2016

COMMUNITY HEALTH
NEEDS ASSESSMENT

Texas Health Resources Community Health Needs Assessment: Implementation Strategy System-Wide Report 2017-2019

Contents

Executive Summary

ABOUT TEXAS HEALTH RESOURCES

Texas Health Resources is one of the largest faith-based, nonprofit health care delivery systems in the United States and the largest in North Texas in terms of patients served. The system's primary service area consists of 16 counties in north central Texas, home to more than 6.8 million people. Texas Health was formed in 1997 with the assets of Fort Worth-based Harris Methodist Health System and Dallas-based Presbyterian Healthcare Resources. Later that year, Arlington Memorial Hospital joined the Texas Health system. Texas Health has 24 acute-care and short-stay hospitals that are owned, operated, joint-ventured or affiliated with the system. It has more than 3,800 licensed beds, more than 20,500 employees of fully-owned/operated facilities plus 2,100 employees of consolidated joint ventures, and counts more than 5,500 physicians with active staff privileges at its hospitals.

MISSION, VISION AND VALUES

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.

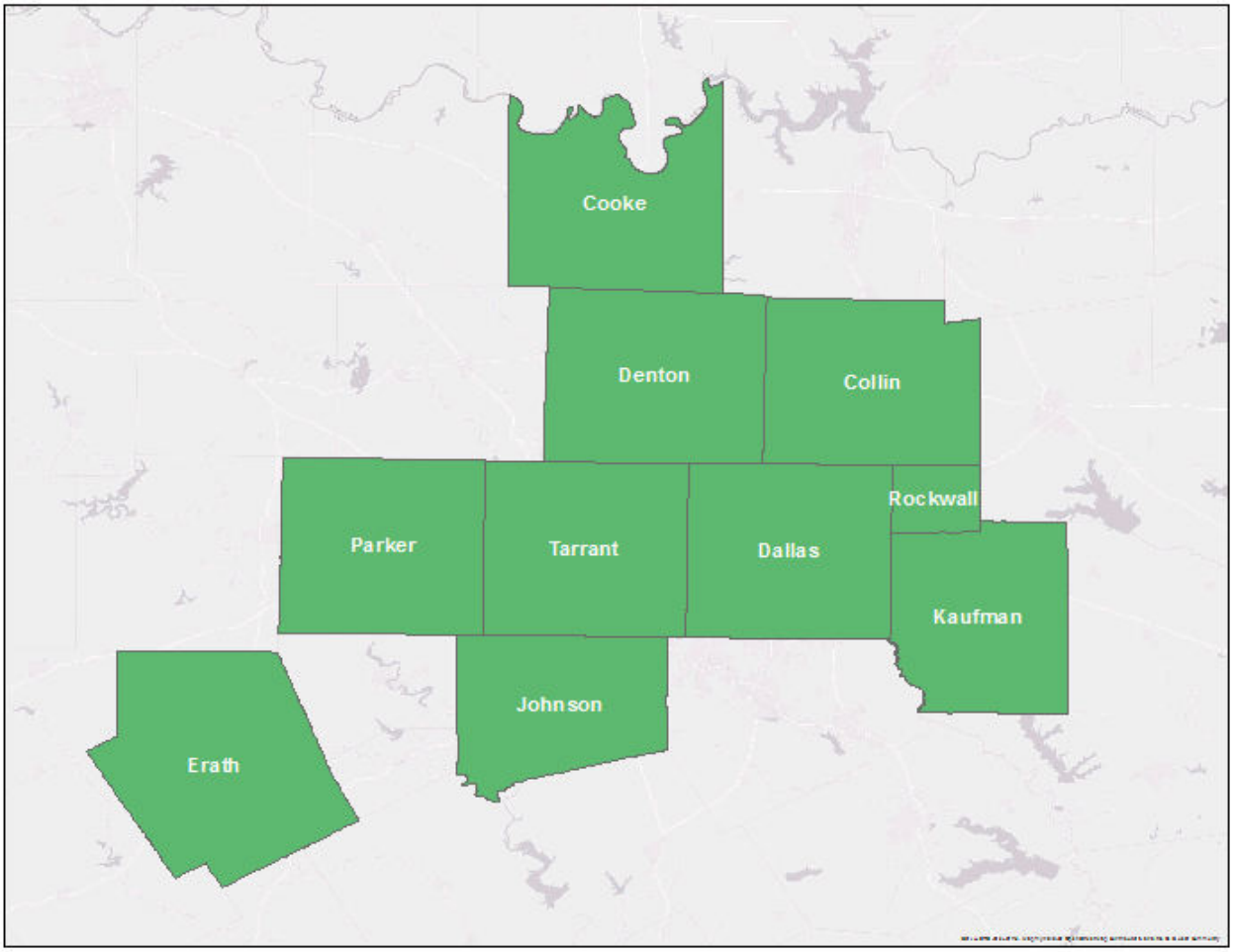
DIVERSITY STATEMENT

We will provide and maintain a fair and equitable environment for all by valuing and respecting individual differences for our enrichment and that of the communities we serve.

COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGY

As stated in the Affordable Care Act, the IRS requires all non-profit hospitals to complete a Community Health Needs Assessment (CHNA) and adopt an Implementation Strategy (IS) to meet identified needs every 3 years. This report summarizes the 2016 IS planning process, at a system level, for 23 of Texas Health's wholly-owned, non-profit and joint venture hospitals.

Figure 1: Map of Texas Health Service Area Counties



Headquartered in Arlington, Texas, Texas Health serves the fourth-largest metropolitan region in the United States: the Dallas-Fort Worth Metroplex. The health care system includes 24 wholly owned hospitals and joint-venture facilities, and a network of physician practices that serve 16 counties. Figure 1 shows the service area counties of the 23 Texas Health facilities included in the assessment. The north zone includes Cooke, Denton, Collin, and Tarrant counties and the