

City of Garland Health Department: Community Health Assessment



A Profile of health in our community

December 2014



Revised November 2017-January 2018

Table of Contents



Introduction: Vision and Values	3
Healthy Garland Steering Committee	4
Community Partners	5
Background and Planning Process	6
Summary of Assessment Findings	8
Demographics and Description of City of Garland	11
Geography.....	11
Demographics and Community Profile.....	11
Transportation and Commuting.....	20
Housing.....	26
Forces of Change Assessment	31
Community Themes and Strengths Assessment—Survey	35
Local Public Health System Assessment	40
Community Health Status Assessment	53
Review of other Health Assessments.....	55
Limitations and Revision, 2017-2018.....	64
Conclusion.....	65
Appendix A: Data Sources and sources consulted.....	66
Appendix B: Definitions.....	68
Appendix C: Community Assets.....	71
Appendix D: Community Health Status Assessment.....	72
Appendix D: Community Health Survey Results.....	122

Introduction

The community health vision and values were developed by the Healthy Garland Steering Committee with input from community members and Garland Health Department staff.

Garland strives to be a compassionate and safe community where essential needs are met and we are empowered with tools to lead a purposeful life and where everyone in our community has:

- Affordable and stable housing
- Healthy and affordable food
- Access to adequate educational opportunities
- Knowledge about healthy choices and healthy behaviors
- Access to health resources and information
- Access to affordable, quality health care
- An environment that promotes health and wellness
- Social support and connections to support health
- The ability and desire to contribute positively to society



Healthy Garland Steering Committee



We would like to thank and acknowledge the individuals and organizations who have contributed to this report:

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 - Garland Health Department
 - Garland Health Department
 - Garland Independent School District
 - Baylor Garland Medical Center
 - Garland Fire Dept
 - Garland GIS
 - Garland City Council
 - Garland citizen
 - Hope Clinic
 - Psychologist
 - Garland Health Department
 - Parkland Hospital
 - Dependable Health Care
 - Hope Clinic
 - Garland Fire Department
 - Garland Health Department
 - Garland Health Department
 - Garland citizen
 - Garland Health Department
 - Hope Clinic

“We need to develop and disseminate an entirely new paradigm and practice of collaboration that supersedes the traditional silos that have divided governments, philanthropies and private enterprises for decades and replace it with networks of partnerships working together to create a globally prosperous society.”-Simon Mainwaring

Community Partners

Alpha Charter School	Mayberry Gardens Assisted Living
Baylor Family Medical Center	New Beginnings Center
Baylor Medical Center Garland	Oak Park School
Carter Blood Care	Parkland Health and Hospital System
Chambrel at Club Hill Assisted Living	PR Ministries
Chandler Heights Neighborhood Association	Remington College
Coldwell Banker Apex	Senior Care
Dallas County Health & Human Services	TDSHS
Dallas County Medical Reserve Corps	Viet Face TV
Dependable Care Health Service	Winters Park Assisted Living Center
Early Head Start Garland	
First Baptist Church of Garland	City of Garland
Garland Association for Hispanic Affairs	Office of the Mayor
Garland NAACP	City Council
Garland Toastmasters	Parks and Recreation
Good Shepherd Catholic Church	Health Department
Head Start of Greater Dallas	Animal Services
Hope Clinic	Office of Emergency Management
Imagination Station	Geographic Information Services
Kids Green Acres	Fire Department
Lake Cities Montessori School	Neighborhood Vitality
Garland, Get Fit	Housing & Community Services
Garland Pawsibilities	

After the initial Community Health Improvement Plan was completed, infrastructure was put in place to support ongoing implementation. This involved engaging different groups in implementation. While several members of the original groups stayed active, several members left and new members and groups joined over the last 3 years. These groups have a wide variety of experience and expertise in their group's priority health issue. Together, they identify key areas for alignment and collaboration within the community. Additionally, each group has a chair that convenes the group and helps it move forward, with some staff support from the Garland Health Department. Over the last 3 years, community groups began working together to gain clarity around how to move forward with the priority health issues identified in the Community Health Improvement Plan as well as find opportunities for collaboration and collective action. This work continues to evolve.

Background and Planning Process



The **Healthy Garland Initiative** is a comprehensive approach to assessing community health and developing and implementing action-plans to improve community health through community member and partner engagement. This includes two distinct yet connected processes:

- The **community health assessment** process engages community members and partners to collect and analyze health-related data and information from a variety of sources. The findings of the community health assessment inform community decision-making, the prioritization of health problems, and the development and implementation of a community health improvement plan.
- The **community health improvement plan** is action-oriented and outlines the community health priorities (based on the community health assessment and community input). The plan also includes how the priority issues will be addressed to improve the health of the community.

This document presents the results of the community health assessment that was conducted by GHD in collaboration with a Healthy Garland Steering Committee (see page five for a list of members) which held committee meetings to complete the community health assessment.

GHD and the steering committee followed the Mobilizing for Action through Planning and Partnerships (MAPP) framework. MAPP is a model developed by the National Association of County and City Health Officials (NACCHO).

The MAPP process involves different layers of community health assessment, strategic plan development and goal and strategy formulation. Then follows a cycle of action steps, planning, implementation and evaluation. The MAPP ideal is to shroud all public health improvement activities and initiatives in a continual cycle of quality improvement. “Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is not an agency-focused assessment process; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems.” <http://www.naccho.org/topics/infrastructure/mapp/>.



The first step in the MAPP process is to conduct the four community health assessments to form an overarching picture of the health of the Garland Community. Beginning in February and completed in August, 2014, the Garland Health Department with the invaluable help of both City of Garland and community partners, overseen by the Healthy Garland Executive and Steering Committees, each of the four assessments were completed.

- **Forces of Change Assessment** to identify trends, factors, or events that influence health, quality of life, and the local public health system
- **Community Themes and Strengths Assessment** to provide a deeper understanding of the issues important to community residents.
- **Local Public Health System Assessment** to identify strengths and weaknesses of the local public health system.
- **Community Health Status Assessment** to analyze health data showing the health status of the community.

This report was developed with input from people representing the broad interest of the community and people with special knowledge or expertise in public health. Creating healthy communities requires a high level of mutual understanding and collaboration with individuals and partner groups. This CHA brings together information from community health leaders and providers, along with local residents, for the purpose of researching, prioritizing and documenting the health needs of the geographic area served. This assessment also culls information from the Dallas County Community Health Needs Assessment and Baylor Garland

Health Needs Assessment. It serves as the foundation for community health improvement efforts for the few three years.

The importance and benefit of compiling information from other recognized assessments are as follows:

1. Increases knowledge regarding community health needs and resources.
2. Creates a common understanding of the community's priorities as it relates to health needs.
3. Enhances relationships and mutual understanding between and among stakeholders.
4. Provides a basis upon which community stakeholders can make decisions about how they can contribute to improving the health of the community.
5. Provides rationale for current and future financers to support efforts to improve the health of the community.
6. Creates opportunities for collaboration in the delivery of services to the community.
7. Provides the department with guidance as to how it can align its services and community Health programs to best meet needs.

Act as if what you do makes a difference. It does. William James

Summary of Assessment Findings



The five leading causes of death in Garland are:

- Heart Disease

- Cancer
- Chronic Obstructive Pulmonary Disease
- Cerebrovascular Disease
- Diabetes Mellitus

The City of Garland is **not meeting Healthy People 2020** goals for the following health indicators, but the indicators are **showing improvement** since 2009:

- Heart disease mortality rate
- Infant mortality rate

The City of Garland **is meeting Healthy People 2020** goals for the following health indicators, but the indicators are **trending upward (worse)** since 2009:

- Motor vehicle accident mortality rate
- Accidental poisoning mortality rate
- Cancer mortality rate

The City of Garland **is not meeting Healthy People 2020** goals for the following health indicators, and the indicators are **trending upward (worse)** since 2009:

- Suicide mortality rate
- Injury related emergency department visits
- Cerebrovascular disease/stroke mortality rate
- Birth outcomes, rate of very low birth weight births

Other health indicators **trending upward** since 2009:

- All accident mortality rate
- Chronic obstructive pulmonary disease mortality rate
- Diabetes mortality rate

The five most commonly self-reported personal and/or familial health conditions:

- High blood pressure
- High cholesterol
- Arthritis
- Stress/Depression
- Diabetes (Type II)

The five least commonly self-reported personal and/or familial health conditions:

- HIV/AIDS
- Domestic violence (children)
- Gang related violence

- ATV injuries
- Homicide

The top five perceived health risks in the City of Garland are:

- Overweight adults
- Youth drug use
- Overweight children
- Poor eating habits
- Youth tobacco use

Over 50% of survey respondents reported satisfaction with the following in Garland:

- Quality of life
- Local healthcare system
- Access to immunizations
- Parks/sport/recreational facilities

Other key findings:

- Most people feel they have a good quality of life
- The City of Garland population is becoming older and more ethnically diverse
- The community is a good and safe place to raise children
- Despite overall good health, challenges and disparities are hidden among the averages
- Mental health and teenage pregnancies/Sex Education are a concern to the community
- Health insurance is unaffordable to many
- A large percentage of emergency room visits can be prevented

Next steps

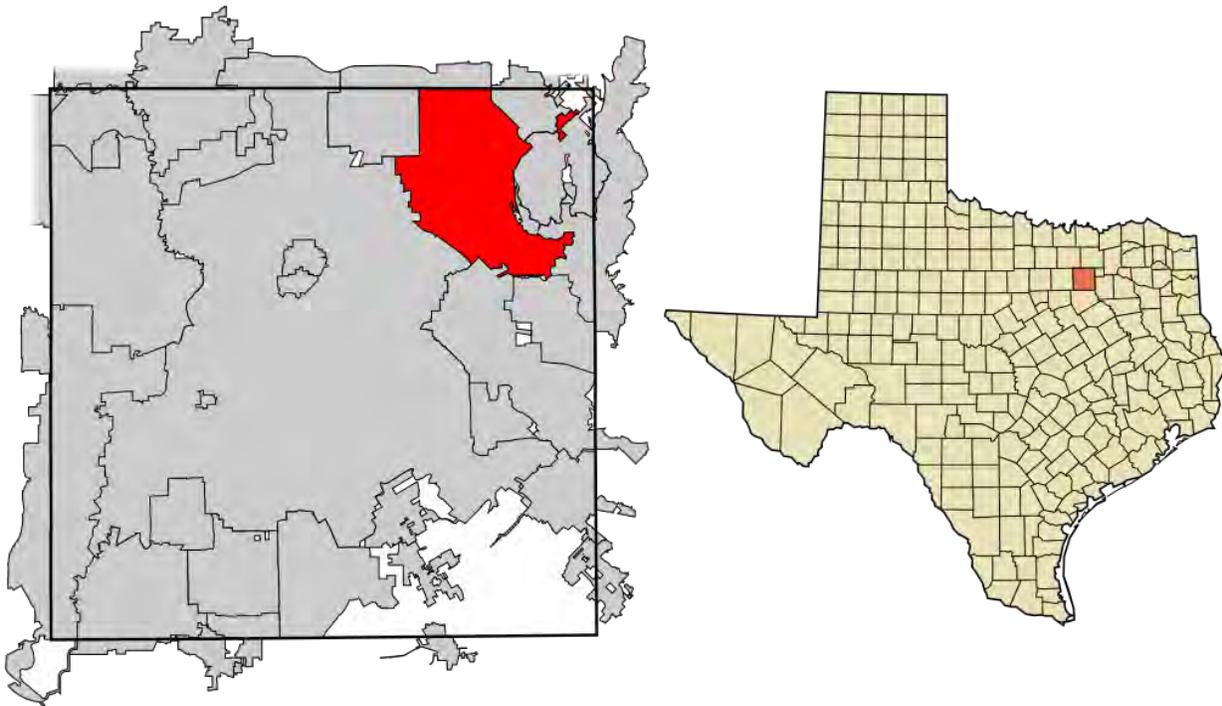
Each of the four assessment categories combines to form a comprehensive 360 degree review of the City of Garland's health status. However, as raw data, it simply serves as a broad tool to guide the efforts of a dedicated community. With that in mind, this information will be shared with a cross-section of community partners and leaders in an effort to narrow the focus to 4-5 priority areas targeted for improvement. Once the priorities are established, workgroups for each priority area will be established and a community health improvement plan will be initiated.

Demographics and Description



Geography

Garland is a large city northeast of Dallas and is a part of the Dallas–Fort Worth metroplex and located almost entirely within Dallas County, except a small portion located in Collin and Rockwall Counties. As of the 2010 census, the city had a population of 226,876, making it the 87th-most populous city in the United States of America and the 12th-most populous city in the state of Texas. Garland is second only to the City of Dallas in Dallas County by population. According to the United States Census Bureau, the city has a total area of 57.1 square miles (147.9 km²), all land. The population per square mile was 3,974.4. The city is part of the Upper Trinity Watershed and two major waterways running through it include Duck Creek and Rowlett Creek.



Demographic data and Community profile

The U.S. Census (2010), the American Community Survey, and the City of Garland Office of Community Planning and Development were used as data sources for this profile. The former provides estimates of the number of people that can be considered Low, Low to Moderate, and Low, Moderate, and Medium income persons according to annually revised income limits. The ACS Survey 5-year 2006-2010 Low and Moderate Income Summary Data went into effect on July 1, 2014. According to the Low/Mod Income data, the City of Garland is comprised of 62 census tracts and 163 census block groups.

The City of Garland had a total population of 226,876 persons at the time of the 2010 Census. The 2000 Census reflects a population of 215,768. Garland’s population grew by 11,108 persons (5.1%) over the ten year period from 2000 to 2010. Each year, the Garland Planning &

Community Development Department prepares an Annual Housing and Population Summary that includes a population projection based on building permit data, changes to occupancy rates, and household size. Based on the methodology, the January 1, 2015 population estimate is 234,533 persons which is 3.4% greater than the 2010 population.

According to the 2010 Census, the racial makeup of the community was majority White (57.5%), but also included populations identifying themselves as Black or African American (14.5%), Asian (9.4%), American Indian and Alaska Native (0.8%), and other races, including two or more races (3.3%). Approximately 38% of the Garland population identified themselves as being of Latino or Hispanic ethnic origin. See Table 1 below.

The demographic trends indicate that there are significant changes occurring in the City. From the 2000 to 2010 Census counts, the White population declined by 7.4% while all other population groups increased. Garland’s Black or African American population increased by 28.8%; Asian population increased by 35.1%; American Indian and Alaska Native population increased by 44.2%; persons with two or more races increased by 18.4%, and persons of Hispanic or Latino Origin grew by the largest overall percentage at 55.4%. Maps 2 and 3 below shows the distribution of Black or African American persons and persons of Hispanic origin. The maps indicates that the highest percentage of persons of Hispanic origin are primarily located in the areas of low and moderate income.

These overall demographic shifts, especially in the increases in persons of Hispanic or Latino origin, impacts several areas such as employment, transportation, healthcare, and housing needs.

According to the 2013 American Community Survey (ACS 5-year estimate), 73.0% of the people living in Garland were native residents of the United States. This is a decrease from the 2000 Census count of 79.8%. Fifty-two percent (52%) of 2013 ACS residents were living in the state in which they were born.

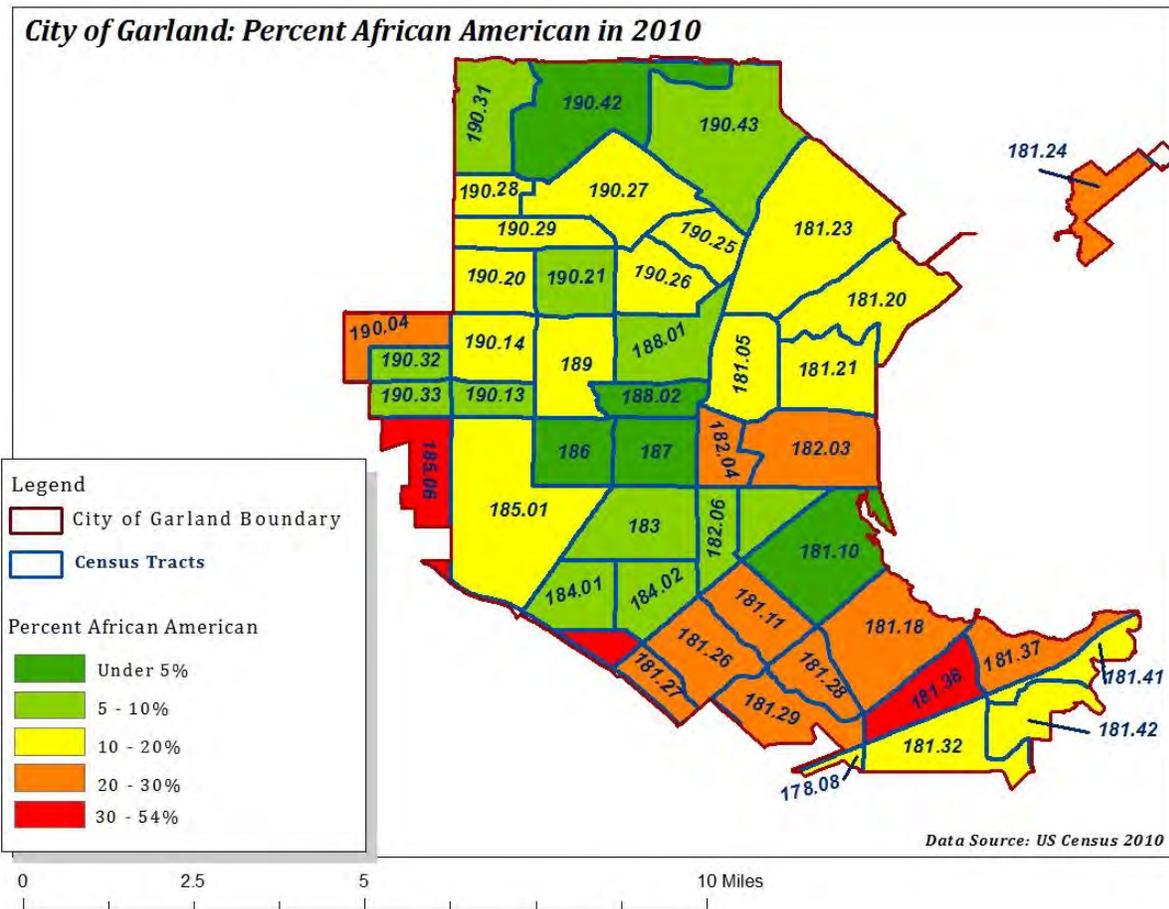
In 2013, 27.0% of the people living in Garland were foreign born (defined by the ACS as those born outside of the United States). This represents a 6.8 percentage point increase since the 2000 Census count of 20.2%. Of the foreign born population, 35.3% were naturalized U.S. citizens, and 64.7% were not U.S. citizens. As noted in Table 2 below, the mix of male and female population did not change significantly.

Table 1. Population/Race/Ethnicity: 2000 and 2010 Census Changes—City of Garland TX

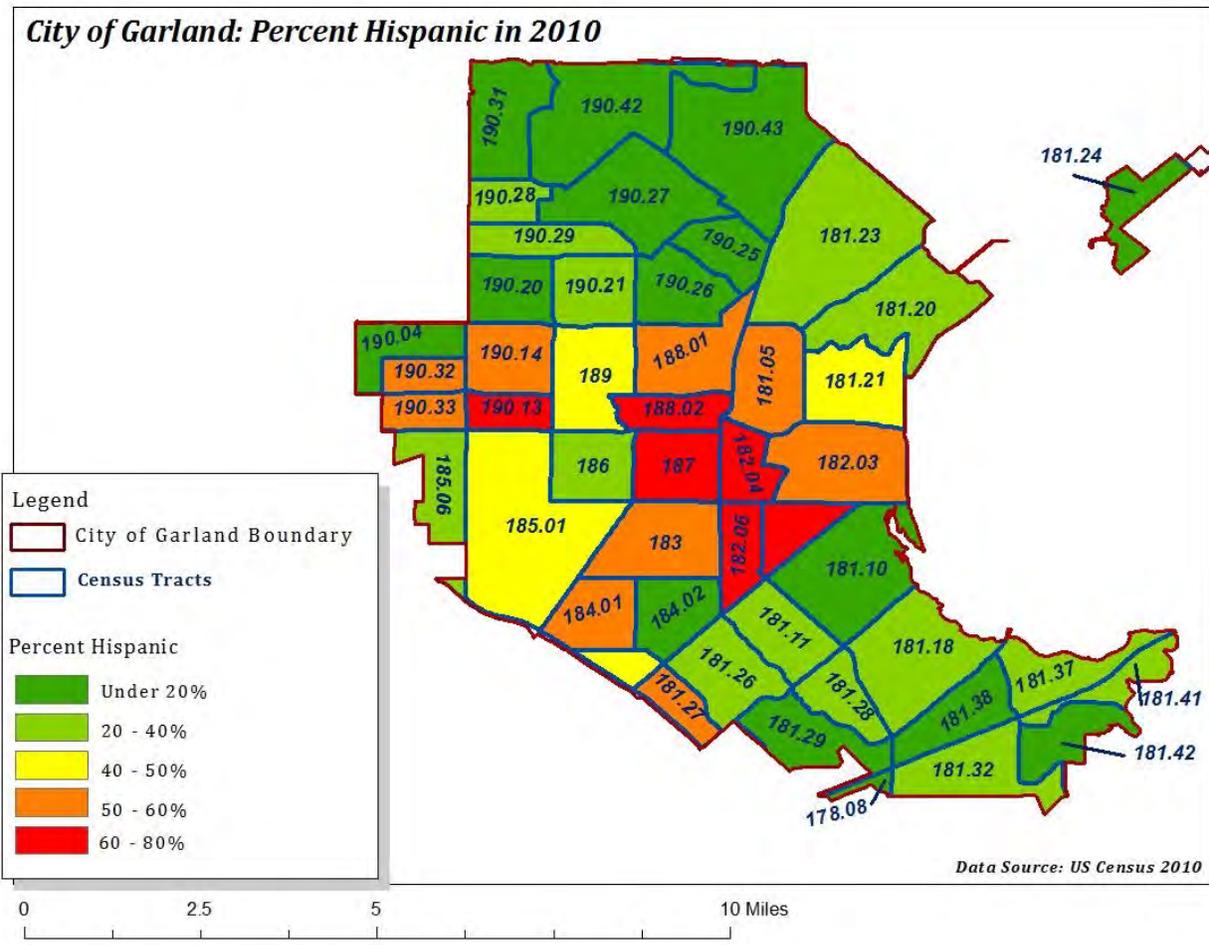
	2000 Population	% of Total 2000 Population	2010 Population	% of Total 2010 Population	2000 to 2010 % Change

Total population	215,768	100%	226,876	100	5.1%
Black/African American	25,609	11.9%	32,980	14.5%	28.8%
Asian	15,806	7.3%	21,352	9.4%	35.1%
American Indian	1,284	0.6%	1,851	0.8%	44.2%
White	140,835	65.3%	130,368	57.5%	7.4%
Two or More Races	6,231	2.9%	7,539	3.3%	21%
Hispanic or Latino Origin	55,192	25.6%	85,784	37.8%	55.4%

Map 1. Percentage Persons of Hispanic Origin 2010 – City of Garland TX



Map 2. Percentage Persons of Hispanic Origin 2010 – City of Garland TX



Household Characteristics

The average household size in Garland in 2000 was 2.93 persons and according to the 2013 ACS, the average household size increased to 3.09 persons per household. According to the 2013 ACS, among the 74,189 Garland households, family households (households with family members related through birth, marriage, or adoption) represented 76.1% of all households (56,424 households), including 39,102 (52.7%) married couple family households; 4,870 (6.6%) male-headed households; and 12,542 (16.9%) female-headed households. Non-family households comprised a significant amount of the population at 17,765 (23.9%) of all households.

Income Characteristics

The City of Garland is primarily located in Dallas County with a small area located in Rockwall and Collin counties. Dallas County is part of the Dallas, TX HUD Metro FMR Area which contains Collin County, Dallas County, Delta County, Denton County, Ellis County, Hunt County, Kaufman County, and Rockwall County. HUD’s 2013 Income Limits for the Dallas County, TX defined

Extremely Low (30%) Income Limits as those earning no more than \$20,250; Very Low Income (50%) Income Limits as those earning no more than \$33,750; and Low Income (80%) Income Limits as those earning no more than \$54,000. All figures are based on a household size of four (4) and a 2013 Area Median Income of \$67,500 for Dallas County. Although Income Limits were available from HUD for 2014, 2013 data was used for comparison with 2013 ACS data.

Table 2. FY 2013 Income Limits Summary Dallas County TX

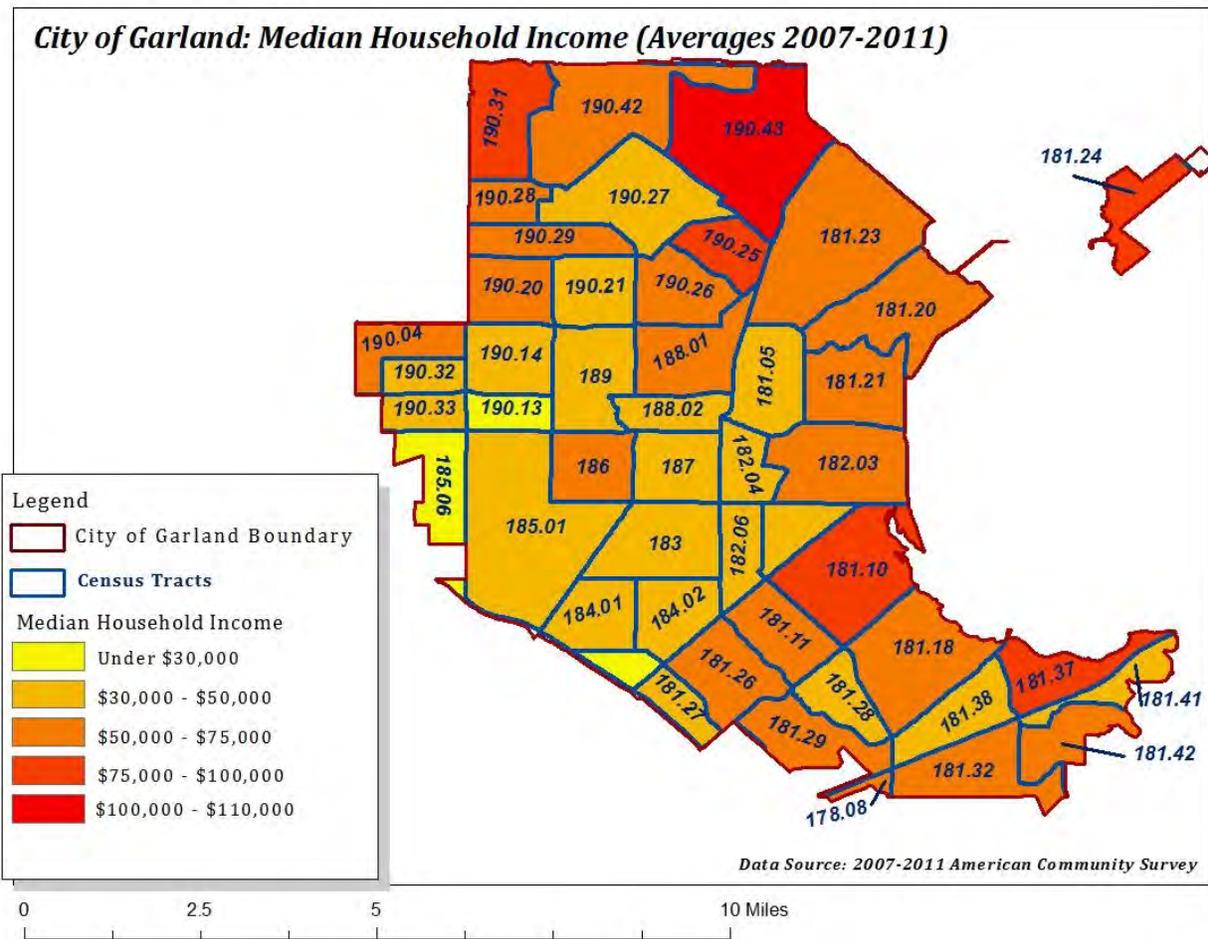
FY 2013	1	2	3	4	5	6	7	8
Income Limit Category	Person Household	Person HH						
Extremely Low (30%) Income Limits	\$14,200	\$16,200	\$18,250	\$20,250	\$21,900	\$23,500	\$25,150	\$26,750
Very Low (50%) Income Limits	\$23,650	\$27,000	\$30,400	\$33,750	\$36,450	\$39,150	\$41,850	\$44,550
Low (80%) Income Limits	\$37,800	\$43,200	\$48,600	\$54,000	\$58,350	\$62,650	\$67,000	\$71,300

Source: U.S. Department of Housing and Urban Development (HUD)

According to the 2013 HUD Income Limits Summary, the median household income in Dallas County was \$67,500. Within just the city limits of Garland, however, there was a lower median household income of \$51,842 (2013 ACS). In 2000, the City of Garland’s median household income was \$49,156 (2000 U.S. Census). Map 3 shows the median household income distribution in the City of Garland.

The 2013 ACS further illustrates that of the 74,189 households in Garland, 18.6% (13,794) earned less than \$25,000 annually, with another 29.6% (21,992) having earned between \$25,000 and \$50,000. For the middle and upper income brackets in 2013, 21.1% (15,671) earned between \$50,000 and \$75,000; 12.4% (9,227) earned between \$75,000 and \$100,000; and 18.2% (13,505) earned \$100,000 and up.

Map 3. Median Household Income 2007-2011 City of Garland TX



Per the 2013 American Community Survey, 16.2% of the Garland population subsists below the poverty level. This reflects a significant increase from 2000, when 8.9% of the population was below poverty level. In 2013, people ages 65 years and over had experienced an overall lower rate of poverty at 7.9%. People in families also experienced an overall lower rate of poverty in 2013 at 15.1%. Married couple families had the lowest poverty rate at 7.7%. Female-headed households experienced poverty at the greatest rate of all groups: 26.9% of female households with no husband present; 35.1% of female households with related children less than 18 years old; and 45.0% of female households with related children less than 5 years old only. This measurement is particularly stark when compared to their incidence in the total population (female-headed households with children make up 9.8% of all Garland households).

Table 3. Household Income Levels 2013- City of Garland TX. (ACS 2013, U.S. Census Bureau)

INCOME LEVEL	# OF HOUSEHOLDS	% OF HOUSEHOLDS
Less than \$10,000	3,151	4.2%
\$10,000 to \$14,999	2,743	3.7%
\$15,000 to \$24,999	7,900	10.6%
\$25,000 to \$34,999	9,445	12.7%
\$35,000 to \$49,999	12,547	16.9%
\$50,000 to \$74,999	15,671	21.1%
\$75,000 to \$99,999	9,227	12.4%
\$100,000 to \$149,99	9,190	12.4%
\$150,000 to \$199,999	2,920	3.9%
\$200,000 or more	1,395	1.9%

Of the 74,189 Garland households in 2013, 22.6% received Social Security income; 3.8% received Supplemental Security Income; 1.7% received cash public assistance income; 12.2% received retirement income; and 12.4% received Food Stamp/SNAP benefits.

Table 4. People Living Below Poverty Level 2013—Garland TX (ACS 2013, U.S. Census Bureau)

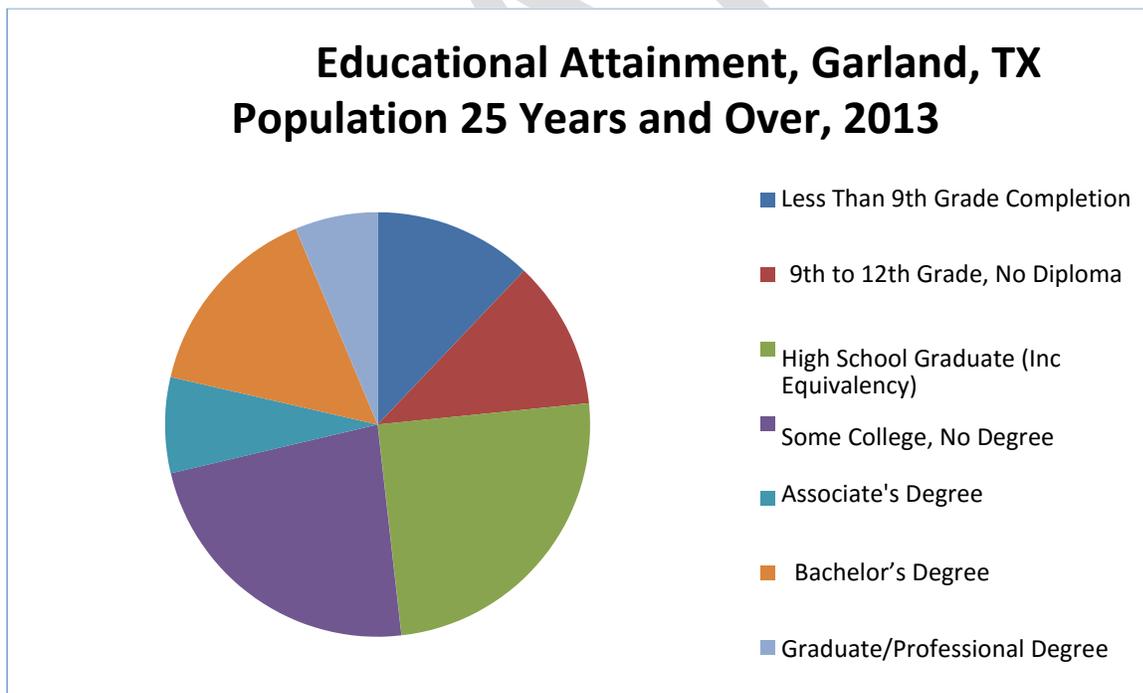
All People	16.2%
Under 18 Years	24.3%
Related Children Under 18 Years	24.1%
Related Children Under 5 Years	28.2%
Related Children 5 to 17 Years	22.6%
18 Years and Over	12.9%
18 to 64 Years	13.6%
65 Years and Over	7.9%
People in Families	15.1%
Unrelated Individuals 15 Years and Over	23.8%

Educational Attainment

Within the 2013 Garland population of persons 25 years and over (ACS), 24.8% of people had at least graduated from high school (including equivalency), 15.1% had a bachelor's degree, and 6.3% had a graduate or professional degree. Of the same population (25 years and older), 23.4% had less than a high school education diploma.

The total school enrollment for the population aged 3 years and over in Garland was 66,139 in 2013 (ACS). School enrollment is broken down into the following categories: 5.3% in nursery school/preschool; 6.2% in kindergarten; 44.2% in elementary school (grades 1-8); 23.0% in high school (grades 9-12); and 21.3% in college or graduate school

Figure 1. Educational Attainment



Employment

As of 2013, the Garland population aged 16 years and over numbered 171,649 persons, of which approximately 71.4% (122,551) were in the labor force and 64.1% (110,097) were employed. This reflects a significant increase in the unemployment since 2000 when Garland had 158,599 persons aged 16 and over. In 2000, 70.4% (111,712) of those persons were in the labor force and 67.1% (106,449) were employed.

The following figures give a larger view of the labor force changes within Dallas County, Texas, from January 1990 to November 2014.

Figure 2. Dallas County TX Civilian Labor Force, 1990-2014



The City of Garland has job opportunities in a diversified economy, and the character of its population is reflected in the major industries of employment. According to the 2013 ACS, the six top industries provide employment for 73.1% of the City’s civilian workforce:

Education services, and health care and social assistance -----	18.8%
Manufacturing -----	13.2%
Professional, scientific, management and administrative and waste management	
Services -----	11.5%
Retail trade -----	11.5%
Construction -----	9.3%
Arts, entertainment, and recreation, and accommodation and food services -----	8.9%

The top employer in Garland is the Garland Independent School District with 7,300 employees followed by the City of Garland, which hires 2,000 persons according to Garland Economic Development Partnership.

Transportation

Dallas Area Rapid Transit (DART) is a regional transportation agency serving 13 cities including the City of Garland. The major transit services include fixed-route bus service, light rail, and paratransit services.

In terms of services to protected class members, DART buses and trains are accessible by persons with disabilities and fares are reduced for seniors, age 65 and older, persons with disabilities, and persons with a Medicare card. Certified paratransit-eligible riders may use the bus and train services free. The reduced fare structure for the bus and train service is:

- Day Pass is \$2.50
- 2-hr pass is \$1.25
- Monthly pass is \$40.00

The hours of operation for DART services are convenient with hours between 4 a.m. and 12 a.m.



Paratransit services are available to persons with disabilities who are unable to use DART buses or trains. The service is operated with accessible vehicles and taxicabs. In order to utilize the paratransit service, riders must meet the ADA eligibility standards. Paratransit services operates on a daily schedule that is similar to the fixed route bus or rail services. Fares for paratransit is \$3 and personal care attendants ride free of charge.

There are two stations located in the City of Garland. They are the Forest/Jupiter Station and the Downtown Garland Station both of which are within Garland's largest employment centers. The Downtown Garland Station has the Garland City Hall, the second top employer, within its ½ mile radius. Both stations are an example of successful transit oriented development (TOD). According to the DART website, DART rail is seen as a catalyst for TOD and over \$8 billion in new projects is clustered near stations. The City's Comprehensive Plan, Envision Garland 2030, states that Garland's existing transportation network provides convenient access to the urban

center and major employment corridors in the region. Envision Garland 2030 includes a goal of integrating public transit into land use planning and development projects by:

- Advocating for a partner with DART in the planning and development of additional light rail/transit stations adjacent to major activity centers;
- Working with transit providers, developers, and property owners to integrate transit services and facilities in activity centers and other major destinations; and
- Continuing to support transit-oriented development.

In addition to jobs in close proximity to the transit stations, affordable housing is also available in close proximity thereby connecting low and moderate-income persons to employment opportunities. The Forest/Jupiter Station has several apartment complexes nearby including Forest Glen Apartments, Garland Gardens Apartments, Whisperwood Apartments, Jupiter Place Apartments, Shadowwood Apartments, Spanish Villa Apartments, and Parkwood Apartments. The Legacy Point Apartments is a Low Income Housing Tax Credit (LIHTC) project that is also in the immediate vicinity of the station and is comprised of 183 affordable housing units.

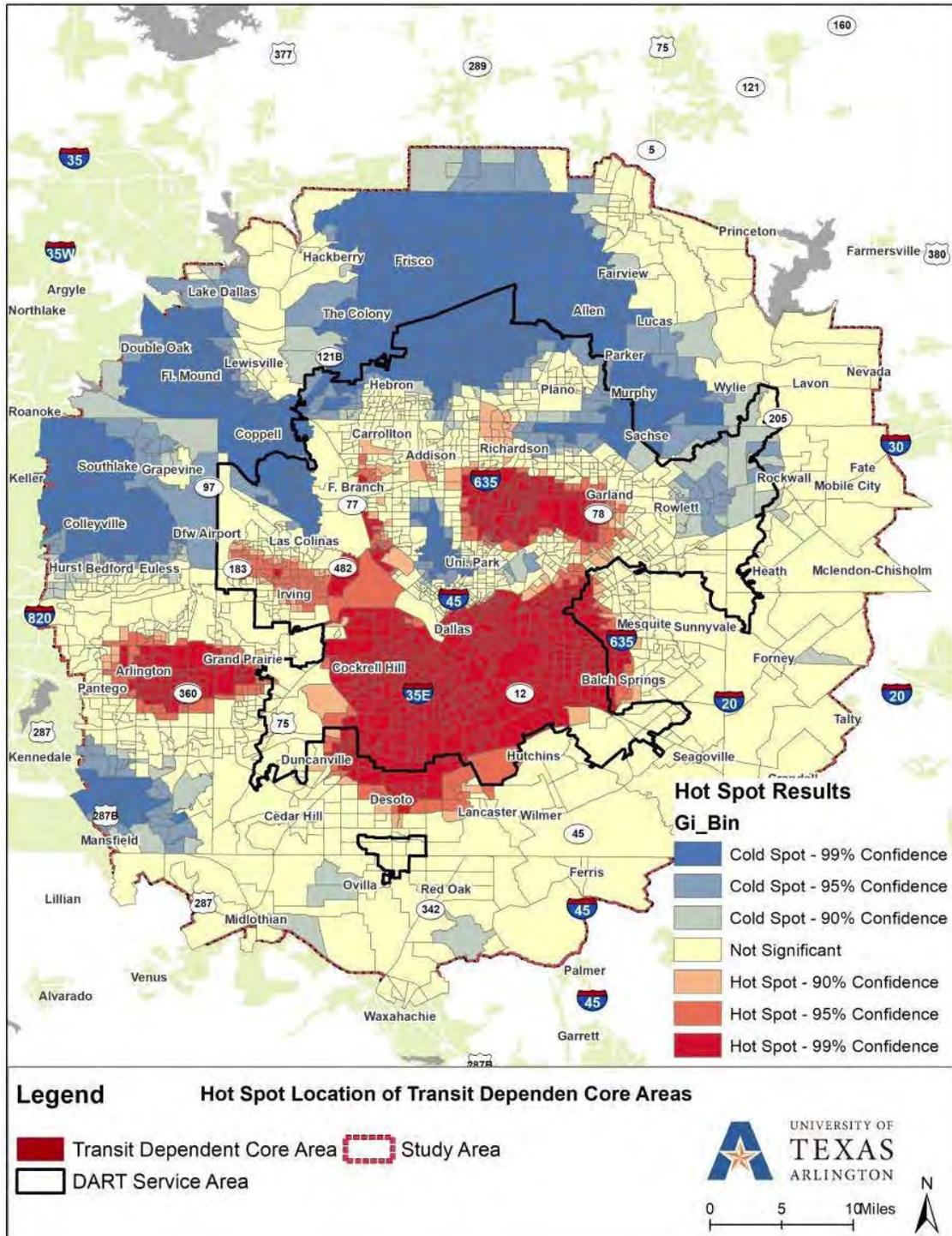
Insufficient public transportation and the siting of public transportation can have an impact on fair housing choice when it restricts access for riders who are of low- and moderate-income, persons with disabilities, and persons who are elderly. The City of Garland is currently providing transportation and affordable housing in relation to employment sites thus allowing minorities and low- and moderate-income persons more opportunities to secure employment and reducing barriers to fair housing.

However, in a recent report by University of Texas Arlington’s Institute of Urban Studies, “Transportation Equity and Access to Opportunity for Transit-Dependent Population in Dallas (county)” performed by the Mobility Solutions, Infrastructure and Sustainability Committee noted these key findings regarding the region/county:

- Transportation is unaffordable to 97.44 percent of the population of Dallas.
- More than 65 percent of residents who are dependent on transit have access to less than 4 percent of regional jobs.
- More than 73 percent of Section 8 Multifamily Affordable Housing properties in Dallas are unaffordable when transportation costs are factored in.
- About a third of Dallas residents and transit-dependent residents do not have walking access to a transit station.
- On average, just 18 to 22 percent of the population has access to high frequency service during morning and afternoon peak hours; but during off peak hours, that number drops to just 9 percent of the population. In the late evening, half the population must wait 30 minutes or more for transit or has no transit at all.

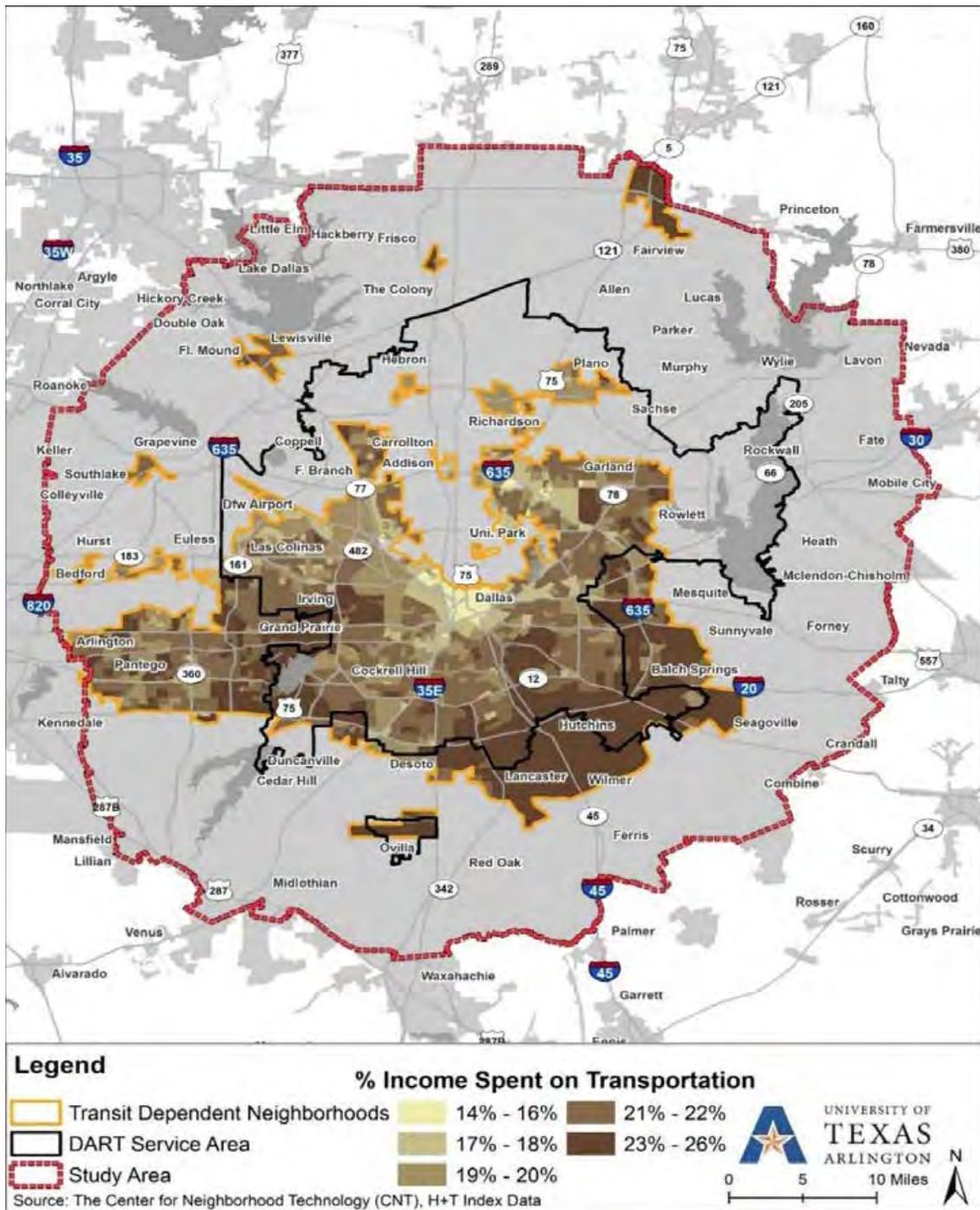
- Even though DART boasts the nation's longest light rail network, DART Ranks 23 out of 29 for large- and medium-sized transit agencies in the U.S. in terms of bus passenger miles per capita

Map 4. DFW Regional Hot Spot Transit-Dependent Locations, UTA 2014.



