

Texas Health Resources — Southern Region

Texas Health Presbyterian Hospital Kaufman



2022 Community Health Needs Assessment



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Executive Summary

Introduction & Purpose

Texas Health Resources is pleased to present its 2022 Community Health Needs Assessment (CHNA) for the Southern Region surrounding 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 Southern Region's service areas 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 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-serving 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 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 healthcare 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.

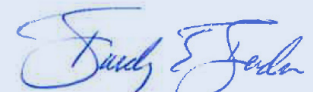
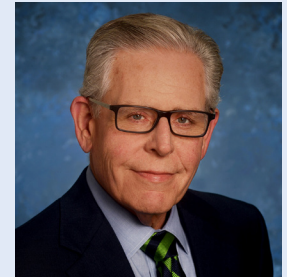
In this report, we're going to share our approach to how we have moved towards addressing challenges by focusing on solutions.

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, lack of public transportation and access to healthy food.

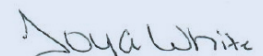
The 2022 CHNA report highlights the community voice and represents our vision — partnering with you for a lifetime of health and well-being. Because we believe that collaboration is at the core of every solution.

By working together, we continue to make a difference.

Sincerely,



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



Toya White, MBA, MSN,
APRN, FNP-C, FACHE
Chief Operating Officer/
Chief Nursing Officer
Texas Health Presbyterian
Kaufman

Regional Leadership Councils

Texas Health Community Impact Leadership Councils represent five unique regions 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 Health 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 Southern Region \$1.5 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 Southern Leadership Council for the Southern Region. These organizations were actively engaged in the prioritization process for the region.

- City of Cleburne
- City of Mabank
- Compassion Counseling Center
- Erath County Senior Citizens, Inc. dba Meals on Wheels of Erath County
- H-E-B Grocery
- Interim HealthCare Granbury
- Kaufman County
- Meals on Wheels North Central Texas
- Oakdale and Hannibal United Methodist Churches
- Pinnacle Bank
- Southwestern Adventist University
- Specialized Fleet Services
- Texas A&M AgriLife
- Texas Veterans Commission
- The University of Texas at Arlington
- Tri-County Ford
- Trinity Valley Electric Cooperative

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, Research Assistant, MPH and Dari Goldman, MPH – Senior Project Specialist.



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 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 Resources 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.



Southern Region of Texas Health Resources

This section covers the population and geographic area for the Southern Region.

Ellis County lies to the east of Johnson County and has a population of approximately 202,678 citizens according to the 2021 U.S. Census Record¹. This is a population increase of 5.3 percent since the 2020 Census. Waxahachie serves as the county seat². Ellis County is the most populated county in the region.

Erath County is a rural county located in the north central part of Texas. Stephenville serves as the county seat to a county population of approximately 43,378 citizens according to the 2021 U.S. Census Record³, a population increase of 2 percent since the 2020 Census. Erath County is the least populated county in this region⁴.

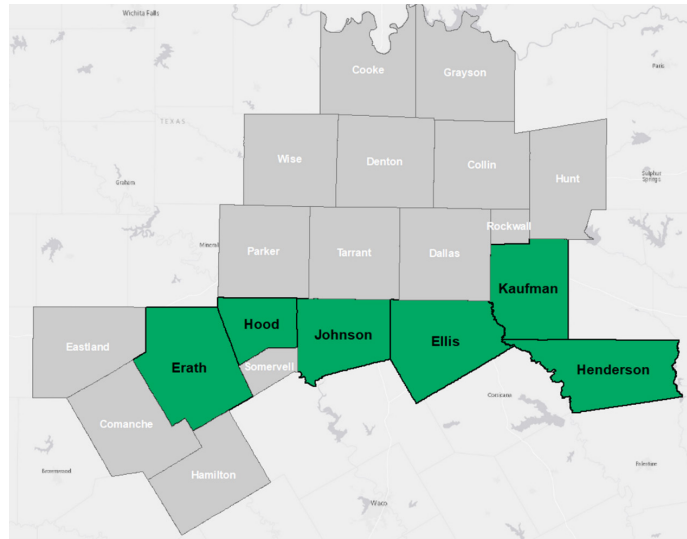
Henderson County has a population of approximately 83,667 citizens according to the 2021 U. S. Census Record⁵. This is a population increase of 1.8 percent since the 2020 Census. The county seat is Athens. Henderson is the second least populated county in the region.

Hood County has a population of approximately 64,222 citizens according to the 2021 U. S. Census Record⁶. This is a population increase of 4.3 percent since the 2020 Census. The county seat is Granbury.

Johnson County has a population of approximately 187,280 citizens according to the 2021 U.S. Census Record⁷. This is a population increase of 4.1 percent since the 2020 Census. Cleburne serves as the county seat. Johnson is the second most populated county in the Southern Region⁸.

Kaufman County lies to the east of Ellis County. It has a population of approximately 157,768 citizens according to the 2021 U.S. Census Record⁹. This is a population increase of 8.6 percent since the 2020 Census. The City of Kaufman serves as the county seat¹⁰.

FIGURE 1. TEXAS HEALTH SERVICE AREA COUNTIES: SOUTHERN REGION



1. United States Census Bureau. (2022). QuickFacts. <https://www.census.gov/quickfacts/fact/table/elliscountytexas,TX/PST045221>
2. Ellis County, Texas. (2022). Our History. Demographics. <https://www.co.ellis.tx.us/64/Demographics>
3. United States Census Bureau. (2022). QuickFacts. <https://www.census.gov/quickfacts/fact/table/erathcountytexas,TX,US/PST045221>
4. Erath County, Texas. (2022). County Information. <https://www.co.erath.tx.us/>
5. United States Bureau. (2022). Quickfacts. <https://www.census.gov/quickfacts/fact/table/hendersoncountytexas/PST045221>
6. United States Bureau. (2022). Quickfacts. <https://www.census.gov/quickfacts/fact/table/hoodcountytexas/PST045221>
7. United States Census Bureau. (2022). QuickFacts. <https://www.census.gov/quickfacts/fact/table/johnsoncountytexas,erathcountytexas,TX,US/PST045221>
8. Johnson County, Texas. (2022). Historical Commission. <https://www.johnsoncountytexas.org/home>
9. United States Census Bureau. (2022). QuickFacts. <https://www.census.gov/quickfacts/fact/table/kaufmancountytexas,elliscountytexas,TX/PST045221>
10. Kaufman County, Texas. (2022). Welcome to Kaufman County. <https://www.kaufmancounty.net/>

Facility Description

Texas Health Presbyterian Kaufmann

Texas Health Presbyterian Hospital Kaufman serves the communities of Kaufman, Crandall, Forney, Gun Barrel City, Mabank, Terrell and other cities in Kaufman and Henderson counties with advanced medical treatments and an experienced staff that provides compassionate care. With a mission of improving the health of the people in the communities we serve, Texas Health Kaufman and the physicians on its medical staff are committed to your well-being and the health and wellness of your family. Texas Health Kaufman offers:

- Diabetes care
- Digestive health
- Emergency department
- General Surgery
- Healthy Education and Lifestyles Program
- Heart and vascular
- Imaging
- Orthopedics
- Physical therapy
- Urology

Texas Health Kaufman was the only Dallas-Fort Worth area hospital to earn a Top 5 percent ranking two year in a row for the treatment of pneumonia by the U.S. Centers for Medicare and Medicaid Services and Premier Inc. The hospital has also earned an "A" grade for patient safety, according to the most recent hospital safety scores from The Leapfrog Group, and it earned a Stage 7 award from the Healthcare Information and Management Systems Society for the highest level of electronic health record adoption a hospital can achieve. Texas Health Kaufman is a 91-bed hospital conveniently located at Highway 175 and Ed Hall Drive in Kaufman.

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 disproportionately 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, healthcare, 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 the 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 healthcare 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 truly collaborative project aimed at reducing the barriers to physical activity by providing middle school age children in the Pleasant Grove community of Dallas with sports and nutritional resources to promote health and overall wellness. Texas Health and collaborators will increase the participation of at least 130 socio-economically disadvantaged youth in sports. The grant provides access to nutrition education, physical literacy resources, athletic training, and community education both in-person and virtually. To date this program has served over 99 adolescents.

• *Texas Health Community Vaccination Program:* Texas Health Community COVID-19 Vaccination launched in January 2021 to in response to Texas Health's aim to provide equitable care. With the understanding the individuals in medically underserved communities may have limited access to the COVID-19 Vaccine. The Mobile Health team included COVID-19 vaccination 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

the 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 healthcare 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 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>. 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

