Texas Health Hospital Mansfield

2026 - 2028 Community Health Plan

Texas Health Hospital® MANSFIELD

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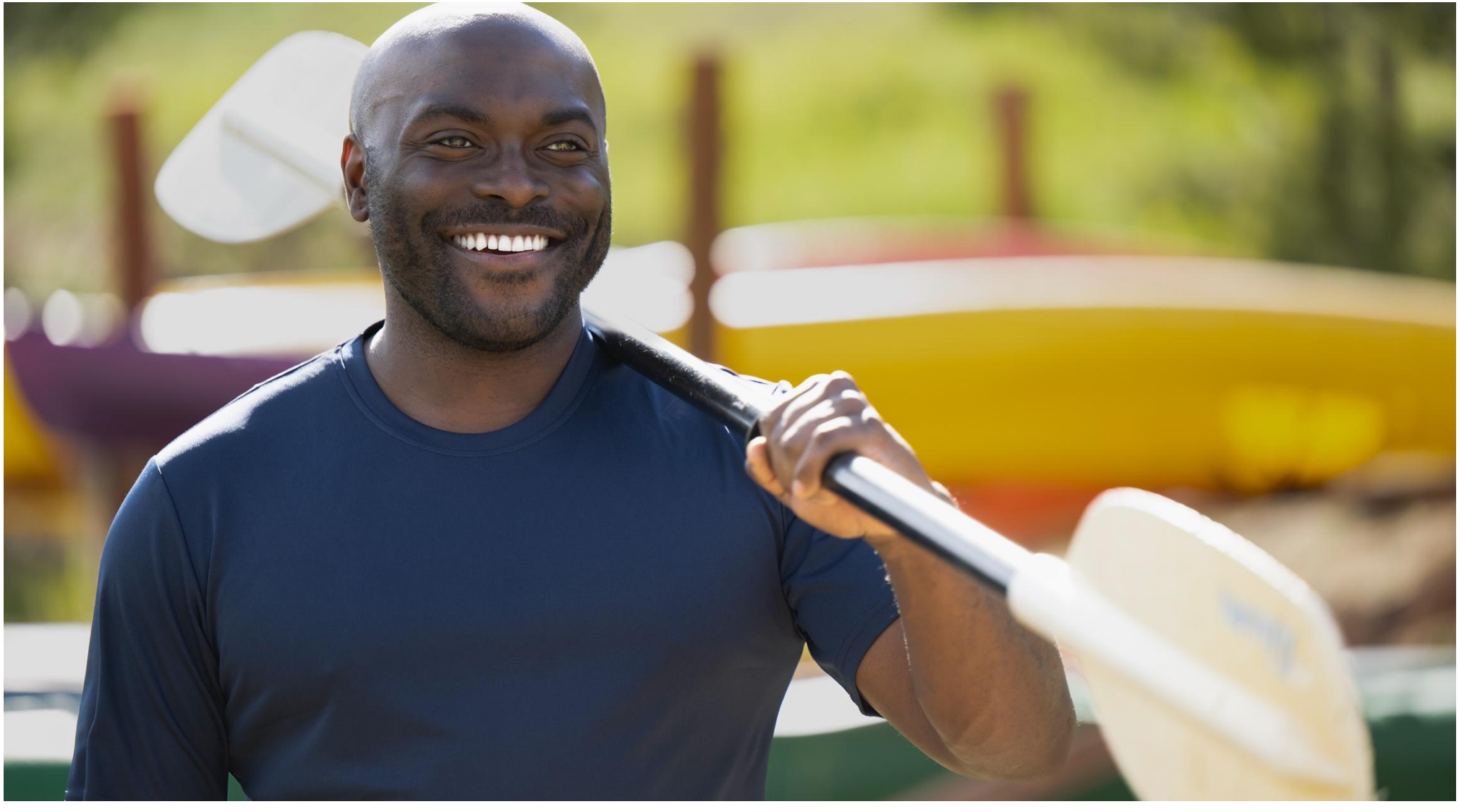
Acknowledgements

This community health plan was prepared by Lindsey Trook, with contributions from members of Texas Health Mansfield Community Health Needs Assessment Committee representing health leaders in the community and Texas Health Mansfield leaders.

We are especially grateful for the internal and external partners who helped guide the development of the community health plan which will enable our teams to continue fulfilling our mission of Extending the Healing Ministry of Christ.



Executive Summary

Executive Summary

Texas Health Hospital Mansfield is owned by Texas Health Huguley, Inc. and therefore operates as a part of the joint venture between Texas Health Resources and AdventHealth. Texas Health Hospital Mansfield will be referred to in this document as Texas Health Hospital Mansfield or the “Hospital”.

Community Health Needs Assessment Process

Texas Health Hospital Mansfield in Mansfield, Texas was included in a regional Community Health Needs Assessment (CHNA) in cooperation with Texas Health Resources and ECG Management Consultants. The assessment identified the health-related needs of the community, including low-income, minority and other underserved populations.

In order to ensure broad community input, the Hospital engaged nearly 650 stakeholders—including community leaders, residents, and partner organizations—through interviews, focus groups, and a distributed survey to ensure the assessment reflected a wide range of perspectives.

