Texas Health Resources — Dallas/Rockwall Region

Texas Health Presbyterian Rockwall

2022 Community Health Needs Assessment

Texas Health Resources®

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Executive Summary

Introduction & Purpose

Texas Health Resources is pleased to present its 2022 Community Health Needs Assessment (CHNA) for the Dallas/Rockwall Region in the Dallas/Fort Worth area. This CHNA report provides an overview of the process and methods used to identify and prioritize significant health needs across the Dallas/Rockwall Region's service area as federally required by the Affordable Care Act.

The purpose of this CHNA is to offer a deeper understanding of the health needs across the region and guide Texas Health 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 approach that included Texas Health employees, community-based organizations, and community members from within areas of focus that gave us input and knowledge of issues and solutions and those who share our commitment to improve health and quality of life. The 2022 CHNA planning effort pushed Texas Health beyond our 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 our ability to understand the needs of the community and develop programs and services that will positively impact the health and well-being of those we serve.

Letter from Our CEO

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

Texas Health develops a CHNA every three years to help us build programs that meet the specific needs of our communities. We collect data through key informant interviews, which included in-depth interviews with community leaders and residents, and focus groups to obtain a better understanding of the community needs.

Behavioral health, chronic disease, access to health services, and health care navigation and literacy continue to be prevailing issues in the communities served by Texas Health.

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 and well-being.

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 such as depression, high blood pressure and lack of health 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 2022 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

Cindy Perrin, FACHE
President/CEO

Regional Leadership Councils

Texas Health Community Impact Leadership Councils represent five unique counties in the Texas Health service area; Collin; Dallas/Rockwall; Denton/Wise, Tarrant/Parker; and Southern (Ellis, Erath, Hood, Johnson, and Kaufman counties). The Texas Health Community Impact Leadership Councils are comprised of community leaders responsible for recommending outcome-driven programs and collaborations. The Texas Community Impact Board was created to serve as a system-wide strategic advisory group as well as a fiduciary board, who in 2022 was responsible for allocating $8 million dollars across all five regions. In the Dallas/Rockwall Region $2 million was allocated.

Texas Health Community Impact brings together agencies from different sectors — education, healthcare, government, grassroots organizations and others — to make measurable change in communities where social determinants of health contribute to poor overall health. These investments are designed to improve the health of the most vulnerable and underserved. Efforts are currently focused on connecting people to appropriate resources that help address behavioral health and food insecurity, which the pandemic exacerbated. The Texas Health Community Impact Board allocates funding to the Leadership Councils based on the regional strategic plans. The Texas Health Community Impact Leadership Councils award the grants to specific projects.

The following organizations are represented on the Texas Health Community Impact Dallas/Rockwall Leadership Council for Dallas/Rockwall Region. These organizations were actively engaged in the prioritization process for the region.

- CCR & Associates
- City of Dallas
- Comerica Bank
- Communities Foundation of Texas
- Fischer & Company
- International Leadership of Texas
- The Senior Source

Consultants

Texas Health commissioned Conduent Healthy Communities Institute (HCI) to support report preparation for its 2022 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: Eileen Aguilar, MS – Public Health Consultant: Margaret Mysz – MPH – Community Data Analyst; Olivia Dunn – Community Data Analyst; Samreen Fathima, MPH - Research Associate; Clarice Pan – Research Assistant, Gautami Shikare, MPH and Dari Goldman, MPH – Senior Project Specialist.

Introduction

Texas Health Resources Health System

Texas Health 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 29 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 4,100 licensed hospital beds, 6,400 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

To partner 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 is moving beyond episodic sick care, by focusing on anticipating communities' 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.

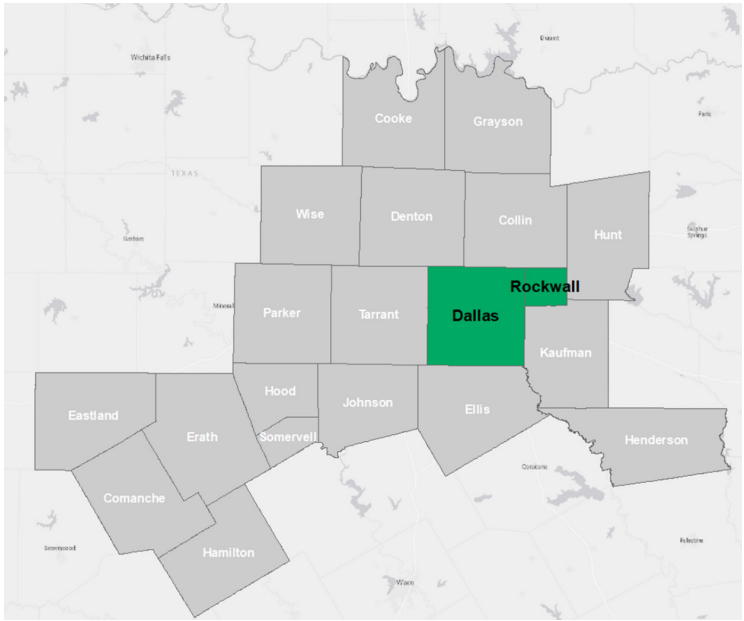
Dallas/Rockwall Region of Texas Health Resources

Dallas County[1] is an urban county located in the north central part of Texas. The city of Dallas serves as the county seat to a county population of approximately 2,586,050 citizens according to the 2021 U.S. Census Record, a population increase of 9.2 percent since the 2020 Census. Rockwall County[2] lies to the Northeast of Dallas County and has a smaller population of approximately 116,381 citizens according to the 2021 U.S. Census Record. This is a population increase of 48.5 percent since the 2010 Census. The map in Figure 1 highlights the Dallas/Rockwall Region among the other counties that fall into the Texas Health service area. For the purpose of this CHNA, special attention has been given to the needs of vulnerable populations, unmet health needs or gaps in services and input from the community.

1. Dallas County Texas. (2022). About Us. https://www.dallascounty.org/

2. Rockwall County Texas. (2022). Know Your County. https://www.rockwallcountytexas.com/

FIGURE 1. TEXAS HEALTH SERVICE AREA COUNTIES: DALLAS/ROCKWALL REGION



Facility Description

Texas Health Presbyterian Rockwall

Texas Health Hospital Rockwall is committed to serving Rockwall County and surrounding areas with high-quality care combined with compassion, understanding and personal attention.

Texas Health Rockwall currently offers 60 inpatient beds for acute medical and surgical needs. The hospital recently began a multi-million-dollar expansion that will effectively double the size of the hospital and bring new services, including a Level 2 NICU, Cardiac Catheterization Lab, interventional radiology, expanded labor and delivery, operating rooms, emergency rooms and ancillary services. Visiting campus today you will find a Women's Imaging and Breast Center, a bariatric clinic, an ambulatory surgery center and a variety of physician practices all dedicated to our evolving community health needs.

Additionally, we are proud to offer a separate full-service emergency room (ER) serving communities in and around North Rockwall and southern Collin County. There you will receive the same high-quality, compassionate emergency care that we provide at our main campus ER. Located at 2265 North Lakeshore Drive, this 24/7 emergency room offers 11 patient rooms, on-site imaging and lab.

What makes us different? As Cindy Perrin, hospital president says, "The difference is found in the heart of our facility — our staff and physicians — and in the way we love, respect and care about our community and each other. We treat our hospital like our home, treat each other like family, and treat our patients like neighbors. It's just who we are!

Texas Health Hospital Rockwall is a joint venture owned by Texas Health Resources and physicians dedicated to the community and meets the definition under federal law of physician-owned hospital.

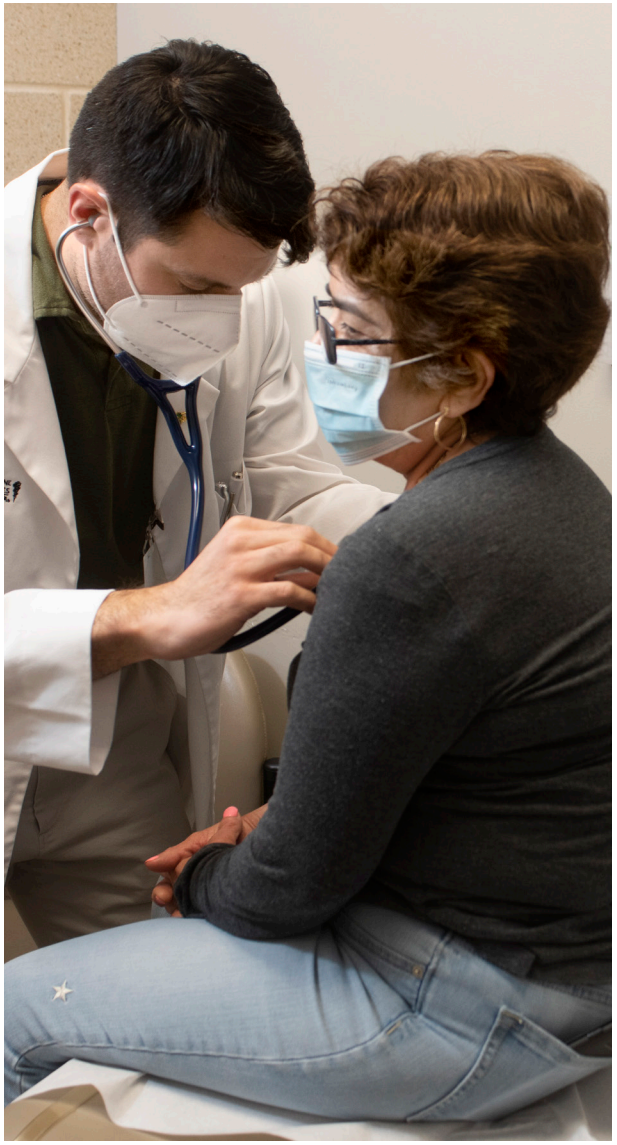
Impact Since Last CHNA

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 2019. The priority areas were:

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

Texas Health built upon efforts from the 2019 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:* In 2019, Texas Health launched the Texas Health Community Impact initiative to address behavioral health issues and the barriers to social determinants of health for individuals residing in Texas Health designated high-need ZIP codes. Through this initiative, Texas Health has awarded over $10M to community-based organizations to date. The aim of this Texas Health initiative is to advance the prevention and management of social, physical, and behavioral health in underserved communities, with the goal of reducing health disparities and improving health equity. The initiative calls on agencies from different sectors — education, health care, government, grassroots organizations, and others — to unite against the CHNA identified health and social issues.

Chronic Disease Prevention and Management

• *Evidence Based Programs – Chronic Disease Self-Management Program (CDSMP); Diabetes Self-Management Program (DSMP); Chronic Pain Self-Management Program (CPSMP) and A Matter of Balance (AMOB):* Texas Health began offering Evidence Based Programs in 2013, in collaboration with local community partners to address the chronic disease prevention and management priority identified in the CHNA. These nationally recognized programs enable participants to build the self-confidence and motivation they need to manage the challenges of living with a chronic disease. Participants are adults experiencing chronic health conditions such as hypertension, arthritis, heart disease, stroke, lung disease, and diabetes. Initially, the program workshops were exclusively in-person; however, telephonic, virtual, and guided self-study formats were adopted in 2020 to maintain safe distancing due to the onset of the COVID-19 pandemic. These formats continued to be the most prevalent in 2021, due to the ongoing COVID-19 pandemic. With the assistance of the local Area Agencies on Aging, eight CDSMP workshops and 18 CDSMP guided self-study formats; 15 DSMP workshops and 12 DSMP guided self-study formats; six CPSMP workshops and four CPSMP guided self-study; and 17 AMOB workshops were offered to community members.

• *Clinic Connect:* Historically, Texas Health has funded the work of local community health clinics in our mission to improve the health of the people in the communities we serve. In 2016, Texas Health launched Clinic Connect, a streamlined process for receiving and evaluating funding requests from clinics that reach vulnerable populations and serve as outpatient resources for our acute care hospitals. The goal of Clinic Connect is to create a collaborative relationship with local non-profit community-based clinics by providing financial support, educational opportunities, information sharing, and expanded services to improve healthcare access and quality for underserved, vulnerable populations. Clinics receiving funds are required to report on specific process and outcome measures, including average wait time for appointments and percentage of diabetic patients whose A1c levels are less than nine percent. Texas Health awarded over $795,000 to community clinics across the Metroplex to date.

• *Wellness for Life — Mobile Health Program:* The Wellness for Life mobile health teams deliver preventive and chronic disease management services traveling across the greater Dallas-Fort/Worth (DFW) area to reach medically underserved communities. Our team of family nurse practitioners, registered nurses, community health workers and mammography technologists provide prevention and early detection services, and teach evidence-based practices in partnership with community-based health clinics and organizations. Utilizing state-of-the-art mobile health vehicles, the medical team delivers essential healthcare services at churches, schools, grocery stores, community centers and public parks. The ethnically and culturally diverse health care team creates a welcoming environment which fosters trusting relationships. In 2021, Texas Health improved access to care by delivering the following healthcare services to community members: 10,882 COVID-19 vaccine doses, 1,772 screening mammograms, 177 cervical exams, and 68 colon kits.

• *Healthy Education Lifestyle Program (HELP):* The Healthy Education Lifestyle Program (HELP) is an innovative way of delivering diabetes and hypertension management for uninsured populations. Every HELP visit is comprised of three key components: an individual visit with a mid-level practitioner, including necessary lab testing; an education session by the nurse to increase health literacy; and social determinants of health support. HELP provides program participants with ongoing health coaching and education resources to support patients learning to effectively manage their chronic disease and to encourage them to take an active role in reducing the negative toll their chronic conditions will otherwise take on their lives. The monthly office visits ensure those who are uninsured gain access to lab tests and medications necessary to help them effectively self-manage their disease. HELP has seen impressive results, including improvement in individual bio-metric scores. In 2021, HELP was able to serve 1,475 individuals across the system.

