TEXAS HEALTH RESOURCES

All Regions

APPENDICES

Table of Contents

Appendix A. Collin Region	3
Appendix B. Dallas/Rockwall Region	61
Appendix C. Denton-Wise Region	149
Appendix D. Southern Region	227
Appendix E. Tarrant/Parker Region	324

Appendix A. Collin Region

TEXAS HEALTH RESOURCES

COLLIN REGION

APPENDICES

Secondary Data Methodology

Secondary Data Sources

The main source for the secondary data, or data that has been previously collected, is the community indicator database maintained by Conduent Healthy Communities Institute. The following is a list of both local and national data sources used in Texas Health Resources Collin County regional Community Health Needs Assessment report.

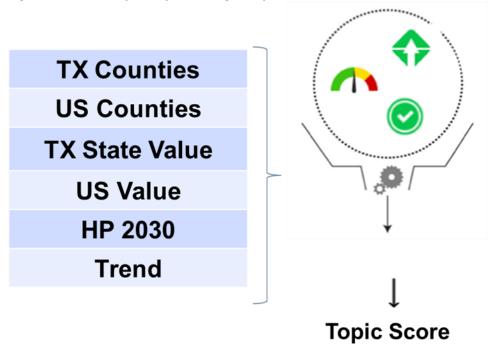
Data Sources

- American Community Survey
- American Lung Association
- CDC PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- County Health Rankings
- Feeding America
- Healthy Communities Institute
- National Cancer Institute
- National Center for Education Statistics
- National Environmental Public Health Tracking Network
- Texas Department of Family and Protective Services
- DFWHC Foundation Regional Data, Q1-Q4, 2017-2019. DFWHC Foundation, Irving Texas. October 15, 2021,

- Texas Education Agency
- Texas Department of Health Services
- U.S Bureau of Labor Statistics
- U.S. Census County Business Patterns
- U.S. Census Bureau Small Area Health Insurance Estimates
- U.S. Department of Agriculture Food Environment Atlas
- U.S. Environmental Protection Agency
- United for ALICE

Secondary Data Scoring

HCl's Data Scoring Tool (Figure 1A) was used to systematically summarize multiple comparisons in order to rank indicators based on highest need. For each indicator, the community value was compared to a distribution of Texas and US counties, state and national values, Healthy People 2030, and significant trends were noted. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities and changes in methodology over time. The comparison scores were summarized for each indicator, and indicators were then grouped into topic areas for a systematic ranking of community health needs. Figure 1A: Summary of Topic Scoring Analysis



Index of Disparity

An important part of the CHNA process is to identify health disparities, the needs of vulnerable populations and unmet health needs or gaps in services. There were several ways in which subpopulation disparities were examined by county. For secondary data health indicators, the Index of Disparity tool was utilized to see if there were large, negative, and concerning differences in indicator values between each subgroup data value and the overall county value. The Index of Disparity was run for each county, and the indicators with the highest race or ethnicity index value were found.

Health Equity Index

Every community can be described by various social and economic factors that can contribute to disparities in health outcomes. Conduent HCI's Health Equity Index (formerly SocioNeeds [®] Index) considers validated indicators related to income, employment, education, and household environment to identify areas at highest risk for experiencing health inequities.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic needs correlated with preventable hospitalizations and premature death.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Health Equity Index, with darker coloring associated with higher relative need.

Food Insecurity Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in outcomes and opportunities to thrive. Conduent HCI's Food Insecurity Index considers validated indicators related to income, household environment and well-being to identify areas at highest risk for experiencing food insecurity.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest food insecurity, which is correlated with household and community measures of food-related financial stress such as Medicaid and SNAP enrollment.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Food Insecurity Index, with darker coloring associated with higher relative need.

Mental Health Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in mental health outcomes. Conduent HCI's Mental Health Index considers validated indicators related to access to care, physical health status, transportation, employment and household environment to identify areas at highest risk for experiencing poor mental health.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic and health needs correlated with self-reported poor mental health.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Mental Health Index, with darker coloring associated with higher relative need.

Data Considerations

Several limitations of data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and health-related areas, data availability varies by health topic. Some topics contain a robust set of secondary data indicators, while others may have a limited number of indicators or limited subpopulations covered by those specific indicators. Data scores represent the relative community health need according to the secondary data for each topic and should not be considered a comprehensive result on their own. In addition, these scores reflect the secondary data results for the population as a whole and do not represent the health or socioeconomic need that is much greater for some subpopulations. Moreover, many of the secondary data indicators included in the findings are collected by survey, and though specific methods are used to best represent the population at large, these measures are subject to instability, especially for smaller populations. The Index of Disparity is also limited by data availability, where indicator data varies based on the population groups and service areas being analyzed.

Race or ethnic and Special Population Groupings

The secondary data presented in this report derive from multiple sources, which may present race and ethnicity data using dissimilar nomenclature. For consistency with data sources throughout the report, subpopulation data may use different terms to describe the same or similar groups of community members.

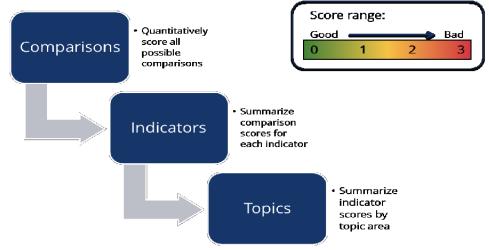
Zip Codes and Zip Code Tabulation Areas

This report presents both Zip Code and Zip Code Tabulation Area (ZCTA) data. Zip Codes, which were created by the U.S. Postal Service to improve mail delivery service, are not reported in this assessment as they may change, include P.O. boxes or cover large unpopulated areas. This assessment cover ZCTAs or Zip Code Tabulation Areas which were created by the U.S. Census Bureau and are generalized representations of Zip Codes that have been assigned to census blocks.

Demographics for this report are sourced from the United States Census Bureau, which presents ZCTA estimates. Tables and figures in the Demographics section of this report reference Zip Codes in title (for purposes of familiarity) but show values of ZCTAs. Data from other sources are labeled as such.

Secondary Data Scoring Detailed Methodology

Data Scoring is done in three stages:



For every indicator available, each county in the Hospital Service Area is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time. Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic. Secondary data for this report are up to date as of November 1, 2021.

Comparison to a Distribution of County Values: Within State and Nation

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

Comparison to Values: State, National, and Targets

The county is compared to the state value, the national value, and target values. Target values include the nation-wide Healthy People 2030 (HP2030) goals. Healthy People 2030 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' (DHHS) Healthy People Initiative. For all value comparisons, the scoring depends on whether the county value is better or worse than the comparison value, as well as how close the county value is to the target value.

Trend Over Time

The Mann-Kendall statistical test for trend was used to assess whether the county value is increasing over time or decreasing over time, and whether the trend is statistically significant. The trend comparison uses the four most recent comparable values for the county, and statistical significance is determined at the 90% confidence level. For each indicator with values available for four time periods, scoring was determined by direction of the trend and statistical significance.

Missing Values

Indicator scores are calculated using the comparison scores, availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators on the community dashboard, it will be included in the indicator score. After exclusion of comparison types with inadequate availability, all missing comparisons are substituted with a neutral score for the purposes of calculating the indicator's weighted average. When information is unknown due to lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

Indicator Scoring

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated, and the indicator is excluded from the data scoring results.

Topic Scoring

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. Resulting scores range from 0-3, where a higher score indicates a greater level of need as evidenced by the data. A topic score is only calculated if it includes at least three indicators.

County Data Scoring Indicators Results

Collin County Indicator Scores

	ALCOHOL & DRUG		COLLIN				MEASUREMENT		
SCORE	USE	UNITS	COUNTY	HP2030	ТХ	U.S.	PERIOD	HIGH DISPARITY*	Source
	Adults who Binge								
1.75	Drink	percent	16.7			16.4	2018		3
	Age-Adjusted ER	ER visits/ 10,000							
	Rate due to Opioid	population 18+							
1.75	Use	years	2.2		0.7		2017-2019		16
	Age-Adjusted	hospitalizations/							
	Hospitalization	10,000							
	Rate due to Opioid	population 18+							
1.75	Use	years	0.3		0.1		2017-2019		16
		percent of driving							
		deaths with							
	Alcohol-Impaired	alcohol							
1.56	Driving Deaths	involvement	28.3	28.3	25.7	27	2015-2019		6
	Age-Adjusted ER	ER visits/ 10,000							
	Rate due to	population 18+							
1.25	Substance Use	years	9.7		20.6		2017-2019		16
	Age-Adjusted	hospitalizations/							
	Hospitalization	10,000							
	Rate due to	population 18+							
1.25	Substance Use	years	0.9		1.2		2017-2019		16
	Liquor Store	stores/ 100,000							
1.06	Density	population	6.5		6.9	10.5	2019		18
	Age-Adjusted Drug								
	and Opioid-	Deaths per							
	Involved Overdose	100,000							
1.00	Death Rate	population	7.8		12.1	22.8	2017-2019		4

	Death Rate due to	deaths/ 100,000							
0.33	Drug Poisoning	population	7.3		10.6	21	2017-2019		6
SCORE	CANCER	UNITS	COLLIN COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Breast Cancer	cases/ 100,000			112.				
2.58	Incidence Rate	females	127.2		8	125.9	2013-2017		9
2.47	Cancer: Medicare Population	percent	8.7		7.6	8.4	2018		5
	Prostate Cancer	cases/ 100,000							
1.50	Incidence Rate	males	94.5		94	104.5	2013-2017		9
1.33	Colon Cancer Screening	percent	65.4	74.4		66.4	2018		3
1.33	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	10.6		11	11.8	2013-2017		9
1.22	Cervical Cancer Screening: 21-65	Percent	84.3	84.3		84.7	2018		3
	All Cancer	cases/ 100,000			407.				
1.14	Incidence Rate	population	402.3		7	448.7	2013-2017		9
0.94	Mammogram in Past 2 Years: 50-74	percent	76.2	77.1		74.8	2018		3
0.75	Adults with Cancer	percent	5.9			6.9	2018		3
0.64	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	16.3	15.3	19.8	20.1	2013-2017		9
0.61	Cervical Cancer Incidence Rate	cases/ 100,000 females	4.4		9.2	7.6	2013-2017		9

0.44	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	10.6	8.9	13.9	13.7	2013-2017		9
0.36	Colorectal Cancer Incidence Rate	cases/ 100,000 population	30.8		37.6	38.4	2013-2017		9
0.25	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	15	16.9	17.6	19	2013-2017	Black (41.3) White (15.8)	9
0.11	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	123.6	122.7	148. 8	155.5	2013-2017		9
0.11	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	27.3	25.1	34.1	38.5	2013-2017		9
0.08	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	42.5		50.6	58.3	2013-2017		9

SCORE	CHILDREN'S HEALTH	UNITS	COLLIN COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
JEONE	Food Insecure	01113	COONT	11F2030		0.3.	PERIOD	HIGH DISPART	Jource
	Children Likely								
	Ineligible for								_
2.50	Assistance	percent	56		34	23	2019		7
	Children with								
1.50	Health Insurance	percent	92		87.3	94.3	2019		1
	Children with Low								
	Access to a								
1.33	Grocery Store	percent	3.8				2015		20
	Projected Child								
	Food Insecurity								
0.92	Rate	percent	16.7		23.6		2021		7
	Substantiated	cases/ 1,000							
0.92	Child Abuse Rate	children	4.5	8.7	9.1		2020		12
	Child Food								
0.67	Insecurity Rate	percent	13.3		19.6	14.6	2019		7

SCORE	COMMUNITY	UNITS	COLLIN COUNTY	1102020	TV	U.S.	MEASUREMENT PERIOD		Source
JUNE		UNITS	COUNTY	HP2030	ТХ	0.5.	PERIOD	HIGH DISPARITY*	Jource
2.02	Solo Drivers with a				20.0	27	2015 2010		C
2.92	Long Commute	percent	46.5		38.9	37	2015-2019		6
	Median Household								
2.67	Gross Rent	dollars	1389		1045	1062	2015-2019		1
	Median Monthly								
	Owner Costs for								
	Households								
	without a								
2.67	Mortgage	dollars	859		514	500	2015-2019		1
	Mortgaged								
	Owners Median								
	Monthly								
2.67	Household Costs	dollars	2194		1606	1595	2015-2019		1
		membership							
		associations/							
		10,000							
2.36	Social Associations	population	6.4		7.5	9.3	2018		6
	Mean Travel Time								
2.31	to Work	minutes	28.9		26.6	26.9	2015-2019		1
1.97	Linguistic Isolation	percent	5.1		7.7	4.4	2015-2019		1
		percent of driving							
		deaths with							
	Alcohol-Impaired	alcohol							
1.56	Driving Deaths	involvement	28.3	28.3	25.7	27	2015-2019		6

	Workers Commuting by Public							Black (1.9) White (0.8) Asian (1.9) AIAN (0) NHPI (6.6) Mult (3) Other (0.9)	
1.44	Transportation	percent	1.1	5.3	1.4	5	2015-2019	Hisp (0.9)	1
4.35	Female Population 16+ in Civilian		co 7		57.0	50.2	2015 2010		4
1.25	Labor Force	percent	62.7		57.8	58.3	2015-2019		1
1.25	Homeownership	percent	61.1		54.9	56.2	2015-2019		1
1.25	Persons with Health Insurance	percent	87.5	92.1	79.3		2019		19
1.08	Social Worker Rate	workers/ 100,000 population	69.2		82.7		2020		13
1.08	Workers who Drive Alone to Work Households with	percent	80.9		80.5	76.3	2015-2019		1
1.00	No Car and Low Access to a Grocery Store	percent	0.6				2015		20
1.00	Voter Turnout: Presidential Election	percent	66.4		58.8		2016		15
0.92	Persons with an Internet Subscription	percent	93.5		84.2	86.2	2015-2019		1
0.92	Substantiated Child Abuse Rate	cases/ 1,000 children	4.5	8.7	9.1		2020		12

0.83	Households with One or More Types of Computing Devices	percent	97.9		91	90.3	2015-2019		
0.81	Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions	deaths/ 100,000	6.8	10.1	13	11.3	2017-2019		
0.81		population	0.8	10.1	13	11.5	2017-2019		
0.81	Total Employment Change	percent	4.2		2.9	1.6	2018-2019		
0.64	Population 16+ in Civilian Labor Force	percent	68.1		61	59.6	2015-2019		
0.53	People 25+ with a High School Degree or Higher	percent	93.8		83.7	88	2015-2019		
0.50	Households with an Internet Subscription	percent	92.9		82.1	83	2015-2019		
	Median Housing				2E+0	2E+0			
0.33	Unit Value	dollars	315300		5	5	2015-2019	Black (9.7) White (3.4) Asian (3.7) AIAN (4.4)	
0.08	Children Living Below Poverty Level	percent	7		20.9	18.5	2015-2019	NHPI (2.2) Mult (6.6) Other (22.8) Hisp (17.5)	
	Median Household				6187	6284		I \ _/	
0.08	Income	dollars	96913		4	3	2015-2019		

0.08	People 25+ with a Bachelor's Degree or Higher	percent	52.3		29.9	32.1	2015-2019		1
0.00		percent	52.5		3127	3410	2013 2013		
0.08	Per Capita Income	dollars	44548		7	3	2015-2019		1
	Single-Parent								
0.08	Households	percent	15.5		26.3	25.5	2015-2019		1
								Black (7.6)	
								White (4.3)	
								Asian (5.8)	
								AIAN (9.1)	
								NHPI (4.5)	
	People Living							Mult (7.1)	
	Below Poverty							Other (14.8)	
0.00	Level	percent	6.3	8	14.7	13.4	2015-2019	Hisp (12.9)	1

SCORE	DIABETES	UNITS	COLLIN COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Age-Adjusted ER	ER visits/ 10,000							
	Rate due to	population 18+							
1.75	Diabetes	years	16.5		9.4		2017-2019		16
	Age-Adjusted ER	ER visits/ 10,000							
	Rate due to Type 2	population 18+							
1.75	Diabetes	years	14.7		8.6		2017-2019		16
	Age-Adjusted	hospitalizations/							
	Hospitalization	10,000							
	Rate due to	population 18+							
1.75	Diabetes	years	11.6		5.3		2017-2019		16
	Age-Adjusted	hospitalizations/							
	Hospitalization	10,000							
	Rate due to Type 2	population 18+							
1.75	Diabetes	years	8.6		4		2017-2019		16
	Diabetes:								
	Medicare								
0.97	Population	percent	24.9		28.8	27	2018		5
	Age-Adjusted								
	Death Rate due to	deaths/ 100,000							
0.64	Diabetes	population	9.2		22	21.5	2017-2019		4

SCORE	ECONOMY	UNITS	COLLIN COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Median Household								
2.67	Gross Rent	dollars	1389		1045	1062	2015-2019		1
	Median Monthly								
	Owner Costs for								
	Households								
	without a								
2.67	Mortgage	dollars	859		514	500	2015-2019		1
	Mortgaged								
	Owners Median								
2.67	Monthly Household Costs	dollars	2194		1606	1595	2015-2019		1
2.07		uonurs	2194		1000	1292	2013-2019		1
	Food Insecure								
	Children Likely								
2.50	Ineligible for Assistance	norcont	56		34	23	2019		7
2.50		percent	50		34	23	2019		/
2.00	WIC Certified	stores/ 1,000	0.1				2010		20
2.00	Stores	population	0.1				2016		20
1.00	SNAP Certified	stores/ 1,000	0.4				2017		20
1.86	Stores	population	0.4				2017		20
	Mortgaged Owners Spending								
	30% or More of								
	Household Income								
1.75	on Housing	percent	27.6		26.5	26.5	2019		1
	Renters Spending								
	30% or More of								
	Household Income								
1.42	on Rent	percent	43.5		47.8	49.6	2015-2019		1
1.36	Size of Labor Force	persons	583416				44348		17

	Female Population						
	16+ in Civilian						
1.25	Labor Force	percent	62.7	57.8	58.3	2015-2019	1
1.25	Homeownership	percent	61.1	54.9	56.2	2015-2019	1
	Overcrowded	percent of					
1.14	Households	households	2.4	4.8		2015-2019	1
	Students Eligible						
	for the Free Lunch						
1.14	Program	percent	22.1			2019-2020	10
	Food Insecurity						
1.00	Rate	percent	11.1	14.1	10.9	2019	7
	Households that						
	are Above the						
	Asset Limited,						
	Income						
	Constrained,						
	Employed (ALICE)						
1.00	Threshold	percent	71.2	56		2018	22
	Households that						
	are Asset Limited,						
	Income						
	Constrained,						
1.00	Employed (ALICE)	percent	22.1	30		2018	22
	Households that						
	are Below the						
	Federal Poverty						
1.00	Level	percent	6.6	14		2018	22
	Low-Income and						
	Low Access to a						
1.00	Grocery Store	percent	2.3			2015	20

	Projected Child Food Insecurity							
0.92	Rate	percent	16.7	23.6		2021		7
	Projected Food							
0.92	Insecurity Rate	percent	13.1	16.5		2021		7
							Black (10.1)	
							White (6.3)	
							Asian (8.6)	
							AIAN (14.2)	
							NHPI (0) Mult	
	People 65+ Living						(6.4) Other	
0.81	Below Poverty Level	porcont	7.1	10.6	9.3	2015-2019	(13.6) Hisp (10.8)	1
0.81		percent	/.1	10.0	9.3	2015-2019	(10.8)	1
0.81	Total Employment Change	porcont	4.2	2.9	1.6	2018-2019		18
0.01		percent	4.2	2.9	1.0	2018-2019		10
0.69	Severe Housing Problems	percent	12.9	17.4	18	2013-2017		6
0.09		percent	12.9	17.4	10	2013-2017		0
	Unemployed Workers in Civilian							
0.69	Labor Force	percent	5.1	6.7	6.1	44348		17
0.05	Child Food	percent	5.1	0.7	0.1			1/
0.67	Insecurity Rate	percent	13.3	19.6	14.6	2019		7
	Households with	percent	10.0	2010	1.110	2023		
	Cash Public							
0.64	Assistance Income	percent	0.8	1.4	2.4	2015-2019		1
	Population 16+ in	P						
	Civilian Labor							
0.64	Force	percent	68.1	61	59.6	2015-2019		1

Above Poverty Above Poverty 0.36 Level percent 82.9 65.7 69.1 2015-2019 Median Housing 2E+0 2E+0 2E+0 2E+0 0.33 Unit Value dollars 315300 5 5 2015-2019 Black (9.7) White (3.4) Asian (3.7) AlAN (4.4) Asian (3.7) AlAN (4.4) NHPI (2.2) Children Living Mult (6.6) Mult (6.6) Other (22.8)	1
0.33 Unit Value dollars 315300 5 5 2015-2019 Black (9.7) White (3.4) White (3.4) Asian (3.7) Asian (3.7) AIAN (4.4) NHPI (2.2) NHPI (2.2) Mult (6.6) Mult (6.6)	1
Black (9.7) White (3.4) Asian (3.7) AIAN (4.4) NHPI (2.2) Children Living Mult (6.6)	1
White (3.4) Asian (3.7) AIAN (4.4) NHPI (2.2) Children Living Mult (6.6)	-
Asian (3.7) AIAN (4.4) NHPI (2.2) Children Living Mult (6.6)	
AIAN (4.4) NHPI (2.2) Children Living Mult (6.6)	
NHPI (2.2) Children Living Mult (6.6)	
Children Living Mult (6.6)	
Below Poverty Other (22.8)	
Other (22.8)	
0.08 Level percent 7 20.9 18.5 2015-2019 Hisp (17.5)	1
Black (6.8)	
White (2.7)	
Asian (3.8)	
AIAN (6.6)	
NHPI (3) Mult	
Families Living (7.1) Other	
Below Poverty (10.2) Hisp	
0.08 Level percent 4.4 11.3 9.5 2015-2019 (11.5)	1
Median Household 6187 6284	
0.08 Income dollars 96913 4 3 2015-2019	1
3127 3410	
0.08 Per Capita Income dollars 44548 7 3 2015-2019	1
Persons with	
Disability Living in	
0.08 Poverty (5-year) percent 9.5 23.2 26.1 2015-2019	

								Black (7.6)	
								White (4.3)	
								Asian (5.8)	
								AIAN (9.1)	
								NHPI (4.5)	
	People Living							Mult (7.1)	
	Below Poverty							Other (14.8)	
0.00	Level	percent	6.3	8	14.7	13.4	2015-2019	Hisp (12.9)	1

SCORE	EDUCATION	UNITS	COLLIN COUNTY	HP2030	ΤХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Student-to-								
1.69	Teacher Ratio	students/ teacher	14.8				2019-2020		10
								Black (2)	
								White (0.8)	
								Asian (0.3)	
								AIAN (2.7) PI	
	High School Drop							(0) Mult (0.8)	
1.14	Out Rate	percent	1.2		1.9		2019	Hisp (2.3)	14
								Black (3.7)	
	Infants Born to							White (2.1)	
	Mothers with <12							Other (2.3)	
0.61	Years Education	percent	6.2		17.4	13.3	2017	Hisp (22.2)	13
	People 25+ with a								
	High School								
0.53	Degree or Higher	percent	93.8		83.7	88	2015-2019		1
	People 25+ with a								
	Bachelor's Degree								
0.08	or Higher	percent	52.3		29.9	32.1	2015-2019		1

SCORE	ENVIRONMENTAL HEALTH	UNITS	COLLIN COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
JEONE	Asthma: Medicare	01113	COONTI	1172030		0.5.	FERIOD	HIGH DISPARTT	Jource
2.19	Population	percent	5.4		4.9	5	2018		5
	Fast Food	restaurants/	_						
2.14	Restaurant Density	1,000 population	0.9				2016		20
	WIC Certified	stores/ 1,000							
2.00	Stores	population	0.1				2016		20
	SNAP Certified	stores/ 1,000							
1.86	Stores	population	0.4				2017		20
	Grocery Store	stores/ 1,000							
1.83	Density	population	0.1				2016		20
	Annual Ozone Air								
1.75	Quality		F				2017-2019		2
	Number of								
1.64	Extreme Precipitation Days	days	39				2016		11
1.04	Farmers Market	markets/ 1,000	39				2010		
1.50	Density	population	0				2018		20
1.50	Months of Mild	population	0				2010		
1.36	Drought or Worse	months per year	5				2016		11
	Number of								
1.36	Extreme Heat Days	days	5				2016		11
	Number of								
	Extreme Heat								
1.36	Events	events	2				2016		11
1.36	PBT Released	pounds	369.9				2019		21
	Recognized								
	Carcinogens								
1.36	Released into Air	pounds	105.6				2019		21

	Children with Low					
1.33	Access to a Grocery Store	percent	3.8		2015	20
1.17	Daily Dose of UV Irradiance	Joule per square meter	3218	3538	2015	11
	People with Low Access to a					
1.17	Grocery Store	percent	12.7		2015	20
1.14	Overcrowded Households	percent of households	2.4	4.8	2015-2019	1
1.08	Weeks of Moderate Drought or Worse	wooks par yoar	2		2016	11
1.08		weeks per year	3		2016	11
1.06	Liquor Store Density	stores/ 100,000 population	6.5	6.9	10.5 2019	18
1.00	Households with No Car and Low Access to a Grocery Store	percent	0.6		2015	20
1.00	Low-Income and Low Access to a Grocery Store	percent	2.3		2015	20
1.00	People 65+ with Low Access to a Grocery Store	percent	0.9		2015	20
1.00	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1		2016	20
0.75	Adults with Current Asthma	percent	8		9.2 2018	203
0.75	can che / Schind	percent	0		5.2 2010	5

0.69	Severe Housing Problems	percent	12.9	17.4	18	2013-2017	6
0.67	Access to Exercise Opportunities	percent	90.1	80.5	84	2020	6
0.53	Food Environment Index		8.4	5.9	7.8	2021	6

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	COLLIN COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Adults who have								
1.75	had a Routine Checkup	percent	74.1			76.7	2018		3
	Adults without								
1.58	Health Insurance	percent	16.5			12.2	2018		3
1.50	Children with Health Insurance	percent	92		87.3	94.3	2019		1
1.50	Adults with Health	percent	52		07.5	54.5	2019		I
1.33	Insurance	percent	85.9		75.5	87.1	2019		1
	Non-Physician	providers/							
	Primary Care	100,000							
1.33	Provider Rate	population	76.2		88.6		2020		6
	Persons with								
1.25	Health Insurance	percent	87.5	92.1	79.3		2019		19
		workers/ 100,000							
1.08	Social Worker Rate	population	69.2		82.7		2020		13
	Adults who Visited								
0.92	a Dentist	percent	69.1			66.5	2018		3
	N A a stall the alth	providers/			120				
0.67	Mental Health Provider Rate	100,000 population	123.6		120. 9		2020		6
0.07		dentists/ 100,000	125.0				2020		0
0.33	Dentist Rate	population	68.6		59.6		2019		6
0.00	Sentise nuce	providers/	00.0						5
	Primary Care	100,000							
0.33	Provider Rate	population	101.4		60.9		2018		6

SCORE STROKE UNITS COUNTY HP2030 TX U.S. PERIOD HIGH DISPARIT	* Source
Atrial Fibrillation:	
Medicare	
2.75 Population <i>percent</i> 9 7.8 8.4 2018	5
Hyperlipidemia:	
Medicare	
2.50 Population <i>percent</i> 55.2 49.5 47.7 2018	5
Adults who Have	
Taken Medications	
for High Blood	-
2.08 Pressure <i>percent</i> 73.4 75.8 2017	3
Hypertension:	
Medicare 59.9 57.2 2018	5
Ischemic Heart Disease: Medicare	
1.92 Population <i>percent</i> 27.8 29 26.8 <i>2018</i>	5
Age-Adjusted ER ER visits/ 10,000	
Rate due to population 18+	
1.75 Hypertension <i>years</i> 28.2 10.5 2017-2019	16
Age-Adjusted hospitalizations/	
Hospitalization 10,000	
Rate due to population 18+	10
1.75 Hypertension years 0.4 0.1 2017-2019	16
Stroke: Medicare1.69Populationpercent4.14.23.82018	5
1.69 Population percent 4.1 4.2 3.8 2018 High Blood High Blood	5
Pressure	
0.94 Prevalence <i>percent</i> 29.6 27.7 32.4 2017	3

	Cholesterol Test							
0.92	History	percent	83.6			81.5	2017	3
	High Cholesterol							
	Prevalence: Adults							
0.92	18+	percent	32.3			34.1	2017	3
	Age-Adjusted							
	Death Rate due to							
	Cerebrovascular	deaths/ 100,000						
0.86	Disease (Stroke)	population	34.1	33.4	40.2	37.2	2017-2019	4
	Age-Adjusted	deaths/ 100,000						
	Death Rate due to	population 35+						
0.86	Heart Attack	years	46.9		70.1		2018	11
	Adults who							
	Experienced a							
0.75	Stroke	percent	2.4			3.4	2018	3
	Adults who							
	Experienced							
	Coronary Heart							
0.75	Disease	percent	5			6.8	2018	3
	Heart Failure:							
	Medicare							
0.64	Population	percent	11.7		15.6	14	2018	 5
	Age-Adjusted							
	Death Rate due to							
	Coronary Heart	deaths/ 100,000						
0.06	Disease	population	64.6	71.1	93	90.5	2017-2019	 4

	IMMUNIZATIONS & INFECTIOUS								
CODE			COLLIN				MEASUREMENT		Course
SCORE	DISEASES	UNITS	COUNTY	HP2030	ТХ	U.S.	PERIOD	HIGH DISPARITY*	Source
	Age-Adjusted								
	Hospitalization								
	Rate due to								
	Immunization-	hospitalizations/							
	Preventable	10,000							
	Pneumonia and	population 18+							
1.75	Influenza	years	0.3		0.1		2017-2019		16
		cases/ 100,000							
1.64	HIV Diagnosis Rate	population	9.8		15.7		2018		13
	COVID-19 Daily								
	Average Case-	deaths per 100							
1.42	Fatality Rate	cases	1.6		4.3	2	24-Sep-21		8
	Gonorrhea	cases/ 100,000			163.				
1.33	Incidence Rate	population	89.2		6	179.1	2018		13
	Tuberculosis	cases/ 100,000							
1.28	Incidence Rate	population	2.6	1.4	4.3		2015-2019		13
	Syphilis Incidence	cases/ 100,000							
1.22	Rate	population	3		8.8	10.8	2018		13
	Overcrowded	percent of							
1.14	Households	households	2.4		4.8		2015-2019		1
	Chlamydia	cases/ 100,000			508.				
1.06	Incidence Rate	population	284.5		2	539.9	2018		13
	Age-Adjusted								
	Death Rate due to								
	Influenza and	deaths/ 100,000							
0.89	Pneumonia	population	10.6		11.8	13.8	2017-2019		4
0.00	· ···cumonia	population	10.0		11.0	10.0	2017 2013		т

	COVID-19 Daily						
	Average Incidence	cases per 100,000					
0.69	Rate	population	32.3	47.1	51.4	24-Sep-21	8

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	COLLIN COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Mothers who								
	Received Early								
1.72	Prenatal Care	percent	65.9		60.5	77.3	2017		13
1.22	Preterm Births	percent	10.9	9.4	12.2		2017		13
								Black	
								(2.66393442)	
								(2.00333442) White	
								(0.88834697)	
								Other	
								(1.1111111)	
	Babies with Very							Hisp	
1.11	Low Birth Weight	percent	1.1			1.4	2015	(0.88062622)	13
								Black (1.1)	
								White (0.4)	
								Other (0) Hisp	
0.94	Teen Births	percent	0.6		2.1	3.1	2017	(1.5)	13
	Infant Mortality	deaths/ 1,000 live							
0.81	Rate	births	4	5	5.6	5.9	2015		13
								Black (3.7)	
	Infants Born to							White (2.1)	
	Mothers with <12							Other (2.3)	
0.61	Years Education	percent	6.2		17.4	13.3	2017	Hisp (22.2)	13
	Babies with Low								
0.50	Birth Weight	percent	7.2		8.2	8.1	2015		13
	MENTAL HEALTH		COLLIN						
	& MENTAL		COUNT	HP203			MEASUREMEN	HIGH	
SCORE	DISORDERS	UNITS	Υ	0	ТΧ	U.S.	T PERIOD	DISPARITY*	Source

	Depression:							
	Medicare							
2.42	Population	percent	19.5		18.2	18.4	2018	
	Alzheimer's							
	Disease or							
	Dementia:							
	Medicare							
2.25	Population	percent	12.3		12.6	10.8	2018	
	Age-Adjusted	hospitalizations/						
	Hospitalization	10,000						
	Rate due to Adult	population 18+						
1.75	Mental Health	years	2.2		1.7		2017-2019	
	Age-Adjusted ER	ER visits/ 10,000						
	Rate due to Adult	population 18+						
1.25	Mental Health	years	4.3		8.9		2017-2019	
	Age-Adjusted							
	Death Rate due to	deaths/ 100,000						
0.81	Suicide	population	11.4	12.8	13.5	14.1	2017-2019	
	Poor Mental							
0.75	Health: 14+ Days	percent	10.6			12.7	2018	
	Frequent Mental							
0.67	Distress	percent	10.6		11.6	13	2018	
		providers/						
	Mental Health	100,000			120.			
0.67	Provider Rate	population	123.6		9		2020	

SCORE	OLDER ADULTS	UNITS	COLLIN COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Osteoporosis:					0.0.			
	Medicare								
2.92	Population	percent	8.2		6.8	6.6	2018		5
	Atrial Fibrillation:								
	Medicare								
2.75	Population	percent	9		7.8	8.4	2018		5
	Hyperlipidemia:								
	Medicare								
2.50	Population	percent	55.2		49.5	47.7	2018		5
	Cancer: Medicare								
2.47	Population	percent	8.7		7.6	8.4	2018		5
	Depression:								
	Medicare								
2.42	Population	percent	19.5		18.2	18.4	2018		5
	Alzheimer's								
	Disease or								
	Dementia:								
2.25	Medicare	norcont	12.3		12.6	10.8	2018		5
2.25	Population	percent	12.3		12.0	10.8	2018		5
2.19	Asthma: Medicare	norcont	5.4		4.9	5	2018		5
2.19	Population	percent	5.4		4.9	5	2018		5
	Chronic Kidney								
2.00	Disease: Medicare	a crecet	24.0		26.7	24 5	2010		F
2.08	Population	percent	24.6		26.7	24.5	2018		5
	Hypertension:								
2.00	Medicare		60.0		50.0	F7 0	2010		-
2.08	Population	percent	60.9		59.9	57.2	2018		5

	Rheumatoid Arthritis or						
	Osteoarthritis: Medicare						
2.08	Population	percent	35.6	34.	2 33.5	2018	5
	Ischemic Heart						
	Disease: Medicare						
1.92	Population	percent	27.8	29	26.8	2018	5
	Stroke: Medicare						
1.69	Population	percent	4.1	4.2	2 3.8	2018	5
	Adults 65+ who						
	Received						
	Recommended						
	Preventive						
1.42	Services: Males	percent	30.4		32.4	2018	3
	Colon Cancer		<u></u>				
1.33	Screening	percent	65.4	74.4	66.4	2018	3
	People 65+ with						
4.00	Low Access to a		0.0			2015	20
1.00	Grocery Store Diabetes:	percent	0.9			2015	20
	Medicare						
0.97	Population	percent	24.9	28.	8 27	2018	5
	Adults 65+ who	p					
	Received						
	Recommended						
	Preventive						
0.92	Services: Females	percent	31.8		28.4	2018	3

								Black (10.1) White (6.3) Asian (8.6) AIAN (14.2) NHPI (0) Mult	
	People 65+ Living							(6.4) Other	
	Below Poverty							(13.6) Hisp	
0.81	Level	percent	7.1		10.6	9.3	2015-2019	(10.8)	1
0.75	Adults 65+ with Total Tooth Loss	percent	8.9			13.5	2018		3
0.75	Adults with		20.4			25.0	2040		2
0.75	Arthritis	percent	20.4			25.8	2018		3
0.64	COPD: Medicare	norcont	8.3		11.2	11.5	2018		F
0.64	Population	percent	8.3		11.2	11.5	2018		5
0.64	Heart Failure: Medicare		447		45.0		2010		_
0.64	Population	percent	11.7		15.6	14	2018		5
SCORE	ORAL HEALTH	UNITS	COLLIN COUNT Y	HP203 0	ТХ	U.S.	MEASUREMEN T PERIOD	HIGH DISPARITY*	Source
	Age-Adjusted ER								
	Rate due to Dental	ER visits/ 10,000							
1.75	Problems	population	18.3		11.1		2017-2019		16
	Oral Cavity and Pharynx Cancer	cases/ 100,000							
1.33	Incidence Rate	population	10.6		11	11.8	2013-2017		9
0.92	Adults who Visited a Dentist		69.1			66.5	2018		3
0.92		percent	09.1			00.5	2010		5

0.75	Adults 65+ with Total Tooth Loss	percent	8.9	13.5	2018	3
		dentists/ 100,000				
0.33	Dentist Rate	population	68.6	59.6	2019	6

	OTHER		COLLIN				MEASUREMENT		
SCORE	CONDITIONS	UNITS	COUNTY	HP2030	ТХ	U.S.	PERIOD	HIGH DISPARITY*	Source
	Osteoporosis:								
	Medicare								
2.92	Population	percent	8.2		6.8	6.6	2018		5
	Chronic Kidney								
	Disease: Medicare								
2.08	Population	percent	24.6		26.7	24.5	2018		5
	Rheumatoid								
	Arthritis or								
	Osteoarthritis:								
	Medicare								
2.08	Population	percent	35.6		34.2	33.5	2018		5
	Adults with								
0.75	Arthritis	percent	20.4			25.8	2018		3
	Adults with Kidney								
0.75	Disease	Percent of adults	2.3			3.1	2018		3

	PHYSICAL		COLLIN				MEASUREMENT		
SCORE	ACTIVITY	UNITS	COUNTY	HP2030	ТΧ	U.S.	PERIOD	HIGH DISPARITY*	Source
	Fast Food	restaurants/							
2.14	Restaurant Density	1,000 population	0.9				2016		20
	WIC Certified	stores/ 1,000							
2.00	Stores	population	0.1				2016		20
	SNAP Certified	stores/ 1,000							
1.86	Stores	population	0.4				2017		20
	Grocery Store	stores/ 1,000							
1.83	Density	population	0.1				2016		20
	Farmers Market	markets/ 1,000							
1.50	Density	population	0				2018		20

	Children with Low						
	Access to a						
1.33	Grocery Store	percent	3.8			2015	20
	People with Low						
	Access to a						
1.17	Grocery Store	percent	12.7			2015	20
	Households with						
	No Car and Low						
	Access to a						
1.00	Grocery Store	percent	0.6			2015	20
	Low-Income and						
	Low Access to a						
1.00	Grocery Store	percent	2.3			2015	20
	People 65+ with						
	Low Access to a						
1.00	Grocery Store	percent	0.9			2015	20
	Recreation and	facilities/ 1,000					
1.00	Fitness Facilities	population	0.1			2016	20
	Access to Exercise	<u> </u>					
0.67	Opportunities	percent	90.1	80.5	84	2020	6
0.07		μετιεπι	30.1	80.5	04	2020	0
	Food Environment					2024	-
0.53	Index		8.4	5.9	7.8	2021	6

S	CORE	PREVENTION & SAFETY	UNITS	COLLIN COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	0.69	Severe Housing Problems	percent	12.9		17.4	18	2013-2017		6
	0.33	Death Rate due to Drug Poisoning	deaths/ 100,000 population	7.3		10.6	21	2017-2019		6
		Age-Adjusted Death Rate due to Unintentional	deaths/ 100,000							
	0.28	Injuries	population	26.5	43.2	38.7	48.9	2017-2019		4

	RESPIRATORY		COLLIN				MEASUREMENT		6
SCORE	DISEASES	UNITS	COUNTY	HP2030	TX	U.S.	PERIOD	HIGH DISPARITY*	Source
	Asthma: Medicare		- 4			_	2010		-
2.19	Population	percent	5.4		4.9	5	2018		5
	Age-Adjusted								
	Hospitalization								
	Rate due to								
	Immunization-	hospitalizations/							
	Preventable	10,000							
4 75	Pneumonia and	population 18+	0.2		0.1		2017 2010		10
1.75	Influenza	years	0.3		0.1		2017-2019		16
	COVID-19 Daily								
	Average Case-	deaths per 100				2			0
1.42	Fatality Rate	cases	1.6		4.3	2	24-Sep-21		8
	Tuberculosis	cases/ 100,000							
1.28	Incidence Rate	population	2.6	1.4	4.3		2015-2019		13
	Age-Adjusted								
	Death Rate due to								
	Influenza and	deaths/ 100,000			_				
0.89	Pneumonia	population	10.6		11.8	13.8	2017-2019		4
0.83	Adults who Smoke	percent	11.8	5		15.5	2018		3
0.75	Adults with COPD	Percent of adults	4.6			6.9	2018		3
	Adults with								
0.75	Current Asthma	percent	8			9.2	2018		3
	COVID-19 Daily								
	Average Incidence	cases per 100,000							
0.69	Rate	population	32.3		47.1	51.4	24-Sep-21		8
	COPD: Medicare								
0.64	Population	percent	8.3		11.2	11.5	2018		5

	0.11	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	27.3	25.1	34.1	38.5	2013-2017		9
ļ	0.08	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	42.5		50.6	58.3	2013-2017		9
	SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	COLLIN COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1			cases/ 100,000							
	1.64	HIV Diagnosis Rate	population	9.8		15.7		2018		13
1		Gonorrhea	 cases/ 100,000			163.				
	1.33	Incidence Rate	population	89.2		6	179.1	2018		13
		Syphilis Incidence	cases/ 100,000							
	1.22	Rate	population	3		8.8	10.8	2018		13
		Chlamydia	cases/ 100,000			508.				
	1.06	, Incidence Rate	population	284.5		2	539.9	2018		13
		WELLNESS &		COLLIN				MEASUREMENT		
	SCORE	LIFESTYLE	UNITS	COUNTY	HP2030	ТΧ	U.S.	PERIOD	HIGH DISPARITY*	Source
	1.25	Insufficient Sleep	percent	35	31.4	34.4	35	2018		6
		High Blood								
		Pressure								
	0.94	Prevalence	percent	29.6	27.7		32.4	2017		3
		Poor Physical								
	0.75	Health: 14+ Days	percent	9.6			12.5	2018		3
		Frequent Physical								_
ļ	0.50	Distress	percent	9.3		11.6	11	2018		6
1										

			COLLIN				MEASUREMENT		
SCORE	WOMEN'S HEALTH	UNITS	COUNTY	HP2030	ТХ	U.S.	PERIOD	HIGH DISPARITY*	Source
	Breast Cancer	cases/ 100,000			112.				
2.58	Incidence Rate	females	127.2		8	125.9	2013-2017		9
	Cervical Cancer								
1.22	Screening: 21-65	Percent	84.3	84.3		84.7	2018		3
	Mammogram in								
0.94	Past 2 Years: 50-74	percent	76.2	77.1		74.8	2018		3
0.64	Age-Adjusted Death Rate due to	deaths/ 100,000	16.2	15.2	10.0	20.1	2012 2017		0
0.64	Breast Cancer	females	16.3	15.3	19.8	20.1	2013-2017		9
	Cervical Cancer	cases/ 100,000							
0.61	Incidence Rate	females	4.4		9.2	7.6	2013-2017		9

Collin County Data Sources

Кеу	Source Title
1	American Community Survey
2	American Lung Association
3	CDC - PLACES
4	Centers for Disease Control and Prevention
5	Centers for Medicare & Medicaid Services
6	County Health Rankings
7	Feeding America
8	Healthy Communities Institute
9	National Cancer Institute
10	National Center for Education Statistics
11	National Environmental Public Health Tracking Network
12	Texas Department of Family and Protective Services
13	DFWHC Foundation Regional Data, Q1-Q4, 2017-2019. DFWHC Foundation, Irving Texas. October 26, 2021
14	Texas Education Agency
15	Texas Secretary of State
16	THR Texas Department of Health Services
17	U.S. Bureau of Labor Statistics
18	U.S. Census - County Business Patterns
19	U.S. Census Bureau - Small Area Health Insurance Estimates
20	U.S. Department of Agriculture - Food Environment Atlas
21	U.S. Environmental Protection Agency
22	United For ALICE

Collin County Topic Scores

Health and Quality of Life Topics	Score
Other Conditions	1.72
Older Adults	1.66
Diabetes	1.44
Heart Disease & Stroke	1.37
Mental Health & Mental Disorders	1.32
Sexually Transmitted Infections	1.31
Physical Activity	1.31
Environmental Health	1.31
Children's Health	1.31
Alcohol & Drug Use	1.30
Immunizations & Infectious Diseases	1.24
Women's Health	1.20
Community	1.13
Health Care Access & Quality	1.10
Economy	1.04
Oral Health	1.02
Maternal, Fetal & Infant Health	0.99
Respiratory Diseases	0.95
Cancer	0.93
Wellness & Lifestyle	0.86
Education	0.81
Prevention & Safety	0.43

Community Input Assessment Tools

Key Informant Interview Guide and Questions

INTRODUCTION

HCI Facilitator: Introduce yourself and any others on the team

OPENING SCRIPT: TEXAS HEALTH RESOURCES (THR) has invited you to take part in this Key Informant Interview because of your content expertise and your experience working in the community. Our work on behalf of THR is focused on understanding what health issues and challenges impact the residents of **COLLIN** County and how to improve their overall health. The insights and perspectives collected in this interview will provide important information that will ultimately be combined with the results of a key informant interviews, focus groups, and data analysis of state and national indicators. These data components will be compiled into a comprehensive report outlining the health needs in the Southern Region which includes **COLLIN** County. The final reports will be completed in the summer of 2022.

CONFIDENTIALITY: For this interview, we will be taking notes on your responses, your names will not be associated with any direct quotes. Your identity will be kept confidential.

1. To begin, could you please tell us a little about the organization you work for and the geographic location it serves?

- a. (only probe if necessary) What is your organization's mission? What are the top priority health issues that your organization addresses?
- b. (only ask if not clear) Does your organization provide direct care, operate as an advocacy organization, or have another role in the community?
- c. Which geographic location(s) does your organization serve? (to help us understand or confirm relevant service areas)

2. Considering the impact of Covid-19, what would you consider the top 5 health issues exacerbated by the pandemic in COLLIN county?

- **a.** What are the possible solutions to improve the health issues you've described?
- **b.** What solutions have your organization/agency put in place or considered to help improve the health issues you described?
- c. How can Texas Health support these health improvement efforts?

- 3. Along the same lines, what would you consider the top 5 socioeconomic needs exacerbated by the pandemic in [County Name/Zip code]?
 - a. What are the possible solutions to improve the socioeconomic needs you've described?
 - b. What specific solutions have your organization/agency put in place or considered to help improve the socioeconomic issues you described?
 - c. How can Texas Health support these socioeconomic improvement efforts?
- 4. Thinking about the solutions you described to address the health and socioeconomic needs, to what extent does your organization/agency have what it needs to deliver these services/resources in the community effectively?
 - a. How do aspects of this community's [County Name/Zip code] infrastructure (i.e., physical environment, policies, partnerships) help or hinder your ability to deliver the services/resources you described?
 - b. How can Texas Health support the success of these services/resources?
- 5. How can community leaders, community-based organizations, and health care systems work collaboratively to address this community's [County Name/Zip codes] health and socioeconomic?
 - a. To your knowledge, what strategies have been used in the past to drive collaboration across these partners? What worked, what didn't, and why?
 - b. What challenges/barriers should Texas Health anticipate in its efforts to work with community leaders and members to address the health and socioeconomic needs in this community?
 - c. How can Texas Health proactively address these challenges/barriers?
- 6. Finally, what do you consider the best practices that are currently going on to improve the health and socio-economic needs in this community [County/Zip codes]?
- 7. What is the most crucial message/feedback you want Texas Health to take away from this interview?
 - a. Is there anything else you would like to add about any of the topics we've discussed or other areas that we didn't discuss but you think are essential?

CLOSING SCRIPT: Thank you so much for your time and participation today. In terms of next steps, we will be collecting and analyzing the data for this needs assessment over the next few months. The final report will be available to everyone who participated, as well as the general public. If you have additional comments or thoughts after our conversation today, please feel free to reach out to *Eileen Aguilar* or Oge/Sika. *HCI Facilitator: Send a follow-up email to the key informant, thanking them for their time and make sure to include a link to the survey!*

Focus Group Guide and Questions

INTRODUCTION

{Introduce Yourself and Others on the Team}

{"Let's get started...}

Opening Script: Thank you for taking the time to speak with us to support the Texas Health Resources (THR) Community Health Needs Assessment. We anticipate that this discussion will last no more than 60 minutes. You have been invited to take part in this focus group because of your experience living and/or working in Collin County. The focus of our Community Health Needs Assessment is how to improve health in the community and understand what challenges residents are facing. We are going to ask a series of questions related to health issues in the community. We hope to get through as many questions as possible and hear each of your perspectives as much as time allows.

For this discussion group, I will invite you to share as much or little as you feel comfortable sharing with the others in the group. The results of this assessment will be made available to the public. We will be taking notes on your responses, but your names will not be associated with any direct quotes. Your identity will be kept confidential, so please share your honest opinions.

SHOW SLIDES (if applicable)--We do have a few ground rules for this virtual discussion that I would like to review with you. It is important that everyone has a chance to be heard, so we ask that only one person talks at a time (most important ground rule for today). You may use the "raise hand" functions when you have something to say [*give instructions and test*]. We may also call on you to sure ensure everyone has a chance to speak but if you have nothing to share, please just say "pass".

You may want to mute yourself when you are not speaking to cut down on background noise [give instructions and test mute/unmute]. Finally, please respect the opinions of others, as the point of the discussion is to collect various points of view. And remember, there are no right or wrong answers, so please share freely and openly. Does anyone have any questions before we get started?

Okay, let's get started by going around and introducing ourselves. Please tell everyone your first name, what community you live in, and if you are interested in sharing, your involvement in the community (could be your job or volunteer work for example). {Introductions}

Thank you for introducing yourselves. Now we will get started with our discussion.

COVID-19 QUESTION

1. We know that COVID-19 has significantly impacted everyone's lives. What have you seen as the biggest challenges in XXXXX County during the pandemic?

[Probe 1: Which groups of people are having the hardest time right now?] [Probe 2: How have you seen these challenges being addressed, if at all?] [Probe 3: What programs have addressed COVID related issues? What has worked?] [Probe 4: What hasn't been effective and, in your opinion, why?]

GENERAL HEALTH QUESTIONS

2. What would you say are the top three health related problems that people in your community are facing that you would like to change or improve?

[Probe 1: Why do you think these are the most important health issues? [Probe 2: What would you do to address these problems?] [Probe 3: What else is needed to address these problems? Examples could be specific policies, programs, or services.]

3. What might prevent someone from accessing care for the health challenges identified above?

[Examples could include lack of transportation, lack of health insurance coverage, doctor's office hours, language, or cultural barriers, etc.]

4. Are there specific groups in your community that are most impacted by the health issues or challenges discussed earlier (2-3)? Which groups are these?

[Probe: Are these health challenges different if the person is a particular age, or gender, race, or ethnicity? Or lives in a certain part of the county for example?]

5. From the health issues and challenges we've just discussed, which do you think can be addressed in the next three years?

[Probe 1: How do you think these health issues can be addressed?} [Probe 2: Are some of these issues more urgent or important than others? If so, why?]

6. In 2019, Depression and anxiety among adults 18+ were identified as important health issues in your community. Do you know of any programs or services that are available in your community to address this issue?

[Prompt: Have you or someone you know benefited from these programs or services? If so, what do you think has worked? What do you think can be improved?]

7. What resources are currently available for residents in your community for the identified health/social determinant problem/s we've discussed today?

[Probe 1: Are there specific community organizations or agencies that you see taking a strong leadership role for improving the health of particular groups in your community?] [Probe 2: Do you see residents taking advantage of them? Why or why not?] [Probe 3: What additional programs and resources do you think are needed to best meet the needs of residents in _____ County?] [Probe 4: Are you aware of any THR-Community Health Improvement program(s) in your community?]

CLOSING QUESTION

8. Can you think of any other ways we could improve the health of residents in the community that we have not already talked about today?

[Probe: Is there anything else you would like to add that we haven't discussed?]

CONCLUSION

{Review the summary points and key takeaways from discussion} {Check if note taker needs any clarification}

CLOSURE SCRIPT: Thank you very much for your time and willingness to share your experiences with us today. We will include your comments in our data to describe how health can be improved for residents in your community. Please remember, your name will not be connected to any of the comments you made today. Please let us know if you have any questions or concerns about this.

Listening Session Questions

- 1. Name of the organization you represent.
- 2. What region/county/counties do your organization provide direct services to? (select all that apply)
 - a. Dallas County
 - b. Rockwall County
 - c. Collin County
 - d. Parker County
 - e. Denton County
 - f. Wise County
 - g. Collin County
 - h. Ellis County
 - i. Erath County
 - j. Henderson County
 - k. Johnson County
 - I. Kaufman County
- 3. In 2019, Texas Health Resources (THR) identified behavioral health, chronic disease prevention and management, access, awareness, health literacy and navigation as its priority areas. Are you aware of any THR programs, initiatives, resources, specifically addressing any of these priorities in your community?
- 4. What is THR doing well within the behavioral health, chronic disease prevention and management, access, health literacy and navigation areas? Feel free to address one or all priorities.
- 5. What are areas of opportunity within these priority areas? Feel free to address one or all priorities.
- 6. What can THR do to improve the awareness of its Community Health Needs Assessment (CHNA) findings and implementation strategies?
- **7.** Texas Health Resources is currently developing its 2022 CHNA reports and have identified these preliminary issues for the following regions:

Southern Region

Healthcare Access & Quality (lack of/limited insurance, delay in care)

Mental Health (depression, anxiety, isolation) Abuse/Violence (domestic violence, child abuse, intimate partner violence) Substance Abuse (isolation leading to increased substance use and addiction)

Denton/Wise Region-

Mental Health (increased need for adolescents, anxiety, lack of behavioral health services) Access to healthcare services (Provider shortages, language barriers, uninsured/underinsured) COVID-19 Impact (mental health, trust in healthcare system, delay in services) Food insecurity (lack of food, access to healthy foods, food deserts)

Tarrant/Parker Region-

Chronic conditions (heart disease, diabetes) COVID-19 Impact (Mental Health/Substance abuse, isolation, financial issues, delay in care, food insecurity) Health Behaviors (fear, stigma towards vaccine) Healthcare Access & Quality (Lack of providers, lack of bilingual providers, uninsured/underinsured)

Dallas/Rockwall Region-

Access to care (delay in care, uninsured, underinsured) Mental Health (isolation, depression exacerbated by COVID-19) Financial/Economic impact (unemployment, housing insecurity) Food insecurity (lack of healthy foods, lack of food)

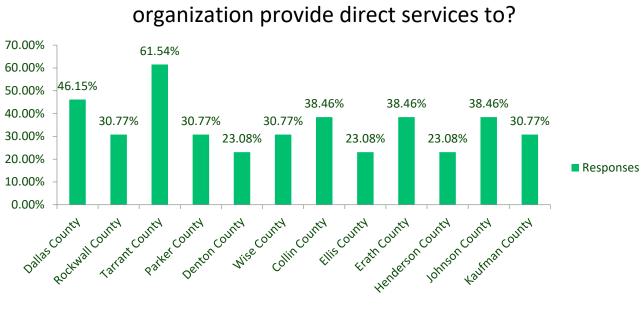
Collin Region-

Access to care (delay in services, high deductibles, affordability of insurance, knowledge of where to get care)

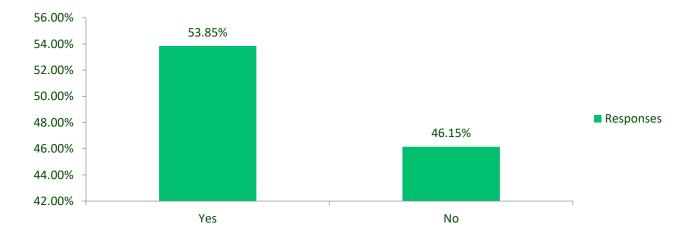
Mental Health (stigma in accessing care, cultural barriers, anxiety) Economic/financial issues (difficulty paying rent/utilities, unemployment, loss of jobs) Housing (lack of affordable housing, discrimination)

7a. How can THR prioritize these health topics that have surfaced as issues in the region?

Listening Session Results



Question #3-Are you aware of any THR programs, initiatives, resources, specifically addressing any of these priorities in your community?



Question #2-What region/county/counties do your organization provide direct services to?

Question #4-What is THR doing well within the behavioral health, chronic health, chronic disease prevention & management, access, health literacy, and navigation areas?

- While there is some generalize awareness of THR efforts, there is not sufficient publicity of these efforts to elicit significant engagement from the public.

-I navigate the Plano Up program funded by THR focusing on anxiety and depression in youth in the 75074 zip. Beyond Blue is another program funded by THR to address mental health in the senior population in the 75069 zip

- The Community Impact program and its regional councils are a great model to impact health priorities.

- It's hard to say due to the Pandemic really. THR has been sending email and reminders to people to do their screenings, testing and seeing their Dr, even telemedicine

- Their willingness to fund organizations that promote access and health literacy is awesome.

- Excellent work with chronic disease prevention and management. Also, good initiative with mental health in rural areas. Doing a good job of bringing these topics, education, and interventions to the people and communities THR serves.

- THR's Community Impact team has done a great job at leveraging relations with community leaders, nonprofits, thought leaders to strengthen efforts to improve health outcomes that are negatively impacted by the social determinants of health. They are also using data to drive their decision and to measure positive improvements in the areas of exercise, health and chronic disease prevention.

- Connect deeper to faith-based organizations, and schools where the under-resource families are nearest and partner with other foundations to strengthen the ability to sustain efforts.

Q5- Are there areas of opportunity within these priority areas? Feel free to address

-Behavioral health partnerships between THR, JPS, and the City of Arlington would be good way to have a meaningful impact on this issue. A formalized partnership with COA/Fire PH unit, Mission Arlington, School Districts, UTA school of Nursing and Social Work, JPS, TCPH and MCA could result in a cost effective and impactful approach to many of these issues.

- I feel mental health is still a large concern. However, I feel healthcare is out of reach for many people even for those with the ability to pay. Living expenses have increased to the point where many people cannot afford to maintain their physical or mental well-being

- There are many opportunities to impact health outcomes - particularly chronic diseasethrough increased awareness and support of patients affected by memory decline. This can include those at risk for cognitive decline (diverse communities are at higher risk, as are those who have comorbidities) and create opportunities for early detection—also, outcomes related to caregiver health.

- With the start of the Pandemic in March 2020, people have not seen their health care providers as they should, thus causing now two years later, many, many additional medical problems.

- Behavioral health is an awesome place to start. We need to train paraprofessionals to go into the neighborhood.

- Health literacy training for health care and service providers would enhance THR's current efforts within chronic disease management.

Question 6- What can THR do to improve the awareness of its Community Health Needs Assessment findings and implementation strategies?

-Partner directly with the City of Arlington Office of Communications

-Present to city and nonprofits the results of the assessment. Many citizens have no idea of the health status of our city.

- More programs focused on prevention and mobile solutions. We have to realize that many people cannot get to appointments even with coverage. Housing, food and transportation costs

- Increasing channels of communication, implementing practical action steps and a starting point for those needing the services, enhanced relationship building with community partners.

- Send them to community orgs as well as posting on their website. If both of these were done, I would recommend a way to ensure that all orgs doing any social service-related work get notified of the CHNA and implementation plan.

- Work directly with Community-Based Organizations (CBOs), such as the Alzheimer's Association or Area Agency on Aging, to promote these results and how a partnership with the CBO will impact the health outcomes. Continue to provide grants to CBOs to ensure that community support continues for all those in need.

- Perhaps THR can advertise the CHNA can run local ads on television and radio.

- As we emerge from the Pandemic, continue to reach those who are not connected by smart phones and emails

- A spot on the major networks or continuous radio spots would help.

- Personally, I think that THR does a great job of disseminating CHNA findings. They and Cook are regional leaders in that work. I'm not sure if THR already works closely with rural Extension

services to disseminate findings and implement programming. If not, that may be another avenue. Also, engaging FQHC's in CHNA implementation strategies is important.

- Take the information out to the community who are impacted the most. (Churches, Schools, Stores, barbershops, beauty shops and perhaps convenience store.

Question #7-How can THR prioritize these health topics that have surfaced as issues in the region? 50.00% 60.00% 50.00% 30.00% 40.00% 20.00% 30.00% 20.00% 10.00% 0.00% Option 1: Keep the health topics Option 2: Specify the issues within Option 3: Other (Explain below) broad and develop aligned each health topic that THR should programs/initiatives. address (e.g. Diabetes, Depression/Anxiety, etc.). Responses

> -59

Community Resource and Partner List

This highlights existing resources that organizations are currently using and available widely in the community. It also highlights community partners who were involved during the collection process for this CHNA.

Community Resource List

- Area Agency on Aging
- Beyond Blue Grant
- Branch Baptist Church
- Carevide Farmersville Family Medical Center
- City on a Hill
- Collin County Assistance Center
- Collin County Mental Health Mental Retardation Center
- Community Health Impact Leadership Council for Collin County: Beyond Blue Grant
- Community Lifeline Center
- CoServ Electric
- Douglas Community Clinic
- Food for Kids Initiative
- Hillcrest Animal Rescue to provide dog/cat food to food banks
- Julia's Center
- Life Path
- North Texas Food Bank
- One Month Away Programs
- Plano UP Program
- Serve Denton
- The Hope Clinic of McKinney
- TXU Energy Foundation
- United Methodist Church runs through Farmersville Outreach Alliance
- VFW programs
- 211

Community Partner List

- Branch Baptist Church
- Collin County Mental Health Mental Retardation Center
- Community Lifeline Center

Appendix B. Dallas/Rockwall Region

TEXAS HEALTH RESOURCES

DALLAS/ROCKWALL REGION

APPENDICES

Secondary Data Methodology

Secondary Data Sources

The main source for the secondary data, or data that has been previously collected, is the community indicator database maintained by Conduent Healthy Communities Institute. The following is a list of both local and national data sources used in Texas Health Resources Dallas County and Rockwall County regional Community Health Needs Assessment report.

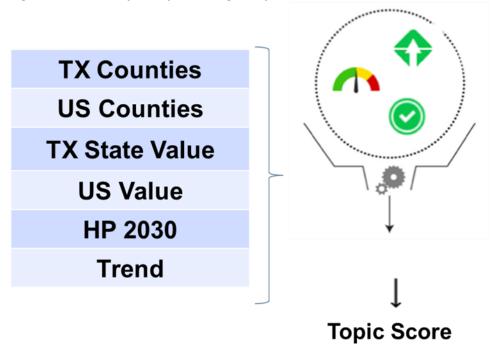
Data Sources

- American Community Survey
- American Lung Association
- CDC PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- County Health Rankings
- Feeding America
- Healthy Communities Institute
- National Cancer Institute
- National Center for Education Statistics
- National Environmental Public Health Tracking Network
- Texas Department of Family and Protective Services
- DFWHC Foundation Regional Data, Q1-Q4, 2017-2019. DFWHC Foundation, Irving Texas. October 15, 2021,

- Texas Education Agency
- Texas Department of Health Services
- U.S Bureau of Labor Statistics
- U.S. Census County Business Patterns
- U.S. Census Bureau Small Area Health Insurance Estimates
- U.S. Department of Agriculture Food Environment Atlas
- U.S. Environmental Protection Agency
- United for ALICE

Secondary Data Scoring

HCl's Data Scoring Tool (Figure 1A) was used to systematically summarize multiple comparisons in order to rank indicators based on highest need. For each indicator, the community value was compared to a distribution of Texas and US counties, state and national values, Healthy People 2030, and significant trends were noted. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities and changes in methodology over time. The comparison scores were summarized for each indicator, and indicators were then grouped into topic areas for a systematic ranking of community health needs. Figure 1A: Summary of Topic Scoring Analysis



Index of Disparity

An important part of the CHNA process is to identify health disparities, the needs of vulnerable populations and unmet health needs or gaps in services. There were several ways in which subpopulation disparities were examined by county. For secondary data health indicators, the Index of Disparity tool was utilized to see if there were large, negative, and concerning differences in indicator values between each subgroup data value and the overall county value. The Index of Disparity was run for each county, and the indicators with the highest race or ethnicity index value were found.

Health Equity Index

Every community can be described by various social and economic factors that can contribute to disparities in health outcomes. Conduent HCI's Health Equity Index (formerly SocioNeeds [®] Index) considers validated indicators related to income, employment, education, and household environment to identify areas at highest risk for experiencing health inequities.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic needs correlated with preventable hospitalizations and premature death.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Health Equity Index, with darker coloring associated with higher relative need.

Food Insecurity Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in outcomes and opportunities to thrive. Conduent HCI's Food Insecurity Index considers validated indicators related to income, household environment and well-being to identify areas at highest risk for experiencing food insecurity.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest food insecurity, which is correlated with household and community measures of food-related financial stress such as Medicaid and SNAP enrollment.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Food Insecurity Index, with darker coloring associated with higher relative need.

Mental Health Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in mental health outcomes. Conduent HCI's Mental Health Index considers validated indicators related to access to care, physical health status, transportation, employment and household environment to identify areas at highest risk for experiencing poor mental health.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic and health needs correlated with self-reported poor mental health.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Mental Health Index, with darker coloring associated with higher relative need.

Data Considerations

Several limitations of data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and health-related areas, data availability varies by health topic. Some topics contain a robust set of secondary data indicators, while others may have a limited number of indicators or limited subpopulations covered by those specific indicators. Data scores represent the relative community health need according to the secondary data for each topic and should not be considered a comprehensive result on their own. In addition, these scores reflect the secondary data results for the population as a whole and do not represent the health or socioeconomic need that is much greater for some subpopulations. Moreover, many of the secondary data indicators included in the findings are collected by survey, and though specific methods are used to best represent the population at large, these measures are subject to instability, especially for smaller populations. The Index of Disparity is also limited by data availability, where indicator data varies based on the population groups and service areas being analyzed.

Race or ethnic and Special Population Groupings

The secondary data presented in this report derive from multiple sources, which may present race and ethnicity data using dissimilar nomenclature. For consistency with data sources throughout the report, subpopulation data may use different terms to describe the same or similar groups of community members.

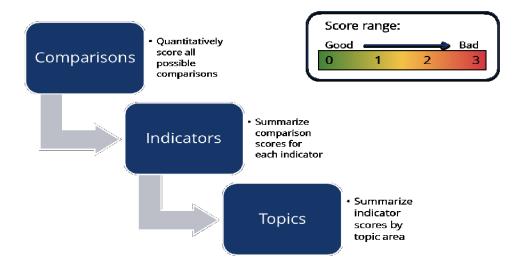
Zip Codes and Zip Code Tabulation Areas

This report presents both Zip Code and Zip Code Tabulation Area (ZCTA) data. Zip Codes, which were created by the U.S. Postal Service to improve mail delivery service, are not reported in this assessment as they may change, include P.O. boxes or cover large unpopulated areas. This assessment cover ZCTAs or Zip Code Tabulation Areas which were created by the U.S. Census Bureau and are generalized representations of Zip Codes that have been assigned to census blocks.

Demographics for this report are sourced from the United States Census Bureau, which presents ZCTA estimates. Tables and figures in the Demographics section of this report reference Zip Codes in title (for purposes of familiarity) but show values of ZCTAs. Data from other sources are labeled as such.

Secondary Data Scoring Detailed Methodology

Data Scoring is done in three stages:



For every indicator available, each county in the Hospital Service Area is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time. Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic. Secondary data for this report are up to date as of November 1, 2021.

Comparison to a Distribution of County Values: Within State and Nation

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

Comparison to Values: State, National, and Targets

The county is compared to the state value, the national value, and target values. Target values include the nation-wide Healthy People 2030 (HP2030) goals. Healthy People 2030 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' (DHHS) Healthy People Initiative. For all value comparisons, the scoring depends on whether the county value is better or worse than the comparison value, as well as how close the county value is to the target value.

Trend Over Time

The Mann-Kendall statistical test for trend was used to assess whether the county value is increasing over time or decreasing over time, and whether the trend is statistically significant. The trend comparison uses the four most recent comparable values for the county, and statistical significance is determined at the 90% confidence level. For each indicator with values available for four time periods, scoring was determined by direction of the trend and statistical significance.

Missing Values

Indicator scores are calculated using the comparison scores, availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators on the community dashboard, it will be included in the indicator score. After exclusion of comparison types with inadequate availability, all missing comparisons are substituted with a neutral score for the purposes of calculating the indicator's weighted average. When information is unknown due to lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

Indicator Scoring

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated, and the indicator is excluded from the data scoring results.

Topic Scoring

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. Resulting scores range from 0-3, where a higher score indicates a greater level of need as evidenced by the data. A topic score is only calculated if it includes at least three indicators.

