City of Dallas

1500 Marilla Street, Room 6ES
Dallas, Texas 75201

Public Notice

200724

Quality of Life, Arts, and Culture Committee

September 21, 2020

9:00 AM

This Quality of Life, Arts, and Culture meeting will be held by videoconference. The meeting will broadcast live on Spectrum Cable Channel 95 and online at bit.ly/cityofdallastv.

The public may also listen to the meeting as an attendee at the following videoconference link: https://dallascityhall.webex.com/dallascityhall/onstage/g.php?MTID=e83bd1de933d82c71f9347147f4249351.

2020 CITY COUNCIL APPOINTMENTS

COUNCIL COMMITTEE	
ECONOMIC DEVELOPMENT Atkins (C), Blewett (VC), Gates, McGough, Narvaez, Resendez, West	**ENVIRONMENT AND SUSTAINABILITY** Narvaez (C), Atkins (VC), Blackmon, Blewett, Gates
GOVERNMENT PERFORMANCE AND FINANCIAL MANAGEMENT Gates (C), Mendelsohn (VC), Arnold, Bazaldua, Kleinman, Narvaez, Thomas	**HOUSING AND HOMELESSNESS SOLUTIONS** West (C), Thomas (VC), Arnold, Blackmon, Kleinman, Mendelsohn, Resendez
PUBLIC SAFETY McGough (C), Arnold (VC), Bazaldua, Blewett, Medrano, Mendelsohn, Thomas	**QUALITY OF LIFE, ARTS, AND CULTURE** Arnold (C), Gates (VC), Atkins, Narvaez, West
TRANSPORTATION AND INFRASTRUCTURE Kleinman (C), Medrano, (VC), Atkins, Bazaldua, Blewett, McGough, West	**WORKFORCE, EDUCATION, AND EQUITY** Thomas (C), Resendez (VC), Blackmon, Kleinman, Medrano
AD HOC JUDICIAL NOMINATING COMMITTEE McGough (C), Blewett, Mendelsohn, Narvaez, West	**AD HOC LEGISLATIVE AFFAIRS** Johnson (C), Mendelsohn (VC), Atkins, Gates, McGough
AD HOC COMMITTEE ON COVID-19 RECOVERY AND ASSISTANCE Thomas (C), Atkins, Blewett, Gates, Mendelsohn, Narvaez, Resendez	

(C) – Chair, (VC) – Vice Chair

Note: A quorum of the Dallas City Council may attend this Council Committee meeting.

Call to Order

Invocation and Pledge of Allegiance

MINUTES

A 20-1808 Approval of August 17, 2020 Minutes

Attachments: Minutes

Special Recognition

B 20-1843 September Heritage Month

BRIEFING ITEMS

C 20-1817 Community Health Needs Assessment Implementation Plan Update
[Felicia Miller, EVP and Chief Talent Officer, Michael Malaise, SVP of Communications and External Affairs, Jessica Hernandez, SVP of Community Integrated Health, Angela Morris, Senior Director of Community Relations, Parkland Hospital]

Attachments: Presentation
Attachment A: Access to Care & Coverage
Attachment B: Asthma
Attachment C: Behavioral Health
Attachment D: Breast Health
Attachment E: Cultural Competency Program Description
Attachment F: Diabetes
Attachment G: Hypertension
Attachment H: STIs

D 20-1816 Fair Park Master Plan Update
[Ryan O'Connor, Assistant Director, Park & Recreation; Darren James, Chairman of the Board and Brian Luallen, Executive Director, Fair Park First]

Attachments: Presentation

E 20-1810 Update on Juanita J. Craft Civil Rights House
[Jennifer Scripps, Director and Nikki Christmas, Manager III; Office of Arts and Culture]

Attachments: Presentation

F 20-1813 Briefing by Memorandum: Public Art Project Updates
[Joey Zapata, Assistant City Manager]

Attachments: Memorandum

G 20-1818 Briefing by Memorandum: Short Term Rental Taskforce Update - September 2020
[Joey Zapata, Assistant City Manager]

Attachments: Memorandum

H 20-1842 Briefing by Memorandum: September 23, 2020 City Council Agenda - Upcoming Agenda Item #37
[Joey Zapata, Assistant City Manager]

Attachments: Memorandum

ADJOURNMENT

EXECUTIVE SESSION NOTICE

A closed executive session may be held if the discussion of any of the above agenda items concerns one of the following:

1. seeking the advice of its attorney about pending or contemplated litigation, settlement offers, or any matter in which the duty of the attorney to the City Council under the Texas Disciplinary Rules of Professional Conduct of the State Bar of Texas clearly conflicts with the Texas Open Meetings Act. [Tex. Govt. Code §551.071]

2. deliberating the purchase, exchange, lease, or value of real property if deliberation in an open meeting would have a detrimental effect on the position of the city in negotiations with a third person. [Tex. Govt. Code §551.072]

3. deliberating a negotiated contract for a prospective gift or donation to the city if deliberation in an open meeting would have a detrimental effect on the position of the city in negotiations with a third person. [Tex. Govt. Code §551.073]

4. deliberating the appointment, employment, evaluation, reassignment, duties, discipline, or dismissal of a public officer or employee; or to hear a complaint or charge against an officer or employee unless the officer or employee who is the subject of the deliberation or hearing requests a public hearing. [Tex. Govt. Code §551.074]

5. deliberating the deployment, or specific occasions for implementation, of security personnel or devices. [Tex. Govt. Code §551.076]

6. discussing or deliberating commercial or financial information that the city has received from a business prospect that the city seeks to have locate, stay or expand in or near the city and with which the city is conducting economic development negotiations; or deliberating the offer of a financial or other incentive to a business prospect. [Tex Govt. Code §551.087]

7. deliberating security assessments or deployments relating to information resources technology, network security information, or the deployment or specific occasions for implementations of security personnel, critical infrastructure, or security devices. [Tex Govt. Code §551.089]

Agenda Information Sheet

File #: 20-1808 **Item #:** A

Approval of August 17, 2020 Minutes

Quality of Life, Arts & Culture Committee
Meeting Record

The Quality of Life, Arts & Culture Committee meetings are recorded. Agenda materials are available online at www.dallascityhall.com.

Meeting Date: August 17, 2020 **Convened:** 9:03 a.m. **Adjourned:** 11:27 a.m.

Committee Members Present:
Carolyn King Arnold, Chair
Jennifer S. Gates, Vice Chair
Tennell Atkins
Omar Narvaez
Chad West

Committee Members Absent:

Other Council Members Present:

Presenters:
Ed Jamison, Director, Dallas Animal Services
Jennifer Scripps, Director, Office of Arts and Culture
Ryan O'Connor, Assistant Director, Park and Recreation
Brian Luallen, Executive Director, Fair Park First
Darren James, Chairman of the Board, Fair Park First
Kimberly Bizor Tolbert, Chief of Staff, City Manager's Office
Catherine Cuellar, Director, Office of Communications, Outreach & Marketing
David Noguera, Director, Department of Housing & Neighborhood Revitalization
Cynthia Rogers-Ellickson, Assistant Director, Department of Housing & Neighborhood Revitalization
Brandon Ayala, Grant Compliance Specialist, Department of Housing & Neighborhood Revitalization
Joey Zapata, Assistant City Manager

AGENDA

Call to Order (9:03 a.m.)

Invocation and Pledge of Allegiance

A. Approval of the June 15, 2020 Minutes
Action Taken/Committee Recommendation(s): A motion was made to approve the minutes for the June 15, 2020 Quality of Life, Arts, and Culture Committee meeting. The motion passed unanimously.

Motion made by: Tennell Atkins
Item passed unanimously: X
Item failed unanimously:

Motion seconded by: Chad West
Item passed on a divided vote:
Item failed on a divided vote:

B. Briefing by Memorandum: DAS Receives COVID-19 Emergency Relief Grant from PetSmart Charities, Inc.
Presenter(s): Ed Jamison, Director, Dallas Animal Services
Action Taken/Committee Recommendation(s): Dallas Animal Services provided an informational overview to the Committee on the COVID-19 Emergency Relief Grant. The Committee requested a follow-up via memorandum on if funding from this grant could be used in a preventative capacity. Information only.

C. Briefing by Memorandum: DAS Receives Pet Foster Care Stimulus Grant from Maddie's Fund

Presenter(s): Ed Jamison, Director, Dallas Animal Services

Action Taken/Committee Recommendation (s): Dallas Animal Services (DAS) provided an informational overview to the Committee on the Pet Foster Care Stimulus Grant from Maddie's Fund. DAS was rewarded this grant to aid in the operations of its shelter during the COVID-19 pandemic. The Committee requested a follow-up via memorandum on if funding from this grant could be used in a preventative capacity. Information Only.

D. Briefing by Memorandum: Community Artist Program (CAP) Update

Presenter(s): Jennifer Scripps, Director, Office of Arts and Culture

Action Taken/Committee Recommendation(s): The Committee was provided with an update on the Community Artist Program (CAP) and provisions made during to the program to accommodate needed changes as a result of the COVID-19 pandemic. Information only.

E. Public Art Program Updates

Presenter(s): Jennifer Scripps, Director, Office of Arts and Culture

Action Taken/Committee Recommendation(s): The Committee was provided with an update on the Public Arts Program. Specifically, the Office of Arts and Culture provided an update on the Arthello Beck project at Twin Falls Park, policy development for the City's public art that depicts specific individuals or organizations, and projects in program and requested by City Council resolutions on Confederate Monuments. Information only.

F. Fair Park Master Plan

Presenter(s): Ryan O'Connor Assistant Director, Park & Recreation; Brian Luallen, Executive Director and Darren James, Chairman of the Board, Fair Park First

Action Taken/Committee Recommendation(s): Fair Park First briefed the Committee on the Fair Park Master Plan. Fair Park First provided information on the intended changes and next steps regarding fundraising to implement the proposed master plan. The Committee requested a follow-up presentation at the next Quality of Life, Arts, and Culture Committee meeting. Information only.

G. 2020 Update: Fair Park Multimedia Center

Presenter(s): Kimberly Bizor Tolbert, Chief of Staff, City Manager's Office; Catherine Cuellar, Director, Office of Communications, Outreach, & Marketing

Action Taken/Committee Recommendation(s): The Committee was briefed on the development of the City's Fair Park Multimedia Center. Staff provided information on the intended purpose, city and community benefits, as well as next steps regarding the opening of the studio for use. The Committee requested staff follow-up with updates. Information only.

H. Overview of the Lead Based Paint Grant Program

Presenter(s): David Noguera, Director; Cynthia Rogers-Ellickson, Assistant Director, and Brandon Ayala, Grant Compliance Specialist, Department of Housing & Neighborhood Revitalization

Action Taken/Committee Recommendation(s): The Department of Housing and Neighborhood Revitalization staff provided an update to the Committee on the Lead Based Paint Grant Program which aims to provide homeowners with lead-based paint inspections to determine hazards, opportunity for reductions and renovations, outreach and education on the prevalence of lead poisoning and lead certification to the local workforce to address lead hazards in the construction industry. Information only.

Adjourn (11:27 a.m.)

APPROVED BY:

Carolyn King Arnold, Chair
Quality of Life, Arts & Culture Committee

ATTESTED BY:

Arnelle Woods, Coordinator
Quality of Life, Arts & Culture Committee

Agenda Information Sheet

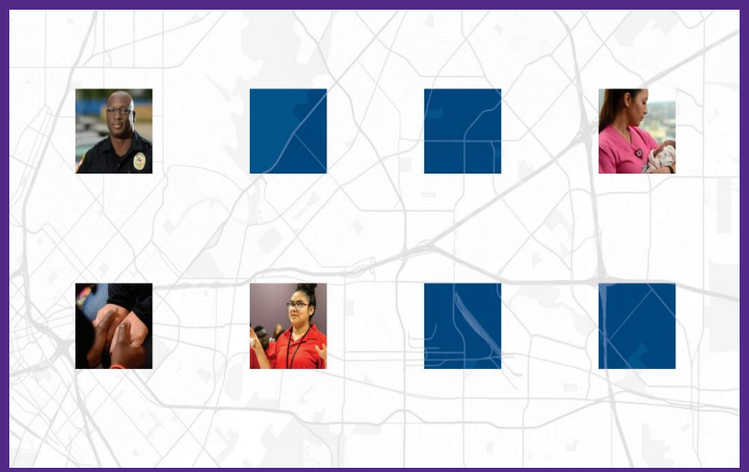
File #: 20-1843 **Item #:** B

September Heritage Month

Agenda Information Sheet

File #: 20-1817 **Item #:** C

Community Health Needs Assessment Implementation Plan Update
[Felicia Miller, EVP and Chief Talent Officer, Michael Malaise, SVP of Communications and External Affairs, Jessica Hernandez, SVP of Community Integrated Health, Angela Morris, Senior Director of Community Relations, Parkland Hospital]



Dallas County Community Health Needs Assessment

CHNA Regulations

Enacted in 2010 by the Patient Protection and Affordable Care Act, section 501(r)(3) and reinforced by IRS 26 CFR Part 1, 53 and 602

Charitable and governmental hospital organizations shall complete a triennial CHNA addressing the following:

- Define the community it serves
- Assess the health of the community it serves
- Solicit community input
- Collaborate with a public health agency
- Release a public report

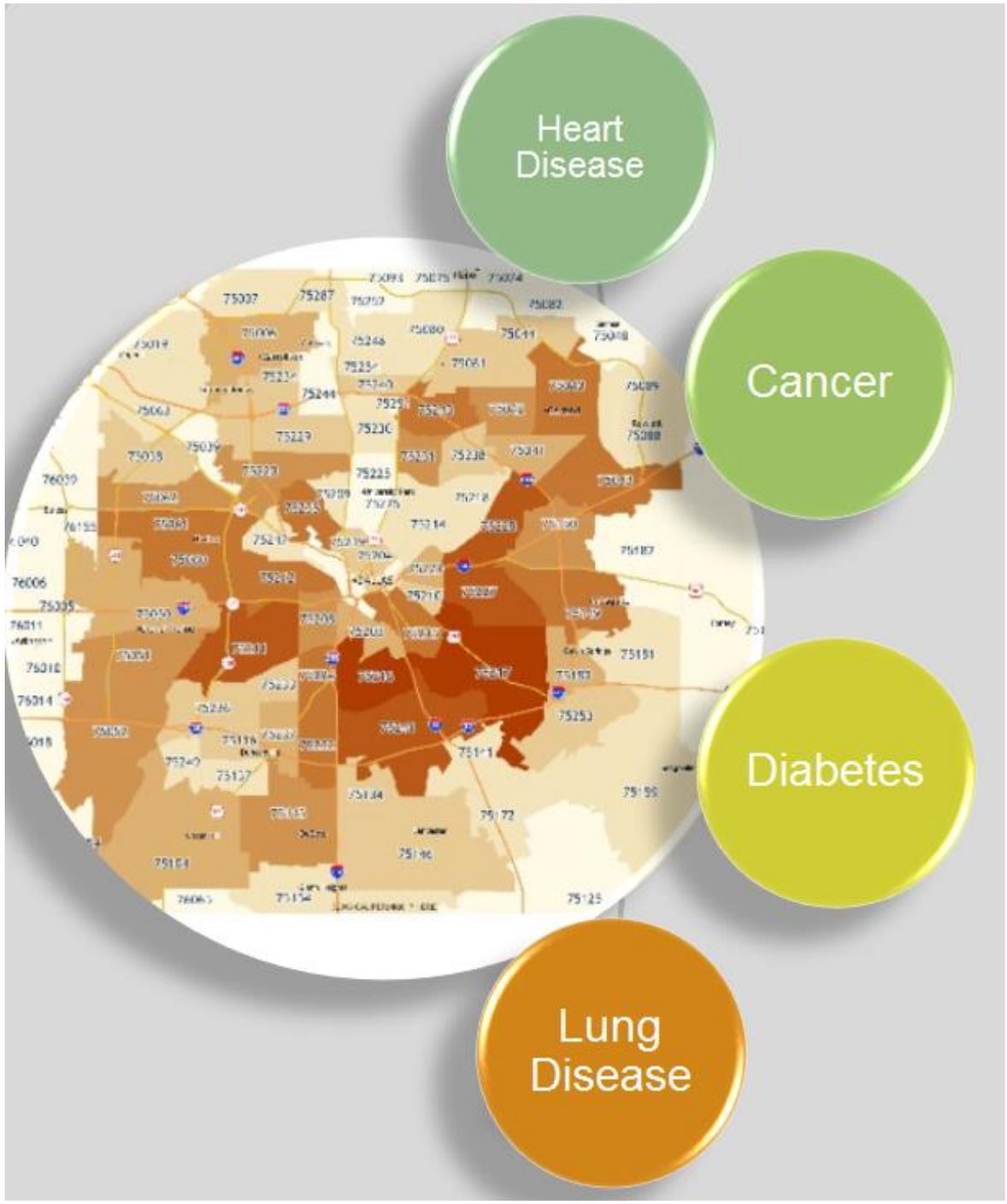
The implementation plan shall:

- Describe the actions to be taken that will:
  - a. address the health needs
  - b. the anticipated impact, and
  - c. identify the programs and resources allocated
- Complete an evaluation

CHNA Findings

CHNA Target ZIP Codes: **75210, 75211, 75215, 76216, 75217, 75241**

- Access to care and coverage
- Cultural competency
- Health literacy
- Behavioral health
- Maternal mortality
- Sexually transmitted infections
- Chronic diseases



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COMMUNITY HEALTH NEEDS ASSESSMENT PROGRAM DESCRIPTION: **MATERNAL AND CHILD HEALTH**

Problem Statement

1. Most deaths occur after 60 days postpartum, a period beyond the postpartum window covered by Medicaid.
2. African American women have the highest risk of pregnancy-related mortality.
3. Substance abuse, cardiac conditions and behavioral health are leading causes of maternal mortality.
4. Accurate data collection of maternal morbidity and mortality associated with pregnancy during antepartum period, delivery and up to 1 year postpartum is lacking.

Strategy

Because after pregnancy, women lose their Medicaid coverage 60 days postpartum, this program will follow enrolled high-risk African American women through the first year postpartum. The program model concentrates on screening, recognition and treatment of conditions with high prevalence in the African American community of women which are also associated with pregnancy related maternal mortality. Targeted risk assessments screen for hypertension, diabetes, depression and substance use disorders. Moreover, important social determinants of health disparities and other environmental risks are intentionally addressed in the programmatic strategies.

Program Metrics

METRIC 1: Percentage of patients from the targeted population enrolled into the Extending Maternal Care After Pregnancy (eMCAP) program (target population is defined as postpartum women who reside in target ZIP Codes.)

Maternal and Child Health

Activity 1

- Define the target population and establish a data infrastructure to measure the baseline characteristics of healthcare outcomes and quality metrics.

Activity 2

- Implement a surveillance system for women from the target region. Connect with women before discharge from the hospital and enroll in the program.

Activity 3

- Deploy a mobile health unit and/or establish local fixed site clinics for improved access to care for women after pregnancy in the target region.

Activity 4

- Maintain regular contact with participants through a combination of home visits, telehealth, phone, text message, etc.

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COMMUNITY HEALTH NEEDS ASSESSMENT PROGRAM DESCRIPTION: **BREAST HEALTH**

Problem Statement:

1. When compared to the rest of the county, Southeast Dallas has the highest number of cancer morbidity and mortality
2. These areas have higher rates of low socio-economic status as well as a higher rate of minority populations, as an example, African American and Hispanics

Strategy

Build upon Parkland's Breast Cancer Health Equity efforts launched in 2019 that provide the foundational work to establish a "Multicomponent Intervention." Multicomponent Intervention is an evidenced-based strategy recommended by the Community Preventive Services Task Force (CPSTF) to promote breast cancer screenings in underserved populations.

Program Metrics

METRIC 1: Number of women from the targeted population who received a mammogram.

METRIC 2: Percentage of "Lost to Care" patients from the targeted population (as an example, not cleared and treatment non-initiated).

Breast Health

Activity 1

- Deploy a data-driven cancer screening campaign.
- Deploying seamless workflows to handoff patients throughout continuum of care.

Activity 2

- Strengthen Parkland's breast cancer continuum of care to ensure patients remain in care until clear or treatment is completed.
- Adopt high alert notification through electronic health records.

Activity 3

- Enhance care coordination by integrating CHWs, patient advocates and nurse navigators.
- Establish a joint Parkland-DCHHS cancer epidemiological approach to reduce cancer rates in high priority areas of Dallas County.

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COMMUNITY HEALTH NEEDS ASSESSMENT PROGRAM DESCRIPTION: **BEHAVIORAL HEALTH**

Problem Statement:

Dallas County does not have enough behavioral health capacity to support the high demand for these services. Navigating the health system in Dallas County is difficult for those with behavioral health needs and there is a lack of integration between behavioral health and physical health. According to input provided by focus group participants, the demand for behavioral health services for school children, youth and seniors is concerning.

Strategy

Increase behavioral health capacity and further improve coordination among behavioral health providers and community-based organizations.

Program Metrics

METRIC 1: Number of patients from the targeted population with a behavioral health encounter.

METRIC 2: Number of pediatric patients from the targeted population with a behavioral health encounter.

METRIC 3: Number of interventions by RIGHT Care teams.

Behavioral Health

Activity 1

- Expand adult behavioral health services in community-based clinics for individuals diagnosed with mild to moderate mental illness.
- Expand pediatric mental health services in 2 clinics: deHaro-Saldivar Health Center and the Southeast Dallas Health Center.

Activity 2

- Expand RIGHT CARE by 3 multi-disciplinary teams citywide: 1 South, 1 North, 1 Float.
- 1 complex care team for highest utilizers of jail and ER resources (North Texas Behavioral Health Authority [NTBHA], DPD).
- 1 follow-up team (NTBHA, DPD).
- 911 Call Center to be staffed by NTBHA Care Coordinator.

Activity 3

- Engage organizations within the community to create a “no wrong door” approach to serving those with behavioral health needs.

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COMMUNITY HEALTH NEEDS ASSESSMENT PROGRAM DESCRIPTION: **PEDIATRIC ASTHMA "BREATH FOR LIFE & LEARN FOR LIFE"**

Problem Statement:

High asthma morbidity among pediatric population in the following ZIP Codes: 75210, 75211, 75215, 75216, 75217 and 75241.

Strategy

Implement "Breath For Life & Learn For Life" asthma program. This is a data-driven model for cross-sector linkage and coordination between Dallas County schools and its health system. The purpose of this program is to enroll children with an asthma diagnosis in a text notification program and risk-driven clinical intervention that drive patients and/or parents to follow appropriate preventive measures to avoid asthma exacerbation.

Program will deploy outreach into communities in the involved ZIP Codes, screen asthma children and refer them to PCPs for asthma management. If they do not have a PCP, they will be referred into the Parkland system for asthma medical management and education.

Program Metrics

METRIC 1: Percentage of patients with asthma from the targeted population who were prescribed an asthma therapy.

METRIC 2: Number of pediatric patients with asthma from the targeted population enrolled in the notification program.

METRIC 3: Percentage of patients with asthma from the targeted population who received a flu shot.

Pediatric Asthma

Activity 1

- Enroll Parkland's existing pediatric asthma patients who are not enrolled through the system's health plan into the Breath For Life & Learn For Life program.

Activity 2

- Establish collaboration between Parkland, Dallas County Health and Human Services, Dallas Independent School District (DISD) and Asthma Chasers.
- Identify and solve for any legal barriers (FERPA, HIPAA, etc.).
- Identify and address any barriers of technological interoperability and sustainability.

Activity 3

- Dallas County Health and Human Services will assist in the development of asthma self-management education policy/procedures (AS-ME).
- Identify districts with clean diesel bus routes and/or anti-idling policy.
- Identify housing authorities and programs that use CHWs and train CHWs.

Activity 4

- Support policies and provide technical assistance to improve air quality including modifying multi-unit housing codes and tobacco free policies.

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COMMUNITY HEALTH NEEDS ASSESSMENT PROGRAM DESCRIPTION: **DIABETES**

Problem Statement:

There is a high prevalence of diabetes among residents living in CHNA target ZIP Codes 75210, 75211, 75215, 75216, 75217 and 75241.

Strategy

Deploy Primary, Secondary and Tertiary interventions as described in the activity section that focuses on individuals from CHNA target ZIP Codes.

Program Metrics

METRIC 1: Number of patients from the targeted population screened for diabetes and receiving targeted follow-up based on screening results (higher is better).

METRIC 2: Percentage of patients with diabetes from the targeted population who performed an HbA1c test (higher is better).

METRIC 3: Percentage of patients with diabetes from the targeted population whose most recent HbA1c level is > 9.0% (lower is better).

METRIC 4: Percentage of patients with diabetes from the targeted population with HbA1c level > 9.0% and PSAM score (medication adherence) < 60% (lower is better).

METRIC 5: Percentage of patients with diabetes from the targeted population who received a foot exam (higher is better).

METRIC 6: Percentage of patients with a diagnosis of a diabetic foot problem from the targeted population who experienced an amputation (lower is better).

Diabetes

Activity 1

- Identify people who have or may have diabetes and are not aware and link them to the right level of care through:
- Collaboration with local community-based organizations.
- CHW deployment to high-risk areas.

Activity 2

- Link new diabetes patients to primary care and prevent diabetes complications by addressing social determinants of health.

Activity 3

- Link high-risk patients to Diabetes Consult Team.

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COMMUNITY HEALTH NEEDS ASSESSMENT PROGRAM DESCRIPTION: **SEXUALLY TRANSMITTED INFECTIONS**

Problem Statement:

Over the past 10 years the rate of sexually transmitted infections has increased, and 800 people are newly diagnosed with HIV every year.

Strategy

Parkland will partner with DCHHS, which is leading the effort to reduce the transmission rate of sexually transmitted diseases. DCHHS' 90-90-90 program aims to have 90% of the population with HIV aware of their condition, 90% on treatment and 90% virally suppressed by the year 2030.

Program Metrics

METRIC 1: Percentage of patients from the targeted population who were tested for chlamydia.

METRIC 2: Number of patients with chlamydia from the targeted population who offered expedited partner treatment.

METRIC 3: Number of patients from the targeted population who were tested for HIV.

METRIC 4: Percentage of inmates from the targeted population who were tested for HIV.

METRIC 5: Percentage of patients from the targeted population who tested positive for HIV and were prescribed treatment within 30 days from test.

METRIC 6: Percentage of HIV positive patients from the targeted population with a viral load less than 200/copies ml.

[1] Parkland and Dallas County Health and Human Services. 2019 Community Health Needs Assessment, available at: https://www.parklandhospital.com/dallas-community-health

Sexually Transmitted Infections

Activity 1

- Parkland will implement an expedited partner treatment program, including education regarding how to approach partners.

Activity 2

- Parkland has initiated “opt out” HIV testing in its emergency room and will expand approach to the Dallas County Jail.

Activity 3

- Parkland and Dallas County Health and Human Services have begun providing pre-exposure prophylaxis (PrEP) for individuals at high risk of contracting HIV.

Activity 4

- Continued expansion of community outreach efforts regarding STIs, consolidation of Dallas County Health and Human Services’ STI clinic, now renamed Sexual Health Clinic, and increased visits by 28% between 2018 and 2019.
- Dallas County Health and Human Services will expand after hours services at its Sexual Health Clinic to evenings and Saturdays and explore the need for other sexual health clinic expansion.

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COMMUNITY HEALTH NEEDS ASSESSMENT PROGRAM DESCRIPTION: **HYPERTENSION**

Problem Statement

Heart disease is the leading cause of death in Dallas County with African Americans suffering from particularly high mortality rates related to the condition.

Strategy

Establish high blood pressure program that adheres to the State of Texas public strategies for addressing heart disease and stroke (2019-2023). The program will focus on patients residing in ZIP Codes 75210, 75211, 75215, 75216, 75217 and 75241. In addition, the program will have a particular focus on African Americans as they have a significantly higher mortality rate related to hypertension than other race/ethnicities.

Program Metrics

METRIC 1: Number of patients from the targeted population screened for high blood pressure and follow-up documentation.

METRIC 2: Percentage of patients from the targeted population whose blood pressure at the most recent visit is adequately controlled.

METRIC 3: Percentage of patients with diabetes from the targeted population whose blood pressure at the most recent visit is adequately controlled.

Case Definition

Stage 1: Systolic 130 to 139 mmHg or diastolic 80 to 89 mmHg

Stage 2a: Systolic 140 to 159 mmHg or diastolic 90 to 99 mmHg

Stage 2b: Systolic at least 160 179 mmHg or diastolic at least 100 110 mmHg

Above 180/110 Urgent Assessment

Hypertension

Activity1

- Develop an enhanced surveillance system for chronic diseases.
- Establish a heart disease registry.

Activity 2

- Align clinical teams and CHWs to support patients with uncontrolled high blood pressure.
- Explore technology and care delivery models away from main campus.
- Adopt social marketing strategies.

Activity 3

- Reduce the burden of hypertension and heart disease in Southeast Dallas through policy and environmental changes to increase access to healthy foods and physical activities.

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COMMUNITY HEALTH NEEDS ASSESSMENT PROGRAM DESCRIPTION: **ACCESS TO CARE**

Problem Statement:

1. South and Southeast Dallas have a concentration of ZIP Codes with high SocioNeeds Index (SNI) scores and high mortality and morbidity.
2. Hispanics living in the CHNA target ZIP Codes have the lowest insurance coverage rates in the county, limiting their access to health services.
3. In ZIP Codes 75216 and 75217, more than 40% of the population lacks an internet connection.

Strategy

Increase access points for health services as well as financial eligibility applications in the Southern sector of Dallas.

Program Metrics

METRIC 1: Number of community partners helping patients with PFA application submission.

METRIC 2: Number of primary care encounters provided in targeted areas.

Access to Care

Activity1

- Establish community hubs to assist patients with health coverage, immunizations, health screenings, telehealth set up, and referrals to social services.
- Expand Parkland's Community Health Workers program to improve access/outreach and reduce the number of patients lost to care.
- Further expand telehealth/virtual care opportunities through partnerships with community-based organizations.

Activity 2

- Train staff at partner organizations (as an example, local FQHCs) to help patients navigate Parkland's coverage eligibility and financial assistance processes from off-site locations.

Activity 3

- Expand clinic access in the Redbird area (new COPC).

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COMMUNITY HEALTH NEEDS ASSESSMENT PROGRAM DESCRIPTION: **CULTURAL COMPETENCY**

Problem Statement

The ever-increasing diversity of Dallas County requires greater resources devoted to cultural competency including the establishment of best practices for Race, Ethnicity, Age, Language (REAL) and Sexual Orientation and Gender Identification (SOGI) data collection.

Strategy

Conduct a Cultural Competencies Organizational Self-Assessment

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

Develop an implementation plan based on the assessment

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

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

Strategy Metric

Percentage of employees who participated in the organizational assessment.

Cultural Competency & Workforce Development

Activity 1

- Conduct a cultural competency organizational self-assessment.
- Develop an implementation plan based on the summary report that addresses the following:
  - Culturally and Linguistically Appropriate Services (CLAS)
  - Sexual Orientation Gender Identification (SOGI),
  - Race Ethnicity Age Language (REAL),
  - Patient literacy level, and
  - Trauma informed care training.

Activity 2

- Workforce development activities include:
- Identify an experienced workforce development leader to guide and execute strategic roadmap.
- Increase guidance and career support resources for Parkland employees in entry-level jobs.
- Optimize healthcare internships for high school and college students who live in ZIP Codes with disproportionately high SocioNeeds Index (SNI) scores.
- Secure and expand educational partnerships to build new programs that promote entry to healthcare jobs and increase diversity within Dallas County's healthcare workforce.
- Target recruitment in ZIP Codes with a high SNI score.
- Establish a Parkland Career Advisory program.