Awareness, Health Literacy, and Navigation

• *Health to Housing Program: A Pathway to Healing Collaborative:* In partnership with Austin Street Center and City Square Housing, Texas Health launched the Health to Housing program in September 2020 to provide medical respite care to homeless adults discharged from Texas Health Dallas (THD). Using a three-pronged approach, patients receive medical services such as medication management, wound care, blood pressure screening, physical therapy; case management services such as job training, connection to supplemental benefits; and appropriate housing solutions. Since launching in September 2020, the Health to Housing program has served over 57 homeless individuals.

• *YES Dallas:* The YES Dallas Initiative is a collaborative project aimed at reducing barriers to physical activity by providing middle school age children in Southern Dallas with sports and nutritional resources to promote health and overall wellness. As a research initiative, YES Dallas is a research initiative designed and implemented by Texas Health Resources with funding from the U.S. Department of Health and Human Services to meet the following objectives: Increase participation in physical activity for youth who do not meet current physical activity guidelines at baseline; Improve physical literacy; increase consumption of dark green, orange, and red vegetables; whole fresh fruit; and decreased consumption of sugar-sweetened beverages. To date, the program has served over 170 socioeconomically disadvantaged youth.

• *Texas Health Community Vaccination Program:* Texas Health Community COVID-19 Vaccination launched in January 2021 in response to Texas Health's aim to provide equitable care with the understanding that individuals in medically underserved communities may have limited access to the COVID-19 Vaccine. The Mobile Health team included COVID-19 vaccinations to its services. Partnering with approximately 74 community-based organizations, and with grant support from the Communities Foundation of Texas (CFT) and the Human Resources Services Administration (HRSA), Texas Health administered 10,878 COVID-19 Vaccines to 6,013 individuals across 210 community clinics, in addition to educating 6,310 individuals and raising awareness of the COVID-19 vaccine.

• *Texas Health Sexual Assault Nurse Examiner Program:* The Sexual Assault Nurse Examiner (SANE) program provides compassionate and comprehensive care for patients who have experienced sexual assault. Part of the SANE department is the Safety and Well-Being Prevention Program (SWBPP) which offers violence prevention education, awareness and professional development programs to schools, businesses, and community organizations across the system. SWBPP focuses on protective and risk factors that bring awareness to violence. Topics of the classes include dynamics of a healthy relationship, teen dating violence, digital abuse and web safety, human trafficking awareness, bystander intervention training, gender socialization and violence, awareness training for parents, trauma informed response, sexual assault, and complexities of child abuse among others. To date, SANE has delivered over 69 community presentations and outreach events to more than 2,672 individuals and provided clinical services to over 776 victims of sexual assault.

• *Faith Community Nursing:* Faith Community Nursing (FCN) is a system-wide program offered by Texas Health to link faith communities with health-related resources that focus on holistic care including body, mind, and spirit. Program emphasis is placed on prevention and wellness through education, coaching, advocacy, and coordination of healthcare. Through strong relationships with faith organizations (churches, synagogues, mosques), the FCN program can reach people outside of the traditional hospital or clinic setting to provide education and resources that help improve the health and well-being of individuals across North Texas. FCN promotes wellness, prevention, and wholeness before, during and after disease. The program also creates safe and sacred places for healing and advocates for compassion, mercy and dignity at Christian, Jewish and Muslim congregations. In 2021, the FCN program worked with 106 congregations (reaching 131,322 people) and 297 volunteer nurses and lay health promoters to serve communities across North Texas. Flu vaccinations were given to 5,180 uninsured and high-risk community members who may not otherwise have received preventative care. In addition, over $1.7 million in health-related cost savings and avoidance was recorded by the congregations we work with. Savings included health care dollars and the cost to provide for social determinants of health. Due to COVID-19, FCNs also supported faith communities with consultation and implementation of infection prevention measures and COVID vaccine education and information. Additionally, the FCN team provided nursing leadership for five of the Texas Health COVID Vaccine Clinics that vaccinated thousands of North Texas residents.

Blue Zones Project

Blue Zones Project is a community-led well-being improvement initiative that focuses on changing the environment around us to make healthy choices easier. In early 2019, Blue Zones Project work moved under the umbrella of North Texas Healthy Communities (NTHC), the community outreach arm of Texas Health that focuses on the delivery of community benefit through well-being improvement initiatives. NTHC continues to work to sustain Blue Zones Project's momentum while expanding support into high-need schools, faith communities, worksites and neighborhoods identified by Texas Health's CHNA.

During the pandemic, Blue Zones shifted its focus to address pandemic-related needs in underserved communities by distributing food, developing vaccination awareness campaigns, and promoting community vaccination clinics. Since the last CHNA, this program has engaged over 365 participating organizations and served over 95,000 individuals.

Community Feedback

The 2019 Texas Health Resources CHNA 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

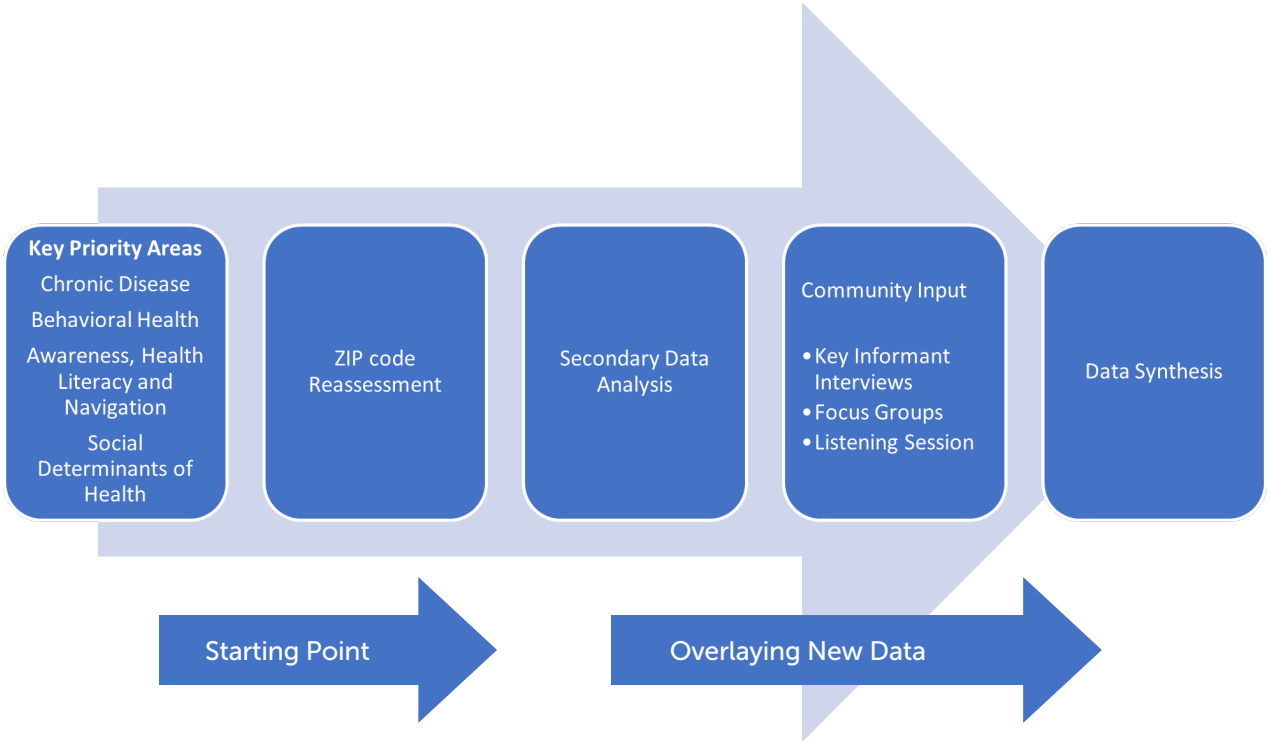
Overview

Two types of data were used in this assessment: primary and secondary data. Primary data is data that have been collected for the purposes of this community assessment. Primary data was obtained through focus groups and key informant interviews. Secondary data is health indicator data that has been collected by public sources such as government health departments.

Building on 2019 CHNA Process

For the 2022 CHNA process, Texas Health built on key findings and achievements from the 2019 CHNA process and Implementation Strategy. This process included over 463 ZIP codes within the Texas Health primary and secondary service areas. In Figure 2, Texas Health, with the support of five regional community councils, utilized primary and secondary data to narrow the geography down to 56 prioritized ZIP codes. These communities were experiencing disproportionate health outcomes in the areas of Chronic Disease, Behavioral Health and Awareness, and Health Literacy and Navigation.

FIGURE 2. CHNA TIERED PROCESS



Overview of ZIP Code Reassessment

The ZIP code reassessment included the Conduent HCI project team reviewing, analyzing, and synthesizing the Health Equity Index (formerly, SocioNeeds Index) and seven key indicators available for 20 counties (Collin, Comanche, Dallas, Denton, Eastland, Ellis, Erath, Henderson, Hood, Hunt, Johnson, Kaufman, Parker, Rockwall, Tarrant, Wise, Cooke, Somervell, Grayson, and Hamilton), which includes 463 ZIP codes that receives services through Texas Health hospitals and joint ventures. The following indicators were used to reassess and determine Texas Health priority ZIP codes for its 2022 cycle:

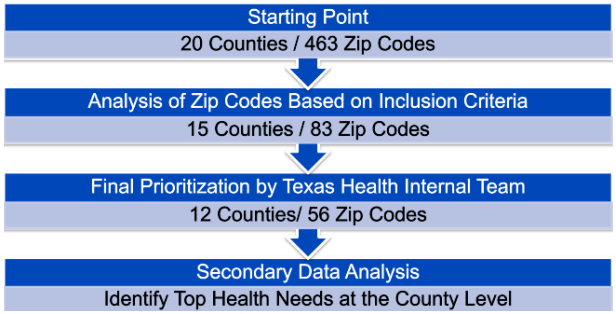
- Demographics
- Median household income
- Percent of uninsured adults
- Percent of people living below the poverty level (200 percent)
- Unemployment rate
- Percent receiving SNAP assistance
- Educational attainment for adults 25+ with a high school degree

Data were analyzed at the ZIP code level when available. Findings from the analysis were used to identify fifteen counties and 83 priority ZIP codes for the 2022 CHNA process.

CHNA Process and Texas Health ZIP Code Prioritization

The CHNA process began with reviewing 15 counties and 83 ZIP codes. HCI analyzed the ZIP codes based on the HCI inclusion criteria and Texas Health reviewed the data, ranked the ZIP codes and a final prioritization list was created with 12 counties and 56 ZIP codes. Figure 3 illustrates how the 12 counties and 56 ZIP codes were identified.

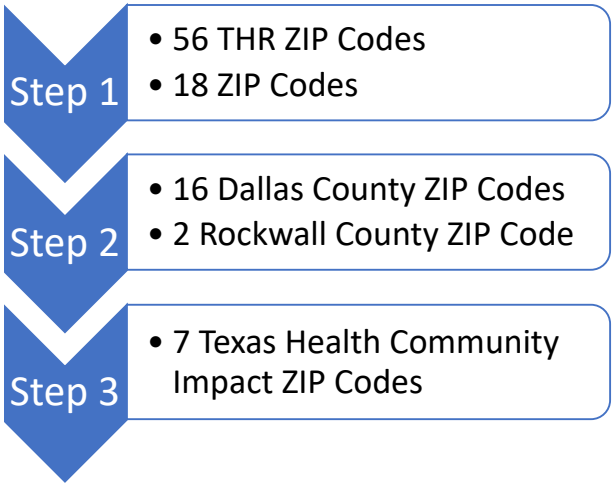
FIGURE 3. METHODOLOGY OVERVIEW



Dallas/Rockwall ZIP Codes Prioritization

The Dallas/Rockwall Region is comprised of 17 prioritized ZIP codes: fifteen in Dallas County and two in Rockwall County. The purpose of the deeper dive into the ZIP codes during this CHNA process was to purposefully identify areas of impact where place-based programs could be built, grown and replicated through investments. ZIP codes were ranked on the perceived and identified need per the Health Equity Index (a measure of socioeconomic need). The results yielded 18 ZIP codes from which seven community impact ZIP codes were identified. An extensive data review and data gathering, including key data indicators were conducted in these areas. The diagram in Figure 4 summarizes the overall ZIP code prioritization process for the 2022 CHNA.

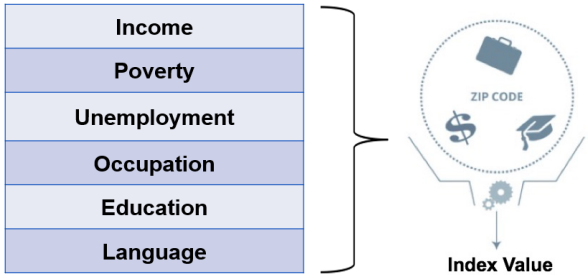
FIGURE 4. DALLAS/ROCKWALL REGION ZIP CODE PRIORITIZATION



Health Equity Index

Figure 5 is an illustration of the HEI (Health Equity Index) (formerly, SocioNeeds Index). The HEI incorporates estimates for six different social and economic determinants of health that are associated with poor health outcomes. The data, which cover income, poverty, unemployment, occupation, educational attainment, and linguistic barriers, are then standardized and averaged to create one composite index value for every ZIP code in the United States. The areas must have a population of at least 200. ZIP codes have index values ranging from zero to 100, where higher values are estimated to have the highest socioeconomic need and are correlated with poor health outcomes including preventable hospitalizations and premature death.

