COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION:

Access to Care and Coverage

Parkland
Care. Compassion. Community.

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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.

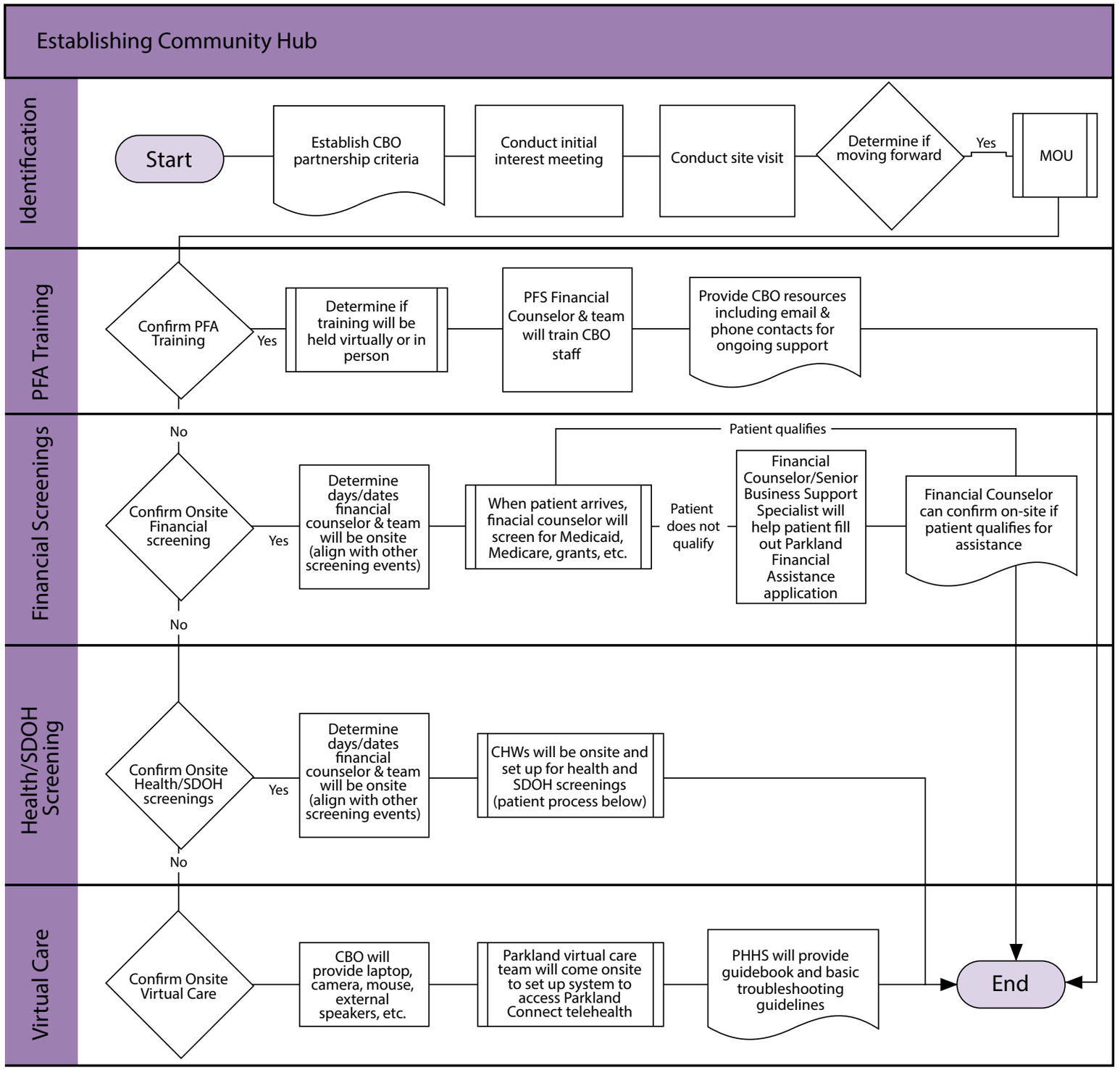
[4] Visit capacity is calculated utilizing a volume formula including hours available for screenings, standard PTO, other job functions, continuing education hours, etc. Currently the department of Telehealth has hired one physician dedicated to telehealth, as demand increases COPC providers can add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

