Texas Health Resources

System Report

2019 Community Health Needs Assessment

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Executive Summary

Introduction & Purpose

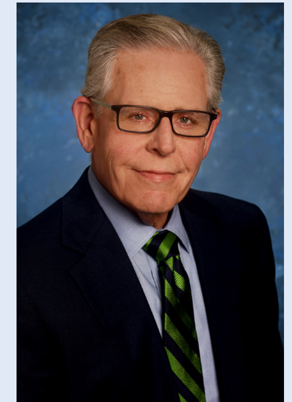
Texas Health Resources is pleased to present its 2019 Community Health Needs Assessment (CHNA). This CHNA report provides an overview of the process and methods used to identify and prioritize significant health needs, at a system level, for 24 of Texas Health's wholly-owned, non-profit and joint venture hospitals, as federally required by the Affordable Care Act.

The purpose of this CHNA is to offer a deeper understanding of the health needs across the region 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.

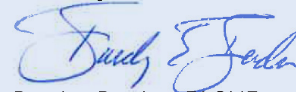
In this report, we're going to share our approach to how we have moved towards addressing challenges by focusing on solutions.

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

David Tesmer, MPA, Chief Community & Public Policy Officer

Community Benefit Leadership and Team

The following individuals are members of the Texas Health Community Health Improvement Team that has led the 2019 CHNA process.

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Texas Health Community Impact Board and Leadership Councils

After Texas Health underwent a governance restructuring in October 2017 that impacted Texas Health's separate hospital boards, a new Community Impact structure was created that brought together former hospital board members and community leaders to serve as strategic advisors for Texas Health Community Health Improvement. The Texas Health Community Impact (THCI) Board was created to serve as a system strategic advisory group as well as a fiduciary board, who in 2019 was responsible for allocating $5.2 million dollars to the regional THCI Leadership Councils. Five THCI Leadership Councils were established — one in each of the five geographic regions served by Texas Health. THCI Leadership Councils recommend outcomes-driven programs and partnerships to receive funds based on an extensive request for proposals (RFP) process. Across the five regions served by Texas Health, THCI Leadership Councils have been actively engaged in the CHNA prioritization process of their respective regions.

> "The Texas Health Community Impact Board and Leadership Councils have played an instrumental role in ensuring community efforts move outside of our hospital walls and are inclusive and community centered. We are grateful to everyone who has played a role in helping us define the needs and identify solutions that resonate within communities."
>
> *— David Tesmer, Chief Community and Public Policy Officer*

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 CHNA. 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 24 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

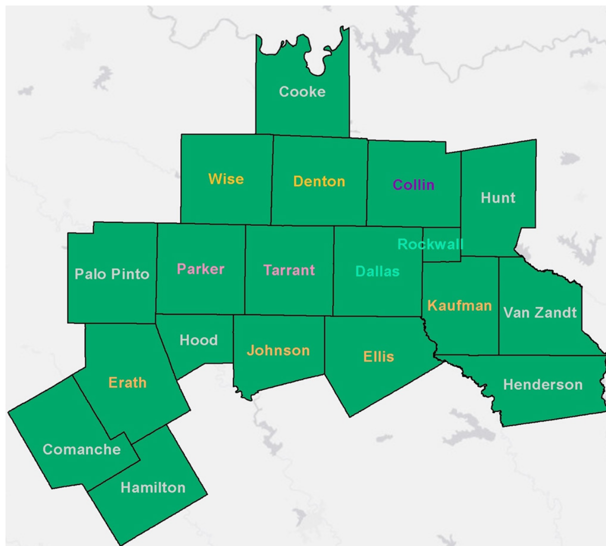
- *Respect* Respecting the dignity of all persons, fostering a corporate culture characterized by teamwork, diversity and empowerment.
- *Integrity* Conduct corporate and personal lives with integrity; relationships based on loyalty, fairness, truthfulness and trustworthiness.
- *Compassion* Sensitivity 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.

Texas Health Service Area

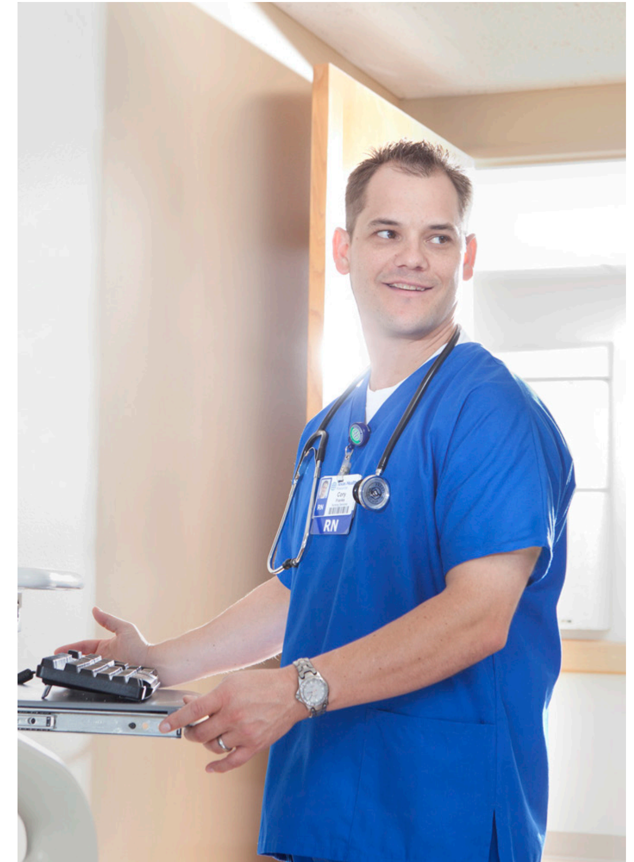
Headquartered in Arlington, Texas, Texas Health serves the fourth-largest metropolitan region in the United States: the Dallas-Fort Worth Metroplex. The health care system includes 24 wholly owned hospitals (14) and joint-venture facilities (10), and a network of physician practices that serve 16 counties. Figure 1 shows the service area counties of the 24 Texas Health facilities included in the assessment. The counties presented in color represent counties that have been highlighted though the 2019 CHNA prioritization process for initial program implementation.

FIGURE 1. TEXAS HEALTH SERVICE AREA COUNTIES



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. The following is a list of the 24 Texas Health facilities included in this assessment categorized by respective region.

TEXAS HEALTH FACILITIES
Collin Region
Texas Health Frisco
Texas Health Center for Diagnostics and Surgery Plano
Texas Health Presbyterian Allen
Texas Health Presbyterian Plano
Denton/Wise Region
Texas Health Flower Mound
Texas Health Presbyterian Denton
Dallas/Rockwall Region
Texas Institute of Surgery at Texas Health Presbyterian Dallas
Texas Health Presbyterian Dallas
Texas Health Presbyterian Rockwall
Southern Region
Texas Health Harris Methodist Cleburne
Texas Health Harris Methodist Stephenville
Texas Health Presbyterian Kaufman
Tarrant/Parker Region
Texas Health Arlington
Texas Health Harris Methodist Alliance
Texas Health Harris Methodist Azle
Texas Health Harris Methodist Fort Worth
Texas Health Harris Methodist Hurst-Euless-Bedford (HEB)
Texas Health Harris Methodist Southwest Fort Worth
Texas Health Heart and Vascular Arlington (AMH Cath Labs)
Texas Health Huguley Hospital Fort Worth South
Texas Health Southlake
Texas Health Specialty Hospital Fort Worth
USMD Arlington
USMD Fort Worth



Texas Health Priority Areas for FY 2020-2022 are:

- Behavioral Health
- Chronic Disease
- Awareness, Health Literacy and Navigation

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

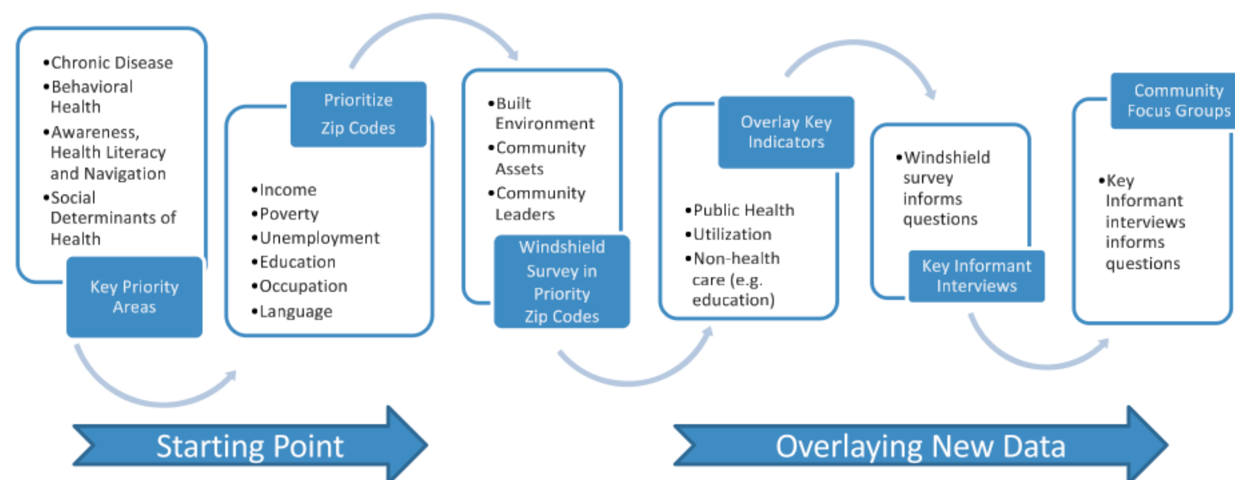
The following section explores the data collection and prioritization process for the 2019 Texas Health CHNA. There were two types of data used in this assessment: primary and secondary data. Primary data are data that have been collected for the purposes of this community assessment. Primary data were 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 Texas Health service area and beyond 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.

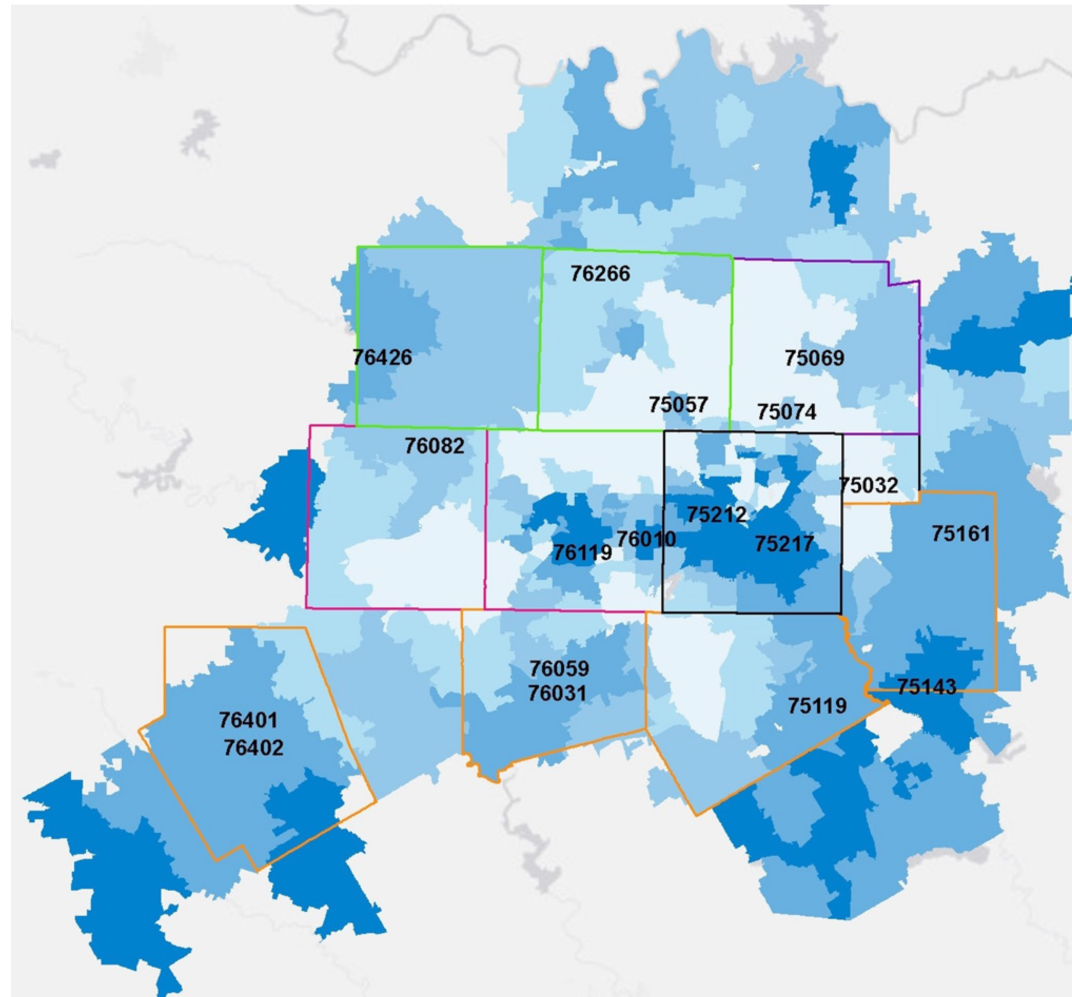
SocioNeeds Index

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

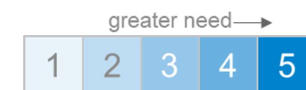
FIGURE 4. TEXAS HEALTH SOCIONEEDS INDEX MAP



The map in Figure 4 highlights SNI values for zip codes across the 16 counties within the Texas Health service area. Darker shades of blue indicate a higher index value and thus higher levels of need within those zip codes. As shown, many of the highest need zip codes are concentrated within Tarrant and Dallas Counties. The final prioritized community impact zip codes across the five regions are also illustrated.

