Texas Health Center for Diagnostics & Surgery Plano

2016 Community Health Needs Assessment: Implementation Strategy Report

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Background

About Texas Health Resources

Mission

To improve the health of the people in the communities we serve.

Vision

Texas Health Resources, a faith-based organization joining with physicians, will be the health care system of choice.

Values

- **Respect** – Respecting the dignity of all persons, fostering a corporate culture characterized by teamwork, diversity and empowerment.
- **Integrity** – Conduct our corporate and personal lives with integrity; Relationships based on loyalty, fairness, truthfulness and trustworthiness.
- **Compassion** – Sensitivity to the whole person, reflective of God's compassion and love, with particular concern for the poor.
- **Excellence** – Continuously improving the quality of our service through education, research, competent and innovative personnel, effective leadership and responsible stewardship of resources.

Your feedback on this report is welcomed and encouraged. Please direct any questions or feedback to:

Texas Health Resources System Services
Community Health Improvement
612 E. Lamar Blvd., Suite 1400 | Arlington, TX 76011
Email: THRCHNA@texashealth.org
Phone: 682-236-7990

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About Texas Health Center for Diagnostics & Surgery Plano

At Texas Health Center for Diagnostics & Surgery, we've combined the expertise of the area's most respected physicians with advanced technology and a superior level of care.

Designed with a boutique hotel in mind, we offer a more comfortable setting than what is typically offered in a large, full-service traditional hospital. From a gourmet coffee bar in the lobby to room service meals prepared by a culinary trained chef, our entire staff is driven by compassionate care to provide an overall exceptional hospital experience for you and your family.

The hospital is accredited by The Joint Commission, an independent, not-for-profit organization that accredits and certifies health care firms and is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

At Texas Health Center for Diagnostics & Surgery, our method of care is based on the notion that the patient and the family are the central focus. Members of our health care team strive to understand what is important to you, the patient, and actively engage you in all aspects of care and support a culture of caring and healing.

Texas Health Center for Diagnostics & Surgery is a joint venture owned by Texas Health Resources and physicians dedicated to the community and meets the definition under federal law of physician-owned hospital. As a for-profit hospital, Texas Health Center for Diagnostics & Surgery is not required to complete a Community Health Needs Assessment but has done so in collaboration with Texas Health Presbyterian Hospital Plano.

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CHNA & IS Process Overview

CHNA Report

Community Input Collection & Analysis

- In depth **interviews** and **focus groups** were conducted with individuals. An **online community survey** was also distributed to collect input on **community health needs, assets, and barriers** from **community members**. Each form of community input was analyzed, and **significant health needs, barriers, and assets/resources** were identified.

Secondary Data Analysis

- The **Healthy North Texas platform** was leveraged along with **PQI data from The DFW Hospital Council**. HCI's **data scoring methodology** was used to **compare indicator values** at **national, state, and county levels** as well as **trends over time** and **HP2020 targets**. HCI's **data scoring methodology** was used to **compare indicator values** at **national, state, and county levels** as well as **trends over time** and **HP2020 targets**.

Data Synthesis & Significant Health Needs

- The **qualitative (community input/primary data) and quantitative (secondary data)** analysis findings were **synthesized to identify significant community health needs**. Health needs were considered **"significant" if at least two** of the following **data types cited the topic** as a pressing health concern: **Key Informant/Focus Group Findings, Survey Findings, Secondary Data Findings**.

Prioritization of Significant Health Needs

- **Key hospital staff and stakeholders utilized** the **data** analysis and synthesis **findings to vote** on which **significant health needs will be prioritized for implementation strategy** development consideration. Participants engaged in **multiple rounds of voting and discussion**, and **considered specific system-wide criteria for prioritizing** significant health needs.

Texas Health Center for Diagnostics & Surgery's Priority Health Needs for 2016 CHNA

Access to Health Services, Healthcare Navigation, & Literacy (Transportation, Lack of Insurance Coverage, & Cost)	**Exercise, Nutrition, & Weight**	**Mental Health & Mental Disorders and Substance Abuse**	**Older Adults & Aging**

IS Report

Implementation Strategy

- **Key hospital staff and stakeholders** considered the **prioritized health needs** in developing an implementation strategy. Participants examined **current initiatives and resources**, discussed **potential new programs and partnerships** within the community, and considered overall **Texas Health strategic planning process** to determine which **needs to address in the Implementation Strategy**.

