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Texas Health Community Impact (THCI) And Community Health Improvement (CHI) Program Evaluation

Submission deadline: 5:00 pm CT, Friday August 28, 2020

Designated Contact
Direct all communication to:

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All proposals must be received by 5:00 pm CT on August 28, 2020, for consideration. Texas Health reserves the right to extend deadline with written addendum to the RFP.

CALENDAR OF EVENTS

Activity	Due Date
RFP Publication	July 13, 2020
Question Submission Deadline	July 20, 2020 *5 pm CT*
Responses Posted	July 28, 2020
Proposal Deadline (Electronic Only)	August 28, 2020 *5 pm CT*
Proposal Review Period	August 31 – September 7, 2020
Top Proposals Invited to Present to THR Executives and THCI Board Members	September 9, 2020
Finalist Presentations	September 21, 2020
Notifications to Finalists	October 2020
Anticipated Start Date	January 4, 2021

OVERVIEW

Texas Health is seeking competitive proposals from qualified organizations to:

1) Serve as the evaluation team for Texas Health Community Impact (THCI) and

2) In partnership with Texas Health develop an evaluation framework for the Texas Health-Community Health Improvement (CHI) division.

INTRODUCTION

Health inequities have left many communities around the nation with health disparities that are beyond their control, and communities in North Texas are no exception to this trend. With the understanding that a person's zip code may be a better predictor of their health than their genetic code[1], Texas Health through its community health needs assessment (CHNA) process, intentionally focused on identifying underserved zip codes across North Texas that would benefit from health initiatives that drive long-lasting outcomes at the different levels of the ecological system. The CHNA process led to the identification of 41 high-need zip codes and a decision to launch the Texas Health Community Impact initiative in 16 prioritized zip codes across Tarrant/Parker, Collin, Dallas/Rockwall, Denton/Wise, and Southern Regions (Johnson, Ellis, Hood, Erath, and Kaufman).

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1. Parks T. (2016). Death by zip code: Investigating the root causes of health inequity. American Medical Association. https://www.ama-assn.org/delivering-care/patient-support-advocacy/death-zip-code-investigating-root-causes-health-inequity

TEXAS HEALTH COMMUNITY IMPACT

Community Health Improvement invites proposals from qualified researchers to design and conduct an evaluation of Texas Health Community Impact (THCI). Texas Health launched the THCI initiative in January 2018 to drive collaborative community-based efforts, improve capacity and access to behavioral health services in traditional and non-traditional settings, and facilitate a coordinated care model that disrupts the existing delivery system within target communities.[2] A community led funding mechanism, THCI, allows Texas Health to make strategic investments aimed at reducing health disparities, addressing social determinants of health and improving targeted health outcomes. Communities targeted for investments were prioritized by the THCI Leadership Councils in support of the THCI strategy.

THCI objectives include:

- Strengthen existing care delivery systems across the continuum;
- Empower community organizations to implement innovative strategies that improve behavioral health care availability and delivery;
- Facilitate a coordinated care approach by multi-agencies to improve the individual experience; and
- Build the capacity of community organizations to become financially and operationally capable of continuing the work beyond the grant period.

The contracted scope of work will include evaluation design and implementation for the THCI initiative and its grantees. THCI's first grant cycle ends in December 2020 and to date, it has produced preliminary outcomes evident of improved access and navigation to behavioral health services. Texas Health will sustain its commitment to the communities served in the 2018 cycle by making an additional investment of $5,000,000 in 2021. The second TCHI RFP was published in June 2020 to recruit community organizations interested in implementing programs that drive coordinated service delivery in Community Impact zip codes. Awardees will be announced in October 2020.

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2. The North Texas Community Health Collaborative (2017). Behavioral Health Community Health Needs Assessment. http://www.healthyntexas.org/content/sites/dallasfortworth/BHCHNA__16_Counties_CHC.DFWHCFoundation2018.pdf

The new THCI evaluation framework should be informed by and build upon 2018-2020 evaluation efforts. Texas Health expects an evaluation method that is evidence-based, innovative and responsive to the diverse capacity and experience levels of THCI grantees. The evaluation method should focus on clearly demonstrating the impact of THCI at the micro level (individual), meso level (organization and community), and macro level (Policy)[3]. We require the evaluation design also begin in the Fall of 2020 to establish appropriate measures of success, protocols for data capture, tools and training needs for grantees, as well as processes for reporting.

For the 2021-2022 grant cycle evaluation work will examine granted projects in 23 target zip codes across the Texas Health service area. The number of grantees is not currently known and will be defined in October 2020. The funding cycle for grantees will extend from Q1 2021 to Q4 2022. Cross-sector collaborative programs to be evaluated address behavioral health issues – specifically: depression, anxiety, social isolation and resiliency along with social determinants such as food insecurity, access to health services, and/or transportation.

Evaluation efforts will enable Texas Health to define to what extent THCI grantees have contributed to the attainment of established regional strategies and objectives as defined in the regional Impact Plans developed by the THCI Leadership Councils. Additionally, Texas Health is interested in assessing the degree to which THCI work effects healthcare utilization and cost savings. THCI evaluation results will be key in ascertaining effectiveness of models that can be scaled up across Texas Health's 16-county service area.

Regional goals and target zip codes for 2021 THCI grants can be found in appendix 1. Appendix 2 outlines the corresponding logic model and highlights potential indicators used to effectively quantify grantee progress and program impact.

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3. World Health Organization (2002). Global report: Innovative care for chronic conditions, building blocks for action. Retrieved from https://www.who.int/chp/knowledge/publications/iccc_ch2.pdf

COMMUNITY HEALTH IMPROVEMENT

The contracted evaluation team will also be responsible for developing an evaluation framework for the CHI division. Unlike the THCI initiative, which are community programs that are funded by Texas Health and implemented by community organizations, CHI programs are designed and implemented by Texas Health staff, with a goal to strengthen the delivery of care system through an integrated model. The CHI team has done tremendous work to lay a robust foundation (appendix 3) for an evaluation model, and is currently looking to develop the framework that will support storytelling efforts on populations served, impact as well as best practices and that will additionally allow the division to effectively use data to strategize and define operational needs. The evaluation team is expected to allocate 20% of their time on this aspect of the scope of work.

