Methodist
HEALTH SYSTEM

COMMUNITY HEALTH NEEDS ASSESSMENT

DALLAS COUNTY HEALTH COMMUNITY

METHODIST CHARLTON MEDICAL CENTER
METHODIST DALLAS MEDICAL CENTER
METHODIST REHABILITATION HOSPITAL

Approved by: Methodist Health System Board of Directors on July 12, 2022
Approved by: Methodist Rehabilitation Hospital Board of Directors on August 7, 2022
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COMPASSIONATE HEALTHCARE IN NORTH TEXAS

The Methodist ministers and civic leaders who opened their doors in 1927 could not have imagined where Methodist Health System would be today. From humble beginnings, their renowned health system has become one of the leading healthcare providers in North Texas, with several locations across the region.

But all of their growth, advancements, accreditation, awards, and accomplishments have been earned under the guidance of their founding principles: life, learning, and compassion. They are still growing, learning, and improving — grounded in a proud past and looking ahead to an even brighter future.

MISSION, VISION, AND VALUES OF METHODIST HEALTH SYSTEM

MISSION

To improve and save lives through compassionate quality healthcare.

VISION

To be the trusted choice for health and wellness.

CORE VALUES

Methodist Health System core values reflect our historic commitment to Christian concepts of life and learning:

- **Servant Heart** – compassionately putting others first

- **Hospitality** – offering a welcoming and caring environment

- **Innovation** – courageous creativity and commitment to quality

- **Noble** – unwavering honesty and integrity

- **Enthusiasm** – celebration of individual and team accomplishment

- **Skillful** – dedicated to learning and excellence

Where compassion is our compass. Where hearts and minds operate as one. Where a glass half empty is filled with hope. Where healing is believing.

Whatever the medical need, Methodist Health System is honored that patients entrust them with their health and safety. They understand that Methodist has a solemn responsibility to each patient and patient families, and they can trust that the Methodist team takes that commitment very seriously.

Methodist Health System further illustrates this commitment through periodic community health needs assessments which include plans on addressing those needs with a wide range of outreach initiatives. These Community Heath Needs Assessment (CHNA) activities also satisfy federal requirements outlined in the Patient Protection and Affordable Care Act.

Methodist Health conducts periodic reviews of public health indicators and benchmark analyses comparing communities it serves to an overall state of Texas value. In this way, it can determine where deficiencies lie and the opportunities for improvement are greatest.

Through interviews, focus groups and surveys, Methodist gains a clearer understanding of the community needs from the perspective of the members of each community. This helps it identify the most pressing needs a community is facing and develop Implementation Plans to focus on those prioritized needs.

The process includes input from a wide range of knowledgeable people who represent the myriad interests of the community in compliance with 501(r)(3) regulations. The CHNA process overview can be found in **Appendix A.**

The CHNA serves as the foundation for community health improvement planning efforts over the next three years, while the implementation plans will be evaluated annually.

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) REPORT

Methodist owns and operates multiple individually licensed hospital facilities serving the residents of North Texas. This assessment applies to the following Methodist hospital facilities:

- **Methodist Charlton Medical Center**

- **Methodist Dallas Medical Center**

- **Methodist Rehabilitation Hospital**

The community served is Dallas County. The community includes the geographic area where more than 60 percent of the admitted patients live according to the hospital facilities' in-patient admissions over the 12-month period of 2019Q2-2020Q1. Those facilities with overlapping counties of patient origin collaborated to provide a joint CHNA report in accordance with the U.S. Treasury regulations and 501(r)(3) of the Internal Revenue Code. All of the collaborating hospital facilities included in a joint CHNA report define their communities to be the same for the purposes of the CHNA report.

Dallas County Health Community Map
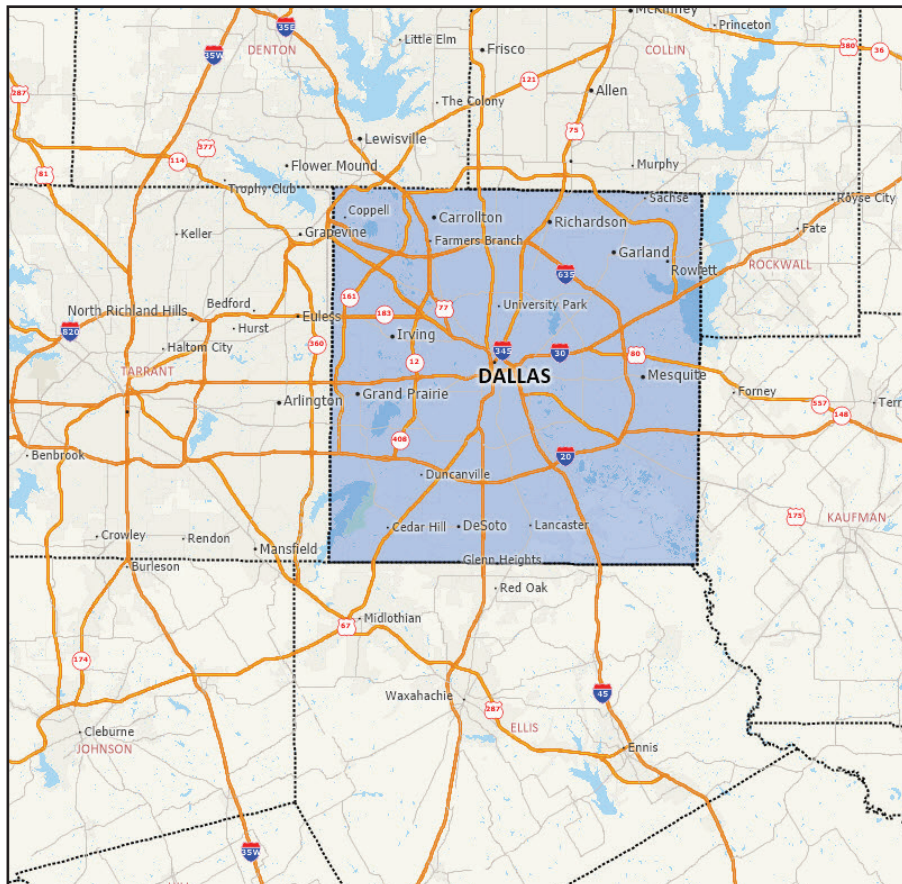
Methodist engaged with IBM Watson Health, a nationally respected consulting firm, to conduct a Community Health Needs Assessment (CHNA) in accordance with the requirements of the Patient Protection and Affordable Care Act (PPACA) for the health communities they serve.

THE CHNA PROCESS INCLUDED:

Define the Community	*Assess the Community*	*Identify and Prioritize "Significant Needs"*

1. Gathering and analyzing 59 public and 45 proprietary health data indicators to provide a comprehensive assessment of the health status of the communities. The complete list of health data indicators is included in **Appendix B**.

2. Creating a benchmark analysis comparing the communities to overall state of Texas and United States (US) values.

3. Conducting focus groups, key informant interviews and stakeholder surveys, including input from public health experts, to gain direct input from the community for a qualitative analysis.

