Community Health Needs Assessment

September, 2013

METHODIST RICHARDSON MEDICAL CENTER
COMMUNITY HEALTH NEEDS ASSESSEMENT

Background of Methodist Health System

The primary mission of all the members of the Methodist Health System is to improve and save lives through quality compassionate care and in a manner that reflects "a commitment to Christian concepts of life and learning." Specifically, this mission is pursued by operating four general acute-care hospitals and other health care services, education and support programs needed by the communities in North Central Texas including Methodist Dallas Medical Center, a 515-licensed-bed teaching referral hospital in the southwestern quadrant of the City of Dallas, providing primary, secondary, and tertiary care; and Methodist Charlton Medical Center a 285-bed community hospital, providing primary and secondary care in the southern portions of Dallas and nearby suburban cities, approximately 12 miles southwest of Methodist Dallas; Methodist Mansfield Medical Center is located in Mansfield, Texas residing in the far southwest corner of Tarrant County and Methodist Richardson Medical Center, a 209-bed facility located in Richardson, Texas in the north Dallas section of the Metroplex.

Vision for the Future
To be the trusted provider of integrated quality health care in North Texas.

Core Values
Methodist Health System core values reflect our historic commitment to Christian concepts of life and learning:

Servant Heart – compassionately putting others first
Hospitality – offering a welcoming and caring environment
Innovation – courageous creativity and commitment to quality
Noble – unwavering honesty and integrity
Enthusiasm – celebration of individual and team accomplishment
Skillful – dedicated to learning and excellence

As the health care model across the nation and certainly Dallas continues to transform before our eyes, Methodist Health System has a goal to be transformative in the way care is delivered, bringing together multi-disciplinary teams to deliver specialized care to meet the demands of a growing population.

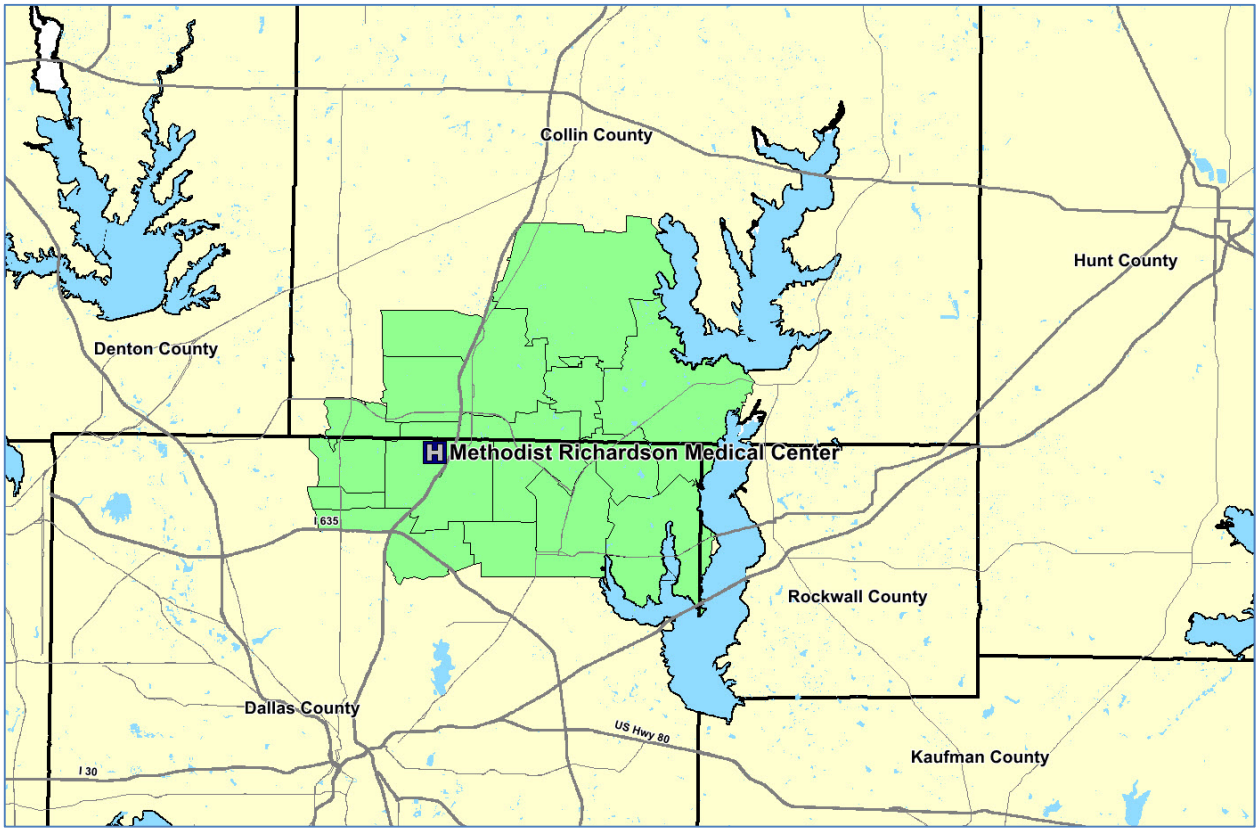
In October 2011, Methodist Health System acquired Richardson Regional Medical Center, continuing to operate the facility in the Methodist system under its new name, Methodist

Richardson Medical Center. The new Methodist Richardson, which began as a community-owned hospital in 1966, has two medical campuses – the Campbell and Bush/Renner campuses. Methodist is expected to accelerate the expansion at Bush/Renner, which is currently home to a medical office building as well as an outpatient hospital and cancer center that opened in October 2008.

Since 1966, **Methodist Richardson Medical Center** has served the residents of Richardson, Plano, North Dallas, and our surrounding communities. The Campbell Campus is a 205-bed acute care facility staffed by independently practicing physicians offering more than thirty-five different specialties. The Bush/Renner campus in east Richardson includes an outpatient hospital with a full-service emergency department. It's also home to Methodist Richardson Cancer Center, where some of the latest advancements in medical, surgical and radiation oncology are provided in one convenient location. The Bush/Renner campus is includes a five-story, 100,000 square foot physician pavilion with more than 30 physicians in a full range of specialties.

Identification of Populations and Communities Served by Methodist Richardson Medical Center

As seen on the map below, the Methodist Richardson Medical Center's service area is located in the northern section of Dallas County and southern Collin County.



Service Area Demographics				
Metric	MRMC Service Area	MHS Service Area	DFW Metroplex	Texas
2010 Total Population	727,201	1,964,382	6,362,518	25,145,248
2013 Total Population	764,518	2,065,119	6,699,756	26,297,165
2018 Total Population	828,684	2,240,025	7,275,567	28,332,799
% Change 2013 - 2018	8.4%	8.5%	8.6%	7.7%
Average HH Income	$83,579	$68,866	$76,646	$68,955
% Unemployment	6.6%	8.5%	7.8%	7.2%
% Managed Care	40.6%	33.7%	36.8%	32.3%
% Below poverty	8.2%	12.6%	10.5%	13.2%
Age Group				
0-14	22.0%	23.9%	23.1%	22.6%
15-17	4.5%	4.8%	4.5%	4.4%
18-24	9.0%	9.6%	9.4%	10.2%
25-34	13.4%	13.4%	14.1%	13.9%
35-54	29.6%	28.4%	28.7%	26.8%
55-64	11.2%	10.6%	10.6%	10.9%
65+	10.3%	9.4%	9.7%	11.1%
Sex				
Male	49.3%	48.9%	49.3%	49.6%
Female	50.7%	51.1%	50.7%	50.4%
Race/Ethnicity				
White	48.3%	33.4%	47.7%	43.5%
Black	13.4%	24.8%	15.2%	11.5%
Hispanic	25.2%	34.1%	29.1%	39.0%
Asian & Pacific Islander	10.7%	5.8%	5.8%	4.1%
All Others	2.4%	1.9%	2.2%	1.8%

Source: TruvenHealth Analytics

According to Claritas census data the demographics for the service area are cited above. While there certainly are pockets of Methodist Richardson's service area that are weaker than others, overall in comparison to the DFW Metroplex, Methodist Richardson's service area is stronger in that it:

- has a higher average household income than the Metroplex;
- has a lower unemployment rate
- has a higher insured rate than both the MHS Svc Area, DFW Metroplex and the State of Texas; and
- has a lower below poverty percentage

Background on Methodist Richardson Medical Center Service Area

Methodist Richardson Medical Center's service area is experiencing lower unemployment (6.6%) and a higher average household income ($83,579) than the DFW Metroplex with 27.3% of the population reporting household incomes above $100,000 annually. The area is educated with 38.1% of adults over the age of 25 having earned a bachelor's, masters or PhD. If we include residents with some form of secondary education (Associate Arts, certification, licensure) this increases the educated population to 67.6%.

Upon review of the payer mix for all inpatients from the area in 2011, the primary payer source was Managed Care (37.7%). The rest of the payer mix includes Medicare at 31.8%, Medicaid 18.6%, Self-Pay/Charity Indigent Care at 8.9% and All Others, 2.0%.

The projected population growth is about the same at 6.7% when compared with the surrounding DFW Metroplex. The largest age cohort for this community is 35-54 (29.6%) followed by 0-17 (22.0%). Women of child- bearing years are expected to grow by 2.6% for this community. The age 55+ age cohort is expected to grow 24.4% over the next five years. Over the next five years the product lines with the greatest projected growth include Cardiovascular, Orthopedics and Nephrology/Urology.

Approximately 8.2% of families are below the level of poverty in the service area (TruvenHealth Analytics 2013 data). This percentage is lower than both the state of Texas and US averages.

Dubbed the Telecom Corridor®, Richardson is home to more than 600 high-technology companies, the majority of which are located within an 11-square mile core area. The corridor is currently experiencing revitalization from the telecom bust of the early 2000's. Several major companies have recently relocated to the area or expanded area operations and encompass all types of industries; insurance, telecom, manufacturing, aerospace, education, distribution and financial services.

Richardson has two nationally acclaimed public school systems, one state university, two community colleges, two public university satellite campuses, a flourishing hospitality industry, a renowned orchestra and a thriving arts and culture community that enhance the city's quality of life and business.

The Methodist Richardson service area is located partly within northern Dallas County and partly within southern Collin County and therefore for the purposes of meeting the IRS' community health needs assessment reporting requirements, Methodist Richardson Medical Center will refer in part to the completed ***"Horizons: The Dallas County Community Health Needs Assessment"*** to outline the current health needs of its service area in Dallas County and in part will refer to the completed ***"Texas Healthcare Transformation and Quality Improvement Program"*** required CHNA for Regional Healthcare Partnership 18 covering three counties including Collin, Grayson and Rockwall counties.

Pages 6-186: The following excerpts on pages 6 through 186 are taken directly from the "Horizons: The Dallas County Community Health Needs Assessment" and are subject to the following citation:

Reproduction of this report in whole or in part should include the following recommended citation: *Edwards, J., Pickens, S., Schultz, L., Erickson, N., Dykstra, D. (2012). Horizons: The Dallas County Community Health Needs Assessment. Dallas, TX: Dallas County Health and Human Services and Parkland Health and Hospital System.*

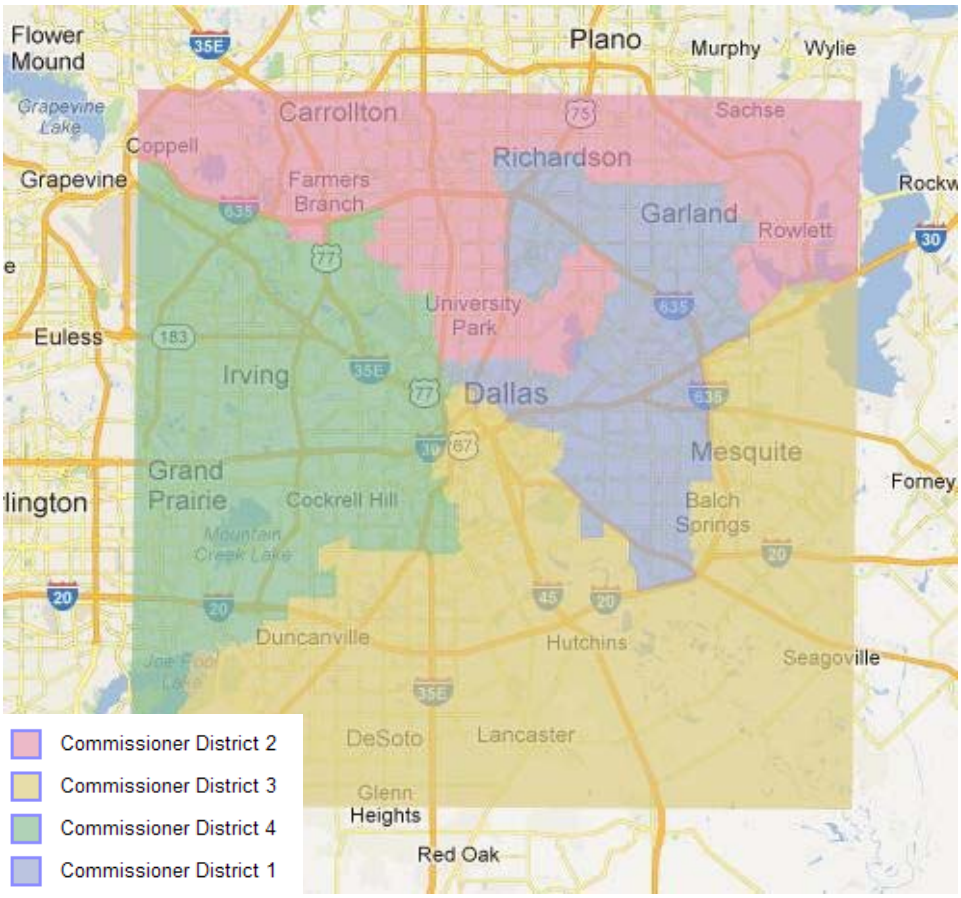
Pages 187-202: Excerpts on pages 187 through 202 are taken directly from the published "Texas Healthcare Transformation and Quality Improvement Program" required CHNA for Regional Healthcare Partnership 18 covering three counties including Collin, Grayson and Rockwall counties.

Pages 203-206: Excerpts on pages 203 through 206 are reproduced here with permission from Texas Health Resources and show the results of their Community Input Summary for parts of Collin County to bring additional primary data for Collin County to this CHNA analysis.

DCHHS led this Community Health Needs Assessment (CHNA) in collaboration with the Parkland Community Health Institute. The supporting Public Health Improvement (PHI) Workgroup consisted of healthcare executives from the leading hospital systems in Dallas County; leadership of civic organizations, schools and health departments; and representatives of local universities (Appendix A). This needs assessment effort will ensure that our entire local public health system continues to effectively and efficiently serve the 2.4 million residents of our county.

Figure 1.1

Dallas County: 2011 Commissioner Precincts



Source: Dallas County Commissioners Court (2012). Who is my Commissioner? http://www.dallascounty.org/department/comcrt/whois.php

Healthy People 2020, the national plan to improve the nation's health, outlines a detailed ten year agenda that encompasses the entire continuum of prevention and care. The overarching *Healthy People 2020* goals are to:

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages (*Healthy People 2020, 2012*).

The goals of the Dallas County Community Health Needs Assessment support these *Healthy People 2020* goals. The specific objectives are to:

- Identify existing and emerging population health needs throughout Dallas County.
- Outline current Dallas County assets and issues considering the uninsured/underinsured, low income and minority populations.
- Define Dallas County's health and social service system strengths, challenges, and areas for improvement.
- In conjunction with the PHI Workgroup, develop a community health improvement plan to align resources and services to meet the diverse needs of Dallas County residents.

METHODOLOGY

A triangulation of secondary quantitative data, focus group data, and interview data inform the Dallas County CHNA. The CHNA reflects a community-based approach that considers both quantitative and qualitative data. Oversight of the CHNA was provided by the Dallas County Health and Human Services Public Health Infrastructure Division and the PHI Workgroup. The PHI workgroup provided a diverse perspective on health issues, assets and priorities.

Two community focus groups early in the data collection process and key informant interviews as key health issues began to emerge provided context for and understanding of the secondary quantitative data. This allowed the PHI Workgroup to identify and prioritize the top health issues that face Dallas County residents.

The CHNA methodology is informed by the CDC National Public Health Performance Standards Program, Public Health Accreditation Board standards, and IRS Form 990 (Schedule H) guidance. CHNA instruments, analysis, and recommendations also consider local application of the 2011-2016 Texas State Health Plan: A Roadmap to a Healthy Texas. This plan identifies the following characteristics affecting the healthcare system in Texas: demographic review of the general population, demographic review of the health professions workforce, access to healthcare, technology enhancements, and prevention and education (Texas Statewide Health Coordinating Council, 2011).

The draft of the Dallas County CHNA was posted on the Dallas County Health and Human Services website for a two week public comment period. Availability of the draft was announced at the Dallas County Public Health Advisory Committee Meeting, Parkland Board of Managers Meeting, and shared with CHNA qualitative participants and PHI Workgroup for distribution. The PHI Workgroup co-chairs responded to all comments that were received.

Secondary Data Sources

Dallas County is fortunate to have active healthcare, schools, social service, and business leadership whose organizations have collected, organized and vetted a wide range of secondary data used in this CHNA. As necessary, the original data sources were accessed to provide additional information or insight, as well as to address discrepancies. Significant secondary data sources include:

- Texas Department of State Health Services (DSHS) Center for Health Statistics
- U.S. Census
- Parkland Community Health Institute (PCHI) Dashboards and Data
- Dallas County Health and Human Services (DCHHS) Division Data Summaries
- Dallas/Ft. Worth (DFW) Hospital Council Healthy North Texas Dashboard
- Communities Foundation of Texas: “Assets and Opportunities in Dallas”
- Dallas County Behavioral Health System Redesign Task Force: “Assessment of the Community Behavioral Health Delivery System in Dallas County

- Regional Health Partnership Region 9: Community Health Needs Assessment Task Force: "Regional Health Partnership 9: Community Needs Assessment Report". (Draft)Dallas Fort Worth Hospital Council
- Dignity Health (formerly Catholic Healthcare West) Community Need Index
- Community Council of Greater Dallas Sourcebook 2012 Directory of Services

Due to the volume of available data, this report provides an overview of the most significant findings with much of the data in a reader-friendly graphic format. Greater detail is provided in the report appendices. Original datasets used for this CHNA are available upon request to Dallas County Health and Human Services by calling the DCHHS Public Information Office at (214) 819-2000.

Focus Group Discussions

Two focus groups provided different perspectives about the health needs of the Dallas County community. The first focus group, conducted by DCHHS/New Solutions, Inc., included executive director and management level staff of leading social service agencies. The second group, conducted by Parkland Health and Hospital System (PHHS), included community members who serve in advisory capacities to the Community Oriented Primary Care (COPC) clinics.

The same discussion guide was used for both groups. It was developed to meet the focus group objectives which included:

- Define healthy community characteristics in Dallas.
- Identify Dallas County issues and assets that impact population health.
- Identify community barriers to good health overall and by subpopulations.
- Discuss specific issues and needs of subpopulations including women, children, men, and diverse racial and ethnic groups.
- Identify disparities by geography and/or population.
- Outline priority health needs that should be addressed over the next three to five years.

A participant packet allowed participants to record answers to specific questions during the groups. It also contained the Dallas County communities map and the demographic and socioeconomic overview of the county and each community to inform the participants.

DCHHS/New Solutions, Inc. transcribed the executive director/manager focus group, and written responses from the packets were included in the analysis. PHHS provided the response summary from the COPC community leader group for inclusion in the analysis.

The focus group guide and participant packet can be found in Appendix B.

Key Informant Interviews

Eight key informant interviews were conducted with community leaders identified by the Dallas County PHI Workgroup. They were conducted after the Midterm Draft data was submitted in order to:

- Identify CHNA priorities and suggested approaches for the PHI Workgroup's priority setting process.
- Discuss the Dallas County healthy community continuum of care, identifying key issues, asset and gaps.
- Identify strategies to minimize gaps and reduce disparities.
- Discuss innovative models to improve population health including local, statewide and national approaches in order to determine their relevance for Dallas County.
- Determine recommended improvement strategies based on submitted data.

Results were used to expand the CHNA report and develop CHNA recommendations.

Notes on Data Sources

In reviewing the document, the following notes will support understanding.

Color-Indicator Tables

- Throughout the Health Profiles, the reader will find tables that use red, yellow and green colored indicators. These tables provide ratings defined by the standards in the PCHI's "Dallas County Community Health Dashboard" and the DFW Hospital Council's "Healthy North Texas Community Dashboard." Indicator colors were taken directly from these dashboards. The following defines these indicator colors:
    - **Dallas County vs. "Healthy People 2020" Target**
        - Most recent county data is compared to targets based on *Healthy People 2020* (HP2020) guidance.
        - Green: most recent Dallas County data doing better than HP2020 target.
        - Yellow: most recent Dallas County data the same as HP2020 target.
        - Red: most recent Dallas County data worse than HP2020 target (Parkland Community Health Institute, 2011).
    - **Dallas County Trend**

      If only one to three years of previous county data was available, percent change was calculated from earliest year available. If four or more years of previous county data is available, 95% confidence intervals are determined from the distribution of all previous annual data.
        - Green: most recent data percent/statistically significantly better.
        - Yellow: most recent data the same/not significantly different.
        - Red: most recent data worse/statistically significantly worse (Parkland Community Health Institute, 2011).
    - **Healthy North Texas Community Dashboard**

      Indicator data values from Texas counties are ranked from those doing best to those doing worst. The rank is then distributed into statistical quartiles.
        - Green: county rank is in best two quartiles (1-50%).
        - Yellow: county rank is in the third best quartile (50-75%).
        - Red: county rank is in the worst quartile (75-100%) (Healthy North Texas, (n.d.).

Dallas County and Its Communities

- The CHNA includes information about Dallas County, but it also focuses on "communities" within the county. These communities are defined by contiguous U.S. postal ZIP codes. The community definitions have been used for health planning for many years and have been referred to as both "planning zones" and "service areas" in past studies. For the CHNA, they will be referred to as either communities or service areas.

- Since the ZIP code boundaries do not exactly match county line boundaries, some differences in geographic coverage and population totals result. The ZIP-defined communities have 97,365 (4%) more residents than Dallas County. Data accounting for the entire ZIP code was included in cases where a ZIP code may extend outside of Dallas County. A map comparing the Dallas County boundaries with the communities' ZIP code boundaries can be found in Appendix C. The most specific level of data available for each indicator was used.

U.S. Census 2010

- Service Area population is based on the 2010 U.S. Census. Service Area demographics were aggregated using Dallas County ZIP Code Tabulation Area (ZCTA) data. ZCTAs are statistical geographic entities produced by the U.S. Census Bureau for tabulating higher data level summary statistics from the 2010 Census.

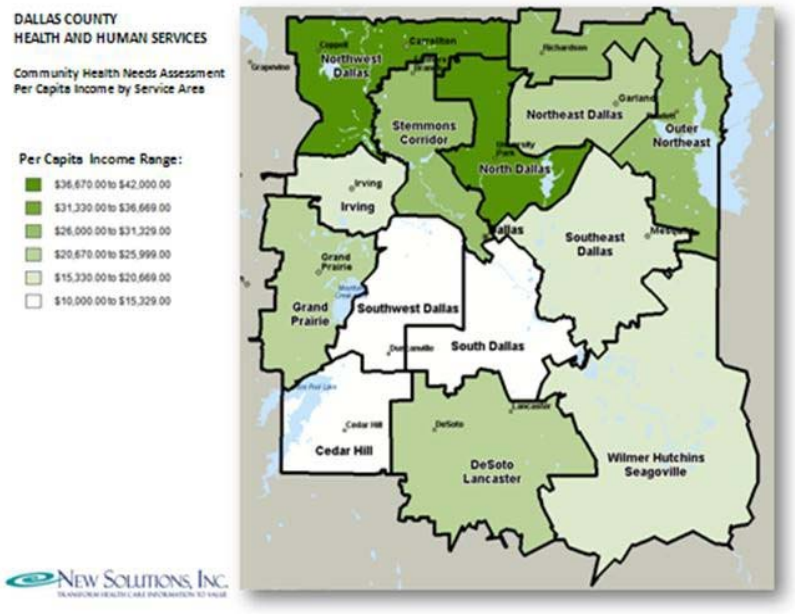
DALLAS COUNTY GEOGRAPHY AND SOCIO-DEMOGRAPHICS

Dallas County

Dallas County, the ninth largest county in the United States, is a growing and thriving area. Between 2000 and 2010, the population increased over 20% to nearly 2.4 million people (Dallas County QuickFacts, 2012). Most of Dallas County's growth occurred in suburban areas with the City of Dallas population increasing less than 1% during this time. Growth can be attributed to a strong economic environment, business growth, and employment opportunities. This has resulted in:

- Wide range of economic status and security.
  - Dallas County 2010 per capita household income was $24,200. Figure 3.1 presents the range of per capita income in Dallas County.
  - In 2010, 14% of Dallas County residents were living below the federal poverty level (FPL).
  - In mid-2010, nearly 9% of County residents were unemployed. This was the average for the U.S. at that time, but in Dallas County, ten of 13 communities had unemployment rates below 6.2%. Thus, three Dallas County communities were experiencing very high unemployment.

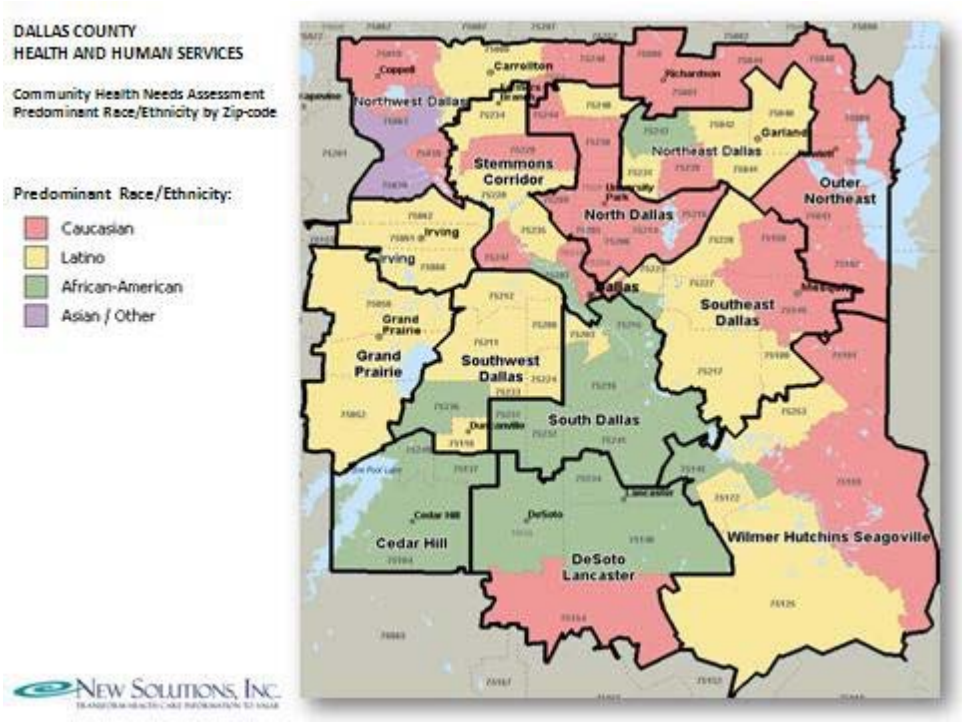
Figure 3.1



- Education levels vary across Dallas County.
  - 24.5% of County residents have NOT graduated from high school. This ranges from 8.8% in Northwest Dallas to 48.4% in South Dallas.
  - 28% of County residents have Bachelor's degrees. Caucasians are four times more likely than African-Americans and seven times more likely than Latinos to have a Bachelor's degree (Weidich, 2012).
- A relatively young county:
  - In the 2010 U.S. Census, children under 15 years of age were 23% of the County population while adults 15 – 64 years were 68% and seniors age 65+ were 9%.
  - This compares to 10% of the Texas population who are 65+ years and 13.3% for the U.S.
- Racial and Ethnic Diversity.

- Latinos represent the County's largest population group, 38%. Caucasians follow with 34% and African-Americans 22%. Asian-Americans and "Other" total 7%.
- The predominant racial or ethnic group in each Dallas County community is presented in Figure 3.2

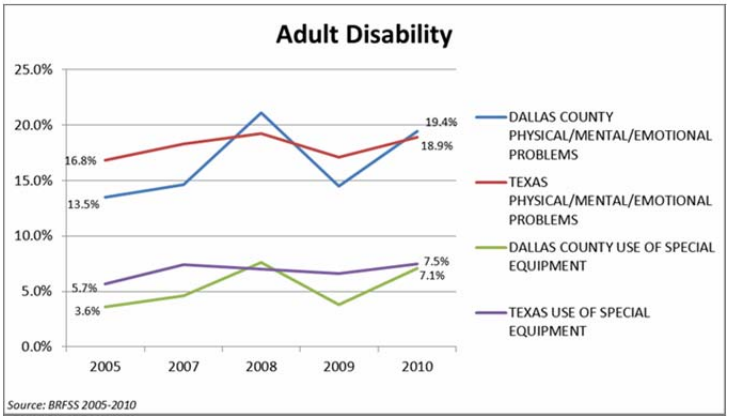
Figure 3.2



Between 2005 and 2010, adult disability increased in Dallas County and in Texas.

- Dallas County adults who reported a physical, mental or emotional problem increased from 13.5% to 19.4%, a 44% increase. Texas increased 12.5% during this time.
- Dallas County adults who required the use of special equipment increased 3.5% between 2005 and 2010. This is nearly a 100% increase.

Figure 3.3



Dallas County Communities

Dallas County has traditionally been divided into 13 geographic communities using U.S. postal ZIP codes. This CHNA used these communities to more precisely target assets, issues, needs and gaps for each of these sub-sections of the county for this CHNA. Figure 3.4 presents the area map with the communities outlined.[1]

North Dallas

- North Dallas is home to 241,575 people which is 10.2% of the Dallas County total.
- With 11% of residents age 65+, North Dallas has the second highest percentage of all Dallas County communities.
- North Dallas is predominantly Caucasian, 64%, followed by Latino, 24%. African-American and Asian-American/others are 7% and 5% respectively.
- North Dallas had the highest 2010 per capita income of all the communities, $41,100. Despite 4.4% unemployment, 12% of residents were living below the FPL in 2010.

Northeast Dallas

- Northeast Dallas (NE Dallas) has 250,928 residents, comprising 10.6% of Dallas County's population.
- NE Dallas closely matches the race/ethnicity of Dallas County with 40% Latino, 31% Caucasian, and 20% African-American.
- Per capita income in 2010 was $21,400; unemployment was 6.6%; and 14% were living below the FPL.

Figure 3.4

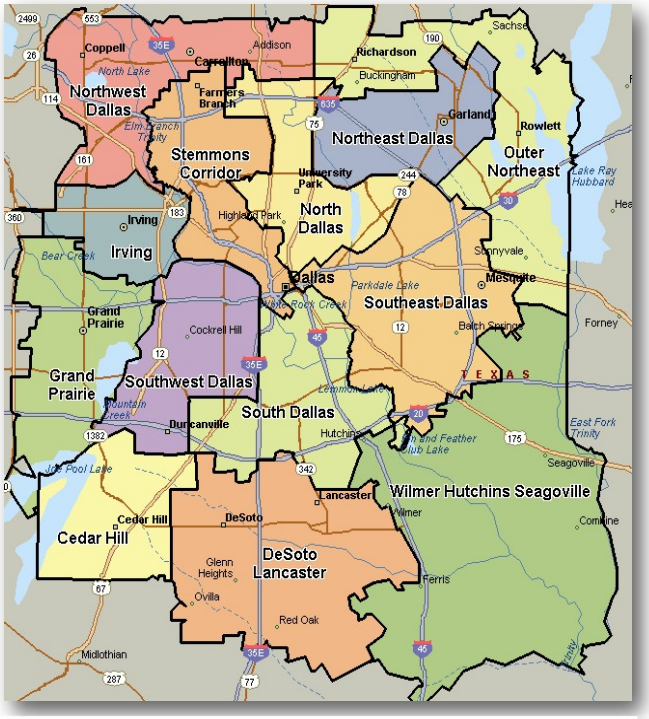
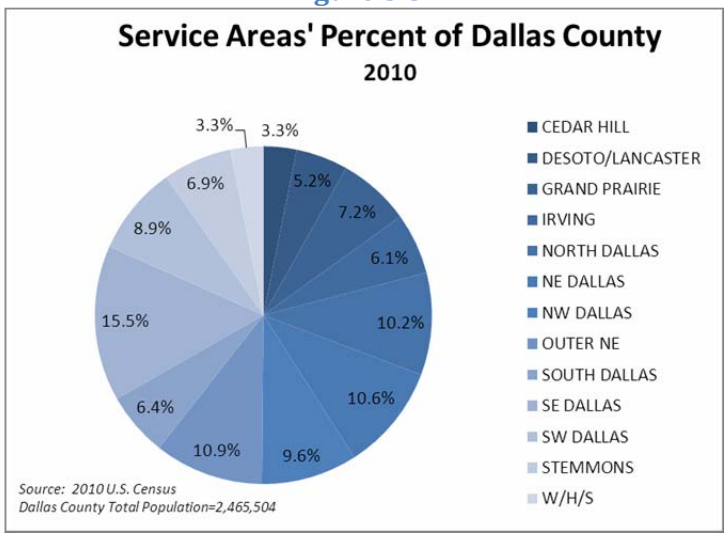


Figure 3.5



[1] Information in this section is presented graphically in Figure 3.5 on this page and Figures 3.6 through 3.12 on pages 13-14.

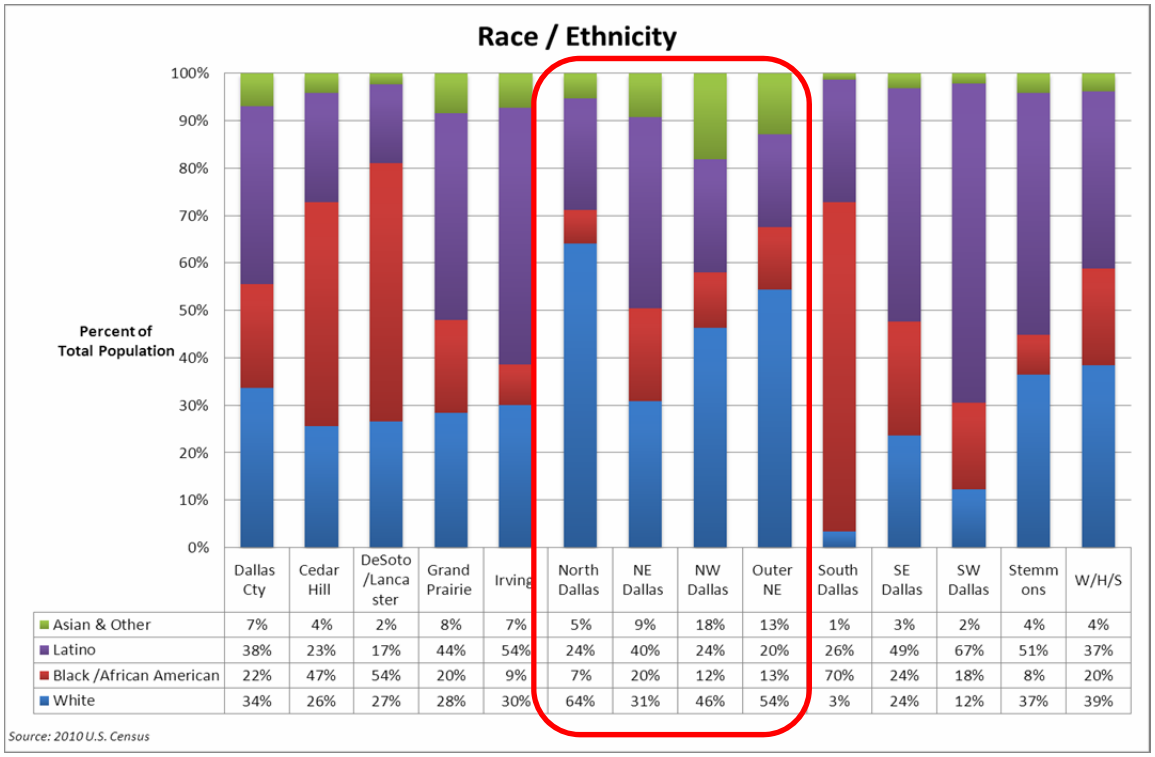
Northwest Dallas

- With 9.6% of the Dallas County population, 228,016 residents, Northwest Dallas (NW Dallas) has a population that is similar to the County in relation to age.
- Northwest Dallas has the largest Asian-American/other population in the County, 18%. Of this, 16% is Asian-American. Other racial/ethnic groups include: Caucasian 46%, Latino 24% and African-American 12%.
- NW Dallas has one of the highest economic indicators of all communities.
    - Per capita 2010 income was the second highest of the communities, $39,800.
    - Unemployment was very low at 3.2%.
    - Six percent of residents were living below the FPL.
- It also has the highest percentage of adults who have completed high school, 91.2%.

Outer Northeast

- Outer Northeast Dallas (Outer NE), with 257,479 residents, has the largest population of the northern communities. This is nearly 11% of the Dallas County population.
- Ten percent of residents are 65 years of age and older.
- Caucasian is the majority racial group, 54%, followed by Latino, 20%. Both African-American and Asian-American/other comprise 13% of the Outer NE population.
- The per capita 2010 income was $28,300; unemployment was 3.8%, and 5% were living below FPL.
- Ninety percent of Outer NE adults are high school graduates.

Figure 3.6



	Dallas Cty	Cedar Hill	DeSoto /Lancaster	Grand Prairie	Irving	North Dallas	NE Dallas	NW Dallas	Outer NE	South Dallas	SE Dallas	SW Dallas	Stemmons	W/H/S
Asian & Other	7%	4%	2%	8%	7%	5%	9%	18%	13%	1%	3%	2%	4%	4%
Latino	38%	23%	17%	44%	54%	24%	40%	24%	20%	26%	49%	67%	51%	37%
Black /African American	22%	47%	54%	20%	9%	7%	20%	12%	13%	70%	24%	18%	8%	20%
White	34%	26%	27%	28%	30%	64%	31%	46%	54%	3%	24%	12%	37%	39%

Source: 2010 U.S. Census

Figure 3.7

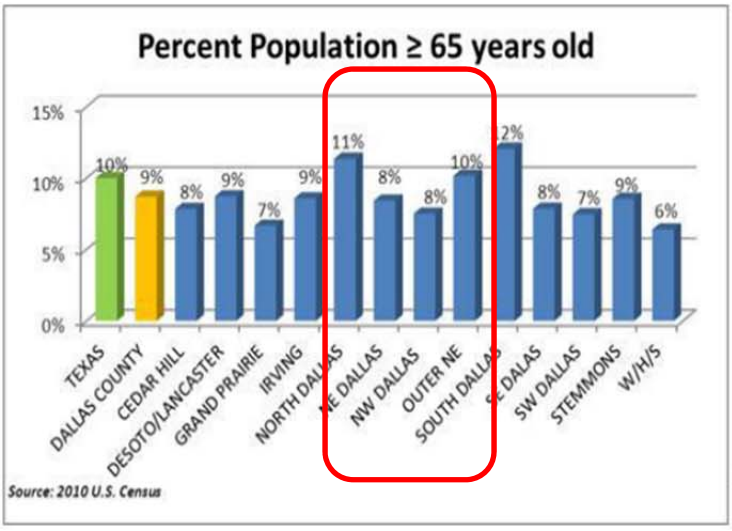


Figure 3.8

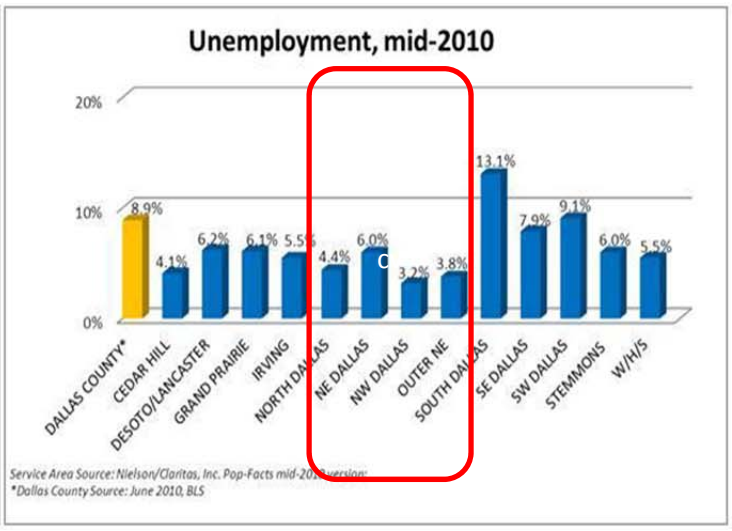


Figure 3.9

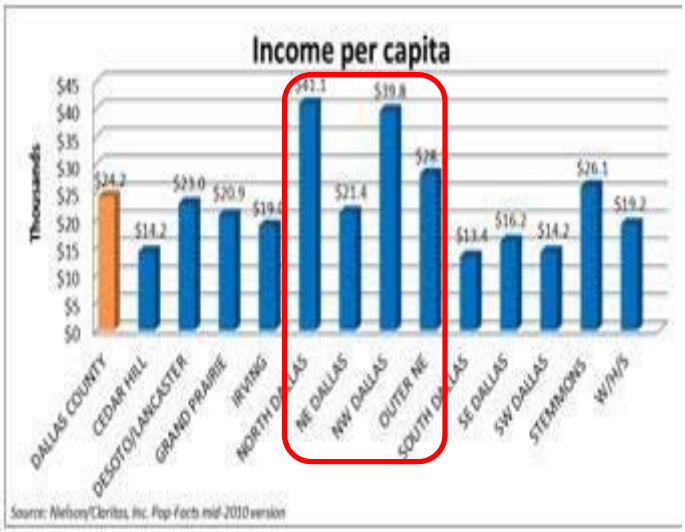


Figure 3.10

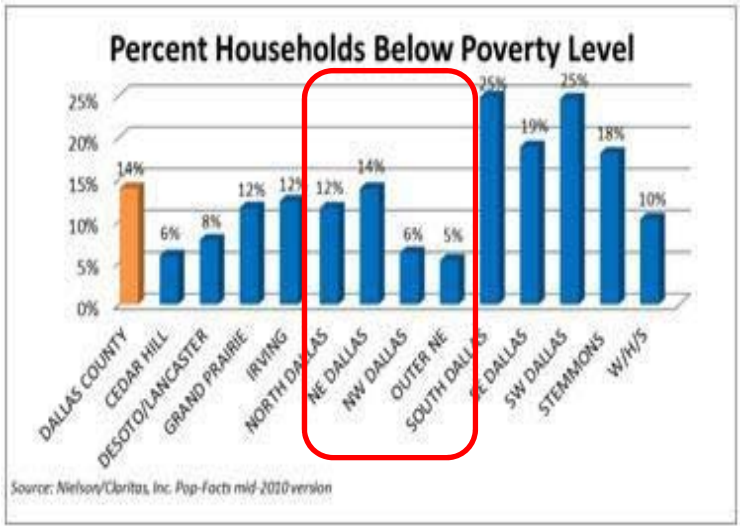


Figure 3.11

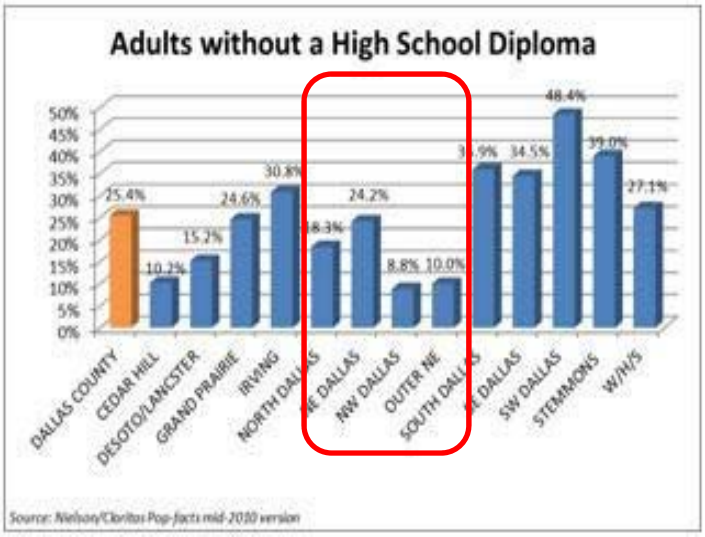
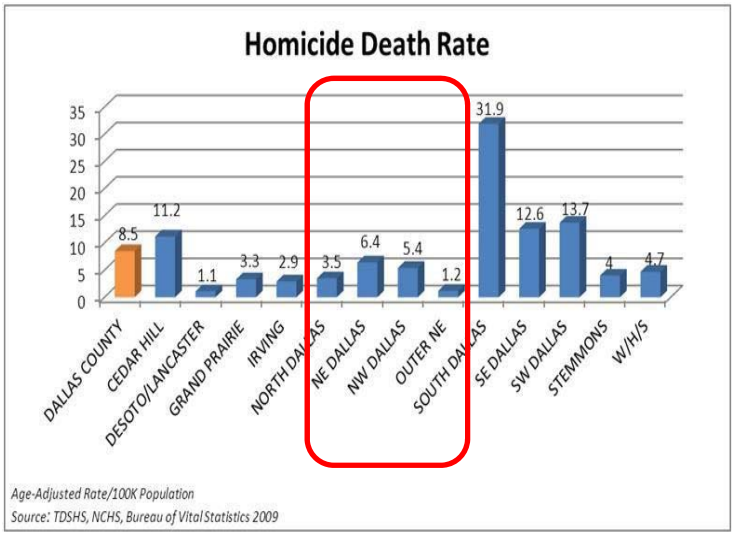


Figure 3.12



Community Need Index

Dignity Health's[2] Community Need Index (CNI) provides a numerical indicator that accounts for the underlying socioeconomic and access barriers that affect population health status. In developing the CNI, Dignity Health identified five prominent barriers related to income, culture/language, education, insurance, and housing. It has been developed at a ZIP code level.

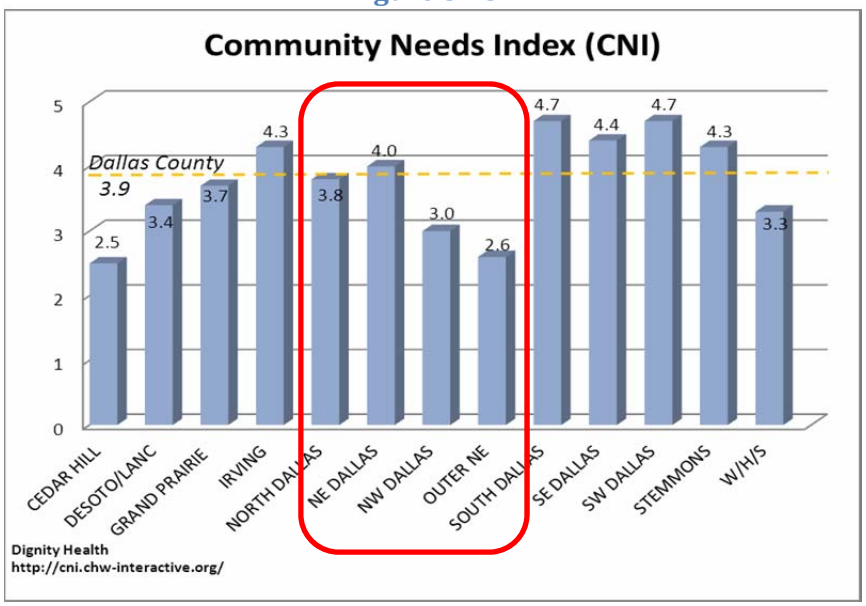
A score of 1.0 indicates a ZIP code with the least socio-economic barriers, while a score of 5.0 represents a ZIP code with the most socio-economic barriers.

- A comparison of CNI scores to hospital utilization shows a strong correlation between high need and high use—communities with high CNI scores can be expected to have higher hospital utilization.
- There is also a causal relationship between CNI scores and preventable hospitalizations for manageable conditions—communities with high CNI scores have more hospitalizations that could have been avoided with improved healthy community structures and appropriate outpatient/ primary care (Community Health, (n.d.)).

Dallas County has a CNI of 3.9. Considering Dallas County communities:

- Cedar Hill and Outer NE have the two lowest CNIs, 2.5 and 2.6 respectively.
  - This is of interest because the race/ethnicity and income of these two communities is very different. Cedar Hill is predominantly African-American with per capita income of $14,200, and Outer NE is predominantly Caucasian with income of $28,300. In addition, geographically they are on opposite ends of the County.
  - They are similar in their low unemployment, low percentage of residents at the FPL and their high percentage of residents with a high school diploma.
- Both South and Southwest Dallas have the highest CNI scores, 4.7. They are followed by Southeast Dallas, 4.4, and Irving and Stemmons Corridor, 4.3.

Figure 3.13



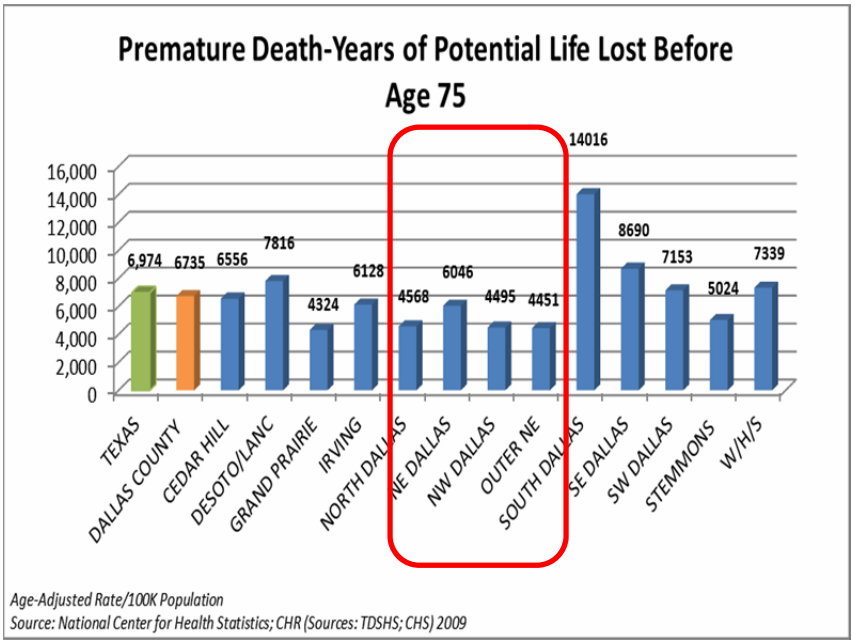
[2] Formerly Catholic Healthcare West

Premature Death

Premature death or years of potential life lost (YPLL) is a measure of early death. It represents the number of years not lived by people who die before a given age (usually 75 years) (NAPHSIS, n.d.). High premature death rates are found in Dallas County services areas with lower socioeconomic indicators relating to income, unemployment, poverty, and percentage without a high school diploma.

- Dallas County's premature death rate of 6,735/100,000 is 3% lower than found throughout Texas.
- Eight of 13 communities have premature death rates below the Dallas County rate.
  - Grand Prairie, Outer NE, and North Dallas have the lowest rates, all of which are below 5,000/100,000.
- All of the communities with premature death rates above the Dallas County average are located in the southern side of the County:
  - South Dallas' rate is more than twice that of the County at 14,016/100,000.
  - Other communities with high rates include: SE Dallas, DeSoto Lancaster, Wilmer Hutchins Seagoville and SW Dallas.

Figure 3.14



DALLAS COUNTY HEALTH PROFILE

HEALTHCARE ACCESS

Dallas County communities with low socioeconomic status experience disparities in health status and access to resources. These disparities and resource deserts are evidenced by uninsured status, limited access to primary care physicians and health services, and inappropriate use of hospital/emergency department services for conditions that could have been treated with preventive and primary care.

Background

Access to comprehensive, quality healthcare services is important for the achievement of health equity and healthy lifestyles for Dallas County residents. Access to healthcare impacts:

- Overall physical, social, and mental health status
- Prevention of disease and disability
- Detection and treatment of health conditions
- Quality of life
- Preventable death and life expectancy

Disparities in healthcare access negatively impact each of these outcomes. Access is governed by a range of systemic barriers across the continuum prevention and care. These include: location of health facilities, resident geographic location, transportation infrastructure, health literacy and awareness, and ability to pay for services. These barriers can lead to:

- Unmet health needs
- Inability to access preventive services
- Emphasis on emergency treatment instead of prevention and primary care
- Hospitalizations that could have been prevented

Disparities Associated with Low Socioeconomic Status

According to *Healthy People 2020,* socioeconomic factors contribute to observed disparities in disease incidence and mortality among racial, ethnic and underserved groups. This can be clearly seen in Dallas County. The southern areas of the county also align with areas with lower socioeconomic status (SES). Southern areas of the county also have more uninsured residents, fewer healthcare providers, and more conditions treated in an emergency room that would have been more appropriately and cost effectively treated in an outpatient setting.

Studies have found that income/SES, over race or ethnicity, predicts the likelihood of an individual's or group's access to:

- Education
- Health insurance
- Safe and healthy living and working conditions, including places free from exposure to environmental toxins (*Healthy People 2020, 2012)*

SES also appears to play a major role in:

- Prevalence of behavioral risk factors like tobacco smoking, physical inactivity, obesity, and excessive alcohol use.
- Rates of preventive screenings, with those with lower SES having fewer screenings (*Healthy People 2020, 2012).*

Healthy People 2020 identifies four components of access to care which will be used to frame this discussion: health insurance coverage, services, timeliness, and adequate and appropriate workforce.

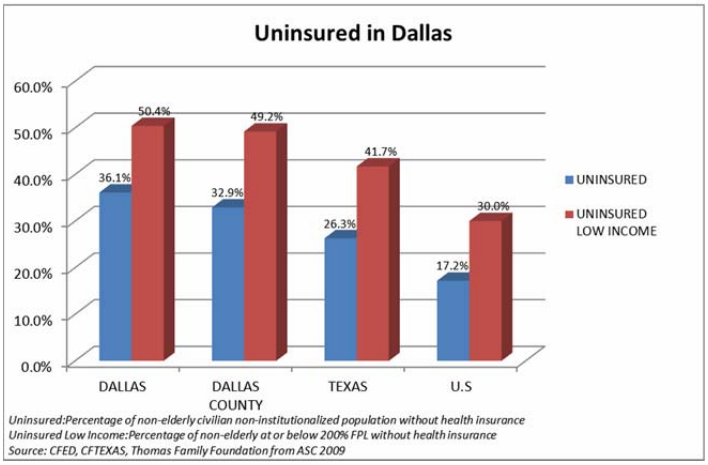
Health Insurance Coverage—Uninsured

Health insurance coverage provides people with the security to access more affordable preventive services and clinical care when needed. It has been documented that people without insurance will not be offered the same range of medical services as those who are insured (Kim, McCue & Thompson, 2009).

In addition, ongoing contact with physicians fosters more comprehensive health awareness that informs preventive care and illness management. The uninsured do not think about their health or medical conditions in the same comprehensive way as do the insured (Becker, 2001). When a medical condition occurs, they may delay treatment and/or use the emergency department instead of a lower cost, more appropriate primary care setting. The uninsured are:

- Less likely to receive needed medical care.
- More likely to have more years of potential life lost.
- More likely to have poor health status.

Figure 4.1



Dallas County

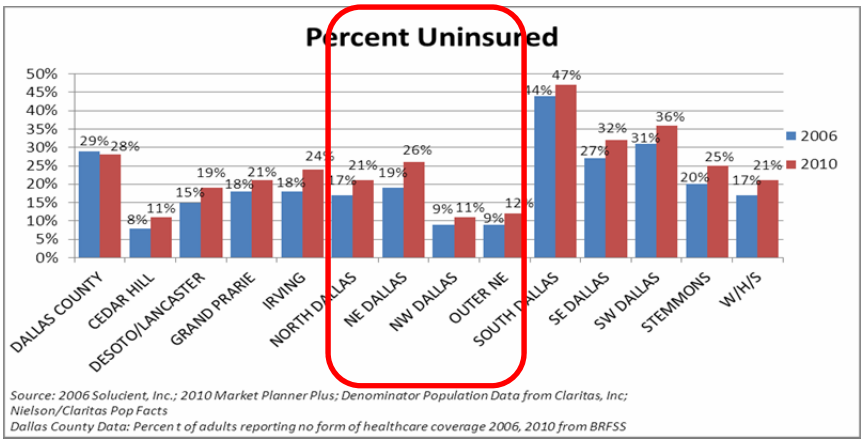
Dallas County has much higher percentage of uninsured residents than Texas or the United States. Figure 4.1 provides a comparison of total uninsured as well as low income (below 200% of FPL) uninsured developed by The Communities Foundation of Texas. They found:

- Nearly a third of non-elderly, non-institutionalized Dallas County residents are uninsured
- Nearly 50% of Dallas County residents considered low income are not insured.

- Low SES county residents not only lack awareness of available healthcare services and how to access them but also how to apply for Medicaid and Medicare (Weidich, 2012).

Considering changes in insurance status between 2006 and 2010, the percent of uninsured residents has increased in all Dallas County communities.

Figure 4.2



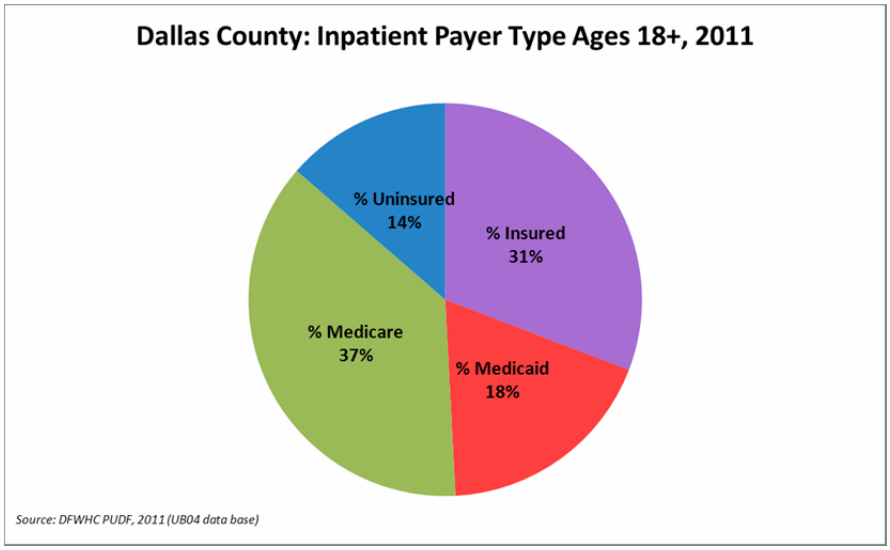
- The highest rates of uninsured residents are found in those communities with the highest levels of employment, regardless of income. These include Cedar Hill, NW Dallas and Outer NE Dallas.
- Conversely, the highest percentages of uninsured are found in the low-income areas with the highest levels of unemployment. These include South Dallas, SW Dallas, and SE Dallas (Refer to Figure 4.2).

Health Insurance Coverage—Insurance and Insurance Trends

Health Insurance Trends in Dallas County

Adult Dallas County residents hospitalized in 2011 only included 14% uninsured. The most frequent payer was Medicare, 37%, followed by privately insured, 31% and Medicaid 18%.

