July 1, 2013 - June 30, 2016

Community Health Needs Assessment

FINAL

Approved by:
Mission and Community Benefits Committee
April 11, 2013

Approved by:
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Approved by:
Baylor Specialty Health Center's Board
of Trustees
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BAYLOR
Our Children's House
at Baylor

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Executive Summary

Our Children's House at Baylor (OCH) is committed to serving all the neighborhoods in its service area and recognizes the importance of keeping a local focus in effectively meeting community needs. This Community Health Needs Assessment (CHNA) was conducted during the tax year ending June 30, 2013. Its purpose is to identify the health needs of the communities served by OCH and meet the requirements for community benefit planning as set forth in state and federal laws, including, but not limited to: Texas Health and Safety Code Chapter 311 and Internal Revenue Code Section 501(r).

About the Hospital

An affiliate of Baylor Health Care System, OCH was founded in 1993 with a mission to provide coordinated, comprehensive services to children with special health care needs. Located on the Baylor University Medical Center at Dallas (Baylor Dallas) campus, OCH is a licensed pediatric hospital dedicated to giving quality care to children from infancy to age 18 who need medical care and treatment for developmental and birth disorders, traumatic injury and severe illness. In addition to the inpatient hospital on the Baylor Dallas campus, OCH operates outpatient centers in Allen, Dallas, Frisco, Grapevine, Las Colinas, Rockwall, Plano and Waxahachie.

About Baylor Health Care System

BHCS is comprised of legal entities including: philanthropic foundations; a research institute; a physician network; acute care hospitals; short-stay hospitals; specialty hospitals; ambulatory surgery centers; senior centers and other health care providers. All these entities work together to meet the community's health needs. Services of BHCS are provided through a large, faith-based integrated health care delivery system (System), serving the needs of the 12 county Dallas-Fort Worth Metroplex area through a network of more than 300 access points.

CHNA Summary

Creating healthy communities requires a high level of mutual understanding and collaboration with individuals and partner groups. This CHNA brings together information from community health leaders and providers, along with local residents, for the purpose of researching, prioritizing and documenting the health needs of the geographic area served by OCH. It serves as the foundation for community health improvement efforts for the next three years.

The FY 2013 CHNA brings together information from a variety of sources. This assessment consolidates information from the recent community health needs assessments conducted for the Texas' Regional Healthcare Partnership Region 9 (Region 9 RHP), the Dallas County Community Health Needs Assessment and the Consumer Health Report conducted by the National Research Corporation (NRC) for Baylor Dallas. Each of these reports was developed with input from people representing the broad interest of the community and people with special knowledge or expertise in public health.

The importance and benefit of compiling information from other recognized assessments are as follows:

1. Increases knowledge regarding community health needs and resources.
2. Creates a common understanding of the community's priorities as it relates to health needs.
3. Enhances relationships and mutual understanding between and among stakeholders.

4. Provides a basis upon which community stakeholders can make decisions about how they can contribute to improving the health of the community.
5. Provides rationale for current and future financers to support efforts to improve the health of the community.
6. Creates opportunities for collaboration in the delivery of services to the community.
7. Provides the hospital with guidance as to how it can align its services and community benefit programs to best meet needs.

Community Health Needs

Analysis of the Region 9 RHP report, the Dallas County Community Health Needs Assessment and the Consumer Health Report revealed the following community health needs in the OCH service area.

- Access to Care for Low Income Population
    - The community suffers a lack of preventive health care, quality medical care and supportive post-acute care services that promote the health of its residents. Community health and patient-centered medical home locations may not promote convenient access. Enrollment in health insurance programs is inconsistent across the demographic. In the consumer survey for the hospital's service area, a significant percentage of respondents utilize hospital services for "routine care" (i.e. primary care).
- Multiple Chronic Conditions
    - Compared to the region, state and nation, the community is at a higher risk for several chronic conditions.
    - Similar to national trends, total service area (TSA) residents exhibit increasing diagnoses of chronic conditions. It is common that the pathology for one condition may also affect other body systems, resulting in co-occurrence or multiple chronic conditions (MCC). The presence of MCCs adds a layer of complexity to disease management.
    - The NRC consumer survey identified the following chronic conditions as high risk for the TSA when compared to the region, state or nation: allergies, diabetes, sinus problems and obesity.
- Chronic Disease–Adult and Pediatric
    - Dallas County residents are increasingly being diagnosed with one or more chronic diseases, including, cancer, diabetes and cardiovascular disease. Addressing common risk factors through health programs, medical homes, screening and better personal fitness can improve the overall health of area residents.
    - Compared to *Healthy People 2010* targets, the hospital service area exceeded goals for cigarette smoking, high blood pressure and obesity. In regards to chronic diseases, the Dallas County CHNA found the following:
        - Cardiovascular disease is the leading cause of death in Dallas County. Age-adjusted mortality rates (AAMR) vary significantly by:
            - Race/ethnicity–with African-Americans having the highest AAMR.
            - Gender–with men having a significantly higher AAMR than women.
            - Community–with southern Dallas County communities having higher AAMR than northern suburbs.

        - The burden of asthma, chronic obstructive pulmonary disease (COPD) and other respiratory diseases affects individuals, their families, schools, workplaces and neighborhoods. The highest asthma and COPD rates are found in the county's six southern communities.
        - While disparities in cancer mortality and incidence are not significant between Dallas County communities, disparities based on race/ethnicity are present. African-Americans have the highest incidence and mortality rates for all types of cancer. Dallas County cancer rates for most cancers are higher than overall state rates.
        - The prevalence of diabetes is higher in Dallas County than in Texas or the U.S. In Dallas County, 11.4 percent of the population suffers from this illness compared to 9.6 percent in Texas and 8 percent in the U.S. Communities with the highest diabetes mortality are in the southern half of Dallas County.
        - Despite a strong network of parks and recreational options, more than half of Dallas County residents have sedentary lifestyles. Physical activity in Dallas County declined 6.5 percent between 2006 and 2010.
        - Obesity among Dallas County residents increased by 17.6 percent between 2005 and 2010.
        - Tobacco use in Dallas County is decreasing, but 16 percent of the population continues to smoke.
- Health Care Access
    - A significant percentage of survey respondents utilize hospital services for "routine care."
    - The demand for primary and specialty care services exceeds that of available physicians in these areas, thus limiting health care access.
    - 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, as well as the physician to population ratios for the insured.
    - The changing environment calls for monitoring provider acceptance of new patients by payment source. It also needs to inform eligible persons of any changing insurance eligibility requirements.
    - There is a shortage of primary care physicians (PCPs), and they are unequally distributed within the county, thereby leaving some areas underserved. According to the Dallas County CHNA, 25 percent of Dallas County adults do not have a personal physician. There are 99 PCPs per 100,000 adults. Texas overall is the fourth worst state in the U.S. for PCP-to-adult ratio with only 70 PCPs per 100,000 adults.
    - Resource deserts for women's outpatient services are found primarily in communities outside the center of the City of Dallas.
    - Twenty-eight percent of Dallas County residents are uninsured. In the non-elderly population, 33 percent of residents are uninsured. While new legislation may increase Medicaid enrollment, the physician shortage raises the question of who will treat these newly insured patients.

- Capacity–Primary and Specialty Care
    - RHP 9 identified that the demand for primary and specialty care services exceeds available physicians in these areas, thus limiting health care access.
    - The Dallas County CHNA found:
        - Twenty-eight percent of county residents do not have health insurance. Among non-elderly, non-institutionalized residents, 33 percent are uninsured compared to 26 percent in Texas and 17 percent in the U.S.
        - Dallas County has both a shortage and unequal distribution of primary care and specialty physicians, particularly in the southern half of the county.
- Behavioral Health–Adult, Pediatric and Jail Populations
    - Behavioral health–either as a primary or secondary condition–accounts for substantial volume and costs for health care providers, and is often utilized at capacity. Despite this, behavioral health remains a substantial unmet need in the population.
    - Dallas County residents suffering from behavioral health illnesses often confront decision-making barriers. These barriers can impact preventive care and treatment decisions, thereby influencing aspects of their physical health.
    - The presence of a co-occurring behavioral health condition is associated with increased case severity of medical encounters and a 36 percent increase in the average charges-per-encounter. In RHP 9, 100 percent of the 10 most frequently admitted patients had a co-occurring behavioral health diagnosis. These 10 individuals incurred more than $26 million in costs between 2007 and 2011; however, only one-fifth of their hospital emergency department visits were for a mental health or substance abuse issue. Sixty-one percent of those 10 individuals were uninsured, while 24 percent were on Medicaid, 12 percent were on Medicare and 3 percent were insured.
    - The number of Dallas County children receiving publicly funded mental health services tripled from 2000 to 2010. In Dallas County, the number of children identified with a diagnosable emotional disturbance or addictive disorder has increased to approximately 142,000 children with 5 percent of those children experiencing a significant impairment as a result. Among youth between the ages of 12-17, 7.2 percent have experienced a major depressive episode.
    - The structure of the behavioral health system (including mental health and substance abuse) in RHP 9 struggles to meet the demand of patients in the community. Unlike most of Texas, the majority of behavioral health services for Medicaid and indigent patients are delivered through the NorthSTAR program instead of the traditional Local Mental Health Authority (LMHA) system. NorthSTAR provides both mental health and substance abuse treatment to over 60,000 Medicaid enrollees and indigent uninsured annually. While NorthSTAR has greatly expanded access to care, it has struggled with funding and infrastructure challenges. The growth in enrollment has outpaced funding such that the funding per person served is 30 percent less than when the program started in 1999 and is half that of the state average for other LMHAs. Texas is 50th in mental health funding nationwide, and therefore the funding per person served in RHP 9 is among the lowest in the nation.

    - The number of NorthSTAR enrollees booked into jail has been steadily increasing, and 27 percent of all bookings to the Dallas County Jail are currently referred to jail behavioral health services.
- Patient Safety and Hospital-acquired Conditions
    - Hospitals in the region address patient safety and care quality on a daily basis. They are paramount for any health care entity. An ongoing, coordinated effort among providers is needed to improve patient safety and quality throughout the region.
    - The Dallas Fort Worth Hospital Council Foundation's (DFWHCF) 77 hospitals had 1,706 adverse hospital events in 2010. These events included air embolism, Legionnaires, iatrogenic pneumothorax, delirium, blood incompatibility, glycemic control issues and *clostridium difficile*–none of which are included in the 10 adverse events specified by Centers for Medicaid and Medicare Service (CMS).
- Emergency Department (ED) Usage and Readmissions
    - ED visits are on the rise, and EDs are becoming overcrowded due to reduced inpatient capacity and impaired patient flow.
    - An analysis of ED encounters demonstrates that many members of the population are accessing EDs for both urgent and non-urgent conditions. This is mostly due to the patient's lack of understanding of their medical conditions, and/or uninsured/underinsured status. The RHP 9 finds the following related to ED usage:
        - Over the most recent four quarters of available data, conditions for which the most volume of care was provided in an emergency outpatient setting were: low back pain, hypertension, pain/joint aching, chronic bronchitis and asthma.
        - Further assessment demonstrates that, with the exception of asthma, over 68 percent of encounters for the top primary health conditions listed above were either non-emergent or emergent/primary care treatable, meaning that the care could have been provided effectively in a primary care setting.
        - For ED encounters that resulted in a hospital admission, the most common health conditions by volume were stroke, diabetes, congestive heart failure, weak/failing kidneys, chronic bronchitis and heart attack.
        - When reviewing by payer type, diabetes is the top condition for the uninsured and Medicaid.
    - The Dallas County CHNA found the South Dallas non-emergency visit rate was 51 visits per 100,000 residents, whereas the rate for Dallas County overall was 34 visits per 100,000 residents. This was a significant finding for the hospital due to its proximity to South Dallas.
- 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 maximizing available public health funds.
    - Maximizing resources includes promotion of health literacy. In Dallas County, 21 percent of adults 16 and older do not have basic literacy skills, and 39 percent speak a language other than English at home. 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.
- Preventive Health Screenings
    - According to *Healthy People 2010*, the community has not achieved several national preventive health metrics.
    - However, preventive health behavior services for underserved households in the TSA exceed the market average in the following areas:
        - Mental health screening
        - Osteoporosis testing
        - Pre-natal care
    - Preventive health behavior services for underserved households in the TSA fall below the market average in the following areas:
        - Blood pressure testing
        - Eye exams
        - Cholesterol testing
        - Flu shots
        - Dental exams
        - Routine physical exams
        - Pap smear
        - Mammograms
        - Diabetes screening
        - Cardiovascular stress testing
        - Colon screening
        - Hearing tests
        - Body mass index screening
        - Prostate screening
        - Weight loss programs
- Smoking Cessation
    - The *Healthy People 2010* goal is to reduce smoking to 12 percent of adults 18 years of age and older. In the hospital's TSA, 26 percent of respondents identified as being smokers.
- High Blood Pressure
    - The *Healthy People 2010* goal is to reduce the percentage of the adult population with high blood pressure to 16 percent. In the hospital's TSA, 36 percent of residents report high blood pressure.
- Obesity
    - In the TSA, 16 percent of respondents taking the survey identified as being obese. The *Healthy People 2010* goal is to reduce the proportion of adults 18 years of age and older who are obese by 15 percent.
- Health Disparities–Resource Deserts
    - Large geographic areas of southern Dallas County, including suburban areas, suffer from disproportionate disease rates and substantial resource "deserts."

- 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.
- Disparities primarily are found within southern Dallas County and pockets of northern suburban areas. These communities also suffer from high levels of unemployment and low socioeconomic status. The Dallas County CHNA found that 36 percent of Dallas County zip codes contain food deserts. These areas lack key resources, including access to health services, safe environments and healthy foods. The use of public food assistance nutrition programs also increased between 2009 and 2011. 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 percent more renter occupied apartments.
  - More single parent homes—44 percent more single parent homes.
  - High poverty—28 percent of the residents in food deserts report income below the poverty level compared to only 15 percent of residents who do not live in food deserts.
  - High crime—nearly twice the amount of total crime occurs in food deserts compared to non-food deserts (Martin et al., 2012, p. 8).

The identified community health needs as outlined below were reviewed and prioritized with input from BHCS senior leadership, the BHCS Mission and Community Benefit Committee and approved by the BHCS Board of Trustees. In prioritizing the needs of the community BHCS adopted the methodology established in the collaborated CHNAs used for this assessment. Priority will be assigned as follows:

- Needs identified as Top Priorities in the each of the collaborated CHNAs are assigned High Priority for BHCS.
- Needs identified as Top Priorities in more than one of the collaborated CHNAs are assigned Medium Priority for BHCS.
- Needs identified as Top Priorities in only one of the collaborated CHNAs are assigned Low Priority for BHCS.

In developing a plan to address all identified community health needs, the Hospital and the System found that aggregating the needs allows for significant, crosscutting initiatives. Therefore, the Hospital's community health implementation plan organizes the aggregated, prioritized needs as follows:

High Priority

- Access to Care for Low Income Population/Underserved
- Multiple Chronic Conditions

Medium Priority

- Behavioral Health
- Patient Safety and Hospital-acquired Conditions
- Emergency and Urgent Care

Low Priority

- Preventive Health Screenings
- Health care Infrastructure

Key Contributors

Regional Healthcare Partnership Region 9

- Baylor Health Care System
- Children's Medical Center
- Dallas County Medical Society
- Dallas Fort Worth Hospital Council
- HCA North Texas
- Lakes Regional MHMR
- Methodist Health System
- North Texas Behavioral Authority
- Parkland Health and Hospital System
- Texas Health Resources
- Texas Scottish Rite Hospital for Children
- University of Texas Southwestern Medical Center

Dallas County Community Health Needs Assessment

- AIDS Arms
- American Diabetes Association
- American Heart Association Southwest Affiliate
- Baylor Health Care System
- CDC Regional Minority Health Consultant
- City of Garland Health Department
- Community Council of Greater Dallas
- Community Dental Care
- Dallas County Health and Human Services
- Dallas Independent School District
- Dallas Women's Foundation
- Dallas Fort Worth Hospital Council
- Desoto ISD
- Health Industry Council
- Injury Prevention Center of Greater Dallas
- Los Barrios Unidos Community Clinic
- Martin Luther King Jr. Family Health Clinic
- Methodist Health System
- North Texas Behavioral Health Authority
- Parkland Health and Hospital System
- Resource Center Dallas
- Texas Health Resources

- The YMCA of Metropolitan Dallas
- U.S. Environmental Protection Agency Region 6
- United Way
- University of Texas at Dallas
- Urban League of Greater Dallas and North Central Texas

Assessment Methodology

To complete this CHNA, BHCS staff participated in the development of several CHNAs with other health care providers throughout the Dallas/Fort Worth Metroplex. These include the Region 9 RHP report, the Dallas County Community Health Needs Assessment, and the Baylor Dallas Consumer Health Report conducted by National Research Corporation (NRC). The methodology for each is detailed below (see the appendix for the complete assessments). Once the assessments were completed, the identified community health needs were reviewed and prioritized with input from OCH management and BHCS senior leadership. In prioritizing the needs of the community BHCS adopted the methodology established in the collaborated CHNAs used for this assessment. Priority will be assigned as follows: Needs identified as Top Priorities in the each of the collaborated CHNAs are assigned High Priority for BHCS. Needs identified as Top Priorities in more than one of the collaborated CHNAs are assigned Medium Priority for BHCS. Needs identified as Top Priorities in only one of the collaborated CHNAs are assigned Low Priority for BHCS.

Regional Healthcare Partnership Region 9

The Texas Health and Human Services Commission originally defined the geographic boundaries of RHP 9 as Collin, Dallas, Denton, Ellis, Fannin, Grayson, Kaufman, Navarro and Rockwall counties. However, subsequently, in May 2012, the Health and Human Services Commission issued a revised state map, reducing RHP 9 to two counties: Dallas and Kaufman. In analyzing demographic and patient flow patterns, it was determined that the CHNA would cover the original Texas Health and Human Services Commission-defined region. Specific county information is available as appropriate and provided in this report.

To conduct this CHNA, a CHNA Task Force was convened with representatives from local hospitals, medical centers, and other health care providers from a multi-county geographic area. Members of the CHNA Task Force included experts from the following organizations: Baylor Health Care System; Children's Medical Center; Dallas County Behavioral Health Leadership Team; Dallas County Medical Society; HCA North Texas; Homeward Bound; Methodist Health System; North Texas Behavioral Health Authority; Parkland Health and Hospital System; Scottish Rite Hospital for Children; Texas Health Resources; UT Southwestern Medical Center; ValueOptions of Texas.

This core planning team reviewed and identified the regional priorities through data analysis, expert presentations and committee feedback. The criteria used by the Task Force to identify the regional priorities were: degree of population impact, financial burden on the health care system, alignment with intervention categories, and health issues whose solutions lend themselves to regional-based approaches. Whenever possible, regional, county and local data were obtained for assessment. Indicators and data sources were selected based on consistency and availability of data from reliable data sources.

Dallas County Community Health Needs Assessment

A collection 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. The Dallas County Health and Human Services Public Health Infrastructure (PHI) Division and the PHI Workgroup provided oversight of the CHNA. The PHI Workgroup provided diverse perspectives on health issues, assets and priorities.

Two community focus groups conducted early on in the data collection process and interviews conducted 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 CDC National Public Health Performance Standards Program, Public Health Accreditation Board Standards and IRS Form 990 (Schedule H) informed the CHNA methodology. 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 takes into account the following considerations as they relate to health care in Texas: demographic review of the general population, demographic review of the health professions workforce, access to health care, 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. Its availability for distribution was announced at the Dallas County Public Health Advisory Committee meeting, Parkland Board of Managers meeting, and shared with CHNA qualitative participants and the PHI Workgroup. The PHI Workgroup co-chairs responded to all comments that were received.

Secondary Data Sources

Dallas County is fortunate to have active health care, school, social service and business leadership whose organizations have collected, organized and vetted a wide range of secondary data used in this CHNA. The original data sources were accessed as necessary 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 presented in a reader-friendly graphic format. Greater detail is provided in the report appendices. Original data sets used for this CHNA are available upon request by calling the DCHHS Public Information Office at (214) 819-2000.

Focus Group Discussions

Two focus groups provided different perspectives on the health needs of the Dallas County population. 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:

- Define healthy community characteristics in Dallas.
- Identify Dallas County issues and assets that impact the population's health.
- Identify community barriers to good health both 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.

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, assets and gaps.
- Identify strategies to minimize gaps and reduce disparities.
- Discuss innovative models to improve the population's health, including local, statewide and national approaches in order to determine their relevance for Dallas County.
- Recommend improvement strategies based on submitted data. Results were used to expand the CHNA report and develop CHNA recommendations.

Baylor Dallas/OCH Service Area Survey

The NRC Consumer Health Report provides a detailed view of the health need, health status, behaviors, and perceptions of residents within Baylor Dallas' community. The NRC Consumer Health Report is conducted annually across communities in more than 200 of the nation's largest metropolitan statistical areas (MSAs). State and national surveys also are conducted.

Sample Size

The Baylor Dallas Total Service Area (TSA) sample for 2011 was comprised of 3,527 households. The standard error range for the sample was ± 1.7 percent at the 95 percent confidence level.

Benchmarks

The Dallas-Fort Worth-Arlington CBSA sample for 2011 was comprised of 5,694 households. The standard error range for the sample was ± 1.3 percent at the 95 percent confidence level.

The Texas sample for 2011 was comprised of 20,075 households. The standard error range for the sample was ± 0.7 percent at the 95 percent confidence level.

The national sample for 2011 was comprised of 278,824 households, which includes the largest 180 MSAs within the U.S. The standard error range for the sample was ± 0.2 percent at the 95 percent confidence level.

Survey Instrument

The survey document was an Internet-based questionnaire that respondents received through Internet invitations. The questionnaires were developed utilizing NRC's experience in the design and implementation of hundreds of consumer research studies. Questions were designed to meet the objectives as determined by the combined input of health care marketing directors and strategic planners nationwide.

The questions were presented in a clear and concise manner, in an easy-to-understand format, and the questionnaire was thoroughly pre-tested in an actual field situation to ensure respondents' question comprehension.

Survey Timing

Beginning in May 2008, ongoing data collection was implemented for the survey. Internet survey invitations were sent on the first of each month. The 22nd of each month was the completion deadline.

The Respondent

The respondent was the individual in the household who is most often the target for health care communications—the primary health care decision-maker. This individual most often selects the hospitals, physicians, and health care products and services utilized by household members.

The Sample
Survey invitations were sent to households that were representative of the 48 contiguous states. The national balancing criteria included:

- U.S. census regions
- Age of head of household
- Population density

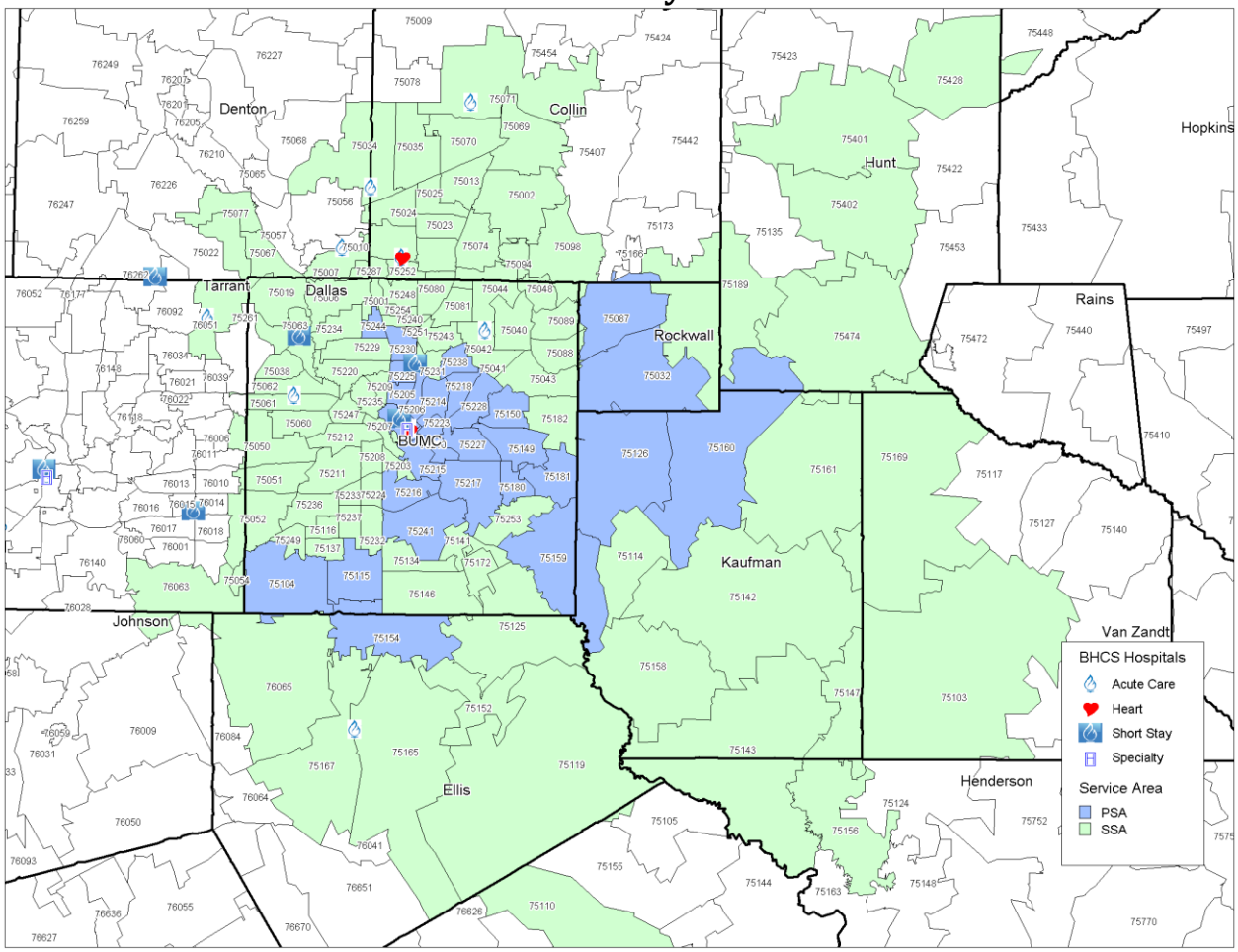
The survey data was electronically coded and tabulated by the National Research Corporation according to an innovative and thorough tabulation specification plan.

Weighting the Data
To ensure proper sample representation within each tabulated market area, the data was weighted according to a number of key demographic variables:

- Age of head of household
- Area population
- Race
- Household income
- Presence of children
- Marital status

Weighting ensured that the sample was representative of the population being surveyed. For example, if 20 percent of households within the market area were headed by a family member 18 to 24 years old, then 20 percent of the sample was comprised of heads of households who were 18 to 24 years old. This weighting pattern was held consistent across all variables.

OCH Community Definition



BHCS and its affiliated hospitals serve a 12 county area known as the Dallas/Fort Worth Metroplex. BHCS divides its service areas into three regions: the Eastern Region, the Central Region and the Western Region. BHCS' health care services are provided through a network of more than 300 access points, including 30 owned/operated/ventured/affiliated hospitals, joint ventured ambulatory surgical centers, satellite outpatient locations, senior centers and more than 180 HealthTexas Provider Network physician clinics. BHCS uses the health care industry's standard "80 percent" rule to define each hospital service areas.

- 80 Percent Rule = 50 percent of inpatient volume from Primary Service Area (PSA) + 30 percent inpatient volume from Secondary Service Area (SSA)–both of which make up the Total Service Area (TSA)

The following steps were taken to assure true representation of the area served:

- Outlier zip codes were removed.
- Missing zip codes adjacent to the facility were included.
- Zip codes needed to complete the contiguous service area were included.

Located in Dallas County, Baylor Dallas serves the Central Region of the System. Its total service area includes zip codes from Dallas, Collin, Denton, Ellis, Henderson, Hunt, Kaufman, Rockwall and Tarrant counties. The service area comprises:

- An urban/suburban geographic area
- Service area population: 4,196,259
- Service area ethnicity: White Non-Hispanic = 45.9 percent; Black Non-Hispanic = 15.6 percent; Hispanic = 30.8 percent; Asian and Pacific Islanders Non-Hispanic = 5.6 percent; All others = 2.2 percent
- Service area payer mix: Managed Care = 35.1 percent; Medicaid = 18.8 percent; Medicare = 34.7 percent; Self-pay/Charity = 11.0 percent; Other = 0.5 percent
- Service area average household income = $76,541
- Service area living below the Federal Poverty Level (FPL): 11.2 percent (compared to 10.5 percent living below the FPL in the Dallas/Fort Worth Metroplex, and 10.2 percent living below the FPL in the United States)
- Number of other hospitals serving the community: 55 hospitals other than Baylor Dallas
- Medically underserved: Baylor Dallas service area contains 25 medically underserved areas or populations
- Service area education: less than high school = 9.3 percent; some high school = 9.7 percent; high school diploma = 22.0 percent; some college/associates degree = 27.1 percent; bachelor's degree or greater = 31.9 percent
- Service area male population = 2,117,421; Service area female population = 2,078,838

Service area age: 0-14 = 24.0 percent; 15-17 = 4.2 percent; 18-24 = 8.9 percent; 25-34 = 15.6 percent; 35-54 = 29.0 percent; 55-64 = 9.5 percent; 65+ = 8.8 percent

OCH Service Area Providers

Hospitals
Baylor Jack and Jane Hamilton Heart and Vascular Hospital
Baylor Institute for Rehabilitation
Baylor Institute for Rehabilitation at Frisco
Baylor Medical Center at Frisco
Baylor Medical Center at Garland
Baylor Medical Center at Uptown
Baylor Medical Center at Waxahachie
Baylor Specialty Hospital
Baylor University Medical Center at Dallas
Children's Medical Center of Dallas
Columbia Medical Center of McKinney Subsidiary, LP
Dallas Medical Center, LLC
Dallas Regional Medical Center
Ennis Regional Medical Center
Forest Park Medical Frisco
Forest Park Medical Center
GlobalRehab
Hunt Regional Community Hospital
Hunt Regional Medical Center Greenville
Irving Coppell Surgical Hospital

Kindred Hospital - Dallas
Kindred Hospital Dallas Central
Kindred Hospital-Mansfield
Lake Pointe Medical Center
Las Colinas Medical Center
Lifecare Hospitals of Dallas
Medical Center Of McKinney-Wysong Campus
Mesquite Rehabilitation Hospital
Mesquite Specialty Hospital
Methodist Dallas Medical Center
Methodist Charlton Medical Center
Methodist Hospital for Surgery
Methodist Mansfield Medical Center
Methodist McKinney Hospital, LLC
Methodist Rehabilitation Hospital
Navarro Regional Hospital
North Central Surgical Center, LLP
Our Children's House at Baylor
Paris Regional Medical Center North Campus
Parkland Memorial Hospital
Pine Creek Medical Center
Renaissance Hospital Terrell
Select Specialty Hospital-South Dallas
South Hampton Community Hospital
Texas Health Presbyterian Hospital Dallas
Texas Health Presbyterian Hospital Flower Mound
Texas Health Presbyterian Hospital Kaufman
Texas Health Presbyterian Hospital Rockwall
Texas Institute for Surgery at Texas Health Presbyterian Dallas
Texas Regional Medical Center at Sunnyvale
Texas Scottish Rite Hospital for Children
Texas Specialty Hospital at Dallas
The Hospital at Craig Ranch
UT Southwestern University Hospital-St Paul
UT Southwestern University Hospital-Zale Lipshy
Vibra Specialty Hospital

<u>Ambulatory Surgery Centers</u>
Ambulatory Endoscopy Clinic of Dallas, Ltd
Baylor Ambulatory Endoscopy Center
Baylor Surgicare
Baylor Surgicare at Ennis, LLC
Baylor Surgicare at Garland
Baylor Surgicare at Grapevine
Baylor Surgicare at Heath
Baylor Surgicare at Mansfield
Baylor Surgicare at Plano
Baylor Surgicare at Plano Parkway, LLC

Baylor Surgicare at Valley View
Beltline Surgery Center, LLC
Breckenridge Surgery Center
Centennial Surgery Center
Children 1st Dental & Surgery Center
Children 1st Grand Prairie, LLC
Children's Pavilion Surgery Center
Cook Children's Pediatric Surgery Center
Dallas Day Surgery of Texas North, Ltd
Dallas Endoscopy Center, Ltd
Dallas IVF Surgery Center, LLC
Dallas Surgi Center, Inc
Endoscopy Center at Redbird Square
Frisco Reproductive Surgery Center
Gastrointestinal Endoscopy Center
Greenville Surgery Center
Heritage Surgery Center
Highland Park Plastic Surgery Center
Institute for Minimally Invasive Surgery
Key Whitman Surgery Center
Las Colinas Surgery Center
Legacy Surgery Center of Frisco
Lonestar Ambulatory Surgical Center
Macarthur Surgery Center, LP
McKinney Surgery Center
Medical City Dallas Ambulatory Surgery Center
Medical Village Surgery Center Inc
Microsurgery Institute, of Dallas
MISI ASC Dallas, LLC
North Carrier Surgicenter
North Dallas Surgicare
North Garland Surgery Center, LLP
North Texas Surgery Center
North Texas Team Care Surgery Center, LLC
Old Town Endoscopy Center
Ophthalmology Surgery Center of Dallas, LLC
Outpatient Surgery Center
Pain Care of North Texas, LLC
Park Ventura Endoscopy Center
Physicians Daysurgery Center
Plastic and Cosmetic Surgery Center Of Texas
Precision Surgery Center of Dallas
Preston Plaza Surgery Center
Reagan Eye Center
Rockwall Surgery Center
Simmons Ambulatory Surgery Center
Southwestern Women's Surgery Center, LP
Specialty Surgery Center

Specialty Surgery Center of Dallas
Spine Team Texas Rockwall, ASC, LP
Stonebridge Surgery Center
Surgery Center of Plano
Surgery Center of Richardson
Surgery Center of Texas
Surgery Center of Waxahachie
Surgeyecare General Partnership
Surgistar, LP
Swiss Avenue Surgicenter, LP
Texas Endoscopy
Texas Endoscopy, LLC
Texas GI Endoscopy Center
The Surgery Center of Dallas
The Surgery Centre at Craig Ranch
Tuscan Surgery Center at Las Colinas, LLC
Vivere - Dallas Surgery Center
Walnut Hill Surgery Center, LP
Waxahachie Surgery Pavilion
Windhaven Surgery Center, LLC
Women's Specialty Surgery Center of Dallas, LLC

Freestanding ER
Legacy ER
First Choice Emergency Room - Murphy
E-Care Emergency Center
ER Centers of America, Inc
First Choice Emergency Room - Plano
Highland Park Emergency Room

Psychiatric Facilities
Timberlawn Mental Health System
Texas Health Seay Behavioral Health Center Plano
Glen Oaks Hospital
Hickory Trail Hospital

Community Health Needs Assessment

Public Participation

OCH and BHCS have fostered continued community participation and outreach activities through membership in the Dallas Fort Worth Hospital Council. They have used data from this collaboration of health care providers, including data that served as the basis for this CHNA. This data–drawn from a variety of local, state and federal sources–represents the most recent evaluation of Dallas/Fort Worth residents' health status and the assets available to the community for improving health.

In addition, data was drawn from the *Healthy North Texas* website (www.healthytexas.org), which was created under the direction of the Dallas Fort Worth Hospital Council Foundation's Community Health Collaborative. The website features data regarding overall population health. It boasts more than 100 local health indicators that can be compared across other Texas regions and the nation. The information can be used to expose crucial health concerns in North Texas, including incidents of diabetes, breast cancer and suicide. The site also has a database of information detailing ways to combat these health ailments. Sponsors of the site include Blue Cross Blue Shield of Texas, Communities Foundation of Texas, HCA North Texas, JPS Health Network, Methodist Health System, Texas Health Resources, University of North Texas Health Science Center and Baylor Health Care System.

BHCS Community Benefit Committee

Community health needs identified in this document have also been reviewed and approved by the BHCS Community Benefit Committee.

The mission and role of the BHCS Community Benefit Committee is to assist the Board of Trustees in setting direction, identifying priorities, and monitoring performance in mission and vision integration into community benefits across BHCS. The Committee is comprised of trustees (current System and community board members) and other community representatives appointed by the BHCS board of trustees. The Committee will meet twice annually, or upon the request of the Committee chair. The current chair is Dr. Jim Denison.

NRC Baylor Dallas/OCH Service Area Survey (Executive Summary)

The Community Assessment conducted by NRC on behalf of Baylor Dallas identified the following community health needs (See the Appendix for more detail).

- Primary care: Forty-seven percent of respondents sought access to routine care.
- Specialty care, particularly for patients lacking of insurance coverage: Forty-six percent of respondents identified Parkland as a facility providing service for those unable to pay. The next closest facility was only identified by 8 percent of respondents. When looking at several chronic conditions, a higher percentage of the lower income population is at risk.
- Multiple Chronic Conditions: Several chronic conditions are identified as high risk for the community when compared to the region, state or nation. The highest are allergies, diabetes, sinus problems and obesity.

Healthy People 2010 Targets: *Healthy People* provides science-based, 10-year national objectives for improving the health of all Americans. It has established benchmarks and monitored progress over time in order to:

A. Encourage collaborations across communities and sectors.
B. Empower individuals toward making informed health care decisions.
C. Measure the impact of prevention activities.

- Smoking Cessation: The community exceeds the cigarette smoking goal of 12 percent among adults 18 years plus.
- High Blood Pressure: The community exceeds the goal of 16 percent of adults with high blood pressure.
- Obesity: The community's percent of adults who are obese is greater than the national average.
- Pediatric services and prenatal care: Dental care for children is below national targets. Childhood immunizations are below the goal of 80 percent. The prenatal goals of 90 percent care beginning in the first trimester of pregnancy and 90 percent early and adequate pre-natal care are not being met.
- Preventive Health Screenings: The community is well below several national preventive health metric goals

Regional Healthcare Partnership Region 9 (Executive Summary)

To develop the CHNA, a regional Task Force was convened by representatives from the following organizations: Baylor Health Care System, Children's Medical Center, Dallas County Medical Society, Dallas County Behavioral Health Leadership Team, HCA North Texas, Methodist Health System, North Texas Behavioral Health Authority, Parkland Health & Hospital System, Scottish Rite Hospital for Children, Texas Health Resources, UT Southwestern Medical Center and ValueOptions of Texas.

This Task Force reviewed and identified the regional needs through data analysis, expert presentations and committee discussions. The major criteria used to identify and rank regional priorities included population impact, alignment with intervention categories, and whether solutions lend to regional-based approaches. The following priorities were identified as the region's major community health needs:

Capacity - Primary and Specialty Care
The demand for primary and specialty care services exceeds that of available physicians in these areas, thus limiting health care access.

Behavioral Health - Adult, Pediatric and Jail Populations
Behavioral health, either as a primary or secondary condition, accounts for substantial volume and costs for health care providers, and is often utilized at capacity, while still leaving a substantial unmet need in the population.

Chronic Disease - Adult and Pediatric
Many individuals in North Texas suffer from chronic diseases that present earlier in life. They also are becoming more prevalent and result in health complications.

Patient Safety and Hospital-acquired Conditions
Hospitals in the region address patient safety and care quality on a daily basis. It is a continuous process and always at the forefront of any strategy of a health care entity. An ongoing coordinated effort among providers is needed to improve patient safety and quality throughout the region.

Emergency Department Usage and Readmissions
Emergency departments are treating high volumes of patients with preventable conditions or conditions that could be addressed in a primary care setting. Additionally, readmissions are higher than desired, particularly for those with severe chronic disease or behavioral health issues.

Palliative Care
Overall, costs are higher in skilled nursing facilities, long-term care facilities, hospice and home health sectors, and slightly higher in physician services.

Oral Health
In Texas, preventive dental visits are below the recommended levels, and access can be a problem for minorities, the elderly, children on Medicaid and other low-income children. Compounding the problem is the shortage of dentists in Texas, which stands at approximately 60 percent of the national ratio of dentists-to-population.

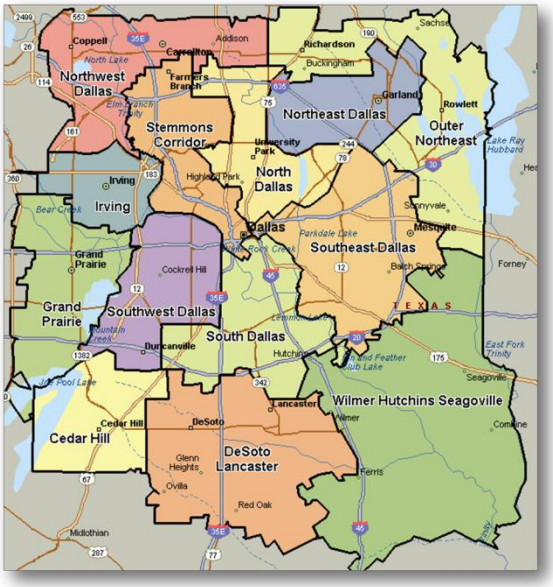
Dallas County Community Health Needs Assessment (Executive Summary)

BACKGROUND

The Dallas County Community Health Needs Assessment (CHNA) was designed to ensure that the Dallas County public health system continues to effectively and efficiently serve the 2.4 million residents of the county. Dallas County Health and Human Services (DCHHS) is one of seven local health departments in the nation participating in the Centers for Disease Control and Prevention (CDC) National Public Health Improvement Initiative. In support of that initiative, DCHHS designed and led this CHNA in collaboration with the Parkland Community Health Institute to determine the top health issues facing Dallas County residents and recommendations for improvement. A public health improvement workgroup comprised of healthcare executives, leaders of civic organizations, schools, health departments, and representatives of local universities, provided development and implementation guidance.

The CHNA uses detailed public health outcome secondary data at the county and community level to identify health assets, gaps, disparities and trends. This data was supported with primary data from two focus groups and eight key informant interviews. The Dallas County communities considered throughout the CHNA are pictured in Figure ES-1.

Figure ES-1



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 percent to nearly 2.4 million people. Most of Dallas County's growth occurred in suburban areas with the City of Dallas population increasing less than 1 percent during that time. Growth can be attributed to a strong economic environment, business expansion and employment opportunities. The county's strengths have not been uniformly distributed across residents, with communities in the southern half of the county demonstrating disparities relative to those in the north.

The following is a sample of the differences and disparities identified in this CHNA:

- Fourteen percent of Dallas County residents live below the federal poverty level (FPL). The range is from 5 percent in Outer Northeast Dallas to 25 percent in both South and Southwest Dallas.
- In mid-2010, Dallas County unemployment was at 8.9 percent, but 10 of 13 communities had unemployment at 6.2 percent or lower.
- Of county residents, 24.5 percent have NOT graduated from high school. The range is from 8.8 percent in Northwest Dallas to 48.4 percent in South Dallas.
- Dallas County is racially and ethnically diverse with 38 percent being Latino residents, 34 percent Caucasian, 22 percent African-American, and 7 percent Asian-American and Other.
- Twenty-eight percent of county residents do not have health insurance. Among non-elderly, non-institutionalized residents, the percentage is 33 percent, which compares to 26 percent in Texas and 17 percent in the US.
- Dallas County has a shortage and unequal distribution of primary care and specialty physicians,

particularly in the southern half of the county.

The CHNA identified disparities in Dallas County residents' incidence and prevalence of illness:

- Cardiovascular disease is the leading cause of death in Dallas County. Age adjusted mortality rates (AAMR) vary significantly by:
    - Race/ethnicity, with African-Americans having the highest AAMR.
    - Gender, with men having a significantly higher AAMR than women.
    - Community, with southern Dallas County communities having higher AAMR than northern suburbs.
    - The burden of asthma, chronic obstructive pulmonary disease (COPD) and other respiratory diseases affects individuals, their families, schools, workplaces and neighborhoods. The highest asthma and COPD rates are found in the county's six southern communities.
- While disparities in cancer mortality and incidence are not significant between Dallas County communities, disparities based on race/ethnicity are present. African-Americans have the highest incidence and mortality rates for all types of cancer. The rates in Dallas County for most cancers are higher than found in the State.
- The prevalence of diabetes is higher in Dallas County than in Texas or the U.S. In Dallas County, 11.4 percent of the population suffers from this illness compared to 9.6 percent in Texas and 8 percent in the U.S. Communities with the highest diabetes mortality are in the southern half of Dallas County.

Healthy community indicators identify food deserts in southern communities and sedentary lifestyles throughout the county:

- All very high, high and moderate food desert areas are located in the southern half of Dallas County.
- Despite a strong network of parks and recreational options, more than half of Dallas County residents have sedentary lifestyles. Physical activity in Dallas County declined 6.5 percent between 2006 and 2010.
- Obesity among Dallas County residents increased 17.6 percent between 2005 and 2010.
- Tobacco use in Dallas County is decreasing, but 16 percent of the population continues to smoke.

TOP FIVE HEALTH ISSUES

Five health issues emerged from the analysis as being critical to improving the health of Dallas County residents. They include:

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

Health Care Access Community prevention, clinical prevention, quality medical care and supportive post-acute services will promote the health of Dallas County residents. Expanding access requires: (1) localized community health and patient-centered medical home models, (2) increased access to health insurance, (3) improved health literacy to promote individual access, and (4) reduced barriers.

Health Disparities and Resource Deserts Disparities are found within southern Dallas County and pockets of northern 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.

Infrastructure—Unifying Prevention Efforts and Maximizing Resources Dallas County has a wide range of health programs and improvement plans that are often being implemented in silos. Effective collaboration will enhance countywide efforts while reducing competition for resources. This will maximize available public health personnel and funds.

Behavioral Health Dallas County residents suffering from behavioral health issues often confront decision-making barriers. These barriers can impact preventive care and treatment decisions, thereby influencing aspects of their physical health.

Appendix A

Baylor University Medical Center Service Area Survey
(Source: 2011 NRC Healthcare Market Guide, National Research Corporation)

Study Objectives
National Research Corporation (NRC) Consumer Health Report is a valuable resource in determining the health status, health risk/chronic conditions, preventive health behaviors, physician access and community perceptions of healthcare in BAYLOR - BUMC TSA.

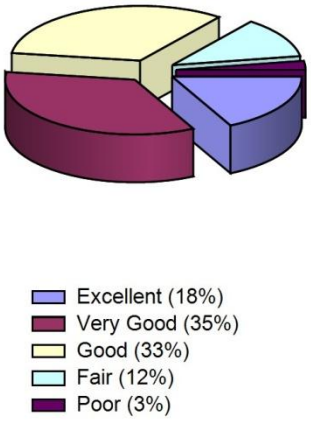
The Consumer Health Report provides a tool to enable organizations to strengthen the health of their community by assisting in the following:

1. Measurement and evaluation of health status and healthcare utilization within the community.
2. Identification of the prevalence of chronic conditions within various demographic and geographic segments within the community.
3. Profiling of high-risk populations.
4. Identification of gaps in care and preventive health behaviors among various demographic and geographic segments within the community.

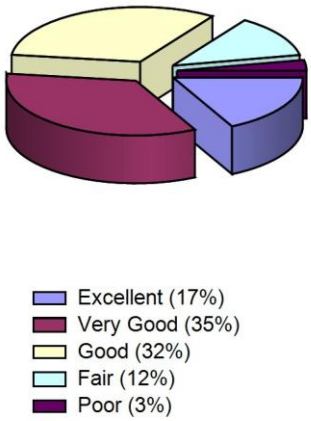
Executive Summary
Consumer Health Report Card
BAYLOR - BUMC TSA

Overall Household Health Status

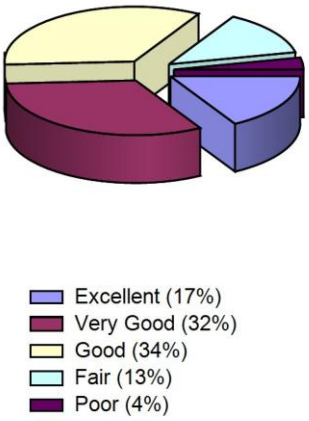
BAYLOR - BUMC TSA



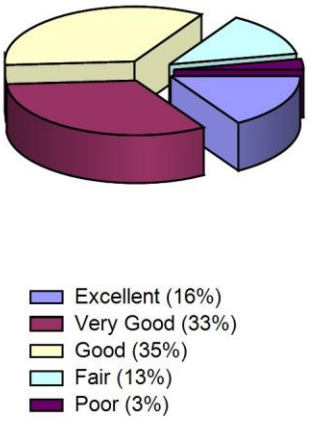
Dallas-Fort Worth-Arlington, TX CBSA



State of TEXAS



National

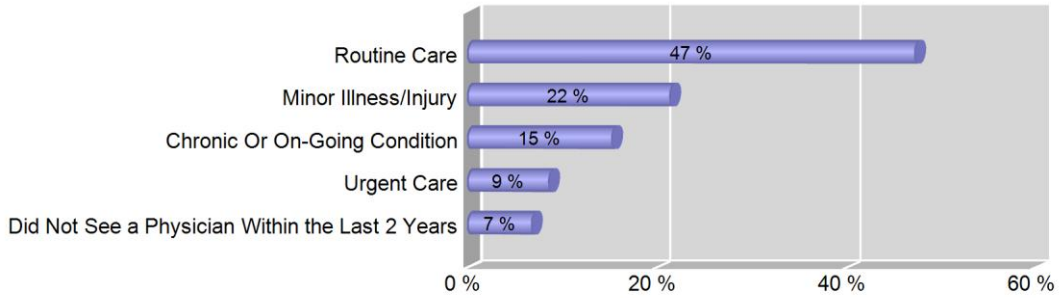


Source: 2011 NRC Healthcare Market Guide, National Research Corporation

Executive Summary
Consumer Health Report Card
BAYLOR - BUMC TSA

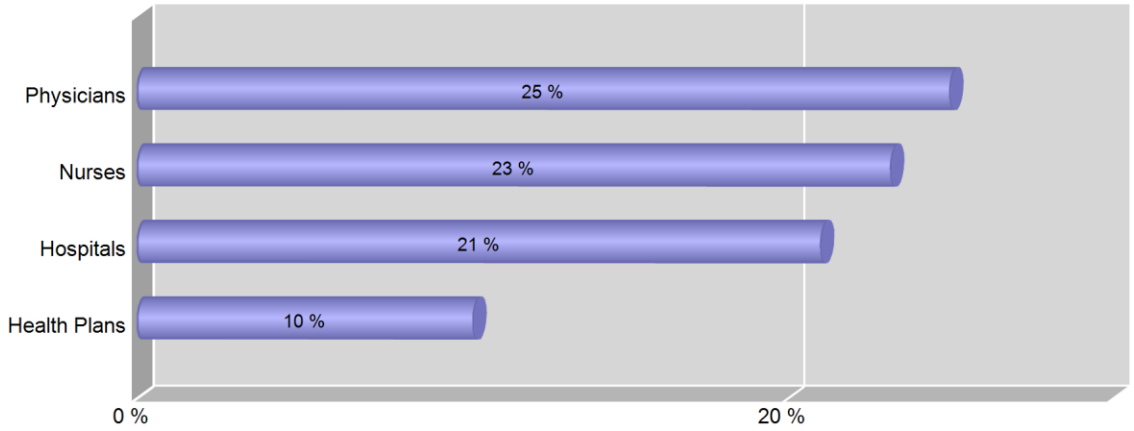
Your Consumers' Access to Healthcare

- Purpose of Physician Visit (force ranked high to low):



- Days to Appointment for Routine Care

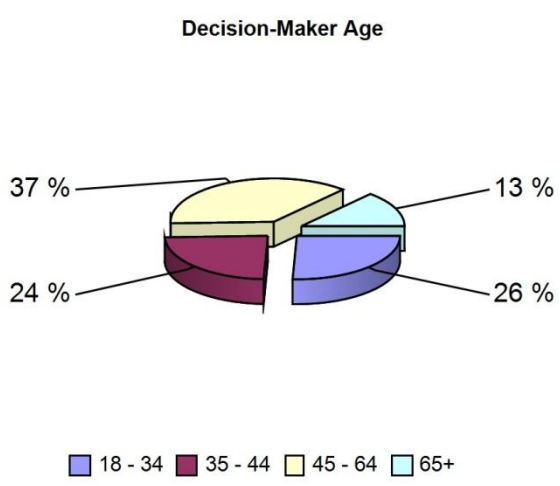
Your Community's Trust and Confidence in Healthcare

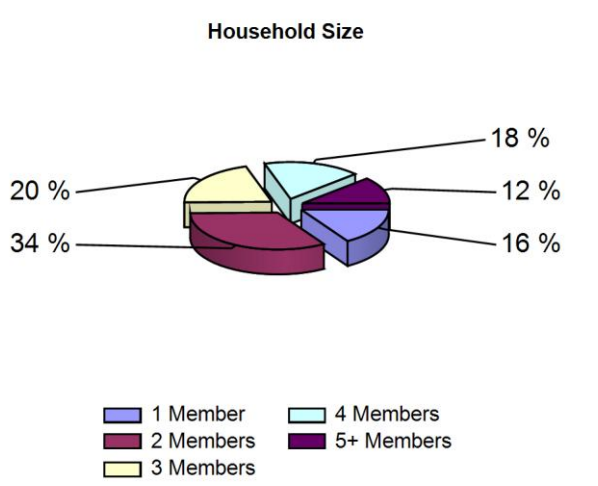


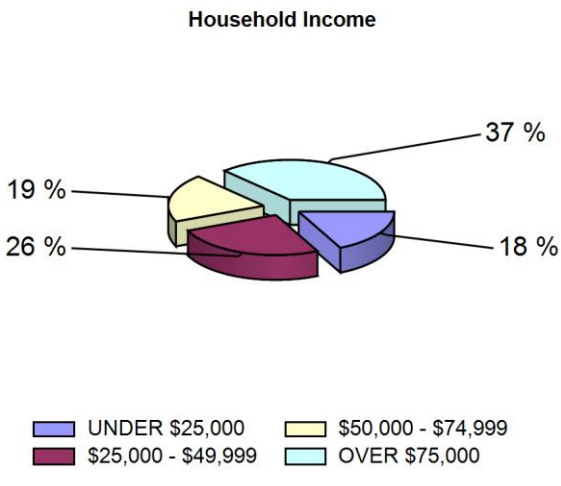
Community Demographics

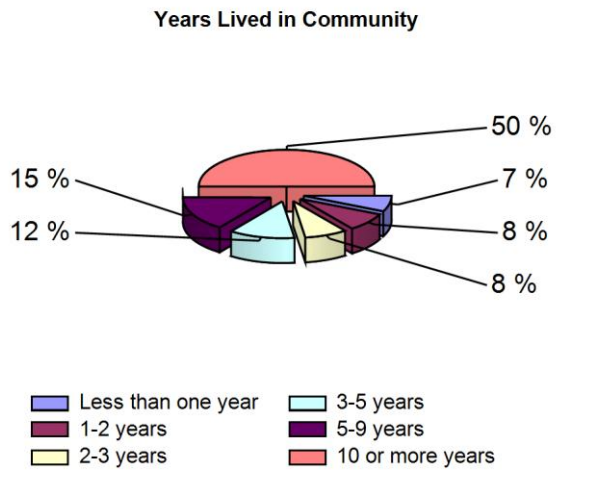
Provided below is a presentation of four key demographic factors for BAYLOR - BUMC TSA respondents within the annual Healthcare Consumer Health Report survey. The majority of questions within the Consumer Health Report can be analyzed across any one of these factors.

BAYLOR - BUMC TSA Demographics





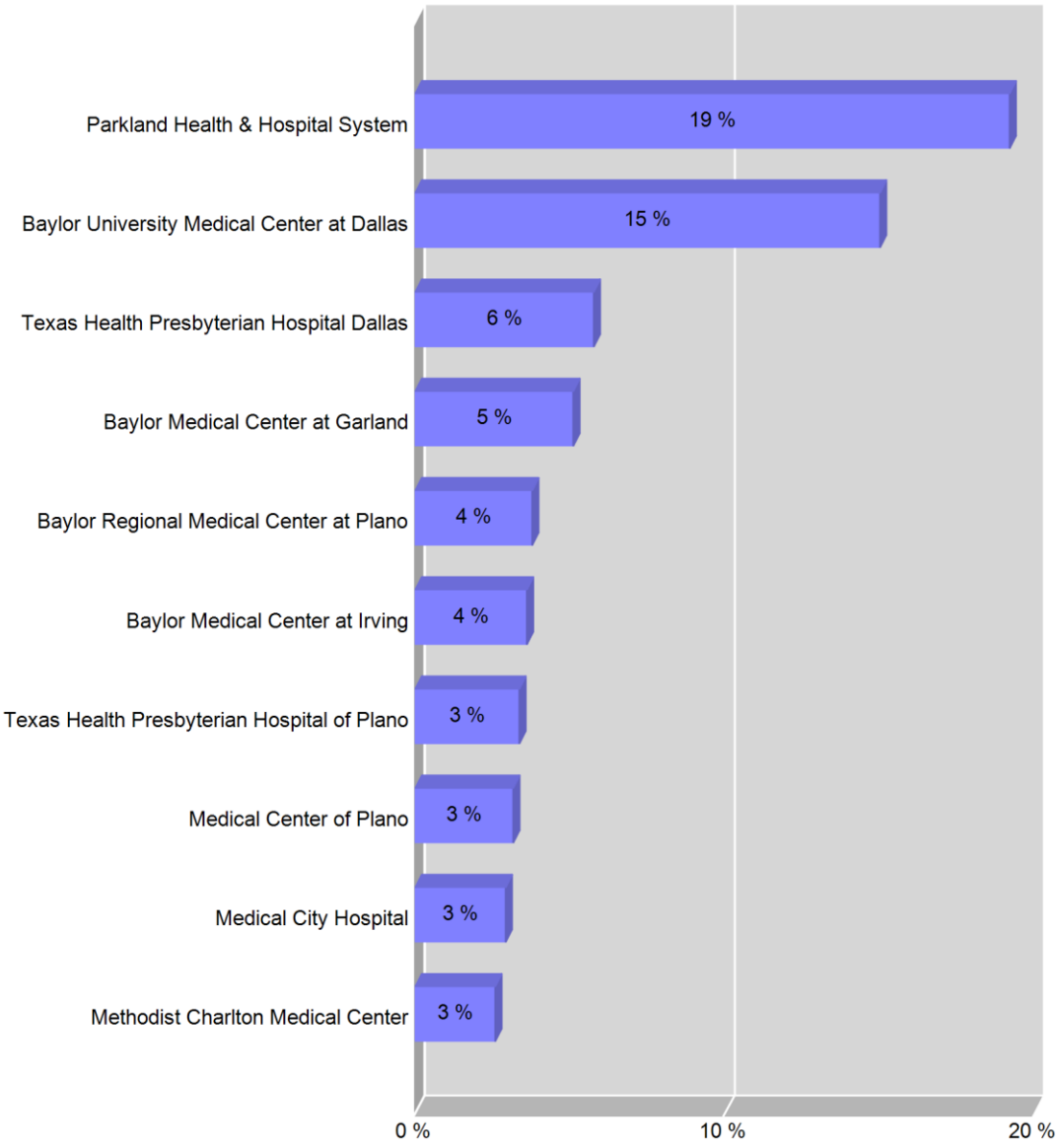




Consumer Perception of Best Community Health Programs

This section reports consumer perception of community health programs by hospital name. BAYLOR - BUMC TSA respondents were asked to name the hospital/facility they perceive has the Best Community Health Programs in their area.