   • Gathering input from state, local and/or regional public health department members who have the pulse of the community's health.

   • Identifying and considering input from individuals or organizations serving and/or representing the interests of medically underserved low-income and minority populations in the community to help prioritize the community's health needs.

   • The represented organizations that participated are included in **Appendix C**.

IBM Watson Health provided current and forecasted demographic, socioeconomic, and utilization estimates for each of the communities.

Demographic and Socioeconomic Summary

The most important demographic and socioeconomic findings for the Dallas County Health Community CHNA are:

1 The community is growing faster than the U.S. but slightly slower than the State of Texas.

2 The median age of the population is younger than the U.S. and the state of Texas.

3 The median household income is higher than both the State and the U.S.

4 The community served has a lower percentage of uninsured than Texas but a higher percentage of Medicaid.

Further demographic and socioeconomic information for the Dallas County Health Community is included in **Appendix D**.

Health Community Data Summary

IBM Watson Health's utilization estimates and forecasts indicate the following for the Dallas County Health Community:

1 Inpatient discharges in the community are expected to grow by 7.2% by 2030 with the largest growing product lines to include:

- Pulmonary Medical
- General Medicine
- Cardiovascular Diseases

2 Outpatient procedures are expected to increase by 32.8% by 2030 with the largest areas of growth including:

- Labs
- General & Internal Medicine
- Physical & Occupational Therapy
- Psychiatry

3 Emergency Department visits are expected to grow by 12.6% by 2025.

4 Hypertension represents 73.5% of all heart disease cases.

5 Cancer incidence is expected to increase by 10.5% by 2025.

Further health community information for the Dallas County Health Community is included in **Appendix E**.

Priority Health Needs

Using these and other data collection and interpretation methods, Methodist Health System identified what it considers to be the community's key health needs. The resulting prioritized health needs for this community include:

Priority	Need	Category of Need
1	Chronic Conditions Management	Conditions/Diseases
2	Lack of Healthy Food Options	Environment
3	Gap in Behavioral Health/Substance Abuse	Health Behaviors
4	Prenatal Care Issues	Maternal & Child Health
5	Escalating Health Needs of Aging Community	Utilization
6	Cancer Incidence	Conditions/Diseases
7	Many Non-English Speakers	Population

PRIORITY 1: CHRONIC CONDITIONS MANAGEMENT

The following data indicates greater need for chronic illness management in terms of diabetes, stroke and hyperlipidemia.

Category	Data Shows Greater Need	Key Informants Indicate Less Need or Not Mentioned
Conditions/ Diseases	• *Diabetes Admission* • *Medicare Population: Hyperlipidemia* • *Medicare Population: Stroke*	• *Not specifically mentioned*

Conditions/Diseases: Diabetes Admission
(Number Diabetes Patients Observed/Adult Population Age 18+ by County)

The indicator of diabetes admission is defined as the number of diabetes admissions observed divided by the adult population (age 18 and older) and is based on data from Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations.

Dallas County has 42.35 diabetes patients per 100,000 adult individuals which is 7.2% higher than the state benchmark of 39.50. This indicates a slightly greater need than the state and a slightly larger vulnerable population.

This indicator ranked as the twenty-third indicator (23rd) among all 59 public indicators within Dallas County which indicates greater need and a larger vulnerable population.County which indicates higher need and a larger vulnerable population.

COUNTY INDICATOR VALUES

42.35

◇◇◇◇ STATE BENCHMARK   ▬▬ US BENCHMARK

RANK WITHIN COUNTY

5   10   15   20   **23**   30   35   40

HIGHER NEED _____ STATE BENCHMARK _____ LOWER NEED
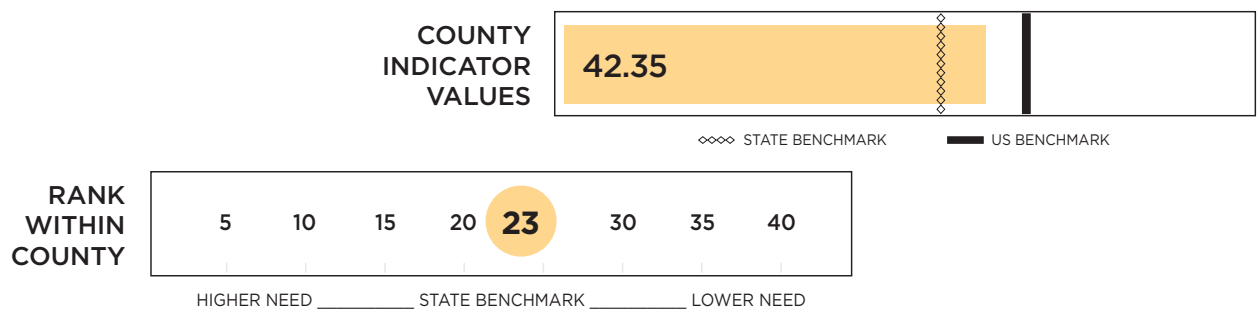
Conditions/Diseases: Medicare Population: Hyperlipidemia
(Prevalence of Hyperlipidemia Over All Medicare Beneficiaries by County)

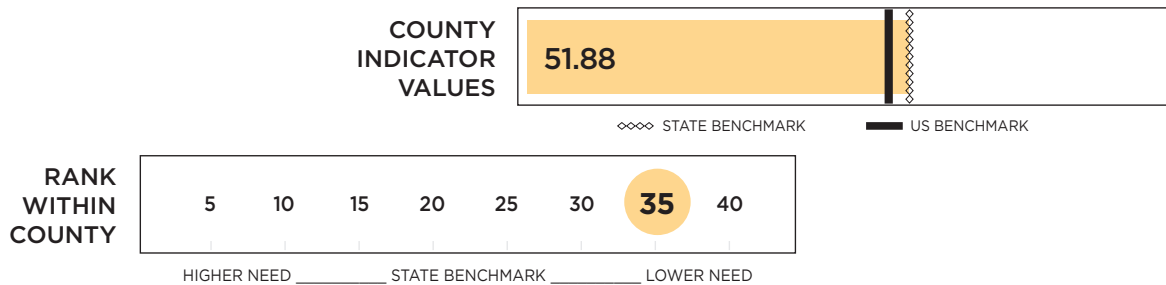Dallas County has a 51.88% prevalence rate among total Medicare beneficiaries which is 0.2% higher than the state benchmark of 51.80%. This indicates a greater need than the state and a larger vulnerable population.

This indicator ranked thirty-fifth (35th) among all 59 public indicators within Dallas County, which indicates a greater need and a larger vulnerable population.