County Data Scoring Indicators Results

Dallas County Indicator Scores

SCORE	ALCOHOL & DRUG USE	UNITS	DALLAS COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
JCORE		percent of driving	COONTI	117 2030		0.5.	FERIOD	HIGH DISPART	Jource
	Alcohol-Impaired	deaths with alcohol							
1.94	•	involvement	30.6	28.3	25.7	27	2015-2019		7
1.94	Driving Deaths	mvoivement	30.0	28.5	25.7	27	2015-2019		/
1.02	Adults who Binge	noveoiet	17 4			10 4	2010		л
1.92	Drink	percent	17.4			16.4	2018		4
		ER visits/ 10,000							
	Age-Adjusted ER Rate	population 18+							. –
1.75	due to Opioid Use	years	3.5		0.7		2017-2019		17
		ER visits/ 10,000							
	Age-Adjusted ER Rate	population 18+							
1.75	due to Substance Use	years	32.2		20.6		2017-2019		17
	Age-Adjusted	hospitalizations/							
	Hospitalization Rate	10,000 population							
1.75	due to Opioid Use	18+ years	0.3		0.1		2017-2019		17
	Age-Adjusted	hospitalizations/							
	Hospitalization Rate	10,000 population							
1.75	due to Substance Use	18+ years	1.4		1.2		2017-2019		17
1.75		101 years	1.7		1.2		2017 2015		1/
	Age-Adjusted Drug	_ ,							
	and Opioid-Involved	Deaths per 100,000							
1.50	Overdose Death Rate	population	15.7		12.1	22.8	2017-2019		5
	Death Rate due to	deaths/ 100,000							
1.39	Drug Poisoning	population	13		10.6	21	2017-2019		7
		stores/ 100,000							
1.39	Liquor Store Density	population	7.4		6.9	10.5	2019		19

			DALLAS				MEASUREMENT		
SCORE	CANCER	UNITS	COUNTY	HP2030	ТХ	U.S.	PERIOD	HIGH DISPARITY*	Source
	Colon Cancer	_							_
2.33	Screening	percent	56.2	74.4		66.4	2018		4
	Cancer: Medicare								
1.97	Population	percent	8.4		7.6	8.4	2018		6
	Cervical Cancer								
1.94	Screening: 21-65	Percent	80.3	84.3		84.7	2018		4
	Age-Adjusted Death							Black (35.4)	
	Rate due to Prostate	deaths/ 100,000						White (17.6)	
1.86	Cancer	males	19.6	16.9	17.6	19	2013-2017	Hisp (14.1)	10
	Breast Cancer	cases/ 100,000			112.	125.		<u> </u>	
1.81	Incidence Rate	females	118.8		8	9	2013-2017		10
	Age-Adjusted Death								
	Rate due to Breast	deaths/ 100,000							
1.69	Cancer	females	21.2	15.3	19.8	20.1	2013-2017		10
1.05	All Cancer Incidence	cases/ 100,000	21.2	10.0	407.	448.	2010 2017		
1.64	Rate	population	421.1		407. 7	440. 7	2013-2017		10
1.04		population	421.1		/	/	2013 2017		
	Age-Adjusted Death	1							
	Rate due to	deaths/ 100,000	4 4 7	0.0	12.0	407	2012 2017		10
1.44	Colorectal Cancer	population	14.7	8.9	13.9	13.7	2013-2017		10
	Oral Cavity and	araaa (100 000							
1.39	Pharynx Cancer Incidence Rate	cases/ 100,000	11.1		11	11.8	2013-2017		10
1.59		population	11.1		11		2013-2017		
4.96	Prostate Cancer	cases/ 100,000	00.4		0.4	104.	2042 2047		40
1.36	Incidence Rate	males	98.4		94	5	2013-2017		10
	Cervical Cancer	cases/ 100,000							
1.33	Incidence Rate	females	9.1		9.2	7.6	2013-2017		10
	Mammogram in Past								
1.28	2 Years: 50-74	percent	71.2	77.1		74.8	2018		4

	Colorectal Cancer	cases/ 100,000							
1.19	Incidence Rate	population	38.2		37.6	38.4	2013-2017		10
1115	Age-Adjusted Death	deaths/ 100,000	30.2		148.	155.	2010 2017		10
0.83	Rate due to Cancer	population	149.9	122.7	140. 8	155. 5	2013-2017		10
0.75	Adults with Cancer	percent	5.4	122.7	0	6.9	2018		4
0.75	Lung and Bronchus	percent	5.4			0.9	2018		4
	Cancer Incidence	cases/ 100,000							
0.42	Rate	population	49.2		50.6	58.3	2013-2017		10
0.42	nate	population	+5.2		50.0	50.5	2013 2017		10
								Black (42.6)	
	Age-Adjusted Death	do at h o / 100 000						White (36.7)	
0.22	Rate due to Lung	deaths/ 100,000	22.2	2E 1	24.1	<u> 20 г</u>	2012 2017	API (16.1) Hisp	10
0.33	Cancer	population	32.3	25.1	34.1	38.5	2013-2017	(12.9)	10
			DALLAS	HP203			MEASUREMEN	HIGH	<u> </u>
SCORE	CHILDREN'S HEALTH	UNITS	COUNTY	0	ТХ	U.S.	T PERIOD	DISPARITY*	Source
	Child Food Insecurity								_
1.83	Rate	percent	20.3		19.6	14.6	2019		8
	Children with Health								
1.83	Insurance	percent	83		87.3	94.3	2019		1
	Projected Child Food								
1.75	Insecurity Rate	percent	24.9		23.6		2021		8
	Substantiated Child	cases/ 1,000							
1.72	Abuse Rate	children	9.8	8.7	9.1		2020		13
	Children with Low								
	Access to a Grocery								
1.50	Store	percent	4.6				2015		21
	Food Insecure								
	Children Likely								
	Ineligible for								
1.50	Assistance	percent	28		34	23	2019		8

			DALLAS	HP203			MEASUREMEN	HIGH	
SCORE	COMMUNITY	UNITS	COUNTY	0	тх	U.S.	T PERIOD	DISPARITY*	Source
	Solo Drivers with a								
2.92	Long Commute	percent	43.2		38.9	37	2015-2019		7
	Median Monthly	-							
	Owner Costs for								
	Households without								
2.67	a Mortgage	dollars	596		514	500	2015-2019		1
2.64	Homeownership	percent	45.8		54.9	56.2	2015-2019		1
	Persons with Health								
2.58	Insurance	percent	74.9	92.1	79.3		2019		20
	Mean Travel Time to								
2.42	Work	minutes	27.7		26.6	26.9	2015-2019		1
2.36	Linguistic Isolation	percent	10.8		7.7	4.4	2015-2019		1
	Single-Parent								
2.36	Households	percent	30.5		26.3	25.5	2015-2019		1
	Median Household				104	106			
2.33	Gross Rent	dollars	1105		5	2	2015-2019		1
		membership							
		associations/							
2.19	Social Associations	10,000 population	7.4		7.5	9.3	2018		7
	Mortgaged Owners								
	Median Monthly				160	159			
2.17	Household Costs	dollars	1600		6	5	2015-2019		1
		percent of driving							
	Alcohol-Impaired	deaths with alcohol							
1.94	Driving Deaths	involvement	30.6	28.3	25.7	27	2015-2019		7
	Children Living Below								
1.75	Poverty Level	percent	23.3		20.9	18.5	2015-2019		1

	Substantiated Child	cases/ 1,000							
1.72	Abuse Rate	children	9.8	8.7	9.1		2020		13
	People Living Below								
1.67	Poverty Level	percent	15.4	8	14.7	13.4	2015-2019		1
	Voter Turnout:								
1.67	Presidential Election	percent	58.3		58.8		2016		16
	People 25+ with a								
	High School Degree								
1.58	or Higher	percent	79.3		83.7	88	2015-2019		1
	Persons with an								
1.58	Internet Subscription	percent	82.2		84.2	86.2	2015-2019		1
	Workers who Drive								
1.58	Alone to Work	percent	78.8		80.5	76.3	2015-2019		1
	Total Employment								
1.47	Change	percent	2.1		2.9	1.6	2018-2019		19
	Households with an								
1.33	Internet Subscription	percent	81.3		82.1	83	2015-2019		1
	Workers Commuting by Public							Black (5.5) White (1.8) Asian (2) AIAN (2.2) NHPI (0) Mult (1.7) Other (2.1)	
1.22	Transportation	percent	2.6	5.3	1.4	5	2015-2019	Hisp (1.7)	1
	Age-Adjusted Death Rate due to Motor Vehicle Traffic	deaths/ 100,000							
1.17	Collisions	population	11.2	10.1	13	11.3	2017-2019		5
		workers/ 100,000							
1.14	Social Worker Rate	population	91.5		82.7		2020		14

Households with No Car and Low Access 2015 21 1.00 to a Grocery Store percent 1.2 2015 21 Households with One or More Types of - - 2 2015 21 1.00 Computing Devices percent 90.4 91 90.3 2015-2019 1 1.00 Computing Devices percent 174900 5 505 2015-2019 1 1.00 Value dollars 174900 5 505 2015-2019 1 9.07 Civilian Labor Force percent 65.5 61 59.6 2015-2019 1 9.09 Income dollars 59607 74 43 2015-2019 1 9.01 Income dollars 59607 74 43 2015-2019 1 9.058 Income dollars 59607 74 43 2015-2019 1 9.58 Force percent 61.5 57.8 58.3 2										
1.00to a Grocery Storepercent1.2 2015 21Households with One or More Types of<		Households with No								
Households with One or More Types of Computing Devices percent 90.4 91 90.3 2015-2019 1 Median Housing Unit 2E+0 2E+ 100 Value dollars 174900 5 0.5 2015-2019 1 Population 16+ in 100 Value dollars 174900 5 0.5 2015-2019 1 0.97 Civilian Labor Force percent 65.5 61 59.6 2015-2019 1 Median Household 618 628 1 100 10 10 Female Population 16+ in Civilian Labor 10 10 10 10 10 Female Population 16+ in Civilian Labor 10 10 10 10 10 10 10 People 25+ with a Bachelor's Degree or 31.5 29.9 32.1 2015-2019 1 10 0.58 Higher percent 31.5 29.9 32.1 2015-2019 1 0.58 Per Capita Income dollars 32653 77 03 2015-2019 1 1.75 D		Car and Low Access								
or More Types of Computing Devices percent 90.4 91 90.3 2015-2019 1 Median Housing Unit 2E+0 2E+ 2E+ 100 Value dollars 174900 5 05 2015-2019 1 Oute dollars 59607 74 43 2015-2019 1 Median Household 6118 628 0.92 1 0.93 2015-2019 1 Female Population 16+ in Civilian Labor 59607 74 43 2015-2019 1 Percent 61.5 57.8 58.3 2015-2019 1 Bachelor's Degree or 90.33 2015-2019 1 1 OLS8 Per Capita Income dollars 32653 77 <th>1.00</th> <th>to a Grocery Store</th> <th>percent</th> <th>1.2</th> <th></th> <th></th> <th></th> <th>2015</th> <th></th> <th>21</th>	1.00	to a Grocery Store	percent	1.2				2015		21
1.00 Computing Devices percent 90.4 91 90.3 2015-2019 1 Median Housing Unit 2E+0 2E+ 2E+ 1 1 Population 16+ in 0.97 Civilian Labor Force percent 65.5 61 59.6 2015-2019 1 0.97 Civilian Labor Force percent 65.5 61 59.6 2015-2019 1 0.97 Civilian Labor Force percent 65.5 61 59.6 2015-2019 1 Median Household 6138 628 1 1 1 0.92 Income dollars 59607 74 43 2015-2019 1 Female Population 16+ in Civilian Labor 57.8 58.3 2015-2019 1 People 25+ with a Bachelor's Degree or 31.5 29.9 32.1 2015-2019 1 0.58 Higher percent 31.5 29.9 32.1 2015-2019 1		Households with One								
Median Housing Unit 2E+0 2E+ 1.00 Value dollars 174900 5 05 2015-2019 1 Population 16+ in 1 1 1 1 0.97 Civilian Labor Force percent 65.5 61 59.6 2015-2019 1 0.97 Civilian Labor Force percent 65.5 61 59.6 2015-2019 1 0.92 Income dollars 59607 74 43 2015-2019 1 Female Population 16+ in Civilian Labor 61.5 57.8 58.3 2015-2019 1 People 25+ with a 31.5 29.9 32.1 2015-2019 1 0.58 Higher percent 31.5 29.9 32.1 2015-2019 1 0.58 Per Capita Income dollars 32653 77 03 2015-2019 1 0.58 Per Capita Income dollars 32653 77 03 2015-2019 1		or More Types of								
1.00Valuedollars1749005052015-20191Population 16+ in O.97Civilian Labor Forcepercent65.56159.62015-20191Median Household61862811D.92Incomedollars5960774432015-20191Female Population 16+ in Civilian LaborFemale Population 16+ in Civilian Labor57.858.32015-20191People 25+ with a Bachelor's Degree or Higherpercent61.557.858.32015-201910.58Higherpercent31.529.932.12015-201910.58Per Capita Incomedollars3265377032015-201910.58Per Capita Incomedollars3265377032015-20191DALLASHP203 population 18+MEASUREMENHIGHER visits/ 10,000 	1.00	Computing Devices	percent	90.4		91	90.3	2015-2019		1
Population 16+ in Civilian Labor Force percent 65.5 61 59.6 2015-2019 1 Median Household 618 628 628 1 1 0.92 Income dollars 59607 74 43 2015-2019 1 Female Population 16+ in Civilian Labor Female Population 16+ in Civilian Labor 1 1 0.69 Force percent 61.5 57.8 58.3 2015-2019 1 People 25+ with a Bachelor's Degree or Higher percent 31.5 29.9 32.1 2015-2019 1 0.58 Per Capita Income dollars 32653 77 03 2015-2019 1 SCORE DIABETES UNITS COUNTY 0 TX US. T PERIOD DISPARITY* Source ER visits/ 10,000 population 18+ 46.4 9.4 2017-2019 17 Age-Adjusted ER Rate ER visits/ 10,000 population 18+ 9.4 2017-2019 17		Median Housing Unit				2E+0	2E+			
0.97 Civilian Labor Force percent 65.5 61 59.6 2015-2019 1 Median Household 618 628 628 618 628 1 0.92 Income dollars 59607 74 43 2015-2019 1 Female Population 16+ in Civilian Labor Fermale Population 16+ in Civilian Labor 74 43 2015-2019 1 People 25+ with a Bachelor's Degree or Percent 61.5 57.8 58.3 2015-2019 1 0.58 Higher percent 31.5 29.9 32.1 2015-2019 1 0.58 Per Capita Income dollars 32653 77 03 2015-2019 1 SCORE DIABETES UNITS COUNTY 0 TX U.S. TPERIOD DISPARITY* Source 428 - Adjusted ER Rate population 18+ 46.4 9.4 2017-2019 17 Age-Adjusted ER Rate ER visits/ 10,000 population 18+ 9.4 2017-2019 17	1.00	Value	dollars	174900		5	05	2015-2019		1
Median Household6186281ncomedollars5960774432015-20191Female Population 16+ in Civilian Laborfemale Population 18+female Populationfemale Popula		Population 16+ in								
0.92 Income dollars 59607 74 43 2015-2019 1 Female Population 16+ in Civilian Labor Female Population 16+ in Civilian Labor Female Population 16+ in Civilian Labor 17 0.69 Force percent 61.5 57.8 58.3 2015-2019 1 People 25+ with a Bachelor's Degree or Bachelor's Degree or 31.5 29.9 32.1 2015-2019 1 0.58 Higher percent 31.5 29.9 32.1 2015-2019 1 0.58 Per Capita Income dollars 32653 77 03 2015-2019 1 SCORE DIABETES UNITS COUNTY 0 TX U.S. T PERIOD DISPARITY* Source ER visits/ 10,000 population 18+ years 46.4 9.4 2017-2019 17 Age-Adjusted ER Rate ue to Type 2 ER visits/ 10,000 population 18+ 46.4 9.4 2017-2019 17	0.97	Civilian Labor Force	percent	65.5		61	59.6	2015-2019		1
Female Population 16+ in Civilian Labor0.69Forcepercent61.557.858.32015-20191People 25+ with a Bachelor's Degree orBachelor's Degree or110.58Higherpercent31.529.932.12015-201910.58Per Capita Incomedollars3265377032015-20191DIABETESUNITSCOUNTY0TXU.S.T PERIODDISPARITY*SourceER visits/ 10,000 Age-Adjusted ER Rate due to Diabetesyears46.49.42017-201917Age-Adjusted ER Rate population 18+ER visits/ 10,000 population 18+January HolderJanuary HolderJanuary Holder		Median Household				618	628			
16+ in Civilian Labor0.69Forcepercent61.557.858.32015-20191People 25+ with a Bachelor's Degree orBachelor's Degree or31.529.932.12015-201910.58Higherpercent31.529.932.12015-201910.58Per Capita Incomedollars3265377032015-20191DALLASHP203MEASUREMENHIGHCOUNTY0TXU.S.T PERIODDISPARITY*SourceER visits/ 10,000 population 18+46.49.42017-201917Age-Adjusted ER Rate due to Type 2ER visits/ 10,000 population 18+46.49.42017-201917	0.92	Income	dollars	59607		74	43	2015-2019		1
0.69Forcepercent61.557.858.32015-20191People 25+ with a Bachelor's Degree orBachelor's Degree or12015-201910.58Higherpercent31.529.932.12015-201910.58Per Capita Incomedollars3265377032015-201915COREDIABETESUNITSDALLASHP203 COUNTYMEASUREMENHIGH DISPARITY*Source4ge-Adjusted ER Rate due to Diabetespopulation 18+ years46.49.42017-201917Age-Adjusted ER Rate due to Type 2ER visits/10,000 population 18+172017-201917		Female Population								
People 25+ with a Bachelor's Degree or0.58Higherpercent31.529.932.12015-201913123413123413413123410.58Per Capita Incomedollars3265377032015-20191DALLASHP203 COUNTYMEASUREMENHIGH DISPARITY*SCOREDIABETESUNITSCOUNTY0TXU.S.T PERIODDISPARITY*SourceER visits/ 10,000 Age-Adjusted ER Rate due to Diabetesyears46.49.42017-201917Age-Adjusted ER Rate due to Type 2ER visits/ 10,000 population 18+46.49.42017-201917		16+ in Civilian Labor								
Bachelor's Degree or0.58Higherpercent31.529.932.12015-201913123413413413413413413410.58Per Capita Incomedollars3265377032015-20191DALLASHP203MEASUREMENHIGHSCOREDIABETESUNITSCOUNTY0TXU.S.T PERIODDISPARITY*SourceAge-Adjusted ER Ratepopulation 18+46.49.42017-201917Age-Adjusted ER RateER visits/ 10,000 population 18+FR visits/ 10,000 population 18+1.7540.49.42017-201917	0.69	Force	percent	61.5		57.8	58.3	2015-2019		1
0.58Higherpercent31.529.932.12015-201913123413123413413413413413410.58Per Capita Incomedollars3265377032015-20191DALLASHP203 COUNTYMEASUREMENHIGH DISPARITY*SourceER visits/ 10,000Age-Adjusted ER Rate due to Diabetespopulation 18+46.49.42017-201917Age-Adjusted ER Rate due to Type 2ER visits/ 10,000 population 18+9.42017-201917		People 25+ with a								
0.58Per Capita Incomedollars32653341 77032015-20191SCOREDIABETESUNITSDALLAS COUNTYHP203 0MEASUREMEN THIGH DISPARITY*SourceSCOREDIABETESUNITSCOUNTY 0TXU.S.T PERIOD TDISPARITY*SourceI.75due to Diabetesyears46.49.42017-201917Age-Adjusted ER Rate due to Type 2ER visits/ 10,000 population 18+High 10,000 18+DALLAS COUNTY17		Bachelor's Degree or								
0.58Per Capita Incomedollars3265377032015-20191SCOREDIABETESUNITSDALLAS COUNTYHP203 0TXU.S.MEASUREMEN T PERIODHIGH DISPARITY*SourceSCOREDIABETESUNITSCOUNTY0TXU.S.T PERIODDISPARITY*SourceAge-Adjusted ER Rate due to Diabetespopulation 18+ years46.49.42017-201917Age-Adjusted ER Rate due to Type 2ER visits/ 10,000 population 18+FR visi	0.58	Higher	percent	31.5		29.9	32.1	2015-2019		1
SCOREDIABETESUNITSDALLASHP203 COUNTYMEASUREMENHIGH DISPARITY*SourceSCOREDIABETESUNITSCOUNTY0TXU.S.T PERIODDISPARITY*SourceAge-Adjusted ER Ratepopulation 18+due to Diabetesyears46.49.42017-201917Age-Adjusted ER RateER visits/ 10,000population 18+JJJJAge-Adjusted ER RateER visits/ 10,000JJJJJustice CountryJJJJJJustice						312	341			
SCOREDIABETESUNITSCOUNTY0TXU.S.T PERIODDISPARITY*SourceAge-Adjusted ER Ratepopulation 18+due to Diabetesyears46.49.42017-201917Age-Adjusted ER RateER visits/ 10,000population 18+1717Age-Adjusted ER RateER visits/ 10,000population 18+17	0.58	Per Capita Income	dollars	32653		77	03	2015-2019		1
SCOREDIABETESUNITSCOUNTY0TXU.S.T PERIODDISPARITY*SourceAge-Adjusted ER Ratepopulation 18+due to Diabetesyears46.49.42017-201917Age-Adjusted ER RateER visits/ 10,000population 18+1717Age-Adjusted ER RateER visits/ 10,000population 18+17										
ER visits/ 10,000Age-Adjusted ER Ratepopulation 18+1.75due to Diabetesyears46.49.42017-2019Age-Adjusted ER RateER visits/ 10,000due to Type 2population 18+				DALLAS	HP203			MEASUREMEN	HIGH	
Age-Adjusted ER Ratepopulation 18+1.75due to Diabetesyears46.49.42017-201917Age-Adjusted ER Rate due to Type 2ER visits/10,000 population 18+FR visits/10,000 population 18+FR visits/10,000 population 18+FR visits/10,000 population 18+FR visits/10,000 population 18+	SCORE	DIABETES	UNITS	COUNTY	0	ТХ	U.S.	T PERIOD	DISPARITY*	Source
1.75due to Diabetesyears46.49.42017-201917Age-Adjusted ER Rate due to Type 2ER visits/10,000 population 18+FR visits/10,000 										
Age-Adjusted ER RateER visits/ 10,000due to Type 2population 18+		Age-Adjusted ER Rate	population 18+							
due to Type 2 population 18+	1.75	due to Diabetes	,	46.4		9.4		2017-2019		17
		Age-Adjusted ER Rate	ER visits/ 10,000							
1.75 Diabetes <i>years</i> 43.2 8.6 2017-2019 17			population 18+							
	1.75	Diabetes	years	43.2		8.6		2017-2019		17

	Age-Adjusted	hospitalizations/							
	Hospitalization Rate	10,000 population							
1.75	due to Diabetes	18+ years	22.9		5.3		2017-2019		17
	Age-Adjusted								
	Hospitalization Rate	hospitalizations/							
	due to Type 2	10,000 population							
1.75	Diabetes	18+ years	17,9		4		2017-2019		17
	Diabetes: Medicare								
1.64	Population	percent	28.4		28.8	27	2018		6
	Age-Adjusted Death	deaths/ 100,000							
1.58	Rate due to Diabetes	population	19.9		22	21.5	2017-2019		5
			DALLAS	HP203			MEASUREMEN	HIGH	
SCORE	ECONOMY	UNITS	DALLAS COUNTY	HP203 0	тх	U.S.	MEASUREMEN T PERIOD	HIGH DISPARITY*	Source
SCORE	ECONOMY Median Monthly	UNITS	-		ТХ	U.S.		-	Source
SCORE		UNITS	-		ТХ	U.S.		-	Source
SCORE	Median Monthly	UNITS	-		ТХ	U.S.		-	Source
SCORE 2.67	Median Monthly Owner Costs for	UNITS	-		TX 514	U.S. 500		-	Source 1
	Median Monthly Owner Costs for Households without		COUNTY				T PERIOD	-	
2.67	Median Monthly Owner Costs for Households without a Mortgage	dollars	COUNTY 596		514	500	T PERIOD 2015-2019	-	1
2.67	Median Monthly Owner Costs for Households without a Mortgage Homeownership	dollars	COUNTY 596		514 54.9	500 56.2	T PERIOD 2015-2019	-	1
2.67 2.64	Median Monthly Owner Costs for Households without a Mortgage Homeownership Median Household Gross Rent	dollars percent	COUNTY 596 45.8		514 54.9 104	500 56.2 106	T PERIOD 2015-2019 2015-2019	-	1 1
2.67 2.64	Median Monthly Owner Costs for Households without a Mortgage Homeownership Median Household Gross Rent Mortgaged Owners	dollars percent	COUNTY 596 45.8		514 54.9 104	500 56.2 106	T PERIOD 2015-2019 2015-2019	-	1 1
2.67 2.64	Median Monthly Owner Costs for Households without a Mortgage Homeownership Median Household Gross Rent	dollars percent	COUNTY 596 45.8		514 54.9 104 5	500 56.2 106 2	T PERIOD 2015-2019 2015-2019	-	1 1

							Black (18.5)	
							White (6.1)	
							Asian (14.2)	
							AIAN (15.1)	
							NHPI (0) Mult	
							(17.1) Other	
	People 65+ Living						(16.5) Hisp	
2.14	Below Poverty Level	percent	11.1	10.6	9.3	2015-2019	(16.9)	1
		stores/ 1,000						
2.14	SNAP Certified Stores	population	0.6			2017		21
	Students Eligible for							
	the Free Lunch							
2.14	Program	percent	68.3			2019-2020		11
	Mortgaged Owners							
	Spending 30% or							
	More of Household							
2.11	Income on Housing	percent	31.7	26.5	26.5	2019		1
	Severe Housing							
2.08	Problems	percent	21.3	17.4	18	2013-2017		7
		stores/ 1,000						
2.00	WIC Certified Stores	population	0.1			2016		21
	Overcrowded	percent of						
1.86	Households	households	6.7	4.8		2015-2019		1
	Child Food Insecurity							
1.83	Rate	percent	20.3	19.6	14.6	2019		8
	Children Living Below							
1.75	Poverty Level	percent	23.3	20.9	18.5	2015-2019		1
	Projected Child Food							
1.75	Insecurity Rate	percent	24.9	23.6		2021		8

	Unemployed								
1 00	Workers in Civilian Labor Force	a crecet	C 4		67	C 1	lun 21	1	0
1.69		percent	6.4		6.7	6.1	Jun-21		8
1.67	Food Insecurity Rate	percent	14		14.1	10.9	2019	8	3
	People Living Below								
1.67	Poverty Level	percent	15.4	8	14.7	13.4	2015-2019	1	L
	Families Living Below								
1.58	Poverty Level	percent	12.1		11.3	9.5	2015-2019	1	1
	People Living 200%								
1.58	Above Poverty Level	percent	61.8		65.7	69.1	2015-2019	1	1
	Projected Food								
1.58	Insecurity Rate	percent	16.7		16.5		2021	8	3
	Food Insecure	<i>p</i> · · · · · · ·							
	Children Likely								
	Ineligible for								
1.50	Assistance	percent	28		34	23	2019	8	3
	Low-Income and Low								
	Access to a Grocery								
1.50	Store	percent	7				2015	2	1
1.50	Renters Spending	percent	/				2015	۲	<u> </u>
	30% or More of								
	Household Income								
1.50	on Rent	percent	46.5		47.8	49.6	2015-2019	1	1
1.50	Total Employment	percent	10.5		17.0	13.0	2010 2019		-
1.47	Change	percent	2.1		2.9	1.6	2018-2019	1	9
1.4/		percent	2.1		2.9	1.0	2010-2013	1	5
	Households with								
	Cash Public						2215 2212	_	_
1.36	Assistance Income	percent	1.6		1.4	2.4	2015-2019	1	
1.36	Size of Labor Force	persons	1385007				Jun-21	1	8

	Households that are						
	Asset Limited,						
	Income Constrained,						
1.33	Employed (ALICE)	percent	28.1	30		2018	23
	Households that are						
	Above the Asset						
	Limited, Income						
	Constrained,						
	Employed (ALICE)						
1.17	Threshold	percent	59.4	56		2018	23
	Households that are						
	Below the Federal						
1.17	Poverty Level	percent	12.5	14		2018	23
	Median Housing Unit			2E+0	2E+		
1.00	Value	dollars	174900	5	05	2015-2019	1
	Population 16+ in						
0.97	Civilian Labor Force	percent	65.5	61	59.6	2015-2019	1
	Median Household			618	628		
0.92	Income	dollars	59607	74	43	2015-2019	1
	Female Population						
	16+ in Civilian Labor						
0.69	Force	percent	61.5	57.8	58.3	2015-2019	1
				312	341		
0.58	Per Capita Income	dollars	32653	77	03	2015-2019	1
	Persons with						
	Disability Living in						
0.58	Poverty (5-year)	percent	23.2	23.2	26.1	2015-2019	1

SCORE	EDUCATION	UNITS	DALLAS COUNTY	HP203 0	тх	U.S.	MEASUREMEN T PERIOD	HIGH DISPARITY*	Source
000112						0.01		Black (11.7)	
								White (6.7)	
								Asian (2.8)	
								AIAN (16.2) PI	
								(28.6) Mult	
	High School Drop Out							(15.6) Hisp	
2.42	Rate	percent	10		1.9		2019	(10.5)	15
	Student-to-Teacher								
1.97	Ratio	students/ teacher	15.7				2019-2020		11
								Black (14.7)	
	Infants Born to							White (5.9)	
	Mothers with <12							Other (11.6)	
1.94	Years Education	percent	20.3		17.4	13.3	2017	Hisp (30.5)	14
	People 25+ with a								
	High School Degree								
1.58	or Higher	percent	79.3		83.7	88	2015-2019		1
	People 25+ with a								
	Bachelor's Degree or								
0.58	Higher	percent	31.5		29.9	32.1	2015-2019		1
	ENVIRONMENTAL		DALLAS	HP203			MEASUREMEN	HIGH	
SCORE	HEALTH	UNITS	COUNTY	0	ТΧ	U.S.	T PERIOD	DISPARITY*	Source
	Fast Food Restaurant	restaurants/ 1,000							
2.14	Density	population	0.9				2016		21
		stores/ 1,000							
2.14	SNAP Certified Stores	population	0.6				2017		21
	Asthma: Medicare								
	Population	percent	5.7		4.9	5	2018		6

	Severe Housing						
2.08	Problems	percent	21.3	17.4	18	2013-2017	7
		stores/1,000					
2.00	WIC Certified Stores	population	0.1			2016	21
1.92	PBT Released	pounds	5394.5			2019	22
	Annual Particle						
1.89	Pollution		3			2017-2019	2
	Overcrowded	percent of					
1.86	Households	households	6.7	4.8		2015-2019	1
	Annual Ozone Air						
1.75	Quality	grade	F			2017-2019	2
	Number of Extreme						
1.64	Precipitation Days	days	40			2016	12
	Children with Low						
	Access to a Grocery						
1.50	Store	percent	4.6			2015	21
	Farmers Market	markets/ 1,000					
1.50	Density	population	0			2018	21
	Grocery Store	stores/ 1,000					
1.50	Density	population	0.2			2016	21
	Low-Income and Low						
	Access to a Grocery						
1.50	Store	percent	7			2015	21
		stores/ 100,000					
1.39	Liquor Store Density	population	7.4	6.9	10.5	2019	19
	Number of Extreme						
1.36	Heat Events	events	2			2016	12
	Recognized						
	Carcinogens Released						
1.36	into Air	pounds	44442.7			2019	22

	People with Low						
	Access to a Grocery						
1.33	Store	percent	16.6			2015	21
	Food Environment	,					
1.19	Index		7.2	5.9	7.8	2021	7
1.17	Adults with Asthma	percent	10.7	10.9	13.3	2012	3
	Daily Dose of UV	Joule per square		353			
1.17	Irradiance	meter	3269	8		2015	12
	Recreation and	facilities/ 1,000					
1.17	Fitness Facilities	population	0.1			2016	21
	Adults with Current						
1.08	Asthma	percent	9.2		9.2	2018	4
	Number of Extreme						
1.08	Heat Days	days	5			2016	12
	Weeks of Moderate						
1.08	Drought or Worse	weeks per year	1			2016	12
	Households with No						
	Car and Low Access						
1.00	to a Grocery Store	percent	1.2			2015	21
	People 65+ with Low						
	Access to a Grocery						
1.00	Store	percent	1.3			2015	21
	Access to Exercise						
0.50	Opportunities	percent	96.3	80.5	84	2020	7

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	DALLAS COUNTY	HP203 0	тх	U.S.	MEASUREMEN T PERIOD	HIGH DISPARITY*	Source
JCORE	-	UNITS	COUNTY	0		0.3.	IPERIOD	DISPARIT	Source
2.58	Persons with Health	norcont	74.0	02.1	70.2		2010		20
2.58	Insurance	percent	74.9	92.1	79.3		2019		20
	Adults who have had		_			_			
2.08	a Routine Checkup	percent	72			76.7	2018		4
	Adults without								
2.08	Health Insurance	percent	28.7			12.2	2018		4
	Adults who Visited a								
1.92	Dentist	percent	54			66.5	2018		4
	Adults with Health								
1.83	Insurance	percent	70.8		75.5	87.1	2019		1
	Children with Health								
1.83	Insurance	percent	83		87.3	94.3	2019		1
1.05	insurance	workers/ 100,000			07.5	54.5	2015		⊥
1.14	Social Worker Rate	population	91.5		82.7		2020		14
1.14			91.5				2020		14
	Mental Health	providers/ 100,000			120.				_
0.50	Provider Rate	population	157		9		2020		7
	Primary Care	providers/ 100,000							
0.50	Provider Rate	population	69.5		60.9		2018		7
		dentists/ 100,000							
0.33	Dentist Rate	population	86.8		59.6		2019		7
	Non-Physician								
	Primary Care	providers/ 100,000							
0.33	Provider Rate	population	113.8		88.6		2020		7
		- · ·							
	HEART DISEASE &		DALLAS	HP203			MEASUREMEN	HIGH	
SCORE	STROKE	UNITS	COUNTY	0	ΤХ	U.S.	T PERIOD	DISPARITY*	Source
COORE		0.1110	000111	<u> </u>		0.0.			000100

	Age-Adjusted Death							
	Rate due to							
	Cerebrovascular	deaths/ 100,000						
2.28	Disease (Stroke)	population	47.2	33.4	40.2	37.2	2017-2019	5
	Age-Adjusted Death	deaths/ 100,000						
	Rate due to Heart	population 35+						
2.14	Attack	years	115.4		70.1		2018	12
	Adults who Have							
	Taken Medications							
	for High Blood							
2.08	Pressure	percent	73.1			75.8	2017	4
	Stroke: Medicare							
2.03	Population	percent	4.4		4.2	3.8	2018	 6
	Hyperlipidemia:							
1.97	Medicare Population	percent	50		49.5	47.7	2018	 6
	Hypertension:							
1.81	Medicare Population	percent	60.5		59.9	57.2	2018	 6
		ER visits/ 10,000						
	Age-Adjusted ER Rate	population 18+						
1.75	due to Hypertension	years	50.3		10.5		2017-2019	17
	Age-Adjusted	hospitalizations/						
	Hospitalization Rate	10,000 population						
1.75	due to Hypertension	18+ years	0.4		0.1		2017-2019	 17
	Cholesterol Test		_			_		
1.75	History	percent	79.3			81.5	2017	4
	Heart Failure:							
1.47	Medicare Population	percent	15.3		15.6	14	2018	6
	Atrial Fibrillation:							
1.31	Medicare Population	percent	7.6		7.8	8.4	2018	 6
	High Blood Pressure							
1.17	Prevalence	percent	33.2	27.7		32.4	2017	 4

	Ischemic Heart Disease: Medicare							
0.97	Population	percent	25.3		29	26.8	2018	6
	Adults who							
0.92	Experienced a Stroke	percent	3.3			3.4	2018	4
	Adults who							
	Experienced							
	Coronary Heart							
0.92	Disease	percent	6.3			6.8	2018	4
	High Cholesterol							
	Prevalence: Adults							
0.92	18+	percent	34			34.1	2017	4
	Age-Adjusted Death							
	Rate due to Coronary	deaths/ 100,000						
0.67	Heart Disease	population	86.1	71.1	93	90.5	2017-2019	5

	IMMUNIZATIONS & INFECTIOUS		DALLAS	HP203			MEASUREMEN	HIGH	
SCORE	DISEASES	UNITS	COUNTY	пр205 0	тх	U.S.	T PERIOD	DISPARITY*	Source
JEONE	Gonorrhea Incidence	cases/ 100,000	000111	•	163.	179.	TTEMOD	DISTANT	Jource
2.67	Rate	population	283.8		105. 6	1	2018		14
,	Chlamydia Incidence	cases/ 100,000	200.0		508.	539.	2020		
2.39	Rate	population	720.9		2	9	2018		14
	Syphilis Incidence	cases/ 100,000			_				
2.39	Rate	population	14.3		8.8	10.8	2018		14
		cases/ 100,000			0.0				
1.86	HIV Diagnosis Rate	population	30.7		15.7		2018		14
	Overcrowded	percent of							
1.86	Households	households	6.7		4.8		2015-2019		1
	Age-Adjusted								
	Hospitalization Rate								
	due to Immunization-								
	Preventable	hospitalizations/							
	Pneumonia and	10,000 population							
1.75	Influenza	18+ years	0.2		0.1		2017-2019		17
	Tuberculosis	cases/ 100,000							
1.67	Incidence Rate	population	6.2	1.4	4.3		2015-2019		14
	COVID-19 Daily								
4 47	Average Case-Fatality	deaths per 100	2.4		4.2	2	21 Car 21		0
1.47	Rate	cases	2.1		4.3	2	21-Sep-21		9
	Age-Adjusted Death								
4.20	Rate due to Influenza	deaths/ 100,000	10 F		11.0	12.0	2017 2010		-
1.28	and Pneumonia COVID-19 Daily	population	12.5		11.8	13.8	2017-2019		5
	Average Incidence	cases per 100,000							
0.69	Rate	population	34.1		47 1	51.4	21-Sep-21		9
0.00		population	5 1.1			51.7	21 300 21		

	MATERNAL, FETAL &		DALLAS	HP203			MEASUREMEN	HIGH	
SCORE	INFANT HEALTH	UNITS	COUNTY	0	ТΧ	U.S.	T PERIOD	DISPARITY*	Source
		deaths/ 1,000 live							
2.31	Infant Mortality Rate	births	6.8	5	5.6	5.9	2015		14
	Mothers who								
	Received Early								
2.22	Prenatal Care	percent	54.6		60.5	77.3	2017		14
								Black (14.7)	
	Infants Born to							White (5.9)	
	Mothers with <12							Other (11.6)	
1.94	Years Education	percent	20.3		17.4	13.3	2017	Hisp (30.5)	14
	Babies with Low Birth								
1.89	Weight	percent	8.4		8.2	8.1	2015		14
								Black	
								(2.94561057)	
								White	
								(0.98073151)	
								Other	
								(0.85967831)	
	Babies with Very Low							Hisp	
1.89	Birth Weight	percent	1.6			1.4	2015	(1.43109908)	14
1.42	Preterm Births	percent	11.5	9.4	12.2		2017		14
								Black (2.7)	
								White (0.4)	
								Other (0.3)	
1.17	Teen Births	percent	2.2		2.1	3.1	2017	Hisp (3.1)	14

	MENTAL HEALTH &		DALLAS	HP203			MEASUREMEN	HIGH	
SCORE	MENTAL DISORDERS	UNITS	COUNTY	0	ТХ	U.S.	T PERIOD	DISPARITY*	Source
	Depression:								
2.42	Medicare Population	percent	19.8		18.2	18.4	2018		6
	Alzheimer's Disease								
	or Dementia:								
2.33	Medicare Population	percent	13.4		12.6	10.8	2018		6
	Age-Adjusted ER Rate	ER visits/ 10,000							
	due to Adult Mental	population 18+							
1.75	Health	years	15.6		8.9		2017-2019		17
	Age-Adjusted								
	Hospitalization Rate	hospitalizations/							
	due to Adult Mental	10,000 population							
1.75	Health	18+ years	2.4		1.7		2017-2019		17
	Poor Mental Health:								
1.42	14+ Days	percent	13.6			12.7	2018		4
	Frequent Mental								
1.33	Distress	percent	13.3		11.6	13	2018		7
								Black (5.8)	
								White (14.3)	
	Age-Adjusted Death	deaths/ 100,000						API (5.8) Hisp	
1.14	Rate due to Suicide	population	11.6	12.8	13.5	14.1	2017-2019	(6.2)	5
	Mental Health	providers/ 100,000			120.				
0.50	Provider Rate	population	157		9		2020		7

			DALLAS	HP203			MEASUREMEN	HIGH	
SCORE	OLDER ADULTS	UNITS	COUNTY	0	ТΧ	U.S.	T PERIOD	DISPARITY*	Source
	Osteoporosis:								
2.92	Medicare Population	percent	7.6		6.8	6.6	2018		6
	Chronic Kidney								
	Disease: Medicare					_			
2.75	Population	percent	28.8		26.7	24.5	2018		6
	Depression:								
2.42	Medicare Population	percent	19.8		18.2	18.4	2018		6
	Alzheimer's Disease								
	or Dementia:								
2.33	Medicare Population	percent	13.4		12.6	10.8	2018		6
	Colon Cancer								_
2.33	Screening	percent	56.2	74.4		66.4	2018		4
								Black (18.5)	
								White (6.1)	
								Asian (14.2) AIAN (15.1)	
								NHPI (0) Mult	
								(17.1) Other	
	People 65+ Living							(16.5) Hisp	
2.14	Below Poverty Level	percent	11.1		10.6	9.3	2015-2019	(16.9)	1
	Adults 65+ who								
	Received								
	Recommended								
	Preventive Services:								
2.08	Males	percent	22.4			32.4	2018		4
	Asthma: Medicare								
2.08	Population	percent	5.7		4.9	5	2018		6
	Stroke: Medicare								
2.03	Population	percent	4.4		4.2	3.8	2018		6

	Cancer: Medicare						
1.97	Population	percent	8.4	7.6	8.4	2018	6
	Hyperlipidemia:						
1.97	Medicare Population	percent	50	49.5	47.7	2018	6
	Rheumatoid Arthritis						
	or Osteoarthritis:						
1.97	Medicare Population	percent	35.8	34.2	33.5	2018	6
	Adults 65+ who	,					
	Received						
	Recommended						
	Preventive Services:						
1.92	Females	percent	23.6		28.4	2018	4
	Hypertension:						
1.81	Medicare Population	percent	60.5	59.9	57.2	2018	6
	Diabetes: Medicare						
1.64	Population	percent	28.4	28.8	27	2018	6
	Adults 65+ with Total						
1.58	Tooth Loss	percent	16.1		13.5	2018	4
	Heart Failure:						
1.47	Medicare Population	percent	15.3	15.6	14	2018	6
	Atrial Fibrillation:						
1.31	Medicare Population	percent	7.6	7.8	8.4	2018	6
	COPD: Medicare	•					
1.00	Population	percent	10.2	11.2	11.5	2018	6
	People 65+ with Low						
	Access to a Grocery						
1.00	Store	percent	1.3			2015	21
	Ischemic Heart	p 0. 00/10					_
	Disease: Medicare						
0.97	Population	percent	25.3	29	26.8	2018	6
	•	•					

0.75	Adults with Arthritis	percent	20.2			25.8	2018		4
			DALLAC	110202					
	004111541511		DALLAS	HP203			MEASUREMEN	HIGH	6
SCORE	ORAL HEALTH	UNITS	COUNTY	0	TX	U.S.	T PERIOD	DISPARITY*	Source
	Adults who Visited a								
1.92	Dentist	percent	54			66.5	2018		4
	Age-Adjusted ER Rate								
	due to Dental	ER visits/ 10,000							
1.75	Problems	population	45.6		11.1		2017-2019		17
	Adults who have had								
	Permanent Teeth								
1.67	Extracted	percent	45.7		42.8	44.5	2012		3
	Adults 65+ with Total								
1.58	Tooth Loss	percent	16.1			13.5	2018		4
	Oral Cavity and								· · ·
	Pharynx Cancer	cases/ 100,000							
1.39	Incidence Rate	population	11.1		11	11.8	2013-2017		10
		dentists/ 100,000							
0.33	Dentist Rate	population	86.8		59.6		2019		7
0.33	Dentist Nate	ροραιατισπ	00.0		55.0		2015		,
			DALLAC						
			DALLAS	HP203			MEASUREMEN	HIGH	<u> </u>
SCORE	OTHER CONDITIONS	UNITS	COUNTY	0	ТХ	U.S.	T PERIOD	DISPARITY*	Source
	Osteoporosis:								
2.92	Medicare Population	percent	7.6		6.8	6.6	2018		6
	Chronic Kidney								
	Disease: Medicare								
2.75	Population	percent	28.8		26.7	24.5	2018		6
	Rheumatoid Arthritis								
	or Osteoarthritis:								
1.97	Medicare Population	percent	35.8		34.2	33.5	2018		6
1.57		percent	55.0		54.2	55.5	2010		0

0.92	Adults with Kidney Disease	Percent of adults	3.1			3.1	2018		4
0.75	Adults with Arthritis	percent	20.2			25.8	2018		4
0.75		percent	20.2			25.0	2010		
			DALLAS	HP203			MEASUREMEN	HIGH	
SCORE	PHYSICAL ACTIVITY	UNITS	COUNTY	0	ΤХ	U.S.		DISPARITY*	Source
	Fast Food Restaurant	restaurants/ 1,000							
2.14	Density	population	0.9				2016		21
	/	stores/ 1,000							
2.14	SNAP Certified Stores	population	0.6				2017		21
		stores/ 1,000							
2.00	WIC Certified Stores	population	0.1				2016		21
	Children with Low								
	Access to a Grocery								
1.50	Store	percent	4.6				2015		21
	Farmers Market	markets/ 1,000							
1.50	Density	population	0				2018		21
	Grocery Store	stores/ 1,000							
1.50	Density	population	0.2				2016		21
	Low-Income and Low								
	Access to a Grocery								
1.50	Store	percent	7				2015		21
	People with Low								
	Access to a Grocery								
1.33	Store	percent	16.6				2015		21
1.10	Food Environment		7.0		F 0	7.0	2024		7
1.19	Index	• ··· · · · · · ·	7.2		5.9	7.8	2021		7
	Recreation and	facilities/ 1,000					2246		
1.17	Fitness Facilities	population	0.1				2016		21

1.00	Households with No Car and Low Access to a Grocery Store	percent	1.2		2015	21
	People 65+ with Low Access to a Grocery					
1.00	Store	percent	1.3		2015	21
0.50	Access to Exercise Opportunities	percent	96.3	80.5 84	2020	7

	PREVENTION &		DALLAS	HP203			MEASUREMEN	HIGH	
SCORE	SAFETY	UNITS	COUNTY	0	ТΧ	U.S.	T PERIOD	DISPARITY*	Source
	Severe Housing								
2.08	Problems	percent	21.3		17.4	18	2013-2017		7
	Death Rate due to	deaths/ 100,000							
1.39	Drug Poisoning	population	13		10.6	21	2017-2019		7
	Age-Adjusted Death								
	Rate due to	deaths/ 100,000							
0.72	Unintentional Injuries	population	38.6	43.2	38.7	48.9	2017-2019		5
	RESPIRATORY		DALLAS	HP203			MEASUREMEN	HIGH	
SCORE	DISEASES	UNITS	COUNTY	0	ТΧ	U.S.	T PERIOD	DISPARITY*	Source
	Asthma: Medicare								
2.08	Population	percent	5.7		4.9	5	2018		6
	Age-Adjusted								
	Hospitalization Rate								
	due to Immunization-								
	Preventable	hospitalizations/							
4 75	Pneumonia and	10,000 population	0.2		0.1		2017 2010		17
1.75	Influenza	18+ years	0.2		0.1		2017-2019		17
4.67	Tuberculosis	cases/ 100,000	6.2	4 4	4.0		2015 2010		1.4
1.67	Incidence Rate	population	6.2	1.4	4.3		2015-2019		14
	COVID-19 Daily Average Case-Fatality	deaths per 100							
1.47	Rate	cases	2.1		4.3	2	21-Sep-21		9
1.47	-	Cuscs	2.1		7.5	2	21 500 21		
	Age-Adjusted Death Rate due to Influenza	doaths (100 000							
1.28	and Pneumonia	deaths/ 100,000 population	12.5		11.8	13.8	2017-2019		5
1.28	Adults who Smoke	• •	12.5	5	11.0	15.8	2017-2019		4
	-	percent		5	10.9	13.3	2018		
1.17	Adults with Asthma	percent	10.7		10.9	13.3	2012		3

	Adults with Current								
1.08	Asthma	percent	9.2			9.2	2018		4
	COPD: Medicare								
1.00	Population	percent	10.2		11.2	11.5	2018		6
0.75	Adults with COPD	Percent of adults	6.2			6.9	2018		4
	COVID-19 Daily								
	Average Incidence	cases per 100,000							
0.69	Rate	population	34.1		47.1	51.4	21-Sep-21		9
	Lung and Bronchus								
	Cancer Incidence	cases/ 100,000							
0.42	Rate	population	49.2		50.6	58.3	2013-2017		10
	Age-Adjusted Death							Black (42.6) White (36.7)	
	Rate due to Lung	deaths/ 100,000						API (16.1) Hisp	
0.33	Cancer	population	32.3	25.1	34.1	38.5	2013-2017	(12.9)	10

TRANSMITTED DALLAS HP203 MEASUREMEN HIGH	
SCORE INFECTIONS UNITS COUNTY 0 TX U.S. T PERIOD DISPARI	FY* Source
Gonorrhea Incidence cases/100,000 163. 179.	
2.67 Rate <i>population</i> 283.8 6 1 2018	14
Chlamydia Incidence cases/100,000 508. 539.	
2.39 Rate <i>population</i> 720.9 2 9 <i>2018</i>	14
Syphilis Incidence cases/ 100,000	
2.39 Rate <i>population</i> 14.3 8.8 10.8 2018	14
cases/ 100,000	
1.86 HIV Diagnosis Rate population 30.7 15.7 2018	14
WELLNESS & DALLAS HP203 MEASUREMEN HIGH	
SCORE LIFESTYLE UNITS COUNTY 0 TX U.S. T PERIOD DISPARI	TY* Source
1.92 Insufficient Sleep percent 36.9 31.4 34.4 35 2018	7
Frequent Physical	
1.67 Distress percent 12.9 11.6 11 2018	7
High Blood Pressure	
1.17 Prevalence percent 33.2 27.7 32.4 2017	4
Poor Physical Health:	
1.08 14+ Days percent 12.7 12.5 2018	4
DALLAS HP203 MEASUREMEN HIGH	
SCORE WOMEN'S HEALTH UNITS COUNTY 0 TX U.S. T PERIOD DISPARI	FY* Source
Cervical Cancer	
1.94 Screening: 21-65 Percent 80.3 84.3 84.7 2018	4
Breast Cancer <i>cases/100,000</i> 112. 125.	
1.81 Incidence Rate females 118.8 8 9 2013-2017	10

	Age-Adjusted Death Rate due to Breast	deaths/ 100,000						
1.69	Cancer	females	21.2	15.3	19.8	20.1	2013-2017	10
	Cervical Cancer	cases/ 100,000						
1.33	Incidence Rate	females	9.1		9.2	7.6	2013-2017	10
	Mammogram in Past							
1.28	2 Years: 50-74	percent	71.2	77.1		74.8	2018	4

Dallas County Data Sources

Кеу	Source Title
1	American Community Survey
2	American Lung Association
3	Behavioral Risk Factor Surveillance System
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	County Health Rankings
8	Feeding America
9	Healthy Communities Institute
10	National Cancer Institute
11	National Center for Education Statistics
12	National Environmental Public Health Tracking Network
13	Texas Department of Family and Protective Services
14	DFWHC Foundation Regional Data, Q1-Q4, 2017-2019. DFWHC Foundation, Irving Texas. October 19, 2021
15	Texas Education Agency
16	Texas Secretary of State
17	THR Texas Department of Health Services
18	U.S. Bureau of Labor Statistics
19	U.S. Census - County Business Patterns
20	U.S. Census Bureau - Small Area Health Insurance Estimates
21	U.S. Department of Agriculture - Food Environment Atlas
22	U.S. Environmental Protection Agency
23	United For ALICE

Dallas County Topic Sources

Health and Quality of Life Topics	Score
Sexually Transmitted Infections	2.33
Other Conditions	1.86
Older Adults	1.84
Maternal, Fetal & Infant Health	1.83
Immunizations & Infectious Diseases	1.80
Diabetes	1.70
Education	1.70
Children's Health	1.69
Alcohol & Drug Use	1.68
Community	1.65
Economy	1.61
Women's Health	1.61
Mental Health & Mental Disorders	1.58
Heart Disease & Stroke	1.52
Environmental Health	1.48
Wellness & Lifestyle	1.46
Oral Health	1.44
Physical Activity	1.42
Prevention & Safety	1.40
Cancer	1.39
Health Care Access & Quality	1.37
Respiratory Diseases	1.14

Rockwall County Indicator Scores

	-		ROCKWA					HIGH	
	ALCOHOL &		LL	HP203			MEASUREMENT	DISPARIT	
SCORE	DRUG USE	UNITS	COUNTY	0	ТХ	U.S.	PERIOD	Υ*	Source
	Alcohol-Impaired	percent of driving deaths							
3.00	Driving Deaths	with alcohol involvement	35	28.3	25.7	27	2015-2019		6
	Adults who								
2.25	Binge Drink	percent	18.1			16.4	2018		3
	Age-Adjusted ER								
	Rate due to	ER visits/ 10,000							
1.75	Opioid Use	population 18+ years	3		0.7		2017-2019		16
	Age-Adjusted								
	Hospitalization								
	Rate due to	hospitalizations/ 10,000							
1.75	Opioid Use	population 18+ years	0.6		0.1		2016-2018		16
	Age-Adjusted ER								
	Rate due to	ER visits/ 10,000							
1.25	Substance Use	population 18+ years	10.2		20.6		2017-2019		16
	Age-Adjusted								
	Hospitalization								
	Rate due to	hospitalizations/ 10,000							
1.25	Substance Use	population 18+ years	0.7		1.2		2017-2019		16
	Age-Adjusted								
	Drug and Opioid-								
	Involved								
	Overdose Death	Deaths per 100,000							
1.17	Rate	population	11.6		12.1	22.8	2017-2019		4
	Death Rate due								
	to Drug	deaths/ 100,000							
1.06	Poisoning	population	10.3		10.6	21	2017-2019		6

	Liquor Store	stores/ 100,000					
0.75	Density	population	2.9	6.9	10.5	2019	18

			ROCKWA LL	HP203			MEASUREMENT	HIGH DISPARIT	
SCORE	CANCER	UNITS	COUNTY	0	тх	U.S.	PERIOD	ΟΙΣΡΑΝΤΙ Υ*	Source
	Breast Cancer								
2.17	Incidence Rate	cases/ 100,000 females	130.8		112.8	125.9	2013-2017		9
	Oral Cavity and	, , , , , , , , , , , , , , , , ,							
	Pharynx Cancer	cases/ 100,000							
2.08	, Incidence Rate	population	14		11	11.8	2013-2017		9
	Age-Adjusted								
	Death Rate due								
	to Prostate								
1.86	Cancer	deaths/ 100,000 males	19.8	16.9	17.6	19	2013-2017		9
	Age-Adjusted								
	Death Rate due								
1.69	to Breast Cancer	deaths/ 100,000 females	21	15.3	19.8	20.1	2013-2017		9
	Cancer:								
	Medicare				_	_			
1.69	Population	percent	8		7.6	8.4	2018		5
	Colon Cancer								
1.33	Screening	percent	64.7	74.4		66.4	2018		3
	All Cancer	cases/ 100,000							
1.31	Incidence Rate	population	407.1		407.7	448.7	2013-2017		9
	Mammogram in								
	Past 2 Years: 50-		_			_			_
1.28	74	percent	73.4	77.1		74.8	2018		3
	Lung and								
	Bronchus Cancer	cases/ 100,000							
1.14	Incidence Rate	population	50.9		50.6	58.3	2013-2017		9
	Adults with								
1.08	Cancer	percent	6.7			6.9	2018		3

	Age-Adjusted								
	Death Rate due	deaths/ 100,000							
1.08	to Cancer	population	145.9	122.7	148.8	155.5	2013-2017		9
	Age-Adjusted								
	Death Rate due								
	to Colorectal	deaths/ 100,000							
1.00	Cancer	population	13.9	8.9	13.9	13.7	2013-2017		9
	Cervical Cancer								
0.89	Screening: 21-65	Percent	85.5	84.3		84.7	2018		3
								Black	
								(284.9)	
								White	
								(79.5)	
	Prostate Cancer							Hisp	
0.58	Incidence Rate	cases/ 100,000 males	86.7		94	104.5	2013-2017	(84.9)	9
	Age-Adjusted								
	Death Rate due	deaths/ 100,000							
0.33	to Lung Cancer	population	31.2	25.1	34.1	38.5	2013-2017		9
	Colorectal								
	Cancer Incidence	cases/ 100,000							
0.08	Rate	population	28.4		37.6	38.4	2013-2017		9

			ROCKWA					HIGH	
	CHILDREN'S		LL	HP203			MEASUREMENT	DISPARIT	
SCORE	HEALTH	UNITS	COUNTY	0	ТΧ	U.S.	PERIOD	Y*	Source
2.50	Food Insecure Children Likely Ineligible for Assistance	percent	64		34	23	2019		7
1.78	Substantiated Child Abuse Rate	cases/ 1,000 children	9.1	8.7	9.1		2020		12
1.67	Children with Low Access to a Grocery Store	percent	6.3				2015		20
1.50	Children with Health Insurance	percent	88.1		87.3	94.3	2019		1
0.92	Projected Child Food Insecurity Rate	percent	16.1		23.6		2021		7
	Child Food	· · · · · ·							
0.50	Insecurity Rate	percent	12.8		19.6	14.6	2019		7
SCORE	COMMUNITY	UNITS	ROCKWA LL COUNTY	HP203 0	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARIT Y*	Source
	Alcohol-Impaired	percent of driving deaths							
3.00	Driving Deaths	with alcohol involvement	35	28.3	25.7	27	2015-2019		6
2.92	Mean Travel Time to Work	minutes	34.4		26.6	26.9	2015-2019		1
2.67	Median Household Gross Rent	dollars	1429		1045	1062	2015-2019		1

Median MonthlyOwner Costs forHouseholdswithout a2.67Mortgagedollars792514	0 2015-2019 1
without a Additional and the second	0 2015-2019 1
2.67 Mortgage <i>dollars</i> 792 514 50	0 2015-2019 1
	0 2015-2019 1
Mortgaged	
Owners Median	
Monthly	
2.67 Household Costs <i>dollars</i> 1978 1606 15	95 <i>2015-2019</i> 1
Solo Drivers with	
2.64 a Long Commute <i>percent</i> 60.8 38.9 3	7 2015-2019 6
membership	
Social associations/ 10,000	
2.47 Associations population 7.4 7.5 9.	3 2018 6
Substantiated	
1.78 Child Abuse Rate cases/1,000 children 9.1 8.7 9.1	2020 12
Persons with	
1.69Health Insurancepercent85.192.179.3	<i>2019</i> 19
Workers	
Commuting by	
Public	
1.44Transportationpercent0.85.31.45	2015-2019 1
Social Worker workers/100,000	
1.36 Rate <i>population</i> 64.6 82.7	2020 13
Age-Adjusted	
Death Rate due	
to Motor Vehicle <i>deaths/ 100,000</i>	
1.08 Traffic Collisions population 8.8 10.1 13 11	.3 2017-2019 4
Workers who	
Drive Alone to	
1.08 Work <i>percent</i> 81 80.5 76	.3 2015-2019 1

	Households with						
	No Car and Low						
	Access to a						
1.00	Grocery Store	percent	1			2015	20
	Female	I					
	Population 16+						
	in Civilian Labor						
0.97	Force	percent	60.3	57.8	58.3	2015-2019	1
	Population 16+	•					
	in Civilian Labor						
0.97	Force	percent	65.3	61	59.6	2015-2019	1
	Voter Turnout:	-					
	Presidential						
0.86	Election	percent	69.4	58.8		2016	15
	Households with						
	One or More						
	Types of						
	Computing						
0.83	Devices	percent	97.1	91	90.3	2015-2019	1
	Total						
	Employment						
0.81	Change	percent	3.7	2.9	1.6	2018-2019	18
	Persons with an						
	Internet						
0.75	Subscription	percent	94.9	84.2	86.2	2015-2019	1
	Linguistic						
0.69	Isolation	percent	1.6	7.7	4.4	2015-2019	1
	People 25+ with						
	a High School						
0.53	Degree or Higher	percent	92.7	83.7	88	2015-2019	1
	5 5						

	the extention of							
	Households with							
	an Internet							_
0.50	Subscription	percent	93.1		82.1	83	2015-2019	1
	Single-Parent							
0.36	Households	percent	13.6		26.3	25.5	2015-2019	1
	Median Housing				17250	21750		
0.33	Unit Value	dollars	266200		0	0	2015-2019	1
	Children Living							
	Below Poverty							
0.08	Level	percent	6.2		20.9	18.5	2015-2019	1
0.08	Homeownership	percent	78.8		54.9	56.2	2015-2019	1
	Median							
	Household							
0.08	Income	dollars	100920		61874	62843	2015-2019	1
	People 25+ with							
	a Bachelor's							
0.08	Degree or Higher	percent	40.7		29.9	32.1	2015-2019	1
	Per Capita							
0.08	Income	dollars	42346		31277	34103	2015-2019	1
	People Living							
	Below Poverty							
0.00	Level	percent	4.7	8	14.7	13.4	2015-2019	1

								HIGH	
			ROCKWALL	HP203			MEASUREMENT	DISPARITY	
SCORE	DIABETES	UNITS	COUNTY	0	ТХ	U.S.	PERIOD	*	Source
	Age-Adjusted ER								
	Rate due to	ER visits/ 10,000							
1.75	Diabetes	population 18+ years	17.8		9.4		2017-2019		16
	Age-Adjusted ER								
	Rate due to Type	ER visits/ 10,000							
1.75	2 Diabetes	population 18+ years	14.8		8.6		2017-2019		16
	Age-Adjusted								
	Hospitalization								
	Rate due to	hospitalizations/ 10,000							
1.75	Diabetes	population 18+ years	12		5.3		2017-2019		16
	Age-Adjusted								
	Hospitalization								
	Rate due to Type	hospitalizations/ 10,000							
1.75	2 Diabetes	population 18+ years	8.4		4		2017-2019		16
	Diabetes:								
	Medicare								
0.81	Population	percent	23.7		28.8	27	2018		5
	Age-Adjusted								
	Death Rate due	deaths/ 100,000							
0.50	to Diabetes	population	11.4		22	21.5	2017-2019		4

								HIGH	
SCORE	ECONOMY	UNITS	ROCKWALL COUNTY	HP20 30	ТΧ	U.S.	MEASUREMENT PERIOD	DISPARITY *	Source
JCORE	Median	UNITS	COUNTY	50		0.3.	PERIOD		Jource
	Household Gross								
2.67	Rent	dollars	1429		1045	1062	2015-2019		1
	Median Monthly		1.23		2010	1002	2010 2013		
	Owner Costs for								
	Households								
	without a								
2.67	Mortgage	dollars	792		514	500	2015-2019		1
	Mortgaged								
	Owners Median								
	Monthly								
2.67	Household Costs	dollars	1978		1606	1595	2015-2019		1
	Food Insecure								
	Children Likely								
	Ineligible for								
2.50	Assistance	percent	64		34	23	2019		7
	SNAP Certified								
2.00	Stores	stores/ 1,000 population	0.4				2017		20
	WIC Certified								
2.00	Stores	stores/ 1,000 population	0.1				2016		20
	Size of Labor								
1.36	Force	persons	54618				44348	#NAME?	17
	Households that								
	are Asset								
	Limited, Income								
	Constrained,								
	Employed		<u> </u>				2212		
1.33	(ALICE)	percent	29.5		30		2018		22

	1						
	Low-Income and						
1 17	Low Access to a	norrout	2.7			2015	20
1.17	Grocery Store	percent	3.7			2015	20
	Students Eligible						
	for the Free						
1.14	Lunch Program	percent	22.8			2019-2020	10
	Households that						
	are Above the						
	Asset Limited,						
	Income						
	Constrained,						
	Employed						
	(ALICE)						
1.00	Threshold	percent	64.5	56		2018	22
	Households that						
	are Below the						
	Federal Poverty						
1.00	Level	percent	6	14		2018	22
	Mortgaged						
	Owners						
	Spending 30% or						
	More of						
	Household						
	Income on						
1.00	Housing	percent	24.5	26.5	26.5	2019	1
	Renters						
	Spending 30% or						
	More of						
	Household						
1.00	Income on Rent	percent	43.3	47.8	49.6	2015-2019	1

Population 16+ in Civilian LaborPercent 60.3 57.8 58.3 $2015-2019$ 0.97Forcepercent 60.3 57.8 58.3 $2015-2019$ Population 16+ in Civilian Laborin Civilian Laborin Civilian Labor0.97Forcepercent 65.3 61 59.6 $2015-2019$ Projected Child Food Insecuritypercent 16.1 23.6 2021 0.92Ratepercent of households 1.6 4.8 $2015-2019$ Overcrowded </th <th></th>	
0.97 Force percent 60.3 57.8 58.3 2015-2019 Population 16+ in Civilian Labor	
Population 16+ in Civilian Labor . 0.97 Force percent 65.3 61 59.6 2015-2019 Projected Child Food Insecurity . . . 2021 0.92 Rate percent 16.1 23.6 2021 Overcrowded 0.86 Households percent of households 1.6 4.8 2015-2019 Total 0.81 Change percent 3.7 2.9 1.6 2018-2019 Projected Food 0.81 Change percent 11.5 16.5 2021 Severe Housing 0.69 Problems percent 12.5 17.4 18 2013-2017 Unemployed 	
in Civilian Labor 0.97 Force percent 65.3 61 59.6 2015-2019 Projected Child Food Insecurity Food Insecurity Food Insecurity Food Insecurity Food Insecurity 0.92 Rate percent 16.1 23.6 2021 Overcrowded Ford I Food Insecurity Food Insecurity Food Insecurity 0.86 Households percent of households 1.6 4.8 2015-2019 Total Employment Insecurity Rate percent 3.7 2.9 1.6 2018-2019 0.81 Change percent 11.5 16.5 2021 Severe Housing percent 11.5 16.5 2021 Severe Housing percent 12.5 17.4 18 2013-2017 Unemployed Workers in Civilian Labor Force percent 5.2 6.7 6.1 Jun-21	1
0.97 Force percent 65.3 61 59.6 2015-2019 Projected Child Food Insecurity Ford Insecurity Ford Insecurity Ford Insecurity Ford Insecurity 0.92 Rate percent 16.1 23.6 2021 Overcrowded Ford Insecurity Ford Insecurity Ford Insecurity Ford Insecurity 0.86 Households percent of households 1.6 4.8 2015-2019 Total Employment Ford Insecurity Rate percent 3.7 2.9 1.6 2018-2019 0.81 Change percent 3.7 2.9 1.6 2018-2019 Projected Food Ford Food Ford Food Ford Food Ford Food Ford Food 0.69 Problems percent 12.5 17.4 18 2013-2017 Unemployed Workers in Force percent 5.2 6.7 6.1 Jun-21	
Projected Child Food Insecurity0.92Ratepercent16.123.62021Overcrowded Householdspercent of households1.64.82015-20190.86Householdspercent of households1.64.82015-2019Total Employmentpercent3.72.91.62018-20190.81Changepercent3.72.91.62018-2019Projected Foodpercent11.516.520210.69Problemspercent12.517.4182013-2017Unemployed Workers in Civilian Laborpercent5.26.76.1Jun-21	
Food Insecurity 0.92 Rate percent 16.1 23.6 2021 Overcrowded Overcrowded Image: Construction of the second of	1
0.92Ratepercent16.123.62021Overcrowded	
Overcrowded Householdspercent of households1.64.82015-2019Total EmploymentTotal Employment0.81Changepercent3.72.91.62018-2019Projected Food Insecurity Ratepercent11.516.52021Severe Housing Problemspercent12.517.4182013-2017Unemployed Workers in Civilian Laborpercent5.26.76.1Jun-21	
0.86Householdspercent of households1.64.82015-2019Total EmploymentTotalEmploymentInsecurityInsecurityInsecurityInsecurity0.81Changepercent3.72.91.62018-20190.75Insecurity Ratepercent11.516.520210.75Severe HousingProblemspercent12.517.4182013-20170.69Problemspercent12.517.4182013-20170.69Forcepercent5.26.76.1Jun-21	7
Total Employment 0.81 Change percent 3.7 2.9 1.6 2018-2019 Projected Food Projected Food 0.75 Insecurity Rate percent 11.5 16.5 2021 Severe Housing percent 12.5 17.4 18 2013-2017 Unemployed Workers in civilian Labor 5.2 6.7 6.1 Jun-21	
Employment Changepercent3.72.91.62018-20190.75Projected Food Insecurity Ratepercent11.516.520210.69Severe Housing Problemspercent12.517.4182013-20170.69Morkers in Civilian Laborpercent5.26.76.1Jun-21	1
0.81 Change percent 3.7 2.9 1.6 2018-2019 Projected Food Insecurity Rate percent 11.5 16.5 2021 0.75 Insecurity Rate percent 11.5 16.5 2021 Severe Housing Problems percent 12.5 17.4 18 2013-2017 Unemployed Workers in Civilian Labor 5.2 6.7 6.1 Jun-21	
Projected Food0.75Projected FoodInsecurity Ratepercent11.516.52021Severe HousingProblemspercent12.517.4182013-2017UnemployedWorkers inCivilian Labor0.69Forcepercent5.26.76.1Jun-21	
0.75 Insecurity Rate percent 11.5 16.5 2021 Severe Housing Problems percent 12.5 17.4 18 2013-2017 Unemployed Workers in Civilian Labor 5.2 6.7 6.1 Jun-21	18
Severe Housing0.69Problemspercent12.517.4182013-2017Unemployed Workers in Civilian Labor <td></td>	
0.69 Problems percent 12.5 17.4 18 2013-2017 Unemployed Workers in - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - <t< td=""><td>7</td></t<>	7
Unemployed Workers in Civilian Labor Force percent 5.2 6.7 6.1 Jun-21	
Workers in Civilian Labor0.69Forcepercent5.26.76.1Jun-21	6
Civilian Labor 0.69 Force percent 5.2 6.7 6.1 Jun-21	
0.69 Force <i>percent</i> 5.2 6.7 6.1 <i>Jun-21</i>	
Child Food	17
0.50 Insecurity Rate <i>percent</i> 12.8 19.6 14.6 2019	7
Food Insecurity	
0.50 Rate <i>percent</i> 9.6 14.1 10.9 2019	7

							Black (7.3) White	
							(2.4)	
							Asian	
							(9.2)	
							AIAN (0)	
							NHPI (0)	
							Mult	
							(10.4)	
	People 65+						Other	
	Living Below						(20.3)	
0.50	Poverty Level	percent	2.8	10.6	9.3	2015-2019	Hisp (4.3)	1
							Black	
							(15.5)	
							White	
							(2.4)	
							Asian	
							(7.4)	
							AIAN (0)	
							NHPI (0)	
	Formilian Living						Mult (4.2)	
	Families Living						Other	
0.36	Below Poverty Level	percent	3.8	11.3	9.5	2015-2019	(2.3) Hisp (6.1)	1
0.50	Persons with	percent	5.0	11.5	9.5	2013-2019	(0.1)	
	Disability Living							
	in Poverty (5-							
0.36	year)	percent	10.8	23.2	26.1	2015-2019		1
	Median Housing	p 0. 00,70		17250	21750			
0.33	Unit Value	dollars	266200	0	0	2015-2019		1
0.00		40/14/5	200200	v	•	2010 2015		<u> </u>

	Children Living							
	Below Poverty							
0.08	Level	percent	6.2		20.9	18.5	2015-2019	1
0.08	Homeownership	percent	78.8		54.9	56.2	2015-2019	1
	Households with							
	Cash Public							
	Assistance							
0.08	Income	percent	0.4		1.4	2.4	2015-2019	1
	Median							
	Household							
0.08	Income	dollars	100920		61874	62843	2015-2019	1
	People Living							
	200% Above							
0.08	Poverty Level	percent	85.6		65.7	69.1	2015-2019	1
	Per Capita							
0.08	Income	dollars	42346		31277	34103	2015-2019	1
	People Living							
	Below Poverty							
0.00	Level	percent	4.7	8	14.7	13.4	2015-2019	1

								HIGH	
			ROCKWALL	HP20			MEASUREMENT	DISPARITY	
SCORE	EDUCATION	UNITS	COUNTY	30	ТХ	U.S.	PERIOD	*	Source
	Student-to-								
2.00	Teacher Ratio	students/ teacher	16.3				2019-2020		10
								Black (0)	
								White	
								(0.3)	
								Asian	
								(1.9)	
								AIAN (0)	
	High School Drop							Mult (0)	
1.00	Out Rate	percent	0.4		1.9		2019	Hisp (0.8)	14
	People 25+ with								
	a High School								
0.53	Degree or Higher	percent	92.7		83.7	88	2015-2019		1
	Infants Born to								
	Mothers with							White	
	<12 Years							(2.8) Hisp	
0.33	Education	percent	6.7		17.4	13.3	2017	(19.5)	13
	People 25+ with								
	a Bachelor's								
0.08	Degree or Higher	percent	40.7		29.9	32.1	2015-2019		1

				DOCKMAN	11020				HIGH	
c	CORE	ENVIRONMENTAL HEALTH	UNITS	ROCKWALL COUNTY	HP20 30	ТХ	U.S.	MEASUREMENT PERIOD	DISPARITY *	Source
3	CORE	Fast Food	UNITS	COUNTY	50	17	0.3.	PERIOD	-	Jource
		Restaurant	restaurants/ 1,000							
	2.14	Density	population	0.9				2016		20
	2.14		ροραιατισπ	0.9				2010		20
	2 00	Grocery Store	stance / 1 000 seculation	0.1				2016		20
	2.00	Density	stores/ 1,000 population	0.1				2016		20
		SNAP Certified	<i>.</i>	_						
	2.00	Stores	stores/ 1,000 population	0.4				2017		20
		WIC Certified								
	2.00	Stores	stores/ 1,000 population	0.1				2016		20
		Children with								
		Low Access to a								
	1.67	Grocery Store	percent	6.3				2015		20
		Number of								
		Extreme								
		Precipitation								
	1.64	Days	days	40				2016		11
		Farmers Market	markets/ 1,000							
	1.50	Density	population	0				2018		20
		People with Low								
		Access to a								
	1.50	Grocery Store	percent	20.2				2015		20
		Annual Ozone								
	1.44	Air Quality	grade	D				2017-2019		2
		Number of								
		Extreme Heat								
	1.36	Events	events	2				2016		11
	1.36	PBT Released	pounds	4.5				2019		21

1.17	Daily Dose of UV Irradiance	Joule per square meter	3243	3538		2015	1
	Low-Income and						
	Low Access to a						
1.17	Grocery Store	percent	3.7			2015	2
	People 65+ with						
	Low Access to a						
1.17	Grocery Store	percent	1.8			2015	2
	Recreation and	facilities/ 1,000					
1.14	Fitness Facilities	population	0.1			2016	2
	Number of						
	Extreme Heat						
1.08	Days	days	5			2016	1
	Weeks of						
	Moderate						
1.08	Drought or Worse	weeks per year	1			2016	1
1.00	Households with	weeks per yeur	L			2010	
	No Car and Low						
	Access to a						
1.00	Grocery Store	percent	1			2015	2
	Adults with						
0.92	Current Asthma	percent	8.4		9.2	2018	
	Overcrowded						
0.86	Households	percent of households	1.6	4.8		2015-2019	
	Liquor Store	stores/ 100,000					
0.75	Density	population	2.9	6.9	10.5	2019	1
	Severe Housing						
0.69	Problems	percent	12.5	17.4	18	2013-2017	(

	Access to Exercise						
0.67	Opportunities	percent	90.2	80.5	84	2020	6
	Food						
	Environment						
0.53	Index		8.5	5.9	7.8	2021	6
	Asthma:						
	Medicare						
0.42	Population	percent	4	4.9	5	2018	5

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	ROCKWALL COUNTY	HP20 30	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY *	Source
	Adults who have had a Routine								
1.75	Checkup	percent	73.9			76.7	2018		3
1.69	Persons with Health Insurance	percent	85.1	92.1	79.3		2019		19
1.58	Adults without Health Insurance	percent	18	52.1	, 5.5	12.2	2018		3
1.50	Children with Health Insurance	percent	88.1		87.3	94.3	2019		1
1.36	Social Worker Rate	workers/ 100,000 population	64.6		82.7		2020		13
1.33	Adults with Health Insurance	percent	85.2		75.5	87.1	2019		1
0.92	Adults who Visited a Dentist	percent	67.6			66.5	2018		3
0.89	Dentist Rate	dentists/ 100,000 population	76.3		59.6		2019		6
0.75	Primary Care Provider Rate	providers/ 100,000 population	76.5		60.9		2018		6
0.67	Mental Health Provider Rate	providers/ 100,000 population	128.7		120.9		2020		6
0.67	Non-Physician Primary Care Provider Rate	providers/ 100,000 population	96.3		88.6		2020		6

SCORE	HEART DISEASE & STROKE	UNITS	ROCKWALL COUNTY	HP20 30	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY *	Source
JCOIL	Age-Adjusted	01115	COUNT			0.5.	FLNIOD		Jource
	Death Rate due								
	to								
	Cerebrovascular	deaths/ 100,000							
2.58	Disease (Stroke)	population	49.4	33.4	40.2	37.2	2017-2019		4
	Atrial	population							
	Fibrillation:								
	Medicare								
2.14	Population	percent	8.9		7.8	8.4	2018		5
	Adults who Have								
	Taken								
	Medications for								
	High Blood								
2.08	Pressure	percent	73.8			75.8	2017		3
	Hyperlipidemia:								
	Medicare								
2.00	Population	percent	50.6		49.5	47.7	2018		5
	Age-Adjusted ER								
	Rate due to	ER visits/ 10,000							
1.75	Hypertension	population 18+ years	25.5		10.5		2017-2019		16
1.75	Age-Adjusted		23.5		10.5		2017 2015		10
	Hospitalization								
	Rate due to	hospitalizations/ 10,000							
1.75	Hypertension	population 18+ years	0.7		0.3		2016-2018		16
	Age-Adjusted								
	Death Rate due								
	to Coronary	deaths/ 100,000							
1.72	Heart Disease	population	93.8	71.1	93	90.5	2017-2019		4
1.76		population	55.0	/ 1.1		50.5	2017 2013		–

