FORT WORTH MEDICAL CENTER

Denton, Hood, Johnson, Parker Tarrant & Wise Counties

Cook Children's

2021 CHNA

IMPLEMENTATION STRATEGY PLAN

Public comment on this report is encouraged and should be sent via email to: **CHNAFeedback@cookchildrens.org**
This report is provided in fulfillment of the Internal Revenue Service Section 501(r)(3)(A) requirements for Charitable Hospitals to conduct a Community Health Needs Assessment (CHNA). The 2021 CHNA report and this Implementation Strategy Plan were approved by Cook Children's Board of Trustees on April 26, 2022.

WHO WE ARE

Cook Children's Health Care System embraces an inspiring Promise—**to improve the health of every child through the prevention and treatment of illness, disease and injury.** We're proud of our rich tradition of serving the children of our community. Our not-for-profit organization is comprised of eight companies, including our original medical center in Fort Worth, physician network, home health company, surgery centers, health plan, health services, and health foundation. For more than 100 years we've worked to improve the health of children from across our original service area of Denton, Hood, Johnson, Parker, Tarrant and Wise counties. Construction for a second medical center is currently underway in the Prosper, TX area and is set to open in the fall of 2022. Currently, the Prosper area is home to a new Cook Children's urgent care clinic, surgery center, and eight primary care offices.

At Cook Children's, we believe that childhood should be simple. But when things get complicated, we also believe that every child has the right to the very best care possible.

PURPOSE OF THIS PLAN

This is a companion document to the Cook Children's Health Care System **Community Health Needs Assessment (CHNA) Report for Tax Year 2021**. Our 2021 CHNA is a joint report for the main Cook Children's Medical Center-Fort Worth and the new Cook Children's Medical Center-Prosper. The Fort Worth Medical Center's primary service area encompasses Denton, Hood, Johnson, Parker, Tarrant, and Wise Counties. The Prosper Medical Center serves the primary counties of Collin, Denton, and Grayson. This plan describes the community benefit implementation strategies for the **Cook Children's Medical Center – Fort Worth service area**, undertaken by Cook Children's as approved by the Board of Trustees. The Community Health Needs Assessment Report and this Community Benefit Implementation Plan are prominently displayed with requests for public comments under the "About Us" section accessed from the main landing page for Cook Children's at http://www.cookchildrens.org. Cook Children's created an email address specifically for public comments (CHNAFeedback@cookchildrens.org), but none received to date were related to Cook Children's CHNA (sales promotions and business solicitations were the only correspondence received).

BACKGROUND & OVERVIEW OF PROCESS

In 2009, Cook Children's began conducting formal community health needs assessments (CHNAs) every 3 years to identify the health needs of children in our original service area for the Fort Worth Medical Center. To determine or confirm community health priorities for action, we established the Community-wide Children's Health Assessment and Planning Survey (CCHAPS), reviewed publicly available data, and conducted focus groups with parents and children. Recognizing that children's health issues are complex and successful solutions require a collaborative effort among a broad range of organizations, Cook Children's engages multiple community partners in this effort to research, understand, communicate and address children's health issues. CHNAs were conducted and implementation strategies developed in 2009, 2012, 2015, 2018, and now 2021.

Cook Children's created the Center for Children's Health in 2011 to provide an infrastructure for using children's health assessment data to guide community programs and stakeholder collaborations that *prevent* illness, disease and injuries for children. The Center oversees a regular community health needs assessment, community research and community health outreach. All three categories of Center activities focus on increasing access to preventive services for underserved populations. Figure 1 illustrates our Cook Children's community benefit process in relation to the Internal Revenue Service Section 501(r)(3)(A) requirements. This Community Health Implementation Plan fulfills step two within the process and presents **strategies developed to address community health needs in the Fort Worth Medical Center service area for the next three years (FY2022 – FY2024)**.

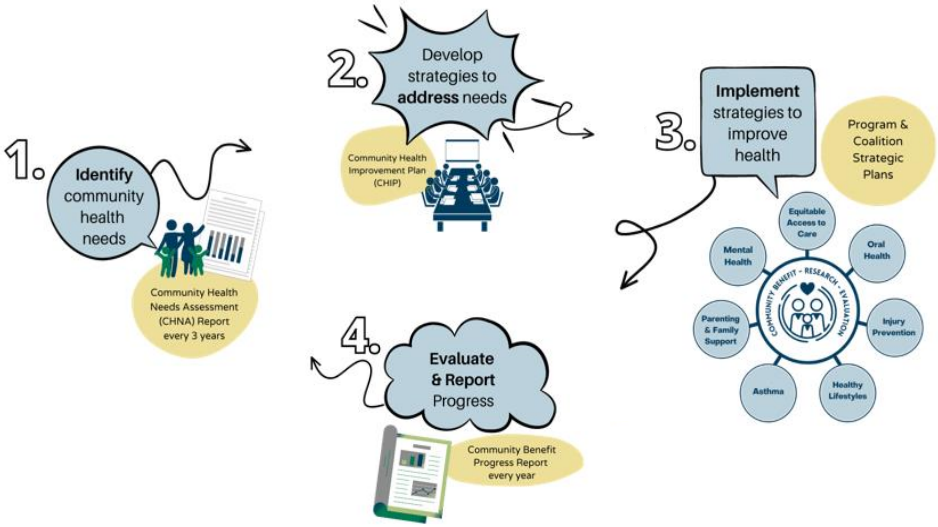

Figure 1. Cook Children's community benefit process.

PRIORITY HEALTH ISSUES

Based on the 2009 initial assessment results for the Fort Worth Medical Center service area, Cook Children's Board of Trustees prioritized the children's health issues identified by parents and community leaders on April 28, 2009 using group process techniques followed by a nominal voting exercise. Reviews of data findings from subsequent CHNA processes in 2012, 2015 and 2018 confirmed the importance of these issues for continuing focused intervention. Although progress in addressing these issues is consistent, the growing number of children and the overwhelming need outlined in this and earlier reports are evidence that continued focus on these issues is paramount.

The intention of our 2021 CHNA is to build upon previous assessment efforts in order to refine services for existing health priority areas and to identify new areas of concern for the community. This assessment focuses on the child health issues previously prioritized by Cook Children's Board of Trustees with an emphasis on community-level social determinants of health and the impact of COVID-19. The seven issues prioritized in 2021 are equitable access to health care, asthma, healthy lifestyles (obesity prevention), mental health, oral health, parenting and family support (child abuse & neglect prevention), and injury prevention. These health issues are intentionally phrased to be more solution based. For example, instead of prioritizing child abuse and neglect, we're rephrasing this priority to parenting and family support to emphasize how Cook Children's and our community can best address the needs identified. The intersectionality of these issues, illustrated in Figure 2, was a key consideration during the implementation strategies development for each priority issue.

Figure 2. Health issues prioritized from Cook Children's 2021 CHNA.

OUR COMMUNITY SERVED

For community benefit reporting purposes Cook Children's defines its *primary* community served as the eight-counties of Collin, Denton, Grayson, Hood, Johnson, Parker, Tarrant and Wise Counties within North Central Texas. This North Central Texas area is home to **Cook Children's Medical Center - Fort Worth (FWSA)** campus and the **Cook Children's Medical Center – Prosper (PSA)** campus, which opens fall of 2022. For our joint 2021 Community Health Needs Assessment report, both campuses defined their community and population served characteristics to be the same.

The counties defined within the Fort Worth Service Area and Prosper Service Area are shown on the right. Due to the proximity of Denton County to both medical center campuses, **Denton County is intentionally included in both services areas**—but is only represented *once* within the eight-county parent survey results.

Fort Worth Service Area (FWSA)

Denton
Hood
Johnson
Parker
Tarrant
Wise

Prosper Service Area (PSA)

Collin
Denton
Grayson

The U.S. Census Bureau classifies these counties as follows: Collin County (mostly urban, 5% rural), Denton County (mostly urban, 7% rural), Grayson County (rural 43%), Hood County (mostly urban, 33% rural), Johnson County (mostly urban, 38% rural), Parker County (rural 56%), Tarrant County (mostly urban, 1% rural), and Wise County (mostly rural 72%).

According to US Census estimates, Cook Children's eight-county service area is home to a diverse population of 4,414,214 people and **1,269,810 (28%) are children 17 years and younger** (FWSA comprises 972,470 children ages 0–17, while the PSA includes 512,680 children between the ages of 0–17). The 2019 American Community Survey 5-year estimates report the annual median income for families with children under age 18 ranges between $63,311 in Grayson County to $117,935 in Collin County. Additionally, nearly 150,000 children live in households with income below poverty level – estimating 12% of the 1.2 million children in the eight-county service area. The percent of children in households that receive Supplemental Security Income (SSI), cash public assistance, or Food Stamps/SNAP benefits ranges from 8% in Collin County to 27% in Grayson County. The Cook Children's eight-county service area contains three designated medically underserved areas and two designated medically underserved populations as defined by the Health Resources & Services Administration.

For a full description of our service area population, please refer to our 2021 Community Health Needs Assessment report.

2021 CHNA METHODOLOGY

PARENTS AND CAREGIVERS of CHILDREN AGES 0-17

Parent/Caregiver Survey. The key element to our 2021 CHNA is our parent survey, also known as CCHAPS (Community-wide Children's Health Assessment & Planning Survey). ETC Institute administered this survey to primary caregivers by a combination of mail, phone, or the Internet to a random sample of families with children ages 0–17 in the eight-county service area during November 2020 through March 2021. The survey, available in English and Spanish, gathered statistically representative data of children ages 0–17 living in Collin, Denton, Grayson, Hood, Johnson, Parker, Tarrant and Wise counties. A total of 5,715 parents/caregivers completed the survey, which represents a 13.1% response rate. Only one parent per household was selected. Respondent demographics were monitored throughout the data collection process to ensure a representative sample according to gender, race/ethnicity, marital status, education, and household income. The overall results have a precision of at least +/-1.3% at the 95% level of confidence.

The 56 survey questions assessed access to health care, health insurance, overall health and wellbeing, oral health, emotional and mental health, healthy lifestyles (nutrition, physical activity), home and neighborhood safety, and family and caregiver relationships. Many survey questions aligned with national and state data benchmarks such as the National Survey for Children's Health, Healthy People 2030, Youth Risk Behavior Surveillance, US Gallup Poll, Mental Health America, and Safe Kids Worldwide.

Focus Groups or Case Studies. From April through May of 2021, a team from the University of North Texas Health Science Center, School of Public Health conducted six virtual focus groups and one interview with parents across the eight-county service area. These focus groups provided an opportunity for parents and caregivers to share additional information beyond questions within in the parent survey. Priority topics within these focus groups included asthma, oral health, mental health, healthy lifestyles, injury prevention, parenting support, COVID-19, and equitable access to care.

UNDER-REPRESENTED POPULATIONS

Face-to-Face Survey Interviews. MHMR of Tarrant County administered the CHNA parent/caregiver survey to a purposive sample of caregivers within families experiencing homelessness in shelters or within families with at least one undocumented member through one-on-one interviews. Interviews were conducted with parents and caregivers from local shelters and social service organizations. This sample of respondents is *not* representative of our eight-county service area, yet it provides a better understanding into the unique challenges these families undergo with accessing healthcare and community resources for their children.

Hidden Homeless Motel Survey. The Center for Transforming Lives conducted a separate survey of families with children ages 0–17 years, who were living within motels or extended stay properties throughout Tarrant County from February–October 2021. Seventy families completed the anonymous surveys on-site at the motel locations. The majority of survey respondents were from Fort Worth or Arlington, and the sample of respondents is *not* representative of our eight-county service area. Selected results from this survey are included within our 2021 CHNA.