COUNTY INDICATOR VALUES	51.88

◇◇◇◇ STATE BENCHMARK   ▬ US BENCHMARK

RANK WITHIN COUNTY

5   10   15   20   25   30   **35**   40

HIGHER NEED _____ STATE BENCHMARK _____ LOWER NEED

Conditions/Diseases: Medicare Population: Stroke
(Prevalence of Stroke Over All Medicare Beneficiaries by County)

The indicator Medicare population: stroke is defined as the prevalence of stroke across all Medicare beneficiaries and is based on data from CMS.gov Chronic conditions. Dallas County has a 4.42% prevalence rate among total Medicare beneficiaries which is 1.5% higher than the state benchmark of 4.35%. This indicates a slightly higher need than the 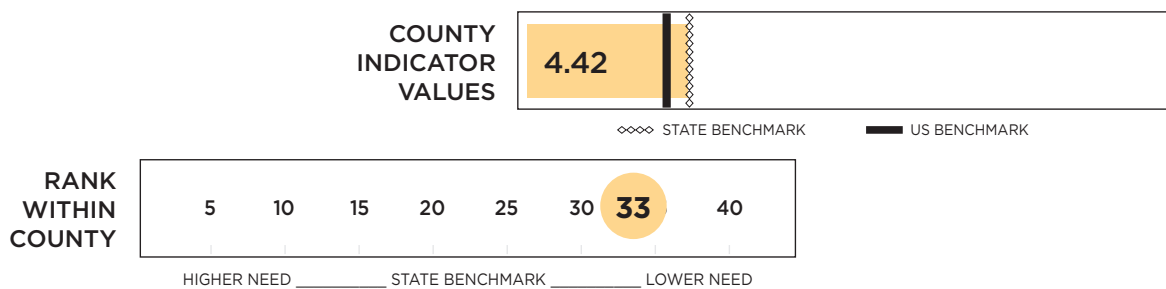state and a larger vulnerable population. This indicator ranked thirty-third (33rd) among all 59 public indicators within Dallas County and indicates a higher need and a larger vulnerable population.

COUNTY INDICATOR VALUES	4.42

◇◇◇◇ STATE BENCHMARK   ▬ US BENCHMARK

RANK WITHIN COUNTY

5   10   15   20   25   30 **33**   40

HIGHER NEED _____ STATE BENCHMARK _____ LOWER NEED

The focus group participants did not discuss the conditions of diabetes, hyperlipidemia, and stroke specifically.

In the prioritization session, the hospital and community leaders agreed that there is insufficient chronic illness management in the community. They added that there is a need in the community to increase monitoring and work with patients to manage "sugar, salt and fat" intakes.

PRIORITY 2: LACK OF HEALTHY FOOD OPTIONS

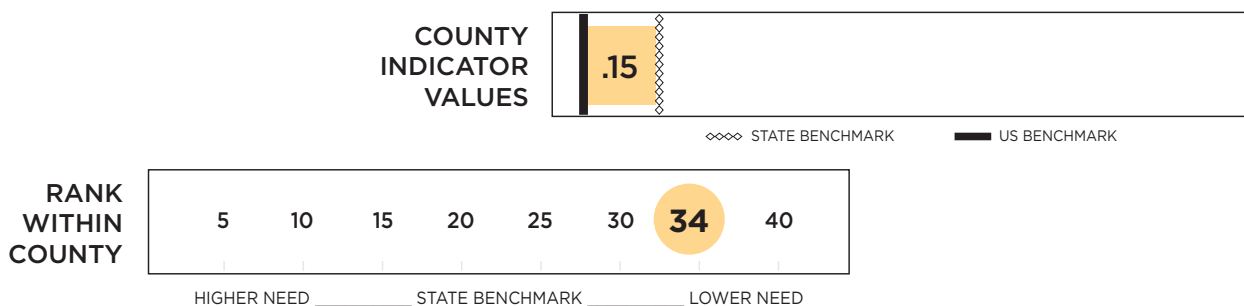The following data indicates greater need in terms of food insecurity in the health community.

Category	Data Shows Greater Need	Key Informants Indicate Greater Need
Environment	• **Food insecure**	• **Food deserts**

Environment: Food Insecure
(Percentage of Population Who Lack Adequate Access to Food During the Past Year by County)

The Food Insecure measure is defined as the percentage of population who lack adequate access to food during the past year. The indicator is based on data from County Health Rankings County Health Rankings & Roadmaps, Map the Meal Gap, Feeding America.

Dallas County had 0.15% population who lack adequate access to food during the past year which is at the state benchmark of 0.15% (0.7% higher which is not seen due to rounding). This indicates a need and a vulnerable population. This indicator ranked as the thirty-fourth indicator (34th) among all 59 public indicators within Dallas County which indicates a greater need and a vulnerable population.

COUNTY INDICATOR VALUES: .15

◇◇◇◇ STATE BENCHMARK   ▬▬ US BENCHMARK

RANK WITHIN COUNTY

5   10   15   20   25   30   **34**   40

HIGHER NEED _____ STATE BENCHMARK _____ LOWER NEED

The key informants commented that there are food deserts in Dallas County and that there is limited access to affordable and healthy food options. They recognized increased efforts during COVID through food drives and other support but stated that the problem is not a lack of food but a lack of healthy food.

In the prioritization session, hospital leadership agreed that there is a lack of healthy food options in the community that needs to be addressed.

PRIORITY 3: GAP IN BEHAVIORAL HEALTH/SUBSTANCE ABUSE

The following data indicates greater need in terms of depression among the Medicare population and mentally unhealthy days among the community population.

Category	Data Shows Greater Need	Key Informants Indicate Greater Need
Mental Health **Health Behaviors**	• **Mentally unhealthy days** • **Opioid-involved accidental deaths** • **Drug poisoning deaths**	• **Gap in mental/behavioral health services** • **Gap in substance abuse services**

Mental Health Conditions/Diseases: Mentally Unhealthy Days
(Average Number of Mentally Unhealthy Days Reported in Past 30 Days by County)

The Mentally Unhealthy Days measure is defined as the average number of mentally unhealthy days reported in the past 30 days. The indicator is based on data from County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS).

Dallas County has a reported 4.35 days per month which is 15.9% higher than the state benchmark of 3.76 days per month. This indicates a higher need than the state and a larger vulnerable population. This indicator ranked as the fourteenth (14th) among all 59 public indicators within Dallas County and indicates greater need and a larger vulnerable population.
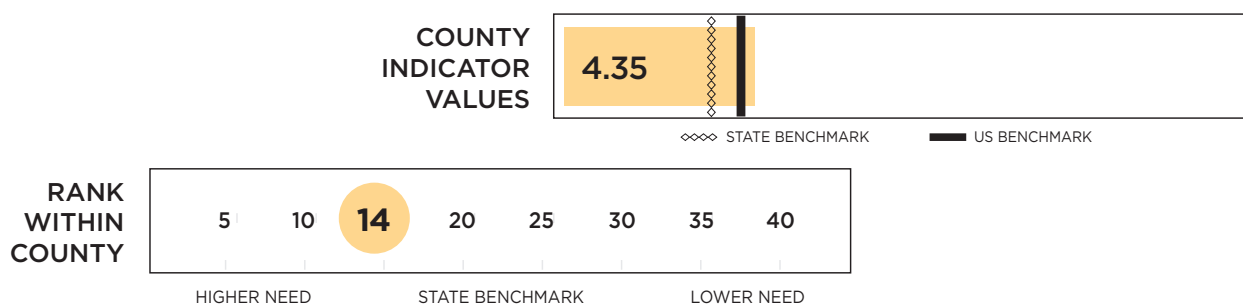
Mental Health Conditions/Diseases: Opioid Involved Accidental Poisoning Death
(Annual Estimates of Accidental Opioid Positing Deaths per 100,000 Population by County)

The Opioid involved accidental poisoning death is defined as the Annual Estimates of the Resident Population Accidental Poisoning Deaths where Opioids Were Involved divided by 100,000 population and is based on data from U.S. Census Bureau, Population Division and Texas Health and Human Services Center for Health Statistics Opioid related deaths in Texas.