Figure 4.3

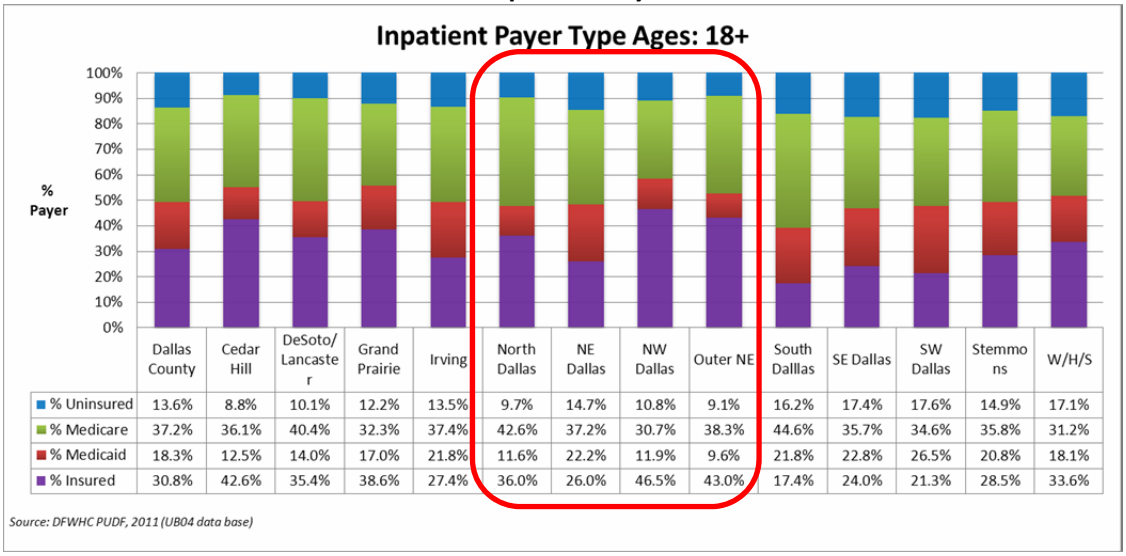


The 2011 health insurance payer mix by community reflects relationships to age and employment status.

- Communities with higher percentages of residents age 65 and older have larger percentages paying with Medicare. These include: South Dallas (45%) and North Dallas (43%).
- Communities with higher employment have larger percentages with private insurance. These include: NW Dallas (47%), Outer NE (43%), Cedar Hill (43%).
- Uninsured status ranges from 9% in Cedar Hill to 18% in SW Dallas.

Table 4.1

Adult Inpatient Payer Mix



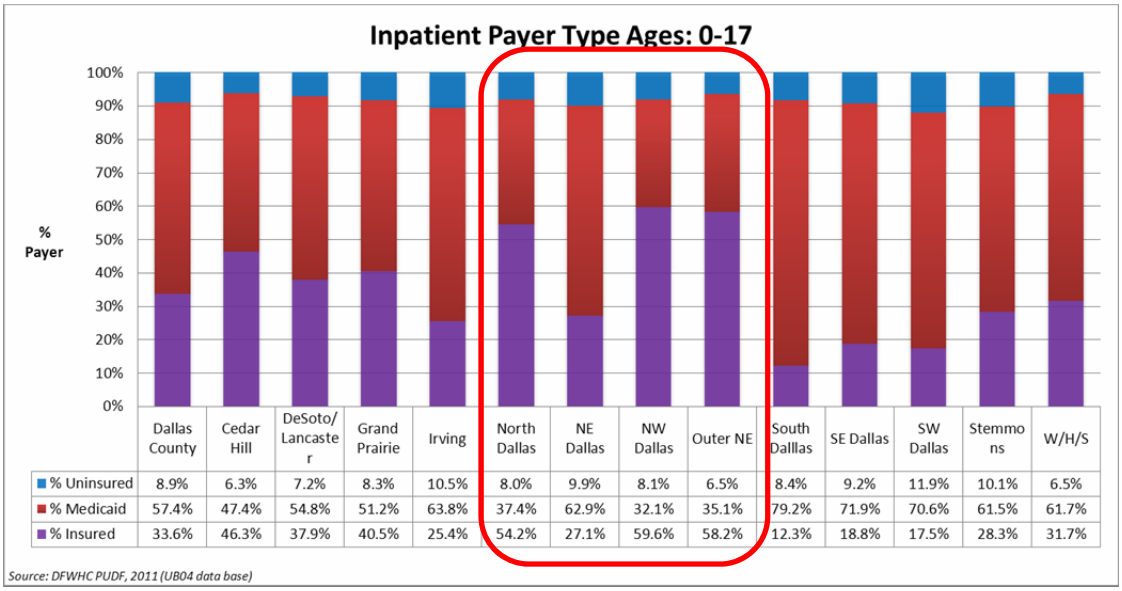
	Dallas County	Cedar Hill	DeSoto/ Lancaster	Grand Prairie	Irving	North Dallas	NE Dallas	NW Dallas	Outer NE	South Dalllas	SE Dallas	SW Dallas	Stemmons	W/H/S
% Uninsured	13.6%	8.8%	10.1%	12.2%	13.5%	9.7%	14.7%	10.8%	9.1%	16.2%	17.4%	17.6%	14.9%	17.1%
% Medicare	37.2%	36.1%	40.4%	32.3%	37.4%	42.6%	37.2%	30.7%	38.3%	44.6%	35.7%	34.6%	35.8%	31.2%
% Medicaid	18.3%	12.5%	14.0%	17.0%	21.8%	11.6%	22.2%	11.9%	9.6%	21.8%	22.8%	26.5%	20.8%	18.1%
% Insured	30.8%	42.6%	35.4%	38.6%	27.4%	36.0%	26.0%	46.5%	43.0%	17.4%	24.0%	21.3%	28.5%	33.6%

Source: DFWHC PUDF, 2011 (UB04 data base)

The 2011 payer mix for Dallas County children under 18 years includes 57% with Medicaid, 35% with private insurance and 9% uninsured.

- The communities with the highest percentages of children with Medicaid are in the lowest income areas including South Dallas (79%), SE Dallas (72%), and SW Dallas (71%).
- The communities with the highest percentages of children with private insurance include NW Dallas (60%), Outer NE (58%), and North Dallas (54%).
- Communities with high percentages of uninsured children include SW Dallas (12%), Irving (11%) and NE Dallas (10%).
    - Most hospitalized children from families with lower SES are enrolled in either Medicaid or the Children's Health Insurance Program (CHIP). Therefore, it may be assumed that many children without insurance may be from families that lack documentation.

Table 4.2
Child Inpatient Payer Type



	Dallas County	Cedar Hill	DeSoto/ Lancaster	Grand Prairie	Irving	North Dallas	NE Dallas	NW Dallas	Outer NE	South Dalllas	SE Dallas	SW Dallas	Stemmons	W/H/S
% Uninsured	8.9%	6.3%	7.2%	8.3%	10.5%	8.0%	9.9%	8.1%	6.5%	8.4%	9.2%	11.9%	10.1%	6.5%
% Medicaid	57.4%	47.4%	54.8%	51.2%	63.8%	37.4%	62.9%	32.1%	35.1%	79.2%	71.9%	70.6%	61.5%	61.7%
% Insured	33.6%	46.3%	37.9%	40.5%	25.4%	54.2%	27.1%	59.6%	58.2%	12.3%	18.8%	17.5%	28.3%	31.7%

Source: DFWHC PUDF, 2011 (UB04 data base)

Coverage—Children's Health Insurance Program[3]

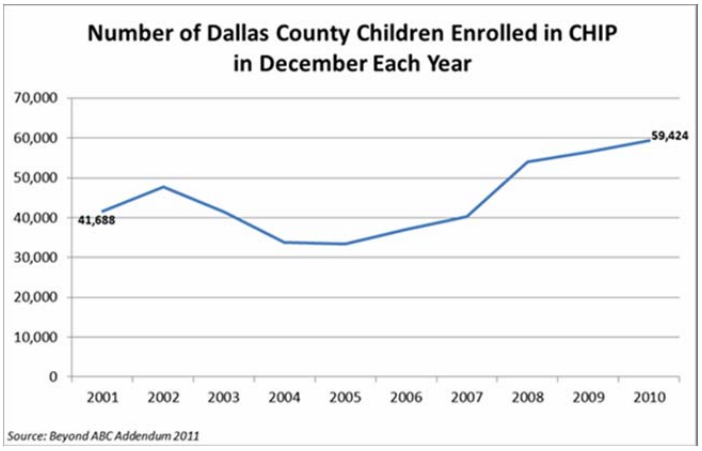
"2011 Beyond ABC: Assessing Children's Health" states that of the 654,273 children under 18 living in Dallas County, more than 29% live in poverty and 17.9% are uninsured (2011). This 2010 percentage, which is significantly below the overall percentage of Dallas County uninsured, resulted from coordinated, community-wide advocacy and actions. Beginning in 2004, actions undertaken to increase enrollment in both programs included:

- Easing the enrollment process for families,
- Implementing a 12-month eligibility period for Medicaid,
- Implementing an aggressive marketing and outreach campaign,
- Increasing the reimbursement rates paid to healthcare providers.

The result was a steady increase in the number of enrolled children, nearly doubling to 60,000 enrolled in 2010 (Refer to Figure 4.4). The level of Medicaid physician payment has been shown to affect a physician's willingness to accept any Medicaid patients. Since that time, a decline in CHIP physician reimbursement has resulted in a decline from 67% to 42% of Texas physicians who accept patients with CHIP reimbursement (2011 beyond ABC, 2011).

[3] CHIP is a joint federal and state program. It provides affordable healthcare coverage for working families who earn too much to qualify for Medicaid but cannot afford private health coverage. Eligibility requires that a child be a U.S. citizen or legal permanent resident, under age 19 and uninsured for at least 90 days. Family income and resources must be above the Medicaid eligibility limit and at/below 200% of the federal poverty level.

Figure 4.4



Physicians Accepting New Patients by Insurance Status

For Dallas County residents with insurance, consideration must be given to the type of insurance since that also affects healthcare access. A recent national study found that although 96% of physicians (PCP) accepted new patients in 2011, rates varied by payment source: 30% of physicians were unwilling to accept any new Medicaid patients; 17% would not accept new Medicare patients; and 18% of physicians would not accept new privately insured patients.

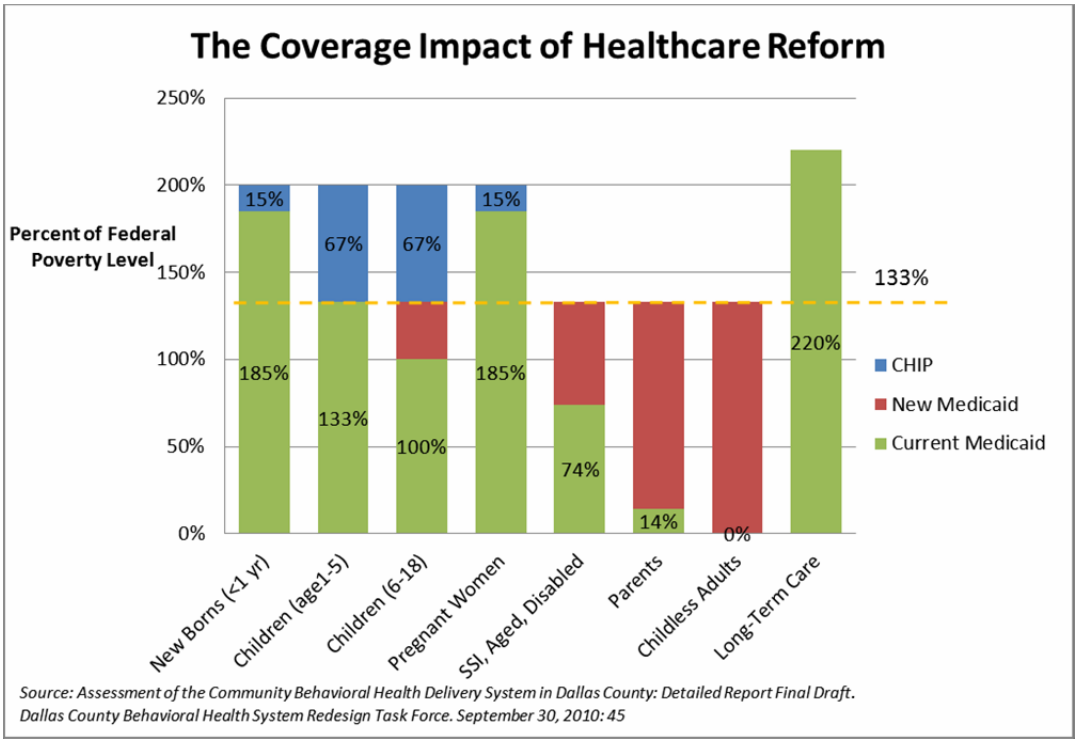
This study found that 30% of Texas physicians would not accept new Medicaid patients. (Decker, 2012). The Texas Medical Association found that in 2012, 31% of Texas physicians and 24% of Dallas County physicians will not accept Medicaid (Udall & Annear, 2012).

Affordable Care Act

If Affordable Care Act (ACA) provisions are implemented, Medicaid payment rates for primary care services provided by primary care physicians will increase to 100% of Medicare rates in 2013 and 2014. Prior evidence suggests that physicians' acceptance of Medicaid patients will increase as Medicaid payment rates increase (Decker, 2012).

It has been estimated that the ACA will increase the number of Medicaid eligibles in Texas by 25% (1,000,000 more eligible persons, in addition to the projected 4,000,000 that would otherwise be covered). Statewide costs for the expansion are projected at $1.7 billion in state funds and over $12 billion in federal funds, in federal fiscal year 2014. The primary eligibility groups expected to grow are childless adults under 133% FPL (currently they have no coverage), parents under 133% FPL (currently covered up to 14% of FPL), SSI/Aged/Disabled up to 133% FPL (currently covered at 74% of FPL), and children age 6 to 18 under 133% FPL (currently covered at 100% of FPL) (Assessment of the community, 2010). Current and projected coverage is presented in Figure 4.5.

Figure 4.5



The number of people with healthcare coverage through Medicaid is expected to increase at the same time as Medicaid payment rates for primary care physicians are expected to increase. Therefore, the healthcare workforce and demand ratio will be changing.

Services

Care Coordination—Medical Homes

Improving healthcare access depends, in part, on ensuring that people have a standard and consistent source of preventive care and clinical treatment. One method to accomplish this is through patient-centered medical homes. This model provides personalized, comprehensive medical care using a physician led multidisciplinary team that might also include nurse practitioners, nurses, case managers, community health workers and other medical personnel. Medical homes hold promise to transform the delivery of healthcare by improving quality, safety, efficiency and effectiveness. This will ultimately result in better health outcomes and fewer disparities and costs (PCMH: Home, n.d.).

Conveniently locating medical homes and other primary care in local communities further supports access. Providers who are invested in the community promote meaningful and sustained relationships between themselves, their patients, and patient families. Medical homes may be led by PCPs at clinics, hospitals, and health departments. Medical homes are also enriched by preventive and treatment services from nurse practitioners, parish nurses, community health workers and navigators among others. As a result, medical homes are associated with:

- Greater patient trust in the provider
- Effective patient-provider communication
- Increased likelihood that patients will receive appropriate care
- Decreased duplication and disconnection of health services provided (PCMH: Home, n.d.).

Care Coordination—Accountable Care

The North Texas Accountable Healthcare Partnership (NTAHP) is a non-profit organization of healthcare stakeholders committed to collaborative transformation of the healthcare delivery system for a 15 county area. Using a $4.9 million infrastructure development grant from DSHS, NTAHP seeks to be the region's primary driver and champion of healthcare value through the establishment of four critical standards:

1. Reporting of evidence-based quality metrics specific to disease states;
2. Redesign of Care Coordination services through the physician's office;
3. Provision of new payment models that promote and reward high quality care and cost savings;
4. Adoption of common health plan designs that encourage patient accountability consistent with the quality metrics (North Texas accountable, 2012).

To achieve the goals of improved health outcomes and reduced costs accountable care organizations, such as NTAHP, will:

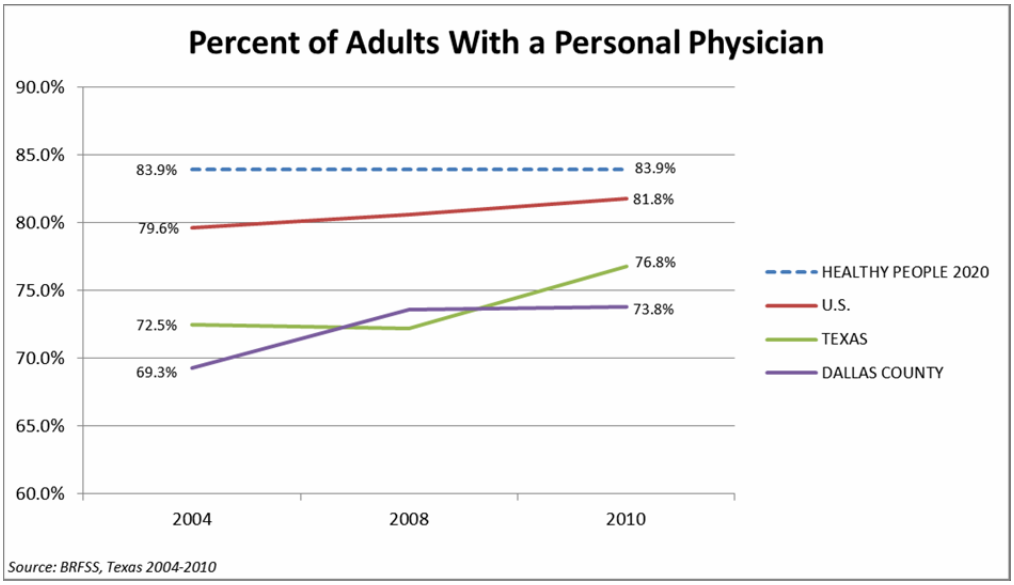
- Expand community and clinical preventive care,
- Focus on local, community-based services,
- Coordinate care using a multi-disciplinary teams led by the physicians,
- Develop data bases to improve treatment on both an individual and population basis (North Texas accountable, 2012).

Primary Care Physicians in Dallas County

The percentage of Dallas County residents with a PCP has increased from 69% in 2004 to 74% in 2010.

- The 2010 percentage, however, is lower than found in Texas or the U.S.
- It is also 10% below than the *Healthy People 2020* goal.

Figure 4.6



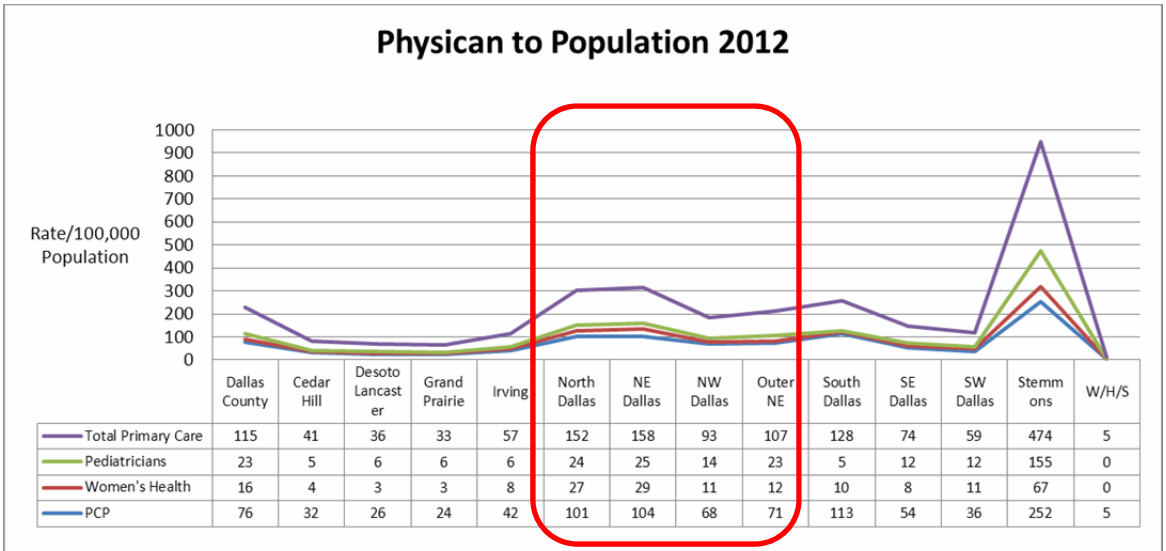
Dallas County has a rate of 99 PCPs/100,000. To compare, Texas has 70 PCPs per 100,000, which is the fourth lowest state rate in the U.S. The state median is 91/100,000 (2011 state physician workforce, 2011).[4]

PCPs are maldistributed in Dallas County. The vast majority are located in Stemmons Corridor leaving some communities with few PCPs.[5]

- Besides Stemmons Corridor, communities with large concentrations of PCPs include: NE Dallas, North Dallas and South Dallas.
- Areas with the lowest concentrations of PCPs include Wilmer Hutchins Seagoville, Grand Prairie, DeSoto Lancaster, and Cedar Hill.

[4] The AAMC study identified PCPs as internists, family practitioners, geriatricians, and pediatricians.
[5] Refer to Appendix D for specialties included in PCP categories.

Figure 4.7



	Dallas County	Cedar Hill	Desoto Lancaster	Grand Prairie	Irving	North Dallas	NE Dallas	NW Dallas	Outer NE	South Dallas	SE Dallas	SW Dallas	Stemmons	W/H/S
Total Primary Care	115	41	36	33	57	152	158	93	107	128	74	59	474	5
Pediatricians	23	5	6	6	6	24	25	14	23	5	12	12	155	0
Women's Health	16	4	3	3	8	27	29	11	12	10	8	11	67	0
PCP	76	32	26	24	42	101	104	68	71	113	54	36	252	5

Sources: Licensed Texas Physicians, January 2012; U.S. Census zip (ZCTA)-level data
http://www.tmb.state.tx.us/consumers/products/PHY_layout.pdf

Dallas County Clinics

Dallas County clinics are depicted below using asset maps. These maps provide a visual depiction of provider locations, making areas of clinic concentration as well as areas of limited or no clinics very clear. Detailed clinic lists with name and addresses can be found in Appendix D.

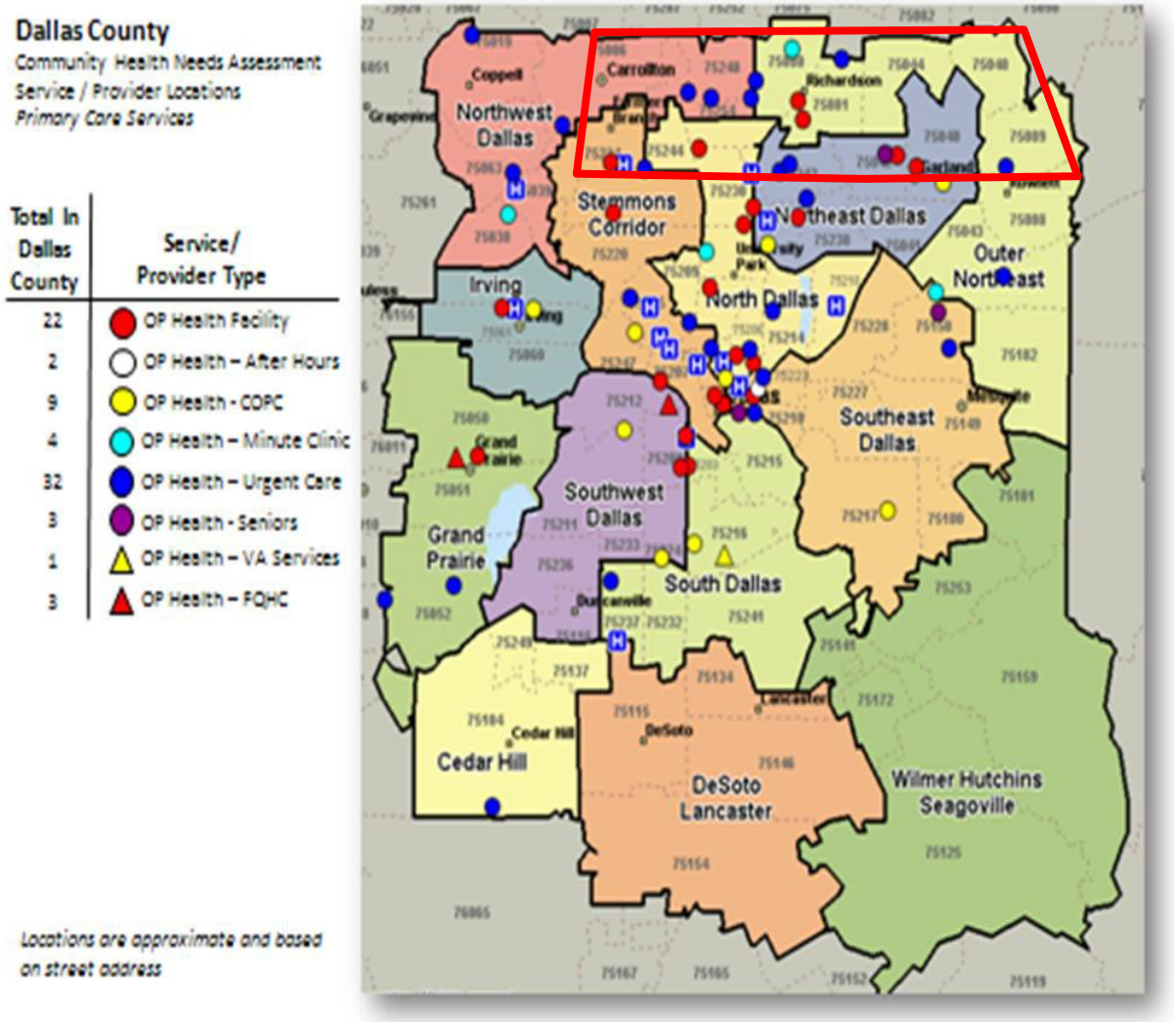
Map 1 (Figure 4.8) presents Outpatient Health Facilities in Dallas County.

- The 22 outpatient health facilities include charity and general primary care clinics.
- Nine Community Oriented Primary Care (COPC) clinics, operated by Parkland Health and Hospital System (PHHS), offer a range of services focusing on primary care treatment.
- Thirty two urgent care centers[6] were identified. One is in Cedar Hill, one in Southeast Dallas, two in Grand Prairie, two in South Dallas, two in Grand Prairie, and the remainder (24) in Stemmons Corridor and the northern suburbs.
- Three Federally Qualified Health Centers (FQHC) are operating in Dallas County.
- Four outpatient pharmacy-based clinics were identified; however, this is an emerging preventive care resource particularly for immunizations.
- Outpatient health facility deserts are found in DeSoto Lancaster, Wilmer Hutchins Seagoville, Cedar Hill, portions of SE Dallas and SW Dallas.

[6] Clinics offering walk-in outpatient healthcare for non-life threatening conditions, with lower prices and typically shorter wait times than a hospital emergency room.

Figure 4.8

Map 1
Outpatient Health Facilities



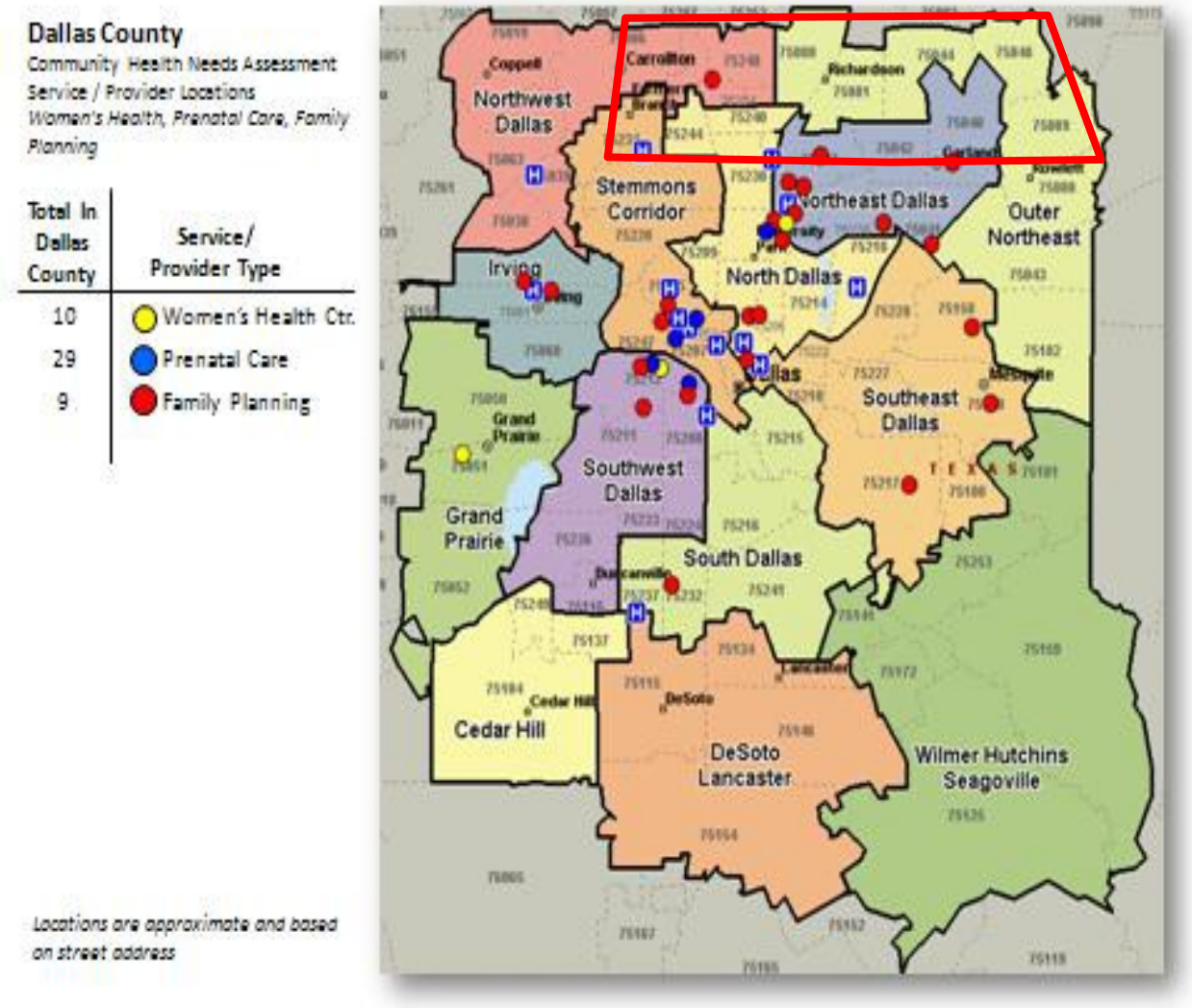
Map 2 (Figure 4.9) presents Women's Outpatient Facilities. Most are located in Stemmons Corridor, North and Northeast Dallas.

- Ten provide women's healthcare.
- 29 provide prenatal care and nine provide family planning
- Women's health outpatient resource deserts are found in communities outside the center of the City of Dallas. These include: NW Dallas, Outer NE Dallas, Wilmer Hutchins Seagoville, DeSoto Lancaster, Cedar Hill. A new facility in Grand Prairie alleviates the shortages found in that community.

Figure 4.9

Map 2

Women's Health Outpatient Facilities

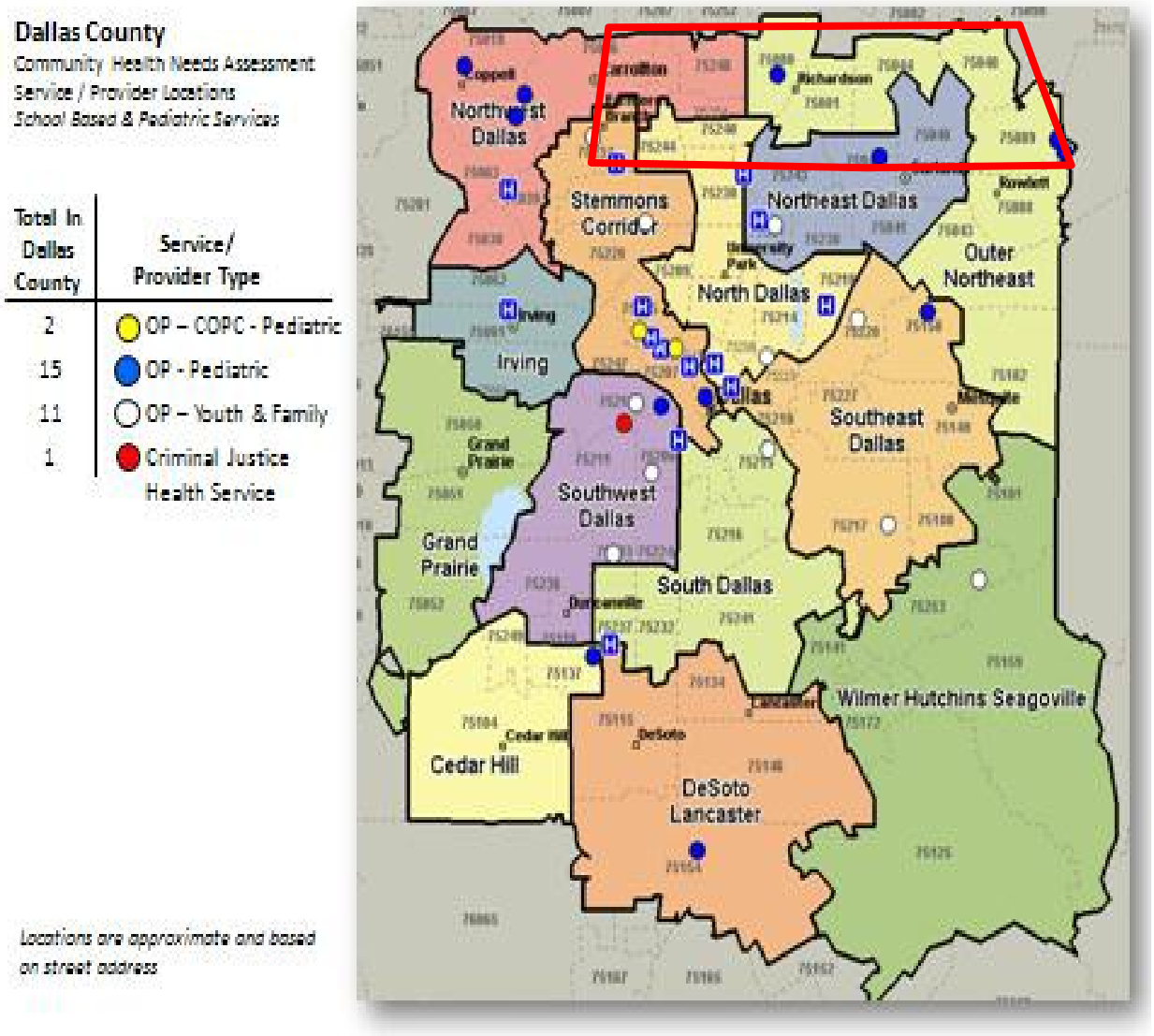


Map 3 (Figure 4.10) presents Children's Outpatient Facilities.

- Thirteen are operated by PHHS including two pediatric COPCs and 11 Youth and Family Centers.
  - Youth and Family Centers are well distributed at Dallas Independent Schools throughout the county.
- The 15 pediatric outpatient health facilities tend to be located near the center of Dallas or in the northern suburbs. In the south, one is located in Cedar Hill and one in DeSoto Lancaster.
- Pediatric outpatient facilities resource deserts are seen in Grand Prairie, Irving, South Dallas, Cedar Hill, DeSoto Lancaster, and portions of Wilmer Hutchins Seagoville.

Figure 4.10

Map 3
Children's Outpatient Facilities

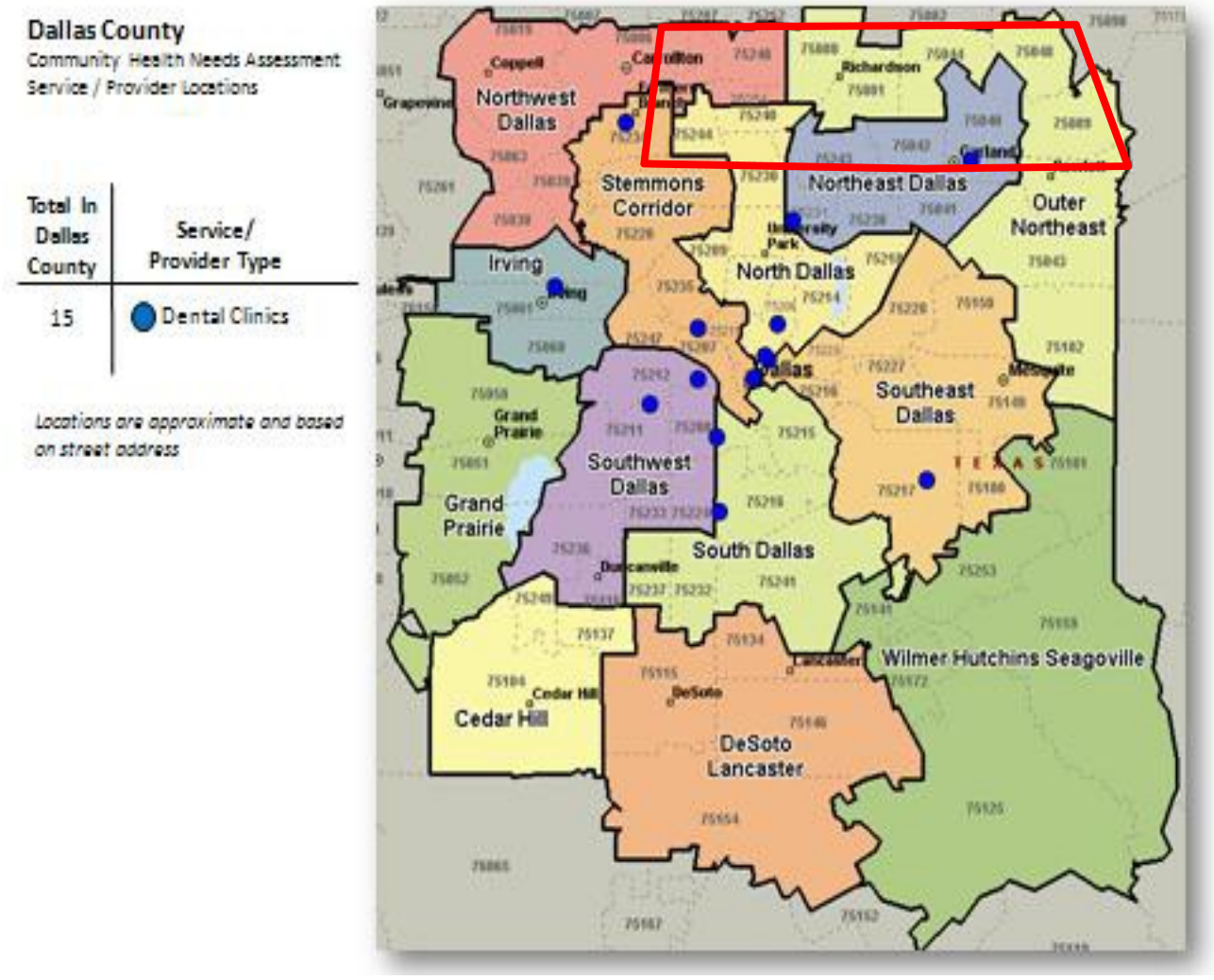


Map 4 (Figure 4.11) presents 15 Dental Clinics.

- Dental Clinics are dispersed around the central Dallas community. Nine dental clinics are operated by Community Dental Clinics at COPC sites.[7]
- Dental clinic deserts are found in the far north and far south communities.

Figure 4.11

Map 4
Dental Clinics



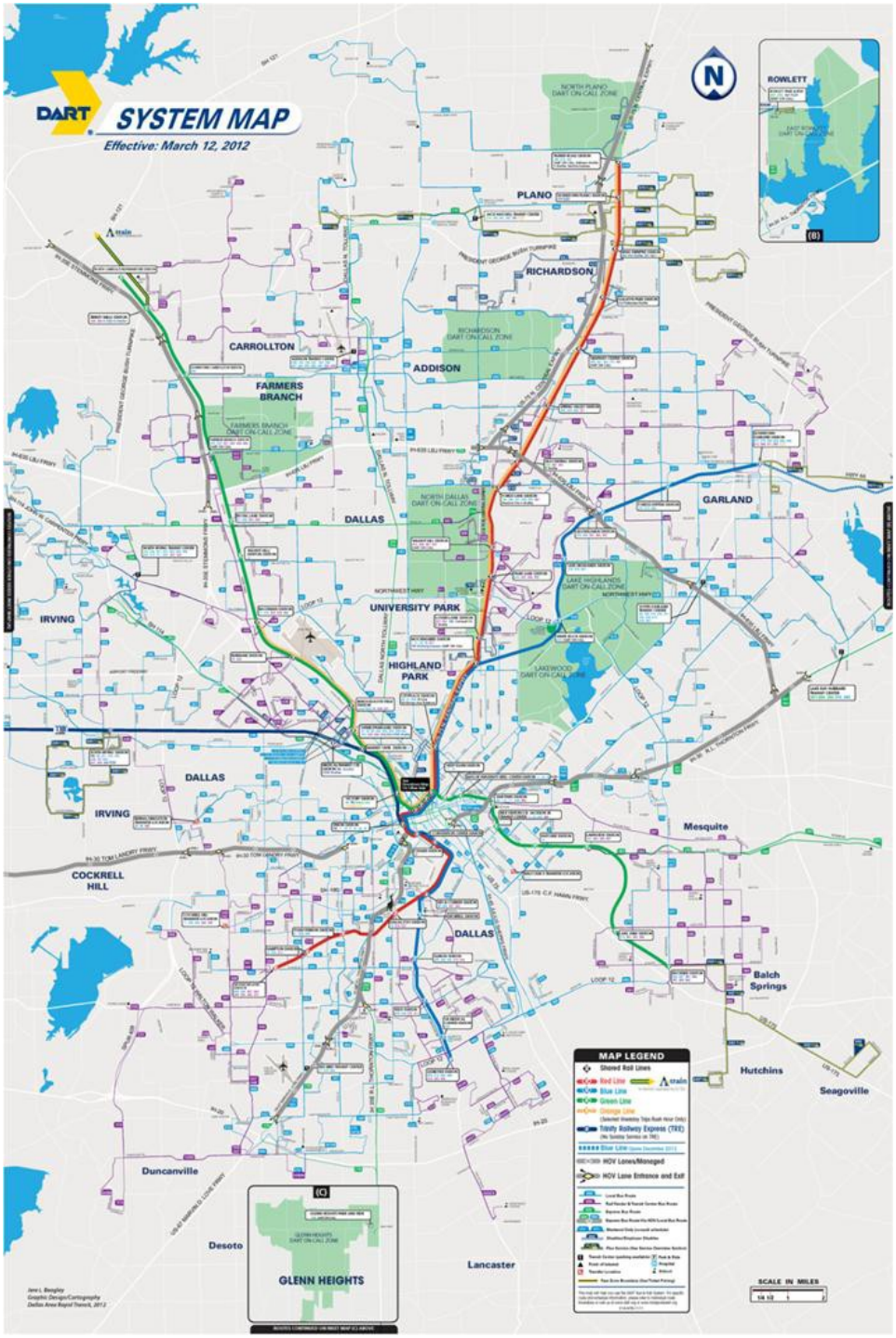
[7] For a complete list of providers on each of these maps, refer to Appendix D.

Map 5 (Figure 4.12) shows Dallas County's public transportation system via DART. This compares with Maps 1 through 4 to identify public transportation available compared to the location of outpatient healthcare facilities. Transportation is a core component integral to healthcare access.

Figure 4.12

Map 5

Dallas County Public Transportation System



Timeliness of Services

A key indicator of the timeliness of services is emergency department (ED) utilization for conditions that could have been treated in a primary care setting. These include both unnecessary emergency department visits for minor, treatable conditions and visits for conditions that progressed as a result of not accessing timely treatment in an outpatient setting.

Reasons for accessing the ED instead of a more appropriate, lower acuity level of care include:

- No regular source of primary care
- Lack of health insurance
- Cost including the inability to pay co-pays for office visits
- Transportation issues
- Practices without extended office hours
- Undocumented citizenship status

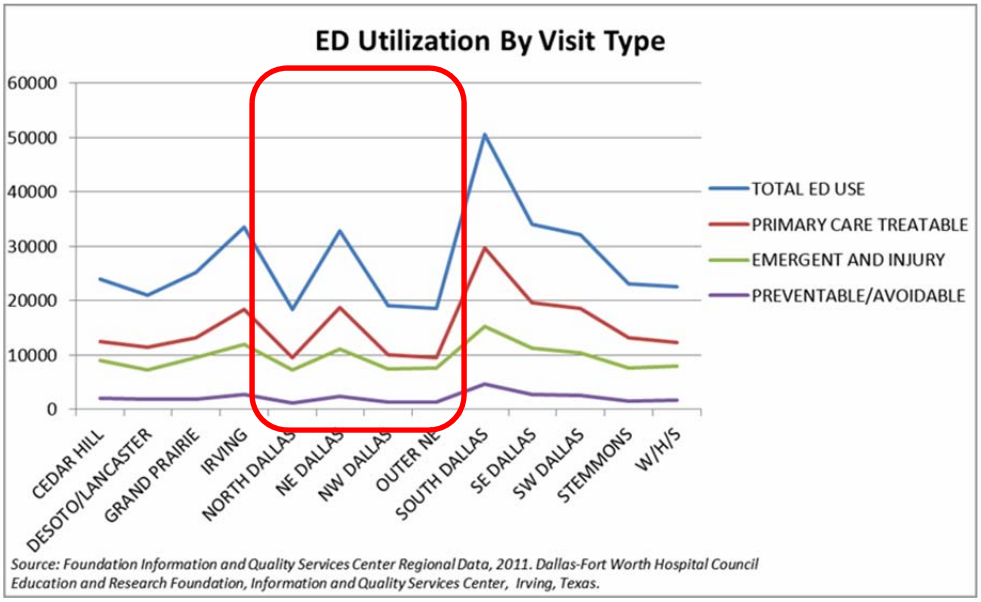
ED Usage by Community, Case Type and Payer

Primary care treatable conditions are indicators emergency department (ED) use by patients who would have more appropriately been cared for in an outpatient primary setting. The charts below identify the number, rate and percentage of ED visits that might have been treated in another setting for Dallas County and each community. Both the primary care treatable conditions and the preventable/avoidable conditions are reflected in Figure 4.13.

Primary care treatable conditions represent the most frequent type of ED visit in 2011.

- South Dallas, the community with low SES and high levels of uninsured residents, had the largest number of ED visits including both primary care treatable and preventable/avoidable.
- This is followed by NE Dallas, SE Dallas, SW Dallas and Irving.
- North, NW and Outer NE Dallas have the lowest number of primary care treatable and preventable/avoidable visits.

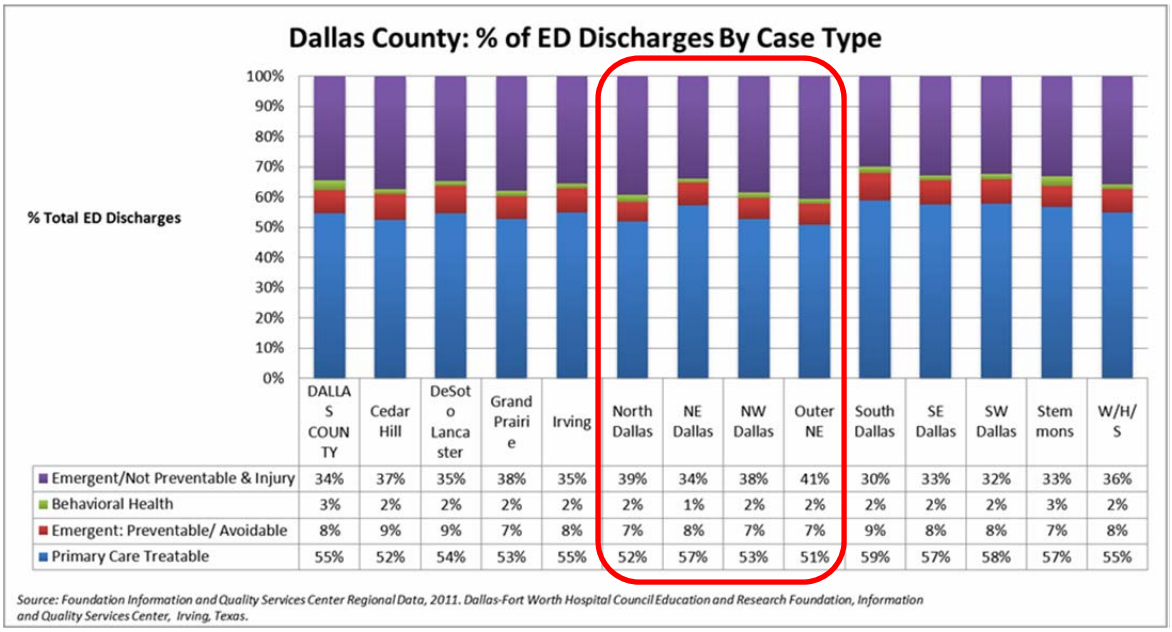
Figure 4.13



Considering the percentage of ED visits type by for each community finds South Dallas, SW Dallas and Stemmons having the highest percentage of primary care treatable discharges.

Preventable/avoidable ED discharges range from 7% to 9%. The higher percentage is found in Cedar Hill, DeSoto Lancaster and South Dallas.

Figure 4.14

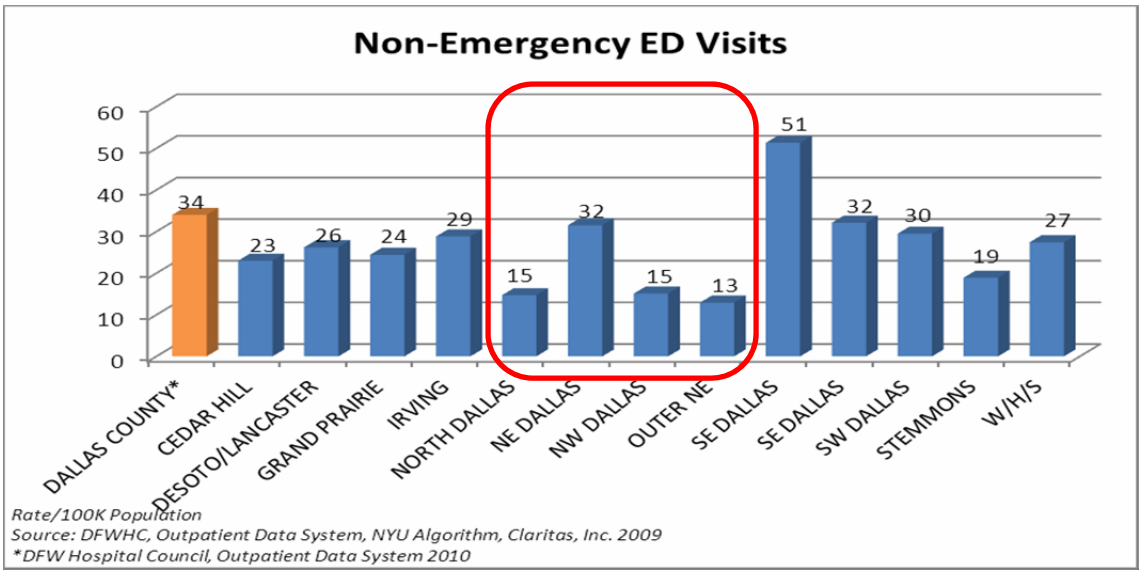


	DALLAS COUNTY	Cedar Hill	DeSoto Lancaster	Grand Prairie	Irving	North Dallas	NE Dallas	NW Dallas	Outer NE	South Dallas	SE Dallas	SW Dallas	Stemmons	W/H/S
Emergent/Not Preventable & Injury	34%	37%	35%	38%	35%	39%	34%	38%	41%	30%	33%	32%	33%	36%
Behavioral Health	3%	2%	2%	2%	2%	2%	1%	2%	2%	2%	2%	2%	3%	2%
Emergent: Preventable/ Avoidable	8%	9%	9%	7%	8%	7%	8%	7%	7%	9%	8%	8%	7%	8%
Primary Care Treatable	55%	52%	54%	53%	55%	52%	57%	53%	51%	59%	57%	58%	57%	55%

These findings were reinforced by the 2010 non-emergency ED visit rate per 100,000 residents (Figure 4.15).

- Dallas County has an overall rate of 34 non-emergency ED visits/100,000 residents.
- South Dallas had a significantly higher non-emergency visit rate, 51 visits/100,000. This was followed by NE Dallas, SE Dallas and SW Dallas.

Figure 4.15



Dallas County 2010 ED visits by payer includes 23% insured, 11% Medicare, 26% Medicaid and 40% Uninsured.

- The community with the largest percentage of uninsured ED visits is Stemmons (50%). This is followed by SE and SW Dallas, each with 43% uninsured.
- The communities with the largest percentage of insured ED visits are NW and Outer NE Dallas with 37%.
- The communities with the largest percentage of Medicare ED visits are North and South Dallas with 14%.
- The communities with the largest percentage of Medicaid ED visits are NE Dallas (32%) and Irving (31%)

Figure 4.16

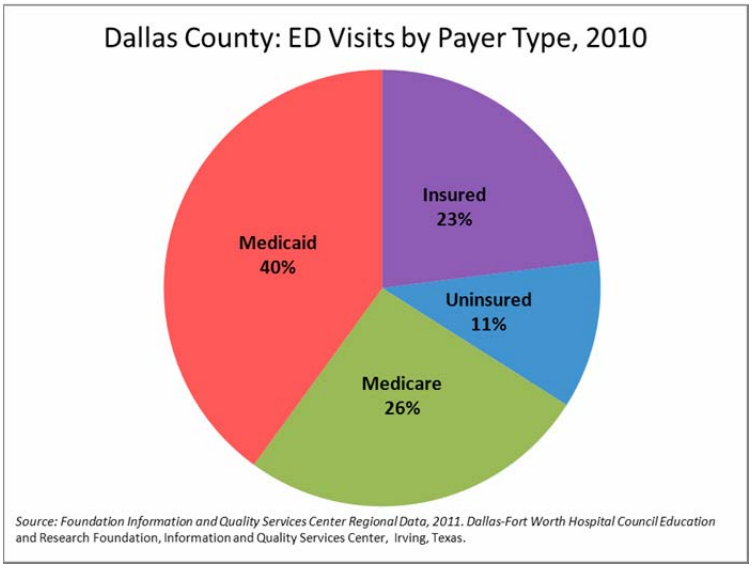
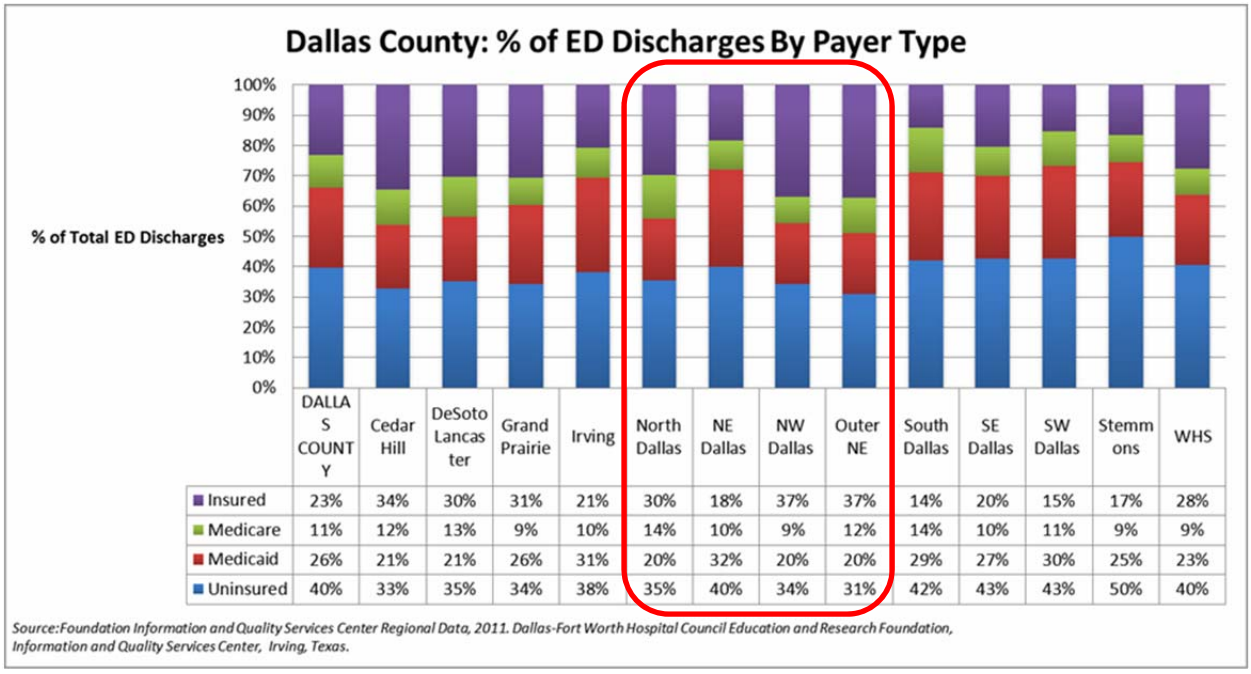


Figure 4.17



	DALLAS COUNTY	Cedar Hill	DeSoto Lancaster	Grand Prairie	Irving	North Dallas	NE Dallas	NW Dallas	Outer NE	South Dallas	SE Dallas	SW Dallas	Stemmons	WHS
Insured	23%	34%	30%	31%	21%	30%	18%	37%	37%	14%	20%	15%	17%	28%
Medicare	11%	12%	13%	9%	10%	14%	10%	9%	12%	14%	10%	11%	9%	9%
Medicaid	26%	21%	21%	26%	31%	20%	32%	20%	20%	29%	27%	30%	25%	23%
Uninsured	40%	33%	35%	34%	38%	35%	40%	34%	31%	42%	43%	43%	50%	40%

Source:Foundation Information and Quality Services Center Regional Data, 2011. Dallas-Fort Worth Hospital Council Education and Research Foundation, Information and Quality Services Center, Irving, Texas.

Workforce

A key to enhancing access is to increase the availability of high quality community prevention services, clinical prevention services as well as community-based care and treatment. To accomplish this, a well-trained, culturally competent public and private sector workforce is required. The workforce must hold expertise in wellness, preventive care, chronic-illness care and public health.

Nationally, PCPs are in short supply, and according to the Lewin Group, the demand for PCPs will increase between 3% and 6% with the initiation of healthcare reform (Physician supply, 2006). As described above, Texas is experiencing a shortage of PCPs. It has the fourth lowest concentration of PCPs in the country. Dallas County has a maldistribution of PCPs, with the majority in the Stemmons community and the northern suburbs.

Patient navigators and community healthcare workers are assuming new roles in community prevention and community healthcare. In 2011, Dallas County experienced a significant increase in community health workers, 4.4/100,000 population (Table 4.3).

Pharmacists are also increasing in importance on the healthcare team. Dallas County witnessed as steady increase in pharmacists between 2008 and 2011.

The Medical Reserve Corps volunteers are also supporting healthcare access in Dallas County as depicted in Table 4.4.

Table 4.3

Dallas County
Employment Trends: Community Health Workers and Pharmacists

Dallas County	2011			2010			2009			2008		
	Workforce Supply Total	Ratio of Population per Worker*	Worker per 100 K Population	Workforce Supply Total	Ratio of Population per Worker*	Worker per 100K Population	Workforce Supply Total	Ratio of Population per Worker*	Worker per 100K Population	Workforce Supply Total	Ratio of Population per Worker*	Worker per 100K Population
Promotores(as) (Community Health Workers)	108	22,780	4.4	23	105,910	0.9	11	219,312	0.5	30	78,164	1.3
Pharmacists	2,316	1,062	94.1	2,231	1,092	91.6	2,155	1,119	89.3	2,074	1,131	88.4
Data available online at: http://www.dshs.state.tx.us/chs/hprc/health.shtm												

Table 4.4

Medical Reserve Corp Volunteers
2012

Medical Reserve Corps	Total Number Volunteers	Number of New Volunteers	Total Number of Trainings	Number of Volunteers Trained
Dallas County	1464	113	27	372
Source: Dallas County Health and Human Services (2012). Public Health Preparedness Division.				

