Texas Health Harris Methodist Hospital Fort Worth

2016 Community Health Needs Assessment: Implementation Strategy Report

Texas Health Resources®

Report Contents

Appendix Contents

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
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About Texas Health Harris Methodist Hospital Fort Worth

Texas Health Harris Methodist Hospital Fort Worth serves Fort Worth and surrounding communities with advanced medical treatments and an experienced staff that provides compassionate care. With a mission of improving the health of the people in the communities we serve, Texas Health Fort Worth and the physicians on its medical staff are committed to your well-being and the health and wellness of your family.

Texas Health Fort Worth offers:

- Bariatric Surgery
- Business/Employee Health Services
- Cancer Care
- Complementary & Alternative Medicine
- Diabetes Care
- Emergency Department
- Executive Health Program
- Fitness Center
- Heart and Vascular
- Home Health
- Hospitalist Program
- Imaging
- Kidney Transplant Program
- Mobile Health Unit
- Neurosciences
- Occupational Health
- Orthopedics
- Outpatient Surgery
- Palliative Care
- Rehabilitation
- Senior Health & Wellness
- Sports Medicine
- Stroke Care
- Vascular & Interventional Radiology
- Women and Infants Care
- Wound Care

Texas Health Fort Worth has been named to *U.S. News & World Report's* list of best hospitals in the Dallas/Fort Worth area each year since the program's inception. The hospital is designated an Emergency Center of Excellence by Emergency Excellence, a national organization specializing in emergency department benchmarking, and has been voted the "Best Place to Have a Baby" 20 times by readers of *Fort Worth Child* magazine. Texas Health Fort Worth is a 720-bed hospital conveniently located in the heart of Fort Worth, south of Interstate 30 at the corner of Pennsylvania Avenue and Henderson Street.

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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 Fort Worth Priority Health Needs for 2016 CHNA

Access to Health Services, Healthcare Navigation, & Literacy	Mental Health & Mental Disorders	Exercise, Nutrition, & Weight

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**.

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.

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 the need for more mental health service providers, especially for low-income and uninsured adults and children. 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 76104, 76105, 76106, 76110, 76111, 76112, 76114, 76115, 76117, 76119 • African American and Hispanic populations • Hispanic women with less than a high school education
Goals	Increase individuals' awareness of and access to health information and services that are accurate, accessible, and actionable; address social determinants of health by partnering with community organizations.
Strategic Alignment	Consumer Focus
Resources	• Texas Health Fort Worth Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff • Educators and Other Staff • Texas Health Fort Worth 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)	Anticipated Impact		
				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 Fort Worth 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 Fort Worth staff and externally with community partners	• Increase both Texas Health Fort Worth 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 partners through behavioral health coalitions within service areas		• Research behavioral health-focused coalitions within Texas Health Fort Worth service areas • Assess appropriate involvement or mobilize community partners in creation of new behavioral health-focused coalition			

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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. 29% of adults in Tarrant County are obese, and 11% are diabetic. Community survey participants named weight/obesity as the first most pressing health need for the community, while diabetes was named as the second, and heart disease was the third. The Healthy People 2020 goal to reduce chronic conditions - such as diabetes and heart disease - and complications from chronic conditions through better prevention, detection, treatment, and education efforts. *Source: County Health Rankings*
Target Populations	• Low-income, uninsured/underinsured populations • Zip codes 76104, 76105, 76106, 76110, 76111, 76112, 76114, 76115, 76117, 76119* • African American and Hispanic populations • Hispanic women with less than a high school education
Goals	Increase individuals' awareness of and access to health information and services that are accurate, accessible, and actionable; address social determinants of health by partnering with community organizations.
Strategic Alignment	Consumer Focus, Exceptional Care, Value Creation, Culture of Excellence
Resources	• Texas Health Fort Worth Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff • Educators and Other Staff • Texas Health Fort Worth 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 Fort Worth 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 held between 2017-2019 will be held 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 Fort Worth 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 will be contacted for follow-up evaluation at various intervals following workshop completion			

