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Community Health Needs Assessment

FINAL

Approved by:
Mission and Community Benefits Committee
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Approved by:
Baylor Health Care System Operation, Policy
and Procedure Board
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Executive Summary

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

About the Hospital

Baylor Orthopedic and Spine Hospital at Arlington (BOSHA) specializes in providing comprehensive outpatient and inpatient treatment of orthopedic and spine disorders. For everything from simple back or neck strains to the most complex spine surgeries, we combine exceptional care with personal attention and compassion. The only orthopedic surgery and specialty hospital of its kind in the Dallas and Fort Worth Metroplex, BOSHA brings experts close to home.

Our 24-hour emergency department is always ready to handle sudden pain or injuries, while six technologically advanced operating rooms help our physicians deliver the highest level of surgical care. Extensive diagnostic imaging includes CT (computed tomography), MRI (magnetic resonance imaging), X-ray, arthograms, and myelograms. We offer minimally-invasive treatments for hips, knees, shoulders and spine or, if indicated by the diagnosis, full joint replacements and complex spinal surgery.

About Baylor Health Care System

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

CHNA Summary

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

The FY 2013 CHNA brings together information from a variety of sources. This assessment uses information from the recent community health needs assessments conducted for the Texas’ Regional Healthcare Partnership Region 10 (Region 10 RHP). This report was developed with input from people representing the broad interest of the community and people with special knowledge or expertise in public health.
The identified community health needs as outlined below were reviewed and prioritized with input from BOSHA management and BHCS Senior Leadership. In prioritizing the needs of the community BHCS adopted the methodology established in the collaborated CHNA used for this assessment. The identified needs are assigned a High, Medium or Low priority as a reflection of the priority given in the collaborated CHNA.

The importance and benefit of compiling information from other recognized assessments are as follows:
1. Increases knowledge regarding community health needs and resources.
2. Creates a common understanding of the community's priorities as it relates to health needs.
3. Enhances relationships and mutual understanding between and among stakeholders.
4. Provides a basis upon which community stakeholders can make decisions about how they can contribute to improving the health of the community.
5. Provides rationale for current and future financers to support efforts to improve the health of the community.
6. Creates opportunities for collaboration in the delivery of services to the community.
7. Provides the hospital with guidance as to how it can align its services and community benefit programs to best meet needs.

**Community Health Needs**
Analysis of the Region 10 RHP report revealed the following community health needs in the BOSHA community.

**High Priority**
- Access to Care for Low Income Population
- Primary care
- Specialty Care, particularly for patients lacking coverage
- Behavioral and mental health services
- Dental Care

**Medium Priority**
- Care Coordination and Care Transitions
- Emergency and Urgent Care Services

**Low Priority**
- Multiple Chronic Conditions
- Pediatric Services and Prenatal Care
**High Priority**

- Access to Care for Low Income Population
  - The community suffers a lack of preventive health care, quality medical care and supportive post-acute care services that promote the health of its residents. Community health and patient-centered medical home locations may not promote convenient access. Enrollment in health insurance programs is inconsistent across the demographic.

- Primary care
  - Tarrant County has been identified as a Health Professional Shortage Area for Primary Care. The CHNA found insufficient primary care providers and extended wait times.
  - Providers overwhelmingly list “lack of coverage/financial hardship” as a major barrier for low-income patients. “Lack of affordable care” also was cited.
  - In the outlying counties, affordable primary care physicians—particularly for the uninsured—was identified as an ongoing health need and barrier to care.
    - Hood County has a growing Hispanic/Latino population, resulting in language barriers between patients and providers.
    - Parker County residents report extended wait times for primary care appointments.
  - In addition to the current shortage, the Region 10 RHP project regional physician demand will increase by 30 percent over the next five years.

- Specialty Care, particularly for patients lacking coverage
  - Region 10 Stakeholder Survey respondents agreed that routine specialty care treatment is “difficult” to access. Barriers cited include:
    - Lack of coverage/financial hardship (most frequently cited barrier)
    - Difficulty navigating system/lack of awareness of available resources
    - Lack of provider capacity
  - Demand for specialty care in the region is high and projected to continue to grow.
  - According to Thomson Reuters data, the most frequently sought inpatient services for Region 10 in 2011 included the specialty areas of cardiology, pulmonology, general surgery and orthopedics.
  - The Region is projected to experience a 22 percent to 36 percent growth in provider demand across all specialties. The specialties with the greatest expected growth include vascular health, urology, hematology/oncology, cardiology and nephrology.
  - The CHNA found that a higher percentage of low income residents are at risk for several chronic conditions. As a result, these consumers have a high demand for specialty medical treatment, but options are often limited.
  - The CHNA identified geographic barriers to specialty care. Specifically:
    - The vast geographic expanse of Region 10 and the high level of provider concentration within Tarrant County combine to create serious specialty and primary care access barriers for many individuals in the Region’s rural counties.
In the BHCS consumer survey of TSA residents, 45 percent identified JPS, the county hospital, as a facility providing service for those who are unable to pay.

Consumers living outside Tarrant County and undocumented residents have limited access to JPS services.

- Behavioral and mental health services
  - Behavioral and mental health services were identified as needs throughout the hospital’s service area.
  - Community stakeholders identified insufficient integration of mental health care into the primary care medical care system.
  - Behavioral health access was identified as difficult for low income residents. Tarrant, Hood and Parker counties are recognized as Health Professional Shortage Areas for mental health providers.
  - Tarrant County mental/behavioral health and substance abuse services were considered “very difficult” to access.
  - Hood County does not have a psychiatrist in the county. Instead, residents use telemedicine psychiatrists. A need for a psychiatric nurse as a supplement was identified. Care coordination between primary care and psychiatry is fragmented in Hood County.
  - Johnson County—which has one psychiatrist in the county—is not considered a mental Health Professional Shortage Area. The county’s Community Mental Health Center is highly utilized, currently serving more than 600 patients. However, a need for additional mental health professionals was identified in the CHNA, as were concerns associated with limited access to Mental Health Mental Retardation (MHMR) services.

- Dental Care
  - The Region 10 needs assessment identified Tarrant County as a dental Health Professional Shortage Area. Hood, Johnson and Parker counties are not considered dental Health Professional Shortage Areas.
  - A wide range of providers offer free or low cost dental services to community residents:
    - JPS operates six neighborhood dental clinics for legal Tarrant County residents who qualify based on low socioeconomic status (250 percent of federal poverty level).
    - Catholic Charities offers free or reduced cost dental services for all residents of the 28-county Diocese. Services are rendered through a new dental clinic in Tarrant County as well as arrangements with local dentists in outlying counties.
    - Beautiful Feet Ministries has a two chair dental clinic for the homeless in Tarrant County.
    - Mission Arlington Allen Saxe Dental clinic offers free services to residents in select zip codes.
    - AIDS Outreach Center provides two dentists and one dental hygienist for people living with HIV/AIDS and those of low socioeconomic status.
    - Tarrant County College Dental Hygiene Program offers free teeth cleaning services using student dental hygienists.
- Many area dentists accept Medicaid reimbursement for dental care.

**Medium Priority**

- Care Coordination and Care Transitions
  - Medical claims statistics show that the top 5 percent of patient volume results in 60 percent of reimbursed or paid health care costs while 80 percent of patients only comprise 14 percent of reimbursed or paid health care costs. The top 5 percent must be managed more efficiently and effectively to reduce the overall cost of health care.
  - The need for enhanced care coordination was a resounding theme of the CHNA. Care coordination is considered a solution to many of the health problems and access barriers identified. However, achieving effective coordination requires expanded resources, including manpower, knowledge and electronic health information exchange. Specific CHNA findings to consider:
    - Better overall coordination and service integration across the Region’s providers was identified as the most serious community health need. It was identified as a need in all service area counties.
    - In the Region 10 Stakeholder Survey, participants reported that the Region’s primary care providers, hospitals and specialists were not coordinating care effectively.
    - The survey identified barriers to care coordination, including: complexity of coordination, lack of staff, lack of financial integration, fragmented service systems and practice norms that allow providers to work in silos.
    - Inadequate health IT infrastructure and limited interoperability to support information sharing between providers also hinders care coordination.
- Emergency and Urgent Care Services
  - Too frequently, high cost emergency department (ED) visits are used as a substitute for lower cost, but less accessible, primary care. The only exception may be Parker County where emergency care is reportedly difficult to access.
  - In the Region 10 Stakeholder Survey, emergency services were identified as the most easily accessible health care service. The following statements are indicative:
    
    “Put simply, uninsured patients tend to use hospital emergency departments and urgent care centers as a last resort, rather than managing their health through more cost-effective primary care clinics and physician offices.”
    
    “Demand for ED visits is on the rise and EDs are becoming overcrowded due to reduced inpatient capacity and impaired patient flow. As a Region, there were 1.1 million visits to hospital EDs in 2010, with a rate of 447.5 visits per 1,000 persons. The 2007 national ED visit rate was 390.5 per 1,000 persons, increasing 23 percent since 1997, but lower than the ED visit rate of Region 10.”

**Low Priority**
Multiple Chronic Conditions
  o Similar to national trends, total service area (TSA) residents exhibit increasing diagnoses of chronic conditions. It is common that the pathology for one condition may also affect other body systems, resulting in co-occurrence or multiple chronic conditions (MCC). The presence of MCCs adds a layer of complexity to disease management.
  o The CHNA identified Region 10’s more prevalent conditions including:
    ▪ Diabetes
    ▪ Obesity
    ▪ Hypertension
    ▪ Heart failure
    ▪ Chronic obstructive pulmonary disease (COPD)
  o Conditions contributing to most preventable hospitalizations in Region 10 are related to these conditions and include:
    ▪ Hypertension
    ▪ Uncontrolled diabetes
    ▪ COPD
    ▪ Congestive heart failure
    ▪ Diabetes short-term complications
  o Needs were identified for more education, resources and promotion of healthy lifestyles, including free and safe places to exercise, health screenings, health education, healthy environments, etc…
  o RHP 10 survey respondents reported that residents were most likely to get their health education and information from friends, family, the Internet and their physician.

Pediatric Services and Prenatal Care
  o Live births in the TSA ranged from 585 in Hood County and 1,390 in Parker County to 29,400 in Tarrant County.
  o Adolescent mothers, who are at high risk for poor health outcomes for themselves and their baby, account for 4.9 percent of all Texas births, but a much lower percentage in TSA counties. The teen birth rate ranged from 3.1 percent in Hood County to 4.3 percent in Tarrant County and 4.5 percent in Johnson County.
  o The Texas average for low birth weight infants was 8.4 percent of live births. All TSA counties were below this level, ranging from 6.2 percent in Hood County to 8.3 percent in Tarrant County.
  o In Texas, 60.1 percent of mothers accessed prenatal care in their first trimester, which was lower than the national rate of 71 percent. Tarrant and Parker counties were lower than the state average at 53.5 percent and 59.4 percent, respectively.
Key Contributors

Regional Healthcare Partnership Region 10

- Baylor Health Care System
- Cook Children's Health Care System
- Ennis Regional Medical Center
- Glen Rose Medical Center
- HCA North Texas
- Helen Farabee Centers
- JPS Health Network
- Lake Granbury Medical Center
- Lakes Regional MHMR
- Methodist Health System
- MHMR Tarrant County
- Navarro Regional Hospital
- North Texas Area Community Health Centers
- North Texas Behavioral Authority
- Parker County Hospital District
- Pecan Valley Centers for Behavioral and Developmental HealthCare
- Tarrant County Public Health
- Texas Health Resources
- UNT Health Sciences Center
- Weatherford Regional Medical
- Wise Regional Health System
Assessment Methodology

To complete this CHNA, BHCS staff participated in the development of several CHNAs with other health care providers throughout the Dallas/Fort Worth Metroplex. These efforts include the Region 10 RHP report. The methodology for this report is detailed below (see the appendix for the complete assessments). Once the assessments were completed, the identified community health needs were reviewed and prioritized with input from BOSHA management and BHCS Senior Leadership. In prioritizing the needs of the community BHCS adopted the methodology established in the collaborated CHNA used for this assessment. The identified needs are assigned a High, Medium or Low priority as a reflection of the priority given in the collaborated CHNA.

Regional Healthcare Partnership Region 10

Region 10 RHP consists of health care providers spread across a nine county area of North Central Texas. It encompasses Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, Tarrant, and Wise counties. Key partners in the region include Baylor Health Care System, Cook Children’s, Ennis Regional, Glen Rose Medical Center, HCA North Texas, JPS Health Network, Lake Granbury Medical Center, Lakes Regional MHMR, MHMR Tarrant County, Navarro Regional Hospital, Parker County Hospital District, Tarrant County Public Health, Texas Health Resources, UNT Health Sciences Center and Wise Regional. This CHNA was conducted by COPE Health Solutions on behalf of the Region 10 RHP. It presents a summary that highlights the data findings, key health needs and opportunities for action. As part of this assessment, an analysis and review of both qualitative and quantitative data was conducted.

Primary data was collected through stakeholder surveys and provider readiness assessments conducted by the RHP. Additionally, a review of existing community health needs assessments conducted in the region was also reviewed and incorporated as appropriate. Secondary data was collected from a variety of national and state sources to create a community profile encompassing birth and death characteristics, access to health care, chronic diseases, social issues, and school and student characteristics. When pertinent, these data sets are presented by county, region, state and national, framing the scope of an issue as it relates to individual counties and the region. Analyses were conducted at the county level to the extent possible.

Data Sources

**American Factfinder** (www.factfinder2.census.gov)

**Centers for Disease Control – Behavioral Risk Factor Surveillance System** (http://apps.nccd.cdc.gov/brfss-smart/SelMMSAPrevData.asp)

**Centers for Disease Control – Office of Minority Health & Health Disparities** (www.cdc.gov/omhd/populations/definitionsREMP.htm)

**Center for Health Statistics** (www.dshs.state.tx.us/chs/datalist.shtml)

**County Health Rankings** (www.countyhealthrankings.org)

**Health.Data.Gov** (www.data.gov/health)

**Health Indicators Warehouse** (www.healthindicators.gov)

**Health Professional Shortage Areas** (http://hpsafind.hrsa.gov/)

**Health Resources County Comparison Tool** (http://arf.hrsa.gov/arfwebtool/index.htm)

**Health Resources Services Administration** (http://bhpr.hrsa.gov/shortage/hpsas/index.html)

**Kaiser Family Foundation** (www.kff.org)

**Medically Underserved Areas** (http://muafind.hrsa.gov/index.aspx)

**State Health Facts** (www.statehealthfacts.org)
Texas Department of State Health Services (www.dshs.state.tx.us/chs/healthcurrents/)
Texas Department of State Health Services (www.dshs.state.tx.us/diabetes/tdcdata.shtm)
Thompson Reuters, 2011
United States Census Bureau
(www.census.gov/population/www/projections/projectionsagesex.html)
United States Census Bureau – (http://quickfacts.census.gov/qfd/states/48000.html)
United States Department of Health & Human Services – Community Health Status Indicators (http://www.communityhealth.hhs.gov/homepage.aspx?j=1)
BHCS and its affiliated hospitals serve a 12 county area known as the Dallas/Fort Worth Metroplex. BHCS divides its service areas into three regions: the Eastern Region, the Central Region and the Western Region. BHCS’ health care services are provided through a network of more than 300 access points, including 30 owned/operated/ventured/affiliated hospitals, joint ventured ambulatory surgical centers, satellite outpatient locations, senior centers and more than 180 HealthTexas Provider Network physician clinics. BHCS uses the health care industry’s standard “80 percent” rule to define each hospital service areas.

