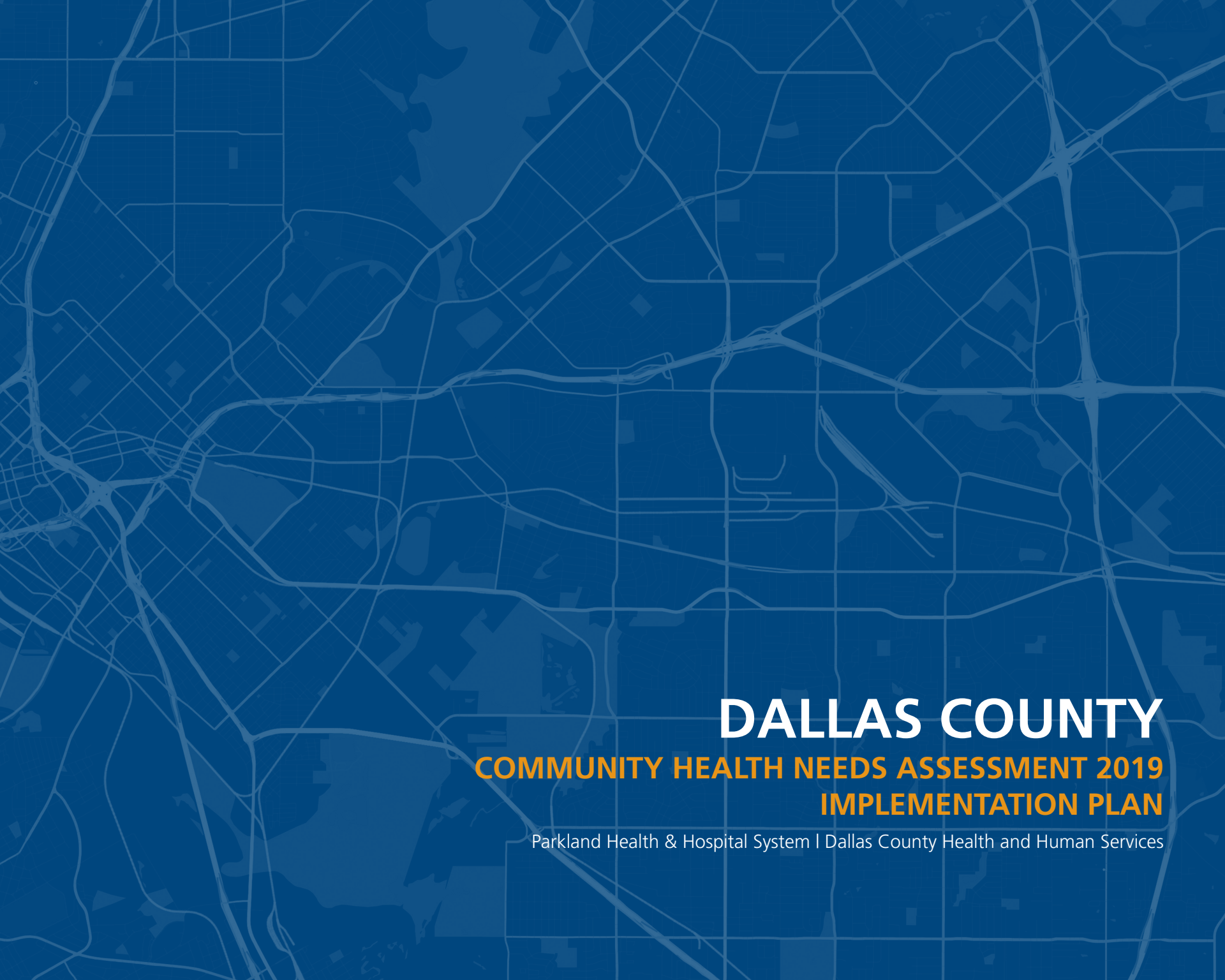

DALLAS COUNTY

COMMUNITY HEALTH NEEDS ASSESSMENT 2019
IMPLEMENTATION PLAN

Parkland Health & Hospital System | Dallas County Health and Human Services

Parkland CEO Fred Cerise, MD, MPH and DCHHS Director Philip Huang, MD, MPH discuss CHNA findings at a Dallas community forum.

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Parkland Health & Hospital System (Parkland) and Dallas County Health and Human Services (DCHHS) are pleased to present the implementation plan in response to the 2019 Community Health Needs Assessment (CHNA) report released on Sept. 30, 2019.

To access the full CHNA report visit the following links:

Parkland:
www.parklandhospital.com/CHNA

DCHHS:
https://www.dallascounty.org/Assets/uploads/docs/hhs/chna/CHNA-2019.pdf

In accordance with the Patient Protection and Affordable Care Act (ACA) this plan describes the strategies that Parkland and DCHHS will deploy to address the key findings of the CHNA. More importantly, the document serves as a vehicle to demonstrate Parkland's and DCHHS' commitment to:

I. Transparency: By providing a full description of the strategies that Parkland and DCHHS will deploy over the next three years to address the key findings of the 2019 CHNA.

