Texas Health Harris Methodist Hospital Southlake

2016 Community Health Needs Assessment: Implementation Strategy Report

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Report Contents

- Background
  - About the Organizations
  - CHNA Overview
  - Implementation Strategy Design Process
- Implementation Plan
  - Priority 1: Behavioral Health
  - Priority 2: Chronic Disease (Diabetes) Prevention & Management, including Exercise, Nutrition & Weight
  - Priority 3: Awareness, Health Literacy & Navigation
  - Priority 4: Older Adults & Aging

Appendix Contents

I. Project Team

II. Consulting Organization

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 Southlake

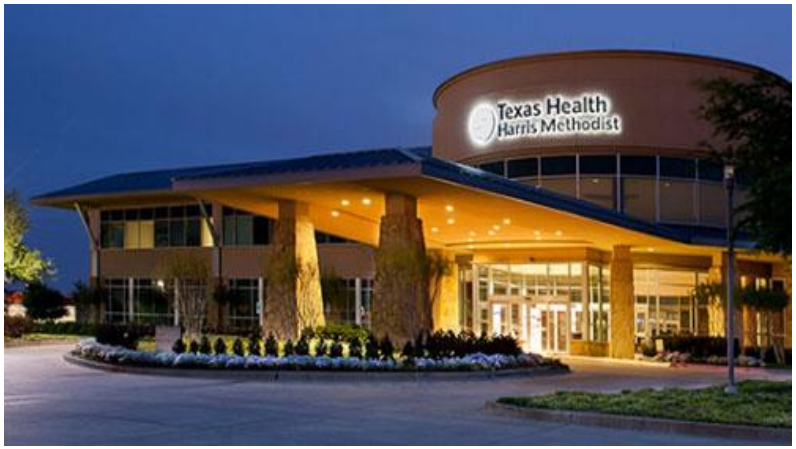
Texas Health Southlake is a multi-specialty surgical hospital located across the street from Southlake Town Square. Bringing the 84-year history of Harris Methodist Hospitals to the Southlake community, our team is committed to our patients, our community and our employees.

Our vision is to be the premier provider of selected clinical services; an organization where employees want to work, physicians want to practice and patients receive compassionate care. It is our mission to promote exemplary health care, compassion, innovation and personal service to all we serve. We appreciate you choosing this community hospital for your healthcare needs and allowing us to serve you. Our staff is passionate about what they do and has created principles by which the organization consistently functions.

We use the acronym "CHOICE" for our core values because we all have a choice where we work as employees, where we practice medicine as physicians, and where we receive care as a patient.

C.H.O.I.C.E.

- Compassion – Provide care that is focused and expresses empathy and understanding of individual needs.
- Healing – Treatment of the whole person, mind and body.
- Oneness – Working together in harmony to achieve our mission and vision.
- Integrity – Honesty, trust, reliability and commitment to uphold the highest ethical and compliance standards.
- Commitment – Pledge to our stakeholders.
- Excellence – Distinction, quality, superiority.



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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 Southlake Priority Health Needs for 2016 CHNA

Mental Health & Mental Disorders	Older Adults & Aging	Exercise, Nutrition, & Weight	Diabetes

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 Harris Methodist Hospital Southlake 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 Harris Methodist Hospital Alliance 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 resources and affordable mental health services for the uninsured, as well as the stigma of mental illness and sustance 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 76148, 76180 • African Americans • Hispanic women with less than a high school education
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 Alliance Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff • Educators and Other Staff • Texas Health Alliance 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 Alliance 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 Alliance staff and externally with community partners	• Increase both Texas Health Alliance 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 Alliance service areas • Assess appropriate involvement or mobilize community partners in creation of new behavioral health-focused coalition			

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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)
1.2 Strengthen community capacity to reduce the stigma of mental illness through program designed to improve participants' knowledge and modify their attitudes and perceptions about mental health and related issues, including how to respond to individuals who are experiencing one or more acute mental health crises or are in the early stages of one or more chronic mental health problems	1.2.1 Continue implementation of Youth Mental Health First Aid (MHFA) program	• Texas Health Alliance Community Health Advocate • Emergency Department Patient Navigator	• Partner with Faith Community Nurses, MHMR of Tarrant County and other internal and external partners to implement and evaluate program • Establish baseline measurements to track impact	• 5% improvement over baseline in number of participants able to recognize symptoms of a mental health crisis or chronic mental health condition • 5% improvement over baseline in number of participants who demonstrate improved knowledge of mental health support and treatment resources and self-reported increased confidence in providing help to an individual with mental health problems	• 10% improvement over baseline in number of participants able to recognize symptoms of a mental health crisis or chronic mental health condition • 10% improvement over baseline in number of participants who demonstrate improved knowledge of mental health support and treatment resources and self-reported increased confidence in providing help to an individual with mental health problems	• 15% improvement over baseline in number of participants able to recognize symptoms of a mental health crisis or chronic mental health condition • 15% improvement over baseline in number of participants who demonstrate improved knowledge of mental health support and treatment resources and self-reported increased confidence in providing help to an individual with mental health problems

Priority Area 2: Chronic Disease Prevention & Management

Priority Area #2:	Chronic Disease (Diabetes) 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, 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. *Source: County Health Rankings*
Target Populations	• Low-income, uninsured/underinsured populations • Zip codes 76148, 76180* • African Americans • Hispanic women with less than a high school education
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 Alliance Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff • Educators and Other Staff • Texas Health Alliance 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 Prevention & Management (cont'd)