Hypertension: Medicare1.64Population $percent$ 59.659.957.220185Ischemic Heart Disease: MedicareIschemic Heart Disease: Medicare26.72926.8201851.58Population $percent$ 26.72926.8201851.9Population $percent$ 3.84.23.820185High Blood Pressure $present$ 31.227.732.4201731.00Prevalence $percent$ 8381.520173Cholesterol Test Prevalence: 0.92 Adults 18+ $percent$ 33.434.1201730.92Adults 18+ $percent$ 33.434.1201733Age-Adjusted Death Rate due $deaths/100,000$ $deaths/100,0$									
1.64 Population percent 59.6 59.9 57.2 2018 5 Ischemic Heart Disease: Medicare									
Ischemic Heart Disease: Medicare									
Disease: Medicare 1.58 Population percent 26.7 29 26.8 2018 5 1.19 Population percent 3.8 4.2 3.8 2018 5 High Blood pressure pressure 7 32.4 2017 3 1.00 Prevalence percent 31.2 27.7 32.4 2017 3 Cholesterol Test 2017 3 High Cholesterol 2017 3 Prevalence: 33.4 34.1 2017 3 0.92 Adults 18+ percent 33.4 34.1 2017 3 Age-Adjusted 34.1 2017 3 0.86 to Heart Attack population 35+ years 47.4 70.1 2018 11 Heart Failure: 5 3.4 2018 5 0.86 Population percent 13.5 15.6 14 2018 </td <td>1.64</td> <td>•</td> <td>percent</td> <td>59.6</td> <td></td> <td>59.9</td> <td>57.2</td> <td>2018</td> <td>5</td>	1.64	•	percent	59.6		59.9	57.2	2018	5
Medicare Populationpercent26.72926.820185Stroke: Medicare Populationstroke: Medicarestroke: Medicare<									
1.58 Population percent 26.7 29 26.8 2018 5 1.19 Population percent 3.8 4.2 3.8 2018 5 High Blood Pressure									
Stroke: Medicare Population percent 3.8 4.2 3.8 2018 5 High Blood Pressure Pressure 7.7 32.4 2017 3 1.00 Prevalence percent 31.2 27.7 32.4 2017 3 0.92 History percent 83 81.5 2017 3 High Cholesterol Fest Prevalence: 7.4 70.1 2017 3 Age-Adjusted Death Rate due deaths/ 100,000 11 11 Death Rate due deaths/ 100,000 12.7 7.1 2018 11 Heart Failure: Medicare 9opulation 35+ years 47.4 70.1 2018 11 Heart Katack population 35+ years 47.4 70.1 2018 11 Heart Failure: Medicare S 5 3.4 2018 5 0.88 Population percent 13.5 15.6 14 2018 5 0.75 Stroke percent 2.7 3.4 2018 3									
1.19 Population percent 3.8 4.2 3.8 2018 5 High Blood Pressure Prevalence percent 31.2 27.7 32.4 2017 3 0.92 History percent 83 81.5 2017 3 High Cholesterol Test	1.58	Population	percent	26.7		29	26.8	2018	5
High Blood Pressurepercent31.227.732.4201731.00Prevalencepercent8381.5201730.92Historypercent8381.520173High Cholesterol Prevalence:percent33.434.120173Age-Adjusted Death Rate due deaths/ 100,000 to Heart Attackpercent33.470.1201811Heart Failure: Medicarepercent13.515.614201850.83Populationpercent13.515.614201850.75Strokepercent2.73.420183Adults who Experienced a2.73.420183		Stroke: Medicare							
Pressure1.00Prevalencepercent31.227.732.420173Cholesterol Test	1.19	Population	percent	3.8		4.2	3.8	2018	5
1.00Prevalencepercent31.227.732.420173Cholesterol Test		High Blood							
Cholesterol Test Historypercent8381.520173High Cholesterol Prevalence:		Pressure							
0.92Historypercent8381.520173High Cholesterol Prevalence:Prevalence:33.434.1201730.92Adults 18+percent33.434.120173Age-Adjusted Death Rate duedeaths/ 100,0005511110.86to Heart Attack population 35+ years47.470.1201811Heart Failure: MedicareMedicare514201850.83Populationpercent13.515.614201850.75Strokepercent2.73.420183Adults who Experienced a Coronary Heart2.73.420183	1.00	Prevalence	percent	31.2	27.7		32.4	2017	3
High Cholesterol Prevalence:0.92Adults 18+percent33.434.120173Age-Adjusted Death Rate due to Heart Attackdeaths/ 100,000201811Heart Failure: Medicaremedicare13.515.614201850.83Populationpercent13.515.614201850.75Strokepercent2.73.420183Adults who Experienced a Coronary Heart2.73.420183		Cholesterol Test							
Prevalence:0.92Adults 18+percent33.434.120173Age-Adjusted Death Rate due to Heart Attackdeaths/100,000 to population 35+ years47.470.1201811Heart Failure: Medicare Populationpercent13.515.614201850.83Populationpercent13.515.614201850.75Strokepercent2.73.420183Adults who Experienced a Coronary Heart2.73.420183	0.92	History	percent	83			81.5	2017	3
Prevalence:0.92Adults 18+percent33.434.120173Age-Adjusted Death Rate due to Heart Attackdeaths/100,000 to population 35+ years47.470.1201811Heart Failure: Medicare Populationpercent13.515.614201850.83Populationpercent13.515.614201850.75Strokepercent2.73.420183Adults who Experienced a Coronary Heart2.73.420183		High Cholesterol							
Age-Adjusted Death Rate due to Heart Attackdeaths/ 100,000 population 35+ years47.470.1201811Heart Failure: Medicare13.515.614201850.83Populationpercent13.515.61420185Adults who Experienced a Strokepercent2.73.420183Adults who Experienced a Coronary Heart111111		-							
Age-Adjusted Death Rate due to Heart Attackdeaths/ 100,000 population 35+ years47.470.1201811Heart Failure: Medicare13.515.614201850.83Populationpercent13.515.61420185Adults who Experienced a2.73.420183Adults who Experienced a2.73.420183	0.92	Adults 18+	percent	33.4			34.1	2017	3
Death Rate due to Heart Attackdeaths/ 100,000 population 35+ years47.470.1201811Heart Failure: Medicare		Δσe-Adjusted							
0.86to Heart Attackpopulation 35+ years47.470.1201811Heart Failure: MedicareMedicare			deaths/ 100 000						
Heart Failure: Medicare0.83Populationpercent13.515.61420185Adults who Experienced a5514201830.75Strokepercent2.73.420183Adults who Experienced Coronary Heart5555	0.86			47.4		70.1		2018	11
Medicare Populationpercent13.515.61420185Adults who Experienced a <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
0.83Populationpercent13.515.61420185Adults who Experienced a Strokepercent2.73.420183Adults who Experienced Coronary HeartLLLLL									
Adults who Experienced a 0.75 Stroke percent 2.7 3.4 2018 3 Adults who Experienced Coronary Heart	0.85		norcont	12 5		15.6	1/	2018	5
0.75 Experienced a Stroke percent 2.7 3.4 2018 3 Adults who Experienced Coronary Heart	0.05		percent	15.5		15.0	14	2018	
0.75Strokepercent2.73.420183Adults who Experienced Coronary Heart <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
Adults who Experienced Coronary Heart	0			2 7			2.4	2010	2
Experienced Coronary Heart	0.75	Stroke	percent	2.7			3.4	2018	3
Coronary Heart									
0.75 Disease percent 5.8 6.8 2018 3									
	0.75	Disease	percent	5.8			6.8	2018	3

SCORE	IMMUNIZATION S & INFECTIOUS DISEASES	UNITS	ROCKWAL L COUNTY	HP20 30	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARIT Y*	Source
	COVID-19 Daily								
	Average	cases per 100,000							
1.53	Incidence Rate	population	51.3		47.1	51.4	21-Sep-21		8
	HIV Diagnosis	cases/ 100,000							
1.47	Rate	population	6		15.7		2018		13
1.22	Syphilis Incidence Rate	cases/ 100,000 population	4		8.8	10.8	2018		13
0.94	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	12.1		11.8	13.8	2017-2019		4
0.94	Tuberculosis Incidence Rate	cases/ 100,000 population	0.8	1.4	4.3		2015-2019		13
0.89	Gonorrhea Incidence Rate	cases/ 100,000 population	45.7		163.6	179.1	2018		13
0.86	Overcrowded Households	percent of households	1.6		4.8		2015-2019		1
0.69	COVID-19 Daily Average Case- Fatality Rate	deaths per 100 cases	0.5		4.3	2	21-Sep-21		8
0.61	Chlamydia Incidence Rate	cases/ 100,000 population	169.9		508.2	539.9	2018		13

CODE	MATERNAL, FETAL & INFANT		ROCKWALL	HP20			MEASUREMENT	HIGH DISPARITY *	C
SCORE	HEALTH	UNITS	COUNTY	30	TX	U.S.	PERIOD	*	Source
	Babies with Low								
1.72	Birth Weight	percent	8.1		8.2	8.1	2015		13
	Babies with Very								
	Low Birth								
1.72	Weight	percent	1.5			1.4	2015		13
1.58	Preterm Births	percent	12.6	9.4	12.2		2017		13
	Mothers who								
	Received Early								
0.94	Prenatal Care	percent	71.2		60.5	77.3	2017		13
0.61	Teen Births	percent	0		2.1	3.1	2017		13
	Infant Mortality								
0.53	Rate	deaths/ 1,000 live births	3.9	5	5.6	5.9	2015		13
	Infants Born to								
	Mothers with							White	
	<12 Years							(2.8) Hisp	
0.33	Education	percent	6.7		17.4	13.3	2017	(19.5)	13

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	ROCKWALL COUNTY	HP20 30	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY *	Source
	Depression:								
	Medicare								
2.42	Population	percent	19.5		18.2	18.4	2018		5
	Alzheimer's								
	Disease or								
	Dementia:								
	Medicare								
2.31	Population	percent	13.3		12.6	10.8	2018		5
	Age-Adjusted								
	Death Rate due	deaths/ 100,000							
2.14	to Suicide	population	16.3	12.8	13.5	14.1	2017-2019		4
	Age-Adjusted ER								
	Rate due to								
	Adult Mental	ER visits/ 10,000							
1.25	Health	population 18+ years	4.2		8.9		2017-2019		16
	Age-Adjusted								
	Hospitalization								
	Rate due to								
	Adult Mental	hospitalizations/ 10,000							
1.25	Health	population 18+ years	1		1.7		2017-2019		16
	Frequent Mental								
1.00	Distress	percent	12		11.6	13	2018		6
	Poor Mental								
0.92	Health: 14+ Days	percent	11.8			12.7	2018		3
	Mental Health	providers/100,000							
0.67	Provider Rate	population	128.7		120.9		2020		6

			ROCKWALL	HP20			MEASUREMENT	HIGH DISPARITY	
SCORE	OLDER ADULTS	UNITS	COUNTY	30	ТХ	U.S.	PERIOD	*	Source
	Depression:								
	Medicare								
2.42	Population	percent	19.5		18.2	18.4	2018		5
	Alzheimer's								
	Disease or								
	Dementia:								
	Medicare								
2.31	Population	percent	13.3		12.6	10.8	2018		5
	Atrial								
	Fibrillation:								
	Medicare								
2.14	Population	percent	8.9		7.8	8.4	2018		5
	Hyperlipidemia:								
	Medicare								
2.00	Population	percent	50.6		49.5	47.7	2018		5
	Osteoporosis:								
	Medicare								
1.97	Population	percent	6.6		6.8	6.6	2018		5
	Rheumatoid								
	Arthritis or								
	Osteoarthritis:								
	Medicare								
1.81	Population	percent	35		34.2	33.5	2018		5
	Cancer:								
	Medicare								
1.69	Population	percent	8		7.6	8.4	2018		5

	Hypertension: Medicare							
1.64	Population	percent	59.6		59.9	57.2	2018	5
	Adults 65+ who							
	Received							
	Recommended							
	Preventive							
1.58	Services: Males	percent	28.3			32.4	2018	3
	Ischemic Heart							
	Disease:							
	Medicare							
1.58	Population	percent	26.7		29	26.8	2018	5
	Adults 65+ who							
	Received							
	Recommended							
	Preventive							
	Services:							
1.42	Females	percent	28			28.4	2018	3
	Colon Cancer							
1.33	Screening	percent	64.7	74.4		66.4	2018	3
	Stroke: Medicare							
1.19	Population	percent	3.8		4.2	3.8	2018	5
	People 65+ with							
	Low Access to a							
1.17	Grocery Store	percent	1.8				2015	20
	Chronic Kidney							
	Disease:							
	Medicare							
1.14	Population	percent	22.8		26.7	24.5	2018	5

SCORE	ORAL HEALTH	UNITS	ROCKWAL L COUNTY	HP20 30	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARIT Y*	Source
0.42	Medicare Population	percent	4		4.9	5	2018		5
0.50	Poverty Level Asthma:	percent	2.8		10.6	9.3	2015-2019	Hisp (4.3)	1
0.50	People 65+ Living Below	percent	9.7		11.2	11.5	2018	Black (7.3) White (2.4) Asian (9.2) AIAN (0) NHPI (0) Mult (10.4) Other (20.3)	5
	COPD: Medicare	·			11.2				
0.75	Adults with Arthritis	percent	22.3			25.8	2018		3
0.81	Population Adults 65+ with Total Tooth Loss	percent	<u>23.7</u> 9.7		28.8	27 13.5	2018		5
0.83	Heart Failure: Medicare Population Diabetes: Medicare	percent	13.5		15.6	14	2018		5

2.08	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	14	11	11.8	2013-2017	9
	Age-Adjusted ER						
	Rate due to	ER visits/ 10,000					
1.75	Dental Problems	population	17.2	11.1		2017-2019	16
	Adults who						
0.92	Visited a Dentist	percent	67.6		66.5	2018	3
		dentists/ 100,000					
0.89	Dentist Rate	population	76.3	59.6		2019	6
	Adults 65+ with						
0.75	Total Tooth Loss	percent	9.7		13.5	2018	3

	OTHER		ROCKWALL	HP20			MEASUREMENT	HIGH DISPARITY	
SCORE	CONDITIONS	UNITS	COUNTY	30	ТХ	U.S.	PERIOD	*	Source
1.97	Osteoporosis: Medicare Population	percent	6.6		6.8	6.6	2018		5
1.57	Rheumatoid Arthritis or Osteoarthritis: Medicare	percent	0.0		0.0	0.0			
1.81	Population	percent	35		34.2	33.5	2018		5
	Chronic Kidney Disease: Medicare								
1.14	Population	percent	22.8		26.7	24.5	2018		5
0.75	Adults with Arthritis	percent	22.3			25.8	2018		3
0.75	Adults with Kidney Disease	Percent of adults	2.5			3.1	2018		3

	PHYSICAL		ROCKWALL	HP20			MEASUREMENT	HIGH DISPARITY	
SCORE	ACTIVITY	UNITS	COUNTY	30	тх	U.S.	PERIOD	*	Source
	Fast Food					0.0.	121100		
	Restaurant	restaurants/ 1,000							
2.14	Density	population	0.9				2016		20
	Grocery Store								
2.00	Density	stores/ 1,000 population	0.1				2016		20
	SNAP Certified								
2.00	Stores	stores/ 1,000 population	0.4				2017		20
	WIC Certified								
2.00	Stores	stores/ 1,000 population	0.1				2016		20
	Children with								
	Low Access to a								
1.67	Grocery Store	percent	6.3				2015		20
	Farmers Market	markets/ 1,000							
1.50	Density	population	0				2018		20
	People with Low								
	Access to a								
1.50	Grocery Store	percent	20.2				2015		20
	Low-Income and								
	Low Access to a								
1.17	Grocery Store	percent	3.7				2015		20
	People 65+ with								
	Low Access to a								
1.17	Grocery Store	percent	1.8				2015		20
	Recreation and	facilities/ 1,000							
1.14	Fitness Facilities	population	0.1				2016		20
	Households with								
1.00	No Car and Low	percent	1				2015		20

	Access to a								
	Grocery Store								
	Access to								
	Exercise								
0.67	Opportunities	percent	90.2		80.5	84	2020		6
	Food								
	Environment								
0.53	Index		8.5		5.9	7.8	2021		6
								HIGH	
	PREVENTION &		ROCKWALL	HP20			MEASUREMENT	DISPARITY	
SCORE	SAFETY	UNITS	COUNTY	30	ТХ	U.S.	PERIOD	*	Source
	Death Rate due								
	to Drug	deaths/ 100,000							
1.06	Poisoning	population	10.3		10.6	21	2017-2019		6
	Age-Adjusted								
	Death Rate due								
	to Unintentional	deaths/ 100,000							
0.83	Injuries	population	28.2	43.2	38.7	48.9	2017-2019		4
	Severe Housing								
0.69	Problems	percent	12.5		17.4	18	2013-2017		6

SCORE	RESPIRATORY DISEASES	UNITS	ROCKWALL COUNTY	HP20 30	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY *	Source
	COVID-19 Daily Average	cases per 100,000							
1.53	Incidence Rate	population	51.3		47.1	51.4	21-Sep-21		8
1.14	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	50.9		50.6	58.3	2013-2017		9
0.94	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	12.1		11.8	13.8	2017-2019		4
0.94	Tuberculosis Incidence Rate	cases/ 100,000 population	0.8	1.4	4.3		2015-2019		13
0.92	Adults with Current Asthma	percent	8.4			9.2	2018		3
0.83	Adults who Smoke	percent	13.9	5		15.5	2018		3
0.75	Adults with COPD	Percent of adults	5.6			6.9	2018		3
0.69	COVID-19 Daily Average Case- Fatality Rate	deaths per 100 cases	0.5		4.3	2	21-Sep-21		8
0.00	COPD: Medicare		0.0		7.5	£	21 500 21		
0.50	Population	percent	9.7		11.2	11.5	2018		5
0.42	Asthma: Medicare Population	percent	4		4.9	5	2018		5

	Age-Adjusted Death Rate due	deaths/ 100,000							
0.33	to Lung Cancer	population	31.2	25.1	34.1	38.5	2013-2017		9
	SEXUALLY							HIGH	
	TRANSMITTED		ROCKWALL	HP20			MEASUREMENT	DISPARITY	
SCORE	INFECTIONS	UNITS	COUNTY	30	ТХ	U.S.	PERIOD	*	Source
	HIV Diagnosis	cases/ 100,000							
1.47	Rate	population	6		15.7		2018		13
	Syphilis	cases/ 100,000							
1.22	Incidence Rate	population	4		8.8	10.8	2018		13
	Gonorrhea	cases/ 100,000							
0.89	Incidence Rate	population	45.7		163.6	179.1	2018		13
	Chlamydia	cases/ 100,000							
0.61	Incidence Rate	population	169.9		508.2	539.9	2018		13
	-								
								HIGH	
	WELLNESS &		ROCKWALL	HP20			MEASUREMENT	DISPARITY	
SCORE	LIFESTYLE	UNITS	COUNTY	30	ТХ	U.S.	PERIOD	*	Source
	High Blood								
	Pressure								
1.00	Prevalence	percent	31.2	27.7		32.4	2017		3
0.86	Insufficient Sleep	percent	33	31.4	34.4	35	2018		6
	Poor Physical								
0.75	Health: 14+ Days	percent	10.5			12.5	2018		3
	, Frequent	· ·							
0.67	Physical Distress	percent	10		11.6	11	2018		6
							====		<u> </u>

SCORE	WOMEN'S HEALTH	UNITS	ROCKWALL COUNTY	HP20 30	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY *	Source
SCORE	Breast Cancer	01113	coonn			0.5.	T ENIOD		500100
2.17	Incidence Rate	cases/ 100,000 females	130.8		112.8	125.9	2013-2017		9
	Age-Adjusted Death Rate due								
1.69	to Breast Cancer	deaths/ 100,000 females	21	15.3	19.8	20.1	2013-2017		9
	Mammogram in Past 2 Years: 50-								
1.28	74	percent	73.4	77.1		74.8	2018		3
	Cervical Cancer								
0.89	Screening: 21-65	Percent	85.5	84.3		84.7	2018		3

Rockwall County Data Sources

Кеу	Source Title	
1	American Community Survey	
2	American Lung Association	
3	CDC - PLACES	
4	Centers for Disease Control and Prevention	
5	Centers for Medicare & Medicaid Services	
6	County Health Rankings	
7	Feeding America	
8	Healthy Communities Institute	
9	National Cancer Institute	
10	National Center for Education Statistics	
11	National Environmental Public Health Tracking Network	
12	Texas Department of Family and Protective Services	
13	DFWHC Foundation Regional Data, Q1-Q4, 2017-2019. DFWHC Foundation, Irving Texas. October 19, 2021	
14	Texas Education Agency	
15	Texas Secretary of State	
16	THR Texas Department of Health Services	
17	U.S. Bureau of Labor Statistics	
18	U.S. Census - County Business Patterns	
19	U.S. Census Bureau - Small Area Health Insurance Estimates	
20	U.S. Department of Agriculture - Food Environment Atlas	
21	U.S. Environmental Protection Agency	
22	United For ALICE	

Rockwall County Topic Scores

Health and Quality of Life Topics	Score
Alcohol & Drug Use	1.58
Women's Health	1.51
Mental Health & Mental Disorders	1.50
Children's Health	1.48
Heart Disease & Stroke	1.44
Physical Activity	1.42
Diabetes	1.39
Older Adults	1.36
Other Conditions	1.28
Oral Health	1.28
Environmental Health	1.25
Cancer	1.22
Health Care Access & Quality	1.19
Community	1.18
Maternal, Fetal & Infant Health	1.06
Sexually Transmitted Infections	1.05
Immunizations & Infectious Diseases	1.02
Economy	0.95
Prevention & Safety	0.86
Wellness & Lifestyle	0.82
Respiratory Diseases	0.82
Education	0.79

Community Input Assessment Tools

Key Informant Interview Guide and Questions

INTRODUCTION

HCI Facilitator: Introduce yourself and any others on the team

OPENING SCRIPT: TEXAS HEALTH RESOURCES (THR) has invited you to take part in this Key Informant Interview because of your content expertise and your experience working in the community. Our work on behalf of THR is focused on understanding what health issues and challenges impact the residents of **Dallas/Rockwall Region** and how to improve their overall health. The insights and perspectives collected in this interview will provide important information that will ultimately be combined with the results of a key informant interviews, focus groups, and data analysis of state and national indicators. These data components will be compiled into a comprehensive report outlining the health needs in the Southern Region which includes **Dallas/Rockwall Region**. The final reports will be completed in the summer of 2022.

CONFIDENTIALITY: For this interview, we will be taking notes on your responses, your names will not be associated with any direct quotes. Your identity will be kept confidential.

- 1. To begin, could you please tell us a little about the organization you work for and the geographic location it serves?
 - a. (only probe if necessary) What is your organization's mission? What are the top priority health issues that your organization addresses?
 - b. (only ask if not clear) Does your organization provide direct care, operate as an advocacy organization, or have another role in the community?
 - c. Which geographic location(s) does your organization serve? (to help us understand or confirm relevant service areas)

2. Considering the impact of Covid-19, what would you consider the top 5 health issues exacerbated by the pandemic in TARRANT county?

- **a.** What are the possible solutions to improve the health issues you've described?
- **b.** What solutions have your organization/agency put in place or considered to help improve the health issues you described?
- c. How can Texas Health support these health improvement efforts?

- 3. Along the same lines, what would you consider the top 5 socioeconomic needs exacerbated by the pandemic in [County Name/Zip code]?
 - a. What are the possible solutions to improve the socioeconomic needs you've described?
 - *b.* What specific solutions have your organization/agency put in place or considered to help improve the socioeconomic issues you described?
 - c. How can Texas Health support these socioeconomic improvement efforts?
- 4. Thinking about the solutions you described to address the health and socioeconomic needs, to what extent does your organization/agency have what it needs to deliver these services/resources in the community effectively?
 - a. How do aspects of this community's [County Name/Zip code] infrastructure (i.e., physical environment, policies, partnerships) help or hinder your ability to deliver the services/resources you described?
 - b. How can Texas Health support the success of these services/resources?
- 5. How can community leaders, community-based organizations, and health care systems work collaboratively to address this community's [County Name/Zip codes] health and socioeconomic?
 - a. To your knowledge, what strategies have been used in the past to drive collaboration across these partners? What worked, what didn't, and why?
 - b. What challenges/barriers should Texas Health anticipate in its efforts to work with community leaders and members to address the health and socioeconomic needs in this community?
 - c. How can Texas Health proactively address these challenges/barriers?
- 6. Finally, what do you consider the best practices that are currently going on to improve the health and socio-economic needs in this community [County/Zip codes]?
- 7. What is the most crucial message/feedback you want Texas Health to take away from this interview?
 - a. Is there anything else you would like to add about any of the topics we've discussed or other areas that we didn't discuss but you think are essential?

CLOSING SCRIPT: Thank you so much for your time and participation today. In terms of next steps, we will be collecting and analyzing the data for this needs assessment over the next few months. The final report will be available to everyone who participated, as well as the general public. If you have additional comments or thoughts after our conversation today, please feel free to reach out to *Eileen Aguilar* or Oge/Sika. *HCI Facilitator: Send a follow-up email to the key informant, thanking them for their time and make sure to include a link to the survey!*

Focus Group Guide and Questions

INTRODUCTION

{Introduce Yourself and Others on the Team}

{"Let's get started...}

Opening Script: Thank you for taking the time to speak with us to support the Texas Health Resources (THR) Community Health Needs Assessment. We anticipate that this discussion will last no more than 60 minutes. You have been invited to take part in this focus group because of your experience living and/or working in Dallas/Rockwall County. The focus of our Community Health Needs Assessment is how to improve health in the community and understand what challenges residents are facing. We are going to ask a series of questions related to health issues in the community. We hope to get through as many questions as possible and hear each of your perspectives as much as time allows.

For this discussion group, I will invite you to share as much or little as you feel comfortable sharing with the others in the group. The results of this assessment will be made available to the public. We will be taking notes on your responses, but your names will not be associated with any direct quotes. Your identity will be kept confidential, so please share your honest opinions.

SHOW SLIDES (if applicable)--We do have a few ground rules for this virtual discussion that I would like to review with you. It is important that everyone has a chance to be heard, so we ask that only one person talks at a time (most important ground rule for today). You may use the "raise hand" functions when you have something to say [*give instructions and test*]. We may also call on you to sure ensure everyone has a chance to speak but if you have nothing to share, please just say "pass".

You may want to mute yourself when you are not speaking to cut down on background noise [give instructions and test mute/unmute]. Finally, please respect the opinions of others, as the point of the discussion is to collect various points of view. And remember, there are no right or wrong answers, so please share freely and openly. Does anyone have any questions before we get started?

Okay, let's get started by going around and introducing ourselves. Please tell everyone your first name, what community you live in, and if you are interested in sharing, your involvement in the community (could be your job or volunteer work for example). {Introductions}

Thank you for introducing yourselves. Now we will get started with our discussion.

COVID-19 QUESTION

1. We know that COVID-19 has significantly impacted everyone's lives. What have you seen as the biggest challenges in XXXXX County during the pandemic?

[Probe 1: Which groups of people are having the hardest time right now?] [Probe 2: How have you seen these challenges being addressed, if at all?] [Probe 3: What programs have addressed COVID related issues? What has worked?] [Probe 4: What hasn't been effective and, in your opinion, why?]

GENERAL HEALTH QUESTIONS

2. What would you say are the top three health related problems that people in your community are facing that you would like to change or improve?

[Probe 1: Why do you think these are the most important health issues? [Probe 2: What would you do to address these problems?] [Probe 3: What else is needed to address these problems? Examples could be specific policies, programs, or services.]

3. What might prevent someone from accessing care for the health challenges identified above?

[Examples could include lack of transportation, lack of health insurance coverage, doctor's office hours, language, or cultural barriers, etc.]

4. Are there specific groups in your community that are most impacted by the health issues or challenges discussed earlier (2-3)? Which groups are these?

[Probe: Are these health challenges different if the person is a particular age, or gender, race, or ethnicity? Or lives in a certain part of the county for example?]

5. From the health issues and challenges we've just discussed, which do you think can be addressed in the next three years?

[Probe 1: How do you think these health issues can be addressed?} [Probe 2: Are some of these issues more urgent or important than others? If so, why?]

6. In 2019, Depression and anxiety among adults 18+ were identified as important health issues in your community. Do you know of any programs or services that are available in your community to address this issue?

[Prompt: Have you or someone you know benefited from these programs or services? If so, what do you think has worked? What do you think can be improved?]

7. What resources are currently available for residents in your community for the identified health/social determinant problem/s we've discussed today?

[Probe 1: Are there specific community organizations or agencies that you see taking a strong leadership role for improving the health of particular groups in your community?] [Probe 2: Do you see residents taking advantage of them? Why or why not?] [Probe 3: What additional programs and resources do you think are needed to best meet the needs of residents in _____ County?] [Probe 4: Are you aware of any THR-Community Health Improvement program(s) in your community?]

CLOSING QUESTION

8. Can you think of any other ways we could improve the health of residents in the community that we have not already talked about today?

[Probe: Is there anything else you would like to add that we haven't discussed?]

CONCLUSION

{Review the summary points and key takeaways from discussion} {Check if note taker needs any clarification}

CLOSURE SCRIPT: Thank you very much for your time and willingness to share your experiences with us today. We will include your comments in our data to describe how health can be improved for residents in your community. Please remember, your name will not be connected to any of the comments you made today. Please let us know if you have any questions or concerns about this.

Listening Session Questions

- 1. Name of the organization you represent.
- 2. What region/county/counties do your organization provide direct services to? (select all that apply)
 - a. Dallas County
 - b. Rockwall County
 - c. Tarrant County
 - d. Parker County
 - e. Denton County
 - f. Wise County
 - g. Collin County
 - h. Ellis County
 - i. Erath County
 - j. Henderson County
 - k. Johnson County
 - I. Kaufman County
- 3. In 2019, Texas Health Resources (THR) identified behavioral health, chronic disease prevention and management, access, awareness, health literacy and navigation as its priority areas. Are you aware of any THR programs, initiatives, resources, specifically addressing any of these priorities in your community?
- 4. What is THR doing well within the behavioral health, chronic disease prevention and management, access, health literacy and navigation areas? Feel free to address one or all priorities.
- 5. What are areas of opportunity within these priority areas? Feel free to address one or all priorities.
- 6. What can THR do to improve the awareness of its Community Health Needs Assessment (CHNA) findings and implementation strategies?
- **7.** Texas Health Resources is currently developing its 2022 CHNA reports and have identified these preliminary issues for the following regions:

Southern Region

Healthcare Access & Quality (lack of/limited insurance, delay in care)

Mental Health (depression, anxiety, isolation) Abuse/Violence (domestic violence, child abuse, intimate partner violence) Substance Abuse (isolation leading to increased substance use and addiction)

Denton/Wise Region-

Mental Health (increased need for adolescents, anxiety, lack of behavioral health services) Access to healthcare services (Provider shortages, language barriers, uninsured/underinsured) COVID-19 Impact (mental health, trust in healthcare system, delay in services) Food insecurity (lack of food, access to healthy foods, food deserts)

Tarrant/Parker Region-

Chronic conditions (heart disease, diabetes) COVID-19 Impact (Mental Health/Substance abuse, isolation, financial issues, delay in care, food insecurity) Health Behaviors (fear, stigma towards vaccine) Healthcare Access & Quality (Lack of providers, lack of bilingual providers, uninsured/underinsured)

Dallas/Rockwall Region-

Access to care (delay in care, uninsured, underinsured) Mental Health (isolation, depression exacerbated by COVID-19) Financial/Economic impact (unemployment, housing insecurity) Food insecurity (lack of healthy foods, lack of food)

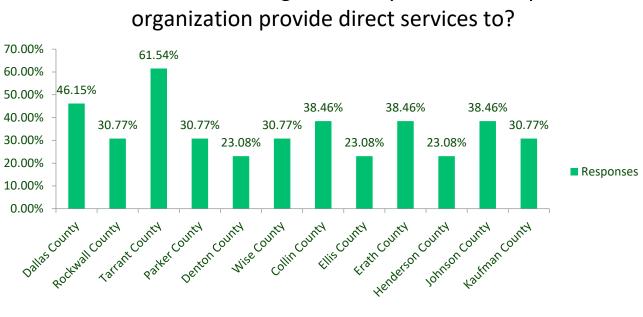
Collin Region-

Access to care (delay in services, high deductibles, affordability of insurance, knowledge of where to get care)

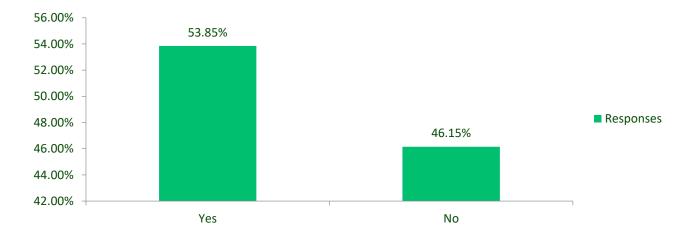
Mental Health (stigma in accessing care, cultural barriers, anxiety)

Economic/financial issues (difficulty paying rent/utilities, unemployment, loss of jobs) Housing (lack of affordable housing, discrimination)

7a. How can THR prioritize these health topics that have surfaced as issues in the region?



Question #3-Are you aware of any THR programs, initiatives, resources, specifically addressing any of these priorities in your community?



Question #2-What region/county/counties do your

Question #4-What is THR doing well within the behavioral health, chronic health, chronic disease prevention & management, access, health literacy, and navigation areas?

- While there is some generalize awareness of THR efforts, there is not sufficient publicity of these efforts to elicit significant engagement from the public.

-I navigate the Plano Up program funded by THR focusing on anxiety and depression in youth in the 75074 zip. Beyond Blue is another program funded by THR to address mental health in the senior population in the 75069 zip

- The Community Impact program and its regional councils are a great model to impact health priorities.

- It's hard to say due to the Pandemic really. THR has been sending email and reminders to people to do their screenings, testing and seeing their Dr, even telemedicine

- Their willingness to fund organizations that promote access and health literacy is awesome.

- Excellent work with chronic disease prevention and management. Also, good initiative with mental health in rural areas. Doing a good job of bringing these topics, education, and interventions to the people and communities THR serves.

- THR's Community Impact team has done a great job at leveraging relations with community leaders, nonprofits, thought leaders to strengthen efforts to improve health outcomes that are negatively impacted by the social determinants of health. They are also using data to drive their decision and to measure positive improvements in the areas of exercise, health and chronic disease prevention.

- Connect deeper to faith-based organizations, and schools where the under-resource families are nearest and partner with other foundations to strengthen the ability to sustain efforts.

Q5- Are there areas of opportunity within these priority areas? Feel free to address

-Behavioral health partnerships between THR, JPS, and the City of Arlington would be good way to have a meaningful impact on this issue. A formalized partnership with COA/Fire PH unit, Mission Arlington, School Districts, UTA school of Nursing and Social Work, JPS, TCPH and MCA could result in a cost effective and impactful approach to many of these issues.

- I feel mental health is still a large concern. However, I feel healthcare is out of reach for many people even for those with the ability to pay. Living expenses have increased to the point where many people cannot afford to maintain their physical or mental well-being

- There are many opportunities to impact health outcomes - particularly chronic diseasethrough increased awareness and support of patients affected by memory decline. This can include those at risk for cognitive decline (diverse communities are at higher risk, as are those who have comorbidities) and create opportunities for early detection—also, outcomes related to caregiver health.

- With the start of the Pandemic in March 2020, people have not seen their health care providers as they should, thus causing now two years later, many, many additional medical problems.

- Behavioral health is an awesome place to start. We need to train paraprofessionals to go into the neighborhood.

- Health literacy training for health care and service providers would enhance THR's current efforts within chronic disease management.

Question 6- What can THR do to improve the awareness of its Community Health Needs Assessment findings and implementation strategies?

-Partner directly with the City of Arlington Office of Communications

-Present to city and nonprofits the results of the assessment. Many citizens have no idea of the health status of our city.

- More programs focused on prevention and mobile solutions. We have to realize that many people cannot get to appointments even with coverage. Housing, food and transportation costs

- Increasing channels of communication, implementing practical action steps and a starting point for those needing the services, enhanced relationship building with community partners.

- Send them to community orgs as well as posting on their website. If both of these were done, I would recommend a way to ensure that all orgs doing any social service-related work get notified of the CHNA and implementation plan.

- Work directly with Community-Based Organizations (CBOs), such as the Alzheimer's Association or Area Agency on Aging, to promote these results and how a partnership with the CBO will impact the health outcomes. Continue to provide grants to CBOs to ensure that community support continues for all those in need.

- Perhaps THR can advertise the CHNA can run local ads on television and radio.

- As we emerge from the Pandemic, continue to reach those who are not connected by smart phones and emails

- A spot on the major networks or continuous radio spots would help.

- Personally, I think that THR does a great job of disseminating CHNA findings. They and Cook are regional leaders in that work. I'm not sure if THR already works closely with rural Extension

services to disseminate findings and implement programming. If not, that may be another avenue. Also, engaging FQHC's in CHNA implementation strategies is important.

- Take the information out to the community who are impacted the most. (Churches, Schools, Stores, barbershops, beauty shops and perhaps convenience store.

Question #7-How can THR prioritize these health topics that have surfaced as issues in the region? 50.00% 60.00% 50.00% 30.00% 40.00% 20.00% 30.00% 20.00% 10.00% 0.00% Option 1: Keep the health topics Option 2: Specify the issues within Option 3: Other (Explain below) broad and develop aligned each health topic that THR should programs/initiatives. address (e.g. Diabetes, Depression/Anxiety, etc.). Responses

Community Resource and Partner List

This highlights existing resources that organizations are currently using and available widely in the community. It also highlights community partners who were identified during the collection process for this CHNA.

Community Resource List

Austin City Center Baylor Scott & White Medical Center - Lake Pointe **Bonton Farms** Brother Bill's Care Center Center for Integrative Counseling and Psychology Chamber of Commerce **Compassion Center** Concilio **Dallas Community Center** Dallas Homelessness Collaborative run by Our Calling, Dallas Hunger Solutions, Metro Dallas Homeless Alliance Dallas Hunger Initiative **Dallas YMCA** Dallas Area Rape Crisis Center Food to Families program Food to Families program Grace Clinic **Healing Hands Ministries Helping Hands** Inspired Vision Lifesavers Foundation Literacy Achieves Los Barrios Unidos Community Clinic Mission East Dallas MLK Health North Texas Food Bank Northwest Community Center Parkland Transgender clinic Parkland's DeHaro-Saldivar Health Center Pleasant Grove Food Pantry PRISM health of North Texas PRISM health of North Texas Safer Dallas Better Dallas- The SANE Initiative Salvation Army Texas A&M AgriLife researchers and extension The Turning Point Vickery Meadows West Dallas Multipurpose Center

Community Partner List

Alzheimer's Association Austin City Center **Blue Zones Bonton Farms** Bridge Association (outreach to rehabilitate) City of Fort Worth Northside Community Center Community Action Agency **Cooper Street YMCA** Cornerstone Assistance Network: free vision/dental services by referral only for low-income folks Dallas Area Rape Crisis Center Dental health Arlington **Eastside Ministries** Galvin Clinic Inspiring body of Christ Dallas John Peter Smith Hospital: satellite clinics to bring services to people and increase access Lake Point Church Literacy Achieves **Mission Oak Cliff Rockwall County** Safer Dallas, Better Dallas Texas Health Hospital Rockwall Texas Women's Foundation

Appendix C. Denton-Wise Region

Denton-Wise Region

TEXAS HEALTH RESOURCES APPENDICES

Secondary Data Methodology

Secondary Data Sources

The main source for the secondary data, or data that has been previously collected, is the community indicator database maintained by Conduent Healthy Communities Institute. The following is a list of both local and national data sources used in Texas Health Resources Denton County and Wise County regional Community Health Needs Assessment report.

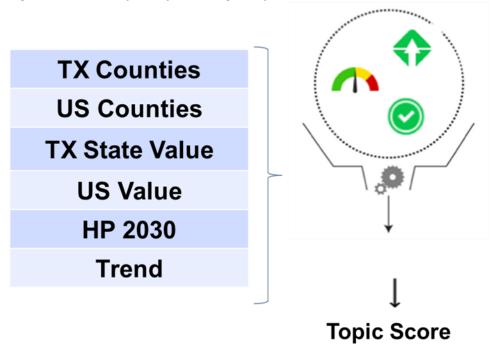
Data Sources

- American Community Survey
- American Lung Association
- CDC PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- County Health Rankings
- Feeding America
- Healthy Communities Institute
- National Cancer Institute
- National Center for Education Statistics
- National Environmental Public Health Tracking Network
- Texas Department of Family and Protective Services
- DFWHC Foundation Regional Data, Q1-Q4, 2017-2019. DFWHC Foundation, Irving Texas. October 15, 2021,

- Texas Education Agency
- Texas Department of Health Services
- U.S Bureau of Labor Statistics
- U.S. Census County Business Patterns
- U.S. Census Bureau Small Area Health Insurance Estimates
- U.S. Department of Agriculture Food Environment Atlas
- U.S. Environmental Protection Agency
- United for ALICE

Secondary Data Scoring

HCl's Data Scoring Tool (Figure 1A) was used to systematically summarize multiple comparisons in order to rank indicators based on the highest need. For each indicator, the community value was compared to a distribution of Texas and US counties, state and national values, Healthy People 2030, and significant trends were noted. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities and changes in methodology over time. The comparison scores were summarized for each indicator, and indicators were then grouped into topic areas for a systematic ranking of community health needs. Figure 1A: Summary of Topic Scoring Analysis



Index of Disparity

An important part of the CHNA process is to identify health disparities, the needs of vulnerable populations and unmet health needs or gaps in services. There were several ways in which subpopulation disparities were examined by county. For secondary data health indicators, the Index of Disparity tool was utilized to see if there were large, negative, and concerning differences in indicator values between each subgroup data value and the overall county value. The Index of Disparity was run for each county, and the indicators with the highest race or ethnicity index value were found.

Health Equity Index

Every community can be described by various social and economic factors that can contribute to disparities in health outcomes. Conduent HCI's Health Equity Index (formerly SocioNeeds [®] Index) considers validated indicators related to income, employment, education, and household environment to identify areas at highest risk for experiencing health inequities.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic needs correlated with preventable hospitalizations and premature death.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Health Equity Index, with darker coloring associated with higher relative need.

Food Insecurity Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in outcomes and opportunities to thrive. Conduent HCI's Food Insecurity Index considers validated indicators related to income, household environment and well-being to identify areas at highest risk for experiencing food insecurity.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest food insecurity, which is correlated with household and community measures of food-related financial stress such as Medicaid and SNAP enrollment.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Food Insecurity Index, with darker coloring associated with higher relative need.

Mental Health Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in mental health outcomes. Conduent HCI's Mental Health Index considers validated indicators related to access to care, physical health status, transportation, employment and household environment to identify areas at highest risk for experiencing poor mental health.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic and health needs correlated with self-reported poor mental health.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Mental Health Index, with darker coloring associated with higher relative need.

Data Considerations

Several limitations of data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and health-related areas, data availability varies by health topic. Some topics contain a robust set of secondary data indicators, while others may have a limited number of indicators or limited subpopulations covered by those specific indicators. Data scores represent the relative community health need according to the secondary data for each topic and should not be considered a comprehensive result on their own. In addition, these scores reflect the secondary data results for the population as a whole and do not represent the health or socioeconomic need that is much greater for some subpopulations. Moreover, many of the secondary data indicators included in the findings are collected by survey, and though specific methods are used to best represent the population at large, these measures are subject to instability, especially for smaller populations. The Index of Disparity is also limited by data availability, where indicator data varies based on the population groups and service areas being analyzed.

Race or ethnic and Special Population Groupings

The secondary data presented in this report derive from multiple sources, which may present race and ethnicity data using dissimilar nomenclature. For consistency with data sources throughout the report, subpopulation data may use different terms to describe the same or similar groups of community members.

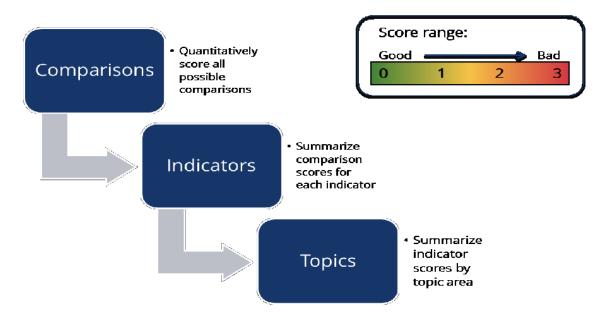
Zip Codes and Zip Code Tabulation Areas

This report presents both Zip Code and Zip Code Tabulation Area (ZCTA) data. Zip Codes, which were created by the U.S. Postal Service to improve mail delivery service, are not reported in this assessment as they may change, include P.O. boxes or cover large unpopulated areas. This assessment cover ZCTAs or Zip Code Tabulation Areas which were created by the U.S. Census Bureau and are generalized representations of Zip Codes that have been assigned to census blocks.

Demographics for this report are sourced from the United States Census Bureau, which presents ZCTA estimates. Tables and figures in the Demographics section of this report reference Zip Codes in title (for purposes of familiarity) but show values of ZCTAs. Data from other sources are labeled as such.

Secondary Data Scoring Detailed Methodology

Data Scoring is done in three stages:



For every indicator available, each county in the Hospital Service Area is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time. Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic. Secondary data for this report are up to date as of November 1, 2021.

Comparison to a Distribution of County Values: Within State and Nation

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

Comparison to Values: State, National, and Targets

The county is compared to the state value, the national value, and target values. Target values include the nation-wide Healthy People 2030 (HP2030) goals. Healthy People 2030 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' (DHHS) Healthy People Initiative. For all value comparisons, the scoring depends on whether the county value is better or worse than the comparison value, as well as how close the county value is to the target value.

Trend Over Time

The Mann-Kendall statistical test for trend was used to assess whether the county value is increasing over time or decreasing over time and whether the trend is statistically significant. The trend comparison uses the four most recent comparable values for the county, and statistical significance is determined at the 90% confidence level. For each indicator with values available for four time periods, scoring was determined by the direction of the trend and statistical significance.

Missing Values

Indicator scores are calculated using the comparison scores, the availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators on the community dashboard, it will be included in the indicator score. After the exclusion of comparison types with inadequate availability, all missing comparisons are substituted with a neutral score for the purposes of calculating the indicator's weighted average. When information is unknown due to a lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

Indicator Scoring

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated, and the indicator is excluded from the data scoring results.

Topic Scoring

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. The resulting scores range from 0-3, where a higher score indicates a greater level of need as evidenced by the data. A topic score is only calculated if it includes at least three indicators.

County Data Scoring Indicators Results Denton County Indicator Scores

SCORE	ALCOHOL & DRUG USE	UNITS	DENTON COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
						16.			
2.25	Adults who Binge Drink	percent	19.8			4	2018		3
		ER visits/ 10,000							
	Age-Adjusted ER Rate	population 18+							
1.75	due to Opioid Use	years	1.8		0.7		2017-2019		16
	Age-Adjusted	hospitalizations/							
	Hospitalization Rate	10,000 population							
1.75	due to Opioid Use	18+ years	0.2		0.1		2017-2019		16
		ER visits/ 10,000							
	Age-Adjusted ER Rate	population 18+							
1.25	due to Substance Use	years	9.1		20.6		2017-2019		16
	Age-Adjusted	hospitalizations/							
	Hospitalization Rate	10,000 population							
1.25	due to Substance Use	18+ years	0.8		1.2		2017-2019		16
	Age-Adjusted Drug and								
	Opioid-Involved	Deaths per 100,000				22.			
1.00	Overdose Death Rate	population	7.7		12.1	8	2017-2019		4
		stores/ 100,000				10.			
0.92	Liquor Store Density	population	6.9		6.9	5	2019		18
		percent of driving							
	Alcohol-Impaired	deaths with alcohol							
0.78	Driving Deaths	involvement	22.9	28.3	25.7	27	2015-2019		6
	Death Rate due to	deaths/ 100,000							
0.61	Drug Poisoning	population	7.5		10.6	21	2017-2019		6

SCORE	CANCER	UNITS	DENTON COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Cancer: Medicare								
2.47	Population	percent	8.4		7.6	8.4	2018		5
	Breast Cancer	cases/ 100,000			112.				
2.31	Incidence Rate	females	127		8	126	2013-2017		9
	Prostate Cancer	cases/ 100,000							
1.86	Incidence Rate	males	103.6		94	105	2013-2017		9
	Colon Cancer					66.			
1.83	Screening	percent	60.6	74.4		4	2018		3
	Oral Cavity and								
	Pharynx Cancer	cases/ 100,000				11.			
1.50	Incidence Rate	population	10.9		11	8	2013-2017		9
	All Cancer Incidence	cases/ 100,000			407.				
1.47	Rate	population	408.5		7	449	2013-2017		9
	Cervical Cancer					84.			
1.28	Screening: 21-65	Percent	84	84.3		7	2018		3
	Mammogram in Past 2					74.			
0.94	Years: 50-74	percent	74.8	77.1		8	2018		3
	Cervical Cancer	cases/ 100,000							
0.89	Incidence Rate	females	6.1		9.2	7.6	2013-2017		9
0.75	Adults with Cancer	percent	5.7			6.9	2018		3
	Age-Adjusted Death								
	Rate due to Breast	deaths/ 100,000				20.			
0.69	Cancer	females	17.5	15.3	19.8	1	2013-2017		9
	Age-Adjusted Death								
	Rate due to Prostate	deaths/ 100,000	_		_	_			
0.58	Cancer	males	15.6	16.9	17.6	19	2013-2017		9
	Age-Adjusted Death					4.2			
0.44	Rate due to Colorectal	deaths/ 100,000	10.0	0.0	12.0	13.	2012 2017		0
0.44	Cancer	population	10.9	8.9	13.9	7	2013-2017		9

	Age-Adjusted Death Rate due to Lung	deaths/ 100,000				38.		
	e e e e e e e e e e e e e e e e e e e							
0.33	Cancer	population	30.8	25.1	34.1	5	2013-2017	9
	Lung and Bronchus	cases/ 100,000				58.		
0.25	Cancer Incidence Rate	population	46.7		50.6	3	2013-2017	9
	Age-Adjusted Death	deaths/ 100,000			148.			
0.11	Rate due to Cancer	population	129.6	122.7	8	156	2013-2017	9
	Colorectal Cancer	cases/ 100,000				38.		
0.08	Incidence Rate	population	31.8		37.6	4	2013-2017	9

SCORE	CHILDREN'S HEALTH	UNITS	DENTON COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Food Insecure Children Likely Ineligible for								
2.50	Assistance	percent	53		34	23	2019		7
	Children with Health					94.			
1.50	Insurance	percent	90.3		87.3	3	2019		1
	Children with Low								
	Access to a Grocery								
1.50	Store	percent	5.2				2015		20
	Substantiated Child	cases/ 1,000							
1.33	Abuse Rate	children	7.4	8.7	9.1		2020		12
	Projected Child Food								
0.92	Insecurity Rate	percent	17.5		23.6		2021		7
	Child Food Insecurity					14.			
0.67	Rate	percent	13.8		19.6	6	2019		7

SCORE	COMMUNITY	UNITS	DENTON COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
JEONE	Solo Drivers with a	UNITS	coolin	111 2030		0.5.	TENIOD	HIGH DISLART	Jource
2.92	Long Commute	percent	47.6		38.9	37	2015-2019		6
	Median Household				104	106			
2.67	Gross Rent	dollars	1218		5	2	2015-2019		1
	Median Monthly								
	Owner Costs for								
	Households without a								
2.67	Mortgage	dollars	773		514	500	2015-2019		1
	Mortgaged Owners								
	Median Monthly				160	159			
2.67	Household Costs	dollars	2015		6	5	2015-2019		1
		membership							
		associations/ 10,000							
2.64	Social Associations	population	5.6		7.5	9.3	2018		6
	Mean Travel Time to					26.			
2.31	Work	minutes	29		26.6	9	2015-2019		1
								Black (1.6)	
								White (0.6)	
								Asian (1) AIAN	
								(2.8) NHPI (4.2)	
	Workers Commuting							Mult (1.4)	
1 70	by Public	novoont	0.0	гэ	1 1	F	2015 2010	Other (1) Hisp	1
1.72	Transportation	percent	0.8	5.3	1.4	5	2015-2019	(1)	1
1.00	Persons with Health		06.6	02.4	70.2		2010		10
1.69	Insurance	percent	86.6	92.1	79.3		2019		19
1.00		workers/ 100,000	60 0		oo -		2020		42
1.36	Social Worker Rate	population	69.3		82.7		2020		13
	Substantiated Child	cases/ 1,000							
1.33	Abuse Rate	children	7.4	8.7	9.1		2020		12

	Workers who Drive					76.		
1.19	Alone to Work	percent	80.4		80.5	3	2015-2019	1
	Voter Turnout:							
1.17	Presidential Election	percent	63.9		58.8		2016	15
1.03	Linguistic Isolation	percent	3.4		7.7	4.4	2015-2019	1
	Households with No							
	Car and Low Access to							
1.00	a Grocery Store	percent	0.7				2015	20
	, Female Population 16+					58.		
0.92	in Civilian Labor Force	percent	66.4		57.8	3	2015-2019	1
	Persons with an					86.		
0.92	Internet Subscription	percent	93.3		84.2	2	2015-2019	1
UIJE	Households with One	percent	55.5		04.2	~	2013 2013	
						90.		
0.83	or More Types of Computing Devices	percent	97.1		91	90. 3	2015-2019	1
0.85	Total Employment	percent	97.1		91	5	2013-2019	1
0.81	Change	percent	4.3		2.9	1.6	2018-2019	18
0.01	Change	•	4.5		2.5	1.0	2010-2019	10
		percent of driving						
0.70	Alcohol-Impaired	deaths with alcohol	22.0	20.2	25.7	27	2015 2010	c
0.78	Driving Deaths	involvement	22.9	28.3	25.7	27	2015-2019	6
0.00		norrout	C1 2		F 4 0	56. 2	2015 2010	1
0.69	Homeownership	percent	61.2		54.9	Z	2015-2019	1
	Age-Adjusted Death Rate due to Motor							
	Vehicle Traffic	deaths/ 100,000				11.		
0.67	Collisions	population	6.7	10.1	13	11. 3	2017-2019	4
0.07		ροραιατισπ	0.7	10.1	13		2017-2019	4
0.64	Population 16+ in	norcont	60.9		61	59.	2015 2010	1
0.64	Civilian Labor Force	percent	69.8		61	6	2015-2019	1
	People 25+ with a High							
0.53	School Degree or	norcont	92.5		83.7	88	2015-2019	1
0.55	Higher	percent	92.5		03./	õõ	2013-2019	1

	Households with an								
0.50	Internet Subscription	percent	91.9		82.1	83	2015-2019		1
	Median Housing Unit				2E+	###			
0.33	Value	dollars	277800		05	#	2015-2019		1
								Black (14.2)	
								White (4.4)	
								Asian (7.4)	
								AIAN (6) NHPI	
								(0) Mult (7.1)	
	Children Living Below					18.		Other (12.3)	
0.08	Poverty Level	percent	8.4		20.9	5	2015-2019	Hisp (15.6)	1
	Median Household				618	###			
0.08	Income	dollars	86913		74	#	2015-2019		1
	People 25+ with a								
	Bachelor's Degree or					32.			
0.08	Higher	percent	45.1		29.9	1	2015-2019		1
					312	###			
0.08	Per Capita Income	dollars	41153		77	#	2015-2019		1
	Single-Parent					25.			
0.08	Households	percent	17.8		26.3	5	2015-2019		1
								Black (11.2)	
								White (5.5)	
								Asian (7.9)	
								AIAN (8.7)	
								NHPI (15.4)	
								Mult (8.2)	
	People Living Below					13.		Other (10.8)	
0.06	Poverty Level	percent	7.6	8	14.7	4	2015-2019	Hisp (12.6)	1

			DENTON	HP203			MEASUREME	HIGH	Sour
SCORE	DIABETES	UNITS	COUNTY	0	ТΧ	U.S.	NT PERIOD	DISPARITY*	ce
		ER visits/ 10,000							
	Age-Adjusted ER Rate	population 18+							
1.75	due to Diabetes	years	19.1		9.4		2017-2019		16
		ER visits/ 10,000							
	Age-Adjusted ER Rate	population 18+							
1.75	due to Type 2 Diabetes	years	17		8.6		2017-2019		16
	Age-Adjusted	hospitalizations/							
	Hospitalization Rate	10,000 population							
1.75	due to Diabetes	18+ years	13.9		5.3		2017-2019		16
	Age-Adjusted	hospitalizations/							
	Hospitalization Rate	10,000 population							
1.75	due to Type 2 Diabetes	18+ years	10.3		4		2017-2019		16
	Diabetes: Medicare								
0.83	Population	percent	25.2		28.8	27	2018		5
	Age-Adjusted Death	deaths/ 100,000				21.			
0.36	Rate due to Diabetes	population	15.6		22	5	2017-2019		4

			DENTON	HP203			MEASUREME	HIGH	Sour
SCORE	ECONOMY	UNITS	COUNTY	0	ТΧ	U.S.	NT PERIOD	DISPARITY*	се
	Median Household				104	106			
2.67	Gross Rent	dollars	1218		5	2	2015-2019		1
	Median Monthly								
	Owner Costs for								
	Households without a								
2.67	Mortgage	dollars	773		514	500	2015-2019		1
	Mortgaged Owners								
	Median Monthly				160	159			
2.67	Household Costs	dollars	2015		6	5	2015-2019		1
	Food Insecure Children								
	Likely Ineligible for								
2.50	Assistance	percent	53		34	23	2019		7
		stores/ 1,000							
2.00	WIC Certified Stores	population	0.1				2016		20
		stores/ 1,000							
1.86	SNAP Certified Stores	population	0.3				2017		20
	Renters Spending 30%								
	or More of Household					49.			
1.64	Income on Rent	percent	45.3		47.8	6	2015-2019		1
	Low-Income and Low								
	Access to a Grocery								
1.17	Store	percent	4.3				2015		20
	Students Eligible for								
	the Free Lunch								
1.14	Program	percent	27.7				2019-2020		10
						10.			
1.00	Food Insecurity Rate	percent	11.3		14.1	9	2019		7

1.00	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	percent	68.2	56		2018	22
1.00	Households that are Asset Limited, Income Constrained, Employed (ALICE)	percent	24.5	30		2018	22
1.00	Households that are Below the Federal Poverty Level	percent	7.3	14		2018	22
0.92	Female Population 16+ in Civilian Labor Force	percent	66.4	57.8	58. 3	2015-2019	1
0.92	Projected Child Food Insecurity Rate	percent	17.5	23.6		2021	7
0.92	Projected Food Insecurity Rate	percent	13.5	16.5		2021	7
0.86	Overcrowded Households	percent of households	2.3	4.8		2015-2019	1
0.86	Severe Housing Problems	percent	13.7	17.4	18	2013-2017	6
0.81	Total Employment Change	percent	4.3	2.9	1.6	2018-2019	18
0.69	Homeownership	percent	61.2	54.9	56. 2	2015-2019	1
0.69	Unemployed Workers in Civilian Labor Force	percent	5.2	6.7		Jun-21	17
0.67	Child Food Insecurity Rate	percent	13.8	19.6	14. 6	2019	7

							Black (6.1)	
							White (4.6)	
							Asian (5.5)	
							AIAN (9.7)	
							NHPI (0) Mult	
							(1.8) Other	
	People 65+ Living						(11.4) Hisp	
0.64	Below Poverty Level	percent	5.1	10.6	9.3	2015-2019	(7.9)	1
	Population 16+ in				59.			
0.64	Civilian Labor Force	percent	69.8	61	6	2015-2019		1
	Mortgaged Owners							
	Spending 30% or More							
	of Household Income				26.			
0.50	on Housing	percent	23.5	26.5	5	2019		1
	Households with Cash							
	Public Assistance							
0.36	Income	percent	0.9	1.4	2.4	2015-2019		1
	Median Housing Unit			2E+	###			
0.33	Value	dollars	277800	05	#	2015-2019		1
							Black (14.2)	
							White (4.4)	
							Asian (7.4)	
							AIAN (6) NHPI	
							(0) Mult (7.1)	
	Children Living Below				18.		Other (12.3)	
0.08	Poverty Level	percent	8.4	20.9	5	2015-2019	Hisp (15.6)	1

								Black (7.8)	
								White (2.8)	
								Asian (4.9)	
								AIAN (10.5)	
								NHPI (0) Mult	
								(7.2) Other	
	Families Living Below							(8.2) Hisp	
0.08	Poverty Level	percent	4.6		11.3	9.5	2015-2019	(10.1)	1
	Median Household				618	###			
0.08	Income	dollars	86913		74	#	2015-2019		1
	People Living 200%					69.			
0.08	Above Poverty Level	percent	80.7		65.7	1	2015-2019		1
					312	###			
0.08	Per Capita Income	dollars	41153		77	#	2015-2019		1
	Persons with Disability								
	Living in Poverty (5-					26.			
0.08	year)	percent	13.6		23.2	1	2015-2019		1
								Black (11.2)	
								White (5.5)	
								Asian (7.9)	
								AIAN (8.7)	
								NHPI (15.4)	
								Mult (8.2)	
	People Living Below					13.		Other (10.8)	
0.06	Poverty Level	percent	7.6	8	14.7	4	2015-2019	Hisp (12.6)	1

			DENTON	HP203			MEASUREME	HIGH	Sour
SCORE	EDUCATION	UNITS	COUNTY	0	ТΧ	U.S.	NT PERIOD	DISPARITY*	ce
	Student-to-Teacher								
1.69	Ratio	students/ teacher	14.5				2019-2020		10
								Black (2.8)	
								White (1.3)	
								Asian (1.5)	
								AIAN (5.5) PI	
	High School Drop Out							(0) Mult (2.8)	
1.67	Rate	percent	2.2		1.9		2019	Hisp (3.9)	14
								Black (4.1)	
	Infants Born to							White (2.4)	
	Mothers with <12					13.		Other (5.6)	
0.61	Years Education	percent	8.4		17.4	3	2017	Hisp (24.2)	13
	People 25+ with a High								
	School Degree or								
0.53	Higher	percent	92.5		83.7	88	2015-2019		1
	People 25+ with a								
	Bachelor's Degree or					32.			
0.08	Higher	percent	45.1		29.9	1	2015-2019		1

	ENVIRONMENTAL		DENTON	HP203			MEASUREME	HIGH	Sour
SCORE	HEALTH	UNITS	COUNTY	0	ТХ	U.S.	NT PERIOD	DISPARITY*	се
	Asthma: Medicare					_			_
2.19	Population	percent	5.4		4.9	5	2018		5
		stores/ 1,000							
2.00	Grocery Store Density	population	0.1				2016		20
		stores/ 1,000							
2.00	WIC Certified Stores	population	0.1				2016		20
		stores/ 1,000							
1.86	SNAP Certified Stores	population	0.3				2017		20
	Fast Food Restaurant	restaurants/ 1,000							
1.81	Density	population	0.7				2016		20
	Annual Ozone Air								
1.75	Quality	Grade	F				2017-2019		2
	Number of Extreme								
1.64	Precipitation Days	days	38				2016		11
	Children with Low								
	Access to a Grocery								
1.50	Store	percent	5.2				2015		20
	Farmers Market	markets/ 1,000							
1.50	Density	population	0				2018		20
	Months of Mild								
1.36	Drought or Worse	months per year	5				2016		11
	Number of Extreme								
1.36	Heat Events	events	1				2016		11
	Recognized								
	Carcinogens Released								
1.36	into Air	pounds	26.4				2019		21
	People with Low								
	Access to a Grocery								
1.33	Store	percent	18.6				2015		20

	Daily Dose of UV	Joule per square		353			
1.17	Irradiance	meter	3277	8		2015	11
	Low-Income and Low						
	Access to a Grocery						
1.17	Store	percent	4.3			2015	20
	Recreation and Fitness	facilities/ 1,000					
1.17	Facilities	population	0.1			2016	20
	Number of Extreme						
1.08	Heat Days	days	2			2016	11
1.08	PBT Released	pounds	137.2			2019	21
	Households with No						
	Car and Low Access to						
1.00	a Grocery Store	percent	0.7			2015	20
	People 65+ with Low						
	Access to a Grocery						
1.00	Store	percent	1.4			2015	20
	Adults with Current						
0.92	Asthma	percent	8.5		9.2	2018	3
		stores/ 100,000			10.		
0.92	Liquor Store Density	population	6.9	6.9	5	2019	18
	Overcrowded	percent of					
0.86	Households	households	2.3	4.8		2015-2019	1
	Severe Housing						
0.86	Problems	percent	13.7	17.4	18	2013-2017	6
	Food Environment						
0.53	Index		8.2	5.9	7.8	2021	6
	Access to Exercise						
0.50	Opportunities	percent	94.5	80.5	84	2020	6

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	DENTON COUNTY	HP2030	тх	U.S.	MEAS. PERIOD	HIGH DISPARITY*	Sourc e
JEONE	Primary Care Provider	providers/ 100,000	coontr	111 2030	IX	0.5.	WIEAS. TERIOD		
2.00	Rate	population	54		60.9		2018		6
	Adults who have had a					76.			
1.92	Routine Checkup	percent	73.6			7	2018		3
	Adults without Health					12.			
1.75	Insurance	percent	18.8			2	2018		3
	Persons with Health								
1.69	Insurance	percent	86.6	92.1	79.3		2019		19
	Children with Health					94.			
1.50	Insurance	percent	90.3		87.3	3	2019		1
		workers/ 100,000							
1.36	Social Worker Rate	population	69.3		82.7		2020		13
	Adults with Health					87.			
1.33	Insurance	percent	85.7		75.5	1	2019		1
	Non-Physician Primary	providers/ 100,000							
1.33	Care Provider Rate	population	67.9		88.6		2020		6
	Adults who Visited a					66.			
1.25	Dentist	percent	66.3			5	2018		3
		dentists/ 100,000							
0.83	Dentist Rate	population	57.6		59.6		2019		6
	Mental Health Provider	providers/100,000			120.				
0.83	Rate	population	118.6		9		2020		6
									_
SCOR	HEART DISEASE &		DENTON	HP203			MEASUREME	HIGH	Sour
E	STROKE	UNITS	COUNTY	0	ТХ	U.S.	NT PERIOD	DISPARITY*	се
	Hyperlipidemia:					47.			_
2.47	Medicare Population	percent	53.3		49.5	7	2018		5

	Adults who Have Taken							
	Medications for High					75.		
2.08	Blood Pressure	percent	71.9			8	2017	3
	Hypertension:					57.		
1.92	Medicare Population	percent	59.3		59.9	2	2018	5
	Atrial Fibrillation:							
1.81	Medicare Population	percent	8.4		7.8	8.4	2018	5
		ER visits/ 10,000						
	Age-Adjusted ER Rate	population 18+						
1.75	due to Hypertension	years	27.4		10.5		2017-2019	16
	Age-Adjusted	hospitalizations/						
	Hospitalization Rate	10,000 population						
1.75	due to Hypertension	18+ years	0.6		0.1		2017-2019	16
	Stroke: Medicare							
1.36	Population	percent	3.9		4.2	3.8	2018	5
1.50	Age-Adjusted Death	percent	5.5		7.2	5.0	2010	
	Rate due to							
	Cerebrovascular	deaths/ 100,000				37.		
1.11	Disease (Stroke)	population	37.2	33.4	40.2	2	2017-2019	4
	Ischemic Heart							
	Disease: Medicare					26.		
1.00	Population	percent	26.3		29	8	2018	5
	High Blood Pressure					32.		
0.94	Prevalence	percent	29.7	27.7		4	2017	3
	Cholesterol Test	·				81.		
0.92	History	percent	81.9			5	2017	3
	High Cholesterol					34.		
0.92	Prevalence: Adults 18+	percent	31.9			1	2017	3
	Adults who							
0.75	Experienced a Stroke	percent	2.4			3.4	2018	3
		percent				5.1		

	Adults who								
	Experienced Coronary								
0.75	Heart Disease	percent	5.1			6.8	2018		3
	Age-Adjusted Death	deaths/ 100,000							
	Rate due to Heart	population 35+							
0.58	Attack	years	41.9		70.1		2018		11
	Heart Failure:								
0.36	Medicare Population	percent	12.2		15.6	14	2018		5
	Age-Adjusted Death								
	Rate due to Coronary	deaths/ 100,000				90.			
0.28	Heart Disease	population	61.1	71.1	93	5	2017-2019		4
SCOR	IMMUNIZATIONS &		DENTON	HP203			MEASUREME	HIGH	Sour
Е	INFECTIOUS DISEASES	UNITS	COUNTY	0	ТΧ	U.S.	NT PERIOD	DISPARITY*	се
	Age-Adjusted								
	Hospitalization Rate								
	due to Immunization-								
	Preventable	hospitalizations/							
	Pneumonia and	10,000 population							
1.75	Influenza	18+ years	0.2		0.1		2017-2019		16
		cases/ 100,000							
1.64	HIV Diagnosis Rate	population	10.4		15.7		2018		13
	Tuberculosis Incidence	cases/ 100,000							
1.42	Rate	population	2.5	1.4	4.3		2015-2019		13
	COVID-19 Daily								
	Average Case-Fatality	deaths per 100							
1.14	Rate	cases	0.7		3	1.6	17-Sep-21		8
		cases/ 100,000				10.			
1.08	Syphilis Incidence Rate	population	2.6		8.8	8	2018		13
	Gonorrhea Incidence	cases/ 100,000			163.				
1.06	Rate	population	89.9		6	179	2018		13

	COVID-19 Daily	cases per 100,000				59.			
0.97	Average Incidence Rate	population	49.3		59.9	2	17-Sep-21		8
	Chlamydia Incidence	cases/ 100,000			508.				
0.92	Rate	population	279		2	540	2018		13
	Overcrowded	percent of							
0.86	Households	households	2.3		4.8		2015-2019		1
	Age-Adjusted Death								
	Rate due to Influenza	deaths/ 100,000				13.			
0.33	and Pneumonia	population	9.5		11.8	8	2017-2019		4
		F - F							
SCOR	MATERNAL, FETAL &		DENTON	HP203			MEASUREME	HIGH	Sour
E	INFANT HEALTH	UNITS	COUNTY	0	тх	U.S.	NT PERIOD	DISPARITY*	ce
1.72	Babies with Very Low Birth Weight	percent	1.4			1.4	2015	Black (3.69989722) White (1.32068452) Hisp (1.09135004)	13
	Babies with Low Birth								
1.56	Weight	percent	7.9		8.2	8.1	2015		13
	Mothers who Received					77.			
1.28	Early Prenatal Care	percent	67.4		60.5	3	2017		13
1.03	Preterm Births	percent	9.8	9.4	12.2		2017		13
0.94	Teen Births	percent	0.9		2.1	3.1	2017	Black (1) White (0.4) Other (0) Hisp (2.3)	13
	Infants Born to Mothers with <12	1,				13.		Black (4.1) White (2.4) Other (5.6)	
0.61	Years Education	percent	8.4		17.4	3	2017	Hisp (24.2)	13

		deaths/ 1,000 live							
0.53	Infant Mortality Rate	births	3.5	5	5.6	5.9	2015		13
SCOR	MENTAL HEALTH &		DENTON	HP203			MEASUREME	HIGH	Sour
Е	MENTAL DISORDERS	UNITS	COUNTY	0	ТΧ	U.S.	NT PERIOD	DISPARITY*	ce
	Alzheimer's Disease or					_			
	Dementia: Medicare					10.			
1.97	Population	percent	12.2		12.6	8	2018		5
	Depression: Medicare					18.			
1.83	Population	percent	18.9		18.2	4	2018		5
	Age-Adjusted ER Rate	ER visits/ 10,000							
	due to Adult Mental	population 18+							
1.25	Health	years	3.3		8.9		2017-2019		16
	Age-Adjusted								
	Hospitalization Rate	hospitalizations/							
	due to Adult Mental	10,000 population							
1.25	Health	18+ years	0.8		1.7		2017-2019		16
	Age-Adjusted Death	deaths/ 100,000				14.			
1.14	Rate due to Suicide	population	11.9	12.8	13.5	1	2017-2019		4
	Poor Mental Health:					12.			
0.92	14+ Days	percent	11.8			7	2018		3
	Mental Health Provider	providers/100,000			120.				
0.83	Rate	population	118.6		9		2020		6
	Frequent Mental								
0.67	Distress	percent	11.6		11.6	13	2018		6
SCOR			DENTON	HP203			MEASUREME	HIGH	Sour
E	OLDER ADULTS	UNITS	COUNTY	пр205 0	тх	U.S.	NT PERIOD	DISPARITY*	ce
E		UIVITS	COUNTY	U	IA	0.3.	NI PERIOD	DISPARIT	LE
	Osteoporosis:	nove	7.2		<u> </u>	<u> </u>	2010		-
2.75	Medicare Population	percent	7.3		6.8	6.6	2018		5

	Cancer: Medicare						
2.47	Population	percent	8.4	7.	5 8.4	2018	5
	Hyperlipidemia:	•			47.		
2.47	Medicare Population	percent	53.3	49		2018	5
	Asthma: Medicare	-					
2.19	Population	percent	5.4	4.) 5	2018	5
	Chronic Kidney						
	Disease: Medicare				24.		
2.08	Population	percent	24.9	26	75	2018	5
	Rheumatoid Arthritis						
	or Osteoarthritis:				33.		
2.08	Medicare Population	percent	35.3	34	25	2018	5
	Alzheimer's Disease or						
	Dementia: Medicare				10.		
1.97	Population	percent	12.2	12	6 8	2018	5
	Hypertension:				57.		
1.92	Medicare Population	percent	59.3	59		2018	5
	Colon Cancer				66.		-
1.83	Screening	percent	60.6	74.4	4	2018	3
	Depression: Medicare				18.		
1.83	Population	percent	18.9	18	2 4	2018	5
	Atrial Fibrillation:		_				
1.81	Medicare Population	percent	8.4	7.	8 8.4	2018	5
	Adults 65+ who						
	Received Recommended						
	Preventive Services:				32.		
1.58	Males	percent	29		52. 4	2018	3
1.55	Stroke: Medicare	percent	25			2010	5
1.36	Population	percent	3.9	4.	2 3.8	2018	5
1.50		ρειτεπ	5.5	4.	0	2010	J

	Adults 65+ who							
	Received							
	Recommended							
	Preventive Services:				28.			
1.25	Females	percent	29.5		4	2018		3
	Ischemic Heart							
	Disease: Medicare				26.			
1.00	Population	percent	26.3	29	8	2018		5
	People 65+ with Low							
	Access to a Grocery							
1.00	Store	percent	1.4			2015		20
	Diabetes: Medicare							
0.83	Population	percent	25.2	28.8	27	2018		5
	Adults 65+ with Total				13.			
0.75	Tooth Loss	percent	9.6		5	2018		3
					25.			
0.75	Adults with Arthritis	percent	20.8		8	2018		3
							Black (6.1)	
							White (4.6)	
							Asian (5.5)	
							AIAN (9.7)	
							NHPI (0) Mult	
							(1.8) Other	
	People 65+ Living						(11.4) Hisp	
0.64	Below Poverty Level	percent	5.1	10.6	9.3	2015-2019	(7.9)	1
	Heart Failure:							
0.36	Medicare Population	percent	12.2	15.6	14	2018		5
	COPD: Medicare				11.			
0.25	Population	percent	10.1	11.2	5	2018		5

SCOR			DENTON	HP203			MEASUREME	HIGH	Sour
E	ORAL HEALTH	UNITS	COUNTY	0	ТΧ	U.S.	NT PERIOD	DISPARITY*	се
	Age-Adjusted ER Rate								
	due to Dental	ER visits/ 10,000							
1.75	Problems	population	25		11.1		2017-2019		16
	Oral Cavity and								
	Pharynx Cancer	cases/ 100,000				11.			
1.50	Incidence Rate	population	10.9		11	8	2013-2017		9
	Adults who Visited a					66.			
1.25	Dentist	percent	66.3			5	2018		3
		dentists/ 100,000							
0.83	Dentist Rate	population	57.6		59.6		2019		6
	Adults 65+ with Total					13.			
0.75	Tooth Loss	percent	9.6			5	2018		3
SCOR			DENTON	HP203			MEASUREME	HIGH	Sour
SCOR E	OTHER CONDITIONS	UNITS	DENTON COUNTY	HP203 0	тх	U.S.	MEASUREME NT PERIOD	HIGH DISPARITY*	Sour ce
	OTHER CONDITIONS Osteoporosis:	UNITS			ТХ	U.S.			
		UNITS percent			TX 6.8	U.S. 6.6			
E	Osteoporosis:		COUNTY				NT PERIOD		се
E	Osteoporosis: Medicare Population		COUNTY				NT PERIOD		се
E	Osteoporosis: Medicare Population Chronic Kidney		COUNTY			6.6	NT PERIOD		се
E 2.75	Osteoporosis: Medicare Population Chronic Kidney Disease: Medicare Population	percent	COUNTY 7.3		6.8	6.6 24.	NT PERIOD		<u>ce</u> 5
E 2.75	Osteoporosis: Medicare Population Chronic Kidney Disease: Medicare Population Rheumatoid Arthritis	percent	COUNTY 7.3		6.8	6.6 24. 5	NT PERIOD		<u>ce</u> 5
E 2.75	Osteoporosis: Medicare Population Chronic Kidney Disease: Medicare Population Rheumatoid Arthritis or Osteoarthritis:	percent	COUNTY 7.3		6.8	6.6 24.	NT PERIOD		<u>ce</u> 5
E 2.75 2.08	Osteoporosis: Medicare Population Chronic Kidney Disease: Medicare Population Rheumatoid Arthritis	percent percent	COUNTY 7.3 24.9		6.8 26.7	6.6 24. 5 33.	NT PERIOD 2018 2018		<u>се</u> 5 5
E 2.75 2.08	Osteoporosis: Medicare Population Chronic Kidney Disease: Medicare Population Rheumatoid Arthritis or Osteoarthritis:	percent percent	COUNTY 7.3 24.9		6.8 26.7	6.6 24. 5 33. 5	NT PERIOD 2018 2018		<u>се</u> 5 5
E 2.75 2.08 2.08	Osteoporosis: Medicare Population Chronic Kidney Disease: Medicare Population Rheumatoid Arthritis or Osteoarthritis: Medicare Population Adults with Arthritis	percent percent percent	COUNTY 7.3 24.9 35.3		6.8 26.7	6.6 24. 5 33. 5 25.	NT PERIOD 2018 2018 2018		се 5 5 5
E 2.75 2.08 2.08	Osteoporosis: Medicare Population Chronic Kidney Disease: Medicare Population Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent percent percent	COUNTY 7.3 24.9 35.3		6.8 26.7	6.6 24. 5 33. 5 25.	NT PERIOD 2018 2018 2018		се 5 5 5

SCOR			DENTON	HP203			MEASUREME	HIGH	Sour
E	PHYSICAL ACTIVITY	UNITS	COUNTY	0	ТΧ	U.S.	NT PERIOD	DISPARITY*	се
		stores/1,000							
2.00	Grocery Store Density	population	0.1				2016		20
		stores/ 1,000							
2.00	WIC Certified Stores	population	0.1				2016		20
		stores/ 1,000							
1.86	SNAP Certified Stores	population	0.3				2017		20
	Fast Food Restaurant	restaurants/ 1,000							
1.81	Density	population	0.7				2016		20
	Children with Low								
	Access to a Grocery								
1.50	Store	percent	5.2				2015		20
	Farmers Market	markets/ 1,000							
1.50	Density	population	0				2018		20
	People with Low								
	Access to a Grocery						2245		~~
1.33	Store	percent	18.6				2015		20
	Low-Income and Low								
1.17	Access to a Grocery Store	percent	4.3				2015		20
1.17		facilities/ 1,000	4.5				2015		20
1.17	Recreation and Fitness Facilities	population	0.1				2016		20
1.17		ροραιατισπ	0.1				2010		20
	Households with No								
1.00	Car and Low Access to a Grocery Store	norcont	0.7				2015		20
1.00	People 65+ with Low	percent	0.7				2015		20
	Access to a Grocery								
1.00	Store	percent	1.4				2015		20
	Food Environment								
0.53	Index		8.2		5.9	7.8	2021		6

	Access to Exercise								
0.50	Opportunities	percent	94.5		80.5	84	2020		6
SCOR	PREVENTION &		DENTON	HP203			MEASUREME	HIGH	Sour
E	SAFETY	UNITS	COUNTY	0	ТХ	U.S.	NT PERIOD	DISPARITY*	се
	Severe Housing								
0.86	Problems	percent	13.7		17.4	18	2013-2017		6
	Death Rate due to	deaths/ 100,000							
0.61	Drug Poisoning	population	7.5		10.6	21	2017-2019		6
	Age-Adjusted Death								
	Rate due to	deaths/ 100,000				48.			
0.56	Unintentional Injuries	population	26.6	43.2	38.7	9	2017-2019		4
	· · · ·								
SCOR	RESPIRATORY		DENTON	HP203			MEASUREME	HIGH	Sour
E	DISEASES	UNITS	COUNTY	0	тх	U.S.	NT PERIOD	DISPARITY*	ce
_	Asthma: Medicare	01110				0.01			
2.19	Population	percent	5.4		4.9	5	2018		5
2.15	Age-Adjusted	percent	5.4		4.5		2010		
	Hospitalization Rate								
	due to Immunization-								
	Preventable	hospitalizations/							
	Pneumonia and	10,000 population							
1.75	Influenza	18+ years	0.2		0.1		2017-2019		16
	Tuberculosis Incidence	cases/ 100,000							
1.42	Rate	population	2.5	1.4	4.3		2015-2019		13
1.76	COVID-19 Daily	ροραιατισπ	2.5	T 14	т.Ј		2013 2013		
	Average Case-Fatality	deaths per 100							
1.14	Rate	cases	0.7		3	1.6	17-Sep-21		8
1.14			0.7		5	59.	_ 1/ 300 21		0
0.97	COVID-19 Daily Average Incidence Rate	cases per 100,000	49.3		59.9		17 Con 21		8
0.97	Average incluence kate	population	49.5		59.9	2	17-Sep-21		Ŏ

0.02	Adults with Current		0.5			0.2	2010		2
0.92	Asthma	percent	8.5			9.2	2018		3
0.83	Adults who Smoke	percent	13.8	5		15. 5	2018		3
		•		5			2018		
0.75	Adults with COPD	Percent of adults	5.1			6.9	2018		3
	Age-Adjusted Death								
	Rate due to Influenza	deaths/ 100,000				13.			_
0.33	and Pneumonia	population	9.5		11.8	8	2017-2019		4
	Age-Adjusted Death					~~			
	Rate due to Lung	deaths/ 100,000	20.0	25.4	24.4	38.	2012 2017		•
0.33	Cancer	population	30.8	25.1	34.1	5	2013-2017		9
	COPD: Medicare		_			11.			
0.25	Population	percent	10.1		11.2	5	2018		5
	Lung and Bronchus	cases/ 100,000				58.			
0.25	Cancer Incidence Rate	population	46.7		50.6	3	2013-2017		9
	SEXUALLY								
SCOR	TRANSMITTED		DENTON	HP203			MEASUREME	HIGH	Sour
E	INFECTIONS	UNITS	COUNTY	0	ТΧ	U.S.	NT PERIOD	DISPARITY*	се
		cases/ 100,000							
1.64	HIV Diagnosis Rate	population	10.4		15.7		2018		13
		cases/ 100,000				10.			
1.08	Syphilis Incidence Rate	population	2.6		8.8	8	2018		13
	Gonorrhea Incidence	cases/ 100,000			163.				
1.06	Rate	population	89.9		6	179	2018		13
	Chlamydia Incidence	cases/ 100,000			508.				
0.92	Rate	population	279		2	540	2018		13
SCOR			DENTON	HP203			MEASUREME	HIGH	Sour
E	WELLNESS & LIFESTYLE	UNITS	COUNTY	0	тх	U.S.	NT PERIOD	DISPARITY*	ce
		ONITS	COUNT	0	17	0.5.			

