Methodist Charlton Medical Center
Methodist Dallas Medical Center
Methodist Rehabilitation Hospital

Community Health Needs Assessment – 2019

Implementation Strategy

As a result of the Patient Protection and Affordable Care Act (PPACA), all tax-exempt organizations operating hospital facilities are required to assess the health needs of their community through a Community Health Needs Assessment (CHNA) once every three years.

The written CHNA Report must include descriptions of the following:

- The community served and how the community was determined
- The process and methods used to conduct the assessment including sources and dates of the data and other information as well as the analytical methods applied to identify significant community health needs
- How the organization took into account input from persons representing the broad interests of the community served by the hospital, including a description of when and how the hospital consulted with these persons or the organizations they represent
- The prioritized significant health needs identified through the CHNA as well as a description of the process and criteria used in prioritizing the identified significant needs
- The existing healthcare facilities, organizations, and other resources within the community available to meet the significant community health needs
- An evaluation of the impact of any actions that were taken, since the hospital facility(s) most recent CHNA, to address the significant health needs identified in that last CHNA

PPACA also requires hospitals to adopt an Implementation Strategy to address prioritized community health needs identified through the assessment. An Implementation Strategy is a written plan that addresses each of the significant community health needs identified through the CHNA and is a separate but related document to the CHNA report.

The written Implementation Strategy must include the following:

- List of the prioritized needs the hospital plans to address and the rationale for not addressing other significant health needs identified
- Actions the hospital intends to take to address the chosen health needs
- The anticipated impact of these actions and the plan to evaluate such impact (e.g. identify data sources that will be used to track the plan's impact)
- Identify programs and resources the hospital plans to commit to address the health needs
- Describe any planned collaboration between the hospital and other facilities or organizations in addressing the health needs

The Methodist Charlton Medical Center, Methodist Dallas Medical Center, and Methodist Rehabilitation Hospital community has been identified as the geographical area of Dallas County. The CHNA process identified significant health needs for this community (see list below). Significant health needs were identified as those where the qualitative data (interview and focus group feedback) and quantitative data (health indicators) converged. In addition, other needs were identified by leveraging the professional experience and community knowledge of the hospital leadership via discussion.

- Mental Health
  (e.g.: Providers, Frequent Mental Distress; Intentional Self-Harm; Suicide)
- Chronic Conditions
  (e.g.: Diabetes, Obesity; Stroke; Hypertension)
- Infectious Disease
  (e.g.: HIV Prevalence)
- Environment
  (e.g.: Food Insecurity; Housing)
- Social Determinants of Health
  (e.g.: Poverty (Adults and Children); Language Barriers)
- Access to Care
  (e.g.: Uninsured Adults and Children; Transportation)
- Injury and Death – Children
  (e.g.: Infant and Child Mortality)
- Health Behaviors – Substance Abuse
  (e.g.: Drug Overdose Deaths – Opioids; Drug Poisoning Deaths; Motor Vehicle Driving Deaths with Alcohol Involvement)
- Preventable Hospitalizations
  (e.g.: Adult and Pediatric Perforated Appendix Admissions)

Methodist Charlton, Methodist Dallas, and Methodist Rehabilitation prioritized these significant community healthcare needs based on the following:

- Magnitude: The need impacts a large number of people, actually or potentially.
- Severity: What degree of disability or premature death occurs because of the problem? What are the potential burdens to the community, such as economic or social burdens?
- Vulnerable Populations: There is a high need among vulnerable populations and/or vulnerable populations are adversely impacted.
- Root Cause: The issue is a root cause of other problems, thereby possibly affecting multiple issues.

Selecting the Health Needs to be addressed by Methodist

To choose which of the prioritized health needs Methodist would address through its corresponding implementation plans, the participants representing Methodist Charlton Medical Center, Methodist Dallas Medical Center, and Methodist Rehabilitation Hospital collectively as a group rated each of the prioritized significant health needs on the following selection criteria:

- Expertise & Collaboration: Confirm health issues can build upon existing resources and strengths of the organization. Ability to leverage expertise within the organization and resources in the community for collaboration.
- Feasibility: Ensure needs are amenable to interventions, acknowledge resources needed, and determine if need is preventable.
- Quick Success & Impact: Ability to obtain quick success and make an impact in the community.

Through the prioritization process, the following four significant needs were selected to be addressed via the Methodist Charlton, Methodist Dallas, and Methodist Rehabilitation CHNA Implementation Strategy:

- Hypertension
- Stroke
- Diabetes
- HIV

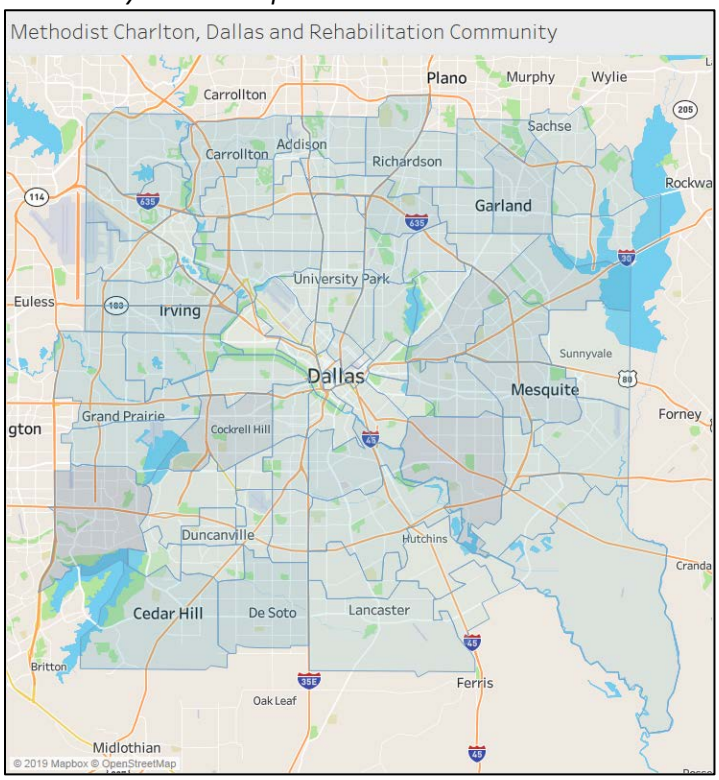
All other significant health needs were not chosen for a combination of the following reasons:

- The need was not well-aligned with organizational strengths.
- There are not enough existing organizational resources to adequately address the need.
- Implementation efforts would not impact as many community residents (magnitude) as those that were chosen.

Community Served

Methodist Charlton Medical Center, Methodist Dallas Medical Center, and Methodist Rehabilitation Hospital defined the facilities' community using the county in which at least 75% of patients reside. Using this definition, Methodist Charlton Medical Center, Methodist Dallas Medical Center, and Methodist Rehabilitation Hospital have defined their community to be the geographical area of Dallas County for the 2019 CHNA.

Community Served Map



Demographic and Socioeconomic Summary

According to population statistics, the population in this health community is expected to grow 6.6% in five years, just below the Texas growth rate of 7.1%. The median age was younger than the Texas and national benchmarks. Median income was above both the state and the country. The community served had a lower proportion of Medicare beneficiaries than the state of Texas.

Demographic and Socioeconomic Comparison:
Community Served and State/U.S. Benchmarks

