2020 – 2022 Community Health Needs Assessment (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 ❖ Access, Health literacy, and Navigation] Sustainability/Resources *Inclusive of social determinants that negatively impact each priority area.*

Huguley Hospital Fort Worth South opened in 1977 as a member of Adventist Health System Sunbelt Healthcare Corporation, a 501(c)(3) organization d/b/a AdventHealth. In 2012, Texas Health Resources and Adventist Health System formed a partnership to own Texas Health Huguley Hospital, with Adventist Health System managing the daily operations of the hospital. The 2020-2022 Implementation Plan was completed by Texas Health Resources and was approved by the Texas Health Huguley Board on May 8, 2020. The Board approved the goals, objectives and next steps. A link to the 2020 Implementation Plan was posted on the Hospital's website prior to May 15, 2020. The Community Health Plan can be found at https://www.adventhealth.com/community-health-needs-assessments.Texas Health Huguley's fiscal year is January – December. Implementation of the 2020 CHP begins upon its approval by the Board. The first annual evaluation will begin from the date of implementation through the end of the calendar year. 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.

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	**Outputs**	**Outcomes**		
Integration/Resources		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 &*	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 - % of no-show rates - % from high-needs zip code	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.

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 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	**Outputs**	**Outcomes**		
Integration/Resources		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 referred 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	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: - Food security - Health literacy - Access to healthcare services and - Transportation	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 - Social Isolation	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	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.).			

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	**Outputs**	**Outcomes**		
Integration/Resources		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: - Healthy Behaviors	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

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<tr>
<td rowspan="2">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</td>
<td>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</td>
<td rowspan="2">measured by improvements in:
- Food security
- Health literacy
- Access to healthcare services and
- Transportation</td>
<td rowspan="2">- Health Status</td>
<td rowspan="2">with strategic CHI interventions.

Demonstrate Cost-Benefits (ROI) of Community Health Interventions to THR Health Systems.</td>
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<td>Number and types of services offered to participants in CHI interventions (i.e., screenings, education, referrals, treatment, etc.).</td>
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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		**Outputs**	**Outcomes**	
Integration/Resources			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*)		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.

Ambulatory, Post-Acute, and Channel Support Services 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 - Cholesterol - Depression - Social Isolation - Healthy Behaviors - Health Status	Appropriate screening measures (i.e., PhQ-9, Self-reported Health, DSSI, Social Needs Screening Tool) Retrospective and prospective data from these THR tracking platforms (Epic, Slicer Dicer).	Annually
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).	Annually

	Dallas Fort Worth Hospital Council (DFWHC)	
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