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

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

- Outlier zip codes were removed.
- Missing zip codes adjacent to the facility were included.
- Zip codes needed to complete the contiguous service area were included.
BOSHA serves the West Region of the System. Its TSA includes zip codes from Arlington, Ft Worth, Grand Prairie and Mansfield. The service area comprises:

- An urban/suburban geographic area
- Service area population: 738,608
- Service area ethnicity: White Non Hispanic = 44.8 percent; Black Non Hispanic = 17.4 percent; Hispanic = 29.6 percent; Asian and Pacific Islanders Non-Hispanic = 5.8 percent; all others = 2.3 percent
- Service area payer mix: managed Care = 38.4 percent; Medicaid = 14.8 percent; Medicare = 35.1 percent; self pay/charity = 11.0 percent; other = 0.6 percent
- Service area household average income: $68,311
- Service area living below the Federal Poverty Level (FPL): 10.0 percent (compared to 10.5 percent living below the FPL in the Dallas/Fort Worth Metroplex, and 10.2 percent living below the FPL in the United States)
- Number of other hospitals serving the community: 10 hospitals other than BOSHA
- Medically underserved: Tarrant County is partially medically underserved. The areas designated as underserved by the Texas Department of State Health Services comprise the Diamond Hill area census tracts, the East Side low income census tracts and the Central Tarrant low income census tracts
- Service area education: less than high school = 7.6 percent; some high school = 9.0 percent; high school diploma = 26.3 percent; some college/associates degree = 31.4 percent; bachelor’s degree or greater = 25.7 percent
- Service area male population: 371,270; service area female population: 367,338
- Service area age: 0-14 = 24.7 percent; 15-17 = 4.4 percent; 18-24 = 9.3 percent; 25-34 = 15.9 percent; 35-54 = 29.0 percent; 55-64 = 9.1 percent; 65+ = 7.6 percent

**BOSHA Hospital at Fort Worth Service Area Providers**

**Hospitals**
- Baylor Orthopedic And Spine Hospital At Arlington
- Healthsouth Rehabilitation Hospital Of Arlington
- Kindred Hospital-Mansfield
- Kindred Hospital-Tarrant County
- Kindred Rehabilitation Hospital Arlington
- Methodist Mansfield Medical Center
- Texas General Hospital
- Texas Health Arlington Memorial Hospital
- Texas Health Heart & Vascular Hospital Arlington
- USMD Hospital At Arlington
- Medical Center-Arlington

**Ambulatory Surgery Centers**
- Arlington Day Surgery Center
- Baylor Surgicare At Arlington
- Baylor Surgicare At Mansfield
- Central Park Surgery Center
Children 1st Grand Prairie LLC
Doctors Surgery Center At Huguley
JPS Surgical Center-Arlington
Medical Village Surgery Center Inc
North Carrier Surgicenter
North Texas GI Center
Same Day Surgicare
Southwest Endoscopy & Surgery Center Ltd
Trinity Park Surgery Center

Freestanding ER

Psychiatric Facilities
Millwood Hospital
Sundance Hospital
Community Health Needs Assessment

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

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

BHCS Community Benefit Committee

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

The mission and role of the BHCS Community Benefit Committee is to assist the Board of Trustees in setting direction, identifying priorities, and monitoring performance in mission and vision integration into community benefits across BHCS. The Committee is comprised of trustees (current System and community board members) and other community representatives appointed by the BHCS board of trustees. The Committee will meet twice annually, or upon the request of the Committee chair. The current chair is Dr. Jim Denison.
Regional Healthcare Partnership Region 10 (Executive Summary)

Health Care Coverage Snapshot
Region 10’s 2010 uninsured rate of 18 percent is closer to the national uninsured rate of 15.5 percent than Texas’ statewide rate of 23.7 percent. More Region 10 residents have private insurance as compared to the rest of Texas (51.2 percent) or the nation (54 percent). The Region’s public insurance coverage rates are: 11 percent for Medicaid, 8.9 percent for Medicare and 1.4 percent for the dually enrolled. The highest rates of uninsured residents are in Erath County and Navarro County (30.2 percent and 28.0 percent, respectively) commensurate with these counties’ higher rates of poverty and lower median household incomes as compared to the rest of Region 10.

The proportion of Region 10 residents who remain uninsured in 2016 is projected to drop to 11.3 percent. Of those who will be newly insured, an estimated 58.1 percent will be covered by direct or employer-sponsored private insurance, while an estimated additional 15.7 percent of Region 10 residents will receive coverage through Medicaid and 10.2 percent through Medicare. The accuracy of these projections, however, depends highly on various federal policies, state policies and market factors, including availability and affordability of insurance products offered in the local market, impact of any potential state or federal health insurance exchange, and whether or not the state moves forward with a Medicaid expansion.

Health Care Infrastructure Snapshot
Region 10’s health care infrastructure consists of 46 acute care hospitals (the majority of which are privately owned), two psychiatric hospitals and 3,726 physicians. The Region has a total of 6,491 licensed beds for acute care and 170 licensed beds for psychiatric care. The Region’s provider options also include four MHMRs and one FQHC.

Providers are mostly concentrated within Tarrant County, particularly in Fort Worth, Region 10’s major urban center. The vast geographic expanse of Region 10 and the high level of provider concentration within Tarrant County combine to create serious specialty and primary care access barriers for many individuals in the Region’s rural counties.

The most frequent inpatient services sought for Region 10 in 2011 were obstetrics, internal medicine, cardiology, pulmonology, general surgery and orthopedics, according to Thomson Reuters. The Region’s top outpatient services were laboratory services, internal medicine, physical therapy, diagnostic radiation, psychiatry and pulmonology.

Overall, physician demand in Region 10 is projected to increase by 30 percent over the five-year waiver period. Demand for various specialties and types of providers is projected to increase anywhere from 22 percent to 36 percent, according to Thomson Reuters. The greatest demand increases are expected in obstetrics/gynecology, vascular medicine, cardiology, oncology/hematology and nephrology.

Five of Region 10’s counties – including Tarrant County, the Region’s most populous county – are at least partially designated by the U.S. Health and Human Services Agency as Medically Underserved Areas (MUAs). Ellis, Erath, Johnson and Navarro are the Region’s other MUA counties.
Four of Region 10’s nine counties are also designated as partial primary care Health Professional Shortage Areas (HPSAs). Additionally, Tarrant, Wise and Ellis Counties are federal dental HPSAs. Perhaps most alarming, all but one of Region 10’s counties are federally designated mental HPSAs (only Johnson County is not a mental HPSA). These findings correlate with the stakeholder surveys and provider readiness assessments Region 10 conducted as part of RHP plan development.

**Stakeholder Surveys**
Region 10 RHP also conducted a stakeholder survey. The stakeholder survey collected qualitative data and feedback on the following:
1. Access to care,
2. Care coordination and
3. Community health.

The Region collected surveys over a period of one month via a web-based survey tool, yielding a total of 191 stakeholder responses.

**Access to Care**
Most survey respondents agreed that routine hospital services, routine primary/preventive care and routine specialty care were “difficult” to access. Mental/behavioral health care services were identified as the most difficult for low-income patients to access, while emergency services were consistently noted as the least difficult to access. The same access barriers were identified for all types of care:
- Lack of coverage/financial hardship (consistently the most frequently cited barrier)
- Difficulty navigating system/lack of awareness of available resources
- Lack of provider capacity

**Care Coordination**
The top barriers to effective care coordination (between providers and systems) cited by survey respondents were the complexity of coordination, lack of staff, lack of financial integration, fragmented service systems and practice norms that allow providers to work in silos. Most respondents said they did not believe that low-income patients could:
- choose and establish a relationship with a primary care provider;
- access private primary care providers;
- access community health centers, free clinics or public clinics; and
- access behavioral/mental health providers.

**Community Health**
Region 10’s most prevalent chronic conditions as reported by survey respondents are diabetes, obesity, hypertension, heart failure and chronic obstructive pulmonary disease (COPD). Survey respondents also reported that the conditions contributing most to preventable hospitalizations in Region 10 are (in decreasing order of importance) hypertension, uncontrolled diabetes, COPD, congestive heart failure and diabetes short-term complications.
Respondents reported that behavioral health, substance abuse and insufficient access to care were the top issues to target for population health improvement. Respondents reported that Region 10 residents were most likely to get their health education and health information from friends and family, the Internet and their doctor.

**Key Survey Takeaways**
Respondents overwhelmingly listed a lack of coverage and/or financial hardship as the most significant barrier to care for low-income patients. Survey respondent write-in comments also cited an overuse of emergency department services and patient inability to access primary and preventive care (due to difficulty navigating the system and a lack of capacity). Most respondents also indicated that the Region’s primary care providers, hospitals and specialists were not coordinating care effectively.

**Key Health Challenges**

**Region 10 RHP Pregnancy and Birth-Related Statistics**
Teen pregnancy increases the risk of poor health outcomes for both young mothers and their children. Pregnancy and delivery negatively impact a teenager’s health both directly and indirectly and often result in long-term negative consequences, including increased risk of poverty and low socioeconomic status. Babies born to teen mothers are more likely to be born preterm and/or low birth weight; much of this increased risk is attributable to delayed onset of prenatal care. For this reason, *Healthy People 2020* stresses the importance of responsible sexual behavior to reduce unintended pregnancies and the number of births to adolescent females. Region 10 fares slightly better than the state overall in regards to its teen pregnancy rate (4.3 percent versus 4.9 percent) and incidence of low birth weight babies (7.2 percent versus 8.4 percent). However, Region 10 has a slightly lower rate of early (first trimester) prenatal care than the state overall (58.1 percent versus 60.1 percent). Navarro and Somervell Counties have Region 10’s highest teen pregnancy rates (6.2 percent and 5.4 percent compared with the Region average of 4.3 percent). Navarro and Tarrant Counties have the Region’s highest percentages of low birth weight babies and its lowest rates of early prenatal care.

**Morbidity and Mortality**
Cancer and obesity are Region 10’s most common morbidity factors. Hood and Navarro Counties have the Region’s highest cancer rates. Obesity rates are statistically the same across all nine counties in Region 10 at around 26 to 29 persons per 100,000. Johnson County has the Region’s highest rate of diabetes at 10.0 per 100,000. Tarrant County has the Region’s highest HIV rate, though small sample sizes reduce the precision of county-level HIV statistics across the Region.

Cardiovascular disease is the number one killer in Region 10 (4,931 deaths in 2011). Cancer is Region 10’s second most frequent cause of death (3,668 deaths in 2011). These two causes of death are also the two highest for Texas overall.

**Preventable Hospitalization**
Region 10’s preventable hospitalization rate of 931 per 100,000 persons is lower than both the state average of 5,923 per 100,000 and the national average of 1,433 per 100,000. Navarro County’s preventable hospitalization rate is the Region’s highest (17 per 1,000 persons).
followed by Johnson County (14 per 1,000 persons). Region 10’s most prevalent cause of preventable hospitalization is congestive heart failure (195 per 1,000 Medicare enrollees), closely followed by anginas without procedures (190 per 1,000 Medicare enrollees).

Access to Care
County Health Ranking surveys place difficulty in accessing care due to lack of insurance coverage as the top health care problem. Although county-level information is difficult to interpret with certainty because of variations in county response levels, it appears that Johnson and Ellis counties reported the greatest access problems throughout the Region (Figure 11).

Overall, Region 10 performs at or slightly better than the rest of the state in providing diabetes and mammography screenings. Within the Region, Wise County and Navarro County have the lowest screening levels for diabetes and mammography and are below both state and national average screening rates. Wise County’s diabetes screening rate is 76 percent, compared with the statewide and national rates of 84 percent and 80 percent, respectively. Navarro County has the Region’s lowest mammography screening rate at 55 percent, compared with statewide and national rates of 60 percent and 59 percent, respectively.

Communicable Diseases
In general, Region 10 has lower rates of communicable disease than the rest of the state, although prevalence rates for Region 10’s Somervell County are statistically questionable because of its small population size. Specifically, Region 10 has lower AIDS rates (3.4 per100,000), tuberculosis rates (2.3 per100,000), and whooping cough rates (10.3 per100,000) than the state. However, Region 10 has a much higher rate for chicken pox infections (26.3 percent) versus the overall rate in Texas of 17.9 percent. Tarrant County has the Region’s highest TB infection rate. Johnson, Navarro and Tarrant counties have the Region’s highest rates of AIDS (6.1, 7.9 and 6.1 per100,000 respectively). Hood County has the Region’s highest chicken pox and whooping cough infections.

Sexually Transmitted Diseases
Region 10 generally has lower reported sexually transmitted disease rates (STDs) than the state overall. For example, Region 10 has lower rates of syphilis (2.7 versus 4.9 per 100,000) and gonorrhea (99.0 versus 504.1 per 100,000) than the state overall. Conversely, though, Region 10 has a higher rate of chlamydia infections than the state overall (533.7 versus 467.3 per 100,000).

Ellis County had the Region’s highest infection rates for gonorrhea and chlamydia. Ellis and Tarrant counties had the Region’s highest syphilis infection rates (10 and 8.3 per100,000 respectively). However, these rates are still significantly lower than the national average. Ellis, Navarro and Tarrant counties have the Region’s highest gonorrhea infection rates (504.1, 141.4 and 139.0 per100,000 respectively). Ellis County also had a chlamydia infection rate roughly five times higher than the rest of the Region.

Health Outcomes
As previously noted, county-specific health outcomes are difficult to assess because of small sample sizes in a few counties (Somervell and Navarro). However, the County Health Rankings data set indicates that Region 10’s population self-reported having fewer poor or fair health days than the rest of the state (17 percent versus 19 percent). Johnson County has the Region’s highest
percentage of respondents reporting poor or fair health and the highest reported levels of poor mental health days. Hood County respondents have the Region’s highest reported number of poor physical health days.

Health Behaviors
The Region’s top identified health behaviors negatively impacting and influencing health outcomes are adult obesity (30 percent) and physical inactivity (28 percent). These behaviors are followed by smoking (19 percent) and excessive drinking (15 percent). Counties appeared to have fairly comparable levels for these behaviors. Johnson County had the Region’s highest rates for nearly all harmful health behaviors: adult smoking, adult obesity, physical inactivity and excessive drinking. Navarro, Parker and Wise counties also had slightly higher adult obesity rates than the state (See County Health Rankings).

Access to Healthy Foods
The Region fares slightly better than the state overall in terms of access to healthy foods in poor communities (10 percent versus 12 percent). Residents in Ellis and Johnson counties have the worst access to healthy foods in poor communities, but their rates are still significantly better than the statewide average. Overall, Region 10 has fast food restaurant access rates similar to the statewide average. Johnson County has the Region’s highest percentage of fast food restaurants at 60 percent.

Conclusions
While on average Region 10 fares as well as or slightly better than the rest of the state on many health need indicators, the poorest and most vulnerable residents of Region 10 live in communities struggling with very significant levels of unmet health care needs. Through DSRIP, Region 10 RHP is committed to a revitalized community-oriented regional health care delivery system. A system that is focused on the triple aims of improving the experience of care for all patients and their families, improving the health of the Region’s population, and reducing the cost of care without compromising quality with a particular focus on the community health needs of our most vulnerable residents.

Summary
While there are areas in which, as a region, health outcomes are mostly consistent with the state, there are also areas of significant unmet need throughout the region that can be addressed. The major areas of unmet need include (see Appendix B for detail):

- Behavioral and mental health services
- Primary care
- Specialty care, particularly for patients lacking of coverage
- Care coordination and care transitions
- Pediatric services and prenatal care
- Emergency and urgent care services
- Dental care
Appendix A

Region 10 RHP Community Needs Assessment


Section III. Community Health Needs Assessment

Region 10 RHP’s Community Health Needs Assessment (CHNA) offers Regional data and related county-specific health needs information to inform the selection of the delivery system reform projects that will effectively transform the health care experiences of our Region’s residents by addressing unmet needs and contributing to overall population health improvements. This section summarizes Region 10’s most pressing community health needs and the societal and market contexts in which they have developed. It also underscores the connections between the projects proposed by the participating providers listed in Section II and the Region’s most serious community health needs, which are: (1) access to primary and specialty care, particularly in underserved areas of the Region and for low-income residents; (2) access to behavioral health resources and integration of behavioral and physical health care services; (3) improved primary care management and self-management of chronic care conditions; and (4) better overall coordination and service integration across the Region’s providers.

Methodology

Region 10 RHP’s CHNA includes both qualitative and quantitative data. Our primary data collection activities included stakeholder surveys and provider readiness assessments. Additionally, the RHP plan team reviewed and incorporated relevant and appropriate prior existing sub-Regional community health needs assessments. We also collected secondary data from national and state sources to create a full community profile that includes birth and death characteristics, indicators of health care access, chronic disease prevalence rates, as well as demographic variables affecting Regional health such as insurance status, socioeconomic status and educational attainment level. Some data is presented in this section with comparisons to state and national data, framing the scope of an issue as it relates to individual counties and the Region. (Please see Appendix D for all supplemental materials related to this Community Health Needs Assessment.)

