

Texas Health Harris Methodist Hospital Hurst-Euless-Bedford

*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
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Texas Health Harris Methodist Hospital Hurst-Eules-Bedford (HEB) serves the communities of Hurst, Eules, Bedford, Colleyville, Grapevine, Southlake, Richland Hills, North Richland Hills, Watauga, Haltom City and Keller 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 HEB and the physicians on its medical staff are committed to your well-being and the health and wellness of your family.

Texas Health HEB offers:

- [Asthma Care](#)
- [Behavioral Health](#)
- [Cancer Care](#)
- [Diabetes Care](#)
- [Digestive Health](#)
- [Ear, Nose and Throat](#)
- [Emergency Department](#)
- [Fitness Center](#)
- [Heart and Vascular](#)
- [Imaging](#)
- [Physical Medicine and Rehabilitation](#)
- [Respiratory Care](#)
- [Stroke Center](#)
- Weight Loss Surgery
- [Women and Infants Care](#)
- [Wound Care](#)



Texas Health HEB is the only hospital in NE Tarrant County designated as a Level III Trauma Unit. The hospital also earned Cycle IV Chest Pain Accreditation from the Society of Cardiovascular Patient Care and is certified as a Primary Stroke Center. Texas Health HEB is conveniently located just south of Highway 183, the Airport Freeway, at the Texas 121 merge in Bedford.

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 HEB Priority Health Needs for 2016 CHNA

Children’s Health

Exercise, Nutrition, & Weight

Mental Health & Mental Disorders

Overarching themes of Healthcare Navigation & Literacy and Transportation

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**.

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			
Need Statement	Mental disorders and substance abuse problems are among the most common forms of disability. Key informants and focus group participants noted a need for more accessible mental health services, as well as a lack of education and the economic and social factors surrounding 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	<ul style="list-style-type: none"> • Low-income, uninsured/underinsured populations • Zip codes 776040, 76053, 76117 • African American and Hispanic populations 	<ul style="list-style-type: none"> • Hispanic women with less than a high school education • Tongan population 		
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	<ul style="list-style-type: none"> • Texas Health HEB Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff 	<ul style="list-style-type: none"> • Educators and Other Staff • Texas Health HEB Community Health/Community Benefit Budget 	<ul style="list-style-type: none"> • Internal Service Lines • Community Partner Organizations/Agencies 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Texas Health HEB Community Health Advocate • System-Level Community Health Improvement/ Vice President, Program Directors, Program Manager, Community Health Specialists, and Data Analyst Potential Partner: <ul style="list-style-type: none"> • Hurst/Eules/ Bedford Police Departments, Mental Health Coordinator 	<ul style="list-style-type: none"> • Complete detailed assessment of behavioral health needs and barriers in primary and secondary service area zip codes 	<ul style="list-style-type: none"> • Increase understanding of behavioral health needs and evidence-based behavioral health programs both internally with Texas Health HEB staff and externally with community partners 	<ul style="list-style-type: none"> • Increase both Texas Health HEB and community capacity to address behavioral health needs, targeting underserved populations • Increase capacity to evaluate behavioral health programs 	<ul style="list-style-type: none"> • 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		<ul style="list-style-type: none"> • 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		<ul style="list-style-type: none"> • Research behavioral health-focused coalitions within Texas Health HEB service areas • Assess appropriate involvement or mobilize community partners in creation of new behavioral health-focused coalition 			
	1.1.4 Engage partners through behavioral health coalitions within service areas					

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)
1.2 Strengthen Delivery System Reform Incentive Payment (DSRIP) program	3.3.1 Continue implementation of behavioral health program	<ul style="list-style-type: none"> • DSRIP Project Lead 	<ul style="list-style-type: none"> • 93% of achievement of available dollars for DY6 • Proactively prepare for anticipated changes to DSRIP 	<ul style="list-style-type: none"> • 5% improvement over baseline in selected bundle measures 	<ul style="list-style-type: none"> • 10% improvement over baseline in selected bundle measures 	<ul style="list-style-type: none"> • 15% improvement over baseline in selected bundle measures

