements in blood pressure and hypertension is not meaningful. However, the connection of 70 guests to HSNT for 273 total encounters (average: 4 (SD: 4.2, range: 1-19)), regardless of diabetes or hypertension status, demonstrates success in helping guests establish a relationship with primary care that has the potential to impact chronic disease outcomes, address other health concerns, and improve overall quality of life.

Participant Perspectives

Participants were very grateful for both the services and emotional support provided. Several participants were especially thankful for the respectful nature of care received in Denton, compared with the care received in other towns. A challenge reported by participants was lack of resources, with one participant noting he was not able to afford necessary medication.

Overall, participants expressed positive feelings about the program, reflecting on their good experiences. Additional comments focused on an increased need for resources for unhoused people in Denton.

1.1%
Decrease in the proportion of 911 calls-to-guests

70
ODB guests with healthcare visits at HSNT

> **Well, we had a success of helping a person, one of our guests, be able to walk without being in pain. I mean, he had either osteo or rheumatoid arthritis in both knees. Getting him to the doctor. And it just made him not be so angry. His attitude is so much better. He came in just like in tears, just letting us know how grateful he was for getting him set up with one of the doctors at Health Services of North Texas.**
> *– HCSS Team Member*

Overall Assessment

HCSS utilized a multidisciplinary care team to deliver coordinated, efficient care to guests at the ODB homeless shelter. By stationing the LVN and Care Coordinator onsite at ODB, guests could receive immediate attention for their critical health needs and were directly connected to full-service primary care and other supportive services. While chronic disease management outcomes could not be assessed, HCSS successfully facilitated connection to primary care, an outcome which aligns more closely with the program's design. HSNT and ODB established a new partnership through this program with both organizations demonstrating a strong commitment to collaboration and program success. Attention to role delineation and refining data collection processes could enable more robust tracking of participants, services, and outcomes, enhancing the ability to demonstrate long-term impact.

Denton Wise Parker

Project Health, Hand, Hope

Center of Hope

Project Help, Hand, Hope (HHH) is a collaboration between Parker County Center of Hope and Safe Harbor Counseling aimed at expanding safety net services that were established during the 2021-2022 grant cycle in Springtown (76082). Through basic assistance (e.g., food distribution) and extended services (e.g., job training, tutoring), Project HHH aims to improve food security and quality of life in the 76082 area. Further, through the counseling partnership with Safe Harbor, this program aims to improve mental health (i.e., depression, anxiety) in the community.

Project HHH solidified its presence in the Springtown community, engaging more residents and offering an expanded range of comprehensive services.

New service programs and a new building allowed Project HHH to increase their presence and continue to build trust in the Springtown area. Basic services such as food distribution and financial assistance allowed for Project HHH to meet participants immediate needs, while extended services such as counseling through Safe Harbor, education, and job training allowed for the program to improve mental health and quality of life longer-term. Camp HOPE provided a touchpoint to address student's crisis needs like providing food, hygiene products, and clothing during a time where constant interaction with schools has been interrupted.

> **This grant has helped us get a real good foothold in the Springtown ZIP code. It was conducting some roundtables with people in the community, literally going to RV park, trailer parks, apartment complexes and handing out flyers. We attend Chamber events. You know, we try to be as involved in the community as we can.**
>
> *– Project HHH Team Member*

Project HHH provided essential services to new participants while maintaining strong engagement with participants from the previous grant cycle.

Of 842 total participants, 602 (72%) were new in the 2023-2024 grant cycle while 240 were participants who remained engaged from the 2021-2022 grant cycle.

715 participants received basic services including financial assistance, prescription assistance, food distribution, and health assistance. Basic services were well utilized with 2,925 instances of groceries provided, 805 financial vouchers provided, and 305 Toys for Tots Christmas baskets distributed.

127 (15%) received at least one extended service. 732 extended services were provided. The top utilized extended services are displayed. As a result of participation in extended services, 5 participants graduated with their General Education Diploma (GED) and one participant achieved U.S. citizenship. 45 students participated in Camp HOPE with participation improving in Year 2 due to increased presence in the community.