FIGURE 5. HEALTH EQUITY INDEX



The map in Figure 6 highlights HEI values for ZIP codes across the Southern Region. Darker shades of blue indicate a higher index value and thus higher levels of need within those ZIP codes. As shown, many of the prioritized ZIP codes are also identified as highest need ZIP codes within the region.

FIGURE 6: DALLAS/ROCKWALL REGIONAL HEI MAP

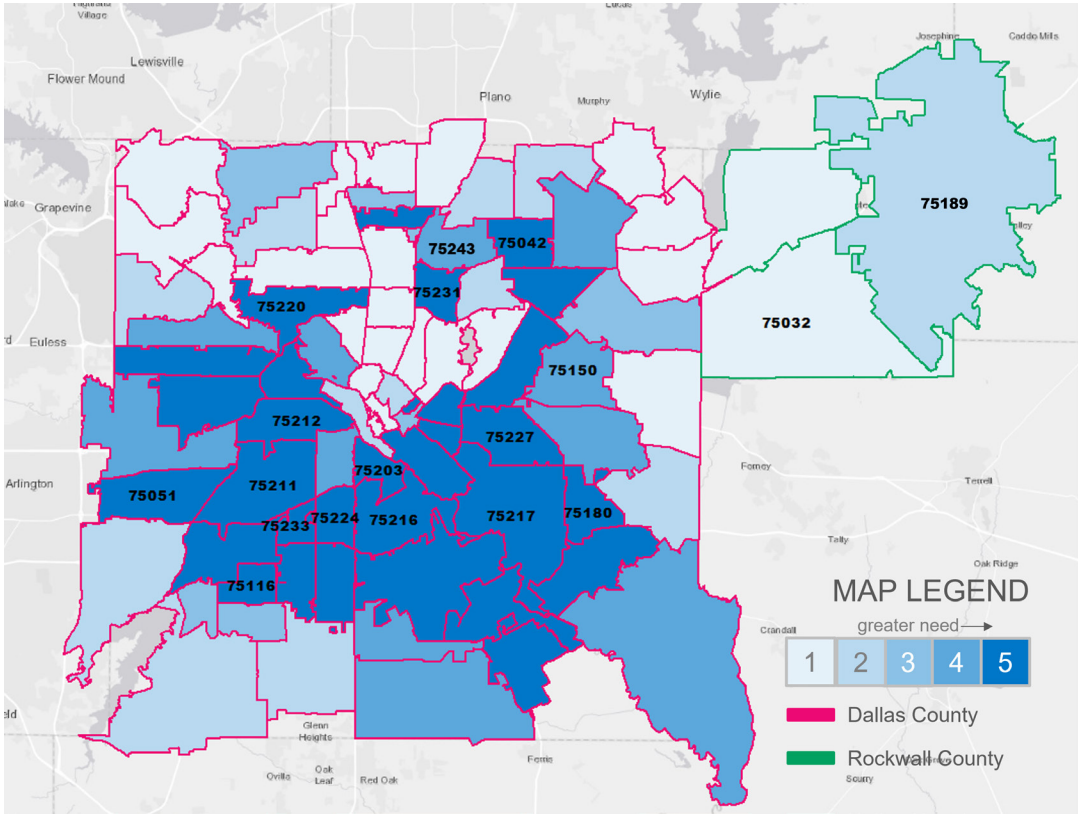


TABLE 1. HEI VALUES FOR PRIORITIZED ZIP CODES

COUNTY	ZIP CODE	HEI VALUE
Dallas	75042	94.4
	75051	90.3
	75116	82.6
	75150	67
	75180	93.2
	75203	96.4
	75211	96.5
	75212	98.4
	75216	97.7
	75217	97.6
	75220	94
	75223	95.1
	75224	96.9
	75227	95.1
	75231	88.1
	75243	74.2
Rockwall	75032	9.2
	75189	22.4

Demographics

The following section explores the demographic profile of the Texas Health Dallas/Rockwall Region service area. It is important to understand the demographics of a community because it can significantly impact its health profile. Communities are becoming more diverse with different races and ethnicities, gender identities, ages, and socioeconomic groups. Each component has its own unique needs and requires varied approaches to health improvement efforts[3]. All demographic estimates are sourced from American Community Survey one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

3. National Academies Press (US); 2008. Institute of Medicine (US) Roundtable on Health Disparities. Challenges and Successes in Reducing Health Disparities: Workshop Summary. https://www.ncbi.nlm.nih.gov/books/NBK215371/ DOI: 10.17226/12154

Population

According to the U.S. Census Bureau's 2015-2019 American Community Survey, the Dallas/Rockwall Region had a combined population of 708,123. Table 2 below shows the population breakdown for the prioritized ZIP codes within the Dallas/Rockwall Region. 75217 and 75211 are the most heavily population ZIP codes in the region and are both located in Dallas County.

TABLE 2: TOTAL POPULATION BY ZIP CODE

COUNTY	ZIP CODE	TOTAL POPULATION ESTIMATE
Dallas	75042	42,009
	75051	40,923
	75116	19,867
	75150	60,671
	75180	23,941
	75203	17,367
	75211	77,570
	75212	26,720
	75216	53,327
	75217	89,163
	75220	17,280
	75223	59,924
	75224	37,592
	75227	39,183
	75231	40,371
	75243	68,308
Rockwall	75032	29,135
	75189	33,080

Age

As shown in Figure 7, 25.8 percent of Dallas County and 26.6 percent of Rockwall County is under 18 years old. The Dallas/Rockwall Region has a similar proportion of residents under 18 compared to the state (25.5 percent) and a higher proportion compared to the nation (22.3 percent).

Figure 8 illustrates that 11.1 percent of the population in Dallas County and 12.8 percent of the population in Rockwall County are adults over the age of 65. Dallas County has a smaller proportion of older adults compared to the State of Texas (12.9 percent) while Rockwall County has a similar proportion to the State of Texas. Both counties have a smaller proportion compared to the U.S. (16.5 percent).

Figure 9 shows that Rockwall County has a smaller proportion of residents under 5 years old (6.1 percent) compared to Texas (6.9 percent) and a similar proportion compared to the U.S. (6.0 percent). Dallas County has a similar proportion of residents under 5 years old (7.3 percent) compared to Texas and a larger proportion compared to the U.S.

FIGURE 7. POPULATION UNDER 18

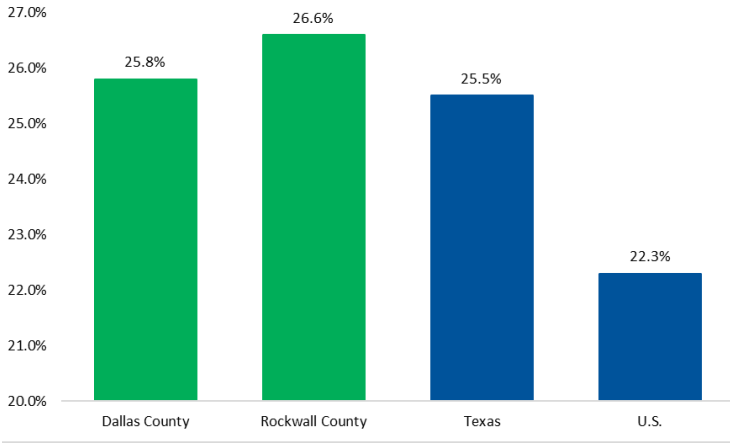


FIGURE 8. POPULATION OVER 65

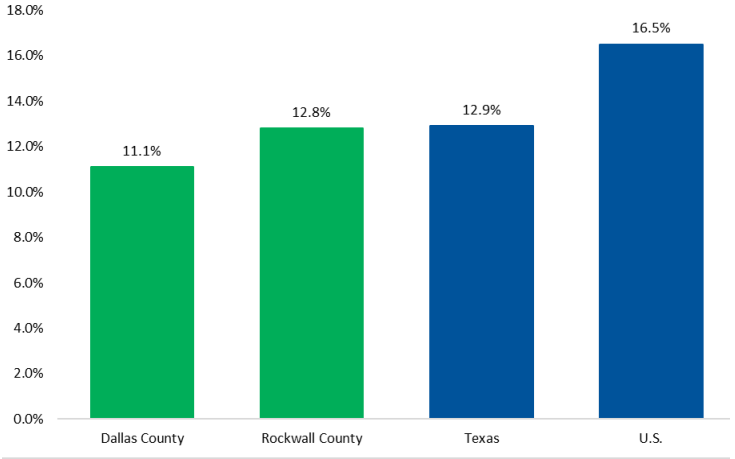
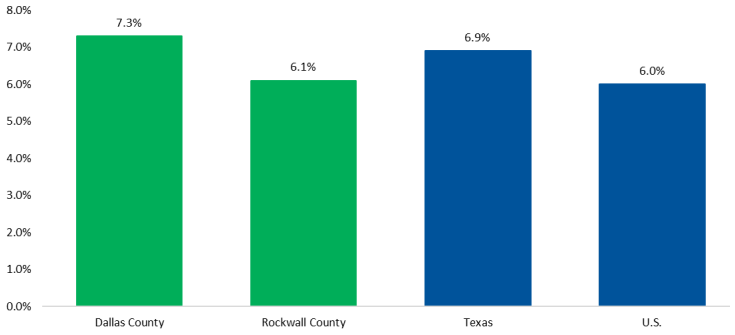


FIGURE 9. POPULATION UNDER 5



Race/Ethnicity

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

Figure 10 shows the racial composition of residents in Rockwall County and Dallas County. Rockwall County has a racial composition with 69.0 percent of residents identifying as White, Non-Hispanic; 18.6 percent as Hispanic or Latino (of any race); 7.4 percent as Black or African American; 3.2 percent as Asian; and 3.0 percent as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", or "Two or more races."

Dallas County has a racial composition with 28.3 percent of residents identifying as White, Non-Hispanic; 40.8 percent as Hispanic or Latino (of any race); 23.6 percent as Black or African American; 6.7 percent as Asian; and 3.2 percent as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, "Some other race", or "Two or more races."

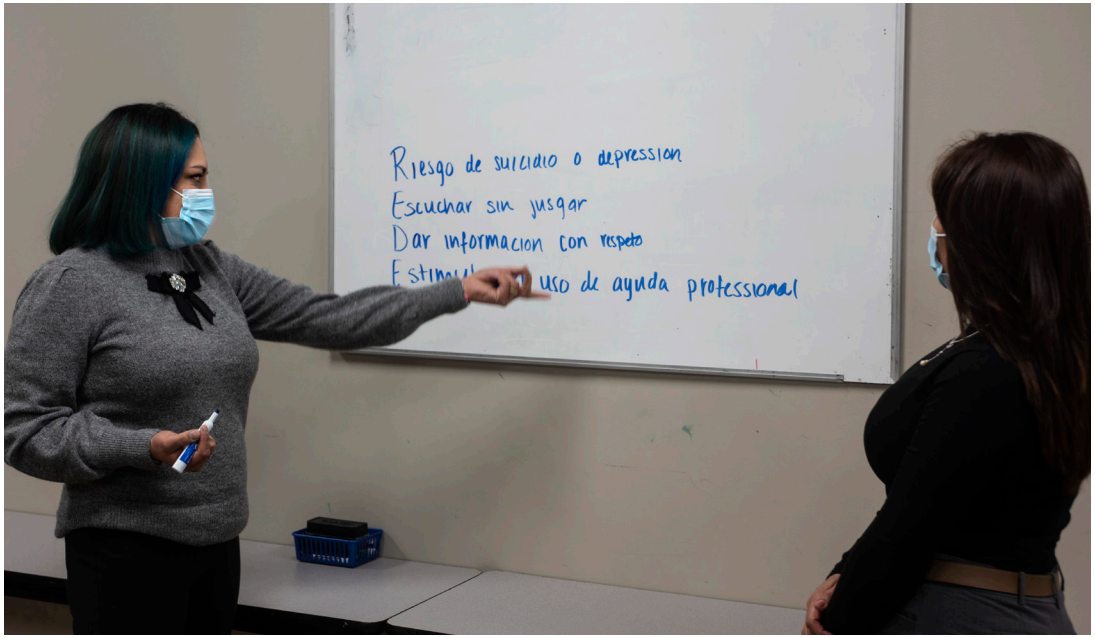
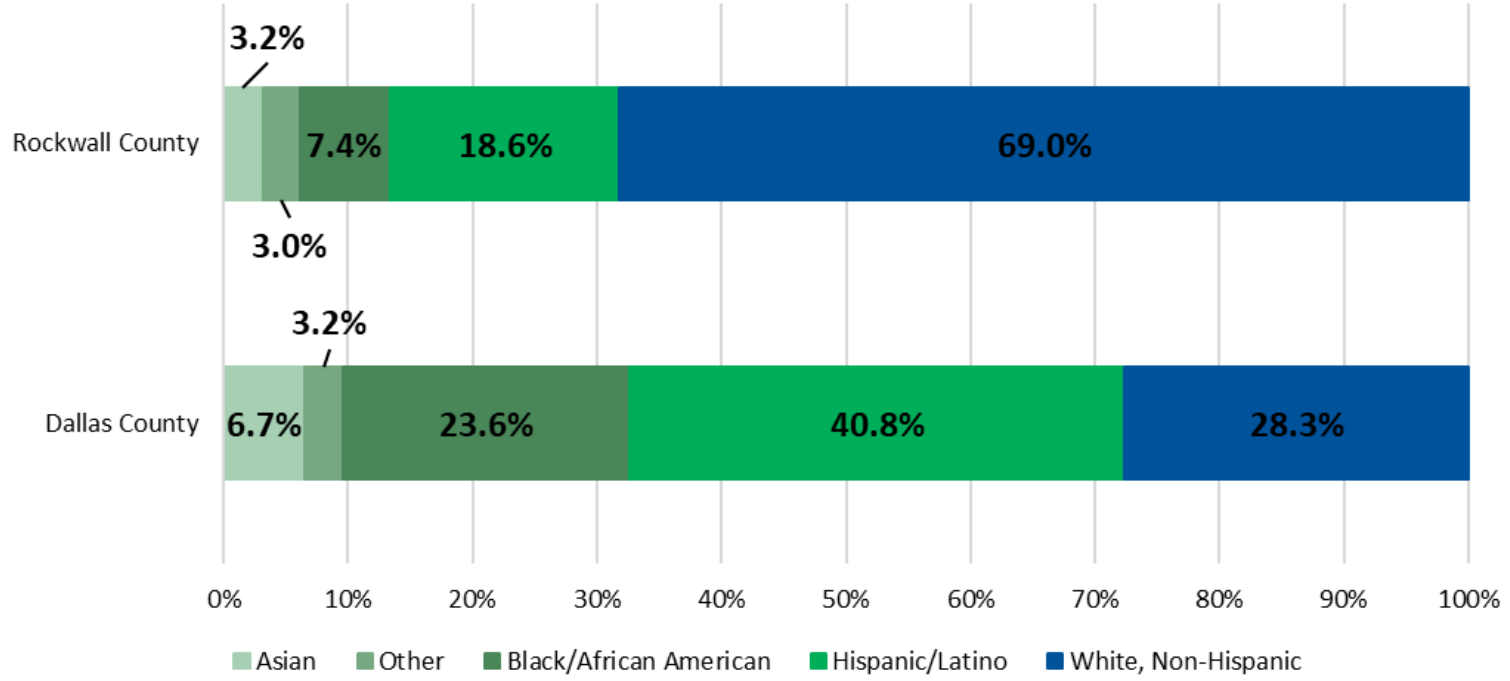