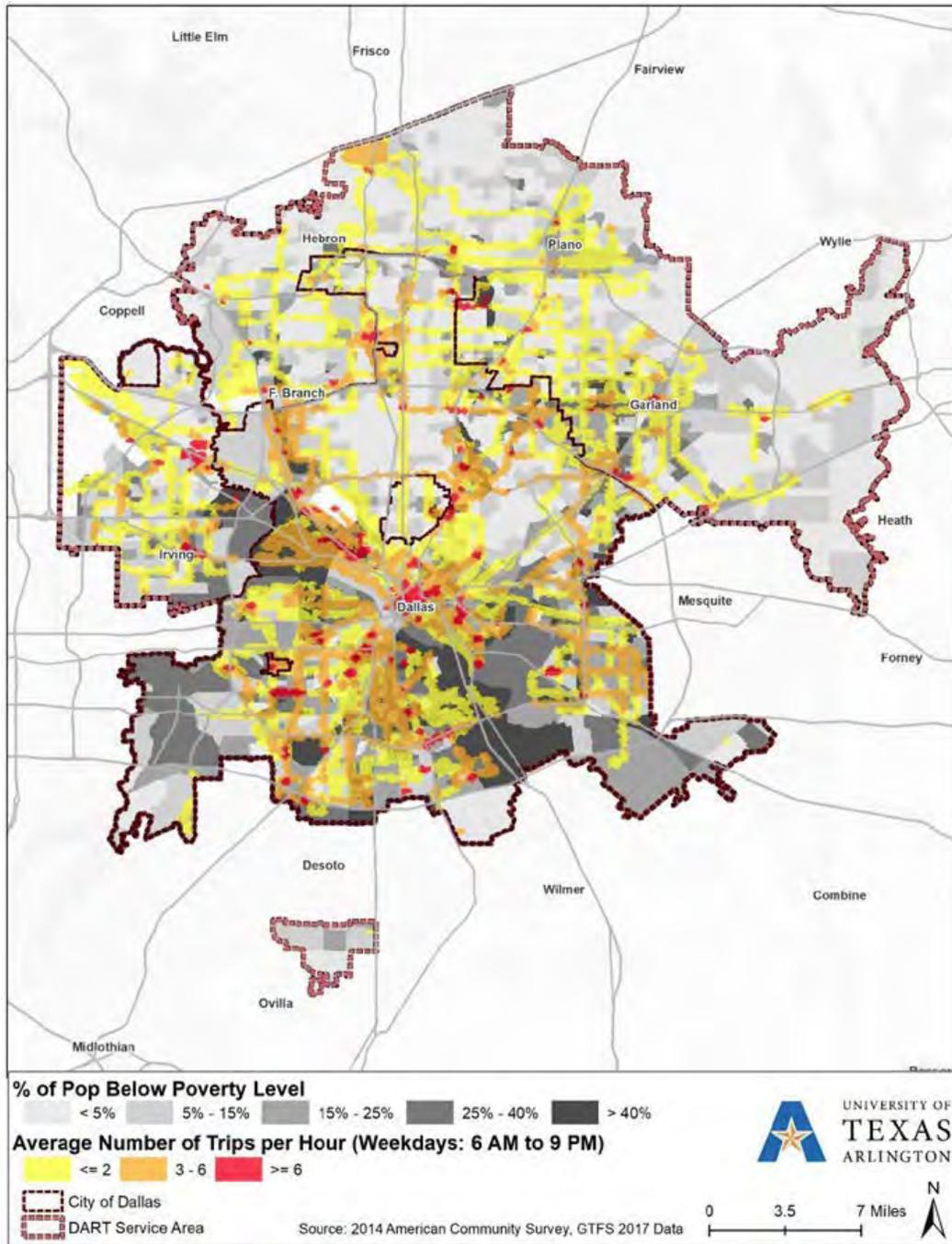
In this study, those who were defined as transit-dependent included minority groups, senior populations, low-income groups, and people with disabilities and without a license to drive. This map indicates a significant portion of Garland is transit-dependent. The following map indicates that a large portion of Garland, areas in dark brown north of Hwy 635 and along Hwy 78, spend 23-26% of their income on transportation.

Map 5. Disparities in Transportation Affordability. UTA 2014 data.



The study reported that a third of county residents and transit dependent areas do not have walking access (0.25 mile for bus and 0.5 mile for rail) to a transit station, that walking access to the transit station does not guarantee walkability, and that physical distance to transit stations could be a major barrier of transit use for this population. As indicated in the following map, the majority of Garland has less than two trips per hour.

Map 6. Transit Coverage: Average Number of Trips per hour. UTA, 2014.



Commuting

According to the 2013 ACS, 78.6% of Garland workers drove to work alone, 13.8% carpooled, and 2.3% used public transportation. Among those who commuted to work, it took them on average 27.6 minutes to get to work. A review of the ACS data shows that approximately 17.5% of commuters spent less than 15 minutes or more commuting one way to work. An additional 35.7% spent less than 30 minutes commuting one way to work. The largest group of commuters (21.3% of all commuters) spent less than 30 to 34 minutes commuting one way to work. The figure and table below show the modes of transportation used by Garland commuters and the commute time. The City’s Future Land Use Plan includes several ‘Building Blocks’ including the Employment Centers Building Block. This block provides accessible employment opportunities and due to the proximity of employment and residential uses, this type of development reduces commute times and distances.

Figure 3. Modes of Transportation—Commuting 2013. Garland TX

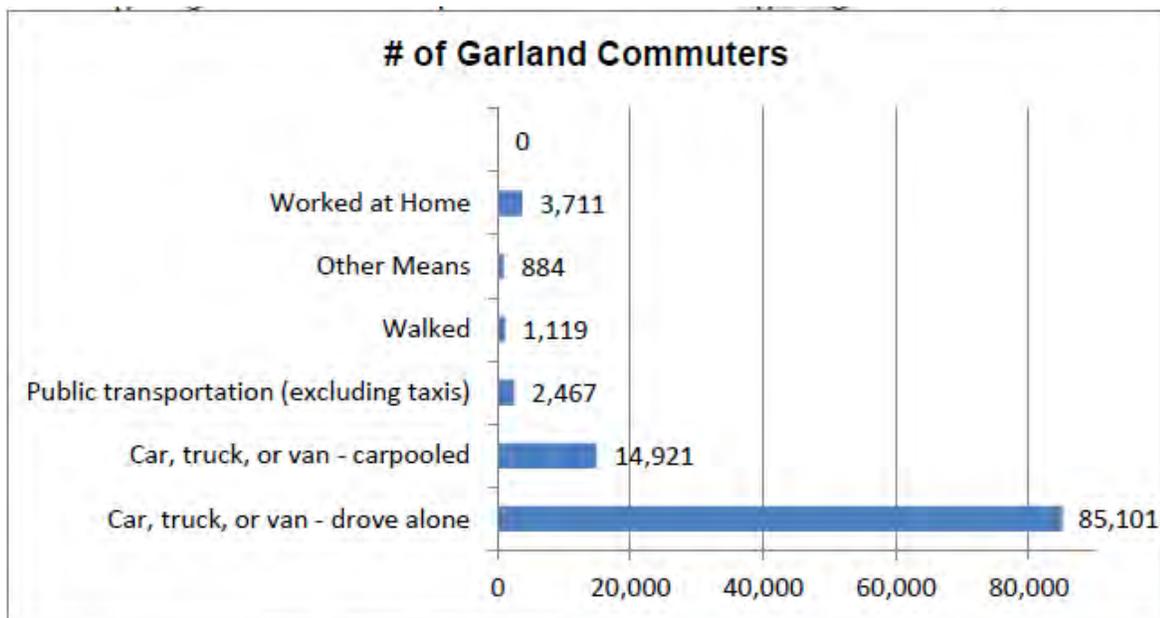


Table 3. Commute Times, 2013. City of Garland TX

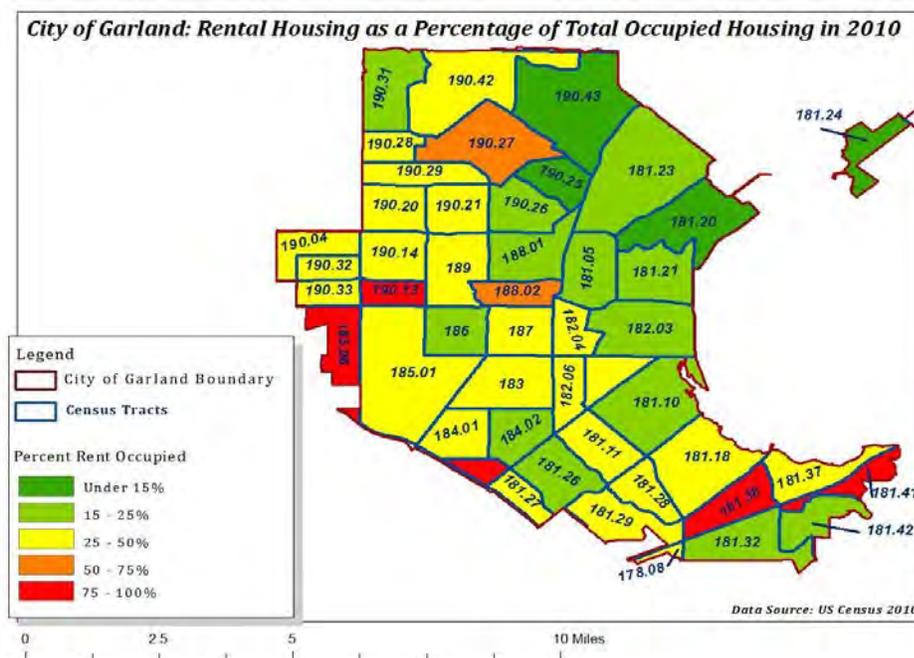
Travel Time to Work (one way)	Rate (%)
Less than 10 minutes	6.4%
10 to 14 minutes	11.1%
15 to 19 minutes	14.9%
20 to 24 minutes	14.2%
25 to 29 minutes	6.6%
30 to 34 minutes	21.3%
35 to 44 minutes	8.4%
45 to 59 minutes	10.4%
60 or more minutes	6.8%

Housing Profile

According to the 2010 U.S. Census, there are 80,834 housing units in Garland. The number of housing units has grown by 7.3% from 75,300 in 2000. The City's vacancy rate also rose from 2.7% in 2000 to 6.4% in 2010. In 2010, the City of Garland contained 75,696 owner-occupied units (61.1%), 26,321 renter-occupied units (32.5%), and 5,138 vacant units (6.4%). Figure 6 below shows housing tenure for Garland.

Not including vacant units, of the 75,696 occupied housing units in Garland in 2010, approximately 65.2% (49,375) were owner-occupied and 34.8% (26,321) were renter-occupied. This represents a slight decrease in the rate of homeownership, down from 65.6% in 2000, and a corresponding increase in rental tenure, 34.4% in 2000.

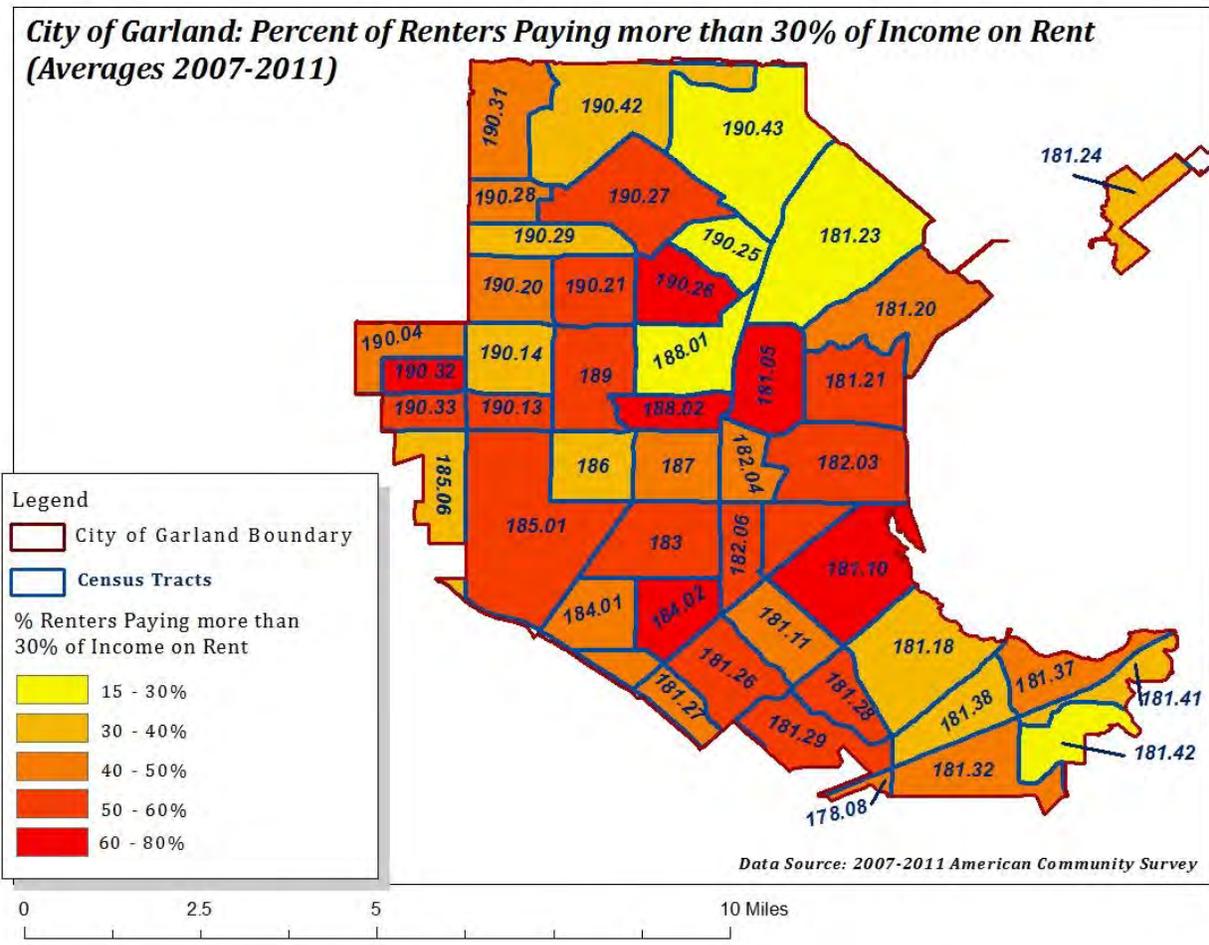
Map 4. Rental Housing as a Percentage of Total Occupied Housing.



Housing Condition

The predominant type of housing in Garland, as noted in Table 11, is single unit detached structures (72.2%), followed by structures with 5-19 units (13.2%), and structures with 20 or more units (6.5%).

The age of the housing stock in Garland as shown in Table 12 has an aging housing stock with 52.3% being built between 1970 and 1989 and 80% of units built before 1990. In terms of housing needs, the older units, may be in need of repair if they have not been rehabilitated or



There are 24,555 occupied units paying rent and 12,140 or 49.4% pay 30% or more of their household income on rental housing costs monthly; of this number 2,495 or 10.3% pay 30 to 34.9% of their income on rental housing costs. Another 9,645 or 39.8% pay 35% or more on renter housing costs.

Housing Problems

A disproportionately greater need exists when the members of racial or ethnic group at a given income level experience *severe housing problems* at a greater rate (10 percentage points or more) than the income level as a whole. This Section will analyze disproportionate greater need for income levels 0-30%, >30-50%, >50-80%, >80-100% AMI, by race or ethnicity. The severe housing problems included are as follows: overcrowding –more than one person per room, not including bathrooms, porches, foyers, halls, or half-rooms; and cost burden greater than 50%.

Table 5. Severe Housing Problems by Income Category and Race 0-30% AMI—Garland TX

Severe Housing Problems*	Has one or more of four housing problems	Has none of the four housing problems	Household has no/negative income, but none of the other housing problems
Jurisdiction as a whole	5,490	1,140	445
White	1,630	535	180
Black / African American	1,410	225	180
Asian	385	100	0
American Indian, Alaska Native	4	0	0
Pacific Islander	0	0	0
Hispanic	1,880	270	70

Table 6. Severe Problems by Income Category and Race 30-50% AMI- Garland TX

Severe Housing Problems*	Has one or more of four housing problems	Has none of the four housing problems	Household has no/negative income, but none of the other housing problems
Jurisdiction as a whole	4,655	5,030	0
White	1,165	1,895	0
Black / African American	800	560	0
Asian	450	265	0
American Indian, Alaska Native	4	40	0
Pacific Islander	0	0	0
Hispanic	2,110	2,140	0

Table 7. Severe Housing Problems by Income Category and Race 50-80% AMI –Garland TX

Severe Housing Problems*	Has one or more of four housing problems	Has none of the four housing problems	Household has no/negative income, but none of the other housing problems
Jurisdiction as a whole	2,280	12,220	0
White	610	5,060	0
Black / African American	230	1,500	0
Asian	175	820	0
American Indian, Alaska Native	0	65	0
Pacific Islander	0	0	0
Hispanic	1,140	4,280	0

Analysis of the 2007-2011 CHAS data for Garland indicates that various racial or ethnic group at given income levels are experiencing *severe housing problems*, including cost burden greater

than 50%, at a disproportionately greater rate in comparison to the jurisdiction as a whole, as follows:

- American Indian, Alaska Native in the 0-30% AMI;
- White in the >30-50% AMI;
- Black/African American in the >30-50% AMI;
- Asian in the >30-50% AMI

Disabilities

Of the residents surveyed a recent Garland Fair Housing survey, 17.6% stated that they or someone in their household had a disability or handicap. Conversely, 58.8% of respondents answered that they or someone in their household did not have a disability or handicap. Finally, 23.5% of respondents skipped the question entirely. The census however indicated 7.4% of people under age 65 years with a disability.

Conclusions

The city of Garland is a unique city with an increasingly diverse population, having disproportionately more Latino and Asian residents than Dallas county as a whole. This brief demographic profile identified areas of the city that are more likely to experience adverse health outcomes or other barriers to accessing healthcare due to socioeconomic status, race, ethnicity, or other factors that precipitate disparities and health inequities. Future programs, interventions, and community feedback will account for these observations.



Forces of Change Assessment (2014)



The Forces of Change Assessment was conducted by the Healthy Garland Steering Committee on April 30, 2014. This assessment identifies trends, factors, or events that influence the health and quality of life of the community and the work of the local public health system. It answers the questions: What is occurring that affects the health of our community? What threats or opportunities may be generated by these occurrences? The following table presents key findings of this assessment.

Forces of Change (trends, events, factors)	Opportunities	Threats
<p>Changes in Healthcare</p> <ul style="list-style-type: none"> • Healthcare reform • Access to basic physical, dental and mental health care has improved with an increase in providers but it is still not affordable and accessible to all • Health insurance costs are high and coverage is poor • Hospital revenue 	<ul style="list-style-type: none"> • Healthcare reform has the potential to increase access to health services • Development of a medical home model in primary care clinics which has the potential to help improve and manage the health of patients • Opening of Methodist Richardson 	<ul style="list-style-type: none"> • State and federal proposed legislation that could negatively affect access to health care • Parkland over capacity • Closure of Baylor Garland • MRDOs/Antibiotic resistance
<p>COMMUNITY DISENGAGEMENT</p> <ul style="list-style-type: none"> • Lack of community events, community involvement, and community identity • Disengagement with current events and social and political Responsibility • Vaccine denial 	<ul style="list-style-type: none"> • Community needs to find local solutions for local issues • Create a purpose or reason for people to volunteer • Focus on building leaders in unengaged community groups 	<ul style="list-style-type: none"> • Lack of engagement may lead to lack of community resources • Regular volunteers can become overextended • Re-emergence of pertussis, measles

<p>Changing Demographics</p> <ul style="list-style-type: none"> • Increased cultural and ethnic diversity (Hispanic/Latino, other ethnicities) • Increase in retirement population • Increased divide between income levels 	<ul style="list-style-type: none"> • Increases business opportunities positively • Greater cultural diversity leads to greater cultural richness • Brings more financial resources to the community 	<ul style="list-style-type: none"> • Some services are not sufficient to serve the population • Concerns about immigration issues
<p>Hwy 635 Corridor Location</p> <ul style="list-style-type: none"> • Drug trafficking present • LBJ Frwy road improvements • An increase in commuting 	<ul style="list-style-type: none"> • Garland could be a hub in the state for resources and activities 	<ul style="list-style-type: none"> • Proximity to population centers may create an unwanted urban environment • Local resources used for non-residents
<p>Economic Trends</p> <ul style="list-style-type: none"> • Increasing unemployment • Fewer higher paying jobs • High poverty (49% residents @ 200% FPL). • Aging housing stock 	<ul style="list-style-type: none"> • New collaborations and advocacy groups • Larger workforce to choose from • Opportunity to identify inefficiencies and increase in community involvement 	<ul style="list-style-type: none"> • Services reduced • Further loss of jobs and infrastructure • Increase in substance abuse trends • Increasing homelessness
<p>Politics and Government</p> <ul style="list-style-type: none"> • State and federal differences in laws about drugs • ACA contested • Texas has not extended Medicaid under ACA • Governmental budget cuts 	<ul style="list-style-type: none"> • Advocacy and education at all levels • Garland smoking ordinance 	<ul style="list-style-type: none"> • Continued budget cuts • Increase in levels of drug use and underage drinking • Texas' Women's Health Program underfunded

<ul style="list-style-type: none"> • Cottage food bill 		<ul style="list-style-type: none"> • Decrease in medical providers due to heightened financial requirements
<p>Environmental</p> <ul style="list-style-type: none"> • Climate change • Air quality issues 	<ul style="list-style-type: none"> • Potential for clean and renewable energy • Encourage development of non-motorized transportation 	<ul style="list-style-type: none"> • Poor air quality; DFW non-attainment area (TCEQ) • Increased risk of flooding with climate change
<p>Changes in Leadership</p> <ul style="list-style-type: none"> • Organizational leadership • State and local government 	<ul style="list-style-type: none"> • Develop a formal process for orientation to community services for new leaders 	<ul style="list-style-type: none"> • With elected officials changing, programs and ideas can get lost
<p>Home life/Family Environment</p> <ul style="list-style-type: none"> • Resources 	<ul style="list-style-type: none"> • Focusing on positive home life may result in positive health outcomes 	<ul style="list-style-type: none"> • Manage familial stress •
<p>Access to Healthy Foods</p> <ul style="list-style-type: none"> • Local ag support for access to healthy foods • Local foods more available • Local agencies adopting policies and procedures around access to healthy foods 	<ul style="list-style-type: none"> • Education on benefits to local foods • Community events that promote access • Local community gardens • More local businesses that promote local foods 	<ul style="list-style-type: none"> • Climate and geography • Local programs don't have as solid of a base as they could have
<p>Educational Infrastructure</p> <ul style="list-style-type: none"> • Healthy Schools Initiative 	<ul style="list-style-type: none"> • New Gilbreath-Reed Career Center 	<ul style="list-style-type: none"> • Higher education costs; continue to rise

<ul style="list-style-type: none"> • People considering the value vs. cost of higher education • Better identification of developmental disabilities in students 	<ul style="list-style-type: none"> • More non-traditional career paths • Students with disabilities have more opportunities 	<ul style="list-style-type: none"> • Students in need slip through the cracks in the system
<p>Land Use/Development</p> <ul style="list-style-type: none"> • Unintentional environmental consequences from development (flooding, erosion) • Garland build-out—not much undeveloped land 	<ul style="list-style-type: none"> • Establish policy and education on building in flood plains • Develop better policies/transit-oriented/pedestrian-friendly development 	<ul style="list-style-type: none"> • Home damage due to flooding

Conclusion

The Forces of Change assessment revealed that several factors, both specific to Garland and shared with other communities, are affecting or could affect the health of our community. Each of these presents important opportunities to improve the community’s health or threats that may need to be addressed or considered. Participants noted that Garland’s aging population is a trend that can negatively affect cerebrovascular disease and stroke mortality rates. Since this assessment was originally done, one major force of change that precipitated this revision is the closing of a major hospital in Garland, Baylor Scott and White Garland, scheduled to close February 28, 2018. Threats anticipated from this even include more adverse health outcomes, especially events that require urgent critical care, increased stress on the local Emergency Services and local public health system, and decreased access to care.

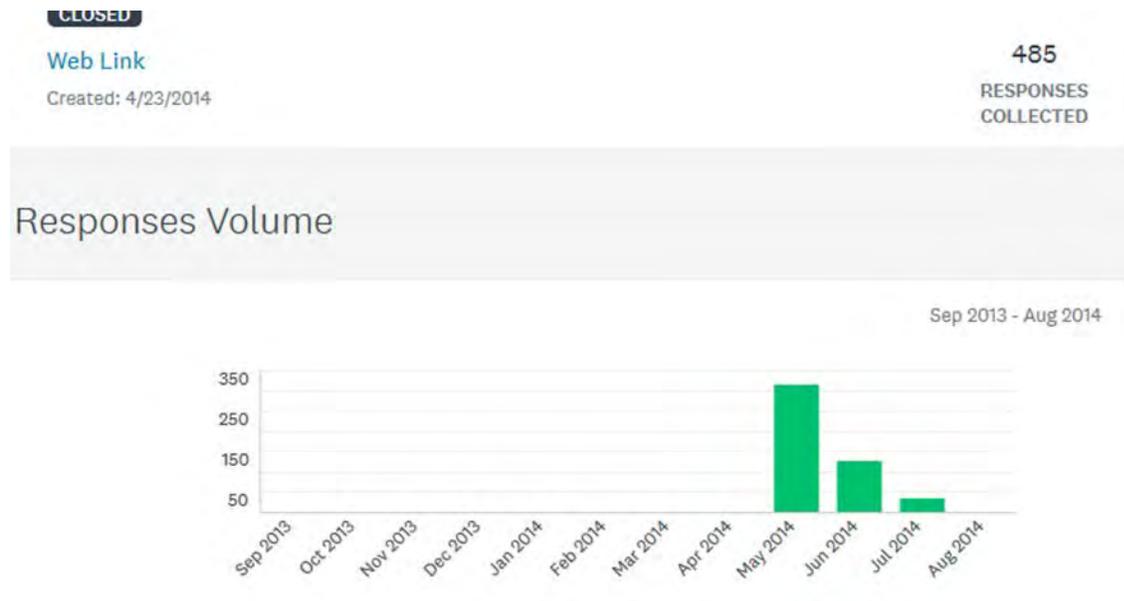
Community Themes and Strengths Assessment

The Garland Community Themes and Strengths Assessment was conducted over a 2-month period from May 1 to June 30, 2014. The assessment used an on-line survey tool and was open to the citizens of Garland. The assessment tool was completed anonymously and consisted of 16 questions designed to allow participants to self-report on personal and familial medical conditions, perceived public health problems in the community, and to offer input on assets, programs, and facilities available or needed in order to live a healthy lifestyle. This assessment helps to provide a deeper understanding of what issues residents feel are important, how quality of life is perceived, and what community assets we have that can be used to improve community health.



The community health survey was distributed electronically and in libraries and community centers and 485 surveys were completed. The survey asked questions regarding quality of life, health care, children, elderly, economic opportunity, safety, social support, community health, stress, and risk behaviors in the community. Some limitations of the survey's applicability to the general population are that respondents were disproportionately female and white. In other words, men and African Americans are under-represented in this survey. The complete results of this survey as displayed by surveymonkey.com can be found in Appendix E.

Figure 3. Community Health Survey, Garland TX 2014. Response rate on surveymonkey.

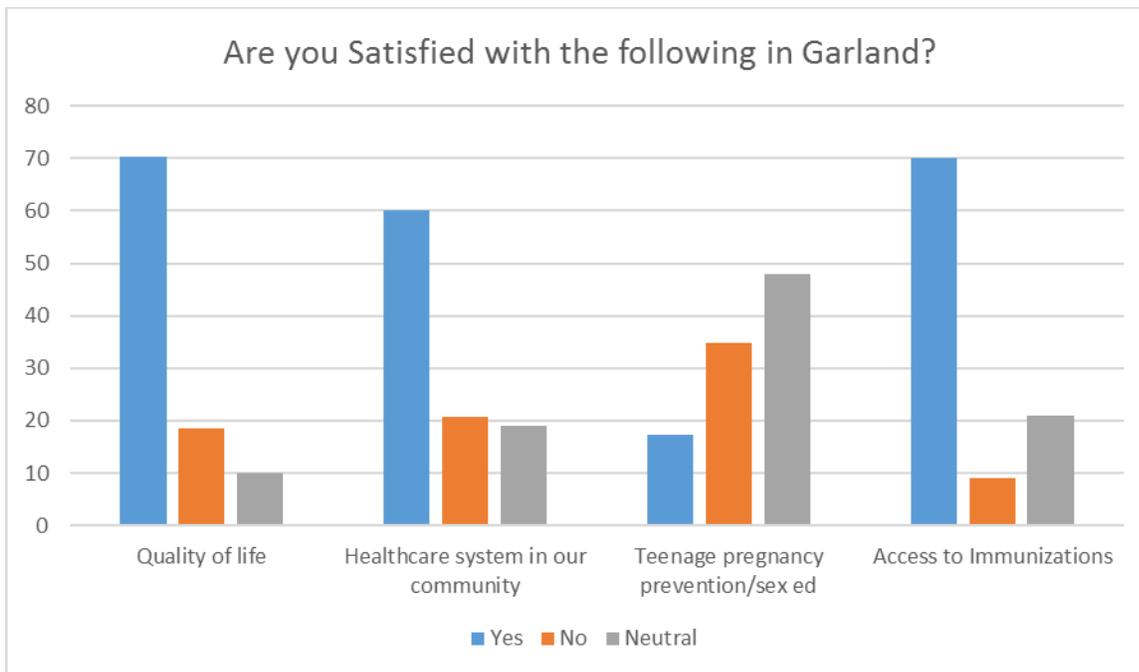


Quality of Life

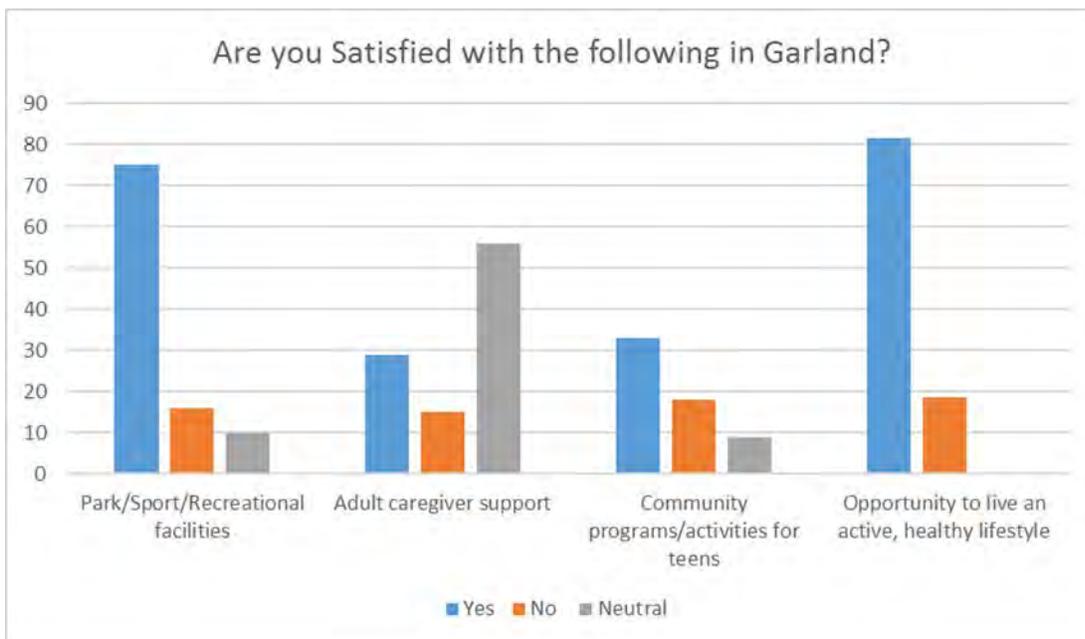
The survey asked the question, “Are you satisfied with the following in Garland?”: *Quality of life, Healthcare system in our community, Teenage pregnancy prevention/sex education, Access to immunizations, opportunities to live an active, healthy lifestyle, Park/Sport/Recreational facilities, adult caregiver support, community programs/activities for teens.*

The responses to this set of questions indicated several areas that could be improved. Although the majority of respondents (70%) satisfaction with the quality of life in our community, which approximates national figures, the proportion of respondents answering in the affirmative to how satisfied they are with teenage pregnancy prevention/sex education, adult caregiver support, and community programs/activities for teens was significantly lower at 17%, 29%, and 33 % respectively. Moreover, only 60% responded to being satisfied with the healthcare system in our community. These areas will be investigated by the subcommittee to evaluate to what extent messaging, linking people to services, or service gaps are impinging on these perceptions

Graph 1. Community Health Survey – Garland TX, 2014.



Graph 2. Community Health Survey –Garland TX, 2014.



Nearly one in four survey respondents responded that they had foregone healthcare due to inability to pay in the previous year, slightly higher than the national average of approximately one in five. This is further corroboration of the need to focus on access to health services and the financial barriers many encounter when seeking to be treated. Of those responding to this survey, only 45% responded positively to having their child visit a dentist within the past year, a number significantly lower than the average of 84.7% of children (2-17 years old).

The survey response indicated that around 27% of respondents were covered by some form of government insurance or Government-provided care (Medicare, VA, Medicaid, and CHIP). This is slightly lower than the national average of 30%, but not statistically significant. In the United States, about 17% of health care costs are paid for out-of-pocket. Having to pay for health care in this way contributes significantly to many bankruptcies in the U.S. In this survey response, 25% of respondents reported paying cash (no insurance) for health care, which tracks the previous question assessing health care system engagement due to lack of funds.

Nearly 25% of survey respondents reported going without healthcare in the previous year because they could not pay for it. This is consistent with national data. A Commonwealth Fund report, a private foundation that conducts independent research on health and social issues, finds that even though more Americans now have health insurance, many still avoid seeing doctors because of high out-of-pocket expenses. Because of high health insurance deductibles, approximately 23 percent of Americans ages 19 to 64 were considered underinsured. This amounts to 31 million people who chose not to fill essential prescriptions, undergo necessary diagnostic tests or procedures or see specialists out of fear that doing so would leave them in a financial lurch. Also notable in this section, over 41% of respondents reported that underage drinking is a problem in Garland. Obesity was also a concern, with 70% of respondents reporting concern about the number of overweight children.

The majority of respondents for this set of questions answered affirmatively when asked whether the Garland community is a safe place to live, grow old, and a good place to raise children. Although, roughly one in five respondents answered negatively to whether Garland is a good place to grow old, which comports with the previous question that indicated low satisfaction with adult caregiver support.

Among top concerns reported by this question, a consistent theme emerged. The perceived health risk of overweight adults and children weighed in at nearly 40% and 35% respectively, following closely by inactive lifestyle, and poor eating habits. Alcohol, tobacco, and drug use among youth were also leading perceived health risks, with the number of respondents reporting youth drug use as a top concern at 35%. The Healthy Garland steering committee identified these areas as priorities for formulating future interventions and programming.

The community health survey revealed that in general, people who answered the survey feel they have a good quality of life. The community is a good, safe place to raise children, but sometimes the support systems are lacking. Moreover, concerns were raised about the lack of economic opportunity, lack of teenage pregnancy prevention/sex education programs, and dissatisfaction with the local health care system. Survey respondents are most stressed about money/finances, work/jobs, and family responsibilities. Mental health concerns were also a major source of stress. Respondents believe that good jobs and a healthy economy, access to health care, and having healthy behaviors and lifestyles are the most important factors for a healthy community. Yet, youth tobacco use, poor eating habits, drug/alcohol abuse, and overweight adults and children were the major concerns in the community. The five most commonly reported personal and/or familial health conditions were high blood pressure, high cholesterol, arthritis, depression/stress, and Type II Diabetes.



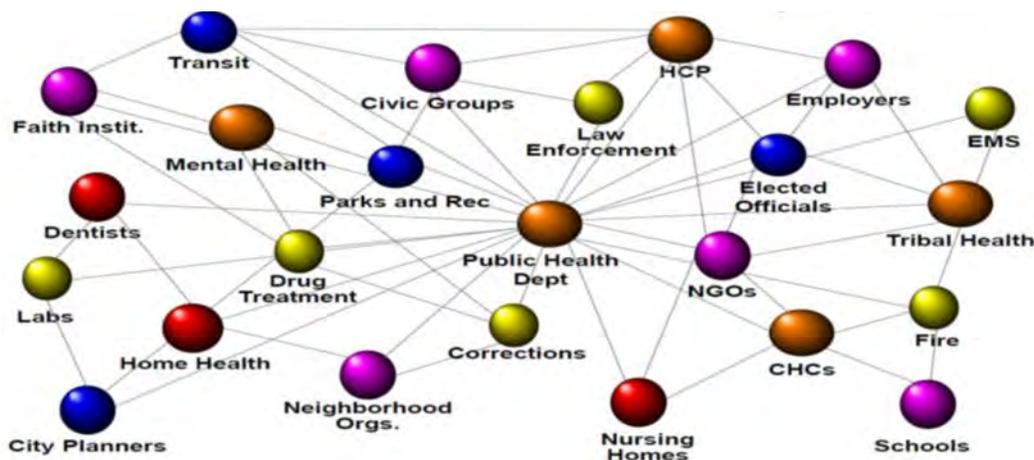
Local Public Health System Assessment

The Local Public Health System Assessment uses a survey tool from the National Public Health Performance Standards Program that was completed by the Community Health Improvement Steering Committee along with other community members and public health system partners such as Garland’s Office of Emergency Management, Parkland Hospital, Department of State Health Services, Hope Clinic, and Garland Public Health Department. The tool is based on the Ten Essential Public Health Services and seeks to identify strengths and weaknesses of the local public health system.



The local public health system is comprised of all the organizations and entities that contribute to public health in a community. The LPHS can be visualized with the graphic below:

Figure 11. Local Public Health System.



This assessment answers the questions: What are the components, activities, competencies, and capacities of our local public health system? How are the Ten Essential Public Health Services being provided to the community? The information obtained from assessments may then be used to improve and better coordinate public health activities at state and local levels. In addition, the results gathered provide an understanding of how state and local public health systems and governing entities are performing. This information helps local, state and national partners make better and more effective policy and resource decisions to improve the nation's public health as a whole.

The Local Public Health System Assessment was conducted on February 27, 2014 and included participants from diverse partners representing areas of the Local Public Health System (LPHS). This assessment uses a tool developed by the Centers for Disease Control and Prevention to determine the level at which the 10 Essential Public Health Services are provided by the LPHS.

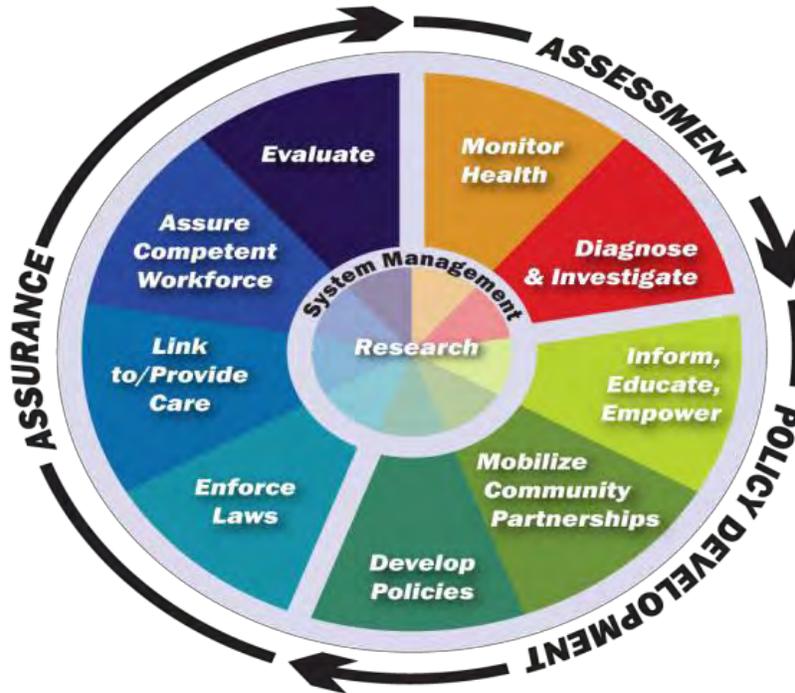
High-functioning LPHSs provide all of the 10 Essential Public Health Services to their communities. These are:

- Monitor the health status of the community
- Investigate and diagnose health problems and hazards
- Inform and educate people regarding health issues
- Mobilize partnerships to solve community problems
- Support policies and plans to achieve health goals
- Enforce laws and regulations to protect health and safety
- Link people to needed personal health services
- Ensure a skilled, competent public health workforce
- Evaluate effectiveness, accessibility and quality of health services
- Research and apply innovative solutions

The self-assessment is structured around the Model Standards for each of the ten Essential Public Health Services, (EPHS), hereafter referred to as the Essential Services, which were developed through a comprehensive, collaborative process involving input from national, state and local experts in public health.

Altogether, for the local assessment, 30 Model Standards serve as quality indicators that are organized into the ten essential public health service areas in the instrument and address the three core functions of public health. Figure 4 below shows how the ten Essential Services align with the three Core Functions of Public Health.

Figure 4. The ten Essential Public Health Services and how they relate to the three Core Function of Public Health



This report is designed to facilitate communication and sharing among and within programs, partners, and organizations, based on a common understanding of how a high performing and effective public health system can operate. This shared frame of reference will help build commitment and focus for setting priorities and improving public health system performance. Outcomes for performance include delivery of all ten essential public health services at optimal levels.

Each question was scored using five categories ranging from No Activity to Optimal Activity. For each question, the participants asked “How well are we doing this activity in our local public health system?”

Table 7. Summary of Assessment Response Options

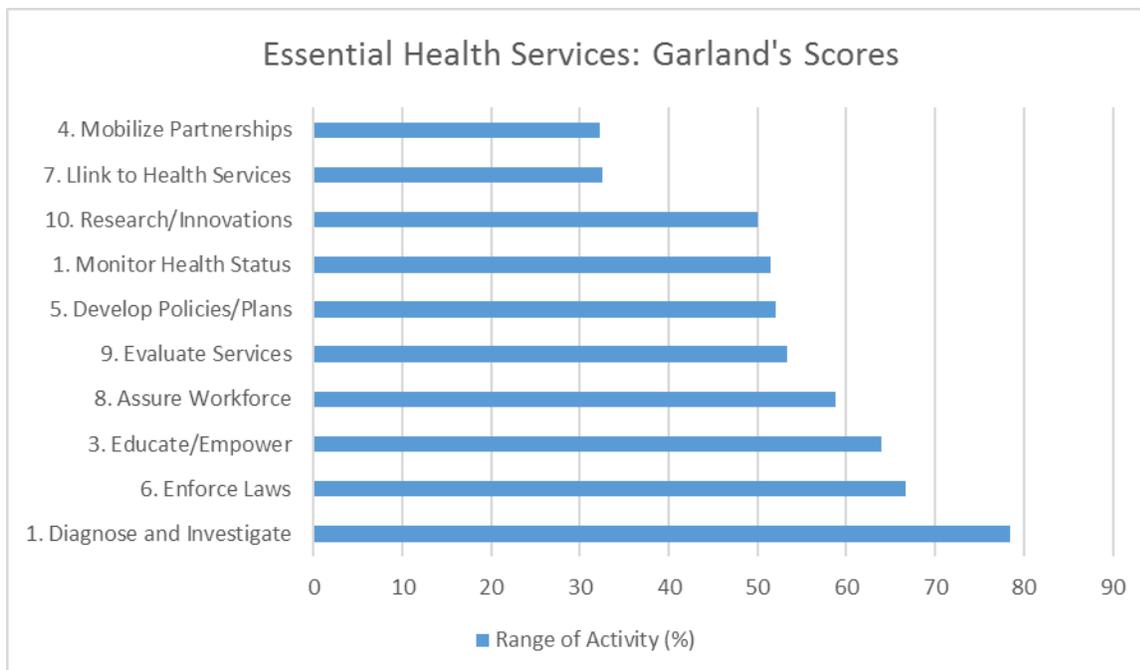
Optimal Activity (76-100%)	Greater than 75% of the activity described within the question is met.
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Significant Activity (51-75%)	Greater than 50%, but no more than 75% of the activity described within the question is met.
Moderate Activity (26-50%)	Greater than 25%, but no more than 50% of the activity described within the question is met.
Minimal Activity (1-25%)	Greater than zero, but no more than 25% of the activity described within the question is met.
No Activity (0%)	0% or absolutely no activity.

Essential Services

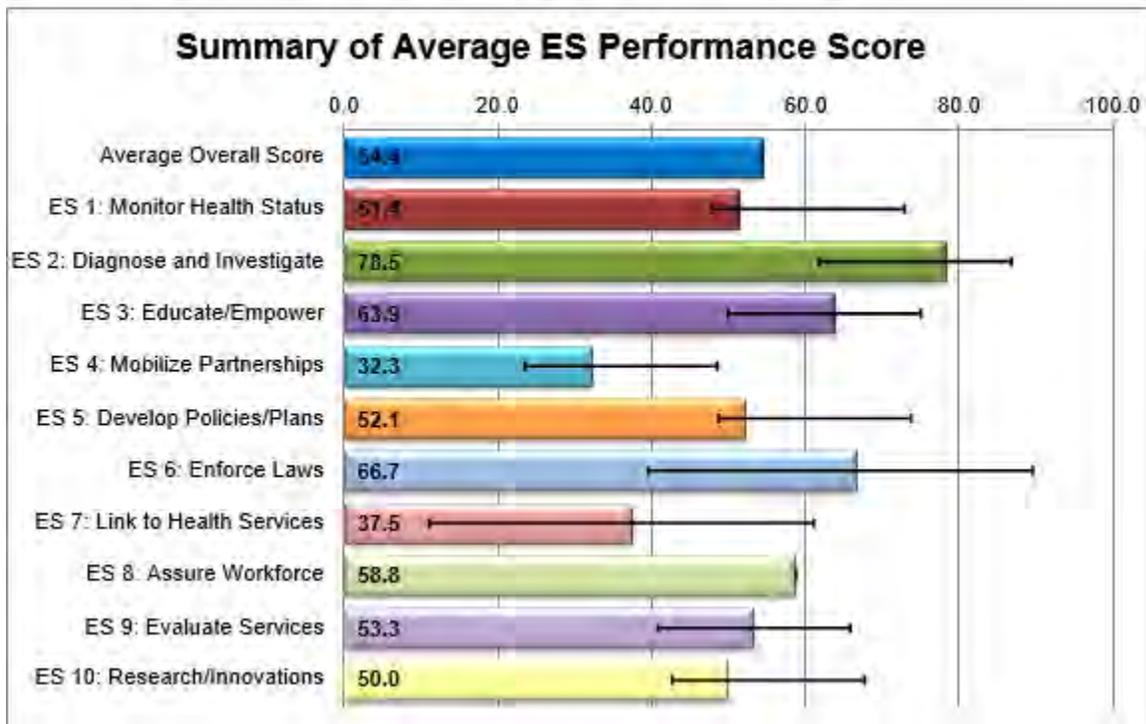
When each question and model standard scores were averaged, two of the Ten Essential Public Health Services scored in the moderate range of activity (26%-50%) and eight scored in the significant range of activity (51%-75%).

Graph 3. Garland’s Essential Services Scores, Garland TX 2014.



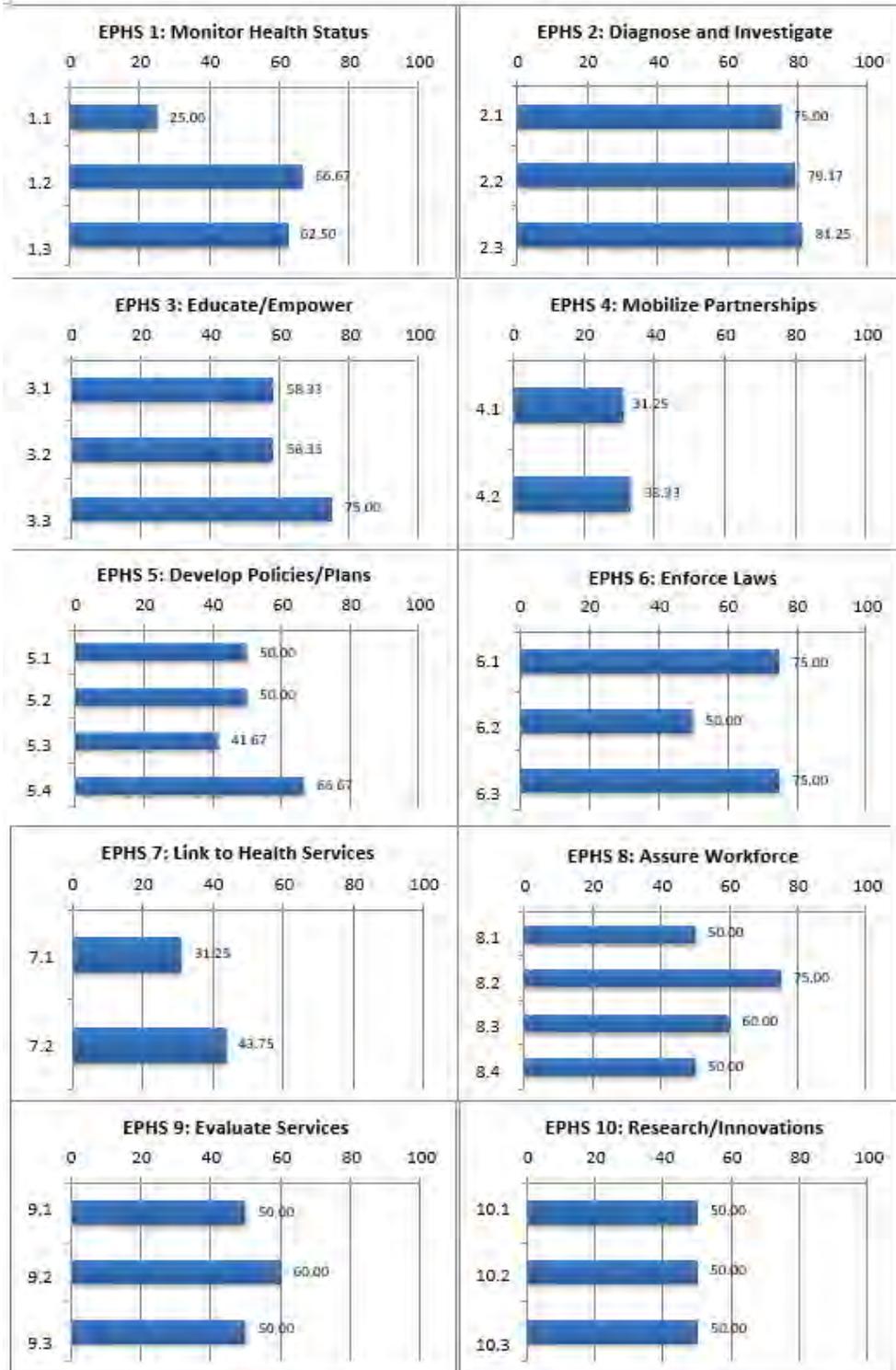
Graph 3 displays the average score for each Essential Service, along with an overall average assessment score.