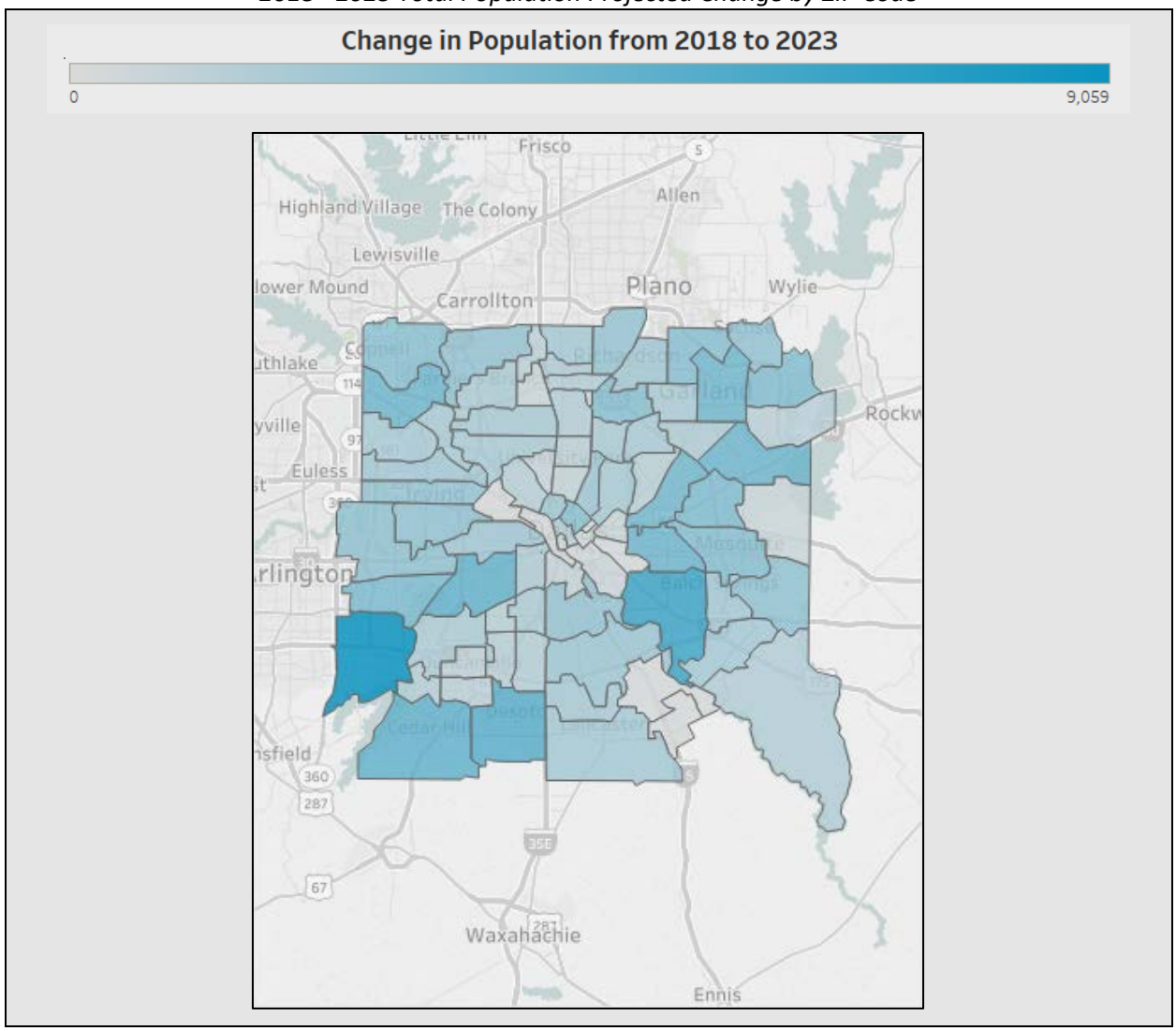
Geography		Benchmarks		Community Served
		United States	Texas	
Total Current Population		326,533,070	28,531,631	2,685,226
5 Yr Projected Population Change		3.5%	7.1%	6.6%
Median Age		42.0	38.9	34.7
Population 0-17		22.6%	25.9%	26.5%
Population 65+		15.9%	12.6%	10.7%
Women Age 15-44		19.6%	20.6%	21.6%
Non-White Population		30.0%	32.2%	49.4%
Hispanic Population		18.2%	39.4%	39.7%
Insurance Coverage	Uninsured	9.4%	19.0%	19.6%
	Medicaid	19.0%	13.4%	15.6%
	Private Market	9.6%	9.9%	9.4%
	Medicare	16.1%	12.5%	11.4%
	Employer	45.9%	45.3%	43.9%
Median HH Income		$61,372	$60,397	$62,126
Limited English		26.2%	39.9%	46.8%
No High School Diploma		7.4%	8.7%	10.5%
Unemployed		6.8%	5.9%	5.8%

Source: IBM Watson Health / Claritas, 2018; US Census Bureau 2017 (U.S. Median Income)

The population of the community served is expected to grow 6.6% by 2023, an increase of more than 178,000 people. The 6.6% projected population growth is slightly less than the state's 5-year projected growth rate (7.1%) but higher when compared to the national projected growth rate (3.5%). The ZIP codes expected to experience the most growth in five years are:

- 75052 Grand Prairie – 9,059 people
- 75217 Dallas – 6,525 people
- 75115 Desoto – 5,299 people

2018 - 2023 Total Population Projected Change by ZIP Code

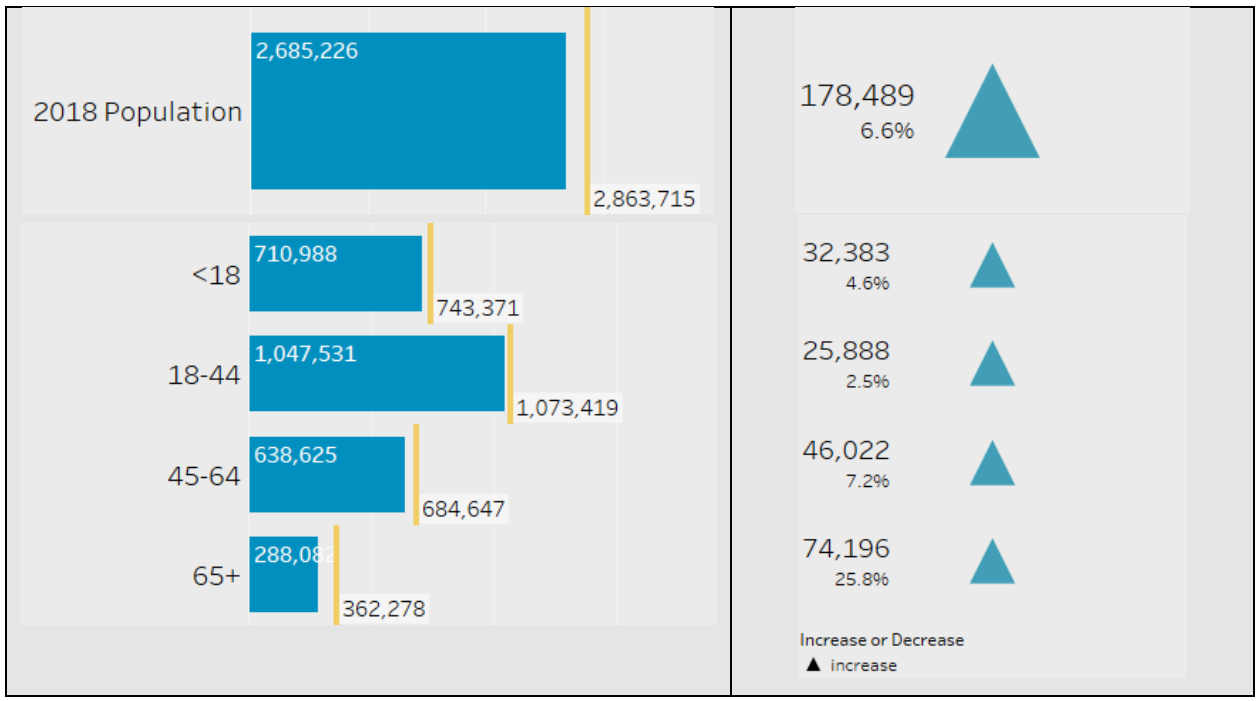


Source: IBM Watson Health / Claritas, 2018

The community's population skewed younger with 39% of the population ages 18-44 and 26.5% under age 18. The largest cohort (18-44) is expected to grow by 25,888 people by 2023. The age 65 plus cohort was the smallest but is expected to experience the fastest growth (25.8%) over the next five years, adding 74,196 seniors to the community. Growth in the senior population will likely contribute to increased utilization of services as the population continues to age.