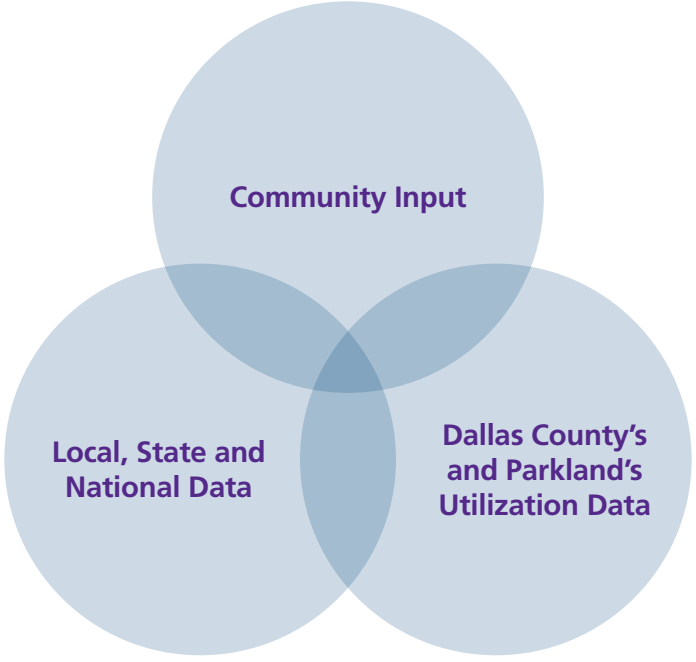
II. Accountability: Describing the quality metrics that will demonstrate progress toward a healthier community.

III. Collaboration: A call to action to strive for health equity by addressing the complex social, economic and systemic factors known as social determinants of health (SDOH) that contribute to the chronic and endemic disparities present in Dallas County. In this spirit, Parkland and DCHHS invite Dallas County residents to read and provide input on this important work at the link provided below:

www.parklandhospital.com/CHNA2019

In addition to describing the strategies that Parkland and DCHHS will deploy over the next three years, this document is meant to serve as the foundational work for future programs that strive for health equity.

The prioritization of community health needs was conducted in a multiphase approach that included public health practice and Community-Based Participatory Research. First, county, state and national health data were gathered and analyzed against Dallas County's and Parkland's utilization data to determine the major causes of mortality, morbidity and utilization. Second, 24 focus groups sessions were conducted throughout the county to gain community input, and 12 of these focus groups were conducted in ZIP Codes with the highest SocioNeeds Index and with the most significant health disparities. The input from these sessions was coded and categorized according to the Centers for Disease Control and Prevention (CDC) social determinants of health (SDOH) to determine the contributing factors to health disparities.[1,2]



The Venn diagram depicts the three data sources used to identify morbidity, mortality and utilization trends. The common trends among the three categories, i.e. the intersection point, represent the key findings of the CHNA.

[1] Center for Disease Control and Prevention. Social Determinants of Health. Know What Affects Health. Available at https://www.cdc.gov/socialdeterminants/index.htm
[2] Office of Disease Prevention and Health Promotion. HealthyPeople2020. Available at https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

The priority health conditions were grouped in four categories: chronic diseases (including hypertension, diabetes, asthma, and cancer), maternal and child health, infectious diseases and behavioral health. Common to all conditions are challenges related to access to care, SDOH and cultural competency of the health system. A brief description for each priority health condition is provided below.

1. Chronic Diseases

Heart disease was the leading cause of death in Dallas County from 2013-2017. Major risk factors for heart disease include tobacco use, hypertension and diabetes.

Cancer is the second leading cause of death in Dallas County. Lung cancer remains the leading cause of cancer death and its mortality rate has declined significantly in the past 18 years along with the decline in tobacco use. Patients with breast cancer who are treated at Parkland present with late stage disease at twice the U.S. rate.

Another significant cause of morbidity and mortality is chronic lung disease which includes pediatric asthma.

2. Maternal and Child Health

While Dallas County's access to prenatal care has been celebrated at the local, state and national[3] level access to postpartum care is limited among women on Medicaid since that coverage ends at 60 days after delivery. The lack of postpartum care and the consequences to maternal health were recently highlighted by the 2018 Texas Maternal Mortality Review. More than half (56%) of all of maternal deaths in Texas during 2012 occurred more than 60 days following delivery, a period after Medicaid expires. Drug overdose, cardiac conditions, suicide and homicide were the most common reasons for maternal death in women up to 365 days after delivery. Maternal deaths were found disproportionately among African American women in Texas.[4] Therefore, increased access to health services during the year after delivery, especially for women of color, is a priority.

3. Infectious Diseases

Sexually transmitted infections (STIs) rates have increased over the past 10 years in Dallas County including over 800 new cases of HIV every year. Prevention of STIs is an essential primary care strategy for safeguarding and improving reproductive health.[5]

4. Behavioral Health Services

Behavioral health has been shown to be a key indicator of quality of life and health-related quality of life.[6] Of all the CHNA focus group responses that fell within the Health and Healthcare domain, access to behavioral health services was the top concern, cited by 29% of respondents.

[3] Testimony from David B. Nelson, MD Chief of Obstetrics at Parkland Hospital to 116th United States Congress Energy and Commerce Subcommittee on Health met September 10, 2019 at a hearing entitled, "Maternal Health: Legislation to Advance Prevention Efforts and Access to Care." https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Testimony-Nelson-Improving%20Maternal%20Health_091019.pdf. Accessed November 22, 2019.

[4] Maternal Mortality and Morbidity Task Force. Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. As Required by Chapter 34, Texas Health and Safety Code, Section 34.0152018 September 2018

[5] Office of Disease Prevention and Health Promotion. Healthy People 2020. Sexually Transmitted Disease. Available at https://www.healthypeople.gov/2020/topics-objectives/topic/sexually-transmitted-diseases.

