Community Health Needs Assessment

September, 2013

METHODIST MANSFIELD MEDICAL CENTER
COMMUNITY HEALTH NEEDS ASSESSEMENT

Background of Methodist Health System

The primary mission of all the members of the Methodist Health System is to improve and save lives through quality compassionate care and in a manner that reflects "a commitment to Christian concepts of life and learning." Specifically, this mission is pursued by operating four general acute-care hospitals and other health care services, education and support programs needed by the communities in North Central Texas including Methodist Dallas Medical Center, a 515-licensed-bed teaching referral hospital in the southwestern quadrant of the City of Dallas, providing primary, secondary, and tertiary care; and Methodist Charlton Medical Center a 285-bed community hospital, providing primary and secondary care in the southern portions of Dallas and nearby suburban cities, approximately 12 miles southwest of Methodist Dallas; Methodist Mansfield Medical Center is located in Mansfield, Texas residing in the far southwest corner of Tarrant County and Methodist Richardson Medical Center, a 209-bed facility located in Richardson, Texas in the north Dallas section of the Metroplex.

Vision for the Future
To be the trusted provider of integrated quality health care in North Texas.

Core Values
Methodist Health System core values reflect our historic commitment to Christian concepts of life and learning:

Servant Heart – compassionately putting others first
Hospitality – offering a welcoming and caring environment
Innovation – courageous creativity and commitment to quality
Noble – unwavering honesty and integrity
Enthusiasm – celebration of individual and team accomplishment
Skillful – dedicated to learning and excellence

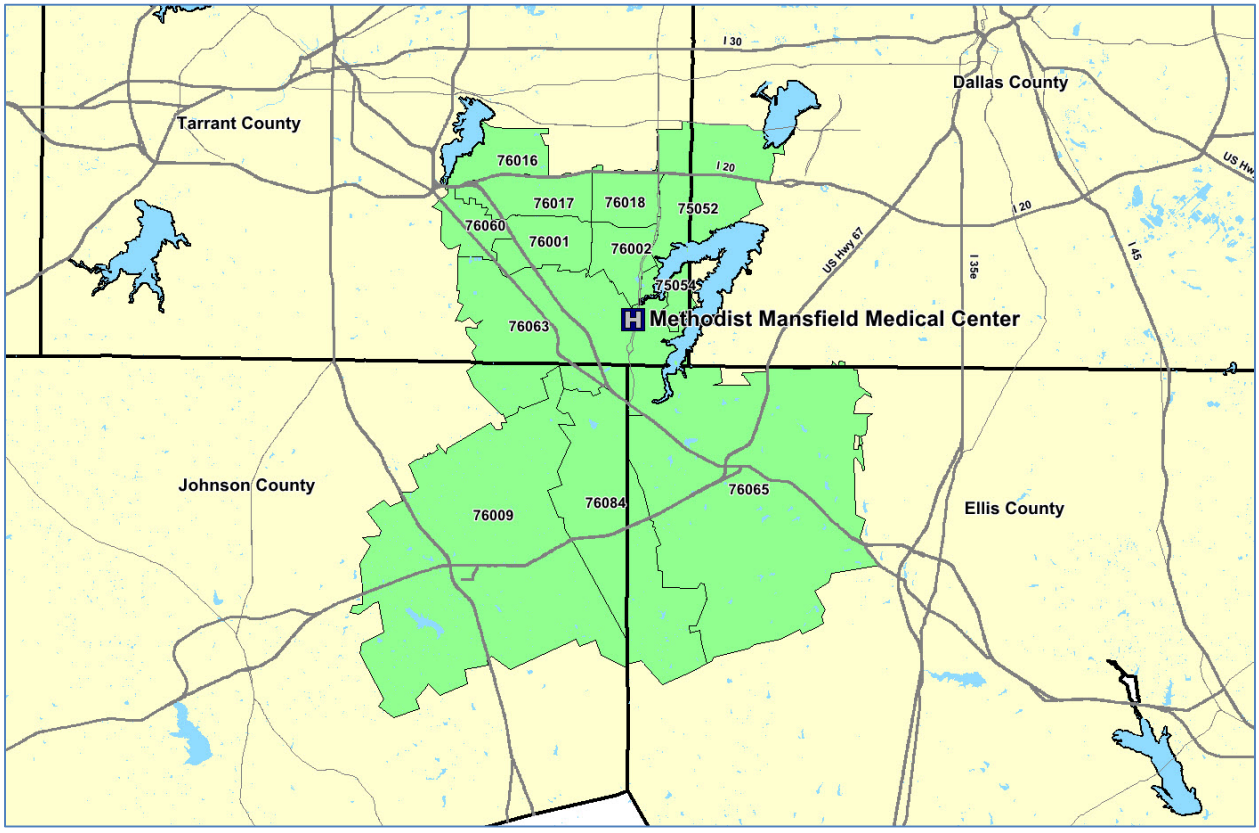
Methodist Mansfield Medical Center opened with 88 beds on December 27, 2006. It was recognized that the region south of Methodist Charlton moving west was growing rapidly but there was little active provider base to serve this growing region. Methodist Health System chose to build a full service community hospital in Mansfield as an anchor for attracting the establishment of more physicians and other types of health care providers. This facility has exceeded volume

projections since receiving its license. Since its opening 6 years ago, Methodist Mansfield has continued to grow. In July 2010 Methodist Mansfield Medical Center celebrated its newly expanded Emergency Department, Intensive Care Unit, and telemetry floor. The $37 million expansion doubled the size of the emergency department with 35 treatment rooms, added eight ICU treatment rooms and 36 telemetry patient rooms on the fourth floor of the hospital. The new areas provide a more comfortable environment for the efficient care and treatment of patients and address the growing demand for patient care in the community.

To ensure Methodist Mansfield continues to meet the demand of women's services, a $9 million expansion of the Women's Pavilion was completed in 2012. With the new 9,413-square-foot addition, Labor and Delivery services at Methodist Mansfield have a total of 13 LDR suites that will accommodate up to 3,800 deliveries each year. And added: Six new labor/delivery/recovery suites (LDR); larger family waiting areas; expanded antepartum area; expanded nurse/physician work areas; and expanded C-section recovery and support.

Identification of Populations and Communities Served by Methodist Mansfield Medical Center

As seen on the map below, the majority of Methodist Mansfield's service area based on population is located in the southwest quadrant of Tarrant County. Three less populated zip codes fall into East Johnson County and the Northwest corner of Ellis County.



Service Area Demographics				
Metric	MMMC Service Area	MHS Service Area	DFW Metroplex	Texas
2010 Total Population	383,700	1,964,382	6,362,518	25,145,248
2013 Total Population	407,208	2,065,119	6,699,756	26,297,165
2018 Total Population	446,641	2,240,025	7,275,567	28,332,799
% Change 2013 - 2018	9.7%	8.5%	8.6%	7.7%
Average HH Income	$79,257	$68,866	$76,646	$68,955
% Unemployment	7.3%	8.5%	7.8%	7.2%
% Managed Care	47.9%	33.7%	36.8%	32.3%
% Below poverty	6.5%	12.6%	10.5%	13.2%
Age Group				
0-14	23.7%	23.9%	23.1%	22.6%
15-17	5.3%	4.8%	4.5%	4.4%
18-24	9.1%	9.6%	9.4%	10.2%
25-34	12.2%	13.4%	14.1%	13.9%
35-54	30.6%	28.4%	28.7%	26.8%
55-64	11.0%	10.6%	10.6%	10.9%
65+	8.1%	9.4%	9.7%	11.1%
Sex				
Male	49.0%	48.9%	49.3%	49.6%
Female	51.0%	51.1%	50.7%	50.4%
Race/Ethnicity				
White	48.8%	33.4%	47.7%	43.5%
Black	18.9%	24.8%	15.2%	11.5%
Hispanic	23.0%	34.1%	29.1%	39.0%
Asian & Pacific Islander	6.8%	5.8%	5.8%	4.1%
All Others	2.5%	1.9%	2.2%	1.8%

Source: TruvenHealth Analytics

According to Claritas census data the demographics for the service area are cited above. While there certainly are pockets of Methodist Mansfield' service area that are weaker than others, overall in comparison to the DFW Metroplex, Methodist Dallas' service area is stronger in that it:

- is growing at a faster rate than the Metroplex overall;
- has a higher average household income than the Metroplex;
- has a lower unemployment rate
- has a higher insured rate; and
- has a lower below poverty percentage

Background on Methodist Mansfield Medical Center's Service Area

Unlike other communities, Methodist Mansfield's service area is experiencing slightly lower unemployment (7.3%) and higher average household incomes ($79,257) than the DFW Metroplex with 26.1% of the population reporting household incomes above $100,000 annually. The majority of these individuals are employed as Office/Administrative Support, Management or Sales. According to the Mansfield Economic Development group, the average home value in Mansfield is $197,592. Mansfield is located within a 30-minute commute of one of the largest labor pools in the DFW Metroplex. Future projections show that this availability will continue, making Mansfield and Tarrant County one of the strongest labor markets in the area.

The area is educated with 29.5% of adults over the age of 25 having earned a bachelor's, masters or PhD. If we include residents with some form of secondary education (Associate Arts, certification, licensure) this increases the educated population to 62.6%. Upon review of the payer mix for all inpatients from the Mansfield area in 2011, the primary payer source was Managed Care (48.5%); with Medicare at 33.3%, Medicaid 8.6%, Self-Pay/Charity Care at 8.9% and All Others, 0.7%.

Approximately 6.5% of families are below the level of poverty in the Methodist Mansfield service area (TruvenHealth Analytics 2013 data). This percentage is lower than the state of Texas (13.2%) and US (11.3%) averages.

The projected population growth is higher at 9.7% when compared with the surrounding DFW Metroplex (8.6%). The largest age cohort for this community is 35-54 (30.6%) followed by 0-17 (29.0%). Women of child-bearing years are expected to increase by 4.4% for this community and the 55+ age cohort is expected to grow 30.0% over the next five years.

The majority of Methodist Mansfield Medical Center's primary service area is located within Tarrant County, primarily southeast Tarrant County with three lesser populated zip codes falling into Eastern Johnson County and northwest Ellis County. Therefore for the purposes of meeting the IRS' community health needs assessment reporting requirements, Methodist Mansfield Medical Center will refer in large part to the completed ***"Texas Healthcare Transformation and Quality Improvement Program"*** required CHNA for Regional Healthcare Partnership 10 covering nine counties including Tarrant, Johnson and Ellis counties.

The following excerpts are taken directly from the published "Texas Healthcare Transformation and Quality Improvement Program" required CHNA for Regional Healthcare Partnership 10 covering nine counties including Tarrant, Johnson and Ellis counties.

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 Appendix D-1.1 for a map of Region 10. Additional count- specific information can also be found in Appendix D-4.)*

Demographics: Population by Age Cohort

Region 10 had a population of 2,444,642 in 2011. The majority of Region 10 residents are working-age adults (62% ages 18-64). The remaining population is made up of seniors (11% of total Regional population) and children (28% of Regional total population). Region 10 is similar to the rest of Texas in terms of its 18-and-under proportion of total residents with the exception of Hood, Somervell and Navarro Counties. Hood County trends significantly older, with a larger proportion of seniors (20.1%), offset by a smaller adult population (57.8%) and child population

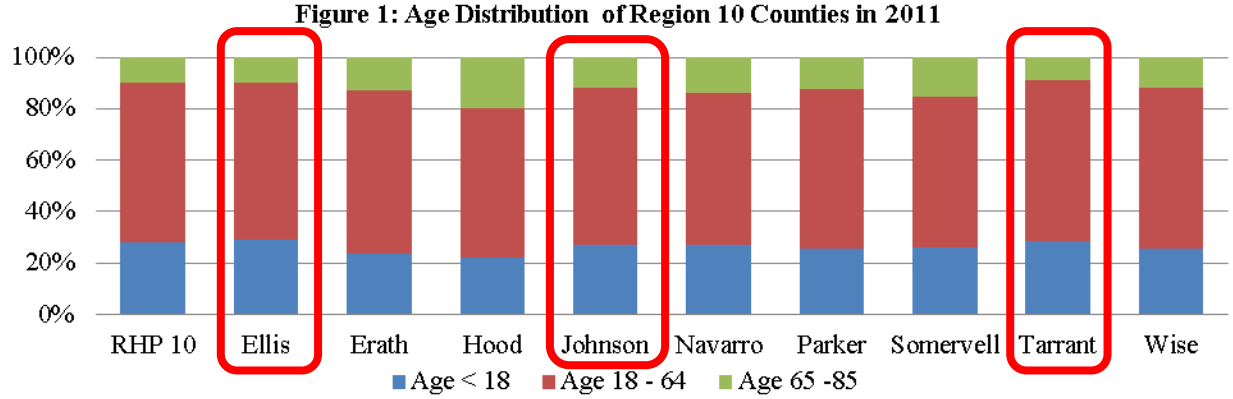
(22.1%). Both Somervell and Navarro also have higher proportions of elderly residents than the rest of the Region, but lower than that for Hood County. In Somervell, the senior population is 15.5% of the total population, with a smaller proportion of working-age adults (58.3%) and a child population similar to the Region (26.2%). Navarro's proportion of elderly residents is similar to Somervell's with seniors representing 14.0% of its population; working-age adults and children represent 59.1% and 26.9% of the county respectively. Tarrant and Ellis Counties have slightly higher proportions of children as a percentage of their total county population (28.4% and 29.4%, respectively) than the rest of the Region.

