DALLAS *county*

COMMUNITY HEALTH NEEDS ASSESSMENT

2022 IMPLEMENTATION PLAN

Parkland | *Care. Compassion. Community.*

DCHHS
Dallas County Health and Human Services
Healthy People Healthy Communities
Health and Social Equity

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The Community Health Needs Assessment (CHNA) Implementation Plan describes the course of action that Parkland Health (Parkland) and Dallas County Health and Human Services (DCHHS) will follow in response to the findings of the Dallas County 2022 CHNA report.

To access the full report, visit either of the following links:

Parkland:
https://www.parklandhealth.org/CHNA

DCHHS:
https://www.dallascounty.org/Assets/uploads/docs/hhs/chna/CHNA-2022-WEB.pdf

In accordance with the Patient Protection and Affordable Care Act (ACA) the plan was accepted by Parkland's Board of Managers on February 22, 2023, and reflects Parkland's and DCHHS' commitment to the following:

Transparency Providing a thorough description of the strategies that Parkland and DCHHS will deploy over the next three years.

Accountability Adopting quality metrics to demonstrate progress toward a healthier community.

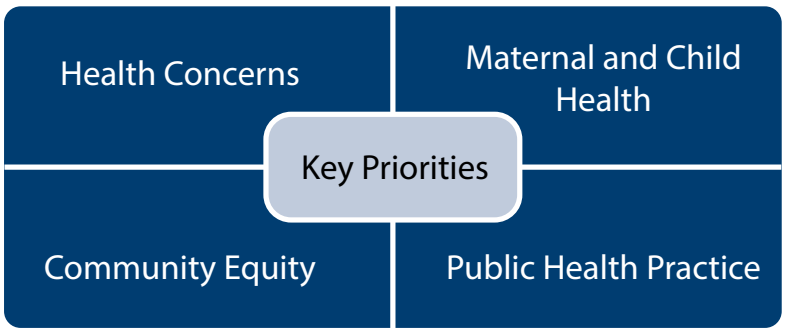
Health Equity Improving access to preventive, primary and specialty care in locales with high Chronic Disease Vulnerability Index (CDVI) scores and strengthening the infrastructure gaps related to access to care and coverage, housing, access to healthy food, and other social determinants/drivers of health (SDOH).

Collaboration A "Collective Impact" call to action to strive for health equity by addressing the complex social, economic and systemic factors known as SDOH that contribute to the chronic and endemic disparities present in Dallas County. In this spirit, Parkland and DCHHS invite Dallas County residents to read and provide input on this important work at the following link https://www.parklandhealth.org/dallas-community-health.

COMMUNITY HEALTH NEEDS ASSESSMENT KEY PRIORITIES

The prioritization of community health needs was conducted in a multiphase approach with integration of quantitative and qualitative data. Quantitative data was collected from county, state and national sources and analyzed against Dallas County and Parkland utilization data to determine the major causes of mortality, morbidity and utilization. Qualitative data was gathered through focus groups and an online survey, resulting in 278 individuals attending one of 40 focus group sessions sharing their insights and lived experience with Dallas County's health system. An additional 437 individuals completed an online survey allowing a private environment for input without time limitations.

For key priorities emerged:



1. Health Concerns

a. Chronic Diseases

Between 2000 and 2020, heart disease and cancer remained the leading causes of death in Dallas County. Furthermore, chronic diseases, particularly diabetes, emerged as the top health concern among focus group participants. The mortality rate associated with diabetes increased from 18 to 21 per 100,000 residents between 2019 and 2022. The volume of diabetes outpatient services in Dallas County is expected to grow by 22% between 2019 and 2024, and 44% by 2029.

Whereas the mortality rate for heart disease and cancer in Dallas County are below the U.S. rates, the mortality rate among Hispanics and Black/African American, non-Hispanic for these two diseases exceed the county rates by far.

b. Mental and Behavioral Health

Mental health ranked second behind chronic diseases among the health concerns focus group participants view as health risks to the community. Focus group participants described that financial stress and COVID-19 related issues such as isolation are a cause of anxiety and depression.

c. Preventive Care

Availability of preventive services, including health education, ranked as the third health concern among focus group participants.

2. Maternal and Child Health

Hispanic and Black/African American women who reside in the southern region of Dallas County and have diabetes and chronic hypertension experience worse prenatal and postpartum outcomes than women with these conditions who reside in other sectors of the county. Women in this region also face barriers to care due to limited physician and clinic availability.

a. Pediatric Asthma

Pediatric asthma prevalence is higher in the southern region of Dallas County.

b. Pediatric Behavioral Health

The demand for pediatric behavioral health services continues to grow in Dallas County.

3. Community Equity

Specific geographic areas with concentrated low economic investment and low infrastructure, as defined by the Center for Health Disparities Research at the University of Wisconsin, are correlated with worse health outcomes including maternal and child health indicators in Dallas County. Consistent negative features of these well-defined areas are higher poverty rates, low access to food, higher mortgage forbearance rate, higher uninsured rates, shortage of physicians and limited access to healthcare facilities. A higher concentration of Black/African Americans, non-Hispanic and Hispanics reside in these areas.

4. Public Health Practice

a. The process and restrictions pertaining to data sharing across public health and healthcare systems delay preemptive planning and response to chronic conditions.

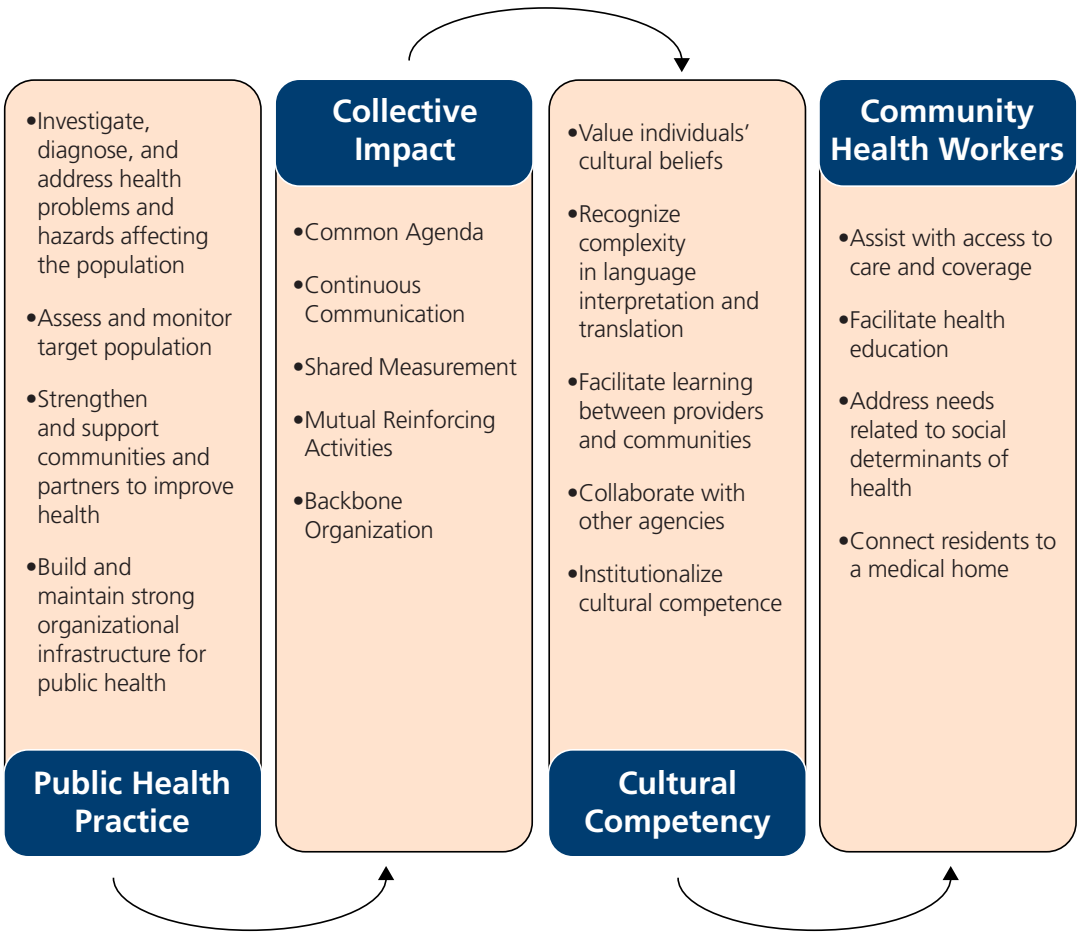
b. The increase in chronic disease rates in Dallas County calls for health systems and stakeholders to reevaluate their approach to patient activation and chronic disease self-management strategies.