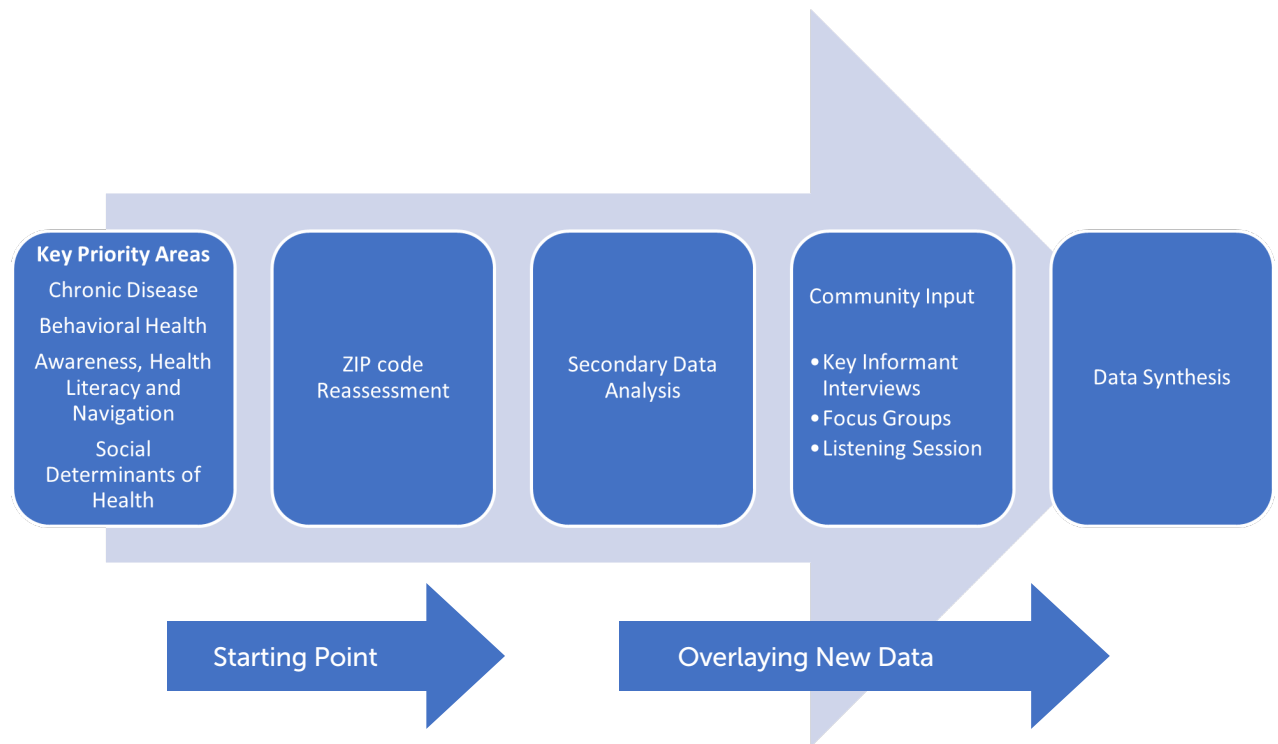
Overview

Two types of data were used in this assessment: primary and secondary data. Primary data is data collected directly from main sources in the community. 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, a tool developed by Conduent Healthy Communities Institute. This tool measures socioeconomic need 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

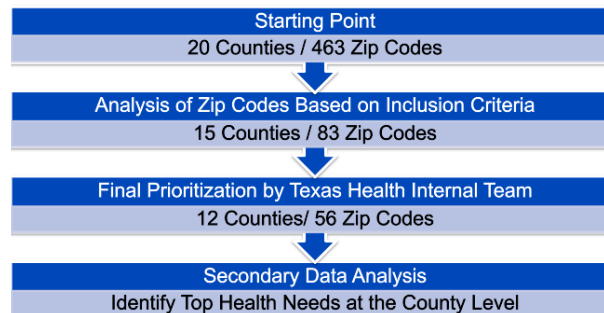


Data were analyzed at the ZIP code level when available. Findings from the analysis were used to identify fifteen counties and 83 priority ZIP codes for the 2022 CHNA process.

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.

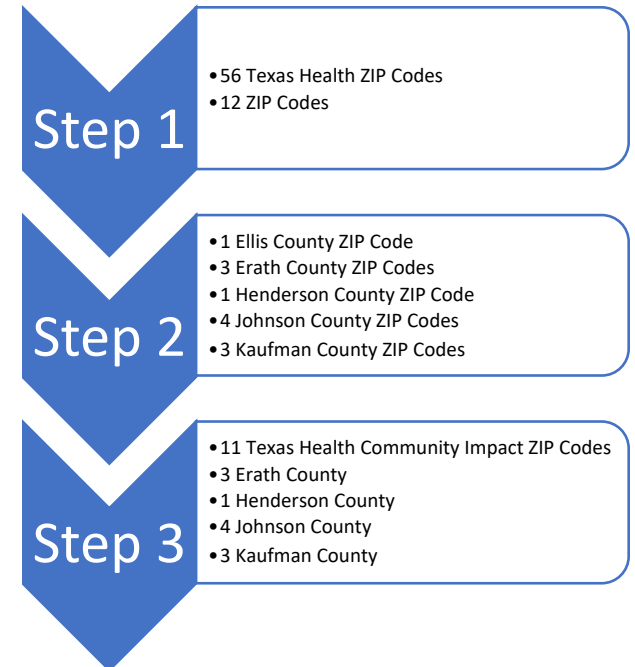
FIGURE 3. METHODOLOGY OVERVIEW



Southern ZIP Code Prioritization

The Southern Region is comprised of 12 prioritized ZIP codes: one in Ellis County, three in Erath County, one in Henderson County, four in Johnson County, and three in Kaufman County. ZIP codes were ranked on perceived need and identified need per the Health Equity Index (a measure of socioeconomic need). The results yielded 12 ZIP codes, from which 11 ZIP codes will be the target areas the Texas Health Community Impact Southern Leadership Council will focus their work on for the next three years and provide funds that will address health priorities identified in the process. The diagram in Figure 4 summarizes the overall ZIP code prioritization process for the 2022 CHNA.

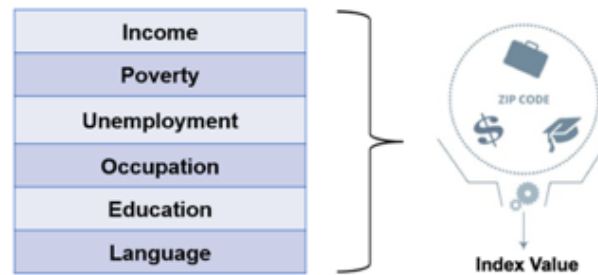
FIGURE 4. SOUTHERN ZIP CODE PRIORITIZATION



Health Equity Index

Figure 5 is an illustration of the Health Equity Index (HEI) — formerly, the SocioNeeds Index), which incorporates estimates for six different social and economic determinants of health that are associated with poor health outcomes. The data, which covers 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 in Table 1, many of the prioritized ZIP codes are also identified as highest need ZIP codes within the region.



FIGURE 6: SOUTHERN REGION HEI MAP

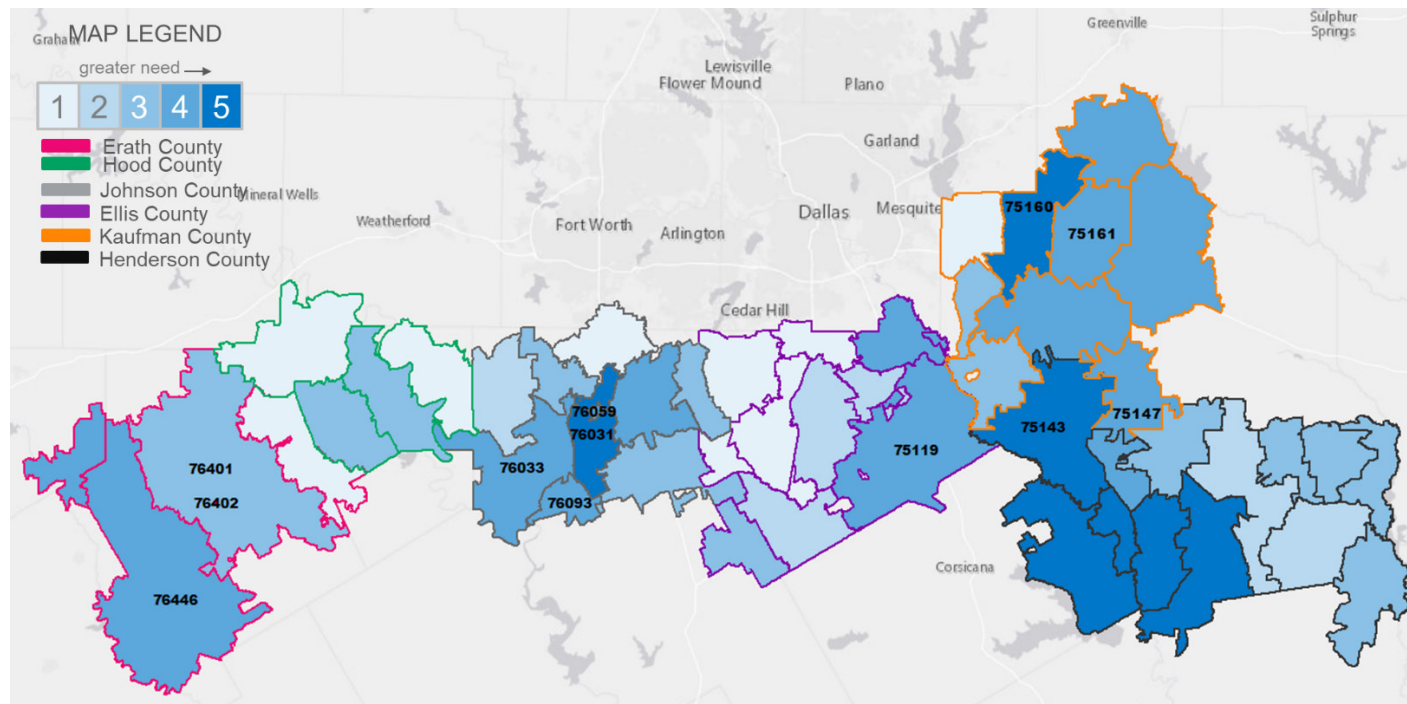


TABLE 1. HEI VALUES FOR PRIORITIZED ZIP CODES

COUNTY	ZIP CODE	HEI VALUE
Ellis	75119	72.2
Erath	76401	58
	76402	26.1
	76446	77.3
Henderson	75143	85.7
Johnson	76031	79.6
	76033	67.3
	76059	75.8
	76093	76.3
Kaufman	75147	70.6
	75160	80.7
	75161	73.5

Demographics

The following section explores the demographic profile of the Texas Health Southern 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 efforts¹¹. All demographic estimates are sourced from American Community Survey one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.