By 2016, the Region is projected to see its population grow by an estimated 9.4% to a Regional total of 2,674,022 people (60.7% adults ages 18-64; 27.8% children ages 0-18; and 11.5% seniors ages 65 and older). This projected growth is unevenly spread across the counties: Ellis and Parker counties will see the greatest population growth (13.9% and 11.2%, respectively).

Erath and Navarro will see a much lower rate of growth than the rest of the Region (3.9% and 4.3%, respectively). The other five counties in Region 10 are projected to have population growth similar to that of the Region as a whole.

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

Figure 1: Age Distribution of Region 10 Counties in 2011



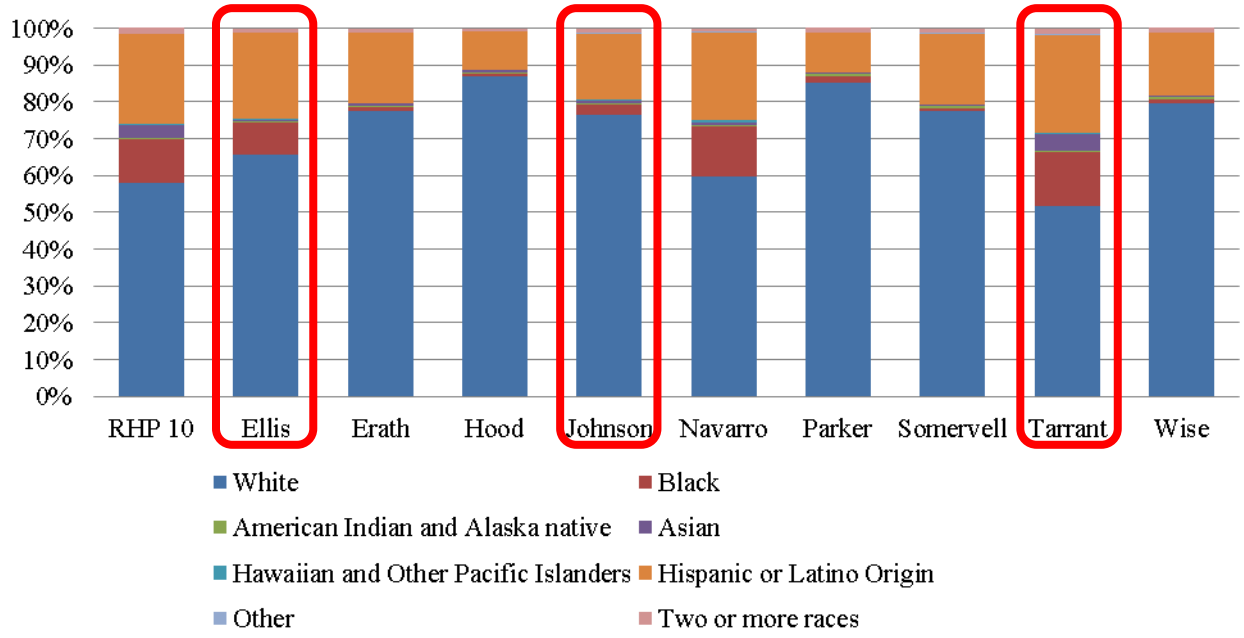
Source: Thomson Reuters 2011

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)*.

Figure 2: Race/Ethnicity Distribution of Region 10 Counties in 2010

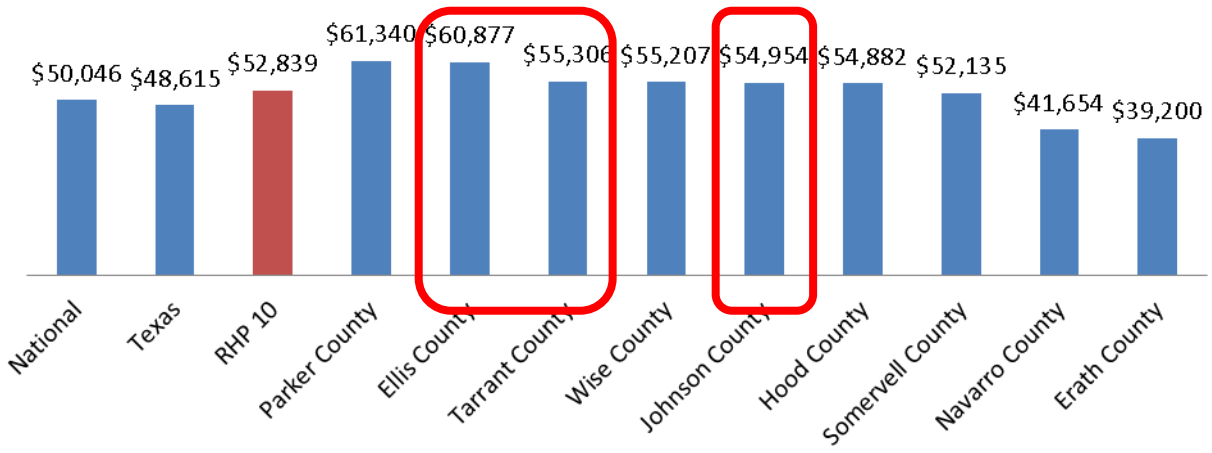


Source: Thomson Reuters, 2011

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.

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



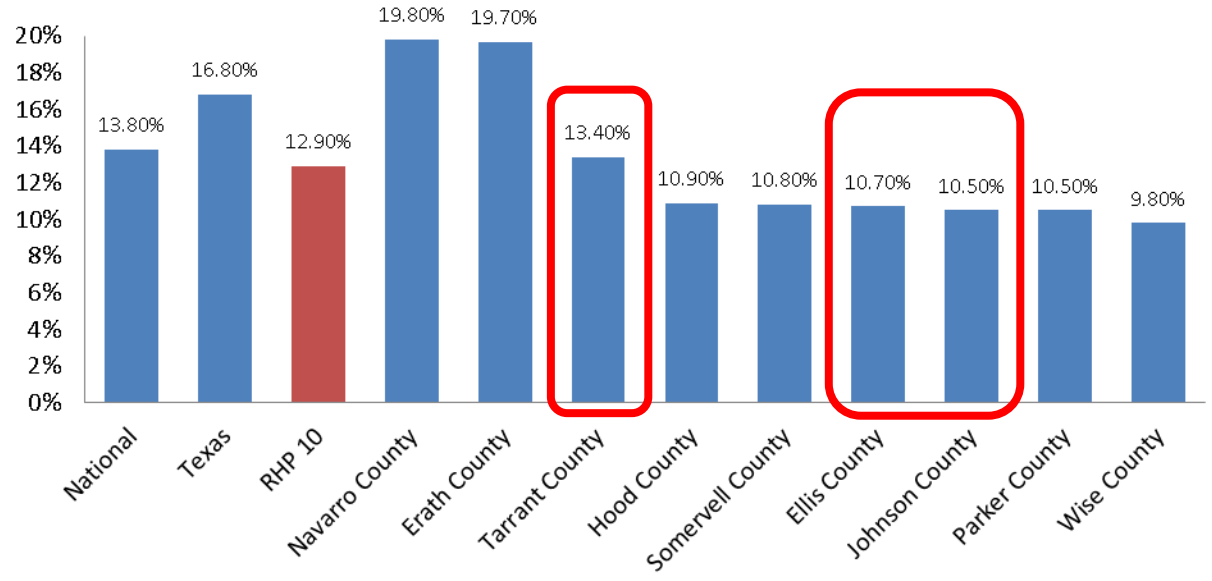
Source: Thomson Reuters, 2011

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.[ii] 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)*.[iii] 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.

Figure 4: Population at or below 100% Federal Poverty Level in 2011



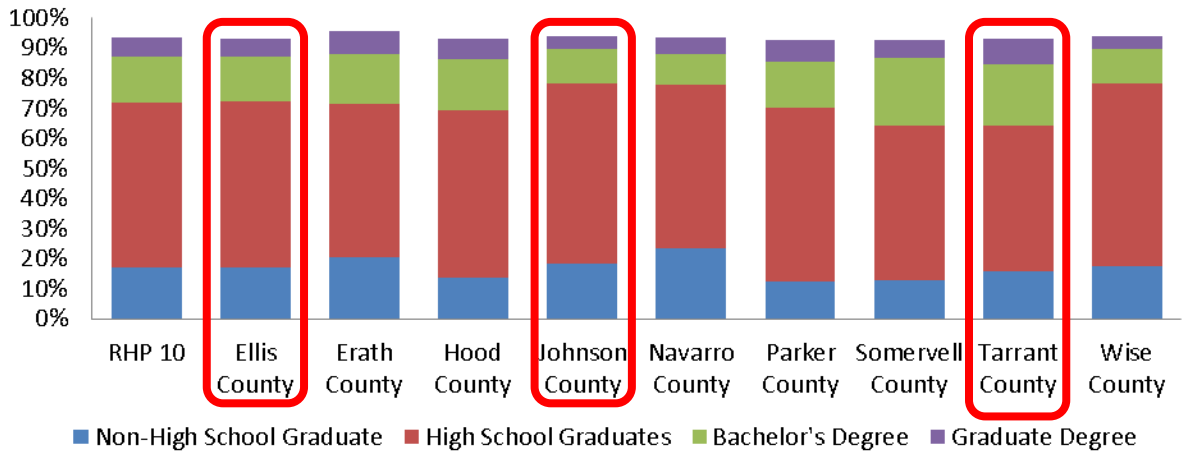
Notes: FPL 2011: $10,890 for an individual, or $22,350 for a family of four
Source: Texas Association of Counties, HealthData.Gov – Health Resources County Comparison Tool

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).

Figure 5: Education Distribution of Region 10 Counties in 2011

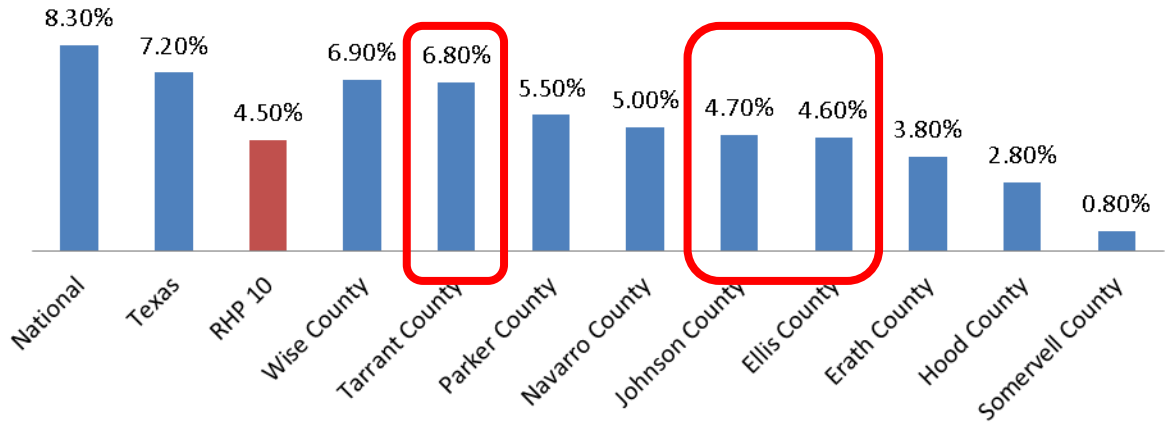


Source: U.S. Census 2011

Demographics: Employment

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

Figure 6: Percent Unemployment of Region 10 in 2010



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

Insurance Status

Being uninsured is a major barrier to accessing primary and preventive care in Region 10. People without insurance tend to be working-age adults with less secure employment, lower wage levels, and pre-existing conditions. When individuals defer care because of cost concerns they are more likely to seek care when symptoms have become more severe and receive care in more expensive,

acute and emergent care settings. Individuals who defer care also have a greater likelihood of poor long-term outcomes.