Information on the CHI programs included in the evaluation framework can be found on the Texas Health Community Health Improvement website and include: Mobile Health, Healthy Education Lifestyle Program (HELP), Faith Community Nursing, Sexual Assault Nurse Examiner (SANE) and Texas Health trajectory projects. Appropriate alignment should be outlined for CHI grant programs that already have evaluation teams such as Reduce-SILOS and Yes! Dallas. These multi-year programs are funded by AARP and HHS respectively.

SCOPE OF WORK

The section below describes key components required for this project:

1) **Evaluation Methodology**
   - Submitted proposals must include a description of the evaluation approach, with a discussion of the relative merits and limitations including how quantitative and qualitative methods will be incorporated and utilized for comprehensive evaluation.
   - The proposed approach for both THCI and the CHI framework should include a description of:
     - The analytical framework, evaluation approaches – inclusive of quantitative and qualitative methodologies, and statistical techniques recommended.
     - How preferred approach considers scalability and aligns with CHI framework.

- Alignment opportunities with certain healthcare indicators such as: healthcare utilization (e.g. preventable emergency department visits, readmission rates) and cost benefits (ROI).
- Decision protocols used to select, and methodology used to assess and develop case studies of promising practices.

- CHI methodology should include design for system framework, metric recommendations aligned with appendix 3, data collection processes, analysis and reporting methods that will drive standardization across all CHI programs.

2) **Metric Definition, Data Collection and Management**

- Goals and objectives are defined by Texas Health as outlined in appendix 1, but grantees are allowed to establish, in collaboration with the evaluation team and THCI staff, additional metrics that support desired outcomes based on their intervention and required metrics consistent with the CHNA implementation strategy as outlined in appendix 3.
- The evaluation team will be responsible for creating and implementing a strong data collection plan to ensure that THCI grantees effectively deliver program demographics, process measures, outputs and outcomes that align with and lead up to the overall goals of THCI outlined in appendix 1-2.
- The data collection protocol should focus on accuracy and efficiency and will ensure consistent processes and tools across all grantees for regular reporting and easy access to data.
- The evaluation team must provide the necessary training and technical support to equip grantees and THCI staff with the skills to successfully navigate through the data collection processes and tools. Training should be offered directly from the evaluation team to grantees and THCI staff.

3) **Reporting**

- Texas Health has existing tools such as Alteryx and Tableau that could be assessed for suitability and leveraged where appropriate. Submitted proposals should consider

these options. In addition, Texas Health will consider recommendations for the adoption of new platforms that will drive efficiency in the reporting process for the THCI initiative and CHI programs.

- Visual monthly dashboards and quarterly reports are required tools and should be made available to THCI staff to allow for effective communication to key stakeholders. Dashboards and reports should reflect population data as well as key quantitative indicators and qualitative themes. Data presentation should consider intended audience to ensure proper understanding/messaging and to support grant management.

- Quarterly reports are required in two formats: 1) A word document for grant administrators and THCI staff. 2) A PowerPoint presentation appropriate for Texas Health executive leadership and non-technical audiences. Detailed report formats will be discussed and approved by Texas Health leadership at onset of contract.

- The final report will integrate, summarize, and interpret key findings of the evaluation process; highlight promising practices; and provide recommendations for the sustainability and scalability of the initiative. The report should also provide an overview of cumulative outcomes at the different stages: micro level (individual), meso level (organization and community), and macro level (Policy).

- Proposals should include sample reports.

SUBCONTRACTING

The evaluation team may use a subcontractor for aspects of the proposed scope of work. The use of subcontractors is encouraged to ensure that appropriate staffing support and expertise is represented on the evaluation team.

DATA TRANSITION

Proposal narrative should review how data will be transferred, if appropriate based on proposed model, out once evaluation contract is finalized. This includes a comprehensive transfer of all data, files, reports, and records generated for THCI throughout the contract period.

BUDGET

Proposals must include detailed itemized budget and supporting justifications for implementation for proposed scope of work.

SUBMISSION GUIDELINES

- All proposals (including corresponding attachments) must be emailed in a PDF format on or before August 28, 2020 to THRCHI@TexasHealth.org. Please use the following *Email Subject Line*: **2021 THCI Evaluation Proposal**.

- **Proposals submitted later than the deadline WILL NOT be accepted nor considered.** Proposals submitted within the deadline will receive an email confirmation acknowledging receipt.

- There will be an opportunity to submit written questions for clarification regarding this RFP. All questions should be directed by email to THRCHI@TexasHealth.org by July 20, 2020. Please use the following *Email Subject Line:* **THCI Program Evaluation RFP Questions**. Submitted questions and corresponding answers will be posted on Texas Health evaluation webpage by on July 28, 2020.

PROPOSAL EVALUATION CRITERIA

All proposals will be evaluated using the following criteria:

- <u>Technical Capability</u>
    - o Clear articulation of evaluation methodology and technical competence.
    - o Demonstrated knowledge and experience with community health evaluation models and program evaluation that supports design and implementation of scope of work outlined in proposal.
    - o Experience providing data collection/evaluation training and technical assistance.
    - o Cultural competency and capacity.

- Management Strength
  - Appropriate staffing for scope of work, defined roles and responsibilities, time allocation and a clear timeline of the evaluation process including key milestones.
  - Staff qualifications, relevant prior experience and command of existing research/evaluation on community health programs and ability to present findings as outlined in proposal.
- Cost Effectiveness
  - Feasible breakdown including administration and staffing costs, technology and software costs as well as other necessary expenses required for proposed evaluation design and implementation of scope of work.

Proposal Narrative should not exceed 12 pages, using normal margins and no less than 11-point font. Please include the following information:

Recommended Proposal Outline and Possible Points

Technical Capability (40 points)

- *Methodology*: Provide a brief abstract of the proposal by summarizing the background, goals and objectives, proposed methodology, and expected output and outcome metrics. The body of the proposal should reflect an understanding of the THCI and CHI programs, and a detailed approach to address the scope of work. Outline the step by step methods that will be taken to evaluate the program outputs and outcomes and how these would roll up to the goals and objectives that were achieved. Describe how these outlined methods will accomplish the desired results in the RFP. The proposal should also identify any challenges that may be encountered during execution and propose practical and sound solutions to the identified limitations. Additionally, the proposal should proactively identify expected roles and responsibilities undertaken by the Texas Health team to ensure successful implementation.