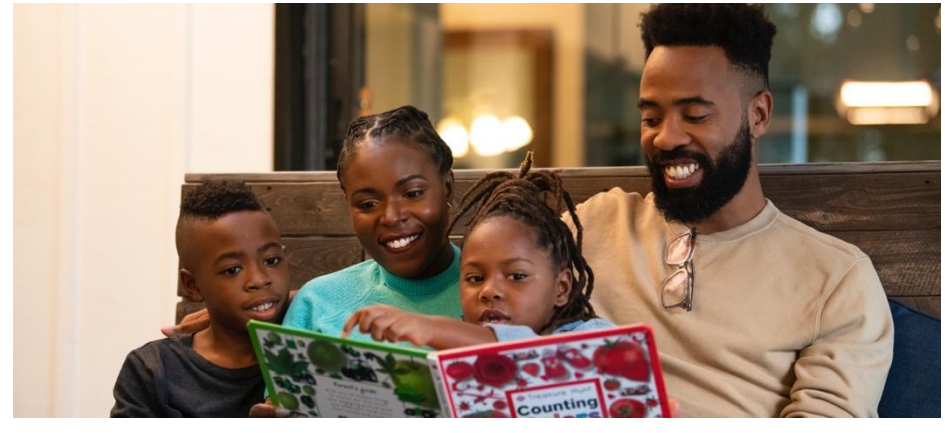
The Board of Directors for Texas Health Huguley and Texas Health Hospital Mansfield reviewed the data from the regional CHNA and from Texas Health Huguley’s and Texas Health Hospital Mansfield’s primary service area. The regional CHNA also included priority ZIP code reassessment, secondary data analysis, and data synthesis to identify community health needs. The board selected the needs the Hospital could most effectively address to support the community based on both internal Hospital and external resources available.

Community Health Plan Process

The Community Health Plan (CHP), or implementation strategy, is the Hospital’s action plan to address the priorities identified from the CHNA. The plan was developed by the Community Health Needs Assessment Committee (CHNAC), and input was received from stakeholders across sectors, including public health, faith-based, business and those individuals directly impacted.

The CHP outlines targeted interventions and measurable outcomes for each priority noted below. It includes resources the Hospital will commit and notes any planned collaborations between the Hospital and other community organizations and hospitals.

The defined goals and activities were carefully crafted, considering evidence-based resources and sought to align with AdventHealth’s organizational and strategic plans. Texas Health Huguley is committed to addressing the needs of the community, especially the most vulnerable populations, to bring wholeness to our communities.



Executive Summary

Priorities Addressed

The priorities addressed include:

1. Healthcare Access, Navigation, and Literacy
2. Food Insecurity
3. Connectedness
4. Transportation

See page 10 for the defined strategies and next steps for each priority selected to be addressed.

Priorities Not Addressed

The priorities not addressed include:

1. Chronic Disease
2. Behavioral Health
3. Disabilities
4. Income
5. Employment
6. Housing Stability
7. Educational Attainment

See page 19 for an explanation of why the Hospital is not addressing these issues.

The Community Health Plan is a three-year strategic plan and may be updated during implementation based on changing community needs and priorities. AdventHealth recognizes community health is not static and high-priority needs can arise or existing needs can become less pressing. The Hospital may pivot and refocus efforts and resources to best serve the community.

