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

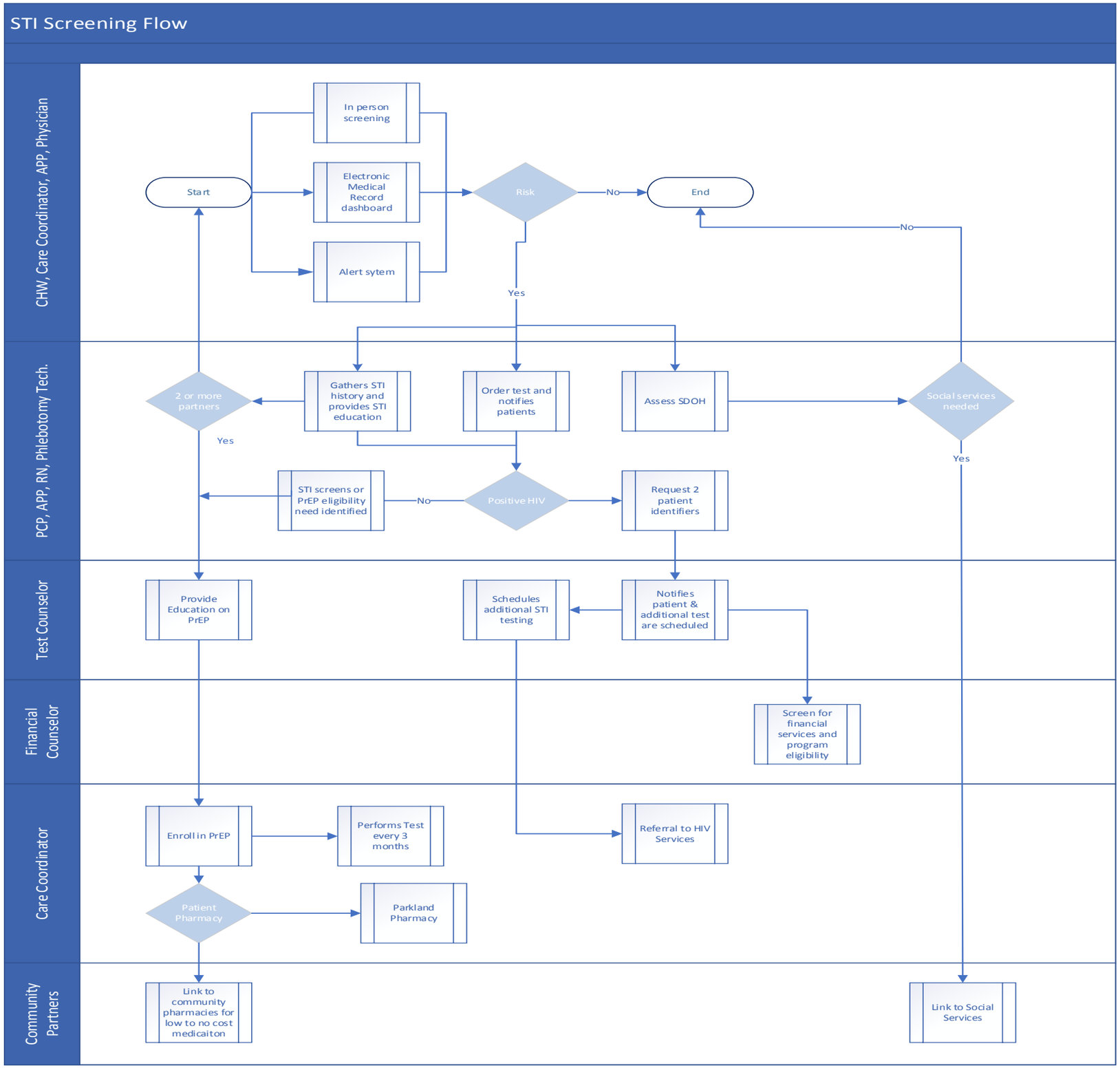
Goal 6: Patients from the targeted population tested for HIV, provided treatment within 30 days from test and patients with a viral load less than 200/copies ml