Priority Area 2: Chronic Disease Prevention & Management

Priority Area #2:	Chronic Disease Prevention & Management, including Exercise, Nutrition & Weight			
Need Statement	<p>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, and diabetes was named as the second. 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.</p> <p><i>Source: County Health Rankings</i></p>			
Target Populations	<ul style="list-style-type: none"> • Low-income, uninsured/underinsured populations • Zip codes 776040, 76053, 76117* • African American and Hispanic populations 	<ul style="list-style-type: none"> • Hispanic women with less than a high school education • Tongan population 		
Goals	<p>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.</p>			
Strategic Alignment	<p>Consumer Focus, Exceptional Care, Value Creation, Culture of Excellence</p>			
Resources	<ul style="list-style-type: none"> • Texas Health HEB Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff 	<ul style="list-style-type: none"> • Educators and Other Staff • Texas Health HEB Community Health/Community Benefit Budget 	<ul style="list-style-type: none"> • Internal Service Lines • Community Partner Organizations/Agencies 	<ul style="list-style-type: none"> • Texas Health Buildings • Partner Organization Locations • Community Locations
Timeline	<p>2017-2019</p>			

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	<ul style="list-style-type: none"> Texas Health HEB Community Health Advocate System-Level Community Health Improvement/Program Manager Partner Organizations: <ul style="list-style-type: none"> Community Council of Greater Dallas/Area Agency on Aging of Dallas County 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 75% of program graduates will indicate an increase towards the total confidence rate in self-managing their chronic condition Increase Texas Health HEB and community capacity to address the management of chronic conditions in underserved populations 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> North Central Texas Council of Governments Area Agency on Aging 	<ul style="list-style-type: none"> 10% of program participants between 2017-2019 will be patients from THPG 			
	2.1.3 Explore expanding the reach of DSMP to the local Tongan population	<ul style="list-style-type: none"> Sixty and Better Tarrant County Public Health 	<ul style="list-style-type: none"> Identify facilitators familiar with the population Identify partner organizations 			
	2.1.4 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	<ul style="list-style-type: none"> United Way of Tarrant County/Area Agency on Aging of Tarrant County 	<ul style="list-style-type: none"> 50% of program graduates between 2017-2019 will be contacted for follow-up evaluation at various intervals following workshop completion 			

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)
3.3 Strengthen Delivery System Reform Incentive Payment (DSRIP) program	3.3.1 Continue implementation of diabetes education and management program	• DSRIP Project Lead	<ul style="list-style-type: none"> • 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
	3.3.2 Continue implementation of congestive heart failure program					
2.5 Partner with Healthy Tarrant County Collaboration (HTCC) on the execution of grants	2.5.1 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	<ul style="list-style-type: none"> • HTCC/ Executive Director • Texas Health HEB Community Health Advocate 	<ul style="list-style-type: none"> • 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 	• Increase Texas Health HEB's capacity to address food insecurity as a barrier to health	• Increase number of outlets supplying fresh fruits and vegetables in Tarrant County communities identified as having the greatest need	• Advance health equity by decreasing barriers to health by expanding access to fresh fruits and vegetables