Safe Harbor Counseling provided counseling services to 30 participants, with engagement from the previous grant cycle remaining especially high for this service. 18 of these individuals are 2021-2022 grant cycle clients who have remained in the counseling service. 3 counseling participants are children under 18.

STEPS goal setting course
85 people
85 classes

Tutoring
20 people
401 classes

ESL class
7 people
68 classes

CALM anxiety class
6 people
56 classes

Computer classes
10 people
40 classes

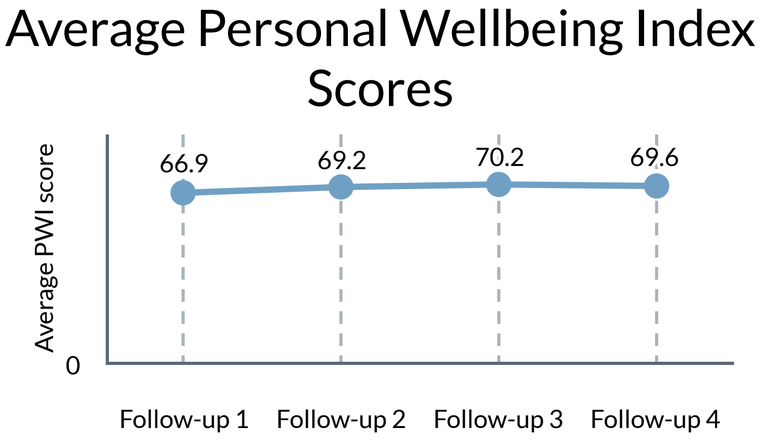
Participant Perspectives

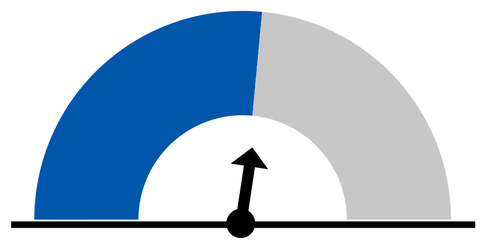
Participants reported that the informational support was “priceless", the program met tangible needs, provided emotional support, created community to reduce social isolation and facilitated social connections to support various needs were seen as invaluable. Program staff were perceived as highly professional, “going above and beyond”, and providing a welcoming atmosphere.

Suggestions for program improvement included larger facilities to accommodate demand and transportation, which was noted as a common access barrier.

Food insecurity and personal wellbeing significantly improved among Project HHH clients over time. Mental health outcomes had limited follow-up.

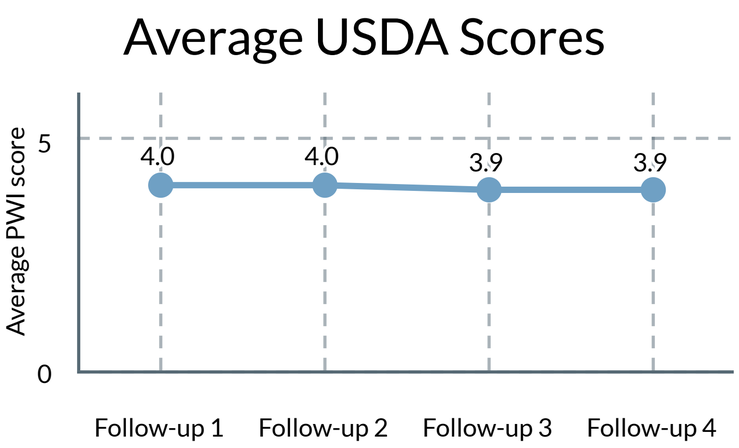
773 clients completed a baseline Personal Wellbeing Index (PWI) assessment, with an average score of 57.2 (SD: 23.2). 447 completed at least one follow-up. **For each follow-up, participants PWI scores significantly increased (i.e., improved) by a half of a point** when controlled for age, sex, race, marital status, education, housing, extended services receipt and clustered on cohort. Of clients with follow-up and less than perfect baseline scores, 232 (53%) had a higher score at last follow-up compared to baseline.