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Implementation Strategy Design Process

This report summarizes the plans for Texas Health Resources to address the prioritized needs identified in the 2016 Community Health Needs Assessment (CHNA). Texas Health developed a system-wide community benefit strategy to leverage internal and external resources and increase its ability to impact community health needs.

The top prioritized health needs across the system were:

1. Mental Health & Substance Abuse
2. Exercise, Nutrition, & Weight
3. Access to Health Services and Healthcare Navigation & Literacy

From 2017-2019, Texas Health will implement strategies and activities aimed at addressing these areas. Mental Health & Substance Abuse is categorized as **Behavioral Health**; Exercise, Nutrition, & Weight is grouped under **Chronic Disease**, which has been a strategic area of focus for Community Health Improvement since the 2013 CHNA; and Access to Health Services and Healthcare Navigation & Literacy is jointly titled **Awareness, Health Literacy, & Navigation**.

Texas Health Center for Diagnostics & Surgery Plano is a joint venture owned by Texas Health Resources and physicians dedicated to the community. The hospital completed a CHNA in collaboration with Texas Health Presbyterian Hospital Plano and will support the implementation strategy of their partner hospital.

In accordance with requirements in the Affordable Care Act and IRS 990 Schedule H requirements, this plan was approved by the Texas Health Board of Directors on April 24, 2017.

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Implementation Plan

Priority Area 1: Behavioral Health

Priority Area #1:	Behavioral Health
Need Statement	Mental disorders and substance abuse problems are among the most common forms of disability. Key informants and focus group participants noted a lack of affordable mental health services and resources in Collin County as an issue facing the community, as well as the stigmas associated with mental illness and substance abuse. The Healthy People 2020 goal is to improve mental health and reduce substance abuse through prevention and by ensuring access to appropriate, quality behavioral health services.
Target Populations	• Low-income, uninsured/underinsured populations • Zip codes 75006, 75057, 75069, 75074, 75234 • African American and Hispanic populations • Hispanic women with less than a high school education • Immigrant populations
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	• Texas Health Plano Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff • Educators and Other Staff • Texas Health Plano Community Health/Community Benefit Budget • Internal Service Lines • Community Partner Organizations/Agencies • Texas Health Buildings • Partner Organization Locations • Community Locations
Timeline	2017-2019

Priority Area 1: Behavioral Health (cont'd)

Priority Area #1:	Behavioral Health					
Strategies	Activities	Lead Dept / Staff	Process Objectives (SMART)	Short-Term Outcomes (1 year)	Intermediate Outcomes (1-3 years)	Long-Term Outcomes (3+ years)
1.1 Explore opportunities for new system-wide behavioral health community program(s)	1.1.1 Define behavioral health topic area for strategic implementation	• Texas Health Plano Community Health Advocate • System-Level Community Health Improvement/ Vice President, Program Directors, Program Manager, Community Health Specialists, and Data Analyst	• Complete detailed assessment of behavioral health needs and barriers in primary and secondary service area zip codes	• Increase understanding of behavioral health needs and evidence-based behavioral health programs both internally with Texas Health Plano staff and externally with community partners	• Increase both Texas Health Plano and community capacity to address behavioral health needs, targeting underserved populations • Increase capacity to evaluate behavioral health programs	• Advance health equity by improving access to behavioral health services for underserved populations • Reduce the stigma associated with behavioral health conditions through community education and support
	1.1.2 Collaborate with System Services and other entities to determine appropriate system-wide approach to addressing behavioral health needs with particular attention to evidence-based programs and leverage internal and external partnerships to implement		• Complete comprehensive inventory of evidence-based behavioral health community programs and current and potential collaborators • Assess internal resources • Improve linkage between internal clinical and community service lines to better address community behavioral health needs • Identify appropriate behavioral health-specific program curriculum • Pilot program • Create training and have Community Health Advocate and educators trained • Partner with Faith Community Nurses/Community Health Workers, Behavioral Health service line, community partners and others to implement program prioritized to underserved populations			
	1.1.3 Collaborate with System Services and other entities to develop evaluation framework to track and report program impact to both internal and external stakeholders					
	1.1.4 Engage with partners through Collin County Behavioral Health Coalition, Collin County Homeless Coalition, and continued collaboration with LifePath Systems		• Provide support for work of coalitions and partners either fiscally or through the sharing of data and other resources			