following facilities: Texas Health Allen, Texas Health Plano, Texas Health Diagnostics & Surgery, Texas Health Denton, Texas Health Flower Mound, Texas Health Alliance, Texas Health HEB, and Texas Health Southlake. The southeast zone includes Dallas, Rockwall, and Kaufman counties and the following facilities: Texas Health Dallas, Texas Institute for Surgery, Texas Health Rockwall, and Texas Health Kaufman. The southwest zone includes Dallas, Tarrant, Erath, Johnson, and Parker counties and the following facilities: Texas Health Arlington Memorial, Texas Health Heart & Vascular, Texas Health Stephenville, Texas Health Cleburne, Texas Health Huguley, Texas Health Azle, USMD Fort Worth, Texas Health Fort Worth, Texas Health Specialty, Texas Health Southwest, and USMD Arlington. A full list of the prioritized needs by facility is included in Appendix A.

Texas Health partnered with Conduent Healthy Communities Institute (HCI) to complete the Implementation Strategy for each facility listed above through the following steps:

- Providing program inventory worksheet
- Conducting evidence-based practice research
- Developing template for IS data collection
- Authoring IS Reports

IMPLEMENTATION STRATEGY REPORT

This report summarizes the plans for Texas Health Resources to address the prioritized needs identified in the 2016 CHNA. The top priority health needs across the Texas Health system were Mental Health & Substance Abuse; Exercise, Nutrition, & Weight; and Access to Health Services and Healthcare Navigation & Literacy.

Texas Health developed a system-wide community benefit strategy to leverage internal and external resources to increase its ability to impact community health needs. 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's 2016 CHNA & IS Overview

Each of the CHNA and IS project steps that were undertaken for the 23 facilities are outlined below in Figure 2:

Figure 2: CHNA & IS Project Steps

This report details the Implementation Strategy for the top priority health needs at the Texas Health system level. The most frequently prioritized health needs in the 2016 CHNA among the 23 Texas Health facilities are (in order): Mental Health and Substance Abuse; Exercise, Nutrition, and Weight; and Access to Health Services and Healthcare Navigation and Literacy**.** A full list of the prioritized needs by facility is included in Appendix A.