Executive Summary

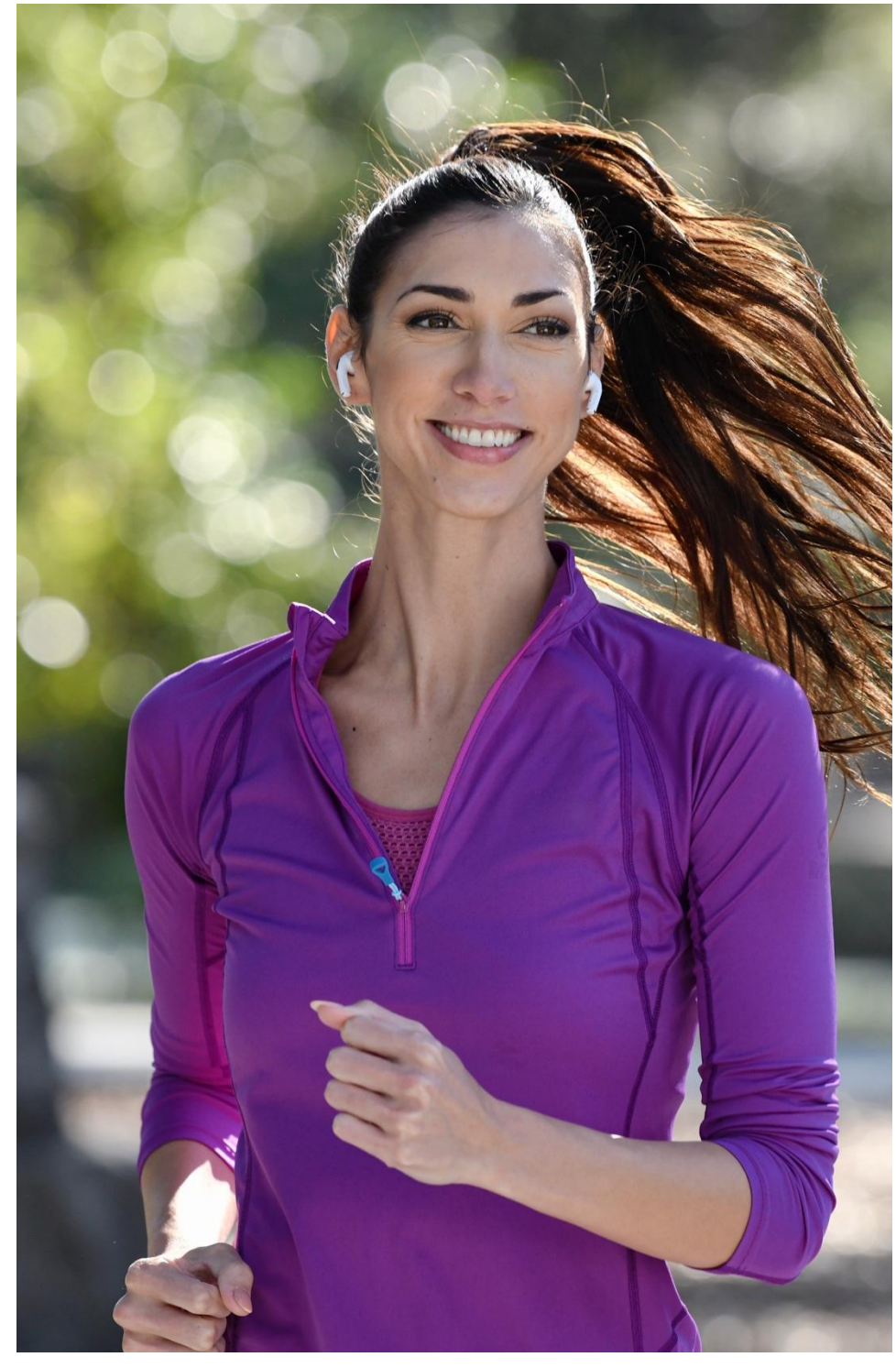
Board Approval

On March 26, 2026, the Texas Health Hospital Mansfield Board approved the Community Health Plan goals, activities and next steps. A link to the 2026-2028 Community Health Plan was posted on the Hospital's website on the Hospital's website on May 15, 2026.

Texas Health Mansfield's fiscal year is January 1 – December 31. For 2026, the Community Health Plan will be deployed beginning March 26, 2026, and evaluated at the end of the calendar year. In 2027 and beyond, the CHP will be evaluated annually for the 12-month period beginning January 1 and ending December 31. Evaluation results will be attached to the Hospital's IRS Form 990, Schedule H. The collective monitoring and reporting will ensure the plan remains relevant and effective.

For More Information

Learn more about the Community Health Needs Assessment and Community Health Plan for Texas Health Mansfield adventhealth.com/community-health-needs-assessments.