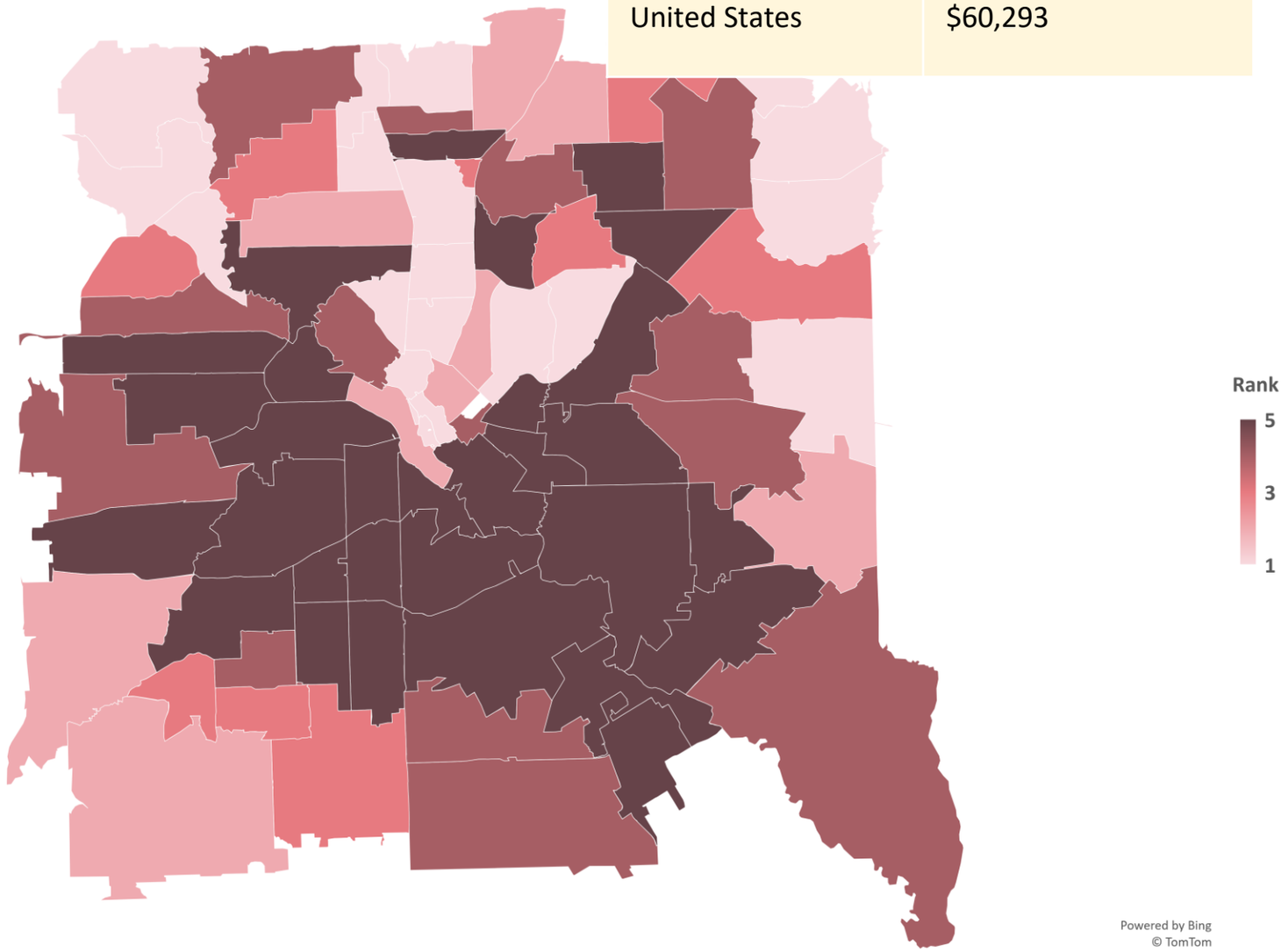
Target Recruitment: Hires from CHNA Zip Codes

Rank	Zip Code	SNI Index	Hires
6	75211	97.3	45
7	75227	96.6	43
39	75235	73	38
4	75217	98.2	35
35	75243	79.6	34
3	75216	98.6	32
2	75212	98.8	29
38	75150	73.6	27
17	75228	94.2	25
26	75241	90.7	24
Total CHNA Zip Codes Hires*			
680*			

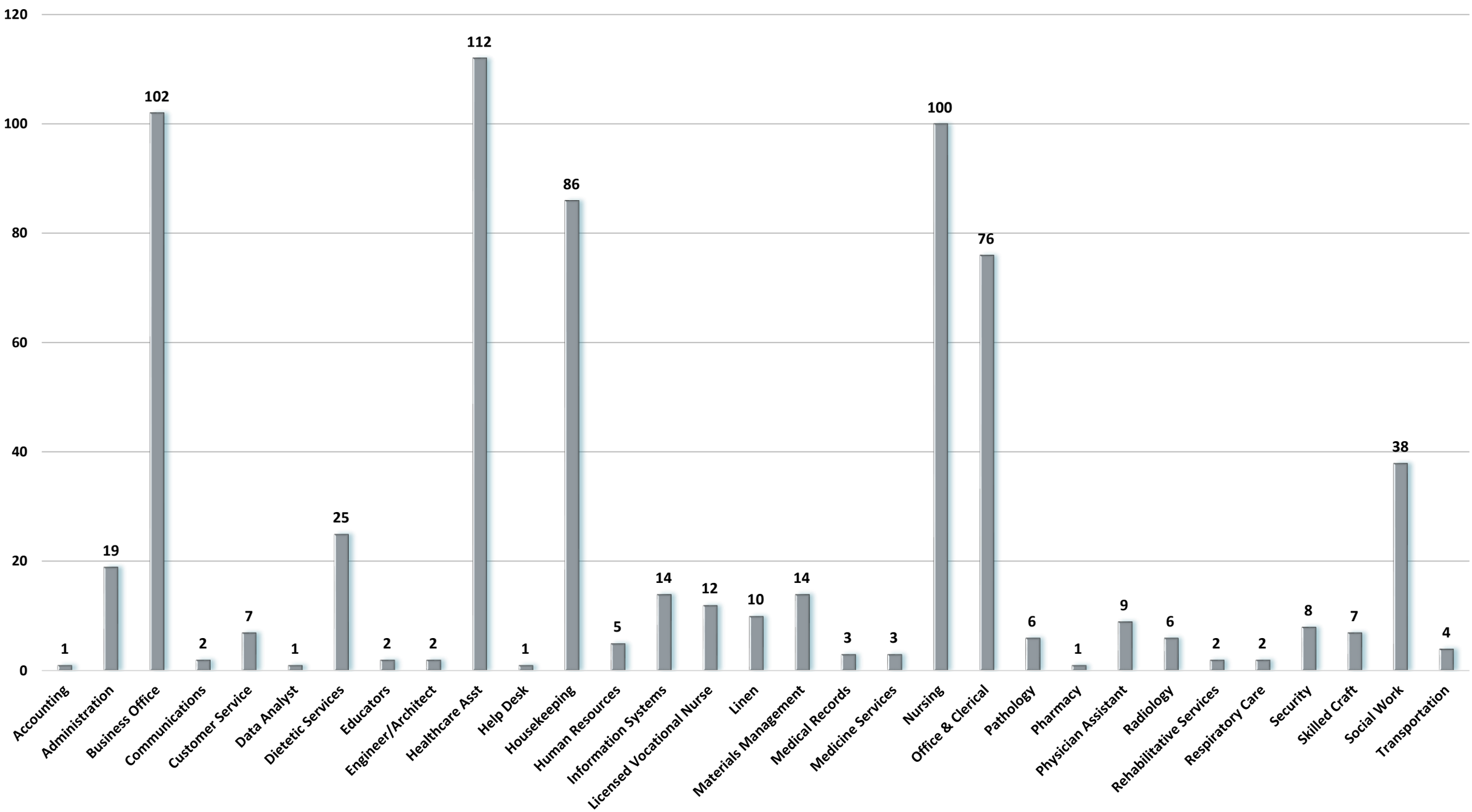
Average salary: $42,847

***Hiring Volumes from Q1-Q3 FY2020 (October 2019-June 2020)**

2018 Median Household Income	
Dallas County	$56,854
United States	$60,293



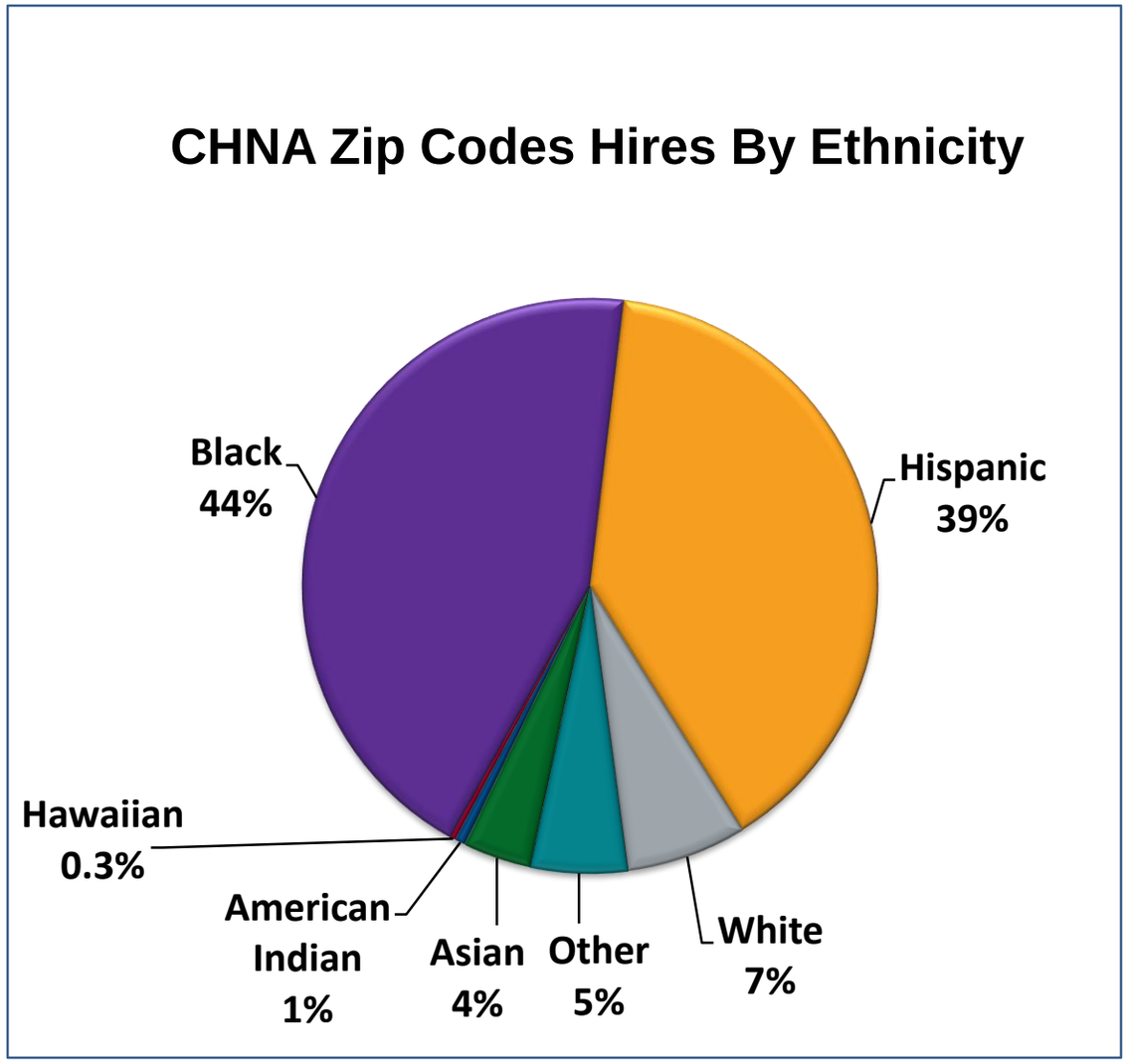
CHNA ZIP Code Hiring by Job Family



Total Hires from CHNA Zip Codes: 680*

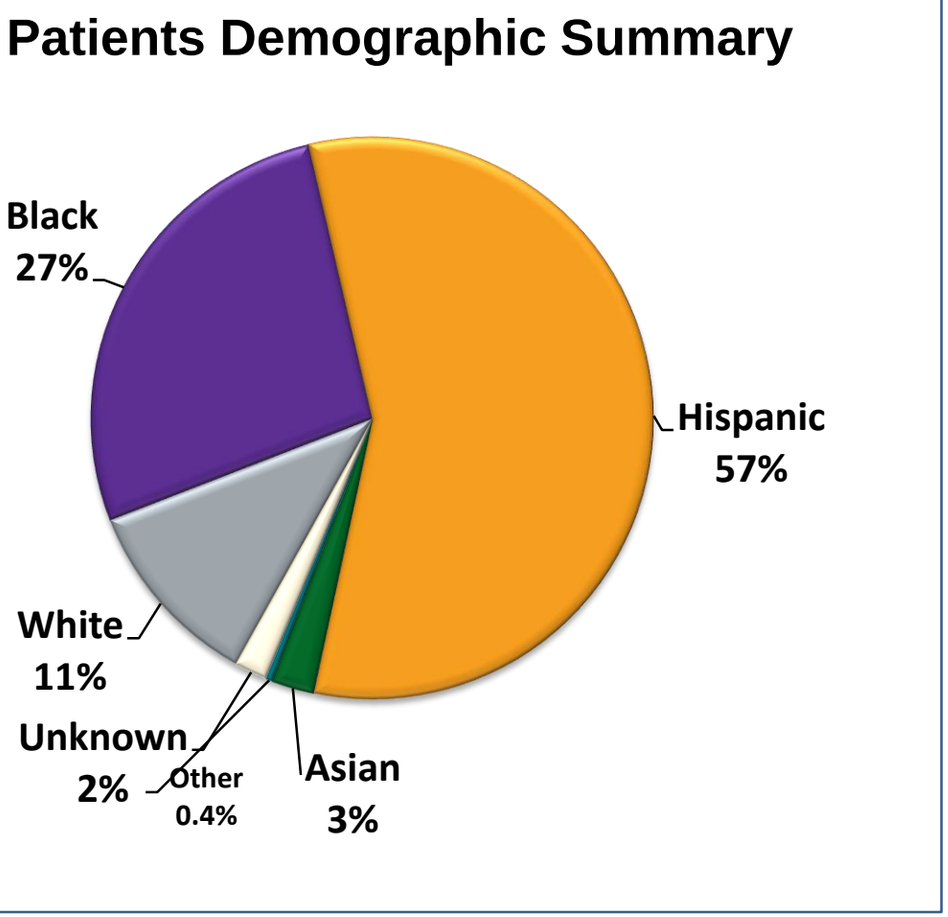
***Hiring Volumes from Q1-Q3 FY2020**
(October 2019-June 2020)

CHNA ZIP Codes Hiring by Ethnicity

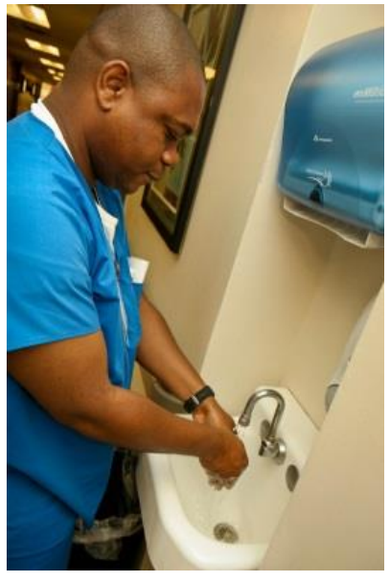


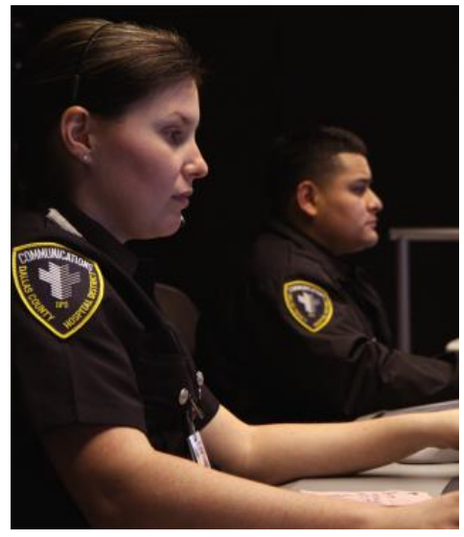
Ethnicity	Hires
Black	298
Hispanic	267
White	46
Other	37
Asian	26
American Indian	4
Hawaiian	2
Total CHNA Zip Codes Hires*	
680*	

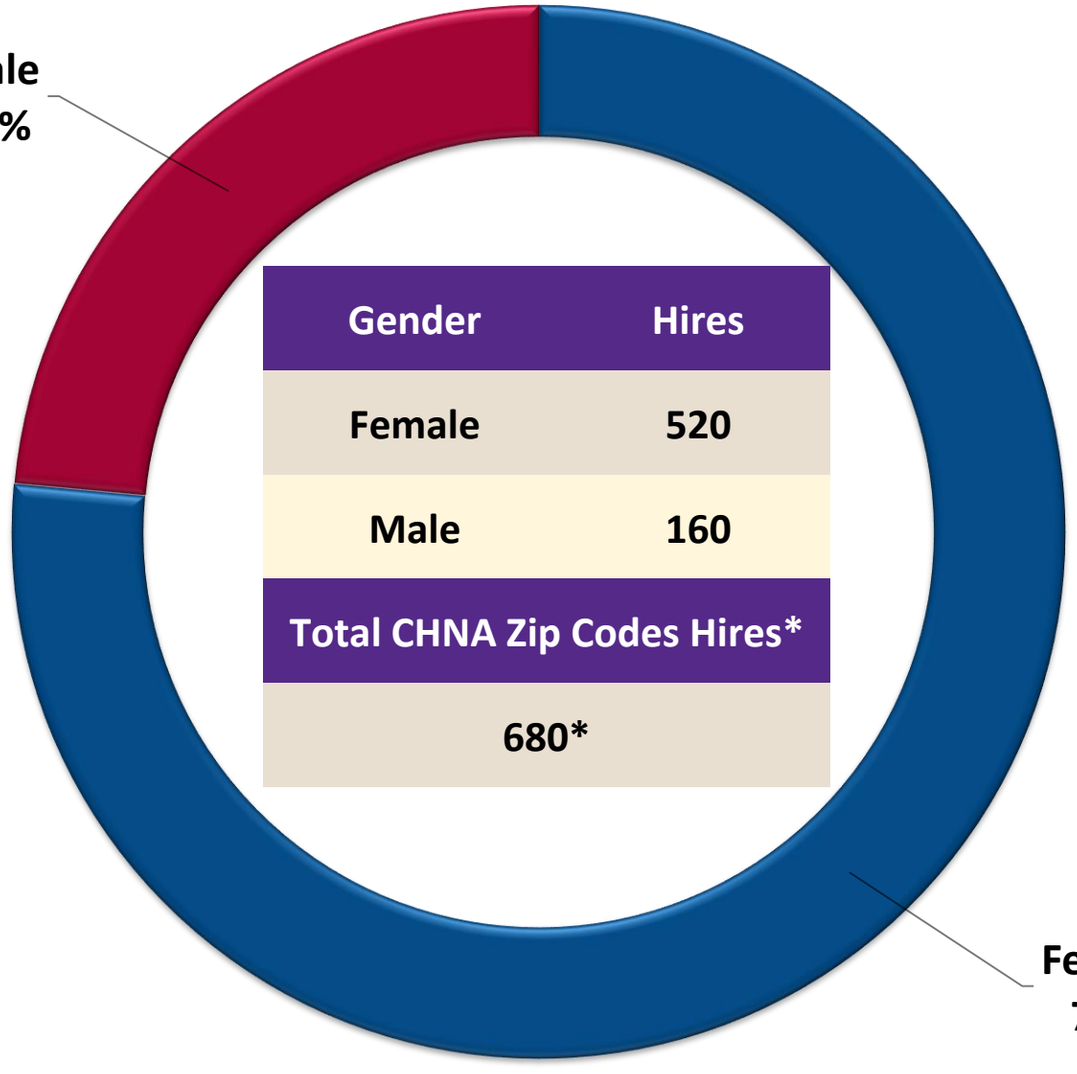
*Hiring Volumes from Q1-Q3 FY2020 (October 2019-June 2020)



CHNA ZIP Codes Hiring by Gender







Gender	Hires
Female	520
Male	160
Total CHNA Zip Codes Hires*	
680*	

*Hiring Volumes from
Q1-Q3 FY2020
(October 2019-June 2020)

Community Partners

Education

- Cornerstone Crossroads Academy
- Dallas College Cedar Valley Campus
- Dallas Independent School District
- Paul Quinn College*
- University of North Texas at Dallas*

Faith Based

- African American Pastors' Coalition*
- Pleasant Grove Ministerial Alliance

Government

- City of Dallas
- Dallas County Health and Human Services
- Dallas Housing Authority
- Mexican Consulate

**** Exploratory phase***

Community Partners

Healthcare

- Abide Women's Health Services
- Baylor Scott & White Health and Wellness Center
- Federally Qualified Health Centers
- Homeward Bound
- North Texas Behavioral Health Authority*

Non-Profit

- Asthma Chasers
- Catholic Charities Dallas
- Community Council
- Crossroads Community Services
- Inspired Vision Compassion Center
- Voice of Hope
- YMCA

**** Exploratory phase***

COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION:

Access to Care and Coverage

Parkland
Care. Compassion. Community.

TABLE OF CONTENTS

COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION

Access to Care and Coverage

A. PROBLEM STATEMENT

1. South and Southeast Dallas have a concentration of ZIP Codes with high SocioNeeds Index (SNI) scores and high mortality and morbidity

2. Hispanics living in the CHNA target ZIP Codes have the lowest insurance coverage rates in the county, limiting their access to health services

3. In ZIP Codes 75216 and 75217, more than 40% of the population lacks an internet connection

B. STRATEGY

Increase access points for health services as well as financial eligibility applications in the Southern sector of Dallas

C. METRICS

1. Number of community partners helping patients with PFA (Parkland Financial Assistance) application submission

2. Number of primary care encounters provided in targeted areas

D. BUDGET (as of August 31, 2020)

Access to Care
Financial Summary

	Year 1	Year 2	Year 3	Year 4	Year 5
Gross Revenue	$0	$0	$0	$0	$0
Deductions from Revenue	-	-	-	-	-
Net Revenue	-	-	-	-	-
Expenses					
Salaries	515,033	614,317	632,747	651,729	671,281
Benefits	111,247	132,692	136,673	140,773	144,997
Drugs	-	-	-	-	-
Med/Surg Supplies-Baxter	4,200	10,320	12,540	15,420	21,540
Lab Supply Costs	-	-	-	-	-
IT Equipment (laptop per FTE, and cell phone for CHW's) one-time cost	20,440	-	3,960	-	-
Monthly IT Expense (air cards and cell phone plan)	16,800	16,800	16,800	16,800	16,800
IT Cost per Team (portable printer, scanner)	1,000	-	1,000	-	-
Medical Equipment per Team (Dinamap for BP, Glucometer, privacy screens)	3,050	-	3,050	-	-
Mileage	20,880	20,880	20,880	20,880	20,880
Office Supplies	2,400	2,400	2,400	2,400	2,400
Promotional Items	6,000	8,040	9,996	11,040	12,000
Printed Materials/Education Material	8,040	3,492	6,000	3,480	3,480
Uniforms (for CHWs) one-time expense	768	-	-	-	-
Total Expenses	**709,859**	**808,942**	**846,046**	**862,522**	**893,377**
Net Income	$ (709,859)	$ (808,942)	$ (846,046)	$ (862,522)	$ (893,377)
Indirect Expense Allocation	-	-	-	-	-
Net Income after Indirect Expenses	**$ (709,859)**	**$ (808,942)**	**$ (846,046)**	**$ (862,522)**	**$ (893,377)**
Capital	**-**	**-**	**-**	**-**	**-**
Total	**$ (709,859)**	**$ (808,942)**	**$ (846,046)**	**$ (862,522)**	**$ (893,377)**
FTEs	**10**	**12**	**12**	**12**	**12**
Total Direct Expenses	**709,859**	**808,942**	**846,046**	**862,522**	**893,377**

E. STAFFING (Year 1 FTEs approved as of 8/31/2020)

#	FTE Description	Scope of Service	FTEs # by Year 1	FTEs # by Year 2	FTEs # by Year 3
1	Community Health Worker (CHW)	1. Collaborates with key areas within the health system, as well as coordinates with multiple external agencies to best serve the needs of the patient by acting as a patient advocate and liaison between the patient, caregivers, healthcare team and community service agencies. 2. The CHW will serve as an extension of the healthcare team and will be responsible for helping patients and their families navigate Parkland services as well as access community resources to improve population health outcomes and increase patient self-sufficiency. As a priority activity the CHW will work to promote, maintain and improve the health and well-being of patients as well as the community by providing public health education, follow-up, outreach, basic health services, screenings and home visits. 3. May be required to perform basic health services such as glucose screenings, blood pressure checks and body mass index (BMI) as a means to facilitate closing gaps in care by educating patients about preventive monitoring and working with clinical teams to schedule screening/diagnostic testing. CHWs will perform these duties and utilize the CHNA Community Screening Tool during organized screening events at CBO locations. 4. Identifies and assists vulnerable individuals and/or individuals with complex and unmet health needs in underserved populations who are not yet connected to the healthcare system, such as people living in geographically isolated locations or individuals with language barriers by implementing care strategies to prevent healthcare crises, ensure consistent follow-up occurs and maintain compliance with care plans, etc. 5. Provides referrals to medical and community resources, assists with patient access to community and governmental based service agencies including help with completing applications and registration forms as well as overcoming financial / transportation barriers to obtaining recommended care, domestic violence, housing, food insecurity, unemployment, etc. Conducts eligibility determination, enrollment and follow-up with uninsured patients. 6. Educates and encourages individuals and communities with adopting healthy behaviors, providing information on available resources, promoting preventive care and screenings, etc. Help patients set personal goals and attend appointments as well as assists with patient care activities to include basic hygiene care, assisting with range of motion exercises, lifting and ambulating. 7. Engages in ways to monitor condition of patient environment and equipment as well as learning to correct problems with the recommendations and guidance of supervisor. Implements sanitation, infection control, safety, supplies and equipment usage in daily tasks. 8. Engages in ongoing education and professional growth, with the guidance and in collaboration with the supervisor by attending in-service sessions, department meetings, workshops and reading magazines or journals to keep abreast of current trends in the field. Integrates knowledge gained into current work practice with support of supervisor.	**7.0**	**0.0**	**0.0**

#	FTE Description	Scope of Service	FTEs # by Year 1	FTEs # by Year 2	FTEs # by Year 3
2	**Community Health Worker Supervisor/ Instructor (CHWI)**	1. Supervises community health workers and other community health staff. Provides ongoing training, community health curriculum, SDOH and other trainings to staff and community. Provides supervision, support and guidance for students and interns. 2. Manages community projects, programs and activities in collaboration with stakeholders within the health system as well as coordinates with multiple external agencies to best serve the needs of the patient by acting as a patient advocate and liaison between the patient, care givers, healthcare team and community service agencies. 3. **The CHWI will ensure all CHWs understand and best perform their role.** The CHW will serve as an extension of the healthcare team and will be responsible for helping patients and their families navigate Parkland services and access community resources to improve population health outcomes and increase patient self-sufficiency. As a priority activity, the CHW will work to promote, maintain and improve the health and well-being of patients as well as the community by providing public health education, follow-up, outreach, basic health services, screenings and home visits. 4. **The CHWI will provide training to support CHWs** as they may be required to perform basic health services such as glucose screenings, blood pressure checks and body mass index (BMI) checks as a means to facilitate closing gaps in care by educating patients about preventive monitoring and working with clinical teams to schedule screening/diagnostic testing. 5. **Manage CHWs** as they identify and assist vulnerable individuals and/or individuals with complex and unmet health needs in underserved populations who are not yet connected to the healthcare system, such as people living in geographically isolated locations or individuals with language barriers by implementing care strategies to prevent health care crises, ensure consistent follow-up occurs, and maintain compliance with care plans, etc. 6. **Oversee CHWs** as they provide referrals to medical and community resources, assists with patient access to community and governmental based service agencies including help with completing applications and registration forms, as well as overcoming financial / transportation barriers to obtaining recommended care, domestic violence, housing, food insecurity, unemployment, etc. Conducts eligibility determination, enrollment and follow-up with uninsured patients. 7. **Train CHWs** to educate and encourage individuals and communities with adopting healthy behaviors, providing information on available resources, promoting preventive care and screenings, etc. Help patients set personal goals and attend appointments as well as assists with patient care activities to include basic hygiene care, assisting with range of motion exercises, lifting and ambulating. 8. **Supervise CHWs** engaged in ways to monitor the condition of patient environment and equipment as well as learning to correct problems with the recommendations and guidance of supervisor. Implements sanitation, infection control, safety, supplies and equipment usage in daily tasks. 9. Engage in ongoing education and professional growth with the guidance and in collaboration with the supervisor, by attending in-service sessions, department meetings, workshops and reading magazines or journals to keep abreast of current trends in the field. Integrates knowledge gained into current work practice, with support of supervisor. **10. Must be certified by the Texas Department of State Health Services Community Health Worker Instructor (CHWI) within 12 months of hire into this role.**	**1.0**	**0.0**	**0.0**

#	FTE Description	Scope of Service	FTEs # by Year 1	FTEs # by Year 2	FTEs # by Year 3
	Senior Business Support Specialist	1. Obtain, verify and update accurate demographic, financial and insurance information in the process of registration. Including the entry of patient/guarantor information in the patient registration/accounting systems. Ensure accounts are billed accurately and timely. Guarantee that medical record numbers are not duplicated or overlays created. 2. Reviews patient accounts for financial status to identify non-funded and/or under-funded patients. Refers appropriate cases to financial counseling for follow-up and consultation and Case Management for clinical justification for pre-authorization as necessary. 3. Educates patients about financial liabilities, employs proper, compliant patient liability collection techniques before, during and after date of service. Performs cash reconciliation and secured payment entry in adherence to financial and cash control policies and procedures. 4. Clearly document actions taken in account notes to ensure information is available and understandable for other departments to review. Tracks productivity/quality and provides cumulative reports daily, weekly and monthly as required. Ensures Patient Rights & Responsibilities as well as other required documents are properly explained and presented to patients. 5. Supports financial counselor and financial screening activities at CBOs during organized onsite events. Actively reviews documents and engages with patients during screening process. 6. Receives, classifies, reconciles, consolidates and/or summarizes documents and information ensuring accuracy. Assures thorough and complete control procedures in order to maintain accurate records of documents processed. 7. Compiles regular and special reports in accordance with established formats and procedures.	**0.0**	**1.0**	**1.0**
	Financial Counselor	1. Screens patient demographic and financial documentation to identify appropriate funding program(s) to ensure that all patients who are qualified for assistance are properly instructed and receive benefits. Verify and obtain insurance benefits and forward referrals and pre-certifications to clinical staff to ensure that patient information is complete and accurate and ensure Parkland's financial viability is secure at the most basic level. 2. Assists patients in completing the certification process with all appropriate public funding source agencies to ensure applications are complete, deadlines are met and the certification process is expedited prior to the patient's discharge. Sets up and encourages applicants to keep appointments to ensure patient complete the process to qualify for financial assistance. 3. Communicates to the patient their financial responsibility and collects co-pays and/or unpaid balances. Provides patients with billing information as required. Enters payments into the computer system to document financial transactions/payment posting. Balances cash drawer at the end of each day. Documents actions taken in the hospital accounting system. 4. Assign appropriate coverage to accounts, including outside agencies when appropriate to ensure patient financial responsibilities are fulfilled. Documents actions in hospital accounting system. 5. Performs registration functions to include verifying patient identification, patient demographics and all third-party funding payors in order to ensure Parkland's financial viability is secured at the most basic level. Distributes, offers explanations and obtains signatures and dates on all required forms as needed. Attaches all appropriate coverages, prioritizes correct filing order and documents actions taken in the hospital accounting system. 6. Tracks productivity and provides cumulative reports on a daily, weekly or monthly basis. 7. Monitors and administers all assigned accounts until the patient's application, certification and/or denial process or review is complete and all appropriate coverages are attached and prioritized correctly for proper billing. 8. Maintains a positive working relationship with contacts at all agencies and funding programs, patients, insurance companies, government entities, clinical personnel, other financial counselors and management, to promote teamwork, cooperation and a positive public image for Parkland. Serves as a positive role model for staff and patients, demonstrates strong interpersonal and persuasive abilities to ensure client compliance and cooperation with state/ federal agencies. Accepts constructive criticism and integrates suggestions in effective ways.	**0.0**	**1.0**	**1.0**
	Total FTEs		**8.0**	**2.0**	**2.0**

F. INTERVENTION DEPLOYMENT

Goal: Increase number of community partners helping patients with PFA (Parkland Financial Assistance) application submission (2020: 7, 2021: 12, 2022: 11)

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact

1	Establish Community Hubs (access points)	Q2 2020 – Q4 2022	• CBO to provide physical space for Parkland staff (CHW, financial counselor, etc.) to assist local patients with health coverage, immunizations, health screenings, telehealth set up, MyChart set up, referrals to social services, develop relationship, system navigation efforts, etc.
			• Key component for onsite CHW will be to create and maintain long-term relationships with patients
			• Other CHNA initiatives (Diabetes, Hypertension, Asthma, Breast Health, etc.) will have the opportunity to conduct their community activities utilizing hub's space – prioritizing hub space to provide well-rounded services for patients
				• Implementation:
				  • Population Health: Colette White & Grace Mathew
				  • Community Relations: Angela Morris
				  • Patient Financial Services: Gerry Baker, Kyle Cross, Bart Ensley
				  • Virtual Care: Molly Case
				• Ongoing (physical presence at sites):
				  • CHWs
				  • Financial Counselor
				  • Senior Business Support Specialist
				• Virtually:
				  • Telehealth providers
				  • Educators for classes (may also be in person)
					30 hubs/access points created by end of 3 years
					# of CBOs contacted for partnership
					# of CBOs participating in multiple initiative's activities
					# of total hours physically spent in CBOs/community space by CHWs/Financial Services
						Established Community Hubs
						2020: 7
						2020: 12
						2022: 11

2	Financial Services Screenings	Dates determined in collaboration with CBO after assessing traffic & needs of CBO's clientele (i.e. CBO that serve 1000+ families daily, Parkland may be there 2-3 times a week for 4-8 hours, or CBO that serve 100 families/ day, Parkland may hold 3-4 events a month) – financial screenings will likely coincide with health/SDOH screenings	• Onsite financial counselor will assess eligibility for Medicare, Medicaid, grants/programs, Parkland Financial Assistance (PFA), etc. • If patient is found eligible for a program or PFA – financial counselor and/or senior business support specialist will help patient enroll • Assist individuals needing help completing the Parkland Financial Assistance (PFA) application – help patients understand what is being asked, provide guidance on where or how to obtain necessary documents, etc.	• Financial Counselor • Senior Business Support Specialist	# of total patients screenings for financial services # of PFA applications submitted # of PFA applications approved # of patients receiving health coverage as a result of financial screening # of patients who renewed their PFA as a result of community screening event	**Financial Screenings** 2020: 0 2021: 2119 2022: 4398

Goal: Increase number of community partners helping patients with PFA (Parkland Financial Assistance) application submission (2020: 7, 2021: 12, 2022: 11)						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
3	PFA Training	Starting September 2020 – ongoing	• Patient Financial Services will provide training to CBO staff/volunteers who will help their clients complete the Parkland Financial Assistance application form • Training sessions will include education on PFA, education on coverage and eligibility options for clients, resources for CBOs and for patients, FAQs, etc. • As any updates are made to PFA process, additional training sessions will be held for CBO partners • Patient Financial Services will provide email and telephone support for CBOs needing further assistance • Training sessions will be held in person or virtually depending on needs of CBO & social distancing measures in place at time of training • Patient Financial Services will have an eligibility call center that partners and patients can utilize	• Financial Counselors • Patient Financial Services Trainers • Senior Business Support Specialist	# of CBOs in target areas trained on PFA # of CBO staff trained # of patients from target ZIP Codes provided support by partner CBO # of training sessions held	**CBO Trainings** 2020: 7 2020: 19 2022: 30

Goal: Increase the number of primary care encounters provided in targeted areas by 2022 (2020: 144,042 2021: 151,604 2022: 158,086)						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**

1	Patient Identification	Health Screenings at CBOs, PCP and virtual care
		
		Dates determined in collaboration with CBO after assessing traffic & needs of CBO's clientele (i.e. CBO that serve 1000+ families daily, Parkland may be there 2-3 times a week for 4-8 hours, or CBO that serve 100 families/day, Parkland may hold 3-4 events a month
			• Parkland CHWs will administer Community Screening Tool to assess health needs for CBO clients[1]
			  • 2020: 0 screenings (limited community outreach due to COVID-19)
			  • 2021: 14,958 CHW led health screenings
			  • 2022: 19,944 CHW led health screenings
			• Screening questionnaire will include: blood pressure check, glucose check, A1c, family history, risk factors, etc.
			• CHW will assess patient for follow-up care determined by patient's acuity level based on screening.[2] Example:
			  • **Acuity Level 1**: acute medical symptoms/signs, exacerbation of chronic conditions, poorly controlled health conditions; glucose screening results >300 uncontrolled blood sugar with symptoms of hyperglycemia; blood pressure reading of SBP >160 mmHg or <90 mmHg DBP >100 mmHg or <50 mmHg; pulse >120 bpm or <50 bpm – patient may be referred to ED/UCED
			  • **Acuity Level 2:** Stable complex chronic health conditions/fairly controlled chronic medical conditions; glucose screening results of 200-300 OR A1c >9%, blood pressure of SBP 140 – 159 mmHg AND/OR DBP 90-99 mmHg–-- recommended further evaluation within 30 days (either to their PCP or will refer to/make appointment for patient at medical home (COPC) – treated as high/normal priority depending on how many factors patient has
			  • **Acuity Level 3:** stable chronic conditions, at risk for developing chronic conditions; blood pressure reading SBP 120-139 mmHg and/or DBP 80-89 mmHg – recommended routine evaluation, discuss medical home for patient, set up follow-up appointment – normal priority
			• If patient is a Parkland patient or being referred to medical home with Parkland – CHW can/will assist patient in signing up for a MyChart profile
			• If patient has an existing PCP or continuing care at another clinic/ health system – CHW will provide additional information to client and help with system navigation to avoid loss to care
			• Host other initiatives' activities (mammogram screenings, STI/HIV screening, asthma, etc.) at same time of health screenings when possible to provide full service for patients
				• CHWs	# of individuals screened
					
					# of individuals referred for follow-up care
					
					# of individuals needing immediate care/emergency care
					
					# of individuals joining Parkland medical home
					
					# of patients signed up in MyChart
						Number of Encounters
						2020: 144,042
						2021: 151,604
						2022: 158,086

[1] Screening capacity is calculated utilizing a CHW volume formula including hours available for screenings, standard PTO, other job functions, continuing education hours, etc.
[2] Acuity levels are based on clinical guidelines and policies

Goal: Increase the number of primary care encounters provided in targeted areas by 2022 (2020: 144,042 2021: 151,604 2022: 158,086)						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**

2	Patient Identification - Social Determinants of Health (SDOH) Screenings	Dates determined in collaboration with CBO after assessing traffic & needs of CBO's clientele (i.e. CBO that serve 1000+ families daily, Parkland may be there 2-3 times a week for 4-8 hours, or CBO that serve 100 families/day, Parkland may hold 3-4 events a month (events will coincide with #1 Intervention Health Screening)	• Parkland CHWs will administer Social Determinants of Health (SDOH) Screening Tool to assess social needs for CBO clients[3]
			  • 2020: 0 screenings (limited community outreach due to COVID-19)
			  • 2021: 14,958 CHW led SDOH screenings
			  • 2022: 19,944 CHW led SDOH screenings
			• Screening will assess: financial resource strain, transportation needs, alcohol use, depression, intimate partner violence, social connections, physical activity, tobacco use, stress and food insecurity
			• Based on screening results: CHW will recommend programs/ services in existence at Parkland or use Aunt Bertha to refer patients for social aid
			  • Aunt Bertha allows staff to search by patients' ZIP Code for area services
			• CHW will aid in follow-up with patients to impact loss to care and system navigation
				• CHWs	# of individuals screened
					# of individuals referred for follow-up care through Parkland services
					# of patients referred through Aunt Bertha to CBOs
						Primary Care Encounters
						2020: 144,042
						2021: 151,604
						2022: 158,086

3	Telehealth/ Virtual Care	One-time set up for Parkland – ongoing use for CBO's clientele during CBO's open hours	• Parkland Virtual Care team will set up telehealth at CBO using "Parkland Connect"
			  • CBO will provide laptop with camera access, a mouse, external speakers, and if available, but not necessary, a larger monitor for easier viewing
			• Virtual visits will allow patients to meet with physician (currently 1 FTE) for follow-up care appointments
			  • Provider is able to order labs, order/renew prescriptions, conduct all routine assessments to analyze, diagnose and treat virtually
			  • Currently only available to existing Parkland patients (if a patient is seen in person, and then wants to move virtual, opportunity may exist)
			• Training will be provided to CBO staff for commonly asked questions or basic troubleshooting, but if CHW is onsite, CHW can also help patient navigate virtual appointment
				• Parkland's Virtual Care Team
				• CHWs
					# of patients utilizing telehealth services for routine follow-up care appointments
					# of prescriptions renewed via virtual care to address medication adherence
						Patients Linked to Telehealth Visits
						2020: 4,500
						2021: 4,500
						2022: 4,500

[3] Screening capacity is calculated utilizing a CHW volume formula including hours available for screenings, standard PTO, other job functions, continuing education hours, etc.