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Priority Area 2: Chronic Disease

Priority Area #2:	Chronic Disease Prevention & Management, including Exercise, Nutrition & Weight
Need Statement	Chronic conditions are a significant public health issue and societal cost. However, regular physical activity, a healthful 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. 25% of adults in Collin County are obese, 8% are diabetic, and 50.4% of the Medicare population has hyperlipidemia (high cholesterol). Community survey participants named diabetes as the third most pressing health need for the community, heart disease/stroke as the second, and obesity/weight was named the first. The Healthy People 2020 goal to reduce chronic conditions - such as diabetes - and complications from chronic conditions through better prevention, detection, treatment, and education efforts. *Source: County Health Rankings, Healthy North Texas Dashboard*
Target Populations	• Low-income, uninsured/underinsured populations • Zip codes 75006, 75057, 75069, 75074, 75234* • African American and Hispanic populations • Hispanic women with less than a high school education • Immigrant populations
Goals	Improve quality of life and reduce healthcare overutilization 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	• Texas Health Plano Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff • Educators and Other Staff • Texas Health Plano Community Health/Community Benefit Budget • Internal Service Lines • Community Partner Organizations/Agencies • Texas Health Buildings • Partner Organization Locations • Community Locations
Timeline	2017-2019

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Priority Area 2: Chronic Disease (cont'd)

Priority Area #2:	Chronic Disease Prevention & Management, including Exercise, Nutrition & Weight					
Strategies	Activities	Lead Dept / Staff	Process Objectives (SMART)	Anticipated Impact		
				Short-Term Outcomes (1 year)	Intermediate Outcomes (1-3 years)	Long-Term Outcomes (3+ years)
2.1 Continue implementation of Stanford University's Chronic Disease/Diabetes Self-Management Programs (CDSMP/DSMP)	2.1.1 Hold CDSMP/DSMP workshops under the Texas Health program license and collaborate with community organizations/agencies to hold workshops under partners' program licenses; partner with Faith Community Nurses/Community Health Workers, community partners and others to deliver workshops to underserved populations	• Texas Health Plano Community Health Advocate • System-Level Community Health Improvement/ Program Manager Partner Organizations: • Community Council of Greater Dallas/Area Agency on Aging of Dallas County • North Central Texas Council of Governments Area Agency on Aging • Sixty and Better • Tarrant County Public Health • United Way of Tarrant County/Area Agency on Aging of Tarrant County	• 75% of workshops will be held between 2017-2019 in zip codes with the highest socioeconomic need* • 75% of participants enrolled in a workshop between 2017-2019 will complete 4 out of 6 sessions ("graduate") • 90% of program graduates between 2017-2019 will complete both a pre- and post-survey	• 75% of program graduates will indicate an increase towards the total confidence rate in self-managing their chronic condition • Increase Texas Health Plano and community capacity to address the management of chronic conditions in underserved populations	• 90% of program graduates will self-report "always" or "often" taking medications exactly as prescribed • 60% of DSMP graduates will self-report an A1C level below 9.0	• 30% decrease in preventable participant healthcare utilization related to chronic conditions in zip codes with the highest socioeconomic need • 50% decrease in overall preventable participant healthcare utilization related to chronic conditions following the completion of CDSMP/DSMP
	2.1.2 Collaborate with Texas Health Physician Group (THPG) to recommend patients to CDSMP/DSMP workshops		• 10% of program participants between 2017-2019 will be patients from THPG			
	2.1.3 Collaborate with System Services to develop evaluation plan to track workshop participants' sustained behavior changes related to the management of chronic conditions and self-reported biometrics at various intervals following completion of the workshop		• 50% of program graduates between 2017-2019 will be contacted for follow-up evaluation at various intervals following workshop completion			
	2.1.4 Establish follow-up accountability group for workshop graduates		• 90% of graduates will be invited to participate in accountability group following completion of the program			