COMMUNITY LEADERS AND STAKEHOLDERS

Community Leader Survey. During February – March 2021, ETC Institute also administered an email survey to a purposive sample of community leaders to obtain input regarding children's health issues from their perspective. The survey included general questions about children's health priorities and questions designed to assess the impact of Adverse Childhood Experiences (ACES) in their communities. The mailing list included 1,881 representatives from city/county governments, county public health departments, agencies, non-profit organizations, schools, faith based/clergy, and health care/public health professionals. A total of 306 responses were received for a 16% response rate. The results for the random sample of 306 respondents have a 95% level of confidence with a precision of at least +/- 5.6%.

Community Leader Interviews. From April through May of 2021, a team from Cook Children's Center for Children's Health conducted 20 virtual interviews with community leaders across the eight-county service area. These interviews provided an opportunity to collect information from a wide-range of community leaders with first-hand knowledge about the community. Interviewees discussed pressing issues or concerns in the community, providing additional context to the community leader and parent survey findings. Priority topics discussed during the interviews included the impact of COVID-19, mental health, adverse childhood experiences, housing/food security, healthy lifestyles, injury prevention, and equitable access to healthcare.

External Advisory Committee. From July 2020 through August 2021, an External Advisory Committee convened consisting of 21 community partners on behalf of the eight-counties within our service area, who graciously shared their time and insight with us as we were finalizing our parent and community leader survey questions. They also spent time creating awareness of our surveys during data collection and some provided community leader interviews. Feedback from this committee that Cook Children's applied to our CHNA included best practices for survey communication methods, inclusivity for reaching diverse populations, and question enhancement for better assessing health equity. Committee members represented backgrounds in academia, public health, local government, public school systems, and non-profit organizations.

PUBLICLY AVAILABLE DATA

Secondary Data Review. As a supplement to findings from parent and community leader surveys and our qualitative data collection—secondary data from national, state, local public health, schools, and academic sources provided a deeper understanding of complex social, economic, and environmental factors that influence child health outcomes at the individual and community level. We utilized at least eight – ten sources for each of the eight priority health issues to determine national, state, and if available, local trends.

OVERVIEW OF STRATEGY PLAN

The following sections within our strategy plan describe community outreach strategies, key measures, anticipated impact and key resources available within Cook Children's to support our work around community benefit for the next three years.

This plan begins with a section on Overall Health and Well-Being which summarizes the Center for Children's Health (C4CH) implementation strategies for our overall approach to community outreach for children's health. These are based on the general health care findings for the service area along with key concerns around health access and inequities that are not necessarily specific to an individual priority health issue. Starting with these strategies reflects the values and culture we strive to honor as we design and implement all C4CH community outreach programs and community collaborations. The priority issue strategies are then presented in the same order as reported in the 2021 Community Health Needs Assessment (CHNA). It is essential to note that each of these priority health issues are of *equal* concern.

Strategies for our priority issues are presented in the following order:

- Overall Health and Well-Being
- Oral health
- Mental Health
- Healthy Lifestyles
- Parenting and Family Support
- Injury Prevention
- Asthma

Due to the deep intersectionality among these health issues, particularly from the lens of a child's overall health and well-being and the need for equitable access to care, community collaboration is key. The strategies presented in this plan represent community outreach work provided by C4CH, but Cook Children's Health Plan (CCHP) also developed population health strategies based on the 2021 CHNA findings for each priority issue. CCHP and C4CH often partner to successfully implement strategies that align from both plans. These are included in the Appendix for reference.

It is important to remember that the strategies outlined in this document do not represent all of the many health care services offered throughout Cook Children's Medical Center-Fort Worth and CCHP. These strategies focus on the services aligned with the priority health issues provided through community-based partnerships and directly connected to key activities within the Center for Children's Health.

OVERALL HEALTH AND WELL-BEING BRIEF

Most children in the eight-county service area are healthy, with parents reporting **excellent or very good health status** for 88% of children. The 2021 rate for children with excellent or very good health remains consistent with health status rates collected in 2015 and 2018. Regrettably, **1 in 8 local children** (12%) do not enjoy the benefits of excellent health; this represents approximately **147,450 children** in the service area.

In the eight-county service region **88% of children receive preventative care**, compared to 81% statewide and 83% nationally, and a large majority (97%) of children in the 8-county service area are up-to-date on vaccinations for their age. However, more than **1 in 4 children (28%) did not receive all medical care needed** in the prior year (an estimated 353,000 children). The local rate of forgone medical, dental and mental health care is higher than national and state estimates prior to and during the pandemic.

H.E.L.P. for Health Equity

H	Health	**Equitable Access to Care & Basic Needs** A majority of the children in the eight-county service area had continuous **insurance coverage** for the prior year (91%), but 4% (53,780 children) had a gap in coverage during the year and 5% (56,780 children) are currently uninsured.
E	Environment	**Safety Where Children Live, Learn & Play** Many children live in motels, cars or overcrowded homes because **affordable housing is not available**. Families reported that these living conditions may continue for six months or longer.
L	Learning	**Readiness & Support for Academic Success** About 71% of children ages 3–5 in the eight-county service area are **ready to be in school**; but 10% of **children ages 3–17** have a **developmental delay**, 5% have an **intellectual delay** and 13% have a **learning disability.** These rates are higher than national and state estimates prior to and during the pandemic.
P	Parenting	**Parenting & Family Support** In order for children to receive timely health care, parents and families need supportive services to address social determinants of health. Leaders reported that poverty and geography make it difficult for some children to access needed health care and proper nutrition, which may be exacerbated by housing instability and food insecurity related to job loss. An estimated **303,000 children (nearly 1 in 4 children)** live in households that **could not always afford nutritious foods**. Inadequate insurance coverage, geography, and poverty also impact the ability to obtain preventative care.

For more information, please see the full 2021 CHNA Report or visit our CHNA dashboard

Goal: Increase equitable access to overall health & well-being for children with a community-based service delivery system

The Center for Children's Health
led by Cook Children's

Community Benefit Strategies	Community Benefit Measures	Anticipated Impact	Key Resources Available within Cook Children's*
Ensure that C4CH programs and community involvement exemplify Cook Children's Promise. Maintain focus of C4CH service delivery program designs on the principles of community collaboration, evidence-based information and practices, and reducing health disparities and inequities. Monitor and identify priority children's health issues in Cook Children's 6-county Fort Worth Service Area (FWSA) to guide equitable service delivery program designs: – Conduct a **Community Health Needs Assessment (CHNA)** as required by Internal Revenue Service Section 501(r)(3)(A), collecting data from parents, caregivers, community leaders, health care professionals and social service providers. – Develop internal and external advisory committees to obtain guidance from multiple sectors within the service delivery system. – Share results of the CHNA with community partners through regional and local child health summits, media outlets, and presentations at local, state, and regional venues. – Share the results with CCHCS leadership to prioritize community outreach programming. Draw on the power of community partnerships to increase the reach for equitable health care information and services to disproportionally impacted populations (**C4CH Coalitions**): – Lead community coalitions with multi-sector, geographically diverse membership. *Continued*	Service delivery designs are modified as required; program evaluation outcomes for service delivery and family demographics reach benchmarks. Formative (process) measures for the CHNA: – Health issues and Social Determinants of Health (SDoH) for children are identified. – Community partner engagement in CHNA process (community, parent and caregiver perspectives are included). – CHNA meets regulatory requirements; CCHCS Board approves the CHNA and develops implementation strategies. – Attendance and event outcomes for regional and local child health summits. Coalition engagement outcomes with community partners and volunteers. Distribution of evidence-informed prevention and wellness educational materials, practical tools, and toolkits (e.g., oral health kits, locks, water watcher tags). *Continued*	C4CH has a better understanding of how SDoH impact access to health care for children. Intervention services and program designs for caregivers are focused on addressing SDoH needs. Parents and caregivers have a better understanding of prevention behaviors. C4CH programs address SDoH barriers (e.g., service locations and partners, family service demographics, etc.). Access to quality health care increases, reducing the impact of disparities. Children's health care outcomes improve and fewer children are unintentionally injured. Collaborative efforts with key stakeholders expand the reach of messaging, resource distribution, and organizational/policy change.	**Community coalitions led by Center for Children's Health:** **●ACEs Task Force ●Children's Oral Health Coalition ●Hood County for Healthy Children ● Healthy Children Coalition for Parker County ●Johnson County Alliance for Healthy Kids ●Safe Baby Sleep Council ●Safe Kids North Texas-Fort Worth ●Wellness Alliance for Total Children's Health ●Wise Coalition for Healthy Children** **Checkup Magazine:** Quarterly children's health newsletter mailed to all households of Hispanic ethnicity with children 0-14 and an income of $30,000 to $60,000 in Cook Children's 8-ccounty service region. **JOY Campaign (Just Breathe, Open Up, You Matter):** A suicide prevention communication initiative led by Cook Children's that aims to bring hope and needed resources to children and families facing struggles and dark times in their lives. **Asthma 411:** A collaboration with multiple partners working to equip school nurses with medication needed for students with asthma. **Immunization Collaboration of Tarrant County (ICTC):** A collaboration of over 40 organizations committed to eradicating childhood, adolescent, and adult vaccine-preventable diseases in Tarrant County. ICTC offers low cost vaccines to over 7,000 children, teens, and adults annually. **Mental Health Connection**: Cook Children's is a founding member of this Tarrant County community collaboration that connects organizations to address gaps in the mental health system of care and to track emerging needs. *Continued*

Community Benefit Strategies	Community Benefit Measures	Anticipated Impact	Key Resources Available within Cook Children's*
– Develop and initiate partnership distribution of evidence-informed educational materials and practical tools that are clear, easy to understand, and use words familiar to a wide audience (e.g., **Checkup Magazine, JOY Campaign**). Serve as an active partner on collaborations *led by other community organizations* to advocate for and improve the system of care for children with disparities (see descriptions at right): – **Asthma 411** – **Immunization Collaboration of Tarrant County** – **Mental Health Connection** – **Children at Risk** – **Texas Health Institute** Explore opportunities to support Cook Children's Health Plan, Neighborhood Clinics, and Physician Network in providing family centered care (sharing CHNA data, prevention education materials, tools, and training opportunities). Support Cook Children's Case Management Department partnerships with Tarrant County homeless shelters to provide a medical home and increase access to pediatric medical care for homeless children (**Homeless Initiative**). Identify, monitor and support local/state/national opportunities for policy changes to prevent childhood injuries and improve children's health.	Distribution of asthma educational materials, medication and supplies to schools; School Nurse Symposium engagement and education outcomes for provider professional development. Immunizations provided to children in targeted locations. Outcomes from the Homeless Initiatives regarding children served, connections to a medical home, etc. Qualitative impact stories of organizational change from partners.		**Children at Risk**: Statewide organization focused on improving the quality of life for Texas children through strategic research, public policy analysis, education, collaboration, and advocacy. **Texas Health Institute**: Non-profit, non-partisan public health institute working to facilitate collaboration on public health and health care issues in Texas and the nation. Key activities include research, translating evidence into action, and supporting collaborations to advance collective impact. **Homeless Initiative:** Cook Children's Case Management Department partners with Tarrant County homeless shelters to provide a path to medical care for children residing in homeless shelters. Children are connected to a primary care physician who provides appointments for well checks, ear infections and upper respiratory conditions. Mental health services and trauma-informed care are also provided.

*Many services are offered throughout our health care system to support priority children's health needs identified in the CHNA. This list focuses on internal and external partners directly working with C4CH to support increasing awareness with key prevention messages. External community resources and partners are outlined in the AVAILABLE RESOURCES section.