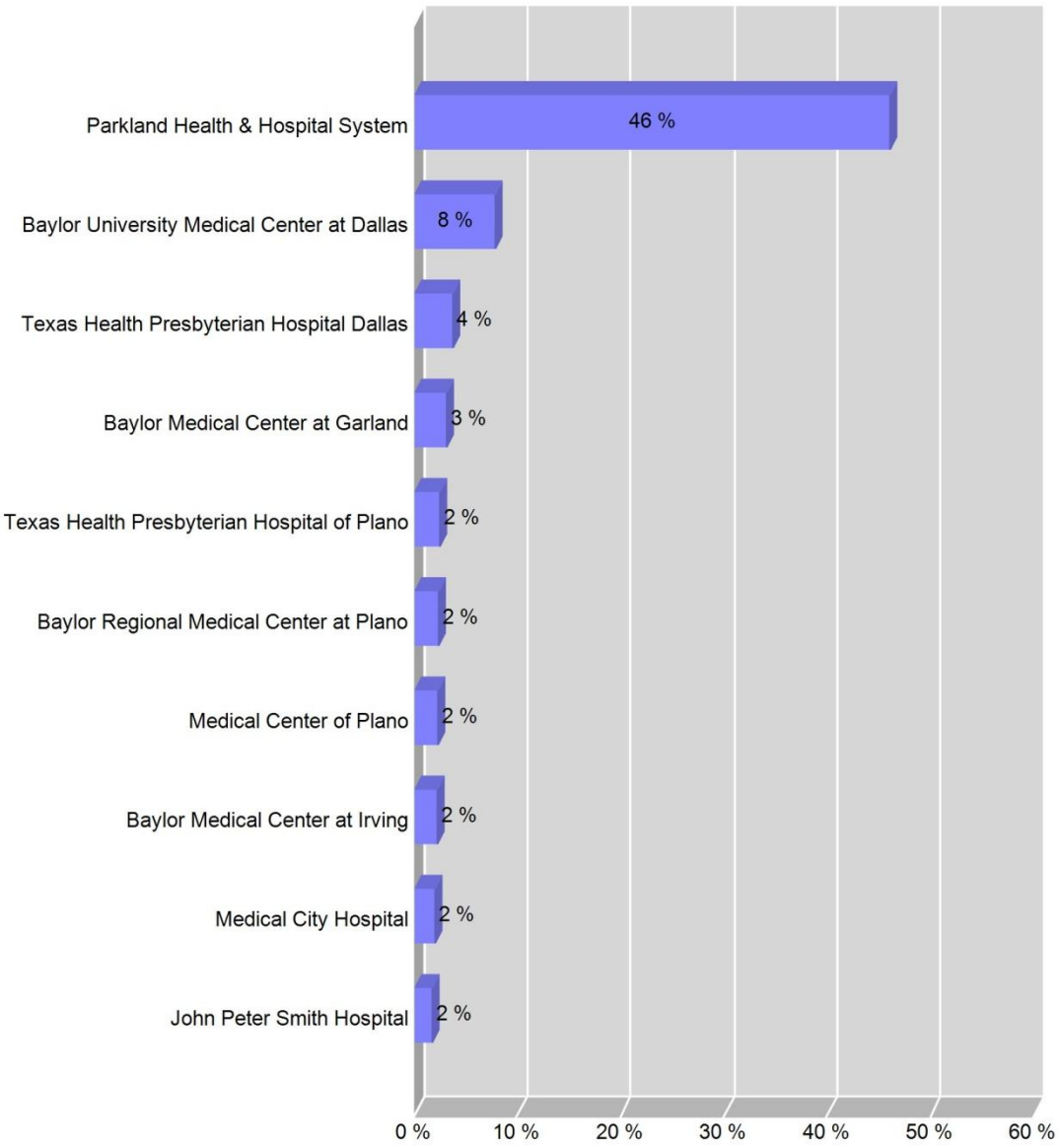
Hospital/Facility with Best Community Health Programs
BAYLOR - BUMC TSA, TX
(% of Respondents Naming Facility)



Providers to Those Unable to Pay

BAYLOR - BUMC TSA respondents were asked to name the hospital/facility they perceive provides care to those unable to pay.

Top of Mind Hospital/Facility Provides Care to Those Unable to Pay
BAYLOR - BUMC TSA, TX
(% of Respondents Naming Facility)



Health Status and Utilization

This section reports the various self-reported measures of the general physical health among BAYLOR - BUMC TSA residents, including information regarding healthcare service utilization.

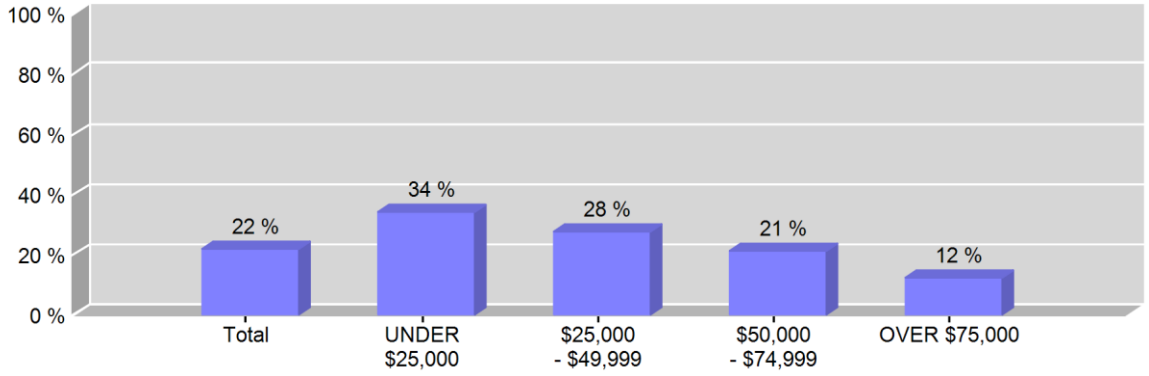
Overall Health Status

Health status within the NRC Consumer Health Report is measured by asking residents to individually rate
the health status of themselves and each member of their household, and creating a household score.

Household Health Status

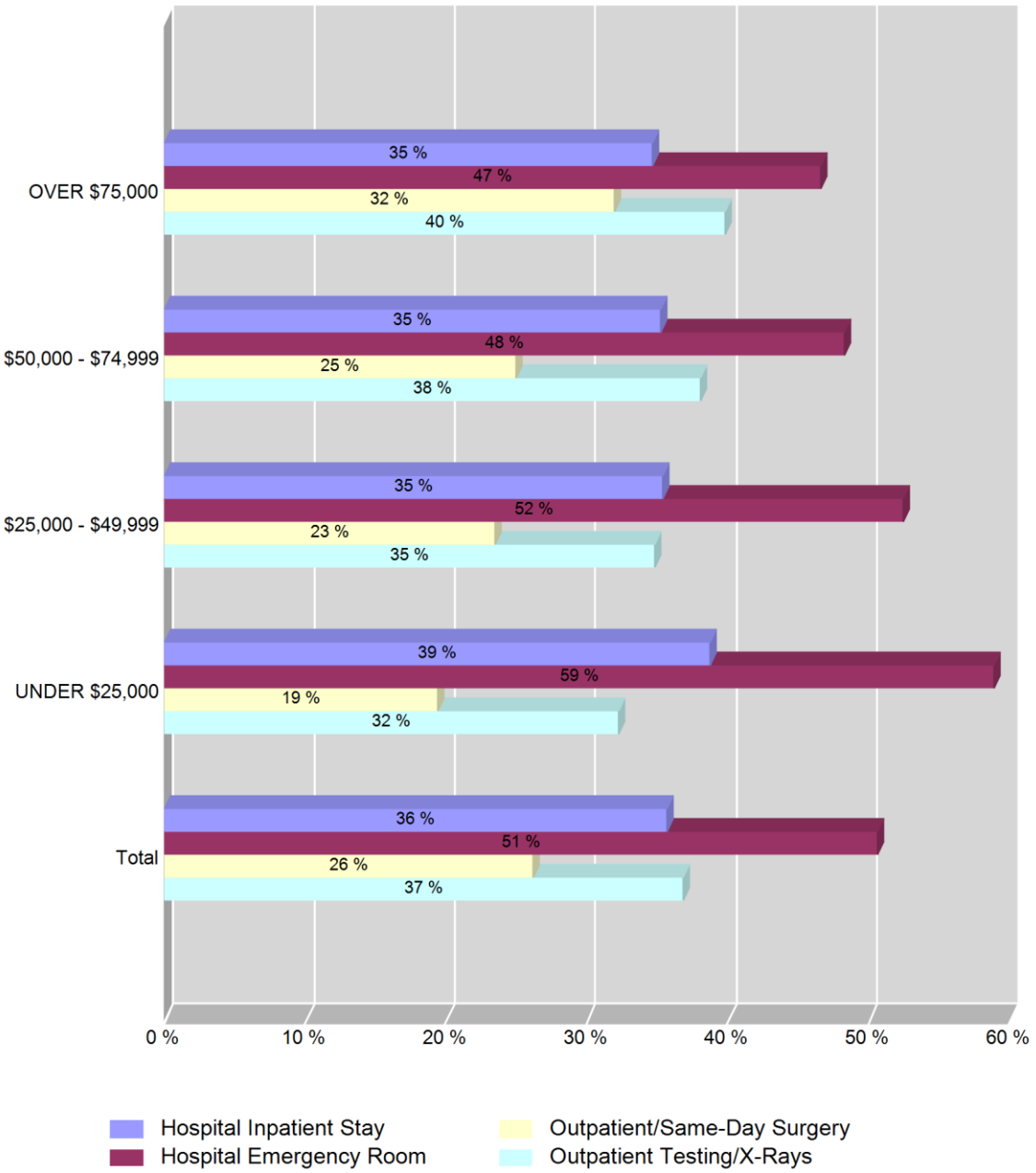
- Within the national sample , with a score of 0%, represent the lowest percentage who responded their health status was either "Fair or Poor"

BAYLOR - BUMC TSA Household Health Status by Income Bottom 2 Box (Fair and Poor)



Healthcare Service Utilization

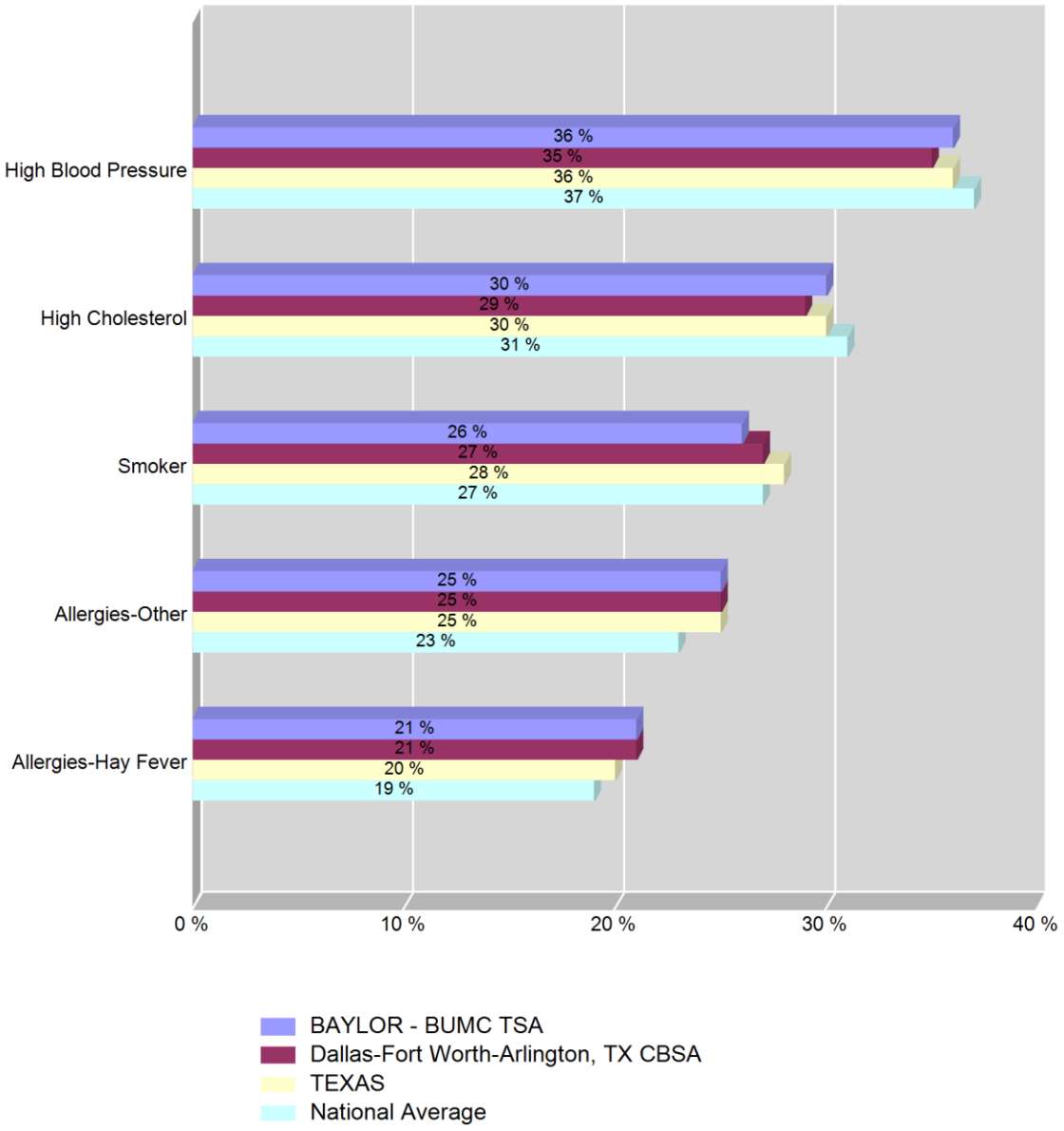
BAYLOR - BUMC TSA Service Utilization Last 36 Months by Income



Health Risk Profiles

This section reports the various self-reported measures of the general physical health among BAYLOR - BUMC TSA residents, including information regarding the existence of various health risks, health behaviors, and chronic conditions.

Represented below is the percentage of BAYLOR - BUMC TSA households that report one or more household members have been diagnosed with having the following chronic condition. Comparison benchmarks are given for the MSA, state and national.



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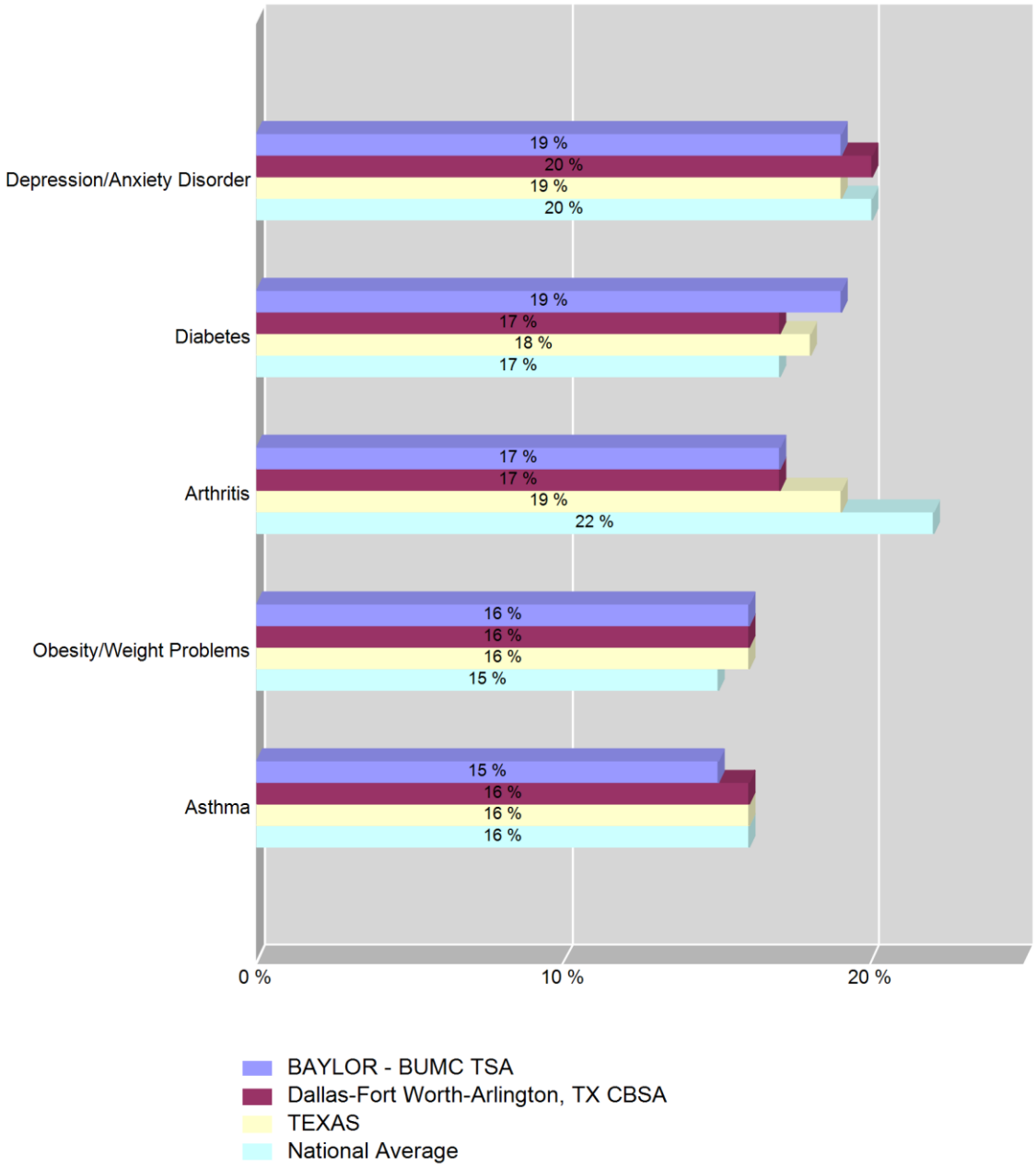

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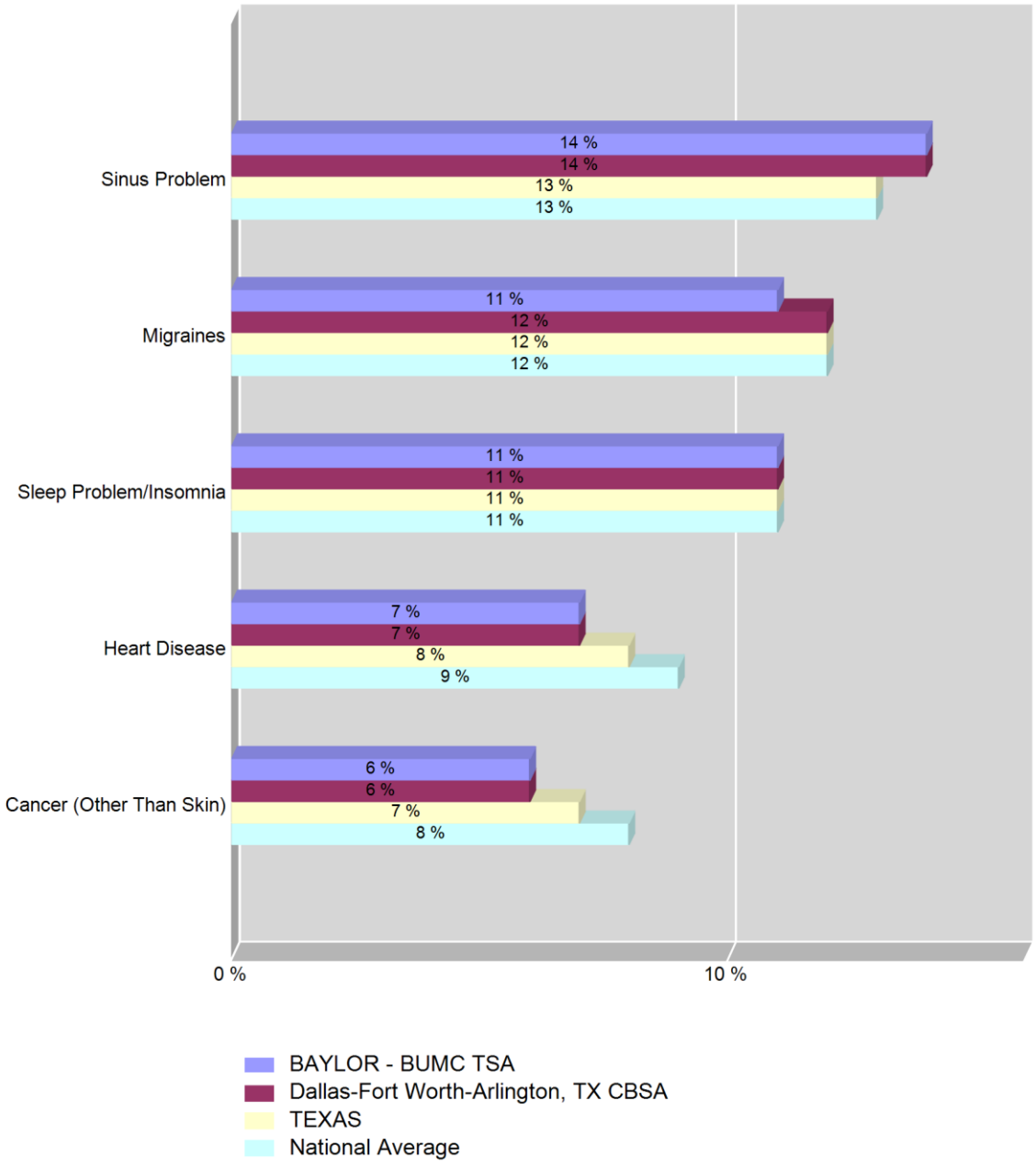

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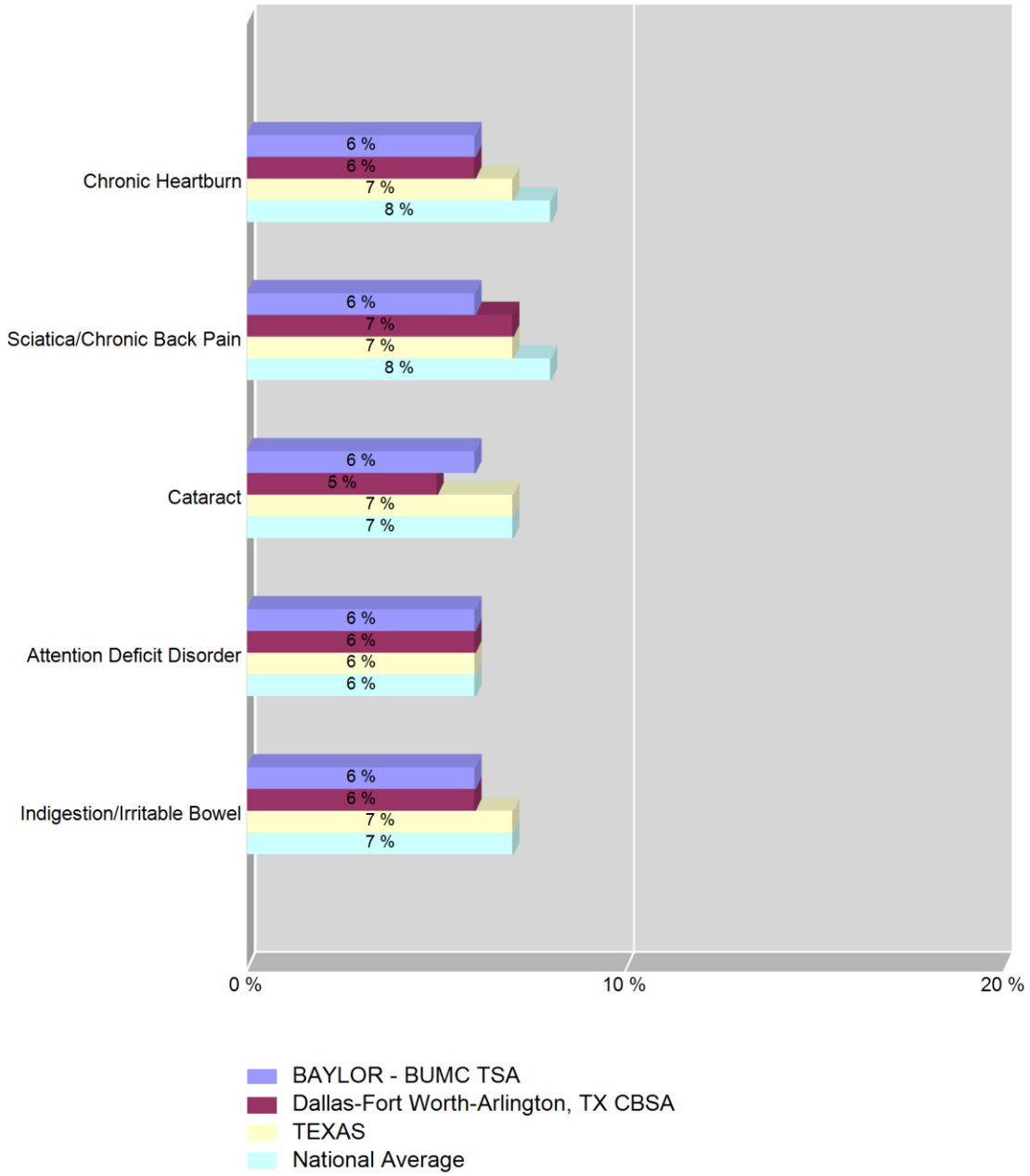

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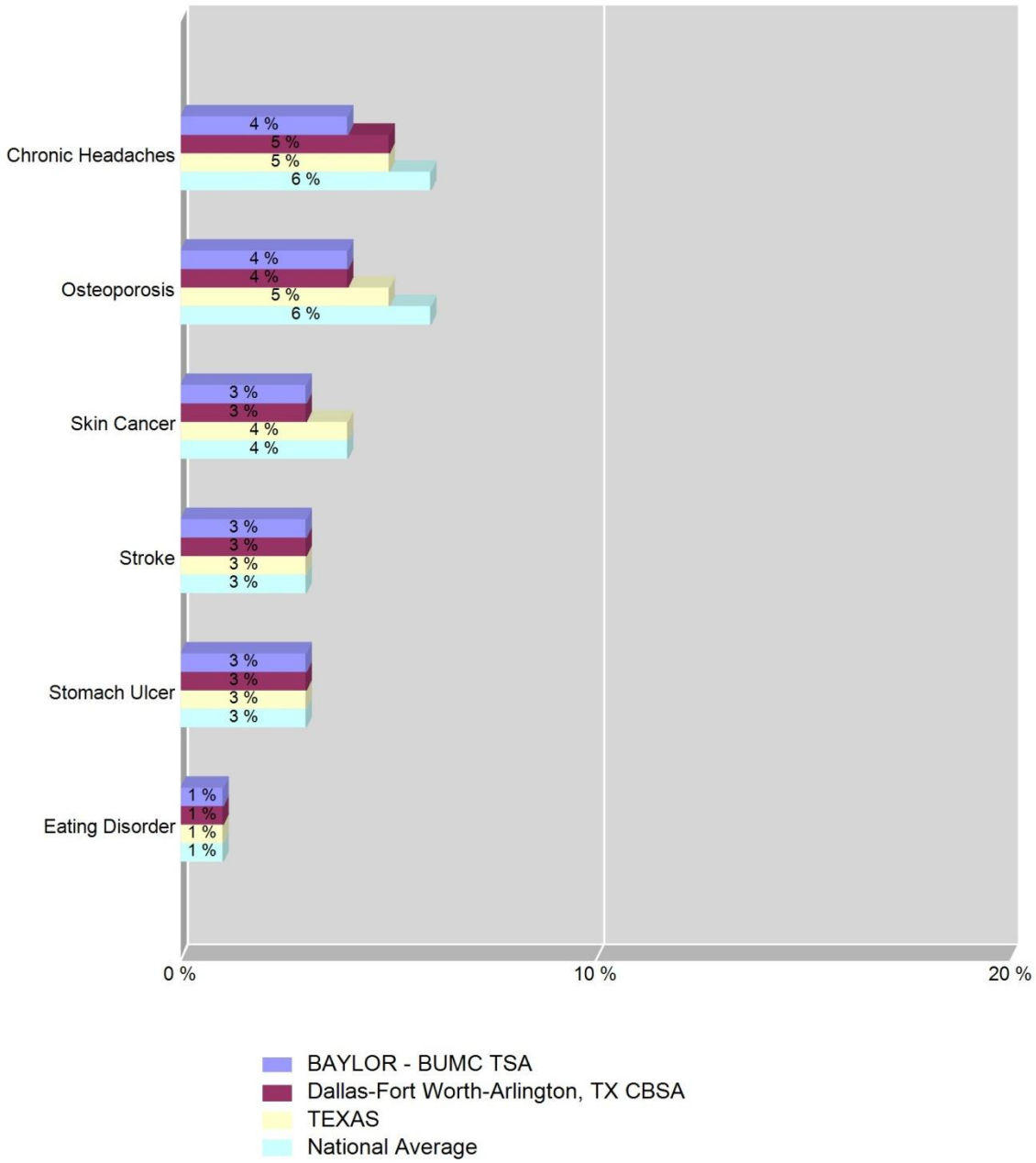
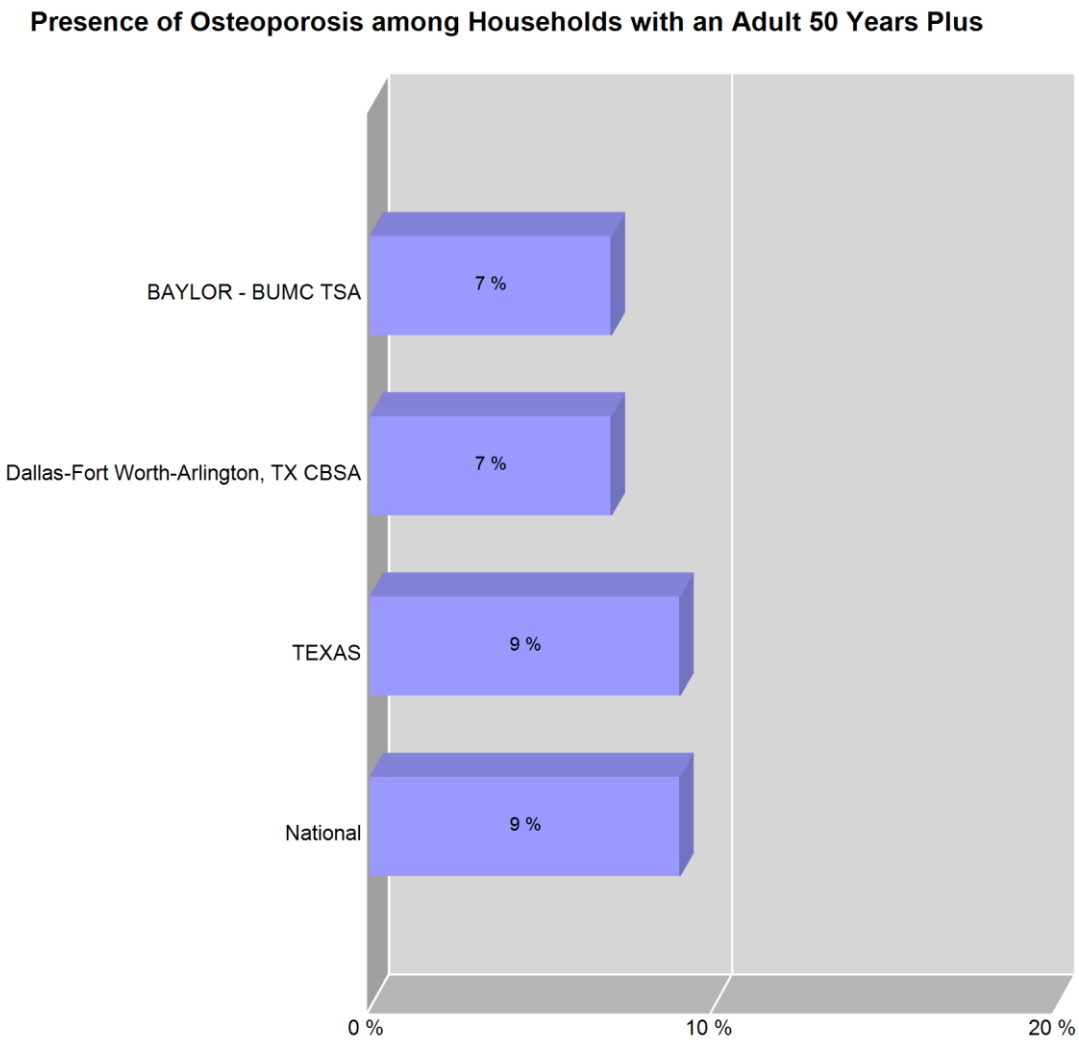


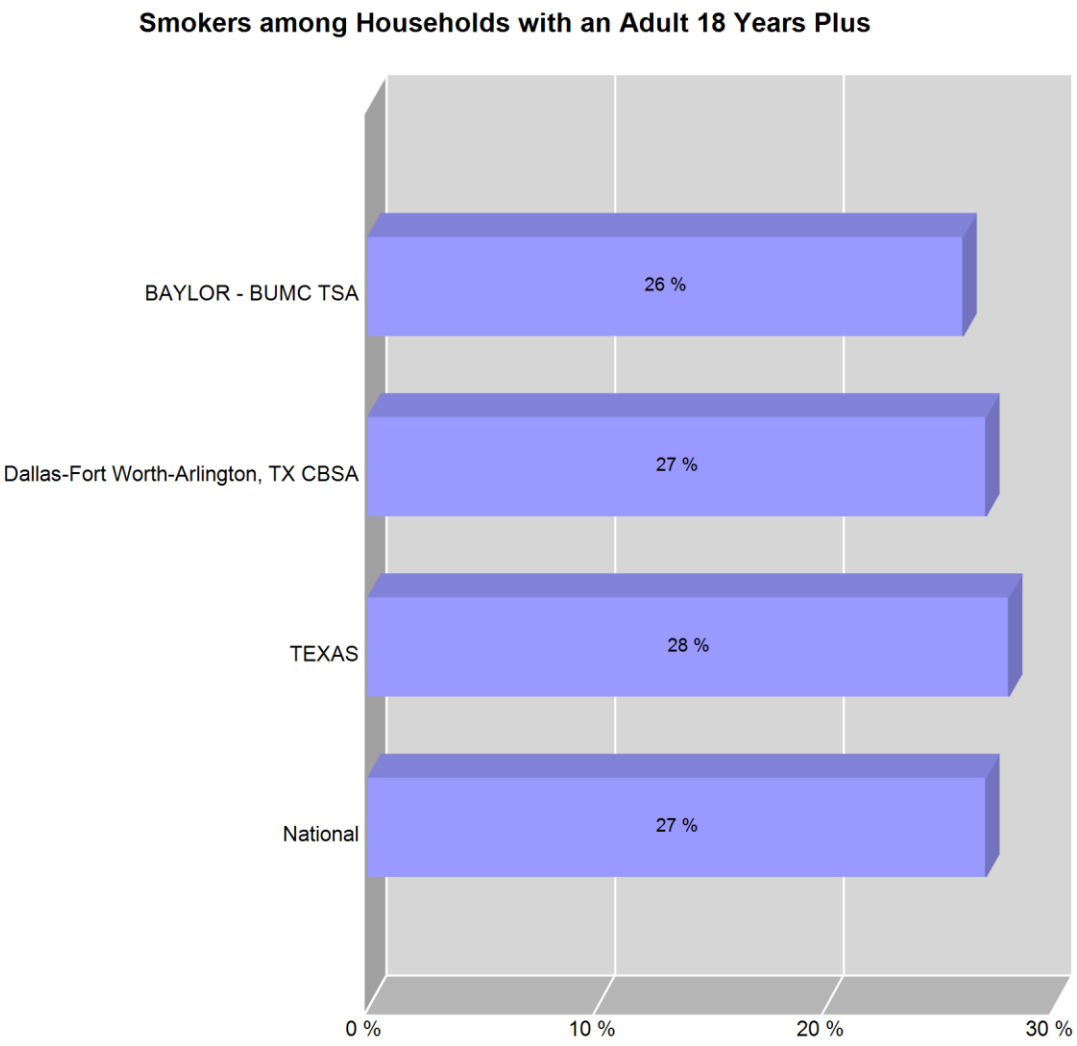
Health Risk Profiles Compared to Healthy People 2010



Healthy People 2010 Target:

- 8% adults 50 years plus as measured by bone mineral density test had the disease.

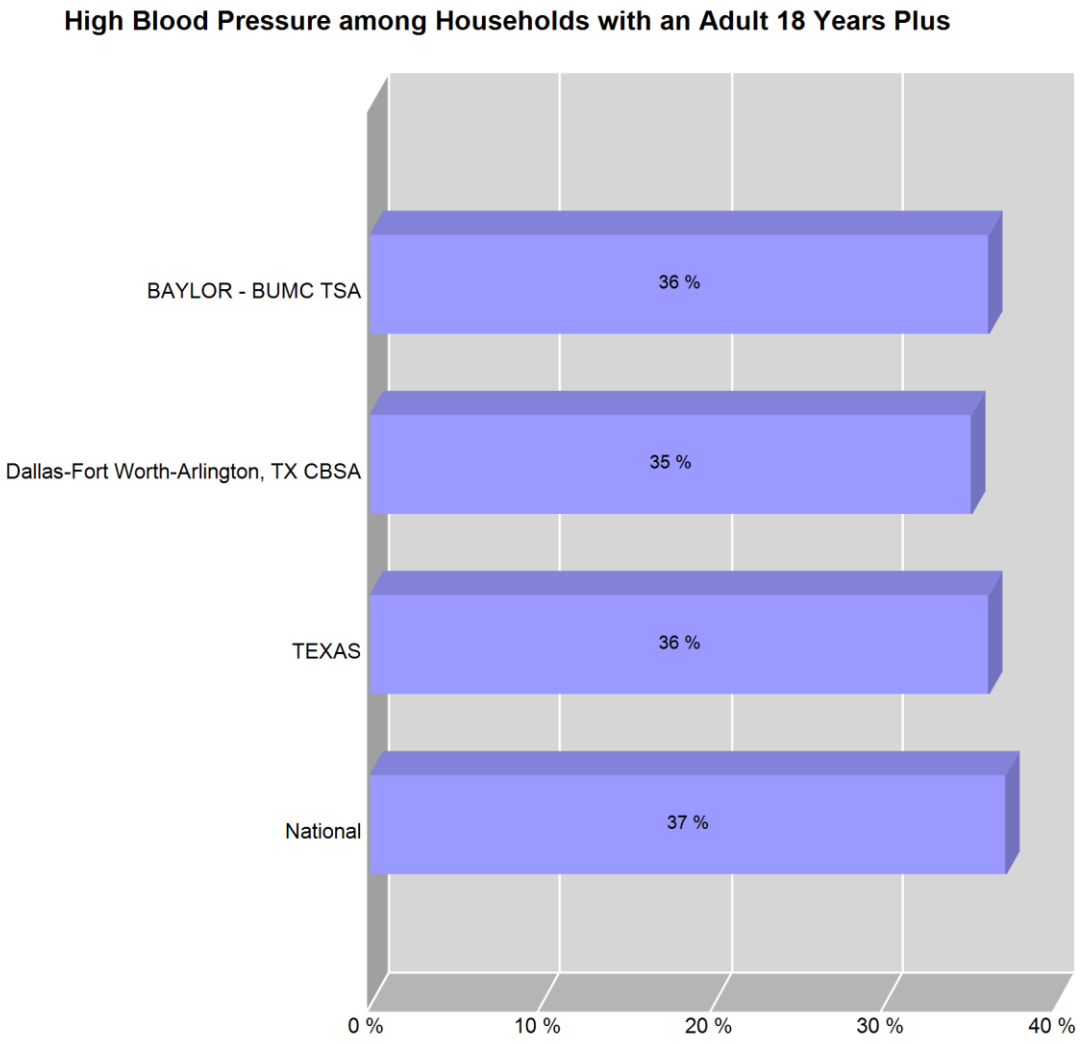
Health Risk Profiles Compared to Healthy People 2010



Healthy People 2010 Target:

- Reduce cigarette smoking to 12% among adults 18 years plus.

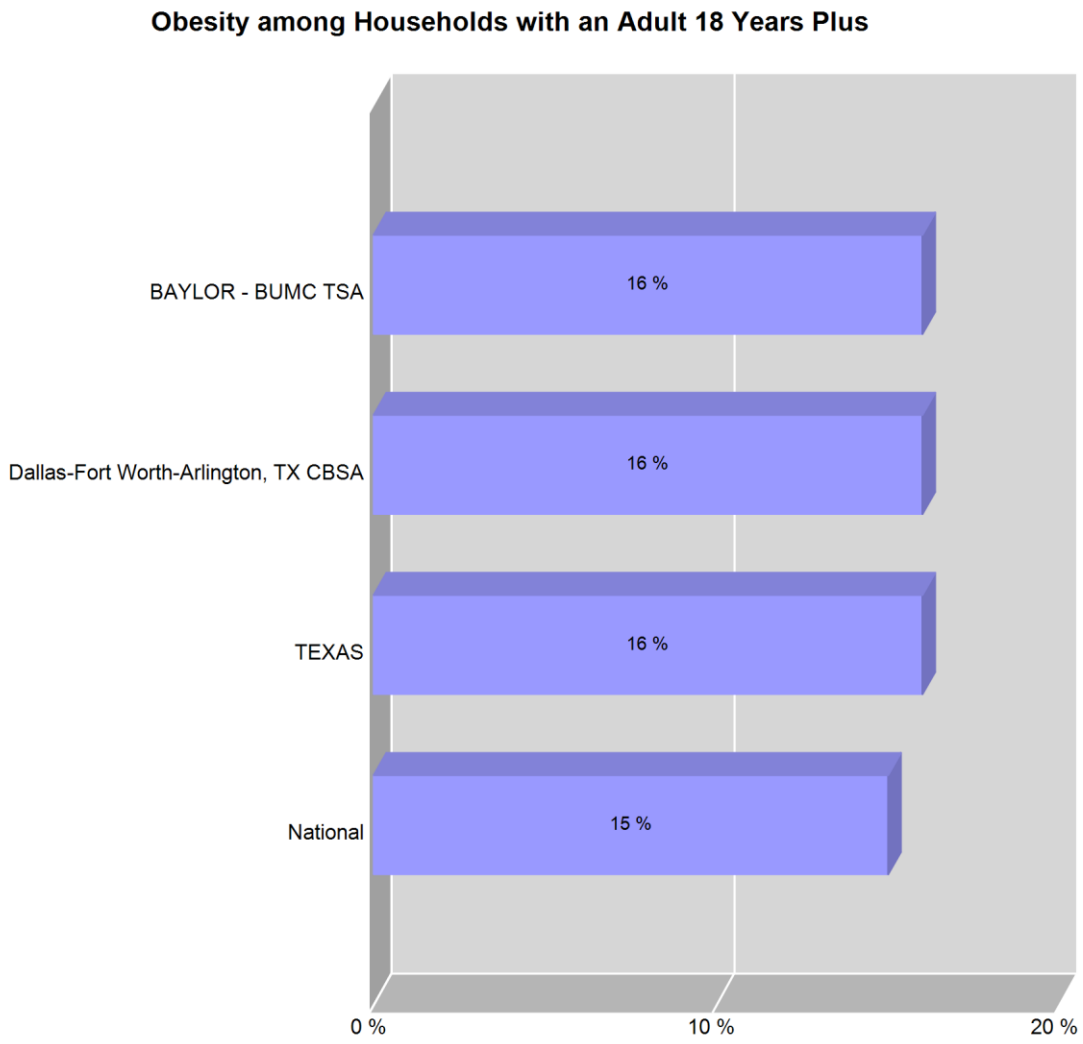
Health Risk Profiles Compared to Healthy People 2010



Healthy People 2010 Target:

- Reduce the proportion of adults with high blood pressure to 16%.

Health Risk Profiles Compared to Healthy People 2010

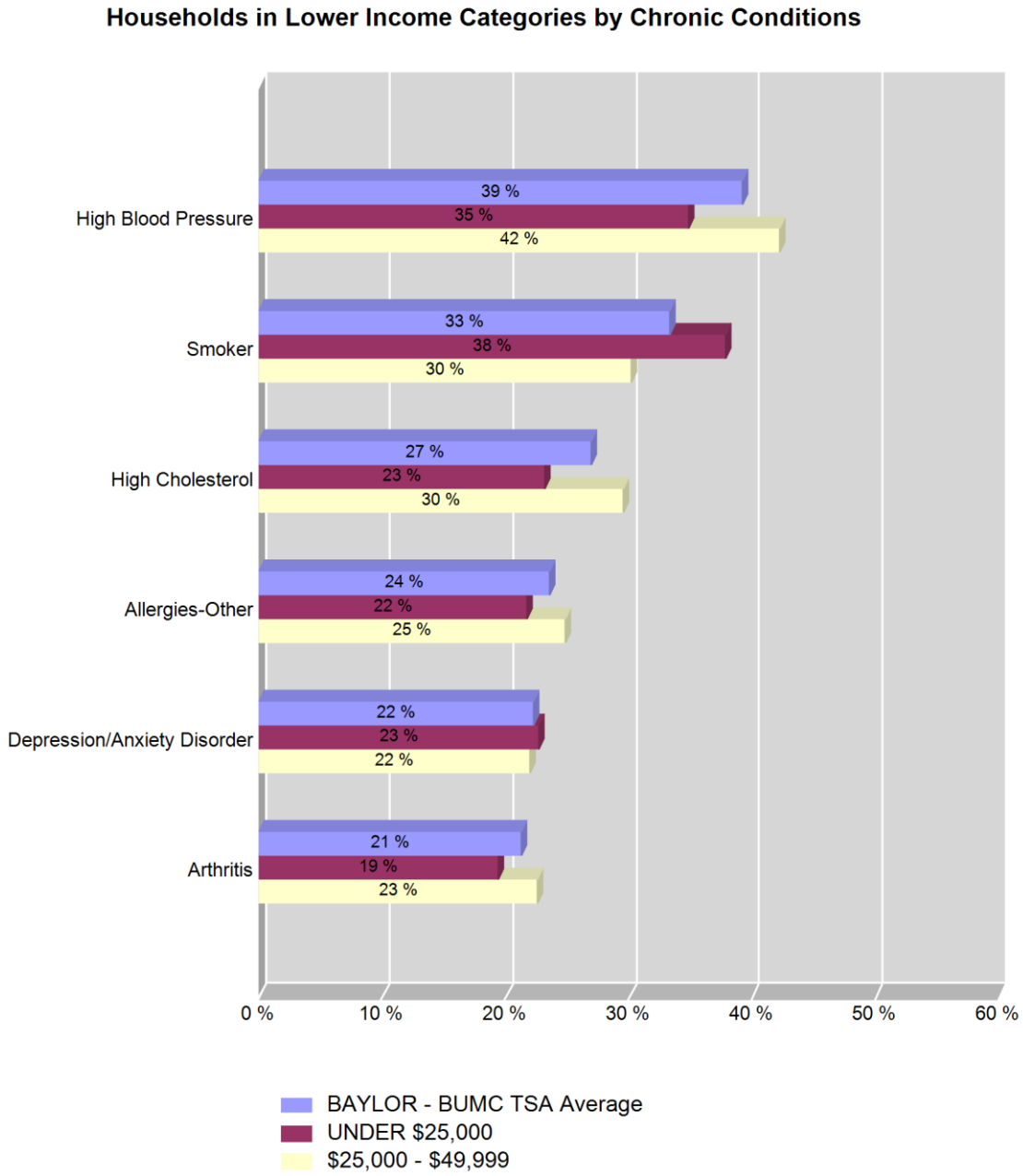


Healthy People 2010 Target:

- Reduce the proportion of adults who are obese by 15%.

Health Risk Profiles - Low Income

Represented below is the percentage of BAYLOR - BUMC TSA households in lower income categories that report one or more household members have been diagnosed with the chronic condition, compared to the market average.