c. The lack of standard collection of REAL (race, ethnicity, and language) and SOGI (sexual orientation and gender identity) data across health programs and health organizations remains a challenge.

IMPLEMENTATION PLAN

As required by the ACA, the following initiatives are built upon the previous CHNA Implementation Plan as well as the knowledge acquired from 2019 CHNA cycle (2020 – 2022). Initiatives achieving goals and reaching program maturity for practice, infrastructure and operations, will be integrated into their corresponding Parkland service line for continued operation, monitoring, and leadership oversight.

The complex nature of the CHNA findings requires dynamic, interactive, creative and flexible interventions following a standard foundation. Consequently, disease specific evidence-based practices for prevention, control and reduced complications are key drivers. The underpinnings of all interventions are public health practice, collective impact, cultural competency, and community health workers.



CHRONIC DISEASES

Mental and Behavioral Health	
Problem Statement	**Mental health ranked second behind chronic diseases among the health concerns focus group participants view as health risks to the community. Focus group participants described that financial stress and COVID-19 related issues such as isolation are a cause of anxiety and depression, particularly among Hispanics.**
Parkland Strategy	Increase behavioral health capacity and further improve coordination among behavioral health providers and community-based organizations.
Metric 1	Number of patients from the targeted population with a behavioral health encounter.
Metric 2	Number of pediatric patients from the targeted population with a behavioral health encounter.
Metric 3	Number of interventions by RIGHT Care teams.
Activity 1	**Access to Behavioral Health Services** a. Streamline processes to link patients to the right level of care and service provider in the community. b. Conduct process improvement activities to identify areas of improvement in behavioral health screenings conducted in Community Oriented Primary Care (COPC) health centers and other settings to identify Hispanics who can benefit from behavioral health services. c. Conduct an evaluation of current recruitment and retention practices for community behavioral health providers to identify areas of improvement. Utilize the information to create a Parkland-specific plan to address the critical shortage. d. Implement community outreach and education for Hispanics in targeted geographic areas.
Activity 2	**Pediatric Behavioral Health** a. Strengthen access to care for pediatric patients who are screened as high risk and were linked to care based on patient's needs: internal or external to Parkland. b. Develop quality metrics for pediatric behavioral health service delivery at Parkland Health. c. Improve access for women seeking behavioral health services during pregnancy to help promote healthy childhood development of their newborn. d. Establish a process to assess efficiency and accountability for program sustainability.
Activity 3	**Improve patient navigation across behavioral health system** a. Engage organizations within the community to create a "no wrong door" approach to serving those with behavioral health needs. This entails working with groups ranging from mental health and substance abuse advocates to churches and community centers to establish a referral system within the community to ensure that as many people as possible know what behavioral health resources are available, and how and when to appropriately access those services. b. Engage behavioral health partners in quarterly meetings to discuss referrals, quality metrics, systemic gap assessment, and shared successes.

Mental and Behavioral Health	
Activity 4	**Trauma Informed Care** a. Complete a comprehensive assessment of Parkland Health to identify opportunities on how to address trauma and create a strategic plan to educate staff. b. In collaboration with Parkland leadership, implement Trauma Informed Care in a phased-in approach.
Activity 5	**Reduce behavioral health stigma via a mental health campaign** a. Launch a behavioral health campaign in collaboration with Parkland partners to outreach and engage high-risk communities, particularly Hispanics. b. Establish a Patient Family Advisory Council (PFAC) for behavioral health. c. Support Mental Health First Aid training. d. Develop a mechanism to evaluate behavioral health education activities.
Activity 6	**RIGHT Care** a. Link individuals to care, i.e., clinic, hospital voluntarily, hospital involuntarily, Dallas Deflection Center, North Texas Behavioral Health Authority Living Room, substance use treatment facility, etc. b. Establish a process to assess effectiveness and accountability for program maturity. c. Expand RIGHT Care interventions to include child and adolescents within targeted populations. d. Leverage Parkland's Electronic Health Record to develop a data collection system for monitoring and reporting productivity and quality metrics. e. Utilize information from the data collection system to identify gaps to help with systemic impact.
DCHHS Strategy	**Strengthen opioid overdose monitoring and surveillance systems**
Metric 1	Establish partnership with Dallas Fire-Rescue to receive response data.
Metric 2	Establish system to upload opioid data into ODMAP.
Metric 3a	Number of infrastructure improvements to laboratory capacity.
Metric 3b	Number of opioid tests conducted.
DCHHS Activity 1	Work with Dallas Fire-Rescue to obtain response data including opioid overdose data.
DCHHS Activity 2	Work to facilitate participation in the Overdose Detection Mapping Application Platform (ODMAP).
DCHHS Activity 3	Develop DCHHS laboratory capacity to conduct opioid testing to support Dallas County-wide efforts to address the opioid crisis.