IMMUNIZATIONS

Dallas County Health and Human Services, Garland Health Department, and primary care hospital and clinic providers work diligently to provide required vaccines to children and adults throughout Dallas County. The result is improving vaccine rates and stable or declining disease rates.

Dallas County is working to support the nation's public health goals that focus on reducing illness, hospitalization, and death from vaccine-preventable diseases and other infectious diseases.

Childhood Immunizations

Vaccine rates among Dallas County preschool children increase with age. By the time children enter kindergarten, 98% - 99% have the complete complement of required vaccines. Prior to entering school, however, some infants and children continue to be at risk for diseases that can be prevented by immunization.

- While one-third of children under two were not fully immunized in 2010 (*2011 beyond ABC*, 2011), by the age of three, this 2009 percentage declined to 26.1% (Figure 4.18).
- By the time the children reach school age, almost all are fully vaccinated except conscientious objectors (Table 4.5).

Table 4.5

2011-2012 Annual Report Completely Vaccinated: Dallas County		
Grade	Vaccine Name	%
Kindergarten	DTP/DTaP/DT/Td	98.2%
Kindergarten	Hepatitis A	98.2%
Kindergarten	Hepatitis B	99.0%
Kindergarten	MMR (2 doses)	98.7%
Kindergarten	Polio	98.6%
Kindergarten	Varicella (2 doses)	98.1%
Seventh Grade	Hepatitis B	99.5%
Seventh Grade	Meningococcal	99.1%
Seventh Grade	MMR (2 doses)	99.6%
Seventh Grade	Polio	99.5%
Seventh Grade	Tdap	98.9%
Seventh Grade	Varicella (2 doses)	99.0%
Source: DCHHS		

Figure 4.18

Figure 4.18 demonstrates improved rates for vaccinations for children ages 19 to 35 months between 2001 and 2009, from 63% to nearly 74%.

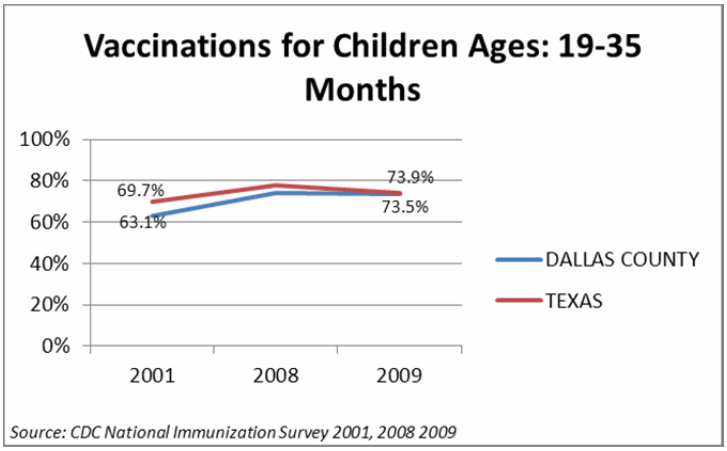


Table 4.6 demonstrates improvement in kindergarten immunization status between 2007 and 2011. Significant increases are shown in Hepatitis A vaccine percentages during this time.

Table 4.6

Dallas County Kindergarten Immunization Status
Fall 2007-2011

Year	DTP/ DTaP/ DT/Td	Hep A	Hep B	MMR 2 doses	Polio	Varicella 2 doses	Measles 1	Measles 2	Mumps	Rubella
2011	98.2%	98.2%	99.0%	98.7%	98.6%	98.1%	n/a	n/a	n/a	n/a
2010	97.4%	97.6%	98.5%	98.0%	98.6%	98.1%	n/a	n/a	n/a	n/a
2009	97.8%	97.5%	98.9%	99.1%	98.8%	98.4%	n/a	n/a	n/a	n/a
2008	97.9%	79.2%	99.0%	n/a	98.7%	99.4%	99.4%	98.6%	99.3%	99.3%
2007	98.0%	81.0%	98.9%	n/a	98.9%	99.4%	99.4%	98.5%	99.4%	99.4%

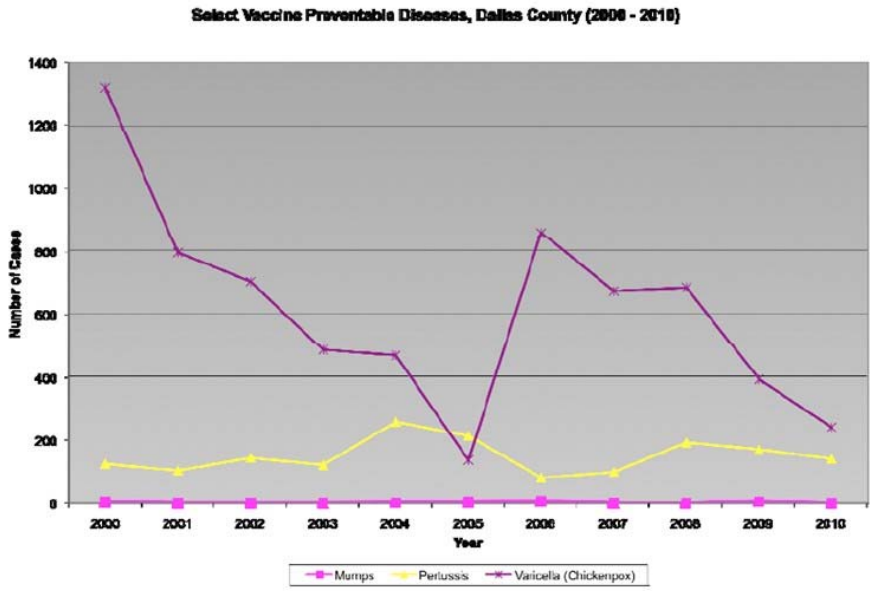
Source: Texas Annual Report of Immunization Status

Chickenpox cases in the United States dropped almost 80% between 2000 and 2010 in 31 states following routine use of the varicella vaccine. Updated figures recently published by the CDC also show that in the four years after a two-dose vaccine was recommended for children in 2006, cases of chickenpox declined about 70%. The biggest drop occurred in children between the ages of 5 and 9 (Steele, 2012).

- Since 2006 Dallas County witnessed a decline in varicella/chicken pox from over 800 to 200. This is presented in Figure 4.19.
- Between 2000 and 2010 cases of mumps were negligible; and cases of pertussis were low (Refer to Figure 4.19).

Figure 4.19

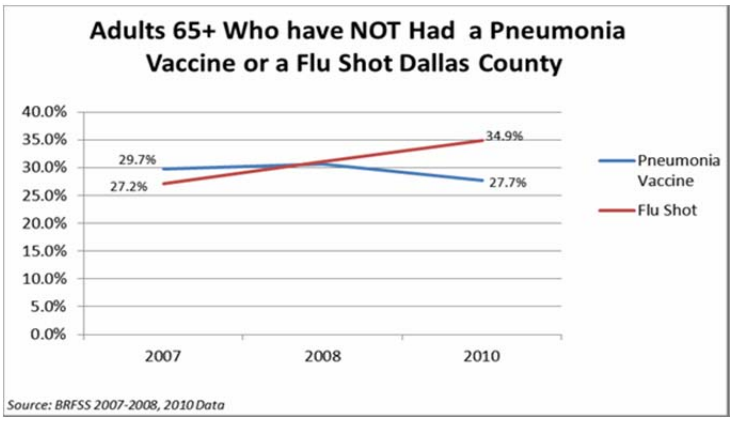
Communicable Disease Epidemiology: Mandatory Reportable Conditions 2000-2010



Vaccine Preventable Diseases have been declining overall in Dallas County. No outbreaks of pertussis have been reported in Dallas County in 2010.

Adult Immunizations

Figure 4.20



It is recommended that all adults age 19 and older receive an annual flu vaccine and adults age 65 and older receive on lifetime dose of pneumonia vaccine (*Recommended adult immunization*, 2012).

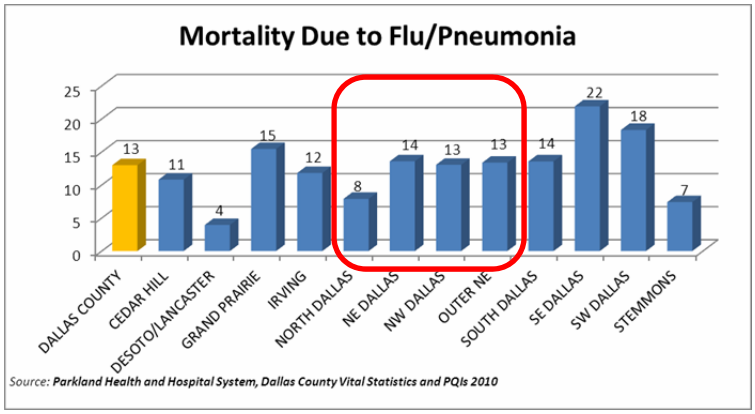
- In Dallas County, adults receiving the annual flu vaccine increased annually between 2007 and 2010 to 35%.
- The percentage receiving the pneumonia vaccine declined to 27.7% in 2010 from 29.7% in 2007.

Mortality due to Flu/Pneumonia

Figure 4.21

The 2010 Dallas County age adjusted death rate due to flu/pneumonia was 13/100,000.

- It ranged from 4/100,000 in DeSoto Lancaster to 22/100,000 in SE Dallas.
- South Dallas had a rate similar to the County average despite the highest percentage of 65+ residents in Dallas County (12%).

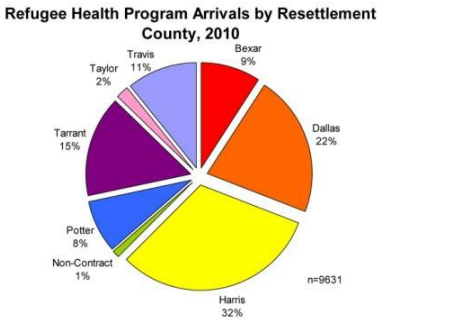


Refugee Immunizations

Dallas County is a designated refugee resettlement site, where refugees and Dallas County residents have differing innate immunity and vaccination rates (*Immunization report card*, 2010, p. 1). Refugee immunizations serve to protect refugees from illnesses prevalent in the United States while protecting Dallas County residents from illnesses spread by refugees who may have innate immunity.

- Twenty-two percent (22%) of refugees that resettled in Texas settled in Dallas County in 2010 (Figure 4.22).
- Considering arrivals between 2007 and 2011 finds 2010 as the peak year with 1,911 arrivals (Figure 4.23).
- That year, the DCHHS Refugee Health Screening Program administered over 21,000 vaccines to 2,338 refugees.
- Figure 4.24 presents the many countries of origin for Dallas County refugees. Bhurma, Iraq and Butan were the counties of origin for the largest percentages of refugees.

Figure 4.22



Harris County received the most arrivals (32%), followed by Dallas County (22%), Tarrant County (15%), Travis County (11%), Bexar County (9%), Potter County (8%), and Taylor County (2%). The remaining 1% were resettled in non-contract counties.

Figure 4.23

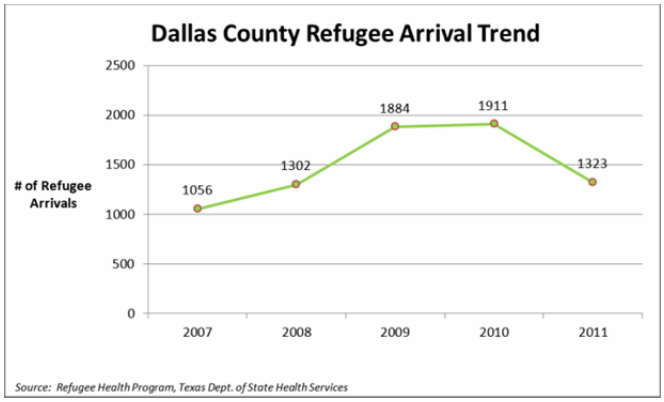
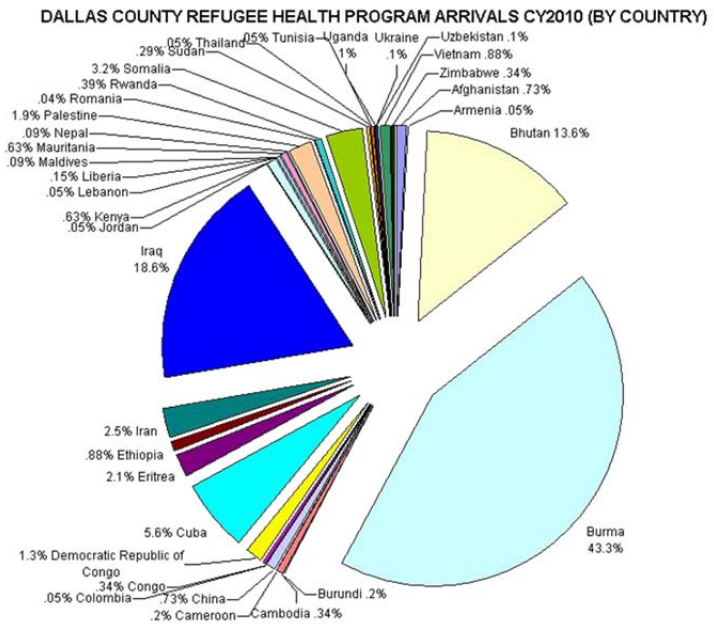


Figure 4.24

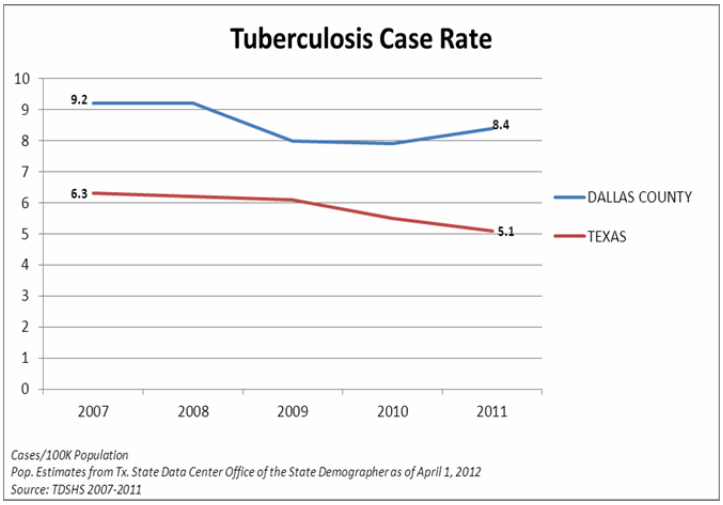


Tuberculosis

Between 2007 and 2011 the tuberculosis case rate in Dallas has been consistently higher than found in Texas (Figure 4.25).

- The State case rate steadily decreased by nearly 20% during this time.
- Dallas County's case rate declined 13% between 2007 and 2009 but has increased 5% since that time.

Figure 4.25

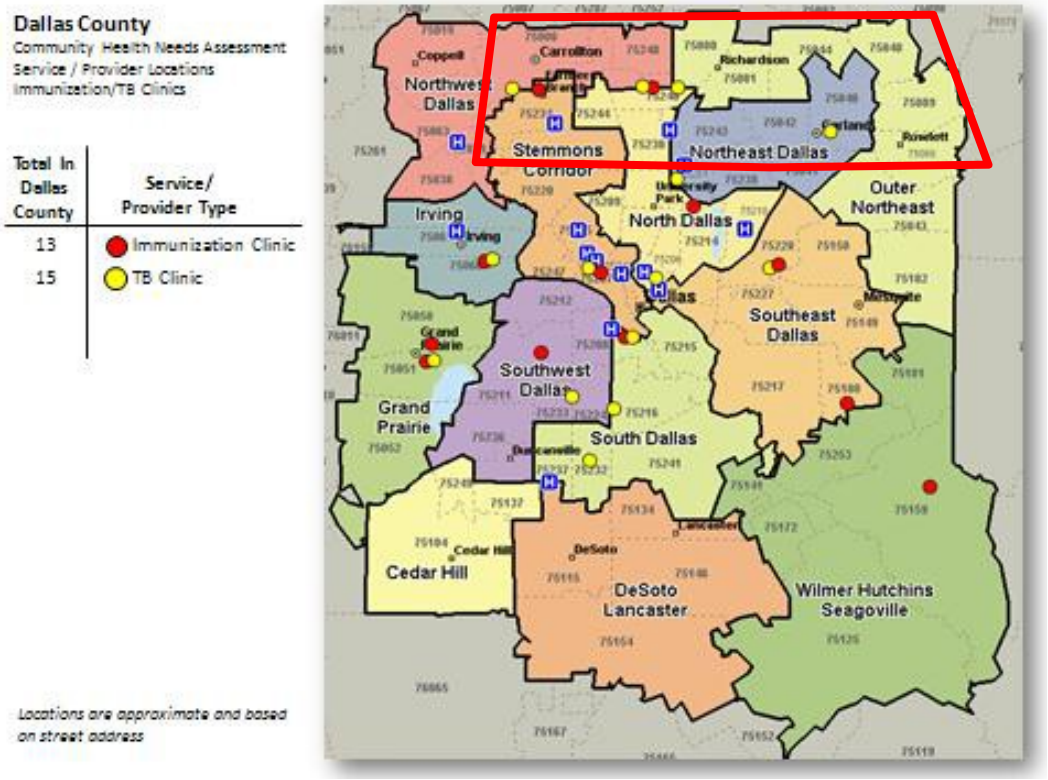


Locations of DCHHS Immunization and TB Clinics

The map below presents the locations of all DCHHS Immunization and TB clinics. These clinics are well distributed, particularly remembering that the southern sectors of DeSoto Lancaster and Wilmer Hutchins Seagoville are not in Dallas County.

Figure 4.26

Immunization and TB Clinics



COMMUNICABLE DISEASES

Dallas County's incidence of reportable infectious diseases is lower than the Texas average, but incidence of sexually transmitted diseases is higher than found throughout the State.

Notifiable Infectious Disease

The responsibilities of epidemiologists fall into four areas:

1. Outbreak surveillance, detection, and investigation
2. Intensive case investigations for complex cases
3. Maintenance of programmatic disease surveillance
4. Public health emergency-related disease surveillance

Healthy People 2020 goals for infectious diseases are rooted in evidence-based clinical and community activities and services for their prevention and treatment.

- Objectives focus on ensuring that States, local public health departments, and nongovernmental organizations are strong partners in the Nation's attempt to control the spread of infectious diseases.
- They also reflect a more mobile society with diseases crossing state and country borders. Awareness of disease and completing prevention and treatment courses remain essential components for reducing infectious disease transmission (*Healthy People 2020*, 2012).

When compared to Texas, Dallas County has lower incidence rates for four notifiable communicable diseases: campylobacteriosis, aseptic meningitis, pertussis, salmonellosis (Figure 4.27).

- Cryptosporidiosis is a bacterial intestinal parasite acquired through contaminated water or food. It typically runs its course over two weeks unless the patient is immuno-compromised, in which case it can be life threatening.
- The following charts present trends in select bacterial diseases and enteric diseases and zoonotic diseases in Dallas County between 2000 and 2010. They are taken from the "2010 DCHHS Epidemiology Division Summary."

Figure 4.27

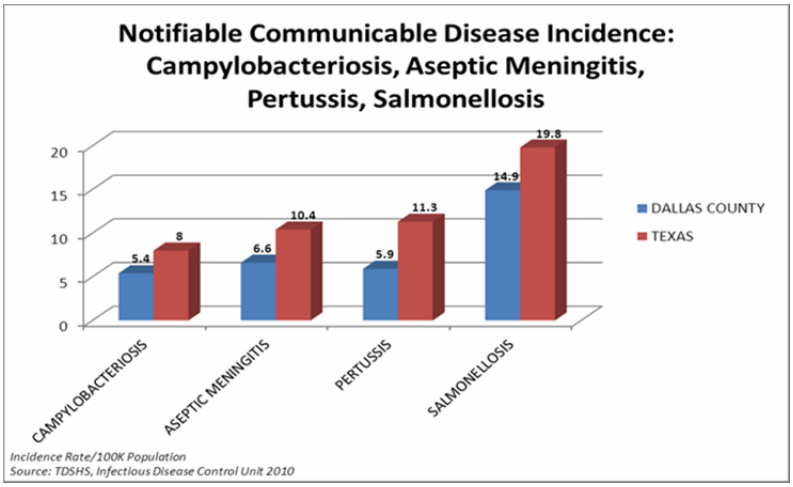
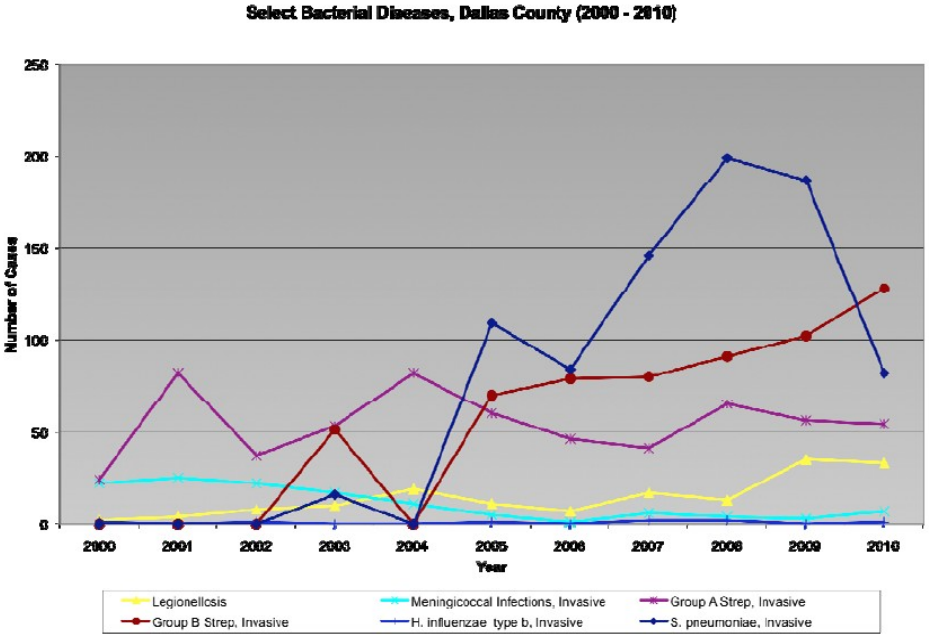


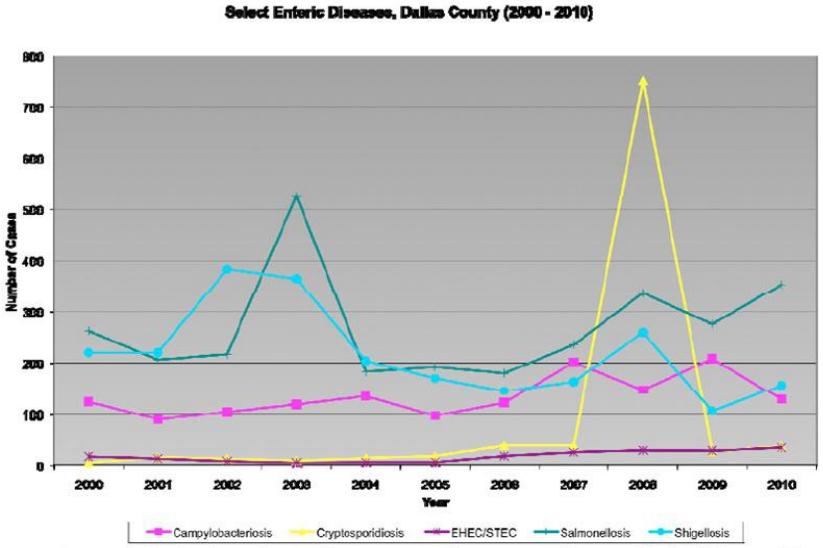
Figure 4.28

Communicable Disease Epidemiology: Mandatory Reportable Conditions 2000-2010



Vaccine-preventable bacterial infections have remained low in Dallas County.

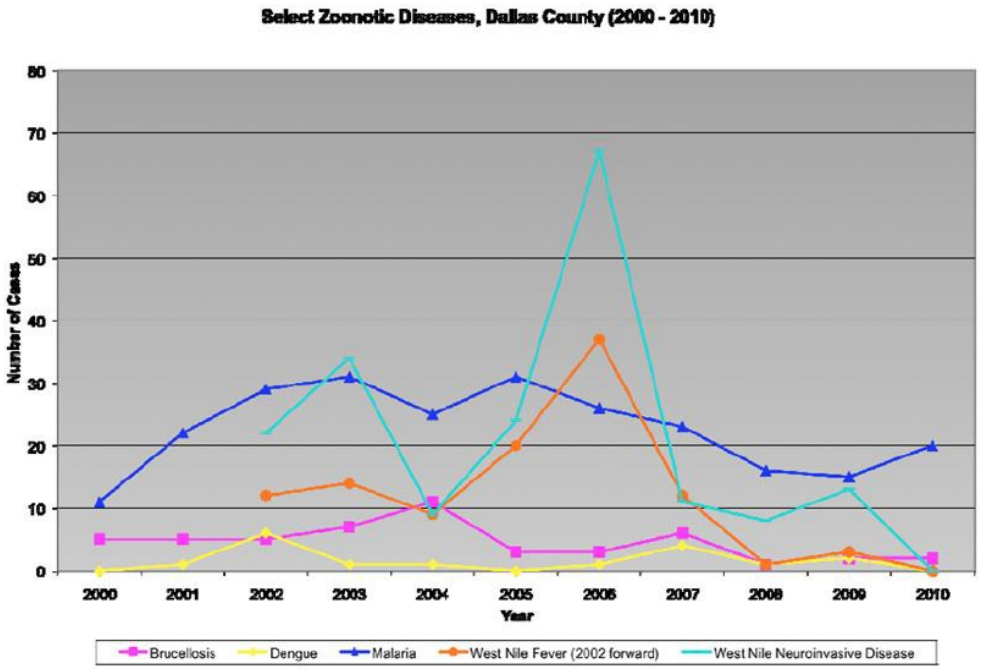
Figure 4.29



Reports of enteric infections in Dallas County have overall remained fairly stable, with the exception of outbreaks. Improvements in testing and public health reporting may account for some of the slight increases. National outbreak detection technologies have improved markedly in recent years, leading to increased recognition of outbreak-associated cases.

Figure 4.30 demonstrates a peak in West Nile virus cases in 2006 with 40 cases. In 2012, however, Dallas County witnessed a significant outbreak. As of August 23, 2012, there were 288 West Nile virus cases in the County including 11 deaths. Unfortunately, over 50% of these cases were "neuroinvasive," the most severe form of the disease (Zwirko, 2012). Ongoing federal, state and local partnerships have supported preparedness and response efforts, including both ground and aerial spraying.

Figure 4.30



Cases of West Nile Virus have declined in recent years. Zoonoses otherwise remain relatively uncommon in Dallas County.

Table 4.7 presents annual data about Dallas County DHHS vector control program.

Table 4.7

DCHHS Vector Control Program Facts	*Mosquito traps set*	*Mosquitoes identified*	*Mosquito pools tested*	*Positive mosquito pools*	*Service requests/ inspections*	*Acres sprayed*
2009	655	25,806	576	126	130	4,927
2010	953	33,088	868	1	41	383
Source: Dallas County Health & Human Services. *Environmental Health Services Division*. Dallas, TX; 2011.						

While cases of hepatitis A declined between 2000 and 2010, cases of hepatitis C increased.

Figure 4.31

Communicable Disease Epidemiology: Mandatory Reportable Conditions 2000-2010

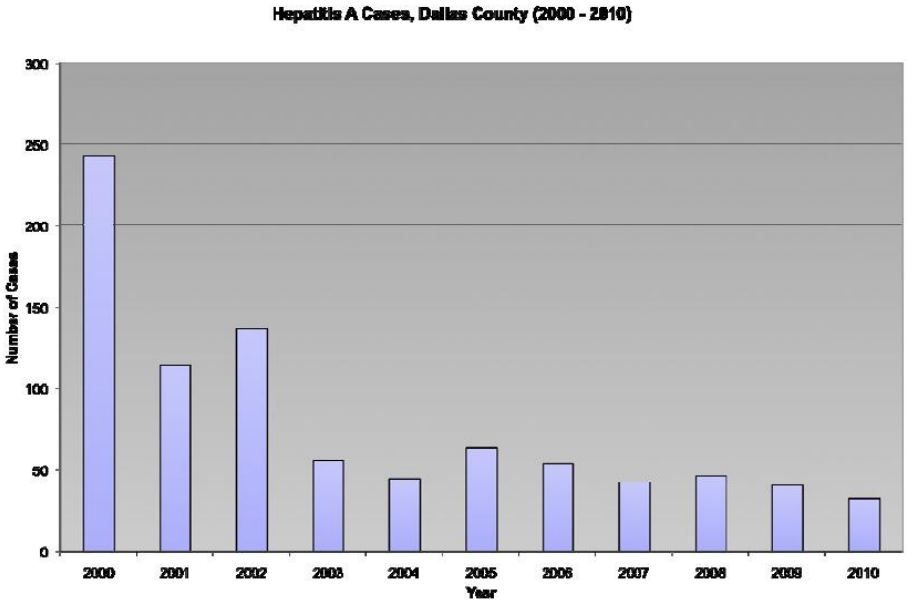
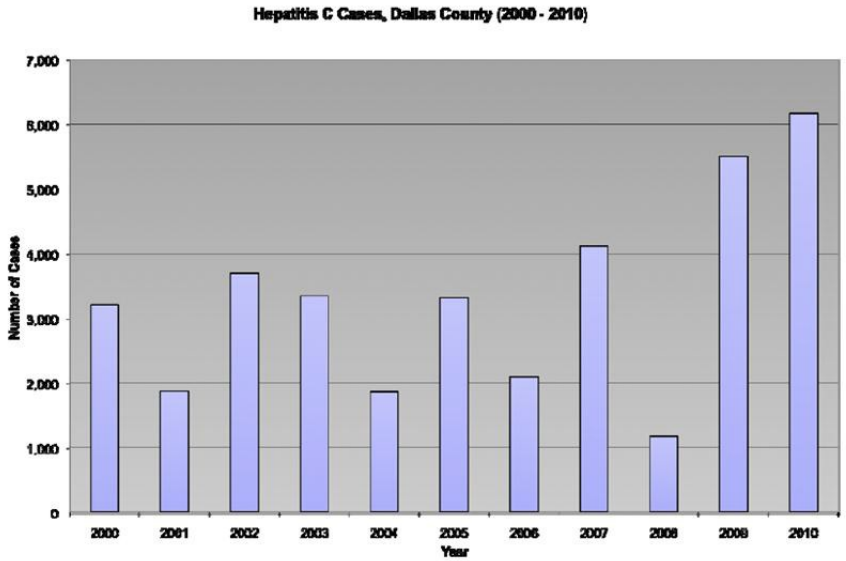


Figure 4.32



Reports of Acute and Chronic Hepatitis B have declined in Dallas County. Hepatitis C reporting remains inaccurate due to inadequate electronic database systems for tracking reports and insufficient staffing to investigate this large volume of cases. (See further detailed description in Hepatitis C section.)

Table 4.8 reflects activity in the Dallas County Health and Human Services Food Protection Program in 2009 and 2010.

Table 4.8

DCHHS Food Protection Program Facts	*Food establishment inspections*	*Food establishment complaints*	*Foodborne illness complaints*	*Food Handlers trained*	*Food Manager certifications*
2009	1,504	38	13	24	91
2010	1,643	34	8	64	68
Source: Dallas County Health & Human Services. *Environmental Health Services Division*. Dallas, TX; 2011.					

Sexually Transmitted Diseases

Background

Sexually transmitted diseases (STD) refer to more than 25 infectious organisms that are transmitted primarily through (unprotected) sexual activity. STDs remain a significant public health problem in the Dallas County and the United States. Factors that affect the spread of STDs include:

- Asymptomatic nature of STDs.
  - The majority of STDs either do not produce any symptoms, or they produce symptoms so mild that they are unnoticed. As a result, many infected persons do not know that they need medical care.
- Gender disparities.
  - Women suffer more frequent and more serious STD complications than men including pelvic inflammatory disease, ectopic pregnancy, infertility, and chronic pelvic pain (*Immunization and infectious diseases*, 2012).
- Age disparities.
  - Nationally, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs than older adults (*Immunization and infectious diseases*, 2012).

Dallas County Gonorrhea Incidence

Figure 4.33 presents 2010 gonorrhea incidence for Texas, Dallas County, and each community. Key findings include:

- Dallas County's gonorrhea incidence is 71% higher than Texas overall.
- South Dallas gonorrhea incidence, 560/100,000, is more than twice the rate of Stemmons, the community with the second highest rate, 252/100,000.
- Other communities with high rates include: DeSoto Lancaster, SE Dallas, Cedar Hill.
- Communities with low 2010 gonorrhea rates include: NW Dallas, Outer NE, Irving and Grand Prairie.
- Figure 4.34 provides an overview of gonorrhea incidence in Dallas County by ZIP code.

Figure 4.33

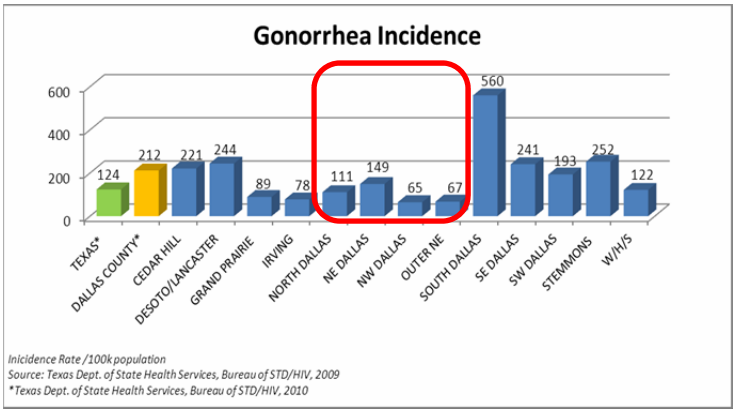
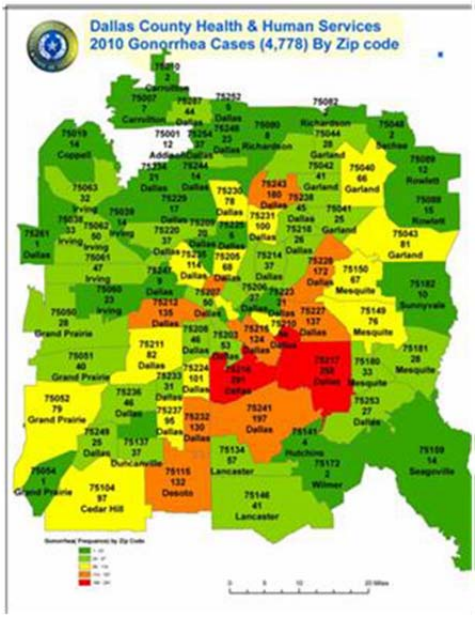


Figure 4.34

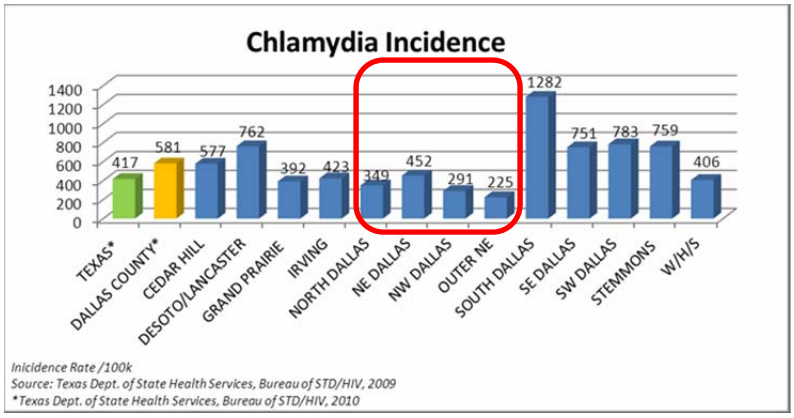


Dallas County Chlamydia Incidence

Figure 4.35 presents 2010 chlamydia incidence for Texas, Dallas County, and each community. Key findings include:

- Dallas County's chlamydia incidence is 39% higher than Texas overall.
- South Dallas chlamydia incidence, 1,282/100,000, is significantly higher than other communities.
- Communities above the Dallas County average include: SW Dallas, DeSoto Lancaster, Stemmons, and SE Dallas.
- Communities with low 2010 chlamydia rates include: Outer NE, NW Dallas, North Dallas.

Figure 4.35



Dallas County Syphilis Incidence

Dallas County's 2010 primary and secondary (P&S) syphilis incidence rate, 7.5/100,000, is the same as that for the state of Texas.

- The South Dallas community's P&S syphilis incidence rate is more than six times higher than the County rate, 46.6/100,000.
- DeSoto Lancaster and Stemmons Corridor have syphilis rates that are double the County average.
- Irving, Grand Prairie and Outer NE have the lowest syphilis rates (Figure 4.36).
- The maps in Figures 4.37 and 4.38 present the concentration of syphilis cases in Dallas County.

Figure 4.36

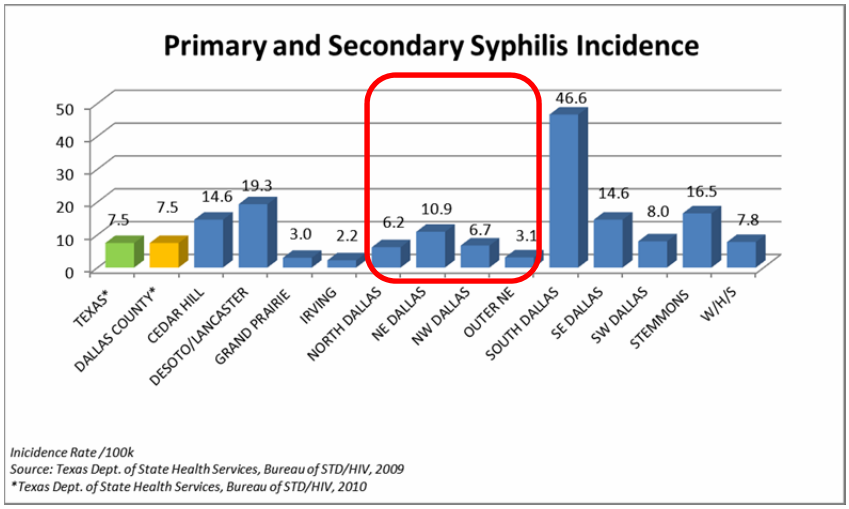
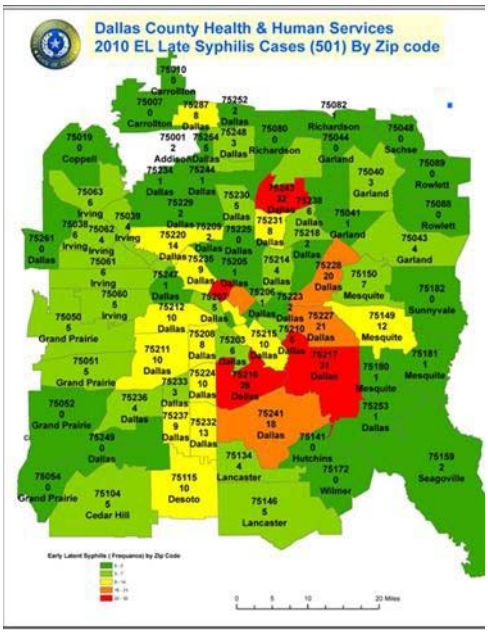


Figure 4.37

Figure 4.38



HIV/AIDS

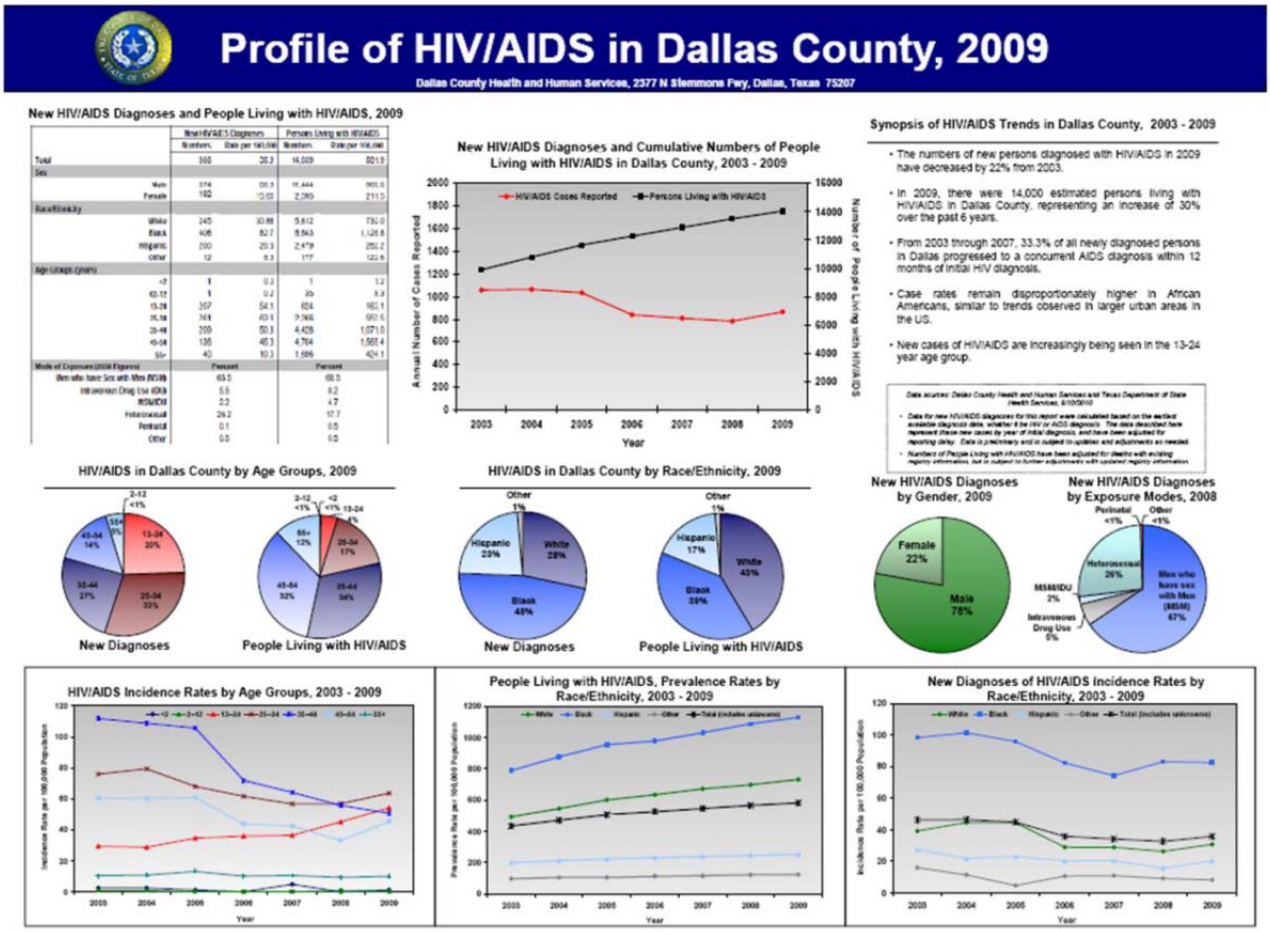
The number of people living with HIV/AIDs in Dallas County is increasing, with over 14,000 residents living with the disease in 2009.

- Between 2003 and 2009 incidence (new cases) declined, but prevalence steadily increased.
- According to the Comprehensive HIV Needs Assessment (Ryan White Planning Council of the Dallas Area, 2010), male sex with men continues to be the predominant transmission mode in the Dallas EMA (eligible metropolitan area). The prevalence rate is highest among males with 69% reporting the transmission mode of male sex with men.
- African-Americans have significantly higher incidence and prevalence rates than other racial groups. They are followed by Caucasians and Latinos.
- The 13 – 24 age group demonstrates an increasing incidence while the 35 to 44 group is declining.

Between 2003 and 2007, one-third of all Dallas residents who were diagnosed with HIV were subsequently diagnosed with AIDS within 12 months. Since the incubation period to transition from HIV to AIDS can be as long as nine years, this may indicate cases of late diagnoses.

Figure 4.39 includes new HIV/AIDS diagnoses and rates as well as people living with HIV/AIDS diagnoses and rates. The data is reported by sex, race, age group (0-55+), and mode of exposure (e.g. men who have sex with men, injection drug use, heterosexual, perinatal). The enlarged diagram with the most recent data is available on the Dallas County HHS website under the Clinical Services tab, HIV/STD Statistics menu option.

Figure 4.39


Profile of HIV/AIDS in Dallas County, 2009
Dallas County Health and Human Services, 2377 N Stemmons Fwy, Dallas, Texas 75207
New HIV/AIDS Diagnoses and People Living with HIV/AIDS, 2009
New HIV/AIDS Diagnoses and Cumulative Numbers of People Living with HIV/AIDS in Dallas County, 2003 - 2009
HIV/AIDS Cases Reported
Persons Living with HIV/AIDS
Annual Number of Cases Reported
Number of People Living with HIV/AIDS
Year
Synopsis of HIV/AIDS Trends in Dallas County, 2003 - 2009
• The numbers of new persons diagnosed with HIV/AIDS in 2009 have decreased by 22% from 2003.
• In 2009, there were 14,000 estimated persons living with HIV/AIDS in Dallas County, representing an increase of 30% over the past 6 years.
• From 2003 through 2007, 33.3% of all newly diagnosed persons in Dallas progressed to a concurrent AIDS diagnosis within 12 months of initial HIV diagnosis.
• Case rates remain disproportionately higher in African Americans, similar to trends observed in larger urban areas in the US.
• New cases of HIV/AIDS are increasingly being seen in the 13-24 year age group.
HIV/AIDS in Dallas County by Age Groups, 2009
New Diagnoses
People Living with HIV/AIDS
HIV/AIDS in Dallas County by Race/Ethnicity, 2009
Other 1%
Hispanic 23%
White 28%
Black 48%
Other 1%
Hispanic 17%
White 43%
Black 39%
New Diagnoses
People Living with HIV/AIDS
New HIV/AIDS Diagnoses by Gender, 2009
Female 22%
Male 78%
New HIV/AIDS Diagnoses by Exposure Modes, 2008
Perinatal <1%
Other <1%
Heterosexual 26%
MSM/IDU 2%
Intravenous Drug Use 5%
Men who have sex with Men (MSM) 67%
HIV/AIDS Incidence Rates by Age Groups, 2003 - 2009
Incidence Rate per 100,000 Population
Year
People Living with HIV/AIDS, Prevalence Rates by Race/Ethnicity, 2003 - 2009
Prevalence Rate per 100,000 Population
Year
New Diagnoses of HIV/AIDS Incidence Rates by Race/Ethnicity, 2003 - 2009
Incidence Rate per 100,000 Population
Year

Dallas County Youth

Dallas County has alarming STD and HIV rates among youth. The following STD and HIV 2010 diagnoses among Dallas County 13 to 18 year olds demonstrate the severity of the problem. In 2010, there were:

- Thirty-five new diagnoses of HIV infection in persons between the ages of 13 to 18 years in Dallas County, which represented 3.9% of the total new diagnoses in all age groups.
- Eleven new diagnoses of primary/secondary syphilis in adolescents age 13 to 18 which was 6.2% of the total new diagnoses in all age groups in Dallas County.
- 1,269 gonorrhea diagnoses among adolescents, which represented 25% of the total diagnoses in all age groups in Dallas County.
- Nearly 4,000 chlamydia diagnoses in youths between the ages of 13 to 18 years. This was the most wide spread STD. Adolescents accounted for 26% of the total 2010 Dallas County chlamydia diagnoses (Jones, Mullins, Dukes, Worthey, & Smith, 2012).
    - Between 2006 and 2010, STD diagnoses among Dallas County 13 to 18 year olds were highest among young women. They accounted for 83% of chlamydia, 67% of gonorrhea, and 60% primary and secondary syphilis 60% diagnoses (Edwards et al., 2012, p. 11, 16, 21).

The maps in Figures 4.40 through 4.43 present the geographic concentration of HIV and each STD among Dallas County 13 to 18 year olds. They make it clear that the southern part of the county and select ZIP codes in the northeastern part of the county have the highest incidence rates.

Figure 4.40

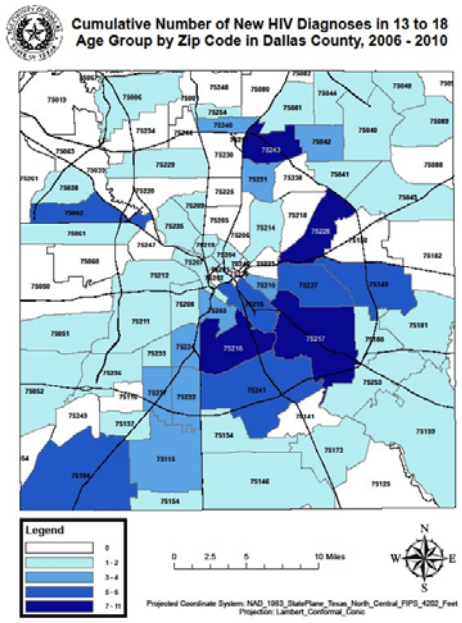


Figure 4.41

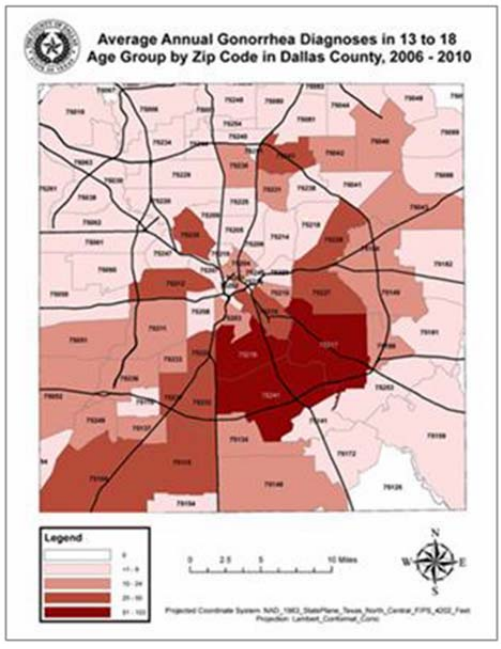


Figure 4.42

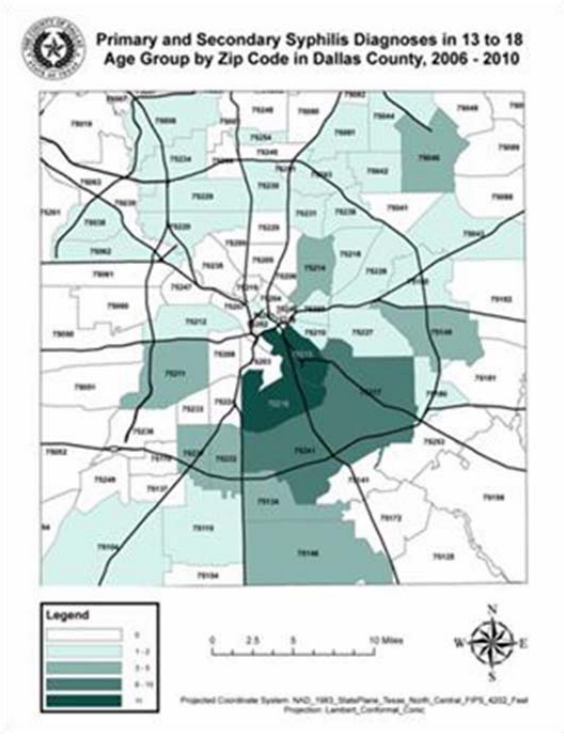
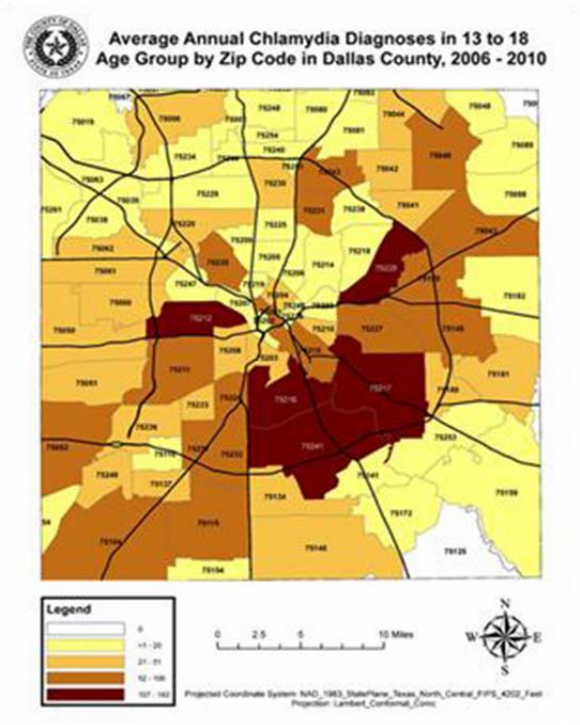


Figure 4.43



A 2012 Dallas County Health and Human Services survey of 10 school districts located in Dallas County found:

- 70% have a STD/HIV educational curriculum targeting 13 to 18 year olds.
- 64% of parental consent forms granted permission for students to participate in STD/HIV education (Jones et al., 2012, p. 1). Thus, 36% of students were not permitted to participate.

DCHHS recommended the following to address STD/HIV prevention among Dallas County 13 to 18 year olds:

1. Form a CBO Partnership to improve STD/HIV education among 13 to 18 year olds in Dallas County. Community-based organizations, including churches, should work with each other and with parents to encourage consent for student participation in school STD/HIV education.
2. Lead parental focus groups/surveys to determine where the gap in parental consent for course participation might exist: student transmittal home, parental approval barriers, student transmittal back to school, etc. The collaborative should also benchmark districts with lower STD/HIV rates among 13 to 18 year olds to inform focus group/survey questions. The focus group/survey should evaluate whether parents are unaware of the 9issue, unengaged and why, considering consent, have specific reasons not to give consent, or have specific reasons to give consent.
3. Analyze findings and publicly report them. Consider reporting to School Health Advisory Councils (SHACs), School Boards, and Superintendents; and share findings with DCHHS.
4. Encourage charter schools and private schools to conduct assessments of their current STD/HIV education programs for the 13 to 18 age group.

STD Incidence Comparisons

Comparing Dallas County with the *Healthy People 2020* target for STD incidence:

- Dallas County was worse than the *Healthy People 2020* target for Chlamydia. Dallas County was similar to the *Healthy People 2020* target for gonorrhea. Dallas County was similar to the *Healthy People 2020* target for syphilis.
- Considering the Dallas County STD incidence trends, they were poor for chlamydia and gonorrhea and average for syphilis (Figure 4.44).

Figure 4.44

STD INCIDENCE		
Rates per 100K	*Dallas County vs. Healthy People 2020 Target*[1]	*Dallas County Trend*[1]
Chlamydia		
Gonorrhea		
Primary / Secondary Syphilis		

[1] Dallas County Community Dashboard Parkland Health and Hospital System, 2011
[2] Healthy North Texas Community Dashboard, 2012

STD Risk Factors

The spread of STDs is directly affected by social, economic, and behavioral factors. These include:

- Racial and ethnic disparities.
  - African-Americans are disproportionately affected by new HIV infections and STDs in all age groups in Dallas County (Jones et al., 2012, p. 25).
  - Rates of STD incidence in Dallas County are highest in communities with lowest SES including South Dallas, SE and SW Dallas, Stemmons Corridor and DeSoto Lancaster.
- Access to healthcare
- Substance abuse
- Sexual networks—groups of people who can be considered "linked" by sequential or concurrent sexual partners. A person may have only one sex partner, but if that partner is a member of a sexual network that engages in high risk behaviors, then the person is at higher risk for STDs than a similar individual from a network engaging in low risk behaviors (*Respiratory diseases*, 2012).

Figure 4.45

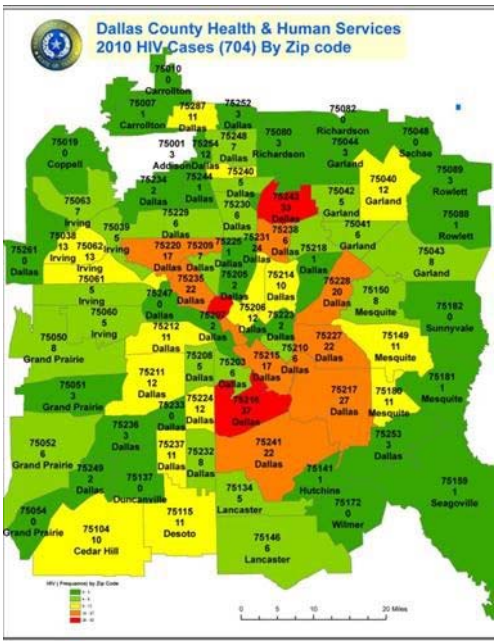
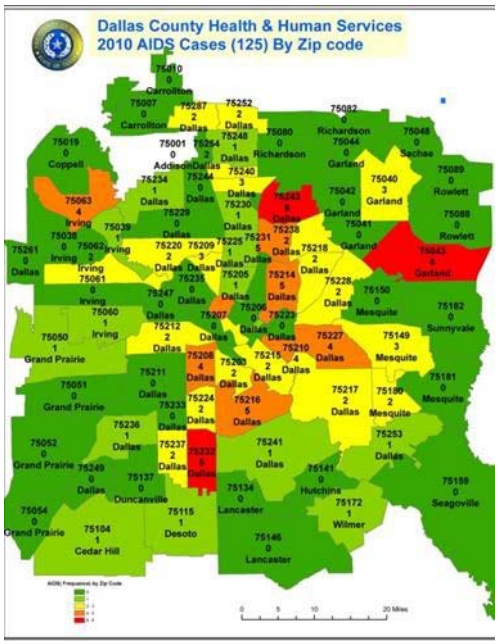


Figure 4.46



ASTHMA AND OTHER RESPIRATORY DISEASES

The burden of asthma, COPD and other respiratory diseases affects individuals and their families, schools, workplaces, and neighborhoods. In Dallas County the adult asthma rate is particularly high, with incidence 23% above the Texas average. The highest rates are found in the County's six southern communities.

Asthma—Background

- Currently in the United States more than 23 million people have asthma. Asthma affects people of all ages, but it most often starts during childhood. About 7 million of those in the U.S. with asthma are children (*Healthy people 2020, 2012*).
- The exact cause of asthma is not known. Researchers think some genetic and environmental factors interact to cause asthma, most often early in life. These factors include:
  - An inherited tendency to develop allergies.
  - Parents who have asthma.
  - Certain respiratory infections during childhood.
  - Contact with some airborne allergens or exposure to some viral infections in infancy or in early childhood when the immune system is developing (*Who is at risk for asthma?*, 2012).
  - Allergy and asthma "triggers," include plant pollens, dust, animals and stinging insects and cockroaches. Cockroach allergy is a problem among people who live in inner-cities or in the South and are of low socioeconomic status.
    - In one study of inner-city children, 37% were allergic to cockroaches, 35% to dust mites, and 23% to cats. Those who were allergic to cockroaches and were exposed to them were hospitalized for asthma 3.3 times more often than other children. This was true even when compared with those who were allergic to dust mites or cats.
    - Cockroach allergy is more common among low SES African-Americans. Experts believe that this is not because of racial differences; rather, it is because of the disproportionate number of African-Americans living in the inner cities (*Information about asthma*, 2011).

Asthma—Dallas County

Dallas County's rate of adult asthma is 26% higher than found in the state of Texas, making it a significant health burden among the population.