[6] Office of Disease Prevention and Health Promotion. Mental Health and Mental Disorders. Healthy People 2020. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders

The plan herein is designed to address the key health needs outlined earlier and be informed by evidenced-based practices, promising practices, and most importantly, to work in partnership with community stakeholders who strive for the following goals and objectives.

A. IMPLEMENTATION PLAN GOAL AND OBJECTIVES:

1. Long-Term Goal

a. Decrease disparities in Southern Dallas County and address health outcomes in specific populations.

2. Short-Term Objectives

a. Develop data systems and analytic capacity, establish measures and describe baseline performance, set goals for improvement and use data to track progress in order to address disparities identified in the CHNA.

b. Coordinate DCHHS and Parkland efforts with other community partners to maximize impact.

c. DCHHS will enhance capacity to address chronic disease and other non-communicable disease issues.

d. Expand community outreach efforts and engage the community in implementation.

e. Develop long-term, comprehensive strategies to break the cycles that are responsible for the disparities and address upstream social determinants of health.

B. OVERARCHING STRATEGIES

Parkland and DCHHS have adopted collective impact, cultural competency and community health workers as the foundational components of this implementation plan.

1. Collective Impact

Given the complex nature of the health disparities in Dallas County, Parkland and DCHHS are committed to mobilize internal and external stakeholders to address the findings of the 2019 CHNA. Collective Impact emphasizes cross-section collaboration to channel large-scale change[7] and is also considered a quality improvement framework to address complex social problems.[8]

The five conditions of Collective Impact are:[9]

Common Agenda:	The participants have a common understanding of the problem that needs to be solved, shared vision and joint approach to solve the problem through agreed upon actions.
Shared Measurement:	Collecting data and measuring results consistently across all participants to ensure alignment and accountability.
Mutual Reinforcing Activities:	The work of each participant is identified and differentiated through a common plan.
Continuous Communications:	Ongoing and consistent communications across all stakeholders is imperative to build trust, support common goals and promote collaboration.
Backbone Support:	Parkland and DCHHS will allocate staff and resources to develop the common plan, coordinate activities among participants and push forward the agenda.

[7] Dankwa-Mullan I, Pérez-Stable EJ. Addressing Health Disparities Is a Place-Based Issue. Am J Public Health. 2016;106(4):637–639. doi:10.2105/AJPH.2016.303077
[8] Aragón TJ, Garcia BA; Population Health Division Leadership Team. Designing a learning health organization for collective impact. J Public Health Manag Pract. 2015;21 Suppl 1(Suppl 1):S24–S33. doi:10.1097/PHH.0000000000000154
[9] Kania J, Kramer M. Collective Impact. Stanford Social Innovation Review. 2011

2. Cultural Competency (CC)

CC is defined as a set of congruent behaviors, attitudes and policies that enable a system, agency or group of professionals to work effectively in multicultural environments such as Dallas County. Very importantly, systemic CC is not static or something that is achieved or completed once. Systemic CC is active responsiveness and an ongoing process that reflects organizational commitment and entails periodic reassessment and adjustments.[10]

In accordance with the guidelines set forth by the Substance Abuse and Mental Health Services Administration (SAMSHA), Parkland and DCHHS are committed to establishing a joint CC Plan responsive to the CHNA priorities.

Parkland will assign the Executive Vice President & Chief Talent Officer to oversee the CC assessment and implementation plans. This will include oversight of policies and procedures to ensure adherence to the Cultural Linguistic Appropriate Services (CLAS) standards.

Conduct a CC Organizational Self-Assessment

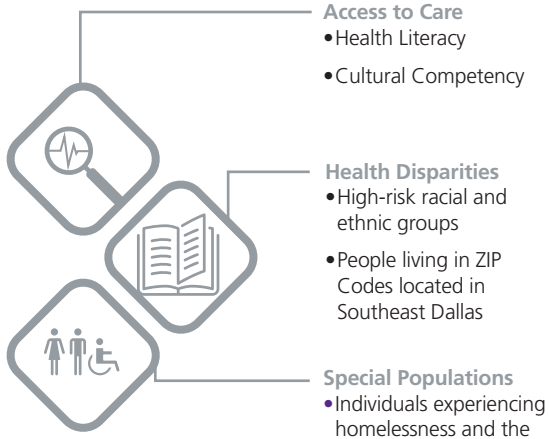
Strategy Metric: Percentage of employees who participated in the organizational assessment.

1. Use a third party, e.g., consultants and/or external evaluators to select, analyze and manage the assessment.
2. Identify external stakeholders who can provide valuable feedback about current strengths and areas in need of improvement regarding the function of Parkland and DCHHS and the needs of the communities they serve.
3. Determine distribution, administration and data collection procedures (e.g., confidentiality, participant selection methods).

Develop an implementation plan based on the assessment

Based on the information gleaned from the assessment, establish priorities for the organizations and incorporate them into a cultural competency implementation plan. Included in the plan will be a system to provide ongoing monitoring and performance improvement strategies. The plan is expected to include the following components:

1. Consistent collection of relevant data to gain better understanding of the health needs of vulnerable or special populations:
    - I. Race, Ethnicity, Age and Language data (REAL)
    - II. Sexual Orientation and Gender Identification (SOGI) data
    - III. Patient literacy level
2. Trauma informed care training
3. Workforce development:
    - I. Identify an experienced workforce development leader to guide and execute strategic roadmap
    - II. Increase guidance and career support resources for Parkland employees in entry-level jobs
    - III. Optimize healthcare internships for high school and college students who live in ZIP Codes with disproportionately high SocioNeeds Index (SNI) scores.
    - IV. Secure and expand educational partnerships to build new programs that promote entry to healthcare jobs and increase diversity within Dallas County's healthcare workforce.
    - V. Target recruitment in ZIP Codes with high SNI scores.
    - VI. Establish a Parkland Career Advisory program.



