Texas Health Community Impact

Evaluation Report

2021-2022 Grant Cycle

Final Report

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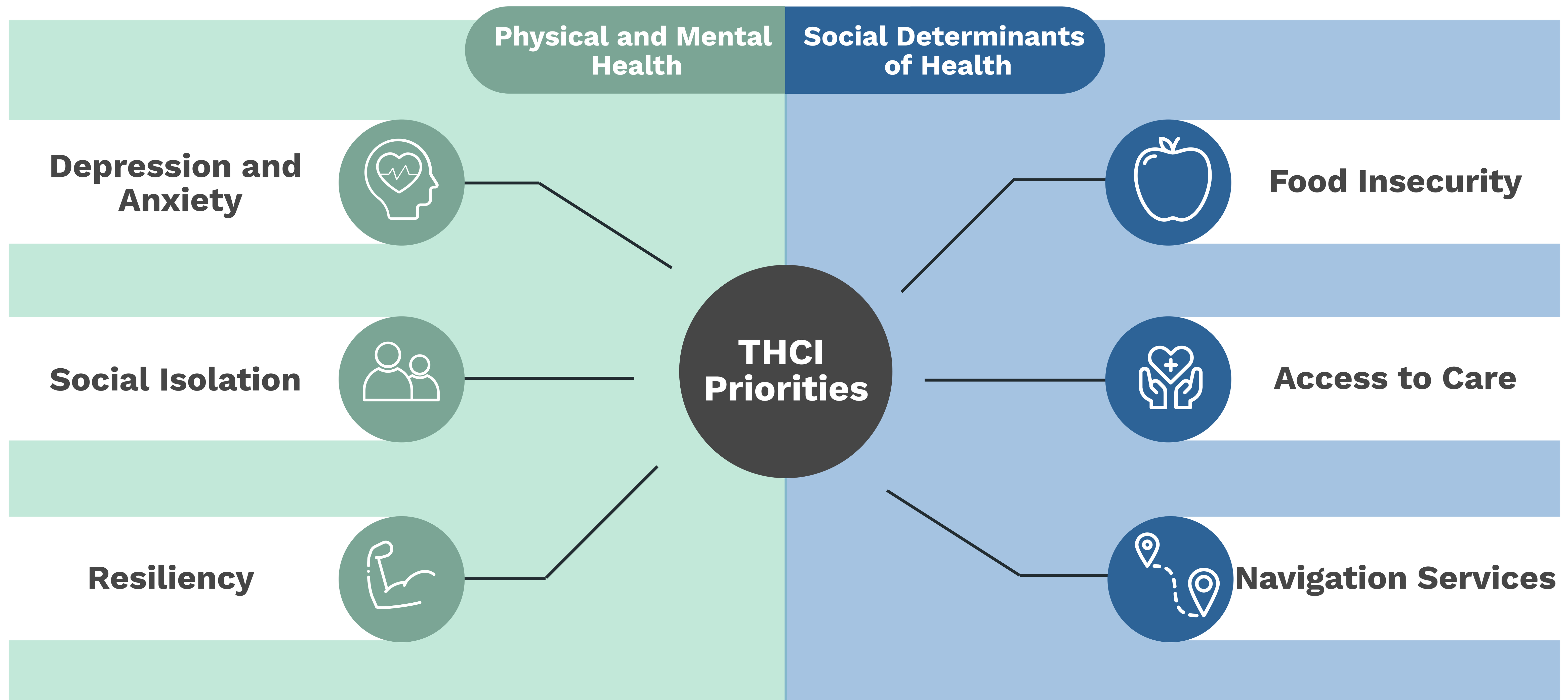
EXECUTIVE SUMMARY

Texas Health Community Impact (THCI) launched in 2018 with the goal of improving lives of North Texans by supporting cross-sector collaborations addressing local needs in innovative ways.

THCI projects leverage existing community relationships and use data to drive community health improvement at the local level. Projects focus on addressing priority areas identified by the Texas Health Resources Community Health Needs Assessment.



In the 2021-2022 grant cycle, twelve projects across five North Texas regions were funded:

Region	Project	Location
Collin	Beyond Blue	East McKinney (75069)
	Plano UP!	East Plano (75074)
Dallas-Rockwall	Well Together: AVANCE	Dallas (75211, 75212, 75217, 75231)
	Well Together: The Center	Dallas/Rockwall (75211, 75212, 75217, 75231, 75032)
	Well Together: Lakepointe Church	Rockwall (75032)
Denton-Wise	Promoting Resiliency Among Vulnerable Children	Bridgeport (76426)
	Promoting Resiliency Among Vulnerable Children	Lewisville (75057)
	THRIVE	Sanger (76266)
Southern	Erath County Community Bridges	Stephenville/Dublin (76401, 76402, 76446)
Tarrant-Parker	Project Empower	Arlington/Parker County (76010, 76011, 76082)
	Project Help, Hand, Hope	Springtown (76082)
	The Railroad Project	Southeast Fort Worth (76119)

EXECUTIVE SUMMARY

The Program Evaluation team at the UTHealth Houston School of Public Health in Dallas conducted an external evaluation of the THCI projects. This report summarizes the key learnings from the 2021-2022 THCI-funded projects.

The overarching aim was to comprehensively evaluate each project and generate findings across the initiative. The evaluation was guided by the RE-AIM[1] framework and was conducted in close collaboration with each grantee team and THCI staff to 1) develop a data collection plan that reflected the context, services, and goals of the project, 2) integrate quantitative and qualitative data to assess promise of the proposed project, progress on implementation, and potential for impact of each project, and 4) synthesize data in real-time to share findings, monitor progress, troubleshoot issues, and adapt to changes.

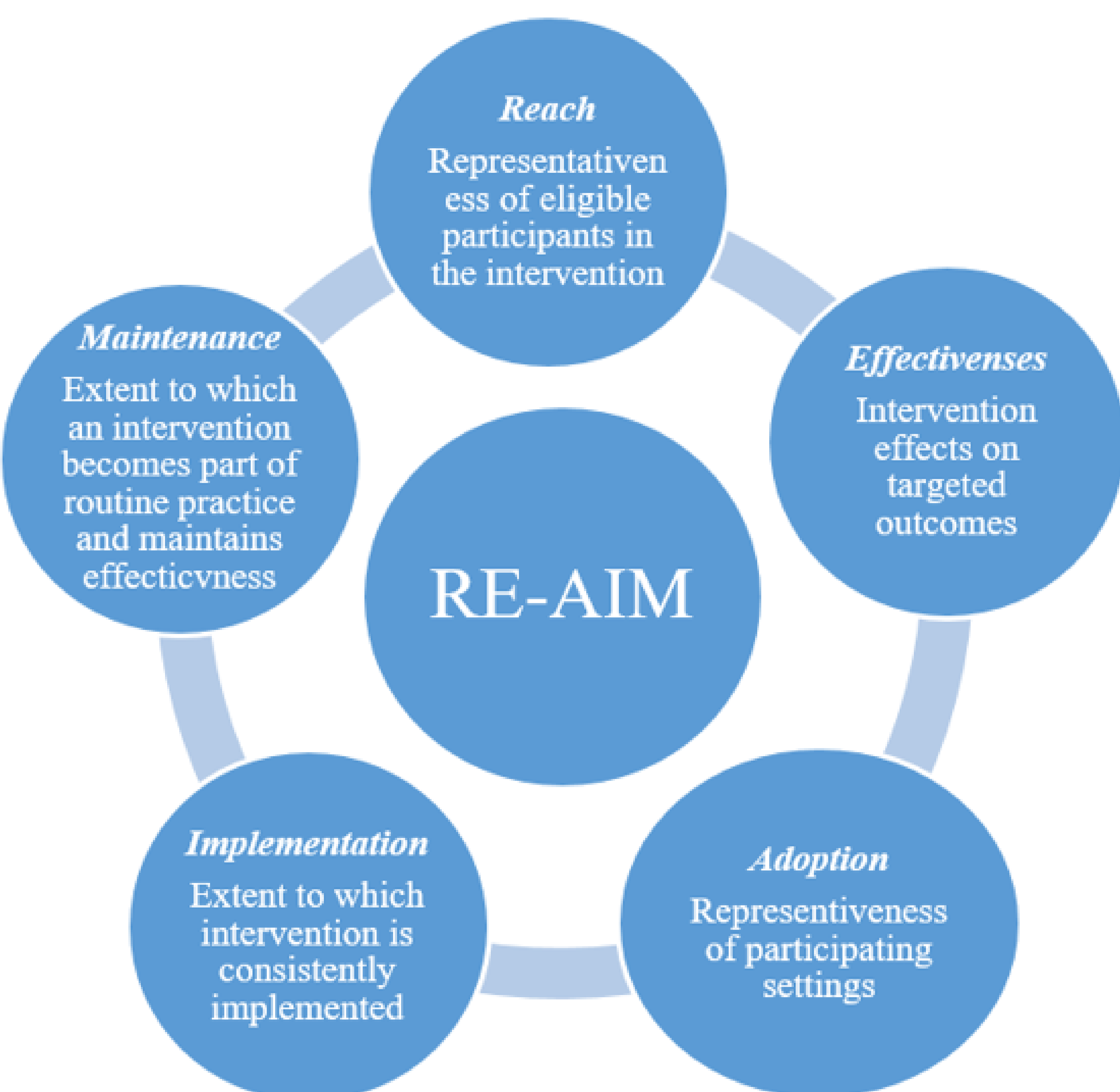
Reach (e.g., the number, proportion, and representativeness of the project)

Effectiveness (e.g., the impact of each community project on specified outcomes)

Adoption (e.g., the willingness of stakeholders and the target population to actively participate in each project)

Implementation (e.g., the degree to which each project is implemented as intended)

Maintenance (e.g., the sustainability of individual- and project-level effects and assesses the extent to which funded projects become institutionalized)

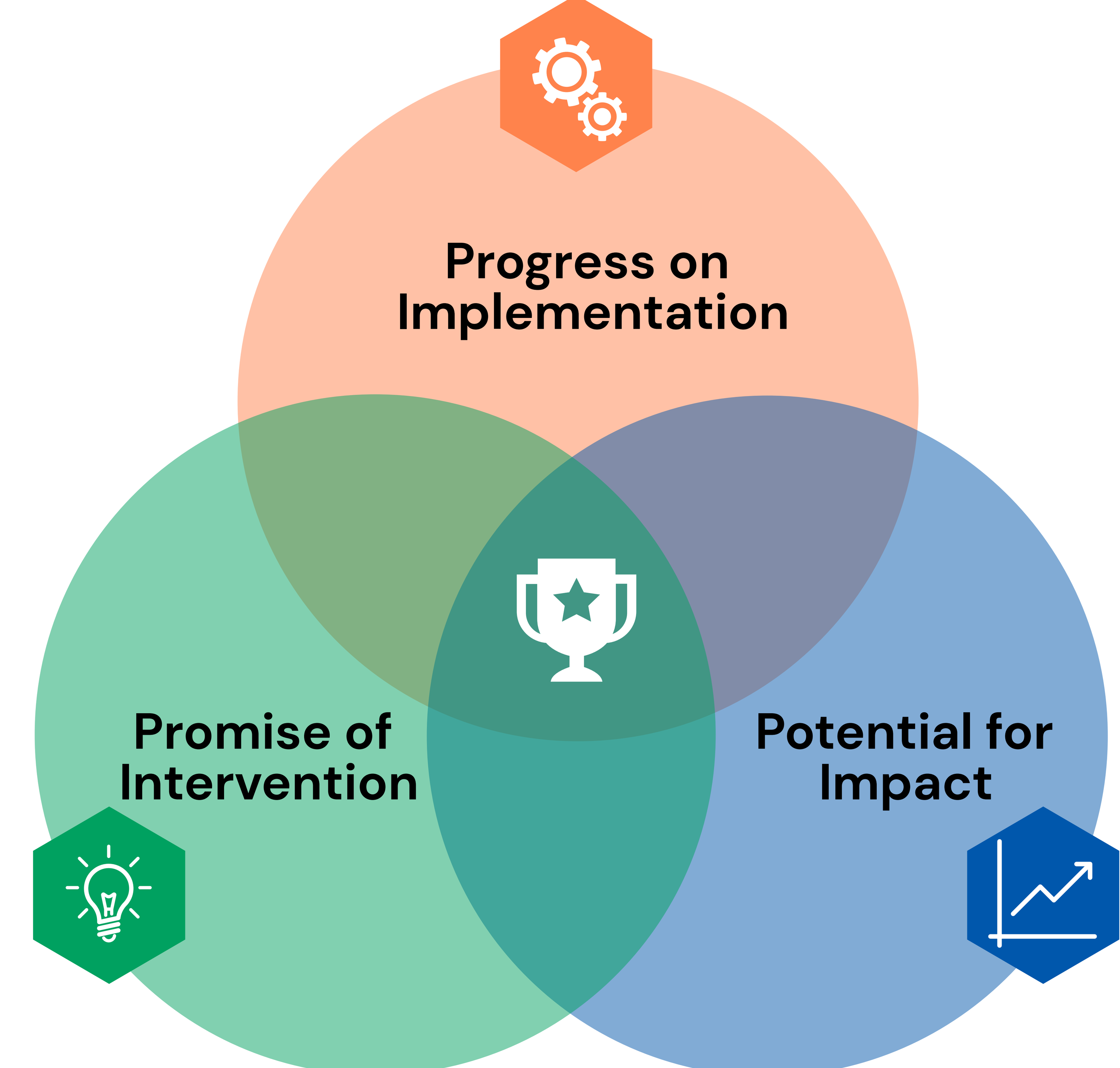


Building on the RE-AIM framework, project impact was rated on three domains.

Promise of Intervention
Assessment of project design. Does it have a strong evidence base or rooted in community expertise? Are there sufficient resources for successful implementation and measurement? Is it designed in a way that will successfully reach the target audience?

Progress on Implementation
Assessment of Implementation. Did the project reach the intended population at the level or rate planned? Are the project components successfully implemented and is there uptake of services?

Potential for Impact
Assessment of effectiveness in terms of outcome measures an overall impact. Is outcome change likely? Are services impactful? Is the project making a meaningful difference to those it serves?



[1] Glasgow RE, Vogt TM, Boles SM. Evaluating the public health impact of health promotion interventions: the RE-AIM framework. Am J Public Health. (1999) 89:1322–7. 10.2105/AJPH.89.9.1322

IMPACT OF THCI PROJECTS

Who did the THCI projects reach?

Over 9,000 North Texas residents were reached through the THCI projects and over 5,000 received needed services.

Clients were connected to programs in a variety of ways: community-based screening and recruitment, partner referrals, attending events or other promotional/advertisement efforts, and school-based programming. Some projects focused on recruiting high-needs, underserved clients who were experiencing poverty or other access barriers while others focused on identifying clients experiencing depression, anxiety, or emotional regulation issues. Most projects screened or assessed clients for specific health or social needs and created pathways to connect them to services in-house or with partner programs.

What types of services did the THCI projects provide?

Projects provided a wide variety of evidence-based and innovative services to clients. Projects were thoughtfully designed and employed a mix of:

- **Utilizing evidence-based programs** such as VitalSigns6 for depression and screening, the promotora community health worker model, and employing validated screening tools.
- **Offering services that were responsive to clients'** needs including case management, transportation assistance, mental health counseling, peer support, provision of healthy foods, medical care, tutoring and mentorship, academic support, financial assistance, job training, and more.
- **Providing education along with direct services**. Most programs included a component of educating clients on behavioral health and self-efficacy topics to sustain improvements and engagement in services. Many programs also included provider and staff education to continually improve the level and quality of services the projects provided.
- **Assembling robust partner and referral networks** to connect clients with additional services. Lead grantee organizations collaborated with community partners to provide comprehensive services to clients and their families. The most common partners were mental health and counseling organizations and food banks.

How well were projects implemented?

Grantee teams implemented cross-sector, collaborative projects that were aligned with the needs of their communities. Grantees rapidly established or formalized partnerships with THCI support and developed implementation plans and data collection protocols supported by the ENHANCE evaluation team as needed. All projects provided a variety of services and referrals to enrolled clients, with success often depending on the strength of partner relationships, the presence of a strong central coordinating person or organization, and the data infrastructure to track participation and needs over time.

Did projects demonstrate changes in the THCI priority areas?

Eight of twelve projects demonstrated significant improvements in the priority areas of depression, anxiety, resiliency, food security, or self-efficacy.

Additional project-level impacts and trends can be found in the grantee spotlights section. All projects employed validated screening and assessment tools, but challenges with follow-up data collection and small eligible samples made further assessment of impact difficult. Additional time for enrollment, selection of outcome measures, and development of data collection infrastructure could help further demonstrate outcome change.

Grantee Spotlights

This section, organized by region, provides key evaluation findings from each project.

BEYOND BLUE

LifePath Systems

What is Beyond Blue?

Beyond Blue is a collaboration of six non-profit organizations established in 2019 to address depression, social isolation, and food insecurity among low-income adults in East McKinney (75069). Beyond Blue focused on improving strength of social relationships, management of chronic conditions, food insecurity, relationships between case managers and clients, and making an overall positive impact on people's lives. Beyond Blue envisions a community where all adults have optimal behavioral and physical health and are socially connected to live full and meaningful lives.

Beyond Blue established a diverse and robust partner network with a strong central coordinating organization.