ORAL HEALTH BRIEF

Child oral health is achieved through proper preventive care and prompt treatment for dental problems for both children and pregnant women. Children with untreated dental problems may have difficulty with pain, eating, self-esteem or school attendance. In more severe cases, children need emergency care, hospitalization or surgical procedures.

In the eight-county service area, **1 in 4** children ages 1–17 (26%) **do not have excellent or very good oral health** (about 313,270 children). These children have poor, fair or good condition of their teeth, as reported by their parents. This rate is higher than the statewide (18%) and national (20%) rates. Children ages 6–11, children of color, and children from low-income families are less likely to have excellent or very good oral health.

H.E.L.P. for Oral Health

H	Health	**Equitable Access to Care & Basic Needs** **One in 7** children ages 1–17 (175,000 children) did not receive all needed dental care. This rate is nearly 9 times higher than the national estimates and 5 times higher than state estimates before the pandemic. Contributing factors were the COVID-19 pandemic, inadequate insurance to cover costs, and limited services in a family's area. **One in 6** children (206,000 children) did not have a preventive dental visit, which was most common with children 5 years or younger, children of color, or children from low-income families.
E	Environment	**Safety Where Children Live, Learn & Play** Children from **lower-income households or homeless shelters** have higher rates of poor oral health and dental problems, and are **3 times more likely** to miss school as a result of dental problems.
L	Learning	**Readiness & Support for Academic Success** **Three in 10** school-age children (257,000 children) do not have excellent or very good oral health, and these children are **twice as likely** to miss school due to dental problems.
P	Parenting	**Parenting & Family Support** Parents report the need for increased access to preventative and restorative dental care and infant and child oral health education from reliable sources.

For more information, please see the full 2021 CHNA Report or visit our CHNA dashboard

Goal: Improve child oral health

Community Benefit Strategies	Community Benefit Measures	Anticipated Impact	Key Resources Available within Cook Children's*
Respond to the urgent needs of children at increased risk of poor oral health. – Lead and sustain the **Save a Smile Advisory Committee;** and the **Children's Oral Health Coalition (COHC)** to plan and implement oral health collaborative interventions. – Develop and distribute evidence-informed oral health resources to educate families, medical/dental providers and other community partners. – Continue **Save a Smile** programming to conduct limited oral health evaluations for low-income children; identify those with acute dental problems in targeted schools; and provide comprehensive social and dental treatment services. – Provide evidence-based training to caregivers and children; pregnant women; school nurses; medical/dental providers; and other community partners. – Facilitate and track community-level oral health screening outcomes. – Reduce barriers to oral health care for pregnant teens and women. – Explore potential partnership with Renaissance Dental Clinic to expand patient family education opportunities. Support community awareness campaigns and events to encourage good oral health (**February National Dental Health Month**, and others).	Engagement outcomes for (a) volunteer dentists offering free treatment services; (b) school administrators and nurses; (c) medical/dental providers; (d) **Save a Smile Advisory Committee;** (e) **COHC;** and (f) other community partners. Direct and indirect distribution of evidence-informed educational material, prevention resources, and toolkits (e.g., oral heath kits, partner education toolkits, videos, etc.). Social services provided, including health histories, making appointments, transportation, referrals and follow-up. Education or professional development outcomes (e.g., Ask-A-Doc, ambassador trainings, etc.). Outcomes for reducing barriers to oral health care for pregnant teens and women. Qualitative impact stories from dentist volunteers, parents, caregivers, and other partners. Community engagement in awareness campaigns/events and media coverage.	Collaborative efforts with key stakeholders expand the reach of messaging, resource distribution, and organizational/policy change. Community awareness for parents and caregivers improves regarding recommended oral health practices for children. Improved oral and overall health for children receiving services and treatment for oral health problems.	**Center for Children's Health:** **Save a Smile:** An innovative, nationally recognized, collaborative program led by Cook Children's. Provides preventive and restorative dental care for children from low-income families with the help of volunteer dentists and community health workers. The **Save a Smile Advisory Committee** is a group that provides information from hands-on health professionals for practical implementation of services. **Children's Oral Health Coalition (COHC): D**edicated to improving the oral health of children in Tarrant County and the surrounding areas through community collaboration, family and provider education, resource distribution and advocacy efforts. **Coordinated Care for Pregnant Teens + Women**: A COHC program that facilitates collaboration between dental and medical providers to eliminate barriers to health care for pregnant teens and women. **Oral Health Director** **Tonya Fuqua, D.D.S.** *Program Champions:* **Shawne Barron, D.D.S.** **Sheela Patel, D.D.S** Neighborhood Clinic Renaissance

*Many services are offered throughout our health care system to support priority children's health needs identified in the CHNA. This list focuses on internal partners directly working with C4CH to support increasing awareness with key prevention messages. External community resources and partners are outlined in the AVAILABLE RESOURCES section.

MENTAL HEALTH BRIEF

Mental health is essential for a child's well-being but finding and accessing the resources required to address mental health disorders in children is a common problem for parents. Mental health disorders are serious changes in the way children typically learn, behave, or handle their emotions which cause distress and problems functioning on a daily basis. Children and adolescents with mental health conditions may also participate in risky behaviors, such as substance use and self-harm. In more severe cases of mental health disorders, children may need emergency care or in-patient treatment.

The four most commonly diagnosed mental health disorders in children are attention-deficit/hyperactivity disorder (ADHD), behavior/conduct problems, anxiety and depression. **One in 3 children** ages 6–17 in our eight-county service area have a diagnosed mental health need. This represents an estimated **267,730** school-age children, and the rate in our eight-county service area is higher than state and national rates. In the eight-county region, 31% of children have at least one diagnosed mental health condition, which is higher than the statewide rate (23%) and national rate (23%).

H.E.L.P. for Mental Health

H	Health	**Equitable Access to Care & Basic Needs** Of the 252,000 school-age children who needed mental health treatment or counseling, 46% have a caregiver who experienced difficulty getting this care while 6% were unable to get needed care. **Barriers to care** included the pandemic, cost of care, inadequate insurance, scheduling conflicts and limited service availability in their areas.
E	Environment	**Safety Where Children Live, Learn & Play** School-age children most likely to be diagnosed with at least one of the four most common mental health disorders are children who are white; experiencing homelessness or living with an undocumented parent or caregiver; living in households with income below $50,000; or living in counties designated as mostly rural.
L	Learning	**Readiness & Support for Academic Success** Mental health disorders contribute to lower academic, behavioral, and social functioning that often continue into adulthood. Of **school-age children** in the eight-county service area, parents report that **4 in 5** are unable to stay calm and control when faced with a challenge, nearly **2 in 5** are bullied at school, and **1 in 6** do not care about doing well in school.
P	Parenting	**Parenting & Family Support** **Nearly 7 in 10** children have a caregiver who is not very familiar with mental health services in the community.

For more information, please see the full 2021 CHNA Report or visit our CHNA dashboard

Goal: Improve child mental health and well-being

Community Benefit Strategies	Community Benefit Measures	Anticipated Impact	Key Resources Available within Cook Children's*
Respond to the increasing critical need for mental health services to serve children. – Lead and sustain the **Wellness Alliance for Total Children's Health (WATCH)** and **Adverse Childhood Experiences (ACEs) Task Force** to plan and implement mental health collaborative interventions, targeting high-risk populations. – Sustain a strong community network of quality mental health services to support mental health services and treatment (**Mental Health Connection).** – Develop and implement evidence-informed education and interventions for caregivers, children and adolescents to expand the reach of mental health messaging and strengthen connections to health care and community resources (**Children's Feelings are a Work of Art, WatchDenton.org).** – Provide professional development opportunities for mental health providers who will share skills, knowledge, and tools with colleagues and caregivers within their reach (**Wellness Workshops**). *Continued*	Community partner engagement outcomes for **WATCH and ACEs Taskforce.** Distribution of evidence-informed educational material, prevention resources, and toolkits (e.g., coping cards, journals, wellness toolkits for children, etc.). Education and engagement outcomes for children, adolescents and families through virtual and in-person events. Community partner engagement and provider professional development education outcomes (CEUs); use of education toolkits with families. Engagement of families and community partners in awareness campaigns and events; media coverage. Engagement outcomes for community partners that demonstrate organizational change (e.g., Denton ISD Behavioral Health campus). *Continued*	Collaborative efforts with key stakeholders expand the reach of messaging, resource distribution, and organizational/policy change. Stigma associated with mental health improves and awareness of mental health issues and community resources increases for families and community members. Mental health outcomes for children improve. Children's overall health and well-being improves.	**Center for Children's Health (C4CH):** **Wellness Alliance for Total Children's Health (WATCH) of Denton County***:* A collaboration of both public and private organizations and individuals who work to increase awareness of and access to mental health services. **ACEs Task Force***:* A collaboration of community partners using a two-generation approach to reduce the impact of adverse childhood experiences (ACEs) on children prenatal to five years of age and prevent ongoing adversity for families. Focus is to improve school readiness, literacy, and overall child well-being. **Mental Health Connection**: Cook Children's is a founding member of this Tarrant County community collaboration that connects organizations to address gaps in the mental health system of care and to track emerging needs. **Children's Feelings are a Work of Art**: A youth art contest that raises awareness and encourages conversations about children's mental health. Children and teens are encouraged to participate in the contest while focusing on expressing themselves through artwork. The art contest is followed by an art gallery, where all of the artists are celebrated for participating and their artwork is displayed in their community. Games and community resources relating to children's mental health are also offered at the gallery. **WatchDenton.Org**: A website maintained by WATCH with a focus on improving the mental health of children in Denton County. Information about mental health and available resources are provided for kids, teens, parents/caregivers, and professionals. *Continued*

Community Benefit Strategies	Community Benefit Measures	Anticipated Impact	Key Resources Available within Cook Children's*
Support community campaigns and events to reduce stigma and promote awareness about mental health and well-being (**Okay to Say™**, **Mental Health Awareness Month**, **JOY Campaign**).	Community engagement in awareness campaigns/events and media coverage. Qualitative impact stories from parents, caregivers, and partners.		**UNICEF Kid Power**: A free online video platform with physical activity and social-emotional content that empowers children to make a real-world impact in local and global communities. Combines philanthropy and fun with a focus on social-emotional wellness and mental health, child rights, and equity and access for students. **Wellness Workshops**: Learning opportunities held throughout the year, providing quality continuing education credits based on evidence-informed practices. The audience for these workshops include professionals as well as parents and community members. **Okay to Say™**: Initiated by Meadows Mental Health Policy Institute, Okay to Say fuels open conversations about mental health and encourages Texans to speak up and share hope to support friends and family with a mental health concern. It's okay to say you're not okay! **JOY Campaign (Just Breathe, Open Up, You Matter):** A suicide prevention communication initiative led by Cook Children's that aims to bring hope and needed resources to children and families facing struggles and dark times in their lives. *Program Champion:* **Lisa Elliott, Ph.D**. Cook Children's Behavioral Health Psychology Clinic, Denton **Lisa Farmer** Director, Psychiatric Services

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HEALTHY LIFESTYLES BRIEF

Children who live a healthy lifestyle are better able to manage their weight, stress and self-esteem for lifelong health. Children who do not have a normal body weight have a greater risk of chronic disease as children and in adulthood. Obesity in childhood is associated with anxiety, depression, bullying and lower quality of life. **Nearly 2 in 5** children ages 10–17 in the eight-county service area (an estimated 223,800) do not have a normal body weight. Children need access to health care, nutritious food and opportunities for physical activity to achieve and maintain a normal, healthy body weight. In the eight-county service area, 39% of children ages 10-17 do not have a normal body weight, which is slightly higher than the statewide and national rates (both 37%).

