Texas Health Huguley

2026 – 2028 Community Health Plan

Texas Health
Huguley Hospital®
FORT WORTH SOUTH

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Acknowledgements

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

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

Executive Summary

Executive Summary

Texas Health Huguley, Inc. d/b/a Texas Health Huguley Hospital Fort Worth South will be referred to in this document as Texas Health Huguley or the "Hospital".

Community Health Needs Assessment Process

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

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

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

Community Health Plan Process

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

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

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

Executive Summary

Priorities Addressed

The priorities addressed include:

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

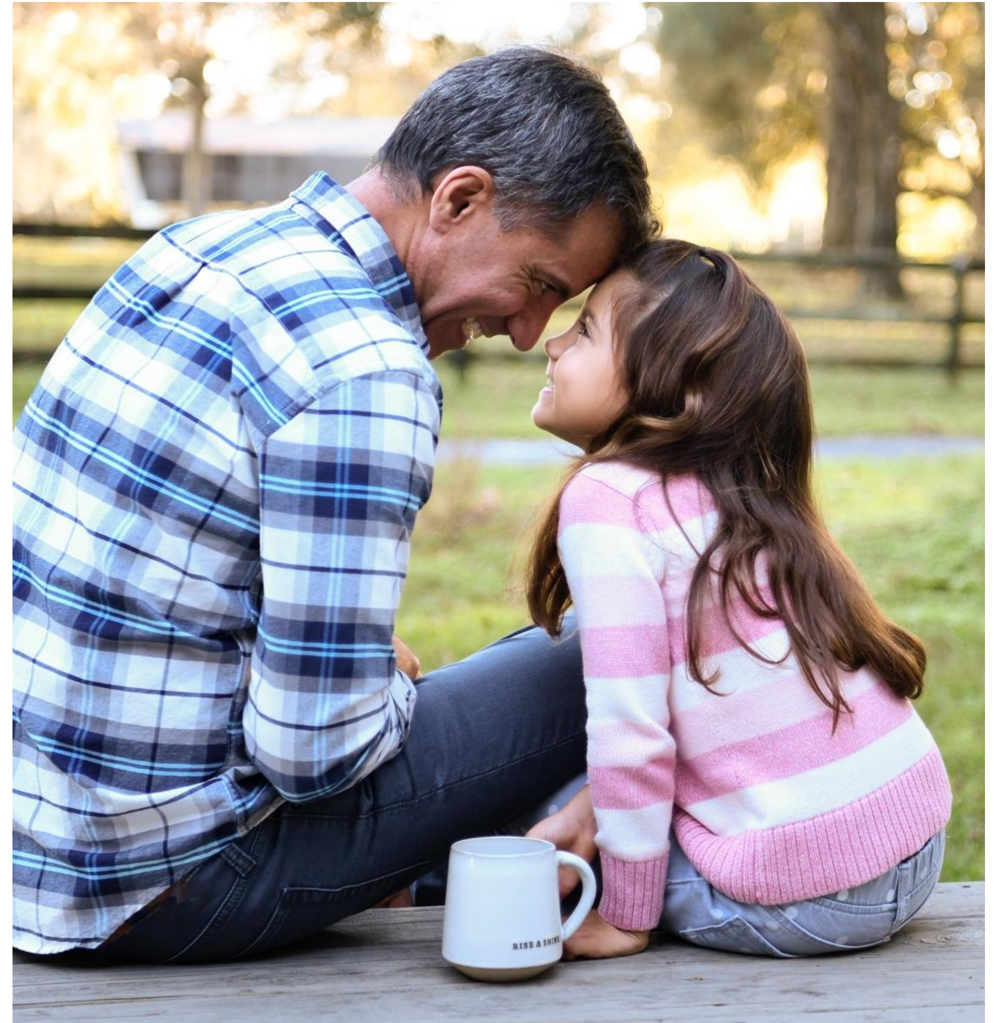
See page 10 for the defined strategies and next steps for each priority selected to be addressed.

Priorities Not Addressed

The priorities not addressed include:

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

See page 18 for an explanation of why the Hospital is not addressing these issues.



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

Executive Summary

Board Approval

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

Texas Health Hugley's fiscal year is January 1 – December 31. For 2026, the Community Health Plan will be deployed beginning May 15, 2026 and evaluated at the end of the calendar year. In 2027 and beyond, the CHP will be evaluated annually for the 12-month period beginning January 1 and ending December 31. Evaluation results will be attached to the Hospital's IRS Form 990, Schedule H. The collective monitoring and reporting will ensure the plan remains relevant and effective.