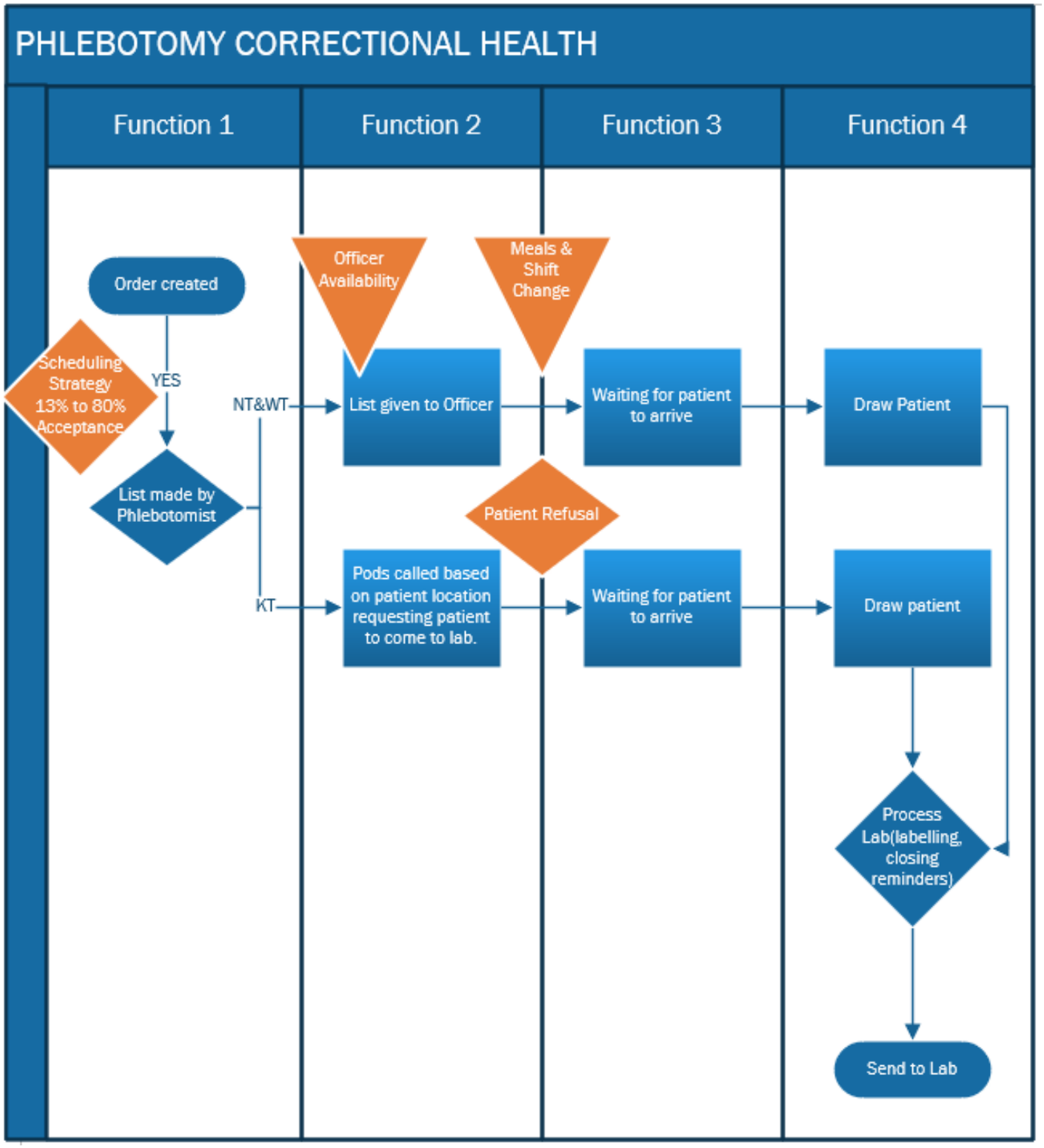
	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact
1	Opt-out HIV Testing: • ED • Other testing site at PHHS	Day #0	• Blood draw • Lab test	• ED HCW • Prevention staff	# of HIV test result Interpretations	**HIV Tested** 2020: 24,650 2021: 29,580 2022: 34,510
2	HIV results	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

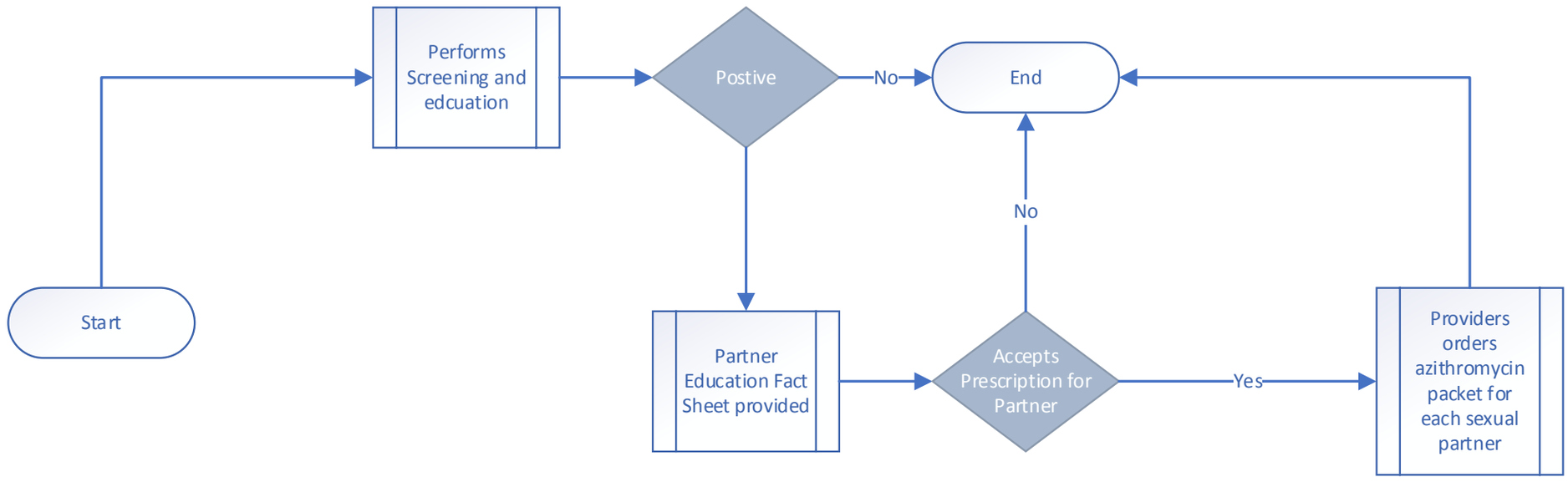
G. STI PROCESS FLOW




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