H.E.L.P. for Healthy Lifestyles

H	Health	**Equitable Access to Care & Basic Needs** The nearly 2 in 5 children (ages 10–17) who do not have a normal body weight are **less likely** than children with a normal BMI to practice **key healthy lifestyle behaviors**, such as eating the recommended amount of healthy foods, getting the recommended amount of daily physical activity, or limiting daily screen time on most days. These children area also **more likely** to miss having family meals on most days.
E	Environment	**Safety Where Children Live, Learn & Play** **Twenty-four percent** of local children ages birth–17 (303,080 children) live in households that cannot always afford to eat good, nutritious meals. Children experiencing homelessness or living with an undocumented parent or caregiver have the highest rate of food insecurity. Food insecurity is also higher for **Hispanic and Black, Non-Hispanic** children, and children living in **rural areas** or in **low-income** households. These three groups of children are also less likely to get the recommended amount of daily physical activity.
L	Learning	**Readiness & Support for Academic Success** The COVID-19 pandemic disrupted access to meals and opportunities for physical activity at school. Children who are overweight or obese are **more likely** to be teased or bullied by peers.
P	Parenting	**Parenting & Family Support** Most of the children who do not have a normal body weight have parents or caregivers who are not concerned about their children's weight.

For more information, please see the full 2021 CHNA Report or visit our CHNA dashboard

Goal: Improve access to nutritious food and physical activity for children

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Community Benefit Strategies	Community Benefit Measures	Anticipated Impact	Key Resources Available within Cook Children's*
Respond to the general health and wellness needs of families. – Lead and sustain the **Johnson County Alliance for Healthy Kids (JCAHK), Healthy Children Coalition for Parker County (HCCPC), and UNICEF Kid Power** to plan and implement family wellness collaborative interventions. – Develop and distribute evidence-informed education and interventions for children to promote healthy lifestyles, nutritious food consumption, and physical activity (**5210+ Every Day Coaching Sessions** and **UNICEF Kid Power).** – Provide healthy lifestyles training to providers and community members who will share skills, knowledge, and tools with caregivers within their reach (**5210+ Every Day Facilitator Training**). – Support community awareness campaigns and events to encourage healthy lifestyles (**National Gardening Week**, **Child Health Summits**, and others).	Community partner engagement outcomes for **Johnson County Alliance for Healthy Kids** and **Healthy Children Coalition for Parker County.** Distribution of evidence-informed educational material, prevention resources, and toolkits (e.g., container gardens; materials teaching GO, SLOW and WHOA foods; and family education toolkits). Education and engagement outcomes for children and families through virtual and in-person events (e.g., **5210+ Every Day** presentations, garden presentations, and healthy living campaigns). Education and engagement outcomes for community partners and trained ambassadors; use of education toolkits with families. Children physically active using the **UNICEF Kid Power** platform and donations unlocked by watching videos for local nonprofit wellness organizations (Tarrant Area Food Bank and Texas A&M AgriLife gardening supplies). Engagement of families and community partners in awareness campaigns and events; media coverage. Engagement outcomes for community partners that demonstrate organizational change (e.g., schools adopting 5210+ curriculum). Qualitative impact stories from parents, caregivers, and partners	Collaborative efforts with key stakeholders expand the reach of messaging, resource distribution, and organizational/policy change. Parents and caregivers increase awareness regarding healthy lifestyles. Food security, physical activity, and general wellness increases for children.	**Center for Children's Health:** **Johnson County Alliance for Healthy Kids and Healthy Children Coalition for Parker County:** Collaborations of both public and private organizations and individuals who work on identifying positive nutrition and fitness solutions to address the local concern for children's physical health. **UNICEF Kid Power**: A free online video platform with physical activity and social-emotional content that empowers children to make a real-world impact in local and global communities. Combines philanthropy and fun with a focus on social-emotional wellness and mental health, child rights, and equity and access for students. **5210+ Every Day**: A toolkit adapted from two nationally recognized and evidence based programs that encourages children to adopt healthy nutrition and physical activity practices. *Program Champion* **Sanu Nair, MD, MPH** Cook Children's Emergency Department and Urgent Care

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PARENTING AND FAMILY SUPPORT BRIEF

Parenting is hard and all families benefit from a strong community parenting and a family support system, but families trying to navigate these challenges while experiencing adverse experiences are especially at risk for negative outcomes without parent and family support. **Adverse Childhood Experiences (ACEs)** refer to potentially traumatic events that occur in children ages 0–17 years and include experiencing or witnessing violence, abuse, or neglect in the home or community. Dozens of research studies demonstrate **a correlation between early adversity and poor outcomes later in life**. Fortunately, people who experience significant adversities are not irreparably damaged and can benefit from parent and family support.

One in 7 children (14%) have two or more ACEs in the eight-county service area (approximately 170,960 children ages 0–17). This rate is slightly less than the statewide rate at 16% and the national rate at 15%. For children locally, statewide, and nationally, the most common ACE is divorce or separation, followed by home exposure to mental illness.

H.E.L.P. for Parenting and Family Support

H	Health	**Equitable Access to Care & Basic Needs** Children experiencing ACEs are at **higher risk** for chronic health problems, mental illness, and substance abuse in adulthood. Local children with two or more ACEs are less likely to have received all needed medical care or have nutritious foods.
E	Environment	**Safety Where Children Live, Learn & Play** Children experiencing **homelessness or living with an undocumented parent or caregiver** are 3 times more likely to have at least two ACEs. Rates of child abuse across the nation and locally fell or were stable in 2020 rather than increasing as expected. This unexpected outcome may illustrate the power of positive childhood experiences such as government assistance during times of financial distress, increased parent presence in the home, stronger parent and children relationships, and positive parent practices.
L	Learning	**Readiness & Support for Academic Success** Nearly 133,000 school-age children **have two or more ACEs**. Children with two or more ACEs are less likely to care about doing well in school and are more likely to have behavioral or conduct problems.
P	Parenting	**Parenting & Family Support** The vast majority of children in the service area (98%) have parents reporting that they are **coping well** (very or somewhat) with the day-to-day demands of raising children, and they have a source for emotional support with parenting (86%).

For more information, please see the full 2021 CHNA Report or visit our CHNA dashboard

Goal: Increase family resiliency through parenting and family support

Community Benefit Strategies	Community Benefit Measures	Anticipated Impact	Key Resources Available within Cook Children's*
Respond to the urgent needs of families raising children through challenging times or serious adversities (often referred to as Adverse Childhood Experiences). – Lead and sustain **Adverse Childhood Experiences (ACEs) Task Force** to plan and implement collaborative interventions to prevent or reduce trauma and protect well-being for children. – Lead and sustain **Hood County for Healthy Children** and **Wise Coalition for Healthy Children** to plan and implement programming that increases access to community resources and supports healthy parents and family resiliency. – Develop and distribute ACEs/evidence-informed education and interventions for parents, caregivers and ACEs survivors (**Build a Bridge®** and **Caregiver Alliance; Parent Cafés; and Survivors Like Us**). – Provide ACEs/evidence-informed education to providers and community members who will share skills, knowledge and tools with caregivers within their reach (**Parent Café Facilitator Training, Early Detection of Child Abuse and Neglect**). – Support community awareness campaigns and events to reduce child abuse and neglect (**April National Child Abuse Awareness Month**, **Child Health Summits**, and others). – Develop **PRO-TX** analytical tool for informing ACEs programming and resource allocation at Cook Children's and state agencies.	Community partner engagement outcomes for **ACEs Task Force**, **Hood County for Healthy Children**, **Wise Coalition for Healthy Children**, and **Caregiver Alliance.** Distribution of evidence-informed educational material, prevention resources, and toolkits (e.g., medical home files, coping skills cards, fidgets, JOY campaign). Education and engagement outcomes for caregivers through virtual and in-person events. Education and engagement outcomes for providers and community partners (e.g., post-training test completion/surveys, CEUs earned, etc.). Engagement of families and community partners in awareness campaigns and events; media coverage. Engagement outcomes for community partners that demonstrate organizational change (e.g., County agrees to include safe baby sleep materials to families requesting birth certificates). Qualitative impact stories from parents, caregivers, and partners.	Collaborative efforts with key stakeholders expand the reach of messaging, resource distribution, and organizational/policy change. Awareness for parents and caregivers improves regarding healthy parenting and family interactions. Protective factors increase for families (e.g., parent support networks, etc.). The impact of trauma is reduced and family resiliency increases.	**Center for Children's Health:** **ACEs Task Force:** A collaboration of community partners using a two-generation approach to reduce the impact of ACEs on children prenatal to five years of age, and prevent ongoing adversity for families to improve school readiness, literacy, and overall child well-being. **Hood County for Healthy Children** and **Wise Coalition for Healthy Children** are collaborations of both public and private organizations and individuals who implement **Parent Cafés** and other programs to support positive parenting and family resiliency. **Build-a-Bridge®:** A program that strengthens connections for children and families to health care and community resources, encouraging better overall health and well-being **Caregiver Alliance** is dedicated to improving the health of children through parenting and family support. Offers feedback from parents that improves health and access to care for the community. **Survivors Like Us**: A Facebook group for sharing information helpful to survivors of child abuse and neglect **Early Detection of Child Abuse and Neglect**: Online professional development course for medical professionals and first responders to recognize ACEs and report early signs and symptoms of child abuse or neglect. *Program Champion:* **Jayme Coffman, MD,** CARE Team

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INJURY PREVENTION BRIEF

Injury prevention focuses on preventing harm or death to children due to accidental or unintentional injuries. Unintentional injuries are the leading cause of death for children ages 1–17 in the U.S. and Texas. The leading cause of unintentional injury deaths varies by age group:

- **Infants**: suffocation due to unsafe sleep environments.
- **Children 1–4 years**: drowning.
- **Children 5–17 years**: motor vehicle traffic accidents.
- **Young children and teens**: unintentional poisoning and firearm injuries.

H.E.L.P. for Injury Prevention

H	Health	**Equitable Access to Care & Basic Needs** **One in 8 children** received emergency care for an accidental injury. This represents approximately **147,770 children** ages 0–17 (12%) in the eight-county service area. Aspects of injury prevention coincide with mental health — specifically self-harm, suicide, substance abuse and opioid addiction. **Nearly 9 in 10 community leaders** were concerned that COVID-19 was having a negative impact on safety in the home.
E	Environment	**Safety Where Children Live, Learn & Play** • Nearly **2 in 5 young children do not sleep alone** in their own cribs or beds • During swim time, 7% of young children **were not within reach of an adult** and 12% were not within reach of an adult during bath time. 80% of older children do not wear a life jacket. • **1 in 5 children** are not always buckled up while in a vehicle, and rates vary by age group and decrease with older children. • **1 in 4 young children** live in a home with medication or household cleaners that are not always safely stored away. • **10%** of young children, **20%** of 6–11 year olds and **30%** of 12–17 year olds live in a home with a **gun** that is **not always safely locked away**.
L	Learning	**Readiness & Support for Academic Success** **1 in 10 school-age children missed school** due to an accidental injury, with the highest percentage among children ages 12–17. Children experiencing **homelessness or living with an undocumented parent or caregiver** were twice as likely to have missed school due to accidental injury.
P	Parenting	**Parenting & Family Support** Parents need evidence-based education and training to increase awareness of the injury prevention measures for each stage of their child's life. Prioritize children in low-income areas, children in rural areas, and children of color.