Dallas County reported 6.40 opioid involved accidental poisoning deaths per 100,000 population which is 30.6% higher than the state benchmark of 4.90. This indicates a higher need than the state and a larger vulnerable population. This indicator ranked as the fourth (4th) among all 59 public indicators within Dallas County and indicates greater need and a larger vulnerable population.

COUNTY INDICATOR VALUES

6.40

◇◇◇◇ STATE BENCHMARK   ▬ US BENCHMARK

RANK WITHIN COUNTY

4   10   15   20   25   30   35   40

HIGHER NEED _____ STATE BENCHMARK _____ LOWER NEED

Health Behaviors: Drug Poisoning Deaths
(Number of Drug Poisoning Deaths per 100,000 by County)

The Drug Poisoning Deaths indicator is defined as the Number of Drug Poisoning Deaths (Drug Overdose Deaths) per 100,000 Population. The indicator is based on data from County Health Rankings & Roadmaps, CDC WONDER Mortality Data.

Dallas County reported 12.96 drug poisoning deaths per 100,000 people which is 22.1% higher than the state benchmark of 10.62. This indicates a higher need than the state and a larger vulnerable population. This indicator ranked as the eighth (8th) among all 59 public indicators within Dallas County and indicates greater need and a larger vulnerable population.
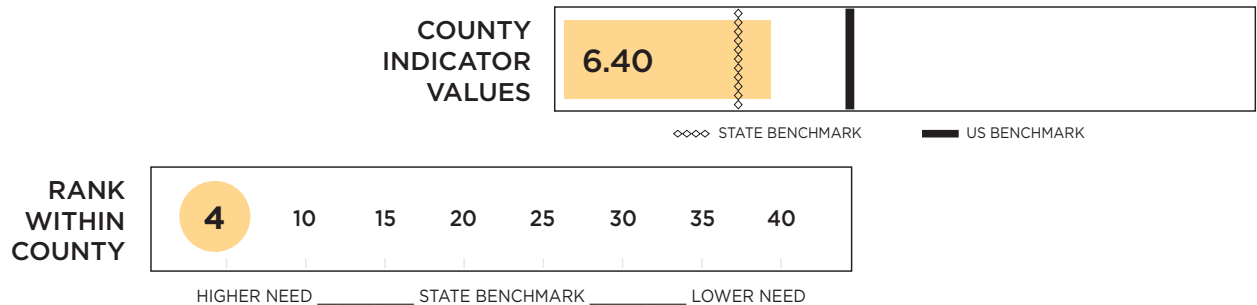
COUNTY INDICATOR VALUES

12.96

◇◇◇◇ STATE BENCHMARK   ▬ US BENCHMARK

RANK WITHIN COUNTY

5   **8**   15   20   25   30   35   40

HIGHER NEED _____ STATE BENCHMARK _____ LOWER NEED

The key informants of the focus group recognize that there are gaps in mental health and substance abuse services and therefore these patients do not have a resource to receive care from. They noted that the pandemic widened the gap as the number of substance abusers increased. They added that caregivers and others fail to recognize mental health issues which delays treatment for these patients.

In the prioritization session, hospital leadership agreed that there is a need to address the gaps in mental and behavioral health services in the community by connecting patients to available resources.

PRIORITY 4: PRENATAL CARE ISSUES

The following data indicates greater need in terms of prenatal care among the community population.

Category	Data Shows Greater Need	Key Informants Indicate Less Need or Not Mentioned
Maternal & Child Health	• *Prenatal care: First trimester entry into prenatal care* • *Low birth weight rate*	• *Not specifically mentioned*

Maternal & Child Health: Prenatal Care: First Trimester Entry Into Prenatal Care
(Percent of Births with Prenatal Care in First Trimester by County)

The Prenatal care: First trimester entry into prenatal care indicator is defined as the Percent of births with prenatal care onset in first trimester and is based on data from Texas Health and Human Services - Vital statistics annual report.

Dallas County reported 56% of births with prenatal care in the first trimester which is 9.1% lower than the state benchmark of 61.60%. This indicates a higher need than the state and a larger vulnerable population. This indicator ranked as the nineteenth (19th) among all 59 public indicators within Dallas County and indicates greater need and a larger vulnerable population.
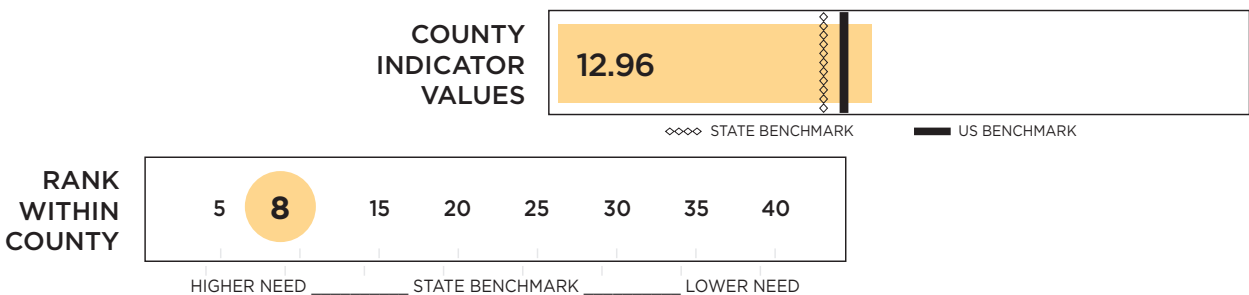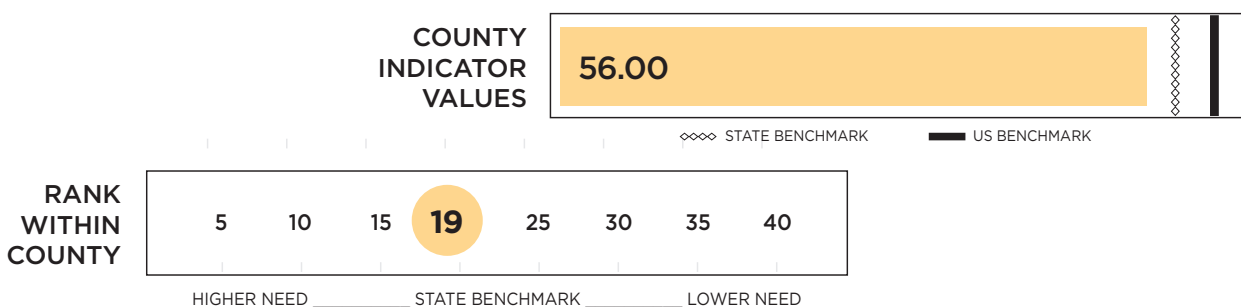
COUNTY INDICATOR VALUES

56.00

◇◇◇◇ STATE BENCHMARK   ▬ US BENCHMARK

RANK WITHIN COUNTY

5   10   15   **19**   25   30   35   40

HIGHER NEED _____ STATE BENCHMARK _____ LOWER NEED

Maternal & Child Health: Low-Birth-Weight Rate
(Percent of Newborns With Low or Very Low Birthweight Including Under 2,500 Grams by County)

The Low-Birth-Weight Rate indicator is defined as the percent of newborns with low or very low birthweight including under 2,500 grams by county and is based on data from Texas Certificate of Live Birth.