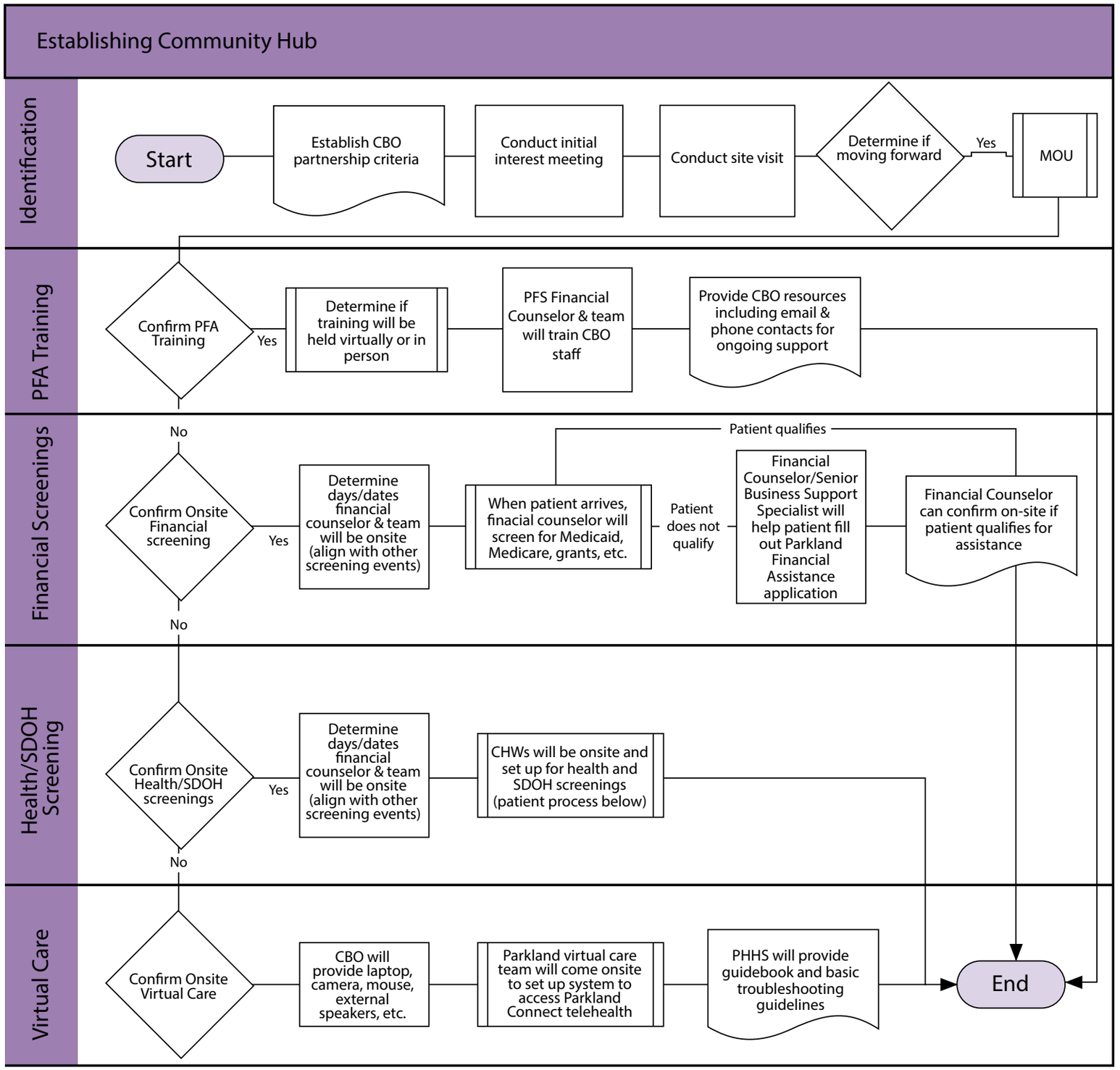
[4] Visit capacity is calculated utilizing a volume formula including hours available for screenings, standard PTO, other job functions, continuing education hours, etc. Currently the department of Telehealth has hired one physician dedicated to telehealth, as demand increases COPC providers can add capacity to deliver this service.

Goal: Increase the number of primary care encounters provided in targeted areas by 2022 (2020: 144,042 2021: 151,604 2022: 158,086)						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
4	Health Education	As required by guidelines set forth by the following initiatives: Asthma Breast Health Diabetes Hypertension, etc.	• CHWs onsite at CBOs will hold education sessions on various topics based on the needs of the CBO's clientele; may include: healthy living with diabetes, mindfulness, stress management, tobacco cessation, exercise, etc. • If a class or group is already being held by Parkland programs, CHW will help patients enroll/join these existing classes and groups for ongoing education • With virtual classes growing, these will also be offered to CBO clients • Packets and brochures with take-home information will be provided when applicable (nutrition class may take home healthy recipes, stress management may take home examples of self-coping, etc.)	• CHWs	# of participants in classes. Class subjects offered tracked # of patients referred for ongoing education/groups # of patients referred to social resource as a result of health education (i.e. if patient comes to nutrition class and expresses (or is found out to have) food insecurity, CHW can refer patient to nearby food pantry)	**Participants in Health Education Sessions** 2020: 0 2021: 480 2022: 960

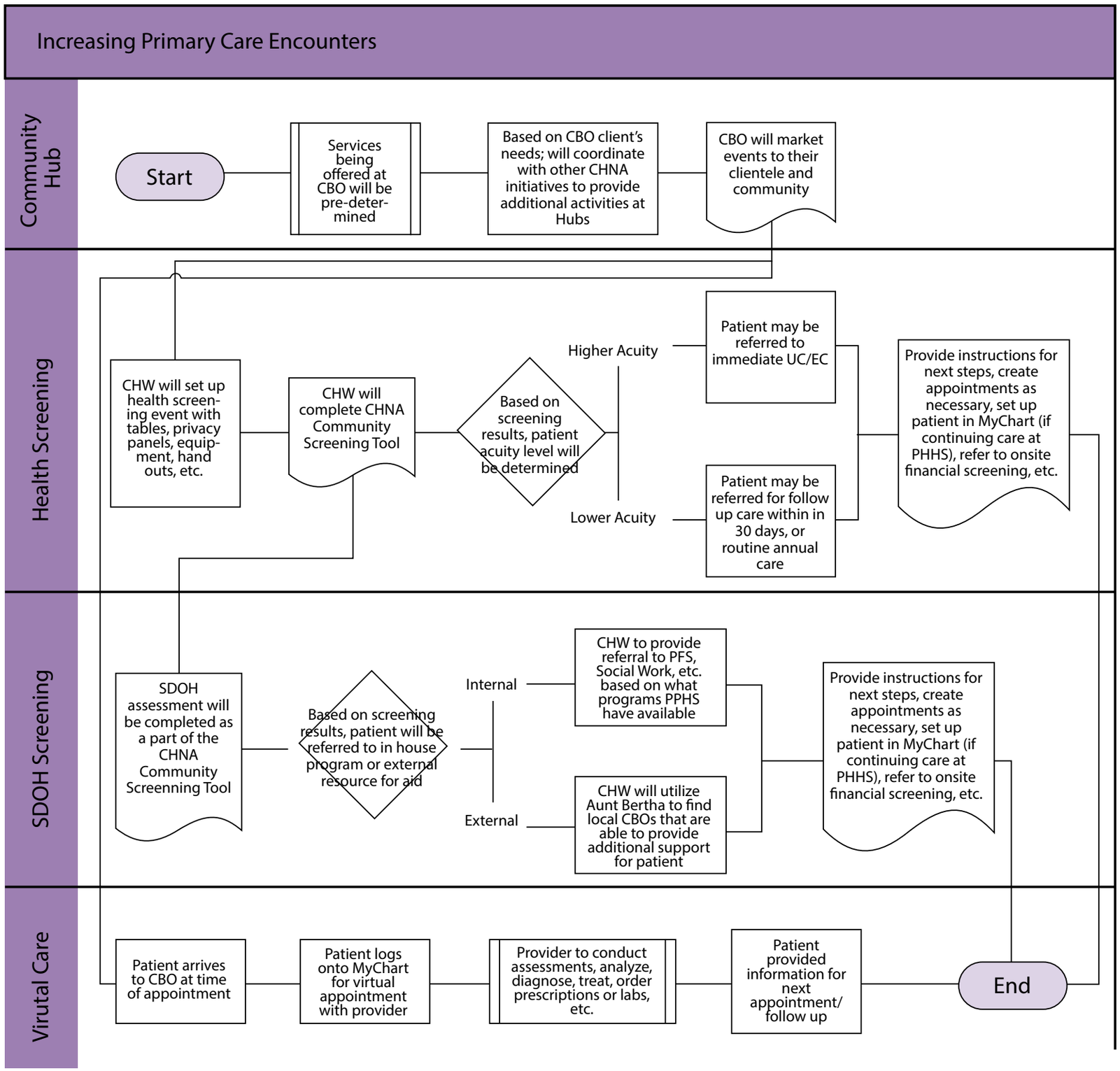
[5] Screening capacity is calculated utilizing a CHW volume formula including hours available for screenings, standard PTO, other job functions, continuing education hours, etc.

G. SERVICE DELIVERY PROCESS FLOW

1. Establishing Community Hubs



2. Increasing Primary Care Encounters



CHW SCOPE OF SERVICES

VISIT	OBJECTIVE	ASSESSMENT	EDUCATION	REMEDIATION	TOOLS
CBO On-site Health Screening	• Ascertain patient/client health status • Promote preventive care and chronic disease management	CHNA Community Screening Tool	Health Education: • Blood Pressure • Diabetes • Weight • Nutrition • Heart Disease • Breast Health	Refer patient for follow-up care based on acuity level	EPIC Medical Equipment: Blood Pressure machine, Glucose tests, etc.
CBO On-site SDOH Screening	• Ascertain social needs of patient/client affecting their overall health	CHNA Community Screening Tool – Social Determinants of Health Assessment	Social Resources: • Financial • Transportation • Housing • Food Insecurity • Alcohol or Smoking Cessation • Partner Violence Advocacy • Depression	Refer patient to in-house program Refer patient to CBO in local area for additional aid Refer patient to Patient Financial Services	EPIC Aunt Bertha
CBO On-site (no screening events)	• Continue developing relationship with patient/ client – aid in follow-up care to reduce patient's loss to care • Bridge any gap between patient and external CBO providing SDOH care		• Health Education • Social Resources	Actively engage patient/client and participate in their follow-up – warm hand offs if necessary (for example if patient is having trouble completing their PFA application, directly connecting them with onsite Patient Financial Counselor/Senior Business Support Specialist for further assistance)	EPIC Aunt Bertha

H. PARTNERSHIPS

#	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
1	Inspired Vision Compassion Center	75217	IVCC is a non-profit that provides access to basic needs in a grocery store format to residents of Dallas in need. Services include: food, clothing, furniture, personal hygiene, animal supplies, emergency baby items, medical/first aid supplies, school supplies, etc. Each spring – they host a "Free Prom Store."	• All ages • Providing groceries for 1,400 – 1,900 families/day/5 days a week • Majority Hispanic population • No ZIP Codes restrictions/no ID restrictions	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care	Negotiation Phase/Outlining Agreement
2	City of Dallas – Parks & Recreation: Larry Johnson	75210	Recreation center features include: fitness center, gymnasium, kitchen, large meeting room, outdoor basketball court, parking, playground, small meeting room, youth programs, afterschool and summer camps, active adult and senior programs, adult sports programs	• Heavy senior concentration • 50-60 daily individuals (pre-COVID-19)	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services	Negotiation Phase/Outlining Agreement
3	City of Dallas – Parks & Recreation: John C. Phelps	75216	Recreation center features include: baseball field, fitness center, gymnasium, kitchen, large meeting room, outdoor basketball court, parking, playground, small meeting room, tennis court, walking trails, picnic area, youth dance instruction and cheerleading, after school programs, senior activities, and adult fitness classes	• Larger senior population	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services	Negotiation Phase/Outlining Agreement
4	City of Dallas – Parks & Recreation: Janie C. Turner	75217	Recreation center features include: baseball field, fitness center, gymnasium, kitchen, large meeting room, outdoor basketball court, parking, small meeting room, tennis court, youth cheerleading & dance instruction, after school programs, adult fitness classes, senior activities, computer room, and popular boxing program for kids in partnership with DPD	• All ages	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care	Negotiation Phase/Outlining Agreement
5	Community Council of Greater Dallas	HQ: 75247, however serves all of Dallas County and immediate areas	Community action agency/social services organization focusing on poverty alleviation – increasing awareness and access to services. Current programs include: 1. serving seniors with benefits counseling, nutritional services, care coordination, caregiver support & advocacy, meals, transportation, and other senior assistance 2. Coordinating with a network of 1,000 agencies to deliver programs/services to low-income residents – removing barriers to employment and transitioning people out of poverty by providing job training, education, and wrap around services 3. 2-1-1- hotline information and referrals – fielding calls for meals, transportation, and assistance for aging, elderly, senior citizens and people with disabilities	• Aging, elderly, senior citizens • Low-income • People with disabilities	PFA Training	Negotiation Phase/Outlining Agreement

#	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
6	Dallas Housing Authority (DHA)	Various; starting with 75212	DHA provides quality, affordable housing to low-income families and individuals through administration of housing assistance programs across North Texas. DHA is interested in providing access to supportive resources for families – creating housing solutions in healthy, inclusive communities that offer economic, educational and social growth opportunities.	• 46% of clients are seniors or persons with disabilities • Average annual income: $14,000 • 83% female head of households • 86% African American • Average age: 49 • Serving ~55,000 individuals across 4,903 rental housing units	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care PFA Training	Negotiation Phase/Outlining Agreement
7	Los Barrios Unidos Community Clinic	75211, 75212	Los Barrios operates a community health clinic in a high need area – known for having quality bilingual staff in English and Spanish. They do not turn away anyone for inability to pay, and accepts Medicaid, CHIP, Medicare, private insurance, and offers a sliding fee scale based on federal poverty level guidelines. The clinic is a federally qualified health center that provides comprehensive primary care services to prevent illness and promote health.	• Economically disadvantages, low-income, and poor populations, minorities • ~87,000+ annual patient visits	PFA Training	Negotiation Phase/Outlining Agreement
8	Healing Hands Ministries	75243, 75231	Healing Hands operates 7 clinics including a patient-centered community health center. It can serve as a permanent medical home for uninsured, underinsured, and has a goal to teach refugees how to care for their children. They also provide shared medical appointments where groups of 10-12 people are educated in a group setting allowing for peer discussion and support. They have 3 translators on staff and employ a language line.	• 20,000+ individual patients annually who speak 68 different languages • 61,000+ patient visits annually • Children and families • 67% of patients are women	PFA Training	Negotiation Phase/Outlining Agreement
9	Foremost Family Health Center	75215, 75180	Foremost is a federally qualified health center offering access to affordable and comprehensive medical, dental, and behavioral health services, regardless of ability to pay.	• ~6,161 patients	PFA Training	Negotiation Phase/Outlining Agreement
10	Crossroads Community Services	HQ: 75236, however serves Dallas, Ellis, and Navarro counties	Crossroads provides nutritious food and supportive education to low-income families and individuals. They have a main hub that serves as a food pantry, and have partnered with 1200+ community distribution partners (CDPs) to expand their food assistance reach. Crossroads is also committed to meeting peoples basic needs and works with local partners to improve economic and health outcomes for their clients (UTSW, NTFB, Sharing Life Community Outreach, Parkland through BUILD Health Challenge project, DCHHS, University of Dallas)	• ~75,000 people including 26,500 children • Distributes ~9 million pounds of groceries annually • Low-income/economically disadvantaged individuals • Homeless • Unemployed/underemployed	Virtual Care PFA Training	Executed

#	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
11	Cornerstone Crossroads Academy	75215	CCA's mission is to develop urban youth through education. They are a certified secondary/high school and host youth development programs. Their primary target is older students who need a 2nd chance to earn a high school diploma or returning students. Many of CCA's students are transient. Tuition is free to students, and in lieu of tuition, students participate in community service opportunities. In addition to curriculum, students also meet 1:1 with a life coach weekly to identify areas of concern: social, emotional and physical support for students who are on the verge or already homeless/in crisis. CCA has purchased the Phyllis Wheatley School and plans to expand services at its new location in the coming years. CCA also provides community access to healthy foods by partnering with Crossroads Community Services.	• Ethnic/racial minorities • Ages 16+	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care	Negotiation Phase/Outlining Agreement
12	Voice of Hope	Physically located in 75212, but draws a large crowd from 75211	Voice of Hope is a non-profit seeking to provide character building, education support, life skills, and family support services to their clients. They work to equip families with resources and skills needed to overcome and break the poverty cycle. Youth programs include: ASPIRE after school program (homework help & a meal), Summer Day Camps, Kids Across America. Family and Community support programs include: Food Pantry as a community distribution partner with Crossroads Community Services, Fruits and Vegetables Outreach (with Hardies), holiday outreach, neighborhood watch groups, and activities for senior citizens including Bible studies and knitting groups. Voice of Hope also partners with NTFB, DISD, World Vision, YMCA, Young Life, Mercy Street Dallas and the West Dallas Initiative.	• All ages with a focus on school-aged children and senior citizens	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care	Negotiation Phase/Outlining Agreement

COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION:

Breath for Life
Learn for Life

Parkland
Care. Compassion. Community.

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COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION

Asthma

A. PROBLEM STATEMENT

High asthma morbidity among pediatric population in the following ZIP Codes: 75210, 75211, 75215, 75216, 75217 and 75241.

B. STRATEGY

Implement Breath For Life & Learn For Life asthma program. This is a data-driven model for cross-sector linkage and coordination between Dallas County schools and its health system. The purpose of this program is to enroll children with an asthma diagnosis in a text notification program and risk-driven clinical intervention that drive patients and/or parents to follow appropriate preventive measures to avoid asthma exacerbation.

Program will deploy outreach into communities in the involved ZIP Codes, screen asthma children, and refer them to PCPs for asthma management. If they do not have a PCP, they will be referred into the Parkland system for asthma medical management and education.

C. METRICS

1. Percentage of patients with asthma from the targeted population who were prescribed an asthma therapy

2. Number of pediatric patients with asthma from the targeted population enrolled in the notification program

3. Percentage of patients with asthma from the targeted population who received a flu shot

D. STAFFING

Additional staffing was not identified for 2020. As program enrollment increases over the next two years staffing patterns will be reassessed as well as the expansion of the community partners' network.

E. BUDGET (as of August 31, 2020)

Parkland has entered in a contract with PCCI to develop and deploy the asthma predictive risk model and text messaging platform components of this program, the budget presented below reflects costs associated to this contract.

CHNA Pediatric Asthma Financial Summary

	Year 1 FY21	Year 2 FY22	Year 3 FY23	Total
Gross Revenue	$0	$0	$0	**$0**
Deductions from Revenue	-	-	-	-
Net Revenue	-	-	-	-
Expenses				
Salaries * :				
Executive Oversight	43,000	43,000	33,970	**119,970**
Senior Clinician	24,570	24,570	18,900	**68,040**
Data Scientist	66,600	166,500	57,720	**290,820**
Data/Business Analyst	-	37,900	-	**37,900**
Project Coordinator	34,570	72,570	34,052	**141,192**
Total Salaries	168,740	344,540	144,642	657,922
Benefits	-	-	-	-
IT Services				
(Text messaging cost and Cloud hosting environment)	30,800	105,000	105,000	**240,800**
Total Expenses	**199,540**	**449,540**	**249,642**	**898,722**
Net Income before Capital Expenditure	**$ (199,540)**	**$ (449,540)**	**$ (249,642)**	**$ (898,722)**
Capital Purchases	-	-	-	-
Net Income including Capital	**$ (199,540)**	**$ (449,540)**	**$ (249,642)**	**$ (898,722)**
FTEs	-	-	-	-
Volumes/Visits	-	-	-	-
Net Revenue Per Patient	$ -	$ -	$ -	**$ -**
Expense Per Patient	$ -	$ -	$ -	**$ -**
Net Income Per Patient	**$ -**	**$ -**	**$ -**	**$ -**

F. INTERVENTION DEPLOYMENT

Goal: Increase the percentage of patients with asthma from the targeted population who were prescribed an asthma therapy from 96% to 97% by 2022

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact
1	Patient Identification	Asthma screening and patient	In-person screening conducted by Parkland staff or Asthma Chasers in community settings including but not limited to schools and PCP visit • Complete Asthma Control Test (ACT) questionnaire • Spirometry test • Referrals • Students referred by DISD Asthma Chasers • Data analytics • Predictive risk model	• Asthma Chasers • Parkland Respiratory Therapist • DISD School Nurse • PCCI	# of ACTs completed # of spirometry tests completed # of patients referred by DISD # high risk patient identified through data analytics	**Patients Identified** 2020: 776 2021: 1,776 2022: 2,650
2	Referral to PCP	Within 1 week from screening	Contact the family to help facilitate an appointment with either a Youth & Family Clinic or COPC health center Patient Financial Services for COPC will reach out to the family pre-visit to perform a financial screening	• Respiratory Therapist • Financial Counselor	# of PCP appointments # of financial consults	**PCP Referrals** 2020: 776 2021: 1,705 2022: 2,570

3	Asthma Treatment	Established Parkland patient 2 – 4 weeks from screening
		DISD student 2 – 4 from referral
			Assess the level of asthma severity by completing the following:
			• Asthma assessment (lung capacity assessment, ACT, etc.)
			• Medication adherence
			• Asthma treatment plan
			• Asthma education including but not limited to:
			  • Asthma self-management
			  • Medication adherence
			  • Environmental risk factors
				• PCP
				• CHW
				• Parkland Respiratory Therapist
					# of asthma assessment plans
					# of asthma treatment plans
					# of asthma education sessions
						Assessments
						2020: 745
						2021: 1,705
						2022: 2,570
						Treatment Plans
						2020: 745
						2021: 1,705
						2022: 2,570
						Education Sessions
						2020: 745
						2021: 1,705
						2022: 2,570

4	On-site or remote asthma monitoring	Every 2 - 3 months post first PCP visit based on level of asthma severity	• Complete ACT
			• Complete spirometry test
			• Health literacy including but not limited to:
			  • Asthma symptoms
			  • Asthma devices
			  • Medication adherence
			  • Environmental risk factors
				• Parkland Respiratory Therapist
				• Asthma Chasers
					# of patients monitored
					# of ACTs completed
					# of spirometry tests
						Patients Monitored
						2020: 745
						2021: 1,705
						2022: 2,570
						Monitoring Sessions
						2020: 6,984
						2021: 15,984
						2022: 23,850

Goal: Increase the percentage of patients with asthma from the targeted population who were prescribed an asthma therapy from 96% to 97% by 2022

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact

5	Home Visits		**Visit 1:**
			• Complete ACT and establish baseline
			• Complete "Asthma home visit questionnaire"
			• Educate household about asthma on the following:
			  • Create asthma self-management skill
			  • Work with household and medical provider to create asthma management plan if family does not have one
			  • Collaborate with clinical partners
			Visit 2:
			• Conduct room-by-room assessment of the home using Environmental Protection Agency (EPA) checklist
			• Identify environmental asthma triggers in the home
			• Educate household on the following:
			  • Share information with household about identified asthma triggers and action steps to reduce these triggers
			  • Conduct basic tobacco cessation counseling and referrals when applicable
			  • Collaborate with community partners
			Visit 3
			• Assist family in accessing available social resources based on social needs assessment
			• Assess using ACT or C-ACT
			  • Assess progress on previously recommended solutions
			  • Make referrals to social services
			Follow-up call 1, 6 months from home visit 1
			• Assess improvement from baseline
			• Follow-up on previous recommendations
			Follow-up call 2, 12 months from home visit 1
			• Assess improvement from baseline
			• Follow-up on previous recommendations
			• Encourage family to participate in asthma treatment plan
				DCHHS and Parkland
				CHWs
					# of home visits 1
					# of home visits 2
					# of home visits 3
					# of follow-up calls 1
					# of follow-up calls 2
						Home Visit 1
						2020: 2,328
						2021: 5,328
						2022: 7.950
						Home Visit 2
						2020: 2,328
						2021: 5,328
						2022: 7.950
						Home Visit 3
						2020: 2,328
						2021: 5,328
						2022: 7.950
						Follow-up Call 1
						2020: 2,328
						2021: 5,328
						2022: 7.950
						Follow-up Call Home 2
						2020: 2,328
						2021: 5,328
						2022: 7.950

Goal: Increase the percentage of patients with asthma from the targeted population who received a flu shot from 50.16% to 80% by 2022

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact
1	Influenza Prevention	PCP visits	• Administer influenza vaccinations	Registered Nurse	# of influenza vaccinations delivered	**Influenza Vaccinations** 2020: 456 2021: 1,243 2022: 2,120

Goal: Number of pediatric patients with asthma from the targeted population enrolled in the notification program

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact

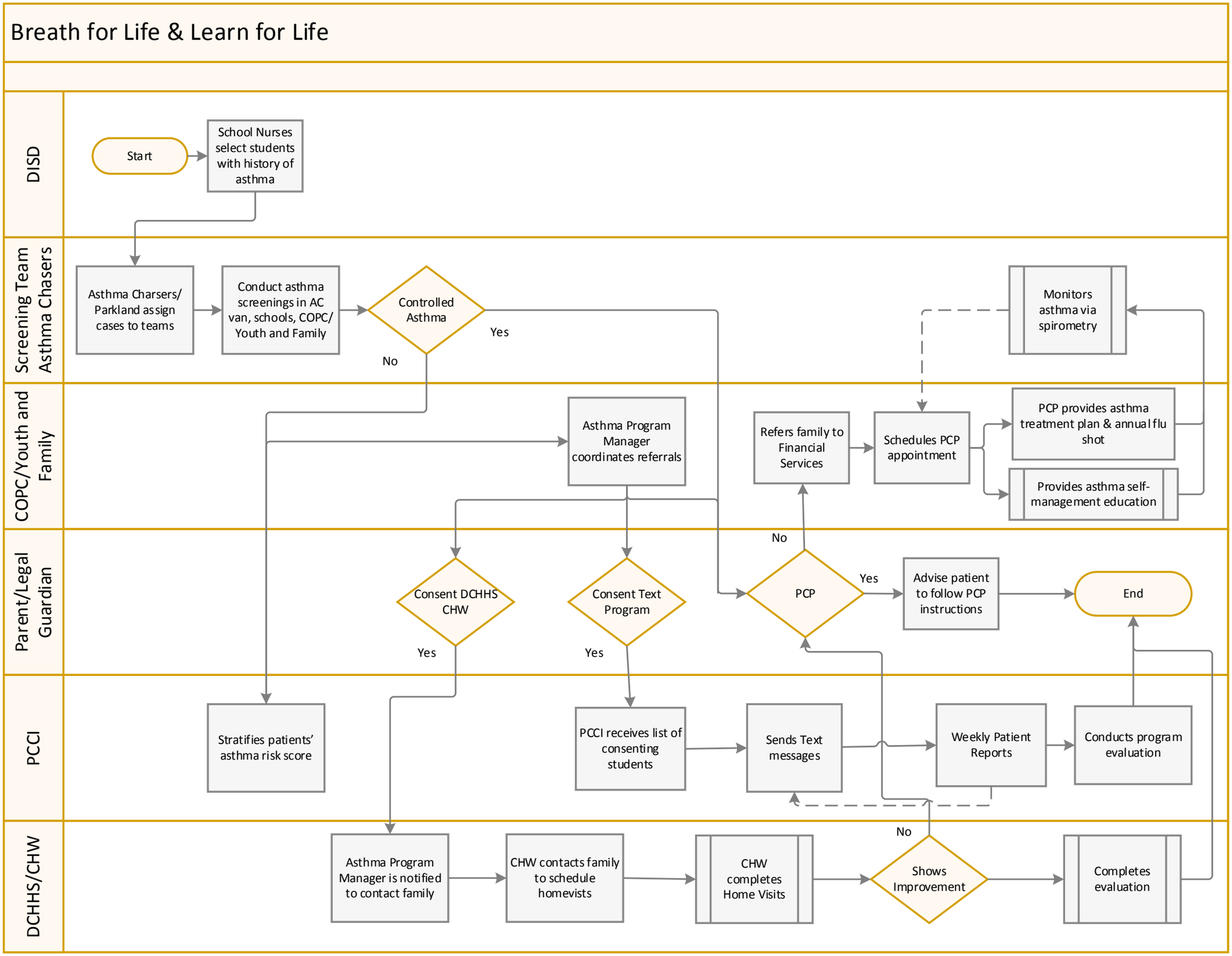
1	Patient Identification	Screening	In-person screening, i.e. community settings including schools and PCP visit
			• Complete Asthma Control Test (ACT) questionnaire
			• Spirometry test
			• Referrals
			  • Students referred by DISD school nurses
			• Data analytics
			  • High-risk predictive model
				Asthma Chasers
				Parkland Respiratory Therapist
				DISD School Nurse
				PCCI
					# of ACTs completed
					# of spirometry tests completed
					# of patients referred by DISD
					# of high-risk patient identified through data analytics
						Patients Identified
						2020: 776
						2021: 1,776
						2022: 2,650

2	Obtain consent for enrollment	In real time for patients screened in community settings
		Within 1 – 2 weeks post referrals from DISD, PCCI and data analytics
			Parent/Legal Guardian are contacted to obtain consent for child's participation
			• Referrals
			  • Students referred by DISD School Nurses
			• Data analytics
			  • predictive risk model
				Asthma Chasers
				Parkland Respiratory Therapist
				DISD School Nurse
				CHW
				Call Center Staff while Social Distancing guidelines are in place
						Consents
						2020: 776
						2021: 1,776
						2022: 2,650

Goal: Number of pediatric patients with asthma from the targeted population enrolled in the notification program						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
3	Welcome Message	Upon enrollment	• Patient is welcomed to the text notification program (Texts are available in English and Spanish and are delivered based on patients' preferred language)	PCCI	# of welcome messages delivered	**Welcome of Messages Delivered** 2020: 612 2021: 1,421 2022: 2,120
4	Asthma Diary Text	Monday & Thursday	Asthma diary and subsequent messages based on patient response including but not limited to: • Medication Adherence Questionnaire • Thank you message • Warning message, if necessary	PCCI	# of Asthma diary messages delivered	**Asthma Diary Texts Messages Delivered**[1] 2020: 32,282 2021: 146,763 2022: 220,480
5	Health Literacy or Medication Reminder Texts	Tuesday & Saturday	Medication education topics include: • Medication reminders • Environmental risk factors	PCCI	# of Health literacy messages delivered	**Asthma Health Literacy Text Messages Delivered**[1] 2020: 32,282 2021: 147,763 2022: 220,480
6	Warning messages	Based on evaluation of Asthma Diary responses; If recipient reports poorly controlled asthma	• Instruct the patient to contact PCP for advice • Instruct the patient to call 911 if patient cannot breathe	PCCI	Inquire about percentages of warning responses per patient	TBD
7	Patient Satisfaction	4 weeks post enrollment and every 3 months, thereafter	Questions include whether the program has taught them how to better care for their child's asthma, whether their asthma is better controlled and whether they would recommend the program	PCCI	# of patient satisfaction text messages delivered	**Patient Satisfaction Text Messages Delivered**[1] 2020: 10,554 2021: 24,154 2022: 36,040

[1] Assuming 80% retention rate for the full year.

G. SERVICE DELIVERY PROCESS FLOW



H. PARTNERSHIPS

	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
1	**Asthma Chasers**	75210 75211 75215 75216 75217 75241	Asthma Chasers provides a broad scope of services including: • Asthma screenings including pulmonary function testing and Asthma Control Testing • Asthma medication assistance • Case management • Childhood asthma education • Community asthma education • Provide asthma devices, such as peak flow meters and spacers	Low income families living in ZIP Codes with high asthma incidence and prevalence rates	• Asthma screenings including pulmonary function testing • Asthma Control Testing • Childhood asthma education • Community asthma education	In progress
2	**DISD**	16 cities in Dallas County	Operates schools across Dallas	154,000 students in pre-kindergarten through 12th grade, in 230 schools	• Refer students with asthma to Parkland • Obtain consent from parents to enroll child/children in asthma text program • Asthma data sharing	In progress
3	**Dallas County Health and Human Services**	Dallas County	Public health services	Dallas County population	• Complete home visits • Obtain consent from parents to enroll child/children in text program	N/A

COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION:

Behavioral Health

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COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION

Behavioral Health

A. PROBLEM STATEMENT

Dallas County does not have enough behavioral health capacity to support the high demand for these services. Navigating the health system in Dallas County is difficult for those with behavioral health needs and there is a lack of integration between behavioral health and physical health. According to input provided by focus group participants, the demand for behavioral health services for school children, youth and seniors is concerning.