For more information, please see the full 2021 CHNA Report or visit our CHNA dashboard

The Center for Children's Health led by Cook Children's

Goal: Increase safe infant sleep practices to reduce unintentional injuries to children

Community Benefit Strategies	Community Benefit Measures	Anticipated Impact	Key Resources Available within Cook Children's*
Respond to the urgent needs of families with unsafe sleep environments. – Lead and sustain **Safe Baby Sleep Council** to plan and implement safe sleep collaborative interventions. – Develop and distribute evidence-informed resources to promote or create safe sleep environments for infants, (e.g., sleep sacks, pack and plays). – Provide evidence-informed education and interventions for parents and caregivers that encourage safer habits (**Safe Baby Sleep and the ABCs of Zzzs).** – Provide safe baby sleep training to providers and community members who will share skills, knowledge, and safe sleep tools with caregivers within their reach (**Safe Baby Sleep Symposium**). – Support community awareness campaigns and events to encourage safe sleep practices.	Community partner engagement outcomes for **Safe Baby Sleep Council.** Distribution of evidence-informed educational material, prevention resources, and toolkits. Education and engagement outcomes for children and families. Education and engagement outcomes for provider professional development outcomes; use of education toolkits with families. Engagement of families and community partners in awareness campaigns and events; media coverage. Engagement outcomes for community partners that demonstrate organizational change (e.g., County agrees to include safe baby sleep materials to families requesting birth certificates). Qualitative impact stories from parents, caregivers, and partners.	Collaborative efforts with key stakeholders expand the reach of messaging, resource distribution, and organizational/policy change. Community awareness for parents and caregivers improves regarding safe sleep practices for infants. Injuries and deaths of infants caused by unsafe sleep practices are reduced.	**Center for Children's Health:** **Safe Kids North Texas-Fort Worth:** Community partners work together in a long-term, multifaceted effort to create sustainable community change that prevents unintentional childhood injuries. **Safe Baby Sleep Council:** Partners and key stakeholders across our community work together in an effort to create sustainable community change that prevents injuries and deaths to children caused by unsafe sleep practices. *Program Champion:* **Daniel Guzman, M.D.** Cook Children's Emergency Department

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Goal: Reduce drownings for children through collaborative prevention efforts

Community Benefit Strategies	Community Benefit Measures	Anticipated Impact	Key Resources Available within Cook Children's*
Respond to the urgent needs of children in settings where drownings are more likely to occur. – Lead and sustain **Safe Kids North Texas-Fort Worth** coalition to plan and implement water safety collaborative interventions. – Lead and sustain **Lifeguard your Child™** campaign to support water safety training and shared messaging for providers and community leaders who will share skills, knowledge and drowning prevention tools with partners and caregivers within their reach. – Develop and distribute evidence-informed resources to promote and support water safety for children (e.g., life jackets, water watcher tags, bathtub kneelers, pool signs, community partner toolkits, etc.). – Provide evidence-informed education and interventions for parents and caregivers on planned and unplanned water safety for pools, lakes, and bathtubs. – Support community awareness campaigns and events to reduce drownings.	Community partner engagement outcomes for **Safe Kids North Texas-Fort Worth** and **Lifeguard your Child™.** Distribution of evidence-informed educational material, prevention resources, and toolkits through **Lifeguard your Child™** and other outlets. Partner engagement for **Loaner Life Jacket Stations.** Education and engagement outcomes for children and caregivers (e.g., **Water Safety Club**). Education, engagement and organizational change outcomes for providers and community leaders from participation in **Lifeguard your Child™** (e.g., integrate drowning prevention messaging in publications, encourage use of prevention tools such as pool signs, etc.). Engagement of families and community partners in awareness campaigns and events; media coverage. Qualitative impact stories from parents, caregivers, and partners.	Collaborative efforts with key stakeholders expand the reach of messaging, resource distribution, and organizational/policy change. Community awareness for parents and caregivers improves regarding water safety practices for children. Injuries and deaths of children caused by drownings are reduced.	**Center for Children's Health:** **Safe Kids North Texas-Fort Worth:** Community partners work together in a long-term, multifaceted effort to create sustainable community change that prevents unintentional childhood injuries. **Lifeguard your Child™**: Annual drowning prevention campaign that includes community partners across 9 counties who align consistent messages and educational goals across our region. **Water Safety Club**: Free swim lessons and online resources are offered to children. **Loaner Life Jacket Stations**: Parents are able to borrow life jackets for their children at 21 lake locations throughout the region. *Program Champion:* **Daniel Guzman, M.D.** Cook Children's Emergency Department

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Goal: Increase child passenger safety practices to reduce unintentional injuries to children

The Center for Children's Health led by Cook Children's

Community Benefit Strategies	Community Benefit Measures	Anticipated Impact	Key Resources Available within Cook Children's*
Respond to the urgent needs of children who do not have car seats or properly installed car seats. – Lead and sustain **Safe Kids North Texas-Fort Worth** coalition to plan and implement motor vehicle safety collaborative interventions. – Develop and distribute evidence-informed resources to promote and support child passenger safety for children. – Provide evidence-informed education and interventions for parents and caregivers to keep children safe in the car and on the road – from car seats to car keys (**Car Seat Checks**). – Provide national Child Passenger Safety (CPS) Certification Course to providers and community members who will share skills and knowledge with caregivers within their reach. – Support community awareness campaigns and events to reduce injuries from motor vehicle crashes.	Community partner engagement outcomes for **Safe Kids North Texas-Fort Worth.** Distribution of evidence-informed educational material and prevention resources (e.g., car seats, booster seats). Education and engagement outcomes for caregivers through virtual and in-person car seat events (car seat checks and training). Education and engagement outcomes for providers and community leaders (car seat technician training participation and CEUs). Engagement outcomes for community partners that demonstrate organizational change (e.g., host car seat checks, train staff members as certified car seat technicians, etc.). Engagement of families and community partners in awareness campaigns and events; media coverage. Qualitative impact stories from parents, caregivers, and partners.	Collaborative efforts with key stakeholders expand the reach of messaging, resource distribution, and organizational/policy change. Community awareness for parents and caregivers improves regarding child passenger safety practices for children. Injuries and deaths of children caused by car crashes are reduced.	**Center for Children's Health:** **Safe Kids North Texas-Fort Worth:** Community partners work together in a long-term, multifaceted effort to create sustainable community change that prevents unintentional childhood injuries. **Car Seat Checks**: Parents and caregivers make an online appointment with a certified technician at strategic locations targeting areas with a higher number of injuries from motor vehicle crashes. FREE car seat checks and assistance to families who may need a car seat are provided. **Child Passenger Safety (CPS) Certification Course**: 3-day course to prepare technicians for training parents on the proper installation of car seats. *Program Champion:* **Daniel Guzman, M.D.** Cook Children's Emergency Department

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Goal: Increase poison prevention practices to reduce unintentional injuries to children

The Center for Children's Health led by Cook Children's

Community Benefit Strategies	Community Benefit Measures	Anticipated Impact	Key Resources Available within Cook Children's*
Respond to the urgent needs of children who were recently prescribed medication or have risk for accidental ingestion/overdose. – Lead and sustain **Safe Kids North Texas-Fort Worth** coalition to plan and implement poison prevention collaborative interventions. – Develop and distribute evidence-informed resources to promote and support poison prevention for children. – Provide evidence-informed education and interventions for parents and caregivers on methods and importance of medication safety and safe storage of household chemicals (**Safe Dosage, Safe Storage, and Safe Disposal**). – Provide ambassador training to providers and community members who will share skills, knowledge and poison prevention tools with caregivers within their reach. – Support community awareness campaigns and events to encourage poison prevention practices.	Community partner engagement outcomes for **Safe Kids North Texas-Fort Worth.** Distribution of evidence-informed educational material and prevention resources (e.g., medication lock boxes, cabinet locks, medication schedules, prescription bags, etc.). Education and engagement outcomes for caregivers and teens. Education and engagement outcomes for ambassadors (e.g., ambassador use of toolkits with families). Engagement outcomes for community partners that demonstrate organizational change (e.g., permanent medication drop locations, DEA Takeback events, etc.). Engagement of families and community partners in awareness campaigns and events; media coverage. Qualitative impact stories from parents, caregivers, and partners.	Collaborative efforts with key stakeholders expand the reach of messaging, resource distribution, and organizational/policy change. Community awareness for parents and caregivers improves regarding medication safety and safe storage of household chemicals. Injuries and deaths of children caused by unintentional poisoning are reduced.	**Center for Children's Health:** **Safe Kids North Texas-Fort Worth:** Community partners work together in a long-term, multifaceted effort to create sustainable community change that prevents unintentional childhood injuries. **Safe Dosage, Safe Storage, and Safe Disposal:** A best practices and education initiative to reach parents and caregivers and encourage safe practices for preventing unintentional poisonings. Strategies include medication schedules to facilitate safe dosing, medication lock boxes and education on safely storing medications and household chemicals; and safe disposal through using drug take back locations. *Program Champions:* **Daniel Guzman, M.D.** Cook Children's Emergency Department **Artee, Ghandi, M.D.** Medical Director CCHCS Pain Management Clinic Cook Children's Opioid Stewardship Committee

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The Center for Children's Health led by Cook Children's

Goal: Increase gun safety practices to reduce unintentional injuries to children

Community Benefit Strategies	Community Benefit Measures	Anticipated Impact	Key Resources Available within Cook Children's*
Respond to the urgent needs of children more likely to have a gun-related injury in the home. – Lead and sustain **Safe Kids North Texas-Fort Worth** coalition to plan and implement gun safety collaborative interventions. – Develop and distribute evidence-informed resources to promote and support gun safety for children. – Provide evidence-informed education and interventions for parents and caregivers on methods and importance of safe storage and gun safety (**Aim for Safety® - Safe Storage. Safe Children. Safe Play**). – Provide ambassador training to providers and community members who will share skills, knowledge, and gun safety tools with caregivers within their reach. – Support community awareness campaigns and events to reduce gun-related injuries.	Community partner engagement outcomes for **Safe Kids North Texas-Fort Worth.** Distribution of educational material and prevention resources (e.g., locks, safes or vaults). Education and engagement outcomes for children, teens and families (e.g., new content development and family use of augmented reality opportunities in partner retail settings). Education and engagement outcomes for community partners, trained ambassadors, and teen champions; organizational change outcomes from partners. Engagement of families and community partners in awareness campaigns and events; media coverage. Qualitative impact stories from parents, caregivers, and partners.	Collaborative efforts with key stakeholders expand the reach of messaging, resource distribution, and organizational/policy change. Community awareness for parents and caregivers improves regarding gun safety. Injuries and deaths of children caused by unintentional access to guns are reduced.	**Center for Children's Health:** **Safe Kids North Texas-Fort Worth:** Community partners work together in a long-term, multifaceted effort to create sustainable community change that prevents unintentional childhood injuries. **Aim for Safety®-Safe Storage. Safe Children. Safe Play:** A Cook Children's initiative designed to help reduce the number injuries we see every year among children through gun safety education. This is not about whether guns are right or wrong. It's about taking the necessary steps to protect our children. *Program Champion:* **Daniel Guzman, M.D.** Cook Children's Emergency Department

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ASTHMA BRIEF

Child asthma is a lung disease with symptoms of breathing difficulties. Asthma symptoms can be managed with appropriate medications and reduced exposure to allergens within a child's environment. If symptoms are not properly managed, children miss school, need emergency care or require hospitalization. **One in 10 children** (an estimated 118,700 children) in our eight-county service area currently have asthma. Of these children, 8% visited an emergency room in the past year because of asthma symptoms. The local rate (10%) is slightly higher than the statewide rate (7%) and the national rate (8%).