[10] U. S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Improving Cultural Competence. Quick Guide for Administrators. Available at https://store.samhsa.gov/system/files/sma16-4932.pdf

3. Community Health Workers (CHWs)

Mounting evidence demonstrates the benefits and versatility of adopting CHWs in public health programs.[11] Furthermore, systemic reviews by the Community Preventive Services Task Force (CPSTF) provide strong evidence of the positive impact of CHWs on improving blood pressure and cholesterol control, breast cancer screening, and diabetes prevention and management.[12] This, coupled with the racial and ethnic diversity that characterizes Dallas County, provides strong rationale for establishing a coordinated CHW program.

CHW Program Description

CHWs will assist with access to care, healthy literacy and delivery of services that address the social determinants of health, bridging the gaps among communities, individuals and providers through targeted community outreach and education.

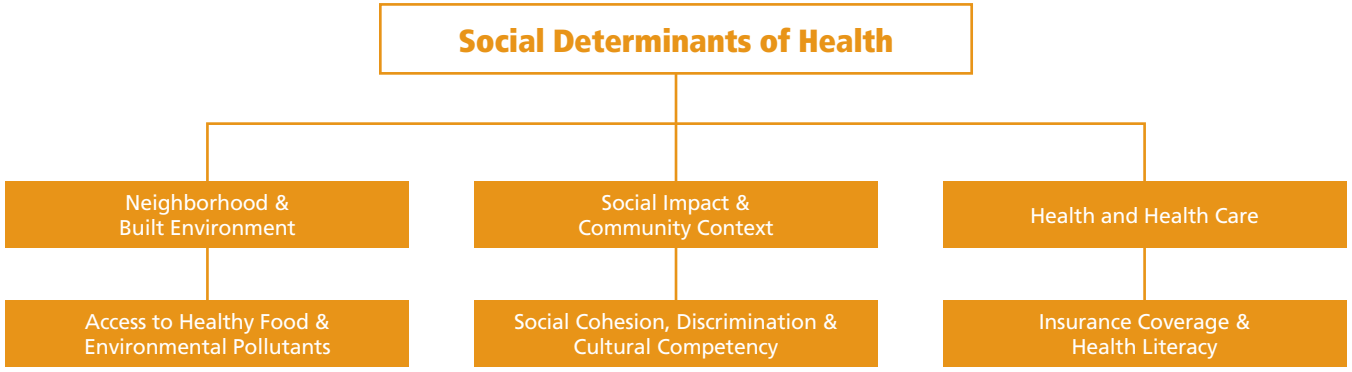
- CHWs provide safe and high-quality basic care, improve the overall health of communities and strengthen health systems.
- CHWs extend care to underserved communities where they improve health equity, enhance access to health services and promote people's trust in and use of the health system.
- CHWs foster self-reliance of communities and local participation.

[11] Landers S, Levinson M. Mounting Evidence of the Effectiveness and Versatility of Community Health Workers. Am J Public Health. 2016;106(4):591–592. doi:10.2105/AJPH.2016.303099

[12] The Community Guide. Community Health Workers. Available at https://www.thecommunityguide.org/search/community%20health%20workers

CHW Scope of Work

Three out of the five SDOH categories, as defined by Healthy People 2020, emerge as chief contributors to the widespread and chronic health disparities in Dallas County.



Access to Care:

1. Explain and help navigate application for health insurance coverage, specifically Parkland Financial Assistance
2. Medication refills, medication adherence, prescription literacy, etc.
3. Appointment reminders, navigation, follow-up, connect to PCP/clinics

Health Literacy:

1. Education on disease prevention and disease management
2. Adherence to medication
3. Application for durable medical equipment
4. MyChart enrollment and navigation
5. Telehealth