CHRONIC DISEASES

Breast Health	
Problem Statement	**When compared to the rest of the county, Southeast Dallas has the highest number of cancer morbidity and mortality. These communities have higher rates of low socio-economic status as well as a higher rate of minority populations, i.e., African American and Hispanic.**
Parkland Strategy	Build upon Parkland's Breast Cancer Health Equity efforts launched in 2019 that provide the foundational work to establish a "Multicomponent Intervention." Multicomponent Intervention is an evidenced-based strategy recommended by the CPSTF to promote breast cancer screenings in underserved populations.
Metric 1	Number of women from the targeted population who received a mammogram.
Metric 2	Percentage of "Lost to Care" patients from the targeted population (i.e., not cleared and treatment non-initiated).
Activity 1	**Deploy a data driven cancer screening campaign:** a. Deploy mammography services to target geographic areas based on data. b. Develop partnerships with community resources involved in breast health services. c. Increase the number of breast health community events within the priority ZIP Codes. d. Leverage CHWs to engage and link women at risk to schedule mammogram screenings and follow-up appointments. e. Monitor established Parkland female patients for screening according to guidelines. f. Work in collaboration with other healthcare providers including but not limited to Federally Qualified Health Centers (FQHCs) to provide screening mammograms.
Activity 2	**Strengthen Parkland's breast cancer continuum of care to ensure patients remain in care until clear or treatment is completed:** a. Navigate women who have a suspicious breast cancer mammogram. b. Adopt a navigation module to monitor patients from initial screening until linked to treatment or cleared. c. Complete Social Determinants of Health Questionnaire for all patients receiving mammograms to determine barriers to care. d. Refer patients with access to care barriers such as childcare, coverage, transportation, etc., that prevent women from getting a screening mammogram to community partners that can address these barriers.
Activity 3	**Enhance care coordination by:** a. Deploying seamless workflows to handoff patients throughout the Parkland system. b. Monitor show rate to identify trends and identify strategies to improve appointment completion.
Activity 4	**Deploy breast health awareness and education campaigns:** a. Develop culturally sensitive outreach and education materials in collaboration with Breast Health PFAC. b. Conduct annual Coming Together for the Cure (CTC) conference. c. Resume "Road Shows," i.e., one-on-one breast health education at the COPCs, Moody Outpatient Center and community events.

CHRONIC DISEASES

Breast Health	
Activity 5	Create a dashboard to track and monitor all breast health activities (assess education and follow-up with screening).
Activity 6	Align CHNA Breast Health plan with Breast Health Integrated Practice Units (IPU) priorities.
DCHHS Strategy	**Strengthen Dallas County breast cancer surveillance and monitoring system.**
Metric 1	Obtain resolution from Commissioners Court by June 30, 2023.
Metric 2	Obtain and store electronic case reports and cancer registry data from Dallas County area hospital systems for breast cancer by October 31, 2023.
Metric 3	Ingest the Dallas County breast cancer hospital electronic case report and cancer registry data by December 31, 2023.
Metric 4	Produce first breast cancer electronic case report of Dallas County by March 31, 2024.
Metric 5	Number of relevant community partners engaged in addressing breast cancer.
DCHHS Activity 1	Obtain a resolution passed by the Dallas County Commissioners Court to affirm importance of breast cancer as a public health issue.
DCHHS Activity 2	Obtain electronic case reports from Dallas County area hospital systems for breast cancer diagnosis.
DCHHS Activity 3	Ingest electronic case reports on breast cancer from local Dallas County hospital systems into DCHHS Epidemiologic Surveillance System.
DCHHS Activity 4	Conduct epidemiological analysis for breast cancer to support Dallas County activities.
DCHHS Activity 5	Convene relevant key community partners to coordinate collective impact on breast cancer.

CHRONIC DISEASES

Lung Cancer

Problem Statement	**For the past 20 years, lung cancer has remained the leading cause of cancer deaths among adults in Dallas County.**
Parkland Strategy	Develop the infrastructure to expand lung cancer risk assessment and increase access to existing lung cancer prevention (i.e., smoking cessation) and screening (i.e., low dose CT scan - LDCT) in accordance with Centers for Medicare & Medicaid Services (CMS) beneficiary criteria. a. Have a 20-pack per year or more smoking history; and b. Smoke now or have quit within the past 15 years; and c. Are between 50 and 77-years old.
Metric 1	Number of high-risk patients who completed an annual LDCT screening.
Metric 2	Number of Parkland patients with completed lung cancer risk assessment (i.e., based on Epic tobacco use assessment tool and Care Gaps).
Metric 3	Number of individuals with completed risk assessment for lung cancer in the community.
Metric 4	Percentage of referred high-risk patients who completed the shared decision-making appointment.
Metric 5	Percentage of annual low-dose CT scan orders that are completed.
Metric 6	Percentage of patients with abnormal LDCT with appropriate follow-up (either follow-up imaging or referral to appropriate clinical services).
Metric 7	Percentage of patients who are actively smoking identified through risk assessment referred to a smoking cessation program.
Metric 8	Percentage of patients referred to tobacco cessation services who successfully completed the program.
Activity 1	Adopt a standard approach to lung cancer screening program as recommended by the Parkland Health Lung Cancer Screening and Prevention Workgroup in community, primary care and inpatient settings.
Activity 2	Develop an Epic patient registry for patients at high-risk for lung cancer as defined by CMS beneficiary criteria.
Activity 3	Deploy CHWs to screen community members for tobacco use and lung cancer risk assessment.
Activity 4	Link individuals who use tobacco products to tobacco cessation programs and refer high-risk patients for lung cancer screening shared decision-making appointment.

CHRONIC DISEASES

Lung Cancer	
Activity 5	Support tobacco cessations and clean air policies for Dallas County residents.
Activity 6	Identify and work in collaboration with organizations such as the American Lung Association, American Cancer Society, Cancer Alliance of Texas, and American Heart Association that focus on lung cancer awareness and monitoring strategies.
Activity 7	Promote tobacco-free policies in alignment with nationally and locally recognized tobacco prevention and education programs.
Activity 8	Deploy CHWs to educate community members on risks associated with smoking e-cigarettes and vaping.
Activity 9	Develop measures for Parkland tobacco cessation programs to monitor program efficacy.
DCHHS Strategy	**Advance tobacco-free policies in alignment with nationally and locally recognized tobacco prevention and education programs.**
Metric 1	Obtain resolution from Commissioners Court by June 30, 2023.
Metric 2	Number of workplaces/public spaces and/or group settings that implement tobacco, vaping and smoke-free environment policies as a result of advocacy/education efforts.
Metric 3	Number of other policies/system or environmental changes implemented to reduce tobacco use.
Metric 4	Number of municipal partners.
Metric 5	Obtain Dallas County lung cancer electronic case report data by October 31, 2023.
Metric 6	Ingest Dallas County lung cancer data into surveillance system by December 31, 2023.
Metric 7	Produce first lung cancer epidemiologic report of Dallas County by March 31, 2024.
Metric 8	Number of additional tobacco prevention and cessation bilingual education programs implemented.
Metric 9	Number of local Dallas area school districts contacted for staff vaping prevention facilitator training program.

CHRONIC DISEASES

Lung Cancer	
Metric 10	Number of local Dallas area school districts staff completing vaping prevention facilitator program training.
Metric 11	Number of additional youth/young adults smoking prevention programs implemented.
Metric 12	Number of newly implemented tobacco-free campus policies in higher education institutions.
Metric 13	Number of local Dallas area apartments/multiple housing units and congregate housing contacted to modify smoking policies.
Metric 14	Number of contacted local Dallas-area apartments/multiple housing units and congregate housing who have enacted modified smoking policies in their buildings.
Metric 15	Number of local Dallas-area apartments/multiple housing units and congregate housing participants in smoking prevention/cessation classes.
DCHHS Activity 1	Work with municipalities, including planning and development departments, to promote and implement favorable policies, system, and environmental changes to reduce tobacco use, exposure to secondhand smoke, and address disparities in ZIP Codes identified as high risk.
DCHHS Activity 2	Obtain a resolution passed by the Dallas County Commissioners Court to affirm importance of lung cancer as a public health issue.
DCHHS Activity 3	Ingest Dallas County electronic hospital case report on lung cancer.
DCHHS Activity 4	Expand tobacco prevention and cessation bilingual (Spanish and English) education program in Dallas County.
DCHHS Activity 5	Increase outreach and provide training to local Dallas-area school districts staff to become vaping prevention facilitators.
DCHHS Activity 6	Increase outreach with local Dallas area school districts to expand youth/young adults smoking prevention program.
DCHHS Activity 7	Promote and support implementation of tobacco free campus policies in higher education institutions.
DCHHS Activity 8	Work with local Dallas-area apartments/multiple housing units and congregate housing to modify smoking policies.
DCHHS Activity 9	Promote and provide smoking prevention/cessation classes to local Dallas-area apartments/multiple housing units and congregate housing.
DCHHS Activity 10	Utilize Epic tobacco screening as part of intake in DCHHS clinics.
DCHHS Activity 11	Establish a Parkland-DCHHS referral system for tobacco cessation.