H.E.L.P. for Asthma

H	Health	**Equitable Access to Care & Basic Needs** Of children with asthma in the eight-county service area, **1 in 6** do not have a personal doctor and **1 in 7** did not receive needed medical care during the pandemic. **One in 12 children** with asthma visited an emergency department due to symptoms in the past year — rates are highest among children in households with incomes below $50,000, Hispanic or Non-Hispanic Black children.
E	Environment	**Safety Where Children Live, Learn & Play** Although children experiencing **homelessness or living with an undocumented parent or caregiver** have slightly lower rates of asthma, these children are twice as likely to not have a personal doctor or continuous insurance coverage, and are nearly three times as likely to not receive care. Children living in **households with income below $50,000** have higher rates of asthma and are **12 times more likely** to visit an emergency room for asthma symptoms when compared with children in higher-income families.
L	Learning	**Readiness & Support for Academic Success** Of school-age children with asthma in the eight-county service area, **1 in 4** missed school due to asthma symptoms. Children experiencing homelessness or living with an undocumented parent or caregiver have higher rates of missed school.
P	Parenting	**Parenting & Family Support** Focus group parents recommend increased community awareness about asthma symptoms and triggers to provide additional support from the local community.

For more information, please see the full 2021 CHNA Report or visit our CHNA dashboard.

The Center for Children's Health led by Cook Children's

Goal: Improve control of childhood asthma

Community Benefit Strategies	Community Benefit Measures	Anticipated Impact	Key Resources Available within Cook Children's*
Healthy Homes Respond to the urgent needs of children with increased risk of uncontrolled asthma. – Coach families to identify asthma triggers in the home. – Purchase and distribute practical asthma trigger remediation items and services to maintain a clean home environment. – Equip families with educational materials and practical tools for adopting prevention-oriented practices. – Follow up with families to support progress. – Connect families with community resources to address immediate needs (health care, food, etc.). – Support community campaigns and events to increase awareness about uncontrolled asthma. **Asthma 411** Support prevention-oriented care in school settings. – Equip school nurses with the necessary training and medication needed to quickly respond to a child in respiratory distress. – Enhance school asthma services.	Family coaching session outcomes (virtual and home visits) such as reduction of dust, pests, strong smells and smoke. Home services and equipment provided (vacuum cleaners, air conditioner filters, pest control, etc.). Distribution of educational materials and practical tools. Referrals made for community resources. Follow up services provided. Progress of child's asthma symptoms. Engagement of families and community partners in awareness campaigns and events; media coverage. Qualitative impact stories from parents, caregivers, and partners. Distribution of educational materials, medication and supplies to schools. School Nurse Symposium engagement and education outcomes for provider professional development; use of education toolkits with families.	Parents and caregivers improve awareness regarding prevention-oriented care for children with asthma. Children with asthma live in homes with reduced or no asthma triggers. School nurses increase awareness of asthma prevention and have access to needed resources for children in respiratory distress. Number of visits to school nurses and emergency room for asthma decrease. Overall health and quality of life improve for children receiving services.	**Center for Children's Health:** **Healthy Homes:** Improves the quality of life for children with asthma and their families. Services help eliminate potential triggers in the home and provide cleaning supplies and education to make the home a healthier place for the child with asthma. Participants are in the program for three months and receive home visits and follow-up calls every month to evaluate the progress of the child's asthma symptoms and monitor use of school nurse or emergency room visits. **Asthma 411:** A school-based program to equip school nurses with medication needed for students with asthma to reduce missed school and emergency department visits. Cook Children's, along with UNT Health Science Center, SaferCare Texas, JPS/Acclaim Physician Group and Tarrant County school districts, work together to enhance services and training for school nurses. *Program Champion:* **Phillip Scott, M.D.** Hospitalist, Cook Children's Medical Center

*Many services are offered throughout our health care system to support priority children's health needs identified in the CHNA. This list focuses on internal partners directly working with C4CH to support increasing awareness with key prevention messages. External community resources and partners are outlined in the AVAILABLE RESOURCES section.

CHILD HEALTH ISSUES NOT DIRECTLY ADDRESSED

Children and their families face many health issues identified in our assessment which are beyond the scope, resources and capacity for Cook Children's to develop active community programs. Those issues are being addressed in the community and Cook Children's takes active leadership or supporting roles in such child health areas as Infant Mortality, Teen Pregnancy, Child Drug Use and Substance Abuse, School Graduation Rates, Vision and Hearing Screening and others. Currently Cook Children's is active in the following community-wide initiatives:

Big Tent Mental Health Connection Parker County
Children's Well-Being Collaborative (Tarrant)
Children's Hospital Association Board, Child Health Committee
Johnson County Community Resource Group
Blue Zones Project Fort Worth
Johnson County Mental Health Connection
Burleson Be Healthy Initiative (Johnson)
Mental Health Connection of Tarrant County (Tarrant)
Child Fatality Review Team – Tarrant County
NorTex Community Advisory Board
Denton Regional Suicide Prevention Coalition (Denton)
Tarrant Area Food Bank
Early Learning Alliance of North Texas (Tarrant)
Children at Risk - North Texas
North Texas Asthma Consortium
North Texas Health Alliance
Community Response to Homelessness in Early Childhood (Tarrant)
Nurse Family Partnership Advisory Board (Tarrant)
Denton County Behavioral Health Leadership
Parker County Community Resource Group
Denton County Healthy Communities Coalition
Texas Child Heat Stroke Task Force
Fort Worth Drowning Prevention Coalition (Tarrant)
Texas Drowning Prevention Alliance Fort Worth Safe Communities (Tarrant)
THR Harris Fort Worth Community Health Council (Tarrant)
United Way Steering Committee – Arlington (Tarrant)
Healthy Tarrant County Collaboration
Early Childhood Wellness Council (Tarrant)
UNT Health Science Center - Community Advisory Board
Hood County Substance Abuse Council
UNT Health Science Center SaferCare Texas
Immunization Collaboration of Tarrant County
Wise County Health Forum
First3Years (All 8 counties)
Tarrant Cares (Governance Board)—Tarrant
Mental Health Connection (Recognize & Rise Steering Committee)—Tarrant
Health Equity Alliance (HEAL)—Tarrant
MHMR-Help Me Grow North Texas (All 8 counties)
Urban Strategies (Tarrant)
Best Place for Kids (Tarrant)
TexProtects

AVAILABLE RESOURCES

Selected key resources are listed below for the children's health needs identified in this assessment for the eight-county primary area served by **Cook Children's Medical Center–Fort Worth and Cook Children's Medical Center-Prosper**. Many additional community resources are available and accessible through 211 Texas (www.211texas.org); Tarrant Cares and TXT 4 Tarrant Cares (www.tarrantcares.org).

SELECTED COMMUNITY RESOURCES		
Priority	**Organization**	**County**
Parenting & Family Support	ACH Children and Family Services	Tarrant
	Center of Hope	Parker
	City House	Collin
	Children's Advocacy Center	Collin, Denton, Grayson, Hood, Johnson, Parker, Tarrant, Wise
	Court Appointed Special Advocates (CASA)	Collin, Denton, Grayson, Hood, Johnson, Parker, Tarrant, Wise
	Family Resource Center	Denton
	Help Me Grow North Texas	Collin, Denton, Grayson, Hood, Johnson, Parker, Tarrant, Wise
	Children @ Risk	Collin, Denton, Grayson, Hood, Johnson, Parker, Tarrant, Wise
	Lena Pope Counseling Services	Parker, Tarrant
	MasterKey Ministries of Grayson County	Grayson
	Mission Granbury	Hood
	Rancho Brazos Community Center	Hood
	The Parenting Center	Tarrant
	The Women's Center of Tarrant County	Tarrant

Oral Health Care	Catholic Charities Dental	Tarrant
	Collin County Community College Dental Hygiene Center	Collin
	Denton Kiwanis Club Children's Clinic	Denton
	Family Health Center on Virginia	Collin
	Denton County Public Health – Dental Hygiene Clinic	Denton
	First Refuge Ministries Dental	Denton
	Fort Worth District Dental Society	Tarrant
	Mercy Clinic (Medical, Dental)	Tarrant
	Tarrant County College Dental Hygiene Clinic	Tarrant
	Texas Woman's University Dental Hygiene Clinic	Denton
	Community Dental Care	Collin, Grayson
	Dental Health Arlington	Tarrant
	Four Rivers Dental Clinic	Denton
	Mission Arlington	Tarrant
	Smiles for Everyone Foundation	Collin, Denton, Grayson
	Texas Dental Association Smiles Foundation	Collin, Denton, Grayson
General Health & Injury Prevention	Beautiful Feet Ministries | Homeless Services	Tarrant
	Clinica Guadalupe	Tarrant
	Southeast Community Health Center	Tarrant
	Health Equity Alliance (HEAL)	Tarrant
	Community Healthcare Clinic	Collin
	Cornerstone Assistance Network and Medical Services	Tarrant
	Crowley House of Hope Clinic	Tarrant

	Denton County MHMR	Denton
	Grand Prairie Community Health Center	Tarrant
	Grapevine Relief and Community Exchange	Tarrant
	Grayson County MHMR	Grayson
	JPS Health Network	Tarrant
	LifePath Systems (Collin County MHMR)	Collin
	MHMR Tarrant County	Tarrant
	Mission Arlington	Tarrant
	North Texas Area Community Health Centers	Tarrant
	Open Arms Health Clinic	Tarrant
	UNT Health Science Center, Patient Care Center, Pediatrics	Tarrant
Hospitals	Baylor Medical Center Irving	Collin, Denton
	Baylor Scott and White Health	Collin, Denton, Grayson, Tarrant
	Children's Medical Center	Collin, Denton, Grayson
	Denton Regional Medical Center	Denton
	Huguley Memorial Medical Center	Tarrant
	Lake Granbury Medical Center	Hood
	JPS Health Network	Tarrant
	Medical City Healthcare	Collin
	Methodist Charlton Family Medicine Center	Collin
	North Texas Medical Center	Grayson
	Plaza Medical Center of Fort Worth	Tarrant
	Presbyterian Hospital of Denton	Denton
	Texas Health Resources / Texas Health Presbyterian	Collin, Denton, Grayson, Johnson, Parker, Tarrant

	Texhoma Medical Center	Grayson, Collin
	University Behavioral Health of Denton	Denton
	Wilson N. Jones Regional Medical Center	Grayson, Collin
	Wise Health System	Wise
Last Resort Funding	Community Services, Inc.	Collin, Denton
	Christian Community Action	Denton
	Christian Homes & Family Services	Collin, Denton, Grayson
	Family Promise of Collin County	Collin
	Family Promise of Grayson County	Grayson
	Gill Children's	Tarrant
	Masonic Children and Family Services of Texas	All counties
	Northwest Christian Community Services	Denton
	Patient Access Network Foundation	Collin, Denton, Grayson
	United HealthCare Children's Foundation	Collin, Denton, Grayson
Public Health Agencies	Collin County Public Health	Collin
	Denton County Public Health	Denton
	Parker County Hospital District	Parker
	Tarrant County Public Health	Tarrant

Cook Children's Health Care System offers a medical center, **seven** neighborhood clinics to serve low-income families in Tarrant County, and over **40** primary care offices and urgent care centers in Collin, Denton, Hood, Johnson, Parker and Tarrant counties. Please see www.cookchildrens.org for specific locations.