Put simply, uninsured patients tend to use hospital emergency departments and urgent care centers as a last resort, rather than managing their health through more cost-effective primary care clinics and physician offices. This unmanaged, episodic and health-event driven approach to seeking care has both serious financial cost implications at the county, Regional and national levels as well as potentially devastating health consequences for individuals.[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

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

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

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

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[v] (*Figure 9*).

Figure 9: Health Professional Shortage Areas by County

HPSA Category	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Primary Care	x				x			x	x
Dental Care	x							x	
Mental Health	x	x	x		x	x	x	x	x

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

PPRA Domain		Need(s) Identified								
		Erath	Ellis	Hood	Johnson	Somervell	Tarrant	Wise	Navarro	Parker
Population Health		Yes	No	Yes	No	No	Yes	No	*	*
Provider Capacity	Hospital Provider	No	Yes	Yes	No	No	Yes	No	*	*
	MHMR	Yes	Yes	No	No	No	Yes	No	*	*
	Physician Organization	*	*	*	*	*	*	*	*	*
	Other	*	*	*	*	*	*	*	*	*
Functional Patient Care Teams		Yes	No	Yes	Yes	Yes	Yes	Yes	*	*
Use of HIT		Yes	Yes	No	No	No	Yes	No	*	*
Care Coordination		Yes	Yes	Yes	Yes	Yes	Yes	Yes	*	*

*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

	U.S.	Texas	RHP 10	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Access to Care	*	*	16%	18%	N/A	15%	22%	N/A	12%	N/A	16%	15%
Emergency Department Visits	*	*	1,093,860	74,949	22,748	23,994	68,934	17,199	44,794	5,708	798,904	36,630
Diabetic Screening	89%	80%	84%	80%	81%	87%	89%	82%	79%	92%	82%	76%
Mammography Screening	74%	59%	60%	59%	59%	47%	73%	55%	53%	56%	62%	46%

* Data unavailable

Source: County Health Rankings, 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.

Identification Number	Brief Description of Community Needs Addressed Through RHP Plan	Data Source for Identified Need
CN.1	**Lack of provider capacity.** Patients find difficulty in navigating the system and have noted the difficulty in finding a provider, particularly Medicaid providers. Five counties are recognized as medically underserved areas.	Stakeholder Survey, Texas CHS, County 2010 Health Rankings, Providers Readiness Assessments, Health Professional Shortage Areas
CN.2	**Shortage of primary care services** (e.g., pediatric, prenatal, family care). Four counties have such shortages.	Health Professional Shortage Areas
CN.3	**Shortage of specialty care.** 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.	Health Professional Shortage Areas
CN.4	**Lack of access to mental health services.** All but one county in Region 10 are recognized as health professions shortage areas for mental health providers.	Health Resources County Comparison Tool, Health Indicators Warehouse, Texas Dept. of State Health Services
CN.5	**Insufficient integration of mental health care in the primary care medical care system.** Community stakeholders cite a need to achieve better integration of primary and behavioral health services in the primary care setting.	Stakeholder surveys
CN.6	**Lack of access to dental care.** Two of the 9 counties are nationally recognized with a shortage of dental providers.	Health Professional Shortage Areas.
CN.7	**Need to address geographic barriers that impede access to care**. 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.	Health Resources County Comparison Tool, Health Indicators Warehouse, Texas Dept. of State Health Services
CN.8	**Lack of access to health care due to financial barriers (i.e., lack of affordable care).** Providers overwhelmingly list lack of coverage/financial hardship as a major barrier for low-income patients.	U.S. Census Bureau, County Health Rankings Survey
CN.9	**Need for increased geriatric, long-term, and home care resources (e.g., beds, Medicare providers).** 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.	Thomson Reuters, 2011

Identification Number	Brief Description of Community Needs Addressed Through RHP Plan	Data Source for Identified Need
CN.10	**Overuse of emergency department (ED) services.** 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.	Stakeholder Survey, Texas CHS, 2010 County Health Rankings, UCSF Trends and Characteristics of U.S. Emergency Department Visits, 1997-2007
CN.11	**Need for more care coordination.** 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.	Region 10 Stakeholder Survey
CN.12	**Need for more culturally competent care to address unmet needs (e.g., Latino-population need care, translators, translated-materials).** 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.	American Fact Finder 2010 Census Data, U.S. Census Bureau
CN.13	**Necessity of patient education programs.** Many community residents lack basic health literacy.	U.S. Census, National Adult Literacy Survey (NALS)
CN.14	**Lack of access to healthy foods.** The Region and the state has more than double the percentage of all restaurants that are fast food establishments compared to the nation.	Community Health Rankings
CN.15	**Need for more education, resources and promotion of healthy lifestyles (free and safe places to exercise, health screenings, health education, healthy environments, etc.).** 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.	County Health Rankings, 2010
CN.16	**Higher incidence rates of syphilis and chlamydia.** 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.	Texas CHS
CN.17	**Incomplete management of varicella (chicken pox) cases.** 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).	Texas CHS, Centers for Disease Controls and Preventions
CN.18	**Incomplete management of pertussis (whooping cough) cases.** The Region has nearly a 50% higher rate than state, with rate of 10.3 compared to 5.54 per 100,000, respectively).	Texas CHS, Centers for Disease Controls and Preventions
CN.19	**Need for more and earlier onset of prenatal care.** 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.	Texas CHS
CN.20	**Improved Public Health Surveillance to Promote Individual and Population Health.** West Nile and other disease outbreaks locally highlight areas in the local public health surveillance system that are unaddressed.	Texas DSHS and National Electronic Disease Surveillance System (CDC)

Identification Number	Brief Description of Community Needs Addressed Through RHP Plan	Data Source for Identified Need
CN.21	**High tuberculosis (TB) prevalence** and low treatment completion rates of latent tuberculosis infection (LTBI) LTBI treatment	Healthy People 2020
CN.22	**Inadequate health IT infrastructure** and limited interoperability to support information sharing between providers hinders care coordination.	Region 10 RHP Community Health Needs Assessment, Regional Stakeholder Survey Summary, June 2012

Appendix D:
Additional Community Health Needs Assessment Information

D-1: Community Profile

Figure D-1.1 Map of Region 10 Area

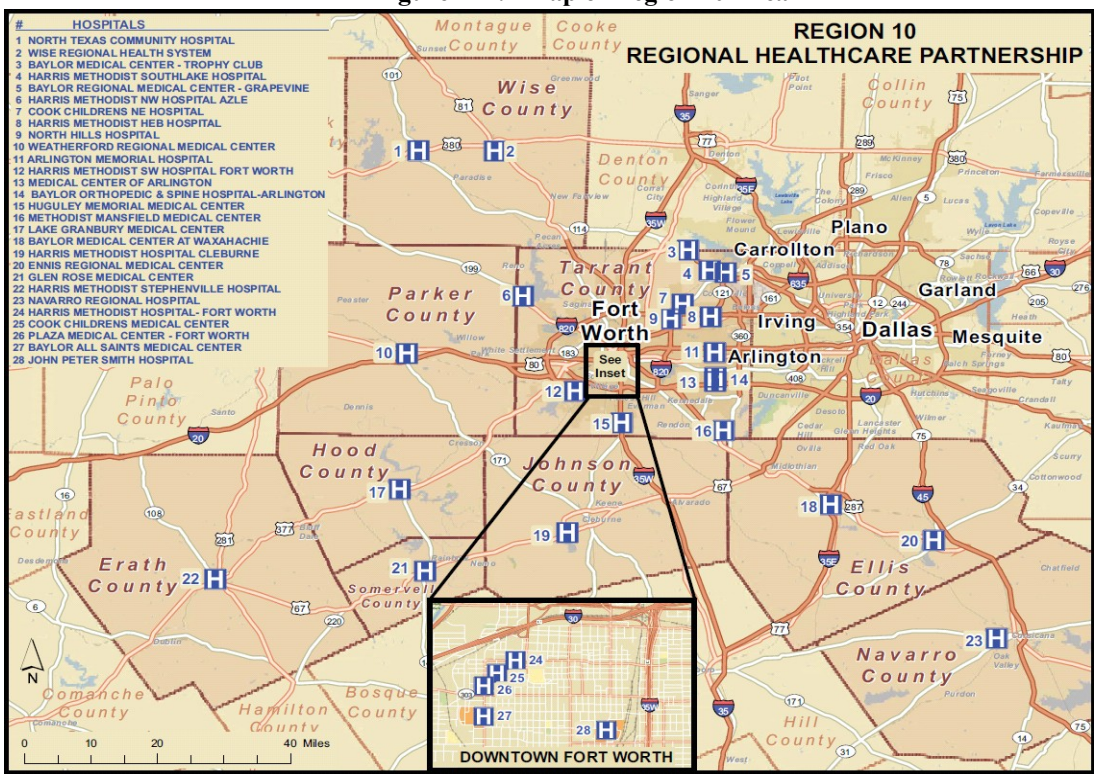


Figure D-1.2: 2010 Population by Race and Ethnicity

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

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

	Total Population for 2011
U.S.	311,591,917
Texas	25,674,681

	Total Population			Children (0-18 years)			Adult (18-64 years)			Seniors (65+ years)		
	2011	2016	Δ%	2011	2016	Δ%	2011	2016	Δ%	2011	2016	Δ%
U.S.				75,596,680	78,091,453		193,707,411	197,037,935		41,346,659	47,902,230	
Texas				7,091,699	7,607,608		15,645,996	16,527,932		2,697,616	3,258,281	
RHP 10	**2,444,642**	**2,674,022**	**9%**	**683,196**	**743,625**	**9%**	**1,518,294**	**1,622,314**	**7%**	**244,752**	**308,083**	**26%**
Ellis	163,972	186,721	14%	48,230	53,234	10%	100,752	111,620	11%	16,590	21,867	32%
Erath	35,565	36,944	4%	8,327	8,713	5%	22,671	23,105	2%	4,567	5,126	12%
Hood	54,128	59,318	10%	11,967	13,220	10%	31,304	32,935	5%	10,857	13,163	21%
Johnson	170,881	187,136	10%	46,151	49,439	7%	104,660	112,358	7%	20,070	25,339	26%
Navarro	49,839	51,961	4%	13,397	13,894	4%	29,444	30,181	3%	6,998	7,886	13%
Parker	107,263	119,320	11%	27,583	29,303	6%	66,506	72,563	9%	13,174	17,454	32%
Somervell	7,584	8,188	8%	1,988	2,047	3%	4,419	4,698	6%	1,177	1,443	23%
Tarrant	1,797,679	1,961,608	9%	510,706	558,225	9%	1,122,631	1,196,495	7%	164,342	206,888	26%
Wise	57,731	62,826	9%	14,847	15,550	5%	35,907	38,359	7%	6,977	8,917	28%

*Data pending Source: Thomson Reuters, 2011**311,591,91725,674,681**

Figure D-1.4: Population by Education, 2010

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

Source: U.S. Census Bureau

D-2: Health care Infrastructure

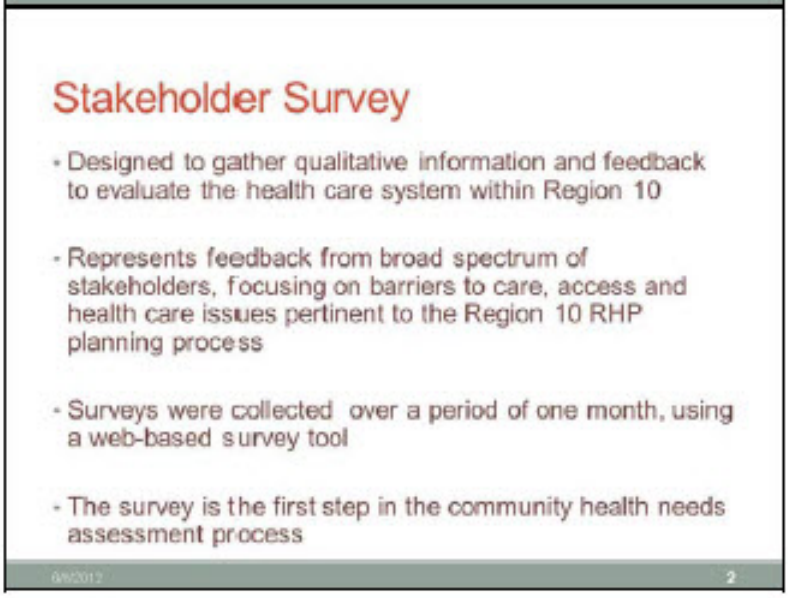
Figure D-2.1: Current Physician Supply (FTE) vs. Projected Physician Demand (% Increase from 2010-2015)