Graph 3. Summary of Average Essential Public Health Service Performance Scores. 2014



Graph 4 and table 2 display the average performance score for each of the Model Standards within each Essential Service. This level of analysis enables you to identify specific activities that contributed to high or low performance within each Essential Service.

Graph 4. Performance Scores by Essential Public Health Service for Each Model Standard. 2014



In Table 2 below, each score (performance, priority, and contribution scores) at the Essential Service level is a calculated average of the respective Model Standard scores within that Essential Service. Note – The priority rating and agency contribution scores will be blank if the Priority of Model Standards Questionnaire and the Agency Contribution Questionnaire are not completed.

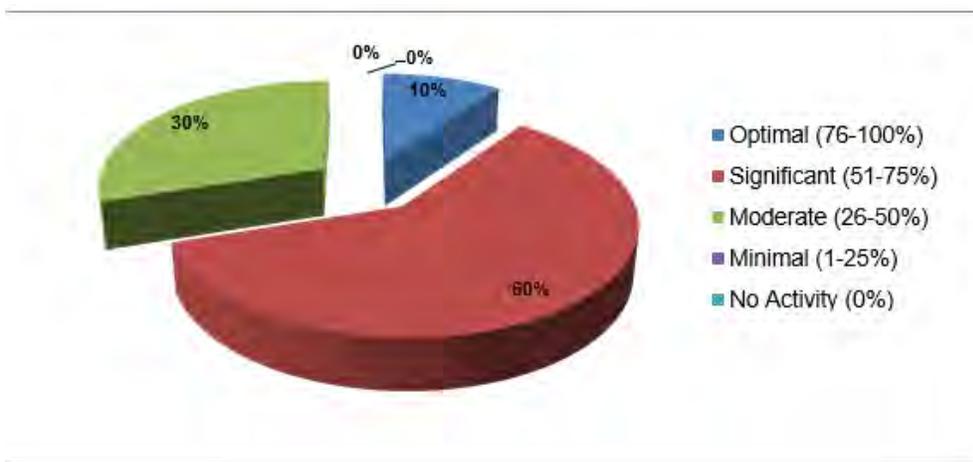
Table 2. Overall Performance, Priority, and Contribution Scores by Essential Public Health Service and Corresponding Model Standard

Model Standards by Essential Services	Performance Scores	Priority Rating	Agency Contribution Scores
ES 1: Monitor Health Status	51.4		75.0
1.1 Community Health Assessment	25.0		75.0
1.2 Current Technology	66.7		75.0
1.3 Registries	62.5		75.0
ES 2: Diagnose and Investigate	78.5		100.0
2.1 Identification/Surveillance	75.0		100.0
2.2 Emergency Response	79.2		100.0
2.3 Laboratories	81.3		100.0
ES 3: Educate/Empower	63.9		75.0
3.1 Health Education/Promotion	58.3		75.0
3.2 Health Communication	58.3		75.0
3.3 Risk Communication	75.0		75.0
ES 4: Mobilize Partnerships	32.3		50.0
4.1 Constituency Development	31.3		50.0
4.2 Community Partnerships	33.3		50.0
ES 5: Develop Policies/Plans	52.1		93.8
5.1 Governmental Presence	50.0		100.0
5.2 Policy Development	50.0		100.0
5.3 CHIP/Strategic Planning	41.7		75.0
5.4 Emergency Plan	66.7		100.0
ES 6: Enforce Laws	66.7		100.0
6.1 Review Laws	75.0		100.0
6.2 Improve Laws	50.0		100.0
6.3 Enforce Laws	75.0		100.0
ES 7: Link to Health Services	37.5		50.0
7.1 Personal Health Service Needs	31.3		50.0
7.2 Assure Linkage	43.8		50.0
ES 8: Assure Workforce	58.8		62.5
8.1 Workforce Assessment	50.0		75.0
8.2 Workforce Standards	75.0		75.0
8.3 Continuing Education	60.0		50.0
8.4 Leadership Development	50.0		50.0
ES 9: Evaluate Services	53.3		50.0
9.1 Evaluation of Population Health	50.0		50.0
9.2 Evaluation of Personal Health	60.0		50.0
9.3 Evaluation of LPHS	50.0		50.0
ES 10: Research/Innovations	50.0		50.0
10.1 Foster Innovation	50.0		75.0
10.2 Academic Linkages	50.0		50.0
10.3 Research Capacity	50.0		25.0
Average Overall Score	54.4	NA	70.6
Median Score	52.7	NA	68.8

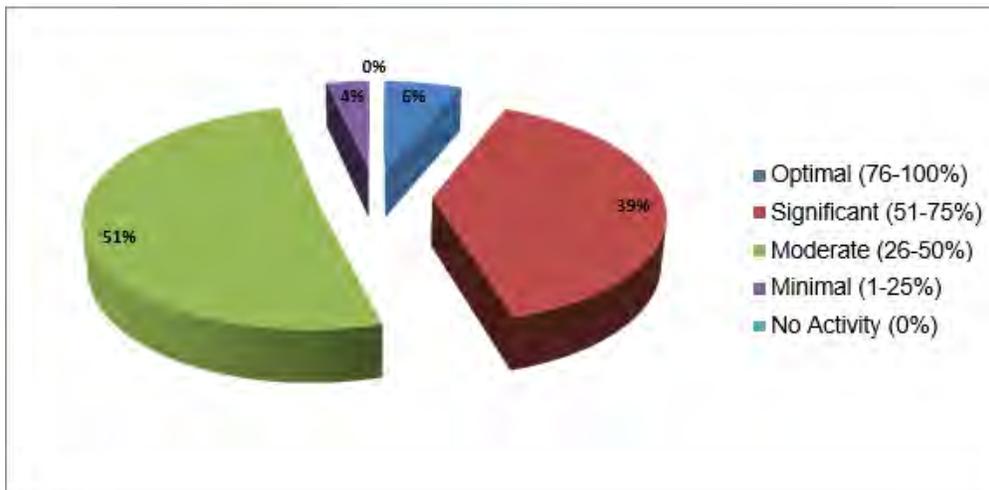
Performance Relative to Optimal Activity

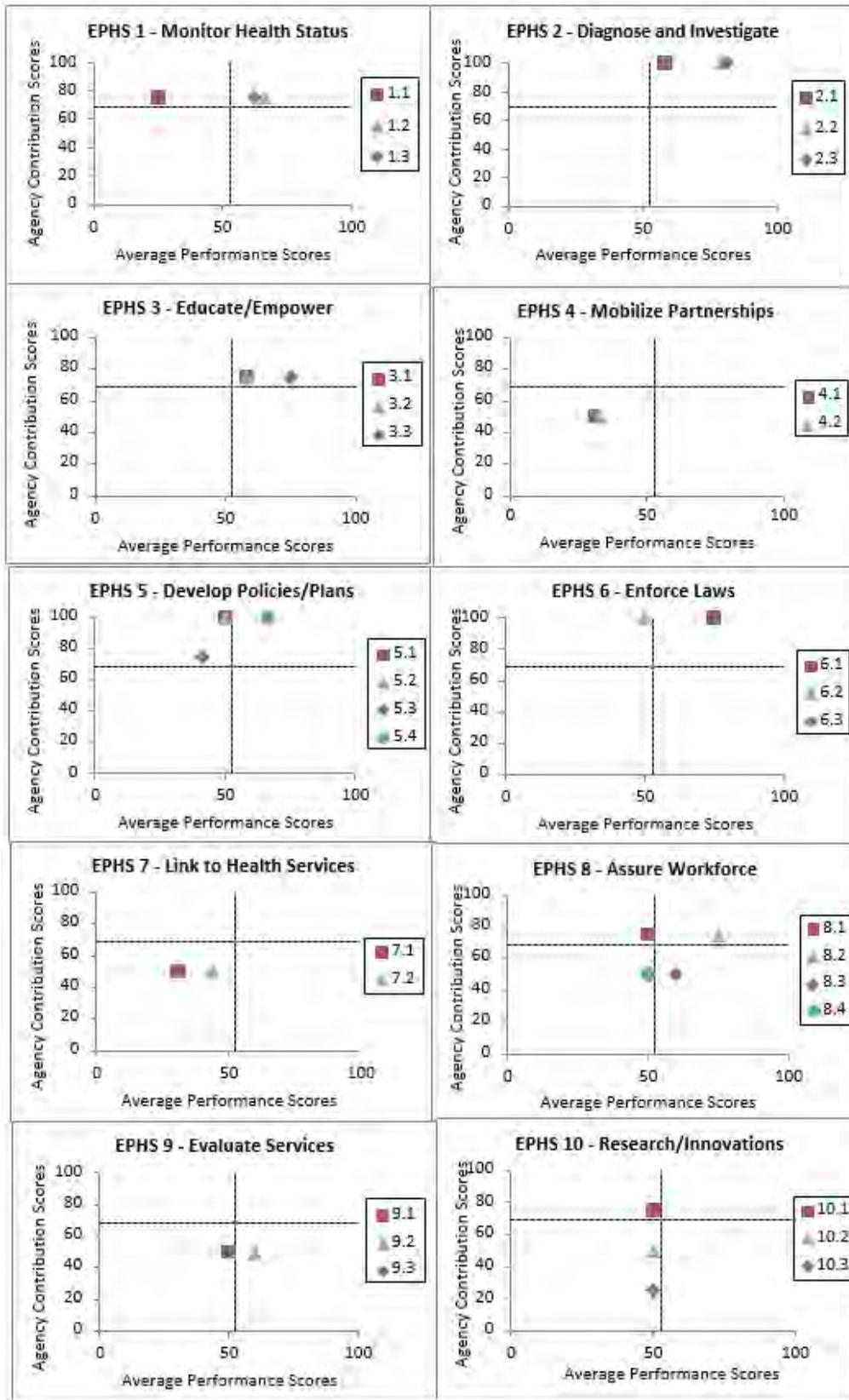
Graphs 5 and 6 display the proportion of performance measures that met specified thresholds of achievement for performance standards. The five threshold levels of achievement used in scoring these measures are shown in the legend below. For example, measures receiving a composite score of 76-100% were classified as meeting performance standards at the optimal level.

Graph 5. Percentage of the system's Essential Services scores that fall within the five activity categories. This chart provides a high level snapshot of the information found in Graph 2, summarizing the composite performance measures for all 10 Essential Services.



Graph 6. Percentage of the system's Model Standard scores that fall within the five activity categories. This chart provides a high level snapshot of the information found in Figure 3, summarizing the composite measures for all 30 Model Standards.





Graph 7. Summary of Essential Public Health Service Performance Scores and Contribution Ratings.

Analysis and Discussion

Although eight of the essential services scored in the significant range of activity (51%-75%) for the local public health system, the scores appeared to fall on the lower range of average scores. Particularly notable are ES1 Monitoring health status, ES4 Mobilizing Partnerships, and ES5 Developing Policies and plans. This signals areas for improvement. Although Garland has a wide range of health programs, many of them are often being implemented in silos. Effective collaboration is needed to enhance efforts in these essential services, maximizing available public health personnel and funds. Graphs 4, 7 and Table 2 delineated specifically where within each service activities that contributed to the score, further enabling the more efficient strategic planning efforts.

Community Health Assessments, Personal Health Service Needs, and Constituency Developments/partnerships scored particularly low. Using the results will help the committee enhance system performance and generate priorities for improvement, as well as possible improvement projects.

The following will be considered as we build an Action Plan to address the priorities identified:

- Public health partners will be considered when approaching quality improvement for the system
- The success of our improvement activities are dependent upon the active participation and contribution of member of the systems
- An integral part of performance improvement is working consistently to have long-term effects
- A multi-disciplinary approach that employs measurement and analysis is key to accomplishing and sustaining improvements

We have found the following acronym/heuristic helpful to move from assessment and analysis to action and intend to use it for future planning.

F.O.C.U.S.

F Find an opportunity for improvement using results.

O Organize a team of public health system partners to work on the improvement. Someone in the group should be identified as the team leader. Team members should represent the appropriate organizations that can make an impact.

C Consider the current process, where simple improvements can be made and who should make the improvements.

U Understand the problem further if necessary, how and why it is occurring, and the factors that contribute to it. Once we've identified priorities, finding solutions entails delving into possible reasons, or "root causes," of the weakness or problem. Only when participants determine why performance problems (or successes!) have occurred will they be able to identify workable solutions that improve future performance. Most performance issues may be traced to well-defined system causes, such as policies, leadership, funding, incentives, information, personnel or coordination. Many QI tools are applicable. You may consider using a variety of basic QI tools such as brainstorming, 5-whys, prioritization, or cause and effect diagrams to better understand the problem (refer to Appendix C for resources).

S Select the improvement strategies to be made. Consider using a table or chart to summarize our Action Plan. Many resources are available to assist in putting the plan on paper, but in general we'll want to include the priority selected, the goal, the improvement activities to be conducted, who will carry them out, and the timeline for completing the improvement activities. When complete, the Action Plan should contain documentation on the indicators to be used, baseline performance levels and targets to be achieved, responsibilities for carrying out improvement activities and the collection and analysis of data to monitor progress.

Conclusion

The Local Public Health System assessment revealed that the local public health system has many strengths as well as weaknesses. Strengths are in the areas of laws and regulations, policies and plans (especially emergency plans), and investigating health problems. Weaknesses are in the area of evaluation, linking to health services, and mobilizing partnerships. Through the process, much was learned about the various partners in the local public health system and intentional collaboration as a system should be the norm in the future. Below is a table summarizing key findings.

Essential Public Health Service (EPHS)	Model Standard	Strengths and Weaknesses
<p>1. Monitor health status to identify and solve community health problems.</p>	<ul style="list-style-type: none"> · Population Based Community Health Profile · Current Technology to Manage and Communicate Population Health Data · Maintenance of Population Health Registries 	<p>+ Areas of strength in EPHS 1 include maintaining and contributing to population health registries such as the Texas Immunization Registry (ImmTrac), although this registry is the only one utilized besides required hospital reporting.</p> <p>- Areas of weakness include the ability of the local public health system to track data over time, use health data to monitor progress towards health goals, and use community health assessment results to inform policy and planning decisions. However, much of this is currently in progress with the current community health assessment. Other areas of weakness include access to technology and geo-coded data.</p>
<p>2. Diagnose and investigate health problems and health hazards in the community.</p>	<ul style="list-style-type: none"> · Identification and Surveillance of Health Threats · Investigation and Response to Public Health Threats and Emergencies · Laboratory Support for Investigation of Health Threats 	<p>+ The primary area of strength in EPHS 2 is in the area of laboratory support for investigation of health threats. The local public health system has ready access to licensed and credentialed laboratories for diagnostic, surveillance, and emergency needs. Also, the system in place for reporting, surveillance, and investigation of communicable diseases is strong.</p> <p>- Despite the strong systems in place, resources are limited for disease surveillance and investigation activities.</p>
<p>3. Inform, educate, and empower people about health issues.</p>	<ul style="list-style-type: none"> · Health Education and Promotion · Health Communication · Risk Communication 	<p>+ For EPHS 3, risk communication plans, resources for rapid communications response, and policies and procedures for public information officers are considered to be strong. Health education and health promotion campaigns are also strengths given that many local public health system partners engage in health promotion activities.</p> <p>- One area of weakness within risk communication was identified to be a lack of crisis and emergency communications training for local public health system partners.</p>
<p>4. Mobilize community partnerships and action to identify and solve health problems.</p>	<ul style="list-style-type: none"> · Constituency Development · Community Partnerships 	<p>- Weaknesses identified include the lack of a directory of partners who comprise the local public health system and lack of a system for reviewing community health partnerships.</p>
<p>5. Develop policies and plans that support individual and community health efforts.</p>	<ul style="list-style-type: none"> · Governmental Presence at the Local Level · Public Health Policy Development · Community Health Improvement Process and Strategic Planning 	<p>+ Areas of strength in EPHS 5 mostly have to do with the strong emergency plans that are in place in the community. There is a functioning emergency management system in which public health partners are actively engaged, and public health emergency and city-wide emergency plans are developed and revised regularly. In addition, the Garland Health Department maintains a presence in the community, and a community health improvement plan is currently in progress.</p> <p>- Areas of weakness include a lack of sufficient resources for Garland Health Department, public health policy development, and resources to implement the community health improvement plan.</p>

Essential Public Health Service (EPHS)	Model Standard	Strengths and Weaknesses
<p>6. Enforce laws and regulations that protect health and ensure safety.</p>	<ul style="list-style-type: none"> · Review and Evaluation of Laws, Regulations, and Ordinances · Involvement in the Improvement of Laws, Regulations, and Ordinances · Enforcement of Laws, Regulations, and Ordinances 	<p>+ EPHS 6 was a strong point in the local public health system assessment. There is a strong infrastructure in place to review and evaluate, improve, and enforce laws, regulations and ordinances.</p> <p>– One area of weakness identified was the lack of a system to identify public health issues that can be addressed through laws, regulations, or ordinances.</p>
<p>7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.</p>	<ul style="list-style-type: none"> · Identification of Personal Health Service Needs of Populations · Assuring the Linkage of People to Personal Health Services 	<p>– Providing assistance to vulnerable populations in accessing health services is a weakness in this area as well as identifying people who may have barriers to health care.</p>
<p>8. Assure competent public and personal health care workforce.</p>	<ul style="list-style-type: none"> · Workforce Assessment, Planning, and Development · Public Health Workforce Standards · Life-Long Learning Through Continuing Education, Training, and Mentoring · Public Health Leadership Development 	<p>+ Areas of strength in EPHS 8 include having clear licensure and certification guidelines and written position descriptions for people working in the local public health system. There is also good interaction with local public health system partners and the local academic institution, Texas A&M Commerce.</p> <p>– Areas of weakness include a lack of activity around local workforce assessment and evaluation, recruitment of new and diverse leaders, and opportunities to develop core public health competencies.</p>
<p>9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.</p>	<ul style="list-style-type: none"> · Evaluation of Population-Based Health Services · Evaluation of Personal Health Services · Evaluation of the Local Public Health System 	<p>– Evaluation activities for population based health services is limited due to lack of resources. In addition, a local public health system assessment has not been utilized in the past and it is unclear if there will be a system in the future for continuing to evaluate the local public health system.</p>
<p>10. Research for new insights and innovative solutions to health problems.</p>	<ul style="list-style-type: none"> · Fostering Innovation · Linkage with Institutions of Higher Learning and/or Research · Capacity to Initiate or Participate in Research 	<p>+ In EPHS 10, strengths include good collaboration with the academic community. Innovation is encouraged community wide.</p> <p>– Actual capability to conduct public health research is limited due to lack of resources and lack of a graduate program focusing on public health.</p>

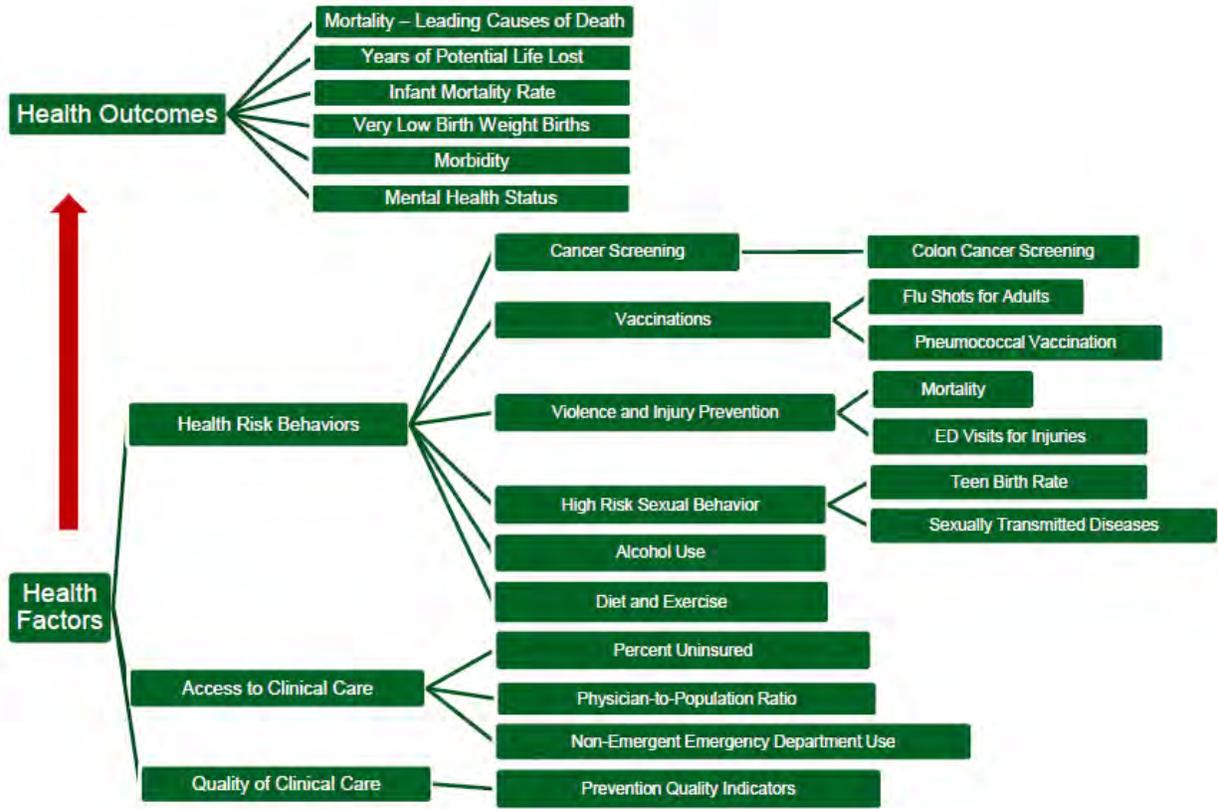
Community Health Status Assessment

The Community Health Status Assessment is focused on gathering and analyzing data on health indicators that describe the health status of the community, quality of life, and behavioral risk factors. The Community Health Status Assessment was compiled using the Organizational Model for Parkland Health and Hospital System's Community Health Dashboard. This organizational model ties health factors to health outcomes by analyzing common community health indicators and comparing those indicators across differing populations. The goals of this model are to identify opportunities for health improvement across all populations and to detect health disparities among different populations.



Data for the community health indicators are derived from public health outcome secondary data, community and county level, and primary data from two focus groups to identify health assets, gaps, disparities and trends. Sources such as the Texas Department of State Health Services, the Dallas Fort Worth Hospital Council, the Centers for Disease Control and Prevention, the United States Census Bureau and many others were used. It uses Community health indicator benchmarks used in this assessment are derived from the Healthy People 2020 goals, and these benchmarks are noted for each community health indicator where they apply.

Organizational Model for the Community Health Dashboard.



Key Findings

The Age-Adjusted All Accident Mortality Rate per 100,000 in the City of Garland appears to be increasing yearly. This could reflect the aging population that is more likely to experience accidental falls. It is slightly higher than that of Dallas County, but very close to the rate of the state of Texas. Garland and Dallas County appear to be below the Healthy People 2020 goal for Motor Vehicle Accident Mortality Rate at 11.4 and 9.6 in 2012, although these numbers increased slightly since 2009.

Access to Care and insurance coverage findings

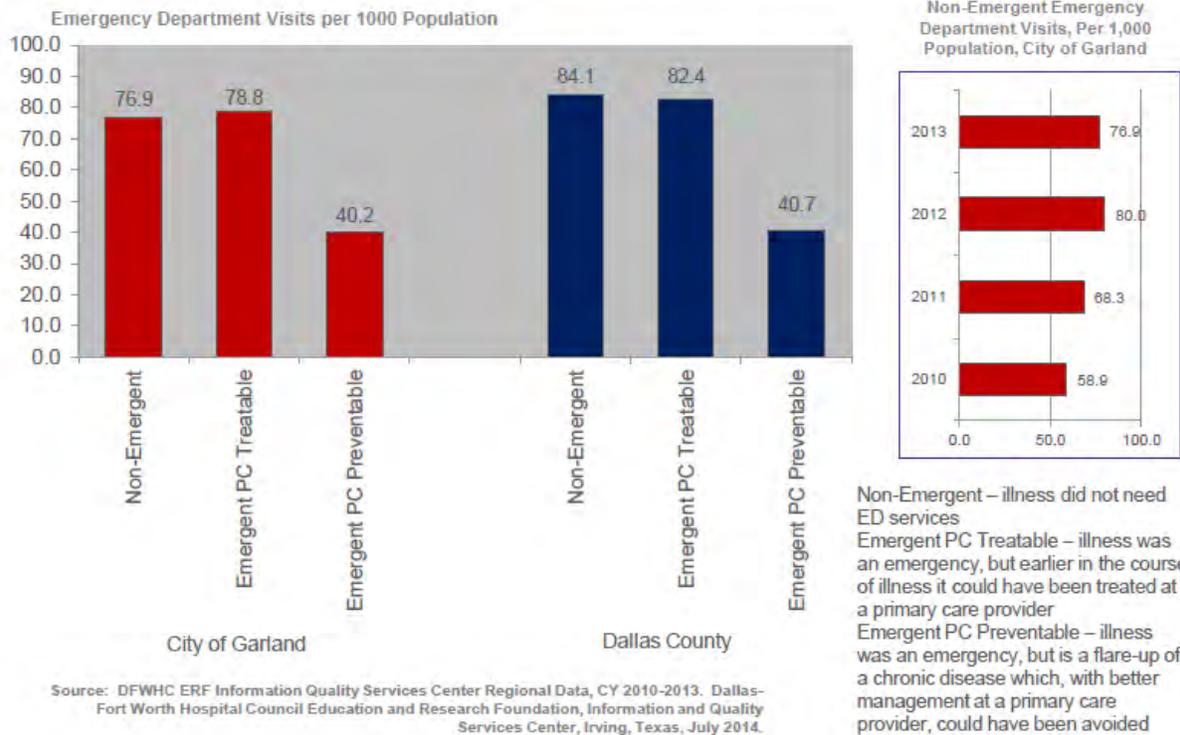
- The primary care physician population ratio for Garland was 59.7 compared to 96.7 for Dallas County as a whole. This indicates a comparatively low density of primary care doctors that affects access to care for some segments of the population. In 2016, the physician needs is 50% higher than availability. With such a shortage of physicians, many residents seek primary care and non-emergent treatment in emergency departments, resulting in increased healthcare costs and higher volumes of preventable and avoidable cases in the ED.

- The percentage lacking health insurance at the time of this data collection was overall 14.6% for the city and highest in the zip codes 75041 and 75042 at approximately 18%.
- For every 1000 emergency department (ED) visits, the number of illnesses that did not need ED services was 76.9, the number of illnesses that were emergencies, but could have been treated by a primary care physician earlier in the course was 78.8, and the number of illnesses that were emergencies, but flare-ups of a chronic disease which could have been avoided with better management by a primary care provider was 40.2. Combined, these account for one fifth of ED visits that were preventable or avoidable. This number is reflected in national estimates that indicate 13% to 27% of ED visits in the United States could be managed in physician offices, clinics, and urgent care centers at a savings of \$4.4 billion annually.



Parkland

Preventable ED Visits, 2013 City of Garland



Compared to Dallas County as a whole, Garland citizens seek emergency department care for non-emergent illnesses at a lower rate. However, the increase in preventable emergency department visits between 2010 and 2013 is notable. As referenced in the chart above, the most common type of preventable emergency department visits are for illnesses that are considered emergencies, *but earlier in the course of illness could have been treated by a primary care provider*. This data coincides with results of the Local Public Health System

Assessment, which found that one of the areas of improvement needed in the Local Public Health System is Essential Service 7, Link to Health Services.

According to Thomson Reuters Market data, the uninsured rates for the five zip codes in Garland in 2014 are:

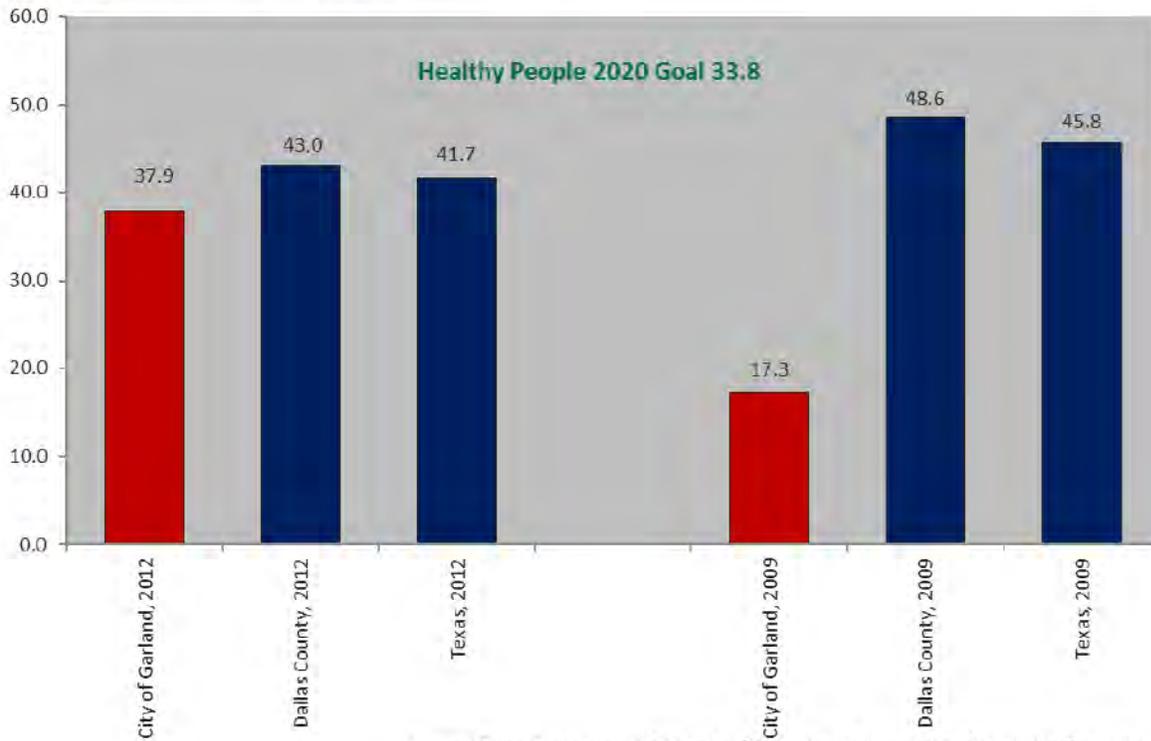
ZIP Code	Percent Uninsured	Percent Medicaid	Percent Medicare	Percent Private Insurance
75040	12.2%	9.1%	9.7%	68.9%
75041	18.2%	13.5%	10.7%	57.6%
75042	18.5%	13.8%	10.2%	57.6%
75043	15.8%	11.7%	12.5%	59.9%
75044	10.2%	7.6%	12.7%	69.5%
Total	14.6%	10.9%	11.2%	63.3%

Cerebrovascular Disease/Stroke Mortality Rates: The Healthy People 2020 goal for cerebrovascular disease/stroke mortality rate is 33.8 deaths per 100,000 population. As seen in the chart below, rates for Garland citizens in 2014 is 4.1 above this goal. More importantly, between 2009 and 2012, the rate increased by 20.6 deaths per 100,000 population, a change of +45.6% as indicated in the graph below.

Diabetes is a potentially fatal consequence of obesity. In fact, deaths from diabetes increased in Garland by 20% in the years between 2009 and 2012. While below the Dallas County and Texas rates, death rates from diabetes in Dallas County and Texas decreased during this same time period.

City of Garland Diabetes Mortality Rate

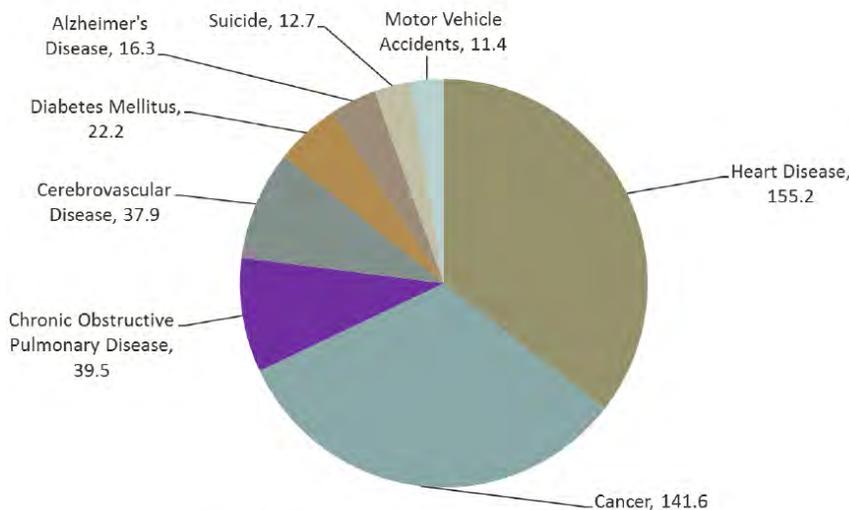
Age-Adjusted Deaths per 100,000



Source: Texas Department of State Health Services, Bureau of Vital Statistics; denominator population data from Nielsen Pop-Facts

Cerebrovascular disease/stroke, diabetes and heart disease account for 215.3 deaths per 100,000 Garland citizens in 2012. Heart disease is the most common cause of death in Garland, cerebrovascular disease/stroke is the 4th leading cause and diabetes the 5th.

City of Garland: Leading Causes of Death in 2012



Source: Texas Department of State Health Services, Bureau of Vital Statistics; denominator population data from Nielsen Pop-Facts

Conclusion

This profile of health behaviors, outcome/indicators, and other ‘upstream’ factors is an essential component of Public health’s concerns with threats to the overall health of the community and enables the department and stakeholders to prioritize health issues that are impacting community members the most. The city is committed to providing services to improve the health of the public as evidenced in vaccination programs, free educational materials, environmental health programs, and animal services programs for rabies/zoonotic disease prevention. Garland Health will work closely with area partners to identify gaps in services, areas of overlap, and other collaboration/coordination opportunities that can potentially strengthen the public health infrastructure. The data in this status assessment will be updated in upcoming revisions of the Garland Community Health Assessment and Community Health Improvement Plan.

See complete assessment results in Appendix D.

Review of other Community Health Assessments

Analysis of the Region 9 RHP report, the Dallas County Community Health Needs Assessment, Parkland dashboard data, Garland Fair Housing study, and the National Research Corporation Consumer Health Report revealed the following community health needs in the Garland service area.

Access to Care for Low Income Population

The community suffers a lack of preventive health care, quality medical care and supportive post-acute care services that promote the health of its residents.

Community health and patient-centered medical home locations may not promote convenient access. Enrollment in health insurance programs is inconsistent across the demographic. In the consumer survey for the service area, a significant percentage of respondents utilize hospital services for “routine care” (i.e. primary care).

Multiple Chronic Conditions

- Compared to the region, state and nation, the community is at a higher risk for several chronic conditions.
- Similar to national trends, residents exhibit increasing diagnoses of chronic conditions. It is common that the pathology for one condition may also affect other body systems, resulting in co-occurrence or multiple chronic conditions (MCC). The presence of MCCs adds a layer of complexity to disease management.
- The NRC consumer survey identified the following chronic conditions as high risk for the area when compared to the region, state or nation: high blood pressure, high cholesterol, smoking, allergies, diabetes, obesity and sinus problems.

Chronic Disease—Adult and Pediatric

- Dallas County and Garland residents are increasingly being diagnosed with one or more chronic diseases including cancer, diabetes and cardiovascular disease. Addressing common risk factors through health programs, medical homes, screening and better personal fitness can improve the overall health of area residents.
- Compared to *Healthy People 2010* targets, the hospital service area exceeded goals for cigarette smoking, high blood pressure and obesity. In regards to chronic diseases, the Dallas County CHNA found the following:
 1. Cardiovascular disease is the leading cause of death in Dallas County. Age-adjusted mortality rates (AAMR) vary significantly by:
 - Race/ethnicity—with African-Americans having the highest AAMR.
 - Gender—with men having a significantly higher AAMR than women.
 2. The burden of asthma, chronic obstructive pulmonary disease (COPD) and other respiratory diseases affects individuals, their families, schools, workplaces and neighborhoods.
 3. While disparities in cancer mortality and incidence are not significant between Dallas County communities, disparities based on race/ethnicity are present. African-Americans have the highest incidence and mortality rates for all types of cancer. Dallas County/Garland cancer rates for most cancers are higher than overall state rates.
 4. The prevalence of diabetes is higher in Dallas County/Garland than in Texas or the U.S. In Dallas County, 11.4 percent of the population suffers from this illness compared to 9.6 percent in Texas and 8 percent in the U.S.
 5. Despite a strong network of parks and recreational options, more than half of Dallas County/Garland residents have sedentary lifestyles. Physical activity declined 6.5 percent between 2006 and 2010.

6. Obesity among Dallas County/Garland residents increased by 17.6 percent between 2005 and 2010.
7. Tobacco use in Dallas County and Garland is decreasing, but 16 percent of county residents continue to smoke.

Health Care Access

- A significant percentage of survey respondents utilize hospital services for “routine care.”
- The demand for primary and specialty care services exceeds that of available physicians in these areas, thus limiting health care access.
- Dallas County and Garland have a large portion of residents who are uninsured. Implementation of the Affordable Care Act will impact the percentage of adults and children receiving health insurance coverage, as well as the physician-to-population ratios for the insured.
- The changing environment calls for monitoring provider acceptance of new patients by payment source. It also needs to inform eligible persons of any changing insurance eligibility requirements.
- There is a shortage of primary care physicians (PCPs), and they are unequally distributed within the county, thereby leaving some areas underserved. According to the Dallas County CHNA, 25 percent of Dallas County adults do not have a personal physician. There are 99 PCPs per 100,000 adults. Texas overall is the fourth worst state in the U.S. for PCP-to-adult ratio with only 70 PCPs per 100,000 adults.
- Resource deserts for women’s outpatient services are found primarily in communities outside the center of the city of Dallas, including Garland.
- Twenty-eight percent of Dallas County residents are uninsured. In the non-elderly population, 33 percent of residents are uninsured. While new legislation may increase Medicaid enrollment, the physician shortage raises the question of who will treat these newly insured patients.

Capacity—Primary and Specialty Care

- RHP 9 identified that the demand for primary and specialty care services exceeds available physicians in these areas, thus limiting health care access.
- The Dallas County CHNA found:
 1. Twenty-eight percent of county residents do not have health insurance. Twenty-seven percent in Garland. Among non-elderly, non-institutionalized residents, 33 percent are uninsured compared to 26 percent in Texas and 17 percent in the U.S.

2. Dallas County and Garland have both a shortage and unequal distribution of primary care and specialty physicians.

Behavioral Health—Adult, Pediatric and Jail Populations

- Behavioral health—either as a primary or secondary condition—accounts for substantial patient volume and costs for health care providers, and is often utilized at capacity.

Dallas County and Garland residents suffering from behavioral health illnesses often confront decision-making barriers. These barriers can impact preventive care and treatment decisions, thereby influencing aspects of their physical health.

- The presence of a co-occurring behavioral health condition is associated with increased case severity of medical encounters and a 36 percent increase in the average charges per- encounter. In RHP 9, 100 percent of the 10 most frequently admitted patients had a co-occurring behavioral health diagnosis. These 10 individuals incurred more than \$26 million in costs between 2007 and 2011; however, only one-fifth of their hospital emergency department visits were for a mental health or substance abuse issue. Sixty one percent of those 10 individuals were uninsured, while 24 percent were on Medicaid, 12 percent were on Medicare and 3 percent were insured.
- The number of Dallas County children receiving publicly funded mental health services tripled from 2000 to 2010. In Dallas County, the number of children identified with a diagnosable emotional disturbance or addictive disorder has increased to approximately 142,000 children with 5 percent of those children experiencing a significant impairment as a result. Among youth between the ages of 12-17, 7.2 percent have experienced a major depressive episode.
- The structure of the behavioral health system (including mental health and substance abuse) in RHP 9 struggles to meet the demand of patients in the community. Unlike most of Texas, the majority of behavioral health services for Medicaid and indigent patients are delivered through the NorthSTAR program instead of the traditional Local Mental Health Authority (LMHA) system. NorthSTAR provides both mental health and substance abuse treatment to over 60,000 Medicaid enrollees and indigent uninsured annually. While NorthSTAR has greatly expanded access to care, it has struggled with funding and infrastructure challenges. The growth in enrollment has outpaced funding such that the funding per person served is 30 percent less than when the program started in 1999 and is half that of the state average for other LMHAs. Texas is 50th in mental health funding nationwide, and therefore the funding per person served in RHP 9 is among the lowest in the nation.
- The number of NorthSTAR enrollees booked into jail has been steadily increasing, and 27 percent of all bookings to the Dallas County Jail are currently referred to jail behavioral health services.

Patient Safety and Hospital-acquired Conditions

- Hospitals in the region address patient safety and care quality on a daily basis. They are paramount for any health care entity. An ongoing, coordinated effort among providers is needed to improve patient safety and quality throughout the region.
- The Dallas Fort Worth Hospital Council Foundation's (DFWHCF) 77 hospitals had 1,706 adverse hospital events in 2010. These events included air embolism, Legionnaires, iatrogenic pneumothorax, delirium, blood incompatibility, glycemic control issues and *clostridium difficile*—none of which are included in the 10 adverse events specified by Centers for Medicaid and Medicare Service (CMS).

Emergency Department (ED) Usage and Readmissions

- ED visits are on the rise, and EDs are becoming overcrowded due to reduced inpatient capacity and impaired patient flow.
- An analysis of ED encounters demonstrates that many members of the population are accessing EDs for both urgent and non-urgent conditions. This is mostly due to the patient's lack of understanding of their medical conditions, and/or uninsured/underinsured status. The RHP 9 finds the following related to ED usage:
 1. Over the most recent four quarters of available data, conditions for which the most volume of care was provided in an emergency outpatient setting were: low back pain, hypertension, pain/joint aching, chronic bronchitis and asthma.
 2. Further assessment demonstrates that, with the exception of asthma, over 68 percent of encounters for the top primary health conditions listed above were either non-emergent or emergent/primary care treatable, meaning that the care could have been provided effectively in a primary care setting.
 3. For ED encounters that resulted in a hospital admission, the most common health conditions by volume were stroke, diabetes, congestive heart failure, weak/failing kidneys, chronic bronchitis and heart attack.
 4. When reviewing by payer type, diabetes is the top condition for the uninsured and Medicaid.

Preventive Health Screenings

- According to *Healthy People 2010*, the community has not achieved several national preventive health metrics.
- However, preventive health behavior services for underserved households in the areas exceed the market average in the following areas:

→ Child immunizations

→Cardiovascular stress testing

→Pre-natal care

→Mental health screening

→Carotid artery screening

- Preventive health behavior services for underserved households in the area fall below the market average in the following areas: Blood pressure testing, Eye exams, Cholesterol screenings, Dental exams, Routine physical exams, Pap smear, Diabetes screening, Mammogram, Colon screening, Prostate screening, Body mass index screening, Weight loss programs, Osteoporosis testing, Smoking cessation

Health Disparities and Social Determinants of Health

Large geographic areas of Dallas County, including some parts of Garland, suffer from disproportionate disease rates and substantial resource “deserts.”

These disparities are evidenced by uninsured status, limited access to primary care physicians and health services, and inappropriate use of hospital/emergency department services for conditions that could have been treated with preventive and primary care. These communities also suffer from high levels of unemployment and low socio-economic status. The Dallas County CHNA found that 36 percent of Dallas County zip codes contain food deserts. These areas lack key resources, including access to health services, safe environments and healthy foods. The Garland community contributes to and reflects these Dallas county trends.

The use of public food assistance nutrition programs also increased between 2009 and 2011. Dallas County food deserts have:

1. Nearly double the percentage of African-American and Latino residents.
2. Less education than those individuals who do not live in food deserts.
3. More homes/apartments occupied by renters—28 percent more renter occupied apartments.
4. More single parent homes—44 percent more single parent homes.
5. High poverty—28 percent of the residents in food deserts report income below the poverty level compared to only 15 percent of residents who do not live in food deserts.

Prenatal Care

Pregnancy can provide an opportunity to identify existing health risks in women and to prevent future health problems for women and their children. According to Healthy People 2020, factors that affect pregnancy and childbirth, include: Preconception health status, including stress

- Age
- Access to appropriate preconception and interconception healthcare
- Poverty

Texas DSHS Office of Decision Support outlines Perinatal Periods of Risk to assist in prioritizing and targeting prevention and intervention efforts (Feto-infant mortality in Dallas County, 2011). These include

1. Maternal Health/Prematurity

- Preconception Health
- Health Behaviors
- Perinatal Care

2. Maternal Care

- Prenatal Care
- High Risk Referral
- Obstetric Care

3. Newborn Care

- Perinatal Management
- Neonatal Care
- Pediatric Surgery

4. Infant Health

- Sleep Position
- Smoking
- Breast Feeding

Key findings include:

2005-2008 Dallas County feto-infant mortality rates were:

- 14.0/1,000 live births for African-Americans
- 7.9/1,000 live births for Latinas
- 6.9/1,000 live births for Caucasians
- 9.3/1,000 live births for Teens

Furthermore, excess feto-infant mortality rates were:

- 8.9/1,000 live births for African-Americans
- 2.9/1,000 live births for Latinas
- 4.2/1,000 live births for Teens

Potentially 64% of African-American fetal and infant deaths were preventable. African-Americans had the highest excess rates in all four risk periods, with a rate 11 times that of the Caucasian rate in the Maternal Health/Prematurity period (Feto-infant mortality in Dallas County, 2011).

Garland Fair Housing and Disabilities

Four fair housing surveys were created and issued online through SurveyMonkey, an Internet survey service, from October 7, 2014 to January 2015. The surveys were made available to all Garland residents, housing providers/advocate agencies, area Realtors, and lending institutions and were anonymous. The survey asked respondents about their experience and perception of housing discrimination, knowledge of fair housing laws, and experience with City housing assistance and social service programs, fair housing issues, and opinions about housing and social service needs in the City. The surveys were also directly administered in paper formats at events and through social service agencies. A Spanish language version of the survey was also available for residents. The findings from these activities are discussed in turn.

The survey asked if there was an adequate supply of affordable housing available to residents with disabilities, senior citizen residents, and residents with children. For residents with disabilities, 63.6% of respondents felt that there was not an adequate supply of affordable housing while 27.3% felt residents with disabilities did have an adequate supply of fair housing. For senior citizen residents, 54.5% of respondents felt that there was not an adequate supply of affordable housing while 27.3% (3 persons) felt residents with disabilities did have an adequate supply of fair housing.

Public meetings and focus group sessions were advertised on the City's website and in newspapers of general circulation. The public meetings were conducted to solicit input on fair housing discrimination and impediments to fair housing from the City, various industry representatives and service providers, and the public stakeholders at large. In addition, public notices providing for reasonable accommodation and alternative formats for information were

offered to persons with Limited English Proficiency and persons with disabilities, including the hearing-impaired. Additional information was gathered via teleconferences and email correspondence with nonprofit and advocacy groups. Staff of the City of Garland's Fair Housing Services and Housing and Community Services departments actively participated in the public meetings and focus groups.