B. STRATEGY

Increase behavioral health capacity and further improve coordination among behavioral health providers and community-based organizations

C. METRICS

1. Number of patients from the targeted population with a behavioral health encounter

2. Number of pediatric patients from the targeted population with a behavioral health encounter

3. Number of interventions by the RIGHT Care teams

D. BUDGET (as of August 31, 2020)

Behavioral Health
Financial Summary (Staffing Only)

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Gross Revenue	$0	$0	$0	$0	$0	$0
Deductions from Revenue	-	-	-	-	-	-
Net Revenue	-	-	-	-	-	-
Expenses						
Salaries	1,108,692	1,491,945	1,534,246	1,577,816	1,622,694	7,335,393
Benefits	239,477	322,260	331,397	340,808	350,502	1,584,445
Drugs	-	-	-	-	-	-
Med/Surg Supplies-Baxter	-	-	-	-	-	-
Miscellaneous Supplies	-	-	-	-	-	-
Total Expenses	1,348,169	1,814,205	1,865,643	1,918,625	1,973,196	8,919,838
Net Income	(1,348,169)	(1,814,205)	(1,865,643)	(1,918,625)	(1,973,196)	(8,919,838)
Indirect Expense Allocation	-	-	-	-	-	-
Net Income after Indirect Expenses	$ (1,348,169)	$ (1,814,205)	$ (1,865,643)	$ (1,918,625)	$(1,973,196)	$ (8,919,838)
Capital	-	-	-	-	-	-
Total	$ (1,348,169)	$ (1,814,205)	$ (1,865,643)	$ (1,918,625)	$ (1,973,196)	$ (8,919,838)
FTEs	12.00	17.00	17.00	17.00	17.00	13.14
Net Revenue Per Cycle	$ -	$ -	$ -	$ -	$ -	$ -
Expense Per Cycle	$ -	$ -	$ -	$ -	$ -	$ -
Net Income Per Cycle	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Total Direct Expenses	1,348,169	1,814,205	1,865,643	1,918,625	1,973,196	8,919,838

E. STAFFING (Year 1 FTEs approved as of 8/31/2020)

#	FTE Description	Scope of Service	Year 1	Year 2
1	Staff Physician Psychiatrist (Pedi/ Adult)	This position will work with primarily in the pediatric setting in the COPC's. Provides psychiatric assessments through personal interviews, review of records, interviews of third parties and formal evaluation procedures in order to make/classify an accurate mental health diagnosis. Assesses and intervenes in crisis and emergency situations to minimize potential harm to patient. Provides psychiatric treatment through personal interaction to aid patients to relieve emotional distress/psychiatric symptoms, clarify patient goals/priorities and expand social support networks in group or family.	1.0	1.0
2	Advanced Practice Practitioner	This position will work in the Integrated BH setting in the COPC's. Performs all clinical practitioner service activities in designated specialty area including obtains histories, performs physical exams, makes assessments, orders tests to adequately assess, determine diagnoses and plan of care. Provides optimal medical decision making and patient care management.	1.0	2.0
3	Pediatric Psychologist/Assessor	This position will work in the Integrated Pediatric BH setting in the COPC's. Provides psychological assessments through personal interview, review of records, interviews of third parties and/or formal evaluation procedures and makes/classifies mental health diagnosis, identifies problems and determines plan of intervention to optimize psychological service. Assesses and intervenes in crisis and emergency situations. Provides psychological treatment through personal interaction to aid patients to relieve emotional distress/psychiatric symptoms, clarify patient goals/priorities, expand social support networks in group or family format and find adaptive solutions to current life problems.	1.0	1.0
4	Lead Mental Health Counselor/LCSW	This position will serve as lead to all integrated child mental health counselors and integrated adult BH counselors in the COPC's. Works with Lead Psychologist and with other administrative staff in assigned department/division, to manage the selection, development, training, implementation and supervision of Mental Health Counselors. The Lead Mental Counselor monitors and revises annual goals and objectives. Provides counseling to clients and their families to relieve emotional distress, clarify patient goals/priorities, expand social support networks in individual or group format and find adaptive solutions to current life problems.	1.0	1.0
5	Mental Health Counselor/LCSW	This position will serve in the Integrated pediatric BH setting in the COPC's. Provides counseling to clients and their families to relieve emotional distress, clarify patient goals/priorities, expand social support networks in individual or group format and find adaptive solutions to current life problems.	0.25	1.0
6	Psychiatric RN II	This position will work closely with the Child Psychiatrist and APP in the Integrated BH setting in the COPC's. Provides care for assigned patient population in accordance with the current State of Texas Nurse Practice Act, established protocols, multidisciplinary plan of care and clinical area specific standards. Provides continuous assessment, consults with other team members as required and provides nursing care which demonstrates patient centered/patient valued care.	0.0	1.0
7	Senior Medical Assistant	This position will work in the pediatric and adult integrated BH setting in the COPC's. Performs specified patient care activities which may include administering immunizations and PPD's, drawing blood, performing lab procedures and collection of specimens, performing diagnostic tests, and taking vital signs, confirms appointment date and time, verifies and/or obtains demographic information and insurance identification to ensure patient information is documented in a timely manner. Reviews and updates patient accounts to ensure Parkland has accurate and current information to process claims and obtain payment. May rotate into other business staff positions including appointment scheduling, check-in/check-out, posting charges/payments, medical record and referral management	0.25	1.0

#	FTE Description	Scope of Service	Year 1	Year 2
8	Medical Practice Assistant	This position will work in the pediatric and adult integrated BH setting in the COPC's. Greets patient and checks the patient into the clinic. Correctly identifies patient prior to performing tasks. Reviews and updates patient account to ensure registration and coverage is current and complete. Confirms or verifies coverage as needed. Identifies and refers patients for financial counseling as appropriate. Assists with the process of internal and external appointments, referrals and information retrieval. Schedules appointments in accordance with clinical team directive and patient desires/availability.	0.5	2.0
9	Community Health Educator	Will provide education on mental health first aid and trauma informed care to the community. Evaluates educational needs, develops and presents materials to educate target groups to promote health awareness and good health practices. Review charts, set appointments or classes, review results of screenings, and provide emotional support to clients as indicated. May refer clients to community resources as deemed appropriate. Oversees and executes employee education seminars and health education events providing educational training and public speaking on various health topics to promote public awareness and good health practices	1.0	1.0
10	Social Worker II	These positions will serve on the RIGHT Care Teams. These teams will be based out of South Central police station. Their main function is to respond to 911 mental health emergencies. They perform psychosocial assessments including diagnosis on psychiatric and/or chemical dependent patient needs are properly identified and appropriate interventions are integrated into the plan of care. Assesses patient's and family's psychosocial risk factors through evaluation of prior functioning levels, appropriateness and adequacy of support systems, reaction to illness and ability to cope, understanding of present circumstances and patient/family priorities/needs. Collaborates with the patient, family and multidisciplinary team to assure psychosocial needs are addressed. Counsels patients and families regarding emotional, social and financial consequences of illness and/or disability and other psychosocial issues identified. Provides crisis intervention and counseling for patients and families. Promotes patient and family empowerment and independence. Participates in discharge planning activities.	5.0	5.0
11	Social Work Supervisor	This position will serve as a supervisor for the RIGHT Care Teams. These teams will be based out of South Central police station. Their main function is to respond to 911 mental health emergencies. Works with Social Work Management. Assists in selecting, training, scheduling, motivating, supervising, evaluating and makes recommendations for disciplinary actions up to and including termination, to ensure maximum utilization of individual and group capabilities. Ensures that assigned employees receive opportunities to further their knowledge. Collaborates with management team in service areas to develop and implement a system for providing social work coverage and accountability that meets the needs of patient care and organizational efficiency.	1.0	1.0
Total FTEs			**12.0**	**17.0**

F. INTERVENTION DEPLOYMENT

Goal 1: Increase the number of patients from the targeted population with a behavioral health encounter by 2022 (2020: 144,042, 2021: 151,604 and 2022: 158,086)						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
1	**Increase Access Points**	**During Primary Care Visit**	Conduct brief screenings in primary care for the following conditions: • Depression • Suicidality Administer PHQ-2 to screen for depression yearly or more frequently if needed; a score ≥ 3 triggers the administration of the PHQ-9 Integrate in EMR the measures that result from patient screening	• Intake Nurse • Primary Care Provider	# of PHQ-2 screens # of suicide screenings # of measures integrated in EMR	**PHQ-2 screenings** 2020: 144,042 2021: 151,604 2022: 158,086 **Suicide screenings** 2020: 144,042 2021: 151,604 2022: 158,086 **Measures integrated in EMR** 2020: 144,042 2021: 151,604 2022: 158,086
2	**Patient Identification and enrollment**	**Referral submitted to behavioral health referral hub upon completion of screening**	Upon receiving the referral, a clinical review is completed to determine services for mild/moderate BH conditions as follows: **Mild /Moderate:** • At-risk substance use • Chronic pain • Family/marital issues • Mild memory problems/ dementia without significant behavioral problems or hallucinations • Mild/moderate anxiety and depression • Patients with high service utilization • Psychosocial stressors • Sleep problems **Moderate:** • Depression and anxiety • Bipolar disorder • Schizophrenia • Dementia • Trauma/ PTSD • Women's Mental Health • Geriatric specialty/ memory clinic • Co-morbidity medical history with complicated psychiatric disorders Reviews insurance coverage and completes financial screening	• Financial Counselor • Nurse Navigator • Referral Coordinators	# of patients with mild to moderate symptoms who were established with Parkland BH services within 30 days # of patients whose insurance coverage screenings were completed	**Patients with mild to moderate depression symptoms** 2020: 57,617 2021: 60,624 2022: 63,234 **Patients at risk for suicide**[1] 2020: 1,152 2021: 1,212 2022: 1,264 **Insurance Converge screenings** 2020: 27,368 2021: 28,805 2022: 30,036

[1] Parkland's historical suicide screening data shows that 2% of individuals are at risk for suicide

Goal 1: Increase the number of patients from the targeted population with a behavioral health encounter by 2022 (2020: 144,042, 2021: 151,604 and 2022: 158,086)						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
3	**Severe Symptoms**	**Within 15 days from clinical review**	Links patient to community BH network resources for patients who fall out of Parkland's BH scope of practice or out of network for Parkland BH services Parkland clinician provides psychoeducation	• Nurse Navigator • Schedulers • Referral Coordinators	# of referrals to external BH network resources	TBD
4	**Integrated Behavioral Health Services for Mild/Moderate Symptoms**	**30 days post clinical review**	Focus on patients with mild to moderate psychiatric conditions and psychosocial stressors. • Psychiatric Evaluations and Medication Management • eConsult psychiatry services • Provides Individual/Crisis Psychotherapy • Group Psychoeducation • Community referrals	• Psychiatric Providers[2] • Psychologists • Mental Health Counselors	# of BH Encounters # of eConsult	**Therapy visits per patient/year[3]** 2020: 1,008,294 2021: 1,061,228 2022: 1,106,602 **Psychiatric visits per patient/year[4]** 2020: 864,252 2021: 909,624 2022: 948,516 **eConsult[5]** 2020: 7,202 2021: 7,580 2022: 7,904
5	**Integrated Behavioral Health Services for Moderate Symptoms**	**Specialty Behavioral Health – 30 days post clinical review**	Focus on patients with psychiatric illnesses and high co-morbidity medical issues. • Psychiatric Evaluations and Medication Management • Case Management • Group Psychotherapy • Neuropsychological and Psychological Testing • Provides Individual/Crisis Psychotherapy • Community referrals	• Psychiatric Providers • Psychiatric Nurses • Psychologists • Psychiatric Social Workers	# of BH Encounters	**Therapy visits per patient/year[6]** 2020: 1,872,546 2021: 1,970,852 2022: 2,055,118 **Psychiatric visits per patient/year[7]** 2020: 864,252 2021: 909,624 2022: 948,516

[2] Psychiatrist and psychiatric advanced practice provider

[3] Estimated based on an average of seven visits per patient per year

[4] Estimated based on an average of six visits per patient per year

[5] Estimated based on current eConsults, i.e. 5%

[6] Estimated based on an average of 12-16 therapy visits per patient/year

[7] Estimated based on an average of 6 psychiatric visits per patient/year

Goal 2: Increase the number of pediatric patients from the targeted population with a behavioral health encounter by 2022 (2020: 226, 2021: 344 and 2022: 537)

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact
1	**Increase Access Points**	**DISD – Intake visit with DISD MH Staff** **Parkland – Pediatric Visit and/or Initial Evaluation with Parkland Pediatric BH staff**	Work in collaboration with DISD Mental Health Services to screen pediatric patients for the BH conditions based on the following levels of care: • Severe, imminent • Severe, stable • Mild to moderate DISD/Parkland are in the process of assessing universal screening tools for the following BH behavioral and emotional concerns: • Suicidal Ideation – ASQ (Parkland) • Suicide risk post report – Columbia (DISD) • Depression • Anxiety • Sleep Behaviors • Substance use (tobacco, alcohol and drug use) • Trauma • ADHD (DISD – At intake; Parkland as clinically indicated)	• DISD MH staff at intake will screen for suicide risk, depression, anxiety, sleep behaviors, substance use, trauma and ADHD. • Parkland Intake Nurse and Pediatrician at point of entry to screen for suicide and depression. • Parkland Mental Health Counselors, Psychologists, and Child Psychiatrist will screen for depression, anxiety, sleep behaviors, substance use and trauma during initial evaluation.	# of patients with severe stable symptoms linked to community services # of patients with mild to moderate symptoms	**Pediatric Patients** 2020: 226 2021: 344 2022: 537 **Pediatric Patient with Mild to Moderate BH Symptoms** 2020: 90 2021: 137 2022: 214 **Pediatric Patient at Risk for Suicide** 2020: 1 2020: 1 2022: 2
2	**Patient enrollment – Referral Hub**	**Referral submitted to BH upon completion of screening**	Upon receiving the referral, a clinical review is completed to determine services for mild/moderate BH conditions as follows: **Mild to Moderate:** • Assess for Developmental Delays • Assess for Learning Difference • Assess for Autism Spectrum Disorder • Assess and Treat ADHD • Mild to Moderate Depression • Mild to Moderate Anxiety Sleep Disturbance • Grief/Bereavement • Obesity/Weight Concerns/Eating Behaviors • Adherence Issues • Parent-Child Relational Issues • Mild to moderate Behavioral Issues Reviews insurance coverage and completes financial screening	• Parkland Financial Counselor • Nurse Navigator • Referral Coordinators	# of patients with mild to moderate symptoms who were established with Parkland BH services within 30 days # of patients whose insurance coverage review were completed	**Establish Pediatric Patient** 2020: 90 2021: 137 2022: 214 **Insurance Coverage Reviews** 2020: 43 2021: 65 2022: 102

Goal 2: Increase the number of pediatric patients from the targeted population with a behavioral health encounter by 2022 (2020: 226, 2021: 344 and 2022: 537)						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
2	**Referral** **Severe Symptoms**	**Within 15 days from clinical review**	Links patient to community BH network resources for patients who fall out of Parkland's BH scope of practice or out of network for Parkland BH services Parkland clinician provides psychoeducation	• Nurse Navigator • Referral Coordinators • Schedulers	# of referrals to external BH network resources	No historical data available
3	**Integrated Behavioral Health Services for** **Mild/Moderate Symptoms**	**Within 15 days post screenings**	Focus on patients with mild to moderate psychiatric conditions and psychosocial stressors. • Psychiatric Evaluations and Medication Management • Pediatric Psychological Testing • Provides Individual/ Crisis Psychotherapy • Group Psychotherapy • Community referrals • eConsult psychiatric services	• Psychiatric Providers • Psychologists • Mental Health Counselors	# of BH Encounters # of eConsults	**Therapy visits per patient/year**[8] 2020: 633 2021: 963 2022: 1,504 **Psychiatric visits per patient/year**[9] 2020: 633 2021: 963 2022: 1,504 **eConsult**[10] 2020: 633 2021: 963 2022: 1,504

[8] Estimated based on an average of seven visits per patient per year

[9] Estimated based on an average of six visits per patient per year

[10] Estimated based on current eConsults, i.e. 5%

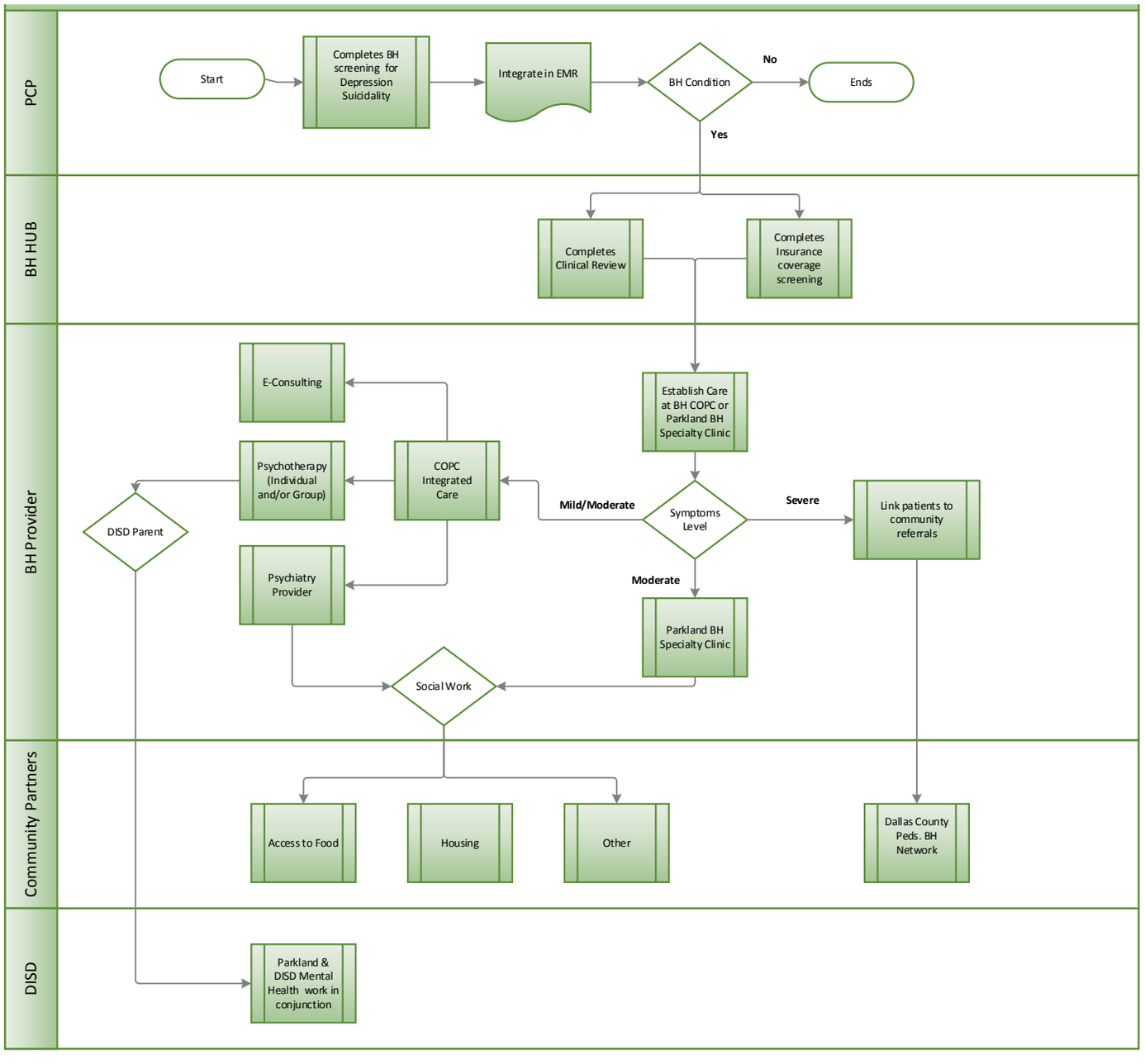
Goal 3: Increase the number of interventions by the RIGHT Care teams (2020: 1790, 2021: 3,580 and 2022: 5,370)						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
1	**911 Call Triage**	**Real time**	Identify patients who may benefit from RIGHT Care Team intervention due to the following criteria: Criminal justice history secondary to mental illness Enrolled in Level Care 4 High utilizer History of Mental Health and Emergency Department encounters Mental Health Disorder	• Completed by NTBHA Care Coordinators	# of triage calls	Process currently under revision
2	**RIGHT Care Team Deployment**	Dispatched by 911 Call Center Patrol Officer Requests RCT Assistance	LMSW/LCSW is deployed with RIGHT Care Team to respond to incident on site	• Parkland SW	# of deployments	2020: 1,790 2021: 3,580 2022: 5,370

Goal 3: Increase the number of interventions by the RIGHT Care teams (2020: 1790, 2021: 3,580 and 2022: 5,370)

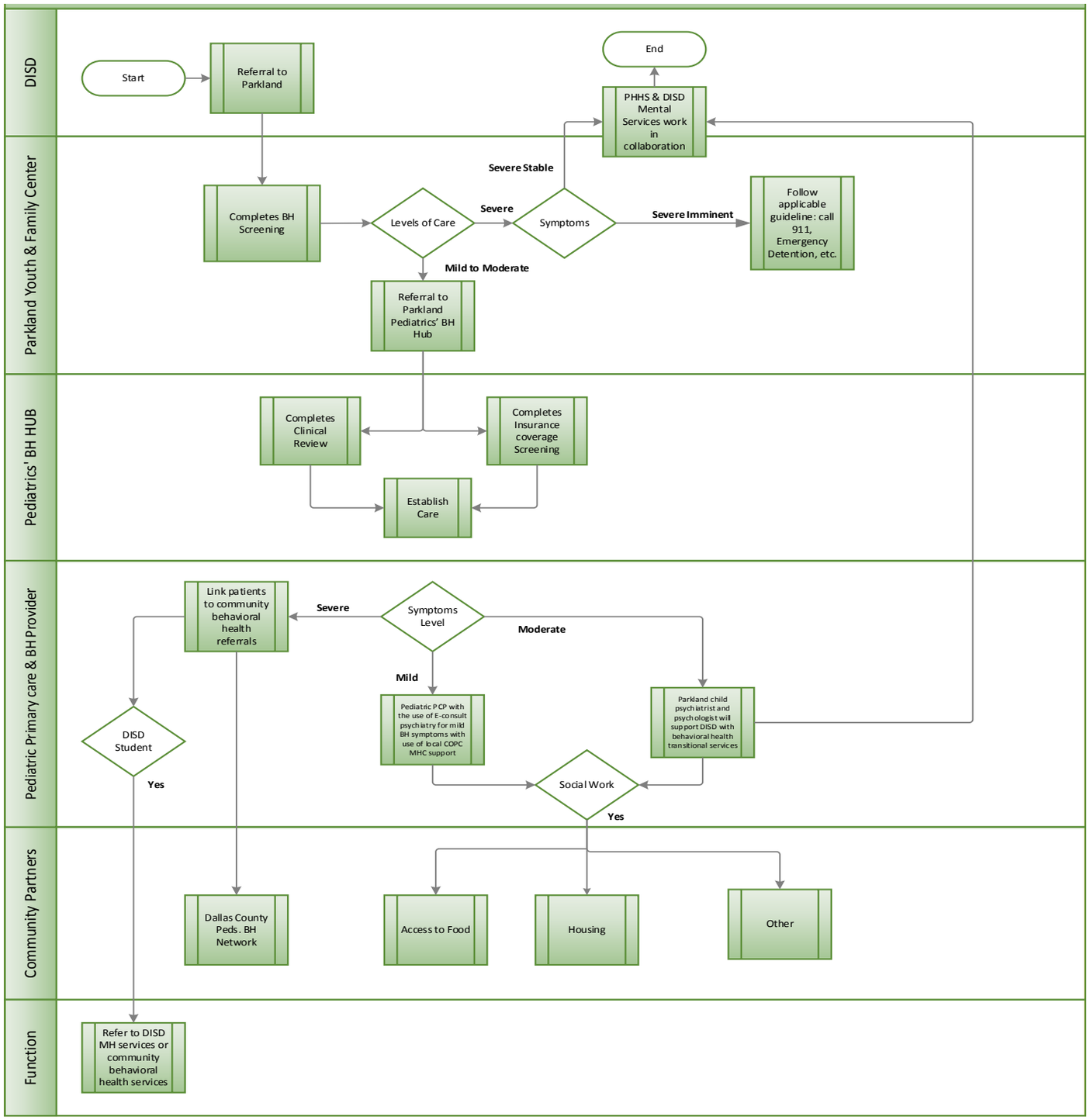
	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact
3	**Clinical Assessment**	On site	Completes a psychosocial assessment to determine patients' capacity to function in social setting and identifies strengths, limitations and barriers for nearly every aspect of life including: • familial support • financial stability • housing • insurance • legal issues • medical health • mental health • social functioning • substance use • transportation needs • other stressors Completes a risk assessment to help determine what level of risk a patient is to him or herself. Some of the items this assessment considers are: • history of suicide attempts • current suicidal thoughts • risk factors • protective factors Disposition of the encounter determined based on assessment	Parkland SW	# of Clinical Assessments # of referrals to community-based resources based on clinical assessment need identified # of patients diverted from jail # of patients diverted from ED # of patients referred to BH intake	**Clinical Assessments Completed** 2020: 1,790 2021: 3,580 2022: 5,370 **Diverted from Hospital (unduplicated)** 2020: 326 2021: 653 2022: 979 **Diverted from Jail** 2020: 173 2021: 346 2022: 519 **Emergency Detentions t to the closest ED** 2020: 242 2021: 485 2022: 727 **Connected to BH Provider** 2021: 617 2022: 925 **Housing Issue Resolved** 2020: 51 2021: 102 2022: 154 **RIGHT Care Team Follow-up** 2020: 442 2021: 884 2022: 1326
4	**Transition to Parkland ED**	In real time post RIGHT Care assessment	Warm handoff to Parkland ED team	Parkland Social Worker	# of patients brought to Parkland ED by RIGHT Care team	**# of patients admitted to Parkland Psych Intake** 2019: 130 2020: 116

G. SERVICE DELIVERY PROCESS FLOW

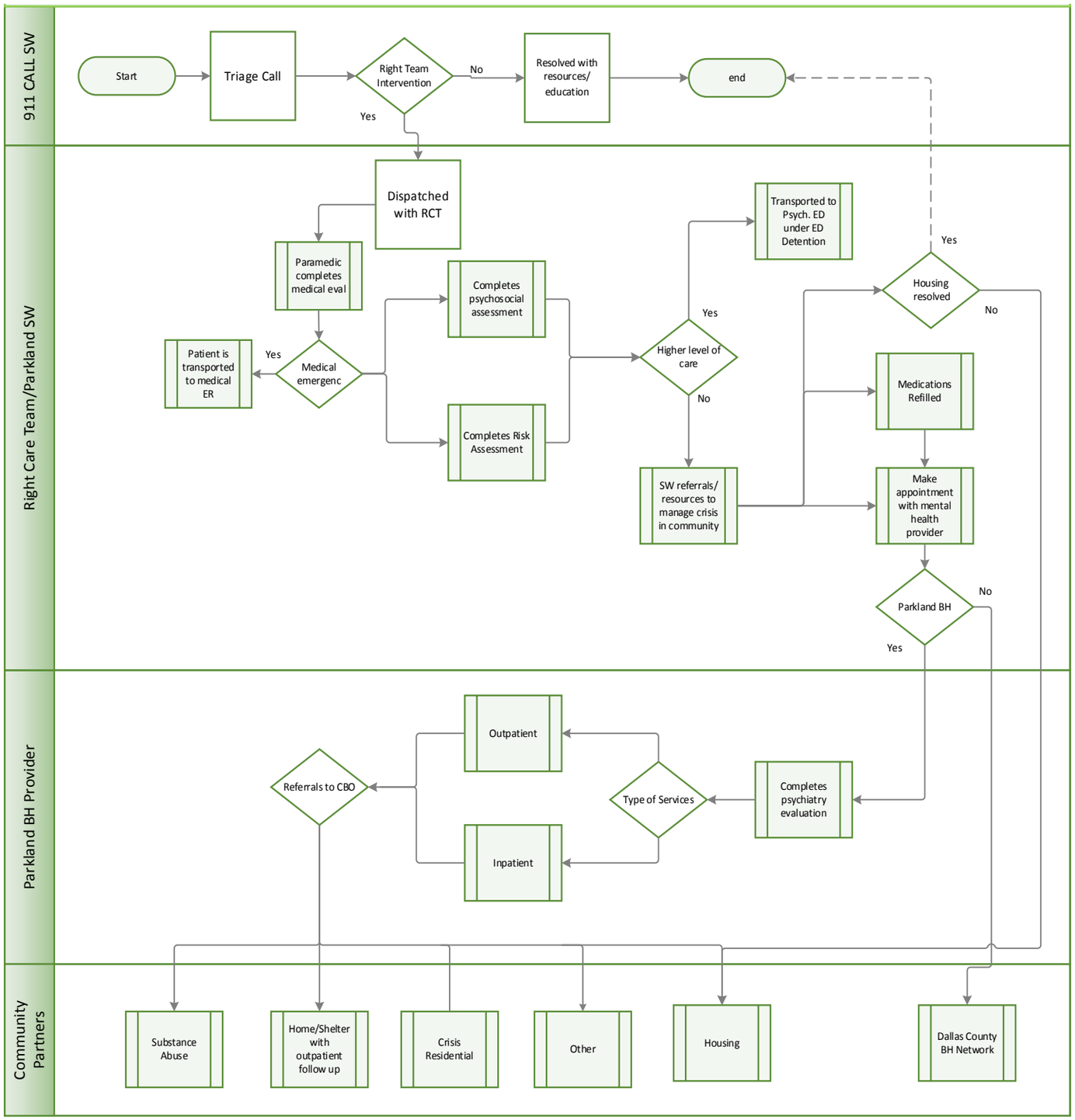
1. Adult Service Delivery Process Flow



2. Pediatric Service Delivery Process Flow



2. RIGHT Care Team Process Flow



H. PARTNERSHIP

#	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status

1	Dallas MetroCare (Lancaster Kiest Clinic) – mental health clinic – Same day mental health appointment, medication management, wrap around case management services.	75228
		75221
		75051
		75216
		75243
			• Outpatient mental health treatment
			• Pharmacy services
			• Primary care services
				• Special populations such as:
				  • Individuals with behavioral health disorders
				  • Indigent/NTBHA funded
				  • Insured patients
					• Mental health treatment
					• Case management
					• Assertive Community Treatment
					• SNOPS (Special Needs Offender Program)
					• Medication management
					• Primary care
					• Pharmacy services
					• Same day clinic appointment for RIGHT Care patients
						MOU with COPCs for data sharing

2	Child & Family Guidance Center (Oak Cliff, Mesquite and Harry Hines locations) outpatient mental health clinics	75235
		75149
		75208
		75093
			• Outpatient mental health treatment	• Special populations such as:
				  • Individuals with behavioral health disorders
				  • Indigent/NTBHA funded
				  • Insured patients
					• Mental health treatment
					• Case management
					• Assertive Community Treatment
					• Medication management	

3	IPS – mental health and substance use treatment outpatient clinic in downtown Dallas	75201	• Outpatient Mental Health treatment
			• Outpatient substance use treatment
				• Special populations such as:
				  • Individuals with behavioral health disorders
				  • Indigent/NTBHA funded
				  • Insured patients
					• Mental health treatment
					• Substance use treatment
					• Medication management
					• Case management
					• Medication Assisted Therapy (MAT)
					• Detox
					• IOP/SOP	

4	True Mental Health (outpatient services)	75235	• Outpatient mental health treatment	• Special populations such as: • Individuals with behavioral health disorders	• Mental health treatment • Case management • Assertive Community Treatment • Medication management	

#	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status

5	Charlton Methodist	75237	• Inpatient BH treatment
			• Outpatient BH treatment
			• Outpatient substance use treatment
				• Special populations such as:
				  • Individuals with behavioral health disorders
				  • Individuals with Substance use disorders
					• Inpatient BH treatment
					• Inpatient substance use treatment
					• Outpatient BH treatment
					• BH intensive outpatient treatment
					• Partial day program
					• Substance use intensive outpatient treatment	

6	Dallas Behavioral Healthcare Hospital	75115	• Emergency psychiatric services
			• Inpatient BH treatment
			• Outpatient BH treatment
			• Dual diagnosis treatment
				• Special populations such as:
				  • Individuals with behavioral health disorders
				  • Indigent/NTBHA funded
					• Psychiatric emergency services
					• Inpatient BH treatment
					• Intensive outpatient treatment
					• Partial hospitalization
					• Detox	

7	Hickory Trail	75115	• Emergency psychiatric services
			• Inpatient BH treatment
			• Outpatient BH treatment
			• Substance use treatment
			• Dual diagnosis treatment
				• Special populations such as:
				  • Individuals with behavioral health disorders
				  • Patients with substance use disorders
				  • Indigent/NTBHA funded
					• Psychiatric emergency services
					• Inpatient BH treatment
					• Intensive outpatient
					• Partial hospitalization treatment
					• Detox
					• Chemical dependency program	

8	Methodist Central	75203	• Inpatient BH treatment
			• Outpatient BH treatment
			• Outpatient substance use treatment
				• Special populations such as:
				  • Individuals with behavioral health disorders
				  • Patients with substance use disorders
				  • Insured patients
					• Inpatient BH treatment
					• Inpatient substance use treatment
					• Outpatient BH treatment
					• BH intensive outpatient treatment
					• Partial Day program
					• Substance use
					• Intensive outpatient treatment	

#	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
9	VA Medical Center	75261	• Inpatient BH treatment • Outpatient BH treatment • Substance use treatment • Dual diagnosis treatment	• Veterans with behavioral health disorders • Veterans with substance use disorders	• Psychiatric emergency services • Inpatient BH treatment • Outpatient BH treatment • Outpatient dual diagnosis • Outpatient geriatric BH treatment	
10	NTBHA Resources	Dallas County	• Mental health services • Substance use services • Care coordination • Funding and development of projects that affect BH/ Substance use treatment • Jail mental health services	• Indigent patients with behavioral health and substance use diagnoses	• Living room for connection to care • Care coordination in Parkland PEOU/PED • Terrell State Hospital placement • Level of care authorization for BH services • Assist with data sharing in some cases • OSAR/Substance use treatment • RIGHT Care (911 call center)	Interlocal Agreement signed July 2020 MOU with NTBHA's OSAR program for substance use treatment/resources

11	Homeward Bound – Crisis Residential (dual diagnosis) and substance use treatment programs	75241	• Crisis residential
			• Substance use treatment
			• Outpatient BH treatment
			• Outpatient substance use treatment
				• Special populations such as:
				  • Individuals with behavioral health disorders
				  • Patients with substance use disorders
					• Crisis residential
					• Detox
					• Male/female residential substance use treatment
					• Peer support	

#	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
12	Licensed Boarding Homes	75241 75215 75216 75217 75228 75227 75323 75233 75203 75319	• Housing	• Behavioral health patients	• Housing • Medication adherence • Transportation to appointments	
13	Our Calling	Downtown Dallas Area	• Homeless services	• Unsheltered homeless	• Identifying needs • Homeless services	
14	Shelters: The Bridge, Austin Street, Dallas Life, Salvation Army	75201 75226 75215 75235	• Homeless Shelter	• Homeless population	• Housing services • Mental health services • Primary care • Case management • Substance use services • Benefit services	
15	Sober living homes (Oxford Houses)	75243 75214 75229 75248 75227 75228 75240 75252 75287 75246 75288	• Sober Housing	• Individuals living in recovery from substance use	• Housing • Substance use resources • Financial assistance	

COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION:

Breast Health

Parkland
Care. Compassion. Community.

TABLE OF CONTENTS

COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION

Breast Health

A. PROBLEM STATEMENT

1. When compared to the rest of the county, Southeast Dallas has the highest number of cancer morbidity and mortality

2. These areas have higher rates of low socio-economic status as well as a higher rate of minority populations, e.g., African American and Hispanics

B. STRATEGY

Build upon Parkland's Breast Cancer Health Equity efforts launched in 2019 that provide the foundational work to establish a "Multicomponent Intervention." Multicomponent Intervention is an evidenced-based strategy recommended by the Community Preventive Services Task Force (CPSTF) to promote breast cancer screenings in underserved populations.

C. METRICS

1. Number of women from the targeted population who received a mammogram

2. Percentage of "Lost to Care" patients from the targeted population (i.e., not cleared and treatment non-initiated)

CHNA ZIP Codes: 75210, 75211, 75215 75216, 75217, 75241, 75060, 75243, 75061

D. BUDGET (as of August 31, 2020)

Breast Health
Financial Summary (staffing only)

	Year 1	Year 2	Year 3	Year 4	Year 5
Gross Revenue	$0	$0	$0	$0	$0
Deductions from Revenue	-	-	-	-	-
Net Revenue	-	-	-	-	-
Expenses					
Salaries	268,008	276,048	284,330	292,859	301,645
Benefits (21.2%)	56,818	58,522	60,278	62,086	63,949
	-	-	-	-	-
	-	-	-	-	-
Total Expenses	**324,826**	**334,570**	**344,607**	**354,946**	**365,594**
Net Income	(324,826)	(334,570)	(344,607)	(354,946)	(365,594)
Indirect Expense Allocation (N/A)	-	-	-	-	-
Net Income after Indirect Expenses	**$ (324,826)**	**$ (334,570)**	**$ (344,607)**	**$ (354,946)**	**$ (365,594)**
Capital	**-**	**-**	**-**	**-**	**-**
Total	**$ (324,826)**	**$ (334,570)**	**$ (344,607)**	**$ (354,946)**	**$ (365,594)**
FTEs	3.00	3.00	3.00	3.00	3.00
Volumes/Visits		-	-	-	-

NOTE: BC screenings volumes for year 2 to year 5 will be determined after evaluation of 1st year results.