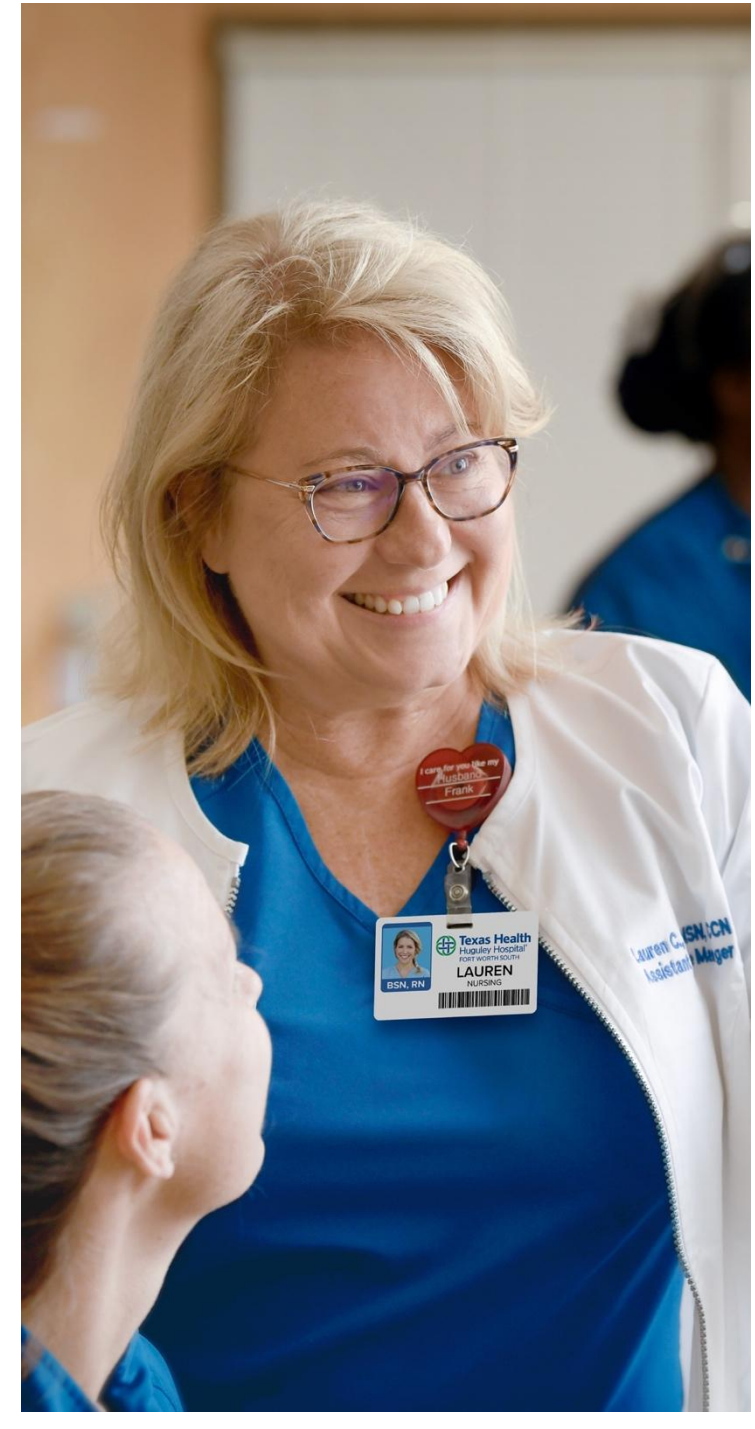
About Texas Health Mansfield

About AdventHealth

Texas Health Texas Health Mansfield is part of AdventHealth. With a sacred mission of Extending the Healing Ministry of Christ, AdventHealth strives to heal and restore the body, mind and spirit through our connected system of care. More than 100,000 talented and compassionate team members serve over 8 million patients annually. From physician practices, hospitals and outpatient clinics to skilled nursing facilities, home health agencies and hospice centers, AdventHealth provides individualized, whole-person care at more than 50 hospital campuses and hundreds of care sites throughout nine states. Committed to your care today and tomorrow, AdventHealth is investing in new technologies, research and the brightest minds to redefine wellness, advance medicine and create healthier communities.

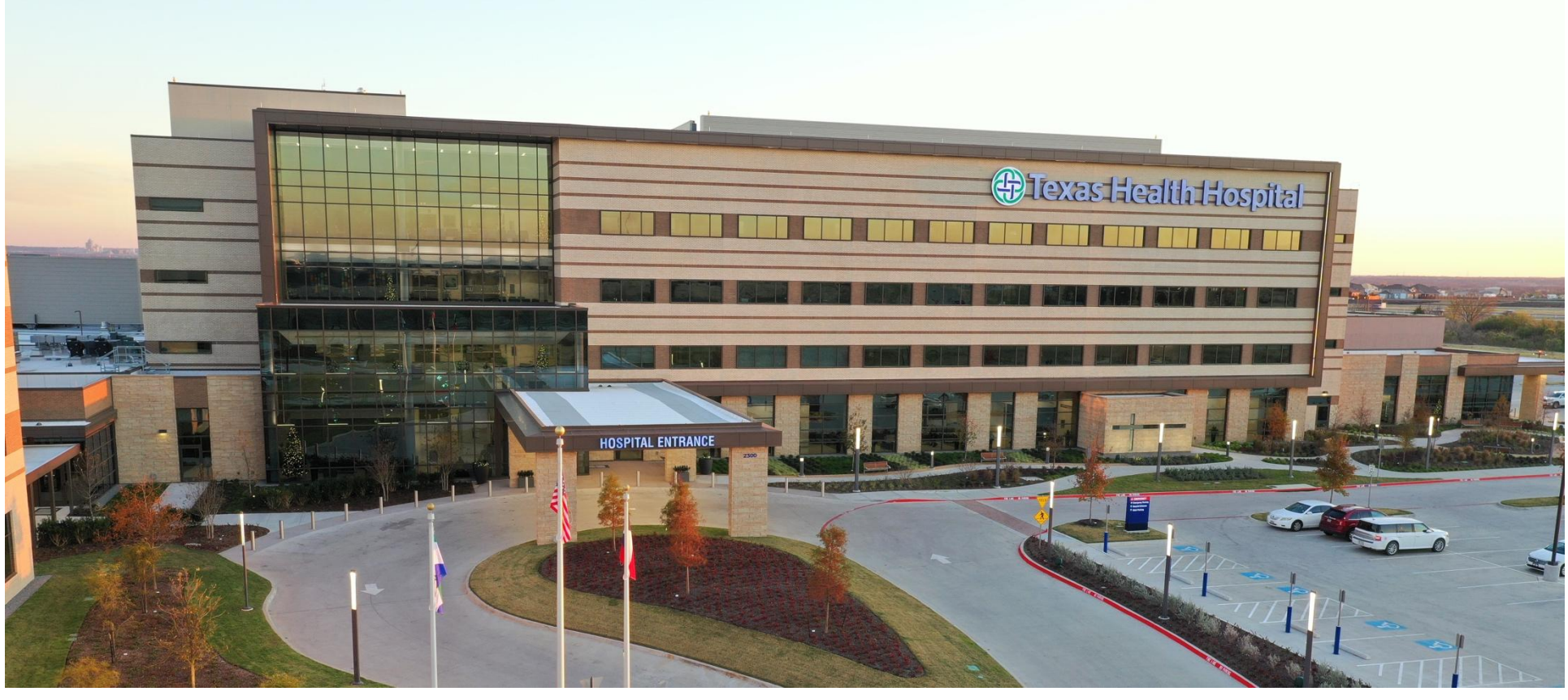
In a 2020 study by Stanford University, physicians and researchers from AdventHealth were featured in the ranking of the world's top 2% of scientists. These critical thinkers are shaping the future of health care. Amwell, a national telehealth leader, named AdventHealth the winner of its Innovation Integration Award. This telemedicine accreditation recognizes organizations that have identified connection points within digital health care to improve clinical outcomes and user experiences. AdventHealth was recognized for its innovative digital front door strategy, which is making it possible for patients to seamlessly navigate their health care journey. From checking health documentation and paying bills to conducting a virtual urgent care visit with a provider, we're making health care easier — creating pathways to wholistic care no matter where your health journey starts.