- The Dallas County trend for adult asthma has been poor, and the County received a poor rating in comparison to the *Healthy People 2020* asthma incidence target (Figure 4.47).
- The rate of asthma in adults under 40 years of age is less than one fifth that of adults overall (Figures 4.47 and 4.48).
- Communities with adult asthma rates higher than the County average include: South Dallas, Wilmer Hutchins Seagoville, SE Dallas, DeSoto Lancaster, Cedar Hill and SW Dallas (Figure 4.47).
- Among adults under 40 years of age with asthma, South Dallas and DeSoto Lancaster have the highest rates (Figure 4.48).

Figure 4.47

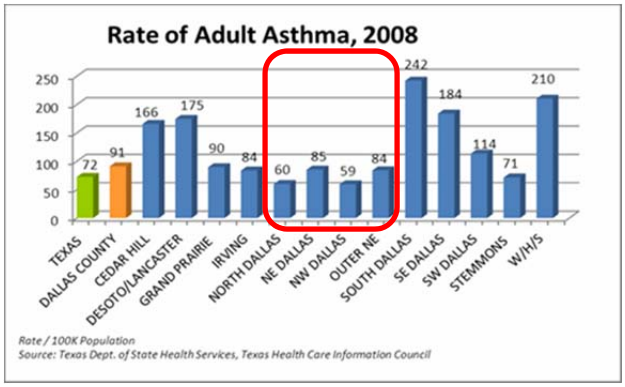
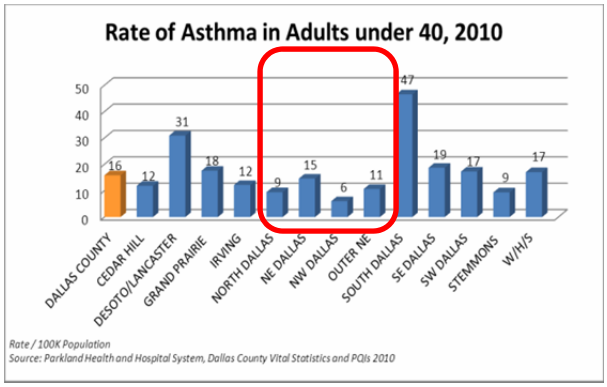


Figure 4.48



COPD—Background

- Approximately 13.6 million adults have been diagnosed with COPD, and an approximately equal number have not yet been diagnosed (*Healthy People 2020, 2012*)
- Dallas County was rated better than the average for the COPD incidence trend and relative to the *Healthy People 2020* target.
- COPD mortality was rated worse than the *Healthy People 2020* target. The COPD mortality trend has not changed (Figure 4.49).

Figure 4.49

FLU & OTHER RESPIRATORY DISEASE

Rates per 100K, age adjusted	*Dallas County vs. Healthy People 2020 Target*[1]	*Dallas County Trend*[1]	*Healthy N. Texas Community Dashboard*[2]
Adult Asthma Incidence			
COPD Mortality			*n/a*
COPD Incidence			*n/a*
Bacterial Pneumonia Incidence			*n/a*

[1] Dallas County Community Dashboard Parkland Health and Hospital System, 2011

[2] Healthy North Texas Community Dashboard, 2012

CANCER

Cancer mortality is declining in Dallas County. Additional screening, healthy lifestyles and interventions targeting residents with socioeconomic disparities are needed to further reduce mortality and achieve the Healthy People 2020 goal.

Cancer Mortality

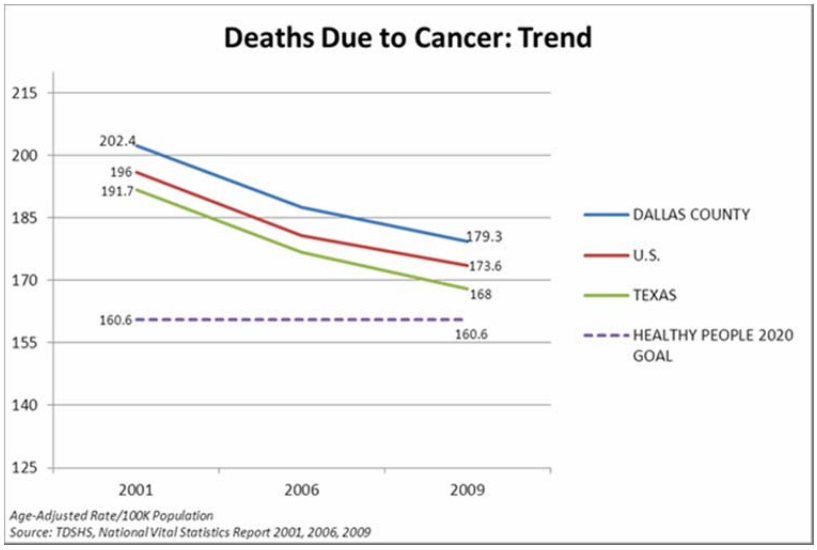
Overall Trends

Cancer is the second leading cause of death in Dallas County, with a 2010 rate of 166 deaths for every 100,000 residents.

Between 2001 and 2009, cancer deaths declined in Dallas County, Texas and the U.S. (Figure 4.50)

- Dallas County and the U.S. both decreased by 11.4%, and the Texas decline was 12.3%.
- None of these areas have yet achieved the *Healthy People 2020* Goal of 160.6 deaths per 100,000 residents.

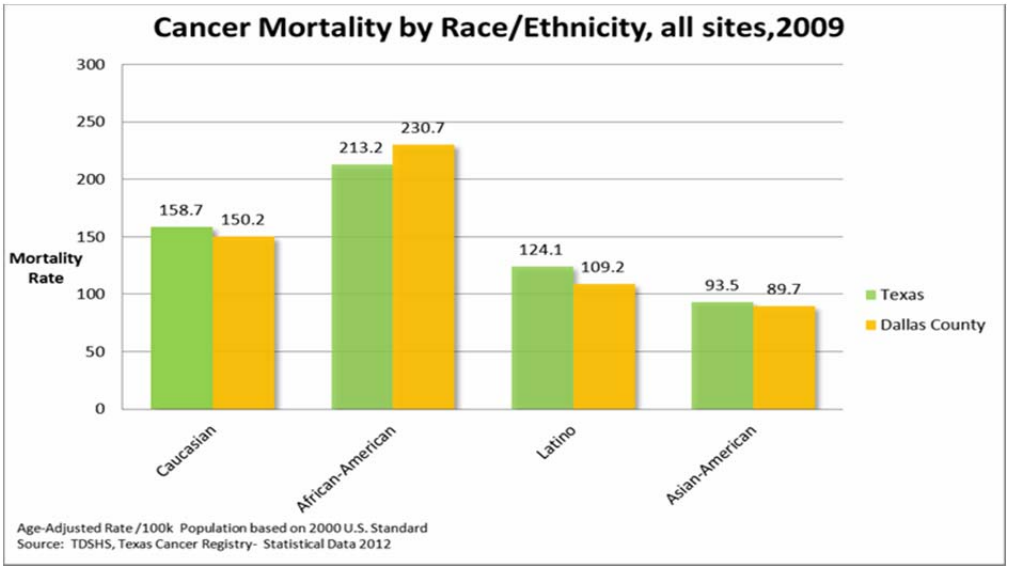
Figure 4.50



Considering age-adjusted mortality rates (AAMR) for all cancers by race/ethnicity:

- African-Americans have the highest AAMR. Dallas County's African-American rate is higher than the Texas state average, 230.7/100,000 vs. 213.2/100,000 (Figure 4.51).
- The Dallas County Caucasian AAMR is 65% of the African-American AAMR. The Latino and Asian-American AAMRs are 47% and 39% of the African-American AAMR, respectively.
- The Dallas County AAMRs are below the statewide AAMRs for Caucasians, Latinos and Asian-Americans.

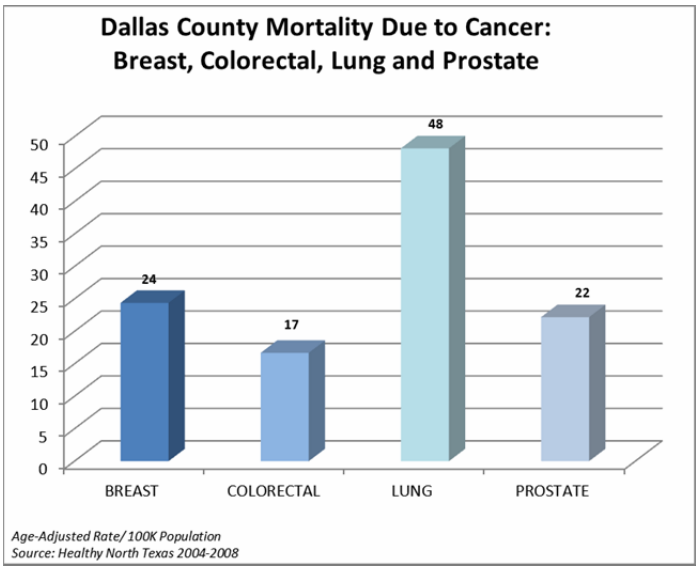
Figure 4.51



Mortality by Cancer Site

The four most frequent types of cancer for both incidence and mortality are breast, colorectal, lung/bronchus and prostate (Figure 4.52).

Figure 4.52

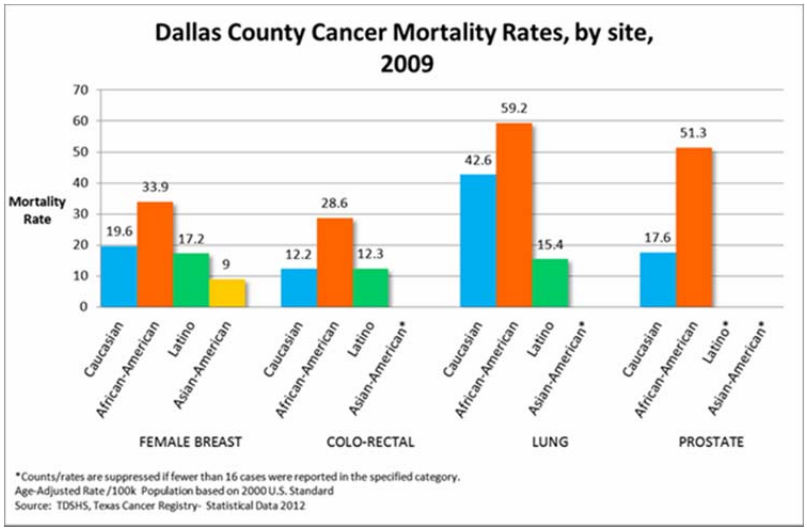


- With 48 deaths/100,000 Dallas County residents between 2004 and 2008, lung cancer had the highest AAMR of all cancers.
- Breast cancer follows with half the number of deaths, 24/100,000.
- Prostate was third with 22 deaths/100,000.

Considering AAMR by race/ethnicity, African-Americans had the highest rates for all cancer types.

- With a rate of 59.2/100,000 for lung cancer, the African-American rate was higher than that of Caucasians, 42.6/100,000 and nearly 4 times that of Latinos.
- Prostate cancer is noteworthy because the African-American rate is three times that among Caucasians. The African-American prostate cancer AAMR is higher than the rate of any other cancer type in any population except the African-American AAMR for lung cancer (Figure 4.53).

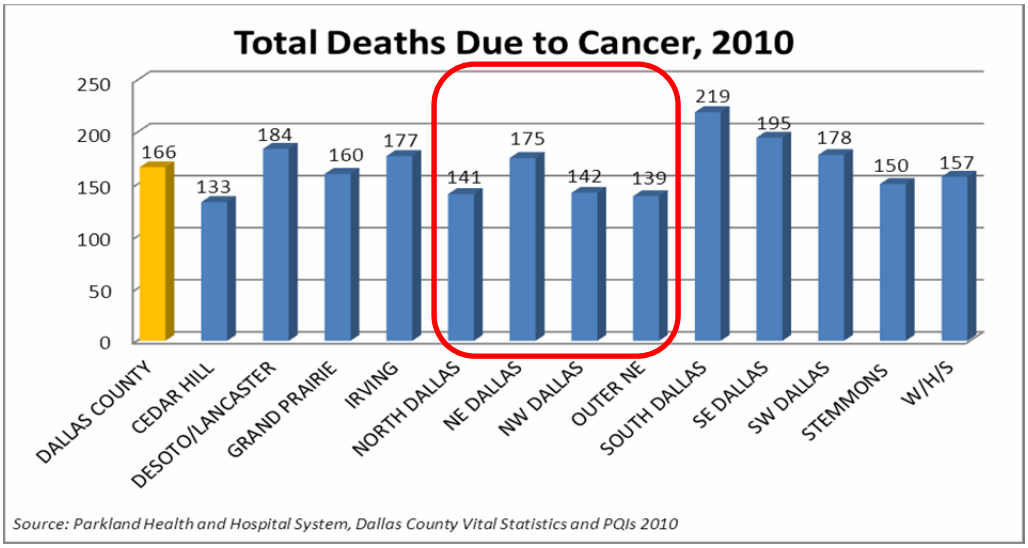
Figure 4.53



Dallas County Communities

Cancer mortality tends to be higher in communities with lower SES, such as South Dallas, SE Dallas, SW Dallas and DeSoto Lancaster. However, exceptions occur as seen in the 2010 cancer mortality in NE Dallas.[8]

Figure 4.54



[8] It should be noted that in 2009 Cedar Hill had the second highest mortality rate of 206/100,000.

Cancer Incidence

Examining the incidence along with the mortality reveals that the most deadly cancer is lung, with an incidence rate that is significantly lower than prostate and breast, but the highest mortality rate.

- The Dallas County incidence of prostate cancer between 2004 and 2008 was 140/100,000.
- Breast cancer was 129/100,000.
- Lung was 55/100,000 and colorectal was 37/100,000 (Figure 4.55).

Figure 4.55

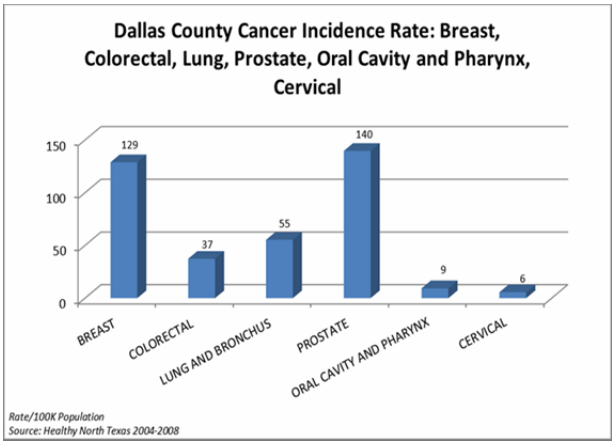
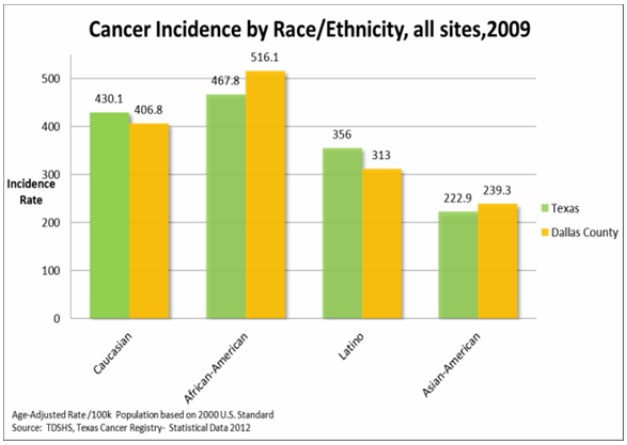


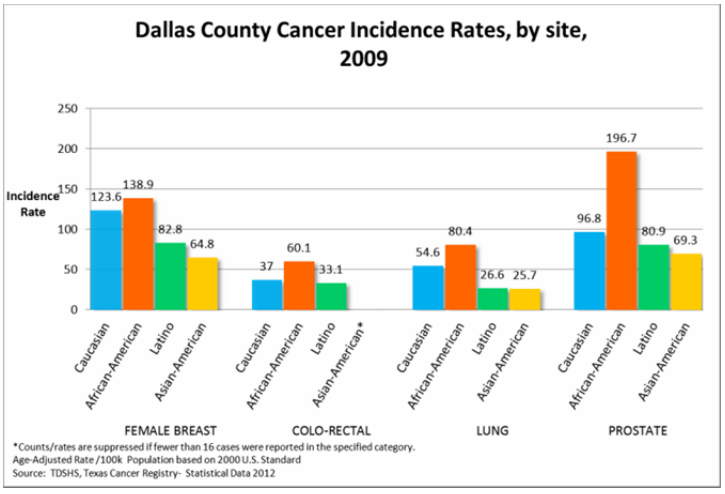
Figure 4.56



- Dallas County African-Americans had the highest incidence among racial/ethnic groups at both the County and State levels (Figure 4.57).
- Caucasians and Latinos have rates lower than the statewide rates for their racial/ethnic group.

In 2009, the highest cancer incidence rate by race/ethnicity was prostate cancer among African-Americans, 196.7/100,000. This was followed by breast cancer among African-Americans, 138.9/100,000.

Figure 4.57



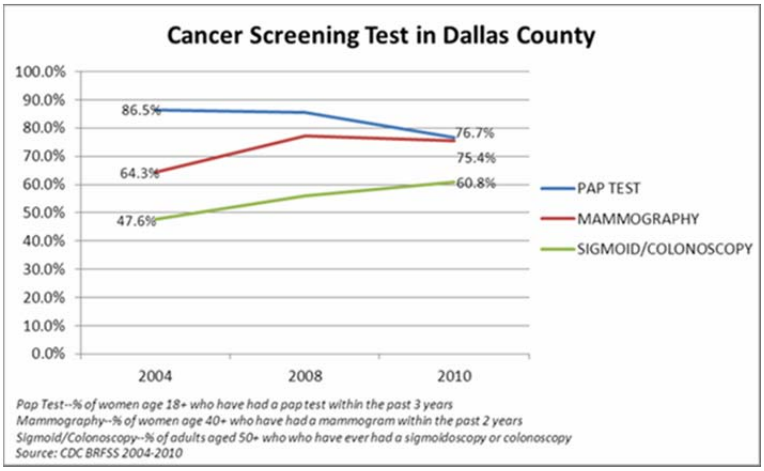
- Breast cancer had the highest incidence among both Caucasians and Latinos, 123.6/100,000 and 82.8/100,000, respectively (Figure 4.57).

Cancer Screening

Screening is effective in identifying some types of cancers including:

- Breast cancer (using mammography):
  - In Dallas County, the percentage of women age 40 and over who had mammograms in the past two years increased between 2004 and 2008, but did not change from 2008 through 2010.
- Cervical cancer (using Pap tests):
  - The percentage of Dallas County women 18 years of age and older who had a Pap test in the past three years declined 10% (an 11.3% change) between 2004 and 2010 to 76.7%.
- Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy):
  - The percentage of Dallas County adults who have ever had this screening increased by 28% between 2004 and 2010 (Figure 4.58).

Figure 4.58



Research shows that a recommendation from a healthcare provider is the most important reason patients cite for having cancer screening tests (*Cancer*, 2012).

Susan G. Komen for the Cure

Dallas County is fortunate to be headquarters to the international breast cancer foundation, Susan G. Komen for the Cure. The 2010 Dallas County affiliate "Community Profile Report" provides insight into breast cancer incidence and mortality along with key priorities for increased screening and early detection, particularly in communities with high mortality rates. The Profile Report states,

> *"With regard to breast health in Dallas County, some of the highest breast cancer mortality and incidence rates actually occur in areas that are included in the higher income brackets. Given the Affiliate's commitment to the underserved areas, the focus of this Community Profile Report remains in the South Dallas area, where there are not only equally high mortality rates, but also larger portions of the population that are unemployed or working unsalaried jobs, and are likely uninsured."*(*Community profile report*, 2010, page 6)

DIABETES

Diabetes is a significant health concern in Dallas County with prevalence higher than both Texas and the U.S. While all communities are affected, disparities exist in the southern Dallas County communities.

The three common types of diabetes are:

- Type 2—caused by a combination of resistance to the action of insulin and insufficient insulin production.
- Type 1—results when the body loses its ability to produce insulin.
- Gestational—a common complication of pregnancy that can lead to perinatal complications in mother and child. It is a risk factor for development of Type 2 diabetes after pregnancy.

Diabetes is the seventh leading cause of death in the U.S. Complications include:

- Reduced life expectancy by up to 15 years,
- Increases risk of heart disease by two to four times,
- Leading cause of kidney failure, limb amputations, and adult onset blindness,
- Significant financial costs in healthcare, lost productivity and early death (*Diabetes,* 2012*)*.

Almost 25% of Americans with diabetes are undiagnosed, and another 57 million Americans have blood glucose levels that greatly increase their risk of developing diabetes in the next several years (*Diabetes*, 2012*).*

Dallas County

Diabetes affects 11.4% of Dallas County residents, a higher percentage than found in Texas (9.6%) and the U.S. (8%). Factors contributing to diabetes prevalence overall and in Dallas County include:

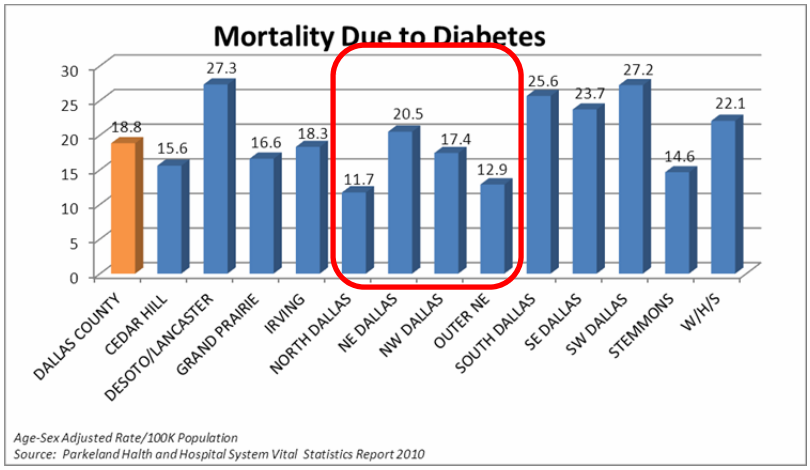
- Obesity
- Lack of physical activity
- Family history
- Environmental resources including such things as the availability of wholesome food, healthcare access and recreational availability.

A September 2011 study, "Diabetes in Dallas County Provider Report" (Doughty & Jones, 2011, p. 3), outlines the impact of diabetes in Dallas County including:

- Comorbidity in heart disease, stroke, pneumonia/respiratory failure, and kidney failure.
  - 35% of the top five inpatient diagnoses have diabetes as an underlying condition (Doughty & Jones, 2011, p. 3).

- Increased mortality and early death:
  - In 2010, people hospitalized with diabetes had a higher mortality percentage than those without in four of the top five diagnoses (Doughty, et. al., page 6).
  - Nationally, the risk of death among people with diabetes is twice that of people of similar age with without diabetes (*National diabetes fact sheet*, 2011).
  - Diabetes 2010 mortality in Dallas County was 18.8 (Refer to Figure 4.59).
  - Communities with the highest diabetes morality are all in the southern half of Dallas county and include:
    - DeSoto Lancaster (27.3), SW Dallas (27.2), South Dallas (25.6), SE Dallas (23.7), Wilmer/Hutchins/ Seagoville (22.1)
- Increasing cost of healthcare treatment.
  - Increasing length of hospital stay by 1.5 days, or 26% (Doughty & Jones, 2011, p. 8).
  - Nationally medical expenses for people with diabetes are more than two times higher than for people without diabetes (*National diabetes fact sheet*, 2011).

Figure 4.59



Dallas County's diabetes complication rates are comparable to the *Healthy People 2020* target and the Dallas County trend. This includes:

- Long term complications
- Lower extremity amputations
- Uncontrolled diabetes (Refer to Figure 4.60).

Comparing diabetes complications for Dallas County and the communities:

- South Dallas residents have the highest rate in every category; in many cases nearly double the Dallas County average.
- SW Dallas, SE Dallas, Grand Prairie and DeSoto Lancaster also have high complication rates.

Figure 4.60

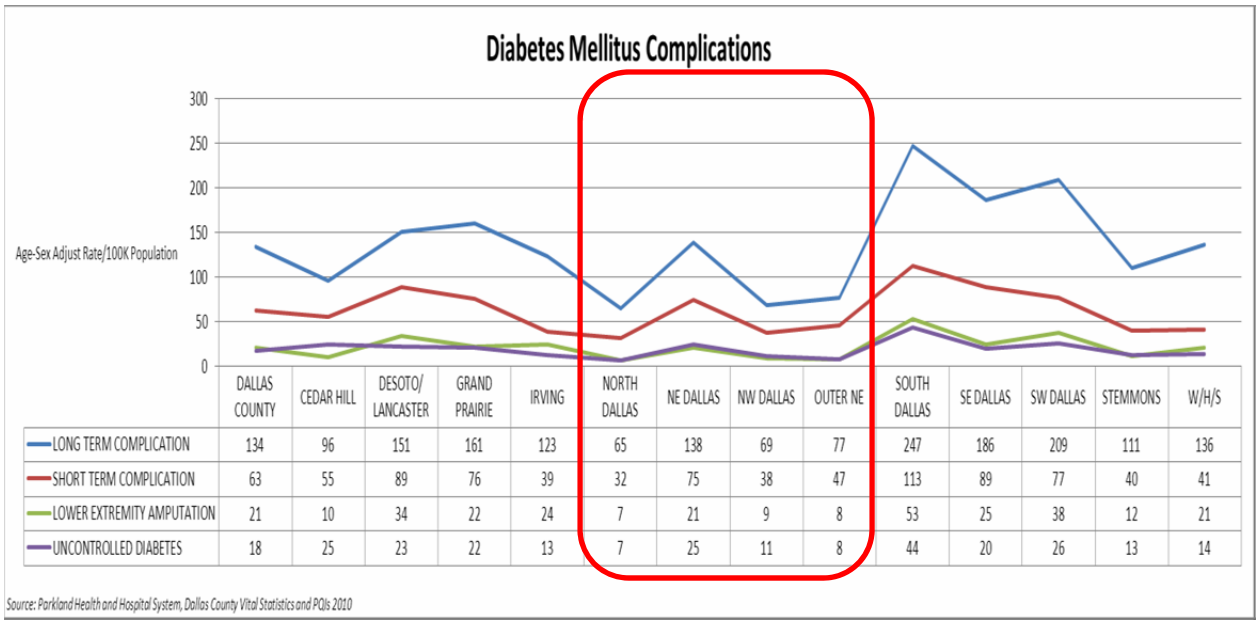
DIABETES		
PQI Rates per 100K, risk-adjusted	*Dallas County vs. Healthy People 2020 Target*[1]	*Dallas County Trend*[1]
Diabetes Short Term Complications		
Diabetes Long Term Complications		
Diabetics' Lower Extremity Amputations		
Uncontrolled Diabetes		

[1] Dallas County Community Dashboard Parkland Health and Hospital System, 2011

[2] Healthy North Texas Community Dashboard, 2012

- While NE Dallas is similar to the County for long term complications and lower extremity amputations, residents have higher rates for short term complications and uncontrolled diabetes (Refer to Figure 4.61).

Figure 4.61



	DALLAS COUNTY	CEDAR HILL	DESOTO/ LANCASTER	GRAND PRAIRIE	IRVING	NORTH DALLAS	NE DALLAS	NW DALLAS	OUTER NE	SOUTH DALLAS	SE DALLAS	SW DALLAS	STEMMONS	W/H/S
LONG TERM COMPLICATION	134	96	151	161	123	65	138	69	77	247	186	209	111	136
SHORT TERM COMPLICATION	63	55	89	76	39	32	75	38	47	113	89	77	40	41
LOWER EXTREMITY AMPUTATION	21	10	34	22	24	7	21	9	8	53	25	38	12	21
UNCONTROLLED DIABETES	18	25	23	22	13	7	25	11	8	44	20	26	13	14

Source: Parkland Health and Hospital System, Dallas County Vital Statistics and PQIs 2010

Disparities in diabetes prevalence and complication rates can be found nationally and in Dallas County:

- Minorities are more frequently affected by Type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes in the United States and represent the majority of children and adolescents with Type 2 diabetes.
- Since 2000, Dallas Children's Medical Center has witnessed a 34% increase in admissions with primary are secondary diagnoses of juvenile diabetes.
  - In addition, the number of children with Type II diabetes (adult onset diabetes) is increasing with the rise of sedentary lifestyles and obesity (2011 Beyond ABC, 2011, p. 36).
- The highest complications rates are found in the lower-income communities of Dallas County. The following factors foster these disparities:
  - Financial factors including income, employment status, health insurance coverage.
  - Environmental factors including availability of healthy food and recreational opportunities.
  - Health literacy factors including an understanding of the disease process and actions to optimally manage it (*Diabetes,* 2012).

Collaborations to Reduce the Diabetes in Dallas County

Diabetes is such a pervasive issue in Dallas County that a variety of initiatives are currently underway. These include:

- American Diabetes Association—Living with Type II Diabetes and collaboration with BC/BS of Texas with Healthy Kids-Healthy Families Initiatives
- Charting the Course—Childhood Obesity Collaborative
- Community Diabetes Education Program—1,000 annual consultations to individuals living with diabetes. Uses community health workers. Partnership between City Square and Baylor Health Care System.
- Diabetes Equity Project—led by Baylor Health Care System and grant from Merck, this program employs community healthcare workers to educate and support low SES diabetics to improve treatment compliance and improve health status.
- DFW Business Group on Health—"Road Trip to Peak Performance" has an overweight/obesity and diabetic component.
- Juanita Craft Diabetes Center, at the Juanita Craft Recreation Center, is the cornerstone of Baylor Health Care System's South Sector Health Initiative.
- North Texas Community Health Collaborative Diabetes Strategic Initiative
- United Way Child Health Promotion in collaboration with the Cooper Institute—"Health Zone School Fitness Program."
- YMCA—partnering with United Healthcare for obesity and diabetes programs—culturally competent diabetes support targeting Latinas.

CARDIOVASCULAR DISEASE

Cardiovascular disease is the leading cause of death in Dallas County. Cardiovascular morbidity and mortality can be reduced by minimizing risk factors and improving the overall health of the community.

Heart disease and stroke are among the most widespread and costly health problems facing the nation today. Cardiovascular health is significantly influenced by the physical, social, and political environment, including:

- Maternal and child health
- Access to educational opportunities
- Availability of healthy foods, physical education, and extracurricular activities in schools
- Opportunities for physical activity, including access to safe and walkable communities
- Access to healthy foods
- Quality of working conditions and worksite health
- Availability of community support and resources
- Access to affordable, quality healthcare (*Heart Disease,* 2012*)*

Mortality

Cardiovascular Disease

Cardiovascular disease (CVD) includes morbidity and mortality related heart disease and stroke. In 2009, the age-adjusted mortality rate (AAMR) due to CVD in Dallas County was 266/100,000. This was significantly higher compared to the State rate of 252.9/100,000.

- African-Americans had a significantly higher AAMR due to CVD than all other racial and ethnic groups.
  - The rate was 361.2/100,000 compared to Caucasians with 266.8/100,000, Latinos with 162.2/100,000 and other with 188.8/100,000.
- Dallas County males had a significantly higher AAMR due to CVD as compared to females, 304.8 per 100,000 vs. 233.9/100,000, respectively (Ang, 2012).

Heart Disease

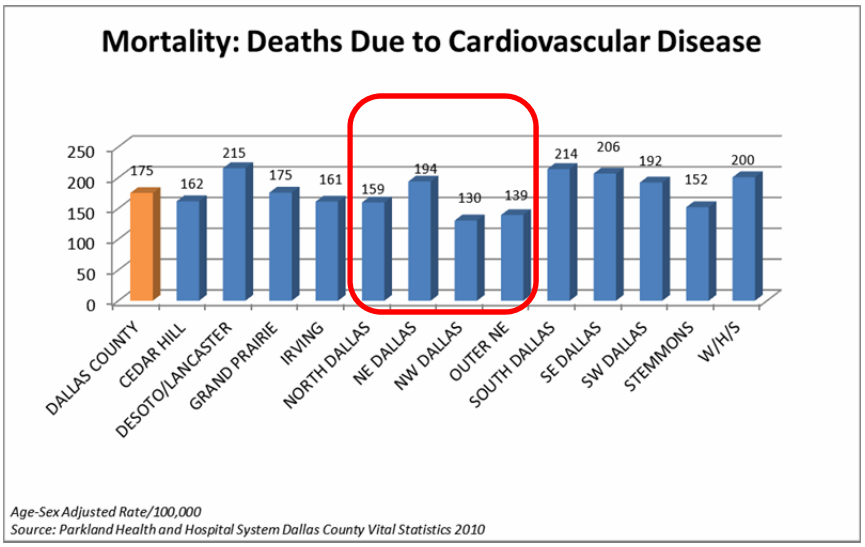
Heart disease is the leading cause of death in the United States and Dallas County.

- In 2009, the AAMR from heart disease was 180/100,000 for the U.S., 189/100,000 for Texas, and 198/100,000 for Dallas County. The *Healthy People 2020* benchmark is 100.8/100,000.
- In Dallas County, African-Americans' 2009 AAMR due to heart disease was 263.7/ 100,000. This is significantly higher than the rate for Caucasians (202.7/100,000), Latinos (113.9/100,000), and Other (131.8/100,000)
- Males had a significantly higher AAMR due to heart disease as compared to females, 239.6/100,000 compared to 165.2/100,000 (Ang, 2012).

In 2010, Dallas County's AAMR declined to 175/100,000 or 12%.

- The communities with the highest heart disease mortality rates are predominately in the southern side of the County with the exception of NE Dallas.
- The communities with the lowest mortality include NW Dallas and Outer NE Dallas (Figure 4.62).

Figure 4.62



Stroke

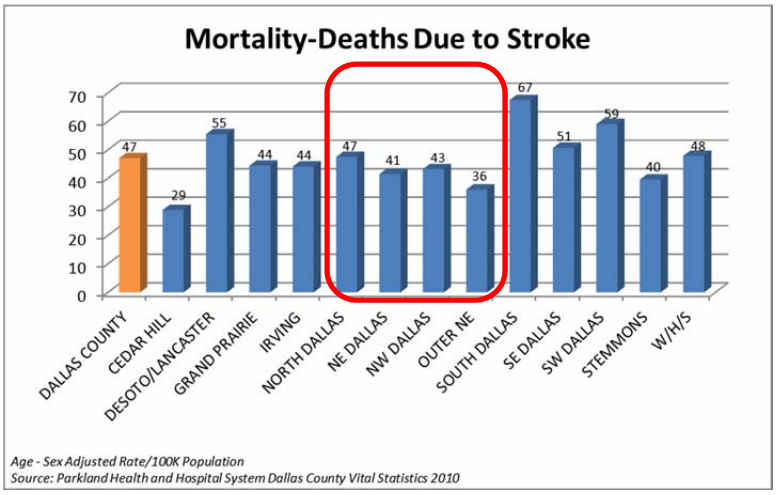
Stroke is the third leading cause of death in the United States.

- In 2009, the age adjusted death rate for stroke was 40/100,000 in the U.S., 47/100,000 for Texas and 50/100,000 for Dallas County. The *Healthy People 2020* benchmark is 33.8/100,000.
- In Dallas County, African-Americans had a significantly higher AAMR due to stroke compared to other racial groups. The rates were 70/100,000 for African-Americans, 47.2/100,000 for Caucasians, 35.3/100,000 for Latinos and 43.5/100,000 for other.
- Females had a higher AAMR due to stroke as compared to males in Dallas County but the difference was not statistically significant. (Ang, 2012).

In 2010, Dallas County's AAMR due to stroke declined to 47/100,000 residents.

- The southern Dallas communities had the highest mortality rates including South Dallas, SW Dallas, DeSoto Lancaster, and SE Dallas.
- The lowest 2010 stroke mortality was found in Cedar Hill followed by Outer NE Dallas (Figure 4.63).

Figure 4.63



Morbidity

The Behavioral Risk Factor Surveillance System (BRFSS) annual survey asks residents about their health status.

Cardiovascular Disease

According to Texas BRFSS 2007-2010, an estimated 7.8% of adults in Dallas County reported having been diagnosed with CVD. Additional findings include:

- In Dallas County, Caucasians had higher prevalence of CVD (10.1%) as compared to African-Americans (6.8%), and Latinos (6.1%).
- There were not any statistically significant differences in the prevalence of CVD among education groups in Dallas County. However, a decrease was observed with an increase in education.
- Adults living in a household with income less than $25,000 had the highest prevalence of CVD in Dallas County, 11%. This was significantly higher compared to adults living in a household with an income of $50,000 or more (4.2%) (Ang, 2012).

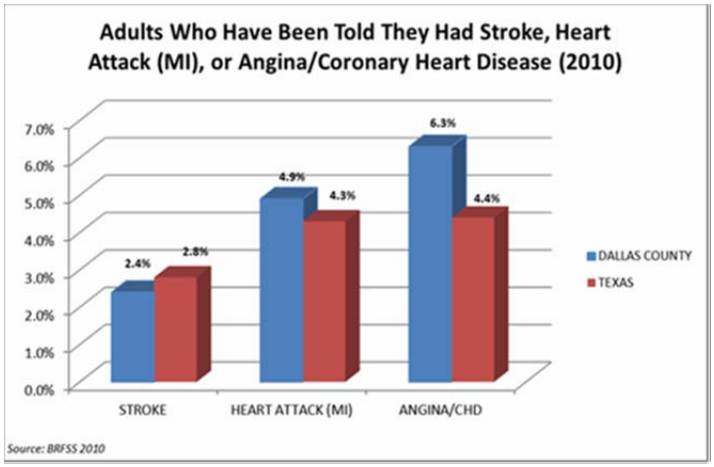
Heart Disease

According to Texas BRFSS 2007-2010, an estimated 6.5% of adults in Dallas County reported having been diagnosed with heart disease.

- There were not any significant differences in prevalence of heart disease among racial/ethnic groups or education groups in Dallas County.
- Adults living in households with income less than $25,000 had the highest prevalence of heart disease in Dallas County, 8.8%. This was significantly higher compared to adults living in a household with an income of $50,000 or more (3.7%) (Ang, 2012).

Stroke

Figure 4.64



According to Texas BRFSS 2007-2010, an estimated 2.1% of adults in Dallas County reported having been diagnosed with stroke.

- There were no statistically significant differences in prevalence of stroke among racial/ethnic groups or education groups in Dallas County. However, a decreasing trend was observed with an increase in education.
- Adults living in households with incomes less than $25,000 (3.6%) had the highest prevalence of stroke in Dallas County. This was significantly higher compared to adults living in households with incomes of $50,000 or more (0.7%).

Dallas County vs. Texas

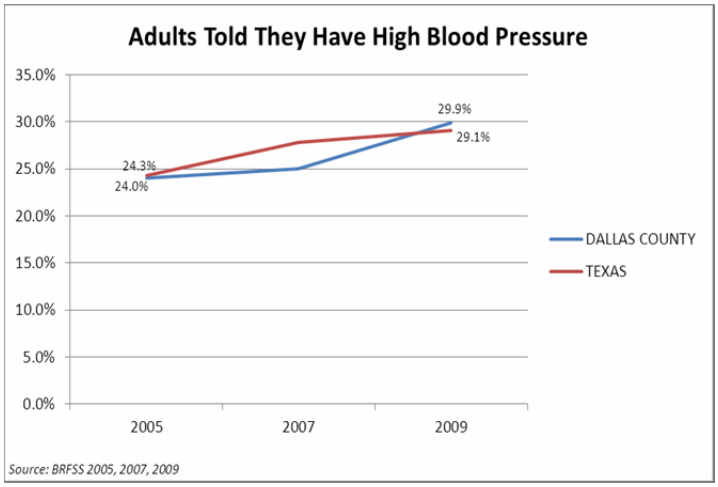
The 2010 BRFSS survey found:

- A smaller percentage of Dallas County residents had been told they had a stroke than Texas residents.
- A greater percentage of Dallas County residents had been told they had heart attacks and angina than residents statewide (Figure 4.64).

Risk Factors

Many of the leading controllable risk factors for heart disease and stroke are also healthy community indicators. According to the American Heart Association, headquartered in Dallas, the risk factors for developing cardiovascular disease include:

Figure 4.65



- High blood pressure—with the percentage of Dallas residents reporting this risk increasing 21% between 2005 and 2009 to 29% in the latter year (Figure 4.65).
- High cholesterol
- Cigarette smoking
- Physical inactivity
- Poor diet, overweight and obesity
- Diabetes

Over time, these risk factors cause changes in the heart and blood vessels that can lead to heart attacks, heart failure, and strokes (*Heart attack risk assessment,* 2012).

Hospitalizations

In 2009, the age-adjusted hospitalization rate (AAHR) due to CVD in Dallas County was 146.6/10,000. This was significantly lower compared to the state rate of 159/10,000.

- Males had a significantly higher AAHR due to both CVD and heart disease as compared to females in Dallas County. There were no significant differences in stroke AAHR based on gender.
- The 2009 AAHR for CVD among African-Americans was significantly higher than Caucasians, Latinos and Other residents of Dallas County. Rates ranged from 218.4/10,000 for African-Americans to 143.7/10,000 for Caucasians and 103.5/10,000 for Latinos.
- African-Americans also had significantly higher AAHR due to heart disease and stroke when compared to other races and ethnicities.

Preventable Hospitalizations

Prevention quality indicators (PQI) identify hospitalizations that could have been prevented with appropriate primary care. They help identify populations with unchecked risk factors and barriers to treatment at the appropriate level.

Hypertension

- Considering the rate of hypertension PQI, both Dallas County and Texas increased between 2000 and 2009.
  - Dallas County experienced a 60% increase.
- South Dallas has the highest hypertension PQI rate, 155/100,000. This is followed by DeSoto Lancaster, SE Dallas, and Cedar Hill.
- The services areas with the lowest PQI rates are Outer NE Dallas, Stemmons Corridor, and North Dallas.

Figure 4.66

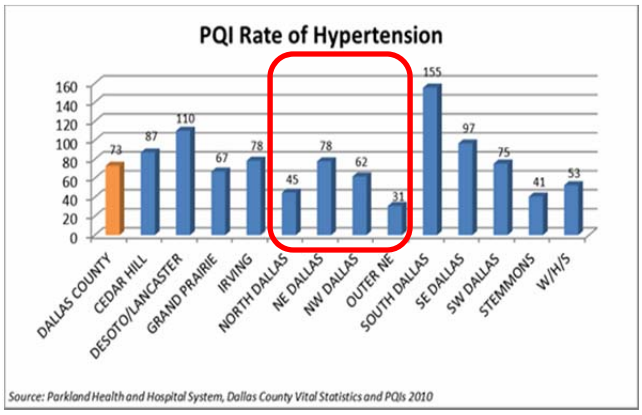
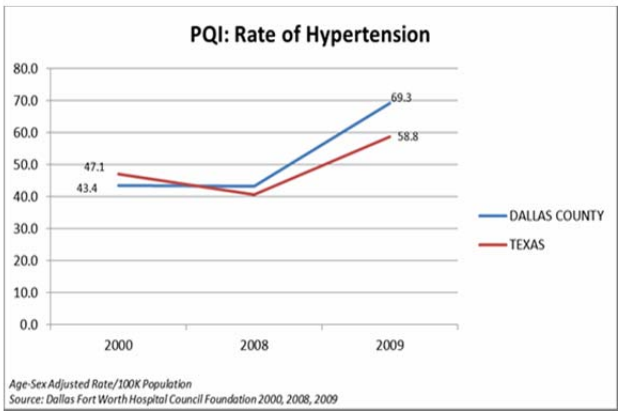


Figure 4.67



Congestive Heart Failure

- Considering PQIs for congestive heart failure (CHF), Dallas County's rate decreased between 2000 and 2009 by 33%.
- The 2010 County CHF PQI rate was 354/100,000.
  - Considering communities, South Dallas' CHF PQI rate, 760/100,000, was more than double the county average and significantly higher than other communities.
  - The communities with the second and third highest rates were SW Dallas (472/100,000) and DeSoto Lancaster (470/100,000).

Figure 4.68

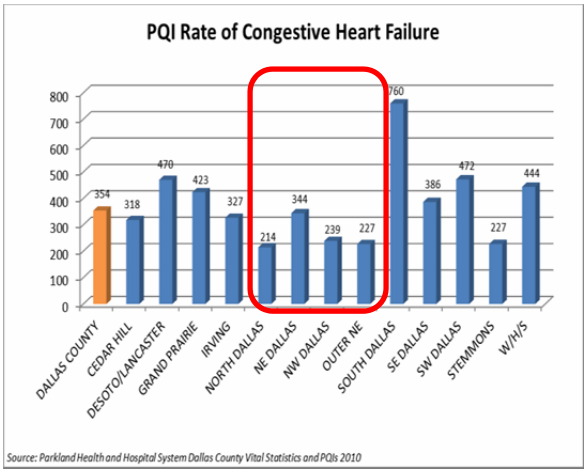
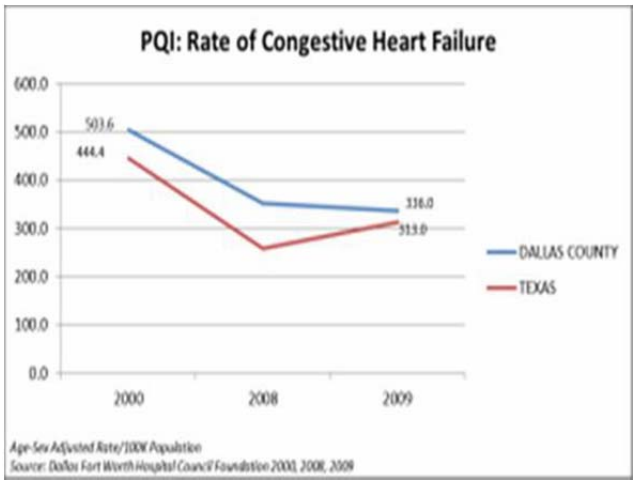


Figure 4.69



- Dallas County is in the bottom quartile for mortality due to heart disease. However, the County trend is improving.
- PCHI rates Dallas County stroke mortality below average, but Healthy N. Texas rates it as average. Again the trend is considered positive.
- The Dallas County rate of preventable hospitalizations for hypertension is average, but the rates for CHF and angina are better than average.

Disparities

The mortality and morbidity data demonstrate significant disparities in the burden of cardiovascular disease based on race/ethnicity, gender, education, geographic location, and SES.

The Dallas County communities with large percentages of African-Americans, large percentages of residents who did not graduate from high school, and with low SES are at greatest risk for morbidity and mortality from cardiovascular diseases, particularly heart disease.

Figure 4.70

CARDIOVASCULAR DISEASE			
Rates per 100K, age-sex adjusted	*Dallas County vs. Healthy People 2020 Target*[1]	*Dallas County Trend*[1]	*Healthy N. Texas Community Dashboard*[2]
Mortality due to Heart Disease			
Mortality due to Stroke			
PQI: Rate of Hypertension			*n/a*
PQI: Rate of Congestive Heart Failure			*n/a*
PQI: Angina without cardiac procedure			*n/a*

[1] Dallas County Community Dashboard Parkland Health and Hospital System, 2011

[2] Healthy North Texas Community Dashboard, 2012

The PQIs by community further target geographic areas with high risk residents. The indicators for hypertension and CHF identify South Dallas as the community with the most severe cardiovascular disparities. Other southern Dallas communities also experience disparities in cardiovascular risk factors and access.

It can be expected that the risk factors associated with these conditions are most severe and access barriers more significant in these communities.

MATERNAL-FETAL HEALTH

Latinos have the highest birthrate in Dallas County and African-Americans have the highest infant mortality and low birth weight babies. The Dallas County Fetal Infant Mortality Review committee, part of the Healthy Texas Babies Local Coalition, works to improve these outcomes.

Family Planning

For many women, a family planning clinic is the entry point into the healthcare system and one they consider their usual source of care. The availability of family planning services allows individuals to achieve desired birth spacing and family size, and contributes to improved health outcomes for infants, children, women, and families. Family planning services include:

- Contraceptive and broader reproductive health services, including patient education and counseling
- Breast and pelvic examinations
- Breast and cervical cancer screening
- Sexually transmitted diseases (STD) and human immunodeficiency virus (HIV) prevention education, counseling, testing, and referral
- Pregnancy diagnosis and counseling (*Healthy People 2020,* 2012).

According to *Healthy People 2020,* barriers to use of family planning services include:

- Cost of services
- Limited access to publicly funded services
- Limited access to insurance coverage
- Family planning clinic locations and hours that are not convenient for clients
- Lack of awareness of family planning services among hard-to-reach populations
- No or limited transportation
- Inadequate services for men
- Lack of youth-friendly services

Almost half of all pregnancies in the U.S. are unplanned. This is associated with a host of prenatal concerns including:

- Delays in initiating care
- Reduced likelihood of breastfeeding, resulting in less healthy children
- Maternal depression
- Increased risk of physical violence during pregnancy (*Maternal, infant, and child health,* 2012)

The rates of unplanned pregnancy are highest among the following groups:

- Women ages 18 to 24
- Women who were cohabitating
- Women whose income is below the poverty line
- Women with less than a high school diploma
- African-American or Latina women (*Maternal, infant, and child health,* 2012)

One in five unplanned pregnancies each year is among teens; and 82% of pregnancies to mothers aged 15 to 19 are unintended. Teen mothers:

- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately $3,500 less per year, when compared with those who delay childbearing until their 20s.
- Receive nearly twice as much Federal aid for nearly twice as long (*Maternal, infant, and child health,* 2012).

Births resulting from unplanned pregnancies can have negative consequences including birth defects and low birth weight. Children from unintended pregnancies are more likely to experience poor mental and physical health during childhood, and have lower educational attainment and more behavioral issues in their teen years. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers. (*Maternal, infant, and child health,* 2012).

Dallas County Teen Births

Dallas County teen births among 15 to 17 years olds are better than the *Healthy People 2020* goal (Figures 4.71 and 4.72).

Between 2000 and 2008, Dallas County teens were more likely to:

- Gain less than 15 pounds during pregnancy, which is risk factor for very low birth weight neonates.
- Have inadequate or no first trimester prenatal care
- Be African-American or Latina than Caucasian or Asian-American/Other

Communities with teen birth rates above the *Healthy People 2020* goal include: South Dallas, SW Dallas, Stemmons, SE Dallas, Irving, and NE Dallas.

Communities with teen birth rates below the *Healthy People 2020* goal include: Outer NE Dallas, DeSoto Lancaster, NW Dallas, Cedar Hill, North Dallas, Grand Prairie and Wilmer Hutchins Seagoville.

Figure 4.71

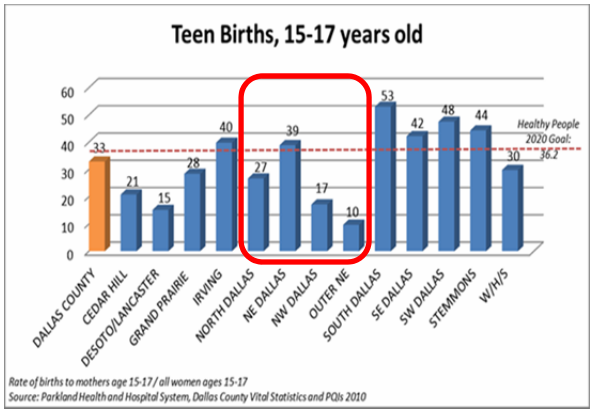
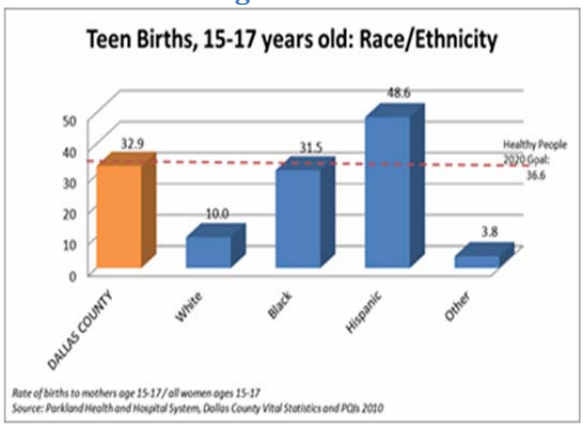
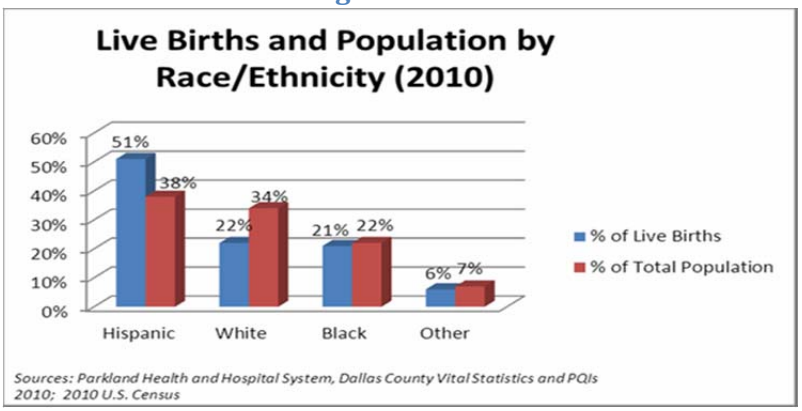


Figure 4.72



Prenatal Care

Figure 4.73



Pregnancy can provide an opportunity to identify existing health risks in women and to prevent future health problems for women and their children.

According to *Healthy People 2020,* factors that affect pregnancy and childbirth, include:

- Preconception health status, including stress
- Age
- Access to appropriate preconception and interconception healthcare
- Poverty

Considering 2010 live births in Dallas County:

- More than half were Latino births. This racial group is 38% of the total population.
- 22% of births were to Caucasian mothers. This racial group is 34% of County residents.
- 21% of births were to African-Americans, and they represent 22% of the population.

In 2010, nearly 59% of Dallas County expectant families initiated prenatal care within the first trimester.

- This includes 70% of Caucasian, 57% of Latino, and 50% of African-American expectant families.
- 70% of North Dallas, 68% of NW Dallas and 65% of Outer NE Dallas expectant families initiated prenatal care in the first trimester to 47% of South Dallas and 51% of SW Dallas expectant families.

On the other hand, 4% of Dallas County expectant families did not access prenatal care in 2010.

- This includes 6% of African-American, 4% of Latino and 2.4% of Caucasian births.
- Considering communities, percentages range from 7.6% in South Dallas to 2.1% in Outer NE Dallas who did not access prenatal care.

Figure 4.74

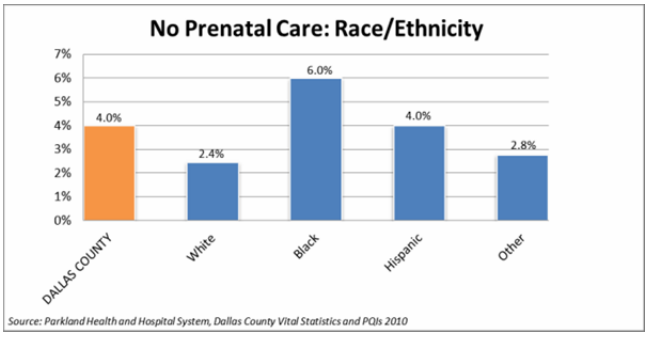


Figure 4.75

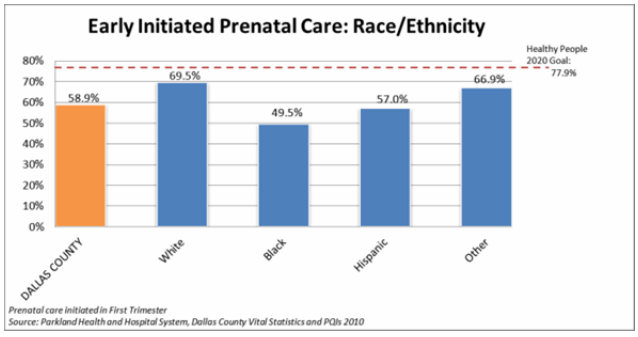


Figure 4.76

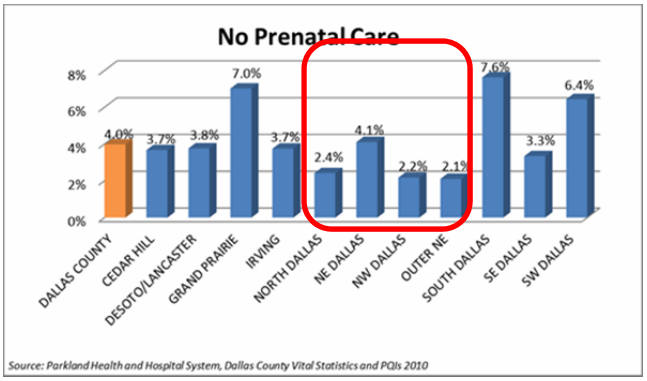
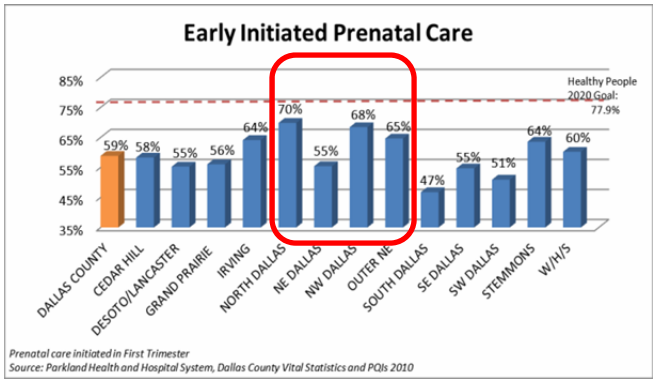


Figure 4.77



Ratings of Maternal-Fetal Health

Dallas County Very Low Birth Weight Percentage:

- Below the *Healthy People 2020* target.
- The trend from previous years has not improved.
- Healthy North Texas Community Dashboard finds it similar to other Texas counties.

Dallas County Infant Mortality Rate:

- Below the *Healthy People 2020* target.
- Health North Texas Community Dashboard finds mortality rate similar to other Texas counties.

Figure 4.78

MATERNAL-FETAL HEALTH			
Indicator	***Dallas County vs. Healthy People 2020 Target*** [1]	***Dallas County Trend*** [1]	***Healthy N. Texas Community Dashboard*** [2]
Very Low Weight Birth Percentage			
Infant Mortality Rate			
Teen Birth Rate, 15-17 years old	*n/a*		

[1] Dallas County Community Dashboard Parkland Health and Hospital System, 2011

[2] Healthy North Texas Community Dashboard, 2012

Dallas County Teen Birth Rate (15 – 17 Year Olds):

- Positively rated relative to previous trends and other Texas counties.

Dallas County infant mortality and very low weight births were worse than the *Healthy People 2020* goals.

- Overall, African-Americans had the highest rate of infant mortality and the highest percentage of very low weight births.
- Latinas had an infant mortality rate higher than the *Healthy People 2020* goal, but the Latina percentage of very low weight births was below the *Healthy People 2020* goal and below all population groups.
- Considering infant mortality by community, South Dallas and Grand Prairie had the highest rates, and Cedar Hill and North Dallas the lowest.
- Considering very low weight births by community, South Dallas had the highest percentage followed by Cedar Hill, and Irving. Outer NE Dallas had the lowest percentage and thus the best outcomes.