- *Evaluation Plan and Milestones*: The proposal should briefly describe several phases into which the proposed work can logically be divided and performed. A schedule of milestones and deadlines should be specified for the completion of the various elements:

  o THCI initiative: review of selected grantees' applications, evaluation methodology, data collection design, tool development and training, data collection, analysis, progress reports, preliminary drafts and final report.

  o CHI programs: review of CHI programs, draft of evaluation framework, data collection, analysis, reporting process and tool recommendations.

  o *Data Requirements*: Texas Health will provide necessary background information. The proposal should identify any additional data to be supplied by Texas Health.

Management Strength (35 points)

Resource capability and program management for scope of work will be highly considered in the proposal selection process. Personnel assigned to this work must be described in this section in terms of numbers of people and their professional classification (e.g. project manager, analyst, etc.). Resumes detailing the education and relevant experience of each assigned personnel are required. The selected evaluation team will be required to notify Texas Health of any changes in key personnel during this project, which will be subject to approval by Texas Health.

Specific requirements for this section include:

- *Business Management Organization and Personnel*: The proposal must provide a brief narrative description of the organization that will perform the proposed work, and the authority responsible for controlling resources and personnel. This should also include an organizational overview of any proposed subcontractors.

- *Staffing Plan*: Describe the proposed staff distribution to accomplish this work, including an organization chart that clearly show the relationships of key proposed staff to manage/direct the project, lead key tasks, etc. The staffing plan should also present a chart that partitions the time commitment of each professional staff member to the project's tasks and schedule. The proposal should clearly identify the relationship of key

project personnel to the contracting organization, including subcontractors and consultants.

- *Relevant Prior Experience*: The proposal should describe the qualifications and experience of the organization and the individual personnel to be assigned to the project. Information should include direct experience with the specific subject-matter areas (e.g. community health, behavioral health, social determinants of health) as well as quantitative and qualitative evaluation methods. Include client references: organizations, addresses, contact persons, and telephone numbers.
- *Contract Agreement Requirements*: This section of the proposal should contain any special requirements that the applicant wants to have included in the contract.

Cost Effectiveness (25 points)

- Proposals must contain thorough and itemized budget information, including direct labor costs consistent with the staffing plan, labor overhead costs, travel (if appropriate), estimated cost of any subcontracts, as well as other direct costs (such as those for creating or maintaining a database).
- The applicant should include estimated expenses (if applicable) for at least two-in person meetings at Texas Health offices in Arlington, Texas. This should include a kickoff meeting to clarify and refine the schedule, scope, roles of the applicant and Texas Health staff, and discuss any key issues/challenges and for final presentation of study findings. This activity will be over and above routine conference calls, email communications and/or meetings (in person if located in the DFW metropolitan area).
- The contract awarded will allow for payments on a quarterly schedule based on completing identified deliverables and each quarterly progress report and final report. The contract terms shall remain firm during the project and shall include all charges that may be incurred in fulfilling the terms of contract.

Right to Reject

Texas Health Resources reserves the right to:

- Reject any or all applications submitted.

- Request additional information from any or all applicants.

- At their sole discretion, conduct discussions with any applicant to assure full understanding of and responsiveness to the RFP requirements.

No applicant will be reimbursed for the cost of developing or presenting a proposal in response to this RFP. The submission of proposals to Texas Health will not result in any obligation to fund a proposal. All applications will be reviewed, and finalists will be determined solely by the criteria outlined in this RFP.

APPENDICES

Important Links

- [Texas Health Community Health Improvement Page](#)
- [Texas Health Community Impact Page](#)
- [Texas Health Community Health Needs Assessment Page](#)
- [Texas Health System 2019 - 2022 Community Health Needs Assessment PDF](#)
- [Texas Health System Report 2020 - 2022 Implementation Plan](#)

Appendix 1: Texas Health Community Impact Regional Goals

Approved funding allocations and objectives for Tarrant/Parker Region

Regional Goal: To maximize the impact of programs addressing Behavioral Health and Social Determinants of Health (SDoH) in the target communities/zip codes of Tarrant and Parker Counties.

- Texas Health Community Impact Tarrant/Parker Leadership Council has approved $1,000,000 to fund community-based interventions that will improve access to a range of cultural relevant behavioral health services; improve food insecurity; and establish navigation services that empower individuals in these communities/zip codes: East Arlington 76010 and 76011, North Parker County 76082, and Southeast Fort Worth 76119.
    - **Objective 1:** Decrease depression and/or anxiety by one stage of severity from baseline as measured by the Patient Health Questionaire-9 (PHQ-9) and General Anxiety Disorder-7 (GAD-7), among low-income individuals ages 18+ in East Arlington (76010/76011), Southeast Fort Worth (76119), and Parker (76082) by December 2022.
    - **Objective 2:** Increase food security by 10 percent from baseline as measured by the USDA Food Security Questionnaire (Short Form) among low-income individuals ages 18+ in East Arlington (76010/76011), Southeast Fort Worth (76119), and Parker (76082) by increasing access and navigation to healthy foods by December 2022.
    - **Objective 3:** Improve self-efficacy by 10% from baseline as measured by the General Self-Efficacy Scale (GSE) among low-income individuals ages 18+ in East Arlington (76010/76011), Southeast Fort Worth (76119), and Parker (76082) by empowering individuals to successfully navigate health care services and social assistance within or in surrounding communities by December 2022.

- **Measure of Success** will involve the effectiveness of comprehensive referral and navigation in helping to reduce levels of depression and anxiety among low-income adults. Targeted individuals include low-income community residents, especially minorities, who are at risk for depression and anxiety as identified by integrated screening efforts aimed at addressing behavioral health or social determinants of care.

Approved funding allocations and objectives for Dallas/Rockwall Region

Regional Goal: To mitigate depression and promote access to health care services in individuals ages 10+ in the Dallas/Rockwall Region.

