2013

2013 Amarillo Community Health Improvement Plan (CHIP) -

Developed by:
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Acknowledgements

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I. Executive Summary

On behalf of The Northwest Texas Healthcare System (NWTHS), the Texas Health Institute completed a Community Health Improvement Plan (CHIP) for Amarillo, Texas in 2013. Matt Richardson, Director of the Amarillo Department of Public Health (ADPH) served as the project liaison. The plan is based on community input garnered from all facets of the Amarillo community and elicited in a number of different venues and through a variety of mediums, including objective data analysis, in-person interviews, focus groups, and online survey.

In early summer of 2013, a review of the 2007, 2010 and 2013 Community Health Assessments was undertaken, as was a review of all relevant pubic data sources describing the public health and socioeconomic conditions characterizing the community health of Amarillo. These analyses were combined in a Findings Report which identified several key areas of concern, including relatively low educational attainment, high rates of poverty, teen pregnancy and sexually transmitted infection rates, and rising rates of obesity and prevalence of chronic disease risk factors. The report also indicated a need for more information on the status of mental and behavioral health needs and services.

The Findings Report was sent to 14 Key Informants (KI) in the Amarillo community identified by NWTHS and ADPH, who are stakeholders from all sectors of the Amarillo community, including education, elected office, criminal justice, and health. In July, each were interviewed by THI staff about how they would prioritize issues raised in the Findings Report. Four themes emerged from KI Interviews as priorities to address to improve Amarillo public health: Teen Pregnancy, Behavioral Health, Educational Attainment and Culture. The latter –as expressed by KIs –had to do with a widespread view that persons living in poverty in Amarillo are not taking steps to pull themselves and their families out of poverty and that poverty is normalized among this segment of the population. The cultural issues were tabled as a priority area because they were deemed beyond the scope of this planning effort. NWTHS and ADPH representatives also decided that educational attainment is being addressed by other planning efforts in Amarillo and is therefore not an appropriate focus for the CHIP. ADPH representatives felt strongly about broadening the Teen Pregnancy priority area to include sexually transmitted infections due to the high rates of these locally. The resulting two priority areas were 1) Risky Sexual Behavior/Teen Pregnancy and 2) Mental/Behavioral Health.

A survey was designed to identify community consensus around the most appropriate public health interventions to bring about change in the priority areas. The survey was launched in mid-September and was open for two weeks. The link to the online survey was sent to a broad range of community leaders and stakeholders identified by NWTHS, ADPH and KIs themselves. There were 72 responses, 51 of which were complete. Respondents identified schools as the best venue for risky sexual behavior/teen pregnancy prevention interventions and high school and middle school students as appropriate targets for these interventions. For behavioral health, respondents stated residents do not know what services are available and face stigma in accessing services. They also reported a lack of behavioral health providers and a dearth of substance abuse services for youth and adults.

In October 2013, two focus groups were held – one for each of the two priority issues. Participants were all stakeholders in the respective issue areas who indicated in the survey that they wanted to participate in planning around these issues. The focus groups were designed to guide participants in the drafting of goals and objectives for each of the priority areas. In each group meeting, participants were given an overview of the CHIP process, provided with a summary of the survey results and were given handouts on the development of goals and objectives. Focus group participants were given an opportunity to respond to the survey results and then began group brainstorming of goals and objectives and, to a lesser extent, strategies. The THI facilitator worked off the drafted goals and objectives following each meeting, reorganizing elements and in some cases, adding Healthy People 2020 goals and objectives or Medicaid 1115 targets if they aligned well and reflected the direction and interests of the focus group participants. The resultant goals and objectives were vetted via email by all participants. Below is an abbreviated version of the CHIP goals and objectives. To see the full plan, with strategies and baselines, go to page 35.

Behavioral/Mental Health

Goal 1: Improve access to behavioral/mental health services in Amarillo.

Objective 1.1: By the end of 2016, expand substance abuse prevention services by 10%. (A possible model for this is the mentoring program operated by Impact Futures.)

Objective 1.2: By the end of 2016, provide integrated primary care and behavioral health services to a total of 494 persons through co-located sites.[1]

Objective 1.3: By the end of 2016, develop and implement crisis respite/stabilization services in the community, aiming to serve 158 unduplicated individuals.[2]

Objective 1.4: By the end of 2016, increase the number of behavioral health providers serving the Amarillo community by 10%.

Objective 1.5: By end of 2016, increase the number of adults and youth receiving inpatient and outpatient substance abuse services in Amarillo by 10%.

Objective 1.6: To combat stigma of mental/behavioral health disorders, by the end of 2016, implement a peer support program to serve 200 consumers.[3]

Risky Sexual Behavior/Teen Pregnancy

Goal 1: Replace the norm regarding acceptability of teen pregnancy/risky sexual behavior in the community with a new norm of safe sex and delaying pregnancy.

[1] This is an RHP 12 1115 Waiver project under TPC - 127378105.2.2. This objective is a Healthy People 2020 objective (MHMD -5)
[2] This is an RHP 12 1115 Waiver project under TPC - 127378105.1.1.
[3] This is an RHP 12 1115 Medicaid waiver project under TPC – 127378105.2.3.

Objective 1.1 – By the end of 2016, reduce the rate of Chlamydia by 10% in Potter County. [4]

Objective 1.2 – By the end of 2016, reduce the rate of gonorrhea by 10% in Potter County.[5]

Objective 1.3 – By the end of 2016, decrease the proportion of females at risk of unintended pregnancy[6] or their partners who used contraception at most recent sexual intercourse by 10%.

To implement the CHIP, a steering committee of key stakeholders will need to be formed to guide the overall process of implementation. In addition, an advisory committee of community leaders and stakeholders will need to be formed for each priority area -both Risky Sexual Behavior/Teen Pregnancy and Behavioral/Mental Health priority areas. Stakeholders who attended each of the focus groups are a logical place to start in the recruitment of these advisory groups which will develop strategies, tasks and will identify resources for implementation. Timelines and considerations for implementation can be found in the full report on page 40.

[4] Modeled on HP 2020 STD objectives.
[5] Modeled on HP 2020 STD objectives.
[6] Females at risk of unintended pregnancy include those under 20 years of age, those with less than or equal to a high school education and those who are Medicaid eligible.

II. Findings Report

In early summer of 2013, THI staff conducted a review of recent Amarillo Needs Assessments was undertaken, as was a review of all relevant pubic data sources describing the public health and socioeconomic conditions characterizing the community health of Amarillo. These analyses were combined in the following report which identifies several key areas of concern, including relatively low educational attainment, high rates of poverty, teen pregnancy and sexually transmitted infection rates, and rising rates of obesity and prevalence of chronic disease risk factors. The report also indicates a need for more information on the status of mental and behavioral health needs and services.

Methodology: The following findings are based on the 2007 and 2010 Amarillo Health Survey and Needs Assessments, the 2013 Potter and Randall County Community Health Assessment[7], and public data sources such as the Behavioral Risk Factor Surveillance System (BRFSS), Department of State Health Services (DSHS) Vital Statistics, the American Community Survey (ACS) and a variety of sources accessed through County Health Rankings and the Community Health Needs Assessment Toolkit. Areas requiring further consideration are identified throughout.

Demographics and Socioeconomic Indicators

1. Finding: Well over a third of Potter County children (38%) are living in poverty[8] and face a number of social and economic barriers to wellness.

- The 2010 ACS child poverty rate for the City of Amarillo is 25.3%, just under the state rate of 26%. Poverty rates for non-white children are much higher than those for white children. [9]
- Potter County (71%) has a much higher than state average (50%) proportion of children who qualify for free and reduced price lunch.[10] Children attending Amarillo ISD have poorer outcomes than the average school age child in Texas:

[7] See Appendix for more information on comparing Assessments with one another.
[8] US Census Bureau, 2010 American Community Survey 1 Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml, accessed May 18, 2013.
[9] US Census Bureau, 2010 American Community Survey 1 Year Estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml, accessed May 18, 2013.
[10] U.S. Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Public School Universe File, 2010-2011, http://nces.ed.gov/ccd/pubschuniv.asp, accessed through the Community Health Needs Assessment Toolkit, http://assessment.communitycommons.org/CHNA/, accessed May 18, 2013.