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Priority Area 2: Chronic Disease (cont'd)

Priority Area #2:	Chronic Disease Prevention & Management, including Exercise, Nutrition & Weight					
Strategies	Activities	Lead Dept / Staff	Process Objectives (SMART)	Anticipated Impact		
				Short-Term Outcomes (1 year)	Intermediate Outcomes (1-3 years)	Long-Term Outcomes (3+ years)
2.2 Provide education to older adults in the community on health topics of concern and importance	2.2.1 Host "Lunch & Learn" sessions for older adults	• Texas Health Plano Community Health Advocate	• Target population: Adults age 65 and older • Determine topics and create curriculum for Lunch & Learns that respond to needs of older adults in Texas Health Plano's service areas • Create referral line from CDSMP/DSMP and AMOB workshops • 75% of older adults referred to Lunch & Learns attend one or more sessions • Develop evaluation framework to track and report impact to internal and external stakeholders	• Increase Texas Health Plano's capacity to address health issues and concerns effecting older adults, including risk factors for heart failure and stroke and recommended cancer screening guidelines	• 50% of participants will verbalize understanding of what they learned following each session • 90% of participants who previously attended CDSMP/DSMP will self-report "always" or "often" taking medications exactly as prescribed • 60% of participants who previously attended DSMP will self-report an A1C level below 9.0	• 75% of participants will verbalize understanding of what they learned following each session • 50% decrease in overall preventable healthcare utilization related to chronic conditions by participants who have both completed CDSMP/DSMP and attended a Lunch & Learn session

Priority Area 3: Awareness, Health Literacy & Navigation

Priority Area #3:	Awareness, Health Literacy & Navigation
Need Statement	13% of Collin County residents lack health insurance, and 8.3% of people residing in Texas Health Plano's service area live below the Federal Poverty Level. But coverage is not the only need. Low health literacy--an individuals' 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 2020 goals and objectives and are important measures to improve health equity and quality of life. *Sources: County Health Rankings, U.S. Census Bureau*
Target Populations	• Low-income, uninsured/underinsured populations • Zip codes 75006, 75057, 75069, 75074, 75234* • African American and Hispanic populations • Hispanic women with less than a high school education • Immigrant populations
Goals	Increase individuals' awareness of and access to health information that is accurate, accessible, and actionable; address social determinants of health by partnering with community organizations.
Strategic Alignment	Consumer Focus
Resources	• Texas Health Plano Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff • Educators and Other Staff • Texas Health Plano Community Health/Community Benefit Budget • Aunt Bertha Platform and Other Technologies • Internal Service Lines • Community Partner Organizations/Agencies • Texas Health Buildings • Partner Organization Locations • Community Locations
Timeline	2017-2019

Priority Area 3: Awareness, Health Literacy & Navigation (cont'd)