Health Risk Profiles - Low Income

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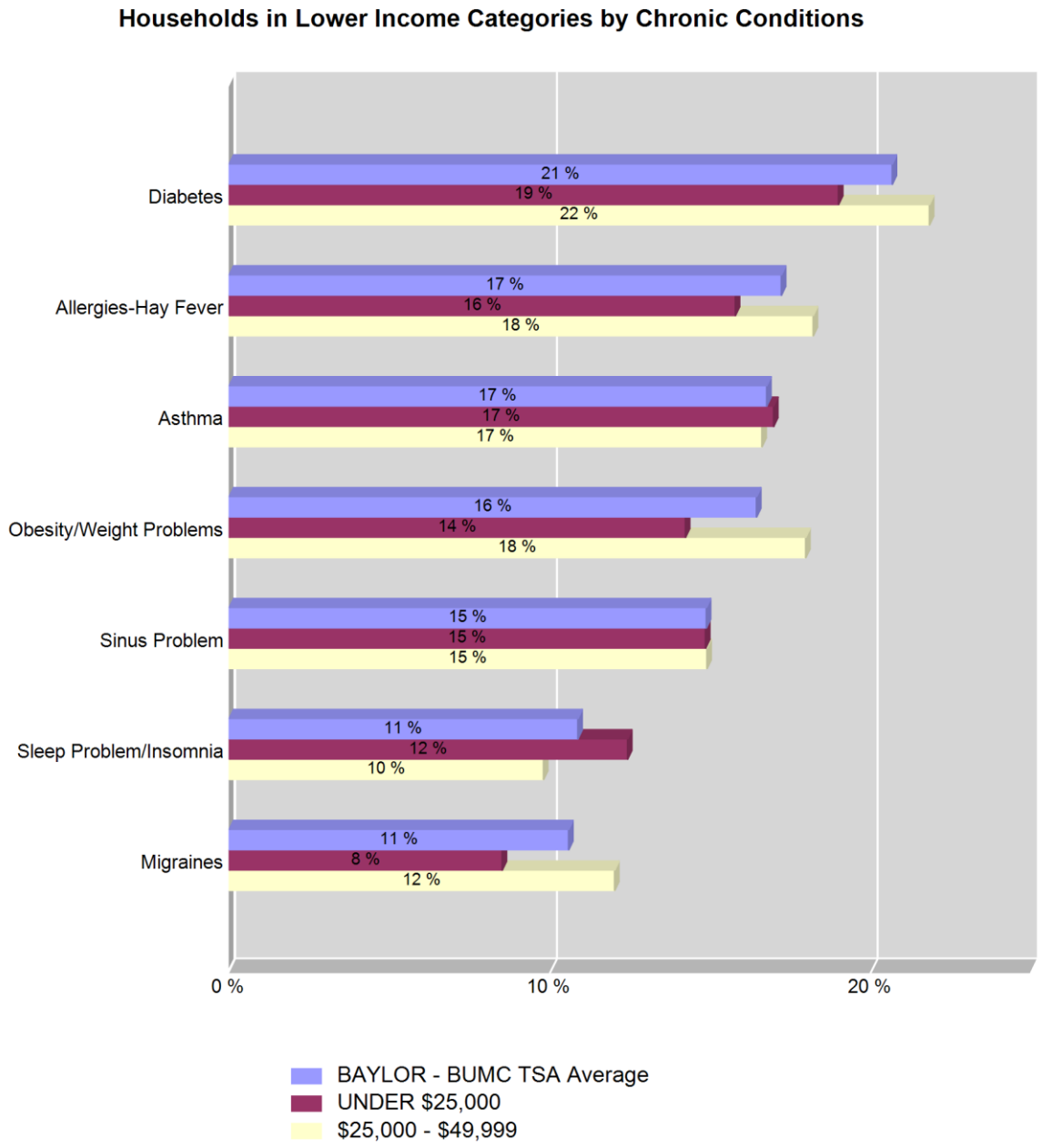

Health Risk Profiles - Low Income

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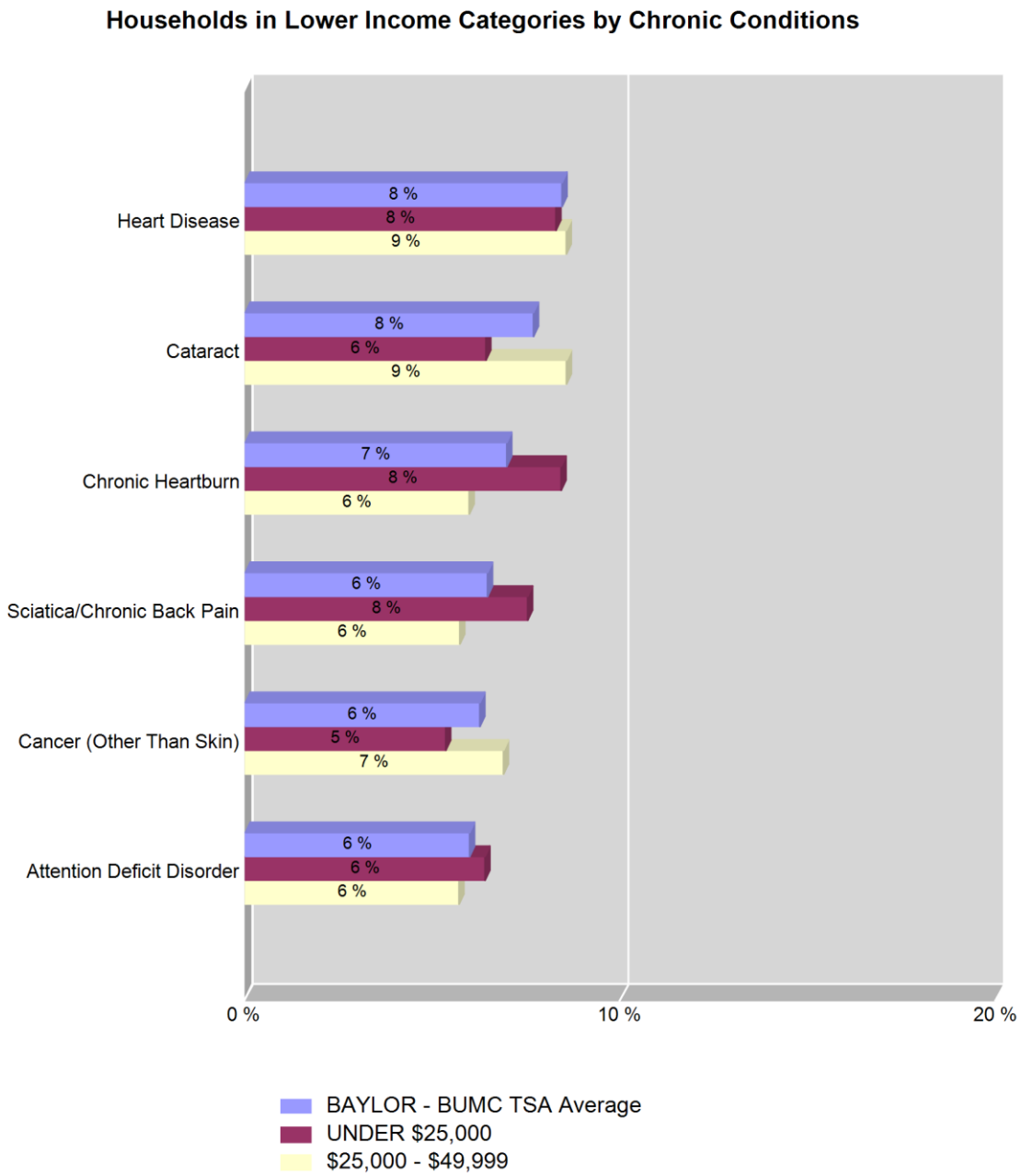

Health Risk Profiles - Low Income

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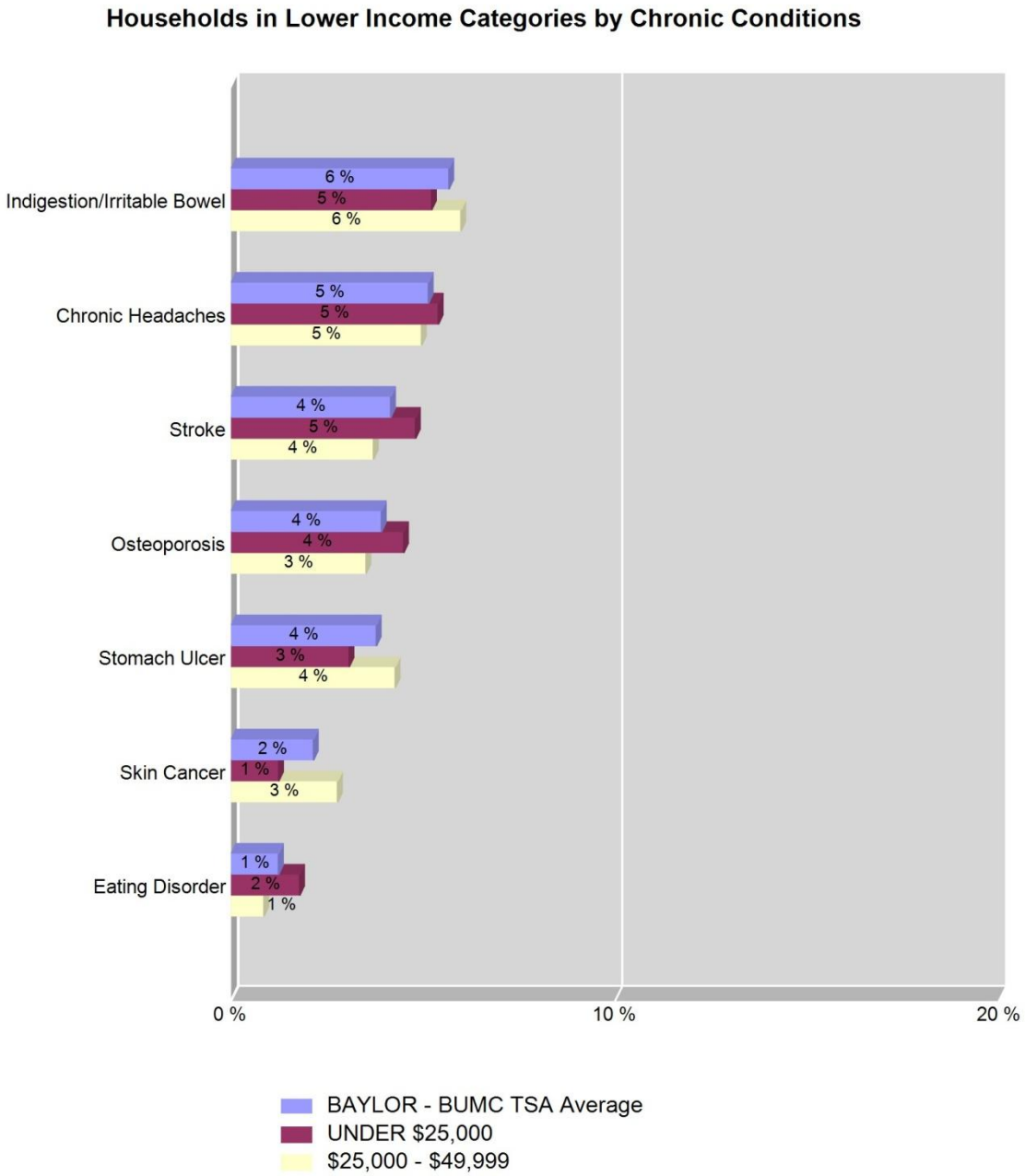
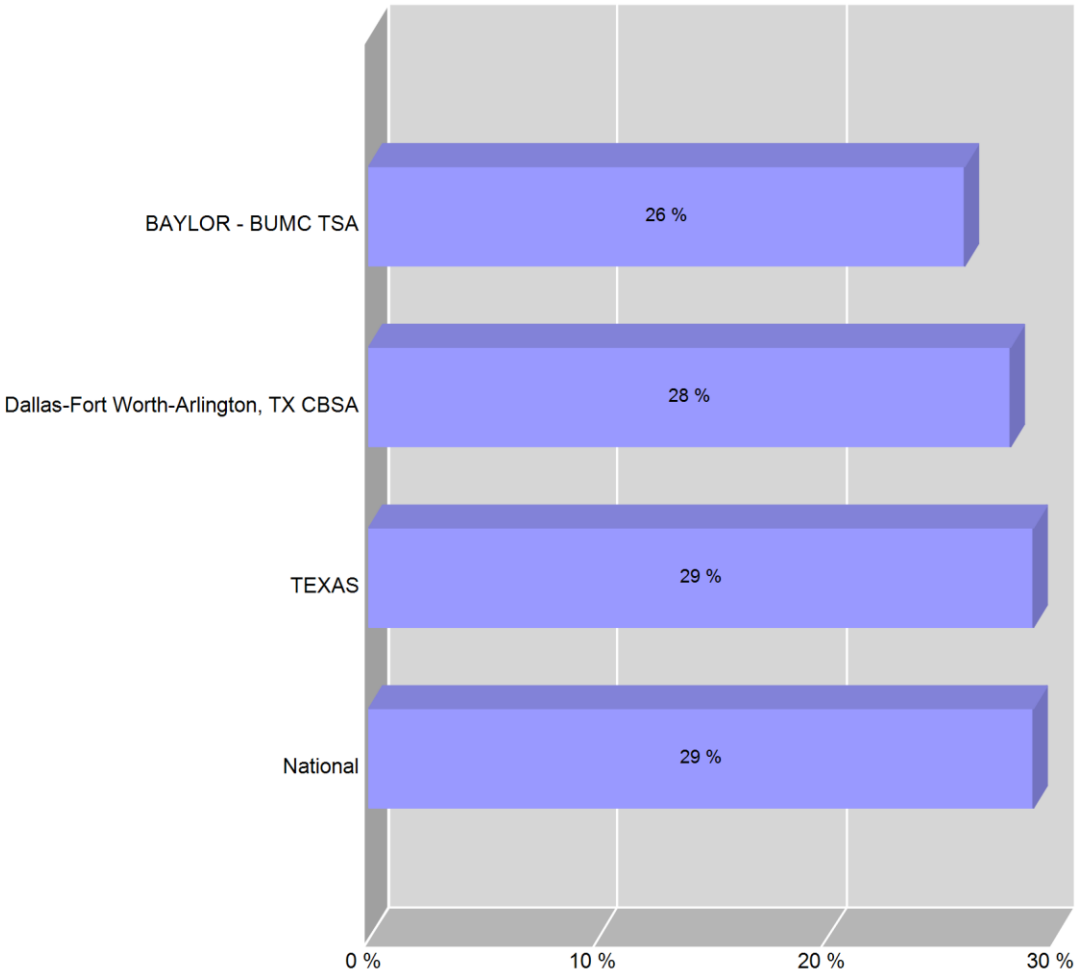


Preventive Health Behaviors Compared to Healthy People 2010

Child Immunizations among Households with Children

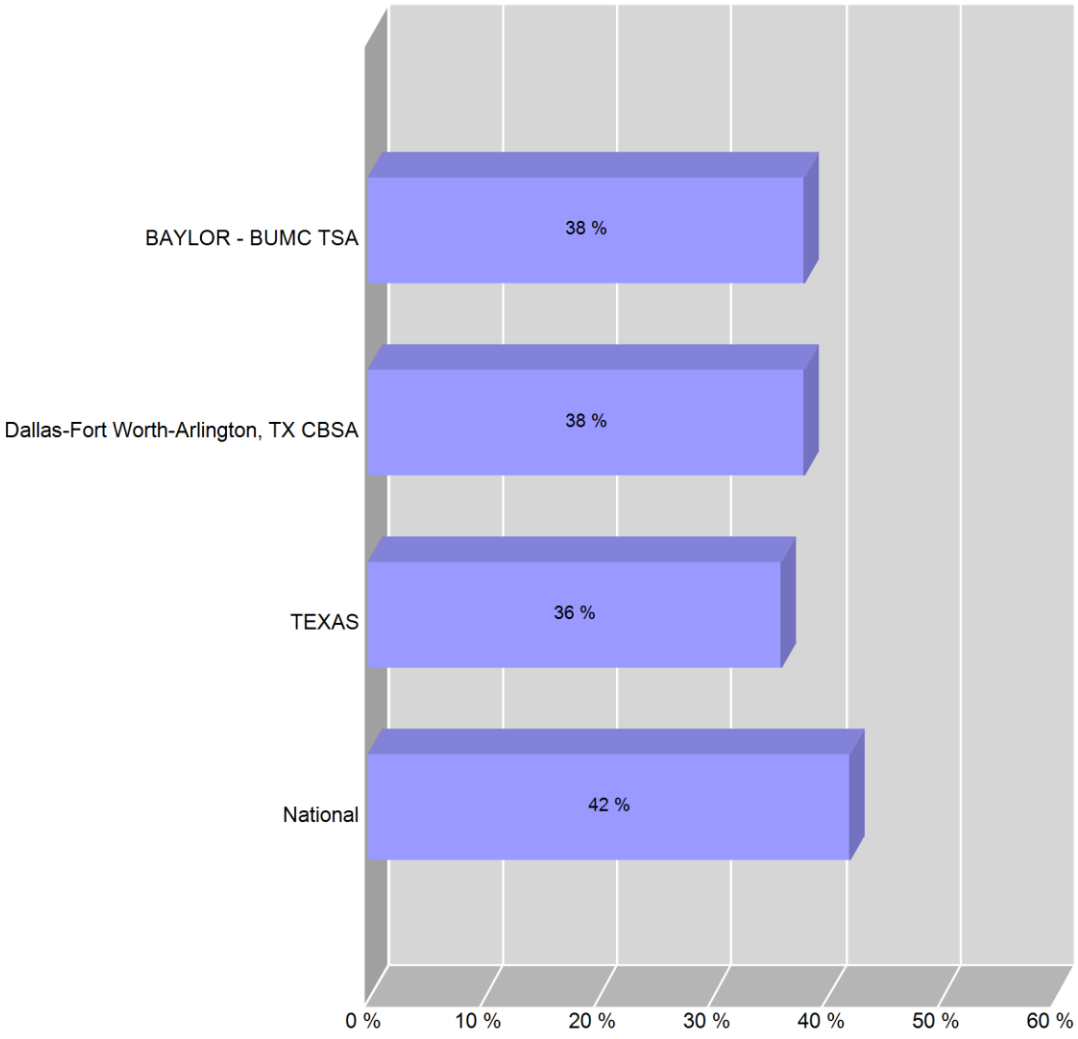


Healthy People 2010 Target:

- Increase the proportion of young children and adolescents who receive all vaccines that have been recommended or universal administration for at least 5 years to 80%.

Preventive Health Behaviors Compared to Healthy People 2010

Mammograms among Households with a Female 40 Years Plus

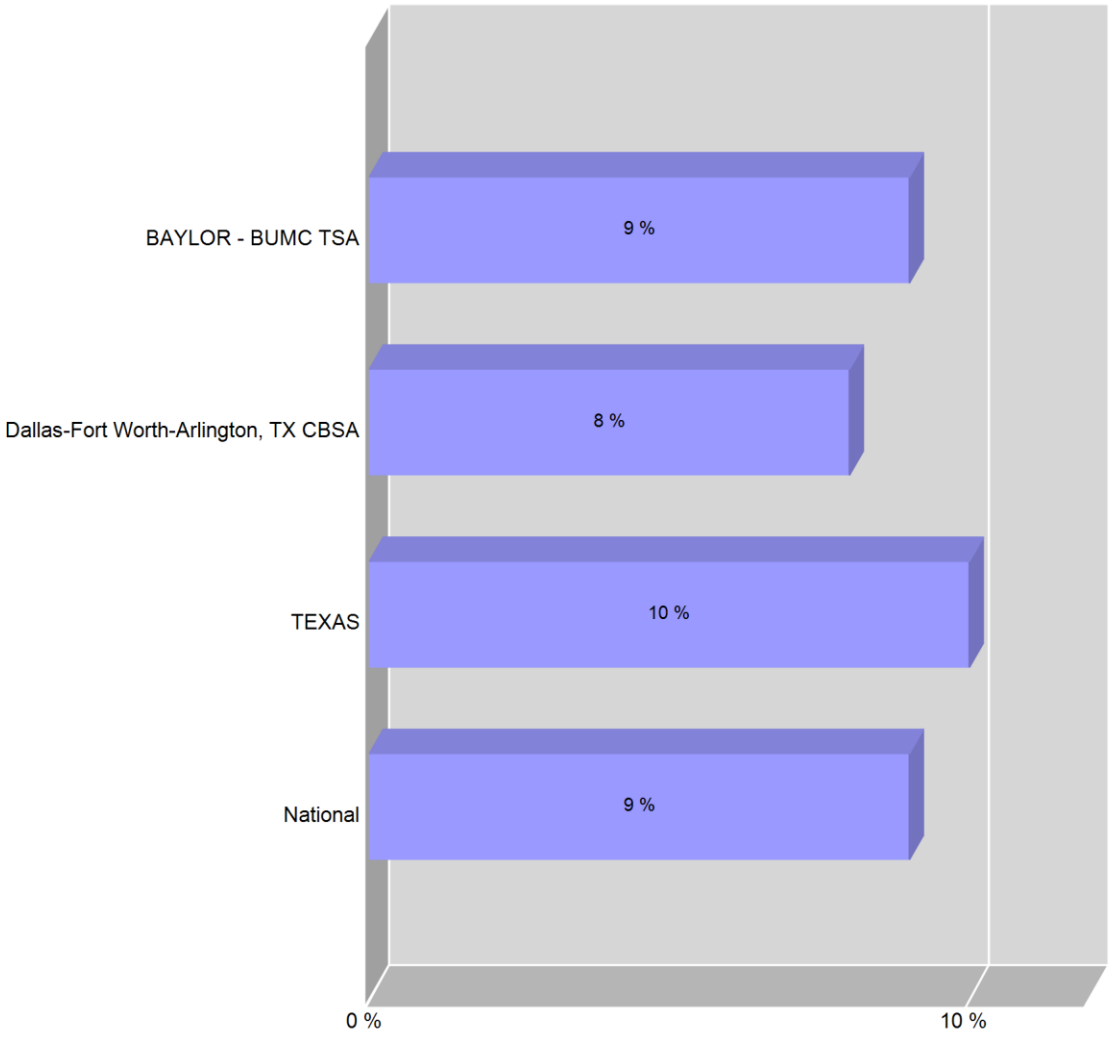


Healthy People 2010 Target:

- 70% women 40 years plus have had mammogram within past 2 years.

Preventive Health Behaviors Compared to Healthy People 2010

Osteoporosis Testing among Households with an Adult 50 Years Plus

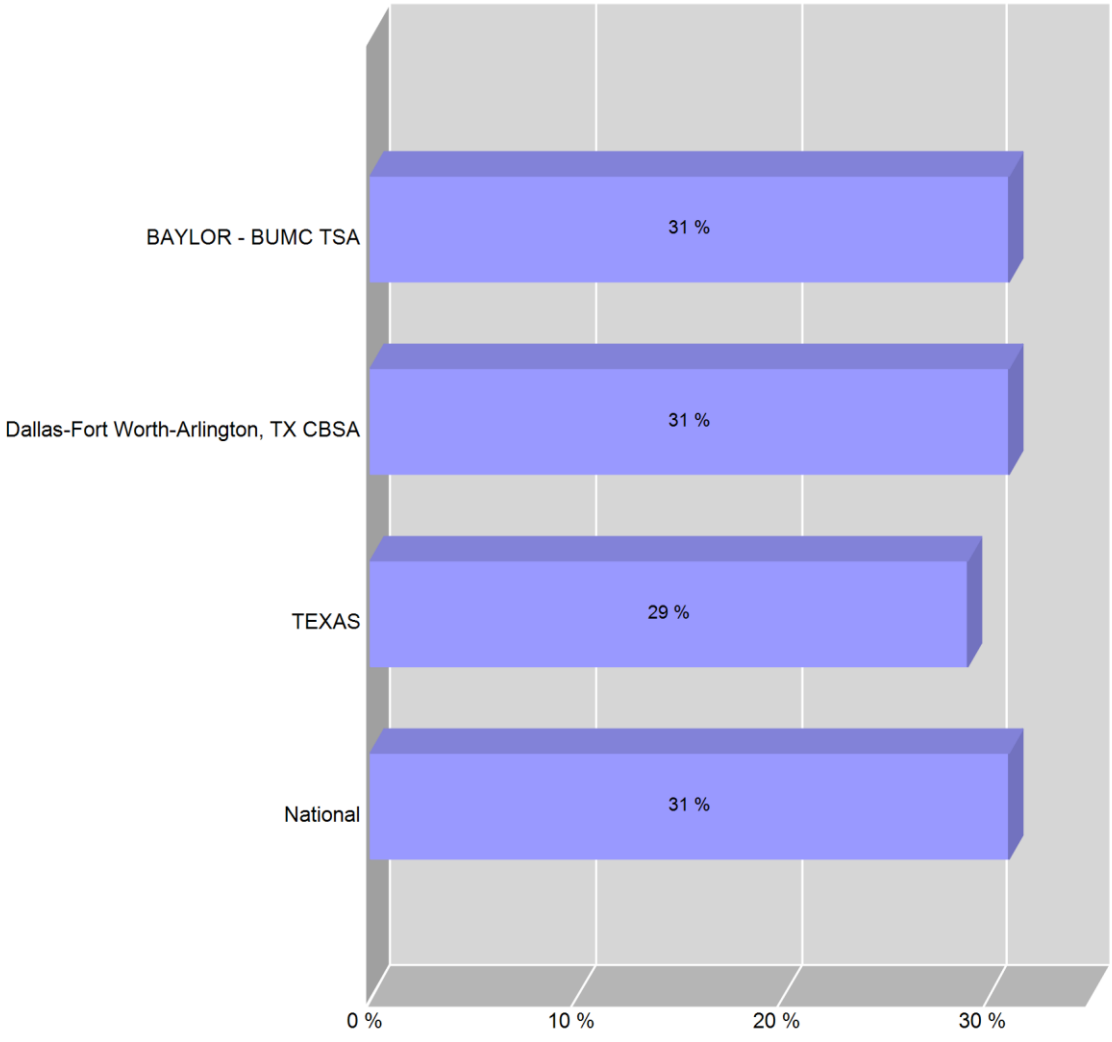


Healthy People 2010 Target:

- 8% adults 50 years plus as measured by bone mineral density test had the disease.

Preventive Health Behaviors Compared to Healthy People 2010

Pap Smear Test among Households with a Female 18 Years Plus

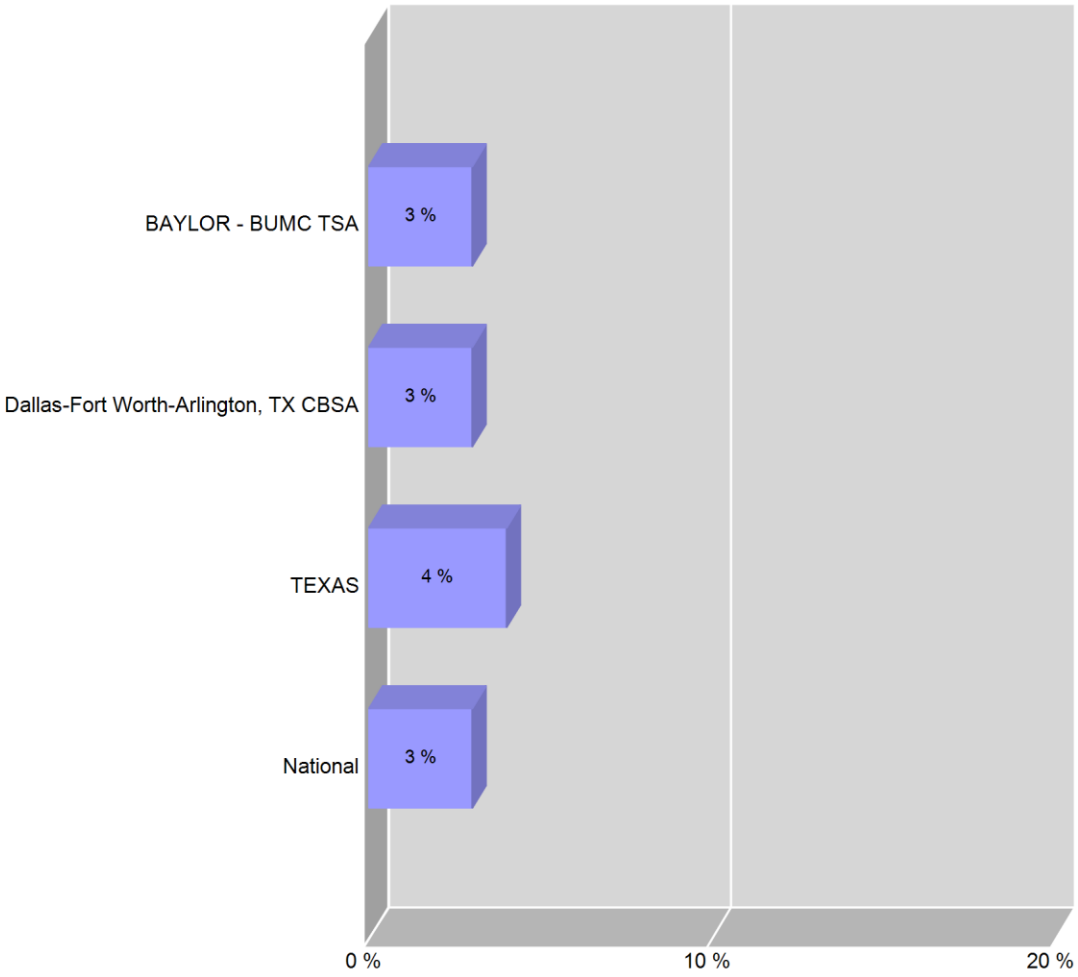


Healthy People 2010 Target:

- 97% women 18 years plus have had pap smear test.

Preventive Health Behaviors Compared to Healthy People 2010

Pre-Natal Care among Households with a Female 15 Years Plus

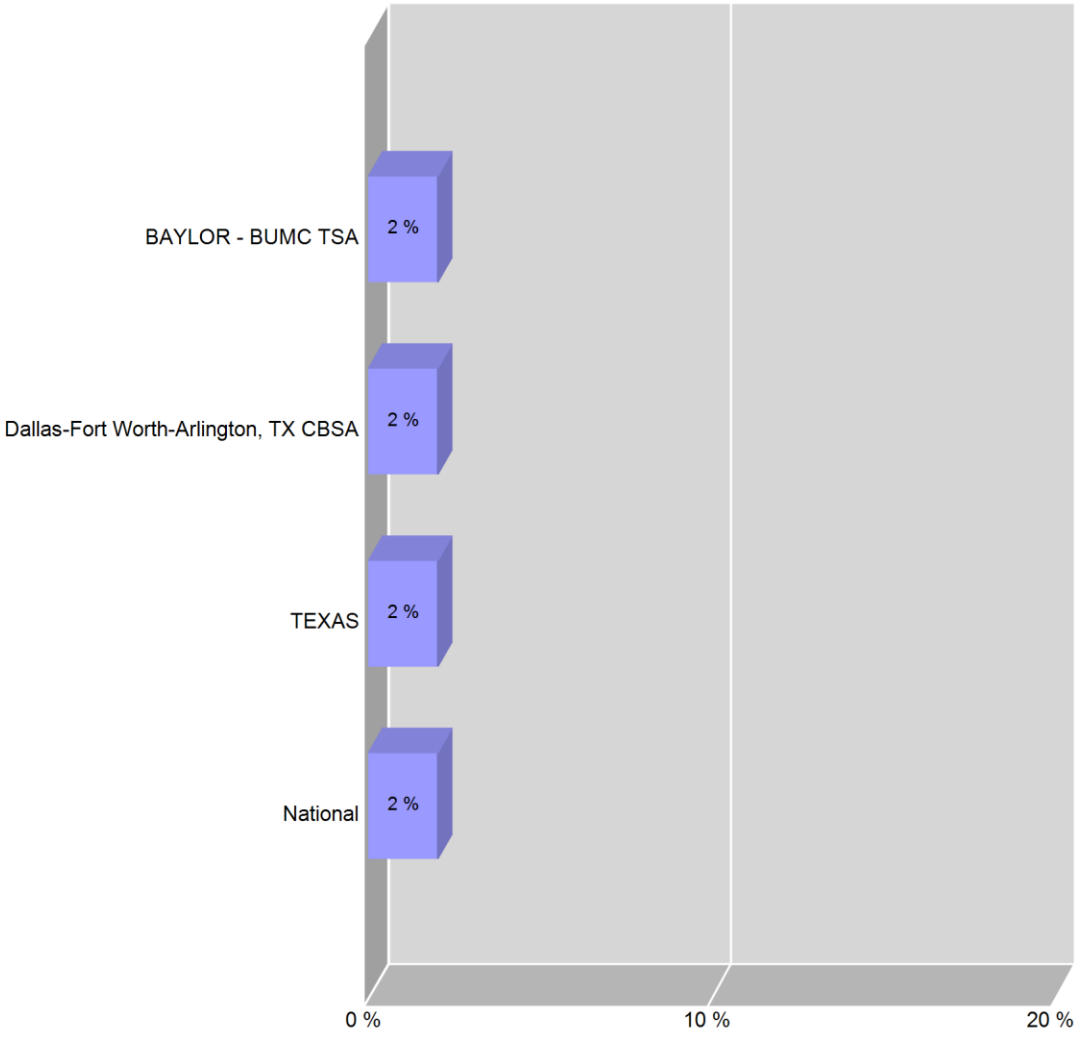


Healthy People 2010 Target:

- 90% care beginning in the first trimaster of pregnancy.
- 90% early and adequate pre-natal care.

Preventive Health Behaviors Compared to Healthy People 2010

Stop Smoking Program among Households with an Adult 18 Years Plus

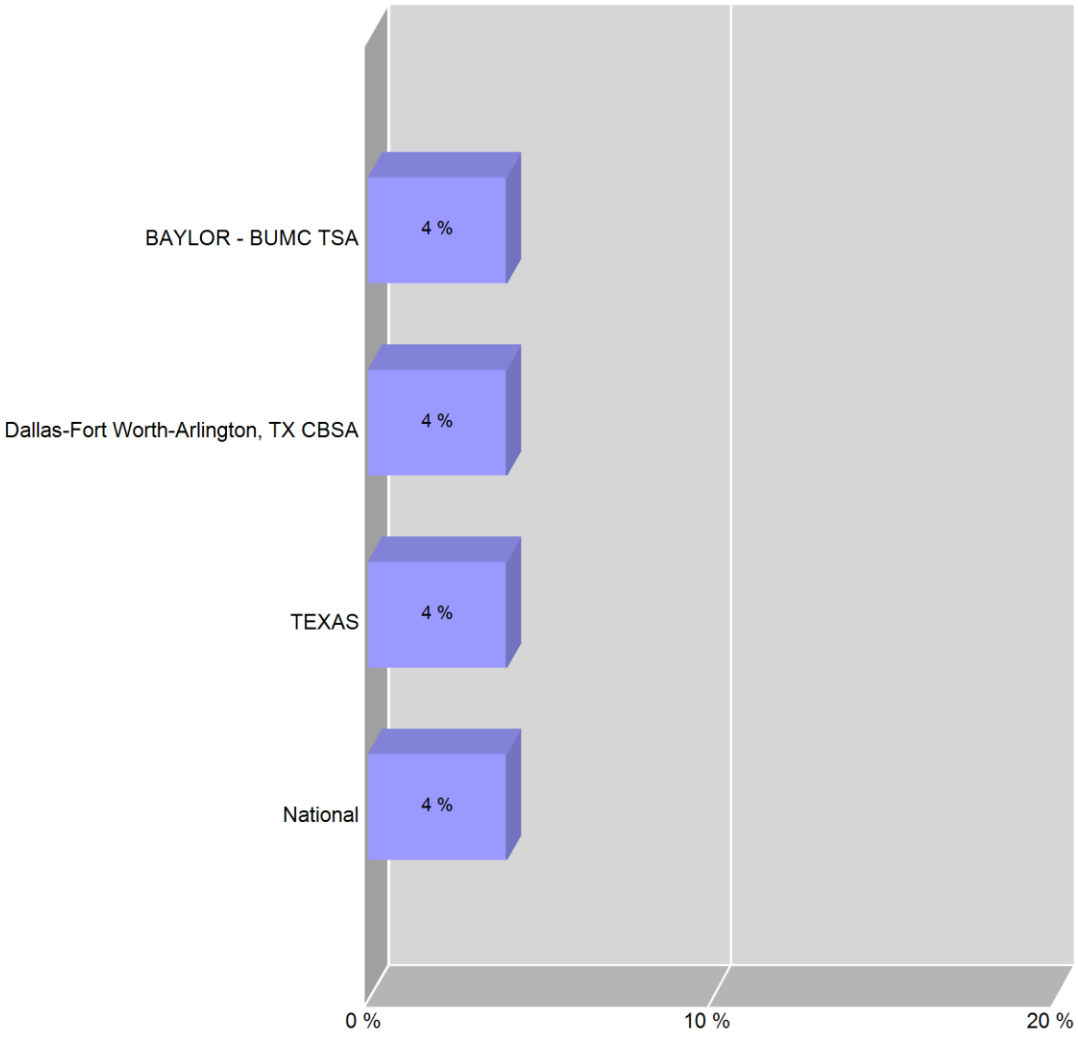


Healthy People 2010 Target:

- Increase smoking cessation attemps to 75% by adult smokers.

Preventive Health Behaviors Compared to Healthy People 2010

Weight Loss Program among Households with an Adult 20 Years Plus

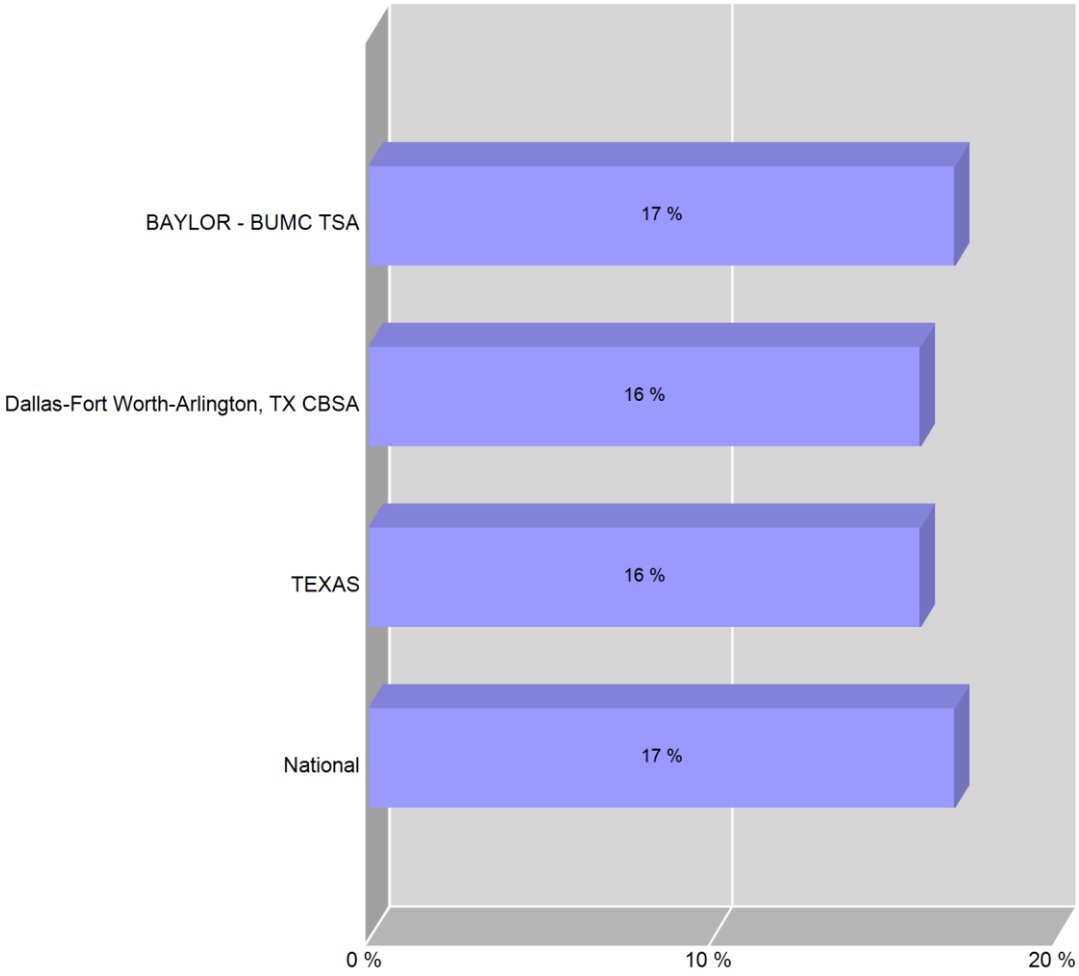


Healthy People 2010 Target:

- 60% adults 20 years plus at a healthy weight (Body Mass Index of 18.5 to 25).

Preventive Health Behaviors Compared to Healthy People 2010

Colon Screening among Households with an Adult 50 Years Plus

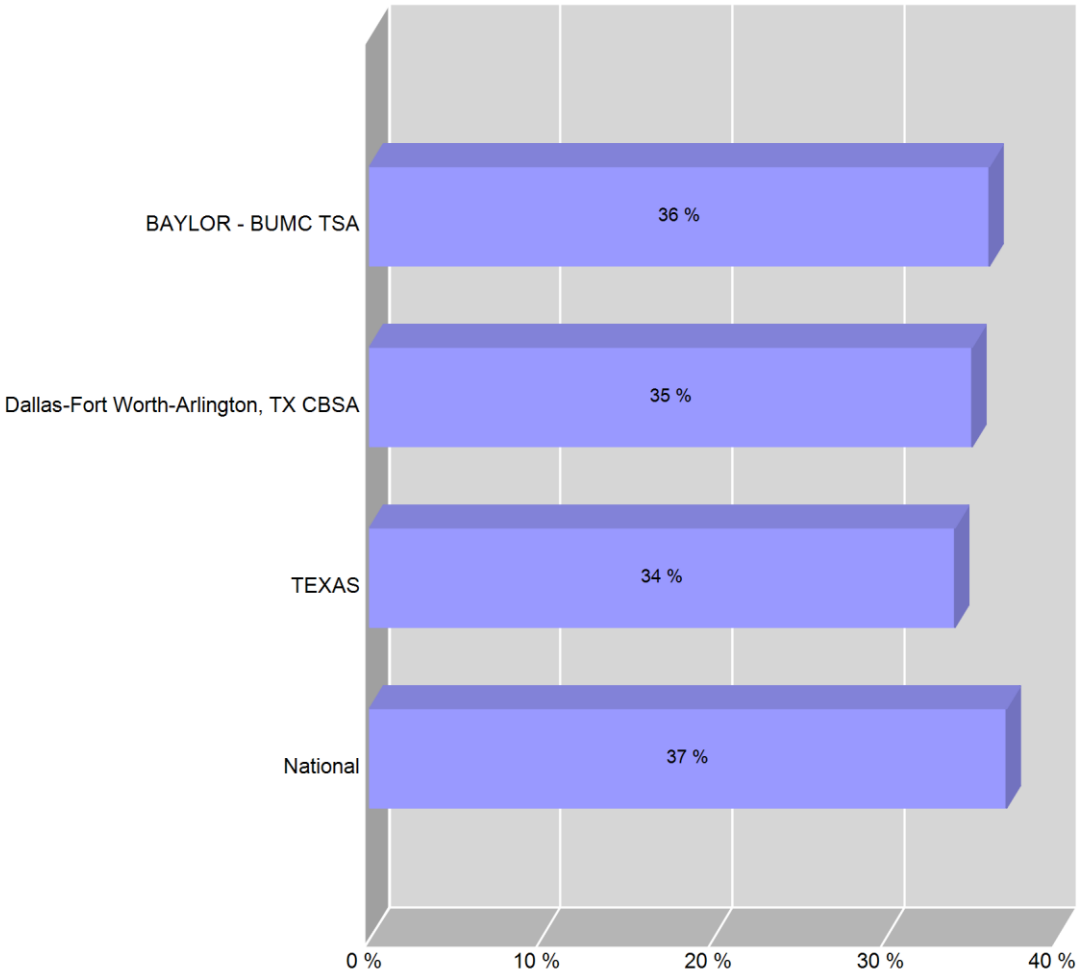


Healthy People 2010 Target:

- Increase the proportion of adults who receive a colorectal cancer screening examination to 50%

Preventive Health Behaviors Compared to Healthy People 2010

Cholesterol Test among Households with an Adult 18 Years Plus

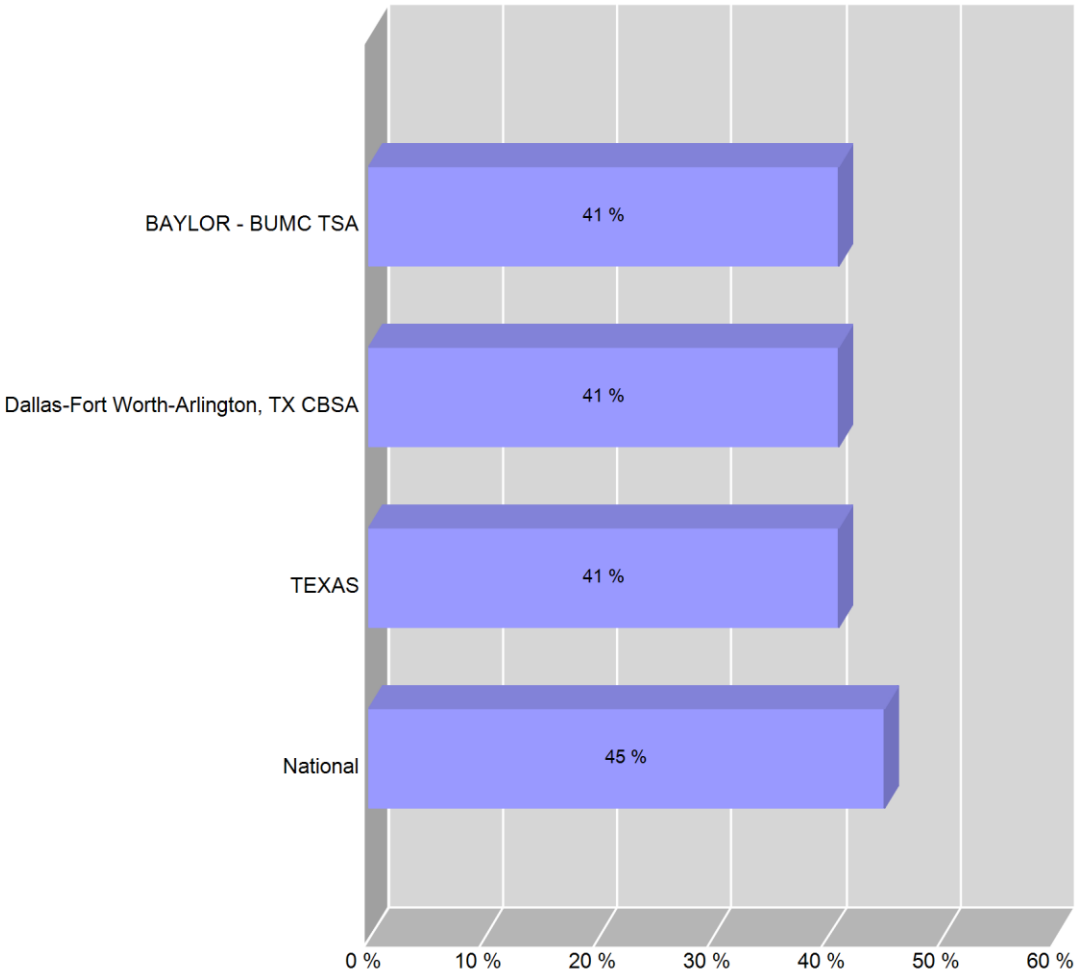


Healthy People 2010 Target:

- Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years to 80%

Preventive Health Behaviors Compared to Healthy People 2010

Dental Exam among Households with Children

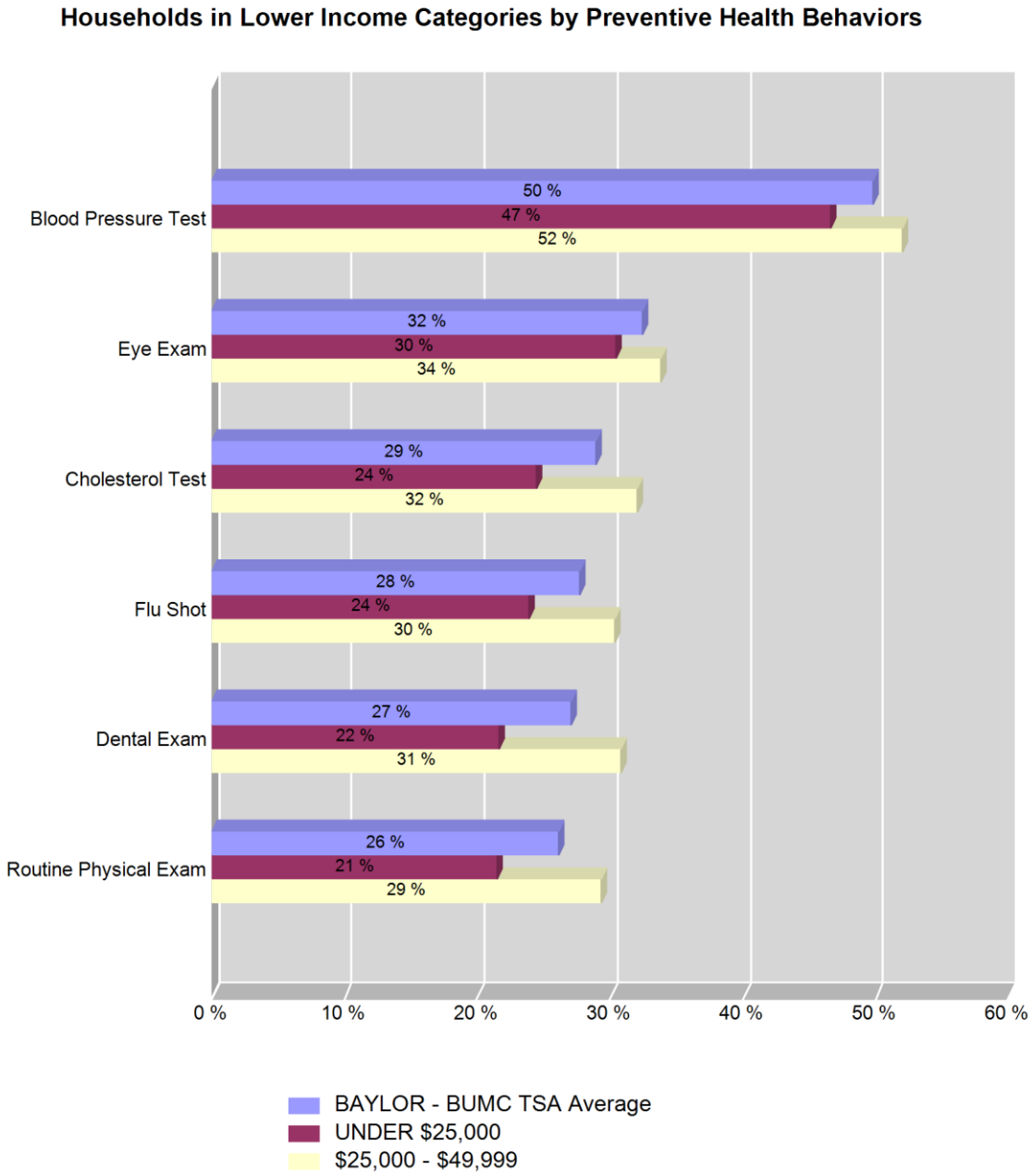


Healthy People 2010 Target:

- Increase the proportion of children and adults who use the oral health care system each year by 56%

Preventive Health Behaviors - Low Income

Represented below is the percentage of BAYLOR - BUMC TSA households in lower income categories that have had the following preventive healthcare services or tests in the last 12 months, compared to the market average.



Preventive Health Behaviors - Low Income

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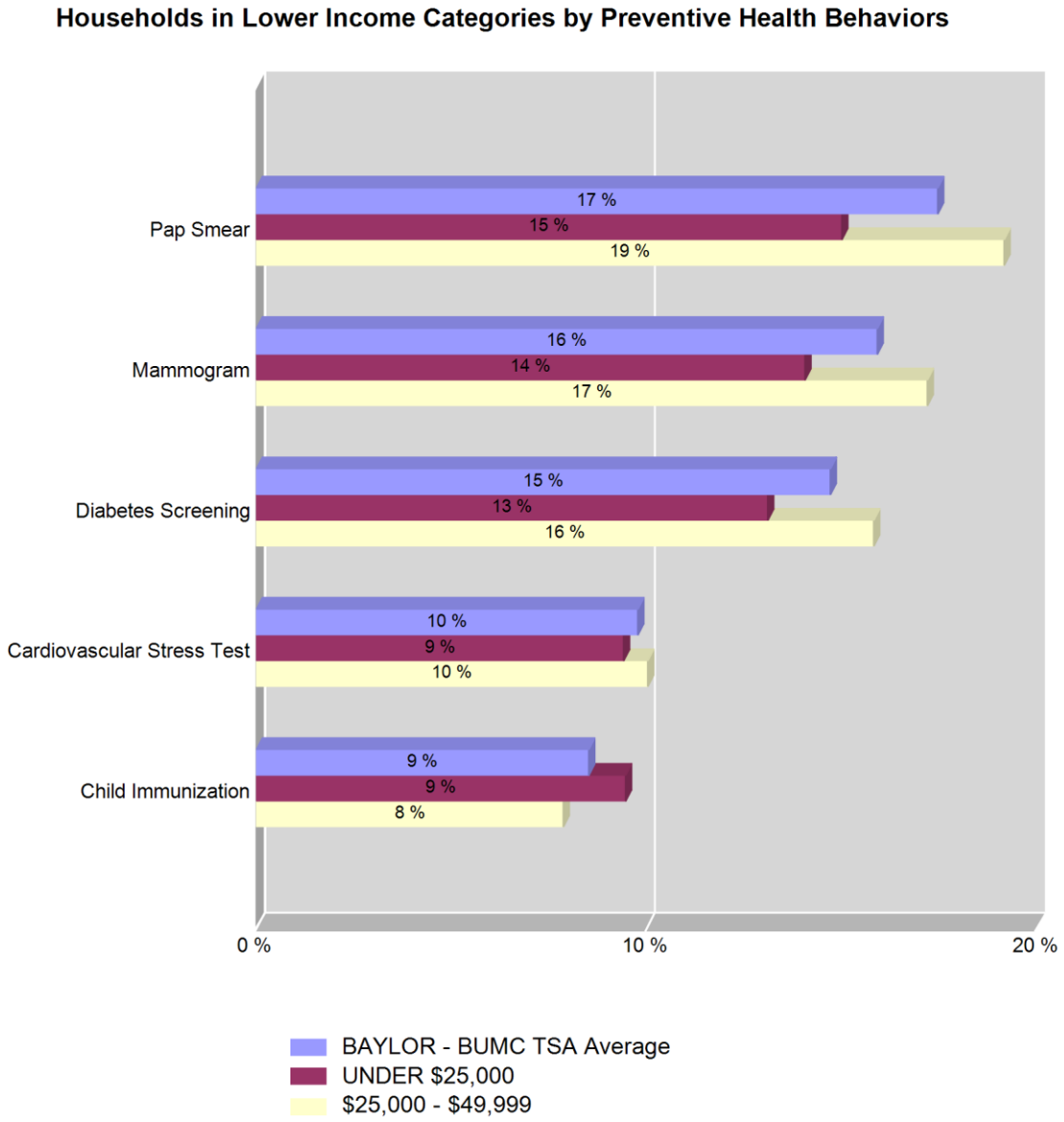

Preventive Health Behaviors - Low Income

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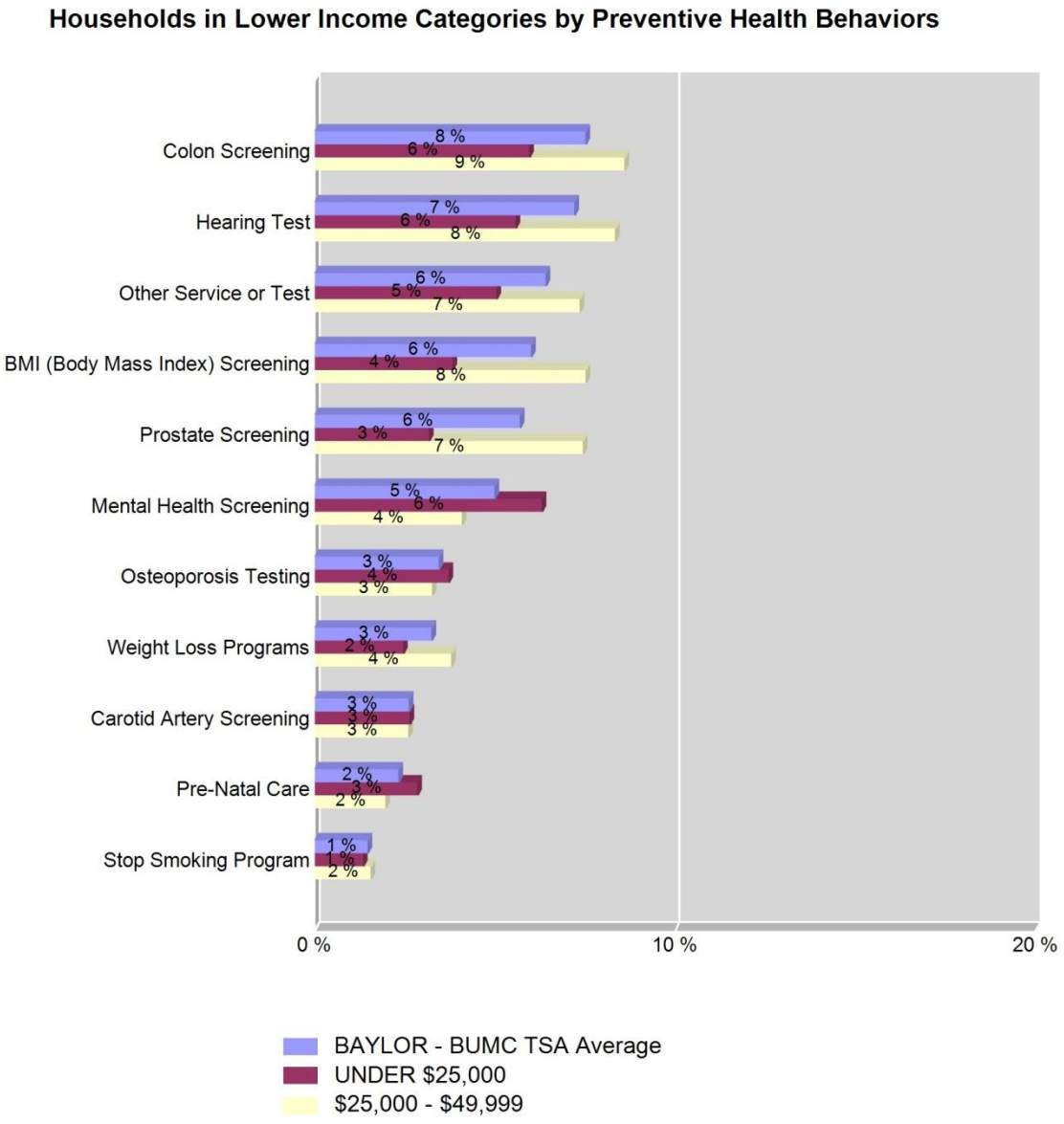
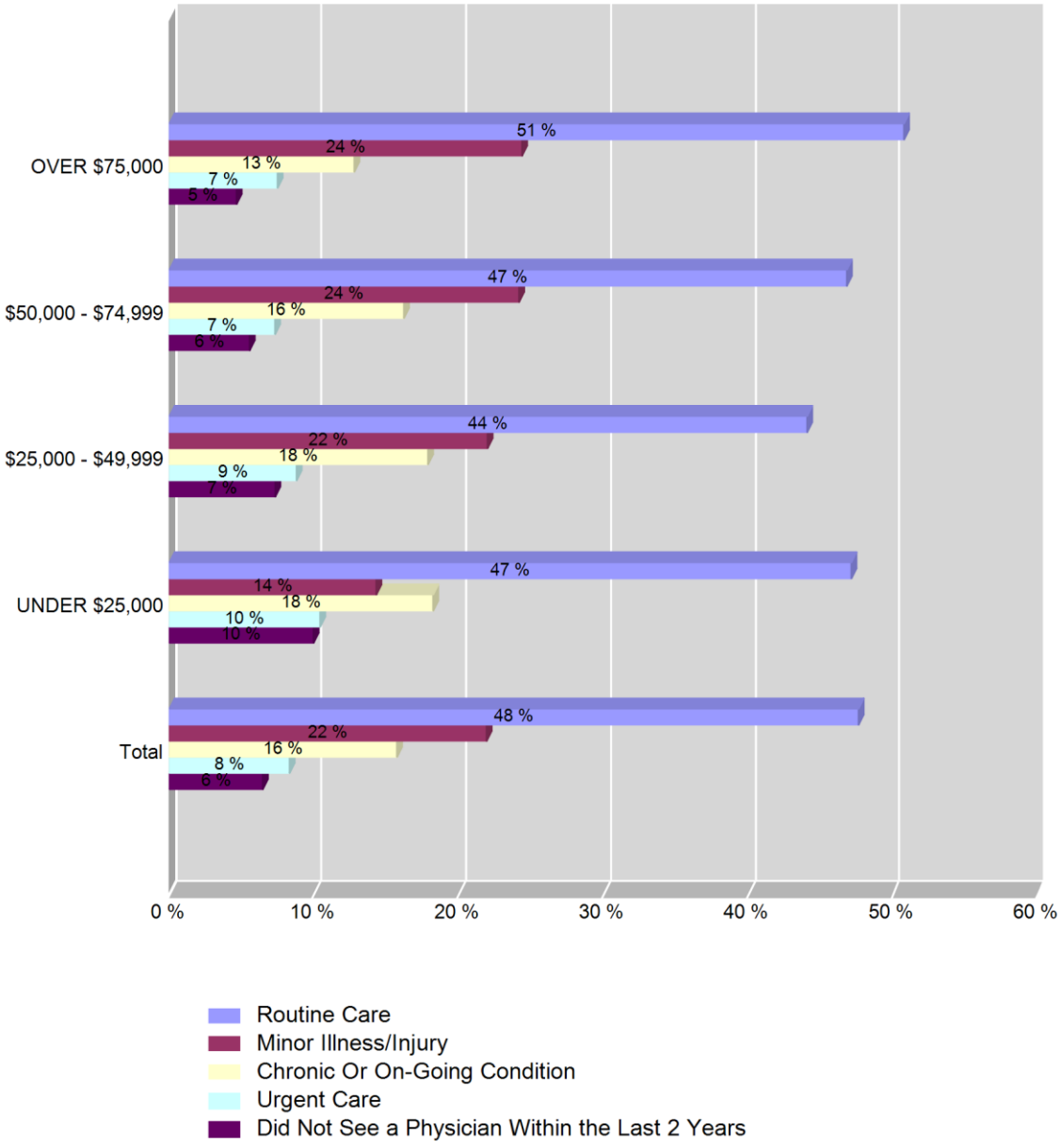


Physician Visit Usage and Access

This section outlines the household's last physician visit usage and days to appointment access, including purpose of visit.

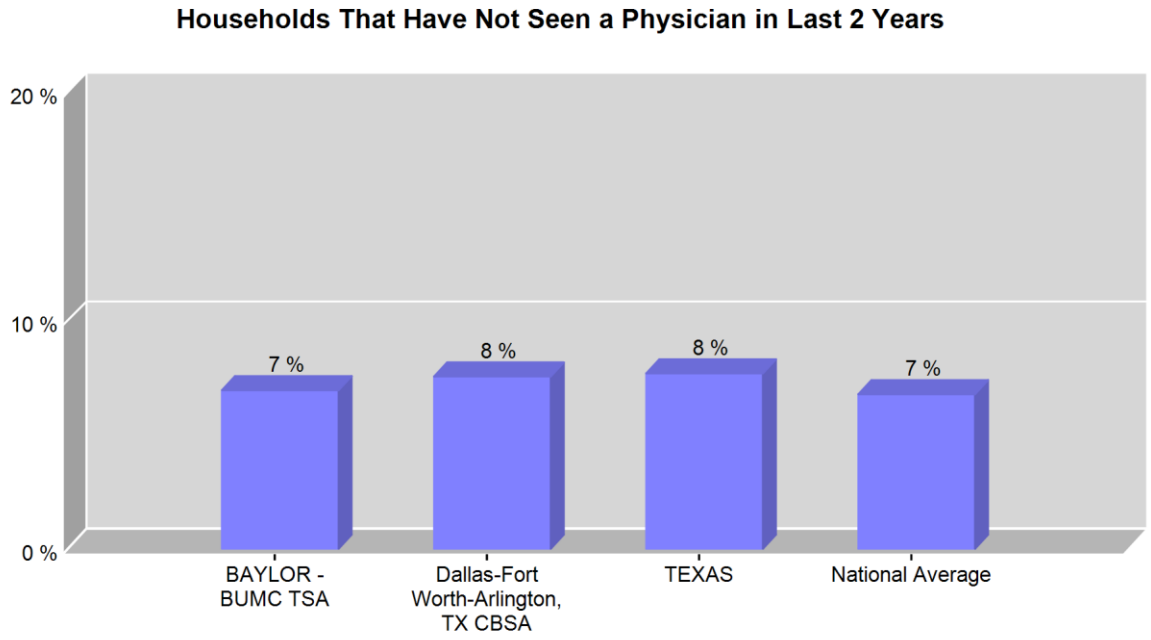
Purpose of Physician Visit by Income
BAYLOR - BUMC TSA



Physician Visit Usage and Access

No Physician Visit

- Within the national sample has the highest percentage of households at 0% who reported they have not seen a physician within the last two years.
- Within the national sample, has the lowest percentage of households at 0% who reported they have not seen a physician within the last two years.