AdventHealth is also an award-winning workplace aiming to promote personal, professional and spiritual growth with its team culture. Recognized by Becker's Hospital Review on its "150 Top Places to Work in Healthcare" several years in a row, this recognition is given annually to health care organizations that promote workplace diversity, employee engagement and professional growth. In 2024, the organization was named by Newsweek as one of the Greatest Workplaces for Diversity and a Most Trustworthy Company in America.



About Texas Health Mansfield

Texas Health Hospital Mansfield is owned by Texas Health Huguley, Inc. and therefore operates as a part of the joint venture between Texas Health Resources and AdventHealth. Texas Health Hospital Mansfield believes that total health is achieved through a balance of physical, mental, social, and spiritual well-being. Texas Health Hospital Mansfield includes a licensed 59-bed acute care hospital and an 80,000 square foot medical staff office building that houses primary care and specialty practices, as well as an outpatient center offering lab, therapy, and imaging services. Hospital services include an emergency department, cardiovascular, orthopedics, general surgery, and women's services.



Priorities Addressed

Healthcare Access, Navigation, and Literacy

With an overall goal of improving an individual's ability to navigate and utilize the healthcare system, healthcare access, navigation, and literacy includes improving access to affordable care, assistance in navigation through the continuum of care and strengthening health knowledge to allow for informed decision-making.

Goal

Improve residents' ability to access timely, affordable, and coordinated health care by increasing navigation support, expanding outreach, and reducing barriers to preventive and primary care.

Activity

Establish a coordinated referral process with the Mansfield Mission Center (MMC) Linda Nix Clinic to connect Emergency Department patients to primary care follow up. In Year 1, develop the workflow and implement a process for referral documentation; in Year 2, begin sending referrals; and in Year 3, track patient engagement and follow-up outcomes through created process.

Output

Year 1 (Process Development & System Build):

- Completion of a standardized ED to clinic referral workflow.
- Number of staff trained for referrals and tracking.
- Referral pathway created and tested with the Linda Nix Clinic.

Year 2 (Referral Launch):

- Number of ED patients referred to the Linda Nix Clinic.
- Number of successful referral transmissions received by the clinic.
- Number of patient education materials distributed about follow up care.

Year 3 (Tracking & Monitoring):

- Number of patients who complete a primary care visit within 7–14 days.
- Number of referral updates or feedback reports provided by the Linda Nix Clinic.

Hospital Contributions

- Emergency Department Director & Managers, Health Navigators

Community Partnership

- MMC Linda Nix Clinic will provide free follow up care to THM patients who leave the Emergency Department without an established primary care provider.

Outcome

By December 31, 2028, all emergency department managers and directors, 100% of patient navigation teams, and the Linda Nix Clinic staff will complete training designed to strengthen coordination and referral processes. This training will support smoother care transitions and more reliable follow-up for uninsured patients after ED discharge.

Healthcare Access, Navigation, and Literacy

Activity

Support MMC Linda Nix Clinic by offering financial resources designated to increase appointment availability, extend clinic hours, or add staff capacity so more community members can establish an ongoing primary care relationship.

Output

- Number of additional appointment slots created at the Linda Nix Clinic due to TH Mansfield's financial support.
- Number of extended clinic hours or added clinic days made possible.
- Number of patients scheduled for primary care visits as a direct result of increased clinic capacity.

Outcome

By December 31, 2028, expanded capacity at the Linda Nix Clinic will enable 25% of uninsured emergency department patients to obtain timely primary care appointments and establish ongoing care relationships. This will lead to fewer delays in accessing needed services.

Hospital Contributions

- Director of Community will ensure that a contribution of $5,000 will be donated to the clinic in 2027 and 2028.

Community Partnership

- MMC Linda Nix Clinic

Food Insecurity

Food insecurity refers to the lack of consistent access to safe, nutritious, and affordable food. Addressing this issue supports overall wellbeing by ensuring individuals can obtain healthy foods and gain the knowledge needed to make informed choices about nourishing their bodies.

Goal

Increase access to consistent, nutritious food for residents experiencing food insecurity by providing education, navigation support, and connection to reliable food resources.

Activity

Provide food resource navigation and referral support by helping patients identify nearby food banks, pantries, and emergency food programs, and by offering guidance on eligibility, service hours, and how to access recurring food assistance.

Output

- Number of printed or digital food resource materials distributed.
- Number of QR code/resource center engagements.
- Number of ED staff trained to provide food resource guidance.

Outcome

By December 31, 2028, at least 100 patients will increase their awareness of available food assistance options, improve their ability and confidence to access recurring food resources, and be connected consistently to appropriate community-based food support through hospital referrals.