COMMUNITY PROFILE

Region 10 consists of nine contiguous counties in north central Texas. It is characterized by one urban center surrounded by a number of rural and suburban communities. This Region has a significant geographic footprint, spanning 7,221 square miles. Region 10’s nine counties are: Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, Tarrant and Wise. (See to Appendix D-1.1 for a map of Region 10. Additional count- specific information can also be found in Appendix D-4.)

Demographics: Population by Age Cohort

Region 10 had a population of 2,444,642 in 2011. The majority of Region 10 residents are working-age adults (62% ages 18-64). The remaining population is made up of seniors (11% of total Regional population) and children (28% of Regional total population). Region 10 is similar to the rest of Texas in terms of its 18-and-under proportion of total residents with the exception of Hood, Somervell and Navarro Counties. Hood County trends significantly older, with a larger proportion of seniors (20.1%), offset by a smaller adult population (57.8%) and child population (22.1%). Both Somervell and Navarro also have higher proportions of elderly residents than the
rest of the Region, but lower than that for Hood County. In Somervell, the senior population is 15.5% of the total population, with a smaller proportion of working-age adults (58.3%) and a child population similar to the Region (26.2%). Navarro’s proportion of elderly residents is similar to Somervell’s with seniors representing 14.0% of its population; working-age adults and children represent 59.1% and 26.9% of the county respectively. Tarrant and Ellis Counties have slightly higher proportions of children as a percentage of their total county population (28.4% and 29.4%, respectively) than the rest of the Region.

By 2016, the Region is projected to see its population grow by an estimated 9.4% to a Regional total of 2,674,022 people (60.7% adults ages 18-64; 27.8% children ages 0-18; and 11.5% seniors ages 65 and older). This projected growth is unevenly spread across the counties: Ellis and Parker counties will see the greatest population growth (13.9% and 11.2%, respectively). Erath and Navarro will see a much lower rate of growth than the rest of the Region (3.9% and 4.3%, respectively). The other five counties in Region 10 are projected to have population growth similar to that of the Region as a whole.

Overall, Region 10’s elderly population (65 and older) is anticipated to grow more rapidly as a percentage of total population than its working-age adults and children (Figure 1). The highest percentages of elderly are projected for Ellis and Parker counties at a rate of 32% for both counties, compared with the Region-wide estimate of 26%. In contrast, Erath and Navarro counties’ elderly populations as a percentage of total county population will grow much less than the rest of the Region (12% and 13%). (Please see Appendix D-1.2, 1.3 and 1.4 for summary data tables of Region 10’s population, including projected population growth.)

**Figure 1: Age Distribution of Region 10 Counties in 2011**

Source: Thompson Reuters 2011

**Demographics: Population by Race and Ethnicity**

Region 10’s population is predominantly White (57.9%), Hispanic (24.4%), and African-American (11.9%). The Region is less diverse than the state, but more diverse than the nation. Region 10 also
has a smaller proportion of Hispanic residents than the state (24.4% versus 40%), but the Region’s Hispanic population is still a significantly larger proportion of total population than nationally. Hispanics and other minorities are projected to have higher population growth rates over time. Much of Region 10’s racial diversity is concentrated in Ellis, Navarro and Tarrant counties. Of Region 10’s remaining six counties, Hood and Parker counties are the least diverse at 87.1% and 85.3% White, respectively (Figure 2).

Source: Thompson Reuters, 2011

**Demographics: Household Income**

Region 10 has a higher per capita income than Texas or the nation with a median household income of $52,839 per year, compared to $48,615 median state income and $50,046 national median income (Figure 3). The wealthiest counties in Region 10 are Ellis and Parker, which have higher median household incomes of $60,877 and $61,340, respectively. Conversely, Erath and Navarro are the Region’s least affluent counties with median household incomes of $39,200 and $41,654, respectively.
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, 2011

Poverty is highly correlated with poorer health status and poorer health outcomes. Empirical research has demonstrated conclusively that people living on limited incomes are likely to forego visits to the doctor in order to meet their more pressing financial responsibilities, such as food and housing. Low-income wage earners are less likely to be covered by an employer’s health insurance program, and even if they are covered, they are often less able to pay for premiums or out-of-pocket expenses.

Analysis of the Regional and county populations at or below the federal poverty level (FPL) mirrors the findings of the median household income analysis above (Figure 4). Overall, Region 10 has fewer people living in poverty than the rest of Texas and the nation as a percentage of the total Regional population. However, the poorest Region 10 residents tend to be concentrated in a few counties and specific communities within the remainder of the Region. Erath and Navarro counties contain the highest relative percentage of population living in poverty with almost 20% of each county’s population at or below 100% of the federal poverty level.

Source: Thompson Reuters, 2011

Demographics: Population Living in Poverty

Figure 3: Median Household Income of Region 10 Counties in 2011

<table>
<thead>
<tr>
<th>County</th>
<th>Median Household Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>$50,046</td>
</tr>
<tr>
<td>Texas</td>
<td>$48,615</td>
</tr>
<tr>
<td>RHP 10</td>
<td>$52,839</td>
</tr>
<tr>
<td>Parker County</td>
<td>$61,340</td>
</tr>
<tr>
<td>Ellis County</td>
<td>$60,877</td>
</tr>
<tr>
<td>Tarrant County</td>
<td>$55,306</td>
</tr>
<tr>
<td>Wise County</td>
<td>$55,207</td>
</tr>
<tr>
<td>Johnson County</td>
<td>$54,954</td>
</tr>
<tr>
<td>Hood County</td>
<td>$54,882</td>
</tr>
<tr>
<td>Somervell County</td>
<td>$52,135</td>
</tr>
<tr>
<td>Navarro County</td>
<td>$41,654</td>
</tr>
<tr>
<td>Erath County</td>
<td>$39,200</td>
</tr>
</tbody>
</table>
Demographics: Education Level

Educational attainment level is another demographic variable that correlates strongly with overall health status as well as poverty level. Low levels of formal education are often cited as a major indicator of poor health. Lack of education is a formidable barrier to securing living-wage and higher-wage jobs, and further increases an individual’s probability of living in poverty, being uninsured and having children who grow up in poverty. Those with low levels of formal education and literacy are less likely to understand how personal behavior and lifestyle can affect health status and health outcomes. Educational attainment level is also related to a person’s ability to understand medical information and recognize early symptoms of disease. While Region 10 has a smaller percentage of adults without a high school diploma (16.9%) than the rest of Texas, the proportion of the Region’s population without a diploma is higher than the national rate of 14.4% (Figure 5). Reflecting the correlations that exist between poverty level and education, Navarro and Erath counties contain the highest percentages of population that did not complete a high school education (23.6% and 20.5%, respectively), while the most affluent counties – Hood, Parker and Somervell – have the smallest proportions of residents without a high school diploma (13.8%, 12.6% and 12.7%, respectively).
So urce: U.S. Census 2011

**Demographics: Employment**

Generally, the Region has a higher rate of employed residents than the rest of the state and the nation (4.5% unemployment in Region 10 versus 7.2% and 8.3% unemployment for Texas and U.S., respectively) *(Figure 6)*. Tarrant and Wise counties have the Region’s highest unemployment rates at (6.8% and 6.9%, respectively). Somervell has a significantly lower unemployment rate 0.8% than the rest of Region

10. Source: Texas Department of State Health Services, United States Census Bureau

**Insurance Status**

Being uninsured is a major barrier to accessing primary and preventive care in Region 10. People without insurance tend to be working-age adults with less secure employment, lower wage levels, and pre-existing conditions. When individuals defer care because of cost concerns they are more likely to seek care when symptoms have become more severe and receive care in more expensive, acute and emergent care settings. Individuals who defer care also have a greater likelihood of poor long-term outcomes.
Put simply, uninsured patients tend to use hospital emergency departments and urgent care centers as a last resort, rather than managing their health through more cost-effective primary care clinics and physician offices. This unmanaged, episodic and health-event driven approach to seeking care has both serious financial cost implications at the county, Regional and national levels as well as potentially devastating health consequences for individuals.\textsuperscript{iv}

Region 10’s 2010 uninsured rate of 18\% is closer to the national uninsured rate of 15.5\% than Texas’ statewide rate of 23.7\% (Figure 7). More of Region 10’s residents have private insurance than the rest of Texas (51.2\%) or the nation (54\%). The Region’s public coverage rates are 11\% for Medicaid, 8.9\% for Medicare and 1.4\% for the dually enrolled. The highest rates of uninsured residents are found Erath and Navarro Counties (30.2\% and 28.0\%, respectively) commensurate with the counties’ higher rates of poverty and lower median household incomes than the rest of Region 10.

\textbf{Figure 7: Uninsured vs. Insured, 2011}

<table>
<thead>
<tr>
<th></th>
<th>Total Uninsured</th>
<th>Total Insured</th>
<th>Private: Employer Sponsored Insurance</th>
<th>Private: Direct Insurance</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Other Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>15.5%</td>
<td>84.5%</td>
<td>49.0%</td>
<td>5.0%</td>
<td>16.0%</td>
<td>12.0%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Texas</td>
<td>24.7%</td>
<td>76.3%</td>
<td>45.0%</td>
<td>4.0%</td>
<td>16.0%</td>
<td>9.0%</td>
<td>2.3%</td>
</tr>
<tr>
<td><strong>Region 10</strong></td>
<td><strong>18.0%</strong></td>
<td><strong>82.0%</strong></td>
<td><strong>55.3%</strong></td>
<td><strong>5.3%</strong></td>
<td><strong>11.1%</strong></td>
<td><strong>8.9%</strong></td>
<td><strong>1.4%</strong></td>
</tr>
<tr>
<td>Ellis</td>
<td>13.5%</td>
<td>86.5%</td>
<td>59.1%</td>
<td>5.7%</td>
<td>10.5%</td>
<td>9.7%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Erath</td>
<td>36.5%</td>
<td>63.5%</td>
<td>35.7%</td>
<td>3.5%</td>
<td>10.6%</td>
<td>11.9%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Hood</td>
<td>13.5%</td>
<td>86.5%</td>
<td>51.4%</td>
<td>5.1%</td>
<td>8.8%</td>
<td>19.6%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Johnson</td>
<td>14.0%</td>
<td>86.0%</td>
<td>56.7%</td>
<td>5.5%</td>
<td>11.0%</td>
<td>11.4%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Navarro</td>
<td>31.1%</td>
<td>68.9%</td>
<td>34.0%</td>
<td>3.3%</td>
<td>15.7%</td>
<td>12.8%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Parker</td>
<td>13.6%</td>
<td>86.4%</td>
<td>60.4%</td>
<td>5.9%</td>
<td>8.7%</td>
<td>10.5%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Somervell</td>
<td>14.2%</td>
<td>85.8%</td>
<td>55.5%</td>
<td>5.5%</td>
<td>11.2%</td>
<td>12.4%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Tarrant</td>
<td>18.5%</td>
<td>81.5%</td>
<td>55.6%</td>
<td>5.4%</td>
<td>11.4%</td>
<td>7.9%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Wise</td>
<td>16.1%</td>
<td>83.9%</td>
<td>56.8%</td>
<td>5.5%</td>
<td>9.7%</td>
<td>10.8%</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, Thompson Reuters 2011

The proportion of Region 10 residents who remain uninsured in 2016 is projected to drop to 11.3\%. Of those who will be newly insured, an estimated 58.1\% will be covered by direct or employer-sponsored private insurance, while an estimated additional 15.7\% of Region 10 residents will receive coverage through Medicaid and 10.2\% through Medicare. These projections, however, are highly dependent on various federal and state policy and market factors, including availability and affordability of insurance products offered in the local market, impact of any potential state or federal health insurance exchange, and whether or not the state moves forward with a Medicaid expansion.
HEALTH CARE INFRASTRUCTURE AND ENVIRONMENT

(See Appendix D-2 for additional information regarding Region 10’s health care infrastructure.)

Facilities and Health Care Workforce
Region 10’s health care infrastructure consists of 46 acute care hospitals (the majority of which are privately owned), two psychiatric hospitals and 3,726 physicians (Figure 8). The Region has a total of 6,491 acute care licensed beds and 170 psychiatric care licensed beds. The Region’s provider options also include four MHMRs and one FQHC. (See Appendix D-5 for a list of health care facilities by county.)

Providers are most concentrated within Tarrant County and particularly in Fort Worth, Region 10’s major urban center. The vast geographic expanse of Region 10 and the high level of provider concentration within Tarrant County combine to create serious specialty and primary care access barriers for many individuals in the Region’s rural counties.

Figure 8: Acute Care Resources, 2009

<table>
<thead>
<tr>
<th></th>
<th>RHP 10</th>
<th>Ellis</th>
<th>Erath</th>
<th>Hood</th>
<th>Johnson</th>
<th>Navarro</th>
<th>Parker</th>
<th>Somervell</th>
<th>Tarrant</th>
<th>Wise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospitals</td>
<td>46</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>36</td>
<td>2</td>
</tr>
<tr>
<td>Investor Owned Hospitals</td>
<td>28</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Non-Profit Hospitals</td>
<td>18</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Psychiatric Hospitals</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Acute Care Licensed Beds</td>
<td>6,491</td>
<td>129</td>
<td>98</td>
<td>83</td>
<td>137</td>
<td>162</td>
<td>99</td>
<td>16</td>
<td>5,583</td>
<td>184</td>
</tr>
<tr>
<td>Psychiatric Care Licensed Beds</td>
<td>170</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>170</td>
<td>0</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Health Resources County Comparison Tool, Health Indicators Warehouse, Texas Department of State Health Services

The most frequent inpatient services for Region 10 in 2011 were obstetrics, internal medicine, cardiology, pulmonology, general surgery and orthopedics, according to Thomson Reuters. The Region’s top outpatient services were laboratory services, internal medicine, physical therapy, diagnostic radiation, psychiatry and pulmonology.

Overall Regional physician demand is projected to increase by 30% over the five-year Waiver period. Demand for various specialties and types of providers is projected to increase anywhere from 22% to 36%, according to Thomson Reuters. The greatest demand increases are expected for obstetrics/gynecology, vascular medicine, cardiology, oncology/hematology and nephrology (See Appendix D-2.1: for a table of Provider Supply and Demand by Specialty).

Medically Underserved Areas and Health Professional Shortage Areas
Five of Region 10’s counties – including Tarrant County, the Region’s most populous county – are at least partially designated by the U.S. Health and Human Services Agency as Medically
Underserved Areas (MUAs). Ellis, Erath, Johnson and Navarro are the Region’s other MUA counties.

Four of Region 10’s nine counties are also designated as partial primary care Health Professional Shortage Areas (HPSAs). Additionally, Tarrant, Wise and Ellis Counties are federal dental health professional shortage areas. Perhaps most alarming, all but one of Region 10’s counties are federally designated mental health provider shortage areas (only Johnson County is not a MHPSA). These findings correlate with the Stakeholder Surveys and Providers Readiness Assessments Region 10 conducted as part of RHP plan development⁵ (Figure 9).

**Figure 9: Health Professional Shortage Areas by County**

<table>
<thead>
<tr>
<th>HPSA Category</th>
<th>Ellis</th>
<th>Erath</th>
<th>Hood</th>
<th>Johnson</th>
<th>Navarro</th>
<th>Parker</th>
<th>Somervell</th>
<th>Tarrant</th>
<th>Wise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Care</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>

Source: Region 10 Stakeholder Survey, Health Professional Shortage Areas

**Health Care Infrastructure: Performing Provider Readiness Assessment**

Region 10 RHP created and fielded a readiness assessment tool to assess current health care delivery competencies, capabilities and gaps with relation to integrated care delivery and population health management for all major providers within each county and across the Region. All providers participating in the DSRIP program completed this assessment. Region 10 also asked major health care providers and stakeholders in each Region 10 county not actively participating in DSRIP (e.g., hospitals, MHMRs, medical groups, independent physician associations, public health clinics and ambulance companies) to complete the assessment. Survey respondents assessed and specified gaps and needs in the Region’s health care infrastructure across five domains:

1. Population health management,
2. Provider capacity,
3. Functional patient care teams,
4. Use of health information technology (HIT), and
5. Care coordination abilities.

Figure 10 shows respondents’ assessment of system gaps and needs in each Region 10 County. (“Yes” indicates a gap exists.) We received a total of 15 responses, representing the majority of the Region 10 RHP performing providers.

