July 1, 2013 - June 30, 2016

Community Health Needs Assessment

FINAL

Approved by:
Mission and Community Benefits Committee
April 11, 2013

Approved by:
Baylor Health Care System Board of Trustees
April 23, 2013

Approved by:
Baylor Health Care System Operation, Policy and Procedure Board
May 28, 2013
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Executive Summary

Baylor Regional Medical Center at Grapevine (Baylor Grapevine) 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 Baylor Grapevine 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 Grapevine—an affiliate of Baylor Health Care System—is a not-for-profit hospital that serves the residents of more than 20 cities throughout the Dallas/Fort Worth area. Striving to be the best place to give and receive safe, quality, compassionate health care, the 256-bed hospital offers advanced medical services for cardiovascular care, women's health, diagnostic imaging, neonatal intensive care, sleep disorders, intensive and emergency care, and more.

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 Baylor Grapevine. 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 consolidates information from the recent community health needs assessments conducted for Texas’ Regional Healthcare Partnership Region 9 (Region 9 RHP) and Region 10 (Region 10 RHP), as well as the Consumer Health Report conducted by the National Research Corporation (NRC) for Baylor Grapevine. Each of these reports was developed with input from people representing the broad interest of the community and people with special knowledge or expertise in public health.

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, the Region 9 RHP report, and the Consumer Health Report revealed the following community health needs in the Baylor Grapevine community.

- Multiple Chronic Conditions
  - Compared to the region, state and nation, the community is at a higher risk for several chronic conditions.
  - 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.
  - The NRC consumer survey identified the following chronic conditions as high risk for the TSA when compared to the region, state or nation: allergies, depression and sleep problems.
  - The CHNA identified Region 10’s more prevalent conditions including:
    - Diabetes
    - Obesity
    - Hypertension
    - Heart failure
    - Chronic obstructive pulmonary disease (COPD)
  - 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
  - Comparing all TSA residents to those with very low incomes (below $25,000) finds those with very low incomes have higher percentages of the following conditions:
    - Asthma
    - Diabetes
    - Sciatica/Chronic Back Pain
    - Cancer (not skin)
  - Comparing all TSA residents with those with low incomes ($25,000 - $49,999) finds those with low incomes have higher percentages of the following conditions:
    - Chronic heartburn
- Indigestion/irritable bowel
- Heart disease
- Attention deficit disorder

**Preventive Health Screenings**
- According to *Healthy People 2010*, the community has not achieved several national preventive health metrics.
- However, preventive health behavior services for underserved households in the TSA exceed the market average in the following areas:
  - Body mass index screening
  - Mental health screening
  - Weight loss programs
  - Pre-natal care
- Preventive health behavior services for underserved households in the TSA fall below the market average in the following areas:
  - Blood pressure testing
  - Eye exams
  - Cholesterol testing
  - Dental exams
  - Flu shots
  - Routine physical exams
  - Mammograms
  - Pap smear
  - Diabetes screenings
  - Colon screenings
  - Child immunizations
  - Hearing testing
  - Cardiovascular stress testing
  - Prostate screening
  - Osteoporosis screening
  - Smoking cessation
  - Carotid artery screening
- 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...
- 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.

**Capacity–Primary and Specialty Care**
- RHP 9 identified that the demand for primary and specialty care services exceeds available physicians in these areas, thus limiting health care access.

**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 a consumer survey of the hospital’s service area, less than half (45 percent) of respondents reported seeking access to routine health care. In addition, a majority of respondents stated they did not believe 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.

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 Health—Adult, Pediatric and Jail Populations
- Behavioral health—either as a primary or secondary condition—accounts for substantial patient volume and costs for health care providers, and is often utilized
at capacity. Despite this, behavioral health remains a substantial unmet need in the population.

- The presence of a co-occurring behavioral health condition is associated with increased case severity of medical encounters and a 36 percent increase in the average charges-per-encounter. In RHP 9, 100 percent of the 10 most frequently admitted patients had a co-occurring behavioral health diagnosis. These 10 individuals incurred more than $26 million in costs between 2007 and 2011; however, only one-fifth of their hospital emergency department visits were for a mental health or substance abuse issue. Sixty-one percent of those 10 individuals were uninsured, while 24 percent were on Medicaid, 12 percent were on Medicare and 3 percent were insured.

- The structure of the behavioral health system (including mental health and substance abuse) in RHP 9 struggles to meet the demand of patients in the community. Unlike most of Texas, the majority of behavioral health services for Medicaid and indigent patients are delivered through the NorthSTAR program instead of the traditional Local Mental Health Authority (LMHA) system. NorthSTAR provides both mental health and substance abuse treatment to over 60,000 Medicaid enrollees and indigent uninsured annually. While NorthSTAR has greatly expanded access to care, it has struggled with funding and infrastructure challenges. The growth in enrollment has outpaced funding such that the funding per person served is 30 percent less than when the program started in 1999 and is half that of the state average for other LMHAs. Texas is 50th in mental health funding nationwide, and therefore the funding per person served in RHP 9 is among the lowest in the nation.

- The number of NorthSTAR enrollees booked into jail has been steadily increasing, and 27 percent of all bookings to the Dallas County Jail are currently referred to jail behavioral health 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.

- **Emergency Department (ED) Usage and Readmissions**
  - ED visits are on the rise, and EDs are becoming overcrowded due to reduced inpatient capacity and impaired patient flow.
  - An analysis of ED encounters demonstrates that many members of the population are accessing EDs for both urgent and non-urgent conditions. This is mostly due to the patient’s lack of understanding of their medical conditions, and/or uninsured/underinsured status. The RHP 9 finds the following related to ED usage:
    - Over the most recent four quarters of available data, conditions for which the most volume of care was provided in an emergency outpatient setting were: low back pain, hypertension, pain/joint aching, chronic bronchitis and asthma.
    - Further assessment demonstrates that, with the exception of asthma, over 68 percent of encounters for the top primary health conditions listed above were either non-emergent or emergent/primary care treatable, meaning that the care could have been provided effectively in a primary care setting.
    - For ED encounters that resulted in a hospital admission, the most common health conditions by volume were stroke, diabetes, congestive heart failure, weak/failing kidneys, chronic bronchitis and heart attack.
    - When reviewing by payer type, diabetes is the top condition for the uninsured and Medicaid.

- **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 accessibly 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.”

- **Osteoporosis**
  - In the hospital’s TSA, 12 percent of residents identified as having osteoporosis. The Healthy People 2010 goal is to reduce the presence of osteoporosis to 8 percent in adults 50 years of age and older.

- **Smoking Cessation**
The Healthy People 2010 goal is to reduce smoking to 12 percent of adults 18 years of age and older. In the hospital’s TSA, 23 percent of respondents identified as being a smoker. Smoking in the TSA ranges from 18 percent of adults in Tarrant and Parker counties to 23 percent in Johnson County.

- **High Blood Pressure**
  - The Healthy People 2010 goal is to reduce the percentage of the adult population with high blood pressure to 16 percent. In the hospital’s TSA, 33 percent of residents report high blood pressure.

- **Obesity**
  - The Healthy People 2010 goal is to reduce the proportion of adults 18 years of age and older who are obese by 15 percent. In the TSA, 16 percent of respondents taking the survey identified as being obese.
  - The Region’s top identified health behaviors negatively impacting and influencing health outcomes are adult obesity (30 percent) and physical inactivity (28 percent). Obesity ranges from 28 percent of adults in Tarrant County to 32 percent of adults in Parker and Johnson counties.

- **Patient Safety and Hospital-acquired Conditions**
  - Hospitals in the region address patient safety and care quality on a daily basis. They are paramount for any health care entity. An ongoing, coordinated effort among providers is needed to improve patient safety and quality throughout the region.
  - The Dallas Fort Worth Hospital Council Foundation’s (DFWHCF) 77 hospitals had 1,706 adverse hospital events in 2010. These events included air embolism, Legionnaires, iatrogenic pneumothorax, delirium, blood incompatibility, glycemic control issues and *clostridium difficile*–none of which are included in the 10 adverse events specified by Centers for Medicaid and Medicare Service (CMS).

- **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.

- Pediatric Services and Prenatal Care
  - Immunizations and dental care for Region 10 children are below Healthy People 2010 targets. Parker County was identified as an area where it is difficult to access pediatric care.
  - The Healthy People 2010 goals of 90 percent of prenatal care beginning in the first trimester of pregnancy and 90 percent early and adequate prenatal care are not being met in the TSA. However, TSA counties are faring better than the Texas state average on most these measures.
  - Live births in the TSA ranged from 585 in Hood County and 1,390 in Parker County to 29,400 in Tarrant County.
  - 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.
  - 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.
  - 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.

- 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.

The identified community health needs as outlined below were reviewed and prioritized with input from BHCS senior leadership, the BHCS Mission and Community Benefit Committee and approved by the BHCS Board of Trustees. In prioritizing the needs of the community BHCS adopted the methodology established in the collaborated CHNAs used for this assessment. Priority will be assigned as follows:

- Needs identified as Top Priorities in the each of the collaborated CHNAs are assigned High Priority for BHCS.
- Needs identified as Top Priorities in more than one of the collaborated CHNAs are assigned Medium Priority for BHCS.
- Needs identified as Top Priorities in only one of the collaborated CHNAs are assigned Low Priority for BHCS.

In developing a plan to address all identified community health needs, the Hospital and the System found that aggregating the needs allows for significant, crosscutting initiatives. Therefore, the Hospital’s community health implementation plan organizes the aggregated, prioritized needs as follows:

**High Priority**

- Access to Care
- Multiple Chronic Conditions

**Medium Priority**

- Preventive Health Screenings
- Behavioral Health
- Emergency and Urgent Care

**Low Priority**

- Patient Safety and Hospital-acquired Conditions
- Care Coordination and Care Transitions
- Pediatric Services and Prenatal Care
- Dental Care
Key Contributors

Regional Healthcare Partnership Region 9

- Baylor Health Care System
- Children’s Medical Center
- Dallas County Medical Society
- Dallas Fort Worth Hospital Council
- HCA North Texas
- Lakes Regional MHMR
- Methodist Health System
- North Texas Behavioral Authority
- Parkland Health and Hospital System
- Texas Health Resources
- Texas Scottish Rite Hospital for Children
- University of Texas Southwestern Medical Center

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 Region 9 RHP report and the Baylor Grapevine Consumer Health Report conducted by National Research Corporation (NRC). The methodology for each 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 the Baylor Grapevine management and BHCS senior leadership. In prioritizing the needs of the community BHCS adopted the methodology established in the collaborated CHNAs used for this assessment. Priority will be assigned as follows: Needs identified as Top Priorities in the each of the collaborated CHNAs are assigned High Priority for BHCS. Needs identified as Top Priorities in more than one of the collaborated CHNAs are assigned Medium Priority for BHCS. Needs identified as Top Priorities in only one of the collaborated CHNAs are assigned Low Priority for BHCS.