E. STAFFING (Year 1 FTEs approved as of 8/31/2020)

#	FTE Description	Scope of Service	Year 1	Year 2
1	**Mobile Mammogram Coordinator**	1. Create, coordinate, communicate logistical needs for every mobile mammography outreach and special event. 2. Maintain all records of mobile repairs and maintenance agreements. Communicates any issues that may arise to lessen mobile downtime. 3. Work with Community Development Specialist (CDS) to ensure mobile mammography scheduling, follow-up. Ensures mobile volumes are optimized for each event 4. Review each patient submitted for scheduling by CDS to ensure patient qualifies for mobile services and refers them to financial services and grants. 5. Deliver staff education, patient education seminars at outreach and Moody Breast Center.	1.0	1.0
2	**Nurse Navigator**	1. Provide patient navigation support to patients and radiologists. 2. Conduct comprehensive assessment of patient in-person, by telephone or by review of medical records; gather information from patient records and consult clinical team as needed. 3. Educate patient on their diagnosis, treatment plan, referral process, clinic criteria, authorization process, payor/plan coverage, funding sources and refers them to social worker and community resources available to the patient. 4. Assist providers with developing a patient plan of care, help with scheduling follow-up imaging, call patients with results and work to provide care coordination with oncology clinic.	1.0	1.0
3	**Patient Educator**	1. Develop patient education handouts and protocols. 2. Evaluate commercial education resources such as brochures, books, audiotapes, videotapes and Internet materials and selects instructional materials appropriate for patient's readiness to learn and level of understanding. 3. Work in developing systems to facilitate use of patient education materials and the effectiveness of the content. 4. Utilize family conferences when appropriate. 5. Participate in health education presentations to community groups. 6. Maintain an awareness of emerging technologies and provide detailed reports regarding educational offerings and groups that were provided education.	1.0	1.0
	Total FTEs		**3.0**	**3.0**

F. INTERVENTION DEPLOYMENT

Goal: Increase the number of women from the targeted population who received a mammogram by 2022 (2020: 10,996, 2021: 12,995, 2022: 14,994)

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact
1	Patient Identification	Community events[1] Annual Exam and Self-referral at COPC and mobile vans New order – BPA alert	Perform mammogram screening services at the event Provide Breast Health education (topics including but not limited to: • What is a mammogram • Concerning breast symptoms • What to expect on the day of the exam • Breast biopsy • Breast density • Facts for Life Patient Family Advisory Committee (PFAC) to share their breast health experience and educate community members of breast health during community events. Community Relations team establishes new contacts and strengthens existing relationships with community leaders and Community Based Organizations All patients are provided a mammogram regardless of their financial status or eligibility for grant funding. Collect information on financial coverage, if applicable Perform mammogram screening as self-referral, annual exam or new order Expansion of the mobile van services at the COPCs for continued effort to increase mammogram screening Annual reminder postcards sent to patients to improve patients' access to care. Provide breast health education (topics including but not limited to: • What is a mammogram • Concerning breast symptoms • What to expect on the day of the exam • Breast density • Breast biopsy • Facts for Life	Community Health Workers Community Development Specialist Mobile Mammogram Coordinator Patient Family Advisory Committee (PFAC) comprising of members from CHNA ZIP Codes Navigators Radiologists	# of patients screened # of patients educated for breast health # of patients whose financial coverage information is collected, if applicable # of patients who self-referred	**Patients screened**[2] 2020: 10,996 2021: 12,995 2022: 14,994 **Patients educated for breast health** 2020: 10,996 2021: 12,995 2022: 14,994 **Patients' financial coverage information collected (if applicable)** 2020: 10,996 2021: 12,995 2022: 14,994

[1] Mobile coordinator and community development specialists (CDS) work in conjunction with community leaders and Community Based Organizations (CBOs) in scheduling mobile mammography event in the targeted ZIP Codes and ensuring mobile volumes are adequate for the event. Mobile coordinator to oversee for qualification and funding available for outreach events.

[2] CHNA metrics: Age 40 -74, screened in 24 months

Goal: Increase the number of women from the targeted population who received a mammogram by 2022 (2020: 10,996, 2021: 12,995, 2022: 14,994)						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
2	Notification of Mammogram Screening Results (Normal/ Negative)	Notification sent to patients within 5 days of result	Patients notified of screening test results through a letter by mail Automatic notifications sent to patients for scheduling routine annual mammogram or self-referral	Breast Registrar Navigators	# of scheduled routine annual mammograms # of notification letters sent	**Patient notified with results**[3] 2020: 9,567 2021: 11,306 2022: 13,045
3	Notification of Mammogram Screening Results (Abnormal or Positive)	Notification sent to patients within 5 days of result	Patients notified of screening test results through a letter and a call made for diagnostic follow-up imaging Schedule patients for diagnostic evaluation	Breast Registrar Navigators	# of patients notified of results # of patients scheduled for a diagnostic mammogram	**Patient notified with results**[4] 2020: 1,429 2021: 1,689 2022: 1,949

[3] Calculation based on Parkland's historical data reflecting 87% normal results of mammogram screening

[4] Calculation based on Parkland's historical data reflecting 13% unclear results of mammogram screening

Goal: To reduce the percentage of "Lost to Care" patients from the target population from 18.5 % to 5% by 2022						
#	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact
1	Perform Diagnostic Evaluation	Scheduled for diagnostic evaluation within 10 days of patients' receipt of the notification	Perform diagnostic evaluation Review and communicate results with staff Provide patients with results Reschedule mammogram appointment for patients who missed appointments (recall list) Results are given the day of (if applicable) and through a written discharge summary sheet	Radiologists Breast Registrar Navigators	# of mammograms # of patients notified of test results # of rescheduled mammograms	**Mammograms**[5] 2020: 1,429 2021: 1,689 2022: 1,949 **Patient notified with test results** 2020: 1,429 2021: 1,689 2022: 1,949 **Reschedule mammogram** To be determined
2	Follow-up on diagnostic evaluation: Benign or probably benign results (results not requiring biopsy	Average 7-14 days to send diagnostic results	Results are given the day of (if applicable) and through a written discharge summary sheet Automatic notifications sent through mailed letter to patients for annual test	Breast Registrar Radiologists Technologists Navigators	# of patients scheduled for annual test # of patients scheduled for an earlier appointment	**Patient notified of normal results**[6] 2020: 1155 2021: 1366 2022: 1576
3	Follow-up on diagnostic evaluation: Suspicious for breast cancer (results requiring biopsy)	14 days post diagnostic results	Schedule a biopsy Assign a navigator to the patient who works with the oncology clinic to coordinate care Provide patient education and what to expect during the biopsy	Technologists Navigators	# of patients assigned a navigator # of patient scheduled for a biopsy # of patients educated	**Patient assigned a navigator** 2020: 274 2021: 324 2022: 374 **Biopsy Scheduled**[7] 2020: 274 2021: 324 2022: 374 **Patient Educated** 2020: 274 2021: 324 2022: 374

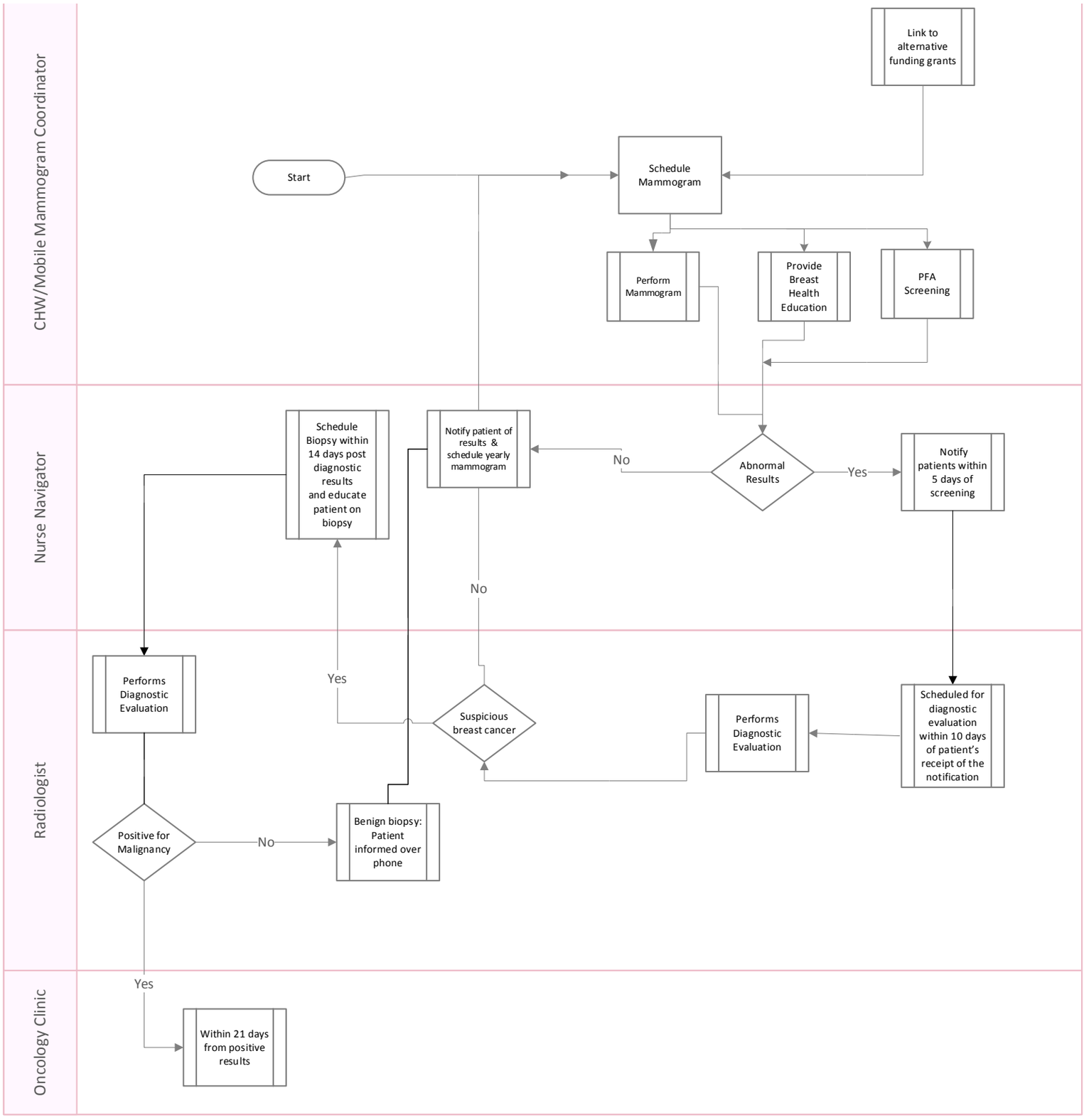
[5] Calculation based on Parkland's historical data reflecting 13% unclear results of mammogram screening

[6] Calculation based on Parkland's historical data reflecting 80.83% normal results of diagnostic mammogram

[7] Calculation based on Parkland's historical data reflecting 19.17% suspicious results of diagnostic mammogram

Goal: To reduce the percentage of "Lost to Care" patients from the target population from 18.5 % to 5% by 2022						
#	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact
4	Perform Biopsy	Within 28 days of abnormal diagnostic evaluation	Perform biopsy procedure Results Positive for Malignancy: • Referral placed to the Breast Surgical Oncology Clinic in EPIC • Care coordination with Breast Surgical Oncology Clinic Results Benign: • Navigator informs the patient by phone	Radiologists Nurse Navigators Tech Navigators	# of biopsies performed # of patients with positive results # of patients with benign results # of referrals sent to the Breast Surgical Oncology Clinic in EPIC	**Biopsy Performed** 2020: 274 2021: 324 2022: 374 **Positive Results** To be determined **Referral to Breast Surgical Oncology Clinic** To be determined
5	Transition to Breast Surgery Oncology Clinic	Within 21 days from positive result and referral placed in Oncology Clinic in EPIC	Discuss treatment plan with patients based on the diagnosis and treatment initiated Provide patients with education material for breast cancer or breast disease Refer to medical oncology for additional treatment, if needed	Referral coordinator Clinical nurse navigator Provider	# of patients with referral who have scheduled appointments # of patients provided education # of patient provided treatment	**Patients provided Education** To be determined **Patients provided Treatment** To be determined

G. SERVICE DELIVERY PROCESS FLOW



H. PARTNERSHIP

#	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
1	Inspired Vision Compassion Center (IVCC)	75217	IVCC provides access to basic needs in a grocery store format to residents of Dallas in need. Services provided include: food, clothing, furniture, personal hygiene, animal supplies, emergency baby items, home medical & first aid supplies, school supplies	• 1,000 families/daily	Community outreach events	Pending
2	Spring Fellowship Church	75217	Church ministries are designed and constantly refined to effectively minister to the entire family while providing support, leadership and care for each individual. Their focus is on helping every believer advance in his or her relationship with God.	• Congregation	Community outreach events	N/A
3	Good Street Baptist Church	75216	The Church facilitates a Social Service Center that provides a variety of services i.e. food pantry, clothing, referrals to other social services, health care system navigation	• Congregation	Community outreach events	N/A
4	Mercado 369	75208	Mercado369 galleries are filled with one-of-a-kind original art, sculpture, jewelry, textiles. Their 7,000-square-foot facility is perfect for community events.	• All visitors	Community outreach events	N/A
5	Mexican Consulate	75247	The Consulate General of Mexico in Dallas is the consular representation of Mexico and its staff serves the Mexican constituents living in Dallas and surrounding counties.	• All individuals presenting to the Consulate for assistance.	Scheduled monthly community outreach events. Annual Binational Health Fair – Ventanillas de Salud	N/A
6	YMCAs	Various locations throughout Dallas County including 75215, 75232 and 75243	The YMCA is a not-for-profit social services organization dedicated to youth development, healthy living and social responsibility.	• Everyone in the community regardless of age, income or background.	Community outreach events	Under Review
7	Eastfield College Pleasant Grove Campus	75217	Dallas College Pleasant Grove Center (formerly Eastfield College Pleasant Grove Campus) is a student-centered learning community adding value to the lives of students and a community	• Serves more than 148,000 residents and 3,600 businesses.	Community outreach events	Under Review
8	KwanzaaFest		A 2-day cultural celebration held at the automobile building in the Fair Park. It is one of the largest “free events” in the Metroplex. Free health services include: blood pressure, glucose, dental, and prostate screenings.	• KwanzaaFest hosts in excess of 50,000 patrons and embraces the seven principles of the African American holiday, KwanzaaFest.	Community outreach event	Annual sponsorship application completed

#	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
9	Healing Hands Ministries	75243	A Federally Qualified Health Center (FQHC) offering comprehensive patient services including family practice, pediatric, behavioral health, women's, dental and vision services.	• More than 20,000 patients cared for by dedicated providers. More than 61,000 patient visits.	Community outreach events	N/A
10	Foremost Family Health Center (South Dallas and Balch Springs campuses)	75215 75180	A Federally Qualified Health Center (FQHC), Foremost Family Health Centers has been recognized as Patient-Centered Medical Home. It serves to improve the health of families and individuals by offering the highest level of service and care through access to affordable and comprehensive medical, dental and behavioral health services, regardless of the ability to pay.		Community outreach events	N/A
11	Los Barrios Unidos Community Center	75211 75212	As a Federally Qualified Health Center (FQHC), Los Barrios provides comprehensive quality care to all people, creating a safe, affordable, and accessible healthcare experience.	• Los Barrios Unidos Community Clinic is a unique organization for a unique community	Community outreach events	N/A
12	Light of the World Church of Christ	75232	A non-denominational, non-instrumental, revolutionary New Testament community working to connect God's message to individuals. The organization is committed to creating more affordable housing for seniors, safe havens for battered women, and a model prison ministry for incarcerated men and women.	• Congregation	Community outreach events. Location for Parkland's Annual Coming Together for the Cure Mammography Outreach and Educational Workshop	N/A
13	Jubilee Park & Community Center	75223	Through empowerment and advocacy, Jubilee neighbors work together toward better jobs, safe and quality housing, and a more vibrant community.	• 1,600 individuals served annually	Resource for opportunity, education, health, safety, and financial literacy	Signed 1/2020
14	Susan G. Komen	75380	Susan G. Komen® Dallas County is the local source for funding breast cancer education, screening and treatment in Dallas County. Events such as the Komen Dallas Race for the Cure®, Komen Dallas County funds life-saving breast health services to help uninsured and underinsured residents in the fight today.	• Dallas County	Provides funding for diagnostic and procedures	N/A
15	Breastcancer.org		It is a nonprofit organization dedicated to providing information and community to those touched by breast cancer. It has been a source of comfort, knowledge, and support.	• Supported more than 153 million people affected by breast cancer around the world	• Provides information and community to those touched by breast cancer	N/A

#	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
16	National Breast Cancer Foundation		Provides assistance and inspires hope to those affected by breast cancer through early detection, education, and support services.	• Everyone living with breast cancer	• Provides funding for screening, education, and transportation	N/A
17	American Cancer Society		Raises funds for conducting research, sharing expert information, supporting patients, and spreading the word about prevention.	• Everyone living with cancer	• Education and Resources	N/A
18	Sisters Network Dallas	75374	Sisters Network® Dallas is a community-based organization made up of African American breast cancer survivors. The organization's purpose is to save lives and provide a broader scope of knowledge that addresses the breast cancer survivorship crisis affecting African American women.	• Primarily African American women. There are more than 40 affiliate survivor-run chapters nationwide with a total of over 3,000 members.	• Support services for cancer survivors	N/A
19	Cancer Support Community of North Texas	75231	Organization ensures that all people impacted by cancer are empowered by knowledge, strengthened by action, and sustained by community.	• Everyone living with cancer	• Health Literacy	N/A
20	Bridge Breast Network	75246	The organization provides access to diagnostic and treatment services for breast cancer to low income, uninsured, and underinsured individuals.	• Low income, uninsured, and underinsured individuals care in North Texas. Since 1992, The Bridge Breast Network has assisted more than 150,000 individuals with lifesaving medical care in North Texas.	• Access to care	N/A
21	Breast Cancer Can Stick It!	75374	Music-centric events fund Parkland services for breast cancer treatment, research, trials, mammograms and education.	• Dallas	• Provides funding for screening and diagnostics	Parkland Foundation fund intention form
22	**Partnerships under exploratory phase:** City of Dallas – Parks and Recreation Centers Dallas County Community College District (various locations) Pleasant Grove Ministerial Alliance South Dallas Fair Park Coalition African American Pastors' Coalition Frazier Revitalization (Frazier Courts)					

COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION:

Cultural Competency

Parkland
Care. Compassion. Community.

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COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION

Cultural Competency

A. PROBLEM STATEMENT

The lack of a clear strategy to address Social Impact and Community Context within the health system was identified as a barrier to healthcare

The ever-increasing diversity of Dallas County requires greater resources devoted to cultural competency including the establishment of best practices

B. STRATEGY

Deploy a Cultural Competency (CC) Program in accordance to Culturally Linguistically Appropriate Services (CLAS) standards and relevant to the socio and cultural norms of Dallas County population and the trauma-genic nature of Dallas County communities

C. METRICS

Percentage of employees who participated in the organizational assessment

A. STAFFING

#	FTE Description	Scope of Service
1	**SVP and Associate Chief Talent Officer**	Senior Office of Talent Management operations leader, including strategic management and integration leader for all Talent Management services. Lead/Business Owner for the Cultural Competency Survey including: development and launch of the survey for internal and external stakeholders; assessment of Parkland's cultural competency survey data/output; assess Best Practices specific to Collecting Race, Ethnicity, Age and Language (REAL) data; collection and evaluation of Sexual Orientation and Gender Identification data; assess and deliver trauma-informed care training.
2	**SVP Talent Management Development**	Sets direction for corporate learning and development solutions, investments and resourcing, including formal workforce development programs designed to grow the talent pipeline from within the community and expand career growth pathways from unskilled services into healthcare roles.
3	**Director of Workforce Development**	Evaluates the pipeline need, directs the development and implementation of workforce development strategies that support the mission and objectives of Parkland. Leads, grows and manages academic partnerships that benefit the community and talent pipeline. Serves as a Parkland representative with partnering education and community based programs. Measures and reports on programs investments, benefits, participation and plans.
4	**Workforce Development Program Staff**	Program managers, workforce development staff (4): Responsible for execution and monitoring of key programs including apprenticeships, high school partnerships, interns and student placement. Career navigators (2): Provide customized support to Parkland employees seeking guidance for career growth and/or access to workforce development programs. Education specialist (1): Designs methods for measuring the impact of workforce development programs. Workforce development coordinators (1.5): Coordinates student rotations and monitors agreements with academic institutions, Parkland sponsors, observers and legal.
5	**Diversity & Inclusion Program Manager**	Develops cultural awareness programming. Manages Employee Resource Groups. Serves as lead cultural competency data analyst, system education and training expert, program development coordination.
6	**Director of Cultural Competency**	Senior leader of the Diversity and Inclusion department. Lead developer of the Cultural Competency Plan, strategic programming, curriculum/education and training, program and adaptation evaluation and development of three-year (2024) system re-survey/reassessment.
	Total FTEs	

B. BUDGET

$50,000 allocated in FY20 for Cultural Competency Assessment (COA360).
As the program expands the budget will be adjusted accordingly.

C. INTERVENTION DEPLOYMENT

Goal: Percentage of employees who participated in the organizational assessment 70% employees

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact
1	Deploy a Cultural Competency (CC) Program in accordance to Culturally Linguistically Appropriate Services (CLAS) standards and relevant to the socio and cultural norms of the Dallas County population and the trauma-genic nature of Dallas County communities	October 2020	Assess Parkland's current CC state (upon completion of the COA360) Adopt a CC plan based on assessment Establish policies to: Collect Race, Ethnicity, Age and Language data Collect Sexual Orientation and Gender Identification data Determine current patient literacy level Deliver trauma-informed care training	CC Plan # of CC Trainings developed # of best practices established # of staff trained on REAL data collection policy # of staff trained on SOGI data collection policy COA360 Assessment Findings Organizational Chart reflecting CC structure	Patients are flagged in Epic via a reporting workbench list based on patient ZIP Code.	**Survey participation** 2020: 8,339
2	Increase diversity of Parkland workforce (particularly from CHNA target ZIP Codes: 75210, 75211, 75215, 75216, 75217 and 75241	Target hiring staff within the CHNA ZIP Codes Increase guidance and career support resources for Parkland employees in entry-level jobs Optimize healthcare internships for high school and college students who live in target CHNA ZIP Codes Secure and expand educational partnerships; build new programs that promote entry to healthcare jobs	eMCAP team visits the patient in the hospital to introduce themselves and the program.	Talent Acquisition team Workforce Development Career Navigators Program managers Intern/Apprentice/ ISD/ Student programs Workforce Development Education Specialist – measurement & reporting Director of Workforce Development	Increase in hires from key ZIP Codes Increase employee engagement and mobility into mid-level positions, earning potential Apprenticeship program curriculum and reporting tool	1,191 (10%) of employees will represent the CHNA target ZIP Codes 238 employees from internships 7 CHW's hired covering the following High SNI score ZIP Codes: 75223, 75215, 75216, 75228, 75220, 75243, 75238, 75241, 75237
3	Trauma-Informed Care		Assess Parkland's current state of trauma awareness Create a trauma plan based on assessment Implement training and practice in the organization and the community	Parkland Behavioral Health Team OTM	# of training sessions completed # of community trainings	TBD

D. PARTNERSHIPS

	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
1	**DISD Schools: Pinkston**	75212	The P-Tech program in partnership with local Independent School Districts prepare students for a career in healthcare. Students will acquire a Patient Care Technician certification before graduating from high school		N/A	Initiating Process
2	**DISD Schools: Pinkston, Madison, Roosevelt, Sunset Molina, Adamson, Skyline South Oak**	75212, 75215, 75203, 75208, 75211, 75227 and 75216	The grant-funded Learning & Experience Apprenticeship Program (LEAP) is designed to provide both an educational and employment opportunity for recent Dallas County high school graduates who have an interest in pursuing a career in the healthcare arena.		N/A	Pending
3	**DISD**	75241	The P-Tech program in partnership with local Independent School Districts prepare students for a career in healthcare. Students will acquire a Patient Care Technician certification before graduating from high school.		N/A	Pending
4	**Dallas College**	Dallas County	DOL Grant – The grant-funded Department of Labor Apprenticeship Program provides Dallas County residents an opportunity to advance in their career while participating in development opportunities to include work-based learning strategies, hands-on experience, peer mentors and career coaches at Parkland		N/A	Active
5	**Dallas County Health and Human Services**	Dallas County	Cultural Competency Assessment will be given to DCHHS staff	Dallas County population	N/A	N/A

COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION:

Diabetes

Parkland
Care. Compassion. Community.

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COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION

Diabetes

A. PROBLEM STATEMENT

There is a high prevalence of diabetes among residents living in CHNA target ZIP Codes 75210, 75211, 75215, 75216, 75217 and 75241.

B. STRATEGY

Deploy primary, secondary and tertiary interventions as described in the activity section that focuses on individuals from CHNA target ZIP Codes.

C. METRICS

1. Number of patients from the targeted population screened for diabetes and receiving targeted follow-up based on screening results

2. Percentage of patients with diabetes from the targeted population who performed an HbA1c test

3. Percentage of patients with diabetes from the targeted population whose most recent HbA1c level is > 9.0%

4. Percentage of patients with diabetes from the targeted population with HbA1c level > 9.0% and PSAM score < 60%

5. Percentage of patients with diabetes from the targeted population who received a foot exam

6. Percentage of patients with a diagnosis of a diabetic foot problem from the targeted population who experienced an amputation

D. BUDGET (as of August 31, 2020)

Diabetes
Financial Summary

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Gross Revenue	$0	$0	$0	**$0**	**$0**	**$0**
Deductions from Revenue	-	-	-			**-**
Net Revenue	-	-	-			**-**
Expenses						
Salaries	289,194	301,176	313,618	326,535	336,331	**1,566,854**
Benefits	62,466	65,054	67,741	70,532	72,647	**338,440**
Med/Surg Supplies-Baxter	7,200	4,000	11,200	6,800	8,800	**38,000**
Lab Costs	3,000	10,000	13,000	17,000	22,000	**65,000**
IT Cost	15,500	6,700	7,900	5,500	9,100	**44,700**
Screen Toolkit Equipment	2,300	-	2,300	600	600	**5,800**
Supplies COPC Podatric Team	-	-	18,000	-	-	**18,000**
Transportation Options (Est. $50 p/patient)	1,500	5,000	6,500	8,500	11,000	**32,500**
Management Platform Diabetes Device	-	3,000	3,000	3,000	3,000	**12,000**
Marketing and Educational Materials	4,595	6,595	6,595	7,595	7,595	**32,795**
Miscellaneous Supplies	4,100	7,200	7,200	8,200	9,200	**35,900**
Total Expenses	**389,855**	**408,726**	**457,054**	**454,261**	**480,273**	**2,190,169**
Net Income	(389,855)	(408,726)	(457,054)	(454,261)	(480,273)	**(2,190,169)**
Indirect Expense Allocation (0% of Total Expenses)	-	-	-	-	-	**-**
Net Income after Indirect Expenses	**$ (389,855)**	**$ (408,726)**	**$ (457,054)**	**$ (454,261)**	**$ (480,273)**	**$ (2,190,169)**
Capital	-	-	-	-	-	-
Total	**$ (389,855)**	**$ (408,726)**	**$ (457,054)**	**$ (454,261)**	**$ (480,273)**	**$ (2,190,169)**
FTEs	**3.70**	**3.80**	**3.90**	**4.00**	**4.00**	**3.88**
Total Direct Expenses	**389,855**	**408,726**	**457,054**	**454,261**	**480,273**	**2,190,169**

E. STAFFING (as of 8/31/20)

#	FTE Description	Scope of Service	Year 1
1	Diabetes Care and Education Specialist (CDCES)	The overall scope of services of this position is: 1. CHW training, ongoing oversight / support 2. Developing curriculum for Diabetes education and community awareness programs 3. Act as community liaison between CHW and community partners 4. Connecting patients to Parkland Health & Hospital Systems care – COPC, OPC, and hospital 5. Metric / Data collection support 6. Participates in providing training/resources to multidisciplinary health care team PRN on diabetes community initiatives	2.0
2	Social Worker (LMSW)	1. Assist in patient screening, SDOH assessment completion, and Psychosocial needs evaluation 2. Function as a clinical extension of CHW, particularly for high risk stratification 3. Counsels - Emotional, social, and financial consequences of illness and/or disability 4. Connecting patients to Parkland Health & Hospital Systems care – COPC, OPC, and hospital	1.0
3	Registered Nurse - RN II	1. Provide guidance and support to on-site screening staff 2. Responsible for logistics and risk stratification for community screening 3. Support CDCES and CHW in providing basic education and awareness to screened patients 4. Coordinate and schedule follow-up within Parkland	0.5
	Medical Assistant	1. Communicates effectively with patients and their families regarding the care plan 2. Provides clinical and administrative support to community screening events 3. Ensure patients' follow-ups are scheduled in a timely manner 4. Serves as a patient advocate, focusing on patient needs, confidentiality, and preferences. 5. Monitors ongoing patient status and responds to any change in patient's condition by notifying the care team members.	0.2
	Total FTEs		**3.7**

F. INTERVENTION DEPLOYMENT

Goal 1: Increase the number of patients from the targeted population screened for diabetes and receiving targeted follow-up based on screening results by 2022 (2020: 2,838, 2021: 3,265, 2022: 3,998)						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
1	Identify Community Partners / stakeholders	Community Screening	• Identify and establish collaborative partnerships with community stakeholders – both clinical and nonclinical (eg. SDOH) to identify and coordinate community opportunities, build community capacity, reduce service duplication and optimize available resources	• Diabetes CHNA Team • Parkland Community Relations Team	# of community partners # of collaborative activities Community partner satisfaction	Community Partners 2020: 7 2021: 12 2022: 11

2	Patient Identification	Community Screening	• Administer Diabetes Screening Questionnaire
			• Perform Random Blood Glucose (RBG) screenings to identify patients with diabetes according to the following guidelines:
			  • RBG <140 mg/dL
			  • RBG >=140 mg/dL
			  • RBG > 400 mg/dL
			• SDOH screening & resource connection
			• Complete insurance coverage verification or referral to PFA
				• CHW
				• RN
				• PCP
				• PFA
					# of patients screened
					# of PFA enrollments
					# of patients referred to a Parkland PCP
					# of patients sent to ED
					# of SDOH assessments
					# of patients link to care
						Screenings
						2020: 2,838
						2021: 3,265,
						2022: 3,998
						PFA Referral
						2020: 539
						2021: 620
						2022: 770

[1] Assumption: 19% of Dallas County population is uninsured as noted in Community Health Needs Assessment

Goal 1: Increase the number of patients from the targeted population screened for diabetes and receiving targeted follow-up based on screening results by 2022 (2020: 2,838, 2021: 3,265, 2022: 3,998)

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact

3	Random capillary blood (RBG) glucose:
	RBG < 140 mg/dL
		Real Time during screening	Provide Healthy Living education to the patient that highlights the following:
			• Understanding diabetes[2]
			  • Understanding type of diabetes the patient has and its related symptoms
			• Healthy eating
			  • Emphasis on 3 planned meals that are low in carbohydrates
			• Exercise
			  • Promotes physical activity 30 minutes a day, 5 days a week
			• Taking medication
			  • Understanding the type of medication using timely administration. Also, focusing on medication refills
			• Monitoring blood glucose
			  • Promotes self-check of blood glucose at regular intervals
			• Lowering risk
			  • Understanding ways to avoid complications of the disease
			• Healthy coping
			  • Promotes change in the way to approach diabetes
			• No formal follow-up required when the RBG is <140 mg/dL:
			  • provide written resources
			  • consider Diabetes Prevention Program / alternate prevention resources
				• CHW
				• CDCES
				• RN
					# of patients with BG <140mg/dL
					# of patients receiving education
						Normal Screenings[3]
						2020: 2,540
						2021: 2,922
						2022: 3,578
						Education Sessions
						2020: 2,540
						2021: 2,922
						2022: 3,578

[2] Based on Parkland Health & Hospital System's Healthy Living with Diabetes Class Program - Recognized by the American Diabetes Association for Quality Self-Management Education and Support. https://www.parklandhospital.com/Uploads/Public/Documents/PDFs/Diabetes/Diabetes%20Book.pdf

[3] Data based on Texas data https://demographics.texas.gov/Resources/publications/2018/2018_12_17_DiabetesProfile.pdf

Goal 1: Increase the number of patients from the targeted population screened for diabetes and receiving targeted follow-up based on screening results by 2022 (2020: 2,838, 2021: 3,265, 2022: 3,998)

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact

4	Random capillary blood (RBG) glucose:
	RBG ≥ 140 mg/dL - Hi
		At the time of screening	Document recommendation for formal follow-up diabetes screening as follows:
			• Schedule established Parkland patient for confirmatory test
			  • Fasting Blood Glucose
			  OR
			  • HbA1c
			• Based on clinical assessment, schedule confirmatory test within the following timeframes:
			  • RBG 140-199mg/dl - 6 months
			  • RBG 200-399mg/dL - 3 months
			  • RBG 400mg/dL- ≤Hi - 14 days
			  • RBG 'Hi' - Emergent Assessment
			• Document recommendation for patient to go to Urgent Care or Emergency Department
			• Provide information / diabetes education to the community member / patient which may address the following:
			  • To include lifestyle information for BG<140mg/dL, as well as consider:
			  • **Taking medication**
			  Understanding medication, timely administration, medication refills
			  • **Monitoring blood glucose**
			  Self-blood glucose checks, glucose targets
			  • **Lowering risk**
			  Reducing complication risk, annual health screening recommendations
			  • **Healthy coping**
			  Disease acceptance, reducing distress
			• Recommend participation in and provide program resources for formalized diabetes self-management education program if not attended in previous year
			• When a patient has a PCP external to Parkland, he or she is advised to follow-up with PCP for confirmatory test in the same timeframe as above.
				• CHW
				• RN
				• CDCES
					# of patients with RBG: 140-199 mg/dl
					# of patients with RBG 200-399 mg/dL
					# of patients with RBG 400 mg/dL- <Hi
					# of patients with RBG 'Hi'
					# of patients with completed Fasting Blood Glucose
					# of patients with completed HbA1c
					# of patients who require a primary care connection
					# of patients with external primary care
					# of patients sent to ED
						TBD

5	Parkland diabetes screening	Real Time	• Identify at-risk for diabetes patients at Parkland • Perform lab HbA1c screening test (Not POC A1c) • Ensure timely care team follow-up	• MD/APP • Pharmacist	# of patients screened # of patients diagnosed with pre-diabetes and diabetes	TBD

Goal 2: Increase percentage of patients with diabetes from the targeted population who performed an HbA1c from 87.59% to 90% by 2022						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
	Identify Parkland patients with an existing ICD10 diagnosis of diabetes	Annually	• Identify Parkland patients with an ICD-10 diagnosis for diabetes across COPC, OPC and hospital locations who have not had a POC or lab A1c test completed in the reporting year via: • EPIC Problem List • EPIC Health Maintenance • EPIC Diabetes Overview Snapshot • Care gaps RWB • Other sources	• MD / APPs • Multi-disciplinary clinical team • Business staff	# of patients requiring an A1c in the reporting year # of patients who completed an A1c in the reporting year	
1	Community diabetes screening follow-up established Parkland patients with RBG 140-199 mm/dL	6 months from screening	• Conduct clinic visit with PCP/APP as per guidelines and perform confirmatory test HbA1c • Document the results and schedule follow-up visit according to patients' clinical assessment • Identifying opportunities to connect patients to community resources • Provide diabetes education materials and /or refer patients diagnosed with diabetes to multidisciplinary team members and / or Healthy Living with Diabetes (HLWD) education for any or all of the following diabetes relevant topics: • Understanding diabetes • Healthy eating recommendations • Physical activity • Understanding medication • Diabetes monitoring / glucose management • Reducing risk – maintaining health • Healthy coping	• MD/APP • RN • CHW • CDCES	# of patients who completed an A1c in the reporting year Time duration from screening date # of patients receiving education materials # of patients referred for multi- disciplinary visit # of patients referred for HLWD program # of patients connected with CBOs	**TBD**