Hospital Contributions

- Emergency Department will serve as the navigators for this activity. Educational materials and QR codes linking patients to local food banks and community assistance programs will be provided.

Community Partnership

- Mansfield Mission Center Food Bank
- Harvesting in Mansfield Food Bank

Food Insecurity

Activity

Host recurring community food distribution events in underserved neighborhoods identified by Mansfield ISD to provide recurring opportunities for residents and families to obtain fresh produce and pantry staples along with an opportunity for community connectedness. Expand on previous program to add additional resources and two additional neighborhoods to the distribution days.

Output

- Number of food distribution events (9 total)
- Number of residents receiving fresh produce and pantry staples
- Number of community partners

Outcome

By December 31, 2028, increase access for 50 families to nutritious food among residents in underserved neighborhoods identified by MISD. This will strengthen community awareness of available food resources and improve the hospital's ability to consistently connect food insecure households with regular, reliable sources of fresh food.

Hospital Contributions

- Hospital team members will volunteer at the food distributions
- Hospital will contribute $5,000.00 per year to support HIM Center Food Bank in providing fresh food to each distribution.

Community Partnership

- YMCA
- Trinity Foundation
- HIM Center Food Bank

Connectedness

Having a sense of belonging, social support and meaningful relationships within a community is directly linked to better health outcomes. Connectedness includes fostering connections that help build resilient, healthier communities.

Goal

Strengthen social connectedness by increasing opportunities for residents to build meaningful relationships, engage with community supports, and reduce social isolation.

Activity

Host recurring senior engagement gatherings at the Mansfield Activities Center where older adults can build social connections through shared meals, interactive activities such as bingo, health check-ins with clinical staff, and educational presentations tailored to their needs, creating a consistent space for relationship building and reducing social isolation.

Output

- Number of engagement gatherings (9 total)
- Number of senior adults participating (40 seniors per gathering)

Outcome

By the end of 2028, at least 100 (unique participants) older adults will strengthen their social connectedness by increasing opportunities to build meaningful relationships, engage in community-based activities, and access supportive health and educational resources, helping reduce social isolation and improve their sense of community belonging.

Hospital Contributions

- Food & Nutrition Services will provide the meal each month and hospital volunteers will attend to serve and interact with the participants.
- A nurse and/or doctor will attend to provide blood pressure checks and provide health education.

Community Partnership

- The Mansfield Activities Center (MAC) will provide space at their location for the monthly events.

Connectedness

Activity

Host a recurring mentorship initiative in partnership with local school district mentor programs, where hospital team members volunteer weekly to meet with students, build positive relationships, provide guidance and encouragement, and help them overcome obstacles to succeed in school.

Output

- Number of team members volunteering as mentors (5 team members)
- Number of one-on-one meetings with students and mentors (12 per mentor)

Outcome

By the end of 2028, at least 10 students will enhance their sense of connectedness by increasing access to supportive adult relationships, strengthening their confidence, and improving their engagement in school through participation in the mentorship program.

Hospital Contributions

- Team members will volunteer to commit to one hour a week to the mentor program.

Community Partnership

- Mansfield Independent School District
- Midlothian Independent School District

Connectedness

Activity

Host three annual community events at the hospital that provide a free, welcoming space for nearby neighborhoods to gather for fellowship, entertainment, and shared activities, creating recurring opportunities for residents to build social connections and strengthen their sense of community belonging.

Output

- Number of community events (3 per year)
- Number of community members attending community gatherings

Outcome

By the end of 2028, at least 450 nearby residents will increase their social connectedness by participating in accessible, welcoming hospital-based activities that create opportunities to build relationships, engage in community activities, and strengthen their sense of belonging through shared experiences.

Hospital Contributions

- The Director of Community will work with the Events Coordinator to plan and execute three yearly events. The marketing team will assist in creating materials used to invite the community.

Community Partnership

- Variety of Food Trucks/Vendors and possible local sponsors

Transportation

Transportation directly affects a person's ability to access healthcare, healthy food, employment, and other non-medical support. Without reliable, affordable, and safe transportation, individuals may face delays in care, increased isolation, and limited opportunities for maintaining overall well-being.

Goal

Reduce transportation barriers that prevent residents from accessing medical care and essential health-related services by increasing availability of reliable, low-cost transportation options.

Activity

Partner with Mansfield Mission Center and Harvesting in Mansfield to provide gas cards and Uber gift cards for distribution to community members, expanding their access to reliable transportation for medical appointments, including primary care visits, specialist referrals, diagnostic testing, and preventive screenings.

Output

- Number of gas cards and Uber gift cards distributed to community members.
- Number of individuals assisted with transportation support for medical appointments.
- Year 1: Number of transportation assistance needs identified through request tracking.
- Years 2 & 3: Amount of transportation assistance provided through Uber rides and gas card distribution.