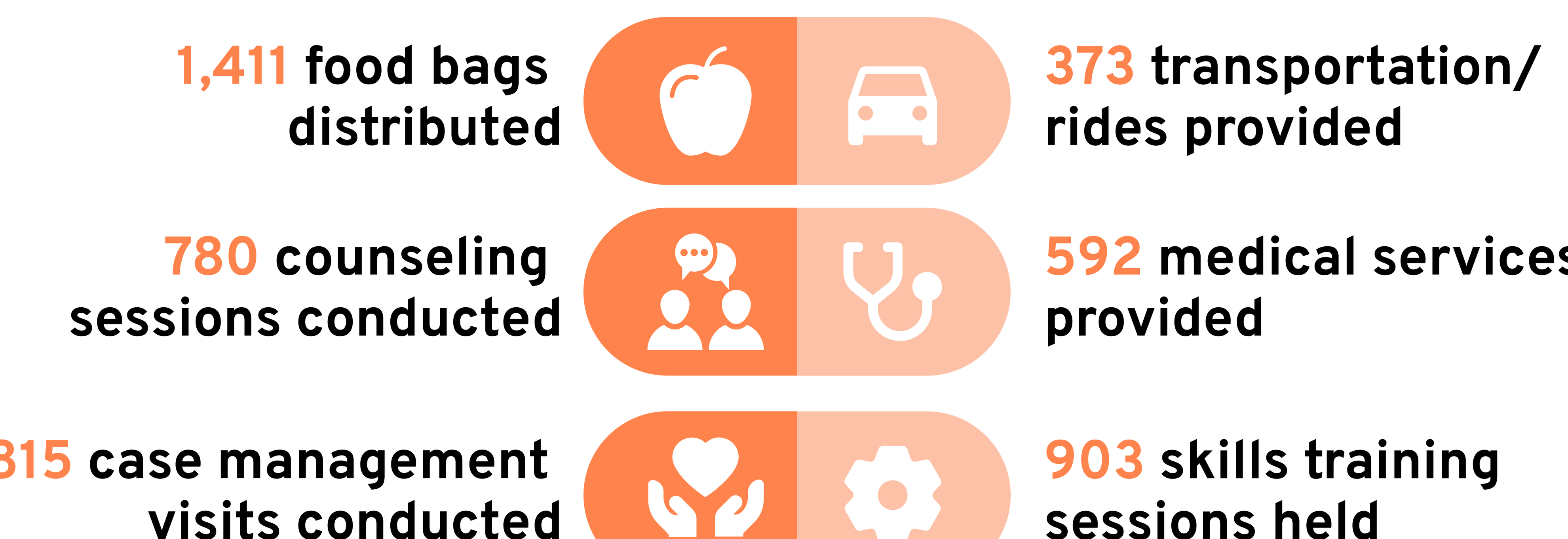
Beyond Blue assembled a network of medical, food assistance, behavioral health, and case management providers to address multiple priority needs in a coordinated way. LifePath Systems, the lead agency, was well positioned to serve as the central organization by facilitating referrals, coordinating partner relationships, and managing data systems and information sharing.

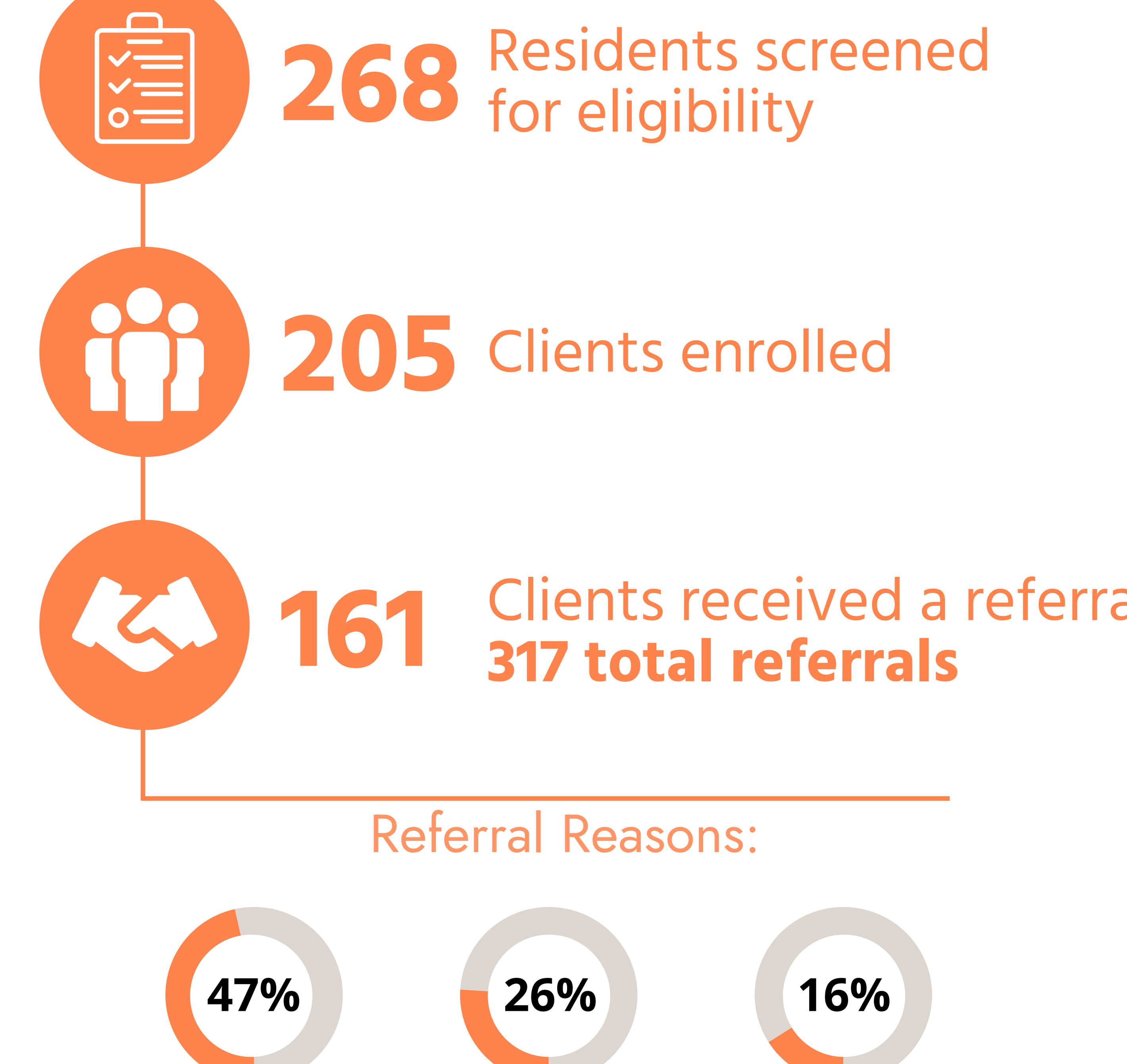
The group is very collaborative. I think that is the best thing that we've done. We meet every single month, and it is very much viewed as everybody [partners] has ownership in everything.
– Beyond Blue team member

Beyond Blue reached their target population and successfully referred clients to partner services to address medical, mental health, and food needs.

Beyond Blue screened 268 adults and enrolled 205 clients with depression or anxiety symptoms in the East McKinney area.

Beyond Blue clients received many services directly from the lead agency, Lifepath Systems, and through referrals to partner agencies. Over the grant period, they also added additional services including mental health first aid training, educational and nutritional counseling group meetings, and formalized a partnership with Community Garden Kitchen to provide healthy meals.



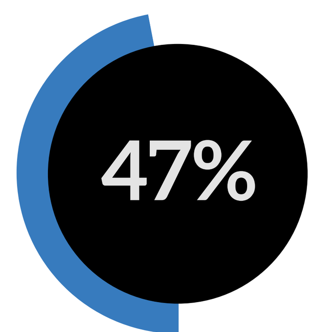


For us, the food is a big part, because a lot of people do need food, and the fact that we offer delivery with Beyond Blue was like, "Oh that's a bonus." "Like you're going to help me with skills training and my mental health and everything, but you're going to deliver food to me? Of course, I'll sign up."
– Beyond Blue partner

Beyond Blue's mental health services were associated with improvements in depression outcomes.

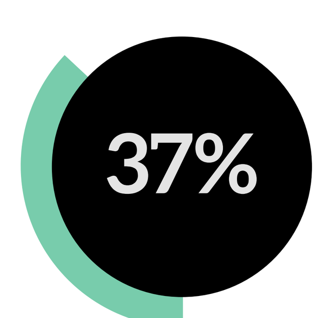
Beyond Blue used the PHQ-9 assessment to measure depression and GAD-7 assessment to measure anxiety. 119 (58%) clients completed a baseline and at least one follow-up assessment.

On average, depression severity scores significantly decreased by 0.1 points.

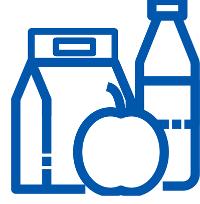


of clients reduced their **PHQ-9 score** by at least one severity category

Anxiety severity scores also decreased, but less dramatically than PHQ-9 for depression.

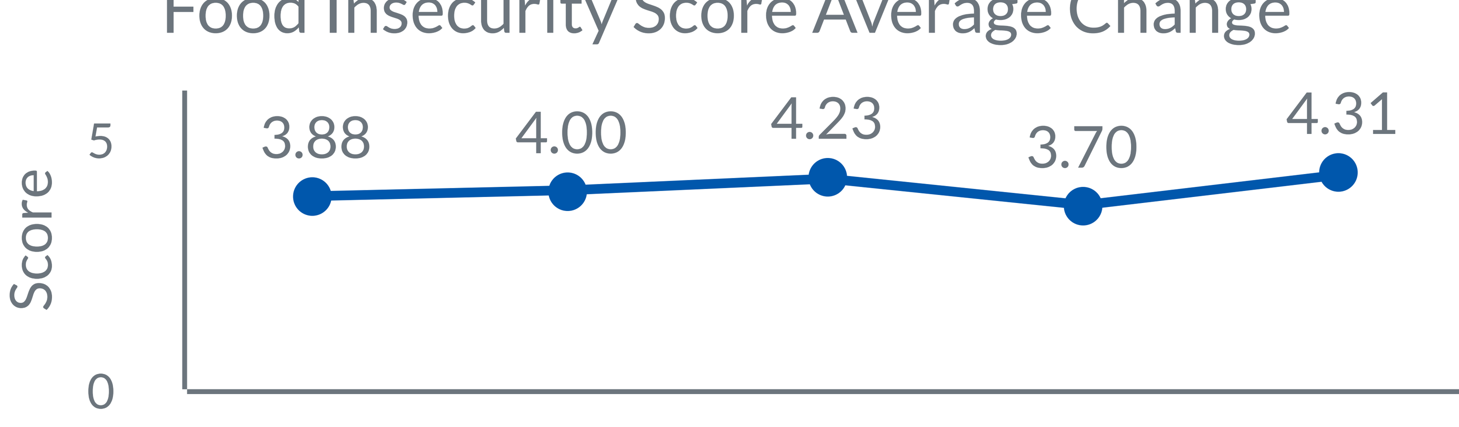


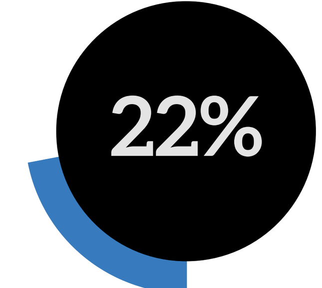
of clients reduced their **GAD-7 score** by at least one severity category



Beyond Blue addressed food security of their clients.

Beyond Blue used the USDA 6-item food security module to measure food security. 68 (33%) of clients completed at least one follow-up. Average food insecurity assessment stores remained stable during the project period.





of clients reduced their **USDA food insecurity score** by at least one status level

> **I am hearing a lot of good things about people starting off with really high [depression] scores a couple of months ago, getting counseling for some time, and then getting reevaluated in three months and their scores drop drastically and they improve their symptoms with their depression and anxiety. And then there's just that feel good part where you hear people saying — when the Community Garden Kitchen, one of our partners, opened up their doors, we had people who felt a lot of dignity being able to take their families in when they wouldn't be able to afford that before and get a warm meal and be served in a restaurant style environment, and just hearing stuff like that is really cool too.**
>
> *– Beyond Blue partner*

Overall Assessment

Beyond Blue developed a robust partner network, provided a variety of services, and coordinated referrals to address the physical, mental health, and social support needs of their clients. The mental health services resulted in a significant decrease in depression symptom severity and many clients had improvements in anxiety symptoms and food security status. Beyond Blue was managed by a strong central coordinating organization that invested in partner relationships, community outreach, and client engagement. They addressed client needs comprehensively and had the community presence, resources, and expertise to successfully implement this collaborative project.

PLANO UP!

Plano ISD Education Foundation

What is Plano UP! ?

PlanoUP! is a collaborative health initiative for middle and high school students who are considered at-risk for depression and anxiety at three schools in East Plano (75074). The goal of the project is to provide behavioral health and navigation services as well as increased access to healthy foods for students on campus in a timely and convenient manner.

Plano UP! offered evidence-based mental health programs and valuable services and resources for students and families.

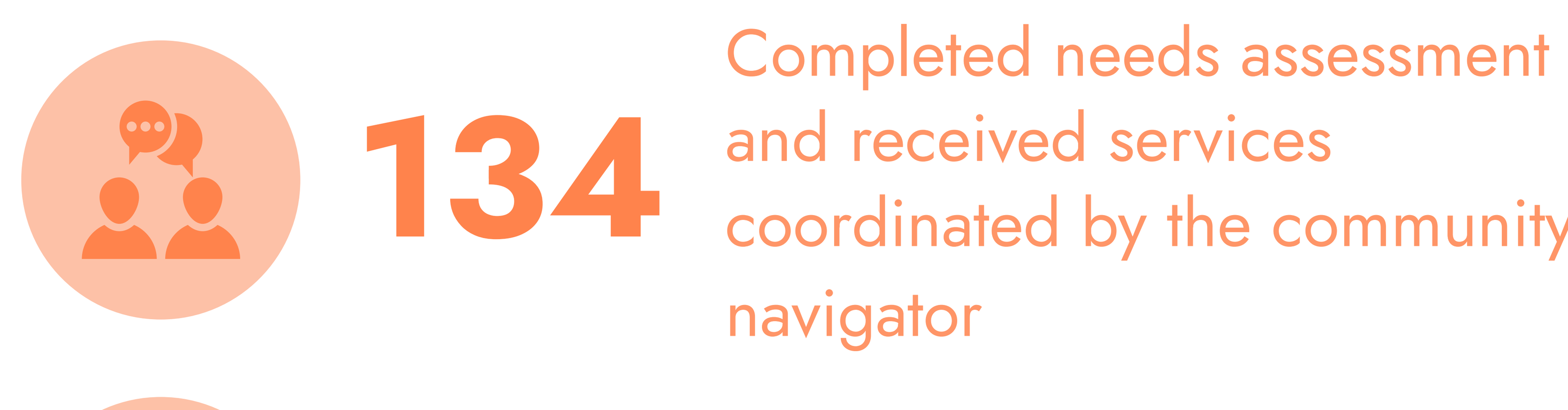
Plano UP!'s mental health programs (VitalSign6 and Youth Aware of Mental Health) are promising approaches with demonstrated effectiveness. The mental health education and treatment programs partnered with Plano UP!'s community navigator model and robust service network enhanced student engagement and ensured that student needs were appropriately identified, monitored, and addressed.

> **We know that this [program] is really needed. We know that prevention is key in depression and suicide, so we know that the best place for prevention programs with students is in schools, because most students are – most kids are found in schools.**
>
> *– Plano UP! Partner*

Plano UP! successfully screened and enrolled students across three schools. Enrolled students received consistent navigation and were highly engaged.

Students at participating schools were referred to PlanoUP! by counselors, teachers, or by self-identification. Students were screened for depression and anxiety and those with moderate severity indicated could enroll in PlanoUP!. Enrolled students were connected to the community navigator to complete a needs assessment and have quarterly check-ins to review progress and connect to resources. The most common student needs identified were life skills training, mental health, and food assistance.

Plano UP! also partnered with Minnie's Food Pantry to increase healthy food access for students and their families. 38 food drives were held and 4,440 family food boxes distributed.

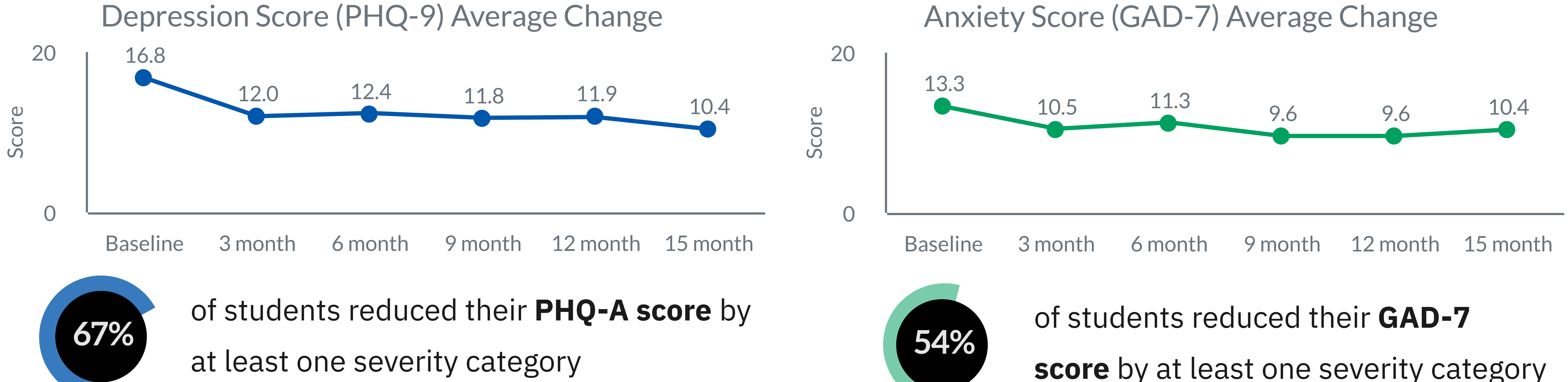


> **Reasons why people participate is...they see the ease of the program. They see that it makes it easier to get the services. They can't fit it into their schedule otherwise. They cannot afford it otherwise. They believe that it will help, and they are at a point – I've talked to a lot of parents who are literally at their wit's end, because they don't know what to do. And so they want this to be a way for their kids to start to improve. And they're willing to try anything for their kids."**
>
> *– PlanoUP! partner*

Depression and anxiety symptom severity reduced for Plano UP! students with at least moderate depression severity.