MAP LEGEND

greater need

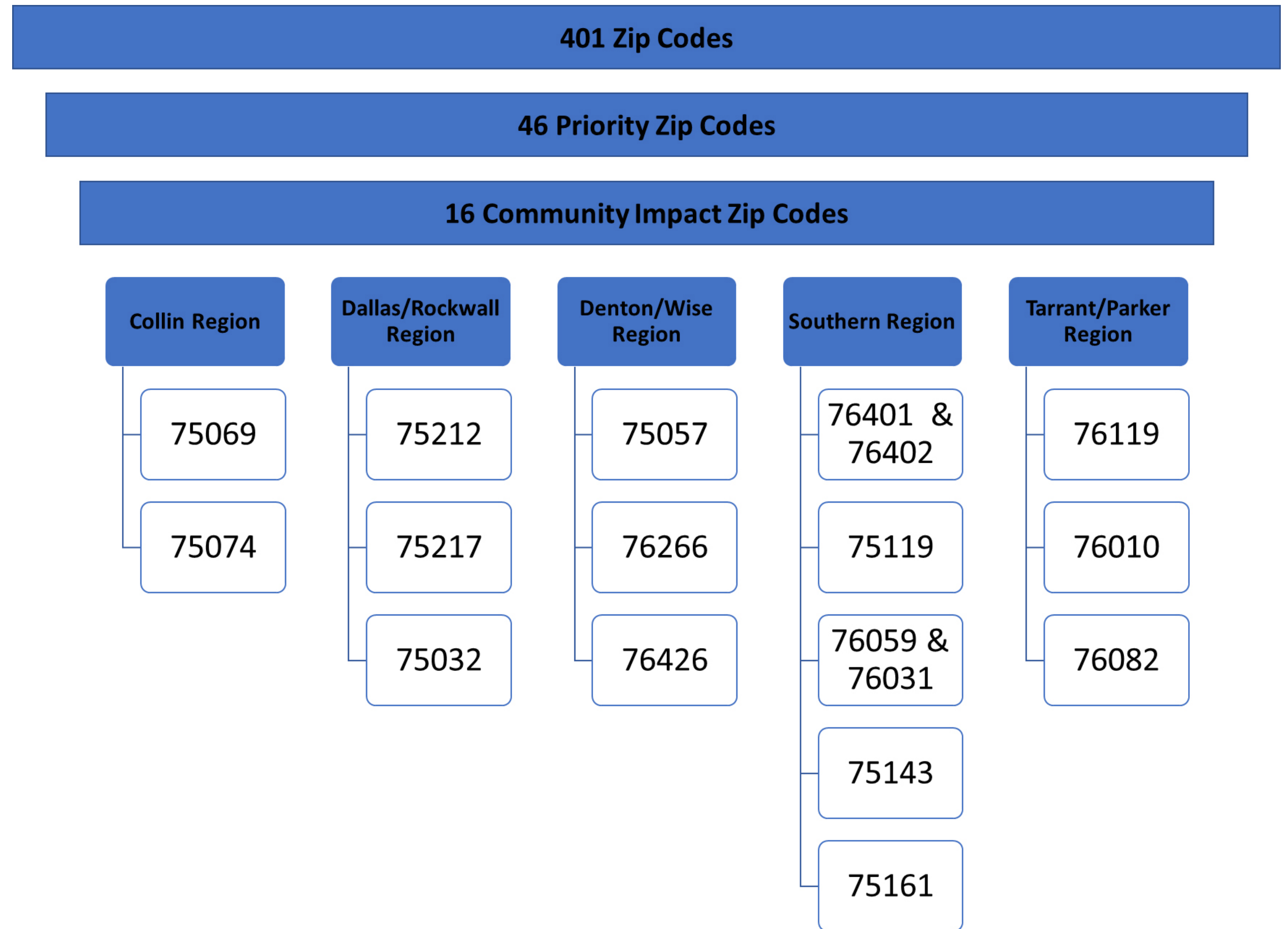


Denton Wise Region
Collin Region
Tarrant Parker Region
Dallas Rockwall Region
Southern Region

Texas Health Zip Code Prioritization

During the 2019 CHNA process, Texas Health initiated the prioritization process by considering all 401 zip codes across the 16 counties that comprise the service area. Zip codes were ranked on perceived need and identified need per the SocioNeeds Index (a measure of socioeconomic need). The initial ranking yielded 46 priority zip codes across the five regions (four in Collin, 13 in Dallas/Rockwall, eight in Denton/Wise, ten in Southern, and 11 in Tarrant/Parker). This triggered an extensive data review and complementary data gathering, including windshield surveys, community readiness assessments that included key informant interviews, and focus groups. The Regional TCHI Leadership Councils reviewed available data for the 46 zip codes and narrowed the scope to 16 community impact zip codes. The Southern Region's prioritization resulted in slightly different results compared to the others. Due to geographical proximity and size of some prioritized zip codes in the region, the Southern Region TCHI Leadership Council selected five priority areas, which include seven community impact zip codes. The diagram in Figure 5 summarizes the overall zip code narrowing/prioritization process for the 2019 CHNA.

FIGURE 5. TEXAS HEALTH 2019 CHNA ZIP CODE PRIORITIZATION



Demographics

The following section highlights the demographic profiles of the counties that contain the 16 community impact zip codes that resulted from the Prioritization Process described earlier.

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 understanding 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 total population of the eleven Texas Health service area counties prioritized though the 2019 CHNA process is 5,097,780. Table 1 shows the population breakdown for the community impact zip codes within these counties.

TABLE 1. POPULATION BY ZIP CODE

COUNTY	ZIP CODE	TOTAL POPULATION ESTIMATE
Collin	75069	36,879
	75074	48,977
Dallas	75212	26,120
	75217	85,249
Denton	75057	14,562
	76266	15,439
Ellis	75119	27,514
Erath	76401	29,478
	76402	831
Johnson	76059	5,211
	76031	18,050
Kaufman	75143	14,138
	75161	6,577
Rockwall	75032	31,399
Parker	76082	18,030
Tarrant	76119	48,380
	76010	57,813
Wise	76426	12,453

Age

As shown in Figure 6, Denton, Parker, Wise, and Erath counties have a smaller proportion of residents under 18 years old compared to the state value, 26.0%. The proportion of residents under 18 years old is 25.8% in Denton County; 24.7% in Parker County; 25.1% in Wise County; and 21.1% in Erath County. Ellis, Dallas, Collin, Tarrant, Rockwall, and Kaufman counties have a larger proportion of residents under 18 years compared to Texas and the U.S. The proportion of residents under 18 years old is 27.1% in Ellis County; 26.8% in Dallas County; 26.9% in Collin and Tarrant County; 27.7% in Rockwall County; and 27.8% in Kaufman County. Johnson County's proportion of residents under the age of 18 (26.2%) is similar to Texas. Cells highlighted in orange in Figure 6 are reflective of values that fall above the state value. Cells in green contain values that are similar to or the same as the state value. Those cells highlighted in blue indicate that the value falls below the state value.

Figure 6 also illustrates the proportion of the population of adults over 65 years. Ellis, Kaufman, Collin, Dallas, Denton, Rockwall, and Tarrant counties have a smaller proportion of older adults compared to Texas (12.3%) and the U.S. (15.6%). The proportion of residents over 65 years is 12.0% in Ellis County; 11.8% in Kaufman County; 6.4% in Collin County; 10.0% in Dallas County; 9.2% in Denton County; 12.0% in Ellis County; 11.7% in Rockwall County; and 10.5% in Tarrant County. Erath, Johnson, Parker, and Wise counties all have a larger proportion of older adults 65 years and older compared to the Texas value. The proportion of residents 65 years and older is 13.8% in Erath County; 13.5% in Johnson County; 14.8% in Parker County; and 14.6% in Wise County.

Additionally, as shown in Figure 6, all counties have a smaller proportion of residents under 5 years of age compared to 7.2% of Texas, except for Collin and Dallas counties. The proportion of residents under 5 years of age is 10.1% in Collin County and 7.6% in Dallas County. Counties with a smaller proportion of residents under 5 years of age compared to the state value include Erath County (5.9%) as well as Ellis and Wise counties (6.7% each). Kaufman and Tarrant counties have similar values to the Texas value (7.1%, and 7.2%, respectively).

FIGURE 6. COUNTY AGE DISTRIBUTION

	Population Under 18	Population Under 5	Population Over 65
Collin	26.9%	10.1%	6.4%
Dallas	26.8%	7.6%	10.0%
Denton	25.8%	6.6%	9.2%
Ellis	27.1%	6.7%	12.0%
Erath	21.1%	5.9%	13.8%
Johnson	26.2%	6.6%	13.5%
Kaufman	27.8%	7.1%	11.8%
Parker	24.7%	6.1%	14.8%
Rockwall	27.7%	6.3%	11.7%
Tarrant	26.9%	7.2%	10.5%
Wise	25.1%	6.7%	14.6%
Texas	26.0%	7.2%	12.5%
U.S.	22.6%	7.2%	15.6%

Race/Ethnicity

The race and ethnicity composition of a population is 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 7 shows the racial composition of residents per county in the Texas Health service area.

FIGURE 7. RACE/ETHNICITY

County	White, non-Hispanic	Black or African American	Asian	Hispanic or Latino (of any race)	Other
Collin	57.3%	9.1%	13.2%	14.6%	5.8%
Dallas	27.8%	20.7%		36.5%	9.4%
Denton	58.5%	8.9%	18.4%	7.5%	6.8%
Denton	58.5%	8.9%	7.5%	18.4%	6.8%
Ellis	58.7%	8.7%		23.9%	8.0%
Erath	72.3%			19.7%	5.7%
Johnson	71.9%			19.8%	4.8%
Kaufman	63.9%	10.1%		19.1%	5.9%
Parker	82.4%	1.3%		11.2%	4.6%
Rockwall	69.9%			16.5%	5.4%
Tarrant	44.8%	14.7%	4.7%	26.1%	9.6%

County	Racial composition
Collin County	The racial make-up of residents in the Collin Region is comprised of 57.3% of residents who identify as White; 14.6% who identify as Hispanic or Latino (of any race); 9.1% who identify as Black or African American; 13.2% who identify as Asian; and 5.8% who identify as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", or "Two or more races".
Dallas County	The racial composition of residents in Dallas County consists of 27.8% of residents identifying as White; 36.5% as Hispanic or Latino (of any race); 20.7% as Black or African American; 5.5% as Asian; and 9.4% as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", or "Two or more races".
Denton County	The racial composition of residents in Denton County consists of 58.5% of residents identifying as White; 18.4% as Hispanic or Latino (of any race); 8.9% as Black or African American; 7.5% as Asian; and 6.8% as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", or "Two or more races".
Ellis County	Ellis County has a racial composition of 58.7% of residents identifying as White; 23.9% as Hispanic or Latino (of any race); 8.7% as Black or African American; 0.6% as Asian; and 8.0% as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", or "Two or more races".
Erath County	The racial composition of residents in Erath County is made-up of 72.3% of residents identifying as White; 19.7% as Hispanic or Latino (of any race); 1.6% as Black or African American; 0.7% as Asian; and 5.7% as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", or "Two or more races".
Johnson County	Johnson County has a racial composition of 71.9% of residents identifying as White; 19.8% as Hispanic or Latino (of any race); 2.8% as Black or African American; 0.8% as Asian; and 4.8% as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", or "Two or more races".
Kaufman County	Kaufman County has a racial composition of 63.9% of residents identifying as White; 19.1% as Hispanic or Latino (of any race); 10.1% as Black or African American; 1.0% as Asian; and 5.9% as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", or "Two or more races".
Parker County	The racial make-up of Parker County is comprised of 82.4% of residents identifying as White; 11.2% as Hispanic or Latino (of any race); 1.3% as Black or African American; 0.5% as Asian; and 4.6% as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", or "Two or more races".
Rockwall County	The racial composition of residents in Rockwall County consists of 69.9% of residents identifying as White; 16.5% as Hispanic or Latino (of any race); 5.8% as Black or African American; 2.3% as Asian; and 5.4% as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", or "Two or more races".
Tarrant County	Tarrant County has a racial composition of 44.8% of residents identifying as White; 26.1% as Hispanic or Latino (of any race); 14.7% as Black or African American; 4.7% as Asian; and 9.6% as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", or "Two or more races".
Wise County	Wise County has a racial composition of 75.6% of residents identifying as White; 18.3% as Hispanic or Latino (of any race); 1.2% as Black or African American; 0.5% as Asian; and 4.4% as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", or "Two or more races".