CHRONIC DISEASES

Diabetes	
Problem Statement	**There is a high rate of diabetes morbidity among residents living in CHNA target ZIP Codes 75210, 75211, 75215, 75216, 75217 and 75241.**
Parkland Strategy	Deploy a data driven diabetes screening campaign to identify high-risk patients in key ZIP Codes and enhance and strengthen Parkland's diabetes continuum of care to ensure new and existing patients remain in care and their diabetes is under control.
Metric 1	Number of patients from the targeted population screened for diabetes in the community and receiving targeted follow-up based on the screening results.
Metric 2	Percentage of patients with diabetes from the targeted population who performed an HbA1c test.
Metric 3	Percentage of patients with diabetes from the targeted population whose most recent HbA1c level is > 9.0%.
Metric 4	Percentage of patients with diabetes from the targeted population with HbA1c level > 9.0% and Parkland Score for Adherence to Medication (PSAM) < 60%.
Metric 5	Percentage of patients with diabetes from the targeted population who received a foot exam.
Metric 6	Percentage of patients with a diagnosis of a diabetic foot problem from the targeted population who experienced an amputation.
Activity 1	**Identify people in the community who have or may have diabetes and are not aware and link them to right level of care and services by:** a. Conducting regular community disease screening and awareness campaigns in target ZIP Codes. This collaborative effort focuses on partnering with the Access to Care & Coverage CHNA team and community-based organizations to screen people living in target ZIP Codes who may be at risk for diabetes. b. Connecting community members and existing patients to clinically appropriate diabetes care settings/services across Parkland Health and into the community. c. Developing, implementing and evaluating diabetes education activities, including community lay person/peer training. d. Building sustained community partnerships connected to identified high-risk ZIP Codes (i.e., Dallas Housing Authority, Parks and Recreation, North Texas Food Bank, Dallas County Texas A&M AgriLife Extension, public libraries, DCHHS). e. Development of a Diabetes Community Coalition comprised of key community stakeholders to drive coordinated and collaborative diabetes-related community activity and improved diabetes health in high-risk ZIP Codes. f. Review available Parkland Health and external data sources and services to identify possible gaps to guide needed interventions.

CHRONIC DISEASES

Diabetes	
Activity 2	**Link patients with diabetes to evidence-based standards of diabetes care in primary care by:** a. Screening patients for development of disease-related complications based on American Diabetes Association Standards of Diabetes Medical Care recommendations. b. Verifying patients achieve diabetes-related measures through receipt of guideline-based care for treatment of condition and related co-morbidities. c. Leveraging PSAM to encourage providers to discuss access to medication with patients. d. Identify a patient cohort with a low PSAM score to identify reasons for sub-optimal medication taking behavior and apply targeted interventions (i.e., medication delivery, transportation, etc.) to improve health outcomes. e. Screening patients seen in primary care and specialty care for SDOH factors and leveraging the care team, including identified community partners, to address SDOH factors that pose health risks.
Activity 3	**Improve diabetes care and effective discharge processes for high-risk patients in the hospital by:** a. Reviewing the criteria for recommended referral of high-risk patients to the Diabetes Consult Team. b. Stratifying inpatient diabetes education for high-risk patients. c. Integrating referrals, communications, and support for other chronic diseases such as hypertension, asthma, cancer and behavioral health. d. Targeted diabetes training of relevant hospital clinical personnel. e. Connecting high-risk patients to a medical home at the appropriate discharge interval. f. Connecting patients to required SDOH resources following discharge.
Activity 4	Establish a Diabetes Specialty Care Clinic in the southern area of Dallas County.

CHRONIC DISEASES

Diabetes	
DCHHS Strategy	**Enhance Diabetes prevention and control strategies.**
Metric 1	Number of Diabetes Prevention Program (DPP) cohorts.
Metric 2	Number of Diabetes self-management classes offered.
Metric 3	Number of physical activity programs/policies/environmental changes implemented to improve physical activity.
Metric 4	Number of persons impacted by physical activity interventions.
Metric 5	Obtain resolution from Commissioners Court by June 30, 2023.
Metric 6	Obtain electronic case reports from Dallas County area hospital systems for diabetes diagnosis by October 31, 2023.
Metric 7	Ingest the Dallas County diabetes data into the surveillance system by December 31, 2023.
Metric 8	Produce first diabetes report of Dallas County by March 31, 2024.
Metric 9	Number of new community gardens/policies/environmental changes implemented throughout Dallas County to improve access to healthy foods in underserved areas of Dallas County.
DCHHS Activity 1	Provide diabetes education through expansion of the DPP.
DCHHS Activity 2	Provide diabetes self-management education.
DCHHS Activity 3	Work with municipalities, including planning and development departments, to promote favorable policies and environmental changes to increase access to physical activity in underserved areas of Dallas County.
DCHHS Activity 4	Obtain a resolution passed by the Dallas County Commissioners Court to affirm importance of diabetes as a public health issue.
DCHHS Activity 5	Obtain electronic case report from Dallas County area hospital systems for diabetes diagnosis.
DCHHS Activity 6	Ingest Dallas County electronic hospital case report on diabetes.
DCHHS Activity 7	Work with municipalities, including Dallas County planning and development departments, to implement community gardens and promote access to healthy foods in underserved areas of Dallas County.

CHRONIC DISEASES

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.
Parkland Strategy	Establish a High Blood Pressure program that focuses on African American patients residing in ZIP Codes 75210, 75211, 75215, 75216, 75217, 75241 and adheres to the State of Texas public strategies for addressing heart disease and stroke (2019-2023).
Metric 1	Number of patients from the targeted population screened for high blood pressure and follow-up documentation.
Metric 2	Percentage of patients from the targeted population whose blood pressure at the most recent visit is adequately controlled.
Metric 3	Percentage of patients with diabetes from the targeted population whose blood pressure at the most recent visit is adequately controlled.
Activity 1	**Adopt a data-driven strategy for the planning and development of heart disease interventions by:** a. Establishing a collaboration with DCHHS to create a heart disease surveillance program/dashboard. b. Using the Parkland heart disease registry to identify high-risk patients and prevent heart disease complications. c. Adopt the CDVI to identify geographic areas with high/at risk population to conduct blood pressure screenings.
Activity 2	**Improve hypertension care by:** a. Aligning clinical teams and CHWs to conduct screenings to identify patients with uncontrolled high blood pressure. b. Leveraging CHWs to support patients with uncontrolled blood pressure and provide appropriate follow-up and resources.
Activity 3	**Leverage technology and care delivery models that decentralize care from main campus:** a. Increase Remote Patient Monitoring to serve more high-risk patients. b. Implement Text Notification Program for moderate-risk patients. c. Offer virtual appointments.
Activity 4	**Incorporate community input provided through focus groups in CHNA-targeted ZIP Codes to identify best outreach and communication vehicles for targeted education and health literacy efforts:** a. Establish a Public Health Educational Campaign to educate community members on heart disease. b. Work with Marketing and PFAC to develop culturally sensitive materials. c. In conjunction with community partners, deploy education and health literacy programs into CHNA-targeted ZIP Codes.
Activity 5	Establish a mechanism to standardize blood pressure re-checks in CHNA ZIP Codes at screenings and primary care appointments.