FIGURE 10. RACE/ETHNICITY



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 11. POPULATION (5+) THAT SPEAKS A LANGUAGE OTHER THAN ENGLISH AT HOME

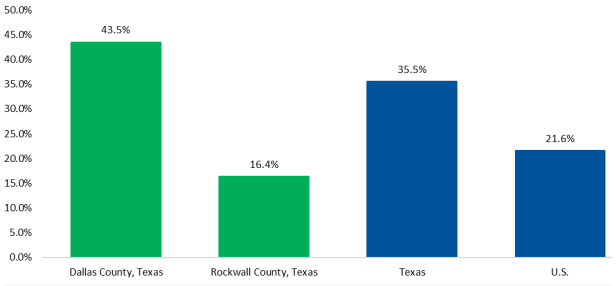


Figure 11 shows the proportion of residents in the Dallas/Rockwall Region who speak a language other than English at home. Rockwall County (16.4 percent) has a lower percentage of residents who speak a language other than English at home compared to both Texas (35.5 percent) and U.S. (21.6 percent). Dallas County (43.5 percent), however, has a higher percentage of residents who speak a language other than English at home compared to both the state and national value.

As shown in Table 3, ZIP codes 75220 and 75211 in Dallas County have the largest proportion of residents who speak a language other than English at home (75.5 percent and 74.9 percent, respectively). In these ZIP codes, 74.2 percent of their populations speak Spanish at home. This is an important consideration for the effectiveness of services and outreach efforts, which may be more effective if conducted in languages other than English alone.

TABLE 3. POPULATION (5+) WHO SPEAKS A LANGUAGE OTHER THAN ENGLISH AT HOME

COUNTY	ZIP CODE	PERCENT POPULATION THAT SPEAKS A LANGUAGE OTHER THAN ENGLISH AT HOME	PERCENT POPULATION THAT SPEAKS SPANISH AT HOME
Dallas	75042	75.5%	74.2%
	75051	62.2%	59.0%
	75116	40.4%	38.9%
	75150	42.9%	36.8%
	75180	53.1%	51.7%
	75203	49.9%	48.9%
	75211	74.9%	74.2%
	75212	62.6%	58.6%
	75216	38.1%	37.3%
	75217	64.9%	64.5%
	75220	51.3%	49.4%
	75223	57.4%	56.6%
	75224	58.2%	55.9%
	75227	67.9%	50.7%
	75231	49.4%	31.0%
	75243	42.8%	20.3%
Rockwall	75032	19.4%	18.1%
	75189	20.1%	13.4%

Additionally, it can be seen in Table 4 that ZIP codes 75211 and 75220 in Dallas County have larger portions of their populations who have difficulty speaking English at home (35.5 percent and 32.7 percent, respectively).

TABLE 4. POPULATION (14+) WITH DIFFICULTY SPEAKING ENGLISH BY ZIP CODE

COUNTY	ZIP CODE	PERCENT POPULATION WITH DIFFICULTY SPEAKING ENGLISH
Dallas	75042	32.7%
	75051	27.1%
	75116	13.4%
	75150	6.2%
	75180	15.8%
	75203	14.7%
	75211	35.5%
	75212	17.8%
	75216	15.4%
	75217	14.2%
	75220	15.2%
	75223	13.4%
	75224	13.7%
	75227	21.5%
	75231	17.7%
	75243	11.3%
Rockwall	75032	2.3%
	75189	2.1%

Social and Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health in the Dallas/Rockwall Region's service area. Social determinants of health 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[4].

4. Office of Disease Prevention and Health Promotion. (2014). *Healthy People 2020: Social Determinants of Health.* Retrieved from Healthy People 2020: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

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. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one's ability to work.[5]

FIGURE 12. MEDIAN HOUSEHOLD INCOME

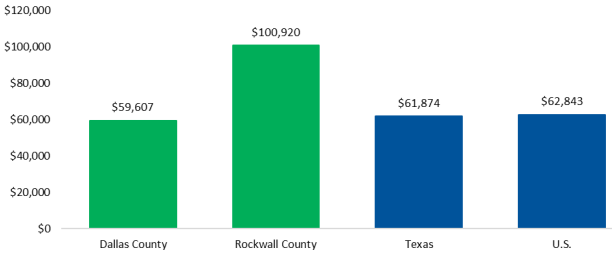


Figure 12 shows the median household income of Dallas County is $59,607 which is similar to the median household income in the state of Texas ($61,874) and the U.S. ($62,843). Rockwall County has a median household of $100,920 which is higher than both state value and national value.

5. Robert Wood Johnson Foundation. Health, Income, and Poverty. https://www.rwjf.org/en/library/research/2018/10/health--income-and-poverty-where-we-are-and-what-could-help.html

6. Office of Disease Prevention and Health Promotion. "Poverty | Healthy People 2020." *Healthypeople.gov*, 2014, www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/poverty.

Poverty

The Census Bureau sets federal poverty thresholds every year and varies by size of family and ages of family members. A high poverty rate is both a cause and a consequence of poor economic conditions. A high poverty rate indicates that local employment opportunities are not sufficient to provide for the local community. Through decreased buying power and decreased taxes, poverty is associated with lower quality schools and decreased business survival.[6]

Figure 13 shows the percentage of people living below the poverty level for Dallas County (15.4 percent) and Rockwall County (4.7 percent). Rockwall County has a value lower than the state of Texas value (14.7 percent) and the U.S. value of (13.4 percent) while Dallas County has a similar value to the state and national value.

Figure 14 shows the percentage of people living below the poverty level by race/ethnicity. Overall, Dallas County has a higher percentage of people living below the poverty rate than Rockwall County regardless of race/ethnicity. Black/African Americans and Hispanic/Latinos have the highest percentages in both counties.

FIGURE 13. PEOPLE LIVING BELOW POVERTY LEVEL

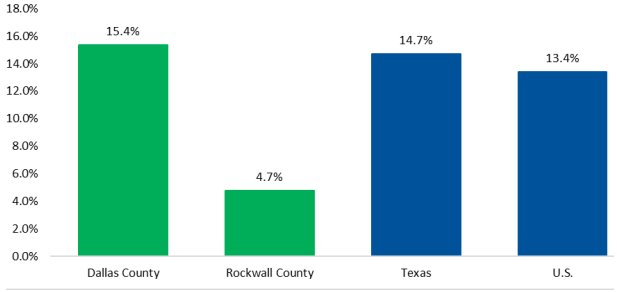
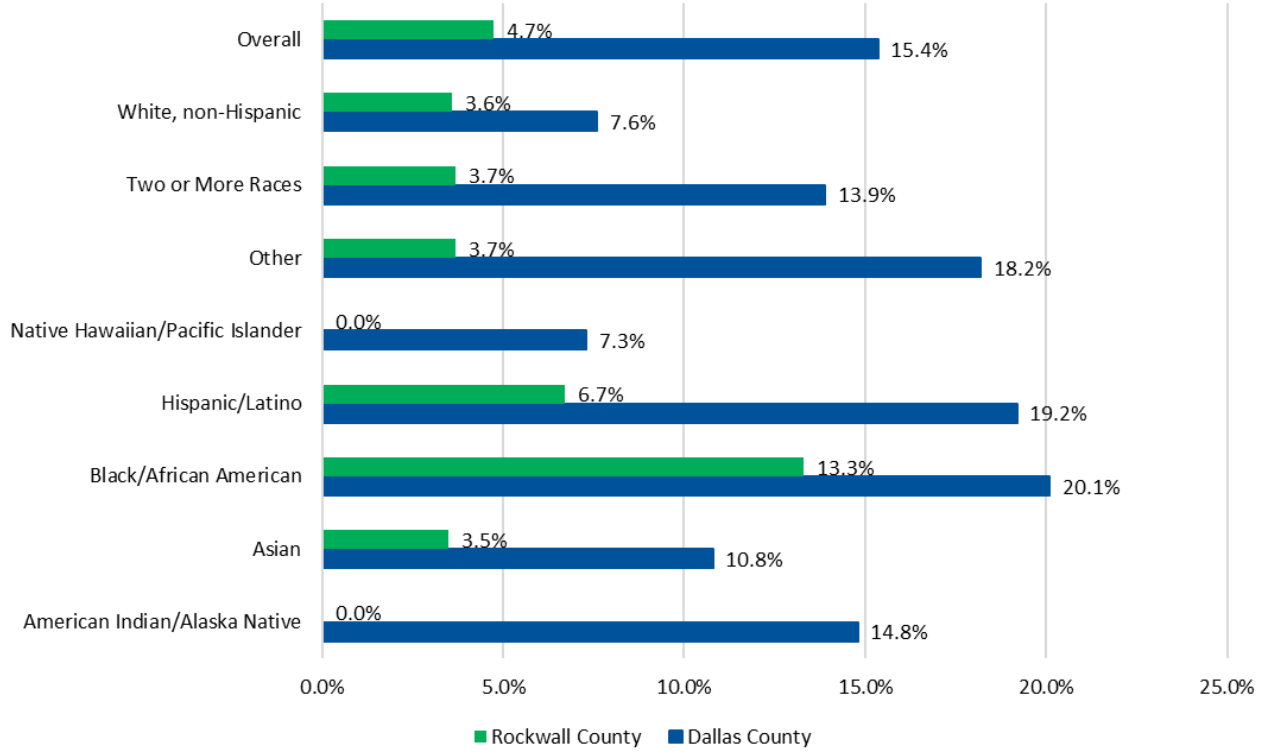


FIGURE 14. PEOPLE LIVING BELOW POVERTY LEVEL BY RACE/ETHNICITY



Food Insecurity

The Supplemental Nutrition Assistance Program (SNAP) is a federal assistance program that provides low-income families with electronic benefit transfers (EBTs) that can be used to purchase food. The goal of the program is to increase food security and reduce hunger by increasing access to nutritious food.[7]

FIGURE 15. HOUSEHOLDS WITH CHILDREN RECEIVING SNAP

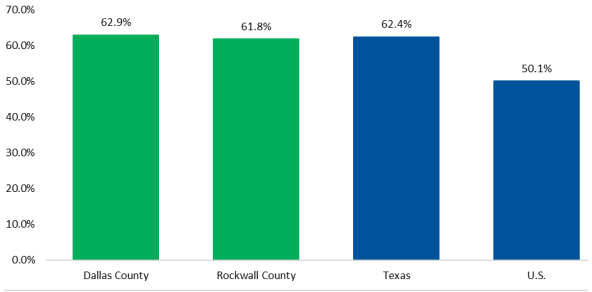


Figure 15 shows the percentage of households receiving food stamps/SNAP benefits with children under 18 years old. Dallas County (62.9 percent) and Rockwall County (61.8 percent) both have similar percentages than both the Texas state value (62.4 percent) and are higher than the U.S. value (50.1 percent).

Conduent's Food Insecurity Index (FII) estimates areas of low food accessibility correlated with social and economic hardship. In this index, ZIP codes are ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 16a. According to the FII, food insecurity affects Dallas County, specifically central Dallas County, more than Rockwall County. Most of the prioritized ZIP codes within Dallas County are identified as having the highest food insecurity in the region.