For More Information

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

About Texas Health Huguley

About AdventHealth

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

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

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

About Texas Health Huguley

Operated by AdventHealth, Texas Health Huguley, Inc. Hospital Fort Worth South is the largest not-for-profit Protestant healthcare organization in the U.S. In 2012, Texas Health Resources and Adventist Health System formed a partnership to own Texas Health Huguley, Inc. Hospital, with Adventist Health System managing the daily operations of the hospital. As a member of Adventist Health System, Texas Health Huguley is operated in a tradition of healthcare that recognizes that total health is achieved through the proper balance of physical, mental, social and spiritual well-being. Describing the facility of Texas Health Huguley is easy. We are a **346**-bed acute care hospital located on I-35W in south Fort Worth. The hospital includes a medical intensive care unit, a cardiovascular critical care unit, a progressive care unit, open heart surgery center and behavioral health. We have an accredited bone and joint program, Diabetes Center, Chest pain center, and an award-winning emergency department available 24 hours a day, seven days a week.

Priorities Addressed

Healthcare Access, Navigation, and Literacy

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

Goal

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

Activity

Increase referral navigation by establishing a coordinated referral process with local clinics and FQHCs so patients leaving the hospital or emergency department can be directly connected to a primary care home for follow-up care.

Output

- Number of clinics with formal referral agreements
- Number of patients referred

Outcome

By December 31, 2028, increase the percentage of referred patients who complete a primary care follow-up appointment within 30-days of hospital of emergency department discharge.

Hospital Contributions

- Staff: Care Management; Care Navigators
- Hospital grant funding opportunities

Community Partnership

- Crowley House of Hope – Free/Reduced Cost Primary Care Clinic
- Texas Health Huguley Care Clinic – Free Post-acute Care (CHF & Diabetes Focus)
- Caring Physicians Charity Network – Free Clinic (Primary Care & Women's)

Healthcare Access, Navigation, and Literacy

Activity

Co-host insurance enrollment events with trusted community agencies and partner with safety-net organizations to help residents enroll in Medicaid, the Children's Health Insurance Program, and Marketplace plans, ensuring individuals do not experience lapses in coverage.

Output

- Number of insurance enrollment events
- Number of residents receiving one-on-one enrollment assistance
- Formalize partnerships with safety-net organizations and insurance brokers(s)

Outcome

By the end of each year, increase the number of uninsured residents who enroll in Medicaid, the Children's Health Insurance Program, or Marketplace coverage through hospital-supported enrollment events.

Hospital Contributions

- Staff: Care Management; Care Navigators
- Hospital grant funding opportunities

Community Partnership

- Harvest House (Medicaid, CHIP Enrollment)
- Medicaid Enrollment Navigator (Internal)
- Insurance Broker (TBD)

Activity

Support low-cost clinics and mobile health accessibility by offering financial resources designated to increase appointment availability, extend hours, or add staff capacity so more community members can establish an ongoing primary care relationship.

Output

- Number of low-cost clinics receiving financial or in-kind support
- Amount of financial support given
- Number of additional primary care appointment slots made available through supported clinics

Outcome

By December 31, 2028, increase the number of patients successfully connected to post-hospitalization and/or ongoing primary care through partnered low-cost clinics and mobile health services.

Hospital Contributions

- Staff for Care Clinic & Mobile Health Unit
- Hospital grant funding opportunities

Community Partnership

- Texas Health Huguley Mobile Health Unit
- Crowley House of Hope Clinic
- Caring Physicians Charity Network
- Texas Health Huguley Care Clinic

Food Insecurity

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

Goal

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

Activity

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

Output

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

Outcome

By December 31, 2028, increase the number of foods-insecure patients who are successfully connected to community food resources through hospital-supported navigation and referrals.

Hospital Contributions

- Staff: ER; Care Managers; Care Navigators; THMA Clinic Staff
- Awareness material & QR code for local food bank resources

Community Partnership

- Harvest House
- Crowley House of Hope
- Promises

Food Insecurity

Activity

Host hospital-wide food drive events in support of our community partners with food banks with emphasis on healthy options.

Output

- Number of hospital-wide food drives conducted annually (one per quarter)
- Pounds of food donated and distributed to community food bank partners
- Number of individuals served

Outcome

By December 31, 2028, community food bank partners report improved capacity to meet immediate food needs of residents as a result of hospital-supported food drive efforts.

Hospital Contributions

- Staff: Community Relations; All Employees; Paid Volunteers
- Hospital grant funding opportunities

Community Partnership

- Harvest House
- Crowley House of Hope
- S.H.I.N.E.
- Promises

Activity

Support enrollment in federal nutrition programs by assisting community members with SNAP and WIC applications and by facilitating enrollment or renewal days to help reduce coverage gaps.

Output

- Number of SNAP and WIC enrollment or renewal events supported
- Number of individuals receiving application assistance for federal nutrition programs
- Number of referrals made to community partners for SNAP or WIC enrollment

Outcome

By December 31, 2028, eligible residents experience improved access to federal nutrition benefits, as demonstrated by a year-over-year increase in completed SNAP and WIC applications supported by hospital-led navigation efforts.