Language

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

Figure 8 shows the proportion of residents by county in the Texas Health service area who speak a language other than English at home. Dallas County is the only county with a larger proportion of residents who speak a language other than English at home (42.6%) compared to 35.3% in Texas and 21.3% in the U.S. The proportion of residents who speak a language other than English at home is 18.5% in Ellis County; 18.4% in Erath County; 15.8% in Johnson County; 16.7% in Kaufman County; 26.8% in Collin County; 23.1% in Denton County; 8.6% in Parker County; 16.0% in Rockwall County; 28.4% in Tarrant County; and 15.0% in Wise County. Cells highlighted in orange in Figure 8 are reflective of values that fall above the state value. Those cells highlighted in blue indicate values that fall below the state value.

Dallas County in the only county with a larger proportion of residents with difficulty speaking English (21.2%) compared to the state of Texas (14.2%). The proportion of residents who have difficulty speaking English is 7.9% in Ellis County; 5.8% in Erath County; 5.4% in Johnson County; 6.4% in Kaufman County; 9.3% in Collin County; 8.0% in Denton County; 3.1% in Parker County; 5.3% in Rockwall County; 12.3% in Tarrant County; and 6.3% in Wise County.

As shown in Table 2, the prioritized zip codes 76119, 76010, 75057, 75212, 75217, 75069, 75074, 76059, and 76031 have a larger proportion of residents who speak a language other than English at home than their respective counties. 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.

FIGURE 8. LANGUAGE OTHER THAN ENGLISH AT HOME

	Language other than English Spoken at Home	Difficulty Speaking English
Collin	26.8%	9.3 %
Dallas	42.6%	21.2%
Denton	23.1%	8.0%
Ellis	18.5%	7.9%
Erath	18.4%	5.8%
Johnson	15.8%	5.4%
Kaufman	16.7%	6.4%
Parker	8.6%	3.1%
Rockwall	16.0%	5.3%
Tarrant	28.4%	12.3%
Wise	15.0%	6.3%
Texas	35.3%	14.1%
U.S.	21.3%	8.5%

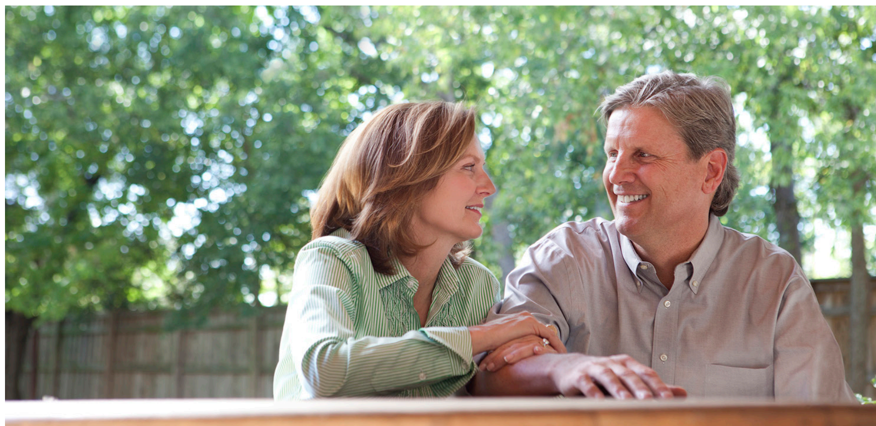


TABLE 2. POPULATION WITH LANGUAGE OTHER THAN ENGLISH SPOKEN AT HOME BY ZIP CODE

COUNTY	ZIP CODE	LANGUAGE OTHER THAN ENGLISH SPOKEN AT HOME
Collin	75069	32.3%
	75074	43.5%
Dallas	75212	60.6%
	75217	63.0%
Denton	75057	44.2%
	76266	8.8%
Ellis	75119	31.2%
Erath	76401	15.2%
	76402	16.4%
Johnson	76059	30.7%
	76031	22.2%
Kaufman	75143	9.2%
	75161	13.8%
Rockwall	75032	19.5%
Parker	76082	8.1%
Tarrant	76119	41.0%
	76010	63.9%
Wise	76426	24.4%

As shown in Table 3, the prioritized zip codes 75069, 75074, 75212, 75217, 75057, 75119, 76059, 76031, 76119, 76010, 75032, 76426, 76059, and 76031, have a larger proportion of residents with difficulty speaking English than their respective counties.

TABLE 3. POPULATION WITH DIFFICULTY SPEAKING ENGLISH BY ZIP CODE

COUNTY	ZIP CODE	DIFFICULTY SPEAKING ENGLISH AT HOME
Collin	75069	14.0%
	75074	20.5%
Dallas	75212	30.1%
	75217	27.3%
Denton	75057	19.7%
	76266	3.3%
Ellis	75119	15.8%
Erath	76401	3.9%
	76402	0.7%
Johnson	76059	10.5%
	76031	8.7%
Kaufman	75143	2.9%
	75161	5.4%
Rockwall	75032	2.1%
Parker	76082	7.4%
Tarrant	76119	21.8%
	76010	34.5%
Wise	76426	12.9%

For all the counties highlighted across the Texas Health service area, English is the predominant language spoken followed by Spanish. Table 4 highlights the languages spoken by the largest percentages of the population within these counties.

TABLE 4. PREDOMINANT LANGUAGES SPOKEN BY COUNTY

COUNTY	ENGLISH (%)	SPANISH (%)	OTHER (%)
Collin	73.17	11.07	2.53 (Chinese)
Dallas	57.39	34.79	1.18 (Vietnamese)
Denton	76.90	14.0	—
Ellis	81.50	17.27	—
Erath	81.55	17.79	—
Johnson	80.45	18.29	—
Kaufman	83.33	15.17	—
Rockwall	84.05	11.75	—
Parker	91.45	7.59	—
Tarrant	71.64	21.04	—
Wise	84.96	14.07	—

Social Determinants of Health

This section explores the social determinants of health of the counties that contain the 16 community impact zip codes that resulted from the Texas Health prioritization process described earlier. 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 9 shows that 10 of the 11 counties of Texas Health Resources are above both the state and national values for Median Household Income. Dallas and Erath counties fall below the state and national values.

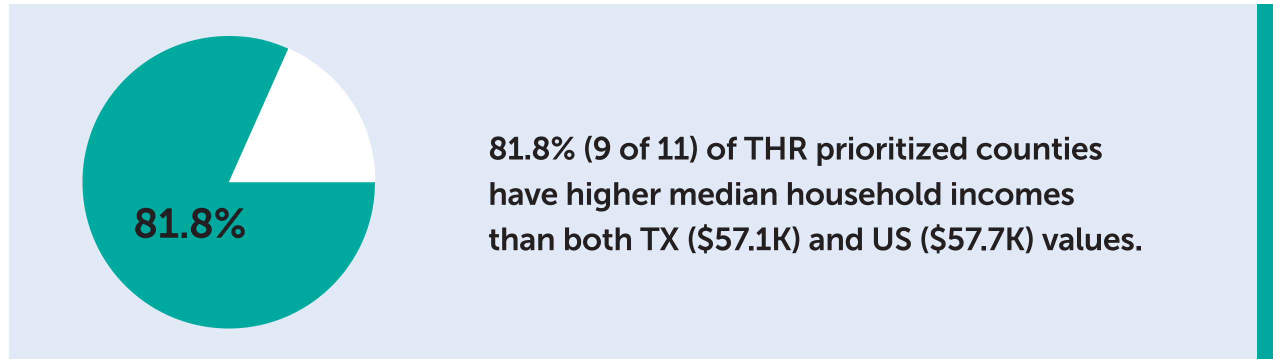
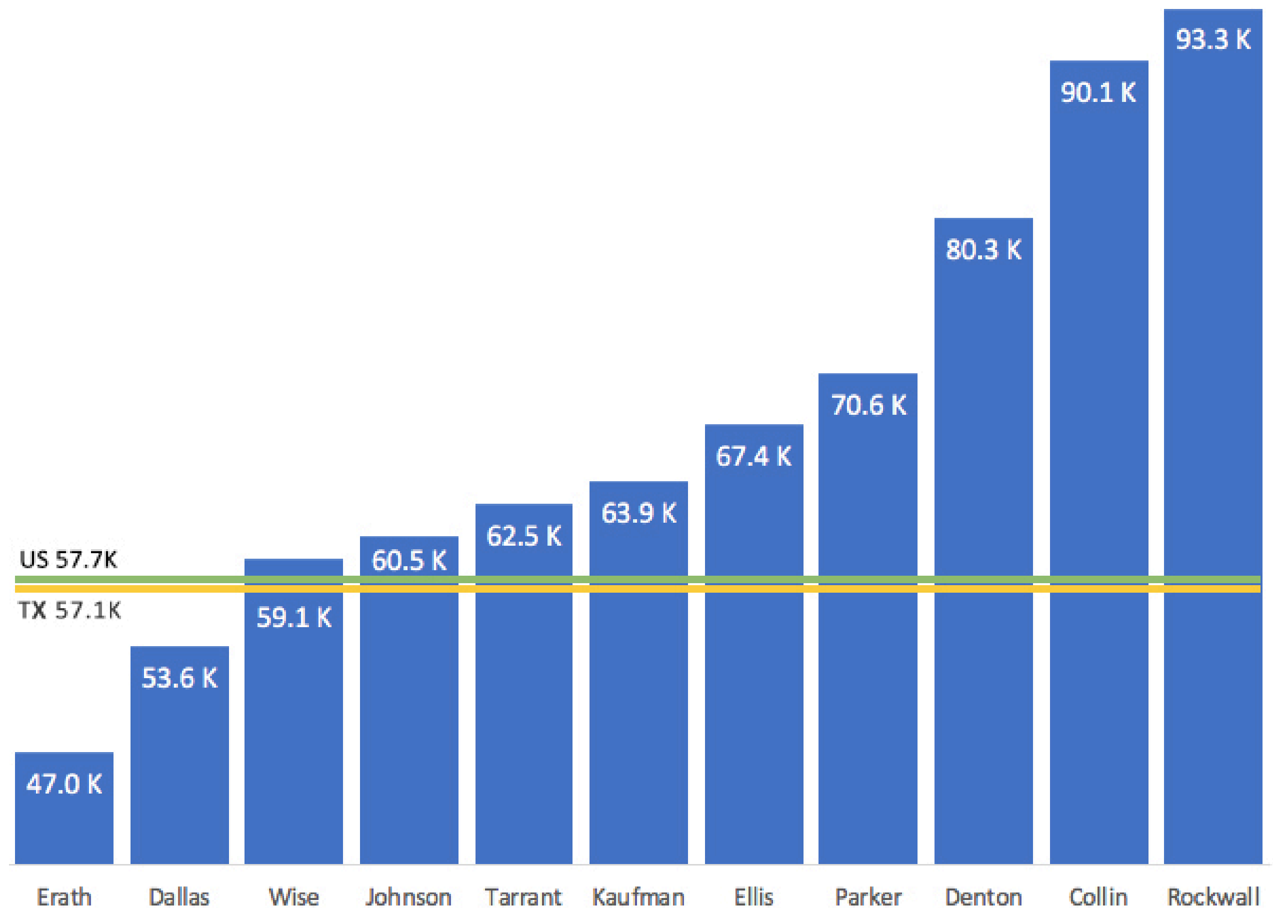