% Economically Disadvantaged and At Risk[11]				
	Amarillo ISD		Texas	
	Economically Disadvantaged	At Risk	Economically Disadvantaged	At Risk
2006-2007	59.8%	54.3%	55.5%	48.3%
2007-2008	62.2%	53.5%	55.3%	48.4%
2009-2010	64.9%	45.7%	59.0%	47.2%
2010-2011	65.6%	43.8%	59.2%	46.3%
2011-2012	66.8%	39.1%	60.4%	45.4%

Children growing up in poverty are more likely than their more affluent peers to develop and die earlier as adults from a range of disease, particularly type II diabetes and cardiovascular disease.[12] Other poor health outcomes associated with child poverty include: low birth weight, inadequate nutrition and hunger, higher incidence of chronic conditions such as anemia, pneumonia and asthma, and a higher likelihood of early smoking and sexual activity.[13]

2. Finding: The 2010 proportion of the population of all ages living at or below the poverty rate is higher in Potter County (24%) than in the State of Texas (18%). Poverty affects a community's ability to engage in healthy behaviors and can be a barrier to access to care. [14] Compared with affluent adults, poor adults are nearly five times as likely to be in poor or fair health. In fact, persons with relatively high incomes can expect to live at least six and a half years longer than those living in poverty.[15]

In the two-county region, poverty is concentrated in Hispanic communities, which have nearly twice the poverty than that of non-Hispanic communities. African American communities in the two counties also have higher rates of poverty than their white counterparts.[16] Racial and ethnic minorities often receive

[11] Texas Education Agency, AEIS Reports, 2006-2012. "At risk" is defined as at risk of dropping out of school due to a number of factors including but not limited to parenthood, pregnancy, poor school performance, failure to advance to the next grade, previously dropped out, or is on probation, parole or other form of conditional release.
[12] Raphael, D., "Poverty in Childhood and Adverse Health Outcomes in Adulthood", *Maturitas*, Vol. 69 (1), May 6, 2011, and Jean Brooks-Gunn and Greg Duncan, "Effects of Poverty on Children", Journal of Children and Poverty, Vol. 7 (2), Summer/Fall 1997.
[13] American Psychological Association, "Effects of Poverty, Homelessness and Hunger on Children and Youth", http://www.apa.org/pi/families/poverty.aspx, accessed June 8, 2013.
[14] Community Health Needs Assessment Toolkit, "Population in Poverty (100%)", http://assessment.communitycommons.org/CHNA/, accessed June 9, 2013.
[15] Paula Braveman and Susan Egerter, "Overcoming Obstacles to Health: Report from the Robert Wood Johnson Foundation to the Commission to Build a Healthier America," Robert Wood Johnson Foundation (2008), available at http://commissiononhealth.org/PDF/ObstaclesToHealth-Report.pdf, accessed June 9, 2013.
[16] US Census Bureau, American Community Survey 5 Year Estimates, 2007-2011, accessed through the Community Health Needs Assessment Toolkit, http://assessment.communitycommons.org/CHNA/, May 18, 2013.

lower quality health care and face more barriers in seeking care including preventive care, acute treatment, and chronic disease management than their non-Hispanic white counterparts.[17]

3. Finding: Educational attainment in the Amarillo area is lower than state averages. 32% of Texas residents have at least an associate's degree, while in Potter County, this proportion is only 22%.[18] Just under a quarter of Potter County (24%) residents do not possess a high school diploma compared to 20% of Texas residents. [19] While they are improving, graduation rates for Amarillo youth are lower than the state average.

High School Graduation Rates[20]			
	Amarillo ISD	**Texas**	**U.S.**
2007	75.8%	78.0%	68.8%
2010	82.7%	84.3%	78.2%

The higher a person's educational attainment and income, the more likely that person is to have a longer life expectancy.[21] While of course poor academic performance does not cause illness, it is linked to childhood chronic conditions such as overweight, asthma and diabetes.[22]

4. Finding: By 2030, nearly 25,000 persons will move into the 65+ age category in Randall and Potter Counties.[23] Older adults are disproportionately affected by chronic diseases and conditions, such as arthritis, diabetes, heart disease, and disabilities resulting from falls. In fact, at least 60% of persons 65 or older will be managing more than one chronic condition by 2030.[24] More information is needed to determine what future needs are regarding healthcare infrastructure, services and providers for this population.

[17] US Department of Health and Human Services, "HHS Action Plan to Reduce Racial and Ethnic Health Disparities", September 2011, http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf, accessed June 8, 2013.
[18] Community Health Needs Assessment Toolkit, http://assessment.communitycommons.org/CHNA/, accessed May 18, 2013.
[19] US Census Bureau, American Community Survey 5 Year Estimates, 2007-2011, accessed through the Community Health Needs Assessment Toolkit, http://assessment.communitycommons.org/CHNA/, May 18, 2013.
[20] Texas Education Agency, Completion, Graduation and Dropout Rates, http://www.tea.state.tx.us/acctres/dropcomp/years.html#comp, accessed May 18, 2013.

[21] Paula Braveman and Susan Egerter, "Overcoming Obstacles to Health: Report from the Robert Wood Johnson Foundation to the Commission to Build a Healthier America," Robert Wood Johnson Foundation (2008), available at http://commissiononhealth.org/PDF/ObstaclesToHealth-Report.pdf, accessed June 9, 2013.
[22] Task Force for Access to Health Care, "Code Red: Education and Health", 2012, http://www.coderedtexas.org/files/Report_Chapter09.pdf, accessed June 10, 2013.
[23] Texas State Data Center Population Projections, 0.5 Scenario, accessed May 20, 2013.
[24] US Department of Health and Human Services, Healthy People 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=31, accessed June 8, 2013.

Population Projections by Age Group (.5 Scenario)

	Potter				Randall				Texas			
	2010		2030		2010		2030		2010		2030	
Under 18	33,653	28%	38,013	26%	30,103	25%	32,430	22%	6,865,824	27%	8,142,896	25%
18-24	12,133	10%	14,057	10%	13,073	11%	15,491	10%	2,572,969	10%	3,118,065	9%
25-44	33,482	28%	40,046	27%	31,441	26%	39,361	26%	7,071,855	28%	8,692,487	26%
45-64	28,663	24%	31,304	21%	31,029	26%	33,915	23%	6,033,027	24%	7,420,048	23%
65+	13,142	11%	23,977	16%	15,079	12%	29,018	19%	5,553,749	10%	2,601,886	17%
TOTAL	121,073		147,397		120,725		150,215		25,145,561		32,927,245	

5. Finding: 16% of Amarillo households are Spanish-speaking households. Of these, 3% (or 3,195 households) are households in which no one 14 and over speaks English only or speaks English "very well". [25] 5% of the Amarillo population is comprised of foreign-born Spanish speakers who speak English "less than very well". [26] Families that are linguistically isolated often face significant barriers to accessing health care. Persons with limited English proficiency are more likely than proficient English speakers to experience poor quality patient-provider interactions[27], to have poor health outcomes, to have children with unmanaged chronic health problems, and to end up in the emergency with costly and serious complications.[28]

Health Status and Behavior

6. Finding: Nearly 20% of Amarillo area residents report poor or fair health and these persons are concentrated on the low end of income and educational attainment spectrums. Just under half (49.4%) of those reporting poor or fair health in 2013 are Spanish speaking, while less than 6% of the total 2013 respondents speak Spanish.

[25] US Census Bureau, 2010 American Community Survey 1 Year Estimates, Table B 16002, http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml, accessed May 20, 2013.
[26] US Census Bureau, 2010 American Community Survey 1 Year Estimates, Table C 16005, http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml, accessed May 21, 2013.
[27] US Department of Health and Human Services, "HHS Action Plan to Reduce Racial and Ethnic Health Disparities", September 2011, http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf, accessed June 8, 2013.
[28] Agency for Health Care Research and Quality, "Demographics and Health Care Access and Utilization of Limited English Proficient Hispanics", http://meps.ahrq.gov/data_files/publications/rf28/rf28.pdf, February 2008, accessed June 10, 2013.

% Reporting Poor or Fair Health

	2007	2010	2013
Amarillo Area[29]	22%	18%	19%
Texas[30]	20%	17%	n/a

The proportion of residents reporting poor or fair health in Potter County has typically exceeded 20%. Note that 2011 BRFSS sample sizes for Randall and Potter County are below 50 so BRFSS data is not reliable for these counties individually.[31]

7. Finding: The Potter County Teen (ages 15-19) birth rate is 108 per 1,000 population compared to a state rate of 63 per 1,000 in population. Non-white mothers make up the largest proportions of births to teen mothers in Potter County. [32]

Teen (15-19) Births per 1,000 population

	White (non-Hispanic)	Black (non-Hispanic)	Asian	Hispanic
Potter and Randall	45.4	103	56.9	125.6
Potter	75.4	114.3	56.9	145.7
Randall	30.4	51.7	No data	77.4
Texas	33.2	65.5	13.3	97.10
Nation	26.3	62.4	16.7	79.7

2010 data from DSHS shows that the teen (13-17) pregnancy rate in Potter County is fluctuating and decreased to a five-year low in 2010[33]:

Teen (13-17) Births per 1,000 population

	2010	2009	2008	2007	2006
Potter County	26.4	38.6	34.2	41.9	38.2
Texas	21.4	24.7	26.1	26.3	26.0

[29] These figures are from the 2007-2013 Assessments. See the appendix for more information on comparing data from these Assessments.
[30] Texas DSHS, BRFSS Query System, http://www.dshs.state.tx.us/chs/brfss/query/brfss_form.shtm, accessed May 30, 2013. 2011 data is the most recent available.
[31] Email communication with Anna Vincent of DSHS, May 18, 2013.
[32] CDC National Vital Statistics Systems, 2003-2009, accessed through Community Health Needs Assessment Toolkit, http://assessment.communitycommons.org/CHNA/, accessed May 20, 2013.
[33] DSHS, Maternal and Child Health Profile, Region 1, Potter County, http://www.dshs.state.tx.us/WorkArea/DownloadAsset.aspx?id=8589973894, accessed May 18, 2013.