**Figure 10: Delivery Gaps Identified by the Performing Provider Readiness Assessments, 2012**

<table>
<thead>
<tr>
<th>PPRA Domain</th>
<th>Erath</th>
<th>Ellis</th>
<th>Hood</th>
<th>Johnson</th>
<th>Somervell</th>
<th>Tarrant</th>
<th>Wise</th>
<th>Navarro</th>
<th>Parker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Health</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>
Stakeholder Surveys
Region 10 RHP also conducted a stakeholder survey. The stakeholder survey collected qualitative data and feedback on the following:
1) Access to care,
2) Care coordination and
3) Community health.

The Region collected surveys over a period of one month via a Web-based survey tool for a total of 191 stakeholder responses. (See Appendix D-2.2 for a PowerPoint Discussion of Stakeholder Responses and Results).

Access to Care
Most survey respondents agreed that routine hospital services, routine primary/preventive care and routine specialty care were “difficult” to access. Mental/behavioral health care services were identified as the most difficult for low-income patients to access, while emergency services were consistently noted as the least difficult to access. The same access barriers were identified for all types of care:
- Lack of coverage/financial hardship (consistently the most frequently cited barrier);
- Difficulty navigating system/lack of awareness of available resources; and
- Lack of provider capacity.

Care Coordination
Top barriers to effective care coordination (between providers and systems) cited by survey respondents were the complexity of coordination, lack of staff, lack of financial integration, fragmented service systems and practice norms that allow providers to work in silos. Most respondents said they did not believe that low-income patients could:
- Choose and establish a relationship with a primary care provider;
- Access private primary care providers;
- Access community health centers, free clinics or public clinics; and
- Access behavioral/mental health providers.

Community Health
Region 10’s most prevalent conditions are diabetes, obesity, hypertension, heart failure and
chronic obstructive pulmonary disease (COPD), survey respondents reported. Survey respondents also reported that the conditions contributing most to preventable hospitalizations in Region 10 are hypertension, uncontrolled diabetes, COPD, congestive heart failure and diabetes short-term complications (in decreasing order of importance). Respondents reported that behavioral health, substance abuse and insufficient access to care were the top issues to target for population health improvement. Respondents reported that Region 10 residents were most likely to get their health education and health information from friends and family, the Internet and their doctor.

**Key Survey Takeaways**
Respondents overwhelmingly listed a lack of coverage and/or financial hardship as the most significant barrier to care for low-income patients. Survey respondent write-in comments also cited an overuse of emergency department services and patient inability to access primary and preventive care (due to difficulty navigating the system and a lack of capacity). Most respondents also indicated that the Region’s primary care providers, hospitals and specialists were not coordinating care effectively.

**Other Major Delivery System Reform Initiatives**
We have identified several federal initiatives in which Region 10 providers participate. The majority of these are related to diabetes, cancer and infectious diseases. One of our participating providers, Baylor Health Systems, collaborates with AHRQ, NCI, and the National Institute of Allergy and Infectious Diseases on vaccine research, and diabetes and health care quality initiatives. Another Region 10 participating provider, The University of North Texas Health Science Center, works with several federal agencies on Alzheimer’s, education and health disparities research. Another Region 10 participating provider, Tarrant County Department of Public Health, is a consortium member of the North Texas Accountable Healthcare Partnership, a recipient of HITECH funds awarded to 12 Regional HIEs in the state of Texas. We will provide in our final and complete RHP Plan submission a comprehensive listing of all participating providers’ federal initiative involvement based on the list specified in the DSRIP Companion Document issued on October 15, 2012. (See Appendix D-6 for the draft survey questionnaire sent to all Region 10 participating providers to develop a complete list of each provider’s federal initiative participation activities.)

**KEY HEALTH CHALLENGES**
Population health statistics for Region 10 residents reveal important trends and opportunities for delivery system improvement. The most important of these statistical trends are summarized below. (See Appendix D-3 for additional information, including summary data tables.)

**Region 10 RHP Pregnancy and Birth-Related Statistics**
Teen pregnancy increases the risk of poor health outcomes for both young mothers and their children. Pregnancy and delivery negatively impact a teenager’s health both directly and indirectly and often result in long-term negative consequences including increased risk of poverty and low socioeconomic status. Babies born to teen mothers are more likely to be born preterm and/or low birth weight; much of this increased risk is attributable to delayed onset of prenatal care. For this reason, Healthy People 2020 stresses the importance of responsible sexual behavior to reduce unintended pregnancies and the number of births to adolescent females.
Region 10 fares slightly better than the state overall in its teen pregnancy rate (4.3% versus 4.9%) and the incidence of low birth weight babies (7.2% versus 8.4%). However, Region 10 has a slightly lower rate of early (first trimester) prenatal care than the state overall (58.1% versus 60.1%). Navarro and Somervell Counties have Region 10’s highest teen pregnancy rates (6.2% and 5.4% compared with the Regional average of 4.3%). Navarro and Tarrant Counties have the Region’s highest percentages of low birth weight babies and its lowest rates of early prenatal care.

**Morbidity and Mortality**

Cancer and obesity are Region 10’s most common morbidity factors. Hood and Navarro Counties have the Region’s highest cancer rates. Obesity rates are statistically the same across all nine counties in Region 10 at around 26 to 29 persons per 100,000. Johnson County has the Region’s highest rate of diabetes at 10.0 per 100,000. Tarrant County has the Region’s highest HIV rate, though small sample sizes reduce the precision of county-level HIV statistics across the Region.

Cardiovascular disease is the number one killer in Region 10 (4,931 deaths in 2011). Cancer is Region 10’s second most frequent cause of death (3,668 deaths in 2011). These two causes of death are also the two highest for Texas overall.

**Preventable Hospitalization**

Region 10’s preventable hospitalization rate of 931 per 100,000 persons is lower both than the state’s average of 5,923 per 100,000 and the national average of 1,433 per 100,000. Navarro County’s preventable hospitalization rate is the Region’s highest (17 per 1,000 population), followed by Johnson County (14 per 1,000 population). Region 10’s most prevalent cause of preventable hospitalization is congestive heart failure (195 per 1,000 Medicare enrollees), closely followed by anginas without procedures (190 per 1,000 Medicare enrollees).

**Access to Care**

County Health Ranking surveys place difficulties in accessing care due to lack of insurance coverage at the top of health care problems. Although the county-level information is difficult to interpret with certainty because of variations in county response levels, it appears that Johnson and Ellis Counties reported the greatest access problems throughout the Region (*Figure 11*).

Overall Region 10 performs at or slightly better than the rest of the state in providing diabetes and mammography screenings. Within the Region, Wise County and Navarro County have the lowest screening levels for diabetes and mammography and are below both state and national average screening rates. Wise County’s diabetes screening rate is 76%, compared with the statewide and national rates of 84% and 80%, respectively. Navarro County has the Region’s lowest mammography screening rate at 55%, compared with statewide and national rates of 60% and 59%, respectively.

*Figure 11: Utilization of Health Services, 2011*
### Communicable Diseases

In general, Region 10 has lower rates of communicable disease than the rest of the state, although prevalence rates for Region 10’s Somervell County are statistically questionable because of its small population size. Specifically, Region 10 has lower AIDS rates (3.4), tuberculosis rates (2.3) and whooping cough rates (10.3) than the state. However, Region 10 has a much higher rate for chicken pox infections (26.3%) versus the overall rate in Texas of 17.9%. Tarrant County has the Region’s highest TB infection rate. Johnson, Navarro and Tarrant Counties have the Region’s highest rates of AIDS infections (6.1, 7.9 and 6.1, respectively). Hood County had the Region’s highest chicken pox and whooping cough infections.

### Sexually Transmitted Diseases

Region 10 generally has lower reported sexually transmitted disease rates (STDs) than the overall state rates. Region 10 has lower rates of syphilis (2.7 versus 4.9 per 100,000) and gonorrhea (99.0 versus 504.1 per 100,000) than the state overall. Conversely, Region 10 has a higher rate of chlamydia infections than the state overall (533.7 versus 467.3 per 100,000).

Ellis County had the Region’s highest infection rates for syphilis, gonorrhea and chlamydia. Ellis and Tarrant Counties had the Region’s highest syphilis infection rates (10 and 8.3 respectively). However, these rates are still significantly lower than the national average. Ellis, Navarro and Tarrant Counties have the Region’s highest gonorrhea infection rates (504.1, 141.4 and 139.0, respectively). Ellis County also had a chlamydia infection rate roughly five times higher than the rest of the Region.

### Health Outcomes

As previously noted, county-specific health outcomes are difficult to assess because of small sample sizes in a few counties (Somervell and Navarro). However, the County Health Rankings data set indicates that Region 10’s population self-reported having fewer poor or fair health days than the rest of the state (17% versus 19%). Johnson County has the Region’s highest percentage of respondents reporting poor or fair health and the highest reported levels of poor mental health days. Hood County respondents have the Region’s highest reported number of poor physical health days.

### Health Behaviors

The Region’s top identified health behaviors negatively impacting and influencing health outcomes are adult obesity (30%) and physical inactivity (28%). These behaviors are followed by smoking (19%) and excessive drinking (15%). Counties appeared to have fairly comparable levels for these behaviors. Johnson County had the Region’s highest rates for nearly all harmful health behaviors: adult smoking, adult obesity, physical inactivity and excessive drinking. Navarro, Parker and Wise also had slightly higher adult obesity rates than the state (See County Health Rankings).
Access to Healthy Foods
The Region fares slightly better than the state overall in terms of access to healthy foods in poor communities (10% versus 12%). Residents in Ellis and Johnson counties have the worst access to healthy foods in poor communities, but their rates are still significantly better than the statewide average. Overall Region 10 has fast food restaurant access rates similar to the statewide average. Johnson County has the Region’s highest percentage of fast food restaurants at 60%.

Conclusions
While on average Region 10 fares as well as or slightly better than the rest of the state on many health need indicators, the poorest and most vulnerable residents of Region 10 live in communities struggling with very significant levels of unmet health care need. Through DSRIP, Region 10 RHP is committed to a revitalized community-oriented Regional health care delivery system focused on the triple aims of improving the experience of care for all patients and their families, improving the health of the Region’s population, and reducing the cost of care without compromising quality with a particular focus on the community health needs of our most vulnerable residents.

SUMMARY TABLE OF COMMUNITY NEEDS
The table below provides a concise summary of the community needs we have outlined in Section III. *(See Appendix D for additional detail and contextual data).* The DSRIP projects proposed by Region 10 RHP participating providers have been selected to address many of the health care challenges outlined in this CHNA and highlighted in the summary table below.

<table>
<thead>
<tr>
<th>Identification Number</th>
<th>Brief Description of Community Needs Addressed Through RHP Plan</th>
<th>Data Source for Identified Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>CN.1</td>
<td>Lack of provider capacity. Patients find difficulty in navigating the system and have noted the difficulty in finding a provider, particularly Medicaid providers. Five counties are recognized as medically underserved areas.</td>
<td>Stakeholder Survey, Texas CHS, County 2010 Health Rankings, Providers Readiness Assessments, Health Professional Shortage Areas</td>
</tr>
<tr>
<td>CN.2</td>
<td>Shortage of primary care services (e.g., pediatric, prenatal,</td>
<td>Health Professional Shortage</td>
</tr>
<tr>
<td>Identification Number</td>
<td>Brief Description of Community Needs Addressed Through RHP Plan</td>
<td>Data Source for Identified Need</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CN.3</td>
<td><strong>Shortage of specialty care.</strong> The Region is facing a 22-36% growth in provider demand, across all specialties. The specialties with the greatest growth in demand are obstetrics/gynecology, vascular health, urology, hematology/oncology, cardiology, and nephrology.</td>
<td>Health Professional Shortage Areas</td>
</tr>
<tr>
<td>CN.4</td>
<td><strong>Lack of access to mental health services.</strong> All but one county in Region 10 are recognized as health professions shortage areas for mental health providers.</td>
<td>Health Resources County Comparison Tool, Health Indicators Warehouse, Texas Dept. of State Health Services</td>
</tr>
<tr>
<td>CN.5</td>
<td><strong>Insufficient integration of mental health care in the primary care medical care system.</strong> Community stakeholders cite a need to achieve better integration of primary and behavioral health services in the primary care setting.</td>
<td>Stakeholder surveys</td>
</tr>
<tr>
<td>CN.6</td>
<td><strong>Lack of access to dental care.</strong> Two of the 9 counties are nationally recognized with a shortage of dental providers.</td>
<td>Health Professional Shortage Areas</td>
</tr>
<tr>
<td>CN.7</td>
<td><strong>Need to address geographic barriers that impede access to care.</strong> There is a skewed distribution of providers in Region 10, with most located in the major urban centers, particularly Fort Worth, Tarrant County. Individuals from rural counties have difficulty with access to care, especially specialty care.</td>
<td>Health Resources County Comparison Tool, Health Indicators Warehouse, Texas Dept. of State Health Services</td>
</tr>
<tr>
<td>CN.8</td>
<td><strong>Lack of access to health care due to financial barriers (i.e., lack of affordable care).</strong> Providers overwhelmingly list lack of coverage/financial hardship as a major barrier for low-income patients.</td>
<td>U.S. Census Bureau, County Health Rankings Survey</td>
</tr>
<tr>
<td>CN.9</td>
<td><strong>Need for increased geriatric, long-term, and home care resources (e.g., beds, Medicare providers).</strong> Region 10’s population is projected to grow 9% by 2016, with a 26% increase in the senior population (ages 65+). Three counties have senior populations of between 14-20% of total population.</td>
<td>Thomson Reuters, 2011</td>
</tr>
<tr>
<td>CN.10</td>
<td><strong>Overuse of emergency department (ED) services.</strong> Demand for ED visits is on the rise and EDs are becoming overcrowded due to reduced inpatient capacity and impaired patient flow. As a Region, there were 1.1 million visits to hospital EDs in 2010, with a rate of 447.5 visits per 1,000 persons. The 2007 national ED visit rate was 390.5 per 1,000 persons, increasing 23% since 1997, but lower than the ED visit rate of Region 10.</td>
<td>Stakeholder Survey, Texas CHS, 2010 County Health Rankings, UCSF Trends and Characteristics of U.S. Emergency Department Visits, 1997-2007</td>
</tr>
<tr>
<td>CN.11</td>
<td><strong>Need for more care coordination.</strong> All counties identified it as a system cap and need. Barriers include complexity of coordination, lack of staff, lack of financial integration, fragmented system service, and practicing in silos. Providers did not feel there was strong care coordination between primary care providers, hospitals, and specialists.</td>
<td>Region 10 Stakeholder Survey</td>
</tr>
<tr>
<td>CN.12</td>
<td><strong>Need for more culturally competent care to address unmet needs (e.g., Latino-population need care, translators, translated-materials).</strong> Over 40% of the Region’s population is not Caucasian, and nearly one-quarter are Hispanic or Latino origin. Hispanic and minority populations have higher growth rates than the White population. Research shows that culturally competent care shows better health outcomes.</td>
<td>American Fact Finder 2010 Census Data, U.S. Census Bureau</td>
</tr>
<tr>
<td>Identification Number</td>
<td>Brief Description of Community Needs Addressed Through RHP Plan</td>
<td>Data Source for Identified Need</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>CN.13</td>
<td><strong>Necessity of patient education programs.</strong> Many community residents lack basic health literacy.</td>
<td>U.S. Census, National Adult Literacy Survey (NALS)</td>
</tr>
<tr>
<td>CN.14</td>
<td><strong>Lack of access to healthy foods.</strong> The Region and the state has more than double the percentage of all restaurants that are fast food establishments compared to the nation.</td>
<td>Community Health Rankings</td>
</tr>
<tr>
<td>CN.15</td>
<td><strong>Need for more education, resources and promotion of healthy lifestyles (free and safe places to exercise, health screenings, health education, healthy environments, etc.).</strong> Top identified health behaviors impacting and influencing health outcomes in Region 10 are adult obesity (30%) and physical activity (28%). Region had a lower rate of health screening rate than nation and state.</td>
<td>County Health Rankings, 2010</td>
</tr>
<tr>
<td>CN.16</td>
<td><strong>Higher incidence rates of syphilis and chlamydia.</strong> Two counties have higher rates of syphilis than the state. One county had significantly higher rate of chlamydia, while entire Region 10 has higher rate than the state and nation.</td>
<td>Texas CHS</td>
</tr>
<tr>
<td>CN.17</td>
<td><strong>Incomplete management of varicella (chicken pox) cases.</strong> Region 10 has poor rates of some chicken pox, with nearly a 50% higher rate than national average (with rate of 26.3 compared to 17.9 per 100,000, respectively).</td>
<td>Texas CHS, Centers for Disease Controls and Preventions</td>
</tr>
<tr>
<td>CN.18</td>
<td><strong>Incomplete management of pertussis (whooping cough) cases.</strong> The Region has nearly a 50% higher rate than state, with rate of 10.3 compared to 5.54 per 100,000, respectively.</td>
<td>Texas CHS, Centers for Disease Controls and Preventions</td>
</tr>
<tr>
<td>CN.19</td>
<td><strong>Need for more and earlier onset of prenatal care.</strong> Nearly 60% of Region 10 mothers access prenatal care within first trimester, compared with 71% national rate. Region 10 has higher teen birth rates than the national average, while also having a lower rate of low birth weight.</td>
<td>Texas CHS</td>
</tr>
<tr>
<td>CN.20</td>
<td><strong>Improved Public Health Surveillance to Promote Individual and Population Health.</strong> West Nile and other disease outbreaks locally highlight areas in the local public health surveillance system that are unaddressed.</td>
<td>Texas DSHS and National Electronic Disease Surveillance System (CDC)</td>
</tr>
<tr>
<td>CN.21</td>
<td><strong>High tuberculosis (TB) prevalence</strong> and low treatment completion rates of latent tuberculosis infection (LTBI) LTBI treatment</td>
<td>Healthy People 2020</td>
</tr>
<tr>
<td>CN.22</td>
<td><strong>Inadequate health IT infrastructure</strong> and limited interoperability to support information sharing between providers hinders care coordination.</td>
<td>Region 10 RHP Community Health Needs Assessment, Regional Stakeholder Survey Summary, June 2012</td>
</tr>
</tbody>
</table>
Appendix D:
Additional Community Health Needs Assessment Information
### Community Profile