Dallas County reported 8.69% of newborns with low or very low birthweight, which is 2.9% higher than the state benchmark of 8.44%. This indicates a higher need than the state and a larger vulnerable population. This indicator ranked as the thirtieth (30th) among all 59 public indicators within Dallas County and indicates greater need and a larger vulnerable population.

The focus group participants did not discuss prenatal care or low birth weight specifically.

In the prioritization session, the hospital and community leaders agreed that there is insufficient prenatal care in the community, which many times leads to low birth weight. They also noted that many pregnant patients in the community have no established obstetrician.

COUNTY INDICATOR VALUES	8.69

◇◇◇◇ STATE BENCHMARK ▬▬ US BENCHMARK

RANK WITHIN COUNTY

5　10　15　20　25　**30**　35　40

HIGHER NEED _____ STATE BENCHMARK _____ LOWER NEED
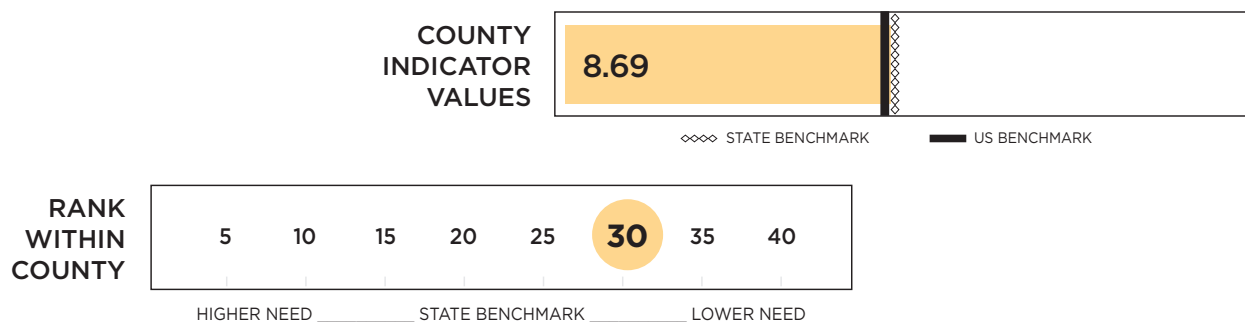
PRIORITY 5: ESCALATING HEALTH NEEDS OF AGING COMMUNITY

The following data indicates greater need in the area of escalating health needs of the aging community and specifically Medicare spending per beneficiary (MSPB) index among the Medicare population.

Category	Data Shows Greater Need	Key Informants Indicate Greater Need
Utilization	• *Medicare spending per beneficiary (MSPB) index*	• *Escalating health needs of aging community*

Utilization: Medicare Spending Per Beneficiary (MSPB) Index
(Average Episode Spending per Medicare Beneficiary by County)

CMS calculates the ratio of the average standardized episode spending over the average expected episode spending. This ratio is multiplied by the average episode spending level across all hospitals. This value is based on data from CMS Medicare Spending Per Beneficiary (MSPB), Hospital Value-Based Purchasing (VBP) Program.

Dallas County has a ratio of 1.30 for Medicare spending per beneficiary, which is 25% higher than the state benchmark of 1.04. This indicates a greater need than the state and a larger vulnerable population. This indicator ranked sixth (6th) among all 59 public indicators within Dallas County which indicates higher need and a larger vulnerable population.

COUNTY INDICATOR VALUES	1.30

◇◇◇◇ STATE BENCHMARK   ▬▬ US BENCHMARK

RANK WITHIN COUNTY	**6**	10	15	20	25	30	35	40

HIGHER NEED _____ STATE BENCHMARK _____ LOWER NEED
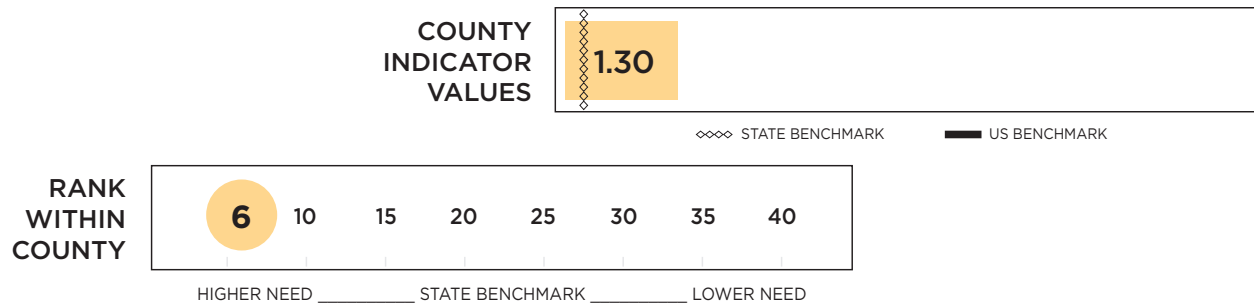
The key informants acknowledged that there is a large aging population in the community. This population is contributing to the escalating health needs observed.

In the prioritization session, hospital leadership agreed that the health needs of the aging population are escalating and need to be addressed. They felt that members of the senior community with chronic conditions are a priority.

PRIORITY 6: CANCER INCIDENCE

The following data indicates greater need in the areas of cancer incidence (all causes, colon, female breast and prostate) although it was not discussed by the key informants specifically.

Category	Data Shows Greater Need	Key Informants Indicate Less Need or Not Mentioned
Conditions/ Diseases	• *Cancer Incidence: All Causes* • *Cancer Incidence: Colon* • *Cancer Incidence: Female Breast* • *Cancer Incidence: Prostate*	• *Not specifically mentioned*

Conditions/Diseases: Cancer Incidence: All Causes
(Cases per 100,000 Population in County)

The indicator Cancer Incidence: All Causes is defined as the age-adjusted cancer (all) incidence rate of cases per 100,000 population. It includes all races, including Hispanic; both sexes; and all ages. The measure is based on data from State Cancer Profiles, National Cancer Institute (CDC).

Dallas County has 421.10 cancer cases per 100,000 population which is 3.3% higher than the state benchmark of 407.70. This indicates a higher need than the state and a larger vulnerable population. This indicator ranked twenty-ninth (29th) among all 59 public indicators within Dallas County and indicates higher need and a larger vulnerable population.