7. USDA. "Supplemental Nutrition Assistance Program (SNAP) | USDA-FNS." Usda.gov, 2018, www.fns.usda.gov/snap/supplemental-nutrition-assistance-program

FIGURE 16A: DALLAS/ROCKWALL REGION FOOD INSECURITY INDEX BY ZIP CODE

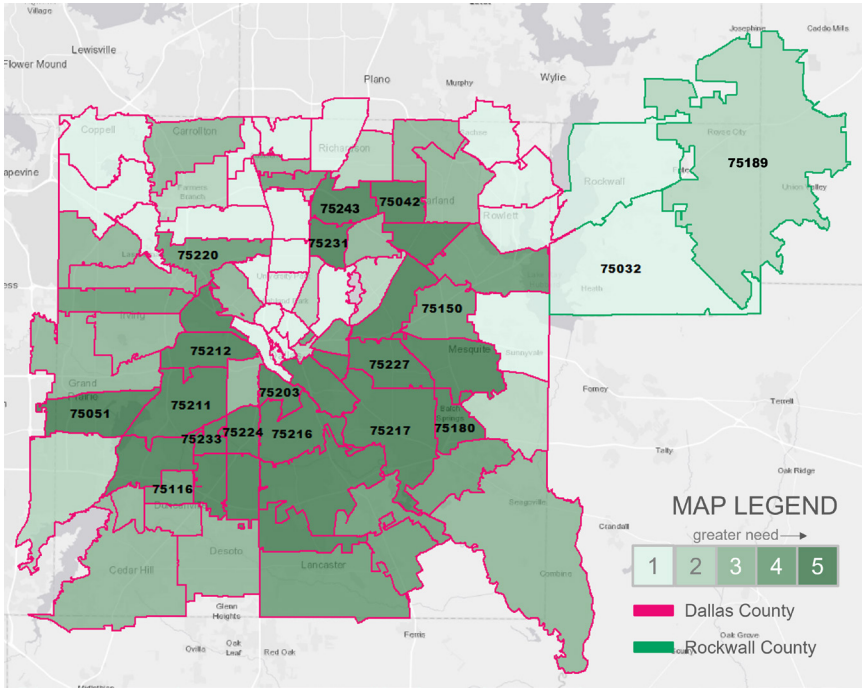


TABLE 5: FOOD INSECURITY INDEX VALUES BY PRIORITIZED ZIP CODES

COUNTY	ZIP CODE	FII VALUE
Dallas	75042	92.6
	75051	90.7
	75116	78.3
	75150	87.8
	75180	91.8
	75203	93.2
	75211	90.3
	75212	97.5
	75216	97.1
	75217	97
	75220	87.7
	75223	85.5
	75224	94.1
	75227	97.2
	75231	89.6
	75243	90
Rockwall	75032	12.5
	75189	21.8

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. A high unemployment rate places strain on financial support systems, as unemployed persons qualify for unemployment benefits and food stamp programs.[8]

FIGURE 16B. UNEMPLOYED WORKERS IN CIVILIAN LABOR FORCE

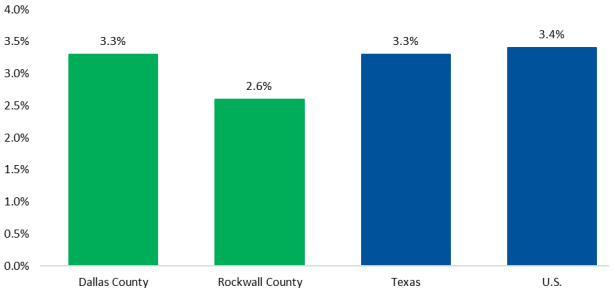


Figure 16b shows the percentage of unemployed workers in the civilian labor force. The percentage in Dallas County (3.3 percent) is similar to both the state of Texas value (3.3 percent) and the U.S. value (3.4 percent) while Rockwall County (2.6 percent) has a slightly lower percentage of unemployed workers in the civilian labor force.

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.[9]

FIGURE 17. PEOPLE 25+ WITH A HIGH SCHOOL DEGREE OR HIGHER

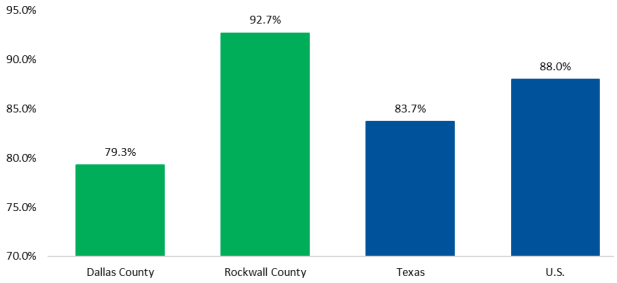


Figure 17 shows the percentage of People 25 Years or Older with a High School Degree or Higher. Rockwall County (92.7 percent) is higher than the state of Texas value (83.7 percent) and the U.S. value (88.0 percent). Dallas County (79.3 percent) has a smaller value compared to the other three locations.

FIGURE 18. PEOPLE 25+ WITH A BACHELOR'S DEGREE OR HIGHER

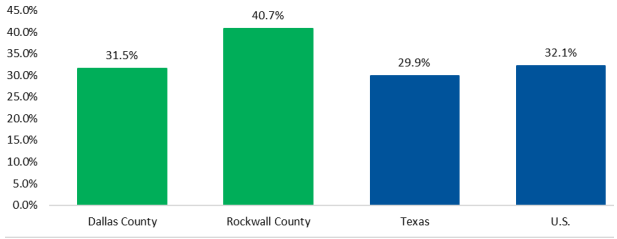


Figure 18 shows the Percentage of People 25 Years or Older with a Bachelor's Degree or Higher. While Rockwall County (40.7 percent) is higher than the state of Texas value (29.9 percent) and the U.S. value (32.1 percent), Dallas County (31.5 percent) is similar to the state and national value.

Transportation

Lengthy commutes cut into workers' free time and can contribute to health problems such as headaches, anxiety, and increased blood pressure.[10] Longer commutes require workers to consume more fuel, which is both expensive for workers and damaging to the environment.[11]

FIGURE 19. MEAN TRAVEL TIME TO WORK (MINUTES)

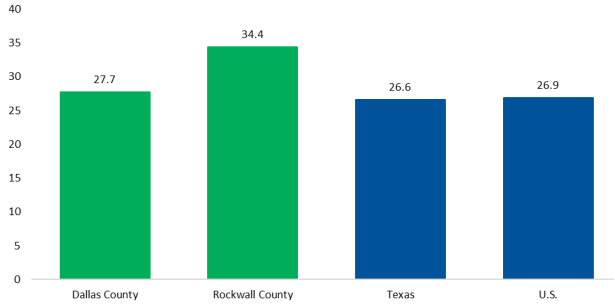


Figure 19 shows the mean travel time to work for Dallas County (27.7 minutes) and Rockwall County (34.4 minutes). Dallas County has a similar value to the state of Texas value (26.6 minutes) and the U.S. value (26.9 minutes) while Rockwall County has a slightly higher value.

8. U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/employment

9. Robert Wood Johnson Foundation, Education and Health. https://www.rwjf.org/en/library/research/2011/05/education-matters-for-health.html

10. Hoehner, Christine M., et al. "Commuting Distance, Cardiorespiratory Fitness, and Metabolic Risk." American Journal of Preventive Medicine, vol. 42, no. 6, June 2012, pp. 571–578, 10.1016/j.amepre.2012.02.020.

11. Shapiro RJ, H. K. (2002). Conserving energy and preserving the environment: The role of public transportation. *American Public Transportation Association.*

Dallas/Rockwall Health Care Utilization

Texas Health patient utilization data were provided by DFWHC Foundation and analyzed by HCI at the ZIP code level based on patients' resident ZIP code listed in discharge summaries.[12] Age-adjusted rates were calculated using the 2010 Census Standard Population estimates and data are available for ZIP codes if case counts are above 10 and population is greater than 300 for the 2017-2019 three-year rolling time period. The information below highlights relevant utilization data for this region, with community impact ZIP codes highlighted. Rates are calculated per 10,000 population.

12. DFWHC Foundation Regional Data, Q1-Q4, 2017-2019. DFWHC Foundation, Irving Texas. October 19, 2021

Figure 20 shows the Age-Adjusted ER Visit Rate due to Diabetes by ZIP code. The highest rates are within Dallas County. As shown in Table 6, the community impact ZIP code 75211 has one of the highest rates in the region.

FIGURE 20. AGE-ADJUSTED ER VISIT RATE DUE TO DIABETES

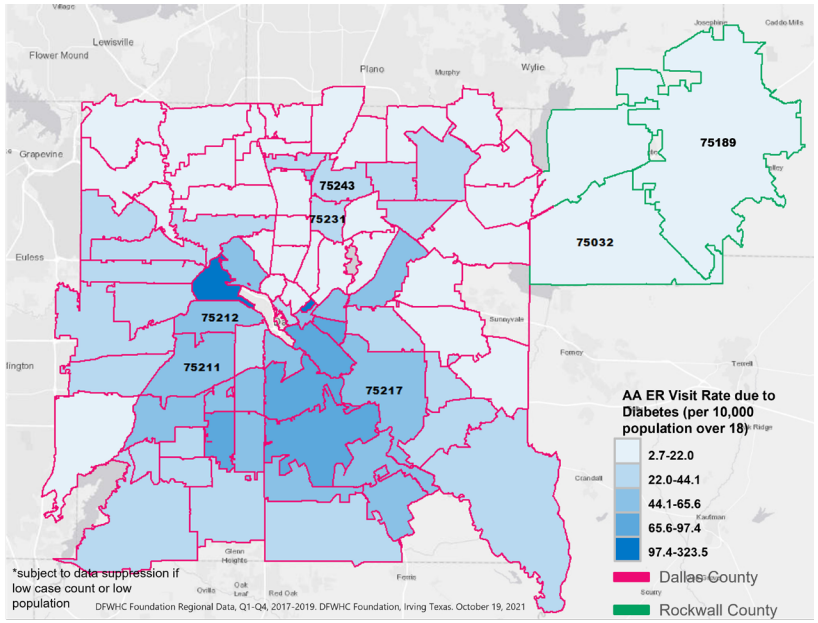


TABLE 6. AGE-ADJUSTED EMERGENCY ROOM VISIT RATES DUE TO DIABETES

COUNTY	COMMUNITY IMPACT ZIP CODE	AA ER VISIT RATE (PER 10,000 POP)
Dallas	75211	64.7
	75212	49
	75217	49.6
	75231	41
	75243	36.1
Rockwall	75032	10.6
	75189	19.0

Figure 21 shows the Age-Adjusted ER Visit Rate due to Type 2 Diabetes by ZIP code. The highest rates are within Dallas County. As shown in Table 7, the community impact ZIP code 75211 has among the highest rates in the region.

FIGURE 21. AGE-ADJUSTED ER VISIT RATE DUE TO TYPE 2 DIABETES

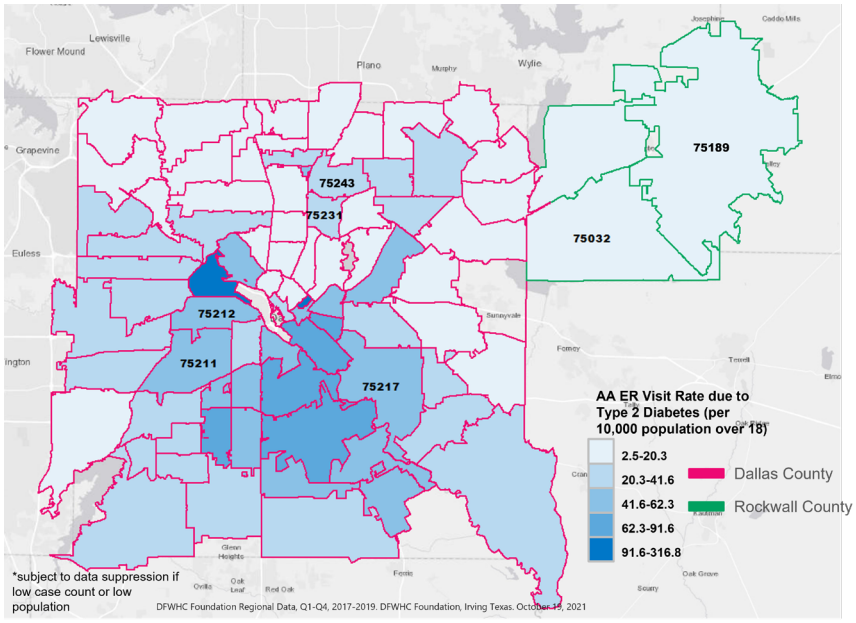


TABLE 7. AGE-ADJUSTED EMERGENCY ROOM VISIT RATES DUE TO TYPE 2 DIABETES

COUNTY	COMMUNITY IMPACT ZIP CODE	AA ER VISIT RATE (PER 10,000 POP)
Dallas	75211	60.9
	75212	47.2
	75217	47.6
	75231	36.7
	75243	34.2
Rockwall	75032	9.1
	75189	19.0

Figure 22 shows the Age-Adjusted ER Visit Rate due to Hypertension by ZIP code. The highest rates are within Dallas County. As shown in Table 8, community impact ZIP code 75211 has among the highest rates in the region.