#### Figure D-1.1 Map of Region 10 Area

#### Figure D-1.2: 2010 Population by Race and Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Hispanic/Latino</th>
<th>Black</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Two or more races</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>64.0%</td>
<td>16.0%</td>
<td>12.0%</td>
<td>5.0%</td>
<td>1.0%</td>
<td>2.0%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Texas</td>
<td>42.0%</td>
<td>40.0%</td>
<td>11.0%</td>
<td>5.0%</td>
<td>0%</td>
<td>1.0%</td>
<td>6.0%</td>
</tr>
<tr>
<td>RHP 10</td>
<td>57.9%</td>
<td>24.4%</td>
<td>11.9%</td>
<td>3.8%</td>
<td>0.4%</td>
<td>1.6%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Ellis</td>
<td>65.5%</td>
<td>23.5%</td>
<td>8.8%</td>
<td>0.6%</td>
<td>0.4%</td>
<td>1.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Erath</td>
<td>77.5%</td>
<td>19.2%</td>
<td>1.1%</td>
<td>0.6%</td>
<td>0.4%</td>
<td>0.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Hood</td>
<td>87.1%</td>
<td>10.2%</td>
<td>0.4%</td>
<td>0.7%</td>
<td>0.6%</td>
<td>0.9%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Johnson</td>
<td>76.6%</td>
<td>18.1%</td>
<td>2.5%</td>
<td>0.9%</td>
<td>0.5%</td>
<td>1.3%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Navarro</td>
<td>59.9%</td>
<td>23.8%</td>
<td>13.6%</td>
<td>1.3%</td>
<td>0.3%</td>
<td>1.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Parker</td>
<td>85.3%</td>
<td>10.6%</td>
<td>1.6%</td>
<td>0.5%</td>
<td>0.7%</td>
<td>1.3%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Somervell</td>
<td>77.7%</td>
<td>19.2%</td>
<td>0.6%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>1.2%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Tarrant</td>
<td>51.8%</td>
<td>26.7%</td>
<td>14.5%</td>
<td>4.8%</td>
<td>0.4%</td>
<td>1.7%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Wise</td>
<td>79.7%</td>
<td>17.1%</td>
<td>1.0%</td>
<td>0.4%</td>
<td>0.6%</td>
<td>1.2%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

Source: United States Census Bureau 2010, Kaiser Health Foundation, 2010
<table>
<thead>
<tr>
<th>U.S.</th>
<th>Texas</th>
<th>Total Population</th>
<th>Children (0-18 years)</th>
<th>Adult (18-64 years)</th>
<th>Seniors (65+ years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td></td>
<td>75,596,680</td>
<td>78,091,453</td>
<td></td>
<td>193,707,411</td>
</tr>
<tr>
<td>Texas</td>
<td></td>
<td>7,091,699</td>
<td>7,607,608</td>
<td></td>
<td>15,645,996</td>
</tr>
<tr>
<td>RHP 10</td>
<td></td>
<td>2,444,642</td>
<td>2,674,022</td>
<td>9%</td>
<td>683,196</td>
</tr>
<tr>
<td>Ellis</td>
<td></td>
<td>163,972</td>
<td>186,721</td>
<td>14%</td>
<td>48,230</td>
</tr>
<tr>
<td>Erath</td>
<td></td>
<td>35,565</td>
<td>36,944</td>
<td>4%</td>
<td>8,327</td>
</tr>
<tr>
<td>Hood</td>
<td></td>
<td>54,128</td>
<td>59,318</td>
<td>10%</td>
<td>11,967</td>
</tr>
<tr>
<td>Johnson</td>
<td></td>
<td>170,881</td>
<td>187,136</td>
<td>10%</td>
<td>46,151</td>
</tr>
<tr>
<td>Navarro</td>
<td></td>
<td>49,839</td>
<td>51,961</td>
<td>4%</td>
<td>13,397</td>
</tr>
<tr>
<td>Parker</td>
<td></td>
<td>107,263</td>
<td>119,320</td>
<td>11%</td>
<td>27,583</td>
</tr>
<tr>
<td>Somervell</td>
<td></td>
<td>7,584</td>
<td>8,188</td>
<td>8%</td>
<td>1,988</td>
</tr>
<tr>
<td>Tarrant</td>
<td></td>
<td>1,797,679</td>
<td>1,961,608</td>
<td>9%</td>
<td>510,706</td>
</tr>
<tr>
<td>Wise</td>
<td></td>
<td>57,731</td>
<td>62,826</td>
<td>9%</td>
<td>14,847</td>
</tr>
</tbody>
</table>

*Data pending  Source: Thomson Reuters, 2011
Figure D-1.4: Population by Education, 2010

<table>
<thead>
<tr>
<th></th>
<th>Non-High School Graduate</th>
<th>High School Diploma</th>
<th>Bachelor's Degree</th>
<th>Graduate Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>14.4%</td>
<td>49.8%</td>
<td>17.7%</td>
<td>10.4%</td>
</tr>
<tr>
<td>Texas</td>
<td>19.3%</td>
<td>48.4%</td>
<td>17.3%</td>
<td>8.6%</td>
</tr>
<tr>
<td><strong>RHP 10</strong></td>
<td><strong>16.9%</strong></td>
<td><strong>54.9%</strong></td>
<td><strong>15.5%</strong></td>
<td><strong>6.2%</strong></td>
</tr>
<tr>
<td>Ellis</td>
<td>17.0%</td>
<td>55.2%</td>
<td>15.0%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Erath</td>
<td>20.5%</td>
<td>51.1%</td>
<td>16.3%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Hood</td>
<td>13.8%</td>
<td>55.5%</td>
<td>16.8%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Johnson</td>
<td>18.4%</td>
<td>59.6%</td>
<td>11.8%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Navarro</td>
<td>23.6%</td>
<td>54.1%</td>
<td>10.3%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Parker</td>
<td>12.6%</td>
<td>57.6%</td>
<td>15.4%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Somervell</td>
<td>12.7%</td>
<td>51.7%</td>
<td>22.5%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Tarrant</td>
<td>16.0%</td>
<td>48.4%</td>
<td>20.1%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Wise</td>
<td>17.4%</td>
<td>60.7%</td>
<td>11.7%</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau
### D-2: Health care Infrastructure

**Figure D-2.1: Current Physician Supply (FTE) vs. Projected Physician Demand (% Increase from 2010-2015)**

<table>
<thead>
<tr>
<th></th>
<th>NHP 10</th>
<th>Elts</th>
<th>Erath</th>
<th>Hood</th>
<th>Johnson</th>
<th>Navaro</th>
<th>Parker</th>
<th>Somerville</th>
<th>Tarrant</th>
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Source: Thompson Reuters, 2011
The Regional stakeholder survey was distributed to participants during the months of April and June to solicit feedback on access to care, care coordination and population health.

**REGIONAL STAKEHOLDER SURVEY SUMMARY**

Region 10 RHP Community Health Needs Assessment

June 2012

**Stakeholder Survey**

- Designed to gather qualitative information and feedback to evaluate the health care system within Region 10

- Represents feedback from broad spectrum of stakeholders, focusing on barriers to care, access and health care issues pertinent to the Region 10 RHP planning process

- Surveys were collected over a period of one month, using a web-based survey tool

- The survey is the first step in the community health needs assessment process
Question format

1) Respondents were asked to rate the difficulty low-income patients faced when trying to access care

2) Respondents were then asked to rank potential barriers to care from 1 – 8.

“Other” responses

- “Limited specialty services and limited indigent eligibility”
- “Because access for ‘routine hospital services’ is ‘difficult,’ EDs (the most expensive location to receive medical services) is overused.”
- “Providers not well informed of various programs and how they work”
- “Without insurance, unable to get treatment until condition is emergent/life threatening”
**Question 4a**

Difficulty low-income patients face when trying to access emergency care services:

- Very easy: 18
- Easy: 60
- Neutral: 45
- Difficult: 30
- Very difficult: 6
- N/A: 7

**Question 4b**

Difficulty low-income patients face when trying to access prenatal care:

- Very easy: 1
- Easy: 23
- Neutral: 64
- Difficult: 41
- Very difficult: 2
- N/A: 32

**Question 4b, cont.**

**Barriers to access to emergency care services for low-income patients**

- Lack of coverage/financial hardship
- Difficulty navigating system/limited awareness of available resources
- Lack of capacity (e.g., insufficient providers/inconsistent wait times)
- Eligibility screening process for beneficiaried services
- Delays in authorization/referral approval
- Lack of access due to provider distance
- Other (Specify below)
- Scheduling (system not sufficient—standard process)

**Question 4b, cont.**

**Barriers to access to prenatal care for low-income patients**

- Lack of coverage/financial hardship
- Difficulty navigating system/limited awareness of available resources
- Lack of capacity (e.g., insufficient providers/inconsistent wait times)
- Lack of access due to provider distance
- Other (Specify below)
- Eligibility screening process for beneficiaried services
- Delays in authorization/referral approval
- Scheduling (system not sufficient—standard process)

**“Other” responses**

- “Using emergency medical is easy..., but is it NOT be BEST way for them to receive medical care.”
- “Lack of psychiatric availability for dual diagnosed (MH/MR) individuals. Also lack of substance abuse treatment capacity.”
- “Limited number of area providers.”

**“Other” responses**

- “Local Hospital does not provide.”
- “No OB physicians or services at hospital.”
- “Lack of knowledge about resources available.”
"Other" responses

- "Some area physicians are not providing immunization services."
- "Low reimbursement makes me unable to allow scheduling of Medicaid patients. It is easy for cash paying patients to get a visit and be seen in my office."
- "Physician offices/Providers do not offer non-traditional hours, for example: after work and on weekends."

"Other" responses

- "A glaring issue for individuals with disabilities who are often living below the poverty level is transportation. Many individuals who depend on public transportation are stuck in one area and unable to cross transportation lines due to a lack of providers able to cross into other areas. This is especially relevant for those in rural areas or those living outside of the city of Fort Worth."
“Other” responses

- “Lack of providers of specialty care for Behavioral Health and Children and Adults with behavioral disorders.”
- “[Lack of] transportation to Specialty practices in another county”
- “Specialists will not accept patients with no resources.”

“Other” responses

- “Many individuals with intellectual disabilities are unaware of other urgent care facilities and most are dependent on assistive transportation resulting in a higher incident of costly ER usage for medical needs.”
- “Lack of knowledge regarding resources that are available at low or no cost”
Question 10a: Difficulty low-income patients face when trying to access mental/behavioral health care:

- Lack of coverage/financial hardship
- Difficulty navigating system/acknowledgment of available resources
- Lack of capacity (e.g., insufficient providers/limited wait times)
- Eligibility screening process for benefit/insurance services
- Lack of access due to provider distance
- Delays in authorization/obtaining approval
- Scheduling (lack of efficiency/non-standard process)
- Other (Specify below)

Question 10b: Barriers to access to mental/behavioral health care for low-income patients

- Lack of coverage/financial hardship
- Difficulty navigating system/acknowledgment of available resources
- Lack of capacity (e.g., insufficient providers/limited wait times)
- Eligibility screening process for benefit/insurance services
- Lack of access due to provider distance
- Delays in authorization/obtaining approval
- Scheduling (lack of efficiency/non-standard process)
- Other (Specify below)

“Other” responses

- “Lack of Bilingual and Culturally Sensitive Mental Health Professions”


Question 11a: Difficulty low-income patients face when trying to access substance abuse services:

- Lack of coverage/financial hardship
- Difficulty navigating system/acknowledgment of available resources
- Lack of capacity (e.g., insufficient providers/limited wait times)
- Lack of access due to provider distance
- Eligibility screening process for benefit/insurance services
- Delays in authorization/obtaining approval
- Scheduling (lack of efficiency/non-standard process)
- Other (Specify below)

Question 11b: Barriers to access to substance abuse services for low-income patients

- Lack of coverage/financial hardship
- Difficulty navigating system/acknowledgment of available resources
- Lack of capacity (e.g., insufficient providers/limited wait times)
- Lack of access due to provider distance
- Eligibility screening process for benefit/insurance services
- Delays in authorization/obtaining approval
- Scheduling (lack of efficiency/non-standard process)
- Other (Specify below)

“Other” responses

- “Lack of providers. No residential treatment, or intensive outpatient services available.”

- “Lack of Cultural and Bilingual Professional Staff.”

- “[I am] unaware of any local services available for low income patients in need.”
Access to Care: Key Takeaways

- The top three barriers for access to all types of care:
  - Lack of coverage/financial hardship (#1 for all types)
  - Difficulty navigating the system/lack of awareness of available resources
  - Lack of capacity (e.g. insufficient provider/extended wait times)

Access to Care: Key Takeaways

- For routine hospital care, routine primary/preventive care and routine specialty care the majority of respondents rated them as "difficult" to access

- For Mental/behavioral health care the majority of respondents rated it as "very difficult" to access

- Emergency care was rated by most respondents as "easy" to access

Question Format

1. Respondents were asked to state whether they agreed or disagreed that their county had certain types of care coordination

2. Respondents were then asked to rate the effectiveness of certain types of care coordination

Summary of Responses: Care Coordination

Private primary care providers are accessible to patients in low-income communities:

- Strongly Agree: 17.5%
- Agree: 3.9%
- Neutral: 13.0%
- Disagree: 22.7%
- Strongly Disagree: 42.9%

n = 154
Question 14

Community health centers, free clinics or public clinics are accessible to patients in low-income communities:

- Strongly Agree: 10.4%
- Agree: 26.0%
- Neutral: 33.1%
- Disagree: 9.1%
- Strongly Disagree: 24.4%

n = 154

Question 17

Low income patients discharged from the hospital are able to see a primary care provider within 7 days of discharge:

- Strongly Agree: 11.7%
- Agree: 4.5%
- Neutral: 30.5%
- Disagree: 14.9%
- Strongly Disagree: 38.3%

n = 154

Question 15

Behavioral/mental health providers are accessible to patients in low-income communities:

- Strongly Agree: 11.7%
- Agree: 26.8%
- Neutral: 31.8%
- Disagree: 26.6%
- Strongly Disagree: 3.2%

n = 154

Question 18

Effectiveness of the transition of a patient's care from the hospital setting to their primary care provider:

- Very Effective: 6%
- Somewhat Effective: 22%
- Somewhat Ineffective: 24%
- Very Ineffective: 21%
- Don't know/Not Applicable: 26%

n = 125

Question 19

Substance abuse providers are accessible to patients in low-income communities:

- Strongly Agree: 24.7%
- Agree: 10.4%
- Neutral: 31.5%
- Disagree: 26.6%
- Strongly Disagree: 2.6%

n = 154

Question 20

Barriers to effective overall care coordination in counties:

- Complexity of coordination for patients with high levels of need and/or with frequent hospital and clinic visits:
- Lack of staff time for investment in coordination (at the practice and broader community levels):
- Limited financial integration across most providers:
- Limited health IT infrastructure and interoperability:
- Fragmented, stand alone services, rather than an integrated delivery system:
- Lack of clear financial incentives for care coordination for providers:
- Practice norms that encourage physicians to act in silos rather than coordinate with each other:
- Limited primary care provider involvement in inpatient care:
- Other (Please specify below):
- Patient self-reports about which the Patient-Centered Medical Home is unaware:
- Miscommunication regarding primary care and limits to information sharing (HIPAA):

n = 148

Least significant  Most significant
“Other” responses

- “Clients cannot sit and wait for hours and miss more work when they have a limited income.”
- “General lack of primary care physicians, and FPs not paid well to see their own patients in the hospital (eliminates need to ‘coordinate’ care)”
- “Poor patient compliance with recommended follow-up, they are discharged from hospital or ER and just plan on returning to ER when their condition gets out-of-hand again”
- “Rate of reimbursement too low and government requirements too time consuming”

Comments (Continued)

- “Lack of communication. Patients are either seen/treated for a medical condition or a psychiatric condition. It does not seem that both are addressed. It is whichever is prevalent at the time in crisis.”
- “The mental health resources are limited at best. MHMR is flooded with people with substance abuse issues and cannot adequately respond. This creates a system where physicians are often put in a tough place of diagnosing mental health issues as well as other physical ailments without anyone local to refer patients to for counseling.”