Priority Area #3:	Awareness, Health Literacy & Navigation					
Strategies	Activities	Lead Dept / Staff	Process Objectives (SMART)	Anticipated Impact		
				Short-Term Outcomes (1 year)	Intermediate Outcomes (1-3 years)	Long-Term Outcomes (3+ years)
3.1 Continue investment in Community Connect and Collin County Cares Online Resource Guides	3.1.1 Collaborate with System Services to raise awareness and disseminate information on Community Connect to internal and external stakeholders 3.1.2 Collaborate with Assistance Center of Collin County to provide financial support for Collin County Cares website	• Texas Health Plano Community Health Advocate • System-Level Community Health Improvement/ Program Manager	• Disseminate resources to external stakeholders, particularly those working with underserved populations • Develop standard protocols for utilization and programmatic integration of tool internally and externally • Adapt tool to meet the needs of target populations	• Increase overall utilization of tools • Increase strategic utilization with particular focus on underserved populations • Increase Texas Health Plano capacity to provide consumers with information on navigating the healthcare system that is accurate, accessible and actionable	• Increase community capacity to provide consumers with information on navigating the healthcare system that is accurate, accessible and actionable	• 25% increase in use of tool by individuals living in zip codes with the highest socioeconomic need* • Advance health equity by improving access to healthcare resources for underserved populations • Improve discharge planning through integration of tool into internal processes
3.2 Manage and strengthen operations of Clinic Connect for optimal performance	3.2.1 Continue to address awareness, literacy and navigation through grants awarded to local charitable clinic	• Texas Health Plano Community Health Advocate • System-Level Community Health Improvement/ System Programs and Reporting Director	• Provide financial funding to clinic as support for services provided by clinic to uninsured and underinsured patients • Identify patients that meet eligibility criteria developed and agreed upon by Texas Health and clinic and contact clinic with requests for patient appointments • Patients referred to clinic by Texas Health Plano will be seen in the clinic within 2 business days of the referral and have access to appropriate clinicians at clinic during normal business hours	• 70% of patients referred to all Texas Health-funded clinics by hospital staff will be seen within 3 business days	• 75% of all partnered clinics will have an average wait time for next available appointment that is no more than 7-10 days • 10% decrease in preventable healthcare utilization by patients referred to all Texas Health-funded clinics by hospital staff	• 60% of adults with diagnosed hypertension receiving care in any Texas Health-funded clinic will have a most recent blood pressure less than 140/90 • 15% decrease in preventable healthcare utilization by patients referred to all Texas Health-funded clinics by hospital staff

Priority Area 3: Awareness, Health Literacy & Navigation (cont'd)

Priority Area #3:	Awareness, Health Literacy & Navigation					
Strategies	Activities	Lead Dept / Staff	Process Objectives (SMART)	Anticipated Impact		
				Short-Term Outcomes (1 year)	Intermediate Outcomes (1-3 years)	Long-Term Outcomes (3+ years)
3.3 Address overutilization of care by lowering readmissions rates and inappropriate Emergency Department (ED) use	3.3.1 Explore expansion of post-discharge home visits by Clinical Nurse Leaders	• Care Management • Texas Health Operations for Physicians (THOP) Regional Physician Practice Operations/Director	• Establish proof of concept and plan for expansion of program and tracking of readmission rates of participants	• 15% reduction in readmissions and ED visits for participants	• 25% reduction in readmissions and ED visits for participants	• 50% reduction in readmissions and ED visits for participants
	3.3.2 Support Plano Fire-Rescue (PFR) on continued implementation of Paramedicine Program	• Cardiovascular Dept./Director • Care Management	• Provide resources and financial funding to PFR for medication management program • Refer Texas Health Plano patients diagnosed with congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) for follow-up appointments with PFR personnel	• 10% reduction in readmissions and ED visits for patients referred to program	• 20% reduction in readmissions and ED visits for patients referred to program	• 30% reduction in readmissions and ED visits for patients referred to program

Priority Area 4: Older Adults & Aging

Priority Area #4:	Older Adults & Aging
Need Statement	Older adults are among the fastest growing age group and are at a high risk for developing chronic illness and related disabilities which lower quality of life and contribute to the leading cause of death among this population. 8.8% of adults in Texas Health Plano's service area are age 65 and older. Key informants noted the number of older adults living in poverty and their inability to pay for medical services or prescriptions. Between 2011-2015, 6.8% of older adults in Collin County lived below Federal Poverty Level. The HP2020 goal is to improve the health, function, and quality of life of older adults. *Sources: Healthy North Texas Dashboard*
Target Populations	• Low-income, uninsured/underinsured populations • Zip codes 75006, 75057, 75069, 75074, 75234* • Zip codes 75007, 75024, 75034, 75056, 75093** • African American and Hispanic populations • Hispanic women with less than a high school education • Immigrant populations
Goals	Improve quality of life and reduce healthcare overutilization of adults age 65 and over through continued management of chronic conditions and prevention of injury; address social determinants of health by partnering with community organizations.
Strategic Alignment	Consumer Focus, Value Creation, Culture of Excellence
Resources	• Texas Health Plano Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff • Educators and Other Staff • Texas Health Plano Community Health/Community Benefit Budget • Internal Service Lines • Community Partner Organizations/Agencies • Texas Health Buildings • Partner Organization Locations • Community Locations
Timeline	2017-2019

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Priority Area 4: Older Adults & Aging (cont'd)

