Texas Health Resources — Collin Region

Texas Health Frisco

2019 Community Health Needs Assessment

Texas Health Resources®

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Executive Summary

Introduction & Purpose

Texas Health Resources is pleased to present its 2019 Community Health Needs Assessment (CHNA) for the Collin Region in the Dallas/Fort Worth area. This CHNA report provides an overview of the process and methods used to identify and prioritize significant health needs across the Collin Region's service area, as federally required by the Affordable Care Act.

The purpose of this CHNA is to offer a deeper understanding of the health needs in the Collin Region's service area and guide Texas Health's planning efforts to address needs in actionable ways and with community engagement. Findings from this report will be used to identify and develop efforts to address disparities, improve health outcomes, and focus on social determinants of health in order to improve the health and quality of life of residents in the community.

Acknowledgements

The development of Texas Health's CHNA was a collective effort that included Texas Health employees, community-serving organizations, and community members from within areas of focus that provided input and knowledge of issues and solutions and those who share in the commitment to improve health and quality of life. The 2019 CHNA planning effort pushed Texas Health beyond the traditional primary service area in an effort to directly impact prioritized health needs in areas of the community with greatest health needs. This was an integral step to ensuring an ability to understand the needs of the community and develop programs and services that will positively impact the health and well-being of those being served.

Leadership Letter

Improving the health and well-being of our communities is a journey, not a race.

We develop a Community Health Needs Assessment every three years to help us build programs that meet the specific needs of our communities. We collect data through windshield surveys, community readiness assessments, and in-depth interviews with community leaders and residents to obtain a better understanding of their needs.

Behavioral health, chronic disease, access to health services, and health care navigation and literacy continue to be prevailing issues in the communities we've targeted.

That's why instead of turning our focus elsewhere, we're diving deeper into these issues to address the health disparities and social and environmental conditions that affect overall health.
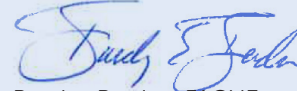
In this report, we're going to share our approach to how we have moved towards addressing challenges by focusing on solutions.

You'll see the prevailing issues we've identified in various communities—issues like depression, high blood pressure and lack of insurance. We've also explored the social determinants driving those negative health outcomes, such as isolation and lack of public transportation and access to healthy food.

The 2019 CHNA report highlights the community voice and represents our vision − partnering with you for a lifetime of health and well-being. Because we believe that collaboration is at the core of every solution.

By working together, we continue to make a difference.

Sincerely,

Barclay Berdan, FACHE,
Chief Executive Officer,
Texas Health Resources

Brett Lee, FACHE,
President, Texas Health Frisco

Community Benefit Leadership and Team

Catherine Oliveros, DrPH, VP Community Health Improvement

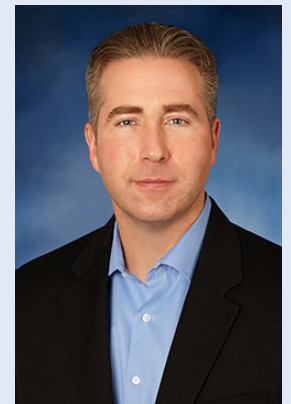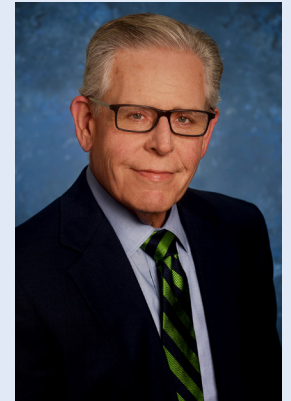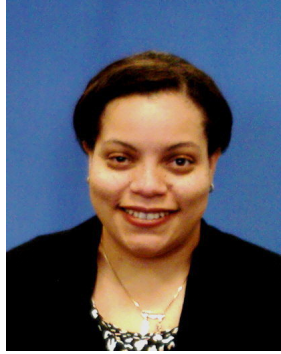**Marsha Ingle**, BS, MA, CHES, Sr. Director Community Health Improvement

Danelle Parker, RN, BSN, Director, Community Health Improvement

Cindy Long, RN, BSN, Program Manager, Community Health Improvement

Kayla Fair, DrPH, Program Manager, Community Health Improvement

Roselyn Cedeno Davila, MS, Gunnin Fellow

Tonychris Nnaka, MPH, BSN, RN, CPH, Gunnin Fellow

Texas Health Community Impact Leadership Council

The following organizations are represented on the Collin Texas Health Community Impact (TCHI) Leadership Council. These individuals were actively engaged in the prioritization process for the region.

- Allen Community Outreach
- ARTA Travel
- Cigna
- City of Plano
- Frisco Chamber of Commerce
- Iconic Consulting Group, Inc.
- Northbridge Church
- Plano ISD
- Professional Office Services of Dallas
- Texas Department of State Health Services
- Toyota Motor North America

Community Research Support

Texas Health would like to recognize Jonathon Fite from the Professional Development Institute at University of North Texas and Dr. Marcy Paul, from University of North Texas Health Science Center for their support with Focus Group and PhotoVoice implementation.

Consultants

Texas Health Resources commissioned Conduent Healthy Communities Institute (HCI) to support report preparation for its 2019 Community Health Needs Assessment. HCI works with clients across the nation to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems, and implementing performance evaluation processes. To learn more about Conduent Healthy Communities Institute, please visit https://www.conduent.com/community-population-health. The following HCI team members were involved in the development of this report: Ashley Wendt, MPH – Public Health Consultant, Courtney Kaczmarsky, MPH – Public Health Consultant, Zack Flores – Project Coordinator, Margaret Mysz, MPH – Research Associate, Monica Duque, MPH – Research Associate, and Liora Fiksel – Research Assistant.

Introduction

Texas Health Resources Health System

Texas Health Resources is a faith-based, nonprofit health system that cares for more patients in North Texas than any other provider.

With a service area that consists of 16 counties and more than 7 million people, the system is committed to providing quality, coordinated care through its Texas Health Physicians Group and 26 hospital locations under the banners of Texas Health Presbyterian, Texas Health Arlington Memorial, Texas Health Harris Methodist, and Texas Health Huguley. Texas Health access points and services, ranging from acute-care hospitals and trauma centers to outpatient facilities and home health and preventive services, provide the full continuum of care for all stages of life. The system has more than 4,000 licensed hospital beds, 6,200 physicians with active staff privileges and more than 25,000 employees. For more information about Texas Health, call 1-877-THR-WELL, or visit www.TexasHealth.org.

Mission

To improve the health of the people in the communities we serve.

Vision

Partnering with you for a lifetime of health and well-being.

Values

- *Respect* Respecting the dignity of all persons, fostering a corporate culture characterized by teamwork, diversity and empowerment.

- *Integrity* Conduct corporate and personal lives with integrity; relationships based on loyalty, fairness, truthfulness and trustworthiness.

- *Compassion* Sensitivity to the whole person, reflective of God's compassion and love, with particular concern for the poor.

- *Excellence* Continuously improving the quality of service through education, research, competent and innovative personnel, effective leadership and responsible stewardship of resources.

Texas Health Resources is moving beyond episodic sick care, by focusing on anticipating consumers' needs, and offering affordable and personalized products and experiences as the organization seeks to meet consumers' health and well-being needs for their lifetime. Texas Health has elevated the needs and preferences of consumers as the unifying voice that focuses every aspect of the organization.

Collin Region for Texas Health Resources

This main portion of this report covers the population and geographic area for Texas Health Community Impact in the Collin Region. Collin County (https://www. collincountytx.gov) is a county located in the north central part of Texas that is part of the Dallas, Fort Worth, Arlington, Texas Metropolitan Area. McKinney serves as the county seat to a county population of approximately 1,005,146 citizens according to the 2018 U.S. Census Record, a population increase of 28.5% since the 2010 Census. The map in Figure 1 highlights the Collin Region among the other counties that fall into the Texas Health service area. For the purpose of this CHNA, special attention has been given to the needs of vulnerable populations, unmet health needs or gaps in services and input from the community.

FIGURE 1. COLLIN COUNTY MAP
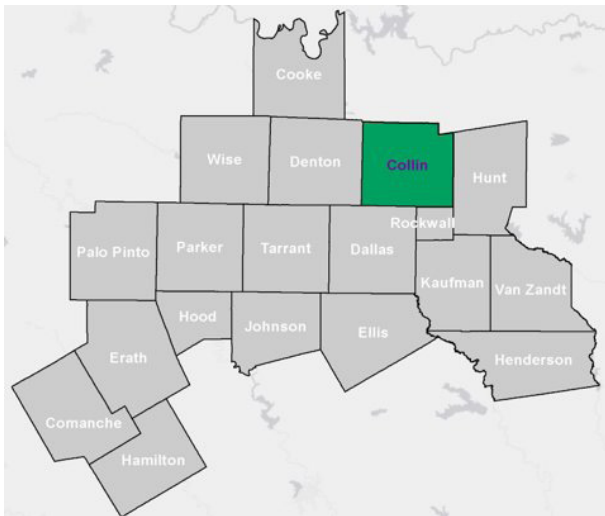
Facility Description

Built in collaboration with UT Southwestern, Texas Health Frisco has everything you would anticipate from an advanced medical center, including a collaboration with world-renowned UT Southwestern. The open-medical staff will include community physicians as well as physicians from the UT Southwestern faculty.