CHRONIC DISEASES

Hypertension	
DCHHS Strategy	**Enhance Hypertension prevention and control strategies.**
Metric 1	Number of community screening, treatment and management sites in underserved areas implemented.
Metric 2	Number of participants in community-based programs.
Metric 3	Number of participants in self-management education program.
Metric 4	Obtain resolution from Dallas County Commissioners Court by June 30, 2023.
Metric 5	Obtain and store electronic case reports from Dallas County area hospital systems for hypertension by October 31, 2023.
Metric 6	Ingest the Dallas County hypertension data by December 31, 2023.
Metric 7	Produce first hypertension electronic case report of Dallas County by March 31, 2024.
Metric 8	Number of relevant community partners engaged in addressing hypertension.
DCHHS Activity 1	Implement community screening, treatment, and management sites in underserved areas of Dallas County in collaboration with stakeholders.
DCHHS Activity 2	Conduct evidence-based Self-Management Education.
DCHHS Activity 3	Obtain a resolution passed by the Dallas County Commissioners Court to affirm importance of hypertension as a public health issue.
DCHHS Activity 4	Obtain electronic case reports from Dallas County-area hospital systems for hypertension.
DCHHS Activity 5	Ingest electronic case reports on hypertension from local Dallas County hospital systems into DCHHS Epidemiologic Surveillance System.
DCHHS Activity 6	Conduct epidemiological analysis for hypertension program implementation and evaluation.
DCHHS Activity 7	Convene relevant key community partners to coordinate collective impact on hypertension.

INFECTIOUS DISEASES

Sexually Transmitted Infections (STI) and Human Immunodeficiency Virus (HIV)	
Problem Statement	**Since 2010, STI and HIV have remained a public health challenge in Dallas County, particularly in some geographic areas.**
Parkland Strategy	Parkland and Correctional Health in collaboration with DCHHS will adopt a community-based strategy to strengthen STI and HIV wellness and disease prevention capacity.
Metric 1	Percentage of patients from the targeted population who were tested for chlamydia.
Metric 2	Percentage of patients with chlamydia from the targeted population who were offered expedited partner treatment.
Metric 3	Number of patients from the targeted population who were tested for HIV.
Metric 4	Percentage of inmates 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 the test.
Metric 6	Percentage of HIV-positive patients from the targeted population with a viral load less than 200/copies ml.
Activity 1	**Strengthen efforts to reduce chlamydia reinfection and persistent infections.** a. Initiate a formal quality improvement project to address untreated chlamydia cases found via outreach activities. b. Continue to offer expedited partner treatment and education.

Sexually Transmitted Infections (STI) and Human Immunodeficiency Virus (HIV)

Strengthen HIV prevention and treatment strategies

a. Enhance HIV testing

i. Implement a systemic HIV high-risk predictive model in the HIV screening best practice advisory (BPA).

ii. Incentivize the staff and patients at Correctional Health to increase the HIV test acceptance rate.

iii. Parkland will continue to refine "opt-out" HIV testing in its ED and outpatient setting to increase the number of patients tested for HIV according to recommended guidelines.

iv. Leverage PCCI data to identify high-risk geographic areas to conduct HIV community testing events.

b. Strengthen linkage to care

i. Implement an Adult Comprehensive Care and Engagement Support Services (ACCESS) Clinic Newly Diagnosed Program for ED/COPC testing.

ii. Deploy process to more robustly accommodate same-day antiretroviral therapy (ART) initiation.

Activity 2

iii. Improve ED linkage protocols for patients diagnosed after hours.

iv. Increase access for new HIV-diagnosed patients through immediate start of ART.

c. Enhance patient viral load monitoring and patient retention

i. Prioritize CHNA dashboard to present patients with care gaps at multidisciplinary clinic team huddles.

ii. Develop and implement a plan for long-acting injectable antiretroviral therapy for patients.

iii. Improve access to virtual care services by leveraging remote, CHNA virtual care sites, including those areas not traditionally accessed by medical services.

iv. Increase access to mental healthcare and substance use to increase behavioral health referrals.

v. Increase workforce of HIV providers through support of HIV fellowship and hiring of additional faculty.

vi. Increase access to appointments, particularly same-day access for return-to-care patients, through expansion of hours, increased virtual video visits and increasing appointment flexibility in high-risk ZIP Codes.

Adopt public health campaign strategies for STI/HIV education and awareness:

Activity 3

a. Work in collaboration with Parkland's Corporate Communications team to develop a communication plan and education materials based on feedback from focus groups.

b. Enhance education for patients and clinical teams.

c. Deploy social media STI educational awareness campaign.

d. Partner with organizations to collectively increase awareness and testing events.

Sexually Transmitted Infections (STI) and Human Immunodeficiency Virus (HIV)	
Activity 4	**Expand STI screening activities:** a. Conduct a formal quality improvement project to address untreated chlamydia cases found via outreach activities. b. Implement data-driven solutions for identifying eligible patients for syphilis routine screening. c. Establish a workflow for having an exchange related to the completion of syphilis treatment with DCHHS. d. Conduct an annual review of labs to optimize testing and missed opportunity.
Activity 5	**Establish programmatic metrics to assess program readiness to transition to service line oversight:** a. Percentage of eligible patients screened for syphilis. b. Percent of patients with a score of 75 or greater via the HIV predictive model that are tested annually. c. Percentage of patients from the targeted population who tested positive for HIV and were prescribed treatment within 7 days from the test. d. Percentage of HIV patients from the targeted population relinked to care after contact in 30 days. e. Number of Correctional Health patients who were tested for HIV. f. Number of Correctional Health HIV patients linked to care after release. g. Percentage of Correctional Health patients with HIV blood draw screening with syphilis screen collected. h. Percentage of Correctional Health patients screened positive for syphilis and medication administered.
Activity 6	**Work in collaboration with DCHHS to establish systemic metrics to monitor patients' care:** a. Percentage of patients with syphilis who have received at least one order of treatment at Parkland, confirmation of receiving full treatment regimen will come from DCHHS. b. Percentage of Correctional Health patients with at least 1 order, receiving full treatment regimen.
Activity 7	Pursue grants that support CHNA-related activities.
DCHHS Strategy	**Strengthen access to Sexual Health services to reduce the transmission rate of sexually transmitted infections and improve access to preventive care.**
Milestone 1	New Sexual Health Clinic site identified and approved by Dallas County Commissioners Court.
Milestone 2	Operational plans developed for new Sexual Health Clinic.
Metric 3	Number of syphilis index patients who identify at least one partner during interview(s).
Metric 4	Percentage of pregnant patients receiving all 3 syphilis screens per state regulations (collaborative with Dallas County area hospital systems).