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.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.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)
Regional Healthcare Partnership Region 9
The Texas Health and Human Services Commission originally defined the geographic boundaries of RHP 9 as Collin, Dallas, Denton, Ellis, Fannin, Grayson, Kaufman, Navarro and Rockwall counties. However, subsequently, in May 2012, the Health and Human Services Commission issued a revised state map, reducing RHP 9 to two counties: Dallas and Kaufman. In analyzing demographic and patient flow patterns, it was determined that the CHNA would cover the original Texas Health and Human Services Commission-defined region. Specific county information is available as appropriate and provided in this report.

To conduct this CHNA, a CHNA Task Force was convened with representatives from local hospitals, medical centers, and other health care providers from a multi-county geographic area. Members of the CHNA Task Force included experts from the following organizations: Baylor Health Care System; Children’s Medical Center; Dallas County Behavioral Health Leadership Team; Dallas County Medical Society; HCA North Texas; Homeward Bound; Methodist Health System; North Texas Behavioral Health Authority; Parkland Health and Hospital System; Scottish Rite Hospital for Children; Texas Health Resources; UT Southwestern Medical Center; ValueOptions of Texas.

This core planning team reviewed and identified the regional priorities through data analysis, expert presentations and committee feedback. The criteria used by the Task Force to identify the regional priorities were: degree of population impact, financial burden on the health care system, alignment with intervention categories, and health issues whose solutions lend themselves to regional-based approaches. Whenever possible, regional, county and local data were obtained for assessment. Indicators and data sources were selected based on consistency and availability of data from reliable data sources.
Baylor Regional Medical Center at Grapevine Service Area Survey
The NRC Consumer Health Report provides a detailed summary of the health needs, health status, behaviors and perceptions of residents within Baylor Grapevine’s community. The NRC Consumer Health Report is conducted annually across communities in more than 200 of the nation's largest metropolitan statistical areas (MSAs). State and national surveys also are conducted.

Sample Size
The Baylor Grapevine TSA sample for 2011 was comprised of 707 households. The standard error range for the sample was ± 3.7 percent at the 95 percent confidence level.

Benchmarks
The Dallas-Fort Worth-Arlington CBSA sample for 2011 was comprised of 5,694 households. The standard error range for the sample was ± 1.3 percent at the 95 percent confidence level.

The Texas sample for 2011 was comprised of 20,075 households. The standard error range for the sample was ± 0.7 percent at the 95 percent confidence level.

The national sample for 2011 was comprised of 278,824 households, which includes the largest 180 MSAs within the U.S. The standard error range for the sample was ± 0.2 percent at the 95 percent confidence level.

Survey Instrument
The survey document was an Internet-based questionnaire that respondents received through Internet invitations. The questionnaires were developed utilizing NRC’s experience in the design and implementation of hundreds of consumer research studies. Questions were designed to meet the objectives as determined by the combined input of health care marketing directors and strategic planners nationwide.

The questions were presented in a clear and concise manner, in an easy-to-understand format, and the questionnaire was thoroughly pre-tested in an actual field situation to ensure respondents’ question comprehension.

Survey Timing
Beginning in May 2008, ongoing data collection was implemented for the survey. Internet survey invitations were sent on the first of each month. The 22nd of each month was the completion deadline.

The Respondent
The respondent was the individual in the household who is most often the target for health care communications—the primary health care decision-maker. This individual most often selects the hospitals, physicians, and health care products and services utilized by household members.
**The Sample**
Survey invitations were sent to households that were representative of the 48 contiguous states. The national balancing criteria included:

- U.S. census regions
- Age of head of household
- Population density

The survey data was electronically coded and tabulated by the NRC according to an innovative and thorough tabulation specification plan.

**Weighting the Data**
To ensure proper sample representation within each tabulated market area, the data was weighted according to a number of key demographic variables:

- Age of head of household
- Area population
- Race
- Household income
- Presence of children
- Marital status

Weighting ensured that the sample was representative of the population being surveyed. For example, if 20 percent of households within the market area were headed by a family member 18 to 24 years old, then 20 percent of the sample was comprised of heads of households who were 18 to 24 years old. This weighting pattern was held consistent across all variables.
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.
Located in Tarrant County, Baylor Grapevine serves the Western Region of the System. Its total service area (TSA) includes zip codes from Tarrant, Denton and Dallas counties. The TSA comprises:

- An urban/suburban geographic area
- Service area population: 783,365
- Service area ethnicity: White Non Hispanic = 69.8 percent; Black Non Hispanic = 5.6 percent; Hispanic = 15.2 percent; Asian and Pacific Islanders Non-Hispanic = 6.5 percent; all others = 2.9 percent
- Service area payer mix: managed care = 50.5 percent; Medicaid = 9.0 percent; Medicare = 31.0 percent; self pay/charity = 9.2 percent; other = 0.4 percent
- Service area household average income: $94,463
- Service area living below the Federal Poverty Level (FPL): 4.7 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 Baylor Grapevine
- 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 = 2.6 percent; some high school = 4.7 percent; high school diploma = 20.6 percent; some college/associates degree = 33.4 percent; bachelor’s degree or greater = 38.7 percent
- Service area male population = 391,579; service area female population = 391,786
- Service area age: 0-14 = 24.4 percent; 15-17 = 4.5 percent; 18-24 = 8.2 percent; 25-34 = 14.8 percent; 35-54 = 30.9 percent; 55-64 = 10.2 percent; 65+ = 7.0 percent

**Baylor Regional Medical Center at Grapevine Service Area Providers**

**Hospitals**
- Baylor Medical Center at Trophy Club
- Baylor Regional Medical Center at Grapevine
- Continuum Rehabilitation Hospital of North Texas, LP
- Cook Children’s Northeast Hospital
- Irving Coppell Surgical Hospital
- North Hills Hospital
- Reliant Rehabilitation Hospital Mid-Cities
- Southwest Surgical Hospital
- Texas Health Harris Methodist Hospital Hurst-Euless-Bedford
- Texas Health Harris Methodist Hospital Southlake
- Texas Health Presbyterian Hospital Flower Mound
- Baylor All Saints

**Ambulatory Surgery Centers**
- Baylor Surgicare at Bedford
- Baylor Surgicare at Grapevine
Calloway Creek Surgery Center
Center for Assisted Reproduction
Children’s Ambulatory Surgery Center at Southlake
Clearview Surgery Center, Inc.
Endoscopy Center at Central Park
Lonestar Ambulatory Surgical Center
North Richland Hills Endoscopy Center
Specialty Surgery Center of Fort Worth
Spine Team Texas, Asc, LP
St. Michaels Center for Special Surgery DFW
Surgical and Diagnostic Center, LLP
Texas Eye Surgery Center, LLP
Texas Pediatric Surgery Center

Freestanding ER
First Choice Emergency Room – Fort Worth
First Choice Emergency Room – Flower Mound
Southlake Emergency Care Center

Psychiatric Facilities
Texas Health Springwood Hospital Hurst-Euless-Bedford
Community Health Needs Assessment

Public Participation
Baylor Grapevine 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.
NRC Baylor Regional Medical Center at Grapevine Service Area Survey (Executive Summary)

The Community Assessment conducted by NRC on behalf of Baylor Grapevine identified the following as community health needs (see appendix for more detail).

- **Primary care:** Forty-three percent of respondents sought access to routine care.
- **Multiple Chronic Conditions:** Several chronic conditions are identified as high risk for the community when compared to the region, state or nation. The highest are allergies, depression and sleep problems.

**Healthy People 2010 Targets:** Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. It has established benchmarks and monitored progress over time in order to:

- A. Encourage collaborations across communities and sectors.
- B. Empower individuals toward making informed health care decisions.
- C. Measure the impact of prevention activities.

- **Osteoporosis:** The community exceeds the goal of limiting the disease to 8 percent adults 50 years plus as measured by a bone mineral density test.
- **Smoking Cessation:** The community exceeds the cigarette smoking goal of 12 percent among adults 18 years plus.
- **High Blood Pressure:** The community exceeds the goal of 16 percent of adults with high blood pressure.
- **Obesity:** The community’s percent of adults who are obese is greater than the national average.
- **Pediatric services and prenatal care:** Immunizations and dental care for children are below national targets. The prenatal goals of 90 percent care beginning in the first trimester of pregnancy and 90 percent early and adequate pre-natal care are not being met.
- **Preventive Health Screenings:** The community is well below several national preventive health metric goals.
**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
Regional Healthcare Partnership Region 9 (Executive Summary)
To develop the Community Needs Assessment, a regional Task Force was convened by representatives from the following organizations: Baylor Health Care System, Children’s Medical Center, Dallas County Medical Society, Dallas County Behavioral Health Leadership Team, HCA North Texas, Methodist Health System, North Texas Behavioral Health Authority, Parkland Health & Hospital System, Scottish Rite Hospital for Children, Texas Health Resources, UT Southwestern Medical Center, and ValueOptions of Texas.

This Task Force reviewed and identified the regional needs through data analysis, expert presentations, and committee discussions. The major criteria used to identify and rank regional priorities included population impact, alignment with intervention categories, and whether solutions lend to regional based approaches. The following priorities were identified as the region’s major community health needs:

Capacity - Primary and Specialty Care
The demand for primary and specialty care services exceeds that of available physicians in these areas, thus limiting health care access.

Behavioral Health - Adult, Pediatric and Jail Populations
Behavioral health, either as a primary or secondary condition, accounts for substantial volume and costs for health care providers, and is often utilized at capacity, while still leaving a substantial unmet need in the population.

Chronic Disease - Adult and Pediatric
Many individuals in North Texas suffer from chronic diseases that present earlier in life. They also are becoming more prevalent and result in health complications.

Patient Safety and Hospital-acquired Conditions
Hospitals in the region address patient safety and care quality on a daily basis. It is a continuous process and always at the forefront of any strategy of a health care entity. An ongoing coordinated effort among providers is needed to improve patient safety and quality throughout the region.

Emergency Department Usage and Readmissions
Emergency departments are treating high volumes of patients with preventable conditions or conditions that could be addressed in a primary care setting. Additionally, readmissions are higher than desired, particularly for those with severe chronic disease or behavioral health issues.

Palliative Care
Overall, costs are higher in skilled nursing facilities, long-term care facilities, hospice and home health sectors, and slightly higher in physician services.