11. 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 Southern Region had a combined population of 686,875. Table 2 below shows the population breakdown for the prioritized ZIP codes within the Southern Region. 76401 in Erath County and 75119 in Ellis County are the most heavily populated prioritized ZIP codes in the region.

TABLE 2: POPULATION ESTIMATES FOR PRIORITIZED ZIP CODES IN THE SOUTHERN REGION

COUNTY	ZIP CODE	TOTAL POPULATION ESTIMATE
Ellis	75119	28,598
	76401	30,003
	76446	7,709
Henderson	75143	14,510
	76031	17,668
Johnson	76033	26,081
	76059	5,601
	76093	1,792
	75147	6,636
Kaufman	75160	25,525
	75161	6,529

Age

As shown in Figure 7, 25.9 percent of Johnson County, 26.5 percent of Ellis County, and 27.9 percent of Kaufman County are under 18 years which are higher proportions compared to the state (25.5 percent) and nation (22.3 percent). Johnson County (25.9 percent) has a similar proportion of residents under 18 compared to the state (25.5 percent).

Figure 8 illustrates that 11.8 percent of the population in Kaufman County is over 65, which is a smaller percentage to Texas (12.9 percent) and the U.S. (16.5 percent). The population over 65 in Hood, Henderson, Earth and Johnson County are higher (25.0 percent, 22.4 percent, 14.7 percent and 14.3 percent respectively), than the overall Texas value. Ellis County (13.1 percent) has a similar proportion of the population over 65 as Texas.

Figure 9 shows that Johnson County and Ellis County have a similar proportion of residents under five years old (6.6 percent and 6.7 percent, respectively) compared to Texas (6.9 percent) and a similar proportion compared to the U.S. (6.0 percent). Kaufman County has a higher proportion (7.2 percent). Erath, Henderson and Hood have a smaller percentage of the population under age five (5.7 percent, 5.4 percent and 5.4 percent respectively) compared to Texas and the U.S.



FIGURE 7. POPULATION UNDER AGE 18

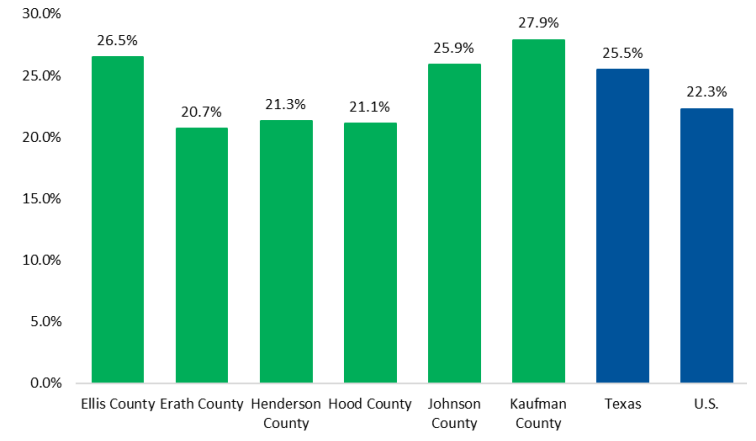


FIGURE 8. POPULATION OVER AGE 65

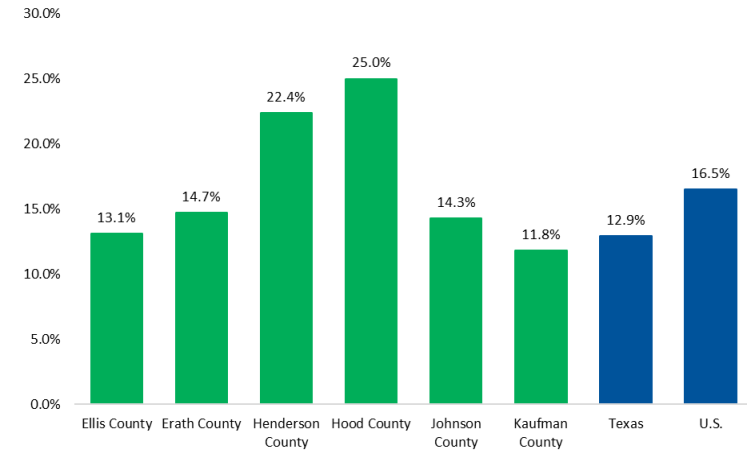
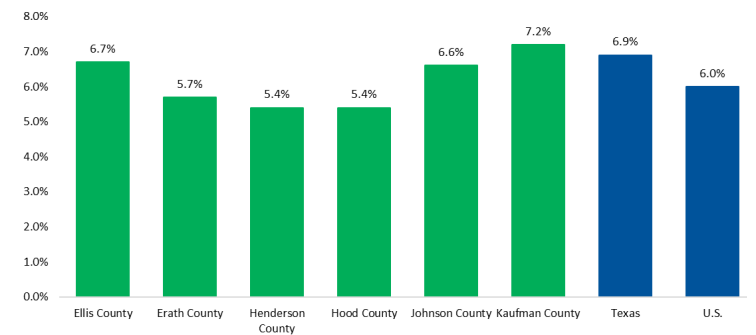


FIGURE 9. POPULATION UNDER AGE 5



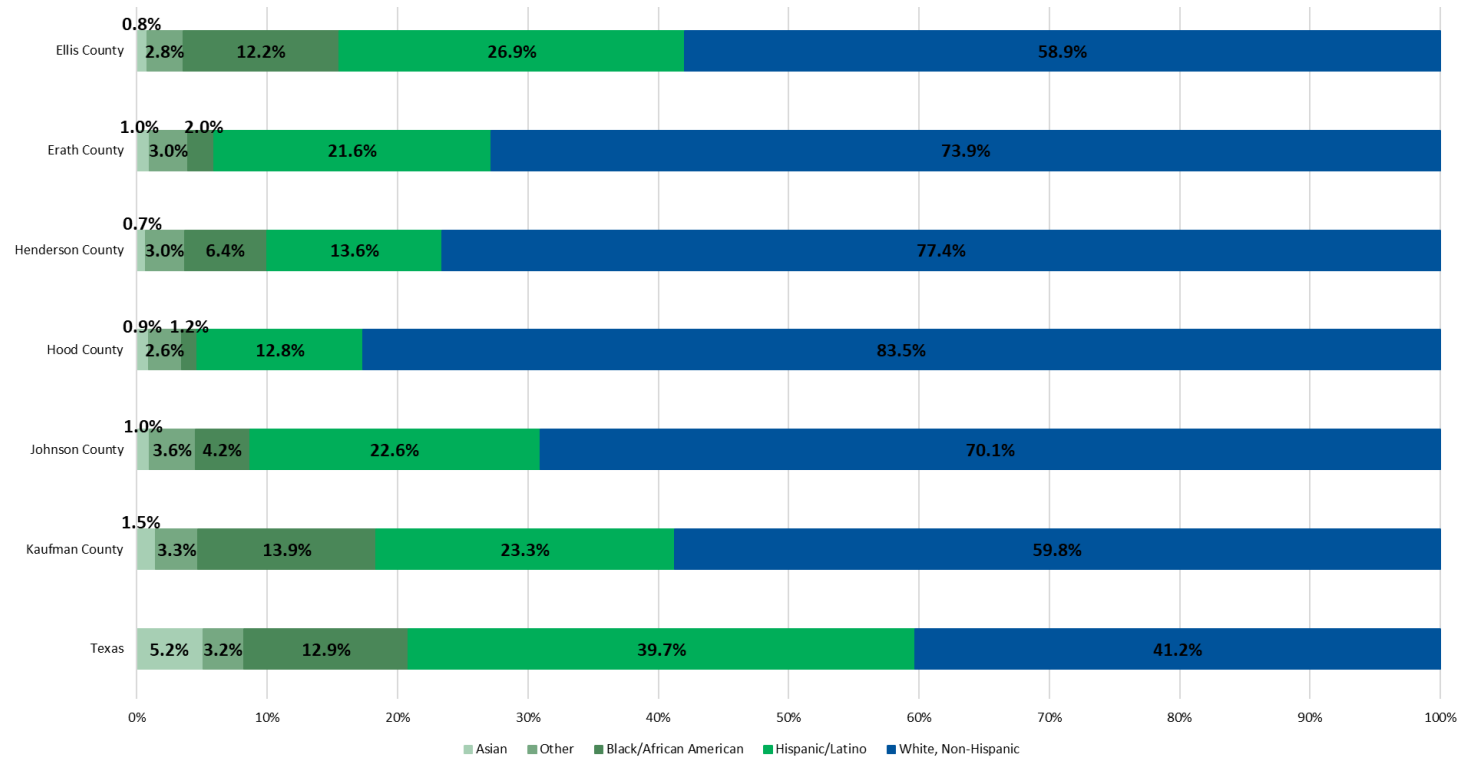
Race/Ethnicity

The race and ethnicity composition of a population are important in planning for future community needs, particularly for schools, businesses, community centers, healthcare 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 and ethnic composition of residents in each county within the Southern Region. Compared to other counties within the Southern Region, Henderson County (77.4 percent) and Hood County (83.5 percent) have a higher percentage of residents identifying as White, Non-Hispanic. Ellis County (26.9 percent) and Kaufman County (23.3 percent) have the highest percentage of residents identifying as Hispanic/Latino. Additionally, Ellis (12.2 percent) and Kaufman (13.9 percent) counties have the highest percentage of residents identifying as Black/African American in the region.