COUNTY INDICATOR VALUES	421.10	

◇◇◇◇ STATE BENCHMARK   ▬ US BENCHMARK

RANK WITHIN COUNTY

| 5 | 10 | 15 | 20 | 25 | **29** | 35 | 40 |

HIGHER NEED _____ STATE BENCHMARK _____ LOWER NEED
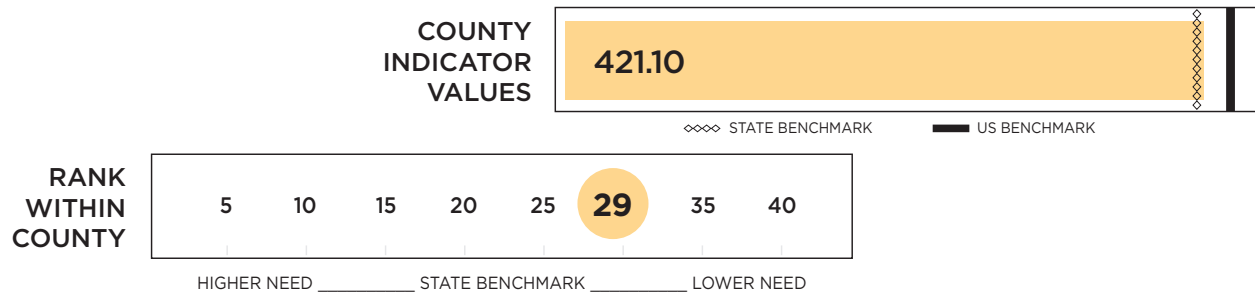
Conditions/Diseases: Cancer Incidence: Colon
(Cases per 100,000 Population in County)

The indicator Cancer Incidence: Colon is defined as the age-adjusted colon and rectum cancer incidence rate of cases per 100,000. It includes all races, including Hispanic; both sexes; and all ages. The measure is based on data from State Cancer Profiles, National Cancer Institute (CDC).

Dallas County has 38.20 colon cancer cases per 100,000 population which is 1.6% higher than the state benchmark of 37.60. This indicates a greater need than the state and a larger vulnerable population. This indicator ranked thirty-second (32nd) among all 59 public indicators within Dallas County and indicates higher need and a larger vulnerable population.

COUNTY INDICATOR VALUES	38.20	

◇◇◇◇ STATE BENCHMARK   ▬ US BENCHMARK

RANK WITHIN COUNTY

| 5 | 10 | 15 | 20 | 25 | **32** | 35 | 40 |

HIGHER NEED _____ STATE BENCHMARK _____ LOWER NEED

Conditions/Diseases: Cancer Incidence: Female Breast
(Cases per 100,000 Female Population in County)

The indicator Cancer Incidence: Female Breast is defined as the age-adjusted breast cancer incidence rate of cases per 100,000 females. It includes all races, including Hispanic and all ages. The measure is based on data from State Cancer Profiles, National Cancer Institute (CDC).

Dallas County has 27.10 female breast cancer cases per 100,000 population which is 1.6% higher than the state benchmark of 22.50. This indicates a greater need than the state and a larger vulnerable population. This indicator ranked eleven (11th) among all 59 public indicators within Dallas County and indicates higher need and a larger vulnerable population.

COUNTY INDICATOR VALUES 27.10

◇◇◇◇ STATE BENCHMARK   ▬ US BENCHMARK

RANK WITHIN COUNTY

| 5 | **11** | 15 | 20 | 25 | 30 | 35 | 40 |

HIGHER NEED _____ STATE BENCHMARK _____ LOWER NEED

Conditions/Diseases: Cancer Incidence: Prostate

(Cases per 100,000 Male Population in County)

The indicator Cancer Incidence: Prostate is defined as the age-adjusted prostate incidence rate of cases per 100,000 males. It includes all races, including Hispanic and all ages. The measure is based on data from State Cancer Profiles, National Cancer Institute (CDC).

Dallas County has 98.40 prostate cancer cases per 100,000 male population which is 4.7% higher than the state benchmark of 94. This indicates a greater need than the state and a larger vulnerable population. This indicator ranked twenty-seventh (27th) among all 59 public indicators within Dallas County and indicates higher need and a larger vulnerable population.
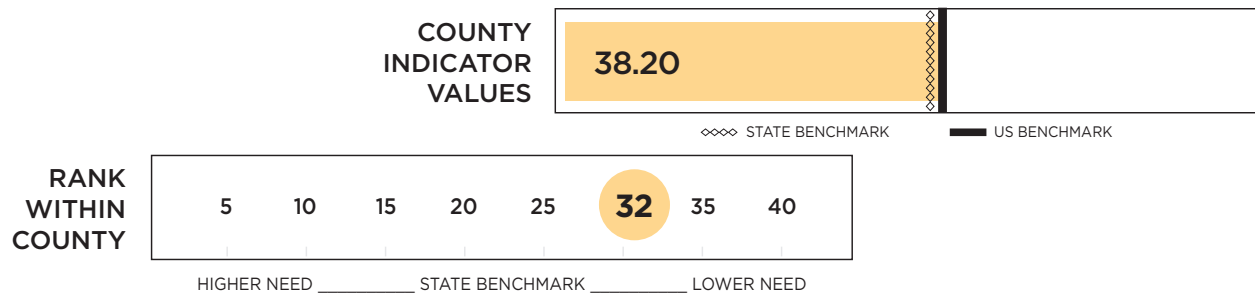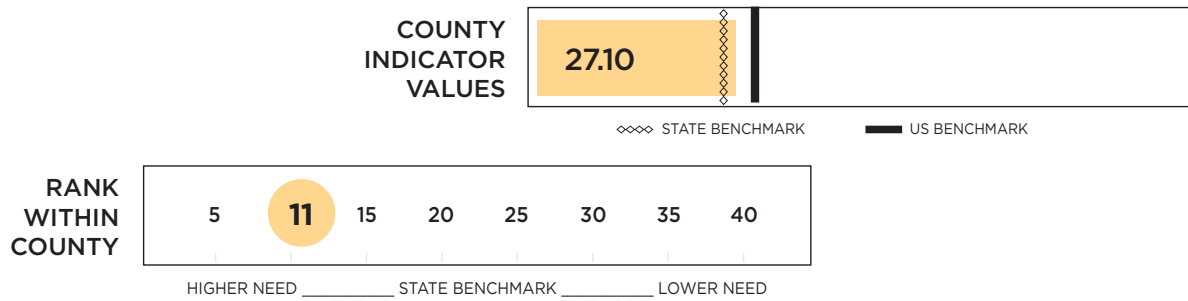
COUNTY INDICATOR VALUES 98.40

◇◇◇◇ STATE BENCHMARK   ▬ US BENCHMARK

RANK WITHIN COUNTY

| 5 | 10 | 15 | 20 | 2 **27** 30 | 35 | 40 |

HIGHER NEED _____ STATE BENCHMARK _____ LOWER NEED

Cancer incidence was not discussed by the key informants specifically.