Following the completion of the 2016 CHNA, Texas Health Resources developed a detailed implementation plan outlining how it will implement strategies and activities aimed at addressing these areas in 2017-2019. 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 has developed a system-wide Community Benefit Strategy to leverage internal and external resources to increase its ability to impact community health needs.

Each facility will align its Implementation Strategy to the Texas Health system-wide Community Benefit Strategy, customizing the shared implementation approach and producing its own implementation strategy report with its specific programs, resources, and priorities. Some facilities will not address certain needs in their Implementation Strategy, but will continue work in many of the related areas. Reasons that a facility is not addressing a need might include rationale such as resource constraints, lack of expertise, low priority assigned, lack of effective intervention, need already being addressed, and continued level of support.

Implementation Strategy Plan

Texas Health Resources is pleased to share its 2017-2019 Implementation Strategy Plan, which follows the development of the 2016 Community Health Needs Assessment (CHNA). In accordance with requirements in the Affordable Care Act and IRS 990 Schedule H requirements, the Texas Health Board of Directors approved this plan on April 24, 2016.

The following plan includes a description of the actions the health system intends to take to address **Behavioral Health, Chronic Disease, and Awareness, Health Literacy, & Navigation** and the anticipated impact of these actions. It also includes a description of the resources committed to address each need and any planned collaboration with other facilities or organizations. Texas Health will work with local community groups and government organizations to maximize investment of time and resources to improve the health of the people in the communities Texas Health serves. While Texas Health provides additional support for community benefit activities in the communities it serves, not all will be covered in this report.

These three priority areas are in strategic alignment with the most recent Texas Health 10-Year Strategic Plan, focusing efforts to fulfill its mission to improve the health of the people in the communities Texas Health serves. Specifically, these three priority areas strengthen the following strategic objectives: **Exceptional Care, Value Creation, Consumer Focus,** and **Culture of Excellence.**

PRIORITY AREA: 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. The Statewide Behavioral Health Coordinating Council recently released a five-year Texas Statewide Behavioral Health Strategic Plan for 2017-2021, which identified gaps and challenges related to coordination, access, and service provision within the behavioral health system in Texas. Mental health and substance abuse were the most commonly prioritized needs across 23 Texas Health facilities. Common themes from the system-wide CHNA report include issues related to dementia, depression, tobacco use, and alcohol use. *Source: U.S. Surgeon General, Texas Health and Human Services Commission, Healthy People 2020, Texas Statewide Behavioral Health Strategic Plan, Texas Health System-Wide CHNA Report*
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	• 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 FRAMEWORK: 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	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			

PRIORITY AREA: CHRONIC DISEASE

Priority Area #2:	Chronic Disease Prevention & Management, including Exercise, Nutrition & Weight
Need Statement	Chronic conditions are a significant public health issue and societal cost. 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. Exercise, nutrition, and weight was the second most commonly prioritized needs across 23 Texas Health facilities. Common themes from the system-wide CHNA report include issues related to the availability of healthy foods, the built environment, and obesity. *Source: Dallas County Health & Human Services, Texas Health System-Wide CHNA Report*
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	• 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 FRAMEWORK: CHRONIC DISEASE

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	• 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	• 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	• 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		• 50% of program graduates will be contacted for follow-up evaluation at various intervals following workshop completion			

	conditions and self-reported biometrics at various intervals following completion of the workshop	• United Way of Tarrant County/Area Agency on Aging of Tarrant County		• Increase Texas Health and community capacity to address the management of chronic conditions in underserved populations	• Increase Texas Health capacity to capture and compare data on varying audiences - both patients and community members - through internal linkages and external partnerships	
	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			• 30% decrease in preventable participant healthcare utilization related to chronic conditions in zip codes with the highest socioeconomic need
2.2.1 Manage and strengthen Delivery System Reform Incentive Payment (DSRIP) programs	2.2 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: 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. Access to health services and health literacy and navigation were the third most commonly prioritized needs across 23 Texas Health facilities. Common themes from the system-wide CHNA report include issues related to low health insurance coverage, healthcare provider shortage, health literacy, language and cultural barriers, and resource navigation *Source: The Henry J. Kaiser Family Foundation, U.S. Department of Health and Human Services, Texas Health System-Wide CHNA Report*
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	• 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