Figure 4.79

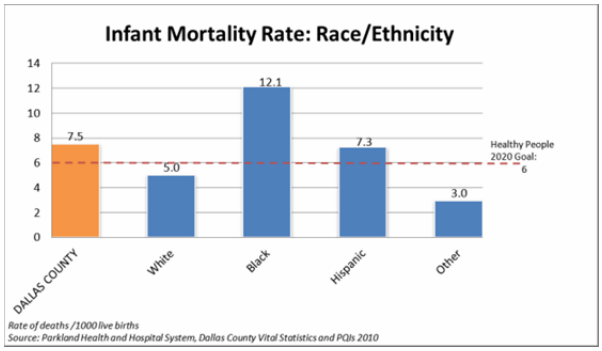


Figure 4.80

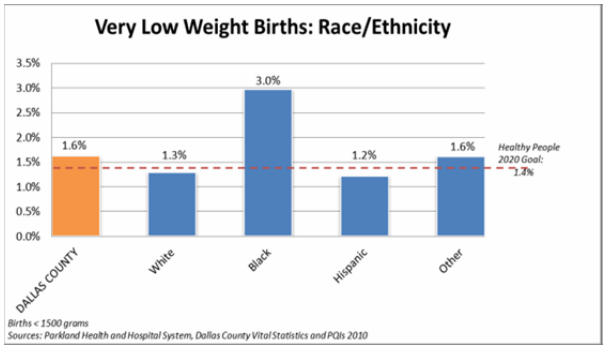


Figure 4.81

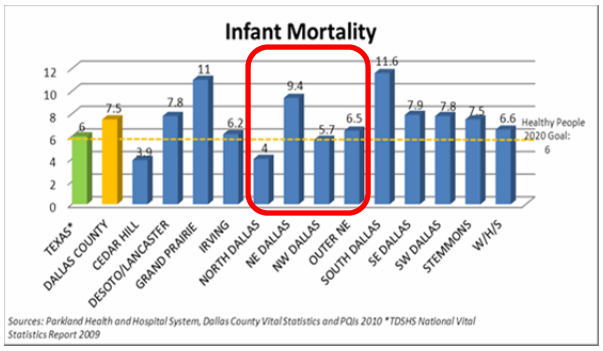
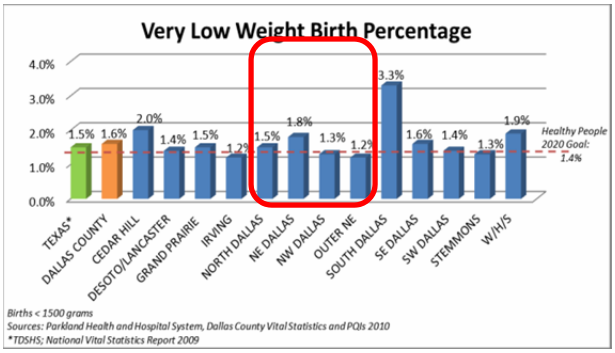


Figure 4.82



Disparities in Maternal and Infant Health

Dallas County evidences racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African-Americans. Nationally, women with lower levels of education and income, uninsured women, Latina women, and African-American women are less likely to have access to family planning services.

DSHS Perinatal Periods of Risk

Texas DSHS Office of Decision Support outlines Perinatal Periods of Risk to assist in prioritizing and targeting prevention and intervention efforts (*Feto-infant mortality in Dallas County*, 2011). These include:

1. *Maternal Health/Prematurity*
   - Preconception Health
   - Health Behaviors
   - Perinatal Care
2. *Maternal Care*
   - Prenatal Care
   - High Risk Referral
   - Obstetric Care
3. *Newborn Care*
   - Perinatal Management
   - Neonatal Care
   - Pediatric Surgery
4. *Infant Health*
   - Sleep Position
   - Smoking
   - Breast Feeding

Key findings include:

2005-2008 Dallas County feto-infant mortality rates[9] were:

- 14.0/1,000 live births for African-Americans
- 7.9/1,000 live births for Latinas
- 6.9/1,000 live births for Caucasians
- 9.3/1,000 live births for Teens

Furthermore, excess feto-infant mortality rates[10] were:

- 8.9/1,000 live births for African-Americans
- 2.9/1,000 live births for Latinas
- 4.2/1,000 live births for Teens

Potentially 64% of African-American fetal and infant deaths were preventable. African-Americans had the highest excess rates in all four risk periods, with a rate 11 times that of the Caucasian rate in the Maternal Health/Prematurity period (*Feto-infant mortality in Dallas County*, 2011).

[9] F-IMR = number of fetal and infant deaths >=500 grams and >=24 weeks gestation / number of live births & fetal deaths >=500 grams and >=24 weeks gestation;

[10] Excess Feto-Infant Mortality is the difference between the exposure group (i.e. African-American, Caucasian, Latina, teen) and the reference group.

Recommendations identified African-American maternal health and prematurity as the target population with the greatest potential impact. They also provided a wide range of recommendations to improve fetal and infant mortality, including:

1. Target Maternal Health/Prematurity, Maternal Care and Infant Health-related interventions to African-Americans.
2. Target Maternal Health/Prematurity and Infant Health related interventions to teens.
3. Target Maternal Health/Prematurity among Latinas.

Specifically:

- Reduce the number of women gaining less than 15 lbs.
- Improve access to and use of prenatal care
- Stress importance of early entry into care
- Target interventions that reduce high parity for age
- Target interventions that reduce rates of teen pregnancy
- Target interventions that reduce parental smoking
- Target interventions that reduce birth defects
- Target interventions that promote breast feeding
- Target interventions that reduce prematurity, birth defects, and SIDS among African-Americans and teens

Family Planning and Women's Services Access

Women's health physicians are concentrated in the Stemmons Corridor community with 67 physicians/100,000 residents.

- NE Dallas and North Dallas follow with 29/100,000 and 27/100,000, respectively.
- Few women's health physicians are found in DeSoto Lancaster, Grand Prairie or Cedar Hill.

Locations of family planning and women's health clinics follow a similar pattern to physician availability. The map in Figure 4.84 presents these locations in Dallas County.

Figure 4.83

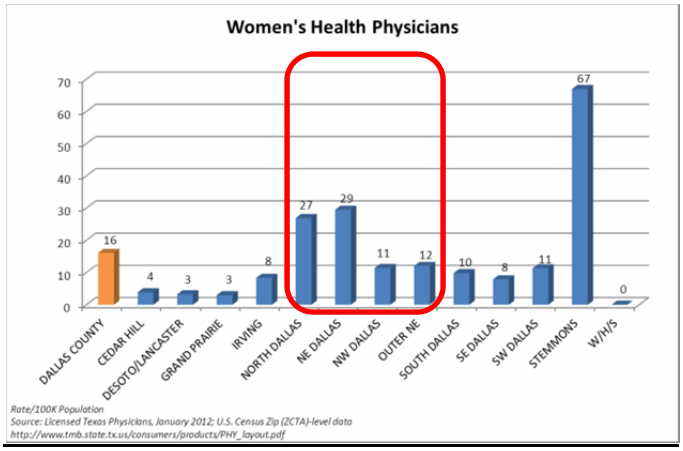
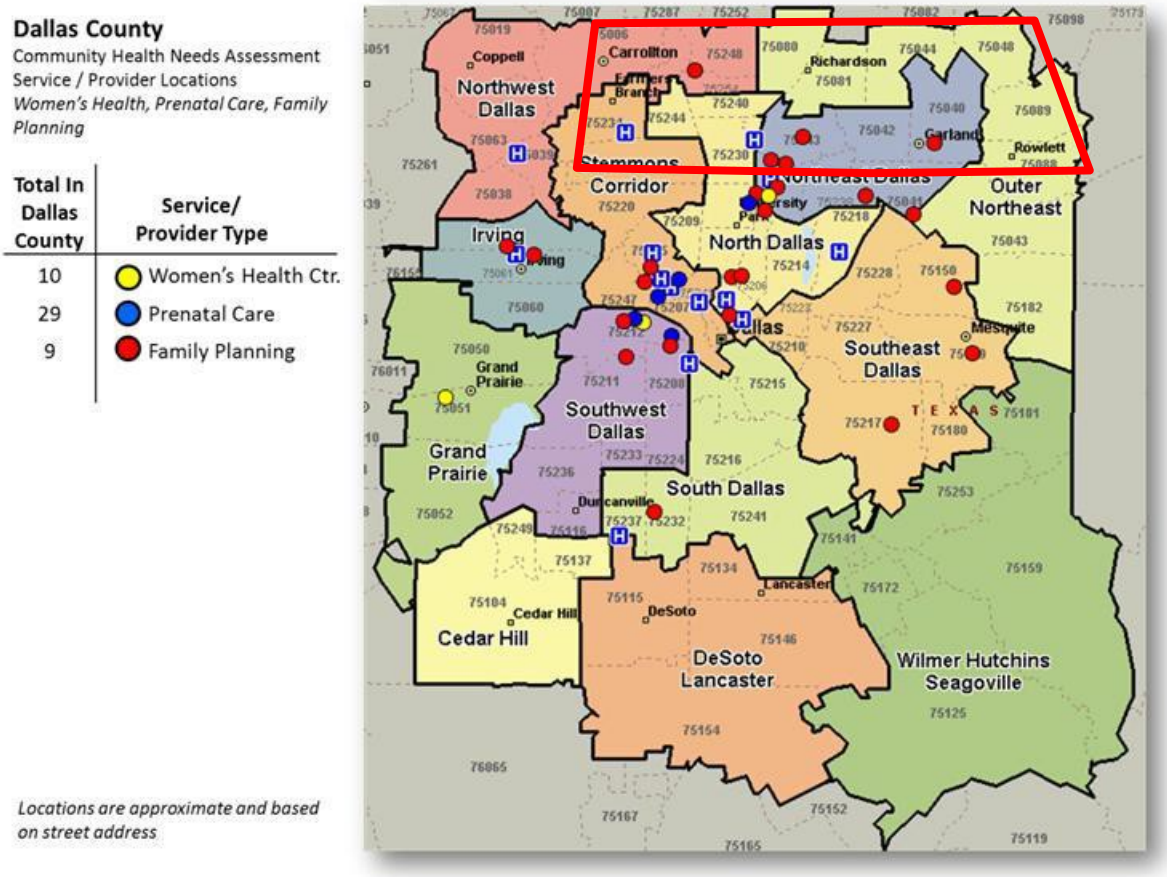


Figure 4.84



Lead

Preventing children from coming in contact with lead and treating children who have been poisoned is critical. Children under age 6 are at risk for lead poisoning, as well as children living at or below the poverty line or living in older housing. Lead poising is preventable. Families can test paint and dust in homes for lead, regularly wash hands and toys, mop floors and wet-wipe windows, and avoid children playing in bare soil. Lead exposure often occurs with no obvious symptoms, and can be found in the air, water, food, dust, and soil causing temporary or permanent damage in children. Five micrograms per deciliter (µg/dL) is the recommended threshold blood lead level where public health actions should be initiated (Centers for Disease Control, 2012; Texas DSHS, 2012).

MENTAL AND BEHAVIORAL HEALTH

Mental and behavioral health (includes chemical dependency) is increasingly being linked to physical health indicators. Most Dallas County behavioral health indicators are equal to or better than found in Texas, but community analysis identifies areas of disparity. It is expected that in the future behavioral health systems will be embedded in new structures such as accountable care organizations, integrated healthcare systems and preferred provider organizations (Jarvis, 2010).

Behavioral Health Continuum of Care

The Dallas County behavioral health system differs from that of the rest of the state in that the majority of services for Medicaid and indigent patients with behavioral health needs are delivered via the NorthSTAR program instead of a traditional Local Mental Health Authority. Besides NorthSTAR, other significant partners include the Dallas County adult and juvenile criminal justice systems, PHHS, and the homeless services continuum. This results in a complex and at times difficult system to navigate (DFW Hospital Council RHP90, page 10).

Mental Health

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. There is often a stigma associated with mental health diagnoses and treatment, particularly among African-Americans and Latinos (*Mental health and mental disorders*, 2012).

- Mental disorders are among the most common causes of disability.
  - According to the National Institute of Mental Health (NIMH), in any given year, an estimated 1 in 17 Americans have a seriously debilitating mental illness.
- Mental health disorders are the leading cause of disability in the United States and Canada, accounting for 25% of all years of life lost to disability and premature mortality.
  - Mental health plays a major role in people's ability to maintain good physical health.
  - Problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery (*Mental health and mental disorders*, 2012).

Dallas County

Dallas County residents reported mental health status that is the same as that reported by Texas residents (Table 4.9).

- In Dallas County, 20% reported their mental health was "not good" for five or more days of the last 30.
- Dallas County residents reported 3.1 mentally unhealthy days in the past 30, or 10% of the time.

Table 4.9

MENTAL HEALTH STATUS		
INDICATOR	**DALLAS COUNTY**	**TEXAS**
Mental Health Status (% who said their mental health was not good for 5 or more days in the past 30 days)	20.4%	20.0%
Poor Mental Health Days Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	3.1	3.2
*Source: TDSHS, BRFSS 2009-2010, **CHR** BRFSS 2004-2010*		

Suicide is the 11th leading cause of death in the United States, accounting for the deaths of approximately 30,000 Americans each year. The 2010 suicide rate in Dallas County was 10.6/100,000. Specifics include:

Figure 4.85

BEHAVIORAL HEALTH

Rates per 100K, age adjusted	*Dallas County vs. Healthy People 2020 Target* [1]	*Dallas County Trend* [1]	*Healthy N. Texas Community Dashboard* [2]
Suicide Mortality			

[1] Dallas County Community Dashboard Parkland Health and Hospital System, 2011

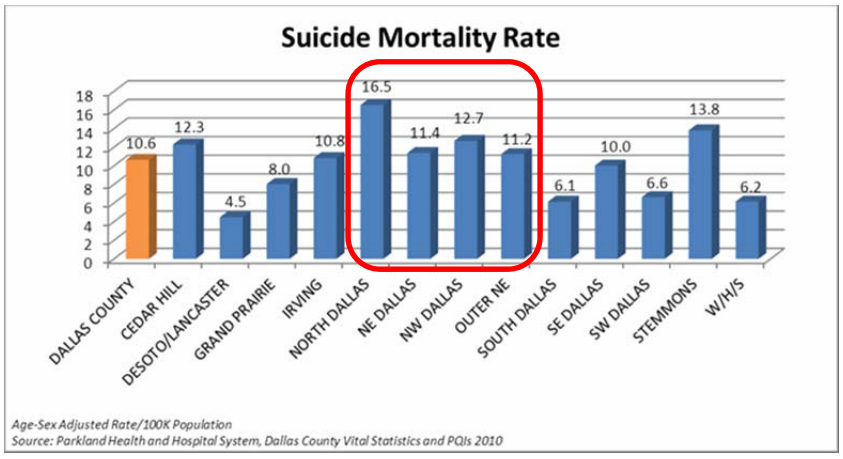
[2] Healthy North Texas Community Dashboard, 2012

- The rate of suicide mortality was considered poor in comparison to the *Healthy People 2020* target.
- The Dallas County trend has not changed relative to previous years.
- The Healthy North Texas Community Dashboard provides a more positive perspective, finding the Dallas County suicide rate below that of the majority of Texas counties (Figure 4.85).

Dallas County Communities

- The communities with the highest suicide mortality rates include: North Dallas, Stemmons, NW Dallas, and Cedar Hill.
- The communities with the lowest suicide mortality rates include: DeSoto Lancaster, South Dallas, Wilmer Hutchins Seagoville, and SW Dallas (Figure 4.86).

Figure 4.86



Crisis service utilization has been increasing, and was identified as a continuing service need during the key informant interviews.

- The RHP9: Community Needs Assessment Report identified a sharp spike in 23-hour observation utilization, with Feb 2012 visits 26% higher compared to Dec 2011 (and 25% higher compared to Feb 2011).
- The Assessment of the Community Behavioral Health Delivery System in Dallas County recommended enhancing funding for a crisis stabilization unit as well as developing a crisis stabilization continuum of care. (*Assessment of the community*, 2010, p. 148).

Substance Use/Abuse

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems.

In 2005, an estimated 22 million Americans struggled with a drug or alcohol problem. Almost 95% of people with substance use problems are considered unaware of their problem (*Healthy People 2020,* 2012).

Dallas County residential substance abuse treatment beds have remained flat and at capacity since 2005, while outpatient substance use services rose steadily until a sharp decrease in November 2009, due to controls on use. Taken together, these trends suggest the capacity for substance abuse treatment has not kept pace with population growth and need (*Assessment of the community*, 2010).

Between 2004 and 2010, alcohol use declined in Dallas County:

- Reported binge drinking in Dallas County declined from 16.5% to 10.9%. This compared to the Texas binge drinking at 14.7% and U.S. at 15.1%.
- Despite a spike in 2008, heavy drinking declined to 4% in 2010.

Figure 4.87

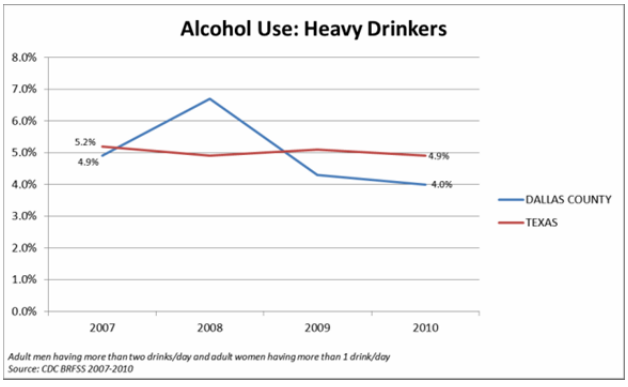
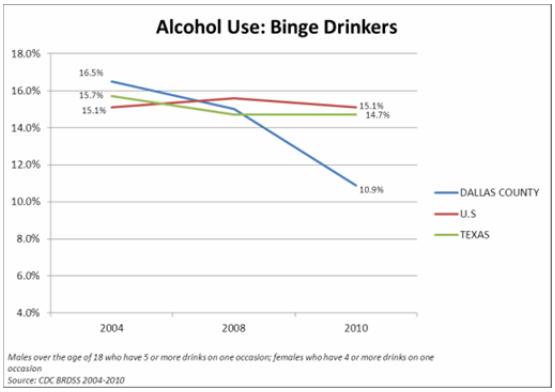


Figure 4.88



Behavioral Health

Given the interplay of behavioral health and physical health, Dallas County residents with mental health disorders or substance use issues often have more severe needs across the spectrum of both prevention and care.

Behavioral health issues faced by Dallas County and local providers include: providing appropriate access and funding for services; reaching underserved Dallas County behavioral health populations; recognizing the critical interplay between individual health, medical treatment and behavioral health and improving outcomes; providing of culturally competent behavioral health treatment. Each is described briefly below.

Access to Services

The 2010 assessment of the Dallas County community behavioral health system found that over the past decade the NorthSTAR system has greatly expanded access to behavioral healthcare, though it does not represent all mental and behavioral health patients. This high level of access has resulted in infrastructure challenges.

- Since the program's inception, the growth in enrollment has outpaced funding such that the funding per person served is 30% less than when the program started in 1999 and is half that of the state average for other local mental health areas (*Assessment of the community*, 2010, p. 20).
- Proportionally, NorthSTAR identifies fewer adults in need of higher levels of care, as compared to other urban counties (*Assessment of the community*, 2010, p. 20).
- The proportion of NorthSTAR members served in acute care settings (emergency departments, 23-hour observation, acute inpatient units) grew dramatically (9.3%) from December 2009 through May 2010, an increase particularly driven by people without a current specialty provider network and assigned level of care (*Assessment of the community*, 2010, p. 26).
- Without a data or patient tracking system, NorthSTAR is unable to monitor individuals who present in emergency departments or 23-hour observation units, receive referrals for follow up through the NorthSTAR Specialty Provider Network, but do not keep their appointments. Consequently, a significant number of persons could "fall through the cracks" in a way that is "invisible" within the system (*Assessment of the community*, 2010, p. 26).

Underserved Populations

Underserved populations include:

- *Individuals with severe mental health disorders*—Data suggest people may be presenting in crisis having not received appropriate care through a specialty provider network (*Assessment of the community*, 2010, p. 26).
- *Latinos*—Latinos comprise 38% of the population, but 24% of NorthSTAR clients served (*Assessment of the community*, 2010, p. 37).
- *Individuals with substance abuse treatment needs—"*Only a fraction" of individuals with substance abuse treatment needs (9.7) are being served by NorthSTAR (*Assessment of the community*, 2010, p. 20).

- *Individuals with co-occurring mental health and substance abuse needs*—The 2010 behavioral health assessment found that "too few persons with co-occurring mental health and substance use needs are being identified and served by NorthSTAR." (*Assessment of the community*, 2010, p. 20).
- *Special populations* including jail and prison inmates, juvenile justice residents, child welfare recipients and homeless people also have a wide range of behavioral health needs. "Their treatment requirements are increasing at a rate higher than available funding." (*Assessment of the community*, 2010, p. 270).

Impact on Acute Care

Behavioral health diagnoses affect the overall health of the individual. Healthy behaviors, preventive care and treatment, and compliance with medical regimens for chronic diseases may all be compromised if an individual suffers from a behavioral health condition.

Within Texas, a recent study found that the mortality for the mental health population was consistently higher than for the general population. The majority of these deaths are a result of cardiovascular disease. Dallas County was unique in that it was one of only four local mental health areas in the state in which age-adjusted mortality rates were statistically significantly higher (Reynolds, Shafer, & Baker, 2012, p. 39).

The Regional Health Partnership 9: Community Needs Assessment Report found the presence of a co-occurring behavioral health condition is associated with increased case severity of medical encounters and a 36% increase in the average charges per encounter. Specifically:

- A frequent user analysis found 100% of the 10 most frequently admitted patients had a co-occurring behavioral health diagnosis.
- These 10 individuals incurred a cost of over $26 million between 2007-2011. However only 20% of their hospital emergency department visits were for a mental health or substance abuse issue.
- Sixty-one percent were uninsured (24% Medicaid, 12% Medicare, and 3% Insured) placing a significant financial burden on the hospital systems (Collins, 2012, p. 12).

Primary Care—Behavioral Health Integration

The behavioral health needs assessment recommended expansion of community-based services and integration of behavioral health with primary care treatment, specifically in the PHHS Community Oriented Primary Care clinics. Several randomized studies have documented the effectiveness of collaborative care models to treat anxiety, panic disorders, and depression in adults and older adults (*Assessment of the community*, 2010, p. 144). That needs assessment outlined a model with the following components:

1. Mental health professionals are integrated into primary care settings to help educate consumers, monitor adherence and outcomes, and provide brief behavioral treatments according to evidence-based structured protocols;
2. Psychiatric and psychological consultation and supervision of care managers are available to provide additional mental health expertise where needed. The role of the PCP changes, as the PCP and behavioral health provider collaborate to develop and implement the treatment plan.

3. Increased screening, consumer education and self-management support, mental health specialty referrals as needed for severe illness or high diagnostic complexity, and linkages with other community services.
4. Integrated information technology and shared electronic health records with routine outcomes tracking.

Culturally Competent Treatment

Providing culturally appropriate behavioral health treatment for minority and even refugee populations has been led by the community-based providers. This needs to be codified with best practices used by all providers.

- Latinos comprise 38% of Dallas County residents, but 24% of NorthSTAR clients served. Issues identified in the 2010 assessment include:
  - Lack of Spanish programming materials or enrollee-specific communication around denials.
  - Lack of Spanish public service announcements or other promotional materials for NorthSTAR involvement resulting in lack of awareness of NorthSTAR services.
  - Provider reports that they believe very few Hispanics even know that NorthSTAR exists (*Assessment of the community*, 2010, p. 38).
- There is evidence that suggests that in Dallas County a smaller percentage of persons with serious needs are receiving services in primary care settings than in comparable systems across the country, with 19.8% receiving services as PHHS vs. 37.1% nationally (*Assessment of the community*, 2010, p. 19).
- African-American and Latino parents and youth perceive a need for more community-based interventions, such as community/school education and stigma reduction, access to youth/teen peer groups, and home-based services. Consumers report higher levels of stigma in minority communities for behavioral health needs (*Assessment of the community*, 2010, p. 214).
- Other barriers to accessing behavioral health services include transportation and wait times (*Assessment of the community*, 2010, p. 39).

Behavioral Health Providers

The map below presents outpatient mental health facilities, residential and outpatient substance abuse treatment, and behavioral health programs.

The majority of providers are located in central Dallas. Few or no providers are found in the farthest outlying communities including: Outer NE Dallas, Wilmer Hutchins Seagoville, Cedar Hill, Grand Prairie, Irving.

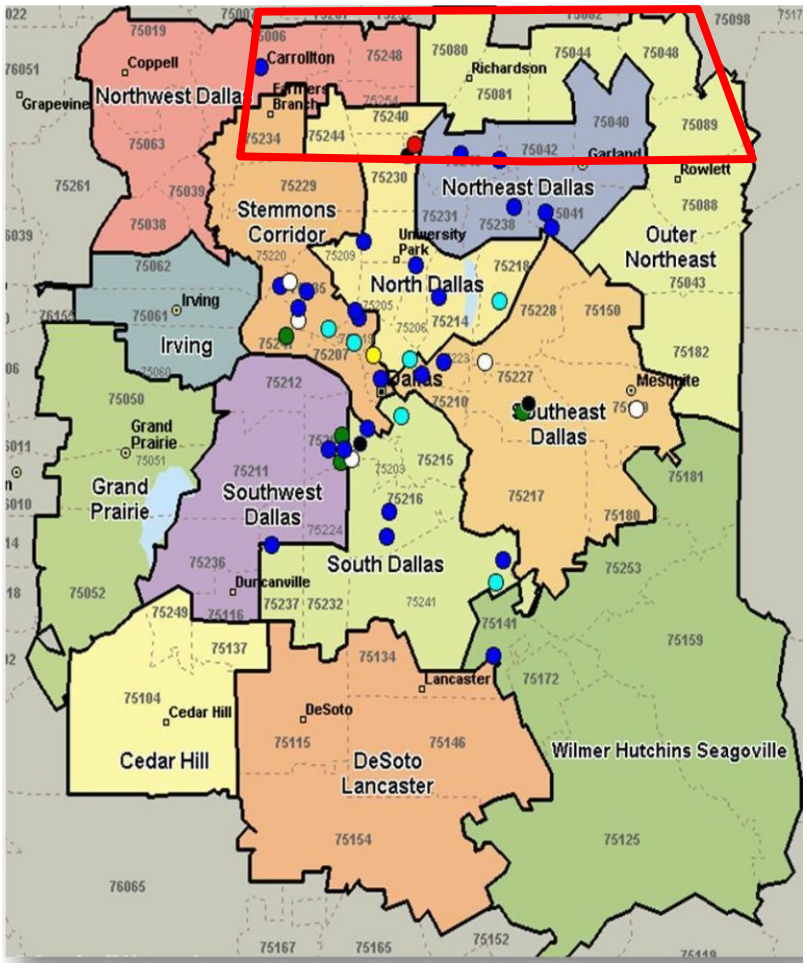
Figure 4.89

Dallas County

Community Health Needs Assessment
Service / Provider Locations
Women's Health, Prenatal Care, Family Planning

Total In Dallas County	Service/ Provider Type
10	Women's Health Ctr.
29	Prenatal Care
9	Family Planning

Locations are approximate and based on street address



VIOLENCE AND INJURIES

Dallas County has high rates of mortality due to falls, accidental poisoning, and homicide. Supporting healthier environments can reduce the threat of unintentional injury and violence.

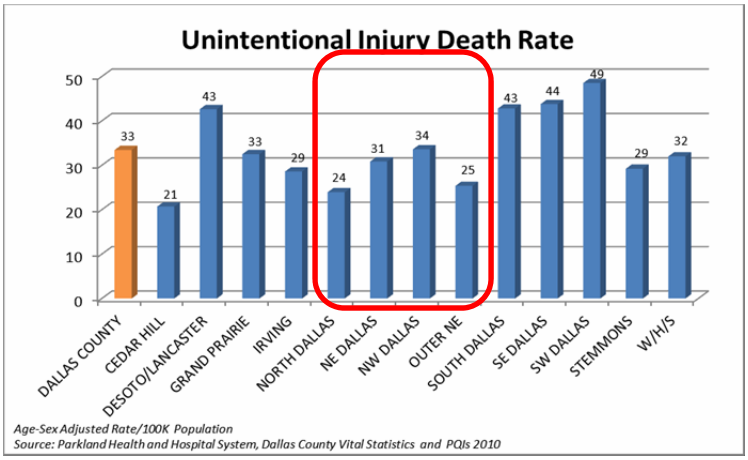
Nationally, injuries and acts of violence result in significant morbidity and mortality.

- Unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages.
- Injuries are the number one cause of death for Americans ages 1 to 44.
- Injuries are a leading cause of disability for all ages, regardless of sex, race/ethnicity, or SES (*Injury and violence prevention*, 2012).

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death
- Disability
- Poor mental health
- High medical costs
- Lost productivity

Figure 4.90



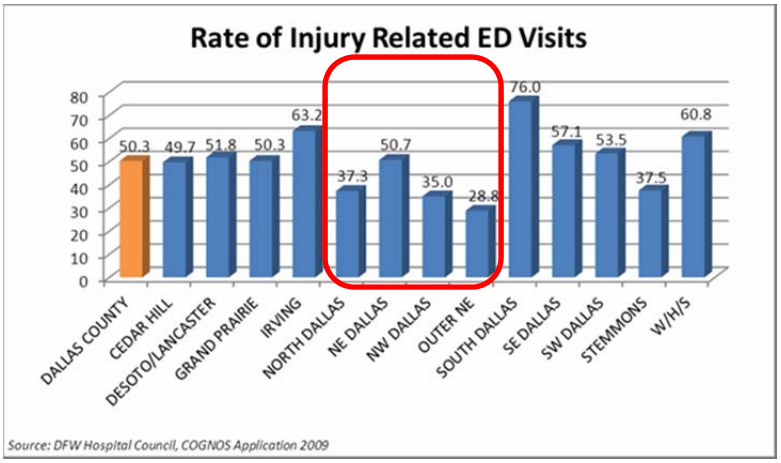
In Dallas County, the 2010 unintentional injury death rate was 33/100,000. This is similar to the *Healthy People 2020* goal.

- Southern Dallas communities tend to have unintentional injury death rates above the County average, with the highest in SW Dallas—49/100,000.

The 2009 Dallas County rate of injury related ED visits was 50.3/100,000.

- SW Dallas had the highest rate, followed by Irving and Wilmer Hutchins Seagoville.
- Outer NE Dallas, NW Dallas, North Dallas and Stemmons Corridor had the lowest rates (Figure 4.91).

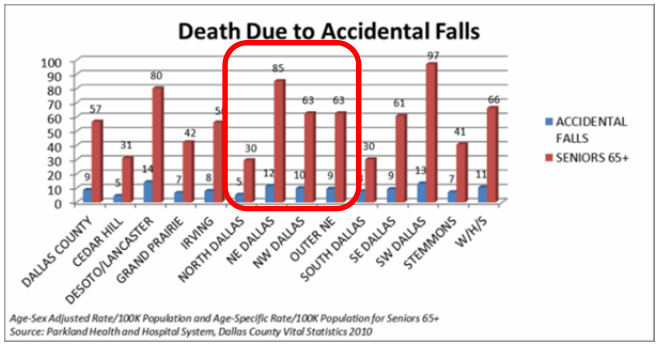
Figure 4.91



Dallas County 2010 death rate due to accidental falls averaged 9/100,000. Deaths of residents age 65 and older, due to falls was 57/100,000.

- In both cases, this compared poorly with the *Healthy People 2020* goal.
- Deaths of the general population ranged from 5/100,000 in Cedar Hill and North Dallas to 14/100,000 in DeSoto Lancaster.
- Deaths of residents age 65 and older ranged from 30/100,000 in North Dallas and South Dallas to 97/100,000 in SW Dallas (Figure 4.92).

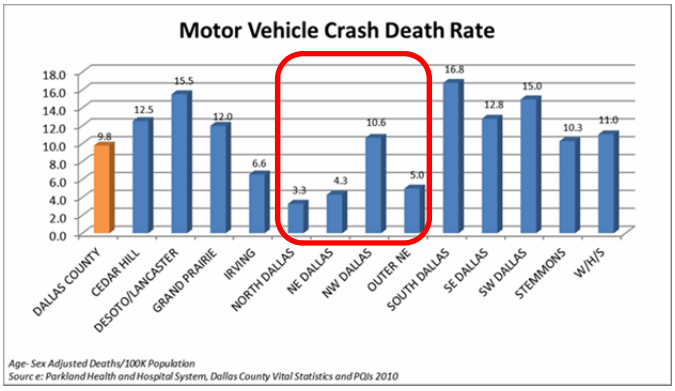
Figure 4.92



The Dallas County 2010 motor vehicle crash death rate, 9.8/100,000, compared favorably to the *Healthy People 2020* goal and to previous years' trends.

- The areas with the highest rates were in the southern communities.
- North Dallas, NE Dallas and Outer NE Dallas have the lowest motor vehicle crash death rates (Figure 4.93).

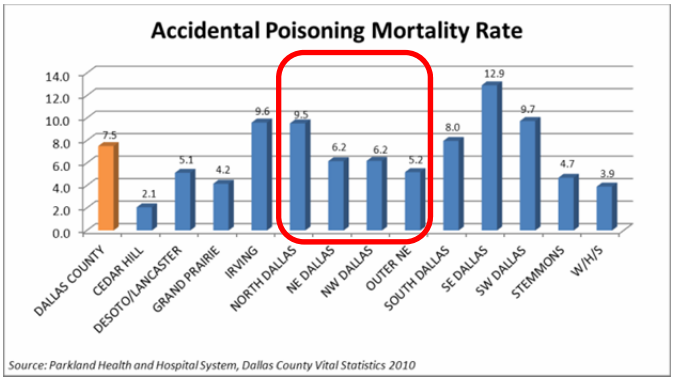
Figure 4.93



Dallas County 2010 accidental poisoning death rate, 7.5/100,000, compared favorably to the *Healthy People 2020* goal.

- SE Dallas, Irving and North Dallas had the highest accidental poisoning mortality rates.
- Cedar Hill had the lowest mortality rate, 2.1/100,000 residents (Figure 4.94).

Figure 4.94



Dallas County's 2010 homicide death rate, 8.5/100,000, compared poorly to the *Healthy People 2020* goal.

- South Dallas' rate exceeds all other communities' rates by a wide margin and is 3.7 times higher than the county average.
- SW Dallas, SE Dallas and Cedar Hill have rates that are somewhat above the County average.
- All other communities have homicide rates that range from 1.1/100,000 to 6.4/100,000 residents (Figure 4.95).

Figure 4.95

Injury/Violence Prevention

Healthy People 2020 asserts most events resulting in injury, disability, or death are predictable and preventable. For unintentional injuries, there is a need to better understand the trends, causes, and prevention strategies. Specifically:

- Individual behaviors—choices people make such as alcohol use or risk-taking.
- Physical environment—home and community that affect the rate of injury related to falls, fires and burns, drowning, violence.
- Social environment—individual social relationships, community, societal-level factors (*Injury and violence prevention*, 2012).

Figure 4.96

VIOLENCE AND INJURIES		
Rates per 100K, age adjusted	*Dallas County vs. Healthy People 2020 Target*[1]	*Dallas County Trend*[1]
Mortality Due to Fall		
Mortality Due to Fall, 65+ (age specific)		
Unintentional Poisoning Death Rate		
Homicide Mortality		
Unintentional Injury Death		
Motor Vehicle Crash Death		

[1] Dallas County Community Dashboard Parkland Health and Hospital System, 2011

[2] Healthy North Texas Community Dashboard, 2012

HEALTHY COMMUNITY INDICATORS

Despite a strong network of parks and varied recreational options, more than half of Dallas County residents have sedentary lifestyles. This, coupled with limited access to healthy foods in the southern communities, is resulting in steadily increasing obesity among Dallas County residents.

According to the Centers for Disease Control and Prevention (CDC), poor diet and physical inactivity have nearly caught up with tobacco use as the second leading actual cause of death in the United States (Sanchez, Weinraub, Tagtow, & King Collier, 2008).

It has been estimated that total annual economic cost of overweight and obesity in the United States and Canada combining medical costs, excess mortality and disability was approximately $300 billion in 2009 (Behan et al., 2010, p. 1).

In trying to promote healthy eating as a way to raise the health status of individuals and communities, the high prices for fresh fruits, fresh vegetables, and whole grains have put that common sense, non-medical approach out of reach for those already living in the margins of poverty. The reality is that it is cheaper to eat poorly (Sanchez et al., p. 1).

Diet and Nutrition

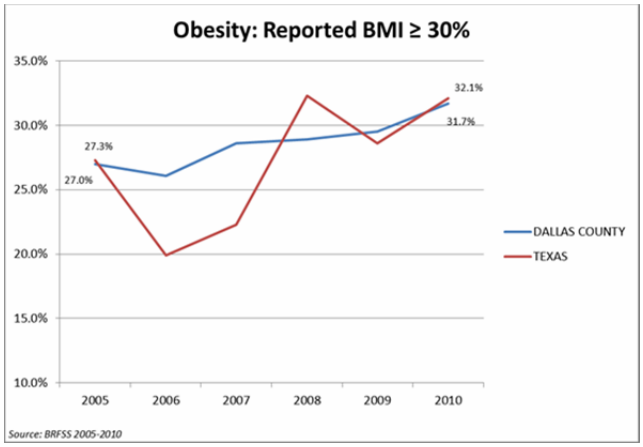
Diet and body weight are related to health status. A healthy diet reduces risks for many health conditions discussed in this report, including:

- Overweight and obesity
- Heart disease
- High blood pressure
- Stroke
- Type 2 diabetes
- Osteoporosis
- Oral disease
- Some cancers
- Complications during pregnancy (*Nutrition and weight status*, 2012)

Texas has one of the highest obesity rates in the country, with 31% of state residents reporting a body mass index (BMI) of 30% or greater. This compares to 35.7% in the United States (*Obesity and overweight for professionals*, 2012). According to the CDC, obesity is more common in low income populations, with ethnic minority populations having the highest rates. Low income African-Americans have the highest rate (44.1%) compared with Mexican-Americans (39.3%), all Latinos (37.9%) and Caucasians (32.6%) (*Obesity and overweight for professionals*, 2012).

Dallas County

Figure 4.97



Obesity

Obesity among Dallas County residents increased steadily between 2005 and 2010.

- The 17.6% change can be seen as a steady increase in Figure 4.97.

Public Food Assistance

Dallas County recipients of most public assistance nutrition programs increased between 2009 and 2011.

- Supplemental Nutritional Assistance Program (SNAP) participants increased 28%.
- School lunch recipients increased 1%.
- School breakfast recipients increased 10%.
- On the other hand, Women-Infants-Children (WIC) program participants decreased 3.4%. WIC is the federal assistance program for healthcare and nutrition of low-income pregnant women, breastfeeding women, and infants and children under the age of five. The eligibility requirement is a family income below 185% of the FPL.

Table 4.10

CHANGE IN SNAP, WIC AND SCHOOL MEAL ENROLLMENT DALLAS COUNTY 2009 – 2011			
	2009	**2011**	**% Change**
SNAP participants (% pop)	12.12	15.49	27.8%
WIC participants (% pop),	4.00	3.87	-3.4%
School Lunch participants (% pop)	13.13	13.24	0.9%
School Breakfast participants (% pop)	6.17	6.80	10.2%
Summer Food participants (% pop)	0.74	0.67	-8.9%
Source: U.S. Food Environment Atlas			

Dallas Food Deserts

One reason for increasing obesity among low income residents is limited access to healthy food and high access to non-nutritious food. These food "deserts" have been defined as areas with "limited access to affordable and nutritious food, particularly...(in) predominantly lower income neighborhoods and communities" (Martin et al., 2012, p. 10).

- 36% of Dallas County ZIP codes contain food deserts (Martin et al., 2012, p. 3)

- Families who live in food desert communities are less likely to consume adequate amounts of fruits and vegetables.

Between 2007 and 2009, Dallas County witnessed an increase in the number of fast food restaurants, a decrease in the number of grocery stores, and a decrease in the number of recreation and fitness facilities (Table 4.11).

Table 4.11

CHANGE IN FAST FOOD RESTAURANTS, GROCERY STORES AND RECREATION			
DALLAS COUNTY 2007 - 2009			
	2007	**2009**	**% Change**
Fast-food restaurants	1,804	1,837	1.8%
Grocery stores	392	360	-8.2%
Recreation & fitness facilities	188	179	-4.8%
Source: U.S. Food Environment Atlas			

Dallas County has 10 Farmer's Markets. All are located in northern Dallas communities except one in Cedar Hill.

Figure 4.98 presents a food desert analysis of all Dallas County ZIP codes. Using a census tract level analysis, ZIP codes were rated based on the availability of fresh food.

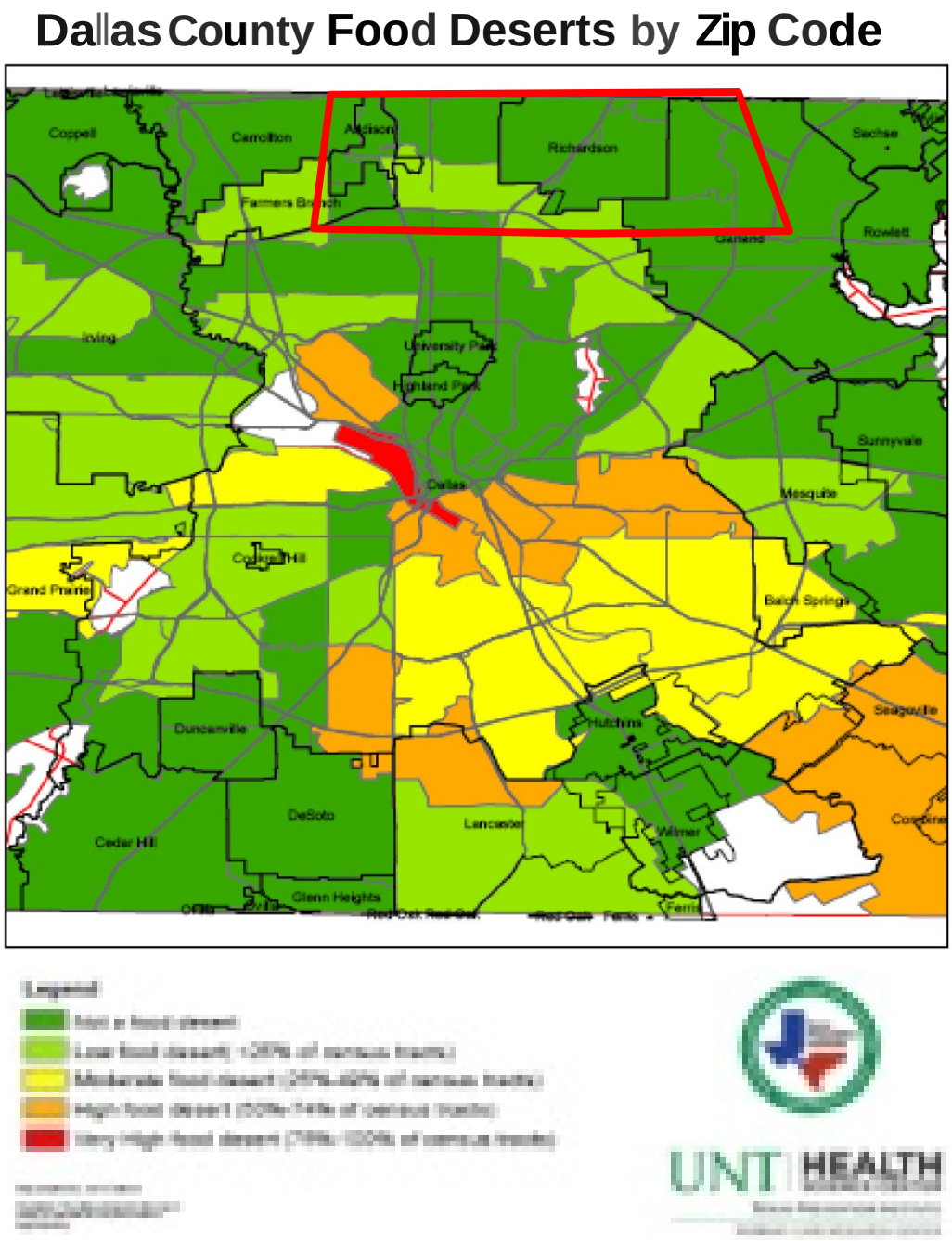
- One ZIP code in the Southwest Dallas community (75207) is a very high food desert, 100% of census tracts in that ZIP were identified as food deserts.
- Nine ZIP codes were rated as high food deserts with 50% to 74% of census tracts designated as food deserts. These are identified in orange on the map.
- Six ZIP codes were rated as moderate food deserts with 25% to 49% of census tracts designated as food deserts, pictured in yellow on the map.

It is important to note that all very high, high and moderate food desert areas are located in the southern half of Dallas County.

There are various demographic differences and economic disparities between ZIP codes in Dallas County that are considered food desert areas. Dallas County food deserts have:

- Nearly double the percentage of African-American and Latino residents.
- Less education than those individuals who do not live in food deserts.
- More homes/apartments occupied by renters—28% more renter occupied apartments.
- More single parent homes—44% more single parent homes.
- High poverty—28% of the residents in food desert areas have income below the poverty level compared to only 15% of the residents who live in non-food desert areas.
- High crime—nearly twice the amount of total crime occurs in food deserts compared to non-food deserts (Martin et al., 2012, p. 8).

Figure 4.98


Dallas County Food Deserts by Zip Code
Coppell
Carrollton
Addison
Richardson
Sachse
Farmers Branch
Garland
Rowlett
Irving
University Park
Highland Park
Sunnyvale
Dallas
Mesquite
Cockrell Hill
Grand Prairie
Balch Springs
Duncanville
Hutchins
Seagoville
DeSoto
Lancaster
Wilmer
Cedar Hill
Glenn Heights
Ferris
Legend
UNT HEALTH

Physical Activity and Exercise

Released in 2008, the "Physical Activity Guidelines for Americans" is the first-ever publication of national guidelines for physical activity.

- More than 80% of adults do not meet the guidelines for both aerobic and muscle-strengthening activities.
- More than 80% of adolescents do not do enough aerobic physical activity to meet the guidelines for youth (*Physical activity*, 2012).

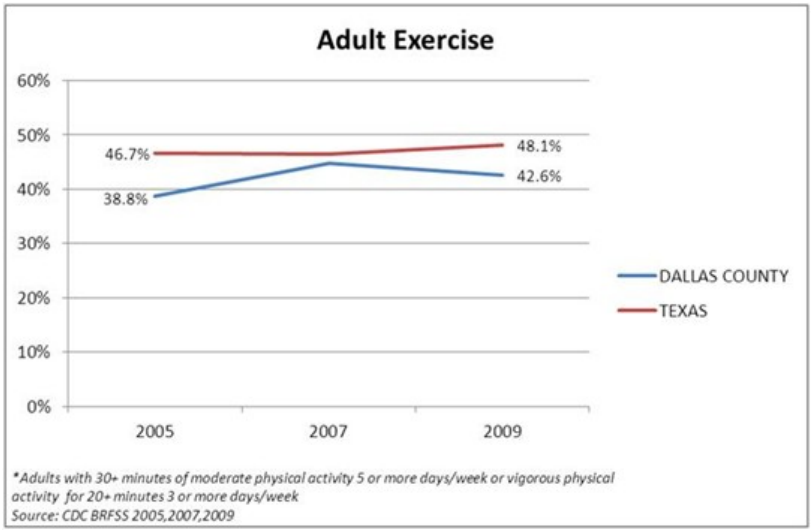
Table 4.12

Factors Associated with Pursuing Physical Activity	
Positive Factors	**Negative Factors**
Postsecondary education	Advancing age
Higher income	Low income
Enjoyment of exercise	Lack of time
Expectation of benefits	Low motivation
Belief in ability to exercise (self-efficacy)	Rural residency
History of activity in adulthood	Perception of great effort needed for exercise
Social support from peers, family, or spouse	Overweight or obesity
Access to and satisfaction with facilities	Perception of low health
Enjoyable scenery	Being disabled
Safe neighborhoods	Transportation and cost of Program
Source: *Healthy People 2020*	

Dallas County

Between 2006 and 2010 Texas resident's physical activity gradually increased. Dallas County, on the other hand, did not have a steady trend and physical activity declined 6.5% during this time period (Refer to Figure 4.99).

Figure 4.99



Schools

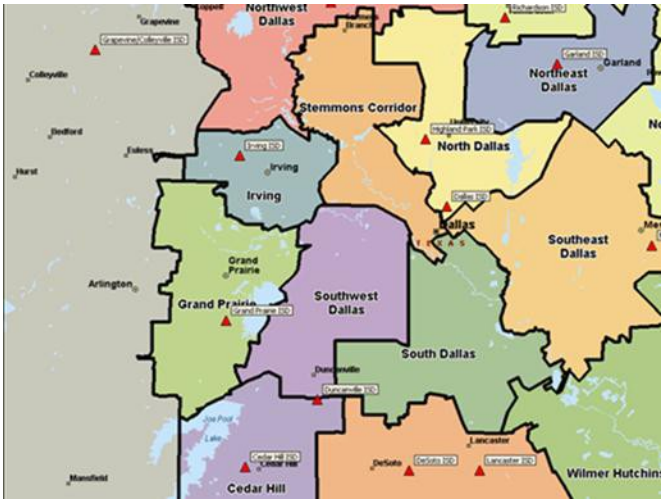
Dallas County schools are required to test the fitness levels of all students enrolled in physical education classes. Table 4.13 demonstrates that fitness levels decline with increasing student grade/age. The percentages reflect students that pass at least five of six fitness tests.

- Third graders have the highest percentages, ranging from a low of 19% in Duncanville ISD to a high of 49% in Highland Park ISD.
- Among high school seniors, percentages range from zero (possibly not required to take physical education) to 23% in Coppell ISD.
- A map of school district headquarters is presented in Figure 4.100.

Table 4.13

Dallas County Schools Student Fitness—Using "FitnessGram"					
Physical Fitness Assessment Initiative Data by District 2009-2010 School Year		**Percent Completing 5+ Healthy Fitness Zones (Tests)****			
Service Area	**School District**	**Grade 3**	**Grade 6**	**Grade 9**	**Grade 12**
NE Dallas	Garland ISD	39.9%	34.8%	17.1%	11.8%
NW Dallas	Coppell ISD	48.3%	41.4%	41.1%	22.8%
Dallas	Dallas ISD	23.2%	15.7%	5.3%	4.8%
Grand Prairie	Grand Prairie ISD	28.3%	19.2%	22.6%	15.8%
NW Dallas	Carrollton/Farmers Branch	42.8%	28.1%	24.8%	8.1%
Cedar Hill	Cedar Hill ISD	41.6%	14.7%	9.4%	2.9%
Outer NE Dallas	Sunnyvale ISD	45.3%	32.7%	37.2%	21.3%*
North Dallas	Highland Park ISD	48.8%	54.5%	14.3%	0.0%
Irving	Irving ISD	31.0%	20.5%	13.1%	7.9%
DeSoto Lancaster	DeSoto ISD	32.7%	27.5%	6.3%	9.6%
Dallas	Duncanville ISD	19.1%	25.2%	0.3%	2.0%
DeSoto Lancaster	Lancaster ISD	27.1%	19.9%	0.0%	0.0%
SE Dallas	Mesquite ISD	31.0%	18.9%	15.3%	9.5%
Outer NE Dallas	Richardson ISD	41.2%	42.3%	28.9%	12.2%
* Sunnyvale ISD had no reported 12th grade scores, 11th grade was substituted. **Includes only students enrolled in physical fitness class.					
Source: http://www.tea.state.tx.us/FitnessData.html					

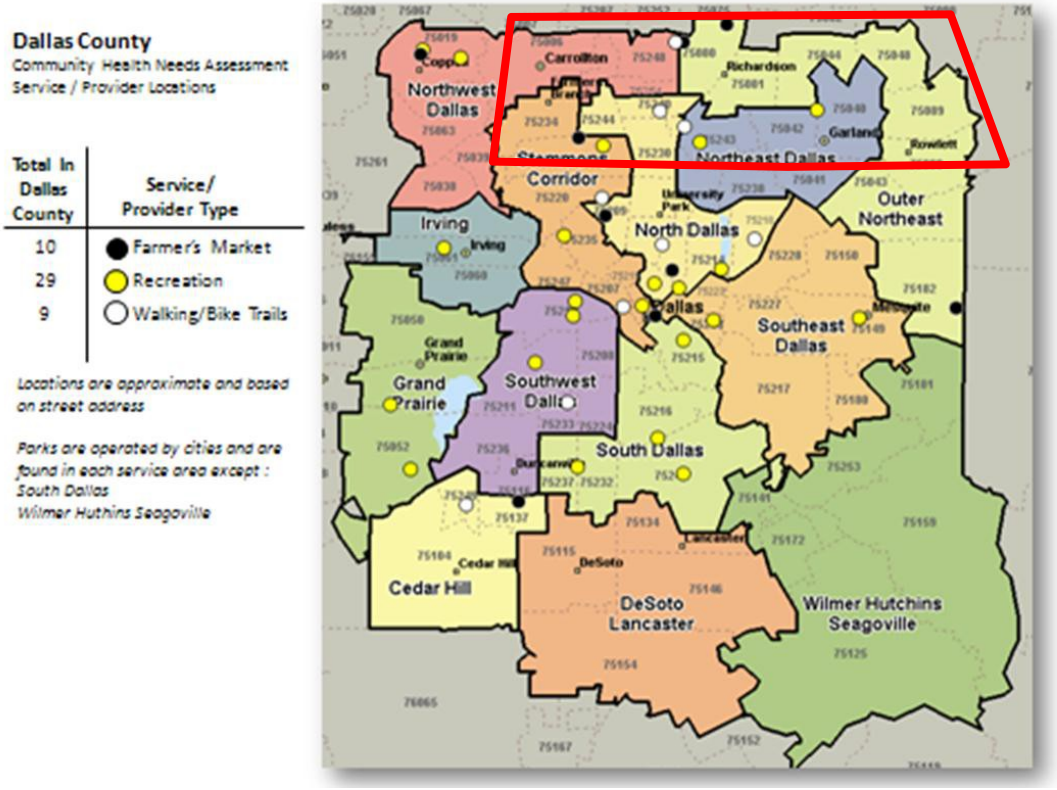
Figure 4.100



Farmer's Markets, Recreation Centers and Walking/Bike Trails

Dallas County has a strong network of recreation centers, including YMCAs and Boys and Girls Clubs. However, none are located in Outer NE, Wilmer Hutchins Seagoville, or DeSoto Lancaster. Locations of these and other recreation centers are presented in the map in Figure 4.101 below.

Figure 4.101



Parks

The City of Dallas provides details on each of its parks through its parks and recreation website. The City park system includes over 18,000 acres of parks with a wide range of amenities.

The table below categorizes City of Dallas parks by community and expands that list with parks in other cities/communities in the County. In all, 545 parks were identified in all communities throughout Dallas County.

Table 4.14

Dallas County Parks by Community	
Community	**Number of Parks**
Cedar Hill	30
DeSoto Lancaster	24
Grand Prairie	9
Irving	31
North Dallas	67
Northeast Dallas	34
Northwest Dallas	74
Outer North East Dallas	37
South Dallas	68
Southeast Dallas	63
Southwest Dallas	44
Stemmons Corridor	52
Wilmer Hutchins Seagoville	12
Total	545
For communities outside the City of Dallas, park information was obtained by internet searches by ZIP code.	

Tobacco Use

Tobacco use in Dallas County is decreasing, but 16% of the population continues to smoke.

Tobacco use is the single most preventable cause of death and disease in the United States. The hazards of tobacco use are well known.

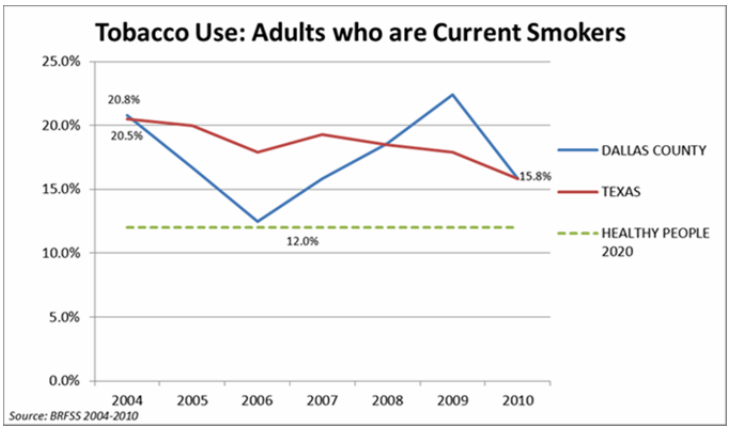
- Cigarette smokers are at high risk for cancer, heart disease, respiratory diseases, and premature birth.
- Secondhand smoke causes heart disease and lung cancer in adults and asthma, respiratory infections, ear infections and sudden infant death syndrome (SIDS) in children.
- Smokeless tobacco causes serious oral health problems, including mouth and gum cancer, periodontitis, and tooth loss.
- Cigar and pipe use causes cancer of the larynx, mouth, esophagus, and lung (*Tobacco use*, 2012).

Dallas County

Smoking is declining in Dallas County and Texas.

- Between 2004 and 2010, smoking declined 24% in both Dallas County and Texas.
- While Texas experienced a steady downward trend, Dallas County has been more erratic with 15.8% reporting smoking in 2010.
- The *Healthy People 2020* goal is 12% (Figure 4.102).

Figure 4.102



HEALTH LITERACY

Increasing health literacy may be a key to improving the health of Dallas County residents.

Healthcare literacy is essential for patient, family and provider to understand the components of patient engagement. Providers must maintain awareness of the healthcare literacy level of the patient and respond accordingly. Acknowledgement and appreciation of diverse backgrounds is an essential part of the engagement process (*Nursing experts*, 2012).

The Agency for Healthcare Research and Quality (AHRQ) has defined health literacy as the ability to obtain, process, and understand basic health information and services needed to make appropriate healthcare prevention and treatment decisions. This includes language proficiency to comprehend prevention and treatment measures. Low health literacy is associated with:

- Poor management of chronic diseases,
- Poor ability to understand and adhere to medication regimes,
- Increased hospitalizations,
- Poor health outcomes (*Health literacy universal precautions toolkit*, 2010).

People with low health literacy may also have difficulty:

- Locating providers and services,
- Filling out complex health forms,
- Sharing their medical history with providers,
- Seeking preventive healthcare,
- Following prescription instruction,
- Following general treatment compliance timelines (*About health literacy*, n.d.).

The Health Resources and Services Administration (HRSA) reports that low health literacy is more prevalent among:

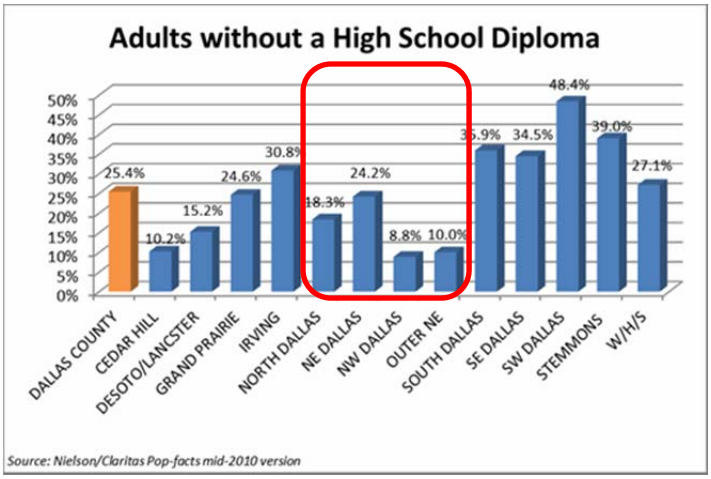
- Older adults,
- Minority populations,
- Those who have low SES,
- Medically underserved people (*Health literacy*, n.d.).

Dallas County

While health literacy data is limited, general literacy data can be extrapolated. In Dallas County, nearly 375,000 adults age 16 and over do not meet basic literacy skills.

- This is 21% of the 16 and older population.
- Over a quarter of Dallas County residents have not completed high school.
  - The communities with the largest percentages without high school diplomas include SW Dallas, Stemmons Corridor, South Dallas, SE Dallas and Irving.
- Thirty-nine percent (39%) of the Dallas County population speaks a language other than English at home.