FIGURE 10. RACE/ETHNICITY OF COUNTIES WITHIN THE SOUTHERN REGION



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 (AGE 5+) WHO SPEAKS A LANGUAGE OTHER THAN ENGLISH AT HOME

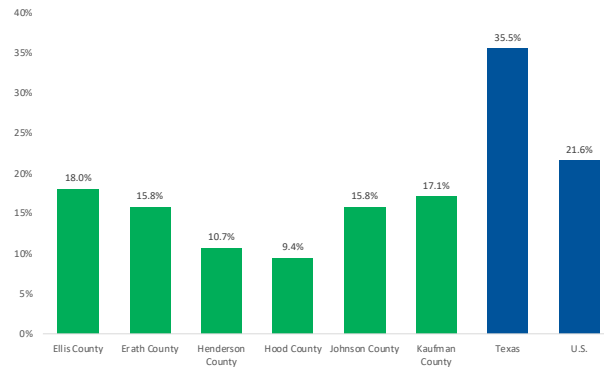


Figure 11 shows the proportion of residents who speak a language other than English at home. Ellis, Erath, Henderson, Hood, Johnson and Kaufman (18.0 percent, 15.8 percent, 10.7 percent, 9.4 percent, 15.8 percent, and 17.1 percent respectively) have a lower percentage of residents who speak a language other than English at home compared to Texas (35.5 percent). As shown in Table 3, ZIP codes 75119 in Ellis County and 76059 in Johnson County have the largest proportion of residents who speak a language other than English at home (33.1 percent and 32.3 percent, respectively). In these ZIP codes, 31.9 percent and 22.4 percent, respectively, 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 (AGE 5+) WHO SPEAKS A LANGUAGE OTHER THAN ENGLISH AT HOME BY PRIORITIZED ZIP CODE

COUNTY	ZIP CODE	PERCENT POPULATION THAT SPEAKS A LANGUAGE OTHER THAN ENGLISH AT HOME	PERCENT POPULATION THAT SPEAKS SPANISH AT HOME
Ellis	75119	33.1%	31.9%
Erath	76401	12.8%	11.8%
	76402	24.9%	19.6%
	76446	30.5%	26.7%
Henderson	75143	10.7%	9.9%
Johnson	76031	21.4%	21.3%
	76033	14.9%	13.7%
	76059	32.3%	22.4%
	76093	12.1%	11.9%
Kaufman	75147	4.6%	2.7%
	75160	22.2%	21.2%
	75161	9.8%	8.0%

As shown in Table 4, ZIP codes 75119 and 76059 in Ellis and Johnson Counties have larger portions of their populations who have difficulty speaking English at home (6.9 percent and 6.8 percent, respectively).

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

COUNTY	ZIP CODE	PERCENT POPULATION WITH DIFFICULTY SPEAKING ENGLISH
Ellis	75119	6.9%
Erath	76401	1.4%
	76402	N/A
	76446	3.4%
	75143	0.9%
Johnson	76031	4.9%
	76033	3.8%
	76059	6.8%
Kaufman	76093	4.8%
	75147	1.1%
	75160	3.6%
	75161	2.8%



Social and Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health in the Southern 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 life¹².



12. 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 work¹³.

FIGURE 12. MEDIAN HOUSEHOLD INCOME

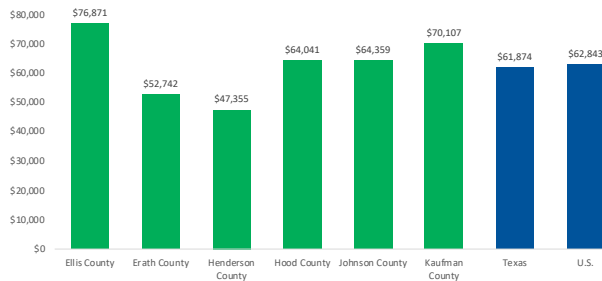


Figure 12 shows that Ellis County (\$76,871) and Kaufman County (\$70,107) are the highest in the Southern Region. Both Erath County (\$52,742) and Henderson County (\$47,355) have lower median household incomes than both the state of Texas (\$61,874) and the U.S. (\$62,843) and are the lowest in the Southern Region.

13. 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>

14. 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 survival¹⁴.

Figure 13 shows the percentage of people living below the poverty level for Erath County (18.4 percent) and Henderson County (17.1 percent). Both Erath and Henderson counties are higher than the Texas state value (14.7 percent) and the U.S. value (13.4 percent). Ellis, Hood, Johnson and Kaufman (8.8 percent, 9.7 percent, 10.2 percent and 11.4 percent respectively) counties show values lower than the state of Texas and the U.S.

Figure 14 shows the percentage of people living below the poverty level by race/ethnicity. People identifying as Native Hawaiian/Pacific Islander, Other Race, Two or More Races or Black/African American generally have the highest poverty rates in the region, particularly in Erath County.

FIGURE 13. PEOPLE LIVING BELOW POVERTY LEVEL

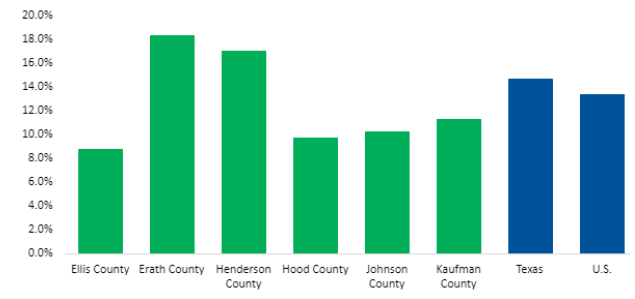
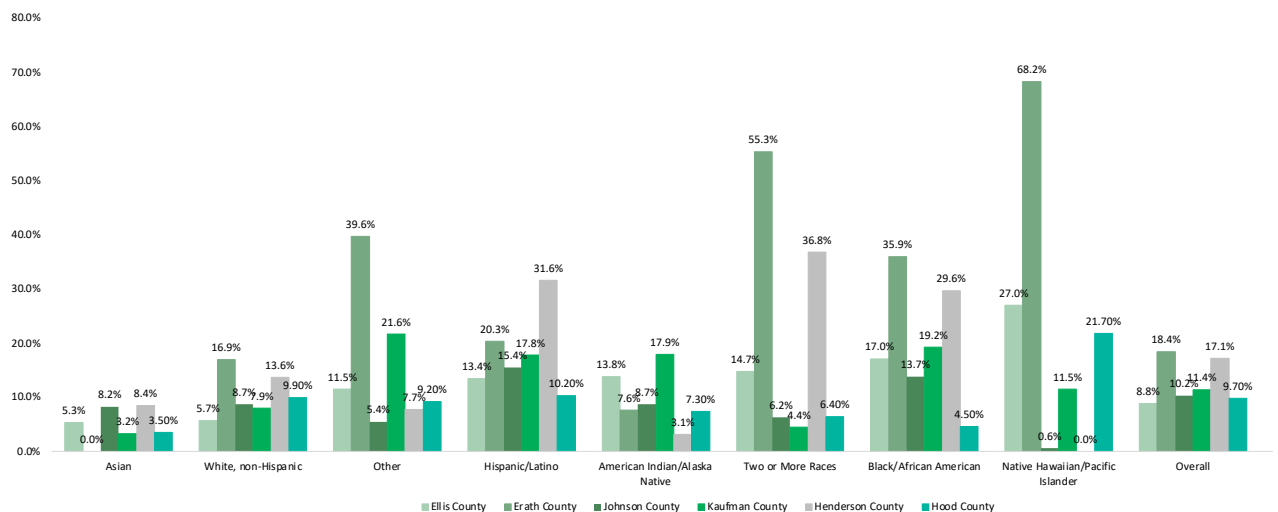


FIGURE 14. PEOPLE LIVING BELOW POVERTY LEVEL BY RACE/ETHNICITY



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 food¹⁵.

FIGURE 15. HOUSEHOLDS WITH CHILDREN RECEIVING SNAP

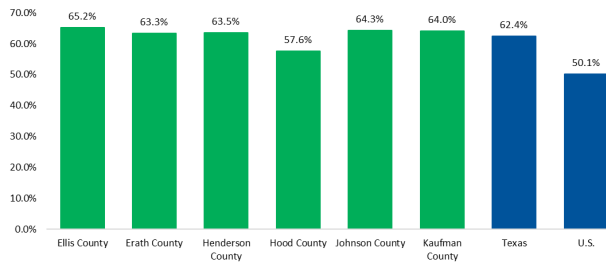


Figure 15 shows the percentage of households with children under 18 years old receiving food stamps/ SNAP benefits. Ellis (65.2 percent), Erath (63.3 percent), Henderson (63.5 percent), Johnson (64.3 percent), and Kaufman (64.0 percent) counties have slightly higher percentages than both the Texas State value (62.4 percent) and U.S. value (50.1 percent), respectively. Hood County (57.6 percent) has a lower value than the state of Texas value and U.S. value.

Conduent’s Food Insecurity Index (FII) estimates areas of low food accessibility correlated with social and economic hardship. 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. 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. Most of the prioritized ZIP codes in this region are identified as having the highest economic and social burden for the area as shown in Table 5.