PRIORITY AREA FRAMEWORK: 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	• 25% increase in use of tool by individuals living in zip codes with the highest socioeconomic need* • Advance health equity by improving access to healthcare resources for underserved populations • Improve discharge planning through integration of tool into internal processes

3.2 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	• 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		
	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		• 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
	3.2.4 Develop and implement process to		• 90% of program graduates will be cross-checked against Texas Health			

	cross-reference workshop participant information with Electronic Health Records (EHRs) to determine utilization rates	County	EHRs for readmission rates both pre- and post-workshop	• Increase Texas Health and community capacity to address the fear of falling and fall prevention in underserved populations	• Increase Texas Health capacity to capture and compare data on varying audiences - both patients and community members - through internal linkages and external partnerships	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
3.3.1 Manage and strengthen Delivery System Reform Incentive Payment (DSRIP) programs	3.3 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
3.4.1 Manage and strengthen operations of Clinic Connect for optimal performance	3.4 Continue to address awareness, literacy and navigation through grants awarded to community clinics	System-Level Community Health Improvement/ System Programs and	• 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)	• 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	

		Reporting Director	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		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
3.5 Continue collaboration on Fort Worth Blue Zones Project	3.5.2 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

Conclusion

Texas Health's system-wide 2016 CHNA and IS efforts have culminated in this report, outlining plans for 2017-2019. The CHNA included the analysis and synthesis of quantitative and qualitative data, including community input gathered through interviews, focus groups, and a community survey, to determine significant needs. Each of the 23 Texas Health facilities included in the assessment took the data into account, along with specific criteria, to prioritize the health needs of the communities they serve. Mental health and substance abuse; exercise, nutrition, and weight; and access to health services and healthcare navigation and literacy were found to be the most pressing health needs across Texas Health's service area.

Following the completion of the CHNA, Texas Health developed a plan to address these needs in 2017-2019. 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 is committed to improving the overall health and wellness of the people in the communities it serves. Texas Health will continue to collaborate with local government and community partners to implement effective strategies to address community needs. Texas Health will monitor and evaluate any progress made, adjusting goals and strategies to continually improve on meeting community needs.