CONTACT INFORMATION

2021 CHNA Implementation Strategy Plan

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For additional information:

- Email chnafeedback@cookchildrens.org
- Visit centerforchildrenshealth.org
- Review our full 2021 Community Health Needs Assessment

APPENDIX A

Cook Children's Health Plan

FORT WORTH MEDICAL CENTER

Denton, Hood, Johnson, Parker Tarrant & Wise Counties

Cook Children's Health Plan

IMPLEMENTATION STRATEGY PLAN

Population Health Needs aligned with Cook Children's Priority Focus Areas

2021 Community Health Needs Assessment

Approved by Population Health Subcommittee March 29, 2022

OVERALL HEALTH & EQUITABLE ACCESS TO CARE

Goal: Increase equitable access to quality health care for children by supporting a community-base service delivery system

Health Plan Strategies	Measures	Anticipated Impact	Key Health Plan Resources and Community-Based Collaborations
Maintain a **family-centered care delivery approach** to aid in the recovery and healing process for children and support each child's growth and wellbeing. ***Professional Training*** – Family-centered care skills (Cook Children's Medical Center Family Support Services training-October 2022-2023-2024). – Best practice parent-mentor support and coaching skills. – SDOH education and screening to identify basic needs (STAR/Chip). – Early childhood intervention (developmental screenings and referrals) for children ages 0 – 6. (Help Me Grow North Texas-Family Services, Early Childhood Intervention services of Texas, Star Kids Care Management and CHIP/STAR Case Management teams). – Community resources available and how to connect families to appropriate referrals and help them navigate receiving services. *Continued*	Staff increased knowledge about family-centered care; SDoHs; evidence-based practices for impoverished and special populations; and community resources and referral processes for basic needs. Staff increased knowledge about developmental screenings, interventions for young children and referral processes. Staff skills in providing family-centered care and interventions based on specific family needs (SDoHs). Staff use of progress records to assess members' ability to understand their disease. *Continued*	Staff have a better understanding of how various SDoHs impact member health conditions; and the core concepts of family-centered care (respect and dignity, information sharing, participation, and collaboration). Increased efficiency in CCHP resource information collection, storing, and disseminating. Intervention services and program designs for health conditions are focused on addressing the specific SDoH needs (e.g., intake assessments ask the right SDoH questions to discover and address each family's barriers to managing care). SDoH barriers are reduced or removed (e.g., asthma triggers removed from home environment). *Continued*	**PRAPARE**: A data collection resource designed to equip healthcare and associated community partners to better understand and act on individuals' SDoH. Provides an Implementation and Action Toolkit with resources, best practices, lessons learned to guide implementation, data collection, and responses to SDoH needs. **PAM**: A 100-point quantifiable scale determining patient engagement in healthcare. PAM measures the ability of patients to self-manage problems, engage in activities that maintain functioning, be involved in treatment and diagnostic choices, and to select and collaborate with quality providers. **Baby Steps:** CCHP members who are pregnant receive support to have a healthy pregnancy and baby. Members can receive pregnancy and newborn information (English, Spanish or other languages) mailed to their home, educational materials, phone help from nurses, information about programs such as WIC, and help with rides to medical appointments. **Care Management Population Health Program**: A health and wellness opportunity for CCHP members that promotes health screenings and wellness programs. Services include individualized case management by an RN, social worker or community health worker to guide members through an assessment of their health and SDoH needs. Then a collaborative plan for addressing those needs is done with the member, case manager and any others in the member's realms of family and health care team. *Continued*

Health Plan Strategies	Measures	Anticipated Impact	Key Health Plan Resources and Community-Based Collaborations
– Team meetings and presentations throughout 2022 with each of the Community Based Organizations. – Ongoing support and coaching for families to follow through on evidence-based interventions. ***Family Feedback*** – Continue seeking feedback from participating parents about their experience receiving care to ensure continued focus on the family experience through post program participation surveys. ***Data Management*** *(CCHP resources that facilitate timely and accurate identification of member families' needs to prevent or address health inequities).* – Utilize the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (**PRAPARE**) data tool to analyze 16 measures of social determinates of health (SDoH) and their correlation with health status. – Utilize Patient Activation Measures (**PAM**) to measure the ability of members to self-manage their own or their child's health conditions. *Continued*	Members and their parents and caregivers have a better understanding of disease management, and the emotional support needed to independently manage the condition and obtain earlier treatment. SDoH screening data is analyzed quarterly and specific target populations are identified using multiple factors that could be related to poor health, and trends in membership needs. SDoH screening data is analyzed to identify areas of focus for SDoH strategic plan. PAM scores are analyzed to assess the ability of members to self-manage their own or their child's health conditions. Progress records are analyzed to assess members' ability to understand the health condition. *Continued*	Healthy parenting and family interactions increase. Collaborative continuity of care improves quality of care. The member healthcare experience and their children's recovery and healing process improves. Children receive the care they need and health outcomes improve. Fewer acute exacerbations of health conditions leads to reduced need for health care services. Community partnerships increase with key stakeholders who provide proven interventions to overcome SDoHs and health care conditions. Collaborative efforts with key stakeholders expand the reach of messaging, resource distribution, and organizational/policy change.	**Parent Partner Program:** CCHP members across all lines of business can receive mentoring from a Parent Partner Coordinator with experience caring for a child with special health care needs and navigating the journey many parents face in these circumstances (e.g., former Medicaid recipient). The coordinator is trained in best-practice parenting and provides emotional support and connections to community resources. **Center for Children's Health**: Conducts a CHNA every three years to identify priority children's health issues and barriers to care that produce healthcare inequities. A parent survey is conducted on an ongoing basis to provide current data. The center uses CHNA data to guide community programs and stakeholder collaborations that *prevent* illness, disease and injuries for children. CCHP works closely with the community outreach arm for Cook Children's to stay informed about barriers to care and support community initiatives that impact member families. **Safe Baby Sleep Council**: A collaboration led by Cook Children's and supported by numerous partners and key stakeholders across our community. They work together in a long-term, multifaceted effort to create sustainable community change that prevents injuries and deaths to children caused by unsafe sleep practices. **Safe Kids North Texas-Fort Worth:** A coalition led by Cook Children's and supported by numerous partners and key stakeholders across our community. They work together in a long-term, multifaceted effort to create sustainable. *Continued*

Health Plan Strategies	Measures	Anticipated Impact	Key Health Plan Resources and Community-Based Collaborations
– Review Z codes from claims to identify areas in our community that need additional support with SDoH resources. Work with **Center for Children's Health** to periodically review the community health needs assessment (CHNA) data. ***Community Resources*** *(Manage, integrate and update comprehensive local, regional, and national resources to fully address the wide range of support needs for families).* – Continue fostering ongoing professional relationships with key service providers to remain informed about resources needed by member families and facilitate referrals *(see examples of key partners at right).* – Develop a **Community Resources Committee** to research new community resources and create a centralized access point for staff to easily find them. ***Community & Provider Collaboration*** *(Support collaborative parent support initiatives to extend the reach of health messaging, resource distribution and educational opportunities*). – Collaborate with Primary Care Physician (PCP), specialists, member and family regarding ongoing care. Work with the providers in our alternative payment programs (APM) to enhance the care they are giving. *Continued*	CHNA findings help identify and address barriers to health care as reported by parents. Formative (process) outcomes for the Community Resources Committee and the creation of a centralized access point for finding community resources. CCHP support for coalition collaborative initiative outcomes.		community change that prevents unintentional childhood injuries. Programs for families focus on child passenger safety, drowning prevention, poison prevention and gun safety. **Asthma 411** is a school-based program to equip school nurses with medication needed for students with asthma to avoid missed school and emergency department visits. Cook Children's, along with UNT Health Science Center, SaferCare Texas, JPS/Acclaim Physician Group and Tarrant County school districts, work together to enhance services and training for school nurses. **Healthy Homes** improves the quality of life for children with asthma and their families. Services help eliminate potential triggers in the home and provide cleaning supplies and education to make the home a healthier place for the child with asthma. Participants are in the program for three months and receive home visits and follow-up calls every month to evaluate the progress of the child's asthma symptoms and monitor use of school nurse or emergency room visit **Center for Transforming Lives**: Focuses on disrupting the cycle of poverty for Tarrant County women and children. Services are two-generational and establish long-term financial and emotional well-being. Comprehensive services include housing, early childhood education, economic mobility, and clinical counseling services **Help Me Grow North Texas** (a program of My Health, My Resources Tarrant): Works to promote collaboration across child-serving sectors in order to build a more efficient and effective system that promotes the optimal health development of young children. Focuses on linking families to information and community resources related to pregnancy, child development, and parenting. Provides staff training for community organizations to help parents understand and track their child's developmental stages. *Continued*

Health Plan Strategies	Measures	Anticipated Impact	Key Health Plan Resources and Community-Based Collaborations
– Provide training to providers and community members to better understand the role of SDOHs in family-centered care and available community resources through Z code training and APMs. Participate in collaborative initiatives that make a collective impact for families in our service area (see Community-Based Collaborations at right).			**Special Supplemental Nutrition Program for Women, Infants and Children**: Popularly known as **WIC**, this nutrition program for pregnant women and families younger than five provides healthy food, one-on-one nutrition counseling, recipes and cooking demonstrations, nutrition classes and breastfeeding support. **Tarrant Area Food Bank**: An organization working to empower communities in 13 North Texas counties to alleviate hunger by providing food, education, and resources. Some of the services available include coaching on distribution, preparation and safe storage of nutritious food, assistance with SNAP applications, nutrition counseling and classes on purchasing food and preparing healthy recipes. **Healthy Texas Women program** offers **women's** health and famil planning services at no cost to eligible **women** in **Texas.** **Family Connects** North Texas **is a FREE nurse home visiting program for all families with newborns.** **Nurse-Family Partnership** is a program for women who are having their first baby. A registered nurse will visits in home throughout pregnancy and continue to visit until the baby is 2 years old.).

MENTAL HEALTH

Goal: Improve child mental health and well-being

Health Plan Strategies	Measures	Anticipated Impact	Key Health Plan and Community-Based Collaborations
Support access to care and services for families struggling with mental health challenges. – Provide mental health education to parents of children with mental health challenges (e.g., ADHD) about their child's condition, possible medications and potential side effects, managing the child's condition, and the importance of following up with physicians or other providers (**CCHP Population Health Program**). – Provide mental health education to pregnant and post-partum mothers about mental health concerns such as depression that sometimes occur during pregnancy and after the birth of their baby (**CCHP Population Health Program, Baby Steps**). – Increase access to mental health resources for low-income women and children to promote diagnosis and treatment and reduced barriers to health care (**Baby Steps**). – Provide evidence-informed education and interventions for mental health care including assessment and coaching. – Support members to enroll in Healthy Texas Women and Healthy Texas Women plus program.	Children diagnosed with ADHD and filling prescriptions for the first time will have a follow up visit with their providers within 30 days of starting their medications. Education and engagement outcomes for parents and caregivers. Engagement and community initiative outcomes for coalitions and collaborative efforts. CCHP support for coalition collaborative initiative outcomes.	Parents increase understanding about the diagnosis and treatment of their child's mental health issues. Pregnant and postpartum mothers increase understanding about the impact of depression occurring during and after pregnancy, and the impact on their ability to care for their newborn and family. Women recognize the signs of mental illness and seek resources to address it for their health as well as that of their child and family. Increased access to care and treatment for mental health concerns result in better attendance and success in school, and better relationships in the home environment. Collaborative efforts with key stakeholders expand the reach of messaging, resource distribution, and organizational/policy change.	**CCHP Population Health Program:** A health and wellness opportunity for CCHP members that promotes health screenings and wellness programs. Services include individualized case management by an RN, social worker or community health worker to guide members through an assessment of their health and SDoH needs. Then a collaborative plan for addressing those needs is done with the member, case manager and any others in the member's realms of family and health care team. **My Health, My Resources (MHMR**) - For over 50 years, MHMR has provided community-based services for youth and adults with intellectual and developmental disabilities (IDD), mental health conditions, and substance use disorders, as well as babies and young children with developmental delays. MHMR employees use a person-centered approach to fulfill the mission: We Change Lives! Using innovative approaches, MHMR partners with community organizations to provide services and a hopeful future. **Baby Steps:** CCHP members who are pregnant receive support to have a healthy pregnancy and baby. Members can receive pregnancy and newborn information (English, Spanish or other languages) mailed to their home, educational materials, phone help from nurses, information about programs such as WIC, and help with rides to medical appointments. **Nurse-Family Partnership** is a program for women who are having their first baby. A registered nurse will visits in home throughout pregnancy and continue to visit until the baby is 2 years old).