Figure 4.103



Medical Homes Promote Health Literacy

A 2001 study by Becker found that community members who are insured and have a regular physician were much more knowledgeable about their illness than were the uninsured. Therefore, developing medical homes will support health literacy by:

- Providing personalized, family-centered care and treatment.
- Increasing provider understanding of patients' literacy levels and providing appropriate educational materials.
- Delivering care with culturally competent, multidisciplinary teams.
- Providing appropriate follow-up to confirm and reinforce patient understanding and compliance.

FOCUS GROUPS AND KEY INFORMANTS SUMMARY

A. FIVE MOST IMPORTANT HEALTH NEEDS – FOCUS GROUPS

Each participant of the Dallas County Health and Human Services/New Solutions, Inc. focus group identified the "Five Most Important Dallas County Health Needs that should be addressed over the next Three to Five Years." The most frequent responses are presented below followed by specific comments.

1. Healthcare Access

- Access to primary care
- Affordable, accessible needed by everyone, especially the working poor
- Access to healthcare—South and West side
- Healthcare Access/Disparities –Identify geographic service areas and populations to enhance access to services by identifying gaps in access/services

2. Healthy Lifestyles

- Overall fitness—including dental, diet and nutrition, access to food, community gardens—especially Cedar Hill, South and SW Dallas
- Continuing education program for health lifestyle—eating, portion control
- Healthier food choices in low income neighborhoods—south Dallas, SE Dallas, west Dallas and east Dallas
- Access healthy food—in areas identified as food deserts
- Access to affordable nutrition—should be based on data where there are shortages
- Healthy lifestyles—African-American, Latino, and immigrant populations
- Develop infrastructure and make appropriate changes to encourage healthy lifestyles—target population groups and communities who would benefit greatly from these investments

3. Health Education and Health Literacy

- Health Education—African-American, Latino, and immigrant populations
- Information, awareness and education across the whole county
- Enhance educational opportunities and social services/health education—Identify communities that require specific targeted measures related to obesity, diabetes, prevention and education
- Health Education—marketing healthy behaviors through TV, Hispanic radio and TV, church and schools—particularly target SW Dallas
- Community outreach—take education to the area of need

4. Safe Places/Centered Communities.

- Able to walk to groceries, healthcare, schools
- Access to safe physical activity—should be based on data showing high risk areas
- Safe places to play throughout the county
- Develop infrastructure and make appropriate changes to encourage healthy lifestyles—target population groups and communities who would benefit greatly from these investments

5. Behavioral Health

- Mental health treatment—this will prevent so many other health needs—uninsured, low income in all areas but especially those with lowest education and income
- Changing attitudes about it
- Behavioral health and physical health integration

The Parkland Health and Hospital System focus group was comprised of five members of the community advisory boards of COPC clinics, which are conveniently located neighborhood health centers. The five most important health needs to improve community health identified by this group included:

1. Access to care – primary and specialty care
2. Education, health literacy, knowledge of services
3. City infrastructure – community centers, bike trails, etc.
4. Behavioral health/substance abuse – including changing attitudes about it
5. Healthy community conversations – bringing together stakeholders

B. TOP PRIORITIES TO IMPROVE DALLAS COUNTY RESIDENTS' HEALTH—KEY INFORMANTS

1. Support Healthy Communities

- Healthy Communities—community wide initiative in community gardens, public safety and community health. Evaluate, improve and strive for excellence in student diet.
- Community health—mobilize churches, volunteers—make it very specific and very targeted
- Prevention should focus on four things that can improve health: Obesity—nutrition; healthy food access; Exercise; Tobacco Reduction—stop smoking; Reduce alcohol. These are cross cutting.
- Good preventive health habits
- Us a total healthy family approach
- Health literacy

2. Healthcare Access

- Understanding the healthcare system and how to access it when you need to access it—using other resources than the ED. People end up in the ED or not doing anything at all—then they get into a situation that is worse than it needs to be—it is a conundrum.
- There is a huge gap for the near poor (very low income, close to the poverty level but who don't qualify for benefits). There is no Medicaid available for this group.

- They need financial assistance planning for seniors. Seniors need to manage the little money they have.

3. Multiple Chronic Diseases

- Limited individual health education and understanding. Group education does not seem to catch on. Health practitioner with one on one is needed due to complicated diagnoses—these patients can be very complicated.
- Chronic disease—tremendous need—for basic primary care doctors. People call their elder support program and have trouble finding a doctor. Many do not accept Medicare.
- Diabetes

4. Behavioral Health

- Mental Health
- Incorporating needed behavioral health treatment in medical diagnoses will improve outcomes, reduce costs, and reduce readmissions
- The whole (behavioral health) system is at a breaking point. Have/need outpatient structure to keep people out of crisis.
- Need a redesign of crisis services. They are backing up medical ERs
- Need to integrate services and integrate data tracking

5. Violence and Injury

- Violence Prevention in Low communities with low SES
  - "When we got the mom's group together, our first priority was domestic violence then child abuse. We have a handle on these now, but now there is youth violence—in every school.
  - One-on-one mentoring is the most effective (intervention) once youth are at that age. Once they are grown men—never possible.
  - Need more programs, but they are hard to run and hard to make successful.
  - A lot of violence—Hispanics and Blacks and everyone picks on refugees."

6. Infrastructure

- Need a cross sector advisory group to become authority on improving health.
- Harness systems by using industrial engineers skill and competence with a description of what is in place and how the community might use these resources in a more efficient/cost-effective way to get more bang for the buck.

ASSETS AND GAPS ANALYSIS

The top assets in Dallas County include: national health experts in Dallas County, strong disease intervention structure, immunization services, STD/HIV screening treatment, and support services, and maternal and child health resources. The following detailed review of assets and gaps integrates results of this CHNA for each topic including data analysis, focus group findings and key informant comments.

Dallas County Demographics, Socioeconomics and Infrastructure

Assets

- Dallas County is a growing and thriving area with a business-friendly environment and very low unemployment. In mid-2010, unemployment was 6.2% or lower in 10 of 13 communities.
- Dallas County is headquarters for many national and regional businesses as well as home to many strong local companies.
- Between 2000 and 2010, the County's population increased over 20% to nearly 2.4 million people.
- Racial and ethnic diversity provide a strong foundation for the County.
- Suburban communities in the northern half of Dallas County tend to have higher SES and higher educational attainment.
- A wide range of coalitions and collaborative bring together businesses, hospitals and healthcare systems, insurers, and community-based organizations to develop programs improve the health of Dallas county residents.

Gaps

- Between 2000 and 2010, the City of Dallas population increased 1% while Dallas County population increased 20%.
- Dallas County has a high percentage (24.5%) of residents without a high school diploma.
- Communities in the southern half of Dallas County tend to have lower educational attainment and lower SES..
- Safety is an issue in some southern sector neighborhoods with high homicide rates.
- Focus group participants and key informants discussed organizations operating in "silos," reducing overall resources and effectiveness for the community. Competitiveness, particularly related to funding, was identified as a cause of limited collaboration.

Healthcare Access

Dallas County communities with low socioeconomic status experience disparities in health status and access to resources. These disparities are evidenced by uninsured status, limited access to primary care physicians and health services, and inappropriate use of hospital/emergency department services for conditions that could have been treated with preventive and primary care.

Assets

Services

- Access to immunization services.
- Access to STD/HIV screening, treatment, and support services.
- Nationally recognized, top quality hospitals and healthcare systems throughout Dallas County.
- Leading edge acute care services.
- Health systems are reaching out into the community to provide clinical prevention services, primary care and an array of outpatient services (i.e. radiology, ambulatory surgery, etc.).
- Medical homes that provide clinical prevention, primary care and post-acute follow-up using a multidisciplinary team lead by primary care physicians (PCP) are beginning to be implemented throughout Dallas County. Medical homes targeting the chronically ill and disabled are a particularly efficient and effective use of resources.
- Parkland COPC and Student and Family Clinics are well distributed throughout Dallas County.
- Parkland COPC sites offer a range of services in addition to primary care. These include women's health, case management, behavioral health counseling.
- Available free/low cost dental treatment for adults and children with sites co-located with COPC clinics and other locations in the county.

Health Insurance Status

- A wide range of employers in Dallas provide private insurance coverage.
- Communities with low unemployment have low percentages of uninsured, even if overall income is low, i.e. Cedar Hill.
- Local business support of healthy communities and affordable insurance practices for businesses.
- Emerging leading accountable care resources.

Timeliness of Services

- Patient centered medical homes and accountable care organizations will increase community prevention, expand access, and improve culturally appropriate education/health literacy. All of this will result in improved health and health outcomes.

Workforce

- Dallas County organizations have a strong medical workforce, ranging from nationally renowned public health professionals, physicians, nurses, midlevel practitioners, pharmacists, case managers, mental health counselors and community health workers.
- Community health worker training resources are available from local colleges, non-profits, and other educational organizations.

Gaps

Acute and Primary Care

- Most acute care facilities are located in central and northern portions of the county.
- Limited outpatient services in southern Dallas County communities with low SES. These include adult and pediatric primary care, women's health, family planning and dental care.

- Access to primary care was identified as a top need over the next three to five years by both focus groups.
- 25% of Dallas County adults do not have a personal physician.
- Physician specialists difficult to access for uninsured/underinsured.
- Inappropriate use of emergency rooms for conditions that could have been treated in primary care settings.
- According key informants, students in low SES communities receive primary care from school nurses due to cost and convenience.
- Limited healthcare available to the undocumented population. Key informant identified reluctance to come forward for care due to deportation fears. One key informant stated, "We have four clinics nearby, but they are not being used to capacity. People fear the cost, there is a language barrier and being turned in to the government [immigration]."

Health Insurance Status

- Twenty-eight percent (28%) of Dallas County residents are uninsured. This increases to 33% of the non-elderly, non-insured population.
- A key informant stated, "There is a huge gap for the near poor (very low income, close to the poverty level but who don't qualify for benefits). Medicaid is not available for this group."
- Declining Medicaid rates, resulting in fewer physicians willing to accept these patients.
- In 2013 and 2014, expected changes resulting from the Affordable Care Act may expand access and increase Medicaid rates. However, associated issues include a physician shortage to treat the newly insured patients, and possible changes to the rate structure in 2015.

Timeliness of Services

- Use of the emergency department for treatment of conditions that could have been appropriately treated in the primary care setting identifies individuals with limited healthcare access, lack of understanding of the medical condition, and/or uninsured/underinsured status. In 2011, up to 63% of Dallas County emergency department may have been treated in a less acute setting.

Workforce

- Dallas County has a shortage of PCP, pediatric and women's health practitioners in private and public health.
- Dallas County has a maldistribution of PCP, pediatric and women's health practitioners.
- Physician shortages which will become more acute with implementation of the Affordable Care Act.

Immunizations

Dallas County Health and Human Services, Garland Health Department, and primary care hospital and clinic providers work diligently to provide required vaccines to children and adults throughout Dallas County. The result is improving vaccine rates and stable or declining disease rates.

Assets

- Children's vaccine rates improve with age. For the 2011-2012 school year, all required vaccines were provided to between 98% and 99% of entering kindergarteners.
- Immunization clinics are well distributed throughout Dallas County.
- Key informants considered immunizations very important since they are preventable diseases that should not occur.

Gaps

- Infants and children below school age have lower vaccination rates and continue to be at risk for diseases that can be prevented by immunization.
- Under 30% of adults 65 years of age and older have received the lifetime pneumonia vaccine.
  - Key informants that work with seniors suggested marketing campaigns directed toward consumers and physicians to increase awareness of this need.
- Key informants reported:
  - Lack of funding for immunizations.
  - Changes in eligibility for low/no cost immunizations.
  - Limited availability and high cost of immunizations at private pediatricians' offices.
  - College students "opting out" of the required meningitis vaccine due to cost.

Communicable Diseases

Dallas County's incidence of reportable infectious diseases is lower than the Texas average, but incidence of sexually transmitted diseases is higher than found throughout the State.

Assets

- Dallas County has strong surveillance systems to monitor and manage reportable communicable diseases. In this way Dallas County has benefited from very low rates of reportable communicable diseases.
- Dallas County has an strong refugee vaccine program that administers more than 20,000 vaccines annually to refugees moving to the county from around the world.
- A significant outbreak of West Nile virus occurred during the summer of 2012 requiring both ground and aerial spraying to address over 300 cases. Dallas County effectively implemented public health preparedness measures engaging federal, state, and local partners to monitor and control the outbreak (pending as of the date of this report).

Gaps

- Dallas County tuberculosis case rate is higher than Texas overall.
- Dallas County's 2010 gonorrhea incidence is 71% higher than Texas overall.
- Dallas County's 2010 chlamydia incidence is 39% higher than Texas overall.
- Dallas County's 2010 primary and secondary syphilis incidence is that same as Texas overall.
- Low SES communities within Dallas County tend to have STD rates higher than the county average.

  - South Dallas has the significantly higher rates than the County and other communities for gonorrhea, chlamydia and syphilis.
- HIV prevalence is increasing, and incidence is increasing in 13 – 24 year olds.
  - One-third of new HIV cases diagnosed between 2003 and 2007 converted from HIV to AIDS within 12 months, indicating late to care.
- Dallas County has alarming STD and HIV rates among youth. With the highest STD percentages among young women and HIV rates among young men of color.
- Key informant comments related to STDs and HIV:
  - "STD prevention is a huge need and very frustrating because nothing is happening. I have had trouble getting responses (from agencies for education and testing). (One agency) did a very good job in their summer program, but schools won't let them in."
  - "Chlamydia and HPV are epidemic. We have an abstinence only curriculum so there are limitations on what you can talk to students about."
  - "Kids are putting themselves at risk without knowing what they are doing."

Asthma and Other Respiratory Diseases

The burden of asthma, COPD and other respiratory diseases affects individuals and their families, schools, workplaces, and neighborhoods. The highest rates are found in the County's six southern communities.

Assets

- Dallas County has leading experts in asthma care and treatment available to area residents.
- Relative to other community health issues, key informants felt that asthma is less important. It was not identified as a top concern during the focus group discussions.
- The rate of chronic obstructive pulmonary disease is below that found throughout Texas.

Gaps

- In Dallas County the adult asthma rate is 23% above the Texas average.
- The asthma rate increases for adults over 65 years of age.
- The highest rates of asthma are found in Dallas County's southern communities.
  - One key informant commented, "Asthma is definitely increasing. The days of school and work missed are high. It is affecting the African-American population."

Cancer

Cancer mortality is declining. Additional screening, healthy lifestyles and interventions targeting residents with socioeconomic disparities are needed to further reduce mortality and achieve the Healthy People 2020 goal.

Assets

- Between 2001 and 2009, cancer deaths declined in Dallas County, Texas and the U.S.

  - Cancer mortality in Dallas County decreased by 11.4%.
- Between 2004 and 2010 the percentage of people receiving breast cancer and colon cancer screening increased.
- Dallas County is home to the national headquarters of Susan G. Komen for the Cure.

Gaps

- Despite declines in Dallas County cancer mortality, neither the County nor the State has achieved the *Healthy People 2020* Goal of 160.6 deaths per 100,000 residents.
- Cancer mortality does not vary significantly by community.
- Lung cancer is the most virulent form of cancer with the lowest incidence and the highest mortality.
- Disparities in mortality and incidence exist.
  - African-Americans have the highest 2009 age-adjusted mortality rate overall and for all types of cancer. Dallas County's overall African-American rate is higher than the Texas African-American rate.
  - In 2009, the highest cancer incidence rate by race/ethnicity was prostate cancer among African-Americans, 196.7/100,000. This was followed by breast cancer among African-Americans, 138.9/100,000.
- Between 2004 and 2010 the percentage of women screened for cervical cancer declined.
- Breast, cervical or colon cancer screening rates ranged between 61% and 76%, so large percentages of the population are not accessing these screening tests.
- Availability of cancer health behavior-related data and local ZIP code public health datasets.

Diabetes

Diabetes is a significant health concern in Dallas County with prevalence higher than both Texas and the U.S. While all communities are affected, disparities exist in the southern Dallas County communities.

Assets

- Targeted programs to address the obesity and diabetes epidemics are currently in place.
- A wide range of collaborations to combat obesity and diabetes are occurring throughout the County. Many of these combine the expertise of hospitals/healthcare providers with the cultural competence of neighborhood-focused community organizations.

Gaps

- Dallas County's diabetes prevalence is 11.4% compared to 9.6% in Texas and 8% in the U.S.
- Diabetes 2010 mortality in Dallas County was 18.8/100,000. Communities with the highest diabetes mortality are in the southern half of Dallas County, demonstrating racial and ethnic disparities. Mortality rates in these communities are as high as 27.3/100,000 in DeSoto Lancaster.
  - South Dallas residents have the highest complication rates; in many cases nearly double the Dallas County average.
  - SW Dallas, SE Dallas, Grand Prairie and DeSoto Lancaster also have high complication rates.

- Diabetes is a comorbidity in heart disease, stroke, pneumonia/respiratory failure, and kidney failure. In 2011 in Dallas County, 35% of the top five inpatient diagnoses have diabetes as an underlying condition.
- Nationally nearly 25% of people with diabetes are undiagnosed, and comments by focus group participants identify issues of "stigma," "denial," and concern for "keeping their jobs" if diagnosed.
- Availability of diabetes health behavior-related data and local ZIP code public health datasets.

Cardiovascular Disease

Cardiovascular disease (CVD), including both heart disease and stroke, is the leading cause of death in Dallas County. Cardiovascular morbidity and mortality can be reduced by reducing risk factors and improving the overall health of the community.

Assets

- In 2010, heart disease mortality declined 12% from a year earlier.
- In 2009, the age-adjusted hospitalization rate due to CVD in Dallas County was significantly lower compared to the State rate.
- Considering PQIs for congestive heart failure (CHF), Dallas County's rate decreased between 2000 and 2009 by 33%.

Gaps

- Heart disease is the leading cause of death in Dallas County.
- In 2009, the Dallas County age-adjusted mortality rate due to CVD was significantly higher compared to the State rate.
- In 2009, the age adjusted death rate for stroke was 40/100,000 in the U.S., 47/100,000 for Texas and 50/100,000 for Dallas County. The *Healthy People 2020* benchmark is 33.8/100,000.
- Mortality and morbidity data demonstrate significant disparities in the burden of cardiovascular disease based on race/ethnicity, gender, education, geographic location, and SES.
  - African-Americans had significantly higher AAMR due to CVD than all other racial and ethnic groups.
  - The Dallas County communities with large percentages of African-Americans, large percentages of residents who did not graduate from high school, and low SES are at greatest risk for morbidity and mortality from cardiovascular diseases, particularly heart disease.
- The percentage of Dallas County residents reporting high blood pressure risk increased from 21% in 2005 to 29% in 2009, a 38% increase.
- Considering the rate of hypertension PQI[11], Dallas County residents experienced a 60% increase between 2000 and 2009.
  - These indicators for hypertension and CHF identify South Dallas as the community with the most severe cardiovascular disparities. Other southern Dallas communities also experience disparities in cardiovascular risk factors and access.

[11] PQI indicates a hospitalization that could have been avoided with appropriate outpatient treatment.

Maternal Fetal Health

Latinos have the highest birthrate in Dallas County and African-Americans have the highest infant mortality and low birth weight babies.

Assets

- Dallas County teen births among 15 to 17 years olds are better than the *Healthy People 2020* goal.
- Latina percentage of very low weight births was better than the *Healthy People 2020* goal and the best of all population groups.
- The Dallas County Fetal Infant Mortality Review committee, part of the Healthy Texas Babies Local Coalition, works to improve these outcomes.

Gaps

- In 2010, while 59% of Dallas County pregnancies initiated prenatal care within the first trimester, 41% did not.
- Initiation of prenatal care in the first trimester varies by race/ethnicity. Seventy percent (70%) of Caucasian mothers initiated prenatal care in the first trimester, 57% of Latina mothers, and 50% of African-American mothers initiated prenatal care in the first trimester.
  - Four percent (4%) of Dallas County expectant families did not access prenatal care in 2010, including 6% of African-American births, 4% of Latino births and 2.4% of Caucasian births.
  - Dallas County infant mortality and very low weight births were worse than the *Healthy People 2020* goals.
  - Overall, African-Americans had the highest rate of infant mortality and the highest percentage of very low weight births.
  - Latinos had an infant mortality rate higher than the *Healthy People 2020* goal.
  - Potentially 64% of African-American fetal and infant deaths were preventable.
  - Women's health physicians are concentrated in the Stemmons Corridor community with 67 physicians/100,000 residents. Few women's health physicians are located in DeSoto Lancaster, Grand Prairie or Cedar Hill.
  - Focus group participants stated:
    - "Breast feeding campaign used to be a high priority. You no longer hear about it. It no longer seems to be a priority."
    - "Women put others ahead of themselves, so they may not get the care they need."
  - Key informant stated, "There are 34 pregnant girls at our high school at all times. Some of these girls were high achievers and excellent students."

Behavioral Health

Behavioral health (mental health and chemical dependency) is increasingly being linked to physical health indicators. Most Dallas County behavioral health indicators are equal to or better than found in Texas, but community analysis identifies areas of disparity. It is expected that in the future behavioral healthcare systems will be embedded in new structures such as accountable care organizations, integrated healthcare systems and preferred provider organizations (Jarvis, 2010).

Assets

- Dallas County residents reported mental health status that is the same as that reported by Texas residents. This included 20% who reported their mental health status was "not good" for five or more days of the last 30.
- Between 2004 and 2010 binge drinking and heavy drinking declined in Dallas County.

Gaps

- The Dallas County behavioral health system can be complex and difficult to navigate.
- The Dallas County rate of suicide mortality was considered poor in comparison to the *Healthy People 2020* target.
- Crisis service utilization has been increasing, and has been identified as a continuing service need during the key informant interviews.
- Trends in residential and outpatient substance abuse treatment suggest the capacity for treatment has not kept pace with population growth and need.
- Growth in enrollment in the behavioral health system has outpaced funding, resulting in reduced levels of treatment provided to enrollees.
- The proportion of persons served in acute care settings (emergency departments, 23-hour observation, acute inpatient units) grew dramatically (9.3%) from December 2009 through May 2010, an increase particularly driven by people without a current specialty provider network and assigned level of care.
- Underserved populations include: individuals with severe mental disorders, Latinos, people with substance abuse treatment needs, individuals with co-occurring mental health and substance abuse disorders, and special populations such as inmates, child welfare recipients and homeless individuals.
- Mortality for the mental health population is higher than for the general population.
- Key informant comments related to behavioral health included
  - "Youth and Family Clinic counseling service (in our neighborhood) has a waiting list."
  - "There is a lack of behavioral health capability for Medicaid patients."
  - "We see depression and anxiety in moms the most, but we also see it in children."
  - "Behavioral health is very important. Resource allocation is the issue—money is not available."

Violence and Injuries

Dallas County has high rates of mortality due to falls, accidental poisoning, and homicide. Supporting healthier environments can reduce the threat of unintentional injury and violence.

Assets

- In Dallas County, the 2010 unintentional injury death rate was similar to the *Healthy People 2020* goal.
- The Dallas County 2010 motor vehicle crash death rate compared favorably to the *Healthy People 2020* goal and to previous years' trends.
- Dallas County 2010 accidental poisoning death rate compared favorably to the *Healthy People 2020* goal.

Gaps

- Dallas County 2010 death rate due to accidental falls averaged 9/100,000. Death of residents age 65 and older, was more than six times higher. In both cases, this compared poorly with the *Healthy People 2020* goal.
- Dallas County's 2010 homicide death rate, 8.5/100,000, compared poorly to the *Healthy People 2020* goal.

- Focus group comments included:
  - "Violence is pervasive throughout the County and contributes to people not going outside."
  - "People don't feel safe, children don't play outside."

Diet and Exercise

Despite a strong network of parks and varied recreational options, more than half of Dallas County residents have sedentary lifestyles. This, coupled with limited access to healthy foods in the southern communities, is resulting in steadily increasing obesity among Dallas County residents.

Assets

- Dallas County has 545 parks and a wide range of recreation centers.

Gaps

- Obesity among Dallas County residents increased steadily between 2005 and 2010.
- The number of Dallas County recipients of most public assistance nutrition programs increased between 2009 and 2011
- 36% of Dallas County ZIP codes contain food deserts.
- All very high, high and moderate food desert areas are located in the southern half of Dallas County.
- Physical activity in Dallas County declined 6.5% 2006 and 2010.
- Based on school fitness testing, fitness levels among students decline with increasing student grade/age.

- Homeless persons' access and use of shelters, and the relationship to outdoor parks and recreation.
- Key informant comments included:
  - "Kids think lunch is a bag of Cheetos and a Coke. They don't have a taste for fresh foods."
  - "We had a program to bring fresh foods into schools so the children could see them."
  - "You need to offer sports of interest to various cultural groups—refugees and Latinos prefer soccer."
  - "People don't exercise because it is an unsafe neighborhood."
  - "Community prevention is critical to improve health in Dallas County."

Tobacco

Tobacco use in Dallas County is decreasing, but 16% of the population continues to smoke.

Assets

- Between 2004 and 2010, smoking declined 24% in both Dallas County and Texas.

Gaps

- While Texas experienced a steady downward trend, Dallas County has been more erratic with 15.8% reporting smoking in 2010.
- The *Healthy People 2020* goal is 12%.
- Key informants made the following suggestions:
  - Targeted anti-smoking campaigns.
  - "Prevention should focus on the four things that can improve health, and stopping smoking is one of them."
  - "Stopping smoking is a no brainer—it can significantly improve health."
- Focus group participants made the following suggestion:
  - "Enact more non-smoking restrictions and laws including no smoking in all public places and non-smoking apartment complexes."

Health Literacy

Increasing health literacy may be a key to improving the health of Dallas County residents.

Assets

- Many Dallas County community-based organizations and other providers seek to provide culturally competent, literacy-level appropriate services.
- A variety of Dallas County agencies support students' academic achievement and high school completion.

Gaps

- Nearly 375,000 Dallas County adults age 16 and over do not meet basic literacy skills. This is 21% of this population.

- Cultural competence of healthcare providers.
- Over a quarter of Dallas County residents have not completed high school.
  - The communities with the largest percentages without high school diplomas include SW Dallas, Stemmons Corridor, South Dallas, SE Dallas and Irving.
- Nearly 40% of the Dallas County population speaks a language other than English at home.
- Key informant comments related to literacy and health literacy include:
  - "I have never heard a worker say they have a problem with a patient not being able to read—it is an unrecognized problem."
  - "We have a bilingual staff for non-English speaking patients, but it is very difficult."
  - "(Clients) often have limited individual health education and understanding. Group education does not seem to catch on. One-on-one (with health practitioner) is needed due to complicated diagnoses."
  - "A big component of health literacy is educating the family members so they can provide support."
- Six focus group participants identified "health education" as a need.

Table 6.1
Disparities within each Community

	Socioeconomic Indicators 2010				Healthcare Access						Immunizations
County / Service Area	*Per Capita Household Income*	*Families Below Poverty Level*	*Unemployment (mid 2010)*	Community Needs Index (CNI)	Premature Death	Percent Uninsured	Total Primary Care to Population Ratio	Primary Care Physician to Population Ratio	Pediatricians to Population Ratio	Non-Emergency ED Visits (2009)	Mortality Due to Flu/Pnemonia
Healthy People 2020 Goal	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*0%*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
DALLAS COUNTY	$ 24,240	13.9%	8.9%	3.9	6735	28%	115	76	23	34	13.0
CEDAR HILL											
DESOTO/ LANCASTER											
GRAND PRAIRIE											
IRVING											
NORTH DALLAS											
NE DALLAS											
NW DALLAS											
OUTER NE											
SOUTH DALLAS											
SE DALLAS											
SW DALLAS											
STEMMONS											
W/H/S											

Methodology: Using the Dallas County avg. as the midpoint, service areas with indicator values +/-20% were considered the Same = Yellow; Better = Green; Worse = Red.

	Communicable Diseases				*Flu and Other Respiratory Diseases*		*Cancer*	*Diabetes*				
County / Service Area	**Gonorrhea Incidence**	**Chlamydia Incidence**	**HIV Mortality**	**Syphilis Incidence**	**Rate of Adult Asthma, 2008**	**Rate of Asthma Adults under 40, 2010**	**Total Deaths due to Cancer**	**Mortality Due to Diabetes**	**Long Term Diabetes Complications**	**Short Term Diabetes Complications**	**Lower Extremity Amputation due to Diabetes**	**Uncontrolled Diabetes**
Healthy People 2020 Goal	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*0%*	*160.6*	*65.8 (Related Deaths)*	*0%*	*N/A*	*N/A*	*N/A*
DALLAS COUNTY	211.70	580.7	4.25	12.2	91.1	15.8	166.5	18.8	134.3	62.9	20.6	18.1
CEDAR HILL												
DESOTO/ LANCASTER												
GRAND PRAIRIE												
IRVING												
NORTH DALLAS												
NE DALLAS												
NW DALLAS												
OUTER NE												
SOUTH DALLAS								R				
SE DALLAS												
SW DALLAS												
STEMMONS												
W/H/S												

Methodology: Using the Dallas County avg. as the midpoint, service areas with indicator values +/-20% were considered the Same = Yellow; Better = Green; Worse = Red.

	Cardiovascular Disease				*Maternal-Fetal Health*					
County / Service Area	**Deaths due to Cardiovascular Disease**	**Deaths Due to Stroke**	**PQI Rate of Hypertension**	**PQI Rate of Congestive Heart Failure**	**Teen Births, 15-17**	**No Prenatal Care**	**Early Initiated Prenatal Care %**	**Infant Mortality**	**Very Low Birth Weight %**	**Women's Health Physicians**
Healthy People 2020 Goal	*100.8*	*33.8*	*N/A*	*N/A*	*36.2*	*N/A*	*77.9%*	*6*	*1.40%*	*N/A*
DALLAS COUNTY	174.9	47.0	72.9	353.6	32.9	4.0%	58.9%	7.5	1.6%	16.1
CEDAR HILL										
DESOTO/ LANCASTER										
GRAND PRAIRIE										
IRVING										
NORTH DALLAS										
NE DALLAS										
NW DALLAS										
OUTER NE										
SOUTH DALLAS										
SE DALLAS										
SW DALLAS										
STEMMONS										
W/H/S										

Methodology: Using the Dallas County avg. as the midpoint, service areas with indicator values +/-20% were considered the Same = Yellow; Better = Green; Worse = Red.

	Behavioral Health	*Violence and Injuries*					
County / Service Area	**Suicide Mortality Rate**	**Unintentional Injury Death Rate**	**Rate of Injury Related ED Visits**	**Death Due to Accidental Fall**	**Motor Vehicle Crash Death**	**Accidental Poisoning Mortality Rate**	**Homicide Death Rate**
Healthy People 2020 Goal	*10.2*	*36*	*n/a*	*7*	*12.4*	*13.1*	*5.5*
DALLAS COUNTY	10.6	33.45	50.3	8.72	9.79	7.51	7.27
CEDAR HILL							
DESOTO/ LANCASTER							
GRAND PRAIRIE							
IRVING							
NORTH DALLAS							
NE DALLAS							
NW DALLAS							
OUTER NE							
SOUTH DALLAS							
SEDALLAS							
SWDALLAS							
STEMMONS							
W/H/S							

Methodology: Using the Dallas County avg. as the midpoint, service areas with indicator values +/-20% were considered the Same = Yellow; Better = Green; Worse = Red.

TOP 5 HEALTH ISSUES IMPACTING DALLAS COUNTY RESIDENTS

After reviewing CHNA data and findings presented in Sections 1 through 4, the PHI Workgroup identified the top health issues that impact Dallas County residents as follows:

Chronic Disease—Multiple Diagnoses

Dallas County residents are increasingly being diagnosed with having more than one chronic disease, including, cancer, diabetes, and cardiovascular disease. Addressing common risk factors through health programs, medical homes, screening, and improved personal fitness can improve the overall health of our residents.

Healthcare Access—Health Insurance Coverage and Physician Shortage

Dallas County has a large portion of residents who are uninsured. Implementation of the Affordable Care Act will impact the percentage of adults and children receiving health insurance coverage, and will also impact physician to population ratios for the insured. The changing environment will call for monitoring provider acceptance of new patients by payment source, as well as a need to inform eligible persons of any changing insurance eligibility requirements. There is also a shortage of primary care physicians, and they are maldistributed within the county thereby leaving areas underserved.

Health Disparities—Resource Deserts

Portions of suburban areas and large geographic areas of southern Dallas County often suffer from disproportionate disease rates and substantial resource deserts. These deserts lack key resources that other portions of the county have, including access to health services—primary and specialty care—and access to healthy foods.

Infrastructure—Unifying Prevention Efforts and Maximizing Resources

Dallas County has an abundance of health programs and improvement plans currently being implemented in silos. Collaboration to increase awareness of countywide efforts, while reducing competition for financial resources, is critical to maximize available public health funds.

Mental and Behavioral Health—Illness Impact on Health Decisions

Individuals in Dallas County suffering from mental and behavioral illnesses face decision-making barriers. These barriers impact compliance with preventive care and treatment thereby compromising aspects of their physical health also.

This list is the result of a workgroup vote on a larger list of issues determined based on the qualitative and quantitative data (Appendix E). Key findings and details for these critical health issues are as follows:

CHRONIC DISEASE—MULTIPLE DIAGNOSES

Similar to national trends, Dallas County residents are exhibiting increasing diagnoses for chronic conditions. It is common that the pathology for one condition may also affect other body systems, resulting in co-occurrence of multiple chronic conditions (MCC). The presence of MCCs adds a layer of complexity to disease management.

Key Findings

- A key finding from "Regional Health Partnership 9: Community Needs Assessment Report" is that many individuals in Dallas County suffer from "chronic diseases that present earlier in life, are becoming more prevalent, and exhibit more severe complications."

- The resource implications for addressing multiple chronic conditions are significant: 66% of total healthcare spending is directed toward care for the approximately 27% of Americans with MCC. These costs are incurred by the individual, the insurer and the healthcare system (*Multiple chronic conditions*, 2010).

- Nationally between 2000 and 2010, the percentage of adults aged 45–64 with two or more chronic conditions increased 20% for African-Americans, 35% for Caucasians, and 31% for Latinos. During this period, the prevalence of two or more chronic conditions among those aged 65+ increased 18% for African-Americans, 22% for Caucasians, and 32% for Latinos (*NCHS data briefs*, 2012).

- To address gaps in care coordination, several models that have emerged in recent years emphasize patient-centered multidisciplinary care, provider communication and cooperation to smooth transitions across settings, and incorporation of public health and community resources. These models include patient-centered medical homes, community health teams, accountable care organizations, primary care and behavioral health integration models (*Multiple chronic conditions*, 2010).

- Due to the complexity associated with MCC, effective daily management can be difficult. This is compounded for seniors with cognitive or mobility issues and persons with low health literacy. One key informant stated, "It is a lot to process—the easiest way to deal with it is to ignore it."

- Key informants discussed the importance of community prevention in reducing the incidence of chronic conditions. It was further stated, once a person is diagnosed with MCC, it is important to get acute care and post-acute care to work together "so they are no longer working in silos."

HEALTHCARE ACCESS—HEALTH INSURANCE COVERAGE AND PHYSICIAN SHORTAGE

Access to community prevention, clinical prevention, quality medical care and supportive post-acute services will promote the health of Dallas County residents. Expanding access requires: (1) enhanced service networks, (2) increased access to health insurance, (3) improved health literacy to promote individual access, and (4) reduced access barriers.

Key Findings

- Nearly 25% of Dallas County residents are uninsured with an even higher percentage among those with low socioeconomic status.
- Low and no-cost primary care clinics are available in many communities throughout the County. These offer a range of general medical, women's health, pediatric and dental treatment.
- Nevertheless, over 60% of emergency room visits are for conditions that could have been treated in a primary care setting.
- The patient centered medical home model of care supports access to prevention, treatment and post-acute care.
- Physicians are concentrated in the Stemmons Corridor and in northern suburbs. A shortage and maldistribution of primary care physicians and other public health personnel exists within the county resulting in underserved areas, particularly in the southern communities with lower socioeconomic status.
- A finding of the Regional Health Partnership 9: Community Needs Assessment Report states, "The demand for primary and specialty care services exceeds that of available medical physicians in these areas, thus limiting healthcare access for many low level management or specialized treatment for prevalent health conditions (Collins, 2012, p. 5).
- Literacy rates in Dallas County are low, with 25% of the population without a high school diploma, and nearly 40% of the population speaking a language other than English at home. This translates to potentially low levels of health literacy.
- Dallas County has a strong professional and para-professional healthcare workforce, as well as excellent educational/training programs. This increases availability of nurse practitioners, physician assistants, nurse, pharmacists, social works/case manager, patient navigators and community health workers and others to provide services and support access.

HEALTH DISPARITIES—RESOURCE DESERTS

Disparities are found within southern Dallas County and pockets of suburban areas. These communities suffer from high levels of unemployment, low socioeconomic status, disproportionate disease rates, and substantial resource deserts. These areas lack key resources including access to health services, safe environments and healthy foods.

Key Findings

- Dallas County residents living poverty exhibit the worst health status. Employment, education, income, and race are important factors in a person's ability to access healthcare.

- Health disparities are closely linked with social, economic, and environmental disadvantage such as lack of access to quality affordable healthcare, healthy food, safe opportunities for physical activity, and educational and employment opportunities. In Dallas County, disparities can be found in:
  - Communities with limited access to community prevention services as evidenced by high rates of diabetes associated with obesity and poor cardiovascular health associated with smoking, obesity and sedentary lifestyles.
  - Communities with limited healthcare access identified by high percentages of residents without health insurance and limited access to primary care services.
  - Low SES communities that have health outcomes below the County average.
  - Communities with food deserts.
    - A recommendation of 2011 Beyond ABC: Assessing Children's Health in Dallas County" is to "work to eliminate food deserts in southern and western Dallas County." (2011 Beyond ABC, 2011, p.14).

- The United Way of Metropolitan Dallas Health Value Statements include: Given current and projected population demographics, there must be an even stronger focus on culturally and linguistically sensitive care."

- Health disparities in communities with low socioeconomic status were discussed in detail during the focus groups and key informant interviews. All agreed that health services, interventions, and education must be culturally competent, educationally appropriate, and linguistically appropriate.
  - Two different programs targeting Latina diabetics with disease management and nutrition education classes were identified as effective. These are delivered in their communities, in Spanish, incorporating culturally appropriate foods.
  - A key informant stated, "Communities with low SES often have no community center, no library, no churches, no place for people to go. The only possibilities are the new schools that are empty at night and on the weekend."

INFRASTRUCTURE—UNIFYING PREVENTION AND MAXIMIZING RESOURCES

Dallas County has a wide range of health programs and improvement plans which are often being implemented in silos. Effective collaboration will enhance countywide efforts and maximize available public health personnel and funds.[12]

Key Findings

- The importance of effective collaboration is recognized by health planning groups throughout Dallas County. These needs assessments recommend collaboration as a strategy. These organizations include:
  - United Way of Metropolitan Dallas
  - Regional Health Partnership 9
  - Behavioral Health Leadership Team

- Successful collaboration requires personnel and financial resources. It takes skill to effectively convene and lead without having the coalition "owned" by one organization.

- Key informants identified three different collaboratives/coalitions with excellent value propositions that were not able to be established due to lack of funding.
  - Competition for funds was identified as an important reason that organizations work in silos.

- Key informants, as members of coalitions throughout the County, had suggestions for developing and expanding the collaborative infrastructure. Specifically:
  - "Lead the way on collaborations that have 'punch.' Don't just create reports. Bring high ranking people together to solve a problem."
  - Coalitions can be small and local—draw in community leadership, churches, schools.
  - "Must have measurable results."
  - "Work with public-private partnerships."

- Coalition building presents an opportunity for public health. Key informant comments included:
  - "The Health Department can do some things that could inform others—serve as the backbone for funding opportunities."
  - "Representatives of the Health Department would be welcome at all coalitions."
  - "The Health Department will give credit and credibility (to collaborations)."

- A strong, regional accountable care organization (ACO) is being developed for the north Texas region. It focuses on improved quality, cost savings and enhanced care coordination using technology and collaboration. One key informant stated, "[The North Texas Accountable Healthcare Partnership] will be the medical providers to those with means."
  - DCHHS, PHHS and representatives of other organizations serving those without insurance and with low SES may benefit from collaborating with NTAHP.

[12] A list of coalitions identified during the key informant interviews is provided in Appendix F.

MENTAL AND BEHAVIORAL HEALTH—IMPACT ON HEALTH DECISIONS

Dallas County residents suffering from behavioral health illnesses confront decision-making barriers. These impact compliance with preventive care and treatment thereby compromising aspects of their physical health.

Key Findings

- The behavioral health service continuum is limited with bed shortages for residential substance abuse treatment and acute psychiatric treatment, no outpatient partial hospital services and limited intensive outpatient services. Users also experience limited service access, reduced length of treatment, and increased utilization of crisis services for financial reasons.

- A detailed behavioral health needs assessment was conducted in 2010. Development of the Dallas County Behavioral Health Leadership Team was among the recommendations. This group is now leading the following activities:
  - Primary Care-Behavioral Health Integration
  - Improvement, expansion and integration of the crisis intervention and acute care management continuum of care
  - Recovery-oriented systems of care and services for mental health and substance use disorders.
  - Services for cultural and linguistic minorities.

- A finding of the Regional Health Partnership 9: Community Needs Assessment Report states, "Behavioral health, either as a primary or secondary condition, accounts for substantial volume and costs for existing healthcare providers, and is often utilized at capacity, despite a substantial unmet need in the population (Collins, 2012, p.5).
  - Development of services to treat behavioral health conditions will support overall community health in Dallas County.

- Key informants' comments included:
  - "We have to consider behavioral health's role in other priorities and it weave into these. Behavioral health is not a stand alone issue."
  - "Patient navigators and peer support works well in behavioral health. A national leader in this field is located in Dallas (and can serve as a resource)."
  - "The whole (behavioral health) system is at a breaking point. We need and outpatient structure to keep people out of crisis. We need a redesign of crisis services. These patients are backing up medical ERs."
  - "Psychiatry is a loss preventer—every single other focus area will have poorer outcomes if they (patients) have behavioral health comorbidity."
  - "Lack of behavioral health capability for Medicaid patients."
  - "Health literacy—depression affects the ability to focus and understand."

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APPENDIX A

DALLAS COUNTY PUBLIC HEALTH IMPROVEMENT WORKGROUP

Martha Blaine, MBA	Community Council of Greater Dallas
Richard Briley, MS	City of Garland Health Department
Ray Bunyard, CPA	Baylor Health Care System
Leslie Casey	Health Industry Council Jennifer
Coleman, MA	Baylor Health Care System
Summer Collins, MPH	Dallas/Ft. Worth Hospital Council
Cece Cox, JD	Resource Center Dallas
Rhonda Dalfonso, RN	Desoto ISD
Natalie Dean-Wood, FACHE	Texas Health Resources
CDR James Dickens, FNP-C, FAANP	CDC Regional Minority Health Consultant
Jennifer Edwards, PhD	Dallas County Health and Human Services
Forney Fleming, III, MD, MBA	University of Texas at Dallas
Devin Hill, MBA	Baylor Health Care System Dena
Jackson, PhD	Dallas Women's Foundation
Kristin Jenkins, JD, MBA, FACHE	Dallas/Ft. Worth Hospital Council
Loretta Johnson	Urban League of Greater Dallas
Edward Jones	AIDS Arms
Suzanne Kubelka	Dallas Independent School District
Brenda Lockey, MBA	Methodist Health System
Leonor Marquez, MBA, MSW	Los Barrios Unidos Community Clinic
Sue Pickens, MEd	Parkland Health and Hospital System
Jill Scigliano	United Way
Joyce Tapley, MHA	Martin Luther King Jr. Family Health Clinic
Vikki Yeatts, MSN, RN	City of Garland Health Department

BIOGRAPHIES: DALLAS COUNTY PUBLIC HEALTH IMPROVEMENT WORKGROUP

Martha T. Blaine, MBA is the Executive Director of the Community Council of Greater Dallas, a position she has held for seventeen years. In her 45 years of nonprofit leadership she also held executive positions with MADD – Dallas Chapter; the Dallas Symphony Orchestra, The Science Place Dallas; and arts organizations across the country. Early in her career she was a professional flutist, performing with orchestra ballet and opera companies. As the Executive Director of the Community Council of Greater Dallas she leads a staff of 75 in advocacy efforts on a wide variety of human service issues; directs the Dallas Area Agency on Aging, providing services for people ages 60+; provides oversight of the 2-1-1 North Texas Region - Dallas information and referral service assisting 541,000+ people annually; and supervises the Coalition and Planning division which facilitates community-wide collaborative efforts to prevent childhood obesity, improve infrastructure in the Vickery Meadow Neighborhood, and enroll children and families in CHIP and Children's Medicaid. Ms. Blaine earned a Bachelor in Music from Manhattan School of Music New York, and her MBA in nonprofit management from the Anderson Graduate School of Management at UCLA. Ms. Blaine is the Treasurer of the National Association of Planning Councils. In 2009 she won the Changemaker: Women in Business Award from the Dallas Business Journal.

Richard Briley, MS is the Managing Director of Health & Code Compliance for the City of Garland. He directs the operation of five municipal departments: Environmental & Consumer Health, Clinical Services, Animal Services, Neighborhood Standards and Housing Standards. Richard has been with the City of Garland for twenty-two years. Prior to coming to the Garland Health Department, he served four years as County Sanitarian for Hunt County, Texas. He received his B.S. and M.S. degrees in Biological Sciences from Texas A&M University – Commerce. He has authored fifteen journal publications related to environmental health inspection methods and public health management. Richard has written several opinions on Environmental Health policy at the request of the Texas Attorney General's Office. He served as an elected officer in the Texas Environmental Health Association for fifteen years, acting as the organization's President in 2004. Currently, as part of the Garland City Manager's Administrative Team, Mr. Briley is active in initiating new projects to ensure vital neighborhoods; track departmental performance measures and develop policy that assure Garland's residents of a safe and healthy community to call home.

Ray Bunyard, CPA is Vice President of Tax Management for Baylor Health Care System, a large, multi-hospital, integrated healthcare delivery system including both tax exempt and for profit entities. Ray has been with Baylor for over 14 years and is responsible for the direction and oversight of the tax planning and compliance matters and the community benefits reporting for the system. He also participates in the physician contracting review and approval process and for the system. Ray is a certified public accountant in the State of Texas and is a member of the Texas Society of Certified Public Accountants. He currently serves as a member of the IRS Gulf Coast Tax Exempt/ Governmental Entities Council and has participated in several projects with the American Hospital Association, Texas Hospitals Association and other organizations regarding the Form 990 reporting, community benefit reporting and other tax related issues facing nonprofit tax exempt entities.

Leslie Casey has 17-years of experience in Marketing with a concentration in Healthcare. Recognizing her fervor for this industry segment in college, she has had responsibility for public relations, service-line business plans, event projects & physician communications. After working on the hospital side, Leslie joined an advertising agency and honed her skills as a client service representative and helped large corporations with promotional projects including Pepsi, Hershey and General Mills. Leslie was re-introduced into healthcare by becoming a Marketing Manager for

healthcare partners at Arthur Andersen. After Andersen, Leslie co-owned Sole Graphics and Marketing in Fort Worth building creative brands and events for a wide variety of clients. It was here that she honed skills and a passion for promoting prevention and healthy lifestyles. After working with the Health Industry Council for several years on the Community Health & Wellness and Champions in Health Task Forces she joined the Health Industry Council staff in 2009 becoming the Vice President of Membership. In her current role, Leslie uses her creative and customer service background to plan networking and education events for industry executives making collaboration and innovation possible for healthcare in North Texas. She also currently serves on committees for the Community Health Collaborative at the DFW Hospital Council, the Tarrant County Obesity Policy Council, the United Way of Dallas County's Childhood Obesity Council, and chairs the Community Themes and Strengths Assessment portion of the MAPP process being undertaken by Tarrant County Public Health. Leslie graduated from Texas Tech University and lives with her husband and two children in North Richland Hills, Texas.

Jennifer Coleman, MA serves as senior vice president of consumer affairs for Baylor Health Care System headquartered in Dallas. She has worked in various marketing and public relations positions at Baylor since 1980. She holds a master's degree in English from the University of Texas at Austin and a bachelor of arts degree in English from the University of South Florida. Jennifer oversees marketing, public relations and community benefit activities at this $5 billion-in-assets, 30-hospital system that serves 82 counties in North Texas. She has helped convene Health Community activities for Baylor in the 1990s, focusing on East Dallas in collaboration with the federal Weed & Seed program. She is on the advisory board of The Concilio and is a member of the board of the Texas Health Institute where she is assisting in bringing The Benefits Bank to North Texas. This program will assist indigent people with obtaining federal and state benefits for which they qualify but are not enrolled. She is the former president of Dallas Reads and is a member of the Dallas Summit. She has been recognized by PR News as not-for-profit PR professional in 2011 and by the Dallas Business Journal as a "Woman in Business Winner" in 2010.

Summer Collins, MPH holds her degree from Columbia University and has 12 years of expertise in public health research. In her current role as Director of Population and Public Health Research for the Dallas Fort Worth Hospital Council Foundation, Summer coordinates and designs multiple initiatives to improve community health. Prior to her work with the Foundation, Summer has worked extensively at institutions and organizations such as Northwestern University, Columbia University, OMNI Colorado Department of Public Health, and OMNI Institute in Denver, Colorado. She is a member of the American Public Health Association, Council of State and Territorial Epidemiologists, National Prevention Network, and the Association for Community Health Improvement. Whether through unique partnerships and collaborations, analysis of quantitative or qualitative measures, or evaluation design, Summer's translational research efforts help to improve the health of local North Texans.

Rhonda L. Dalfonso R.N. has been the Nursing Coordinator for DeSoto I.S.D. for 3 years, she was a School Nurse for 11yrs. and one year for Dallas ISD. From December 1991 to April 1999, she worked for several physicians, from Urologists to Reconstructive Surgeons. She assisted them in the office, in surgery, and ran their private O.R. and Recovery Rms. She ordered surgical supplies and maintained O.R. gases, narcotics, OSHA, HCFA and CLIA. Most importantly she provided patients with educational care and follow-ups. During this time, she co-authored with Dr. Kent C. Hughes, 2 abstracts for the American Society of Plastic and Reconstructive Surgeons. Both abstracts were inducted into the ASPRS/PSEF/ASMS 68th Annual Scientific Meeting, held on October 24-27th 1999. They are entitled: "*Breast Implant Volume as it Relates to Increase in Overall Breast Size Post-Augmentation Mammoplasty"* and "*Use of Titanium Osseointegrated Auricular Prosthesis for Reconstruction of Traumatic Ear Amputation*." In 1982, R.N. Dalfonso received a B.S. Degree from

U.T. in Austin, Texas and in 1991 a B.S. Degree from U.T. in Arlington, Texas. Rhonda worked closely with DCHHS during the H1N1 flu outbreak and received a Letter of Commendation signed by The Dallas County Commissioners Court for her dedicated work. She also worked on the SPAN Project conducted by researchers at the Michael and Susan Dell Center for Healthy Living, U.T. School of Public Health, at the Austin Regional Campus.

Natalie Dean-Wood, FACHE is the Director of Community Health for Texas Health Resources in Arlington, Texas. With more than 20 years of experience in health care, she has previously served in roles that include Director of Community Benefit at Trinity Health in Novi, Michigan and Director of Community & Government Affairs at St. Joseph Mercy Hospital – Oakland, in Pontiac, Michigan. Natalie serves as a key partner in work on the national level to create standards and guidelines for community benefit planning and reporting. A few of her recent national activities include contributing to the Catholic Health Association's "A Guide for Planning & Reporting Community Benefit" (2008), "A Guide for Planning and Reporting Community Benefit" (2006), and serving as Chairperson of the Catholic Health Care System Community Benefit Steering Committee (2005–2008), Natalie is a current member of the Saint Louis University Advisory Board for the Certification in Community Benefit program, chairperson for the University of North Texas Health Science Center's Community Advisory Board, and a Fellow in the American College of Healthcare Executives.

Commander (CDR) James L. Dickens is a Senior Program Officer for the Office Secretary for Health (OS) in the Dallas Regional Office. He joined OS in 2010 and is a Lead for the Office of Minority Health covering the five state areas of Texas, Arkansas, Louisiana, Oklahoma and New Mexico. CDR Dickens holds a Bachelor and a Master degree of Science in Nursing from Hampton University. He is an experienced Registered Nurse and Board Certified Family Nurse Practitioner with over twenty years of combined federal healthcare experience. CDR Dickens is a Fellow for the American Academy of Nurse Practitioners. Prior to joining the OS, CDR Dickens worked for the Centers for Medicare and Medicaid Services, Department of Defense, Veteran's Affairs, and the Federal Bureau of Prisons. CDR Dickens' clinical experience includes orthopedics, emergency department, operating room, long-term care, and primary care settings. CDR Dickens is a Commissioned Officer in the United States Public Health Service, whose mission is to promote, protect and advance the health and safety of the Nation. As a member of the Uniformed Services, he responds to national disasters and currently serves on a Regional Incident Support Team and continually prepares for national disasters and emergencies. In 2008, he was selected to participate as a clinical team member for the Afghanistan Health Initiative (AHI) in Kabul, Afghanistan. The mission of the AHI is to improve quality of care, as well as the maternal and infant mortality rates at the Rabia Balkhi Women's' Hospital in Kabul. CDR Dickens has deployed to Afghanistan multiple times, and was responsible for the training of over one hundred nurses and lay midwives in the clinical standards of practice of the operating theater. CDR Dickens resides in Denton, Texas, is involved in numerous community activities, enjoys teaching BLS, and is a college and professional football enthusiast. He is currently a student at Texas Tech University Health Sciences Center completing a Doctorate in Nursing Practice with an emphasis in Executive Leadership. CDR Dickens is a member of the American Academy of Nurse Practitioners, American Nurses Association, North Texas Nurses Practitioners Association and the North Texas Nurses Practitioners Association. He is the current Chair of the AANP Nomination's Committee. Lastly, CDR Dickens is on the Strategic Advisory Committee for the State of Texas. This committee is in direct response to the Institute of Medicine's report "The Future of Nursing: Leading Change, Advancing Health."

Jennifer J. Edwards, PhD is a leader in health program planning and evaluation to support population health improvement at Dallas County Health and Human Services. Dr. Edwards has prior experience as a management consultant for national health organizations including the American College of Physicians, National Osteoporosis Foundation, and the Federation of State Boards of Physical

Therapy. She has completed National Institutes of Health (NIH) research training at the University of Florida J.H. Miller Health Science Center; and has worked in public affairs and evaluation at a federal scientific agency. During this time, Dr. Edwards wrote presidential appointee testimony submitted to the U.S. Congressional Record. She earned a Doctoral degree specializing in health programs and policy, and a Graduate Certificate in International Studies from Howard University in Washington, D.C. She has a Bachelor of Science from Florida A&M University. Dr. Edwards is a new Board Member for Susan G. Komen North Texas, Health & Quality of Life Committee Chairperson for the National Urban League of Greater Dallas Young Professionals, and she is a member of Delta Sigma Theta, a public service organization.

Forney Fleming, MD, MBA is a Clinical Professor at the University of Texas at Dallas, and the Director of the Master of Science in Healthcare Management degree program in the Jindal School of Management. He earned his Bachelor's degree from the University of Texas at Austin, his Medical Degree from The University of Texas Medical Branch at Galveston and an MBA from the University of Houston at Clear Lake. He brings to the School of Management not only decades of experience as a practicing physician but also years of understanding he developed by running hospital committees, training future doctors and managing his practice in orthopedic surgery. Dr. Fleming is a Fellow, American College of Surgeons (FACS), a Fellow, American Academy of Orthopedic Surgeons, and Diplomat, American Board of Orthopedic Surgery. He is a member of the AMA, TMA, and Dallas County Medical Society. He is also a member of Beta Gamma Sigma national business honor society, Sigma Iota Epsilon national marketing honors society, and Golden Key International Honor Society.

Devin Hill, MBA serves as the Director of Market Research for Baylor Healthcare Systems. Mr. Hill has spent his entire 19-year career in the healthcare planning/market research field. Prior to joining Baylor Healthcare systems, Mr. Hill was Manager, Planning and Market Research for Methodist Health System in Dallas for three years. He also spent ten years with Texas Health Resources in Arlington as Manager of Strategic Information Resources. With work experience for the three major not-for-profit health systems in the Dallas/Fort Worth market, Mr. Hill has an extensive breadth and depth of knowledge of the region's care delivery strengths, weaknesses and its competitive landscape. Mr. Hill began his health care research career with VHA of Oklahoma/Arkansas where he spent four years. Mr. Hill received both his Bachelor of Science (Marketing) & MBA from Oklahoma State University.

Dena L. Jackson, PhD currently serves as VP of Grants & Research at the Dallas Women's Foundation (DWF). Dr. Jackson has worked on both the for-profit and non-profit arenas. Her for-profit work included 12 years in health care administration in the physician, insurer, and hospital sides primarily focused on women's health and managed care process improvement. She made the jump to the nonprofit arena in 2001 with Susan G. Komen for the Cure where she worked with Komen staff and volunteers around the country on how to develop, manage, and evaluate their local breast cancer grants. Dr. Jackson relocated briefly to south Florida which allowed her to advance her development skills with FundRaising Advantage Consultants in Ft. Lauderdale, Florida. Most recently, Dr. Jackson spent five years at The University of Texas at Dallas as Assistant VP of Foundation Relations then Assistant VP of Research Development. Dr. Jackson earned her Doctoral degree in Health Studies at Texas Women's University.

Kristin Jenkins, JD, MBA, FACHE has been in the healthcare legal, compliance, quality and operations field since leaving her private law practice in 1997. She has served as a Tarrant County Assistant District Attorney and as a Senior Vice President of the JPS Health Network – a public hospital and healthcare system in Tarrant County, Texas. She served for three years as the Administrator of the JPS Diagnostic and Surgery Hospital of Arlington and is currently the President of the Dallas Fort

Worth Hospital Council Foundation and Senior Vice President of the Dallas Fort Worth Hospital Council. She also serves as an alderwoman for the City of Annetta North, Parker County, Texas. Ms. Jenkins serves on the boards of the North Texas Regional Extension Center (ONC Program), the local American Cancer Society, and is Chair of the North Texas Accountable Healthcare Partnership's Health Information Exchange Steering Committee. She is past President of the North Texas Healthcare Compliance Association and the Tarrant County Young Lawyers Association. She served on the Texas Hospital Association Leadership Development Council from 2005 to 2009 and is currently an ex-officio member of the Texas Hospital Association Quality Policy Council. In 2002 Ms. Jenkins received the Modern Healthcare Up & Comer Award at the American College of Healthcare Executives' National Conference. Ms. Jenkins has testified on multiple occasions for the Texas Senate and House Health Committees on topics ranging from proposed regulation of mental health facilities to proposed state patient privacy and security statutes, conflicts with federal HIPAA statutes and the practical application of these proposed laws in the healthcare delivery environment. Finally, Ms. Jenkins has presented at numerous national and state conferences related to compliance and quality topics, diabetes programs, health information technology and healthcare workforce initiatives in North Texas.

Loretta Johnson has been the Director of Health for the Urban League of Greater Dallas & North Central Texas Inc. for the past 8.5 years. She manages the health programs, staff, and budget and is responsible for generating revenue for the health programs. Since her tenure, she has increased the Urban League health department budget from $260,000 to over $850,000 per year. She has spent 25 years of her life serving in various areas of Community Health Care. The remainder of her professional career has been as an entrepreneur and in serving at risk adolescents, prison and re-entry populations, individuals, families and communities infected and /or affected with HIV/ AIDS, Substance Abuse and violence. Prior to her tenure at the Urban League, Loretta worked diligently for 11.5 years as a Parkland Health & Hospital System employee where she was instrumental in the development of 10 school based health clinics (Youth & Family Centers) located on campuses of the Dallas Independent and Carrollton Farmers Branch School Districts. The Youth and Family Centers received the first National Award ever given to a School Based Health Clinic through the National Assembly of School Based Health Care, Washington, D.C. for exemplifying a model of excellence in school based health care. Her second year of employment at Parkland Health & Hospital System she received the "Employee Who Goes Beyond Award". The American Medical Association (AMA), Chicago, Illinois presented her with an award for the development of a program in Adolescent Health Care and the City of Dallas presented her with the "Top of the Mountain Award" for services to the City of Dallas. Loretta has served on several local, state and National Board of Directors over the years. She was recently awarded VIP status on the Biltmore Who's Who Registry of Executives and Professionals. She completed the Ministry Training Institute through Covenant Church in Carrollton, Texas as well as served on the mission fields in Nicaragua and Costa Rica.