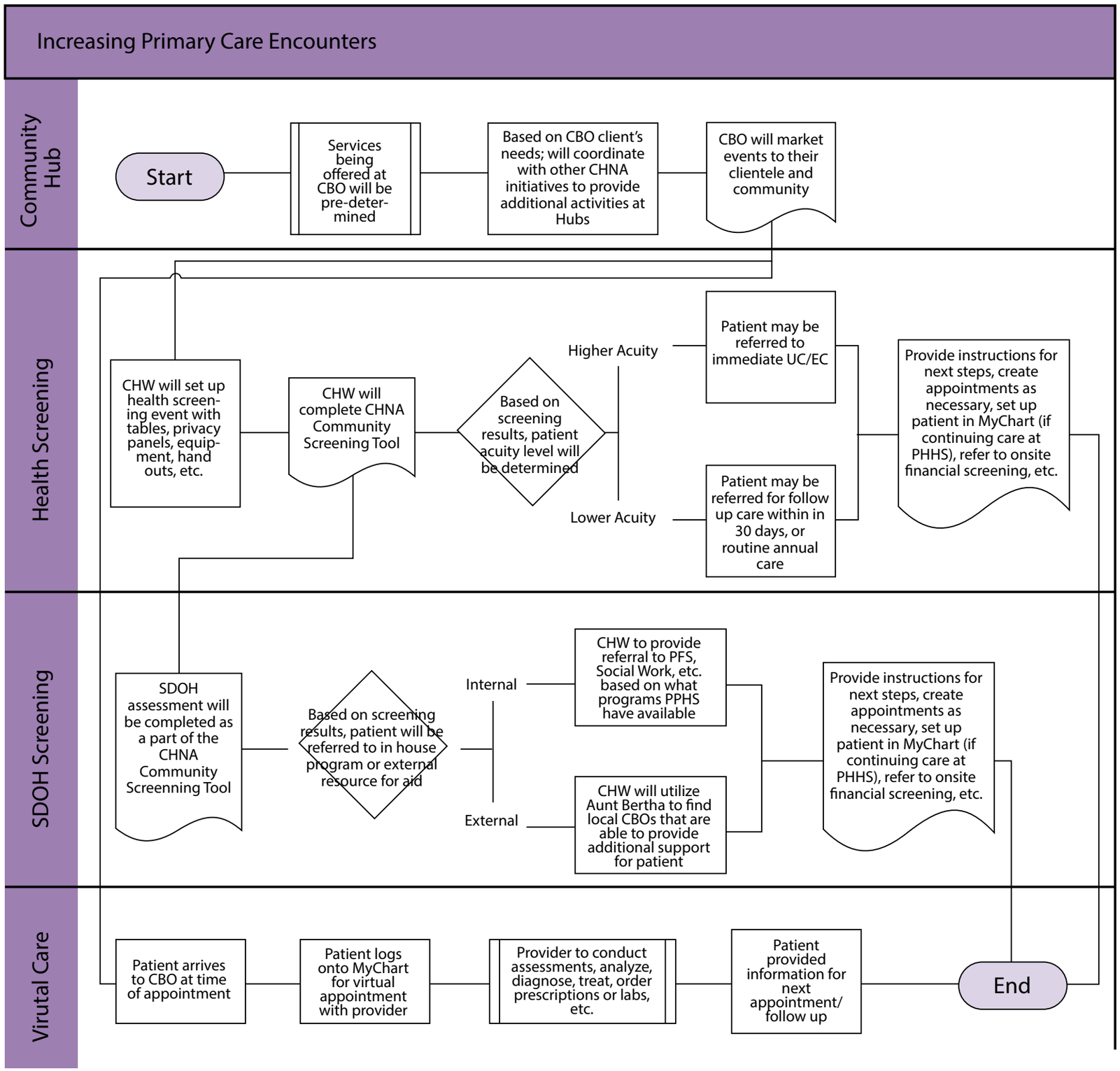
[5] Screening capacity is calculated utilizing a CHW volume formula including hours available for screenings, standard PTO, other job functions, continuing education hours, etc.

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