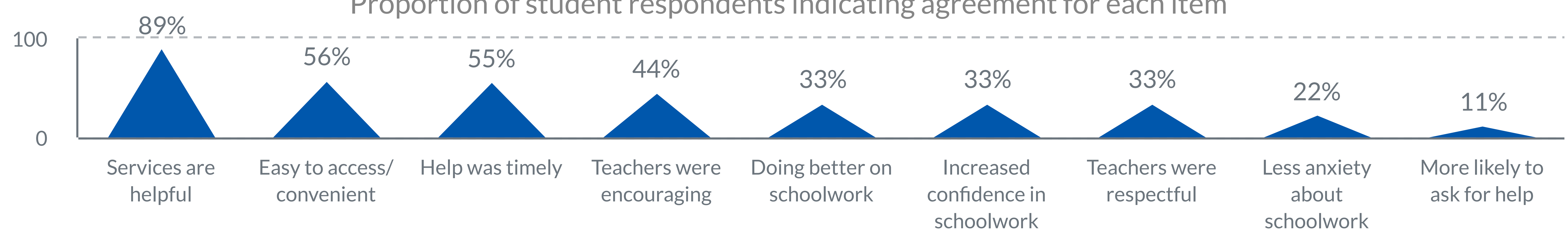
PlanoUP! used the PHQ-A assessment to measure depression and the GAD-7 to measure anxiety. 123 (86%) students completed a baseline and at least one follow-up assessment.

Depression (PHQ-A) and anxiety (GAD-7) severity scores significantly decreased, with average decreases in score per time point of 0.28.



Students and counselors reported that academic support services provided by PlanoUP! were beneficial.

Plano UP! administered a survey to assess how academic support services provided to enrolled students helped them. The survey was completed by 9 students and 6 counselors in Fall 2022. **Overall, students (89%) and counselors (89%) thought the support services were helpful to students.**



If we can help one student to completely turn it around and, turn their whole life around, I think it's [implementing the program] worth it. But definitely just seeing the students, completely understand, "These are the techniques that I need to use to help me when I'm feeling anxious or depressed, and, you know, there's more to life than this one thing that I'm stressing out about."

– Plano UP! team member

Overall Assessment

PlanoUP! implemented an on-campus program that significantly improved mental health wellbeing of enrolled students and provided a substantial amount of student resources. They employed an evidence-based education program, training for teachers and staff, and comprehensive services coordinated through a dedicated navigator who could ensure students' needs were addressed. Their partnership with Minnie's Food Pantry allowed for students and their families to have increased access to healthy foods. PlanoUP! also made a thoughtful shift from assessing grade improvement to garnering the perspective of students and counselors via survey to gauge the impact of the academic support services. Continuing this survey in future efforts could provide further insight into this impact with a larger respondent pool. PlanoUP!'s success provides a foundation to expand and tailor program features to other schools in the district.

GRANTEE SPOTLIGHT DALLAS-ROCKWALL

WELL TOGETHER INITIATIVE

AVANCE North Texas (AVANCE)

What is Well Together Initiative - AVANCE?

Well Together is a collaborative initiative between three organizations- AVANCE, The Center, and Lakepointe Church to reduce depression among underserved populations by increasing mental health education and reducing barriers to counseling. AVANCE's main objective is to reduce depression and the stigma related to mental illness in low-income individuals in Vickery Meadow (75231), West Dallas (75211, 75212), and Southeast Dallas (75217). AVANCE built its program on the evidence-based Promotora model using trained community health workers providing mental health education tailored to Spanish-speaking communities and offering case management and mental health counseling referrals.

AVANCE's program combined culturally appropriate evidence-based mental health education with case management and mental health referrals.

AVANCE trained community health workers (promotoras) to provide mental health education. This model is evidence-based and empowers community members to address the mental health needs of their communities in a culturally appropriate way. AVANCE's hybrid model added components of case management, routine mental health screenings, and referrals to a professional counseling partner, The Center, to assist with meeting client needs holistically.

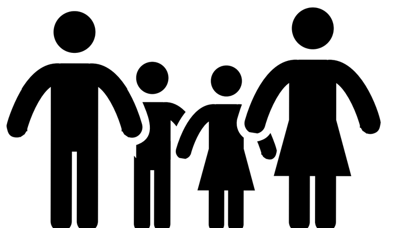
> **[What] we learned is there's such a stigma in our culture, in the Hispanic community, where they don't want to talk about mental health...But as long as we educate them – and for us it's not trying to change the [symptoms] that comes out of the PHQ9, it's more of seeing has there been a slight change over time and have we been able to identify that change, but also at the same time help them find those resources so that their kid – and maybe another family member can find success along the way.**
>
> *– AVANCE team member*

AVANCE reached diverse, high needs families in the target area.

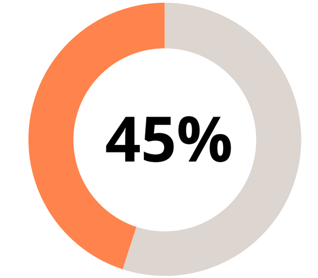
AVANCE provided promotora education to 141 families with families receiving 6 visits on average. Nearly half of families meeting criteria for a mental health counseling referral to The Center (16/38, 42%) received one during the project.

Ongoing pandemic challenges resulted in AVANCE reformatting the promotora sessions from in-home visits to group education sessions held at churches and other community sites. This meant education sessions were less individualized and less intensive, but this allowed for more families to attend at once and sessions were generally well received. They also faced significant staff turnover that strained the capacity of remaining staff and leadership.

In September 2022, AVANCE recruited 66 families who were well engaged with the project. This suggests that their workflow disruptions may have stabilized and AVANCE could continue to successfully deliver the program after THCI funding ends.



141 Families



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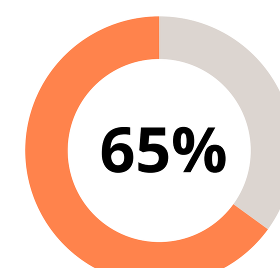
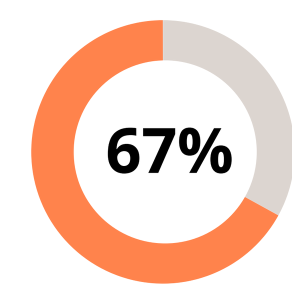


Limited English proficiency



Head of Household under- or unemployed/

41% completed 8-week promotora education program

29% completed case management needs assessment

AVANCE successfully recruited and trained a diverse group of promotoras.

AVANCE recruited a total of 29 promotoras throughout the 2-year program. Promotoras came from diverse backgrounds, including various nationalities to achieve cultural competence for the families they serve. The majority (72%) were of Mexican nationality.

Promotoras were mostly female (97%) and those from outside the US had been in the US for an average of 18 years. The average age was 43 years old, and the majority of promotoras were married (79%). Many of the promotoras were college graduates (34%) or had completed trade school (14%).

We're addressing it in a way that we're reaching [the target population]. The people that are going out are Latin or Hispanic...We're also speaking to them – we're not saying, "Oh, here's just a pamphlet. Learn on your own." It's, "No. This is what it [mental health] looks like. These are the areas that we're gonna talk about. And if we notice – if there's other things that you need, we're gonna help you kind of guide that." And having that connection with them...I think that that's key.

– AVANCE team member

Families had low depression symptom severity on average, with indication of improvement among those with elevated symptom severity.

AVANCE used the PHQ-9 assessment to measure depression. 65 participants completed baseline and follow-up assessments. Overall, there was no appreciable change in PHQ9 score. This is because most participants (69%) had low scores at baseline.

Of the 20 participants that had a baseline PHQ-9 > 5, over half (N=11, 55%) reduced their severity by at least one category. The small sample size made it difficult to further assess improvements in outcomes.

The Mental Health Literacy Scale (MHLS) was used to measure the impact of the education program. MHLS data were not collected systematically throughout the project period in order to assess change.

I see the difference inside of the home... when [head of household] started getting all this help and her husband saw the difference, he was asking, also, for therapy...And it was not only her, because all the family needs help. And that's how I know it's working.

– AVANCE implementer

Overall Assessment

AVANCE had an innovative and comprehensive project design but faced several implementation challenges and had to make many adaptations. However, their implementation success towards the end of the grant indicates potential for impact beyond the funded period. They were able to recruit and maintain a diverse promotora workforce and reached high-needs and underserved families. More attention to the integration of case management and counseling/other service referrals could be beneficial, but the foundation is in place. A main limitation with the promotora component was that they were volunteers and were not compensated in any way. A stronger model would include incentives to help with retention. The MHLS is an appropriate assessment for the promotora education program and ensuring resources for data collection and tracking would help demonstrate impact.

GRANTEE SPOTLIGHT DALLAS-ROCKWALL

WELL TOGETHER INITIATIVE

The Center for Integrative Counseling and Psychology (The Center)

What is Well Together Initiative - The Center?

Well Together is a collaborative initiative between three organizations- AVANCE, The Center, and Lakepointe Church to reduce depression among underserved populations by increasing mental health education and reducing barriers to counseling. The Center provides mental health screenings and hosts educational workshops at partner organization's community events. The Center works with community partners across Dallas and Rockwall to identify and refer clients in need of professional mental health services and provides age-appropriate therapy or counseling onsite and via telehealth.

The Center's program provided consistent, evidence-based assessments and mental health treatment to clients in need.

The design of the Well Together Initiative allowed for trusted community organizations to facilitate connections to The Center, removing major barriers faced by residents in accessing mental health care. This collaborative approach allowed for each partner to provide the services in which they are experts while maintaining client trust and preventing duplication of effort.

It's really about meeting people where they are, going to the community, finding out where the needs are and serving them where they reside, where they live, where they work...A lot of people don't understand counseling. It's [about]...helping people understand we all deal with mental health. Every life is a series of seasons, and everybody could use help. And just getting people to understand that and being receptive and willing to ask for it.

– The Center team member

The Center effectively screened, enrolled, and provided counseling to clients in need.

The Center partnered with seven community organizations to identify clients in need of mental health counseling or other appropriate therapy. They screened 342 individuals and provided counseling to 171 clients. Once clients were connected to The Center they stayed well engaged. The Center also hosted 26 educational workshops at the partner sites throughout the grant period serving 1,554 attendees.

We go to areas in the community where people may have never had the opportunity to have counseling. May have such a barrier or stigma that they aren't willing to ask for help. May have so much hurt that all they can do is put one foot in front of the other and not think about their whole life and how that impacts their children, their parents and the communities that they operate in. So I believe that this program really helps achieve...the mission, the vision of The Center at its core. And it provides it in a way to where, you know, health insurance and salary is not taken into account.

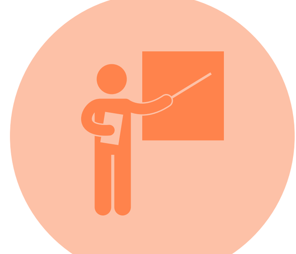
– The Center team member

342 Mental health screenings completed

171 Individuals receiving counseling

76 Average number of clients receiving counseling each month

4,246 Total counseling sessions provided



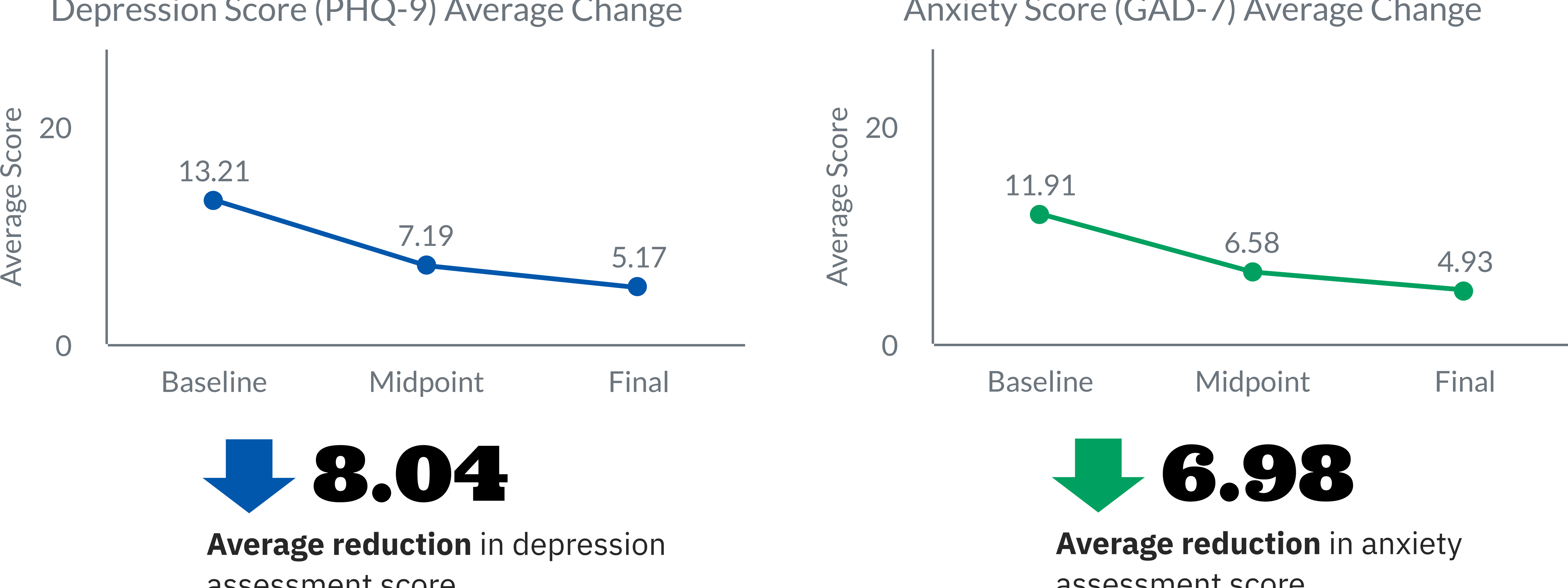
26 Total educational workshops held

1,554 Total workshop attendees

Depression and anxiety symptom severity reduced for clients who completed therapy.

The Center used the PHQ-9 assessment to measure depression and the GAD-7 assessment to measure anxiety. 31% of enrolled adults (43 adult clients).

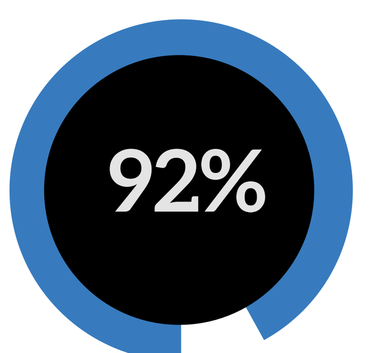
Clients demonstrated significant decreases in average PHQ-9 and GAD-7 by the end of therapy.



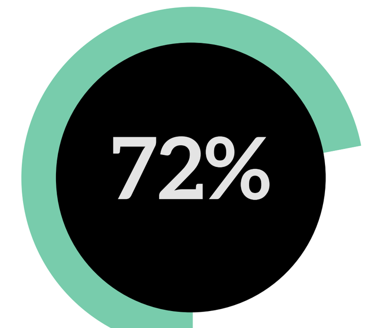
Average reduction in depression assessment score

Average reduction in anxiety assessment score

The majority of adult clients completing therapy who entered with at least mild severity (N=37) reduced their severity stage by at least one category.



of adult clients reduced their **PHQ-9 score** by at least one severity category



of adult clients reduced their **GAD-7 score** by at least one severity category

Other clients have even expressed that, hey, this has generational impact. We had one client that just had a lot of success through counseling. It benefitted their life, and then they'd go back and teach that to their family members, to their kids. They go back to their parents, and that's what I mean to say it's changing generations where people wouldn't ask for help. They'd have a stigma and then...they're teaching those skills...not only to their family but their community.

– The Center team member

Overall Assessment

The Center's counseling program helped clients improve their depression and anxiety symptoms. The Well Together Initiative had a strong design by enabling community organizations to facilitate a connection to The Center, a professional mental health provider, so that appropriate therapy services can be provided.

The Center has an opportunity to strengthen and expand partner relationships to further increase their reach in target communities. Strategies to increase therapy completion, or longer-term follow-up, could help further demonstrate impact.

WELL TOGETHER INITIATIVE

Lakepointe Church

What is Well Together Initiative - Lakepointe Church?

Well Together is a collaborative initiative between three organizations- AVANCE, The Center, and Lakepointe Church to reduce depression among underserved populations by increasing mental health education and reducing barriers to counseling. Lakepointe serves the Lake Rockwall Estates (LRE) community in Rockwall (75032) and provides extensive health services, mental health counseling, and education to reduce the negative stigma associated with mental health. Lakepointe's partners approach mental health screenings within a broader healthcare initiative to reduce the cultural stigma of mental health care through education, privacy, and access to care.

Lakepointe's program tailored an evidence-based mental health program to the cultural needs of an underserved community while offering appropriate mental and physical health care.

Lakepointe has a trusted presence in the Lake Rockwall Estates (LRE) community and was able to tailor a mental health program to the cultural, faith, and language needs of their clients. Lakepointe utilized the evidence-based VitalSign6 program and included a partnership with Grace Clinic and The Center so mental and physical health needs could be appropriately addressed.

> **...trying to re-educate and go against established culture is a slow go, but if we can affect a few families and those families share their success with others, then we can maybe create that next generational change in the perception [of mental health]...So, there's some immediate benefits we'll see from the grant, but I think we look up in 10 years...that's when we really see how successful this ends up being.**
>
> *– Lakepointe team member*

Lakepointe successfully reached their target population and connected clients to primary care.

Lakepointe screened 95 LRE residents for depression and provided primary care referrals to 105. Depression screening and referrals to primary care (Grace Clinic) were very successful.

