Texas Health Presbyterian Hospital Rockwall

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:

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About Texas Health Presbyterian Hospital Rockwall

Located on 33 acres in the heart of Rockwall, Texas Health Presbyterian Rockwall offers 50 inpatient beds for acute medical and surgical needs, advanced medical technology and comprehensive services focused on quality patient care and safety, close to home.

The hospital serves as the cornerstone of a campus designed to expand to meet area growth and evolving community health needs. The campus includes a 40,000 square foot medical office building, an Outpatient Imaging Center, Women's Imaging and Breast Center, Wound Care Clinic, Bariatric Clinic and ancillary medical office buildings.

Additionally, Texas Health Rockwall is proud to offer a separate full-service emergency room for those communities in and around North Rockwall and Southern Collin County, with the same high-quality, compassionate emergency care that is provided at its primary campus ER on Horizon Road. Located at 2265 N. Lakeshore Drive, this 24/7 emergency room offers 11 patient rooms, on-site imaging and lab, as well as an observation unit.

Texas Health Rockwall is a joint venture owned by Texas Health Resources and physicians dedicated to the community.

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 Rockwall's Priority Health Needs for 2016 CHNA

Older Adults & Aging (with a focus on Healthcare Navigation & Literacy)	Mental Health & Mental Disorders (includes Substance Abuse)	Children's Health (in relation to Healthcare Navigation & Literacy)

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 Presbyterian Hospital Rockwall is a joint venture owned by Texas Health Resources and physicians dedicated to the community. They will support the system-wide implementation strategy of Texas Health.

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	6,454,144 Texans (any age) have a diagnosable mental illness. Of these individuals, 2,527,864 live below 200% of the Federal Poverty Level (FPL). Mental disorders and substance abuse problems are among the most common forms of disability. 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. *Source: U.S. Surgeon General, Texas Health and Human Services Commission, and Healthy People 2020*
Goals	Improve quality of life through awareness, detection, treatment, and management of behavioral health conditions
Strategic Alignment	Consumer Focus
Resources	• System-Level Community Health Improvement Staff • Entity-Level Community Health Improvement Advocates • Educators and Other Staff • System-Level Community Health Improvement Budget • Entity-Level Community Health/Community Benefit Budgets • 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					
				Anticipated Impact		
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	System-/Entity-Level Community Health Improvement/ Vice President, Program Directors, Program Manager, Community Health Specialists, and Community Health Advocates	• Complete detailed assessment of behavioral health needs and barriers across 10 Texas Health primary service area counties	• Increase understanding of behavioral health needs and evidence-based behavioral health programs both internally with Texas Health staff and externally with community partners	• Increase Texas Health 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 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 at 1-3 entities • Create training and have all Community Health Advocates 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 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 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 Prevention & Management

Priority Area #2:	Chronic Disease Prevention & Management, including Exercise, Nutrition & Weight
Need Statement	Chronic conditions are a significant public health issue and societal cost. 66% of healthcare spending is directed toward people with multiple chronic conditions. 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. The Healthy People 2020 goal is to reduce chronic conditions, such as diabetes, and complications from chronic conditions through better prevention, detection, treatment, and education efforts. *Source: Dallas County Health & Human Services*
Goals	Improve quality of life and reduce healthcare overutilization through the continued prevention and management of chronic conditions
Strategic Alignment	Consumer Focus, Exceptional Care, Value Creation, Culture of Excellence
Resources	• System-Level Community Health Improvement Staff • Entity-Level Community Health Improvement Advocates • Educators and Other Staff • System-Level Community Health Improvement Budget • Entity-Level Community Health/Community Benefit Budgets • 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 Prevention & Management (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	System-/Entity-Level Community Health Improvement/ Program Manager and Community Health Advocates 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 in zip codes with the highest socioeconomic need • 75% of participants enrolled in a workshop will complete 4 out of 6 sessions ("graduate") • 90% of program graduates 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 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 • Increase Texas Health capacity to capture and compare data on varying audiences - both patients and community members - through internal linkages and external partnerships	• 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 • Advance Community Health Improvement linkages to system-wide Key Performance Indicators (KPI) through enhanced internal and external data capturing and mining
	2.1.2 Complete system-wide data analysis of preventable hospitalizations and Emergency Department (ED) utilizations for strategic deployment of intervention					
	2.1.3 Establish proof of concept and plan for collaboration with Texas Health Physician Group (THPG) to recommend patients to CDSMP/DSMP workshops		• 10% of program participants will be patients from THPG			
	2.1.4 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			
	2.1.5 Develop and implement process to cross-reference workshop participant information with internal Electronic Health Records (EHRs) to determine utilization rates		• 90% of program graduates will be cross-checked against Texas Health EHRs for readmission rates both pre- and post-workshop			