INFECTIOUS DISEASES

Sexually Transmitted Infections (STI) and Human Immunodeficiency Virus (HIV)	
Metric 5	Percentage of partners notified of syphilis or HIV exposure that were tested or treated.
Metric 6	Percentage of women of child-bearing age who test positive for syphilis who have a documented pregnancy status.
Metric 7	Number and/or percentage of partners who received at least one dose of treatment (SYPH).
Metric 8	Number and/or percentage of index patients interviewed within 3 days of assignment date (SYPH).
Metric 9	Number and/or percentage of clients diagnosed with HIV through opt-out testing through local area hospitals.
Metric 10	Number and/or percentage of clients diagnosed with HIV through non-healthcare settings, including community outreach events.
Metric 11	Number of new healthcare settings that have implemented opt-out HIV screening.
Metric 12	Number and/or percentage of DCHHS sexual health clinics patients with elevated risk for HIV rescreened for HIV.
Metric 13	Number and/or percentage of persons who received public health follow up.
Metric 14	Number and/or percentage of index patients interviewed within 7 days of assignment date (HIV).
Metric 15	Number and/or percentage of clients linked to social support services.
Metric 16	Complete electronic integration of housing and HIV care data systems to enhance coordination of service delivery.
Metric 17	Number and/or percentage of clients prescribed PrEP through sexual health clinic.
Metric 18	Number of interactions reported through social media campaigns.
Metric 19	Number and/or percentage of clients re-linked to HIV medical care.
Metric 20	Number and/or percentage of clients linked to HIV medical care.
Metric 21	Percentage retained in care.
Metric 22	Percentage virally suppressed.
Metric 23	Development of a working DCHHS STI/HIV comprehensive disease surveillance and electronic case reporting system.

INFECTIOUS DISEASES

Sexually Transmitted Infections (STI) and Human Immunodeficiency Virus (HIV)	
DCHHS Activity 1 (SHC)	DCHHS will identify site and begin operational plans for satellite Sexual Health Clinic in CHNA target ZIP Code areas.
DCHHS Activity 2 (STD/HIV)	**Strengthen efforts to identify and link patients to care.** a. Identify two partners per patient who are newly diagnosed with early syphilis interviewed by DCHHS. b. Ensure 60% of partners notified of syphilis or HIV exposure are tested or treated. c. Ensure that 80% of women of child-bearing age diagnosed with syphilis have a documented pregnancy status. d. Ensure pregnant women diagnosed with syphilis are adequately treated. e. Ensure 75% of patients newly diagnosed with syphilis interviewed receive at least one dose of treatment.
DCHHS Activity 3 (EHE)	**Diagnose - Diagnose all people with HIV as early as possible.** a. Expand or implement routine opt-out HIV screening in healthcare and other institutional settings in high prevalence communities. b. Develop locally tailored HIV testing programs to reach persons in non-healthcare settings. c. Increase at least yearly re-screening of persons at elevated risk for HIV per CDC. testing guidelines, in healthcare and non-healthcare settings.
DCHHS Activity 4 (EHE)	**Prevent - Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).** a. Addressing HIV Care through Data Integration to Improve Health Outcomes along the HIV Care Continuum. b. Identify models for the electronic integration of housing and HIV care data systems to enhance coordination of service delivery. c. Expand access to PrEP, especially for priority populations. d. Create awareness and education on availability of PrEP to community members.
DCHHS Activity 5 (EHE)	**Treat - Treat people with HIV rapidly and effectively to reach sustained viral suppression** a. Collaborate with partners and providers, so that people who receive a positive test result for HIV are quickly linked to care, and HIV treatment started as soon as possible after diagnosis. b. Help partners expand local programs that identify and follow up with people who have stopped receiving HIV care and treatment. c. Data-to-Care tools and approaches will encourage them to get back in HIV care and treatment.
DCHHS Activity 6 (STI/HIV)	Work with the Texas Department of State Health Services (DSHS) to develop a DCHHS STI/HIV comprehensive disease surveillance and electronic case reporting system.

PREVENTIVE CARE

Access to Care and Coverage	
Problem Statement	**South and Southeast Dallas have a large concentration of communities with high chronic disease vulnerability index (CDVI) score. Residents in these areas have the highest uninsured rates in the county and have higher rates of medical debt – limiting their access to health services. In ZIP Codes 75216 and 75217, more than 40% of the population lacks an internet connection.**
Parkland Strategy	Increase access points for health services as well as financial eligibility applications in the southern sector of Dallas County.
Metric 1	Number of community partners helping patients with PFA (Parkland Financial Assistance) application submission.
Metric 2	Number of primary care encounters provided in targeted areas.
Activity 1	Establish community hubs to increase access points in Southern and Southeast Dallas. Individual/family assistance may include health insurance coverage, financial assistance for healthcare, transportation, food, housing, employment and education.
Activity 2	Identify additional community hub partners as appropriate (i.e., North Texas Food Bank, DISD, community-based organizations, places of worship, etc.).
Activity 3	Train staff at partner organizations (i.e., local FQHCs, community-based organizations, places of worship, etc.) to help patients navigate Parkland's coverage eligibility and financial assistance processes.
Activity 4	Parkland's CHWs to improve access/outreach and reduce the number of patients lost to care.
Activity 5	Expand access to clinics for patients identified as needing follow-up in primary care.
Activity 6	Establish ATCC dashboard to allow for efficient reporting for screening activities and inform strategic priorities.
Activity 7	**Establish programmatic metrics to assess program readiness to transition to service line oversight:** a. Number of total Access to Care & Coverage (ATCC) appointments completed. b. Number of total ATCC completed appointments, unique patients. c. Number of total ATCC screenings performed. d. ATCC screening for diabetes and follow up required. e. ATCC screening for diabetes and follow up scheduled. f. ATCC screening for diabetes and follow up completed. g. ATCC screening for hypertension and follow up required. h. ATCC screening for hypertension and follow up scheduled. i. ATCC screening for hypertension and follow up completed.
DCHHS Strategy	**Increase access points for DCHHS services in the Southern Sector of Dallas County**
Milestone 1	New DCHHS Satellite Clinic (including Sexual Health Clinic) site identified and approved by Dallas County Commissioners Court.
Milestone 2	Operational plans developed for new DCHHS Satellite/Sexual Health Clinic.
DCHHS Activity 1	DCHHS will identify site and begin operational plans for satellite clinic (Including Sexual Health Clinic) in CHNA target ZIP Code areas.