8. Finding: County Health Rankings show that 31% of Potter County residents are physically inactive compared to 25% across the state. [34] 21% of Amarillo 2010 Assessment participants claimed they did not participate in physical activity in the previous month, compared to a state rate for 2010 of 27%.[35] In the 2013 Assessment, this proportion increased to 30%.[36] Note that County Health Rankings and the Assessment use two slightly different questions regarding physical activity.

9. Finding: Sexually transmitted infection rates in Potter County (943 per 100,000 population) are more than twice the state rate (476 per 100,000 population).[37] An area for further exploration is unmet need for women's health services and the loss of Texas Medicaid family planning dollars and any resultant area clinic closures or service reductions in the Amarillo area.

Morbidity and Mortality

10. Finding: The prevalence of some risk factors for chronic conditions are either on the rise or are higher in the Amarillo area than in the state on average.

- Overweight and Obesity – While no Assessment data is available for 2007, 2010 Assessment data shows that Amarillo is below the state and national average of persons who are overweight or obese, though this proportion rose in 2013 to 65%.

% Overweight or Obese[38]

	1999[39]	2010	2011	2013
Amarillo Area	54.4	61.1	n/a	65.2
Texas	n/a[40]	67	65.8	n/a
Nation	n/a	64.3	63.3	n/a

  - In 2013, more than half of Assessment respondents who are actually overweight according to their body mass index (BMI) thought they were at a normal weight (52%).
  - County Health Rankings data shows 34% of Potter County residents are obese compared to 29% statewide. [41]
  - The proportion of Texas residents who are obese is expected to reach 57% by 2030.

[34] BRFSS 2009 estimate accessed through County Health Rankings, http://www.countyhealthrankings.org/app#/texas/2013/compare-counties/375+381, accessed May 21, 2013.
[35] DSHS, Texas BRFSS, http://www.dshs.state.tx.us/chs/brfss/query/brfss_form.shtm, accessed May 21, 2013.
[36] See appendix for more information on comparing data from 2007 and 2010 Assessments with that of the 2013 Assessment.
[37] National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), 2010, accessed through County Health Rankings, http://www.countyhealthrankings.org/app#/texas/2013/measure/factors/45/map, accessed May 21, 2013.
[38] Amarillo Area data is from Assessments. Other data from DSHS, Texas BRFSS, http://www.dshs.state.tx.us/chs/brfss/query/brfss_form.shtm, accessed May 30, 2013.
[39] The methodology for the 1999 Assessment is unknown.
[40] The earliest year for which the DSHS BRFSS Query system can provide data is 2002.
[41] BRFSS 2009 Data accessed through County Health Rankings, http://www.countyhealthrankings.org/app#/texas/2013/measure/factors/11/datasource, accessed May 18, 2013.

    - Obesity is associated with chronic conditions such as arthritis, type 2 diabetes, some forms of cancer, heart disease, stroke and hypertension.[42]
- Physical inactivity – see finding 8 above.
- Adult smoking –Assessment data shows that the proportion of Amarillo area residents that smoke every day has increased from 32% in 2010 to 41% in 2013. 2007 and 2010 Assessment data shows the proportions of Amarillo adults reporting that they have ever smoked or those reporting that they are currently smokers are both slightly higher than state proportions, though both proportions decreased from 2007 to 2010. BRFSS data from 2005-2011 shows that the percent of the population who regularly smoke is 23% in Potter County and 18% in the state as a whole.[43] Amarillo smokers are concentrated at lower income and educational attainment levels. Hospitalizations attributed to chronic obstructive pulmonary disease cost Potter County $3.3 M in 2010.[44]
- Proportions of BRFSS respondents reporting ineffective high blood pressure management are higher in Potter County (27%) than the state average (22%).[45] Potentially preventable hospitalizations attributed to hypertension in 2010 in Potter County have resulted in $1.4 M in hospital charges.[46]

11. Finding: Chronic diseases are a persistent (and preventable) cause of poor health in the Amarillo area.

- The proportion of deaths due to cardiovascular disease in the Amarillo area is higher than the state average. 2010 data for Potter County show that 338 deaths out of the 1,102 (31%) were attributed to cardiovascular disease. In the same year, Randall County had 291 deaths due to cardiovascular disease of out 912 (32%). [47] The 2010 Texas proportion of deaths due to cardiovascular disease is 23%.[48]
- Costs attributed to potentially preventable hospitalizations for congestive heart failure for Potter and Randall Counties in 2010 total $33M.[49]
- The 2013 Assessment shows that the proportion of residents reporting having been told they had a heart attack is the same as the state average (4%). This proportion has been declining

[42] Trust for America's Health, "F as in Fat: How Obesity Threatens America's Future", September 2012, http://healthyamericans.org/report/100/, accessed May 21, 2013.
[43] BRFSS 2005-2011, accessed through the Community Health Needs Assessment Toolkit, http://assessment.communitycommons.org/CHNA/Report.aspx?page=5&id=305, accessed May 20, 2013.
[44] DSHS, Potter County Potentially Preventable Hospitalizations 2005-2010, accessed May 20, 2013.
[45] CDC, BRFSS 2006-2010, accessed through Community Health Needs Assessment site, http://assessment.communitycommons.org/CHNA/, May 20, 2013.
[46] DSHS, Potentially Preventable Hospitalizations, 2005-2010, https://www.dshs.state.tx.us/ph/default.shtm, accessed May 20, 2013.
[47] DSHS Center for Health Statistics, Table 23C, http://www.dshs.state.tx.us/chs/vstat/vs10/t23c.shtm#P, accessed May 20, 2013.
[48] DSHS Center for Health Statistics, Table 16, http://www.dshs.state.tx.us/chs/vstat/vs10/t16.shtm, accessed May 20, 2013.
[49] DSHS, Potentially Preventable Hospitalizations, 2005-2010, https://www.dshs.state.tx.us/ph/default.shtm, accessed May 20, 2013.

according to the 2007 and 2010 Assessments. Similarly, 2013 Assessment data shows a decrease in the proportion of respondents who have been told they have coronary disease or angina (6% in 2010 to 4% in 2013). The 2010 Texas proportion was 4%. An area for further consideration may be an examination of any new interventions that may be in use in the area or perhaps this minor change in the data is attributable to methodological changes in administration of the phone surveys. [50]

- The proportion of survey respondents reporting that they have been told they have asthma in the Amarillo area has fluctuated from 15% in 2013 to 20% in 2010 to 16% in 2007. All these proportions are higher than the 2010 and 2007 state averages of 7% and 15%, respectively. BRFSS data from 2006-2010 shows that proportions of asthma prevalence in Randall and Potter County are four percentage points higher than that of the state.[51]
- The proportion of Amarillo residents reporting that a doctor had told them they had diabetes is steadily rising from 7% in 2007 to 9% in 2010 to 11% in 2013. The Texas average for this proportion was 10% in 2010.

12. Finding: Proportions of Amarillo area residents reporting that they had obtained some forms of preventative care services are often lower than state averages and/or are on the decline:

- The 2010 Assessment shows that 58% of Amarillo residents visited a doctor for a check-up even when feeling healthy. This declined to 52% in 2013. Those not receiving preventative care are more likely to have low incomes, to be Spanish speaking, and to have lower educational attainment than their counterparts who did receive a check-up.
- Potentially preventable hospitalizations cost the Amarillo area $46M in 2010.[52]
- In 2013, 24% of female Amarillo survey respondents stated that they had not had a Pap in the previous three years, up from 19% in 2010. In 2010, 70% of Potter County women reported having had a Pap in the last three years compared to the 77% state average.[53] As with many other preventative care services, patient compliance increases as income increases, as can be seen in demographic breakouts in the Assessments. Amarillo area women over 45 are less likely to report having received a Pap in the previous three years than their younger counterparts, according to Assessment data.
- 62% of male Amarillo residents reported not having had a Prostate-Specific Antigen (PSA) test in 2010, compared to 48% in Texas. This proportion rose to 68% in Amarillo in 2013. Note that of

[50] See the appendix of this document and the methodological section of the 2013 Assessment for more information on interpretation of changes between 2010 and 2013 Assessment data.
[51] CDC, 2006-2010 BRFSS data reported in the Community Health Needs Assessment site, http://assessment.communitycommons.org/CHNA/Report.aspx?page=6&id=651, accessed June 7, 2013.
[52] DSHS, Potentially Preventable Hospitalizations, 2005-2010, https://www.dshs.state.tx.us/ph/default.shtm, accessed May 20, 2013. These conditions include but are not limited to pneumonia, urinary tract infection, dehydration, asthma, diabetes complications, angina, congestive heart failure, and hypertension. The term means that if an individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred.
[53] BRFSS 2004-2010, accessed through Community Health Needs Assessment Toolkit, accessed May 21, 2013.

those male Amarillo area residents who had ever had a PSA test, 12% indicated that they had been told they had prostate cancer in 2013, up from just 4% in 2010.[54]

- 40% of Texans reported not ever having had a digital rectal exam in 2010, compared to 57% of Amarillo survey respondents. [55] This question was not included in the 2013 survey.