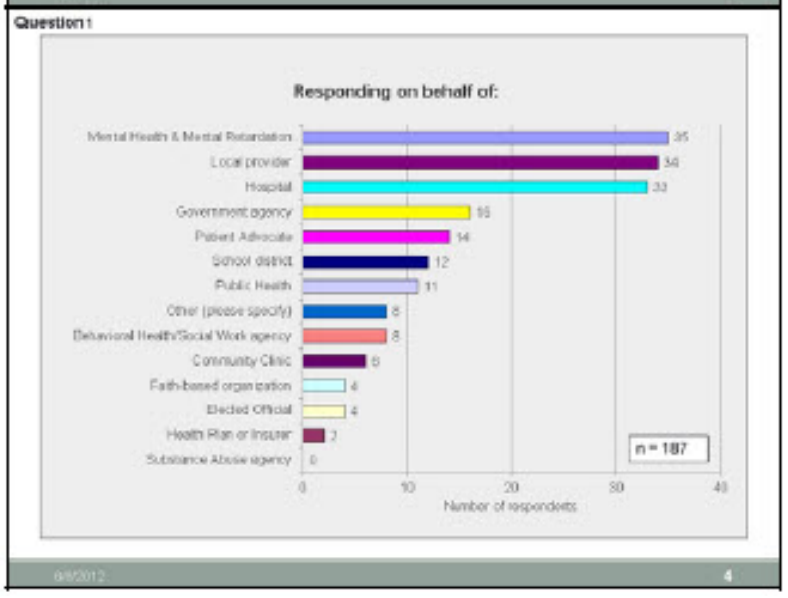
	RHP 10		Ellis		Erath		Hood		Johnson		Navarro		Parker		Somervell		Tarrant		Wise	
	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand
Allergy/Immunology	22	30%	0	31%	0	40%	0	29%	1	27%	1	35%	0	29%	0	28%	21	28%	0	27%
Cardio/Thoracic Surgery	19	33%	0	36%	0	33%	0	29%	0	32%	0	33%	0	34%	0	31%	19	35%	0	33%
Cardiology	118	34%	1	41%	2	22%	2	27%	6	37%	1	23%	1	40%	0	28%	105	40%	1	37%
Colorectal Surgery	15	32%	1	32%	0	42%	0	30%	0	30%	0	41%	0	31%	0	31%	14	31%	0	30%
Dermatology	58	30%	0	34%	0	26%	1	26%	2	30%	3	26%	0	32%	0	26%	52	31%	0	30%
Emergency/Critical Care	212	27%	6	26%	0	31%	3	30%	10	25%	5	31%	9	25%	0	28%	176	26%	4	28%
Endocrinology	20	31%	0	31%	0	43%	0	30%	2	29%	0	39%	0	30%	0	31%	18	29%	0	29%
Gastroenterology	77	32%	1	32%	0	40%	1	30%	5	30%	2	39%	2	31%	0	31%	65	31%	0	30%
General Surgery	149	32%	7	34%	5	28%	2	28%	8	32%	2	31%	4	33%	0	27%	117	34%	5	32%
General/Family Practice	737	31%	35	33%	10	31%	15	27%	33	30%	9	31%	23	31%	4	27%	587	32%	22	30%
Hematology/Oncology	69	34%	0	40%	0	26%	2	28%	2	36%	0	26%	3	39%	0	30%	62	38%	1	35%
Infectious Disease	17	32%	0	34%	0	36%	0	29%	0	31%	0	35%	0	33%	0	30%	17	33%	0	32%
Internal Medicine	489	32%	19	35%	8	33%	10	28%	23	32%	5	32%	10	34%	2	29%	408	34%	5	33%
Nephrology	44	34%	0	39%	0	28%	0	29%	0	36%	1	28%	0	38%	0	30%	42	38%	1	35%
Neurology	61	32%	0	34%	1	34%	0	28%	0	31%	0	33%	2	33%	0	28%	58	33%	1	32%
Neurosurgery	34	31%	0	32%	0	41%	0	29%	0	29%	0	39%	0	30%	0	30%	34	31%	0	29%
Obstetrics/Gynecology	290	36%	8	36%	3	49%	4	30%	11	34%	4	43%	6	35%	0	30%	249	37%	5	36%
Ophthalmology	83	33%	2	38%	2	30%	2	28%	2	34%	2	29%	2	36%	1	30%	70	36%	0	34%
Orthopedic Surgery	172	32%	5	34%	3	37%	4	29%	6	31%	1	35%	5	32%	0	29%	144	33%	5	31%
Other Pediatric Subspecialti	37	26%	0	29%	0	28%	0	27%	0	25%	0	23%	0	25%	0	20%	37	26%	0	23%
Otolaryngology	54	32%	3	33%	1	41%	2	30%	3	30%	1	37%	1	31%	1	29%	43	31%	1	30%
Pain Management	17	32%	2	34%	0	33%	0	29%	0	32%	0	34%	0	34%	0	30%	15	34%	0	32%
Pediatric Cardiology	15	27%	0	30%	0	30%	0	28%	0	26%	0	25%	0	26%	0	21%	15	27%	0	24%
Pediatric EMCC	46	22%	0	24%	0	20%	0	23%	0	22%	0	16%	0	20%	0	15%	46	23%	0	18%
Pediatric Endocrinology	4	26%	0	29%	0	28%	0	27%	0	25%	0	23%	0	25%	0	20%	4	26%	0	23%
Pediatric Pulmonology	6	26%	0	29%	0	27%	0	27%	0	25%	0	23%	0	25%	0	20%	6	26%	0	23%
Pediatrics	287	26%	14	30%	3	27%	5	27%	9	25%	4	23%	7	25%	0	21%	241	26%	4	23%
Physical Medicine/Rehab	53	32%	5	33%	0	36%	0	29%	1	31%	0	35%	0	33%	0	30%	46	32%	1	31%
Plastic Surgery	40	30%	0	30%	0	39%	0	30%	2	28%	0	37%	0	29%	0	29%	37	28%	1	28%
Psychiatry	139	30%	2	28%	2	52%	0	31%	5	26%	0	44%	4	27%	0	30%	125	27%	2	26%
Pulmonology	50	33%	0	37%	0	32%	1	29%	4	33%	1	31%	1	36%	0	30%	42	35%	1	33%
Radiology	191	*	0	*	2	*	3	*	3	*	2	*	7	*	0	*	171	*	2	*
Rheumatology	20	32%	0	35%	0	35%	0	29%	1	32%	0	33%	1	34%	0	30%	18	33%	0	32%
Urology	65	34%	2	37%	1	36%	1	29%	1	34%	3	33%	1	36%	0	30%	55	36%	1	33%
Vascular	16	35%	0	40%	1	26%	0	29%	1	37%	0	27%	0	40%	0	30%	14	38%	0	36%

Source: Thompson Reuters, 2011

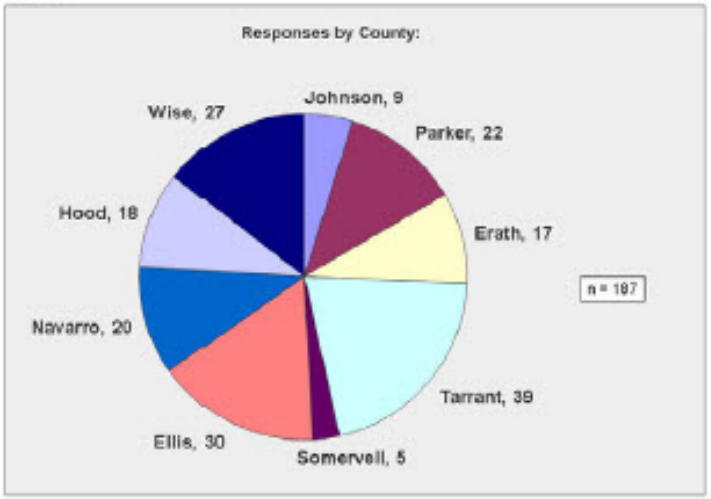
Figure D-2.2: Regional Stakeholder Survey Summary Results

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.





Question 2



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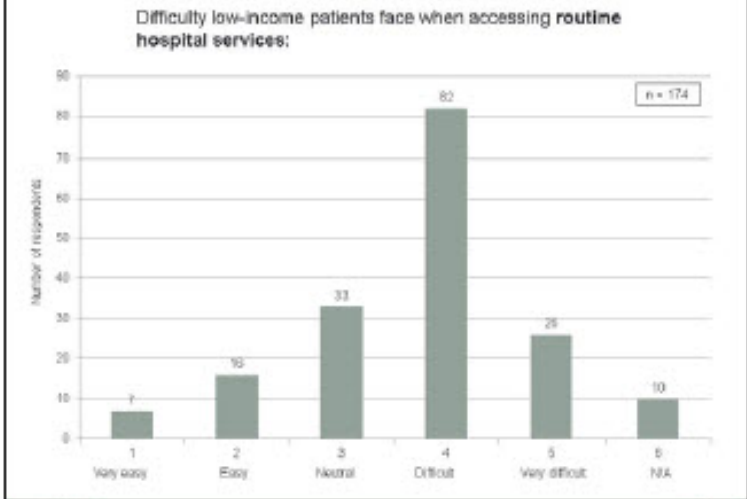
Question 3a

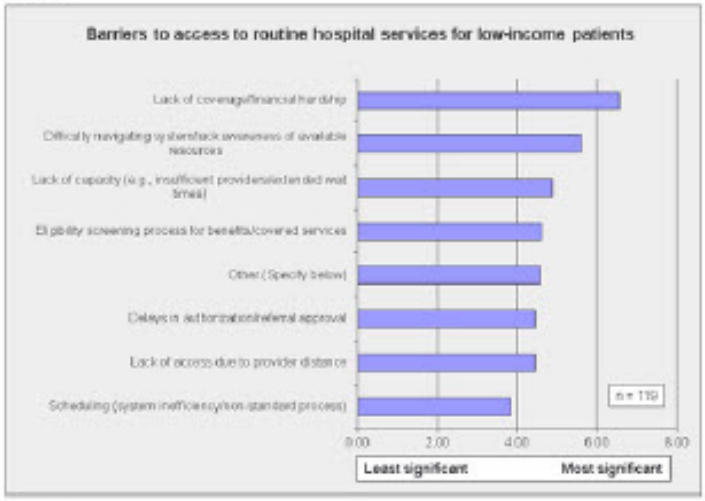


8

SUMMARY OF RESPONSES: ACCESS TO CARE

6

Question 3b



9

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.

7

Question 3b, cont.

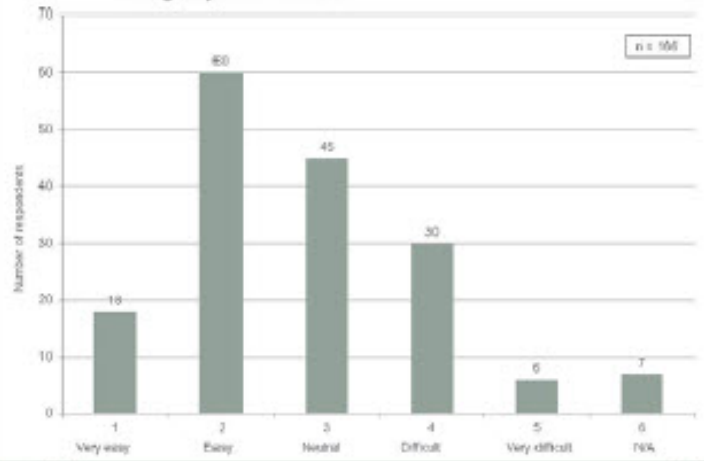
"Other" responses

- "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"

10

Question 4a

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



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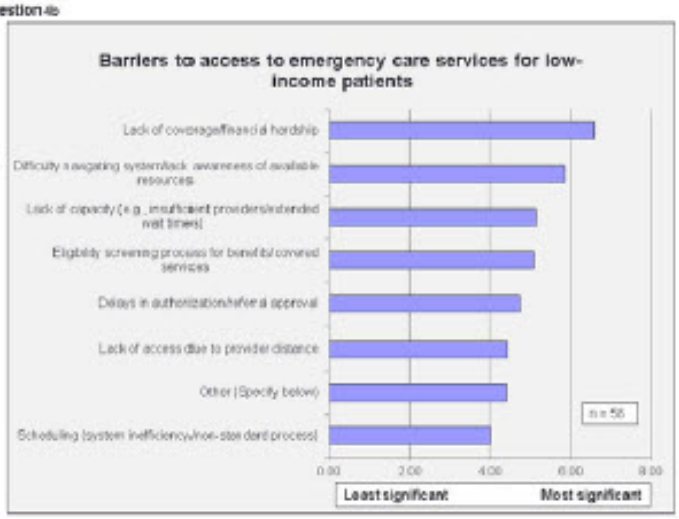
Question 4b

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



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Question 4b, cont.