Population Distribution by Age

2018 Population by Age Cohort *Change by 2023*

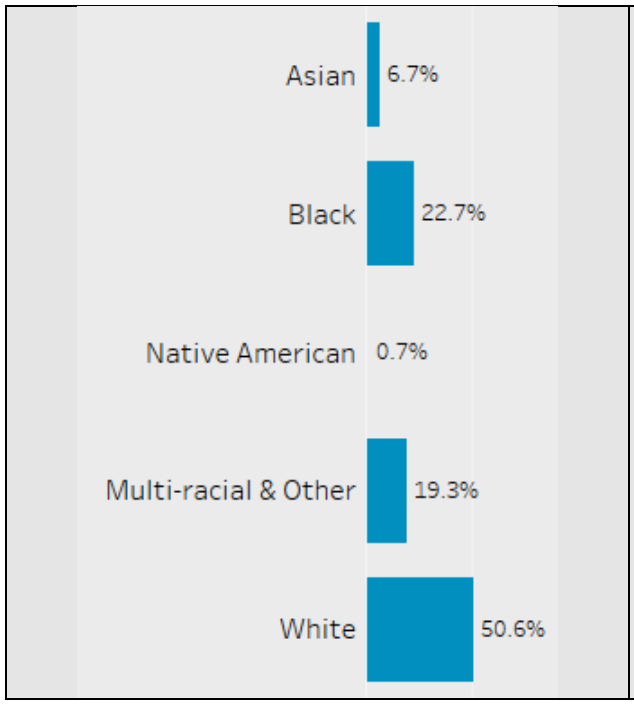


Source: IBM Watson Health / Claritas, 2018

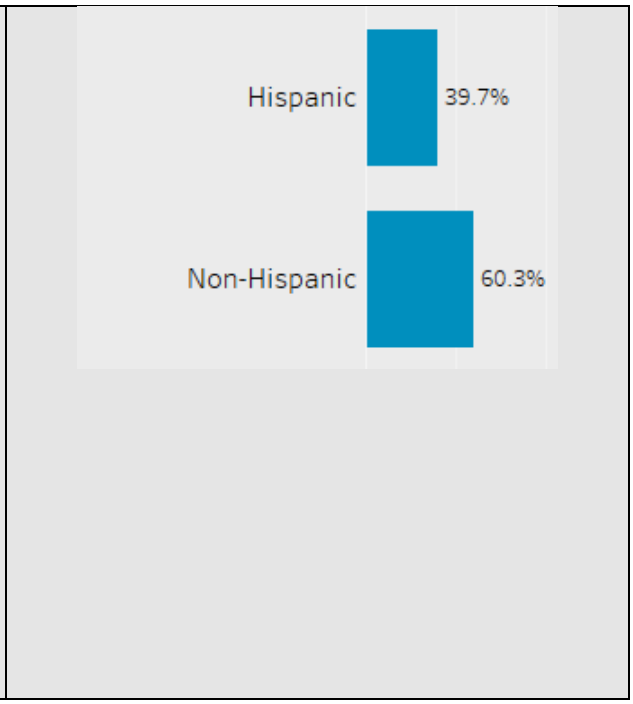
Population statistics are analyzed by race and by Hispanic ethnicity. The largest groups in the community were White Non-Hispanic (29.4%), Black Non-Hispanic (22.3%), and White Hispanic (21.2%). The expected growth rate of the Hispanic population (all races) is almost 106,000 people (9.9%) by 2023, while the non-Hispanic population (all races) is expected to grow by 72,563 people (4.5%) by 2023. The highest growth rate is projected for Asian/Pacific Islanders, but they are currently less than 7% of the population.