- Texas Health Community Impact Dallas/Rockwall Leadership Council has approved $1,200,000 to fund community-based interventions that will promote positive outcomes for individuals at-risk for depression, reduce stigma related to mental illness, establish a continuum of care model to deliver integrated care services in a cost-effective manner, and assess the effectiveness of the referral and navigation processes associated with the intervention that are implemented in these communities/zip codes: West Dallas (75212 and 75211), Dallas (75231), Southeast Dallas (75217), South Rockwall (75032).
  - o **Objective 1:** Decrease depression by one stage of severity from baseline as measured by the Patient Health Questionnaire-9 (PhQ-9) among underserved individuals ages 10-34 in Dallas (75231), West Dallas (75212 and 75211) and Southeast Dallas (75217), and individuals ages 25-54 in South Rockwall (75032) by December 2022.
  - o **Objective 2:** Assess the viability of executing longer-term strategies to navigate underserved individuals to readily available resources in the identified target areas and by December 2022.

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- **Measure of Success** will include the effective implementation of a comprehensive mental health strategy including education to reduce stigma, behavioral health screening, and provision, referral, and navigation to care, with special consideration for multigenerational needs among low-income community members affected by social determinants of health.

Approved funding allocations and objectives for Denton/Wise Region

Regional Goal: To maximize the impact of interventions addressing Behavioral Health and Social Determinants of Health (SDoH) in the target areas of Denton and Wise Counties.

- Texas Health Community Impact Denton/Wise Leadership Council has approved $850,000 to fund community-based interventions that will improve access to a range of age appropriate and culturally relevant behavioral health services, promote positive outcomes in individuals at risk for food insecurity, and establish navigation services designed to empower individuals with the skills and knowledge to utilize resources and solutions exacerbated by the Coronavirus pandemic: Sanger (76266), Lewisville (75057), and Bridgeport (76426).
  - **Objective 1:** Increase resiliency by 10% from baseline as measured by a benchmark validated tool *like* the RISC-10 known as the Conner Davidson Resiliency Scale among low-income youths and family units in Sanger (76266), Lewisville (75057), and Bridgeport (76426) by December 2022.
  - **Objective 2:** Increase food security by 10 percent from baseline as measured by the USDA Food Security Questionnaire (Short Form) among low-income youth and family units in Sanger (76266), Lewisville (75057), and Bridgeport (76426) by December 2022.
  - **Objective 3:** Improve self-efficacy by 10% from baseline as measured by General Self-Efficacy Scale (GSE) among low-income youth and family units in Sanger (76266), Lewisville (75057), and Bridgeport (76426) by empowering individuals to navigate health care and social assistance services by December 2022.

- **Measure of Success** will involve the effectiveness of comprehensive program referral and navigation in helping to increase resiliency low-income youth and family units. Targeted individuals include low-income community residents who are at risk for low resiliency scores as identified by integrated screening and navigation efforts aimed at addressing behavioral health and/or social determinants of care.

Approved funding allocations and objectives for Collin Region

Regional Goal: To maximize the impact of interventions addressing behavioral health; access to healthy foods, and education support services through a continuum of care approach targeting low-income communities in Collin County.

- Texas Health Community Impact Collin Leadership Council has approved $950,000 to fund community-based interventions that will improve access to a range of culturally relevant behavioral health services, promote positive outcomes in individuals at risk for food insecurity, and promote education support services designed to assist youths impacted by the distance learning due to the Coronavirus pandemic in these communities: East McKinney (75069), East Plano (75074)
  - **Objective 1**: Decrease depression and anxiety by one stage of severity from baseline as measured by the Patient Health Questionaire-9 (PHQ-9) and General Anxiety Disorder-7 (GAD-7), among low-income individuals age 18+ in McKinney (75069) by December 2022.
  - **Objective 2**: Increase food security by 10 percent from baseline as measured by USDA Food Security Questionnaire (Short Form) within low-income individuals ages 18+ in McKinney (75069), increasing access and navigation to healthy foods by December 2022.

- o **Objective 3**: Decrease depression and anxiety by one stage of severity from baseline as measured by the Patient Health Questionaire-9 (PHQ-9) and General Anxiety Disorder-7 (GAD-7), among low-income youth ages 11-19 in Plano (75074) by December 2022.
- o **Objective 4**: Increase food security by 10 percent from baseline as measured by USDA Food Security Questionnaire (Short Form) within low-income youth and family units ages 11-19 in Plano (75074), increasing access and navigation to healthy foods by December 2022.
- o **Objective 5**: 70% of students participating in educational support services will demonstrate academic success by passing all classes.

- **Measure of Success** will involve the effectiveness of a comprehensive program and activities in reducing levels of depression and anxiety among low-income adults 18+ in (McKinney 75069) and youth 11-19 in (Plano 75074). Targeted individuals include low-income community residents who are at risk for depression and anxiety, measured by reducing the PHQ9 or GAD7 by one level. By using integrated screening efforts, these individuals identified and placed in a program aimed at addressing behavioral health and social determinants of health.