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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 Strengthen Delivery System Reform Incentive Payment (DSRIP) program	2.2.1 Continue implementation of diabetes education and management program	• DSRIP Project Lead	• 93% of achievement of available dollars for DY6 • Proactively prepare for anticipated changes to DSRIP	• 5% improvement over baseline in selected bundle measures	• 10% improvement over baseline in selected bundle measures	• 15% improvement over baseline in selected bundle measures
	2.2.2 Continue implementation of congestive heart failure program					
	2.2.3 Continue implementation of cystic fibrosis program					
2.3 Explore opportunities for collaboration with community partners to address food insecurity and nutritional needs in the community through the implementation of food hubs or community gardens	2.3.1 Establish and strenghten partnerships with community groups working to help community members reduce risk for chronic disease and lead healthier lives through the consumption of healthful diets	• Texas Health Fort Worth Community Health Advocate	• Identify zip codes and communities with greatest need (i.e., limited/no access to fresh fruits and vegetables) • Determine effective implementation action • Establish proof of concept and plan for implementation and evaluation	• Increase Texas Health Fort Worth's capacity to address food insecurity as a barrier to health	• Increase number of outlets supplying fresh fruits and vegetables in Texas Health Fort Worth communities identified as having the greatest need	• Advance health equity by decreasing barriers to health by expanding access to fresh fruits and vegetables
	2.3.2 Continue partnership with Healthy Tarrant County Collaboration (HTCC) on the execution of grants and support HTCC's goal to continue diabetes prevention and management efforts in Tarrant County through promotion of healthy retail policies and procedures to increase availability of healthy foods	• HTCC/Executive Director • Texas Health Fort Worth Community Health Advocate	• Provide financial and in-kind support • Support HTCC in the growth and execution of projects • Serve on Steering Committee • Texas Health leadership to provide representation on Board of Directors			

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Priority Area 3: Awareness, Literacy & Navigation

Priority Area #3:	Awareness, Health Literacy & Navigation
Need Statement	20% of Tarrant County residents lack health insurance, and 17.7% of people residing in Texas Health Fort Worth'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 76104, 76105, 76106, 76110, 76111, 76112, 76114, 76115, 76117, 76119* • Zip codes 76028, 76108, 76114, 76116, 76132, 76133** • African American and Hispanic populations • Hispanic women with less than a high school education
Goals	Increase individuals' awareness of and access to health information and services that are accurate, accessible, and actionable; address social determinants of health by partnering with community organizations.
Strategic Alignment	Consumer Focus
Resources	• Texas Health Fort Worth Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff • Educators and Other Staff • Texas Health Fort Worth 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

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Priority Area 3: Awareness, 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 Online Resource Guide	3.1.1 Collaborate with System Services to raise awareness and disseminate information on Community Connect to internal and external stakeholders	• Texas Health Fort Worth 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 tool • Increase strategic utilization with particular focus on underserved populations • Increase Texas Health Fort Worth 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

Priority Area 3: Awareness, 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)
3.2 Continue implementation of Maine Health's A Matter of Balance Fall Prevention Program (AMOB)	3.2.1 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 Fort Worth 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 held between 2017-2019 will be held 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 Fort Worth 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
	3.2.2 Collaborate with THPG to recommend patients to AMOB workshops		• 10% of program participants between 2017-2019 will be patients from THPG			
	3.2.3 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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Priority Area 3: Awareness, 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 Strengthen Delivery System Reform Incentive Payment (DSRIP) program	3.3.1 Continue implementation of emergency department (ED) navigation program 3.3.2 Continue implementation of palliative care program 3.3.3 Continue implementation of medication management program 3.3.4 Continue operation of mobile health unit	• DSRIP Project Lead	• 93% of achievement of available dollars for DY6 • Proactively prepare for anticipated changes to DSRIP	• 5% improvement over baseline in selected bundle measures	• 10% improvement over baseline in selected bundle measures	• 15% improvement over baseline in selected bundle measures
3.4 Manage and strengthen operations of Clinic Connect for optimal performance	3.4.1 Continue to address awareness, literacy and navigation through grants awarded to local charitable clinic	• Texas Health Fort Worth 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 Fort Worth will be seen in the clinic within 3 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

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The following information can be found in the Appendices:

I. Project Team

II. Consulting Organization

Appendices

Appendix I: Project Team

- **Kimberlin Moore, BSN, RN**, Community Health Manager, Texas Health Fort Worth
- **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
- **Lillie Biggins, RN, FACHE**, President, Texas Health Fort Worth
- **Michael Thornsberry, MD, MBA, FACHE, FAAFP**, Chief Medical Officer, Texas Health Fort Worth
- **Elaine Nelson, DNP, RN, NEA-BC, CENP**, Chief Nursing Officer, Texas Health Fort Worth

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

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