13. Finding: Access to healthy food is limited in the Amarillo area.

- There is relatively high fast-food restaurant access and conversely, limited grocery store access in Potter County. There are as many liquor stores in Potter as there are grocery stores and more than twice the number of liquor stores in Randall than grocery stores.[56]
- 2013 Assessment data shows that 34% of Potter and Randall County residents report experiencing worry or stress about having sufficient funds to buy nutritious food "always", "usually" or "sometimes".
- 2013 USDA data shows that nearly 15% of low income Potter residents experience low food access which is defined as being more than one mile in an urban setting or more than 10 miles in a rural setting from a food retailer.[57]
- Potter and Randall Counties have lower than state average food retailers accepting WIC.[58]

Health Coverage and Access to Care

14. Finding: Amarillo area residents report facing barriers in accessing health care. In many cases, residents with limited access to care are concentrated at lower educational attainment and income levels.

- More than one in five Amarillo area residents (21%) reported that they did not see a doctor due to prohibitive costs in 2010, compared to 15% and 19% across the nation and state, respectively. In 2013, the proportion of survey respondents indicating that they could not see a doctor due to prohibitive costs reached 23%. A quarter (25%) of Amarillo area residents reported an inability to afford healthcare for children, according to the 2013 Assessment.
- 31% of Amarillo residents reported not having a personal health care provider or doctor, up from 26% in 2010 and 23.6% in 2007.
- In general, the Assessments show that difficulty getting appointments (14-18%) for self or child is correlated with income and educational attainment. More information is needed about the sufficiency of the number of providers in the area.
- While still at only 5% in 2010 and 2013, persons reporting lack of transportation to medical appointments as a barrier to care nearly doubled between 2007 and 2010 for adults. This

[54] Sample sizes for this question are very small and likely yield unreliable estimates for this indicator.
[55] DSHS, BRFSS, 2010, http://www.dshs.state.tx.us/chs/brfss/query/brfss_form.shtm, accessed May 21, 2013.
[56] US Census Bureau, 2011 County Business Patterns Data, accessed through the Community Health Needs Assessment Toolkit, http://assessment.communitycommons.org/CHNA/,accessed, May 18, 2013.
[57] USDA Food Access Atlas, 2013, accessed through the Community Health Needs Assessment Toolkit, http://assessment.communitycommons.org/CHNA/, accessed May 18, 2013.
[58] USDA Food Access Atlas, 2012, accessed through the Community Health Needs Assessment Toolkit, http://assessment.communitycommons.org/CHNA/, accessed May 18, 2013.

proportion for persons seeking healthcare for a child is 5% in 2013, up from 3% in 2010. Very small proportions of Amarillo residents use public transportation or bike or walk to work, but 12% percent reported utilizing carpool arrangements in 2010.[59] More information is needed to understand needs or gaps in transportation and how or if these may affect health care access.

- The southern portion of Potter County is designated as having a shortage of primary medical care providers, while both Potter and Randall Counties are designated as having a shortage of dental providers.[60]

15. Finding: More information is needed to determine if there are sufficient numbers of Medicaid and CHIP providers in Amarillo.

- The 2010 Assessment states that 23% of Amarillo children were enrolled in either Medicaid or CHIP. The 2013 Assessment shows a substantial increase in this proportion to nearly 40%.[61] A slightly larger proportion of children are enrolled in CHIP in Potter County than in Randall County or the State of Texas. [62] CHIP rates of enrollment will fall statewide in the coming months, as children between 100 and 138% FPL currently on CHIP will be covered under Medicaid as of January 2014 as a result of the Patient Protection and Affordable Care Act (PPACA).
- ACS data shows nearly 20% of Potter County residents of all ages were enrolled in Medicaid between 2008 and 2010.[63] These rates will persist as Medicaid does not appear to be slated for optional expansion in Texas per the PPACA.
- Assessment data from 2007 through 2013 shows that between 3 and 4% of adults are on Medicaid, about 60% carry private insurance through employment, and about 20% are covered on Medicare.

16. Finding: Rates of uninsurance for all ages in Potter County have been higher than the state average, which has had the distinction of being the highest in the nation for several years. The following table summarizes the rates of uninsurance in the Amarillo area and shows the change in the rates after full implementation of the health insurance subsidies under the PPACA.[64]

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[59] US Census Bureau, American Community Survey 1 Year Estimates, Table C08134, http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml, accessed May 21, 2013.

[60] US Department of Health and Human Services, Health Resources and Services Administration, "Find Shortage Areas", http://hpsafind.hrsa.gov/HPSASearch.aspx, accessed May 14, 2013. Note that the CHNA site did not indicate that Potter or Randall Counties are designated as having provider shortages.

[61] Note that sample sizes for these indicators are small.

[62] HHSC, Texas CHIP and Medicaid Enrollment Statistics, http://www.hhsc.state.tx.us/research/MedicaidEnrollment/MedicaidEnrollment.asp, accessed May 14, 2013. The ACS estimates for population by age, which were used to find the rate of enrollment, include children who are 19, though only children 18 and under are eligible for CHIP.

[63] US Census Bureau, American Community Survey 3 year estimates, Table B27001, accessed through the Community Health Needs Assessment Toolkit, http://assessment.communitycommons.org/CHNA/, accessed May 14, 2013.

[64] US Census Bureau, 2007 and 2010 American Community Survey 1 Year Estimates, Table B27001, http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml, accessed May 21, 2013.

Proportions of Persons Without Insurance

	Amarillo	Potter County	Randall County	Texas	Nation
2007[65]	21.4%	n/a	n/a	n/a	n/a
2010[66]	24%	27.8%	13.3%	23.1%	15.1%
Uninsured After Implementation of PPACA[67]	n/a	17.5%	15.4%	17.3%	n/a

- Note that the most recent ACS data (2011) shows that 22.3% of Amarillo residents of all ages were without insurance.
- The 2013 Assessment shows that 27% of Amarillo area residents are without insurance.
- Assessment data shows that since 2007, a declining percentage of Amarillo areas children are uninsured, from 14% in 2007 to 11% in 2010 to a low of 10% in 2013.
- The 2010 and 2013 Assessments show that most of the persons at risk due to lack of insurance are between 18 and 34. Under the PPACA as of 2012, persons in these groups up to age 26 are able to remain on their parents' policy.

17. Finding: More information is needed to understand the need for mental and behavioral health care in Amarillo, including current service capacity in the Amarillo area.

- The proportion of survey respondents reporting that either they or a family member sought mental health care was 15% in 2010 and 12% in 2013. No corresponding questions, such as those in the BRFSS which ask about poor mental health days, are included in the survey to help ascertain whether there is unmet need for mental health services.[68] This is particularly important given stigma issues that frequently keep persons needing services from accessing them.
- More information is needed on the need for substance abuse services in the Amarillo area.
- Children's need for and use of mental health services are not captured in the Assessment data.
- Survey respondents reported difficulty in obtaining appointments, wait times, transportation and cost.[69]

[65] The ACS began tracking health insurance status in 2008. The uninsured figure for Amarillo for 2007 is from the Assessment of that same year. Figures from the Assessment do not include persons under 18.
[66] The 2010 number for Amarillo is from the 2010 ACS 1 Year Estimates for the Amarillo Metro Area.
[67] Center for Public Policy Priorities, "Randall County and the ACA" and "Potter County and the ACA", http://library.cppp.org/files/3/MedEx%20county%20level%20data%20combined.pdf, accessed May 15, 2013. Note that the estimates of those benefitting from health insurance subsidies are based on 2010 estimates of the uninsured. This could account for the inconsistency in the Randall County figures post-PPACA.
[68] As mentioned previously, the sample sizes for BRFSS at the County level for Potter and Randall do not exceed 50 and are therefore unreliable.
69 Sample sizes are very small for survey questions regarding mental health care.

Health Workforce and Infrastructure

18. Finding: More information is needed to identify improvements that could be made to Amarillo area health care utilization.

- The 2010 Assessment indicates that 61% adults surveyed would seek needed health care through their doctor or HMO. 13% would seek care in the ER, 12% in an urgent care center and and 5% in the JO Wyatt Clinic. 2013 Assessment data shows movement away from doctor or HMO utilization (52%) toward urgent care centers (19%), ERs (14%) and the JO Wyatt Clinic (9%).
- There is similar movement away from a doctor or HMO to other sources of care for children seen between 2010 and 2013, according to Assessment data. This is particularly apparent in data showing providers for immunizations, though sample sizes for this indicator are very small. In 2010, 80% of children were immunized by a private health care provider but in 2013 this proportion fell to just 46%, with related increases in immunization care provided at the Health Department, pharmacies, and local clinics.
- More information is needed regarding the current number of Amarillo providers, including primary care physicians and specialists, as well as those accepting CHIP, Medicaid and Medicare.
- Current hospital and clinic capacity, as well as any healthcare facilities in development need to be cataloged and analyzed to determine gaps or duplication in services.

Appendix: Comparison of Samples for 2007 and 2010 Amarillo Health Survey and Needs Assessments and the 2013 Potter and Randall County Community Health Assessment

Samples for 2007 and 2010 Assessments were drawn from the following zip codes:

Zip code	County	2010 % Responding	2007 % Responding	Average
79101	Potter	.9	1.0	0.95
79102	Potter	4.8	5.9	5.35
79103	Potter	3.5	5.5	4.5
79104	Potter	3.2	4.3	3.75
79106	Potter	16.4	13.6	15
79107	Potter	11.2	15.7	13.45
79108	Potter	5.4	5.4	5.4
79109	Randall	26.2	24.1	25.15
79110	Randall	9.2	11.1	10.15
79111	Potter	0.9	.6	0.75
79118	Randall	3.7	1.3	2.5
79119	Randall	4.1	3.4	3.75
79121	Randall	3.7	3.1	3.4
79124	Potter	3.9	4.1	4
Other		2.9	1.0	1.95
Randall Total	**45%**			
Potter Total	**53%**			

Source: United States Postal Service Zip Codes, May 2013.