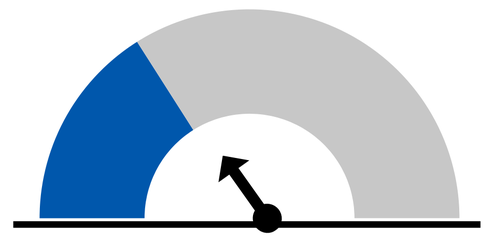




53% of participants improved their Personal Well-Being score by final follow-up

785 clients completed a baseline USDA food-security assessment, with an average score of 4.1 at baseline indicating low food security. 435 completed at least one follow-up assessment. **For each follow-up, participants USDA scores significantly decreased (i.e., improved) by 0.1 points** when controlled for age, sex, race, marital status, education, housing, extended services receipt and clustered on cohort.





32% of participants improved their USDA score by final follow-up

Of 424 clients with a follow-up and food insecurity at baseline, 141 (32%) had an improved score at last follow-up compared to baseline, but no participant improved their USDA category. Due to small sample sizes, mental health outcomes for Safe Harbor clients cannot be assessed.

> **There was a gentleman that came in. You could tell he was pretty broken, kind of down on his luck. Yesterday I went to our Jobs for Life graduation and that same gentleman was in our Job for Life class. And to see him and hear him give his testimony on how that class has changed him and brought back some of the joy that he had lost in his life, and I think that he had lost his joy in God...It just was so inspiring to hear. It’s been a long journey, but he's finally getting there. And I see a lot of hope in his story continuing to get better and better.**
>
> *– Project HHH Team Member*

Overall Assessment

Project HHH exceeded its primary enrollment goal and delivered a variety of services to residents of the Springtown region. Participants who were actively engaged reported significant improvements in food security and overall well-being. Through two cycles of THCI funding, Center of Hope has solidified its presence in Springtown and is well positioned for continued growth as an invaluable resource in the community. Project HHH demonstrated a strong dedication to supporting clients facing complex circumstances by helping them meet their basic needs and provide services that encouraged self-efficacy and self-sufficiency. Moving forward, they have an opportunity to leverage this strong foundation to increase awareness of and participation in their services.

Tarrant The Railroad Project

Eastside Ministries

The Railroad Project is a partnership between Eastside Ministries, Community Crossroads and Virtue Us Investments aimed at improving the overall well-being of low-income adults in Southeast Fort Worth (76104, 76105, 76119) through a comprehensive service delivery program primarily held at community health events. Consistent participation in the wide variety of service opportunities provided are intended to promote improved the physical, mental, and financial health of this high-needs population.

The Railroad Project partnered with community organizations to deliver a wide variety of services through community events and individualized follow-up.

New partnerships and an expanded target area allowed The Railroad Project to increase both the number of events held and the number of high-needs participants served by the program. Events offered onsite services (food distribution, health screenings) and referrals and information about additional program offerings outside the events. After events, participants were connected with an Accountability Partner who helped them set goals and connected them with services and community resources tailored to their needs. The Railroad Project is a client-centered initiative led by a trusted community institution that is deeply committed to fostering meaningful community engagement and health equity.

> **The Railroad itself is a kinetic thing, right? The way we want to help people out of poverty is keep them moving - that we're ever moving, we're ever changing. Anything that needs to be changed, we'll do it, but our core competency remains the same. We will serve our people with excellence.**
> *– The Railroad Project Team Member*

The Railroad Project effectively reached high needs residents of the target area and delivered a diverse range of services with strong participant engagement.

The Railroad Project held 33 community events with 1,298 unique attendees from the target zip codes.

Enrolled participants were highly engaged in services offered through the events. Accountability partners conducted at least one coaching call with 1,094 (84%) clients. During coaching calls, Accountability Partners encouraged self-monitoring of blood pressure, provided information on healthcare and other community resources, and discussed a topic of the client's choosing. Most common call topics included utilities/financial assistance, employment, childcare/family, dating/relationships, and mental health.

The Railroad Project sought to identify individuals with high blood pressure and provide them with education and resources to monitor blood pressure at home. 1,203 (93%) met criteria for elevated blood pressure and 853 (66%) met the criteria for hypertension. 411 blood pressure monitors were distributed, allowing them to be more knowledgeable about their blood pressure status and to obtain a referral for services when necessary.