"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."

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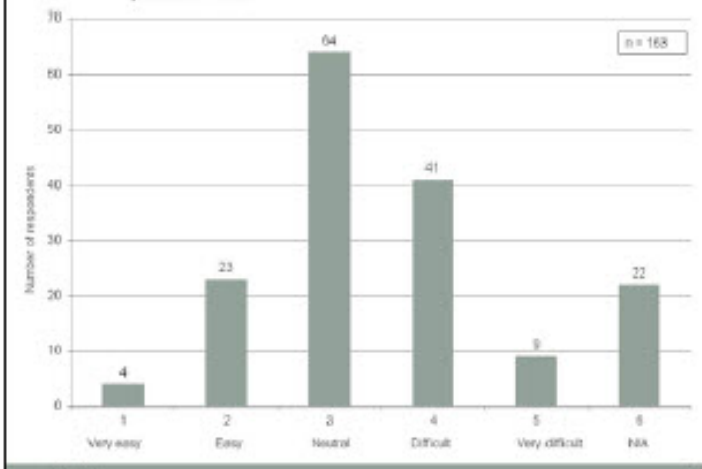
Question 6a

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



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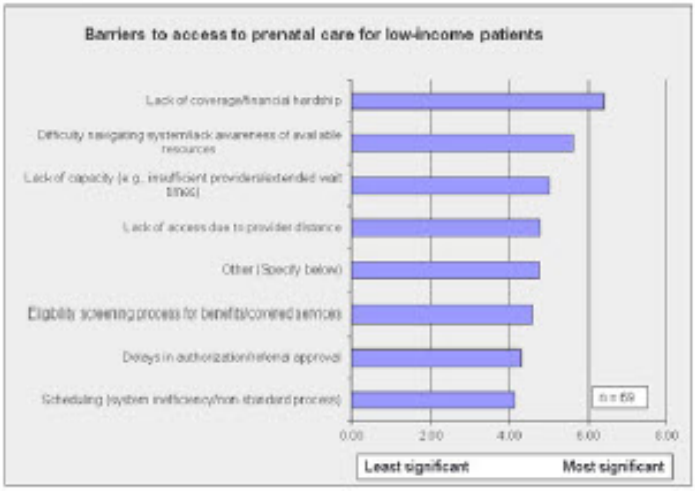
Question 6b

Barriers to access to prenatal care for low-income patients



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Question 6b, cont.

"Other" responses

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

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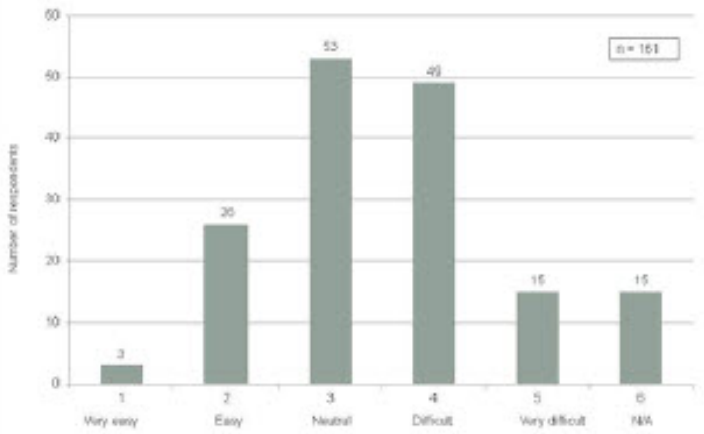
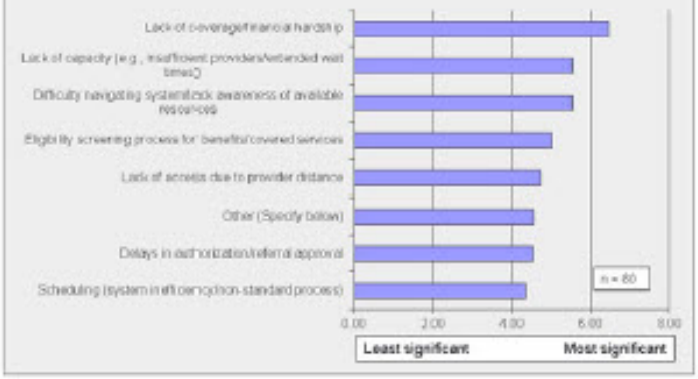
Question 6a

Difficulty low-income patients face when trying to access **pediatric/well-child services:**



Question 6b

Barriers to access to pediatric/well-child services for low-income patients



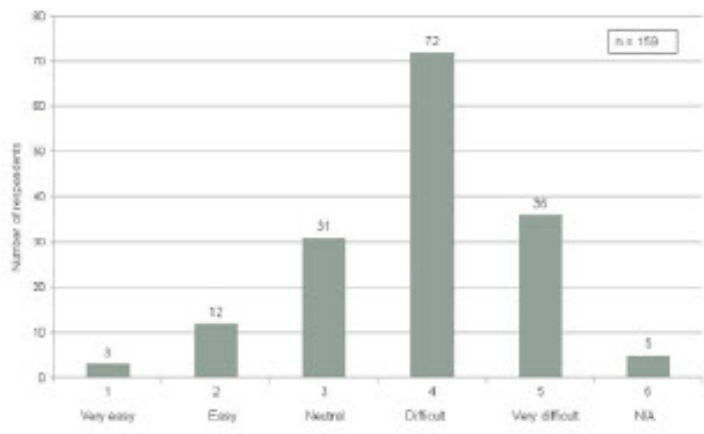
Question 6b, cont.

"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."

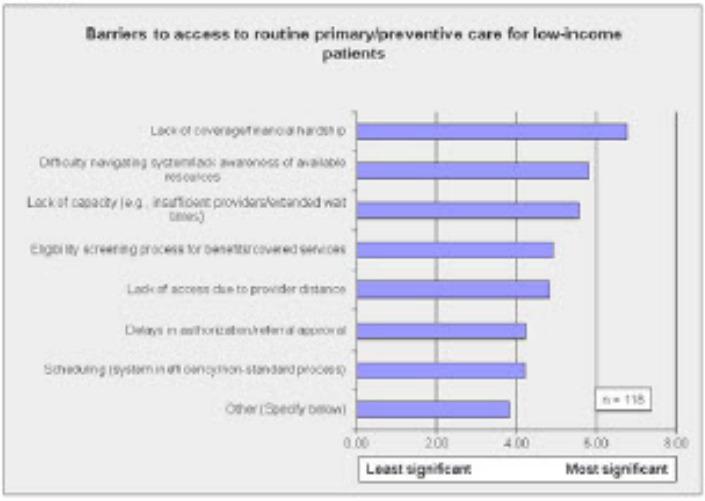
Question 7a

Difficulty low-income patients face when trying to access **routine primary/preventive care:**



Question 7b

Barriers to access to routine primary/preventive care for low-income patients



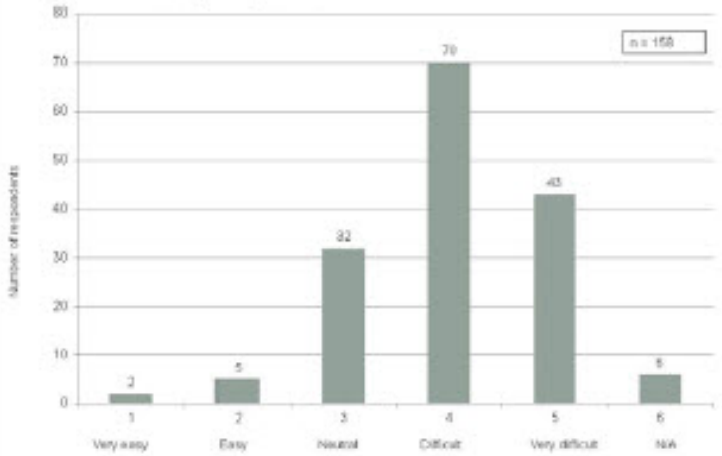
Question 7b, cont.

"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**:



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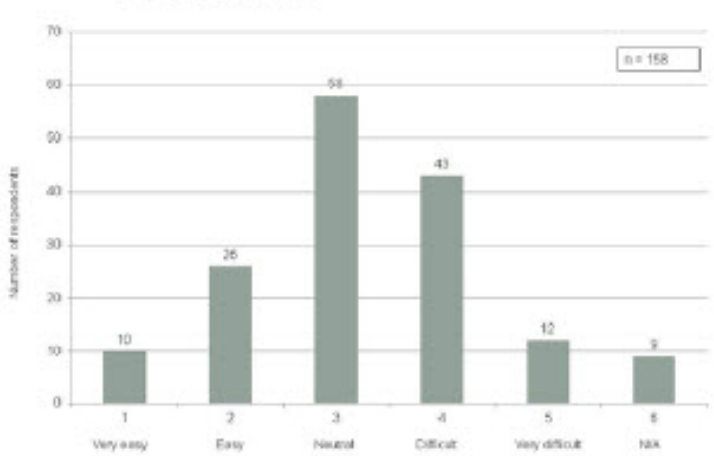
Question 9a

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



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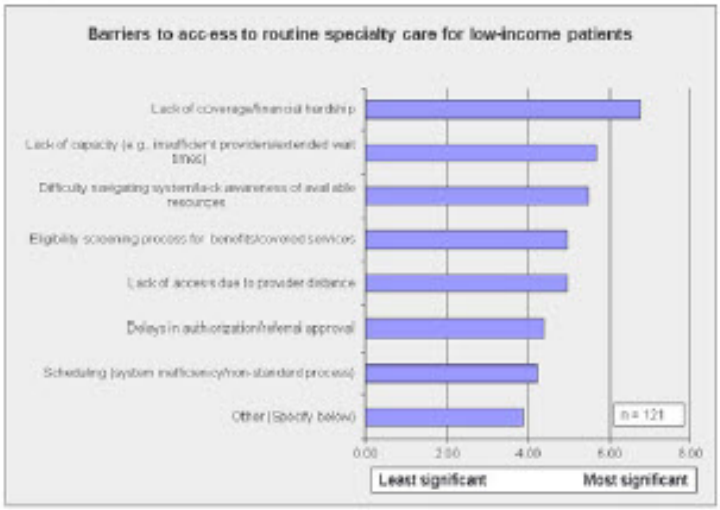
Question 9b

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



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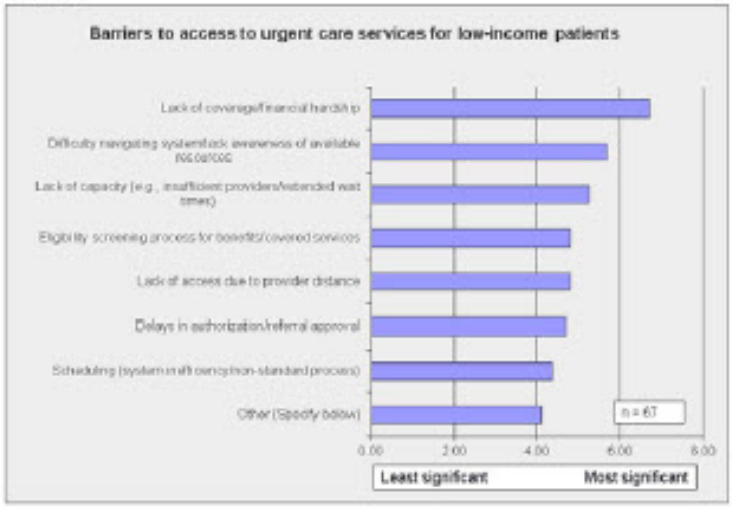
Question 9b

Barriers to access to urgent care services for low-income patients



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Question 9b, cont.

"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."

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Question 9b, cont.