Comparatively, the 2013 Potter and Randall County Community Health Assessment drew its sample from Potter (n=379) and Randall (n=421) Counties. This means that 47% of the 2013 sample is from Potter and 53% is from Randall County.

Note that cell phone lines were utilized in the 2013 survey. Different proportions of residents in Randall and Potter rely exclusively on cell phones (as opposed to having a land line in addition).The CDC has cautioned BRFSS users in interpreting changes observed in data following inclusion of cell phones in surveys. It is unclear how this methodological change has affected the data.

III. List of Key Informants (KIs)

Below is a list of stakeholders referred to as Key Informants (KIs) chosen by ADPH and NWTHS to prioritize issues raised in the Findings Report. KIs are community leaders from all sectors of the Amarillo community, including education, elected office, criminal justice, and health. In July of 2013, each were interviewed by THI staff.

List of Key Informants (KIs)

Gary Molberg, Chamber of Commerce

Brian Thomas, Potter County Sheriff

Gary Jackson, Potter County Justice of the Peace, Precinct 3

Rod Schroder, Superintendent of Amarillo Independent School District

Paul Matney, President of Amarillo College

Mark Crawford, CEO/Managing Partner of Northwest Texas Healthcare System

Edwina Wood, Amarillo Junior League

Paul Harpole, Mayor of Amarillo

Ellen Robertson Green, City Commissioner

Lilia Escajeda, City Commissioner

Mark Love, Central Church of Christ

Kelly Hayes, Catholic Family Services

Leon Church, Potter County Commissioner

IV. Key Informant Interview Template

The following tool was designed by THI staff to interview Key Informants (KIs) identified by ADPH and NWTHS. Interviews were conducted in July of 2013. The template was used to give community leaders an opportunity to prioritize areas of concern raised in the Findings Report and to consider which of these areas are able to be addressed through some kind of public health or community intervention.

Amarillo Community Health Improvement Plan
Key Informant Interview Template

Interviewee:

Date:

Purpose: We are interviewing community leaders such as yourself to identify how the Amarillo community can achieve positive health outcomes. We'd like to understand what public health issues you think are able to be affected by local intervention, what resources and partnerships are needed, and specifically, what interventions might be most successfully applied in this community. Your input will be used to prioritize areas of concern highlighted in Community Health Needs Assessment and other data on the Amarillo area and to help develop a Community Health Improvement Plan to address those areas of concern.

1. I'd like to start by getting your feedback about the Findings report. *The interviewee will have received the Findings before the interview takes place. If not, provide the interviewee with the report and give he/she a moment to review it.* Of the findings listed in the report, which do you feel are the most critical to address? Ideally, we'd like to cull the list down to 3 or 4 priority areas.

2. Of the priority areas you've identified, which can the local community effect change in? In other words, does the community have the collective buy-in, resources, and political will to bring about change or movement in this area? Keep in mind that the CHIP timeframe for change implementation is in 3 year cycles, and so work on a certain priority area can be iterative and can build on that of a prior planning and implementation cycle. *Note that the interviewee will*

have an opportunity later to expound on resources, partners and buy-in and does not need to give these details here. This question is intended to cull the list of priority areas to eliminate those that may not be able to be addressed for any number of reasons right now in the local community.

3. Now, of the priority areas you feel Amarillo is able to effect change in, are you able to prioritize them?

4. Can you name "owners" and/or partners of each of these priority areas? In other words, who are the stakeholders for each of the priority areas? Who must be at the table to move the needle on each of the priority areas? We want to be as inclusive as possible in planning to address these priority areas.

5. Catalog any existing activities or programming that are related to this area. What is already happening? What is planned? Note any opportunities to leverage or match efforts.

6. What are some key resources required to address each of these priority areas?

7. Do you have any ideas for interventions for these priority areas? Are there any best or promising practices in these areas that you know of? List for each of your priority areas.

8. Do you have any ideas for evaluation of efforts to address these priority areas? In other words, what are some indicators for measuring success regarding each of these priority areas? If we are successful in moving the needle on the priority areas identified, what will we see?

9. Are there any priority areas or issues that are not in the report that you think are critical to the community achieving positive health outcomes?

Thank you so much for your time. We appreciate your contribution toward the development of the Amarillo Community Health Improvement Plan.

V. Key Informant (KI) Interview Summary

The following document was created by THI and summarizes input from Key Informants (KIs) garnered through interviews conducted in July 2013. Four themes emerged from KI Interviews as priorities to address to improve Amarillo public health: Teen Pregnancy, Behavioral Health, Educational Attainment and Culture. The latter –as expressed by KIs –had to do with a widespread view that persons living in poverty in Amarillo are not taking steps to pull themselves and their families out of poverty and that poverty is normalized among this segment of the population. The cultural issues were tabled as a priority area because they were deemed beyond the scope of this planning effort. NWTHS and ADPH representatives also decided that educational attainment is being addressed by other planning efforts in Amarillo and is therefore not an appropriate focus for the CHIP. ADPH representatives felt strongly about broadening the Teen Pregnancy priority area to include sexually transmitted infections due to the high rates of these locally. The resulting two priority areas were 1) Risky Sexual Behavior/Teen Pregnancy and 2) Mental/Behavioral Health. These themes formed the basis for development of a survey designed to further narrow the focus of work to improve public health in Amarillo.

Amarillo Community Health Improvement Plan
Key Informant Interview Summary
July 28, 2013

Methodology: Amarillo Public Health Department and Northwest Texas Healthcare System leadership identified 14 stakeholders in the Amarillo community to be interviewed on their reactions to the Findings report. These interviewees ranged from officials in the public health sphere, social service agency leaders, local elected officials and community leaders. Interviews were conducted in person on July 16 and 17, 2013 with the exception of the interview with Mark Benton who was unable to meet at the agreed upon time and responded to the interview questions via email. Interviews were transcribed and responses were coded according to the priority level (1 to 4) assigned by the interviewee and the frequency with which the area of concern was named as a priority by interviewees. Responses were weighted accordingly and totals were scored, revealing the four areas described below. Any solutions suggested were recorded and will be inserted into further discussion.

Note that some of the priorities can be deemed subcategories or, conversely, macrocosms of others, depending on the vantage point of the reader. Many of the priorities are related to one another, particularly when the list of priorities is viewed through the lens of possible solutions. The list of priorities corresponds as closely as was reasonable to the Findings report, but new categories had to be added to reflect KI responses.

Summary: KIs named the following issues and concerns as priorities to address in the Amarillo community in the following order:

1. Low educational attainment of the population

Many KIs described the lack of educational attainment as underlying the issues described in the Findings report. Some linked the relatively low level of educational attainment in the area with economic and social barriers many face in earning a degree or certificate while others felt that norms and beliefs about education and its value undergird the low levels of attainment in Amarillo.

Some KIs pointed to the success in making supportive services (food pantry, child care) available to students, while others criticized these programs as enabling cultural norms discussed in #4 to continue to erode the potential of Amarillo residents.

Another point discussed was the need for and value in non-degree programs in Amarillo to train youth to get a good paying job, for those youth that are not college-bound.

Several KIs mentioned a need for better translation and ESL services for refugees living in the community. Many stated that lack of ESL services is affecting local education funding via "high-stakes testing".

2. Inadequate mental/behavioral health resources

KIs stated that the facilities and resources (psychiatric treatment, counseling and other supports) available for folks experiencing mental/behavioral health problems are inadequate. There was also an emphasis on the need to combat the stigma that prevents many from accessing services. Some KIIs stated that what resources do exist are difficult to access. One KI stated that the Panhandle MHMR can only treat certain diagnoses and this leaves a range of other mental health diagnoses with no avenues for treatment (personality disorders)[70]. The Panhandle MHMR struggles with limited resources and waiting lists.

Folks in law enforcement called the mental health issue an "epidemic" and reported having to allocate substantial resources to treating mental illness in jail. Many KIs reported that untreated mental illness, including substance abuse, is creating a spill-over effect in the criminal justice system. An estimated 30-40% of the average daily inmate population (480) of the Potter County jail has a mental or behavioral health issue. Extra bed checks, confinement in isolation or the medical unit and suicide watch for these inmates are some of the extra costs incurred by this population of persons with untreated mental illness. The jail does not have adequate funding to sustainably offer these services.

KIs reported a critical lack of substance abuse services and that Amarillo residents must travel to Lubbock or Plainview to receive services. One KI stated that 75% of all crime in Amarillo is drug-related and that 90% of drug-related crime is tied to Methamphetamine production, sale or use.

Interestingly, there were varying levels of understanding amongst KIs regarding what mental/behavioral health resources are available in the community. Some KIs reported that the Pavilion accepts only private paying inpatients, though the facility serves indigent persons as well and offers outpatient programming.

[70] This has not been verified by an MHMR representative.

