Texas Institute for Surgery

2016 Community Health Needs Assessment: Implementation Strategy Report

Texas Health Resources®

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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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Community Health Improvement
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About Texas Institute for Surgery

The Texas Institute for Surgery (TIS) at Texas Health Presbyterian Hospital Dallas is a joint venture with physicians and Value Management Group. The facility has nine operating rooms, three pain management or specialty treatment rooms, and nine in-patient beds. Texas Health holds a majority ownership share in TIS, and the facility is operated by Value Management Group. The institute opened in October 2004.

Surgeons with TIS specialize in orthopedic surgery, back and spinal surgery, ENT procedures, plastic surgery, foot and ankle surgery, urological surgical care, and sports medicine.

TIS has completed a Community Health Needs Assessment in collaboration with Texas Health Presbyterian Hospital Dallas.

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.

TIS's Priority Health Needs for 2016 CHNA

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

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**.

The Texas Institute for Surgery completed a CHNA in collaboration with Texas Health Presbyterian Hospital Dallas 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.

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 severe lack of mental health services and resources in Dallas County as an issue facing the community, as well as the stigmas associated with mental illness and substance abuse. The Healthy People 2020 goal is to improve mental health and reduce substance abuse through prevention and by ensuring access to appropriate, quality behavioral health services.
Target Populations	• Low-income, uninsured/underinsured populations • Zip codes 5041, 75042, 75143, 75180, 75216, 75217, 758220, 75223, 75227, 75228, 75231, 75240, 75243 • African American and Hispanic populations
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 Dallas Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff • Educators and Other Staff • Texas Health Dallas 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 Dallas 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 Dallas staff and externally with community partners	• Increase both Texas Health Dallas 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 Dallas 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 Delivery System Reform Incentive Payment (DSRIP) program	1.2.1 Continue partnership with Healing Hands Ministries to provide behavioral health services to low-income/uninsured population through the Medicaid 1115 Waiver	• 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

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. 30.6% of adults in Dallas County are obese, and 12% are diabetic. Community survey participants named diabetes as the second most pressing health need for the community, while obesity/weight was named as the first. The Healthy People 2020 goal to reduce chronic conditions - such as diabetes - and complications from chronic conditions through better prevention, detection, treatment, and education efforts. *Source: Healthy North Texas Dashboard*
Target Populations	• Low-income, uninsured/underinsured populations • Zip codes 5041, 75042, 75143, 75180, 75216, 75217, 758220, 75223, 75227, 75228, 75231, 75240, 75243* • African American and Hispanic populations
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 Dallas Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff • Educators and Other Staff • Texas Health Dallas 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					
				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)
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 Dallas Community Health Advocate • System-Level Community Health Improvement/ Program Manager Partner Organizations: • Community Council of Greater Dallas/Area Agency on Aging of Dallas County • North Central Texas Council of Governments Area Agency on Aging • Sixty and Better • Tarrant County Public Health • United Way of Tarrant County/Area Agency on Aging of Tarrant County	• 75% of workshops will be held between 2017-2019 in zip codes with the highest socioeconomic need* • 75% of participants enrolled in a workshop between 2017-2019 will complete 4 out of 6 sessions ("graduate") • 90% of program graduates between 2017-2019 will complete both a pre- and post-survey	• 75% of program graduates will indicate an increase towards the total confidence rate in self-managing their chronic condition • Increase Texas Health Dallas 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			
	2.1.4 Recommend graduates to Diabetes Support Group for continued accountability		• 90% of DSMP graduates will be invited to participate in Diabetes Support Group following completion of the program			