Texas Health, in collaboration with UT Southwestern Medical Center, is building a health care campus that includes Texas Health Hospital Frisco, a 325,000-square-foot, 73-bed acute care hospital, UT Southwestern Medical Center at Frisco, a 120,000-square-foot medical office building that will house a multispecialty clinic, along with a multi-level parking garage. The campus will also include many amenities, including a walking path, café and comfortable indoor and outdoor areas designed to promote relaxation and a sense of family.
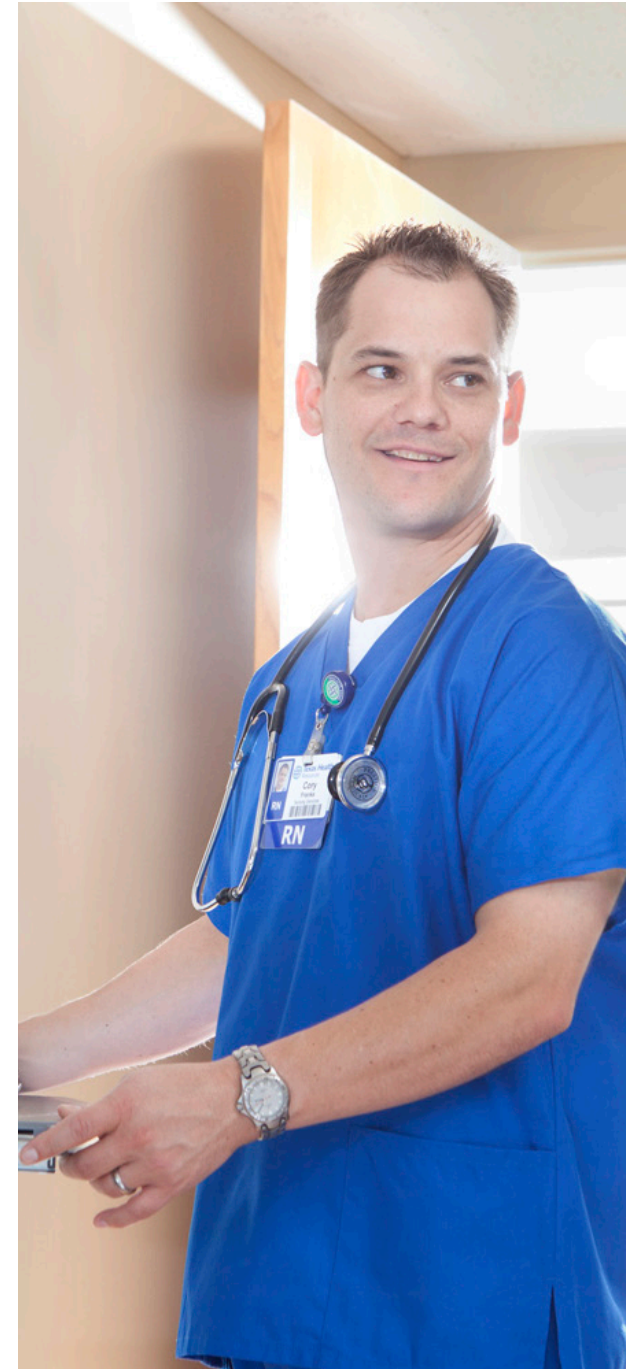
Impact Since Last CHNA

The CHNA process should be viewed as a three-year cycle. An important part of that cycle is revisiting the progress made on priority topics from previous CHNAs. By reviewing the actions taken to address priority areas and evaluating the impact of these actions in the community, an organization can better focus and target its efforts during the next CHNA cycle.

The previous Texas Health CHNA was conducted in 2016. The priority areas in FY17-19 were:

- Behavioral Health

- Chronic Disease

- Awareness, Health Literacy and Navigation

Texas Health Resources built upon efforts from the previous 2016 CHNA to directly target communities and populations who disproportionally experience the prioritized health challenges identified above. Of the activities implemented, the most notable are detailed on the next page:

Behavioral Health	• *Texas Health Community Impact:* Texas Health Community Impact (THCI) is a data driven initiative that positions Texas Health to serve as a convener, funder and catalyst. Community-driven representatives serve on the THCI Board and regional TCHI Leadership Councils and play an important role in defining strategy for community health improvement efforts. As part of Community Impact, Texas Health awards cross-sector collaborative grants that address local needs focused on behavioral health and social determinants of health through innovative and disruptive models. • *Evidence-based Programs:* Texas Health launched a system-wide approach to addressing behavioral health by leveraging internal and external partnerships to implement evidence-based programs. Two of the initial evidence-based programs were in partnership with faith communities and schools to implement an evidence-based program called Mental Health First Aid (MHFA). As a part of this initiative, Texas Health also funded the Program to Encourage Active, Rewarding Lives (PEARLS). Both initiatives are described more fully below. • *Mental Health First Aid (MHFA):* Texas Health launched a system-wide approach to addressing behavioral health by leveraging external partners with faith communities and schools to implement an evidence-based program called Mental Health First Aid. The goal of MHFA is to reduce stigma associated with mental health by increasing the ability to identify people with symptoms of mental illness and refer them to the appropriate level of care. • *Program to Encourage Active, Rewarding Lives (PEARLS):* PEARLS is a national program to reduce depression in socially isolated seniors. This program brings high quality mental health care into community-based settings that reach vulnerable older adults. Texas Health is implementing PEARLS in collaboration as a part of THCI in targeted zip codes. • *Texas Health Faith Community Nursing (FCN):* The goal of Faith Community Nursing is to reduce stigma associated with mental health issues in congregational settings. Integration of spiritual care and mental health awareness is crucial to better address community behavioral health needs. Through the FCN program, communities of faith are able to provide proactive care and improve connections to community services.

Chronic Disease Prevention & Management (including Exercise, Nutrition and Weight)	• *Medicaid 1115 Waiver:* Texas Health continues to address the treatment and management of chronic conditions (Diabetes, Congestive Heart Failure, Hypertension, and Hyperlipidemia) in underserved populations through programs provided under the Delivery System Reform Incentive Payment (DSRIP) Medicaid 1115 Waiver. » HELP or Healthy Education Lifestyle Program is a disease management program designed to improve access to high quality care for vulnerable and underserved populations. HELP has successfully addressed access for uninsured populations and simultaneously addressed social determinants of health through community partnerships.
Awareness, Health Literacy, Navigation	• *Clinic Connect:* Clinic Connect is a collaboration between Texas Health entities and local community clinics aimed at connecting vulnerable populations seen at Texas Health facilities to community based medical homes. Funds provided by Texas Health help support operational costs for partner clinics and ensures timely navigation for patients to needed services. This program addresses awareness, literacy and navigation through grants awarded to community clinics. • *Mobile Health Program (MHP):* Professionally staffed and fully equipped mobile health vehicles travel to neighborhoods and communities addressing the challenges of access to health care, cultural isolation, language barriers, and lack of transportation. MHP provides disease prevention information, screening, and early detection services, along with education and referral resources. • *Blue Zones Project:* Blue Zones Project Fort Worth is a community-wide well-being improvement initiative to help make healthy choices easier for everyone in the Fort Worth area. As of January 2019, this project now falls under the umbrella of Texas Health Resources.

Community Feedback

The 2016 Texas Health Resources Community Health Needs Assessment Reports and Implementation Strategies were made available to the public via the website https://www.texashealth.org/community-engagement/community-health-improvement-chi/community-health-needs-assessment. In order to collect comments or feedback, a unique email was used: THRCHNA@texashealth.org. No comments had been received on the preceding CHNA via the email at the time this report was written.

Methodology

Overview

The following section explores the data collection and prioritization process for the 2019 Texas Health CHNA. There were two types of data used in this assessment: primary and secondary data. Primary data are data that have been collected for the purposes of this community assessment. Primary data were obtained through windshield surveys, focus groups, PhotoVoice and key informant interviews. Secondary data are health indicator data that have been collected by public sources such as government health departments.

Building on 2016 CHNA Process

For the 2019 CHNA process, Texas Health built on key findings and achievements from the 2016 CHNA process and Implementation Strategy. This process included casting a wide net of consideration over all 401 zip codes within and alongside Texas Health's primary and secondary service areas. Through the tiered process summarized in the diagram in Figure 2, Texas Health, with the support of five regional community councils, utilized primary and secondary data to narrow the geography down to 16 prioritized zip codes where communities were experiencing disproportionate health outcomes in the areas of Chronic Disease, Behavioral Health, and Awareness, Health Literacy and Navigation.

The health categories of Behavioral Health, Chronic Disease, as well as Awareness, Health Literacy and Navigation were prioritized during the 2016 Texas Health CHNA. During secondary data analysis, over 100 community indicators covering more than 20 topics in the areas of health, social determinants of health, and

quality of life were considered. These data were primarily derived from state and national public secondary data sources. Under the Behavioral Health category, the key health indicators of concern that were considered were Depression, Substance Abuse, and Alzheimer's Disease. For Chronic Disease, the indicators of concern were Obesity, Food Insecurity, Access to Exercise Opportunities, and the Built Food Environment. Finally, related to Awareness, Health Literacy and Navigation, the top indicators of concern were Low Provider Rates and Low Rates of Health Insurance Coverage. These indicators are still relevant for the 2019 CHNA as Texas Health continues to build on the work initiated in 2016. For full and complete findings from the 2016 CHNA and up-to-date health indicators by county, please refer to the Appendix documents.

FIGURE 2. 2019 CHNA DATA COLLECTION PROCESS
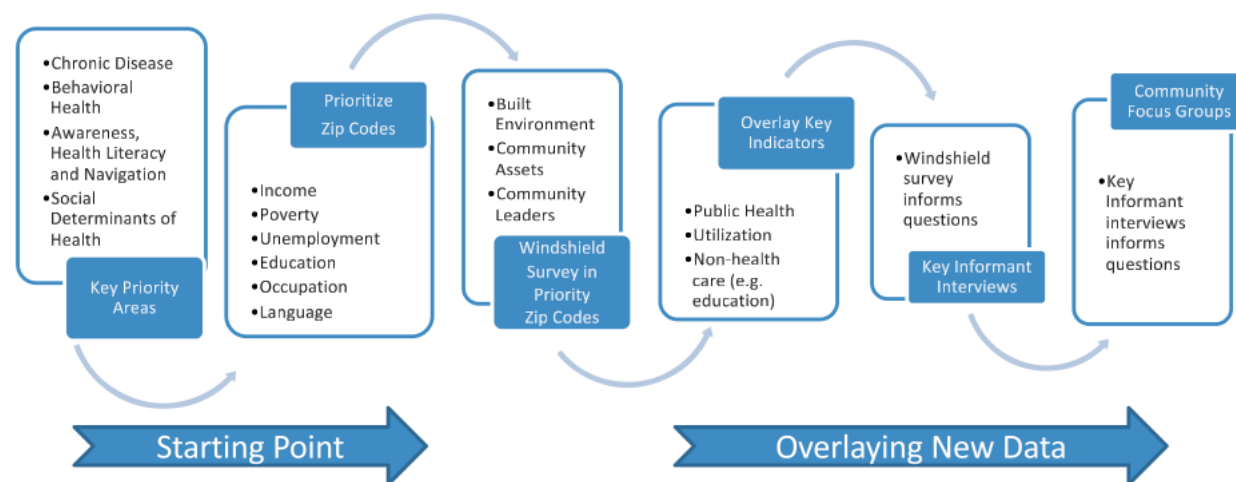
Overview of Multi-tiered Zip Code Prioritization

For the initial prioritization process, zip codes across the Collin Region were ranked on perceived need and identified need per the SocioNeeds Index described below. In contrast to previous CHNA prioritization processes, zip codes that did not fall within the hospital service area for this region were included in the analysis. This allowed for identification of zip codes within these communities, regardless of their hospital provider, that are considered "highest need." Thus, this process allowed Texas Health to extend the scope of this project to the larger community and broaden the impact of their interventions.