FIGURE 22. AGE-ADJUSTED ER VISIT RATE DUE TO HYPERTENSION

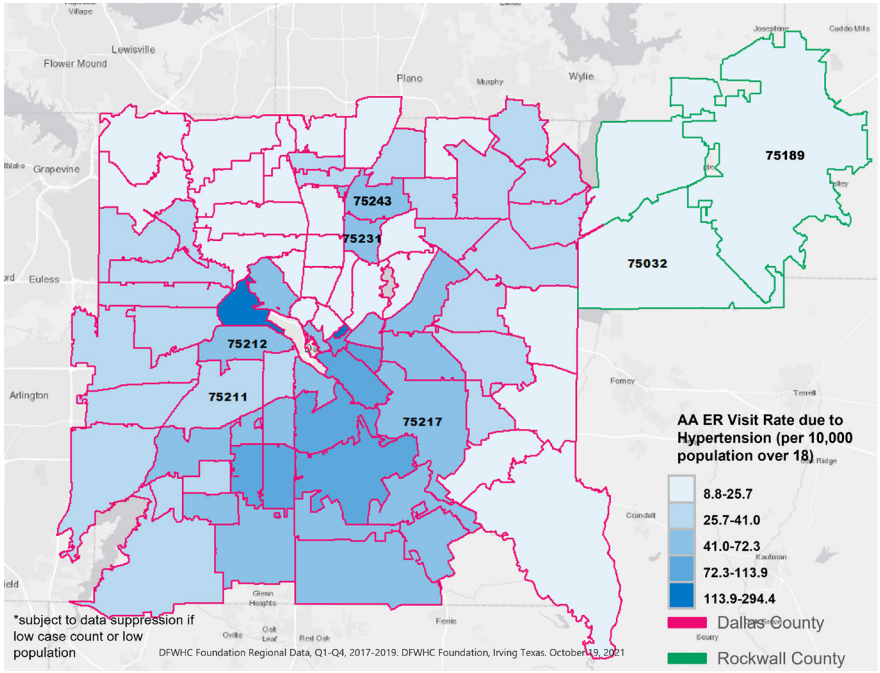


TABLE 8. AGE-ADJUSTED EMERGENCY ROOM VISIT RATES DUE TO HYPERTENSION

COUNTY	COMMUNITY IMPACT ZIP CODE	AA ER VISIT RATE (PER 10,000 POP)
Dallas	75211	56.4
	75212	45.5
	75217	37.1
	75231	44.7
	75243	50.9
Rockwall	75032	22.4
	75189	20.4

Figure 23 shows the Age-Adjusted ER Visit Rate due to Adult Mental Health by ZIP code. The highest rates are within Dallas County and the community impact ZIP code 75231 has one of the highest rates among the community impact ZIP codes (Table 9). Many ZIP codes within this region have missing data for the 2017-2019 time period due to low case counts. The Mental Health Index (Figure 25) can be used in addition to the data shown below to help direct mental health resources within the region.

FIGURE 23. AGE-ADJUSTED ER VISIT RATE DUE TO ADULT MENTAL HEALTH

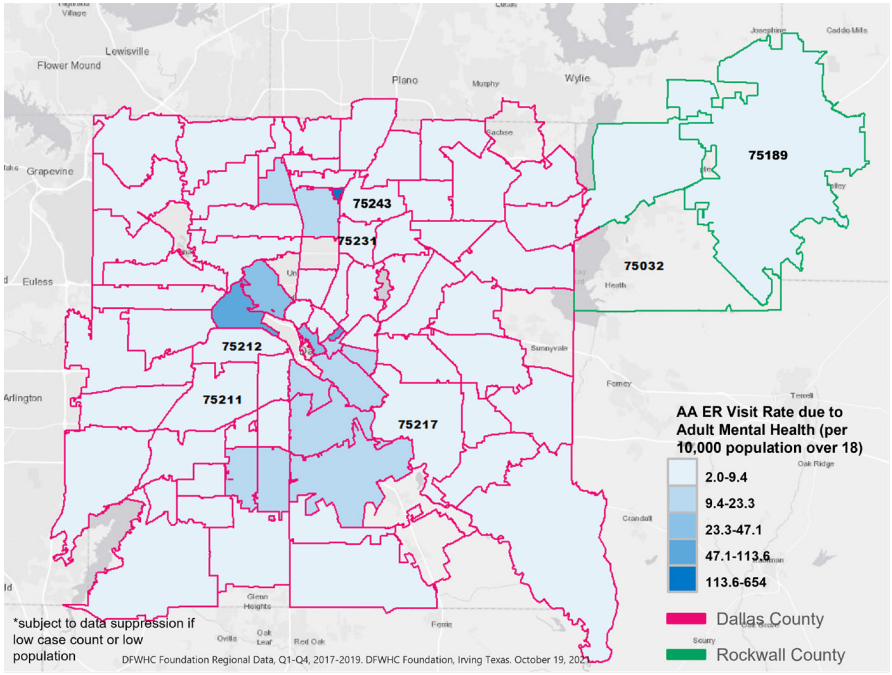


TABLE 9. AGE-ADJUSTED EMERGENCY ROOM VISIT RATES DUE TO ADULT MENTAL HEALTH

COUNTY	COMMUNITY IMPACT ZIP CODE	AA ER VISIT RATE (PER 10,000 POP)
Dallas	75211	6.3
	75212	5.3
	75217	5.3
	75231	9.4
	75243	9.2
Rockwall	75032	N/A
	75189	2.3

Primary Methodology

Community Key Informant Interviews

Key informant interviews (KIIs) were conducted with leaders and staff from organizations that provide services directly to the community and officials that represent governmental and non-governmental entities. Interviewees invited to participate were recognized as having expertise in public health, special knowledge of community health needs, representing the broad interests of the community served by the hospital, and/or being able to speak to the needs of medically underserved or vulnerable populations.

Forty-one individuals from all Texas Health Regions agreed to participate as key informants. The list add on the right includes the organizations that participated in the interviews.

The 41 KIIs took place from October 2021 through March 2022 across all five regions. Each of the 41 interviews was conducted via web conference. The questions focused on the interviewee's background and organization, the biggest perceived health needs and barriers of concern in the community, and the impact of health issues on the populations they serve. A list of the questions asked in the KIIs can be found in Appendix B.

Alzheimer's Association	Lewisville ISD
Arlington Police Department	Literacy Achieves
Austin City Center	Mansfield Mission Center
Bohan Farms	Meadowbrook Poly UMC
Branch Baptist Church	Mission Oak Cliff
Children's Advocacy Center for North Texas	North Texas Behavioral Health Authority
Christian Help Center	Paluxy River Children's Advocacy Center
City of Ennis	Parker County Center of Hope
Cleburne Fire Department	Rockwall County
Collin County Mental Health Mental Retardation Center	SafeHaven of Tarrant County
Community Lifeline Center	Safer Dallas, Better Dallas
Cooper Street YMCA	Senior Connect
Cornerstone Assistance Network	TAPS Transportation
Cross Timbers Family Services	Tarrant Community Center
Dallas Area Rape Crisis Center	Tarrant County College
Dallas Foundation	Texas Department of State Health Services
Eastside Ministries	Texas Health Community Impact Board
Erath County Extension	Texas Health Hospital Rockwall
Johnson County Family Crisis Center	Wise County
Lakepointe Church	YMCA Tarrant

Key Informant Analysis Results

Transcripts captured during the KIIs were uploaded to the web-based qualitative data analysis tool, Dedoose[13]. Interview excerpts were coded by relevant topic areas and key health themes. The approach used to assess the relative importance of the needs discussed in the interviews including the frequency by which a topic was described by the key informant as a barrier or challenge, and the frequency by which a topic was mentioned per interviewee.

13. Dedoose Version 8.0.35, web application for managing, analyzing, and presenting qualitative and mixed method research data (2018). Los Angeles, CA: Sociocultural Research Consultants, LLC www.dedoose.com

Community Focus Groups

Texas Health and Conduent HCI conducted focus groups to gain deeper insight into perceptions, attitudes, experiences, or beliefs held by community members about their health. It is important to note that the information collected in an individual focus group is exclusive to that group and is not representative of other groups. A total of nineteen virtual and in-person focus groups were conducted from November 2021 through May 2022. In the Dallas/Rockwall Region, there were five focus groups conducted, two in English, two in Spanish, and one in Burmese. Table 10 shows the five focus groups completed, which included a total of forty-two participants. Individuals recruited for focus groups included those who were living in and/or working in the Dallas/Rockwall Region. The virtual and in-person focus group sessions lasted 60 minutes.

TABLE 10: DALLAS/ROCKWALL REGION FOCUS GROUP COMPLETED

COUNTY	FACILITATION LANGUAGE	TOTAL COMMUNITY PARTICIPANTS
Dallas	English	3
	Spanish	8
	Burmese	12
Rockwall	English	9
	Spanish	10

An array of residents and employees from the Dallas/Rockwall Region provided insights when facilitators asked a series of nine questions to prompt discussion on top community health issues, barriers/challenges to health, and the impact of COVID-19. Facilitators recorded the sessions and notes from the focus groups and uploaded them to the web-based qualitative data analysis tool, Dedoose. Focus group transcripts were coded using a pre-designed codebook, organized by themes, and analyzed for significant observations. The relative importance of health and/or social need was determined, in part, by the frequency of the topic or issue discussed across all three focus groups.

Table 11 lists the top themes from the Dallas/Rockwall Region analysis:

TABLE 11: KEY INFORMANT INTERVIEWS & FOCUS GROUP THEMES — DALLAS/ROCKWALL REGION

TOP HEALTH CONCERNS/ISSUES	SOCIAL DETERMINANTS OF HEALTH	IMPACTED POPULATIONS
Healthcare Access and Quality: Lack of access to specialty care including dentists, vision care, OBGYN; transportation barriers; difficulties navigating health system "health illiteracy" i.e., how to fill out medical paperwork, finding a doctor who take their insurance; financial barriers—lack of insurance/underinsured, high costs, provider not accepting Medicaid; fear/mistrust due to racism, immigration policies, deportation fear **Mental Health & Mental Disorders:** Lack of psychiatrists/counseling centers to meet the need, cost of care, long wait lists, stigma **Chronic Conditions:** Heart conditions: hypertension, high blood pressure due to stress, diabetes, obesity **COVID-19 Impact:** Delay in care: chronic conditions worsened, mental health: worsened for those already struggling, lack of inpatient beds, isolation led to severe depression/anxiety, past childhood experiences exacerbate PTSD, abuse/neglect: child abuse, domestic violence, misinformation/politicization of the pandemic: excess COVID-19 morbidity & mortality	Food Insecurity/food accessibility Housing Transportation Technology/internet barriers Childcare issues Lack of or limited insurance Economic instability/employment Language barriers	Black/African Americans: not serviced as well as others due to discrimination/bias/racism Transgender community Hispanic/Latino population Low-income families Migrant/Immigrant/Refugee/Undocumented populations: fear of government in seeking care/services Older adults People experiencing homelessness Uninsured/underinsured/coverage gap groups: low-income families making too much money to qualify for Medicaid, but can't afford insurance

Listening Session

Texas Health and Conduent HCI conducted an online survey with key community stakeholders to capture quantitative data in relation to Texas Health 2019 CHNA and Implementation Plan. Conduent HCI hosted a follow-up virtual discussion with the stakeholders to capture qualitative insights and feedback. Texas Health identified the community partners and extended the invitations for this discussion. Because health and wellness can be influenced by environmental matters existing outside of health care, a wide variety of community partners were invited to participate in the listening session. The main goal of the listening session was to determine opportunities to strengthen collaborations within the communities served by Texas Health Resources Health System.

A total of 13 participants completed the online survey and two attended the follow-up session. Table 12 lists the 13 organizations who participated in the Listening Session. In Dallas County, 46.15 percent of the organizations provide direct services to the community and 30.77 percent in Rockwall County.

Invited community leaders were from the following sectors: education, non-profit, philanthropy, for-profit, and healthcare. At the virtual session, participants provided facilitators with additional feedback when asked questions about the results of the survey, what Texas Health was doing well, areas of opportunities in the priority areas, and what Texas Health could do to improve the awareness of the CHNA to partnering organizations and the community. Appendix B provides the detailed results of the listening session.

TABLE 12: LISTENING SESSION ORGANIZATIONS – ALL REGIONS

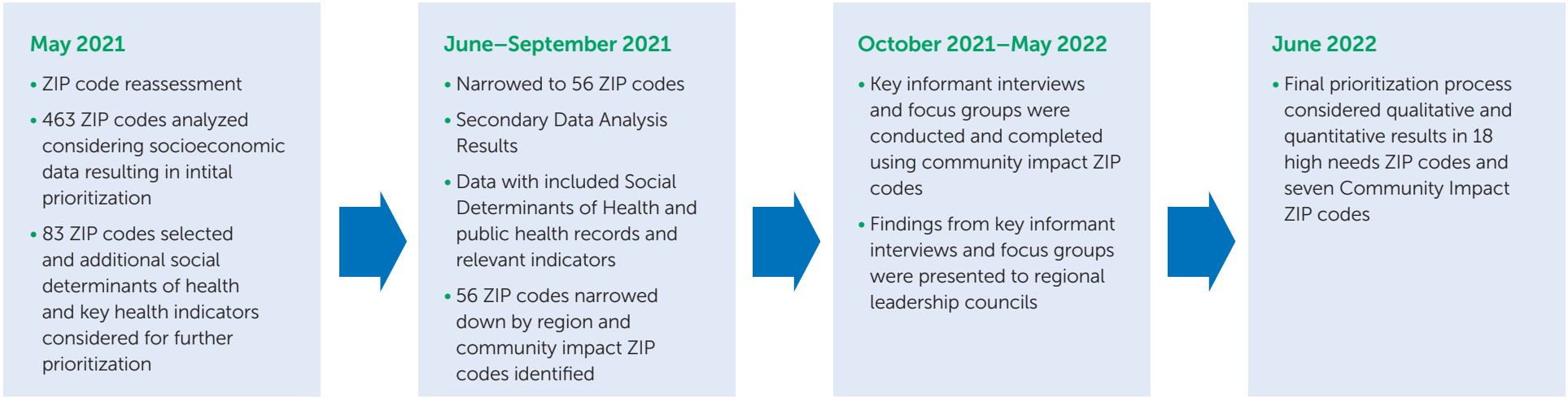
Alzheimer's Association	Lakepointe Church
Assistance Center of Collin County	LVTRise
Catholic Diocese of Fort Worth	STAR Council
CitySquare	Stephenville Medical and Surgical Clinic
Collin College	University of Texas at Arlington
Eastside Ministries	YMCA

Prioritization Process

Initial ZIP code Prioritization

To identify high-need ZIP codes within and outside the Texas Heath Resource service area and to narrow the focal area from 463 ZIP codes across 12 counties to 83 ZIP codes, then to 56 ZIP codes, Texas Health utilized the SocioNeeds Index as well as other socio-demographic data and key health indicators. Of the 56 ZIP codes across the 12-county area that were considered, 17 of them were identified as high priority ZIP codes and of those, five were identified as the community impact ZIP codes from the Dallas/Rockwall Region. Figure 24 demonstrates the steps of the prioritization process.