"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"

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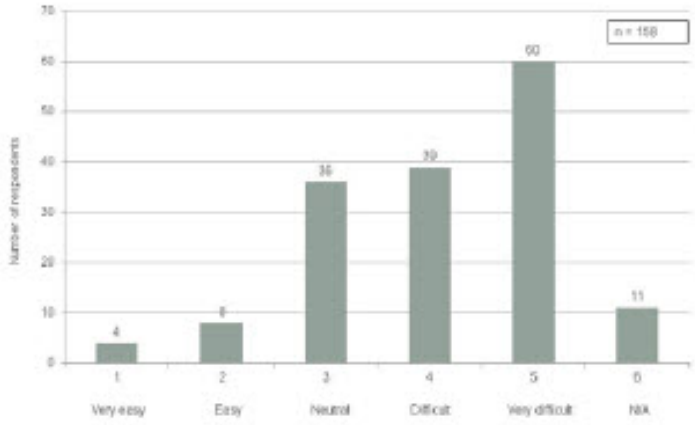
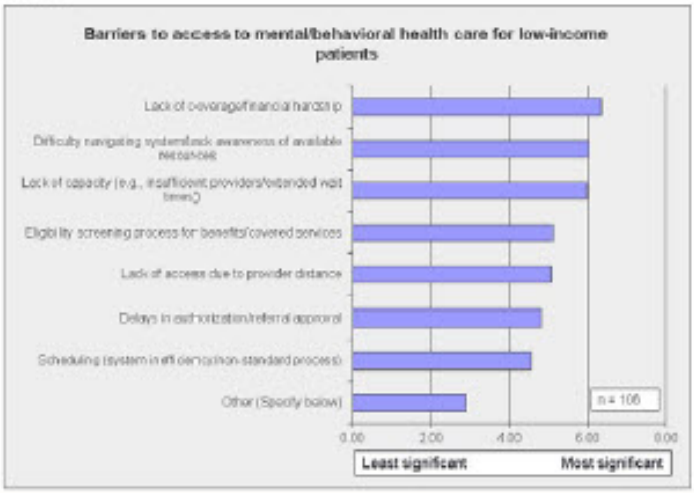
Question 10a

Difficulty low-income patients face when trying to access **mental/behavioral health care:**



Question 10b

Barriers to access to mental/behavioral health care for low-income patients



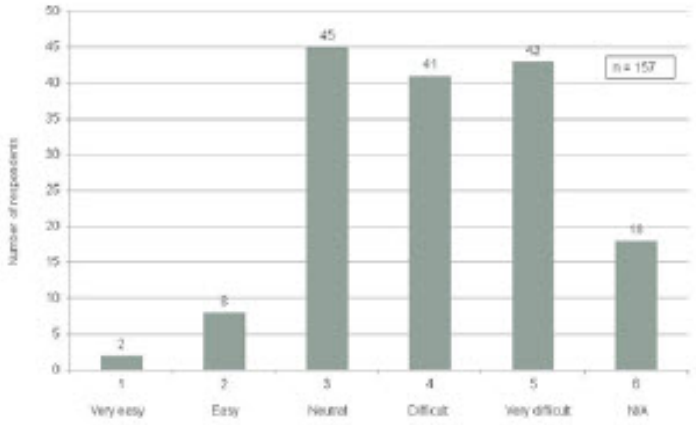
Question 10b, cont.

"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."

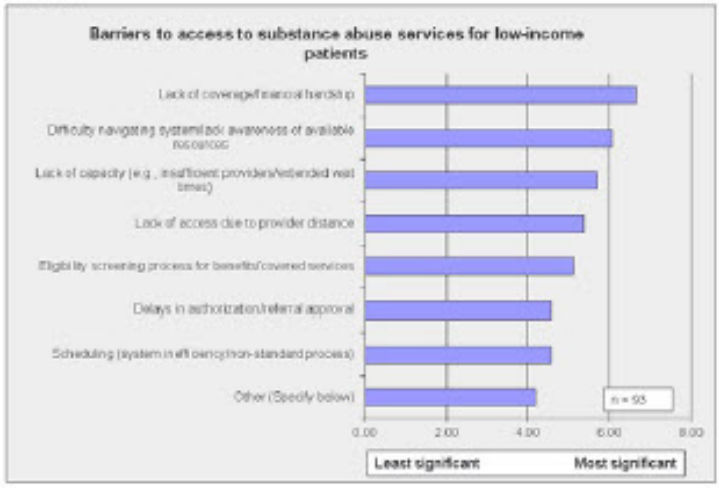
Question 11a

Difficulty low-income patients face when trying to access **substance abuse services:**



Question 11b

Barriers to access to substance abuse services for low-income patients



Question 11b, cont.

"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

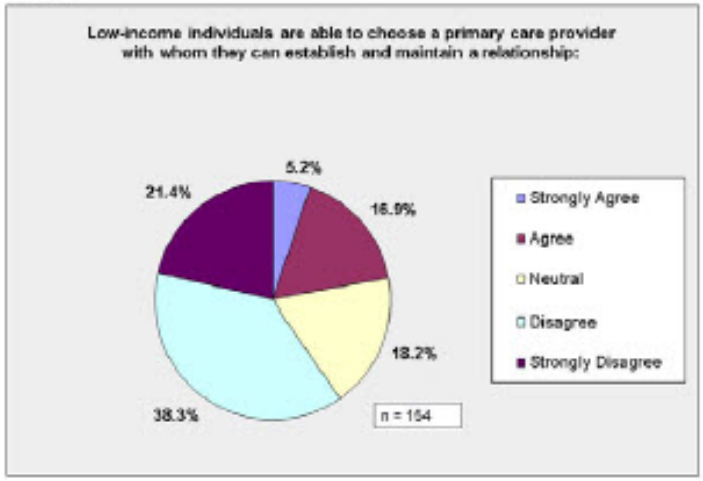
- For routine hospital care, routine primary/preventive care and routine specialty care the majority of respondents rated them as "difficult" to access
- For Mental/behavioral health care the majority of respondents rated it as "very difficult" to access
- Emergency care was rated by most respondents as "easy" to access

SUMMARY OF RESPONSES: CARE COORDINATION

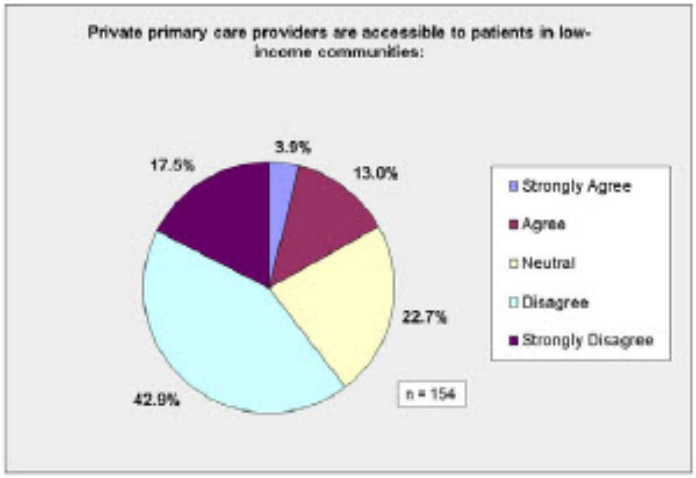
Question Format

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

Question 12

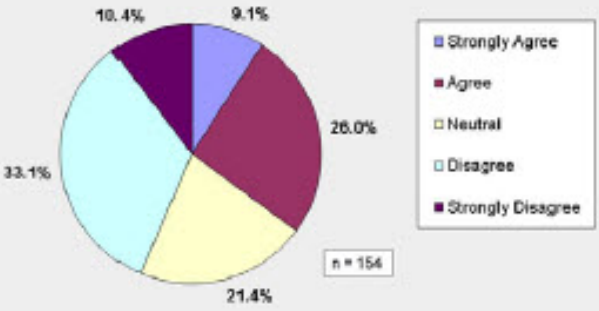


Question 13



Question 14

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



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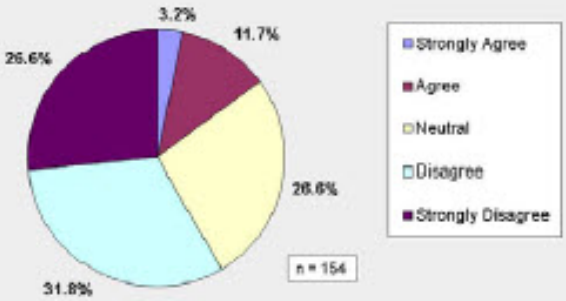
Question 15

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



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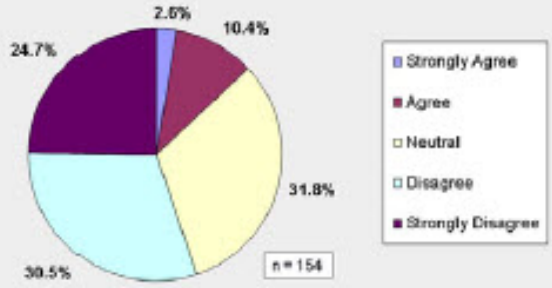
Question 16

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



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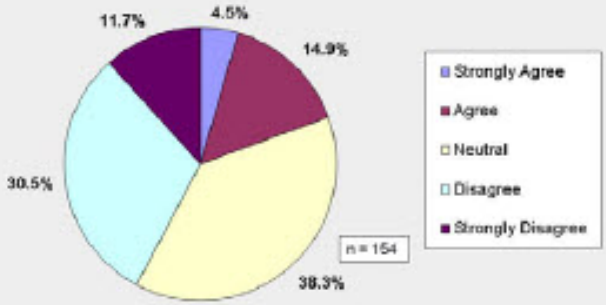
Question 17

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



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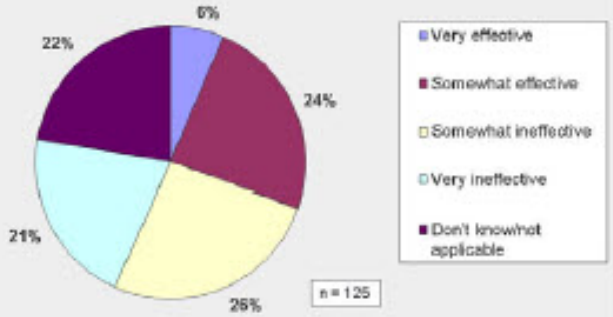
Question 18

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



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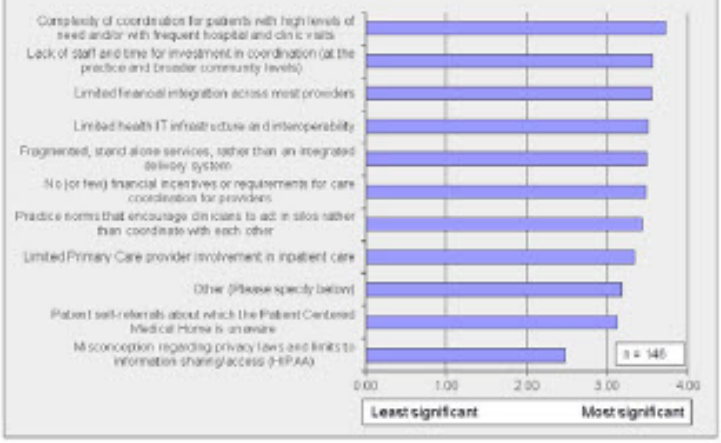
Question 19

Barriers to effective overall care coordination in counties:



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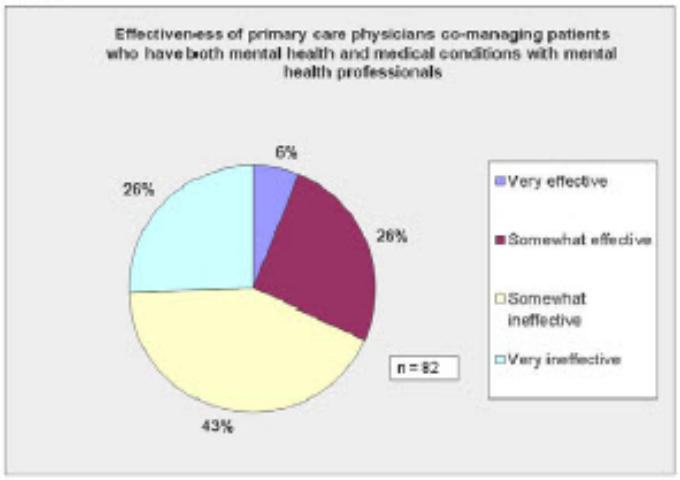
Question 19, cont.

"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"

Question 20



Question 20, cont.

Comments

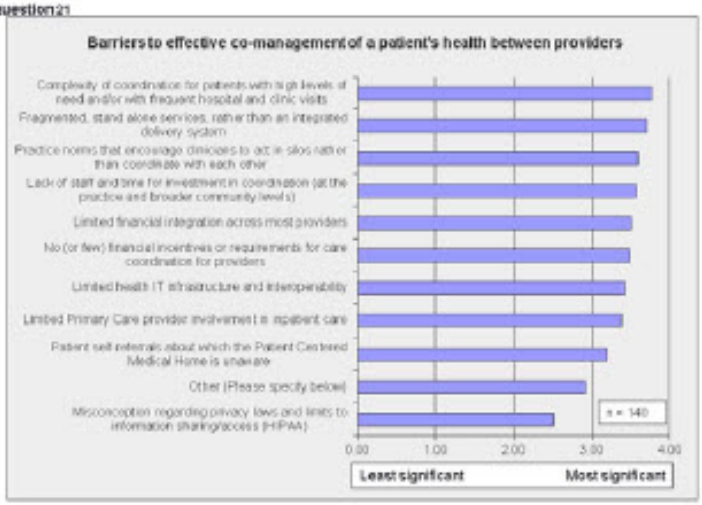
- "Doctors don't seem to talk with other physicians and work together to find a solution to health problems. Rather they "bounce" the patient from this specialist to that specialist…"
- "Many of the mental health patient's do not even know what medications they are currently on. The primary care must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

Question 20, cont.