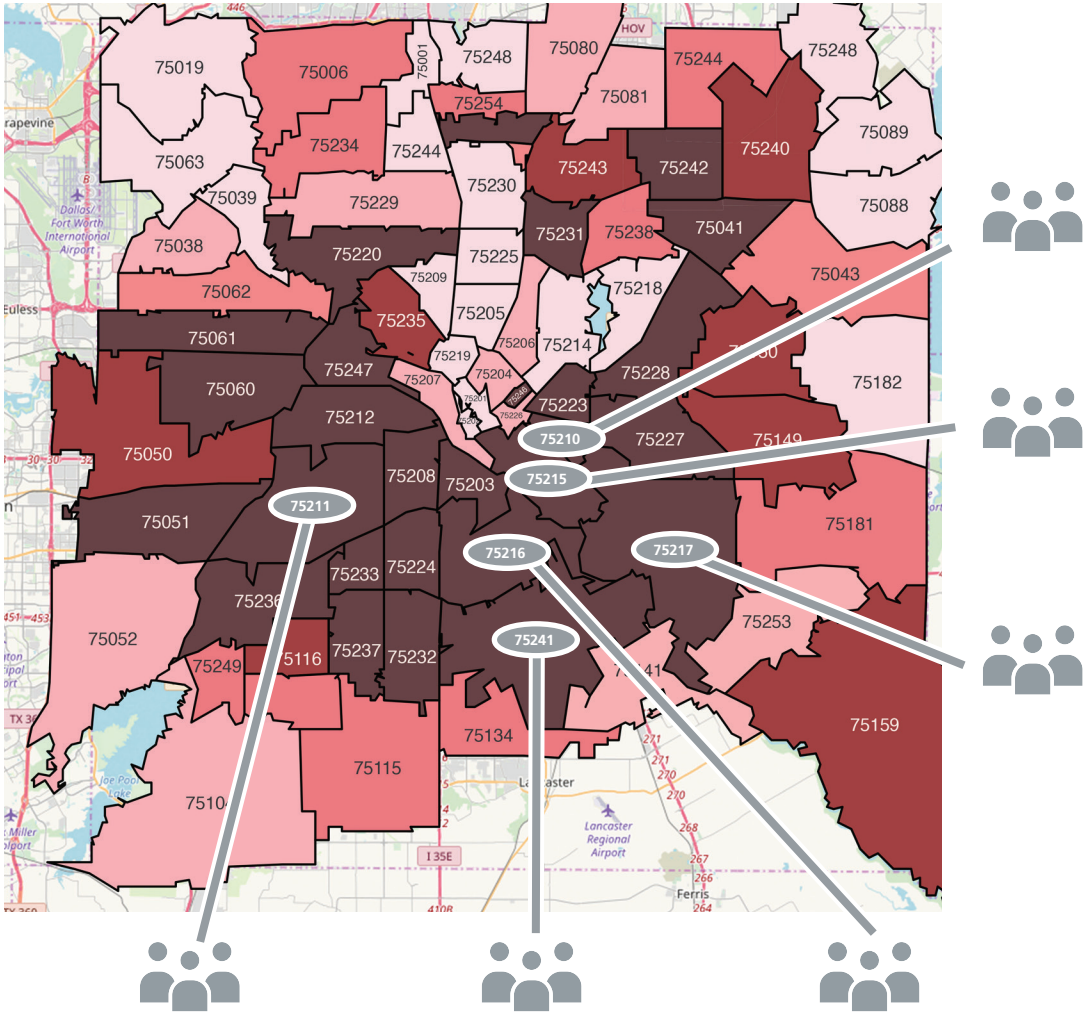
Address SDOH:

1. Transportation (to/from appointments), Dallas Area Rapid Transit (DART) navigation
2. Home assessment (safety, environment, food, etc.)
3. Assess and help enroll in qualifying social services (e.g., SNAP)
4. Link to community-based organizations

Central to the success of a CHW program is recruiting, hiring and training CHWs who live in the communities they will serve. This serves two purposes:

1. Building trust with community members.

2. Developing the workforce, particularly in ZIP Codes with high SNI scores.



C. Chronic Diseases Strategies

C.1 Hypertension	
Problem Statement	Heart disease is the leading cause of death in Dallas County with African Americans suffering from particularly high mortality rates related to the condition.
Strategy	Establish high blood pressure program that adheres to the State of Texas public strategies for addressing heart disease and stroke (2019-2023). The program will focus on patients residing in ZIP Codes 75210, 75211, 75215, 75216, 75217, 75241. In addition the program will have a particular focus on African Americans as they have a significantly higher mortality rate related to hypertension than other race/ethnicities
Metric 1	Number of patients from the targeted population screened for high blood pressure and follow-up documentation
Metric 2	Percentage of patients from the targeted population whose blood pressure at the most recent visit is adequately controlled
Metric 3	Percentage of patients with diabetes from the targeted population whose blood pressure at the most recent visit is adequately controlled.
Activity 1	Work with DCHHS to develop an enhanced surveillance system for chronic diseases. Establish a heart disease registry.
Activity 2	Align clinical teams and CHWs to support patients with uncontrolled high blood pressure
Activity 3	Explore technology and care delivery models that decentralize care from main campus
Activity 4	Conduct focus groups in CHNA target ZIP Codes to identify best outreach and communication vehicles for targeted education and health literacy efforts
Activity 5	In conjunction with community partners, deploy education and health literacy program into CHNA targeted ZIP Codes
DCHHS Activity	• Establish a joint Parkland-DCHHS chronic disease epidemiological approach to reduce hypertension rates and heart disease in high priority areas of Dallas County • Work with community partners (other hospitals, CBOs, FQHCs, etc.) to continue chronic disease epidemiological approach utilizing DCHHS hypertension rates and heart disease surveillance data • Reduce the burden of hypertension and heart disease in Southeast Dallas through policies and environmental changes to increase access to healthy foods and physical activities