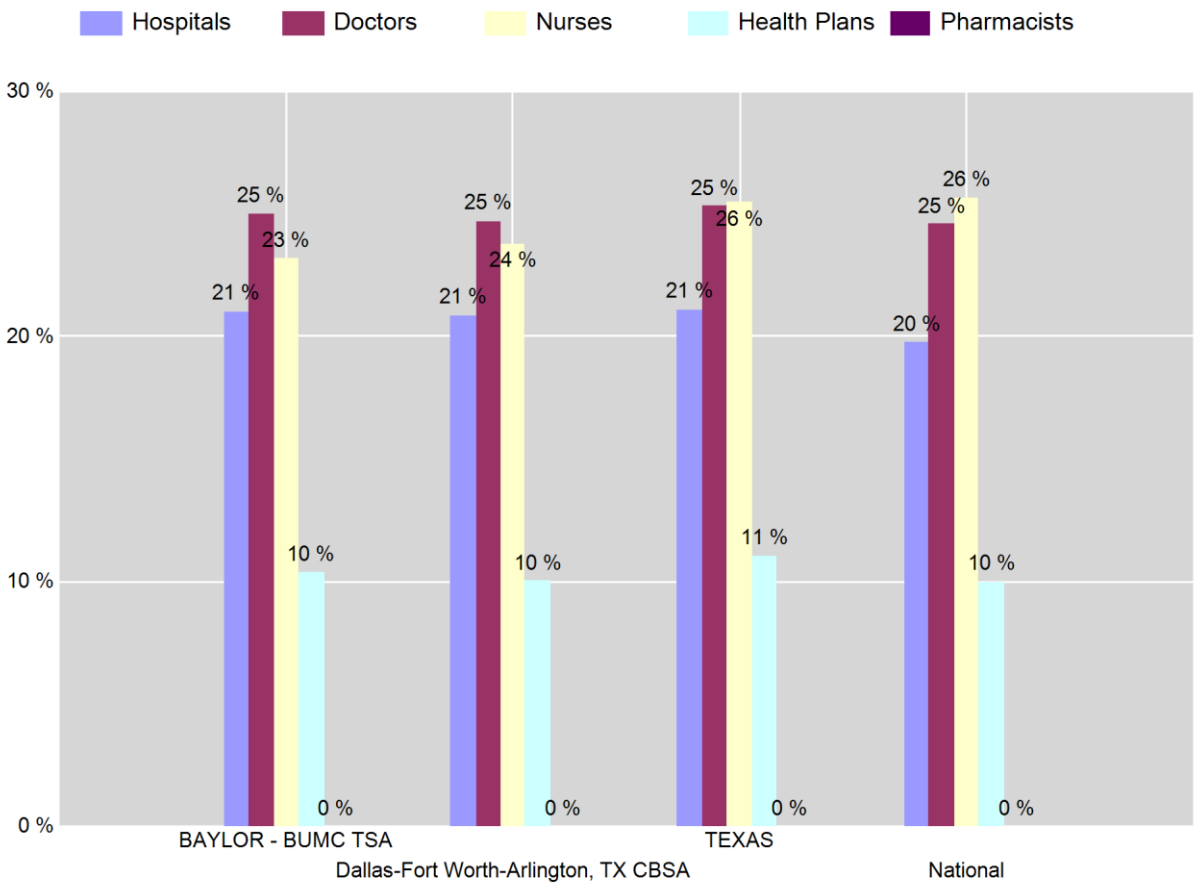


Community Trust and Confidence in Healthcare

This section reports the various self-reported measures regarding the communities trust and confidence in healthcare, including measurements of trust in doctors, nurses, and health plans.

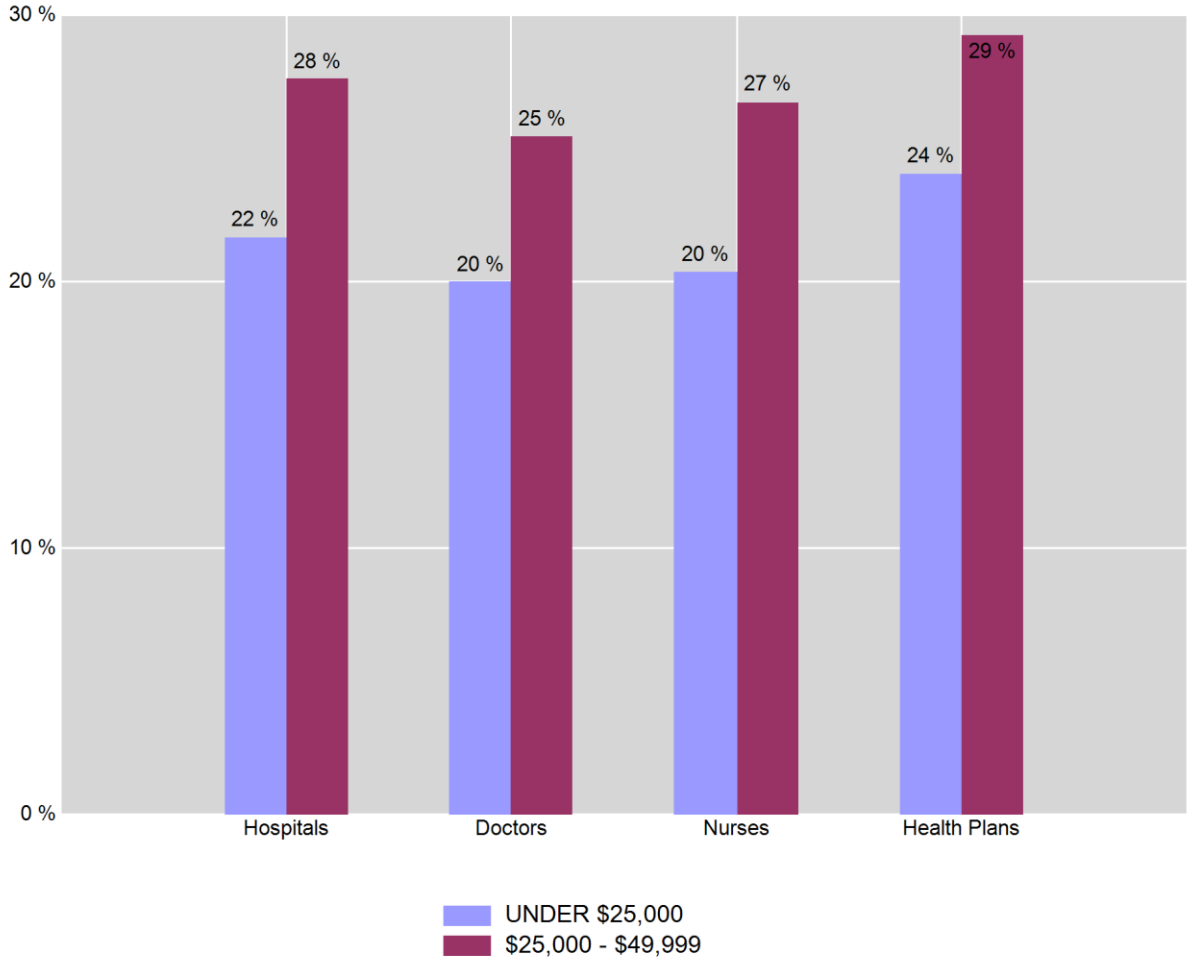
Level of Trust and Confidence - "Very High"

Market/Trust in	BAYLOR - BUMC TSA	Dallas-Fort Worth-Arlington, TX CBSA	TEXAS	National
Hospital	21 %	21 %	21 %	20 %
Doctors	25 %	25 %	25 %	25 %
Nurses	23 %	24 %	26 %	26 %
Health Plans	10 %	10 %	11 %	10 %
Pharmacists	0 %	0 %	0 %	0 %



"Very High" Trust/Confidence in Lower Income Categories

BAYLOR - BUMC TSA



Appendix B

Regional Healthcare Partnership Region 9 Community Needs Assessment

Section III. Community Needs Assessment

To develop the Community Needs Assessment, a regional Task Force was convened by representatives from the following organizations: Baylor Health Care System, Children's Medical Center, Dallas County Medical Society, Dallas County Behavioral Health Leadership Team, HCA North Texas, Methodist Health System, North Texas Behavioral Health Authority, Parkland Health & Hospital System, Scottish Rite Hospital for Children, Texas Health Resources, UT Southwestern Medical Center, and ValueOptions of Texas.

This Task Force reviewed and identified the regional needs through data analysis, expert presentations, and committee discussions. The major criteria used to identify and rank regional priorities included population impact, alignment with intervention categories, and whether solutions lend to regional based approaches. The following priorities were identified as the region's major community health needs:

Capacity - Primary and Specialty Care - The demand for primary and specialty care services exceeds that of available medical physicians in these areas, thus limiting healthcare access.

Behavioral Health - Adult, Pediatric and Jail Populations - 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.

Chronic Disease - Adult and Pediatric - Many individuals in North Texas suffer from chronic diseases that present earlier in life, are becoming more prevalent, and exhibit complications.

Patient Safety and Hospital Acquired Conditions – Hospitals in the region address patient safety and care quality on a daily basis. It is a continuous improvement initiative and is always at the forefront of any strategy for a health care entity. An ongoing coordinated effort among providers is needed to improve patient safety and quality throughout the region.

Emergency Department Usage and Readmissions - Emergency departments are treating high volumes of patients with preventable conditions, or conditions that are suitable to be addressed in a primary care setting. Additionally, readmissions are higher than desired, particularly for those with severe chronic disease or behavioral health.

Palliative Care - Overall, costs are high in skilled nursing facilities, long term care facilities, hospice and home health sectors, and slightly higher in physician services.

Oral Health - In Texas, preventive dental visits are below the recommended levels, and access can be a problem for minorities, the elderly, children on Medicaid, and other low income children. Compounding the issue is the shortage of dentists in Texas at approximately 60% of the national ratio of dentists to the population.

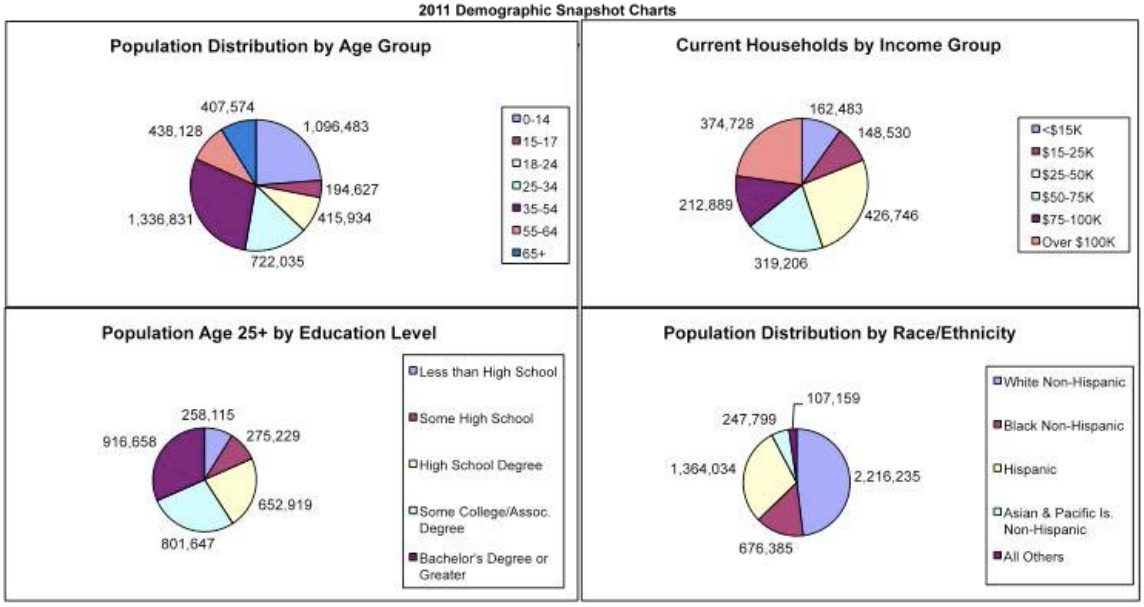
Demographics and Regional Description

Based on population alone, Texas is the second largest state in the nation with more than 25 million people. From 2000 to 2010, Texas experienced a 20% growth in population, as compared to only a 9.7% increase nationally. Originally, the North Texas RHP 9 Region was defined to include Collin, Dallas, Denton, Ellis, Fannin, Grayson, Kaufman, Navarro, and Rockwall counties. The broader demographics were considered to be representative of the narrower final RHP boundaries and as demonstrated in Figure 3 below, there is considerable in- migration from the original RHP counties to Dallas County for health care services.

In the North Texas RHP 9 region (original definition), the 2011 population is estimated to be 4,611,612 and is expected to grow by 9.5% by 2016 to 5,048,283 residents.[3] The most prevalent age group is 35-54 years (27.6%), followed by the 0-14 age group (20.2%).
While 15.1% of adults have less than some high school level of education, approximately 85% of adults have at least a high school degree.

White non-Hispanics represent 48.1% of the population, followed by Hispanics, Black non-Hispanics, Asians, and others, respectively.[4] Approximately 44% of Dallas-Fort Worth residents are New Americans (defined as either foreign born or the children of foreign born) of which 46% are undocumented. English is not the language spoken in 32% of homes in North Texas and over 239 languages are spoken in the North Texas Area, with more than 1/3 reflecting African cultures new to the region.[5]

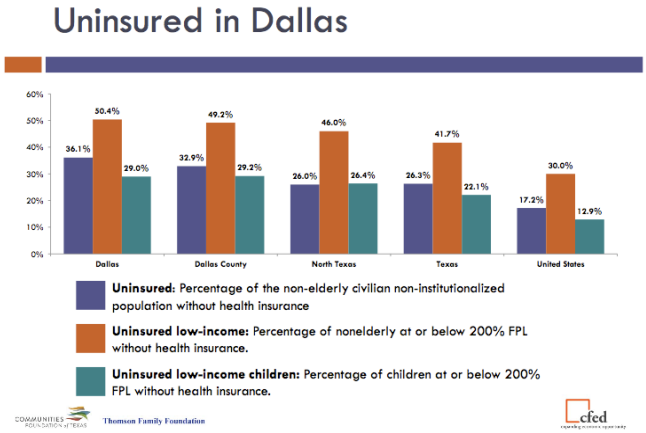
Figure 1: Regional Demographic Snapshot



[3] US Census Data, Thompson Reuters/Claritas Market Expert Data Extract, 2012.
[4] ibid.
[5] DFW International Community Alliance. 2010 North Texas Progress Report.

Within Dallas County specifically, 29.6% of children under 18 live below the federal poverty level and 15.8% of adults between 18 to 64 years live below the federal poverty level.[6]

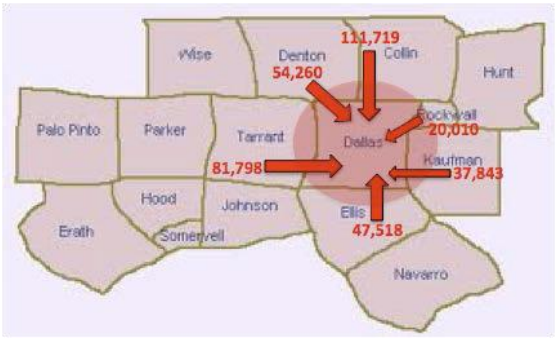
Figure 2: Summary of Uninsured in Dallas County[7]



Health Delivery System and Patient Migration Patterns

Data analysis identified patient migration patterns within multiple RHP regions. Many individuals receive healthcare services in nearby counties. In the pediatric population, Dallas County residents account for 75% of the outpatient services and 74% of the inpatient services. In the adult population, Dallas County residents account for 77% and 73% of the outpatient and inpatient population, respectively.[8]

Figure 3: Interconnectedness of Healthcare Delivery System: Dallas County Encounters from Patients with Adjacent County of Residence, 2011[9]



The locations of charitable clinics in Dallas County are shown on the map below. Additional analysis is warranted to determine the causal factors of the patient flow and migration patterns and how they relate to the locations of clinics/other service sites in the region. It is apparent though that the data presents strong justification to consider a broader geographic area for the purposes of this assessment.

[6] US Census Data. www.census.gov, 2011.
[7] Communities Foundation of Texas, Assets and Opportunities Profile. February 2012.
[8] DFWHC Foundation, Information and Quality Services Data Warehouse, 2011
[9] ibid

Figure 4: Location of Charitable Clinics in North Texas[10]

Regional Health Care Capacity

Physician Supply and Availability

RHP 9 is affected by the limited physician capacity in primary and select specialties. According to the Health Professions Resource Center, primary care physician supply trends have consistently increased to a current statewide rate of 70 per 100,000 people in 2011.[11] In 2011, the RHP 9 region demonstrated a physician need in excess of over 30% of the current workforce and by 2016 the physician need is expected to be 50% higher than projected availability.[12] With such a shortage of physicians, which is disparately worse in rural areas of Texas, many residents seek primary care and non-emergent treatment in emergency departments, resulting in increased healthcare costs and higher volumes of preventable and avoidable cases in the ED.

Medical Education

Dallas County is home to the University of Texas Southwestern Medical Center, an academic medical center that trains over 1000 medical students and approximately 1300 clinical residents annually. Many training and residency placements are completed within the DFW Metroplex providing an important source of physicians to the local healthcare system.

Medically Underserved and Shortage Areas

A Health Professional Shortage Area (HPSA) is a federally designated geographic area, a facility or population group with a shortage of primary care physicians (or dental or mental health providers) as defined by a population-to-primary care physician ratio of at least 3,500:1 in

[10] Parkland Health & Hospital System. Charitable Clinic Locations Report. 2012.

[11] Health Professions Resource Center, Center for Health Statistics, Department of State Health Services, October 2011.

[12] ibid.

addition to other requirements designated by the U.S. Department of Health and Human Services.[13] Poverty rate, infant mortality rate, fertility rate and physical distance from care are all considerations in scoring for HPSA designation.

Medically Underserved Areas or Populations (MUA/MUP) are generally defined by the federal government to include areas of populations with a shortage of personal health care services or groups of people who may have cultural or linguistic barriers to health care. In RHP 9, Dallas County has significant HPSA and MUA regions that overlap and Kaufman County is a county-level HPSA with no MUAs.

Children/Youth

The impact of the limited primary and specialty care is profound for children and families in the region. The current pediatric need is more than 80% of the current supply in the region. In Dallas County alone, over 36.2% of children were enrolled in Medicaid in 2010, exacerbating the issue of availability of pediatric primary care access and treatment.[14] Data also indicates that many of the pediatric specialists have limited capacity, creating a backlogged pipeline for those needing specialty services after seeking primary care.

Behavioral Health

Behavioral Health System Structure and Funding

The behavioral health system (including mental health and substance use) in RHP 9 differs from that of the rest of the state in that the majority of behavioral services for Medicaid and indigent patients are delivered through the NorthSTAR program instead of the traditional Local Mental Health Authority (LMHA) system. It is a managed behavioral healthcare carve-out program, administered by ValueOptions of Texas under a Medicaid 1915(b) waiver under the oversight of the North Texas Behavioral Health Authority (NTBHA), and it provides both mental health and substance use treatment to over 60,000 Medicaid enrollees and indigent uninsured annually.

Over the past decade, the NorthSTAR program has greatly expanded access to care. However, this high level of access results in funding and 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 LMHAs[15]. Given that Texas is 50th in mental health funding nationwide[16], the funding per person served in RHP 9 is among the lowest in the nation.

Mortality Trends in the Behavioral Health Population

An inadequate supply of behavioral health services is one of the most significant unmet health needs of RHP 9. A recent study in Texas found that NorthSTAR was one of only four LMHAs in which age-adjusted mortality rates were significantly higher for the mental health population compared to the general population. Consistent with the NASMHPD study, the majority of

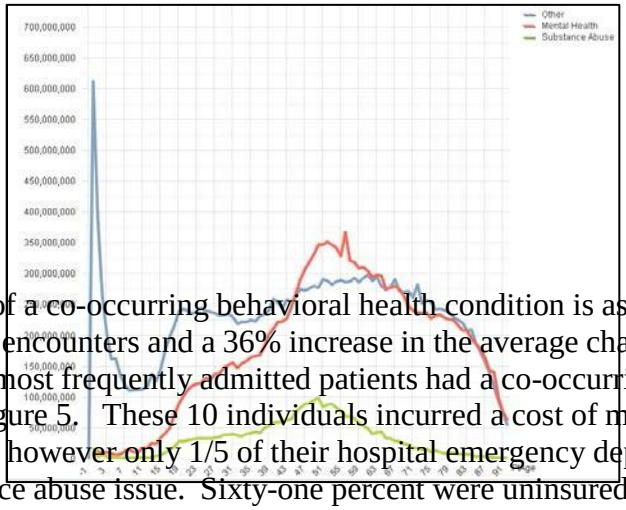
[13] US Department of Health and Human Services. 2012.
[14] Children's Medical Center. Beyond ABC Report, 2011.
[15] TriWest/Zia Partners. Assessment of the Community Behavioral Health Delivery System in Dallas County, 2010.
[16] National Alliance on Mental Illness. State Mental Health Cuts: The Continuing Crisis. March 2011

deaths in this region were due to medical illness, and most of those were due cardiovascular disease.[17] The NorthSTAR system differs from the rest of the state in that it includes patients with primary diagnoses of substance use disorders, a preliminary analysis of death records showed similar mortality rates between the mental health and substance abuse populations.[18]

Cost Trends in the Behavioral Health Population

The financial implications of caring for those with behavioral health conditions are substantial and impact resources within the healthcare institutions of RHP 9. Analysis of DFW Hospital Council Foundation data demonstrates that charges associated with the care of mental health patients more than doubles from $50,000,000 to over $100,000,000 between the ages of 17 through 21. Charges continue to rise through adulthood, and between the ages of 47-65, the estimated charges for mental health encounters are higher than those of all other conditions combined. When substance abuse encounters are included, this difference is even greater.[19]

Figure 5: Age and Charge Distribution by Mental Health and Substance Abuse Encounter (2010Q3-2011Q3)[20]



In RHP 9, 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. In RHP 9, 100% of the 10 most frequently admitted patients had a co-occurring behavioral health diagnosis depicted in Figure 5. These 10 individuals incurred a cost of more than $26 million between 2007 and 2011; however only 1/5 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).

[17] Mortality of Public Mental Health clients treated at the Local Mental Health Authorities of Texas, 2012.
[18] Personal communication between EA Becker and M Balfour
[19] Dallas Fort Worth Hospital Council Foundation, Readmission Patterns by Mental Health & Substance Abuse, 2012
[20] DFWHC Foundation, Information and Quality Services Data Warehouse, 2012.

Figure 6: Mental Health and Substance Abuse: Intersection

Figure 7: Top Ten High Emergency Department Utilizers: Mental Health and Substance Abuse Integration - Behavioral Health and Primary Care

DFWHC Foundation, Information and Quality Services (IQSC) Data Warehouse

Mental Health and Substance Abuse Interactions with Readmissions Patterns: Most Frequent 10 Patients (In and Outpatient)

RHP9 Cohort: 2007Q1 - 2011Q3

QUID	Total Cases	Mental Health	Substance Abuse	2007	2008	2009	2010	2011	Hospitals Visited	Average LOS (Days)	Uninsured	Insured	Medicaid	Medicare	Total Charges	Average Total Charges
430172	571	356	111	98	137	109	138	89	6	1.7375	2%	6%	86%	5%	$1,326,311.	$2,323.
811367	537	396	17	110	117	109	125	76	22	1.0152	0%	0%	0%	100%	$931,952.	$1,735.
1495682	490	267	35	77	125	125	83	80	26	1.3313	6%	15%	79%	0%	$2,310,619.	$4,716.
3554434	397	266	34	45	39	115	121	77	4	3.2897	99%	1%	0%	0%	$577,739.	$1,455.
3358467	379	297	10	15	38	56	116	154	7	1.4190	4%	39%	0%	57%	$369,397.	$975.
3048466	370	297	14	62	143	82	52	31	23	1.9093	11%	4%	24%	61%	$2,145,038.	$5,797.
1590501	362	245	94	60	2	118	101	81	4	10.5363	14%	1%	3%	82%	$289,747.	$800.
1993887	362	201	7	63	68	124	66	41	24	0.9448	7%	8%	84%	1%	$1,805,928.	$4,989.
1308998	361	235	133	37	51	93	122	58	9	1.2975	48%	2%	50%	0%	$1,804,562.	$4,999.
1411963	334	312	1	71	106	26	10	121	19	1.5736	45%	5%	50%	0%	$637,233.	$1,908.

The percentage of residents below 200% Federal Poverty Level in Dallas County who receive behavioral healthcare in primary care settings is 19.8% which is significantly lower than the national average of 37.1%.[21] Parkland, the largest primary care provider to low-income populations in Dallas County, is not a NorthSTAR provider and consequently, some who may be successfully served in primary care settings are referred to NorthSTAR. This may result in dilution of limited NorthSTAR resources, as well as coordination of care issues for those with high complexity co-occurring illness. An analysis of the diabetic population at Parkland revealed that diabetics receiving antipsychotic medications from the NorthSTAR system were twice as likely to receive second-generation antipsychotics, which adversely affect metabolic indicators associated with poor diabetes outcomes, compared to those receiving antipsychotics from the Parkland pharmacy.[22]

[21] TriWest/Zia Partners. Assessment of the Community Behavioral Health Delivery System in Dallas County, 2010. [22] Balfour, ME et al. Highlighting High Utilizers: How can our systems better meet their needs? Institute on Psychiatric Services Annual Meeting, 2011.

The funding challenges combined with the complexity of the behavioral health system may adversely impact sub-populations with the highest needs. The number of NorthSTAR enrollees booked into jail has been steadily increasing as shown below in Figure 8[23], and 27% of all book- ins to the Dallas County Jail are currently referred to jail behavioral health services.[24] Homeless individuals with behavioral health conditions cost three times as much and are booked into jail twice as often as the general NorthSTAR population.[25] Among high utilizers, these relationships are magnified, as illustrated below.

Figure 8: Behavioral Health Patient Factors for Top 20% Utilizers of NorthSTAR, Dallas County Jail, and Terrell State Hospital, 2010

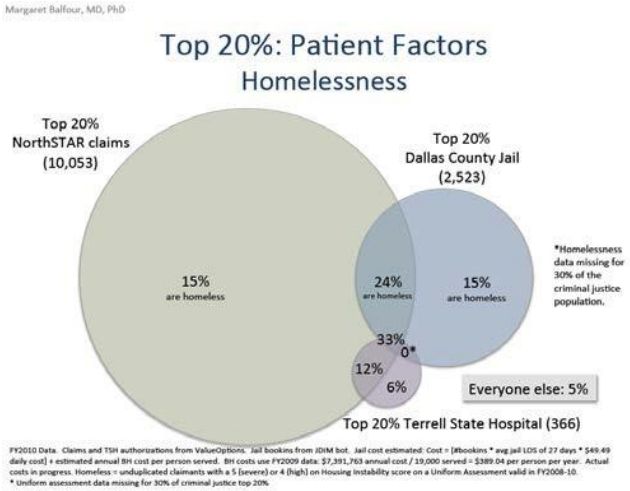
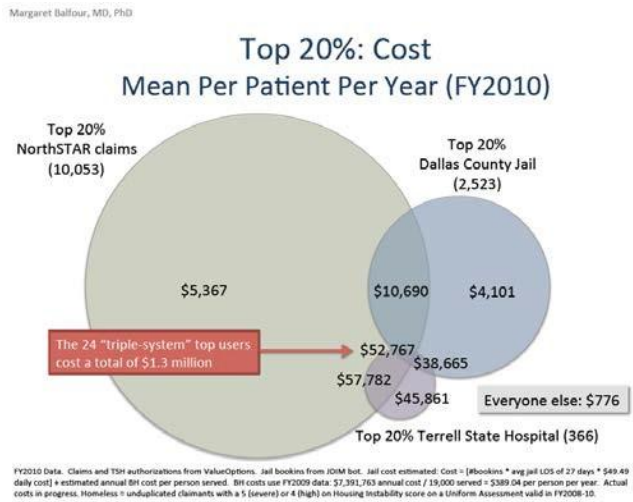


Figure 9: Behavioral Health Costs for Top 20% Utilizers of NorthSTAR, Dallas County Jail, and Terrell State Hospital, 2010



[23] Ron Stretcher and Jill Reese, Dallas County Criminal Justice Department
[24] Communication between Wassem Ahmed, Medical Director-Parkland Jail Behavioral Health and M. Balfour, MD
[25] Balfour, ME. Homelessness, Criminal Justice, and the NorthSTAR Top 200 Report, 2011.

Children/Youth

The number of Dallas County children receiving publicly funded mental health services has tripled from 2000 to 2010. In Dallas County, the number of children identified with a diagnosable emotional disturbance or addictive disorder has increased to approximately 142,000 children with 5% of those children experiencing a significant impairment as a result. Among youth between the ages of 12-17, 7.2% have experienced a major depressive episode.

Cultural and Linguistic Minorities

Hispanics comprise 40% of the population but only 25% of the NorthSTAR population.[26] While there is a lack of services available and written materials available in Spanish, it is difficult to characterize the extent of the need, because data on primary language is not collected.

Demand for Behavioral Health Services

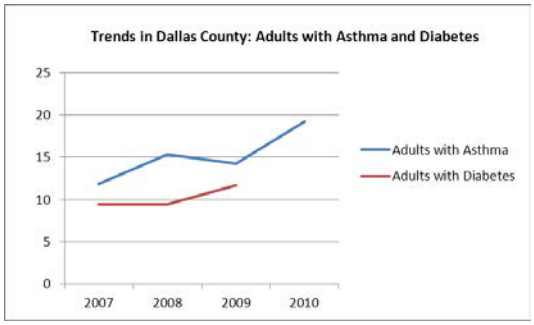
Following the economic downturn in 2009, there was a 17% increase in 23-hour observation visits at Green Oaks Hospital, mostly accounted for by new enrollees to NorthSTAR. More recently, there has been a sharp spike in 23-hour observation utilization, with Feb 2012 visits 26% higher compared to Dec 2011 (and 25% higher compared to Feb 2011).[27] This increase coincided with both regulatory oversight limiting the capacity of Parkland's Psychiatric ED by 50% and a reduction in funding for outpatient services in the NorthSTAR system.

In addition to hospital-type services, there is also a need for less-acute levels of behavioral care in order to prevent the need for these high-cost services. A sub-acute crisis residential level of care exists but there are only 21 beds for the entire NorthSTAR region. The Behavioral Health Leadership Team has identified the highest need for service development to be post-crisis "wraparound" services to reduce the 20% 30-day readmission rate to crisis services, and peer-driven services to engage clients early in order to prevent crisis episodes.

Chronic Disease

Similar to national trends, North Texas is experiencing increasing rates of many chronic diseases, including heart disease, cancer and stroke. Also there are increasing rates of asthma and diabetes in adults within the Dallas County Metropolitan Statistical Area as shown below.

Figure 10: Dallas County Adults with Asthma and Diabetes



In an assessment of ED utilization, the five encounter types that were most frequent and of highest volume ~~are those for chronic conditions~~ of asthma, chronic bronchitis, pain/aching of

[26] TriWest/Zia Partners. Assessment of the Community Behavioral Health Delivery System in Dallas County, 2010.
[27] ValueOptions of Texas

joints, sinusitis, and hay fever.[28] There were slight variations presented when encounters were analyzed by payer type. More Medicaid and uninsured patients sought treatment for asthma than those with insurance or Medicare and for the uninsured specifically, diabetes was listed as the 5th top condition, while not even listed as a top 5 condition for the insured or Medicaid.

Figure 11: Volume for Adult Outpatient Emergency Department Encounters (2010Q3 - 2011Q3)[29]

Highest Volume	1	2	3	4	5
All	Low Back Pain	Hypertension	Pain/Aching of Joints	Chronic Bronchitis	Asthma
Insured	Low Back Pain	Hypertension	Pain/Aching of Joints	Chronic Bronchitis	Asthma
Medicaid	Low Back Pain	Pain/Aching of Joints	Asthma	Chronic Bronchitis	Depression/ Anxiety
Medicare	Low Back Pain	Hypertension	Chronic Bronchitis	Pain/Aching of Joints	Diabetes
Uninsured	Low Back Pain	Pain/Aching of Joints	Hypertension	Asthma	Diabetes

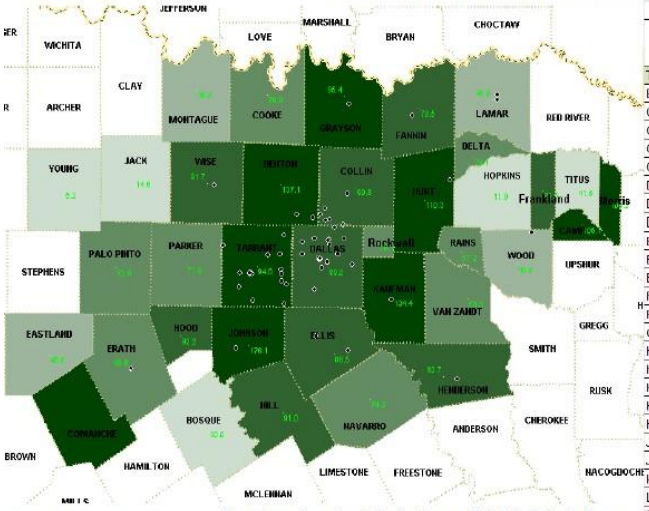
Asthma

Over the past decade, asthma has become a widespread public health problem that has increased in both Texas and the United States. Asthma has a major impact on the health of the population and the burden falls unevenly on some populations. According to Texas Behavioral Risk Factor Surveillance System in 2005, approximately 1.5 million adults (ages 18 and older) and 389,000 children (ages 0-17) were reported to have asthma at the time.[30] And in 2006, the state of Texas spent over $391.5 million for inpatient admissions with a primary discharge diagnosis of asthma.[31]

In 2008, the state of Texas had a risk-adjusted admission rate of 72.5 per 100,000 cases.[32] Although Dallas County had a slightly higher rate at 89.1 per 100,000 cases, six of the ten counties surrounding Dallas County were significantly more burdened with a risk-adjusted admission rate of greater than 92.2 per 100,000 cases. Only one county of the ten had a lower risk-adjusted rate (Rockwall County) at 70.5 per 100,000 cases. Other North Texas counties' astham admission rates are shown in the table below.

[28] Dallas Fort Worth Hospital Council Foundation, Information and Quality Services Data Warehouse. March 2011. [29] Dallas Fort Worth Hospital Council Foundation, Information and Quality Services Data Warehouse. March 2011. [30] Asthma Coalition of Texas. Texas Asthma Plan. 2007-2010.
[31] Asthma Coalition of Texas. 2012.
[32] AHRQ Prevention Indicators. Adult Asthma Admission Rate. 2008

AHRQ Prevention Quality Indicators
Adult Asthma Admission Rate - 2008



Named counties without shading have a Risk Adjusted rate of zero.

Risk Adjusted Rates per 100,000 Population
- 1 to 41.5
- 41.5 to 48.5
- 48.5 to 76.0
- 76.0 to 92.2
- > 92.2
- DI Hospitals

15 Adult Asthma Admission Rate
Asthma is one of the most common reasons for hospital admission and emergency room care. Most cases of asthma can be managed with proper ongoing therapy on an outpatient basis. Most published studies combine admission rates for children and adults; therefore, areas may wish to examine this indicator together with pediatric asthma.

2008				Per 100,000 cases		
county	Observed	Numerator (Outcomes)	Denominator (Population)	Risk Adjusted Rate	Confidence Interval	Stat. Sig
Texas	84.7	15,718	18,560,901	72.5	(71, 73.9)	O
BOSQUE	41.2	6	14,580	30.1	(0, 77.2)	O
CAMP	191.8	18	9,386	105.8	(54.8, 156.8)	O
COLLIN	61.8	324	524,278	90.9	(79.7, 102)	-
COMANCHE	201.0	22	10,947	105.0	(59, 150.9)	O
COOKE	86.6	26	30,030	76.1	(40.1, 112.1)	O
DALLAS	103.2	1,785	1,729,044	89.1	(84.4, 93.8)	-
DELTA	89.4	4	4,472	70.1	(0, 158.2)	O
DENTON	94.4	416	440,803	137.2	(125.1, 149.3)	-
EASTLAND	88.0	13	14,759	46.7	(5.8, 86.6)	O
ELLIS	71.3	75	105,148	86.6	(64, 109.2)	O
ERATH	73.2	20	27,307	70.0	(30.6, 109.4)	O
FANNIN	88.8	24	27,025	79.5	(41.2, 117.9)	O
FRANKLIN	107.1	9	8,401	80.5	(17.6, 143.5)	O
GRAYSON	109.6	102	93,065	95.4	(75.1, 115.8)	-
HENDERSON	105.9	68	64,198	82.7	(59.5, 106)	O
HILL	114.0	32	28,081	91.1	(55.6, 126.6)	O
HOOD	92.3	37	40,068	92.3	(59, 125.5)	O
HOPKINS	15.3	4	26,199	12.0	(0, 48.4)	+
HUNT	134.9	88	65,251	110.4	(86.8, 134)	-
JACK	13.3	1	7,517	14.6	(0, 95.1)	O
JOHNSON	156.6	179	114,276	176.1	(155.2, 197)	-
KAUFMAN	118.1	84	71,115	134.4	(107.8, 161)	-
LAMAR	85.1	33	38,789	46.1	(21.2, 70.9)	+
MONTAGUE	62.9	10	15,908	46.1	(0.9, 91.3)	O
MORRIS	144.3	15	10,398	109.3	(52.5, 166)	O
NAVARRO	89.4	34	38,032	74.2	(43.1, 105.3)	O
PALO PINTO	92.1	20	21,712	72.8	(32.7, 113)	O
PARKER	64.4	54	83,886	71.8	(47.5, 96.1)	O
RAINS	73.6	7	9,507	57.3	(0, 117.5)	O
ROCKWALL	51.1	27	52,789	70.5	(36.5, 104.5)	O
TARRANT	83.7	1,042	1,244,658	94.7	(88.3, 101)	-
TITUS	50.5	11	21,764	41.6	(0.7, 82.5)	O
VAN ZANDT	68.9	29	42,097	58.6	(28.7, 88.5)	O
WISE	77.6	35	45,104	91.8	(57.7, 125.9)	O
WOOD	63.6	22	34,584	48.5	(17.3, 79.8)	O
YOUNG	7.0	1	14,276	5.3	(0, 53.6)	O

Texas Hospital Inpatient Discharge Public Use Date File, FY2006. Texas Health Care Information Council, Austin, Texas. January, 2008.

+ = County's RA rate significantly lower than State RA rate
- = County's RA rate significantly higher
O = No statistical difference

<u>Diabetes</u>

Diabetes affects 11.4% of the population in Dallas County, which is above both the state average of 10% and the national average of 8%. In patients seen throughout the regional healthcare system and who are residents of Dallas County, the top five primary diagnoses, those patients with an underlying condition of diabetes were 29% for pneumonia, 39% for septicemia, 31% for other rehabilitation, 34% of urinary tract infection and 45% of acute kidney failure.[33] Those with diabetes had a higher mortality percentage than those without in four of the five top inpatient diagnoses revealing that a co-morbidity of diabetes increases your risk for mortality.

Dallas County's top seven diagnoses for ER patients were Acute URI Unspecified, Otitis Media, abdominal pain, chest pain unspecified, urinary tract infection, headache and other chest pain. Within those top seven diagnoses, 20%-45% had an underlying condition of diabetes. Specifically, of all patients who came to the ER with chest pain as a diagnosis, 21%-25% had a comorbidity of diabetes. Of patients presenting with abdominal pain, urinary tract infections and headache, 10% also had diabetes.

[33] Doughty, P. et al. Diabetes in Dallas County: Provider Report. 2011

Figure 12: Prevalence of Co-Occurring Diabetes, Dallas County 2009-2010

Top Five Diagnosis **INPATIENTS 2009-2010 Dallas County**	Number of Patients	Number of Patients with Diabetes	% with Diabetes	Mortality %	Mortality % with Diabetes
Pneumonia	4,359	1,279	29%	3.1%	3.5%
Septicemia	3,142	1,217	39%	21.4%	23.0%
Other Rehabilitation	2,816	872	31%	0.1%	0.1%
Urinary Tract Infection	2,447	822	34%	0.5%	0.6%
Acute Kidney Failure Unspecified	2,355	1,068	45%	3.2%	3.5%
Top Seven Diagnosis **ER VISITS 2009-2010 Dallas**	Number of Patients	Number of Patients with Diabetes	% with Diabetes	Mortality %	Mortality % with Diabetes
Acute URI Unspecified	23,979	392	2%	0%	0%
Otitis Media	18,576	84	0%	0%	0%
Abdominal Pain	14,677	1,516	10%	0%	0%
Unspecified Chest Pain	14,511	3,010	21%	0%	0%
Urinary Tract Infection	14,302	1,254	9%	0%	0%
Headache	13,531	1,228	9%	0%	0%
Other Chest Pain	13,217	2,980	25%	0%	0%

Children/Youth.

Between 2000 and 2010, the number of Children's Medical Center admissions of youth with a primary or secondary diagnosis of diabetes increased by 34%. With the association of diabetes and obesity, there is also cause for concern of the future trajectory as low income preschool obesity within the Dallas Metropolitan Statistical Area was 17.2% in 2009, placing many young children at higher rates of developing diabetes in later years.[34]

Cost/Charge.

Isolation of a specific "direct cost" is complicated. However, it is understood that the societal burden for this condition is extremely large and has manifestations in healthcare service utilization due to increases complexity and severity of other co-occurring medical conditions. Additionally, there are important societal costs of lower economic productivity of individuals with severe diabetic complications. The magnitude of the issues is only projected to increase as more people begin to develop diabetes at earlier in life.

Patient Safety and Quality and Hospital Acquired Conditions

The DFWHC Foundation's 77 hospitals had 1,706 adverse hospital events in 2010. These events included air embolism, Legionnaires, Iatrogenic Pneumothorax, delirium, blood incompatibility, glycemic control issues and Clostridium difficile, which are not part of the ten adverse events specified by CMS. A significant portion was made up of Medicare patients (46%) and insured (54%) according to the claims data within the DFWHC Foundation claims data warehouse.

Emergency Department Usage and Readmissions

An analysis of the emergency department encounters demonstrates that many in the population are accessing emergency departments for both urgent and non-urgent conditions. Over the most recent four quarters of data, the conditions for which the most volume of care

[34] Children's Medical Center. Beyond ABC Report, 2012

was provided in an emergency outpatient setting were: low back pain, hypertension, pain/joint

aching, chronic bronchitis, and asthma.Further assessment demonstrates that, with the exception of asthma, over 68% of the encounters for the top primary health conditions listed above were either non-emergent or emergent/primary care treatable, in that the care could have been provided effectively in a primary care setting. For asthma, approximately 98.1% of all encounters were emergent, however the condition could have been potentially avoidable or preventable if effective ambulatory care could have been received during the illness episode.[35]

For emergency department encounters that resulted in a hospital admission, the most common health conditions by volume include stroke, diabetes, congestive heart failure, weak/failing kidneys, chronic bronchitis and heart attack. When reviewing by payer type, diabetes is the top condition for the uninsured and Medicaid and the 5th top condition for those who are insured.

Figure 14: Adult Inpatient Emergency Department Encounters (2010Q3 - 2011Q3)[36]

Highest Volume	1	2	3	4	5
All	Stroke	Congestive Heart Failure	Weak/Failing Kidneys	Chronic Bronchitis	Diabetes
Insured	Stroke	Weak/Failing Kidneys	Congestive Heart Failure	Heart Attack	Diabetes
Medicaid	Diabetes	Congestive Heart Failure	Weak/Failing Kidneys	Stroke	Chronic Bronchitis
Medicare	Congestive Heart Failure	Stroke	Weak/Failing Kidneys	Chronic Bronchitis	Heart Attack
Uninsured	Diabetes	Stroke	Weak/Failing Kidneys	Congestive Heart Failure	Heart Attack

Specific to children, the high volume ED encounters includes asthma, diabetes, pain/aching joints, and arthritis most frequently. Regardless of payer type, asthma and diabetes are the top conditions for ER and inpatient admissions.

Figure 15: Pediatric Inpatient Emergency Department Encounters (2010Q3 - 2011Q3)[37]

Highest Volume	1	2	3	4	5
All	Asthma	Diabetes	Pain/Aching of Joints	Arthritis	Congestive Heart Failure/Liver Condition
Insured	Asthma	Diabetes	Pain/Aching of Joints	Arthritis	Liver Condition
Medicaid	Asthma	Diabetes	Arthritis	Congestive Heart Failure	Pain/Aching of Joints
Uninsured	Asthma	Diabetes	Pain/Aching of Joints	Arthritis	Liver Condition/Low Back Pain

[35] DFWHC Foundation, Information and Quality Services Data Warehouse, 2011.
[36] Ibid.
[37] Ibid.

In North Texas, all-cause readmissions as defined by a subsequent admission within 30 days from the incident encounter of any type has demonstrated a downward trend since 2008.[38] Many hospitals are working to continue improvement in this area, specifically for readmission related to congestive heart failure, acute myocardial infarction, and pneumonia.

As evidenced by an assessment of 10 individual high utilizers in the region, there is a strong relationship between readmissions and behavioral health. Each patient has some component of mental health or substance abuse history over the course of their encounter history.

Figure 16: Top Ten High Emergency Department Utilizers: Mental Health and Substance Abuse

DFWHC Foundation, Information and Quality Services (IQSC) Data Warehouse
Mental Health and Substance Abuse Interactions with Readmissions Patterns: Most Frequent 10 Patients (In and Outpatient)
RHP9 Cohort: 2007Q1 - 2011Q3

QUID	Total Cases	Mental Health	Substance Abuse	2007	2008	2009	2010	2011	Hospitals Visited	Average LOS (Days)	Uninsured	Insured	Medicaid	Medicare	Total Charges	Average Total Charges
430172	571	356	111	98	137	109	138	89	6	1.7375	2%	6%	86%	5%	$1,326,311.	$2,323.
811367	537	396	17	110	117	109	125	76	22	1.0152	0%	0%	0%	100%	$931,952.	$1,735.
1495682	490	267	35	77	125	125	83	80	26	1.3313	6%	15%	79%	0%	$2,310,619.	$4,716.
3554434	397	266	34	45	39	115	121	77	4	3.2897	99%	1%	0%	0%	$577,739.	$1,455.
3358467	379	297	10	15	38	56	116	154	7	1.4190	4%	39%	0%	57%	$369,397.	$975.
3048466	370	297	14	62	143	82	52	31	23	1.9093	11%	4%	24%	61%	$2,145,038.	$5,797.
1590501	362	245	94	60	2	118	101	81	4	10.5363	14%	1%	3%	82%	$289,747.	$800.
1993887	362	201	7	63	68	124	66	41	24	0.9448	7%	8%	84%	1%	$1,805,928.	$4,989.
1308998	361	235	133	37	51	93	122	58	9	1.2975	48%	2%	50%	0%	$1,804,562.	$4,999.
1411963	334	312	1	71	106	26	10	121	19	1.5736	45%	5%	50%	0%	$637,233.	$1,908.

Cost/Charge

From quarter 3 of 2010 to quarter 3 of 2011, the estimated charges associated with all regional emergency outpatient encounters was $312,816,490 and for emergency inpatient encounters, the total charges increase to $2,076,778,420. For emergency inpatient encounters, there was little charge variation across insured, Medicaid, Medicare, and Uninsured payer types.

Palliative Care

Palliative care is an important factor in the care delivery system of RHP 9. Overall, Medicare reimbursements to providers in Dallas County are higher than average and higher than the 50th percentile in the country during a patient's last two years of life signifying a large volume of palliative care services being provided. Even within the health service area of RHP 9, there is variability of the percentage of deaths occurring within hospitals, ranging from 0.69 percent to 1.17 when compared to the national average.

Oral Health

Tooth decay (dental caries) is the most common chronic childhood disease. In 2003, the proportion of Texas children reported to have teeth in excellent or very good condition was lower than the national average and lower within all age, sex, and racial/ethnic subgroups.

[38] DFWHC Foundation, Information and Quality Services Database, 2010.

Figure 17: Oral Health – Condition of Teeth for Texas Children (2003)

	Condition of Teeth: Excellent or very good		Preventive Dental Care: ≥ 1 Visit within Past Year	
	US %	Texas %	US %	Texas %
Age Group				
All children 0–17	64.3	57.6	67.6	61.6
Age (years)				
1–5	75.8	70.7	46.8	48.4
6–11	61.7	50.9	83.4	74.8
12–17	67.4	61.2	79.4	69.7
Socioeconomic status				
0–99% Federal poverty level	45.4	40.7	54.1	56.0
100–199% Federal poverty level	56.5	48.9	61.6	52.6
200–399% Federal poverty level	71.2	66.7	73.0	67.4
≥400% Federal poverty level	78.1	78.3	77.8	73.3
Race/ethnicity				
White	69.3	65.4	70.6	64.4
Black	57.4	53.4	62.6	64.9

Dental problems in adults are equally problematic. According to the U.S. Surgeon[39] most adults in the U.S. show signs of periodontal or gingival diseases and severe periodontal disease affects 14 percent of adults (ages 45–54 years). However, a little less than two-thirds of adults report visiting a dentist within the past 12 months, and those with incomes at or above the poverty level are twice as likely to report a dental visit in the past 12 months as those below the poverty level. The American Dental Association cited the major reason for not accessing regular oral health care is the high cost of dental care. And the number of individuals who lack dental insurance is more than 2.5 times the number of those who lack medical insurance.

Effective health policies intended to expand access, improve quality, or contain costs must consider the supply, distribution, preparation, and utilization of the workforce. According to the National Health Service Corps, Texas needs 784 additional dentists to achieve the recommended ratio of one dentist for every 3,000 residents. The overall supply of dentists in Texas has been consistently below the national average of 59-60 dentists per 100,000 for many years.[40] In 2006, Texas had 36.0 dentists per 100,000 and it has been declining since.

[39] National Institute of Health. National Institute of Dental and Craniofacial Research. "Oral Health in America: A Report of the Surgeon General. 2000.

[40] State Department of Health & Human Services, Center for Health Statistics Health Professions Resource Center. Publication No. 25-12581. E-Publication No. E25-12581. March 2007.

Summary of Community Needs

Identification Number	Brief Description of Community Needs Addressed in RHP Plan	Data Source for Identified Need
CN.1	Community Description – Demographics	US Census Data, DFW International Community Alliance Report, Communities Foundation of Texas Report
CN.2	Regional Healthcare Infrastructure and Patient Migration Patterns	DFWHC Foundation, Information Quality and Services Data Warehouse, Parkland Health and Hospital System
CN.3	Healthcare Capacity	Health Professions Resource Center, Center for Health Statistics, US Department of Health and Human Services; Children's Medical Center Beyond ABC Report; Horizons (2012): The Dallas County Community Health Needs Assessment
CN.4	Primary Care and Pediatrics	Health Professions Resource Center, Center for Health Statistics, US Department of Health and Human Services, Children's Medical Center Beyond ABC Report
CN.5	Behavioral Health	TriWest/Zia Partners Report, National Alliance on Mental Illness, DFWHC Foundation, Information Quality and Services Data Warehouse
CN.6	Behavioral Health and Primary Care	TriWest/Zia Partners Report, National Alliance on Mental Illness, DFWHC Foundation, Information Quality and Services Data Warehouse, Horizons: The Dallas County Community Health Needs Assessment
CN.7	Behavioral Health and Jail Population	Dallas County Criminal Justice Department, Parkland Health and Hospital System
CN.8	Specialty Care	DFWHC Foundation, Information and Quality Services Data Warehouse retrieved March 2012, Children's Medical Center Beyond ABC Report, 2011 US Census Data, Thompson Reuters/Claritas Market Expert Extract prepared by Devin Hill, Baylor Health Care System, generated February 2012.
CN.9	Chronic Disease	DFWHC Foundation Information Quality and Services Data Warehouse, Diabetes in Dallas County Report, Children's Medical Center Beyond ABC Report, Horizons: The Dallas County Community Health Needs Assessment
CN.10	Oral Health	US Department of Health and Human Services Healthy People 2010, Texas Department of State Health Services Oral Health Program, DSHS Primary Care Office
CN.11	Patient Safety and Quality	DFWHC Foundation Information Quality and Services Data Warehouse, Institute of Medicine Report
CN.12	Emergency Department Usage and Readmissions	DFWHC Foundation Information Quality and Services Data Warehouse
CN.13	Palliative Care	Barnato et al., Teno et al., Wennenberg et al.

References

1. TriWest Group, Zia Partners, and Dallas County Behavioral Health System Redesign Task Force. "Assessment of the Community Behavioral Health Delivery System in Dallas County: Detailed Report." Dallas, TX. September 30, 2010.
2. Dallas Fort Worth Hospital Council Foundation. Information and Quality Services (IQSC) Data Warehouse. Irving, TX. Retrieved, March 2012.
3. Dallas Fort Worth Hospital Council Foundation. Healthy North Texas: Community Health Website. www.healthyntexas.org. Irving, TX. Retrieved, March 2012.
4. Institute of Medicine. "For the Public's Health: Investing in a Healthier Future." Washington D.C., April 10, 2012
5. Parkland Health and Hospital System.
6. Public Health Institute. "Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices, and Future Potential. Report of Proceedings from a Public Forum and Interview of Experts." Atlanta, GA. July 11-13, 2011.
7. The Center for Health and Public Service Research, Robert F. Wagner Graduate School of Public Service. New York University. NYU ED Algorithm wagner.nyu.edu/chpsr/index.html?p=25. Retrieved, April 2012.
8. Doughty, P and Jones, J. Dallas Fort Worth Hospital Council Foundation. "Diabetes in Dallas County: Provider Report." September, 2011.
9. North Texas Behavioral Health Authority. Data Book. www.ntbha.org/reports.aspx. Retrieved, April, 2012.
10. Communities Foundation of Texas. Assets and Opportunities Profile, North Texas. http://www.cftexas.org/netcommunity/page.aspx?pid=953. February 16, 2012.
11. US Census Bureau. www.census.gov Retrieved April, 2012.
12. Pickens, S. Parkland Health and Hospital System. Charitable Clinics in North Texas: Presentation. March 2012
13. Anderson, G.F. Medicare and chronic conditions. New England Journal of Medicine. 353(3): 305-209. 2005.
14. deVries E.N., Ramrattan M.A., Smorenburg, S.M., Gouma, D.J., Boermeester, M.A. The incidence and nature of in-hospital adverse events: a systematic review. Quality and Safety in Healthcare. 2008. 17(30): 216-223.
15. Institute of Medicine. Living Well with Chronic Illness: A Call for Public Health Action. Committee on Living Well with Chronic Disease: Public Health Action to Reduce Disability and Improve Functioning and Quality of Life. February 2012.
16. Children's Medical Center. Beyond ABC: Assessing Children's Health in Dallas County. 2011.
17. US Census Data. Thompson Reuters/Claritas Market Expert Extract. Prepared by Devin Hill, Baylor Health Care System. Generated, February 2012.
18. DFW International Community Alliance. 2010 North Texas Progress Report. www.dfwinternational.org. Retrieved, February 2012.
19. US Census Data. www.census.gov. Retrieved, March 2012.
20. National Alliance on Mental Illness. State Mental Health Cuts: The Continuing Crisis. http://www.nami/org/Template.cf.?Section=state_budget_cuts_report. March 2011.
21. Parks J., Svedsen D. (eds). Morbidity and Mortality in People with Serious Mental Illness. Alexandria, VA. The National Association of State Mental Health Program Directors, 2006. http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20n%20Morbidity%20and%20Mortality%20-%20Final%2011-06.pfd

22. Reynolds, R.J, Shafer, A.B., and Becker, E.A. Mortality of Public Mental Health Clients treated at the Local Mental Health Authorities of Texas. Texas Public Health Association Journal. 2012. Apr 64(2):35-40.
23. JEN Associates. Beneficiary Risk Management: Prioritizing High Risk SMI Patients for Case Management/Coordination. February 2010. www.dhcs.ca.gov/progovpart/documents/high%20Priority%20SMI%20Application%20Exec%204Feb2010v2.pfd
24. Balfour, M.E., Van der Feltz-Cornelis C., Rosen L.A., Cline C.A., Moffic S. Highlighting High Utilizers: How can or systems better meet their needs? Institute on Psychiatric Services Annual Meeting. Workshop 3. San Francisco, CA. October 2011.
25. Balfour M.E. Homelessness, Criminal Justice, and the NorthSTAR Top 200. Report to the Dallas County Behavioral Health Leadership Team. February 2011. http://www.dallasbhlt.org/index.php?option=com_content&view=article&id=95
26. Value Options of Texas.
27. 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.
28. Cook Children's Center for Children's Health Data Website. http://www.centerforchildrenshealth.org/en-us/Resources/Pages/Resources.aspx Accessed October 2012.
29. United Way Denton County. Assets and Needs Assessment Report for Denton County. August 2011.