Interviews were also conducted with key individuals from other City Departments, non-profits, HUD, and housing providers to collect additional information about fair housing practices and impediments in the City. Focus group meetings were held on November 5, 6, and 7, 2014 with the following groups:

- Realtors, lenders, property managers, and other housing providers.
- Social service providers and advocates, as well as community housing development organizations, persons with HIV/AIDS, homeless, and persons with disabilities.
- City staff

One of the findings of this Fair Housing Study/Survey was that discrimination cases involving persons with mental disabilities losing housing are increasing. An example is where a tenant with a Section 8 voucher loses it because their disability causes non-compliance with recertification or domestic disturbances requirements. It is often difficult to provide assistance to these persons due to federal Health Insurance Portability and Accountability Act (HIPAA) confidentiality provisions and lack of case management. Unlike physical disabilities, mental disabilities are often not detectable and HIPAA and privacy laws limit what housing providers can ask. Tenants would have to self-disclose. Often, awareness of the disability only occurs when the tenant loses housing and is challenged with an appeals process that would take into consideration the tenant's mental disability on the appeal.

Persons with Intellectual Development Disabilities (IDD) also experience similar impediments.

Limitations and Revision, 2017-2018



After the initial Community Health Assessment was completed in 2014, community input was solicited based on its results and infrastructure was put in place to support ongoing implementation. This involved engaging different groups in implementation. While several members of the original groups stayed active, several members left and new members and groups joined over the last 3 years. Based on the results of the initial assessment, the health department coordinator facilitated the identification of five key priority health issues as well as a 5-year strategic plan that included securing funding for an outreach specialist/Chronic disease specialist and assembling a group of stakeholders to collaborate on strategies to decrease the

number of uninsured citizens. The department failed to secure funding for this position and the collaboration disbanded for a variety of reasons, posing a delay in the implementation of some of the strategies developed by the initial Steering committee. This document was revised beginning in November 2017 to January 2018 due to these emerging issues and unexpected barriers. The announcement of the closure of a major regional healthcare provider, Baylor Scott & White Medical Center in Garland, precipitated re-examining the original forces of change assessment and the consideration of a major unanticipated gap in services. As of January 2018, new committees are being assembled in response to the original assessment as well as these emerging health issues and circumstances that will inevitably impact access to care and morbidity/mortality rates.

Conclusion



Community Health Needs Assessments have long been a tool used by hospitals and public health departments to identify key community health concerns. Although the Affordable Care Act requires all nonprofit hospitals to complete a community health needs assessment process every three years, this process was voluntarily undertaken by the City of Garland Health Department to better serve its community members and citizens and to build on our strengths, while acknowledging our weaknesses and limitations so that we may begin to create a culture of continuous quality improvement. Our hope is that continually refreshing data and engaging community partners will enable our department and the local public health system to better coordinate resources and use the limited resources at our disposal optimally to help create conditions for a thriving, healthy community and city.

Appendices



Appendix A. Data sources and other sources consulted

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Appendix B. Definitions

Healthy community

A defined local area that has equitable access to healthcare and resources to support individual health. This includes: walkable and bikeable neighborhoods, safe public transportation, parks and open spaces, healthy food and fitness environments, cultural resources, good air quality, and access to housing and employment. (Prevention Institute)

Healthcare access

A person's ability to receive preventive services and treatment. Access is governed by: geographic location of health facilities, resident geographic location, transportation

infrastructure, health literacy and awareness, and ability to pay for services, among other systemic barriers along the continuum of care.

Health disparities

A disproportionately negative health outcome in one population group when compared to the group with the best reported outcome. Disparities are evidenced by social determinants of health such as uninsured status, as well as limited physical and financial access to primary care physicians (PCPs) and health services.

Preventive Services

Services rendered by PCPs at clinics, hospitals, and/or the health department, as well as from nurse practitioners, parish nurses, community health workers and navigators to decrease the likelihood of future disease diagnoses.

Medical Home/Patient-Centered Medical Home

A Patient-Centered Medical Home (PCMH) is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes (American College of Physicians). The public health sector in Dallas County supports medical homes through preventive healthcare access and immunizations, local healthcare access analysis and resulting programs, mobile unit services, and benefits provided by community health workers, navigators, and organizers. PCMH facilitates consistent healthcare available along the continuum of care.

Definitions of ethnicity categories referenced in Community Health Needs Assessment text derived from U.S. Census and the United Nations include:

African-American A person having origins in any of the original peoples of Eastern, Middle, Southern, or Western Africa. For example, it includes people who identify as Kenyan, Nigerian, or Haitian.

Asian-American A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

Caucasian A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who identify as Irish, German, Italian, Lebanese, Arab or Moroccan.

Latino A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish

culture or origin regardless of race.

Social Determinants of Health

In order to achieve better health, it is imperative that Garland residents address the social and environmental factors that influence health. The social and environmental resources that affect health are not evenly distributed and impact different people differently. Changing these social determinants is not only an issue for the healthcare community; it is an issue for all citizens.

Engaging the entirety of Garland to address health issues is critical to achieving better health in Garland. To do so, stakeholders must engage the entirety of the community to define:

- What kind of change is important and meaningful to the community
- What will work and why
- What won't work and why

One aspect of the solution is health promotion in the workplace. Promoting workplace cultures that reduce stress, make nutritious food available in cafeterias, snack areas, vending machines and at meetings, promoting physical activity and other healthful behaviors, is one strategy that will create a culture of health within the workforce.

Throughout the process of developing the Garland Community Health Assessment, the stakeholders remarked on the theme of equity and the key role it plays in health of the citizens. Health inequities are the differences in health that are unnecessary and avoidable which are also considered unfair and unjust. Often inequities are tied to factors much larger than healthcare itself—the social determinants of health.

Every individual should have a fair opportunity to live a long and healthy life. Health inequities are frequently rooted in historic injustices that make sub-populations more vulnerable to poor health than comparison groups. Addressing these issues from a broad community perspective is a significant challenge that must be undertaken to improve the overall health and well-being of citizens.

Ensuring that the natural environment, the built environment, everyday activities, the local economy, the community and individual lifestyles are all contributing in a positive way to the health and well-being of individual citizens will help make significant progress in improving the health of everyone.

Poverty is one of the major forces driving this inequity. Other social determinants of health include:

- food deserts and the availability of healthy food

- the supply of affordable housing
- single parent households
- educational attainment
- having safe places to be physically active, and
- Employment and the availability of living wage jobs

Figure 9. Framework for Social Determinants of Health



Appendix C. Community Assets

Garland has a diverse array of valuable assets to utilize in addressing the challenges of improving health for the entire community. From Garland Public Health Clinic to the hospitals and health systems, to governmental entities and law enforcement, to community non-profits who focus on various aspects of the issues we have examined to every citizen of Garland. The amount of resources Garland is able to bring to bear to address these issues is substantial and varied. Understanding the variety of assets available is one component of being able to develop comprehensive strategies that encompass these partners and have the greatest potential of success.

Hospitals, outpatient clinics, and other health services

1. Garland Behavioral Hospital
2. Genesis Women’s Shelter
3. Sundance Hospital
4. The Addicare Group of Texas

5. Garland Women's Health Center
6. Family Centered Maternity Care
7. Children's Medical Center Garland- Pediatric Group
8. Pediamed (three locations)
9. Smiley Dental & Orthodontics
10. South Texas Dental
11. Excellence ER
12. Carenow
13. Concentra Urgen Care
14. Garland East SuperTarget
15. Garland Health Center – COPC PHHS
16. MD Kids Pediatrics
17. Walmart Care Clinic Garland
18. Baylor Family Medicine at Garland
19. Baylor Family Medicine at North Garland
20. Hope Clinic of Garland
21. Parkland COPC Garland Health Center

Parks/Trails, Recreation centers, and Farmers Markets

1. Four Season's Farmer's market
2. Cotton's Produce
3. Garland Community Garden
4. Granger Recreation Center
5. Audubon Recreation Center
6. Bradfield Recreation Center
7. Fields Recreation Center
8. Holford Recreation Center
9. Hollabaugh Recreation Center
10. Spring Creek Nature Preserve and trail system
11. Rowlett Creek Preserve
12. Duck Creek Greenbelt

Over the past decade, trails have become one of the most popular recreational amenities in the U.S. Couples use them to take walks together, parents use them to teach their children how to ride a bicycle, and other use them to help lose weight, stay in shape, train for a race, or as a means by which they can get to work, to school, or to the store. Not surprisingly, studies have shown that trails enhance local property values and can do much to attract residents, tourists, and businesses; reduce traffic; and improve air quality. There are currently over 30 miles of trails (natural surface and paved) but less than a mile of dedicated bike lanes in Dallas County

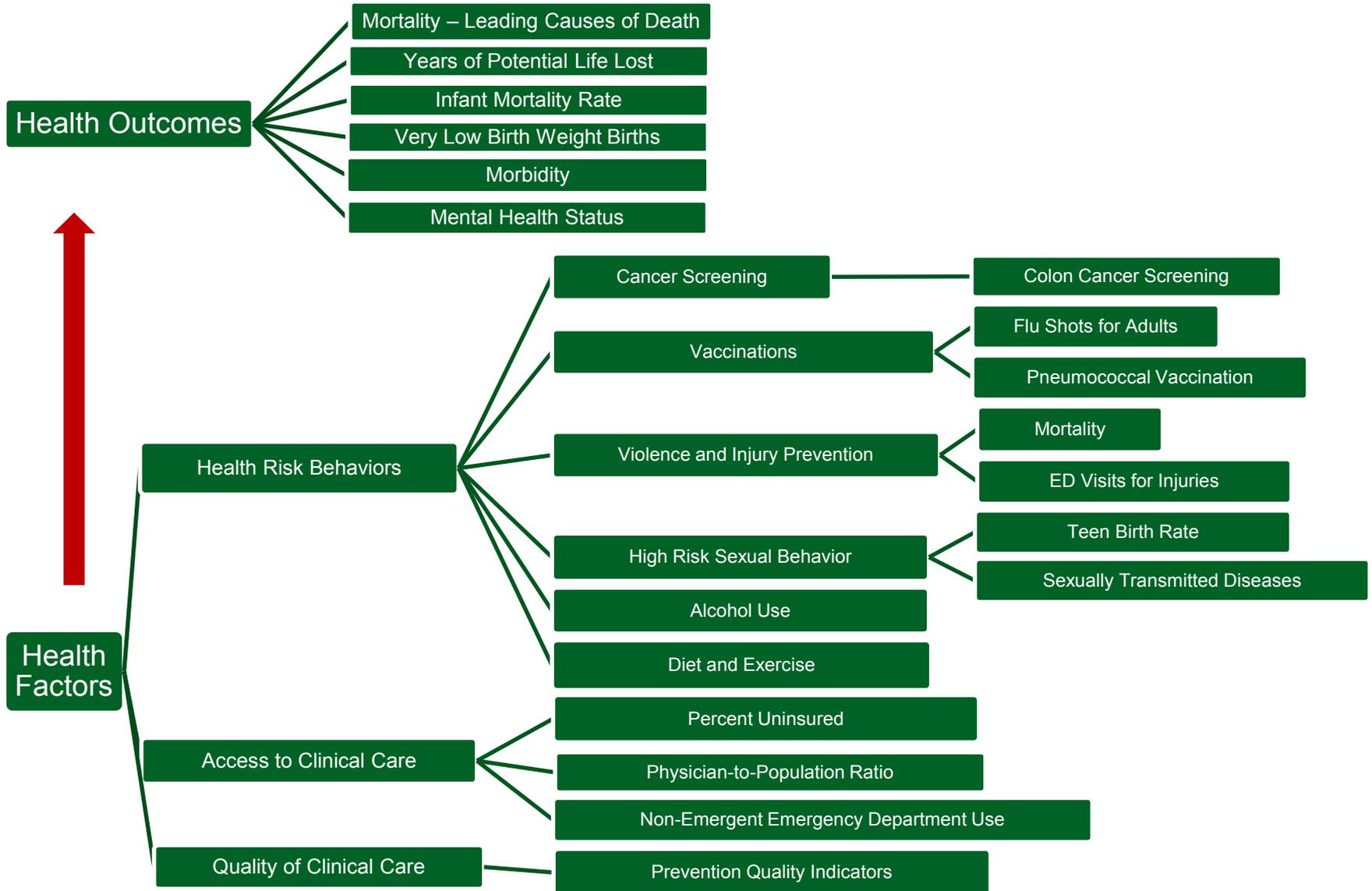
Appendix D. Community Health Status Survey

City of Garland Community Health Status Assessment



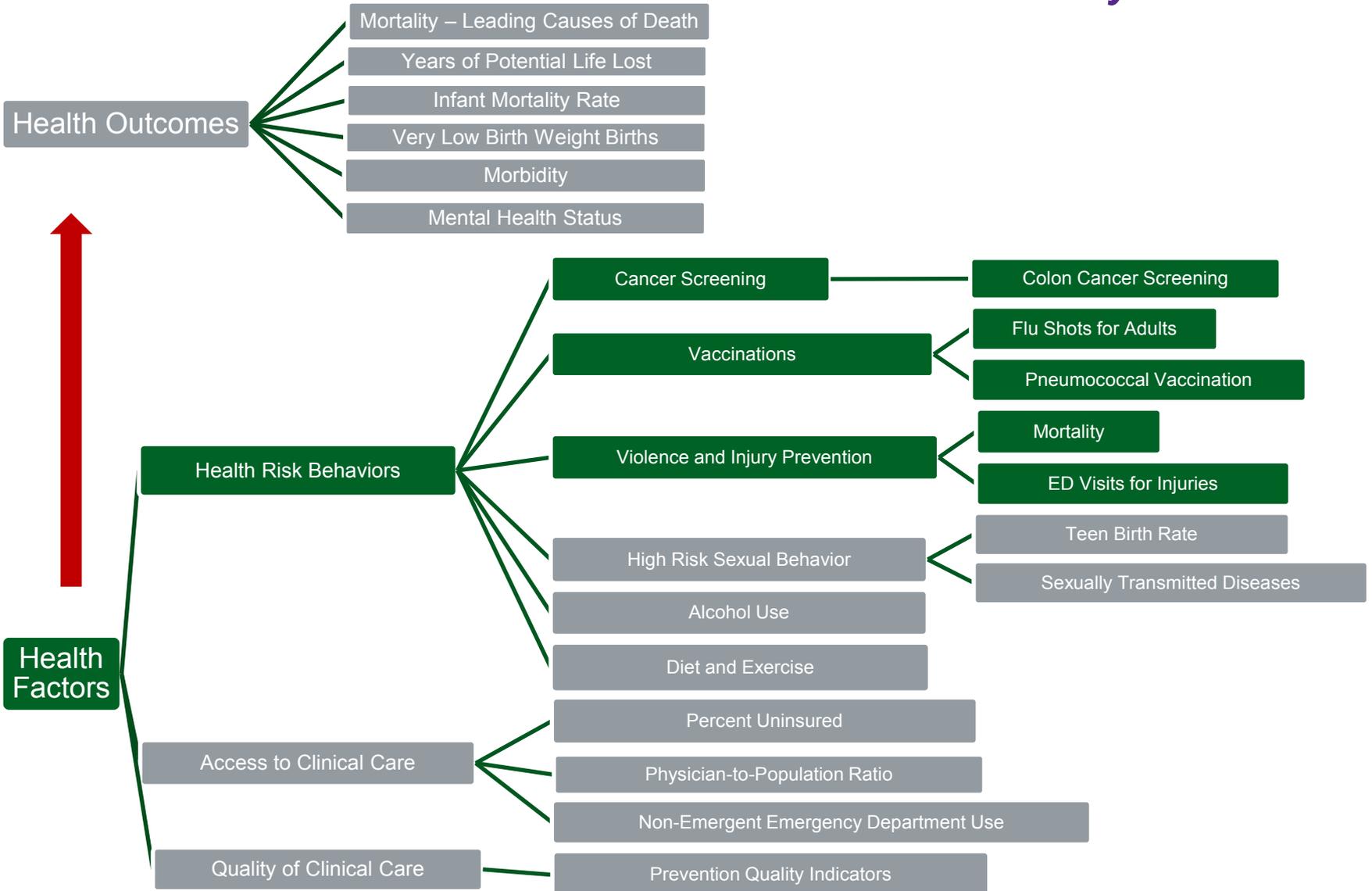


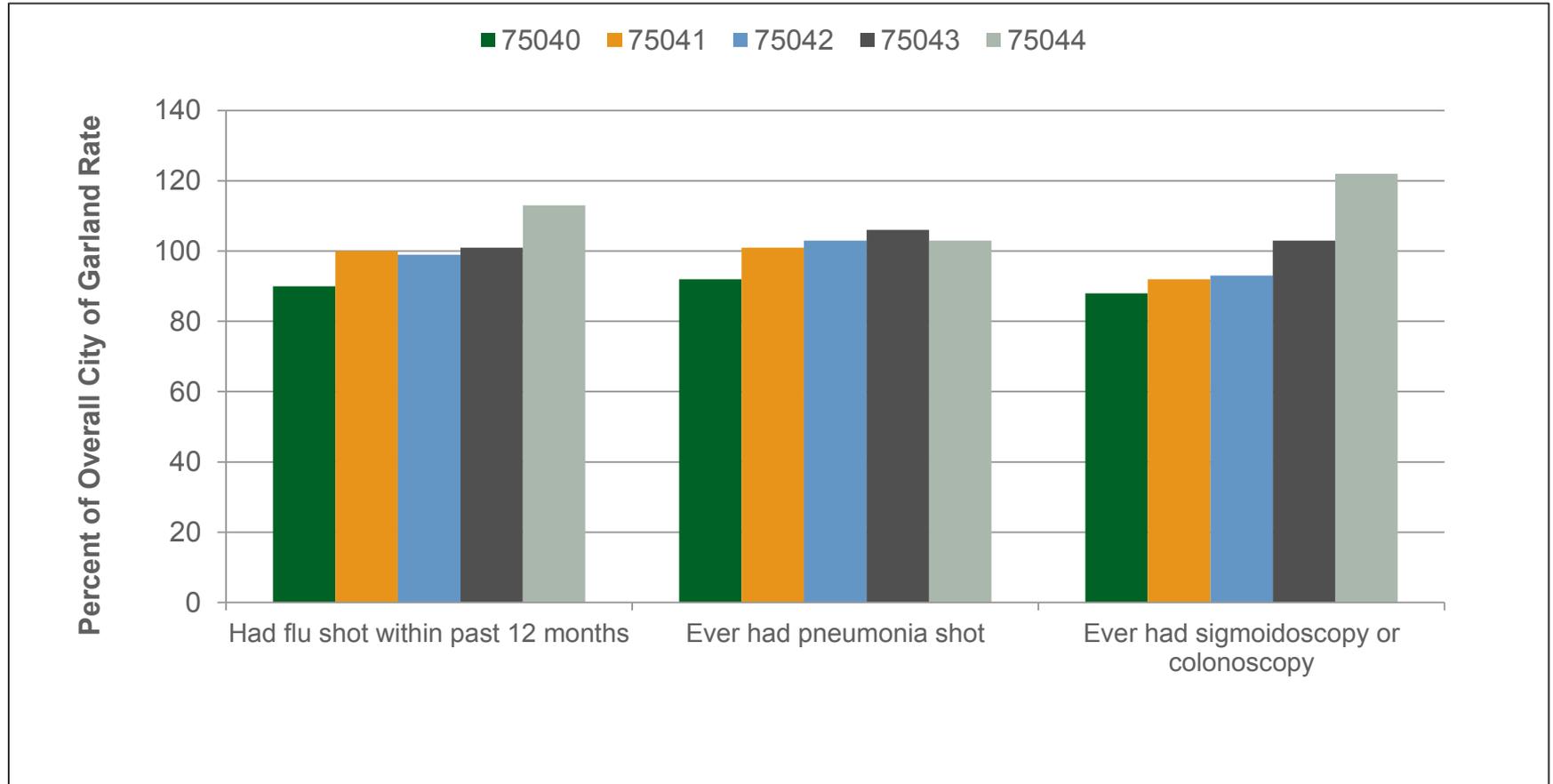
Organizational Model For the Community Health Dashboard





Health Risk Behaviors *City of Garland*

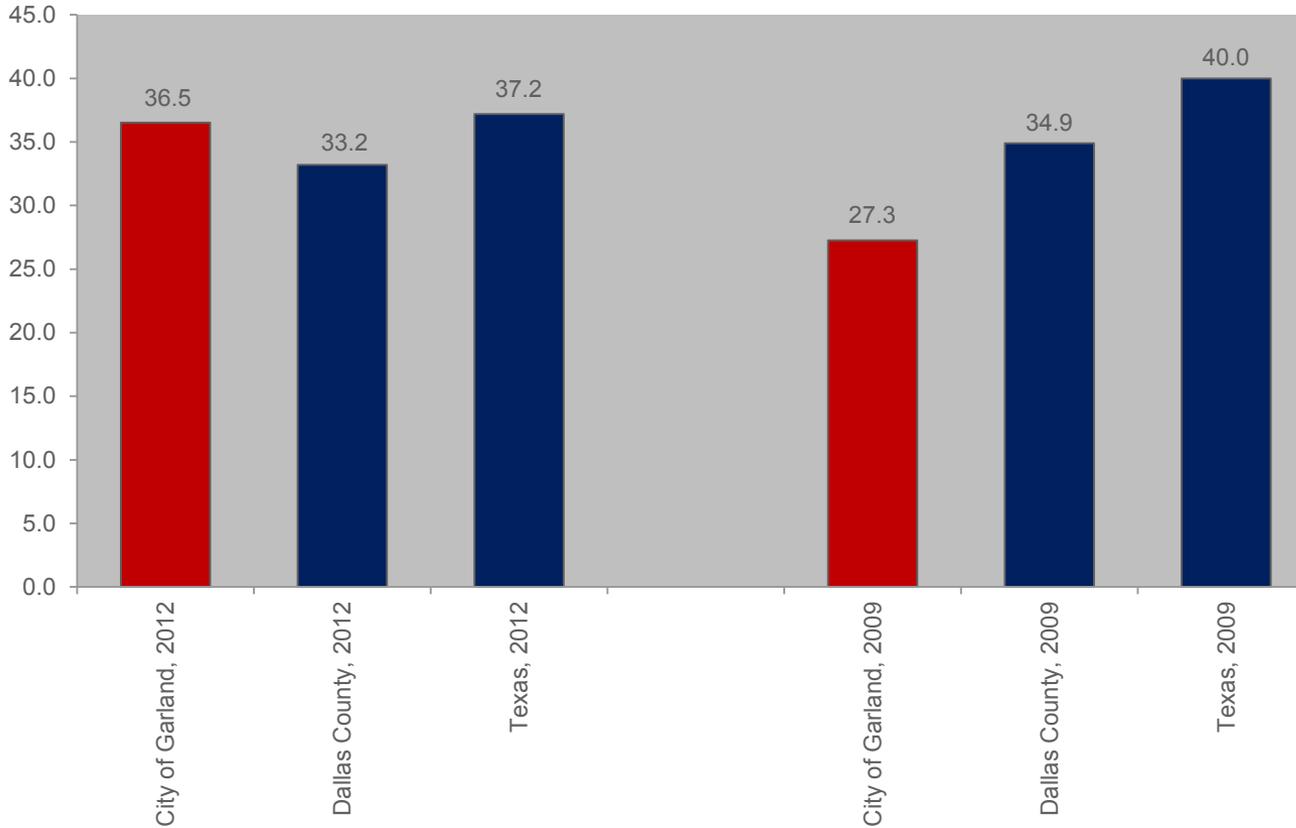




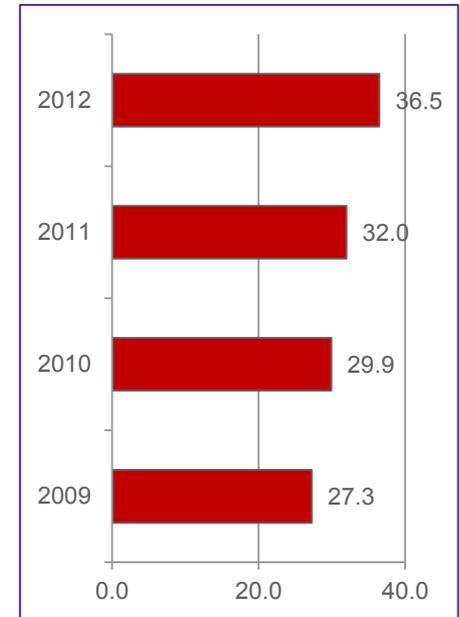
Health Outcomes: All Accident Mortality Rates

City of Garland

Age-Adjusted Deaths per 100,000



All Accident Mortality Rate, Age-Adjusted Death Rate per 100,000, City of Garland

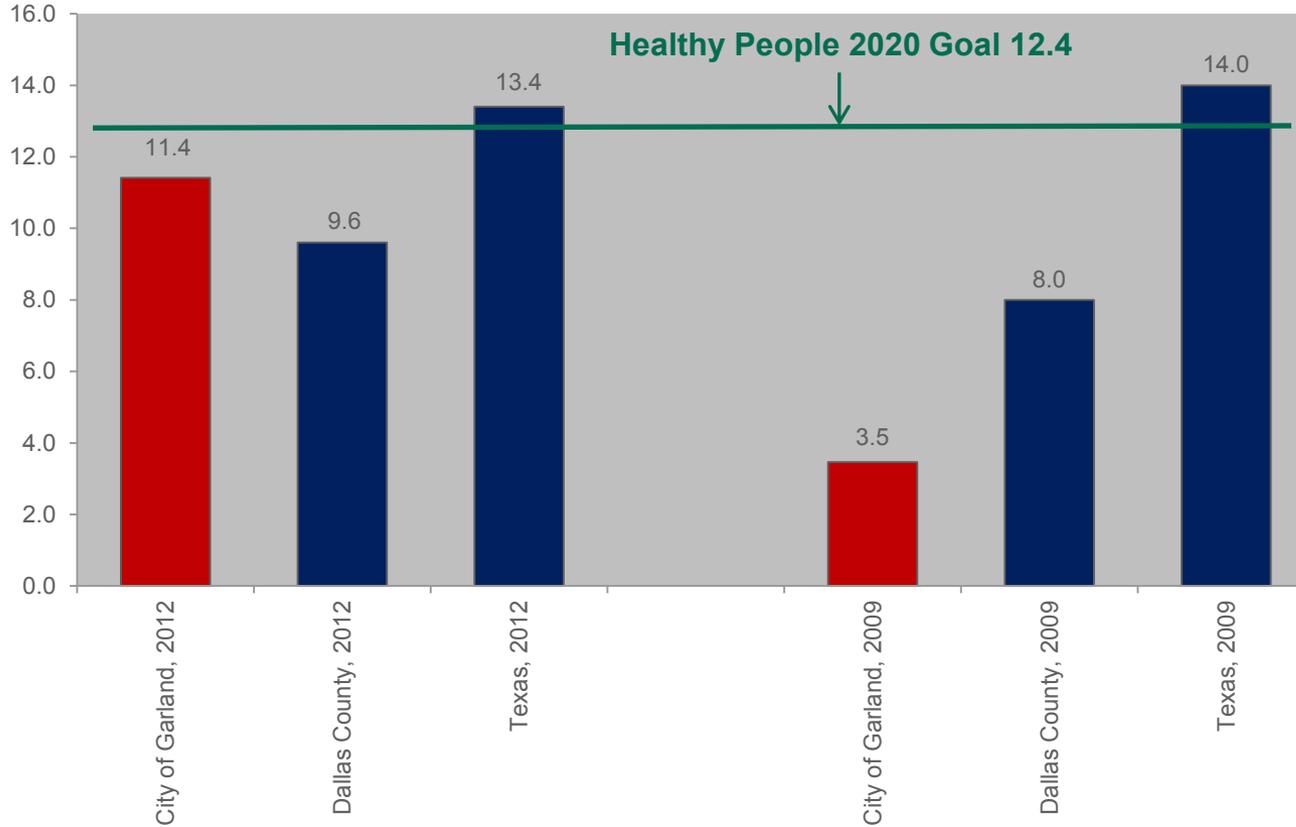


Source: Texas Department of State Health Services, Bureau of Vital Statistics; denominator population data from Nielsen Pop-Facts

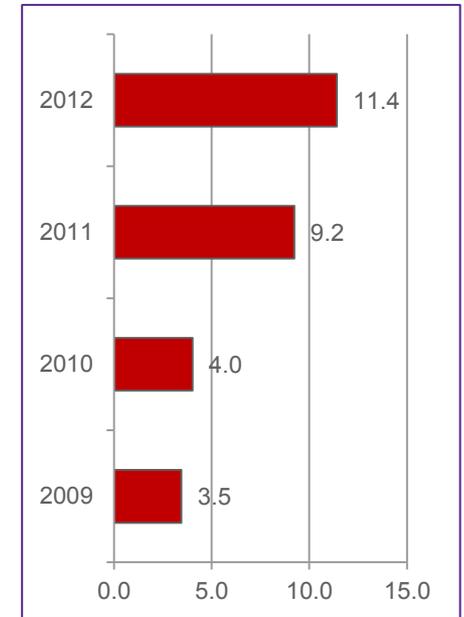
Health Outcomes: Motor Vehicle Accident Mortality Rates

City of Garland

Age-Adjusted Deaths per 100,000



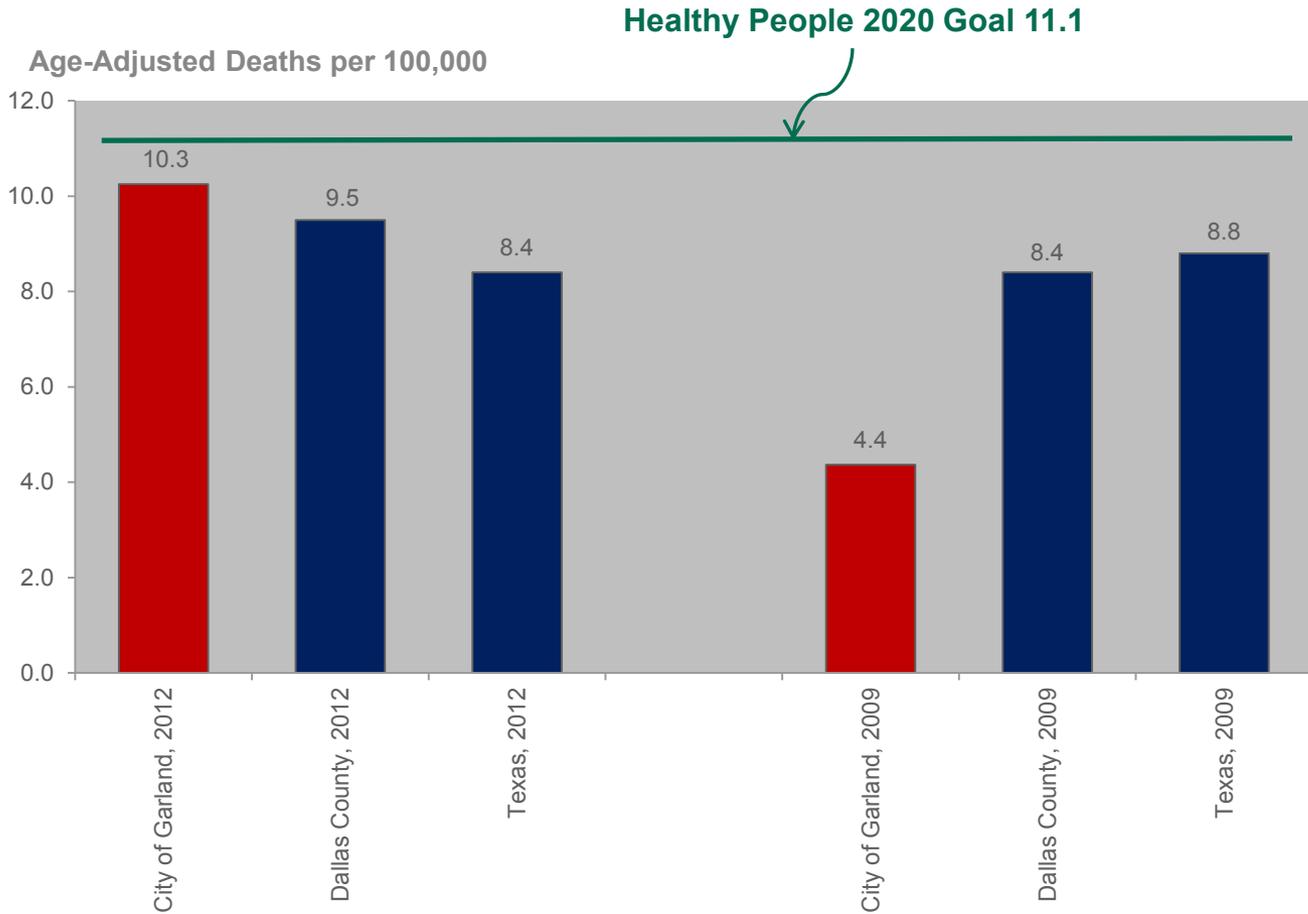
Motor Vehicle Accident Mortality Rate, Age-Adjusted Death Rate per 100,000, City of Garland



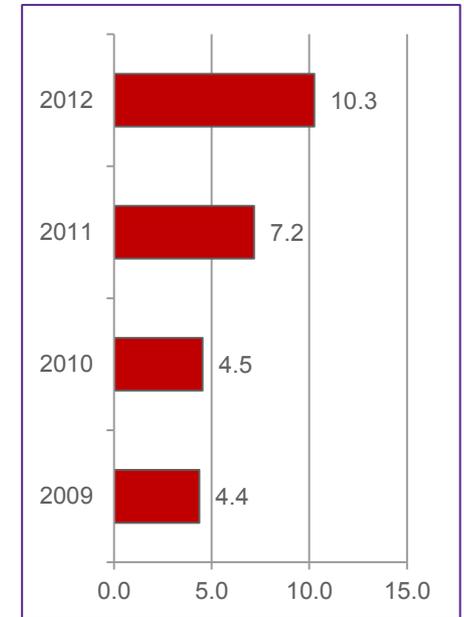
Source: Texas Department of State Health Services, Bureau of Vital Statistics; denominator population data from Nielsen Pop-Facts



Health Outcomes: Accidental Poisoning Mortality Rates *City of Garland*



Accidental Poisoning Mortality Rate, Age-Adjusted Death Rate per 100,000, City of Garland



Source: Texas Department of State Health Services, Bureau of Vital Statistics; denominator population data from Nielsen Pop-Facts

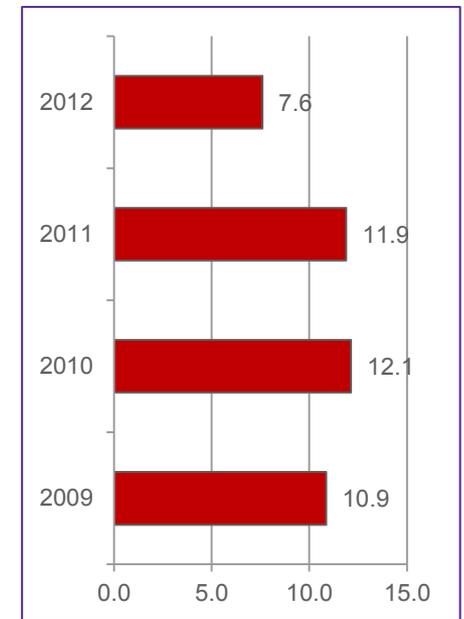


Health Outcomes: Accidental Falls Mortality Rates *City of Garland*

Age-Adjusted Deaths per 100,000



Accidental Poisoning Mortality Rate, Age-Adjusted Death Rate per 100,000, City of Garland

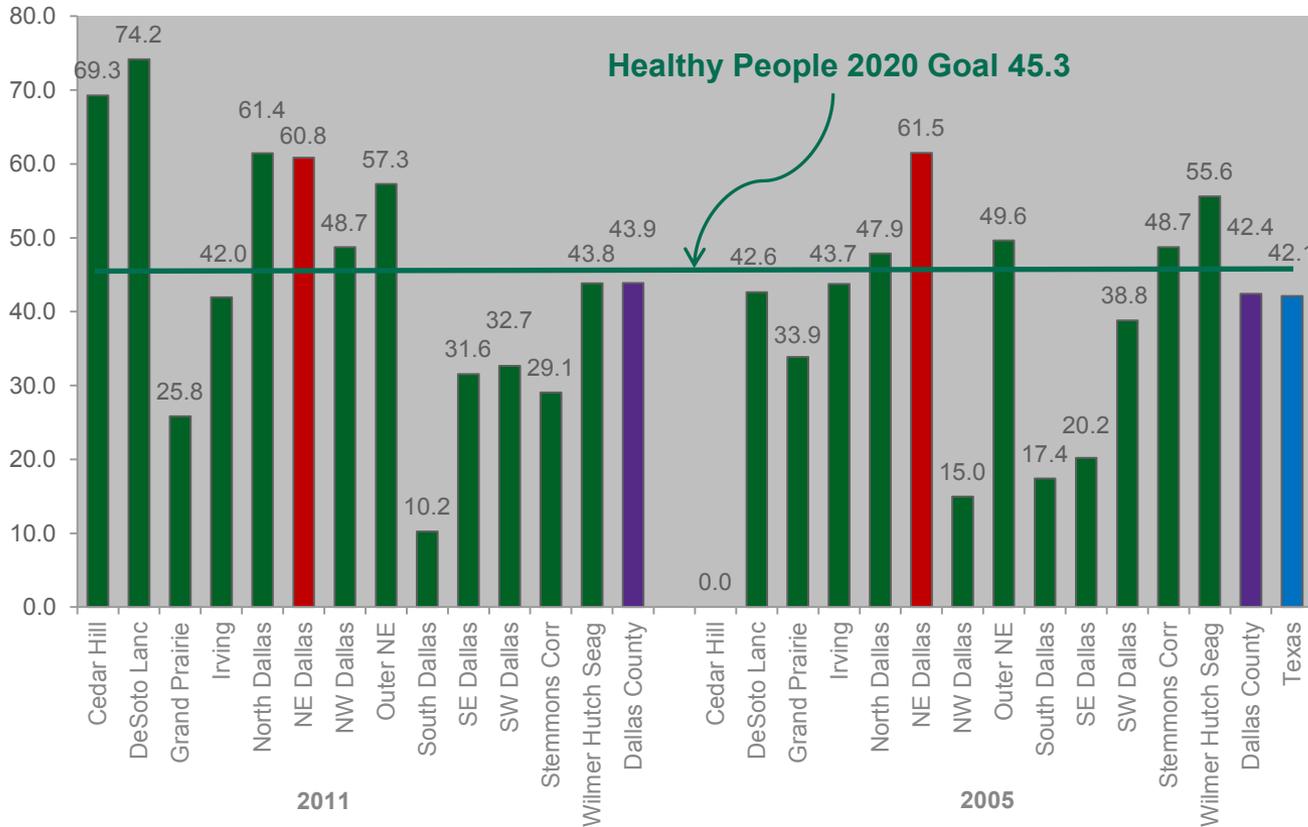


Source: Texas Department of State Health Services, Bureau of Vital Statistics; denominator population data from Nielsen Pop-Facts

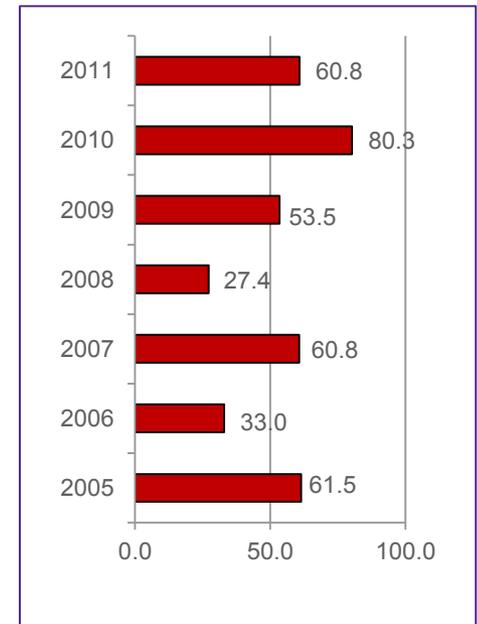


Risk Factors: Falls Death Rates Among Seniors Northeast Dallas Service Area

Falls Deaths Age 65+



Falls fatality rates, ages 65+, per 100,000, Northeast Dallas Service Area

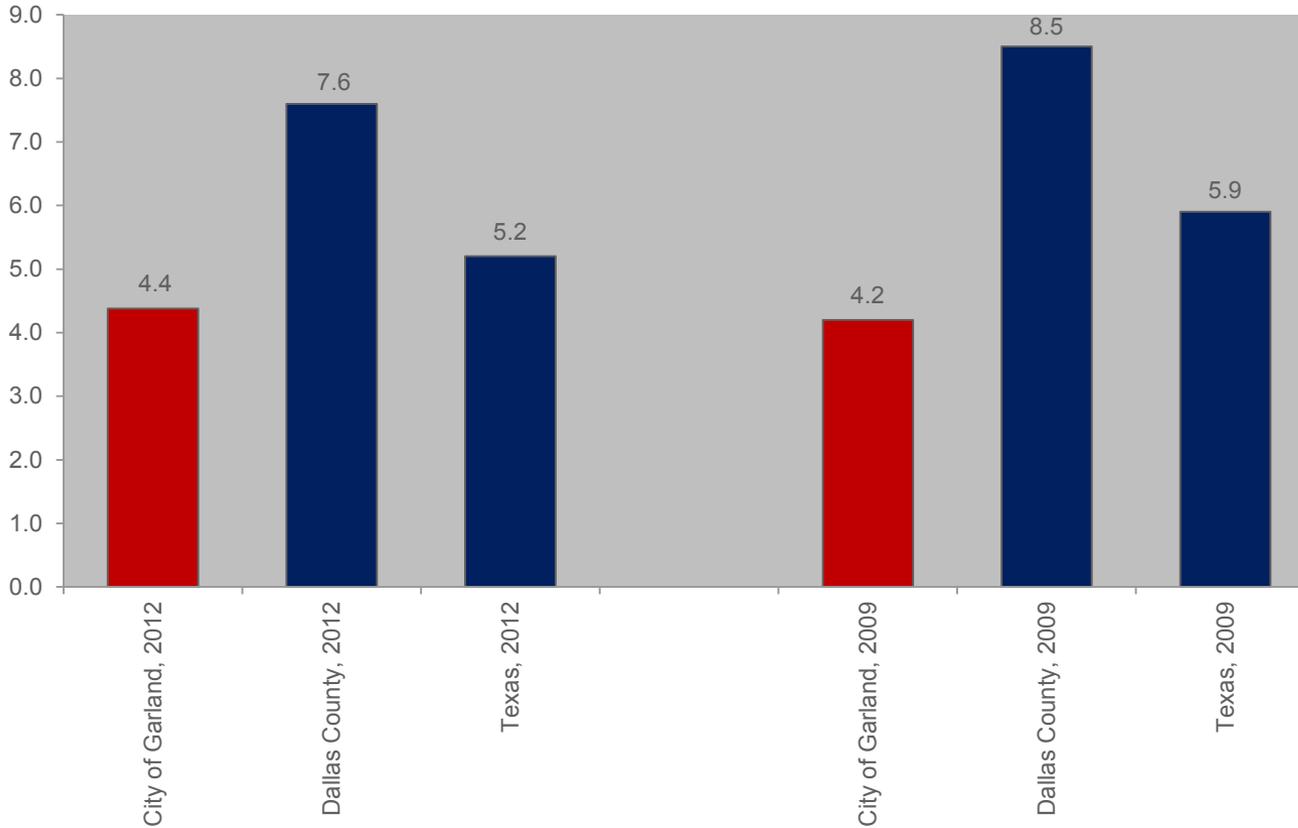


Source: Texas Department of State Health Services, Bureau of Vital Statistics, unpublished data; denominator population data from US Census Bureau American Community Survey. 2005 Dallas County data from Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death File 2005-2006. CDC WONDER On-line Database, compiled from Multiple Cause of Death File 2005-2006 Series 20 No. 2L, 2012. Accessed at <http://wonder.cdc.gov/mcd-icd10.htm> on Mar 25, 2010 2:52:15 PM; 2005 Texas data from <http://soupfin.tdh.state.tx.us/>

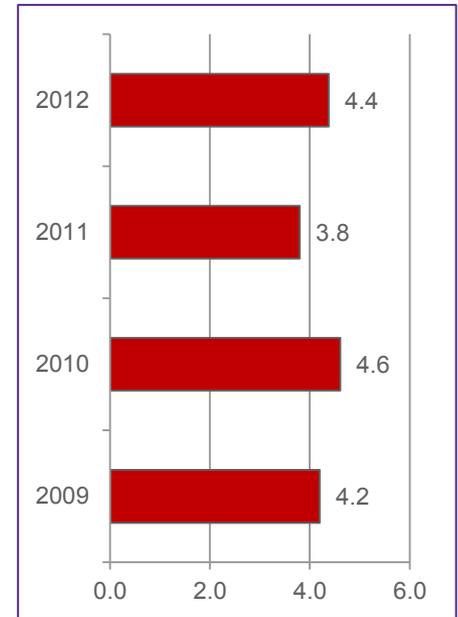
Health Outcomes: Homicide Mortality Rates

City of Garland

Age-Adjusted Deaths per 100,000



Homicide Mortality Rate, Age-Adjusted Death Rate per 100,000, City of Garland



Source: Texas Department of State Health Services, Bureau of Vital Statistics; denominator population data from Nielsen Pop-Facts

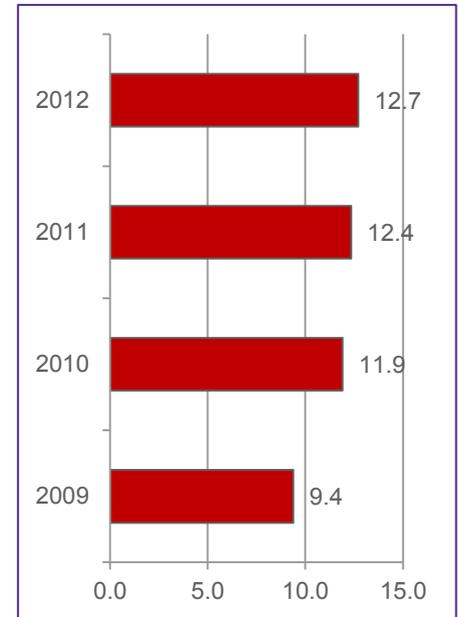
Health Outcomes: Suicide Mortality Rates

City of Garland

Age-Adjusted Deaths per 100,000



Suicide Mortality Rate, Age-Adjusted Death Rate per 100,000, City of Garland



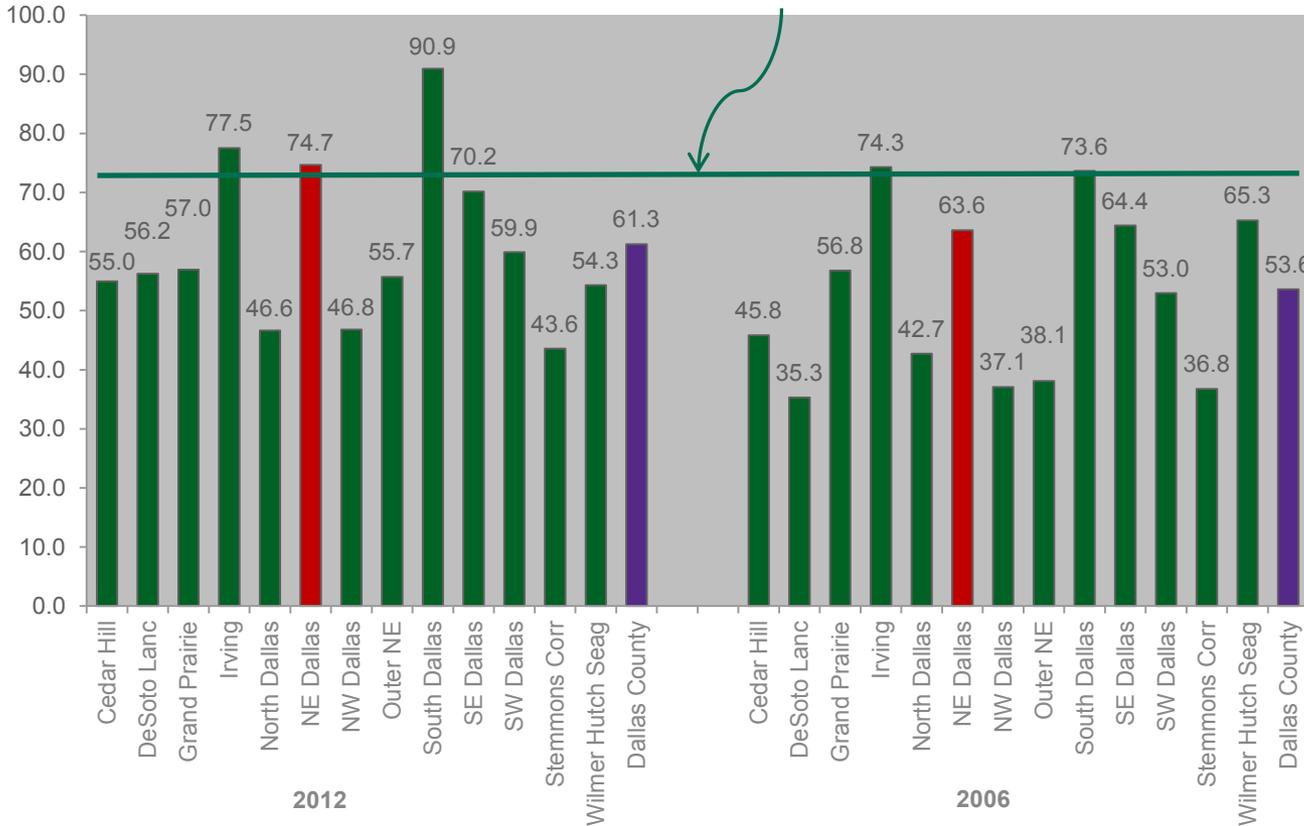
Source: Texas Department of State Health Services, Bureau of Vital Statistics; denominator population data from Nielsen Pop-Facts



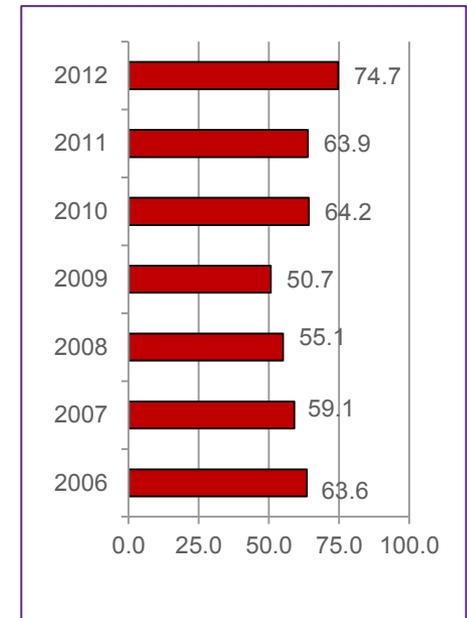
Risk Factors: Rate of Injury-Related ED Visits Northeast Dallas Service Area

Rate of Injury-Related ED Visits

Healthy People 2020 Goal 73.3



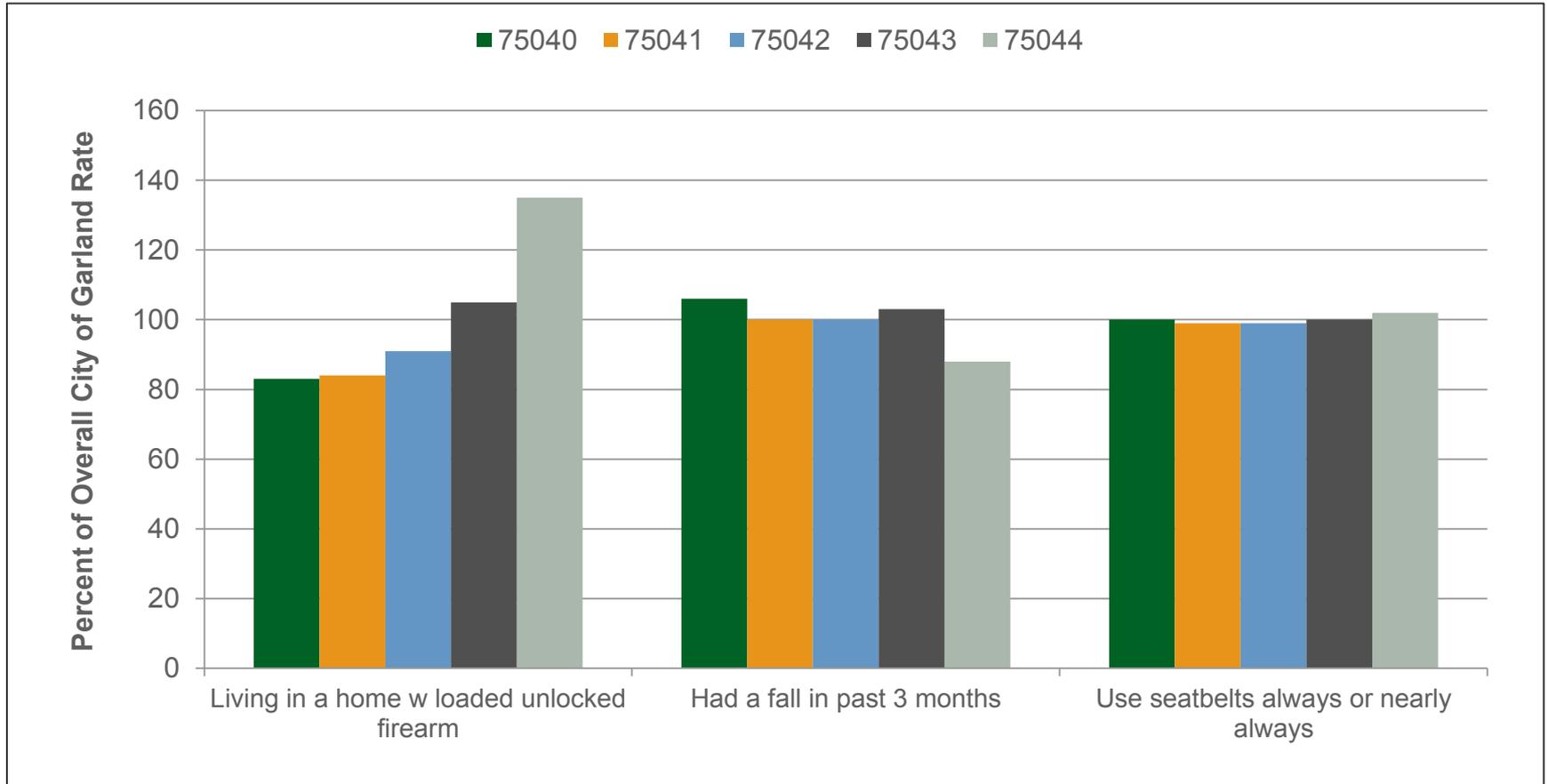
Rate of Injury-Related ED Visits, per 1,000, Northeast Dallas Service Area



Source: DFWHC ERF Information Quality Services Center Regional Data, 2010. Dallas-Fort Worth Hospital Council Education and Research Foundation, Information and Quality Services Center, Irving, Texas. July 2013. Denominator population data from Claritas, Inc.