SocioNeeds Index

Conduent Healthy Communities Institute developed the SocioNeeds Index® (SNI) to easily compare multiple socioeconomic factors across geographies. This index incorporates estimates for six different social and economic determinants of health — income, poverty, unemployment, occupation, educational attainment, and linguistic barriers — that are associated with poor health outcomes including preventable hospitalizations and premature death. Figure 3 summarizes the SocioNeeds Index process.

Zip codes within each county are assigned an index value from 0 (low need) to 100 (high need), based on how those zip codes compare to others in the U.S. Within each county, the zip codes are then ranked from 1 (low need) to 5 (high need) to identify the relative level of need. Zip codes with populations under 300 persons are excluded.

FIGURE 3. SOCIONEEDS INDEX

FIGURE 4. COLLIN REGIONAL MAP

| Zip Code	Index Value	Rank
75069	52.2	5
75074	94.3	5
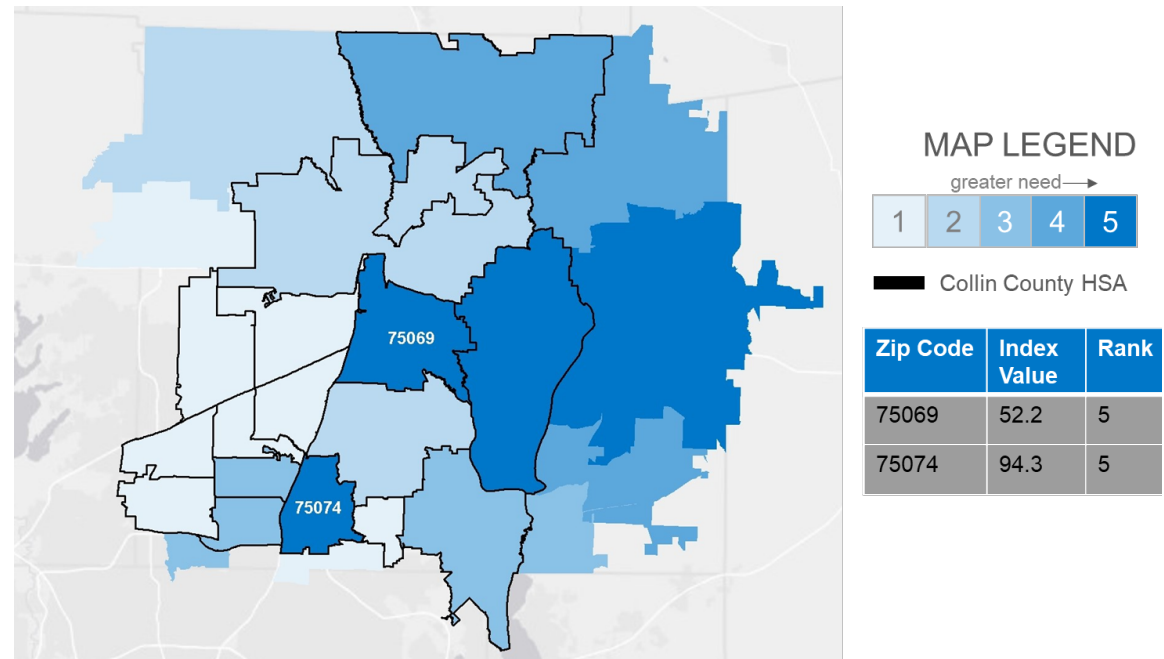
The map in Figure 4 highlights SNI values for zip codes across the Collin Region. Darker shades of blue indicate a higher index value and thus higher levels of need within those zip codes. Additionally, this map highlights the hospital service area (HSA) for each county. As shown, many of the areas of highest need are in the mid-western portion of the county. The final two prioritized zip codes within the region are also illustrated. Both prioritized zip codes in this region fall within the HSA.

Collin Region Zip Code Prioritization

In the Collin Region, zip codes were ranked on perceived need and identified need per the SocioNeeds Index (a measure of socioeconomic need). The TCHI Leadership Council of Collin County narrowed the 31 zip codes of Collin County to two priority zip codes after an extensive data review and complementary data gathering, including a windshield survey, community readiness assessment (key informant interviews), and focus groups. These two priority zip codes are 75069 and 75074. The diagram below summarizes the overall zip code narrowing/prioritization process for the 2019 CHNA process.

FIGURE 5. ZIP CODE PRIORITIZATION

31 Collin County Zip Codes

4 Priority Zip Codes

2 Target Area Zip Codes
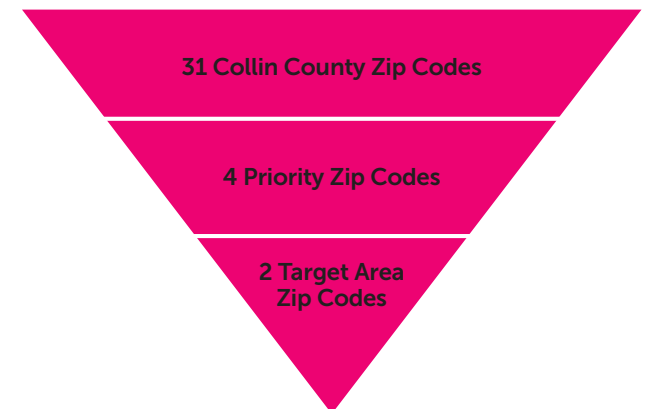
Demographics

The following section explores the demographic profiles of the Collin Region. The demographics of a community significantly impact its health profile. Different race/ethnicity, age, and socioeconomic groups have unique needs and require different approaches to health improvement efforts. All demographic estimates are sourced from the U.S. Census Bureau's 2013-2017 American Community Survey unless otherwise indicated.

Some data within this section is presented at the county level while other data is presented at the zip code level. It should be noted that county level data can sometimes mask what could be going on at the zip code level in many communities. This rationale was behind Texas Health's decision to zoom in the scope and consideration to the zip code for the 2019 CHNA. This allowed for a better understand and an increased potential to address disparities that were showing up within a given zip code, but not at the broader county level.

Population

According to the U.S. Census Bureau's 2013-2017 American Community Survey, the Collin Region had a population of 914,075. Table 1 below shows the population breakdown for the prioritized zip codes within the Collin Region.

TABLE 1. POPULATION BY ZIP CODE

COUNTY	ZIP CODE	TOTAL POPULATION ESTIMATE
Collin	75069	36,879
	75074	48,977

Age

As shown in Figure 6, 26.9% of Collin Region's population is under 18 years old. The Collin Region has a higher proportion of residents under 18 compared to the state and national values, 26.0% and 22.6%, respectively.

Figure 7 illustrated that 10.1% of the population in the Collin Region are adults over the age of 65. This is a slightly smaller proportion of older adults compared to the State of Texas (12.3%) and the U.S. (15.6%).

Figure 8 illustrates that the Collin Region has a proportion of residents under 5 years of age (6.4%), which is smaller than the State of Texas (7.2%) and is similar to the U.S. (6.1%).
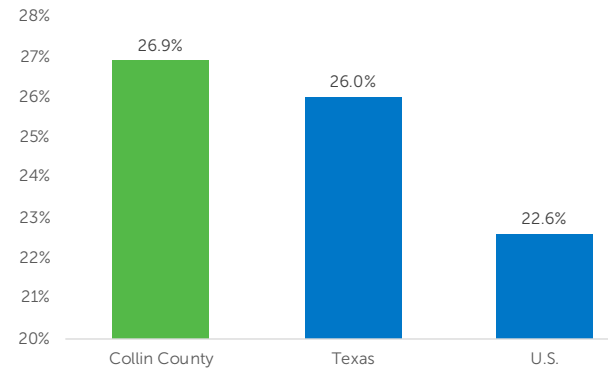
FIGURE 6. POPULATION UNDER 18

Collin County: 26.9%
Texas: 26.0%
U.S.: 22.6%

FIGURE 7. POPULATION OVER 65

Collin County: 10.1%
Texas: 12.3%
U.S.: 15.6%
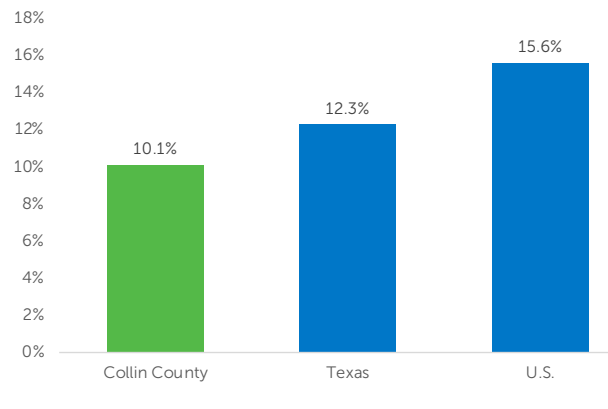
FIGURE 8. POPULATION UNDER 5

Collin County: 6.4%
Texas: 7.2%
U.S.: 6.1%
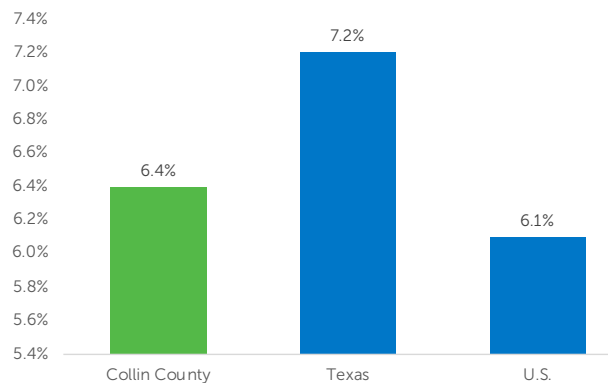
Race/Ethnicity

The race and ethnicity composition of a population are important in planning for future community needs, particularly for schools, businesses, community centers, health care, and childcare. Race and ethnicity data are also useful for identifying and understanding disparities in housing, employment, income, and poverty.