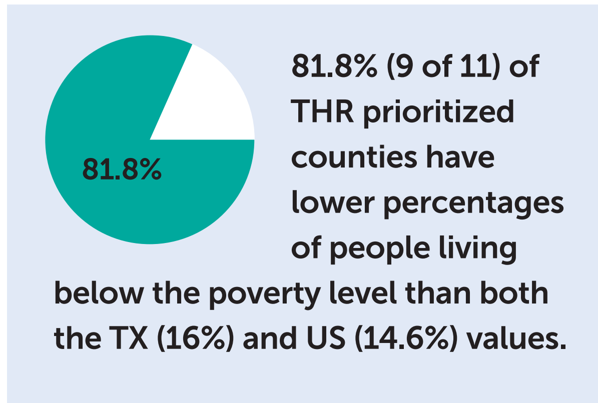
FIGURE 9. MEDIAN HOUSEHOLD INCOME



Poverty

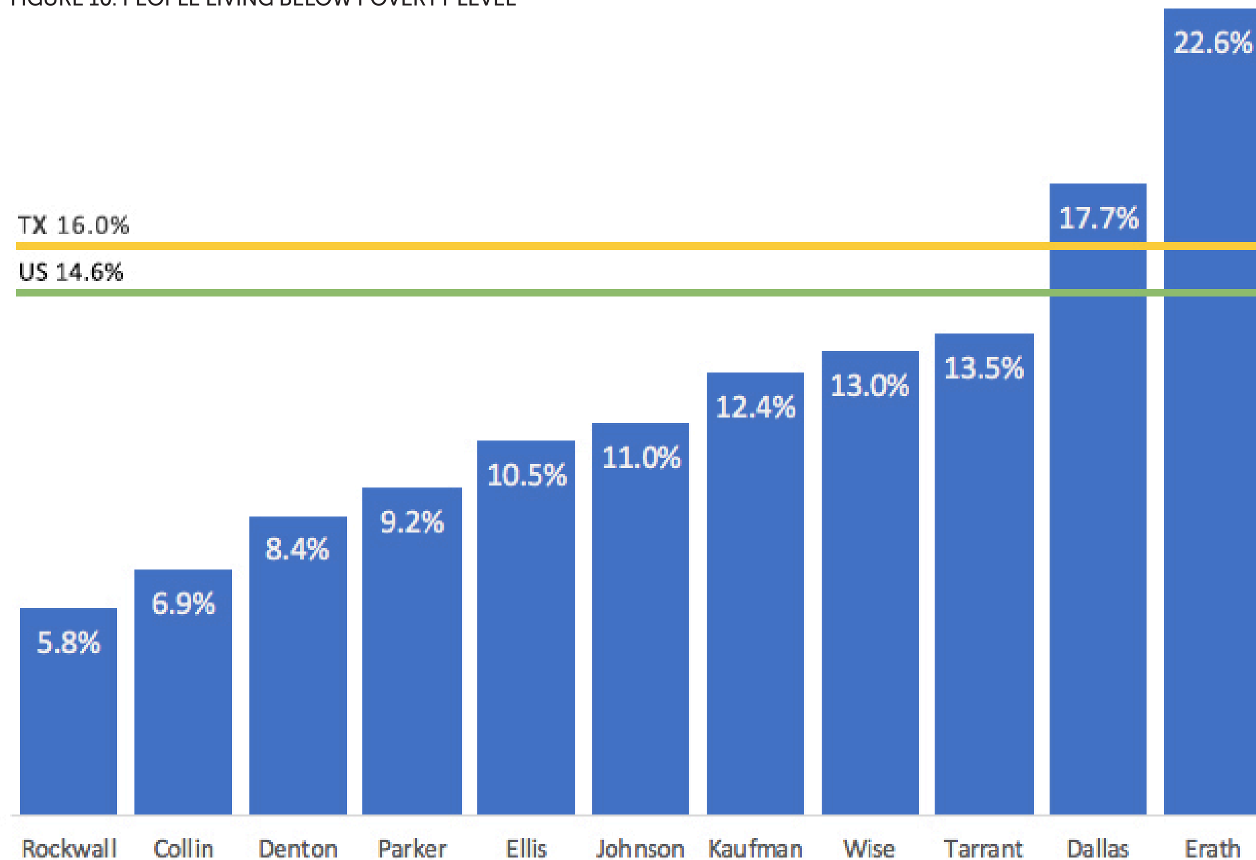
Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. A high poverty rate is both a cause and a consequence of poor economic conditions. A high poverty rate indicates that local employment opportunities are not sufficient to provide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

Figure 10 shows that Dallas and Erath counties fare worse than all other counties prioritized by Texas Health. Additionally, they have higher percentages of poverty than the state and national values.



81.8% (9 of 11) of THR prioritized counties have lower percentages of people living below the poverty level than both the TX (16%) and US (14.6%) values.

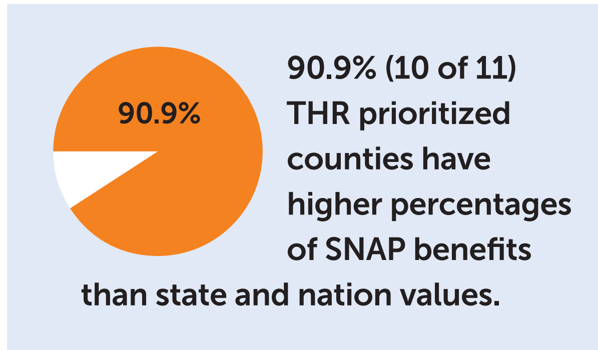
FIGURE 10. PEOPLE LIVING BELOW POVERTY LEVEL



Food Insecurity

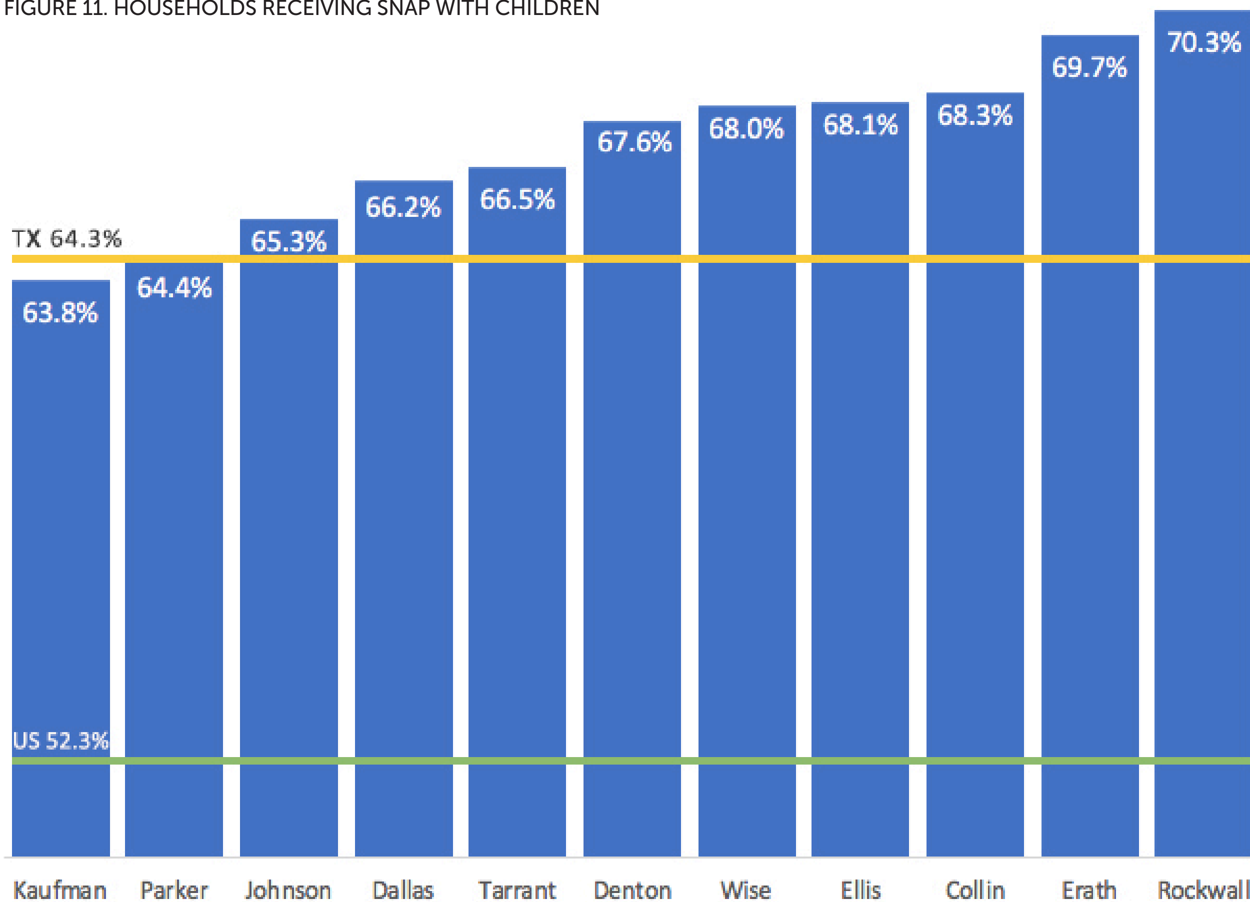
The Supplemental Nutrition Assistance Program (SNAP) is a federal assistance program that provides low-income families with electronic benefit transfers (EBTs) that can be used to purchase food. The goal of the program is to increase food security and reduce hunger by increasing access to nutritious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

Figure 11 shows that all 11 counties prioritized by Texas Health have higher percentages of households with children receiving SNAP than the state value. Meanwhile, Kaufman County has a lower percentage than the state level.



90.9% (10 of 11) THR prioritized counties have higher percentages of SNAP benefits than state and nation values.

FIGURE 11. HOUSEHOLDS RECEIVING SNAP WITH CHILDREN

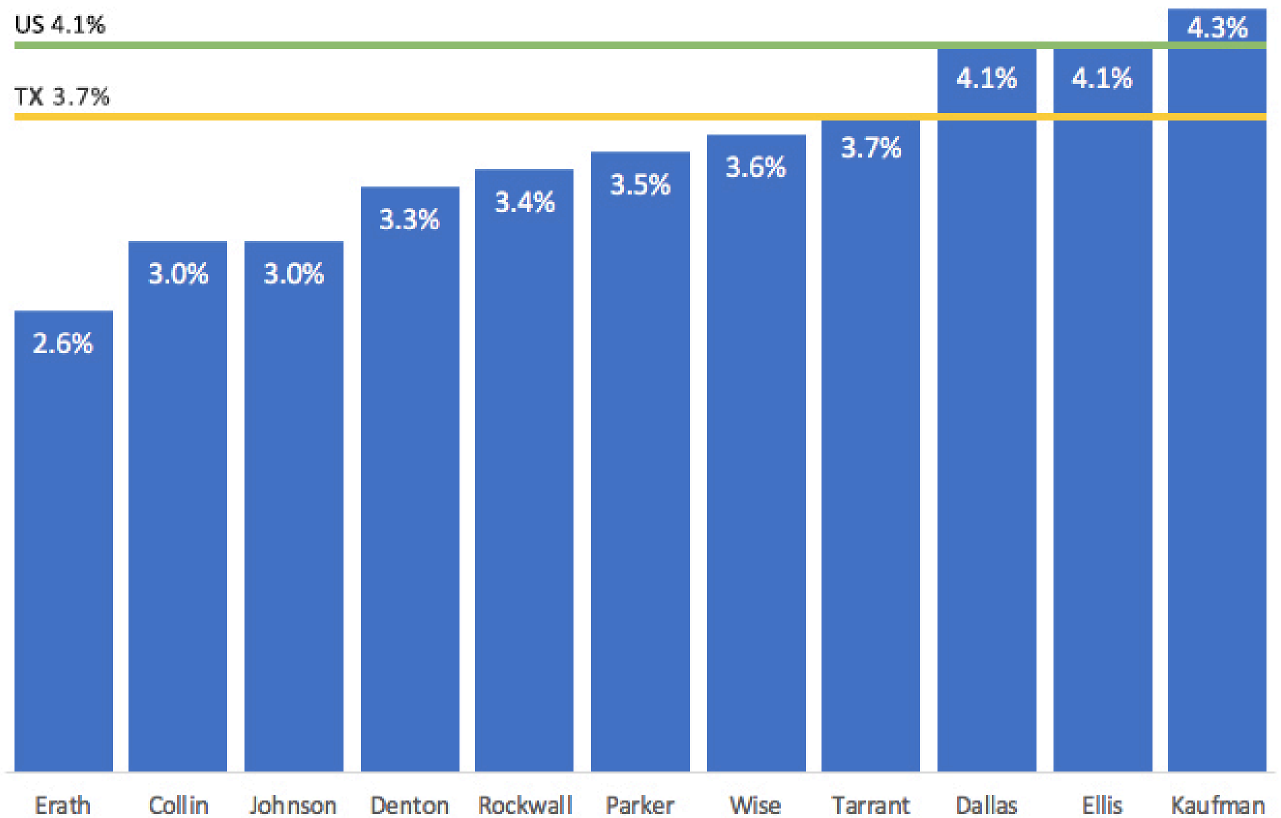


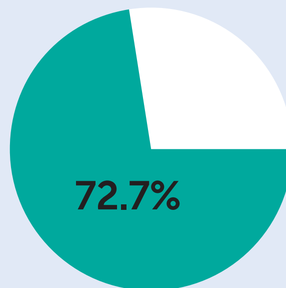
Unemployment

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 severe economic strain and mental stress. Unemployment is also related to access to health care, as many individuals receive health insurance through their employer.