3. Teen Pregnancy

KIs noted that there are not sufficient resources in the community to address this issue. One KI said that private groups are active in looking for solutions. Interviewees noted that political and religious attitudes make it difficult to find solutions to this problem and prevent persons in need of services from accessing them.

Many KIs asserted that the causal factor is lack of self-esteem. Earlier age-appropriate sex education and use of a well-known curriculum (Worth the Wait) were recommended as possible solutions. Others felt that there is a pervasive attitude that pregnancy at a young age is acceptable (see #4 below) and an issue of "learned behavior" that will take many years to correct.

4. Cultural norms/attitudes that keep people in poverty

Many interviewees spoke about their perceptions that the community is in need of "culture change" - a shift away from behaviors described as "laziness", "expecting to get things for free", and "instant gratification". Interviewees linked these norms or attitudes to single-parent families and to historical "failure" within the family in educational institutions, and further, an acceptance of teen pregnancy and a life of poverty. In essence, many KIs reported that poverty is normalized among persons living in poverty in Amarillo. KIs stated that we need to teach youth to make good decisions and to think in the long term to change cultural norms.

Though not related to poverty, cultural attitudes normalizing high calorie diets and lack of physical activity were used by some KIs to explain some aspects of the Findings report.

VI. Amarillo CHIP Survey Summary and Analysis

THI staff designed a survey to identify community consensus around the most appropriate public health interventions to bring about change in the priority areas – Risky Sexual Behavior/Teen Pregnancy and Behavioral/Mental Health. The online survey was launched in mid-September 2013 and was open for two weeks. The link to the survey was sent to a broad range of community leaders and stakeholders identified by NWTHS, ADPH and KIs themselves. There were 72 responses, 51 of which were complete. Respondents identified schools as the best venue for risky sexual behavior/teen pregnancy prevention interventions and high school and middle school students as appropriate targets for these interventions. For behavioral health, respondents stated residents do not know what services are available and face stigma in accessing services. They also reported a lack of behavioral health providers and a dearth of substance abuse services for youth and adults.

Amarillo CHIP Survey Summary and Analysis
September 2013

I. Background and methodology

The survey design was based on input from an assessment of existing data sources (public health data, BRFSS data, and other public data sources) and key informant interviews conducted in June of 2013. These two bodies of information showed that Amarillo community leaders and residents felt that teen pregnancy and behavioral health issues were top priorities to be addressed through the Community Health Improvement Plan (CHIP).

The online survey link was sent to participants via email selected by Northwest Texas Healthcare System and the Amarillo Department of Public Health. The survey was open for approximately two weeks, consisted of 16 questions, and yielded 72 responses, 51 of which were complete. Incomplete responses were included in the analysis whenever possible. Note that 1) respondents were permitted to select more than one response in the multiple choice questions and that 2) multiple choice questions allowed respondents to select “other” and to enter a unique response.

II. Summary Survey Results

Below is a summary analysis of survey results. Each response was sorted by theme and those most frequently mentioned are recorded below. Raw results are available upon request.

A. Risky Behavior

Q3: OPEN ENDED -Risky sexual behavior (unprotected sex, multiple partners, etc.) has been identified as an issue that needs to be addressed in the Amarillo community. Prevention and education activities designed to reduce or eliminate these behaviors that have been implemented in Amarillo have not resulted in sizable reduction of rates of sexually transmitted infection. What do you think might help

reduce these behaviors in this community? Please be as specific as possible about any proposed program and who or what agency is best suited to do this work.
56 respondents

The top 5 responses are as follows:

1. Most survey respondents pointed to education delivered in schools as the best way to address this issue. (10/56).
2. Nine respondents (9/56) stated that the community needs contraceptive education and/or safe sex education. Four respondents stated that contraceptives need to be made available to those at risk of teen pregnancy and/or STDs. (4/56)
3. Eight respondents said that the solution to risky behavior is a church/faith community-led prevention effort. (8/56)
4. Seven respondents said a media campaign is an effective way to combat this problem in the community. (7/56)
5. Parental involvement, sometimes referred to as "parental responsibility" was selected as an effective strategy against this issue by 5 respondents (5/56).

Q4: OPEN ENDED - Teen pregnancy has been identified as a public health issue that needs to be addressed in the Amarillo community. What is the most critical population in the Amarillo community to target with programs or interventions to reduce teen pregnancy? Please be as specific as possible (age group, zip code, neighborhood, etc.).
56 respondents

The top 5 target populations are listed below.

1. High school students/teens (15/56)

2. Middle school students/pre-teens (14/56)

3. Parents (as a target population for educational efforts and programming) (6/56)

4. Zip code 79107 (5/56)

5. a three-way tie between:

    a. Whatever target population is indicated by the data (4/56)

    b. elementary school students (4/56)

    c. youth in poverty (4/56)

Q5: MULTIPLE CHOICE - What groups or organizations are best suited to improve the teen pregnancy rate in Amarillo?
56 respondents, 205 total individual responses

The top 4 recommended organizations or institutions to address teen pregnancy in Amarillo are listed below:

1. Survey respondents pointed to schools as the best institution to tackle this issue. (49/205)

2. TIE: Community non-profit organizations and Faith-based organizations (38/205)

3. Amarillo Department of Public Health (30/205)

4. Health Care Providers (27/205)

Other: Note that 4 respondents chose "Other" and wrote in "parents", while 4 others wrote in that they thought the "whole community" must mobilize to address this issue.

Q6: MULTIPLE CHOICE - Which of the following do you think will be the most effective ways of addressing teen pregnancy in the Amarillo area?
56 respondents, 199 individual responses

The top 5 responses were as follows:

1. Teach pregnancy prevention to youth (40/199)

2. Build self-esteem among youth (36/199)

3. Media campaign designed to reduce teen pregnancy (35/199)

4. Provide opportunities for education for youth (34/199)

5. Provide opportunities for job training and employment for youth (24/199)

Other: 16 respondents selected "other" and of these, 4 stated that other risky behaviors underlie the problem of teen pregnancy, such as low self-esteem and substance abuse. Four others noted the importance of involving parents in education and prevention efforts.

Q 7 and 8 asked for names of folks who want to be involved in further planning efforts in this area.

B. Behavioral Health

Q9: MULTIPLE CHOICE - Behavioral/mental health resources have been identified as a priority that needs to be addressed to improve the health of the Amarillo community. Please indicate areas within this priority that you think are key in addressing this issue.
54 respondents, 155 individual responses

The top 5 responses are as follows:

1. People do not know what behavioral/mental health resources exist in the community and so they can't access them. (31/155)

2. The stigma of mental/behavioral illness makes it difficult for people who need services to access them. (27/155)

3. There are not enough providers of mental/behavioral healthcare in the community. (26/155)

4. Tie: Mental and behavioral health services are available, but they are not affordable AND Mental and behavioral health services are available, but people without health insurance can't access them. (18/155)

5. There are no substance abuse services in Amarillo. (13/155)

Other: Three of those selecting "other" noted that greater coordination is needed between agencies serving or otherwise coming into contact with populations in need of behavioral health needs.

Q10: MULTIPLE CHOICE -What specific areas of behavioral/mental healthcare are the most critically needed in the Amarillo community?
54 respondents, 225 separate responses

The top 5 needs identified are as follows:

1. Substance abuse services for youth (31/225)

2. Substance abuse services for adults (29/225)

3. Community education to raise awareness of mental/behavioral health disorders (28/225)

4. Outpatient psychiatric care for children (27/225)

5. Outpatient psychiatric care for adults (24/225)

Other: Persons writing in "other" noted the need for supportive housing for mentally ill, mental health courts, and follow-up services for those with mental health issues who are released from prison.

C. Educational Attainment

Q13: MULTIPLE CHOICE -Low educational attainment has been identified as a barrier to improving community health in Amarillo. Within this broad category, what do you think are the specific issues that need to be addressed?
52 respondents, 218 individual responses

The top 5 areas are as follows:

1. Lack of social supports (such as child care). (32/218)

2. Lack of educational resources for area students who are not college-bound, but instead need instruction in trade school to obtain a livable wage. TIED with Low high school graduation rates. (26/218)

3. Lack of financial resources. (23/218)

4. Negative attitudes toward educational attainment. (21/218)

5. TIE between Educational attainment is difficult for some segments of the population due to insufficient English as a Second Language (ESL) instruction AND Low levels of completion of trade school, certificate or associate's degree programs. (19/218)

Other: Persons using the "other" category described the need for supportive services and part-time work for students to stay in school, need for enforcement of truancy laws, standardized tests as obstacles to keeping students in school, in-home services for at-risk students, and poverty as the root cause of low educational attainment.

Q 14 and 15 asked for names of folks who want to be involved in further planning efforts in this area.

Q16 was an open-ended comments box for survey respondents to ask broad questions and make suggestions.

VII. Focus Group Participants

In October 2013, two focus groups were held – one for each of the two priority areas -Risky Sexual Behavior/Teen Pregnancy and Behavioral/Mental Health. Participants – listed below - were all stakeholders in the respective issue areas who indicated in the survey that they wanted to participate in planning around these issues. The focus groups were designed to guide participants in the drafting of goals and objectives for each of the priority areas.