Population Distribution by Race and Ethnicity

2018 Population by Race

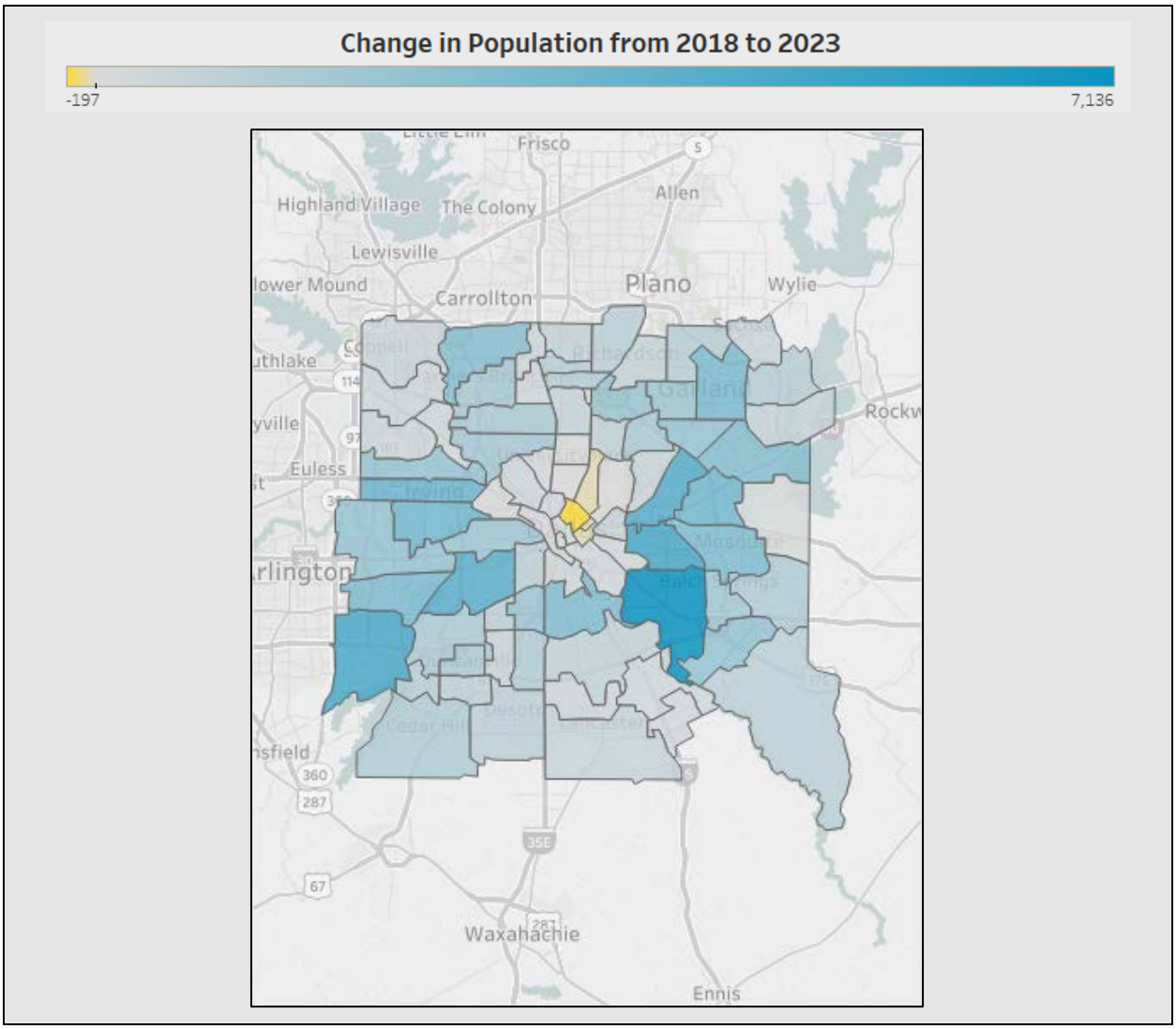


2018 Population by Ethnicity



Source: IBM Watson Health / Claritas, 2018

2018 - 2023 Hispanic Population Projected Change by ZIP Code

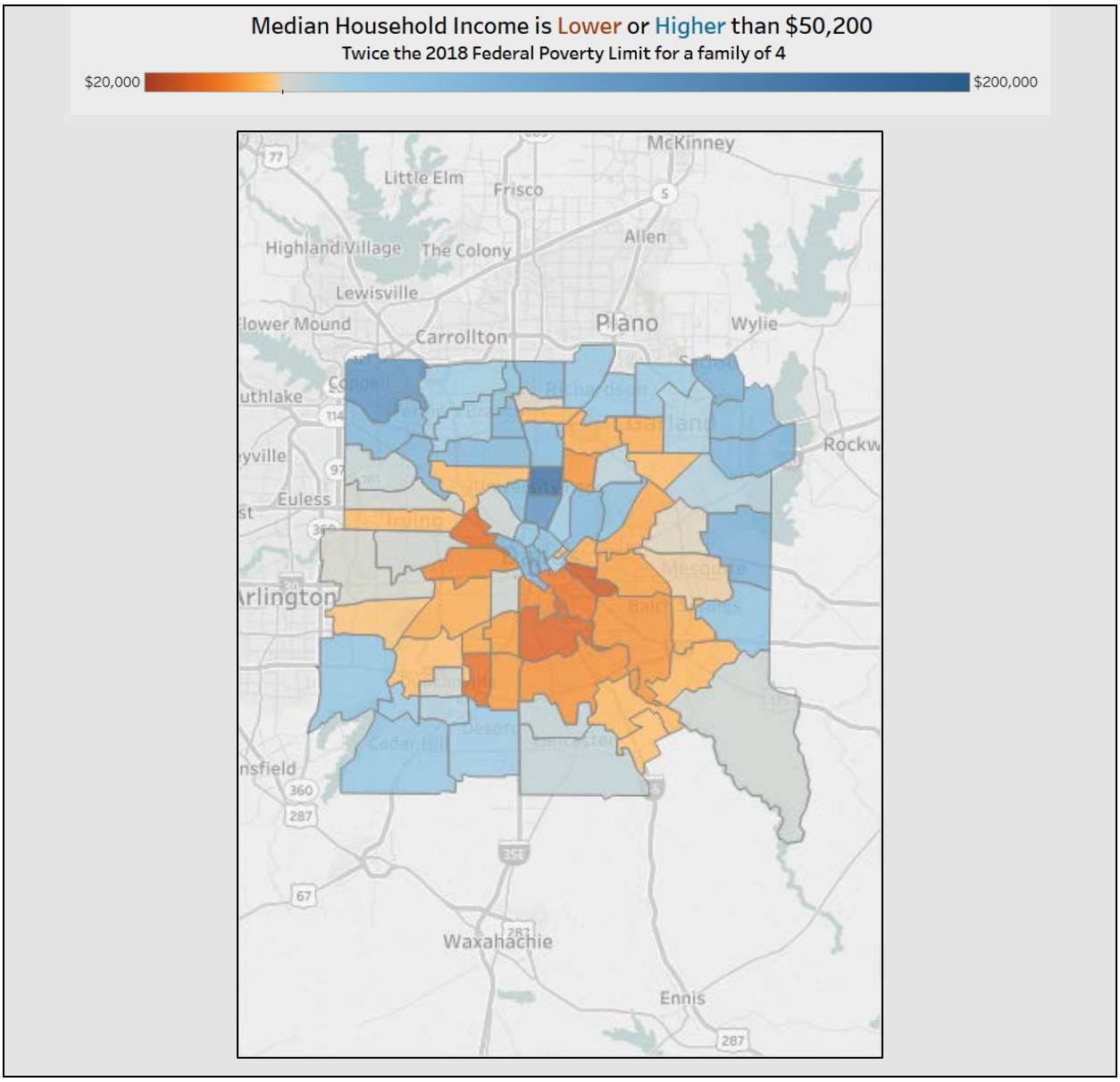


Source: IBM Watson Health / Claritas, 2018

The 2018 median household income for the United States was $61,372 and $60,397 for the state of Texas. The median household income for the ZIP codes within this community ranged from $21,940 for 75210 - Dallas to $169,738 for 75225 - Dallas. There were thirty-three (33) ZIP Codes with median household incomes less than $50,200, twice the 2018 Federal Poverty Limit for a family of four:

- 75254 Dallas - $49,817
- 75150 Mesquite - $49,678
- 75149 Mesquite - $48,436
- 75051 Grand Prairie - $46,798
- 75236 Dallas - $45,849
- 75172 Wilmer - $45,833
- 75220 Dallas - $45,016
- 75061 Irving - $44,965
- 75041 Garland - $44,881
- 75246 Dallas - $43,992
- 75141 Hutchins - $43,968
- 75253 Dallas - $43,956
- 75240 Dallas - $43,473
- 75180 Balch Springs - $43,055
- 75243 Dallas - $42,441
- 75042 Garland - $42,226
- 75211 Dallas - $42,165
- 75223 Dallas - $41,798
- 75228 Dallas - $41,081
- 75233 Dallas - $40,741
- 75227 Dallas - $39,505
- 75224 Dallas - $39,096
- 75232 Dallas - $38,650
- 75231 Dallas - $37,253
- 75217 Dallas - $36,886
- 75241 Dallas - $36,316
- 75203 Dallas - $35,177
- 75212 Dallas - $34,787
- 75215 Dallas - $31,213
- 75237 Dallas - $29,606
- 75247 Dallas - $28,750
- 75216 Dallas - $26,240
- 75210 Dallas - $21,940

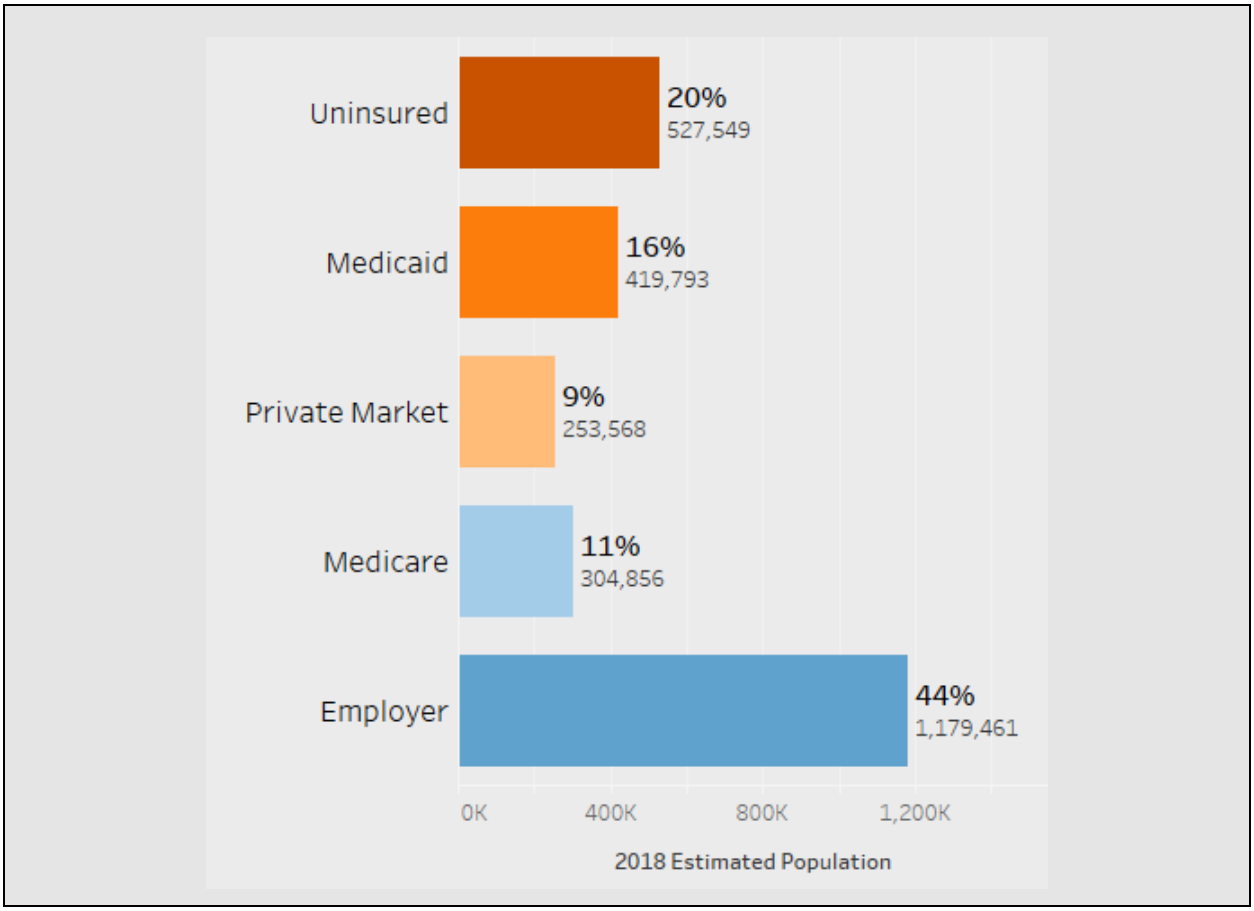
2018 Median Household Income by ZIP Code



Source: IBM Watson Health / Claritas, 2018

The largest segment of population (44%) was insured through employer sponsored health coverage. Twenty percent (20%) of the population did not have health insurance, and 16% was covered by Medicaid. The remainder of the population was Medicare (11%) and private market (the purchasers of coverage directly or through the health insurance marketplace).

2018 Estimated Distribution of Covered Lives by Insurance Category



Source: IBM Watson Health / Claritas, 2018

The community includes 26 Health Professional Shortage Areas and 19 Medically Underserved Areas as designated by the U.S. Department of Health and Human Services Health Resources Services Administration. Appendix C of the CHNA full Report includes the details on each of these designations which can be found at www.methodisthealthsystem.org/about/communityinvolvement.