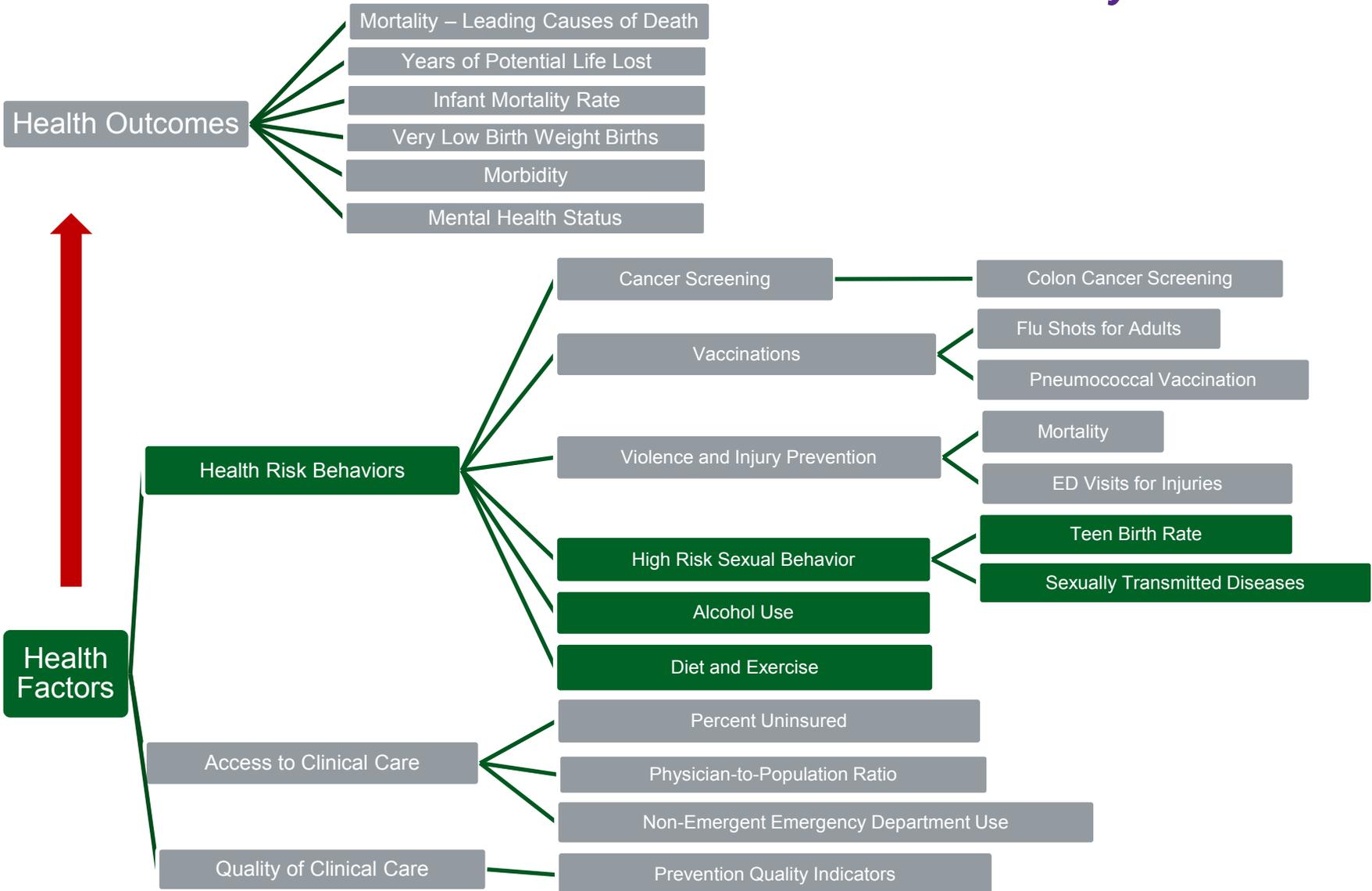


Behavioral Risk Factor Survey Data, 2014 City of Garland





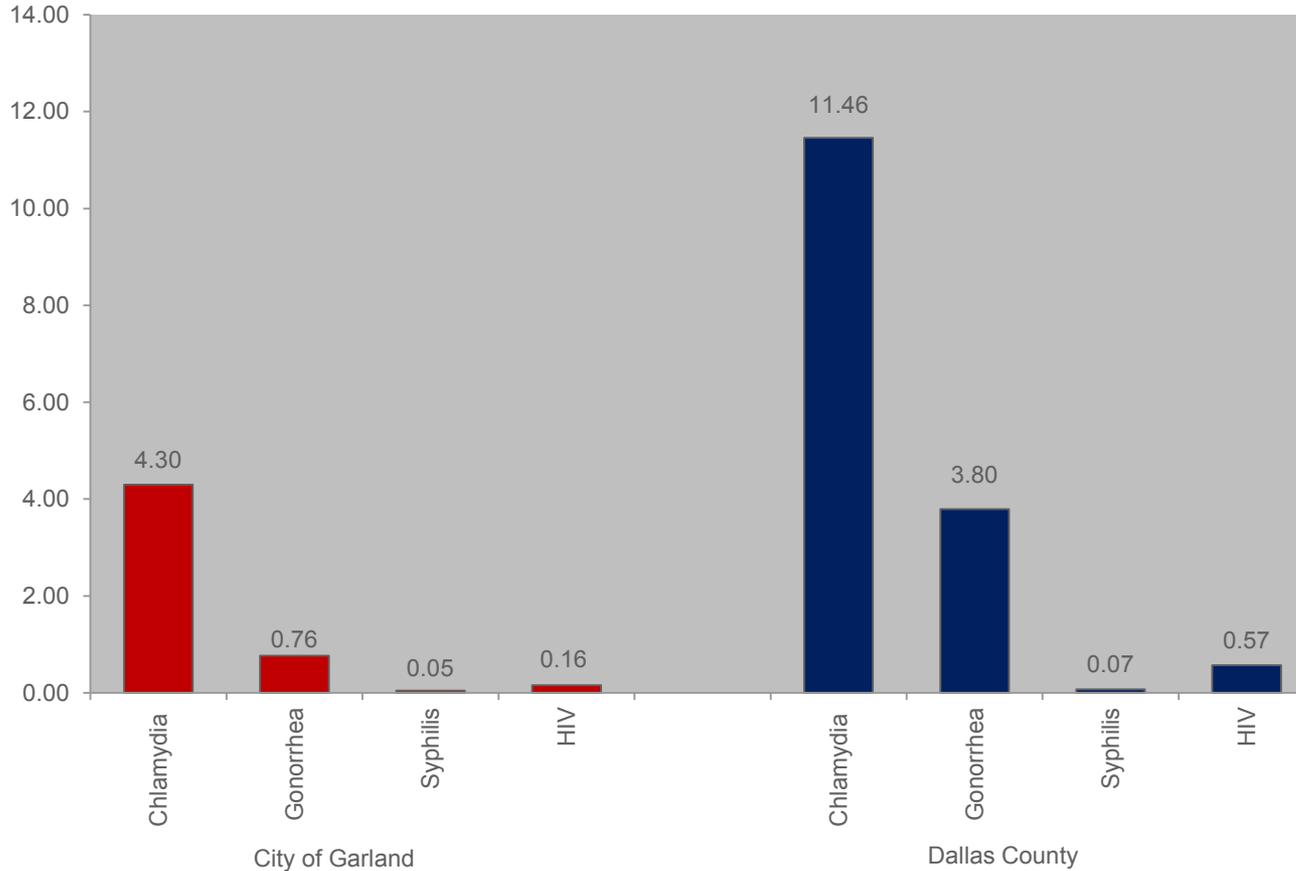
Health Risk Behaviors *City of Garland*



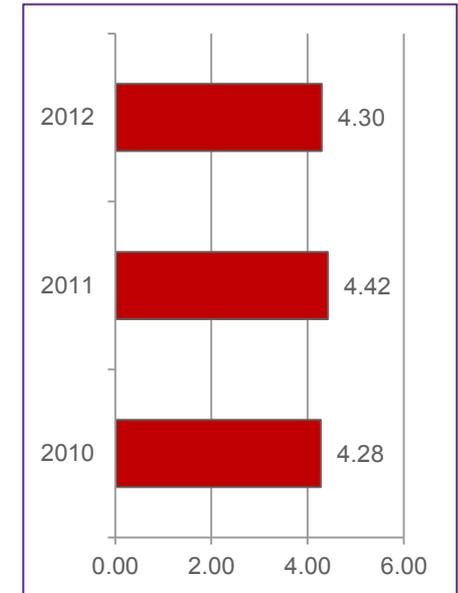
Risk Factors: High Risk Sexual Behavior, Sexually Transmitted Disease Incidence Rates, 2012

City of Garland

New Cases per 1000 Population

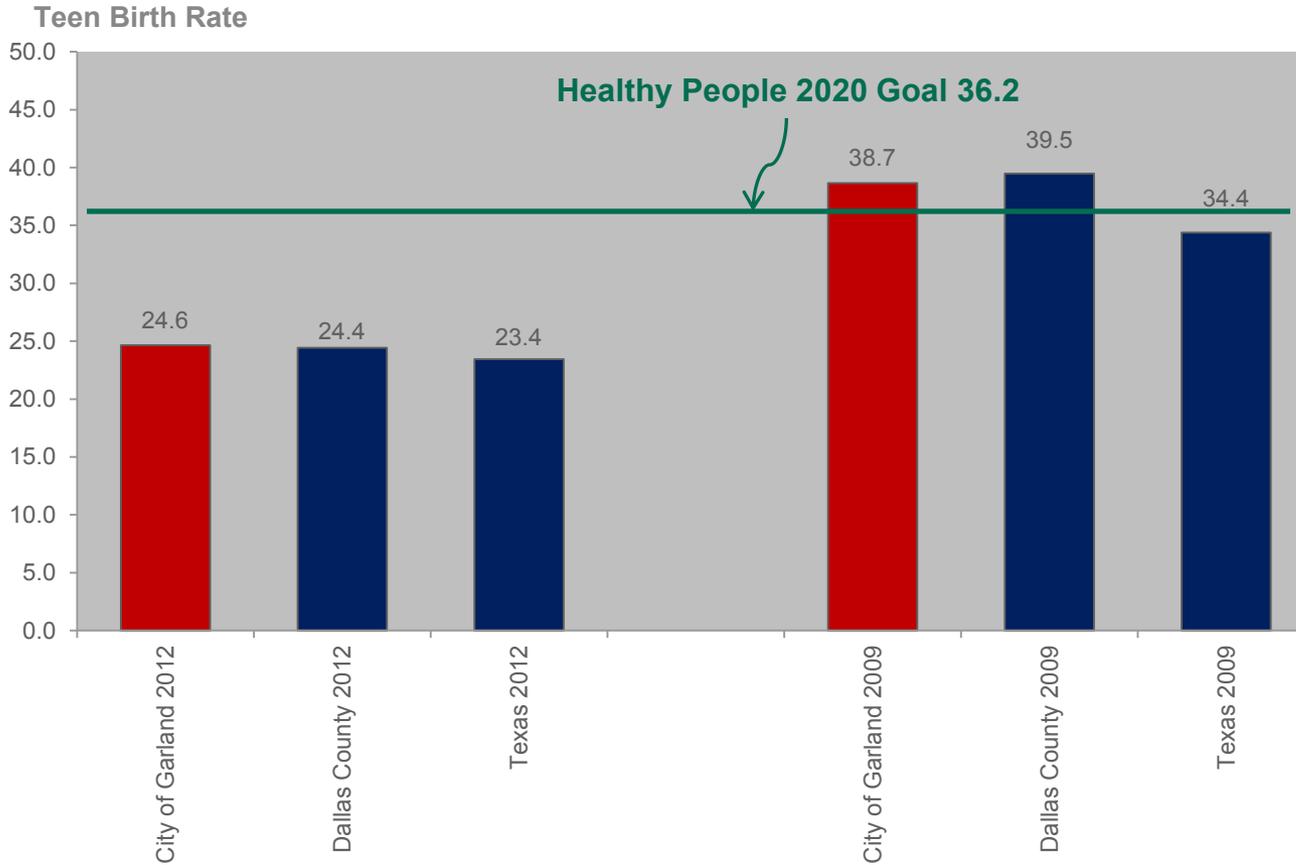


Chlamydia Incidence Rate, Per 1,000 Population, City of Garland

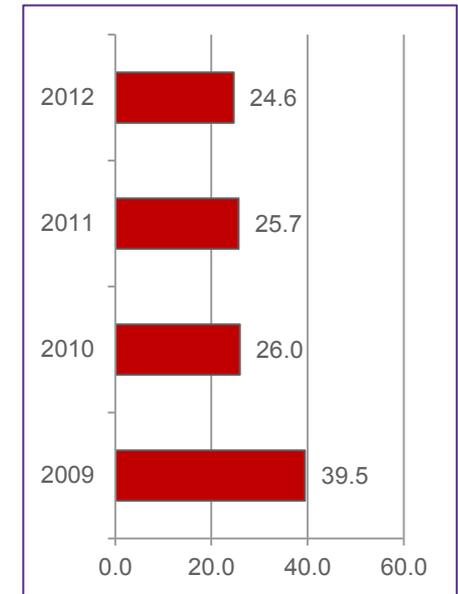


Risk Factors: High Risk Sexual Behavior, Teen Birth Rates

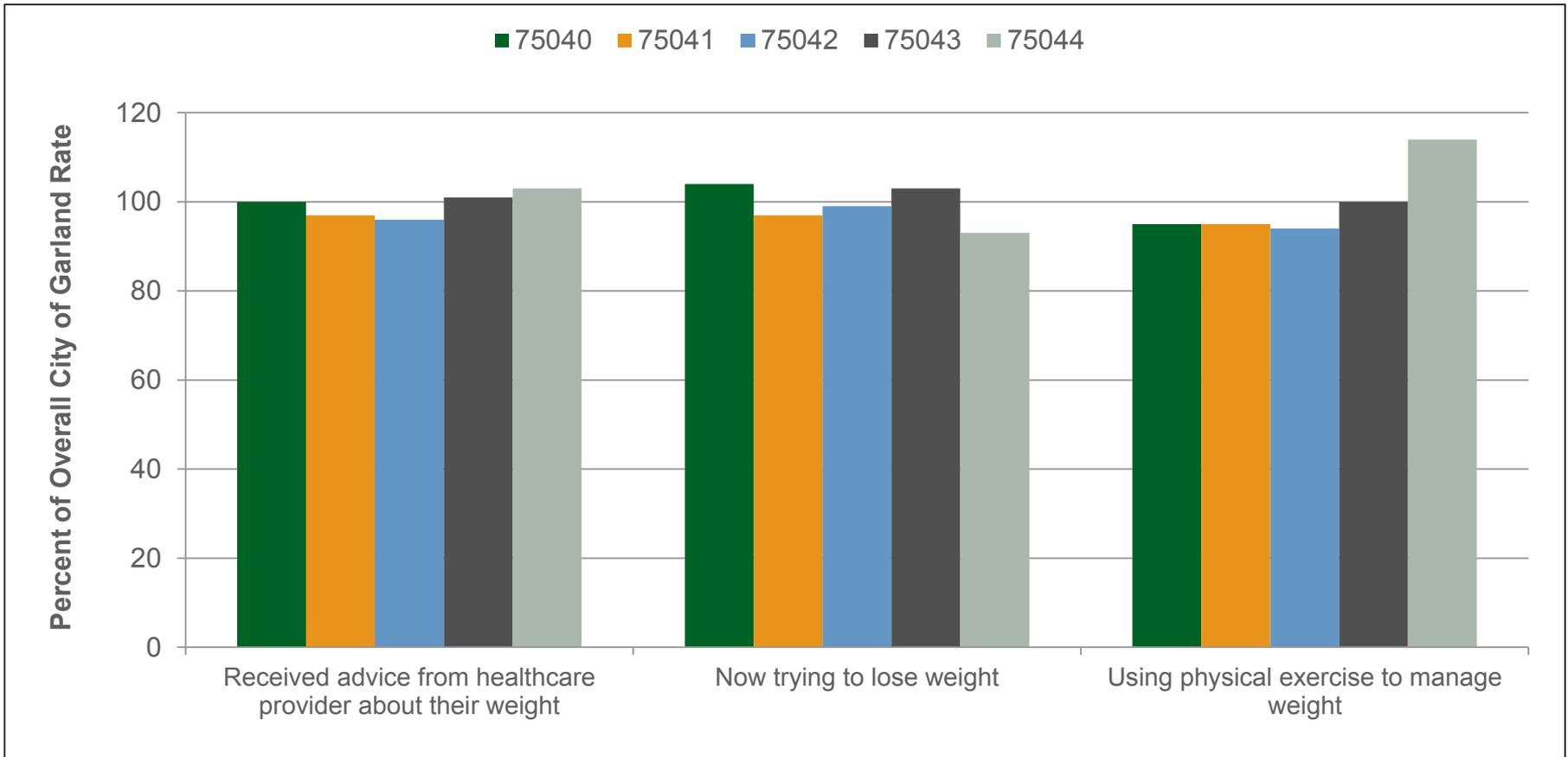
City of Garland

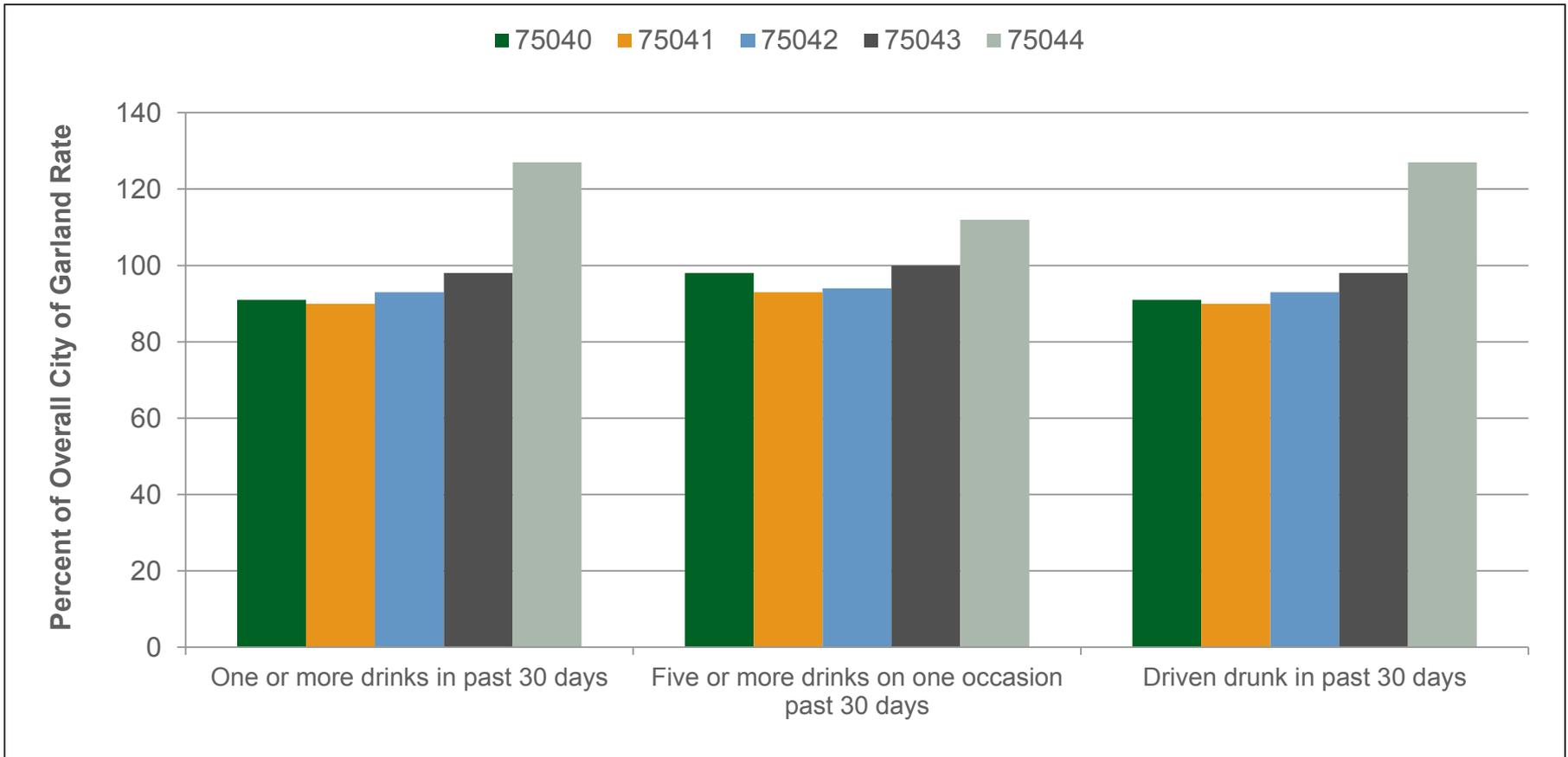


Teen Births, Births Per 1,000 Girls Ages 15-17, City of Garland



Source: Texas Department of State Health Services, Bureau of Vital Statistics; denominator population data Nielson/Claritas Pop Facts and US Census Bureau American Community Survey



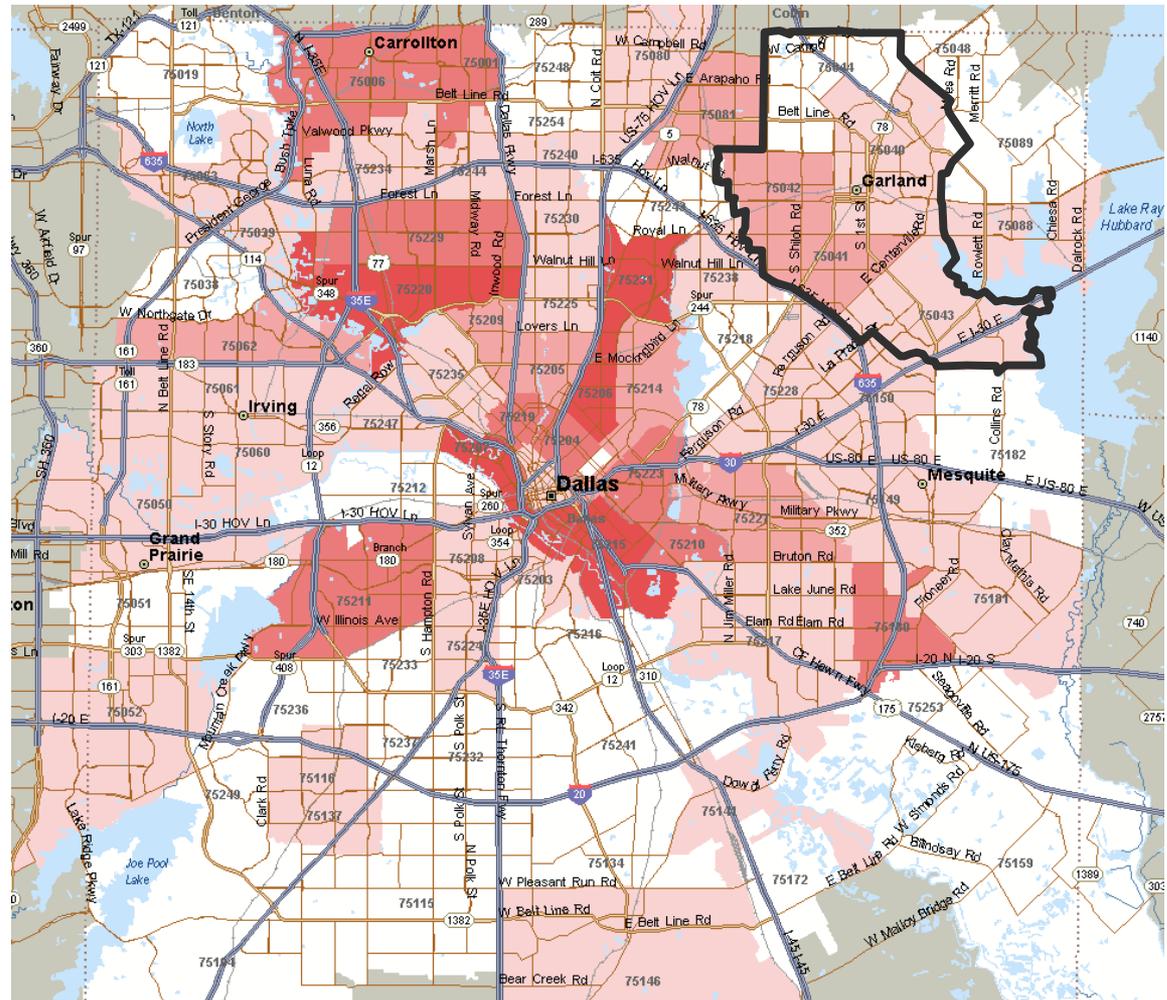
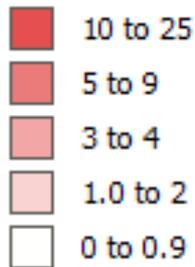




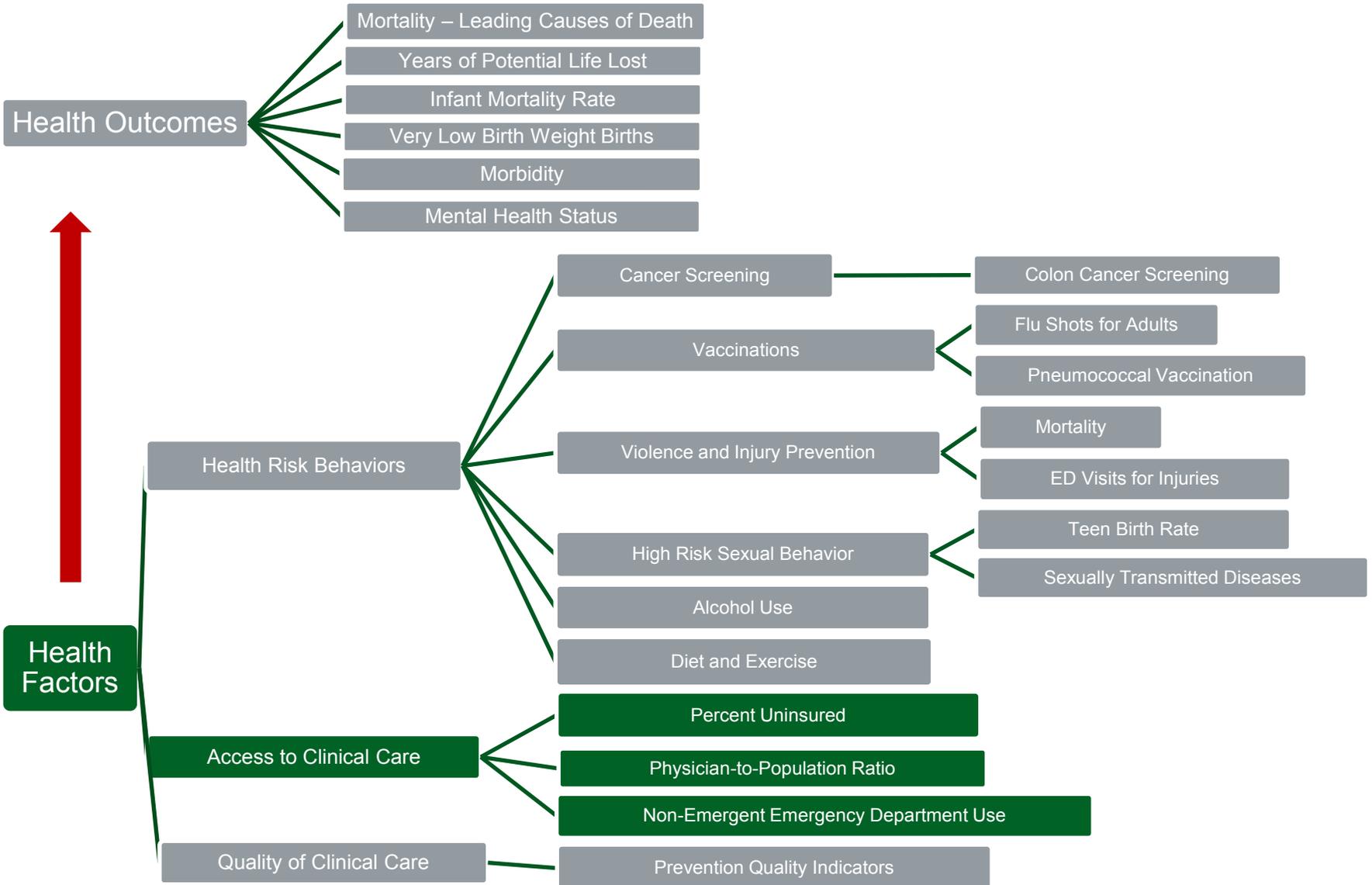
Parkland

Risk Factors: Liquor Store Density, 2012 Dallas County

Number of Liquor Stores by ZIP Code



Source: US Census Bureau, 2012 County Business Patterns; denominator population data from US Census Bureau; NIACS annual business estimates



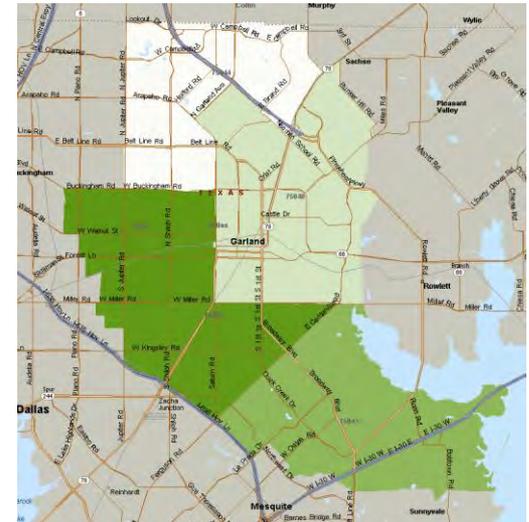


Parkland

Estimated Healthcare Insurance Coverage, 2014 City of Garland

ZIP Code	Percent Uninsured	Percent Medicaid	Percent Medicare	Percent Private Insurance
75040	12.2%	9.1%	9.7%	68.9%
75041	18.2%	13.5%	10.7%	57.6%
75042	18.5%	13.8%	10.2%	57.6%
75043	15.8%	11.7%	12.5%	59.9%
75044	10.2%	7.6%	12.7%	69.5%
Total	14.6%	10.9%	11.2%	63.3%

Percent Uninsured by ZIP Code, 2014

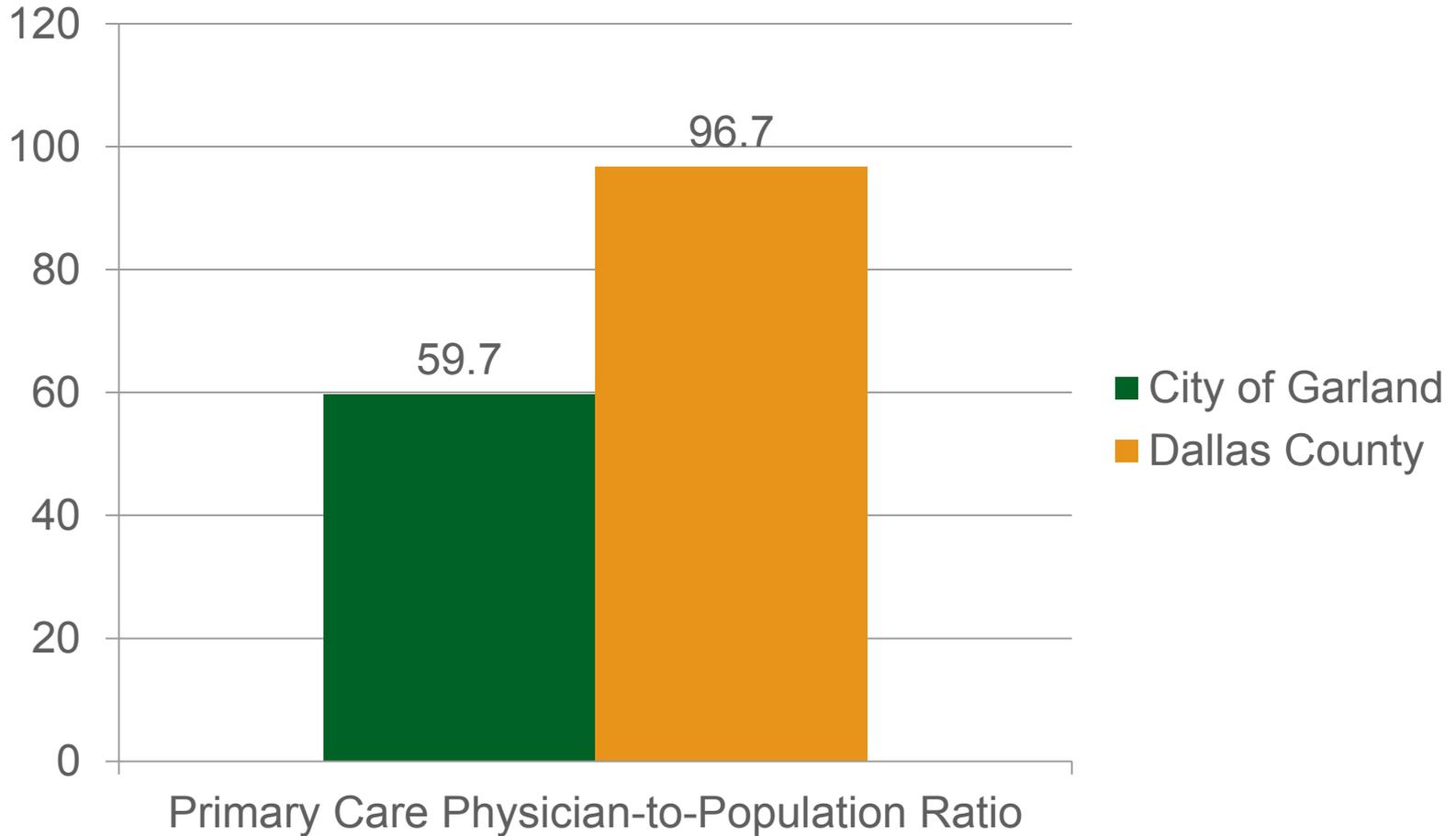




Parkland

Primary Care Physician-to-Population Ratio, 2012

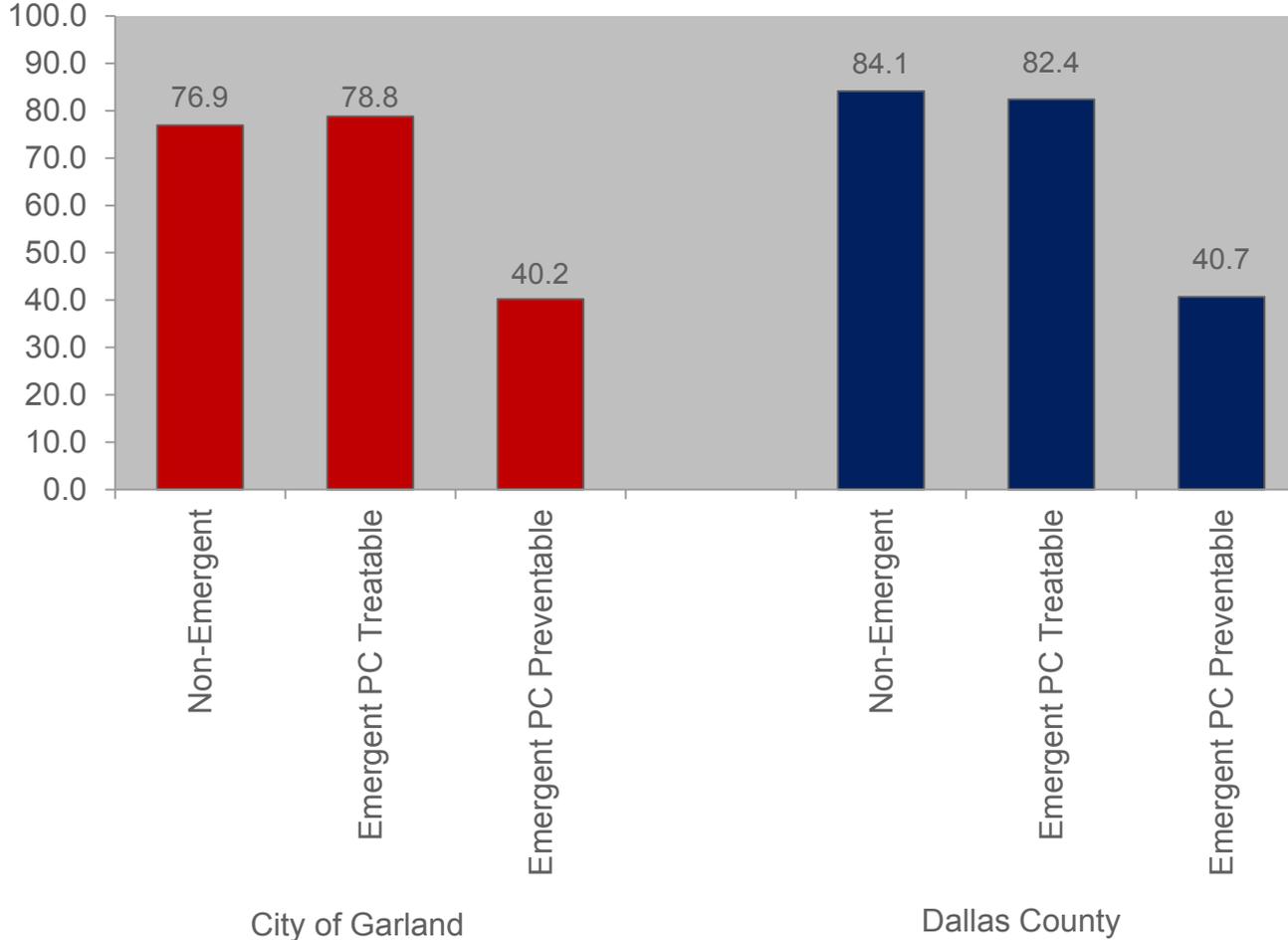
City of Garland



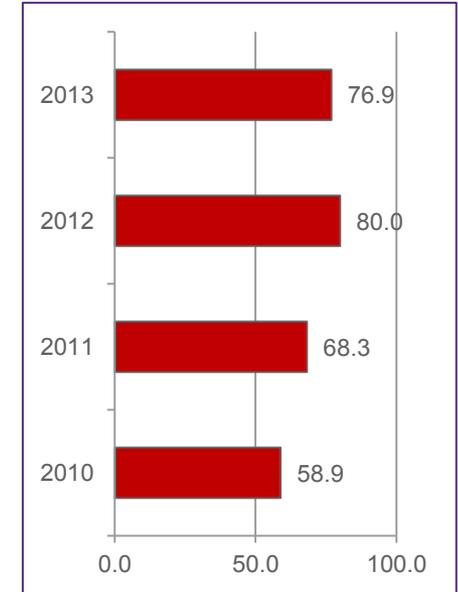


Preventable ED Visits, 2013 City of Garland

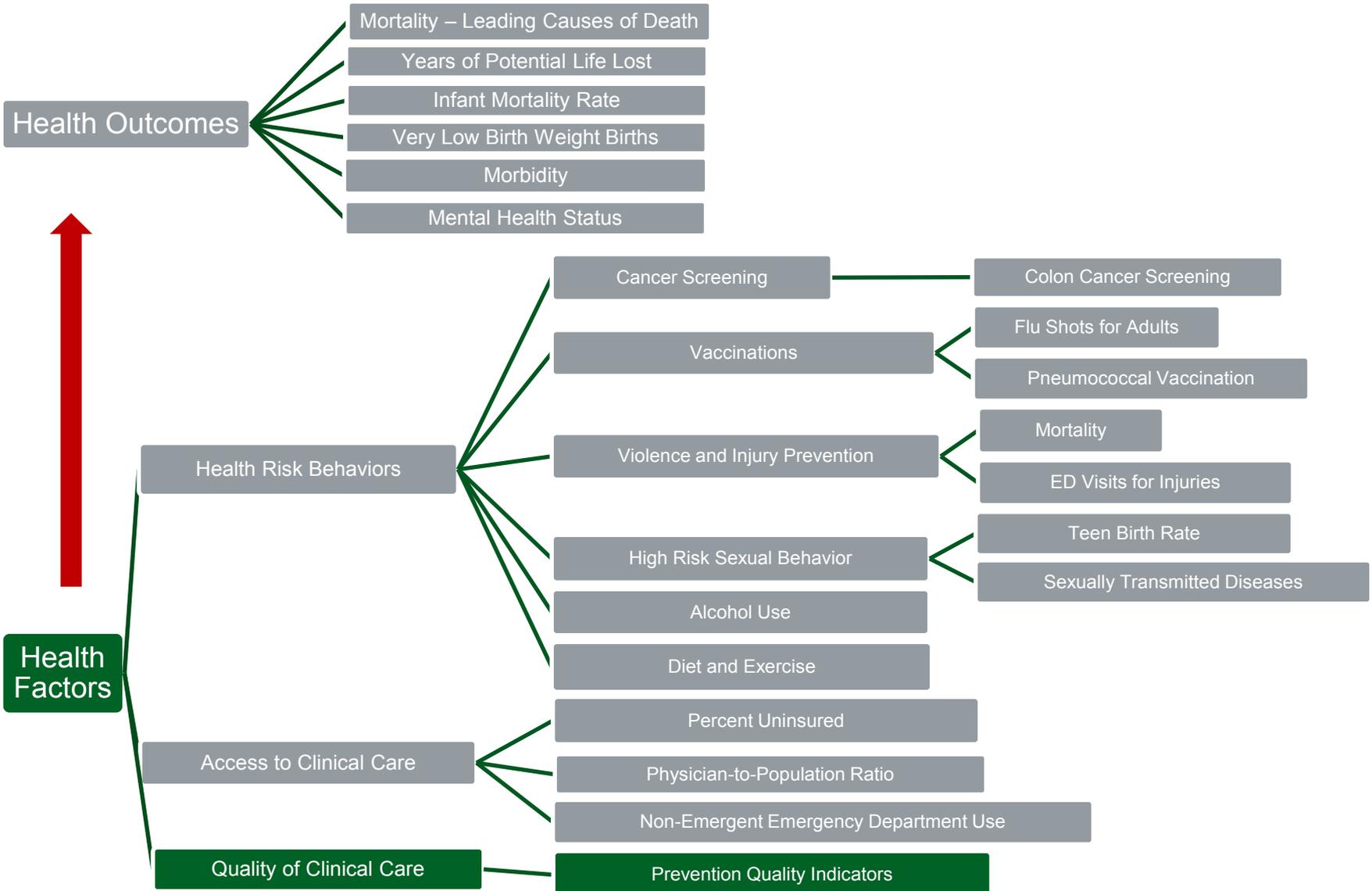
Emergency Department Visits per 1000 Population