Goal: Improve access to nutritious food and physical activity for children

Health Plan Strategies	Measures	Anticipated Impact	Key Health Plan and Community-Based Collaborations
Protect the health of low-income women and infants by supporting exclusive breast feeding for at least six months after birth (**Baby Steps**). – Provide education and coaching for pregnant women on the benefits of breast feeding. – Connect pregnant members with community resources that support breast feeding and healthy infant care (**WIC**). Increase access to resources for low-income women and children to promote health and wellness (**Population Health Program**). – Provide evidence-informed education and interventions for healthy eating habits and physical activity. Guide members in obtaining evidence-informed information and interventions from community partners (e.g., **Tarrant Area Food Bank** to facilitate affordable and healthy food choices).	Baby Step participants will breast feed their newborn exclusively for 6 months. Education and engagement outcomes for families receiving coaching and referrals. Referrals made to community partners (e.g., **Help Me Grow-North Texas**). Coalition engagement outcomes with community partners and volunteers. CCHP support for coalition collaborative initiative outcomes.	Pregnant women increase awareness regarding the health benefits of breast feeding a newborn. Parents and caregivers increase knowledge about caring for children with special needs. Families receive supportive services from community partners; food security and other SDoHs are addressed. Infants are healthier with fewer ear infections, asthma, lower respiratory infections, childhood obesity and other infections and diseases. Collaborative efforts with key stakeholders expand the reach of messaging, resource distribution, and organizational/policy change.	**Baby Steps:** CCHP members who are pregnant receive support to have a healthy pregnancy and baby. Members can receive pregnancy and newborn information (English, Spanish or other languages) mailed to their home, educational materials, phone help from nurses, information about programs such as WIC, and help with rides to medical appointments. **Special Supplemental Nutrition Program for Women, Infants and Children**: Popularly known as **WIC**, this nutrition program for pregnant women and families younger than five provides healthy food, one-on-one nutrition counseling, recipes and cooking demonstrations, nutrition classes and breastfeeding support. **Population Health Program**: A health and wellness opportunity for CCHP members that promotes health screenings and wellness programs. Services include individualized case management by an RN, social worker or community health worker to guide members through an assessment of their health and SDoH needs. Then a collaborative plan for addressing those needs is done with the member, case manager and any others in the member's realms of family and health care team. **Tarrant Area Food Bank**: An organization working to empower communities in 13 North Texas counties to alleviate hunger by providing food, education, and resources. Some of the services available include coaching on distribution, preparation and safe storage of nutritious food, assistance with SNAP applications, nutrition counseling and classes on purchasing food and preparing healthy recipes for children's physical health. CCHP representatives attend meetings, help implement initiatives, and share educational materials with members. **UNICEF Kid Power**, an innovative child health initiative that encourages elementary school-age kids in the United States to get physically active in order to help save the lives of their peers in developing countries. **Help Me Grow North Texas** - promotes child development by working to successfully link families to community resources that meet their needs. This happens through cross system collaboration of existing community resources that meet all family's needs. Help Me Grow North Texas provides an information line that connects a family or provider to child development services and other community-based resources within your area including an experienced child development specialist, a Family Navigator, who can provide education, resources, and information on developmental screenings to meet a family's specific needs. Call 844-NTX-KIDS (844-689-5437) to get connected with a Family Navigator.

PARENTING AND FAMILY SUPPORT

Goal: Increase parenting and family support to promote family resiliency

Health Plan Strategies	Measures	Anticipated Impact	Key Health Plan and Community-Based Collaborations
Provide the emotional and health care support needed for members with special health care needs and their caregivers to aid in the recovery and healing process for children and support each child's growth and wellbeing (**Parent Partner Program** and **Baby Steps**). – Provide evidence-informed education and interventions for health condition management, child development and behavior, parenting, etc. (e.g., **Period of Purple Crying®**). – Provide emotional support services to help parents and caregivers know how to address parent/caregiver stress, burnout, fatigue, lack of motivation, and feeling overwhelmed. – Guide members in obtaining evidence-informed information and interventions from community partners (e.g., **The Parenting Center).**	Education and engagement outcomes for families receiving coaching and referrals. Community partner engagement and referrals to key community-based resources. Learning and engage-ment outcomes for families receiving education, coaching and referrals. Coalition engagement outcomes with community partners and volunteers. CCHP support for coalition collaborative initiative outcomes. Provide gift card incentives for well child checkups through our value added services program.	**Parent Partner participants** have the emotional support and targeted care options they need to adequately care for their child and for themselves. **Parents and caregivers** increase knowledge about caring for children with special needs. **Families receive** supportive services from community partners; food security and other SDoHs are addressed. **Healthy parenting** and family interactions increase. **The recovery and healing** process for children with chronic health conditions improves. Collaborative efforts with key stakeholders expand the reach of messaging, resource distribution, and organizational/policy change.	**Parent Partner Program:** CCHP members across all lines of business can receive mentoring from a Parent Partner Coordinator with experience caring for a child with special health care needs and navigating the journey many parents face in these circumstances (e.g., former Medicaid recipient). The coordinator is trained in best-practice parenting and provides emotional support and connections to community resources. **Baby Steps:** CCHP members who are pregnant receive support to have a healthy pregnancy and baby. Members can receive pregnancy and newborn information (English, Spanish or other languages) mailed to their home, educational materials, phone help from nurses, information about programs such as WIC, and help with rides to medical appointments. **Period of Purple Crying®:** An evidence-based program that teaches parents about early increased infant crying that is a normal part of every infant's development. The education is designed to teach practical tools for avoiding frustration that leads to shaken baby syndrome and abusive head trauma in infants. **The Parenting Center (Fort Worth, TX)**: Provides family members and professionals with resources, tools, and services to reduce the risk of child abuse and other adverse childhood experiences. Key services include family life education, clinical counseling and play therapy, marriage skills training. **Findhelp.org** – Program which connects families with assistance to find help for SDoH needs in the community in which they live and work. **Center for Transforming Lives**: Focuses on disrupting the cycle of poverty for Tarrant County women and children. Services are two-generational and establish long-term financial and emotional well-being. Comprehensive services include housing, early childhood education, economic mobility, and clinical counseling services.

INJURY PREVENTION

Goal: Reduce unintentional injuries to children

Health Plan Strategies	Measures	Anticipated Impact	Key Health Plan and Community-Based Collaborations
Increase safe practices for infant sleep environments, drowning prevention, and child passenger safety. – Provide evidence-informed education and interventions for injury prevention, including drowning prevention, child passenger safety, and safe sleep (**Baby Steps**). – Guide members in obtaining evidence-informed information and interventions from community partners (e.g., **Safe Kids North Texas**). Support collaborative injury prevention initiatives to extend the reach of health messaging, resource distribution and educational opportunities (**Safe Kids North Texas, Safe Baby Sleep Council** and others).	Learning and engagement outcomes for families receiving education, coaching and referrals. Parents and caregivers increase knowledge about injury prevention. Pregnant mothers are educated to obtain and install a car seat prior to birth of their baby. Provide parents with a bath kneeler through our value added services program to prevent tub drownings. Community partner engagement and referrals to key community-based resources (e.g., **Safe Kids North Texas**). CCHP support for coalition collaborative initiative outcomes.	Parents and caregivers increase understanding and about safe sleep environments, drowning prevention and child passenger safety. Parents and caregivers receive prevention tools to aid safety practices (e.g., bath tub kneelers, etc.). Families receive supportive services from community partners; food security and other SDoHs are addressed. Unintentional injuries and deaths of children from SIDS, drowning and motor vehicle crashes are reduced. Collaborative efforts with key stakeholders expand the reach of messaging, resource distribution, and organizational/policy change.	**Baby Steps:** CCHP members who are pregnant receive support to have a healthy pregnancy and baby. Members can receive pregnancy and newborn information (English, Spanish or other languages) mailed to their home, educational materials, phone help from nurses, information about programs such as WIC, and help with rides to medical appointments. **Safe Kids North Texas-Fort Worth:** A coalition led by Cook Children's and supported by numerous partners and key stakeholders across our community. They work together in a long-term, multifaceted effort to create sustainable community change that prevents unintentional childhood injuries. Programs for families focus on child passenger safety, drowning prevention, poison prevention and gun safety. **Safe Baby Sleep Council**: A collaboration led by Cook Children's and supported by numerous partners and key stakeholders across our community. They work together in a long-term, multifaceted effort to create sustainable community change that prevents injuries and deaths to children caused by unsafe sleep practices.

ASTHMA

Goal: Improve control of childhood asthma

Health Plan Strategies	Measures	Anticipated Impact	Key Health Plan and Community-Based Collaborations
Provide parents of children with asthma the education, coaching and referrals to successfully manage asthma triggers and symptoms. – Provide evidence-informed education and interventions for parents and caregivers to understand asthma, medication and equipment options and asthma management (Parent Partner Program and Baby Steps). – Guide members in obtaining evidence-informed information and interventions from community partners (e.g., Healthy Homes). Use CCHP data tools to identify SDoHs and develop target interventions and assess the ability of members to self-manage their child's asthma. Extend the reach of health messaging, resource distribution and educational opportunities through collaborative initiatives that make a collective impact for families in our service area (Asthma 411, and others). Work with providers and our APM programs to enhance collaboration between providers and CCHP CM program. Work with CCMC Asthma CM and Dr. Phillip Scott to enhance the outreach pre and post hospitalization without duplication of services.	Learning and engagement outcomes for families receiving education, coaching and referrals. Community partner engagement and referrals to key community-based resources (e.g., Healthy Homes). CCHP support for coalition collaborative initiative outcomes. Survey members and LARs after participation in the Asthma Program to measure satisfaction and revise program based on this feedback.	Parents and caregivers have a better understanding of asthma management and triggers leading to the ability to independently manage the condition and obtain earlier treatment. Specific barriers to a healthy environment that controls asthma triggers are identified. SDoH barriers are reduced or removed (e.g., asthma triggers removed from home environment). Families receive supportive services from community partners; food security and other SDoHs are addressed. Children and mothers have better control of asthma symptoms (fewer acute asthma exacerbations and fewer visits to the ER). The recovery and healing process for children with asthma improves. Collaborative efforts with key stakeholders expand the reach of messaging, resource distribution, and organizational/policy change.	**Population Health Program**: A health and wellness opportunity for CCHP members that promotes health screenings and wellness programs. Services include individualized case management by an RN, social worker or community health worker to guide members through an assessment of their health and SDoH needs. Then a collaborative plan for addressing those needs is done with the member, case manager and any others in the member's realms of family and health care team. **Healthy Homes** improves the quality of life for children with asthma and their families. Services help eliminate potential triggers in the home and provide cleaning supplies and education to make the home a healthier place for the child with asthma. Participants are in the program for three months and receive home visits and follow-up calls every month to evaluate the progress of the child's asthma symptoms and monitor use of school nurse or emergency room visits. **Asthma 411** is a school-based program to equip school nurses with medication needed for students with asthma to avoid missed school and emergency department visits. Cook Children's, along with UNT Health Science Center, SaferCare Texas, JPS/Acclaim Physician Group and Tarrant County school districts, work together to enhance services and training for school nurses. **Findhelp.org** – Program which connects families with assistance to find help for SDoH needs in the community in which they live and work.