In the prioritization session, hospital leadership agreed that there is a need to increase screenings and education on prevention and early detection, despite past efforts to improve preventative services, offer free screenings and outreach.

PRIORITY 7: MANY NON-ENGLISH SPEAKERS

The following data indicates greater need in terms of the community having many non-English speakers.

Category	Data Shows Greater Need	Key Informants Indicate Less Need or Not Mentioned
Conditions/ Diseases Population	• *English spoken "less than very well" in household*	• *Not specifically mentioned* • *Language barriers*

Population: English Spoken "Less Than Very Well" in Household
(Percent of Households That Speak English Less Than "Very Well" by County)

The indicator Population: English Spoken "Less Than Very Well" in Household is defined as the percentage of households that 'speak English less than "very well"' within all households that 'speak a language other than English.' This value is based on data from American Community Survey 5-Year Estimates, US Census Bureau - American FactFinder.

Dallas County has 47% of households that speak English less than "very well" among households that speak a language other than English. This value is 21.4% higher than the state benchmark of 38.70%. This indicates a greater need than the state and a larger vulnerable population. This indicator ranked ninth (9th) among all 59 public indicators within Dallas County, which indicates higher need and a larger vulnerable population.
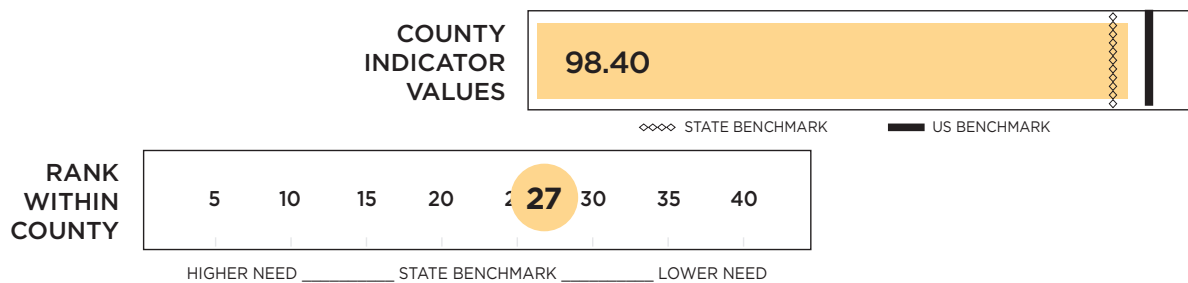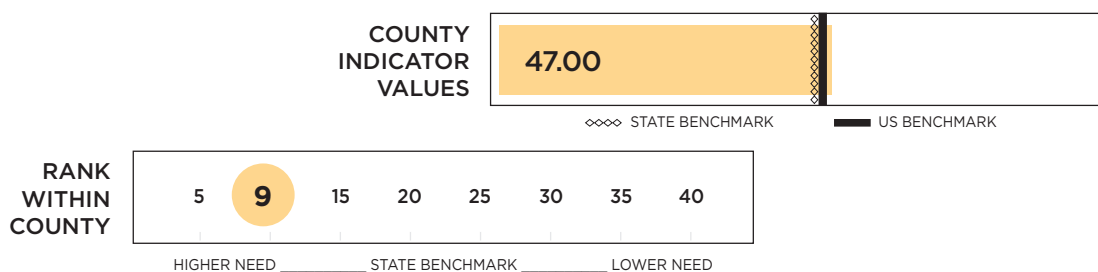
COUNTY INDICATOR VALUES: 47.00
◇◇◇◇ STATE BENCHMARK   ▬ US BENCHMARK

RANK WITHIN COUNTY: 5 **9** 15 20 25 30 35 40
HIGHER NEED _____ STATE BENCHMARK _____ LOWER NEED

The key informants noted that the Dallas community is very diverse with many ethnicities and differences of languages. The healthcare providers, however, are not as diverse. Language gaps between patient and provider lead to limited understanding of both parties.

In the prioritization session, hospital leadership agreed that the language barriers exist and that working to shorten the gap between healthcare providers and the non-English speakers in the community is a priority.

The Community Health Dashboards data referenced above, the prioritized list of significant health needs approved by the hospitals' governing body and the full assessment can be found at **https://www.methodisthealthsystem.org/about/community-involvement**

Existing Resources to Address Health Needs

One part of the assessment process included gathering input on potentially available community resources. A statewide Community Resource Guide and suggestions from some of our assessment participants helped identify community resources that may help address this community's known health needs.

The available community's resources can be referenced in **Appendix G.**

Next Steps

Methodist Charlton, Methodist Dallas and Methodist Rehab started the Community Health Needs Assessment process in March 2021. Using both qualitative community feedback as well as publicly available and proprietary health indicators, Methodist Charlton, Methodist Dallas and Methodist Rehab were able to identify and prioritize community health needs for their facilities. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed for the health needs Methodist Charlton, Methodist Dallas and Methodist Rehab choose to address for the community served.

APPENDIX A: CHNA REQUIREMENT DETAILS

The Patient Protection and Affordable Care Act (PPACA) requires all tax-exempt organizations operating hospital facilities to assess the health needs of their community every three years. The resulting Community Health Needs Assessment (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 used 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; and**

- **An evaluation of the impact of any actions that were taken since the hospital(s) most recent CHNA, to address the significant health needs identified in that report.**

Hospitals also must adopt an Implementation Strategy to address prioritized community health needs identified through the assessment.

CHNA Process

Methodist Health System began the 2022 CHNA process in March of 2021. The following is an overview of the timeline and major milestones:

Define the Community (Complete) →	**Assess the Community (Complete)** →	**Identify Significant Needs and Prioritize (Complete)** →	**Document in Written Report (May 2022)**

CHNA Board Approvals (July 2022) →	**Make CHNA Widely Available on Website (August/ September 2022)** →	**Written Implementation Strategy (October 2022)** →	**Implementation Strategy Board Approval (November 2022)**

Make Implementation Strategy Widely Available on Website (Early 2023) →	**Act on Strategy, Measure, and Report (Ongoing)**

Consultant Qualifications

IBM Watson Health delivers analytic tools, benchmarks, and strategic consulting services to the healthcare industry, combining rich data analytics in demographics, including the Community Needs Index, planning, and disease prevalence estimates, with experienced strategic consultants to deliver comprehensive and actionable Community Health Needs Assessments.

Health Needs Assessment

To identify the health needs of the community, the hospitals established a comprehensive method using all available relevant data including community input. They used the qualitative and quantitative data obtained when assessing the community to identify its community health needs. Surveyors conducted interviews and focus groups with individuals representing public health, community leaders/groups, public organizations, and other providers. In addition, data collected from public sources compared to the state benchmark indicated the level of severity. The outcomes of the quantitative data analysis were compared to the qualitative data findings.