Oral Health
In Texas, preventive dental visits are below the recommended levels, and access can be a problem for minorities, the elderly, children on Medicaid and other low-income children. Compounding the problem is the shortage of dentists in Texas, which stands at approximately 60 percent of the national ratio of dentists-to-population.
Appendix A

Baylor Regional Medical Center at Grapevine Service Area Survey

Study Objectives
National Research Corporation (NRC) Consumer Health Report is a valuable resource in determining the health status, health risk/chronic conditions, preventive health behaviors, physician access and community perceptions of healthcare in BAYLOR - GRAPEVINE TSA.

The Consumer Health Report provides a tool to enable organizations to strengthen the health of their community by assisting in the following:

1. Measurement and evaluation of health status and healthcare utilization within the community.
2. Identification of the prevalence of chronic conditions within various demographic and geographic segments within the community.
3. Profiling of high-risk populations.
4. Identification of gaps in care and preventive health behaviors among various demographic and geographic segments within the community.
Executive Summary
Consumer Health Report Card
BAYLOR - GRAPEVINE TSA

Overall Household Health Status
Executive Summary
Consumer Health Report Card
BAYLOR - GRAPEVINE TSA

Your Consumers' Access to Healthcare

- Purpose of Physician Visit (force ranked high to low):

- Days to Appointment for Routine Care

Your Community's Trust and Confidence in Healthcare
Community Demographics

Provided below is a presentation of four key demographic factors for BAYLOR - GRAPEVINE TSA respondents within the annual Healthcare Consumer Health Report survey. The majority of questions within the Consumer Health Report can be analyzed across any one of these factors.

BAYLOR - GRAPEVINE TSA Demographics

- **Decision-Maker Age**
  - 40%: 18 - 34
  - 25%: 35 - 44
  - 25%: 45 - 64
  - 10%: 65+

- **Household Size**
  - 17%: 1 Member
  - 34%: 2 Members
  - 18%: 3 Members
  - 15%: 4 Members
  - 16%: 5+ Members

- **Household Income**
  - 48%: UNDER $25,000
  - 20%: $25,000 - $49,999
  - 15%: $50,000 - $74,999
  - 10%: $75,000 or more

- **Years Lived in Community**
  - 42%: Less than one year
  - 16%: 1-2 years
  - 15%: 3-5 years
  - 10%: 5-9 years
  - 11%: 10 or more years
This section reports consumer perception of community health programs by hospital name. BAYLOR - GRAPEVINE TSA respondents were asked to name the hospital/facility they perceive has the Best Community Health Programs in their area.

**Hospital/Facility with Best Community Health Programs**

**BAYLOR - GRAPEVINE TSA, TX**

(\% of Respondents Naming Facility)
Providers to Those Unable to Pay

BAYLOR - GRAPEVINE TSA respondents were asked to name the hospital/facility they perceive provides care to those unable to pay.

Top of Mind Hospital/Facility Provides Care to Those Unable to Pay
BAYLOR - GRAPEVINE TSA, TX
(% of Respondents Naming Facility)

- John Peter Smith Hospital: 23%
- Parkland Health & Hospital System: 16%
- Baylor Regional Medical Center at Grapevine: 12%
- Texas Health Harris Methodist Hurst-Euless-Bedford: 10%
- Texas Health Harris Methodist Hospital Fort Worth: 5%
- North Hills Hospital: 4%
- Baylor All Saints Medical Center: 4%
- Medical Center of Lewisville: 4%
- Baylor Health Care System (NS): 3%
- Baylor Medical Center at Irving: 3%
**Health Status and Utilization**

This section reports the various self-reported measures of the general physical health among BAYLOR - GRAPEVINE TSA residents, including information regarding healthcare service utilization.

**Overall Health Status**

Health status within the NRC Consumer Health Report is measured by asking residents to individually rate the health status of themselves and each member of their household, and creating a household score.

**Household Health Status**

- Within the national sample, with a score of 0%, represent the lowest percentage who responded their health status was either "Fair or Poor"
Health Risk Profiles

This section reports the various self-reported measures of the general physical health among BAYLOR - GRAPEVINE TSA residents, including information regarding the existence of various health risks, health behaviors, and chronic conditions.

Represented below is the percentage of BAYLOR - GRAPEVINE TSA households that report one or more household members have been diagnosed with having the following chronic condition. Comparison benchmarks are given for the MSA, state and national.
Health Risk Profiles

Represented below is the percentage of BAYLOR - GRAPEVINE TSA households that report one or more household members have been diagnosed with having the following chronic condition. Comparison benchmarks are given for the MSA, state and national.

- **Allergies-Other**
  - BAYLOR - GRAPEVINE TSA: 22%
  - Dallas-Fort Worth-Arlington, TX CBSA: 25%
  - TEXAS: 25%
  - National Average: 23%

- **Arthritis**
  - BAYLOR - GRAPEVINE TSA: 17%
  - Dallas-Fort Worth-Arlington, TX CBSA: 17%
  - TEXAS: 19%
  - National Average: 22%

- **Asthma**
  - BAYLOR - GRAPEVINE TSA: 17%
  - Dallas-Fort Worth-Arlington, TX CBSA: 16%
  - TEXAS: 16%
  - National Average: 16%

- **Obesity/Weight Problems**
  - BAYLOR - GRAPEVINE TSA: 16%
  - Dallas-Fort Worth-Arlington, TX CBSA: 16%
  - TEXAS: 16%
  - National Average: 15%

- **Diabetes**
  - BAYLOR - GRAPEVINE TSA: 14%
  - Dallas-Fort Worth-Arlington, TX CBSA: 17%
  - TEXAS: 18%
  - National Average: 17%
Represented below is the percentage of BAYLOR - GRAPEVINE TSA households that report one or more household members have been diagnosed with having the following chronic condition. Comparison benchmarks are given for the MSA, state and national.

Health Risk Profiles

Represented below is the percentage of BAYLOR - GRAPEVINE TSA households that report one
or more household members have been diagnosed with having the following chronic condition. Comparison benchmarks are given for the MSA, state and national.

Health Risk Profiles

Represented below is the percentage of BAYLOR - GRAPEVINE TSA households that report one or more household members have been diagnosed with having the following chronic condition.
Comparison benchmarks are given for the MSA, state and national.

Health Risk Profiles Compared to Healthy People 2010
Healthy People 2010 Target:
- 8% adults 50 years plus as measured by bone mineral density test had the disease.
Healthy People 2010 Target:
• Reduce cigarette smoking to 12% among adults 18 years plus.
Healthy People 2010 Target:
• Reduce the proportion of adults with high blood pressure to 16%.
Health Risk Profiles Compared to Healthy People 2010

Healthy People 2010 Target:
• Reduce the proportion of adults who are obese by 15%.
Health Risk Profiles - Low Income

Represented below is the percentage of BAYLOR - GRAPEVINE TSA households in lower income categories that report one or more household members have been diagnosed with the chronic condition, compared to the market average.

Households in Lower Income Categories by Chronic Conditions

- Smoker
  - BAYLOR - GRAPEVINE TSA Average: 34%
  - UNDER $25,000: 23%
  - $25,000 - $49,999: 39%

- High Blood Pressure
  - BAYLOR - GRAPEVINE TSA Average: 33%
  - UNDER $25,000: 25%
  - $25,000 - $49,999: 36%

- Depression/Anxiety Disorder
  - BAYLOR - GRAPEVINE TSA Average: 26%
  - UNDER $25,000: 26%
  - $25,000 - $49,999: 20%

- Allergies-Other
  - BAYLOR - GRAPEVINE TSA Average: 25%
  - UNDER $25,000: 15%
  - $25,000 - $49,999: 25%

- High Cholesterol
  - BAYLOR - GRAPEVINE TSA Average: 23%
  - UNDER $25,000: 23%
  - $25,000 - $49,999: 26%

- Allergies-Hay Fever
  - BAYLOR - GRAPEVINE TSA Average: 23%
  - UNDER $25,000: 23%
  - $25,000 - $49,999: 22%
Health Risk Profiles - Low Income

Represented below is the percentage of BAYLOR - GRAPEVINE TSA households in lower income categories that report one or more household members have been diagnosed with the chronic condition, compared to the market average.

Households in Lower Income Categories by Chronic Conditions

- Arthritis
  - BAYLOR - GRAPEVINE TSA Average: 21%
  - UNDER $25,000: 21%
  - $25,000 - $49,999: 21%
- Asthma
  - BAYLOR - GRAPEVINE TSA Average: 24%
  - UNDER $25,000: 18%
  - $25,000 - $49,999: 15%
- Obesity/Weight Problems
  - BAYLOR - GRAPEVINE TSA Average: 17%
  - UNDER $25,000: 15%
  - $25,000 - $49,999: 17%
- Diabetes
  - BAYLOR - GRAPEVINE TSA Average: 17%
  - UNDER $25,000: 16%
  - $25,000 - $49,999: 13%
- Sleep Problem/Insomnia
  - BAYLOR - GRAPEVINE TSA Average: 15%
  - UNDER $25,000: 15%
  - $25,000 - $49,999: 15%
- Migraines
  - BAYLOR - GRAPEVINE TSA Average: 15%
  - UNDER $25,000: 8%
  - $25,000 - $49,999: 15%
- Sinus Problem
  - BAYLOR - GRAPEVINE TSA Average: 17%
  - UNDER $25,000: 14%
  - $25,000 - $49,999: 7%

Health Risk Profiles - Low Income
Represented below is the percentage of BAYLOR - GRAPEVINE TSA households in lower income categories that report one or more household members have been diagnosed with the chronic condition, compared to the market average.
Health Risk Profiles - Low Income

Represented below is the percentage of BAYLOR - GRAPEVINE TSA households in lower income categories that report one or more household members have been diagnosed with the chronic condition, compared to the market average.
Preventive Health Behaviors Compared to Healthy People 2010

Child Immunizations among Households with Children

Healthy People 2010 Target:

- Increase the proportion of young children and adolescents who receive all vaccines that have been recommended or universal administration for at least 5 years to 80%.
**Mammograms among Households with a Female 40 Years Plus**

![Bar Chart]

**Healthy People 2010 Target:**

- 70% women 40 years plus have had mammogram within past 2 years.
Preventive Health Behaviors Compared to Healthy People 2010

Osteoporosis Testing among Households with an Adult 50 Years Plus

Healthy People 2010 Target:

- 8% adults 50 years plus as measured by bone mineral density test had the disease.
Healthy People 2010 Target:

- 97% women 18 years plus have had pap smear test.
Healthy People 2010 Target:

- 90% care beginning in the first trimester of pregnancy.
- 90% early and adequate pre-natal care.
Stop Smoking Program among Households with an Adult 18 Years Plus

Healthy People 2010 Target:

- Increase smoking cessation attempts to 75% by adult smokers.
Healthy People 2010 Target:
- 60% adults 20 years plus at a healthy weight (Body Mass Index of 18.5 to 25).
Preventive Health Behaviors Compared to Healthy People 2010

Colon Screening among Households with an Adult 50 Years Plus

Healthy People 2010 Target:

- Increase the proportion of adults who receive a colorectal cancer screening examination to 50%
Preventive Health Behaviors Compared to Healthy People 2010

**Healthy People 2010 Target:**

- Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years to 80%
Healthy People 2010 Target:

- Increase the proportion of children and adults who use the oral health care system each year by 56%
Preventive Health Behaviors - Low Income

Represented below is the percentage of BAYLOR - GRAPEVINE TSA households in lower income categories that have had the following preventive healthcare services or tests in the last 12 months, compared to the market average.