Edward Jones of AIDS Arms, Inc. is a force of nature. An educator, a community organizer, and the worst thing to happen to HIV since antiretroviral therapy. Ed started his journey in the field of HIV prevention as a peer educator in May of 2003. After completing a comprehensive course on HIV/AIDS through AAMA, Ed went on to study the effect of STDs on the community and how stigma plays an important role in the propagation of infection. He is a staple in the Dallas AIDS community, facilitating the HIP HOP for HIV event that, last year alone, tested 4000 people in 30 days. Ed toured with Magic Johnson "Testing America" in 2010 and Condom Nation in 2012. Ed regularly, including

the past 3 years, receives the Ambassador Award at AIDS Arms, Inc., where he works as a certified Behavioral Intervention Specialist.

Suzanne Kubelka is Director of Health Services for the Dallas Independent School District. Previously, she served the district as area nursing supervisor, campus school nurse and staff nurse and supervisor in various hospitals in the metroplex including Parkland and Children's Medical Center. Her educational experience includes a baccalaureate in Nursing from Texas Woman's University and Master in Nursing, from the University of Texas at Arlington as a Family Nurse Practitioner. As an officer and member for several professional organizations and advisory boards at the national, state and local levels her major area of focus has been Pediatrics with a secondary interest in research. She served as project director, manager and coordinator for a number of research projects in the areas of immunizations, asthma, nursing leadership and teen pregnancy during the past 15 years. She is a strong advocate for use of the coordinated approach to school health to enable children to reach their optimal level of health and well-being. She lives in the Dallas area, married with three children and nine beautiful grandchildren. When not working she enjoys reading, music and the arts.

Brenda Lockey, MBA is the manager of planning and market research at Methodist Health System, a non-profit health system serving southern Dallas County and surrounding areas. Brenda has been with Methodist for the past three years where she is responsible for the management of planning functions, market research, statistics and analysis. Prior to joining Methodist Health System, she worked for Tenet Healthcare's Texas and Gulf Coast Regions as regional manager of marketing communications and business development for nine years. She holds a Master's Degree in Business Administration from Tulane University.

Leonor Márquez, MBA, MSW joined Los Barrios Unidos Community Clinic (LBUCC) in 2005. Los Barrios Unidos Community Clinic in Dallas is a federally-qualified community health center serving individuals and families of all ages. Leonor leads an organization of 137 employees, including physicians, nurses, dentists, and support staff, with a budget of $11 million. LBUCC's mission is to welcome all and improve quality of life through excellence in accessible, affordable healthcare. Last year, LBUCC had nearly 60,000 health care visits serving 20,000 people, most of whom are low income and uninsured. Leonor was born in El Paso, Texas and has a Master of Business Administration degree from the University of Texas at San Antonio, a Master of Social Work from Our Lady of the Lake University, and a Bachelor of Social Work degree from Arizona State University. Leonor has spent the past 22 years in community health, most recently as CEO of Los Barrios Unidos Community Clinic. Prior to that, she worked at Parkland Health & Hospital System where she ran the Health Care for the Homeless Program and the School Based Clinic Program. She worked for many years in San Antonio, Texas, as a Director at CentroMed, another federally funded community health center serving the uninsured and working poor. Leonor has dedicated her professional life promoting good health for the most vulnerable members of our society. She has worked with the homeless, the working poor

Sue Pickens, MEd has been with Parkland Health & Hospital System in Dallas, Texas, as Director of Population Medicine for the last 19 years. She has been in health care strategic planning for the last 30 years. In strategic planning, she has specialized in healthcare utilization forecasting, community health assessment, market analysis, and health policy development. For 15 years she has worked with and lead the Dallas/Fort Worth Hospital Council community assessment collaborative of over 20 hospitals creating and publishing *Our Community Health Checkup*. She has also worked with The Dallas County Indigent Plan Committee to create the Dallas County Indigent Care Plan submitted to The Centers for Medicaid and Medicare supporting federal funding for indigent care. Sue is

responsible for Parkland's institutional initiatives to analyze, monitor, and assess the community's health including population-based screening, community health assessment and intervention metric sets, health disparities evaluations and other population-based studies. As part of these responsibilities, she has established the Parkland Community Health Institute (CHI) which determines the Parkland System Public Health Priorities with the aim of improving the health and wellness of the community. Sue has a Masters Degree in Education from The University of Texas and is in currently enrolled in the Ph.D. program through the University of Tilburg, Netherlands in Social Construction. She enjoys teaching and has taught health policy and strategic planning at The University of Texas Southwestern Medical School at Dallas, School of Allied Health, The University of Texas at Dallas and Texas Women's University. Sue has published extensively and presented internationally on Servant Leadership, Managing the In-between and community health improvement. Sue also serves on several national, state and local committees and boards.

Jill Scigliano is the Vice President of Community Impact for the United Way of Metropolitan Dallas. Jill has been with the United Way since July 2007, at which time she started working for the UWMD as the Director of Outcomes in the Community Investment department. She helped develop the open community impact grants process as the Senior Director of Community Impact Funding. She is excited to see the investment process evolve into a truly impactful grant process that makes community-level change a top priority with the United 2020 goals, including implementing a multi-year funding process. Prior to joining the UWMD team, Jill lived in Maryland and worked for The Kennedy Institute of Catholic Community Services of DC for nearly 4 years. Jill was the Deputy Director of the Community Living Program which served adults with developmental disabilities, helping them to establish independence in the community. Jill has also had the pleasure of working as a Family Counseling Specialist at the Pressley Ridge Schools in Pittsburgh, PA, and with the YMCA School-Age Child Care Programs in Lancaster, PA. Jill graduated from Millersville University in December, 2001, with a BA in Psychology.

Joyce Tapley, MHA is the Chief Executive Officer at Martin Luther King, Jr. Family Clinic. Ms. Tapley's group is responsible for providing primary and preventive medical, dental and behavioral health care to the residents of Dallas County and surrounding communities. Joyce's focus is to ensure that high quality health services are provided to those who normally do not have access to affordable health care, primarily the low income underinsured and uninsured children and adults. Previously, she has held positions such as Business Operations Director for a multi-specialty 180+ employee medical group in Fort Worth and similar senior director positions in major hospital & trauma centers in Northern and Southern California. In California, she served as Assistant Hospital Administrator at one of the major Level I Trauma Center and Teaching Hospitals – Harbor-UCLA Medical Center, and as a Clinical Laboratory Business Ops Director at San Francisco General Hospital. Ms. Tapley has over 20 years of experience in health management positions, strategic planning, personnel management, fiscal management, fundraising, grant & proposal writing, recruiting, program development and event planning. Ms. Tapley holds a masters degree in health care administration, and a bachelor's degree in mathematics from University of Washington, in Seattle, Washington.

Victoria Yeatts, MSN, RN has been a Registered Nurse for 26 years and the Public Health Administrator for the Garland Health Department's Clinical Services Division for 16 years. I manage the daily operations of the City's Public Health Clinic along with budgetary responsibility for the Texas Department of State Health Services (DSHS) immunization grant and Clinical Services. Previous positions include working for Garland ISD as a school nurse and a Career and Technology educator at Lakeview Centennial High School in Garland. The Garland ISD and Texas Council of PTA's

awarded Yeatts a Life Membership in May 2011 for promoting the health of children in Texas. The American Nurses Association (ANA) awarded Yeatts the September 2011 Immunity Award for ensuring the immunization of students and other efforts to promote vaccinations in the community. Yeatts was nominated by the Texas Municipal League and selected by Texas DSHS in 2011 to represent municipalities with populations of 50,000 to 250,000 as a committee member of the Texas Public Health Funding and Policy Committee, formed out of Senate Bill 969 for a 4 year period. The committee's goals are to identify core public health functions and funding. Victoria Yeatts has a B.S. degree from Texas Woman's University (December 1985), and an M.S.N. degree from Loyola University New Orleans (May 2009).

APPENDIX B
FOCUS GROUP GUIDE AND PARTICIPANT PACKET

NEW SOLUTIONS, INC.
TRANSFORM HEALTH CARE INFORMATION TO VALUE

Dallas County Community Health Assessment
Focus Group Guide
June 6, 2012

Thank you all for coming today. My name is Lynn Schultz and I am a consultant with New Solutions, Inc. We are working with Dallas County on a Community Health Assessment. This assessment will ultimately allow strategies to be developed to improve the health of Dallas County residents. The first step in this process is to gather information about residents' health needs, and that will be the focus of our discussion today.

For those of you who don't know her, I would like to introduce Dr. Jennifer Jones. She is the Dallas County Health and Human Services Performance Improvement Manager who is leading and overseeing this project for the County. (Jennifer to provide a few words of introduction here.)

(Projection of Dallas County map with service areas) Much of our discussion will center on Dallas County overall, but we will also focus on geographic areas within Dallas County. This map shows Dallas County and its 13 service areas. We will be using these service areas for the Community Health Assessment. When you are discussing areas within Dallas County, whenever possible please refer to the appropriate service area.

We have a lot of questions to cover, and we want this group to be fast paced. Since we want everyone to participate, I might limit the time provided for answers. I appreciate your understanding.

1. **Let's begin with introductions.** Please tell the group your name, your organization and any population or geographic area within Dallas County that you represent or have a detailed understanding of the health needs.

2. **Think about a "healthy community."** On the paper in front of you, please take a minute and write down the three most important factors that you feel contribute to a healthy community? Let's review these factors.

(Go around the room, scribe to write key words on flip chart. Possibilities include: access to health care, preventive health care education, healthy behaviors/lifestyles, access to recreation, population with insurance/reasonably priced health care, good jobs/healthy economy, good schools/population literacy, low crime/safe neighborhoods, tolerance for diversity, etc.)

- With these factors in mind, on a scale from one to ten with ten being the most healthy community possible and one being the most unhealthy community possible, please write down your rating for the health of Dallas County.
- Why did you provide this rating?

3. What **key assets** promote health in Dallas County or make Dallas a healthy community?

4. What are the **top health care needs or barriers to good health** that limit the health of people living in Dallas County? (Ensure at least one issue from the key topic areas identified by the PHI Planning Committee are included at this point—these are listed at the end of this document.)

5. Let's discuss some of these key health care needs/barriers in more detail, looking at the causes, communities most affected, and what can be done to reduce this need and improve health.
    - Let's begin by discussing _____ (first need)
        a. What are the causes of this need/barrier?
        b. Does it affect all communities throughout Dallas equally? If no, what communities are most affected and why? If yes, are the causes the same in all communities?
        c. What can be done to reduce this need and improve health (in each identified community or overall)?
            - Proceed with these questions for all needs identified.

Let's spend a little time discussing SPECIFIC POPULATIONS' unfulfilled needs or barriers to good health.

6. Are there any unfilled **WOMEN'S** health needs that we have not discussed? (Family planning, teen pregnancy, early and adequate prenatal care, breast health—mammography, gynecologic care, etc.)
    - If so, ask questions a – c for each.

7. Are there any other unfulfilled health needs predominantly affecting **MEN** that we have not discussed?

8. Are there any health needs we have not discussed affecting **CHILDREN AND YOUTH**?

Let's discuss health disparities in Dallas County. By health disparity, we mean differences in the (incidence, prevalence, mortality or) burden of diseases and other adverse health conditions that exist among specific populations or groups. This often focuses on differences between racial/ethnic groups or socioeconomic groups.

9. Describe any health disparities you are familiar with or have witnessed.
    a. What is the cause of this disparity?
    b. What population(s) or communities are most affected?
    c. What can be done to reduce this disparity and improve health?

10. Are there any disparities we have not discussed affecting **AFRICAN-AMERICANS**?

11. Are there any disparities we have not discussed affecting **LATINO/HISPANIC RESIDENTS**?

12. Are there any disparities affecting the **ASIAN COMMUNITY** that should be considered?

13. Are there any disparities affecting **OTHER POPULATIONS** that we have not discussed that should be considered?

14. **Let's take a look at the service area map. You can find one on the second page of your packet along with some demographic information about each service area.** As I review each service area, please identify any special health care needs or barriers that we have not discussed.

Discussion of key focus areas, strategies and solutions.

15. (The scribe will have written all the needs on a list—sorted by PHI Planning Committee Headings).
    Please review this overall list of needs to improve the health of Dallas County residents. On the last page of your packet, please identify the five most important needs to be addressed over the next three to five years to improve community health. If there is a service area or population to focus on, identify that. Then we will spend our last few minutes discussing your ideas for possible strategies and solutions to address these key issues.

Converting personal motivation to community transformation
Medical Homes
Patient Navigators

Thank you very much for helping today. I appreciate your input into the Dallas County Community Health Assessment. If you have thoughts or suggestions going forward, please contact Jennifer Jones, Ph.D. at 214-819-2034. We want to be sure to consider them in this process.

Key Issues and Assets from PHI Planning Committee

1. **Health Care Access and Disparities**
   Access to Primary Care—Underserved including Undocumented
   Appropriate use of Emergency Department
   Access to Medical/Surgical Specialists
   Access to Dental Care
   Literacy
   Access to Recreation—Physical Activities and Safe Spaces
   Jail Health
   GLBT Health

2. **Children/Youth Health**
   Teen Pregnancy
   Juvenile Drinking (Drugs)

3. **Chronic Conditions**
   Diabetes (7)
   Obesity (6) (Children and Adult)
   Hypertension
   Heart disease (3)
   Asthma (2) (Children and Adult)
   Cancer

4. **Planning, Policy and Programs**
   Comprehensive Prevention Programs
   Funding Cuts
   Environmental Issues—Air Quality
   Health Literacy

5. **STD/STI**
   Access to testing
   Disparities in service areas

6. **Immunizations**
   Children
   Seniors
   Healthcare Workers

7. **Perinatal Health**
   Infant Mortality
   Low Birth Weight
   Breast Feeding and Lactation Support Services

8. **Behavioral Health**
   Mental Health
   Substance Abuse Treatment Facilities
   Alzheimer's

9. **Social Services**
   Senior Services
   Social Services Access
   Domestic Violence Shelters

DALLAS COUNTY HEALTH AND HUMAN SERVICES
COMMUNITY HEALTH NEEDS ASSESSMENT
FOCUS GROUP

Most Important Factors Contributing to a Healthy Community

1.

2.

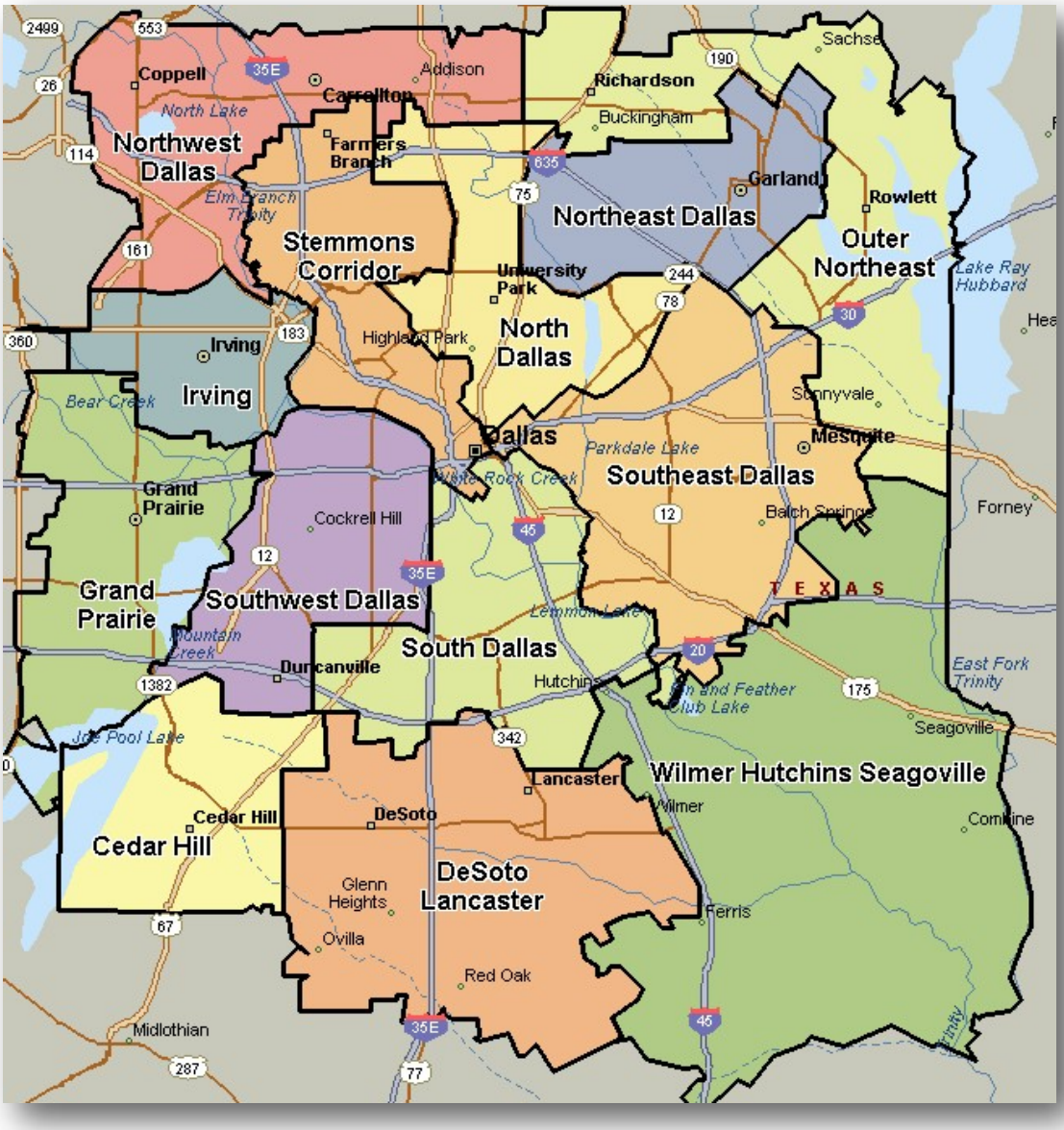
3.

Demographic and Socioeconomic Overview
Dallas County and Service Areas
2010

DALLAS COUNTY
HEALTH AND HUMAN SERVICES

Community Health Needs Assessment Service Areas

- Cedar Hill
- DeSoto Lancaster
- Grand Prairie
- Irving
- North Dallas
- Northeast Dallas
- Northwest Dallas
- Outer Northeast
- South Dallas
- Southeast Dallas
- Southwest Dallas
- Stemmons Corridor
- Wilmer Hutchins Seagoville



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Five Most Important Needs to Be Addressed Over the Next Five Years

Need
Population/Service Area

1.

2.

3.

4.

5.

	General Pop. Indicators				Race/Ethicity/Language Demographic Indicators					Socioeconomic Indicators 2010			Community Needs Index (CNI)
County / Service Area	*Total Population 2010*	*% of Dallas Cty Population*	*% of Pop 65+*	*Population w/o HS Diploma*	*White*	*Black*	*Asian*	*Hispanic*	*Other*	*Per Capita Household Income*	*Families Below Poverty Level*	*Unemployment (mid 2010)*	*Catholic Healthcare West*
DALLAS COUNTY	2,368,139	100.0%	9.4%	25.4%	33.9%	19.9%	5.6%	39.6%	0.8%	$ 24,240	13.9%	8.9%	3.9
CEDAR HILL	77,607	3.3%	7.8%	10.2%	25.7%	47.2%	2.0%	23.1%	2.0%	$ 14,203	24.6%	4.1%	2.5
DESOTO/LANC	123,187	5.2%	8.7%	15.2%	26.7%	54.5%	0.6%	16.5%	1.7%	$ 22,958	7.7%	6.2%	3.4
GRAND PRAIRIE	169,322	7.2%	6.7%	24.6%	28.5%	19.6%	6.3%	43.6%	2.1%	$ 20,874	11.6%	6.1%	3.7
IRVING	143,959	6.1%	8.6%	30.8%	30.2%	8.5%	5.2%	54.1%	1.9%	$ 18,957	12.4%	5.5%	4.3
NORTH DALLAS	241,575	10.2%	11.4%	18.3%	64.1%	7.1%	3.6%	23.5%	1.8%	$ 41,068	11.6%	4.4%	3.8
NE DALLAS	250,928	10.6%	8.4%	24.2%	30.9%	19.7%	7.3%	40.3%	1.8%	$ 21,378	13.9%	6.0%	4.0
NW DALLAS	228,016	9.6%	7.5%	8.8%	46.3%	11.7%	15.7%	23.8%	2.4%	$ 39,756	6.2%	3.2%	3.0
OUTER NE	257,479	10.9%	10.2%	10.0%	54.4%	13.1%	10.3%	19.7%	2.4%	$ 28,307	5.3%	3.8%	2.6
SOUTH DALLAS	152,634	6.4%	12.1%	35.9%	3.4%	69.5%	0.2%	25.8%	1.1%	$ 13,399	24.9%	13.1%	4.7
SE DALLAS	367,435	15.5%	7.9%	34.5%	23.7%	24.0%	1.7%	49.2%	1.5%	$ 16,164	18.9%	7.9%	4.4
SW DALLAS	211,896	8.9%	7.5%	48.4%	12.4%	18.3%	1.2%	67.2%	1.0%	$ 14,203	24.6%	9.1%	4.7
STEMMONS CORRIDOR	162,748	6.9%	8.6%	39.0%	36.6%	8.3%	2.9%	51.0%	1.2%	$ 26,089	18.1%	6.0%	4.3
WILMER/ HUTCH/SEAG	78,718	3.3%	6.4%	27.1%	38.6%	20.3%	1.8%	37.4%	1.9%	$ 19,249	10.3%	5.5%	3.3

Agencies Represented by Focus Group Participants

- American Diabetes Association
- American Heart Association Southwest Affiliate
- Community Dental Care
- Injury Prevention Center of Greater Dallas
- North Texas Behavioral Health Authority
- Parkland Health and Hospital System Asian Outreach
- The YMCA of Metropolitan Dallas
- Urban League of Greater Dallas and North Central Texas
- U.S. Environmental Protection Agency Region 6

Focus Group Demographic Sheet

	General Pop. Indicators			Race/Ethicity/Language Demographic Indicators					Socioeconomic Indicators 2010		
County / Service Area	*Total Population 2010*	*% of Dallas Cty Population*	*Population w/o HS Diploma*	*White*	*Black*	*Asian*	*Hispanic*	*Other*	*Per Capita Household Income*	*Families Below Poverty Level*	*Unemployment (mid 2010)*
DALLAS COUNTY	2,368,139	100.0%	25.4%	33.9%	19.9%	5.6%	39.6%	0.8%	$ 24,240	13.9%	
CEDAR HILL	75,746	3.2%	10.2%	34.4%	41.6%	2.5%	19.7%	1.6%	$ 14,203	24.6%	4.1%
DESOTO/LANC	90,164	3.8%	15.2%	27.3%	54.1%	0.9%	16.0%	1.0%	$ 22,958	7.7%	6.2%
GRAND PRAIRIE	169,705	7.2%	24.6%	30.8%	16.5%	7.0%	45.2%	0.5%	$ 20,874	11.6%	6.1%
IRVING	137,877	5.8%	30.8%	29.6%	8.2%	5.9%	54.4%	1.6%	$ 18,957	12.4%	5.5%
NORTH DALLAS	265,754	11.2%	18.3%	56.4%	5.4%	4.3%	33.6%	0.7%	$ 41,068	11.6%	4.4%
NE DALLAS	274,328	11.6%	24.2%	28.6%	20.7%	8.0%	42.0%	1.5%	$ 21,378	13.9%	6.0%
NW DALLAS	229,789	9.7%	8.8%	51.2%	8.8%	16.9%	23.9%	2.0%	$ 39,756	6.2%	3.2%
OUTER NE	258,313	10.9%	10.0%	57.6%	11.7%	11.3%	18.9%	0.5%	$ 28,307	5.3%	3.8%
SOUTH DALLAS	277,843	11.7%	35.9%	1.8%	39.4%	0.4%	58.1%	1.0%	$ 13,399	24.9%	13.1%
SE DALLAS	372,537	15.7%	34.5%	25.1%	24.3%	2.0%	46.7%	2.0%	$ 16,164	18.9%	7.9%
SW DALLAS	219,984	9.3%	48.4%	11.5%	16.0%	1.5%	70.5%	0.6%	$ 14,203	24.6%	9.1%
STEMMONS CORRIDOR	183,884	7.8%	39.0%	30.4%	5.4%	3.4%	60.0%	1.4%	$ 26,089	18.1%	6.0%
WILMER/ HUTCH/SEAG	65,971	2.8%	27.1%	47.1%	19.0%	2.2%	28.3%	2.5%	$ 19,249	10.3%	5.5%

Key Informant Interview Guide

NEW SOLUTIONS, INC.
TRANSFORM HEALTH CARE INFORMATION TO VALUE

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Alpharetta, GA 30022
TEL: ((404)229-6183
FAX: (770)569-5108
lschultz@newsolutionsinc.com

Dallas County Community Health Needs Assessment: Interview Questions

Name_____ Phone_____

Organization_____ Title_____

1. Please rate the effect of each of issues has on the health of Dallas County residents, where 1 affects residents the least and 5 affects residents the most?
    a. Immunizations
    b. STD/HIV and Communicable Disease
    c. Asthma and Respiratory Illnesses
    d. Cancer
    e. Diabetes
    f. Cardiovascular Disease
    g. Maternal Fetal
    h. Behavioral Health
    i. Injury and Violence
    j. Diet and Exercise
    k. Tobacco Use

2. What of the following is most important in improving the health of Dallas county residents? Why? Which would you rate as second most important? Why?
    - Healthcare Access
    - Health Literacy
    - Healthcare Organizations Partnership Infrastructure
    - Targeting the improvement of disease risk factors
    - Promoting continued care of persons with disease diagnoses

3. For the general Dallas County population who has no current medical diagnosis, what do you see as the most significant barriers to accessing preventive care to improve their general health?
    - Availability
    - Cost
    - Lack of Understanding—Unclear on where to go
    - Competing Priorities
    - Cultural/Language Barriers

    What do you recommend to improve access to preventive services? How does this vary with SES and/or geographic location in Dallas County?

4. We know that people throughout Dallas County are accessing the Emergency Room for conditions that could have been treated in a primary care setting, what do you see as the most significant barriers to more appropriately accessing health care and treatment?

    - Availability
    - Cost
    - Lack of Understanding of the health care system—red tape
    - Health Literacy
    - Cultural/Language Issues

5. The National Prevention Strategy states that disparities can be reduced by focusing on communities are risk. How can disparities across the 13 service areas be equitably addressed?

6. The need for greater collaboration and enhanced linkages between providers was discussed during the leadership focus group. What do you suggest to enhance collaboration and linkage?

7. What is the best way to establish an ongoing, effective structure of health partnerships and accountability across Dallas County hospitals, non-profits, the health department, and others?

8. What innovative approaches would you like to see developed to improve Dallas Count community health?
    - Patient Navigator
    - Community Health Worker

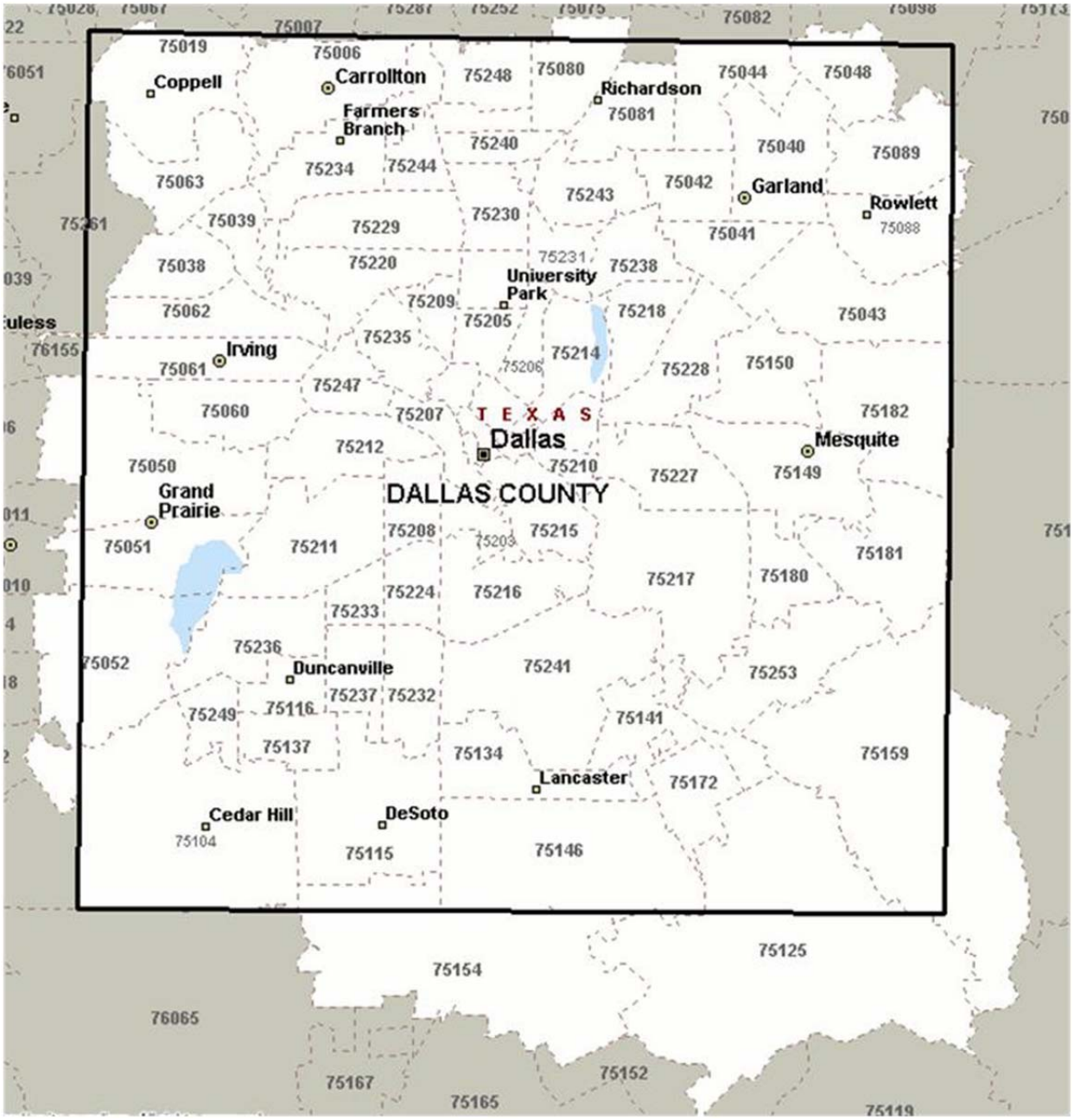
9. What do you consider the top health priorities for Dallas County?

10. Do you have any other suggestions to improve the CHNA or this process?

Thank you for your help and participation.

APPENDIX C

MAP COMPARING DALLAS COUNTY BOUNDARIES WITH THE COMMUNITIES' ZIP CODE BOUNDARIES



ZIP	Service Area
75104	Cedar Hill
75137	Cedar Hill
75249	Cedar Hill

ZIP	Service Area
75115	DeSoto Lancaster
75134	DeSoto Lancaster
75146	DeSoto Lancaster
75154	DeSoto Lancaster

ZIP	Service Area
75050	Grand Prairie
75051	Grand Prairie
75052	Grand Prairie

ZIP	Service Area
75060	Irving
75061	Irving
75062	Irving

ZIP	Service Area
75204	North Dallas
75205	North Dallas
75206	North Dallas
75209	North Dallas
75214	North Dallas
75218	North Dallas
75225	North Dallas
75230	North Dallas
75240	North Dallas
75244	North Dallas
75251	North Dallas

ZIP	Service Area
75040	Northeast Dallas
75041	Northeast Dallas
75042	Northeast Dallas
75231	Northeast Dallas
75238	Northeast Dallas
75243	Northeast Dallas

ZIP	Service Area
75001	Northwest Dallas
75006	Northwest Dallas
75019	Northwest Dallas
75038	Northwest Dallas
75039	Northwest Dallas
75063	Northwest Dallas
75248	Northwest Dallas
75254	Northwest Dallas

ZIP	Service Area
75043	Outer Northeast
75044	Outer Northeast
75048	Outer Northeast
75080	Outer Northeast
75081	Outer Northeast
75088	Outer Northeast
75089	Outer Northeast
75182	Outer Northeast

ZIP	Service Area
75203	South Dallas
75215	South Dallas
75216	South Dallas
75232	South Dallas
75237	South Dallas
75241	South Dallas

ZIP	Service Area
75149	Southeast Dallas
75150	Southeast Dallas
75180	Southeast Dallas
75210	Southeast Dallas
75217	Southeast Dallas
75223	Southeast Dallas
75226	Southeast Dallas
75227	Southeast Dallas
75228	Southeast Dallas
75246	Southeast Dallas

ZIP	Service Area
75116	Southwest Dallas
75208	Southwest Dallas
75211	Southwest Dallas
75212	Southwest Dallas
75224	Southwest Dallas
75233	Southwest Dallas
75236	Southwest Dallas

ZIP	Service Area
75201	Stemmons Corridor
75202	Stemmons Corridor
75207	Stemmons Corridor
75219	Stemmons Corridor
75220	Stemmons Corridor
75229	Stemmons Corridor
75234	Stemmons Corridor
75235	Stemmons Corridor
75247	Stemmons Corridor

ZIP	Service Area
75125	Wilmer Hutchins Seagoville
75141	Wilmer Hutchins Seagoville
75159	Wilmer Hutchins Seagoville
75172	Wilmer Hutchins Seagoville
75181	Wilmer Hutchins Seagoville
75253	Wilmer Hutchins Seagoville

APPENDIX D COMPLETE LIST OF PROVIDERS

Specialties included in each primary care category

For Primary Care we will include:
Family Practice,
General Practice
Internal Medicine--including in the primary specialty field--internal medicine-peds (12 physicians), internal medicine-emergency (1), internal medicine-psychiatry (2). There may be another specialty in the secondary field.
Geriatrics (not psych)
Hospitalist that has
Flexible (2 total being considered--one with family practice and one with nothing in the secondary specialty)
Occupational Medicine
Preventive Medicine
Unspecified but family practice, general practice, geriatrics in secondary field
Urgent Care

For Women's Health we will include:
Gynecology
Maternal and Fetal Medicine
OB/Gyn

For Pediatrics we will include:
Adolescent Health (2 physicians)
Pediatrics (if general pediatrics is in primary specialty field)
Neonatology

Outpatient Health Facilities					
Provider Type	**Provider Name**	**Street Address**	**Town**	**Zip Code**	**Service Area**
Outpatient Health Facility (22)	Agape Clinic at Grace United Methodist Church	4105 Junius St.	Dallas	75246	Southeast Dallas
	AIDS ARMS Peabody Health Center, Inc	351 W. Jefferson #300	Dallas	75208	Southwest Dallas
	Baylor Family Medicine at Garland	601 Clara Barton Blvd., Suite 340	Garland	75042	Northeast Dallas
	Baylor Family Medicine at Worth Street	4001 Worth Street, # A	Dallas	75246	Southeast Dallas
	Christ's Family Clinic	6409 Preston Road	University Park	75205	North Dallas
	City Square (Central Dallas Ministries)	801 N. Peak St.	Dallas	75246	Southeast Dallas
	CITYSQUARE	511 N. Akard St., Ste. 302	Dallas	75201	Stemmons Corridor
	Dallas Department of Health and Human Services	2377 Stemmons, Suite 600	Dallas	75207	Stemmons Corridor
	Grand Prairie Wellness Center	1710 Small St.	Grand Prairie	75050	Grand Prairie
	Healing Hands Ministries	7475 Skillman	Dallas	75231	Northeast Dallas
	Hope Clinic of Garland	808 W Avenue A	Garland	75040	Northeast Dallas
	Irving Interfaith Clinic	1302 Lane Street	Irving	75061	Irving
	Islamic Association of North Texas Clinic	840 Abrams Rd	Richardson	75081	Outer Northeast
	Jackson Internal Medicine Clinic	8200 Walnut Hill Lane	Dallas	75232	South Dallas

	Methodist Dallas Medical Center	1441 N. Beckley	Dallas	75203	South Dallas
	Metrocrest Family Medical Clinic	One Medical Parkway	Dallas	75234	Stemmons Corridor
	Network of Community Ministries Richardson Network	247 S.Sherman Street	Richardson	75081	Outer Northeast
	North Dallas Shared Ministries Medical Clinic	2875 Merrell Road	Dallas	75229	Stemmons Corridor
	Presbyterian Senior Medical Center	10455 N. Central Expressway, Ste. 110	Dallas	75231	Northeast Dallas
	The Stewpot Clinic	408 Park Avenue	Dallas	75201	Stemmons Corridor
	Urban Inter-Tribal Center of Texas	209 E. Jefferson Blvd.	Dallas	75203	South Dallas
	UT Southwestern Medical Center Senior Health Center	5550 Harvest Hill, Ste. 150	Dallas	75230	North Dallas
Outpatient Health Facility--After Hours (2)	Agape Clinic at Grace United Methodist Church	4105 Junius St.	Dallas	75246	Southeast Dallas
	Metrocrest Family Medical Clinic	1 Medical Parkway Plaza 1, Suite 140	Dallas	75234	Stemmons Corridor
Outpatient Health Facility--COPC (11)	COPC- Bluitt Flowers Health Center	303 Overton Road	Dallas	75216	South Dallas
	COPC- Employee Physician Office	7920 Elmbrook Suite 120	Dallas	75247	Stemmons Corridor
	COPC- Garland Health Center	802 Hopkins Drive	Garland	75040	Northeast Dallas
	COPC- Geriatrics and Senior Care Center	1936 Amelia Ct., 2nd Floor	Dallas	75235	Stemmons Corridor

	COPC-DeHaro Saldivar Health Center	1400 N. Westmoreland Road	Dallas	75211	Southwest Dallas
	COPC-East Dallas Health Center	3320 Live Oak	Dallas	75204	North Dallas
	Grand Prairie Health Center	801 Conover Drive (Conover & Carrier Parkway)	Grand Prairie	75051	Grand Prairie
	COPC-Irving Health Center	1800 N. Britian	Irving	75061	Irving
	COPC-Oak West Health Center	4201 Brook Spring	Dallas	75224	Southwest Dallas
	COPC-Southeast Dallas Health Center	9202 Elam Road	Dallas	75217	Southeast Dallas
	COPC-Vickery Health Center	8224 Park Lane	Dallas	75231	Northeast Dallas
Outpatient Health Facility--Minute Clinic (4)	Minute Clinic--CVS Pharmacy	Inside CVS/pharmacy #15 5500 N Macarthur Blvd	Irving	75038	Northwest Dallas
	Minute Clinic--CVS Pharmacy	Inside CVS/pharmacy #4985 8335 Westchester Dr Ste 140	Dallas	75225	North Dallas
	Minute Clinic--CVS Pharmacy	Inside CVS/pharmacy #5869 1413 Oates Dr	Mesquite	75150	Southeast Dallas
	Minute Clinic--CVS Pharmacy	Inside CVS/Pharmacy #7156 605 West Campbell Road	Richardson	75080	Outer Northeast
Outpatient Health Facility--Urgent	Care Club Medical Clinic-Urgent Care	420 N Coit Road Suite 2015	Richardson	75080	Outer Northeast

Care (32)	Care Now	14856 Preston Rd. Suite 100	North Dallas	75254	Northwest Dallas
	Care Now	345 N. Hwy 67	Cedar Hill	75104	Cedar Hill
	Care Now	3950 S Carrier Pkwy	Grand Prairie	75052	Grand Prairie
	Care Now	565 West I-30	Mesquite	75043	Outer Northeast
	Care Now	645 E. State Hwy 121, Suite 600	Coppell	75019	Northwest Dallas
	Care Now	7145 N George Bush Frwy	Garland-North	75044	Outer Northeast
	Children's Medical Center Dallas-Emergency and First Care	1935 Med District Dr.	Dallas	75235	Stemmons Corridor
	CityDoc Urgent Care	2909 McKinney Ave	Dallas	75204	North Dallas
	Complete Med Care	8989 Forest Lane, Suite146	Dallas	75243	Northeast Dallas
	Concentra	4006 Live Oak Street	Dallas	75204	North Dallas
	Concentra - Redbird	5520 Westmoreland Ste. 200	Dallas	75237	South Dallas
	Concentra Urgent Care	1345 Valwood Pkwy Ste. 306	Carrollton	75006	Northwest Dallas
	Concentra Urgent Care	15810 Midway Road	Addison	75001	Northwest Dallas
	Concentra-Las Colinas	5190 N. MacArthur Blvd. Suite 133	Irving	75039	Northwest Dallas
	Doctors Express	9901 Royal Lane Suite 600	Dallas	75231	Northeast Dallas

	Easy Care	5700 Rowlett Road, Suite 140	Rowlett	75089	Outer Northeast
	Edoc Urgent Care Center	651 N. Denton Tap Rd., Suite 100	Coppell	75019	Northwest Dallas
	Grand Prairie Urgent Care and Family Medicine	5204 S. Hwy 360, Suite 400	Grand Prairie	75052	Grand Prairie
	HealthCareClinics	5315 Ross Avenue	Dallas	75206	North Dallas
	Highland Park Emergency Center	5150 Lemmon Ave Suite 108	Dallas	75209	North Dallas
	Neighborhood Medical Center Urgent Care	5915917 Belt Line Road	Dallas	75254	Northwest Dallas
	PrimaCare Medical Center-Urgent Care	11888 Marsh Lane Suite 104	Dallas	75234	Stemmons Corridor
	PrimaCare Medical Center-Urgent Care	11910 Greenville Ave Suite 500	Dallas	75243	Northeast Dallas
	PrimaCare Medical Center-Urgent Care	1280 N. Town East Blvd	Mesquite	75150	Southeast Dallas
	PrimaCare Medical Center-Urgent Care	1810 N Plano Road	Richardson	75081	Outer Northeast
	PrimaCare Medical Center-Urgent Care	6350 E. Mockingbird Lane	Dallas	75214	North Dallas
	PrimaCare Medical Center-Urgent Care	642 Uptown Blvd. #100	Cedar Hill	75104	Cedar Hill
	PrimaCare Medical Center-Urgent Care	7910 Beltline Road	Dallas	75254	Northwest Dallas
	QuestCare Urgent Care	3414 Milton in Snider Plaza	Dallas	75205	North Dallas
	Southwest Family Medicine Urgent Care Center	8877 Harry Hines Blvd.	Dallas	75235	Stemmons Corridor

	Superior Healthcare Centre-Urgent Care	3116 Martin Luther King Blvd.	Dallas	75215	South Dallas
Outpatient Health--Seniors (3)	Baylor Senior Health Center at Fair Park	2835 Grand Avenue	Dallas	75215	South Dallas
	Baylor Senior Health Center at Mesquite	1650 Republic Pkwy., Ste. 150	Mesquite	75150	Southeast Dallas
	Baylor Senior Health Centers	800 North Shiloh Road	Garland	75042	Northeast Dallas
Outpatient Health Facility--VA Services (1)	Veterans Affairs, Department of North Texas Health Care System	4500 S. Lancaster	Dallas	75216	South Dallas
Outpatient Health Facility--FQHC (3)	Los Barrios Unidos Community Clinic	809 Singleton Blvd.	Dallas	75212	Southwest Dallas
	Los Barrios Unidos Grand Prairie Health Clinic	405 Stadium Drive	Grand Prairie	75050	Grand Prairie
	Martin Luther King Jr. Family Clinic	2922 B Martin Luther King, Jr. Blvd.	Dallas	75215	South Dallas
Women's Outpatient Health Facilities					
Provider Type	**Provider Name**	**Street Address**	**Town**	**Zip Code**	**Service Area**
Prenatal Care (6)	Dallas Healthy Start	4917 Harry Hines Blvd.	Dallas	75235	Stemmons Corridor
	Dallas Pregnancy Resource Center	3901 Holystone	Dallas	75212	Southwest Dallas
	Dallas Pregnancy Resource Center	6500 Grenville Ave., Ste 405	Dallas	75206	North Dallas
	Infant Intervention Program: A Family Approach	5201 Harry Hines Blvd.	Dallas	75235	Stemmons Corridor
	Los Barrios Unidos Community Clinic	809 Singleton Blvd.	Dallas	75212	Southwest Dallas

	Martin Luther King Jr. Family Clinic	2922 B Martin Luther King, Jr. Blvd.	Dallas	75215	South Dallas
Family Planning and Women's Health (27)	Birth Choice of Dallas	1902 Record Crossing Road	Dallas	75235	Stemmons Corridor
	Birth Choice of Dallas	8604 Greenville Avenue Suite 102	Dallas	75243	Northeast Dallas
	Catholic Charities	9461 LBJ Freeway, Suite 128	Dallas	75243	Northeast Dallas
	Child and Family Guidance Centers	120 West Main Suite 220	Mesquite	75149	Southeast Dallas
	Dallas Pregnancy Resource Center	12959 Jupiter Rd., Ste 260	Dallas	75238	Northeast Dallas
	Dallas Pregnancy Resource Center	3901 Holystone St.	Dallas	75212	Southwest Dallas
	Dallas Pregnancy Resource Center	6500 Greenville Avenue, Suite 405	Dallas	75206	North Dallas
	Los Barrios Unidos Community Clinic	809 Singleton Blvd.	Dallas	75212	Southwest Dallas
	Martin Luther King Jr. Family Clinic	2922 B Martin Luther King, Jr. Blvd.	Dallas	75215	South Dallas
	Planned Parenthood Addison Clinic	5290 Beltline Road #134	Addison	75254	Northwest Dallas
	Planned Parenthood Garland Clinic	1015 W Centerville Rd., #118	Garland	75041	Northeast Dallas
	Planned Parenthood Irving Clinic	1111 W Airport Freeway #207	Irving	75062	Irving
	Planned Parenthood Mesquite Clinic	1220 Town East Blvd. #240	Mesquite	75150	Southeast Dallas
	Planned Parenthood	140 FM Road	Cedar Hill	75104	Cedar Hill

	of Cedar Hill	1382, Ste 160			
	Planned Parenthood of North Texas	7424 Greenville #206	Dallas	75231	Northeast Dallas
	Planned Parenthood-Shelburne Clinic-Greenville	9100 N. Central Expwy, #169	Dallas	75231	Northeast Dallas
	The Turn Around Agenda	1808 W. Camp Wisdom Rd.	Dallas	75232	South Dallas
	deHaro–Saldivar Women's Health Center	1400 N. Westmoreland	Dallas	75211	Southwest Dallas
	East Dallas Women's Health Center	3320 Live Oak, 5th Floor	Dallas	75204	North Dallas
	Garland Women's Health Center	802 Hopkins, 2nd Floor	Garland	75040	Northeast Dallas
	Irving Women's Health Center	1800 N. Britain	Irving	75061	Irving
	Maple Women's Health Center	6303 Harry Hines Blvd., Suite 101	Dallas	75235	Stemmons Corridor
	Oakwest Women's Health Center	4201 Brook Springs	Dallas	75224	Southwest Dallas
	Routh Street Women's Clinic	4321 N Central Expy	Dallas	75205	North Dallas
	Southeast Women's Health Center	9202 Elam Road	Dallas	75217	Southeast Dallas
	White Rose Women's Center	4313 N. Central Expressway	Dallas	75205	North Dallas
	White Rose Women's Center	8499 Greenville Avenue	Dallas	75231	Northeast Dallas

Children's Outpatient Health Facilities					
Provider Type	**Provider Name**	**Street Address**	**Town**	**Zip Code**	**Service Area**
Outpatient -- COPC Pediatric (1)	Pediatric Primary Care Center	6303 Harry Hines Blvd.	Dallas	75224	Southwest Dallas
Outpatient-- Pediatric (15)	Childgrove Pediatrics	150 S Denton Tap Rd # 116	Coppell	75019	Northwest Dallas
	Coppell Pediatrics	1705 E. Beltline Rd.	Coppell	75019	Northwest Dallas
	Kid's-Klinic	9947 N MacArthur Blvd, Suite 150	Irving	75063	Northwest Dallas
	Lake Pointe Pediatric Associates	6900 Scenic Dr, Suite 103	Rowlett	75088	Outer Northeast
	Lake Ray Hubbard Pediatrics	9100 Lakeview Parkway	Rowlett	75088	Outer Northeast
	Los Barrios Unidos Community Clinic	809 Singleton Blvd.	Dallas	75212	Southwest Dallas
	Martin Luther King Jr. Family Clinic	2922 B Martin Luther King, Jr. Blvd.	Dallas	75215	South Dallas
	Mesquite Specialty Care	1675 Republic Pkwy., Suite 190	Mesquite	75150	Southeast Dallas
	My Children's Dallas (at Bachman Lake)	2750 W. Northwest Hwy. Suite 170	Dallas	75220	Stemmons Corridor
	My Children's Pediatric Practice	294 Uptown Blvd Ste 120	Cedar Hill	75104	Cedar Hill
	Pediatric and Adolescent Associates of Garland	601 Clara Barton	Garland	75042	Northeast Dallas
	Pediatric Southwest	2828 Duke of Gloucester St., Ste. 106	DeSoto	75115	DeSoto Lancaster

	Rainbow Children's Clinic	2985 South State Highway 360 Suite 140	Grand Prairie	75052	Grand Prairie
	Red Oak Family & Pediatric Clinic	273 East Ovilla Road Suite 4	Red Oak	75154	DeSoto Lancaster
	Richardson Pediatric Clinic	1112 Floyd Road, Suite 7	Richardson	75080	Outer Northeast
Outpatient--Youth and Family (11)	Lincoln/EBJ Y&F Center	5000 S. Malcolm X. Blvd.	Dallas	75215	South Dallas
	North Oak Cliff Y&F Center	501 S. Edgefield Ave.	Dallas	75208	Southwest Dallas
	Amelia Flores Y&F Center	9941 Lingo Lane	Dallas	75228	Southeast Dallas
	Fair Oaks Y&F Center	7502 Fair Oaks Ave.	Dallas	75231	Northeast Dallas
	Kiosco Y&F Center	10034 Hedgeway Dr.	Dallas	75229	Stemmons Corridor
	Redbird Y&F Center	3803 Boulder Dr.	Dallas	75223	Southeast Dallas
	Seagoville Y&F Center	15800 Seagoville Rd.	Dallas	75253	Wilmer Hutchins Seagoville
	Spruce Y&F Center	9716 Grady Lane	Dallas	75217	Southeast Dallas
	Vivian Field Y&F Center	13551 Dennis Lane	Farmers Branch	75234	Stemmons Corridor
	West Dallas Y&F Center	3131 N. Hampton Rd.	Dallas	75212	Southwest Dallas
	Woodrow Y&F Center	6006 Reiger Ave.	Dallas	75214	North Dallas
Criminal Justice Health Service (1)	Henry Wade Juvenile Justice Center	2600 Lone Star Dr	Dallas	75212	Southwest Dallas

Immunization and TB Clinics					
Provider Type	**Provider Name**	**Street Address**	**Town**	**Zip Code**	**Service Area**
Immunization Clinics (13)	Balch Springs Immunizations	Balch Springs Recreation Center 4372 Shepherd Ln	Dallas	75180	Southeast Dallas
	Carrollton Farmers Branch Immunization Clinic	2774 Valwood Parkway	Farmers Branch	75234	Stemmons Corridor
	Cockrell Hill Immunizations	Anson Jones Elementary School 3901 Meredith St	Dallas	75211	Southwest Dallas
	Dallas County Health Department Children's Immunization Clinic	2377 N. Stemmons Fwy Rm. 159	Dallas	75207	Stemmons Corridor
	Dallas Immunizations	Ridgewood Clinic 6445 E. Lovers Ln	Dallas	75214	North Dallas
	Grand Prairie Immunization	1413 Densman Street	Grand Prairie	75051	Grand Prairie
	Grand Prairie Immunizations	Immaculate Conception 1710 Small St	Grand Prairie	75050	Grand Prairie
	Irving Branch Immunization Clinic	440 S. Nursery Rd	Irving	75060	Irving
	John West Branch Immunization Clinic	3312 N. Buckner Blvd Ste. 200	Dallas	75228	Southeast Dallas
	Lancaster Immunization	Cedar Valley College 3030 N. Dallas Ave	Dallas	75134	DeSoto Lancaster
	North Dallas Branch Immunization Clinic and Refugee Clinic	8202 Spring Valley Rd Ste. 100	Dallas	75240	North Dallas
	Oak Cliff Branch	1113 E. Jefferson	Dallas	75203	South Dallas

	Immunization Clinic	Blvd Ste. 200			
	Seagoville Immunizations	Church of Christ 510 Kaufman St	Dallas	75159	Wilmer Hutchins Seagoville
TB Clinics (15)	Bethlehem Foundation	1159 W. Camp Wisdom	Dallas	75232	South Dallas
	Bluitt Flowers Clinic	303 E Overton Rd	Dallas	75216	South Dallas
	Carrollton Clinic	2774 Valwood	Carrollton	75234	Stemmons Corridor
	East Dallas Health Center	3320 Live Oak, 4th Floor	Dallas	75204	North Dallas
	George Washington Carver Building	206 Carver	Garland	75040	Northeast Dallas
	Grand Prairie Health Center	1413 Densman	Grand Prairie	75051	Grand Prairie
	Irving Health & Human Resources	440 S Nursery	Irving	75060	Irving
	John West	3312 N. Buckner	Dallas	75228	Southeast Dallas
	Kiest Park Recreation Center	3080 S. Hampton Rd	Dallas	75244	North Dallas
	North Dallas Health Clinic	8202 Spring Valley	Dallas	75240	North Dallas
	Oak Cliff Health Center	1113 E. Jefferson, Ste. 200	Dallas	75203	South Dallas
	Refugee Clinic	8202 Spring Valley Rd. Suite 200	Dallas	75240	North Dallas
	Southeast Dallas Health Center	9202 Elam Rd	Dallas	75217	Southeast Dallas
	STD/HIV Clinics	2377 N. Stemmons Frwy	Dallas	75207	Stemmons Corridor

	Vickery Clinic	8224 Park Ln, Ste. 130	Dallas	75231	Northeast Dallas
Behavioral Health Facilities					
Provider Type	**Provider Name**	**Street Address**	**Town**	**Zip Code**	**Service Area**
Mental Health--Outpatient (5)	ABC Behavorial Health L.L.C.	4600 Samuell Blvd.	Dallas	75228	Southeast Dallas
	Child and Family Guidance Centers	120 West Main Street #220	Mesquite	75149	Southeast Dallas
	Child and Family Guidance Centers	8915 Harry Hines Blvd.	Dallas	75235	Stemmons Corridor
	Metrocare Services	1380 River Bend Dr.	Dallas	75247	Stemmons Corridor
	The Stephen McManus Family Mental Health Clinic	210 West 10th Street	Dallas	75208	Southwest Dallas
Substance Abuse--Outpatient (34)	A.B.O.D.E. Treatment, Inc.	723 S. Peak Street	Dallas	75223	Southeast Dallas
	Dallas Challenge, Inc.	201 S. Tyler Street	Dallas	75208	Southwest Dallas
	Dallas Sigma Counseling Services, Inc.	1902 Country Club Drive, Suite 120	Carrollton	75006	Northwest Dallas
	Demson Counseling & Associates, Inc.	10945 Estate Lane, Suite 105	Dallas	75238	Northeast Dallas
	Enterhealth Outpatient Services, LLC	5949 Sherry Lane Suite 1880	Dallas	75225	North Dallas
	Hickory Trail Hospital, L.P.	2000 N. Old Hickory Trail, Support Building	De Soto	75115	DeSoto Lancaster
	Lois Jordan, Solutions Outpatient Services	4300 MacArthur Avenue, Suite 270	Dallas	75209	North Dallas

	Nexus Recovery Center Inc.	4525 Lemmon Avenue, Ste 201	Dallas	75219	Stemmons Corridor
	Phoenix Associates Counseling Services, Inc.	3884 South Shiloh Rd., Suite 101	Garland	75041	Northeast Dallas
	Psychotherapeutic Services of America, LLC	400 N. St. Paul, Suite 235	Dallas	75201	Stemmons Corridor
	Recovery Healthcare Corporation	9090 North Stemmons, Suite A-2	Dallas	75247	Stemmons Corridor
	The Addicare Group of Texas	2722West Kingsly Suite 115	Garland	75041	Northeast Dallas
	Volunteers of America Texas, Inc.	800 Wintergreen Road	Hutchins	75141	Wilmer Hutchins Seagoville
	Wendy Rickman The Road to Recovery	9401 LBJ Freeway, Suite 270	Dallas	75243	Northeast Dallas
	Adult Rehabilitation Ministry (ARM) Golden Gate Baptist Church	1128 Sabine Street	Dallas	75203	South Dallas
	Chemical Addiction Program VA North Texas Healthcare	4500 S. Lancaster	Dallas	75216	South Dallas
	F.S.C., Inc.	219B Sunset Ave., Suite 101	Dallas	75208	Southwest Dallas
	Genesis Counseling Associates, P.C.	12035 Shilon Road Suite 310	Dallas	75228	Southeast Dallas
	Genesis Counseling Associates, P.C.	2636 Walnut Hill Lane Suite 345 & 325	Dallas	75229	Stemmons Corridor
	Lifenet Community Behavior Healthcare	9708 Skillman Road	Dallas	75243	Northeast Dallas

	Solace Counseling Associates PLLC	1475 Prudential Drive	Dallas	75235	Stemmons Corridor
	St. Frances Angelican Church	3617 Abrams Rd.	Dallas	75228	Southeast Dallas
	Teen Challenge of North Texas	1106 Graham, Ste. 308	Dallas	75223	Southeast Dallas
	TRS Behavioral Care, Inc.	8222 Douglas , Suite 390 One Preston Centre	Dallas	75225	North Dallas
	F.S.C., Inc.	16539 Addison Road	Addison	75001	Northewest Dallas
	Dallas County Juvenile Probation Department	414 South R.L. Thornton Frwy	Dallas	75212	Southwest Dallas
	Dallas County Juvenile Probation Department	1508 East Langdon Road	Dallas	75241	South Dallas
	Demson Counseling & Associates, Inc.	8204 Elmbrook Dr., Suite 345	Dallas	75247	Stemmons Corridor
	Enterhealth Outpatient Services, LLC	8222 Douglas Lane, Suite 375 and 300	Dallas	75225	North Dallas
	Legacy Counseling Center, Inc.	4054 McKinney Avenue, Suite 101 and 102	Dallas	75204	North Dallas
	Mark O'Neal	4549 S. Westmoreland Rd.	Dallas	75237	South Dallas
	TRS Behavioral Care, Inc.	5646 Milton Street, Suite 340	Dallas	75206	North Dallas
	Welcome House, Inc.	4202 S. Lancaster Rd.	Dallas	75216	South Dallas
	The Addicare Group of Texas	2734 West Kingsley, Suite L-2	Garland	75042	Northeast Dallas

Substance Abuse--Residential (7)	Dallas County Juvenile Probation Department	2600 Lone Star Dr	Dallas	75212	Southwest Dallas
	Dallas County Residential Drug Treatment Program	1508 E. Langdon Rd.	Dallas	75241	South Dallas
	Nexus Recovery Center Inc.	8733 LaPrada	Dallas	75228	Southeast Dallas
	Sinai House, Inc.	2719 Holmes Street	Dallas	75215	South Dallas
	The Magdalen House	1302 Redwood Cir.	Dallas	75218	North Dallas
	The Salvation Army	5302 Harry Hines Blvd.	Dallas	75235	Stemmons Corridor
	Welcome House, Inc.	921 N. Peak St.	Dallas	75204	North Dallas
Substance Abuse--Residential and Outpatient (6)	Homeward Bound, Inc.	233 W. 10th St.	Dallas	75208	Southwest Dallas
	Homeward Bound, Inc.	315 Sunset Avenue	Dallas	75208	Southwest Dallas
	Phoenix House	2345 Reagan St.	Dallas	75219	Stemmons Corridor
	Sinai House, Inc.	2503 MLK Blvd.	Dallas	75215	South Dallas
	Texas Youth Commission, Cottrell House	7929 Military Parkway	Dallas	75227	Southeast Dallas
	Union Gospel Mission	3211 Irving Blvd.	Dallas	75247	Stemmons Corridor
Behavioral Health--Outpatient (3)	Green Oaks Hospital	7809 Clodus Fields Drive	Dallas	75251	North Dallas
	Southwest Behavioral Systems, Inc.	3827 South Buckner Blvd.	Dallas	75227	Southeast Dallas
	Urban Inter-Tribal Center of Texas	209 E. Jefferson Blvd.	Dallas	75203	South Dallas

Behavioral Health--Residential (1)	Green Oaks Hospital	7808 Clodus Fields Drive	Dallas	75251	North Dallas
Behavioral Health--Residential and Outpatient (1)	Turtle Creek Manor	2707 Routh St.	Dallas	75201	Stemmons Corridor
Dental Clinics (15)					
Provider Type	**Provider Name**	**Street Address**	**Town**	**Zip Code**	**Service Area**
Dental Clinics (15)	Baylor College of Dentistry	3302 Gaston Ave.	Dallas	75246	Southeast Dallas
	Children's Oral Health Center	5216 Monarch St.	Dallas	75206	North Dallas
	Community Dental Center at Bluitt Flowers Health Center	303 E. Overton Road	Dallas	75216	South Dallas
	Community Dental Center at Carrollton/Farmers Branch	13551 Dennis Lane	Farmers Branch	75234	Stemmons Corridor
	Community Dental Center at DeHare-Saldivar Health Center	1400 N. Westmoreland Road	Dallas	75211	Southwest Dallas
	Community Dental Center at East Dallas Health Center	3320 Live Oak	Dallas	75204	North Dallas
	Community Dental Center at Garland Health Center	802 Hopkins Drive	Garland	75040	Northeast Dallas
	Community Dental Center at Irving Dental Center	1800 N. Britian Road	Irving	75061	Irving
	Community Dental Center at Parkland--Amelia Court	1936 Amelia Ct.	Dallas	75235	Stemmons Corridor

	Community Dental Center at Southeast Health Center	9202 Elam Road	Dallas	75217	Southeast Dallas
	Community Dental Center at The Stewpot	408 Park Avenue	Dallas	75201	Stemmons Corridor
	Community Dental Center at Vickery Meadow Dental Center	8224 Park Lane Suite 130	Dallas	75231	Northeast Dallas
	Los Barrios Unidos Community Clinic	809 Singleton Blvd.	Dallas	75212	Southwest Dallas
	Martin Luther King Jr. Family Clinic	2922 B Martin Luther King, Jr. Blvd.	Dallas	75215	South Dallas
	Urban Inter-Tribal Center of Texas	209 E. Jefferson Blvd.	Dallas	75203	South Dallas
Farmers Markets and Recreation					
Provider Type	**Provider Name**	**Street Address**	**Town**	**Zip Code**	**Service Area**
Farmer's Market (10)	Celebration Market	4515 West Lovers Lane	Dallas	75209	North Dallas
	Cox Farms	1026 South Main Street	Duncanville	75137	Cedar Hill
	Dallas Farmers Market	1010 S. Pearl Expressway	Dallas	75201	Stemmons Corridor
	Il Creeks Farmers Market-Richardson	2701 Custer Parkway	Richardson	75080	Outer Northeast
	Sprouts Farmers Market	110 West Sandy Lake Road	Coppell	75019	Northwest Dallas
	Sprouts Farmers Market	11722 Marsh Lane	Dallas	75229	Stemmons Corridor
	Sprouts Farmers Market	1343 West Campbell Road	Richardson	75080	Outer Northeast

	Sprouts Farmers Market	362 E. FM 1382	Cedar Hill	75104	Cedar Hill
	Sunflower Farmers Market	1800 North Henderson Avenue	Dallas	75206	North Dallas
	Sunnyvale Pecan Orchard	137 Rebecca Road	Sunnyvale	75182	Outer Northeast
Recreation (29)	Boys & Girls Clubs of Greater Dallas, Inc.	4816 Worth St.	Dallas	75246	Southeast Dallas
	Calumet Community Center	321A Calumet Ave.	Dallas	75211	Southwest Dallas
	Coppell Family YMCA	146 Town Center Blvd.	Coppell	75019	Northwest Dallas
	East Dallas Boys and Girls Club	Charles S. Sharp Building 4804 Worth St.	Dallas	75246	Southeast Dallas
	Frazier Courts Boys & Girls Club	4716 Hatcher St.	Dallas	75210	Southeast Dallas
	Garland Family YMCA	1709 N. Garland Ave	Garland	75040	Northeast Dallas
	Grand Prairie Boys & Girls Club	1000 Enterprise Dr.	Grand Prairie	75051	Grand Prairie
	Grand Prairie Family YMCA	4556 S. Carrier Pkwy	Grand Prairie	75052	Grand Prairie
	Irving Family YMCA	2200 W. Irving Blvd.	Irving	75061	Irving
	Lake Highlands Family YMCA	8920 Stults Road	Dallas	75243	Northeast Dallas
	Lakewest Family YMCA	3737 Goldman	Dallas	75212	Southwest Dallas
	Maple Lawn Boys & Girls Club	Maple Lawn Elementary 3120 Inwood Rd.	Dallas	75235	Stemmons Corridor

	Mesquite Boys & Girls Club	John B. O'Hara Building 4869 Gus Thomasson Rd.	Mesquite	75150	Southeast Dallas
	Moorland Family YMCA	907 E. Ledbetter Road	Dallas	75216	South Dallas
	Oak Cliff Boys & Girls Club	Clint W. Murchison, Jr. Building 2907 Linfield Rd.	Dallas	75216	South Dallas
	Oak Cliff Family YMCA	6701 S. Hampton Road	Dallas	75232	South Dallas
	Park South Family YMCA	2500 Romine Ave.	Dallas	75215	South Dallas
	Reinhardt Boys & Girls Club	Reinhardt Elementary 10122 Losa Dr.	Dallas	75235	Stemmons Corridor
	Richardson Boys & Girls Club	St. Luke's Lutheran Church 1210 West Beltline Rd.	Richardson	75080	Outer Northeast
	Roseland Boys & Girls Club	2101 N. Washington Ave.	Dallas	75204	North Dallas
	T. Boone Pickens YMCA	601 N. Akard Street	Dallas	75201	Stemmons Corridor
	Town North Family YMCA	4332 Northaven	Dallas	75229	Stemmons Corridor
	Turnkey Boys & Girls Club	6539 Treetop Ln.	Dallas	75241	South Dallas
	Wellington Place Boys & Girls Club	230 S. MacArthur Blvd. #315	Coppell	75019	Northwest Dallas
	West Dallas Boys & Girls Club	Arlington Park Recreation Center 1505 Record Crossing	Dallas	75235	Stemmons Corridor

	West Dallas Community Centers, Inc.	2828 Fishtrap Rd.	Dallas	75212	Southwest Dallas
	Westlake Village Boys & Girls Club	1057 Cascade #1017D	Mesquite	75149	Southeast Dallas
	Williams Prep Boys & Girls Club	1750 Viceroy Dr.	Dallas	75235	Stemmons Corridor
	YMCA at White Rock	7301 Gaston Avenue	Dallas	75214	North Dallas
Walking/Biking Trails (9)	Bachman Lake Park Loop Trail	4347 W. Northwest Hwy. Suite 180	Dallas	75220	Stemmons Corridor
	Cedar Ridge Preserve Nature Trails	7171 Mountain Creek Parkway	Dallas	75249	Cedar Hill
	Cottonwood Trail	12225 Willowdell	Dallas	75243	Northeast Dallas
	Katy Trail	5207 McKinney Ave STE 9	Dallas	75205	North Dallas
	Oak Cliff Nature Preserve	2875 Pierce Street	Dallas	75233	Southwest Dallas
	Preston Ridge Trail	7522 Campbell Rd., Suite 113-167	Dallas	75248	Northwest Dallas
	Trinity Strand Trail	801 Core Street Suite B	Dallas	75207	Stemmons Corridor
	Valley View Park Nature Trails	7000 Valley View Road	Dallas	75240	North Dallas
	White Rock Lake Park Loop Trail	PMB 281 381 Casa Linda Plaza	Dallas	75218	North Dallas

APPENDIX E

The Health of Dallasites: The Top 5 Health Issues Facing Dallas County Residents

Note: This preliminary list will be narrowed down to five issues following the workgroup vote.