Priority Area #2:	Chronic Disease (Diabetes) Prevention & Management, including Exercise, Nutrition & Weight					
Strategies	Activities	Lead Dept / Staff	Process Objectives (SMART)	Anticipated Impact: Short-Term Outcomes (1 year)	Anticipated Impact: Intermediate Outcomes (1-3 years)	Anticipated Impact: 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 Alliance 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	• Build and expand partnerships with community organizations • 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 Alliance 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			

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Priority Area 2: Chronic Disease Prevention & Management (cont'd)

Priority Area #2:	Chronic Disease (Diabetes) 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 Continue current collaborations and explore opportunities for new collaborations with community partners to increase physical activity among community members	2.2.1 Continue operation of walking clubs with community Home Owners' Associations (HOA) 2.2.2 Explore partnership with Keller Independent School District (KISD) to implement running clubs for students	• Texas Health Alliance Community Health Advocate	• Determine metrics for evaluation (i.e., BMI, physical stamina) • Establish baseline measurements to track impact • Establish proof of concept and plan for implementation and evaluation	• 5% improvement over baseline in selected metrics	• 10% improvement over baseline in selected metrics	• 15% improvement over baseline in selected metrics
2.3 Explore opportunities for collaboration with community partner to address food insecurity and nutritional needs in the community	2.3.1 Expand partnership with Community Storehouse's Food Pantry to provide nutritional education to food pantry clients and community members	• Texas Health Alliance Community Health Advocate	• Determine effective implementation action • Establish proof of concept and plan for implementation and evaluation • Establish baseline measurements to track impact	• Increase Texas Health Alliance's capacity to address food insecurity as a barrier to health and to educate community members on nutritional needs	• Increase in self-reported number of servings of fruits and vegetables consumed by food pantry clients	• Increase in number of servings of fruits and vegetables consumed reported by Behavioral Risk Factor Surveillance System (BRFSS)
2.4 Partner with Healthy Tarrant County Collaboration (HTCC) on the execution of grants	2.4.1 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	• HTCC/ Executive Director • Texas Health Alliance 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	• Increase Texas Health Alliance'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

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Priority Area 3: Awareness, Health Literacy & Navigation

Priority Area #3:	Awareness, Health Literacy & Navigation
Need Statement	20% of Tarrant County residents lack health insurance. 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*
Target Populations	• Low-income, uninsured/underinsured populations • Zip codes 76148, 76180 • African Americans • 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 Alliance Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff • Educators and Other Staff • Texas Health Alliance 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	• Texas Health Alliance 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 Alliance 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

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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)
3.2 Strengthen Delivery System Reform Incentive Payment (DSRIP) program	3.2.1 Continue implementation of emergency department (ED) navigation 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
3.3 Address overutilization of care specific to congestive heart failure (CHF) patients by lowering readmissions and inappropriate Emergency Department (ED) use	3.3.1 Explore expansion of post-discharge home visits by MedStar Mobile Healthcare	• Care Transitions Management	• Establish proof of concept and plan for expansion of program and tracking of readmission rates of participants • Provide resources and financial funding to MedStar for home-visit program • Refer Texas Health Alliance patients diagnosed with congestive heart failure (CHF) for follow-up appointments with MedStar 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. 8.2% of adults in Texas Health Alliance'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, 8.4% of older adults in Tarrant 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 76148, 76180* • Zip codes 76244, 76248** • African Americans • Hispanic women with less than a high school education
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 Alliance Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff • Educators and Other Staff • Texas Health Alliance 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 Alliance 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	• Build and expand partnerships with community organizations • 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 Alliance 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

- **Laura Redman,** Marketing Director, Texas Health Southlake
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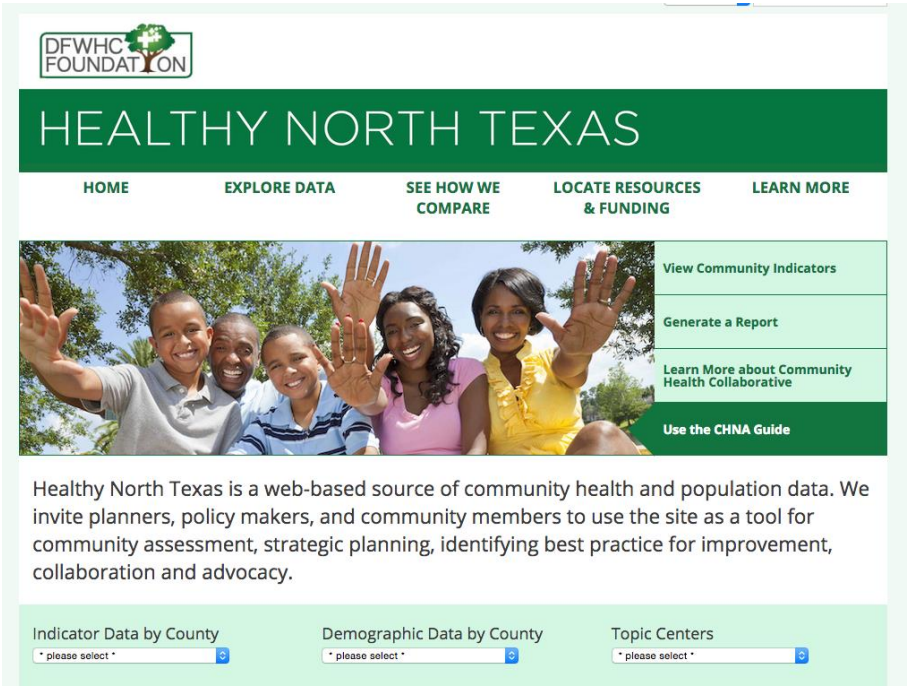
Appendix II: About Healthy Communities Institute

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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