Households in Lower Income Categories by Preventive Health Behaviors

- Blood Pressure Test:
  - BAYLOR - GRAPEVINE TSA Average: 52%
  - UNDER $25,000: 47%
  - $25,000 - $49,999: 35%

- Eye Exam:
  - BAYLOR - GRAPEVINE TSA Average: 30%
  - UNDER $25,000: 31%
  - $25,000 - $49,999: 28%

- Cholesterol Test:
  - BAYLOR - GRAPEVINE TSA Average: 31%
  - UNDER $25,000: 25%
  - $25,000 - $49,999: 13%

- Dental Exam:
  - BAYLOR - GRAPEVINE TSA Average: 27%
  - UNDER $25,000: 27%
  - $25,000 - $49,999: 25%

- Flu Shot:
  - BAYLOR - GRAPEVINE TSA Average: 25%
  - UNDER $25,000: 23%
  - $25,000 - $49,999: 18%
Preventive Health Behaviors - Low Income

Represented below is the percentage of BAYLOR - GRAPEVINE TSA households in lower income categories that have had the following preventive healthcare services or tests in the last 12 months, compared to the market average.
Represented below is the percentage of BAYLOR - GRAPEVINE TSA households in lower income categories that have had the following preventive healthcare services or tests in the last 12 months, compared to the market average.
Physician Visit Usage and Access

This section outlines the household's last physician visit usage and days to appointment access, including purpose of visit.

**Purpose of Physician Visit by Income**

BAYLOR - GRAPEVINE TSA

- **OVER $75,000**
  - Routine Care: 7%
  - Minor Illness/Injury: 14%
  - Chronic Or On-Going Condition: 29%
  - Chronic Or On-Going Condition: 44%
  - Did Not See a Physician Within the Last 2 Years: 7%

- **$50,000 - $74,999**
  - Routine Care: 8%
  - Minor Illness/Injury: 14%
  - Chronic Or On-Going Condition: 23%
  - Chronic Or On-Going Condition: 42%
  - Did Not See a Physician Within the Last 2 Years: 14%

- **$25,000 - $49,999**
  - Routine Care: 8%
  - Minor Illness/Injury: 16%
  - Chronic Or On-Going Condition: 25%
  - Chronic Or On-Going Condition: 44%
  - Did Not See a Physician Within the Last 2 Years: 7%

- **UNDER $25,000**
  - Routine Care: 9%
  - Minor Illness/Injury: 21%
  - Chronic Or On-Going Condition: 21%
  - Chronic Or On-Going Condition: 38%
  - Did Not See a Physician Within the Last 2 Years: 9%

- **Total**
  - Routine Care: 9%
  - Minor Illness/Injury: 16%
  - Chronic Or On-Going Condition: 25%
  - Chronic Or On-Going Condition: 43%
  - Did Not See a Physician Within the Last 2 Years: 7%
Physician Visit Usage and Access

No Physician Visit

- Within the national sample, has the highest percentage of households at 0% who reported they have not seen a physician within the last two years.

- Within the national sample, has the lowest percentage of households at 0% who reported they have not seen a physician within the last two years.

Households That Have Not Seen a Physician in Last 2 Years

Question asked to obtain the results:
- Thinking of your HOUSEHOLD’s last physician visit, what was the purpose of this most recent visit? Source: 2011 NRC Healthcare Market Guide, National Research Corporation
Community Trust and Confidence in Healthcare

This section reports the various self-reported measures regarding the communities trust and confidence in healthcare, including measurements of trust in doctors, nurses, and health plans.

Level of Trust and Confidence - "Very High"

<table>
<thead>
<tr>
<th>Market/Trust in</th>
<th>BAYLOR - GRAPEVINE TSA</th>
<th>Dallas-Fort Worth-Arlington, TX CBSA</th>
<th>TEXAS</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>21 %</td>
<td>21 %</td>
<td>21 %</td>
<td>20 %</td>
</tr>
<tr>
<td>Doctors</td>
<td>24 %</td>
<td>25 %</td>
<td>25 %</td>
<td>25 %</td>
</tr>
<tr>
<td>Nurses</td>
<td>25 %</td>
<td>24 %</td>
<td>26 %</td>
<td>26 %</td>
</tr>
<tr>
<td>Health Plans</td>
<td>10 %</td>
<td>10 %</td>
<td>11 %</td>
<td>10 %</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>0 %</td>
<td>0 %</td>
<td>0 %</td>
<td>0 %</td>
</tr>
</tbody>
</table>
Community Trust and Confidence in Healthcare

"Very High" Trust/Confidence in Lower Income Categories

BAYLOR - GRAPEVINE TSA

- Hospitals: 8% (UNDER $25,000), 29% ($25,000 - $49,999)
- Doctors: 10% (UNDER $25,000), 26% ($25,000 - $49,999)
- Nurses: 9% (UNDER $25,000), 25% ($25,000 - $49,999)
- Health Plans: 9% (UNDER $25,000), 25% ($25,000 - $49,999)
Appendix B

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](image)

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.
Demographics: Population Living in Poverty

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

![Figure 3: Median Household Income of Region 10 Counties in 2011](image-url)
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).
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.

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. 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.

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>Region 10</td>
<td>18.0%</td>
<td>82.0%</td>
<td>55.3%</td>
<td>5.3%</td>
<td>11.1%</td>
<td>8.9%</td>
<td>1.4%</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><strong>Acute Care Hospitals</strong></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>
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<td>12</td>
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<tr>
<td><strong>Psychiatric Hospitals</strong></td>
<td>2</td>
<td>0</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>
</tr>
<tr>
<td><strong>Acute Care Licensed Beds</strong></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><strong>Psychiatric Care Licensed Beds</strong></td>
<td>170</td>
<td>0</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>
</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 development* (Figure 9).

![Figure 9: Health Professional Shortage Areas by County](image)

<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>
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<tbody>
<tr>
<td>Primary Care</td>
<td>x</td>
<td></td>
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<td>Dental Care</td>
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<td></td>
<td></td>
<td></td>
<td>x</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>x</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](image)

<table>
<thead>
<tr>
<th>PPRA Domain</th>
<th>Need(s) Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population Health</strong></td>
<td>Erath</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Provider Capacity</td>
<td>Hospital Provider</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>MHMR</td>
<td>Yes</td>
</tr>
<tr>
<td>Physician Organization</td>
<td>*</td>
</tr>
<tr>
<td>Other</td>
<td>*</td>
</tr>
<tr>
<td>Functional Patient Care Teams</td>
<td>Yes</td>
</tr>
<tr>
<td>Use of HIT</td>
<td>Yes</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*No assessments received.

**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><strong>Lack of provider capacity.</strong> 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><strong>Shortage of primary care services</strong> (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 and low treatment completion rates of latent tuberculosis infection (LTBI) LTBI treatment</strong></td>
<td>Healthy People 2020</td>
</tr>
<tr>
<td>CN.22</td>
<td><strong>Inadequate health IT infrastructure and limited interoperability to support information sharing between providers hinders care coordination.</strong></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
D-1: 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
Figure D-1.3: 2011 National and State Totals and RHP 10 Population by Age, 2011 Current and 2016 Projections

<table>
<thead>
<tr>
<th></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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<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>163,972</td>
<td>186,721</td>
<td>14%</td>
<td>48,230</td>
</tr>
<tr>
<td>Erath</td>
<td>35,565</td>
<td>36,944</td>
<td>4%</td>
<td>8,327</td>
</tr>
<tr>
<td>Hood</td>
<td>54,128</td>
<td>59,318</td>
<td>10%</td>
<td>11,967</td>
</tr>
<tr>
<td>Johnson</td>
<td>170,881</td>
<td>187,136</td>
<td>10%</td>
<td>46,151</td>
</tr>
<tr>
<td>Navarro</td>
<td>49,839</td>
<td>51,961</td>
<td>4%</td>
<td>13,397</td>
</tr>
<tr>
<td>Parker</td>
<td>107,263</td>
<td>119,320</td>
<td>11%</td>
<td>27,583</td>
</tr>
<tr>
<td>Somervell</td>
<td>7,584</td>
<td>8,188</td>
<td>8%</td>
<td>1,988</td>
</tr>
<tr>
<td>Tarrant</td>
<td>1,797,679</td>
<td>1,961,608</td>
<td>9%</td>
<td>510,706</td>
</tr>
<tr>
<td>Wise</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>RHF 10</th>
<th>Elks</th>
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<th>Johnson</th>
<th>Navarro</th>
<th>Parker</th>
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<th>Tarrant</th>
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</table>

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
SUMMARY OF RESPONSES: ACCESS TO CARE

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:

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very easy</td>
<td>19</td>
</tr>
<tr>
<td>Easy</td>
<td>65</td>
</tr>
<tr>
<td>Neutral</td>
<td>45</td>
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<tr>
<td>Difficult</td>
<td>30</td>
</tr>
<tr>
<td>Very difficult</td>
<td>6</td>
</tr>
<tr>
<td>N/A</td>
<td>7</td>
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</tbody>
</table>

**Question 4b:** Difficulty low-income patients face when trying to access prenatal care:

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very easy</td>
<td>4</td>
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<tr>
<td>Easy</td>
<td>23</td>
</tr>
<tr>
<td>Neutral</td>
<td>64</td>
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<td>41</td>
</tr>
<tr>
<td>Very difficult</td>
<td>9</td>
</tr>
<tr>
<td>N/A</td>
<td>32</td>
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</table>

**Question 5a:** Barriers to access to emergency care services for low-income patients

- Lack of cover/financial hardship
- Difficulty navigating/system lack awareness of available resources
- Lack of capacity (e.g., insufficient providers/interpersonal wait times)
- Eligibility screening process for benefits/covered services
- Delays in authorization/referral approval
- Limited access due to provider distance
- Other (specify below)
- Scheduling (system inefficiency/standard process)