Non-Emergent Emergency Department Visits, Per 1,000 Population, City of Garland



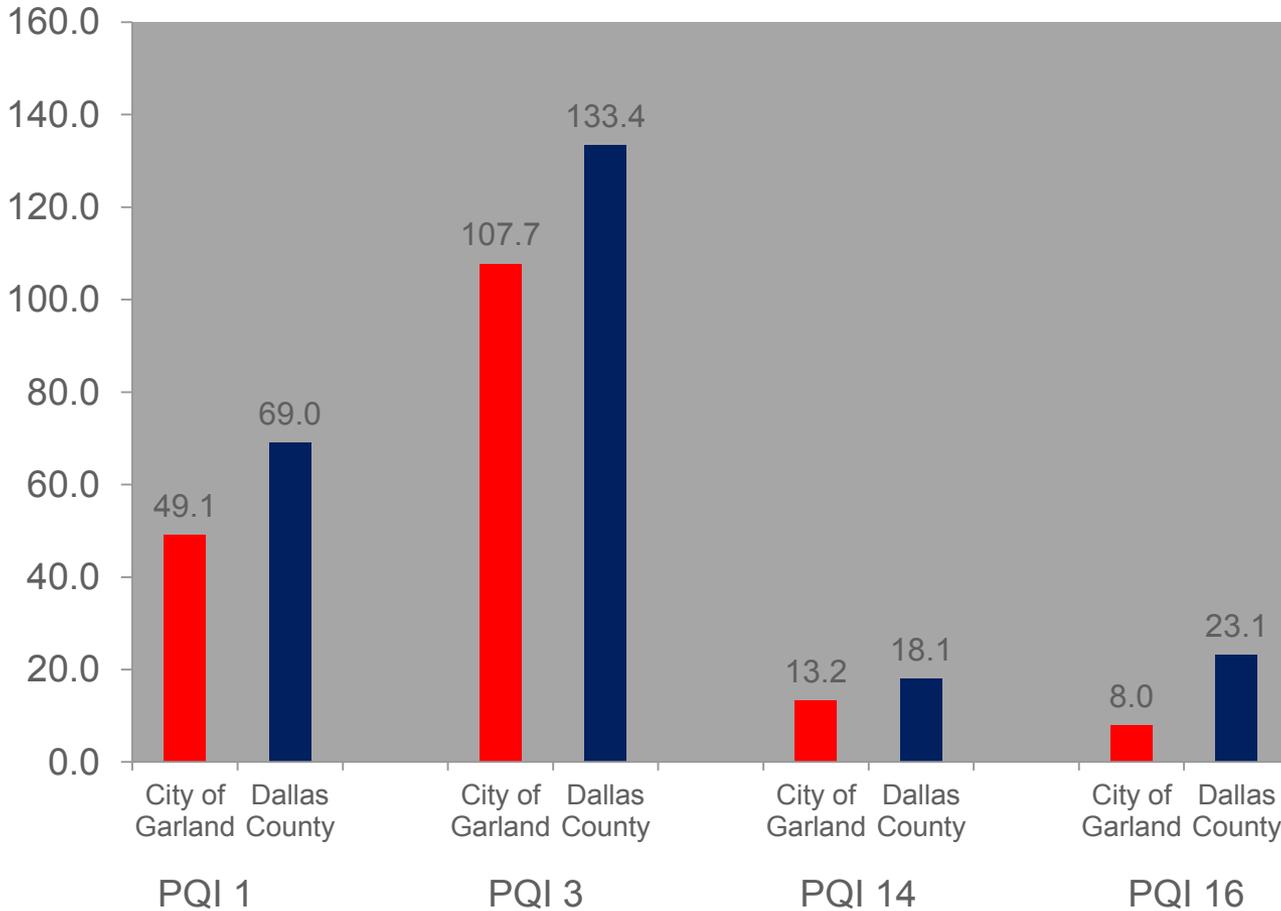
Non-Emergent – illness did not need ED services
 Emergent PC Treatable – illness was an emergency, but earlier in the course of illness it could have been treated at a primary care provider
 Emergent PC Preventable – illness was an emergency, but is a flare-up of a chronic disease which, with better management at a primary care provider, could have been avoided





Preventable Hospitalizations For Diabetes, 2012

Age-Adjusted Deaths per 100,000



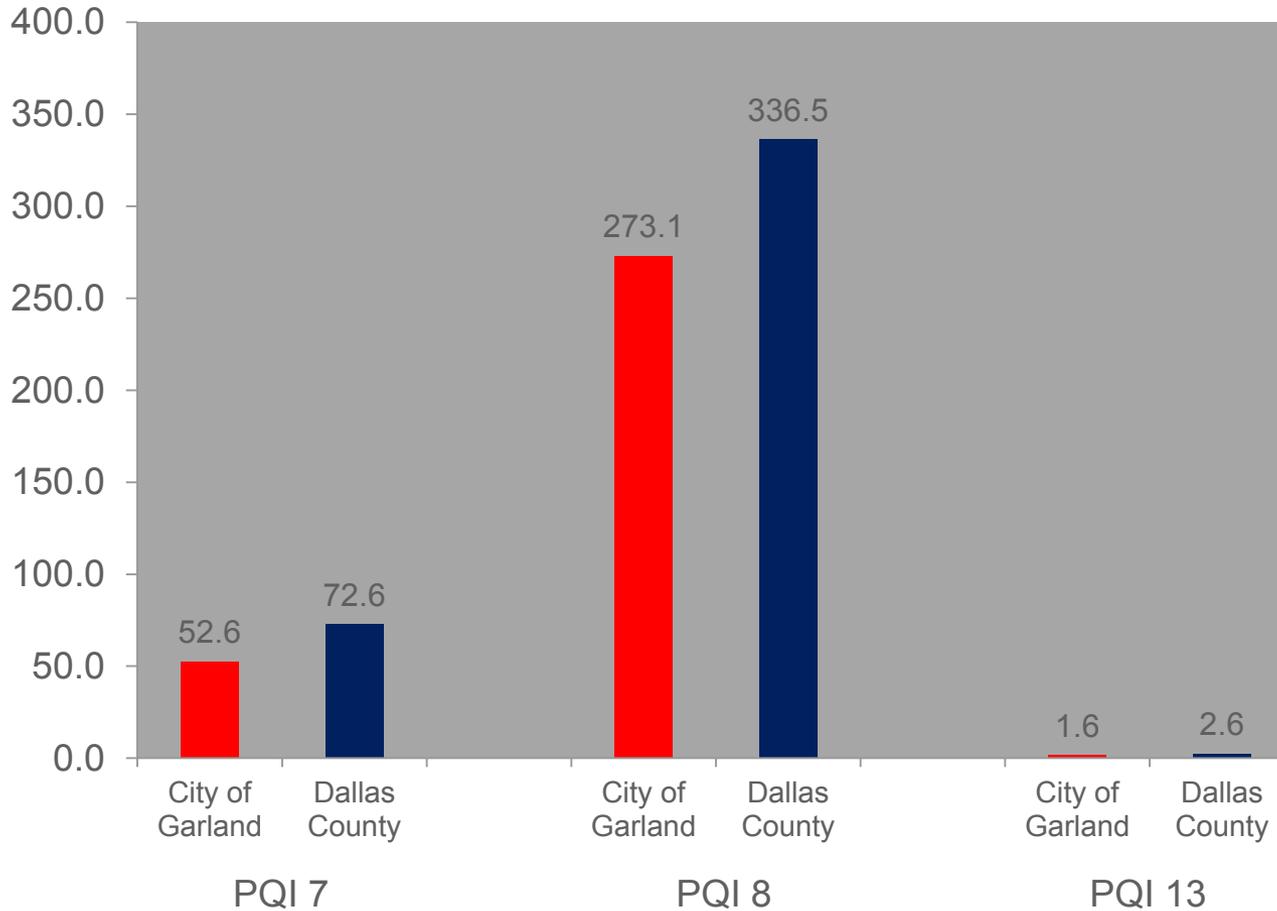
Legend

- PQI 1 Diabetes Short Term Complications – admission for metabolic imbalances related to diabetes such as ketoacidosis, hyperosmolarity and diabetic coma
- PQI 3 Diabetes Long Term Complications – admission for diabetes-related damage to the heart, eyes, kidneys, peripheral nerves or circulation
- PQI 14 Uncontrolled Diabetes
- PQI 16 Lower Extremity Amputation Among Diabetics – admission for amputation of feet or legs due to diabetes complications



Preventable Hospitalizations For Cardiovascular Diseases, 2012

Age-Adjusted Deaths per 100,000



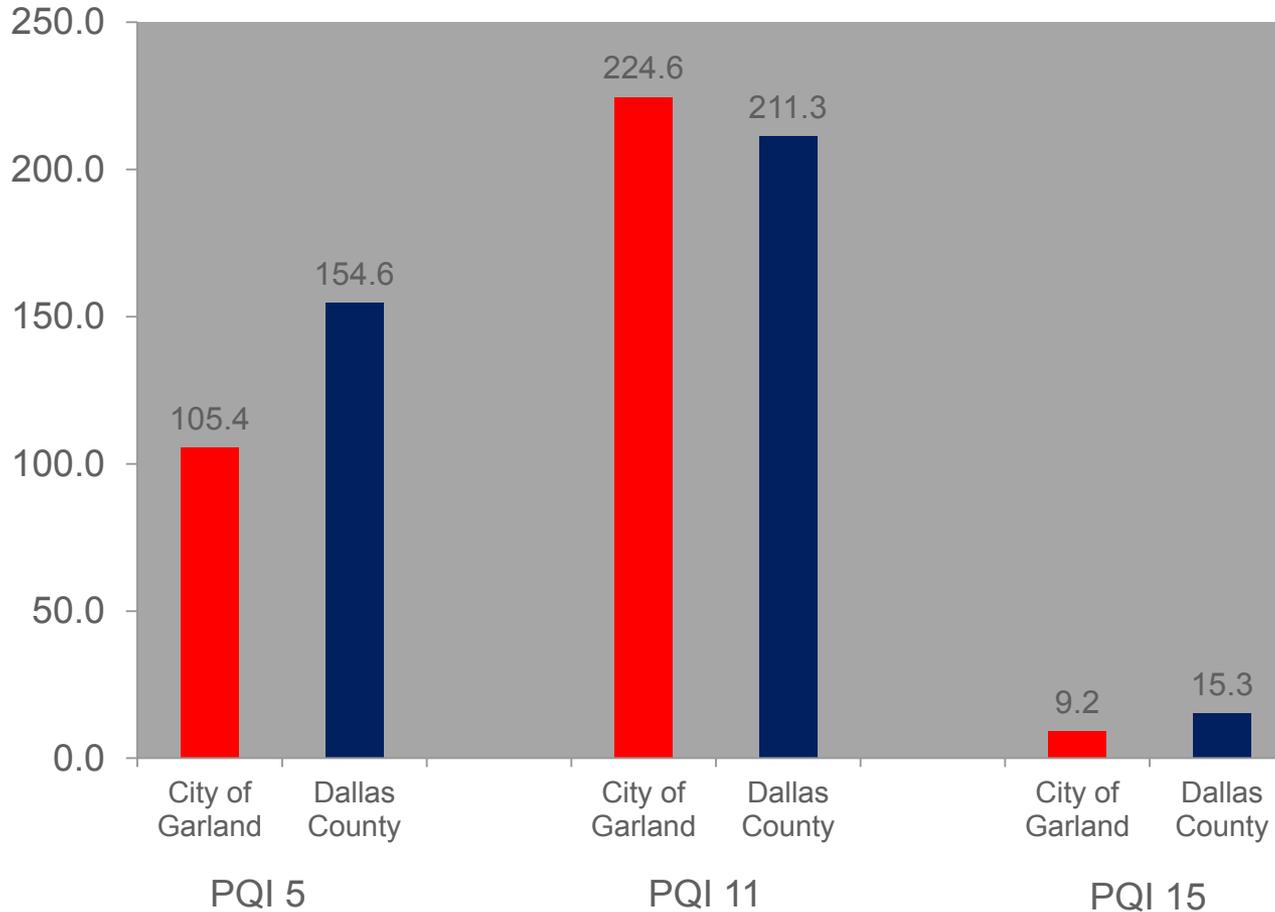
Legend

- PQI 7 Hypertension – hospital admission for high blood pressure without any complication
- PQI 3 Congestive Heart Failure – admission for mid- to late-stage heart disease
- PQI 13 Angina Without Procedure – admission for cardiac chest pain without surgical or other heart procedure to explain it



Preventable Hospitalizations For Pulmonary Diseases, 2012

Age-Adjusted Deaths per 100,000



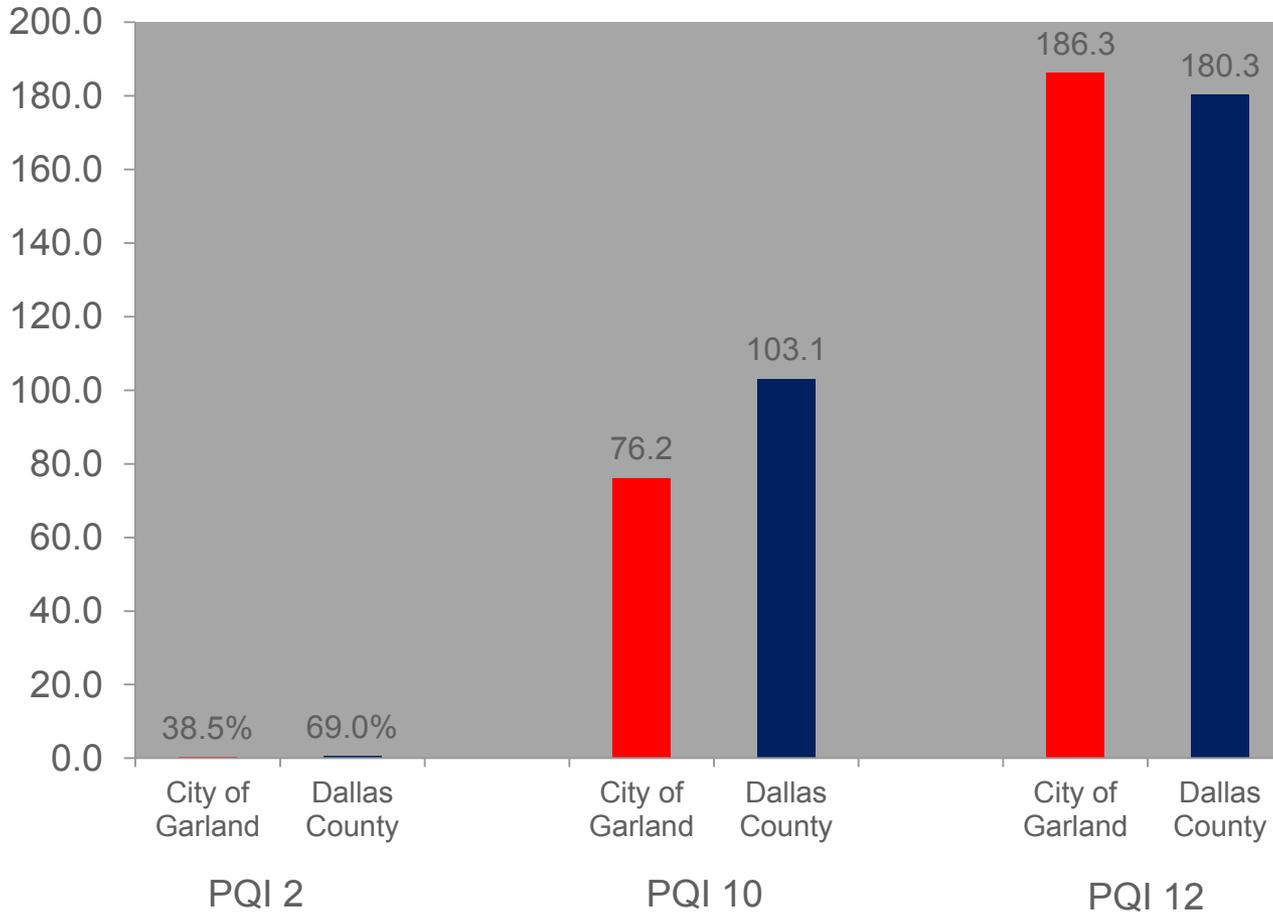
Legend

- PQI 5 Chronic Obstructive Pulmonary Disease and Asthma in Adults 40 and Older – representing long-term pulmonary disease
- PQI 11 Bacterial Pneumonia – often associated with a predisposing risk factor such as COPD, asthma, smoking or influenza infection
- PQI 15 Asthma in Adults Under 40



Other Adult Preventable Hospitalizations, 2012

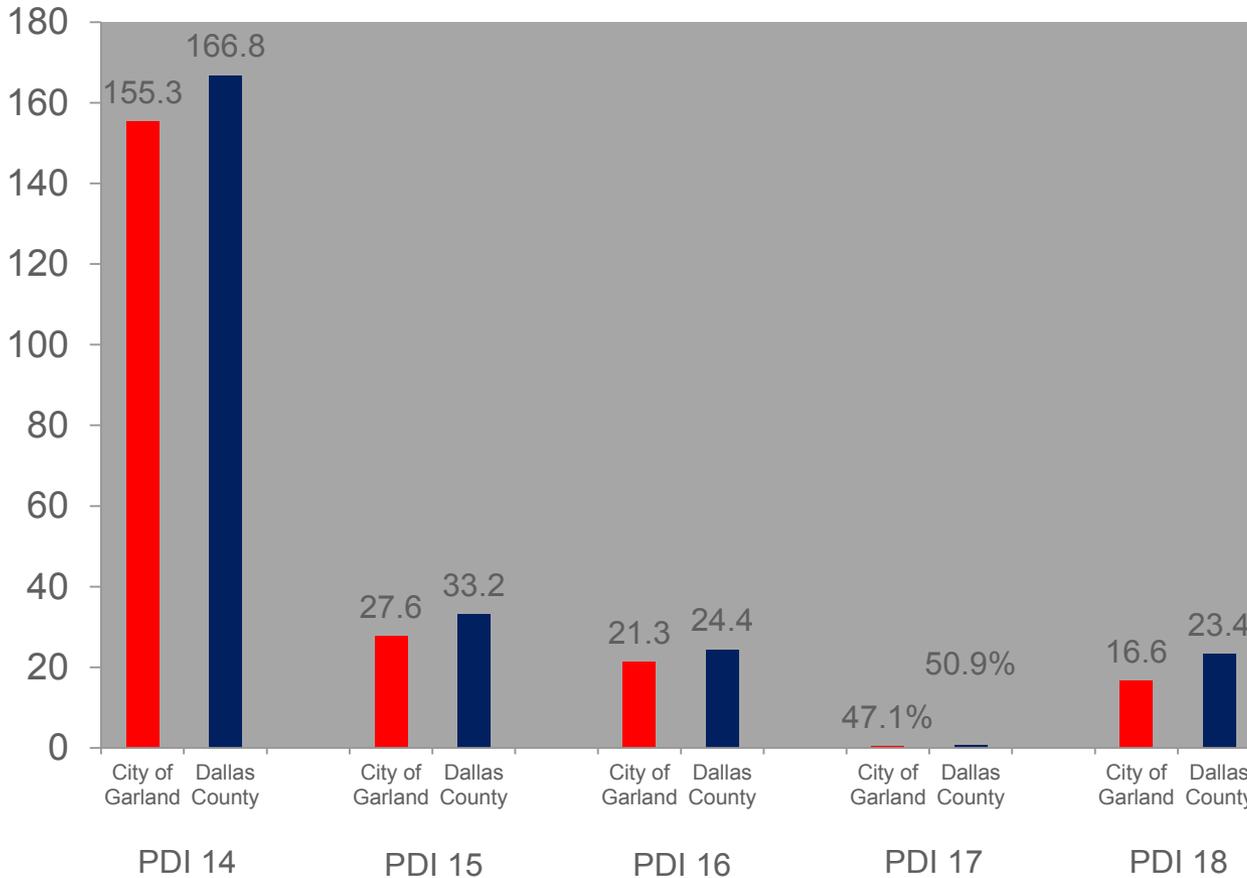
Age-Adjusted Deaths per 100,000



Legend

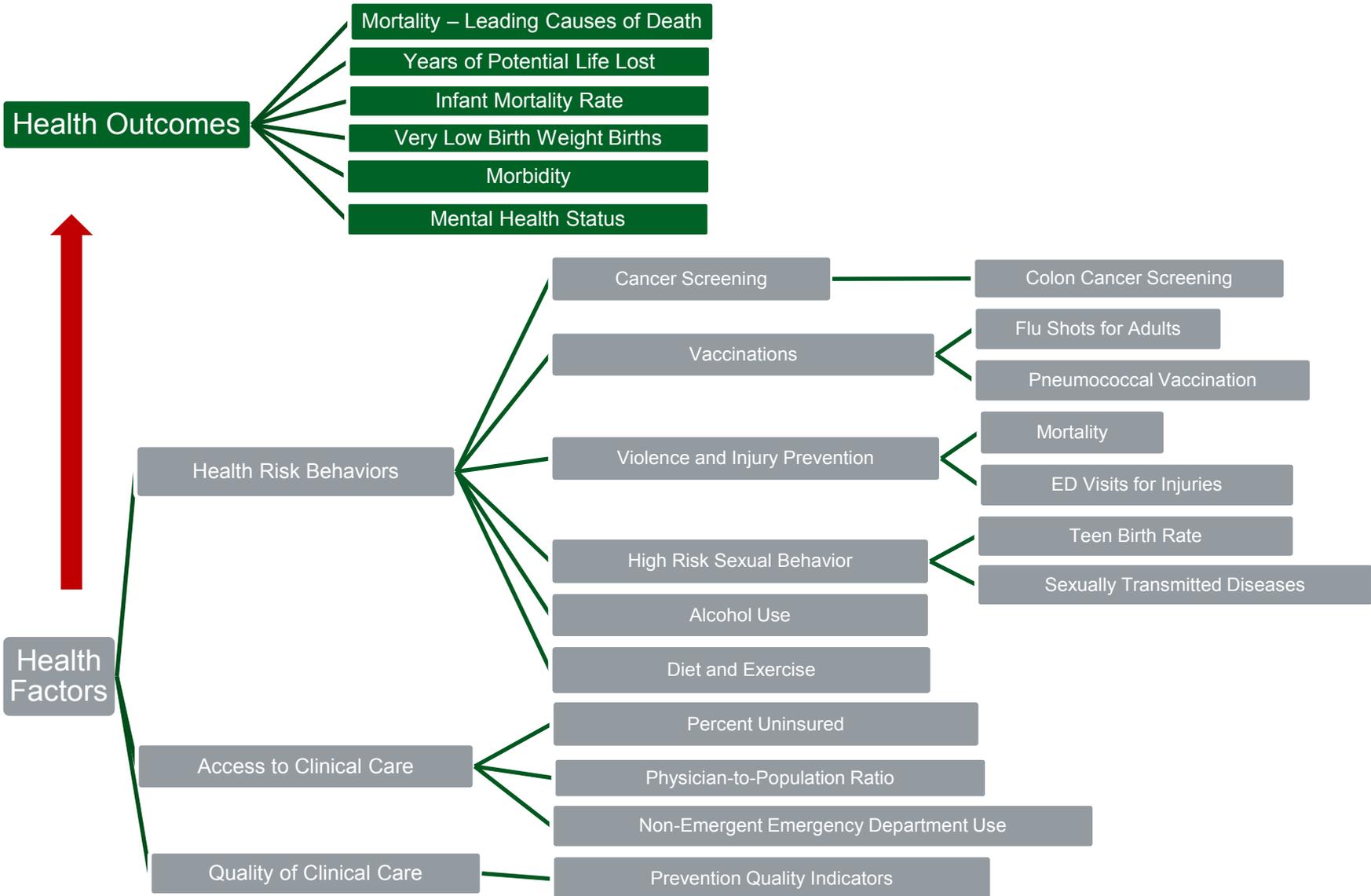
- PQI 2 Percent of Perforated Appendix Among all Adult Appendectomies
- PQI 10 Dehydration – admission for dehydration
- PQI 12 Urinary Tract Infection – admission for urinary tract infection

Age-Adjusted Deaths per 100,000



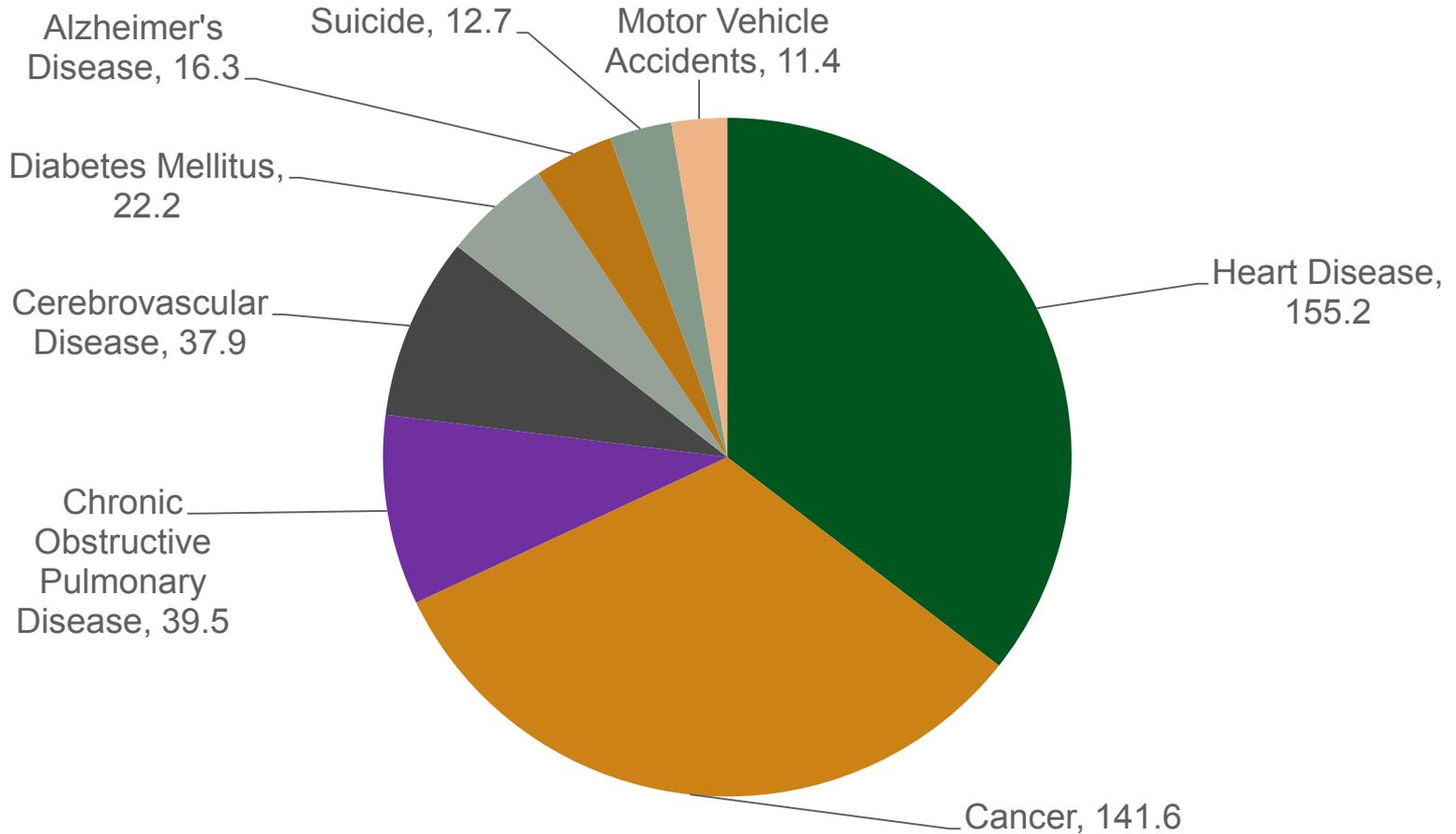
Legend

- PDI 14 Pediatric Asthma Age 2-17
- PDI 15 Diabetes Short-Term Complications Age 6-17 – admission for metabolic imbalances related to diabetes such as ketoacidosis, hyperosmolarity and diabetic coma
- PDI 16 Gastroenteritis Age 3 Months to 17 Years – admission for acute intestinal infection
- PDI 17 Percent of Perforated Appendix Among all Pediatric Appendectomies Ages 1-17
- PDI 18 Urinary Tract Infection Age 3 Months to 17 Years





Leading Causes of Death, 2012 *City of Garland*



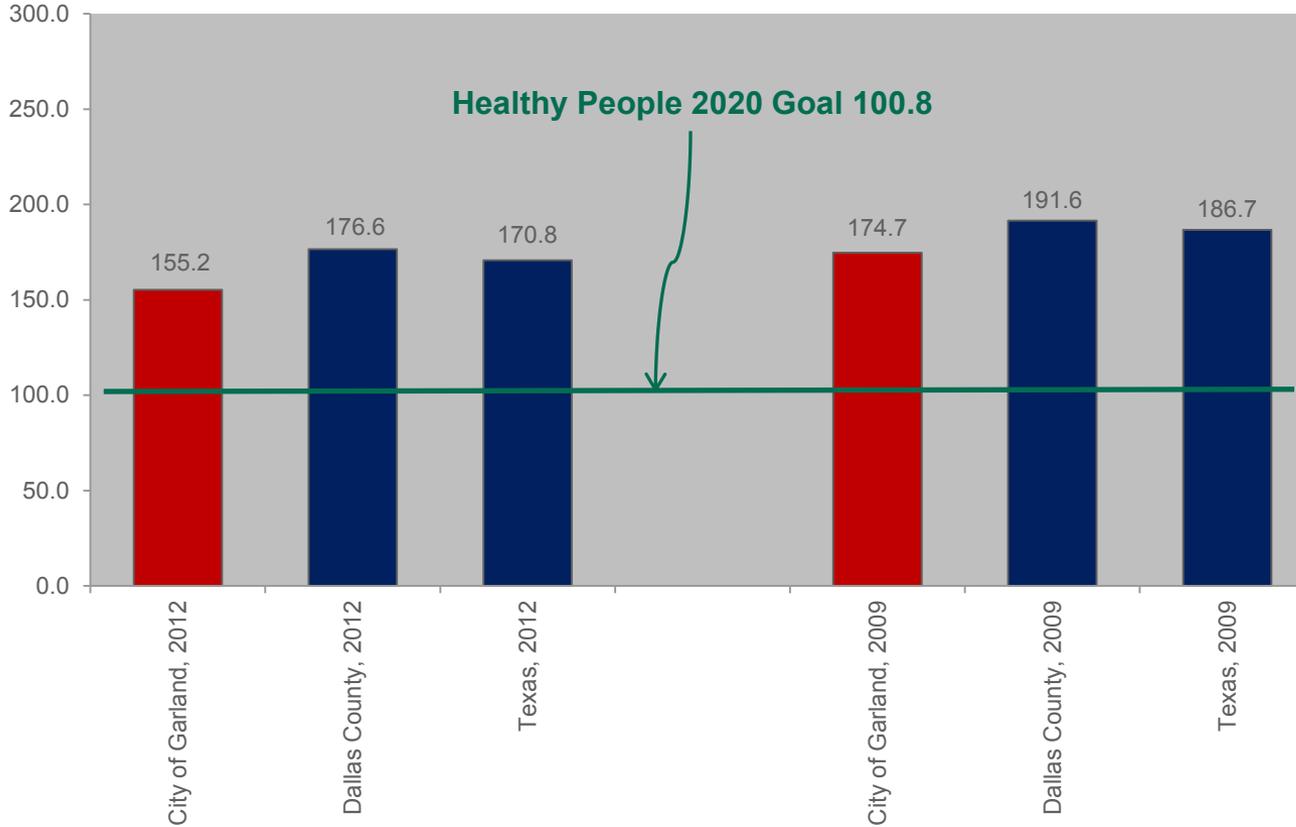
Age-Adjusted Deaths per 100,000

Source: Texas Department of State Health Services, Bureau of Vital Statistics; denominator population data from Nielsen Pop-Facts

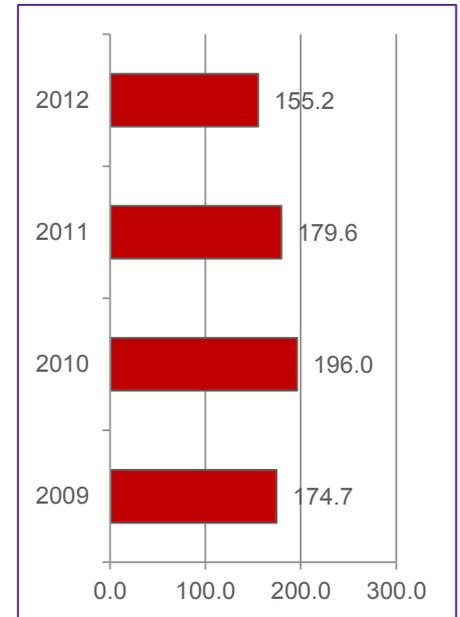
Health Outcomes: Heart Disease Mortality Rates

City of Garland

Age-Adjusted Deaths per 100,000



Heart Disease Mortality Rate, Age-Adjusted Death Rate per 100,000, City of Garland

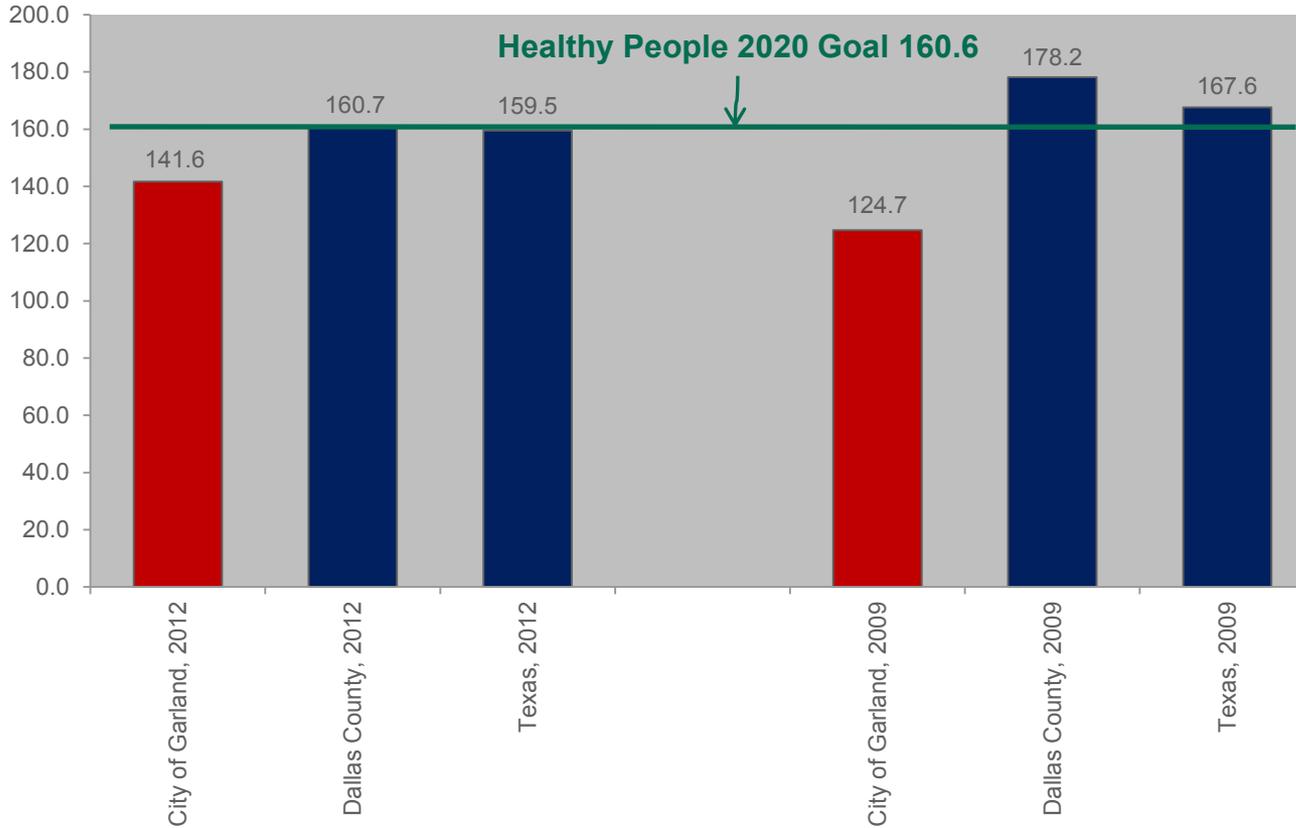


Source: Texas Department of State Health Services, Bureau of Vital Statistics; denominator population data from Nielsen Pop-Facts

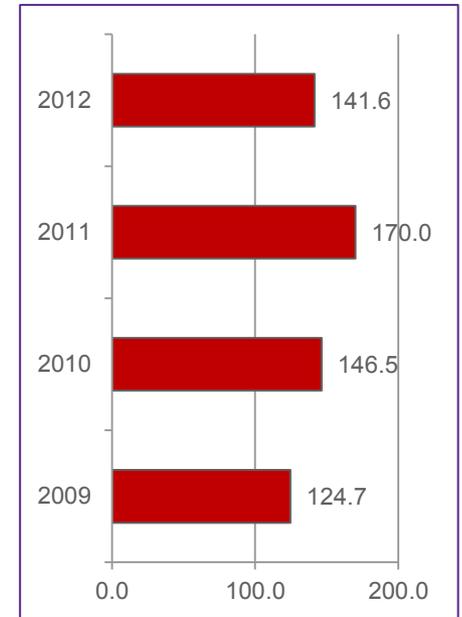


Health Outcomes: Cancer Mortality Rates *City of Garland*

Age-Adjusted Deaths per 100,000



Cancer Mortality Rate, Age-Adjusted Death Rate per 100,000, City of Garland



Source: Texas Department of State Health Services, Bureau of Vital Statistics; denominator population data from Nielsen Pop-Facts



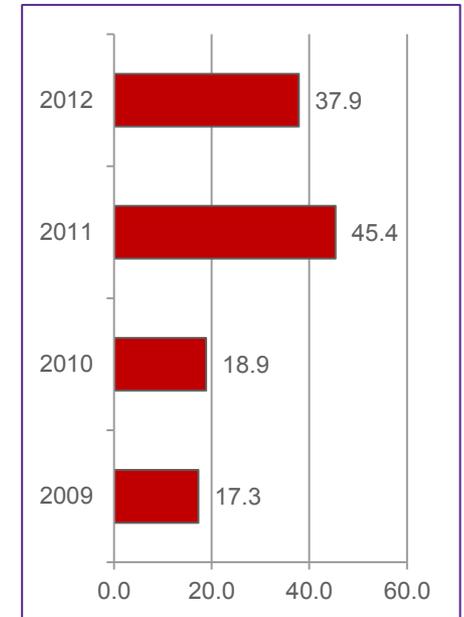
Health Outcomes: Cerebrovascular Disease/Stroke Mortality Rates

City of Garland

Age-Adjusted Deaths per 100,000



Cerebrovascular Disease Mortality Rate, Age-Adjusted Death Rate per 100,000, City of Garland

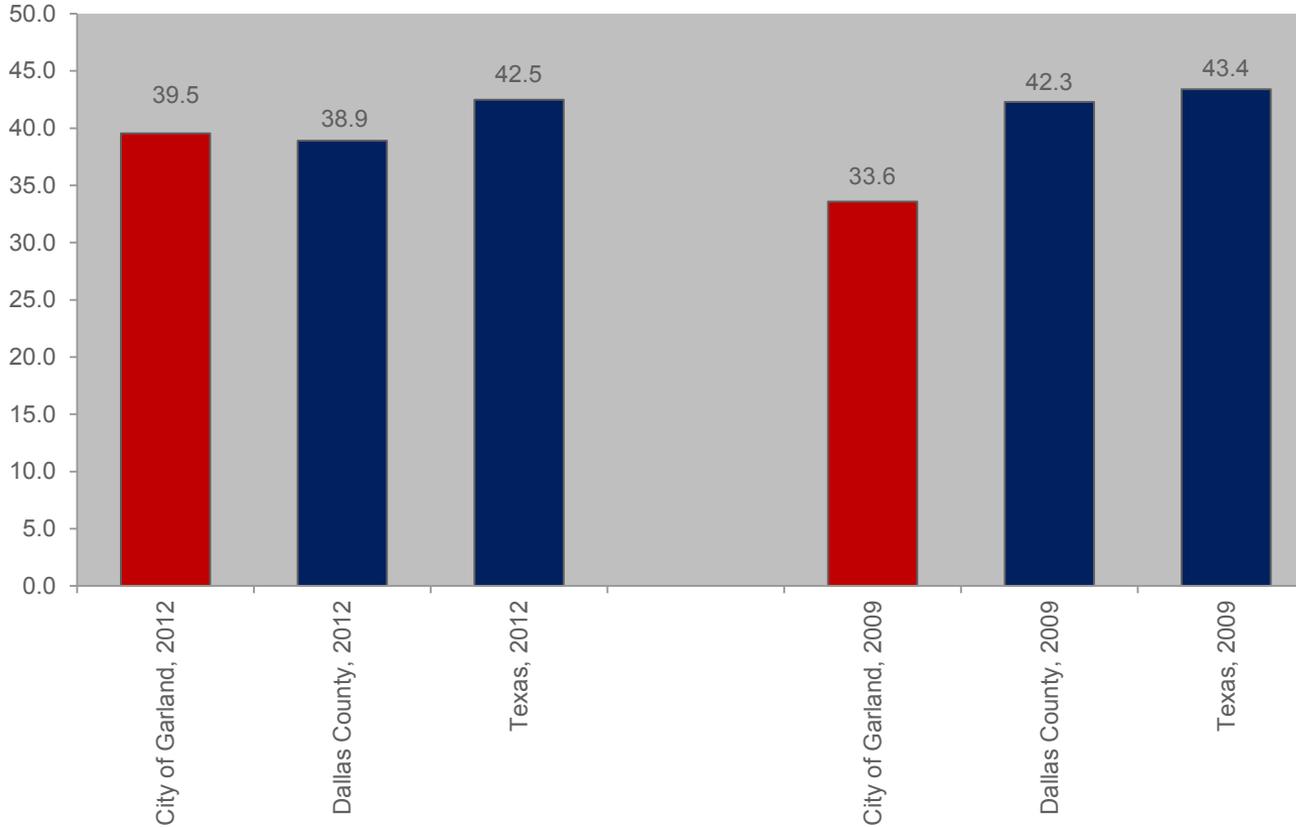


Source: Texas Department of State Health Services, Bureau of Vital Statistics; denominator population data from Nielsen Pop-Facts

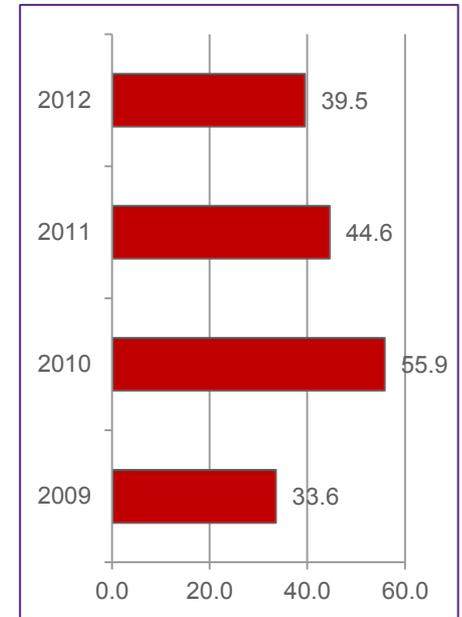
Health Outcomes: Chronic Obstructive Pulmonary Disease Mortality Rates

City of Garland

Age-Adjusted Deaths per 100,000



Chronic Obstructive Pulmonary Disease Mortality Rate, Age-Adjusted Death Rate per 100,000, City of Garland

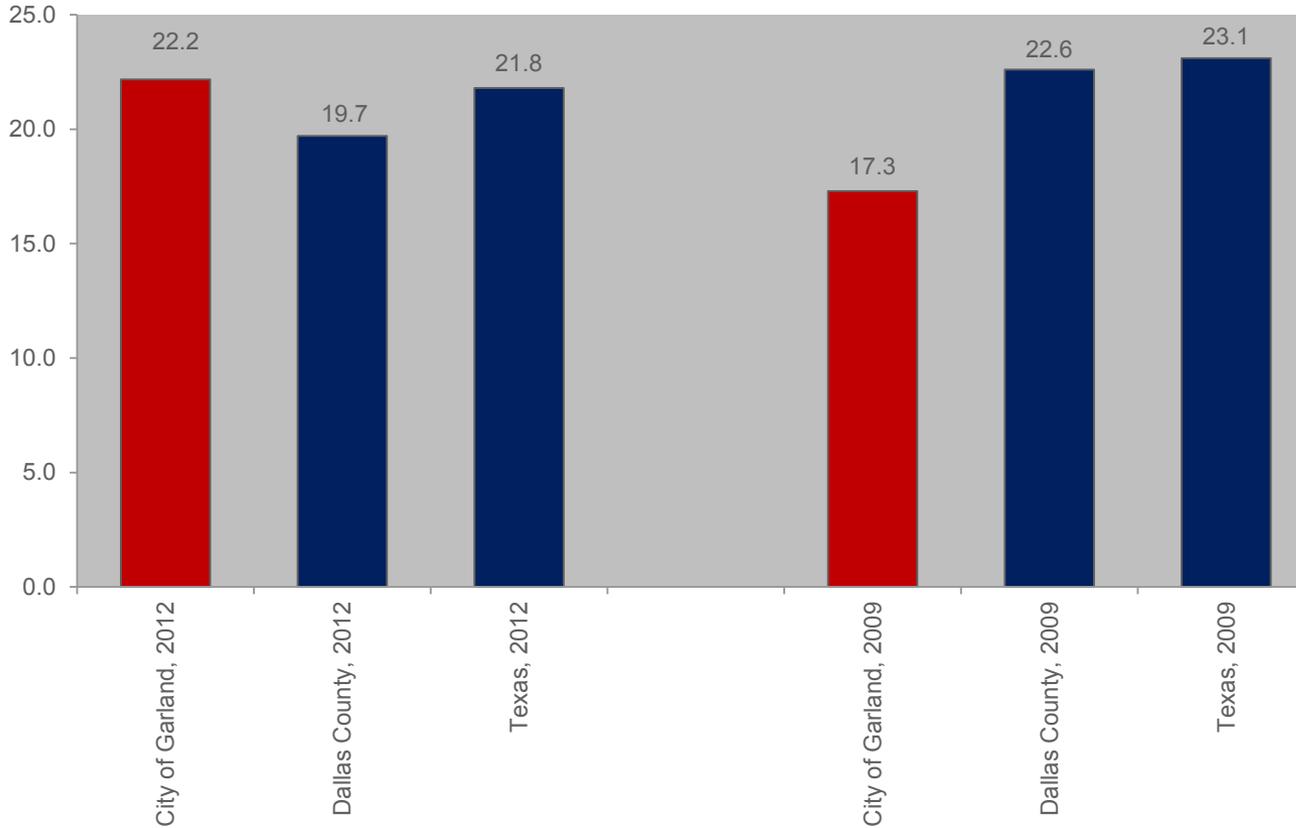


NOTE: No Healthy People 2020 goal matches this metric.