Health Professional Shortage Areas and Medically Underserved Areas and Populations

	Health Professional Shortage Areas (HPSA)				Medically Underserved Area/Population (MUA/P)
Methodist Charlton MC Methodist Dallas MC Methodist Rehabilitation Hospital	**Dental Health**	**Mental Health**	**Primary Care**	**Grand Total**	**MUA/P**
Dallas	8	8	10	26	19
Total	**8**	**8**	**10**	**26**	**19**

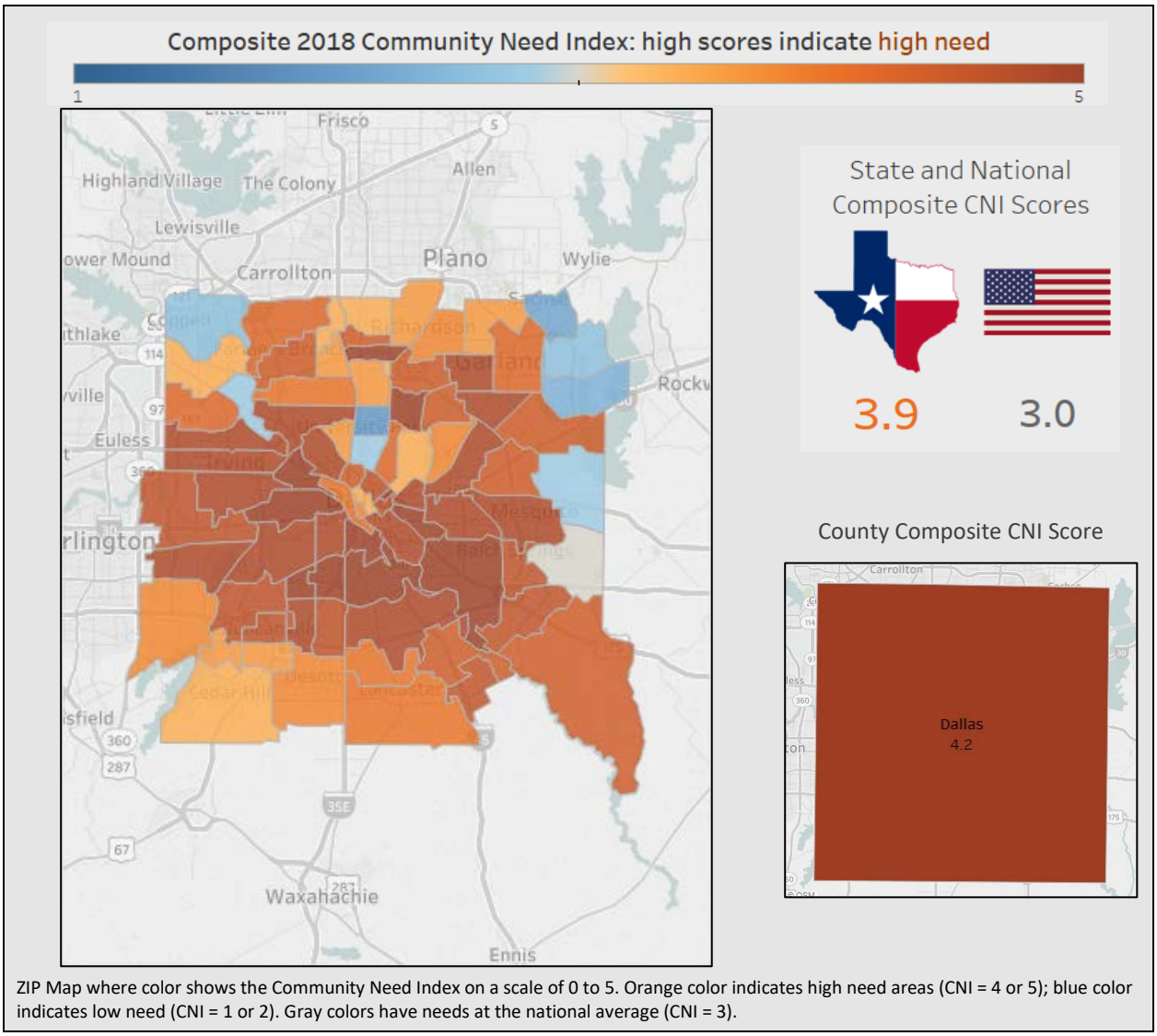
Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, https://data.hrsa.gov/tools/shortage-area

The Watson Health Community Need Index (CNI) is a statistical approach to identifying areas within a community where health disparities may exist. The CNI takes into account vital socio-economic factors (income, cultural, education, insurance and housing) about a community to generate a CNI score for every populated ZIP code in the United States. The CNI strongly links to variations in community healthcare needs and is an indicator of a community's demand for various healthcare services. The CNI score by ZIP code identifies specific areas within a community where healthcare needs may be greater.

Overall, the CNI score for the community served was 4.2, higher than the CNI national average of 3.0, potentially indicating greater health care needs in this community. The CNI score was 5.0 in the following areas, pointing to potentially more significant health needs among the population:

- 75203 - Dallas
- 75210 - Dallas
- 75212 - Dallas
- 75216 - Dallas
- 75217 - Dallas
- 75224 - Dallas
- 75231 - Dallas
- 75233 - Dallas
- 75240 - Dallas
- 75246 - Dallas
- 75247 - Dallas

2018 Community Need Index by ZIP Code



ZIP Map where color shows the Community Need Index on a scale of 0 to 5. Orange color indicates high need areas (CNI = 4 or 5); blue color indicates low need (CNI = 1 or 2). Gray colors have needs at the national average (CNI = 3).

Source: IBM Watson Health / Claritas, 2018

Public Health Indicators

Public health indicators were collected and analyzed to assess community health needs. Evaluation for the community served used 102 indicators. For each health indicator, a comparison between the most recently available community data and benchmarks for the same/similar indicator was made. The basis of benchmarks was available data for the U.S. and the state of Texas.

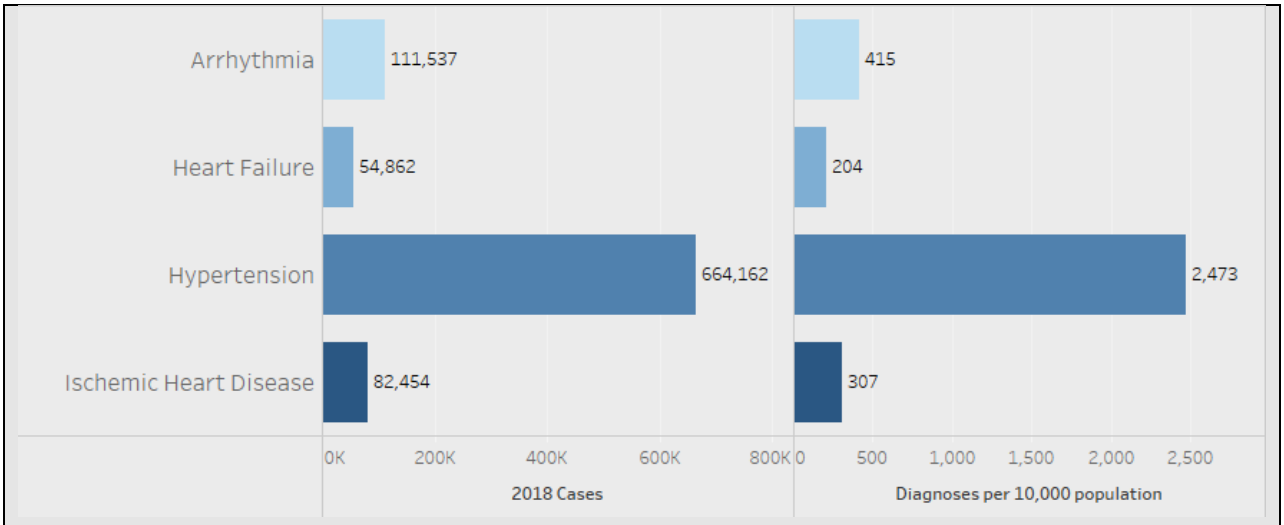
Where the community indicators showed greater need when compared to the state of Texas comparative benchmark, the difference between the community values and the state benchmark was calculated (need differential). These indicators are in Appendix D of the CHNA full Report located at www.methodisthealthsystem.org/about/communityinvolvement. Those highest ranked indicators with need differentials in the 50th percentile of greater severity pinpointed community health needs from a quantitative perspective.

Watson Health Community Data

Watson Health supplemented the publicly available data with estimates of localized disease prevalence of heart disease and cancer as well as emergency department visit estimates.

Watson Health Heart Disease Estimates identified hypertension as the most prevalent heart disease diagnosis; there were over 664,162 estimated cases in the community overall. The 75052 ZIP code of Grand Prairie had the most estimated cases of each heart disease type. The 75225 ZIP code of Dallas had the highest estimated prevalence rates for Arrhythmia (663 cases per 10,000 population), Heart Failure (341 cases per 10,000 population), Hypertension (3,272 cases per 10,000 population), and Ischemic Heart Disease (542 cases per 10,000 population).