1,298
community health event attendees

100% Received Health Sceening

99% Received Food and Clothing

15% Attended a Financial Literacy seminar

32% Received home blood pressure monitor

84% Participated in monthly coaching calls

> **Because one of our goals, we want to cover each zip code every month, and you know, not just because of the numbers, we're really excited about helping people stay healthy.**
> *– The Railroad Project Team Member*

Despite challenges with collecting follow-up assessments, Personal Wellbeing Index scores improved for The Railroad Project clients.

The primary outcome measure is personal wellbeing, encompassing health, safety, life satisfaction and other components measured by an adapted Personal Wellbeing Index (PWI) assessment.

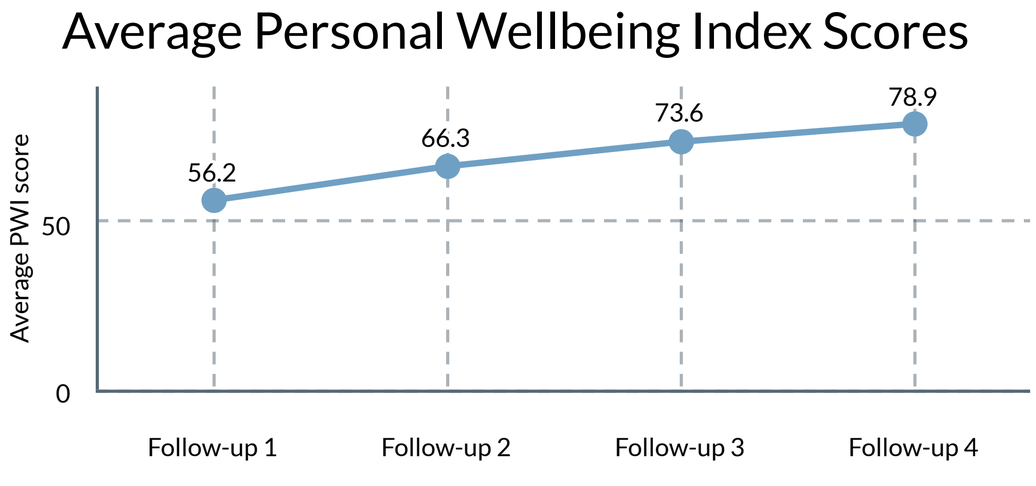
Of 1,297 clients with a baseline assessment, 980 clients had at least one follow-up. **606 (62%) had a higher PWI score at their final follow-up compared to baseline. PWI scores significantly increased (improved) by an average of 7.3 (95% CI: 6.5-8.1, $p<0.001$) points per follow-up,** when clustered on school and controlled for quarter of entry into the program, age, sex, race/ethnicity, primary language, and marital status.

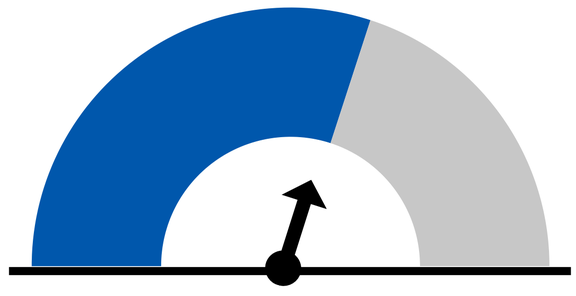
Participant Perspectives

Participants appreciated the reliable food distribution and the supportive staff who helped with skill-building and employment opportunities. The program fostered a sense of community and allowed participants to give back through volunteering.

Participants noted that limited space posed a challenge, which affected the ability to accommodate participants during extreme weather conditions. Participants also called for program expansion, extended hours, and additional supplies such as hygiene and household products. Maintaining the program's personalized approach and expanding food access to better serve the community were highly emphasized.

Follow-up PWI assessments were intended to be collected every every 4 months. PWI collection stopped after June 2024 and only baseline assessments for new program participants were collected at events. Longitudinal improvement of clients may be underrepresented due to program challenges including staffing capacity and training resources.