FIGURE 16A: SOUTHERN REGION FOOD INSECURITY INDEX BY ZIP CODE

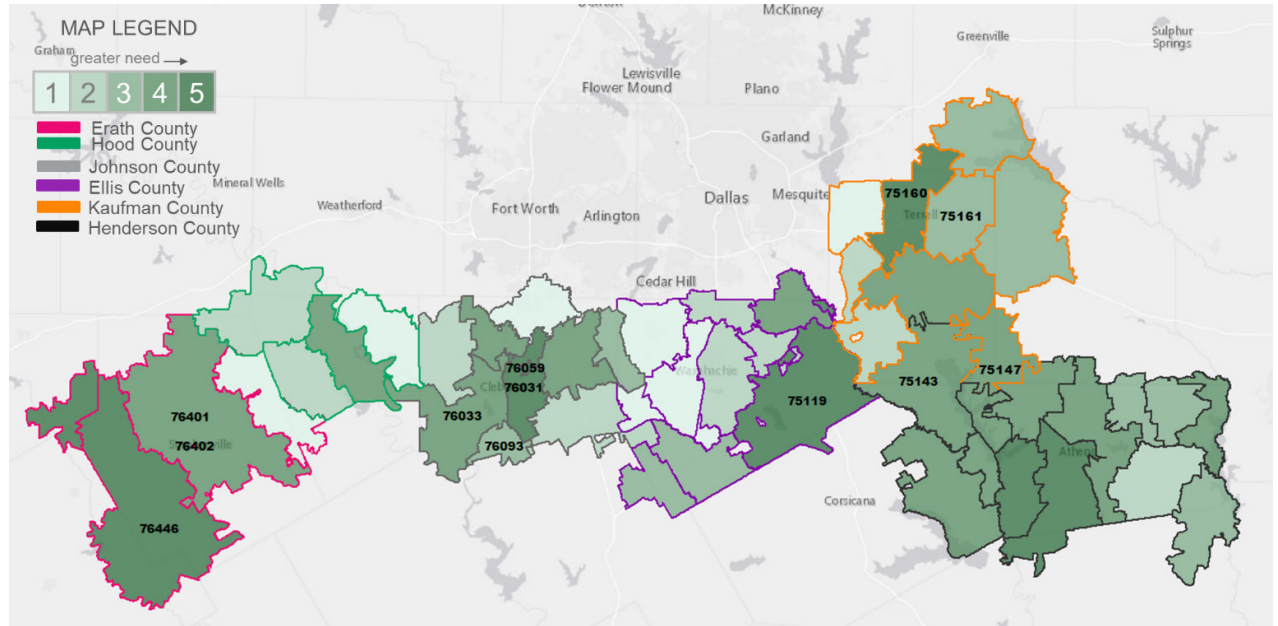


TABLE 5: FOOD INSECURITY INDEX VALUES BY PRIORITIZED ZIP CODES

COUNTY	ZIP CODE	FII VALUE
Ellis	75119	67.7
	76401	74.9
	76402	79.3
Henderson	76446	79.5
	75143	50.7
	75147	56.1
Johnson	76031	75.7
	76033	61.4
	76059	74.3
	76093	51.2
Kaufman	75160	62.3
	75161	63.3



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

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 healthcare, 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 programs¹⁶.

FIGURE 16B. UNEMPLOYED WORKERS IN CIVILIAN LABOR FORCE

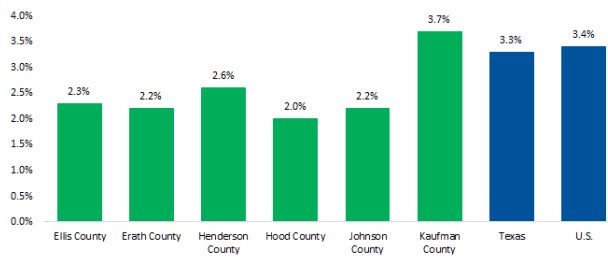


Figure 16b shows the percentage of unemployed workers in the civilian labor force. The percentage in Kaufman County (3.7 percent) is higher than both the Texas state (3.3 percent) and U.S. value (3.4 percent). Ellis, Erath, Henderson, Hood and Johnson Counties (2.3 percent, 2.2 percent, 2.6 percent, 2.0 percent and 2.2 percent respectively) are lower than the state of Texas value (3.3 percent) and the U.S. value (3.4 percent).

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 jobs¹⁷.

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

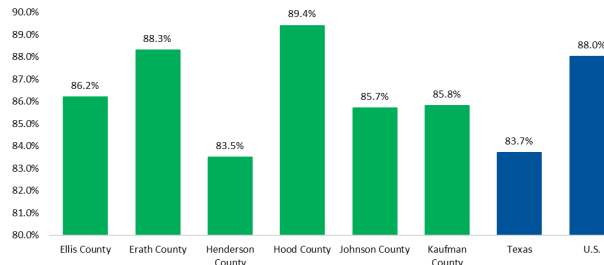


Figure 17 shows the percentage of People 25 Years or Older with a High School Degree or Higher. Ellis, Erath, Hood, Johnson and Kaufman Counties (86.2 percent, 88.3 percent, 89.4 percent, 85.7 percent and 85.8 percent respectively) are higher than the Texas state value (83.7 percent) but Henderson County is lower than the state of Texas (83.7 percent).

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

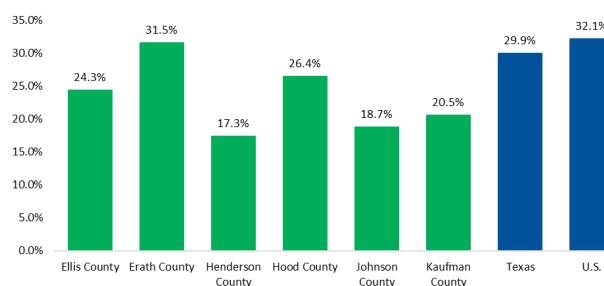


Figure 18 shows the Percentage of People 25 Years or Older with a Bachelor's Degree or Higher. While Erath County (31.5 percent) is higher than the Texas state value (29.9 percent), it is lower than the U.S. value (32.1 percent). Ellis, Henderson, Hood, Johnson and Kaufman Counties (24.3 percent, 17.3 percent, 26.4 percent, 18.7 percent, and 20.5 percent respectively) are lower than both the state of Texas value and U.S. value.

Transportation

Lengthy commutes cut into workers' free time and can contribute to health problems such as headaches, anxiety, and increased blood pressure¹⁸. Longer commutes require workers to consume more fuel, which is both expensive for workers and damaging to the environment¹⁹.

FIGURE 19. MEAN TRAVEL TIME TO WORK (MINUTES)

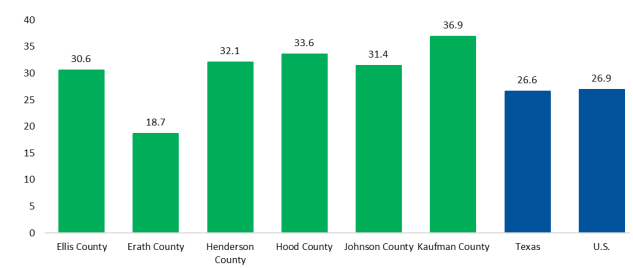


Figure 19 shows the mean travel time to work for Ellis, Henderson, Hood, Johnson and Kaufman (30.6, 32.1, 33.6, 31.4 and 36.9 minutes, respectively) are higher than the Texas state value (26.6 minutes) and the U.S. value (26.9 minutes). Residents in Erath County (18.7 minutes) have the shortest commute time in the region.

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

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

18. 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.

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

Southern Region Healthcare 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 summaries²⁰. 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.

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

Figure 20 shows the Age-Adjusted emergency room (ER) Visit Rate due to Diabetes for the region by ZIP code. The highest rates are within Ellis County. Table 6 shows the Texas Health Community Impact ZIP code 76031 has among the highest rates in the region.

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

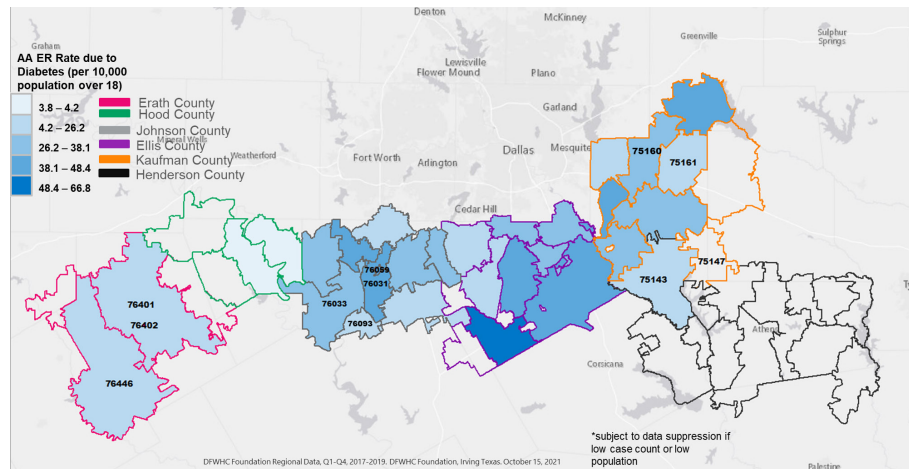


TABLE 6. AGE-ADJUSTED EMERGENCY ROOM VISIT RATES DUE TO DIABETES

COUNTY	COMMUNITY IMPACT ZIP CODE	AA ER VISIT RATE (PER 10,000 POP)
Erath	76401	20.5
	76402	N/A
	76446	25.8
Johnson	76031	48.4
	76033	33.9
	76059	41.1
	76093	24.4
Henderson	75143	18.3
	75160	31.5
Kaufman	75147	N/A
	75161	26.2

Figure 21 shows the Age-Adjusted ER Visit Rate due to Type 2 Diabetes for the region by ZIP code. The highest rates are within Ellis and Johnson counties Table 7 shows that Texas Health Community Impact ZIP code 76031 has among the highest rates in the region.