MATERNAL AND CHILD HEALTH

	extending Maternal Care After Pregnancy (eMCAP)
Problem Statement	**In Dallas County most postpartum deaths occur after 60 days postpartum, a period beyond the postpartum window covered by Medicaid. Substance abuse, cardiac conditions and behavioral health are leading causes of maternal mortality.** **African American women have the highest risk of pregnancy-related mortality.**
Parkland Strategy	Based on learning from approximately 2,600 patients already served in the first two years of eMCAP, the racial breakdown of patients enrolled (67% non-white Hispanic and 29% non-Hispanic Black) and feedback from patients about access barriers, the eMCAP program will extend its catchment area to cover east Dallas to achieve the following outcomes: a. Capture a larger area more heavily concentrated with deliveries among Black women. b. Maximize use of telehealth as the main source of provider interaction to test if this truly reduces access barriers and keep women engaged with services for longer periods.
Metric 1	Percentage of patients from the targeted population enrolled into the eMCAP program.
Metric 2	Number of completed behavioral health referrals (referral made and at least one visit is made by patient with a behavioral health provider).
Metric 3	Number of patients with A1C <7 at 6 months.
Metric 4	Number of patients with AIC <7 at 12 months.
Metric 5	Number of patients with BP < 140/90 at 6 months.
Metric 6	Number of patients with BP <149/90 at 12 months.
Activity 1	Leverage alternative healthcare delivery model such as mobile health unit and/or establish local fixed site clinics, telehealth, virtual care as the means to increase access to care for women after pregnancy in ZIP Codes with high CDVI scores.
Activity 2	Link postpartum women to a healthcare delivery model based on their cultural and social preferences.
Activity 3	Leverage technology to improve women's chronic disease self-management skills (hypertension, diabetes, etc.).
Activity 4	Link postpartum women to resources and services to improve life and interpersonal skills such as parenting skills, self-advocacy, workforce reintegration, health literacy, healthcare system navigation, etc.
Activity 5	Enhance the process to transition patients with a chronic disease who completed eMCAP back to a Primary Care Physician (Parkland's Community Oriented Primary Care health centers and other external clinics such as the Federally Qualified Health Centers) to establish a seamless transition back to a primary care for postpartum women.
Activity 6	Use the eMCAP Analytics Dashboard to monitor program outcomes and use lessons learned for program improvement.
Activity 7	Develop a network of community partners to provide pre- and post-natal support services for women who reside in ZIP Codes with high Chronic Disease Vulnerability Index scores.
DCHHS Strategy	**Establish a Maternal/Child Health program in DCHHS.**
Metric 1	Medical Director of Public Health hired by June 2023.
Metric 2	Number of federal and/or state funding opportunities applied form.
DCHHS Activity 1	Hire new Medical Director of Public Health to develop maternal/child health programs and activities at DCHHS.
DCHHS Activity 2	Identify funding for future DCHHS maternal/child health programs.

MATERNAL AND CHILD HEALTH

Pediatric Asthma	
Problem Statement	**High asthma morbidity among pediatric population in South and Southeast Dallas, including but not limited to 75210, 75211, 75215, 75216, 75217, 75241**
Parkland 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 the health system. The purpose of this program is to enroll children with an asthma diagnosis in a text notification program that alerts patients and/or parents to follow appropriate preventive measures to avoid asthma exacerbation.
Metric 1	Percentage of patients with asthma from the targeted population who were prescribed an asthma therapy.
Metric 2	Number of pediatric patients with asthma from the targeted population enrolled into the notification program.
Metric 3	Percentage of patients with asthma from the targeted population who received a flu shot.
Activity 1	Identify children with high asthma risk and enroll in the ***Breath for Life & Learn*** for Life program.
Activity 2	Establish operational collaboration between Parkland, DCHHS and Dallas Independent School District (DISD): a. Identify students with asthma or at risk for asthma and encourage them to enroll in the ***Breath for Life & Learn for Life*** program. b. Conduct asthma risk assessments and screenings along with education.
Activity 3	Utilize Pediatric Asthma Surveillance System to identify high risk areas and to increase outreach strategies.
Activity 4	Conduct focus groups to better understand flu vaccine hesitancy.
Activity 5	Review controller vs. reliever medication use (asthma medication ratio) in patients with asthma to improve asthma therapy management.
Activity 6	Refer patients to DCHHS' Asthma Self-Management policy/procedures (AS-ME) program.
DCHHS Strategy	**Strengthen Dallas County pediatric asthma prevention and control programs.**
Metric 1	Number of AS-Me home visits conducted (with pre- and post-evaluation).
Metric 2	Number of children reporting controlled asthma at 6-month follow up.
Metric 3	Number of children with an asthma action plan at 6-month follow up.

MATERNAL AND CHILD HEALTH

Pediatric Asthma	
Metric 4	Number of children with initial uncontrolled asthma who improved after AS-ME.
Metric 5	Number of children who received AS-ME.
Metric 6	Number of children referred to Parkland's text notification system.
Metric 7	Number of ISD staff trained to provide AS-ME, and vaping prevention education.
Metric 8	Implementation of Pediatric Asthma Surveillance System (PASS).
Metric 9	Number of Dallas County CHWs and other local healthcare professionals who participated in asthma related training.
Metric 10	Obtain Dallas County pediatric asthma electronic case report data by October 31, 2023.
Metric 11	Ingest Dallas County pediatric asthma data into surveillance system by December 31, 2023.
Metric 12	Produce first pediatric asthma epidemiologic report of Dallas County by March 31, 2024.
DCHHS Activity 1	Expand AS-ME in schools and at home.
DCHHS Activity 2	Work with community partners (other hospitals, CBOs, FQHCs, etc.) to continue asthma epidemiological approach utilizing DCHHS asthma surveillance data.
DCHHS Activity 3	Obtain electronic case report from Dallas County area hospital systems for pediatric asthma diagnosis.
DCHHS Activity 4	Ingest Dallas County electronic hospital case report on pediatric asthma.

COMMUNITY EQUITY

Community Equity	
Problem Statement	**Specific geographic areas with concentrated low economic investment and low infrastructure as defined by the Center for Health Disparities Research at the University of Wisconsin are correlated with worse health outcomes including maternal and child health indicators in Dallas County. Consistent negative characteristic features of these well-defined areas are higher poverty rates, low access to food, higher mortgage forbearance rate, higher uninsured rates, shortage of physicians and limited access to healthcare facilities. A higher concentration of Black/African Americans, non-Hispanic and Hispanics reside in these areas.**
Parkland Strategy	Leverage Parkland's economic strength to develop underinvested communities.
Metric 1	Number of external hires from ZIP Codes with high CDVI scores.
Metric 2	Number of incumbent employees from ZIP Codes with high CDVI scores who experience career mobility.
Metric 3	Number of internal and external individuals from ZIP Codes with high CDVI scores accepted in Workforce Development programs.
Metric 4	Number of employees linked to Work Life Navigator.
Activity 1	Conduct recruiting and hiring efforts in communities with high CDVI scores.
Activity 2	**Workforce Development:** Provide career advancement opportunities for internal and external candidates from ZIP Codes with high CDVI scores through the following programs: a. Learning Experience Apprentice Program b. Career Navigator c. Education At Work d. Internships e. Nursing Advancement Program f. Reach for the Stars (scholarship) g. Tuition Reimbursement Program h. Establish Memorandum of Understanding with schools located in ZIP Codes with high CDVI scores
Activity 3	Complete workforce development data analysis and use results to develop evaluation methodology for Metric 1 and Metric 2, i.e., benchmarks and goals.
Activity 4	Assess employees for eligibility to receive coaching/mentorship through Work Life Navigators.
Activity 5	**Infrastructure Strengthening:** a. Collect and assess gaps in SDOH of health infrastructure such as access to care and coverage, preventive services, access to healthy foods, housing, transportation, childcare, etc. b. Work in collaboration with community partners to close infrastructure gaps related to SDOH.