	High Blood Pressure					32.			
0.94	Prevalence	percent	29.7	27.7		4	2017		3
0.86	Insufficient Sleep	percent	33.5	31.4	34.4	35	2018		6
	Poor Physical Health:					12.			
0.75	14+ Days	percent	10			5	2018		3
	Frequent Physical								
0.67	Distress	percent	10		11.6	11	2018		6
SCOR			DENTON	HP203			MEASUREME	HIGH	Sour
E	WOMEN'S HEALTH	UNITS	COUNTY	0	ТΧ	U.S.	NT PERIOD	DISPARITY*	се
	Breast Cancer	cases/ 100,000			112.				
2.31	Incidence Rate	females	127		8	126	2013-2017		9
	Cervical Cancer					84.			
1.28	Screening: 21-65	Percent	84	84.3		7	2018		3
	Mammogram in Past 2					74.			
0.94	Years: 50-74	percent	74.8	77.1		8	2018		3
	Cervical Cancer	cases/ 100,000							
0.89	Incidence Rate	females	6.1		9.2	7.6	2013-2017		9
	Age-Adjusted Death								
	Rate due to Breast	deaths/ 100,000				20.			
0.69	Cancer	females	17.5	15.3	19.8	1	2013-2017		9

Denton County Sources

- Key Source Title1 American Community Survey2 American Lung Association
- 3 CDC PLACES
- 4 Centers for Disease Control and Prevention
- 5 Centers for Medicare & Medicaid Services
- 6 County Health Rankings
- 7 Feeding America
- 8 Healthy Communities Institute
- 9 National Cancer Institute
- 10 National Center for Education Statistics
- 11 National Environmental Public Health Tracking Network
- 12 Texas Department of Family and Protective Services
- 13 Texas Department of State Health Services
- 14 Texas Education Agency
- 15 Texas Secretary of State DFWHC Foundation Regional Data, Q1-Q4, 2017-2019.
- 16 DFWHC Foundation, Irving Texas. October 15, 2021
- 17 U.S. Bureau of Labor Statistics
- 18 U.S. Census County Business Patterns
- 19 U.S. Census Bureau Small Area Health Insurance Estimates
- 20 U.S. Department of Agriculture Food Environment Atlas
- 21 U.S. Environmental Protection Agency
- 22 United For ALICE

Denton County Topic Scores

Health and Quality of Life Topics	Score
Other Conditions	1.68
Older Adults	1.51
Health Care Access & Quality	1.44

Children's Health	1.40
Diabetes	1.37
Physical Activity	1.34
Environmental Health	1.30
Alcohol & Drug Use	1.28
Mental Health & Mental Disorders	1.23
Women's Health	1.22
Heart Disease & Stroke	1.22
Oral Health	1.22
Sexually Transmitted Infections	1.18
Immunizations & Infectious Diseases	1.12
Community	1.11
Maternal, Fetal & Infant Health	1.10
Cancer	1.05
Economy	0.96
Respiratory Diseases	0.93
Education	0.92
Wellness & Lifestyle	0.81
Prevention & Safety	0.68

Wise County Indicator Scores

SCOR	ALCOHOL &			HP203		MEASUREMEN HIGH		Sour	
 Е	DRUG USE	UNITS	WISE COUNTY	0	ТΧ	U.S.	T PERIOD	DISPARITY*	ce
	Adults who Binge								
1.75	Drink	percent	16.8			16.4	2018		2

	Age-Adjusted ER	ER visits/ 10,000							
	Rate due to	population 18+							
1.75	Opioid Use	years	1.2		0.7		2017-2019		15
	Age-Adjusted								
	Drug and Opioid-								
	Involved	Deaths per							
	Overdose Death	100,000							
1.50	Rate	population	15.7		12.1	22.8	2017-2019		3
	Age-Adjusted ER	ER visits/ 10,000							
	Rate due to	population 18+							
1.25	Substance Use	years	8.5		20.6		2017-2019		15
1.25	Death Rate due	deaths/ 100,000	0.5		20.0		2017 2015		
1.25			12.2		10.6	21	2017 2010		F
1.25	to Drug Poisoning	population	13.2		10.6	21	2017-2019		5
	Liquor Store	stores/ 100,000				_			
1.00	Density	population	8.6		6.9	10.5	2019		17
		percent of driving							
		deaths with							
	Alcohol-Impaired	alcohol							
0.94	Driving Deaths	involvement	24.2	28.3	25.7	27	2015-2019		5
SCOR				HP203			MEASUREMEN	HIGH	Sour
E	CANCER	UNITS	WISE COUNTY	0	ТΧ	U.S.	T PERIOD	DISPARITY*	се
	Lung and								
	Bronchus Cancer	cases/ 100,000							
2.75	Incidence Rate	population	72.1		50.6	58.3	2013-2017		8
	Age-Adjusted								
	Death Rate due	deaths/ 100,000							
2.72	to Lung Cancer	population	55.1	25.1	34.1	38.5	2013-2017		8
	Cancer: Medicare	population		20.1	U 1.1	50.5	2010 2017		
2.58	Population	percent	8.4		7.6	8.4	2018		4

	Age-Adjusted	1						
2.50	Death Rate due	deaths/ 100,000	101 4	100 7	1 4 0 0	4 66 6	2012 2017	0
2.56	to Cancer	population	181.4	122.7	148.8	155.5	2013-2017	8
	Age-Adjusted							
	Death Rate due	deaths/ 100,000						
2.47	to Breast Cancer	females	28.5	15.3	19.8	20.1	2013-2017	8
	Age-Adjusted							
	Death Rate due							
	to Colorectal	deaths/ 100,000						
2.11	Cancer	population	16.5	8.9	13.9	13.7	2013-2017	8
	Colorectal Cancer	cases/ 100,000						
2.03	Incidence Rate	population	43.7		37.6	38.4	2013-2017	8
	Oral Cavity and							
	, Pharynx Cancer	cases/ 100,000						
1.94	Incidence Rate	population	14.1		11	11.8	2013-2017	8
	All Cancer	cases/ 100,000						
1.92	Incidence Rate	population	431.4		407.7	448.7	2013-2017	8
	Mammogram in							
	Past 2 Years: 50-							
1.61	74	percent	69.7	77.1		74.8	2018	2
	Colon Cancer							
1.50	Screening	percent	62.3	74.4		66.4	2018	2
	Cervical Cancer							
1.44	Screening: 21-65	Percent	82.2	84.3		84.7	2018	2
	Adults with							
1.25	Cancer	percent	7.2			6.9	2018	2
	Age-Adjusted							
	Death Rate due							
	to Prostate	deaths/ 100,000						
1.03	Cancer	males	18.5	16.9	17.6	19	2013-2017	8

0.60	Breast Cancer	cases/ 100,000	402.2		112.0	425.0	2042 2047		
0.69	Incidence Rate	females	103.2		112.8	125.9	2013-2017		8
	Prostate Cancer	cases/ 100,000							
0.36	Incidence Rate	males	71.8		94	104.5	2013-2017		8
SCOR	CHILDREN'S			HP203			MEASUREMEN	HIGH	Sour
E	HEALTH	UNITS	WISE COUNTY	0	ТΧ	U.S.	T PERIOD	DISPARITY*	ce
2.17	Food Insecure Children Likely Ineligible for Assistance	percent	35		34	23	2019		6
	Substantiated	cases/ 1,000							
2.06	Child Abuse Rate	children	14.6	8.7	9.1		2020		11
2.00	Child Food	ennaren	14.0	0.7	5.1		2020		
1.83	Insecurity Rate	percent	19.8		19.6	14.6	2019		6
1.05		percent	19.0		19.0	14.0	2019		0
4.00	Children with		04.6		07.0	04.2	2010		4
1.83	Health Insurance	percent	84.6		87.3	94.3	2019		1
	Projected Child								
4 75	Food Insecurity		22.7		22 C		2024		C
1.75	Rate	percent	23.7		23.6		2021		6
	Children with Low								
	Access to a								
1.00	Grocery Store	percent	1.6				2015		19
SCOR				HP203			MEASUREMEN	HIGH	Sour
E	COMMUNITY	UNITS	WISE COUNTY	0	ТХ	U.S.	T PERIOD	DISPARITY*	се
	Mean Travel Time								
2.64	to Work	minutes	32.2		26.6	26.9	2015-2019		1
	Solo Drivers with								
2.64	a Long Commute	percent	48.4		38.9	37	2015-2019		5
	5								-

	Age-Adjusted								
	Death Rate due								
	to Motor Vehicle	deaths/ 100,000							
2.47	Traffic Collisions	population	30.3	10.1	13	11.3	2017-2019		3
	Female								
	Population 16+ in								
	Civilian Labor								
2.25	Force	percent	52.3		57.8	58.3	2015-2019		1
	Substantiated	cases/ 1,000							
2.06	Child Abuse Rate	children	14.6	8.7	9.1		2020		11
	Median Monthly								
	Owner Costs for								
	Households								
	without a								
2.00	Mortgage	dollars	488		514	500	2015-2019		1
	Mortgaged								
	Owners Median								
	Monthly								
2.00	Household Costs	dollars	1544		1606	1595	2015-2019		1
	Persons with								
1.97	Health Insurance	percent	78.4	92.1	79.3		2019		18
	Workers who								
	Drive Alone to								
1.97	Work	percent	82.3		80.5	76.3	2015-2019		1
								Black (0)	
								White (0.2)	
								Asian (0)	
								AIAN (0)	
	Workers							NHPI (0)	
	Commuting by							Mult (0)	
	Public							Other (3.1)	
1.94	Transportation	percent	0.2	5.3	1.4	5	2015-2019	Hisp (0.3)	1

		membership					
	Social	associations/					
1.75	Associations	10,000 population	10	7.5	9.3	2018	5
	Median						
	Household Gross						
1.72	Rent	dollars	966	1045	1062	2015-2019	1
	Linguistic						
1.64	Isolation	percent	4.3	7.7	4.4	2015-2019	1
	Population 16+ in						
	Civilian Labor						
1.64	Force	percent	58	61	59.6	2015-2019	1
	People 25+ with a						
	Bachelor's Degree						
1.58	or Higher	percent	18	29.9	32.1	2015-2019	11
	Persons with an						
	Internet						
1.58	Subscription	percent	80.9	84.2	86.2	2015-2019	11
	Households with						
	an Internet						
1.50	Subscription	percent	77.9	82.1	83	2015-2019	1
	Social Worker	workers/ 100,000					
1.25	Rate	population	54.7	82.7		2020	12
	Voter Turnout:						
	Presidential						
1.19	Election	percent	63.3	58.8		2016	14
	Median Housing			17250	21750		
1.17	Unit Value	dollars	170300	0	0	2015-2019	1
	People 25+ with a						
	High School						
1.08	Degree or Higher	percent	85.3	83.7	88	2015-2019	1

	Per Capita								
1.08	Income	dollars	29418		31277	34103	2015-2019		1
	Total				•	0.200			
	Employment								
1.03	Change	percent	2.6		2.9	1.6	2018-2019		17
	Households with	,							
	No Car and Low								
	Access to a								
1.00	Grocery Store	percent	1.4				2015		19
		percent of driving							
		deaths with							
	Alcohol-Impaired	alcohol							
0.94	Driving Deaths	involvement	24.2	28.3	25.7	27	2015-2019		5
	Households with								
	One or More								
	Types of								
	Computing								
0.83	Devices	percent	91.2		91	90.3	2015-2019		1
								Black (4.5)	
								White	
								(11.6)	
								Asian (0)	
								AIAN (0)	
								NHPI (0)	
	Children Living							Mult (4.9)	
	Below Poverty							Other (0.9)	
0.69	Level	percent	16.3		20.9	18.5	2015-2019	Hisp (29.7)	1
	People Living								
	Below Poverty								
0.61	Level	percent	10.7	8	14.7	13.4	2015-2019		1

Median								
Household								
Income	dollars	64536		61874	62843	2015-2019		1
Homeownership	percent	70.3		54.9	56.2	2015-2019		1
Single-Parent								
Households	percent	17.1		26.3	25.5	2015-2019		1
								Sour
	LINITS			ту	115			
	UNITS		0		0.3.	I PERIOD	DISPARIT	се
	percent	28.8		28.8	27	2018		4
· ·	•							
		21.2		9.4		2017-2019		15
	-							
2 Diabetes	years	19.4		8.6		2017-2019		15
Age-Adjusted								
Hospitalization	hospitalizations/							
Rate due to	10,000 population							
Diabetes	18+ years	11.7		5.3		2017-2019		15
Age-Adjusted								
	hospitalizations/							
Rate due to Type	10,000 population							
2 Diabetes	18+ years	7.5		4		2017-2019		15
Age-Adjusted								
Death Rate due	deaths/ 100,000							
Death hate une								
	Household Income Homeownership Single-Parent Households DIABETES Diabetes: Medicare Population Age-Adjusted ER Rate due to Diabetes Age-Adjusted ER Rate due to Type 2 Diabetes Age-Adjusted Hospitalization Rate due to Diabetes Age-Adjusted Hospitalization Rate due to Diabetes Age-Adjusted Hospitalization Rate due to Diabetes	HouseholdIncomedollarsHomeownershippercentSingle-ParentpercentHouseholdspercentDIABETESUNITSDiabetes:percentMedicarepopulationPopulationpercentAge-Adjusted ERER visits/ 10,000Rate due topopulation 18+DiabetesyearsAge-Adjusted ERER visits/ 10,000Rate due to Typepopulation 18+2 DiabetesyearsAge-AdjustedER visits/ 10,000Rate due to Typepopulation 18+2 DiabetesyearsAge-Adjustedhospitalizations/Rate due to Type10,000 populationDiabetes18+ yearsAge-Adjustedhospitalizations/Rate due to Type10,000 populationDiabetes18+ yearsAge-Adjustedhospitalizations/Rate due to Type10,000 populationDiabetes18+ yearsAge-Adjustedhospitalizations/Rate due to Type10,000 populationAge-Adjustedhospitalizations/Age-Adjustedhospitalizations/Age-Adjustedhospitalizations/Age-Adjustedhospitalizations/Age-Adjustedhospitalizations/Age-Adjustedhospitalizations/Age-Adjustedhospitalizations/Age-AdjustedhospitalizationAge-Adjustedhospitalizations/Age-Adjustedhospitalizations/Age-Adjustedhospitalizatio	Household Incomedollars64536Incomedollars64536Homeownershippercent70.3Single-Parent Householdspercent17.1DIABETESUNITSWISE COUNTYDiabetes: Medicare Populationpercent28.8Age-Adjusted ER DiabetesER visits/ 10,000Rate due to population 18+Diabetesyears21.2Age-Adjusted ER Age-Adjusted ERER visits/ 10,000Rate due to Type population 18+2 Diabetesyears19.4Age-Adjusted Hospitalization10,000 population hospitalizations/ Rate due to Type11.7Age-Adjusted Hospitalizationhospitalizations/ Rate due to Type11.7Age-Adjusted Hospitalization10,000 population population11.7Age-Adjusted Hospitalizationhospitalizations/ Rate due to Type10,000 population populationDiabetes18+ years7.5Age-Adjusted18+ years7.5Age-Adjusted18+ years7.5	Household Incomedollars64536Homeownershippercent70.3Single-Parent Householdspercent17.1Medicarepercent28.8Populationpercent28.8Age-Adjusted ERER visits/ 10,000 Population 18+ Diabetes21.2Age-Adjusted ERER visits/ 10,000 Rate due to population 18+ 2 Diabetes19.4Age-Adjusted FRER visits/ 10,000 Rate due to Type population 18+ 2 Diabetes19.4Age-Adjusted Hospitalization Diabetes11.7Age-Adjusted Hospitalization Diabetes10,000 population 11.7Age-Adjusted Hospitalization Diabetes10,000 population 2 DiabetesJiabetes10,000 population 7Age-Adjusted Hospitalization10,000 population 7Age-Adjusted Hospitalization Age-Adjusted10,000 population 7Age-Adjusted 	HouseholdIncomedollars6453661874Homeownershippercent70.354.9Single-Parent17.126.3Householdspercent17.126.3HP203DIABETESUNITSWISE COUNTY0TXDiabetes:7Medicare28.828.8Populationpercent28.828.8Age-Adjusted ERER visits/ 10,0007Rate due topopulation 18+9.4Diabetesyears21.29.4Age-Adjusted ERER visits/ 10,0008.6Age-Adjusted ERER visits/ 10,0008.68.6Age-Adjusted10,000 population 18+5.32 Diabetesyears19.48.6Age-Adjusted5.33Age-Adjusted10,000 population5.3Age-Adjusted11.75.3Age-Adjusted10,000 population2Diabetes18+ years7.54Age-Adjusted25.3Age-Adjusted18+ years7.5Age-Adjusted18+ years7.5Age-Adjusted18+ years7.5Age-Adjusted18+ years7.5Age-Adjusted18+ years7.5Age-Adjusted18+ yearsAge-AdjustedHosp	Household Incomedollars645366187462843Homeownershippercent70.354.956.2Single-Parent Householdspercent17.126.325.5IP203DIABETESUNITSWISE COUNTY0TXU.S.Diabetes: Medicare Populationpercent28.828.827Age-Adjusted ER LabetesER visits/ 10,000X25.5XAge-Adjusted ER LabetesER visits/ 10,000XXXRate due to Diabetespopulation 18+ population 18+9.4XXDiabetesyears19.48.6XXAge-Adjusted Hospitalization Iabetes11.75.3XXAge-Adjusted Hospitalization hospitalizations/ Rate due to Type 10,000 population11.75.3XAge-Adjusted Hospitalization hospitalizations/ Rate due to Type10,000 populationXXJoiabetes18+ years7.54Age-AdjustedAge-Adjusted18+ years7.54Age-Adjusted	Household Incomedollars6453661874628432015-2019Homeownershippercent70.354.956.22015-2019Single-Parent Householdspercent17.126.325.52015-2019Single-Parent Householdspercent17.126.325.52015-2019DIABETESUNITSWISE COUNTY0TXU.S.TPERIODDiabetes: Medicare Populationpercent28.828.8272018Age-Adjusted ER DiabetesER visits/ 10,000 population 18+ 2 Diabetesyears21.29.42017-2019Age-Adjusted ER Age-Adjusted ER LoabetesER visits/ 10,000 population 18+ 2 Diabetes2017-20193.62017-2019Age-Adjusted ER Hospitalization hospitalizations/ Rate due to 10,000 population11.75.32017-2019Age-Adjusted Hospitalization hospitalizations/ Rate due to Type 10,000 population11.75.32017-2019Age-Adjusted Hospitalization hospitalizations/ Rate due to Type 10,000 population11.75.32017-2019Age-Adjusted Hospitalization hospitalizations/ Rate due to Type 10,000 population2.175.32017-2019Age-Adjusted Hospitalization Age-Adjustedhospitalizations/ Rate due to Type 10,000 population2.175.32017-2019Age-Adjusted Hospitalization Rate due to Type 10,000 population11.75.32017-2019Age-Adjusted Hospitalizations/ Rate due to Type 	Household Income dollars 64536 61874 62843 2015-2019 Homeownership percent 70.3 54.9 56.2 2015-2019 Single-Parent

SCOR				HP203			MEASUREMEN	HIGH	Sour
E	ECONOMY	UNITS	WISE COUNTY	0	ТХ	U.S.	T PERIOD	DISPARITY*	ce
	Female Population 16+ in Civilian Labor								
2.25	Force	percent	52.3		57.8	58.3	2015-2019		1
2.25	Mortgaged Owners Spending 30% or More of Household Income on Housing	percent	32		26.5	26.5	2019		1
2.25	Food Insecure Children Likely Ineligible for	percent			20.5	20.3	2019		
2.17	Assistance	percent	35		34	23	2019		6
	Median Monthly Owner Costs for Households without a								
2.00	Mortgage	dollars	488		514	500	2015-2019		1
	Mortgaged Owners Median Monthly								
2.00	Household Costs	dollars	1544		1606	1595	2015-2019		1
1.86	SNAP Certified Stores	stores/ 1,000 population	0.6				2017		19
1.83	Child Food Insecurity Rate	percent	19.8		19.6	14.6	2019		6
1.83	Food Insecurity Rate	percent	14.4		14.1	10.9	2019		6

	Projected Child						
	Food Insecurity						
1.75	Rate	percent	23.7	23.6		2021	6
	Median						
	Household Gross						
1.72	Rent	dollars	966	1045	1062	2015-2019	1
	Households that						
	are Asset Limited,						
	Income						
	Constrained,						
1.67	Employed (ALICE)	percent	33	30		2018	21
	Population 16+ in						
	Civilian Labor						
1.64	Force	percent	58	61	59.6	2015-2019	1
	Projected Food						
1.58	Insecurity Rate	percent	16.7	16.5		2021	6
	WIC Certified	stores/ 1,000					
1.50	Stores	population	0.1			2016	19
	Overcrowded	percent of					
1.47	Households	households	3.9	4.8		2015-2019	1
	Severe Housing						
1.42	Problems	percent	13.5	17.4	18	2013-2017	5
	Households that	•					
	are Above the						
	Asset Limited,						
	Income						
	Constrained,						
	Employed (ALICE)						
1.33	Threshold	percent	56	56		2018	21

	Students Eligible						
4.24	for the Free		20.0			2010 2020	0
1.31	Lunch Program	percent	39.8			2019-2020	9
	Median Housing			17250	21750		
1.17	Unit Value	dollars	170300	0	0	2015-2019	1
	Renters Spending						
	30% or More of						
	Household						
1.17	Income on Rent	percent	44.4	47.8	49.6	2015-2019	1
	Per Capita						
1.08	Income	dollars	29418	31277	34103	2015-2019	1
	Total						
	Employment						
1.03	Change	percent	2.6	2.9	1.6	2018-2019	17
	Unemployed						
	Workers in						
	Civilian Labor						
1.03	Force	percent	5.9	6.7	6.1	Jun-21	16
	Households that						
	are Below the						
	Federal Poverty						
1.00	Level	percent	11	14		2018	21
	Low-Income and						
	Low Access to a						
1.00	Grocery Store	percent	1.8			2015	19

0.69	Children Living Below Poverty Level	percent	16.3		20.9	18.5	2015-2019	Black (4.5) White (11.6) Asian (0) AIAN (0) NHPI (0) Mult (4.9) Other (0.9) Hisp (29.7)	1
	Households with Cash Public Assistance								
0.69	Income	percent	1.3		1.4	2.4	2015-2019		1
	People Living Below Poverty								
0.61	Level	percent	10.7	8	14.7	13.4	2015-2019		1
	People Living 200% Above								
0.58	Poverty Level	percent	70		65.7	69.1	2015-2019		1
								Black (7.5) White (6) Asian (0) AIAN (1.7) NHPI (0)	
	Families Living							Mult (2.2)	
	Below Poverty							Other (0.7)	
0.53	Level	percent	8.2		11.3	9.5	2015-2019	Hisp (20.1)	1
	Median Household								
0.42	Income	dollars	64536		61874	62843	2015-2019		1
0.36	Homeownership	percent	70.3		54.9	56.2	2015-2019		1

	People 65+ Living Below Poverty								
0.36	Level	percent	7		10.6	9.3	2015-2019		1
0.36	Persons with Disability Living in Poverty (5-year)	percent	10.2		23.2	26.1	2015-2019		1
SCOR E	EDUCATION	UNITS	WISE COUNTY	HP203 0	тх	U.S.	MEASUREMEN T PERIOD	HIGH DISPARITY*	Sour ce
2.25	High School Drop Out Rate	percent	3.3		1.9		2019	Black (0) White (2.9) Asian (0) AIAN (0) PI (0) Mult (0) Hisp (4.5)	13
1.58	People 25+ with a Bachelor's Degree or Higher	percent	18		29.9	32.1	2015-2019		1
1.36	Student-to- Teacher Ratio	students/ teacher	13.2				2019-2020		9
1.08	People 25+ with a High School Degree or Higher	percent	85.3		83.7	88	2015-2019		1
0.50	Infants Born to Mothers with <12 Years Education	percent	12.8		17.4	13.3	2017	White (7) Other (0) Hisp (29)	12
SCOR E	ENVIRONMENTA L HEALTH	UNITS	WISE COUNTY	HP203 0	ТХ	U.S.	MEASUREMEN T PERIOD	HIGH DISPARITY*	Sour ce

	Access to Exercise						
2.50	Opportunities	percent	38.4	80.5	84	2020	5
	Asthma:						
	Medicare						
2.33	Population	percent	5.4	4.9	5	2018	4
	SNAP Certified	stores/ 1,000					
1.86	Stores	population	0.6			2017	19
	Recreation and	facilities/ 1,000					
1.81	Fitness Facilities	population	0			2016	19
	Number of						
	Extreme						
	Precipitation						
1.64	Days	days	43			2016	10
	Adults with						
1.58	Current Asthma	percent	9.3		9.2	2018	2
	Farmers Market	markets/ 1,000					
1.50	Density	population	0			2018	19
	Fast Food						
	Restaurant	restaurants/					
1.50	Density	1,000 population	0.6			2016	19
	Grocery Store	stores/ 1,000					
1.50	Density	population	0.2			2016	19
	WIC Certified	stores/1,000					
1.50	Stores	population	0.1			2016	19
	Overcrowded	percent of					
1.47	Households	households	3.9	4.8		2015-2019	1
	Severe Housing						
1.42	Problems	percent	13.5	17.4	18	2013-2017	5
	Months of Mild						
1.36	Drought or Worse	months per year	3			2016	10
-		- *					

1.36	PBT Released	pounds	0				2019		20
	Recognized								
	Carcinogens								
1.36	Released into Air	pounds	2243				2019		20
	Children with Low								
	Access to a								
1.00	Grocery Store	percent	1.6				2015		19
	Households with								
	No Car and Low								
	Access to a								
1.00	Grocery Store	percent	1.4				2015		19
	Liquor Store	stores/ 100,000							
1.00	Density	population	8.6		6.9	10.5	2019		17
	Low-Income and								
	Low Access to a								
1.00	Grocery Store	percent	1.8				2015		19
	People 65+ with								
	Low Access to a								
1.00	Grocery Store	percent	0.8				2015		19
	People with Low								
	Access to a								
1.00	Grocery Store	percent	6				2015		19
	Food								
	Environment								
0.97	Index		7.8		5.9	7.8	2021		5
	Daily Dose of UV	Joule per square							
0.75	Irradiance	meter	3294		3538		2015		10
	HEALTH CARE								-
SCOR	ACCESS &			HP203			MEASUREMEN	HIGH	Sour
E	QUALITY	UNITS	WISE COUNTY	0	ТХ	U.S.	T PERIOD	DISPARITY*	се

		providers/							
	Primary Care	100,000							
2.17	Provider Rate	population	39.5		60.9		2018		5
		dentists/ 100,000							
2.06	Dentist Rate	population	27.2		59.6		2019		5
	Persons with								
1.97	Health Insurance	percent	78.4	92.1	79.3		2019		18
	Adults who have								
	had a Routine								
1.92	Checkup	percent	73.4			76.7	2018		2
	Adults with	.							
1.83	Health Insurance	percent	74.6		75.5	87.1	2019		1
	Children with					_			
1.83	Health Insurance	percent	84.6		87.3	94.3	2019		1
	Adults who								
1.75	Visited a Dentist	percent	56.8			66.5	2018		2
	Adults without								
1.75	Health Insurance	percent	22.7			12.2	2018		2
		providers/							
	Mental Health	100,000							
1.67	Provider Rate	population	30		120.9		2020		5
	Non-Physician	providers/							
	Primary Care	100,000							
1.33	, Provider Rate	population	75.7		88.6		2020		5
	Social Worker	workers/ 100,000							
1.25	Rate	population	54.7		82.7		2020		12
SCOR	HEART DISEASE			HP203			MEASUREMEN	HIGH	Sour
Е	& STROKE	UNITS	WISE COUNTY	0	ТХ	U.S.	T PERIOD	DISPARITY*	ce

	Hypertension:							
	Medicare							
2.92	Population	percent	66.4		59.9	57.2	2018	4
	Atrial Fibrillation:	percent	00.1		55.5	37.2	2010	·
	Medicare							
2.64	Population	percent	9.6		7.8	8.4	2018	4
	Stroke: Medicare							
2.64	Population	percent	5.6		4.2	3.8	2018	4
	Ischemic Heart							
	Disease:							
	Medicare							
2.50	Population	percent	34.4		29	26.8	2018	4
	Heart Failure:							
	Medicare							
2.47	Population	percent	18.2		15.6	14	2018	4
	Hyperlipidemia:							
	Medicare							
2.31	Population	percent	51.5		49.5	47.7	2018	4
	Age-Adjusted							
	Death Rate due							
	to							
	Cerebrovascular	deaths/ 100,000						
1.94	Disease (Stroke)	population	42.9	33.4	40.2	37.2	2017-2019	3
	Adults who Have							
	Taken							
	Medications for							
4.00	High Blood		75.0			75.0	2017	2
1.92	Pressure	percent	75.2			75.8	2017	2
	Age-Adjusted ER	ER visits/ 10,000						
	Rate due to	population 18+						
1.75	Hypertension	years	19.7		10.5		2017-2019	15

	Age-Adjusted Hospitalization	hospitalizations/							
	Rate due to	10,000 population							
1.75	Hypertension	10,000 population 18+ years	1.2		0.3		2016-2018		15
1.75		101 years	1.2		0.5		2010 2010		15
	Age-Adjusted								
	Death Rate due	1							
4 70	to Coronary Heart	deaths/ 100,000	04.6	74.4	0.2	00 F	2017 2010		2
1.72	Disease	population	94.6	71.1	93	90.5	2017-2019		3
	High Blood								
1.67	Pressure Prevalence	norcont	36.3	27.7		32.4	2017		2
1.07		percent	30.3	27.7		32.4	2017		Ζ
	Adults who								
	Experienced								
	Coronary Heart								
1.58	Disease	percent	7.9			6.8	2018		2
	Cholesterol Test								
1.42	History	percent	80.4			81.5	2017		2
	High Cholesterol								
	Prevalence:								
1.42	Adults 18+	percent	36.6			34.1	2017		2
	Adults who								
	Experienced a								
1.25	Stroke	percent	3.6			3.4	2018		2
	Age-Adjusted	deaths/ 100,000							
	Death Rate due	population 35+							
0.86	to Heart Attack	years	45.2		70.1		2018		10
		,							
	IMMUNIZATIONS								
SCOR	& INFECTIOUS			HP203			MEASUREMEN	HIGH	Sour
E	DISEASES	UNITS	WISE COUNTY	0	тх	U.S.	T PERIOD	DISPARITY*	ce

_										
		COVID-19 Daily								
		Average Case-	deaths per 100							
1	.67	Fatality Rate	cases	1.8		3	1.6	17-Sep-21		7
		COVID-19 Daily								
		Average	cases per 100,000							
1	.50	Incidence Rate	population	58.3		59.9	59.2	17-Sep-21		7
		Overcrowded	percent of					·		
1	.47	Households	households	3.9		4.8		2015-2019		1
		Syphilis Incidence	cases/ 100,000							
1	.22	Rate	population	2.9		8.8	10.8	2018		12
		Tuberculosis	cases/ 100,000							
1	.08	Incidence Rate	population	0.9	1.4	4.3		2015-2019		12
		HIV Diagnosis	cases/ 100,000							
C	.86	Rate	population	0		15.7		2018		12
		Chlamydia	cases/ 100,000							
C).75	Incidence Rate	population	161		508.2	539.9	2018		12
		Gonorrhea	cases/ 100,000							
C).75	Incidence Rate	population	43.9		163.6	179.1	2018		12
		Age-Adjusted								
		Death Rate due								
		to Influenza and	deaths/ 100,000							
C).67	Pneumonia	population	11.9		11.8	13.8	2017-2019		3
			F - F							
		MATERNAL,								
S	COR	FETAL & INFANT			HP203			MEASUREMEN	HIGH	Sour
	E	HEALTH	UNITS	WISE COUNTY	0	ТХ	U.S.	T PERIOD	DISPARITY*	ce
		Babies with Very								
1	.75	Low Birth Weight	percent	1.6			1.4	2015		12

	Mothers who								
	Received Early								
1.44	Prenatal Care	percent	64.6		60.5	77.3	2017		12
								White (0)	
								Other (0)	
1.11	Teen Births	percent	2		2.1	3.1	2017	Hisp (0)	12
0.97	Preterm Births	percent	9.2	9.4	12.2		2017		12
	Babies with Low								
0.78	Birth Weight	percent	6.1		8.2	8.1	2015		12
	Infant Mortality	deaths/ 1,000 live							
0.53	Rate	births	2.4	5	5.6	5.9	2015		12
	Infants Born to							White (7)	
	Mothers with <12							Other (0)	
0.50	Years Education	percent	12.8		17.4	13.3	2017	Hisp (29)	12
		; = = = = =						-1- \ -7	
	MFNTAL HFALTH								
SCOR	MENTAL HEALTH & MENTAL			HP203			MEASUREMEN	HIGH	Sour
SCOR E	MENTAL HEALTH & MENTAL DISORDERS	UNITS	WISE COUNTY	HP203 0	ТХ	U.S.	MEASUREMEN T PERIOD	HIGH DISPARITY*	Sour ce
	& MENTAL	UNITS	WISE COUNTY		ТХ	U.S.			
	& MENTAL DISORDERS	UNITS	WISE COUNTY		ТХ	U.S.			
	& MENTAL DISORDERS Depression:	UNITS	WISE COUNTY 19.7		TX 18.2	U.S. 18.4			
E	& MENTAL DISORDERS Depression: Medicare						T PERIOD		ce
E	& MENTAL DISORDERS Depression: Medicare Population Age-Adjusted Death Rate due	percent deaths/ 100,000	19.7				T PERIOD 2018		ce
E	& MENTAL DISORDERS Depression: Medicare Population Age-Adjusted Death Rate due to Suicide	percent					T PERIOD		ce
E 2.42	& MENTAL DISORDERS Depression: Medicare Population Age-Adjusted Death Rate due to Suicide Alzheimer's	percent deaths/ 100,000	19.7	0	18.2	18.4	T PERIOD 2018		<u>се</u> 4
E 2.42	& MENTAL DISORDERS Depression: Medicare Population Age-Adjusted Death Rate due to Suicide Alzheimer's Disease or	percent deaths/ 100,000	19.7	0	18.2	18.4	T PERIOD 2018		<u>се</u> 4
E 2.42	& MENTAL DISORDERS Depression: Medicare Population Age-Adjusted Death Rate due to Suicide Alzheimer's Disease or Dementia:	percent deaths/ 100,000	19.7	0	18.2	18.4	T PERIOD 2018		<u>се</u> 4
E 2.42 2.31	& MENTAL DISORDERS Depression: Medicare Population Age-Adjusted Death Rate due to Suicide Alzheimer's Disease or Dementia: Medicare	percent deaths/ 100,000 population	19.7 18.7	0	18.2 13.5	18.4	T PERIOD 2018 2017-2019		<u>се</u> 4 3
E 2.42	& MENTAL DISORDERS Depression: Medicare Population Age-Adjusted Death Rate due to Suicide Alzheimer's Disease or Dementia: Medicare Population	percent deaths/ 100,000	19.7	0	18.2	18.4	T PERIOD 2018		<u>се</u> 4
E 2.42 2.31	& MENTAL DISORDERS Depression: Medicare Population Age-Adjusted Death Rate due to Suicide Alzheimer's Disease or Dementia: Medicare	percent deaths/ 100,000 population	19.7 18.7	0	18.2 13.5	18.4	T PERIOD 2018 2017-2019		<u>се</u> 4 3

	DeenMantal								
1.75	Poor Mental Health: 14+ Days	percent	14.3			12.7	2018		2
1.75		providers/	14.5			12.7	2010		2
	Mental Health	100,000							
1.67	Provider Rate	population	30		120.9		2020		5
	Age-Adjusted ER	ER visits/ 10,000							
	Rate due to Adult	population 18+							
1.25	Mental Health	years	2.4		8.9		2017-2019		15
SCOR				HP203			MEASUREMEN	HIGH	Sour
Е	OLDER ADULTS	UNITS	WISE COUNTY	0	ТХ	U.S.	T PERIOD	DISPARITY*	се
	Hypertension:								
	Medicare								
2.92	Population	percent	66.4		59.9	57.2	2018		4
	Atrial Fibrillation:								
	Medicare								
2.64	Population	percent	9.6		7.8	8.4	2018		4
	COPD: Medicare								
2.64	Population	percent	16.4		11.2	11.5	2018		4
	Osteoporosis:								
	Medicare								
2.64	Population	percent	7.8		6.8	6.6	2018		4
	Stroke: Medicare								
2.64	Population	percent	5.6		4.2	3.8	2018		4
	Cancer: Medicare								
2.58	Population	percent	8.4		7.6	8.4	2018		4
	Chronic Kidney								
	Disease:								
	Medicare								
2.58	Population	percent	27		26.7	24.5	2018		4

	Ischemic Heart						
	Disease:						
	Medicare						
2.50	Population	percent	34.4	29	26.8	2018	4
	Heart Failure:						
	Medicare						
2.47	Population	percent	18.2	15.6	14	2018	4
	Depression:						
	Medicare						
2.42	Population	percent	19.7	18.2	18.4	2018	4
	Asthma:						
	Medicare						
2.33	Population	percent	5.4	4.9	5	2018	4
	Alzheimer's						
	Disease or						
	Dementia:						
	Medicare						
2.31	Population	percent	12.8	12.6	10.8	2018	4
	Hyperlipidemia:						
	Medicare						
2.31	Population	percent	51.5	49.5	47.7	2018	4
	Rheumatoid						
	Arthritis or						
	Osteoarthritis:						
	Medicare						
2.31	Population	percent	37.2	34.2	33.5	2018	4
	Diabetes:						
	Medicare						
1.97	Population	percent	28.8	28.8	27	2018	4

1.92	Adults 65+ who Received Recommended Preventive Services: Females	percent	24.6			28.4	2018		2
	Adults 65+ who Received Recommended Preventive		24.6			22.4	2010		2
1.92	Services: Males	percent	24.6			32.4	2018		2
1.58	Adults 65+ with Total Tooth Loss	percent	15.3			13.5	2018		2
1.50	Colon Cancer Screening	percent	62.3	74.4		66.4	2018		2
1.25	Adults with Arthritis	percent	26.3			25.8	2018		2
1.00	People 65+ with Low Access to a Grocery Store	percent	0.8				2015		19
	People 65+ Living Below Poverty								
0.36	Level	percent	7		10.6	9.3	2015-2019		1
SCOR				HP203			MEASUREMEN	HIGH	Sour
E	ORAL HEALTH	UNITS	WISE COUNTY	0	тх	U.S.	T PERIOD	DISPARITY*	се
		dentists/ 100,000							
2.06	Dentist Rate	population	27.2		59.6		2019		5

2.06	Dentist Rate	population	27.2	59.6		2019	5
	Oral Cavity and						
	Pharynx Cancer	cases/ 100,000					
1.94	Incidence Rate	population	14.1	11	11.8	2013-2017	8

	Adults who								
1.75	Visited a Dentist	percent	56.8			66.5	2018		2
	Age-Adjusted ER								
	Rate due to	ER visits/ 10,000							
1.75	Dental Problems	population	26.9		11.1		2017-2019		15
	Adults 65+ with								
1.58	Total Tooth Loss	percent	15.3			13.5	2018		2
SCOR	OTHER			HP203			MEASUREMEN	HIGH	Sour
E	CONDITIONS	UNITS	WISE COUNTY	0	тх	U.S.	T PERIOD	DISPARITY*	се
	Osteoporosis:								
	Medicare								
2.64	Population	percent	7.8		6.8	6.6	2018		4
	Chronic Kidney								
	Disease:								
	Medicare								
2.58	Population	percent	27		26.7	24.5	2018		4
	Rheumatoid								
	Arthritis or								
	Osteoarthritis:								
	Medicare								
2.31	Population	percent	37.2		34.2	33.5	2018		4
	Adults with								
1.25	Arthritis	percent	26.3			25.8	2018		2
	Adults with								
0.92	Kidney Disease	Percent of adults	3.1			3.1	2018		2
SCOR				HP203			MEASUREMEN	HIGH	Sour
E	ACTIVITY	UNITS	WISE COUNTY	0	ТΧ	U.S.	T PERIOD	DISPARITY*	се
	Access to Exercise								
2.50	Opportunities	percent	38.4		80.5	84	2020		5

4.00	SNAP Certified	stores/ 1,000	0.6	2017	10
1.86	Stores	population	0.6	2017	19
	Recreation and	facilities/ 1,000			
1.81	Fitness Facilities	population	0	2016	19
	Farmers Market	markets/ 1,000			
1.50	Density	population	0	2018	19
	Fast Food				
	Restaurant	restaurants/			
1.50	Density	1,000 population	0.6	2016	19
	Grocery Store	stores/ 1,000			
1.50	Density	population	0.2	2016	19
	WIC Certified	stores/ 1,000			
1.50	Stores	population	0.1	2016	19
	Children with Low				
	Access to a				
1.00	Grocery Store	percent	1.6	2015	19
1.00	Households with	percent	1.0	2015	
	No Car and Low				
	Access to a				
1.00	Grocery Store	percent	1.4	2015	19
1.00		percent	1.4	2015	19
	Low-Income and				
	Low Access to a			2015	10
1.00	Grocery Store	percent	1.8	2015	19
	People 65+ with				
	Low Access to a				
1.00	Grocery Store	percent	0.8	2015	19
	People with Low				
	Access to a				
1.00	Grocery Store	percent	6	2015	19

	Food								
	Environment								
0.97	Index		7.8		5.9	7.8	2021		5
SCOR	PREVENTION &			HP203			MEASUREMEN	HIGH	Sour
Е	SAFETY	UNITS	WISE COUNTY	0	тх	U.S.	T PERIOD	DISPARITY*	се
2.56	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	65.7	43.2	38.7	48.9	2017-2019		3
2.30	-	population	05.7	43.2	50.7	40.5	2017 2015		5
1.42	Severe Housing Problems	percent	13.5		17.4	18	2013-2017		5
1.25	Death Rate due to Drug Poisoning	deaths/ 100,000 population	13.2		10.6	21	2017-2019		5
SCOR E	RESPIRATORY DISEASES	UNITS	WISE COUNTY	HP203 0	ТХ	U.S.	MEASUREMEN T PERIOD	HIGH DISPARITY*	Sour ce
2.75	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	72.1		50.6	58.3	2013-2017		8
2.72	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	55.1	25.1	34.1	38.5	2013-2017		8
	COPD: Medicare	population	00.1	2012	0.112	0010	2010 2017		
2.64	Population	percent	16.4		11.2	11.5	2018		4
	Asthma: Medicare								
2.33	Population	percent	5.4		4.9	5	2018		4
	Adults who Smoke								

	COVID-19 Daily								
	, Average Case-	deaths per 100							
1.67	Fatality Rate	cases	1.8		3	1.6	17-Sep-21		7
1.58	Adults with COPD	Percent of adults	8.3			6.9	2018		2
	Adults with								
1.58	Current Asthma	percent	9.3			9.2	2018		2
	COVID-19 Daily								
	Average	cases per 100,000							
1.50	Incidence Rate	population	58.3		59.9	59.2	17-Sep-21		7
	Tuberculosis	cases/ 100,000							
1.08	Incidence Rate	population	0.9	1.4	4.3		2015-2019		12
	Age-Adjusted								
	Death Rate due								
	to Influenza and	deaths/ 100,000							
0.67	Pneumonia	population	11.9		11.8	13.8	2017-2019		3
	SEXUALLY								
SCOR	TRANSMITTED			HP203			MEASUREMEN	HIGH	Sour
E	INFECTIONS	UNITS	WISE COUNTY	0	ТХ	U.S.	T PERIOD	DISPARITY*	се
	Syphilis Incidence	cases/ 100,000							
1.22	Rate	population	2.9		8.8	10.8	2018		12
	HIV Diagnosis	cases/ 100,000							
0.86	Rate	cases/ 100,000 population	0		15.7		2018		12
0.86	-		0		15.7		2018		12
0.86	Rate	population	0		15.7 508.2	539.9	2018 2018		12
	Rate Chlamydia	population cases/ 100,000				539.9			
	Rate Chlamydia Incidence Rate	population cases/ 100,000 population				539.9			
0.75	Rate Chlamydia Incidence Rate Gonorrhea	population cases/ 100,000 population cases/ 100,000	161		508.2		2018		12
0.75	Rate Chlamydia Incidence Rate Gonorrhea	population cases/ 100,000 population cases/ 100,000	161	HP203	508.2		2018	HIGH	12

	Frequent Physical								
1.83	Distress	percent	13.1		11.6	11	2018		5
	High Blood								
	Pressure								
1.67	Prevalence	percent	36.3	27.7		32.4	2017		2
	Poor Physical								
1.58	Health: 14+ Days	percent	14			12.5	2018		2
1.42	Insufficient Sleep	percent	35.6	31.4	34.4	35	2018		5
	-								
SCOR	WOMEN'S			HP203			MEASUREMEN	HIGH	Sour
E	HEALTH	UNITS	WISE COUNTY	0	ТХ	U.S.	T PERIOD	DISPARITY*	ce
	Age-Adjusted								
	Death Rate due	deaths/ 100,000							
2.47	to Breast Cancer	females	28.5	15.3	19.8	20.1	2013-2017		8
	Mammogram in								
	Past 2 Years: 50-								
1.61	74	percent	69.7	77.1		74.8	2018		2
	Cervical Cancer								
1.44	Screening: 21-65	Percent	82.2	84.3		84.7	2018		2
	Breast Cancer	cases/ 100,000							
0.69	Incidence Rate	females	103.2		112.8	125.9	2013-2017		8
	•	>							

Wise County Data Sources

Кеу	Source Name
1	American Community Survey
2	CDC - PLACES
3	Centers for Disease Control and Prevention
4	Centers for Medicare & Medicaid Services
5	County Health Rankings
6	Feeding America
7	Healthy Communities Institute
8	National Cancer Institute
9	National Center for Education Statistics
10	National Environmental Public Health Tracking Network
11	Texas Department of Family and Protective Services
12	Texas Department of State Health Services
13	Texas Education Agency
14	Texas Secretary of State
	DFWHC Foundation Regional Data, Q1-Q4, 2017-2019.
15	DFWHC Foundation, Irving Texas. October 15, 2021
16	U.S. Bureau of Labor Statistics
17	U.S. Census - County Business Patterns
18	U.S. Census Bureau - Small Area Health Insurance Estimates
19	U.S. Department of Agriculture - Food Environment Atlas
20	U.S. Environmental Protection Agency
21	United For ALICE

Wise County Topic Scores

Health and Quality of Life Topics	Score
Older Adults	2.13
Other Conditions	1.94
Mental Health & Mental Disorders	1.93
Heart Disease & Stroke	1.93
Respiratory Diseases	1.85
Oral Health	1.82
Cancer	1.81
Health Care Access & Quality	1.78
Children's Health	1.77
Prevention & Safety	1.74
Wellness & Lifestyle	1.63
Diabetes	1.60
Women's Health	1.55
Community	1.46
Environmental Health	1.41
Physical Activity	1.40
Education	1.35
Alcohol & Drug Use	1.35
Economy	1.28
Immunizations & Infectious Diseases	1.11
Maternal, Fetal & Infant Health	1.01
Sexually Transmitted Infections	0.90

Community Input Assessment Tools

Key Informant Interview Guide and Questions

INTRODUCTION

HCI Facilitator: Introduce yourself and any others on the team

OPENING SCRIPT: TEXAS HEALTH RESOURCES (THR) has invited you to take part in this Key Informant Interview because of your content expertise and your experience working in the community. Our work on behalf of THR is focused on understanding what health issues and challenges impact the residents of **DENTON/WISE** County and how to improve their overall health. The insights and perspectives collected in this interview will provide important information that will ultimately be combined with the results of a key informant interviews, focus groups, and data analysis of state and national indicators. These data components will be compiled into a comprehensive report outlining the health needs in the Southern Region which includes **DENTON/WISE** County. The final reports will be completed in the summer of 2022.

CONFIDENTIALITY: For this interview, we will be taking notes on your responses, your names will not be associated with any direct quotes. Your identity will be kept confidential.

- 1. To begin, could you please tell us a little about the organization you work for and the geographic location it serves?
 - a. (only probe if necessary) What is your organization's mission? What are the top priority health issues that your organization addresses?
 - b. (only ask if not clear) Does your organization provide direct care, operate as an advocacy organization, or have another role in the community?
 - c. Which geographic location(s) does your organization serve? (to help us understand or confirm relevant service areas)

2. Considering the impact of Covid-19, what would you consider the top 5 health issues exacerbated by the pandemic in DENTON/WISE county?

- **a.** What are the possible solutions to improve the health issues you've described?
- **b.** What solutions have your organization/agency put in place or considered to help improve the health issues you described?
- c. How can Texas Health support these health improvement efforts?

- 3. Along the same lines, what would you consider the top 5 socioeconomic needs exacerbated by the pandemic in [County Name/Zip code]?
 - a. What are the possible solutions to improve the socioeconomic needs you've described?
 - b. What specific solutions have your organization/agency put in place or considered to help improve the socioeconomic issues you described?
 - c. How can Texas Health support these socioeconomic improvement efforts?
- 4. Thinking about the solutions you described to address the health and socioeconomic needs, to what extent does your organization/agency have what it needs to deliver these services/resources in the community effectively?
 - a. How do aspects of this community's [County Name/Zip code] infrastructure (i.e., physical environment, policies, partnerships) help or hinder your ability to deliver the services/resources you described?
 - b. How can Texas Health support the success of these services/resources?
- 5. How can community leaders, community-based organizations, and health care systems work collaboratively to address this community's [County Name/Zip codes] health and socioeconomic?
 - a. To your knowledge, what strategies have been used in the past to drive collaboration across these partners? What worked, what didn't, and why?
 - b. What challenges/barriers should Texas Health anticipate in its efforts to work with community leaders and members to address the health and socioeconomic needs in this community?
 - c. How can Texas Health proactively address these challenges/barriers?
- 6. Finally, what do you consider the best practices that are currently going on to improve the health and socio-economic needs in this community [County/Zip codes]?
- 7. What is the most crucial message/feedback you want Texas Health to take away from this interview?
 - a. Is there anything else you would like to add about any of the topics we've discussed or other areas that we didn't discuss but you think are essential?

CLOSING SCRIPT: Thank you so much for your time and participation today. In terms of next steps, we will be collecting and analyzing the data for this needs assessment over the next few months. The final report will be available to everyone who participated, as well as the general public. If you have additional comments or thoughts after our conversation today, please feel free to reach out to *Eileen Aguilar* or Oge/Sika. *HCI Facilitator: Send a follow-up email to the key informant, thanking them for their time and make sure to include a link to the survey!*

Focus Group Guide and Questions

INTRODUCTION

{Introduce Yourself and Others on the Team}

{"Let's get started...}

Opening Script: Thank you for taking the time to speak with us to support the Texas Health Resources (THR) Community Health Needs Assessment. We anticipate that this discussion will last no more than 60 minutes. You have been invited to take part in this focus group because of your experience living and/or working in Denton/Wise County. The focus of our Community Health Needs Assessment is how to improve health in the community and understand what challenges residents are facing. We are going to ask a series of questions related to health issues in the community. We hope to get through as many questions as possible and hear each of your perspectives as much as time allows.

For this discussion group, I will invite you to share as much or little as you feel comfortable sharing with the others in the group. The results of this assessment will be made available to the public. We will be taking notes on your responses, but your names will not be associated with any direct quotes. Your identity will be kept confidential, so please share your honest opinions.

SHOW SLIDES (if applicable)--We do have a few ground rules for this virtual discussion that I would like to review with you. It is important that everyone has a chance to be heard, so we ask that only one person talks at a time (most important ground rule for today). You may use the "raise hand" functions when you have something to say [*give instructions and test*]. We may also call on you to sure ensure everyone has a chance to speak but if you have nothing to share, please just say "pass".

You may want to mute yourself when you are not speaking to cut down on background noise [give instructions and test mute/unmute]. Finally, please respect the opinions of others, as the point of the discussion is to collect various points of view. And remember, there are no right or wrong answers, so please share freely and openly. Does anyone have any questions before we get started?

Okay, let's get started by going around and introducing ourselves. Please tell everyone your first name, what community you live in, and if you are interested in sharing, your involvement in the community (could be your job or volunteer work for example). {Introductions}

Thank you for introducing yourselves. Now we will get started with our discussion.

COVID-19 QUESTION

1. We know that COVID-19 has significantly impacted everyone's lives. What have you seen as the biggest challenges in XXXXX County during the pandemic?

[Probe 1: Which groups of people are having the hardest time right now?] [Probe 2: How have you seen these challenges being addressed, if at all?] [Probe 3: What programs have addressed COVID related issues? What has worked?] [Probe 4: What hasn't been effective and, in your opinion, why?]

GENERAL HEALTH QUESTIONS

2. What would you say are the top three health related problems that people in your community are facing that you would like to change or improve?

[Probe 1: Why do you think these are the most important health issues? [Probe 2: What would you do to address these problems?] [Probe 3: What else is needed to address these problems? Examples could be specific policies, programs, or services.]

3. What might prevent someone from accessing care for the health challenges identified above?

[Examples could include lack of transportation, lack of health insurance coverage, doctor's office hours, language, or cultural barriers, etc.]

4. Are there specific groups in your community that are most impacted by the health issues or challenges discussed earlier (2-3)? Which groups are these?

[Probe: Are these health challenges different if the person is a particular age, or gender, race, or ethnicity? Or lives in a certain part of the county for example?]

5. From the health issues and challenges we've just discussed, which do you think can be addressed in the next three years?

[Probe 1: How do you think these health issues can be addressed?} [Probe 2: Are some of these issues more urgent or important than others? If so, why?]

6. In 2019, Depression and anxiety among adults 18+ were identified as important health issues in your community. Do you know of any programs or services that are available in your community to address this issue?

[Prompt: Have you or someone you know benefited from these programs or services? If so, what do you think has worked? What do you think can be improved?]

7. What resources are currently available for residents in your community for the identified health/social determinant problem/s we've discussed today?

[Probe 1: Are there specific community organizations or agencies that you see taking a strong leadership role for improving the health of particular groups in your community?] [Probe 2: Do you see residents taking advantage of them? Why or why not?] [Probe 3: What additional programs and resources do you think are needed to best meet the needs of residents in _____ County?] [Probe 4: Are you aware of any THR-Community Health Improvement program(s) in your community?]

CLOSING QUESTION

8. Can you think of any other ways we could improve the health of residents in the community that we have not already talked about today?

[Probe: Is there anything else you would like to add that we haven't discussed?]

CONCLUSION

{Review the summary points and key takeaways from discussion} {Check if note taker needs any clarification}

CLOSURE SCRIPT: Thank you very much for your time and willingness to share your experiences with us today. We will include your comments in our data to describe how health can be improved for residents in your community. Please remember, your name will not be connected to any of the comments you made today. Please let us know if you have any questions or concerns about this.

Listening Session Questions

- 1. Name of the organization you represent.
- 2. What region/county/counties do your organization provide direct services to? (select all that apply)
 - a. Dallas County
 - b. Rockwall County
 - c. Denton/Wise County
 - d. Parker County
 - e. Denton County
 - f. Wise County
 - g. Denton/Wise County
 - h. Ellis County
 - i. Erath County
 - j. Henderson County
 - k. Johnson County
 - I. Kaufman County
- 3. In 2019, Texas Health Resources (THR) identified behavioral health, chronic disease prevention and management, access, awareness, health literacy and navigation as its priority areas. Are you aware of any THR programs, initiatives, resources, specifically addressing any of these priorities in your community?
- 4. What is THR doing well within the behavioral health, chronic disease prevention and management, access, health literacy and navigation areas? Feel free to address one or all priorities.
- 5. What are areas of opportunity within these priority areas? Feel free to address one or all priorities.
- 6. What can THR do to improve the awareness of its Community Health Needs Assessment (CHNA) findings and implementation strategies?
- **7.** Texas Health Resources is currently developing its 2022 CHNA reports and have identified these preliminary issues for the following regions:

Southern Region

Healthcare Access & Quality (lack of/limited insurance, delay in care)

Mental Health (depression, anxiety, isolation) Abuse/Violence (domestic violence, child abuse, intimate partner violence) Substance Abuse (isolation leading to increased substance use and addiction)

Denton/Wise Region-

Mental Health (increased need for adolescents, anxiety, lack of behavioral health services) Access to healthcare services (Provider shortages, language barriers, uninsured/underinsured) COVID-19 Impact (mental health, trust in healthcare system, delay in services) Food insecurity (lack of food, access to healthy foods, food deserts)

Tarrant/Parker Region-

Chronic conditions (heart disease, diabetes) COVID-19 Impact (Mental Health/Substance abuse, isolation, financial issues, delay in care, food insecurity) Health Behaviors (fear, stigma towards vaccine) Healthcare Access & Quality (Lack of providers, lack of bilingual providers, uninsured/underinsured)

Dallas/Rockwall Region-

Access to care (delay in care, uninsured, underinsured) Mental Health (isolation, depression exacerbated by COVID-19) Financial/Economic impact (unemployment, housing insecurity) Food insecurity (lack of healthy foods, lack of food)

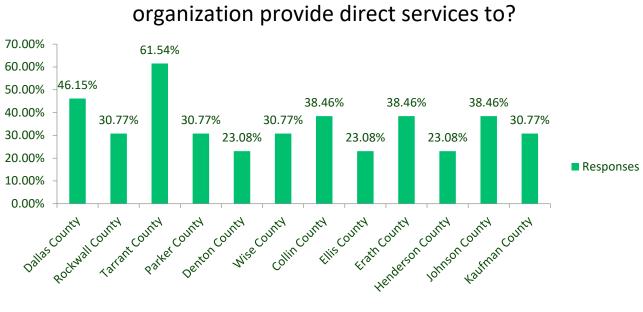
Denton/Wise Region-

Access to care (delay in services, high deductibles, affordability of insurance, knowledge of where to get care) Mental Health (stigma in accessing care, cultural barriers, anxiety)

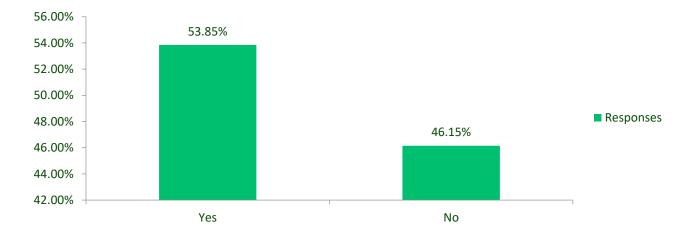
Economic/financial issues (difficulty paying rent/utilities, unemployment, loss of jobs) Housing (lack of affordable housing, discrimination)

7a. How can THR prioritize these health topics that have surfaced as issues in the region?

Listening Session Results



Question #3-Are you aware of any THR programs, initiatives, resources, specifically addressing any of these priorities in your community?



Question #4-What is THR doing well within the behavioral health, chronic health, chronic disease prevention & management, access, health literacy, and navigation areas?

- While there is some generalize awareness of THR efforts, there is not sufficient publicity of these efforts to elicit significant engagement from the public.

-I navigate the Plano Up program funded by THR focusing on anxiety and depression in youth in the 75074 zip. Beyond Blue is another program funded by THR to address mental health in the senior population in the 75069 zip

- The Community Impact program and its regional councils are a great model to impact health priorities.

- It's hard to say due to the Pandemic really. THR has been sending email and reminders to people to do their screenings, testing and seeing their Dr, even telemedicine

- Their willingness to fund organizations that promote access and health literacy is awesome.

- Excellent work with chronic disease prevention and management. Also, good initiative with mental health in rural areas. Doing a good job of bringing these topics, education, and interventions to the people and communities THR serves.

- THR's Community Impact team has done a great job at leveraging relations with community leaders, nonprofits, thought leaders to strengthen efforts to improve health outcomes that are negatively impacted by the social determinants of health. They are also using data to drive their decision and to measure positive improvements in the areas of exercise, health and chronic disease prevention.

- Connect deeper to faith-based organizations, and schools where the under-resource families are nearest and partner with other foundations to strengthen the ability to sustain efforts.

Q5- Are there areas of opportunity within these priority areas? Feel free to address

-Behavioral health partnerships between THR, JPS, and the City of Arlington would be good way to have a meaningful impact on this issue. A formalized partnership with COA/Fire PH unit, Mission Arlington, School Districts, UTA school of Nursing and Social Work, JPS, TCPH and MCA could result in a cost effective and impactful approach to many of these issues.

- I feel mental health is still a large concern. However, I feel healthcare is out of reach for many people even for those with the ability to pay. Living expenses have increased to the point where many people cannot afford to maintain their physical or mental well-being

- There are many opportunities to impact health outcomes - particularly chronic diseasethrough increased awareness and support of patients affected by memory decline. This can include those at risk for cognitive decline (diverse communities are at higher risk, as are those who have comorbidities) and create opportunities for early detection—also, outcomes related to caregiver health.

- With the start of the Pandemic in March 2020, people have not seen their health care providers as they should, thus causing now two years later, many, many additional medical problems.

- Behavioral health is an awesome place to start. We need to train paraprofessionals to go into the neighborhood.

- Health literacy training for health care and service providers would enhance THR's current efforts within chronic disease management.

Question 6- What can THR do to improve the awareness of its Community Health Needs Assessment findings and implementation strategies?

-Partner directly with the City of Arlington Office of Communications

-Present to city and nonprofits the results of the assessment. Many citizens have no idea of the health status of our city.

- More programs focused on prevention and mobile solutions. We have to realize that many people cannot get to appointments even with coverage. Housing, food and transportation costs

- Increasing channels of communication, implementing practical action steps and a starting point for those needing the services, enhanced relationship building with community partners.

- Send them to community orgs as well as posting on their website. If both of these were done, I would recommend a way to ensure that all orgs doing any social service-related work get notified of the CHNA and implementation plan.

- Work directly with Community-Based Organizations (CBOs), such as the Alzheimer's Association or Area Agency on Aging, to promote these results and how a partnership with the CBO will impact the health outcomes. Continue to provide grants to CBOs to ensure that community support continues for all those in need.

- Perhaps THR can advertise the CHNA can run local ads on television and radio.

- As we emerge from the Pandemic, continue to reach those who are not connected by smart phones and emails

- A spot on the major networks or continuous radio spots would help.

- Personally, I think that THR does a great job of disseminating CHNA findings. They and Cook are regional leaders in that work. I'm not sure if THR already works closely with rural Extension

services to disseminate findings and implement programming. If not, that may be another avenue. Also, engaging FQHC's in CHNA implementation strategies is important.

- Take the information out to the community who are impacted the most. (Churches, Schools, Stores, barbershops, beauty shops and perhaps convenience store.

Question #7-How can THR prioritize these health topics that have surfaced as issues in the region? 50.00% 60.00% 50.00% 30.00% 40.00% 20.00% 30.00% 20.00% 10.00% 0.00% Option 1: Keep the health topics Option 2: Specify the issues within Option 3: Other (Explain below) broad and develop aligned each health topic that THR should programs/initiatives. address (e.g. Diabetes, Depression/Anxiety, etc.). Responses

225

Community Resource and Partner List

This highlights existing resources that organizations are currently using and available widely in the community. It also highlights potential community partners who were identified during the qualitative data collection process for this CHNA.

Community Resource and Partner List

Denton

- Lewisville ISD Counseling Center
- Lewisville ISD Community Health Clinic (located at elementary school)
- Children's Advocacy Center for North Texas
- Children's Advocacy Center Movement
- First Refuge
- National school nutrition grant in schools (food trucks, lunch for families)
- Texas Motor Speedway Vaccination Clinic (COVID-19)
- Local Government support (County Judge)

Wise

- Helen Farabee Center
- TAPS (transportation system)
- Healthy Wise County workgroup convened by Wise Health System
- United Way
- County health care system
- ECHO-Wise County Community Coalition
- Dialysis Center-Wise Health System

Community Partner List

Denton

- Children's Advocacy Center for North Texas
- Lewisville ISD

Wise

- County Judge
- Texas Health Community Impact Board Denton and Wise County
- TAPS Transportation

Appendix D. Southern Region

TEXAS HEALTH RESOURCES

SOUTHERN REGION

APPENDICES

Secondary Data Methodology

Secondary Data Sources

The main source for the secondary data, or data that has been previously collected, is the community indicator database maintained by Conduent Healthy Communities Institute. The following is a list of both local and national data sources used in Texas Health Resources Southern Region Community Health Needs Assessment.

Data Sources

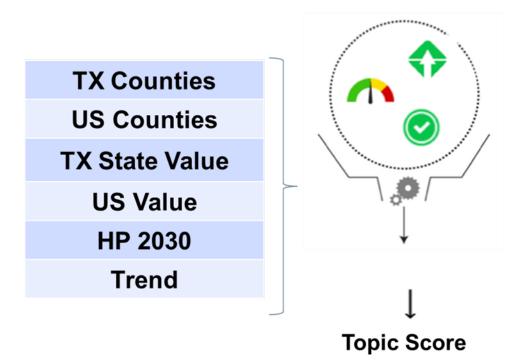
- American Community Survey
- American Lung Association
- CDC PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- County Health Rankings
- Feeding America
- Healthy Communities Institute
- National Cancer Institute
- National Center for Education Statistics
- National Environmental Public Health Tracking Network
- Texas Department of Family and Protective Services
- DFWHC Foundation Regional Data, Q1-Q4, 2017-2019. DFWHC Foundation, Irving Texas. October 15, 2021,

- Texas Education Agency
- Texas Department of Health Services
- U.S Bureau of Labor Statistics
- U.S. Census County Business Patterns
- U.S. Census Bureau Small Area Health Insurance Estimates
- U.S. Department of Agriculture Food Environment Atlas
- U.S. Environmental Protection Agency
- United for ALICE

Secondary Data Scoring

HCl's Data Scoring Tool (Figure 1A) was used to systematically summarize multiple comparisons in order to rank indicators based on highest need. For each indicator, the community value was compared to a distribution of Texas and US counties, state and national values, Healthy People 2030, and significant trends were noted. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities and changes in methodology over time. The comparison scores were summarized for each indicator, and indicators were then grouped into topic areas for a systematic ranking of community health needs. This was completed for each county within the Southern Region.

Figure 1A: Summary of Topic Scoring Analysis



Index of Disparity

An important part of the CHNA process is to identify health disparities, the needs of vulnerable populations and unmet health needs or gaps in services. There were several ways in which subpopulation disparities were examined by county. For secondary data health indicators, the Index of Disparity tool was utilized to see if there were large, negative, and concerning differences in indicator values between each subgroup data value and the overall county value. The Index of Disparity was run for each county, and the indicators with the highest race or ethnicity index value were found.

Health Equity Index

Every community can be described by various social and economic factors that can contribute to disparities in health outcomes. Conduent HCI's Health Equity Index (formerly SocioNeeds [®] Index) considers validated indicators related to income, employment, education, and household environment to identify areas at highest risk for experiencing health inequities.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic needs correlated with preventable hospitalizations and premature death.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Health Equity Index, with darker coloring associated with higher relative needs.

Food Insecurity Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in outcomes and opportunities to thrive. Conduent HCI's Food Insecurity Index considers validated indicators related to income, household environment, and well-being to identify areas at the highest risk for experiencing food insecurity.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest food insecurity, which is correlated with household and community measures of food-related financial stress such as Medicaid and SNAP enrollment.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Food Insecurity Index, with darker coloring associated with higher relative needs.

Mental Health Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in mental health outcomes. Conduent HCI's Mental Health Index considers validated indicators related to access to care, physical health status, transportation, employment, and household environment to identify areas at the highest risk for experiencing poor mental health.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic and health needs correlated with self-reported poor mental health.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Mental Health Index, with darker coloring associated with higher relative needs.

Data Considerations

Several limitations of data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and health-related areas, data availability varies by health topic. Some topics contain a robust set of secondary data indicators, while others may have a limited number of indicators or limited subpopulations covered by those specific indicators. Data scores represent the relative community health need according to the secondary data for each topic and should not be considered a comprehensive result on their own. In addition, these scores reflect the secondary data results for the population as a whole and do not represent the health or socioeconomic need that is much greater for some subpopulations. Moreover, many of the secondary data indicators included in the findings are collected by survey, and though specific methods are used to best represent the population at large, these measures are subject to instability, especially for smaller populations. The Index of Disparity is also limited by data availability, where indicator data varies based on the population groups and service areas being analyzed.

Race or ethnic and Special Population Groupings

The secondary data presented in this report derive from multiple sources, which may present race and ethnicity data using dissimilar nomenclature. For consistency with data sources throughout the report, subpopulation data may use different terms to describe the same or similar groups of community members.

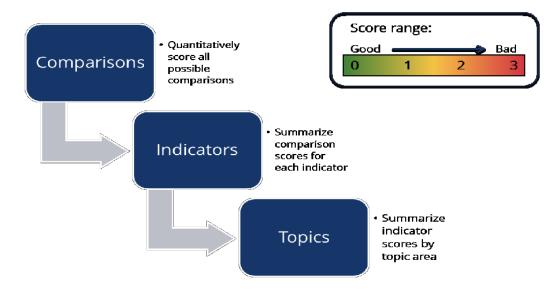
Zip Codes and Zip Code Tabulation Areas

This report presents both Zip Code and Zip Code Tabulation Area (ZCTA) data. Zip Codes, which were created by the U.S. Postal Service to improve mail delivery service, are not reported in this assessment as they may change, include P.O. boxes or cover large unpopulated areas. This assessment cover ZCTAs or Zip Code Tabulation Areas which were created by the U.S. Census Bureau and are generalized representations of Zip Codes that have been assigned to census blocks.

Demographics for this report are sourced from the United States Census Bureau, which presents ZCTA estimates. Tables and figures in the Demographics section of this report reference Zip Codes in title (for purposes of familiarity) but show values of ZCTAs. Data from other sources are labeled as such.

Secondary Data Scoring Detailed Methodology

Data Scoring is done in three stages:



For every indicator available, each county in the Hospital Service Area is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time. Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic. This was completed separately for each county within the Southern Region (Ellis, Erath, Johnson, Kaufman, Hood, and Henderson counties). An aggregate score for each topic was calculated using the average for each topic score across all counties. Secondary data for this report are up to date as of November 1, 2021.

Comparison to a Distribution of County Values: Within State and Nation

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

Comparison to Values: State, National, and Targets

The county is compared to the state value, the national value, and target values. Target values include the nation-wide Healthy People 2030 (HP2030) goals. Healthy People 2030 goals are national objectives for improving the health of the nation set by the Department of Health and

Human Services' (DHHS) Healthy People Initiative. For all value comparisons, the scoring depends on whether the county value is better or worse than the comparison value, as well as how close the county value is to the target value.

Trend Over Time

The Mann-Kendall statistical test for trend was used to assess whether the county value is increasing over time or decreasing over time, and whether the trend is statistically significant. The trend comparison uses the four most recent comparable values for the county, and statistical significance is determined at the 90% confidence level. For each indicator with values available for four time periods, scoring was determined by direction of the trend and statistical significance.