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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 Strengthen Delivery System Reform Incentive Payment (DSRIP) program	2.2.1 Continued partnership with Healing Hands Ministries to provide chronic disease management to low-income/uninsured population 2.2.2 Continued operation of Tri-C Clinic to provide chronic disease management to low-income/uninsured population	• DSRIP Project Lead	• 93% of achievement of available dollars for DY6 • Proactively prepare for anticipated changes to DSRIP	• 5% improvement over baseline in selected bundle measures	• 10% improvement over baseline in selected bundle measures	• 15% improvement over baseline in selected bundle measures
2.3 Explore opportunities for collaboration with community partners to address food insecurity and nutritional needs in the community through the implementation of a food hub or community gardens	2.3.1 Establish partnerships with community groups working to help community members reduce risk for chronic disease and lead healthier lives through the consumption of healthful diets, achievement and maintenance of healthy body weights, and/or increase in physical activity	• Texas Health Dallas Community Health Advocate	• Identify zip codes and communities with greatest need (i.e., limited/no access to fresh fruits and vegetables) • Determine effective implementation action • Establish proof of concept and plan for implementation and evaluation	• Increase Texas Health Dallas's capacity to address food insecurity as a barrier to health	• Increase number of outlets supplying fresh fruits and vegetables in Texas Health Dallas communities identified as having the greatest need	• Advance health equity by decreasing barriers to health by expanding access to fresh fruits and vegetables

Priority Area 3: Awareness, Health Literacy & Navigation

Priority Area #3:	Awareness, Health Literacy & Navigation
Need Statement	32.9% of Dallas County residents lack health insurance, and 49.2% of those uninsured individuals are low income. 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: Dallas County Health and Human Services, Corporation for Enterprise Development*
Target Populations	• Low-income, uninsured/underinsured populations • Zip codes 5041, 75042, 75143, 75180, 75216, 75217, 758220, 75223, 75227, 75228, 75231, 75240, 75243 • African American and Hispanic populations
Goals	Increase individuals' awareness of and access to health information that is accurate, accessible, and actionable; address social determinants of health by partnering with community organizations.
Strategic Alignment	Consumer Focus
Resources	• Texas Health Dallas Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff • Educators and Other Staff • Texas Health Dallas Community Health/Community Benefit Budget • Aunt Bertha Platform and Other Technologies • Internal Service Lines • Community Partner Organizations/Agencies • Texas Health Buildings • Partner Organization Locations • Community Locations
Timeline	2017-2019

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Priority Area 3: Awareness, 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 Collaborate with System Services to raise awareness and disseminate information on Community Connect to internal and external stakeholders	• Texas Health Dallas 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 Dallas 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 Implementation of the Vickery Meadow Access Project (VMAP)	3.2.1 Deploy Community Health Workers (CHWs) to work in partnership with community stakeholders on a two-year pilot to increase access among residents of the Vickery Meadow neighborhood	• Texas Health Dallas Community Health Advocate • Texas Health Dallas Faith Community Nurse Partner Organization: • Healing Hands Ministries	• Connect 1,000 residents (500 annually) to primary health care services through enrollment in health insurance programs, social service programs, and navigation to a patient-centered medical home at Healing Hands Ministries.	• 70% of navigated patients will receive appropriate preventive health screenings with baseline results by the end of year 1	• Increase the knowledge of 2,500 Vickery Meadow residents on community health topics at scheduled community events; 90% of participants will demonstrate increased knowledge through pre-/post-surveys by completion of pilot	

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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 Explore opportunities to improve transportation options within the community	3.3.1 Explore collaboration with Texas Health Kaufman to jointly address transportation as a barrier to healthcare	• Texas Health Dallas Community Health Advocate	• Complete detailed assessment of transportation needs within primary and secondary service areas • Complete inventory of transportation resources currently available through partner organizations • Assess appropriate involvement or mobilize community partners in creation of transportation-focused initiative	• Increase Texas Health Dallas's capacity to identify and address transportation as a barrier to health	• Increase access to transportation in zip codes with the highest percentage of households with no vehicle*	• Advance health equity by improving access to health services for underserved populations by growing transportation options
3.4 Strengthen Delivery System Reform Incentive Payment (DSRIP) program	3.4.1 Continued partnership with Healing Hands Ministries to provide healthcare navigation to low-income/uninsured population	• DSRIP Project Lead	• 93% of achievement of available dollars for DY6 • Proactively prepare for anticipated changes to DSRIP	• 5% improvement over baseline in selected bundle measures	• 10% improvement over baseline in selected bundle measures	• 15% improvement over baseline in selected bundle measures
	3.4.2 Continued partnership with Tri-C Clinic to provide healthcare navigation to low-income/uninsured population	• DSRIP Project Lead				