Approved funding allocations and objectives for Southern Region (Erath, Ellis, Hood, Johnson, and Kaufman).
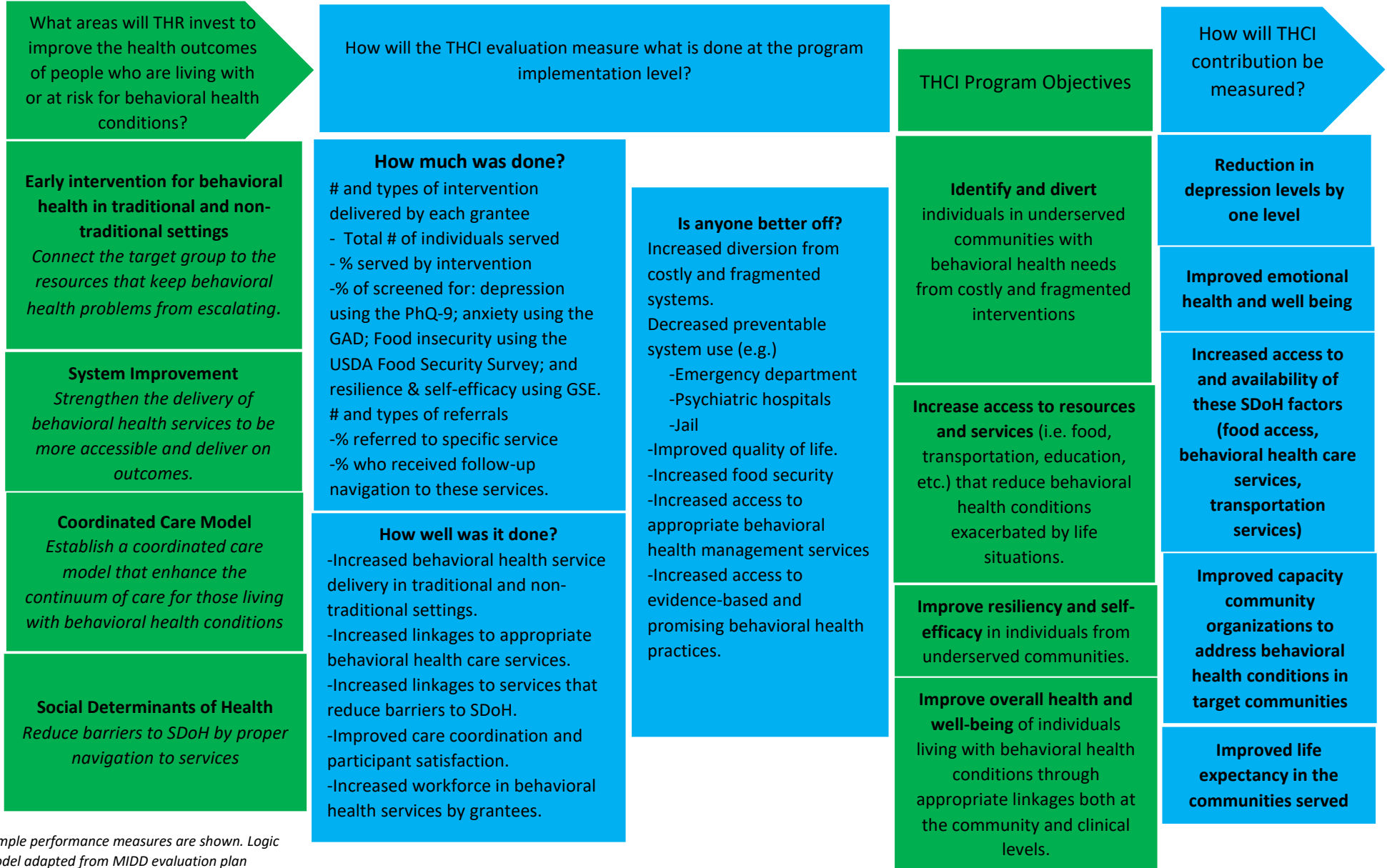
Regional Goal: To maximize the impact of initiatives addressing behavioral health and social determinants of health in the target areas of Erath, Ellis, Hood, Johnson, and Kaufman Counties.

- Texas Health Community Impact Southern Leadership Council has approved $1,000,000 to fund community-based interventions that will decrease depression, anxiety, and social isolation, promote positive outcomes in individuals at-risk for food insecurity and implement navigation services designed to empower individuals with the knowledge and skills to identify

and access solutions to the complex problems exasperated by the Coronavirus pandemic in Erath County (76401, 76402, and 76446), Johnson County (76031, 76033, 76059), and Kaufman County (75143, 75147, 75161).

- o **Objective 1:** Decrease depression and anxiety by one stage of severity from baseline as measured by the Patient Health Questionaire-9 (PHQ-9) and General Anxiety Disorder-7 (GAD-7) among low-income individuals age 40+ in Erath (76401/76402/76446), Johnson (76031/76033/76059), and Kaufman (75143/75147/75161) by December 2022.
- o **Objective 2:** Increase food security by 10 percent as measured by a USDA Food Security Questionnaire (short form) within low-income individuals age 40+ in Erath (76401/76402/76446), Johnson (76031/76033/76059), and Kaufman (75143/75147/75161) by increasing access and navigation to healthy foods by December 2022.

- **Measure of Success** will involve the effectiveness of comprehensive program referral and navigation in helping to reduce levels of depression and anxiety among low-income adults. Targeted individuals include low-income community residents age 40+ who are at risk for depression and anxiety, as identified by integrated screening efforts aimed at addressing behavioral health or social determinants of health.

Appendix 2: THCI Logic Model Framework

What areas will THR invest to improve the health outcomes of people who are living with or at risk for behavioral health conditions?

How will the THCI evaluation measure what is done at the program implementation level?

THCI Program Objectives

How will THCI contribution be measured?

Early intervention for behavioral health in traditional and non-traditional settings
Connect the target group to the resources that keep behavioral health problems from escalating.

System Improvement
Strengthen the delivery of behavioral health services to be more accessible and deliver on outcomes.

Coordinated Care Model
Establish a coordinated care model that enhance the continuum of care for those living with behavioral health conditions

Social Determinants of Health
Reduce barriers to SDoH by proper navigation to services

How much was done?
and types of intervention delivered by each grantee
- Total # of individuals served
- % served by intervention
-% of screened for: depression using the PhQ-9; anxiety using the GAD; Food insecurity using the USDA Food Security Survey; and resilience & self-efficacy using GSE.
and types of referrals
-% referred to specific service
-% who received follow-up navigation to these services.

How well was it done?
-Increased behavioral health service delivery in traditional and non-traditional settings.
-Increased linkages to appropriate behavioral health care services.
-Increased linkages to services that reduce barriers to SDoH.
-Improved care coordination and participant satisfaction.
-Increased workforce in behavioral health services by grantees.

Is anyone better off?
Increased diversion from costly and fragmented systems.
Decreased preventable system use (e.g.)
    -Emergency department
    -Psychiatric hospitals
    -Jail
-Improved quality of life.
-Increased food security
-Increased access to appropriate behavioral health management services
-Increased access to evidence-based and promising behavioral health practices.