Missing Values

Indicator scores are calculated using the comparison scores, the availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators on the community dashboard, it will be included in the indicator score. After the exclusion of comparison types with inadequate availability, all missing comparisons are substituted with a neutral score for the purposes of calculating the indicator's weighted average. When information is unknown due to a lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

Indicator Scoring

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated, and the indicator is excluded from the data scoring results.

Topic Scoring

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. Resulting scores range from 0-3, where a higher score indicates a greater level of need as evidenced by the data. A topic score is only calculated if it includes at least three indicators.

County Data Scoring Indicators Results

Southern Region (Ellis, Erath, Henderson, Hood, Johnson, Kaufman) Topic Scores

Ellis County

Health and Quality of Life Topics	Score
Alcohol & Drug Use	1.23
Cancer	1.66
Children's Health	1.48
Community	1.28
Diabetes	1.48
Economy	1.07
Education	1.32
Environmental Health	1.44
Health Care Access & Quality	1.56
Heart Disease & Stroke	1.53
Immunizations & Infectious Diseases	1.49
Maternal, Fetal & Infant Health	1.35
Mental Health & Mental Disorders	1.68
Older Adults	1.59
Oral Health	1.41
Other Conditions	1.51
Physical Activity	1.53

Prevention & Safety	0.79
Respiratory Diseases	1.49
Sexually Transmitted Infections	1.29
Wellness & Lifestyle	1.25
Women's Health	1.71

SCORE	ALCOHOL & DRUG USE	UNITS	ELLIS COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.75	Age-Adjusted ER Rate due to Opioid Use	ER visits/ 10,000 population 18+ years	1.7		0.7		2017-2019		16
1.61	Alcohol-Impaired Driving Deaths	percent of driving deaths with alcohol involvement	28.5	28.3	25.7	27	2015-2019		6
1.58	Adults who Binge Drink	percent	16.1			16.4	2018		3
1.25	Age-Adjusted ER Rate due to Substance Use	ER visits/ 10,000 population 18+ years	14.2		20.6		2017-2019		16
1.25	Age-Adjusted Hospitalization Rate due to Substance Use	hospitalizations/ 10,000 population 18+ years	0.7	1.2	1.9		2017-2019		16
1.00	Age-Adjusted Drug and Opioid- Involved Overdose Death Rate	Deaths per 100,000 population	10.2		12.1	22.8	2017-2019		4
0.75	Death Rate due to Drug Poisoning	deaths/ 100,000 population	9.1		10.6	21	2017-2019		6
0.61	Liquor Store Density	stores/ 100,000 population	1.6		6.9	10.5	2019		18
SCORE	CANCER	UNITS	ELLIS COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.25	Cancer: Medicare Population	percent	7.9		7.6	8.4	2018		5
2.22	Cervical Cancer Incidence Rate	cases/ 100,000 females	10.1		9.2	7.6	2013-2017		9
2.17	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	21.2	16.9	17.6	19	2013-2017		9
2.11	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	16.2	8.9	13.9	13.7	2013-2017		9
2.08	All Cancer Incidence Rate	cases/ 100,000 population	444.9		407.7	448.7	2013-2017		9

2.03	Colorectal Cancer Incidence Rate	cases/ 100,000 population	42.7		37.6	38.4	2013-2017		9
1.81	Age Adjusted Death Pate due to		20.2	15.3	19.8	20.1	2013-2017		9
1.81	Age-Adjusted Death Rate due to	deaths/ 100,000	20.2	15.3	19.8	20.1	2013-2017		9
	Breast Cancer	females							
1.81	Breast Cancer Incidence Rate	cases/ 100,000	118.7		112.8	125.9	2013-2017		9
		females							
1.61	Oral Cavity and Pharynx Cancer	cases/ 100,000	12.8		11	11.8	2013-2017		9
	Incidence Rate	population							
1.50	Colon Cancer Screening	percent	63.1	74.4		66.4	2018		3
1.44	Cervical Cancer Screening: 21-65	Percent	83	84.3		84.7	2018		3
	_								
1.36	Lung and Bronchus Cancer	cases/ 100,000	56.9		50.6	58.3	2013-2017		9
	Incidence Rate	population							
1.33	Age-Adjusted Death Rate due to	deaths/ 100,000	38.9	25.1	34.1	38.5	2013-2017		9
	Lung Cancer	population		-	-				-
1.28	Mammogram in Past 2 Years: 50-	percent	71.9	77.1		74.8	2018		3
1.20	74	percent	71.5	,,.1		74.0	2010		5
1.17	Age-Adjusted Death Rate due to	deaths/ 100,000	163.2	122.7	148.8	155.5	2013-2017		9
1.17	Cancer		105.2	122.7	140.0	155.5	2013-2017		9
1.00	Adults with Cancer	population	6.2			<u> </u>	2010		
1.08		percent	6.3			6.9	2018		3
1.03	Prostate Cancer Incidence Rate	cases/ 100,000	93.8		94	104.5	2013-2017		9
		males							
SCORE	CHILDREN'S HEALTH	UNITS	ELLIS COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.50	Food Insecure Children Likely	percent	48		34	23	2019		7
	Ineligible for Assistance	,							
1.83	Children with Low Access to a	percent	7				2015		20
	Grocery Store	p 0. 00							
1.50	Children with Health Insurance	percent	87.6		87.3	94.3	2019		1
1.17	Child Food Insecurity Rate	percent	16.8		19.6	14.6	2019		7
1.08	Projected Child Food Insecurity	percent	20.4		23.6	-	2021		7
	Rate	p 0. 00110	_0		_3.0				•
	nate								

0.78	Substantiated Child Abuse Rate	cases/ 1,000 children	7.5	8.7	9.1		2020		12
SCORE	COMMUNITY	UNITS	ELLIS COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.92	Mean Travel Time to Work	minutes	30.6		26.6	26.9	2015-2019		1
2.64	Solo Drivers with a Long Commute	percent	47.2		38.9	37	2015-2019		6
2.50	Median Monthly Owner Costs for Households without a Mortgage	dollars	553		514	500	2015-2019		1
2.50	Workers Commuting by Public Transportation	percent	0.2	5.3	1.4	5	2015-2019	Black (0.2) White (0.3) Asian (0) AIAN (0) NHPI (0) Mult (0) Other (0) Hisp (0)	1
2.33	Mortgaged Owners Median Monthly Household Costs	dollars	1663		1606	1595	2015-2019		1
2.31	Total Employment Change	percent	-0.1		2.9	1.6	2018-2019		18
2.17	Median Household Gross Rent	dollars	1054		1045	1062	2015-2019		1
1.92	Persons with Health Insurance	percent	81.1	92.1	79.3		2019		19
1.86	Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions	deaths/ 100,000 population	14.6	10.1	13	11.3	2017-2019		4
1.69	Workers who Drive Alone to Work	percent	81.7		80.5	76.3	2015-2019		1
1.64	Social Associations	membership associations/ 10,000 population	8.8		7.5	9.3	2018		6
1.61	Alcohol-Impaired Driving Deaths	percent of driving deaths with alcohol involvement	28.5	28.3	25.7	27	2015-2019		6

1.25	People 25+ with a Bachelor's	percent	24.3		29.9	32.1	2015-2019		1
	Degree or Higher								
1.25	Social Worker Rate	workers/ 100,000	58.5		82.7		2020		13
		population							
1.19	Voter Turnout: Presidential	percent	62.1		58.8		2016		15
	Election								
1.08	Persons with an Internet	percent	90		84.2	86.2	2015-2019		1
	Subscription								
1.00	Households with No Car and Low	percent	1.4				2015		20
	Access to a Grocery Store								
0.97	Population 16+ in Civilian Labor	percent	64.4		61	59.6	2015-2019		1
	Force								
0.92	People 25+ with a High School	percent	86.2		83.7	88	2015-2019		1
	Degree or Higher								
0.83	Households with an Internet	percent	88		82.1	83	2015-2019		1
	Subscription								
0.83	Households with One or More	percent	94.4		91	90.3	2015-2019		1
	Types of Computing Devices								
0.83	Median Housing Unit Value	dollars	191400		172500	217500	2015-2019		1
0.78	Substantiated Child Abuse Rate	cases/ 1,000 children	7.5	8.7	9.1		2020		12
0.75	Linguistic Isolation	percent	2.7		7.7	4.4	2015-2019		1
0.69	Female Population 16+ in Civilian	percent	60.6		57.8	58.3	2015-2019		1
	Labor Force								
0.58	Per Capita Income	dollars	32571		31277	34103	2015-2019		1
0.36	Homeownership	percent	69.1		54.9	56.2	2015-2019		1
0.11	People Living Below Poverty Level	percent	8.8	8	14.7	13.4	2015-2019	Black (17) White	1
								(5.7) Asian (5.3)	
								AIAN (13.8) NHPI	
								(27) Mult (14.7)	
								Other (11.5) Hisp	
								(13.4)	

0.08	Children Living Below Poverty	percent	13		20.9	18.5	2015-2019		1
	Level								
0.08	Median Household Income	dollars	76871		61874	62843	2015-2019		1
0.08	Single-Parent Households	percent	17.6		26.3	25.5	2015-2019		1
SCORE	DIABETES	UNITS	ELLIS COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.75	Age-Adjusted ER Rate due to	ER visits/ 10,000	44.7	111 2030	9.7	0.5.	2017-2019		16
1.75	Diabetes	population 18+ years			5.7		2017 2015		10
	Diabetes								
1.75	Age-Adjusted ER Rate due to Type	ER visits/ 10,000	41.1		8.6		2017-2019		16
	2 Diabetes	population 18+ years							
1.75	Age-Adjusted Hospitalization Rate	hospitalizations/	23		5.3		2017-2019		16
	due to Diabetes	10,000 population							
		18+ years							
1.75	Age-Adjusted Hospitalization Rate	hospitalizations/	16.9		4		2017-2019		16
	due to Type 2 Diabetes	10,000 population							
		18+ years							
1.50	Diabetes: Medicare Population	percent	28.4		28.8	27	2018		5
0.36	Age-Adjusted Death Rate due to	deaths/ 100,000	15.8		22	21.5	2017-2019		4
	Diabetes	population							
SCORE	ECONOMY	UNITS	ELLIS COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.50	Food Insecure Children Likely	percent	48	111 2030	34	23	2019		7
2.50	Ineligible for Assistance	percent	-10		54	25	2015		,
2.50	Median Monthly Owner Costs for	dollars	553		514	500	2015-2019		1
2.50	Households without a Mortgage	uonars	555		514	500	2013 2013		-
2.33	Mortgaged Owners Median	dollars	1663		1606	1595	2015-2019		1
2.55	Monthly Household Costs	uununs	1005		1000	1333	2013-2013		Ŧ
2.31	Total Employment Change	percent	-0.1		2.9	1.6	2018-2019		18
2.31	Median Household Gross Rent	dollars	1054		1045	1062	2018-2019		10
2.1/	Median Household Gross Kellt	4011013	1034		1040	1002	2013-2013		

2.00	WIC Certified Stores	stores/ 1,000	0.1			2016	20
		population					
1.86	SNAP Certified Stores	stores/1,000	0.5			2017	20
		population					
1.64	Households with Cash Public	percent	1.6	1.4	2.4	2015-2019	1
	Assistance Income						
1.50	Renters Spending 30% or More of	percent	46.6	47.8	49.6	2015-2019	1
	Household Income on Rent						
1.47	Overcrowded Households	percent of	3.7	4.8		2015-2019	1
		households					
1.33	Low-Income and Low Access to a	percent	6.3			2015	20
	Grocery Store						
1.31	Students Eligible for the Free	percent	42			2019-2020	10
	Lunch Program						
1.17	Child Food Insecurity Rate	percent	16.8	19.6	14.6	2019	7
1.08	Projected Child Food Insecurity	percent	20.4	23.6		2021	7
	Rate						
1.03	Severe Housing Problems	percent	14.1	17.4	18	2013-2017	6
1.00	Food Insecurity Rate	percent	11.5	14.1	10.9	2019	7
1.00	Households that are Above the	percent	65.9	56		2018	22
	Asset Limited, Income						
	Constrained, Employed (ALICE)						
	Threshold						
1.00	Households that are Asset	percent	26.8	30		2018	22
	Limited, Income Constrained,						
	Employed (ALICE)						
1.00	Households that are Below the	percent	7.3	14		2018	22
	Federal Poverty Level						
0.97	Population 16+ in Civilian Labor	percent	64.4	61	59.6	2015-2019	1
	Force						
0.92	Projected Food Insecurity Rate	percent	13.7	16.5		2021	7
0.83	Median Housing Unit Value	dollars	191400	172500	217500	2015-2019	1

0.69	Female Population 16+ in Civilian	percent	60.6		57.8	58.3	2015-2019		1
	Labor Force								
0.58	Per Capita Income	dollars	32571		31277	34103	2015-2019		1
0.58	Unemployed Workers in Civilian	percent	4.8		5.9	5.5	May-21		17
	Labor Force								
0.50	Mortgaged Owners Spending 30%	percent	21.9		26.5	26.5	2019		1
	or More of Household Income on								
	Housing								
0.36	Homeownership	percent	69.1		54.9	56.2	2015-2019		1
0.11	People Living Below Poverty Level	percent	8.8	8	14.7	13.4	2015-2019	Black (17) White	1
								(5.7) Asian (5.3)	
								AIAN (13.8) NHPI	
								(27) Mult (14.7)	
								Other (11.5) Hisp	
								(13.4)	
0.08	Children Living Below Poverty	percent	13		20.9	18.5	2015-2019	· · ·	1
	Level								
0.08	Families Living Below Poverty	percent	6.8		11.3	9.5	2015-2019	Black (14.4) White	1
	Level							(4.4) Asian (0)	
								AIAN (14.5) NHPI	
								(100) Mult (10.4)	
								Other (7.6) Hisp	
								(11.4)	
0.08	Median Household Income	dollars	76871		61874	62843	2015-2019		1
0.08	People 65+ Living Below Poverty	percent	5.4		10.6	9.3	2015-2019	Black (8.1) White	1
	Level							(4.3) Asian (0)	
								AIAN (0) NHPI	
								(100) Mult (23.5)	
								Other (9.6) Hisp	
								(12.7)	
0.08	People Living 200% Above	percent	77.8		65.7	69.1	2015-2019		1
	Poverty Level								

0.08	Persons with Disability Living in Poverty (5-year)	percent	12.8		23.2	26.1	2015-2019		1
SCORE	EDUCATION	UNITS	ELLIS COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.97	High School Drop Out Rate	percent	3.4		1.9		2019	Black (3.9) White (3.1) Asian (0) AIAN (14.3) PI (25) Mult (3.6) Hisp (3.6)	14
1.97	Student-to-Teacher Ratio	students/ teacher	15.2				2019-2020	<u>·</u>	10
1.25	People 25+ with a Bachelor's	percent	24.3		29.9	32.1	2015-2019		1
	Degree or Higher								
0.92	People 25+ with a High School	percent	86.2		83.7	88	2015-2019		1
0.70	Degree or Higher								
0.50	Infants Born to Mothers with <12 Years Education	percent	12.2		17.4	13.3	2017	Black (7.9) White	13
	fears Education							(5.9) Hisp (24.6)	
SCORE	ENVIRONMENTAL HEALTH	UNITS	ELLIS COUNTY	HP2030	ΤХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.00	Grocery Store Density	stores/ 1,000	0.1				2016		20
		population							
2.00	WIC Certified Stores	stores/ 1,000	0.1				2016		20
		population							
1.86	SNAP Certified Stores	stores/ 1,000	0.5				2017		20
		population							
1.83	Access to Exercise Opportunities	percent	66		80.5	84	2020		6
1.83	Children with Low Access to a Grocery Store	percent	7				2015		20
1.75	Asthma: Medicare Population	percent	5		4.9	5	2018		5
1.73	Annual Ozone Air Quality	ρειτεπι			4.3	J	2017-2019		2
1.72	Annual Particle Pollution		B				2017-2019		2
1.67	Fast Food Restaurant Density	restaurants/ 1,000	0.6				2017 2015		20
1.07		population	0.0				2010		20

1.67	People with Low Access to a	percent	23.7				2015		20
	Grocery Store								
1.64	Number of Extreme Precipitation	days	43				2016		11
	Days								
1.64	PBT Released	pounds	112140.5				2019		21
1.64	Recognized Carcinogens Released	pounds	169958.2				2019		21
	into Air								
1.47	Overcrowded Households	percent of	3.7		4.8		2015-2019		1
		households							
1.36	Number of Extreme Heat Events	events	2				2016		11
1.33	Farmers Market Density	markets/ 1,000	0.0				2018		20
		population							
1.33	Low-Income and Low Access to a	percent	6.3				2015		20
	Grocery Store								
1.33	People 65+ with Low Access to a	percent	2.1				2015		20
	Grocery Store								
1.33	Recreation and Fitness Facilities	facilities/ 1,000	0.1				2016		20
		population							
1.17	Daily Dose of UV Irradiance	Joule per square	3294		3538		2015		11
		meter							
1.08	Adults with Current Asthma	percent	9.2			9.2	2018		3
1.08	Number of Extreme Heat Days	days	5				2016		11
1.08	Weeks of Moderate Drought or	weeks per year	1				2016		11
	Worse								
1.03	Severe Housing Problems	percent	14.1		17.4	18	2013-2017		6
1.00	Households with No Car and Low	percent	1.4				2015		20
	Access to a Grocery Store								
0.69	Food Environment Index		7.8		5.9	7.8	2021		6
0.61	Liquor Store Density	stores/ 100,000	1.6		6.9	10.5	2019		18
		population							
SCORE	FAMILY PLANNING	UNITS	ELLIS COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source

0.94	Teen Births	percent	1.4		2.1	3.1	2017	Black (0) White (0.9) Other (0) Hisp (2)	13
0.50	Infants Born to Mothers with <12 Years Education	percent	12.2		17.4	13.3	2017	Black (7.9) White (5.9) Hisp (24.6)	13
SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	ELLIS COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.92	Adults who have had a Routine Checkup	percent	72.4			76.7	2018		3
1.92	Adults without Health Insurance	percent	23.8			12.2	2018		3
1.92	Persons with Health Insurance	percent	81.1	92.1	79.3		2019		19
1.75	Primary Care Provider Rate	providers/ 100,000	42.4		60.9		2018		6
		population							
1.50	Adults with Health Insurance	percent	78.5		75.5	87.1	2019		1
1.50	Children with Health Insurance	percent	87.6		87.3	94.3	2019		1
1.42	Adults who Visited a Dentist	percent	61.3			66.5	2018		3
1.33	Dentist Rate	dentists/ 100,000	33.6		59.6		2019		6
		population							
1.33	Mental Health Provider Rate	providers/ 100,000	66		120.9		2020		6
		population							
1.33	Non-Physician Primary Care	providers/ 100,000	57.9		88.6		2020		6
	Provider Rate	population							
1.25	Social Worker Rate	workers/ 100,000	58.5		82.7		2020		13
		population							
CODE				HP2030	TV				C
SCORE	HEART DISEASE & STROKE	UNITS	ELLIS COUNTY		TX (0.2	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.58	Age-Adjusted Death Rate due to	deaths/ 100,000	52.3	33.4	40.2	37.2	2017-2019		4
	Cerebrovascular Disease (Stroke)	population							
2.03	Stroke: Medicare Population	percent	4.3		4.2	3.8	2018		5
						0.0			-

1.97	Hyperlipidemia: Medicare Population	percent	49.9		49.5	47.7	2018	5
1.92	Adults who Have Taken Medications for High Blood Pressure	percent	74.5			75.8	2017	3
1.81	Atrial Fibrillation: Medicare Population	percent	8.3		7.8	8.4	2018	5
1.81	Hypertension: Medicare Population	percent	60.3		59.9	57.2	2018	5
1.75	Age-Adjusted ER Rate due to Hypertension	ER visits/ 10,000 population 18+ years	54.9		10.5		2017-2019	16
1.75	Age-Adjusted Hospitalization Rate due to Hypertension	hospitalizations/ 10,000 population 18+ years	0.3		0.1		2017-2019	16
1.67	High Blood Pressure Prevalence	percent	35.8	27.7		32.4	2017	3
1.42	Cholesterol Test History	percent	80.5			81.5	2017	3
1.25	High Cholesterol Prevalence: Adults 18+	percent	35.6			34.1	2017	3
1.22	Age-Adjusted Death Rate due to Coronary Heart Disease	deaths/ 100,000 population	84.1	71.1	93	90.5	2017-2019	4
1.17	Age-Adjusted Death Rate due to Heart Attack	deaths/ 100,000 population 35+ years	61.7		70.1		2018	11
0.92	Adults who Experienced a Stroke	percent	3.2			3.4	2018	3
0.92	Adults who Experienced Coronary Heart Disease	percent	6.3			6.8	2018	3
0.92	Heart Failure: Medicare Population	percent	15		15.6	14	2018	5
0.86	Ischemic Heart Disease: Medicare Population	percent	26.2		29	26.8	2018	5

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	ELLIS COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.47	COVID-19 Daily Average Incidence	cases per 100,000	86.8		77.1	62.2	3-Sep-21		8
	Rate	population							
1.81	COVID-19 Daily Average Case-	deaths per 100 cases	1.1		1.7	1	3-Sep-21		8
	Fatality Rate								
1.75	Age-Adjusted Hospitalization Rate	hospitalizations/	0.3		0.1		2017-2019		16
	due to Immunization-Preventable	10,000 population							
	Pneumonia and Influenza	18+ years							
1.64	HIV Diagnosis Rate	cases/ 100,000	10.6		15.7		2018		13
		population							
1.56	Age-Adjusted Death Rate due to	deaths/ 100,000	12.6		11.8	13.8	2017-2019		4
	Influenza and Pneumonia	population							
1.47	Overcrowded Households	percent of	3.7		4.8		2015-2019		1
		households							
1.22	Gonorrhea Incidence Rate	cases/ 100,000	111.5		163.6	179.1	2018		13
		population							
1.22	Syphilis Incidence Rate	cases/ 100,000	4.5		8.8	10.8	2018		13
		population							
1.08	Chlamydia Incidence Rate	cases/ 100,000	380.6		508.2	539.9	2018		13
		population							
0.67	Tuberculosis Incidence Rate	cases/ 100,000	1.2	1.4	4.3		2015-2019		13
		population							
SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	ELLIS COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.31	Infant Mortality Rate	deaths/ 1,000 live	9.4	5	5.6	5.9	2015		13
		births							
1.89	Babies with Very Low Birth	percent	1.7			1.4	2015	Black (7.8125)	13
	Weight							Other (0) Hisp	
								(1.75695461)	

1.56	Babies with Low Birth Weight	percent	7.8		8.2	8.1	2015	Black (17.7083333) White (6.4516129) Hisp (7.61346998)	13
1.33	Mothers who Received Early	percent	60.6		60.5	77.3	2017		13
1.55	Prenatal Care	percent	00.0		00.5	77.5	2017		15
0.94	Preterm Births	percent	10.5	9.4	12.2		2017		13
0.94	Teen Births	percent	1.4		2.1	3.1	2017	Black (0) White (0.9) Other (0) Hisp (2)	13
0.50	Infants Born to Mothers with <12 Years Education	percent	12.2		17.4	13.3	2017	Black (7.9) White (5.9) Hisp (24.6)	13
SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	ELLIS COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.92	Depression: Medicare Population	percent	20.7		18.2	18.4	2018		5
1.97	Age-Adjusted Death Rate due to Suicide	deaths/ 100,000 population	15.2	12.8	13.5	14.1	2017-2019		4
1.97	Alzheimer's Disease or Dementia: Medicare Population	percent	11.9		12.6	10.8	2018		5
1.50	Frequent Mental Distress	percent	13.5		11.6	13	2018		6
1.33	Mental Health Provider Rate	providers/ 100,000 population	66		120.9		2020		6
1.25	Age-Adjusted ER Rate due to Adult Mental Health	ER visits/ 10,000 population 18+ years	5.2		8.9		2017-2019		16
1.25	Age-Adjusted Hospitalization Rate due to Adult Mental Health	hospitalizations/ 10,000 population 18+ years	0.7		1.7		2017-2019		16
1.25	Poor Mental Health: 14+ Days	percent	13.4			12.7	2018		3
	•	-							

SCORE	OLDER ADULTS	UNITS	ELLIS COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.92	Depression: Medicare Population	percent	20.7		18.2	18.4	2018		5
2.75	Chronic Kidney Disease: Medicare Population	percent	27.8		26.7	24.5	2018		5
2.25	Cancer: Medicare Population	percent	7.9		7.6	8.4	2018		5
2.03	Stroke: Medicare Population	percent	4.3		4.2	3.8	2018		5
1.97	Alzheimer's Disease or Dementia:	percent	11.9		12.6	10.8	2018		5
	Medicare Population								
1.97	Hyperlipidemia: Medicare	percent	49.9		49.5	47.7	2018		5
	Population								
1.81	Atrial Fibrillation: Medicare	percent	8.3		7.8	8.4	2018		5
	Population								
1.81	Hypertension: Medicare	percent	60.3		59.9	57.2	2018		5
	Population								
1.81	Rheumatoid Arthritis or	percent	34.8		34.2	33.5	2018		5
	Osteoarthritis: Medicare								
	Population								
1.75	Asthma: Medicare Population	percent	5		4.9	5	2018		5
1.58	Adults 65+ who Received	percent	25.9			28.4	2018		3
	Recommended Preventive								
	Services: Females								
1.58	Adults 65+ who Received	percent	27			32.4	2018		3
	Recommended Preventive								
	Services: Males								
1.50	Colon Cancer Screening	percent	63.1	74.4		66.4	2018		3
1.50	Diabetes: Medicare Population	percent	28.4		28.8	27	2018		5
1.47	COPD: Medicare Population	percent	11.3		11.2	11.5	2018		5
1.33	People 65+ with Low Access to a	percent	2.1				2015		20
	Grocery Store								

1.31	Osteoporosis: Medicare	percent	5.7	6.8	6.6	2018		5
	Population							
0.92	Adults 65+ with Total Tooth Loss	percent	12.4		13.5	2018		3
0.92	Heart Failure: Medicare Population	percent	15	15.6	14	2018		5
0.86	Ischemic Heart Disease: Medicare Population	percent	26.2	29	26.8	2018		5
0.75	Adults with Arthritis	percent	23		25.8	2018		3
0.08	People 65+ Living Below Poverty Level	percent	5.4	10.6	9.3	2015-2019	Black (8.1) White (4.3) Asian (0) AIAN (0) NHPI (100) Mult (23.5) Other (9.6) Hisp (12.7)	1

SCORE	ORAL HEALTH	UNITS	ELLIS COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.75	Age-Adjusted ER Rate due to	ER visits/ 10,000	59		11.1		2017-2019		16
	Dental Problems	population							
1.61	Oral Cavity and Pharynx Cancer	cases/ 100,000	12.8		11	11.8	2013-2017		9
	Incidence Rate	population							
1.42	Adults who Visited a Dentist	percent	61.3			66.5	2018		3
1.33	Dentist Rate	dentists/ 100,000	33.6		59.6		2019		6
		population							
0.92	Adults 65+ with Total Tooth Loss	percent	12.4			13.5	2018		3

SCORE	OTHER CONDITIONS	UNITS	ELLIS COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.75	Chronic Kidney Disease: Medicare	percent	27.8		26.7	24.5	2018		5
	Population								
1.81	Rheumatoid Arthritis or	percent	34.8		34.2	33.5	2018		5
	Osteoarthritis: Medicare								
	Population								

1.31	Osteoporosis: Medicare	percent	5.7		6.8	6.6	2018		5
	Population								
0.92	Adults with Kidney Disease	Percent of adults	2.9			3.1	2018		3
0.75	Adults with Arthritis	percent	23			25.8	2018		3
SCORE	PHYSICAL ACTIVITY	UNITS	ELLIS COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.00	Grocery Store Density	stores/ 1,000	0.1				2016		20
		population							
2.00	WIC Certified Stores	stores/1,000	0.1				2016		20
		population							
1.86	SNAP Certified Stores	stores/ 1,000	0.5				2017		20
		population							
1.83	Access to Exercise Opportunities	percent	66		80.5	84	2020		6
1.83	Children with Low Access to a	percent	7				2015		20
	Grocery Store								
1.67	Fast Food Restaurant Density	restaurants/ 1,000	0.6				2016		20
		population							
1.67	People with Low Access to a	percent	23.7				2015		20
	Grocery Store	,							
1.33	Farmers Market Density	markets/ 1,000	0				2018		20
	· · · · · · · · · · · · · · · · · · ·	population	-						-
1.33	Low-Income and Low Access to a	percent	6.3				2015		20
	Grocery Store								
1.33	People 65+ with Low Access to a	percent	2.1				2015		20
	Grocery Store	P - · · · · · ·							
1.33	Recreation and Fitness Facilities	facilities/ 1,000	0.1				2016		20
		population	•						
1.00	Households with No Car and Low	percent	1.4				2015		20
	Access to a Grocery Store	p = : = = = = =							
0.69	Food Environment Index		7.8		5.9	7.8	2021		6
SCORE	PREVENTION & SAFETY	UNITS	ELLIS COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
		00				0.0.			

1.03	Severe Housing Problems	percent	14.1		17.4	18	2013-2017		6
0.75	Death Rate due to Drug Poisoning	deaths/ 100,000	9.1		10.6	21	2017-2019		6
		population							
0.58	Age-Adjusted Death Rate due to	deaths/ 100,000	35.7	43.2	38.7	48.9	2017-2019		4
	Unintentional Injuries	population							
SCORE	RESPIRATORY DISEASES	UNITS	ELLIS COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.47	COVID-19 Daily Average Incidence	cases per 100,000	86.8		77.1	62.2	3-Sep-21		8
	Rate	population							
1.81	COVID-19 Daily Average Case-	deaths per 100 cases	1.1		1.7	1	3-Sep-21		8
	Fatality Rate								
1.75	Age-Adjusted Hospitalization Rate	hospitalizations/	0.3		0.1		2017-2019		16
	due to Immunization-Preventable	10,000 population							
	Pneumonia and Influenza	18+ years							
1.75	Asthma: Medicare Population	percent	5		4.9	5	2018		5
1.67	Adults who Smoke	percent	17.5	5		15.5	2018		3
1.56	Age-Adjusted Death Rate due to	deaths/ 100,000	12.6		11.8	13.8	2017-2019		4
	Influenza and Pneumonia	population							
1.47	COPD: Medicare Population	percent	11.3		11.2	11.5	2018		5
1.36	Lung and Bronchus Cancer	cases/ 100,000	56.9		50.6	58.3	2013-2017		9
	Incidence Rate	population							
1.33	Age-Adjusted Death Rate due to	deaths/ 100,000	38.9	25.1	34.1	38.5	2013-2017		9
1.00	Lung Cancer	population	0.2			0.2	2010		
1.08	Adults with Current Asthma	percent	9.2			9.2	2018		3
0.92	Adults with COPD	Percent of adults	6.7	1 /	4.2	6.9	2018		3
0.67	Tuberculosis Incidence Rate	cases/ 100,000	1.2	1.4	4.3		2015-2019		13
		population							
SCORE	SEXUALLY TRANSMITTED	UNITS	ELLIS COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
JUNE	INFECTIONS	UNITS				0.3.			Juice
1.64	HIV Diagnosis Rate	cases/ 100,000	10.6		15.7		2018		13
1.04		population	10.0		13.7		2010		10
		population							

1.22	Gonorrhea Incidence Rate	cases/ 100,000 population	111.5		163.6	179.1	2018		13
1.22	Syphilis Incidence Rate	cases/ 100,000 population	4.5		8.8	10.8	2018		13
1.08	Chlamydia Incidence Rate	cases/ 100,000 population	380.6		508.2	539.9	2018		13
SCORE	WELLNESS & LIFESTYLE	UNITS	ELLIS COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.67	High Blood Pressure Prevalence	percent	35.8	27.7		32.4	2017		3
1.42	Insufficient Sleep	percent	35	31.4	34.4	35	2018		6
1.00	Frequent Physical Distress	percent	11.6		11.6	11	2018		6
0.92	Poor Physical Health: 14+ Days	percent	12			12.5	2018		3
SCORE	WOMEN'S HEALTH	UNITS	ELLIS COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.22	Cervical Cancer Incidence Rate	cases/ 100,000 females	10.1		9.2	7.6	2013-2017		9
1.81	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	20.2	15.3	19.8	20.1	2013-2017		9
1.81	Breast Cancer Incidence Rate	cases/ 100,000 females	118.7		112.8	125.9	2013-2017		9
1.44	Cervical Cancer Screening: 21-65	Percent	83	84.3		84.7	2018		3
1.28	Mammogram in Past 2 Years: 50- 74	percent	71.9	77.1		74.8	2018		3

Erath County

Health and Quality of Life Topics	Score
Physical Activity	1.74
Prevention & Safety	1.73
Children's Health	1.73
Mental Health & Mental Disorders	1.69
Health Care Access & Quality	1.65
Maternal, Fetal & Infant Health	1.58
Environmental Health	1.54
Oral Health	1.52
Respiratory Diseases	1.46
Immunizations & Infectious Diseases	1.45
Economy	1.45
Cancer	1.43
Diabetes	1.39
Sexually Transmitted Infections	1.35
Women's Health	1.35
Community	1.34
Wellness & Lifestyle	1.33
Heart Disease & Stroke	1.29
Education	1.18
Older Adults	1.16
Alcohol & Drug Use	1.04
Other Conditions	0.93

SCORE	ALCOHOL & DRUG USE	UNITS	ERATH COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.25	Adults who Binge Drink	percent	18.3			16.4	2018		2
1.25	Age-Adjusted ER Rate due to Substance Use	e ER visits/ 10,000 population	11.3		20.6		2017-2019		15
		18+ years							
0.75	Alcohol-Impaired Driving Deaths	percent of driving deaths	18.9	28.3	25.7	27	2015-2019		5
		with alcohol involvement							
0.61	Death Rate due to Drug Poisoning	deaths/ 100,000 population	7.9		10.6	21	2017-2019		5
0.36	Liquor Store Density	stores/ 100,000 population	2.4		6.9	10.5	2016		17

SCORE	CANCER	UNITS	ERATH COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.17	Age-Adjusted Death Rate due to Lung	deaths/ 100,000 population	39.1	25.1	34.1	38.5	2013-2017		8
	Cancer								
2.11	Cervical Cancer Screening: 21-65	Percent	79	84.3		84.7	2018		2
1.97	Cancer: Medicare Population	percent	7.8		7.6	8.4	2018		4
1.83	Colon Cancer Screening	percent	60.9	74.4		66.4	2018		2
1.72	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	14.5	8.9	13.9	13.7	2013-2017		8
1.67	Mammogram in Past 2 Years: 50-74	percent	69.1	77.1		74.8	2018		2
1.64	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	56.1		50.6	58.3	2013-2017		8
1.56	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	11.5		11	11.8	2013-2017		8
1.31	Colorectal Cancer Incidence Rate	cases/ 100,000 population	37.2		37.6	38.4	2013-2017		8
1.31	Prostate Cancer Incidence Rate	 cases/ 100,000 males	93.9		94	104.5	2013-2017		8
1.22	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	147.6	122.7	148.8	155.5	2013-2017		8
1.08	Breast Cancer Incidence Rate	cases/ 100,000 females	115.5		112.8	125.9	2013-2017		8
1.03	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	20.1	16.9	20.4	22.3	2007-2011		8
0.97	All Cancer Incidence Rate	cases/ 100,000 population	392.7		407.7	448.7	2013-2017		8
0.75	Adults with Cancer	percent	6.1			6.9	2018		2
0.53	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	13.7	15.3	19.8	20.1	2013-2017		8
SCORE	CHILDREN'S HEALTH	UNITS	ERATH COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source

2.22	Substantiated Child Abuse Rate	cases/ 1,000 children	20.1	8.7	9.1		2020	11
1.83	Children with Low Access to a Grocery	percent	7.9				2015	19
	Store							
1.83	Food Insecure Children Likely Ineligible for	percent	31		34	23	2019	6
	Assistance							
1.50	Child Food Insecurity Rate	percent	18.2		19.6	14.6	2019	6
1.25	Projected Child Food Insecurity Rate	percent	21.6		23.6		2021	6

SCORE	COMMUNITY	UNITS	ERATH COUNTY	HP2030	ΤХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.64	Homeownership	percent	47.4		54.9	56.2	2015-2019		1
2.56	Workers Commuting by Public	percent	0	5.3	1.4	5	2015-2019		1
	Transportation								
2.47	Age-Adjusted Death Rate due to Motor	deaths/ 100,000 population	28.8	10.1	13	11.3	2017-2019		3
	Vehicle Traffic Collisions								
2.22	Substantiated Child Abuse Rate	cases/ 1,000 children	20.1	8.7	9.1		2020		11
2.14	Persons with Health Insurance	percent	76.3	92.1	79.3		2019		18
2.00	People Living Below Poverty Level	percent	18.4	8	14.7	13.4	2015-2019	ın (0) AIAN (7.6) NHPI (68.2) Mult (1
1.83	Median Monthly Owner Costs for	dollars	467		514	500	2015-2019		1
	Households without a Mortgage								
1.69	Workers who Drive Alone to Work	percent	81.5		80.5	76.3	2015-2019		1
1.67	Female Population 16+ in Civilian Labor	percent	54		57.8	58.3	2015-2019		1
	Force								
1.67	Median Household Gross Rent	dollars	911		1045	1062	2015-2019		1
1.50	Households with No Car and Low Access to	percent	2.4				2015		19
	a Grocery Store								
1.50	Social Worker Rate	workers/ 100,000	67.4		82.7		2020		12
		population							
1.47	Population 16+ in Civilian Labor Force	percent	58.9		61	59.6	2015-2019		1
1.42	Median Household Income	dollars	52742		61874	62843	2015-2019		1
1.42	Per Capita Income	dollars	27639		31277	34103	2015-2019		1
1.42	Persons with an Internet Subscription	percent	83.4		84.2	86.2	2015-2019		1
1.42	Social Associations	membership associations/	10.8		7.5	9.3	2018		5
		10,000 population							
1.39	Mortgaged Owners Median Monthly	dollars	1387		1606	1595	2015-2019		1
	Household Costs								
1.33	Households with an Internet Subscription	percent	81.2		82.1	83	2015-2019		1
1.17	Median Housing Unit Value	dollars	159900		172500	217500	2015-2019		1

1.17	Voter Turnout: Presidential Election	percent	64.5		58.8		2016		14
0.86	People 25+ with a Bachelor's Degree or	percent	31.5		29.9	32.1	2015-2019		1
	Higher								
0.83	Households with One or More Types of	percent	92.9		91	90.3	2015-2019		1
	Computing Devices								
0.75	Alcohol-Impaired Driving Deaths	percent of driving deaths	18.9	28.3	25.7	27	2015-2019		5
		with alcohol involvement							
0.64	Solo Drivers with a Long Commute	percent	19.5		38.9	37	2015-2019		5
0.58	People 25+ with a High School Degree or	percent	88.3		83.7	88	2015-2019		1
	Higher								
0.50	Mean Travel Time to Work	minutes	18.7		26.6	26.9	2015-2019		1
0.42	Children Living Below Poverty Level	percent	16.1		20.9	18.5	2015-2019) Asian (0) AIAN (0) Mult (56.5) Otł	1
0.42	Linguistic Isolation	percent	1.5		7.7	4.4	2015-2019		1
0.36	Total Employment Change	percent	5.1		2.9	1.6	2018-2019		17
0.08	Single-Parent Households	percent	13.8		26.3	25.5	2015-2019		1

SCORE	DIABETES	UNITS	ERATH COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.75	Age-Adjusted ER Rate due to Diabetes	ER visits/ 10,000 population	28.5		9.4		2017-2019		15
		18+ years							
1.75	Age-Adjusted ER Rate due to Type 2	ER visits/ 10,000 population	26.1		8.6		2017-2019		15
	Diabetes	18+ years							
1.75	Age-Adjusted Hospitalization Rate due to	hospitalizations/ 10,000	14.7		5.3		2017-2019		15
	Diabetes	population 18+ years							
1.75	Age-Adjusted Hospitalization Rate due to	hospitalizations/ 10,000	12.3		4		2017-2019		15
	Type 2 Diabetes	population 18+ years							
0.81	Diabetes: Medicare Population	percent	24		28.8	27	2018		4
0.50	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	18.1		22	21.5	2017-2019		3

SCORE	ECONOMY	UNITS	ERATH COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.64	Homeownership	percent	47.4		54.9	56.2	2015-2019		1
2.36	Severe Housing Problems	percent	20.9		17.4	18	2013-2017		5
2.00	Households that are Below the Federal	percent	21.4		14		2018		21
	Poverty Level								
2.00	Low-Income and Low Access to a Grocery	percent	16.4				2015		19
	Store								
2.00	People Living Below Poverty Level	percent	18.4	8	14.7	13.4	2015-2019	n (0) AIAN (7.6) NHPI (68.2) Mult (1
2.00	Persons with Disability Living in Poverty (5-	percent	28.5		23.2	26.1	2015-2019		1
	year)								

2.00	WIC Certified Stores	stores/ 1,000 population	0.1			2016	1	19
1.97	Renters Spending 30% or More of	percent	49.1	47.8	49.6	2015-2019	1	1
	Household Income on Rent							
1.83	Food Insecure Children Likely Ineligible for	percent	31	34	23	2019	e	6
	Assistance							
1.83	Food Insecurity Rate	percent	14.8	14.1	10.9	2019	E	6
1.83	Median Monthly Owner Costs for	dollars	467	514	500	2015-2019	1	1
	Households without a Mortgage							
1.67	Female Population 16+ in Civilian Labor	percent	54	57.8	58.3	2015-2019	1	1
	Force							
1.67	Households that are Above the Asset	percent	50.9	56		2018	2	21
	Limited, Income Constrained, Employed							
	(ALICE) Threshold							
1.67	Median Household Gross Rent	dollars	911	1045	1062	2015-2019		1
1.58	Projected Food Insecurity Rate	percent	16.9	16.5		2021		6
1.53	SNAP Certified Stores	stores/ 1,000 population	0.7			2017		19
1.50	Child Food Insecurity Rate	percent	18.2	19.6	14.6	2019	6	6
1.47	Population 16+ in Civilian Labor Force	percent	58.9	61	59.6	2015-2019		1
1.42	Median Household Income	dollars	52742	61874	62843	2015-2019		1
1.42	Per Capita Income	dollars	27639	31277	34103	2015-2019		1
1.39	Mortgaged Owners Median Monthly	dollars	1387	1606	1595	2015-2019	1	1
	Household Costs							
1.33	Households that are Asset Limited, Income	percent	27.7	30		2018	2	21
	Constrained, Employed (ALICE)							
1.25	People Living 200% Above Poverty Level	percent	63.1	65.7	69.1	2015-2019	1	1
1.25	Projected Child Food Insecurity Rate	percent	21.6	23.6		2021		6
1.19	Students Eligible for the Free Lunch	percent	46			2019-2020	g	9
	Program							
1.17	Median Housing Unit Value	dollars	159900	172500	217500	2015-2019		1
1.03	Overcrowded Households	percent of households	3.2	4.8		2015-2019		1
0.58	Families Living Below Poverty Level	percent	8.7	11.3	9.5	2015-2019		1
0.58	People 65+ Living Below Poverty Level	percent	9	10.6	9.3	2015-2019		1
0.50	Households with Cash Public Assistance	percent	0.6	1.4	2.4	2015-2019	1	1
	Income							
0.42	Children Living Below Poverty Level	percent	16.1	20.9	18.5	2015-2019		1
0.42	Unemployed Workers in Civilian Labor	percent	4.6	5.9	5.5	May-21	1	16
	Force							
0.36	Total Employment Change	percent	5.1	2.9	1.6	2018-2019	1	L7

SCORE	EDUCATION	UNITS	ERATH COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.42	High School Drop Out Rate	percent	10.6		1.9		2019		13
1.36	Student-to-Teacher Ratio	students/ teacher	13.3				2019-2020		9
0.86	People 25+ with a Bachelor's Degree or	percent	31.5		29.9	32.1	2015-2019		1
	Higher								
0.67	Infants Born to Mothers with <12 Years	percent	13.4		17.4	13.3	2017		12
	Education								
0.58	People 25+ with a High School Degree or	percent	88.3		83.7	88	2015-2019		1
	Higher								
		-							
SCORE	ENVIRONMENTAL HEALTH	UNITS	ERATH COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.36	Severe Housing Problems	percent	20.9		17.4	18	2013-2017		5
2.00	Access to Exercise Opportunities	percent	64.5		80.5	84	2020		5
2.00	Grocery Store Density	stores/ 1,000 population	0.1				2016		19
2.00	Low-Income and Low Access to a Grocery	percent	16.4				2015		19
	Store								
2.00	People with Low Access to a Grocery Store	percent	36.1				2015		19
2.00	WIC Certified Stores	stores/ 1,000 population	0.1				2016		19
1.83	Children with Low Access to a Grocery	percent	7.9				2015		19
	Store								
1.83	People 65+ with Low Access to a Grocery	percent	4.8				2015		19
	Store								
1.69	Fast Food Restaurant Density	restaurants/ 1,000	0.8				2016		19
		population							
1.64	Number of Extreme Precipitation Days	days	43				2016		10
1.64	PBT Released	pounds	0.1				2019		20
1.64	Recognized Carcinogens Released into Air	pounds	71449.1				2019		20
1.58	Adults with Current Asthma	percent	9.5			9.2	2018		2
1.53	SNAP Certified Stores	stores/ 1,000 population	0.7				2017		19
1.50	Farmers Market Density	markets/ 1,000 population	0				2018		19
1.50	Households with No Car and Low Access to	percent	2.4				2015		19
	a Grocery Store								
1.47	Daily Dose of UV Irradiance	Joule per square meter	3468		3538		2015		10
1.42	Food Environment Index		6.5		5.9	7.8	2021		5
1.36	Number of Extreme Heat Days	days	10				2016		10

1.36	Number of Extreme Heat Events	events	1			2016	10
1.33	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1			2016	19
1.08	Weeks of Moderate Drought or Worse	weeks per year	1			2016	10
1.03	Overcrowded Households	percent of households	3.2	4.8		2015-2019	1
0.42	Asthma: Medicare Population	percent	4.2	4.9	5	2018	4
0.36	Liquor Store Density	stores/ 100,000 population	2.4	6.9	10.5	2016	17

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	ERATH COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.14	Persons with Health Insurance	percent	76.3	92.1	79.3		2019		18
2.08	Adults who have had a Routine Checkup	percent	71.8			76.7	2018		2
2.00	Primary Care Provider Rate	providers/ 100,000	54.2		60.9		2018		5
		population							
1.75	Adults without Health Insurance	percent	22.6			12.2	2018		2
1.58	Adults who Visited a Dentist	percent	58.2			66.5	2018		2
1.50	Non-Physician Primary Care Provider Rate	providers/ 100,000	53.9		88.6		2020		5
		population							
1.50	Social Worker Rate	workers/ 100,000	67.4		82.7		2020		12
		population							
1.17	Mental Health Provider Rate	providers/ 100,000	100.7		120.9		2020		5
		population							
1.11	Dentist Rate	dentists/ 100,000	56.2		59.6		2019		5
		population							
SCORE	HEART DISEASE & STROKE	UNITS	ERATH COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.28	Age-Adjusted Death Rate due to Coronary	deaths/100,000 population	130.8	71.1	93	90.5	2017-2019		3
	Heart Disease								

2.20	Age Aujusteu Death Nate due to coronary	<i>uculiis</i> / 100,000 population	130.0	/ 1.1	55	50.5	2017-2015	5
	Heart Disease							
2.22	Age-Adjusted Death Rate due to	deaths/ 100,000 population	44	33.4	40.2	37.2	2017-2019	3
	Cerebrovascular Disease (Stroke)							
2.08	Adults who Have Taken Medications for	percent	73.1			75.8	2017	2
	High Blood Pressure							
2.08	Cholesterol Test History	percent	75.4			81.5	2017	2
1.75	Age-Adjusted ER Rate due to Hypertension	ER visits/ 10,000 population	28.1		10.5		2017-2019	15
		18+ years						
1.69	Age-Adjusted Death Rate due to Heart	deaths/ 100,000 population	83.1		70.1		2018	10
	Attack	35+ years						
1.47	Atrial Fibrillation: Medicare Population	percent	7.9		7.8	8.4	2018	4

L.28	Teen Births	percent	2.1		2.1	3.1	2017	White (0) Other (0) Hisp (0)	12
L.75	Babies with Low Birth Weight	percent	8.5		8.2	8.1	2015		12
L.92	Mothers who Received Early Prenatal Care	percent	59.8		60.5	77.3	2017		12
2.00	Babies with Very Low Birth Weight	percent	2.3		1.4	1.4	2013		12
2.47	Infant Mortality Rate	deaths/ 1,000 live births	11.2	5	5.6	5.9	2015		12
ORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	ERATH COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
).75	Syphilis Incidence Rate	cases/ 100,000 population	0		8.8	10.8	2018		12
L.03	Overcrowded Households	percent of households	3.2		4.8		2015-2019		1
L.03	HIV Diagnosis Rate	cases/ 100,000 population	2.4		15.7		2018		12
L.22	Gonorrhea Incidence Rate	cases/ 100,000 population	131.9		163.6	179.1	2018		12
L.28	Tuberculosis Incidence Rate	cases/ 100,000 population	2.9	1.4	4.3		2015-2019		12
L.33	Age-Adjusted Death Rate due to Influenza and Pneumonia		14.3		11.8	14.2	2016-2018		3
L.81	COVID-19 Daily Average Incidence Rate	cases per 100,000 population	70.1		77.1	62.2	3-Sep-21		7
2.25	COVID-19 Daily Average Case-Fatality Rate	deaths per 100 cases	1.4		1.7	1	3-Sep-21		7
2.39	Chlamydia Incidence Rate	cases/ 100,000 population	610.2		508.2	539.9	2018		12
ORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	ERATH COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
).25	Stroke: Medicare Population	percent	2.8		4.2	3.8	2018		4
	Population								
).25	Ischemic Heart Disease: Medicare	percent	23.7		29	26.8	2018		4
).69	Heart Failure: Medicare Population	percent	13		15.6	14	2018		4
).81	Hyperlipidemia: Medicare Population	percent	41.4		49.5	47.7	2018		4
).92	High Cholesterol Prevalence: Adults 18+	percent	33.4			34.1	2017		2
).92	Adults who Experienced a Stroke	percent	3.1			3.4	2018		2
L.00	High Blood Pressure Prevalence	percent	30.7	27.7		32.4	2017		2
	Disease	percent	0.9			0.0	2010		۷
L.14 L.08	Hypertension: Medicare Population Adults who Experienced Coronary Heart	percent percent	55.6 6.9		59.9	57.2 6.8	2018 2018		4

0.97	Preterm Births	narcant	8.6	9.4	12.2		2017		12
0.97	Infants Born to Mothers with <12 Years	percent	13.4	9.4	17.4	13.3	2017		12
0.67		percent	13.4		17.4	15.5	2017		12
	Education								
SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	ERATH COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.17	Age-Adjusted Death Rate due to Suicide	deaths/ 100,000 population	18.1	12.8	12.4	13.2	2014-2016		3
2.127	Age Adjusted Death Nate due to Suleide		10.1	12.0	12.4	13.2	2014 2010		5
2.08	Poor Mental Health: 14+ Days	percent	15.3			12.7	2018		2
2.00	Frequent Mental Distress	percent	14.8		11.6	13	2018		5
1.67	Alzheimer's Disease or Dementia: Medicare	percent	11.6		12.6	10.8	2018		4
	Population								
1.47	Depression: Medicare Population	percent	17.7		18.2	18.4	2018		4
1.25	Age-Adjusted ER Rate due to Adult Mental	ER visits/ 10,000 population	4.5		8.9		2017-2019		15
	Health	18+ years							
1.17	Mental Health Provider Rate	providers/ 100,000	100.7		120.9		2020		5
		population							
SCORE	OLDER ADULTS	UNITS	ERATH COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.97	Cancer: Medicare Population	percent	7.8		7.6	8.4	2018		4
1.92	Adults 65+ who Received Recommended	percent	24.8			28.4	2018		2
	Preventive Services: Females								
1.92	Adults 65+ who Received Recommended	percent	24.5			32.4	2018		2
	Preventive Services: Males								
1.83	Colon Cancer Screening	percent	60.9	74.4		66.4	2018		2
1.83	People 65+ with Low Access to a Grocery	percent	4.8				2015		19
	Store								
1.67	Alzheimer's Disease or Dementia: Medicare	percent	11.6		12.6	10.8	2018		4
4 50	Population		45.2			42 5	2010		
1.58	Adults 65+ with Total Tooth Loss	percent	15.3		7.0	13.5	2018		2
1.47	Atrial Fibrillation: Medicare Population	percent	7.9		7.8	8.4	2018		4
1.47	Depression: Medicare Population	percent	17.7		18.2	18.4	2018		4
1.31	Osteoporosis: Medicare Population	percent	5.9		6.8	6.6	2018		4
1.17	COPD: Medicare Population	percent	10.8		11.2	11.5	2018		4
1.14	Hypertension: Medicare Population	percent	55.6		59.9	57.2	2018		4
0.92	Chronic Kidney Disease: Medicare	percent	17.9		26.7	24.5	2018		4
0.01	Population		24		20.0	77	2010		
0.81	Diabetes: Medicare Population	percent	24		28.8	27	2018		4

0.81	Hyperlipidemia: Medicare Population	percent	41.4	49.5	47.7	2018		4
0.75	Adults with Arthritis	percent	23.1		25.8	2018		2
0.75	Rheumatoid Arthritis or Osteoarthritis:	percent	32.9	34.2	33.5	2018		4
	Medicare Population							
0.69	Heart Failure: Medicare Population	percent	13	15.6	14	2018		4
0.58	People 65+ Living Below Poverty Level	percent	9	10.6	9.3	2015-2019	Asian (0) AIAN (0) NHPI (0) Mult (6	1
0.42	Asthma: Medicare Population	percent	4.2	4.9	5	2018		4
0.25	Ischemic Heart Disease: Medicare	percent	23.7	29	26.8	2018		4
	Population							
0.25	Stroke: Medicare Population	percent	2.8	4.2	3.8	2018		4

SCORE	ORAL HEALTH	UNITS	ERATH COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.75	Age-Adjusted ER Rate due to Dental	ER visits/ 10,000 population	54.7		11.1		2017-2019		15
	Problems								
1.58	Adults 65+ with Total Tooth Loss	percent	15.3			13.5	2018		2
1.58	Adults who Visited a Dentist	percent	58.2			66.5	2018		2
1.56	Oral Cavity and Pharynx Cancer Incidence	cases/ 100,000 population	11.5		11	11.8	2013-2017		8
	Rate								
1.11	Dentist Rate	dentists/ 100,000	56.2		59.6		2019		5
		population							

SCORE	OTHER CONDITIONS	UNITS	ERATH COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.31	Osteoporosis: Medicare Population	percent	5.9		6.8	6.6	2018		4
0.92	Adults with Kidney Disease	Percent of adults	2.8			3.1	2018		2
0.92	Chronic Kidney Disease: Medicare	percent	17.9		26.7	24.5	2018		4
	Population								
0.75	Adults with Arthritis	percent	23.1			25.8	2018		2
0.75	Rheumatoid Arthritis or Osteoarthritis:	percent	32.9		34.2	33.5	2018		4
	Medicare Population								

SCORE	PHYSICAL ACTIVITY	UNITS	ERATH COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.00	Access to Exercise Opportunities	percent	64.5		80.5	84	2020		5
2.00	Grocery Store Density	stores/ 1,000 population	0.1				2016		19
2.00	Low-Income and Low Access to a Grocery	percent	16.4				2015		19
	Store								
2.00	People with Low Access to a Grocery Store	percent	36.1				2015		19
2.00	WIC Certified Stores	stores/ 1,000 population	0.1				2016		19

1.83	Children with Low Access to a Grocery Store	percent	7.9				2015		19
1.83	People 65+ with Low Access to a Grocery Store	percent	4.8				2015		19
1.69	Fast Food Restaurant Density	restaurants/ 1,000 population	0.8				2016		19
1.53	SNAP Certified Stores	stores/ 1,000 population	0.7				2017		19
1.50	Farmers Market Density	markets/ 1,000 population	0				2018		19
1.50	Households with No Car and Low Access to a Grocery Store	percent	2.4				2015		19
1.42	Food Environment Index		6.5		5.9	7.8	2021		5
1.33	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2016		19
SCORE	PREVENTION & SAFETY	UNITS	ERATH COUNTY	HP2030	ΤХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.36	Severe Housing Problems	percent	20.9		17.4	18	2013-2017		5
2.22	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	54.4	43.2	38.7	48.9	2017-2019		3
0.61	Death Rate due to Drug Poisoning	deaths/ 100,000 population	7.9		10.6	21	2017-2019		5
SCORE	RESPIRATORY DISEASES	UNITS	ERATH COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.25	COVID-19 Daily Average Case-Fatality Rate	deaths per 100 cases	1.4		1.7	1	3-Sep-21		7
2.17	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	39.1	25.1	34.1	38.5	2013-2017		8
1.81	COVID-19 Daily Average Incidence Rate	cases per 100,000 population	70.1		77.1	62.2	3-Sep-21		7
1.64	Lung and Bronchus Cancer Incidence Rate	- · · ·	56.1		50.6	58.3	2013-2017		8
1.58	Adults with Current Asthma	percent	9.5			9.2	2018		2
1.33	Adults who Smoke	percent	17	5		15.5	2018		2
1.33	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	14.3		11.8	14.2	2016-2018		3
1.28	Tuberculosis Incidence Rate	cases/ 100,000 population	2.9	1.4	4.3		2015-2019		12
1.17	COPD: Medicare Population	percent	10.8		11.2	11.5	2018		4

0.42	Asthma: Medicare Population	percent	4.2		4.9	5	2018		4
SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	ERATH COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.39	Chlamydia Incidence Rate	cases/ 100,000 population	610.2		508.2	539.9	2018		12
1.22	Gonorrhea Incidence Rate	cases/ 100,000 population	131.9		163.6	179.1	2018		12
1.03	HIV Diagnosis Rate	cases/ 100,000 population	2.4		15.7		2018		12
0.75	Syphilis Incidence Rate	cases/ 100,000 population	0		8.8	10.8	2018		12
SCORE	WELLNESS & LIFESTYLE	UNITS	ERATH COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.83	Frequent Physical Distress	percent	13.4		11.6	11	2018		5
1.42	Insufficient Sleep	percent	36	31.4	34.4	35	2018		5
1.08	Poor Physical Health: 14+ Days	percent	12.7			12.5	2018		2
1.00	High Blood Pressure Prevalence	percent	30.7	27.7		32.4	2017		2
SCORE	WOMEN'S HEALTH	UNITS	ERATH COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.11	Cervical Cancer Screening: 21-65	Percent	79	84.3		84.7	2018		2
1.67	Mammogram in Past 2 Years: 50-74	percent	69.1	77.1		74.8	2018		2
1.08	Breast Cancer Incidence Rate	cases/ 100,000 females	115.5		112.8	125.9	2013-2017		8
0.53	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	13.7	15.3	19.8	20.1	2013-2017		8

Henderson County

Health and Quality of Life Topics	Score
Women's Health	2.07
Wellness & Lifestyle	2.04
Mental Health & Mental Disorders	1.99
Cancer	1.98
Other Conditions	1.97
Respiratory Diseases	1.88
Oral Health	1.86
Heart Disease & Stroke	1.85
Older Adults	1.83
Children's Health	1.81
Prevention & Safety	1.81
Health Care Access & Quality	1.78
Community	1.77
Maternal, Fetal & Infant Health	1.76
Economy	1.70
Physical Activity	1.67
Immunizations & Infectious Diseases	1.61
Education	1.60
Alcohol & Drug Use	1.59
Environmental Health	1.48
Sexually Transmitted Infections	1.41
Diabetes	1.20

			HENDERSON						
SCORE	ALCOHOL & DRUG USE	UNITS	COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.17	Alcohol-Impaired Driving Deaths	percent of driving deaths with alcohol involvemen	28.9	28.3	25.7	27	2015-2019		5
	Age-Adjusted Drug and Opioid-Involved								
1.83	Overdose Death Rate	Deaths per 100,000 population	24.5		12.1	22.8	2017-2019		3
1.67	Liquor Store Density	stores/ 100,000 population	12.1		6.9	10.5	2019		17
1.56	Death Rate due to Drug Poisoning	deaths/ 100,000 population	18.7		10.6	21	2017-2019		5
	Age-Adjusted ER Rate due to Substance								
1.25	Use	ER visits/ 10,000 population 18+ years	4.1		20.6		2017-2019		15
1.08	Adults who Binge Drink	percent	14.8			16.4	2018		2
			HENDERSON						
	CANCER	UNITS	COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	All Cancer Incidence Rate	cases/ 100,000 population	495.6		407.7	448.7	2013-2017		8
2.67	Cervical Cancer Incidence Rate	cases/ 100,000 females	14.4		9.2	7.6	2013-2017		8
2.50	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	86.1		50.6	58.3	2013-2017		8
	Oral Cavity and Pharynx Cancer Incidence								
	Rate	cases/ 100,000 population	17.4		11	11.8	2013-2017		8
	Mammogram in Past 2 Years: 50-74	percent	67	77.1		74.8	2018		2
	Colorectal Cancer Incidence Rate	cases/ 100,000 population	47.3		37.6	38.4	2013-2017		8
2.08	Adults with Cancer	percent	8.5			6.9	2018		2
	Age-Adjusted Death Rate due to Lung								
	Cancer	deaths/ 100,000 population	50.8	25.1	34.1	38.5	2013-2017		8
2.00	Colon Cancer Screening	percent	59.6	74.4		66.4	2018		2
	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	170.6	122.7	148.8	155.5	2013-2017		8
	Cervical Cancer Screening: 21-65	Percent	80.8	84.3		84.7	2018		2
1.81	Breast Cancer Incidence Rate	cases/ 100,000 females	118.2		112.8	125.9	2013-2017		8
	Age-Adjusted Death Rate due to Breast								
1.58	Cancer	deaths/ 100,000 females	18.2	15.3	19.8	20.1	2013-2017		8
	Age-Adjusted Death Rate due to Colorecta	l							
1.50	Cancer	deaths/ 100,000 population	15.2	8.9	13.9	13.7	2013-2017		8
1.50	Prostate Cancer Incidence Rate	cases/ 100,000 males	94.4		94	104.5	2013-2017		8
1.47	Cancer: Medicare Population	percent	7.6		7.6	8.4	2018		4
	Age-Adjusted Death Rate due to Prostate								
0.81	Cancer	deaths/ 100,000 males	12.3	16.9	17.6	19	2013-2017		8

			HENDERSON						
SCORE	CHILDREN'S HEALTH	UNITS	COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.50	Child Food Insecurity Rate	percent	25.1		19.6	14.6	2019		6
2.08	Projected Child Food Insecurity Rate	percent	29		23.6		2021		6
1.94	Substantiated Child Abuse Rate	cases/ 1,000 children	18.3	8.7	9.1		2020		11
1.67	Children with Health Insurance	percent	85.8		87.3	94.3	2019		1
	Children with Low Access to a Grocery								
1.67	Store	percent	6.1				2015		19
	Food Insecure Children Likely Ineligible for								
1.00	Assistance	percent	22		34	23	2019		6

			HENDERSON					
SCOR	COMMUNITY	UNITS	COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
2.92	Mean Travel Time to Work	minutes	32.1		26.6	26.9	2015-2019	1
2.92	Solo Drivers with a Long Commute	percent	43.9		38.9	37	2015-2019	5
2.64	Population 16+ in Civilian Labor Force	percent	48.9		61	59.6	2015-2019	1

	Age-Adjusted Death Rate due to Motor							
2.47	Vehicle Traffic Collisions	deaths/ 100,000 population	29.3	10.1	13	11.3	2017-2019	
2.36	Children Living Below Poverty Level	percent	27.1		20.9	18.5	2015-2019	Asian (7.5) AIAN (0) NHPI (0) Mult (
	Female Population 16+ in Civilian Labor							
2.36	Force	percent	46.6		57.8	58.3	2015-2019	
2.31	Total Employment Change	percent	-0.5		2.9	1.6	2018-2019	
2.25	Workers who Drive Alone to Work	percent	82.5		80.5	76.3	2015-2019	
2.17	Alcohol-Impaired Driving Deaths	percent of driving deaths with alcohol involvemen	28.9	28.3	25.7	27	2015-2019	
2.14	Persons with Health Insurance	percent	76.8	92.1	79.3		2019	
	People 25+ with a Bachelor's Degree or							
2.00	Higher	percent	17.3		29.9	32.1	2015-2019	
1.94	Substantiated Child Abuse Rate	cases/ 1,000 children	18.3	8.7	9.1		2020	
	Households with No Car and Low Access to	0						
1.83	a Grocery Store	percent	3.3				2015	:
	Households with One or More Types of							
1.83	Computing Devices	percent	84.7		91	90.3	2015-2019	
1.83	People Living Below Poverty Level	percent	17.1	8	14.7	13.4	2015-2019	ian (8.4) AIAN (3.1) NHPI (0) Mult (
1.75		dollars	47355	-	61874	62843	2015-2019	
-								
1.67	Households with an Internet Subscription	percent	75.4		82.1	83	2015-2019	
	Workers Commuting by Public							
1.61	Transportation	percent	0.5	5.3	1.4	5	2015-2019	Asian (0) AIAN (0) NHPI (0) Mult (0
1.58	Per Capita Income	dollars	26121		31277	34103	2015-2019	
1.58	Persons with an Internet Subscription	percent	79.2		84.2	86.2	2015-2019	
	People 25+ with a High School Degree or	,						
1.53	Higher	percent	83.5		83.7	88	2015-2019	
1.50		dollars	108500		172500	217500	2015-2019	
1.36	Homeownership	percent	56.1		54.9	56.2	2015-2019	
1.36		percent	58.9		58.8		2016	
	Mortgaged Owners Median Monthly							
1.33	Household Costs	dollars	1190		1606	1595	2015-2019	
1.25		workers/ 100,000 population	49.3		82.7		2020	
1.22	Median Household Gross Rent	dollars	785		1045	1062	2015-2019	
	Social Associations	membership associations/ 10,000 population	10.8		7.5	9.3	2018	
	Median Monthly Owner Costs for		2010		710	510	2020	
1.06		dollars	418		514	500	2015-2019	
0.69	Linguistic Isolation	percent	1.7		7.7	4.4	2015-2019	
0.42	Single-Parent Households	percent	20.4		26.3	25.5	2015-2019	
	Single Fullent Households	percent	20.4		20.5	23.5	2013 2013	
			HENDERSON					
	DIADETEC		COUNTY	1102020	-			

			HEINDERSUN						
SCORE	DIABETES	UNITS	COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.58	Diabetes: Medicare Population	percent	26.3		28.8	27	2018		4
1.25	Age-Adjusted ER Rate due to Diabetes	ER visits/ 10,000 population 18+ years	6.5		9.4		2017-2019		15
	Age-Adjusted ER Rate due to Type 2								
1.25	Diabetes	ER visits/ 10,000 population 18+ years	5.7		8.6		2017-2019		15
	Age-Adjusted Hospitalization Rate due to								
1.25	Diabetes	hospitalizations/ 10,000 population 18+ years	4.3		5.3		2017-2019		15
	Age-Adjusted Hospitalization Rate due to								
1.25	Type 2 Diabetes	hospitalizations/ 10,000 population 18+ years	2.9		4		2017-2019		15
0.64	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	18.3		22	21.5	2017-2019		3
			HENDERSON						
SCORE	ECONOMY	UNITS	COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.64	Population 16+ in Civilian Labor Force	percent	48.9		61	59.6	2015-2019		1

1 64	Student-to-Teacher Ratio	students/ teacher	13.9				2019-2020		9
2.00	Higher	percent	17.3		29.9	32.1	2015-2019		1
	People 25+ with a Bachelor's Degree or	CIIVIO	COUNTY	HF2030	17	0.3.			Sourc
005	EDUCATION	UNITS	HENDERSON COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Sourc
).50	of Household Income on Housing	percent	23.5		26.5	26.5	2019		1
	Mortgaged Owners Spending 30% or More								
.92		percent	5.4		5.9	5.5	May-21		16
	Unemployed Workers in Civilian Labor								
.00	Assistance	percent	22		34	23	2019		6
	Food Insecure Children Likely Ineligible for								
.03		percent	13.9		17.4	18	2013-2017		5
06	00	dollars	418		514	500	2015-2019		1
	Median Monthly Owner Costs for								
14	People 65+ Living Below Poverty Level	percent	9.1		10.6	9.3	2015-2019	3.5) Asian (0) AIAN (0) Mult (12.9) (1
	Income	percent	1.5		1.4	2.4	2015-2019		
	Households with Cash Public Assistance								
22	Median Household Gross Rent	dollars	785		1045	1062	2015-2019		
	Overcrowded Households	percent of households	3		4.8		2015-2019		
3		dollars	1190		1606	1595	2015-2019		
	Mortgaged Owners Median Monthly								
86		percent	56.1		54.9	56.2	2015-2019		
0	WIC Certified Stores	stores/ 1,000 population	0.1				2016		
)	Median Housing Unit Value	dollars	108500		172500	217500	2015-2019		
3	SNAP Certified Stores	stores/ 1,000 population	0.7				2017		
	Per Capita Income	dollars	26121		31277	34103	2015-2019		
	Families Living Below Poverty Level	percent	12		11.3	9.5	2015-2019) Asian (12.2) AIAN (0) Mult (12.8)	
		dollars	47355		61874	62843	2015-2019		
	Household Income on Rent	percent	48.6		47.8	49.6	2015-2019		
	Renters Spending 30% or More of			-					
	People Living Below Poverty Level	percent	17.1	8	14.7	13.4	2015-2019	ian (8.4) AIAN (3.1) NHPI (0) Mult (
3		percent	12.3				2015		
	Low-Income and Low Access to a Grocery	percent	10.5		-7				
3	Poverty Level	percent	18.3		14		2018		
	Households that are Below the Federal	percent	01.5				2013 2020		
7	Program	percent	61.5				2019-2020		
,	Students Eligible for the Free Lunch	percent	30.1		50		2010		
1	Constrained, Employed (ALICE)	percent	36.1		30		2018		
	Households that are Asset Limited, Income	percent	40.0		50		2010		_
0	(ALICE) Threshold	percent	45.6		56		2018		2
	Households that are Above the Asset Limited, Income Constrained, Employed								
5	year)	percent	30.3		23.2	26.1	2015-2019		
_	Persons with Disability Living in Poverty (5-						2015 2010		
3		percent	59.1		65.7	69.1	2015-2019		
		P =							
8	Projected Food Insecurity Rate	percent	19.4		16.5		2021		
8	Projected Child Food Insecurity Rate	percent	29		23.6	1.0	2021		
1		percent	-0.5		2.9	1.6	2018-2019		1
6		percent	46.6		57.8	58.3	2015-2019		1
50	Children Living Below Poverty Level Female Population 16+ in Civilian Labor	percent	27.1		20.9	18.5	2015-2019	Asian (7.5) AIAN (0) NHPI (0) Mult (1
50 0		percent	<u> </u>		14.1	10.9	2019		6
		· .				10.0	2010		

1.53								
	Higher	percent	83.5		83.7	88	2015-2019	1
	Infants Born to Mothers with <12 Years							
	Education	percent	18.7		17.4	13.3	2017	12
1.31	High School Drop Out Rate	percent	1.3		1.9		2019	e (1.6) Asian (0) AIAN (0) PI (0) Mu 13
			HENDERSON					
	ENVIRONMENTAL HEALTH	UNITS	COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY* Sour
2.00	Access to Exercise Opportunities	percent	62.9		80.5	84	2020	5
	People 65+ with Low Access to a Grocery							
	Store	percent	5.6				2015	19
1.97	Grocery Store Density	stores/ 1,000 population	0.1				2016	19
	Households with No Car and Low Access to							
1.83	a Grocery Store	percent	3.3				2015	19
	Low-Income and Low Access to a Grocery							
1.83	Store	percent	12.3				2015	19
1.81	Fast Food Restaurant Density	restaurants/ 1,000 population	0.7				2016	19
1.75	Adults with Current Asthma	percent	9.8			9.2	2018	2
	Children with Low Access to a Grocery							
1.67	Store	percent	6.1				2015	19
1.67	Liquor Store Density	stores/ 100,000 population	12.1		6.9	10.5	2019	17
1.67	People with Low Access to a Grocery Store	percent	27.3				2015	19
1.64	Months of Mild Drought or Worse	months per year	7				2016	10
1.64	Number of Extreme Precipitation Days	days	32				2016	10
1.64	PBT Released	pounds	12.4				2019	20
1.58	Food Environment Index	,	6.4		5.9	7.8	2021	5
1.53	SNAP Certified Stores	stores/ 1,000 population	0.7				2017	19
1.50	WIC Certified Stores	stores/ 1,000 population	0.1				2016	19
1.36	Number of Extreme Heat Events	events	1				2016	10
1.36	Weeks of Moderate Drought or Worse	weeks per year	13				2016	10
	Farmers Market Density	markets/ 1,000 population	0				2018	19
1.31	Overcrowded Households	percent of households	3		4.8		2015-2019	1
1.17	Daily Dose of UV Irradiance	Joule per square meter	3319		3538		2015	10
	Number of Extreme Heat Days	days	2				2016	10
1.08	Recognized Carcinogens Released into Air	pounds	3850				2019	20
1.03	Severe Housing Problems	percent	13.9		17.4	18	2013-2017	5
1.00	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1		17.7	10	2016	
0.08	Asthma: Medicare Population	percent	3.2		4.9	5	2018	4

			HENDERSON						
SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.50	Primary Care Provider Rate	providers/ 100,000 population	30.4		60.9		2018		5
2.14	Persons with Health Insurance	percent	76.8	92.1	79.3		2019		18
2.08	Adults who Visited a Dentist	percent	52.1			66.5	2018		2
1.94	Non-Physician Primary Care Provider Rate	providers/ 100,000 population	49.6		88.6		2020		5
1.92	Adults without Health Insurance	percent	23.6			12.2	2018		2
1.83	Adults with Health Insurance	percent	69.5		75.5	87.1	2019		1
1.67	Children with Health Insurance	percent	85.8		87.3	94.3	2019		1
1.58	Adults who have had a Routine Checkup	percent	74.8			76.7	2018		2
1.33	Dentist Rate	dentists/ 100,000 population	35.1		59.6		2019		5
1.33	Mental Health Provider Rate	providers/ 100,000 population	56.8		120.9		2020		5