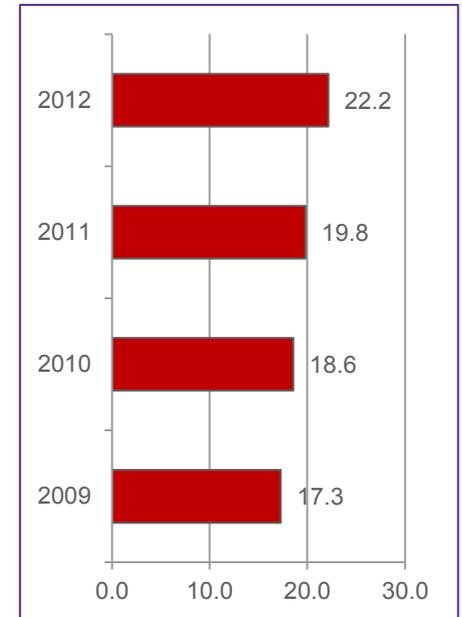
Health Outcomes: Diabetes Mortality Rates

City of Garland

Age-Adjusted Deaths per 100,000



Diabetes Mortality Rate, Age-Adjusted Death Rate per 100,000, City of Garland

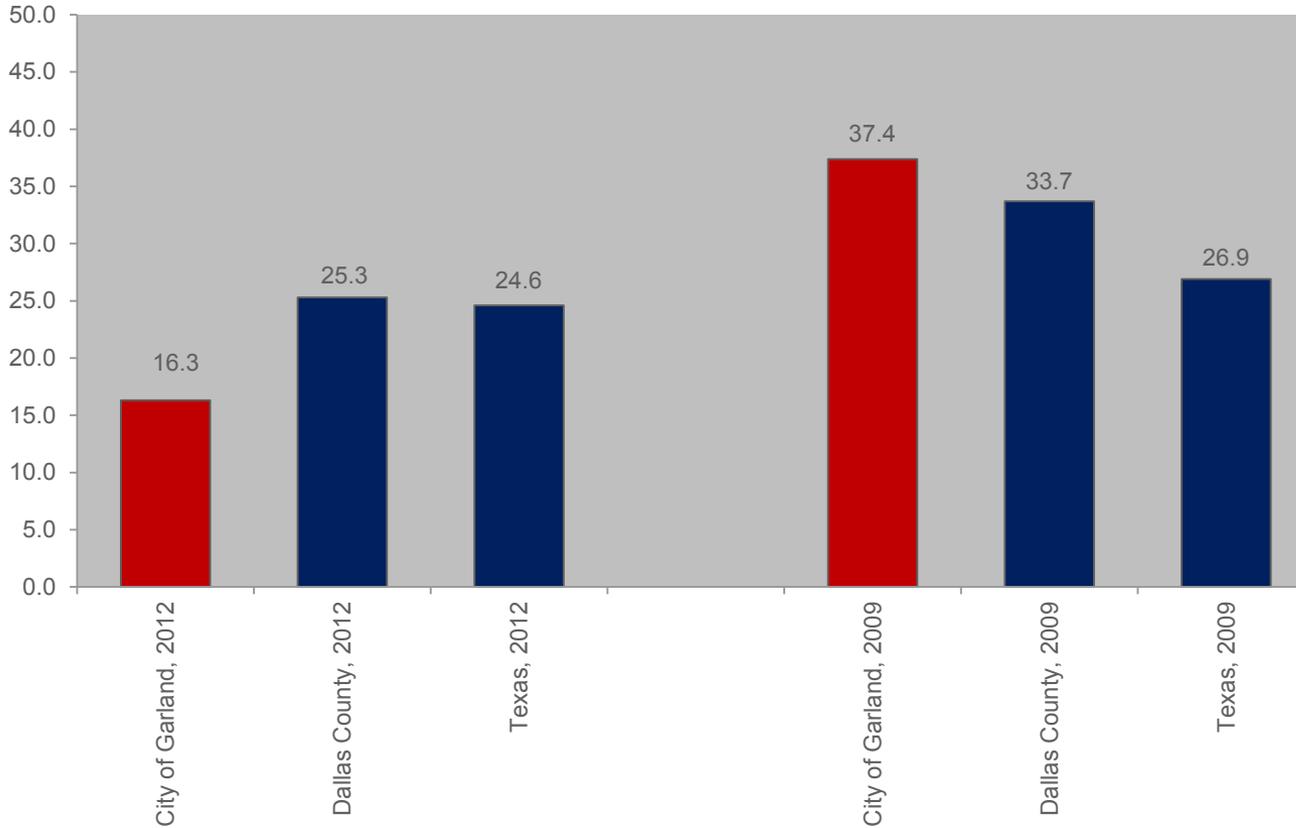


NOTE: No Healthy People 2020 goal matches this metric.

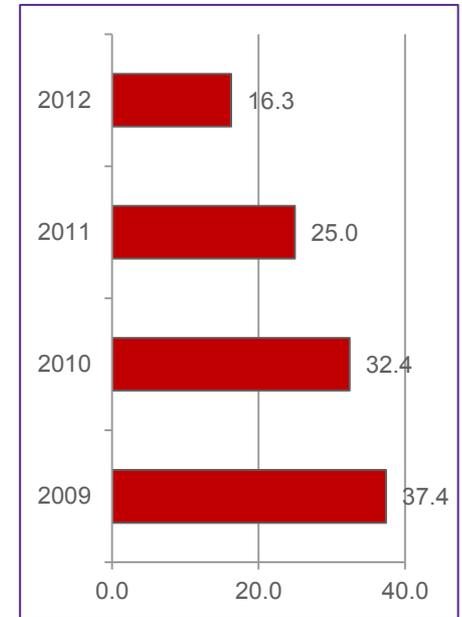
Health Outcomes: Alzheimer's Disease Mortality Rates

City of Garland

Age-Adjusted Deaths per 100,000



Alzheimer's Disease Mortality Rate, Age-Adjusted Death Rate per 100,000, City of Garland

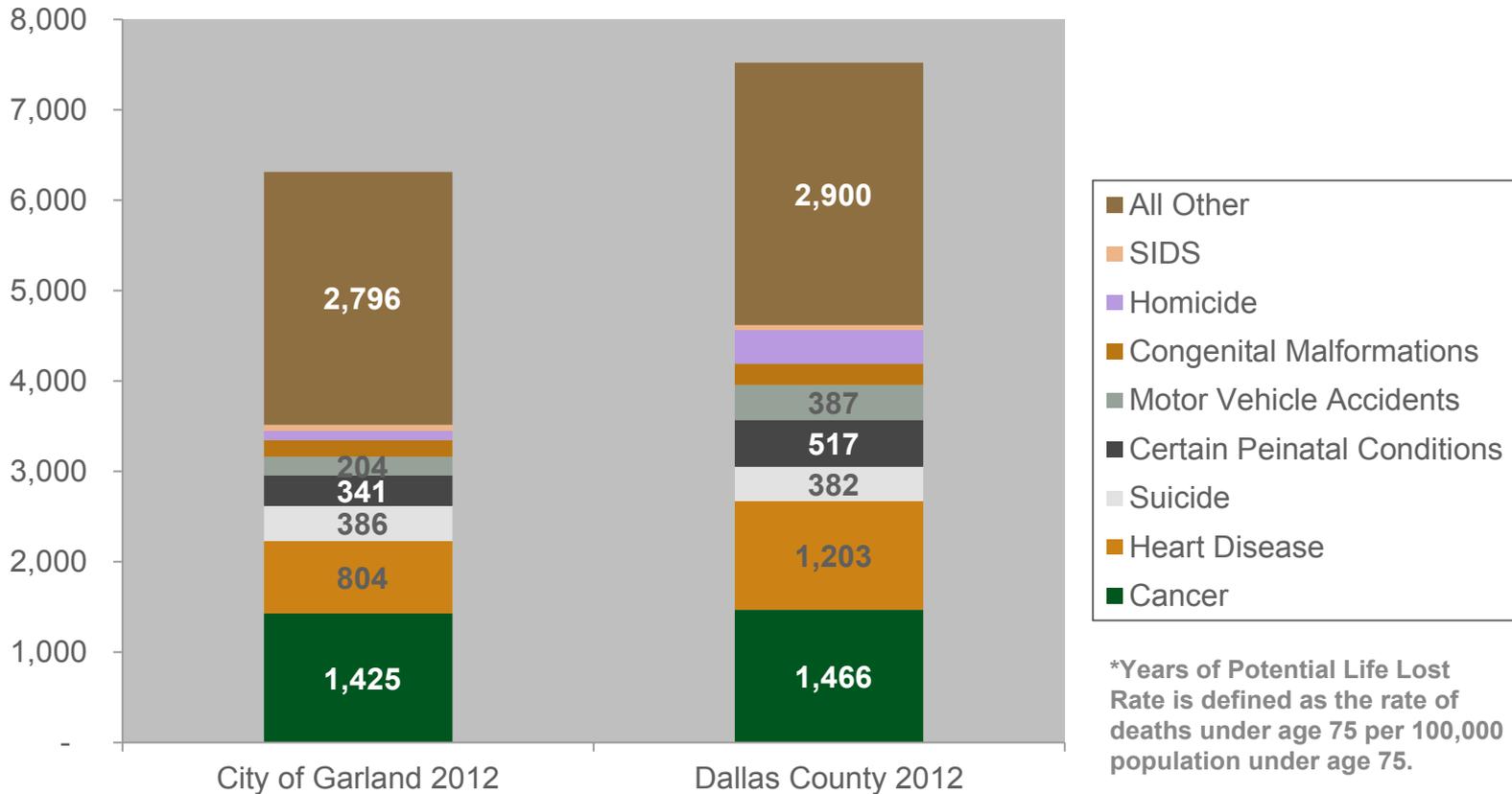


NOTE: No Healthy People 2020 goal matches this metric.

Health Outcomes: Years of Potential Life Lost, All Causes

City of Garland

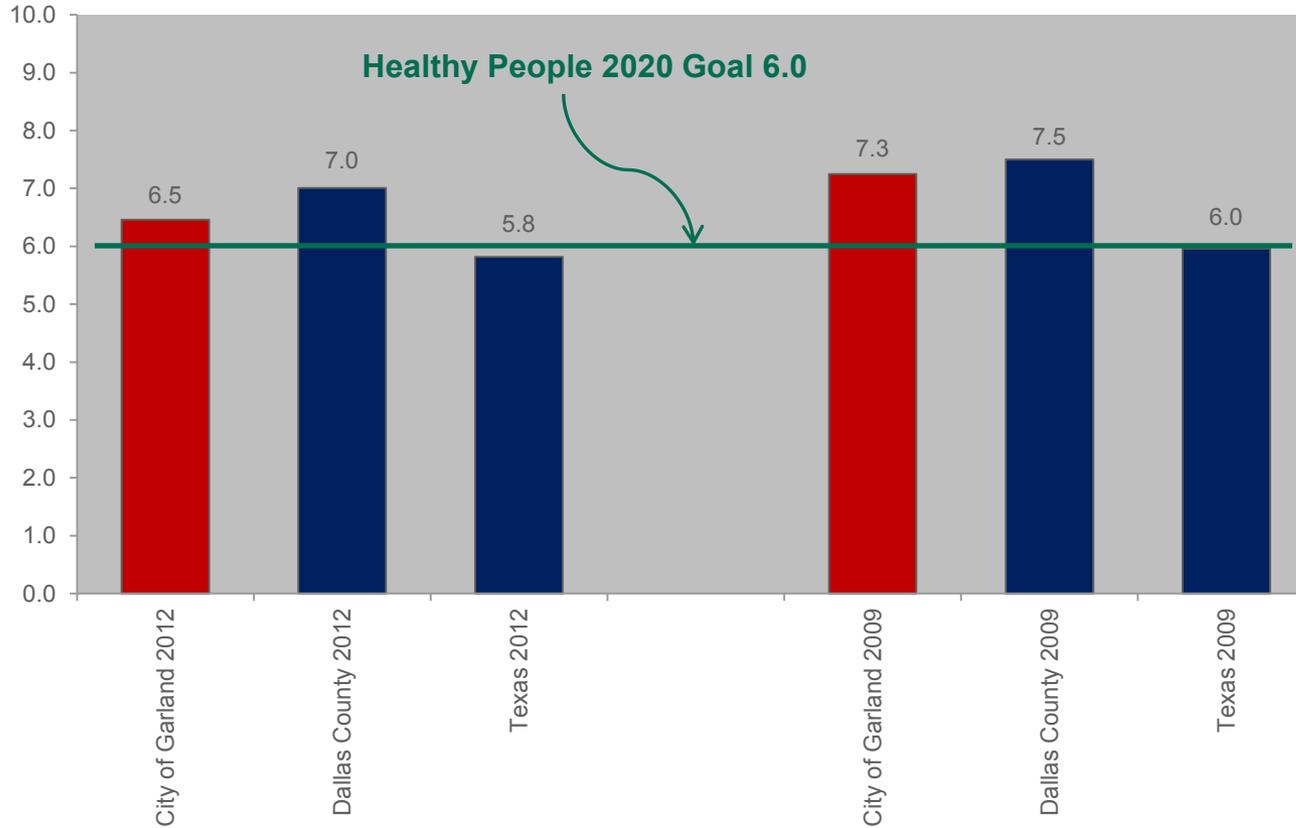
Years of Potential Life Lost Rate per 100,000*



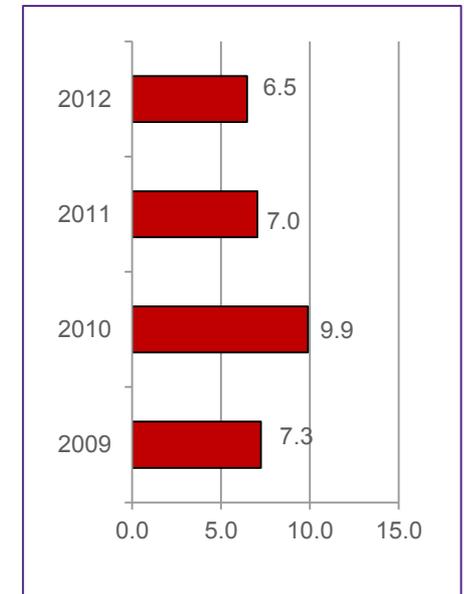
Health Outcomes: Birth Outcomes, Infant Mortality Rate

City of Garland

Infant Mortality Rate

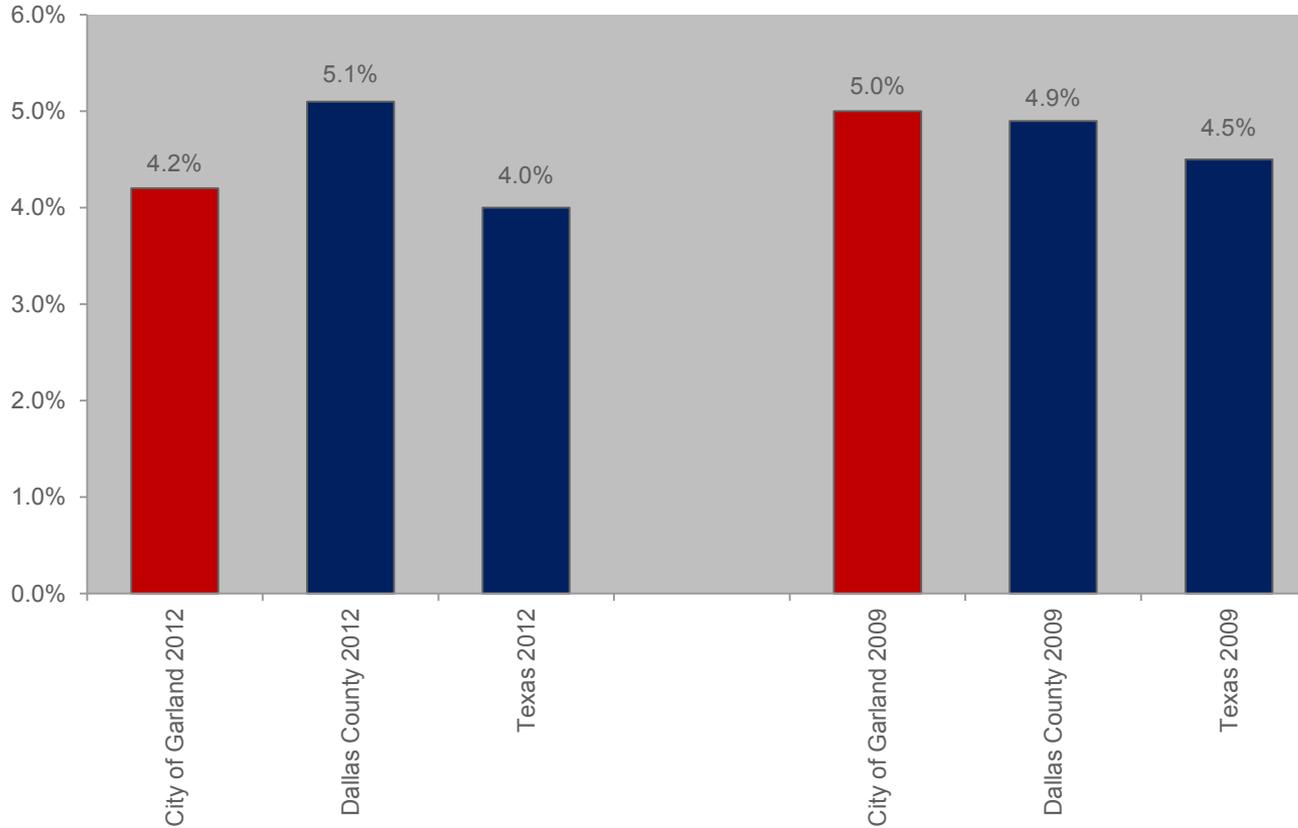


Infant Mortality Rate, Deaths per 1,000 Live Births, City of Garland

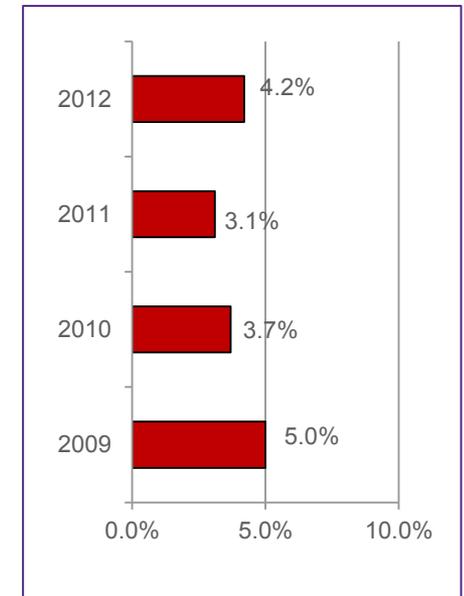


Health Outcomes: Birth Outcomes, Percent of Births with No Prenatal Care *City of Garland*

No Prenatal Care Rate



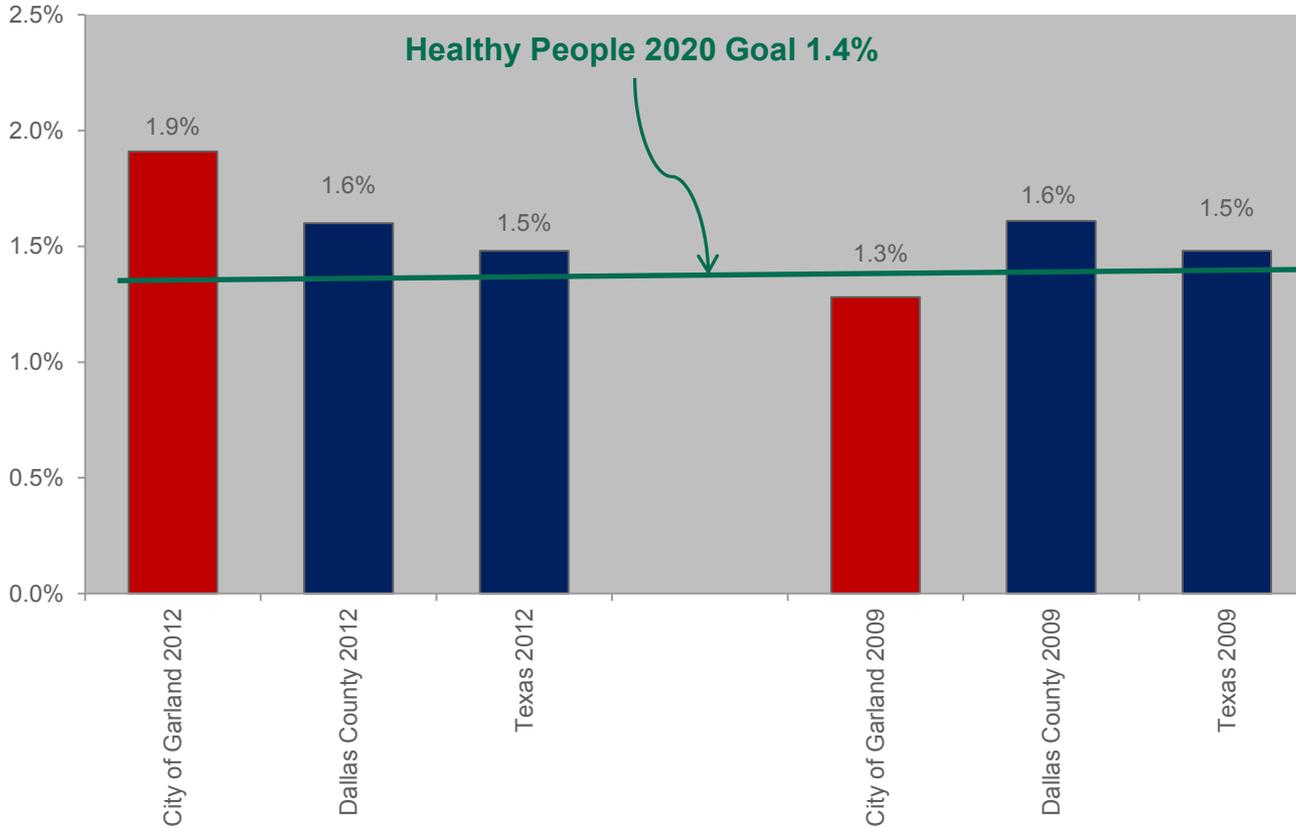
No Prenatal Care Rate, Percent of Live Births, City of Garland



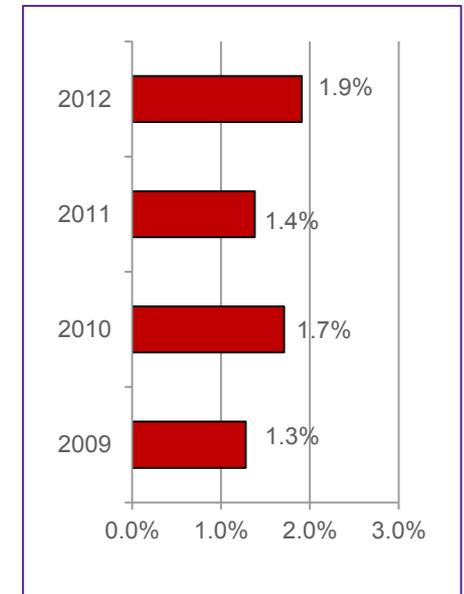
Health Outcomes: Birth Outcomes, Rate of Very Low Birth Weight Births

City of Garland

Very Low Birth Weight Rate



Very Low Birth Weight Rate, % of Births Below 1500 Grams at Birth, City of Garland

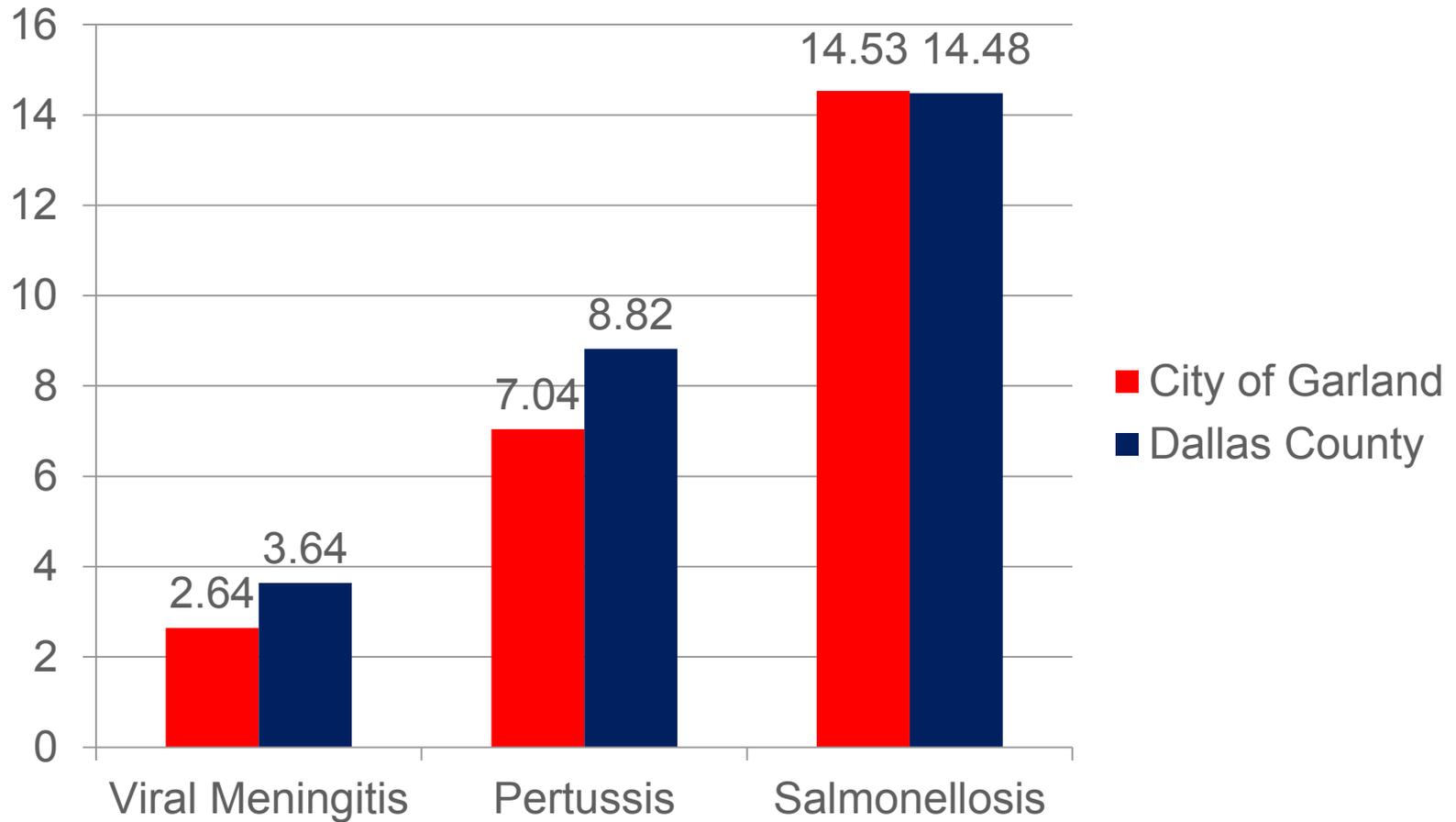


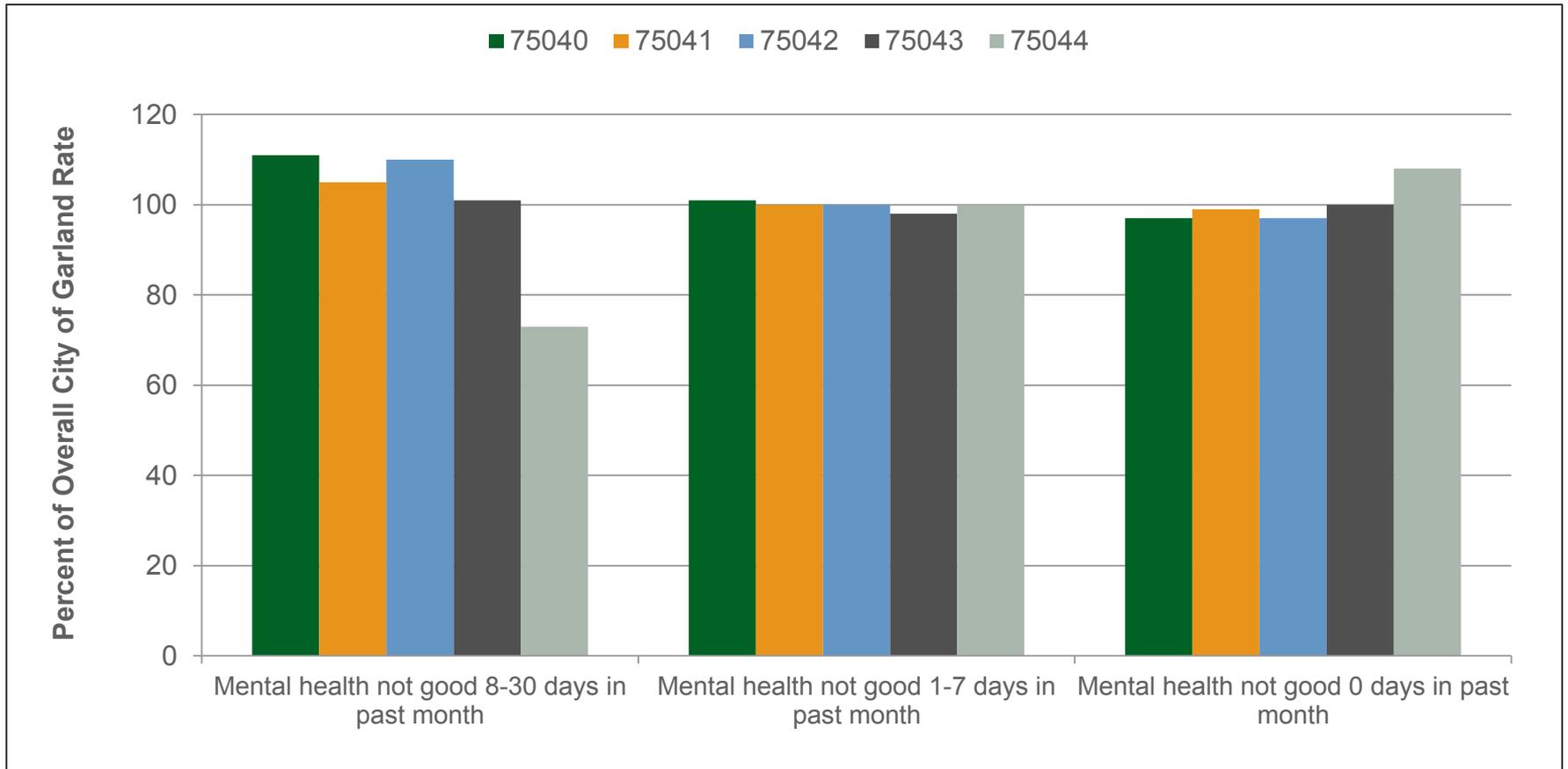


Infectious Disease Rates, 2012

City of Garland

Cases per 100,000 population







Parkland

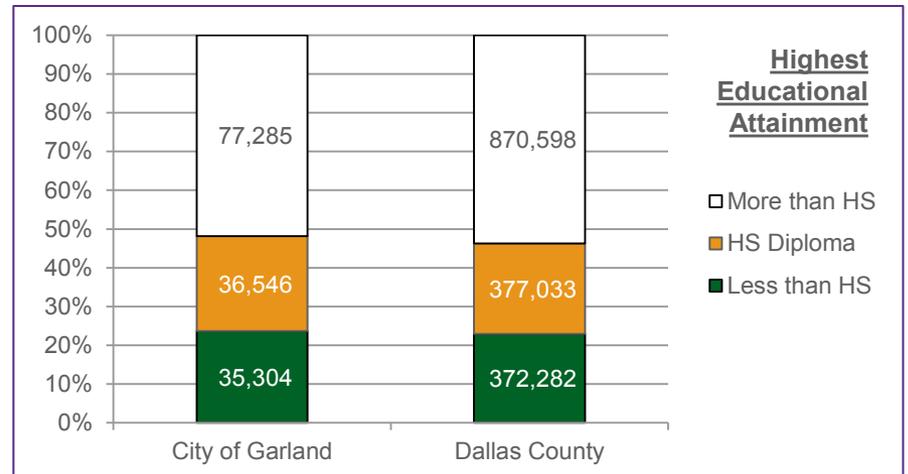
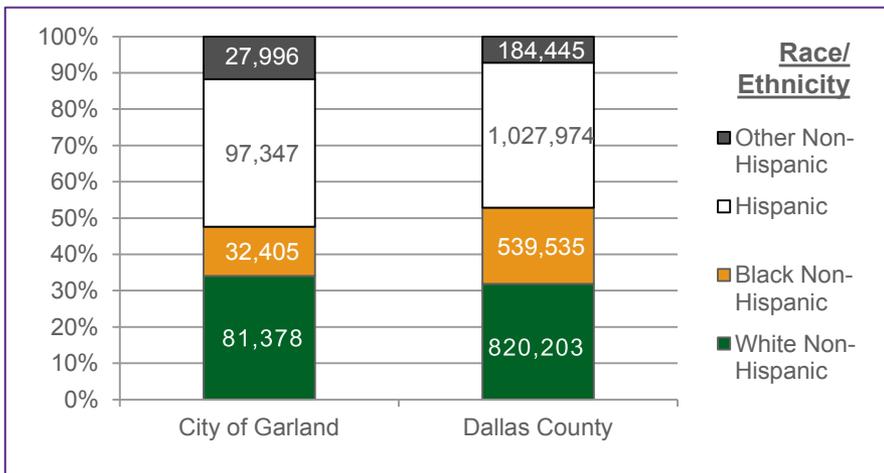
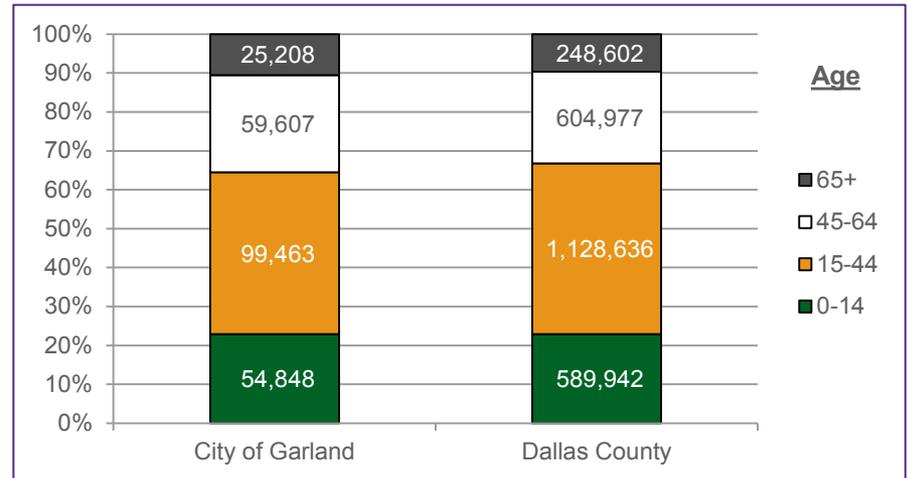
City of Garland

DEMOGRAPHIC DATA

Demographic Profile Northeast Dallas Service Area

The population of Garland is similar to that of Dallas County, although Garland has proportionately more Asian/Other residents than Dallas County. The age distribution is similar to Dallas County's.

The percentage of adults 25 and older in Garland who have not finished high school is slightly higher than that of the County as a whole (23.7% versus 23.0% county-wide).

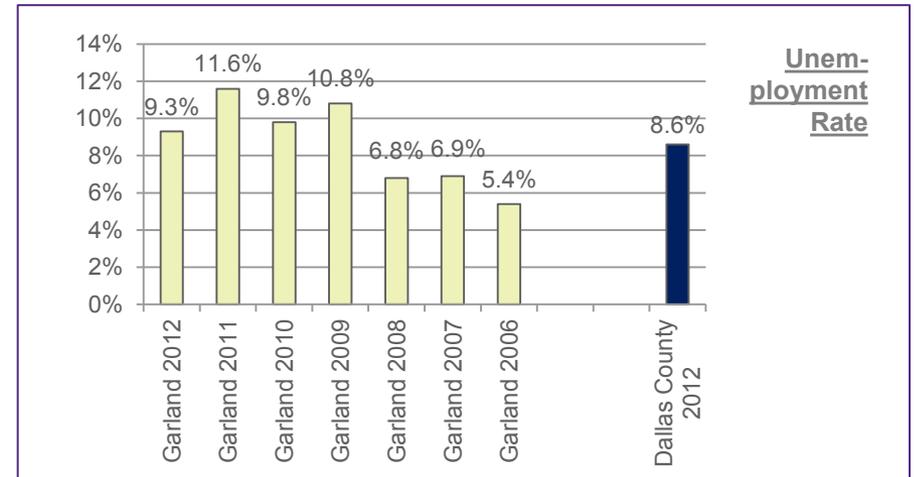
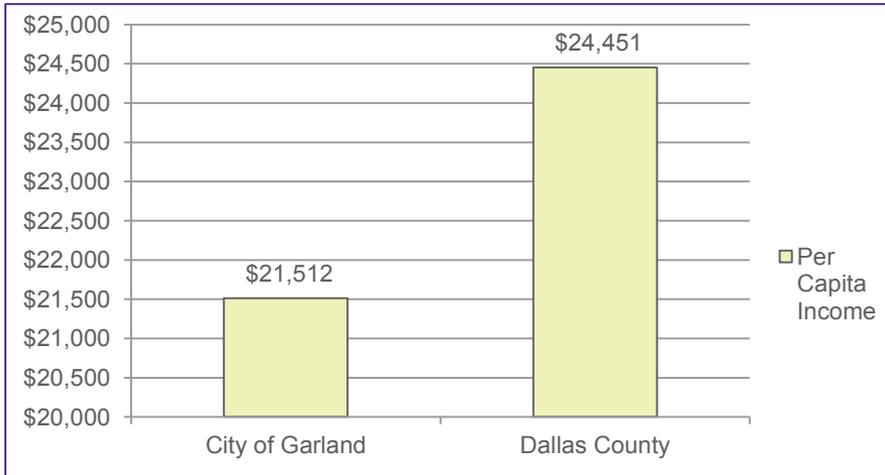
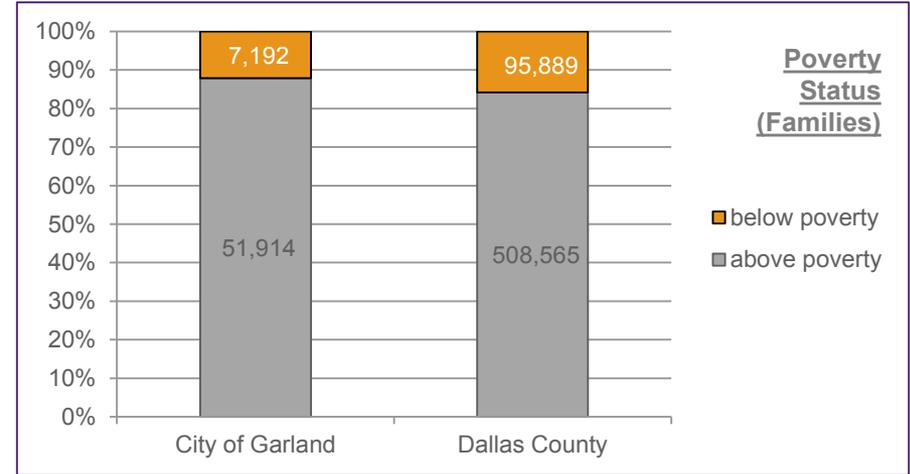


Demographic Profile Northeast Dallas Service Area

The City of Garland has a lower percentage of families in poverty than Dallas County as a whole (12.2%).

Garland's per capita income (\$21,512) was somewhat lower than the per capita income for Dallas County as a whole.

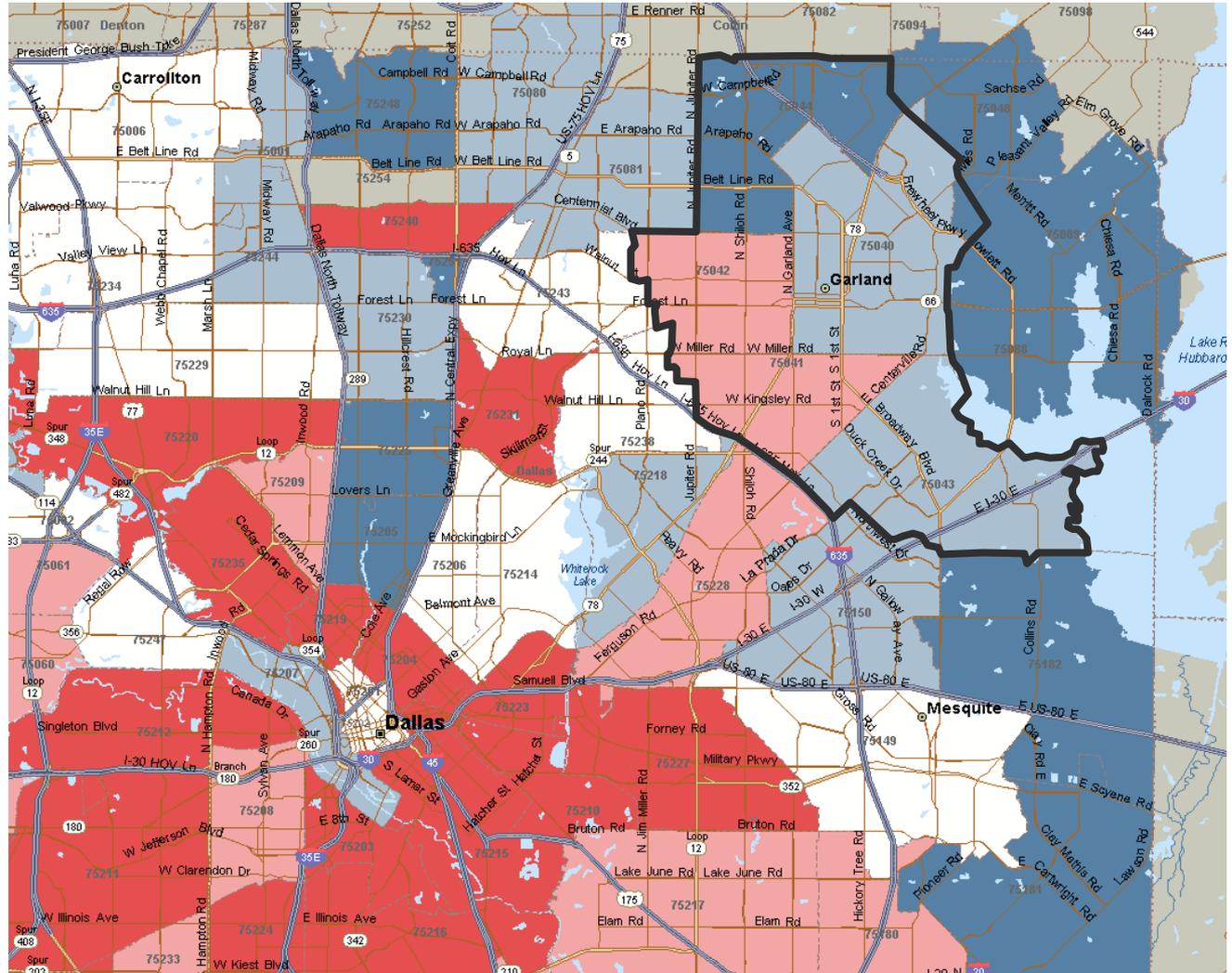
The percent unemployed for the City of Garland in 2012 (9.3%) was somewhat higher than the rate for Dallas County as a whole (8.6%)





The Community Need Index (CNI) uses Census-derived demographic statistics to come up with a need score from 1.0 (lowest need) to 5.0 (highest). The CNI uses statistics such as unemployment, per capita income, number of seniors.

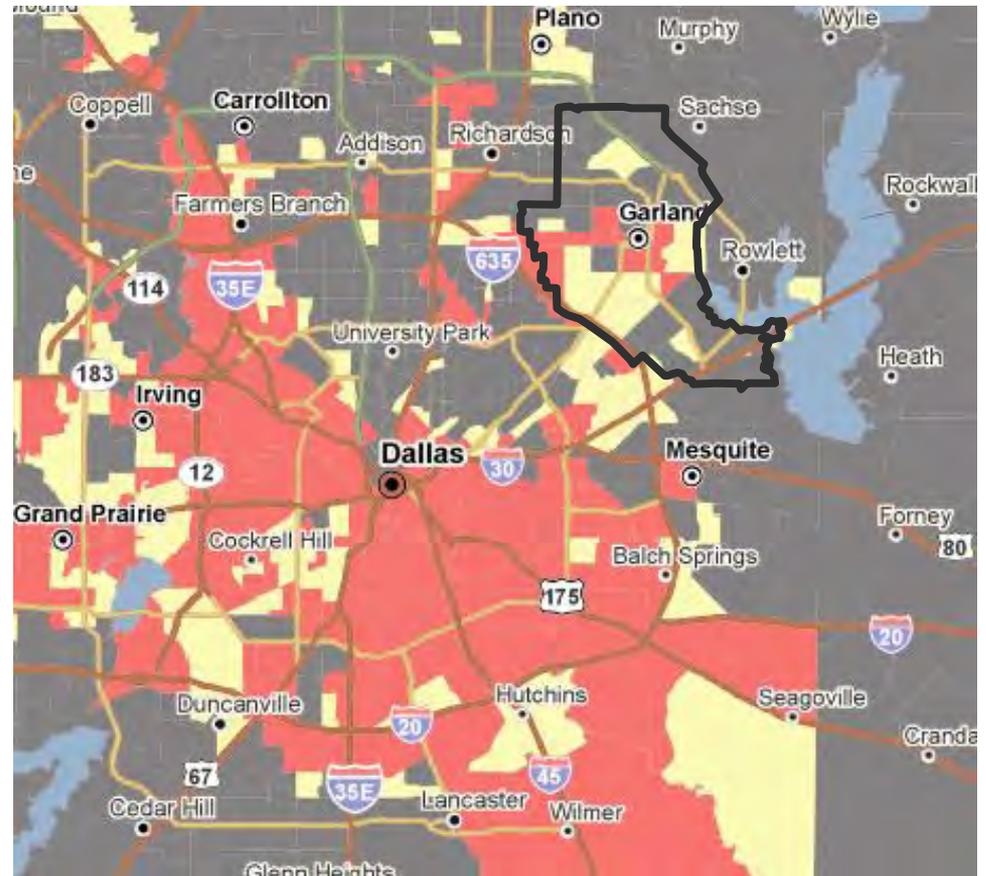
CNI Score



The New Markets Tax Credit (NMTC) program administers grants from the US Treasury Department, in the form of US corporate income tax credits, to businesses that locate in NMTC Eligible or Severely Distressed zones (see map). The purpose is to encourage economic redevelopment of these areas. The City of Dallas' Dallas Development Fund has given NMTC grants to four large projects since 2009.

The NMTC program defines a *low-income census tract* as: any census tract where (1) the poverty rate for that tract is at least 20 percent, or (2) for tracts located within a metropolitan area, the median family income for the tract does not exceed 80 percent of the greater of statewide median family income or the metropolitan area median family income.

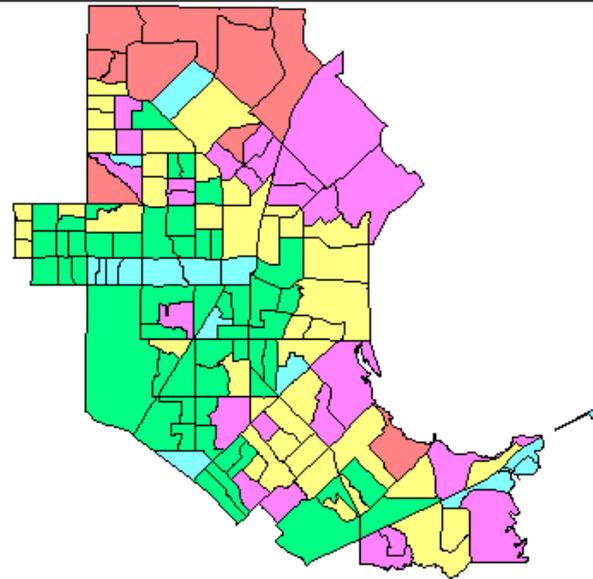
The Healthy Food Financing Initiative (HFFI) Working Group defines a food desert as a *low-income census tract* where a substantial number or share of residents has *low access* to a supermarket or large grocery store. To qualify as low-income, census tracts must meet the Treasury Department's New Markets Tax Credit (NMTC) program eligibility criteria. Furthermore, to qualify as a food desert tract, at least 33 percent of the tract's population or a minimum of 500 people in the tract must have low access to a supermarket or large grocery store.