Goal 2: Increase percentage of patients with diabetes from the targeted population who performed an HbA1c from 87.59% to 90% by 2022						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**

2	Community screening follow-up
	established Parkland patients with
	RBG 200-399 mm/dL
		3 months from screening	• Conduct clinic visit with PCP/APP as per guidelines and perform confirmatory test HbA1c
			• Document the results and schedule follow-up visit according to patients' clinical assessment
			• Identifying opportunities to connect patients to community resources
			• Provide diabetes education materials and /or refer patients diagnosed with diabetes to multidisciplinary team members and / or Healthy Living with Diabetes (HLWD) education for any or all of the following diabetes relevant topics:
			  • Understanding diabetes
			  • Healthy eating recommendations
			  • Physical activity
			  • Understanding medication
			  • Diabetes monitoring / Glucose management
			  • Reducing risk – maintaining health
			  • Healthy coping
				• MD/APP
				• RN
				• CHW
				• CDCES
					# of patients who completed an A1c in the reporting year
					Time duration from screening date
					# of patients receiving education materials
					# of patients referred for multi- disciplinary visit
					# of patients referred for HLWD program
					# of patients connected with CBOs
						TBD

3	Community screening follow-up
	established Parkland patients with
	RBG 400 - <= Hi mm/dL
		14 days from screening	• Conduct clinic visit with PCP/APP as per guidelines and perform confirmatory test HbA1c
			• Document the results and schedule follow-up visit according to patients' clinical assessment
			• Identifying opportunities to connect patients to community resources
			• Patients are educated on diabetes relevant topics such as:
			  • Maintaining healthy weight
			  • Eat healthy diet with low carbohydrates and sugar
			  • Increasing physical fitness
			  • Ways to manage stress
			  • Limiting alcohol
			  • Smoking cessation
			  • Take medications properly
			  • Working with healthcare team
				• MD/APP
				• RN
				• CHW
				• CDCES
					# of patients who completed an A1c in the reporting year
					Time duration from screening date
					# of patients receiving education materials
					# of patients referred for multi-disciplinary visit
					# of patients referred for HLWD program
					# of patients connected with CBOs
						TBD

Goal 2: Increase percentage of patients with diabetes from the targeted population who performed an HbA1c from 87.59% to 90% by 2022						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
4	Follow-up patients when RBG >= 140 mm/dL		• When a patient has a PCP external to Parkland, he or she is advised to follow-up with PCP / medical home for confirmatory test in the same timeframe as above	• CDCES • CHW • RN • SW	# of patients with an external PCP who performed confirmatory test	**TBD**
5	Education and training – Community and Parkland workforce	March 2021-Ongoing	• Develop, implement and evaluate community awareness campaign / education regarding importance of glucose monitoring and A1c completion • Develop, implement and evaluate workforce training activity on importance of glucose monitoring and A1c completion	• Diabetes CHNA team • CDCES • CHW • RN • SW	# of and impact of community awareness campaigns / education # of and impact of workforce training activities	**TBD**
6	Point of care data optimization (EPIC / Diabetes Dashboard)	2021	• Review Information Technology (IT) opportunities to enhance point of care decision tools for clinicians to identify need for A1c test completion	• Parkland IT team • Diabetes CHNA team	Data optimization activity # of patients who completed an A1c in the reporting year Care team satisfaction	**TBD**

Goal 3: Decrease the percentage of patients with diabetes from the targeted population whose most recent HbA1c level is > 9.0% from 37.7% to 32.3% by 2022						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**

1	Identify and follow-up with established patients with HbA1c > 9%	Within 3 months from date of HbA1c > 9%	• Conduct clinic visit with PCP/APP/ Pharmacist as per guidelines to:
			  • Confirm HbA1c level
			  • Evaluate medication regimen and medication adherence
			• Schedule follow-up visit according to patients' clinical assessment
			• Patients are referred to multidisciplinary care team and / or HLWD program for education on any or all of the following topics:
			  • Understanding diabetes
			  • Healthy eating recommendations
			  • Physical activity
			  • Understanding medication
			  • Diabetes monitoring / glucose management
			  • Reducing risk – maintaining health
			  • Healthy coping
			• Identify opportunities to connect patients with appropriate community partners. For non-Parkland patients, provide information on available Diabetes Self-Management Education programs in the community
				• MD/APP
				• Pharmacist
				• RN
				• CDCES
				• CHW
					# of patients with HbA1c>9%
					# of patients scheduled for and who attended follow-up visit (multidisciplinary care team / HLWD program)
					# of completed patient visits
					# of patients connected to CBOs
						TBD

2	Follow-up with established patients with HbA1c ≤ 9%	In 6 months from HbA1c identification ≤ 9%	• Conduct clinic visit with PCP/APP/ Pharmacist as per guidelines to:
			  • Confirm HbA1c level
			  • Evaluate medication regimen and medication adherence
			• Schedule follow-up visit according to patients' clinical assessment
			• Patients are referred to a multidisciplinary care team and / or HLWD program for education on any or all of the following topics:
			  • Understanding diabetes
			  • Healthy eating recommendations
			  • Physical activity
			  • Understanding medication
			  • Diabetes monitoring / glucose management
			  • Reducing risk – maintaining health
			  • Healthy coping
			• Identify opportunities to connect patients with appropriate community partners
				• MD/APP
				• RN
				• CHW
				• CDCES
					# of patients with HbA1c ≤ 9%
					# of patients scheduled for and who attended follow-up visit (multidisciplinary care team / HLWD
					# of patients provided education materials
					# of patients connected to CBOs
						TBD

Goal 3: Decrease the percentage of patients with diabetes from the targeted population whose most recent HbA1c level is > 9.0% from 37.7% to 32.3% by 2022						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
3	Education and training – Community and Parkland workforce	March 2021 -ongoing	• Develop, implement and evaluate community awareness campaigns / education regarding importance of glucose control • Develop, implement and evaluate workforce training activity on importance of glucose control and ADA standards of diabetes care	• Diabetes CHNA team • CDCES • CHW • RN • SW	# of and impact of community awareness campaigns / education # of and impact of workforce training activities	**TBD**
4	Establish care management pathway for A1c>9%	December 2021	• Optimize multidisciplinary care team utilization to reduce A1c>9% • Establish streamlined care recommendations to reduce existing or risk of A1c>9%	• Diabetes CHNA team • MD/APP • Diabetes specialty care teams	Care management pathway development # of patients with an A1c >9% Care team satisfaction and engagement Patient satisfaction	
5	Optimize / Expand visit types	Ongoing – Real Time	• Provide expanded primary care access through alternate visit types (virtual, connected care, SMA, RN led clinic, multi-discipline Visits, etc.) – as part of Care Management Pathway	• MD/APP • Diabetes specialty care teams	# Visit types Care team engagement and satisfaction Patient satisfaction	
6	Point of care data optimization (EPIC / Diabetes Dashboard)	June 2022	• Review Information Technology (IT) opportunities to enhance point of care decision tools for clinicians to establish glucose control and adherence to ADA standards of diabetes care (patient, provider, clinic and system level)	• Parkland IT team • Diabetes CHNA team	Data optimization activity # of patients whose A1c > 9% in the reporting year Care team satisfaction	

Goal 4: Decrease the percentage of patients with diabetes from the targeted population with HbA1c level > 9.0% and PSAM score[4] < 60% from 20.6% to 15% by 2022

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact
1	Identifying patients with A1c > 9% and P-SAM < 60%	Real Time	• Conduct clinic visit with PCP/APP/ clinical pharmacist as per guidelines and confirm the HbA1c level • Utilize PSAM tool in EPIC to identify patients with PSAM < 60% - COPC, Diabetes Specialty Clinic, hospital	• PCP/APP • RN • CDCES • Pharmacist	# of patients with an HbA1c > 9 # of patients with a PSAM < 60% HbA1c and PSAM improvement results	**TBD**

2	Establish care management pathway for patients with HbA1c > 9 and PSAM < 60%	Real Time	• Develop and / or utilize medication adherence assessment tool to understand barriers and develop associated care management pathway for A1c > 9% and low medication adherence (PSAM < 60%) – COPC, Diabetes Specialty Clinic and hospital
			• Identifying and addressing barriers to medication adherence such as:
			  • Lack of understanding
			  • Cost
			  • Access
			  • Complexity of medication
			  • Health literacy
			  • Side effects
			  • Belief systems/culture
			  • Others
			• Schedule patients with relevant provider and / or multidisciplinary team member(s) based on identified barrier(s), optimizing alternate visit types:
			  • Virtual visit
			  • Shared Medical Appointments
			  • RN led clinic
			  • Specialty visits
			• Schedule follow-up visit according to patients' clinical assessment
				• Diabetes CHNA team
				• MD/APP
				• RN
				• SMA
				• SW
				• CDCES
				• Nurse Navigator
				• Pharmacist
					Care management pathway development, implementation and evaluation
					# of patients scheduled for virtual visits
					# of patients scheduled for SMA visit
					# of patients scheduled for RN-led clinic
					# of patients scheduled for specialty visits
					# of patients with medication adherence barriers
					# of patients scheduled for follow-up
						TBD

3	Point of care data optimization (EPIC / Diabetes Dashboard)	December 2021	• Review Information Technology (IT) opportunities to enhance point of care decision tools for clinicians to establish glucose control and medication adherence (patient, provider, clinic and system level) • Explore opportunities for PSAM optimization and provider utilization	• Parkland IT team • Diabetes CHNA team • Pharmacy team	Data optimization activity # of patients whose A1c > 9% in the reporting year and P-SAM < 60% Care team utilization / satisfaction	
4	Education and training: Community and Parkland workforce	Ongoing	Develop, implement and evaluate community awareness campaigns / education regarding importance of glucose control and medication adherence Develop, implement and evaluate workforce training activity on importance of glucose control and medication adherence	Diabetes CHNA team CDCES CHW RN SW	# of and impact of community awareness campaigns / education # of and impact of workforce training activities	

[4] Based on Parkland Score for Adherence to Medication (PSAM) Program https://www.parklandhospital.com/news-and-updates/did-you-take-your-meds-1533#:~:text=An%20innovative%20pilot%20program%20called,chronic%20diseases%20such%20as%20diabetes.

Goal 5: Increase percentage of patients with diabetes from the targeted population who received a foot exam from 52.2% to 76.7% by 2022						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
1	Patient Identification	Community screening	• Educate on performing self-foot assessments during community screening, education and awareness activities to alert individuals with diabetes to the risk of or identification of acute or chronic foot complications • Complete insurance coverage verification or referral to PFS if identified need for medical home or podiatry services at Parkland	• CDCES • CHW • RN • PFA	# of patients with diabetes who received at least annual foot exam # of patients with foot wound	**Screenings** 2020: 2,989 2021: 3,137 2022: 4,199

2	Patient Identification	Parkland Real Time	• All individuals with diabetes attending primary care, diabetes specialty service and where possible, hospital care at Parkland should be assessed for and receive an annual (at minimum) foot exam / screen:
			  • Workforce training on importance of a foot screening
			  • Training to ensure accurate completion of foot exam
			  • Optimize electronic capture of foot exam completion
				• Diabetes CHNA team
				• Primary care providers
				• Diabetes specialty team
				• RNs
					# of patients receiving at least annual foot exam in reporting year	

Goal 5: Increase percentage of patients with diabetes from the targeted population who received a foot exam from 52.2% to 76.7% by 2022						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**

2	Risk stratified approach to foot care	Real Time	• Based on foot risk screening / foot exam:
			  • Low foot risk – Primary care management
			  • Moderate foot risk – Community / COPC podiatry services
			  • High foot risk (wound) – Foot Wound Clinic / specialist team & potentially ED / hospital
			• Refer and schedule established Parkland patient for required initial and follow-up foot care visits:
			  • Primary care provider (Low risk)
			  • Community / COPC podiatry (Moderate risk)
			  • Foot Wound Clinic – High risk (Wound) (and potentially ED / Hospital)
			• Educating patients with diabetes on preventive foot care to avoid complications[5]:
			  • Daily feet check
			  • Regular feet washing
			  • Moisturizing feet daily
			  • Wearing appropriate footwear and socks
			  • Toenail care
			  • Diabetes control
			  • Smoking cessation
			  • Keeping active
			• Identify opportunities to connect patients with appropriate community resources (Podiatrists, footwear, etc.)
			• When a patient has a PCP external to Parkland, he or she is advised to follow-up with PCP as per clinical assessment
				• MD/APP
				• RN
				• Podiatrist
				• SMA
				• CHW
				• CBO
					# of diabetic patients who received a diabetes foot exam
					# of patients who received Podiatrist visit (Community/ COPC, Foot Wound Clinic)
					# of patients educated on self-foot care
					# of patients connected to community partners
						TBD

3	Point of care data optimization (EPIC / Diabetes Foot Dashboard)	December 2021	• Review Information Technology (IT) opportunities to enhance point of care decision tools for clinicians to establish foot exam activity and results (patient, provider, clinic and system level). • Develop broader foot service data dashboard	• Parkland IT team • Diabetes CHNA team • Podiatrists	Data optimization activity # of patients who received an annual foot exam Care team utilization / satisfaction	
4	Education and training: Community and Parkland workforce	Ongoing	• Develop, implement and evaluate community awareness campaigns / education regarding importance of self-foot care and examination • Develop, implement and evaluate workforce training activity on diabetes foot examination	• Diabetes CHNA team • Podiatrists • CDCES • CHW • RN • SW	# of and impact of community awareness campaigns / education # of and impact of workforce training activities	

[5] Based on Parkland's Twelve Tips For Healthy Feet For People With Diabetes https://www.parklandhospital.com/news-and-updates/twelve-tips-for-healthy-feet-for-people-with-diabe-643

Goal 6: Decrease percentage of patients with a diagnosis of a diabetic foot problem from the targeted population who experienced an amputation from 5.09% to 4% by 2022						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
1	Patient Identification	Community Screening	• Education on performing self-foot assessments during community screenings to alert people with diabetes to the risk of or identification of acute or chronic foot complications in order to reduce amputation risk • Complete insurance coverage verification or referral to PFS if identified need for medical home or podiatry services at Parkland	• CDCES • CHW • RN • PFs	# of patients with diabetes who received at least an annual foot exam # of patients with amputation or at-risk feet (e.g. wound)	**Screenings** 2020: 263 2021: 252 2022: 219
2	Patient Identification	Parkland Real Time	• All individuals with diabetes attending primary care or diabetes specialty service visits at Parkland should receive an annual (at minimum) foot exam / screen: • Workforce training on importance of and accurate completion of foot exam	• Diabetes CHNA team • Primary care providers • Diabetes specialty team • RNs	# of patients receiving at least annual foot exam in reporting year	

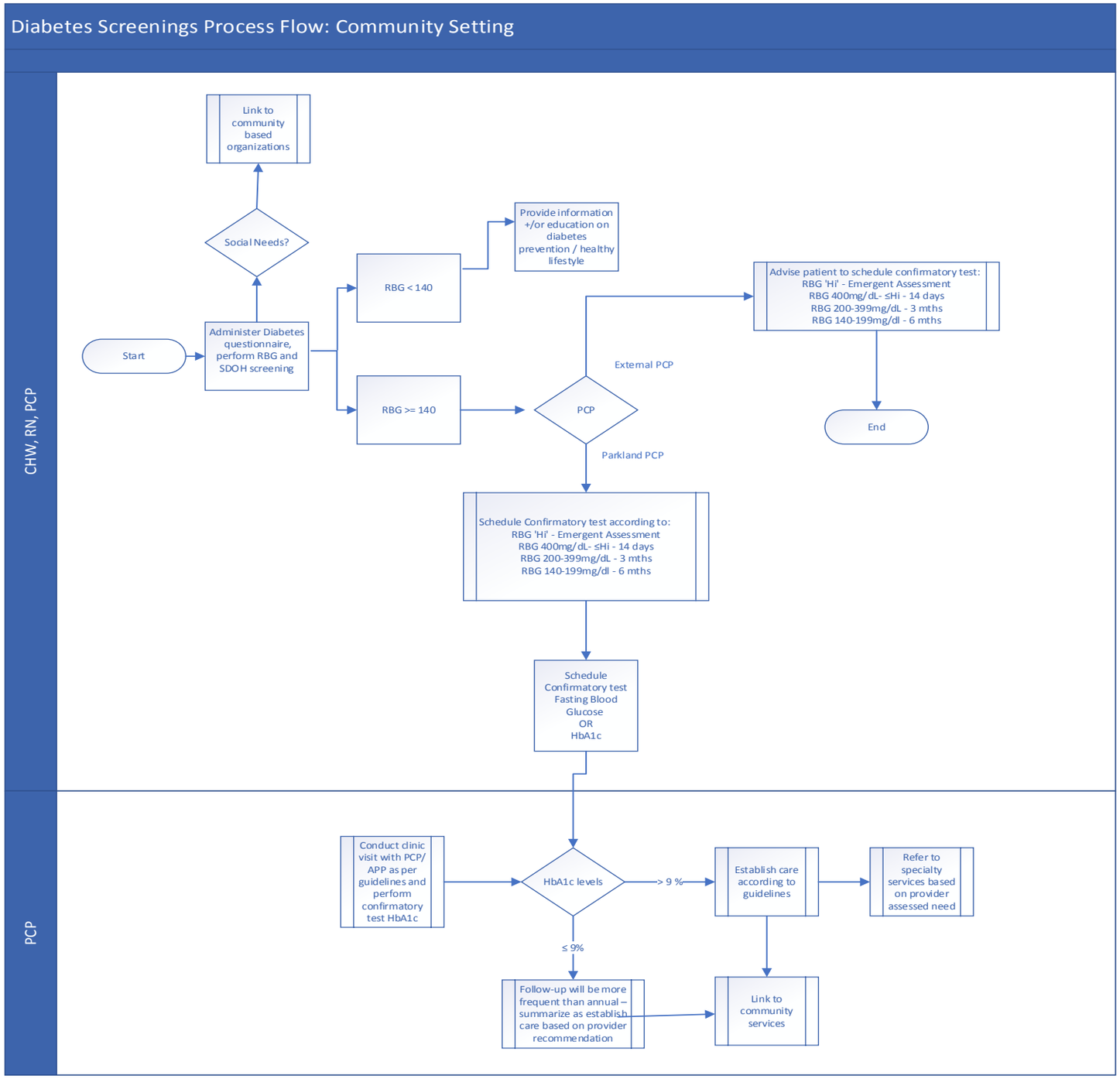
Goal 6: Decrease percentage of patients with a diagnosis of a diabetic foot problem from the targeted population who experienced an amputation from 5.09% to 4% by 2022

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact

2	Risk stratified approach to foot care	Real Time	• Based on foot risk screening / foot exam:
			  • Low foot risk – Primary care management
			  • Moderate foot risk – Community / COPC podiatry services
			  • High foot risk (wound) – Foot Wound Clinic / specialist team
			• Refer and schedule established Parkland patient for required initial and follow-up visits:
			  • Primary care provider (Low risk)
			  • Community / COPC podiatry (Moderate risk)
			  • Foot Wound Clinic – High risk (Wound)
			• Orders for and attainment of required foot supplies, equipment (e.g., boots, orthotics, walking aids, wound supplies)
			• Educating patients with diabetes on preventive foot care to avoid complications:
			  • Daily feet check
			  • Regular feet washing
			  • Moisturizing feet daily
			  • Wearing appropriate footwear and socks
			  • Toenail care
			  • Diabetes control
			  • Smoking cessation
			  • Keeping active
			• Identify opportunities to connect patients with appropriate community resources (Podiatrists, footwear, etc.)
			• When a patient has a PCP external to Parkland, he or she is advised to follow-up with PCP as per clinical assessment
				• MD/APP
				• RN
				• Podiatrist
				• SMA
				• CHW
				• CBO
					# of patients with diabetes referred community and specialty services podiatrists
					# of patients in low, moderate or high foot risk categories
					Time from podiatrist referral to visit across foot risk categories
					# of patients educated on self-foot care
					# of patients connected to community partners or resources
						TBD

3	Education and training: Community and Parkland workforce	Ongoing	• Develop, implement and evaluate community awareness campaigns / education regarding importance of self-foot care and examination • Develop, implement and evaluate workforce training activity on diabetes foot examination and prevention strategies for foot complications. As part, optimize Information Technology (IT) opportunities to enhance point of care decision tools for clinicians to establish foot exam activity and results, disease progression	• Diabetes CHNA team • Podiatrist • CDCES • CHW • RN • SW	# of and impact of community awareness campaigns / education # of and impact of workforce training activities	

G. SERVICE DELIVERY PROCESS FLOW



H. PARTNERSHIPS

	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status

1	Baylor Scott & White Health and Wellness Center at the Juanita J. Craft Recreation Center	Hatcher service area and CHNA ZIP Codes	• Primary care from integrated team of health professionals
			• Physician
			• Nurse Practitioner
			• Behavioral Health Therapist
			• Licensed Social Worker
			• Pharmacist
			• Diabetes Educators
			• Registered Dietitians
			• Referral Coordinator
			• Medical Assistants
			• Community Health Workers
				Hatcher service area and CHNA ZIP Codes	• GLB – Group Lifestyle Balance - 12-week weight loss program
					• HELP – Healthy Eating & Exercise Lifestyle Program
					• National Diabetes Prevention Program
					• CDC recognized
					• For people who have "pre-diabetes" or are at risk of developing type 2 diabetes
					• Year-long program
					  • DSMES – Diabetes Self-Management Education and Support classes taught by registered dietitians, requires physician referral
					  • MNT – Medical nutrition counseling by registered dietitians, requires physician referral
					  • Wrap-around services
					• Farm Stand
					• Cooking demos and classes
					• Fitness classes
						N/A

2	Inspired Vision Compassion Center	75217	IVCC is a non-profit that provides access to basic needs in a grocery store format to residents of Dallas in need. Services provided include: food, clothing, furniture, personal hygiene, animal supplies, emergency baby items, medical/first aid supplies, school supplies, etc. Each spring – they host a "Free Prom Store."	• All ages • Providing groceries for 1,400 – 1,900 families/day/5 days a week • Majority Hispanic population • No ZIP Code restrictions/no ID restrictions	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care	Negotiation Phase/Outlining Agreement

	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
3	City of Dallas – Parks & Recreation: Larry Johnson	75210	Recreation center features include: fitness center, gymnasium, kitchen, large meeting room, outdoor basketball court, parking, playground, small meeting room, youth programs, afterschool and summer camps, active adult and senior programs, adult sports programs	• Heavy senior concentration • 50-60 daily individuals (pre-COVID-19)	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services	Negotiation Phase/Outlining Agreement
4	City of Dallas – Parks & Recreation: John C. Phelps	75216	Recreation center features include: baseball field, fitness center, gymnasium, kitchen, large meeting room, outdoor basketball court, parking, playground, small meeting room, tennis court, walking trails, picnic area, youth dance instruction and cheerleading, after school programs, senior activities and adult fitness classes	• Larger senior population	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services	Negotiation Phase/Outlining Agreement
5	City of Dallas – Parks & Recreation: Janie C. Turner	75217	Recreation center features include: baseball field, fitness center, gymnasium, kitchen, large meeting room, outdoor basketball court, parking, small meeting room, tennis court, youth cheerleading & dance instruction, after school programs, adult fitness classes, senior activities, computer room, and popular boxing program for kids in partnership with DPD	• All ages	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care	Negotiation Phase/Outlining Agreement
6	Community Council of Greater Dallas	HQ: 75247, however serves all of Dallas County and immediate areas	Community action agency/social services organization focusing on poverty alleviation – increasing awareness and access to services. Current programs include: 1. serving seniors with benefits counseling, nutritional services, care coordination, caregiver support & advocacy, meals, transportation, and other senior assistance 2. Coordinating with a network of 1,000 agencies to deliver programs/services to low-income residents – removing barriers to employment and transitioning people out of poverty by providing job training, education, and wrap around services 3. 2-1-1- hotline information and referrals – fielding calls for meals, transportation, and assistance for aging, elderly, senior citizens, and people with disabilities	• Aging, elderly, senior citizens • Low-income • People with disabilities	PFA Training	Negotiation Phase/Outlining Agreement

	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
7	Dallas Housing Authority (DHA)	Various; starting with 75212	DHA provides quality, affordable housing to low-income families and individuals through administration of housing assistance programs across North Texas. DHA is interested in providing access to supportive resources for families – creating housing solutions in healthy, inclusive communities that offer economic, educational, and social growth opportunities.	• 46% of clients are seniors or persons with disabilities • Average annual income: $14,000 • 83% female head of households • 86% African American • Average age: 49 • Serving ~55,000 individuals across 4,903 rental housing units	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care PFA Training	Negotiation Phase/Outlining Agreement
8	Los Barrios Unidos Community Clinic	75211, 75212	Los Barrios operates a Community health clinic in a high need area – known for having quality bilingual staff in English and Spanish. They do not turn away anyone for inability to pay, and accepts Medicaid, CHIP, Medicare, private insurance, and offers a sliding fee scale based on federal poverty level guidelines. The clinic is a federally qualified health center that provides comprehensive primary care services to prevent illness and promote health.	• Economically disadvantages, low-income, and poor people minorities • ~87,000+ annual patient visits	PFA Training	Negotiation Phase/Outlining Agreement
9	Healing Hands Ministries	75243, 75231	Healing Hands operates 7 clinics including a patient-centered community health center. It can serve as a permanent medical home for uninsured, underinsured, and has a goal to teach refugees how to care for their children. They also provide shared medical appointments where groups of 10-12 people are educated in a group setting allowing for peer discussion and support. They have 3 translators on staff and employ a language line.	• 20,000+ individual patients annually who speak 68 different languages • 61,000+ patient visits annually • Children and families • 67% of patients are women	PFA Training	Negotiation Phase/Outlining Agreement
10	Foremost Family Health Center	75215, 75180	Foremost is a federally qualified health center offering access to affordable and comprehensive medical, dental, and behaviorally health services, regardless of ability to pay.	• ~6,161 patients	PFA Training	Negotiation Phase/Outlining Agreement

	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
11	Crossroads Community Services	HQ: 75236, however serves Dallas, Ellis, and Navarro Counties	Crossroads provides nutritious food and supportive education to low-income families and individuals. They have a main hub that serves as a food pantry, and also have partnered with 1200+ community distribution partners (CDPs) to expand their food assistance reach. Crossroads is also committed to meeting peoples basic needs and works with local partners to improve economic and health outcomes for their clients (UTSW, NTFB, Sharing Life Community Outreach, Parkland through BUILD Health Challenge project, DCHHS, University of Dallas)	• ~75,000 people including 26,500 children • Distributes ~9 million pounds of groceries annually • Low-income/economically disadvantaged people, dislocated people, unemployed/ underemployed	Virtual Care PFA Training	Executed
12	Cornerstone Crossroads Academy	75215	CCA's mission is to develop urban youth through education. They are a certified secondary/high school, and host youth development program. Their primary target are older students who need a 2nd change to earn a high school diploma or returning students. Many of CCA's students are transient. Tuition is free to students, and in lieu of tuition, students participate in community service opportunities. In addition to curriculum, students also meet 1:1 with a life coach weekly to identify areas of concern: social, emotional, and physical support for students who are on the verge or already homeless/in crisis. CCA has purchased The Phyllis Wheatley School, and plans to expand their services at its new location in the coming years. CCA also provides their community access to healthy foods by partnering with Crossroads Community Services.	• Ethnic/racial minorities • Ages 16+	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care	Negotiation Phase/Outlining Agreement
13	Voice of Hope	Physically located in 75212, but draws a large crowd from 75211	Voice of Hope is a non-profit seeking to provide character building, education support, life skills, and family support services to their clients. They work to equip families with resources and skills needed to overcome and break the poverty cycle. Youth programs include: ASPIRE after school program (homework help & a meal), Summer Day Camps, Kids Across America. Family and Community support programs include: Food Pantry as a community distribution partner with Crossroads Community Services, Fruits and Vegetables Outreach (with Hardies), holiday outreach, neighborhood watch groups, and activities for senior citizens including bible studies and knitting groups. Voice of Hope also partners with NTFB, DISD, World Vision, YMCA, Young Life, Mercy Street Dallas, and the West Dallas Initiative.	• All ages with a focus on school aged children and senior citizens	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care	Negotiation Phase/Outlining Agreement

COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION:

Hypertension

Parkland
Care. Compassion. Community.

TABLE OF CONTENTS

COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION

Hypertension

A. PROBLEM STATEMENT

Heart disease is the leading cause of death in Dallas County with African Americans suffering from particularly high mortality rates related to the condition

B. STRATEGY

Establish a high blood pressure program that adheres to the State of Texas public strategies for addressing heart disease and stroke (2019-2023). The program will focus on patients residing in ZIP Codes 75210, 75211, 75215, 75216, 75217, 75241. In addition, the program will have a particular focus on African Americans as they have a significantly higher mortality rate related to hypertension than other race/ethnicities.

C. METRICS

1. Number of patients from the targeted population screened for high blood pressure and follow-up documentation.

2. Percentage of patients from the targeted population whose blood pressure at the most recent visit is adequately controlled.

3. Percentage of patients with diabetes from the targeted population whose blood pressure at the most recent visit is adequately controlled.

D. BUDGET (as of August 31, 2020)

Hypertension Financial Summary

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Gross Revenue	$0	$0	$0	$0	$0	$0
Deductions from Revenue	-	-	-	-	-	-
Net Revenue	-	-	-	-	-	-
Expenses						
Salaries	66,831	68,836	70,901	73,028	75,218	**354,813**
Benefits	14,435	14,868	15,315	15,774	16,247	**76,640**
Drugs	-	-	-	-	-	**-**
Med/Surg Supplies-Baxter (10 arm cuffs & 3 wrist cuff)	850	-	-	-	-	**850**
Marketing	19,200	-	9,600	9,600	9,600	**48,000**
Educational Materials	3,275	3,275	3,275	3,275	3,275	**16,375**
IT Equipment (2 Laptops, 3 iPads)	5,460	-	-	-	-	**5,460**
Miscellaneous Supplies	2,400	2,400	2,400	2,400	2,400	**12,000**
Total Expenses	112,451	89,379	101,490	104,077	106,741	**514,137**
Net Income	(112,451)	(89,379)	(101,490)	(104,077)	(106,741)	**(514,137)**
Indirect Expense Allocation (21.7% of Total Expenses)	-	-	-	-	-	-
Net Income after Indirect Expenses	**$(112,451)**	**$(89,379)**	**$(101,490)**	**$(104,077)**	**$(106,741)**	**$(514,137)**
Capital	-	-	-	-	-	-
Total	**$(112,451)**	**$(89,379)**	**$(101,490)**	**$(104,077)**	**$(106,741)**	**$(514,137)**
FTEs	**0.80**	**0.80**	**0.80**	**0.80**	**0.80**	**0.80**
Total Direct Expenses	**112,451**	**89,379**	**101,490**	**104,077**	**106,741**	**514,137**

E. STAFFING (Year 1 FTEs approved as of 8/31/2020)

#	FTE Description	Scope of Service	FTEs # by Year 1
1	**Nurse Navigator**	The overall scope of services of this position is: • Conducting comprehensive assessment of patient at the time of screening. • Provide guidance to patients who are identified through the screening events on questions regarding their blood pressure follow-up. • Determining financial and medical status by reviewing patient's diagnosis, recommended treatment, funding sources and special needs according to Parkland policies and procedures. • Referring unfunded patients to PFS team for financial counseling. • Regularly communicating with patients and their providers regarding plan of care (Parkland and outside). • Ensuring patients are seen in the appropriate time according to the initial blood pressure. • Provide on-site education to patient regarding their diagnosis and treatment plan.	0.5
2	**Clinical Educator**	• To assure that education materials are available and appropriate for the patients. • Assist CHW in deploying education and literacy programs in the community.	0.3
	Total FTEs		**0.8**

F. INTERVENTION DEPLOYMENT

Goal 1: Increase the number of patients from the targeted population screened for high blood pressure and follow-up documentation (2020: 2,838, 2021: 3,265 and 2022: 3,998)						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
1	Patient Identification	Community Screening Access to Care visits PCP visits	Complete blood screenings to identify patients with high blood pressure according to the following guidelines: • Normal: <120/80 • Stage 1: Systolic 130 to 139 mmHg or diastolic 90 to 99 mmHg • State 2a: Systolic 140 to 159 mmHg or diastolic 90 to 99 mmHg • Stage 2b: Systolic at least 160-179 mmHg or diastolic at least 100-110 mmHg Complete insurance coverage verification or referral to PFA	• CHW • Registered Nurse • PCP • PFA	# of patients screened # of PFA enrollments # of patients referred to Parkland PCP # of patients sent to ED # of SDOH Assessments	**Screenings** 2020: 2,838 2021: 3,265 2022: 3,998 **Complete insurance coverage verification** 2020: 2,838 2021: 3,265 2022: 3,998 **PFA Referral** 2020: 539 2021: 620 2022: 770
2	Normal BP	Real time	Provide Healthy Living education to the patient which highlights the following:[1] • **Eat Healthy Foods:** Emphasis on low sodium and saturated fat diet • **Move More:** Promotes physical activity 30 minutes a day, 5 days a week • **Aim for a Healthy Weight:** Promotes losing 3 to 5 percent of body weight to improve blood pressure. • **Manage Stress** Tips to improve stress management • **Tobacco Cessation** Promotes tobacco cessation No follow-up required when the reading is <120/80 mmHg *1 Based on National Heart, Lung and Blood Institute guidelines https://www.nhlbi.nih.gov/health-topics/education-and-awareness/high-blood-pressure*	• CHW • Clinical Educator	# of patients educated	**Screening for Normal BP** 2020: 1,286 2021: 1,796 2022: 2,199
3	Document Referral for Stage 1	At time of screening	Document referral for 6 months from screening as follows: Parkland patient or patient without a PCP refer to Parkland PCP for follow-up via: • Group visit • Nurse led visit • Education in Healthy Living When a patient has a PCP external to Parkland, he or she is advised to follow-up with PCP in 6 months	• CHW • Nurse Navigator	# of documented referral for Stage 1 to Parkland PCP # of patients without a PCP # of patients with external PCP	**Uncontrolled Hypertension[2]** 2020: 1,052 2021: 1,469 2022: 1,469

[1]Assumption: 19% of Dallas County population is uninsured as noted in the Community Health Needs Assessment
[2] 45% U.S. adult population has hypertension. CDC https://www.cdc.gov/bloodpressure/facts.htm

Goal 1: Increase the number of patients from the targeted population screened for high blood pressure and follow-up documentation (2020: 2,838, 2021: 3,265 and 2022: 3,998)						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
4	Stage 2a	At the time of screening	Document referral for 2 to 3 months from screening as follows: If Parkland patient clinic visit or virtual visit with PCP/APP Visit External PCP: Recommended to follow-up in 2-3 months for the same	• Nurse Navigator • CHW	# of documented referrals for Stage 2a to Parkland PCP # of patients without a PCP # of patients with external PCP	**TBD**
5	Follow-up patients' stage 2a without PCP	At the time of screening	Document follow-up scheduling 2-3 weeks post screening as follows: • Recheck BP and confirm if patient is taking any medication • Schedule clinical visit or virtual visit with MD or APP in 2-3 months	• Nurse Navigator • CHW	# of BP rechecked documented	**TBD**
6	Stage 2b Parkland PCP	At the time of screening	Document follow-up for referral within 4-6 weeks post screening as follows: • Schedule a clinic visit or virtual visit with PCP/APP • If External PCP: Recommend patients follow-up in no later than 2 weeks • If without a PCP: Advise to schedule clinic visit or virtual visit with PCP/APP in 4-6 weeks	• Nurse Navigator • CHW	# of documented referral for Stage 2b to Parkland PCP # of patients without a PCP # of patients with external PCP	**Stage 2b**[3] 2020: 473 2021: 661 2022: 809
7	Stage 3	At the time of screening	Document referral to ED or Urgent Care and send patient to Urgent Care or Emergency Department	• RN	# of patients sent to ED	**Screening for Stage 3 BP** TBD

[3] 45% of U.S population with uncontrolled hypertension has stage 2b.