**Question 5b:** Barriers to access to prenatal care for low-income patients

- Lack of cover/financial hardship
- Difficulty navigating/system lack awareness of available resources
- Lack of capacity (e.g., insufficient providers/interpersonal wait times)
- Lack of access due to provider distance
- Other (specify below)
- Eligibility screening process for benefits/covered services
- Delays in authorization/referral approval
- Scheduling (system inefficiency/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.”
**Question 6:** Difficulty low-income patients face when trying to access pediatric/well-child services:

```
<table>
<thead>
<tr>
<th>Barriers to access to pediatric/well-child services for low-income patients</th>
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<tbody>
<tr>
<td>Lack of coverage/financial hardship</td>
</tr>
<tr>
<td>Lack of capacity (e.g., insufficient providers; inadequate wait times)</td>
</tr>
<tr>
<td>Difficulty navigating system/breakdown of available resources</td>
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<tr>
<td>Eligibility screening process for benefits/covered services</td>
</tr>
<tr>
<td>Lack of access due to provider distance</td>
</tr>
<tr>
<td>Other (Specify below)</td>
</tr>
<tr>
<td>Delays in authorization/referral approval</td>
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<td>Scheduling (system inefficiency; non-standard process)</td>
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**Question 7:** Difficulty low-income patients face when trying to access routine primary/preventive care:

```
<table>
<thead>
<tr>
<th>Barriers to access to routine primary/preventive care care for low-income patients</th>
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<td>Lack of coverage/financial hardship</td>
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<tr>
<td>Delays in authorization/referral approval</td>
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<tr>
<td>Scheduling (system inefficiency; non-standard process)</td>
</tr>
<tr>
<td>Other (Specify below)</td>
</tr>
</tbody>
</table>

```

**“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.”
**Question 9a:** Difficulty low-income patients face when trying to access routine specialty care:

- Very easy: 2
- Easy: 2
- Neutral: 32
- Difficult: 79
- Very difficult: 43
- N/A: 5

**Question 9b:** Difficulty low-income patients face when trying to access urgent care services:

- Very easy: 10
- Easy: 28
- Neutral: 50
- Difficult: 43
- Very difficult: 12
- N/A: 9

**Barriers to access to routine specialty care for low-income patients**

- Lack of coverage/financial hardship
- Lack of capacity (e.g., insufficient provider/extended wait times)
- Difficulty navigating system/limited awareness of available resources
- Eligibility screening process for benefits/covered services
- Lack of access due to provider distance
- Delays in authorization/referral approval
- Scheduling (system inefficiency/non-standard process)
- Other (specify below)

**Barriers to access to urgent 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 provider/extended wait times)
- Eligibility screening process for benefits/covered services
- Lack of access due to provider distance
- Delays in authorization/referral approval
- Scheduling (system inefficiency/non-standard process)
- Other (specify below)

**“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.”
“Other” responses

- "Lack of Bilingual and Culturally Sensitive Mental Health Professions"

- "Limited provider base. No substance abuse treatment available. Limited Crisis Respite and Psychiatric Beds available. Limited resources for specialty populations i.e. MH/MR, Autism, SED, children with multiple disabilities.”

“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
“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.”

Question 20

Effectiveness of primary care physicians co-managing patients who have both mental health and medical conditions with mental health professionals

- Very effective: 28%
- Somewhat effective: 26%
- Somewhat ineffective: 43%
- Very ineffective: 6%

n = 82

Question 21

Barriers to effective co-management of a patient's health between providers

Complexity of coordination for patients with high levels of need/higher care need
- Fragmented, stand-alone services rather than an integrated delivery system
- Practice norms that encourage clinicians to act in silos rather than coordinate with each other
- Lack of staff and time for investments in coordination (at the practice/broader community levels)
- Limited financial integration across most providers
- No (or few) financial incentives or requirements for care coordination for providers
- Limited health IT infrastructure and interoperability
- Limited Primary Care provider involvement in inpatient care
- Farmer's market, patient self-referrals, patient self-referrals about which the Patient Centered Medical Home is unaware
- Other (Please specify below)
- Misconception regarding privacy laws and limits to information sharing/access (HIPAA)

Least significant

0.00 1.00 2.00 3.00 4.00

Most significant

n = 848

Question 30, cont.

“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.

Question format

1. Respondents were asked to choose the top five conditions prevalent in their county.
“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”

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.”

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 (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

<table>
<thead>
<tr>
<th></th>
<th>Ellis</th>
<th>Erath</th>
<th>Johnson</th>
<th>Tarrant</th>
<th>Wise</th>
<th>Navarro</th>
<th>Parker</th>
<th>Somervell</th>
<th>Hood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis</td>
<td>2.0</td>
<td>2.8</td>
<td>2.5</td>
<td>6.2</td>
<td>3.4</td>
<td>2.0</td>
<td>1.7</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>All Cancer</td>
<td>447.8</td>
<td>403.8</td>
<td>439.9</td>
<td>446.6</td>
<td>424.6</td>
<td>485.4</td>
<td>462.1</td>
<td>469.8</td>
<td>485.4</td>
</tr>
<tr>
<td>Breast</td>
<td>61</td>
<td>58.4</td>
<td>58.3</td>
<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>
<td>Lung</td>
<td>71.4</td>
<td>N/A</td>
<td>70.0</td>
<td>60.4</td>
<td>74.2</td>
<td>72.0</td>
<td>74.5</td>
<td>N/A</td>
<td>55.2</td>
</tr>
<tr>
<td>Diabetes</td>
<td>8.3</td>
<td>8.8</td>
<td>10.0</td>
<td>8.4</td>
<td>8.6</td>
<td>9.7</td>
<td>9.3</td>
<td>9.3</td>
<td>8.7</td>
</tr>
<tr>
<td>HIV</td>
<td>4.6</td>
<td>0.0</td>
<td>3.8</td>
<td>14.6</td>
<td>0.0</td>
<td>10.1</td>
<td>5.2</td>
<td>12.2</td>
<td>9.7</td>
</tr>
<tr>
<td>Obesity</td>
<td>29.5</td>
<td>27.6</td>
<td>29.6</td>
<td>26.8</td>
<td>29.8</td>
<td>29.5</td>
<td>27.5</td>
<td>26.9</td>
<td>27.1</td>
</tr>
</tbody>
</table>

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

<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>Tuberculosis Cases</td>
<td>11,549</td>
<td>1,477</td>
<td>122.0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>109</td>
<td>2</td>
</tr>
<tr>
<td>Tuberculosis Rate</td>
<td>3.8</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>
</tr>
<tr>
<td>Pertussis (Whooping Cough) Rate</td>
<td>5.54</td>
<td>13.5</td>
<td>10.3</td>
<td>6.5</td>
<td>5.1</td>
<td>16.9</td>
<td>13.4</td>
<td>0</td>
<td>12.2</td>
<td>23.8</td>
<td>11.6</td>
<td>3.3</td>
</tr>
</tbody>
</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>
<td>100</td>
</tr>
<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>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th></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>2,452</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>1264</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>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Texas</th>
<th>U.S.</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>
<th>RHP 10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Deaths</strong></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>
</tr>
<tr>
<td><strong>Disease of the Heart</strong></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><strong>Cerebrovascular Disease</strong></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><strong>Malignant Neoplasms</strong></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><strong>Chronic Lower Respiratory disease</strong></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><strong>Nephritis, Nephrotic Syndrome and Nephrosis</strong></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>
</tr>
<tr>
<td><strong>Accidents</strong></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>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>29</td>
<td>4</td>
<td>11</td>
<td>29</td>
<td>25</td>
<td>25</td>
<td>16</td>
<td>1</td>
<td>273</td>
<td>10</td>
<td>398</td>
<td></td>
</tr>
<tr>
<td><strong>Alzheimer's</strong></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><strong>Influenza and pneumonia</strong></td>
<td>*</td>
<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>
</tr>
<tr>
<td><strong>Assault</strong></td>
<td>*</td>
<td>*</td>
<td>11</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>70</td>
<td>1</td>
<td>92</td>
</tr>
<tr>
<td><strong>Suicide</strong></td>
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<td>*</td>
<td>13</td>
<td>1</td>
<td>9</td>
<td>21</td>
<td>8</td>
<td>12</td>
<td>2</td>
<td>170</td>
<td>9</td>
<td>245</td>
</tr>
<tr>
<td><strong>Septicemia</strong></td>
<td>*</td>
<td>*</td>
<td>15</td>
<td>1</td>
<td>7</td>
<td>7</td>
<td>8</td>
<td>7</td>
<td>0</td>
<td>176</td>
<td>6</td>
<td>227</td>
</tr>
<tr>
<td><strong>Chronic liver disease and Cirrhosis</strong></td>
<td>*</td>
<td>*</td>
<td>14</td>
<td>5</td>
<td>7</td>
<td>13</td>
<td>6</td>
<td>14</td>
<td>2</td>
<td>162</td>
<td>7</td>
<td>230</td>
</tr>
<tr>
<td><strong>Infant death</strong></td>
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<td>2</td>
<td>4</td>
<td>19</td>
<td>3</td>
<td>11</td>
<td>1</td>
<td>194</td>
<td>3</td>
<td>252</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fetal deaths</strong></td>
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<td>1</td>
<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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<td></td>
</tr>
</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><strong>Bacterial Pneumonia</strong></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><strong>Rates</strong></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>
<tr>
<td><strong>Dehydration</strong></td>
<td>837</td>
<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><strong>Rates</strong></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><strong>Urinary Tract Infection</strong></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><strong>Rates</strong></td>
<td>81.7</td>
<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><strong>Angina (without procedures)</strong></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><strong>Rates</strong></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><strong>Congestive Heart Failure</strong></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><strong>Rates</strong></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><strong>Hypertension</strong></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><strong>Rates</strong></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><strong>Asthma</strong></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><strong>Rates</strong></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>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>
<td></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>Chronic Obstructive Pulmonary Disease</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></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>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>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></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>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>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>Region 10</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>Poor or Fair Health</td>
<td>19%</td>
<td>17%</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>
<td>19%</td>
</tr>
<tr>
<td>Poor Physical Health Days*</td>
<td>3.6</td>
<td>3.49</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>
<td>3</td>
</tr>
<tr>
<td>Poor Mental Health Days*</td>
<td>3.3</td>
<td>3.39</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>
<td>3.9</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>Health Behavior</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>Adult Smoking</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>Adult Obesity</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>Physical Inactivity</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>Excessive Drinking</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>Food Access Category</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>Limited Access to Healthy Foods</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>% population with low income and do not live close to a grocery store</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>Fast Food Restaurants</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>
<tr>
<td>Percent of all restaurants that are fast food establishments</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>
</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.

<table>
<thead>
<tr>
<th>ELLIS COUNTY</th>
<th>Workforce Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care Needs</td>
<td></td>
</tr>
<tr>
<td>o Increased psychiatry patients</td>
<td></td>
</tr>
<tr>
<td>o Lack of Communicable Disease Management Programs</td>
<td></td>
</tr>
<tr>
<td>o Tremendous shortage to Dental care</td>
<td></td>
</tr>
<tr>
<td>o Lack of substance abuse services</td>
<td></td>
</tr>
<tr>
<td>o Lack of Transportation</td>
<td></td>
</tr>
<tr>
<td>o Lack of Care Management Programs</td>
<td></td>
</tr>
<tr>
<td>o High need for Behavioral Health Programs</td>
<td></td>
</tr>
<tr>
<td>o Lack of Urgent Care</td>
<td></td>
</tr>
<tr>
<td>o Increase need for Medicare Providers</td>
<td></td>
</tr>
<tr>
<td>o 85% patients have Diabetes</td>
<td></td>
</tr>
<tr>
<td>o Lack of geriatric beds</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce Needs</td>
<td></td>
</tr>
<tr>
<td>o Mobile Services staff</td>
<td></td>
</tr>
<tr>
<td>o Psychiatry Physicians</td>
<td></td>
</tr>
<tr>
<td>o Medicare/Medicaid providers</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOOD COUNTY</th>
<th>Workforce Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care Needs</td>
<td></td>
</tr>
<tr>
<td>o Lack of on site psychiatrist</td>
<td></td>
</tr>
<tr>
<td>▪ Currently have telemedicine psychiatrists</td>
<td></td>
</tr>
<tr>
<td>o Fragmented care coordination between primary care and psychiatry</td>
<td></td>
</tr>
<tr>
<td>o Uninsured/underinsured do not have access to care</td>
<td></td>
</tr>
<tr>
<td>o Lack of patient education programs</td>
<td></td>
</tr>
<tr>
<td>o Language barriers between patients and providers</td>
<td></td>
</tr>
<tr>
<td>o Affordability of care</td>
<td></td>
</tr>
<tr>
<td>o Increased group of Latino population need care</td>
<td></td>
</tr>
<tr>
<td>o Asthma is highly prevalent in Hood county</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce Needs</td>
<td></td>
</tr>
<tr>
<td>o Psychiatric nurses</td>
<td></td>
</tr>
<tr>
<td>o OR nurses</td>
<td></td>
</tr>
<tr>
<td>o Fully trained nurses</td>
<td></td>
</tr>
</tbody>
</table>
### 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
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>Refreno 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></td>
<td></td>
<td>Trinity Mission of Granbury LLC</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Senior Care of Harbor Lakes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Granbury Care Center</td>
<td></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></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Grandview Nursing Home</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heritage Trials Nursing and Rehabilitation Center</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ridgeview Rehabilitation and Skilled Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Colonial Manor Nursing Center</td>
<td></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>
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<td>Global Rehab Hospital Forth Worth</td>
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**Wise County:**

| Facilities by Type |

**Note:** The table above lists facilities by county, starting with Wise County.
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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): ____________________________

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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
Appendix C

Regional Healthcare Partnership Region 9  Community Needs Assessment
Section III. Community Needs Assessment

To develop the Community Needs Assessment, a regional Task Force was convened by representatives from the following organizations: Baylor Health Care System, Children’s Medical Center, Dallas County Medical Society, Dallas County Behavioral Health Leadership Team, HCA North Texas, Methodist Health System, North Texas Behavioral Health Authority, Parkland Health & Hospital System, Scottish Rite Hospital for Children, Texas Health Resources, UT Southwestern Medical Center, and ValueOptions of Texas.

This Task Force reviewed and identified the regional needs through data analysis, expert presentations, and committee discussions. The major criteria used to identify and rank regional priorities included population impact, alignment with intervention categories, and whether solutions lend to regional based approaches. The following priorities were identified as the region’s major community health needs:

**Capacity - Primary and Specialty Care** - The demand for primary and specialty care services exceeds that of available medical physicians in these areas, thus limiting healthcare access.

**Behavioral Health - Adult, Pediatric and Jail Populations** - Behavioral health, either as a primary or secondary condition, accounts for substantial volume and costs for existing healthcare providers, and is often utilized at capacity, despite a substantial unmet need in the population.

**Chronic Disease - Adult and Pediatric** - Many individuals in North Texas suffer from chronic diseases that present earlier in life, are becoming more prevalent, and exhibit complications.

**Patient Safety and Hospital Acquired Conditions** – Hospitals in the region address patient safety and care quality on a daily basis. It is a continuous improvement initiative and is always at the forefront of any strategy for a health care entity. An ongoing coordinated effort among providers is needed to improve patient safety and quality throughout the region.

**Emergency Department Usage and Readmissions** - Emergency departments are treating high volumes of patients with preventable conditions, or conditions that are suitable to be addressed in a primary care setting. Additionally, readmissions are higher than desired, particularly for those with severe chronic disease or behavioral health.

**Palliative Care** - Overall, costs are high in skilled nursing facilities, long term care facilities, hospice and home health sectors, and slightly higher in physician services.

**Oral Health** - In Texas, preventive dental visits are below the recommended levels, and access can be a problem for minorities, the elderly, children on Medicaid, and other low income children. Compounding the issue is the shortage of dentists in Texas at approximately 60% of the national ratio of dentists to the population.
**Demographics and Regional Description**

Based on population alone, Texas is the second largest state in the nation with more than 25 million people. From 2000 to 2010, Texas experienced a 20% growth in population, as compared to only a 9.7% increase nationally. Originally, the North Texas RHP 9 Region was defined to include Collin, Dallas, Denton, Ellis, Fannin, Grayson, Kaufman, Navarro, and Rockwall counties. The broader demographics were considered to be representative of the narrower final RHP boundaries and as demonstrated in Figure 3 below, there is considerable immigration from the original RHP counties to Dallas County for health care services.

In the North Texas RHP 9 region (original definition), the 2011 population is estimated to be 4,611,612 and is expected to grow by 9.5% by 2016 to 5,048,283 residents. The most prevalent age group is 35-54 years (27.6%), followed by the 0-14 age group (20.2%). While 15.1% of adults have less than some high school level of education, approximately 85% of adults have at least a high school degree.

White non-Hispanics represent 48.1% of the population, followed by Hispanics, Black non-Hispanics, Asians, and others, respectively. Approximately 44% of Dallas-Fort Worth residents are New Americans (defined as either foreign born or the children of foreign born) of which 46% are undocumented. English is not the language spoken in 32% of homes in North Texas and over 239 languages are spoken in the North Texas Area, with more than 1/3 reflecting African cultures new to the region.

**Figure 1: Regional Demographic Snapshot**

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4 ibid.
Within Dallas County specifically, 29.6% of children under 18 live below the federal poverty level and 15.8% of adults between 18 to 64 years live below the federal poverty level.\(^6\)

**Figure 2: Summary of Uninsured in Dallas County**\(^7\)

Health Delivery System and Patient Migration Patterns

Data analysis identified patient migration patterns within multiple RHP regions. Many individuals receive healthcare services in nearby counties. In the pediatric population, Dallas County residents account for 75% of the outpatient services and 74% of the inpatient services. In the adult population, Dallas County residents account for 77% and 73% of the outpatient and inpatient population, respectively.\(^8\)

**Figure 3: Interconnectedness of Healthcare Delivery System: Dallas County Encounters from Patients with Adjacent County of Residence, 2011**\(^9\)

The locations of charitable clinics in Dallas County are shown on the map below. Additional analysis is warranted to determine the causal factors of the patient flow and migration patterns and how they relate to the locations of clinics/other service sites in the region. It is apparent though that the data presents strong justification to consider a broader geographic area for the purposes of this assessment.

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\(^7\) Communities Foundation of Texas, Assets and Opportunities Profile. February 2012.

\(^8\) DFWHC Foundation, Information and Quality Services Data Warehouse, 2011

\(^9\) ibid
Regional Health Care Capacity

Physician Supply and Availability
RHP 9 is affected by the limited physician capacity in primary and select specialties. According to the Health Professions Resource Center, primary care physician supply trends have consistently increased to a current statewide rate of 70 per 100,000 people in 2011. In 2011, the RHP 9 region demonstrated a physician need in excess of over 30% of the current workforce and by 2016 the physician need is expected to be 50% higher than projected availability. With such a shortage of physicians, which is disparately worse in rural areas of Texas, many residents seek primary care and non-emergent treatment in emergency departments, resulting in increased healthcare costs and higher volumes of preventable and avoidable cases in the ED.

Medical Education
Dallas County is home to the University of Texas Southwestern Medical Center, an academic medical center that trains over 1000 medical students and approximately 1300 clinical residents annually. Many training and residency placements are completed within the DFW Metroplex providing an important source of physicians to the local healthcare system.

Medically Underserved and Shortage Areas
A Health Professional Shortage Area (HPSA) is a federally designated geographic area, a facility or population group with a shortage of primary care physicians (or dental or mental health providers) as defined by a population-to-primary care physician ratio of at least 3,500:1

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11 Health Professions Resource Center, Center for Health Statistics, Department of State Health Services, October 2011.
12 ibid.
addition to other requirements designated by the U.S. Department of Health and Human Services. Poverty rate, infant mortality rate, fertility rate and physical distance from care are all considerations in scoring for HPSA designation.

Medically Underserved Areas or Populations (MUA/MUP) are generally defined by the federal government to include areas of populations with a shortage of personal health care services or groups of people who may have cultural or linguistic barriers to health care. In RHP 9, Dallas County has significant HPSA and MUA regions that overlap and Kaufman County is a county-level HPSA with no MUs.

Children/Youth
The impact of the limited primary and specialty care is profound for children and families in the region. The current pediatric need is more than 80% of the current supply in the region. In Dallas County alone, over 36.2% of children were enrolled in Medicaid in 2010, exacerbating the issue of availability of pediatric primary care access and treatment. Data also indicates that many of the pediatric specialists have limited capacity, creating a backlogged pipeline for those needing specialty services after seeking primary care.

Behavioral Health

Behavioral Health System Structure and Funding
The behavioral health system (including mental health and substance use) in RHP 9 differs from that of the rest of the state in that the majority of behavioral services for Medicaid and indigent patients are delivered through the NorthSTAR program instead of the traditional Local Mental Health Authority (LMHA) system. It is a managed behavioral healthcare carve-out program, administered by ValueOptions of Texas under a Medicaid 1915(b) waiver under the oversight of the North Texas Behavioral Health Authority (NTBHA), and it provides both mental health and substance use treatment to over 60,000 Medicaid enrollees and indigent uninsured annually.

Over the past decade, the NorthSTAR program has greatly expanded access to care. However, this high level of access results in funding and infrastructure challenges. Since the program’s inception, the growth in enrollment has outpaced funding such that the funding per person served is 30% less than when the program started in 1999 and is half that of the state average for other LMHAs. Given that Texas is 50th in mental health funding nationwide, the funding per person served in RHP 9 is among the lowest in the nation.

Mortality Trends in the Behavioral Health Population
An inadequate supply of behavioral health services is one of the most significant unmet health needs of RHP 9. A recent study in Texas found that NorthSTAR was one of only four LMHAs in which age-adjusted mortality rates were significantly higher for the mental health population compared to the general population. Consistent with the NASMHPD study, the majority of

deaths in this region were due to medical illness, and most of those were due cardiovascular disease. The NorthSTAR system differs from the rest of the state in that it includes patients with primary diagnoses of substance use disorders, a preliminary analysis of death records showed similar mortality rates between the mental health and substance abuse populations.

Cost Trends in the Behavioral Health Population
The financial implications of caring for those with behavioral health conditions are substantial and impact resources within the healthcare institutions of RHP 9. Analysis of DFW Hospital Council Foundation data demonstrates that charges associated with the care of mental health patients more than doubles from $50,000,000 to over $100,000,000 between the ages of 17 through 21. Charges continue to rise through adulthood, and between the ages of 47-65, the estimated charges for mental health encounters are higher than those of all other conditions combined. When substance abuse encounters are included, this difference is even greater.

Figure 5: Age and Charge Distribution by Mental Health and Substance Abuse Encounter (2010Q3-2011Q3)

In RHP 9, the presence of a co-occurring behavioral health condition is associated with increased case severity of medical encounters and a 36% increase in the average charges per encounter. In RHP 9, 100% of the 10 most frequently admitted patients had a co-occurring behavioral health diagnosis depicted in Figure 5. These 10 individuals incurred a cost of more than $26 million between 2007 and 2011; however only 1/5 of their hospital emergency department visits were for a mental health or substance abuse issue. Sixty-one percent were uninsured (24% Medicaid, 12% Medicare, and 3% Insured).

17 Mortality of Public Mental Health clients treated at the Local Mental Health Authorities of Texas, 2012.
18 Personal communication between EA Becker and M Balfour
19 Dallas Fort Worth Hospital Council Foundation, Readmission Patterns by Mental Health & Substance Abuse, 2012
20 DFWHC Foundation, Information and Quality Services Data Warehouse, 2012.
The percentage of residents below 200% Federal Poverty Level in Dallas County who receive behavioral healthcare in primary care settings is 19.8% which is significantly lower than the national average of 37.1%. Parkland, the largest primary care provider to low-income populations in Dallas County, is not a NorthSTAR provider and consequently, some who may be successfully served in primary care settings are referred to NorthSTAR. This may result in dilution of limited NorthSTAR resources, as well as coordination of care issues for those with high complexity co-occurring illness. An analysis of the diabetic population at Parkland revealed that diabetics receiving antipsychotic medications from the NorthSTAR system were twice as likely to receive second-generation antipsychotics, which adversely affect metabolic indicators associated with poor diabetes outcomes, compared to those receiving antipsychotics from the Parkland pharmacy.  

The funding challenges combined with the complexity of the behavioral health system may adversely impact sub-populations with the highest needs. The number of NorthSTAR enrollees booked into jail has been steadily increasing as shown below in Figure 8, and 27% of all bookings to the Dallas County Jail are currently referred to jail behavioral health services. Homeless individuals with behavioral health conditions cost three times as much and are booked into jail twice as often as the general NorthSTAR population. Among high utilizers, these relationships are magnified, as illustrated below.

**Figure 8: Behavioral Health Patient Factors for Top 20% Utilizers of NorthSTAR, Dallas County Jail, and Terrell State Hospital, 2010**

**Figure 9: Behavioral Health Costs for Top 20% Utilizers of NorthSTAR, Dallas County Jail, and Terrell State Hospital, 2010**

23 Ron Stretcher and Jill Reese, Dallas County Criminal Justice Department
24 Communication between Wassem Ahmed, Medical Director-Parkland Jail Behavioral Health and M. Balfour, MD
Children/Youth
The number of Dallas County children receiving publicly funded mental health services has tripled from 2000 to 2010. In Dallas County, the number of children identified with a diagnosable emotional disturbance or addictive disorder has increased to approximately 142,000 children with 5% of those children experiencing a significant impairment as a result. Among youth between the ages of 12-17, 7.2% have experienced a major depressive episode.

Cultural and Linguistic Minorities
Hispanics comprise 40% of the population but only 25% of the NorthSTAR population. While there is a lack of services available and written materials available in Spanish, it is difficult to characterize the extent of the need, because data on primary language is not collected.

Demand for Behavioral Health Services
Following the economic downturn in 2009, there was a 17% increase in 23-hour observation visits at Green Oaks Hospital, mostly accounted for by new enrollees to NorthSTAR. More recently, there has been a sharp spike in 23-hour observation utilization, with Feb 2012 visits 26% higher compared to Dec 2011 (and 25% higher compared to Feb 2011). This increase coincided with both regulatory oversight limiting the capacity of Parkland’s Psychiatric ED by 50% and a reduction in funding for outpatient services in the NorthSTAR system.

In addition to hospital-type services, there is also a need for less-acute levels of behavioral care in order to prevent the need for these high-cost services. A sub-acute crisis residential level of care exists but there are only 21 beds for the entire NorthSTAR region. The Behavioral Health Leadership Team has identified the highest need for service development to be post-crisis “wraparound” services to reduce the 20% 30-day readmission rate to crisis services, and peer-driven services to engage clients early in order to prevent crisis episodes.

Chronic Disease
Similar to national trends, North Texas is experiencing increasing rates of many chronic diseases, including heart disease, cancer and stroke. Also there are increasing rates of asthma and diabetes in adults within the Dallas County Metropolitan Statistical Area as shown below.

Figure 10: Dallas County Adults with Asthma and Diabetes

In an assessment of ED utilization, the five encounter types that were most frequent and of highest volume are those for chronic conditions of asthma, chronic bronchitis, pain/aching of

27 ValueOptions of Texas
joints, sinusitis, and hay fever. There were slight variations presented when encounters were analyzed by payer type. More Medicaid and uninsured patients sought treatment for asthma than those with insurance or Medicare and for the uninsured specifically, diabetes was listed as the 5th top condition, while not even listed as a top 5 condition for the insured or Medicaid.

Figure 11: Volume for Adult Outpatient Emergency Department Encounters (2010Q3 - 2011Q3)