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

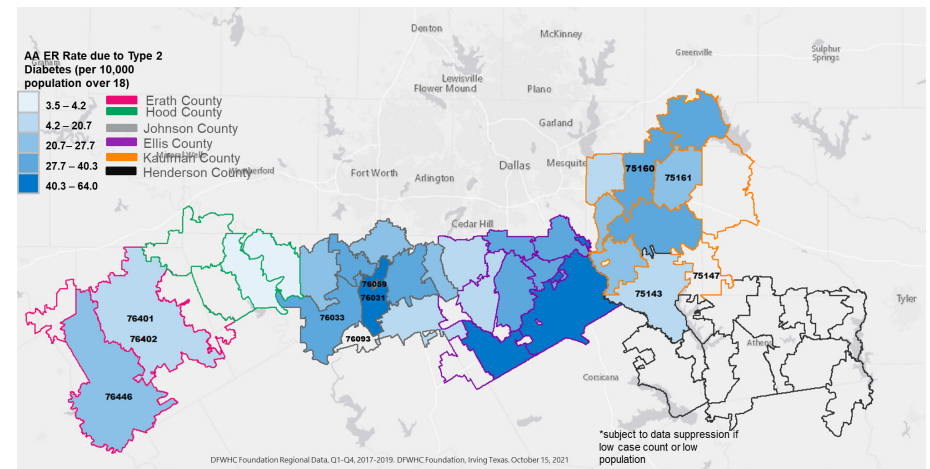


TABLE 7. AGE-ADJUSTED ER VISIT RATES DUE TO TYPE 2 DIABETES

COUNTY	COMMUNITY IMPACT ZIP CODE	AA ER VISIT RATE (PER 10,000 POP)
Erath	76401	18.4
	76402	N/A
	76446	24.6
Johnson	76031	43.9
	76033	29.7
	76059	29.6
	76093	N/A
Henderson	75143	16.4
	75160	30.2
Kaufman	75147	N/A
	75161	23.6

Figure 22 shows the Age-Adjusted ER Visit Rate due to Hypertension for the region by ZIP code. The highest rates are within Ellis and Johnson counties and, as shown in Table 8, community impact ZIP codes 76059 and 76093 have among the highest rates in the region.

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

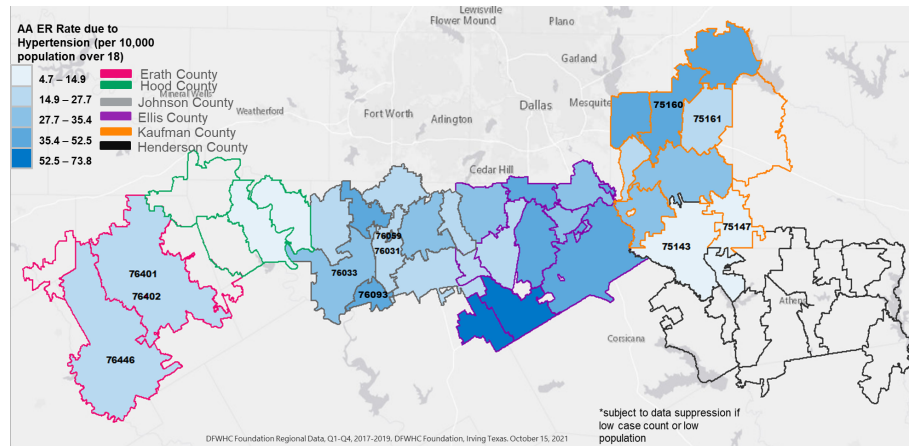


TABLE 8. AGE-ADJUSTED ER VISIT RATES DUE TO HYPERTENSION

COUNTY	COMMUNITY IMPACT ZIP CODE	AA ER VISIT RATE (PER 10,000 POP)
Erath	76401	22.9
	76402	N/A
	76446	19.2
Henderson	75143	14.9
	76031	27.7
Johnson	76033	35.4
	76059	39.3
	76093	39.4
	75147	8.9
Kaufman	75160	38.7
	75161	27.5

Figure 23 shows the Age-Adjusted ER Visit Rate due to Adult Mental Health for the region by ZIP code. Figure 9 shows that the Texas Health Community Impact ZIP code 76401 in Erath County has an age-adjusted rate of 3.3 ER visits due to Adult Mental Health. Many ZIP codes within this region have missing data for the 2017-2019 time period due to low case counts.

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

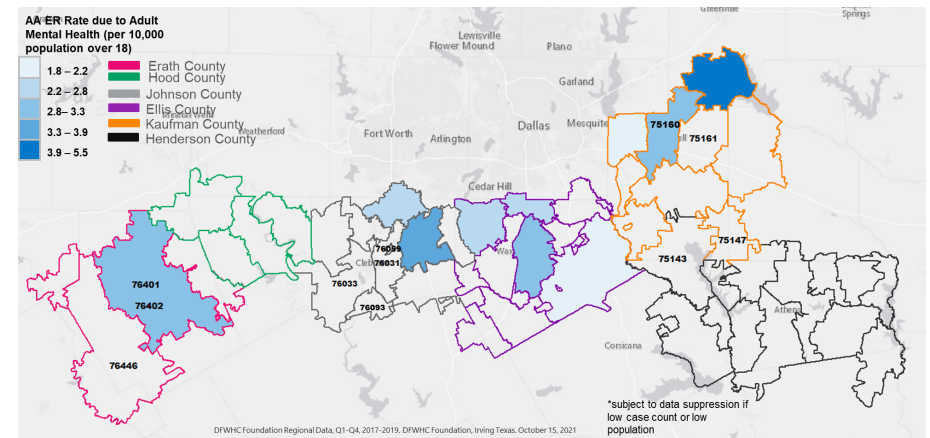


TABLE 9. AGE-ADJUSTED ER VISIT RATES DUE TO ADULT MENTAL HEALTH

COUNTY	COMMUNITY IMPACT ZIP CODE	AA ER VISIT RATE (PER 10,000 POP)
Erath	76401	3.3
	76402	N/A
	76446	N/A
Henderson	75143	N/A
	76031	N/A
Johnson	76033	N/A
	76059	N/A
	76093	N/A
	75147	N/A
Kaufman	75160	3.1
	75161	N/A

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.

Spanning all Texas Health regions, 41 individuals agreed to participate in the KII process. The following organizations 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 Agrilife 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, Dedoose²¹. 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.

21. 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 19 virtual and in-person focus groups were conducted from November 2021 through May 2022. In the Southern Region, there were seven focus groups conducted, three English-speaking groups, one Spanish-speaking, two bilingual (English and Spanish), and one Marshallese group. Table 10 shows the focus groups completed, which included a total of 47 participants. Individuals recruited for focus groups included those who were living in and/or working in the Southern Region. The virtual and in-person focus group sessions lasted 60 minutes.

TABLE 10: SOUTHERN REGION FOCUS GROUPS

COUNTY	NUMBER OF SESSIONS	FACILITATION LANGUAGE	TOTAL COMMUNITY PARTICIPANTS
Johnson/Ellis Erath Kaufman/ Henderson	3	English	23
Kaufman/ Henderson	1	Spanish	8
Johnson/ Erath	2	English/ Spanish	19
Johnson	1	Marshallese	7

An array of residents and employees from the Southern 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.

The following top themes emerged from the Collin region analysis of the transcripts:

TABLE 11: KEY INFORMANT INTERVIEWS & FOCUS GROUP THEMES — SOUTHERN REGION

TOP HEALTH CONCERNS/ISSUES	SOCIAL DETERMINANTS OF HEALTH	IMPACTED POPULATIONS
<p>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 accepts their insurance; financial barriers—lack of insurance/underinsured, high costs, provider not accepting Medicaid; language/cultural barriers contribute to mistrust</p> <p>Mental Health & Mental Disorders: Lack of providers—psychiatrists, school counselors, SANE exam providers; long waiting lists</p> <p>Chronic Conditions: Diabetes, heart conditions: hypertension, high blood pressure due to stress</p> <p>COVID-19 Impact: Mental health/substance abuse, financial impacts due to employment loss which led to loss of health insurance & childcare needs, delay in care/access to healthcare, food insecurity</p>	<p>Food Insecurity/food accessibility</p> <p>Housing</p> <p>Transportation</p> <p>Lack of or limited insurance</p> <p>Economic instability/employment</p> <p>Language barriers</p> <p>Lack of access to space for Physical Activity (parks, community centers)</p>	<p>Black/African Americans: not serviced as well as others due to discrimination/bias/racism</p> <p>Groups experiencing abuse: women/children, sexual assault victims</p> <p>Single parent households</p> <p>Non-English speaking populations</p> <p>Homeless population</p> <p>Older adults</p> <p>Individuals living in rural areas</p> <p>Low-income families/groups that don’t qualify for Medicaid “coverage gap”</p>



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. 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 healthcare, 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.