Lakepointe faced challenges in implementing the depression program and providing referrals to counseling partners. Only 5 clients enrolled in the depression program, based on baseline screening severity level or direct provider referral. Lakepointe had difficulty establishing a referral pathway to The Center, but was able to connect clients interested in mental health counseling to other counseling sites not affiliated with this grant.

95

LRE residents screened for depression

105

LRE residents referred to Grace Clinic for Primary Care

25

LRE residents referred to mental health counseling

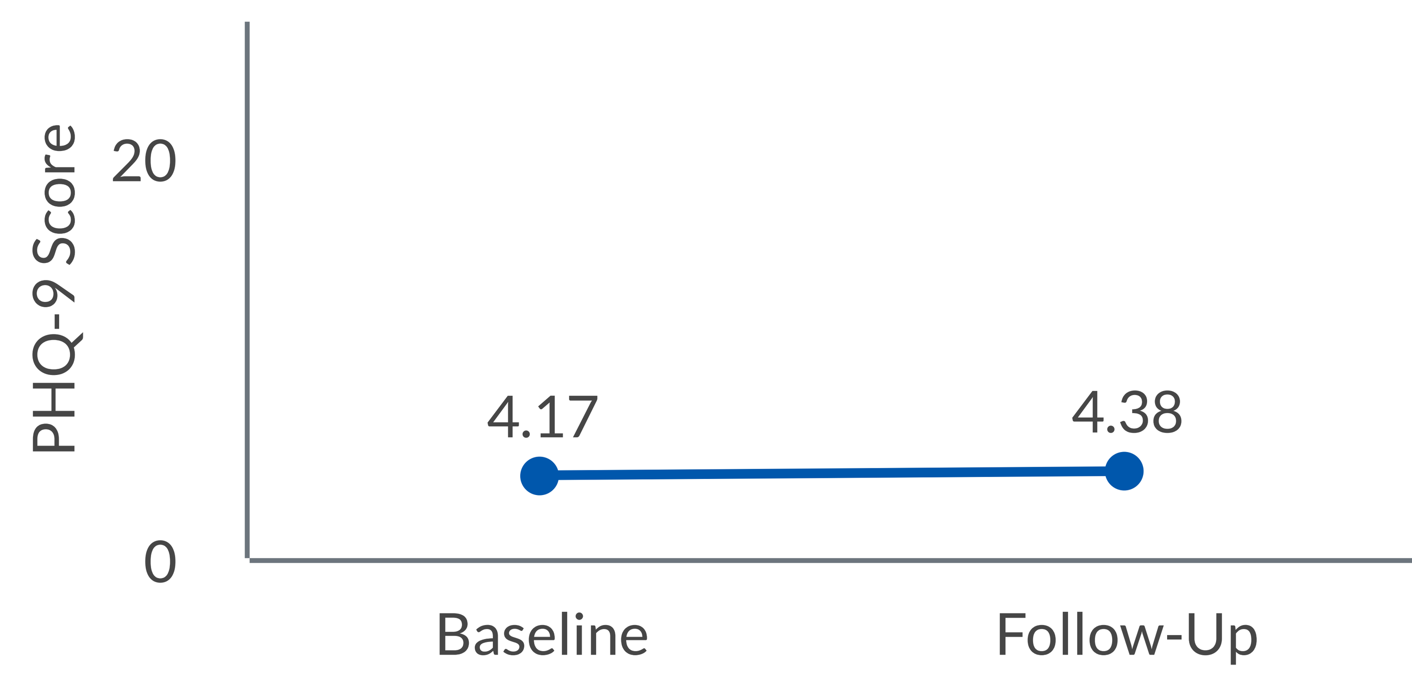
> **I think if we had a better way to communicate to everyone in the community, it would be a lot – we would have a lot more success. It's just the mediums of communication for that area are limited to door-to-door whereabouts. If we could get everybody to show up and get five minutes of their time to explain what's going on and what we have available.**
>
> *– Lakepointe team member*

Lakepointe faced significant challenges implementing follow-up mental health care and measuring health impact.

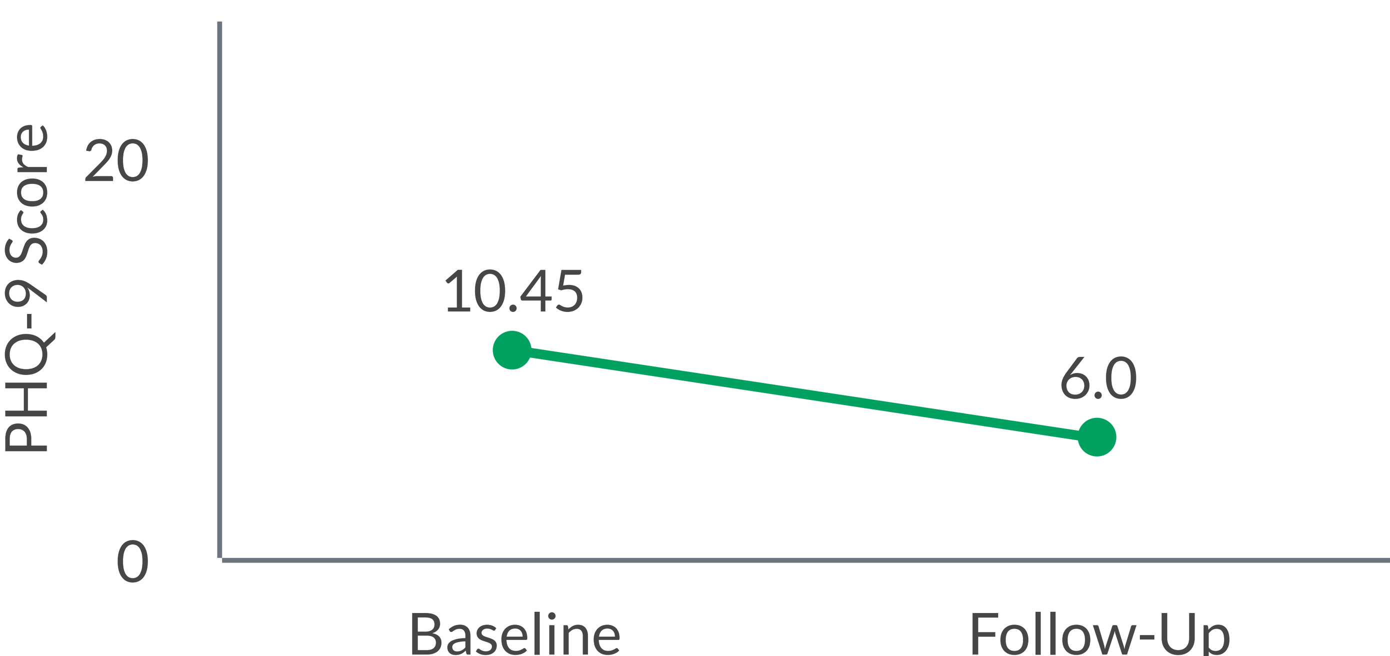
Though referral to primary care was successful, no measures of health impact were collected for this project, making impact difficult to assess.

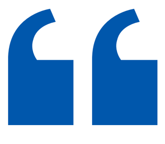
Lakepointe used the PHQ-9 assessment to measure depression. 49 participants had a pre- and post- depression assessment completed. No significant reduction in depression symptoms was observed overall or for the subset of patients referred to counseling. However, for the small group of participants with a baseline PHQ-9 score indicating mild or greater severity (N=15) an average 4-point reduction in score was observed. The small sample size makes further interpretation of change challenging and impact cannot be adequately assessed.

Depression Score (PHQ-9) Average Change



Participants with Elevated Baseline (N=15)





...we're looking at is lowering the [PHQ-9] scores on people...for people to see that mental health is a sixth vital sign. That having mental health issues, anxiety, depression, is not something to be ashamed of or not talked about...the more people we see accepting counseling and willing to go to those appointments is success for us.

– Lakepointe team member

Salient barriers to conducting the PHQ-9 assessment and other services were concerns about legal status and cultural stigma surrounding the topic of mental health. Lakepointe and Grace Clinic's investment in reducing this stigma is not fully captured by the data collected for this project and is an ongoing priority for both organizations.

Well, despite us having trust, it's still an issue – people just trusting to give us their information. Even the health clinic we had; they just don't want to fill out paperwork. They're afraid, when they don't have legal status, that that could be used against them. So, that's a constant barrier.

– Lakepointe team member

Overall Assessment

Lakepointe's program provided residents of an underserved community access to mental health and primary care from a trusted community site in Lake Rockwall Estates. However, workflow and partner challenges, communication and language issues, and mental health stigma limited the overall impact of the program. Additionally, data collection challenges made it difficult to fully measure impact in areas where they were successful (referral to primary care).

Lakepointe continues to serve the LRE community, identify opportunities to normalize mental health issues, and provide high quality clinical care through their ongoing partnership with Grace Clinic. More time to fully establish partnerships, workflows, and data collection systems could allow Lakepointe to revisit this model with success.

GRANTEE SPOTLIGHT | DENTON-WISE

PROMOTING RESILIENCY AMONG VULNERABLE CHILDREN

Children's Advocacy Center North Texas & Bridgeport Independent School District

What is Promoting Resiliency Among Vulnerable Children - Bridgeport?

This collaborative project between the Children's Advocacy Center for North Texas (CAC) and Bridgeport Middle School (76426) aims to create a support network by establishing social services infrastructure in Wise County and providing trust-based relational intervention programming, counseling support, mentoring support, and food access to middle school students to improve resiliency and self-regulation. The project also provides relationship-building support, self-regulation, and coping skills to parents through the Parent Cafe program.

The Bridgeport project established essential social services infrastructure in the region while implementing a school-based program that offered a wide range of services for the whole family.

This project established a new child services resource in Wise County and implemented a resiliency and self-regulation program at Bridgeport Middle School (BMS). All BMS students were screened for emotional regulation risk and at-risk students were prioritized for a wide range of services, although any student who needed services could receive them. The project also provided relationship-building support, self-regulation, and coping skills to parents through implementation of the evidence-based Be Strong Families Parent Cafe program.

So the child themselves, building their resilience but then also the parents' resilience when it comes to access to resources. And then those parent cafes...it's just building those protective factors, aiming to reduce that likelihood of abuse and neglect from happening. But also, to increase the likelihood that a family will report if there's abuse that is a crime.

– CAC Bridgeport team member

BMS successfully screened and provided services to high-risk students and other students in need.

893 students received a DERS-18 assessment measuring emotional regulation problems. 259 were identified to be at-risk for resiliency and emotional regulation problems.

Trust-Based Relational Intervention (TBRI) education was integrated into the curriculum for all BMS students. The BMS counselor collaborated with Communities in Schools to provide additional services including academic counseling, bullying support, a clothing closet, support for emotional concerns, food access, peer mediation, school supplies, social concern support, student check-ins, lunch groups, tutoring, and mentorship meetings. **During the 2021-2022 school year, 1,431 services were provided to 236 students, with 89 being at risk.**

Critical child services infrastructure was brought to Wise County through this project, by establishing a CAC presence to better identify and respond to child abuse cases across the county.

65%

Increase in intake reports reviewed*

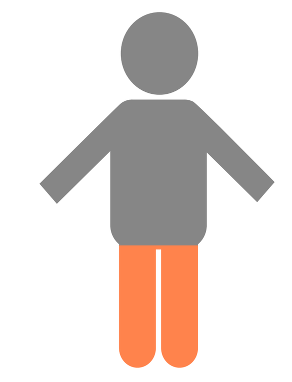
203%

Increase in forensic interviews conducted*

11,277

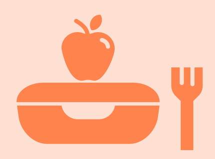
Family advocacy services provided

*Increase from year prior to project (2020) to first year of project (2021)



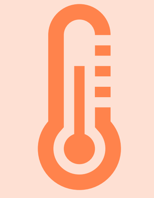
34%

of at-risk students received services (N=89)



Lunch Group
67 students | 334 services

Food Provision
47 students | 258 services



Student Check-Ins
90 students | 238 services

Tutoring
6 students | 8 sessions

Mentorship
2 students | 6 sessions

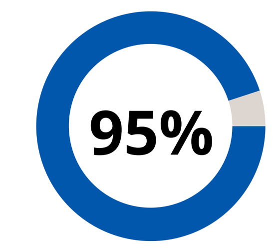
Parent Cafes engaged and educated families and were found to be beneficial by parents.

Be Strong Parent Cafes facilitate family relationship building through improvement of protective factors against child maltreatment, such as resiliency and family functioning. Cafes were available in both English and Spanish and were held in virtual group settings to spark conversation, peer-to-peer learning, and promote group support.

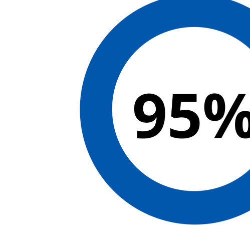
Parents indicated that they were able to improve protective factors against child maltreatment through participation. Overall attendance was low, with 18 BMS parents attending 13 Parent Cafes.

Parent Cafes convened virtually due to the COVID-19 pandemic, which many parents did not feel comfortable attending virtually due to login requirements or found it more challenging to engage in the virtual setting.

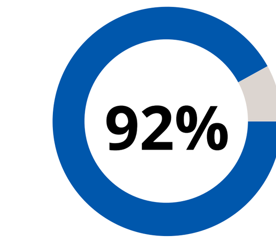
Proportion of parents indicating "agree" or "strongly agree" for each domain



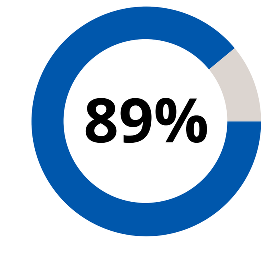
Better Reflect on Challenges



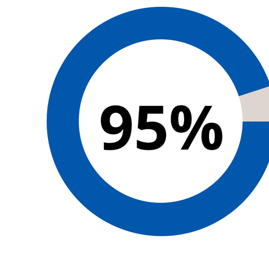
New Ways to Handle Challenges



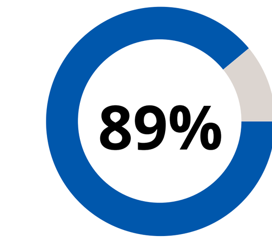
Learned Protective Factors



More Comfortable Seeking Help



Practice Talking to Improve Relationships

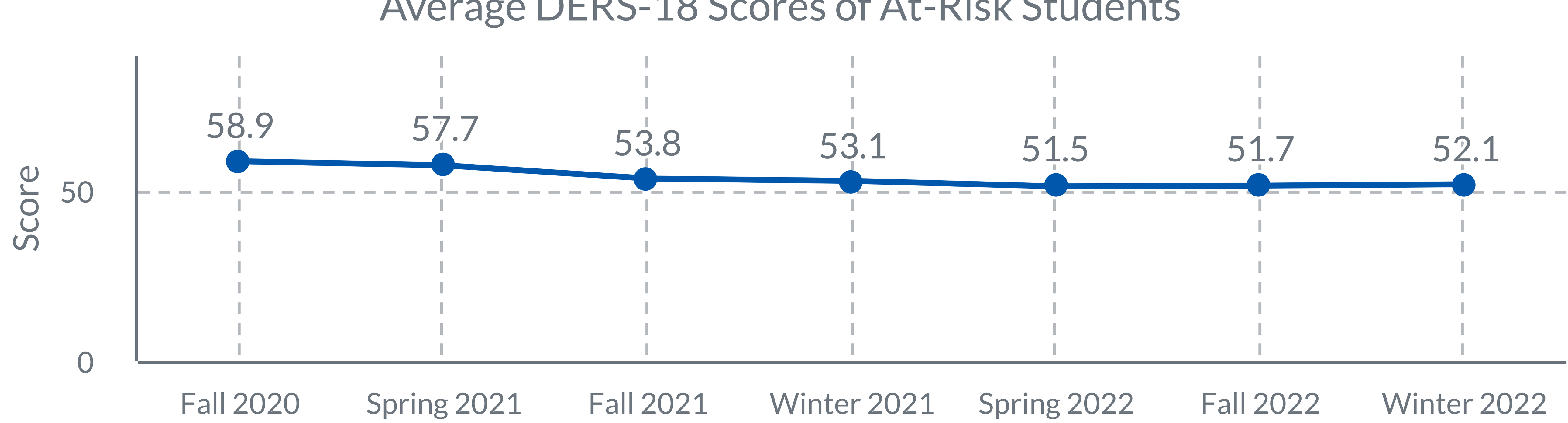


Deal Positively with Challenges

Emotional regulation and resiliency improved among at-risk students.

DERS-18 scores decreased significantly over time, indicating improvement in emotional regulation score.

For each additional follow-up, DERS-18 score decreased by 5.8 points when accounting for risk status, sex, race, ethnicity, and receiving services and clustering on semester of first DERS-18 score (cohort). DERS-18 scores were analyzed by the semester in which each student entered the program (Fall 2020-Winter 2022).



I think having a kid come in and tell you that I feel comfortable in this place, or hey, I've made new friends in lunch group and I feel like I've broadened my horizons. Or hey, I started to get into this fight but I stopped myself and I knew how to regulate. Like when they can tell you that, that's a huge success.

– CAC Bridgeport implementer

Overall Assessment

Bridgeport ISD successfully screened students at Bridgeport Middle School, administered support services, and established a CAC presence in Wise County. The school district displayed strong ability to implement social emotional learning into the curriculum and monitor progress over time, improving sustainability and feasibility of the program. Emotional regulation scores improved significantly and students were well engaged with program services. There is opportunity to further refine the identification of high-risk students to better direct to services. Parent Cafes were well received and addressing barriers to attendance may help further improve emotional regulation of students in the district. The BMS project was thoughtfully designed, well implemented, and the success provides a foundation to expand and tailor to other schools in the district.