Figure 9 shows the racial composition of residents in the Collin Region with 57.3% of residents identifying as White; 14.6% as Hispanic or Latino (of any race); 9.1% as Black or African American; 13.2% as Asian; and 5.8% as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", or "Two or more races".

FIGURE 9. RACE/ETHNICITY

5.8%
14.6%
13.2%
9.1%
57.3%

- White, non-Hispanic
- Black or African American
- Asian
- Hispanic or Latino (of any race)
- Other

Collin County
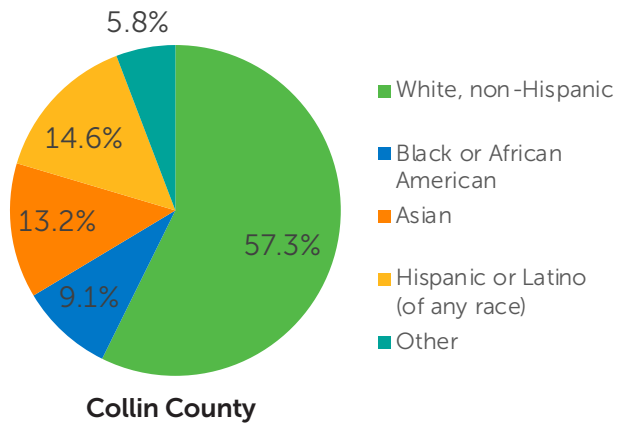
Language

Language is an important factor to consider for outreach efforts to ensure that community members are aware of available programs and services.

FIGURE 10. LANGUAGE OTHER THAN ENGLISH AT HOME

TABLE 2. POPULATION WITH LANGUAGE OTHER THAN ENGLISH SPOKEN AT HOME BY ZIP CODE

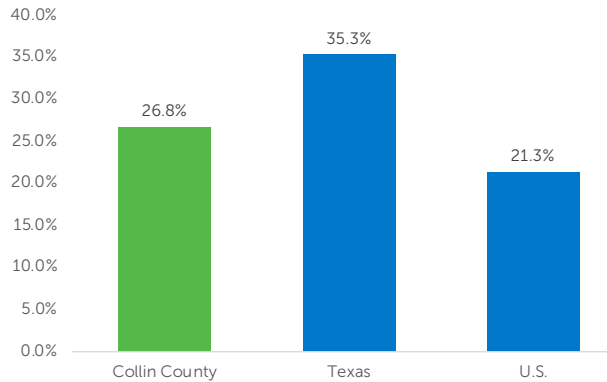| COUNTY	ZIP CODE	LANGUAGE OTHER THAN ENGLISH SPOKEN AT HOME
Collin	75069	32.3%
	75074	43.5%

Figure 10 shows the proportion of residents in Collin Region who speak a language other than English at home. Almost 26.8% of residents in Collin Region speak a language other than English as compared to 35.3% in Texas and 21.3% in the U.S. In Collin County, 73.17% of residents identify English as their primary language, while 11.07% speak Spanish. Another 2.53% of residents speak Chinese (Mandarin or Cantonese). As shown in Table 2; the two prioritized zip codes have a larger proportion of residents who speak a language other than English at home than Collin County.This is an important consideration for the effectiveness of services and outreach efforts, which may be more effective if conducted in languages other than English alone.

TABLE 3. POPULATION WITH DIFFICULTY SPEAKING ENGLISH BY ZIP CODE

COUNTY	ZIP CODE	DIFFICULTY SPEAKING ENGLISH
Collin	75069	14.8%
	75074	20.5%

As shown in Table 3, Collin County has a smaller proportion of residents with difficulty speaking English (9.3%) compared to the state of Texas (14.2%). In Collin County, the prioritized zip codes 75069 and 75074, have a larger proportion of residents with difficulty speaking English (14.8%, 20.5%) that both Collin County and Texas.

Social Determinants of Health

This section explores the social determinants of health in the Collin Region's service area. Social determinants are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. It should be noted that county level data can sometimes mask what could be going on at the zip code level in many communities. While indicators maybe strong at the county level, zip code level analysis can reveal disparities.

Income

Median household income reflects the relative affluence and prosperity of an area. Areas with higher median household incomes are likely to have a greater share of educated residents and lower unemployment rates. Areas with higher median household incomes also have higher home values, and their residents enjoy more disposable income.

FIGURE 11. MEDIAN HOUSEHOLD INCOME
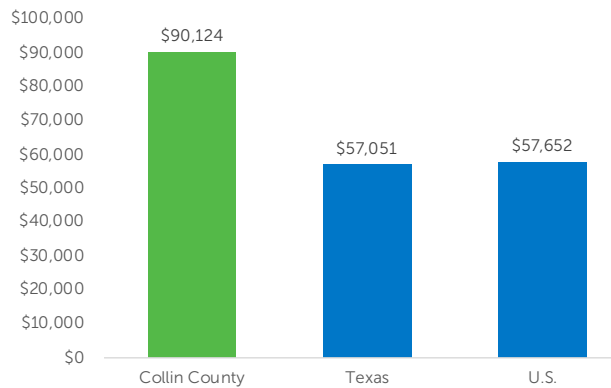
Figure 11 shows the median household income of Collin County is $90,124, which is higher than both the Texas state value of $57,051 and the U.S. value of $57,652.

Poverty

The Census Bureau sets federal poverty thresholds every year and varies by size of family and ages of family members. A high poverty rate is both a cause and a consequence of poor economic conditions. A high poverty rate indicates that local employment opportunities are not sufficient to provide for the local community. Through decreased buying power and decreased taxes, poverty is associated with lower quality schools and decreased business survival.

Figure 12 shows the percentage of people living below the poverty level for Collin County (6.9%). This value is lower both than the Texas state value (16.0%) and the U.S. value (14.6%).

FIGURE 12. PEOPLE LIVING BELOW POVERTY LEVEL

FIGURE 13. PEOPLE LIVING BELOW POVERTY LEVEL BY RACE/ETHNICITY

Food Insecurity

The Supplemental Nutrition Assistance Program (SNAP) is a federal assistance program that provides low-income families with electronic benefit transfers (EBTs) that can be used to purchase food. The goal of the program is to increase food security and reduce hunger by increasing access to nutritious food.

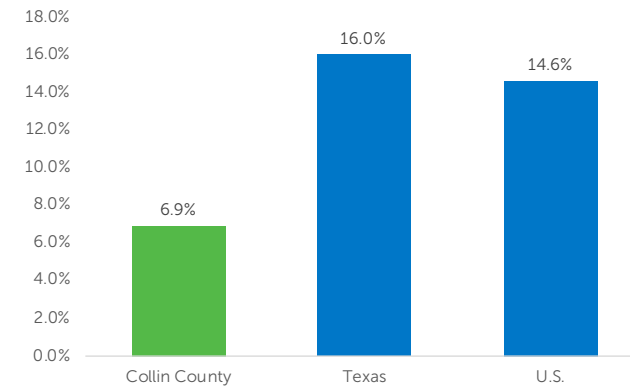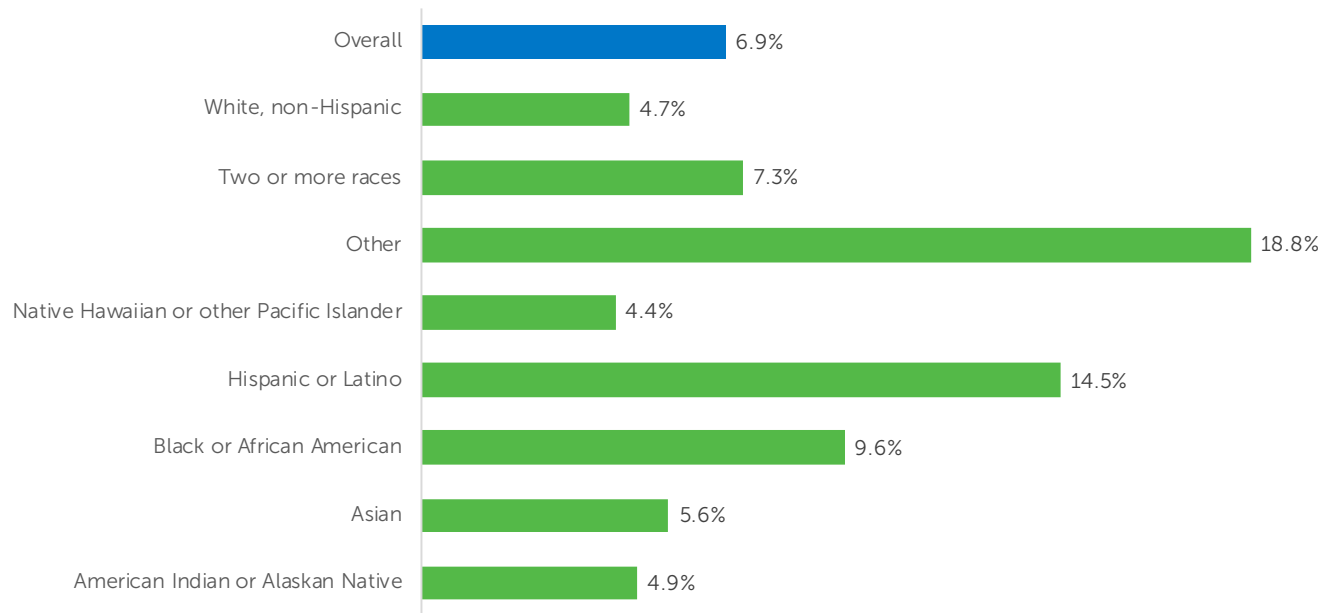FIGURE 14. HOUSEHOLDS RECEIVING SNAP WITH CHILDREN
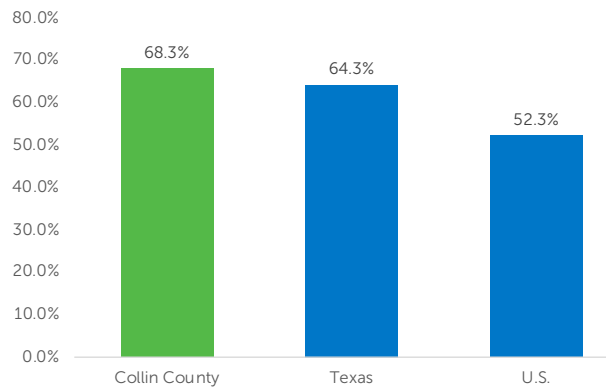
Figure 14 shows the percentage of households receiving food stamps/SNAP benefits with children under 18 years old. The Collin County value (68.3%) is slightly higher than both the Texas state value (64.3%) and the U.S. value (52.3%).