2018 Estimated Heart Disease Cases



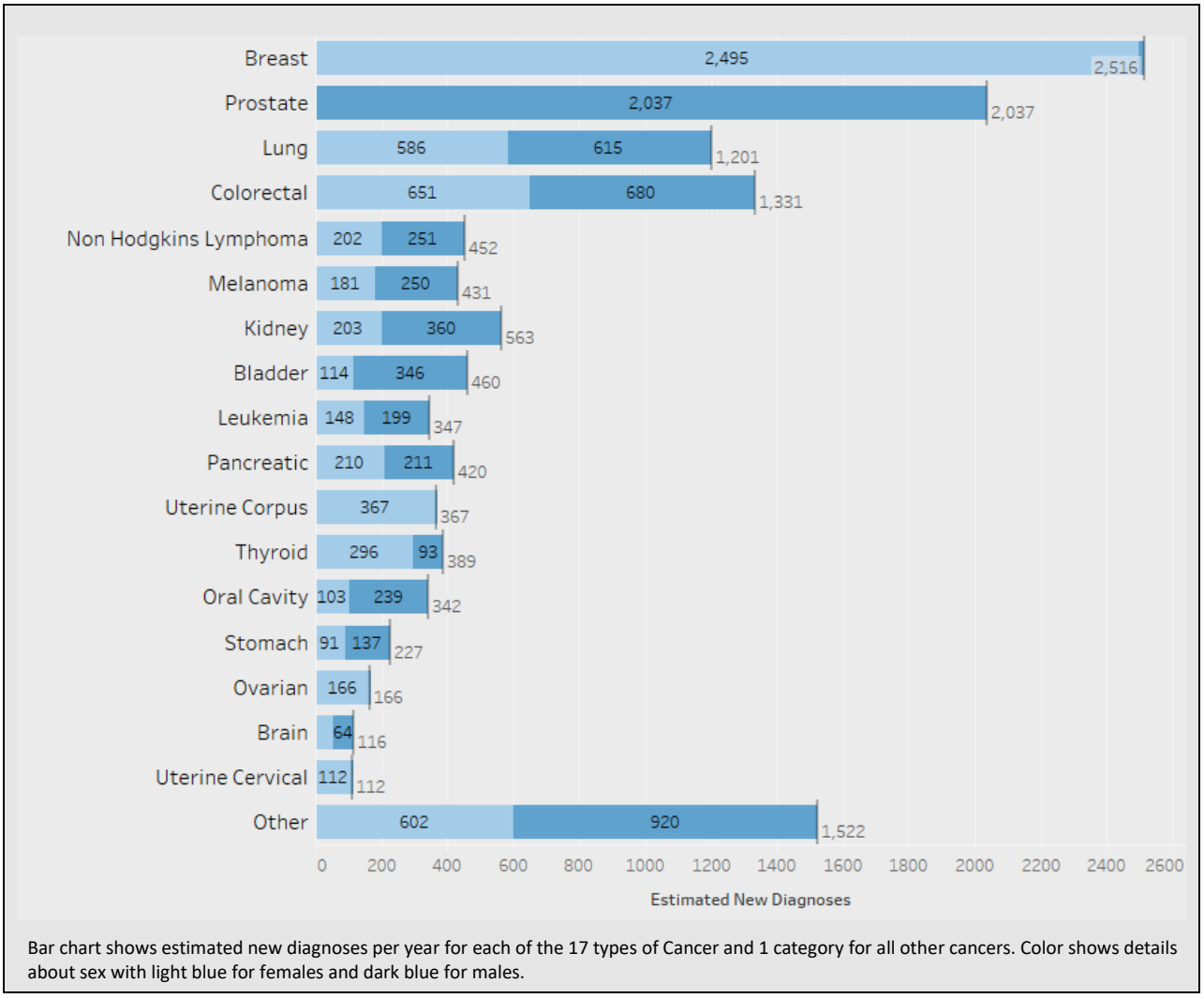
Bar chart shows total number and prevalence rate of 2018 Estimated Heart Disease cases for each of four types: arrhythmia, heart failure, hypertension, and ischemic heart disease

Note: An individual patient may have more than one type of heart disease. Therefore the sum of all four heart disease types is not a unique count of individuals.

Source: IBM Watson Health, 2018

For this community, Watson Health's 2018 Cancer Estimates revealed the cancers projected to have the greatest rate of growth in the next five years were pancreatic, bladder, and kidney; based on both population changes and disease rates. The cancers estimated to have the greatest number of new cases in 2018 were breast, prostate, colorectal, and lung cancers.

2018 Estimated New Cancer Cases



Bar chart shows estimated new diagnoses per year for each of the 17 types of Cancer and 1 category for all other cancers. Color shows details about sex with light blue for females and dark blue for males.

Source: IBM Watson Health, 2018

Estimated Cancer Cases and Projected 5 Year Change by Type

Cancer Type	2018 Estimated New Cases	2023 Estimated New Cases	5 Year Growth (%)
Bladder	460	546	18.8%
Brain	116	128	10.2%
Breast	2,516	2,868	14.0%
Colorectal	1,331	1,396	4.9%
Kidney	563	660	17.3%
Leukemia	347	400	15.1%
Lung	1,201	1,381	15.0%
Melanoma	431	496	15.1%
Non Hodgkins Lymphoma	452	522	15.4%
Oral Cavity	342	396	15.7%
Ovarian	166	185	11.8%
Pancreatic	420	505	20.3%
Prostate	2,037	2,213	8.7%
Stomach	227	263	15.5%
Thyroid	389	451	16.1%
Uterine Cervical	112	117	4.3%
Uterine Corpus	367	427	16.5%
All Other	1,522	1,769	16.2%
Grand Total	**12,998**	**14,723**	**13.3%**

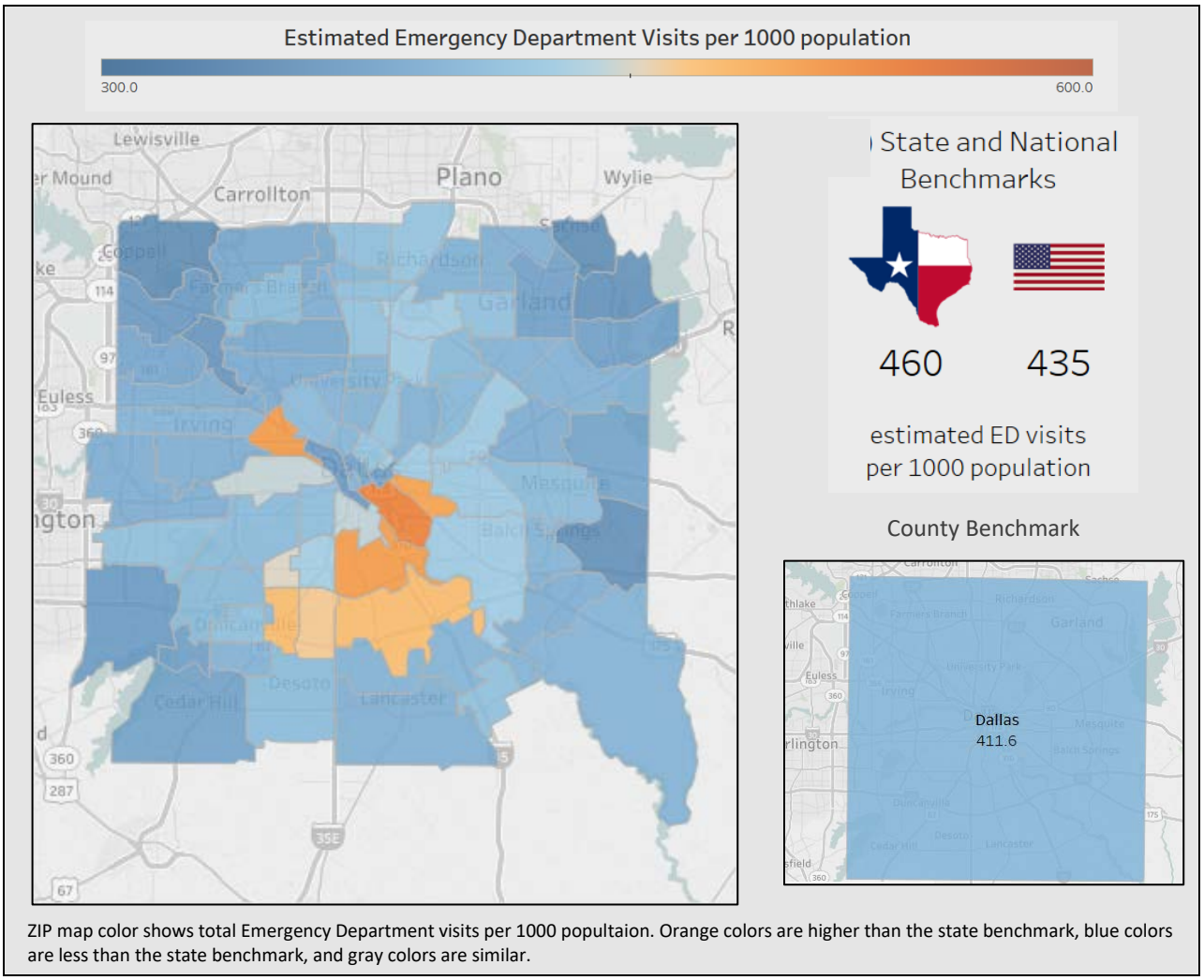
Source: IBM Watson Health, 2018

Based on population characteristics and regional utilization rates, Watson Health projected all emergency department (ED) visits in this community to increase by 7.1% over the next 5 years. The highest estimated ED use rate was in the ZIP code of 72125 -Dallas; 534 ED visits per 1,000 residents compared to the Texas state benchmark of 460 visits and the U.S. benchmark of 435 visits per 1,000.