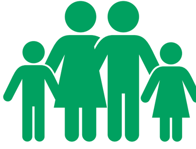
GRANTEE SPOTLIGHT | DENTON-WISE

PROMOTING RESILIENCY AMONG VULNERABLE CHILDREN

Children's Advocacy Center North Texas & Lewisville Independent School District

What is Promoting Resiliency Among Vulnerable Children - Lewisville?

This collaborative project between the Children's Advocacy Center for North Texas (CAC) and Delay Middle School (DMS) in Lewisville (75057) aims to create a support network by providing trust-based relational intervention programming, mental health support, mentoring support, and food access to middle school students in order to improve resiliency and self-regulation. The project also provides relationship-building support, self-regulation, and coping skills to parents through implementation of the Parent Cafe program.



The Lewisville project offered a wide range of school-wide and family-based services.

The resiliency and self-regulation program was implemented school-wide for DeLay Middle School. The school-based program offered a wide range of age-appropriate services to address a variety of student needs and provided relationship-building support, self-regulation, and coping skills to parents through implementation of the evidence-based Be Strong Families Parent Cafe program. The project's inclusion of a food pantry partner to increase food access community-wide strengthened the family-level impact.

[The program] it's side-by-side with our mission to prevent – well, really, that justice and healing for children through education and healing. We are doing all of that, too, through THR. I just think it completely melts together. That's with the Trust-Based Relational Intervention. That's also with the food insecurity piece because if children are hungry, they're not necessarily learning in the classroom. And if we're wanting them to kind of learn these good regulation skills, whether they have been a victim of child abuse or not, that's super important. So, in order for them to even kind of absorb those activities, those trust-based relational activities in the classroom, they have to – like their brain, they have to be fed. And then the resilience piece.

– CAC Lewisville partner

DMS successfully screened and provided services to high-risk students and other students in need.

In the 2021-2022 school year, 769 students received a DERS-18 assessment measuring emotional regulation problems. 226 were identified to be at-risk for resiliency and emotional regulation problems. 210 students received a DERS-18 during the Spring 2021 semester, before service utilization was tracked.

Trust-Based Relational Intervention (TBRI) education was integrated into the curriculum for all DMS students. The DMS navigator provided additional services to students; services most utilized were office visits and TBRI snacks (292 services each, individual students not tracked) and mentoring (266 services to 14 students). **900 services were provided during the 2021-2022 school year.**

In Fall 2022, the end of the project period, 585 students received a DERS-18 assessment with 262 identified as high-risk. Forty-five students, 37 at risk, received services in Fall 2022. The most common were on-campus visits/ check-ins (198 services to 39 students) and food pantry access (40 services to 12 students). Student services and final assessments will be tracked after the funded project period ends.

769 Received DERS-18 assessment

226 Identified to be high risk

900 Services provided by DMS navigator

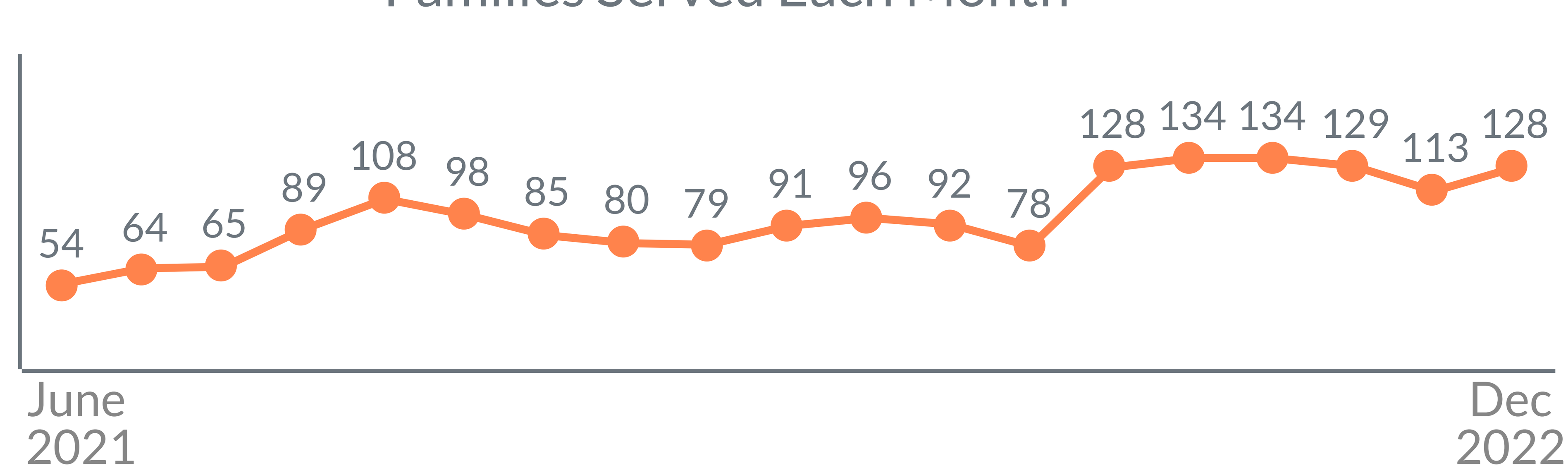
Office Visits
292 services

TBRI Snacks
292 services

Mentorship
266 sessions | 14 students

Access to healthy foods was addressed at the community level through DMS' partnership with a local Food Pantry.

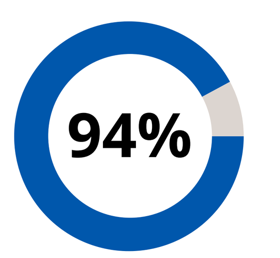
Heart of the City food pantry began partnering with DMS in June 2021 to address food insecurity by expanding services to 75057. **Since the partnership began, Heart of the City has steadily increased the number of families served in Lewisville.**



Parent Cafes were well-attended and found to be beneficial by parents.

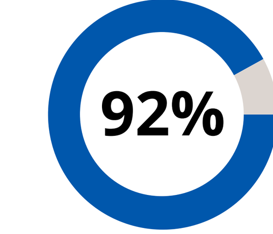
Lewisville ISD parents were offered Be Strong Parent Cafes to facilitate family relationship building. **Parent utilization of the Cafes was sustained throughout the program, with 131 attendees over the course of 40 sessions. These attendees indicated that they were able to improve protective factors against child maltreatment through participation.** Some of the attendees may be repeat participants, so the number of unique parents cannot be determined.

Proportion of parents indicating "agree" or "strongly agree" for each domain



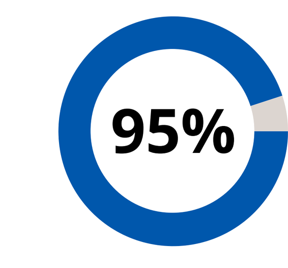
Better Reflect on Challenges

New Ways to Handle Challenges

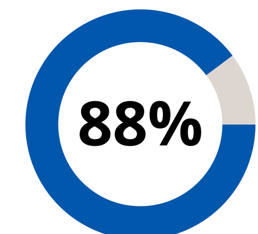


Learned Protective Factors

More Comfortable Seeking Help



Practice Talking to Improve Relationships



Deal Positively with Challenges

The services provided by the project helped increase resiliency and emotional regulation for at-risks students compared to not-at-risk students.

Change in DERS-18 scores was analyzed for the 2021-2022 school year.

Average DERS-18 scores decreased significantly more among at-risk students compared to not-at-risk students.

Larger reduction in DERS-18 score for at-risk students compared to not-at-risk students.

There's an activity in parent cafés at the end where everyone shares a word from the café experience. And some of the words were 'my village', like it's their village. So we hear that a lot that it's their village. That it's safe and nonjudgmental. That parents can come to cafés. They can talk. They don't feel judged. And there's just a lot of togetherness. The parents that have attended, they've repeat attended and they really, I would say, have become friends. Have become a support system.

– CAC Lewisville implementer

Overall Assessment

Lewisville ISD successfully implemented an emotional regulation and resiliency intervention at DeLay Middle School during the 2021-2022 school year. Challenges with collecting a unique student identification number limited the ability to track progress between academic years, though future efforts could benefit from this level of tracking. At-risk students had a significantly higher improvement of emotional regulation, demonstrating that services were effective. Parent Cafes had high turnout and were well received by parents and food pantry services were expanded in the region with the support of this project.

GRANTEE SPOTLIGHT DENTON-WISE

Together Harnessing Resources to Give Individuals Voice & Empowerment (THRIVE)

Sanger Independent School District

What is THRIVE?

THRIVE is a collaborative project between Sanger ISD, First Refuge Ministries of Sanger, First Baptist Church of Sanger, New Life Church of Sanger and the City of Sanger that aims to address the behavioral needs of Sanger ISD (76266) students through a school-based resiliency and counseling program and improve food security by increasing the availability of fresh, healthy food to students and the Sanger community through a food pantry and mobile pantry program.

THRIVE's district-wide implementation featured strong community partnerships, innovative school-based resiliency programming and services, and a food program with community-wide reach.

THRIVE administered the Student Risk Screening Scale (SRSS) bi-annually to all Sanger ISD (SISD) students with students identified to be at risk for behavior challenges considered for the "Red Zone" where they could receive additional supportive services. THRIVE has strong community partners to bolster the type and number of services offered to students and a food program designed to address the needs of the entire Sanger community through multiple access points.

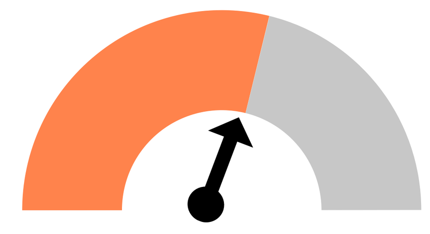
We work really well together. Some people would say churches and school districts and city governments are not supposed to work together, but I disagree. We each have our role, but there are things that we can partner on and cooperate.

– THRIVE partner

THRIVE employed a wide range of student services to address behavioral health needs.

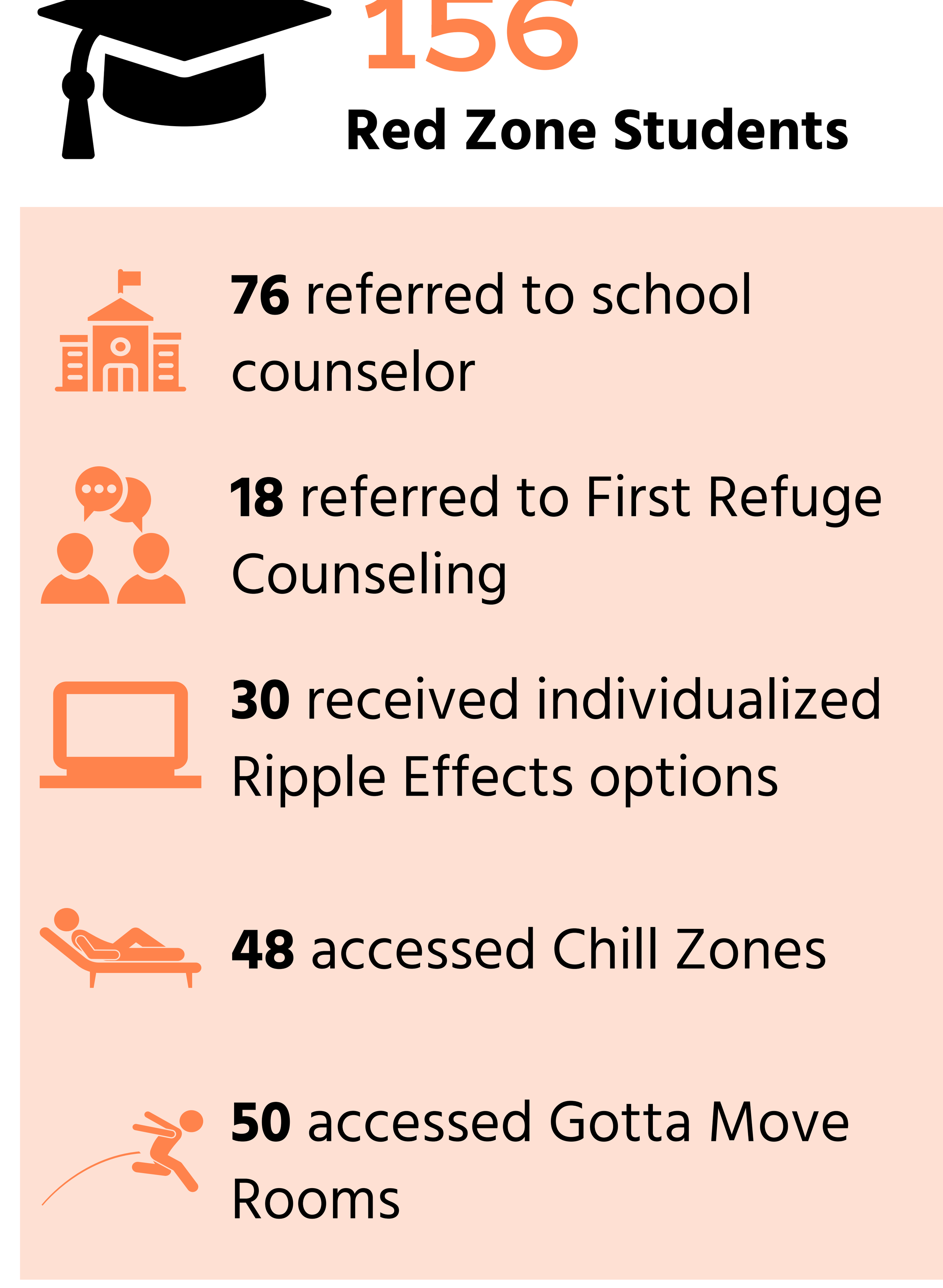
In the 2021-2022 school year, 2,519 unique students were screened for behavior challenges, reaching 96% of the 2,635 students enrolled in the K-12 at the 7 SISD campuses. In Fall 2022, screening was expanded to include pre-kindergarten students with a total of 2,482 students screened.

All SISD students received education through Ripple Effects, a social emotional skill building software that promotes positive behavioral and mental health.



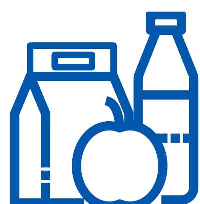
156 students were enrolled into the Red Zone. **90 (57%)** Red Zone students received additional services.

Red Zone students could access additional services: "Chill Zones" to relax quietly, "Gotta Move Rooms" to work off extra energy, more individualized Ripple Effects modules, and referrals to wrap-around services including counseling within the school district or at First Refuge Ministries of Sanger.



Our universal behavioral mental health screening that we do twice a year of all...students in the district, and basically, it's a screener that allows us to identify some students that we need to look at closer and develop a support plan. And a lot of times some of the components of the THRIVE program are what they need, are of benefit to them.

– THRIVE team member



Community food access was sustainably addressed through the implementation of two food pantries in the city of Sanger.

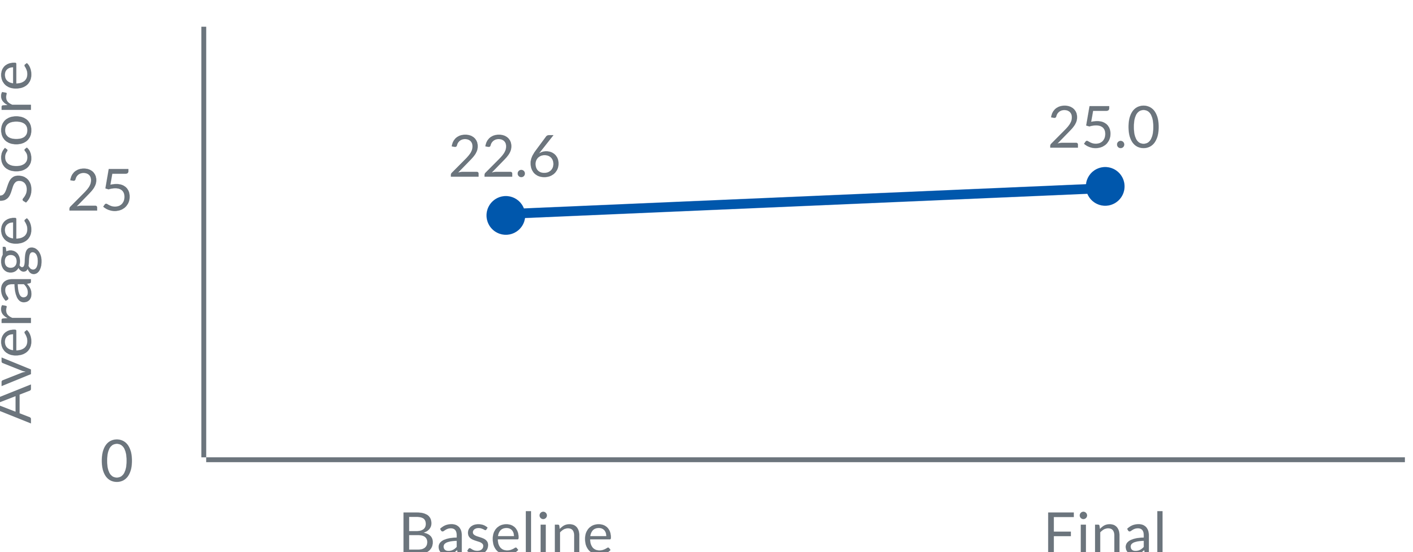
Over 500 families were served by the First Refuge food pantries and Linda Tutt High School grocery store.

Food to stock the pantries was partially sustained from Sanger community gardens and Sanger High School agriculture class. The effect of this innovative program on sustained improvements in food insecurity could not be measured in the short project time period.

Red Zone students had improvements in resiliency and self-efficacy.

Red Zone students completed Connor-Davidson Resiliency Scale (CD-RISC) assessments to measure resiliency and General Self-Efficacy (GSE) assessments to measure self-efficacy. 85 (54%) Red Zone students completed a baseline and follow-up CD-RISC and 45 (29%) completed a baseline and follow-up GSE assessment.