Hospital Contributions

- Staff: Community Engagement
- Hospital grant funding opportunities

Community Partnership

- Harvest House

Connectedness

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

Goal

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

Activity

Support community-based mental wellness and resilience workshops delivered in partnership with agencies that address emotional well-being, helping residents strengthen coping skills, communication skills, and relationship-building abilities.

Output

- Number of mental wellness or resilience workshops delivered
- Number of residents participating in workshops
- Number of partner organizations delivering or co-hosting workshops

Outcome

By December 31, 2028, workshop participants report reduced social isolation and increased confidence in their ability to build connections with others in their community.

Hospital Contributions

- Staff: Behavioral Health Department
- Hospital grant funding opportunities

Community Partnership

- Harvest House
- Crowley House of Hope
- REACH across Johnson County
- N.A.M.I
- ISDs

Transportation

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

Goal

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

Activity

Partner with a local community organization(s) that provides transportation services to expand access to rides for medical appointments, including primary care visits, specialist referrals, diagnostic testing, and preventive screenings.

Output

- Number of partnerships established with transportation providers
- Number of medical rides coordinated or supported through partner organizations
- Number of residents assisted with transportation to medical appointments

Outcome

By December 31, 2028, hospital-supported transportation efforts will result in a 20% reduction in missed or delayed medical appointments among residents receiving transportation assistance.

Hospital Contributions

- Staff: Community Engagement
- Hospital grant funding opportunities(?)

Community Partnership

- Cle-Tran
- Trinity Metro
- Uber

Transportation

Activity

Collaborate with coalitions and nonprofits to amplify policy change efforts at local, state, and federal levels.

Output

- Number of transportation coalitions or advocacy groups engaged
- Number of policy meetings, briefings, or advocacy activities participated in related to transportation access
- Number of transportations-focused policy initiatives or proposals supported through coalition efforts

Outcome

By December 31, 2028, hospital advocacy efforts support at least two policy or funding initiatives that expand or improve public transportation access for residents.

Hospital Contributions

- Staff: Government Relations

Community Partnership

- Cle-Tran
- Trinity Metro
- City/County elected officials
- State representatives
- Federal representatives

Priorities Not Addressed

Priorities Not Addressed

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

Chronic Disease

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

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

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

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

*CDC PLACES (2024)

Behavioral Health

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

The findings indicate there is a need for behavioral health services in the service area, as frequent mental health distress, depression, and cognitive disability affect 15% to 24% of adults in the region. However, behavioral health challenges are localized in south central and west central Tarrant County.* ZIP codes with a higher barrier level typically have a higher risk of experiencing worse behavioral health outcomes.

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

* CDC PLACES (2024)

Priorities Not Addressed

Disabilities

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

The findings indicate mobility limitations are the most common disability across both counties, signals a need for transportation and daily living support. Localized challenges for disabilities persist in central and west central Tarrant County.** ZIP codes with a higher barrier level typically have more disability-related barriers to good health.

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

* CDC, Disability and Health

** CDC PLACES (2024)

Income

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

Tarrant County is below the national benchmarks for median household income, potentially reflecting income barriers in localized parts of Tarrant County. There is variability in income across Tarrant County, with more ZIP codes with a higher barrier level in the central part of the county.

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

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

* American Community Survey (2019-2023).

Priorities Not Addressed

Employment

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

Tarrant County is below the national and state benchmarks for unemployment. Although both counties have a lower unemployment rate, localized barriers persist in various parts of the County. It is also important to note that in Texas, 94.9% of large firms (i.e., 50 or more employees) offer ESI, while 28.7% of small employers offer ESI.*

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

*KFF, Employer Health Benefits Survey (2023).

* American Community Survey (2019-2023).

Educational Attainment

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

Tarrant County is below the national average for adults aged 25 and older with at least a high school diploma or bachelor's degree, potentially reflecting a significant barrier of health literacy in localized areas of Tarrant County.**

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

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

* American Community Survey (2019-2023).

Priorities Not Addressed

Housing Stability

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

Tarrant County is above the national benchmark for housing insecurity and threat of utilities shutting off, potentially reflecting a significant barrier of housing stability in the Tarrant region. However, areas in central and eastern Tarrant County experience greater localized challenges related to housing stability.**

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

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

** CDC PLACES (2024)

Technology Access

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

Tarrant County is below the national benchmark in residents without some type of internet subscription; however, localized challenges persist in central Tarrant County.**

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

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

** American Community Survey (2019-2023).

Texas Health Huguley, Inc. d/b/a

Texas Health Huguley Hospital Fort Worth South

CHP Approved by the Hospital Board on: May 15, 2026

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