Priority Area 3: Awareness, Health Literacy & Navigation

Priority Area #3:		Awareness, Health Literacy & Navigation				
Need Statement	<p>20% of Tarrant County residents lack health insurance, and 8.9% of people residing in Texas Health HEB'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.</p> <p><i>Sources: County Health Rankings, U.S. Census Bureau</i></p>					
Target Populations	<ul style="list-style-type: none"> • Low-income, uninsured/underinsured populations • Zip codes 776040, 76053, 76117* • Zip codes 76021, 76053** • African American and Hispanic populations • Hispanic women with less than a high school education • Tongan population 					
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	<ul style="list-style-type: none"> • Texas Health HEB Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff • Educators and Other Staff • Texas Health HEB 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					
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	<ul style="list-style-type: none"> • Texas Health HEB Community Health Advocate • System-Level Community Health Improvement /Program Manager 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Increase overall utilization of tool • Increase strategic utilization with particular focus on underserved populations • Increase Texas Health HEB capacity to provide consumers with information on navigating the healthcare system that is accurate, accessible and actionable 	<ul style="list-style-type: none"> • Increase community capacity to provide consumers with information on navigating the healthcare system that is accurate, accessible and actionable 	<ul style="list-style-type: none"> • 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, 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)
3.2 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	<ul style="list-style-type: none"> Texas Health HEB Community Health Advocate System-Level Community Health Improvement/Program Manager 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 30% decrease in overall participant healthcare utilization associated with falls or fall-related injuries of participants following the completion of AMOB 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Partner Organizations: Community Council of Greater Dallas/Area Agency on Aging of Dallas County North Central Texas Council of Governments 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Area Agency on Aging Sixty and Better Tarrant County Public Health United Way of Tarrant County/Area Agency on Aging of Tarrant County 	<ul style="list-style-type: none"> 50% of program graduates between 2017-2019 will be contacted for follow-up evaluation at various intervals following workshop completion 			

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 Strengthen Delivery System Reform Incentive Payment (DSRIP) program	3.3.1 Continue implementation of emergency department (ED) navigation program	<ul style="list-style-type: none"> • DSRIP Project Lead 	<ul style="list-style-type: none"> • 93% of achievement of available dollars for DY6 • Proactively prepare for anticipated changes to DSRIP 	<ul style="list-style-type: none"> • 5% improvement over baseline in selected bundle measures 	<ul style="list-style-type: none"> • 10% improvement over baseline in selected bundle measures 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Texas Health HEB Community Health Advocate • System-Level Community Health Improvement /System Programs and Reporting Director 	<ul style="list-style-type: none"> • 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 HEB 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 	<ul style="list-style-type: none"> • 70% of patients referred to all Texas Health-funded clinics by hospital staff will be seen within 3 business days 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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

Rationale for Not Addressing Significant Health Needs

- Rationale for not developing new strategy around the other prioritized issues is detailed below. While these needs are not addressed in the Implementation Strategy, Texas Health HEB will continue its work in many of the related areas.

Priority Area	Resource constraints	Lack of expertise	Low priority assigned	Lack of effective intervention	Need is already being addressed	Continued level of support	Other (please specify)...
<i>Children's Health</i>		x			x		

The following information can be found in the Appendices:

- I. Project Team
- II. Consulting Organization

Appendices

- **Brenda Whitley**, Community Relations Manager, Texas Health HEB
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- **Jamie Judd, MBA**, Program Director, Community Health Improvement, Texas Health Resources
- **Catherine McMains, MPH, CPH**, Community Benefit & Impact Specialist, Texas Health Resources
- **Debora Paganelli, FACHE**, President, Texas Health HEB
- **Susann Land, MD, MBA**, Chief Medical Officer, Texas Health HEB
- **Raymond Kelly, MSN, RN**, Chief Nursing Officer, Texas Health HEB

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 Project Team & Report Authors

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- Rebecca Yae

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



The screenshot shows the 'HEALTHY NORTH TEXAS' website. At the top left is the 'DFWHC FOUNDATION' logo. The main header is a dark green bar with the text 'HEALTHY NORTH TEXAS' in white. Below the header is a navigation menu with five items: 'HOME', 'EXPLORE DATA', 'SEE HOW WE COMPARE', 'LOCATE RESOURCES & FUNDING', and 'LEARN MORE'. The main content area features a large photograph of a diverse group of people waving. To the right of the photo are four menu items: 'View Community Indicators', 'Generate a Report', 'Learn More about Community Health Collaborative', and 'Use the CHNA Guide'. Below the photo is a paragraph of text: 'Healthy North Texas is a web-based source of community health and population data. We invite planners, policy makers, and community members to use the site as a tool for community assessment, strategic planning, identifying best practice for improvement, collaboration and advocacy.' At the bottom of the page are three dropdown menus: 'Indicator Data by County', 'Demographic Data by County', and 'Topic Centers', each with a 'please select' placeholder and a blue arrow icon.