Identify and divert individuals in underserved communities with behavioral health needs from costly and fragmented interventions

Increase access to resources and services (i.e. food, transportation, education, etc.) that reduce behavioral health conditions exacerbated by life situations.

Improve resiliency and self-efficacy in individuals from underserved communities.

Improve overall health and well-being of individuals living with behavioral health conditions through appropriate linkages both at the community and clinical levels.

Reduction in depression levels by one level

Improved emotional health and well being

Increased access to and availability of these SDoH factors (food access, behavioral health care services, transportation services)

Improved capacity community organizations to address behavioral health conditions in target communities

Improved life expectancy in the communities served

Sample performance measures are shown. Logic Model adapted from MIDD evaluation plan

Appendix 3: Texas Health 2020 - 2022 CHNA Implementation Plan

Goal(s)	Integrate and strengthen the delivery systems mechanism to decrease health disparities and improve health outcomes in target communities.

Objective(s)	• Increase the visibility of THR's Community Health Improvement (CHI) interventions among internal and external stakeholders to create opportunities for collaboration and integration at the departmental and system levels.
	   - Measured by the number and types of collaborations between internal and external stakeholders.
	   - Measured by the number of outreach efforts for THR's Community Health interventions through internal and external stakeholders' channels.
	
	 • Finalize sustainability plans and collectively support strategies that increase resources, funding, and collaboration opportunities that strengthen THR's Community Health Improvement interventions.
	   - Measured by the level of funding secured for each priority area.
	
	 • Demonstrate innovation at the departmental or system-level focused on improving the delivery of health services to our target population/communities.
	   - Measured by the types of innovative strategies that are leveraged to enhance the delivery of THR's Community Health Improvement (CHI) interventions between 2020 – 2022.

Target Audience(s)	Individuals and communities (zip codes) experiencing health disparities due to structural inequities that impact Social Determinants of Health (SDoH).
Strategic Alignment	Partnerships, Consumers
Priority Areas	❖ Chronic Disease Prevention and Management ❖ Behavioral Health Sustainability/Resources ❖ Access, Health literacy, and navigation *Inclusive of social determinants that negatively impact each priority area.*

Priority Area 1:	Chronic Disease Prevention and Management
Focus Areas:	Diabetes, Hypertension, Cancer and Cholesterol Management

Needs Statement:	- Chronic diseases are the major causes of illness, disability, and death in Texas, accounting for over 50% of all deaths per year. - There is evidence that the social context of a person's life determines their risk of exposure, degree of susceptibility, and the course and outcome of chronic diseases. - Chronic conditions are devastating for quality of life and are costly conditions to treat and manage. In 2014, Texas reported over $34 billion in hospital charges related to just three chronic diseases: heart disease, cancer, and stroke. - There is mounting evidence that focusing interventions, policies, and investments on addressing structural inequities can improve the health status and outcomes of vulnerable populations, thereby reducing health disparities. *Data Sources:* *Cockerham, W.C., Hamby, B.W., & Oates, G.R. (2017). The Social Determinants of Chronic Disease. Journal of Preventive Medicine, 52, S5 – S12. Retrieved from* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5328595/pdf/nihms847488.pdf *Hellerstedt, J. (2018). The state of health in Texas: Creativity, Collaboration Needed to Reduce the Growing Burden of Chronic Disease. Texas Medicine. 114(2):22-27. Retrieved from* https://www.texmed.org/Template.aspx?id=46540 *Texas Department of State Health Services. (2014). The health status of Texas 2014. Retrieved from* https://www.dshs.texas.gov/chs/HealthStatusTexas2014.pdf. *Weinstein, J.N., Geller, A., Negussie, Y., Baciu, A (2017). Communities in Action: Pathways to Health Equity. The National Academies Press, Washington D.C. Retrieved from* https://www.ncbi.nlm.nih.gov/books/NBK425848/pdf/Bookshelf_NBK425848.pdf

Interventions	Healthy Education Lifestyle Program (HELP) Faith Community Nursing and Health Promotion Wellness for Life (Mobile) Clinic Connect Community CARE (Connect, Ask, Respond, Educate) Program Community Impact Grants

Process Measures	Number of completed referrals across CHI interventions or collaborating departments.	Tracked through the Community Health Improvement (CHI) Dashboard.
	Adoption and integration of appropriate health screening measures across CHI interventions.	Tracked through the Community Health Improvement (CHI) Dashboard.

	Number and types of outreach efforts (internal and external) for CHI interventions.	Tracked through the Community Health Improvement (CHI) Dashboard.
	Demographics of individuals served through the CHI interventions (i.e., age, gender, income, education, zip code, race/ethnicity).	Tracked through the Community Health Improvement Program Intake form (*new resource*).

Inputs		Outcomes		
Integration/Resources	Outputs	Short-Term Outcomes By December 2021	Intermediate Outcomes By December 2022	Long-Term Outcomes By December 2026
Internal Stakeholders Community Health Improvement (*owner*) Entities and THPG Program development and Integration (*Sports Medicine and Behavioral Health*) Texas Health Resources Foundation Consumer Experience (*Integrated and Brand Experience, Analytics*) Community Engagement and Advocacy (*Faith & Spirituality, Public Affairs, Blue Zones Team*)	Number of eligible participants referred to community health interventions by internal or external stakeholders: - Number enrolled or signed up for the intervention. - Number that adhered by completing intervention based on stated requirements. Number of participants seen each quarter in each intervention: - % of new participants - % of recurring participants - % participating in more than one Community Health Improvement intervention	Improve referrals and navigation to chronic disease prevention and management resources. Increase satisfaction rate of participants in community health interventions. Improve access to social determinants of health in target communities – measured by improvements in: - Food security - Health literacy - Access to healthcare services and	Improve participants' self-efficacy to appropriately utilize chronic disease prevention and management resources within their communities. Improve quality of life in participants as measured by improvements in one or more of these health indicators in the appropriate participants: - A1C - Blood Pressure - Cholesterol	Reduce preventable utilization in participants from target communities – measured by: - Changes in Utilization of Emergency Departments (ED). - Changes in readmission rates. Reduce health disparities in target communities with strategic CHI interventions. Demonstrate Cost-Benefits (ROI) of Community Health Interventions to THR Health Systems.