Priority Area #4:	Older Adults & Aging					
Strategies	Activities	Lead Dept / Staff	Process Objectives (SMART)	Anticipated Impact		
				Short-Term Outcomes (1 year)	Intermediate Outcomes (1-3 years)	Long-Term Outcomes (3+ years)
4.1 Continue implementation of Maine Health's A Matter of Balance Fall Prevention Program (AMOB)	4.1.1 Hold AMOB workshops under the Texas Health program license and collaborate with community organizations/agencies to hold workshops under partners' program licenses; partner with Faith Community Nurses/Community Health Workers, community partners and others to deliver workshops to underserved populations, as well as those living in high fall rate areas	• Texas Health Plano Community Health Advocate • System-Level Community Health Improvement/ Program Manager Partner Organizations: • Community Council of Greater Dallas/Area Agency on Aging of Dallas County • North Central Texas Council of Governments Area Agency on Aging • Sixty and Better • Tarrant County Public Health • United Way of Tarrant County/Area Agency on Aging of Tarrant County	• 75% of workshops across the system will be held between 2017-2019 in zip codes with the highest socioeconomic need* or the highest incident rates of falls** • 80% of participants enrolled in a workshop between 2017-2019 will complete 5 out of 8 sessions ("graduate") • 90% of program graduates between 2017-2019 will complete both a pre- and post-survey	• 50% of program graduates will report that they are "not at all" concerned that they will fall in the three months following the last class • 60% of program graduates will report that they are "absolutely sure" that they can find a way to get up if they fall • 50% of program graduates will report that they are "absolutely sure" that they can increase physical strength and become steadier on their feet • Increase Texas Health Plano and community capacity to address the fear of falling and fall prevention in underserved populations	• 30% decrease in overall participant healthcare utilization associated with falls or fall-related injuries of participants following the completion of AMOB	• 40% decrease in healthcare utilization rate related to falls or fall-related injuries for older adults living in zip codes with high economic need • 30% decrease in healthcare utilization rate related to falls or fall-related injuries for older adults living in zip codes with the highest fall incident rates
	4.1.2 Collaborate with THPG to recommend patients to AMOB workshops		• 10% of program participants between 2017-2019 will be patients from THPG			
	4.1.3 Collaborate with System Services to develop evaluation plan to track workshop participants' sustained behavior changes related to fall prevention and fear of falling at various intervals following completion of the workshop		• 50% of program graduates between 2017-2019 will be contacted for follow-up evaluation at various intervals following workshop completion			

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The following information can be found in the Appendices:

I. Project Team

II. Consulting Organization

Appendices

Appendix I: Project Team

- **Leslie Baker,** Director of Marketing, Texas Health Center for Diagnostics & Surgery
- **Catherine Oliveros, MPH, DrPH,** Vice President, Community Health Improvement, Texas Health Resources
- **Jamie Judd, MBA,** Program Director, Community Health Improvement, Texas Health Resources
- **Catherine McMains, MPH, CPH,** Community Benefit & Impact Specialist, Texas Health Resources
- **Larry Robertson,** President, Texas Health Center for Diagnostics & Surgery
- **King Freeland, MD,** Chief Medical Officer, Texas Health Center for Diagnostics & Surgery
- **Kristie Clinard, RN, BSN, CNOR,** Chief Nursing Officer, Texas Health Center for Diagnostics & Surgery

Appendix II: About Healthy Communities Institute

Conduent Healthy Communities Institute (HCI), formerly a Xerox Corporation, was contracted by Texas Health Resources to conduct the 2016 Community Health Needs Assessment, support Implementation Strategy development, and to author the CHNA and IS reports. Based in Berkeley, California, HCI provides customizable, web-based information systems that offer a full range of tools and content to improve community health, and developed the Healthy North Texas Platform. To learn more about Healthy Communities Institute please visit: www.HealthyCommunitiesInstitute.com

HCI's mission is to improve the health, vitality, and environmental sustainability of communities, counties, and states

HCI Project Team & Report Authors

Project Manager

- Mari Muzzio, MPH

Project Support:

- Muniba Ahmad
- Claire Lindsay, MPH
- Rebecca Yae

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