FIGURE 24. TEXAS HEALTH RESOURCES 2022 CHNA PRIORITIZATION PROCESS



Prioritization Results

Texas Health recognizes 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, Texas Health selected ZIP codes in each region based on criteria that included: 1) availability of resources, 2) availability of partners, 3) community readiness, 4) impact opportunity and 5) health needs in one or more of the prioritized health areas. In this region, the five ZIP codes that were chosen as the final target areas were 75211, 75212, 75217, 75231, and 75243 in Dallas County and 75032 and 75189 in Rockwall County. Each of the ZIP codes identified falls within Texas Health's service area. In addition to narrowing down the focus geographically based on evidence and the criteria mentioned above, Texas Health worked with the Texas Health Community Impact Leadership Council for the Dallas/Rockwall Region in selecting issues that fell within the prioritized health areas of Awareness, Health Literacy and Navigation, Behavioral Health, and Chronic Disease. They also considered any social determinants of health that may contribute to these issues. Based on these considerations, the Texas Health Community Impact Leadership Council for the Dallas/Rockwall elected to focus on Access to Healthcare, Chronic Disease, and Behavioral Health/Mental Health across the identified ZIP codes. Table 13 summarizes the Health Priority Areas within each ZIP code.

TABLE 13. HEALTH PRIORITY AREAS IN THE DALLAS/ROCKWALL REGION

COUNTY	ZIP CODE	HEALTH PRIORITY AREA
Dallas	75211	• Access to Healthcare • Chronic Disease • Behavioral Health/ Mental Health
	75212	
	75217	
	75231	
	75243	
Rockwall	75032	
	75189	

Health Priority Areas

The following section provides a deeper look into each health priority to understand how findings from the primary and secondary data led to the health topic becoming a significant need. Texas Health partners with several community-based organizations (CBOs) across the region and works with the Texas Health Community Impact Leadership Councils for Dallas/Rockwall Region, who are comprised of key leaders from these CBOs. The Texas Health Community Impact Leadership Councils have an understanding of the community needs and are valued and trusted by residents, leaders, faith communities, and organizations. With their input, Texas Health can better understand each region's health needs to design and implement upstream solutions. The priorities are presented below.

Access to Healthcare

Access to Healthcare and quality is the connection between people's access to care, understanding of health services, and their own health. Access to health services was identified as a top concern in the Dallas/Rockwall Region KIIs and focus groups. One of the most common problems in gaining access to health services was lack of transportation. Other barriers identified in the primary data collection are listed below.

Barriers

- Aging populations not able to access medical services due to lack of transportation
- Child care: availability/affordability
- Difficult for individuals/families to go to doctor appointments/follow-ups due to one vehicle homes or no vehicles
- Difficulties navigating the health system: lack of health literacy for people living in poverty, and don't know how to advocate for themselves
- Fear of being mistreated by medical professionals within Black community due to historical racism
- Fear of seeking services within immigrant/ undocumented community due to ICE concerns

- Inability to access medication for transgender health care exacerbated by pandemic
- Lack of affordable healthcare options
- Little focus on preventative care/healthcare education
- Lack of financial resources (cost) to gain access to public transportation services
- Lack of public transportation in rural areas
- Financial barriers: cost of insurance, under insured/ uninsured, loss of employment led to loss of insurance
- Transportation barriers: inability to get to pharmacy, healthcare appointments, people needing handicap accessibility unable to use public transportation

Chronic Disease

Chronic diseases include conditions that last one year or more and require on-going medical attention or limit activities of daily living or both[14]. In the Dallas/Rockwall Region, heart disease/stroke and diabetes were top concerns in the KII and focus groups. Table 14 lists some key findings related to heart disases/stroke and diabetes.

TABLE 14: KEY FINDINGS FROM PRIMARY & SECONDARY DATA-DALLAS/ROCKWALL REGION

HEART DISEASE/STROKE	DIABETES
• Lack of education surrounding healthy food • Affordability/availability of healthy food • Families living in high stress environments often lacking coping skills/cannot plan for the future and do not necessarily seek care ahead of time "prevention" (not managing their health because they are just trying to get by) leading to high rates of diabetes/ renal failure/heart disease • COVID-19 long haulers having issues with heart (cardiac rehab center was closed and people put this on hold	• Lack of education surrounding healthy food • Affordability/availability of healthy food • Families living in high stress environments often lacking coping skills/cannot plan for the future and do not necessarily seek care ahead of time "prevention" (not managing their health because they are just trying to get by) leading to high rates of diabetes/ renal failure/heart disease • Access/affordability of medication: • Difficulties managing chronic diseases due to cost of medication, built environment I.e. lack of parks/sidewalk • Diabetes as a result of diet, lack of knowledge surrounding healthy food and nutrition • Unhealthy school food

Opportunities:

Community Education

- Refocus: refocus efforts on community education i.e. teaching healthier food choices, how to prepare food
- Train: utilization of training the trainers model to train community members to then train community
- Events: community fairs/screening events i.e. blood pressure, mental health, A1C
- City-wide database of information "hub" / community organization information sharing
- Food insecurity/nutritional education: price of healthy food is rising/unaffordable and leads to obesity & diabetes, education on how to prepare/ cook healthy food

14. About Chronic Diseases, 2022

Behavioral Health/Mental Health

Behavioral Health is a blanket term that includes mental health. Behavioral Health/Mental Health were identified as a top health concern impacting the Dallas/Rockwall Region by key informants and focus group participants. Behavioral Health/Mental Health was discussed throughout a variety of health issues and community conditions. Some challenges/ barriers identified are listed below.

Barriers

- COVID-19 specific challenges included:
  - » Mental Health worsened during COVID for those already struggling with chronic mental health illness: escalation in symptoms, presenting with more severe symptoms
  - » Isolation led to severe depression and anxiety (past childhood experiences exacerbates PTSD, anxiety)
- Lack of inpatient beds, shortage of counseling services
- More crisis counselors/behavioral health options for addiction are needed. There are long waiting periods to get a bed at a facility
- Largest mental health care facility is the jail which is not responsive mental health care

Opportunities:

Failure to address mental health holistically and the socioeconomic factors that contribute to/exacerbate mental health illnesses/substance use disorder

- Can help with strategizing how to use the funds from the opioid lawsuit to appropriately fund programs
- Integrated psychotherapeutic services (IPS)
- MATS (medicated assisted treatment); services to assist in getting off of opioids with suboxone, buprenorphine
- Rapid rehousing program removes barriers for up to a year for people needing help
- Shared housing initiative: developing opportunities to deal with increasing house prices so they are looking at shared housing options in safe way that maintains a person's dignity (utilizing underutilized housing stock out there)
- Austin street shelter-program with healthcare providers through THR the providers come onsite to the shelter to track and follow and provide ongoing care

Mental Health: HCI's Mental Health Index

It is important to note that Mental Health can be affected by a variety of socioeconomic factors including income, social support, socioeconomic status, gender identity, disability status, and stress caused by structural racism and other systemic barriers[16]. Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. Based on the MHI, in 2021, ZIP codes are ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 25 and Table 15, the highest need ZIP codes in this region are located mostly in Henderson and Kaufman counties. The Mental Health Index can be used in addition to the data shown below to help direct mental health resources within the region.

16. World Health Organization. (2014). Social Determinants of Mental Health. Geneva: WHO. https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf

FIGURE 25: DALLAS/ROCKWALL REGION: MENTAL HEALTH INDEX

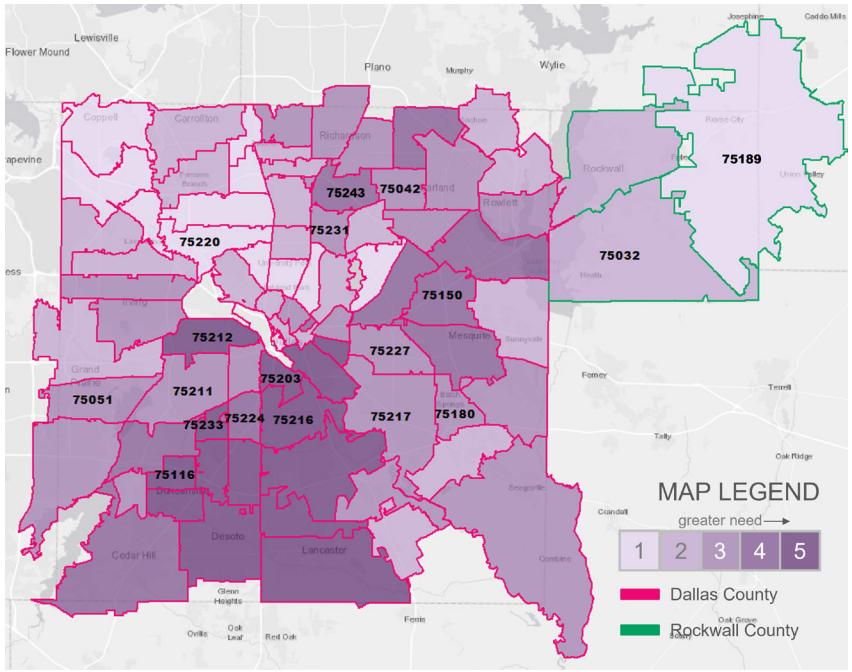


TABLE 15: DALLAS/ROCKWALL REGION PRIORITIZED ZIP CODES: MENTAL HEALTH INDEX VALUES

COUNTY	ZIP CODE	MHI VALUE
Dallas	75042	12.1
	75051	36.7
	75116	72.3
	75150	57.1
	75180	36.7
	75203	78.7
	75211	28.8
	75212	78.3
	75216	96.4
	75217	38.0
	75220	75.0
	75223	43.5
	75224	63.9
	75227	35.6
	75231	43.3
	75243	60.3
Rockwall	75032	10.8
	75189	24.2

Data Limitations

Conduent HCI made substantial efforts to comprehensively collect and analyze data for this assessment. Although there is a wide range of health and health-related areas, there may be varying scope and depth of secondary data indicators and findings within each topic. Data sources do not all function, analyze and categorize information the same way which may lead to variations in results.

Secondary Data

When analyzing secondary data, some health topic areas have a robust set of indicators, while others may have a limited number of indicators available. Population health and demographic data are often delayed in their release, so data is presented for the most recent years available for any given data source. There is also variability in the geographic level at which data sets are available from census tracts or ZIP codes to statewide or national geographies. Whenever possible, the most relevant localized data is reported. Some datasets are not available for the same time span or at the same level of localization due to variations in geographic boundaries, population sizes, and data collection techniques. The Index of Disparity, used to analyze the secondary data, is also limited by the availability of subpopulation data from the data source. In some instances, there was no subpopulation data for indicators, while a select number of race/ethnic groups had minimal values.

Primary Data

For the primary data, efforts were made to include a wide range of secondary data indicators and community member expertise areas. KIIs and focus groups were conducted in all five regions of the Dallas/Fort Worth area.

Opportunities for On-Going Work and Future Impact

While identifying solutions, 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. These factors come together to inform and focus strategies to positively impact a community's health. The following section outlines opportunities for on-going work in the Dallas/Rockwall Region.

Solutions

This section highlights responses from the KII and focus group participants when asked about ways Texas Health could help to improve the health of residents in their community. Responses included:

Access to Care

- Bringing health services into neighborhoods trough mobile units "neighborhood-based clinics that go to where the need is"
- More crisis counselors/behavioral health options for addiction takes a while to get a bed at a facility
  - » Largest mental health care facility is the jail which is not responsive mental health care
  - » Explore potential support for new mental health jail program/facility
  - » Strategize how to utilize funds from opioid lawsuit to appropriately fund programs
- Community Health Workers/Social Workers to help navigate the system
- Cultural competency training for providers
- Addressing transportation needs: partnerships with Uber/Lyft "Uber Health", a corporate account to provide reduced cost rides

Community Education

- Refocus: refocus efforts on community education i.e. teaching healthier food choices, how to prepare food
- Train: utilization of training the trainers model to train community members to then train community
- Events: community fairs/screening events i.e. blood pressure, mental health, A1C
- City-wide database of information "hub" / community organization information sharing

Population specific

- Homeless population
  - » RHMIS city-wide system is outdated: shared system to track where the person experiencing homelessness is in the process of being housed and remaining in stable housing to create a continuum of care for homeless individual/family
  - » Standard practice on safe discharge
  - » Training/expertise for medical social workers i.e. applying for Medicaid, Social Security (warm relationships for appropriate discharge to shelters)
  - » Other knowledge sharing opportunities about medical type interventions
  - » Overall, hospitals should move into teaching role to help people understand what their healthcare options are so people don't have to rely on emergency forms of care
- Sexual Assault Victims/Survivors
  - » More forensic/SANE nurses
  - » Train staff to identify abuse in the hospitals through screenings

Disparities and Barriers

Significant community health disparities are assessed in both the primary and secondary data collection processes. Potential disparities in the Dallas/Rockwall Region include people below the poverty level, specifically in Black/African American, Hispanic/Latino populations, and families who have children. In Dallas County the median household income is lower than the Texas value. Additionally, Dallas County has a larger percentage of age-adjusted emergency room visits due to type one and two diabetes than Rockwall County. Rates for adults who binge drink in Dallas and Rockwall counties are significantly high and in Dallas County adults who smoke, specifically in the southeastern area have higher rates than other part of Dallas and Rockwall counties. Identifying these data-driven disparities at the regional level helps to identify the social and economic disparities that are important to consider during prioritization and will inform future efforts as well.