1.25	Social Worker Rate	workers/ 100,000 population	49.3		82.7		2020		12
			HENDERSON						
SCORE	HEART DISEASE & STROKE	UNITS	COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Sourc
	Age-Adjusted Death Rate due to Coronary								
3.00	Heart Disease	deaths/ 100,000 population	151.8	71.1	93	90.5	2017-2019		3
2.25	Adults who Experienced a Stroke	percent	4.7			3.4	2018		2
	Adults who Experienced Coronary Heart								
2.25	Disease	percent	10.2			6.8	2018		2
2.25	High Cholesterol Prevalence: Adults 18+	percent	40.1			34.1	2017		2
2.00	High Blood Pressure Prevalence	percent	40.3	27.7		32.4	2017		2
	Ischemic Heart Disease: Medicare	· · · · · · · · · · · · · · · · · · ·							
2.00	Population	percent	30.6		29	26.8	2018		4
1.97	Atrial Fibrillation: Medicare Population	percent	8.6		7.8	8.4	2018		4
1.97	Hyperlipidemia: Medicare Population	percent	50.2		49.5	47.7	2018		4
1.97	Hypertension: Medicare Population	percent	61.4		59.9	57.2	2018		4
1.86	Heart Failure: Medicare Population	percent	16.6		15.6	14	2018		4
	Age-Adjusted Death Rate due to Heart	÷							
1.69	Attack	deaths/ 100,000 population 35+ years	79.9		70.1		2018		10
1.42	Cholesterol Test History	percent	81			81.5	2017		2
1.36	Stroke: Medicare Population	percent	3.9		4.2	3.8	2018		4
	Age-Adjusted Death Rate due to								
1.33	Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	40.9	33.4	40.2	37.2	2017-2019		3
1.25	Age-Adjusted ER Rate due to Hypertension	ER visits/ 10,000 population 18+ years	6.6		10.5		2017-2019		15
	Adults who Have Taken Medications for								
1.08	High Blood Pressure	percent	79.3			75.8	2017		2
			HENDERSON						
SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Sourc
2.36	COVID-19 Daily Average Case-Fatality Rate	deaths per 100 cases	1.9		1.7	1	3-Sep-21		7
2.14	COVID-19 Daily Average Incidence Rate	cases per 100,000 population	80.3		77.1	62.2	3-Sep-21		7
1.89	Gonorrhea Incidence Rate	cases/ 100,000 population	166.5		163.6	179.1	2018		12
	Tuberculosis Incidence Rate	cases/ 100,000 population	3.7	1.4	4.3		2015-2019		12
	HIV Diagnosis Rate	cases/ 100,000 population	8.5		15.7		2018		12
	Overcrowded Households	percent of households	3		4.8		2015-2019		1
	Age-Adjusted Death Rate due to Influenza		-						
1.28	and Pneumonia	deaths/ 100,000 population	12.9		11.8	13.8	2017-2019		3
	Syphilis Incidence Rate	cases/ 100,000 population	1.2		8.8	10.8	2018		12
	Chlamydia Incidence Rate	cases/ 100,000 population	322		508.2	539.9	2018		12
	·								
	MATERNAL FETAL & INCANT USAT		HENDERSON	1102020	TV				C -
	MATERNAL, FETAL & INFANT HEALTH	UNITS		HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Sourc
2.75	Infant Mortality Rate	deaths/ 1,000 live births	10	5	5.6	5.9	2015		12
2.06	Teen Births	percent	2.9		2.1	3.1	2017	ack (0) White (2.6) Other (0) Hisp (
1.89	Babies with Very Low Birth Weight	percent	1.6			1.4	2015	ack (0) White (1.73501577) Other	12
4 70	Mathematical Resolution of the Resolution of the		50.0		60 F	77.2	2017		40

1.78 Mothers who Received Early Prenatal Care	percent	59.9		60.5	77.3	2017	12
Infants Born to Mothers with <12 Years							
1.50 Education	percent	18.7		17.4	13.3	2017	12
1.22 Preterm Births	percent	10.7	9.4	12.2		2017	12
1.11 Babies with Low Birth Weight	percent	7.5		8.2	8.1	2015	12

			HENDERSON						
SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	COUNTY	HP2030	ΤХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.47	Depression: Medicare Population	percent	20.3		18.2	18.4	2018		4
	Alzheimer's Disease or Dementia: Medicare								
2.42	Population	percent	12.5		12.6	10.8	2018		4
2.33	Frequent Mental Distress	percent	16.2		11.6	13	2018		5
2.08	Poor Mental Health: 14+ Days	percent	15			12.7	2018		2
2.03	Age-Adjusted Death Rate due to Suicide	deaths/ 100,000 population	21.5	12.8	13.5	14.1	2017-2019		3
1.33	Mental Health Provider Rate	providers/ 100,000 population	56.8		120.9		2020		5
	Age-Adjusted ER Rate due to Adult Mental								
1.25	Health	ER visits/ 10,000 population 18+ years	1		8.9		2017-2019		15

			HENDERSON						
SCORE	OLDER ADULTS	UNITS	COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.64	COPD: Medicare Population	percent	18.6		11.2	11.5	2018		4
2.47	Depression: Medicare Population	percent	20.3		18.2	18.4	2018		4
	Alzheimer's Disease or Dementia: Medicare								
2.42	Population	percent	12.5		12.6	10.8	2018		4
2.31	Osteoporosis: Medicare Population	percent	7		6.8	6.6	2018		4
2.08	Adults with Arthritis	percent	32.2			25.8	2018		2
2.00	Colon Cancer Screening	percent	59.6	74.4		66.4	2018		2
	Ischemic Heart Disease: Medicare								
2.00	Population	percent	30.6		29	26.8	2018		4
	People 65+ with Low Access to a Grocery								
2.00	Store	percent	5.6				2015		19
1.97	Atrial Fibrillation: Medicare Population	percent	8.6		7.8	8.4	2018		4
1.97	Hyperlipidemia: Medicare Population	percent	50.2		49.5	47.7	2018		4
1.97	Hypertension: Medicare Population	percent	61.4		59.9	57.2	2018		4
	Rheumatoid Arthritis or Osteoarthritis:								
1.97	Medicare Population	percent	36.3		34.2	33.5	2018		4
	Adults 65+ who Received Recommended								
	Preventive Services: Males	percent	23.7			32.4	2018		2
1.92	Adults 65+ with Total Tooth Loss	percent	18.6			13.5	2018		2
1.86	Heart Failure: Medicare Population	percent	16.6		15.6	14	2018		4
	Adults 65+ who Received Recommended								
1.75	Preventive Services: Females	percent	25.4			28.4	2018		2
1.58	Diabetes: Medicare Population	percent	26.3		28.8	27	2018		4
1.47	Cancer: Medicare Population	percent	7.6		7.6	8.4	2018		4
	Chronic Kidney Disease: Medicare								
1.42	Population	percent	22.8		26.7	24.5	2018		4
1.36	Stroke: Medicare Population	percent	3.9		4.2	3.8	2018		4
1.14	People 65+ Living Below Poverty Level	percent	9.1		10.6	9.3	2015-2019	3.5) Asian (0) AIAN (0) Muli	t (12.9) (1
0.08	Asthma: Medicare Population	percent	3.2		4.9	5	2018		4
			HENDERSON						
SCORE	ORAL HEALTH	UNITS	COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source

SC	ORE ORAL HEALTH	UNITS	COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Oral Cavity and Pharynx Cancer Incidence								
2.	89 Rate	cases/ 100,000 population	17.4		11	11.8	2013-2017		8
2.	08 Adults who Visited a Dentist	percent	52.1			66.5	2018		2
1.	Adults 65+ with Total Tooth Loss	percent	18.6			13.5	2018		2

	Age-Adjusted ER Rate due to Dental					
1.5	8 Problems	ER visits/ 10,000 population	11.9	11.1	2017-2019	15
1.3	3 Dentist Rate	dentists/ 100,000 population	35.1	59.6	2019	5

			HENDERSON						
SCOR	E OTHER CONDITIONS	UNITS	COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.31	Osteoporosis: Medicare Population	percent	7		6.8	6.6	2018		4
2.08	Adults with Arthritis	percent	32.2			25.8	2018		2
2.08	Adults with Kidney Disease	Percent of adults	3.9			3.1	2018		2
	Rheumatoid Arthritis or Osteoarthritis:								
1.97	Medicare Population	percent	36.3		34.2	33.5	2018		4
	Chronic Kidney Disease: Medicare								
1.42	Population	percent	22.8		26.7	24.5	2018		4

			HENDERSON						
SCORE	PHYSICAL ACTIVITY	UNITS	COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.00	Access to Exercise Opportunities	percent	62.9		80.5	84	2020		5
	People 65+ with Low Access to a Grocery								
2.00	Store	percent	5.6				2015		19
1.97	Grocery Store Density	stores/ 1,000 population	0.1				2016		19
	Households with No Car and Low Access to								
1.83	a Grocery Store	percent	3.3				2015		19
	Low-Income and Low Access to a Grocery								
1.83	Store	percent	12.3				2015		19
1.81	Fast Food Restaurant Density	restaurants/ 1,000 population	0.7				2016		19
	Children with Low Access to a Grocery								
1.67	Store	percent	6.1				2015		19
1.67	People with Low Access to a Grocery Store	percent	27.3				2015		19
1.58	Food Environment Index		6.4		5.9	7.8	2021		5
1.53	SNAP Certified Stores	stores/ 1,000 population	0.7				2017		19
1.50	WIC Certified Stores	stores/ 1,000 population	0.1				2016		19
1.33	Farmers Market Density	markets/ 1,000 population	0				2018		19
1.00	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2016		19

			HENDERSON						
SCO	RE PREVENTION & SAFETY	UNITS	COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Age-Adjusted Death Rate due to								
2.8	33 Unintentional Injuries	deaths/ 100,000 population	67.4	43.2	38.7	48.9	2017-2019		3
1.5	56 Death Rate due to Drug Poisoning	deaths/ 100,000 population	18.7		10.6	21	2017-2019		5
1.0	3 Severe Housing Problems	percent	13.9		17.4	18	2013-2017		5
1.5	33 Unintentional Injuries56 Death Rate due to Drug Poisoning	deaths/ 100,000 population	18.7	43.2	10.6	21	2017-2019		3 5 5

			HENDERSON						
SCORE	RESPIRATORY DISEASES	UNITS	COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.64	COPD: Medicare Population	percent	18.6		11.2	11.5	2018		4
2.50	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	86.1		50.6	58.3	2013-2017		
2.36	COVID-19 Daily Average Case-Fatality Rate	deaths per 100 cases	1.9		1.7	1	3-Sep-21		7
2.17	Adults who Smoke	percent	20.5	5		15.5	2018		2
2.14	COVID-19 Daily Average Incidence Rate	cases per 100,000 population	80.3		77.1	62.2	3-Sep-21		7
	Adults with COPD	Percent of adults	10.3			6.9	2018		2
	Age-Adjusted Death Rate due to Lung								
2.00	Cancer	deaths/ 100,000 population	50.8	25.1	34.1	38.5	2013-2017		8

1.75	Adults with Current Asthma	percent	9.8			9.2	2018		2
1.72	Tuberculosis Incidence Rate	cases/ 100,000 population	3.7	1.4	4.3		2015-2019		12
	Age-Adjusted Death Rate due to Influenza								
1.28	and Pneumonia	deaths/ 100,000 population	12.9		11.8	13.8	2017-2019		3
0.08	Asthma: Medicare Population	percent	3.2		4.9	5	2018		4
			HENDERSON						
CORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.89	Gonorrhea Incidence Rate	cases/ 100,000 population	166.5		163.6	179.1	2018		12
1.47	HIV Diagnosis Rate	cases/ 100,000 population	8.5		15.7		2018		12
1.22	Syphilis Incidence Rate	cases/ 100,000 population	1.2		8.8	10.8	2018		12
1.06	Chlamydia Incidence Rate	cases/ 100,000 population	322		508.2	539.9	2018		12
			HENDERSON						
CORE	WELLNESS & LIFESTYLE	UNITS	COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.17	Frequent Physical Distress	percent	14.4		11.6	11	2018		5
2.08	Poor Physical Health: 14+ Days	percent	16.1			12.5	2018		2
2.00	High Blood Pressure Prevalence	percent	40.3	27.7		32.4	2017		2
1.92	Insufficient Sleep	percent	37.7	31.4	34.4	35	2018		5
			HENDERSON						
CORE	WOMEN'S HEALTH	UNITS	COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Sourc
2.67	Cervical Cancer Incidence Rate	cases/ 100,000 females	14.4		9.2	7.6	2013-2017		8
2.33	Mammogram in Past 2 Years: 50-74	percent	67	77.1		74.8	2018		2
1.94	Cervical Cancer Screening: 21-65	Percent	80.8	84.3		84.7	2018		2

1.81 Breast Cancer Incidence Rate cases/ 100,000 females 118.2 112.8 125.9 2013-2017 8 Age-Adjusted Death Rate due to Breast 1.58 Cancer deaths/ 100,000 females 18.2 15.3 19.8 20.1 2013-2017 8 Hood County

Health and Quality of Life Topics	Score
Other Conditions	2.07
Older Adults	1.78
Women's Health	1.74
Children's Health	1.71
Cancer	1.65
Physical Activity	1.63
Mental Health & Mental Disorders	1.56
Heart Disease & Stroke	1.53
Prevention & Safety	1.53
Respiratory Diseases	1.47
Environmental Health	1.47
Health Care Access & Quality	1.44
Wellness & Lifestyle	1.40
Oral Health	1.36
Community	1.35
Alcohol & Drug Use	1.31
Education	1.31
Maternal, Fetal & Infant Health	1.30
Diabetes	1.25
Economy	1.18
Immunizations & Infectious Diseases	1.08
Sexually Transmitted Infections	1.06

SCORE	ALCOHOL & DRUG USE	UNITS	HOOD COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.75	Age-Adjusted ER Rate due to Opioid Use	sits/10,000 population 18+ y	1.1		0.7		2017-2019		16
1.58	Adults who Binge Drink	percent	16.2		0.7	16.4	2018		3
1.56			15		10.6	21	2017-2019		6
	Age-Adjusted Drug and Opioid-Involved								
1.50	Overdose Death Rate	eaths per 100,000 population	19.1		12.1	22.8	2017-2019		4
	Age-Adjusted ER Rate due to Substance								
1.25	Use	isits/ 10,000 population 18+ y	4.8		20.6		2017-2019		16
0.78	Liquor Store Density	stores/ 100,000 population	6.5		6.9	10.5	2019		18
0.75	Alcohol-Impaired Driving Deaths	driving deaths with alcohol in	19.6	28.3	25.7	27	2015-2019		6
	CANCER	UNITS	HOOD COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.47	Cancer: Medicare Population	percent	9.1		7.6	8.4	2018		5
	Adults with Cancer	percent	9.1			6.9	2018		3
2.25	Cervical Cancer Incidence Rate	cases/ 100,000 females	12.7		9.2	7.6	2013-2017		9
	Age-Adjusted Death Rate due to Lung		44.2	25.4	24.4	20 5	2012 2017		0
1.94	Cancer	deaths/ 100,000 population	44.3	25.1	34.1	38.5	2013-2017		9
1 00	Oral Cavity and Pharynx Cancer Incidence		107		11	11.0	2012 2017		9
1.89	Rate Age-Adjusted Death Rate due to Prostate	cases/ 100,000 population	12.7		11	11.8	2013-2017		9
1.86	Cancer	deaths/ 100,000 males	20.4	16.9	17.6	19	2013-2017		9
1.81	All Cancer Incidence Rate	cases/ 100,000 population	438.4	10.9	407.7	448.7	2013-2017		9
1.81	Breast Cancer Incidence Rate	cases/ 100,000 females	120.9		112.8	125.9	2013-2017		9
1.01	Age-Adjusted Death Rate due to Breast		120.9		112.0	125.5	2013-2017		5
1.75		deaths/ 100,000 females	19.7	15.3	19.8	20.1	2013-2017		9
			2017	2010	10.0	2012	2010 2017		
1.69	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	62.5		50.6	58.3	2013-2017		9
1.64	Prostate Cancer Incidence Rate	cases/ 100,000 males	98.6		94	104.5	2013-2017		9
1.44	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	158.8	122.7	148.8	155.5	2013-2017		9
1.44	Cervical Cancer Screening: 21-65	Percent	83.1	84.3		84.7	2018		3
1.44	Mammogram in Past 2 Years: 50-74	percent	70.3	77.1		74.8	2018		3
1.33	Colon Cancer Screening	percent	65	74.4		66.4	2018		3
	Age-Adjusted Death Rate due to Colorecta								
0.94	Cancer	deaths/ 100,000 population	13.5	8.9	13.9	13.7	2013-2017		9
0.08	Colorectal Cancer Incidence Rate	cases/ 100,000 population	33.6		37.6	38.4	2013-2017		9
					-				
SCORE	CHILDREN'S HEALTH	UNITS	HOOD COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.47	Food Insecure Children Likely Ineligible for		27		24	22	2010		7
2.17	Assistance	percent	37 18	0 7	34 9.1	23	<u>2019</u> 2020		7
1.94	Substantiated Child Abuse Rate Children with Low Access to a Grocery	cases/ 1,000 children	79	8.7	9.1		2020		12
1.67	Store	percent	6.6				2015		20
1.50	Child Food Insecurity Rate	percent	17.9		19.6	14.6	2015		7
1.25	· · · · · · · · · · · · · · · · · · ·	percent	21.9		23.6	14.0	2015		7
1.2.5					20.0		2021		, ,
SCORF	COMMUNITY	UNITS	HOOD COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Solo Drivers with a Long Commute	percent	53	000	38.9	37	2015-2019		6
2.64	Mean Travel Time to Work	minutes	33.6		26.6	26.9	2015-2019		1
2.47	Workers who Drive Alone to Work	percent	86.8		80.5	76.3	2015-2019		1
	Female Population 16+ in Civilian Labor								
2.36	Force	percent	46.2		57.8	58.3	2015-2019		1
2.31	Population 16+ in Civilian Labor Force	percent	52.3		61	59.6	2015-2019		1

	Workers Commuting by Public								
2.22	Transportation	percent	0.2	5.3	1.4	5	2015-2019	Asian (0) AIAN (0) NHPI (100) Mu	l [†] 1
2.22	Age-Adjusted Death Rate due to Motor		0.2	5.5	1.4	5	2015-2019	Asian (0) AIAN (0) NHPI (100) Mu	II 1
2.17	Vehicle Traffic Collisions	deaths/ 100,000 population	19.3	10.1	13	11.3	2017-2019		4
2.00	Median Household Gross Rent	dollars	961	10.1	1045	1062	2017-2019		1
2.00	Mortgaged Owners Median Monthly		501		1045	1002	2013 2013		
2.00	Household Costs	dollars	1477		1606	1595	2015-2019		1
	Substantiated Child Abuse Rate	cases/ 1,000 children	18	8.7	9.1	1555	2019 2019		12
1.54	Median Monthly Owner Costs for		10	0.7	9.1		2020		12
1 72	Households without a Mortgage	dollars	476		514	500	2015-2019		1
1.47	Social Associations	ship associations/ 10,000 po	9.8		7.5	9.3	2019 2019		6
1.47	People 25+ with a Bachelor's Degree or		5.0		7.5	5.5	2010		
1.36	Higher	percent	26.4		29.9	32.1	2015-2019		1
1.36	Persons with Health Insurance	percent	82.2	92.1	79.3	02.12	2019		19
1.36		workers/ 100,000 population	69.9	52.1	82.7		2020		13
1.50	Households with No Car and Low Access to		05.5		02.7		2020		
1.17	a Grocery Store	percent	1.6				2015		20
1.17	Linguistic Isolation	percent	2.6		7.7	4.4	2015-2019		1
1.08	Persons with an Internet Subscription	percent	87.5		84.2	86.2	2015-2019		1
1.00	Voter Turnout: Presidential Election	percent	68.5		58.8	0012	2016		15
	People 25+ with a High School Degree or		0010				2010		
0.86	Higher	percent	89.4		83.7	88	2015-2019		1
0.00					0017		2010 2015		-
0.83	Households with an Internet Subscription	percent	85.4		82.1	83	2015-2019		1
0.05	Households with One or More Types of	percent	05.4		02.1	05	2013 2013		-
0.83	Computing Devices	percent	92.4		91	90.3	2015-2019		1
0.83	Median Housing Unit Value	dollars	193500		172500	217500	2015-2019		1
0.75	Alcohol-Impaired Driving Deaths	driving deaths with alcohol in	19.6	28.3	25.7	21/300	2015-2019		6
0.69	Median Household Income	dollars	64041	20.5	61874	62843	2015-2019		1
0.53	Children Living Below Poverty Level	percent	14.5		20.9	18.5	2015-2019		1
0.44	People Living Below Poverty Level	percent	9.7	8	14.7	13.4	2015-2019		1
0.36	Homeownership	percent	64.9	0	54.9	56.2	2015-2019		1
0.36	Single-Parent Households	percent	15.7		26.3	25.5	2015-2019		1
0.36	Total Employment Change	percent	5.6		2.9	1.6	2018-2019		18
0.25	Per Capita Income	dollars	35606		31277	34103	2015-2019	12) AIAN (83167) NHPI (279498) I	
					012//	0.1200	2010 2015		
SCORE	DIABETES	UNITS	HOOD COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
000112	Age-Adjusted Hospitalization Rate due to	0,1110				0.01			
1.42	Type 2 Diabetes	zations/ 10,000 population 1	4		4		2017-2019		16
	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		•		•		2017 2015		
1.36	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	22.3		22	21.5	2017-2019		4
-	Age-Adjusted ER Rate due to Diabetes	isits/ 10,000 population 18+ y	4.8		9.4	22.0	2017-2019		16
0	Age-Adjusted ER Rate due to Type 2				5		2017 2015		
1.25	Diabetes	sits/10,000 population 18+ y	4.5		8.6		2017-2019		16
0	Age-Adjusted Hospitalization Rate due to				0.0		2017 2015		
1.25	Diabetes	zations/ 10,000 population 1	4.8		5.3		2017-2019		16
0.97	Diabetes: Medicare Population	percent	24.7		28.8	27	2018		5
0.57	Diabetes: Medicare ropulation		27.7		20.0	21	2010		
SCORE	ECONOMY	UNITS	HOOD COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
JEONE	Female Population 16+ in Civilian Labor	Giarra		111 2000	17	0.5.	MENSOREMENT FERIOD		Source
2.36	Force	percent	46.2		57.8	58.3	2015-2019		1
2.30	Population 16+ in Civilian Labor Force	percent	52.3		61	59.6	2015-2019		1
	Renters Spending 30% or More of	percent	52.5		01	55.0			-
2.31	Household Income on Rent	percent	49.7		47.8	49.6	2015-2019		1
2.01	nousenera medine on hent	percent	-3.7		47.0		2013 2013		-

	Food Income Children Libel, Indiaible for							
2.17	Food Insecure Children Likely Ineligible for Assistance	norcont	37		34	23	2019	7
2.17	Median Household Gross Rent	percent dollars	961		1045	1062	2019	/ 1
2.00	Mortgaged Owners Median Monthly	uonurs	901		1045	1002	2013-2019	1
2.00	Household Costs	dollars	1477		1606	1595	2015-2019	1
-		stores/ 1,000 population	0.1		1000	1393	2015-2019	20
2.00	Median Monthly Owner Costs for	310123/ 1,000 population	0.1				2010	20
1.72	Households without a Mortgage	dollars	476		514	500	2015-2019	1
1.67	Food Insecurity Rate	percent	13.5		14.1	10.9	2013-2013	7
1.07	Low-Income and Low Access to a Grocery	percent	15.5		14.1	10.5	2015	,
1.67	Store	percent	9.8				2015	20
1.53	SNAP Certified Stores	stores/ 1,000 population	0.8				2013	20
1.50	Child Food Insecurity Rate	percent	17.9		19.6	14.6	2019	7
1.50	Students Eligible for the Free Lunch	percent	17.5		15.0	14.0	2015	,
1 47	Program	percent	45.2				2019-2020	10
1.47	Households that are Asset Limited, Income	percent	45.2				2019 2020	10
1.33	Constrained, Employed (ALICE)	percent	28.7		30		2018	22
1.25	Projected Child Food Insecurity Rate	percent	21.9		23.6		2021	7
-	Projected Food Insecurity Rate	percent	15.9		16.5		2021	7
	Households that are Above the Asset							
	Limited, Income Constrained, Employed							
1.17		percent	60.6		56		2018	22
	Unemployed Workers in Civilian Labor	percent	0010				2010	
1.08	Force	percent	5.5		5.9	5.5	May-21	17
1.03	Overcrowded Households	percent of households	2.9		4.8		2015-2019	1
	Households that are Below the Federal	, , , , , , , , , , , , , , , , , , ,	-					
1.00	Poverty Level	percent	10.7		14		2018	22
0.97	Severe Housing Problems	percent	13		17.4	18	2013-2017	6
0.83	Median Housing Unit Value	dollars	193500		172500	217500	2015-2019	1
0.69	Median Household Income	dollars	64041		61874	62843	2015-2019	1
0.64	People 65+ Living Below Poverty Level	percent	5.1		10.6	9.3	2015-2019	an (0) AIAN (0) NHPI (21.7) Mult (C 1
0.53	Children Living Below Poverty Level	percent	14.5		20.9	18.5	2015-2019	1
0.44	People Living Below Poverty Level	percent	9.7	8	14.7	13.4	2015-2019	1
0.36	Families Living Below Poverty Level	percent	6.8		11.3	9.5	2015-2019	an (0) AIAN (0) NHPI (100) Mult (3. 1
0.36	Homeownership	percent	64.9		54.9	56.2	2015-2019	1
	Households with Cash Public Assistance							
0.36	Income	percent	0.8		1.4	2.4	2015-2019	1
0.36	Total Employment Change	percent	5.6		2.9	1.6	2018-2019	18
0.25	People Living 200% Above Poverty Level	percent	73.4		65.7	69.1	2015-2019	1
0.25	Per Capita Income	dollars	35606		31277	34103	2015-2019	12) AIAN (83167) NHPI (279498) N 1
	Persons with Disability Living in Poverty (5-							
0.08	year)	percent	15.4		23.2	26.1	2015-2019	1
SCORE	EDUCATION	UNITS	HOOD COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY* Source
1.81	High School Drop Out Rate	percent	2.3		1.9		2019	ite (1.7) Asian (0) AIAN (0) PI (0) M 14
1.69	Student-to-Teacher Ratio	students/ teacher	14.9				2019-2020	10
	People 25+ with a Bachelor's Degree or							
1.36	Higher	percent	26.4		29.9	32.1	2015-2019	1
	People 25+ with a High School Degree or							
0.86	Higher	percent	89.4		83.7	88	2015-2019	1
	Infants Born to Mothers with <12 Years							
0.83	Education	percent	14		17.4	13.3	2017	13
SCORE	ENVIRONMENTAL HEALTH	UNITS	HOOD COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY* Source

	People 65+ with Low Access to a Grocery							
2.00	Store	percent	7.9				2015	20
2.00	WIC Certified Stores	stores/ 1,000 population	0.1				2016	20
1.97	Fast Food Restaurant Density	estaurants/ 1,000 population	0.8				2016	20
1.97	Grocery Store Density	stores/ 1,000 population	0.1				2016	20
1.86	Asthma: Medicare Population	percent	4.9		4.9	5	2018	5
1.83	People with Low Access to a Grocery Store	e percent	32.8				2015	20
1.67	Access to Exercise Opportunities	percent	72.7		80.5	84	2020	6
	Children with Low Access to a Grocery							
1.67	Store	percent	6.6				2015	20
	Low-Income and Low Access to a Grocery							
1.67	Store	percent	9.8				2015	20
1.64	Number of Extreme Precipitation Days	days	50				2016	11
1.64	Recognized Carcinogens Released into Air	pounds	13.9				2019	21
1.53	SNAP Certified Stores		0.8				2017	20
1.50	Farmers Market Density	markets/ 1,000 population	0				2018	20
1.44	Annual Ozone Air Quality		D				2017-2019	2
1.36	Number of Extreme Heat Days	days	4				2016	11
1.36	Number of Extreme Heat Events	events	1				2016	11
1.33	Daily Dose of UV Irradiance	Joule per square meter	3397		3538		2015	11
1.19	Food Environment Index		7.3		5.9	7.8	2021	6
	Households with No Car and Low Access to							
	a Grocery Store	percent	1.6				2015	20
1.08	Adults with Current Asthma	percent	8.9			9.2	2018	3
1.08	Weeks of Moderate Drought or Worse	weeks per year	1		4.0		2016	11
1.03	Overcrowded Households Recreation and Fitness Facilities	percent of households facilities/ 1,000 population	2.9		4.8		2015-2019 2016	<u> </u>
0.97	Severe Housing Problems	percent	13		17.4	18	2013-2017	6
0.78	Liquor Store Density	stores/ 100,000 population	6.5		6.9	10.5	2019	18
			010		0.5	20.0		
SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	HOOD COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD HIGH DISPARI	TY* Source
1.94	Non-Physician Primary Care Provider Rate	providers/ 100 000 population	47.1		88.6		2020	6
1.75	Adults without Health Insurance	percent	19.4		0010	12.2	2018	3
1.75	Primary Care Provider Rate	providers/ 100,000 population	47.9		60.9		2018	6
	· ·							
1.42	Adults who have had a Routine Checkup	percent	76.6			76.7	2018	3
1.36	Persons with Health Insurance	percent	82.2	92.1	79.3		2019	19
1.36	Social Worker Rate	workers/ 100,000 population	69.9		82.7		2020	13
1.25	Adults who Visited a Dentist	percent	62.7		420.0	66.5	2018	3
1.17	Mental Health Provider Rate	providers/ 100,000 population	95.7		120.9		2020	<u> </u>
1.00	Dentist Rate	dentists/ 100,000 population	51.9		59.6		2019	b
SCORE	HEART DISEASE & STROKE	UNITS	HOOD COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD HIGH DISPARI	TY* Source
2.64	Hyperlipidemia: Medicare Population	percent	56.3		49.5	47.7	2018	5
2.58	Atrial Fibrillation: Medicare Population	percent	8.9		7.8	8.4	2018	5
2.25	High Cholesterol Prevalence: Adults 18+	percent	40.2			34.1	2017	3
	High Blood Pressure Prevalence	percent	39.8	27.7		32.4	2017	3
1.97	Heart Failure: Medicare Population	percent	15.9		15.6	14	2018	5
1.00	Adults who Experienced Coronary Heart		0.1			6.0	2010	-
1.92	Disease	percent	9.1		50.0	6.8	2018	3
1.81	Hypertension: Medicare Population	percent	61		59.9	57.2	2018	5

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 1.33 HIV Diagnosis Rate 1.06 Chlamydia Inciden 1.03 Overcrowded Hou 1.00 COVID-19 Daily Av 0.94 Syphilis Incidence 0.94 Tuberculosis Inciden 0.92 Gonorrhea Inciden Age-Adjusted Deat 0.33 and Pneumonia 	e Aate seholds erage Case-Fatality Rate Rate ence Rate nce Rate	cases/ 100,000 population cases/ 100,000 population percent of households deaths per 100 cases cases/ 100,000 population cases/ 100,000 population	5 269.3 2.9 0.6 1.7 0.7	1.4	15.7 508.2 4.8 1.7 8.8	539.9	2018 2018 2015-2019 3-Sep-21		13 13 1 8
 1.33 HIV Diagnosis Rate 1.06 Chlamydia Inciden 1.03 Overcrowded Hou 1.00 COVID-19 Daily Av 0.94 Syphilis Incidence 0.94 Tuberculosis Inciden 0.92 Gonorrhea Inciden Age-Adjusted Deat 0.33 and Pneumonia 	e Aate seholds erage Case-Fatality Rate Rate ence Rate nce Rate	cases/ 100,000 population cases/ 100,000 population percent of households deaths per 100 cases cases/ 100,000 population cases/ 100,000 population	5 269.3 2.9 0.6 1.7 0.7	1.4	15.7 508.2 4.8 1.7 8.8	539.9	2018 2018 2015-2019 3-Sep-21		13 13 1 8
1.06 Chlamydia Inciden 1.03 Overcrowded Hou 1.00 COVID-19 Daily Av 0.94 Syphilis Incidence 0.94 Tuberculosis Inciden 0.92 Gonorrhea Inciden Age-Adjusted Deat 0.33	ice Rate seholds erage Case-Fatality Rate Rate ence Rate ice Rate	cases/ 100,000 population percent of households deaths per 100 cases cases/ 100,000 population cases/ 100,000 population	269.3 2.9 0.6 1.7 0.7	1.4	508.2 4.8 1.7 8.8	1	2018 2015-2019 3-Sep-21		13 1 8
1.03 Overcrowded Hou 1.00 COVID-19 Daily Av 0.94 Syphilis Incidence 0.94 Tuberculosis Incide 0.92 Gonorrhea Inciden Age-Adjusted Deat Agator 0.33 and Pneumonia	seholds erage Case-Fatality Rate Rate ence Rate nce Rate	percent of households deaths per 100 cases cases/ 100,000 population cases/ 100,000 population	0.6 1.7 0.7	1.4	1.7 8.8		3-Sep-21		8
0.94 Syphilis Incidence 0.94 Tuberculosis Incidence 0.92 Gonorrhea Inciden Age-Adjusted Deat 0.33 and Pneumonia	Rate ence Rate nce Rate	cases/ 100,000 population cases/ 100,000 population	1.7 0.7	1.4	8.8				
0.94 Syphilis Incidence 0.94 Tuberculosis Incidence 0.92 Gonorrhea Inciden Age-Adjusted Deat 0.33 and Pneumonia	Rate ence Rate nce Rate	cases/ 100,000 population cases/ 100,000 population	1.7 0.7	1.4	8.8				
0.94 Tuberculosis Incide 0.92 Gonorrhea Incider Age-Adjusted Deat Agata 0.33 and Pneumonia	ence Rate nce Rate	cases/ 100,000 population	0.7	1.4		10.8			13
0.92Gonorrhea IncidenAge-Adjusted Deat0.33and Pneumonia	nce Rate						2015-2019		13
Age-Adjusted Deat 0.33 and Pneumonia					163.6	179.1	2013-2013		13
0.33 and Pneumonia			00.1		105.0	175.1	2018		15
SCORE MATERNAL, FETAL		deaths/ 100,000 population	7.9		11.8	13.8	2017-2019		4
	L & INFANT HEALTH	UNITS	HOOD COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.31 Infant Mortality Ra		deaths/ 1,000 live births	7.4	5	5.6	5.9	2015		13
2.00 Babies with Very L		percent	1.7		1.5	1.5	2007		13
· · · ·		,							
1.58 Mothers who Rece	eived Early Prenatal Care	percent	63		60.5	77.3	2017		13
0.97 Preterm Births		percent	9.1	9.4	12.2		2017		13
	others with <12 Years								
0.83 Education		percent	14		17.4	13.3	2017		13
0.78 Babies with Low B	irth Weight	percent	6.2		8.2	8.1	2015		13
0.61 Teen Births		percent	0		2.1	3.1	2017		13
SCORE MENTAL HEALTH &	& MENTAL DISORDERS	UNITS	HOOD COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.31 Age-Adjusted Deat	th Rate due to Suicide	deaths/ 100,000 population	21	12.8	13.5	14.1	2017-2019		4
Alzheimer's Diseas	se or Dementia: Medicare		12.1		12.6	10.8	2018		5
1.97 Population 1.83 Depression: Medic	are Deputation	percent	12.1		12.6	10.8	2018		5
		percent	19.3			18.4	2018		6
1.50 Frequent Mental D Age-Adjusted ER R	late due to Adult Mental	percent	13.8		11.6	13	2018		0
1.25 Health		isits/ 10,000 population 18+ y	1.4		8.9		2017-2019		16
1.17 Mental Health Pro	vider Rate	providers/ 100,000 population	95.7		120.9		2020		6
0.92 Poor Mental Healt	h: 14+ Days	percent	12.5			12.7	2018		3
SCORE OLDER ADULTS		UNITS	HOOD COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.64 Hyperlipidemia: M		OTHER D	56.3	111 2030	49.5	47.7	2018	HIGH DISPART	5

4 07	Grocery Store Density	stores/ 1,000 population	0.1				2016		20
1.97	Fast Food Restaurant Density	estaurants/ 1,000 population	0.8				2016		20
2.00	WIC Certified Stores	stores/ 1,000 population	0.1				2016		20
2.00	Store	percent	7.9				2015		20
SCORE	PHYSICAL ACTIVITY People 65+ with Low Access to a Grocery	UNITS	HOOD COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.42	Population	percent	22.8		26.7	24.5	2018		5
	Chronic Kidney Disease: Medicare								
-	Adults with Kidney Disease	Percent of adults	3.5			3.1	2018		3
	Adults with Arthritis	percent	30.8		J 4 .2	25.8	2018		3
2.64	Medicare Population	percent	41.7		34.2	33.5	2018		5
2.64	Osteoporosis: Medicare Population Rheumatoid Arthritis or Osteoarthritis:	percent	7.6		6.8	6.6	2018		5
	OTHER CONDITIONS	UNITS	HOOD COUNTY	HP2030	TX	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
		percent							
1.00 0.92	Dentist Rate Adults 65+ with Total Tooth Loss	dentists/ 100,000 population	51.9 12.9		59.6	13.5	<u> </u>		<u> </u>
	Adults who Visited a Dentist	percent	62.7		F0 C	66.5	2018		3
1.75	Problems	ER visits/ 10,000 population	12.1		11.1		2017-2019		16
	Age-Adjusted ER Rate due to Dental					1110			
1.89	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	12.7		11	11.8	2013-2017		9
SCORE	ORAL HEALTH	UNITS	HOOD COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.64	People 65+ Living Below Poverty Level	percent	5.1		10.6	9.3	2015-2019	ian (0) AIAN (0) NHPI (21.7)	Mult (C 1
	Adults 65+ with Total Tooth Loss	percent	12.9			13.5	2018		3
0.97	Population	percent	26		29	26.8	2018		5
	Ischemic Heart Disease: Medicare								
	Diabetes: Medicare Population	percent	24.7		28.8	27	2018		5
	Stroke: Medicare Population	percent	3.7		4.2	3.8	2018		5
	Colon Cancer Screening	percent	65	74.4	20.7	66.4	2018		3
1 42	Chronic Kidney Disease: Medicare Population	percent	22.8		26.7	24.5	2018		5
1.42	Preventive Services: Females	percent	28.2			28.4	2018		3
	Adults 65+ who Received Recommended								
1.75	Preventive Services: Males	percent	26.2			32.4	2018		3
	Adults 65+ who Received Recommended				-				-
	Hypertension: Medicare Population	percent	61		59.9	57.2	2018		5
1.83	Depression: Medicare Population	percent	19.3		18.2	18.4	2018		5
1.92	Asthma: Medicare Population	percent	4.9		4.9	5	2018		5
1.97 1.92	Heart Failure: Medicare Population Adults with Arthritis	percent percent	30.8		15.6	25.8	2018		3
	Population	percent	12.1 15.9		12.6	10.8 14	<u> </u>		5
	Alzheimer's Disease or Dementia: Medicare	e				10.0			
2.00	People 65+ with Low Access to a Grocery Store	percent	7.9				2015		20
2.31	COPD: Medicare Population	percent	14		11.2	11.5	2018		5
	Cancer: Medicare Population	percent	9.1		7.6	8.4	2018		5
2.58	Atrial Fibrillation: Medicare Population	percent	8.9		7.8	8.4	2018		5
2.64	Medicare Population	percent	41.7		34.2	33.5	2018		5
	Rheumatoid Arthritis or Osteoarthritis:								
	Osteoporosis: Medicare Population	percent	7.6		6.8	6.6	2018		5

1.83	People with Low Access to a Grocery Store	percent	32.8				2015	20
1.67	Access to Exercise Opportunities	percent	72.7		80.5	84	2020	6
	Children with Low Access to a Grocery							
1.67	Store	percent	6.6				2015	20
	Low-Income and Low Access to a Grocery							
1.67	Store	percent	9.8				2015	20
1.53	SNAP Certified Stores	stores/ 1,000 population	0.8				2017	20
1.50	Farmers Market Density	markets/ 1,000 population	0				2018	20
1.19	Food Environment Index		7.3		5.9	7.8	2021	6
	Households with No Car and Low Access to)						
1.17	a Grocery Store	percent	1.6				2015	20
1.03	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2016	20
SCORE	PREVENTION & SAFETY	UNITS	HOOD COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
	Age-Adjusted Death Rate due to							
2.06	Unintentional Injuries	deaths/ 100,000 population	53.6	43.2	38.7	48.9	2017-2019	4
1.56	Death Rate due to Drug Poisoning	deaths/ 100,000 population	15	-	10.6	21	2017-2019	6
	Severe Housing Problems	percent	13		17.4	18	2013-2017	6
SCORE	RESPIRATORY DISEASES	UNITS	HOOD COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
2.31	COPD: Medicare Population	percent	14		11.2	11.5	2018	5
2.14	COVID-19 Daily Average Incidence Rate	cases per 100,000 population	77.8		77.1	62.2	3-Sep-21	8
	Age-Adjusted Death Rate due to Lung							
1.94	Cancer	deaths/ 100,000 population	44.3	25.1	34.1	38.5	2013-2017	9
1.86	Asthma: Medicare Population	percent	4.9		4.9	5	2018	5
1.75	Adults with COPD	Percent of adults	8.5			6.9	2018	3
1.69	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	62.5		50.6	58.3	2013-2017	9
1.05	Adults who Smoke	percent	16	5	50.0	15.5	2013-2017	3
1.08	Adults with Current Asthma	percent	8.9			9.2	2018	3
1.00	Addits with current Astimu	percent	0.5			5.2	2010	
1.00	COVID-19 Daily Average Case-Fatality Rate	deaths per 100 cases	0.6		1.7	1	3-Sep-21	8
0.94	Tuberculosis Incidence Rate	cases/ 100,000 population	0.7	1.4	4.3	-	2015-2019	13
0.34	Age-Adjusted Death Rate due to Influenza		0.7	1.4	4.5		2015 2015	15
0.33	and Pneumonia	deaths/ 100,000 population	7.9		11.8	13.8	2017-2019	4
	-							
	SEXUALLY TRANSMITTED INFECTIONS	UNITS	HOOD COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
1.33	HIV Diagnosis Rate	cases/ 100,000 population	5		15.7		2018	13
1.06	Chlamydia Incidence Rate	cases/ 100,000 population	269.3		508.2	539.9	2018	13
0.94	Syphilis Incidence Rate	cases/ 100,000 population	1.7		8.8	10.8	2018	13
0.92	Gonorrhea Incidence Rate	cases/ 100,000 population	66.1		163.6	179.1	2018	13
SCORE	WELLNESS & LIFESTYLE	UNITS	HOOD COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
2.00	High Blood Pressure Prevalence	percent	39.8	27.7		32.4	2017	3
1.33	Frequent Physical Distress	percent	11.9		11.6	11	2018	6
1.25	Poor Physical Health: 14+ Days	percent	13.7			12.5	2018	3
1.03	Insufficient Sleep	percent	34.3	31.4	34.4	35	2018	6
SCORE		UNITS	HOOD COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
	WOMEN'S HEALTH			TF2030		7.6		Source 9
2.25	Cervical Cancer Incidence Rate	cases/ 100,000 females	12.7		9.2	7.6 125.9	2013-2017	9
1.81	Breast Cancer Incidence Rate	cases/ 100,000 females	120.9		112.8	125.9	2013-2017	9
1.75	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	19.7	15.3	19.8	20.1	2013-2017	9
1.75	ounder.		13.7	10.0	10.0	20.1	2015 2017	

1.44 Cerv	rvical Cancer Screening: 21-65	Percent	83.1	84.3	84.7	2018	3
1.44 Man	ammogram in Past 2 Years: 50-74	percent	70.3	77.1	74.8	2018	3

Johnson County

Health and Quality of Life Topics	Score
Women's Health	1.95
Older Adults	1.94
Other Conditions	1.94
Cancer	1.81
Heart Disease & Stroke	1.80
Diabetes	1.74
Respiratory Diseases	1.74
Mental Health & Mental Disorders	1.74
Health Care Access & Quality	1.73
Oral Health	1.66
Children's Health	1.53
Education	1.51
Physical Activity	1.50
Environmental Health	1.46
Wellness & Lifestyle	1.46
Community	1.40
Immunizations & Infectious Diseases	1.38
Maternal, Fetal & Infant Health	1.23
Alcohol & Drug Use	1.23
Sexually Transmitted Infections	1.21
Prevention & Safety	1.14
Economy	1.09

			JOHNSON					
SCORE	ALCOHOL & DRUG USE	UNITS	COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
1.92	Adults who Binge Drink	percent	17.7			16.4	2018	3
1.75	Age-Adjusted ER Rate due to Opioid Use	ER visits/ 10,000 population 18+ years	2.7		0.7		2017-2019	16
	Age-Adjusted Hospitalization Rate due to							
1.58	Substance Use	hospitalizations/ 10,000 population 18+ years	1.3		1.2		2017-2019	16
1.25	Age-Adjusted ER Rate due to Substance Use	ER visits/ 10,000 population 18+ years	15.3		20.6		2017-2019	16
1.22	Death Rate due to Drug Poisoning	deaths/ 100,000 population	11.1		10.6	21	2017-2019	6
	Age-Adjusted Drug and Opioid-Involved							
1.17	Overdose Death Rate	Deaths per 100,000 population	12.1		12.1	22.8	2017-2019	4
0.61	Liquor Store Density	stores/ 100,000 population	1.8		7	10.6	2017	18
0.33	Alcohol-Impaired Driving Deaths	percent of driving deaths with alcohol involvement	20.5	28.3	25.7	27	2015-2019	6

		JOHNSON					
SCORE CANCER	UNITS	COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
2.75 Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	27.5	15.3	19.8	20.1	2013-2017	9
2.31 All Cancer Incidence Rate	cases/ 100,000 population	463.3		407.7	448.7	2013-2017	9
2.25 Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	177.7	122.7	148.8	155.5	2013-2017	9
2.25 Cancer: Medicare Population	percent	7.8		7.6	8.4	2018	5
Age-Adjusted Death Rate due to Prostate							
2.14 Cancer	deaths/ 100,000 males	20.9	16.9	17.6	19	2013-2017	9
2.08 Breast Cancer Incidence Rate	cases/ 100,000 females	118.6		112.8	125.9	2013-2017	9
2.03 Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	68.4		50.6	58.3	2013-2017	9
2.00 Colon Cancer Screening	percent	59.6	74.4		66.4	2018	3
1.89 Cervical Cancer Incidence Rate	cases/ 100,000 females	8.4		9.2	7.6	2013-2017	9
1.83 Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	47.5	25.1	34.1	38.5	2013-2017	9
1.61 Mammogram in Past 2 Years: 50-74	percent	69.4	77.1		74.8	2018	3
1.61 Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	12.7		11	11.8	2013-2017	9
1.50 Prostate Cancer Incidence Rate	cases/ 100,000 males	98.6		94	104.5	2013-2017	9
1.44 Cervical Cancer Screening: 21-65	Percent	82.5	84.3		84.7	2018	3
Age-Adjusted Death Rate due to Colorectal							
1.17 Cancer	deaths/ 100,000 population	14	8.9	13.9	13.7	2013-2017	9
1.08 Adults with Cancer	percent	6.8			6.9	2018	3
0.75 Colorectal Cancer Incidence Rate	cases/ 100,000 population	37.4		37.6	38.4	2013-2017	9

			JOHNSON					
SCORE	CHILDREN'S HEALTH	UNITS	COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
2.06	Substantiated Child Abuse Rate	cases/ 1,000 children	12.3	8.7	9.1		2020	12
1.67	Children with Health Insurance	percent	85.7		87.3	94.3	2019	1
1.67	Children with Low Access to a Grocery Store	percent	6				2015	20
1.33	Child Food Insecurity Rate	percent	17.5		19.6	14.6	2019	7
1.25	Projected Child Food Insecurity Rate	percent	21.5		23.6		2021	7

.17	Assistance	percent	24		34	23	2019		7
ORF	COMMUNITY	UNITS	JOHNSON COUNTY		тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	So
	Mean Travel Time to Work	minutes	31.4		26.6	26.9	2015-2019		
	Solo Drivers with a Long Commute	percent	56.2		38.9	37	2015-2019		
	Workers who Drive Alone to Work	percent	87.7		80.5	76.3	2015-2019		
	Age-Adjusted Death Rate due to Motor Vehicle	percent	07.7		00.5	70.5	2010 2010		
31	Traffic Collisions	deaths/ 100,000 population	17.7	10.1	13	11.3	2017-2019		
	Social Associations	membership associations/ 10,000 population	7.4	10.1	7.5	9.3	2018		
			7.4		7.5	5.5	2010		
22	Workers Commuting by Public Transportation	percent	0.1	5.3	1.4	5	2015-2019	Black (0.9) White (0.1) Asian (0) AIAN (0) NHPI (0) Mult (0) Other (0) Hisp (0)	
	Substantiated Child Abuse Rate	cases/ 1,000 children	12.3	8.7	9.1		2013-2015		
	Median Household Gross Rent	dollars	1008	0.7	1045	1062	2015-2019		
		uonars	1008		1045	1002	2013-2019		
86	People 25+ with a Bachelor's Degree or Higher	percent	18.7		29.9	32.1	2015-2019		
	Persons with Health Insurance	percent	79.8	92.1	79.3	52.1	2015-2015		
7	Median Monthly Owner Costs for Households	percent	79.8	92.1	79.5		2019		
77		dollars	475		514	500	2015-2019		
	without a Mortgage	dollars	475		514	500	2015-2019		
	Mortgaged Owners Median Monthly Household	dollars	1384		1000	1505	2015 2010		
	Costs		58.8		1606 82.7	1595	2015-2019 2020		
57	Social Worker Rate	workers/ 100,000 population	58.8		82.7		2020		
	Households with No Car and Low Access to a	a successful	4.0				2015		
	Grocery Store	percent	1.8		64	50.0	2015		
	· · · · · · · · · · · · · · · · · · ·	percent	60.4		61	59.6	2015-2019		
	Per Capita Income	dollars	28579		31277	34103	2015-2019		
	Voter Turnout: Presidential Election	percent	62.8		58.8		2016		
17	Median Housing Unit Value	dollars	155400		172500	217500	2015-2019		
08	People 25+ with a High School Degree or Higher	percent	85.7		83.7	88	2015-2019		
	Persons with an Internet Subscription	percent	87.9		84.2	86.2	2015-2019		
)3	Linguistic Isolation	percent	2.7		7.7	4.4	2015-2019		
	Total Employment Change	percent	2.6		2.9	1.6	2018-2019		
92	Female Population 16+ in Civilian Labor Force	percent	56.4		57.8	58.3	2015-2019		
	Households with an Internet Subscription	percent	85.9		82.1	83	2015-2019		
	Households with One or More Types of	<i>μ</i> σ.							
	Computing Devices	percent	92.4		91	90.3	2015-2019		
	Children Living Below Poverty Level	percent	14.6		20.9	18.5	2015-2019	Black (16.6) White (11.3) Asian (3.8) AIAN (5) NHPI (0) Mult (6.6) Other (1.8) Hisp (22.7)	
	Median Household Income	dollars	64359		61874	62843	2015-2019		
12	Single-Parent Households	percent	22.6		26.3	25.5	2015-2019		
	Homeownership	percent	67.8		54.9	56.2	2015-2019		
33	Alcohol-Impaired Driving Deaths	percent of driving deaths with alcohol involvement	20.5	28.3	25.7	27	2015-2019		
55 17	People Living Below Poverty Level	percent of univing deaths with aconor involvement	10.2	8	14.7	13.4	2015-2019		
<u> </u>		ρειζεπ	10.2	0	14./	13.4	2013-2013		
			JOHNSON						
	DIABETES	UNITS		HP2030	тх	U.S.	MEASUREMENT PERIOD		S

1.	.97	Diabetes: Medicare Population	percent	29.1	28.8	27	2018	5
1.	.75	Age-Adjusted ER Rate due to Diabetes	ER visits/ 10,000 population 18+ years	46.7	9.4		2017-2019	16
1.	.75	Age-Adjusted ER Rate due to Type 2 Diabetes	ER visits/ 10,000 population 18+ years	40.9	8.6		2017-2019	16
		Age-Adjusted Hospitalization Rate due to						
1.	.75	Diabetes	hospitalizations/ 10,000 population 18+ years	27.4	5.3		2017-2019	16
		Age-Adjusted Hospitalization Rate due to Type						
1.	.75	2 Diabetes	hospitalizations/ 10,000 population 18+ years	19.7	4		2017-2019	16
1.	.47	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	21.7	22	21.5	2017-2019	4

			JOHNSON				
SCOR	E ECONOMY	UNITS	COUNTY HP2030	ΤХ	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
2.00	Median Household Gross Rent	dollars	1008	1045	1062	2015-2019	1
1.86	SNAP Certified Stores	stores/ 1,000 population	0.7			2017	20
	Median Monthly Owner Costs for Households						
1.72	without a Mortgage	dollars	475	514	500	2015-2019	1
1.69	Households with Cash Public Assistance Income	percent	2	1.4	2.4	2015-2019	1
	Mortgaged Owners Median Monthly Household						
1.67	Costs	dollars	1384	1606	1595	2015-2019	11
	Renters Spending 30% or More of Household						
1.64	Income on Rent	percent	45.3	47.8	49.6	2015-2019	1
	Low-Income and Low Access to a Grocery Store	percent	7.4			2015	20
1.50	WIC Certified Stores	stores/ 1,000 population	0.1			2016	20
	Overcrowded Households	percent of households	4	4.8		2015-2019	11
1.33	Child Food Insecurity Rate	percent	17.5	19.6	14.6	2019	7
1.33	Food Insecurity Rate	percent	12.9	14.1	10.9	2019	7
1.33	Students Eligible for the Free Lunch Program	percent	44			2019-2020	10
	Population 16+ in Civilian Labor Force	percent	60.4	61	59.6	2015-2019	1
1.25	Per Capita Income	dollars	28579	31277	34103	2015-2019	1
	Projected Child Food Insecurity Rate	percent	21.5	23.6		2021	7
1.25	Projected Food Insecurity Rate	percent	15.3	16.5		2021	7
	Food Insecure Children Likely Ineligible for						
-	Assistance	percent	24	34	23	2019	7
1.17	<u> </u>	dollars		172500		2015-2019	11
1.03	Total Employment Change	percent	2.6	2.9	1.6	2018-2019	18
	Households that are Above the Asset Limited,						
	Income Constrained, Employed (ALICE)						
1.00	Threshold	percent	65	56		2018	22
	Households that are Asset Limited, Income						
1.00	Constrained, Employed (ALICE)	percent	25.1	30		2018	22
	Households that are Below the Federal Poverty						
1.00	Level	percent	9.9	14		2018	22
	Female Population 16+ in Civilian Labor Force	percent	56.4	57.8	58.3	2015-2019	11
0.86	People Living 200% Above Poverty Level	percent	69.2	65.7	69.1	2015-2019	11

Unemployed Workers in Civilian Labor Force	percent	5.1	5.9	5.5	May-21		17
Severe Housing Problems	percent	12.3	17.4	18	2013-2017		6
Children Living Below Poverty Level	percent	14.6	20.9	18.5	2015-2019	Black (16.6) White (11.3) Asian (3.8) AIAN (5) NHPI (0) Mult (6.6) Other (1.8) Hisp (22.7)	1
Families Living Below Poverty Level	percent	7.6	11.3	9.5	2015-2019	Black (8.1) White (6.5) Asian (14.1) AIAN (8.8) NHPI (0) Mult (2.5) Other (4.9) Hisp (13)	1
Mortgaged Owners Spending 30% or More of							
Household Income on Housing	percent	20.7	26.5	26.5	2019		1
Median Household Income	dollars	64359	61874	62843	2015-2019		1
Homeownership	percent	67.8	54.9	56.2	2015-2019		1
People 65+ Living Below Poverty Level	percent	5.5	10.6	9.3	2015-2019	Black (10.1) White (5) Asian (13.3) AIAN (0) Mult (5.9) Other (0) Hisp (8.9)	1
Persons with Disability Living in Poverty (5-year)	percent	16.3	23.2	26.1	2015-2019		1
People Living Below Poverty Level	percent	10.2 8	3 14.7	13.4	2015-2019		1
	Unemployed Workers in Civilian Labor Force Severe Housing Problems Children Living Below Poverty Level Families Living Below Poverty Level Mortgaged Owners Spending 30% or More of Household Income on Housing Median Household Income Homeownership People 65+ Living Below Poverty Level Persons with Disability Living in Poverty (5-year) People Living Below Poverty Level	Severe Housing ProblemspercentChildren Living Below Poverty LevelpercentFamilies Living Below Poverty LevelpercentMortgaged Owners Spending 30% or More ofpercentHousehold Income on HousingpercentMedian Household IncomedollarsHomeownershippercentPeople 65+ Living Below Poverty LevelpercentPersons with Disability Living in Poverty (5-year)percent	Severe Housing Problemspercent12.3Children Living Below Poverty Levelpercent14.6Families Living Below Poverty Levelpercent7.6Mortgaged Owners Spending 30% or More ofHousehold Income on Housingpercent20.7Median Household Incomedollars64359Homeownershippercent67.8People 65+ Living Below Poverty Levelpercent5.5Persons with Disability Living in Poverty (5-year)percent16.3	Severe Housing Problemspercent12.317.4Children Living Below Poverty Levelpercent14.620.9Families Living Below Poverty Levelpercent7.611.3Mortgaged Owners Spending 30% or More of7.611.3Household Income on Housingpercent20.726.526.5Median Household Incomedollars6435961874Homeownershippercent67.854.9People 65+ Living Below Poverty Levelpercent5.510.6Persons with Disability Living in Poverty (5-year)percent16.323.2	Severe Housing Problemspercent12.317.418Children Living Below Poverty Levelpercent14.620.918.5Families Living Below Poverty Levelpercent7.611.39.5Mortgaged Owners Spending 30% or More of </td <td>Severe Housing Problems percent 12.3 17.4 18 2013-2017 Children Living Below Poverty Level percent 14.6 20.9 18.5 2015-2019 Families Living Below Poverty Level percent 7.6 11.3 9.5 2015-2019 Mortgaged Owners Spending 30% or More of 7.6 11.3 9.5 2015-2019 Mortgaged Owners Spending 30% or More of 20.7 26.5 26.5 2019 Median Household Income on Housing percent 64359 61874 62843 2015-2019 Homeownership percent 67.8 54.9 56.2 2015-2019 People 65+ Living Below Poverty Level percent 5.5 10.6 9.3 2015-2019 Persons with Disability Living in Poverty (5-year) percent 16.3 23.2 26.1 2015-2019</td> <td>Severe Housing Problemspercent12.317.4182013-2017Children Living Below Poverty Levelpercent14.620.918.52015-2019Black (16.6) White (11.3) Asian (3.8) AIAN (5) NHPI (0) Mult (6.6) Other (1.8) Hisp (22.7)Families Living Below Poverty Levelpercent7.611.39.52015-2019Black (8.1) White (6.5) Asian (14.1) AIAN (8.8) NHPI (0) Mult (2.5) Other (4.9) Hisp (13)Mortgaged Owners Spending 30% or More of<!--</td--></td>	Severe Housing Problems percent 12.3 17.4 18 2013-2017 Children Living Below Poverty Level percent 14.6 20.9 18.5 2015-2019 Families Living Below Poverty Level percent 7.6 11.3 9.5 2015-2019 Mortgaged Owners Spending 30% or More of 7.6 11.3 9.5 2015-2019 Mortgaged Owners Spending 30% or More of 20.7 26.5 26.5 2019 Median Household Income on Housing percent 64359 61874 62843 2015-2019 Homeownership percent 67.8 54.9 56.2 2015-2019 People 65+ Living Below Poverty Level percent 5.5 10.6 9.3 2015-2019 Persons with Disability Living in Poverty (5-year) percent 16.3 23.2 26.1 2015-2019	Severe Housing Problemspercent12.317.4182013-2017Children Living Below Poverty Levelpercent14.620.918.52015-2019Black (16.6) White (11.3) Asian (3.8) AIAN (5) NHPI (0) Mult (6.6) Other (1.8) Hisp (22.7)Families Living Below Poverty Levelpercent7.611.39.52015-2019Black (8.1) White (6.5) Asian (14.1) AIAN (8.8) NHPI (0) Mult (2.5) Other (4.9) Hisp (13)Mortgaged Owners Spending 30% or More of </td

			JOHNSON					
SCO	RE EDUCATION	UNITS	COUNTY HP203	30 TX	U.S.	MEASUREMENT PERIOD HIGH DISPA	NRITY*	Source
2.2	15 High School Drop Out Rate	percent	4	1.9		2019		14
1.8	People 25+ with a Bachelor's Degree or Higher	percent	18.7	29.9	32.1	2015-2019		1
1.6	9 Student-to-Teacher Ratio	students/ teacher	14.6			2019-2020		10
1.0	People 25+ with a High School Degree or Higher	percent	85.7	83.7	88	2015-2019		1
	Infants Born to Mothers with <12 Years							
0.6	7 Education	percent	13.7	17.4	13.3	2017	White (8.3) Other (13.9) Hisp (26.7)	13

			JOHNSON				
SCORE	ENVIRONMENTAL HEALTH	UNITS	COUNTY HP203	D TX	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
2.36	Asthma: Medicare Population	percent	6	4.9	5	2018	5
1.86	SNAP Certified Stores	stores/ 1,000 population	0.7			2017	20
1.83	Access to Exercise Opportunities	percent	70.6	80.5	84	2020	6
1.83	Grocery Store Density	stores/ 1,000 population	0.1			2016	20
1.81	Fast Food Restaurant Density	restaurants/ 1,000 population	0.7			2016	20
1.75	Annual Ozone Air Quality	Grade	F			2017-2019	2
1.67	Children with Low Access to a Grocery Store	percent	6			2015	20
1.64	Number of Extreme Precipitation Days	days	48			2016	11
1.64	PBT Released	pounds	2900.1			2019	21
1.64	Recognized Carcinogens Released into Air	pounds	51098.5			2019	21
1.58	Adults with Current Asthma	percent	9.3		9.2	2018	3
1.50	Low-Income and Low Access to a Grocery Store	percent	7.4			2015	20
1.50	People with Low Access to a Grocery Store	percent	22.2			2015	20
1.50	WIC Certified Stores	stores/ 1,000 population	0.1			2016	20
1.47	Overcrowded Households	percent of households	4	4.8		2015-2019	1
1.36	Number of Extreme Heat Events	events	1			2016	11
1.33	Farmers Market Density	markets/ 1,000 population	0			2018	20
	Households with No Car and Low Access to a						
1.33	Grocery Store	percent	1.8			2015	20

1	.33	People 65+ with Low Access to a Grocery Store	percent	2.6			2015	20
1	.19	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1			2016	20
1	.17	Daily Dose of UV Irradiance	Joule per square meter	3360	3538		2015	11
1	.08	Number of Extreme Heat Days	days	3			2016	11
0	.86	Food Environment Index		7.6	5.9	7.8	2021	6
0	.69	Severe Housing Problems	percent	12.3	17.4	18	2013-2017	6
0	.61	Liquor Store Density	stores/ 100,000 population	1.8	7	10.6	2017	18

			JOHNSON					
SCORI	HEALTH CARE ACCESS & QUALITY	UNITS	COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
2.08	Adults who have had a Routine Checkup	percent	71.9			76.7	2018	3
2.08	Adults who Visited a Dentist	percent	53.6			66.5	2018	3
1.92	Adults without Health Insurance	percent	24.8			12.2	2018	3
1.89	Primary Care Provider Rate	providers/ 100,000 population	43.8		60.9		2018	6
1.81	Persons with Health Insurance	percent	79.8	92.1	79.3		2019	19
1.67	Adults with Health Insurance	percent	75.5		75.5	87.1	2019	1
1.67	Children with Health Insurance	percent	85.7		87.3	94.3	2019	1
1.67	Social Worker Rate	workers/ 100,000 population	58.8		82.7		2020	13
1.61	Dentist Rate	dentists/ 100,000 population	39.3		59.6		2019	6
1.33	Mental Health Provider Rate	providers/ 100,000 population	76.2		120.9		2020	6
1.33	Non-Physician Primary Care Provider Rate	providers/ 100,000 population	58.6		88.6		2020	6

			JOHNSON					
SCORE	HEART DISEASE & STROKE	UNITS	COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
2.47	Hyperlipidemia: Medicare Population	percent	52.7		49.5	47.7	2018	5
2.42	Age-Adjusted Death Rate due to Heart Attack	deaths/ 100,000 population 35+ years	176.7		70.1		2018	11
2.25	Hypertension: Medicare Population	percent	62.9		59.9	57.2	2018	5
	Age-Adjusted Death Rate due to Coronary Heart							
	Disease	deaths/ 100,000 population	107.5	71.1	93	90.5	2017-2019	4
2.14	Atrial Fibrillation: Medicare Population	percent	8.8		7.8	8.4	2018	5
	Age-Adjusted Death Rate due to							
	Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	46.6	33.4	40.2	37.2	2017-2019	4
2.03	Stroke: Medicare Population	percent	4.3		4.2	3.8	2018	5
	Adults who Have Taken Medications for High							
1.92	Blood Pressure	percent	74.3			75.8	2017	3
	Heart Failure: Medicare Population	percent	17.1		15.6	14	2018	5
1.75	Age-Adjusted ER Rate due to Hypertension	ER visits/ 10,000 population 18+ years	41		10.5		2017-2019	16
	Age-Adjusted Hospitalization Rate due to							
1.75	Hypertension	hospitalizations/ 10,000 population 18+ years	0.3		0.1		2016-2018	16
1.58	Cholesterol Test History	percent	80			81.5	2017	3
1.50	High Blood Pressure Prevalence	percent	35.3	27.7		32.4	2017	3
	Ischemic Heart Disease: Medicare Population	percent	28.9		29	26.8	2018	5
1.25	High Cholesterol Prevalence: Adults 18+	percent	35.8			34.1	2017	3
	Adults who Experienced Coronary Heart							
1.08	Disease	percent	7.2			6.8	2018	3

0.92	Adults who Experienced a Stroke	percent	3.4			3.4	2018	3
			JOHNSON					
SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	COUNTY	HP2030	ΤХ	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
	Age-Adjusted Hospitalization Rate due to							
	Immunization-Preventable Pneumonia and							
1.75	Influenza	hospitalizations/ 10,000 population 18+ years	0.4		0.1		2017-2019	16
	Age-Adjusted Death Rate due to Influenza and							
1.58	Pneumonia	deaths/ 100,000 population	13.4		11.8	13.8	2017-2019	4
1.50	Tuberculosis Incidence Rate	cases/ 100,000 population	1.5	1.4	4.3		2015-2019	13
1.47	HIV Diagnosis Rate	cases/ 100,000 population	9.3		15.7		2018	13
1.47	Overcrowded Households	percent of households	4		4.8		2015-2019	1
1.33	COVID-19 Daily Average Case-Fatality Rate	deaths per 100 cases	0.9		1.7	1	3-Sep-21	8
1.31	COVID-19 Daily Average Incidence Rate	cases per 100,000 population	60.6		77.1	62.2	3-Sep-21	8
1.22	Gonorrhea Incidence Rate	cases/ 100,000 population	101		163.6	179.1	2018	13
1.22	Syphilis Incidence Rate	cases/ 100,000 population	2.3		8.8	10.8	2018	13
0.92	Chlamydia Incidence Rate	cases/ 100,000 population	322.1		508.2	539.9	2018	13

			JOHNSON						
SCOR	E MATERNAL, FETAL & INFANT HEALTH	UNITS	COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*		Source
2.33	Mothers who Received Early Prenatal Care	percent	59.5		60.5	77.3	2017		13
1.50	Infant Mortality Rate	deaths/ 1,000 live births	5.7	5	5.6	5.9	2015		13
1.25	Babies with Very Low Birth Weight	percent	0.7			1.4	2015	Black (0) White (0.78740157)	13
1.03	Preterm Births	percent	10.1	9.4	12.2		2017		13
0.94	Teen Births	percent	1.8		2.1	3.1	2017	Black (0) White (1.6) Other (0) Hisp (2.5)	13
0.92	Babies with Low Birth Weight	percent	5.9		8.2	8.1	2015		13
	Infants Born to Mothers with <12 Years								
0.67	Education	percent	13.7		17.4	13.3	2017	White (8.3) Other (13.9) Hisp (26.7)	13

			JOHNSON						
SCORI	MENTAL HEALTH & MENTAL DISORDERS	UNITS	COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD HIC	IGH DISPARITY*	Source
2.64	Depression: Medicare Population	percent	22.6		18.2	18.4	2018		5
	Alzheimer's Disease or Dementia: Medicare								
2.03	Population	percent	13.3		12.6	10.8	2018		5
1.97	Age-Adjusted Death Rate due to Suicide	deaths/ 100,000 population	15.5	12.8	13.5	14.1	2017-2019		4
1.83	Frequent Mental Distress	percent	14.4		11.6	13	2018		6
1.58	Poor Mental Health: 14+ Days	percent	14.2			12.7	2018		3
1.33	Mental Health Provider Rate	providers/ 100,000 population	76.2		120.9		2020		6
	Age-Adjusted ER Rate due to Adult Mental								
1.25	Health	ER visits/ 10,000 population 18+ years	5.1		8.9		2017-2019		16
	Age-Adjusted Hospitalization Rate due to Adult								
1.25	Mental Health	hospitalizations/ 10,000 population 18+ years	0.9		1.7		2017-2019		16

		JOHNSON				
SCORE OLDER ADULTS	UNITS	COUNTY HP20	030 TX I	J.S. MEASURE	MENT PERIOD HIGH DISPARITY*	Source
2.75 Chronic Kidney Disease: Medicare Population	percent	28.9	26.7 2	24.5	2018	5
2.64 Depression: Medicare Population	percent	22.6	18.2 1	18.4	2018	5

2.47	Hyperlipidemia: Medicare Population	percent	52.7	49.5	47.7	2018		5
	Rheumatoid Arthritis or Osteoarthritis:							
2.47	Medicare Population	percent	37.9	34.2	33.5	2018		5
2.36	Asthma: Medicare Population	percent	6	4.9	5	2018		5
2.31	Osteoporosis: Medicare Population	percent	7	6.8	6.6	2018		5
2.25	Cancer: Medicare Population	percent	7.8	7.6	8.4	2018		5
2.25	Hypertension: Medicare Population	percent	62.9	59.9	57.2	2018		5
2.17	COPD: Medicare Population	percent	14.4	11.2	11.5	2018		5
2.14	Atrial Fibrillation: Medicare Population	percent	8.8	7.8	8.4	2018		5
	Alzheimer's Disease or Dementia: Medicare							
2.03	Population	percent	13.3	12.6	10.8	2018		5
2.03	Stroke: Medicare Population	percent	4.3	4.2	3.8	2018		5
2.00	Colon Cancer Screening	percent	59.6	74.4	66.4	2018		3
1.97	Diabetes: Medicare Population	percent	29.1	28.8	27	2018		5
1.86	Heart Failure: Medicare Population	percent	17.1	15.6	14	2018		5
	Adults 65+ who Received Recommended							
1.75	Preventive Services: Females	percent	25		28.4	2018		3
	Adults 65+ who Received Recommended							
1.75	Preventive Services: Males	percent	25.2		32.4	2018		3
1.36	Ischemic Heart Disease: Medicare Population	percent	28.9	29	26.8	2018		5
1.33	People 65+ with Low Access to a Grocery Store	percent	2.6			2015		20
1.25	Adults 65+ with Total Tooth Loss	percent	14.6		13.5	2018		3
1.25	Adults with Arthritis	percent	26.5		25.8	2018		3
0.36	People 65+ Living Below Poverty Level	percent	5.5	10.6	9.3	2015-2019	Black (10.1) White (5) Asian (13.3) AIAN (0) Mult (5.9) Other (0) Hisp (8.9)	1

			JOHNSON				
SCORE	ORAL HEALTH	UNITS	COUNTY HP2030	ТХ	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
2.08	Adults who Visited a Dentist	percent	53.6		66.5	2018	3
1.75	Age-Adjusted ER Rate due to Dental Problems	ER visits/ 10,000 population	87.9	11.1		2017-2019	16
1.61	Dentist Rate	dentists/ 100,000 population	39.3	59.6		2019	6
1.61	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	12.7	11	11.8	2013-2017	9
1.25	Adults 65+ with Total Tooth Loss	percent	14.6		13.5	2018	3

			JOHNSON				
SCC	RE OTHER CONDITIONS	UNITS	COUNTY HP2	030 TX	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
2.7	5 Chronic Kidney Disease: Medicare Population	percent	28.9	26.7	24.5	2018	5
	Rheumatoid Arthritis or Osteoarthritis:						
2.4	7 Medicare Population	percent	37.9	34.2	33.5	2018	5
2.3	1 Osteoporosis: Medicare Population	percent	7	6.8	6.6	2018	5
1.2	5 Adults with Arthritis	percent	26.5		25.8	2018	3
0.9	2 Adults with Kidney Disease	Percent of adults	3		3.1	2018	3

			JOHNSON				
SCOR	PHYSICAL ACTIVITY	UNITS	COUNTY H	P2030 TX	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
1.86	SNAP Certified Stores	stores/ 1,000 population	0.7			2017	20
1.83	Access to Exercise Opportunities	percent	70.6	80.5	84	2020	6
1.83	Grocery Store Density	stores/ 1,000 population	0.1			2016	20
1.81	Fast Food Restaurant Density	restaurants/ 1,000 population	0.7			2016	20
1.67	Children with Low Access to a Grocery Store	percent	6			2015	20
1.50	Low-Income and Low Access to a Grocery Store	percent	7.4			2015	20
1.50	People with Low Access to a Grocery Store	percent	22.2			2015	20
1.50	WIC Certified Stores	stores/ 1,000 population	0.1			2016	20
1.33	Farmers Market Density	markets/ 1,000 population	0			2018	20
	Households with No Car and Low Access to a						
1.33	Grocery Store	percent	1.8			2015	20
1.33	People 65+ with Low Access to a Grocery Store	percent	2.6			2015	20
1.19	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1			2016	20
0.86	Food Environment Index		7.6	5.9	7.8	2021	6
			JOHNSON				

			JOHNSON					
SCORE	PREVENTION & SAFETY	UNITS	COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
	Age-Adjusted Death Rate due to Unintentional							
1.50	Injuries	deaths/ 100,000 population	46.1	43.2	38.7	48.9	2017-2019	4
1.22	Death Rate due to Drug Poisoning	deaths/ 100,000 population	11.1		10.6	21	2017-2019	6
0.69	Severe Housing Problems	percent	12.3		17.4	18	2013-2017	6

			JOHNSON					
SCOF	E RESPIRATORY DISEASES	UNITS	COUNTY	HP2030	ΤХ	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
2.36	Asthma: Medicare Population	percent	6		4.9	5	2018	5
2.17	COPD: Medicare Population	percent	14.4		11.2	11.5	2018	5
2.03	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	68.4		50.6	58.3	2013-2017	9
1.83	Adults who Smoke	percent	19	5		15.5	2018	3
1.07	Ass. Adjusted Death Data due to Luna Concern		47 5	25.4	24.1	20 5	2012 2017	0
1.83		deaths/ 100,000 population	47.5	25.1	34.1	38.5	2013-2017	9
	Age-Adjusted Hospitalization Rate due to							
	Immunization-Preventable Pneumonia and							
1.75	Influenza	hospitalizations/ 10,000 population 18+ years	0.4		0.1		2017-2019	16
1.58	Adults with COPD	Percent of adults	7.7			6.9	2018	3
1.58	Adults with Current Asthma	percent	9.3			9.2	2018	3
	Age-Adjusted Death Rate due to Influenza and							
1.58	Pneumonia	deaths/ 100,000 population	13.4		11.8	13.8	2017-2019	4
1.50	Tuberculosis Incidence Rate	cases/ 100,000 population	1.5	1.4	4.3		2015-2019	13
1.33	COVID-19 Daily Average Case-Fatality Rate	deaths per 100 cases	0.9		1.7	1	3-Sep-21	8
1.31	COVID-19 Daily Average Incidence Rate	cases per 100,000 population	60.6		77.1	62.2	3-Sep-21	8
			JOHNSON					
SCOF	E SEXUALLY TRANSMITTED INFECTIONS	UNITS	COUNTY		ΤХ	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source

1.47	HIV Diagnosis Rate	cases/ 100,000 population	9.3	15.7	2018	13
1.22	Gonorrhea Incidence Rate	cases/ 100,000 population	101	163.6 179.1	2018	13
1.22	Syphilis Incidence Rate	cases/ 100,000 population	2.3	8.8 10.8	2018	13
0.92	Chlamydia Incidence Rate	cases/ 100,000 population	322.1	508.2 539.9	2018	13