COMMUNITY EQUITY

Community Equity	
Activity 6	**Establish the Justice, Equity, Diversity and Inclusion (JEDI) Council as the means to:** a. Respond to the diverse and evolving needs of Parkland's stakeholders; and b. Research, develop, advise, promote, and sustain evidence-based initiatives that will help create a safe, supportive, accessible, inclusive, and equitable environment; and c. Assure that JEDI-related activities are closely aligned with Parkland Health's mission, vision, values, strategic priorities, operations and overall business strategy.
DCHHS Strategies	**Address social determinants of health gaps such as access to housing, access to care, health literacy, health education, access to social services, etc.**
Metric 1	Number of accesses to care outreach events held in targeted homeless populations in Dallas County.
Milestones 2	Pathway for "Community First Village." a. Land purchased for "Community First Village." b. Development plans created. c. MOUs or contracts planned and implemented with key partners and on-site service providers.
Metric 3	Implementation of electronic application system for social services programs.
Metric 4	Number of mainstream vouchers distributed through Housing Choice Voucher Program.
Metric 5	Number of project-based vouchers distributed in Emergency Rental/Housing Assistance (ERAP/EHAP) program.
Metric 6	Number of staff trained and certified as a CHW through BSW.
Activity 1	a. Strategically coordinate social services to improve access to services and improve health of low-income Dallas County residents. b. Improve DCHHS presence in the community through expansion of community outreach and targeted community education events. c. Maintain a fully staffed, diverse and bilingual community outreach team.
Activity 2	a. Reduce homelessness and housing insecurity in CHNA identified ZIP Codes and other target areas. b. Increase access to care efforts targeted toward the homeless population or those at risk of homelessness. c. Develop and implement "Community First Village" Housing Development Project to provide social services, housing, and economic opportunities for chronically homeless individuals. d. Provide 78 mainstream vouchers to provide housing assistance to non-elderly persons with disabilities. e. Provide 40* project-based vouchers to assist low to moderate-income individuals and families with decent, safe and sanitary housing.
Activity 3	Partner with Baylor Scott and White to provide CHW training and certification to DCHHS staff.

PUBLIC HEALTH PRACTICE

Public Health Practice	
Problem Statement	**The process and restrictions pertaining to data sharing across public health and healthcare systems delay preemptive planning and response to chronic conditions.** **The increase in chronic disease rates in Dallas County calls for health systems and stakeholders to reevaluate their approach to patient activation and chronic disease self-management strategies.** **The lack of standard collection of REAL (race, ethnicity, and language) and SOGI (sexual orientation and gender identity) data across health programs and health organizations remains a challenge.**
Parkland Strategy	Develop surveillance systems that integrate primary care health data with SDOH and public health data to identify disease specific vulnerability by geographic area and priority populations.
Metric 1	Number of chronic disease surveillance systems launched.
Activity 1	Work in collaboration with DCHHS, PCCI, Correctional Health and community partners to develop chronic disease surveillance systems that integrate primary care health data with SDOH and public health data.
Activity 2	Create a collaborative with Parkland and DCHHS stakeholders to improve data sharing.
Activity 3	Improve the referral process to community-based organizations that offer chronic disease self-management classes.
Activity 4	Leverage Parkland's JEDI Council to advance the standard collection and reporting of REAL (race, ethnicity, and language) and SOGI (sexual orientation and gender identity) data.
Problem Statement	**Community-level public health morbidity and mortality data has historically been limited to publicly available sources, which is often several years behind the current year or is limited to case reporting by a small number of healthcare facilities that make it challenging to illustrate the full scope of community wide health issues and needs.**
DCHHS Strategies	**Leverage DCHHS' role as a key community health strategist to achieve enhanced data sharing and alignment for better understanding of community health conditions via the following strategies:** **a. Develop data sharing agreements and/or MOUs with State and Local healthcare organizations and institutions.** **b. Modernize and enhance public health and social services technology and information systems.**
Metric 1	Mortality Data MOU with DSHS is renewed annually.
Metric 2	Number of clinical and other relevant DCHHS programs fully utilizing Epic EHR system.
Metric 3	Number of conditions included in Comprehensive Disease Surveillance System.

PUBLIC HEALTH PRACTICE

Public Health Practice	
Metric 4	Number of health system partners included in Comprehensive Disease Surveillance System.
Metric 5	Established MOU with Housing Forward for linkage to HMIS system.
Metric 6	Implementation of client management software to streamline client applications for multiple social services.
Metric 7	Number of diseases/conditions DCHHS has implemented electronic case reporting for.
Metric 8	Develop public dashboard with city-specific mortality data.
Metric 9	Implementation of system for obtaining hospital case reporting data for chronic diseases.
Metric 10	Implementation of system to monitor hospital case reporting data for chronic diseases.
Activity 1	Annual review and renewal of Mortality Data MOU from Department of State Health Services.
Activity 2	Implement EPIC Electronic Health Record System (EHR) across DCHHS clinical and other relevant programs.
Activity 3	Implement Comprehensive Disease Surveillance and Investigation system.
Activity 4	Link Homeless Management Information System (HMIS) to internal integrated data management system.
Activity 5	Implement modernized electronic case management and data systems for Social Services programs.
Activity 6	Implement comprehensive electronic lab report ingestion and electronic case reporting systems.
Activity 7	Create city health profiles utilizing mortality and other available public health data.
Activity 8	Develop system for obtaining hospital case reporting data for chronic diseases including hypertension, breast cancer, pediatric asthma, and diabetes to identify priority areas and demographics.
Activity 9	Monitor hospital case reporting data for chronic diseases including breast cancer, pediatric asthma, diabetes and hypertension.

Public Health Practice

a. Enhance joint epidemiological approach to reduce cancer, diabetes, hypertension, heart disease, pediatric asthma and sexually transmitted infections in high priority areas of Dallas County.

b. Establish a joint Parkland-DCHHS maternal health epidemiological approach to reduce mortality in high priority areas of Dallas County.

c. Work with community partners (other hospitals, CBOs, FQHCs, etc.) to continue chronic disease epidemiological approach by integrating public health and primary care data.

d. Reduce the burden of chronic diseases in Southeast Dallas through policies and changes to increase access to healthy foods and physical activities.

Joint Parkland and DCHHS Strategies

e. Improve patient monitoring across the health system:

i. Strengthen monitoring of pregnant patients receiving all 3 syphilis screens.

ii. Increase percentage of pregnant patients receiving full treatment regimen.

iii. Utilize PCCI data support for re-engagement to care for Parkland patients.

iv. Utilizing PCCI data to target high morbidity blocks in Dallas County for sexual health screenings.

v. Parkland will support DCHHS in its efforts to develop data systems and analytic capacity to address disparities identified in the CHNA, to monitor progress, trends, and for program planning and evaluation.

vi. DCHHS will explore need for other sexual health clinic expansions in coordination with Parkland and other community providers.

DALLAS COUNTY
COMMUNITY HEALTH NEEDS ASSESSMENT 2022
IMPLEMENTATION PLAN

Parkland Health | Dallas County Health and Human Services

Parkland
Care. Compassion. Community.

DCHHS
Dallas County Health and Human Services
Healthy People Healthy Communities
Health and Social Equity

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Advancing public health performance