Self-efficacy (GSE) and resiliency (CD-RISC) scores significantly improved for Red Zone students.



We've had several students that were on a trajectory to possibly end up homeless, or addicted, or with severe mental health, needing hospitalization. And through their access to services, some of them, through their work, managing the grocery store at Linda Tutt, their lives have totally changed. We did a CBS interview recently, and they interviewed me about mental health in schools in general, and then they interviewed a student who has had a pretty horrific life, been exposed to multiple ACEs, and he very specifically said that the program saved his life.

– THRIVE team member

Overall Assessment

THRIVE implemented a successful multilevel project improving resiliency and self-efficacy among high-risk students and expanding food access across Sanger. Red Zone students were offered a wide variety of innovative programs and services, and further expansion of services across schools/grades could increase participation. THRIVE's food programs provided healthy food access in schools and across the SISD community. Given implementation challenges and delays of the food pantry components, longer term follow-up may better assess food security improvement in the community. THRIVE has strong potential to improve behavioral health outcomes in the greater Dallas-Fort Worth area with the publication of their THRIVE toolkit, outlining steps to implement the THRIVE program in other school districts.

GRANTEE SPOTLIGHT SOUTHERN

ERATH COUNTY COMMUNITY BRIDGES (ECCB)

Erath County United Way

What is ECCB?

ECCB, led by Erath County United Way (ECUW), is a partnership between mental health counseling services, local food banks, and other community partners aiming to provide residents of Stephenville (76401) and Dublin (76446) with comprehensive services that meet their needs of food security, reduced anxiety and depression, and knowledge of how to navigate social service systems. ECCB employs monthly wrap-around meetings with partners to address individuals' identified needs, and an online platform for referrals with access to shared data to enhance navigation services.

ECCB featured a robust partner network with a strong central coordinating organization and multiple connection points with a streamlined intake process.

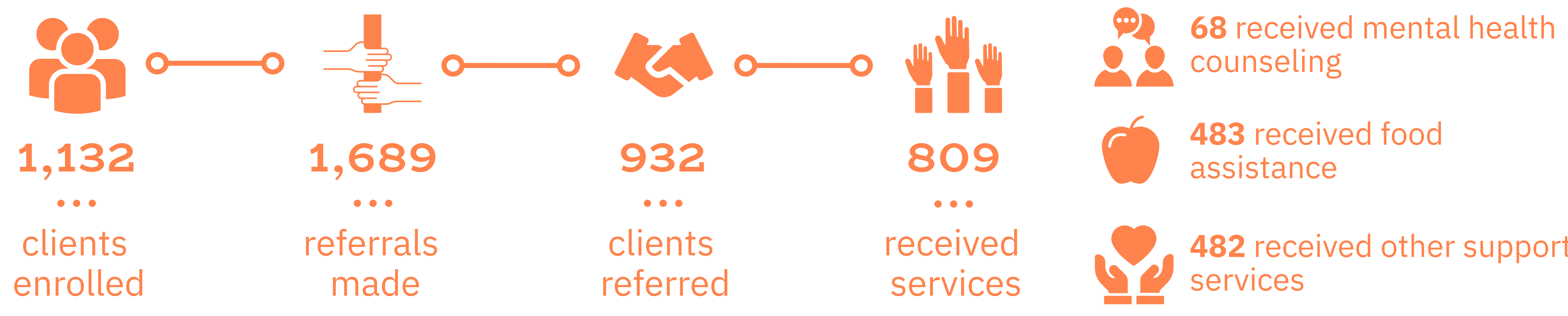
Potential clients could present at any partner agency and complete a brief intake form that was sent to Erath County United Way (ECUW) for review. This increased access for potential clients and allowed for partnership with agencies well established in the target communities but lacking the resources to complete a complex intake process. ECCB featured a network of partners, including a professional counseling provider for direct mental health services. ECUW, the lead agency, was well positioned to serve as the central organization by facilitating referrals, coordinating partner relationships, and implementing data systems.

There's a lot of resources out there to tap into and having more organizations knowing about what you do can be very beneficial. Not only can they possibly help, but they can also refer clients that they work with to us.

– ECCB implementer

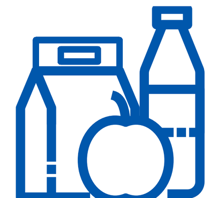
ECCB coordinated referrals to connect clients to mental health, food, and other support services.

ECCB enrolled 1,132 clients. Clients were primarily connected to ECCB when they presented at one of the partner foodbanks and were given the intake screener. ECCB navigators received the screeners, reviewed eligibility, and contacted clients via phone or text to coordinate referrals and connect to services. **81% of enrolled clients received at least one referral and 88% of those referred received services.**



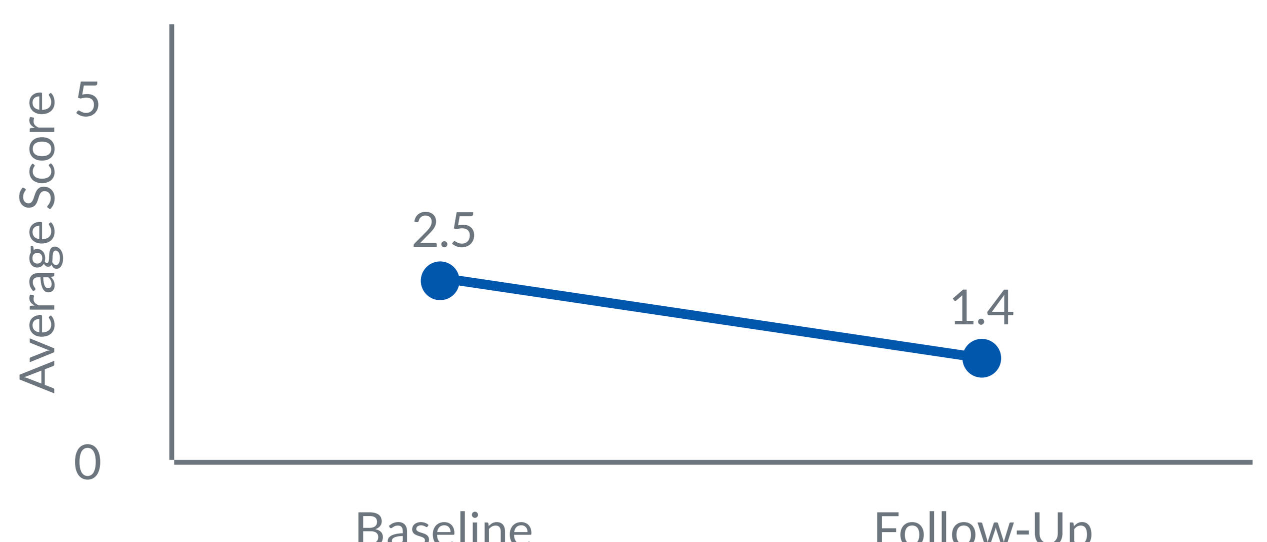
Once people realized what it was that we were trying to do and how it would be beneficial to them, it was well received. The implementation took off really quickly.

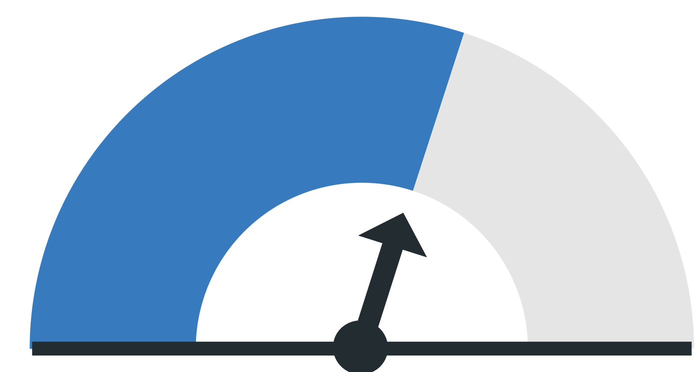
– ECCB implementer



Food insecurity decreased for ECCB clients.

Clients that screened positive for food insecurity at intake (N=958) completed the USDA 6-item food security module to measure food insecurity. 459 (48%) clients completed a baseline and at least one follow-up assessment. **Average food insecurity scores (USDA) significantly decreased over the project period. Of the 386 clients with low or very low food security at baseline, 233 (60%) reduced their food insecurity by at least one level at final follow-up.**



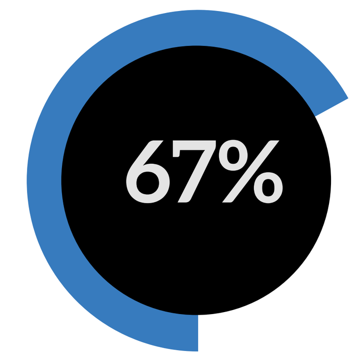


60% of food insecure clients reduced their food insecurity by at least one level

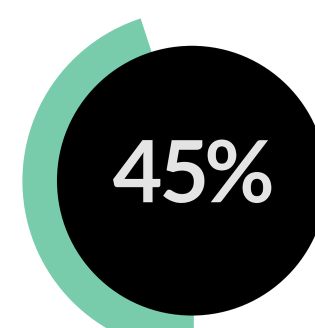
ECCB connected clients with depression and anxiety symptoms to professional mental health counseling.

Clients receiving counseling (N=68) from Safe Harbor completed PHQ-9 assessments measuring depression and GAD-7 assessments measuring anxiety. 24 (35%) completed a baseline and at least one follow-up depression assessment. **Of the 22 clients with a baseline severity of mild or greater, 16 (67%) improved their depression severity by at least one severity stage at final follow-up.**

23 (34%) completed a baseline and at least one follow-up anxiety assessment. **Of the 20 clients with baseline severity of mild or greater, 9 (45%) improved their anxiety severity by at least one severity stage at final follow-up.** The small sample with PHQ-9 and GAD-7 assessments makes further interpretation of score change difficult.



of clients reduced their **PHQ-9 scores** by at least one severity category



of clients reduced their **GAD-7 scores** by at least one severity category

> **We're watching clients that have grown over the sessions and when you see them come in the first time and their face is drawn and they hang their heads. I mean you can tell that they're not happy. And the first time you see them come in with a smile on their face or a kick in their step or you just know that them coming in the door has been the saving grace for them.**
> *– ECCB implementer*

Overall Assessment

ECCB assembled a partnership between several community organizations, most notably food banks, to reach high needs clients in a rural community. They developed a simple intake process and had strong centralized workflows for connecting with clients, identifying needs, and directing to a variety of services. They faced several challenges with partner continuity and engagement but they were able to maintain the program through monthly meetings and a dedicated navigator. In their first cycle of funding, ECCB reached a large number of residents of the target region, coordinated referrals for the vast majority of clients, and managed project disruptions to keep services going. Continued work to strengthen partner relationships and follow-up with enrolled clients could further increase impact.

PROJECT EMPOWER

United Way of Tarrant County

What is Project Empower?

Project Empower is a collaboration of eight community organizations, led by United Way Tarrant County, aiming to empower residents in Arlington (76010/76011) and Parker County (76082) to take steps to alleviate depression and anxiety, consume healthy food, improve self-efficacy and/or overcome transportation barriers of access. Project Empower employs a referral and asset mapping system among its partner agencies to connect participants to the services they need.

Project Empower featured a large partner network and a strong central coordinating agency.

Project Empower had a well-resourced central coordinating organization, United Way of Tarrant County (UWTC), with the ability to coordinate the large partner network and manage data systems. The partner network in Project Empower was comprehensive, featuring food assistance providers, mental health counseling services, and social service and case management organizations who were well-established in the Arlington and Parker County area.

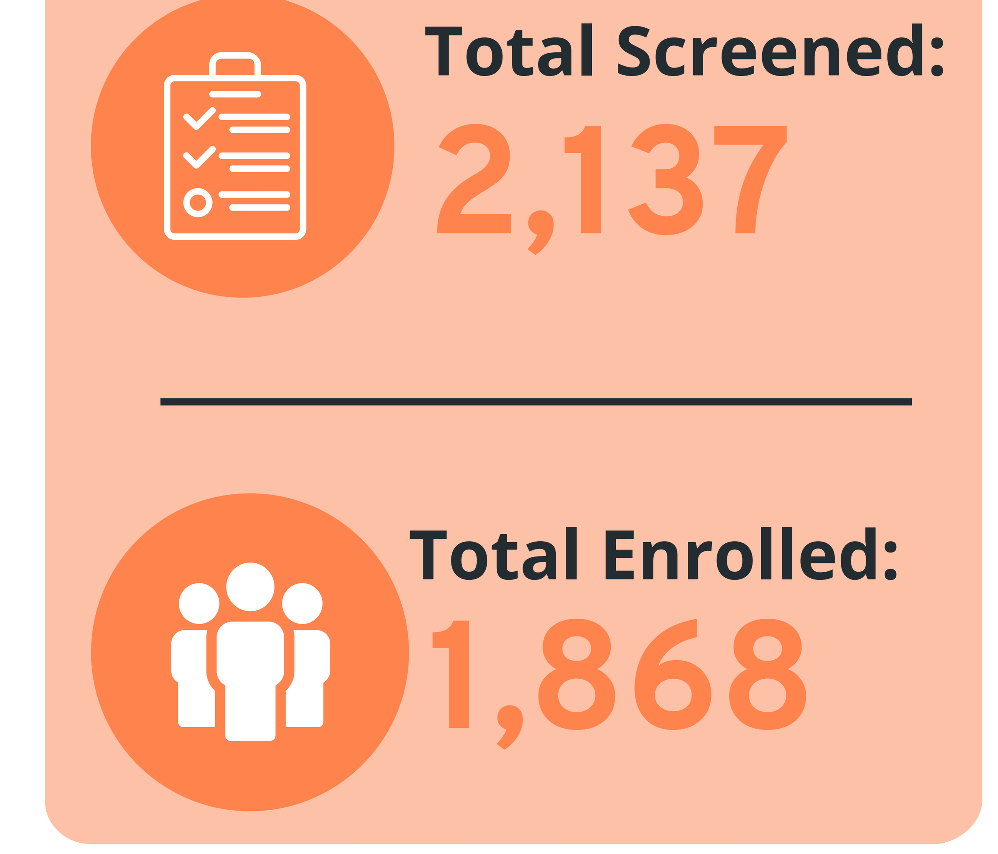
Overall, our goal is to provide vital services to older adults and their caregivers and that's what this is about, providing those vital services to consumers in our county. On a secondary level — on a macro level — it really is about demonstrating the power of collaboration. So, we all here in Tarrant County have our spheres of influence. But I think what we're seeing with this grant is when we actively work together and deliberately work together, we can reach a whole lot more people together than we can individually."

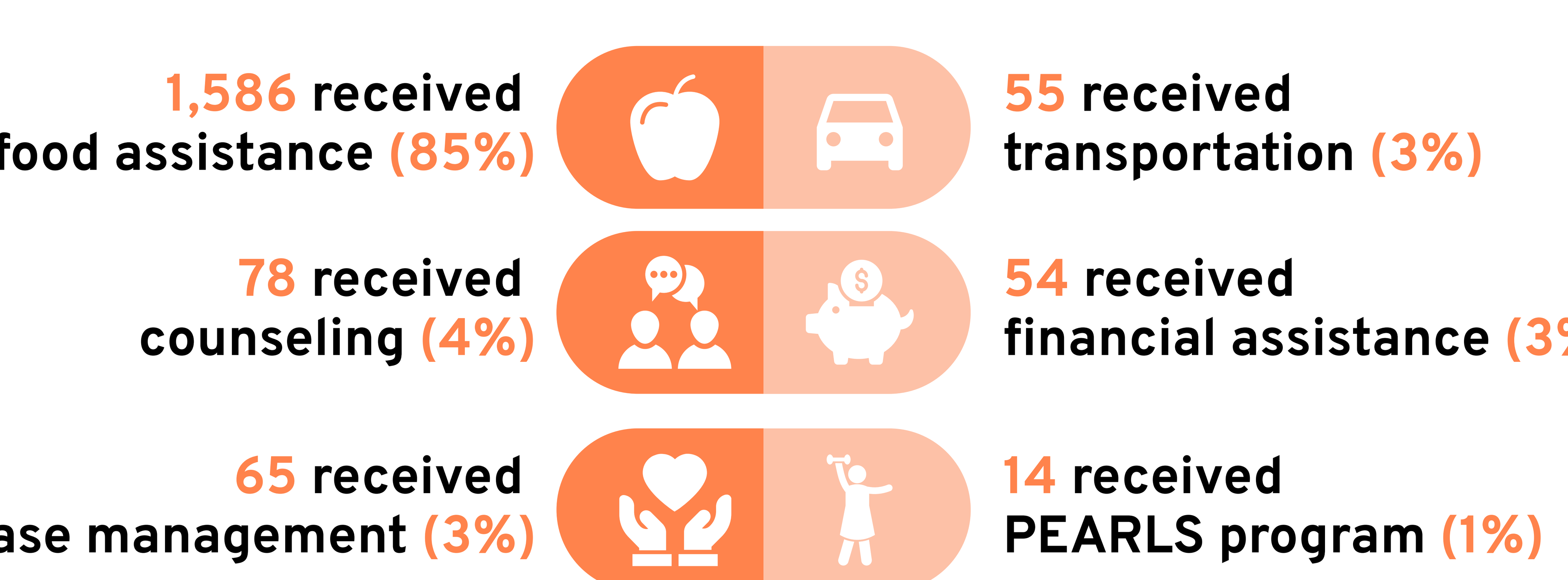
– Project Empower team member

Project Empower partner agencies successfully screened and served a large number of residents from the target communities.