These ED visits consisted of three main types: those resulting in an inpatient admission, emergent outpatient treated and released ED visits, and non-emergent outpatient ED visits that were lower acuity. Non-emergent ED visits present to the ED but can be treated in more appropriate and less intensive outpatient settings.

Non-emergent outpatient ED visits could be an indication of systematic issues within the community regarding access to primary care, managing chronic conditions, or other access to care issues such as ability to pay. Watson Health estimated non-emergent ED visits to increase by an average of 3.1% over the next five years in this community.

Estimated 2018 Emergency Department Visit Rate

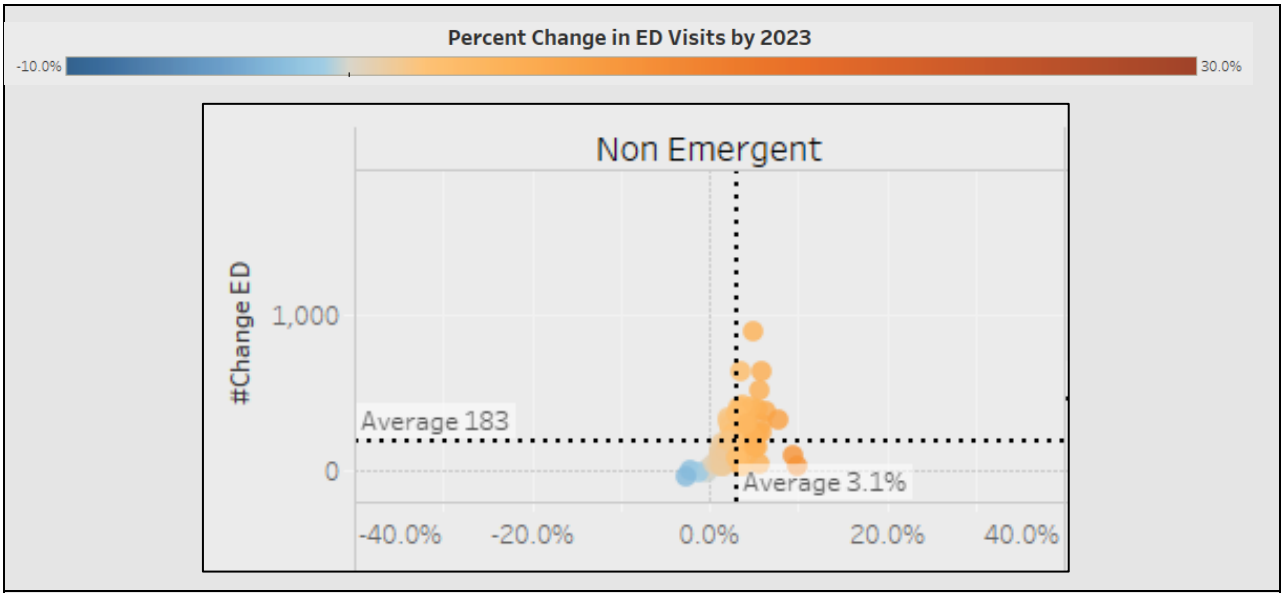


ZIP map color shows total Emergency Department visits per 1000 popultaion. Orange colors are higher than the state benchmark, blue colors are less than the state benchmark, and gray colors are similar.

Note: These are not actual Methodist ED visit rates. These are statistical estimates of ED visits for the population.

Source: IBM Watson Health, 2018

Projected 5 Year Change in Non-Emergent Emergency Department Visits by ZIP Code



This chart show sthe percent change in Emergency Department visits by 2023 at the ZIP level. The average for all ZIPs in the Health Community is labeled. ED visits are defined by the presence of specific CPT® codes in claims. Non-emergency visits to the ED do not necessarily require treatment in a hospital emergency department and can potentially be reated in a fast-track ED, an urgent care treatment center, or a clinical or a physician's private office.

Note: These are not actual Methodist ED visit rates. These are statistical estimates of ED visits for the population.

Source: IBM Watson Health, 2018

Community Input

A summary of the focus groups and interviews conducted for the Methodist Charlton, Methodist Dallas, and Methodist Rehabilitation community can be found on pages 32 and 33 of the CHNA full Report located at wwww.methodisthealthsystem.org/about/communityinvolvement.

Facility Summary

This table is provided to help the reader easily identify which portion of the joint implementation strategy relate to each facility.

Facility	Hypertension	Stroke	Diabetes	HIV
Methodist Charlton Medical Center	✓	✓	✓	
Methodist Dallas Medical Center	✓	✓	✓	✓
Methodist Rehabilitation Hospital		✓		

Methodist Charlton Medical Center CHNA Implementation Strategy

HYPERTENSION / DIABETES / STROKE

Goal: Increase awareness of Hypertension, Diabetes, and Stroke risk factors and prevention by providing added treatment services and educational opportunities

Strategy 1: Leverage existing services and offer enhanced educational and treatment programs and services

Program/Activity	Description	Anticipated Impact	Target Audience	How Results will be Measured	Resources	Partners
Enhance education through retail pharmacy	Diabetes education - medication therapy management, are they following the guidelines; understanding the follow up blood pressure screenings;	Increased awareness	Community	Number of people reached	Pharmacist; education materials	
Enhance support groups with expanded topics and membership	Continue to provide support and education for the community with heart disease and/or diabetes	Increased awareness about heart disease and/or diabetes- Increased reach thru monthly postal and email list reminders	People with heart disease and/or diabetes and their families	Combined to one support group offered each month reaching 60 - 75 people each month	Nursing Administration support since 2014	Hale Law Group, Steven Knight, PharmD-MCMC, Dr. Tim Issac, Bethany Vaunghn, LD-MCMC
Establish an IV infusion program	Prevents unnecessary hospital admissions for intravenous infusion of heart failure related medications	Reduced hospital admissions for IV infusion; Enhanced quality of life for the patient	Heart failure patients	IV infusion program established; Number of patients	Staff and funding to develop implementation plan and implement the program	
Continue to grow Cardiomems program	Program prevents Heart Failure related readmission by proactively monitoring patient's hemodynamic status and adjusting medications as needed	Reduced readmissions; Enhanced quality of life for the patient	Heart failure patients	Number of patients monitored	Staff for oversight and growth of program	
Collaborate with the Best Southwest Partnership to provide enhanced educational opportunities and screening options	Work to make self-blood pressure check resources more available (low-cost home blood pressure machines through food pantries and other providers)	Increased access to blood pressure check resources; Increased awareness	Community	Number of people reached; Number of self-blood pressure check resources	Funding to execute communication and implementation plan	Best Southwest Partnership

HYPERTENSION / DIABETES / STROKE (CONT'D)

Goal: Increase awareness of Hypertension, Diabetes, and Stroke risk factors and prevention by providing added treatment services and educational opportunities

Strategy 1: Leverage existing services and offer enhanced educational and treatment programs and services

Program/Activity	Description	Anticipated Impact	Target Audience	How Results will be Measured	Resources	Partners
Collaborate with the Best Southwest Partnership to provide information regarding stroke warning signs	Publicize stroke warning signs at worksites, home health providers / assisted living sites, places where seniors congregate	Increased awareness of stroke warning signs	Community (seniors)	Number of sites with publicized information; Number of people reached	Staff and leadership to participate in Best Southwest program	Best Southwest Partnership
Collaborate with the Best Southwest Partnership to sponsor and promote community fitness programs	Sponsor and promote community fitness programs (programs at nursing homes and senior living centers, tai chi classes for balance and strength, examine walkability/bike-ability, etc.	Increase awareness	Community	Number of fitness programs sponsored and promoted; Number of people reached	Staff and leadership to participate in Best Southwest program	Best Southwest Partnership
Collaborate with the Best Southwest Partnership to address costs for diabetes control and testing supplies	Poll pharmacies for low-cost alternatives and promote these to physicians	Increased access to low-cost alternatives for diabetes control and testing supplies	Pharmacies, physicians and community	Number of low-cost alternatives identified; Number of physicians; Number of people reached	Staff and leadership to participate in Best Southwest program	Best Southwest Partnership
Collaborate with the Best Southwest Partnership to promote diabetes self-management classes	Promote diabetes self-management classes (available through Parkland, Methodist Health System, Area Agency on Aging, Dallas Concilio) to local physicians, support groups and at fitness program sites	Increased awareness of support services in community	Community	Number of people reached Number of participants in diabetes self-management classes	Staff and leadership to participate in Best Southwest program	Best Southwest Partnership
Provide ongoing lunch-n-learn events	Monthly Lunch n learn events for employees of the city of Duncanville and Desoto	Increase awareness	Community	Number of people reached	Physicians; Clinician speakers	City of Duncanville City of Desoto