Comments

- “Doctors don’t seem to talk with other physicians and work together to find a solution to health problems. Rather they "bounce" the patient from this specialist to that specialist…”
- “Many of the mental health patient’s do not even know what medications they are currently on. The primary care must rely on the patient to tell them.”

“Other” responses

- “Not enough family physicians in community, who are not paid fairly to care for complex patients.”
- “Limited primary care involvement is not related to only inpatient care - PCPs and Mental Health Professionals each treat the patient in a silo...there is no "co-management"...each does their own part.”
Comments

• “Providers work in silos and do not have incentives to coordinate care; additionally, there may be language barriers for clients when utilizing the systems that are in place.”

• “Difficulty getting specialists to accept patients on programs that have low pay rates or are unfamiliar to the providers.”

• “No system appears to be in place to assure communication across providers.”

Care Coordination: Key Takeaways

• In general, respondents felt neutral or did not feel that there was effective care coordination among physicians, specialists, hospitals and other providers for mental health, etc.

• However, respondents did feel that care coordination for chronically-ill patients between primary and specialty care patients was somewhat effective
“Other” responses

- Alzheimer’s Disease
- “All of these diseases are prevalent in our community”
- Dental needs/infection

“Other” responses

- Community health clinics
- Health fairs
- University health center and counseling center
- Provider nurses
- Case managers
- Television
- Dr. Oz
- Agrilife Extension Office
- Home health agencies

“Other” responses

- Mental Health - Bipolar, Schizophrenia, etc.
- Child Asthma
- Congestive heart failure

“Any disease or disorder that requires lifestyle changes and preventative action often become worse due to the lack of follow-up care and coordination of caregiver roles and the patient’s inability to maintain the proper health regimen. This is also compounded by communication disorders or differing awareness levels of physical wellbeing among the disabled making early diagnosis difficult at times.”
“Other” responses

- “Environmental quality and the built environment”
- “Not treating the history of trauma and anxiety”
- “Poor nutrition due to the inability to purchase healthy foods because they cost so much more than the unhealthier options”
- “Lack of transportation to get to needed medical care”

Community Health: Key Takeaways

- The top health conditions affecting Region 10 patients were diabetes, obesity, hypertension, COPD and congestive heart failure.
- Patients mostly get their health education from friends, family, the internet and their doctor.
- Behavioral health and substance abuse were the top issues impacting the patient population.

Additional Comments

“County lacks physicians who will take Medicaid patients. Patients need more transportation to other counties with specialists.”

“Our county has a wealth or resources for its residents. Many simply are unaware that these resources are available.”

“There should be some discussion about population health, health equity and undocumented patients.”

Additional Comments (cont’d)

“Most families have no where to go to get assessments completed or medication management for their children or adult children to get help with the behaviors they exhibit due to their dual diagnosis. Mental health practitioners in the community refuse to see them because of their mental retardation diagnosis and they have to end up going to Dallas, and or staying here and paying out of pocket extremely high payments just to get medications or assessments.”

Additional Comments (cont’d)

“[Both] insured and uninsured patients are not incentivized to pursue preventive care and maintain appropriate follow-up care.”

“The clients must receive both mental and physical health care in one location. The piece meal system no longer works.”
Respondents overwhelmingly listed a lack of coverage/financial hardship as a barrier to care for low-income patients.

Write-in comments in the survey indicated an overuse of the emergency department services and an inability for patients to access primary/preventive care (due to difficulty navigating the system and a lack of capacity, according to responses).

In general, respondents did not feel that there was strong care coordination between primary care providers, hospitals and specialists.
### D-3: Key Health Challenges

#### Figure D-3.1: Causes of Morbidity in Region 10 Counties in 2011

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<td>439.9</td>
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<td>424.6</td>
<td>485.4</td>
<td>462.1</td>
<td>469.8</td>
<td>485.4</td>
</tr>
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<td>70.4</td>
<td>43.2</td>
<td>55.5</td>
<td>74.7</td>
<td>N/A</td>
<td>63.9</td>
</tr>
<tr>
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<td>N/A</td>
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<td>60.4</td>
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<td>72.0</td>
<td>74.5</td>
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<td>8.8</td>
<td>10.0</td>
<td>8.4</td>
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<td>9.3</td>
<td>8.7</td>
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<td>27.5</td>
<td>26.9</td>
<td>27.1</td>
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Source: Community Health Rankings (Rates per 100,000 people, *Data Pending)

#### Figure D-3.2: Communicable Diseases Rates per 100,000 people in Region 10 in 2009

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<tr>
<th></th>
<th>U.S.</th>
<th>Texas</th>
<th>RHP 10</th>
<th>Ellis</th>
<th>Erath</th>
<th>Hood</th>
<th>Johnson</th>
<th>Navarro</th>
<th>Parker</th>
<th>Somervell</th>
<th>Tarrant</th>
<th>Wise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis Cases</td>
<td>11,549</td>
<td>1,477</td>
<td>122.0</td>
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<td>1</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>109</td>
<td>2</td>
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<tr>
<td>Tuberculosis Rate</td>
<td>3.80</td>
<td>6.0</td>
<td>2.3</td>
<td>2</td>
<td>2.6</td>
<td>0</td>
<td>2.4</td>
<td>2</td>
<td>1.8</td>
<td>0</td>
<td>6.1</td>
<td>3.4</td>
</tr>
<tr>
<td>AIDS Cases</td>
<td>34,247</td>
<td>2,286</td>
<td>134.0</td>
<td>6</td>
<td>0</td>
<td>2</td>
<td>10</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>109</td>
<td>0</td>
</tr>
<tr>
<td>AIDS Rate</td>
<td>**</td>
<td>9.2</td>
<td>3.4</td>
<td>3.9</td>
<td>0</td>
<td>3.8</td>
<td>6.1</td>
<td>7.9</td>
<td>2.7</td>
<td>0</td>
<td>6.1</td>
<td>0</td>
</tr>
<tr>
<td>Varicella (Chickenpox) Cases</td>
<td>**</td>
<td>4,445</td>
<td>454.0</td>
<td>13</td>
<td>9</td>
<td>68</td>
<td>34</td>
<td>4</td>
<td>18</td>
<td>0</td>
<td>298</td>
<td>10</td>
</tr>
<tr>
<td>Varicella (Chickenpox) Rate</td>
<td>**</td>
<td>17.9</td>
<td>26.3</td>
<td>8.5</td>
<td>23</td>
<td>127.9</td>
<td>20.7</td>
<td>7.9</td>
<td>15.6</td>
<td>0</td>
<td>16.7</td>
<td>16.6</td>
</tr>
<tr>
<td>Pertussis (Whooping Cough) Cases</td>
<td>16,858</td>
<td>3,358</td>
<td>268.0</td>
<td>10</td>
<td>2</td>
<td>9</td>
<td>22</td>
<td>0</td>
<td>14</td>
<td>2</td>
<td>207</td>
<td>2</td>
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<tr>
<td>Pertussis (Whooping Cough) Rate</td>
<td>5.54</td>
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<td>6.5</td>
<td>5.1</td>
<td>16.9</td>
<td>13.4</td>
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<td>23.8</td>
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<td>3.3</td>
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</table>

Source: Centers for Disease Control
### Figure D-3.3: Region 10 Sexually Transmitted Diseases in 2009

<table>
<thead>
<tr>
<th></th>
<th>Nation</th>
<th>Texas</th>
<th>RHP 10</th>
<th>Ellis</th>
<th>Erath</th>
<th>Hood</th>
<th>Johnson</th>
<th>Navarro</th>
<th>Parker</th>
<th>Somervell</th>
<th>Tarrant</th>
<th>Wise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary and Secondary Syphilis Cases</td>
<td>44,828</td>
<td>1,231</td>
<td>172.0</td>
<td>16</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>151</td>
<td>0</td>
</tr>
<tr>
<td>Primary and Secondary Syphilis Rate</td>
<td>14.74</td>
<td>4.9</td>
<td>2.7</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0.6</td>
<td>3.9</td>
<td>1.7</td>
<td>0</td>
<td>8.3</td>
<td>0</td>
</tr>
<tr>
<td>Gonorrhea Cases</td>
<td>301,174</td>
<td>31,453</td>
<td>3,504.0</td>
<td>803</td>
<td>5</td>
<td>3</td>
<td>57</td>
<td>73</td>
<td>10</td>
<td>2</td>
<td>2,537</td>
<td>14</td>
</tr>
<tr>
<td>Gonorrhea Rate</td>
<td>99.05</td>
<td>124</td>
<td>99.0</td>
<td>504.1</td>
<td>12.6</td>
<td>5.5</td>
<td>33.7</td>
<td>141.4</td>
<td>8.4</td>
<td>23.3</td>
<td>139</td>
<td>22.7</td>
</tr>
<tr>
<td>Chlamydia Cases</td>
<td>1,244,180</td>
<td>118,577</td>
<td>13,368.0</td>
<td>4,356</td>
<td>74</td>
<td>103</td>
<td>355</td>
<td>279</td>
<td>207</td>
<td>15</td>
<td>7,879</td>
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<tr>
<td>Chlamydia Rate</td>
<td>409.19</td>
<td>467.3</td>
<td>533.7</td>
<td>2,734.8</td>
<td>186.4</td>
<td>188.5</td>
<td>209.6</td>
<td>540.5</td>
<td>174.8</td>
<td>174.5</td>
<td>431.6</td>
<td>162.4</td>
</tr>
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</table>

Source: Centers for Disease Control (Rates per 100,000)

### Figure D-3.4: Natality in Region 10 in 2008

<table>
<thead>
<tr>
<th>Total Live Births (Cases)</th>
<th>Texas</th>
<th>RHP 10</th>
<th>Ellis</th>
<th>Erath</th>
<th>Hood</th>
<th>Johnson</th>
<th>Navarro</th>
<th>Parker</th>
<th>Somervell</th>
<th>Tarrant</th>
<th>Wise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Live Births (Cases)</td>
<td>405,242</td>
<td>37,852</td>
<td>2,097</td>
<td>509</td>
<td>585</td>
<td>2,210</td>
<td>709</td>
<td>1,390</td>
<td>111</td>
<td>29,424</td>
<td>817</td>
</tr>
<tr>
<td>Adolescent Mothers under 18 Years of Age (Cases)</td>
<td>19,775</td>
<td>1,622</td>
<td>91</td>
<td>17</td>
<td>18</td>
<td>99</td>
<td>44</td>
<td>57</td>
<td>6</td>
<td>1259</td>
<td>31</td>
</tr>
<tr>
<td>Adolescent Mothers under 18 Years of Age (%)</td>
<td>4.9%</td>
<td>4.3%</td>
<td>4.3%</td>
<td>3.3%</td>
<td>3.1%</td>
<td>4.5%</td>
<td>6.2%</td>
<td>4.1%</td>
<td>5.4%</td>
<td>4.3%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Low Birth Weight (Cases)</td>
<td>34,228</td>
<td>3,056</td>
<td>162</td>
<td>31</td>
<td>36</td>
<td>161</td>
<td>58</td>
<td>93</td>
<td>8</td>
<td>2452</td>
<td>55</td>
</tr>
<tr>
<td>Low Birth Weight (%)</td>
<td>8.4%</td>
<td>7.2%</td>
<td>7.7%</td>
<td>6.1%</td>
<td>6.2%</td>
<td>7.3%</td>
<td>8.2%</td>
<td>6.7%</td>
<td>7.2%</td>
<td>8.3%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Onset of Prenatal Care within First Trimester (Cases)</td>
<td>223,961</td>
<td>19,584</td>
<td>1,136</td>
<td>285</td>
<td>385</td>
<td>1,264</td>
<td>303</td>
<td>798</td>
<td>64</td>
<td>14912</td>
<td>437</td>
</tr>
<tr>
<td>Onset of Prenatal Care within First Trimester (%)</td>
<td>60.1%</td>
<td>58.1%</td>
<td>54.0%</td>
<td>57.7%</td>
<td>64.8%</td>
<td>63.6%</td>
<td>42.1%</td>
<td>59.4%</td>
<td>68.8%</td>
<td>53.5%</td>
<td>59.0%</td>
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</table>

Source: Texas CHS (*Data Pending)
# Figure D-3.5: Mortality Rates per 100,000 persons in Region 10 in 2009

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<thead>
<tr>
<th>Category</th>
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<th>Ellis</th>
<th>Erath</th>
<th>Hood</th>
<th>Johnson</th>
<th>Navarro</th>
<th>Parker</th>
<th>Somervell</th>
<th>Tarrant</th>
<th>Wise</th>
<th>RHP 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Deaths</td>
<td>162,792</td>
<td>2,437,163</td>
<td>997</td>
<td>321</td>
<td>520</td>
<td>1,126</td>
<td>509</td>
<td>857</td>
<td>89</td>
<td>10,478</td>
<td>476</td>
<td>15,373</td>
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<tr>
<td>Disease of the Heart</td>
<td>38,008</td>
<td>599,413</td>
<td>238</td>
<td>84</td>
<td>102</td>
<td>287</td>
<td>98</td>
<td>196</td>
<td>19</td>
<td>2,413</td>
<td>117</td>
<td>3,554</td>
</tr>
<tr>
<td>Cerebrovascular Disease</td>
<td>9,118</td>
<td>128,842</td>
<td>54</td>
<td>36</td>
<td>37</td>
<td>77</td>
<td>24</td>
<td>59</td>
<td>4</td>
<td>635</td>
<td>19</td>
<td>945</td>
</tr>
<tr>
<td>Malignant Neoplasms</td>
<td>35,531</td>
<td>567,628</td>
<td>225</td>
<td>63</td>
<td>123</td>
<td>267</td>
<td>139</td>
<td>200</td>
<td>22</td>
<td>2,349</td>
<td>116</td>
<td>3,504</td>
</tr>
<tr>
<td>Chronic Lower Respiratory disease</td>
<td>8,624</td>
<td>137,353</td>
<td>51</td>
<td>19</td>
<td>32</td>
<td>76</td>
<td>32</td>
<td>72</td>
<td>4</td>
<td>625</td>
<td>40</td>
<td>951</td>
</tr>
<tr>
<td>Nephritis, Nephrotic Syndrome and Nephrosis</td>
<td>*</td>
<td>*</td>
<td>17</td>
<td>3</td>
<td>10</td>
<td>26</td>
<td>6</td>
<td>18</td>
<td>2</td>
<td>217</td>
<td>8</td>
<td>307</td>
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<tr>
<td>Accidents</td>
<td>9,310</td>
<td>118,021</td>
<td>45</td>
<td>23</td>
<td>28</td>
<td>61</td>
<td>16</td>
<td>54</td>
<td>10</td>
<td>537</td>
<td>33</td>
<td>807</td>
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<tr>
<td>Diabetes</td>
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<td>4</td>
<td>11</td>
<td>29</td>
<td>25</td>
<td>16</td>
<td>1</td>
<td>273</td>
<td>10</td>
<td>398</td>
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<td></td>
</tr>
<tr>
<td>Alzheimer's</td>
<td>5,062</td>
<td>79,003</td>
<td>36</td>
<td>8</td>
<td>39</td>
<td>14</td>
<td>30</td>
<td>43</td>
<td>5</td>
<td>287</td>
<td>17</td>
<td>479</td>
</tr>
<tr>
<td>Influenza and pneumonia</td>
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<td>*</td>
<td>11</td>
<td>5</td>
<td>10</td>
<td>27</td>
<td>10</td>
<td>23</td>
<td>0</td>
<td>194</td>
<td>9</td>
<td>289</td>
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<td>Assault</td>
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<td>4</td>
<td>2</td>
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<td>92</td>
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<td>9</td>
<td>21</td>
<td>8</td>
<td>12</td>
<td>2</td>
<td>170</td>
<td>9</td>
<td>245</td>
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<td>Septicemia</td>
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<td>*</td>
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<td>1</td>
<td>7</td>
<td>7</td>
<td>8</td>
<td>7</td>
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<td>176</td>
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<td>227</td>
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<td>Chronic liver disease and Cirrhosis</td>
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<td>5</td>
<td>7</td>
<td>13</td>
<td>6</td>
<td>14</td>
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<td>162</td>
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<td>4</td>
<td>19</td>
<td>3</td>
<td>11</td>
<td>1</td>
<td>194</td>
<td>3</td>
<td>252</td>
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</tr>
<tr>
<td>Fetal deaths</td>
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<td>7</td>
<td>13</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>189</td>
<td>2</td>
<td>230</td>
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</tbody>
</table>