Adult Asthma – Environmental Risks

The Dallas County adult asthma rate is higher than the state average, with the highest rates in the southern Dallas communities. Risks in a person's physical environment can be addressed to decrease chances of developing the condition in many cases.

Chronic Disease – Multiple Diagnoses

Dallas County residents are increasingly being diagnosed with having more than one chronic disease, including, cancer, diabetes, and cardiovascular disease. Addressing common risk factors through health programs, medical homes, screening, and improved personal fitness can improve the overall health of our residents.

Cultural Competence – Health of the Whole Person

Disease prevention requires the consideration of the physical person, their emotional well-being, lifestyle, and what is important to them. The diversity of Dallas County requires that health professionals demonstrate cultural competence by delivering information and treatment in an understandable manner while also accounting for health literacy factors.

Healthcare Access – Health Insurance Coverage and Physician Shortage

Dallas County has a large portion of residents who are uninsured. Implementation of the Affordable Care Act will impact the percentage of adults and children receiving health insurance coverage, and will also impact physician to population ratios for the insured. The changing environment will call for monitoring provider acceptance of new patients by payment source, as well as a need to inform eligible persons of any changing insurance eligibility requirements. There is also a shortage of primary care physicians, and they are maldistributed within the county thereby leaving areas underserved.

Health Disparities – Resource Deserts

Portions of suburban areas and large geographic areas of southern Dallas County often suffer from disproportionate disease rates and substantial resource deserts. These deserts lack key resources that other portions of the county have, including access to health services - primary and specialty care – and access to healthy foods.

Infant Mortality – Preventable Deaths

The rates of unintended pregnancy in Dallas County are highest among African Americans and Latinos, and are often preventable. Latinos have the highest birth rate, and African Americans have the highest infant mortality rates and low birth weight babies.

Infrastructure – Unifying Prevention Efforts and Maximizing Resources

Dallas County has an abundance of health programs and improvement plans currently being implemented in silos. Collaboration to increase awareness of countywide efforts, while reducing competition for financial resources, is critical to maximize available public health funds.

Mental and Behavioral Health – Illness Impact on Health Decisions

Individuals in Dallas County suffering from mental and behavioral illnesses face decision-making barriers. These barriers impact compliance with preventive care and treatment thereby compromising aspects of their physical health also.

Sexual Behaviors – Risk Education and Awareness

Disparities in sexually transmitted disease rates in Dallas County demonstrate a need for targeted risk and awareness interventions surrounding risky behavior and at-risk populations. These same behaviors may contribute to unplanned pregnancy rates as well.

APPENDIX F
DALLAS COUNTY HEALTHCARE COLLABORATIVES IDENTIFIED DURING KEY INFORMANT INTERVIEWS

1. Childhood Obesity Collaborative--Charting the Course
2. North Texas Accountable Healthcare Partnership
3. Dallas Regional Chamber—sunsetting committee on health
4. Children's Health Steering Committee (United Way facilitating)
5. DFW Steering Committee for Child Health Promotion
6. Immunization Collaborative
7. CHIP Coalition
8. Child Abuse Prevention
9. Poverty Coalition
10. 0 – 5 Collaboration has done good work in Bachman
11. Diabetes Coalition
12. United Way of Metropolitan Dallas Health Collaborative Team
13. Cross Sector Advisory Group will become authority in improving health
14. Consortium on MetroCare to build homes
15. Chamber of Human Services Nonprofilts
16. Collaborative for Senior regarding safety and neglect
17. DFW Hospital Council
18. DFW Business Group on Health
19. Tried to have a Dallas-wide Healthy Communities Coalition with the head of police, fire, Parkland
20. Healthy Zones School Program

APPENDIX G ASSESSMENT RESOURCES

The public health improvement workgroup identified these specialized health assessment resources, whose aggregate findings have been considered during HORIZONS development. For more detailed information on select topics, please review the following local resources:

- Assessment of the Community Behavioral Health Delivery System in Dallas County, Dallas County Behavioral Health System Redesign Task Force
- Beyond ABC: Assessing Children's Health in Dallas County, Children's Medical Center
- Community Profile Report, Dallas County Affiliate of Susan G. Komen for the Cure
- Comprehensive HIV Needs Assessment, Ryan White Planning Council of the Dallas Area
- Regional Behavioral Health Needs Assessment, North Texas Behavioral Health Authority
- Regional Health Partnership 9: Community Needs Assessment Report, Dallas Forth Worth Hospital Council
- United 2020, United Way of Metropolitan Dallas

Section II. Executive Overview of RHP 18 Plan

High-level summary of existing RHP healthcare environment

Collin County ranks 1st of all Texas counties in *Health Indicators,* published by the Population Health Institute (PHI) at the University of Wisconsin. Rockwall County ranks 3rd, and Grayson County ranks 125th among Texas' 254 counties. Health indicators are discussed in Section III of this plan. Health indicators computed by the PHI are only one aspect of the total health portrait of RHP-18. This urban/rural area of Texas is growing at a remarkable speed. In one year Collin and Rockwall counties' populations grew by 3.8% each, and Grayson's by 0.4%, with a total of an estimated 1.01 million residents in these three counties as of July 2011. Per-capita income in Collin and Rockwall counties is higher than the average for the State of Texas; and in Grayson County it approximates the Texas average of $24,870. Nearly 77,000 (7.6%) of these individuals are estimated to be living in poverty (6.5% in Collin, 4.5% in Rockwall and 12.6% in Grayson County)[1], and about 124,196 (12%) are uninsured. Approximately 64,288 (6.3%) men, women and children are enrolled in Medicaid in RHP-18.

These counties face similar health challenges as other counties in this State. Among the key health challenges among underserved and uninsured populations are gaps in primary care access to prevent possibly avoidable use of local and remote emergency departments, limited availability of "after-hours" continuity of care clinics that address co-morbid medical/psychiatric conditions, effective linkages with nursing homes, in-home family based care for at-risk youth.

The location of health providers in RHP-18 is outdated and has not kept pace with the growth to the north, or reached out to remote areas to the northeast. Approximately 6,790 individual uninsured admission events were reported by all hospitals that treated residents from RHP 18 in 2010. If the average annual increase from 2008 to 2010 continues, an estimated 9,000 uninsured admission events would occur in 2015.

[1] United Way report on file, 2011-2015 Texoma Needs Assessment, Texoma Council of Governments

In 2010, uncompensated care (UC) represented an average of 4.2% ($197.6 million) of the gross patient revenue for all hospitals in Collin, 7.5% ($69.5 million) in Grayson, and 4.5% ($26.8 million) in

Rockwall counties. With planned changes in how UC is managed and paid, this is likely to decrease, putting some pressures on community providers that cannot serve local needs sufficiently to prevent hospitalization, thus putting additional pressure on Dallas County facilities.

Hospitals and community providers must begin to cooperate in transforming health care in RHP-18.

RHP-18 providers participating in this Medicaid Transformation Waiver are focused on five of the 12 health indicators identified by the U.S. Center for Disease Control in **Healthy People 2020**. These five have emerged as important areas of need in the planning process for the Texas Healthcare Transformation and Quality Improvement Program in Collin, Grayson, and Rockwall counties.

- Access to health services
- Clinical preventive services
- Maternal, Infant, and Child Health
- Nutrition, Physical Activity and Obesity
- Social Determinants of medical and behavioral health problems

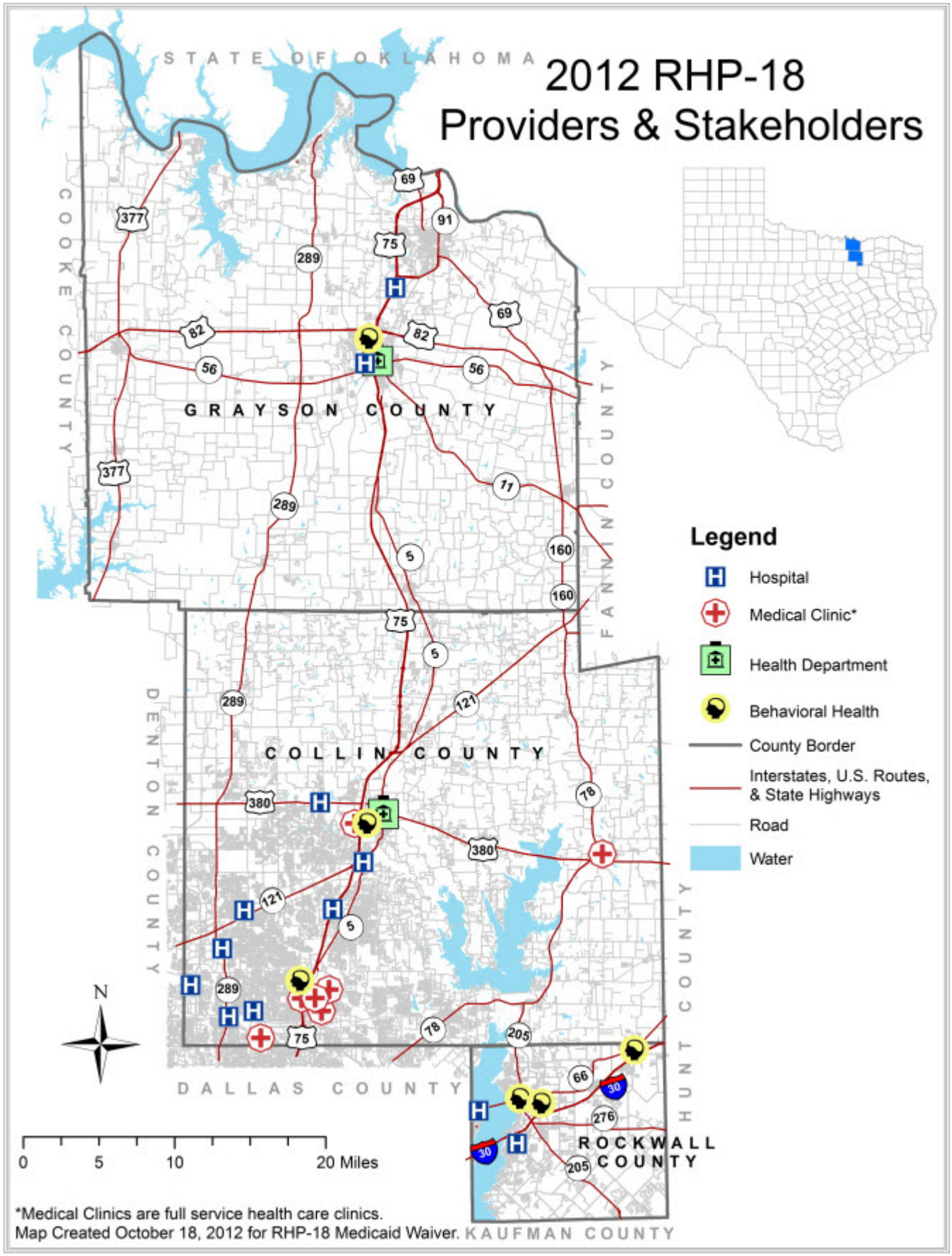
This Plan addresses these areas of need by expanding access to primary prevention and intervention in medical and behavioral health and increasing community education initiatives to prevent or avert and refer non-emergent cases presenting to emergency systems. New and expanded services will be dedicated to serving all ages and all racial and ethnic groups with innovative and collaborative evidence-based strategies. Innovation includes telemedicine, patient tracking systems, outreach and partnerships.

RHP-18 Delivery System Reform Incentive Payment (DSRIP) projects focus on expanding access to primary care for adults and children, establishing effective referral procedures, and monitoring systems. This includes addressing Potentially Preventable Admissions (PPAs) by increasing the number and type/mix of providers, expanding hours of operations, and installing follow up procedures, telephone consultations and case management activities. The medical home model for persons with chronic co-morbid physical and behavioral health conditions will be an important part of the plan. By enhancing culturally responsive programs, implementing disease registry systems, and increasing telehealth services, RHP-18 will reach out to a substantially heretofore underserved community.

Identification of regional areas, specifically listing counties covered under the partnership

RHP-18 consists of three counties in north Texas (Collin, Grayson and Rockwall) that lie as a cluster directly north of Dallas County. In the southern borders of Collin County some metropolitan areas overlap, and may lie within with Dallas County. Geographic, socio-demographic and economic characteristics of RHP-18's counties, as they pertain to this transformation waiver plan, are discussed in Section III.

On the following page we have provided a map of the counties in RHP-18 illustrating the location of healthcare providers.


2012 RHP-18
Providers & Stakeholders
STATE OF OKLAHOMA
COOKE COUNTY
GRAYSON COUNTY
FANNIN COUNTY
DENTON COUNTY
COLLIN COUNTY
DALLAS COUNTY
HUNT COUNTY
ROCKWALL COUNTY
KAUFMAN COUNTY
Legend
Hospital
Medical Clinic*
Health Department
Behavioral Health
County Border
Interstates, U.S. Routes, & State Highways
Road
Water
N
0 5 10 20 Miles
*Medical Clinics are full service health care clinics.
Map Created October 18, 2012 for RHP-18 Medicaid Waiver.

Section III. Community Needs Assessment

This section of the RHP-18 Plan provides information prescribed by HHSC. All data sources are identified.

Geographic, Socio-Demographic and Economic Characteristics

The Regional Healthcare Partnership 18 (RHP-18) consists of three counties (Collin, Grayson and Rockwall) in North Texas, geographically located directly north of Dallas County. In the southern borders of Collin County metropolitan areas overlap with Dallas County. The overlap of city limits across county lines is an important consideration for the RHP-18 plan.

According to the U.S. Census Bureau, there are an estimated 1,014,935 residents in RHP-18, approximately 172,879 (17%) of whom are estimated to be uninsured. The Texas Department of State Health Services (DSHS) Medicaid website reports that in 2012, 64,288 (6.3%) individuals in RHP-18 were enrolled in Medicaid, reflecting increases over 2011, of 10% in Collin, 3% in Grayson, and 2% in Rockwall.

Collin and Rockwall counties are included in the Dallas-Fort Worth-Arlington Standard Metropolitan Statistical Area (SMSA) as defined by the U.S. Census Bureau. Grayson County is part of the Sherman-Denison SMSA. While none of these counties is classified as rural or small, large contiguous areas of each county are considered remote when considering access to health care. The urban population density in Collin County is 2,754 persons per square mile compared to Dallas' 3,401. Regarding rural populations, in Grayson County, 43% of the population lives in rural areas as defined by the U.S. Census Bureau, in Rockwall 16%, and in Collin, 5%. In Grayson County, the rural population density is 58 compared to Collin's 71, and Rockwall's 141. As a comparison, Dallas County's rural density is about 90.

Healthcare providers have historically been located close to the urban sectors of RHP-18, particularly in Collin County where eight acute care hospitals are located along the Southern-most border.

Health Status

Table 2 displays 18 indicators for the three counties in RHP-18 that we believe to be germane to this community needs assessment, with comparison data for Texas and the Nation. The sources are noted below the table.

While these high-level indicators influence the overall approach to the plan for expanding and transforming Medicaid services, data reporting existing services and their utilization, population health status and changes, are proxies for estimates of need. The qualitative analyses of these data combined with the perspectives of the county government, the citizens, and the healthcare providers enable us to pinpoint specific issues/needs that have been subsequently addressed by the performing providers as parties to this plan. Thus this RHP-18 plan relied both on high level and local assessments to establish and guide the projects, milestones, metrics and outcomes selected for the proposed 2011-16, Delivery System Reform Incentive Payment (DSRIP) projects.

Each county in RHP-18 has distinguishing characteristics and some features in common. As shown in Table 1, these communities have relatively healthy economies, and the communities are predominantly comprised of White Non-Hispanic residents. The culture is continuously changing, however, and some demographic features indicate important areas for attention. A distinguishing feature of Collin County for example, is the presence of a large Asian population compared to the rest of Texas and the sizeable proportion of individuals who speak a language other than English at home.

Increases in non-farm employment, retail sales, median and per capita income indicate economic growth in Collin and Rockwall counties. Grayson County appears to have strong economic indicators, but faces a growing elderly population, decreased employment, and limited access to primary medical care.

Table 1. RHP 18 County and State Indicators

	COLLIN	GRAYSON	ROCKWALL	TEXAS
Land area in square miles, 2010	841	933	127	261,231.71
Persons per square mile, 2010	930	130	617	96
Population, 2011 estimate	812,226	121,419	81,290	25,674,681
Population change 4/1/10 - 7/1/11	4%	0.4%	4%	2%
Proportion of population enrolled in Medicaid	5%	13%	6%	13%
Persons under 18 years, percent, 2011	28%	24%	29%	27%
Persons under 18 enrolled in Medicaid	11%	28%	12%	32%
Persons 65 years and over, percent, 2011	8%	16%	10%	11%
Female persons, percent, 2011	51%	51%	51%	50%
Persons below poverty level, percent (2)	7%	14%	6%	17%
Percent population uninsured (ages 0 - 64)	17%	25%	19%	26%
Black	9%	6%	6%	12%
White	76%	89%	89%	81%
White non-Hispanic	62%	78%	73%	45%
Hispanic or Latino	15%	12%	17%	38%
Asian	12%	1%	3%	4%
Other racial ethnic groups	1.0%	2.0%	1.0%	1.0%
Foreign Born (2)	17%	6%	9%	16%
Over age 5: speak other language at home (2)	25%	10%	15%	34%
High school graduates over age 25 (2)	93%	85%	91%	80%
Bachelor's degree or higher over age 25 (2)	48%	19%	36%	26%
Veterans (2)	42,078	10,176	5,425	1,635,367
Housing units (3)	300,960	53,727	27,939	9,977,436
Households (2)	268,042	45,545	24,790	8,539,206
Per capita money in previous 12 months (2)	$37,362	$23,242	$33,274	$24,870
Median household income (2)	$80,504	$46,875	$78,032	$49,646
Private nonfarm employment change 2000-09	56%	-4%	74%	11%
Retail sales per capita, 2007	$16,850	$13,493	$12,797	$13,061

(1) 2011 estimates

(2) Averages for five years 2006-10

(3) for 2010

Table 2 displays key health indicators for each RHP-18 county. These data were obtained for each county at: http://www.countyhealthrankings.org/#app/texas/2012/measures/factors/9/map. Of particular note in this table are the rates of low birth weight infants that are only slightly lower than the average for all Texas counties, and higher than the national average. Also of note, RHP-18 counties overall have lower proportions of uninsured residents than the State as a whole but higher than the national estimates.

Table 2. Health Outcomes and Health Facts (1)

	Texas	Collin	Grayson	Rockwall	National
Health Outcomes		**1**	**125**	**3**	
MORTALITY RANKING		**2**	**138**	**3**	
Premature death	7,186	4,038	8,901	4,58	5,466
MORBIDITY RANKING		**14**	**121**	**8**	
Poor or fair health	19%	11%	19%	6%	10%
Poor physical health days	3.6	2.7	3.7	2.9	2.6
Poor mental health days	3.3	2.5	5.8	3.1	2.3
Low birthweight	8.20%	7.60%	7.40%	7.00%	6%
Health Factors		**2**	**54**	**4**	
HEALTH BEHAVIORS RANKING		**1**	**52**	**5**	
Adult smoking	19%	11%	24%	8%	14%
Adult obesity	29%	25%	27%	27%	25%
Physical inactivity	25%	22%	27%	27%	21%
Excessive drinking	16%	13%	11%	missing	8%
Motor vehicle crash death rate	17	9	25	1	12
Teen birth rate	63	24	63	26	22
CLINICAL CARE RANKING		**2**	**45**	**17**	
Uninsured	26%	17%	25%	19%	11%
Primary care physicians	1,050:1	681:1	1,305:1	1,080:	631:1
Preventable hospital stays	73	66	73	82	49
Diabetic screening	81%	85%	83%	85%	89%
SOCIAL AND ECONOMIC RANKING		**3**	**81**	**5**	
Unemployment	8.20%	7.50%	8.40%	7.60%	5.40%
Children in poverty	26%	10%	21%	9%	13%
Children in single-parent households	32%	18%	33%	20%	20%

(1) University of Wisconsin Population Health Institute. County Health Rankings 2012. Accessible at www.countyhealthrankings.org.

Diabetic screening is the percent of Medicaid patients with diabetes who receive recommended annual screening

Rates of chronic disease vary slightly by source. The sources we used indicate that prevalence rates in RHP-18 for targeted conditions in this plan are equal to or lower than the State of Texas (%) for Asthma (8.2%), Diabetes (9.7%), overweight/obesity (66.7%), and Cardiovascular Disease (8.2%). More than a quarter of pregnant women in each county (28% in Collin, 42% in Grayson, and 31% in Rockwall) do not receive prenatal care within the first trimester. Higher proportions of White, compared to Black and Hispanic women, receive early prenatal care.

None of these counties has a public hospital. Local hospitals, public health departments, and publically funded clinics are the staples of the healthcare system in RHP-18. Table 3 displays total numbers from http://www.healthindicators.gov/ the Health Indicators Warehouse website, for hospital and personnel resources in RHP-18. Regarding public health departments, Collin and Grayson counties have full service public health departments. Rockwall County, however, has a different structure inasmuch as this county utilizes a city office of code enforcement and cooperates with the Dallas County Health Department for other public health related functions.

While none of these counties is a Health Professions Shortage Area or a Medically Underserved Area according to Federal criteria, there are pockets of severely limited access to primary and preventive care leading to potentially preventable hospital admissions (PPAs).

There are currently two Federally Qualified Health Clinics in RHP-18. Although it is difficult to pinpoint precisely how many primary care physicians are available per/1,000 residents, and even more difficult to document the number of physicians who accept Medicaid or uninsured persons (if any), the below table reflects the best available data from the CDC, DSHS, and other few national websites that count healthcare workers at the county level.

Table 3. Healthcare Resources

Hospital Resources	**Collin**	**Grayson**	**Rockwall**	**Total RHP 18**
Acute care hospitals	10	3	2	15
Psychiatric care licensed beds	0	0	0	0
Healthcare Personnel				
Direct Care Physicians	1,483	245	113	1,841
Primary Care Physicians	691	86	60	837
Physician Assistants and Nurse Practitioners	357	55	36	448
EMS Personnel Per 100,000 population	187	447	323	Not Available

http://www.dshs.state.tx.us/chs/hprc/tables/Emergency-Medical-Services-(EMS)-by-County-of-Residence---September,-2011/
Collin ranked 223 for EMS personnel
Grayson ranked 53 for EMS personnel
Rockwall ranked 105 for EMS personnel
Texas ranks 42nd with 212/100,000 physicians

Key health challenges specific to region

Potentially Preventable Hospital Admissions and ED Utilization

Tables 4, 5 and 6 present each county's data for each of the 10 conditions identified by DSHS as Potentially Preventable Hospital Admissions (PPAs) in Texas over a five year period of time (2006-10). We provide presented total admissions, average length of stay (ALOS), total charges in millions, average charge, percent of uninsured admissions, and the zip codes representing approximately half of the total admissions for that county per PPA. Some data were unavailable for Grayson and Rockwall counties (shaded).

Collin County

Table 4 provides Collin County data. The county seat in Collin County is McKinney. The median age in Collin County is 34, and 8% of residents are over age 65 (Table 1). Seven percent of Collin County residents live in poverty. In FY 2009, Collin County reported $669,300 spent for indigent health care.

In Collin County, two zip code areas (75070 and 75069) contributed the largest number of admissions for angina, bacterial pneumonia, congestive heart failure (CHF), dehydration, and hypertension. These factors may suggest that outreach to nursing homes may be important. The top three highest average charges were for pneumonia, CHF, and urinary tract infections (UTI), followed by chronic obstructive pulmonary disease (COPD), long-term diabetes problems, and asthma.

Table 4. Collin County Potentially Preventable Admissions - Five Years: 2006 - 2010

PPA	Total (Per Year)	ALOS*	Total Charges	Ave. Charge	Percent Uninsured	Combining Zip Codes ≥ 50%**
Angina	183 (37)	1.9	$ 3.4	$ 18,366	6.0%	070, 069, 098, 002, other
Asthma	1796 (359)	4.6	$ 54.8	$ 30,501	13.7%	069, 287, 075, other
Bacterial Pneumonia	5090 (1018)	5.6	$ 189.1	$ 37,157	6.5%	069,070, 002, other
Congestive Heart Failure	4950 (990)	5.4	$ 182.5	$ 36,866	5.8%	069, 070, 023, other
COPD	2505 (410)	5.4	$ 87.6	$ 34,970	5.2%	069, 002, 098, other
Dehydration	1394 (279)	3.6	$ 28.9	$ 20,760	4.4%	070, 069, 023, 002, other
Diabetes - Short Term	819 (164)	3.8	$ 22.4	$ 27,950	26.0%	287, 034, 069, 098, 023, other
Diabetes - Long Term	1639 (328)	6.6	$ 69.3	$ 42,276	11.3%	069, 098, 025, 002, other
Hypertension	1016 (203)	2.8	$ 23.1	$ 22,715	18.5%	069, 287, 070, 074, other
UTI	3643 (729)	4.4	$ 92.6	$ 25,418	7.5%	069, 075, 023, 074, 002, other

Grayson County

Table 5 provides Grayson County data. The county seat for Grayson County is Sherman, located near the Oklahoma border. The median age is 40, and 16% of the residents are over age 65 (Table 1). Fourteen percent of the population lives in poverty.

Table 5. Grayson County Potentially Preventable Admissions - Five Years: 2006 - 2010

PPA	Total (Per Year)	ALOS*	Total Charges	Ave. Charge	Percent Uninsured	Combining Zip Codes ≥ 50%**
Angina						
Asthma	519 (104)	4.1	$ 9.7	$ 18,640	13.9%	020, 090, 092
Bacterial Pneumonia	2322 (464)	5.3	$ 51.6	$ 22,229	5.1%	020, 090, 092
Congestive Heart Failure	1982 (396)	5.3	$ 44.3	$ 22,341	3.9%	020, 090, 092
COPD	1624 (325)	4.7	$ 32.6	$ 20,066	4.4%	020, 090
Dehydration	646 (129)	3.9	$ 9.5	$ 14,630	3.4%	020, 090
Diabetes - Short Term	306 (61)	3.8	$ 5.3	$ 17,242	22.5%	020, 090
Diabetes - Long Term	662 (132)	5.8	$ 16.3	$ 24,653	7.3%	090, 020
Hypertension	351 (70)	2.9	$ 4.9	$ 14,002	12.8%	020, 090, 092
UTI	1331 (266)	4.6	$ 22.2	$ 16,670	4.9%	020, 090, 092

In FY 2009, Grayson County reported $1,711,234 spent for indigent health care. In Grayson County, two zip code areas (75020 and 090) contributed the largest number of admissions. The highest charges over this five-year period were for pneumonia, CHF, and COPD, followed by UTI and asthma. These data also suggest follow up with nursing home residents may be important. No data were available for angina.

Rockwall County

Table 6 provides data for Rockwall County. The county seat for Rockwall County is Rockwall. The median age is 36, and 10% of the population is over age 65. In Rockwall County, 6.4% of the residents live in poverty (Table 1). In FY 2009, Rockwall County reported $197,026 spent for indigent health care.

The greatest proportion of admissions for pneumonia, CHF, COPD, and UTI came from zip code 75087. PPAs with the highest charges were long-term complications of diabetes, pneumonia, and CHF. Data were not available for angina, asthma, or hypertension.

Table 6. Rockwall County Potentially Preventable Admissions - Five Years: 2006 - 2010

PPA	Total (Per Year)	ALOS*	Total Charges	Ave. Charge	Percent Uninsured	Combining Zip Codes ≥ 50%**
Angina						
Asthma						
Bacterial Pneumonia	727 (145)	4.9	$ 19.8	$ 27,289	4.1%	087
Congestive Heart Failure	506 (101)	4.5	$ 12.8	$ 25,265	3.8%	087
COPD	403 (80)	4.2	$ 10.1	$ 25,102	0.0%	087
Dehydration	203 (40)	3.1	$ 3.3	$ 16,384	4.9%	087, 032
Diabetes - Short Term						
Diabetes - Long Term	186 (37)	5.0	$ 5.8	$ 31,631	5.4%	189
Hypertension						
UTI	406 (81)	4.0	$ 9.0	$ 22,203	4.4%	087

In every county in RHP-18, the highest proportion of uninsured potentially preventable admissions (PPAs) is diabetes for long-term problems. In Collin and Grayson, asthma and hypertension admissions include a substantial proportion of uninsured events. Of note is the presence of a co-morbid psychiatric condition in between 25% to 50% of these PPAs.

Other issues in PPAs and ED use in contiguous counties

Due to the close proximity and overlap between Collin and Dallas counties admissions to hospitals in Dallas County are of importance in planning the healthcare system. Admissions to Parkland Memorial Hospital (Parkland) for all RHP-18 counties are important, and admissions to all local RHP-18 hospitals are also critical data for planning.

Table 7 provides PPAs to hospitals located in Dallas County for Collin County residents for the past 15 months, by the total number of admissions, and the proportion of private insurance, public insurance, and uninsured events. Dallas County has a health and behavioral health care system of immense resources for Medicaid and uninsured populations, compared to RHP-18. Thus, it is an important aspect of the system when considering healthcare needs in RHP-18, in that patient flow to resources outside of RHP-18 provide an important opportunity to recognize limited or underdeveloped resources in these three counties that if expanded would reduce the burden on hospitals in Dallas particularly Parkland Memorial Hospital as the only major public hospital a large geographic area. RHP-18 also relies on private healthcare facilities in Dallas County for behavioral health emergencies.

Table 7. Collin County PPA to All Dallas County Hospitals January 2011- march 2012

Payment Source	Diabetes Short Term	Diabetes Long Term	Congestive Heart Failure	Bacterial Pneumonia	Dehydration	Hypertension	Angina (Not treated)	Adult Asthma	UTI	COPD	Totals
Totals	***126***	***83***	***168***	***252***	***72***	***48***	***6***	***33***	***164***	***91***	***1043***
Insured & Medicare	71%	43%	38%	48%	58%	52%	50%	55%	38%	43%	48%
	13%	48%	55%	47%	35%	31%	17%	30%	56%	53%	44%
Uninsured	17%	8%	8%	4%	7%	17%	33%	15%	5%	4%	8%

Tables 8 and 9 on the following pages provide information about the admissions from RHP-18 to all hospitals in these three counties and to Dallas County hospitals, combined, and admissions to Parkland Memorial Hospital. Interestingly, as shown in Table 8 and its accompanying graph, admissions were lower for Medicaid patients in 2010 compared to 2009, but higher for uninsured patients in 2010 compared to 2009. It is unclear if this is a trend or an anomaly.

In the first quarter of 2012 there were 14,035 Emergency Department (ED) visits reported for uninsured residents of RHP-18 to hospitals in RHP-18 and Dallas County hospitals combined (18.7% of all events), an increase of 15% over the previous year. Reported Medicaid and Medicare covered ED visits were 22,891, an increase of 23% over the same quarter in 2011. We also know from available data that an estimated 25% of these events are for individuals who are released without needing inpatient care. Between January 2011 and April 2012, Parkland Memorial Hospital (Parkland) discharged 577 uninsured admissions back to RHP-18, 4.3% of which were for PPAs. These individuals represent a population that will have access to expanded primary care services under the DSRIP projects proposed in this plan.

Table 8: RHP 18 Admissions to All Hospitals

Medicaid 2008	Medicaid 2009	Medicaid 2010	Uninsured 2008	Uninsured 2009	Uninsured 2010
6,085	8,643	7,408	4,537	5,022	5,100
2,677	2,791	3,020	1,050	1,170	1,239
668	839	785	468	421	451
9,430	12,273	11,213	6,055	6,613	6,790

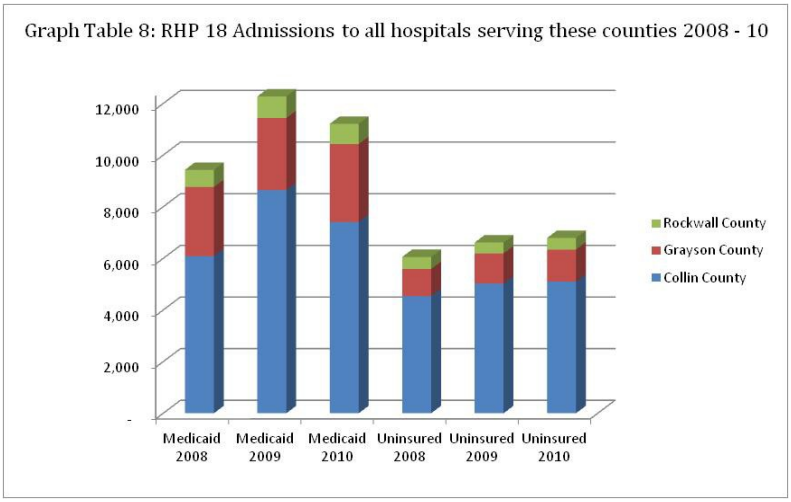
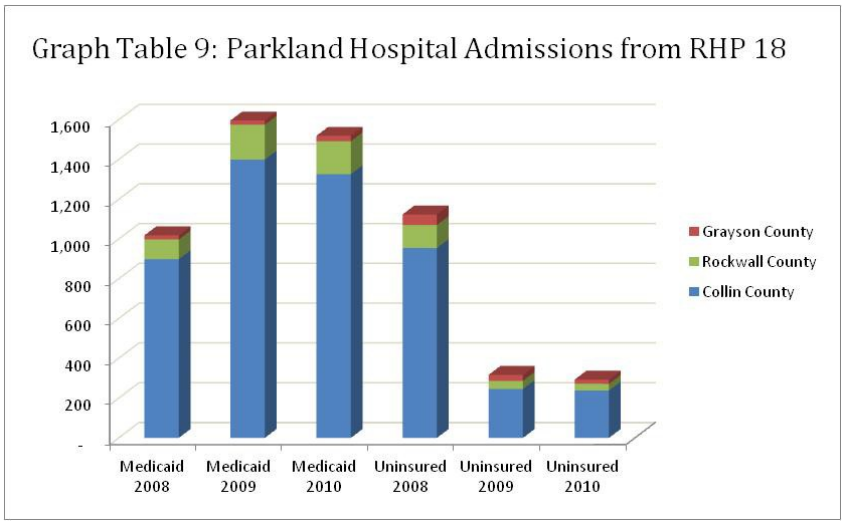


Table 9. RHP 18 Admissions To Parkland Hospital 2008-10

Medicaid 2008	Medicaid 2009	Medicaid 2010	Uninsured 2008	Uninsured 2009	Uninsured 2010
899	1,400	1,327	955	246	238
99	175	165	116	41	34
21	22	28	53	30	21
1,019	1,597	1,520	1,124	317	293



As shown in Table 9 and its accompanying graph above, RHP-18 admissions to Parkland Memorial have decreased in the total number of uninsured events. This may be a function of patient transfers among hospitals in the general metropolitan area or increasing enrollment in Medicaid.

Data in tables 7, 8 and 9 were obtained by request, from the Dallas - Fort Worth Hospital Council Foundation.

The needs in RHP-18 regarding PPAs and ED visits are at the heart of our plan to expand primary care access and implement innovative community interventions.

Children's Health

Compared to 2009, the number of children of Hispanic ethnicity is on the rise in Collin and Grayson counties and on the decline in Rockwall. In addition, there are increases in the number of Black children in all three counties. The Black population nearly doubled in Collin, and there were decreasing numbers of White non-Hispanic children in Collin and Rockwall counties. The infant mortality rate was 5.2 per 1,000 in Collin, 5.7 in Grayson, and 3.0 in Rockwall.

In Collin County, an estimated 26,798 children are uninsured, 8,039 of whom live in households earning 200% or less of the Federal Poverty Level (FPL). Grayson and Rockwall counties have 5,380 (1,264 ≤ 200% FPL) and 3,514 (1,118 ≤ 200% FPL) in that status, respectively. In 2011, rates of confirmed victims of child abuse per 1,000 were 5.4 in Collin, 10.2 in Grayson, and 3.3 in Rockwall counties.

Of the 14,035 reported uninsured ED events for RHP-18, 14.7% were for children under age 15. PPAs for children tend to involve asthma or respiratory illnesses and accidents. National statistics suggest that 1 out of 7 pre-school age children in low-income families is obese, and 17% of children age 2 to 19. White Hispanic boys, and Black, non-Hispanic girls are at higher risk for obesity than other race and ethnic groups.

Statistics for 2008 reflect that in Collin County, ~8% of all births were considered low birth weight babies, in Grayson County, 7%, and in Rockwall County 8.2%. Race, ethnicity, poverty, chronic diseases, health problems, and low birth weight babies are all factors associated with the need for expanded access to primary care for children.

A generally accepted national risk estimate for youth needing mental health and chemical dependency treatment is 9%. Youth are typically underserved because they do not come to the attention of schools or

families without a precipitating event usually violent. Many youth enter the public mental health system though the juvenile justice system. Family courts need more resources for referrals for troubled youth and families ordered for evaluation and possible counseling to avoid the child being removed from the home and placed in supervised living or foster care

Behavioral Health

The greatest three needs in behavioral health (mental health and chemical dependency) are increased access to care, targeted resources to prevent relapse/re-hospitalization/higher cost care, and expanded diversity of evidence-based services such as jail diversion/mental health courts, peer-counseling, and integrated physical/behavioral care. Crisis response systems are limited, and access to public inpatient care is primarily on an emergency basis primarily utilizing local law enforcement and Dallas County based programs for homeless and crisis services. Estimates are that over half of the persons in community based behavioral healthcare programs are uninsured.

Collin and Rockwall counties participate in the NorthSTAR Behavioral Health System operated by Value Options, a private for-profit insurance corporation (3,793 persons received services in the third quarter of 2012). LifePath Systems serves Collin County, and Rockwall County residents are served by Lakes Regional MHMR Center that also serves fourteen other counties in North Texas. Individuals who need behavioral health services in the NorthSTAR area must meet the same clinical criteria used statewide but must also document stricter financial eligibility to gain access to care.

Under the principle of open access, Collin and Rockwall County residents have equal access to care throughout the geopolitical area covered by NorthSTAR. Collin and Rockwall County residents, particularly those in proximity to Dallas, can acquire behavioral health services anywhere in the seven counties by choice or as a consequence of insufficient locally available services. According to the DSHS "NorthSTAR Data Book: Summary Information on County Trends, FY06-FY11", the NorthSTAR system spends less than one-half of the per client amount spent in the rest of Texas. NorthSTAR's open access also has had an unintended consequence of certain services, such as jail diversion, veterans' services, mobile crisis, supported housing, and after hours clinics being centralized in Dallas County rather than distributed more evenly in Collin and Rockwall counties.

Two major shifts in the NorthSTAR system for behavioral health occurred in 2010. Outpatient providers' contract became a flat-rate contract resulting in limited access for new mental health clients with consequent referrals of some residents to other NorthSTAR providers in Dallas. In September of 2009, Value Options eliminated Supportive Outpatient Therapy for substance abuse treatment, requiring these consumers to meet the higher level of care criteria of Intensive Outpatient Treatment to access care.

Collin County has been perceived traditionally by the NorthSTAR system as having less demand for behavioral health services than its largest contiguous county, Dallas. Collin County's behavioral health services needs however, are apparent from the direct and synthetic estimates of need and in the historical patterns of services utilization by Collin County residents documented in a published 2010 report. While the population in Collin County has grown 59% over the past 10 years, LifePath Systems has not expanded its capacity, and due to funding cuts has been forced to reduce services available by almost 50% from the baseline of 1999.

According to a study conducted by The Strategic Planning and Population Medicine Department of the Parkland Health & Hospital System, titled "Collin County Community Checkup 2008", the arrest rate for all drug offenses increased from 180.1 per 100,000 persons in 2002 to 276.1 in 2006. Substance abuse (SA) related death rates increased from 33 per 100,000 persons in 2000 to 33.6 in 2004. These statistics reflect the increasing need for qualified chemical dependency provider, and the importance of early intervention services to prevent criminal justice involvement and SA related deaths. http://www.dfwhc.org/documents/CollinCountyCommunityCheckup2008_000.pdf. Rockwall County has identified a critical need to improve jail diversion services. Family services to improve early intervention with juveniles to prevent criminal activities is also a critical need.

A large population not getting access to treatment is the working-poor not eligible for state-funded services, but unable to actually pay the full cost of behavioral health services. According to a 2012 Substance Abuse and Mental Health Services Administration (SAMHSA) approximately 20% of the population met the criteria for "Any Mental Illness" during a 12 month period, resulting in an estimated 155,685 Collin County individuals each year that should be receiving behavioral health services. http://www.samhsa.gov/data/NSDUH/2k12Findings/CBHSQDataReviewC2MentalHealth2012.htm

Physical and Behavioral Health services are also often not available or available in a timely manner to individuals with Intellectual and Developmental Disabilities (DD).Individuals with DD meet with access obstacles or long waiting periods for appointments, as there are too few providers who accept Medicaid. Few providers are experienced or trained in treating DD individuals with co-morbid psychiatric disorders.

RHP 18 has an estimated 2011 population of 1,014,935 (Census quick facts). The Center for Disease Control (CDC) estimated in 2012 that 1 in 88 individuals has an autism spectrum disorder (ASD). Studies also show that somewhere between one and 3 percent of Americans have DD. Thus approximately 20,289 individuals in RHP-18 may have DD. Using the CDC estimate, 11,533 individuals would have ASD. Approximately 55% of individuals with ASD also have an IQ under 70 (~6,343 individuals). People with ASD are at much higher risk (75%) of developing mental illness than people with IDD. People with IDD are estimated to experience mental illness at a rate of 33%. (Quintero and Flick, 2010)

Lakes Regional MHMR serves Rockwall County, as part of the NorthSTAR service system. Evidence suggests that an area of need is to expand access to services to segments of the community who have heretofore had limited access to care.

Texoma Community Center serves Grayson County. Evidence suggests that an area of need is to expand access to services to segments of the community that have heretofore had limited access to care.

Projected major changes in demographics, insurance coverage, and healthcare infrastructure expected to occur during the waiver period of FFY 2012 – FFY 2016

In the next five years, RHP-18 will increase in population at a rate of approximately 5.5% per year. Growth overall in RHP-18 is expected to be 25% over the 2010 census by the year 2020. The proportion of uninsured adults and children with household incomes ≤ 200% of FPL is likely to increase. There is a gap (100% vs. 200%) between the poverty eligibility criteria in RHP-18 counties and other healthcare systems.

The multi-cultural demographic character of the three counties will continue to become more complex. So much about the health of a community depends on the choices its citizens make and the values upheld by its community organizations, public and private. Economic conditions that drive health consumer choices will need to change to redirect health services utilization patterns away from higher-cost emergent care systems to lower cost effective and sustaining community support systems including health education, prevention, and long-term engagement with the healthcare consumer.

Local private and public providers need to become as easy to access as the ED, if we are going to influence healthcare consumer choices. Medical home models must provide wrap-around continuity of care programs for at-risk patients with co-morbid physical and mental challenges. Local clinics and hospitals must develop community-centered partnerships with efficient targeted patient registries, referral procedures, and follow up services to effectively engage families in a wellness model versus an illness model of care.

The DSRIP projects proposed by hospitals and community services providers are directed at these types of systems changes.

The suicide rate in Grayson County is ~15/100,000 compared to 8.5 for Collin, 10 for Dallas, and 13.8 for Rockwall counties. Counties contiguous with Grayson County have suicide rates similar to those in Grayson County. Evidence points to the need for expanded services and increased rapid access to care as well as continuity of information for patients across county borders. One way to do this in more rural areas is to enhance technical capabilities through telemedicine archiving and transmitting capabilities,

increasing the number of providers with more flexible policies regarding eligible populations, addressing substance abuse, and ensuring services for co-morbid medical and behavioral health conditions.

Summary

RHP-18 subscribes collectively to the principles recommended by the Population Health Institute in the annual national health outcomes and health factors report. These are that healthy communities depend on and are derived from community members working together to assess needs and resources, focus on issues deemed by consensus to be the most important, and create effective policies and programs to favorably impact population health.

In addition to the community needs identified through national, state and local sources, RHP-18 also is attending to six of the 12 health indicators identified by the U.S. Center for Disease Control in **Healthy People 2020**. These six indicators have emerged as important areas of need in the planning process for the Texas Healthcare Transformation and Quality Improvement Program in Collin, Grayson, and Rockwall counties of Texas.

- Access to health services
- Clinical preventive services
- Injury and violence
- Maternal, Infant, and Child Health
- Nutrition, Physical Activity and Obesity
- Social Determinants of medical and behavioral health problems

Table 10 on the following page provides the list of 14 broadly defined community needs (CN) per HHSC protocol to which providers have linked DSRIP projects.

In addition to this needs assessment, in Section V of the plan, all performing providers have included narrative documentation and associated source references for discrete needs associated with each of their proposed projects and anticipated outcomes.

Table 10.

Identification Number	**Brief Description of Community Needs Addressed through RHP Plan**	Data Source for Identified Needs
CN.1	Primary care - adults	Request for Potentially Preventable Admissions (PPA) Data - Texas Department of State Health Services (DSHS) Warehouse
CN.2	Primary care - children	DSHS web site selected data: http://www.dshs.state.tx.us/wellness/data.shtm
CN.3	Prenatal care	DSHS web site selected data: http://www.dshs.state.tx.us/wellness/data.shtm
CN.4	Urgent and Emergency care	Emergency Department data DFW Hospital Council Foundation
CN.5	Co-morbid medical and behavioral health conditions - all ages	DSHS data request; NorthSTAR Dashboard
CN.6	Health professions shortage	Federal Government Health Indicators Warehouse website
CN.7	Preventable acute care admissions	DSHS provided based on data request
CN.8	Diabetes	DSHS PPA Data
CN.9	Cardiovascular Disease	2009 Texas Behavioral Risk Factors Surveillance System, Center for Health Statistics, DSHS: http://www.dshs.state.tx.us/chs/brfss/query/brfss_form.shtm.
CN.10	Elderly at home, and Nursing Home patients	Extrapolated from DSHS PPA data
CN.11	Behavioral Health - all components - all ages	DSHS data website; Previously conducted studies and needs assessments available publicly
CN.12	Other special populations at-risk	DSHS data and surveillance reports
CN.13	Communicable Disease	Center for Disease Control
CN.14	Obesity and its co-morbid risk factors	http://www.window.state.tx.us/specialrpt/obesitycost/epidemic.php

Primary Data Assessment:
Summary of Community Input

Community Input Summary

Survey Responses – Texas Health Presbyterian Hospital Plano Averages

- Twenty-nine (29) persons from the community completed the survey summarized below, with responses ranging 1-5, where 1 is "strongly disagree" and 5 is "strongly agree".
- The top three issues of most concern:
  - ***Lack of adequate resources for indigent (low-income people) in the community***
  - ***Cost of care as a barrier to access (tied for 2nd)***
  - ***Transportation as a barrier to access (tied for 2nd)***

Indicator	Plano Average
Community members are informed and educated about health issues.	3.0
Community members know where to go for needed health services.	2.7
There are adequate health resources for children in the community.	2.8
There are adequate health resources for the elderly in the community.	2.3
There are adequate health resources for the indigent in the community.	2.0
There are adequate health resources for other vulnerable populations.	2.1
Supply (number, type of providers) is a barrier to access in this community.	3.3
Cost of care is a barrier to access in this community.	4.0
Transportation is a barrier to access in this community.	4.0
Language and culture are a barrier to access in this community.	3.6
Previous negative experiences are a barrier to access in this community.	3.2

Community Input Summary

Texas Health Presbyterian Hospital Plano Stakeholder/Community Meeting

STRENGTHS

- Faith Community Nursing Programs
- Other, Similar Community Partnerships
  - » Clinics
  - » Churches, Faith Based Organizations
  - » Plano Independent School District
  - » Texas Health Presbyterian Hospital Plano
  - » United Way
- Assertive Community Treatment (ACT) - Psychiatric Case Management
- Project Access Collin County

GAPS IN SERVICES/CARE

- Access for Uninsured and Under-insured
  - No Parkland or JPS Health Network
  - Some clinics, but not nearly enough capacity
- Transportation
- Mental Health
  - Emergency room is main provider of mental health
  - No ongoing care – only in crises situation
- Care for the Elderly
  - Biggest need for respite care, "sitters" for elderly
  - Dementia care
- Dental for Adults

SUGGESTIONS AND OPPORTUNITIES

- Reach out to service groups with tangible action items for them to do – transportation, whatever – and they will respond
- Need more collaboration information sharing – will allow for support rather than duplication
- Must develop new approaches to care for the elderly – faith based options?
- Expand specialties available through Project Access Collin County – not all specialties

COMMUNITY CONCERNS

- Obesity and Nutrition
- Coping Skills, Daily Life Skills
- Health Literacy and Awareness
- Cultural Barriers to Access
  - Language issues; privacy issues
  - Financial questions raise concerns
- Homelessness
- Bankruptcy Following Major Illness

Participants

Texas Health Presbyterian Hospital Plano /Community Meeting

- Danelle Parker, Texas Health Presbyterian Hospital Plano
- Leslie Baker, Texas Health Center for Diagnostics & Surgery
- Mary Jo Dean, Director of Community Relations, Texas Health Presbyterian Hospital Plano
- Susan Shuler, Executive Director, Plano Children's Medical Clinic
- Terrie Monroe, City of Plano Community Development Coordinator
- Patrick McCoy, Texas Health Resources Trustee
- James Thomas, Plano ISD Administration
- Carolyn Rice, Wellness Center for Older Adults
- Patti Dickson, Wellness Center for Older Adults
- Stephanie Zabel, Nursing Supervisor, DART Fleet Pool
- Seena Thomas, Texas Health Presbyterian Hospital Plano Finance
- Dr. Giep, Internal Medicine Physician
- Carol Macrorie, Texas Heath Plano Social Work
- Amy Wilson, Plano Independent School District Nurse
- Jill Vargas, Plano Independent School District Teacher
- Tonia Cunningham, Frisco Police Department
- Tammy Mahan, Life Path Systems
- John Ernst, Collin County Adult Clinic
- Tanya Stastoque, Assistance Center of Collin County
- Shannon Fitzgerald, St. Elizabeth Ann Seton
- Cassandra Graham RN BSN, Program Coordinator, Faith Community Nursing, Texas Health Presbyterian Hospital Plano
- Joan Conway, Faith Community Nurse and Maternal Child Specialist
- Anne Nejdl, Parish Nurse, Prince of Peace Catholic Church
- Angela Gwinn, Pastoral Care Minister
- Lynda Shirley, Care Van
- Debbie Gonzales, Hispanic Counselor, St. Mark's Catholic Church
- Garnetta Ashmore, Faith Community Nurse, Keller Springs Baptist Church
- Dr. Saima Sulta, American Muslin Women Physician Association
- IB, Madinah Mosque Leader
- Gloria Thomas RN, Lead Nurse, Shiloh Missionary Baptist Church
- Sandra Miller, Faith Community Nurse, Shiloh Missionary Baptist Church
- Karen Green, Director of Haven of Love Ministries Dallas
- Nancy Brill, Faith Community Nurse, St. Peter's Episcopal Church, McKinney