62% of participants improved their Personal Well-Being Index score by final follow-up

> **We bring food, we bring clothing, we bring household items, diapers, sometimes shoes. We bring resources for people, to know that there are resources out there to help you. There's a lot of resources out there that people did not know that they qualify for until we brought this program to the communities.**
> *-The Railroad Project Team Member*

Overall Assessment

The Railroad Project effectively reached high-needs residents of Southeast Fort Worth through well-organized community health events and tailored follow-up. Enrolled participants were highly engaged, accessing a range of services both onsite and after the events. The Accountability Partner model fostered a sense of kinship and connected individuals to additional resources and support in their community. Enrolled participants made significant improvements in overall well-being, though obtaining follow-up data was challenging due to the high volume of participants and staffing capacity issues. The project also identified the chronic disease burden in the community, providing valuable insights for future initiatives focused on chronic disease management.

Tarrant

iHEAL: Improving Health Equity Among Low-income adults

Taste Project

iHEAL is a collaborative partnership aimed at addressing social determinants of health and improving health outcomes for restaurant guests of Taste Project's pay-what you can restaurant and for participants of Taste Project's Culinary Apprenticeship Program. The program is focused on increasing access to wrap-around services such as job training, employment, food access, nutrition counseling, financial literacy education and coaching, healthy living education, and mental health counseling to help improve the target outcomes in Tarrant County.

iHEAL provided multidisciplinary services in a trusted environment, driven by strong cross-sector partnerships and participant input.

iHEAL services were offered to both restaurant guests and culinary apprentices and were designed to address health, wellness, and financial needs of their target population. Service offerings and partners were identified based on feedback from previous apprentices and were designed to address critical needs that the restaurant alone could not fulfill. Culinary apprentices received additional individualized services such as job training, employment skills and life-skills training. Services were offered onsite at Taste Project in order to break down service silos and reduce access barriers.

> **To be able to expand our services in a way that we wouldn't be able to alone, to be able to partner with other organizations to increase access to health assessments, to nutrition counseling to further the financial education for our apprentices...is wonderful and it all very much ties together for the social determinants and for this community that we've become such a part of here and cherish so much.**
>
> *– iHEAL Team Member*

iHEAL provided meals to high needs residents of the target area, with strong interest in the additional services offered through the program.

A foundational component of iHEAL is offering nutritious meals to everyone in their community regardless of one's ability to pay. Through the Taste Project pay-what-you-can restaurant, 9,435 free or subsidized meals were provided to residents of the target area.

9,435
free or subsidized meals provided

iHEAL has two paths to enrollment: participating in the apprenticeship program or indicating interest on an intake form at the restaurant. 658 individuals (220 restaurant guests and 438 culinary apprentices) enrolled in iHEAL. Once enrolled, participants can choose if they'd like to participate in wrap-around services (financial counseling, healthy living education and health assessments, nutritional counseling, and mental health counseling). Overall, 162 clients participated in at least one wrap-around service. Apprentices receive job training, employment services, and life skills training through the apprenticeship program. A total of 83 apprentices received these services.

90 clients participated in healthy living services, with 87 clients completing a baseline healthy lifestyle assessment to identify blood pressure and HbA1c status, food security, sense of community, and quality of life.

- **114** received financial counseling
- **90** participated in healthy living program
- **82** received nutritional counseling
- **18** received mental health counseling
- **83** participated in apprenticeship job training services

iHEAL assessed health outcomes on multiple domains and helped participants identify their chronic disease risk.

iHEAL assessed participant health outcomes through a variety of assessments administered in the healthy living program. Follow-up assessments were limited across all measures, restricting the ability to assess longitudinal changes.

Blood Pressure
87 participants completed a baseline blood pressure assessment with 36 (41%) having an elevated measurement. **Of those with elevated/hypertensive baseline blood pressure, 28% reported a known history of elevated blood pressure or hypertension at intake.** Only 8 of those with elevated baseline blood pressure completed a follow-up assessment.

HbA1C
72 participants completed a baseline A1C reading with 14 (20%) having an elevated A1C measurement. **Of those with an elevated baseline A1C, 50% reported a known history of diabetes or prediabetes at intake**. Only 2 with elevated A1C completed a follow-up assessment.