Goal 2: Increase Percentage of patients from the targeted population whose blood pressure at the most recent visit is adequately controlled from 49.01% to 58% by 2022

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact
1	Control patients in Stage 1	6 months from screening	Conduct clinic visit according to guidelines and provide the patient with the following: • Group visit or Nurse led visit • Education in Healthy Living Schedule follow-up visit according to patients' clinical assessment	• MD/APP • Nurse Navigator	# of established Parkland patients follow-up visits completed # of group visits # of Nurse led visits # of patients educated	**Screening for Stage 1 BP** 2020: 1,277 2021: 1,469 2022: 1,469
2	Control patients in Stage 2a	2 to 3 months from screening	If Parkland PCP: Conduct clinic visit or virtual visit with PCP/APP as per guidelines and • Monitor existing medications • Conduct lab tests including but not limited to • Serum Potassium • Serum Sodium • BUN • Creatinine with eGFR Schedule follow-up visit according to patients' clinical assessment Patients are educated on hypertension relevant topics such as: • Maintaining healthy weight • Eat healthy diet with low sodium • Increasing physical fitness • Ways to manage stress • Limiting alcohol • Smoking cessation • Take medications properly • Working with healthcare team	• RN • MD/APP • CHW	# of established Parkland patients' follow-up visits completed # of patients educated	**Screening for Stage 2a BP** 2020: 1,277 2021: 1,469 2022: 1,469
	Follow-up patients' stage 2a without PCP	2-3 weeks post screening	Contact patient to confirm whether BP was rechecked and if appointment is needed	• RN	# of follow-up call # of appointments scheduled	TBD
3	Follow-up patients' stage 2a without PCP	4-6 weeks post screening	Conduct clinic visit or virtual visit with PCP/APP as per guidelines and • Monitor existing medications • Conduct lab tests including but not limited to • Serum Potassium • Serum Sodium • BUN • Creatinine with eGFR Schedule follow-up visit according to patients' clinical assessment Patients are educated on hypertension relevant topics such as: • Maintaining healthy weight • Eat healthy diet with low sodium • Increasing physical fitness • Ways to manage stress • Limiting alcohol • Smoking cessation • Take medications properly • Working with healthcare team	• RN • MD/APP • CHW	# of established Parkland patients' follow-up visits completed # of patients educated	**Screening for Stage 2b BP** 2020: 1,277 2021: 1,469 2022: 1,469

Goal 3: Increase the percentage of patients with diabetes from the targeted population whose blood pressure at the most recent visit is adequately controlled from 50.08% to 63%

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact
1	Control patients in Stage 1 with Diabetes	6 months from screening	Conduct clinic visit* according to guidelines and provide the patient with the following: • Group visit or Nurse led visit • Education in Healthy Living Schedule follow-up visit according to patients' clinical assessment **See Diabetes intervention under Diabetes Program Description document*	• MD/APP • Nurse Navigator	# of established Parkland patients follow-up visits complete # of group visits # of Nurse led visits # of patients educated	**Patient with Hypertension and Diabetes** 2021:105 2020: 147 2022: 179

2	Control patients in Stage 2a with Diabetes	2 to 3 months from screening	If Parkland PCP:
			Conduct clinic visit or virtual visit with PCP/APP as per guidelines* and
			• Monitor existing medications
			• Conduct lab tests including but not limited to
			  • Serum Potassium
			  • Serum Sodium
			  • BUN
			  • Creatinine with eGFR
			  • HbA1C
			  • Microalbuminuria
			• Schedule follow-up visit according to patients' clinical assessment
			• Patients are educated on hypertension relevant topics such as:
			  • Maintaining healthy weight
			  • Eat healthy diet with low sodium
			  • Increasing physical fitness
			  • Ways to manage stress
			  • Limiting alcohol
			  • Smoking cessation
			  • Take medications properly
			  • Working with healthcare team
			**See Diabetes intervention under Diabetes Program Description document*
				• RN
				• MD/APP
				• CHW
					# of established Parkland patients' follow-up visits completed
					# of patients educated
						TBD

3	Follow-up patients' stage 2a with Diabetes and without PCP	2-3 weeks post screening	Contact patient to confirm whether BP was rechecked and if appointment is needed* **See Diabetes intervention under Diabetes Program Description document*	• RN	# of follow-up call # of appointments scheduled	TBD

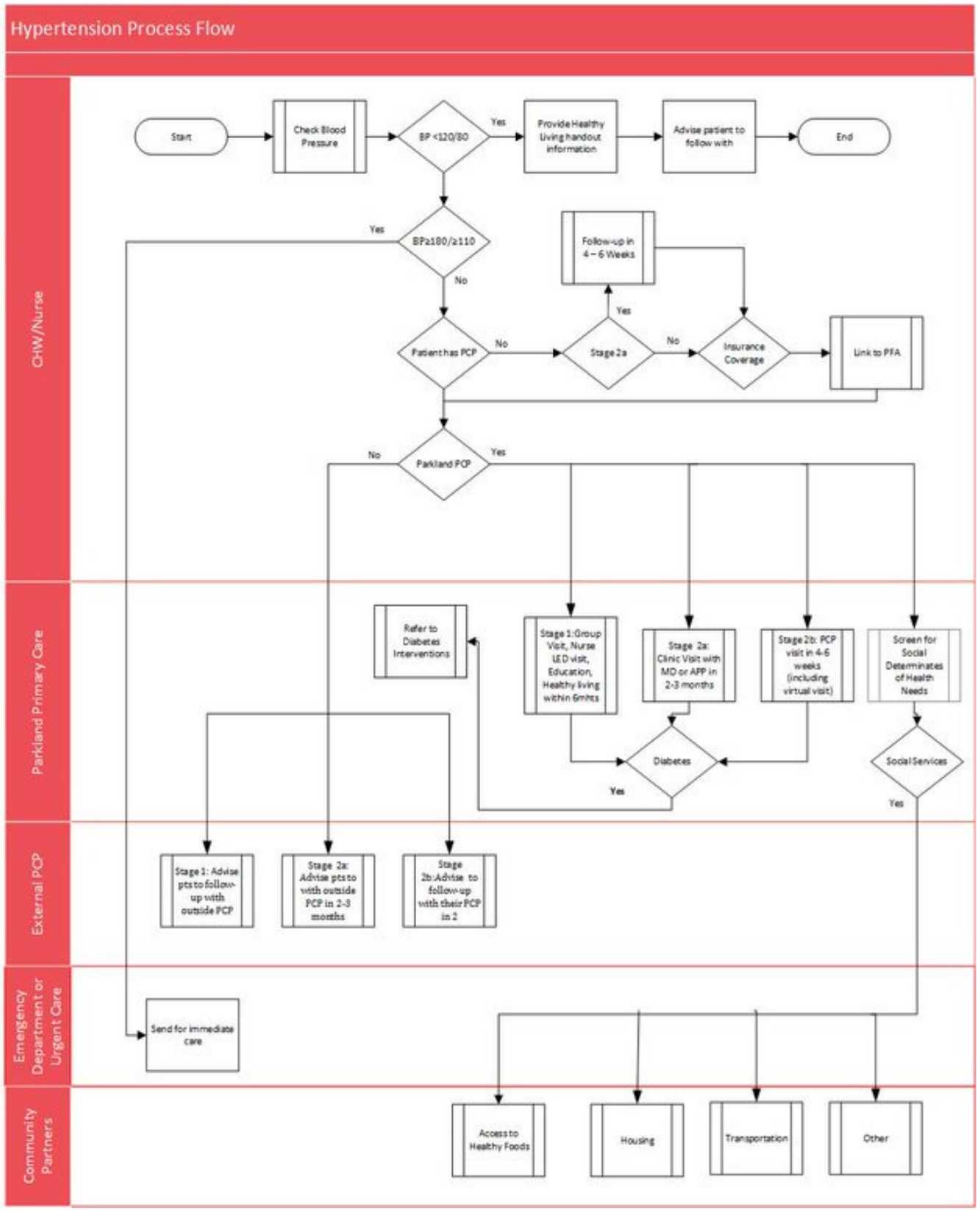
[1] Assuming 80% retention rate for the full year.

Goal 3: Increase the percentage of patients with diabetes from the targeted population whose blood pressure at the most recent visit is adequately controlled from 50.08% to 63%

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact

4	Control established Parkland patients in Stage 2b with Diabetes	4-6 weeks post screening	Conduct clinic visit or virtual visit with PCP/APP as per guidelines* and
			• Monitor existing medications
			• Conduct lab tests including but not limited to
			  • Serum Potassium
			  • Serum Sodium
			  • BUN
			  • Creatinine with eGFR
			  • HbA1C
			  • Microalbuminuria
			Schedule follow-up visit according to patients' clinical assessment
			Patients are educated on Hypertension relevant topics such as:
			  • Maintaining healthy weight
			  • Eat healthy diet with low sodium
			  • Increasing physical fitness
			  • Ways to manage stress
			  • Limiting alcohol
			  • Smoking cessation
			  • Take medications properly
			  • Working with healthcare team
			**See Diabetes intervention under Diabetes Program Description document*
				• RN
				• MD/APP
				• CHW
					# of established Parkland patients' follow-up visits completed
					# of patients educated
						TBD

G. SERVICE DELIVERY PROCESS FLOW



H. PARTNERSHIPS

#	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
1	**Inspired Vision Compassion Center**	75217	IVCC is a non-profit that provides access to basic needs in a grocery store format to residents of Dallas in need. Services provided include: food, clothing, furniture, personal hygiene, animal supplies, emergency baby items, medical/first aid supplies, school supplies, etc. Each spring – they host a "Free Prom Store."	• All ages • Providing groceries for 1,400 – 1,900 families/day/5 days a week • Majority Hispanic population • No ZIP Code restrictions/no ID restrictions	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care	Negotiation Phase/Outlining Agreement
2	**City of Dallas – Parks & Recreation: Larry Johnson**	75210	Recreation center features include: fitness center, gymnasium, kitchen, large meeting room, outdoor basketball court, parking, playground, small meeting room, youth programs, afterschool and summer camps, active adult and senior programs, adult sports programs.	• Heavy senior concentration • 50-60 individuals daily (pre-COVID-19)	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services	Negotiation Phase/Outlining Agreement
3	**City of Dallas – Parks & Recreation: John C. Phelps**	75216	Recreation center features include: baseball field, fitness center, gymnasium, kitchen, large meeting room, outdoor basketball court, parking, playground, small meeting room, tennis court, walking trails, picnic area, youth dance instruction and cheerleading, after school programs, senior activities, and adult fitness classes.	• Larger senior population	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services	Negotiation Phase/Outlining Agreement
4	**City of Dallas – Parks & Recreation: Janie C. Turner**	75217	Recreation center features include: baseball field, fitness center, gymnasium, kitchen, large meeting room, outdoor basketball court, parking, small meeting room, tennis court, youth cheerleading & dance instruction, after school programs, adult fitness classes, senior activities, computer room, and popular boxing program for kids in partnership with DPD.	• All ages	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care	Negotiation Phase/Outlining Agreement
5	**Community Council of Greater Dallas**	HQ: 75247, however serves all of Dallas County and immediate areas	Community action agency/social services organization focusing on poverty alleviation – increasing awareness and access to services. Current programs include: 1. serving seniors with benefits counseling, nutritional services, care coordination, caregiver support & advocacy, meals, transportation and other senior assistance 2. Coordinating with a network of 1,000 agencies to deliver programs/services to low-income residents – removing barriers to employment and transitioning people out of poverty by providing job training, education, and wrap around services 3. 2-1-1- hotline information and referrals – fielding calls for meals, transportation, and assistance for aging, elderly, senior citizens and people with disabilities.	• Aging, elderly, senior citizens • Low-income • People with disabilities	PFA Training	Negotiation Phase/Outlining Agreement

#	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
6	**Dallas Housing Authority (DHA)**	Various; starting with 75212	DHA provides quality, affordable housing to low-income families and individuals through administration of housing assistance programs across North Texas. DHA is interested in providing access to supportive resources for families – creating housing solutions in healthy, inclusive communities that offer economic, educational and social growth opportunities.	• 46% of clients are seniors or persons with disabilities • Average annual income: $14,000 • 83% female head of households • 86% African American • Average age: 49 • Serving ~55,000 individuals across 4,903 rental housing units	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care PFA Training	Negotiation Phase/Outlining Agreement
7	**Los Barrios Unidos Community Clinic**	75211, 75212	Los Barrios operates a community health clinic in a high need area – known for having quality bilingual staff in English and Spanish. They do not turn away anyone for inability to pay, and accepts Medicaid, CHIP, Medicare, private insurance, offers a sliding fee scale based on federal poverty level guidelines. The clinic is a federally qualified health center that provides comprehensive primary care services to prevent illness and promote health.	• Economically disadvantages, low-income, and poor populations, minorities • ~87,000+ annual patient visits	PFA Training	Negotiation Phase/Outlining Agreement
8	**Healing Hands Ministries**	75243, 75231	Healing Hands operates 7 clinics including a patient-centered community health center. It can serve as a permanent medical home for uninsured, underinsured, and has a goal to teach refugees how to care for their children. They also provide shared medical appointments where groups of 10-12 people are educated in a group setting allowing for peer discussion and support. They have 3 translators on staff and employ a language line.	• 20,000+ individual patients annually who speak 68 different languages • 61,000+ patient visits annually • Children and families • 67% of patients are women	PFA Training	Negotiation Phase/Outlining Agreement
9	**Foremost Family Health Center**	75215, 75180	Foremost is a federally qualified health center offering access to affordable and comprehensive medical, dental and behavioral health services, regardless of ability to pay.	• ~6,161 patients	PFA Training	Negotiation Phase/Outlining Agreement
10	**Crossroads Community Services**	HQ: 75236, however serves Dallas, Ellis, and Navarro counties	Crossroads provides nutritious food and supportive education to low-income families and individuals. They have a main hub that serves as a food pantry and has partnered with 1200+ community distribution partners (CDPs) to expand their food assistance reach. Crossroads is also committed to meeting individuals' basic needs and works with local partners to improve economic and health outcomes for their clients (UTSW, NTFB, Sharing Life Community Outreach, Parkland through BUILD Health Challenge project, DCHHS, University of Dallas)	• ~75,000 people including 26,500 children • Distributes ~9 million pounds of groceries annually • Low-income/economically disadvantaged people, homeless, unemployed/underemployed	Virtual Care PFA Training	Executed

#	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
11	**Cornerstone Crossroads Academy**	75215	CCA's mission is to develop urban youth through education. They are a certified secondary/high school and host youth development program. Their primary target is older students who need a 2nd chance to earn a high school diploma or returning students. Many of CCA's students are transient. Tuition is free to students, and in lieu of tuition, students participate in community service opportunities. In addition to curriculum, students also meet 1:1 weekly with a life coach to identify areas of concern: social, emotional and physical support for students who are on the verge or already homeless/in crisis. CCA has purchased The Phyllis Wheatley School and plans to expand services at its new location in the coming years. CCA also provides community access to healthy foods by partnering with Crossroads Community Services.	• Ethnic/racial minorities • Ages 16+	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care	Negotiation Phase/Outlining Agreement
12	**Voice of Hope**	Physically located in 75212, but draws a large crowd from 75211	Voice of Hope is a non-profit seeking to provide character building, education support, life skills and family support services to their clients. They work to equip families with resources and skills needed to overcome and break the poverty cycle. Youth programs include: ASPIRE after school program (homework help & a meal), Summer Day Camps, Kids Across America. Family and community support programs include: Food Pantry as a community distribution partner with Crossroads Community Services, Fruits and Vegetables Outreach (with Hardies), holiday outreach, neighborhood watch groups, and activities for senior citizens including Bible studies and knitting groups. Voice of Hope also partners with NTFB, DISD, World Vision, YMCA, Young Life, Mercy Street Dallas and the West Dallas Initiative.	• All ages with a focus on school aged children and senior citizens	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care	Negotiation Phase/Outlining Agreement

COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION:

Sexually Transmitted Diseases

Parkland
Care. Compassion. Community.

TABLE OF CONTENTS

COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION

Sexually Transmitted Diseases

A. PROBLEM STATEMENT

Over the past 10 years the rate of sexually transmitted infections has increased and 800 people are newly diagnosed with HIV every year.

B. STRATEGY

Parkland will partner with DCHHS, which is leading the effort to reduce the transmission rate of sexually transmitted diseases. DCHHS' 90-90-90 program aims to have 90% of the population with HIV aware of their condition, 90% on treatment and 90% virally suppressed by the year 2030.

C. METRICS

1. Percentage of patients from the targeted population who were tested for chlamydia

2. Number of patients with chlamydia from the targeted population who offered expedited partner treatment

3. Number of patients from the targeted population who were tested for HIV

4. Percentage of inmates from the targeted population who were tested for HIV

5. Percentage of patients from the targeted population who tested positive for HIV and were prescribed treatment within 30 days from test

6. Percentage of HIV positive patients from the targeted population with a viral load less than 200/copies ml

CHNA ZIP codes: 75210, 75211, 75215, 75216, 75217, 75241, 75201, 75207, 75247

D. BUDGET (as of August 31, 2020)

STIs Financial Summary

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Gross Revenue	$2,773,840	$5,658,634	$7,009,706	$9,354,998	$11,927,623	**$36,724,802**
Deductions from Revenue	406,016	828,273	185,848	145,832	185,936	**1,751,905**
Net Revenue	2,367,824	4,830,361	6,823,858	9,209,166	11,741,687	**34,972,897**
Expenses						
Salaries	439,675	522,114	610,290	628,598	647,456	**$2,848,133**
Benefits	94,970	112,777	131,823	135,777	139,851	**$615,197**
Drugs	1,584,597	1,681,718	1,781,914	1,886,158	1,995,165	**$8,929,551**
Med/Surg Supplies	-	-	-	-	-	**$0**
Monitoring Labs - Prep	58,600	117,200	175,800	234,400	293,000	**$879,000**
Test Chlamydia cost $11 per screen	352,000	407,000	495,000	495,000	495,000	**$2,244,000**
HIV Screenings - ED, OPC and Community Fairs (Volumes FY21- 24,650, FY22 29,580, FY23 34,510, then 10% increase p/year)	121,906	146,897	171,888	189,838	209,431	**$839,960**
Correctional Health - HIV Ag/Ab with Reflex Labs	74,800	99,840	109,824	120,806	132,887	**$538,157**
Correctional Health - Chlamydia/GC Amplifications Labs	168,500	185,350	203,885	224,274	246,701	**$1,028,710**
Marketing (Survey)	6,000	6,000	6,000	6,000	6,000	**$30,000**
IT Cost - PREP Model (PCCI) and STI Dashboard build cost, included in the CHNA IT Cost	-	-	-	-	-	**$0**
Miscellaneous Supplies	2,200	2,400	2,400	2,400	2,400	**$11,800**
Total Expenses	**2,903,248**	**3,281,295**	**3,688,822**	**3,923,252**	**4,167,891**	**17,964,508**
Net Income	(535,424)	1,549,066	3,135,036	5,285,915	7,573,796	**17,008,389**
Indirect Expense Allocation	-	-	-	-	-	**-**
Net Income after Indirect Expenses	**$ (535,424)**	**$ 1,549,066**	**$ 3,135,036**	**$ 5,285,915**	**$ 7,573,796**	**$ 17,008,389**
Capital	**-**	**-**	**-**	**-**	**-**	**-**
Total	**$ (535,424)**	**$ 1,549,066**	**$ 3,135,036**	**$ 5,285,915**	**$ 7,573,796**	**$ 17,008,389**
FTEs	**7.00**	**9.00**	**11.00**	**11.00**	**11.00**	**9.80**
Total Direct Expenses	**$ 2,903,248**	**$ 3,281,295**	**$ 3,688,822**	**$ 3,923,252**	**$ 4,167,891**	**$ 17,964,508**

E. STAFFING (Year 1 FTEs approved as of 7/21/2020)

#	FTE Description	Scope of Service	FTEs # by Year 1	FTEs # by Year 2
1	**Comprehensive Care Coordinator**	• Assist, educate and guide patients with positive STI and those receiving PrEP, ensuring they are aware and informed of Parkland and community service programs to treat and support patients, partners and their families. • Conduct comprehensive assessment of patient in person, by telephone or by review of medical records. • Gather information from patient records and consult clinical team for treatment recommendations. • Determine financial and medical status by reviewing patient's diagnosis, treatment plan, funding sources and special needs according to PHHS policies and procedures. Orders STI screenings under Parkland approved protocols and connects patients and partners to appropriate providers for treatment. • Develop patient plan of care and communicates the plan to patients and their families when authorized by the patient. • Oversees implementation of plan of care, ensures scheduling of appointments and provides relevant clinical information to other members of the treatment team to ensure quality and continuity of patient care. • Educate the patient on their diagnosis, treatment plan, referral process, clinic criteria, authorization process, payor/plan coverage, funding sources and community resources available to the patient. • Serve as a patient advocate, focusing on patients' needs, rights, confidentiality and cultural preferences. • Serve as a resource person for specific clinical and patient care issues, negotiates desirable patient outcomes. Serves as a liaison between provider and patient/family to facilitate communication and services. In addition will serve as liaison on for newly released correctional health patients by coordinating with correctional health navigators.	2.0	2.0
2	**Advance Practice Practitioner I (APP I)**	• Serve as the primary care provider, overseeing and coordinating the medical, diagnostic and medication needs of the patients. Most of the work would be virtual with 1 day in clinic. • Order sexually transmitted infection screenings in high risk individuals, initiate PrEP (Pre-Exposure Prophylaxis) and manage a panel of PrEP patients. • Facilitate treatment for patients and partners for sexually transmitted infections. • Participate in community health outreach events related to sexual health and educating populations adverse social determinants of health. • Utilize and monitor patient dashboards for outreach and assurance that organizational metrics are met.	1.0	1.0

3	**Phlebotomy Technician**	• Responsible for collection of routine blood samples by venipuncture or capillary techniques on patients of all age groups. Labels specimens accurately and completely using two patient identifiers at all times. • Order, collect, log-in requested tests in Laboratory Information Systems (LIS) and verifies sample receipt time. Labels samples with bar code label to ensure that all information on the sample matches that on the bar code • Receive specimens, assess specimen integrity, verify labeling and would provide documentation and processing data entry of orders to ensure that patients are appropriately billed. • May perform waived and non-waived point-of-care tests under technical supervision. Reports results in LIS and notifies practitioners of test results as required by laboratory protocol. May perform centrifugation and prepare aliquot tubes as needed. Delivers samples to performing instrument and other labs. Processes specimens for research, reference testing and orders add-ons as needed. • They will identify ways to improve work processes and improve customer satisfaction. Makes recommendations to supervisor, implements, and monitors results as appropriate in support of the overall goals of the department and Parkland. • They will maintain knowledge of applicable rules, regulations, policies, laws, and guidelines that impact the Laboratory area. Develops effective internal controls that promote adherence to applicable state/federal laws, and the program requirements of accreditation agencies and federal, state, and private health plans. Seeks advice and guidance as necessary to ensure proper understanding. • Assist in training students and new employees as assigned. • Stay abreast of the latest developments, advancements, and trends in the field of phlebotomy by attending in services and reading professional journals. Integrates knowledge gained into current work practices. • Accurately document tasks associated with assigned work area. Documentation may include but is not limited to productivity logs, patient test logs, quality control records and reporting in other computer systems as needed.	4.0	6.0
Total FTEs			**7.0**	**9.0**

F. INTERVENTION DEPLOYMENT

Goal 1: Percentage of patients from the targeted population who were tested for chlamydia by 2022 (2020: 58.98%, 2021: 68.98%, 2022: 83.98%)						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
1	Identification of CHNA eligible patients	Annually for sexually active patients 16-34 y/o	• Identified patients via an electronic medical record dashboard or by best practice alert if being seen in clinical setting	CHW Care Coordinator APP	# of patients identified	**Identified for testing (CHNA)** 2020: 12,500 2021: 12,500 2022: 12,500 **Identified for Testing (Dallas County)** 2020: 54,000 patients 2021: 54,000 patients 2022: 54,000 patients
2	Order and collect urine for GC/CT screenings	Annually	• Order tests for eligible patients and notified to provide collection	Physician APP Medical Assistant Registered Nurse Care Coordinator	# of patients screened	**GC/CT Screens** 2020: 55,000 GC/CT tests 2021: 63,000 GC/CT tests 2020: 65,500 GC/CT tests
3	STI educational materials given	At time of GC/CT test	• Provided health literacy and culturally appropriate educational materials with information on safe sex practices	Physician APP Medical Assistant Registered Nurse Care Coordinator	# of patients given education as measured by number of screenings performed	**GC/CT Screens** 2020: 55,000 GC/CT tests 2021: 63,000 GC/CT tests 2020: 65,500 GC/CT tests
4	Community resources for SDOH provided	At time of GC/CT test	• Determine SDOH and depending on needs patients provided resources specific to their needs	Care Coordinator Social Worker	# of patients given resources as measured by number of screenings performed	**GC/CT Screens** 2020: 55,000 GC/CT tests 2021: 63,000 GC/CT tests 2020: 65,500 GC/CT tests
5	PrEP Eligibility Screening	GC or CT (+) results AND HIV (-)	• PrEP acceptance and eligibility performed through questionnaire	APP Care Coordinator	# of patients screened as measured by number of GC/CT (+)	**GC/CT (+) Tests** 2020: 1,300/3,100 tests 2021: 1,500/3,700 tests 2022: 1,600/3,700 tests

Goal 2: Number of patients with chlamydia from the targeted population who offered expedited partner treatment by 2022 (2020: 34, 2021: 64, 2022: 158)

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact
1	Provide treatment for GC/CT (+) tests	At time of GC/CT (+) result	• Provide patients tested positive with directly observed therapy OR virtual appointment • Provide prescription for treatment	• Physician • APP • Care Coordinator	# of patients tested (+) GC/CT	**CT (+) Tests (CHNA)** 2020: 700 tests 2021: 700 tests 2022: 700 tests **GC/CT (+) Tests (Dallas County)** 2020: 1,300/3,100 tests 2021: 1,500/3,700 tests 2022: 1,600/3,700 tests
2	Expedited Partner Treatment (EPT) for partners for CT (+)	At time of CT (+) result	• Provide patient before they leave with either a prescription for treatment OR with the medication in hand for their partner(s) to be treated.	• Physician • APP	# of patients (+) CT offered EPT # of patients with 12m reinfection	**CT (+) offered EPT** 2020: 1,100 prescriptions 2021: 1,300 prescriptions 2022: 1,530 prescriptions **GC/CT 12m reinfections**** 2020: 600 patients 2021: 500 patients 2022: 400 patients
3	Provide information and treatment coordination for partner treatment for GC (+)	At time of GC (+) result	• Provide education on where partners can get treated with the injection needed to treat gonorrhea.	• Physician • APP • Registered Nurse • Care Coordinator	# of patients with GC (+) # of patients with 12m reinfection	**GC/CT (+) Tests** 2020: 1,300 tests 2021: 1,500 tests 2022: 1,600 tests **GC/CT 12m reinfections**** 2020: 300 patients 2021: 250 patients 2022: 400 patients
4	Educational materials given	At time of GC/CT (+) result	• Provide health literacy and culturally appropriate educational materials with information on safe sex practices	• Physician • APP • Medical Assistant • Registered Nurse • Care Coordinator	# of patients given resources as measured by positive tests	**GC/CT (+) Tests** 2020: 1,300/3,100 tests 2021: 1,500/3,700 tests 2022: 1,600/3,700 tests

Goal 2: Number of patients with chlamydia from the targeted population who offered expedited partner treatment by 2022 (2020: 34, 2021: 64, 2022: 158)						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
5	Community resources for SDOH provided	At time of GC/CT (+) result	• Determine SDOH and depending on needs patients are provided resources specific to their needs.	• Care Coordinator • Registered Nurse • Social Worker	# of patients given resources as measured by positive tests	**GC/CT (+) Tests** 2020: 1,300/3,100 tests 2021: 1,500/3,700 tests 2022: 1,600/3,700 tests
6	PrEP Eligibility Screening	GC or CT (+) results	• PrEP acceptance and eligibility performed through questionnaire	• APP • Care Coordinator	# of patients screened as measured by positive tests	**GC/CT (+) Tests** 2020: 1,300/3,100 tests 2021: 1,500/3,700 tests 2022: 1,600/3,700 tests
7	PrEP Treatment Initiation and Monitoring	Eligible on PrEP Screening and HIV (-)	• Baseline and follow up lab order • Monitor every 3 months • Provide education	• APP • Care Coordinator	# of patients initiated on PrEP # of monitored telehealth visits	**PrEP Initiation** 2020: 30 patients 2021: 200 patients 2022: 300 patients **Telehealth Visits** 2020: 120 visits 2021: 800 visits 2022: 1200 visits
8	Financial Assistance for PrEP therapy	At time of PrEP initial visit	• Evaluate medications for financial assistance	• Medication Access Specialist	# of 90-day prescription fills	**PrEP prescriptions** 2020: 120 fills 2021: 800 fills 2022: 1,200 fills

[3] 45% of U.S population with uncontrolled hypertension has stage 2b.

Goal 3: Number of patients from the targeted population who were tested for HIV by 2022 (2020: 24,650, 2021: 29,580, 2022: 34,510)						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
1	Identification of eligible patients seen in Emergency Department and Community Clinics or at community fairs	Annually for anyone ages 13-64 y/o	• Order, draw blood or POC (RAPID) HIV testing	• Test Counselor • Phlebotomy Tech • CHW • APP • Comprehensive Care Coordinator • Social Worker	# of patients tested for HIV	**Patient Tested for HIV** 2020: 24,650 2021: 29,580 2022: 34,510
2	Community resources for SDOH provided	At time of diagnosis	• Provide community resources for SDOH	• CHW • Social Worker • DSHS Nurse • Navigator	# of patients given resources as measured by HIV reactive	**Patient tested HIV (+) referred to community resources** 2020: 300 2021: 325 2022: 350
3	HIV results notification	By end of next business day	• Schedule appointments and notify patients of appointment and information on HIV services	• Test Counselor • Phlebotomy Tech • CHW • APP • Comprehensive Care Coordinator • Social Worker	# of patients who tested HIV (+) # of patients who are HIV(+) and received notifications	**Patient tested HIV (+)** 2020: 300 2021: 325 2022: 350 **HIV (+) Notification** 2020: 300 2021: 325 2022: 350
4	Referral to financial services	HIV (+) results	• Coordination of care for financial services and current eligibility documentation	• Social Worker • Nurse Navigator • CHW	# of patients referred to financial services as measured by HIV (+) notifications	**HIV (+) Referred to financial** services 2020: 300 2021: 325 2022: 350
5	Additional STI screens	At time of HIV (+) initial medical visit	• Notify patients of additional testing	• Test Counselor • Phlebotomy Tech • CHW • APP • Comprehensive Care Coordinator • Social Worker	# of HIV (+) notifications for additional tests	**HIV (+) Notified for Additional Tests** 2020: 300 2021: 325 2022: 350

Goal 3: Number of patients from the targeted population who were tested for HIV by 2022 (2020: 24,650, 2021: 29,580, 2022: 34,510)						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
6	PrEP Eligibility Screening	At time of HIV Screening	• Screen patients who has 2 or more STIs per year and have been measured by HIV (-) results	• Test Counselor • Phlebotomy Tech • APP • Comprehensive Care Coordinator • Social Worker	# of patients screened for PrEP eligibility	**Patients screened for PrEP eligibility** 2020: 500 2021: 1000 2022: 1500
7	Health Literacy	At time of HIV outpatient and community screening	• PrEP Education	• Test Counselor • Comprehensive Care Coordinator	# of patients given PrEP education as measured by HIV tested outpatient and community	**PrEP Education Provided** 2020: 1500 2021: 4000 2022: 6000
8	Link to Care	If eligible for PrEP from PrEP screening	• Referral to care coordinator	• Test Counselor • APP • Comprehensive Care Coordinator • Social Worker	# of PrEP patients referred	**PrEP Referrals** 2020: 30 2021: 200 2022: 300

Goal 4: Percentage of inmates from the targeted population who were tested for HIV from 12.79% to 45.38% by 2022

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact
1	POC HIV testing	Within 1st 72 hours of incarceration	• Blood drawn for HIV (RAPID) screening	• Phlebotomy Tech • RN	# of patients who are HIV tested	**HIV Tested** 2020: 2,370 tests 2021: 9,360 tests 2022: 12,480 tests
2	Additional STI Testing	Within 1st 72 hours	• GC/CT urine collection and Syphilis optional Testing and if positive treatment given	• Phlebotomy Tech • RN	# of GC/CT tests performed	**GC/CT Screens** 2020: 4,829 GC/CT tests 2021: 8,717 GC/CT tests 2022: 11,467 GC/CT tests
3	HIV (+) Treatment	At the time of HIV(+)	• Confirmatory testing and pregnancy test completed • Order all baseline labs and follow-up labs • Prescribe treatment	• ID Physician, • OB/GYN (if pregnant) • APP • RN	# of HIV provider visits for treatment	**HIV Provider Visit for Treatment** 2020: 1,550 2021: 3,360 2022: 3,360
4	Day of release coordination of care	Time of release	• Provide medication at discharge • Linkage to care to community resources	• Nurse Navigator • Comprehensive Care Coordinator	# of inmates testing HIV (+) needing coordination of care # of inmates testing HIV (-) needing coordination of PrEP	**Coordination of Care Inmates testing HIV (+)** In Development **Coordination of Care Inmates testing HIV (-)** In Development

[1] Assuming 80% retention rate for the full year.