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Appendix C

Dallas County Community Health Needs Assessment

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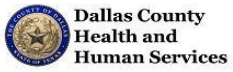

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ACRONYMS

AAHR	Age-adjusted hospitalization rate
AAMR	Age-adjusted mortality rate
ACA	Affordable Care Act
AHRQ	Agency for Healthcare Research and Quality
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
CHF	Congestive Heart Failure
CHIP	Children's Health Insurance Program
CHNA	Community Health Needs Assessment
CNI	Community Need Index
COPC	Community Oriented Primary Care
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular Disease
DCHHS	Dallas County Health and Human Services
DFW	Dallas-Fort Worth
DSHS	Texas Department of State Health Services
ED	Emergency Department
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HIV	Human Immunodeficiency Virus
HP2020	Healthy People 2020
HRSA	Health Resources and Services Administration
LGBT	Lesbian/Gay/Bisexual/Transgender
NE Dallas	Northeast Dallas
NIMH	National Institute of Mental Health
NTAHP	North Texas Accountable Healthcare Partnership
NW Dallas	Northwest Dallas
Outer NE	Outer Northeast Dallas
PCHI	Parkland Community Health Institute
PCMH	Patient-Centered Medical Home
PCP	Primary Care Physician
PHHS	Parkland Health and Hospital System
PHP	Public Health Preparedness
PHI	Public Health Improvement
PQI	Prevention Quality Indicators
SE Dallas	Southeast Dallas
SES	Socioeconomic Status
SIDS	Sudden Infant Death Syndrome
SNAP	Supplemental Nutrition Assistance Program
STD	Sexually Transmitted Disease
Stemmons	Stemmons Corridor
SW Dallas	Southwest Dallas
W/H/S	Wilmer Hutchins Seagoville
WIC	Women, Infants, and Children (special supplemental nutrition program)
YPLL	Years of Potential Life Lost
ZCTA	ZIP Code Tabulation Area

DEFINITIONS

Healthy community
A defined local area that has equitable access to healthcare and resources to support individual health. This includes: walkable and bikeable neighborhoods, safe public transportation, parks and open spaces, healthy food and fitness environments, cultural resources, good air quality, and access to housing and employment. (Prevention Institute)

Healthcare access
A person's ability to receive preventive services and treatment. Access is governed by: geographic location of health facilities, resident geographic location, transportation infrastructure, health literacy and awareness, and ability to pay for services, among other systemic barriers along the continuum of care.

Health disparities
A disproportionately negative health outcome in one population group when compared to the group with the best reported outcome. Disparities are evidenced by social determinants of health such as uninsured status, as well as limited physical and financial access to primary care physicians (PCPs) and health services.

Preventive Services
Services rendered by PCPs at clinics, hospitals, and/or the health department, as well as from nurse practitioners, parish nurses, community health workers and navigators to decrease the likelihood of future disease diagnoses.

Medical Home/Patient-Centered Medical Home
A Patent-Centered Medical Home (PCMH) is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes (American College of Physicians). The public health sector in Dallas County supports medical homes through preventive healthcare access and immunizations, local healthcare access analysis and resulting programs, mobile unit services, and benefits provided by community health workers, navigators, and organizers. PCMH facilitates consistent healthcare available along the continuum of care.

Definitions of ethnicity categories referenced in Community Health Needs Assessment text derived from U.S. Census and the United Nations include:

African-American A person having origins in any of the original peoples of Eastern, Middle, Southern, or Western Africa. For example, it includes people who identify as Kenyan, Nigerian, or Haitian.
Asian-American A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
Caucasian A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who identify as Irish, German, Italian, Lebanese, Arab or Moroccan.
Latino A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race.

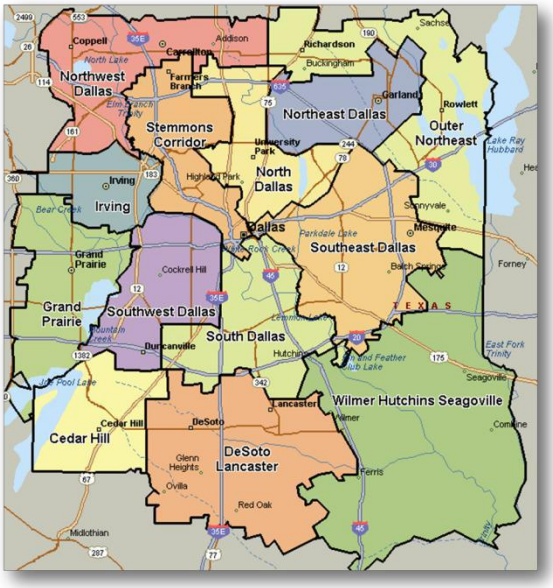
EXECUTIVE SUMMARY

BACKGROUND

The Dallas County Community Health Needs Assessment (CHNA) was designed to ensure that the Dallas County public health system continues to effectively and efficiently serve the 2.4 million residents of the county. Dallas County Health and Human Services (DCHHS) is one of seven local health departments in the nation participating in the Centers for Disease Control and Prevention (CDC) National Public Health Improvement Initiative. In support of that initiative, DCHHS designed and led this CHNA in collaboration with the Parkland Community Health Institute to determine the top health issues facing Dallas County residents and recommendations for improvement. A public health improvement workgroup comprised of healthcare executives, leaders of civic
organizations, schools, health departments, and representatives of local universities, provided development and implementation guidance.

The CHNA uses detailed public health outcome secondary data at the county and community level to identify health assets, gaps, disparities and trends. This data was supported with primary data from two focus groups and eight key informant interviews. The Dallas County communities considered throughout the CHNA are pictured in Figure ES-1.

Figure ES-1



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. 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 expansion, and employment opportunities.

The County's strengths have not been uniformly distributed across residents, with communities in the southern half of the county demonstrating disparities relative to those in the north.

The following is a sample of the differences and disparities identified in this CHNA:

- Fourteen percent (14%) of Dallas County residents live below the federal poverty level (FPL). This ranges from 5% in Outer NE Dallas to 25% in both South and Southwest Dallas.
- In mid-2010, Dallas County unemployment was at 8.9%, but 10 of 13 communities had unemployment at 6.2% or lower.
- 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.

- Dallas County is racially and ethnically diverse with 38% Latino residents, 34% Caucasian, 22% African-American and 7% Asian-American and Other.
- 28% of County residents do not have health insurance. Among non-elderly, non-institutionalized residents, the percentage increases to 33% which compares to 26% in Texas and 17% in the US.
- Dallas County has a shortage and maldistribution of primary care and specialty physicians, particularly in the southern half of the county.

Disparities in Dallas County residents' incidence and prevalence of illnesses were identified by this CHNA:

- Cardiovascular disease is the leading cause of death in Dallas County. Age adjusted mortality rates (AAMR) vary significantly by:
- Race/ethnicity, with African-Americans having the highest AAMR.
    - Gender, with men having a significantly higher AAMR than women.
    - Community, with southern Dallas County communities having higher AAMR than northern suburbs.
    - The burden of asthma, chronic obstructive pulmonary disease (COPD) and other respiratory diseases affects individuals, their families, schools, workplaces, and neighborhoods. The highest asthma and COPD rates are found in the County's six southern communities.
- While disparities in cancer mortality and incidence are not significant between Dallas County communities, disparities based on race/ethnicity are present. African-Americans have the highest incidence and mortality rates for all types of cancer. The rates in Dallas County for most cancers are higher than found in the State.
- Diabetes prevalence is higher in Dallas County than in Texas or the U.S. In Dallas County 11.4% of the population suffers from this illness compared to 9.6% in Texas and 8% in the U.S. Communities with the highest diabetes mortality are in the southern half of Dallas County.

Healthy community indicators identify food deserts in southern communities and sedentary lifestyles throughout the County:

- All very high, high and moderate food desert areas are located in the southern half of Dallas County.
- Despite a strong network of parks and varied recreational options, more than half of Dallas County residents have sedentary lifestyles. Physical activity in Dallas County declined 6.5% between 2006 and 2010.
- Obesity among Dallas County residents increased 17.6% between 2005 and 2010.
- Tobacco use in Dallas County is decreasing, but 16% of the population continues to smoke.

TOP FIVE HEALTH ISSUES

Five health issues emerged from the analysis as critical to improving the health of Dallas County residents. They include:

Multiple Chronic Conditions (MCC) 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.

- 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.

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

- Use of the emergency department (ED) for treatment of conditions that could have been appropriately treated in the primary care setting identifies residents with limited healthcare access, lack of understanding of their medical conditions, and/or uninsured/underinsured status. In 2011, 63% of 2011 Dallas County ED visits might have been treated in other settings.
- Physicians are concentrated in the Stemmons Corridor and in northern suburbs. A shortage and maldistribution of primary care and specialty physicians exists within the county resulting in underserved areas, particularly in the southern communities with lower 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.
- Expansion of the patient-centered medical home model of care at these clinics may enhance
- access for the un/underinsured and those with low socioeconomic status.
- Dallas County has a strong professional and para-professional healthcare work force 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 and Resource Deserts Disparities are found within southern Dallas County and pockets of northern 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.

- Dallas County residents with lower socioeconomic status suffer from poorer health outcomes.
- Employment, education, income, and race are important factors in a person's ability to access preventive healthcare and treatment.
- 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 socioeconomic status communities that have health outcomes below the County average.
- Communities with food deserts.

Infrastructure—Unifying Prevention Efforts and Maximizing Resources Dallas County has a wide range of health programs and improvement plans that are often being implemented in silos. Effective collaboration will enhance countywide efforts while reducing competition for resources. This will maximize available public health personnel and funds.

- The importance of effective collaboration is recognized by health planning groups throughout Dallas County. Needs assessments from these efforts recommend collaboration as a strategy. Some of these planning groups include: United Way of Metropolitan Dallas Blue Ribbon Commission, Regional Health Partnership 9, Behavioral Health Leadership Team, It Takes a Village Planning Team, and the Dallas/Ft. Worth Hospital Council Community Health Collaborative.
- Successful collaboration requires personnel and financial resources.
- Utilizing central public-private partnerships can increase health impact, and maximize competitiveness in grant applications relating to the top health issues that impact Dallas County residents.

Behavioral Health Dallas County residents suffering from behavioral health illnesses often confront decision-making barriers. These barriers can impact preventive care and treatment decisions, thereby influencing aspects of their physical health.

- There is limited service access, reduced length of treatment, and increased utilization of crisis services in the Dallas County behavioral health system.
  - 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."
- 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.
- 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 implementation of other recommendations which include: 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.

CALL TO ACTION: RECOMMENDATIONS

This community health needs assessment represents collective issues facing Dallas County residents, and requires collective action to improve the health of our community. The authors and PHI Workgroup

affiliated with the report served to inform the methodology, analysis, and recommendations, but are not solely responsible for addressing these issues. However, each contributor will consider a health improvement plan that addresses the top community health needs within the capacity of his/her organization. This needs assessment is a call to action for all community-based organizations, policymakers, hospitals, workplaces, faith-based organizations, civic leaders, and citizens to do the same. Here are places to start. You can select the options that work best for your organization from the following list of recommendations:

1. ***Increase Dallas County residents' access to community prevention services.*** Focus should be on nutrition/maintaining ideal weight, physical activity, non-smoking and reducing alcohol consumption.
    A. Bring stakeholders together to identify current services and develop plans for community prevention education and services in order to coordinate and expand services in Dallas County communities with highest need/resource deserts. Stakeholders should include community based organizations, hospitals/health systems, faith-based organizations, businesses and local foundations.
        - Identify successful programs being implemented that might be expanded or customized for other communities in the County.
        - Target neighborhoods/communities with health disparities as focus for risk reduction.
    B. Identify financial, personnel and in-kind resources available to develop new programs in underserved areas with resource deserts, build on successful models and expand existing programs in place.
        - Encourage hospitals/healthcare systems to participate via their community benefit programs.
        - Encourage Dallas County businesses to participate to enhance the health of the local workforce.
    C. Expand immunization services to support community prevention in Dallas County.

2. ***Target South Dallas, SW Dallas, SE Dallas, or disparate suburban neighborhoods with comprehensive interventions to reduce incidence and mortality disparities.***
    A. Using the Spectrum of Prevention model, build multi-sector partnerships that create opportunities for expansion of resources to support health equity and healthy communities. The model considers advocacy, changing workplaces and organizational practices to address disease risks, educating providers, and skill building for individual healthy behavior changes.
    B. Increase access to quality preventive services through community organizing.
    C. Increase the capacity of the healthcare and prevention workforce to address disparities.
    D. Implement strategies that are culturally, linguistically, literacy and age-appropriate at all levels of community organizing, interventions, and treatment.E
    E. Evaluate effectiveness of strategies to ensure progress.

3. ***Expand access to primary care services for all Dallas County residents.***
    A. Encourage healthcare organizations to "right size" their medical staffs to meet the primary care and specialty medical needs of the community based on established physician to population ratios.
        - Evaluate opportunities to locate primary care physicians, women's health specialists and pediatricians in areas identified as resource deserts for these specialties.
    B. Educate providers on the value of the patient-centered medical home model of care.

C. Expand the medical home model to enhance health literacy and service access. Support the development of multidisciplinary teams that include physicians, nurse practitioners, nurses, case managers, physical therapists, pharmacists and community health workers for preventive and primary care provision.

D. Support the development of alternative primary care sites including, but not limited to:
   - School nursing offices, which currently serve as initial points of healthcare contact for many children and youth.
   - Large and medium sized businesses with model programs supporting recent findings that on-site prevention programs and primary care services have positive health benefits for employees and financial benefits for employers.
   - Retail grocery and drug stores providing preventive services and basic primary care.
   - Urgent care center/walk-in clinics.
   - Community based organizations and faith based organizations with co-located services to offer preventive and medical treatment in combination with other social and support services or events.
   - Immunization service clinics.

E. Consider targeted educational programs that expand health literacy, community prevention education, and additional clinical prevention services. Evaluate options to co-locate additional services at these sites.
   - Work with community partners to develop or expand targeted health literacy programs.
   - Support community prevention services to improve nutrition, reduce smoking and enhance physical activity.
   - Provide additional health screening services, possibly through use of mobile vans.
   - Identify funding to support ongoing operation of the Immunization Coalition.

4. ***Maximize the use of proven strategies to improve outcomes for individuals with multiple chronic conditions.***
   - These strategies include patient-centered medical homes, accountable care organizations, primary care and behavioral health integration models.

5. ***Monitor and address any health insurance coverage changes.***

A. Facilitate enrollment of Dallas County residents into available health insurance products.
   - Outline enrollment processes and organizations to support consumers in completing these processes.
   - Develop promotional strategies to educate and inform eligible residents of changing health insurance eligibility requirements and opportunities for coverage.
   - Evaluate trends in provider acceptance rates of available health insurance products.

6. ***Centrally document and build upon the most impactful disease prevention and health promotion initiatives currently underway in Dallas County.***

A. Reach out to the lead organizations to learn from their experiences and expand their models in Dallas County communities with resource deserts.
   - Work with community partners to implement and evaluate these programs.
   - Utilize public-private partnerships to increase health impact, and to maximize competitiveness in grant applications with interventions to address the top

health issues that impact Dallas County residents.
- Identify funding sources.

7. ***Develop strategies to reduce 30 day readmissions and preventable hospitalizations.***

    - Community health workers, nurses and others providing outreach in the community have a role in supporting recently hospitalized community residents to reduce readmission.

8. ***Collaborate with the Dallas County Behavioral Health Leadership Team to support implementation of behavioral health recommendations, particularly pertaining to integration of behavioral health and physical health.***

9. ***Effectively communicate priority messages relating to community prevention, using culturally competent health literacy approaches.***

    - Promote Spanish written and oral translation in prevention and care.
    - Incorporate infographics to convey treatment compliance outcomes and public health issues.
    - Utilize social media for health promotion and idea exchange.
    - Develop a consumer-oriented website for health education and to enhance health literacy.

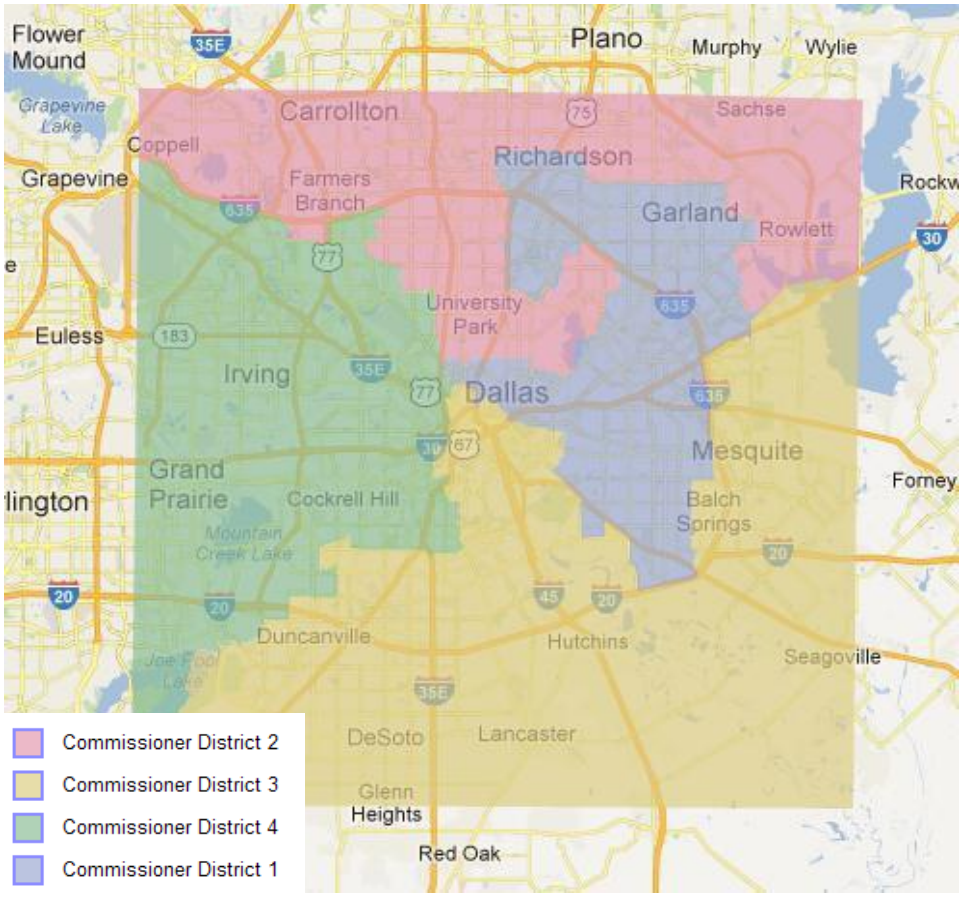
INTRODUCTION

Dallas County Health and Human Services (DCHHS) is one of seven local health departments in the nation participating in the Centers for Disease Control and Prevention (CDC) National Public Health Improvement Initiative. A total of $40 million in funding—partly supported by the Affordable Care Act (ACA)—has been divided among state, tribal, local and territorial health departments and schools of public health to enhance the nation's public health infrastructure.

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*).

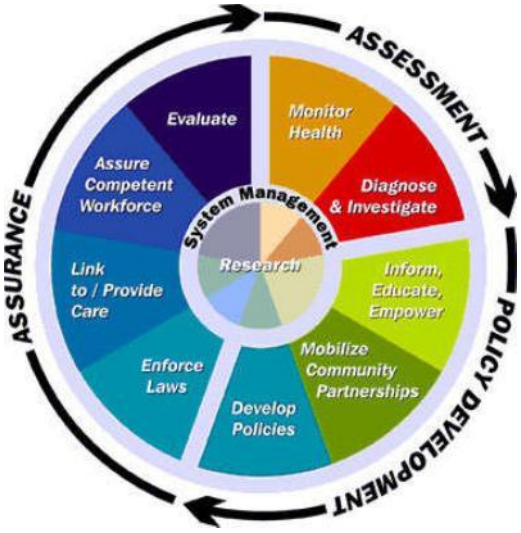
The goals of the Dallas County Community Health Needs Assessment support these *Healthy People 2020* goals. The specific objectives are to:

- 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.

The public health model, presented in Figure 1.2, includes three core functions with ten essential health services (CDC-EHS-EPHLI, 2011). These include:

1. Assessment
   - Monitor Health
   - Diagnose and Investigate
2. Policy Development
   - Inform, Educate, Empower
   - Mobilize Community Partnerships
   - Develop Policies
3. Assurance
   - Enforce Laws
   - Link to/Provide Care
   - Assure Competent Work Force
   - Evaluate

Figure 1.2



The Dallas County CHNA contributes to the core function of Assessment. The recommendations and strategies outlined will strive to improve each individual resident's health with the ultimate goal of enhancing the health and quality of life throughout the Dallas County community.

Community Health Improvement Planning

This CHNA represents collective issues facing Dallas County residents, and requires collective action to improve the health of our community. The end of the CHNA containing assets and gaps analysis as well as recommendations is the foundation for the Dallas County Community Health Improvement Plan (CHIP).

The authors and workgroup affiliated with the report served to inform the methodology, analysis, and recommendations, but are not solely responsible for addressing these issues. However, each contributor will consider a health improvement plan that addresses the top community health needs within the capacity of their organization. This needs assessment is a call to action for all community- based organizations, policymakers, hospitals, workplaces, faith-based organizations, civic leaders, and citizens to do the same.

Please contact DCHHS Public Information Office at (214) 819-2000 to share your final community health improvement plan.

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.

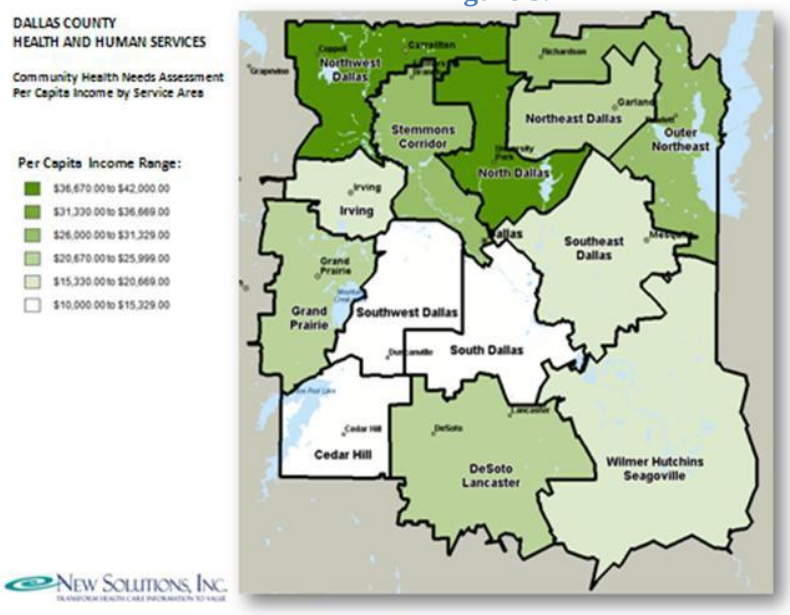
DALLAS COUNTY GEOGRAPHY AND SOCIO-DEMOGRAPHICS

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:

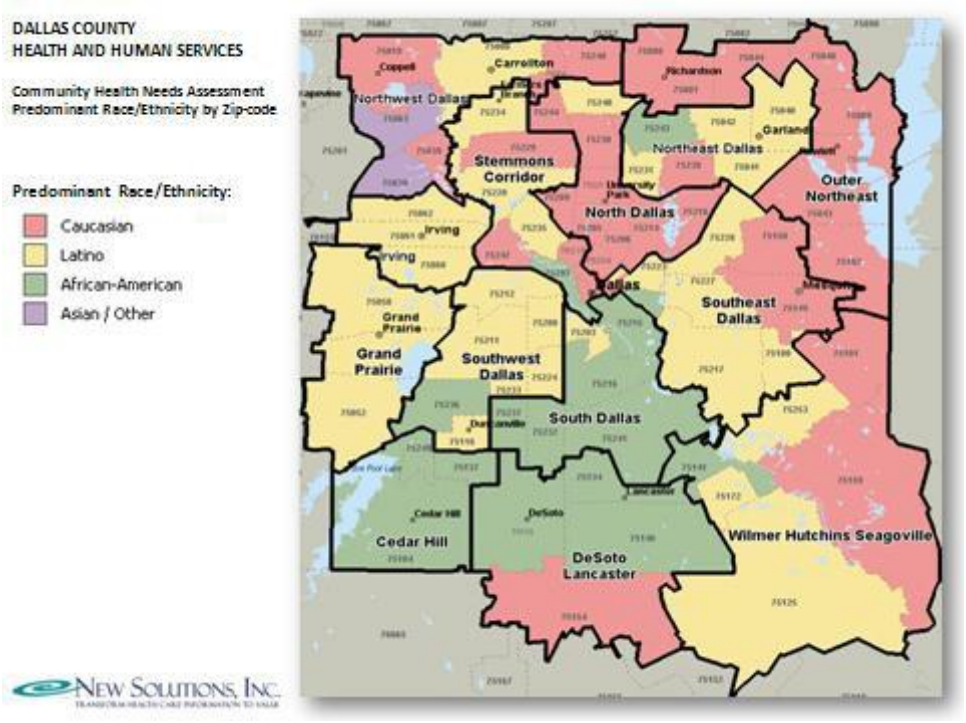
- Wide range of economic status and security.
  - Dallas County 2010 per capita household income was $24,200. Figure 3.1 presents the range of per capita income in Dallas County.
  - In 2010, 14% of Dallas County residents were living below the federal poverty level (FPL).
  - In mid-2010, nearly 9% 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

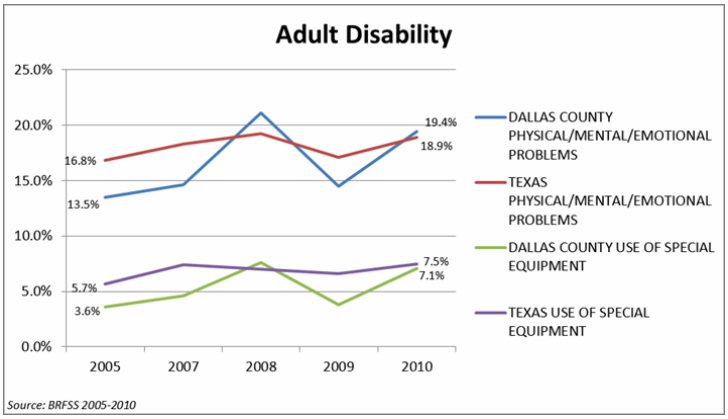


Between 2005 and 2010, adult disability increased in Dallas County and in Texas.

- 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



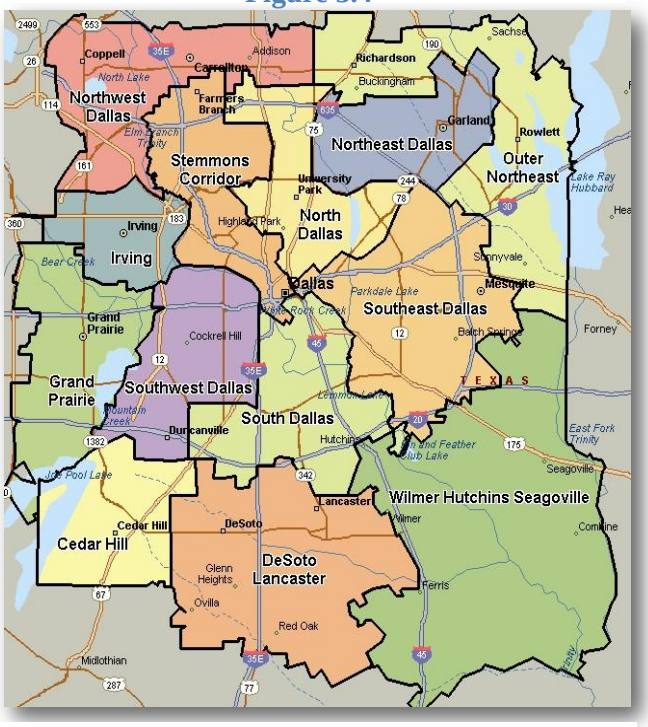
Dallas County Communities

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]

Cedar Hill

- Considering population size, Cedar Hill is the smallest community, with only 77,607 residents, or 3.1% of the Dallas County population.
- African-Americans make up 47% of the Cedar Hill population. Caucasians are 26% and Latinos 23%. Population age mirrors Dallas County overall.
- Despite having one of the lowest 2010 per capita incomes, $14,200, only 6% were unemployed, and 4.2% were living in poverty.
- Nearly 90% have graduated from high school.
- Cedar Hill is one of four communities with a 2009 homicide death rate higher than the Dallas County average. It was 11.2/100,000 compared to Dallas at 8.5/100,000.

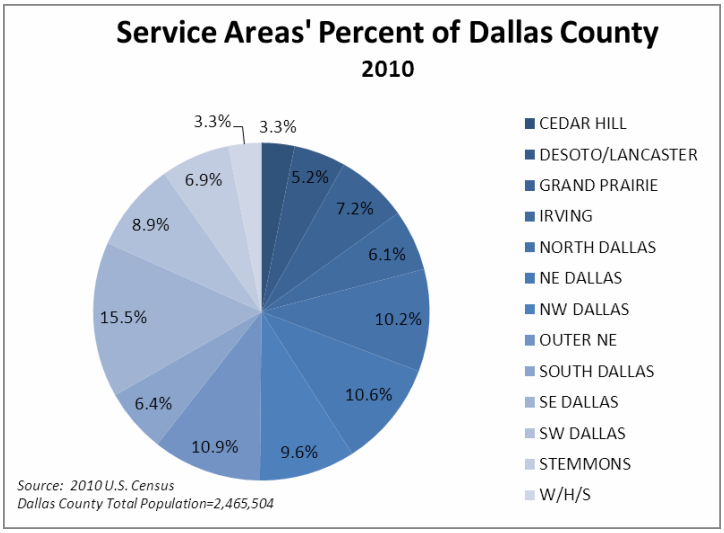
Figure 3.4



DeSoto Lancaster

- With 123,187 residents, DeSoto Lancaster is located in south central Dallas County and is home to 5.2% of the county's population.
- African-Americans are the majority population at 54%. Caucasians are 27% and Latinos 17%.
- Nearly 85% of adults have graduated from high school.
- Per capita income in 2010 was $23,000 with low unemployment and 8% living below the FPL.

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.

Grand Prairie

- The 169,322 Grand Prairie residents comprise 7.2% of the Dallas County population.
- Race/ethnicity includes 44% Latino, 28% Caucasian, 20% African-American and 8% Asian-American and other.
- With 25% of the adult population without a high school diploma, Grand Prairie's 2010 per capita income was $20,900. At that time, unemployment in the community was low at 6.1% and 8% of residents were living below FPL.

Irving

- Irving has 143,959 residents, or 6.2% of the Dallas County population.
- Only 7% of the residents are age 65 and older, compared to 9% for Dallas County overall.
- The majority (54%) of the Irving population is Latino, followed by 30% Caucasian, 9% African- American and 7% Asian-American/other.
- Irving's 2010 per capita income was $19,000; unemployment was 5.5% with 12% were living below FPL.
- Nearly 31% of Irving adults have not completed high school.

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.

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.

South Dallas

- South Dallas, with 152,639 residents, comprises 6.4% of Dallas County's population.
- South Dallas has the largest percentage of residents 65 years of age and older, 12%.
- African-American is the majority racial group, 70%. Latino is 26%, Caucasian 3%.
- South Dallas has the lowest economic indicators of all Dallas County communities:
    - Per capita income of $13,400
    - Unemployment of 13.1%
    - 25% below FPL
- Nearly 36% of South Dallas adults have not graduated from high school.
- South Dallas led the county in homicides in 2009 with a rate of homicide rate 31.9/100,000 which is nearly four times the Dallas County average.

Southeast Dallas

- Southeast Dallas (SE Dallas) is the most populous community with 367,435 residents or 15.5% of Dallas County's population.
- Almost half of SE Dallas residents are Latino. Both Caucasian and African-American comprise 24% of the community population.
- SE Dallas has low socioeconomic status with per capita 2010 income of $16,200, unemployment of 7.9% and 19% of residents living below FPL, and low educational attainment.
- SE Dallas had a 2009 homicide death rate of 12.6/100,000 which is above the Dallas County average.

Southwest Dallas

- Southwest Dallas (SW Dallas) has 8.9% of the County's population, 211,896 residents.
- Latino is the majority racial/ethnic group in SW Dallas, 67%. African-American is 18%, and Caucasian is 12%.
- Economic indicators are low, particularly 25% living below FPL and nearly half of adults without a high school diploma. Per capital income in 2010 was $14,200 and unemployment

9.1%.
- SW Dallas had the second highest 2009 homicide death rate in Dallas County, 13.7/100,000.

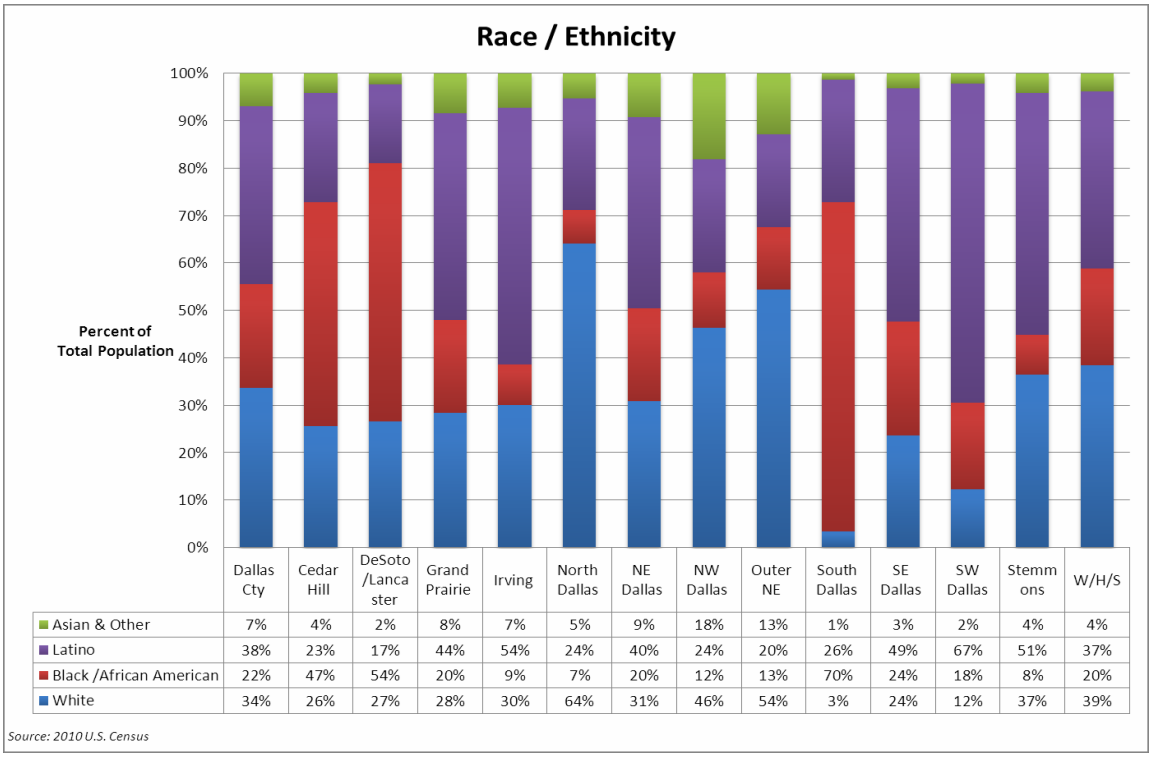
Stemmons Corridor

- Stemmons Corridor (Stemmons) has 162,748 residents, or 6.9% of the Dallas County population.
- Over half (51%) of Stemmons Corridor residents are Latino. Caucasian is 37%, and African-American 8%.
- Unemployment in mid-2010 was 6%, and per capita income was $26,100; 18% were living below FPL.
- Thirty nine percent of Stemmons residents have not completed high school.

Wilmer Hutchins Seagoville

- With 3.3% of Dallas County's population, Wilmer Hutchins Seagoville (W/H/S) has 78,718 residents.
- This community has the smallest percentage of residents age 65 and older at 6%.
- Wilmer Hutchins Seagoville closely matches the race/ethnicity of Dallas County with 39% Caucasian, 37% Latino, 20% African-American and 4% Asian-American/other.
- Per capita 2010 income was $19,200; with 5.5% unemployment, and 10% living below FPL.

Figure 3.6

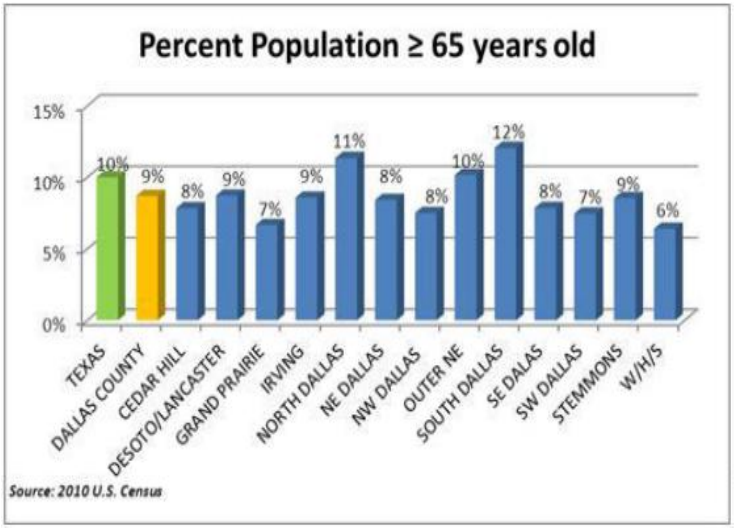


	Dallas Cty	Cedar Hill	DeSoto /Lancaster	Grand Prairie	Irving	North Dallas	NE Dallas	NW Dallas	Outer NE	South Dallas	SE Dallas	SW Dallas	Stemmons	W/H/S
Asian & Other	7%	4%	2%	8%	7%	5%	9%	18%	13%	1%	3%	2%	4%	4%
Latino	38%	23%	17%	44%	54%	24%	40%	24%	20%	26%	49%	67%	51%	37%
Black /African American	22%	47%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



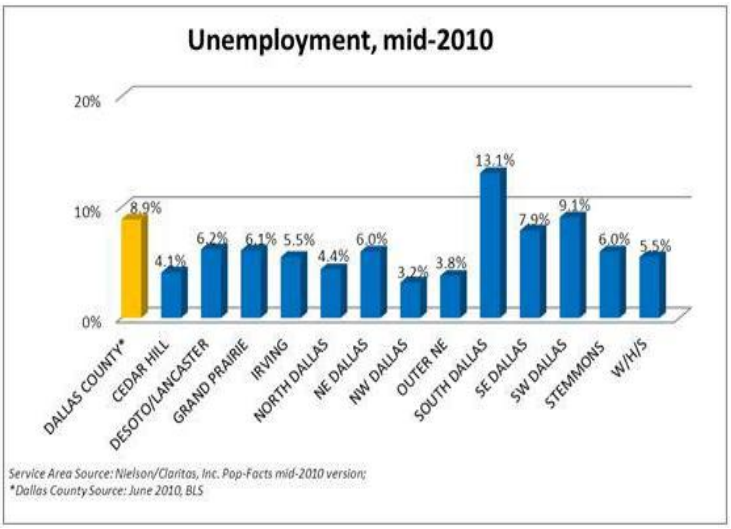


Figure 3.9

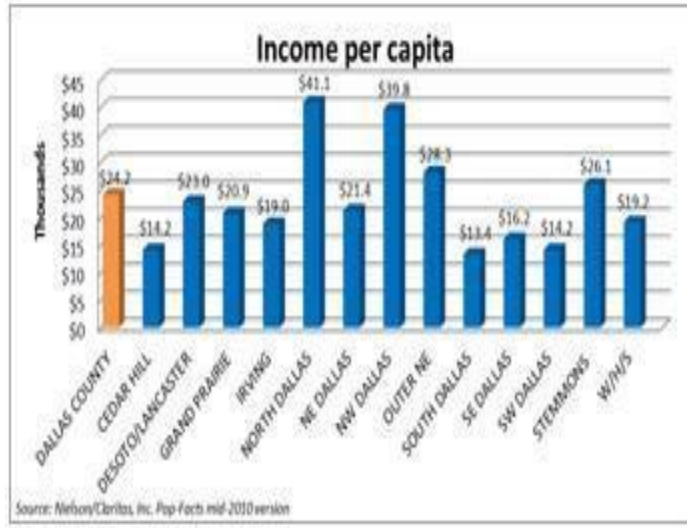


Figure 3.10

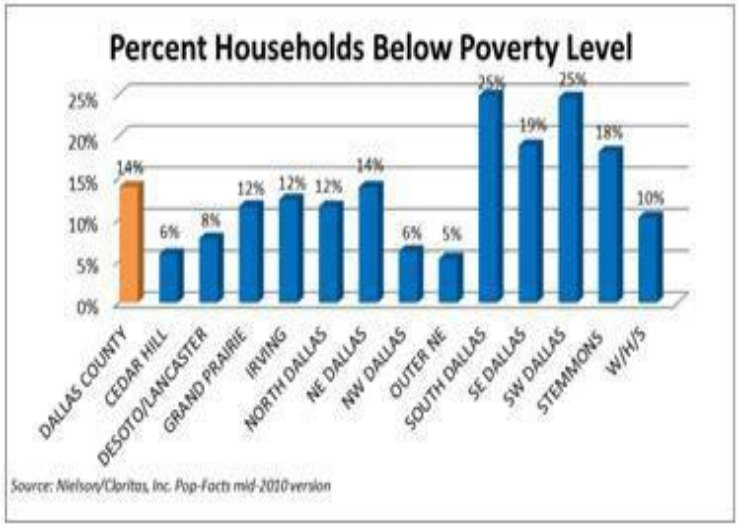


Figure 3.11

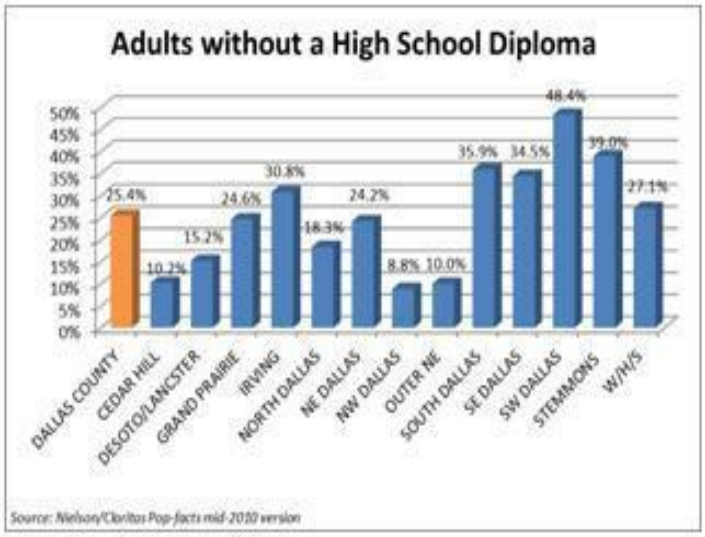
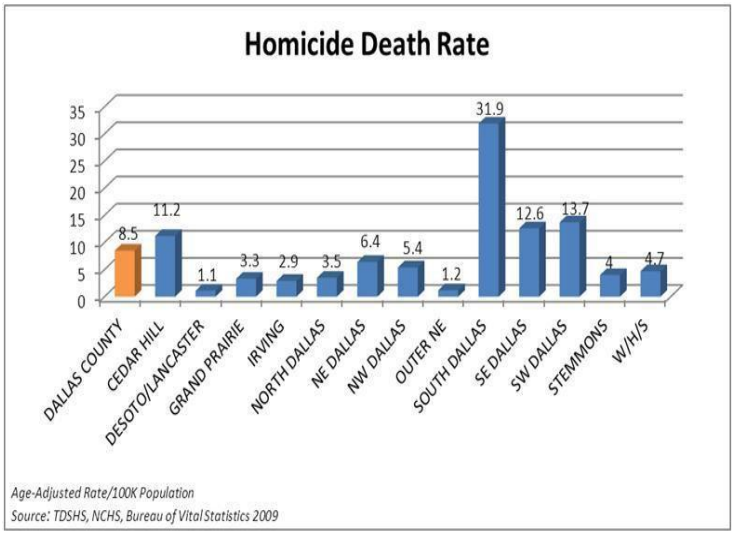


Figure 3.12



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.

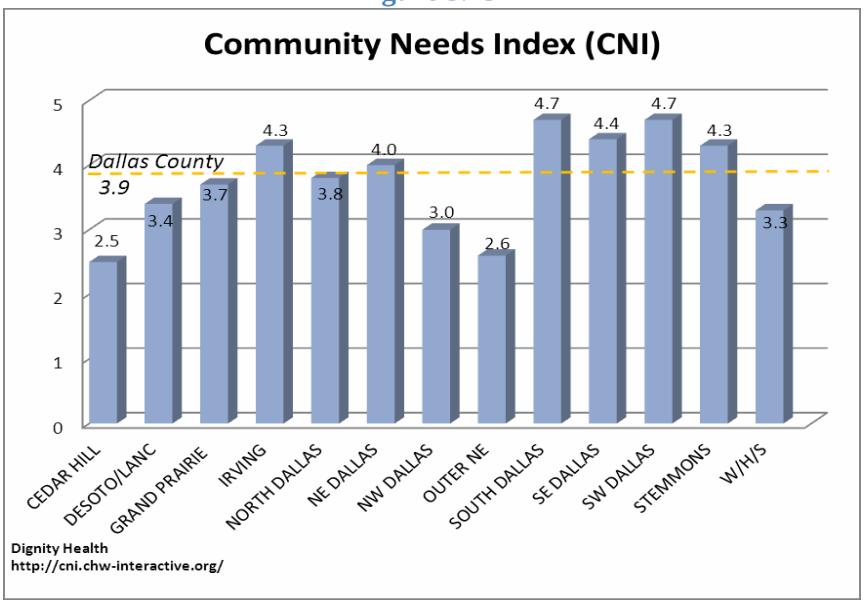
A score of 1.0 indicates a ZIP code with the least socio-economic barriers, while a score of 5.0 represents a ZIP code with the most socio-economic barriers.

- 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



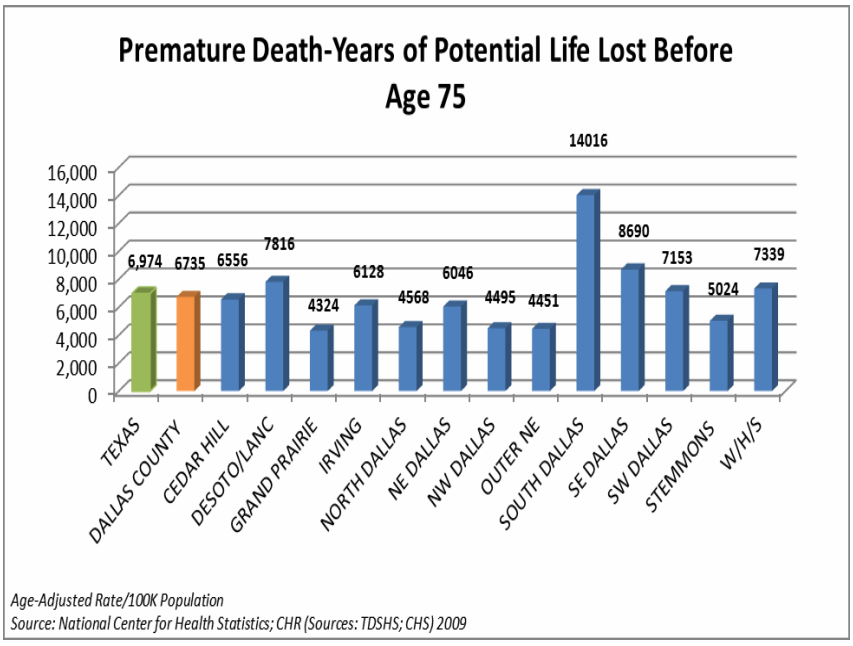
[2] Formerly Catholic Healthcare West

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:

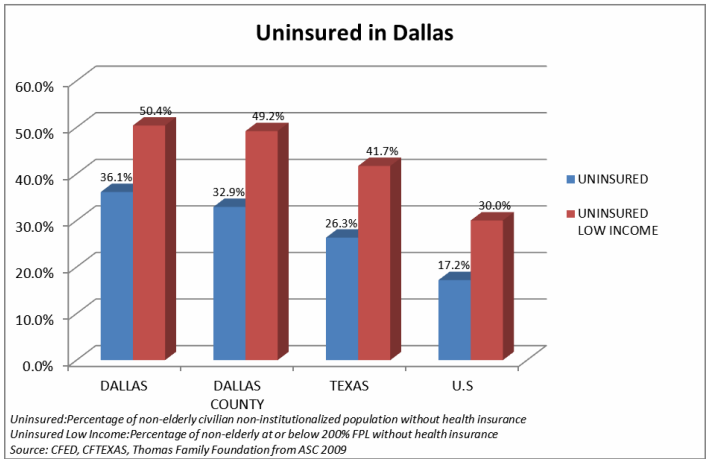
- Less likely to receive needed medical care.
- More likely to have more years of potential life lost.
- More likely to have poor health status.

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).

Figure 4.1



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

- 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).

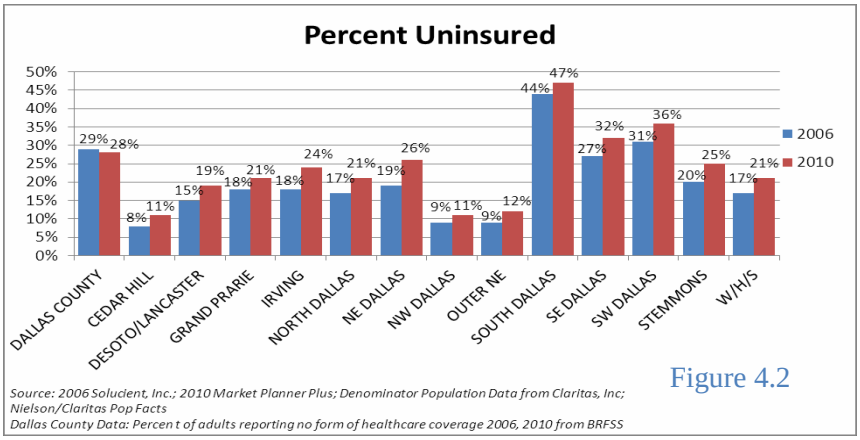


Figure 4.2

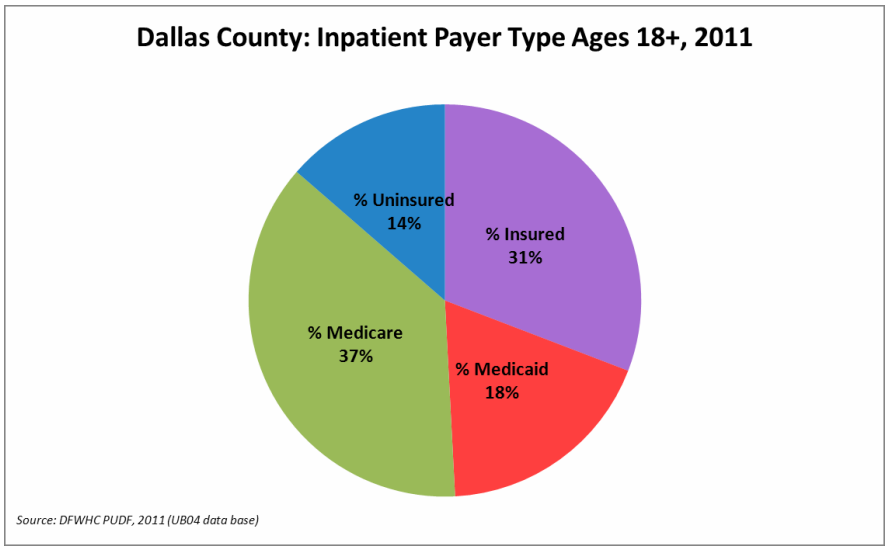
Source: 2006 Solucient, Inc.; 2010 Market Planner Plus; Denominator Population Data from Claritas, Inc; Nielson/Claritas Pop Facts
Dallas County Data: Percent of adults reporting no form of healthcare coverage 2006, 2010 from BRFSS

Health Insurance Coverage—Insurance and Insurance Trends

Health Insurance Trends in Dallas County

Figure 4.3

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%.



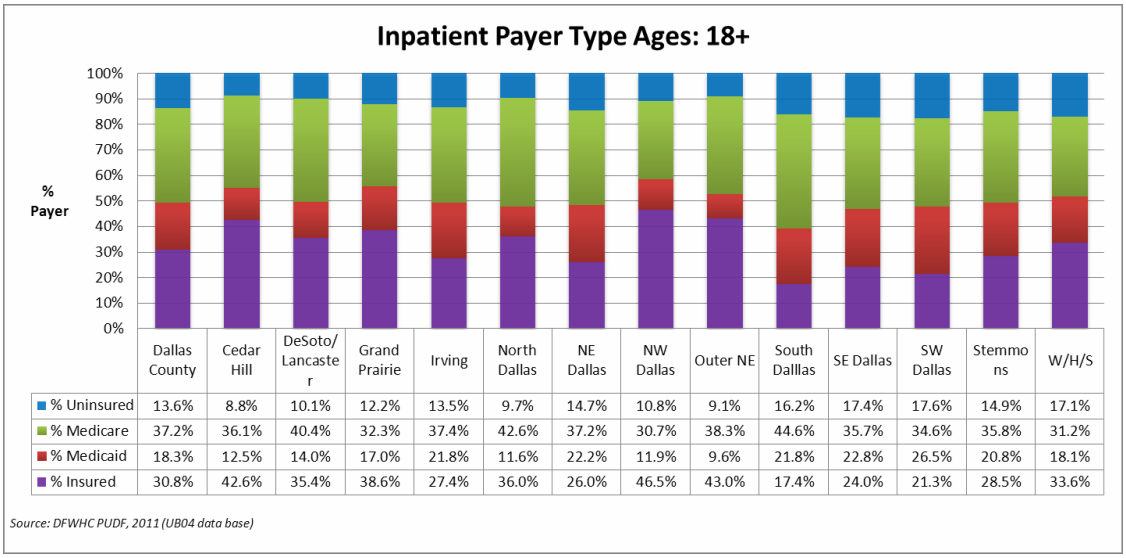
Source: DFWHC PUDF, 2011 (UB04 data base)

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%

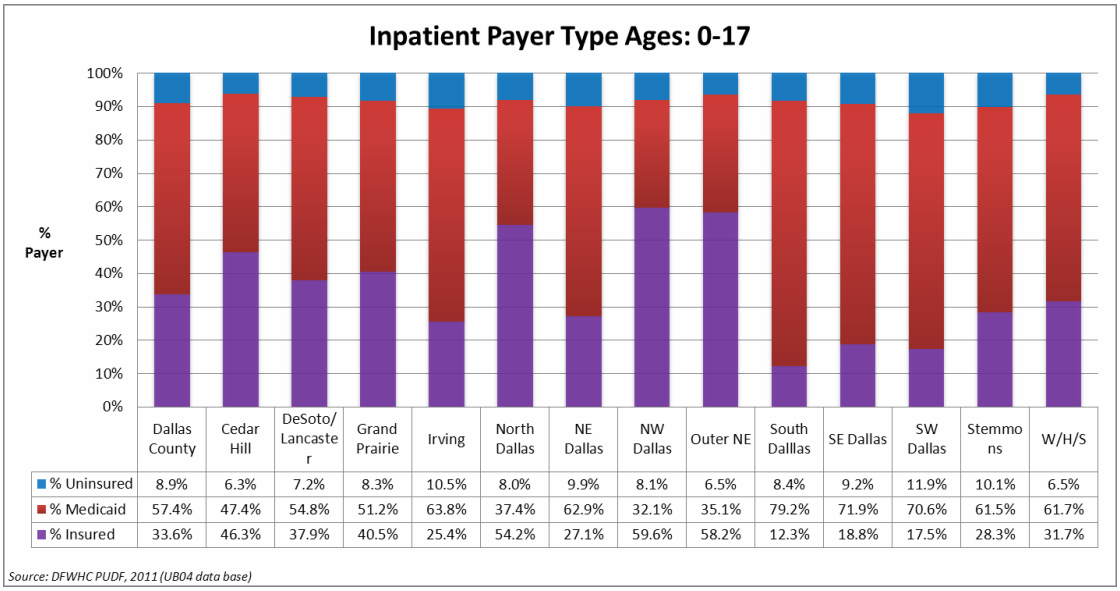
Source: DFWHC PUDF, 2011 (UB04 data base)

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]

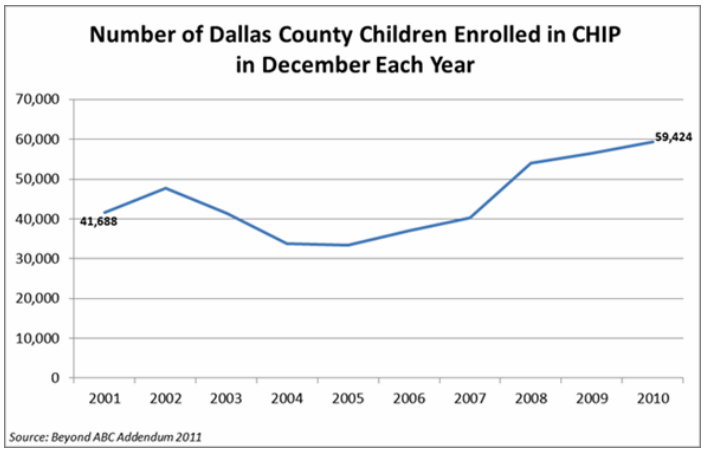
"2011 Beyond ABC: Assessing Children's Health" states that of the 654,273 children under 18 living in Dallas County, more than 29% live in poverty and 17.9% are uninsured (2011). This 2010 percentage, which is significantly below the overall percentage of Dallas County uninsured, resulted from coordinated, 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.