Risky Sexual Behavior/Teen Pregnancy

Staff present:

Matt Richardson, Terry Herndon, Casie Stoughton, all from ADPH
Elizabeth Vela (facilitator)

Participants:

Mryna Raffkind, Teen Pregnancy Prevention Coalition
Susan Barros, United Way
Pam Kinnan, AISD
Ruth Whitehead, Texas Tech
Annette Carlisle, Amarillo 20/20
Krisandra Pope, AISD

Behavioral/Mental Health

Staff present:

Casie Stoughton, Matt Richardson, Terry Herndon, all from ADPH
Elizabeth Vela (facilitator)

Participants:

Amy Hord, Social Work Instructor, WTAMU
Shane Crafton, Crisis Intervention Team, APD
Jim Womack, Planner, Texas Panhandle Centers
*Note that Pavilion Staff did not attend the focus group but did provide input following the meeting.

VIII. Focus Group Agendas

Below are the October 2013 focus group agendas designed by THI staff. Focus groups were held at the Amarillo Department of Public Health and lasted for 1.5 hours. Lunch was served to participants to draw the highest possible participation. The goal of each focus group was to develop goals and objectives for each priority area of the CHIP. In each group meeting, participants were given an overview of the CHIP process, provided with a summary of the survey results and were given handouts on the development of goals and objectives. Focus group participants were given an opportunity to respond to the survey results and then began group brainstorming of goals and objectives and, to a lesser extent, strategies.

Amarillo CHIP: Behavioral Health Focus Group
October 2, 2013

Focus Group Agenda

I. Welcome and introductions	Matt – 10 minutes
II. Background and purpose of CHIP	Matt – 10 minutes
III. Opportunities for further participation in CHIP	Matt – 5 minutes
IV. Brief review of Findings Report, KIs and Survey	Liz – 10 minutes
V. Development of Goals and Objectives and Strategies for Behavioral Health	Liz – 1 hour

For our purposes, a **goal** is a projected state of affairs that you intend to achieve within 3 years of release of the CHIP. It identifies in broad terms how your initiative is going to change things in order to solve the problem you have identified.

Objectives describe the steps that will take place within 3 year's time in order to achieve the change described by your goals. They break goals into manageable parts - typically 2-4 action-oriented phrases to further break down/specify what you are trying to achieve in each goal. Objectives are SMART (simple, measureable, achievable, relevant and time-based).

VI. Group evaluation of Goals and Objectives	Liz – 25 minutes

VII. Next Steps: strategy development in work groups Matt – 10 minutes

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Amarillo CHIP: Risky Behavior Focus Group
October 3, 2013

Focus Group Agenda

I. Welcome and introductions Matt – 10 minutes

II. Background and purpose of CHIP Matt – 10 minutes

III. Opportunities for further participation in CHIP Matt – 5 minutes

IV. Brief review of Findings Report, KIs and Survey Liz – 10 minutes

V. Development of Goals and Objectives and Strategies for Risky Behavior Liz – 1 hour

For our purposes, a **goal** is a projected state of affairs that you intend to achieve within 3 years of release of the CHIP. It identifies in broad terms how your initiative is going to change things in order to solve the problem you have identified.

Objectives describe the steps that will take place within 3 year's time in order to achieve the change described by your goals. They break goals into manageable parts - typically 2-4 action-oriented phrases to further break down/specify what you are trying to achieve in each goal. Objectives are SMART (simple, measureable, achievable, relevant and time-based).

VI. Group evaluation of Goals and Objectives Liz – 25 minutes

VII. Next Steps: strategy development in work groups Matt – 10 minutes

IX. Amarillo CHIP Goals and Objectives

Goals and objectives for Risky Sexual Behavior/Teen Pregnancy and Mental/Behavioral Health are below. The THI facilitator worked off the drafted goals and objectives from each focus group meeting, reorganizing elements and in some cases, adding Healthy People 2020 goals and objectives or Medicaid 1115 targets if they aligned well and reflected the direction and interests of the focus group participants. The resultant goals and objectives were vetted via email by all focus group participants and by representatives at ADPH and NWTHS. [71]

Amarillo CHIP Goals and Objectives: Behavioral/Mental Health

Goal 1: Improve access to behavioral/mental health services in Amarillo.

Objective 1.1: By the end of 2016, expand substance abuse prevention services by 10%. (A possible model for this is the mentoring program operated by Impact Futures.)

Baseline: Unduplicated # receiving substance abuse prevention services from Impact Futures in 2012.

Strategy 1.1.1: By June 2014, form advisory committee: convene all area behavioral/mental health providers in two planning sessions to further develop the CHIP by completing task planning for CHIP Goal and Objectives for behavioral/mental health. Include "grassroots" providers such as AARC. This advisory committee will also identify strategies for capacity building, service expansion, and new funding sources.

Strategy 1.1.2: With strategy 1.1.1 as a starting point, convene existing substance abuse service providers and consider the most effective path toward substance abuse prevention service expansion. Complete a work plan for meeting this objective.

Objective 1.2: By the end of 2016, provide integrated primary care and behavioral health services to a total of 494 persons through co-located sites.[72]

Baseline: n/a. This is a new program.

Strategy 1.2.1: By June 2014, form advisory committee: convene all area behavioral/mental health providers in two planning sessions to further develop the CHIP

[71] Pavilion representatives did not participate in the focus group but did provide input which can be important in shaping strategy and task planning in workgroups following the adoption of the goals and objectives listed here. Main points of emphasis from Pavilion representatives not reflected in this document include: 1) homelessness as a driver of substance abuse, 2)the need for free/low cost meds and 3) the need for intensive outpatient services.

[72] This is an RHP 12 1115 Waiver project under TPC - 127378105.2.2. This objective is a Healthy People 2020 objective (MHMD -5)

by completing task planning for CHIP Goal and Objectives for behavioral/mental health. Include "grassroots" providers such as AARC. This advisory committee will also identify strategies for capacity building, service expansion, and new funding sources. (Because this is an 1115 Waiver project, planning for this objective is already underway but leveraging and complementary efforts can be identified to ensure success of this objective.)

Objective 1.3: By the end of 2016, develop and implement crisis respite/stabilization services in the community, aiming to serve 158 unduplicated individuals.[73]

Baseline: Nonexistent. A new service.

Strategy: 1.3.1: By June 2014, form advisory committee: convene all area behavioral/mental health providers in two planning sessions to further develop the CHIP by completing task planning for CHIP Goal and Objectives for behavioral/mental health. Include "grassroots" providers such as AARC. This advisory committee will also identify strategies for capacity building, service expansion, and new funding sources. (Because this is an 1115 Waiver project, planning for this objective is already underway but leveraging and complementary efforts can be identified to ensure success of this objective.)

Objective 1.4: By the end of 2016, increase the number of behavioral health providers serving the Amarillo community by 10%.

Baseline: Number of providers by type in 2012.

Strategy: 1.4.1: By June 2014, form advisory committee: convene all area behavioral/mental health providers in two planning sessions to further develop the CHIP by completing task planning for CHIP Goal and Objectives for behavioral/mental health. Include "grassroots" providers such as AARC. This advisory committee will also identify strategies for capacity building, service expansion, and new funding sources.

Strategy 1.4.2: By then end of 2016, design and implement a psychiatric residency program at Texas Tech that will produce an average of 5 new providers per year once fully implemented to serve the Amarillo community.

Strategy 1.4.3: By the end of 2016, design and implement a recruitment and retention plan to increase the number of psychiatrists – with an emphasis on child psychiatrists - practicing in the Amarillo community by 10%.

Strategy 1.4.4: By the end of 2016, design and implement at least one mental health certification/training track for mid-level providers (RNs, PAs, CNAs) in Amarillo area community colleges, universities or other training institutions.

[73] This is an RHP 12 1115 Waiver project under TPC - 127378105.1.1.

Objective 1.5: By end of 2016, increase the number of adults and youth receiving inpatient and outpatient substance abuse services in Amarillo by 10%.

Baseline: Number of adults and youth receiving inpatient and outpatient substance abuse services in the Amarillo area in 2012.

Strategy: 1.5.1: By June 2014, form advisory committee: convene all area behavioral/mental health providers in two planning sessions to further develop the CHIP by completing task planning for CHIP Goal and Objectives for behavioral/mental health. Include "grassroots" providers such as AARC. This advisory committee will also identify strategies for capacity building, service expansion, and new funding sources. Dovetail work toward this objective with RHP 12 Medicaid 1115 Waiver project 127378105.2.1 which will provide 30 day outpatient substance abuse treatment services to 210 adults by the end of 2016.

Strategy 1.5.2: With strategy 1.5.1 as a starting point, form a workgroup focused on the expansion of substance abuse services in Amarillo, considering options related to substance abuse provider training, recruitment and retention as well as program development in existing agencies providing related services.

Objective 1.6: To combat stigma of mental/behavioral health disorders, by the end of 2016, implement a peer support program to serve 200 consumers.[74]

Baseline: None. This is a new program.

Strategy 1.6.1: Implement a Mental Health week to reduce stigma associated with mental/behavioral health disorders. Include the Crisis Intervention Team, other relevant departments/staff of the City of Amarillo, the Texas Panhandle Centers, area Universities and local service providers in planning for this annual event. Include web and social media presence, radio and television messaging and community events, including screening and service fairs.