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 21

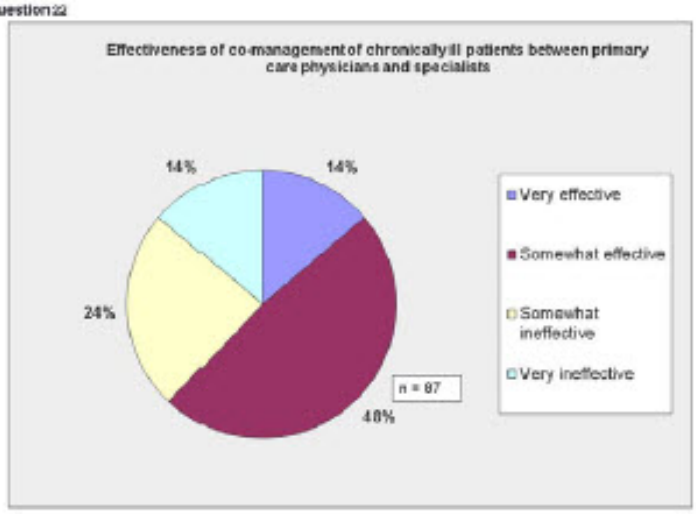


Question 21, cont.

"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."

Question 22



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SUMMARY RESPONSES: COMMUNITY HEALTH

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Question 22, cont.

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."

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Question format

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

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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

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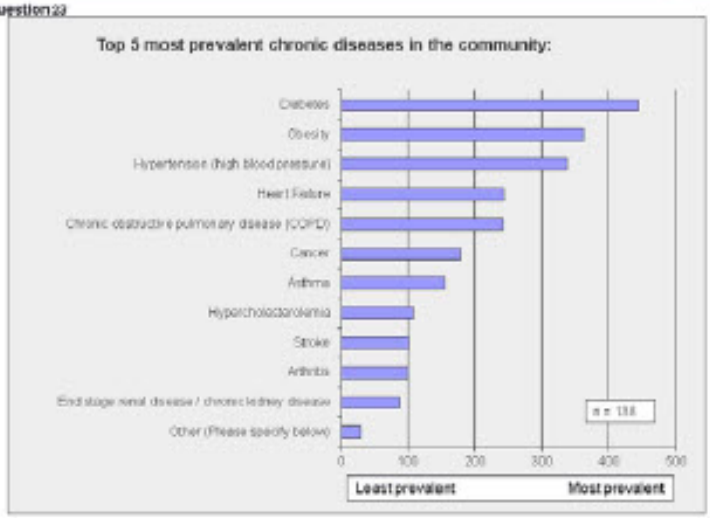
Question 23



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Question 23, cont.

"Other" responses

- Alzheimer's Disease
- "All of these diseases are prevalent in our community"
- Dental needs/infection

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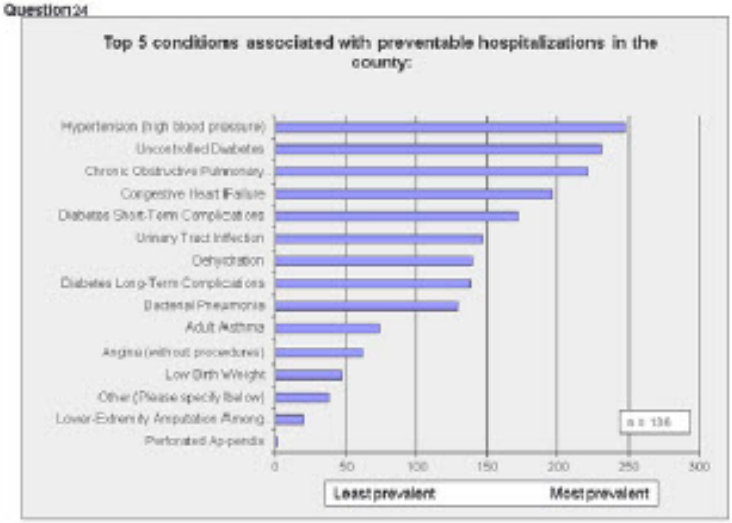
Question 24



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Question 24, cont.

"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."

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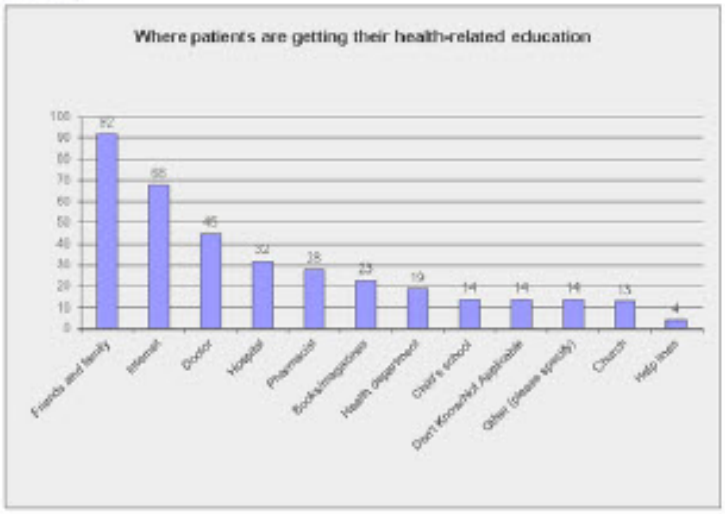
Question 25



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Question 25, cont.

"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

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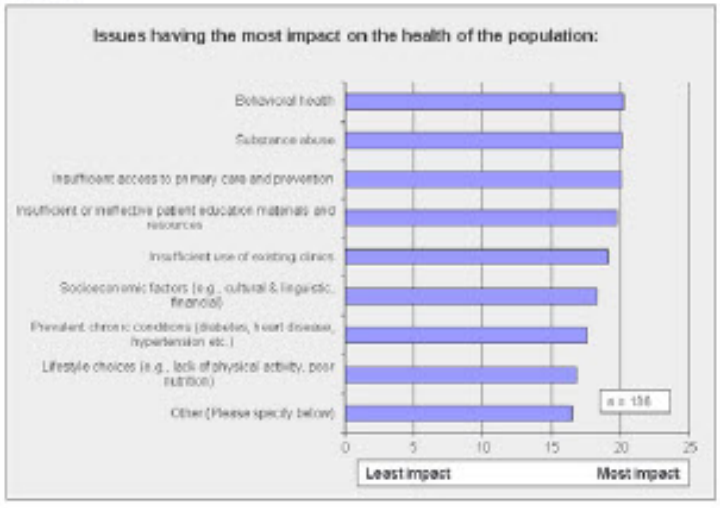
Question 26



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Question26, cont.

"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)

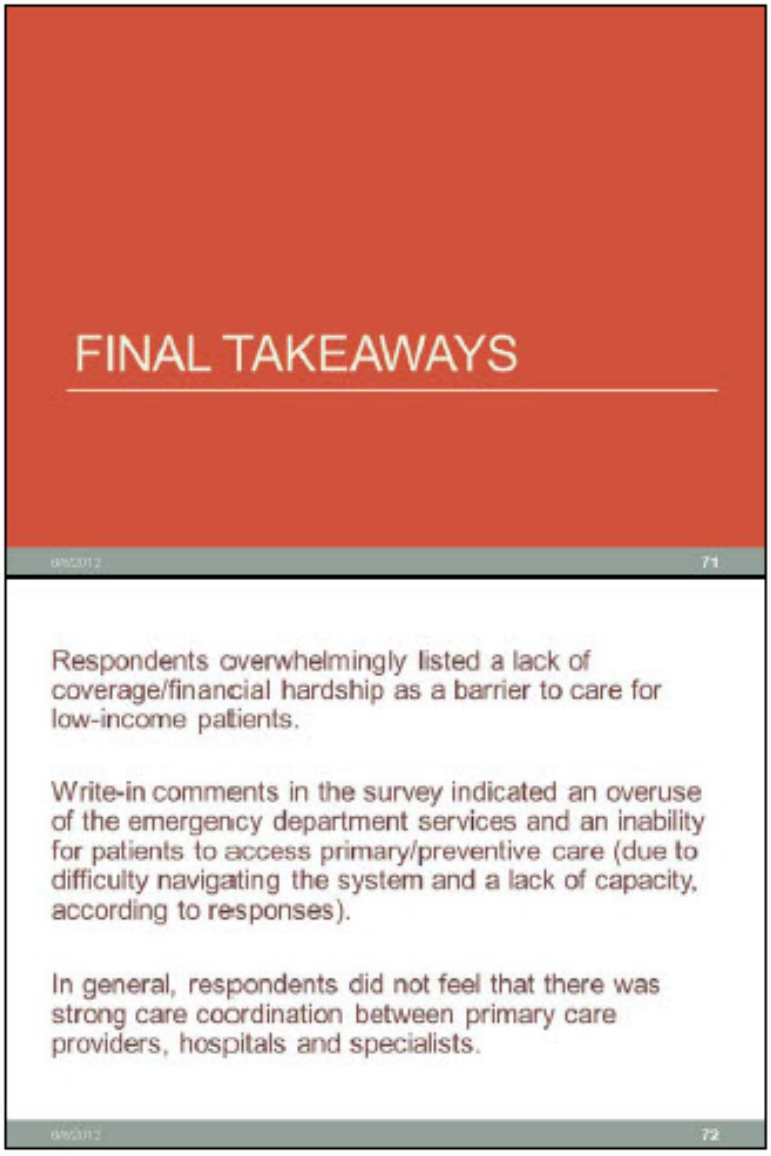
"Most families have no where to go to get assessments completed or medication management for their children or adult children to get help with the behaviors they exhibit due to their dual diagnosis. Mental health practitioners in the community refuse to see them because of their mental retardation diagnosis 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

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."


FINAL TAKEAWAYS
6/6/2012
71
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.
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D-3: Key Health Challenges

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

	Ellis	Erath	Johnson	Tarrant	Wise	Navarro	Parker	Somervell	Hood
Tuberculosis	2.0	2.8	2.5	6.2	3.4	2.0	1.7	0.0	0.0
All Cancer	447.8	403.8	439.9	446.6	424.6	485.4	462.1	469.8	485.4
Breast	61	58.4	58.3	70.4	43.2	55.5	74.7	N/A	63.9
Lung	71.4	N/A	70.0	60.4	74.2	72.0	74.5	N/A	55.2
Diabetes	8.3	8.8	10.0	8.4	8.6	9.7	9.3	9.3	8.7
HIV	4.6	0.0	3.8	14.6	0.0	10.1	5.2	12.2	9.7
Obesity	29.5	27.6	29.6	26.8	29.8	29.5	27.5	26.9	27.1

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

	U.S.	Texas	RHP 10	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Tuberculosis Cases	11,549	1,477	122.0	3	1	0	4	1	2	0	109	2
Tuberculosis Rate	3.80	6.0	2.3	2	2.6	0	2.4	2	1.8	0	6.1	3.4
AIDS Cases	34,247	2,286	134.0	6	0	2	10	4	3	0	109	0
AIDS Rate	**	9.2	3.4	3.9	0	3.8	6.1	7.9	2.7	0	6.1	0
Varicella (Chickenpox) Cases	**	4,445	454.0	13	9	68	34	4	18	0	298	10
Varicella (Chickenpox) Rate	**	17.9	26.3	8.5	23	127.9	20.7	7.9	15.6	0	16.7	16.6
Pertussis (Whooping Cough) Cases	16,858	3,358	268.0	10	2	9	22	0	14	2	207	2
Pertussis (Whooping Cough) Rate	5.54	13.5	10.3	6.5	5.1	16.9	13.4	0	12.2	23.8	11.6	3.3

Source: Centers for Disease Control

Figure D-3.3: Region 10 Sexually Transmitted Diseases in 2009

	Nation	Texas	RHP 10	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Primary and Secondary Syphilis Cases	44,828	1,231	172.0	16	0	0	1	2	2	0	151	0
Primary and Secondary Syphilis Rate	14.74	4.9	2.7	10	0	0	0.6	3.9	1.7	0	8.3	0
Gonorrhea Cases	301,174	31,453	3,504.0	803	5	3	57	73	10	2	2,537	14
Gonorrhea Rate	99.05	124	99.0	504.1	12.6	5.5	33.7	141.4	8.4	23.3	139	22.7
Chlamydia Cases	1,244,180	118,577	13,368.0	4,356	74	103	355	279	207	15	7,879	100
Chlamydia Rate	409.19	467.3	533.7	2,734.8	186.4	188.5	209.6	540.5	174.8	174.5	431.6	162.4