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

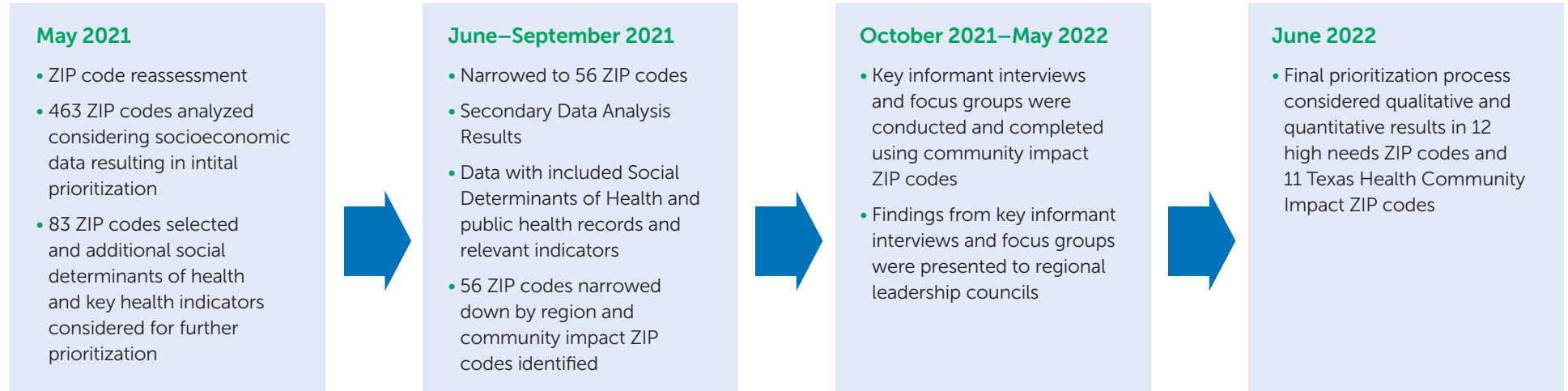


Prioritization Process

Initial ZIP Code Prioritization

To identify high-need ZIP codes within and outside the Texas Health 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® Suite as well as other socio-demographic data and key health indicators. Of the 56 ZIP codes across the 12-county area that were considered, 12 of them were identified as high priority ZIP codes and of those, 11 were identified as the community impact ZIP codes from the Southern 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 11 ZIP codes that were chosen as the final target areas are shown in the table below. Each of the ZIP codes identified fall within Texas Health's Service Area (HSA). 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 Southern Region in selecting issues that fell within the prioritized health areas of Awareness, Health Literacy and Navigation, Behavioral Health, or Chronic Disease. They also considered any social determinants of health that may contribute to these issues. Based on these considerations, Texas Health Community Impact Leadership Council for the Southern Region elected to focus on healthcare access and navigation and mental health across the nine ZIP codes. Table 13 summarizes the Health Priority Areas within each ZIP code.

TABLE 13. HEALTH PRIORITY AREAS IN THE SOUTHERN REGION

COUNTY	ZIP CODE	HEALTH PRIORITY AREA
Erath	76401	<ul style="list-style-type: none"> Healthcare Access & Navigation Mental Health
	76402	
	76446	
Henderson	75143	
Johnson	76031	
	76033	
	76059	
	76093	
Kaufman	75147	
	75160	
	75161	

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. The Texas Health partners with several community-based organizations (CBOs) across the region. The Texas Health Community Impact Leadership Councils are comprised of key leaders from these CBOs, who have an understanding of the community needs and are valued and trusted by residents, leaders, faith communities, and organizations. With their input, we can better understand each region's health needs to design and implement upstream solutions. The priorities are presented below.

Healthcare Access and Quality

Healthcare access is the connection between people's access to care, understanding of healthcare services, and their own health²². Access to healthcare services was identified as a top concern in the Southern Region counties through KIIs and focus groups. One of the most common problems in gaining access to healthcare services was lack of or limited insurance. Other barriers identified in the primary data collection are listed below.

- Due to the pandemic, delay in care
- Lack of resources to help with cost of medications
- Lack of communication between healthcare and community leadership
- Lack of transportation (bus passes, patient navigation program)
- Need for psychiatric services for those without insurance
- Lack of clinics in rural areas
- More education/training in the community: CPR, mental health, COVID-19 vaccines

22. Centers for Disease Control and Prevention (2022). Social Determinants of Health. [cdc.gov/socialdeterminants/about.html](https://www.cdc.gov/socialdeterminants/about.html)

Mental Health

Mental Health and Mental Health Disorders are terms used for a spectrum of health conditions which are each distinct yet often co-occurring and overlapping. Mental Health and Mental Disorders were identified as a top health concern impacting Southern Region communities by key informants and focus group participants. Mental health was discussed throughout a variety of health issues. Some challenges/barriers are listed below.

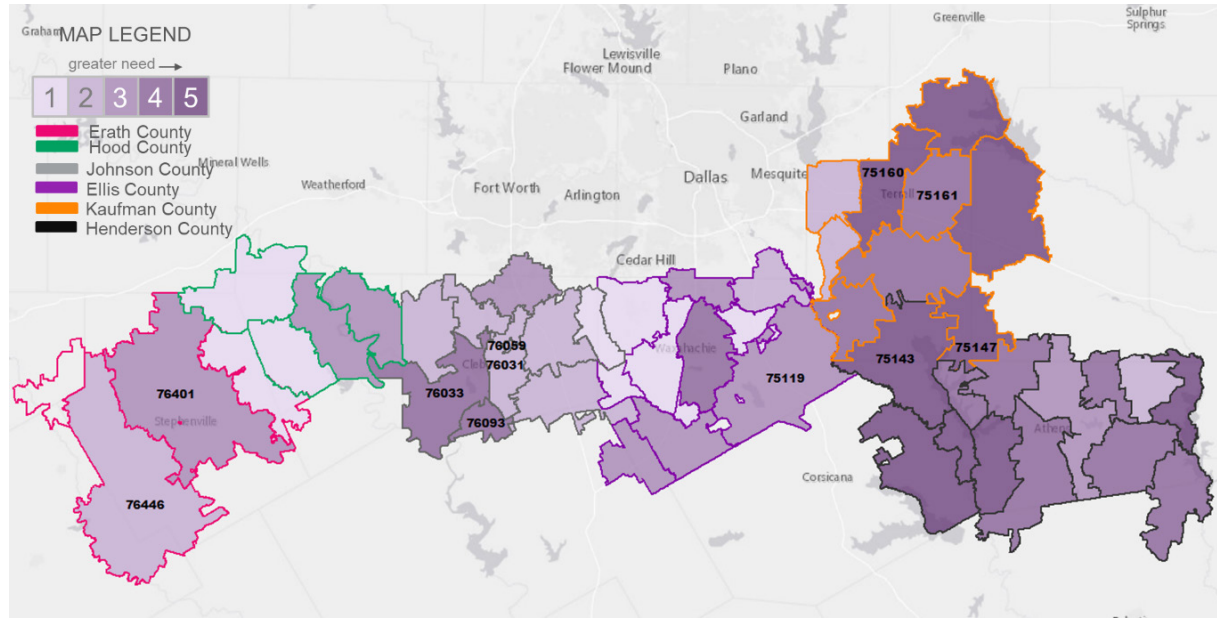
Barriers

- Isolation led to severe depression and anxiety (past childhood experiences exacerbate PTSD anxiety)
- Isolation led to an increase in substance abuse and addiction
- Increased amount of duress due to social isolation (increase in teen suicide, youth anxiety, depression, older adults dealing with isolation)
- Aging related issues like isolation, dementia, unintentional injuries/falls, balance has become worse
- Need for a mental health virtual assessment before being sent to hospital

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 barriers²³. Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. 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

FIGURE 25: SOUTHERN REGION: MENTAL HEALTH INDEX



hospitalizations and premature death. 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. The highest need ZIP codes in this region are located mostly in Henderson and Kaufman counties. The Mental Health Index (Figure 25) can be used in addition to the KIs and focus group data shown below to help direct mental health resources within the region.

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

TABLE 14: SOUTHERN PRIORITIZED ZIP CODES: MENTAL HEALTH INDEX VALUES

COUNTY	ZIP CODE	MHI VALUE
Ellis	75119	29.8
Erath	76401	33.2
	76402	N/A
	76446	15.7
Henderson	75143	77.5
Johnson	76031	19.0
	76033	51.5
	76059	15.5
	76093	46.3
Kaufman	75147	68.0
	75160	86.2
	75161	62.0

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. KIIIs 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 Southern Region as well as potential for future impact.



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

- Resources to help with cost of medication
- Better/more open communication between healthcare and community leaders
- Addressing transportation needs (bus passes, patient navigation program)
- Opening clinics in rural areas
- Mental health virtual assessments (clients get sent to the hospital, Texas Health Huguley Hospital, and they end up doing the virtual meeting anyways with the psychiatrist so it would help if you had access to that first instead of having to send clients to the hospital)

Community Education

- Education/training in the community: CPR, mental health education, COVID-19 vaccine

Provider capacity

- Availability of psychiatric services for those without insurance
- Local SANE nurse: minimize waiting time for nurse to travel from Fort Worth to Stephenville to do SANE exam
- Funding for staffing counseling positions, assisting with community outreach support to increase awareness (i.e., what is consent, what is sexual assault, demographics it effects, better understanding of victim behavior, why people don't report, why cases aren't prosecuted when they should be)
- Train staff to identify abuse in the hospitals through screenings
- Provide trauma-informed care: to identify how the client got to where they are rather than focusing on the current situation/problem
- More mental health providers and dentists

Disparities and Barriers

Significant community health disparities are assessed in both the primary and secondary data collection processes. Potential disparities in the Southern Region include people below the poverty level, people age 25+ with a bachelor's degree or higher, and mean travel times to work. The percentage of people living below poverty level in Erath and Henderson counties is higher than other counties within the region and the Texas state value. However, poverty rates vary by race or ethnicity for all counties within the Southern Region. 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:

- Difficulties navigating the health system "health literacy"
- Challenges with transportation
- Affordable housing, loss of employment led to loss of income, which led to inability to keep up with rent/mortgage
- Financial barriers: lack of or limited health insurance, costs associated with treatment "out of pocket expenses," loss of insurance due to loss of employment from pandemic, providers not accepting Medicaid, people that don't qualify for Medicaid in the coverage gap (making enough money that they don't qualify but can't afford insurance)
- Technology, internet barriers, not having access to the internet and/or technology (computers, laptops)
- Language barriers & cultural barriers leading to mistrust of the health system