[74]This is an RHP 12 1115 Medicaid waiver project under TPC – 127378105.2.3.

Amarillo CHIP Goals and Objectives: Risky Sexual Behavior/Teen Pregnancy

Goal 1: Replace the norm regarding acceptability of teen pregnancy/risky sexual behavior in the community with a new norm of safe sex and delaying pregnancy.

Objective 1.1 – By the end of 2016, reduce the rate of Chlamydia by 10% in Potter County. [75]

Baseline: The 2012 rate of Chlamydia (per 100,000 population) is 964.6.

Strategy 1.1.1: Form advisory committee: build a coalition of healthcare providers, community organizers and representatives (particularly of underserved sectors of the community/and or zip codes with highest rates of STDs and teen pregnancies), the business community, schools and the faith community to facilitate the implementation of CHIP goals and objectives to reduce risky sexual behavior and teen pregnancy. A best practice for this coalition is the United Way of Greater Milwaukee's Teen Pregnancy Prevention Initiative.

Strategy 1.1.2: Increase screening for Chlamydia in area clinics and private medical providers through direct educational efforts aimed healthcare providers. Focus resources on the areas of Potter County with the highest rates of STDs and unintended/teen pregnancies.

Strategy 1.1.3: Design and implement a media campaign that teaches residents of the Amarillo area to practice safe sex and avoid teen pregnancy. This campaign will include social media elements and will also include tailored messages to keep business, faith and other sectors of the community engaged.

Objective 1.2 – By the end of 2016, reduce the rate of gonorrhea by 10% in Potter County.[76]

Baseline: The 2012 rate of gonorrhea (per 100,000 population) is 328.6.

Strategy 1.2.1: Form advisory committee: build a coalition of healthcare providers, community organizers and representatives (particularly of underserved sectors of the community/and or zip codes with highest rates of STDs and teen pregnancies), the business community, schools and the faith community to facilitate the implementation of CHIP goals and objectives to reduce risky sexual behavior and teen pregnancy. A best practice for this coalition is the United Way of Greater Milwaukee's Teen Pregnancy Prevention Initiative.

Strategy 1.2.2: Increase screening for gonorrhea in area clinics and private medical providers through direct educational efforts aimed at healthcare providers. Focus

[75] Modeled on HP 2020 STD objectives.
[76] Modeled on HP 2020 STD objectives.

resources on the areas of Potter County with the highest rates of STDs and unintended/teen pregnancies.

Strategy 1.2.3: Design and implement a media campaign that teaches residents of the Amarillo area to practice safe sex and avoid teen pregnancy. This campaign will include social media elements and will also include tailored messages to keep business, faith and other sectors of the community engaged in this issue.

Objective 1.3 – By the end of 2016, increase the proportion of females at risk of unintended pregnancy[77] or their partners who used contraception at most recent sexual intercourse by 10%.

Baseline: Nonexistent as of CHIP drafting. This baseline will be collected through poll at clinic sites at beginning of CHIP implementation.

Strategy 1.3.1: Form advisory committee: build a coalition of healthcare providers, community organizers and representatives (particularly of underserved sectors of the community/and or zip codes with highest rates of STDs and teen pregnancies), the business community, schools and the faith community to facilitate the implementation of CHIP goals and objectives to reduce risky sexual behavior and teen pregnancy. A best practice for this coalition is the United Way of Greater Milwaukee's Teen Pregnancy Prevention Initiative.

Strategy 1.3.2: By the end of 2016, provide accurate information and education on how to correctly use contraceptives as well as contraceptive supplies to at least 1,000 unduplicated Amarillo residents. A best practice for web content for youth and their parents is Baby Can Wait. Educational programming can involve web and social media presence, direct educational efforts that are curriculum-based, and can also overlap with pieces of the media campaign described in strategies under this goal. Focus resources on the areas of Potter County with the highest rates of STDs and unintended/teen pregnancies.

Strategy 1.3.3: Design and implement a media campaign that teaches the public to practice safe sex and avoid teen pregnancy. This campaign will include social media elements and will also include tailored messages to keep business, faith and other sectors of the community engaged in this issue.

Sources:

Healthy People 2020 Goals and Objectives

Texas Department of State Health Services, TB/HIV/STD Epidemiology and Surveillance Branch, Texas 2012 STD Surveillance Report, http://www.dshs.state.tx.us/hivstd/, accessed October 9, 2013.

[77] Females at risk of unintended pregnancy include those under 20 years of age, those with less than or equal to a high school education and those who are Medicaid –eligible.

X. Next Steps: Three Year Community Implementation Plan for the CHIP

To implement the CHIP, a steering committee of key institutional stakeholders will need to be formed to guide the overall implementation process. Ideally, this group will guide policy development and manage the activities of the advisory committees (formed for each of the priority areas) and would meet as necessary and at the call of the Chair. At least quarterly meetings would be anticipated.

Two advisory committees –again, one for each of the priority areas- of community leaders and stakeholders will need to be formed to provide guidance and management of implementation that is more focused on the specific priority areas. The attendees of each of the focus groups are a logical place to start in the recruitment of these advisory groups[78]. These advisory committees would ideally develop strategies and tasks in support of the CHIP and identify resources for implementation. For both priority areas, advisory committees will confer with and solicit input from a broader level of constituents (a coalition in the Risky Sexual Behavior/Teen Pregnancy work and a group of providers for the Mental/Behavioral Health work). Regular meetings of the Advisory Committees are recommended but are not prescribed in the timelines.

Timelines and considerations for implementation are as follows:

Behavioral/Mental Health Advisory Committee

January 2014	Advisory Committee would be formed and has an initial planning meeting. Specific tasks for this initial meeting include designing the two community-wide planning sessions in the CHIP (Strategy 1.1.1) and beginning to consider options for further strategy and task planning for the CHIP. Subcommittees would be formed on any elements that seem helpful, such as resource development, evaluation and the Medicaid 1115 Waiver, as this presents areas of overlap with CHIP strategies for this priority. Additional data collection will likely be necessary regarding the nuances of behavioral/mental health care needs and gaps in the Amarillo Community. Data and information needs identified by the Steering and/or Advisory Committees will be included in work planning and tracked throughout CHIP Implementation.
Spring 2014	Advisory Committee would host two planning meetings that all behavioral/mental health providers are invited to, including grassroots providers. Specific tasks for these two sessions would include brainstorming, development and approval of strategies and tasks to support the goals and objectives of the CHIP. These meetings would be more efficient if they involved breakout sessions for each objective.
Summer 2014	Strategy and task planning for CHIP would be completed. Advisory Committee would complete vetting of the CHIP.

[78] See Participant list on page 32 of this report.

Fall 2014	Implementation of CHIP would begin.
Fall 2015	Advisory Committee would meet to consider results of the first year of implementation. Mental/behavioral health providers would be convened to share results and check in on progress.
Fall 2016	Advisory Committee would meet to consider results of the first year of implementation. Providers would be convened to share results and check in on progress. A final evaluation of the behavioral/mental health component of CHIP implementation would be completed.

Some important considerations for CHIP implementation include:

- The Medicaid 1115 Waiver and the influx of dollars allocated for behavioral health to the region
- 2014 Sunset of state agencies administering mental/behavioral health programs in the 2014-15 biennium
- Implementation of the Patient Protection and Affordable Care Act and its impact on access to both primary and behavioral/mental health care

Risky Sexual Behavior/Teen Pregnancy Advisory Committee

January 2014	Advisory Committee would be formed and would have an initial planning meeting. Specific tasks for this initial meeting include defining specifically who is part of the coalition described in Strategy 1.1.1 (healthcare providers, community organizers, private sector representatives) and beginning to consider options for further strategy and task planning for the CHIP. Subcommittees could be formed on any elements that seem helpful, such as resource development, evaluation, program development, or could be organized per each of the objectives. Additional data collection will likely be necessary regarding the nuances of Risky Sexual Behavior/Teen Pregnancy needs and gaps in the Amarillo Community. Data and information needs identified by the Steering and/or Advisory Committees will be included in work planning and tracked throughout CHIP Implementation.
Spring 2014	Advisory Committee would host up to two planning meetings that all coalition members would be invited to attend. Specific tasks for these two sessions include brainstorming, development and approval of strategies and tasks to support the goals and objectives of the CHIP. These meetings would be more efficient if they involve breakout sessions for each objective.
Summer 2014	Strategy and task planning for CHIP would be completed. Advisory Committee would complete vetting of the CHIP.

Fall 2014	Implementation of CHIP would begin.
Fall 2015	Advisory Committee would meet to consider results of the first year of implementation. Coalition members would be convened to share results and check in on progress.
Fall 2016	Advisory Committee would meet to consider results of the first year of implementation. Coalition members would be convened to share results and check in on progress. A final evaluation of the risky sexual behavior/teen pregnancy component of CHIP implementation would be completed.

Some important considerations for CHIP implementation include:

- Sunset review of state agencies administering women's health programs in 14-15 biennium
- Implementation of legislation enacted in 83rd legislative session impacting access to women's health care/family planning services (HB 2)
- Impact of the transformation of the Women's Health Program from Medicaid-funded waiver to a state-funded program (now the Texas Women's Health Program)
- Availability of CDC Community Transformation Grant funds