Participant Perspectives

The iHEAL program offered a variety of benefits, including skill development/ enhancement in culinary techniques, teamwork, and an opportunity for culinary exposure. Participants experienced personal growth and built camaraderie, with the program's charitable focus on community service being a notable positive.

However, the program faced challenges such as a toxic workplace culture, lack of appreciation for employees, and insufficient guidance for apprentices. Mental health support, clearer program structure, and the presence of professional mentors were noted as areas in need of improvement.

Quality of Life Measures
iHEAL administered the USDA 10-item Food Security Module, adapted Sense of Community Index, and SF-12v2® Quality of Life Assessment. At baseline, participants completing the food security assessment (N=86) had low food security on average (M: 3.2, SD: 3.0). Participants completing the Sense of Community Index (N=83) had an average baseline score of 47.4 (SD: 9.1) on a scale of 0-59 with higher scores indicating better sense of community. Participants completing the SF-12v2 (N=83) rated their mental component score (M: 45.7, SD: 12.9) and their physical component score (M: 48.0, SD: 10.2) as slightly below the US average. Only 20 participants completed any quality of life follow-up assessments .

iHEAL also tracked outcomes for graduated apprentices. By the end of the grant period, **32 culinary apprentices completed the apprenticeship program with 19 obtaining a living wage job and 6 enrolling in an additional, longer culinary apprentice training track.**

> **I think it would be meaningful if we saw a wide breadth of participation amongst our guests. If a higher percentage of the people that come in to eat at the restaurant also come on [iHEAL service days], I think that would be successful. And then if they felt like they were at Taste enough...that they felt a sense of community and a sense of place at Taste, I think that would be effective.**
> *-iHEAL Team Member*

Overall Assessment

iHEAL excelled at providing meals to residents of the target area through the pay-what-you-can restaurant. The additional services offered through iHEAL were comprehensive and garnered significant interest from restaurant guests and apprentices. The services were thoughtfully shaped by feedback from previous apprentices to address key social determinants of health and offering them onsite at the familiar and accessible Taste Project location helped overcome barriers related to access and comfort. Looking forward, iHEAL has the opportunity to refine its wrap-around service offerings to align even more closely with its mission and identify resources and strategies to increase service participation and engagement.

Summative Findings

This section provides cross-initiative findings and lessons learned that can inform future work and investment in the THCI program.

SUMMATIVE FINDINGS & LESSONS LEARNED

THCI grantees implemented a wide range of innovative projects with multilevel impacts.
THCI projects were thoughtfully designed to serve diverse, high-needs residents in the target areas. Projects were community-centered and employed strategies to intervene with individuals, families, and entire communities/systems. Through a combination of adapting and scaling established programs and implementing new approaches, projects addressed a wide variety of focus areas, each tailored to the unique needs of their local context.

Many THCI projects made significant improvements in key outcome measures.
Several projects demonstrated improvements in biometric measurements, emotional and behavior regulation, healthy behaviors, food security, and overall wellbeing in the short term. These projects can use lessons learned from this grant cycle to identify successful program components and potential need for adaptation to help best address needs of North Texans.

Projects were most successful when partner organizations had clear roles, good communication with lead agencies, and a shared mission across the network.
Project teams that were truly collaborative, with clear responsibilities, a shared vision for goals and activities, and continuous communication and support were best equipped to troubleshoot challenges, manage unforeseen circumstances, and implement effective programs.

Maintaining organizational capacity to manage participant volume and activities is key for sustaining engagement.
Many projects encountered demand or interest that surpassed their capacity. Setting realistic enrollment goals and clearly defining participation components is crucial for maintaining a manageable scope and ensuring participants receive the maximum benefit. Additionally, it facilitates proper resource allocation, manageable workloads, and the ability to produce high quality data that can demonstrate impact and ultimately justify the need to expand services.

While project champions can drive success, strong, supportive teams are essential for sustaining impact.
Projects spearheaded by individual champions benefited from strong leadership and a deep commitment to the success of their programs, but additional support is necessary to ensure program components can be implemented and tracked effectively, especially in the case of employment changes and unforeseen, but inevitable, disruptions.