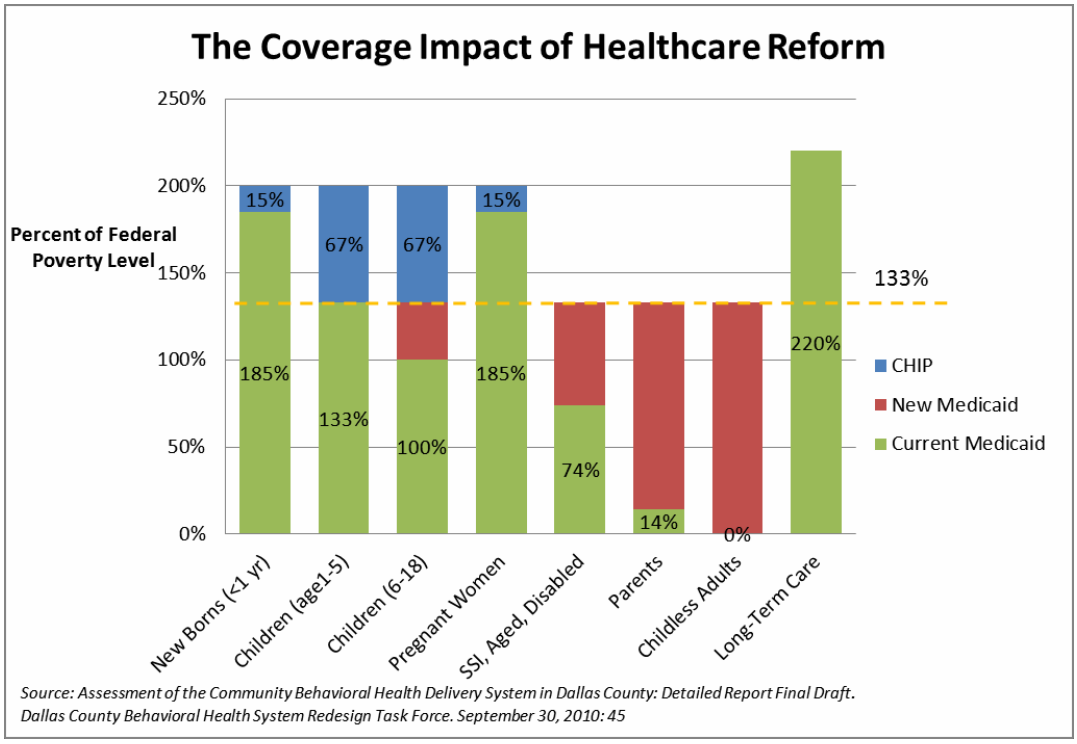
This study found that 30% of Texas physicians would not accept new Medicaid patients. (Decker, 2012). The Texas Medical Association found that in 2012, 31% of Texas physicians and 24% of Dallas County physicians will not accept Medicaid (Udall & Annear, 2012).

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



Source: Assessment of the Community Behavioral Health Delivery System in Dallas County: Detailed Report Final Draft. Dallas County Behavioral Health System Redesign Task Force. September 30, 2010: 45

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:

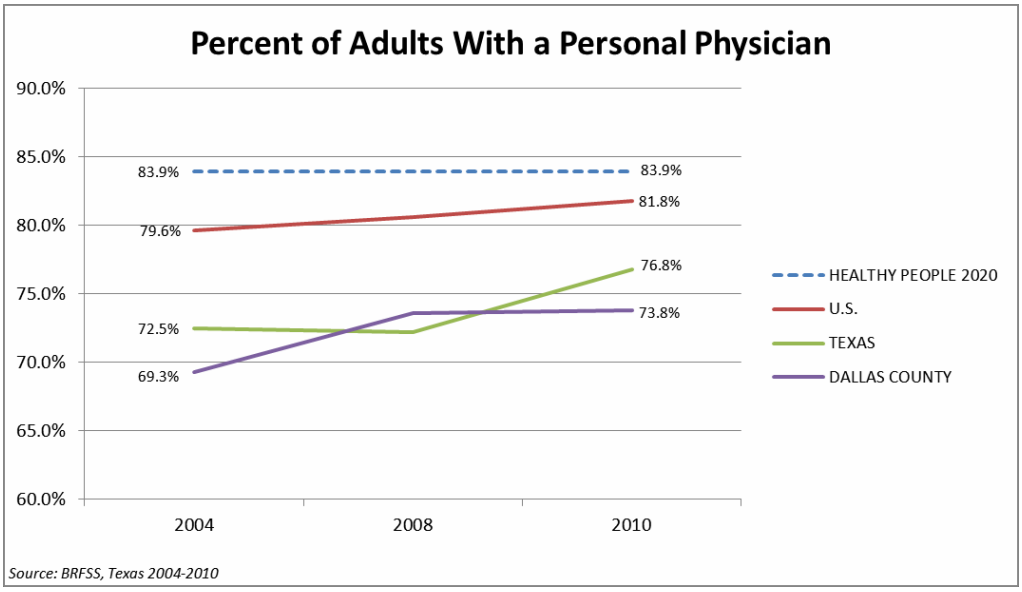
- Expand community and clinical preventive care,
- Focus on local, community-based services,
- Coordinate care using a multi-disciplinary teams led by the physicians,
- Develop data bases to improve treatment on both an individual and population basis (North Texas accountable, 2012).

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



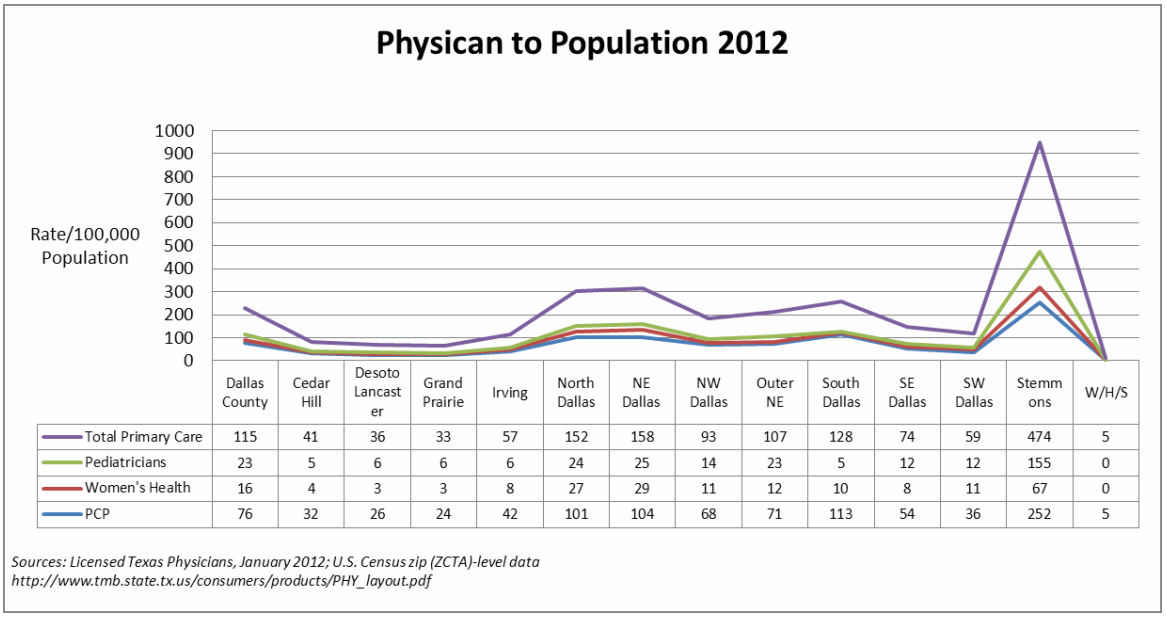
Dallas County has a rate of 99 PCPs/100,000. To compare, Texas has 70 PCPs per 100,000, which is the fourth lowest state rate in the U.S. The state median is 91/100,000 (2011 state physician workforce, 2011).[4]

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.

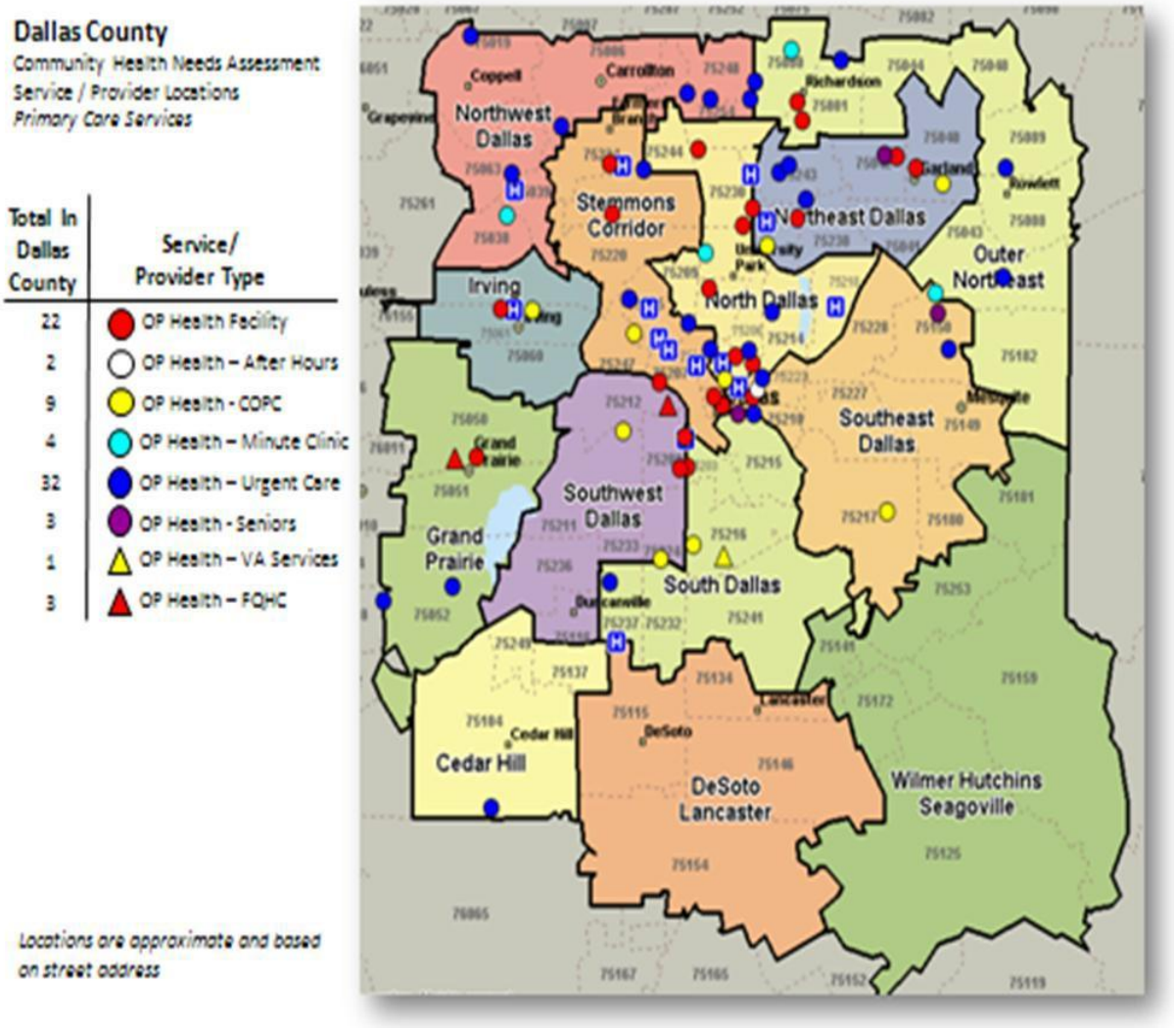
Map 1 (Figure 4.8) presents Outpatient Health Facilities in Dallas County.

- 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



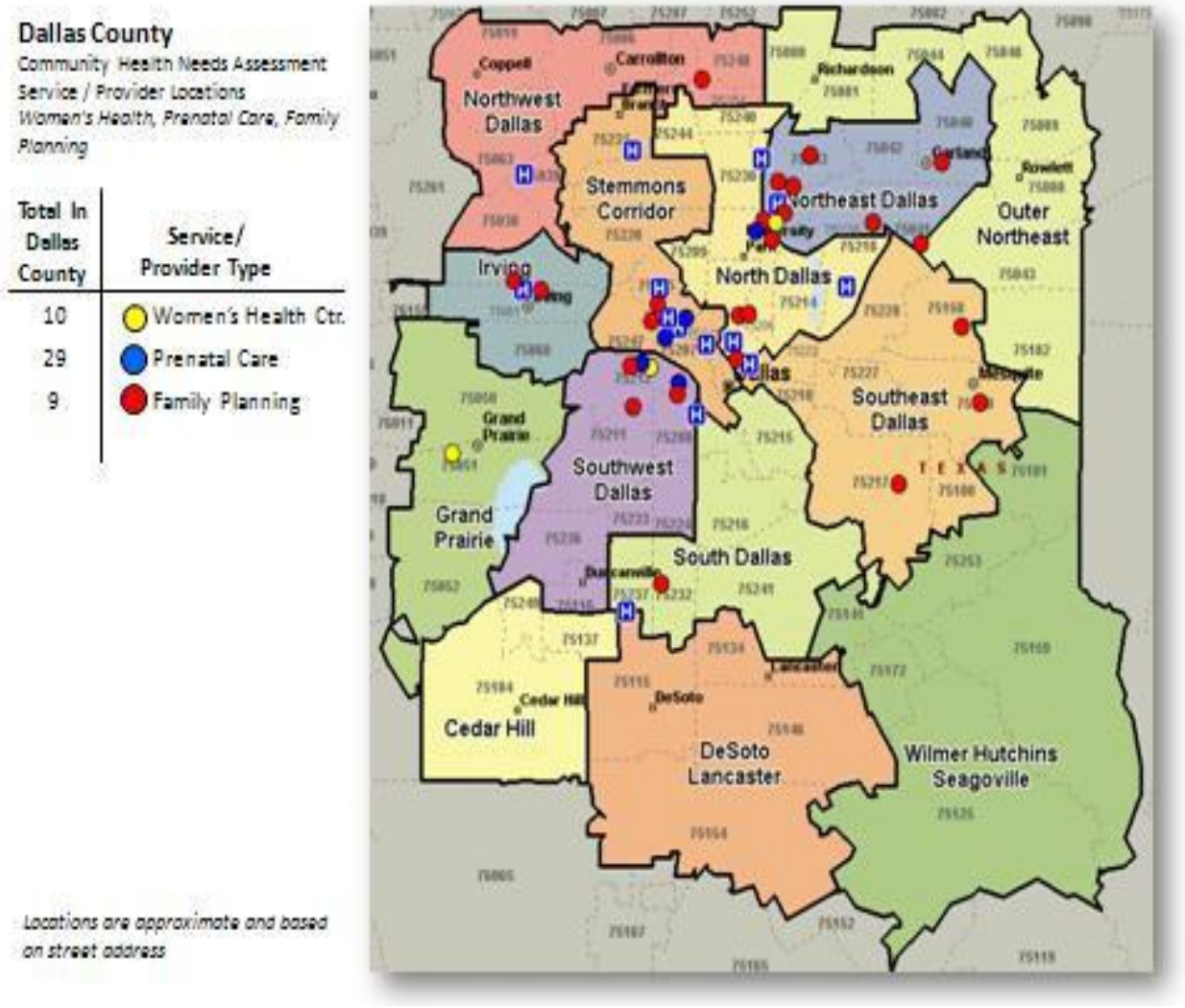
Map 2 (Figure 4.9) presents Women's Outpatient Facilities. Most are located in Stemmons Corridor, North and Northeast Dallas.

- 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.

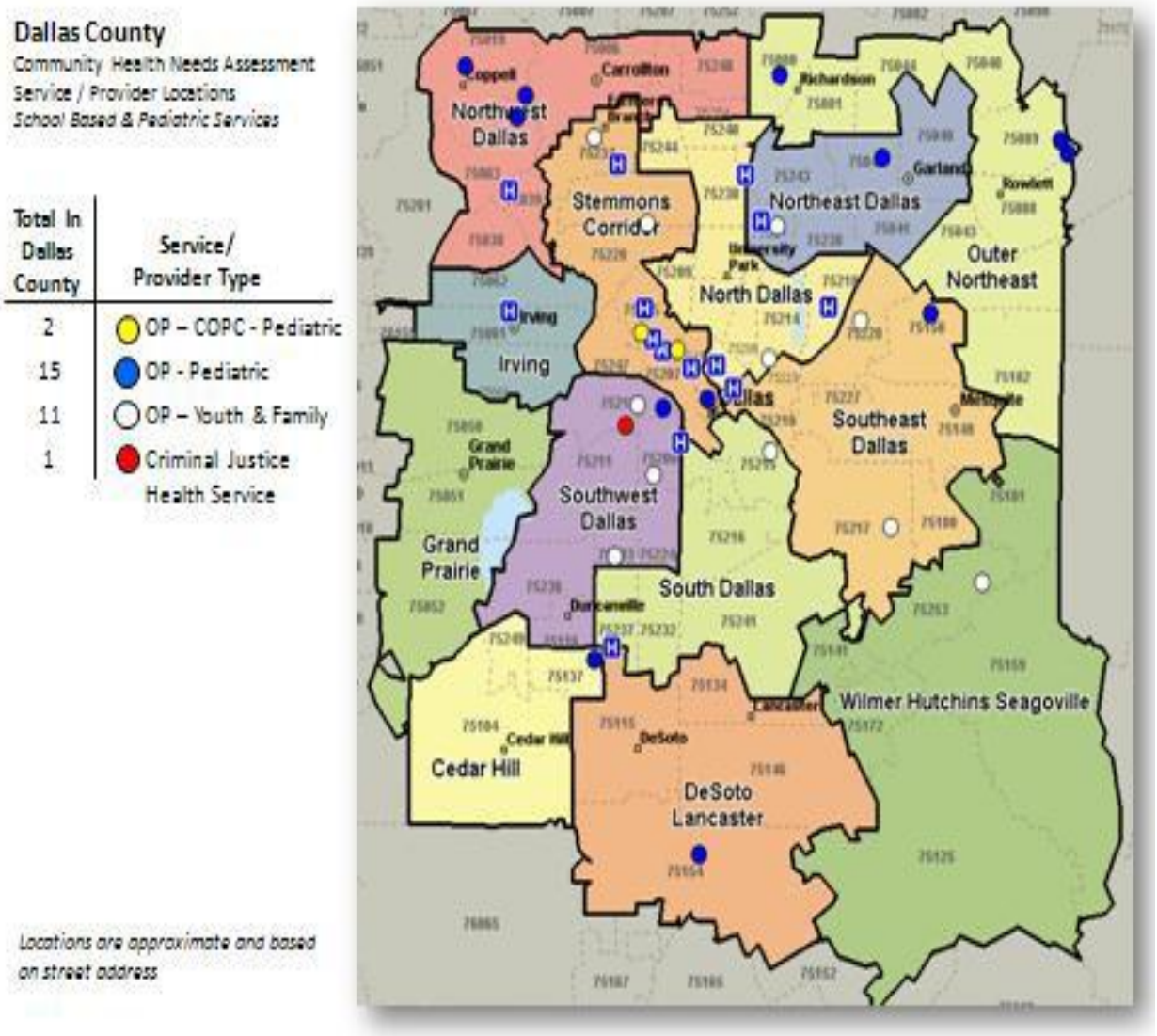
- Thirteen are operated by PHHS including two pediatric COPCs and 11 Youth and Family Centers.

o 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

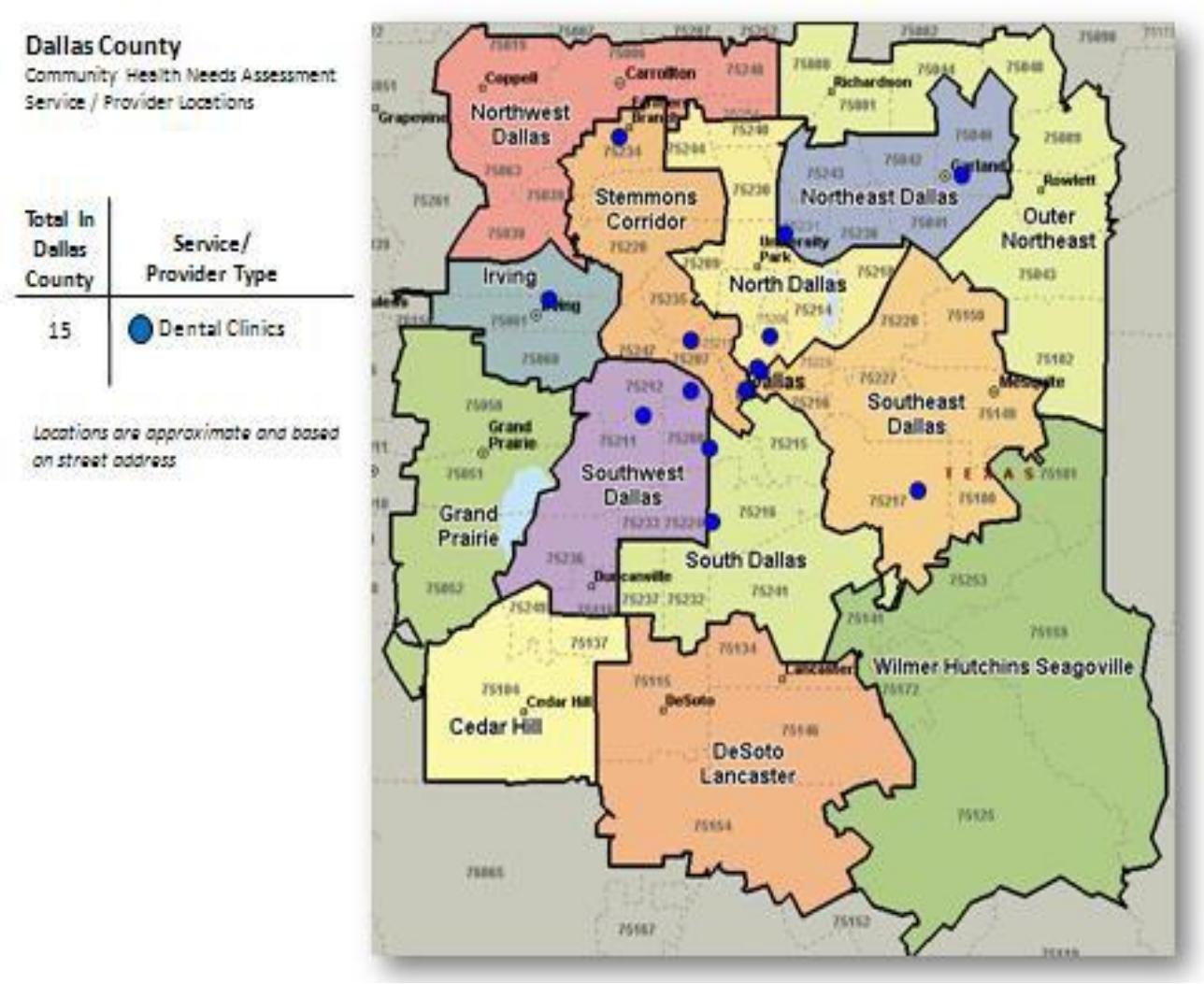


Map 4 (Figure 4.11) presents 15 Dental Clinics.

- 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



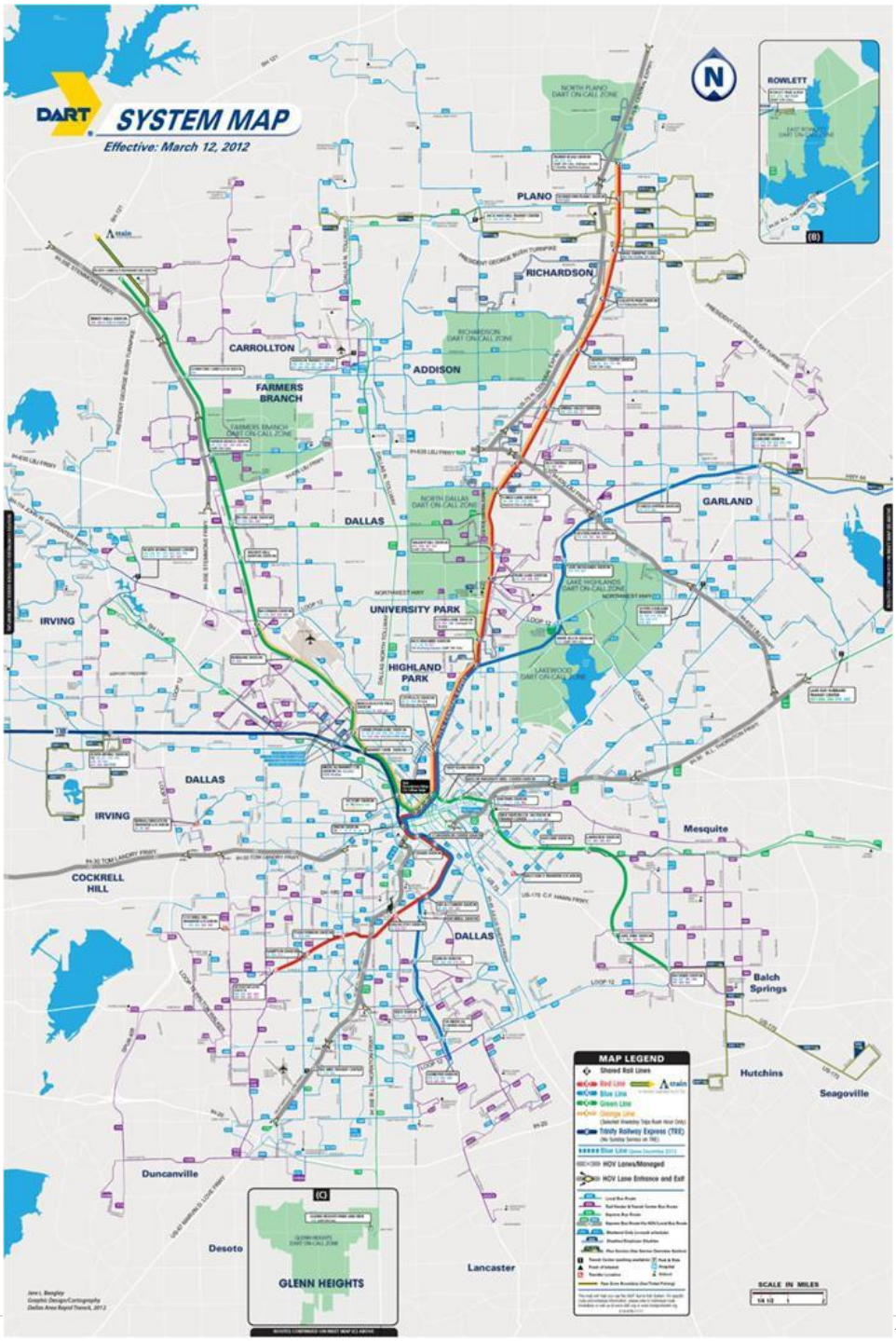
[7] For a complete list of providers on each of these maps, refer to Appendix D.

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

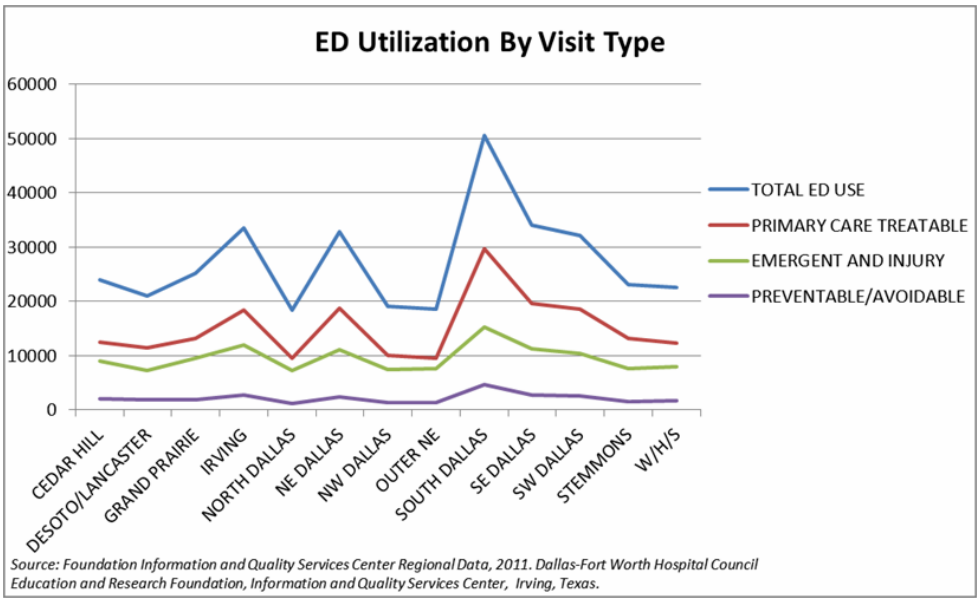
ED Usage by Community, Case Type and Payer

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.

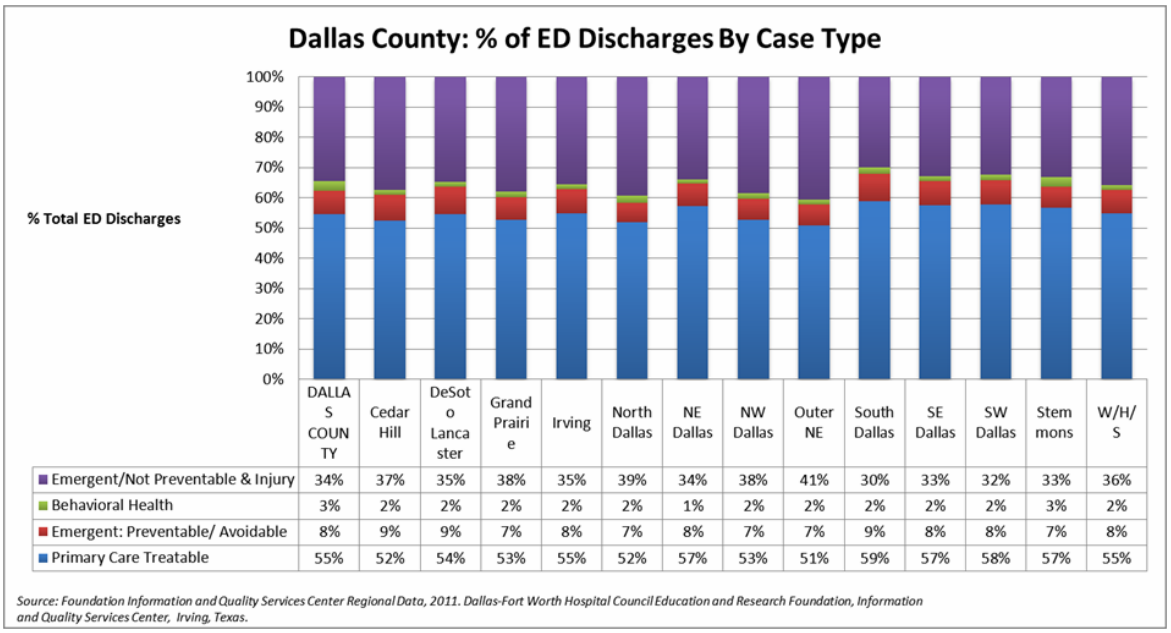
Figure 4.13



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

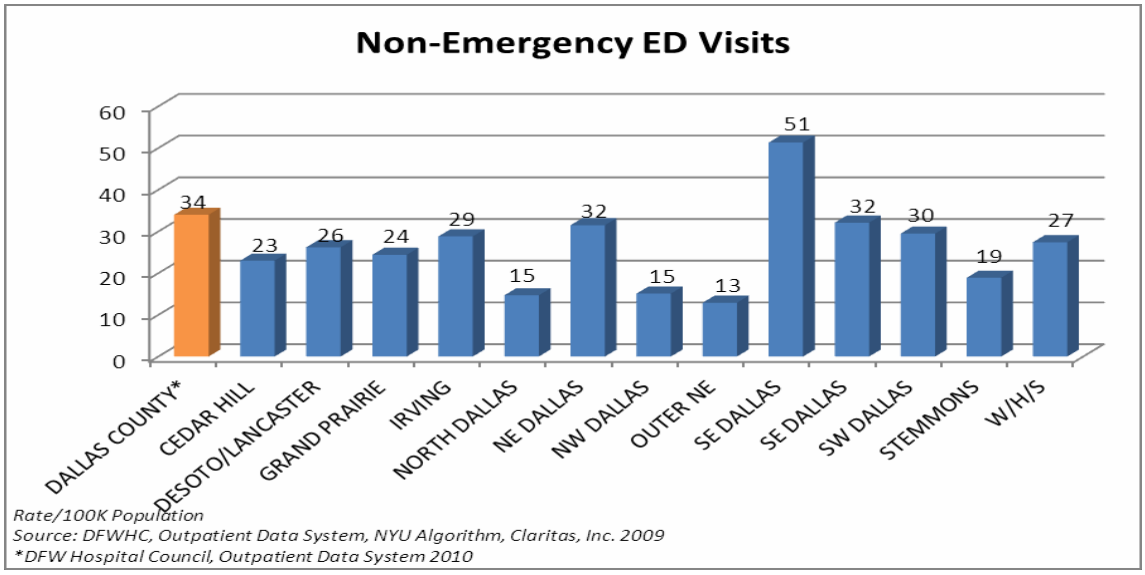


	DALLAS COUNTY	Cedar Hill	DeSoto Lancaster	Grand Prairie	Irving	North Dallas	NE Dallas	NW Dallas	Outer NE	South Dallas	SE Dallas	SW Dallas	Stemmons	W/H/S
Emergent/Not Preventable & Injury	34%	37%	35%	38%	35%	39%	34%	38%	41%	30%	33%	32%	33%	36%
Behavioral Health	3%	2%	2%	2%	2%	2%	1%	2%	2%	2%	2%	2%	3%	2%
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.

Figure 4.16

- 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%)

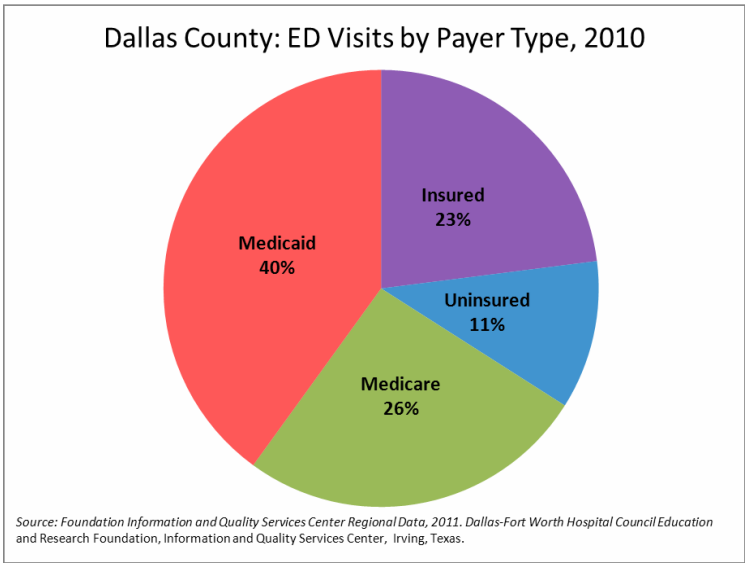
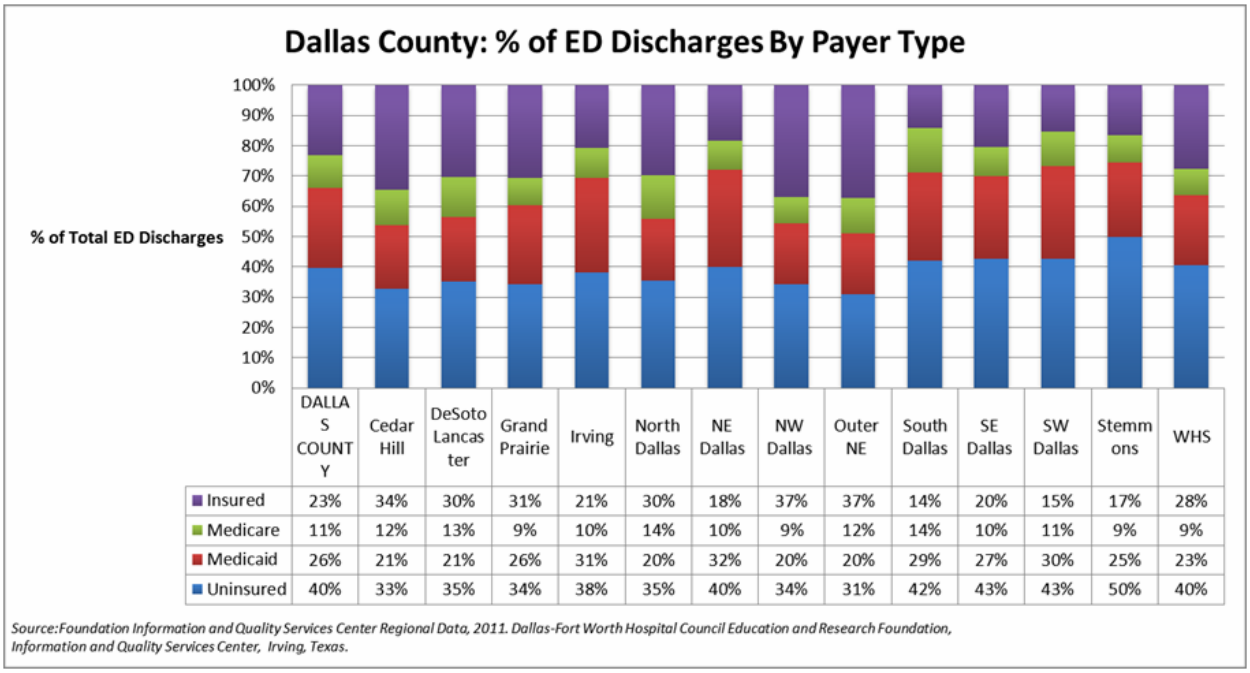


Figure 4.17



	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*	rker per 100K Population	Workforce Supply Total	Ratio of Population per Worker*	rker per 100K Population	Workforce Supply Total	Ratio of Population per Worker*	rker 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/ch s/hprc/health.sh tm												

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 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.

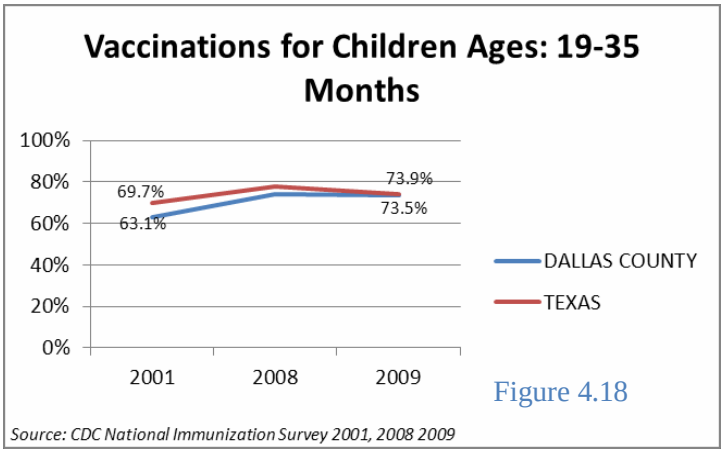


Figure 4.18

Table 4.6

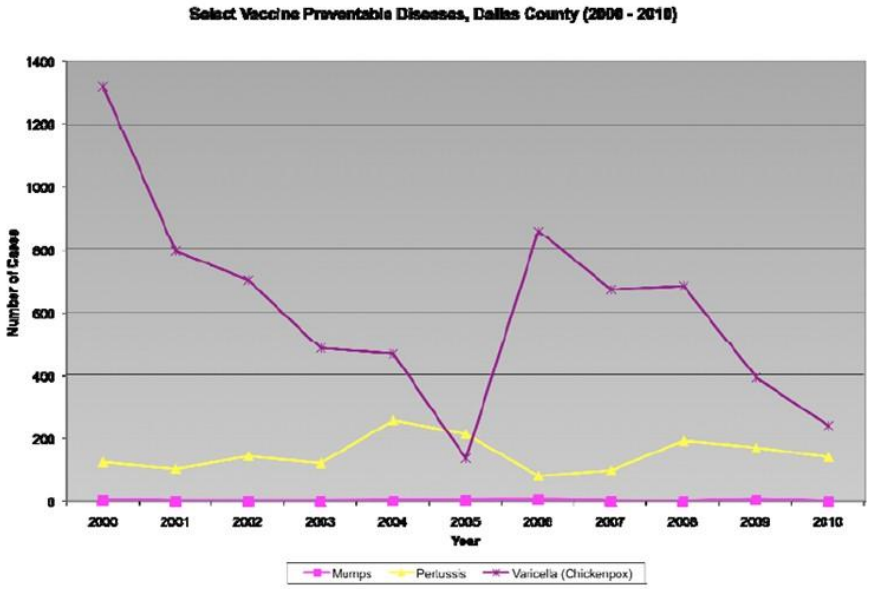
indergarten Immunization Status Fall 2007-2011										
Year	**DTP/ DTaP/ DT/Td**	**Hep A**	**Hep B**	**MMR 2 doses**	**Polio**	**Varicella 2 doses**	**asles 1**	**asles 2**	**Mumps**	**Rubella**
2011	98.2%	98.2%	99.0%	98.7%	98.6%	98.1%	n/a	n/a	n/a	n/a
2010	97.4%	97.6%	98.5%	98.0%	98.6%	98.1%	n/a	n/a	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



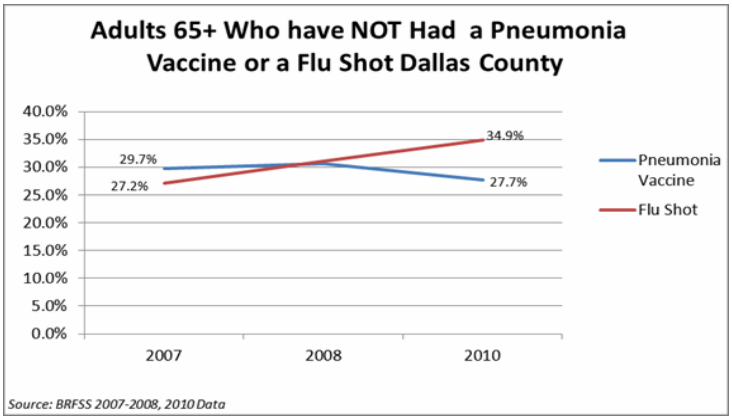
Vaccine Preventable Diseases have been declining overall in Dallas County. No outbreaks of pertussis have been reported in Dallas County in 2010.

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.

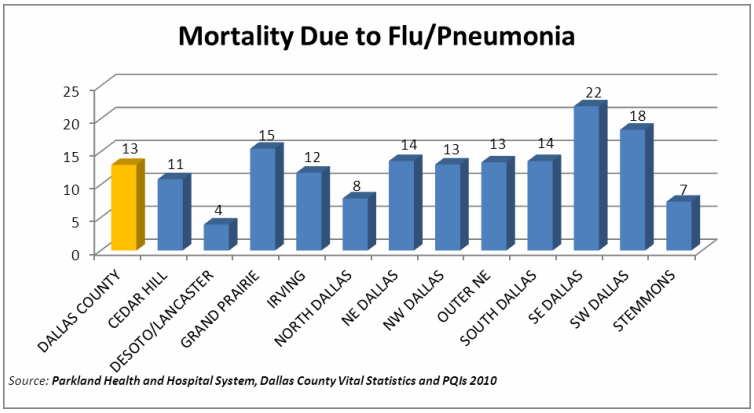


Mortality due to Flu/Pneumonia

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

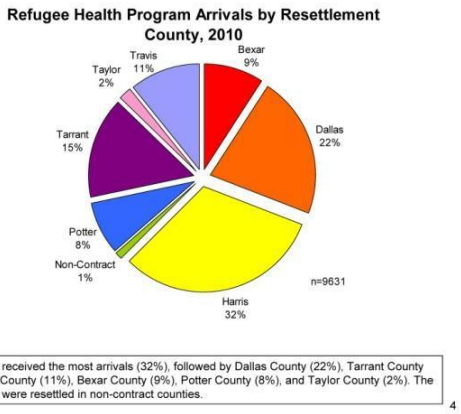


Figure 4.23

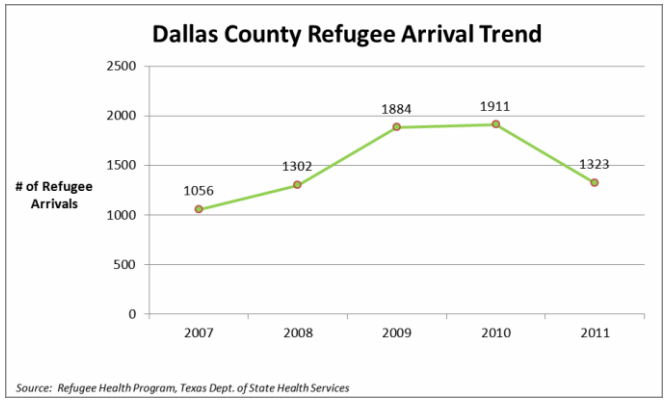
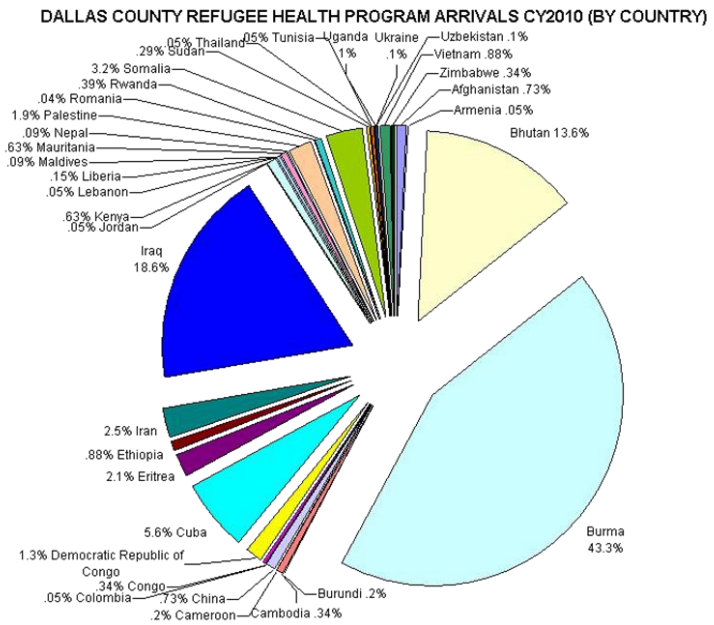


Figure 4.24

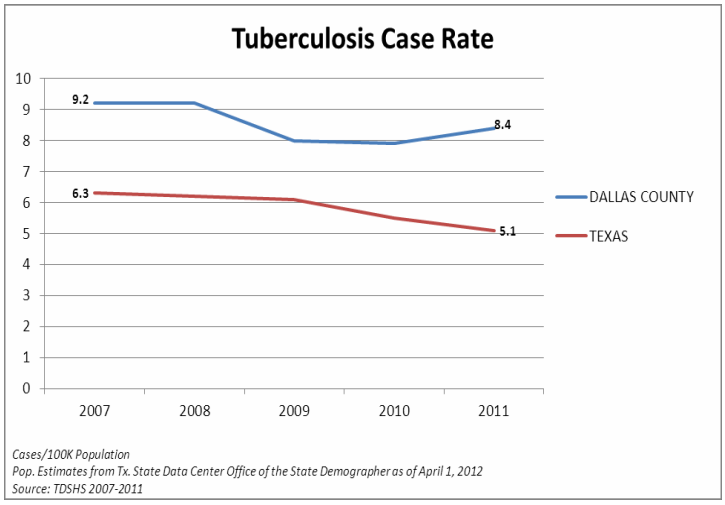


Tuberculosis

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

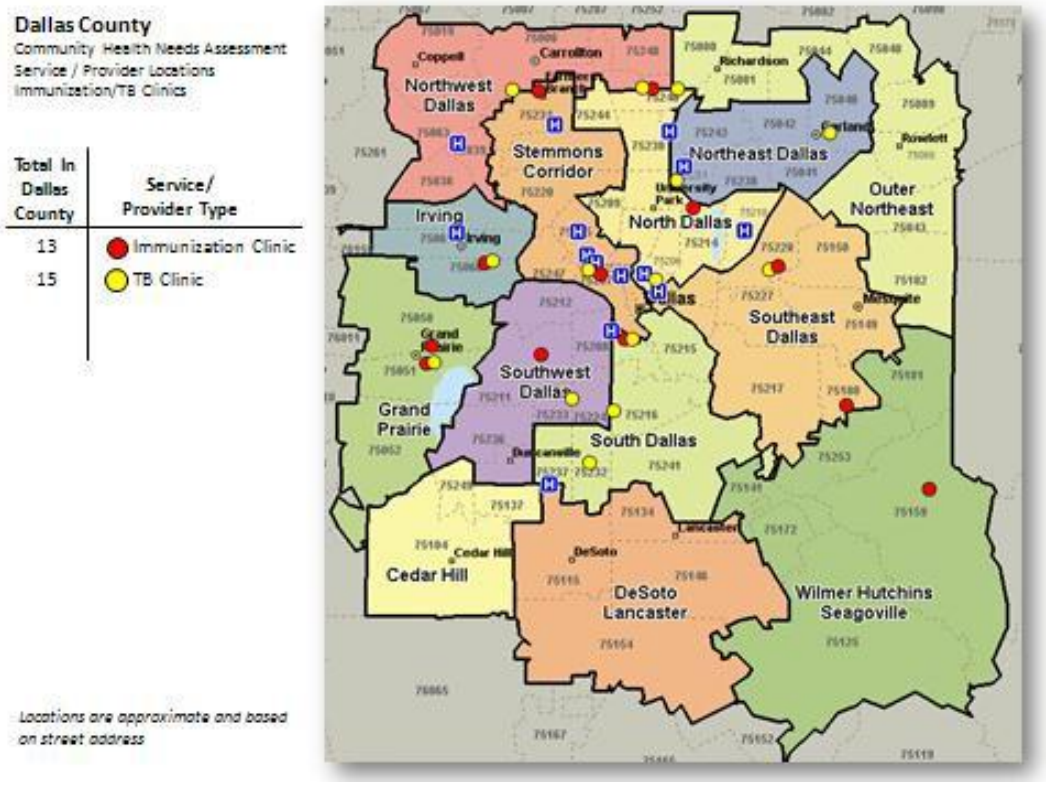


Locations of DCHHS Immunization and TB Clinics

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 Epidemi- ology Division Summary."