C.2 Late Breast Cancer Diagnosis	
Problem Statement	1. When compared to the rest of the county, Southeast Dallas has the highest number of cancer morbidity and mortality 2. These areas have higher rates of low socio-economic status as well as a higher rate of minority populations, e.g., African American and Hispanics
Strategy	Build upon Parkland's Breast Cancer Health Equity efforts launched in 2019 that provide the foundational work to establish a "Multicomponent Intervention." Multicomponent Intervention is an evidenced-based strategy recommended by the CPSTF to promote breast cancer screenings in underserved populations
Metric 1	Number of women from the targeted population who received a mammogram
Metric 2	Percentage of "Lost to Care" patients from the targeted population (i.e. not cleared and treatment non-initiated)
Activity 1	Deploy a data-driven cancer screening campaign to: • Increase the number of breast health community events within the target ZIP Codes • Deploy mammography services to target geographic areas based on data • Develop partnerships with community resources involved in breast health services • Leverage CHWs to engage and link women at risk to schedule mammogram screenings and follow-up appointments
Activity 2	Strengthen Parkland's breast cancer continuum of care to ensure patients remain in care until clear or treatment is completed: • Assign patient navigators to women who have a suspicious breast cancer mammogram • Create electronic health record alert that notifies providers throughout the system if a patient has missed a follow-up appointment or has been difficult to reach for resolution of a test result and instructs that provider to route the patient to a designated patient navigator who can connect the patient with appropriate follow up
Activity 3	Enhancement of care coordination teams by: • Integrating community health workers, patient advocates and nurse navigators • Deploying seamless workflows to handoff patients throughout our system
DCHHS Activity	• Establish a joint Parkland-DCHHS cancer epidemiological approach to reduce cancer rates in high priority areas of Dallas County • Work with community partners (other hospitals, CBOs, FQHCs, etc.) to continue cancer epidemiological approach utilizing DCHHS cancer surveillance data

C.3 Diabetes	
Problem Statement	There is a high rate of diabetes morbidity among residents living in CHNA target ZIP Codes 75210, 75211, 75215, 75216, 75217 and 75241.
Strategy	Deploy simultaneously Primary, Secondary and Tertiary interventions as described in the activity section that focuses on individuals from CHNA target ZIP Codes
Metric 1	Number of patients from the targeted population screened for diabetes and receiving documented follow-up care
Metric 2	Percentage of patients with diabetes from the targeted population who performed an HbA1c test
Metric 3	Percentage of patients with diabetes from the targeted population whose most recent HbA1c level is > 9.0%
Metric 4	Percentage of diabetic patients from the targeted population with HbA1c level > 9.0% and PSAM score (medication adherence) < 60%
Metric 5	Percentage of patients with diabetes from the targeted population who received a foot exam
Metric 6	Percentage of patients with a diagnosis of a diabetic foot problem from the targeted population who experienced an amputation

C.3 Diabetes (continued)	
Activity 1	Primary Intervention: This is designed to identify people who have or may have diabetes and are not aware and link them to right level of care by: • Conducting regular disease screening and awareness/education campaigns in target ZIP Codes. This collaborative effort focuses on partnering with community-based organizations to screen people living in target ZIP Codes who may be at risk for diabetes and to deliver lifestyle intervention education/training to peers and at-risk community members. • Referring individuals qualifying for further care to the appropriate clinical setting. • Enrolling all willing and eligible individuals without established healthcare access who require ongoing care into Parkland or alternate care (as appropriate) and ensure appropriate health coverage (insurance or Parkland Financial Assistance [PFA]) to enable access to care and medications
Activity 2	Secondary Intervention: This intervention focuses on linking new diabetes patients to primary care by: • Verifying patients referred to primary care have adequate health coverage and/or connection to appropriate services • Screening patients seen in primary care settings for SDOH and record data in Epic, and leverage CHW to address SDOH that may pose health risks such as insurance coverage, access to healthy food, health literacy, etc. • Screening patients for development of disease complications based on ADA Standards of Diabetes Medical Care recommendations • Verifying that patients receive guideline-based care for treatment of condition and related co-morbidities • Providing primary care access through alternate visit types (virtual, connected care, SMA, RN led clinic, multi-disciplinary visits etc.) • Ensuring access to medications and monitoring medication adherence for patients prescribed guideline-based care
Activity 3	Tertiary Intervention: This intervention focuses on high risk patients by: • Reviewing the criteria for recommended referral of high risk patients to Diabetes Consult Team • Stratifying inpatient diabetes education for high risk patients • Connecting high risk patients to a medical home at appropriate discharge interval • Verifying follow-up of patients discharged from hospital needing care within the Parkland system • Connecting patients to required SDOH resources following discharge • Providing appropriate medication management and reconciliation on discharge from hospital • Integrating referrals, communications and support for other chronic disease such as hypertension, asthma, cancer and behavioral health • Ensure appropriate health coverage (insurance or PFA) to enable access to care and medications • Targeted diabetes training of relevant hospital clinical personnel
DCHHS Activity	• Establish a joint Parkland-DCHHS chronic disease epidemiological approach to reduce diabetes in high priority areas of Dallas County • Work with community partners (other hospitals, CBOs, FQHCs, etc.) to continue chronic disease epidemiological approach utilizing DCHHS diabetes surveillance data • Reduce the burden of diabetes in Southeast Dallas through policies and environmental changes to increase access to healthy foods and physical activities