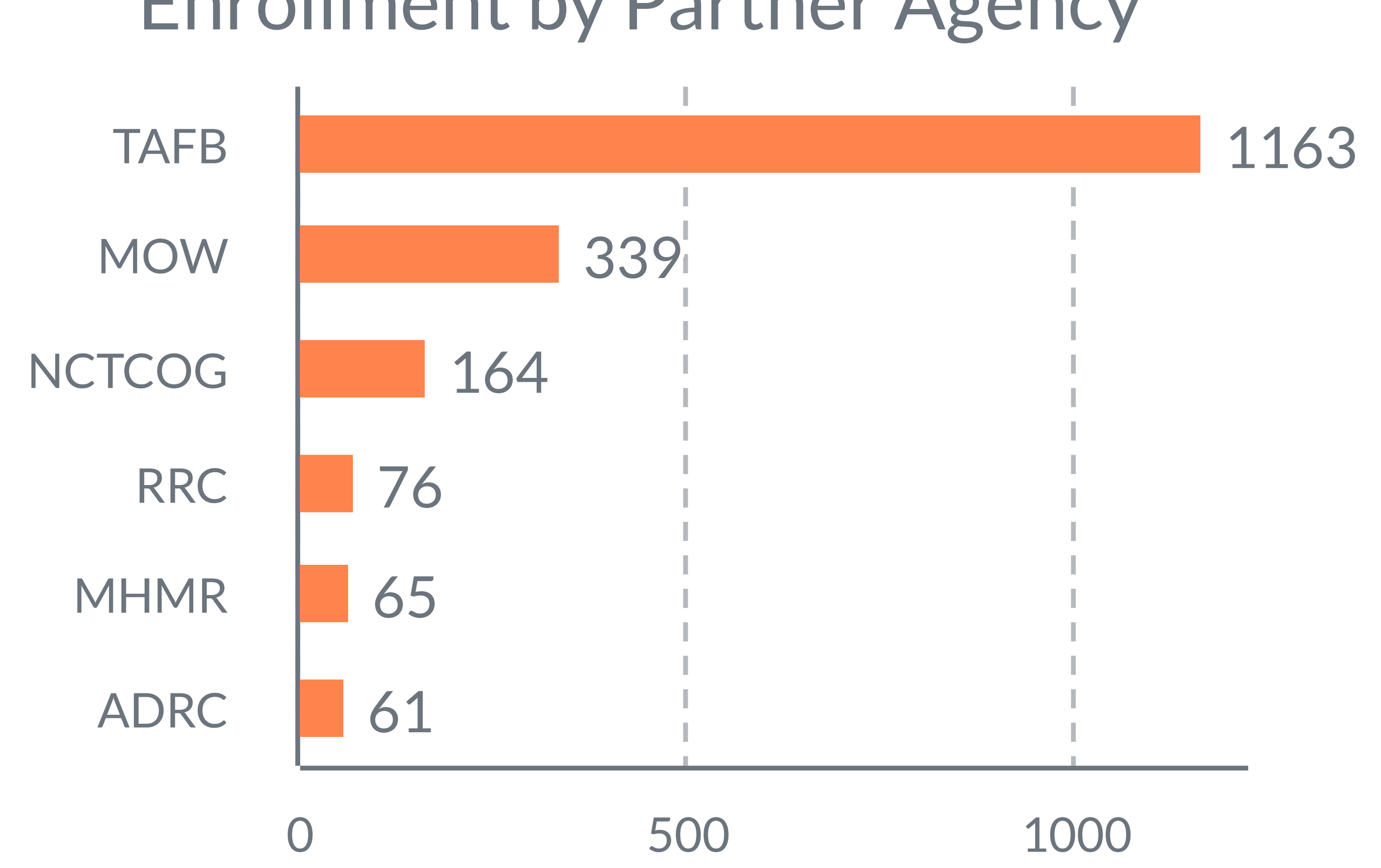
Project Empower clients enroll by engaging with any of the 6 partner agencies. **All partners exceeded their screening and/or enrollment goals**. Nearly two-thirds of clients came from partner Tarrant Area Food Bank (TAFB), who was not able to track participants by the Project Empower ID or track referrals to other Project Empower partners.

Once enrolled, clients received services based on partner expertise. Food assistance was the primary service provided through Project Empower. Depression, anxiety, and self-efficacy services were also provided to clients.





Enrollment by Partner Agency



Project Empower faced challenges in creating a collaborative partner network. The project aimed to create an integrated partner network to connect clients to a variety of services and resources. Clients were well engaged with the partner they first presented for services but only 9% (N=161) of enrolled participants received a referral to a Project Empower partner. Notably, the largest partner, TAFB, did not make or track referrals to other partners. Partners did refer clients to other resources and organizations outside of Project Empower which could provide insight into ways to expand the collaborative and best meet resident needs in the future.

We really have to take a step back and put ourselves in the participants' shoes when it comes to how best to market to that individual, how best to get them to take advantage of the resources that are available.

– Project Empower team member

Depression and anxiety symptom severity and food insecurity were reduced for Project Empower clients.

The project used the PHQ-9 assessments to measure depression, GAD-7 to measure anxiety, GSE to measure self-efficacy, and USDA to measure food insecurity.

Clients with elevated baseline scores had significant reductions in average depression, anxiety, and food insecurity scores. GSE scores remained stable, but the assessment was well implemented by some partners and continues to be used to monitor progress.

Outcome assessment average score change

	Depression Score (N=50)	Anxiety Score (N=40)	Food Insecurity Score (N=124)	Self-Efficacy Score (N=124)
Baseline	11.80	11.38	3.06	28.6
Final	5.17	2.38	2.28	28.61

4.44 **Average reduction** in PHQ-9 score

9.0 **Average reduction** in GAD-7 score

0.78 **Average reduction** in USDA score

0.01 **Average change** in GSE score

56% reduced their **PHQ-9** severity category

93% reduced their **GAD-7** severity category

46% reduced their **USDA** insecurity level

43% improved their **GSE** total score

My favorite tool [Generalized Self-Efficacy scale] on this project to see how clients were doing...now we use it with every client. Just because we are not always going to resolve your depression or anxiety, we're not always going to get that where it needs to be, but we can always help you be, be more self-efficient or know how to recognize resources in your community.

– Project Empower partner

Overall Assessment

Project Empower had a robust partner network, a well-resourced central coordinating organization, and able to reach a large number of residents in the target counties. All partners met their enrollment and/or screening goals and subsets of clients improved depression, anxiety, and food security status. The driving force in Project Empower's reach was the number of clients served by partner TAFB, who was not well engaged with other partners in order to facilitate referrals or track individuals longitudinally. Most partners did not refer clients to other agencies within Project Empower but did connect clients to other resources. These outside referral organizations could serve as an opportunity to identify additional partners to strengthen and expand the collaborative to best meet the needs of the target community.

Project Help, Hand, Hope (Project HHH)

Parker County Center of Hope

What is Project HHH?

Project HHH meets the immediate (crisis) needs of residents of Springtown (76082) through their basic assistance program and provides long term solutions via extended services designed to encourage self-sufficiency. Through a network of volunteers, collaborations with local organizations such as churches, other nonprofits, and local businesses, and a longstanding partnership with Safe Harbor Counseling, Project HHH seeks to decrease levels of anxiety and depression, increase food security, improve level of self-efficacy and elevate ability to navigate social services.

Project HHH offered innovative programs and services tailored to the needs of the community they served.

Project HHH met clients where they were by focusing first on meeting the client's basic or immediate needs before offering extended services. This helped facilitate trust and encouraged sustained engagement in the programs once clients were ready for them. Project HHH offered a variety of programs through Center of Hope and had a strong partnership with a professional mental health provider to connect clients to quality mental health care and reduce financial and access barriers.

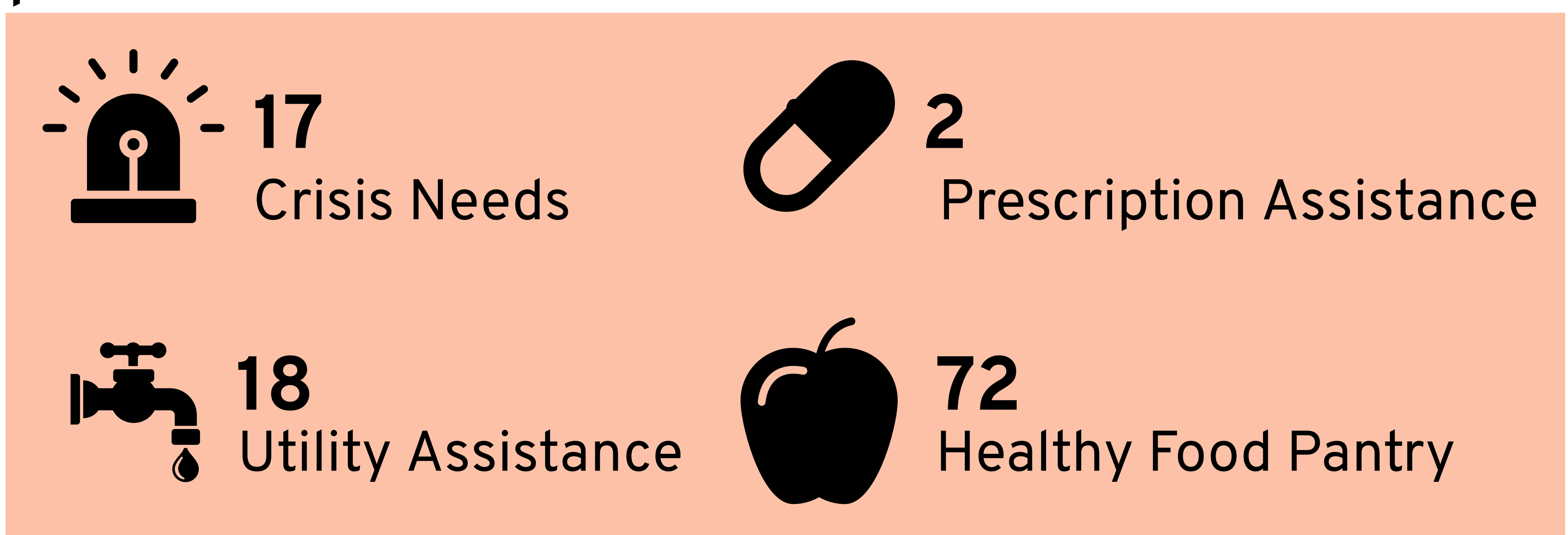
> **All of our programs are targeted to help people and to help them be self-sufficient, and to help them have a better for themselves and make good decisions and be able to change those things that aren't working.**
>
> *– Project HHH implementer*

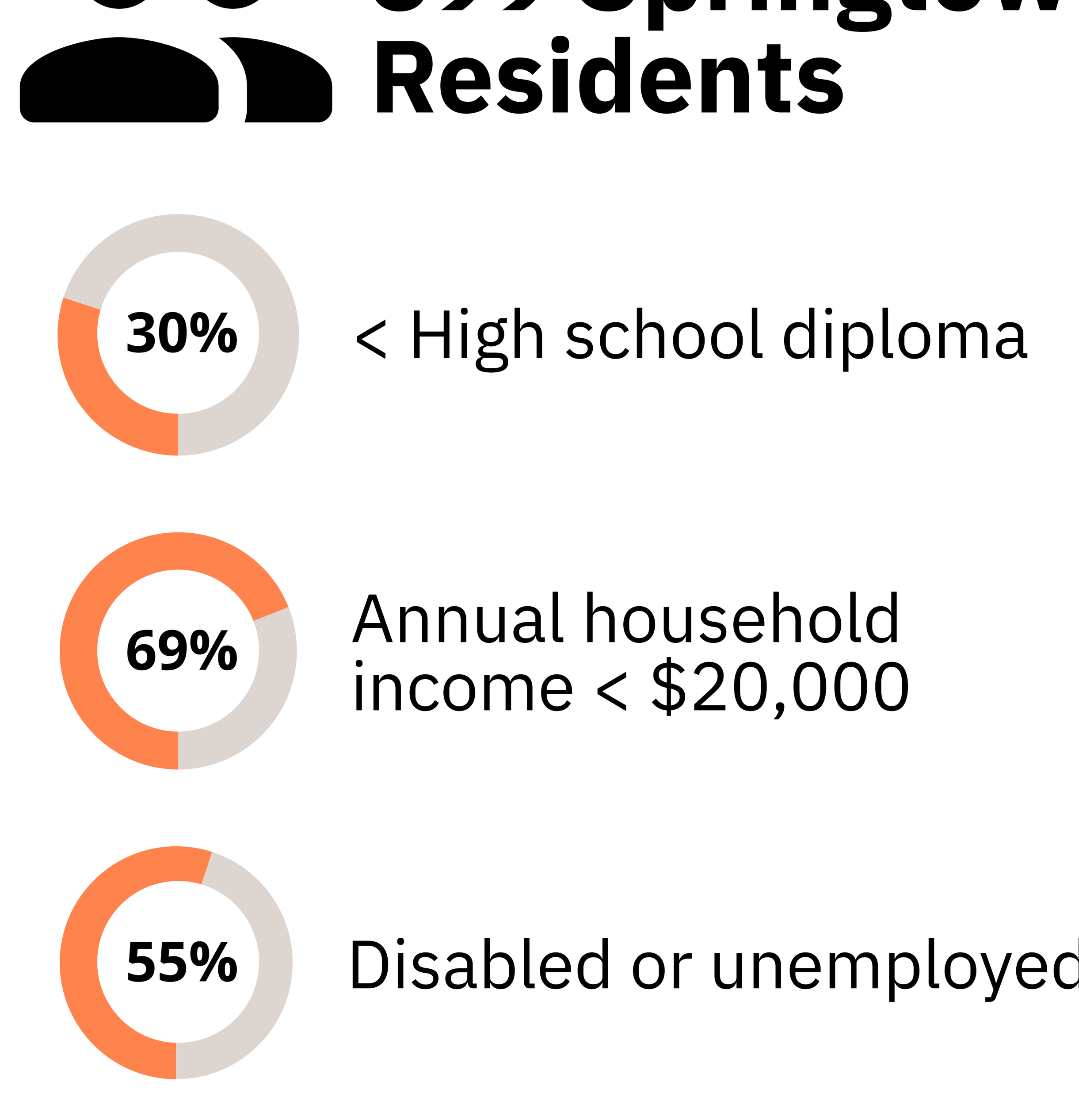
Project HHH provided essential services to high-needs residents of the target community.

Project HHH allowed Center of Hope to extend services to the Springtown area. Clients were offered a variety of services to meet immediate needs, with the healthy food pantry being the most utilized.

Clients connected to the Center of Hope Springtown Coordinator completed an open-ended needs assessment to determine what additional, or extended, services they might benefit from. Project HHH sought to train volunteers to serve as peer navigators for enrolled clients, but the work of establishing a volunteer base in took most of the grant period. Recruitment and trainings are underway and more clients should receive this component in the future.

Average number of **basic assistance** services provided each month





95 Project HHH clients received an extended service. Extended services included the six-week CALM anti-anxiety course, the one-time STEPS goal setting course, job training programs, and connection to Safe Harbor for mental health counseling.

Though the STEPS and CALM course were not well utilized during the grant period, Project HHH provided Safe Harbor vouchers for 30 clients to receive counseling at no cost and engagement in the STEPS class increased in the second year of the grant as the Springtown site was more established.

16%

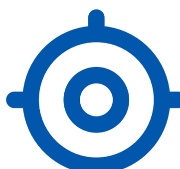
of basic assistance clients received extended services

71 completed the STEPS goal setting course

30 received mental health counseling from Safe Harbor

3 enrolled in the Job Training programs

1 enrolled in the CALM anti-anxiety course



Project HHH employed a variety of assessments to monitor client progress and direct to appropriate services.

Food Insecurity
68 clients reporting food insecurity on the USDA 6-item measure, **17 (25%) reported decrease in the score by at least one level.**

Self-Efficacy
Of those with follow-up (N=77), **31 (40%) increased their General Self-Efficacy Scale (GSE) score by at least one point**.

Depression and Anxiety
Safe Harbor clients completed the PHQ-9 depression assessment and GAD-7 anxiety assessment. All 15 clients with at least one follow-up assessment had at least mild depression and anxiety.

9 (60%) reduced their depression severity and 8 (53%) reduced their anxiety severity by at least one category at final follow-up. The small sample sizes make further of change difficult.

25%
reduced food insecurity by ≥ 1 level (N=17)

40%
improved self efficacy score (N=31)

60%
reduced depression severity by ≥ 1 category (N=9)

53%
reduced anxiety severity by ≥ 1 category (N=8)

Any outcome is successful, whether it's a person no longer needs assistance, or they go to counseling, or they get off of government assistance and they're living on their own, any kind of progress or positive outcome is a success. There's not really one that I can identify more so than any others, that I would consider a success for the program.
– Project HHH Implementer

Overall Assessment

In their first cycle of funding, Center of Hope expanded to a new service area (Springtown) and successfully reached high needs residents. They have built trust in the community, developed essential infrastructure, and established relationships with community partners. Basic services were consistently provided to clients and Project HHH can leverage the foundational work they've done this cycle to increase engagement and awareness of the extended services in the future. Additional attention to identifying appropriate assessments could ease data collection burden on staff and increase the ability to measure impact. Overall, Center of Hope has the expertise and community presence to continue to grow Project HHH and provide valuable services in this community.

THE RAILROAD PROJECT

Eastside Community Services

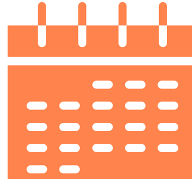
What is The Railroad Project?

The Railroad Project organizes and hosts community health events at churches throughout Southeast Fort Worth (76119). At events, attendees receive basic assistance (food, clothing) and have the opportunity to connect with a variety of services including mental and physical health education, financial literacy, and more. The Railroad Project aims to provide holistic services to their clients and elevate the lives of their clients by providing a food and clothing pantry service, treating mental health/addiction issues and improving self-efficacy.

The Railroad Project was led by a trusted community agency and offered a variety of services with a client-focused mission.

The Railroad Project events were organized by Eastside Community Services, who is a trusted community leader with a strong background in community engagement. The project was client-centered and allowed clients agency to determine their most salient need before services were offered. The community health events employed a combination of social services and education provided onsite and the opportunity to learn about partner agency services clients could participate in outside of the events.