Unemployment

The unemployment rate is a key indicator of the local economy. Unemployment occurs when local businesses are not able to supply enough appropriate jobs for local employees and/or when the labor force is not able to supply appropriate skills to employers. A high rate of unemployment has personal and societal effects. During periods of unemployment, individuals are likely to feel the severe economic strain and mental stress. Unemployment is also related to access to health care, as many individuals receive health insurance through their employer. A high unemployment rate places strain on financial support systems, as unemployed persons qualify for unemployment benefits and food stamp programs.

FIGURE 15. UNEMPLOYED WORKERS IN CIVILIAN LABOR FORCE
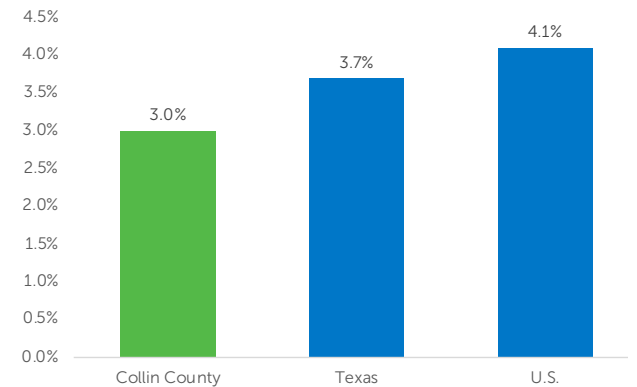
Figure 15 shows the percentage of unemployed workers in the civilian labor force. The Collin County value (3.0%) is lower than both the Texas state value (3.7%) and the U.S. value (4.1%).

Education

Graduating from high school is an important personal achievement and is essential for an individual's social and economic advancement. Graduation rates can also be an important indicator of the performance of an educational system. Having a bachelor's degree opens career opportunities in a variety of fields and is often a prerequisite for higher-paying jobs.

FIGURE 16. PEOPLE 25+ WITH A HIGH SCHOOL DEGREE OR HIGHER
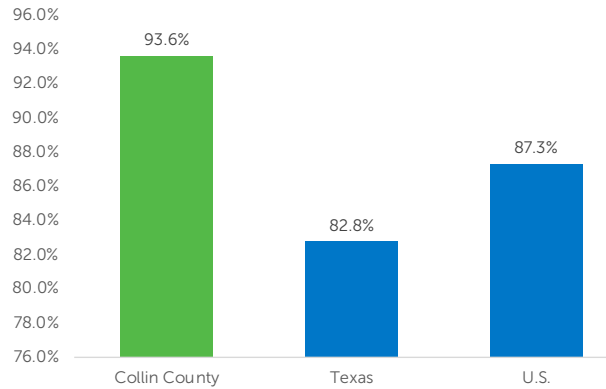
Figure 16 shows the percentage of people 25 years or older who have a high school degree or higher. The Collin County value (93.6%) is higher than both the Texas state value (82.8%) and the U.S. value (87.3%).

FIGURE 17. PEOPLE 25+ WITH A BACHELOR'S DEGREE OR HIGHER
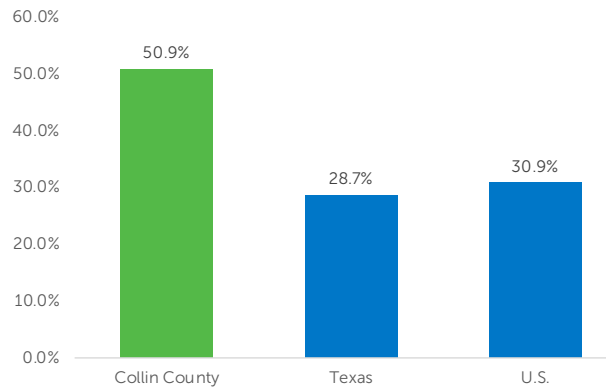
Figure 17 shows the percentage of people 25 years or older who have a bachelor's degree or higher. The Collin County value (50.9%) is higher than both the Texas state value (28.7%) and the U.S. value (30.9%).

Transportation

Lengthy commutes cut into workers' free time and can contribute to health problems such as headaches, anxiety, and increased blood pressure. Longer commutes require workers to consume more fuel, which is both expensive for workers and damaging to the environment.

FIGURE 18. MEAN TRAVEL TIME TO WORK (MINUTES)
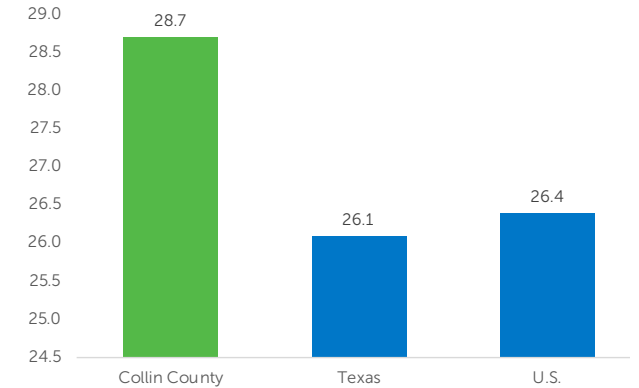
Figure 18 shows the mean travel time to work for Collin County (28.7 minutes), which is higher than the Texas state value (26.1 minutes) and the U.S. value (26.4 minutes).

Prioritization Process

FIGURE 19. TEXAS HEALTH RESOURCES 2019 CHNA PRIORITIZATION PROCESS

April 2018

- 401 zip codes analyzed (CHNA + others) considering socioeconomic data/ index resulting in initial prioritization
- 60 zip codes selected and additional social determinants of health (SDH) and key health indicators considered for further prioritization

May/June 2018

- Narrowed to 41 zip codes
- Deep data dive looked at additional SDH and public health reports/studies and relevant indicators based on availability
- Windshield survey informed development of community readiness assessment
- Readiness assessment and Key Informant Interviews further informed focus groups

July 2018

- Asset mapping was completed from windshield surveys and community readiness assessment findings

August 2018

- Completed 36 out of 40 zip code level focus groups which were informed by previous data collection
- Final prioritization process considered qualitative and environmental scan results and resulted in 16 Community Impact Zip Codes

Initial Zip Code Prioritization

To identify high-need zip codes within and outside the Texas Health service area and to narrow the focal area from 401 zip codes across 12 counties to 60 zip codes, Texas Health utilized the SocioNeeds Index as well as other sociodemographic data and key health indicators. Of the 60 zip codes across the 12-county area that were considered, four of them were high priority zip codes from the Collin Region. The health needs and potential for impact were considered for these zip codes and extensive qualitative data were collected. Windshield surveys, a community readiness assessment, and focus groups were vital components of this CHNA process to capture and integrate community voices and feedback. Figure 19 illustrates the 2019 CHNA Prioritization Process.

Windshield Surveys

The systematic input of neighborhood and communities was collected through windshield surveys. Master-level fellows, part of the Gunnin Fellowship, and the Community Health Impact team implemented the survey in each of the high priority zip codes. The survey consisted of ten items related to the environment and available resources in the environment. The ten topic areas observed were: neighborhood boundaries, housing conditions, use of open spaces, shopping areas, access to food, schools, religious facilities, human services, mode of transportation, protective services, and overall neighborhood life within the community interest. Pictures taken during this process were used to support written observation. The windshield surveys identified strengths and challenges in the area, which in turn helped determine the questions asked in the community readiness assessments. The key findings for the three prioritized zip codes are summarized in Table 4. Potential partner organizations were also identified through the windshield survey process and are listed in the Appendix. The identification of key partner organizations supported focus group efforts and was vital for planning next steps in the implementation of programs and services.