			JOHNSON					
SCORE	WELLNESS & LIFESTYLE	UNITS	COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD HIGH DISPARITY*	Source
1.67	Frequent Physical Distress	percent	12.8		11.6	11	2018	6
1.50	High Blood Pressure Prevalence	percent	35.3	27.7		32.4	2017	3
1.42	Insufficient Sleep	percent	35.5	31.4	34.4	35	2018	6
1.25	Poor Physical Health: 14+ Days	percent	13.4			12.5	2018	3

		JOHNSON						
SCORE WOMEN'S HEALTH	UNITS	COUNTY	HP2030	ТΧ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.75 Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	27.5	15.3	19.8	20.1	2013-2017		9
2.08 Breast Cancer Incidence Rate	cases/ 100,000 females	118.6		112.8	125.9	2013-2017		9
1.89 Cervical Cancer Incidence Rate	cases/ 100,000 females	8.4		9.2	7.6	2013-2017		9
1.61 Mammogram in Past 2 Years: 50-74	percent	69.4	77.1		74.8	2018		3
1.44 Cervical Cancer Screening: 21-65	Percent	82.5	84.3		84.7	2018		3

Kaufman County

Health and Quality of Life Topics	Score
Cancer	1.87
Oral Health	1.86
Women's Health	1.79
Mental Health & Mental Disorders	1.78
Respiratory Diseases	1.76
Health Care Access & Quality	1.66
Children's Health	1.64
Older Adults	1.61
Diabetes	1.6
Heart Disease & Stroke	1.6
Immunizations & Infectious Diseases	1.56
Alcohol & Drug Use	1.54
Community	1.43
Wellness & Lifestyle	1.42
Physical Activity	1.41
Prevention & Safety	1.38
Environmental Health	1.34
Sexually Transmitted Infections	1.32
Education	1.3
Other Conditions	1.29
Economy	1.28
Maternal, Fetal & Infant Health	1.26

			KAUFMAN				MEASUREMENT	HIGH	
SCORE	ALCOHOL & DRUG USE	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
1.92	Adults who Binge Drink	percent	17.6			16.4	2018		3
		percent of driving deaths with							
1.78	Alcohol-Impaired Driving Deaths	alcohol involvement	29.6	28.3	25.7	27	2015-2019		6
		ER visits/ 10,000 population							
1.75	Age-Adjusted ER Rate due to Opioid Use	18+ years	2.1		0.7		2017-2019		16
1.56	Death Rate due to Drug Poisoning	deaths/ 100,000 population	14.7		10.6	21	2017-2019		6
	Age-Adjusted Drug and Opioid-Involved	Deaths per 100,000							
1.50	Overdose Death Rate	population	15.3		12.1	22.8	2017-2019		4
1.28	Liquor Store Density	stores/ 100,000 population	8.1		6.9	10.5	2019		18
	Age-Adjusted ER Rate due to Substance	ER visits/ 10,000 population							
1.25	Use	18+ years	11		20.6		2017-2019		16
	Age-Adjusted Hospitalization Rate due to	hospitalizations/ 10,000							
1.25	Substance Use	population 18+ years	0.7		1.1		2017-2019		16
			KAUFMAN				MEASUREMENT	HIGH	
SCORE	CANCER	UNITS	KAUFMAN COUNTY	HP2030	Texas	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Oral Cavity and Pharynx Cancer Incidence		COUNTY	HP2030			PERIOD		
2.67	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	COUNTY 17.4	HP2030	11	11.8	PERIOD 2013-2017		9
	Oral Cavity and Pharynx Cancer Incidence		COUNTY	HP2030			PERIOD		
2.67 2.58	Oral Cavity and Pharynx Cancer Incidence Rate Breast Cancer Incidence Rate	cases/ 100,000 population cases/ 100,000 females	COUNTY 17.4 131.5		11 112.8	11.8 125.9	PERIOD 2013-2017 2013-2017		9 9
2.67	Oral Cavity and Pharynx Cancer Incidence Rate Breast Cancer Incidence Rate Age-Adjusted Death Rate due to Cancer	cases/ 100,000 population	COUNTY 17.4	HP2030 122.7	11	11.8	PERIOD 2013-2017		9
2.67 2.58 2.56	Oral Cavity and Pharynx Cancer Incidence Rate Breast Cancer Incidence Rate Age-Adjusted Death Rate due to Cancer Age-Adjusted Death Rate due to Lung	cases/ 100,000 population cases/ 100,000 females deaths/ 100,000 population	COUNTY 17.4 131.5 182.1	122.7	11 112.8 148.8	11.8 125.9 155.5	PERIOD 2013-2017 2013-2017 2013-2017		9 9 9
2.67 2.58 2.56 2.42	Oral Cavity and Pharynx Cancer Incidence Rate Breast Cancer Incidence Rate Age-Adjusted Death Rate due to Cancer Age-Adjusted Death Rate due to Lung Cancer	cases/ 100,000 population cases/ 100,000 females deaths/ 100,000 population deaths/ 100,000 population	COUNTY 17.4 131.5 182.1 51.6		11 112.8 148.8 34.1	11.8 125.9 155.5 38.5	PERIOD 2013-2017 2013-2017 2013-2017 2013-2017		9 9 9 9
2.67 2.58 2.56	Oral Cavity and Pharynx Cancer Incidence Rate Breast Cancer Incidence Rate Age-Adjusted Death Rate due to Cancer Age-Adjusted Death Rate due to Lung	cases/ 100,000 population cases/ 100,000 females deaths/ 100,000 population	COUNTY 17.4 131.5 182.1	122.7	11 112.8 148.8	11.8 125.9 155.5	PERIOD 2013-2017 2013-2017 2013-2017		9 9 9
2.67 2.58 2.56 2.42 2.31	Oral Cavity and Pharynx Cancer Incidence Rate Breast Cancer Incidence Rate Age-Adjusted Death Rate due to Cancer Age-Adjusted Death Rate due to Lung Cancer All Cancer Incidence Rate	cases/ 100,000 population cases/ 100,000 females deaths/ 100,000 population deaths/ 100,000 population cases/ 100,000 population	COUNTY 17.4 131.5 182.1 51.6 465.2	122.7	11 112.8 148.8 34.1 407.7	11.8 125.9 155.5 38.5 448.7	PERIOD 2013-2017 2013-2017 2013-2017 2013-2017 2013-2017 2013-2017		9 9 9 9 9 9
2.67 2.58 2.56 2.42	Oral Cavity and Pharynx Cancer Incidence Rate Breast Cancer Incidence Rate Age-Adjusted Death Rate due to Cancer Age-Adjusted Death Rate due to Lung Cancer All Cancer Incidence Rate Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population cases/ 100,000 females deaths/ 100,000 population deaths/ 100,000 population	COUNTY 17.4 131.5 182.1 51.6	122.7	11 112.8 148.8 34.1	11.8 125.9 155.5 38.5	PERIOD 2013-2017 2013-2017 2013-2017 2013-2017		9 9 9 9
2.67 2.58 2.56 2.42 2.31 2.19	Oral Cavity and Pharynx Cancer Incidence Rate Breast Cancer Incidence Rate Age-Adjusted Death Rate due to Cancer Age-Adjusted Death Rate due to Lung Cancer All Cancer Incidence Rate Lung and Bronchus Cancer Incidence Rate Age-Adjusted Death Rate due to Colorectal	cases/ 100,000 population cases/ 100,000 females deaths/ 100,000 population deaths/ 100,000 population cases/ 100,000 population cases/ 100,000 population	COUNTY 17.4 131.5 182.1 51.6 465.2 74.5	122.7 25.1	11 112.8 148.8 34.1 407.7 50.6	11.8 125.9 155.5 38.5 448.7 58.3	PERIOD 2013-2017 2013-2017 2013-2017 2013-2017 2013-2017 2013-2017 2013-2017		9 9 9 9 9 9
2.67 2.58 2.56 2.42 2.31	Oral Cavity and Pharynx Cancer Incidence Rate Breast Cancer Incidence Rate Age-Adjusted Death Rate due to Cancer Age-Adjusted Death Rate due to Lung Cancer All Cancer Incidence Rate Lung and Bronchus Cancer Incidence Rate Age-Adjusted Death Rate due to Colorectal Cancer	cases/ 100,000 population cases/ 100,000 females deaths/ 100,000 population deaths/ 100,000 population cases/ 100,000 population	COUNTY 17.4 131.5 182.1 51.6 465.2	122.7	11 112.8 148.8 34.1 407.7	11.8 125.9 155.5 38.5 448.7	PERIOD 2013-2017 2013-2017 2013-2017 2013-2017 2013-2017 2013-2017		9 9 9 9 9 9
2.67 2.58 2.56 2.42 2.31 2.19	Oral Cavity and Pharynx Cancer Incidence Rate Breast Cancer Incidence Rate Age-Adjusted Death Rate due to Cancer Age-Adjusted Death Rate due to Lung Cancer All Cancer Incidence Rate Lung and Bronchus Cancer Incidence Rate Age-Adjusted Death Rate due to Colorectal	cases/ 100,000 population cases/ 100,000 females deaths/ 100,000 population deaths/ 100,000 population cases/ 100,000 population cases/ 100,000 population	COUNTY 17.4 131.5 182.1 51.6 465.2 74.5	122.7 25.1	11 112.8 148.8 34.1 407.7 50.6	11.8 125.9 155.5 38.5 448.7 58.3	PERIOD 2013-2017 2013-2017 2013-2017 2013-2017 2013-2017 2013-2017 2013-2017		9 9 9 9 9 9

1.83	Colon Cancer Screening	percent	60.1	74.4		66.4	2018		3
1.81	Colorectal Cancer Incidence Rate	cases/ 100,000 population	41.3		37.6	38.4	2013-2017		9
1.78	Cervical Cancer Incidence Rate	cases/ 100,000 females	9.4		9.2	7.6	2013-2017		9
1.61	Mammogram in Past 2 Years: 50-74	percent	69.4	77.1		74.8	2018		3
	Age-Adjusted Death Rate due to Breast								
1.53	Cancer	deaths/ 100,000 females	20.7	15.3	19.8	20.1	2013-2017		9
1.44	Cervical Cancer Screening: 21-65	Percent	83.1	84.3		84.7	2018		3
1.08	Adults with Cancer	percent	6.3			6.9	2018		3
1.03	Cancer: Medicare Population	percent	7.3		7.6	8.4	2018		5
								Black (169.6)	
	Ducatata Canada Indialanan Data	cases/ 100,000 males	89.3		94	104.5	2013-2017	White (87)	9
0.86	Prostate Cancer Incidence Rate	cuses/ 100,000 males	09.5		<u> </u>	104.5	2013 2017	W inte (07)	
0.86	Prostate Cancer Incidence Rate				54	104.5			
0.86	Prostate Cancer Incidence Rate		KAUFMAN			104.5	MEASUREMENT	HIGH	
0.86 SCORE	CHILDREN'S HEALTH	UNITS		HP2030	Texas	U.S.			
			KAUFMAN	HP2030			MEASUREMENT	HIGH	
	CHILDREN'S HEALTH		KAUFMAN	HP2030			MEASUREMENT	HIGH	
SCORE	CHILDREN'S HEALTH Food Insecure Children Likely Ineligible for	UNITS	KAUFMAN COUNTY	HP2030 8.7	Texas	U.S.	MEASUREMENT PERIOD	HIGH	Source
SCORE	CHILDREN'S HEALTH Food Insecure Children Likely Ineligible for Assistance	UNITS	KAUFMAN COUNTY 40		Texas 34	U.S.	MEASUREMENT PERIOD 2019	HIGH	Source 7
SCORE 2.50 1.89	CHILDREN'S HEALTH Food Insecure Children Likely Ineligible for Assistance Substantiated Child Abuse Rate	UNITS percent cases/ 1,000 children	KAUFMAN COUNTY 40 12		Texas 34 9.1	U.S. 23	MEASUREMENT PERIOD 2019 2020	HIGH	Source 7 12
SCORE 2.50 1.89 1.50	CHILDREN'S HEALTH Food Insecure Children Likely Ineligible for Assistance Substantiated Child Abuse Rate Child Food Insecurity Rate	UNITS percent cases/ 1,000 children percent	KAUFMAN COUNTY 40 12 18		Texas 34 9.1 19.6	U.S. 23 14.6	MEASUREMENT PERIOD 2019 2020 2019	HIGH	Source 7 12 7
SCORE 2.50 1.89 1.50 1.50	CHILDREN'S HEALTH Food Insecure Children Likely Ineligible for Assistance Substantiated Child Abuse Rate Child Food Insecurity Rate Children with Health Insurance	UNITS percent cases/ 1,000 children percent percent	KAUFMAN COUNTY 40 12 18 90.2		Texas 34 9.1 19.6 87.3	U.S. 23 14.6	MEASUREMENT PERIOD 2019 2020 2019 2019 2019	HIGH	Source 7 12 7 1

			KAUFMAN			MEASUREMENT	HIGH	
SCORE	COMMUNITY	UNITS	COUNTY HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
2.92	Mean Travel Time to Work	minutes	36.9	26.6	26.9	2015-2019		1
2.92	Solo Drivers with a Long Commute	percent	58.7	38.9	37	2015-2019		6
	Median Monthly Owner Costs for							
2.50	Households without a Mortgage	dollars	558	514	500	2015-2019		1
	Mortgaged Owners Median Monthly							
2.33	Household Costs	dollars	1656	1606	1595	2015-2019		1

								Black (0.2)	
								White (0.1)	
								Asian (0) AIAN	
								(1.2) NHPI (0)	
	Workers Commuting by Public							Mult (0) Other	
2.22	Transportation	percent	0.2	5.3	1.4	5	2015-2019	(0) Hisp (0.2)	1
	Age-Adjusted Death Rate due to Motor								
2.03	Vehicle Traffic Collisions	deaths/ 100,000 population	18.6	10.1	13	11.3	2017-2019		4
2.00	Median Household Gross Rent	dollars	1044		1045	1062	2015-2019		1
1.89	Substantiated Child Abuse Rate	cases/ 1,000 children	12	8.7	9.1		2020		12
		membership associations/							
1.86	Social Associations	10,000 population	7.9		7.5	9.3	2018		6
		percent of driving deaths with							
1.78	Alcohol-Impaired Driving Deaths	alcohol involvement	29.6	28.3	25.7	27	2015-2019		6
	People 25+ with a Bachelor's Degree or								
1.69	Higher	percent	20.5		29.9	32.1	2015-2019		1
1.69	Workers who Drive Alone to Work	percent	81.9		80.5	76.3	2015-2019		1
1.47	Total Employment Change	percent	2.3		2.9	1.6	2018-2019		18
1.44	Persons with Health Insurance	percent	82.9	92.1	79.3		2019		19
1.42	Persons with an Internet Subscription	percent	83.8		84.2	86.2	2015-2019		1
	People 25+ with a High School Degree or								
1.36	Higher	percent	85.8		83.7	88	2015-2019		1
1.33	Households with an Internet Subscription	percent	81.4		82.1	83	2015-2019		1
	Households with No Car and Low Access to								
1.33	a Grocery Store	percent	2				2015		20
1.25	Per Capita Income	dollars	28634		31277	34103	2015-2019		1
1.19	Social Worker Rate	workers/ 100,000 population	75.9		82.7		2020		13
1.19	Voter Turnout: Presidential Election	percent	61		58.8		2016		15
1.03	Linguistic Isolation	percent	2.5		7.7	4.4	2015-2019		1
1.00	Median Housing Unit Value	dollars	178300		172500	217500	2015-2019		1
0.97	Population 16+ in Civilian Labor Force	percent	63		61	59.6	2015-2019		1

	Households with One or More Types of								
0.83	Computing Devices	percent	91.5		91	90.3	2015-2019		1
0.69	Single-Parent Households	percent	22.5		26.3	25.5	2015-2019		1
0.61	People Living Below Poverty Level	percent	11.4	8	14.7	13.4	2015-2019		1
								Black (27.9)	
								White (6.7)	
								Asian (4.4)	
								AIAN (29.2)	
								Mult (0.8)	
								Other (32.3)	
0.53	Children Living Below Poverty Level	percent	14.4		20.9	18.5	2015-2019	Hisp (24.1)	1
	Female Population 16+ in Civilian Labor								
0.42	Force	percent	60.6		57.8	58.3	2015-2019		1
0.36	Homeownership	percent	70.3		54.9	56.2	2015-2019		1
0.08	Median Household Income	dollars	70107		61874	62843	2015-2019		1

			KAUFMAN				MEASUREMENT	HIGH	
SCORE	DIABETES	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
		ER visits/ 10,000 population							
1.75	Age-Adjusted ER Rate due to Diabetes	18+ years	29.8		9.4		2017-2019		16
	Age-Adjusted ER Rate due to Type 2	ER visits/ 10,000 population							
1.75	Diabetes	18+ years	26.1		8.6		2017-2019		16
	Age-Adjusted Hospitalization Rate due to	hospitalizations/ 10,000							
1.75	Diabetes	population 18+ years	17.7		5.3		2017-2019		16
	Age-Adjusted Hospitalization Rate due to	hospitalizations/ 10,000							
1.75	Type 2 Diabetes	population 18+ years	12.4		4		2017-2019		16
1.64	Diabetes: Medicare Population	percent	27.6		28.8	27	2018		5
0.97	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	19.1		22	21.5	2017-2019		4
			KAUFMAN				MEASUREMENT	HIGH	
SCORE	ECONOMY	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source

	Food Insecure Children Likely Ineligible for							
2.50	Assistance	percent	40	34	23	2019		7
	Median Monthly Owner Costs for							
2.50	Households without a Mortgage	dollars	558	514	500	2015-2019		1
	Mortgaged Owners Median Monthly							
2.33	Household Costs	dollars	1656	1606	1595	2015-2019		1
	Renters Spending 30% or More of							
2.31	Household Income on Rent	percent	49.9	47.8	49.6	2015-2019		1
2.14	SNAP Certified Stores	stores/ 1,000 population	0.6			2017		20
2.00	Median Household Gross Rent	dollars	1044	1045	1062	2015-2019		1
2.00	WIC Certified Stores	stores/ 1,000 population	0.1			2016		20
	Students Eligible for the Free Lunch							
1.92	Program	percent	47.4			2019-2020		10
	Mortgaged Owners Spending 30% or More							
1.61	of Household Income on Housing	percent	27.2	26.5	26.5	2019		1
1.50	Child Food Insecurity Rate	percent	18	19.6	14.6	2019		7
1.47	Total Employment Change	percent	2.3	2.9	1.6	2018-2019		18
1.42	Projected Child Food Insecurity Rate	percent	22	23.6		2021		7
							Black (25.3)	
							White (7.8)	
							Asian (23.4)	
							AIAN (0) NHPI	
							(100) Mult	
							(21.3) Other	
							(78.8) Hisp	
1.36	People 65+ Living Below Poverty Level	percent	10.1	10.6	9.3	2015-2019	(15.3)	1
1.33	Food Insecurity Rate	percent	12.9	14.1	10.9	2019		7
	Households that are Asset Limited, Income							
1.33	Constrained, Employed (ALICE)	percent	29.1	30		2018		22
1.31	Overcrowded Households	percent of households	3.3	4.8		2015-2019		1
1.25	Per Capita Income	dollars	28634	31277	34103	2015-2019		1
1.25	Projected Food Insecurity Rate	percent	15.3	16.5		2021		7

Limited, Income Constrained, Employed 1.17 (ALICE) Threshold percent 59.3 56 2018 Low-Income and Low Access to a Grocery End Construction End Constr	2220
1.17 (ALICE) Threshold percent 59.3 56 2018	20
	20
1.17 Store <i>percent</i> 4 2015	
Households that are Below the Federal	
1.00 Poverty Level <i>percent</i> 11.6 14 2018	22
1.00 Median Housing Unit Value dollars 178300 172500 217500 2015-2019	1
Households with Cash Public Assistance	
0.97 Income percent 1.3 1.4 2.4 2015-2019	1
0.97 Population 16+ in Civilian Labor Force percent 63 61 59.6 2015-2019	1
Black	•
White	(5.9)
Asian (C	AIAN
(0) NH	יו (0)
Mult	4.3)
Other	18.5)
0.86 Families Living Below Poverty Level percent 8.8 11.3 9.5 2015-2019 Hisp (.6.3) 1
0.86 Severe Housing Problems percent 13.1 17.4 18 2013-2017	6
Unemployed Workers in Civilian Labor	
0.75 Force percent 5.2 5.9 5.5 May 2021	17
0.61 People Living Below Poverty Level percent 11.4 8 14.7 13.4 2015-2019	1
0.58 People Living 200% Above Poverty Level percent 71.4 65.7 69.1 2015-2019	1
Black	-
White	
Asian	
AIAN	29.2)
Mult	D.8)
Other	32.3)
0.53 Children Living Below Poverty Level percent 14.4 20.9 18.5 2015-2019 Hisp (4.1) 1
Persons with Disability Living in Poverty (5-	
0.53 year) percent 19.9 23.2 26.1 2015-2019	1

	Formula Deputation 10 t in Civilian Labor								
0.42	Female Population 16+ in Civilian Labor Force	percent	60.6		57.8	58.3	2015-2019		1
0.42	Homeownership		70.3		57.8	56.2	2013-2019		1
	Median Household Income	percent dollars	70.3		61874	62843			1
0.08		donurs	/010/		01874	02843	2015-2019		1
			KAUFMAN				MEASUREMENT	HIGH	
SCORE	EDUCATION	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
1.83	Student-to-Teacher Ratio	students/ teacher	15.6	117 2030	Техаз	0.5.	2019-2020	DISPARTI	10
1.05	People 25+ with a Bachelor's Degree or		15.0				2019-2020		10
1.69	Higher	percent	20.5		29.9	32.1	2015-2019		1
1.05	People 25+ with a High School Degree or	percent	20.5		29.9	32.1	2013-2013		
1.36	Higher	percent	85.8		83.7	88	2015-2019		1
1.50	Inglief	percent	05.0		05.7	00	2013-2013	Black (3.4)	
								White (0.8)	
								Asian (0) AIAN	
								(0) PI (0) Mult	
1 1 4	Llich Cohool Dyon Out Date	a crocet	1.2		1.9		2010	., .,	1.4
1.14	High School Drop Out Rate	percent	1.2		1.9		2019	(3.6) Hisp (1) Black (8.8)	14
	Infants Born to Mothers with <12 Years							White (7.6)	
0.50	Education	percent	12.4		17.4	13.3	2017	Hisp (23.8)	13
0.50	Education	percent	12.4		17.4	13.5	2017	1139 (23.8)	
			KAUFMAN				MEASUREMENT	HIGH	
SCORE	ENVIRONMENTAL HEALTH	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
2.17	Access to Exercise Opportunities	percent	58.7		80.5	84	2020		6
2.14	SNAP Certified Stores	stores/ 1,000 population	0.6				2017		20
2.00	WIC Certified Stores	stores/ 1,000 population	0.1				2016		20
1.83	Grocery Store Density	stores/ 1,000 population	0.1				2016		20
1.64	Number of Extreme Precipitation Days	days	43				2016		11
1.58	Adults with Current Asthma	percent	9.3			9.2	2018		3
1.56	Annual Ozone Air Quality	grade	В				2017-2019		2
1.50	Farmers Market Density	markets/ 1,000 population	0.008				2018		20
1.36	Number of Extreme Heat Days	days	10				2016		11
1.36	Number of Extreme Heat Events	events	1				2016		11

1.33	Fast Food Restaurant Density	restaurants/ 1,000 population	0.6			2016	20
	Households with No Car and Low Access to						
1.33	a Grocery Store	percent	2			2015	20
1.33	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1			2016	20
1.31	Overcrowded Households	percent of households	3.3	4.8		2015-2019	1
1.28	Liquor Store Density	stores/ 100,000 population	8.1	6.9	10.5	2019	18
	Low-Income and Low Access to a Grocery						
1.17	Store	percent	4			2015	20
1.08	Recognized Carcinogens Released into Air	pounds	191.3			2019	21
1.08	Weeks of Moderate Drought or Worse	weeks per year	4			2016	11
1.03	Asthma: Medicare Population	percent	4.3	4.9	5	2018	5
1.03	Daily Dose of UV Irradiance	Joule per square meter	3243	3538		2015	11
	Children with Low Access to a Grocery						
1.00	Store	percent	2.3			2015	20
	People 65+ with Low Access to a Grocery						
1.00	Store	percent	1			2015	20
1.00	People with Low Access to a Grocery Store	percent	8.4			2015	20
0.86	Severe Housing Problems	percent	13.1	17.4	18	2013-2017	6
0.58	Food Environment Index		7.7	5.9	7.8	2021	6

			KAUFMAN				MEASUREMENT	HIGH	
SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
2.22	Primary Care Provider Rate	providers/ 100,000 population	28.8		60.9		2018		6
1.92	Adults who have had a Routine Checkup	percent	73.2			76.7	2018		3
1.92	Adults without Health Insurance	percent	24			12.2	2018		3
1.89	Dentist Rate	dentists/ 100,000 population	39.7		59.6		2019		6

1.67	Non-Physician Primary Care Provider Rate	providers/ 100,000 population	51.4		88.6		2020		6
1.58	Adults who Visited a Dentist	percent	57.2			66.5	2018		3
1.50	Adults with Health Insurance	percent	82		75.5	87.1	2019		1
1.50	Children with Health Insurance	percent	90.2		87.3	94.3	2019		1
1.44	Mental Health Provider Rate	providers/ 100,000 population	91.8		120.9		2020		6
1.44	Persons with Health Insurance	percent	82.9	92.1	79.3		2019		19
1.19	Social Worker Rate	workers/ 100,000 population	75.9		82.7		2020		13
			KAUFMAN				MEASUREMENT	HIGH	
SCORE	HEART DISEASE & STROKE	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
	Age-Adjusted Death Rate due to								
2.44	Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	50.5	33.4	40.2	37.2	2017-2019		4
2.31	Hyperlipidemia: Medicare Population	percent	51		49.5	47.7	2018		5
	Age-Adjusted Death Rate due to Coronary								
2.28	Heart Disease	deaths/ 100,000 population	130.2	71.1	93	90.5	2017-2019		4
	Adults who Have Taken Medications for								
2.08	High Blood Pressure	percent	73.9			75.8	2017		3
1.97	Hypertension: Medicare Population	percent	61.8		59.9	57.2	2018		5
1.86	Stroke: Medicare Population	percent	4.2		4.2	3.8	2018		5
		ER visits/ 10,000 population							
1.75	Age-Adjusted ER Rate due to Hypertension	18+ years	37.8		10.5		2017-2019		16
	Age-Adjusted Hospitalization Rate due to	hospitalizations/ 10,000							
1.75	Hypertension	population 18+ years	0.8		0.3		2016-2018		16
1.69	Heart Failure: Medicare Population	percent	15.7		15.6	14	2018		5
1.58	Cholesterol Test History	percent	80			81.5	2017		3
1.33	High Blood Pressure Prevalence	percent	34.2	27.7		32.4	2017		3
1.14	Atrial Fibrillation: Medicare Population	percent	7.4		7.8	8.4	2018		5
1.08	High Cholesterol Prevalence: Adults 18+	percent	34.6			34.1	2017		3

	Ischemic Heart Disease: Medicare						
1.08	Population	percent	28.2	29	26.8	2018	5
	Age-Adjusted Death Rate due to Heart	deaths/ 100,000 population					
1.03	Attack	35+ years	59	70.1		2018	11
0.92	Adults who Experienced a Stroke	percent	3.3		3.4	2018	3
	Adults who Experienced Coronary Heart						
0.92	Disease	percent	6.7		6.8	2018	3

			KAUFMAN				MEASUREMENT	HIGH	
SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
2.64	COVID-19 Daily Average Incidence Rate	cases per 100,000 population	96.5		70.4	56.5	September 10 2021		8
1.97	COVID-19 Daily Average Case-Fatality Rate	deaths per 100 cases	1.7		2.4	1.3	September 10 2021		8
	Age-Adjusted Death Rate due to Influenza								
1.58	and Pneumonia	deaths/ 100,000 population	13.6		11.8	13.8	2017-2019		4
1.50	Chlamydia Incidence Rate	cases/ 100,000 population	383.3		508.2	539.9	2018		13
1.33	HIV Diagnosis Rate	cases/ 100,000 population	9.3		15.7		2018		13
1.31	Overcrowded Households	percent of households	3.3		4.8		2015-2019		1
1.28	Tuberculosis Incidence Rate	cases/ 100,000 population	2.6	1.4	4.3		2015-2019		13
1.22	Gonorrhea Incidence Rate	cases/ 100,000 population	117.4		163.6	179.1	2018		13
1.22	Syphilis Incidence Rate	cases/ 100,000 population	3.9		8.8	10.8	2018		13

			KAUFMAN				MEASUREMENT	HIGH	
SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
2.14	Infant Mortality Rate	deaths/ 1,000 live births	6.5	5	5.6	5.9	2015		13
1.78	Mothers who Received Early Prenatal Care	percent	59.4		60.5	77.3	2017		13
1.56	Preterm Births	percent	11.5	9.4	12.2		2017		13
1.11	Babies with Very Low Birth Weight	percent	1.1			1.4	2015		13

								Black (0) White (1.4) Other (0)	
0.94	Teen Births	percent	1.6		2.1	3.1	2017	Hisp (2.3)	13
0.78	Babies with Low Birth Weight	percent	7		8.2	8.1	2015		13
0.50	Infants Born to Mothers with <12 Years Education	percent	12.4		17.4	13.3	2017	Black (8.8) White (7.6) Hisp (23.8)	13
			KAUFMAN				MEASUREMENT	HIGH	
CORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
2.92	Depression: Medicare Population	percent	21.1		18.2	18.4	2018		5
2.14	Age-Adjusted Death Rate due to Suicide Alzheimer's Disease or Dementia: Medicare	deaths/ 100,000 population	17.3	12.8	13.5	14.1	2017-2019		4
1.97	Population	percent	12.1		12.6	10.8	2018		5
1.67	Frequent Mental Distress	percent	14.2		12.0	10.8	2018		6
1.58	Poor Mental Health: 14+ Days	percent	14.2		11.0	12.7	2018		3
1.44	Mental Health Provider Rate Age-Adjusted ER Rate due to Adult Mental	providers/ 100,000 population ER visits/ 10,000 population	91.8		120.9		2020		6
1.25	Health	18+ years	0.4		1.7		2017-2019		16
1.25	Age-Adjusted Hospitalization Rate due to Adult Mental Health	hospitalizations/ 10,000 population 18+ years	0.8		1.9		2016-2018		16
CORE	OLDER ADULTS	UNITS	KAUFMAN COUNTY	HP2030	Toyac	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.92	DEPRESSION: Medicare Population	percent	21.1	TF2030	Texas 18.2	18.4	2018	DISPARITY	Source 5
2.32	Hyperlipidemia: Medicare Population	percent	51		49.5	47.7	2018		5
2.51	Chronic Kidney Disease: Medicare	percent	51		49.5	4/./	2010		5
2.08	Population	percent	26.3		26.7	24.5	2018		5
	Alzheimer's Disease or Dementia: Medicare	<i>p</i> e.ce	20.0		2017	2	2020		
	Population								

1.97	Hypertension: Medicare Population	percent	61.8	59.9	57.2	2018		5
	Adults 65+ who Received Recommended							
1.92	Preventive Services: Females	percent	24.5		28.4	2018		3
	Adults 65+ who Received Recommended							
1.92	Preventive Services: Males	percent	24.3		32.4	2018		3
1.86	Stroke: Medicare Population	percent	4.2	4.2	3.8	2018		5
1.83	Colon Cancer Screening	percent	60.1	74.4	66.4	2018		3
1.75	COPD: Medicare Population	percent	13.2	11.2	11.5	2018		5
1.69	Heart Failure: Medicare Population	percent	15.7	15.6	14	2018		5
	Rheumatoid Arthritis or Osteoarthritis:							
1.67	Medicare Population	percent	34.9	34.2	33.5	2018		5
1.64	Diabetes: Medicare Population	percent	27.6	28.8	27	2018		5
1.42	Adults 65+ with Total Tooth Loss	percent	15		13.5	2018		3
							Black (25.3)	
							White (7.8)	
							Asian (23.4)	
							AIAN (0) NHPI	
							(100) Mult	
							(21.3) Other	
							(78.8) Hisp	
1.36	People 65+ Living Below Poverty Level	percent	10.1	10.6	9.3	2015-2019	(15.3)	1
1.14	Atrial Fibrillation: Medicare Population	percent	7.4	7.8	8.4	2018		5
	Ischemic Heart Disease: Medicare							
1.08	Population	percent	28.2	29	26.8	2018		5
1.03	Asthma: Medicare Population	percent	4.3	4.9	5	2018		5
1.03	Cancer: Medicare Population	percent	7.3	7.6	8.4	2018		5
	People 65+ with Low Access to a Grocery							
1.00	Store	percent	1			2015		20
0.92	Adults with Arthritis	percent	24		25.8	2018		3
0.86	Osteoporosis: Medicare Population	percent	5.5	6.8	6.6	2018		5

			KAUFMAN				MEASUREMENT	HIGH	
SCORE	ORAL HEALTH	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
	Oral Cavity and Pharynx Cancer Incidence								
2.67	Rate	cases/ 100,000 population	17.4		11	11.8	2013-2017		9
1.89	Dentist Rate	dentists/ 100,000 population	39.7		59.6		2019		6
	Age-Adjusted ER Rate due to Dental								
1.75	Problems	ER visits/ 10,000 population	37.5		11.1		2017-2019		16
1.58	Adults who Visited a Dentist	percent	57.2			66.5	2018		3
1.42	Adults 65+ with Total Tooth Loss	percent	15			13.5	2018		3

			KAUFMAN				MEASUREMENT	HIGH	
SCORE	OTHER CONDITIONS	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
	Chronic Kidney Disease: Medicare								
2.08	Population	percent	26.3		26.7	24.5	2018		5
	Rheumatoid Arthritis or Osteoarthritis:								
1.67	Medicare Population	percent	34.9		34.2	33.5	2018		5
0.92	Adults with Arthritis	percent	24			25.8	2018		3
0.92	Adults with Kidney Disease	Percent of adults	2.9			3.1	2018		3
0.86	Osteoporosis: Medicare Population	percent	5.5		6.8	6.6	2018		5

			KAUFMAN				MEASUREMENT	HIGH	
SCORE	PHYSICAL ACTIVITY	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
2.17	Access to Exercise Opportunities	percent	58.7		80.5	84	2020		6
2.14	SNAP Certified Stores	stores/ 1,000 population	0.6				2017		20
2.00	WIC Certified Stores	stores/ 1,000 population	0.1				2016		20
1.83	Grocery Store Density	stores/ 1,000 population	0.1				2016		20
1.50	Farmers Market Density	markets/ 1,000 population	0				2018		20
1.33	Fast Food Restaurant Density	restaurants/ 1,000 population	0.6				2016		20
	Households with No Car and Low Access to	0							
1.33	a Grocery Store	percent	2				2015		20
1.33	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2016		20

	Low-Income and Low Access to a Grocery		_						
1.17	Store	percent	4				2015		20
	Children with Low Access to a Grocery								
1.00	Store	percent	2.3				2015		20
	People 65+ with Low Access to a Grocery								
1.00	Store	percent	1				2015		20
1.00	People with Low Access to a Grocery Store	percent	8.4				2015		20
0.58	Food Environment Index		7.7		5.9	7.8	2021		6
			KAUFMAN				MEASUREMENT	HIGH	_
SCORE	PREVENTION & SAFETY	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
	Age-Adjusted Death Rate due to								
1.72	Unintentional Injuries	deaths/ 100,000 population	48.1	43.2	38.7	48.9	2017-2019		4
		_							
1.56	Death Rate due to Drug Poisoning	deaths/ 100,000 population	14.7		10.6	21	2017-2019		6
0.86	Severe Housing Problems	percent	13.1		17.4	18	2013-2017		6
			KAUFMAN				MEASUREMENT	HIGH	
SCORE	RESPIRATORY DISEASES	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
									-
2.64	COVID-19 Daily Average Incidence Rate	cases per 100,000 population	96.5		70.4	56.5	September 10 2021		8
	Age-Adjusted Death Rate due to Lung				_				_
2.42	Cancer	deaths/ 100,000 population	51.6	25.1	34.1	38.5	2013-2017		9
2.19	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	74.5		50.6	58.3	2013-2017		9
									-
1.97	COVID-19 Daily Average Case-Fatality Rate	deaths per 100 cases	1.7		2.4	1.3	September 10 2021		8
1.83	Adults who Smoke	percent	18.7	5		15.5	2018		3
1.75	COPD: Medicare Population	percent	13.2		11.2	11.5	2018		5
1.58	Adults with Current Asthma	percent	9.3			9.2	2018		3
	Age-Adjusted Death Rate due to Influenza								
1.58	and Pneumonia	deaths/ 100,000 population	13.6		11.8	13.8	2017-2019		4

1.28	Tuberculosis Incidence Rate	cases/ 100,000 population	2.6	1.4	4.3		2015-2019		13
1.08	Adults with COPD	Percent of adults	7.1	1.4	4.5	6.9	2013-2019		3
1.03	Asthma: Medicare Population	percent	4.3		4.9	5	2018		5
1.05	Astrina. Medicare Population		4.5		4.9	5	2018		5
			KAUFMAN				MEASUREMENT	HIGH	
SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
1.50	Chlamydia Incidence Rate	cases/ 100,000 population	383.3		508.2	539.9	2018		13
1.33	HIV Diagnosis Rate	cases/ 100,000 population	9.3		15.7		2018		13
1.22	Gonorrhea Incidence Rate	cases/ 100,000 population	117.4		163.6	179.1	2018		13
1.22	Syphilis Incidence Rate	cases/ 100,000 population	3.9		8.8	10.8	2018		13
			KAUFMAN				MEASUREMENT	HIGH	
SCORE	WELLNESS & LIFESTYLE	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
1.58	Insufficient Sleep	percent	36.2	31.4	34.4	35	2018		6
1.50	Frequent Physical Distress	percent	12.8		11.6	11	2018		6
1.33	High Blood Pressure Prevalence	percent	34.2	27.7		32.4	2017		3
1.25	Poor Physical Health: 14+ Days	percent	13.1			12.5	2018		3
			KAUFMAN				MEASUREMENT	HIGH	
SCORE	WOMEN'S HEALTH	UNITS	COUNTY	HP2030	Texas	U.S.	PERIOD	DISPARITY*	Source
2.58	Breast Cancer Incidence Rate	cases/ 100,000 females	131.5		112.8	125.9	2013-2017		9
1.78	Cervical Cancer Incidence Rate	cases/ 100,000 females	9.4		9.2	7.6	2013-2017		9
1.61	Mammogram in Past 2 Years: 50-74	percent	69.4	77.1		74.8	2018		3
	Age-Adjusted Death Rate due to Breast								
1.53	Cancer	deaths/ 100,000 females	20.7	15.3	19.8	20.1	2013-2017		9
1.44	Cervical Cancer Screening: 21-65	Percent	83.1	84.3		84.7	2018		3

Community Input Assessment Tools

Key Informant Interview Guide and Questions

INTRODUCTION

HCI Facilitator: Introduce yourself and any others on the team

OPENING SCRIPT: TEXAS HEALTH RESOURCES (THR) has invited you to take part in this Key Informant Interview because of your content expertise and your experience working in the community. Our work on behalf of THR is focused on understanding what health issues and challenges impact the residents of **Southern Region** and how to improve their overall health. The insights and perspectives collected in this interview will provide important information that will ultimately be combined with the results of a key informant interviews, focus groups, and data analysis of state and national indicators. These data components will be compiled into a comprehensive report outlining the health needs in the Southern Region which includes **Southern Region**. The final reports will be completed in the summer of 2022.

CONFIDENTIALITY: For this interview, we will be taking notes on your responses, your names will not be associated with any direct quotes. Your identity will be kept confidential.

1. To begin, could you please tell us a little about the organization you work for and the geographic location it serves?

- a. (only probe if necessary) What is your organization's mission? What are the top priority health issues that your organization addresses?
- b. (only ask if not clear) Does your organization provide direct care, operate as an advocacy organization, or have another role in the community?
- *c.* Which geographic location(s) does your organization serve? (to help us understand or confirm relevant service areas)

2. Considering the impact of Covid-19, what would you consider the top 5 health issues exacerbated by the pandemic in Southern Region?

- **a.** What are the possible solutions to improve the health issues you've described?
- **b.** What solutions have your organization/agency put in place or considered to help improve the health issues you described?
- c. How can Texas Health support these health improvement efforts?

- 3. Along the same lines, what would you consider the top 5 socioeconomic needs exacerbated by the pandemic in [County Name/Zip code]?
 - a. What are the possible solutions to improve the socioeconomic needs you've described?
 - *b.* What specific solutions have your organization/agency put in place or considered to help improve the socioeconomic issues you described?
 - c. How can Texas Health support these socioeconomic improvement efforts?
- 4. Thinking about the solutions you described to address the health and socioeconomic needs, to what extent does your organization/agency have what it needs to deliver these services/resources in the community effectively?
 - a. How do aspects of this community's [County Name/Zip code] infrastructure (i.e., physical environment, policies, partnerships) help or hinder your ability to deliver the services/resources you described?
 - b. How can Texas Health support the success of these services/resources?
- 5. How can community leaders, community-based organizations, and health care systems work collaboratively to address this community's [County Name/Zip codes] health and socioeconomic?
 - a. To your knowledge, what strategies have been used in the past to drive collaboration across these partners? What worked, what didn't, and why?
 - b. What challenges/barriers should Texas Health anticipate in its efforts to work with community leaders and members to address the health and socioeconomic needs in this community?
 - c. How can Texas Health proactively address these challenges/barriers?
- 6. Finally, what do you consider the best practices that are currently going on to improve the health and socio-economic needs in this community [County/Zip codes]?
- 7. What is the most crucial message/feedback you want Texas Health to take away from this interview?
 - a. Is there anything else you would like to add about any of the topics we've discussed or other areas that we didn't discuss but you think are essential?

CLOSING SCRIPT: Thank you so much for your time and participation today. In terms of next steps, we will be collecting and analyzing the data for this needs assessment over the next few months. The final report will be available to everyone who participated, as well as the general public. If you have additional comments or thoughts after our conversation today, please feel free to reach out to *Eileen Aguilar* or Oge/Sika. *HCI Facilitator: Send a follow-up email to the key informant, thanking them for their time and make sure to include a link to the survey!*

Focus Group Guide and Questions

INTRODUCTION

{Introduce Yourself and Others on the Team}

{"Let's get started...}

Opening Script: Thank you for taking the time to speak with us to support the Texas Health Resources (THR) Community Health Needs Assessment. We anticipate that this discussion will last no more than 60 minutes. You have been invited to take part in this focus group because of your experience living and/or working in Southern Region. The focus of our Community Health Needs Assessment is how to improve health in the community and understand what challenges residents are facing. We are going to ask a series of questions related to health issues in the community. We hope to get through as many questions as possible and hear each of your perspectives as much as time allows.

For this discussion group, I will invite you to share as much or little as you feel comfortable sharing with the others in the group. The results of this assessment will be made available to the public. We will be taking notes on your responses, but your names will not be associated with any direct quotes. Your identity will be kept confidential, so please share your honest opinions.

SHOW SLIDES (if applicable)--We do have a few ground rules for this virtual discussion that I would like to review with you. It is important that everyone has a chance to be heard, so we ask that only one person talks at a time (most important ground rule for today). You may use the "raise hand" functions when you have something to say [*give instructions and test*]. We may also call on you to sure ensure everyone has a chance to speak but if you have nothing to share, please just say "pass".

You may want to mute yourself when you are not speaking to cut down on background noise [give instructions and test mute/unmute]. Finally, please respect the opinions of others, as the point of the discussion is to collect various points of view. And remember, there are no right or wrong answers, so please share freely and openly. Does anyone have any questions before we get started?

Okay, let's get started by going around and introducing ourselves. Please tell everyone your first name, what community you live in, and if you are interested in sharing, your involvement in the community (could be your job or volunteer work for example). {Introductions}

Thank you for introducing yourselves. Now we will get started with our discussion.

COVID-19 QUESTION

1. We know that COVID-19 has significantly impacted everyone's lives. What have you seen as the biggest challenges in XXXXX County during the pandemic?

[Probe 1: Which groups of people are having the hardest time right now?] [Probe 2: How have you seen these challenges being addressed, if at all?] [Probe 3: What programs have addressed COVID related issues? What has worked?] [Probe 4: What hasn't been effective and, in your opinion, why?]

GENERAL HEALTH QUESTIONS

2. What would you say are the top three health related problems that people in your community are facing that you would like to change or improve?

[Probe 1: Why do you think these are the most important health issues? [Probe 2: What would you do to address these problems?] [Probe 3: What else is needed to address these problems? Examples could be specific policies, programs, or services.]

3. What might prevent someone from accessing care for the health challenges identified above?

[Examples could include lack of transportation, lack of health insurance coverage, doctor's office hours, language, or cultural barriers, etc.]

4. Are there specific groups in your community that are most impacted by the health issues or challenges discussed earlier (2-3)? Which groups are these?

[Probe: Are these health challenges different if the person is a particular age, or gender, race, or ethnicity? Or lives in a certain part of the county for example?]

5. From the health issues and challenges we've just discussed, which do you think can be addressed in the next three years?

[Probe 1: How do you think these health issues can be addressed?} [Probe 2: Are some of these issues more urgent or important than others? If so, why?]

6. In 2019, Depression and anxiety among adults 18+ were identified as important health issues in your community. Do you know of any programs or services that are available in your community to address this issue?

[Prompt: Have you or someone you know benefited from these programs or services? If so, what do you think has worked? What do you think can be improved?]

7. What resources are currently available for residents in your community for the identified health/social determinant problem/s we've discussed today?

[Probe 1: Are there specific community organizations or agencies that you see taking a strong leadership role for improving the health of particular groups in your community?] [Probe 2: Do you see residents taking advantage of them? Why or why not?] [Probe 3: What additional programs and resources do you think are needed to best meet the needs of residents in _____ County?] [Probe 4: Are you aware of any THR-Community Health Improvement program(s) in your community?]

CLOSING QUESTION

8. Can you think of any other ways we could improve the health of residents in the community that we have not already talked about today?

[Probe: Is there anything else you would like to add that we haven't discussed?]

CONCLUSION

{Review the summary points and key takeaways from discussion} {Check if note taker needs any clarification}

CLOSURE SCRIPT: Thank you very much for your time and willingness to share your experiences with us today. We will include your comments in our data to describe how health can be improved for residents in your community. Please remember, your name will not be connected to any of the comments you made today. Please let us know if you have any questions or concerns about this.

Listening Session Questions

- 1. Name of the organization you represent.
- 2. What region/county/counties do your organization provide direct services to? (select all that apply)
 - a. Dallas County
 - b. Rockwall County
 - c. Southern Region
 - d. Parker County
 - e. Denton County
 - f. Wise County
 - g. Southern Region
 - h. Ellis County
 - i. Erath County
 - j. Henderson County
 - k. Johnson County
 - I. Kaufman County
- 3. In 2019, Texas Health Resources (THR) identified behavioral health, chronic disease prevention and management, access, awareness, health literacy and navigation as its priority areas. Are you aware of any THR programs, initiatives, resources, specifically addressing any of these priorities in your community?
- 4. What is THR doing well within the behavioral health, chronic disease prevention and management, access, health literacy and navigation areas? Feel free to address one or all priorities.
- 5. What are areas of opportunity within these priority areas? Feel free to address one or all priorities.
- 6. What can THR do to improve the awareness of its Community Health Needs Assessment (CHNA) findings and implementation strategies?
- **7.** Texas Health Resources is currently developing its 2022 CHNA reports and have identified these preliminary issues for the following regions:

Southern Region

Healthcare Access & Quality (lack of/limited insurance, delay in care)

Mental Health (depression, anxiety, isolation) Abuse/Violence (domestic violence, child abuse, intimate partner violence) Substance Abuse (isolation leading to increased substance use and addiction)

Denton/Wise Region-

Mental Health (increased need for adolescents, anxiety, lack of behavioral health services) Access to healthcare services (Provider shortages, language barriers, uninsured/underinsured) COVID-19 Impact (mental health, trust in healthcare system, delay in services) Food insecurity (lack of food, access to healthy foods, food deserts)

Tarrant/Parker Region-

Chronic conditions (heart disease, diabetes) COVID-19 Impact (Mental Health/Substance abuse, isolation, financial issues, delay in care, food insecurity) Health Behaviors (fear, stigma towards vaccine) Healthcare Access & Quality (Lack of providers, lack of bilingual providers, uninsured/underinsured)

Dallas/Rockwall Region-

Access to care (delay in care, uninsured, underinsured) Mental Health (isolation, depression exacerbated by COVID-19) Financial/Economic impact (unemployment, housing insecurity) Food insecurity (lack of healthy foods, lack of food)

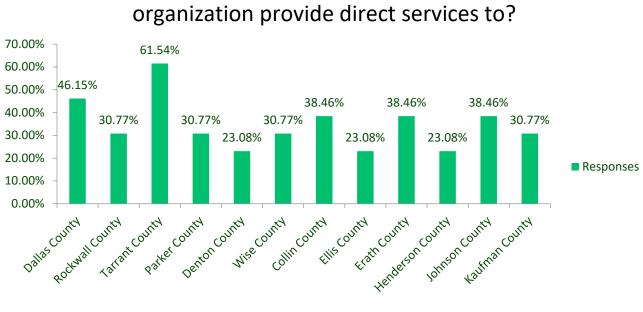
Denton/Wise Region-

Access to care (delay in services, high deductibles, affordability of insurance, knowledge of where to get care) Mental Health (stigma in accessing care, cultural barriers, anxiety)

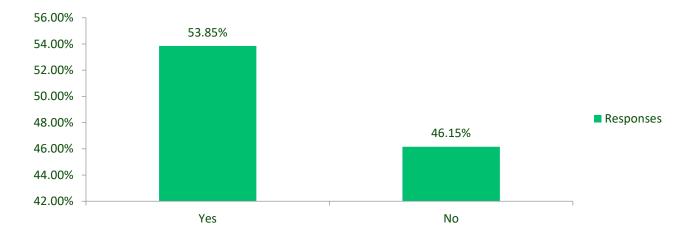
Economic/financial issues (difficulty paying rent/utilities, unemployment, loss of jobs) Housing (lack of affordable housing, discrimination)

7a. How can THR prioritize these health topics that have surfaced as issues in the region?

Listening Session Results



Question #3-Are you aware of any THR programs, initiatives, resources, specifically addressing any of these priorities in your community?



Question #2-What region/county/counties do your organization provide direct services to?

Question #4-What is THR doing well within the behavioral health, chronic health, chronic disease prevention & management, access, health literacy, and navigation areas?

- While there is some generalize awareness of THR efforts, there is not sufficient publicity of these efforts to elicit significant engagement from the public.

-I navigate the Plano Up program funded by THR focusing on anxiety and depression in youth in the 75074 zip. Beyond Blue is another program funded by THR to address mental health in the senior population in the 75069 zip

- The Community Impact program and its regional councils are a great model to impact health priorities.

- It's hard to say due to the Pandemic really. THR has been sending email and reminders to people to do their screenings, testing and seeing their Dr, even telemedicine

- Their willingness to fund organizations that promote access and health literacy is awesome.

- Excellent work with chronic disease prevention and management. Also, good initiative with mental health in rural areas. Doing a good job of bringing these topics, education, and interventions to the people and communities THR serves.

- THR's Community Impact team has done a great job at leveraging relations with community leaders, nonprofits, thought leaders to strengthen efforts to improve health outcomes that are negatively impacted by the social determinants of health. They are also using data to drive their decision and to measure positive improvements in the areas of exercise, health and chronic disease prevention.

- Connect deeper to faith-based organizations, and schools where the under-resource families are nearest and partner with other foundations to strengthen the ability to sustain efforts.

Q5- Are there areas of opportunity within these priority areas? Feel free to address

-Behavioral health partnerships between THR, JPS, and the City of Arlington would be good way to have a meaningful impact on this issue. A formalized partnership with COA/Fire PH unit, Mission Arlington, School Districts, UTA school of Nursing and Social Work, JPS, TCPH and MCA could result in a cost effective and impactful approach to many of these issues.

- I feel mental health is still a large concern. However, I feel healthcare is out of reach for many people even for those with the ability to pay. Living expenses have increased to the point where many people cannot afford to maintain their physical or mental well-being

- There are many opportunities to impact health outcomes - particularly chronic diseasethrough increased awareness and support of patients affected by memory decline. This can include those at risk for cognitive decline (diverse communities are at higher risk, as are those who have comorbidities) and create opportunities for early detection—also, outcomes related to caregiver health.

- With the start of the Pandemic in March 2020, people have not seen their health care providers as they should, thus causing now two years later, many, many additional medical problems.

- Behavioral health is an awesome place to start. We need to train paraprofessionals to go into the neighborhood.

- Health literacy training for health care and service providers would enhance THR's current efforts within chronic disease management.

Question 6- What can THR do to improve the awareness of its Community Health Needs Assessment findings and implementation strategies?

-Partner directly with the City of Arlington Office of Communications

-Present to city and nonprofits the results of the assessment. Many citizens have no idea of the health status of our city.

- More programs focused on prevention and mobile solutions. We have to realize that many people cannot get to appointments even with coverage. Housing, food and transportation costs

- Increasing channels of communication, implementing practical action steps and a starting point for those needing the services, enhanced relationship building with community partners.

- Send them to community orgs as well as posting on their website. If both of these were done, I would recommend a way to ensure that all orgs doing any social service-related work get notified of the CHNA and implementation plan.

- Work directly with Community-Based Organizations (CBOs), such as the Alzheimer's Association or Area Agency on Aging, to promote these results and how a partnership with the CBO will impact the health outcomes. Continue to provide grants to CBOs to ensure that community support continues for all those in need.

- Perhaps THR can advertise the CHNA can run local ads on television and radio.

- As we emerge from the Pandemic, continue to reach those who are not connected by smart phones and emails

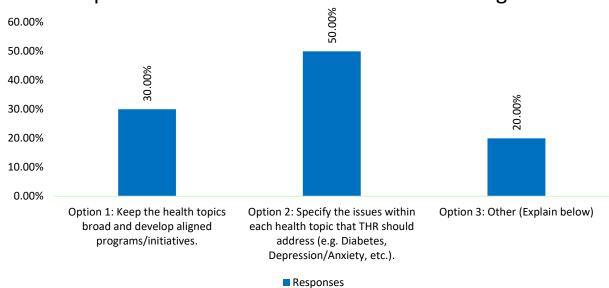
- A spot on the major networks or continuous radio spots would help.

- Personally, I think that THR does a great job of disseminating CHNA findings. They and Cook are regional leaders in that work. I'm not sure if THR already works closely with rural Extension

services to disseminate findings and implement programming. If not, that may be another avenue. Also, engaging FQHC's in CHNA implementation strategies is important.

- Take the information out to the community who are impacted the most. (Churches, Schools, Stores, barbershops, beauty shops and perhaps convenience store.

Question #7-How can THR prioritize these health topics that have surfaced as issues in the region?



Community Resource and Partner List

This highlights existing resources that organizations are currently using and available widely in the community. It also highlights community partners involved in this process for this CHNA.

Community Resource

Assessment Intervention and Referral Services (AIRS) Crazy 8 Ministries, PROMISES, Open Door (Faith-based organizations) Erath County Community Bridges Family Resource Center Johnson County family/youth counseling Kemp Connect Kinship Navigator Program Seven Points Rehabilitation Stephenville Senior Center Stillwaters Rehabilitation The Center at Kaufman THR/Superior Health partnership expanding programs for chronic diseases United Way 211

Community Partner List

Christian Help Center City of Ennis Cleburne Fire Department Cross Timbers Family Services Erath County Extension Johnson County Family Crisis Center North Texas Behavioral Health Authority Paluxy River Children's Advocacy Center Senior Connect Texas Department of State Health Service Appendix E. Tarrant/Parker Region

Texas Health Resources

Tarrant/Parker Region

Appendices

Secondary Data Methodology

Secondary Data Sources

The main source for the secondary data, or data that has been previously collected, is the community indicator database maintained by Conduent Healthy Communities Institute. The following is a list of both local and national data sources used in Texas Health Resources Tarrant County and Parker County regional Community Health Needs Assessment report.

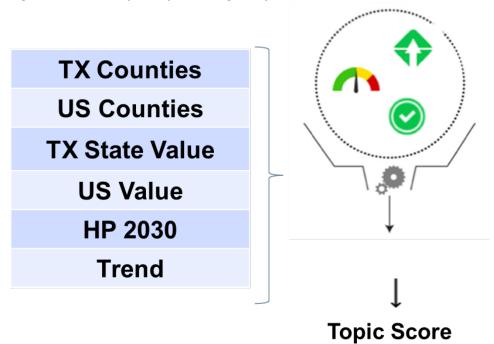
Data Sources

- American Community Survey
- American Lung Association
- CDC PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- County Health Rankings
- Feeding America
- Healthy Communities Institute
- National Cancer Institute
- National Center for Education Statistics
- National Environmental Public Health Tracking Network
- Texas Department of Family and Protective Services
- DFWHC Foundation Regional Data, Q1-Q4, 2017-2019. DFWHC Foundation, Irving Texas. October 15, 2021,

- Texas Education Agency
- Texas Department of Health Services
- U.S Bureau of Labor Statistics
- U.S. Census County Business Patterns
- U.S. Census Bureau Small Area Health Insurance Estimates
- U.S. Department of Agriculture Food Environment Atlas
- U.S. Environmental Protection Agency
- United for ALICE

Secondary Data Scoring

HCI's Data Scoring Tool (Figure 1A) was used to systematically summarize multiple comparisons in order to rank indicators based on highest need. For each indicator, the community value was compared to a distribution of Texas and US counties, state and national values, Healthy People 2030, and significant trends were noted. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities and changes in methodology over time. The comparison scores were summarized for each indicator, and indicators were then grouped into topic areas for a systematic ranking of community health needs. Figure 1A: Summary of Topic Scoring Analysis



Index of Disparity

An important part of the CHNA process is to identify health disparities, the needs of vulnerable populations and unmet health needs or gaps in services. There were several ways in which subpopulation disparities were examined by county. For secondary data health indicators, the Index of Disparity tool was utilized to see if there were large, negative, and concerning differences in indicator values between each subgroup data value and the overall county value. The Index of Disparity was run for each county, and the indicators with the highest race or ethnicity index value were found.

Health Equity Index

Every community can be described by various social and economic factors that can contribute to disparities in health outcomes. Conduent HCI's Health Equity Index (formerly SocioNeeds [®] Index) considers validated indicators related to income, employment, education, and household environment to identify areas at the highest risk for experiencing health inequities.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic needs correlated with preventable hospitalizations and premature death.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Health Equity Index, with darker coloring associated with higher relative need.

Food Insecurity Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in outcomes and opportunities to thrive. Conduent HCI's Food Insecurity Index considers validated indicators related to income, household environment and well-being to identify areas at highest risk for experiencing food insecurity.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest food insecurity, which is correlated with household and community measures of food-related financial stress such as Medicaid and SNAP enrollment.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Food Insecurity Index, with darker coloring associated with higher relative needs.

Mental Health Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in mental health outcomes. Conduent HCI's Mental Health Index considers validated indicators related to access to care, physical health status, transportation, employment, and household environment to identify areas at highest risk for experiencing poor mental health.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic and health needs correlated with self-reported poor mental health.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Mental Health Index, with darker coloring associated with higher relative need.

Data Considerations

Several limitations of data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and health-related areas, data availability varies by health topic. Some topics contain a robust set of secondary data indicators, while others may have a limited number of indicators or limited subpopulations covered by those specific indicators. Data scores represent the relative community health need according to the secondary data for each topic and should not be considered a comprehensive result on their own. In addition, these scores reflect the secondary data results for the population as a whole and do not represent the health or socioeconomic need that is much greater for some subpopulations. Moreover, many of the secondary data indicators included in the findings are collected by survey, and though specific methods are used to best represent the population at large, these measures are subject to instability, especially for smaller populations. The Index of Disparity is also limited by data availability, where indicator data varies based on the population groups and service areas being analyzed.

Race or ethnic and Special Population Groupings

The secondary data presented in this report derive from multiple sources, which may present race and ethnicity data using dissimilar nomenclature. For consistency with data sources throughout the report, subpopulation data may use different terms to describe the same or similar groups of community members.

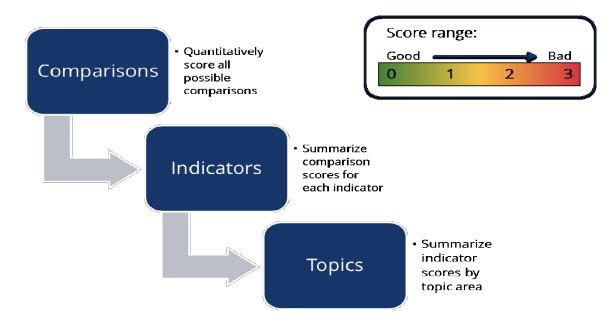
Zip Codes and Zip Code Tabulation Areas

This report presents both Zip Code and Zip Code Tabulation Area (ZCTA) data. Zip Codes, which were created by the U.S. Postal Service to improve mail delivery service, are not reported in this assessment as they may change, include P.O. boxes or cover large unpopulated areas. This assessment cover ZCTAs or Zip Code Tabulation Areas which were created by the U.S. Census Bureau and are generalized representations of Zip Codes that have been assigned to census blocks.

Demographics for this report are sourced from the United States Census Bureau, which presents ZCTA estimates. Tables and figures in the Demographics section of this report reference Zip Codes in title (for purposes of familiarity) but show values of ZCTAs. Data from other sources are labeled as such.

Secondary Data Scoring Detailed Methodology

Data Scoring is done in three stages:



For every indicator available, each county in the Hospital Service Area is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time. Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic. Secondary data for this report are up to date as of November 1, 2021.

Comparison to a Distribution of County Values: Within State and Nation

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

Comparison to Values: State, National, and Targets

The county is compared to the state value, the national value, and target values. Target values include the nation-wide Healthy People 2030 (HP2030) goals. Healthy People 2030 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' (DHHS) Healthy People Initiative. For all value comparisons, the scoring depends on whether the county value is better or worse than the comparison value, as well as how close the county value is to the target value.

Trend Over Time

The Mann-Kendall statistical test for trend was used to assess whether the county value is increasing over time or decreasing over time, and whether the trend is statistically significant. The trend comparison uses the four most recent comparable values for the county, and statistical significance is determined at the 90% confidence level. For each indicator with values available for four time periods, scoring was determined by direction of the trend and statistical significance.

Missing Values

Indicator scores are calculated using the comparison scores, availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators on the community dashboard, it will be included in the indicator score. After exclusion of comparison types with inadequate availability, all missing comparisons are substituted with a neutral score for the purposes of calculating the indicator's weighted average. When information is unknown due to lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

Indicator Scoring

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated, and the indicator is excluded from the data scoring results.

Topic Scoring

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. Resulting scores range from 0-3, where a higher score indicates a greater level of need as evidenced by the data. A topic score is only calculated if it includes at least three indicators.

County Data Scoring Indicators Results Tarrant County Indicator Scores

			TARRANT				MEASUREMENT	HIGH	
SCORE	ALCOHOL & DRUG USE	UNITS	COUNTY	HP2030	тх	U.S.	PERIOD	DISPARITY*	Source
1.92	Adults who Binge Drink	percent	17.1			16.4	2018		4
		ER visits/ 10,000							
	Age-Adjusted ER Rate due	population 18+							
1.75	to Opioid Use	years	2.6		0.7		2017-2019		17
	Age-Adjusted	hospitalizations/							
	Hospitalization Rate due to	10,000 population							
1.75	Opioid Use	18+ years	0.2		0.1		2017-2019		17
	Age-Adjusted	hospitalizations/							
	Hospitalization Rate due to	10,000 population							
1.75	Substance Use	10,000 population 18+ years	1.6		1.2		2017-2019		17
1.75	Substance Use	ER visits/ 10,000	1.0		1.2		2017-2019		
	Age-Adjusted ER Rate due	population 18+							
1.42	to Substance Use	years	20.3		20.6		2017-2019		17
1.42		yeurs	20.3		20.0		2017-2019		1/
	Age-Adjusted Drug and								
	Opioid-Involved Overdose	Deaths per 100,000							
1.00	Death Rate	population	9.6		12.1	22.8	2017-2019		5
		· · ·							
		stores/ 100,000							
0.89	Liquor Store Density	population	5.3		6.9	10.5	2019		19
		percent of driving							
	Alcohol-Impaired Driving	deaths with alcohol							
0.33	Deaths	involvement	21.1	28.3	25.7	27	2015-2019		7
0.55		IIIVOIVEIIIEIIL	21.1	20.5	23.7	21	2013-2013		/
	Death Rate due to Drug	deaths/ 100,000							
0.33	Poisoning	population	8.9		10.6	21	2017-2019		7

			TARRANT				MEASUREMENT	HIGH	
SCORE	CANCER	UNITS	COUNTY	HP2030	TX	U.S.	PERIOD	DISPARITY*	Source
	Cancer: Medicare								
2.47	Population	percent	8.5		7.6	8.4	2018		6
								Black (34.5)	
								White (20.5)	
	Age-Adjusted Death Rate	deaths/ 100,000						API (9) Hisp	
2.25	due to Breast Cancer	females	20.9	15.3	19.8	20.1	2013-2017	(11.4)	10
	Breast Cancer Incidence	cases/ 100,000							
2.25	Rate	females	122.1		112.8	125.9	2013-2017		10
1.83	Colon Cancer Screening	percent	60.1	74.4		66.4	2018		4
		cases/ 100,000							
1.81	All Cancer Incidence Rate	population	437.7		407.7	448.7	2013-2017		10
	Oral Cavity and Pharynx	cases/ 100,000	12.4				2242 2247		
1.72	Cancer Incidence Rate	population	12.1		11	11.8	2013-2017		10
								Black (171.5) White (100.7)	
	Prostate Cancer Incidence	cases/ 100,000						API (53.2) Hisp	
1.58	Rate	males	103.5		94	104.5	2013-2017	(78)	10
					_			(- /	
1	Cervical Cancer Screening:	Deveent	02.0	04.2		047	2010		Δ
1.44	21-65	Percent	82.8	84.3		84.7	2018	Black (34.7)	4
	Age-Adjusted Death Rate	deaths/ 100,000						White (18.1)	
1.36	due to Prostate Cancer	males	18.9	16.9	17.6	19	2013-2017	Hisp (15)	10
	Cervical Cancer Incidence	cases/ 100,000							
1.28	Rate	females	8.2		9.2	7.6	2013-2017		10
	Mammogram in Past 2								
1.28	Years: 50-74	percent	71.2	77.1		74.8	2018		4
	Age-Adjusted Death Rate	deaths/ 100,000							
1.00	due to Cancer	population	153.4	122.7	148.8	155.5	2013-2017		10

0.86	Colorectal Cancer Incidence Rate	cases/ 100,000 population	36.9		37.6	38.4	2013-2017		10
	Age-Adjusted Death Rate	deaths/ 100,000							
0.83	due to Lung Cancer	population	37.4	25.1	34.1	38.5	2013-2017		10
0.75	Adults with Cancer	percent	5.9			6.9	2018		4
	Lung and Bronchus Cancer	cases/ 100,000							
0.75	Incidence Rate	population	55.3		50.6	58.3	2013-2017		10
	Age Adjusted Death Pate	deaths/ 100,000							
0.67	Age-Adjusted Death Rate due to Colorectal Cancer	population	13.5	8.9	13.9	13.7	2013-2017		10
0.07	due to colorectal callee	ρορυιατιστι	13.5	0.9	13.9	15.7	2013-2017		10
			TARRANT				MEASUREMENT	HIGH	
SCORE	CHILDREN'S HEALTH	UNITS	COUNTY	HP2030	ТХ	U.S.	PERIOD	DISPARITY*	Source
	Food Insecure Children								
	Likely Ineligible for								_
2.17	Assistance	percent	37		34	23	2019		8
	Substantiated Child Abuse	cases/ 1,000							
1.89	Rate	children	11.5	8.7	9.1		2020		13
4.00	Children with Low Access		7.4				2015		24
1.83	to a Grocery Store	percent	7.1				2015		21
1.67	Child Food Insecurity Rate	percent	18.4		19.6	14.6	2019		8
	Children with Health								
1.50	Insurance	percent	88.4		87.3	94.3	2019		1
	Durain stand Child Famil								
1 42	Projected Child Food	norcont	22.0		22 G		2021		0
1.42	Insecurity Rate	percent	22.9		23.6		2021		8

			TARRANT				MEASUREMENT	HIGH	
SCORE	COMMUNITY	UNITS	COUNTY	HP2030	ТХ	U.S.	PERIOD	DISPARITY*	Source
	Solo Drivers with a Long								
2.75	Commute	percent	42.6		38.9	37	2015-2019		7
	Median Monthly Owner Costs for Households								
2.67	without a Mortgage	dollars	609		514	500	2015-2019		1
2.07		uonurs	005		514	500	2013 2013		i
		membership							
		associations/ 10,000							
2.47	Social Associations	population	6.8		7.5	9.3	2018		7
	Median Household Gross								
2.33	Rent	dollars	1095		1045	1062	2015-2019		1
	Mortgaged Owners Median								
2.33	Monthly Household Costs	dollars	1658		1606	1595	2015-2019		1
2.25	Mean Travel Time to Work	minutes	27.4		26.6	26.9	2015-2019		1
2.25		minutes	27.4		20.0	20.9	2013-2019		I
	Substantiated Child Abuse	cases/ 1,000							
1.89	Rate	children	11.5	8.7	9.1		2020		13
								Black (1.2) White (0.4)	
								Asian (0.5)	
								AIAN (1.1)	
								NHPI (0.8)	
								Mult (0.3)	
	Workers Commuting by							Other (0.4)	
1.75	Public Transportation	percent	0.6	5.3	1.4	5	2015-2019	Hisp (0.4)	1
1.69	Linguistic Isolation	percent	6.3		7.7	4.4	2015-2019		1
	Persons with Health								
1.64	Insurance	percent	81.1	92.1	79.3		2019		20
1.47	Total Employment Change	percent	2.2		2.9	1.6	2018-2019		19
	Workers who Drive Alone								
1.42	to Work	percent	82		80.5	76.3	2015-2019		1
1.76		percent			00.5	, 0.5	2010 2010		*

1.36	Homeownership	percent	55.8		54.9	56.2	2015-2019	1
	Voter Turnout: Presidential							
1.33	Election	percent	62		58.8		2016	16
1.25	Single-Parent Households	percent	26.2		26.3	25.5	2015-2019	1
	Persons with an Internet							
1.08	Subscription	percent	88.8		84.2	86.2	2015-2019	1
	Households with No Car							
	and Low Access to a							
1.00	Grocery Store	percent	1.3				2015	21
4.00			100500		17250	2175	2015 2010	4
1.00	Median Housing Unit Value	dollars	188500		0	00	2015-2019	1
	Female Population 16+ in							
0.97	Civilian Labor Force	percent	61.1		57.8	58.3	2015-2019	1
	Population 16+ in Civilian							
0.97	Labor Force	percent	64.8		61	59.6	2015-2019	1
		,						
0.92	People 25+ with a High	norcont	86.1		83.7	88	2015-2019	1
0.92	School Degree or Higher	percent	80.1		83.7	88	2015-2019	1
		workers/ 100,000						
0.86	Social Worker Rate	population	118.2		82.7		2020	14
	Households with an							
0.83	Internet Subscription	percent	87.1		82.1	83	2015-2019	1
	Households with One or							
	More Types of Computing							
0.83	Devices	percent	94.4		91	90.3	2015-2019	1
	Age-Adjusted Death Rate							
	due to Motor Vehicle	deaths/ 100,000						
0.58	Traffic Collisions	population	9.7	10.1	13	11.3	2017-2019	5

								Black (24.2)	
								White (6.9)	
								Asian (11.6)	
								AIAN (7.9)	
								NHPI (26.4)	
								Mult (13.6)	
	Children Living Below							Other (25.8)	
0.58	Poverty Level	percent	17.1		20.9	18.5	2015-2019	Hisp (24.1)	1
						3410			
0.58	Per Capita Income	dollars	33292		31277	3	2015-2019		1
						6284			
0.42	Median Household Income	dollars	67700		61874	3	2015-2019		1
	People 25+ with a								
	Bachelor's Degree or								
0.42	Higher	percent	32.3		29.9	32.1	2015-2019		1
0.42	inglici	percent	52.5		25.5	52.1	2013 2013		
		percent of driving							
	Alcohol-Impaired Driving	deaths with alcohol							
0.33	Deaths	involvement	21.1	28.3	25.7	27	2015-2019		7
								Black (17.1)	
								White (6.9)	
								Asian (10.2)	
								AIAN (8.8)	
								NHPI (21.7)	
								Mult (12.1)	
	People Living Below							Other (17.2)	
0.33	Poverty Level	percent	11.9	8	14.7	13.4	2015-2019	Hisp (17.5)	1

			TARRANT				MEASUREMENT	HIGH	
SCORE	DIABETES	UNITS	COUNTY	HP2030	ТХ	U.S.	PERIOD	DISPARITY*	Source
		ER visits/ 10,000							
	Age-Adjusted ER Rate due	population 18+							
1.75	to Diabetes	years	37.8		9.4		2017-2019		17
		ER visits/ 10,000							
	Age-Adjusted ER Rate due	population 18+							
1.75	to Type 2 Diabetes	years	33.9		8.6		2017-2019		17
	Age-Adjusted	hospitalizations/							
	Hospitalization Rate due to	10,000 population							
1.75	Diabetes	18+ years	23.3		5.3		2017-2019		17
	Age-Adjusted	hospitalizations/							
	Hospitalization Rate due to	10,000 population							
1.75	Type 2 Diabetes	18+ years	17.1		4		2017-2019		17
	Diabetes: Medicare								
1.50	Population	percent	28.5		28.8	27	2018		6
	Age-Adjusted Death Rate	deaths/ 100,000							
1.36	due to Diabetes	population	22.2		22	21.5	2017-2019		5

			TARRANT				MEASUREMENT	HIGH	
SCORE	ECONOMY	UNITS	COUNTY	HP2030	TX	U.S.	PERIOD	DISPARITY*	Source
	Median Monthly Owner								
	Costs for Households								
2.67	without a Mortgage	dollars	609		514	500	2015-2019		1
	Median Household Gross								
2.33	Rent	dollars	1095		1045	1062	2015-2019		1
	Mortgaged Owners Median								
2.33	Monthly Household Costs	dollars	1658		1606	1595	2015-2019		1
	· · · ·								
	Food Insecure Children								
2.17	Likely Ineligible for Assistance	percent	37		34	23	2019		8
2.17	Assistance	•	57		- 54	25	2015		0
2.00		stores/1,000	0.1				2016		24
2.00	WIC Certified Stores	population	0.1				2016		21
		stores/ 1,000							
1.86	SNAP Certified Stores	population	0.6				2017		21
1.67	Child Food Insecurity Rate	percent	18.4		19.6	14.6	2019		8
	Renters Spending 30% or								
	More of Household Income								
1.64	on Rent	percent	47.5		47.8	49.6	2015-2019		1
	Students Eligible for the								
1.64	Free Lunch Program	percent	53.4				2019-2020		11
	Unemployed Workers in								
1.53	Civilian Labor Force	percent	6.3		6.7	6.1	Jun-21		18
1.50	Food Insecurity Rate	percent	13		14.1	10.9	2019		8
1.50	Low-Income and Low Access to a Grocery Store	percent	8				2015		21
1.47	Total Employment Change	percent	2.2		2.9	1.6	2018-2019		19
1.4/	Total Employment Change	μειζειι	2.2		2.5	1.0	2010-2019		19