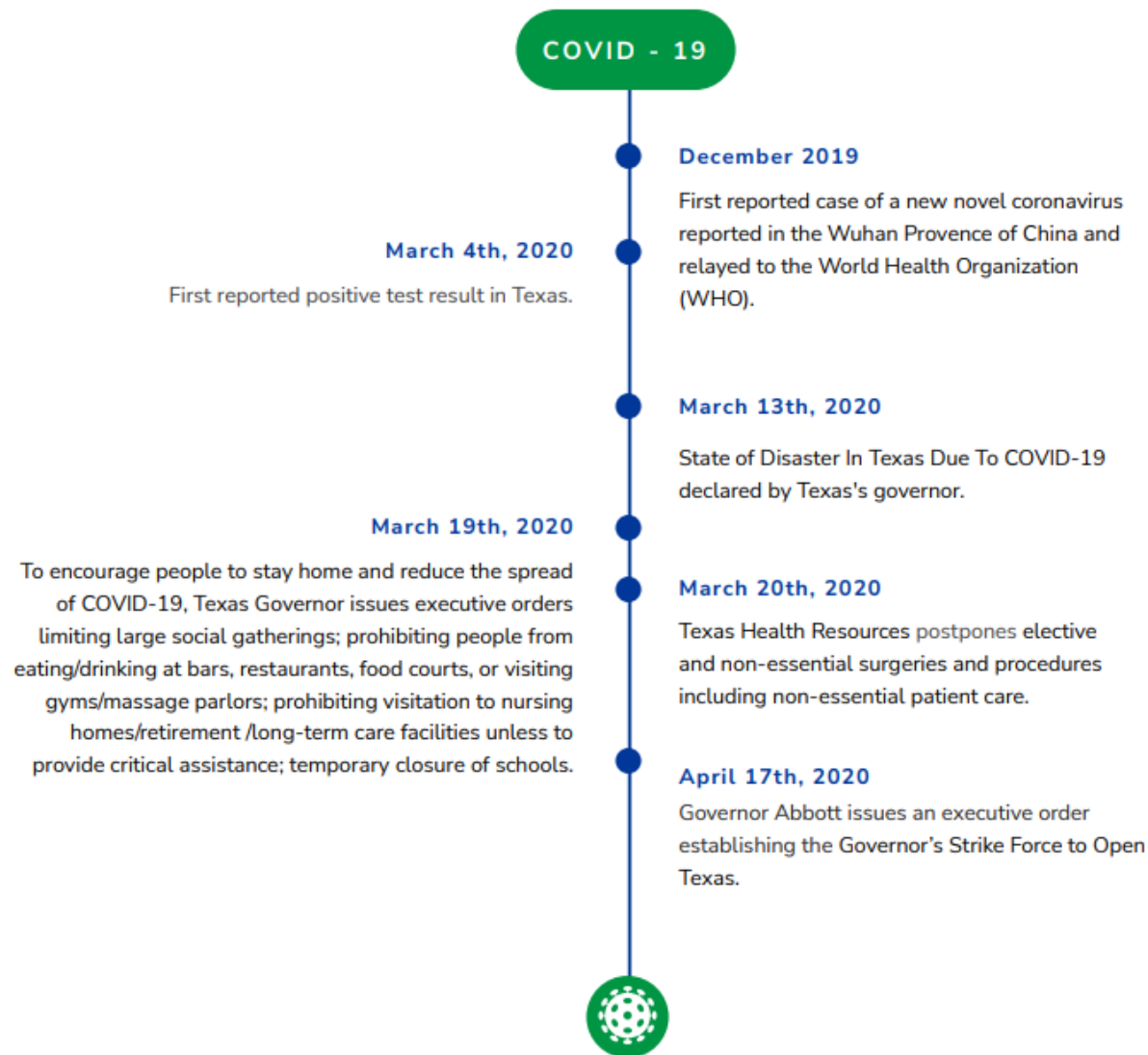
- Health system capacity problems: staffing shortages, limited services available, provider shortages, limited availability of clinic hours, months-long waiting lists
- Childcare, unaffordable daycare for families leading to inability to work
- Built environment: food insecurity/food deserts & lack of access to healthy foods
- Discrimination and systemic racism have led to the current health inequities communities are experiencing

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 the 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](#)²⁴ 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

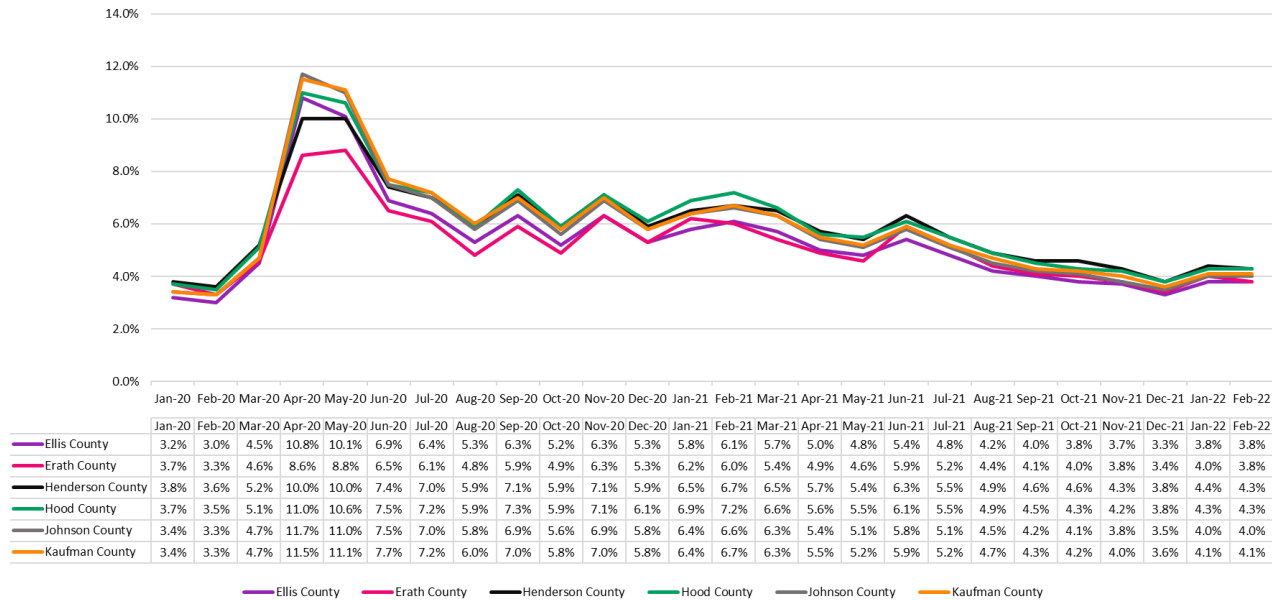
The CHNA project team looked for additional sources of secondary data and gathered primary data to provide a snapshot of the impact of COVID-19 on the Texas Health service area. These data were collected from October 2021 to May 2022. Findings are reported below.

Unemployment Rates

For the Southern Region, unemployment rates rose between March and April 2020 when stay-at-home orders were first announced. As illustrated in Figure 27 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 healthcare access if jobs that are lost include employer-sponsored healthcare.

24. Texas Department of State Health Services. (2022). Texas COVID-19 Data. <https://dshs.texas.gov/coronavirus/AdditionalData.aspx>

FIGURE 27: UNEMPLOYED WORKERS IN CIVILIAN LABOR FORCE, JAN 2020 – FEB 2022



COVID-19 Cases and Deaths in Texas

For current cases and deaths due to COVID-19 visit: <https://dshs.texas.gov/coronavirus/AdditionalData.aspx>

Southern Region Community Feedback

Both KIIs and focus group sessions included questions to capture insights and perspectives on the health needs of the Southern 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 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

- **Mental Health/Substance Abuse**
 - » Isolation led to depression and anxiety (past childhood experiences exacerbate PTSD anxiety)
 - » Isolation led to an increase in substance abuse and addiction
 - » Increased amount of duress due to social isolation (increase in teen suicide, youth anxiety, depression, older adults dealing with isolation)
 - » Aging related issues like isolation, dementia, unintentional injuries/falls, balance has become worse
- **Delay in Care/Access to Healthcare**
 - » Health system capacity problems: hospitals full of COVID-19 patients so other emergencies and services were delayed

- » Delay in care led to exacerbation of chronic conditions
- » Delay in accessing preventative healthcare
- **Violence/Abuse**
 - » Abuse/neglect: domestic violence, child abuse, intimate partner violence all worsened in severity
 - » More need for protective orders, lethality increased, and cases presented more severely at the hospital
 - » COVID-19 exacerbated the trauma children were facing because of abuse
 - » Domestic violence & child abuse is of greater concern due to COVID/social environment at home

COVID-19 Socioeconomic Challenges

- Childcare: unaffordable daycare for families leads to inability to work (parents choosing between childcare or work)
- Food insecurity/food accessibility: food deserts, rising cost of food
- Financial/economic impacts:
 - » Unemployment led to loss of health insurance/ loss of income
- Housing:
 - » Limited affordable options which COVID-19 exacerbated (i.e. Cannot afford rent/mortgage evictions)

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 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>
 - » Earth County Environmental Health Department: <https://co.erath.tx.us/199/Environmental-Health>
 - » Ellis County Texas: <https://www.co.ellis.tx.us/766/COVID-19>
 - » Henderson County: <https://www.henderson-county.com/>
 - » Kaufman County: <https://www.kaufmancounty.net/county-government/covid-19-information/>
 - » Johnson County: <http://www.cleburne.net/1250/Coronavirus-COVID-19>

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 9 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 Southern Leadership Council 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 Southern Region utilized a comprehensive set of secondary data indicators to measure the health and quality of life needs for the Southern 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 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