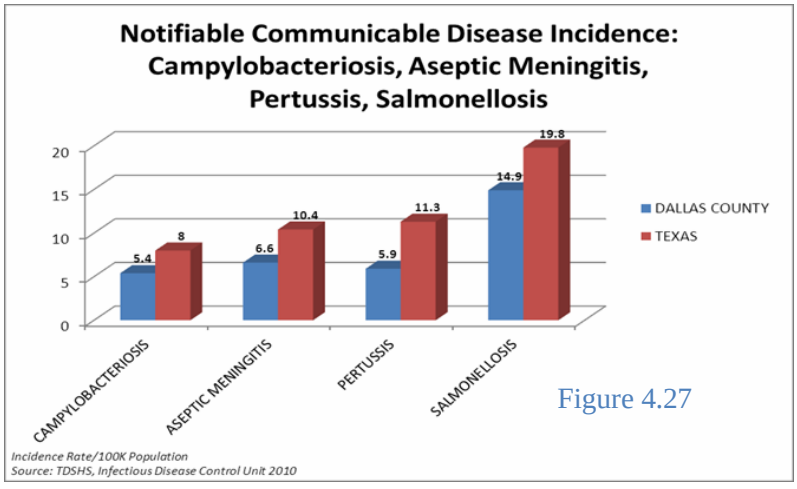
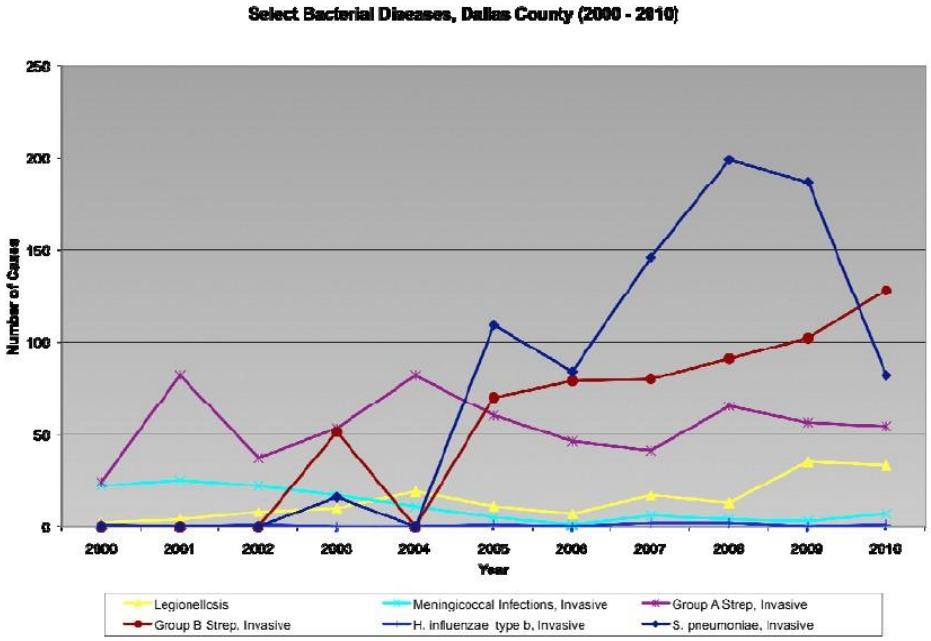


Figure 4.27

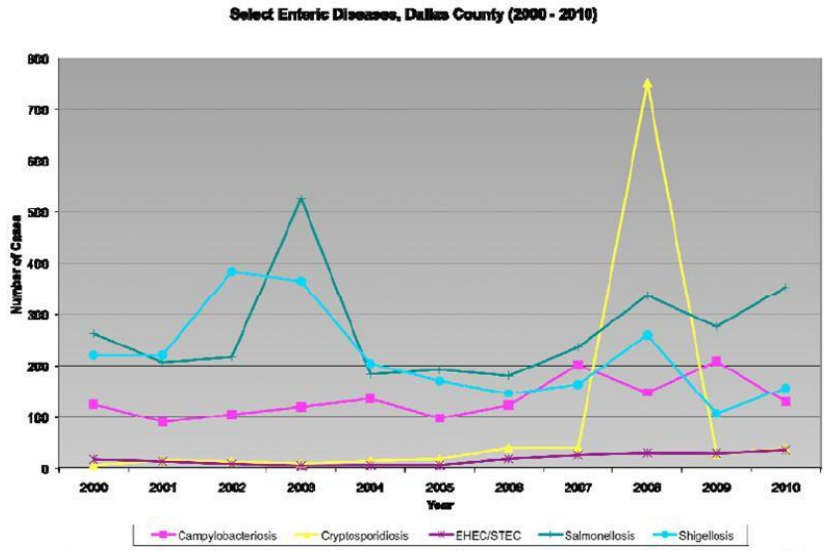
Figure 4.28

Communicable Disease Epidemiology: Mandatory Reportable Conditions 2000-2010



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

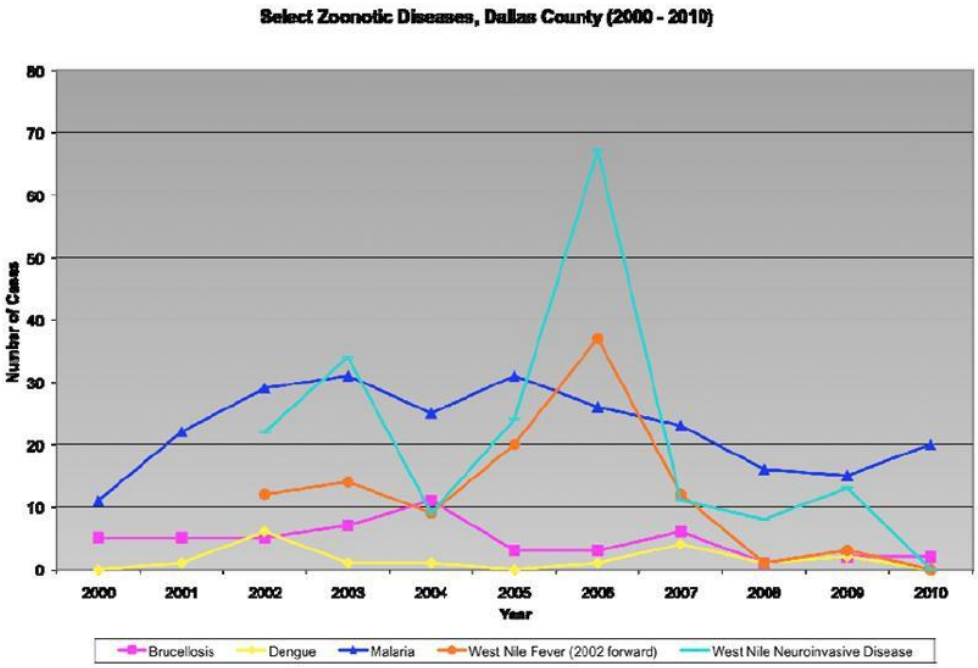
Figure 4.29



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 osquito 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

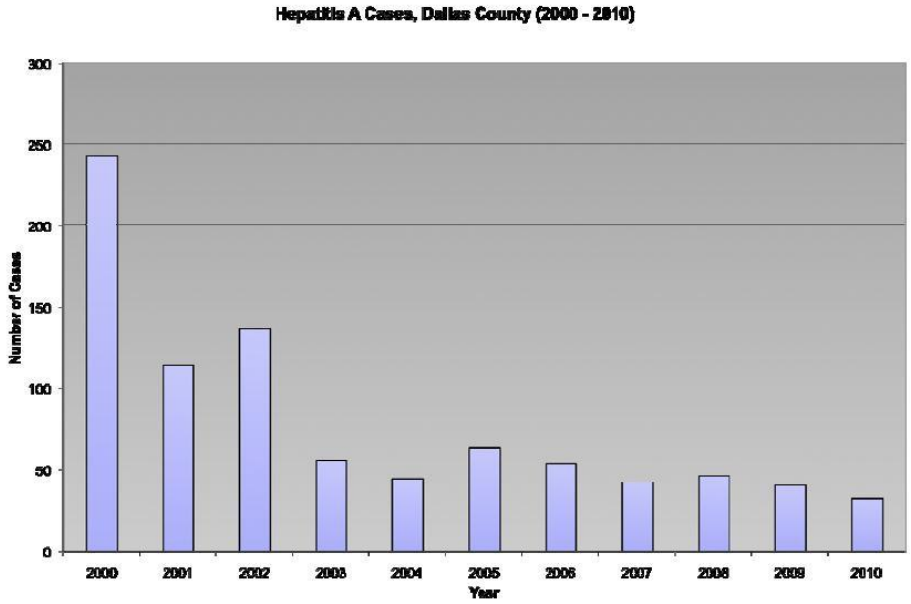
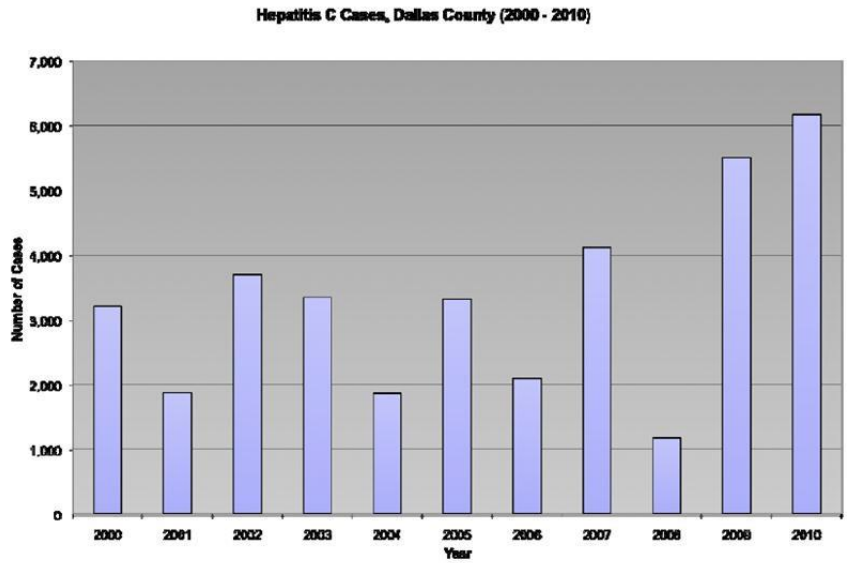


Figure 4.32



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

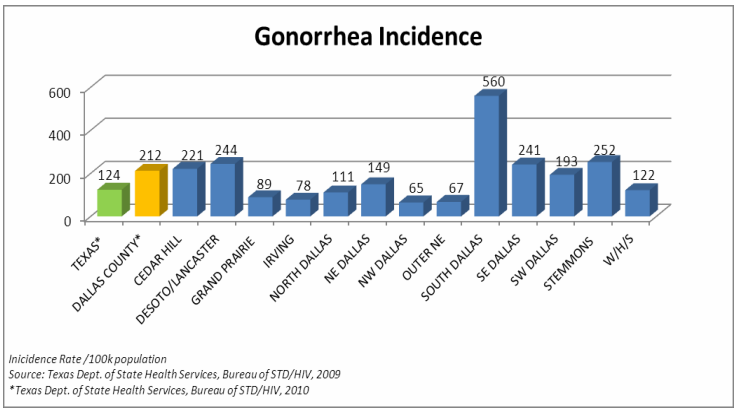
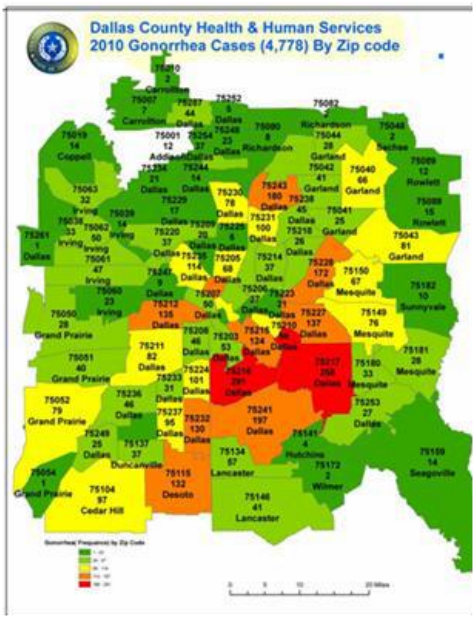


Figure 4.34



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.

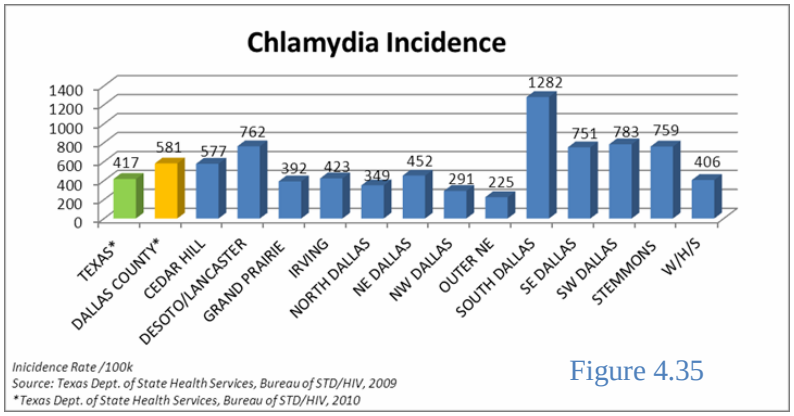


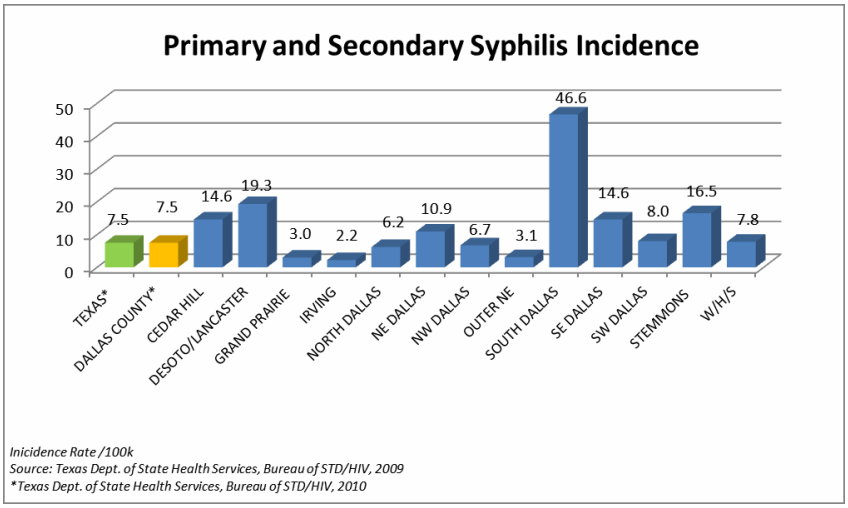
Figure 4.35

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



Inicidence Rate /100k
Source: Texas Dept. of State Health Services, Bureau of STD/HIV, 2009
**Texas Dept. of State Health Services, Bureau of STD/HIV, 2010*

Figure 4.37

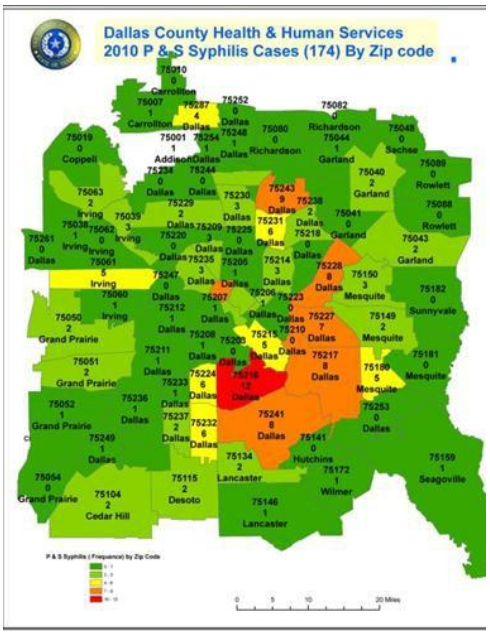
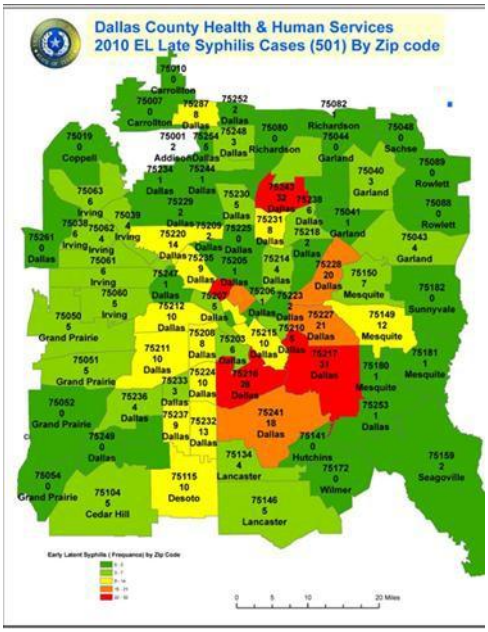


Figure 4.38



HIV/AIDS

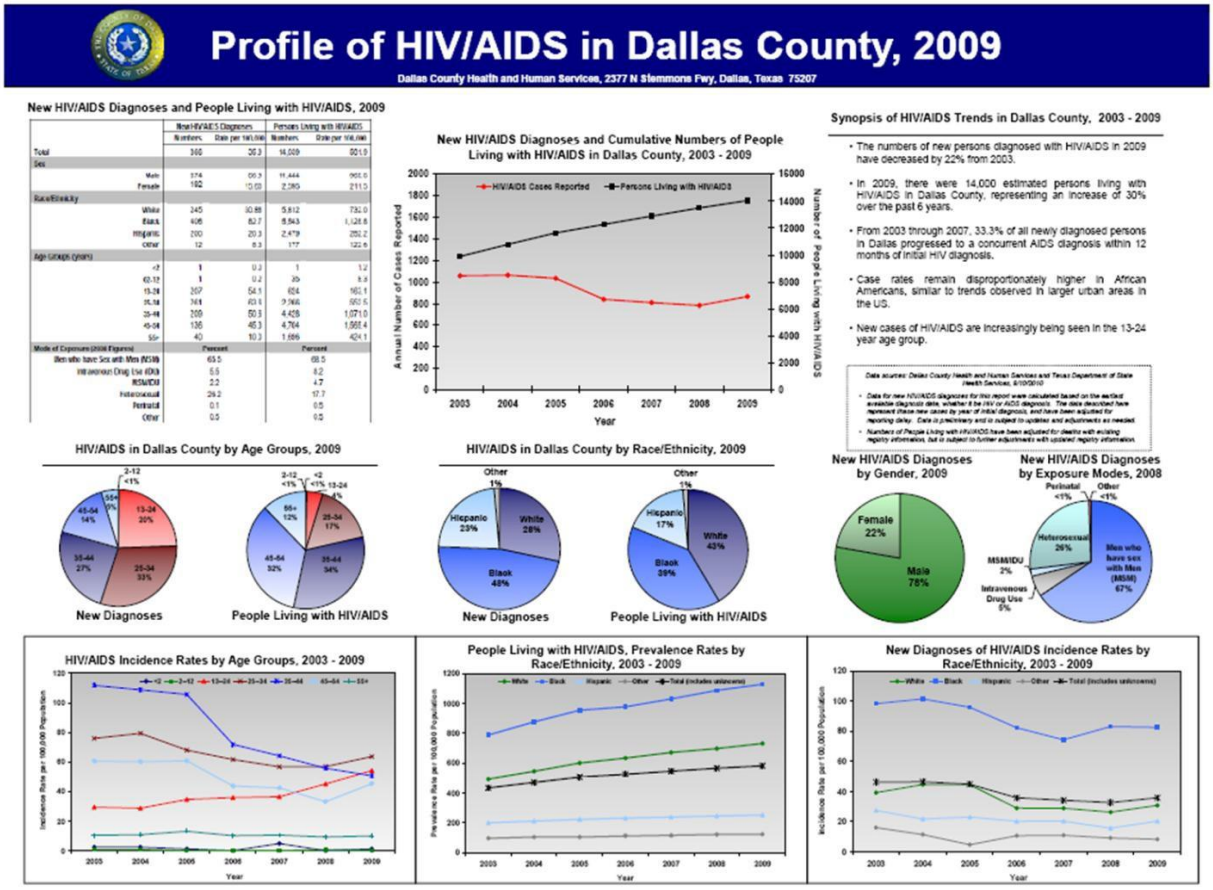
The number of people living with HIV/AIDs in Dallas County is increasing, with over 14,000 residents living with the disease in 2009.

- 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%
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%
Men who have sex with Men (MSM) 67%
MSM/IDU 2%
Intravenous Drug Use 5%
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

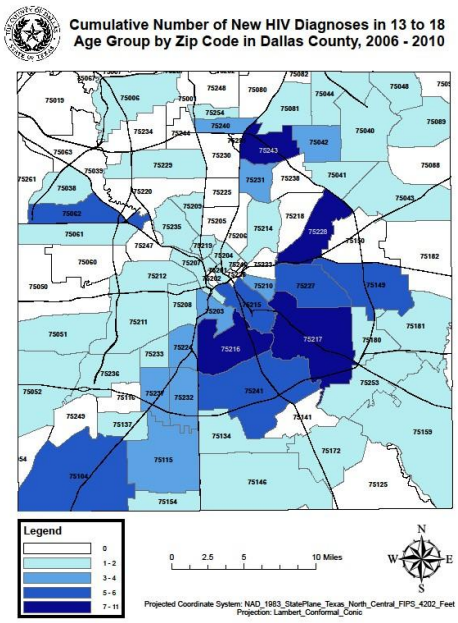


Figure 4.41

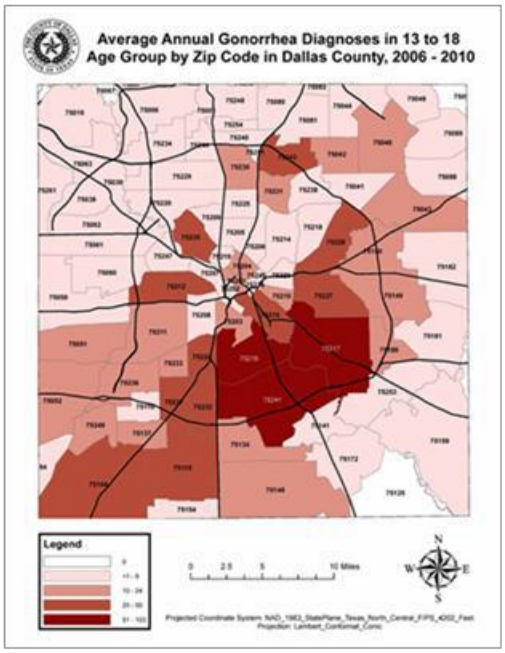


Figure 4.42

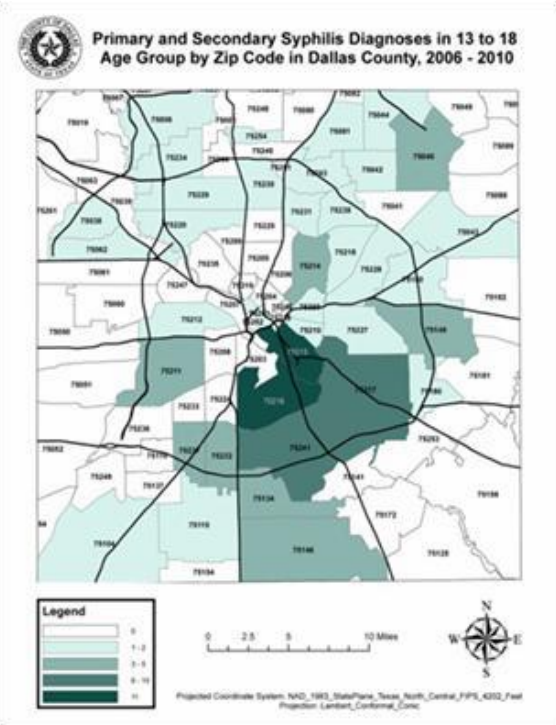
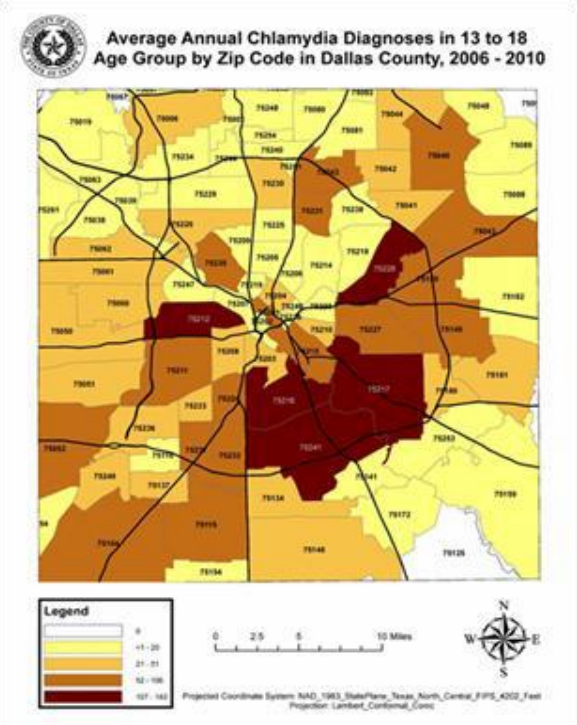


Figure 4.43



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.
2. Community-based organizations, including churches, should work with each other and with parents to encourage consent for student participation in school STD/HIV education.
3. 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.
4. Analyze findings and publicly report them. Consider reporting to School Health Advisory Councils (SHACs), School Boards, and Superintendents; and share findings with DCHHS.
5. 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

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

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).

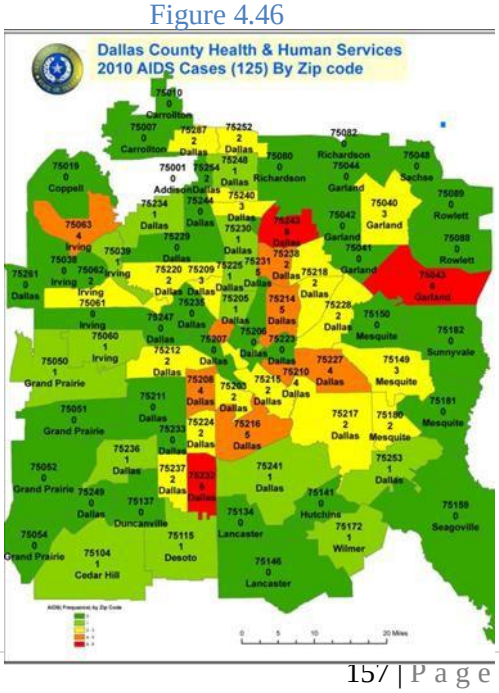
STD Risk Factors

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

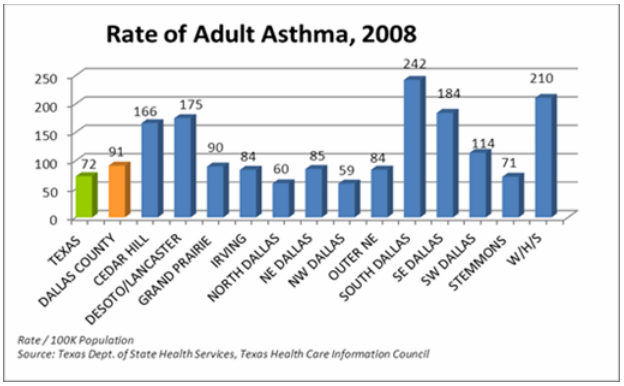
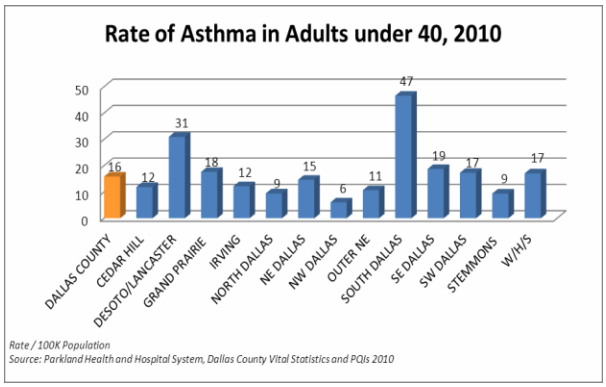


Figure 4.48



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 4.51

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

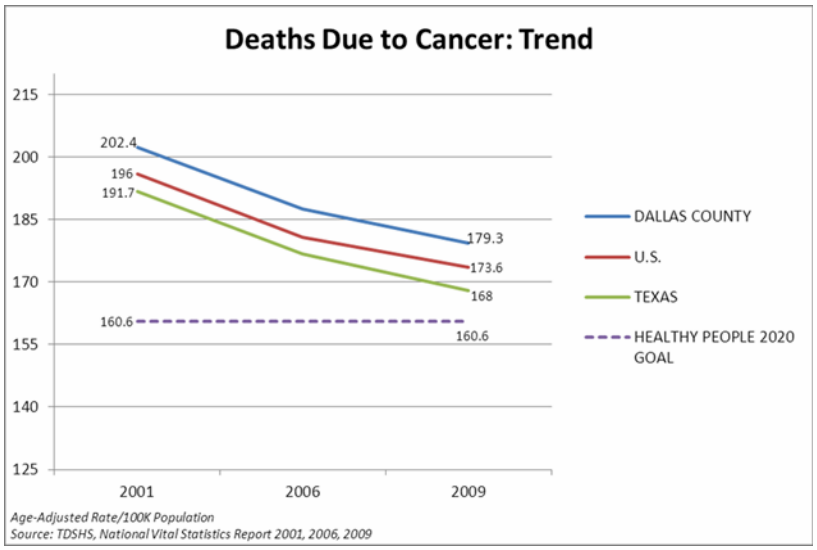
Cancer mortality is declining in Dallas County. Additional screening, healthy lifestyles and interventions targeting residents with socioeconomic disparities are needed to further reduce mortality and achieve the Healthy People 2020 goal.

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.

Figure 4.50



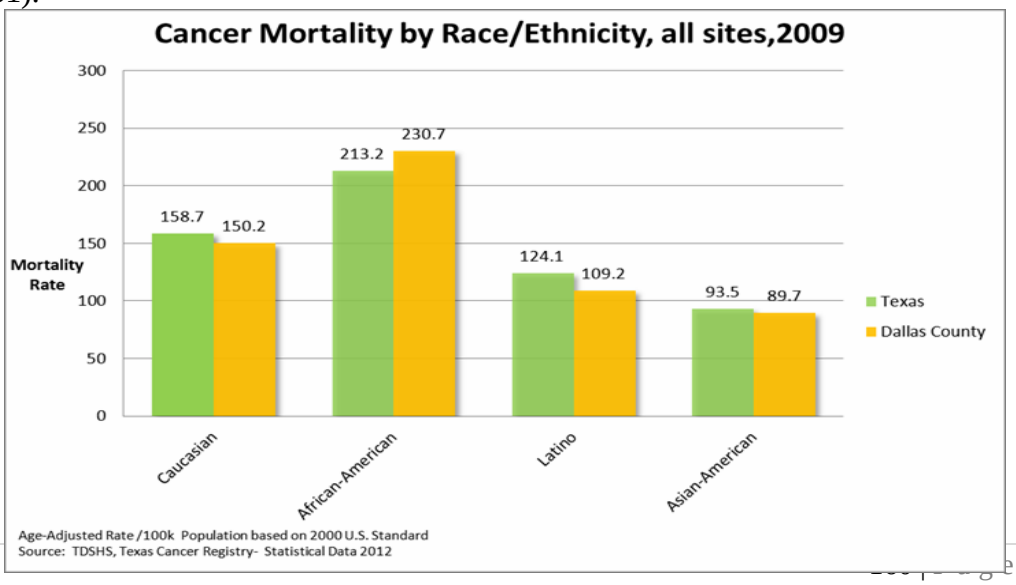
Between 2001 and 2009, cancer deaths declined in Dallas County, Texas and the U.S. (Figure 4.50)

- 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.

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

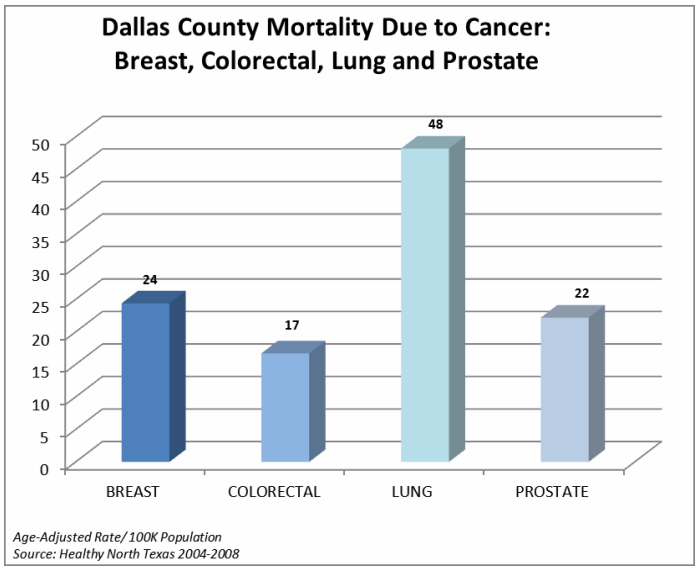


Mortality by Cancer Site

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

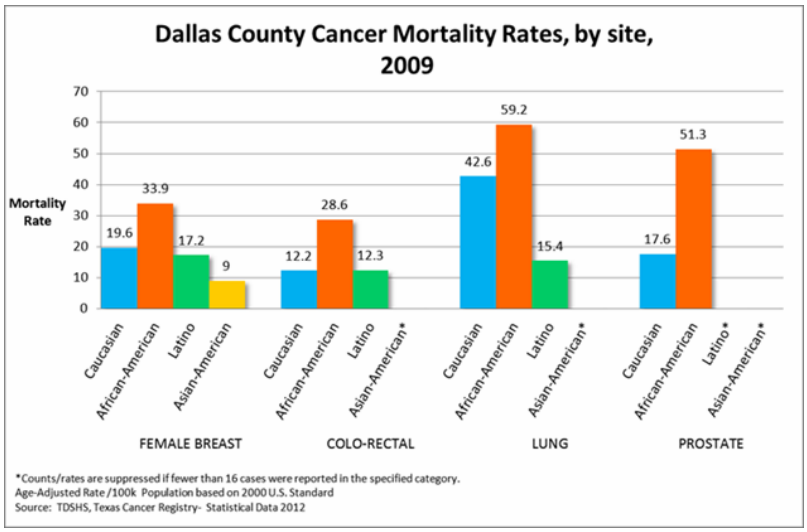
- With 48 deaths/100,000 Dallas County residents between 2004 and 2008, lung cancer had the highest AAMR of all cancers.
- Breast cancer follows with half the number of deaths, 24/100,000.
- Prostate was third with 22 deaths/100,000.



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).

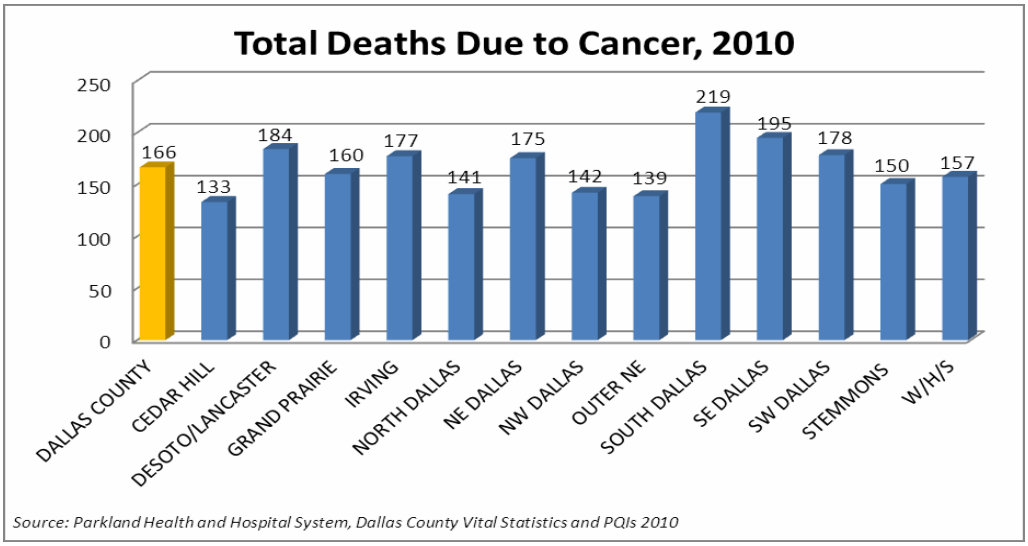
Figure 4.53



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

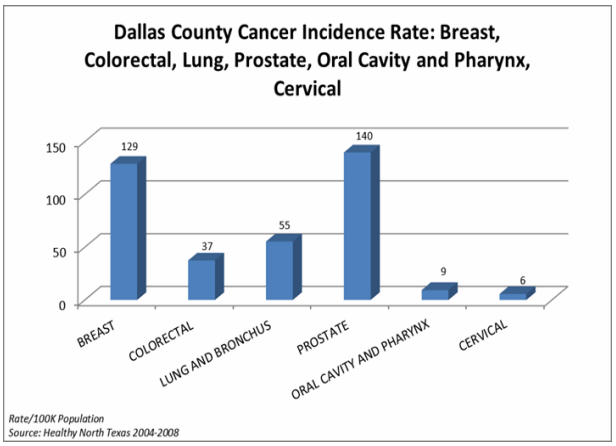
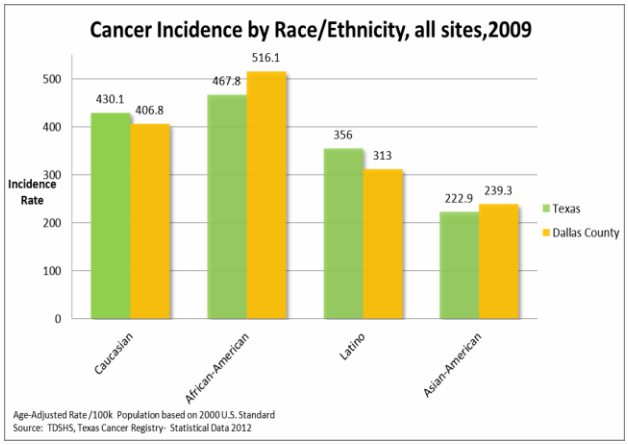


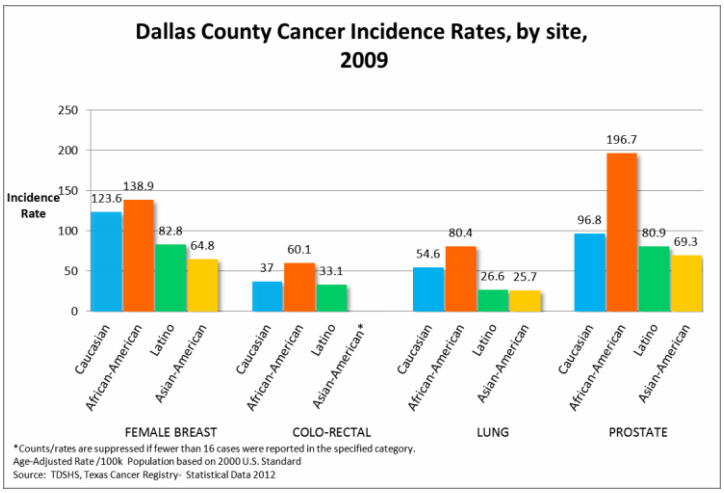
Figure 4.56



- 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



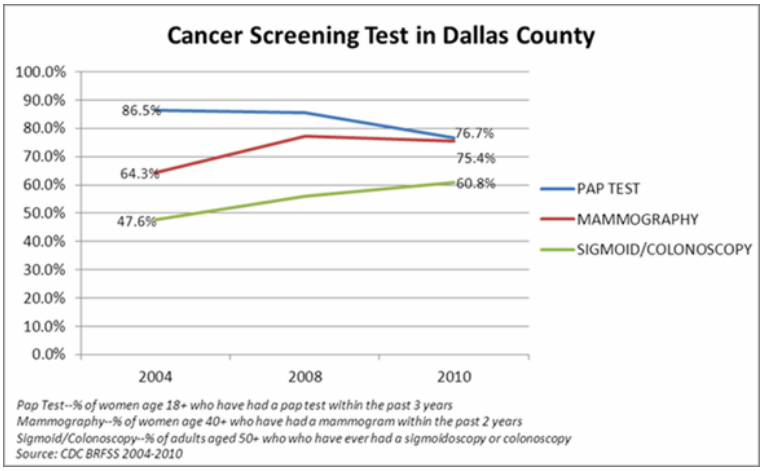
- Breast cancer had the highest incidence among both Caucasians and Latinos, 123.6/100,000 and 82.8/100,000, respectively (Figure 4.57).

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:

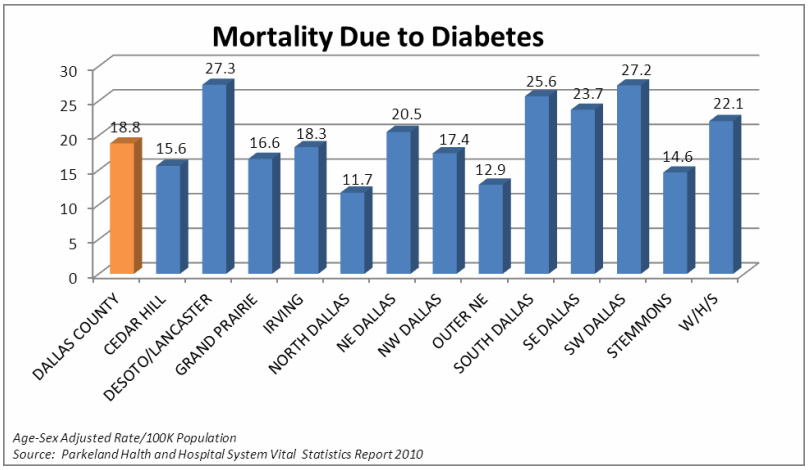
- Obesity
- Lack of physical activity
- Family history
- Environmental resources including such things as the availability of wholesome food, healthcare access and recreational availability.

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:

Figure 4.59



- 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 4.60

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.

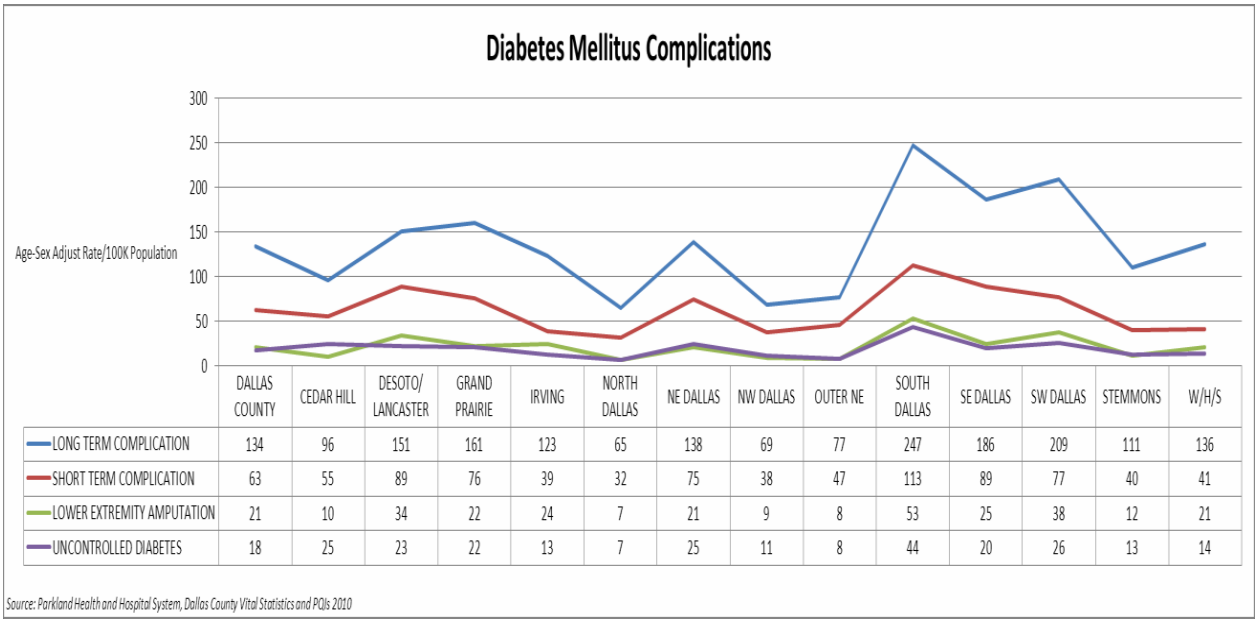
DIABETES		
PQI Rates per 100K, risk-adjusted	*Dallas County vs. Healthy People 2020 Target*[1]	*Dallas County Trend*[1]
Diabetes Short Term Complications		
Diabetes Long Term Complications		
Diabetics' Lower Extremity Amputations		
Uncontrolled Diabetes		

[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

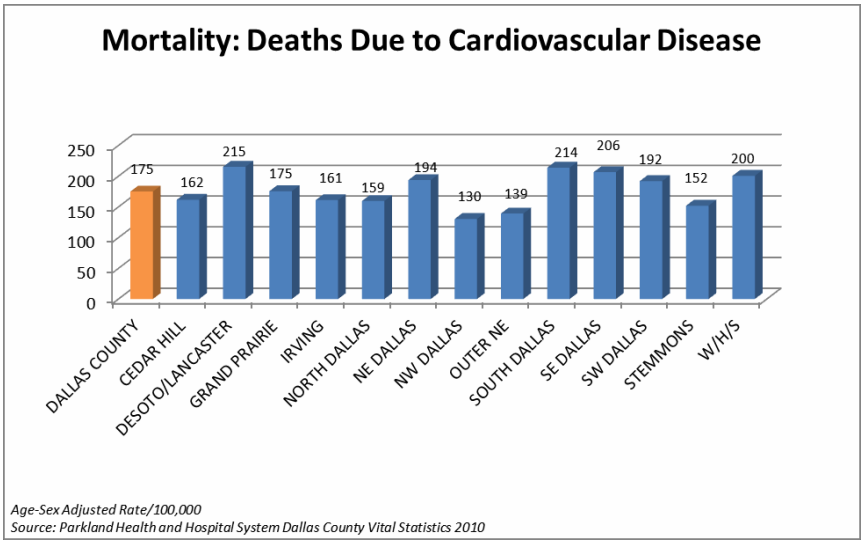
Heart disease is the leading cause of death in the United States and Dallas County.

- 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

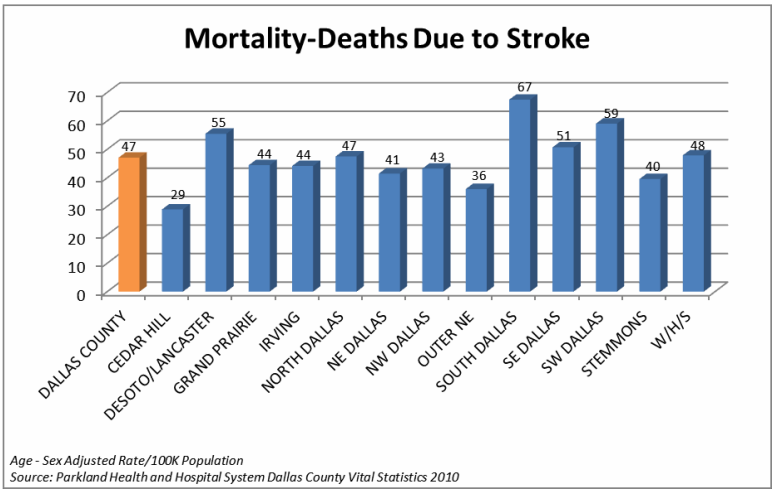


Stroke

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).

Figure 4.63



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).

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).

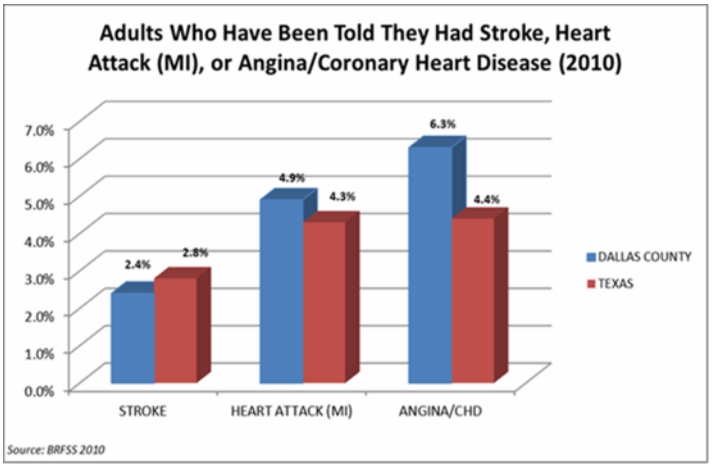
Heart Disease

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:

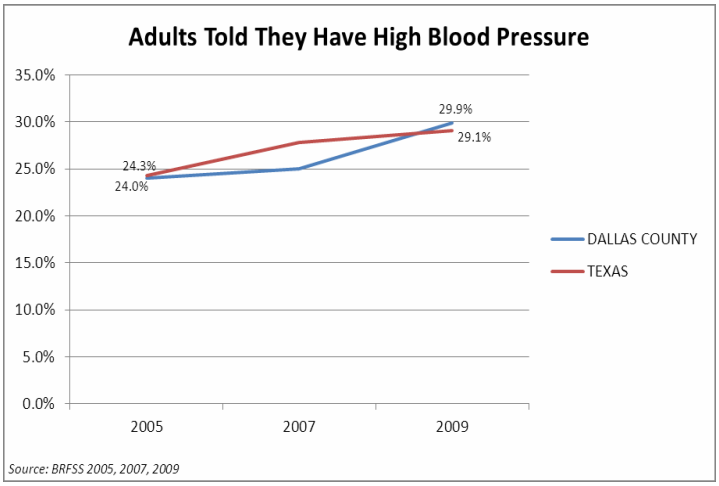
- A smaller percentage of Dallas County residents had been told they had a stroke than Texas residents.
- A greater percentage of Dallas County residents had been told they had heart attacks and angina than residents statewide (Figure 4.64).

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:

- 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

Figure 4.65



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

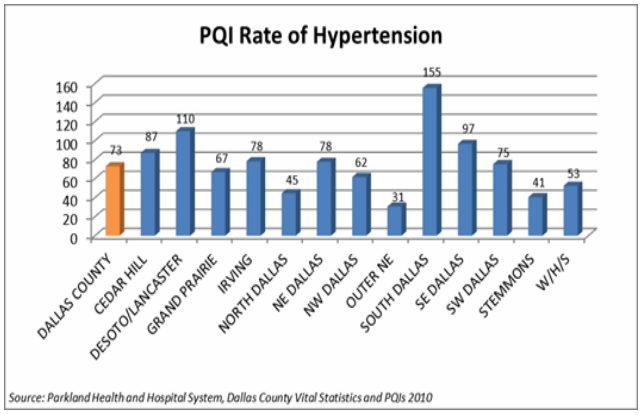
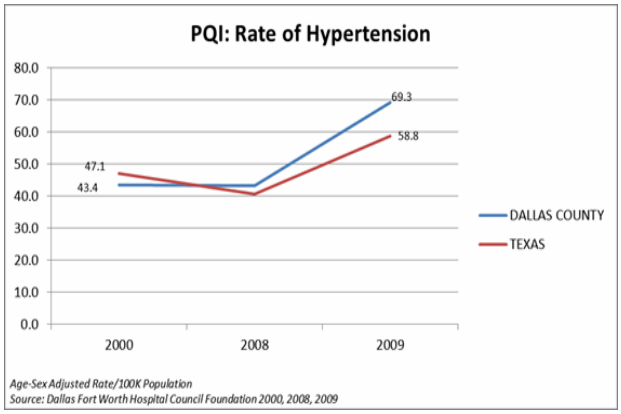


Figure 4.67



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

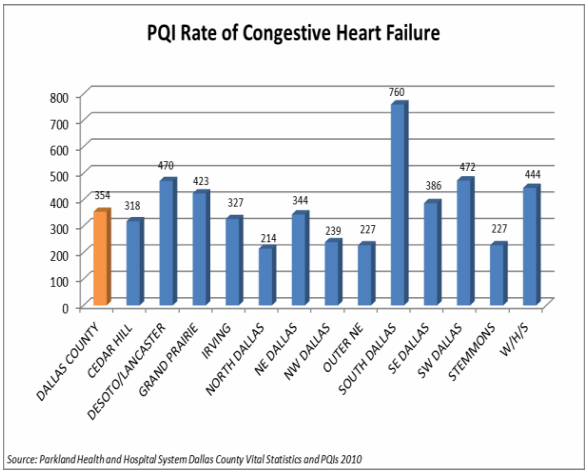
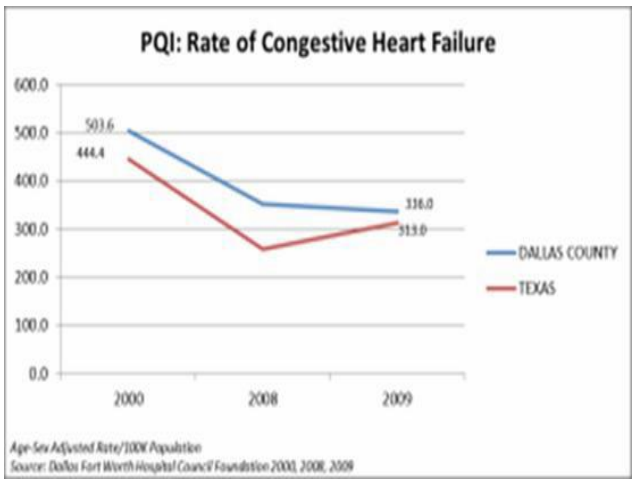


Figure 4.69



- 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

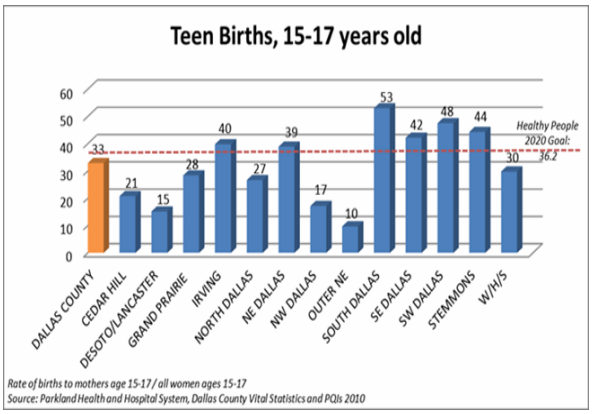
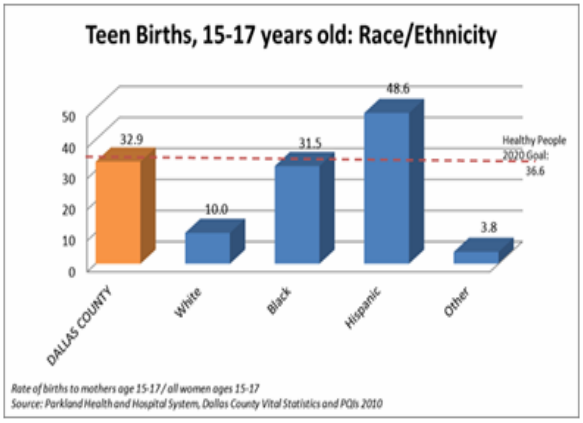
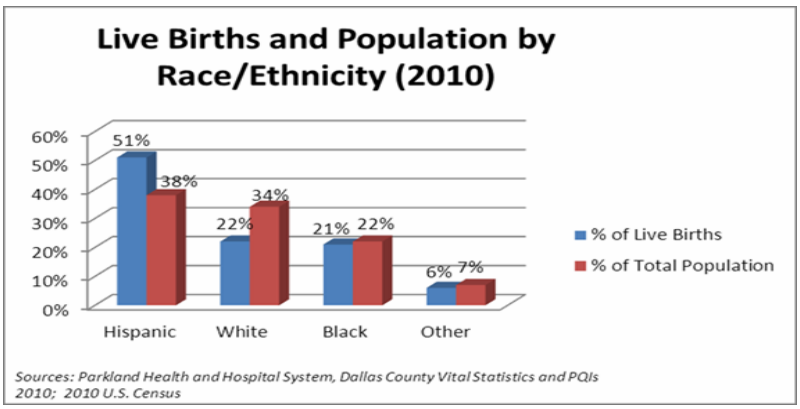


Figure 4.72



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

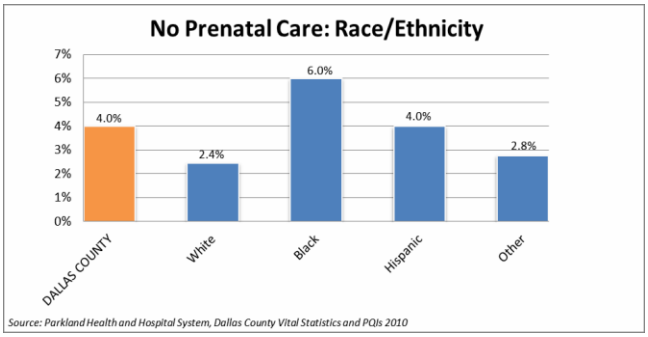
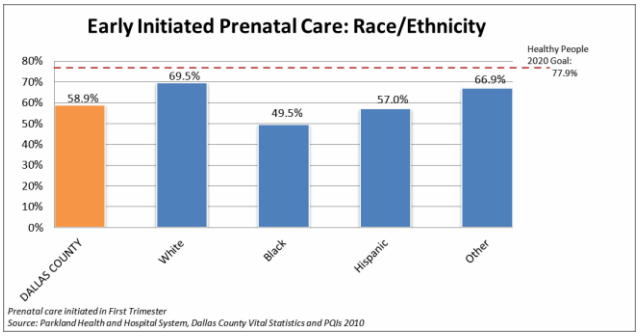


Figure 4.75



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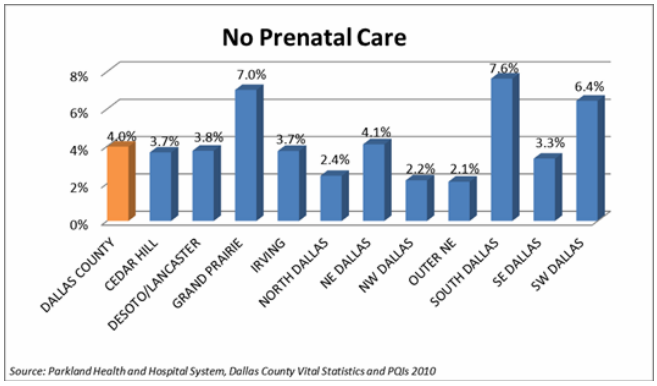

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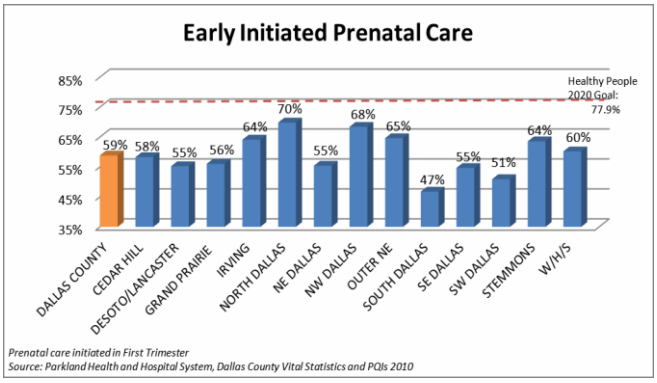


Ratings of Maternal-Fetal Health

<u>Dallas County Very Low Birth Weight Percentage</u>:

- 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.