Ambulatory, Post-Acute, and Channel Support Services Reliable Health (*TREI, Clinical Informatics, and Magnet*) Revenue Planning and Analysis **External Stakeholders** Community and Strategic Collaborators	- % of no-show rates - % from high-needs zip code Number and types of services offered to participants in CHI interventions (i.e., screenings, education, referrals, treatment, etc.).	- Transportation		

Priority Area 2:	Behavioral Health
Focus Areas:	Depression, Social Isolation, Opioid Crisis, and Access to Behavioral Health Services

Needs Statement	- Behavioral health conditions affect nearly one in five Americans and often goes undetected and untreated due to the fragmented behavioral and physical health systems. - If left untreated, uncontrolled behavioral health can lead to high utilization of preventable hospitalization, which in turn leads to high health expenses for many patients and health care systems. According to SAMHSA, the cost of care is 75 percent higher for people with co-morbid behavioral and physical health conditions. - Limited health care access and unsafe environments are potential risk factors for behavioral health disorders. Also, exposures to violence, social isolation, and discrimination are sources of toxic stress that significantly contribute to the development and exacerbation of behavioral health disorders. It is important to empower individuals with the skills and resources to access and utilize appropriate behavioral health services. *Data Sources:* *American Hospital Association (2019). Trend watch: Increasing access to behavioral health advances value for patients, providers, and communities. Retrieved from* https://www.aha.org/system/files/media/file/2019/05/aha-trendwatch-behavioral-health-2019.pdf *American Public Health Association (2014). Support for social determinants of behavioral health and pathways for integrated and better public health. Retrieved from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/58/support-for-social-determinants-of-behavioral-health* *Robert Bree Collaborative. (2017). Behavioral Health Report and Integration Recommendations. Retrieved from* http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf *Substance Abuse and Mental Health Services Administration (SAMHSA). (2018). Health Care and Health Systems Integration. https://www. samhsa.gov/health-care-health-systems-integration*
Interventions	Community Impact Grants Community CARE (Connect, Ask, Respond, Educate) Program Wellness for Life (Mobile) Healthy Education and Lifestyle Program (HELP) Faith Community Nursing and Health Promotion Medical Respite SANE Outreach
Process Measures	Number of completed referrals across CHI interventions or collaborating departments.	Tracked through the Community Health Improvement (CHI) Dashboard.

	Adoption and integration of appropriate health screening measures across CHI interventions.	Tracked through the Community Health Improvement (CHI) Dashboard.
	Number and types of outreach efforts (internal and external) for CHI interventions.	Tracked through the Community Health Improvement (CHI) Dashboard.
	Demographics of individuals served through the CHI interventions (i.e., age, gender, income, education, zip code, race/ethnicity).	Tracked through the Community Health Improvement Program Intake form (*new resource*).

Inputs		Outcomes		
Integration/Resources	Outputs	Short-Term Outcomes By December 2021	Intermediate Outcomes By December 2022	Long-Term Outcomes By December 2026
Internal Stakeholders Community Health Improvement (*owner*) Entities and THPG Program development and Integration (*Sports Medicine and Behavioral Health*) Texas Health Resources Foundation Consumer Experience (*Integrated and Brand Experience, Analytics*)	Number of eligible participants referred to community health interventions by internal or external stakeholders: - Number enrolled or signed up for the referred intervention. - Number that adhered by completing intervention based on stated requirements.	Improve referrals and navigation to behavioral health resources. Increase satisfaction rate of participants in community health interventions. Improve access to social determinants of health in target communities – measured by improvements in:	Improve participants' self-efficacy to utilize behavioral health resources within their communities appropriately. Improve quality of life in participants as measured by improvements in one or more of these indicators in the appropriate participants: - Depression	Reduce preventable utilization in participants from target communities – measured by: - Changes in Utilization of Emergency Departments (ED). - Changes in readmission rates. Reduce health disparities in target communities with strategic CHI interventions. Demonstrate Cost-Benefits (ROI) of Community Health Interventions to THR Health Systems.

Community Engagement and Advocacy (*Faith & Spirituality, Public Affairs, Blue Zones Team*) Ambulatory, Post-Acute, and Channel Support Services Reliable Health (*TREI, Clinical Informatics, and Magnet*) Revenue Planning and Analysis **External Stakeholders** Community and Strategic Collaborators	Number of participants seen each quarter in each intervention: - % of new participants - % of recurring participants - % participating in more than one Community Health Improvement intervention - % of no-show rates - % from high-needs zip code Number and types of services offered to participants in CHI interventions (i.e., screenings, education, referrals, treatment, etc.).	- Food security - Health literacy - Access to healthcare services and - Transportation	- Social Isolation	

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Priority Area 3:	Access, Health Literacy, and Navigation
Focus Areas:	Patient Education and Outreach, Care Coordination, Access to Primary Care Services

Needs Statement	- Approximately 80 million adults in the United States have limited health literacy, which adversely affects the quality and cost of healthcare. - Evidence shows that poor health literacy is associated with higher hospitalizations, greater use of emergency care, lower receipts of screenings and vaccines, reduced ability to demonstrate medication adherence, and poor overall health status and higher mortality rates. - Individuals or groups that lack economic resources, reside in neighborhoods with high conditions of crime, have limited green space, and grocery stores are at risk for adverse health outcomes. There is evidence that a person's zip code has powerful influences on their health status, access to resources, and the ability to navigate those resources. *Data Sources:* *Loignon, C., Dupere, S., Fortin, M., Ramsden, V.R., & Truchon, K. (2018). Health literacy – engaging the community in the co-creation of meaningful health navigation services: a study protocol. BMC Health Serv Res 18, 505 (2018).* https://doi.org/10.1186/s12913-018-3315-3. *McDonald, M., & Shenkman, L.J. (2018). Health literacy and health outcomes of adults in the United States: Implications for providers. Internet Journal of Allied Health Sciences and Practice, 16, 4. Retrieved from* https://nsuworks.nova.edu/cgi/viewcontent.cgi?article=1689&context=ijahsp. *Murray, T.A. (2018). Overview and Summary: Addressing Social Determinants of Health: Progress and Opportunities. The Online Journal of Issues in Nursing, 23, 3. Retrieved from* http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-23-2018/No3-Sept-2018/OS-Social-Determinants-of-Health.html
Interventions	- Wellness for Life (Mobile) - Faith Community Nursing and Health Promotion - Health Education and Lifestyle Program (HELP) - Clinic Connect - Community CARE (Connect, Ask, Respond, Educate) Program - Community Impact Grants - SANE Outreach

Process Measures	Number of completed referrals across CHI interventions or collaborating departments.	Tracked through the Community Health Improvement (CHI) Dashboard.