1.42	Insecurity Rate	percent	22.9	23.6		2021		8
1.42	Severe Housing Problems	percent	16.8	17.4	18	2013-2017		7
1.36	Homeownership	percent	55.8	54.9	56.2	2015-2019		1
1.36	Overcrowded Households	percent of households	4.4	4.8		2015-2019		1
1.36	Size of Labor Force	persons	1092124			Jun-21		18
1.28	Mortgaged Owners Spending 30% or More of Household Income on Housing	percent	26.3	26.5	26.5	2019		1
	Projected Food Insecurity							
1.25	Rate	percent	15.7	16.5		2021		8
1.14	People 65+ Living Below Poverty Level	percent	8.4	10.6	9.3	2015-2019	Black (15.9) White (5.9) Asian (9.9) AIAN (9.1) NHPI (42.9) Mult (9.1) Other (11.1) Hisp (16)	1
1.03	Households with Cash Public Assistance Income	percent	1.4	1.4	2.4	2015-2019		1
1.00	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	percent	63.6	56		2018		23
1.00	Households that are Asset Limited, Income Constrained, Employed (ALICE)	percent	25.5	30		2018		23

1.00	Households that are Below	norcont	10.9	14		2018		23
1.00	the Federal Poverty Level	percent	10.9		2475	2018		23
4 00			400500	17250	2175	2015 2010		4
1.00	Median Housing Unit Value	dollars	188500	0	00	2015-2019		1
	Female Population 16+ in							
0.97	Civilian Labor Force	percent	61.1	57.8	58.3	2015-2019		1
	Population 16+ in Civilian							
0.97	Labor Force	norcont	64.8	61	59.6	2015-2019		1
0.97		percent	04.8	10	59.0	2015-2019	Plack (24.2)	I
							Black (24.2)	
							White (6.9)	
							Asian (11.6)	
							AIAN (7.9)	
							NHPI (26.4)	
							Mult (13.6)	
	Children Living Below						Other (25.8)	
0.58	Poverty Level	percent	17.1	20.9	18.5	2015-2019	Hisp (24.1)	1
							Black (14.4)	
							White (4.1)	
							Asian (8.6)	
							AIAN (6.2)	
							NHPI (17.2)	
							Mult (8.9)	
	Families Living Below						Other (15.1)	
0.58	Poverty Level	percent	8.9	11.3	9.5	2015-2019	Hisp (15.6)	1
	People Living 200% Above							
0.58	Poverty Level	percent	69.8	65.7	69.1	2015-2019		1
		P			3410			
	Der Carita Incomo	dollars	33292	31277	3	2015-2019		1
0.58	Per Capita income							
0.58	Per Capita Income	uonurs	55252	51277	6284	2010 2013		

								Black (17.1)	
								White (6.9)	
								Asian (10.2)	
								AIAN (8.8)	
								NHPI (21.7)	
								Mult (12.1)	
	People Living Below							Other (17.2)	
0.33	Poverty Level	percent	11.9	8	14.7	13.4	2015-2019	Hisp (17.5)	1
	Persons with Disability								
0.25	Living in Poverty (5-year)	percent	19.7		23.2	26.1	2015-2019		1
		<i>p</i> = = = = = = = = = = = = = = = = = = =							
			TARRANT				MEASUREMENT	HIGH	
SCORE	EDUCATION	UNITS	COUNTY	HP2030	тх	U.S.	PERIOD	DISPARITY*	Source
2.14	High School Drop Out Rate	percent	5.7		1.9		2019		15
1.69									
	Student-to-Teacher Ratio	students/ teacher	15.3				2019-2020		11
	Student-to-Teacher Ratio	students/ teacher	15.3				2019-2020	Black (9.6)	11
	Student-to-Teacher Ratio	students/ teacher	15.3				2019-2020	Black (9.6) White (5.6)	11
		students/ teacher	15.3				2019-2020	White (5.6)	11
1.00	Infants Born to Mothers				17.4	13 3		White (5.6) Other (9.5)	
1.00		students/ teacher	15.3		17.4	13.3	2019-2020 2017	White (5.6)	11
1.00	Infants Born to Mothers				17.4	13.3		White (5.6) Other (9.5)	
1.00	Infants Born to Mothers with <12 Years Education				17.4	13.3		White (5.6) Other (9.5)	
	Infants Born to Mothers with <12 Years Education People 25+ with a High School Degree or Higher	percent	14.9				2017	White (5.6) Other (9.5)	14
	Infants Born to Mothers with <12 Years Education People 25+ with a High School Degree or Higher People 25+ with a	percent	14.9				2017	White (5.6) Other (9.5)	14
	Infants Born to Mothers with <12 Years Education People 25+ with a High School Degree or Higher	percent	14.9				2017	White (5.6) Other (9.5)	14

			TARRANT				MEASUREMENT	HIGH	
SCORE	ENVIRONMENTAL HEALTH	UNITS	COUNTY	HP2030	ТХ	U.S.	PERIOD	DISPARITY*	Source
	Asthma: Medicare								
2.36	Population	percent	5.9		4.9	5	2018		6
	Fast Food Restaurant	restaurants/ 1,000							
2.14	Density	population	0.8				2016		21
		stores/ 1,000							
2.00	WIC Certified Stores	population	0.1				2016		21
		stores/ 1,000							
1.86	SNAP Certified Stores	population	0.6				2017		21
	Children with Low Access								
1.83	to a Grocery Store	percent	7.1				2015		21
	,	stores/ 1,000							
1.83	Grocery Store Density	population	0.1				2016		21
1.75	Annual Ozone Air Quality		F				2017-2019		2
1.67	People with Low Access to a Grocery Store	percent	25.6				2015		21
		p =: = = = = =							
1.64	Number of Extreme Precipitation Days	days	38				2016		12
1.64	PBT Released	pounds	3331.2				2019		22
1.04		pounds	5551.2				2015		
1.64	Recognized Carcinogens Released into Air	pounds	504208.5				2019		22
1.58	Adults with Current Asthma	percent	9.3			9.2	2013		4
1.50	Addits with current Astrina		9.5			9.2	2018		4
1 50	Formana Markat Dansity	markets/ 1,000	0				2010		21
1.50	Farmers Market Density	population	0				2018		21
4 50	Low-Income and Low		0				2015		24
1.50	Access to a Grocery Store	percent	8				2015		21
1.42	Severe Housing Problems	percent	16.8		17.4	18	2013-2017		7

	Months of Mild Drought or						
1.36	Worse	months per year	4			2016	12
	Number of Extreme Heat						
1.36	Days	days	5			2016	12
	Number of Extreme Heat		-				
1.36	Events	events	2			2016	12
1.36	Overcrowded Households	percent of households	4.4	4.8		2015-2019	1
1.30		nousenoius	4.4	4.8		2015-2019	1
	People 65+ with Low						
1.33	Access to a Grocery Store	percent	2.4			2015	21
1.25	Annual Particle Pollution		А			2017-2019	2
1.19	Food Environment Index		7.4	5.9	7.8	2021	7
1.17	Adults with Asthma	percent	10.8	10.9	13.3	2012	3
		Joule per square					
1.17	Daily Dose of UV Irradiance	meter	3309	3538		2015	12
4 47	Recreation and Fitness	facilities/ 1,000	0.4			2016	24
1.17	Facilities	population	0.1			2016	21
	Weeks of Moderate						
1.08	Drought or Worse	weeks per year	1			2016	12
	Households with No Car						
1.00	and Low Access to a	norcont	1 0			2015	21
1.00	Grocery Store	percent	1.3			2015	21
		stores/ 100,000					
					10 5		10
0.89	Liquor Store Density	population	5.3	6.9	10.5	2019	19
0.89	Liquor Store Density Access to Exercise	population	5.3	6.9	10.5	2019	19

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	TARRANT COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
JCORE		UNITS	COUNTY	HF 2030		0.3.	PERIOD	DISPARIT	300102
	Adults who have had a								
1.92	Routine Checkup	percent	73.1			76.7	2018		4
	Adults without Health								
1.92	Insurance	percent	24.7			12.2	2018		4
	Adults with Health								
1.67	Insurance	percent	78.2		75.5	87.1	2019		1
						_			
1.64	Persons with Health	norcont	01 1	02.1	70.2		2010		20
1.64	Insurance	percent	81.1	92.1	79.3		2019		20
	Children with Health								
1.50	Insurance	percent	88.4		87.3	94.3	2019		1
	Adults who Visited a								
1.42	Dentist	percent	60.6			66.5	2018		4
		providers/ 100,000							
1.11	Primary Care Provider Rate	population	58.8		60.9		2018		7
0.00		workers/100,000	110.2		02.7		2020		1.4
0.86	Social Worker Rate	population	118.2		82.7		2020		14
	Non-Physician Primary Care	providers/ 100,000							
0.83	Provider Rate	population	88		88.6		2020		7
		dentists/ 100,000							
0.67	Dentist Rate	population	60.4		59.6		2019		7
	Mental Health Provider	providers/ 100,000							
0.67	Rate	population	131.8		120.9		2020		7
		population	10110		120.0		2020		

			TARRANT				MEASUREMENT	HIGH	
SCORE	HEART DISEASE & STROKE	UNITS	COUNTY	HP2030	ТХ	U.S.	PERIOD	DISPARITY*	Source
	Age-Adjusted Death Rate due to Cerebrovascular	deaths/ 100,000							
2.39	Disease (Stroke)	population	46.4	33.4	40.2	37.2	2017-2019		5
2.08	Adults who Have Taken Medications for High Blood Pressure	percent	72.3			75.8	2017		4
1.83	Hyperlipidemia: Medicare Population	percent ER visits/ 10,000	49.7		49.5	47.7	2018		6
1.75	Age-Adjusted ER Rate due to Hypertension	population 18+ years	38.5		10.5		2017-2019		17
1.75	Age-Adjusted Hospitalization Rate due to Hypertension	hospitalizations/ 10,000 population 18+ years	0.5		0.1		2017-2019		17
1.67	Hypertension: Medicare Population	percent	60.2		59.9	57.2	2018		6
1.64	Atrial Fibrillation: Medicare Population	percent	8.1		7.8	8.4	2018		6
1.42	Cholesterol Test History	percent	80.6			81.5	2017		4
1.33	High Blood Pressure Prevalence	percent	33.9	27.7		32.4	2017		4
1.25	High Cholesterol Prevalence: Adults 18+	percent	35			34.1	2017		4
1.25	Stroke: Medicare Population	percent	4.1		4.2	3.8	2018		6
1.19	Heart Failure: Medicare Population	percent	15		15.6	14	2018		6

	Ischemic Heart Disease:								
1.00	Medicare Population	percent	26.5		29	26.8	2018		6
	Adults who Experienced a								
0.92	Stroke	percent	3.1			3.4	2018		4
	Adults who Experienced								
0.92	Coronary Heart Disease	percent	6.2			6.8	2018		4
		deaths/ 100,000							
	Age-Adjusted Death Rate	population 35+							
0.58	due to Heart Attack	years	44.1		70.1		2018		12
	Age-Adjusted Death Rate								
	due to Coronary Heart	deaths/ 100,000							
0.11	Disease	population	76.8	71.1	93	90.5	2017-2019		5
	IMMUNIZATIONS &		TARRANT				MEASUREMENT	HIGH	
SCORE	INFECTIOUS DISEASES	UNITS	COUNTY	HP2030	тх	U.S.	PERIOD	DISPARITY*	Source
JCORL			COONTI	117 2030		0.3.	FERIOD	DISFAILT	Jource
		cases/ 100,000							
2.39	Syphilis Incidence Rate	population	13.6		8.8	10.8	2018		14
	COVID-19 Daily Average	cases per 100,000							
2.00	Incidence Rate	population	54.9		47.1	51.4	21-Sep-21		9
	Age-Adjusted								
	Hospitalization Rate due to	hospitalizations/							
4.75	Immunization-Preventable	10,000 population	0.2		0.4		2017 2010		47
1.75	Pneumonia and Influenza	18+ years	0.3		0.1		2017-2019		17
		cases/ 100,000							
1.64	HIV Diagnosis Rate	population	13.2		15.7		2018		14
		cases/ 100,000							
1.56	Gonorrhea Incidence Rate	population	154		163.6	179.1	2018		14
	Age-Adjusted Death Rate	dootho / 100 000							
1.50	due to Influenza and	deaths/ 100,000	12.1		11.8	13.8	2017-2019		5
1.50	Pneumonia	population	12.1		11.ŏ	13.8	2017-2019		5

		cases/ 100,000						
1.42	Chlamydia Incidence Rate	population	459.1		508.2	539.9	2018	14
		percent of						
1.36	Overcrowded Households	households	4.4		4.8		2015-2019	1
	Tuberculosis Incidence	cases/ 100,000						
1.17	Rate	population	3.3	1.4	4.3		2015-2019	14
	COVID-19 Daily Average	deaths per 100						
1.14	Case-Fatality Rate	cases	1.2		4.3	2	21-Sep-21	9

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	TARRANT COUNTY	HP2030	тх		MEASUREMENT PERIOD	HIGH DISPARITY*	Source
SCORE		UNITS	COUNTY	HP2030		U.S.	PERIOD	DISPARITY	Source
		deaths/ 1,000 live							
1.83	Infant Mortality Rate	births	6.2	5	5.6	5.9	2015		14
	Mothers who Received								
1.78	Early Prenatal Care	narcant	59.2		60.5	77.3	2017		14
1.70		percent	39.2		00.5	11.5	2017		14
	Babies with Low Birth								
1.61	Weight	percent	8.3		8.2	8.1	2015		14
1.56	Preterm Births	percent	11.6	9.4	12.2		2017		14
	Babies with Very Low Birth								
1.28	Weight	percent	1.4			1.4	2015		14
								Black (9.6)	
								White (5.6)	
	Infants Born to Mothers							Other (9.5)	
1.00	with <12 Years Education	percent	14.9		17.4	13.3	2017	Hisp (28.4)	14
								Black (1.9)	
								White (0.7)	
								Other (0.5)	
0.67	Teen Births	percent	1.7		2.1	3.1	2017	Hisp (2.8)	14

			TADDANT						
	MENTAL HEALTH &		TARRANT				MEASUREMENT	HIGH	
SCORE	MENTAL DISORDERS	UNITS	COUNTY	HP2030	ТХ	U.S.	PERIOD	DISPARITY*	Source
	Depression: Medicare								
2.64	Population	percent	20.8		18.2	18.4	2018		6
	Alzheimer's Disease or								
	Dementia: Medicare								
2.19	Population	percent	13.4		12.6	10.8	2018		6
1.50	Frequent Mental Distress	percent	13.8		11.6	13	2018		7
	Poor Mental Health: 14+								
1.42	Days	percent	13.9			12.7	2018		4
								Black (6.5)	
								White (14.8)	
	Age-Adjusted Death Rate	deaths/ 100,000						API (8.8) Hisp	
1.25	due to Suicide	population	13	12.8	13.5	14.1	2017-2019	(6)	5
		ER visits/ 10,000							
	Age-Adjusted ER Rate due	population 18+							
1.25	to Adult Mental Health	years	7.5		8.9		2017-2019		17
	Age-Adjusted	hospitalizations/							
	Hospitalization Rate due to	10,000 population							
1.25	Adult Mental Health	18+ years	1.6		1.7		2017-2019		17
	Mental Health Provider	providers/ 100,000							
0.67	Rate	population	131.8		120.9		2020		7

2.75 C M 2.64 D P 2.47 C P 2.36 A P A D	OLDER ADULTS Chronic Kidney Disease: Medicare Population Depression: Medicare Population Cancer: Medicare Population Asthma: Medicare Population	UNITS percent percent percent	28.2 20.8 8.5	HP2030	TX 26.7 18.2	U.S. 24.5 18.4	2018	DISPARITY*	Source 6
2.75 M 2.64 D 2.47 C 2.36 A A A	Medicare Population Depression: Medicare Population Cancer: Medicare Population Asthma: Medicare	percent	20.8						6
2.64 D P 2.47 P 2.36 A P A D	Depression: Medicare Population Cancer: Medicare Population Asthma: Medicare	percent	20.8						6
2.64 P 2.47 P 4 2.36 A P A D	Population Cancer: Medicare Population Asthma: Medicare				18.2	18.4	2010		
2.47 C P A 2.36 P A D	Cancer: Medicare Population Asthma: Medicare				18.2	18.4	2040		
2.47 P A 2.36 P A A D	Population Asthma: Medicare	percent	8.5				2018		6
2.36 P A D	Asthma: Medicare	percent	8.5						
2.36 P					7.6	8.4	2018		6
2.36 P									
A		percent	5.9		4.9	5	2018		6
D									
	Alzheimer's Disease or								
	Dementia: Medicare		12.4		40.0		2212		-
2.19 P	Population	percent	13.4		12.6	10.8	2018		6
R	Rheumatoid Arthritis or								
0	Osteoarthritis: Medicare								
1.97 P	Population	percent	36		34.2	33.5	2018		6
1.83 C	Colon Cancer Screening	percent	60.1	74.4		66.4	2018		4
н	Hyperlipidemia: Medicare								
	Population	percent	49.7		49.5	47.7	2018		6
	·								
	Adults 65+ who Received								
	Recommended Preventive Services: Females	norcont	25.2			28.4	2018		4
1./5 5	Services: Females	percent	25.2			28.4	2018		4
A	Adults 65+ who Received								
R	Recommended Preventive								
1.75 S	Services: Males	percent	25.9			32.4	2018		4
0	Osteoporosis: Medicare								
	Population	percent	6.6		6.8	6.6	2018		6
н	Hypertension: Medicare								
1.67 P									

	Atrial Fibrillation: Medicare							
1.64	Population	percent	8.1	7.8	8.4	2018		6
	Diabetes: Medicare							
1.50	Population	norcont	28.5	28.8	27	2018		6
1.50	Population	percent	20.5	20.0	27	2018		0
	People 65+ with Low							
1.33	Access to a Grocery Store	percent	2.4			2015		21
	Adults 65+ with Total Tooth							
1.25	Loss	norcont	14		13.5	2018		4
1.25	LOSS	percent	14		15.5	2018		4
	Stroke: Medicare							
1.25	Population	percent	4.1	4.2	3.8	2018		6
	Heart Failure: Medicare							
1.19	Population	norcont	15	15.6	14	2018		6
1.19	Population	percent	15	15.0	14	2018		0
							Black (15.9) White (5.9)	
							Asian (9.9)	
							Alan (9.1)	
							NHPI (42.9)	
							Mult (9.1)	
	People 65+ Living Below						Other (11.1)	
1.14	Poverty Level	percent	8.4	10.6	9.3	2015-2019	Hisp (16)	1
1.14		percent	0.4	10.0	5.5	2015-2015	11130 (10)	⊥
	COPD: Medicare							
1.03	Population	percent	10.7	11.2	11.5	2018		6
	Ischemic Heart Disease:							
1.00	Medicare Population	norcont	26.5	29	26.8	2018		6
		percent		29				
0.75	Adults with Arthritis	percent	22.4		25.8	2018		4

			TARRANT				MEASUREMENT	HIGH	
SCORE	ORAL HEALTH	UNITS	COUNTY	HP2030	ТХ	U.S.	PERIOD	DISPARITY*	Source
	Age-Adjusted ER Rate due	ER visits/ 10,000							
	• •						2217 2212		47
1.75	to Dental Problems	population	48.6		11.1		2017-2019		17
	Oral Cavity and Pharynx	cases/ 100,000							
1.72	Cancer Incidence Rate	population	12.1		11	11.8	2013-2017		10
	Adults who have had								
1.50	Permanent Teeth Extracted	percent	42.9		42.8	44.5	2012		3
	Adults who Visited a								
1.42	Dentist	percent	60.6			66.5	2018		4
	Adults 65+ with Total Tooth								
1.25	Loss	percent	14			13.5	2018		4
		dentists/ 100,000							
0.67	Dentist Rate	population	60.4		59.6		2019		7

			TARRANT				MEASUREMENT	HIGH	
SCORE	OTHER CONDITIONS	UNITS	COUNTY	HP2030	ТХ	U.S.	PERIOD	DISPARITY*	Source
	Chronic Kidney Disease:								
2.75	Medicare Population	percent	28.2		26.7	24.5	2018		6
1.97	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	36		34.2	33.5	2018		6
	Osteoporosis: Medicare								
1.69	Population	percent	6.6		6.8	6.6	2018		6
0.92	Adults with Kidney Disease	Percent of adults	2.8			3.1	2018		4
0.75	Adults with Arthritis	percent	22.4			25.8	2018		4

SCORE	PHYSICAL ACTIVITY	UNITS	TARRANT COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Fast Food Restaurant								
2.14	Density	restaurants/ 1,000 population	0.8				2016		21
	Density		0.0				2010		
2.00	WIC Certified Stores	stores/ 1,000	0.1				2016		21
2.00	wit Certified Stores	population	0.1				2010		21
		stores/ 1,000							
1.86	SNAP Certified Stores	population	0.6				2017		21
	Children with Low Access								
1.83	to a Grocery Store	percent	7.1				2015		21
		stores/ 1,000							
1.83	Grocery Store Density	population	0.1				2016		21
	People with Low Access to								
1.67	a Grocery Store	percent	25.6				2015		21
1.50	Farmers Market Density	markets/ 1,000 population	0				2018		21
1.50	· · · · · · · · · · · · · · · · · · ·	ροραιατισπ	0				2010		
4 50	Low-Income and Low		0				2015		24
1.50	Access to a Grocery Store	percent	8				2015		21
	People 65+ with Low								
1.33	Access to a Grocery Store	percent	2.4				2015		21
1.19	Food Environment Index		7.4		5.9	7.8	2021		7
	Recreation and Fitness	facilities/ 1,000							
1.17	Facilities	population	0.1				2016		21
	Households with No Car and Low Access to a								
1.00	Grocery Store	percent	1.3				2015		21
0.50	Access to Exercise Opportunities	norcont	93.9		80.5	84	2020		7
0.50	opportunities	percent	93.9		80.5	ð4	2020		/

SCORE	PREVENTION & SAFETY	UNITS	TARRANT COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.42	Severe Housing Problems	percent	16.8		17.4	18	2013-2017		7
0.56	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	32	43.2	38.7	48.9	2017-2019		5
0.33	Death Rate due to Drug Poisoning	deaths/ 100,000 population	8.9		10.6	21	2017-2019		7
SCORE	RESPIRATORY DISEASES	UNITS	TARRANT COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.36	Asthma: Medicare Population	percent	5.9		4.9	5	2018		6
2.00	COVID-19 Daily Average Incidence Rate	cases per 100,000 population	54.9		47.1	51.4	21-Sep-21		9
1.75	Age-Adjusted Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza	hospitalizations/ 10,000 population 18+ years	0.3		0.1		2017-2019		17
1.58	Adults with Current Asthma	percent	9.3			9.2	2018		4
1.50	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	12.1		11.8	13.8	2017-2019		5
1.17	Adults who Smoke	percent	15.6	5		15.5	2018		4
1.17	Adults with Asthma	percent	10.8		10.9	13.3	2012		3
1.17	Tuberculosis Incidence Rate	cases/ 100,000 population	3.3	1.4	4.3		2015-2019		14
1.14	COVID-19 Daily Average Case-Fatality Rate	deaths per 100 cases	1.2		4.3	2	21-Sep-21		9

1.03	COPD: Medicare Population	percent	10.7		11.2	11.5	2018	6
0.83	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	37.4	25.1	34.1	38.5	2013-2017	10
0.75	Adults with COPD	Percent of adults	6.2			6.9	2018	4
0.75	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	55.3		50.6	58.3	2013-2017	10

SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	TARRANT COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.39	Syphilis Incidence Rate	cases/ 100,000 population	13.6		8.8	10.8	2018		14
1.64	HIV Diagnosis Rate	cases/ 100,000 population	13.2		15.7		2018		14
1.56	Gonorrhea Incidence Rate	cases/ 100,000 population	154		163.6	179.1	2018		14
1.42	Chlamydia Incidence Rate	cases/ 100,000 population	459.1		508.2	539.9	2018		14

SCORE	WELLNESS & LIFESTYLE	UNITS	TARRANT COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.67	Frequent Physical Distress	percent	12.9		11.6	11	2018		7
1.33	High Blood Pressure Prevalence	percent	33.9	27.7		32.4	2017		4
1.25	Poor Physical Health: 14+ Days	percent	12.9			12.5	2018		4
0.86	Insufficient Sleep	percent	33	31.4	34.4	35	2018		7

SCORE	WOMEN'S HEALTH	UNITS	TARRANT COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
500112						0.01	121100	Black (34.5)	
								White (20.5)	
	Age-Adjusted Death Rate	deaths/ 100,000						API (9) Hisp	
2.25	due to Breast Cancer	females	20.9	15.3	19.8	20.1	2013-2017	(11.4)	10
	Breast Cancer Incidence	cases/ 100,000							
2.25	Rate	females	122.1		112.8	125.9	2013-2017		10
	Comitael Conson Consoning								
1 44	Cervical Cancer Screening:	Doroont	82.8	84.3		84.7	2018		4
1.44	21-65	Percent	82.8	84.3		84.7	2018		4
	Cervical Cancer Incidence	cases/ 100,000							
1.28	Rate	females	8.2		9.2	7.6	2013-2017		10
	Mammogram in Past 2								
1.28	Years: 50-74	percent	71.2	77.1		74.8	2018		4

Tarrant County Sources

- KeySource Title1American Community Survey
- 2 American Lung Association
- 3 Behavioral Risk Factor Surveillance System
- 4 CDC PLACES
- 5 Centers for Disease Control and Prevention
- 6 Centers for Medicare & Medicaid Services
- 7 County Health Rankings
- 8 Feeding America
- 9 Healthy Communities Institute
- 10 National Cancer Institute
- 11 National Center for Education Statistics
- 12 National Environmental Public Health Tracking Network
- 13 Texas Department of Family and Protective Services
- 14 DFWHC Foundation Regional Data, Q1-Q4, 2017-2019. DFWHC Foundation, Irving Texas. October 15, 2021
- 15 Texas Education Agency
- 16 Texas Secretary of State
- 17 THR Texas Department of Health Services
- 18 U.S. Bureau of Labor Statistics
- 19 U.S. Census County Business Patterns
- 20 U.S. Census Bureau Small Area Health Insurance Estimates
- 21 U.S. Department of Agriculture Food Environment Atlas
- 22 U.S. Environmental Protection Agency
- 23 United For ALICE

Tarrant County Topic Scores

Health and Quality of Life Topics	Score
Sexually Transmitted Infections	1.75
Children's Health	1.75
Women's Health	1.70
Older Adults	1.68
Diabetes	1.64
Other Conditions	1.62
Immunizations & Infectious Diseases	1.59
Mental Health & Mental Disorders	1.52
Physical Activity	1.50
Environmental Health	1.47
Cancer	1.42
Maternal, Fetal & Infant Health	1.39
Oral Health	1.39
Heart Disease & Stroke	1.36
Respiratory Diseases	1.32
Community	1.30
Health Care Access & Quality	1.29
Economy	1.29
Wellness & Lifestyle	1.28
Alcohol & Drug Use	1.24
Education	1.23
Prevention & Safety	0.77

Parker County Indicator Scores

			PARKER				MEASUREMENT	HIGH	
SCORE	ALCOHOL & DRUG USE	UNITS	COUNTY	HP2030	тх	U.S.	PERIOD	DISPARITY*	Source
1.92	Adults who Binge Drink	percent	17.2			16.4	2018		3
1.75	Age-Adjusted ER Rate due to Opioid Use	ER visits/ 10,000 population 18+ years	2.9		0.7		2017-2019		16
1.25	Age-Adjusted ER Rate due to Substance Use	ER visits/ 10,000 population 18+ years	14.2		20.6		2017-2019		16
1.25	Age-Adjusted Hospitalization Rate due to Substance Use	hospitalizations/ 10,000 population 18+ years	1.1		1.2		2017-2019		16
1.00	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	Deaths per 100,000 population	9.5		12.1	22.8	2017-2019		4
0.89	Liquor Store Density	stores/ 100,000 population	3.5		6.9	10.5	2019		18
0.72	Alcohol-Impaired Driving Deaths	percent of driving deaths with alcohol involvement	17.5	28.3	25.7	27	2015-2019		6
0.61	Death Rate due to Drug Poisoning	deaths/ 100,000 population	9.2		10.6	21	2017-2019		6
SCORE	CANCER	UNITS	PARKER COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.75	Cancer: Medicare Population	percent	8.9		7.6	8.4	2018		5
2.50	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	14		11	11.8	2013-2017		9
2.39	Cervical Cancer Incidence Rate	cases/ 100,000 females	10.2		9.2	7.6	2013-2017		9
2.31	All Cancer Incidence Rate	cases/ 100,000 population	455.9		407.7	448.7	2013-2017		9
2.17	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	67.7		50.6	58.3	2013-2017		9
2.03	Breast Cancer Incidence Rate	cases/ 100,000 females	130.1		112.8	125.9	2013-2017		9

1.75	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	23.1	15.3	19.8	20.1	2013-2017		9
1.72	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	14	8.9	13.9	13.7	2013-2017		9
1.67	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	44.6	25.1	34.1	38.5	2013-2017		9
1.61	Mammogram in Past 2 Years: 50-74	percent	69.8	77.1		74.8	2018		3
1.58	Adults with Cancer	percent	7.3			6.9	2018		3
1.50	Age-Adjusted Death Rate due to Cancer	deaths/ 100,000 population	164.6	122.7	148.8	155.5	2013-2017		9
1.50	Colon Cancer Screening	percent	61.7	74.4		66.4	2018		3
1.28	Cervical Cancer Screening: 21-65	Percent	84	84.3		84.7	2018		3
1.17	Prostate Cancer Incidence Rate	cases/ 100,000 males	91.6		94	104.5	2013-2017		9
1.03	Colorectal Cancer Incidence Rate	cases/ 100,000 population	37.5		37.6	38.4	2013-2017		9
0.25	Age-Adjusted Death Rate due to Prostate Cancer	deaths/ 100,000 males	13.1	16.9	17.6	19	2013-2017		9
SCORE	CHILDREN'S HEALTH	UNITS	PARKER COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.50	Food Insecure Children Likely Ineligible for Assistance	percent	41		34	23	2019		7
2.06	Substantiated Child Abuse Rate	cases/ 1,000 children	14.9	8.7	9.1		2020		12
1.50	Children with Health Insurance	percent	90.8		87.3	94.3	2019		1
1.50	Children with Low Access to a Grocery Store	percent	4.5				2015		20
1.08	Projected Child Food Insecurity Rate	percent	19.6		23.6		2021		7
1.00	Child Food Insecurity Rate	percent	15.9		19.6	14.6	2019		7

			PARKER				MEASUREMENT	HIGH	
SCORE	COMMUNITY	UNITS	COUNTY	HP2030	ТХ	U.S.	PERIOD	DISPARITY*	Source
2.36	Mean Travel Time to Work	minutes	31.8		26.6	26.9	2015-2019		1
2.36	Solo Drivers with a Long Commute	percent	50.7		38.9	37	2015-2019		6
2.33	Median Monthly Owner Costs for Households without a Mortgage	dollars	545		514	500	2015-2019		1
2.33	Mortgaged Owners Median Monthly Household Costs	dollars	1750		1606	1595	2015-2019		1
2.31	Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions	deaths/ 100,000 population	19.8	10.1	13	11.3	2017-2019		4
2.06	Substantiated Child Abuse Rate	cases/ 1,000 children	14.9	8.7	9.1		2020		12
2.00	Median Household Gross Rent	dollars	1027		1045	1062	2015-2019		1
1.97	Workers who Drive Alone to Work People 25+ with a	percent	83.6		80.5	76.3	2015-2019		1
1.92	Bachelor's Degree or Higher	percent	26.4		29.9	32.1	2015-2019		1
1 70	Workers Commuting by	accout	0.2	F 2	14	_	2015 2010	Black (0.7) White (0.3) Asian (0) AIAN (0) NHPI (0) Mult (0.3) Other (0)	1
1.78	Public Transportation	percent	0.3	5.3	1.4	5	2015-2019	Hisp (0)	1
1.64	Persons with Health Insurance	percent	82.7	92.1	79.3		2019		19
1.47	Female Population 16+ in Civilian Labor Force	percent	55.6		57.8	58.3	2015-2019		1

	Households with No Car							
	and Low Access to a							
1.33	Grocery Store	percent	2				2015	20
	Population 16+ in Civilian							
1.31	Labor Force	percent	59.6		61	59.6	2015-2019	1
		workers/ 100,000						
1.25	Social Worker Rate	population	58.3		82.7		2020	13
		membership associations/						
1.19	Social Associations	10,000 population	9.7		7.5	9.3	2018	6
1.14	People 25+ with a High School Degree or Higher	percent	88.6		83.7	88	2015-2019	1
1.14		percent	88.0		05.7	00	2013-2013	1
	Persons with an Internet							_
1.08	Subscription	percent	88.2		84.2	86.2	2015-2019	1
0.97	Linguistic Isolation	percent	2		7.7	4.4	2015-2019	1
	Voter Turnout: Presidential							
0.86	Election	percent	66.6		58.8		2016	15
	Households with an							
0.83	Internet Subscription	percent	85.4		82.1	83	2015-2019	1
	· · · · ·	<i>p</i> =						
	Households with One or							
0.83	More Types of Computing Devices	norcont	94.4		91	90.3	2015-2019	1
0.85		percent	94.4		91	90.3	2015-2019	I
	Alcohol-Impaired Driving	percent of driving deaths			_			
0.72	Deaths	with alcohol involvement	17.5	28.3	25.7	27	2015-2019	6
0.67	Median Housing Unit	dollars	214200		172500	217500	2015 2010	1
0.67	Value	aonars			172500	217500	2015-2019	1
0.64	Homeownership	percent	69.7		54.9	56.2	2015-2019	1
0.36	Single-Parent Households	percent	14.4		26.3	25.5	2015-2019	1
0.25	Per Capita Income	dollars	35142		31277	34103	2015-2019	1
0.25	Total Employment Change	percent	3.9		2.9	1.6	2018-2019	18
	People Living Below							
0.11	Poverty Level	percent	8.1	8	14.7	13.4	2015-2019	1
	· · · · · · · · · · · · · · · · · · ·	percent	0.1		1,	10.1		-
0.08	Children Living Below	norcont	10.1		20.9	18.5	2015-2019	1
	Poverty Level	percent						1
0.08	Median Household Income	dollars	77503		61874	62843	2015-2019	1

			PARKER				MEASUREMENT	HIGH	
SCORE	DIABETES	UNITS	COUNTY	HP2030	ТХ	U.S.	PERIOD	DISPARITY*	Source
	Age-Adjusted ER Rate due	ER visits/ 10,000 population							
1.75	to Diabetes	18+ years	24		9.4		2017-2019		16
	Age-Adjusted ER Rate due	ER visits/ 10,000 population							
1.75	to Type 2 Diabetes	18+ years	20.8		8.6		2017-2019		16
	Age-Adjusted								
	Hospitalization Rate due to	hospitalizations/ 10,000							
1.75	Diabetes	population 18+ years	16.7		5.2		2017-2019		16
	Age-Adjusted								
	Hospitalization Rate due to	hospitalizations/ 10,000							
1.75	Type 2 Diabetes	population 18+ years	12.4		4		2017-2019		16
	Diabetes: Medicare								
1.50	Population	percent	27.2		28.8	27	2018		5
	Age-Adjusted Death Rate								
1.14	due to Diabetes	deaths/ 100,000 population	19.4		22	21.5	2017-2019		4

SCORE	ECONOMY	UNITS	PARKER COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Food Insecure Children								
	Likely Ineligible for								
2.50	Assistance	percent	41		34	23	2019		7
	Median Monthly Owner								
2.33	Costs for Households without a Mortgage	dollars	545		514	500	2015-2019		1
2.35	Mortgaged Owners	uonurs	545		514	500	2013-2013		1
	Median Monthly								
2.33	Household Costs	dollars	1750		1606	1595	2015-2019		1
	Median Household Gross								
2.00	Rent	dollars	1027		1045	1062	2015-2019		1
2.00	WIC Certified Stores	stores/ 1,000 population	0.1				2016		20
1.86	SNAP Certified Stores	stores/ 1,000 population	0.4				2017		20
	Households with Cash								
1.67	Public Assistance Income	percent	1.9		1.4	2.4	2015-2019		1
	Female Population 16+ in								
1.47	Civilian Labor Force	percent	55.6		57.8	58.3	2015-2019		1
	Population 16+ in Civilian								
1.31	Labor Force	percent	59.6		61	59.6	2015-2019		1
	Mortgaged Owners								
	Spending 30% or More of								
	Household Income on		25 7		26 5	26 5	2010		
1.28	Housing	percent	25.7		26.5	26.5	2019		1
1.17	Food Insecurity Rate	percent	12.5		14.1	10.9	2019		7
	Low-Income and Low								
1.17	Access to a Grocery Store	percent	5.3				2015		20
1.17	Overcrowded Households	percent of households	2.7		4.8		2015-2019		1
	Students Eligible for the								
1.14	Free Lunch Program	percent	29.6				2019-2020		10
	Projected Child Food								
1.08	Insecurity Rate	percent	19.6		23.6		2021		7

	Projected Food Insecurity							
1.08	Rate	percent	14.7	16.5		2021		
1.00	Child Food Insecurity Rate	percent	15.9	19.6	14.6	2019		
1.00	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	percent	63.3	56		2018		
	Households that are Asset Limited, Income Constrained, Employed							
1.00	(ALICE)	percent	26.6	30		2018		
4 00	Households that are Below		10.1			2010		
1.00	the Federal Poverty Level	percent	10.1	14		2018		
1.00	Severe Housing Problems	percent	13.3	17.4	18	2013-2017		
0.83	Renters Spending 30% or More of Household Income on Rent	percent	40.8	47.8	49.6	2015-2019		
0.81	People 65+ Living Below Poverty Level	percent	7.4	10.6	9.3	2015-2019	Black (0) White (7) Asian (0) AIAN (10.2) NHPI (100) Mult (21.8) Other (49.4) Hisp (13.3)	
	Unemployed Workers in							
0.69	Civilian Labor Force	percent	5.2	6.7	6.1	Jun-21		
0.67	Median Housing Unit Value	dollars	214200	172500	217500	2015-2019		
0.64	Homeownership	percent	69.7	54.9	56.2	2015-2019		
		percent			50.2	2010 2013	Black (6.8) White (5) Asian (7.9) AIAN (2.2) NHPI (35.3) Mult (2.8)	
0.20	Families Living Below	norcont	F C	11.2	0.5	2015 2010	Other (17)	
0.36	Poverty Level	percent	5.6	11.3	9.5	2015-2019	Hisp (10.8)	

0.25	Per Capita Income	dollars	35142		31277	34103	2015-2019	1
0.25	Total Employment Change	percent	3.9		2.9	1.6	2018-2019	18
	People Living Below							
0.11	Poverty Level	percent	8.1	8	14.7	13.4	2015-2019	1
	Children Living Below							
0.08	Poverty Level	percent	10.1		20.9	18.5	2015-2019	1
0.08	Median Household Income	dollars	77503		61874	62843	2015-2019	-
	People Living 200% Above							
0.08	Poverty Level	percent	77.2		65.7	69.1	2015-2019	
	Persons with Disability							
0.08	Living in Poverty (5-year)	percent	13.4		23.2	26.1	2015-2019	

SCORE	EDUCATION	UNITS	PARKER COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	People 25+ with a								
	Bachelor's Degree or								
1.92	Higher	percent	26.4		29.9	32.1	2015-2019		1
1.81	High School Drop Out Rate	percent	2.3		1.9		2019	Black (5.6) White (2.5) Asian (0) AIAN (0) Mult (0) Hisp (1.8)	14
1.69	Student-to-Teacher Ratio	students/ teacher	14.7				2019-2020	(-) /	10
1.09		students/ teacher	14.7				2019-2020		10
	People 25+ with a High								
1.14	School Degree or Higher	percent	88.6		83.7	88	2015-2019		1
	Infants Born to Mothers							White (4.4)	
0.33	with <12 Years Education	percent	7.6		17.4	13.3	2017	Hisp (25.8)	13

SCORE	ENVIRONMENTAL HEALTH	UNITS	PARKER COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.17	Access to Exercise Opportunities	percent	52.6		80.5	84	2020		6
2.08	Asthma: Medicare Population	percent	6.1		4.9	5	2018		5
2.00	Grocery Store Density	stores/ 1,000 population	0.1				2016		20
2.00	WIC Certified Stores	stores/ 1,000 population	0.1				2016		20
1.86	SNAP Certified Stores	stores/ 1,000 population	0.4				2017		20
1.81	Fast Food Restaurant Density	restaurants/ 1,000 population	0.7				2016		20
1.64	Number of Extreme Precipitation Days	days	41				2016		11
1.50	Children with Low Access to a Grocery Store	percent	4.5				2015		20
1.50	Farmers Market Density	markets/ 1,000 population	0				2018		20
1.44	Annual Ozone Air Quality	Grade	D				2017-2019		2
1.36	Number of Extreme Heat Days	days	7				2016		11
1.36	PBT Released	pounds	1183.1				2019		21
1.33	Households with No Car and Low Access to a Grocery Store	percent	2				2015		20
1.33	People 65+ with Low Access to a Grocery Store	percent	2.5				2015		20
1.33	People with Low Access to a Grocery Store	percent	17.6				2015		20
1.19	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2016		20
1.17	Low-Income and Low Access to a Grocery Store	percent	5.3				2015		20
1.17	Overcrowded Households	percent of households	2.7		4.8		2015-2019		1
1.08	Adults with Current Asthma	percent	8.9			9.2	2018		3

1.08	Weeks of Moderate Drought or Worse	weeks per year	1			2016	11
1.03	Daily Dose of UV Irradiance	Joule per square meter	3331	3538		2015	11
1.00	Severe Housing Problems	percent	13.3	17.4	18	2013-2017	6
0.89	Liquor Store Density	stores/ 100,000 population	3.5	6.9	10.5	2019	18
0.69	Food Environment Index		7.9	5.9	7.8	2021	6

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	PARKER COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
JCORE	•	ONITS	COONT	111 2030		0.5.	T ENIOD	DISTANT	Jource
1.92	Adults who have had a Routine Checkup	percent	73.5			76.7	2018		3
1.92		· · ·	75.5			70.7	2018		5
		providers/ 100,000							_
1.89	Primary Care Provider Rate	population	41.9		60.9		2018		6
	Adults without Health								
1.75	Insurance	percent	19.2			12.2	2018		3
		dentists/ 100,000							
1.75	Dentist Rate	population	35.7		59.6		2019		6
	Non-Physician Primary	providers/ 100,000							
1.67	Care Provider Rate	population	42.7		88.6		2020		6
	Persons with Health								
1.64	Insurance	percent	82.7	92.1	79.3		2019		19
	Adults with Health			_					
1.50	Insurance	norcont	80.1		75.5	87.1	2019		1
1.50		percent	80.1		75.5	87.1	2019		I
	Children with Health								
1.50	Insurance	percent	90.8		87.3	94.3	2019		1
	Mental Health Provider	providers/ 100,000							
1.33	Rate	population	55.3		120.9		2020		6
	Adults who Visited a								
1.25	Dentist	percent	61.9			66.5	2018		3
		workers/ 100,000							
1.25	Social Worker Rate	population	58.3		82.7		2020		13

SCORE	HEART DISEASE & STROKE	UNITS	PARKER COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Atrial Fibrillation:					0.0.			
2.92	Medicare Population	percent	9.3		7.8	8.4	2018		5
2.42	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	deaths/ 100,000 population	47	33.4	40.2	37.2	2017-2019		4
2.31	Ischemic Heart Disease: Medicare Population	percent	31.1		29	26.8	2018		5
1.97	Hyperlipidemia: Medicare Population	percent	50.1		49.5	47.7	2018		5
1.86	Stroke: Medicare Population	percent	4.2		4.2	3.8	2018		5
1.81	Hypertension: Medicare Population	percent	60.8		59.9	57.2	2018		5
1.75	Adults who Have Taken Medications for High Blood Pressure	percent	76			75.8	2017		3
1.75	Age-Adjusted ER Rate due to Hypertension	ER visits/ 10,000 population 18+ years	29.9		10.5		2017-2019		16
1.75	Age-Adjusted Hospitalization Rate due to Hypertension	hospitalizations/ 10,000 population 18+ years	0.5		0.1		2017-2019		16
1.72	Age-Adjusted Death Rate due to Coronary Heart Disease	deaths/ 100,000 population	96.6	71.1	93	90.5	2017-2019		4
1.42	High Cholesterol Prevalence: Adults 18+	percent	36.4			34.1	2017		3
1.33	Heart Failure: Medicare Population	percent	14.7		15.6	14	2018		5
1.25	Cholesterol Test History	percent	81.6			81.5	2017		3
1.17	High Blood Pressure Prevalence	percent	33.5	27.7		32.4	2017		3
1.08	Adults who Experienced Coronary Heart Disease	percent	7.2			6.8	2018		3

	Anna Andreate d Darath Data								
1.00	Age-Adjusted Death Rate due to Heart Attack	deaths/ 100,000 population 35+ years	51.1		70.1		2018		11
0.92	Adults who Experienced a Stroke	percent	3.2			3.4	2018		3
SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	PARKER COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.50	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	16.1		11.8	13.8	2017-2019		4
1.97	COVID-19 Daily Average Case-Fatality Rate	deaths per 100 cases	3.7		4.3	2	21-Sep-21		8
1.36	COVID-19 Daily Average Incidence Rate	cases per 100,000 population	46.3		47.1	51.4	21-Sep-21		8
1.22	Syphilis Incidence Rate	cases/ 100,000 population	1.4		8.8	10.8	2018		13
1.22	Tuberculosis Incidence Rate	cases/ 100,000 population	1.1	1.4	4.3		2015-2019		13
1.17	Overcrowded Households	percent of households	2.7		4.8		2015-2019		1
1.03	HIV Diagnosis Rate	cases/ 100,000 population	2.2		15.7		2018		13
0.92	Gonorrhea Incidence Rate	cases/ 100,000 population	72.3		163.6	179.1	2018		13
0.33	Chlamydia Incidence Rate	cases/ 100,000 population	213.2		508.2	539.9	2018		13

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	PARKER COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.83	Preterm Births	percent	11.6	9.4	12.2		2017		13
1.39	Mothers who Received Early Prenatal Care	percent	69.2		60.5	77.3	2017		13
1.11	Babies with Very Low Birth Weight	percent	1.2			1.4	2015	White (1.39002453) Other (0) Hisp (0) Black (0) White (0)	13
0.94	Teen Births	percent	0.9		2.1	3.1	2017	Other (0) Hisp (0)	13
0.78	Babies with Low Birth Weight	percent	6.5		8.2	8.1	2015		13
0.75	Infant Mortality Rate	deaths/ 1,000 live births	4.7	5	5.6	5.9	2015		13
0.33	Infants Born to Mothers with <12 Years Education	percent	7.6		17.4	13.3	2017	White (4.4) Hisp (25.8)	13
SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	PARKER COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.47	Alzheimer's Disease or Dementia: Medicare Population	percent	13.6		12.6	10.8	2018		5
1.97	Depression: Medicare Population	percent	19.3		18.2	18.4	2018		5
1.58	Age-Adjusted Death Rate due to Suicide	deaths/ 100,000 population	17.2	12.8	13.5	14.1	2017-2019		4
1.50	Frequent Mental Distress	percent	13.5		11.6	13	2018		6
1.33	Mental Health Provider Rate	providers/ 100,000 population	55.3		120.9		2020		6
1.25	Age-Adjusted ER Rate due to Adult Mental Health	ER visits/ 10,000 population 18+ years	3.3		8.9		2017-2019		16
1.25	Age-Adjusted Hospitalization Rate due to Adult Mental Health	hospitalizations/ 10,000 population 18+ years	0.8		1.7		2017-2019		16

	Poor Mental Health: 14+							
1.25	Days	percent	13		12.7	2018		3
SCORE	OLDER ADULTS	UNITS	PARKER COUNTY	нр2030 ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
JCORL		UNITS	COONT	112030 17	0.3.	PERIOD	DISPARITI	Jource
2.92	Atrial Fibrillation: Medicare Population	percent	9.3	7.8	8 8.4	2018		5
2.75	Cancer: Medicare Population	percent	8.9	7.6	5 8.4	2018		5
2.58	Chronic Kidney Disease: Medicare Population	percent	27.5	26.	7 24.5	2018		5
2.47	Alzheimer's Disease or Dementia: Medicare Population	percent	13.6	12.	6 10.8	2018		5
	COPD: Medicare	percent	15.0	12.	0 10.0	2010		5
2.33	Population	percent	14.9	11.	2 11.5	2018		5
2.31	Ischemic Heart Disease: Medicare Population	percent	31.1	29	26.8	2018		5
2.14	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	36.7	34.	2 33.5	2018		5
2.08	Asthma: Medicare Population	percent	6.1	4.9) 5	2018		5
1.97	Depression: Medicare Population	percent	19.3	18.	2 18.4	2018		5
1.97	Hyperlipidemia: Medicare Population	percent	50.1	49.	5 47.7	2018		5
1.97	Osteoporosis: Medicare Population	percent	6.6	6.8	6.6	2018		5
1.86	Stroke: Medicare Population	percent	4.2	4.2	2 3.8	2018		5
1.81	Hypertension: Medicare Population	percent	60.8	59.	9 57.2	2018		5
1.58	Adults 65+ who Received Recommended Preventive Services: Females	percent	26		28.4	2018		3

SCORE	ORAL HEALTH	UNITS	PARKER COUNTY	НР2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.81	People 65+ Living Below Poverty Level	percent	7.4		10.6	9.3	2015-2019	NHPI (100) Mult (21.8) Other (49.4) Hisp (13.3)	1
								Black (0) White (7) Asian (0) AIAN (10.2)	
0.92	Adults 65+ with Total Tooth Loss	percent	12.5			13.5	2018		3
1.08	Adults with Arthritis	percent	25.8			25.8	2018		3
1.33	People 65+ with Low Access to a Grocery Store	percent	2.5				2015		20
1.33	Heart Failure: Medicare Population	percent	14.7		15.6	14	2018		5
1.50	Diabetes: Medicare Population	percent	27.2		28.8	27	2018		5
1.50	Colon Cancer Screening	percent	61.7	74.4		66.4	2018		3
1.58	Adults 65+ who Received Recommended Preventive Services: Males	percent	27.4			32.4	2018		3

			PARKER				MEASUREMENT	HIGH	
SCORE	ORAL HEALTH	UNITS	COUNTY	HP2030	ТХ	U.S.	PERIOD	DISPARITY*	Source
	Oral Cavity and Pharynx								
2.50	Cancer Incidence Rate	cases/ 100,000 population	14		11	11.8	2013-2017		9
	Age-Adjusted ER Rate due								
1.75	to Dental Problems	ER visits/ 10,000 population	48.1		11.1		2017-2019		16
		dentists/ 100,000							
1.75	Dentist Rate	population	35.7		59.6		2019		6
	Adults who Visited a								
1.25	Dentist	percent	61.9			66.5	2018		3
	Adults 65+ with Total								
0.92	Tooth Loss	percent	12.5			13.5	2018		3

SCORE	OTHER CONDITIONS	UNITS	PARKER COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
	Chronic Kidney Disease:								
2.58	Medicare Population	percent	27.5		26.7	24.5	2018		5
	Rheumatoid Arthritis or								
	Osteoarthritis: Medicare								
2.14	Population	percent	36.7		34.2	33.5	2018		5
	Osteoporosis: Medicare								
1.97	Population	percent	6.6		6.8	6.6	2018		5
1.08	Adults with Arthritis	percent	25.8			25.8	2018		3
0.92	Adults with Kidney Disease	Percent of adults	2.8			3.1	2018		3

			PARKER		-		MEASUREMENT	HIGH	c
SCORE	PHYSICAL ACTIVITY	UNITS	COUNTY	HP2030	TX	U.S.	PERIOD	DISPARITY*	Source
	Access to Exercise								
2.17	Opportunities	percent	52.6		80.5	84	2020		6
2.00	Grocery Store Density	stores/ 1,000 population	0.1				2016		20
2.00	WIC Certified Stores	stores/ 1,000 population	0.1				2016		20
1.86	SNAP Certified Stores	stores/ 1,000 population	0.4				2017		20
1.81	Fast Food Restaurant Density	restaurants/ 1,000 population	0.7				2016		20
1.50	Children with Low Access to a Grocery Store	percent	4.5				2015		20
1.50	Farmers Market Density	markets/ 1,000 population	0				2018		20
1.33	Households with No Car and Low Access to a Grocery Store	percent	2				2015		20
1.55		percent	Ζ				2015		20
1.33	People 65+ with Low Access to a Grocery Store	percent	2.5				2015		20
1.33	People with Low Access to a Grocery Store	percent	17.6				2015		20
1.19	Recreation and Fitness Facilities	facilities/ 1,000 population	0.1				2016		20

	Low-Income and Low	i					2015		20
1.17	Access to a Grocery Store	percent	5.3				2015		20
0.69	Food Environment Index		7.9		5.9	7.8	2021		6
SCORE	PREVENTION & SAFETY	UNITS	PARKER COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.22	Age-Adjusted Death Rate due to Unintentional Injuries	deaths/ 100,000 population	46.4	43.2	38.7	48.9	2017-2019		4
1.00	Severe Housing Problems	percent	13.3	.0.2	17.4	18	2013-2017		6
0.61	Death Rate due to Drug Poisoning	deaths/ 100,000 population	9.2		10.6	21	2017-2019		6
SCORE	RESPIRATORY DISEASES	UNITS	PARKER COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.50	Age-Adjusted Death Rate due to Influenza and Pneumonia	deaths/ 100,000 population	16.1		11.8	13.8	2017-2019		4
2.33	COPD: Medicare Population	percent	14.9		11.2	11.5	2018		5
2.17	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	67.7		50.6	58.3	2013-2017		9
2.08	Asthma: Medicare Population	percent	6.1		4.9	5	2018		5
1.97	COVID-19 Daily Average Case-Fatality Rate	deaths per 100 cases	3.7		4.3	2	21-Sep-21		8
1.67	Age-Adjusted Death Rate due to Lung Cancer	deaths/ 100,000 population	44.6	25.1	34.1	38.5	2013-2017		9
1.50	Adults who Smoke	percent	17.2	5		15.5	2018		3
1.36	COVID-19 Daily Average Incidence Rate	cases per 100,000 population	46.3		47.1	51.4	21-Sep-21		8
1.25	Adults with COPD	Percent of adults	7.3			6.9	2018		3
1.22	Tuberculosis Incidence Rate	cases/ 100,000 population	1.1	1.4	4.3		2015-2019		13

	Adults with Current								
1.08	Asthma	percent	8.9			9.2	2018		3
SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	PARKER COUNTY	HP2030	ТХ	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.22	Syphilis Incidence Rate	cases/ 100,000 population	1.4		8.8	10.8	2018		13
1.03	HIV Diagnosis Rate	cases/ 100,000 population	2.2		15.7		2018		13
0.92	Gonorrhea Incidence Rate	cases/ 100,000 population	72.3		163.6	179.1	2018		13
0.33	Chlamydia Incidence Rate	cases/ 100,000 population	213.2		508.2	539.9	2018		13
SCORE	WELLNESS & LIFESTYLE	UNITS	PARKER COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.25	Insufficient Sleep	percent	34.7	31.4	34.4	35	2018		6
1.17	High Blood Pressure Prevalence	percent	33.5	27.7		32.4	2017		3
1.00	Frequent Physical Distress	percent	11.4		11.6	11	2018		6
0.92	Poor Physical Health: 14+ Days	percent	12.3			12.5	2018		3
SCORE	WOMEN'S HEALTH	UNITS	PARKER COUNTY	HP2030	тх	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.39	Cervical Cancer Incidence Rate	cases/ 100,000 females	10.2		9.2	7.6	2013-2017		9
2.03	Breast Cancer Incidence Rate	cases/ 100,000 females	130.1		112.8	125.9	2013-2017		9
1.75	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	23.1	15.3	19.8	20.1	2013-2017		9
1.61	Mammogram in Past 2 Years: 50-74	percent	69.8	77.1		74.8	2018		3
1.28	Cervical Cancer Screening: 21-65	Percent	84	84.3		84.7	2018		3

Parker County Sources

Кеу	Source Title
1	American Community Survey
2	American Lung Association
3	CDC - PLACES
4	Centers for Disease Control and Prevention
5	Centers for Medicare & Medicaid Services
6	County Health Rankings
7	Feeding America
8	Healthy Communities Institute
9	National Cancer Institute
10	National Center for Education Statistics
11	National Environmental Public Health Tracking Network
12	Texas Department of Family and Protective Services
13	DFWHC Foundation Regional Data, Q1-Q4, 2017-2019. DFWHC Foundation, Irving Texas. October 15, 2021
14	Texas Education Agency
15	Texas Secretary of State
16	THR Texas Department of Health Services
17	U.S. Bureau of Labor Statistics
18	U.S. Census - County Business Patterns
19	U.S. Census Bureau - Small Area Health Insurance Estimates
20	U.S. Department of Agriculture - Food Environment Atlas
21	U.S. Environmental Protection Agency
22	United For ALICE

Parker County Topic Scores

Health and Quality of Life Topics	Score
Older Adults	1.85
Women's Health	1.81
Respiratory Diseases	1.74
Other Conditions	1.74
Cancer	1.72
Heart Disease & Stroke	1.67
Oral Health	1.63
Children's Health	1.61
Diabetes	1.61
Health Care Access & Quality	1.59
Mental Health & Mental Disorders	1.58
Physical Activity	1.53
Environmental Health	1.42
Education	1.38
Immunizations & Infectious	
Diseases	1.30
Community	1.24
Alcohol & Drug Use	1.17
Wellness & Lifestyle	1.09
Economy	1.04
Maternal, Fetal & Infant Health	1.02
Prevention & Safety	0.94
Sexually Transmitted Infections	0.88

Community Input Assessment Tools

Key Informant Interview Guide and Questions

INTRODUCTION

HCI Facilitator: Introduce yourself and any others on the team

OPENING SCRIPT: TEXAS HEALTH RESOURCES (THR) has invited you to take part in this Key Informant Interview because of your content expertise and your experience working in the community. Our work on behalf of THR is focused on understanding what health issues and challenges impact the residents of Tarrant/Parker County and how to improve their overall health. The insights and perspectives collected in this interview will provide important information that will ultimately be combined with the results of a key informant interviews, focus groups, and data analysis of state and national indicators. These data components will be compiled into a comprehensive report outlining the health needs in the Southern Region which includes Tarrant/Parker County. The final reports will be completed in the summer of 2022.

CONFIDENTIALITY: For this interview, we will be taking notes on your responses, your names will not be associated with any direct quotes. Your identity will be kept confidential.

- 1. To begin, could you please tell us a little about the organization you work for and the geographic location it serves?
 - a. (only probe if necessary) What is your organization's mission? What are the top priority health issues that your organization addresses?
 - b. (only ask if not clear) Does your organization provide direct care, operate as an advocacy organization, or have another role in the community?
 - *c.* Which geographic location(s) does your organization serve? (to help us understand or confirm relevant service areas)

2. Considering the impact of Covid-19, what would you consider the top 5 health issues exacerbated by the pandemic in TARRANT county?

- **a.** What are the possible solutions to improve the health issues you've described?
- **b.** What solutions have your organization/agency put in place or considered to help improve the health issues you described?
- c. How can Texas Health support these health improvement efforts?

- 3. Along the same lines, what would you consider the top 5 socioeconomic needs exacerbated by the pandemic in [County Name/Zip code]?
 - a. What are the possible solutions to improve the socioeconomic needs you've described?
 - b. What specific solutions have your organization/agency put in place or considered to help improve the socioeconomic issues you described?
 - c. How can Texas Health support these socioeconomic improvement efforts?
- 4. Thinking about the solutions you described to address the health and socioeconomic needs, to what extent does your organization/agency have what it needs to deliver these services/resources in the community effectively?
 - a. How do aspects of this community's [County Name/Zip code] infrastructure (i.e., physical environment, policies, partnerships) help or hinder your ability to deliver the services/resources you described?
 - b. How can Texas Health support the success of these services/resources?
- 5. How can community leaders, community-based organizations, and health care systems work collaboratively to address this community's [County Name/Zip codes] health and socioeconomic?
 - a. To your knowledge, what strategies have been used in the past to drive collaboration across these partners? What worked, what didn't, and why?
 - b. What challenges/barriers should Texas Health anticipate in its efforts to work with community leaders and members to address the health and socioeconomic needs in this community?
 - c. How can Texas Health proactively address these challenges/barriers?
- 6. Finally, what do you consider the best practices that are currently going on to improve the health and socio-economic needs in this community [County/Zip codes]?
- 7. What is the most crucial message/feedback you want Texas Health to take away from this interview?
 - a. Is there anything else you would like to add about any of the topics we've discussed or other areas that we didn't discuss but you think are essential?

CLOSING SCRIPT: Thank you so much for your time and participation today. In terms of next steps, we will be collecting and analyzing the data for this needs assessment over the next few months. The final report will be available to everyone who participated, as well as the general public. If you have additional comments or thoughts after our conversation today, please feel free to reach out to *Eileen Aguilar* or Oge/Sika. *HCI Facilitator: Send a follow-up email to the key informant, thanking them for their time and make sure to include a link to the survey!*

Focus Group Guide and Questions

INTRODUCTION

{Introduce Yourself and Others on the Team}

{"Let's get started...}

Opening Script: Thank you for taking the time to speak with us to support the Texas Health Resources (THR) Community Health Needs Assessment. We anticipate that this discussion will last no more than 60 minutes. You have been invited to take part in this focus group because of your experience living and/or working in Rockwall County. The focus of our Community Health Needs Assessment is how to improve health in the community and understand what challenges residents are facing. We are going to ask a series of questions related to health issues in the community. We hope to get through as many questions as possible and hear each of your perspectives as much as time allows.

For this discussion group, I will invite you to share as much or little as you feel comfortable sharing with the others in the group. The results of this assessment will be made available to the public. We will be taking notes on your responses, but your names will not be associated with any direct quotes. Your identity will be kept confidential, so please share your honest opinions.

SHOW SLIDES (if applicable)--We do have a few ground rules for this virtual discussion that I would like to review with you. It is important that everyone has a chance to be heard, so we ask that only one person talks at a time (most important ground rule for today). You may use the "raise hand" functions when you have something to say [give instructions and test]. We may also call on you to sure ensure everyone has a chance to speak but if you have nothing to share, please just say "pass".

You may want to mute yourself when you are not speaking to cut down on background noise [give instructions and test mute/unmute]. Finally, please respect the opinions of others, as the point of the discussion is to collect various points of view. And remember, there are no right or wrong answers, so please share freely and openly. Does anyone have any questions before we get started?

Okay, let's get started by going around and introducing ourselves. Please tell everyone your first name, what community you live in, and if you are interested in sharing, your involvement in the community (could be your job or volunteer work for example). {Introductions}

Thank you for introducing yourselves. Now we will get started with our discussion.

COVID-19 QUESTION

1. We know that COVID-19 has significantly impacted everyone's lives. What have you seen as the biggest challenges in XXXXX County during the pandemic?

[Probe 1: Which groups of people are having the hardest time right now?] [Probe 2: How have you seen these challenges being addressed, if at all?] [Probe 3: What programs have addressed COVID related issues? What has worked?] [Probe 4: What hasn't been effective and, in your opinion, why?]

GENERAL HEALTH QUESTIONS

2. What would you say are the top three health related problems that people in your community are facing that you would like to change or improve?

[Probe 1: Why do you think these are the most important health issues? [Probe 2: What would you do to address these problems?] [Probe 3: What else is needed to address these problems? Examples could be specific policies, programs, or services.]

3. What might prevent someone from accessing care for the health challenges identified above?

[Examples could include lack of transportation, lack of health insurance coverage, doctor's office hours, language, or cultural barriers, etc.]

4. Are there specific groups in your community that are most impacted by the health issues or challenges discussed earlier (2-3)? Which groups are these?

[Probe: Are these health challenges different if the person is a particular age, or gender, race, or ethnicity? Or lives in a certain part of the county for example?]

5. From the health issues and challenges we've just discussed, which do you think can be addressed in the next three years?

[Probe 1: How do you think these health issues can be addressed?} [Probe 2: Are some of these issues more urgent or important than others? If so, why?]

6. In 2019, Depression and anxiety among adults 18+ were identified as important health issues in your community. Do you know of any programs or services that are available in your community to address this issue?

[Prompt: Have you or someone you know benefited from these programs or services? If so, what do you think has worked? What do you think can be improved?]

7. What resources are currently available for residents in your community for the identified health/social determinant problem/s we've discussed today?

[Probe 1: Are there specific community organizations or agencies that you see taking a strong leadership role for improving the health of particular groups in your community?] [Probe 2: Do you see residents taking advantage of them? Why or why not?] [Probe 3: What additional programs and resources do you think are needed to best meet the needs of residents in _____ County?] [Probe 4: Are you aware of any THR-Community Health Improvement program(s) in your community?]

CLOSING QUESTION

8. Can you think of any other ways we could improve the health of residents in the community that we have not already talked about today?

[Probe: Is there anything else you would like to add that we haven't discussed?]

CONCLUSION

{Review the summary points and key takeaways from discussion} {Check if note taker needs any clarification}

CLOSURE SCRIPT: Thank you very much for your time and willingness to share your experiences with us today. We will include your comments in our data to describe how health can be improved for residents in your community. Please remember, your name will not be connected to any of the comments you made today. Please let us know if you have any questions or concerns about this.

Listening Session Questions

- 1. Name of the organization you represent.
- 2. What region/county/counties do your organization provide direct services to? (select all that apply)
 - a. Dallas County
 - b. Rockwall County
 - c. Tarrant County
 - d. Parker County
 - e. Denton County
 - f. Wise County
 - g. Collin County
 - h. Ellis County
 - i. Erath County
 - j. Henderson County
 - k. Johnson County
 - I. Kaufman County
- 3. In 2019, Texas Health Resources (THR) identified behavioral health, chronic disease prevention and management, access, awareness, health literacy, and navigation as its priority areas. Are you aware of any THR programs, initiatives, resources, specifically addressing any of these priorities in your community?
- 4. What is THR doing well within the behavioral health, chronic disease prevention and management, access, health literacy and navigation areas? Feel free to address one or all priorities.
- 5. What are areas of opportunity within these priority areas? Feel free to address one or all priorities.
- 6. What can THR do to improve the awareness of its Community Health Needs Assessment (CHNA) findings and implementation strategies?
- **7.** Texas Health Resources is currently developing its 2022 CHNA reports and have identified these preliminary issues for the following regions:

Southern Region

Healthcare Access & Quality (lack of/limited insurance, delay in care)

Mental Health (depression, anxiety, isolation) Abuse/Violence (domestic violence, child abuse, intimate partner violence) Substance Abuse (isolation leading to increased substance use and addiction)

Denton/Wise Region-

Mental Health (increased need for adolescents, anxiety, lack of behavioral health services) Access to healthcare services (Provider shortages, language barriers, uninsured/underinsured) COVID-19 Impact (mental health, trust in healthcare system, delay in services) Food insecurity (lack of food, access to healthy foods, food deserts)

Tarrant/Parker Region-

Chronic conditions (heart disease, diabetes) COVID-19 Impact (Mental Health/Substance abuse, isolation, financial issues, delay in care, food insecurity) Health Behaviors (fear, stigma towards vaccine) Healthcare Access & Quality (Lack of providers, lack of bilingual providers, uninsured/underinsured)

Dallas/Rockwall Region-

Access to care (delay in care, uninsured, underinsured) Mental Health (isolation, depression exacerbated by COVID-19) Financial/Economic impact (unemployment, housing insecurity) Food insecurity (lack of healthy foods, lack of food)

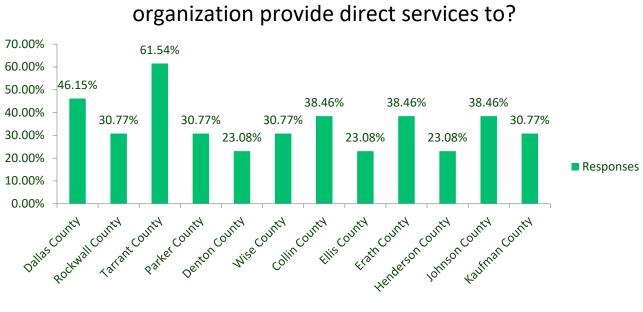
Collin Region-

Access to care (delay in services, high deductibles, affordability of insurance, knowledge of where to get care) Mental Health (stigma in accessing care, cultural barriers, anxiety) Economic/financial issues (difficulty paying rent/utilities, unemployment, loss of jobs) Housing (lack of affordable housing, discrimination)

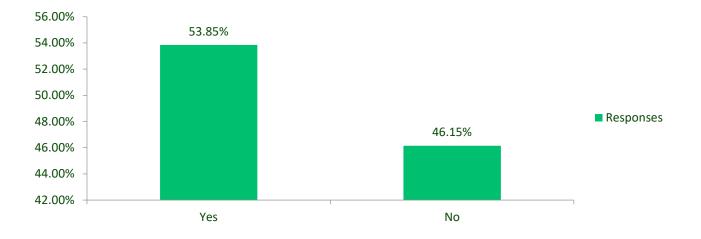
How can THR prioritize these health topics that have surfaced as issues in the region?

8. This survey is part one of a listening session that will be conducted by Texas Health Resources to further the conversation. We have outlined some dates and times in April for this session. Please select your preferred options. An invitation will be sent on the date/time most selected. What day/time is best for you to meet (online) in April?

Listening Session Results



Question #3-Are you aware of any THR programs, initiatives, resources, specifically addressing any of these priorities in your community?



Question #2-What region/county/counties do your organization provide direct services to?

Question #4-What is THR doing well within the behavioral health, chronic health, chronic disease prevention & management, access, health literacy, and navigation areas?

- While there is some generalize awareness of THR efforts, there is not sufficient publicity of these efforts to elicit significant engagement from the public.

-I navigate the Plano Up program funded by THR focusing on anxiety and depression in youth in the 75074 zip. Beyond Blue is another program funded by THR to address mental health in the senior population in the 75069 zip

- The Community Impact program and its regional councils are a great model to impact health priorities.

- It's hard to say due to the Pandemic really. THR has been sending email and reminders to people to do their screenings, testing and seeing their Dr, even telemedicine

- Their willingness to fund organizations that promote access and health literacy is awesome.

- Excellent work with chronic disease prevention and management. Also, good initiative with mental health in rural areas. Doing a good job of bringing these topics, education, and interventions to the people and communities THR serves.

- THR's Community Impact team has done a great job at leveraging relations with community leaders, nonprofits, thought leaders to strengthen efforts to improve health outcomes that are negatively impacted by the social determinants of health. They are also using data to drive their decision and to measure positive improvements in the areas of exercise, health and chronic disease prevention.

- Connect deeper to faith-based organizations, and schools where the under-resource families are nearest and partner with other foundations to strengthen the ability to sustain efforts.

Q5- Are there areas of opportunity within these priority areas? Feel free to address

-Behavioral health partnerships between THR, JPS, and the City of Arlington would be good way to have a meaningful impact on this issue. A formalized partnership with COA/Fire PH unit, Mission Arlington, School Districts, UTA school of Nursing and Social Work, JPS, TCPH and MCA could result in a cost effective and impactful approach to many of these issues.

- I feel mental health is still a large concern. However, I feel healthcare is out of reach for many people even for those with the ability to pay. Living expenses have increased to the point where many people cannot afford to maintain their physical or mental well-being

- There are many opportunities to impact health outcomes - particularly chronic diseasethrough increased awareness and support of patients affected by memory decline. This can include those at risk for cognitive decline (diverse communities are at higher risk, as are those who have comorbidities) and create opportunities for early detection—also, outcomes related to caregiver health.

- With the start of the Pandemic in March 2020, people have not seen their health care providers as they should, thus causing now two years later, many, many additional medical problems.

- Behavioral health is an awesome place to start. We need to train paraprofessionals to go into the neighborhood.

- Health literacy training for health care and service providers would enhance THR's current efforts within chronic disease management.

Question 6- What can THR do to improve the awareness of its Community Health Needs Assessment findings and implementation strategies?

-Partner directly with the City of Arlington Office of Communications

-Present to city and nonprofits the results of the assessment. Many citizens have no idea of the health status of our city.

- More programs focused on prevention and mobile solutions. We have to realize that many people cannot get to appointments even with coverage. Housing, food and transportation costs

- Increasing channels of communication, implementing practical action steps and a starting point for those needing the services, enhanced relationship building with community partners.

- Send them to community orgs as well as posting on their website. If both of these were done, I would recommend a way to ensure that all orgs doing any social service-related work get notified of the CHNA and implementation plan.

- Work directly with Community-Based Organizations (CBOs), such as the Alzheimer's Association or Area Agency on Aging, to promote these results and how a partnership with the CBO will impact the health outcomes. Continue to provide grants to CBOs to ensure that community support continues for all those in need.

- Perhaps THR can advertise the CHNA can run local ads on television and radio.

- As we emerge from the Pandemic, continue to reach those who are not connected by smart phones and emails

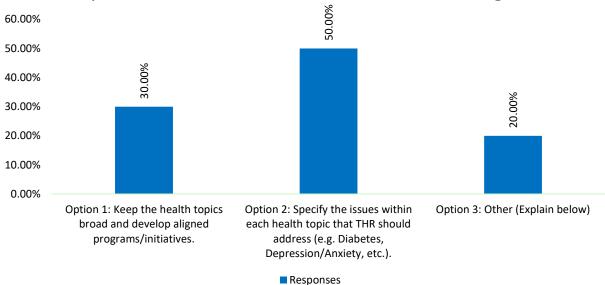
- A spot on the major networks or continuous radio spots would help.

- Personally, I think that THR does a great job of disseminating CHNA findings. They and Cook are regional leaders in that work. I'm not sure if THR already works closely with rural Extension

services to disseminate findings and implement programming. If not, that may be another avenue. Also, engaging FQHC's in CHNA implementation strategies is important.

- Take the information out to the community who are impacted the most. (Churches, Schools, Stores, barbershops, beauty shops and perhaps convenience store.

Question #7-How can THR prioritize these health topics that have surfaced as issues in the region?



Community Resource and Partner List

This highlights existing resources that organizations are currently using and available widely in the community. It also highlights community partners who were involved in the process for this CHNA.

Community Resource List

Alzheimer's Association **Blue Zones** Bridge Association (outreach to rehabilitate) City of Fort Worth Northside Community Center **Community Action Agency** Cornerstone Assistance Network: free vision/dental services by referral only for low-income folks Dental health Arlington **Eastside Ministries** Galvin Clinic Inspiring body of Christ Dallas John Peter Smith Hospital: satellite clinics to bring services to people and increase access JPS Mansfield Mission Center Meals on Wheels Mesa Springs (Hemp Hill Hospital district, 287) North Texas Community Foundation **Oak Street Health** Parker County Center of Hope **Presbyterian Night Shelter Project Transformation** Promise House in Dallas Safe Harbor SafeHaven of Tarrant County **Tarrant County Food Bank Texas Department of Human Services** Texas Health has been providing COVID vaccines on a small-scale clinic at McCray, Bethlehem Center **United Community Centers** Unity Council in Arlington Well Care assists people signing up for Medicare Women's Center of Tarrant County Rape Crisis & Victims Services

YMCA

Community Partner List

Alzheimer's Association Arlington Police Department Community Center Cornerstone Assistance Network Eastside Ministries Mansfield Mission Center Meadowbrook Poly UMC Parker County Center of Hope SafeHaven of Tarrant County Tarrant County College YMCA