TABLE 4. WINDSHIELD KEY SURVEY FINDINGS FOR PRIORITIZED ZIP CODES

ZIP CODE 75074	ZIP CODE 75069
Challenges:	
• Some neighborhood streets and sidewalks are in need of repair » Due to poor access to health facilities, many use the Emergency Department for primary health care	• Most homes in the identified area are older and small with only some having had recent renovations • Older, small apartment complexes are intermingled within neighborhoods. » Known trafficking and illegal drug access makes the community members feel unsafe
Strengths:	
• Over 20 identified Faith Communities, many of which offer community classes	• 3 identified Faith Communities in mentoring partnership with Title 1 elementary schools
• Over 20 non-profits offering a variety of social services » There are parks within walking distance for community members to access	• 2 Free Clinics • 1 Federally Qualified Health Center (FQHC) with dental services • Collin County Clinic » LifePath Systems

Community Readiness Assessments

A Community Readiness Assessment Report was designed based on the Community Readiness Model developed by the Tri-Ethnic Center for Prevention Research at Colorado State University[1]. The process includes: identifying the issue, defining "community", conducting "key informant" interviews, and scoring the interviews to determine the readiness level. Based on population size for small counties, a minimum of four key informants were interviewed and for counties with a larger population, a minimum of six key informants were interviewed. Interviews were conducted by phone or in person and included a series of approximately 25 to 43 questions and lasted from 30 to 60 minutes each. Across the target five zip codes from Collin County, five key informants were interviewed. Table 5 highlights the variety of individuals who participated as key informants. All key informants have worked in one or various targeted zip codes for an average of 12 years. The key informants currently work for non-profit organizations, churches, hospitals and the city. The key health issues the interviews focused on were identified during the 2016 CHNA process: mental health and chronic diseases including arthritis, cancer, diabetes, hypertension, and pulmonary diseases. The questions addressed five dimensions of the community readiness from the identified issues. The five dimensions of the community readiness included:

- *Community Knowledge of Efforts* How much does the community know about the current programs and activities?

- *Leadership* What is leadership's attitude toward addressing the issue?

- *Community Climate* What is the community's attitude toward addressing the issue?

- *Community Knowledge of the Issue* How much does the community know about the issue?

- *Resources* What are the resources that are being used or could be used to address the issue?

TABLE 5. KEY INFORMANTS INTERVIEWED (KII)

PROFESSIONAL TITLE OF KII	NUMBER OF KIIs
Executive Directors	3
Family Center Director	1
Chief Executive Officer	1

Interviews were scored individually and then a total value was calculated in order to determine the community readiness level. Interviews were scored one at a time by two scorers with no previous knowledge of the key informants and of the identified community.

Based on specific interview questions, regarding specific dimensions, each dimension could receive a score level from one to nine according to the scale. Scores then are averaged for each dimension and the final score is averaged across the five dimensions. The final score gives the specific stage of readiness for this issue in the community being addressed. Readiness levels for an issue can increase, decrease and vary based on the issue, the intensity, and appropriateness of community efforts, and external events. Figures 20 and 21 highlight the Overall Stage of Readiness Score and Readiness Dimensions for Collin County. Collin County's current stage of readiness is three

At **stage three**, the following applies:

- A few community members have at least heard about local efforts but know little about them.

- Leadership and community members believe that this issue may be a concern in the community. They show no immediate motivation to act.

- Community members have only vague knowledge about the issue (e.g., they have some awareness that the issue can be a problem and why it may occur).

- There are limited resources (such as a community room) identified that could be used for further efforts to address the issue.

> **Most community members do not think we have any 'real' social issues in Collin County."**

> **Community members do not believe in preventative approaches to community issues."**

> **They are not aware that mental health issues can be prevented."**

Collin County — Zip Code 75074

1 Tri-Ethnic Center for Prevention Research, Colorado State University. Tri-Ethnic Center Community Readiness Handbook, 2nd edition (2014) [PDF file]. Retrieved from: http://tec.wolpe2.natsci.colostate.edu/wp-content/uploads/sites/24/2018/04/CR_Handbook_8-3-15.pdf

FIGURE 20. OVERALL STAGE OF READINESS SCORE FOR DALLAS COUNTY

COMMUNITY READINESS ASSESSMENT REPORT - COLLIN

OVERALL STAGE OF READINESS	STAGE **3**	VAGUE AWARENESS

Current Stage of Readiness
Next Stage of Readiness

Stage 9	Community ownership
Stage 8	Expansion/Confirmation
Stage 7	Stabilization
Stage 6	Initiation
Stage 5	Preparation
Stage 4	Preplanning
Stage 3	Vague Awareness
Stage 2	Denial/Resistance
Stage 1	No Awareness

> **"** There is a lack of health care for low-income population."

> **"** Many community members don't believe in preventative health."

> **"** Other needs are being seen in [the] community as priority, such as homelessness and domestic violence."

Collin County — Zip Code 75069

FIGURE 21. READINESS DIMENSIONS — CONSENSUS SCORES FOR DALLAS COUNTY

COMMUNITY READINESS ASSESSMENT REPORT - COLLIN

CONSENSUS SCORES

Community Knowledge of Efforts	Leadership	Community Climate	Knowledge of Issue	Resources
3	5	4.5	3	3.9
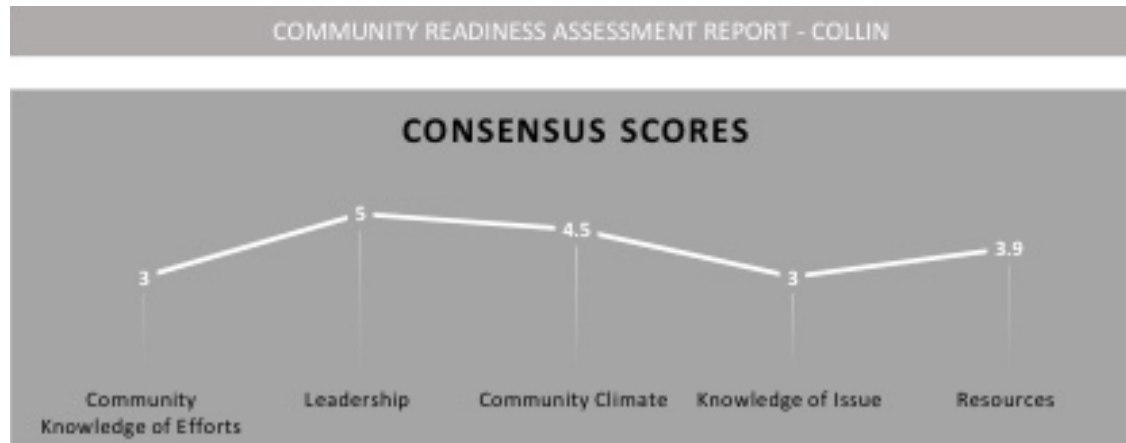
Community Focus Groups

TABLE 6. FOCUS GROUP KEY THEMES FOR PRIORITIZED ZIP CODES — 75074, 75069

COLLIN COUNTY ZIP CODE 75074	COLLIN COUNTY ZIP CODE 75069
• Participants would benefit from Patient Care Assistance program from pharmaceutical companies	• Infrastructure of public transportation is insufficient to meet the needs of the community
• Need for nearby specialist care centers	• Lack of local food banks with plentiful selection create a "food desert"
• Better provision and dissemination of up-to date information on available resources	• Housing costs have pushed out those who seek affordable housing
• Affordable transportation options would help access to services	

A total of three community focus groups were held in three zip codes; two zip codes were identified as high priority by the Collin Region TCHI Leadership Council. These focus groups all fell within Collin County. Input from community residents was collected through verbal discussions with a facilitator from the University of North Texas. Topics of conversation were based upon the data collected from windshield surveys, community readiness surveys, and health data. These topics included access to health services, drivers of chronic disease, and factors that influence depression, addiction, eating habits, and exercise patterns. A total of 25 residents participated in all the focus groups in Collin County. Conducting focus groups also helped identify future potential partnerships and available resources residents are aware of.

While each of the focus groups in the prioritized zip codes identified unique needs and issues in their community, many topics were raised in more than one focus group. Transportation was a universal issue across each zip code. Participants raised transportation as an issue specifically related to accessing health care services, as well as in their daily life. Participants raised challenges with finding affordable medicines and health care providers in proximity, including primary and specialty care services. Limited options for affordable housing and difficulty navigation the housing system was also brought up in both focus groups. Participants in both groups also shared a need for increased access to healthy foods and more food sources overall. Table 6 highlights the key focus group themes for Collin County.

Participants in the focus groups in **Collin County — Zip Code 75069** represented an age range from 45 to 65 years old and identified as Black or African American. The top issues related to behavioral health were the concentration of depression in the community and alcohol and drug addiction. Participants proposed that the medical community partner with local churches to encourage clinical counseling services. Transportation was a top reason people shared for why access to health care services and finding affordable medications are challenges in the community. Participants find scheduling important procedures that would improve quality of life challenging. There was discussion about how chronic diseases often go untreated and that is considered the 'norm' in the community. They shared that people prioritize other costs, especially housing, over treating health issues. Affordable housing has become more difficult to find. In addition, the East McKinney area was described as a 'food dessert' and finding health food was difficult for participants.

Participants in the focus groups in **Collin County — Zip Code 75074** represented a diverse age range, from 18 to over 65, and identified as White and Black/African American. The top issues related to behavioral health were inadequate in-person mental health resources and limited affordable services. Participants shared that there are some free community telephone-based counseling services and adequate programs for substance abuse. The main topics discussed regarding access to health care were challenges with transportation to health care facilities and an absence of resources for uninsured patient. They also brought up challenges with being able to afford health care services and medications. Participants wanted more local primary care providers, better emergency care services, and more information about the services available. Related to chronic diseases, participants suggested improving the quality of the food available at local food pantries and some participants thought that healthier food in general could be more accessible. Additional discussion centered on housing and the need for advocates in to the community to help with securing public housing and the poor state of local homeless shelters.

Prioritization Results

Historically, the Texas Health CHNA process has culminated in the selection of prioritized health needs that fall within the system's health service area. For the newest iteration of the CHNA process, Texas Health shifted the approach, recognizing the role that systems can play in addressing social determinants of health as well as their impact on health outcomes across a broader community. Social determinants were intentionally considered as part of the data collection process with the goal of determining which social determinants of health are present in the community and how they contribute to prioritized health needs. By pinpointing specific zip codes to address the social determinants of health that often result in conditions such as chronic disease and premature death, Texas Health is striving to generate community-driven, collaborative solutions that break traditional silos and address the clinical and social needs of individuals living in North Texas.