	Adoption and integration of appropriate health screening measures across CHI interventions.	Tracked through the Community Health Improvement (CHI) Dashboard.
	Number and types of outreach efforts (internal and external) for CHI interventions.	Tracked through the Community Health Improvement (CHI) Dashboard.
	Demographics of individuals served through the CHI interventions (i.e., age, gender, income, education, zip code, race/ethnicity).	Tracked through the Community Health Improvement Program Intake form (*new resource*).

Inputs		Outcomes		
Integration/Resources	**Outputs**	Short-Term Outcomes By December 2021	Intermediate Outcomes By December 2022	Long-Term Outcomes By December 2026
Internal Stakeholders Community Health Improvement (*owner*) Entities and THPG Program development and Integration (*Sports Medicine and Behavioral Health*) Texas Health Resources Foundation	Number of eligible participants referred to community health interventions by internal or external stakeholders: - Number enrolled or signed up for the referred intervention. - Number that adhered by completing intervention based on stated requirements.	Improve referrals and navigation to health resources (behavioral and physical). Increase satisfaction rate of participants in community health interventions. Improve access to social determinants of health in target communities as	Improve participants' self-efficacy to utilize health resources within their communities appropriately. Improve quality of life in participants - measured by improvements in one or more of these indicators in the appropriate participants:	Reduce preventable utilization in participants from target communities – measured by: - Changes in Utilization of Emergency Departments (ED). - Changes in readmission rates. Reduce health disparities in target communities with strategic CHI interventions. Demonstrate Cost-Benefits (ROI) of Community Health Interventions to THR Health Systems.

Consumer Experience (*Integrated and Brand Experience, Analytics*) Community Engagement and Advocacy (*Faith & Spirituality, Public Affairs, Blue Zones Team*) Ambulatory, Post-Acute, and Channel Support Services Reliable Health (*TREI, Clinical Informatics, and Magnet*) Revenue Planning and Analysis **External Stakeholders** Community and Strategic Collaborators	Number of participants seen each quarter in each intervention: - % of new participants - % of recurring participants - % participating in more than one Community Health Improvement intervention - % of no-show rates - % from high-needs zip code Number and types of services offered to participants in CHI interventions (i.e., screenings, education, referrals, treatment, etc.).	measured by improvements in: - Food security - Health literacy - Access to healthcare services and - Transportation	- Healthy Behaviors - Health Status	

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Focus Area: Sustainability/Resources					
Process Measure	Establish and roll out an integrated Community Health Improvement (CHI) grants strategy that is focused on strengthening existing interventions.				
Inputs ➡		**Outcomes**			
Integration/Resources	**Outputs**	Short-Term Outcomes By December 2020	Intermediate Outcomes By December 2021	Long-Term Outcomes By December 2022	
Internal Stakeholders Community Health Improvement (*owner*) Entities and THPG Program development and Integration (*Sports Medicine and Behavioral Health*) Texas Health Resources Foundation Consumer Experience (*Integrated and Brand Experience, Analytics*) Community Engagement and Advocacy (*Faith & Spirituality, Public Affairs, Blue Zones Team*) Ambulatory, Post-Acute, and Channel Support Services	Funding across all Community Health Improvement (CHI) interventions.	Secure up to $1.5M in grants and sponsorships for Community Health Improvement support.	Secure up to $3M in grants and sponsorships for CHI program support.	Secure up to $5M in grants and sponsorships for CHI program support. Demonstrate Cost Benefits of Community Health Improvement Interventions ROI to THR Health System.	

Reliable Health (*TREI, Clinical Informatics, and Magnet*) Revenue Planning and Analysis **External Stakeholders** Community and Strategic Collaborators				

Tracking Source/Frequency

Short-Term Outcomes	Source	Frequency
Improve referrals and navigation to health resources (behavioral and physical).	CHI Intervention pre and post test; CHI dashboard	Quarterly
Increase satisfaction rate of participants in community health interventions.	Press Ganey; CHI Intervention pre and post test; CHI dashboard	Quarterly
Improve access to social determinants of health in target communities – measured by improvements in: - Food security - Health literacy - Access to healthcare services and - Transportation	Zip Code level Social Needs Index (SNI) data from http://www.healthyntexas.org/	Annually

Intermediate Outcomes	Source	Frequency
Improve participants' self-efficacy to utilize health resources within their communities appropriately.	CHI Intervention pre-and -post test; CHI Dashboard	Quarterly
Improve quality of life in participants - measured by improvements in one or more of these indicators: - A1C - Blood Pressure	Appropriate screening measures (i.e., PhQ-9, Self-reported Health, DSSI, Social Needs Screening Tool)	Annually

	Source	Frequency
- Cholesterol - Depression - Social Isolation - Healthy Behaviors - Health Status	Retrospective and prospective data from these THR tracking platforms (Epic, Slicer Dicer).	
Long-Term Outcomes	**Source**	**Frequency**
Reduce preventable utilization in participants from target communities – measured by: - Changes in Utilization of Emergency Departments (ED). - Changes in readmission rates.	Retrospective and prospective data from these THR tracking platforms (Epic, Slicer Dicer). Dallas Fort Worth Hospital Council (DFWHC)	Annually
Reduce health disparities in target communities with strategic CHI interventions.	Zip code level Social Needs Index (SNI) data from http://www.healthyntexas.org/	Every three years
Demonstrate Cost-Benefits (ROI) of Community Health Interventions to THR Health Systems.	CHI Dashboard for Program Impact Budget report to capture financial revenue and expenses Retrospective and prospective utilization data from EPIC to track cost-savings to THR.	Annually