Figure 12 shows that Dallas, Ellis, and Kaufman counties have higher percentages of unemployed workers than the state value. Additionally, Kaufman county has a higher percentage than the national value.

FIGURE 12. UNEMPLOYED WORKERS IN CIVILIAN LABOR FORCE





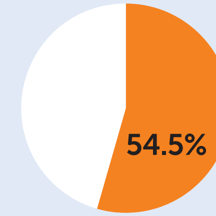
72.7% (8 of 11) of THR prioritized counties have equal to or lower percentages of unemployed workers than both the state (3.7%) and nation (4.1%) values.

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 13 shows that Dallas County has a lower percentage of people 25 years or older with a high school degree or higher as compared to the state, national, and all other county values prioritized by Texas Health.

Figure 14 shows that one-third of counties prioritized by Texas Health have percentages higher than both the state and national values for people 25 years or older with a bachelor's degree or higher.



54.5% (6 of 11) of THR prioritized counties have lower percentages of people 25 years or older with a bachelor's degree or higher than both TX (28.7%) and US (30.9%) values.

FIGURE 13. PEOPLE 25+ WITH A HIGH SCHOOL DEGREE OF HIGHER

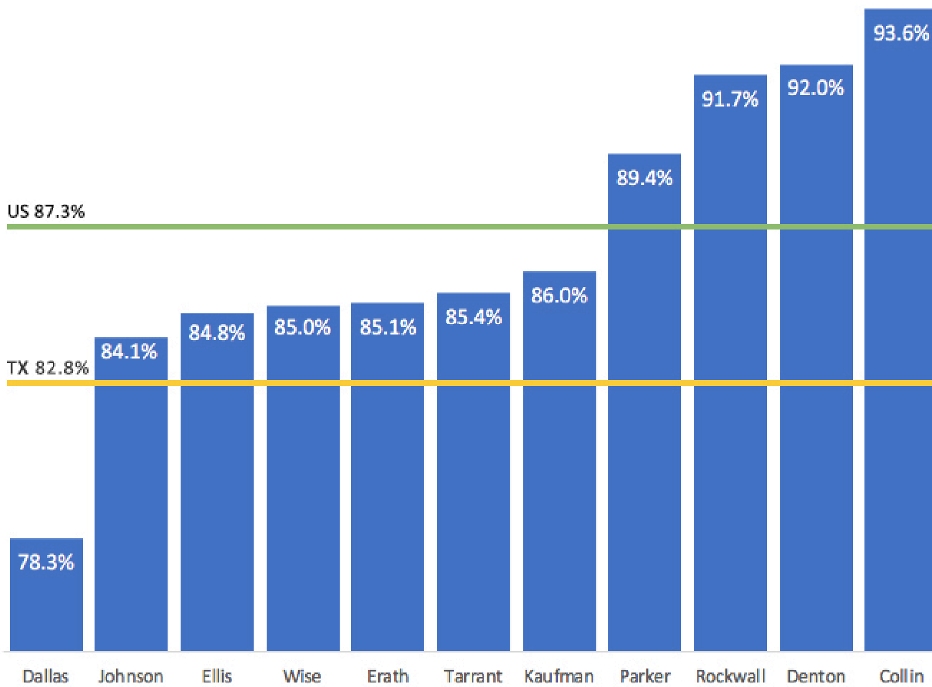
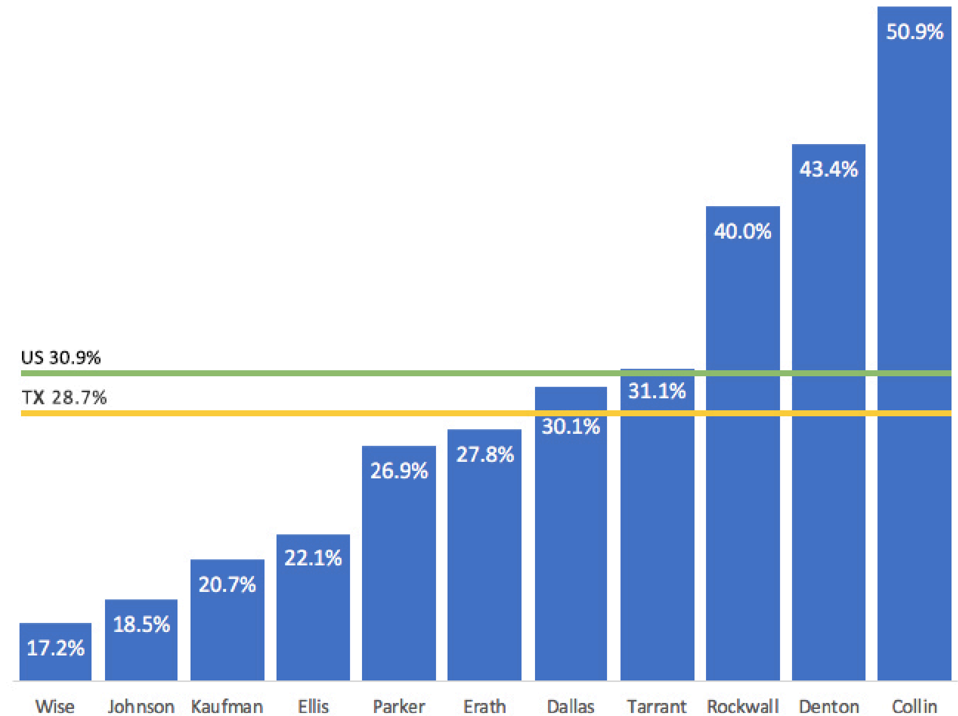


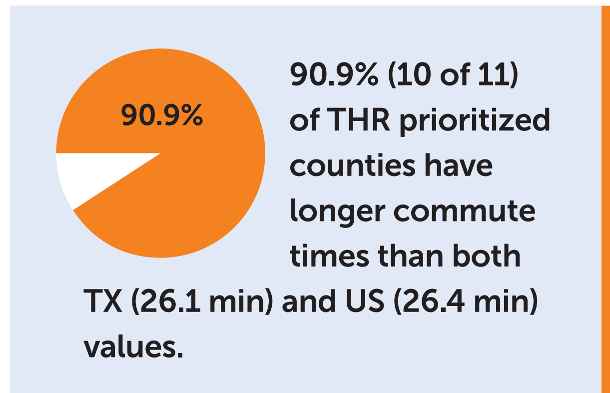
FIGURE 14. PEOPLE 25+ WITH A BACHELOR'S DEGREE OR HIGHER



Transportation

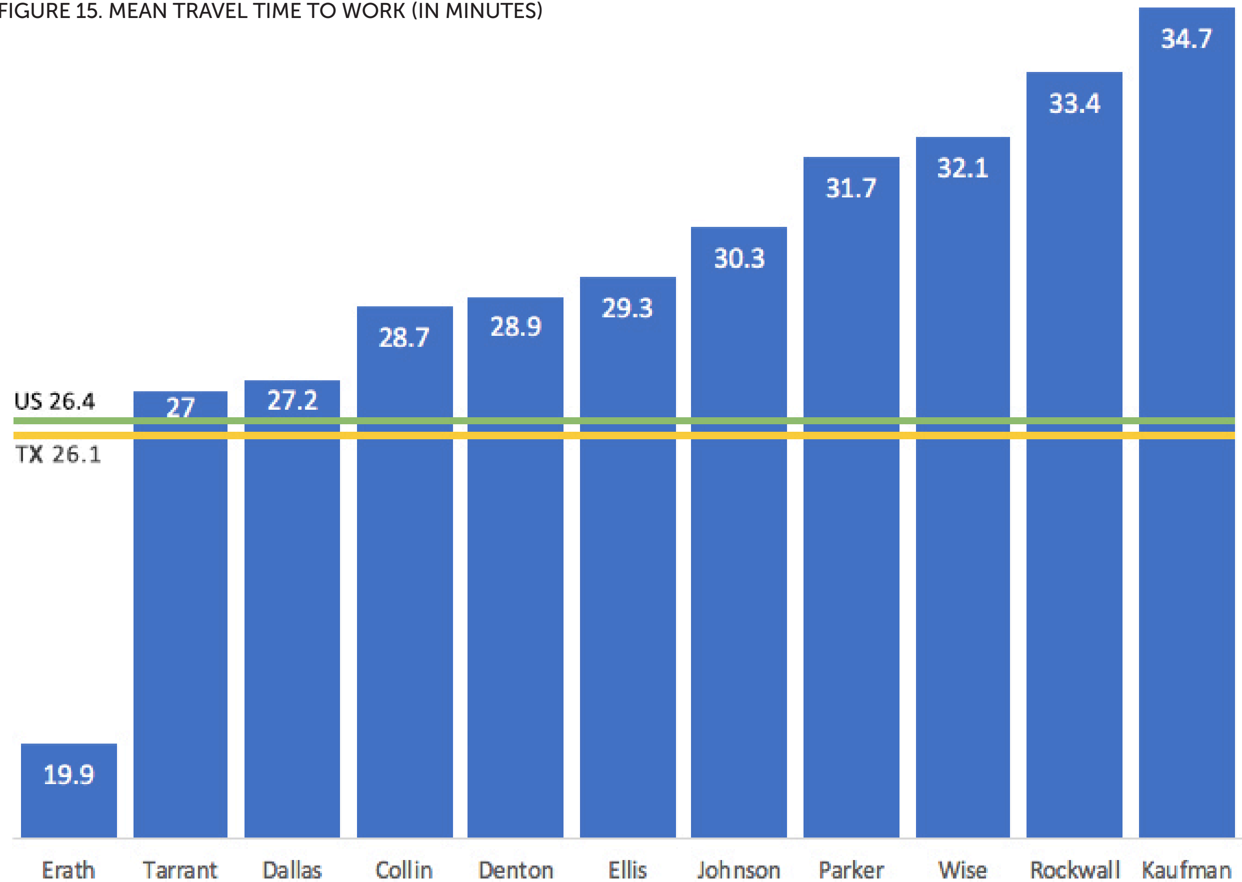
Lengthy commutes cut into workers' free time and can contribute to health problems such as headaches, anxiety, and increased blood pressure. Longer commutes require workers to consume more fuel, which is both expensive for workers and damaging to the environment.

Figure 15 shows that Erath County has a lower mean travel time to work than both the state and national values. All counties have longer commute times to work.



90.9% (10 of 11) of THR prioritized counties have longer commute times than both TX (26.1 min) and US (26.4 min) values.

FIGURE 15. MEAN TRAVEL TIME TO WORK (IN MINUTES)



County Level Focus Groups

In preparation for the 2019 CHNA, Texas Health worked to implement county-level focus groups in counties where no comprehensive county-level information existed due to the historical focus on the service area instead of the county. These additional focus groups, held during Summer 2018 and Summer 2019, were designed to establish a knowledge base for communities where information was limited and to allow for future, deep-dive work into zip code level data analysis and prioritization.