Goal 5: Percentage of patients from the targeted population who tested positive for HIV and were prescribed treatment within 30 days from test by 2022 (2020: 836 prescriptions, 2021: 1,003 prescriptions, 2022: 1,157 prescriptions)

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact
1	Identified Patients (Patients with HIV (+) test)	30 days from positive confirmatory test	• Provide referral • Provide coordination of care for financial services and current eligibility documentation • Provide community resources for SDOH	• Test Counselor • ID Physician • ID APP • Care Coordinator • Social Worker • Medication Access Technician (MAT) • Pharmacist	# of patients who have received a financial screening	**Financial Screens** 2020: 836 patients 2021: 1,003 patients 2022: 1,157 patients
2	Navigation HIV (+) scheduled/notified of appt & given information on HIV services	At time of results notification	• Patients are called to schedule / notified of appointment & given information on HIV services	• Test Counselor • APP • Care Coordinator • Social Worker • Medication Access Technician • Pharmacist	# of HIV initial appt (Patient completes RAPID start visit or initial service visit (ISV) is scheduled)	**HIV Initial Appointment** 2020: 836 patients 2021: 1,003 patients 2022: 1,157 patients
3	Treatment provided and referred to Medication Access Technician	At the time of medical appointment	• Coordination of scheduled appts, lab testing, and refills • Initial service visit/rapid treatment service	• Test Counselor • APP • Care Coordinator • Social Worker • Medication Access Technician • Pharmacist	# of HIV treatments	**HIV Treatment** 2020: 836 prescriptions 2021: 1,003 prescriptions 2022: 1,157 prescriptions

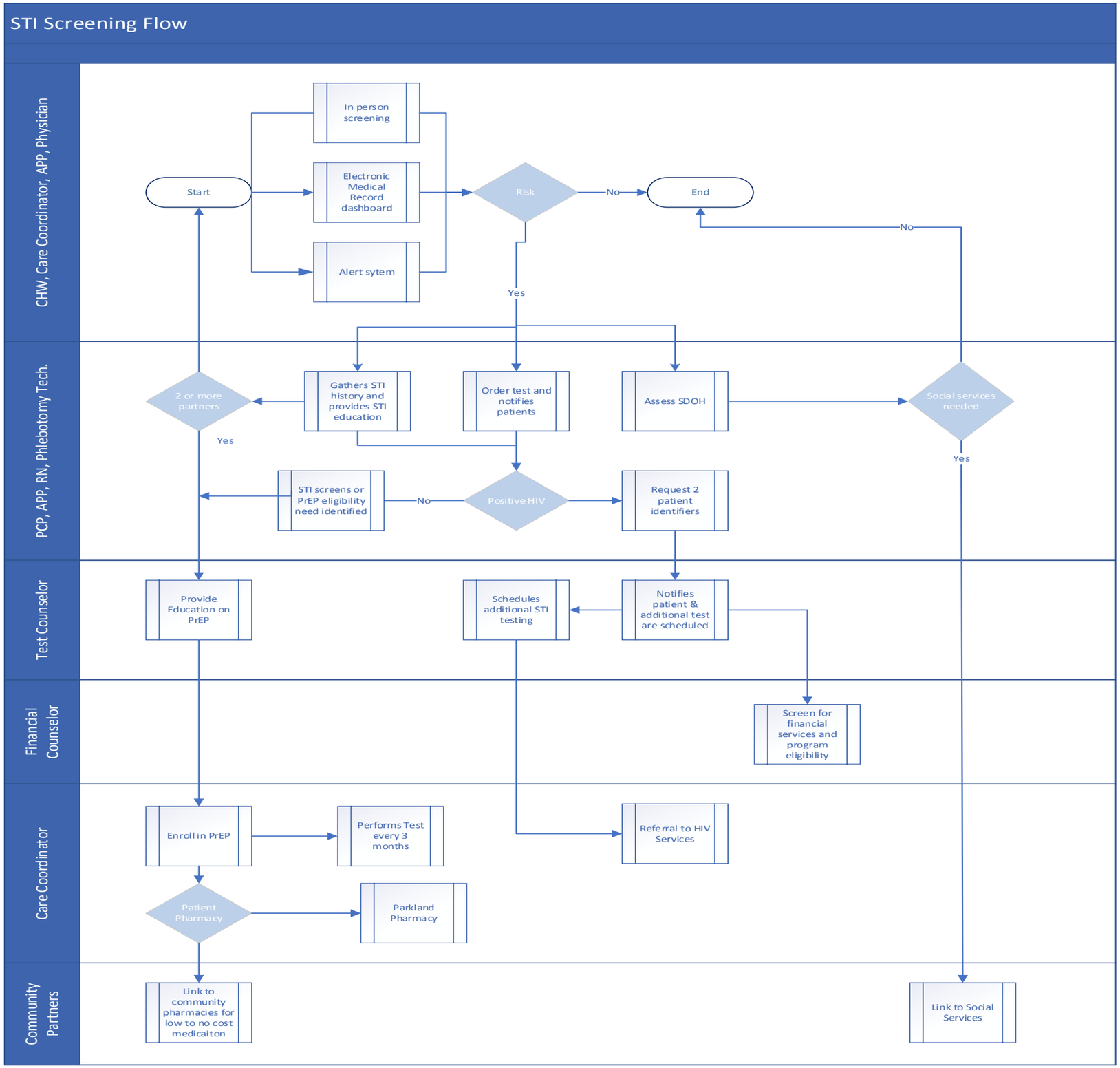
Goal 6: Patients from the targeted population tested for HIV, provided treatment within 30 days from test and patients with a viral load less than 200/copies ml

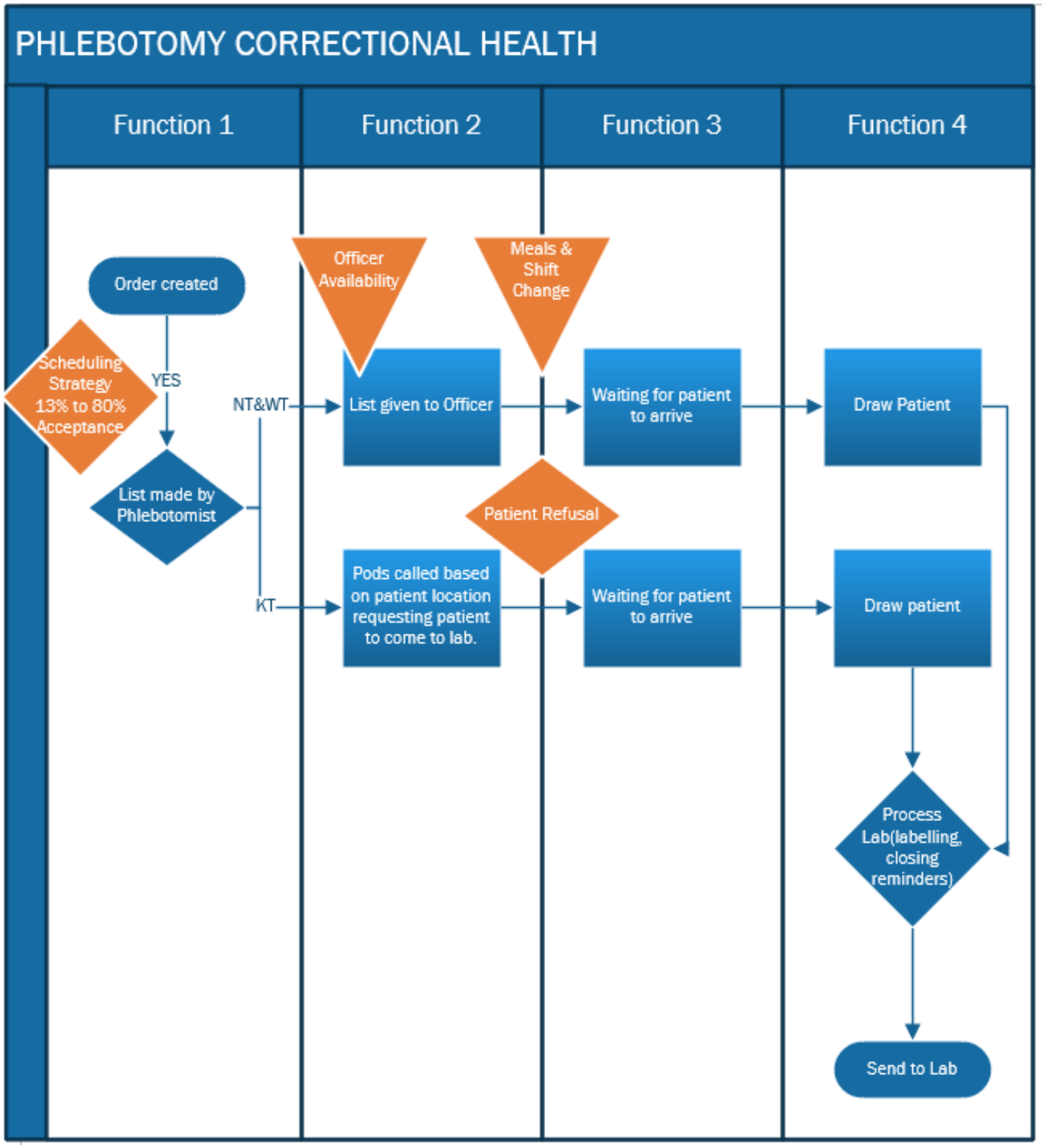
	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact
1	Opt-out HIV Testing: • ED • Other testing site at PHHS	Day #0	• Blood draw • Lab test	• ED HCW • Prevention staff	# of HIV test result Interpretations	**HIV Tested** 2020: 24,650 2021: 29,580 2022: 34,510
2	HIV results	Day # 0-1	• Counseling on HIV disease and treatment options for care	• ED Navigator Prevention staff	# of HIV status # of acceptance of diagnosis	**HIV Positive** 2020: 791 2021: 935 2022: 1,079
3	Linkage to Care	Day # 1-3	• Patient directed to services	• ED Navigator or Prevention staff	# of patients linked to care	**Linkage to care** 2020: 791 2021: 935 2022: 1,079
4	Initial care coordination visit Financial screening and Medication access	Day# 3-5	• Case management Services Ordering labs • Financial screening	• Case managers • Financial staff • Lab personnel • Medication Access Specialists/ Technicians (MAT)	# of financial screenings # of patients enrolled in medical assistance program	**HIV Financial Screening** 2020: 791 2021: 935 screenings 2022: 1,079 screenings **Medication Assistance** 2020: 791 patients 2021: 935 patients 2022: 1,079 patients

5	Initial medical visit	Day # 3-5	• Medical evaluation
			• Prescriptions
			• Counseling:
			  • Adherence
			  • Goals of care
			  • Prevention of transmission
				• Clinicians
				• Nurses
				• MAT
					# of initial visits
					# of prescriptions issued
						Initial Medical Visit
						2020: 791 visits
						2021: 935 visits
						2022: 1,079 visits
						
						HIV Prescriptions
						2020: 791 prescriptions
						2021: 935 prescriptions
						2022: 1,079 prescriptions

6	Follow-up visit	Day # 14-30	• Assessment of side effects (phone or in person) • Repeat safety and monitoring labs (Viral load and CD4 cell counts	• Clinicians • Lab personnel	# of adherence to medications Viral response (Viral load) Immunological response (CD4)	**Viral Load <200 copies/mL** 2020: 791 patients 2021: 935 patients 2022: 1,079 patients

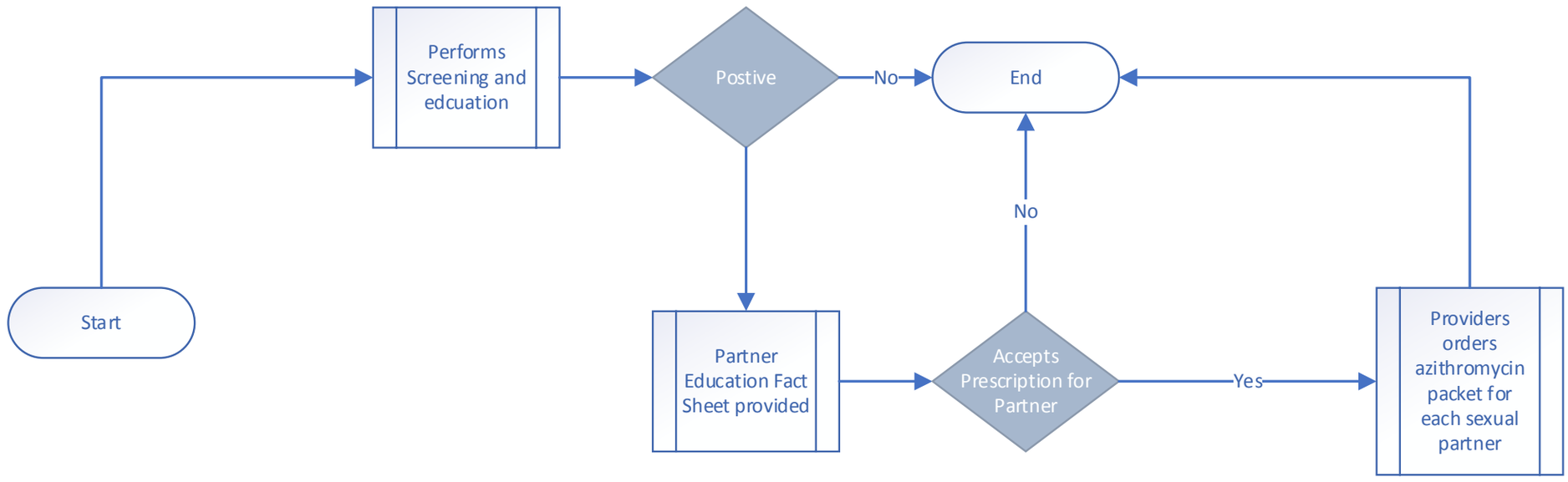
G. STI PROCESS FLOW




PHLEBOTOMY CORRECTIONAL HEALTH
Function 1
Function 2
Function 3
Function 4
Order created
Scheduling Strategy 13% to 80% Acceptance
YES
List made by Phlebotomist
NT&WT
KT
Officer Availability
Meals & Shift Change
List given to Officer
Waiting for patient to arrive
Patient Refusal
Pods called based on patient location requesting patient to come to lab.
Waiting for patient to arrive
Draw Patient
Draw patient
Process Lab(labelling, closing reminders)
Send to Lab

Chlamydia Expedited Partner Treatment Process Flow

PCP Obstetrics WHCS & MFM, and correctional health, etc.



H. PARTNERSHIPS

#	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
1	Center for Health Empowerment	75215	Offers educational services and FDA approved medical treatments at little to no out-of-pocket cost. The CHE wellness clinic provides PrEP and PEP medications, STI screenings, prevention, treatment and continuing care. They work with community partners to help eligible participants find community resources for transportation, housing, mental health and substance abuse	Everyone is eligible for the services. No one is turned away. They have protected more than 2,000 patients from HIV and other STIs	Health literacy and referral partners	N/A
2	Legacy Counseling	75204	To provide affordable and quality mental healthcare, substance abuse treatment, housing services and education to people who are impacted by HIV/AIDS	People impacted by HIV/AIDS	Parkland referrals to organization	N/A
3	Legacy Founders Cottage	75204	Provides home-like environment for people living with AIDS in critical stages of their illness who require 24-hour supervised care.	People impacted by HIV/AIDS	Parkland referrals to organization	N/A
4	Prism Health	75210	Advancing the health of North Texas through education, research, prevention and personalized integrated HIV care.	North Texas	Parkland referrals to organization	N/A
5	TORI (Texas Offenders Reentry Initiative)	75208	The mission is to guide and empower ex-offenders to maximize their potential, increasing their opportunities for successful reintegration into society and to become productive citizens of their communities.	Since 2005, T.O.R.I. has served over 10,000 returning citizens and their families	Health literacy and referral partners	N/A
6	Unlocking DOORS	75243	A comprehensive statewide diversion and reentry brokerage network that is committed to reducing crime and the ever-escalating fiscal impact to the State of Texas and its communities through coordinated collaboration, partnership, public awareness, reporting of evidence-based data and predictive trends, education and training.	Texas	Health literacy and referral partners	N/A
8	AIDS Healthcare Foundation	75207	Providing cutting-edge medicine and advocacy, regardless of ability to pay.	Served more than 1 million patients in over 40 countries worldwide	Health literacy and referral partners	N/A
9	Dallas County Department of Health and Human Services	75207	The mission is to protect the health of the citizens of Dallas County through disease prevention and intervention, and through promotions of a healthy community and environment. This is done through assessment, community input education, disease monitoring, regulation and health services that help control the spread of disease.	Dallas County	Public health partner agency/Collaboration on 90/90/90 plan	An Agreement of Cooperation

#	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
10	Dallas Resource Center: Nelson-Tebedo	75219	Resource Center is a trusted leader that empowers the lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) communities and all people affected by HIV through improving health and wellness, strengthening families and communities and providing transformative education and advocacy.	Lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) communities and all people affected by HIV	Health literacy and referral partners	N/A
12	Access and Information Network	75207	Works to prevent the spread of HIV and serves persons living with HIV/AIDS and other vulnerable populations.	HIV/AIDS and other vulnerable populations	Health literacy and referral partners	N/A
13	LGBT Crisis Hotline (The Trevor Project)	Countywide	Continuum of care approach to services for LGBTQ homeless youth	Special Populations: • Homeless • LBGTQ • Youth	Health literacy and referral partners	N/A

Agenda Information Sheet

File #: 20-1816 **Item #:** D

Fair Park Master Plan Update
[Ryan O'Connor, Assistant Director, Park & Recreation; Darren James, Chairman of the Board and Brian Luallen, Executive Director, Fair Park First]

RENEW! RESTORE! REVITALIZE!

FAIR PARK FIRST

SPECTRA

MWB/E PARTICIPATION

Fair Park First and Spectra report participation to the City of Dallas BID Office and have met and exceeded the MWBE participation goals as outlined in our management agreement.

- **MWBE Goal**: 25.75%
- **Actual MWBE Participation:** 58.31%

FAIR PARK FIRST

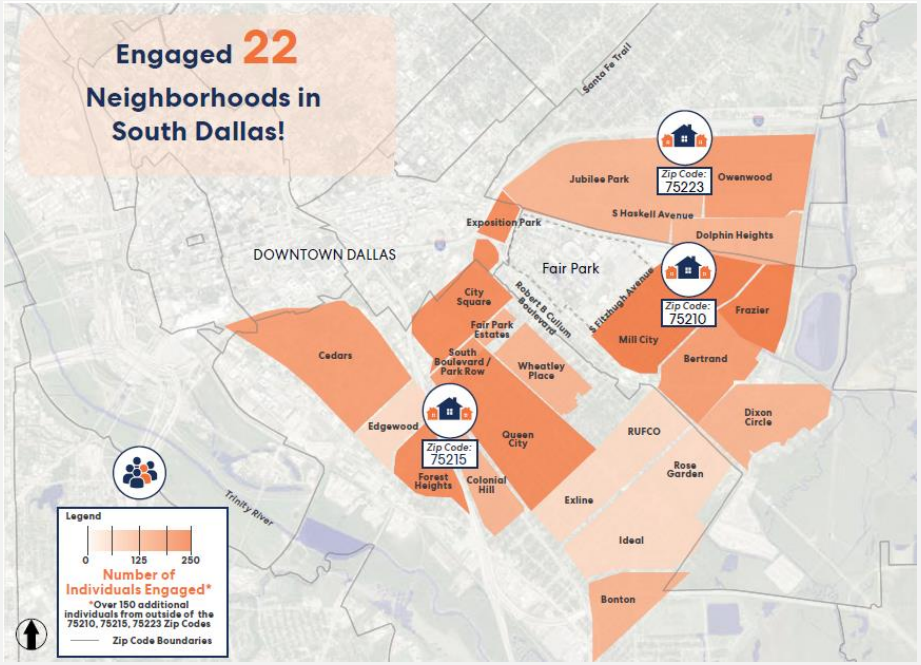
SPECTRA

COMMUNITY ENGAGEMENT

FAIR PARK FIRST

SPECTRA

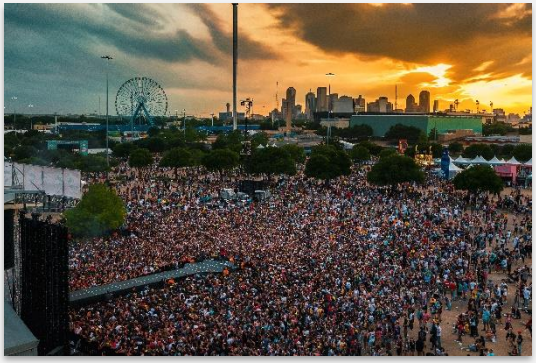
COMMUNITY ENGAGEMENT



LAND USES

As allowed under Texas State Law, Fair Park will be used for:

- Festivals, Concerts and Events
- State Fair of Texas
- Sporting Events
- Hospitality
- Education
- Cultural Institutions
- Nonprofits
- Community Use



FAIR PARK FIRST

SPECTRA

FAIR PARK INTERNSHIP PROGRAM

- Paid summer internship program involving Lincoln and James Madison High Schools (10 interns per school)
- Eight (8) week program featured hands-on training in multiple departments at Fair Park and resident institutions including, marketing, event planning/booking, and operations
- Workshops included business etiquette, resume writing, college prep, among others
- Field Trips to American Airlines Center, AT&T Stadium and the Kay Bailey Hutchison Convention Center
- $1,000 scholarship towards continuing education upon completion

POWERFUL PARTNERSHIPS

Fair Park First and Spectra have secured over $65 million in private equity and investments to date for 3 occupied buildings on Fair Park's campus.

Natural History Building

Fair Park Coliseum

Science Place 1

FAIR PARK FIRST

SPECTRA

NO BOUNDAY EXPANSION

FAIR PARK FIRST

SPECTRA

Agenda Information Sheet

File #: 20-1810 **Item #:** E

Update on Juanita J. Craft Civil Rights House
[Jennifer Scripps, Director and Nikki Christmas, Manager III; Office of Arts and Culture]

City of Dallas

Juanita J. Craft Civil Rights House Update

Quality of Life, Arts, and Culture
September 21, 2020

Jennifer H. Scripps, Director
Nikki Christmas, Facilities & Projects Manager
Office of Arts and Culture
City of Dallas

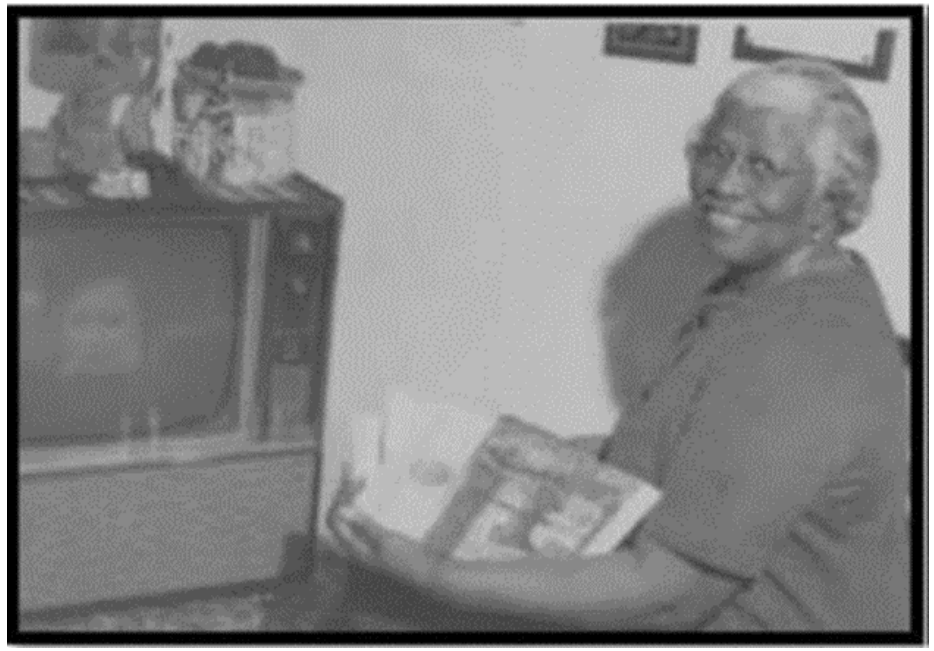
Presentation Overview

- Purpose
- Background
- House Restoration
- Community Partnerships and Fundraising
- Next Steps

Purpose

- Update Committee on status of Craft House project
  - Architecture & Construction
  - Governance
- Discuss next steps

Background



Mrs. Craft holding an official invitation to the inauguration of President Carter January 20, 1977

- Ms. Juanita Craft established a legacy in Dallas of advancing civil rights over five decades on a national, regional, and local stage as an organizer, activist, and Councilwoman

Background

- Her home at 2618 Warren Avenue in South Dallas served as a focal point for an extensive array of civil rights activities from 1950 to 1985

Background

- Upon her death on August 6, 1985, she willed her home to the City of Dallas
- Designated as a Dallas Landmark on May 10, 2000
- Managed by the South Dallas Cultural Center, but has not historically had onsite staff

Background

- In May 2018 - fire sprinkler system failure caused catastrophic flood at the home over Memorial Day weekend
- In Summer 2018 - City performed environment assessments (including materials testing and air quality testing) and Existing Conditions Survey and Infrastructure Assessments
- In January 2019 - City completed interior work in the Little House, painting, and replacing buckled flooring and blinds
- In April 2019 - Historical Elements were removed and categorized from the Big House and Asbestos Abatement and Mold Remediation completed

Background

- $250,000 committed in FY20 capital budget
- Council accepted National Park Service's African American Civil Rights Grant for $500,000
- Staff briefed QOLAC in November 2019

House Restoration

Rear of home

- Spring 2020
  - Advertised RFQ and RFP for historic preservation architects
- Summer 2020
  - Contracted McCoy Collaborative Preservation Architecture to prepare schematic designs and begin pre-construction probes

Community Partnerships (1 of 3)

- Friends of Juanita Craft House and Museum established
  - **Proposed Mission**: To restore and preserve the home and legacy of Honorable Juanita Craft in pursuit of continuous community programming and nation museum status on the Civil Rights Trail

Community Partnerships (2 of 3)

- Members of the Friends Group

Candace Thompson, Chair	Baylor Scott & White Outreach
Stevie Downer	Event Organizer, Community Volunteer
Cannon Flowers	Former Cultural Affairs Commissioner, At-Large
Jesse Hornbuckle	Cultural Affairs Commissioner, D4
Sarah Jackson	Junior League of Dallas
Linda Lydia	Dallas NAACP
Trinity Ojo	Metropolitan Capital Advisers, Community Volunteer
Patricia Perez	Craft Kid, Community Volunteer
Renita Smith	Junior League of Dallas
Chandler Vaughn	Juanita J. Craft Foundation and Estate Executor

Community Partnerships (3 of 3)

- Junior League of Dallas (JLD) announced the Restoration of the Juanita Craft House as their Centennial Anniversary Project

Fundraising and Grant Opportunities

- Grant applications have been submitted to several organizations
- JLD Centennial Committee is raising funds to help complete the renovations and reopen it to the public

Next Steps

- Complete Pre-Design and Schematic Design
- Advertise for Interpretative Planning
- Continue to fundraise for garden design and programming
- Re-opening to the public in Spring 2022

City of Dallas

Juanita J. Craft Civil Rights House Update

Quality of Life, Arts, and Culture
September 21, 2020

Jennifer H. Scripps, Director
Office of Arts and Culture
City of Dallas

Agenda Information Sheet

File #: 20-1813 **Item #:** F

Briefing by Memorandum: Public Art Project Updates
[Joey Zapata, Assistant City Manager]

Memorandum

CITY OF DALLAS

DATE September 17, 2020

TO Honorable Members of the Quality of Life, Arts & Culture Committee

SUBJECT **Public Art Project Updates**

This memorandum provides updates on public art projects, including some that were briefed to the Quality of Life, Arts & Culture Committee on August 17, 2020.

Arthello Beck Project at Twin Falls Park
Contracts for artists Jennifer Cowley and Tyra Goodley were executed August 31, 2020. The artists were also notified on August 31, 2020, and provided with executed contracts as well as instructions for invoicing. On September 9, 2020, public art staff conducted a conference call with each artist to answer any outstanding questions and confirm that they are proceeding with Phase I of the contract. Staff expects invoices for tasks assigned as a part of Phase I prior to the deadline of November 1, 2020, and completion of the project by March 31, 2021.

Policy for Artwork Depicting Individuals/Groups
On September 8, 2020, the Public Art Committee made the following recommendations for review criteria for City of Dallas Public Art depicting individuals or organizations. These recommendations will be forwarded to the Arts and Culture Advisory Commission on September 17, 2020. If approved by the Commission, these review criteria will be used to assess City of Dallas public art depicting individuals or representing organizations.

- Consideration of artworks that represent individuals or organizations who have made ethical and humanitarian contributions.
- At a minimum of every 10 years or in light of new information and support by a majority vote of the Public Art Committee, review documentation of the contributions of individuals or organizations for any issues of inappropriate, unethical, or prejudicial actions or behaviors that are not acceptable in contemporary society.
- Special consideration will be given to artwork that promotes cultural and social equity.

Memorial Marker for Allen Brooks
A site visit at the corner of Akard and Main Streets in downtown Dallas was conducted on September 9, 2020, with representatives from the Park & Recreation, Park Board, Office of Arts & Culture, Equal Justice Initiative Coalition from Dallas County, and DART.

This site is the preferred location for a memorial marker because Allen Brooks' body was suspended from an archway over this intersection on March 3, 1910. The marker will be a part of the Equal Justice Initiative Community Remembrance Project, a program that collaborates with communities to memorialize documented victims of racial violence and support community dialogue about the impact of lynching on communities.

DATE September 17, 2020

SUBJECT **Public Art Project Updates**

DART is expected to begin demolition of the Pegasus Park location for the construction of the D2 Subway in late 2021. Park & Recreation staff will provide a site plan and conduct an investigation of underground conditions at the southeast corner of the intersection where there is sufficient space to display the marker, as well as confirmation that there will be no interference with the construction. The EJI memorial marker stands approximately 5 ½ feet tall and is 24 x 20 inches with text on both sides.

Once the location is confirmed by DART and the Park and Recreation Department to be outside of the scope of demolition from the DART project, the location approval will go to Park Board.

The marker is scheduled to be dedicated on March 3, 2021, which is 111 years after the lynching of Allen Brooks.

Hall of Negro Life Project

King Hollis, a partner with South Pictures, is the selected film maker for the Hall of Negro Life film project and leads a Dallas-based, ALAANA-qualifying film team. Project funding is provided by a National Park Service grant and donors Inspire Art Dallas and Fair Park First.

On September 24, 2020, King Hollis will make a presentation to the steering committee and donors, Inspire Art Dallas and Fair Park First. Research on the Hall of Negro Life is the next phase with completion of the Hall of Negro Life archive at the City of Dallas, the film, and podcasts scheduled for completion by January 2023,

Vaughan Brothers Public Art Project at Kiest Park

Due to COVID-19 restrictions that will not allow a dedication at Kiest Park for a new work of public art paying tribute to the musical contributions of Stevie Ray and Jimmie Vaughan, who grew up near Kiest Park, a series of interviews will be posted on Facebook and the City's Arts and Culture channel. Filmed by the City's Communications and Media team, the interviews will be posted on or before Oct. 3. A celebration is planned at the site for March 20, 2021, if COVID restrictions allow.

Interviews will be conducted with

- Carolyn Arnold-Councilwoman from CD 4
- John Jenkins, Park and Recreation Director
- Jennifer Scripps, Office of Arts and Culture Director
- Kirby Warnock-Lead Fundraiser
- Jimmie Vaughan, Musician
- Gary Clark Jr. Musician

DATE September 17, 2020

SUBJECT **Public Art Project Updates**

For additional information, please contact Jennifer Scripps, OAC Director.

Joey Zapata
Assistant City Manager

c: Chris Caso, City Attorney (Interim)
Mark Swann, City Auditor
Bilierae Johnson, City Secretary
Preston Robinson, Administrative Judge
Kimberly Bizor Tolbert, Chief of Staff to the City Manager
Majed A. Al-Ghafry, Assistant City Manager
Jon Fortune, Assistant City Manager
Joey Zapata, Assistant City Manager
Nadia Chandler Hardy, Assistant City Manager
Dr. Eric A. Johnson, Chief of Economic Development and Neighborhood Services
M. Elizabeth Reich, Chief Financial Officer
Laila Alequresh, Chief Innovation Officer
M. Elizabeth (Liz) Cedillo-Pereira, Chief of Equity and Inclusion
Directors and Assistant Directors

Agenda Information Sheet

File #: 20-1818 **Item #:** G

Briefing by Memorandum: Short Term Rental Taskforce Update - September 2020
[Joey Zapata, Assistant City Manager]

Memorandum

CITY OF DALLAS

DATE September 17, 2020

TO Honorable Members of the Quality of Life, Arts & Culture Committee

SUBJECT **Short-Term Rentals (STR) Task Force Update**

As requested by the Committee in February 2020, a short-term rentals (STR) task force was formed and initiated meetings in June 2020 to develop recommendations on the regulation of STR properties. I will provide an update at the Committee meeting on September 21, 2020.

The task force will complete its recommendations by December 2020 so that the Committee can begin consideration at its meeting in January 2021. A forecast of the timeline for City Council adoption and implementation of any changes will be developed thereafter based on the Committee's recommendations.

Additionally, a staff team is focusing shorter-term, targeted compliance and enforcement measures against several STR properties with chronic quality of life complaints. These measures will include improvements in reporting, escalation of actions to address nuisance issues and get compliance with registration and tax compliance, and voluntary, good-neighbor agreements with owners and operators. Staff will be providing regular updates to councilmembers with targeted properties and a follow-up to Committee by December 2020.

Please contact me if you have questions.

Joey Zapata
Assistant City Manager

c: T.C. Broadnax, City Manager
Chris Caso, City Attorney
Mark Swann, City Auditor
Bilierae Johnson, City Secretary
Preston Robinson, Administrative Judge
Kimberly Bizor Tolbert, Chief of Staff to the City Manager
Majed A. Al-Ghafry, Assistant City Manager
Jon Fortune, Assistant City Manager
Nadia Chandler Hardy, Assistant City Manager and Chief Resilience Officer
Dr. Eric A. Johnson, Chief of Economic Development and Neighborhood Services
M. Elizabeth Reich, Chief Financial Officer
Laila Alequresh, Chief Innovation Officer
M. Elizabeth (Liz) Cedillo-Pereira, Chief of Equity and Inclusion
Directors and Assistant Directors

Agenda Information Sheet

File #: 20-1842 **Item #:** H

Briefing by Memorandum: September 23, 2020 City Council Agenda - Upcoming Agenda Item #37 [Joey Zapata, Assistant City Manager]

Memorandum

CITY OF DALLAS

DATE September 17, 2020

TO Honorable Members of the Quality of Life, Arts and Culture Committee

SUBJECT **September 23, 2020 City Council Agenda - Upcoming Agenda Item #37**

The Office of Arts and Culture (OAC) manages City-owned cultural facilities with non-profit arts and cultural organizations through long-term management and/or operation agreements approved by the City Council. Please see this link to view each facility's management contract at https://dallasculture.org/cultural-venues/agreements/

On April 22, 2020, City Council authorized the acceptance of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), Coronavirus Relief Funds (CRF) to aid the COVID-19 response throughout the City. On June 17, 2020, City Council was briefed on the CRF budget which included $2 million in funds to support partner organizations who manage City cultural and recreational facilities to enable compliance with COVID-19 public health precautions.

After working with our partners to assess the various facilities' needs, OAC recommends distributing $1 million dollars to organizations that manage city-owned facilities under OAC's authority.

These six contracts are scheduled for City Council consideration on September 23, 2020, with the seventh – for the Kalita Humphreys Theater – to be completed by Administrative Action in order to expedite expenditure of the funds in accordance with Federal guidelines. The expenditure of the funds is based on CRF eligibility beginning March 1, 2020 and must be expended no later than December 30, 2020. Receipts of expenditures must be provided to OAC by February 26, 2021.

PARTNER MANAGED OAC FACILITIES		
ORGANIZATION	**VENUE**	
Dallas Symphony Association	Meyerson Symphony Center	$ 225,000.00
Dallas Museum of Art	Dallas Museum of Art	$ 275,000.00
Dallas Center for the Performing Arts Foundation	AT&T Performing Arts Center	$ 225,000.00
Dallas County Heritage Society	Dallas Heritage Village	$ 75,000.00
Dallas Black Dance Theatre	Dallas Black Dance Theatre	$ 75,000.00
Sammons Center for the Arts	Sammons Center	$ 75,000.00
Dallas Theater Center	Kalita Humphreys Theater	$ 50,000.00
	Totals:	$ 1,000,000.00

Initial estimates for the COVID-related public health needs at City-owned, partner-managed cultural venues exceeded $2.5 million. Recommended allocations to partner-managed cultural venues were based on the square footage of the facility. Each partner

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received $75,000 for up to 100,000 square feet, and an additional $50,000 per additional 100,000 square feet thereafter. Kalita Humphreys Theater received $50,000 due to limited use and budget constraints.

Of the other cultural venues that OAC currently holds or formerly held the management agreements for, The Black Academy of Arts and Letters' COVID-related facilities needs will be taken care of by the Convention Center, and the African American Museum, Dallas Historical Society, and DSM Management Group, Inc. are included in the Park and Recreation Department's contract and funding with Fair Park First.

If you have questions please contact Jennifer Scripps, Director of Arts and Culture.

Joey Zapata
Assistant City Manager

c:

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