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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 Manage and strengthen operations of Clinic Connect for optimal performance	3.5.1 Continue to address awareness, literacy and navigation through grants awarded to local charitable clinic	• Texas Health Dallas Community Health Advocate • System-Level Community Health Improvement /System Programs and Reporting Director	• Provide financial funding to clinic as support for services provided by clinic to uninsured and underinsured patients • Identify patients that meet eligibility criteria developed and agreed upon by Texas Health and clinic and contact clinic with requests for patient appointments • Patients referred to clinic by Texas Health Dallas will be seen in the clinic within 2 business days of the referral and have access to appropriate clinicians at clinic during normal business hours	• 70% of patients referred to all Texas Health-funded clinics by hospital staff will be seen within 3 business days	• 75% of all partnered clinics will have an average wait time for next available appointment that is no more than 7-10 days • 10% decrease in preventable healthcare utilization by patients referred to all Texas Health-funded clinics by hospital staff	• 60% of adults with diagnosed hypertension receiving care in any Texas Health-funded clinic will have a most recent blood pressure less than 140/90 • 15% decrease in preventable healthcare utilization by patients referred to all Texas Health-funded clinics by hospital staff
*75216, 75231, 75251						

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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. 9.9% of Dallas County residents are age 65 and older, and 11.4% of those older adults live 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 5041, 75042, 75143, 75180, 75216, 75217, 758220, 75223, 75227, 75228, 75231, 75240, 75243* • Zip codes 75225, 75230, 75231, 75238, 75243** • African American and Hispanic populations
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 Dallas Community Health Improvement Advocate & Staff • System-Level Community Health Improvement Staff • Educators and Other Staff • Texas Health Dallas 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 MaineHealth'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 Dallas Community Health Advocate • System-Level Community Health Improvement/ Program Manager Partner Organizations: • Community Council of Greater Dallas/Area Agency on Aging of Dallas County • North Central Texas Council of Governments Area Agency on Aging • Sixty and Better • Tarrant County Public Health • United Way of Tarrant County/Area Agency on Aging of Tarrant County	• 75% of workshops across the system will be held between 2017-2019 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 Dallas 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			

The following information can be found in the Appendices:

I. Project Team

II. Consulting Organization

Appendices

Appendix I: Project Team

- **Tonya Washington**, Director of Marketing & Communications, Texas Institute for Surgery
- **Catherine Oliveros, MPH, DrPH,** Vice President, Community Health Improvement, Texas Health Resources
- **Jamie Judd, MBA**, Program Director, Community Health Improvement, Texas Health Resources
- **Catherine McMains, MPH, CPH**, Community Benefit & Impact Specialist, Texas Health Resources
- **David Helfer, FACHE**, President, Texas Institute for Surgery
- **Tammy Jarvis**, Vice President of Clinical Services/Chief Nursing Officer, Texas Institute for Surgery

Appendix II: About Healthy Communities Institute

Conduent Healthy Communities Institute (HCI), formerly a Xerox Corporation, was contracted by Texas Health Resources to conduct the 2016 Community Health Needs Assessment, support Implementation Strategy development, and to author the CHNA and IS reports. Based in Berkeley, California, HCI provides customizable, web-based information systems that offer a full range of tools and content to improve community health, and developed the Healthy North Texas Platform. To learn more about Healthy Communities Institute please visit: www.HealthyCommunitiesInstitute.com

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

HCI Project Team & Report Authors

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