Prioritization to Final Zip Codes and Health Priorities

In addition to considering the cumulative results of the quantitative and qualitative data collected throughout the CHNA process, the Collin Region TCHI Leadership Council selected zip codes in their region based on criteria that included: 1) availability of resources, 2) availability of partners, 3) community readiness, 4) impact opportunity and 5) health needs in one or more of the prioritized health areas. In this region, the two zip codes that were chosen as the final target areas were 75074 and 75069. Both zip codes identified fall within Texas Health's Health Service Area (HSA). In addition to narrowing down the focus geographically based on evidence and the criteria mentioned above, the council was also tasked with selecting clinical issues that fell within one of the prioritized health areas of Behavioral Health, Chronic Disease, or Awareness, Health Literacy

and Navigation. They also considered any social determinants of health that may contribute to these clinical issues. Based on these considerations, the TCHI Leadership Council elected to focus on Depression and Anxiety within the Behavioral Health category across the three zip codes. Table 7 summarizes the Health Priority Areas within each zip code as well as the target population.

TABLE 7. COLLIN REGION PRIORITIZED ZIP CODES AND HEALTH AREAS

COUNTY	ZIP CODE	HEALTH PRIORITY AREA
Collin	75074	Depression and anxiety among adults 55+
	75069	Depression and anxiety among youth aged 12-18 years

Photovoice Project

PhotoVoice is a form of storytelling that engages community members through photograph and written narrative to identify what they perceive to be assets and challenges to living a healthy life. The PhotoVoice technique is conducted in groups and has three main goals: 1) to encourage people to record and reflect their community's strengths and concerns, 2) to provide a group space to share photographs and narratives and engage in dialogue about the strengths and concerns while learning from each other, and 3) to reach other community stakeholders and policymakers through a community exhibit of final PhotoVoice projects. During the summer and early fall of 2019, 65 community members residing in 12 designated zip codes in the North Texas area participated in PhotoVoice projects. These projects highlighted community strengths, solutions to health problems, and opportunities for collaboration between Texas Health and local communities.

Results from focus groups conducted during the CHNA process influenced the questions developed for the PhotoVoice project. While focus group findings highlighted challenges to leading a healthy life, PhotoVoice questions focused on solutions to those challenges. Ultimately, 12 questions were developed that covered topics ranging from health care, chronic disease, mental illness, seniors, resources, healthy food, as well as some topics specific to teenagers. Questions which best fit focus group results for a prioritized zip code were implemented with participants from that community.

PhotoVoice project results were analyzed using a qualitative thematic coding methodology utilizing intercoder reliability. Two overarching themes highlighted responses from both adult and teen participants. These two overarching themes were:

1. Solutions and opportunities for access to health care services and providers

2. Solutions for overcoming everyday challenges

Table 8 summarizes the overarching community solutions that came up as a result of the PhotoVoice project.

TABLE 8. PHOTOVOICE COMMUNITY SOLUTIONS SUMMARY

FOCUS GROUP RESULTS	PHOTOVOICE SOLUTIONS
Access to health care services and providers	
Chronic Disease Management	Available resources, information and educational programs at community centers, public libraries, churches, grocery stores, laundromats, and other places people frequent.
Behavioral Health — social isolation and depression	Community centers, more activities (fun, informational, educational), community health workers and navigators, advocates, volunteerism, buddy system, and in-school counselors or referral system.
Healthcare/medical costs	Advocacy, informational meetings.
Resource knowledge	Having resource information available where people frequent — community centers, public libraries, fire stations, and other governmental agencies, schools and the backpack program, places of worship, food pantries, service agencies, public parks, laundromats, restaurants, gas stations. Agencies offering services should be in communities developing relationships with people.
Overcoming everyday challenges	
Transportation	Having hospital and clinics provide transportation for patients. Use church and other agency busses for transportation to healthcare appointments (possibly subsidized by Texas Health Resources, churches, or agencies).
Housing	Abandoned apartment buildings being subsidized and redeveloped into affordable housing.
Healthy food options	Neighborhood and community gardens — neighbors helping neighbors, food pantries collaborating with community centers, further developing Meals on Wheels programs at community centers and other places that encourage socializing activities.

Collin County PhotoVoice Project Findings

Community Impact Zip Code 75069

In Zip Code 75069, Photovoice participants were volunteers from the McKinney Senior Center who were all involved in a variety of programs at the facility. Elderly adults were the target population for this zip code. Ages of participants ranged 61 – 85 years. Ten participants attended the initial session; two individuals dropped out of the program, resulting in eight overall participants. Four of the focus group participants identified themselves as African American, three as White Americans, and one as Filipino Asian. Five participants completed college or technical school, one attended some college, one finished high school, and one did not report their education.

Two questions were proposed to the participants in the 75069 zip code:

Photograph and write about what brings you joy or lifts your spirits in your community that makes you feel healthier, more connected to your community, and/or less lonely?

Photograph and write about what you need to help you live a healthy, happy, safe, and independent life?

Based on the PhotoVoice projects and session discussions the following themes emerged:

When speaking about what brings joy and makes them feel healthier and more connected to their community, participants shared:

1. Outside nature and inside plants and flowers

2. Animal and pets

3. Socializing with others

When discussing what they needed to live healthy, happy, safe, and independent lives, participants shared:

FIGURE 22. COMMUNITY PHOTOS

> **Everyday on one particular branch a beautiful bird with a red face, red breast and a white beak and a beautiful singing voice is perched. I feel like it's singing to me."**

FIGURE 23. PHOTOVOICE PARTICIPANT DEMOGRAPHICS AND SOCIAL DETERMINANTS OF HEALTH
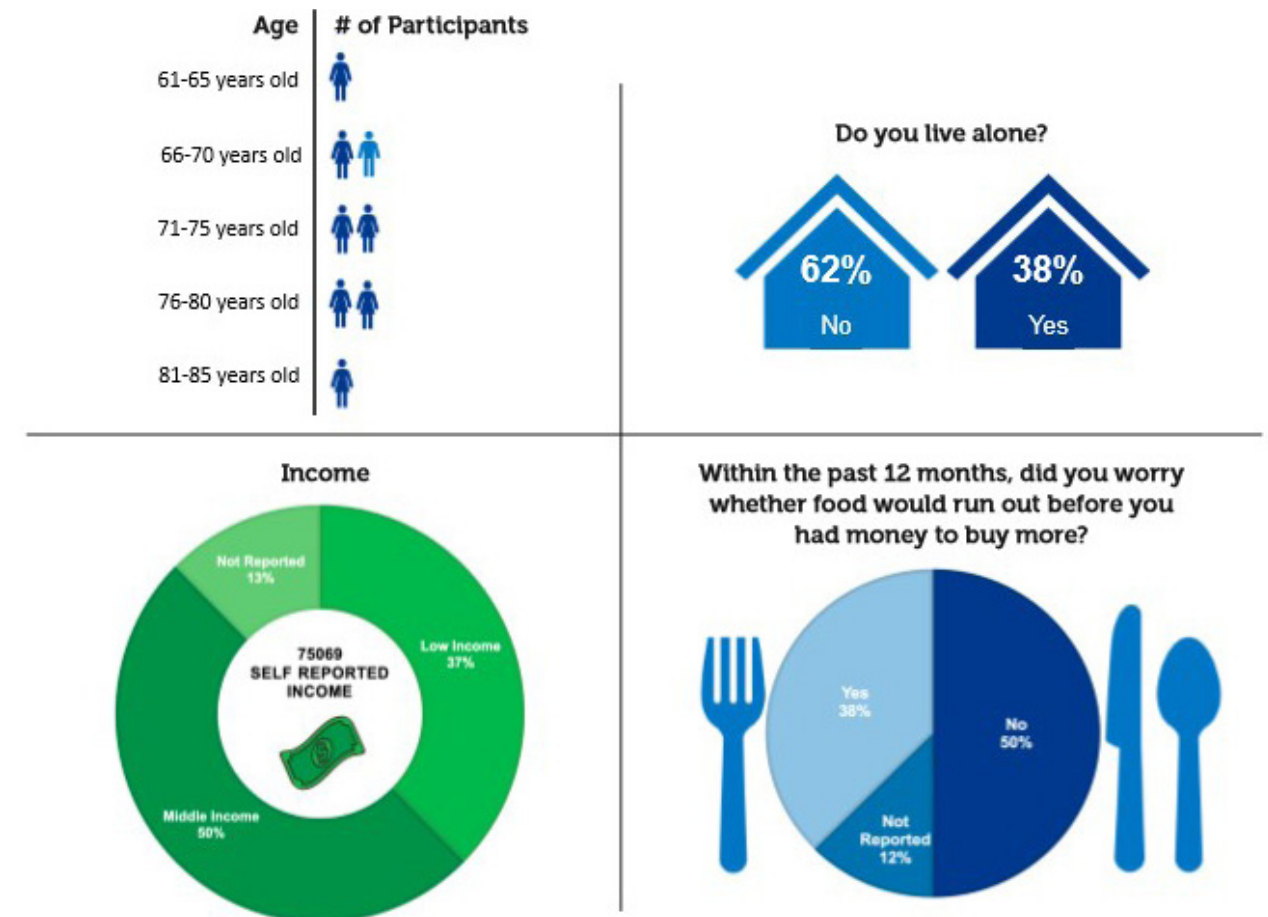
1. Affordable transportation that provides access to

   a. socializing with others while remaining independent

   b. Healthy food resources

   c. healthcare appointments d. essential resources and needs

2. Volunteerism

3. Access to social media

4. Affordable housing

Figure 22 highlights community photos from zip code 75069. Figure 23 illustrates PhotoVoice participant demographic and social determinants of health information.

Community Impact Zip Code 75074

In Zip Code 75074, Photovoice participants were volunteers met at Avenue F Church of Christ in Plano, Texas and were comprised of adults and teens ages 15-65. Initially, three adults and five teens participated. One adult and one teen dropped out, leaving six participants to complete the program. All participants identified as African American. One participant finished trade school, one finished college or technical school, and one completed high school. In regard to accessing healthcare services, one participant reported going to a clinic to receive services regularly while the other reported going to the emergency department regularly. Two adult participants reported having Medicare. Of the teens that completed the program, one participant planned on completing high school while the rest of the participants plan on college or technical school. All participants reported their health being good, and all reported being insured by Medicaid.

The two questions posed to the participants in the 75074 zip code were:

Your school principal received a $100,000 grant to provide resources for teens in middle and high school that would make sure each student has a healthy, safe, and rewarding school year.