<table>
<thead>
<tr>
<th>Highest Volume</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Low Back Pain</td>
<td>Hypertension</td>
<td>Pain/Aching of Joints</td>
<td>Chronic Bronchitis</td>
<td>Asthma</td>
</tr>
<tr>
<td>Insured</td>
<td>Low Back Pain</td>
<td>Hypertension</td>
<td>Pain/Aching of Joints</td>
<td>Chronic Bronchitis</td>
<td>Asthma</td>
</tr>
<tr>
<td>Medicaid</td>
<td>Low Back Pain</td>
<td>Pain/Aching of Joints</td>
<td>Asthma</td>
<td>Chronic Bronchitis</td>
<td>Depression/Anxiety</td>
</tr>
<tr>
<td>Medicare</td>
<td>Low Back Pain</td>
<td>Hypertension</td>
<td>Chronic Bronchitis</td>
<td>Pain/Aching of Joints</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Uninsured</td>
<td>Low Back Pain</td>
<td>Pain/Aching of Joints</td>
<td>Hypertension</td>
<td>Asthma</td>
<td>Diabetes</td>
</tr>
</tbody>
</table>

Asthma

Over the past decade, asthma has become a widespread public health problem that has increased in both Texas and the United States. Asthma has a major impact on the health of the population and the burden falls unevenly on some populations. According to Texas Behavioral Risk Factor Surveillance System in 2005, approximately 1.5 million adults (ages 18 and older) and 389,000 children (ages 0-17) were reported to have asthma at the time. And in 2006, the state of Texas spent over $391.5 million for inpatient admissions with a primary discharge diagnosis of asthma.

In 2008, the state of Texas had a risk-adjusted admission rate of 72.5 per 100,000 cases. Although Dallas County had a slightly higher rate at 89.1 per 100,000 cases, six of the ten counties surrounding Dallas County were significantly more burdened with a risk-adjusted admission rate of greater than 92.2 per 100,000 cases. Only one county of the ten had a lower risk-adjusted rate (Rockwall County) at 70.5 per 100,000 cases. Other North Texas counties’ asthma admission rates are shown in the table below.

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28 Dallas Fort Worth Hospital Council Foundation, Information and Quality Services Data Warehouse. March 2011.
29 Dallas Fort Worth Hospital Council Foundation, Information and Quality Services Data Warehouse. March 2011.
31 Asthma Coalition of Texas. 2012.
32 AHRQ Prevention Indicators. Adult Asthma Admission Rate. 2008
Diabetes
Diabetes affects 11.4% of the population in Dallas County, which is above both the state average of 10% and the national average of 8%. In patients seen throughout the regional healthcare system and who are residents of Dallas County, the top five primary diagnoses, those patients with an underlying condition of diabetes were 29% for pneumonia, 39% for septicemia, 31% for other rehabilitation, 34% of urinary tract infection and 45% of acute kidney failure. They with diabetes had a higher mortality percentage than those without in four of the five top inpatient diagnoses revealing that a co-morbidity of diabetes increases your risk for mortality.

Dallas County’s top seven diagnoses for ER patients were Acute URI Unspecified, Otitis Media, abdominal pain, chest pain unspecified, urinary tract infection, headache and other chest pain. Within those top seven diagnoses, 20%–45% had an underlying condition of diabetes. Specifically, of all patients who came to the ER with chest pain as a diagnosis, 21%–25% had a comorbidity of diabetes. Of patients presenting with abdominal pain, urinary tract infections and headache, 10% also had diabetes.

Children/Youth.
Between 2000 and 2010, the number of Children’s Medical Center admissions of youth with a primary or secondary diagnosis of diabetes increased by 34%. With the association of diabetes and obesity, there is also cause for concern of the future trajectory as low income preschool obesity within the Dallas Metropolitan Statistical Area was 17.2% in 2009, placing many young children at higher rates of developing diabetes in later years.  

Cost/Charge.
Isolation of a specific “direct cost” is complicated. However, it is understood that the societal burden for this condition is extremely large and has manifestations in healthcare service utilization due to increases complexity and severity of other co-occurring medical conditions. Additionally, there are important societal costs of lower economic productivity of individuals with severe diabetic complications. The magnitude of the issues is only projected to increase as more people begin to develop diabetes at earlier in life.

Patient Safety and Quality and Hospital Acquired Conditions

The DFWHC Foundation’s 77 hospitals had 1,706 adverse hospital events in 2010. These events included air embolism, Legionnaires, Iatrogenic Pneumothorax, delirium, blood incompatibility, glycemic control issues and Clostridium difficile, which are not part of the ten adverse events specified by CMS. A significant portion was made up of Medicare patients (46%) and insured (54%) according to the claims data within the DFWHC Foundation claims data warehouse.

Emergency Department Usage and Readmissions

An analysis of the emergency department encounters demonstrates that many in the population are accessing emergency departments for both urgent and non-urgent conditions. Over the most recent four quarters of data, the conditions for which the most volume of care

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34 Children’s Medical Center. Beyond ABC Report, 2012
was provided in an emergency outpatient setting were: low back pain, hypertension, pain/joint aching, chronic bronchitis, and asthma.Further assessment demonstrates that, with the exception of asthma, over 68% of the encounters for the top primary health conditions listed above were
either non-emergent or emergent/primary care treatable, in that the care could have been provided effectively in a primary care setting. For asthma, approximately 98.1% of all encounters were emergent, however the condition could have been potentially avoidable or preventable if effective ambulatory care could have been received during the illness episode.\textsuperscript{35}

For emergency department encounters that resulted in a hospital admission, the most common health conditions by volume include stroke, diabetes, congestive heart failure, weak/failing kidneys, chronic bronchitis and heart attack. When reviewing by payer type, diabetes is the top condition for the uninsured and Medicaid and the 5\textsuperscript{th} top condition for those who are insured.

**Figure 14: Adult Inpatient Emergency Department Encounters (2010Q3 - 2011Q3)\textsuperscript{36}**

<table>
<thead>
<tr>
<th>Highest Volume</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Stroke</td>
<td>Congestive Heart Failure</td>
<td>Weak/Failing Kidneys</td>
<td>Chronic Bronchitis</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Insured</td>
<td>Stroke</td>
<td>Weak/Failing Kidneys</td>
<td>Congestive Heart Failure</td>
<td>Heart Attack</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Medicaid</td>
<td>Diabetes</td>
<td>Congestive Heart Failure</td>
<td>Weak/Failing Kidneys</td>
<td>Stroke</td>
<td>Chronic Bronchitis</td>
</tr>
<tr>
<td>Medicare</td>
<td>Congestive Heart Failure</td>
<td>Stroke</td>
<td>Weak/Failing Kidneys</td>
<td>Chronic Bronchitis</td>
<td>Heart Attack</td>
</tr>
<tr>
<td>Uninsured</td>
<td>Diabetes</td>
<td>Stroke</td>
<td>Weak/Failing Kidneys</td>
<td>Congestive Heart Failure</td>
<td>Heart Attack</td>
</tr>
</tbody>
</table>

Specific to children, the high volume ED encounters includes asthma, diabetes, pain/aching joints, and arthritis most frequently. Regardless of payer type, asthma and diabetes are the top conditions for ER and inpatient admissions.

**Figure 15: Pediatric Inpatient Emergency Department Encounters (2010Q3 - 2011Q3)\textsuperscript{37}**

<table>
<thead>
<tr>
<th>Highest Volume</th>
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<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Asthma</td>
<td>Diabetes</td>
<td>Pain/Aching of Joints</td>
<td>Arthritis</td>
<td>Congestive Heart Failure/Liver Condition</td>
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<tr>
<td>Insured</td>
<td>Asthma</td>
<td>Diabetes</td>
<td>Pain/Aching of Joints</td>
<td>Arthritis</td>
<td>Liver Condition</td>
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<tr>
<td>Medicaid</td>
<td>Asthma</td>
<td>Diabetes</td>
<td>Arthritis</td>
<td>Congestive Heart Failure</td>
<td>Pain/Aching of Joints</td>
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<tr>
<td>Uninsured</td>
<td>Asthma</td>
<td>Diabetes</td>
<td>Pain/Aching of Joints</td>
<td>Arthritis</td>
<td>Liver Condition/Low Back Pain</td>
</tr>
</tbody>
</table>

\textsuperscript{35} DFWHC Foundation, Information and Quality Services Data Warehouse, 2011.
\textsuperscript{36} Ibid.
\textsuperscript{37} Ibid.
In North Texas, all-cause readmissions as defined by a subsequent admission within 30 days from the incident encounter of any type has demonstrated a downward trend since 2008.38 Many hospitals are working to continue improvement in this area, specifically for readmission related to congestive heart failure, acute myocardial infarction, and pneumonia.

As evidenced by an assessment of 10 individual high utilizers in the region, there is a strong relationship between readmissions and behavioral health. Each patient has some component of mental health or substance abuse history over the course of their encounter history.

**Figure 16: Top Ten High Emergency Department Utilizers: Mental Health and Substance Abuse**

<table>
<thead>
<tr>
<th>Category</th>
<th>Total Cases</th>
<th>Mental Health</th>
<th>Substance Abuse</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>Hospitals Visited</th>
<th>Average LOS (Days)</th>
<th>Uninsured</th>
<th>Insured</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Total Charges</th>
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<td>98</td>
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<td>118</td>
<td>89</td>
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<td>2%</td>
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<td>17</td>
<td>510</td>
<td>117</td>
<td>169</td>
<td>125</td>
<td>78</td>
<td>22</td>
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<td>QUID</td>
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<td>171</td>
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<td>82</td>
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<td>0%</td>
<td>0%</td>
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<tr>
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<td>1.4506</td>
<td>6%</td>
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<td>$657,233</td>
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</table>

**Cost/Charge**
From quarter 3 of 2010 to quarter 3 of 2011, the estimated charges associated with all regional emergency outpatient encounters was $312,816,490 and for emergency inpatient encounters, the total charges increase to $2,076,778,420. For emergency inpatient encounters, there was little charge variation across insured, Medicaid, Medicare, and Uninsured payer types.

**Palliative Care**
Palliative care is an important factor in the care delivery system of RHP 9. Overall, Medicare reimbursements to providers in Dallas County are higher than average and higher than the 50th percentile in the country during a patient’s last two years of life signifying a large volume of palliative care services being provided. Even within the health service area of RHP 9, there is variability of the percentage of deaths occurring within hospitals, ranging from 0.69 percent to 1.17 when compared to the national average.

**Oral Health**
Tooth decay (dental caries) is the most common chronic childhood disease. In 2003, the proportion of Texas children reported to have teeth in excellent or very good condition was lower than the national average and lower within all age, sex, and racial/ethnic subgroups.

38 DFWHC Foundation, Information and Quality Services Database, 2010.
Dental problems in adults are equally problematic. According to the U.S. Surgeon 39 most adults in the U.S. show signs of periodontal or gingival diseases and severe periodontal disease affects 14 percent of adults (ages 45–54 years). However, a little less than two-thirds of adults report visiting a dentist within the past 12 months, and those with incomes at or above the poverty level are twice as likely to report a dental visit in the past 12 months as those below the poverty level. The American Dental Association cited the major reason for not accessing regular oral health care is the high cost of dental care. And the number of individuals who lack dental insurance is more than 2.5 times the number of those who lack medical insurance.

Effective health policies intended to expand access, improve quality, or contain costs must consider the supply, distribution, preparation, and utilization of the workforce. According to the National Health Service Corps, Texas needs 784 additional dentists to achieve the recommended ratio of one dentist for every 3,000 residents. The overall supply of dentists in Texas has been consistently below the national average of 59-60 dentists per 100,000 for many years. 40 In 2006, Texas had 36.0 dentists per 100,000 and it has been declining since.

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### Summary of Community Needs

<table>
<thead>
<tr>
<th>Identification Number</th>
<th>Brief Description of Community Needs Addressed in RHP Plan</th>
<th>Data Source for Identified Need</th>
</tr>
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<td>CN.1</td>
<td>Community Description – Demographics</td>
<td>US Census Data, DFW International Community Alliance Report, Communities Foundation of Texas Report</td>
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<tr>
<td>CN.2</td>
<td>Regional Healthcare Infrastructure and Patient Migration Patterns</td>
<td>DFWHC Foundation, Information Quality and Services Data Warehouse, Parkland Health and Hospital System</td>
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<td>CN.3</td>
<td>Healthcare Capacity</td>
<td>Health Professions Resource Center, Center for Health Statistics, US Department of Health and Human Services; Children’s Medical Center Beyond ABC Report; Horizons (2012): The Dallas County Community Health Needs Assessment</td>
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<td>CN.4</td>
<td>Primary Care and Pediatrics</td>
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<td>CN.6</td>
<td>Behavioral Health and Primary Care</td>
<td>TriWest/Zia Partners Report, National Alliance on Mental Illness, DFWHC Foundation, Information Quality and Services Data Warehouse, Horizons: The Dallas County Community Health Needs Assessment</td>
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<td>Behavioral Health and Jail Population</td>
<td>Dallas County Criminal Justice Department, Parkland Health and Hospital System</td>
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<td>CN.9</td>
<td>Chronic Disease</td>
<td>DFWHC Foundation Information Quality and Services Data Warehouse, Diabetes in Dallas County Report, Children’s Medical Center Beyond ABC Report, Horizons: The Dallas County Community Health Needs Assessment</td>
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<td>CN.10</td>
<td>Oral Health</td>
<td>US Department of Health and Human Services Healthy People 2010, Texas Department of State Health Services Oral Health Program, DSHS Primary Care Office</td>
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<td>CN.11</td>
<td>Patient Safety and Quality</td>
<td>DFWHC Foundation Information Quality and Services Data Warehouse, Institute of Medicine Report</td>
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<td>CN.12</td>
<td>Emergency Department Usage and Readmissions</td>
<td>DFWHC Foundation Information Quality and Services Data Warehouse</td>
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<td>CN.13</td>
<td>Palliative Care</td>
<td>Barnato et al., Teno et al., Wennenberg et al.</td>
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</table>
5. Parkland Health and Hospital System.
15. Institute of Medicine. Living Well with Chronic Illness: A Call for Public Health Action. Committee on Living Well with Chronic Disease: Public Health Action to Reduce Disability and Improve Functioning and Quality of Life. February 2012.


26. Value Options of Texas.