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Priority Area 2: Chronic Disease Prevention & Management (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 Manage and strengthen Delivery System Reform Incentive Payment (DSRIP) programs	2.2.1 Continue to address the treatment and management of chronic conditions (Diabetes, Congestive Heart Failure, Hypertension, and Hyperlipidemia) in underserved populations through programs provided under the Medicaid 115 Waiver	System-Level Community Health Improvement/ System Programs and Reporting Director	• 93% of achievement of available dollars for DY6 • Provide training and technical assistance around PFM protocols to ensure alignment of entities/projects • Pursue replication of key DSRIP projects through grants	• 5% improvement over baseline in selected measure bundles related to chronic conditions	• 10% improvement over baseline in selected measure bundles related to chronic conditions	• 15% improvement over baseline in selected measure bundles related to chronic conditions

Priority Area 3: Awareness, Health Literacy & Navigation

Priority Area #3:	Awareness, Health Literacy & Navigation
Need Statement	Overall, 16% of Texans lack health insurance, and 29% of nonelderly Texans (ages 0-64) living below 200% Federal Poverty Level are uninsured. 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. *Source: The Henry J. Kaiser Family Foundation, U.S. Department of Health and Human Services*
Goals	Increase individuals' awareness of and access to health information and services that are accurate, accessible and actionable
Strategic Alignment	Consumer Focus
Resources	• System-Level Community Health Improvement Staff • Entity-Level Community Health Improvement Advocates • Educators and Other Staff • System-Level Community Health Improvement Budget • Entity-Level Community Health/Community Benefit Budgets • 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, 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 Online Resource Guide	3.1.1 Raise awareness and disseminate information on Community Connect to internal and external stakeholders	• System-/Entity-Level Community Health Improvement/ Program Manager and Community Health Advocates	• Disseminate resources to external stakeholders, particularly those working with underserved populations • Establish streamlined process with Care Transitions that ensures appropriate and effective utilization of Community Connect by internal team for discharge and referrals • Establish proof of concept and plan for integration with Texas Health Physician Group (THPG) and Faith Community Nursing, ensuring proper collection and alignment of metrics • Develop collateral resources necessary to train Community Health Advocates, THPG clinicians & staff, and Faith Community Nurses/Community Health Workers on utilization and integration • Create process to use Community Connect data to inform strategic and programmatic decisions	• Increase overall utilization of tool • Increase strategic utilization with particular focus on underserved populations • Increase internal 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	• Advance health equity by improving access to healthcare resources for underserved populations • Improve discharge planning through integration of tool into internal processes

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

Priority Area #3:	Awareness, Health Literacy & Navigation					
				Anticipated Impact		
Strategies	Activities	Lead Dept / Staff	Process Objectives (SMART)	Short-Term Outcomes (1 year)	Intermediate Outcomes (1-3 years)	Long-Term Outcomes (3+ years)
3.2 Continue implementation of MaineHealth'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	System-/Entity-Level Community Health Improvement/ Program Manager and Community Health Advocates 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 in zip codes with the highest socioeconomic need or the highest incident rates of falls • 80% of participants enrolled in a workshop will complete 5 out of 8 sessions ("graduate") • 90% of program graduates 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 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 • Increase Texas Health capacity to capture and compare data on varying audiences - both patients and community members - through internal linkages and external partnerships	• 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 • Advance Community Health Improvement linkages to system-wide Key Performance Indicators (KPI) through enhanced internal and external data capturing and mining
	3.2.2 Establish proof of concept and plan for collaboration with THPG to recommend patients to AMOB workshops		• 10% of program participants will be patients from THPG			
	3.2.3 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 will be contacted for follow-up evaluation at various intervals following workshop completion			
	3.2.4 Develop and implement process to cross-reference workshop participant information with Electronic Health Records (EHRs) to determine utilization rates		• 90% of program graduates will be cross-checked against Texas Health EHRs for readmission rates both pre- and post-workshop			