HYPERTENSION / DIABETES / STROKE (CONT'D)

Goal: Increase awareness of Hypertension, Diabetes, and Stroke risk factors and prevention by providing added treatment services and educational opportunities

Strategy 1: Leverage existing services and offer enhanced educational and treatment programs and services

Program/Activity	Description	Anticipated Impact	Target Audience	How Results will be Measured	Resources	Partners
Launch new standing section of the ongoing SHINE newsletter dedicated to these topics	Publish information regarding hypertension, stroke and diabetes in new standing section of SHINE newsletter for 2 issues each year	Increase awareness	Community	New standing section published Number of people reached	Public relations / writing staff to produce content	
Increase reach of education opportunities through use of social mediums such as social platforms, website, video education and email publications	Publish stories and content relative to hypertension, stroke and diabetes 3x per week online (such as Facebook, Twitter, YouTube channel); offer physician videos around health conditions	Increased educational reach Increased awareness	Community	Number of additional mediums used; Number of educational pieces published; Number of people reached	Public relations / writing staff to produce content	
Monthly Heart Health and Diabetes workshops	Monthly workshops to provide ongoing education about heart health and diabetes management	Increased awareness	Community	Number of events; Number of people reached	Staff and funding to produce events, education materials and content	
Produce Heart to Heart community event	Annual event that provides education about prevention and treatment of cardiovascular disease, healthy diet, exercise and genetics	Increased awareness	Community	Number of people reached	Staff and funding to produce events, education materials and content; speakers	

Methodist Dallas Medical Center CHNA Implementation Strategy

HYPERTENSION / DIABETES

Goal: Increase awareness of Hypertension and Diabetes, risk factors and prevention by providing added treatment services and educational opportunities

Strategy 1: Leverage existing services and offer expanded educational and treatment programs and services

Program/Activity	Description	Anticipated Impact	Target Audience	How Results will be Measured	Resources	Partners
Offer support groups	Monthly meetings to provide a place for people with diabetes to connect and discuss challenges; guest physician speakers	Increased awareness / support to patients and their families	Patients / Community	Number of support groups Number of people reached	Funding to produce the meetings and provide education materials; IP diabetes educator; nurse practitioners; physicians	
Offer healthy cooking classes / demos with health fair or at local recreation centers	Ongoing healthy cooking classes at local rec center; cooking demo at annual community health festival	Increased awareness	Community	Number of classes/demos Number of people reached	Funding for food and time for the nutritionist or cook to come to the Rec Center to teach the class; Printed materials to advertise the event	Hospital clinical nutrition department; Local Rec Center
Collaborate with population subgroups from different neighborhoods in surrounding Oak Cliff and West Dallas community to host health pop-up events	Collaborate with local neighborhood associations to offer health-focused pop-ups; such as healthy cookout and sack race or similar activity, provide education materials about blood pressure risk and prevention and diabetes	Increased awareness	Community	Number of events Number of people reached	Funding for food, activities at the event, promo items and printed educational materials; Hospital volunteer staff	Community neighborhood associations
Expand existing programs/screenings by the Methodist Faith Community Nursing program to additional churches in the community	Working with Faith Community Nursing, determine feasibility, potential new churches and/or businesses to reach; develop expansion plan and execute expansion plan	Increased awareness	Churches and businesses in community	Number of events offered Number of people reached	Faith Community Nursing Funding to execute the expansion plan	Faith Community Nursing teams

HYPERTENSION / DIABETES (CONT'D)

Goal: Increase awareness of Hypertension and Diabetes, risk factors and prevention by providing added treatment services and educational opportunities

Strategy 1: Leverage existing services and offer expanded educational and treatment programs and services

Program/Activity	Description	Anticipated Impact	Target Audience	How Results will be Measured	Resources	Partners
Include education on diabetes and hypertension in discharge instructions	Capitalize on opportunity to distribute educational info to all patients discharged from the hospital; materials would educate about symptoms and prevention	Increased awareness	Patients	Number of people reached	Funding for printing materials	Nursing leadership
Add hypertension screenings to mobile mammography unit	Add blood pressure screenings to mobile mammography unit services	Increased early detection Increased awareness	Community	Number of screenings Number of cases detected Number of people reached	Nurse or nurse practitioner time on the mobile mammography unit	Women's imaging team

STROKE

Goal: Increase awareness of stroke prevention and treatment by providing added treatment services and educational opportunities

Strategy 1: Leverage existing services and offer expanded educational and treatment programs and services

Program/Activity	Description	Anticipated Impact	Target Audience	How Results will be Measured	Resources	Partners
Promote F.A.S.T (education) in Methodist Family Health Centers	Education about the signs of stroke is crucial due to the importance of time to treatment; Primary care clinics are places that patients visit often, more than a hospital; that's why having posters and/or banners on F.A.S.T method at FHCs would be helpful.	Increased awareness	Patients/ community	Number of people reached	Funding for the banners/posters. The stroke team might be able to contribute to this	MDMC Stroke Coordinator Michelle Steiner
Offer support group for families of stroke victims	A support group led by a hospital stroke coordinator would enable patients and family to receive education, advice on how to deal with depression and the recovery process. A monthly support group, that also includes guest speakers, would be ideal	Increased awareness	Patients / Community	Support group established Number of people reached	Funding for stroke-conscious food to be served at the meeting; Printing of education materials	MDMC Stroke Coordinator Michelle Steiner

HIV

Goal: Increase awareness of HIV - Infectious disease prevention and treatment by providing added treatment, testing services and educational opportunities

Strategy 1: Leverage existing services and offer expanded educational and treatment programs and services

Program/Activity	Description	Anticipated Impact	Target Audience	How Results will be Measured	Resources	Partners
Add an HIV physician specialist to the medical staff and a clinic that focuses on serving HIV patients.	Add HIV certified physician specialist to Infectious Disease department to ultimately support a community clinic focused on seeing HIV patients	Increased awareness Increased screenings and early detection	Community	Number of people tested Number of people reached	Funding to bring a doctor on-board through MMG	Infectious Disease department at MDMC; Methodist community pharmacy
Promote testing via PCPs at Methodist FHCs during annual physicals	Work with PCPs to communicate the importance of HIV testing	Increased awareness and detection	Community	Number of people reached	MMG family health center physicians; communication plan for MMG physicians	PCPs at Methodist FHCs
Support advocacy groups that support HIV patients	A number of HIV advocacy groups in Dallas and more locally in Oak Cliff organize events and programming year round, but especially during World AIDS day. MDMC would support these with sponsorships and engage people at events by brining team members from ID and pharmacy	Increase awareness	Community	Number of people reached	Funding for event sponsorships	Infectious Disease department at MDMC; Methodist community pharmacy

Methodist Rehabilitation Hospital CHNA Implementation Strategy

STROKE

Goal: Increase awareness of Stroke risk factors and prevention by providing educational and support opportunities

Strategy 1: Continue and enhance existing Stroke Rehab programs and support services

Program/Activity	Description	Anticipated Impact	Target Audience	How Results will be Measured	Resources	Partners
Provider education about rehab services	Provide education about rehab services to appropriate entities throughout Methodist Health System including annual education to nurse navigators in the ACO nurse navigator program	Increased awareness of services; Enhanced use of services through system referrals to programs and services	Internal resources that interact with Stroke patients who need rehab services and support	Number of entities and frequency reached with education	Stroke coordinators; education materials and educators	
Stroke support group	Provide monthly stroke support group and community awareness	Increased awareness	Stroke patient, family members and caregivers	Number of people reached	Support group coordinator; speakers, and education materials	
Patient education	Provide stroke class 3 days per week for patients and family members prior to discharge (includes education on diet, exercise, medication compliance, connected with appropriate resources for follow up, etc.	Increase awareness; Reduced readmissions; Increase community re-entry	Stroke rehab patients	Number of people reached; Percent of all patient population discharged to home	Patient educator, education materials	