C.4 Pediatric Asthma	
Problem Statement	High asthma morbidity among pediatric population in the following ZIP Codes: 75210, 75211, 75215, 75216, 75217 and 75241.
Strategy	Implement "Breath For Life & Learn For Life" asthma program. This is a data-driven model for cross-sector linkage and coordination between Dallas County schools and its health system. The purpose of this program is to enroll children with an asthma diagnosis in a text notification program that alerts patients and/or parents to follow appropriate preventive measures to avoid asthma exacerbation.
Metric 1	Percentage of patients with asthma from the targeted population who were prescribed an asthma therapy
Metric 2	Number of pediatric patients with asthma from the targeted population enrolled into the notification program
Metric 3	Percentage of patients with asthma from the targeted population who received a flu shot
Activity 1	Enroll Parkland's existing pediatric asthma patients who are not enrolled through the system's health plan in the Breath For Life & Learn For Life program
Activity 2	Establish collaboration between Parkland, DCHHS and Dallas Independent School District (DISD): • Establish data sharing agreements between Parkland and DISD and identify resources and programs that would make such agreements meaningful in terms of outcomes (align to leverage Parkland's Youth & Family Centers, as appropriate) • Identify and solve for any legal barriers (FERPA, HIPAA, etc.) to such collaboration • Identify and address any barriers of technological interoperability and sustainability
DCHHS Activity	DCHHS will coordinate the following efforts: • Further develop epidemiologic/data collection/analysis capacity and convene ongoing working meetings with Parkland staff. Assist in the development of Asthma Self-Management Education policy/procedures (AS-ME) • Identify at least two districts for implementation of AS-ME • Identify districts with clean diesel bus routes and/or anti-idling policies • Identify housing authorities and programs that use CHWs and train CHWs • Provide technical assistance to multi-unit housing and housing authorities on tobacco-free policies • Implement policies, system and environmental changes to reduce tobacco use, exposure to second-hand smoke and address disparities in ZIP Codes identified as high risk • Work with community partners (other hospitals, CBOs, FQHCs, etc.) to continue asthma epidemiological approach utilizing DCHHS asthma surveillance data

D. Maternal and Child Health Strategies

D. Maternal Mortality	
Problem Statement	1. Most deaths occur after 60 days postpartum, a period beyond the postpartum window covered by Medicaid. 2. African American women have the highest risk of pregnancy-related mortality. 3. Substance abuse, cardiac conditions and behavioral health are leading causes of maternal mortality. 4. Accurate data collection of maternal morbidity and mortality associated with pregnancy during antepartum period, delivery and up to 1 year postpartum is lacking.
Strategy	Establish the Extending Maternal Care After Pregnancy (eMCAP) program which is designed to extend postpartum care to one year to at-risk women
Metric 1	Percentage of patients from the targeted population enrolled into the eMCAP program (target population is defined as postpartum women who reside in ZIP Codes: 75207, 75253, 75241, 75231, 75227, 75224, 75217, 75216, 75215, 75213, 75210, 75203, 75172, 75154, 75146, 75141, 75137, 75134, 75115 and 75232.)
Other metrics	To be developed and tracked by eMCAP program. (see Appendix)
Activity 1	Define the target geographic region of focused interest within Dallas County with limited healthcare resources for women following delivery. Based upon the existing physical location of the 10 Parkland Women's Health Center clinics, there is a noted geography of limited access to these clinics. The target region contains ZIP Codes from the CHNA with some of the lowest life expectancies in Dallas County—e.g., 75215 and lacks access care. This geographic domain is estimated to represent approximately 1,000 deliveries at Parkland Memorial Hospital per year
Activity 2	Establish a data infrastructure to measure the baseline characteristics of healthcare outcomes and quality metrics. These metrics will begin with enrollment demographic data to include age, race/ethnicity, and parity as well as specific block-level data and ZIP Code location of residence
Activity 3	Implement a surveillance system for women from the target region. Connect with women before discharge from the hospital and enroll in the program.
Activity 4	Deploy a mobile health unit and/or establish local fixed site clinics for improved access to care for women after pregnancy in the target region. This unit will contain both nursing and advanced practice provider support for women presenting to care in their community as part of an ongoing postpartum healthcare program
Activity 5	Maintain regular contact with participants through a combination of home visits, telehealth, phone, text message, etc.
Activity 6	Utilize the data infrastructure to measure access and healthcare outcomes following implementation of the program

E. Infectious Diseases Strategies

E. Sexually Transmitted Diseases including HIV	
Problem Statement	Over the past 10 years the rate of sexually transmitted infections has increased and 800 people are newly diagnosed with HIV every year.
Strategy	Parkland will partner with DCHHS, which is leading the effort to reduce the transmission rate of sexually transmitted diseases. DCHHS's 90-90-90 program aims to have 90% of the population with HIV aware of their condition, 90% on treatment and 90% virally suppressed by the year 2030
Metric 1	Percentage of patients from the targeted population who were tested for chlamydia
Metric 2	Number of patients with chlamydia from the targeted population who offered expedited partner treatment
Metric 3	Number of patients from the targeted population who were tested for HIV
Metric 4	Percentage of inmates from the targeted population who were tested for HIV
Metric 5	Percentage of patients from the targeted population who tested positive for HIV and were prescribed treatment within 30 days from test
Metric 6	Percentage of HIV positive patients from the targeted population with a viral load less than 200/copies ml
Activity 1	Parkland will implement an expedited partner treatment program, including education regarding how to approach partners, that allows individuals to secure medication for their partners
Activity 2	Opt-Out HIV Testing • Parkland has initiated "opt out" HIV testing in its Emergency Department that increases the number of patients tested for HIV • Parkland will begin "opt out" testing for HIV at the Dallas County Jail
Activity 3	Parkland and DCHHS have begun providing pre-exposure prophylaxis (PrEP) for individuals at high risk of contracting HIV
DCHHS Activity	• Parkland will support DCHHS in its efforts to develop data systems and analytic capacity to address disparities identified in the CHNA, to monitor progress, trends, and for program planning and evaluation • Establish a joint Parkland /DCHHS STI epidemiological approach to reduce STI/HIV rates in high priority areas of Dallas County • As DCHHS expands community outreach efforts regarding STIs, Parkland will collaborate and support as requested. • DCHHS has consolidated DCHHS STI clinic and renamed Sexual Health Clinic (28% increase in clinic visits in 2019 vs 2018) • DCHHS will expand after hours services of Sexual Health Clinic to evenings and Saturdays • DCHHS will explore need for other sexual health clinic expansions in coordination with Parkland and other community providers