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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 Manage and strengthen Delivery System Reform Incentive Payment (DSRIP) programs	3.3.1 Continue to provide Emergency Department (ED) navigation programs to underserved populations under the Medicaid 115 Waiver	System-Level Community Health Improvement/ System Programs and Reporting Director	• 93% of achievement of available dollars for DY6 • Provide training and technical assistance around PFM protocols to ensure alignment of entities/projects • Pursue replication of key DSRIP projects through grants	• 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* grant program for optimal performance	3.4.1 Continue to address awareness, literacy and navigation through grants awarded to community clinics	System-Level Community Health Improvement/ System Programs and Reporting Director	• Work with Community Health Advocates to ensure 80% of grantees meet expectations and demonstrate impact • Develop and document a recruiting process with a goal of two (2) additional clinics for next application cycle • Formalize policy and procedures and strengthen governing committee's role to ensure strategic alignment with metrics • Expand partnerships with Federally Qualified Health Centers (FQHCs) to align with Community Health Improvement mission	• 70% of patients referred to a partnered clinic 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	• 60% of adults with diagnosed hypertension receiving care in partnered clinics will have a most recent blood pressure less than 140/90

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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)
3.5 Continue collaboration on Fort Worth Blue Zones Project	3.5.1 Increase community engagement in Blue Zones activities, particularly healthy eating and movement	System-Level Community Health Improvement/ Health Improvement & Blue Zones Program Director	• Continue progress toward community involvement with a shift in focus to the holistic engagement experience over individual engagement • Continue implementation of community projects, including the Stop 6 Community Redevelopment Project which targets an underserved population • Continue to expand Blue Zones' reach system-wide to Texas Health employees	• 40,766 individuals participate in an engagement activity (personal pledge, cooking demo, purpose workshop, volunteer opportunity, or walking group) • 70,000 employees represented by Blue Zones approved worksites • 63 Blue Zones approved restaurants • 14 Blue Zones approved grocery stores • 44 Blue Zones approved schools • 3,000 participants represented by Blue Zones approved faith-based communities	• Completion of community projects, including the Community Circulator project that fosters alternative transportation connectivity between two significant Fort Worth city sections • Increase in community awareness of walkable neighborhoods and Fort Worth city streets	• Fort Worth Well-Being Index (WBI) score of 64 • 57% of individuals surveyed report exercising 30+ minutes 3 days a week or more • 90% of individuals surveyed report having easy access to affordable fresh fruits and vegetables

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The following information can be found in the Appendices:

I. Project Team

II. Consulting Organization

Appendices

Appendix I: Project Team

- **Melanie Mayfield,** Marketing Manager, Texas Health Rockwall
- **Catherine Oliveros, MPH, DrPH,** Vice President, Community Health Improvement, Texas Health Resources
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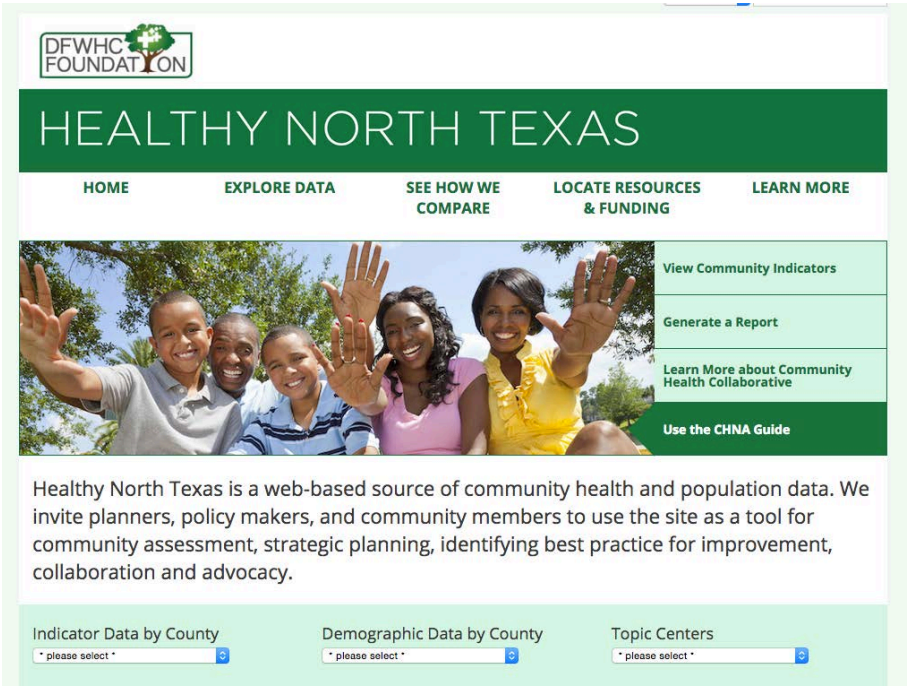
- **Cindy Paris,** President, Texas Health Rockwall
- **Gary Bonacquisti, MD,** Chief Medical Officer, Texas Health Rockwall
- **Tami Hawkins, MSN, NEA-BC,** Vice President of Patient Care/Chief Nursing Officer, Texas Health Rockwall

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



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