Outcome

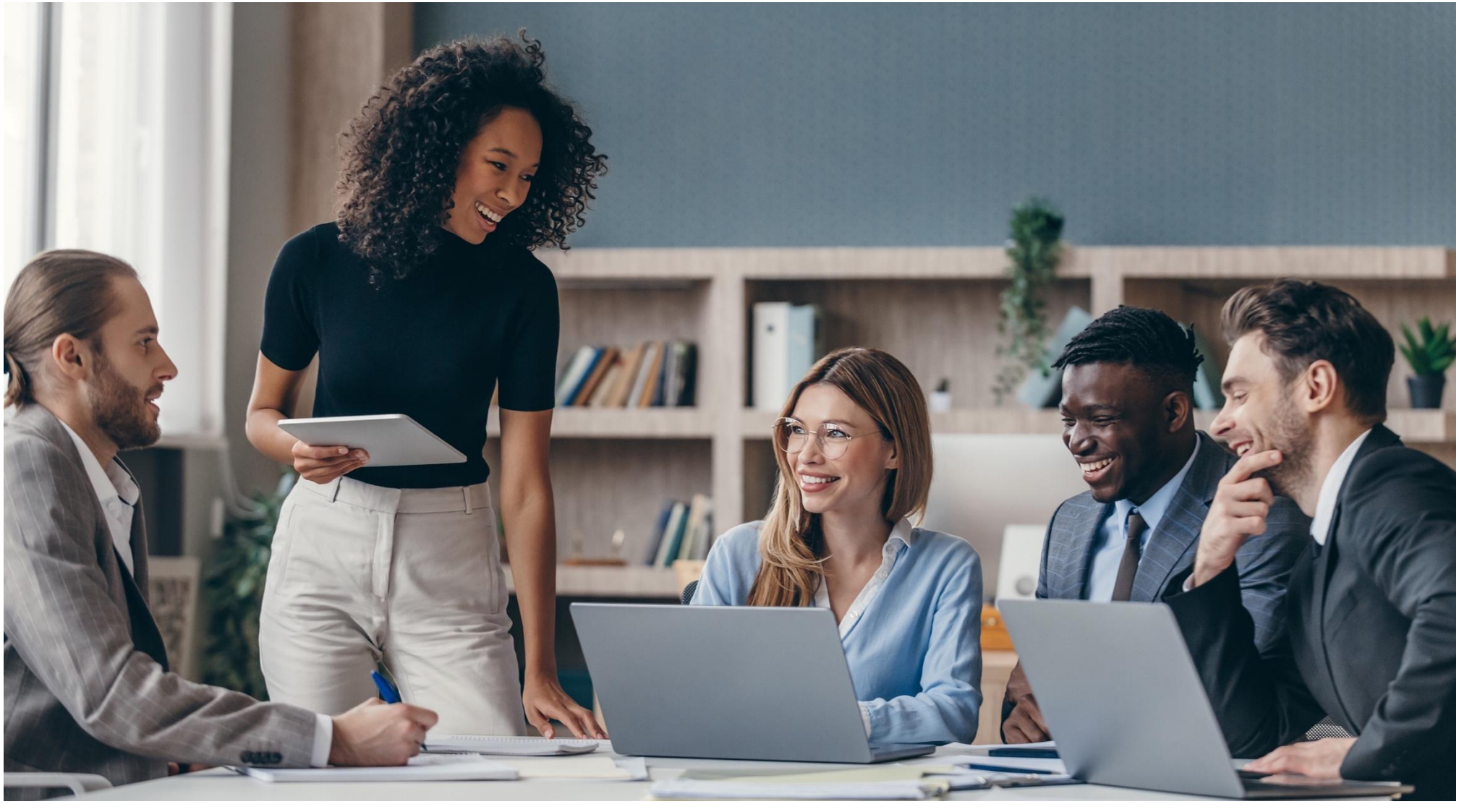
By the end of 2028, at least 50 community members will increase their ability to attend medical appointments by accessing reliable, low-cost transportation options that reduce transportation barriers to care.

Hospital Contributions

- Provide $500 in gas cards to each organization per year.

Community Partnership

- Mansfield Mission Center
- Harvesting in Mansfield



Priorities Not Addressed

Priorities Not Addressed

Texas Health Mansfield also identified the following health needs during the CHNA process. In reviewing the CHNA data, available resources and ability to impact, the Hospital determined these needs will not be addressed.

Chronic Disease

A chronic disease is a long-lasting health condition that typically persists for one year or more and requires ongoing medical attention and/or limits daily activities. This domain evaluates adult prevalence rates of coronary heart disease (CHD), cancer, chronic obstructive pulmonary disease (COPD), high blood pressure (HBP), diabetes, asthma, and obesity across the service area.

The findings indicate that high blood pressure, obesity, and diabetes are the most prevalent chronic conditions across the Southern Region. The highest rates are concentrated in two of the five counties, with Johnson County indicating a moderate-high need for chronic disease management in these areas. ZIP code–level data for all chronic disease indicators can be found in the appendix, which can be used to support localized planning and intervention efforts.*

ZIP codes with a higher barrier level typically experience more chronic disease compared to national benchmarks.

The Hospitals believe that by selecting Healthcare Access, Navigation, and Literacy as a priority to address we will be making a meaningful impact on this need, therefore it was not specifically selected to be addressed.