F. Behavioral Health Services

F. Behavioral Health	
Problem Statement	Dallas County does not have enough behavioral health capacity to support the high demand for these services. Navigating the health system in Dallas County is difficult for those with behavioral health needs and there is a lack of integration between behavioral health and physical health. According to input provided by focus group participants, the demand for behavioral health services for school children, youth and seniors is concerning.
Strategy	Increase behavioral health capacity and further improve coordination among behavioral health providers and community-based organizations
Metric 1	Number of patients from the targeted population with a behavioral health encounter
Metric 2	Number of pediatric patients from the targeted population with a behavioral health encounter
Metric 3	Number of interventions by the RIGHT Care teams
Activity 1	Strengthen Integrated Healthcare: • Expand adult behavioral health services in Community Oriented Primary Care (COPC) health centers for individuals diagnosed with mild to moderate mental illness • Expand pediatric mental health services in 2 clinics: deHaro-Saldivar Health Center and the Southeast Dallas Health Center
Activity 2	Centralized Internal Coordination of Care and Access to Care: • Parkland Behavioral Health Center specialty clinic: Serves as a clearinghouse for Parkland referrals for outpatient behavioral health (e.g., COPCs, Parkland Behavioral Health Center) or refer to outside agencies
Activity 3	Engage organizations within the community to create a "no wrong door" approach to serving those with behavioral health needs. This entails working with groups ranging from mental health and substance abuse advocates to churches and community centers to establish a referral system within the community to ensure that as many people as possible know what behavioral health resources are available, and how and when to appropriately access those services
Activity 4	RIGHT Care Team Expansion: RIGHT Care is a partnership involving specially-trained paramedics from Dallas Fire-Rescue (DFR), Dallas Police Department (DPD) and Parkland behavioral health social workers. Together the team works to divert mental health patients from area emergency rooms and jails by stabilizing them on the scene and getting them to the appropriate services that can meet their needs. Expansion of this program includes: • 3 multi-disciplinary teams citywide: 1 South, 1 North, 1 Float (Parkland, DPD, DFR) • 1 complex care team for highest utilizers of jail and ER resources (North Texas Behavioral Health Authority [NTBHA], DPD) • 1 follow-up team (NTBHA, DPD) • 911 Call Center to be staffed by NTBHA Care Coordinator
DCHHS Activity	Building Community Resilience: DCHHS in collaboration with the City of Dallas is spearheading a county-wide effort to improve the health of children, families and communities by fostering engagement between grassroots community services and public and private systems to develop a protective buffer against adverse childhood experiences (ACEs) occurring in adverse community environments. ACEs such as violence, racism, poverty, maternal depression, incarceration and sexual abuse among others, are risk factors for multigenerational stress and poor health outcomes. To learn more about this initiative visit: http://www.100resilientcities.org/wp-content/uploads/2018/06/Resilient-Dallas-Strategy-PDF-1.pdf

G. SDOH: Access to Care and Coverage

Access to Care and Coverage	
Problem Statement	1. South and Southeast Dallas have a concentration of ZIP Codes with high SocioNeeds Index (SNI) scores and high mortality and morbidity 2. Hispanics living in the CHNA target ZIP Codes have the lowest insurance coverage rates in the county, limiting their access to health services 3. In ZIP Codes 75216 and 75217, more than 40% of the population lacks an internet connection
Strategy	Increase access points for health services as well as financial eligibility applications in the Southern sector of Dallas
Metric 1	Number of community partners helping patients with PFA application submission
Metric 2	Number of primary care encounters provided in targeted areas
Activity 1	Establish Community Hubs to increase access points in Southern and Southeast Dallas. Individual/family assistance may include health insurance coverage, immunizations, access points for telehealth services (in areas with low rates of Internet connectivity), transportation, food, housing, employment, education and job training
Activity 2	Identify Community Hub partners and develop MOUs as appropriate (e.g., Dallas Housing Authority, North Texas Food Bank, DISD, community-based organizations, places of worship, etc.)
Activity 3	Train staff at partner organizations (e.g., local FQHCs) to help patients navigate Parkland's coverage eligibility and financial assistance processes from off-site locations
Activity 4	Expand Parkland's Community Health Workers program to improve access/outreach and reduce the number of patients lost to care
Activity 5	Expand clinic access in the Redbird area (new COPC)

APPENDIX

Maternal Care After Pregnancy

Healthcare outcomes and quality metrics

- Enrollment of women in target region after delivery
- Medical complications rates with ongoing needs for care
- Severe maternal morbidities
- Perinatal outcomes
- Infant outcomes
- Postpartum follow-up rates
- Monthly survey of blood pressure and glucose
- Medication compliance
- Mental health screening
- Mental health service utilization
- Breastfeeding rates
- Emergency services utilization
- Health insurance enrollment
- Preventive health services

DALLAS COUNTY
COMMUNITY HEALTH NEEDS ASSESSMENT 2019
IMPLEMENTATION PLAN

Parkland Health & Hospital System | Dallas County Health and Human Services

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