Photograph and write about what those resources could or should be?

Based on the PhotoVoice projects and session discussions the following theme emerged:

We spend a lot of time at school and we need

a. Our classrooms and bathrooms to be clean and sanitary

b. Safe ways to get to school

c. Safe places like "no bullying" zones

d. Extra adults on the buses to assure no fighting

e. Someone to talk to when we are down

The teens were were asked one additional question: What makes you feel happy and safe?

a. Spending time with family

b. Playing sports

Figure 24 illustrates PhotoVoice participant demographic and social determinants of health information.

The PhotoVoice project allowed Texas Health to further engage with community members in the Collin prioritized zip codes to identify what the community perceived to be assets and challenges to living a healthy life. These projects highlighted community strengths, solutions to health problems, and opportunities for collaboration between Texas Health and local communities going forward.

> **❙❙ The principal can use the $100,000 to plant many trees around the school so there is fresh air and more shade."**

FIGURE 24. PHOTOVOICE PARTICIPANT DEMOGRAPHICS AND SOCIAL DETERMINANTS OF HEALTH
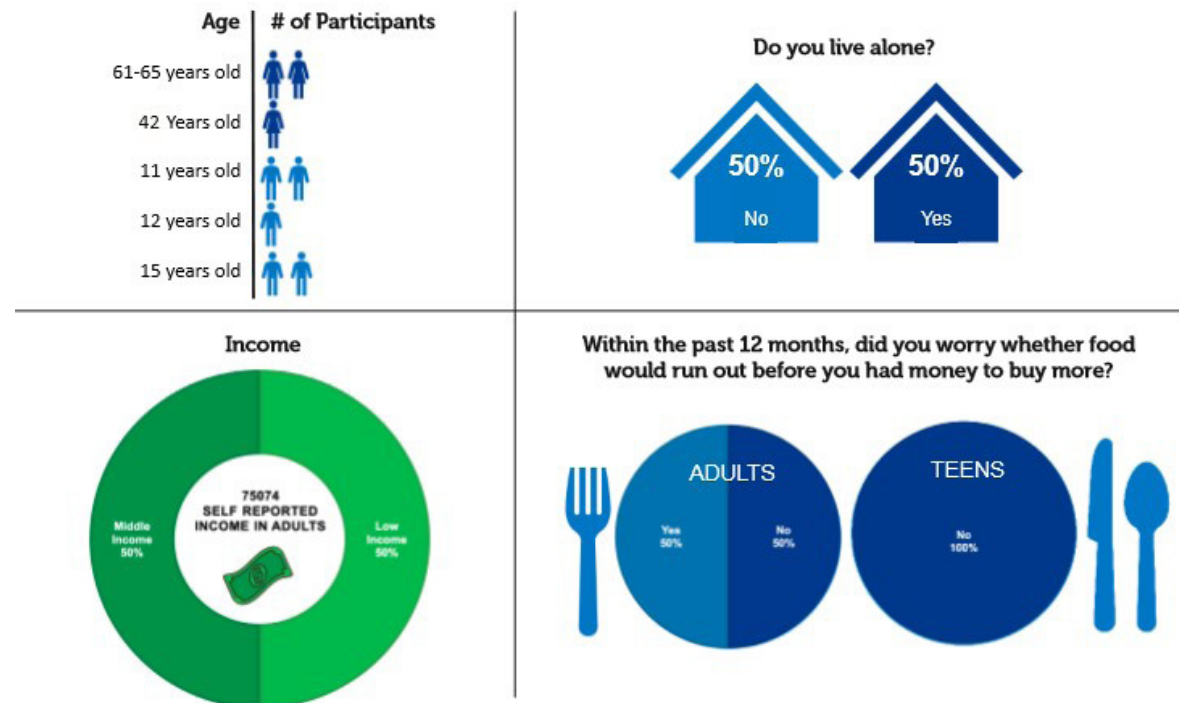
Data Limitations

A key part of any data collection and analysis process is recognizing potential limitations within the data considered. All forms of data have their own strengths and limitations. Each data source for this CHNA process was evaluated based on these strengths and limitations during data synthesis and should be kept in mind when reviewing this report. For both quantitative and qualitative data, immense efforts were made to include as wide a range of secondary data indicators, key informant experts, and community focus group participants as possible.

In addition to general data limitations within this process, there were two other challenges that were faced. Firstly, due to the exploratory nature of work in the zip codes that fell outside Texas Health's primary service area, there were challenges related to meaningfully engaging with community partners and stakeholders during qualitative data collection. This impacted the depth of information that was collected from these communities. Moving forward, more work needs to be done to actively engage these communities and develop deeper relationships with community partners and leaders.

Additionally, the diversity of this region resulted in unanticipated communication barriers during certain data collection efforts. In some instances, there were insufficient interpreters on site to aid with qualitative data collection. This affected participation within the groups and impacted the robustness of the data collected because participants were uncomfortable with the language barrier. To address this, Texas Health provided additional financial resources to overcome the language barrier. In the future, resources and planning efforts will aim to address these challenges from the start.

Opportunities for On-Going Work and Future Impact

While identifying barriers and disparities are critical components in assessing the needs of a community, it is equally important to understand the social determinants of health and other upstream factors that influence a community's health as well. The challenges and barriers faced by a community must be balanced by identifying practical, community-driven solutions. Together, these factors come together to inform and focus strategies to positively impact a community's health. The following section outlines opportunities for on-going work in the Collin Region as well as potential for future impact.

"If we are really going to transform health and health care, we must transform systems and communities. This is our opportunity to play a role in upstream issues that impact health and well-being."

— Catherine Oliveros, DrPH, Texas Health's vice president of Community Health Improvement

Disparities and Barriers

Significant community health disparities are assessed in both the primary and secondary data collection processes. Potential disparities in the Collin Region include households receiving SNAP benefits with children. The region's value is higher than both the Texas state value and the national value. Additionally, the mean travel time to work in the Collin Region is higher than both the Texas state value and the U.S. value. Furthermore, Collin County has a lower percentage of adults under the poverty level than both Texas and the U.S. However, ethnic and racial disparities exist, particularly in those that identify as Other or Hispanic. Identifying these data-driven disparities at the regional level helps to identify the social and economic disparities that can be improved.

Barriers to health and well-being that community leaders and residents raised across the primary data sources reinforced the findings in the secondary data disparities analysis. The key barriers raised by community participants included:

- Challenges with transportation impact access to services
- Affordable housing is limited which makes it difficult to prioritize health needs
- Access to affordable medications and providers, both primary and secondary, is difficult due to geographic location
- Lack of local healthy foods sources

The disparities and challenges highlighted in this section should be viewed as opportunities for the impact, which can be integrated within the work Texas Health has initiated. These areas of opportunity will be considered for future investments, collaborations, and strategic plans, moving Texas Health closer towards our goal of building healthier communities.

Looking Ahead

A total of 41 high-need zip codes were initially prioritized across the five Texas Health Regions and will continue to inform the work being done here into the future. The purpose of the deeper dive into 16 community impact zip codes during this CHNA process was to purposefully identify areas of impact where place-based programs could be built, grown and replicated. While this strategically focused work is being implemented, Texas Health will continue working with TCHI Leadership Councils to revisit data findings and community feedback in an iterative process. Additional opportunities will be identified to grow and expand existing work in prioritized community impact zip codes as well as implementing additional programming in new areas. These on-going strategic conversations will allow Texas Health to build stronger community collaborations and make smarter, more targeted investments to improve the health of the people in the communities we serve. Please refer to the Appendix for a complete list of the 41 high-need zip codes.

Conclusion

The Community Health Needs Assessment for the Collin Region utilized a comprehensive set of secondary data indicators to measure the health and quality of life needs for Collin Region's primary service area and beyond. Furthermore, this assessment was informed by input from knowledgeable and diverse individuals representing the broad interests of the community. Texas Health Resources will review these priorities more closely during the Implementation Strategy development process and design a plan for addressing these prioritized need areas moving forward.

Texas Health Resources invites your feedback on this CHNA report to help inform the next Community Health Needs Assessment process. If you have any feedback or remarks, please send them to THRCHNA@texashealth.org

Appendices Summary

The following support documents are shared separately on the Texas Health Resources Community Health Improvement Website at https://www.texashealth.org/community-health

A. 2016 Texas Health Resources System-Wide CHNA Report

For the 2019 CHNA process, Texas Health built on key findings and achievements from the 2016 CHNA process and Implementation Strategy. The health categories of Behavioral Health, Chronic Disease, as well as Awareness, Health Literacy and Navigation were prioritized during the 2016 Texas Health CHNA. These indicators are still relevant for the 2019 CHNA as Texas Health continues to build on the work initiated in 2016. A copy of the 2016 Texas Health System-wide CHNA report has been included as a reference tool.

B. Texas Health High Need Zip Codes

This table highlights the 41 2016 CHNA high need zip codes from across the five Texas Health Regions. The 16 Community Impact zip codes were selected from this larger list of high need zip codes. Texas Health intends to continue to focus on these target zip codes in future work as represented in the 2020-2022 implementation strategy.

C. Detailed Methodology and Data Scoring Tables

A detailed overview of the Conduent HCI data scoring methodology and indicator scoring results from the secondary data analysis.

D. Community Data Collection Tools

Qualitative data collection tools that were vital in capturing community feedback during the 2019 CHNA process:

- Community Readiness Assessment Tool: Kaufman County Sample Document
- Windshield Survey Questionnaire: Sample Document
- IBM Watson Health: Focus Group Exercise
- UNT Focus Group: Facilitator Guide

E. Community Resources

Increased collaboration and broader regional involvement during the 2019 CHNA process established stronger relationships across the Texas Health's Health Service Area. This document highlights existing resources that organizations are currently using and available widely in the community.

F. Potential Community Partners

The tables in this section highlight potential community partners who were identified during the qualitative data collection process within each of the five Texas Health Regions.

G. Texas Health Resources PhotoVoice Final Report

This is the final, comprehensive report for the SOLUTIONS: A PhotoVoice Project that was implemented by Texas Health Resources as part of the 2019 CHNA process.