Source: Novogradac and Company, http://www.novoco.com/new_markets/resources/map2_popup.php based on US Census Bureau data from the American Community survey 2006-2010 five-year data



Health Status Relative to National Average City of Garland



US Health Status Rank
by Block Group

- 1-Excellent (10)
- 2-Very Good (25)
- 3-Good (43)
- 4-Fair (52)
- 5-Poor (15)

Boundary Styles

Block Group

Scale

1.90 mi/inch

	2014 Households	Avg Score	US Health Status Rank
	8,251	78.27	1-Excellent
	15,651	65.78	2-Very Good
	23,044	56.28	3-Good
	25,354	44.82	4-Fair
	7,867	28.75	5-Poor

Health status is a compilation of 20 factors from Truven’s Pulse Health Survey and the BRFSS survey (Behaviors: no vigorous exercise, tobacco use, wellness program use, alcohol use, no flu shot); (Diet/Nutrition: eat fast food, eat snack foods eat healthy, no breakfast, eat fruits and vegetables, eat dairy, eat grains, eat protein); (Disease: allergies, asthma, arthritis, cancer, COPD, depression, diabetes, GERD, heart disease, high blood pressure, high cholesterol, incontinence, insomnia, irritable bowel problems, lower back pain migraine headache, skin problems, obese BME 30+); (Self Perceived: health status fair/poor; social interference all time/most time; pain very severe/severe; stress extremely stressful and depressed all/most of the time).

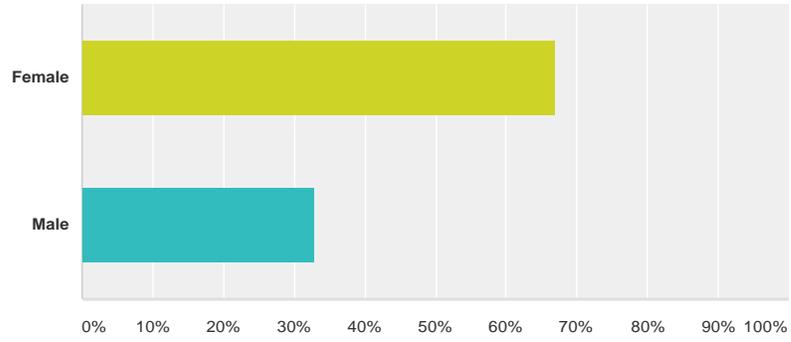
Appendix E. Community Health Survey Results



Garland Community Health Survey 2014

Q2 Sex

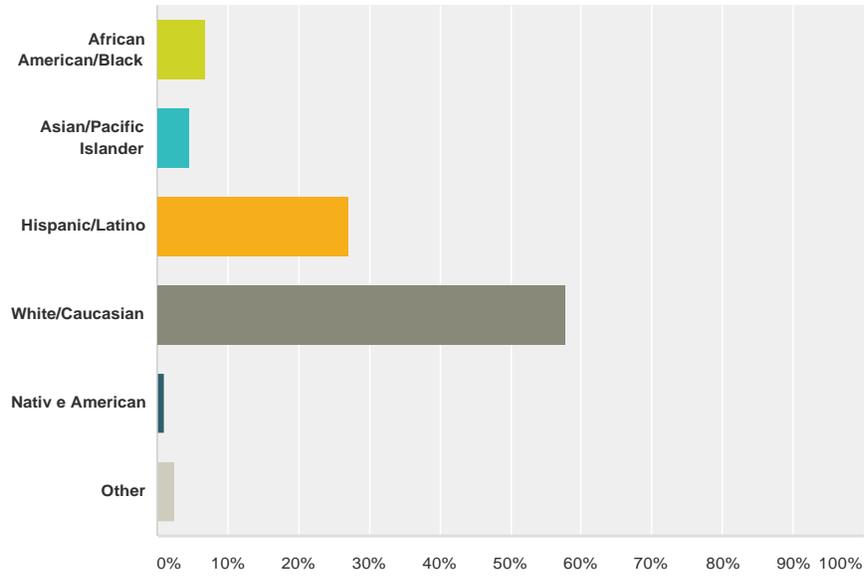
Answered: 477 Skipped: 8



Answer Choices	Responses	
Female	67.09%	320
Male	32.91%	157
Total		477

Q3 Ethnic group you most identify with

Answered: 482 Skipped: 3

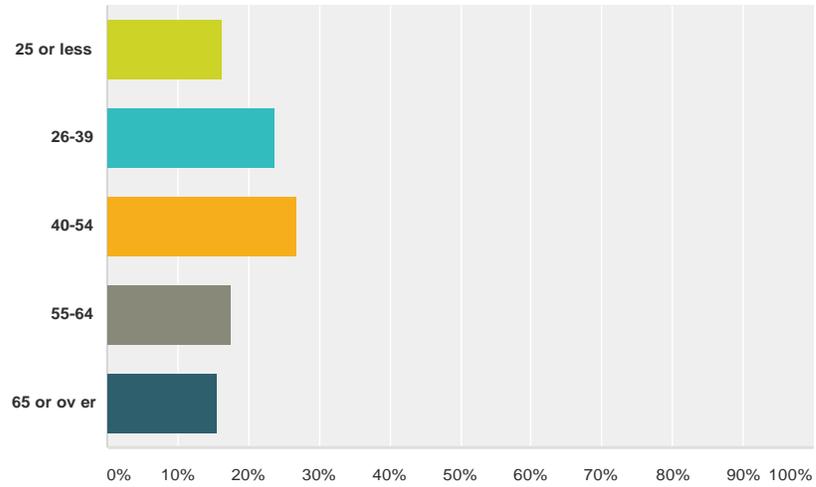


Answer Choices	Responses	Count
African American/Black	6.85%	33
Asian/Pacific Islander	4.56%	22
Hispanic/Latino	27.18%	131
White/Caucasian	57.88%	279
Native American	1.04%	5
Other	2.49%	12
Total		482

Garland Community Health Survey 2014

Q4 Age

Answered: 481 Skipped: 4

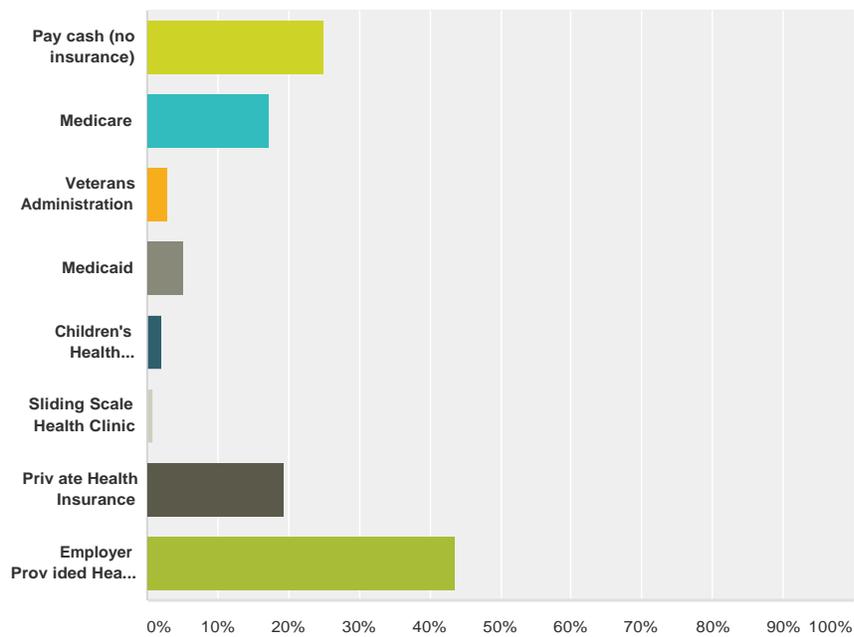


Answer Choices	Responses	
25 or less	16.22%	78
26-39	23.70%	114
40-54	27.03%	130
55-64	17.46%	84
65 or over	15.59%	75
Total		481

Garland Community Health Survey 2014

Q5 How do you pay for your health care? (Check all that apply)

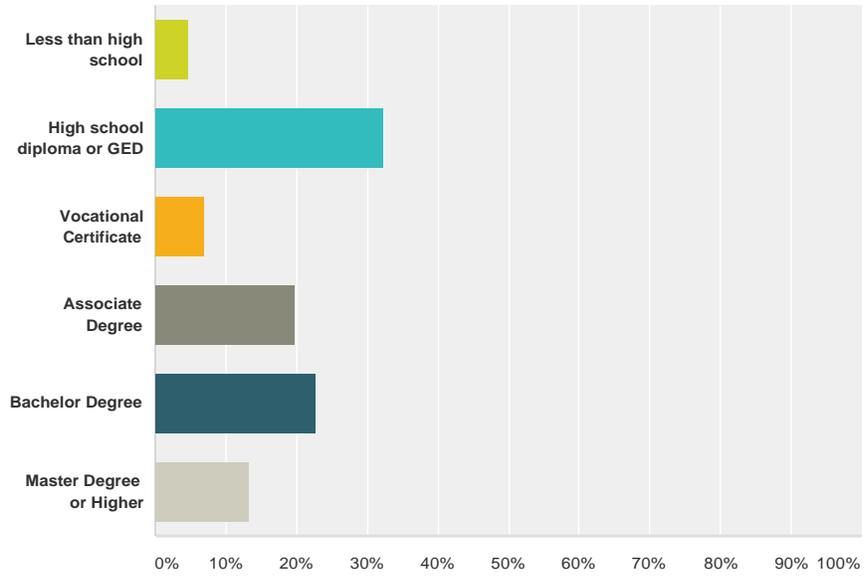
Answered: 483 Skipped: 2



Answer Choices	Responses
Pay cash (no insurance)	25.05% 121
Medicare	17.39% 84
Veterans Administration	2.90% 14
Medicaid	5.18% 25
Children's Health Insurance Program (CHIP)	2.07% 10
Sliding Scale Health Clinic	0.83% 4
Private Health Insurance	19.46% 94
Employer Provided Health Insurance	43.69% 211
Total Respondents: 483	

Q6 Education

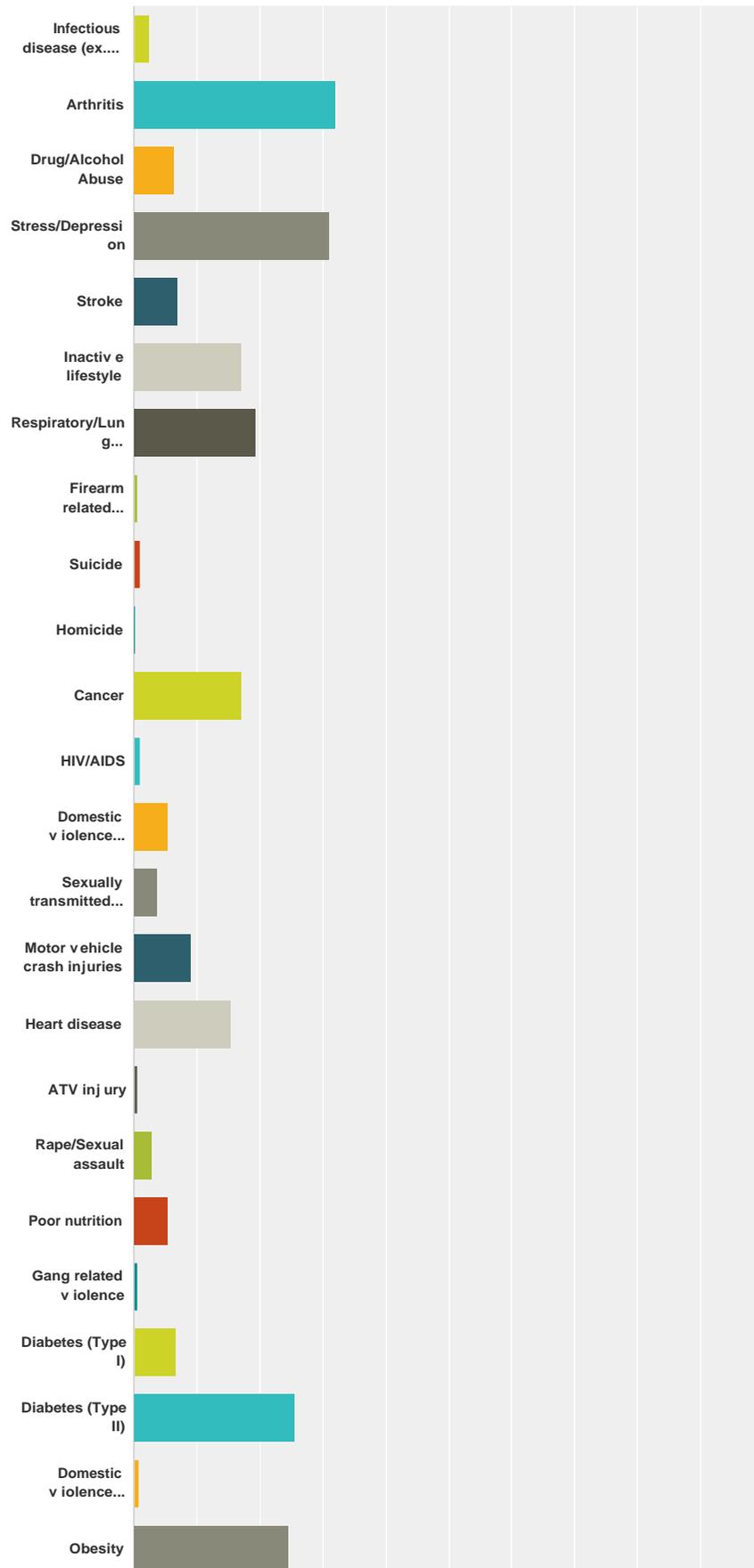
Answered: 437 Skipped: 48



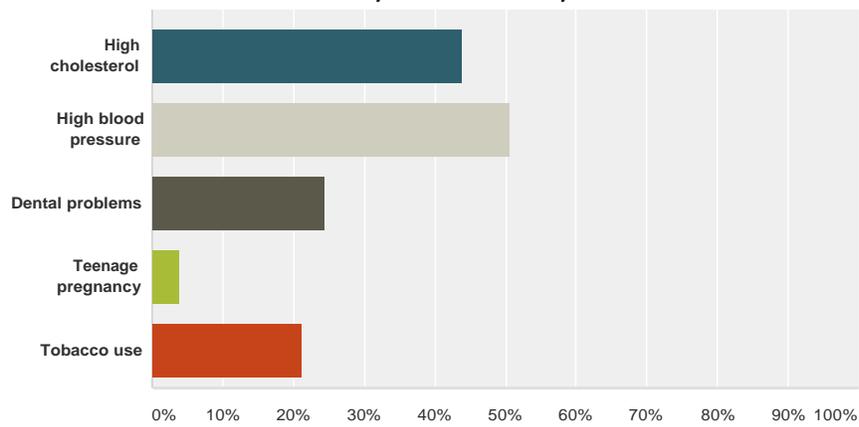
Answer Choices	Responses	
Less than high school	4.81%	21
High school diploma or GED	32.27%	141
Vocational Certificate	7.09%	31
Associate Degree	19.91%	87
Bachelor Degree	22.65%	99
Master Degree or Higher	13.27%	58
Total		437

Q7 Have you or anyone in your household experienced any of the following health issues? (Check all that apply)

Answered: 370 Skipped: 115



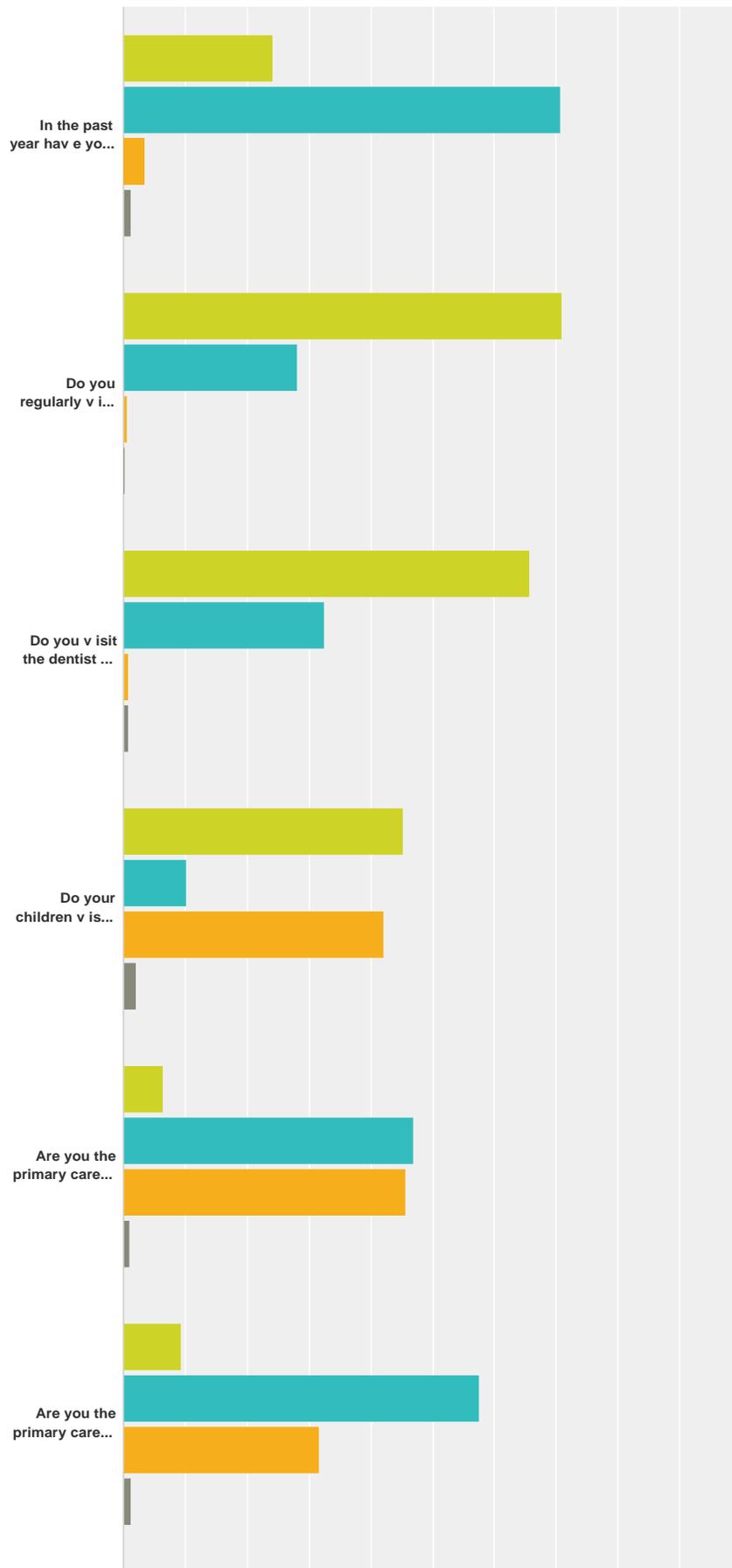
Garland Community Health Survey 2014



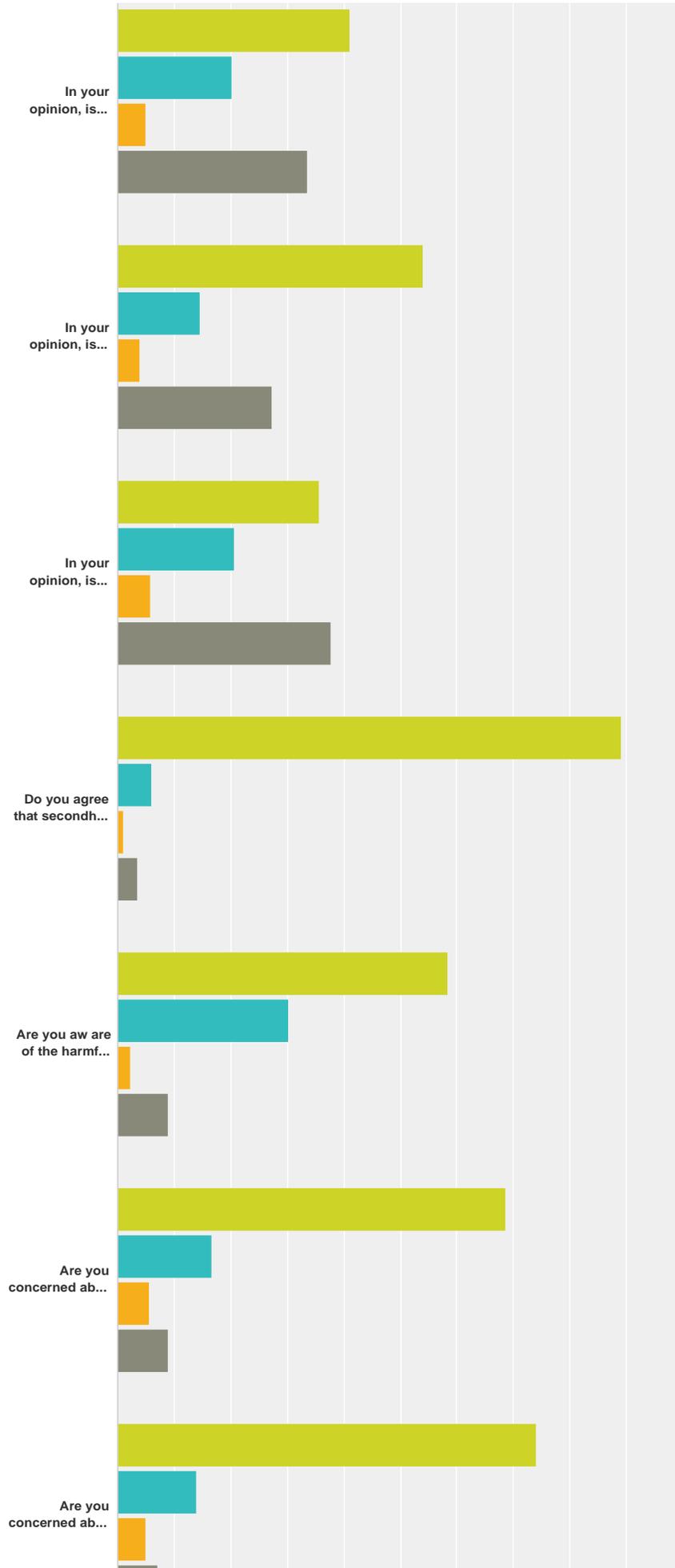
Answer Choices	Responses
Infectious disease (ex. Hepatitis, T B)	2.43% 9
Arthritis	32.16% 119
Drug/Alcohol Abuse	6.49% 24
Stress/Depression	31.08% 115
Stroke	7.03% 26
Inactive lifestyle	17.03% 63
Respiratory/Lung disease/Asthma	19.46% 72
Firearm related injuries	0.54% 2
Suicide	1.08% 4
Homicide	0.27% 1
Cancer	17.03% 63
HIV/AIDS	1.08% 4
Domestic violence (adults)	5.41% 20
Sexually transmitted diseases	3.78% 14
Motor vehicle crash injuries	9.19% 34
Heart disease	15.41% 57
ATV injury	0.54% 2
Rape/Sexual assault	2.97% 11
Poor nutrition	5.41% 20
Gang related violence	0.54% 2
Diabetes (Type I)	6.76% 25
Diabetes (Type II)	25.68% 95
Domestic violence (children)	0.81% 3
Obesity	24.59% 91
High cholesterol	43.78% 162
High blood pressure	50.81% 188
Dental problems	24.32% 90
Teenage pregnancy	4.05% 15
Tobacco use	21.35% 79
Total Respondents: 370	

Q8 Please mark your response to the following questions. (N/A = Not Applicable)

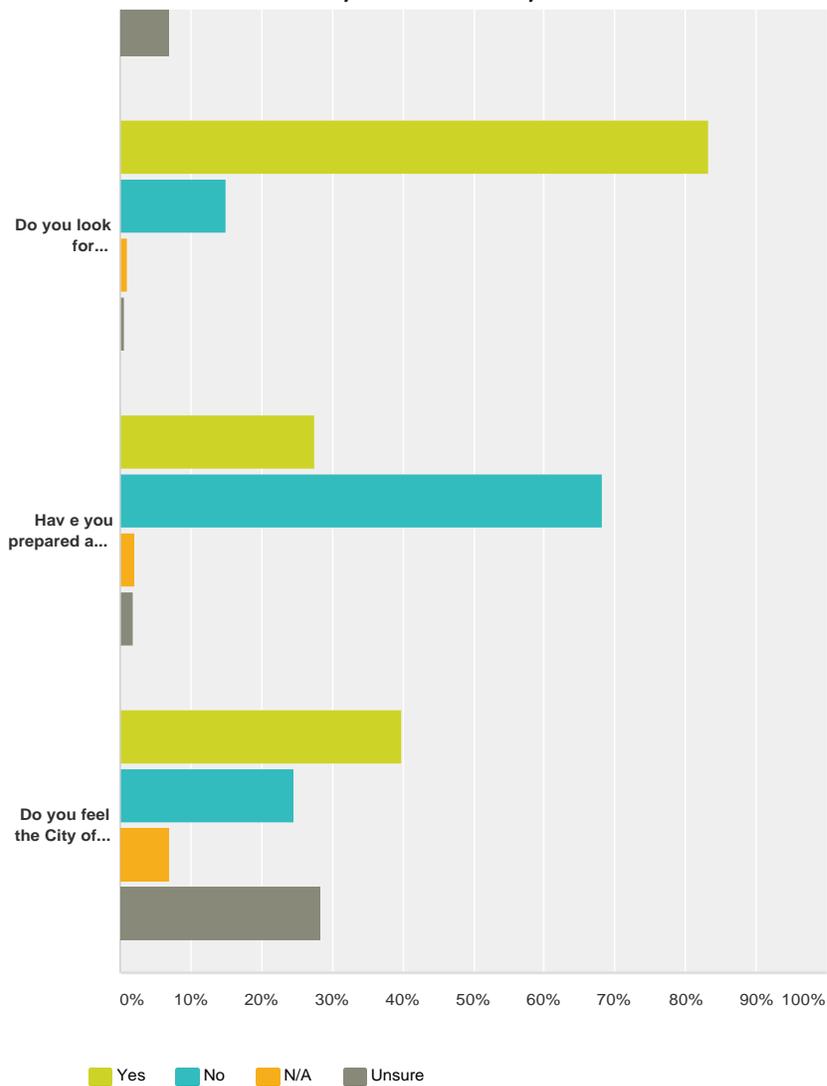
Answered: 480 Skipped: 5



Garland Community Health Survey 2014



Garland Community Health Survey 2014



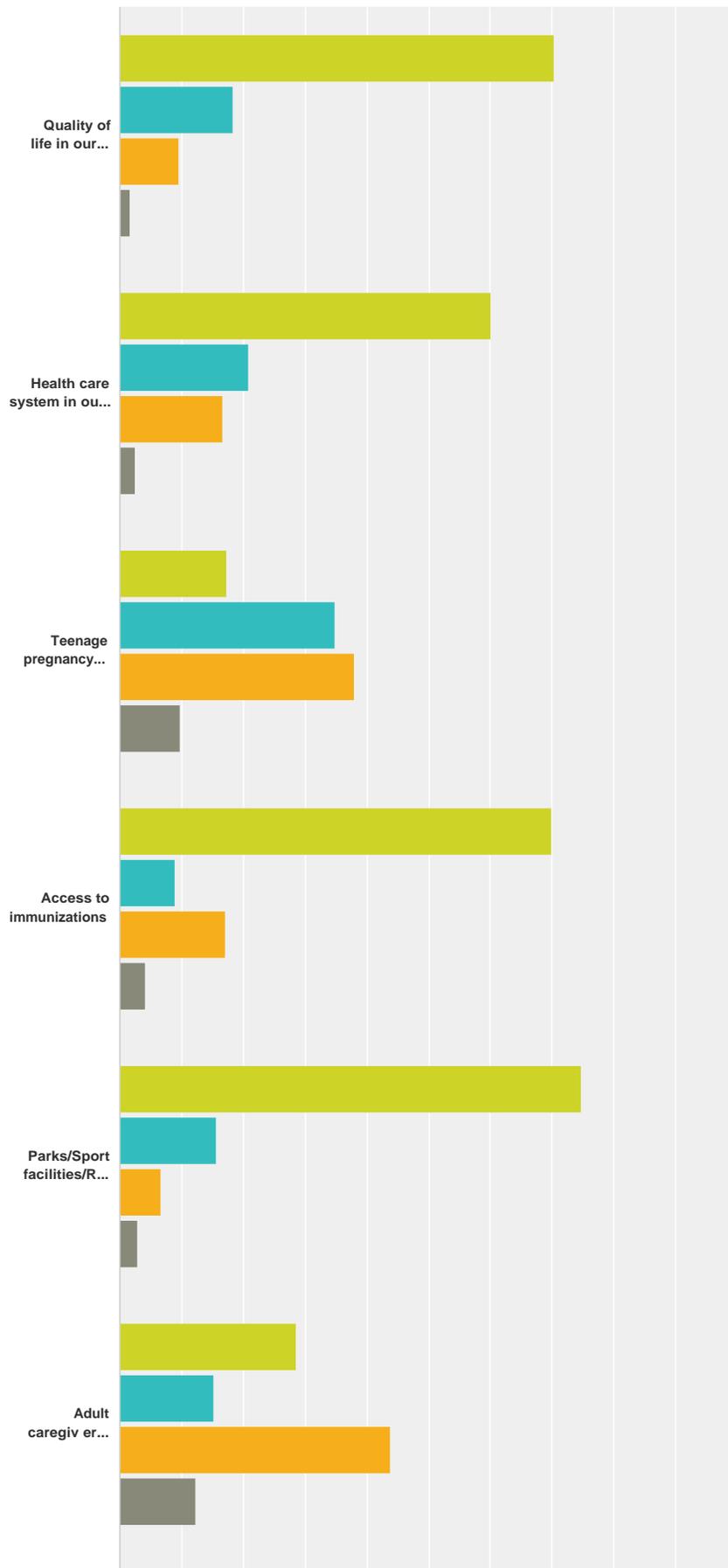
	Yes	No	N/A	Unsure	Total
In the past year have you gone without health care because you could not pay for it?	24.31% 115	70.82% 335	3.59% 17	1.27% 6	473
Do you regularly visit a physician for checkups?	71.07% 339	28.09% 134	0.63% 3	0.21% 1	477
Do you visit the dentist at least once a year?	65.67% 308	32.62% 153	0.85% 4	0.85% 4	469
Do your children visit the dentist at least once a year?	45.40% 212	10.28% 48	42.18% 197	2.14% 10	467
Are you the primary caregiver of your grandchildren?	6.40% 30	46.91% 220	45.63% 214	1.07% 5	469
Are you the primary caregiver of a senior adult?	9.30% 44	57.72% 273	31.71% 150	1.27% 6	473
In your opinion, is underage drinking a problem in Garland?	41.11% 192	20.34% 95	4.93% 23	33.62% 157	467
In your opinion, is illegal drug use a problem in Garland?	54.03% 255	14.62% 69	4.03% 19	27.33% 129	472
In your opinion, is prescription drug abuse a problem in Garland?	35.78% 166	20.69% 96	5.82% 27	37.72% 175	464
Do you agree that secondhand smoke is harmful to health?	89.22% 422	6.13% 29	1.06% 5	3.59% 17	473
Are you aware of the harmful effects of third hand smoke?	58.39% 275	30.36% 143	2.34% 11	8.92% 42	471
Are you concerned about the number of overweight children in Garland?	68.63% 326	16.63% 79	5.68% 27	9.05% 43	475
Are you concerned about the economic impact of obesity?	74.15% 347	13.89% 65	4.91% 23	7.05% 33	468

Garland Community Health Survey 2014

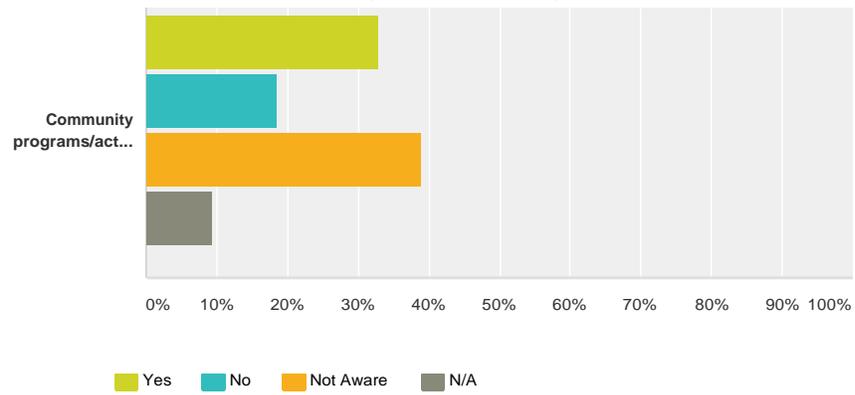
Do you look for opportunities to be physically active?	83.22% 352	15.13% 64	0.95% 4	0.71% 3	423
Have you prepared a Family Disaster Plan (for natural or man made disasters)?	27.49% 113	68.37% 281	2.19% 9	1.95% 8	411
Do you feel the City of Garland is prepared in the event of a disaster?	39.95% 165	24.70% 102	7.02% 29	28.33% 117	413

Q9 Are you satisfied with the following in Garland?

Answered: 422 Skipped: 63



Garland Community Health Survey 2014

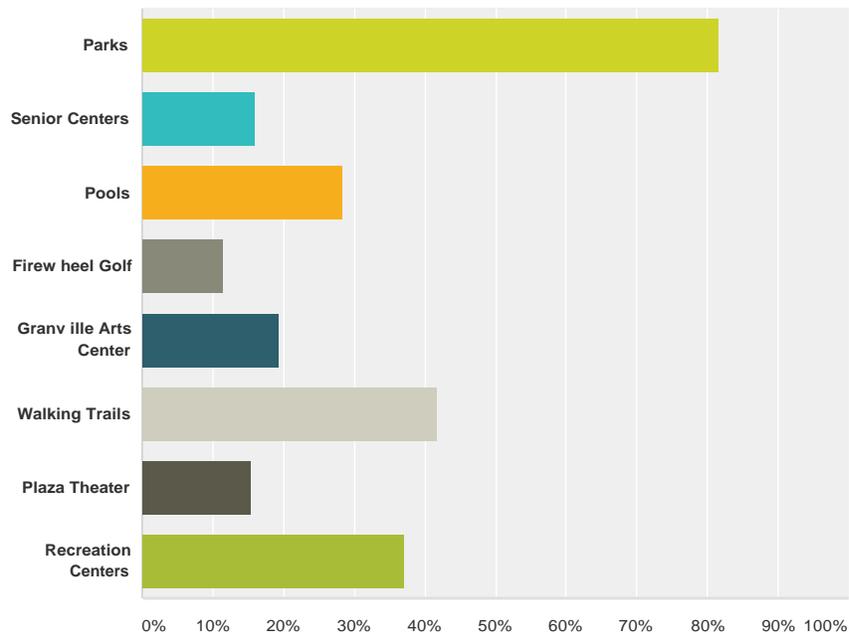


	Yes	No	Not Aware	N/A	Total
Quality of life in our community	70.33% 294	18.42% 77	9.57% 40	1.67% 7	418
Health care system in our community	60.14% 249	20.77% 86	16.67% 69	2.42% 10	414
Teenage pregnancy prevention/sex education	17.39% 72	34.78% 144	37.92% 157	9.90% 41	414
Access to immunizations	69.95% 291	8.89% 37	17.07% 71	4.09% 17	416
Parks/Sport facilities/Recreational facilities	74.76% 311	15.63% 65	6.73% 28	2.88% 12	416
Adult caregiver support	28.67% 119	15.18% 63	43.86% 182	12.29% 51	415
Community programs/activities for teens	33.09% 135	18.63% 76	38.97% 159	9.31% 38	408

Garland Community Health Survey 2014

Q10 Which City of Garland facilities do you use/visit at least twice a year?

Answered: 369 Skipped: 116

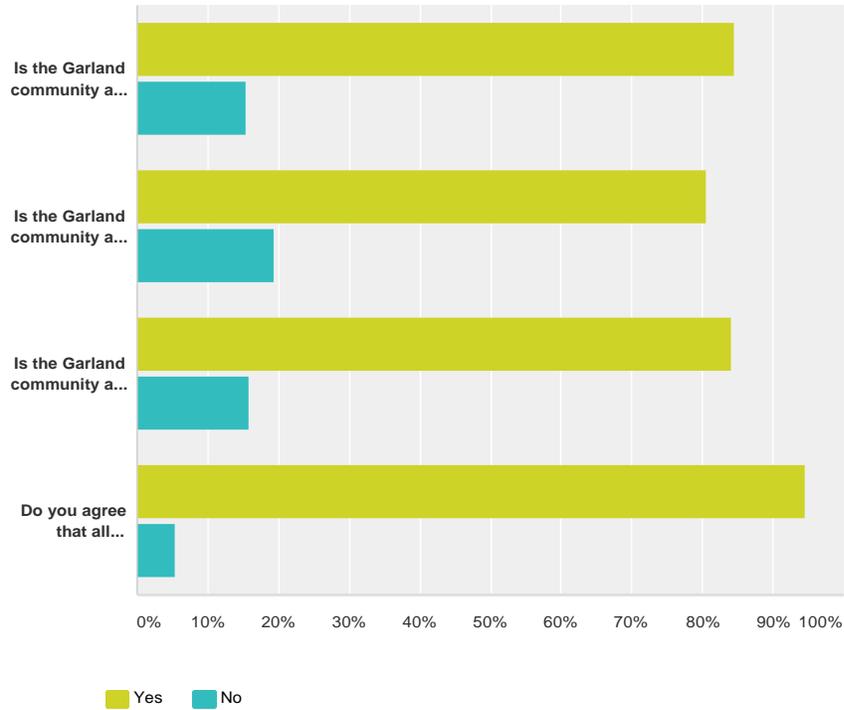


Answer Choices	Responses	Count
Parks	81.57%	301
Senior Centers	15.99%	59
Pools	28.46%	105
Firewheel Golf	11.38%	42
Granville Arts Center	19.51%	72
Walking Trails	41.73%	154
Plaza Theater	15.45%	57
Recreation Centers	37.13%	137
Total Respondents: 369		

Garland Community Health Survey 2014

Q11 In your opinion:

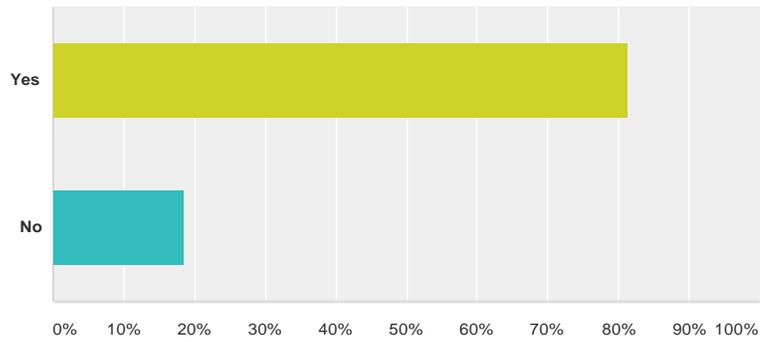
Answered: 456 Skipped: 29



	Yes	No	Total
Is the Garland community a good place to raise children?	84.55% 383	15.45% 70	453
Is the Garland community a good place to grow old?	80.57% 365	19.43% 88	453
Is the Garland community a safe place to live?	84.15% 377	15.85% 71	448
Do you agree that all Garland residents-individually and collectively-can make the Garland community a better place to live?	94.48% 428	5.52% 25	453

Q12 Are you satisfied with the opportunity to live an active, healthy lifestyle in Garland?

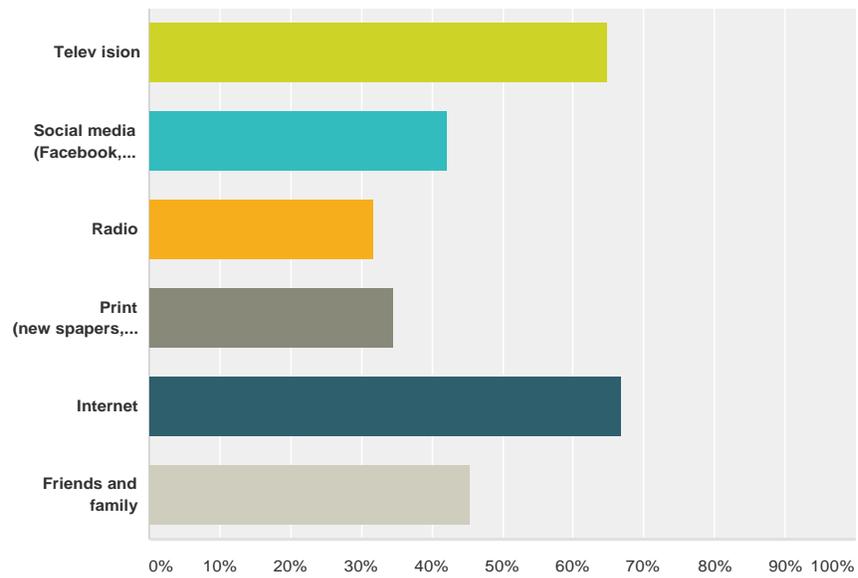
Answered: 449 Skipped: 36



Answer Choices	Responses	
Yes	81.51%	366
No	18.49%	83
Total		449

Q13 From what sources do you receive most of your information?

Answered: 454 Skipped: 31

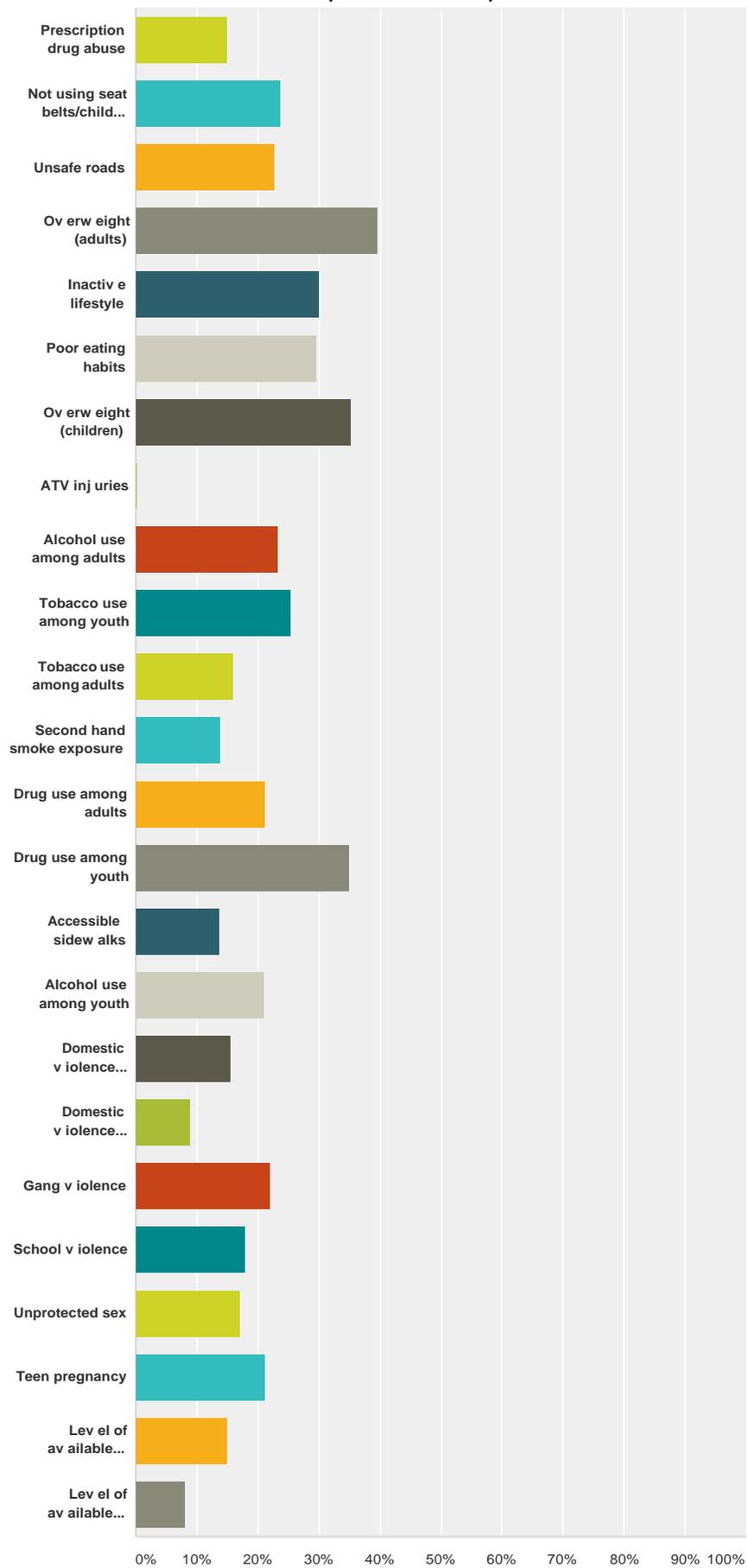


Answer Choices	Responses	Count
Television	64.98%	295
Social media (Facebook, Twitter, etc.)	42.07%	191
Radio	31.72%	144
Print (newspapers, newsletters)	34.58%	157
Internet	66.74%	303
Friends and family	45.59%	207
Total Respondents: 454		

Q14 What do you think are the 5 most important health risks in the Garland community? (Please check only 5)

Answered: 405 Skipped: 80

Garland Community Health Survey 2014



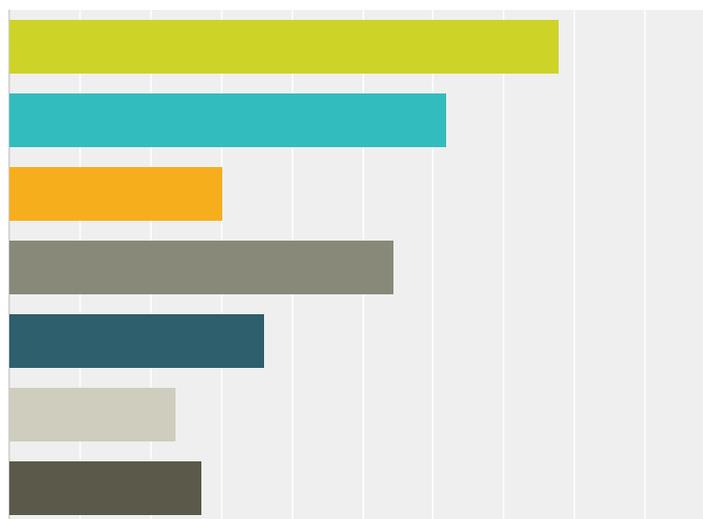
Answer Choices	Responses
Prescription drug abuse	15.06% 61

Garland Community Health Survey 2014

Not using seat belts/c hild seats	23.70%	96
Unsafe roads	22.72%	92
Overweight (adults)	39.75%	161
Inac tive lifestyle	30.12%	122
Poor eating habits	29.63%	120
Overweight (c hildren)	35.31%	143
AT V injuries	0.25%	1
Alc ohol use among adults	23.46%	95
T obac c o use among youth	25.43%	103
T obac c o use among adults	16.05%	65
Sec ond hand smoke exposure	14.07%	57
Drug use among adults	21.23%	86
Drug use among youth	35.06%	142
Ac c essible sidewalks	13.83%	56
Alc ohol use among youth	20.99%	85
Domestic violenc e (adults)	15.56%	63
Domestic violenc e (c hildren)	8.89%	36
Gang violenc e	22.22%	90
Sc hool violenc e	18.02%	73
Unprotec ted sex	17.04%	69
T een pregnanc y	21.23%	86
Level of available mental Health Servic es (adults)	15.06%	61
Level of available Mental Health Servic es (c hildren)	8.15%	33
Total Respondents: 405		

Q15 What do you feel are the three most important characteristics of a healthy community?

Answered: 457 Skipped: 28



A

Garland Community Health Survey 2014

Good place to raise children/good schools/safe neighborhoods	77.90%
Good jobs/healthy economy	61.93%
Access to health care	30.20%
Low crime rate	54.49%
Clean environment	36.11%
Religious/Spiritual values	23.63%
Parks/Recreation	27.35%
Total Respondents: 457	



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