*Data Pending
Source: Texas CHS
Figure D-3.6: Preventable Hospitalizations in Region 10 in 2010

<table>
<thead>
<tr>
<th>Condition</th>
<th>Region 10</th>
<th>Ellis</th>
<th>Erath</th>
<th>Hood</th>
<th>Johnson</th>
<th>Navarro</th>
<th>Parker</th>
<th>Somervell</th>
<th>Tarrant</th>
<th>Wise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacterial Pneumonia (Cases)</td>
<td>4,628</td>
<td>360</td>
<td>79</td>
<td>109</td>
<td>544</td>
<td>137</td>
<td>288</td>
<td>0</td>
<td>2,951</td>
<td>160</td>
</tr>
<tr>
<td>(Rates)</td>
<td>135.2</td>
<td>118.3</td>
<td>174.2</td>
<td>127.0</td>
<td>169.6</td>
<td>310.0</td>
<td>136.0</td>
<td>0</td>
<td>126.8</td>
<td>208.0</td>
</tr>
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<td>Dehydration (Cases)</td>
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<td>66</td>
<td>15</td>
<td>27</td>
<td>86</td>
<td>31</td>
<td>48</td>
<td>0</td>
<td>534</td>
<td>30</td>
</tr>
<tr>
<td>(Rates)</td>
<td>43.2</td>
<td>32.8</td>
<td>26.4</td>
<td>23.4</td>
<td>66.3</td>
<td>75.4</td>
<td>53.9</td>
<td>0</td>
<td>41.6</td>
<td>44.0</td>
</tr>
<tr>
<td>Urinary Tract Infection (Cases)</td>
<td>3,287</td>
<td>177</td>
<td>66</td>
<td>65</td>
<td>256</td>
<td>148</td>
<td>159</td>
<td>0</td>
<td>2,293</td>
<td>123</td>
</tr>
<tr>
<td>(Rates)</td>
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<td>67.5</td>
<td>58.1</td>
<td>66.4</td>
<td>109.3</td>
<td>140.4</td>
<td>83.8</td>
<td>0</td>
<td>81.0</td>
<td>55.8</td>
</tr>
<tr>
<td>Angina (without procedures) (Cases)</td>
<td>247</td>
<td>16</td>
<td>0</td>
<td>10</td>
<td>28</td>
<td>15</td>
<td>20</td>
<td>0</td>
<td>150</td>
<td>8</td>
</tr>
<tr>
<td>(Rates)</td>
<td>190.4</td>
<td>240.6</td>
<td>208.5</td>
<td>213.0</td>
<td>360.4</td>
<td>287.0</td>
<td>246.3</td>
<td>0</td>
<td>163.1</td>
<td>270.6</td>
</tr>
<tr>
<td>Congestive Heart Failure (Cases)</td>
<td>4,736</td>
<td>294</td>
<td>77</td>
<td>122</td>
<td>471</td>
<td>187</td>
<td>223</td>
<td>8</td>
<td>3,271</td>
<td>83</td>
</tr>
<tr>
<td>(Rates)</td>
<td>194.8</td>
<td>196.5</td>
<td>203.2</td>
<td>238.4</td>
<td>312.1</td>
<td>391.7</td>
<td>190.7</td>
<td>94.2</td>
<td>180.8</td>
<td>140.4</td>
</tr>
<tr>
<td>Hypertension (Cases)</td>
<td>1,049</td>
<td>49</td>
<td>10</td>
<td>12</td>
<td>100</td>
<td>36</td>
<td>63</td>
<td>0</td>
<td>753</td>
<td>26</td>
</tr>
<tr>
<td>(Rates)</td>
<td>46.7</td>
<td>36.8</td>
<td>44.9</td>
<td>23.4</td>
<td>62.9</td>
<td>60.8</td>
<td>38.5</td>
<td>0</td>
<td>47.3</td>
<td>45.7</td>
</tr>
<tr>
<td>Asthma (Cases)</td>
<td>1,558</td>
<td>115</td>
<td>21</td>
<td>18</td>
<td>220</td>
<td>32</td>
<td>85</td>
<td>6</td>
<td>1,033</td>
<td>28</td>
</tr>
<tr>
<td>(Rates)</td>
<td>34.4</td>
<td>44.1</td>
<td>39.6</td>
<td>52.8</td>
<td>57.0</td>
<td>64.9</td>
<td>41.1</td>
<td>0</td>
<td>29.5</td>
<td>50.7</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>Region 10</td>
<td>Ellis</td>
<td>Erath</td>
<td>Hood</td>
<td>Johnson</td>
<td>Navarro</td>
<td>Parker</td>
<td>Somervell</td>
<td>Tarrant</td>
<td>Wise</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>---------</td>
<td>---------</td>
<td>--------</td>
<td>-----------</td>
<td>---------</td>
<td>------</td>
</tr>
<tr>
<td>Cases</td>
<td>3,300</td>
<td>198</td>
<td>55</td>
<td>99</td>
<td>367</td>
<td>164</td>
<td>225</td>
<td>6</td>
<td>2,090</td>
<td>96</td>
</tr>
<tr>
<td>Rates</td>
<td>10.2</td>
<td>10.7</td>
<td>0</td>
<td>19.5</td>
<td>18.6</td>
<td>31.4</td>
<td>17.1</td>
<td>0</td>
<td>8.3</td>
<td>13.5</td>
</tr>
<tr>
<td>Diabetes Short-term Complications</td>
<td>1,136</td>
<td>55</td>
<td>17</td>
<td>12</td>
<td>95</td>
<td>29</td>
<td>45</td>
<td>0</td>
<td>856</td>
<td>27</td>
</tr>
<tr>
<td>Cases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rates</td>
<td>135.8</td>
<td>132.3</td>
<td>145.2</td>
<td>193.4</td>
<td>243.2</td>
<td>343.6</td>
<td>192.4</td>
<td>70.7</td>
<td>115.5</td>
<td>162.4</td>
</tr>
<tr>
<td>Diabetes Long-term Complications</td>
<td>1,986</td>
<td>101</td>
<td>22</td>
<td>34</td>
<td>165</td>
<td>67</td>
<td>98</td>
<td>0</td>
<td>1,466</td>
<td>33</td>
</tr>
<tr>
<td>Cases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rates</td>
<td>64.1</td>
<td>76.9</td>
<td>55.4</td>
<td>35.2</td>
<td>145.8</td>
<td>67.0</td>
<td>72.7</td>
<td>70.7</td>
<td>57.1</td>
<td>47.4</td>
</tr>
<tr>
<td>Total</td>
<td>22,764</td>
<td>1,431</td>
<td>362</td>
<td>508</td>
<td>2,332</td>
<td>846</td>
<td>1,254</td>
<td>20</td>
<td>15,397</td>
<td>614</td>
</tr>
</tbody>
</table>

Source: Texas CHS

**Figure D-3.7: Health Outcomes in Region 10 in 2009**

<table>
<thead>
<tr>
<th>Texas</th>
<th>RHP 10</th>
<th>Ellis</th>
<th>Erath</th>
<th>Hood</th>
<th>Johnson</th>
<th>Navarro</th>
<th>Parker</th>
<th>Somervell</th>
<th>Tarrant</th>
<th>Wise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor or Fair Health</td>
<td>19%</td>
<td><strong>17%</strong></td>
<td>13%</td>
<td>14%</td>
<td>NA</td>
<td>21%</td>
<td>NA</td>
<td>18%</td>
<td>NA</td>
<td>16%</td>
</tr>
<tr>
<td>Poor Physical Health Days*</td>
<td>3.6</td>
<td><strong>3.49</strong></td>
<td>25</td>
<td>22</td>
<td>5</td>
<td>4.8</td>
<td>4.1</td>
<td>3.2</td>
<td>NA</td>
<td>3.1</td>
</tr>
<tr>
<td>Poor Mental Health Days*</td>
<td>3.3</td>
<td><strong>3.39</strong></td>
<td>2.5</td>
<td>2.7</td>
<td>3.4</td>
<td>4.9</td>
<td>3.7</td>
<td>2.9</td>
<td>NA</td>
<td>3.1</td>
</tr>
</tbody>
</table>

*in the past 30 days
Source: County Health Rankings 2010
### Figure D-3.1: Region 10 Health Behaviors, by County, in 2011

<table>
<thead>
<tr>
<th></th>
<th>U.S.</th>
<th>Texas</th>
<th>RHP 10</th>
<th>Ellis</th>
<th>Erath</th>
<th>Hood</th>
<th>Johnson</th>
<th>Navarro</th>
<th>Parker</th>
<th>Somervell</th>
<th>Tarrant</th>
<th>Wise</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Smoking</strong></td>
<td>14%</td>
<td>19%</td>
<td>19%</td>
<td>20%</td>
<td>12%</td>
<td>22%</td>
<td>23%</td>
<td>N/A</td>
<td>18%</td>
<td>N/A</td>
<td>18%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Adult Obesity</strong></td>
<td>25%</td>
<td>29%</td>
<td>30%</td>
<td>30%</td>
<td>28%</td>
<td>30%</td>
<td>32%</td>
<td>32%</td>
<td>32%</td>
<td>29%</td>
<td>28%</td>
<td>32%</td>
</tr>
<tr>
<td><strong>Physical Inactivity</strong></td>
<td>21%</td>
<td>25%</td>
<td>28%</td>
<td>25%</td>
<td>26%</td>
<td>26%</td>
<td>30%</td>
<td>31%</td>
<td>30%</td>
<td>28%</td>
<td>22%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Excessive Drinking</strong></td>
<td>8%</td>
<td>16%</td>
<td>15%</td>
<td>18%</td>
<td>16%</td>
<td>17%</td>
<td>17%</td>
<td>9%</td>
<td>13%</td>
<td>N/A</td>
<td>15%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source: Community Health Rankings

### Figure D-3.2: Access to Healthy Foods, 2012

<table>
<thead>
<tr>
<th></th>
<th>U.S.</th>
<th>Texas</th>
<th>RHP 10</th>
<th>Ellis</th>
<th>Erath</th>
<th>Hood</th>
<th>Johnson</th>
<th>Navarro</th>
<th>Parker</th>
<th>Somervell</th>
<th>Tarrant</th>
<th>Wise</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Limited Access to Healthy Foods</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% population with low income and do not live close to a grocery store</td>
<td>N/A</td>
<td>12%</td>
<td>10%</td>
<td>16%</td>
<td>3%</td>
<td>1%</td>
<td>18%</td>
<td>4%</td>
<td>19%</td>
<td>0%</td>
<td>8%</td>
<td>21%</td>
</tr>
<tr>
<td><strong>Fast Food Restaurants</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of all restaurants that are fast food establishments</td>
<td>25%</td>
<td>53%</td>
<td>52%</td>
<td>56%</td>
<td>53%</td>
<td>47%</td>
<td>60%</td>
<td>56%</td>
<td>57%</td>
<td>44%</td>
<td>56%</td>
<td>43%</td>
</tr>
</tbody>
</table>

Source: Community Health Rankings
### D-4: County-specific findings

As part of the outreach process for the RHP, county visioning sessions were held throughout the Region. The purpose of these sessions are to bring together local leadership, stakeholders and performing providers to discuss local health care needs, resources and gaps in the current delivery system, develop a local vision and goals for health care delivery and identify potential opportunities for county and Regional collaboration. The county visioning sessions were also a means to facilitate discussions between providers in the same county about the current health data presented and what their perceived experiences in their service area. These discussions provided a qualitative look at local health care needs and are intended to supplement the quantitative findings in this report. We also aggregated information from various assessments, reports and data that were submitted by Regional providers.

#### ELLIS COUNTY

**Health care Needs**
- Increased psychiatry patients
- Lack of Communicable Disease Management Programs
- Tremendous shortage to Dental care
- Lack of substance abuse services
- Lack of Transportation
- Lack of Care Management Programs
- High need for Behavioral Health Programs
- Lack of Urgent Care
- Increase need for Medicare Providers
- 85% patients have Diabetes
- Lack of geriatric beds

**Workforce Needs**
- Mobile Services staff
- Psychiatry Physicians
- Medicare/Medicaid providers

#### HOOD COUNTY

**Health care Needs**
- Lack of on site psychiatrist
  - Currently have telemedicine psychiatrists
- Fragmented care coordination between primary care and psychiatry
- Uninsured/underinsured do not have access to care
- Lack of patient education programs
- Language barriers between patients and providers
- Affordability of care
- Increased group of Latino population need care
- Asthma is highly prevalent in Hood county

**Workforce Needs**
- Psychiatric nurses
- OR nurses
- Fully trained nurses
JOHNSON COUNTY

Health care Needs
- Need for additional Mental Health Professionals (Only one in County)
- CMHC: over utilization → 600 patients
- Limited access to MHMR
- Lack of access to urgent care

SOMERVELL COUNTY

Health care Needs
- Increasing need for Mental Health Providers
- Lack Substance Abuse
  - No plans for residential treatment → MHMR looking at outpatient service
  - Not funded through State → Medicaid or private pay
  - No services for non paying patients
- Catastrophic injuries that are not funded → very expensive
- Medically complex patients are missing care at Somervell County → they are going somewhere else for care
- Need for ICU (5% transfer from ED → Baylor, THR)
- Need postdischarge support for target-based populations: No formal process in place
- Lack of substance abuse programs
- No OB services
- Need on-site psychiatrists
- Need physical therapists

ERATH COUNTY

Health care Needs
- Diabetes Management Program
- Lack of coverage/financial hardship
- Lack of access due to provider distance
- Difficulty navigating the system/lack of awareness of available resources
- Access to routine hospital care, routine primary/preventive care and routine specialty care rated as “difficult” to access in stakeholder survey
- For Mental/behavioral health care the majority of respondents rated it as “very difficult” to access
- Lack of care coordination
- Not enough emergency department beds to meet demand
- Not confident in ability to coordinate with MHMR for postdischarge support and care transitions

NAVARRO COUNTY

Health care Needs
- Lack of access due to provider distance
- Limited financial integration
- Fragmented, stand-alone services
- Lack of staff time
- Ineffective care coordination
PARKER COUNTY

Health care needs
- Difficult to access: (1) Emergency care, (2) Pediatric care, and (3) Specialty care
- Difficulty navigating the system/lack of awareness of available resources
- Lack of capacity (e.g., insufficient provider/extended wait times)
- Eligibility screening process
- Limited health care IT
- Lack of care coordination
- Large number of the patients have no insurance and no access to primary care
- Need to integrate primary care and behavioral health

WISE COUNTY

Health Care Needs
- Routine hospital care, primary care and specialty care are “difficult” to access
- Lack of coverage/financial hardship
- Eligibility screening process
- Limited primary care access
- Lack of some 24 hour specialty care
- Limited care coordination with all physicians
- Lack of population-focused programs
- Long delays in being able to get the patient an appointment for MHMR