*CDC PLACES (2024)

Behavioral Health

Behavioral health refers to the connection between behaviors, mental well-being, and physical health. It encompasses the prevention, diagnosis, and treatment of mental health conditions, as well as substance use disorders. Therefore, this domain examines rates of frequent mental distress, depression, cognitive disability, binge drinking, and cigarette smoking among adults. Frequent mental distress, depression, and cognitive disability all indicate the prevalence of mental disorders in the service area. Binge drinking and cigarette smoking can be risk factors for substance use disorders.

The findings indicate there is a need for behavioral health services in the service area, as frequent mental health distress, depression, and cognitive disability affect 13% to 26% of adults in the region. Johnson County has a moderate to high rate of frequency of mental health distress, depression, and cognitive disability.* ZIP codes with a higher barrier level typically have a higher risk of experiencing worse behavioral health outcomes.

The Hospitals believe that by selecting Connectedness as a priority to address we will be making a meaningful impact on this need, therefore it was not specifically selected to be addressed.

* CDC PLACES (2024)

Priorities Not Addressed

Disabilities

Disabilities encompass any physical or mental impairment that may limit an individual's ability to perform everyday activities and participate fully in social, economic, or community life. Therefore, this domain examined rates of deafness or difficulty in hearing (hearing); difficulty in doing errands alone, such as visiting a doctor's office or shopping (independent living); difficulty in walking or climbing stairs (mobility); difficulty in dressing or bathing (self-care); and blindness or difficulty in seeing (vision).

The findings indicate mobility limitations are the most common disability across all counties signals a need for transportation and daily living support.* ZIP codes with a higher barrier level typically have more disability-related barriers to good health.

The Hospitals believe other organizations in the community are better positioned to address this need; therefore, it was not selected to be addressed.

* CDC, Disability and Health

Income

Income is a significant predictor in one's ability to afford out-of-pocket medical costs.* The Southern region considers one measure: median household income.

Four of five counties in the region (except for Hood County) is below the state and national benchmarks for median household income, potentially reflecting income barriers in the Southern Region. Some of the greatest barriers are concentrated in central Johnson County.**

The Hospitals believe other organizations in the community are better positioned to address this need; therefore, it was not selected to be addressed.

*KFF, "Key Facto About the Uninsured Population" (2023).

** American Community Survey (2019-2023).

Priorities Not Addressed

Employment

Employment is a significant predictor in one's ability to access commercial health insurance, as most health insurance in the US is employer-sponsored insurance (ESI).* One measure is considered in this domain: the civilian unemployment rate.

Various areas of the Southern Region have slightly higher unemployment rates than the national and state benchmarks.** It is also important to note that in Texas, 94.9% of large firms (i.e., 50 or more employees) offer ESI, while 28.7% of small employers offer ESI.*

However, the Hospitals believe other organizations in the community are better positioned to address this need in the community and will support those efforts, therefore, it was not selected to be addressed.

*KFF, Employer Health Benefits Survey (2023).

** American Community Survey (2019-2023).

Educational Attainment

Research shows that educational attainment is correlated with health literacy, which affects chronic disease management and healthcare navigation.* Two measures are considered in this domain: adults over 25 years of age with at least a high school diploma and adults over 25 years of age with at least a bachelor's degree. These metrics are a proxy for health literacy.

Four of the five counties in the region (except for Hood County) are below the national average for adults aged 25 and older with at least a high school diploma or bachelor's degree, potentially reflecting a significant barrier of health literacy in the Southern region. Additionally, central Johnson County is more vulnerable than the rest of the Southern Region.**

However, the Hospitals believe other organizations in the community are better positioned to address this need in the community and will support those efforts, therefore, it was not selected to be addressed.

* National assessment of Adult Literacy and the Agency for Healthcare Research and Quality.

** American Community Survey (2019-2023).

Priorities Not Addressed

Housing Stability

Housing instability can lead to exposure to toxins, reduced ability to manage chronic disease and other illnesses, and stress.* Three measures are considered in this domain: housing insecurity among adults in the last 12 months, threat of utilities shutting off among adults in the last 12 months, and percentage of households with a housing burden (i.e., spending more than 30% of income on housing). These metrics all describe the housing stability of a service area.

Four of the five counties in the Southern Region (except Hood County) are above the national benchmark for housing insecurity and threat of utilities shutting off, potentially reflecting a significant barrier of housing stability in the Southern Region. However, areas in central Johnson County have the greatest barriers.**

The Hospitals believe other organizations in the community are better positioned to address this need; therefore, it was not selected to be addressed.

* US Department of Health and Human Services, Healthy People 2030.

** CDC PLACES (2024)

Technology Access

Access to technology is increasingly important as the healthcare landscape becomes more digital, with greater reliance on electronic health records, patient portals, and telemedicine.* Two measures are considered in this domain: residents without at least one computer device and residents without some type of internet subscription. These metrics reflect the level of technological access within the service area.

Areas of Johnson County are below the national benchmark in residents without some type of internet subscription; however, localized challenges persist in other parts of the Southern Region.**

The Hospitals believe other organizations in the community are better positioned to address this need; therefore, it was not selected to be addressed.

* ONC, “Individuals’ Access and Use of Patient Portals and Smartphone Health Apps” (2023).

** American Community Survey (2019-2023).

Texas Health Hospital® MANSFIELD

Texas Health Hospital Mansfield

CHP Approved by the Hospital Board on: March 26, 2026

For questions or comments please contact:
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