Continuum of Care

Program Objective

Texas Health's Continuum of Care (CoC) program helps bridge the gap between sickness and health by equipping patients to manage their own health and well-being.
The program supports uninsured and underinsured individuals experiencing non-medical drivers of health (NMDOH) needs through coordinated, community-based support. Participants are identified and referred during their hospital stay by professionals across multiple roles and departments, allowing the program to engage patients at critical transition points. Following referral, participants are connected with Community Health Workers (CHWs) who provide individualized guidance and support for up to six months after discharge. During this period, CHWs focus on education, linkage to community resources, and ongoing follow-up to help individuals navigate systems, reduce barriers, and build stability. By prioritizing continuity, trust, and whole-person support, the CoC program helps participants transition successfully into sustained community supports and establish a strong foundation for long-term well-being.

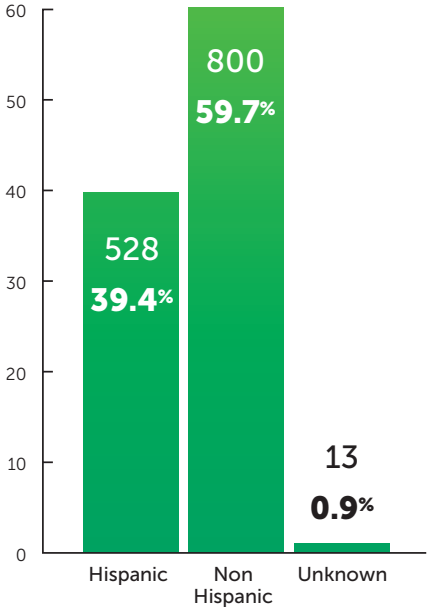
Statement of Need*

NMDOH such as healthcare access, housing instability, food insecurity and transportation challenges significantly affect an individual's ability to achieve stability and well-being, particularly for uninsured and underinsured populations. CHWs are essential in addressing these needs by providing trusted, relationship-based support, education, and resource navigation. Through sustained engagement, CHWs help individuals overcome barriers, strengthen self-sufficiency, and build connections to community supports, promoting long-term well-being beyond the hospital setting.

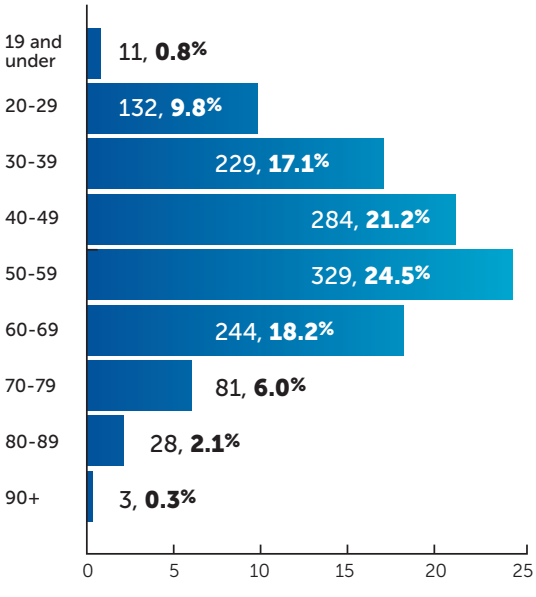
Contiuum of Care Data

RACE N=1,341

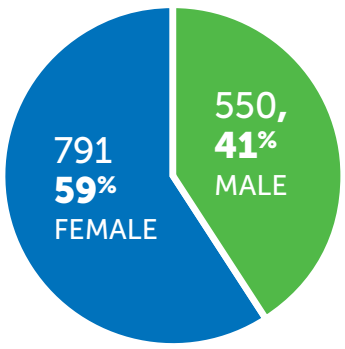
ETHNICITY N=1,341



AGE N=1,341



SEX N=1,341



Texas Health Community Hope

* Texas Health Resources. (2025). 2025 Community Health Needs Assessment. https://www.texashealth.org/-/media/Project/THR/shared/Documents/PDFs/Community-Health/Community-Health-Needs-Assessments-2025/Texas-Health-Resources-2025-Community-Health-Needs-Assessment.pdf



As part of establishing a strong foundation for long-term well-being, CHWs in Texas Health's CoC program teach classes in English and Spanish on various topics, including nutrition and food preparation as part of a healthy lifestyle and chronic disease prevention.

Hospital Utilization (Outcomes)

Hospital utilization is measured to assess how effectively CHW interventions support prevention, care coordination, and connection to community resources. Reductions in preventable emergency department visits, inpatient admissions, and overall hospital use indicate improved access to appropriate care, earlier management of health needs, and decreased reliance on avoidable acute services.

TOTAL HOSPITAL VISITS

57% DECREASE

1,068 6-months pre-enrollment **vs** **459** 6-months post-enrollment

EMERGENCY DEPARTMENT

31% DECREASE

419 6-months pre-enrollment **vs** **291** 6-months post-enrollment

INPATIENT

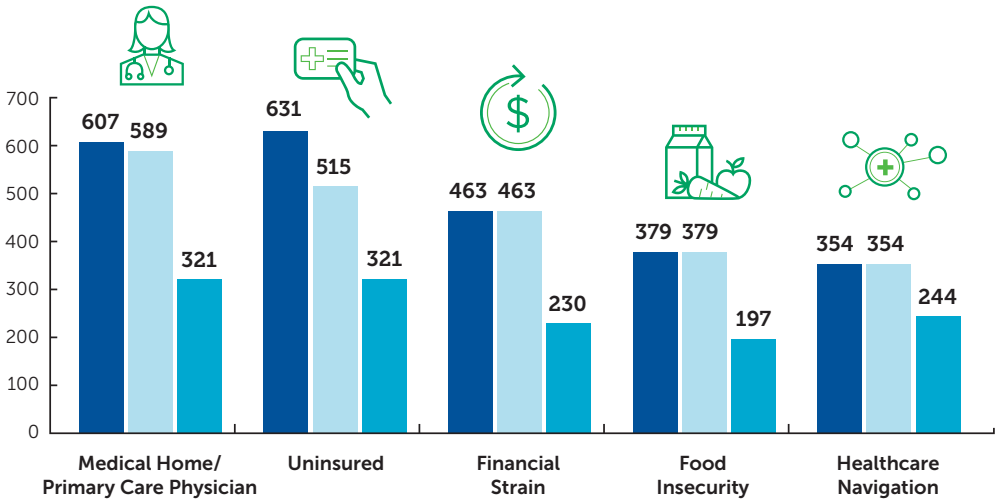
74% DECREASE

649 6-months pre-enrollment **vs** **168** 6-months post-enrollment

NMDOH Barriers (Top 5)

Eligible participants work with a CHW to identify their top NMDOH barrier. CHWs then work alongside participants to refer and connect them to organizations and resources equipped to address the barrier. While CHWs actively support navigation, systemic constraints—such as limited service availability, eligibility requirements, waitlists, or lack of follow-up from external organizations—often create gaps between referral and successful connection.

- Identified
- Referred
- Connected



Outputs

4,078
Referrals
125% increase from 2024

1,341
Patients enrolled*

42%
Uninsured

38%
From priority ZIP codes

256
Patients graduated from the program

* Those not enrolled either declined participation, could not be reached, or did not meet eligibility criteria.

Graduated definition: Patient connected to identified resources and has no further needs or declined further contact.

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