<u>Dallas County Infant Mortality Rate</u>:

- 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

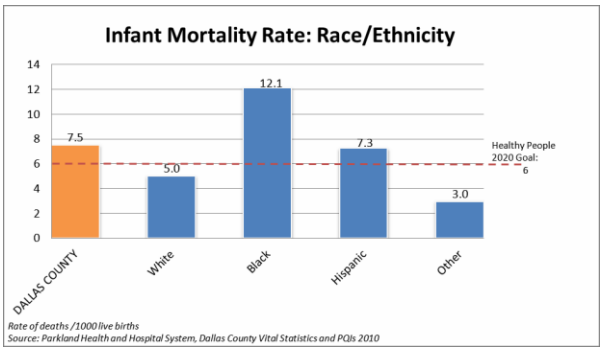


Figure 4.80

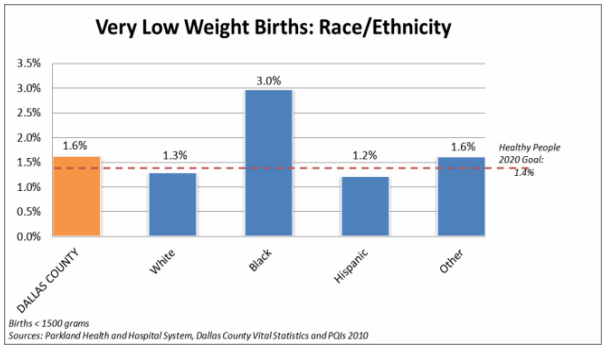


Figure 4.81

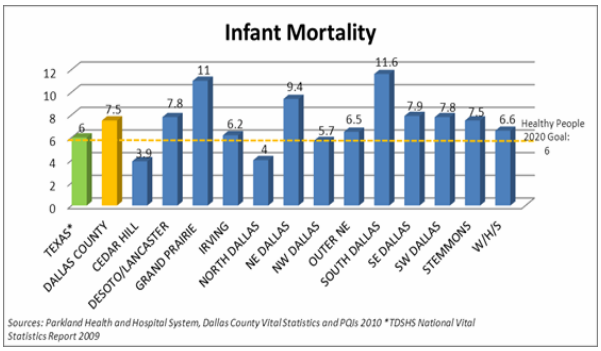
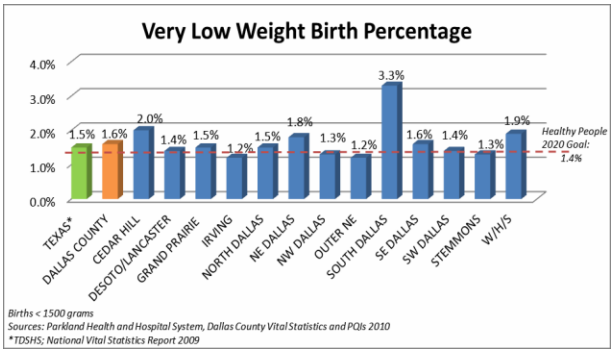


Figure 4.82



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

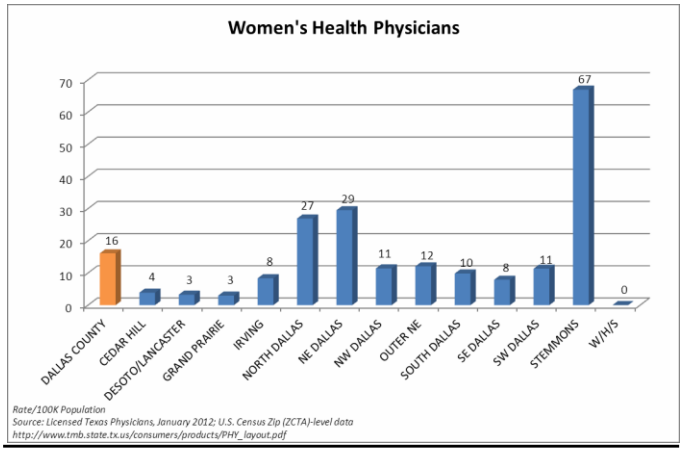
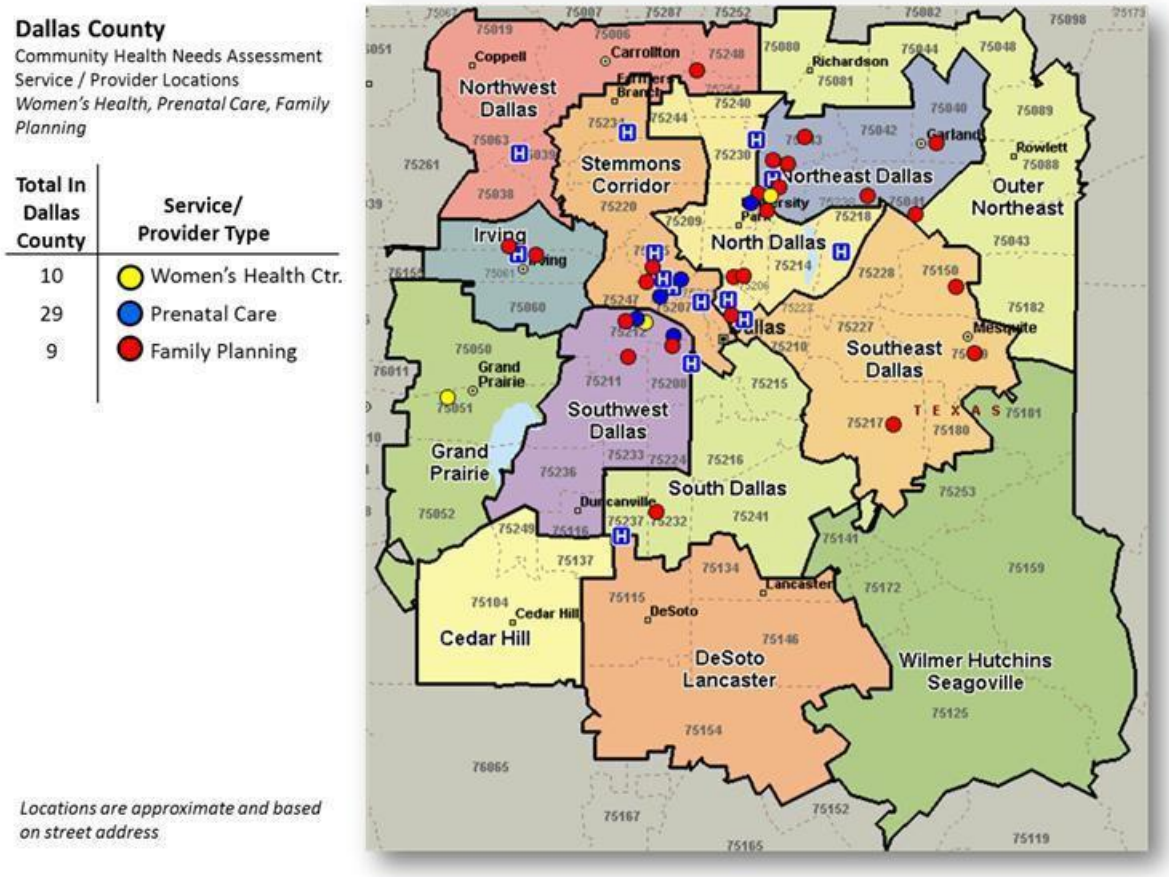


Figure 4.84



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:

- 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).

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			

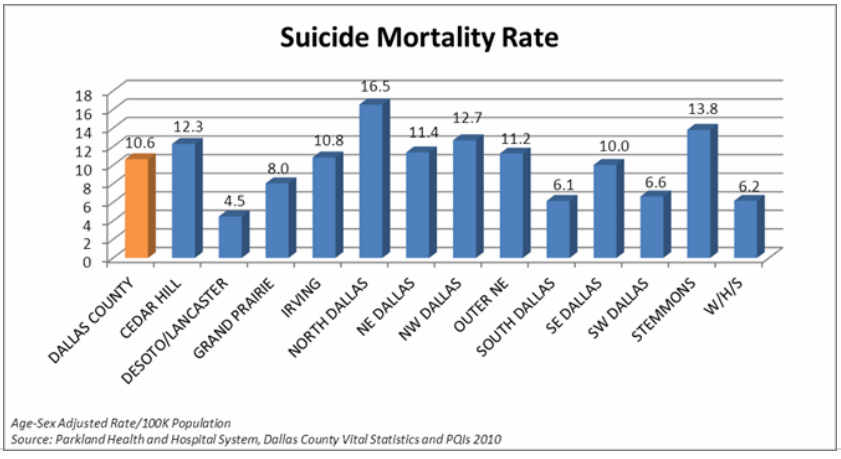
[1] Dallas County Community Dashboard Parkland Health and Hospital System, 2011

[2] Healthy North Texas Community Dashboard, 2012

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

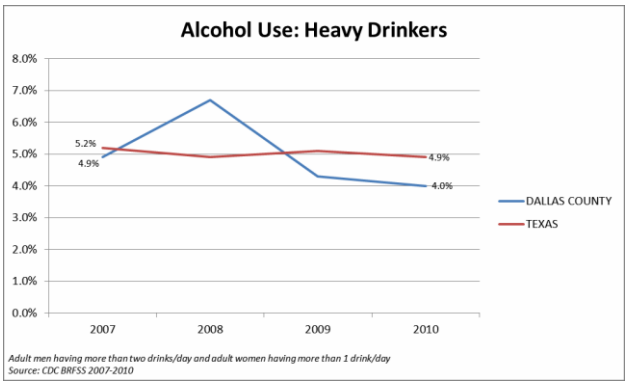
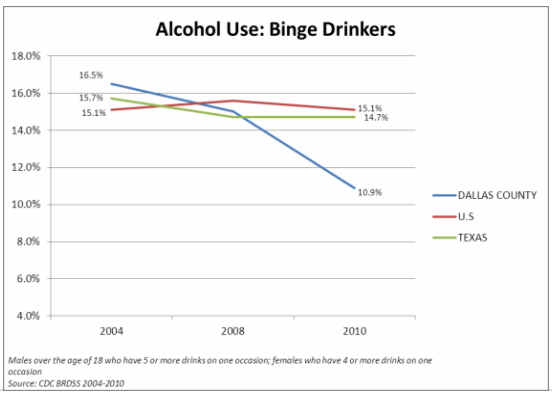


Figure 4.88



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.

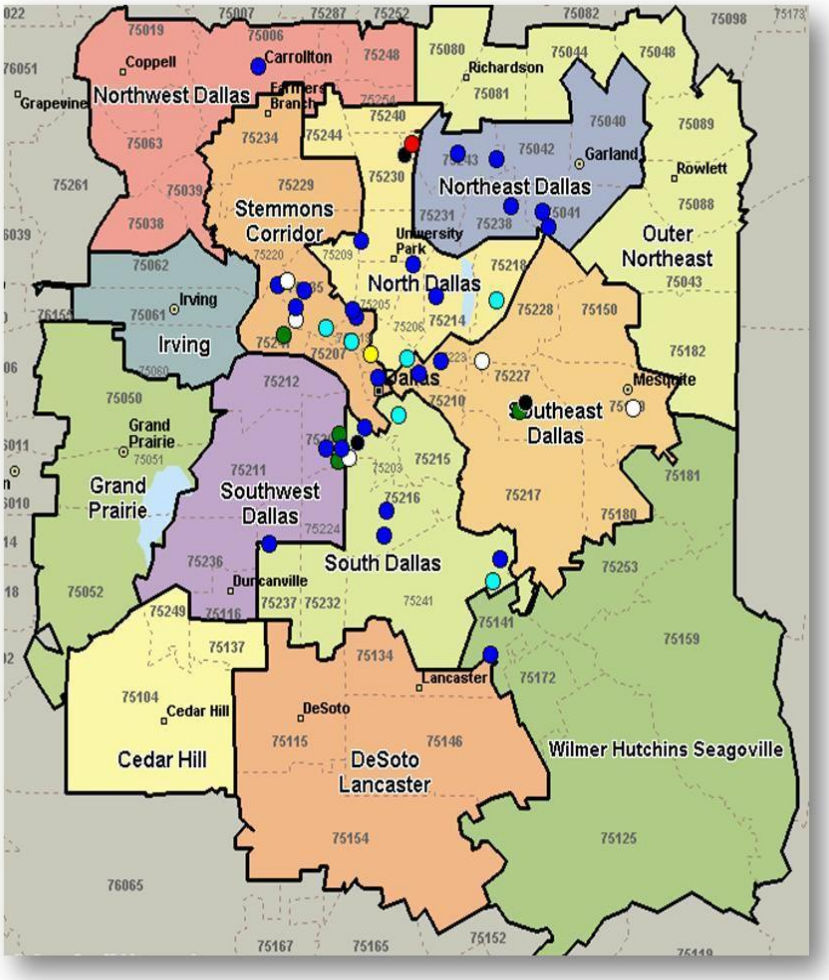
The majority of providers are located in central Dallas. Few or no providers are found in the farthest outlying communities including: Outer NE Dallas, Wilmer Hutchins Seagoville, Cedar Hill, Grand Prairie, Irving.

Figure 4.89

Dallas County
Community Health Needs Assessment
Service / Provider Locations

Total In Dallas County	Service/ Provider Type
	Mental Health
5	Outpatient
	Substance Abuse
34	Outpatient
7	Residential
6	Outpatient & Residential
	Behavioral Health
3	Outpatient
1	Residential
1	Outpatient & Residential

Locations are approximate and based on street address



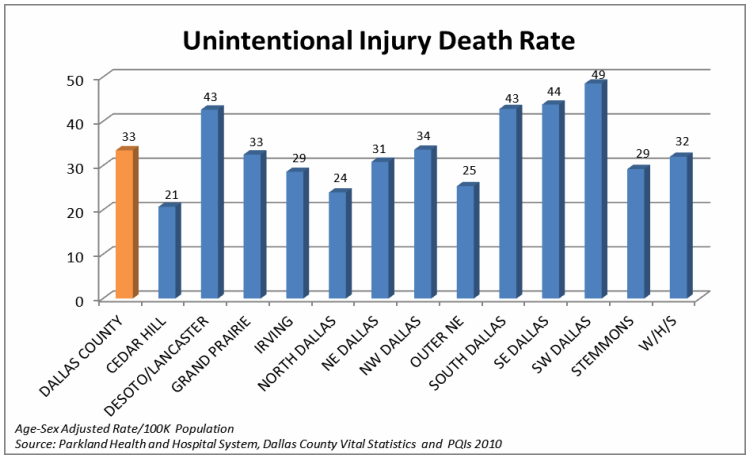
VIOLENCE AND INJURIES

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).

Figure 4.90



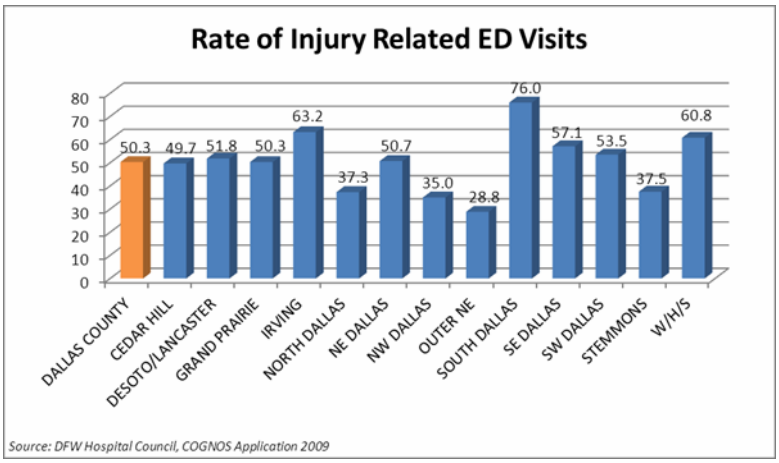
Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

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

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.

Figure 4.91



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).

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).

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).

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 4.92

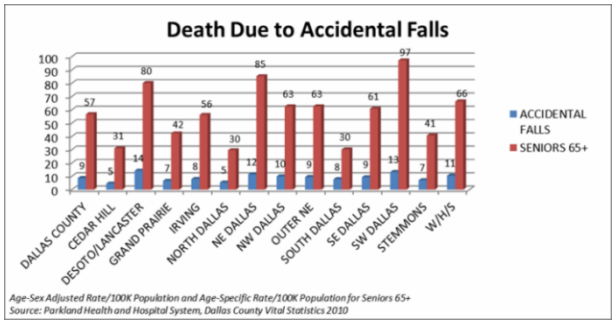


Figure 4.93

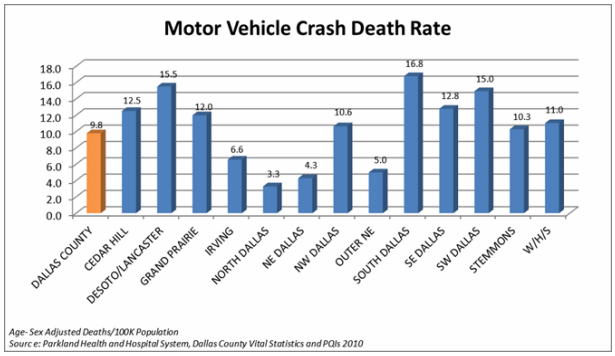
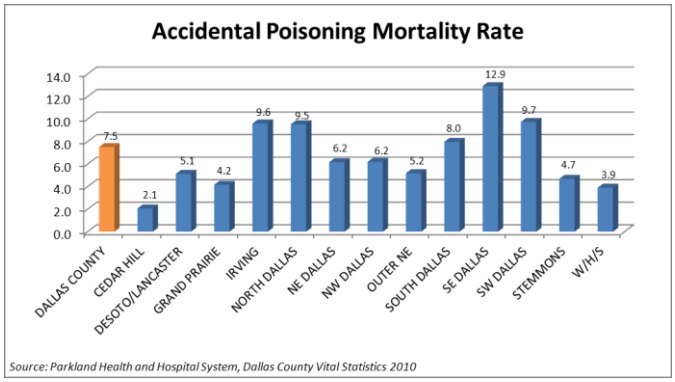


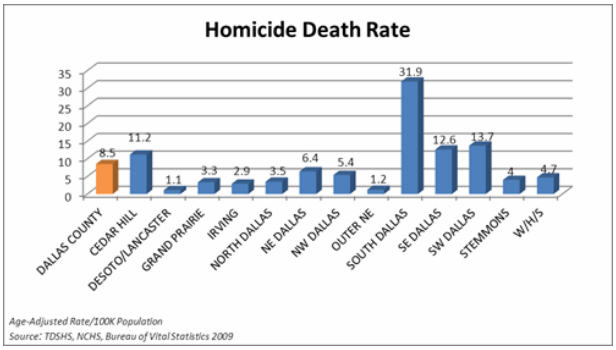
Figure 4.94



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

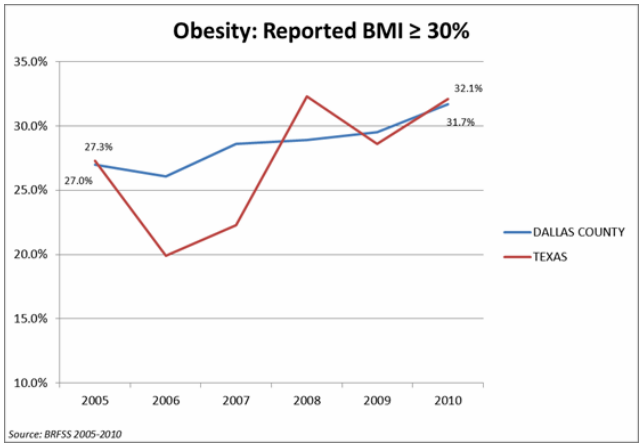
Diet and body weight are related to health status. A healthy diet reduces risks for many health conditions discussed in this report, including:

- 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.

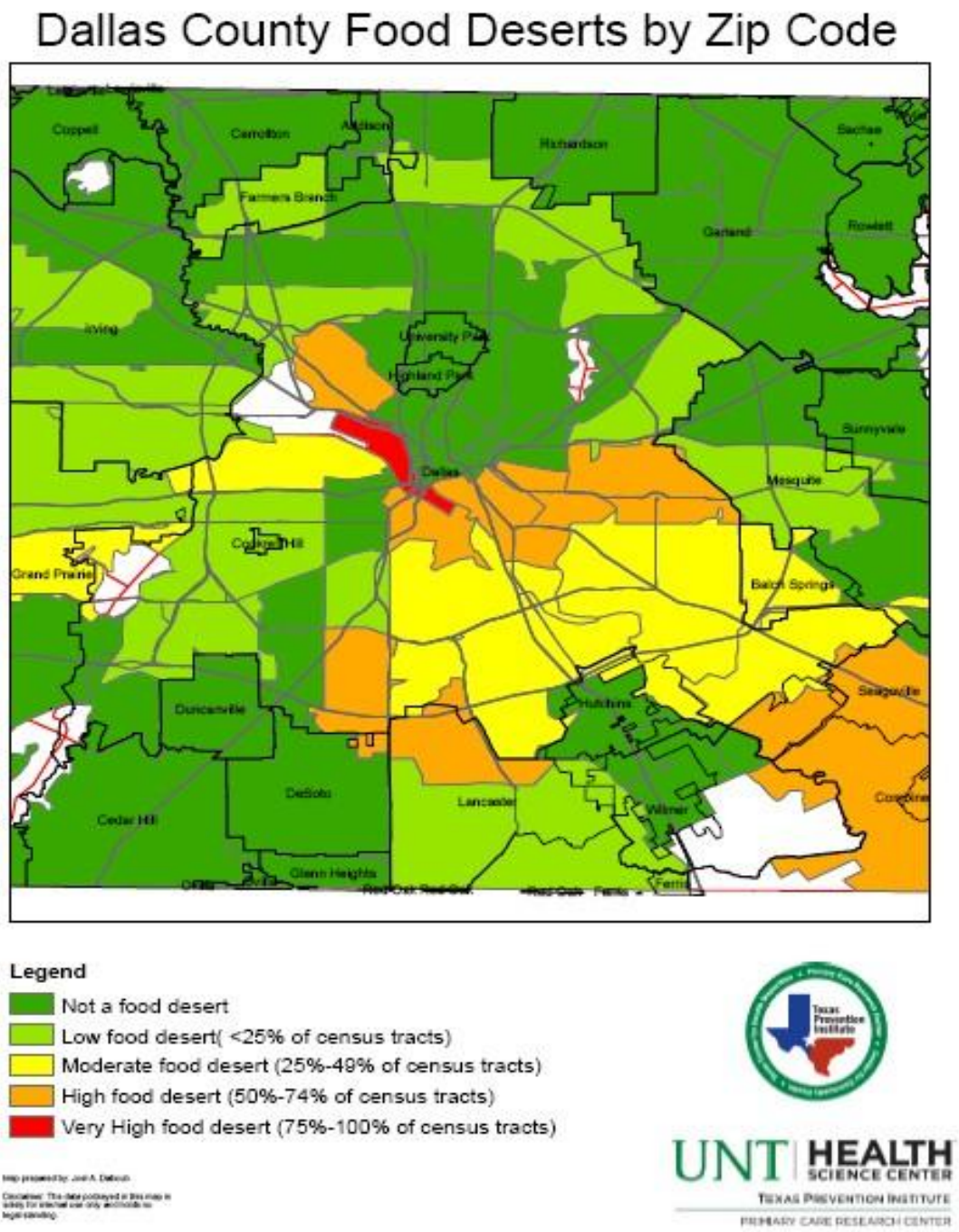
- One ZIP code in the Southwest Dallas community (75207) is a very high food desert, 100% of census tracts in that ZIP were identified as food deserts.
- Nine ZIP codes were rated as high food deserts with 50% to 74% of census tracts designated as food deserts. These are identified in orange on the map.
- 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
Seagoville
Duncanville
Hutchins
DeSoto
Lancaster
Cedar Hill
Glenn Heights
Ferris
Legend
Not a food desert
Low food desert(<25% of census tracts)
Moderate food desert (25%-49% of census tracts)
High food desert (50%-74% of census tracts)
Very High food desert (75%-100% of census tracts)
Texas Prevention Institute
UNT HEALTH SCIENCE CENTER
TEXAS PREVENTION INSTITUTE
PRIMARY CARE RESEARCH CENTER

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).

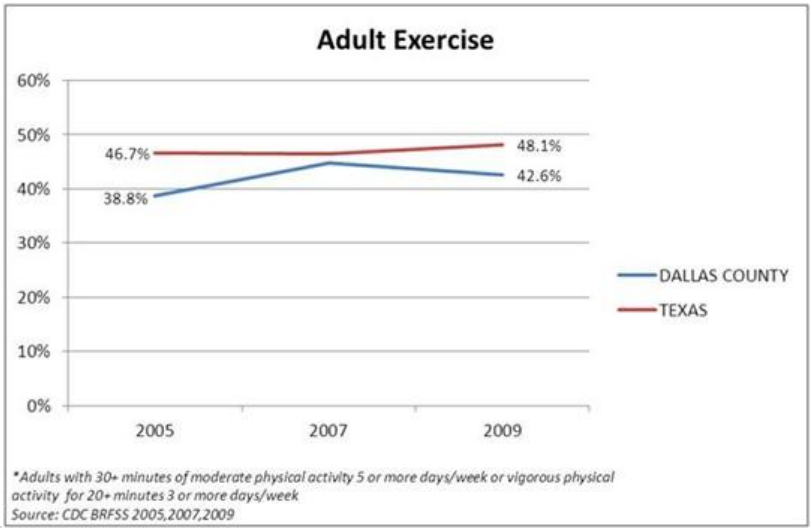
Table 4.12

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

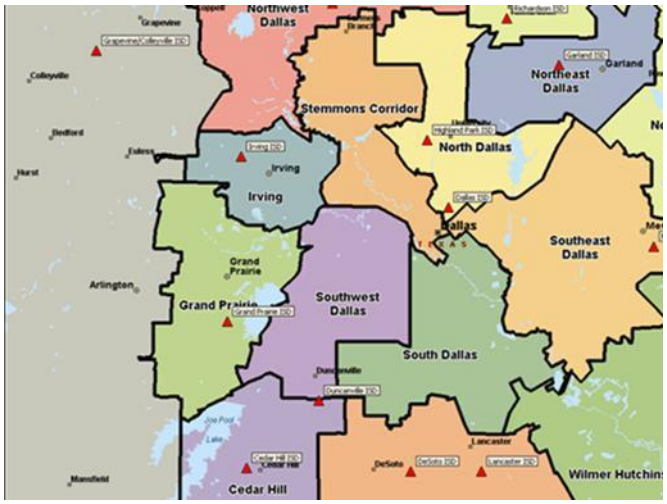
Dallas County schools are required to test the fitness levels of all students enrolled in physical education classes. Table 4.13 demonstrates that fitness levels decline with increasing student grade/age. The percentages reflect students that pass at least five of six fitness tests.

- 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					

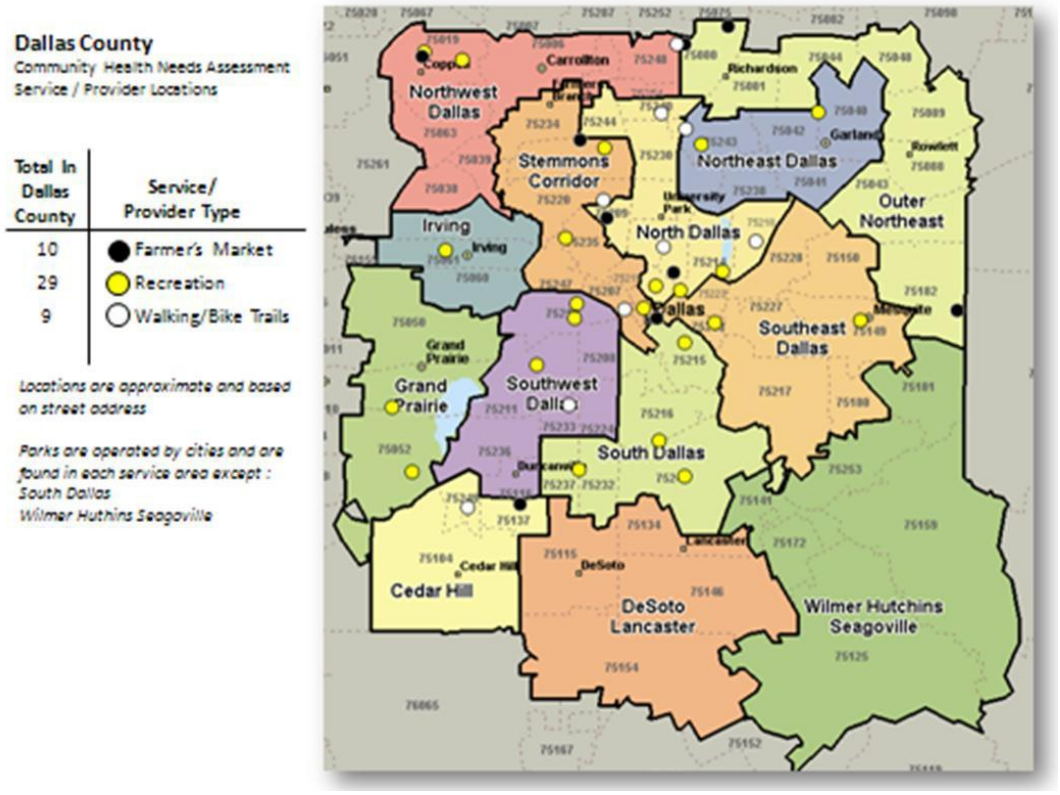
Figure 4.100



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.

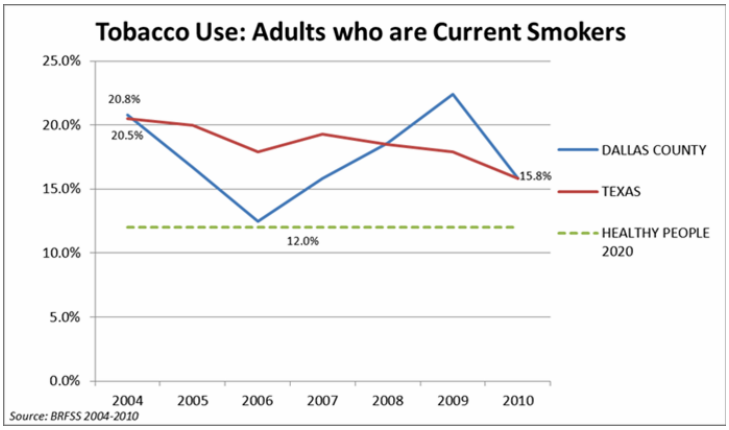
- Cigarette smokers are at high risk for cancer, heart disease, respiratory diseases, and premature birth.
- Secondhand smoke causes heart disease and lung cancer in adults and asthma, respiratory infections, ear infections and sudden infant death syndrome (SIDS) in children.
- Smokeless tobacco causes 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:

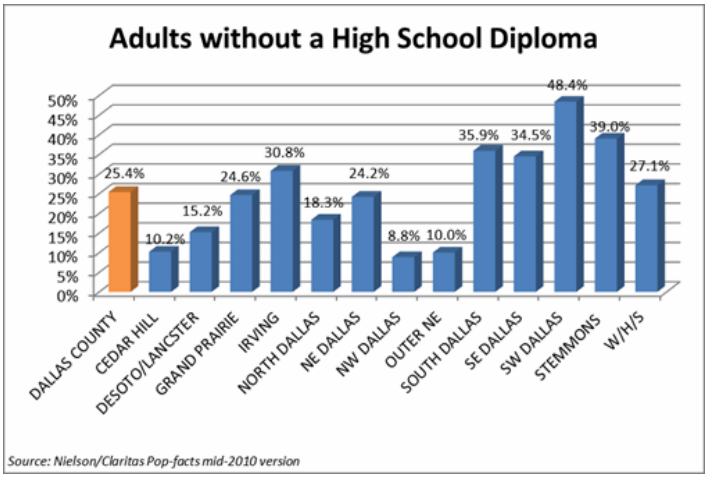
- Older adults,
- Minority populations,
- Those who have low SES,
- Medically underserved people (*Health literacy*, n.d.).

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/Pneumonia
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	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴
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	POI Rate of Hypertension	POI 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							
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.

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."

CALL TO ACTION: RECOMMENDATIONS

This community health needs assessment represents collective issues facing Dallas County residents, and requires collective action to improve the health of our community. The authors and PHI Workgroup affiliated with the report served to inform the methodology, analysis, and recommendations, but are not solely responsible for addressing these issues. However, each contributor will consider a health improvement plan that addresses the top community health needs within the capacity of his/her organization. This needs assessment is a call to action for all community-based organizations, policymakers, hospitals, workplaces, faith-based organizations, civic leaders, and citizens to do the same. Here are places to start. You can select the options that work best for your organization from the following list of recommendations:

1. ***Increase Dallas County residents' access to community prevention services.*** Focus should be on nutrition/maintaining ideal weight, physical activity, non-smoking and reducing alcohol consumption.

1.a. Bring stakeholders together to identify current services and develop plans for community prevention education and services in order to coordinate and expand services in Dallas County communities with highest need/resource deserts. Stakeholders should include community based organizations, hospitals/health systems, faith-based organizations, businesses and local foundations.

- Identify successful programs being implemented that might be expanded or customized for other communities in the County.
- Target neighborhoods/communities with health disparities as focus for risk reduction.

1.b. Identify financial, personnel and in-kind resources available to develop new programs in underserved areas with resource deserts, build on successful models and expand existing programs in place.

- Encourage hospitals/healthcare systems to participate via their community benefit programs.
- Encourage Dallas County businesses to participate to enhance the health of the local workforce.

1.c. Expand immunization services to support community prevention in Dallas County.

2. ***Target South Dallas, SW Dallas, SE Dallas, or disparate suburban neighborhoods with comprehensive interventions to reduce incidence and mortality disparities.***

2.a. Using the Spectrum of Prevention model, build multi-sector partnerships that create opportunities for expansion of resources to support health equity and healthy communities. The model considers advocacy, changing workplaces and organizational practices to address disease risks, educating providers, and skill building for individual healthy behavior changes.

2.b. Increase access to quality preventive services through community organizing.

2.c. Increase the capacity of the healthcare and prevention workforce to address disparities.

2.d. Implement strategies that are culturally, linguistically, literacy and age-appropriate at all levels of community organizing, interventions, and treatment.

2e. Evaluate effectiveness of strategies to ensure progress.

3. Expand access to primary care services for all Dallas County residents.

3.a. Encourage healthcare organizations to "right size" their medical staffs to meet the primary care and specialty medical needs of the community based on established physician to population ratios.

- Evaluate opportunities to locate primary care physicians, women's health specialists and pediatricians in areas identified as resource deserts for these specialties.

3.b. Educate providers on the value of the patient-centered medical home model of care.

3.c. Expand the medical home model to enhance health literacy and service access. Support the development of multidisciplinary teams that include physicians, nurse practitioners, nurses, case managers, physical therapists, pharmacists and community health workers for preventive and primary care provision.

3.d. Support the development of alternative primary care sites including, but not limited to:

- School nursing offices, which currently serve as initial points of healthcare contact for many children and youth.
- Large and medium sized businesses with model programs supporting recent findings that on-site prevention programs and primary care services have positive health benefits for employees and financial benefits for employers.
- Retail grocery and drug stores providing preventive services and basic primary care.
- Urgent care center/walk-in clinics.
- Community based organizations and faith based organizations with co-located services to offer preventive and medical treatment in combination with other social and support services or events.
- Immunization service clinics.

3.e. Consider targeted educational programs that expand health literacy, community prevention education and programs and additional clinical prevention service. Evaluate options to co-locate additional services at these sites.

- Work with community partners to develop or expand targeted health literacy programs.
- Support community prevention services to improve nutrition, reduce smoking and enhance physical activity.
- Provide additional health screening services, possibly through use of mobile vans.
- Identify funding to support ongoing operation of the Immunization Coalition.

4. Maximize the use of proven strategies to improve outcomes for individuals with multiple chronic conditions.

- These strategies include patient-centered medical homes, accountable care organizations, primary care and behavioral health integration models.

5. Monitor and address any health insurance coverage changes.

5.a. Facilitate enrollment of Dallas County residents into available health insurance products.

- Outline enrollment processes and organizations to support consumers in completing these processes.
- Develop promotional strategies to educate and inform eligible residents of changing health insurance eligibility requirements and opportunities for coverage.
- Evaluate trends in provider acceptance rates of available health insurance products.

6. Centrally document and build upon the most impactful disease prevention and health promotion initiatives currently underway in Dallas County.

6.a. Reach out to the lead organizations to learn from their experiences and expand their models in Dallas County communities with resource deserts.

- Work with community partners to implement and evaluate these programs.
- Utilize public-private partnerships to increase health impact, and to maximize competitiveness in grant applications with interventions to address the top health issues that impact Dallas County residents.
- Identify funding sources.

7. Develop strategies to reduce 30 day readmissions and preventable hospitalizations.

- Community health workers, nurses and others providing outreach in the community have a role in supporting recently hospitalized community residents to reduce readmission.

8. Collaborate with the Dallas County Behavioral Health Leadership Team to support implementation of behavioral health recommendations, particularly pertaining to integration of behavioral health and physical health.

9. Effectively communicate priority messages relating to community prevention, using culturally competent health literacy approaches.

- Promote Spanish written and oral translation in prevention and care.
- Incorporate infographics to convey treatment compliance outcomes and public health issues.
- Utilize social media for health promotion and idea exchange.
- Develop a consumer-oriented website for health education and to enhance health literacy.

REFERENCES

2011 beyond ABC: Assessing children's health in Dallas county. (2011). Dallas, TX: Children's Medical Center.

2011 state physician workforce data book. (2011). Washington, D.C.: Center for Workforce Studies: American Association of Medical Colleges.

About health literacy—US Department of Health and Human Services: Health Resources and Services Administration. Retrieved 7/19, 2012, from http://www.hrsa.gov/publichealth/healthliteracy/healthlitabout.html

American Lung Association. (2010). *Smoking out a deadly threat: Tobacco use in the LGBT community* American Lung Association.

Ang, R. (2012). *Health disparities in cardiovascular disease, Dallas county and Texas, 2007-2010.* Health Promotion and Chronic Disease Prevention: CVD and Stroke Program.

Aragon, T., Guerrero, K., & Kirk, S. (2012). *2011-2012 annual report of immunization status.* Austin, TX: Texas Department of State Health Services: Immunizations Branch.

Assessment of the community behavioral health delivery system in Dallas county: detailed report: Final draft. (2010). (Dallas County Behavioral Health System Redesign Task Force). Boulder, CO: TriWest Group and Zia Partners.

Becker, G. (2001). Effects of being uninsured on ethnic minorities' management of chronic illness. *Western Journal of Medicine, 175*(1), 19.

Behan, D., Cox, S., Lin, Y., Pai, J., Pedersen, H., & Yi, M. (2010). *Obesity and its relation to mortality and morbidity costs.* Schaumburg, Illinois: Committee on Life Insurance Research: Society of Actuaries.

Brennan Ramirez, L. K., Baker, E. A., & Metzler, M. (2008). Promoting health equity: A resource to help communities address social determinants of health. *Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention,*

BRFSS-CDC's behavioral risk factor surveillance system—US Department of Health and Human Services. (2012). Retrieved 5/30, 2012, from http://www.cdc.gov/brfss/

Cancer—US Department of Health and Human Services: Healthy people 2020. (2012). Retrieved 8/24, 2012, from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=5

CDC - EHS - EPHLI core essentials (2011). Retrieved 7/1, 2012, from http://www.cdc.gov/nceh/ehs/ephli/core_ess.htm

Centers for Disease Control (2012). *Lead.* Retrieved 11/7, 2012 from http://www.cdc.gov/nceh/lead/

Chronic care: Making the case for ongoing care. (2010). Princeton, NJ: Robert Wood Johnson Foundation.

Collins, S. (2012). *Regional health partnership 9: Community needs assessment report.* Irving, TX: Dallas Fort Worth Hospital Council.

Community health (2012). Retrieved 7/28, 2012, from http://www.dignityhealth.org/Who_We_Are/Community_Health/index.htm

Community health factors—the Prevention Institute. Retrieved 9/14, 2012, from http://www.preventioninstitute.org/initiatives/healthy-places-coalition/tools-and-resources/community-health-factors.html

Community profile report. (2010). Dallas, TX: Susan G. Komen for the Cure- Dallas County.

Dallas county dashboard: Service area specific dashboards: And social index dashboard. (2011). Dallas, TX: Parkland Community Health Institute.

Dallas County Health & Human Services: Environmental health. (2012). Retrieved 8/10, 2012, from http://www.Dallascounty.org/department/hhs/envihealth.html

Dallas County Health & Human Services: Public health preparedness. Retrieved 8/28/2012, 2012, from http://www.Dallascounty.org/department/hhs/medreserve.html

Dallas county QuickFacts from the US Census Bureau (2012). Retrieved 8/10, 2012, from http://quickfacts.census.gov/qfd/states/48/48113.html

Dallas Fort Worth Hospital Council Foundation. (2012). Retrieved 6/1, 2012, from http://www.dfwhcfoundation.org/

Dallas park inventory- city of Dallas Parks and Recreation. (2004). Retrieved 7/10, 2012, from http://www.Dallasparks.org/Downloads/DallasParks_inventoryMasterList.pdf

Decker, S. L. (2012). In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help. *Health Affairs*, *31*(8), 1673-1679.

Diabetes - US Department of Health and Human Services: Healthy people 2020. (2012). Retrieved 7/10, 2012, from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=8

Doughty, P., & Jones, J. (2011). *Diabetes in Dallas county provider report.* Dallas, TX: Dallas Fort Worth Hospital Council.

EPA President's Task Force on Environmental Health Risks and Safety Risks: Coordinated Federal Action Plan to Reduce Racial and Ethnic Asthma Disparities. (2012). Retrieved 11/7, 2012 from http://www.epa.gov/childrenstaskforce/federal_asthma_disparities_action_plan.pdf

Feto-infant mortality in Dallas county. (2011). (Factsheet). Austin, TX: Texas Department of State Health Services: Office of Program Decision Support.

Find shortage areas: MUA/P by state and county Retrieved 8/15/2012, 2012, from http://muafind.hrsa.gov/index.aspx

Fitness data- Texas Education Agency. (2012). Retrieved 7/20, 2012, from http://www.tea.state.tx.us/FitnessData.html

Food Environment Atlas- US Department of Agriculture: Economic Research Service. (2012). Retrieved 7/14, 2012, from http://www.ers.usda.gov/data-products/food-environment-atlas.aspx

Healthcare where you work [Editorial]. (2012, September 3). *The New York Times*, p. A18

Health literacy - US Department of Health and Human Services: Health Resources and Services Administration. Retrieved 8/16, 2012, from http://www.hrsa.gov/healthliteracy/

Health literacy universal precautions toolkit—US Department of Health and Human Services: The agency for healthcare research and quality. (2010). Retrieved 8/10, 2012, from http://www.ahrq.gov/qual/literacy/

Health professions- supply and distribution tables- Texas Department of State Health Services. (2011). Retrieved 6/28, 2012, from http://www.dshs.state.tx.us/chs/hprc/health.shtm

Healthy north Texas: Community dashboard. (2012). Retrieved 5/16, 2012, from http://www.healthyntexas.org/modules.php?op=modload&name=NS-Indicator&file=index

Healthy people 2020 topics and objectives. (2012). Retrieved 6/30, 2012, from http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx

Heart attack risk assessment- American Heart Association. (2012). Retrieved 8/22, 2012, from http://www.heart.org/HEARTORG/Conditions/HeartAttack/HeartAttackToolsResources/Heart- Attack-Risk-Assessment_UCM_303944_Article.jsp

Heart disease and stroke - US Department of Health and Human Services: Healthy people 2020. (2012). Retrieved 8/24, 2012, from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=21

Immunization and infectious diseases - US Department of Health and Human Services: Healthy people 2020. (2012). Retrieved 7/7, 2012, from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=23

Immunization report card. (2010). Dallas, TX: Dallas County Health and Human Services- Preventive Health Division.

Infectious disease control unit-Texas Department of State Health Services. (2012). Retrieved 6/28, 2012, from http://www.dshs.state.tx.us/idcu/

Information about asthma, allergies, food allergies and more! - Asthma and Allergy Foundation of America. (2011). Retrieved 8/24, 2012, from http://www.aafa.org/display.cfm?id=9&sub=22&cont=312

Injury and violence prevention - US Department of Health and Human Services: Healthy people 2020. (2012). Retrieved 7/14, 2012, from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=24

Jarvis, D. (2010). *How are we going to get paid tomorrow? Emerging models for health and behavioral healthcare. working draft.*

Jones, J., Mullins, E., Dukes, V., Worthey, L., & Smith, D. (2012). *Take action: STD/HIV prevention education in Dallas county ISDs 13 to 18 age group.* Dallas, TX: Dallas County Health and Human Services.

Kim, T. H., Mccue, M. J., & Thompson, J. M. (2009). The relationship of financial and mission factors to the level of uncompensated care provided in California hospitals. *Journal of Healthcare Management / American College of Healthcare Executives, 54*(6), 383-401; discussion 401-2.

Local area unemployment MAP- U.S. Bureau of Labor Statistics. (2012). Retrieved 6/15, 2012, from http://data.bls.gov/map/MapToolServlet

Martin, A., Momah, J., Whitaker, D., Shanafelt, C., & Kitzman-Ulrich, H. (2012). *Food dessert communities in Dallas county.* University of North Texas Health Science Center: Texas Prevention Institute: Primary Care Research Center.

Maternal, infant, and child health - US Department of Health and Human Services: Healthy people 2020. (2012). Retrieved 7/10, 2012, from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=26

Medical homes & patient-centered care - What is the patient centered medical home? American College of Physicians. (2012). Retrieved 9/18, 2012, from http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/understanding/what.htm

Mental health and mental disorders - US Department of Health and Human Services: Healthy people 2020. (2012). Retrieved 7/13, 2012, from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28

Multiple chronic conditions: A strategic framework optimum health and quality of life for individuals with multiple chronic conditions. (2010). Washington, D.C.: US Department of Health and Human Services.

NAPHSIS (2012). Retrieved 6/2, 2012, from http://www.naphsis.org/NAPHSIS/files/ccLibraryFiles/Filename/000000001130/ YPLL.pdf

National diabetes fact sheet. (2011). Atlanta: US Department of Health and Human Services: Centers for Disease Control.

National immunization survey homepage- US Department of Health and Human Services: Centers for disease control and prevention. (2012). Retrieved 5/28, 2012, from http://www.cdc.gov/nchs/nis.htm

National vital statistics system homepage- Centers for Disease Control and Prevention: National center for health statistics. (2012). Retrieved 5/30, 2012, from http://www.cdc.gov/nchs/nvss.htm

NCHS data briefs number 100- Centers for Disease Control and Prevention: National Center for Health Statistics. (2012). Retrieved 8/28, 2012, from http://www.cdc.gov/nchs/data/databriefs/db100.htm

North Texas accountable healthcare partnership selects Orion Health for regional health information exchange - Yahoo! finance (2012). Retrieved 8/23/2012, 2012, from http://finance.yahoo.com/news/north-texas-accountable-healthcare-partnership-130000654.html

Nursing experts release guiding principles for patient engagement - RWJF (2012). Retrieved 8/5, 2012, from http://www.rwjf.org/pr/product.jsp?id=74596

Nutrition and weight status - US Department of Health and Human Services: Healthy people 2020. (2012). Retrieved 7/14, 2012, from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=29

Obesity and overweight for professionals: Data and statistics: Adult obesity- US Department Health and Human Services: Centers for Disease Control and Prevention: Division of Nutrition, Physical Activity, and obesity. (2012). Retrieved 7/14, 2012, from http://www.cdc.gov/obesity/data/adult.html

Parkland Health & Hospital system - Dallas, TX. (2012). Retrieved 6/1, 2012, from http://www.parklandhospital.com/

PCMH:Home Retrieved 8/19/2012, 2012, from http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483

Physical activity - US Department of Health and Human Services: Healthy people 2020. (2020). Retrieved 7/15, 2012, from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=33

Physician supply and demand: Projections to 2020. (2006). Retrieved 5/14/2012, 2012, from http://www.lewin.com/publications/publication/334/

Public Health Preparedness Epidemiology division data summary. (2011). (Division Data Summary). Dallas, TX: Dallas County Health and Human Services Epidemiology.

Recommended adult immunization Schedule—United States - 2012. (2012). Atlanta: US Department of Health and Human Services: Centers for Disease Control.

Respiratory diseases - US Department of Health and Human Services: Healthy people 2020. (2012). Retrieved 7/7, 2012, from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=36

Reynolds, R. J., Shafer, A. B., & Becker, E. A. (2012). Mortality of public mental health clients treated at the local mental health authorities of Texas. *Texas Public Health Journal, Spring2012, Vol. 64*(2), 35.

Ryan White Planning Council of the Dallas Area (2010). *2010 Comprehensive HIV Needs Assessment.* Retrieved November 6, 2012 from http://www.dallascounty.org/department/rwpc/media/2012_Comp_Plan.pdf

Sanchez, E., Weinraub, J., Tagtow, A., & King Collier, A. (2008). *Will the food crisis cost our health?* online: Institute for Agriculture and Trade Policy: Food & Society Policy Fellows Program.

Steele, M. (2012). *Chickenpox cases fall 80% over decade: CDC - US News and World Report* Retrieved 8/21, 2012, from http://health.usnews.com/health-news/news/articles/2012/08/16/chickenpox- cases-fall-80-over-decade-cdc

Texas Cancer Registry - Texas Department of State Health Services. (2012). Retrieved 8/1, 2012, from http://www.dshs.state.tx.us/tcr/

Texas Department of State Health Services: Texas Childhood Lead Poisoning Prevention Program. (2012) Retrieved 11/7,2012 from http://www.dshs.state.tx.us/lead/child.shtm

Texas Department of State Health Services: HIV / STD program. (2012). Retrieved 7/06, 2012, from https://www.dshs.state.tx.us/hivstd/default.shtm

Texas Department of State Health Services: Infectious Disease Control unit - Refugee Health program. (2012). Retrieved 8/2, 2012, from http://www.dshs.state.tx.us/idcu/health/refugee_health/

Texas healthcare information collection- Texas Department of State Health Services. (2012). Retrieved 7/28, 2012, from http://www.dshs.state.tx.us/thcic/

Texas Statewide Health Coordinating Council (2011). 2011-2016 Texas State Health Plan: A roadmap to a healthy Texas. Texas Department of State Health Services. *Retrieved 1/7, 2012 from http://www.dshs.state.tx.us/chs/shcc/default.shtm*

Tobacco use - US Department of Health and Human Services: Healthy people 2020. (2012). Retrieved 6/27, 2012, from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=41

Udall, P., & Annear, B. (2012). *Drop in physician acceptance of medicaid, medicare patients- texas medical association.* Retrieved 9/10, 2012, from http://www.texmed.org/Template.aspx?id=24764

Weidich, K. (2012). Assets and opportunity in Dallas: A portrait of financial insecurity among residents.
Assets and Opportunity Nonprofit Workshop, Dallas, TX.

Who is at risk for asthma? - National Institute of Health: National Heart, Lung, and Blood Institute. (2012). Retrieved 8/10, 2012, from http://www.nhlbi.nih.gov/health/health- topics/topics/asthma/atrisk.html

Zwirko, W. (2012). *West Nile in Dallas county: 'we cannot let our guard down' | wfaa.com Dallas - Fort Worth* Retrieved 8/20, 2012, from http://www.wfaa.com/news/health/west-nile/dalco-wnv-167242485.html

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 Iola 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.

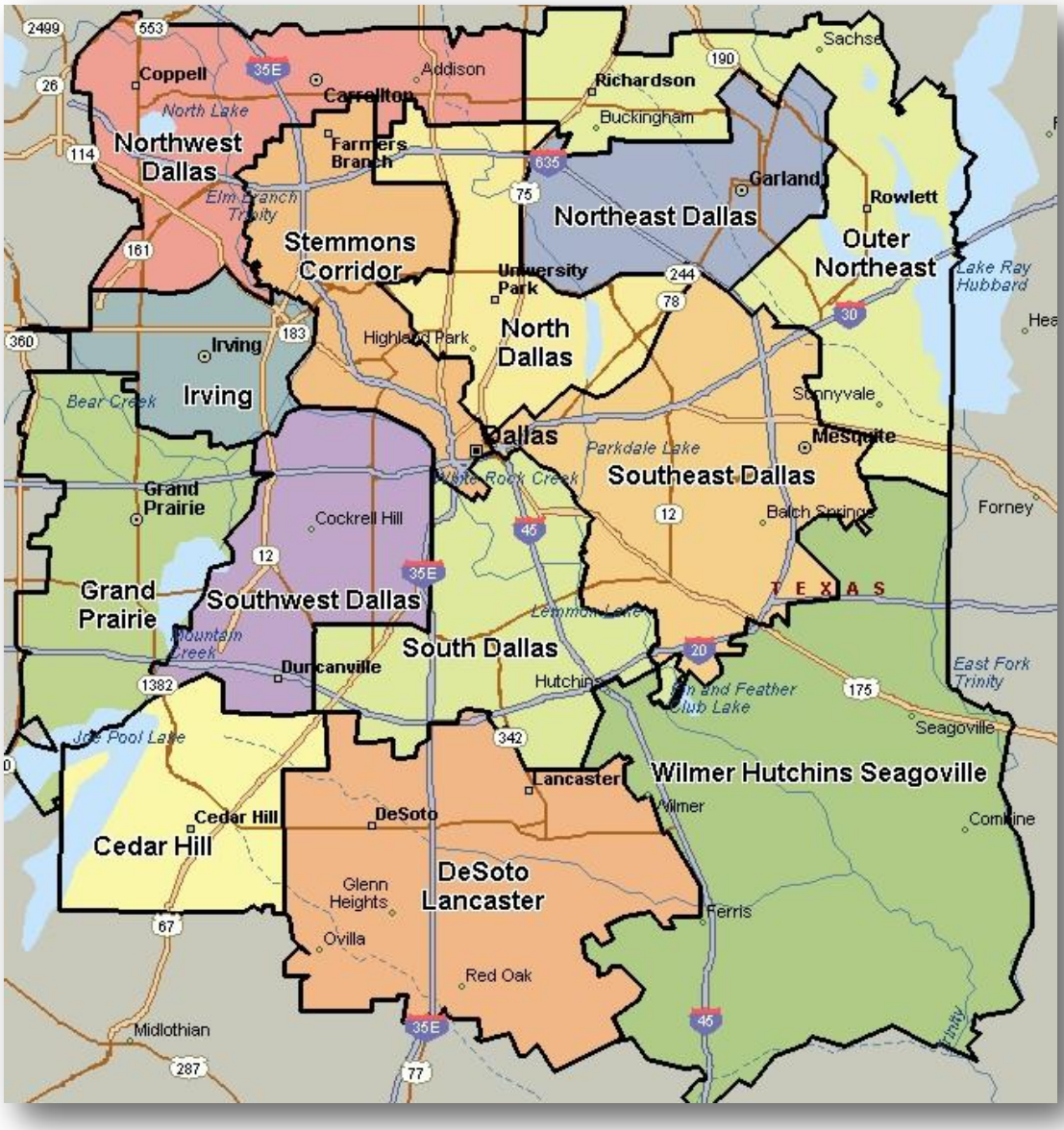
Demographic and Socioeconomic Overview Dallas County and Service Areas

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%	9.0%	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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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

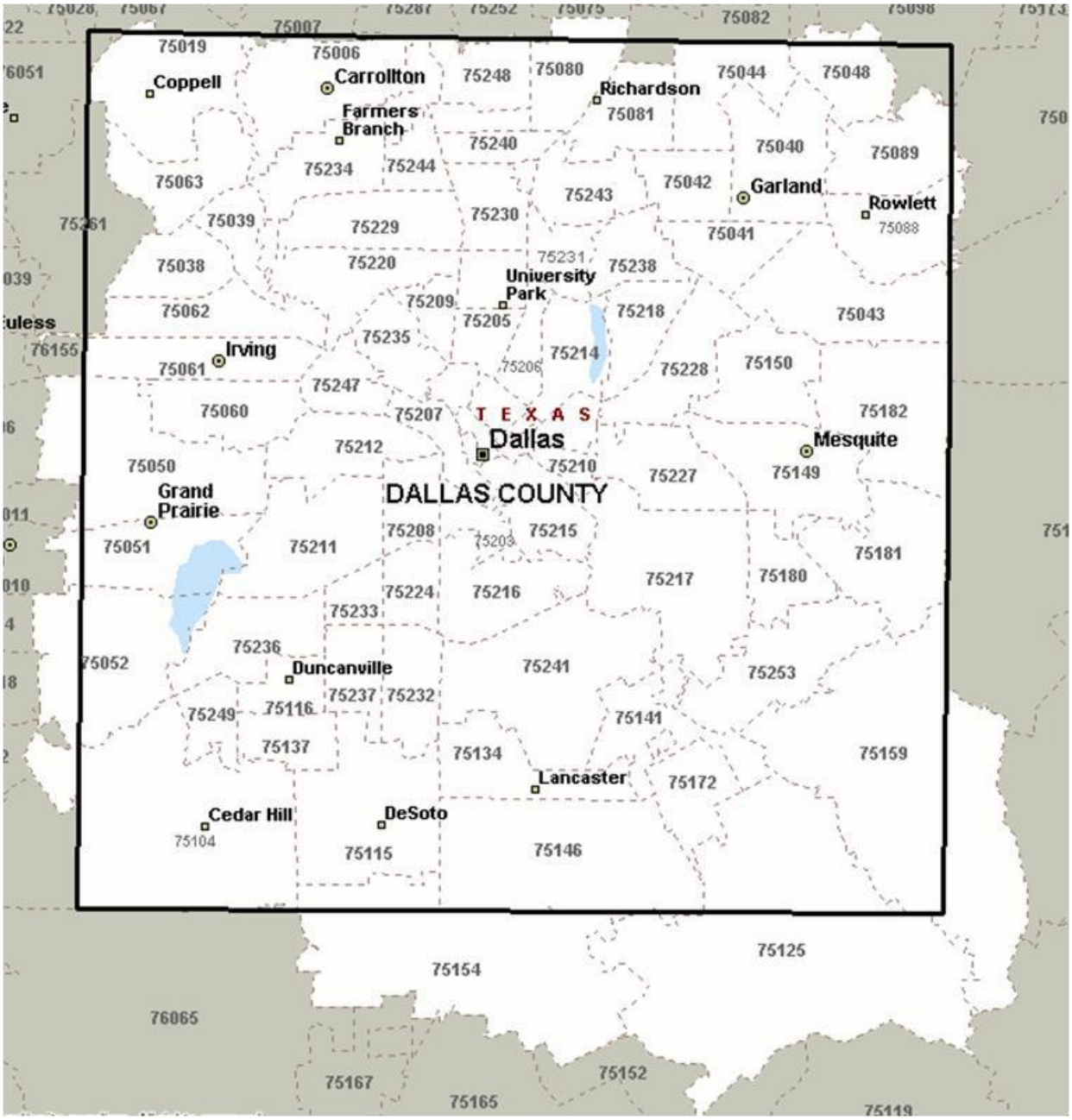
9. What do you consider the top health priorities for Dallas County?

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	7 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	5 Med District Dr.	Dallas	75235	Stemmons Corridor
	CityDoc Urgent Care	09 McKinney Ave	Dallas	75204	North Dallas
	Complete Med Care	8989 Forest Lane, Suite146	Dallas	75243	Northeast Dallas
	Concentra	6 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
	loc Urgent Care Center	651 N. Denton) 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	810 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	7 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	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	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
	nned 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
	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.	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 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
	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	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	3 E. Overton Road	Dallas	75216	South Dallas
	Community Dental Center at Carrollton/Farmers Branch	3551 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	2 Hopkins Drive	Garland	75040	Northeast Dallas
	Community Dental Center at Irving Dental Center	0 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	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	South Main Street	Duncanville	75137	Cedar Hill
	Dallas Farmers Market	1010 S. Pearl Expressway	Dallas	75201	Stemmons Corridor
	II 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
	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
	e 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.

Recommendations Section:

1. Continued Support of Assets (see below)
2. Address Top Factors. Supporting narrative will include emphasis on the following approaches to help inform improvement plans after the release of the CHNA:

a. Risk Targeting
i. Individual Knowledge and Behaviors
ii. Community Risk Awareness
iii. Educating Providers on Targeting Risks
iv. Community Organizing to Address Risks
1. Non-profit, workplaces, and FBO leaders
2. Strategy surrounding the issue/grassroots mobilization
v. Organizational Practices that Address Risks
vi. Policy and Legislation that Addresses Risks
b. Preventive Health Services
i. Screening
ii. Medical Homes

Dallas County Assets:

National Health Experts Located in Dallas County Strong Intervention Infrastructure

Immunization Services

STD/HIV Screening, Treatment, and Support Services Maternal and Child Health Resources

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