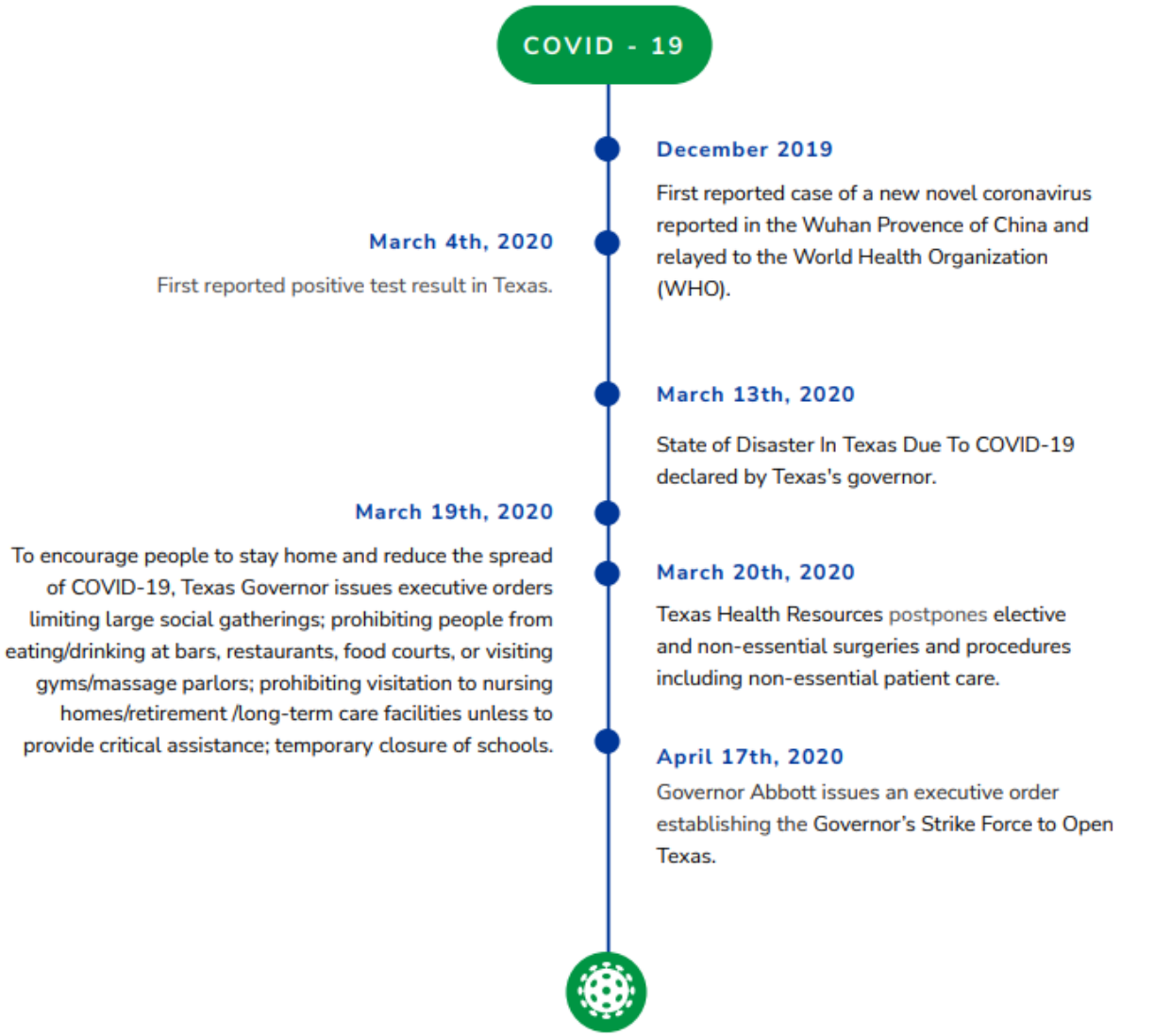
Barriers to health and well-being that community leaders and residents raised across the primary data sources reinforced the findings in the secondary data disparities analysis. The primary barriers included:

- Challenges with transportation
- Affordable housing, loss of employment led to loss of income, which led to inability to keep up with rent/mortgage
- Lack of or limited health insurance
- Technology, internet barriers, not having access to internet and/or technology (computers, laptops)
- Language barriers
- Childcare, unaffordable daycare for families leading to inability to work

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.

COVID-19 Snapshot

COVID-19 Community Impact Timeline



Sources

https://www.who.int/
https://gov.texas.gov
https://www.businessinsider.com/coronavirus-pandemic-timeline-history-major-events-2020-3

Introduction

At the time that Texas Health began its CHNA process, the state of Texas and the nation were continuing to deal with the novel coronavirus (COVID-19) pandemic. The process for conducting the assessment remained fundamentally the same. However, there were some adjustments made during the event to ensure the health and safety of those participating.

Pandemic Overview

On March 13, 2020, a U.S. national emergency was declared over the novel coronavirus outbreak first reported in the Wuhan Province of China in December 2019. Officially named COVID-19 by the World Health Organization (WHO), WHO declared COVID-19 a pandemic on March 11, 2020. To learn more about COVID-19 hospitalization, vaccinations, cases, and deaths in Texas, visit Texas Department of State Health Services[17] Upon completion of this report in May 2022, the pandemic continued to be a health crisis across the United States and in most countries.

Community Insights

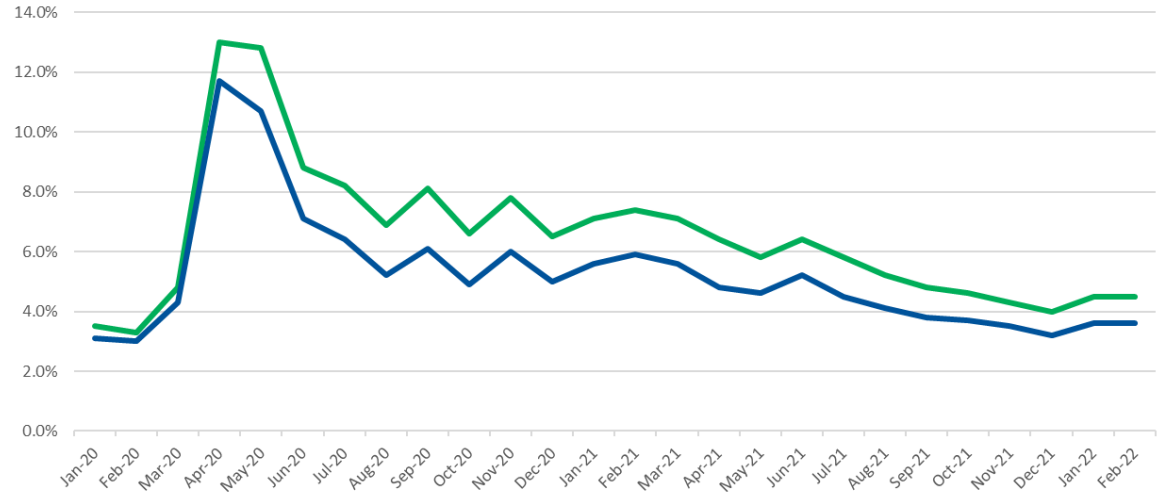
The CHNA project team looked for additional sources of secondary data and gathered primary data to provide a snapshot of the impact of COVID-19 on the Texas Health Resources Health System Service Area. This data was collected from October 2021 to May 2022. Findings are reported below.

Unemployment Rates

For both the Dallas and Rockwall Region, unemployment rates rose between March and April 2020 when stay-at-home orders were first announced. Illustrated in Figure 26 below, as counties began slowly reopening some businesses in late 2020, the unemployment rate gradually began to decrease. As of early 2022, unemployment rates have stabilized and are close to pre-pandemic rates. When unemployment rates rise, there is a potential impact on health insurance coverage and health care access if jobs that are lost include employer-sponsored healthcare.

17. Texas Department of State Health Services. (2022). Texas COVID-19 Data

FIGURE 26: UNEMPLOYED WORKERS IN CIVILIAN LABOR FORCE, JAN 2020 – FEB 2022



	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Dallas County	3.5%	3.3%	4.8%	13.0%	12.8%	8.8%	8.2%	6.9%	8.1%	6.6%	7.8%	6.5%	7.1%	7.4%	7.1%	6.4%	5.8%	6.4%	5.8%	5.2%	4.8%	4.6%	4.3%	4.0%	4.5%	4.5%
Rockwall County	3.1%	3.0%	4.3%	11.7%	10.7%	7.1%	6.4%	5.2%	6.1%	4.9%	6.0%	5.0%	5.6%	5.9%	5.6%	4.8%	4.6%	5.2%	4.5%	4.1%	3.8%	3.7%	3.5%	3.2%	3.6%	3.6%

COVID-19 Cases and Deaths in Texas

For current cases and deaths due to COVID-19 visit: https://www.dallascounty.org/COVID-19/ and/or https://www.rockwallcountytexas.com/1023/COVID-19-Information

Dallas/Rockwall Region Community Feedback

Both KIIs and focus group sessions included questions to capture insights and perspectives on the health needs of Dallas/Rockwall Region . Participants were specifically asked about the biggest challenges their households were currently facing during COVID-19.

Key Informant Interviews and Focus Group Input

Key informants and focus group participants were asked to identify those issues that were currently the biggest challenge for their households because of the COVID-19 pandemic. Data was collected between October 2021 and May 2022. Results below reflect both KIIs and focus group data combined.

COVID-19 Impact or Challenges

- Delay in Care/Access to Healthcare
  - » Overall stress exacerbated chronic conditions (i.e. diabetes, cancer, hypertension)
  - » Unaffordable costs of medication (insulin), loss of insurance due to loss of jobs, language barriers (difficulty accessing services in Spanish)
  - » Existing health disparities exacerbated for already under-resourced communities (immigrants fearful of seeking healthcare, African Americans with comorbidities due to systemic racism in healthcare, low-income families)
- Mental Health/Substance Abuse
  - » Isolation accelerated health conditions in the elderly population (dementia, more falls, more anxiety)
  - » Mental toll of racism on Black/Brown communities
  - » Suicide increases amongst teenagers, and young Hispanic men
  - » Minimal availability of affordable counseling resources, substance use disorder treatment
  - » Increase in anxiety and depression with absence of healthy coping skills
- Violence/Abuse: domestic violence, gender-based violence intimate partner violence, child abuse
  - » Increase in the frequency and severity of violence leading to serious health consequences for women (issues with pregnancy, traumatic brain injury, death)
  - » Increase in gun violence
  - » Domestic violence transcends social class, but need for shelter intervention exists more amongst those who struggle with housing and are resource deprived
- Misinformation/mistrust in healthcare system
  - » Affects access to care as people are reluctant to trust hospitals (misinformation from Facebook, radio and news sources), politicization of the pandemic

COVID-19 Socioeconomic Challenges

- Childcare: unaffordable daycare for families leads to inability to work (parents choosing between childcare or work)
- Technology/internet barriers
- Transportation
- Food insecurity/food accessibility: food deserts, rising cost of food
- Financial/economic impacts:
  - » Unemployment led to loss of health insurance/ loss of income
  - » Low wage jobs do not offer benefits (health insurance)
- Housing:
  - » Loss of employment led to loss of income, which led to inability to keep up with rent/mortgage payment, led to evictions/displacement
  - » Lack of affordable options
  - » Increasing housing prices/rent without increase in wages

Recommended Data Sources

As local, state, and national data are updated and become available, these data can continue to help inform approaches to meeting existing and developing needs related to the pandemic. Recommended data sources are included below.

National Data Sources

- Center for Disease Control: https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/surveillance-data-analytics.html
- Johns Hopkins Coronavirus Resource Center: https://coronavirus.jhu.edu/us-map
- NACCHO Coronavirus Resources for Health: https://COVID19-naccho.hub.arcgis.com/
- Feeding America (The Impact of the Coronavirus on Local Food Insecurity): https://www.feedingamerica.org/sites/default/files/2020-05/Brief_Local percent20Impact_5.19.2020.pdf

State Data Sources

Data and recommendations from the following websites are updated regularly and may provide additional information on the impact of COVID-19 in the state of Texas and the Texas Health Resources Health System regional service area.

- Texas Department of State Health Services: https://www.dshs.state.tx.us/coronavirus/
  - » Unemployment Rates: https://www.twc.texas.gov/news/texas-unemployment-rate-falls-59-percent-august

Looking Ahead

A total of 56 high-need ZIP codes were initially prioritized across the five Texas Health Regions and will continue to inform the work into the future. The purpose of the deeper dive into 17 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 through investments. Although funding will be specifically allocated to the community impact ZIP codes, work outside of these ZIP codes will continue through other community impact programming. While this strategically focused work is being implemented, Texas Health will continue working with Texas Health Community Impact Leadership Councils of the Dallas/Rockwall Region 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.

Conclusion

The CHNA for the Dallas/Rockwall Region utilized a comprehensive set of secondary data indicators to measure the health and quality of life needs for the Dallas/Rockwall Region's primary service area and beyond. Furthermore, this assessment was informed by input from knowledgeable and diverse individuals representing the broad interests of the community. Texas Health 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 invites your feedback on this CHNA report to help inform the next CHNA process. If you have any feedback or remarks, please send them to THRCHNA@texashealth.org

Appendices

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

A. Methodology and Data Scoring Tables

B. Community Data Collection Tools

C. Community Resources and Community Partners