Appendix A. 2016 CHNA Health Priorities by Facility

THR System-Level Priorty Health Topics for 2016 CHNA						
Facility	*County(ies)*	*Priority Needs*				*Notes:*
North Zone						
Texas Health Allen	*Collin*	Diabetes	Exercise, Nutrition, & Weight	Mental Health & Mental Disorders		Overarching themes of Healthcare Navigation & Literacy; Children's Health
Texas Health Alliance	*Tarrant*	Mental Health & Mental Disorders	Older Adults & Aging	Exercise, Nutrition, & Weight	Diabetes	
Texas Health Denton	*Denton & Cooke*	Mental Health & Mental Disorders & Substance Abuse	Access to Health Services	Exercise, Nutrition, & Weight	Diabetes	Transportation, Language/Cultural Barriers, Navigation & Literacy to be included as themes within Access
Texas Health HEB	*Tarrant*	Children's Health	Exercise, Nutrition, & Weight	Mental Health & Mental Disorders		Overarching themes of healthcare navigation & literacy and transportation
Texas Health Plano	*Collin*	Access to Health Services/Healthcare Navigation & Literacy	Exercise, Nutrition, & Weight	Mental Health & Mental Disorders & Substance Abuse	Older Adults & Aging	Overarching themes of Transportation, Lack of Insurance Coverage, & Cost for Access to Health Services
Texas Health Diagnostics & Surgery	*Collin*	Access to Health Services/Healthcare Navigation & Literacy	Exercise, Nutrition, & Weight	Mental Health & Mental Disorders & Substance Abuse	Older Adults & Aging	Overarching themes of Transportation, Lack of Insurance Coverage, & Cost for Access to Health Services
Texas Health Flower Mound	*Denton*	Mental Health & Mental Disorders & Substance Abuse	Access to Health Services	Exercise, Nutrition, & Weight	Diabetes	Transportation, Language/Cultural Barriers, Navigation & Literacy to be included as themes within Access
Texas Health Southlake	*Tarrant*	Mental Health & Mental Disorders	Older Adults & Aging	Exercise, Nutrition, & Weight	Diabetes	
Southeast Zone						
Texas Health Dallas	*Dallas*	Diabetes	Mental Health & Mental Disorders	Exercise, Nutrition, & Weight	Older Adults & Aging	
Texas Health Kaufman	*Kaufman*	Access to Health Services & Transportation	Older Adults & Aging	Healthcare Navigation & Literacy/Language & Cultural Barriers		
Texas Institute for Surgery	*Dallas*	Diabetes	Mental Health & Mental Disorders	Exercise, Nutrition, & Weight	Older Adults & Aging	
Texas Health Rockwall	*Rockwall & Dallas*	Children's Health	Mental Health & Mental Disorders & Substance Abuse	Older Adults & Aging		Healthcare Navigation & provider shortages will be themes within Older Adults & Aging
Southwest Zone						
Texas Health Arlington Memorial	*Tarrant & Dallas*	Mental Health & Mental Disorders	Healthcare Navigation & Literacy	Older Adults & Aging		
Texas Health Azle	*Tarrant & Parker*	Exercise, Nutrition, & Weight	Heart Disease	Access to Health Services		
Texas Health Cleburne	*Johnson*	Mental Health & Mental Disorders & Substance Abuse	Diabetes			Exercise, Nutrition, & Weight to be included as themes for Diabetes
Texas Health Fort Worth	*Tarrant*	Access to Health Services	Mental Health & Mental Disorders	Exercise, Nutrition, & Weight		Healthcare Navigation & Literacy, Economy, & Transportation to be included with Access to Health Services; Exercise, Nutrition, & Weight will focus on management and prevention of chronic conditions
Texas Health Speciality	*Tarrant*	Access to Health Services	Mental Health & Mental Disorders	Exercise, Nutrition, & Weight		Healthcare Navigation & Literacy, Economy, & Transportation to be included with Access to Health Services; Exercise, Nutrition, & Weight will focus on management and prevention of chronic conditions
Texas Health Southwest	*Tarrant*	Heart Disease	Exercise, Nutrition, & Weight	Diabetes	Healthcare Navigation & Literacy	
Texas Health Stephenville	*Erath*	Access to Health Services	Exercise, Nutrition, & Weight	Mental Health & Mental Disorders		
Texas Health Heart & Vascular	*Tarrant & Dallas*	Mental Health & Mental Disorders	Healthcare Navigation & Literacy	Older Adults & Aging		
Texas Health Huguley	*Johnson*	Access to Health Services	Mental Health & Mental Disorders	Exercise, Nutrition, & Weight	Older Adults & Aging	
USMD Arlington	*Tarrant*	Mental Health & Mental Disorders	Healthcare Navigation & Literacy	Older Adults & Aging		
USMD Fort Worth	*Tarrant & Parker*	Heart Disease	Exercise, Nutrition, & Weight	Diabetes	Healthcare Navigation & Literacy	

Appendix B. About HCI & Authors

ABOUT HEALTHY COMMUNITIES INSTITUTE

Conduent Healthy Communities Institute was retained by Texas Health to conduct the 2016 Community Health Needs Assessment and produce Implementation Strategy reports for 23 of their wholly owned, non-profit and joint venture facilities.

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. The organization is composed of public health professionals and health IT experts committed to meeting clients' health improvement goals.

To learn more about Healthy Communities Institute please visit www.conduent.com/community-population-health/.

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