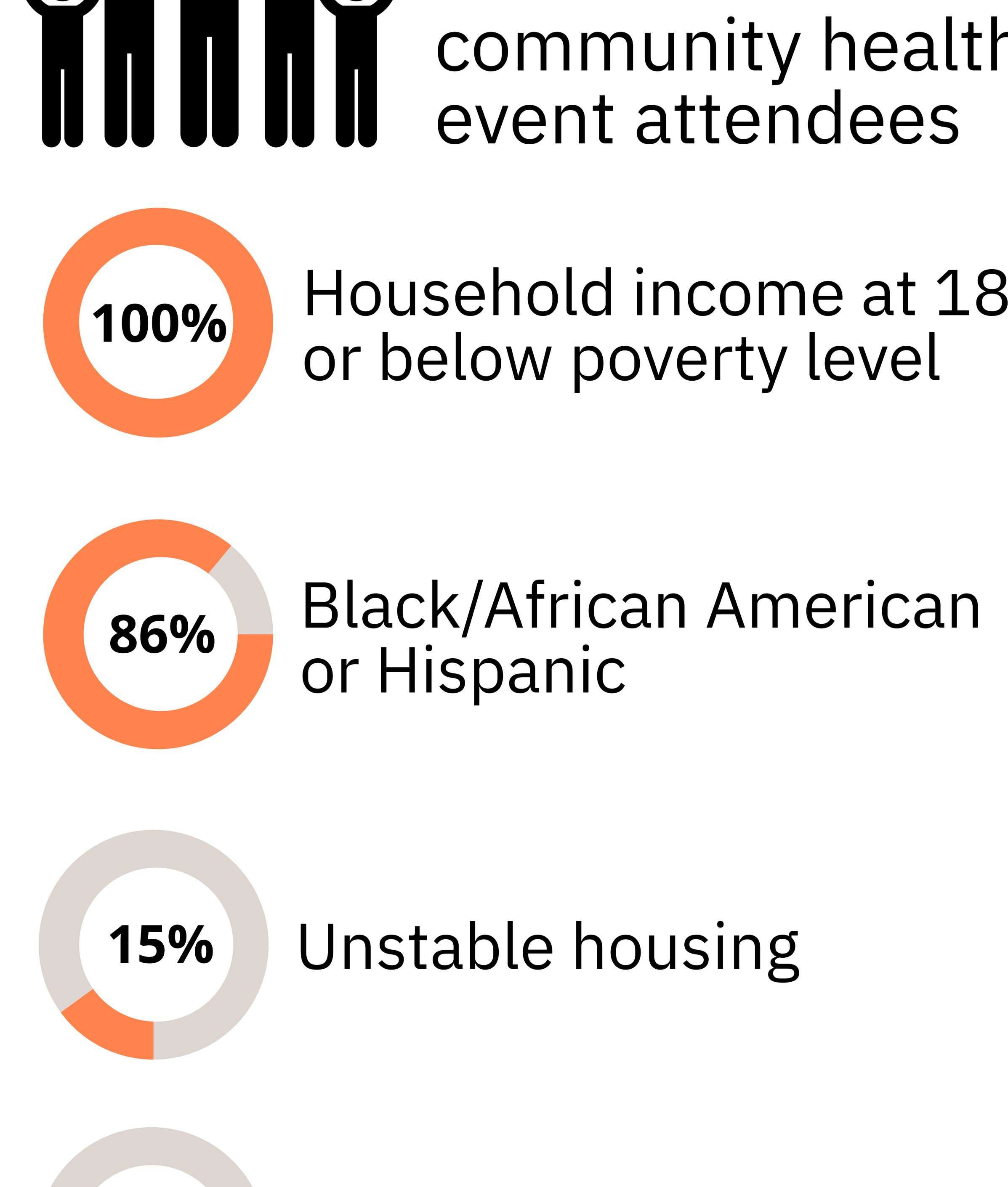
> **One of the things that's really helped us is that [we] has been in business for about 37 years. So, we already had a list of healthcare providers, a list of churches, a list of other nonprofits, we all had the same vision. So, that helped us out a lot [to be successful], that we didn't have to really go out and look for people with like-minded goals.**
> *– The Railroad Project team member*

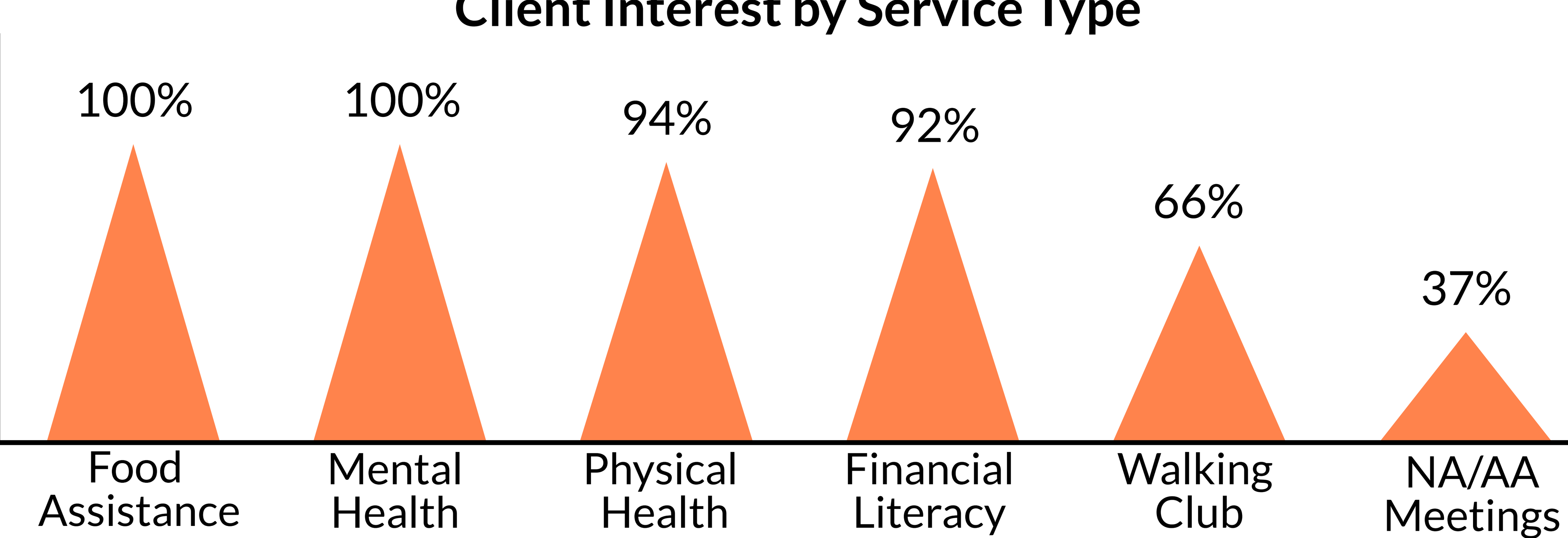


The Railroad Project successfully reached high needs residents of the target area through well organized community health events.

The Railroad Project held 15 community health events with 778 unique attendees in southeast Fort Worth.

There was strong interest in all the services offered by the project. All participants received food and clothing services at the community health events. Early events had low engagement in services after the events and The Railroad Project experienced issues with partners struggling to manage the high level of interest and track participation. The team adjusted their approach to focus on monthly touchbase calls to better meet client demand and address needs.





Through strong leadership and innovative planning, the Railroad Project was able to quickly adapt their model to meet client needs and navigate partner challenges.

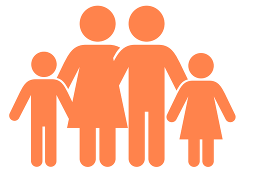
Starting in 2022, The Railroad Project implemented a monthly touchbase call system, where clients were asked at the events if they'd like a Railroad Project team member, including an MSW/LCSW, LPC, and bachelor's-level social worker, to call them monthly. **100% of clients expressed interest in these calls.** During these calls, clients were asked how they were doing, what they needed what their goals were, and what they would like to talk about. This client-directed approach was a strength of the project and consistent with Eastside Community Service's expertise in community-engaged work.

551 clients received an initial touchbase call, with 456 (83%) receiving at least one follow-up call. Other project components such as the financial literacy classes and Heels Up walking group continued to be available to clients without attendance being tracked.

Overall, engagement with the touchbase calls was very strong and there is opportunity to further develop partner relationships to strengthen their impact.

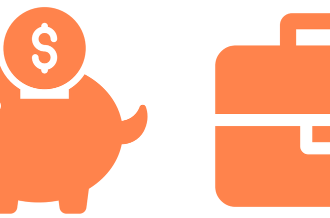
71%

of clients received a touchbase call. Popular call topics include:



Childcare/ Family

Physical Health



Finances/ Housing

Job Training

Dating/ Romance

Mental Health

The Railroad Project screened all clients for depression.

100% of clients were screened for depression using the PHQ-9 assessment at the community health events. Nearly all clients (90%) had baseline scores indicating no severity (average score 2.4).

Very few clients had elevated PHQ-9 scores (N=27) and fewer still completed a follow-up (N=16), making it difficult to assess improvements in outcomes.

100%

of clients (N=778) were screened for depression at the community health events

Our job is literally to teach people not to need us anymore. And with the THR grant, that's exactly what we're doing. Not only does it come alongside what we've been doing, it's furthering our goal, our goal to help people become in self-efficacy. And that's, again, beyond our wildest dream, because Eastside, 37 years ago, was formed to just help people, you know, get food, get clothing. But now we're at that next level where we can teach people how to handle their finances, be mentally and spiritually and physically fit, and learn how to break that cycle.

– The Railroad Project team member

Overall Assessment

In their first cycle of funding, The Railroad Project hosted well attended community health events and provided a variety of resources to all clients. The Railroad Project had excellent community reach and was able to quickly and creatively adapt to changing client and organizational needs. They invested in developing their data collection and client tracking systems over the course of the project and were highly motivated to continue this work. Future efforts could include refining assessment selection to ensure assessments are appropriate and that data collection is feasible given the number of participants involved. The touchbase calls were very successful, and there is an opportunity to further develop their scope to increase impact.

Summative Findings & Lessons Learned

This section provides cross-initiative findings that can inform future work and investment in the THCI program.

SUMMATIVE FINDINGS & LESSONS LEARNED

The THCI grantees implemented innovative projects on a rapid timeline.
Projects were evidence-based, rooted in community expertise, and tailored to the local context and regional priorities. Grantees rapidly established or formalized partnerships with THCI support and developed implementation plans and data collection protocols supported by the ENHANCE evaluation team.

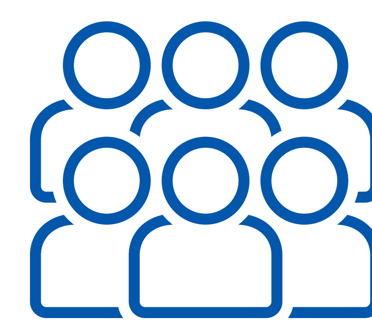
Some THCI grantees demonstrated improved trends on key program priorities.
Several projects demonstrated improvements in depression, anxiety, emotional regulation, and food insecurity in the short term. These projects can serve as promising innovations that can be adapted to other communities to meet the behavioral health needs of North Texans.

School-based provided a unique opportunity to reach a large population of students and families.
These projects had the systems and resources to reach all students in a school or district. Projects included innovative programs engaging students, families, and the larger community to increase the potential for overall impact and sustainability for critical issues such as mental health and food insecurity.

Collaborative networks of community organizations were most successful when there were trusted partnerships with clearly defined roles.
The full potential of collaborative projects could not be realized when partner networks were disorganized, roles and responsibilities were ambiguous, or resources were inadequate. Strong lead agencies and continuous review of partner contributions and needs can facilitate program implementation and sustainability.

Trusted community organizations were well-positioned to lead initiatives that reached vulnerable, high-needs populations.
Organizations with limited experience or resources experienced challenges. Efforts to build their organizational and evaluation capacity can increase their ability to successfully implement programs that reach their community members and measure their success.

Resources are needed for data collection, tracking, and management to enhance continuous quality improvement.
Projects should allocate resources (staff, time, infrastructure) and consider the logistics of longitudinal data collection in order to fully demonstrate their impact. Support is needed in building data infrastructure that strikes the balance of being comprehensive without being burdensome.



Understanding the scope of the population to be reached presents an opportunity for growth and expansion of the THCI initiative.
Enrollment goals in some projects were lower than expected and the loss to follow-up expected in community interventions led to relatively small numbers receiving more intensive assessments and services. Considerations related to challenges and potential solutions should be given to how to increase project reach and engagement to meet regional needs.

Behavioral health and clinical change take time.
Sustained, population-level impacts on the THCI priority areas take time. Process measures, organizational and structural impacts, and outcome metrics that are realistic to collect and that capture meaningful short-term benchmarks should be also emphasized. Metrics for longer term impacts can be incorporated as projects plan for sustainability.

ACKNOWLEDGEMENTS

This evaluation required the full engagement of grantee leadership and community partners. We would like to express our sincere gratitude to the grantee teams for their willingness to collaborate with us and for all the work put into data collection over the grant period. Our evaluation greatly benefited from the expertise, passion, and commitment of the grantees whose deep investment in their communities led to their participation in this initiative. We are particularly grateful to the program leaders, implementers, and partners who participated in interviews in order to better understand each project and demonstrate impact.

We would also like to acknowledge Texas Health Resources for their investment in this evaluation and their partnership and direction during this grant cycle. We look forward to continuing and growing this relationship in the future.

Our goal with this evaluation and report is to identify areas of strength and opportunity for the continued investment in alleviating health disparities and inequities in these North Texas communities.

EVALUATION TEAM

Our multi-disciplinary team consists of senior academic researchers, project managers, and doctoral and graduate student trainees from UTHealth Houston School of Public Health Dallas Campus.

Bijal Balasubramanian, MBBS, PhD, Evaluation Co-Lead
Marlyn Allicock, PhD, Evaluation Co-Lead

Folefac Atem, PhD
Katelyn Jetelina, PhD
Rikki Ward
Sunil Matthew
Diane Berry
Lauren Malthaner
Rebecca Meredith Burgess
Alaina Beauchamp
Elyse McNamara-Pittler
Crystal Costa
Carolina Salmeron
Mike Garcia
Jackson Francis
Chiu Feng Yap
Victoria Perez
Nikita Sojan
Ashna Ahuja

Report prepared February 2023

APPENDIX A: EVALUATION METHODS

EVALUATION DESIGN

The evaluation was conducted by a mixed-methods team of researchers from the UTHealth Houston School of Public Health Dallas Campus. The evaluation approach was guided by the RE-AIM[1] framework, which provides a useful framework to assess multiple domains and levels of programs and their interactions. The research questions were:

Research Question 1: To what extent have grantees achieved THCI objectives of:
(a) Strengthening existing care delivery systems across the continuum; (b) Empowering community organizations to implement innovative strategies that improve behavioral health care availability and delivery; (c) Facilitating a coordinated care approach by multi-agencies to improve the individual experience; (d) Building the capacity of community organizations to becoming financially and operationally capable of continuing the work beyond the grant period?
Research Question 2: To what extent have THCI grantees achieved their program-specific health-related goals (e.g., mental, behavioral health, food security, self-efficacy)?

We used a mixed methods convergent design to integrate qualitative findings from semi-structured interviews and quantitative analysis drawing upon programmatic data. The evaluation received approval by the UTHealth Institutional Review Board.

GRANTEE ENGAGEMENT

We employed the Learning Evaluation[2] model to establish a detailed understanding of grantee implementation plans, provide ongoing training and technical assistance to grantees to support their evaluation design and help ensure the collection of timely, high-quality data; and conduct rapid dissemination of findings with grantees and THR stakeholders.

QUANTITATIVE DATA AND ANALYSIS

We worked with each grantee team to develop an individualized data collection plan that captured deidentified participant-level and aggregate indicators on the RE-AIM domains. Grantees submitted data quarterly throughout the program via a secure portal hosted by UTHealth Houston. Descriptive analyses were conducted to quantify number and characteristics of clients screened, reached, and served. Outcomes were analyzed using descriptive statistics and longitudinal multivariate regression models or univariate statistical tests. The statistical level of significance used in this report is $p < 0.05$.

QUALITATIVE DATA SOURCES AND ANALYSIS

Two rounds of semi-structured interviews were conducted: Round 1 in Quarter 4 of Year 1, Round 2 in Quarter 4 of Year 2. Interviews were conducted with grantee team members at three levels: 1) leadership, 2) implementors, and 3) partners to characterize project reach and implementation, organizational capacity, potential for sustainability, and elucidate challenges and successes beyond what was captured in the quantitative data. Interviews were audio-recorded and professionally transcribed and deidentified prior to analysis. A thematic analysis was conducted to identify themes and patterns within and across projects.

[1] Glasgow RE, Vogt TM, Boles SM. Evaluating the public health impact of health promotion interventions: the RE-AIM framework. Am J Public Health. (1999) 89:1322–7. 10.2105/AJPH.89.9.1322

[2] Balasubramanian BA, Cohen DJ, Davis MM, Gunn R, Dickinson LM, Miller WL, Crabtree BF, Stange KC. Learning Evaluation: blending quality improvement and implementation research methods to study healthcare innovations. Implement Sci. 2015 Mar 10;10:31. doi: 10.1186/s13012-015-0219-z.

Texas Health Resources | Community Health Improvement

Together with community leaders, Community Health Improvement (CHI) works to identify and understand health disparities and the social and environmental conditions that affect overall health. We believe your ZIP code shouldn't be more important than your genetic code when it comes to your health and well-being. In following the data, we focus on efforts through results-driven initiatives, thereby furthering Texas Health's mission of improving the health of the people in the communities we serve.

THRCHI@TexasHealth.org | texashealth.org/Community-Health