IBM Watson Health Focus Groups

In 2018, Baylor Scott & White Health, Texas Health Resources, and Methodist Health System engaged IBM Watson Health to conduct a series of focus groups to assess the perception of the health needs in the Texas communities they serve. Collin County, Dallas County, and Tarrant County were selected during this process to develop a more comprehensive understanding of these communities at a county level. Participants were invited based on their involvement with public health or their work with medically underserved, chronic disease, low-income or minority populations. Participation was also sought from community leaders, other healthcare organizations, and other healthcare providers, including physicians. The focus groups were facilitated by a team from IBM Watson Health and conducted in three parts. The sessions started with the entire group providing a description of the community and determining an overall health score. During the second part, participants were divided into smaller groups (if overall number of participants allowed) for more detailed discussions. The group then came back together for a final exercise. Discussions were oriented around the following:

1. **Describe the community and the current health of the community.**
2. **Identify the factors for the score and separate into strengths and weaknesses.**
3. **Discuss the underlying barriers to health that contribute to the weaknesses.**
4. **Discuss community strengths that can create opportunities for improving health.**
5. **Identify and rank the criteria for prioritization.**

Collin County

The Collin County focus group took place in McKinney and included 11 participants. The group included health agency administrators, other healthcare providers, and representatives from various community organizations. Most of the participants worked with at-risk populations; the group at-large represented low-income populations, minorities, the medically under-served, and populations with chronic diseases.

Focus group participants described Collin County as a fast-growing, increasingly diverse area with a high cost of living. People moved to this community for its high quality of life, good schools, and job growth. Participants described the many outdoor activities, libraries, low crime rate, and abundant music venues that attracted new residents, but the increased cost of housing and taxes were putting some longtime residents and fixed-income seniors at risk for homelessness. Half the county is agricultural, and lower income residents have limited access to health care due to limited public transportation, lack of insurance, and unwillingness to use free services. Participants discussed the top barriers to health care in the area, including limited political will for change, coordination and knowledge of resources, public transportation, services for low income residents, mental health resources, and affordable housing. The area has limited health care services for the uninsured but an abundance of services for those with both insurance and a high income. According to the group, the uninsured had no dental services and received medical treatment at local emergency rooms. Even with insurance, low-and middle-income residents couldn't afford health or dental care. While the local community health clinic and the fifteen charitable clinics in the county provided services for no or low cost, many people couldn't get to the clinics if they didn't have a car.

Dallas County

The south Dallas focus group included 11 participants. The group included representatives from county government, faith communities, providers, local non-profits, and other community-based organizations. Most of the participants worked with at-risk populations; the group at-large serve low-income populations, minorities, the medically under-served, and populations with chronic diseases.

South Dallas is a melting pot of ethnicities and neighborhoods, each with different assets and health care needs. The focus group emphasized the north versus south differences; companies are moving into the northern areas like Frisco and Plano, but the downtown area south of I-40 lacks resources and is characterized by concentrated poverty and segregation. The area is rich with non-profits and service organizations, but services are often uncoordinated and underutilized. The potential for infrastructure investment and coordination is high in this transitioning community. Focus group participants shared that the diversity in the community also presented barriers to good health. Cultural and historical habits in the immigrant populations and lack of cultural sensitivity in providers contributed to a culture of distrust of outsiders. Combined with very limited public transportation, food deserts, and lack of insurance, many residents had no access to preventive services or primary care and used the ED for medical services. The focus group selected expansion of population

health programs as the greatest opportunity to increase health in the community. The goal would be to provide coordinated, centrally located information and services within the housing areas where the community lives and develop education platforms to send healthy messages to the community. Another opportunity is to expand Medicaid to assist the large numbers of working poor that cannot work, afford health care, and provide food for their families. There were a large number of non-profits that offered services in the south Dallas area, but resources are not used efficiently or coordinated well. The focus group suggested the hospital systems develop a structure to link resources with both the healthcare entities and the community non-profits. Case management is essential to build and deliver healthcare in the community. One of the primary barriers to good health in this community is the lack of living wage jobs to pay for insurance, health services, and healthy food. The focus group pointed to many areas of South Dallas that were available for development and investment.

Tarrant County

The Tarrant County-Fort Worth focus group was held in Haltom City and included 11 participants. The group included representatives from local agencies, faith communities, and various community-based organizations. Most of the participants worked with at-risk populations; the group at-large served low-income populations, minorities, the medically under-served, and populations with chronic diseases.

Focus group participants described Tarrant County as a diverse community with both great wealth and significant poverty, lots of country music and great BBQ. Fort Worth is a destination with recognized arts, theatre, shopping, dining, institutions of higher learning, and designation as a "Blue Zone Community". There were multi-ethnic populations with multi-generational families and lifelong residents. Participants described a growing population across Tarrant County that are homeless or transient. Shelters are close to or over capacity and lacked health resources for low income populations. Portions of the community do not accept that a homeless situation exists, fearing that if they acknowledge and provide resources, it will attract more homeless people to the community. Transportation is available in central Fort Worth, but severely lacking throughout the rest of the county and non-existent in Arlington. The focus group discussed the challenges for low income and immigrant populations to access health resources. Low income residents often needed to prioritize basic needs over health needs and didn't have access to affordable health insurance. Gaps in free and low-cost services were specifically noted for low-income African American mothers until Medicaid eligibility kicked in, dental services, and preventive services. It was noted that health systems didn't accept patients without insurance and redirected to community clinics, but often undocumented residents were afraid of to use unfamiliar provider or use preventative healthcare services. Participants would like to see overall expansion of population health programs that are coordinate and centrally located within the housing areas where the community lives. Development of coordinated services that provide the community the ability to have a one stop shop with access to all services. Participants also suggested using mobile clinics that provide care where the population lives and include convenient follow-up care. Many members of the focus group said that the lack of transportation was a major barrier to good health in the Fort Worth area.

These findings from Collin, Dallas, and Tarrant counties are consistent with information that was gathered at the zip code level in these areas. The community feedback is also in alignment with other data that was gathered leading up to the 2019 CHNA prioritization. Table 5 summarizes the themes from these focus groups.

TABLE 5. IBM WATSON HEALTH COUNTY LEVEL FOCUS GROUPS THEMES – COLLIN, DALLAS, TARRANT COUNTIES

COUNTY	CHALLENGES	STRENGTHS
Collin County	• Limited public transportation • Cost of health care • Language/Ethnicity/immigration status barriers • Cross-agency collaboration	• Good school system • Arts and recreation • Safety and low crime rate • Jobs attracting outsiders • Low cost of living compared to other parts of country
Dallas County	• Need for health information — *coordinated, centrally located information, and services* • Centralization of health care services • Lack of jobs and economic security	• Many community non-profits • Churches across the area • Some access to recreation areas
Tarrant County	• Access to care • Transportation • Limited mental health services • Greater collaboration is needed — between organizations and with data sharing	• Higher education • Nice community to raise children • Entertainment and recreation is abundant • Philanthropic community

Texas Health Resources Focus Groups

Texas Health Resources conducted three additional focus groups in Summer 2019 to begin the assessment process of outlying counties within the Texas Health 16-county service area. The purpose was to build on the 2016 CHNA and gather data contributing to a better understanding of the health needs, barriers to health services and social determinants of health in those counties. Of particular interest during these focus groups was gaining a better understanding of how Texas Health can partner with cross sector organizations to serve uninsured, underinsured and underserved populations. The information gathered during this process will serve as the foundation for further assessment work Texas Health will take on during the 2020-2022 CHNA cycle to inform strategic program implementation.

Participants for these focus groups were recruited by the Texas Health Community Health Improvement team and partner networks. Flyers in English and Spanish were distributed via list-serves and community partners. Individuals representing community-based organizations, school districts, health systems, faith communities, and local businesses were sought for participation. Texas Health staff, partners, and physicians were also invited to attend. Translation was offered for Spanish-speaking participants during the sessions.

All focus groups were facilitated by Texas Health Community Health Improvement staff and ranged from two to three hours in duration. The facilitated discussion focused on the following questions:

1. **Describe the health of your county. What factors contribute to your ranking?**
2. **What are the barriers people face in trying to live their healthiest life?**
3. **What are the strengths of the community in your county?**
4. **What are some of the challenges in your county?**
5. **If Texas Health wanted to collaborate in your county — what are some of the areas of opportunities?**

Participants first discussed the health of their county. Their feedback was transcribed onto flip charts until a comprehensive list of issues and themes was achieved. Participants were then asked to rank the health of their community from 1-5 (with 1 indicating "worst" and 5 indicating "excellent") to obtain an average score.

Finally, healthcare challenges, strengths and collaborative opportunities were further discussed. Participants were asked to prioritize these to close out the session. Each participant was given three stickers to elect the strengths, challenges and collaborations they felt were most important in their community.

Comanche County

The Comanche focus group included 13 participants. The group included representatives from local agencies, businesses, health providers, faith communities, and various other community-based organizations.

Economic challenges, transportation difficulties, and the affordability of prescription drugs were the primary barriers to accessing health care services participants raised. Participants also discussed the difficulties patients have with following treatment plans due to economic challenges (ex. affording medications vs. affording utilities). Additional barriers discussed included insurance status, immigration status, and stigma related to people being embarrassed to ask for help. Cultural beliefs around diet and exercise were also brought up as challenges in the community. Participants also spoke to limited exercise options and limited healthy food choices in their community. Overall, participants felt that there is a lack of knowledge of resources available for navigating the health care system and insurance benefits.

Eastland County

The Eastland focus group included ten participants. The group included representatives from local agencies, faith communities, health providers, and various community-based organizations.

The topic of transportation was raised as a top barrier to accessing health services in the county. Participants pointed out that the rural geography of the community makes it challenging to access services, in addition to a lack of urgent care and after-hours clinics. Community members also mentioned encountering difficulties accessing specialty care when it is available to them due to transportation. Other barriers participants raised included the affordability of prescription drugs and an individual's insurance status (i.e. uninsured people will not seek care). The group discussion also centered around the economic challenges in the community that include limited opportunities for job growth, few higher-paying jobs, limited sources of educational attainment, and difficulties with encouraging new businesses to come to community. Participants also mentioned the lack of affordable childcare options for working families as an additional barrier.

Henderson County

The Henderson focus groups included 11 participants. The group included representatives from local businesses, faith communities, health care providers, and various other community-based organizations.

Transportation was the top barrier participants raised while discussing access to health care services. Other challenges included the affordability of prescription drugs for those living on fixed incomes, particularly the elderly, and fear of seeking help due to immigration status. The affordability of medication also came up during the focus group discussion. A specific example was provided related to lack of prescription drug coverage. It was mentioned that sometimes a provider

must resort to providing "samples" of medications for those who cannot afford medications. Furthermore, providers are hesitant to resort to this practice, as it is not a sustainable solution. Additionally, it was discussed that many patients must make decisions about whether to comply with their treatment plans due to competing personal needs (i.e. affording medications vs. affording food). These patients may be deemed "non-compliant" because of the choices they are forced to make. Participants also mentioned that there are limited mental health providers in the area despite this being a major issue in the community. They emphasized the need to focus mental health efforts on resiliency and to educate the community about appropriate use of services.

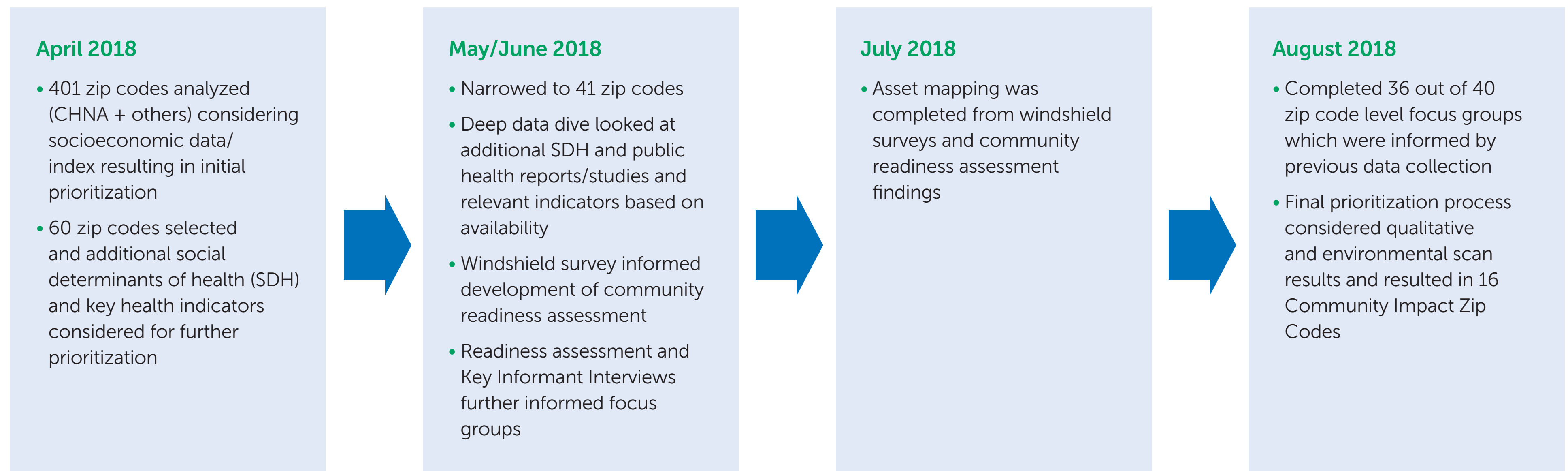
These findings from Comanche, Eastland, and Henderson counties, while consistent with feedback that has been gathered in other communities, reflect the reality in counties where Texas Health will have the opportunity to work in the future. As on-going strategic conversations occur, additional areas for growth and expansion will be considered to improve the overall health of the community. Table 6 summarizes the themes from these focus groups.