Outcome measures should be appropriate, meaningful, and feasible.
Metrics that measure the direct impact of an intervention are important for demonstrating success and are best captured by measuring behavior change, knowledge gain, skill development, and service utilization. Attention to these short-term outcomes can ensure a program is effective and provide measurable milestones toward achieving longer-term goals.

The genuineness, the compassion, them wanting us to succeed, them wanting us to win. That's what I like most about this program.

-NHN Participant

EVALUATION METHODS

EVALUATION DESIGN

The evaluation was conducted by a mixed-methods team of researchers from the UTHealth Houston School of Public Health Dallas Campus. The evaluation approach was guided by the RE-AIM framework and Learning Evaluation approach. The research questions were:

The evaluation was designed to answer the research question: **To what extent have grantees achieved their project-specific goals and THCI initiative and regional objectives?**

We used a mixed methods convergent design to integrate qualitative findings from semi-structured interviews and quantitative analysis drawing upon programmatic data. The evaluation received approval by the UTHealth Houston Institutional Review Board.

GRANTEE ENGAGEMENT

We employed the Learning Evaluation model to establish a detailed understanding of grantee implementation plans, provide ongoing training and technical assistance to grantees to support their evaluation design and help ensure the collection of timely, high-quality data; and conduct rapid dissemination of findings with grantees and THR stakeholders.

Throughout the grant period, we provided training and technical assistance to grantees to support their evaluation design and help ensure the collection of timely, high-quality data that will be used for the THCI evaluation. We worked with each grantee to assess their familiarity and capacity to conduct an evaluation and collect and report high-quality data, provided recommendations, and troubleshot issues throughout the project period.

QUANTITATIVE DATA AND ANALYSIS

We worked with each grantee team to develop a data collection plan tailored to their project. Deidentified participant-level and aggregate data elements aligned with the RE-AIM domains. Grantees submitted data quarterly throughout the program via a secure portal hosted by UTHealth Houston. Descriptive analyses were conducted to quantify number and characteristics of clients screened, reached, and served and services rendered. Outcomes were analyzed using descriptive statistics and longitudinal multivariate regression models or univariate statistical tests. The statistical level of significance used in this report is $p < 0.05$.

QUALITATIVE DATA SOURCES AND ANALYSIS

Two rounds of semi-structured interviews were conducted with grantee representatives: Round 1 in Quarter 4 of Year 1, Round 2 in Quarter 4 of Year 2. Interviews were conducted with grantee team members at three levels: 1) leadership, 2) implementors, and 3) partners to characterize project reach and implementation, organizational capacity, potential for sustainability, and elucidate challenges and successes beyond what was captured in the quantitative data.

In Year 2, interviews and focus groups were conducted with a subset of participants from each project in order to characterize the participant perspective on their experience. Verbal informed consent was obtained for all interviewees and project participants received a financial incentive in recognition of their participation. Interviews were audio-recorded and professionally transcribed and deidentified prior to analysis. A thematic analysis was conducted to identify themes and patterns within and across projects.

ACKNOWLEDGEMENTS

This success of this evaluation was made possible through the engagement of grantee leadership, staff, partners, and participants. We are sincerely grateful to the grantee teams and their participants for their openness and willingness to collaborate. This evaluation was strengthened from the expertise, passion, and commitment of the grantees whose deep investment in their communities led to their participation in this initiative. We are particularly grateful to the team members and participants who participated in interviews and focus groups that helped us tell the story of these projects.

We would also like to acknowledge Texas Health Resources for their investment in this evaluation and their collaboration throughout this grant cycle.

Our goal with this evaluation and report is to highlight areas of strength and opportunity, guiding continued efforts to improve the health of North Texas communities.

EVALUATION TEAM

Our multi-disciplinary team consists of faculty researchers, staff, and doctoral and graduate student trainees from UTHealth Houston School of Public Health in Dallas.

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Report prepared February 2025

Texas Health Resources Community Health Improvement

Together with community leaders, Community Health Improvement (CHI) works to identify and understand health disparities and the social and environmental conditions that affect overall health.

We believe your ZIP code shouldn't be more important than your genetic code when it comes to your health and well-being. In following the data, we focus on efforts through results-driven initiatives, thereby furthering Texas Health's mission of improving the health of the people in the communities we serve.

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