TARRANT COUNTY

Health care Needs
- Lack of care coordination due to limited staff time
- Limited Primary care provider involvement in patient care
- Limited Health care IT infrastructure
- Mental/behavioral and substance abuse services are “very difficult” to access
- Lack of capacity (e.g., insufficient provider/extended wait times)

JPS/United Way Community Health Needs Assessments
As part of this community health needs assessment, a review of United Way’s CHNAs from Tarrant County was conducted. The United Way’s CHNA, findings are substantively similar to the findings reported in this Community Needs Assessment. In addition to United Way’s CHNA data for Tarrant County, a review of JPS Health System’s CHNA was also conducted as comparison. The data findings are similar to this Community Needs Assessment. JPS additionally included a section on appointment wait times for new appointments as well as the follow up appointments in different areas within the county. According to JPS’s analysis, it takes longer for a new patient to be scheduled at a primary care clinic than OB/GYN or pediatric facilities. On the contrary, follow up appointment times are longer for OB/GYN or pediatrics than primary care. Additionally, new patient appointment wait times differ in Tarrant County based on the geographical location of the provider or the clinic.
## D-5: Provider Distribution by County

### Ellis County:

<table>
<thead>
<tr>
<th>Acute Care Hospitals</th>
<th>Facilities by Type</th>
<th>Long-Term Care and Rehab Facilities</th>
<th>Mental Health Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baylor Medical Center at Waxahachie</td>
<td>Palmer Medical Clinic</td>
<td>Ennis Care Center</td>
<td></td>
</tr>
<tr>
<td>Ennis Regional Medical Center</td>
<td>HOPE Clinic</td>
<td>Legend Oaks Healthcare and Rehabilitation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Red Oak Health and Rehabilitation Center</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pleasant Manor health and Rehabilitation Center</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Refrelo Healthcare Center</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trinity Mission Health and Rehab of Italy</td>
<td></td>
</tr>
</tbody>
</table>

### Erath County:

<table>
<thead>
<tr>
<th>Acute Care Hospitals</th>
<th>Facilities by Type</th>
<th>Long-Term Care and Rehab Facilities</th>
<th>Mental Health Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Health Harris Methodist Hospital Stephenville</td>
<td>Community Health Clinic LLP</td>
<td>Community Nursing and Rehabilitation Center</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dublin Family Medicine</td>
<td>Stephenville Nursing and Rehabilitation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cross Timbers Health Clinic Stephenville</td>
<td>Castleview Nursing and Rehab of Stephenville</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Golden Age Manor Nursing Center</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mulberry Manor</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Senior Care at Stephenville</td>
<td></td>
</tr>
</tbody>
</table>
### Hood County:

<table>
<thead>
<tr>
<th>Acute Care Hospitals</th>
<th>Facilities by Type</th>
<th>Long-Term Care and Rehab Facilities</th>
<th>Mental Health Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lake Granbury Medical Center</td>
<td></td>
<td>Granbury Vila Nursing Center</td>
<td></td>
</tr>
<tr>
<td>Trinity Mission of Granbury LLC</td>
<td></td>
<td>Senior Care of Harbor Lakes</td>
<td>Granbury Care Center</td>
</tr>
</tbody>
</table>

### Johnson County:

<table>
<thead>
<tr>
<th>Acute Care Hospitals</th>
<th>Facilities by Type</th>
<th>Long-Term Care and Rehab Facilities</th>
<th>Mental Health Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Health Harris Methodist Hospital Cleburne</td>
<td></td>
<td>Alvarado LTC Partners Inc</td>
<td>Grandview Nursing Home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heritage Trials Nursing and Rehabilitation Center</td>
<td>Ridgeview Rehabilitation and Skilled Nursing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Colonial Manor Nursing Center</td>
</tr>
</tbody>
</table>

### Navarro County:

<table>
<thead>
<tr>
<th>Acute Care Hospitals</th>
<th>Facilities by Type</th>
<th>Long-Term Care and Rehab Facilities</th>
<th>Mental Health Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Navarro Regional Hospital</td>
<td></td>
<td>Trisun Care Center</td>
<td></td>
</tr>
<tr>
<td>Grace and Mercy Health Clinic</td>
<td></td>
<td>Country Meadows Nursing and Rehabilitation Center</td>
<td>Kerens Care Center</td>
</tr>
</tbody>
</table>
### Parker County:

<table>
<thead>
<tr>
<th>Acute Care Hospitals</th>
<th>Facilities by Type</th>
<th>Long-Term Care and Rehab Facilities</th>
<th>Mental Health Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weatherford Regional Medical Center</td>
<td>Campbell Clinic</td>
<td>College Park Rehabilitation and Care Center</td>
<td>Pecan Valley MH/MR, Weatherford Clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Holland Lake Nursing Center</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Keeneland nursing and Rehabilitation LP</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Weatherford Health Care Center</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Crescent Senior Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Santa Fe Health and Rehabilitation Center</td>
<td></td>
</tr>
</tbody>
</table>

### Somervell County:

<table>
<thead>
<tr>
<th>Acute Care Hospitals</th>
<th>Facilities by Type</th>
<th>Long-Term Care and Rehab Facilities</th>
<th>Mental Health Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glen Rose Medical Center</td>
<td></td>
<td>Cherokee Rose Nursing and Rehabilitation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Glen Rose Nursing and Rehab Center</td>
<td></td>
</tr>
</tbody>
</table>

### Tarrant County:

<table>
<thead>
<tr>
<th>Acute Care Hospitals</th>
<th>Facilities by Type</th>
<th>Long-Term Care and Rehab Facilities</th>
<th>Mental Health Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baylor All Saints Medical Center at Fort Worth</td>
<td>Northside Community Health Center</td>
<td>Healthsouth City View Rehabilitation Hospital</td>
<td>Millwood Hospital</td>
</tr>
<tr>
<td>Baylor Orthopedic and Spine Hospital at Arlington</td>
<td>Southeast Community Health Center</td>
<td>Healthsouth Rehabilitation Hospital</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>----------------------------------</td>
<td>-----------------------------------</td>
<td></td>
</tr>
<tr>
<td>Baylor Regional Medical Center at Grapevine</td>
<td></td>
<td>Healthsouth Rehabilitation Hospital of Arlington</td>
<td></td>
</tr>
<tr>
<td>Baylor Surgical Hospital at Fort Worth</td>
<td></td>
<td>Ethicus Hospital Grapevine</td>
<td></td>
</tr>
<tr>
<td>Cook Children's Northeast Hospital</td>
<td></td>
<td>Global Rehab Hospital Forth Worth</td>
<td></td>
</tr>
<tr>
<td>Cook Children's Medical Center</td>
<td></td>
<td>Kindred Hospital – Fort Worth</td>
<td></td>
</tr>
<tr>
<td>JPS Health Network</td>
<td></td>
<td>Kindred Hospital – Mansfield</td>
<td></td>
</tr>
<tr>
<td>Medical Center Arlington</td>
<td></td>
<td>Kindred Hospital – Tarrant County</td>
<td></td>
</tr>
<tr>
<td>North Hills Hospital</td>
<td></td>
<td>Kindred Rehabilitation Hospital of Arlington</td>
<td></td>
</tr>
<tr>
<td>Plaza Medical Center of Fort Worth</td>
<td></td>
<td>LifeCare Hospital of Fort Worth</td>
<td></td>
</tr>
<tr>
<td>Methodist Mansfield Medical Center</td>
<td></td>
<td>Regency Hospital – Fort Worth</td>
<td></td>
</tr>
<tr>
<td>Southwest Surgical Hospital</td>
<td></td>
<td>Texas Health Specialty Hospital Fort Worth</td>
<td></td>
</tr>
<tr>
<td>Texas Health Arlington Memorial Hospital</td>
<td></td>
<td>Reliant Rehabilitation Hospital – Mid-Cities</td>
<td></td>
</tr>
<tr>
<td>Texas Health Harris Methodist Hospital Azle</td>
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<td>Texas Health Harris Methodist Hospital Fort Worth</td>
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<td>Texas Health Harris Methodist Hospital Hurst – Euless -Bedford</td>
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<td>Huguley Memorial Medical Center</td>
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<td>Texas Health Harris Methodist Hospital Southlake</td>
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<td>Texas Health Harris Methodist Hospital Southwest Fort Worth</td>
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<tr>
<td>Texas Health Heart &amp; Vascular Hospital</td>
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<tr>
<td>USMD Hospital at Arlington</td>
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<td>USMD Hospital at Fort Worth</td>
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**Wise County:**
<table>
<thead>
<tr>
<th>Acute Care Hospitals</th>
<th>Clinics</th>
<th>Long-Term Care and Rehab Facilities</th>
<th>Mental Health Facilities</th>
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<tr>
<td>Wise Regional Health System</td>
<td>Alvord Medical Clinic</td>
<td>Senior Care health and Rehabilitation Center – Decatur</td>
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<td>North Texas Community Hospital</td>
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<td>Senior Care Health and Rehabilitation Center – Bridgeport</td>
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<td>Decatur Nursing and Rehabilitation LP</td>
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<td>The hills Nursing and Rehabilitation</td>
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D-6: Survey of Provider Participation in Federal Initiatives

Region 10 RHP
Survey of Potential DSRIP Project Overlap with Federally Funded Initiatives

Region 10 RHP is required to submit an RHP plan to the Texas Health and Human Services Commission (HHSC) and to the Centers of Medicare and Medicaid (CMS) on behalf of the Region’s performing providers that details all proposed Delivery System Reform Incentive Payment (DSRIP) projects. CMS and HHSC guidance indicates that they want performing providers to report their participation in all of the federal initiatives listed below.

Please indicate whether your organization participates in any of the following federal initiatives by indicating “YES,” “NO,” or “UNKNOWN.” If you answer “YES” to an initiative, please also indicate which project(s) potentially overlap by its unique DSRIP Project Identifier number.

Thank you for your continued participation in Region 10 RHP!

Performing Provider Name: ______________________________

Texas Medicaid Provider Identifier (TPI): ______________________________

<table>
<thead>
<tr>
<th>FEDERAL INITIATIVE</th>
<th>YES</th>
<th>NO</th>
<th>UNKNOWN</th>
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<tr>
<td>Accountable Care Organizations (ACOs)</td>
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<td>Advance Payment Model</td>
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<td>Pioneer ACO Model Bundled Payments for Care Improvement</td>
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<tr>
<td>Comprehensive Primary Care Initiative</td>
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<tr>
<td>Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration</td>
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<tr>
<td>Graduate Nurse Education Demonstration</td>
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<tr>
<td>Health Care Innovation Awards</td>
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<td></td>
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<tr>
<td>Independence at Home Demonstration</td>
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<td></td>
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<td>FEDERAL INITIATIVE</td>
<td>YES</td>
<td>NO</td>
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<tr>
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<td>Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents</td>
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<td>Medicaid Emergency Psychiatric Demonstration</td>
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<td>Partnership for Patients</td>
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<td>State Innovation Models Initiative</td>
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<tr>
<td>Strong Start for Mothers and Newborns</td>
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<td>☐</td>
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<td>EHR incentive payments</td>
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<td>Health Information Exchange Grant</td>
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<td>Other HITECH grant or payment(s)</td>
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<td>FQHC/RHC/School-based health center grants, including capital grants</td>
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<td>☐</td>
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<tr>
<td>Health professions loans and workforce development grants</td>
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<tr>
<td>Ryan White funding</td>
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<td>Maternal and child health grants</td>
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<td>Community Mental Health Services Block Grant</td>
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<td>Substance Abuse Prevention and Treatment Block Grant</td>
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<td>Projects for Assistance in Transition from Homelessness (PATH)</td>
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<td>Protection and Advocacy for Individuals with Mental Illness (PAIMI)</td>
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<td>Other mental health and substance abuse grants:</td>
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<td>PLEASE REFER TO THIS PAGE FOR SPECIFIC GRANT DETAILS</td>
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<td>PLEASE LIST ANY OTHER PERTINENT GRANTS:</td>
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<tr>
<td>Immunization grants</td>
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<td>CLASBI/ Hospital acquired infection initiatives</td>
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<td><a href="http://www.cdc.gov/about/business/state_funding.htm">http://www.cdc.gov/about/business/state_funding.htm</a></td>
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</table>
D-6.1: List of Provider Participation in Federal Initiatives

Baylor All-Saints Medical Center at Fort Worth
Not participating in any federally funded initiatives

Cook Children’s Medical Center
- Ryan White Funds
- Maternal and Child Health Grants

Helen Farabee Centers
Not participating in any federally funded initiatives

Lakes Regional MHMR
Not participating in any federally funded initiatives

Texas Health Fort Worth
Not participating in any federally funded initiatives

Ennis Regional Medical Center
- EHR Incentive Payments

Glen Rose Medical Center
- EHR Incentive Payments
JPS Health Network

- Strong Start for Mothers and Newborns
- EHR Incentive Payments
- FQHC/RHC/School-Based health center grants, including capital grants
- Ryan White funding
- Maternal and Child Health grants
- Community Mental Health Services block grant
- Substance Abuse Prevention and Treatment block grant
- Immunization grants

JPS Physician Group

- EHR Incentive Payment
- Health Information Exchange Grant

HCA - Medical Center of Arlington, North Hills Hospital, and Plaza Medical Center Forth Worth

- Partnership for Patients
- Other HITECH grant or payment
- Health professions loans and workforce development grants

Methodist Mansfield Medical Center

- EHR incentive payments

MHMR of Tarrant County

- EHR incentive payments
- Community Mental Health services block grant
- Substance Abuse Prevention and Treatment Block Grant
- Projects for Assistance in Transition from Homelessness (PATH)
- Other mental health and substance abuse grants
Pecan Valley Centers for Behavioral and Developmental Healthcare
- Community Mental Health services block grant

Tarrant County Public Health
- Ryan White funding
- Immunization grants
- Other CDC grants

Texas Health Forth Worth Methodist Hospital
- Accountable Care Organizations
- EHR incentive payments
- Health Information Exchange Grant

Texas Health HEB
- EHR incentive payments

University of North Texas Health Science Center
- Health Care Innovation Awards
- EHR incentive payments
- Health Information Exchange Grant
- Other CDC grants
- HRSA funds

Wise Clinical Care Associates
- EHR incentive payments
Wise Regional Health System

- EHR incentive payments
COMMUNITY NEEDS ASSESSMENT RESOURCES

Data Sources

- American Factfinder (www.factfinder2.census.gov)
- Centers for Disease Control – Behavioral Risk Factor Surveillance System (http://apps.nccd.cdc.gov/brfss-smart/SelMMSAPrevData.asp)
- Centers for Disease Control – Office of Minority Health and Health Disparities (www.cdc.gov/omhd/populations/definitionsREMP.htm)
- Center for Health Statistics (www.dhs.state.tx.us/chs/datalist.shtm)
- County Health Rankings (www.countyhealthrankings.org)
- Health Indicators Warehouse (www.healthindicators.gov)
- Health Professional Shortage Areas (http://hpsafind.hrsa.gov/)
- Health Resources County Comparison Tool (http://arf.hrsa.gov/arfwebtool/index.htm)
- Health Resources Services Administration (http://bhpr.hrsa.gov/shortage/hpsas/index.html)
- Kaiser Family Foundation (www.kff.org)
- Medically Underserved Areas (http://muafind.hrsa.gov/index.aspx)
- State Health Facts (www.statehealthfacts.org)
- Texas Department of State Health Services (www.dhs.state.tx.us/chs/healthcurrents/)
- Texas Department of State Health Services (www.dhs.state.tx.us/diabetes/tdcdata.shtm)
- Thompson Reuters, 2011
- United States Census Bureau (www.census.gov/population/www/projections/projectionsagesex.html)
- United States Census Bureau – (http://quickfacts.census.gov/qfd/states/48000.html)
- United States Department of Health & Human Services – Community Health Status Indicators (http://www.communityhealth.hhs.gov/homepage.aspx?j=1)
D-7: References and Citations

COMMUNITY NEEDS ASSESSMENT RESOURCES

References

This document defines primary care as family medicine, internal medicine, and pediatric medicine.

2 NHIS 2001-2005 Overcoming Obstacles to Health
3 The federal poverty level is $10,890 for an individual, or $22,350 for a family of four, in 2011.
5 Region 10 Stakeholder Survey (Appendix D-2.2)
6 Region 10 RHP County Visioning Sessions