TABLE 6. TEXAS HEALTH RESOURCES COUNTY LEVEL FOCUS GROUP THEMES — COMANCHE, HENDERSON, EASTLAND COUNTIES

COUNTY	CHALLENGES	STRENGTHS
Comanche County	• Lack of information/knowledge related to resources • Compliance due to cost limitations/health behaviors • Language/Ethnicity/immigration status barriers • Stigma in accessing resources/seeking help	• Community organizations/provider • Social Media network • Hospital education programs (lunch and learns) • Charity care at Comanche Medical Center
Eastland County	• Employment challenges • Lack of knowledge of resources related to transportation • Mental health challenges/substance abuse	• Community attitude — *includes community support, neighbors helping neighbors, willingness to volunteer and help others* • Healthcare facilities and nonprofit organizations (participants chose to combine these two themes) focusing on addressing the social determinants of health • Opportunities for education and growth
Henderson County	• Lifestyle choices/health behaviors • Mental health • Transportation • Substance abuse	• Community pride • Quality of health care providers • Church support/faith community

Prioritization Process

FIGURE 16. TEXAS HEALTH RESOURCES 2019 CHNA PRIORITIZATION PROCESS



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 16 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 that were considered, 46 of them were considered high priority zip codes. The health needs and potential for impact were considered for these zip codes and the TCHI Leadership Councils from the five regions voted on a smaller subset of 41 target zip codes for further exploration and consideration. Within these 41 target zip codes, extensive qualitative data were then 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 each region are summarized in Table 7.

TABLE 7. SUMMARY WINDSHIELD SURVEY FINDINGS BY REGION

	STRENGTHS	CHALLENGES
Collin Region	• Number of Faith Communities, many of which offer community classes; some offer mentoring partnerships with Title 1 elementary schools • Number of non-profits offering a variety of social services • Parks within walking distance for community members to access • Health clinics/Federally Qualified Health Centers (FQHCs)	• Access to health services/health care • Use the emergency department for primary care • Most homes in the identified area are older and small with only some having had recent renovations; some neighborhood streets and sidewalks need repairs • Known trafficking and illegal drug activity makes the community members feel unsafe
Denton/Wise Region	• Number of Faith Communities; many of which offer senior groups and/or activities • Safe neighborhoods and schools • Community organizations which serve youth • Parks in walking distance • Health and Wellness: Multiple behavioral health providers; most do not accept insurance, but offer sliding scale payment options	• Some neighborhood streets need repair; Few sidewalks and pedestrian crosswalks; Few zoning laws, not required to add sidewalks • Poor access to health services; Many residents are uninsured and use the emergency department for primary care • Limited medical services; no behavioral health providers-residents must drive elsewhere for services
Dallas/ Rockwall Region	• The number of Faith Communities offering counseling and resources (financial, material, emotional, etc.) • Multipurpose recreation centers for activities and education to improve quality of life • Access to free and reduced primary care clinics offering depression screenings and basic counseling/referral services; no free or reduced-cost primary care clinic was identified in Dallas zip code 75217	• No access to mental and behavioral health treatment service providers • Lacking resources to promote greater participation in existing counseling services; No structured counseling programs • Few Substance Use Disorder (SUD) recovery programs • Behavioral health facilities serve the insured for outpatient services primarily • Need for advanced diagnostic and treatment services • Few nonprofit organizations for underserved communities • Lack of public transportation system
Southern Region	• Large number of Faith Communities; a few of whom offer senior groups and/or activities for seniors • Neighborhood collaborations/community facilities offering senior programming/activities • Number of Behavioral Health providers in the region; some offering counseling services with a variety of coverage options (sliding scale, private insurance, Medicaid/Medicare)	• Access to health services/health care • Use of emergency department by those who are uninsured/underinsured • Access to healthy food • Transportation barriers
Tarrant/ Parker Region	• Large number of Faith Communities; opportunities for partnerships • Number of parks, community centers, and recreation areas with programming/activities • Facilities offering health and wellness services/programs	• Tobacco and alcohol advertisements are notable • Limited or no grocery stores • Older homes/apartments and neighborhoods; little new construction • Limited access to resources by those living in rural areas

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 five regions, 46 key informants were interviewed. Table 8 highlights the variety of individuals who participated as key informants. All key informants have worked in one or various targeted zip codes. The key informants currently work for a variety of non-profit organizations, churches, hospitals, as well as 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 8. KEY INFORMANTS INTERVIEWED (KII)

PROFESSIONAL TITLE OF KII	NUMBER OF KIIs
Executive Director	8
Pastor/Minister	7
Manager	7
President & CEO	5
City Council Member	4
Director of Client Services	3
Director of Programs	3
Outreach Specialist	2
Fire Chief	1
Grant Coordinator	1
Pharmacist	1
Community Advocate	1
Health Planner	1
School Nurse	1
Social Worker	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 average 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. Table 9 summarizes the results of the community readiness assessments conducted during this CHNA. Parker, Rockwall, and Ellis counties were not included in the readiness reports due to a small number of key informants.

> "I need to be able to have food on the table, groceries in the fridge, and a roof over my head; and there's a lot of effort in taking care of that functional thing."
>
> — Tarrant County KII Participant

> "Many residents do not have the financial resources to travel into Fort Worth, even Weatherford, for assistance. Many are experiencing generational poverty."
>
> — Parker County KII Participant

> "Many community members don't believe in preventative health."
>
> — Collin County KII Participant

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

TABLE 9. COMMUNITY READINESS ASSESSMENTS STAGE OF READINESS SUMMARY

COUNTY	STAGE OF READINESS
Collin	Stage 3
Erath	Stage 3
Dallas	Stage 4
Denton	Stage 4
Johnson	Stage 3
Kaufman	Stage 3
Tarrant	Stage 4
Wise	Stage 3

Counties received a stage of readiness score of either Stage 3 or Stage 4. Collin, Erath, Johnson, Kaufman, and Wise counties' 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.

Dallas, Denton, and Tarrant counties' current stage of readiness is four.

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

- Some community members have at least heard about local efforts, but know little about them.
- Leadership and community members acknowledge that this issue is a concern in the community and that something has to be done to address it.
- Community members have limited knowledge about the issue.
- There are limited resources that could be used for further efforts to address the issue.

Community Focus Groups

A total of 36 focus groups were held across the five regions. Input from community residents was collected through verbal discussions with a facilitator from 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 446 residents participated. 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 and some topics came up in multiple regions. Transportation was a universal issue across all zip codes. Participants raised transportation as an issue specifically related to accessing health care services, as well as in their daily life. Limited options for affordable housing was brought up as well. The focus group discussions also identified the cost of health insurance coverage as a limiting factor for seeking services. Participants also raised challenges with finding providers in proximity for both primary and specialty care. Many focus groups participants acknowledged the need for more health education about preventing and managing chronic diseases in their communities and increased access to healthy foods. Table 10 summarizes key focus group themes for prioritized zip codes.

TABLE 10: FOCUS GROUP KEY THEMES FOR PRIORITIZED ZIP CODES

COUNTY	COMMUNITY IMPACT ZIP CODE	KEY FOCUS GROUP THEMES
Collin	75069	• Infrastructure of public transportation is insufficient to meet the needs of the community • Lack of local food banks with plentiful selection create a "food desert" • Housing costs have pushed out those who seek affordable housing
	75074	• Participants would benefit from Patient Care Assistance program from pharmaceutical companies • Need for nearby specialist care centers • Better provision and dissemination of up-to date information on available resources • Affordable transportation options would help access to services
Dallas	75212	• Timeliness and regular access to healthcare (e.g. waiting for doctor; time between appointments) • General cost of healthcare • Availability of food options (no good restaurant options; no major grocery stores) • Reliable and accessible transportation services
	75217	• Cost of healthcare is a big factor, even with insurance • Mental health issues are common • The community is engaged and wants to be part of the solution
Denton	75057	• Cost of living, safe-housing, and health care affordability • Awareness of available resources • Preventative care, dental, and vision • Access to services — barriers of paperwork/bureaucracy • Resources for single parents
	76266	• Reliable and timely transportation; worse when driving long distances for appointments • Lack of pharmacies to get prescriptions filled (only one in Sanger) • Health care costs; rising premiums, deductibles, and cost of medicines
Ellis	75119	• Reliable, same day access to transportation services • Medical services located in the community to limit need for travel • Need for community gathering places with healthcare advocates and counselors

" People are wanting more education, so I think it is important to the people of Kaufman County and to our leaders to find out more about chronic diseases and to be able to get the help they need."

— Kaufman County KII Participant

" (We) would like to work together and get some sort of program started for those living in rural areas that will not travel to town."

— Erath County KII Participant

" I don't think the majority of the community realizes the effect that drugs and alcohol (or mental health) has on their families or our communities."

— Wise County KII Participant

" Food, access, and housing as well as menta health are areas of opportunity for Texas Health Resources in the community."

— Dallas County KII Participant

Erath	76401/76402	• Health literacy and communications • Access to the Texas Health Resources (THR) health book • Lack of services and transportation
Johnson	76059/76031	• Health fairs involving all age groups could drive discussion and community connections • Reliable transportation to access hospitals/clinics and pharmacy • Discount on medical services and food for senior citizens
Kaufman	75143/75161	• Lack of key medical services and places not taking Medicaid; forces residents to drive elsewhere for treatment • Participants lacked knowledge of how health insurance works and what it does
Rockwall	75032	• Immigration/legal status or lack of a Social Security number impedes adults from receiving medical treatment • High copays, deductibles, and drug costs hinder them from receiving the meds or treatment they need • Need more Hispanic/Latino professionals in the area to advocate for them/help them access key services
Parker	76082	• Drugs are major issue in the community as is suicide amongst teens (specifically teenage girls, related to bullying) • Limited access to specialists and transportation are major issues • Good access to pharmacies and grocery stores – however, cost of food is high, and people must travel to find lower cost foods • Child poverty
Tarrant	76119	• High number of new HIV diagnoses • Transportation options not available due to cost/wait • Mental health issues very common, but not treated • Affordable housing limited and hard to get
	76010	• Lack of knowledge about benefits available • Transportation is limited • Affordable housing for seniors is needed • Dental care limited
Wise	76426	• Lack of key medical services and places not taking Medicaid; forces residents to drive elsewhere for treatment • Participants lacked knowledge of how health insurance works and what is does

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 TCHI Leadership Councils 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. Table 11 highlights the zip codes that were chosen as the final community impact zip codes. In addition to narrowing down the focus geographically, based on evidence and the criteria mentioned above, the councils were 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, TCHI Leadership Councils independently elected to focus on Anxiety and/or Depression within the Behavioral Health category in each of the community impact zip codes. Table 11 summarizes the Health Priority Area(s) within each zip code as well as the target population.