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

Figure D-3.4: Natality in Region 10 in 2008

	Texas	RHP 10	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Total Live Births (Cases)	405,242	37,852	2,097	509	585	2,210	709	1,390	111	29,424	817
Adolescent Mothers under 18 Years of Age (Cases)	19,775	1,622	91	17	18	99	44	57	6	1259	31
Adolescent Mothers under 18 Years of Age (%)	4.9%	4.3%	4.3%	3.3%	3.1%	4.5%	6.2%	4.1%	5.4%	4.3%	3.8%
Low Birth Weight (Cases)	34,228	3,056	162	31	36	161	58	93	8	2452	55
Low Birth Weight (%)	8.4	7.2%	7.7%	6.1%	6.2%	7.3%	8.2%	6.7%	7.2%	8.3%	6.7%
Onset of Prenatal Care within First Trimester (Cases)	223,961	19,584	1,136	285	385	1264	303	798	64	14912	437
Onset of Prenatal Care within First Trimester (%)	60.1%	58.1%	54.0%	57.7%	64.8%	63.6%	42.1%	59.4%	68.8%	53.5%	59.0 %

Source: Texas CHS (*Data Pending)

Figure D-3.5: Mortality Rates per 100,000 persons in Region 10 in 2009

	Texas	U.S.	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise	RHP 10
Total Deaths	162,792	2,437,163	997	321	520	1,126	509	857	89	10,478	476	15,373
Disease of the Heart	38,008	599,413	238	84	102	287	98	196	19	2,413	117	3,554
Cerebrovascular Disease	9,118	128,842	54	36	37	77	24	59	4	635	19	945
Malignant Neoplasms	35,531	567,628	225	63	123	267	139	200	22	2,349	116	3,504
Chronic Lower Respiratory disease	8,624	137,353	51	19	32	76	32	72	4	625	40	951
Nephritis, Nephrotic Syndrome and Nephrosis	*	*	17	3	10	26	6	18	2	217	8	307
Accidents	9,310	118,021	45	23	28	61	16	54	10	537	33	807
Diabetes			29	4	11	29	25	16	1	273	10	398
Alzheimer's	5,062	79,003	36	8	39	14	30	43	5	287	17	479
Influenza and pneumonia	*	*	11	5	10	27	10	23	0	194	9	289
Assault	*	*	11	0	3	1	4	2	0	70	1	92
Suicide	*	*	13	1	9	21	8	12	2	170	9	245
Septicemia	*	*	15	1	7	7	8	7	0	176	6	227
Chronic liver disease and Cirrhosis	*	*	14	5	7	13	6	14	2	162	7	230
Infant death			15	2	4	19	3	11	1	194	3	252
Fetal deaths			6	1	7	13	0	12	0	189	2	230

*Data Pending

Source: Texas CHS

Figure D-3.6: Preventable Hospitalizations in Region 10 in 2010

	Region 10	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Bacterial Pneumonia Cases	4,628	360	79	109	544	137	288	0	2,951	160
Rates	135.2	118.3	174.2	127.0	169.6	310.0	136.0	0	126.8	208.0
Dehydration Cases	837	66	15	27	86	31	48	0	534	30
Rates	43.2	32.8	26.4	23.4	66.3	75.4	53.9	0	41.6	44.0
Urinary Tract Infection Cases	3,287	177	66	65	256	148	159	0	2,293	123
Rates	81.7	67.5	58.1	66.4	109.3	140.4	83.8	0	81.0	55.8
Angina (without procedures) Cases	247	16	0	10	28	15	20	0	150	8
Rates	190.4	240.6	208.5	213.0	360.4	287.0	246.3	0	163.1	270.6
Congestive Heart Failure Cases	4,736	294	77	122	471	187	223	8	3,271	83
Rates	194.8	196.5	203.2	238.4	312.1	391.7	190.7	94.2	180.8	140.4
Hypertension Cases	1049	49	10	12	100	36	63	0	753	26
Rates	46.7	36.8	44.9	23.4	62.9	60.8	38.5	0	47.3	45.7
Asthma Cases	1,558	115	21	18	220	32	85	6	1,033	28
Rates	34.4	44.1	39.6	52.8	57.0	64.9	41.1	0	29.5	50.7

	Region 10	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Chronic Obstructive Pulmonary Disease Cases	3,300	198	55	99	367	164	225	6	2,090	96
Rates	10.2	10.7	0	19.5	18.6	31.4	17.1	0	8.3	13.5
Diabetes Short-term Complications Cases	1,136	55	17	12	95	29	45	0	856	27
Rates	135.8	132.3	145.2	193.4	243.2	343.6	192.4	70.7	115.5	162.4
Diabetes Long-term Complications Cases	1,986	101	22	34	165	67	98	0	1,466	33
Rates	64.1	76.9	55.4	35.2	145.8	67.0	72.7	70.7	57.1	47.4
Total	**22,764**	**1,431**	**362**	**508**	**2,332**	**846**	**1,254**	**20**	**15,397**	**614**

Source: Texas CHS

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

	Texas	RHP 10	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Poor or Fair Health	19%	**17%**	13%	14%	NA	21%	NA	18%	NA	16%	19%
Poor Physical Health Days*	3.6	**3.49**	25	22	5	4.8	4.1	3.2	NA	3.1	3
Poor Mental Health Days*	3.3	**3.39**	2.5	2.7	3.4	4.9	3.7	2.9	NA	3.1	3.9

*in the past 30 days

Source: County Health Rankings 2010

Figure D-3.1: Region 10 Health Behaviors, by County, in 2011

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

Source: Community Health Rankings

Figure D-3.2: Access to Healthy Foods, 2012

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

Source: Community Health Rankings

D-4: County-specific findings

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

ELLIS COUNTY

Health care Needs[xxxi]

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

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

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:

Facilities by Type			
Acute Care Hospitals	**Clinics**	**Long-Term Care and Rehab Facilities**	**Mental Health Facilities**
Baylor Medical Center at Waxahachie	Palmer Medical Clinic	Ennis Care Center	
Ennis Regional Medical Center	HOPE Clinic	Legend Oaks Healthcare and Rehabilitation	
		Red Oak Health and Rehabilitation Center	
		Pleasant Manor health and Rehabilitation Center	
		Refreno Healthcare Center	
		Trinity Mission Health and Rehab of Italy	

Johnson County:

Facilities by Type			
Acute Care Hospitals	**Clinics**	**Long-Term Care and Rehab Facilities**	**Mental Health Facilities**
Texas Health Harris Methodist Hospital Cleburne		Alvarado LTC Partners Inc	
		Grandview Nursing Home	
		Heritage Trials Nursing and Rehabilitation Center	
		Ridgeview Rehabilitation and Skilled Nursing	
		Colonial Manor Nursing Center	

Tarrant County:

Facilities by Type			
Acute Care Hospitals	**Clinics**	**Long-Term Care and Rehab Facilities**	**Mental Health Facilities**
Baylor All Saints Medical Center at Fort Worth	Northside Community Health Center	Healthsouth City View Rehabilitation Hospital	Millwood Hospital
Baylor Orthopedic and Spine Hospital at Arlington	Southeast Community Health Center	Healthsouth Rehabilitation Hospital	
Baylor Regional Medical Center at Grapevine		Healthsouth Rehabilitation Hospital of Arlington	
Baylor Surgical Hospital at Fort Worth		Ethicus Hospital Grapevine	
Cook Children's Northeast Hospital		Global Rehab Hospital Forth Worth	
Cook Children's Medical Center		Kindred Hospital – Fort Worth	
JPS Health Network		Kindred Hospital– Mansfield	
Medical Center Arlington		Kindred Hospital – Tarrant County	
North Hills Hospital		Kindred Rehabilitation Hospital of Arlington	
Plaza Medical Center of Fort Worth		LifeCare Hospital of Fort Worth	
Methodist Mansfield Medical Center		Regency Hospital – Fort Worth	
Southwest Surgical Hospital		Texas Health Specialty Hospital FW	
Texas Health Arlington Memorial Hospital		Reliant Rehabilitation Hospital – Mid-Cities	
Texas Health Harris Methodist Hospital Azle			
Texas Health Harris Methodist Hospital Fort Worth			
Texas Health Harris Methodist Hospital Hurst – Euless -Bedford			
Huguley Memorial Medical Center			
Texas Health Harris Methodist Hospital Southlake			
Texas Health Harris Methodist Hospital Southwest			
Texas Health Heart & Vascular Hospital			
USMD Hospital at Arlington			
USMD Hospital at Fort Worth			

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): _____

FEDERAL INITIATIVE	YES	NO	UNKNOWN
Accountable Care Organizations (ACOs)	☐	☐	☐
Advance Payment Model	☐	☐	☐
Pioneer ACO Model Bundled Payments for Care Improvement	☐	☐	☐
Comprehensive Primary Care Initiative	☐	☐	☐
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	☐	☐	☐
Graduate Nurse Education Demonstration	☐	☐	☐
Health Care Innovation Awards	☐	☐	☐
Independence at Home Demonstration	☐	☐	☐

FEDERAL INITIATIVE	YES	NO	UNKNOWN
Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents	□	□	□
Medicaid Emergency Psychiatric Demonstration	□	□	□
Partnership for Patients	□	□	□
State Innovation Models Initiative	□	□	□
Strong Start for Mothers and Newborns	□	□	□
EHR incentive payments	□	□	□
Health Information Exchange Grant	□	□	□
Other HITECH grant or payment(s)	□	□	□
FQHC/RHC/School-based health center grants, including capital grants	□	□	□
Health professions loans and workforce development grants	□	□	□
Ryan White funding	□	□	□
Maternal and child health grants	□	□	□
Community Mental Health Services Block Grant	□	□	□
Substance Abuse Prevention and Treatment Block Grant	□	□	□
Projects for Assistance in Transition from Homelessness (PATH)	□	□	□
Protection and Advocacy for Individuals with Mental Illness (PAIMI)	□	□	□
Other mental health and substance abuse grants: *PLEASE REFER TO THIS PAGE FOR SPECIFIC GRANT DETAILS* http://www.samhsa.gov/Statesummaries/detail/2012/TX.aspx *PLEASE LIST ANY OTHER PERTINENT GRANTS:*	□	□	□
Immunization grants	□	□	□
CLASBI/ Hospital acquired infection initiatives	□	□	□
Other CDC grants: *PLEASE REFER TO THIS PAGE FOR SPECIFIC GRANT DETAILS* http://www.cdc.gov/about/business/state_funding.htm	□	□	□

FEDERAL INITIATIVE	YES	NO	UNKNOWN
PLEASE LIST ANY OTHER PERTINENT GRANTS:			

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

D-7: References and Citations

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.dshs.state.tx.us/chs/datalist.shtm)
- **County Health Rankings** (www.countyhealthrankings.org)
- **Health.Data.Gov** (www.data.gov/health)
- **Health Indicators Warehouse** (www.healthindicators.gov)
- **Health Professional Shortage Areas** (http://hpsafind.hrsa.gov/)
- **Health Resources County Comparison Tool** (http://arf.hrsa.gov/arfwebtool/index.htm)
- **Health Resources Services Administration** (http://bhpr.hrsa.gov/shortage/hpsas/index.html)
- **Kaiser Family Foundation** (www.kff.org)
- **Medically Underserved Areas** (http://muafind.hrsa.gov/index.aspx)
- **State Health Facts** (www.statehealthfacts.org)
- **Texas Department of State Health Services** (www.dshs.state.tx.us/chs/healthcurrents/)
- **Texas Department of State Health Services** (www.dshs.state.tx.us/diabetes/tdcdata.shtm)
- **Thompson Reuters, 2011**
- **United States Census Bureau** (www.census.gov/population/www/projections/projectionsagesex.html)
- **United States Census Bureau** – (http://quickfacts.census.gov/qfd/states/48000.html)
- **United States Department of Health & Human Services – Community Health Status Indicators** (http://www.communityhealth.hhs.gov/homepage.aspx?j=1)

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.

[4] Institute of Medicine, "Hidden Costs, Value Lost," Consequences of Uninsurance Series No. 5, June 2003; and Center for Studying Health System Change, "Triple Jeopardy: Low Income, Chronically Ill and Uninsured in America," Issue Brief No. 49, February 2002.

[5] Region 10 Stakeholder Survey (Appendix D-2.2)

[6] Region 10 RHP County Visioning Sessions