TABLE 11. TEXAS HEALTH PRIORITIZED ZIP CODES AND HEALTH AREAS

COUNTY	COMMUNITY IMPACT ZIP CODE	HEALTH PRIORITY AREA
Collin	75069	Depression and anxiety among youth aged 12-18 years
	75074	Depression and anxiety among adults over the age of 55
Dallas	75212	Depression among adults 18-64
	75217	Depression among adults 18-64
Denton	75057	Depression and anxiety among youth 18 and under
	76266	Depression and anxiety among youth 18 and under
Ellis	75119	Depression and anxiety among adults over the age of 55
Erath	76401	Depression and anxiety among adults over the age of 55
	76402	Depression and anxiety among adults over the age of 55
Johnson	76059	Depression and anxiety among adults over the age of 55
	76031	Depression and anxiety among adults over the age of 55
Kaufman	75143	Depression and anxiety among adults over the age of 55
	75161	Depression and anxiety among adults over the age of 55
Rockwall	75032	Depression among adults 18-64
Parker	76082	Depression and anxiety among adults over the age of 55
Tarrant	76119	Depression and anxiety among adults over the age of 55
	76010	Depression and anxiety among adults 18-64
Wise	76426	Depression and anxiety among youth 18 and under

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. Tables 13 and 14 highlight PhotoVoice demographic and social determinants of health. 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

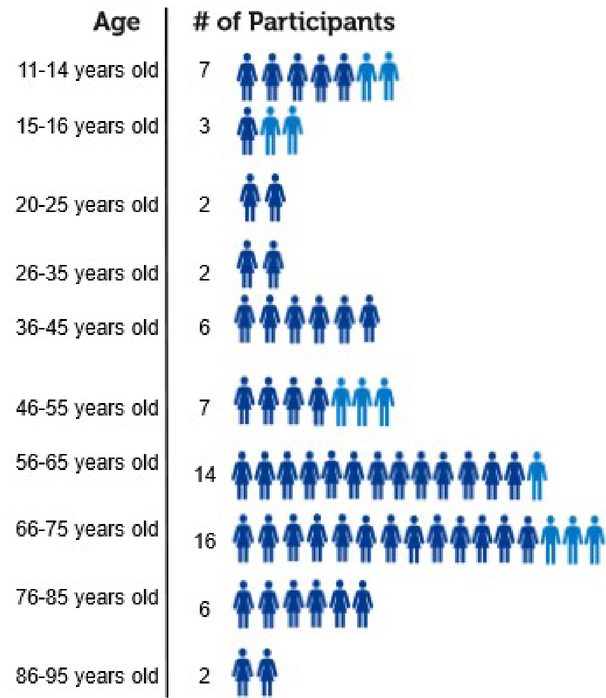
2. Solutions for overcoming everyday challenges

Table 12 summarizes the overarching community solutions that came up as a result of the PhotoVoice project. Figure 22 highlights pictures taken by PhotoVoice participants that represent the solutions identified in table 12.

TABLE 12. PHOTOVOICE COMMUNITY SOLUTIONS SUMMARY

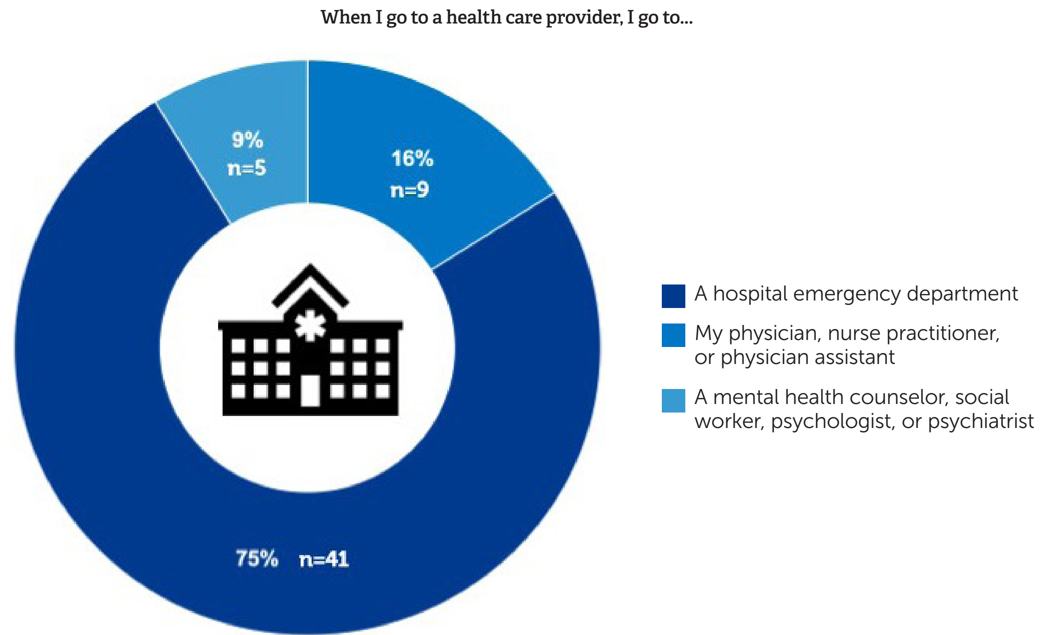
FOCUS GROUP RESULTS	PHOTOVOICE SOLUTIONS
Access to health care services and providers	
Chronic Disease Management	Available resources, information and educational programs at community centers, public libraries, churches, grocery stores, laundromats, and other places people frequent.
Behavioral Health — 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.

TABLE 13. PHOTOVOICE PARTICIPANT DEMOGRAPHIC AND SOCIAL DETERMINANTS OF HEALTH HIGHLIGHTS



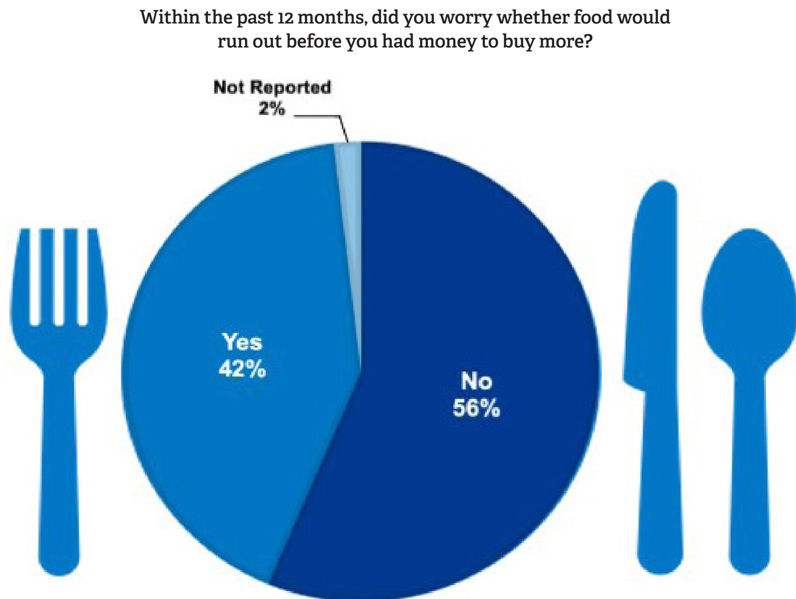
SELF-REPORTED HEALTH CARE ACCESS FOR ALL ADULT PARTICIPANTS n=55 (100%)

When I go to a health care provider, I go to...



SELF-REPORTED FOOD SECURITY FOR ALL ADULT PARTICIPANTS n=54 (98.1%)

Within the past 12 months, did you worry whether food would run out before you had money to buy more?



SELF-REPORTED RACE AND ETHNICITY FOR ALL ADULT PARTICIPANTS n=54 (98.1%)

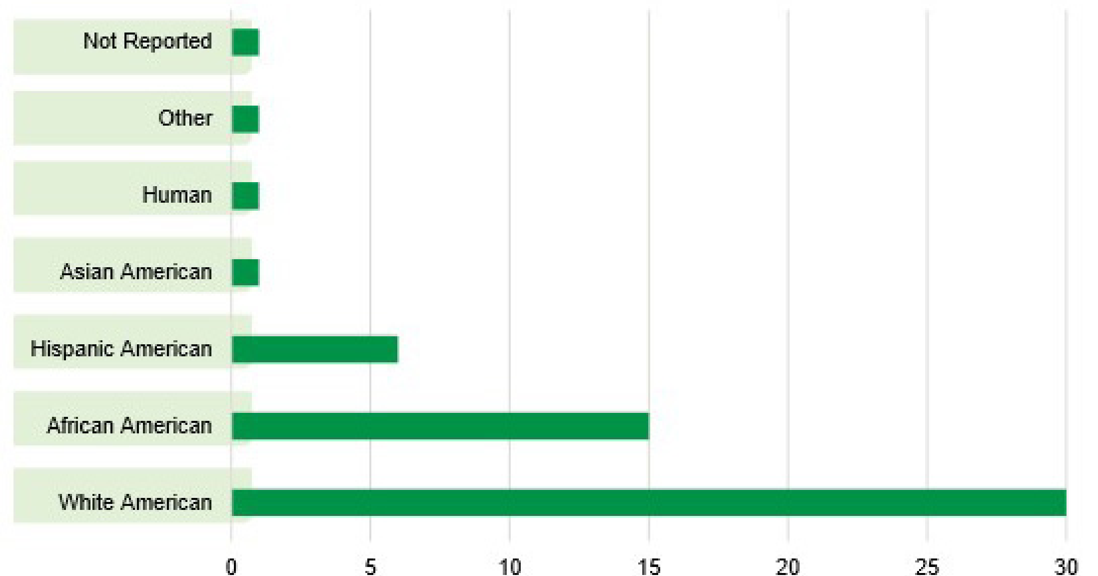
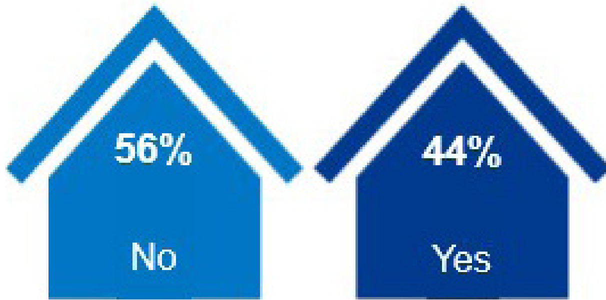


TABLE 14. PHOTOVOICE PARTICIPANT SOCIAL DETERMINANTS OF HEALTH

SELF-REPORTED LIVING SITUATION FOR ALL ADULT PARTICIPANTS n=55 (100%)

Do you live alone?



SELF-REPORTED INCOME FOR ALL ADULTS PARTICIPANTS n=54 (98.1%)

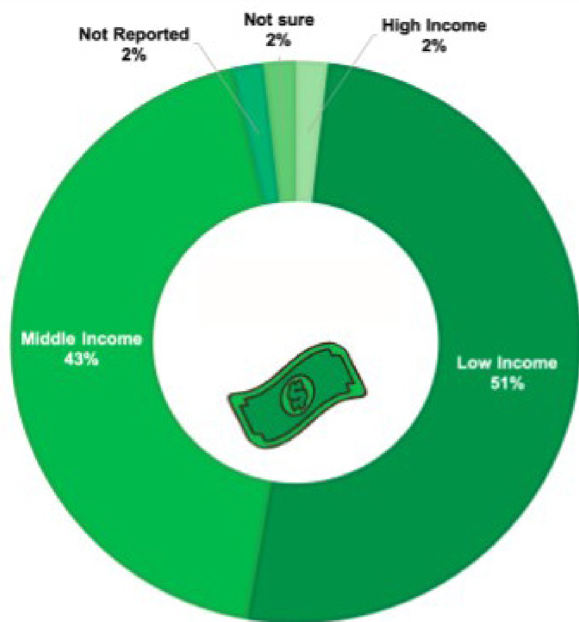


FIGURE 22. COMMUNITY PHOTOS

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 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 disparities that influence health are assessed in both the primary and secondary data collection processes. Potential disparities across the five regions include people living below the poverty level, percentage of unemployed workers, people 25+ with a bachelor's degree or higher, and mean travel times to work. The percentage of people living below poverty level in Dallas and Erath counties fare worse than all other prioritized counties in the region. Both Dallas and Erath counties have poverty values higher than state and national values. Additionally, the percentage of unemployed workers in the civilian labor force is higher for Dallas, Ellis, and Kaufman counties compared to the state value. Kaufman County also has a higher percentage of unemployed workers than the national value. Dallas County has a significantly lower percentage of people aged 25+ who have a bachelor's degree or higher, compared to both state and national values. Finally, all counties except Erath County have longer mean travel times to work than state and national values. Please refer to the tables in the Social and Economic Determinants of Health Section for specific values.

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 primary barriers included:

- Challenges with transportation, including personal access to vehicles and public transportation
- Affordable housing and infrastructure, including lack of sidewalks and parks
- Access to providers, both primary and secondary, due to geographic location and clinic hours
- Lack of local healthy foods sources

Identifying data-driven disparities across the five regions helps to identify the social and economic disparities that are important to consider during prioritization and will inform future efforts as well. The disparities and challenges highlighted in this section should be viewed as opportunities for 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 Texas Health utilized a comprehensive set of secondary data indicators to measure the health and quality of life needs for Texas Health's primary service areas 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.