Data Gathering: Quantitative Assessment of Health Needs – Methodology and Data Sources

The team used quantitative data collection and analyses obtained from public health indicators to assess community health needs. This included over 100 data elements grouped into over 11 categories evaluated for the counties where data was available. Recently, regulations expanded to include new categories addressing mental health, healthcare costs, opioids, and social determinants of health. A table depicting the categories and indicators and a list of sources is in **Appendix B.**

A benchmark analysis of each indicator determined which public health indicators demonstrated a community health need. Benchmark health indicators included overall U.S. values, State of Texas values and other goal-setting benchmarks, such as Healthy People 2020.

According to America's Health Rankings 2021 Annual Report, Texas ranks 22nd out of the 50 states in the area of Health Outcomes (which includes behavioral health, mortality and physical health) and 50th in the area of Clinical Care (which includes avoiding care due to cost, providers per 100,000 population, and preventative services).

The quantitative analysis of the health community used the following methodology:

- **Benchmarks were set for each health community using state value for comparison.**

- **Community indicators not meeting state benchmarks were identified.**

- **From this, a need differential analysis of the indicators was completed, which helped bring additional understanding of the community's relative severity of need.**

- **Using the need differentials, a standardized way to evaluate the degree each indicator differed from its benchmark was established.**

- **This quantitative analysis showed which health community indicators were below the 25th percentile in order of severity and, therefore, which health indicators needed their focus.**

The outcomes of the quantitative data analysis were compared to the qualitative data findings.

Information Gaps

In some areas of Texas, the small population size has an impact on reporting and statistical significance. The team has attempted to understand the most significant health needs of the entire community. It is understood that there is variation of need within the community and Methodist Midlothian may not be able to impact all of the population who truly need the service.

Community Input: Qualitative Health Needs Assessment - Approach

To obtain a qualitative assessment of the health community, the team:

- **Assembled a focus group representing the broad interests of the community served;**

- **Conducted interviews and surveys with key informants — leaders and representatives who serve the community and have insight into its needs; and**

- **Held prioritization sessions with hospital clinical leadership and community leaders to review collection results and identify the most significant healthcare needs based on information gleaned from the focus groups and key informants.**

Focus groups helped identify barriers and social factors influencing the community's health needs. Key informant interviews gave the team even more understanding and insight about the general health status of the community and the various drivers that contributed to health issues.

Multiple governmental public health department individuals were asked to contribute their knowledge, information, and expertise relevant to the health needs of the community. Individuals or organizations that served and/or represented the interests of medically underserved, low-income and minority populations in the community also took part in the process. NOTE: In some cases public health officials were unavailable due to obligations concerning the COVID-19 pandemic.

The hospitals also considered written input received on their most recently conducted CHNA and subsequent implementation strategies. Input that has been received to date was reviewed and considered. The assessment is available for public comment or feedback on the report findings by emailing **CHNAfeedback@mhd.com.**

The CHNA assessment is available on the Methodist website at:
https://www.methodisthealthsystem.org/about/community-involvement

Approach to Prioritizing Significant Health Needs

On January 14, 2022, a session with key leaders from Methodist Charlton, Methodist Dallas and Methodist Rehabilitation along with community leaders was convened to review the qualitative and quantitative data findings of the CHNA to date, discuss at length the significant needs identified, and complete prioritization exercises to rank the community needs. Prioritizing health needs was a two-step process. The two-step process allowed participants to consider the quantitative needs and qualitative needs as defined by the indicator data set and input from focus groups, interviews, and survey participants.

HIGH DATA & LOW QUALITATIVE

Data compared to state benchmark indicates need by a <u>greater</u> magnitude
BUT
Topic was <u>not</u> raised in interviews and focus groups

HIGH DATA & HIGH QUALITATIVE

Data compared to state benchmark indicates need by a <u>greater</u> magnitude
AND
Topic was <u>frequent</u> theme in interviews and focus groups

DATA

QUALITATIVE

QUALITATIVE

DATA

Data compared to state benchmark indicates need by a <u>lesser</u> magnitude
AND
Topic was <u>not</u> raised in interviews and focus groups

Data compared to state benchmark indicates need by a <u>lesser</u> magnitude (or no data)
BUT
Topic was <u>frequent</u> theme in interviews and focus groups

LOW DATA & LOW QUALITATIVE

LOW/ NO DATA & HIGH QUALITATIVE

In the first step, participants reviewed the top health needs for their community using associated data-driven criteria. The criteria included health indicator value(s) for the community and how the indicator compared to the state benchmark.

1. **High Data & High Qualitative:** The community indicators that showed a greater need in the health community overall when compared to the State of Texas comparative benchmark and were also identified as a greater need by the key informants.

2. **High Data & Low Qualitative:** The community indicators that showed a greater need in the health community overall when compared to the State of Texas comparative benchmark but were not identified as a greater need or not specifically identified by the key informants.

3. **Low/No Data & High Qualitative**: The community indicators that showed less need or had no data available in the health community overall when compared to the State of Texas comparative benchmark but were identified as a greater need by the key informants.

Participants held a group discussion about which needs were most significant using the professional experience and community knowledge of the group. A virtual voting method was invoked for individuals to provide independent opinions. This process helped the group define and identify the community's significant health needs.

Prioritization of Significant Needs

In the second step, participants ranked the significant health needs based on prioritization criteria recommended by the focus group conducted for this community:

1. 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?

2. Social Justice: Is the problem more concentrated to a specific vulnerable population? Does addressing this issue lead to unfair social benefit? Are we equitable to all vulnerable populations in our approach?

3. Root Cause: Is the issue a root cause of other problems thereby possibly affecting multiple issues?

Participants voted individually for the needs they considered the most significant for this community. When the votes were tallied, the top identified needs emerged and were ranked based on the number of votes. They prioritized the list of significant health needs based on the overall scores. The outcome of this process was the list of prioritized health needs for this community.

APPENDIX B: KEY PUBLIC HEALTH INDICATORS

IBM Watson Health collected and analyzed fifty-nine (59) public health indicators to assess and evaluate community health needs. 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.

The indicators used and the sources are listed below:

Indicator Name	Indicator Source	Indicator Definition
Adult Obesity	*2021 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System*	*2017 Percentage of the Adult Population (Age 20 and Older) that Reports a Body Mass Index (BMI) Greater than or Equal to 30 kg/m2*
Adults Reporting Fair or Poor Health	*2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)*	*2018 Percentage of Adults Reporting Fair or Poor Health (Age-Adjusted)*
Binge Drinking	*2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)*	*2018 Percentage of a County's Adult Population that Reports Binge or Heavy Drinking in the Past 30 Days*
Cancer Incidence: All Causes	*State Cancer Profiles, National Cancer Institute (CDC)*	*2013-2017 Age-Adjusted Cancer (All) Incidence Rate Cases Per 100,000 (All Races, includes Hispanic; Both Sexes; All Ages. Age Adjusted to the 2000 US Standard Population)*
Cancer Incidence: Colon	*State Cancer Profiles, National Cancer Institute (CDC)*	*2013-2017 Age-Adjusted Colon & Rectum Cancer Incidence Rate Cases per 100,000 (All Races, includes Hispanic; Both Sexes; All Ages. Age Adjusted to the 2000 US Standard Population). Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex race category. If an average count of 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).*

Cancer Incidence: Female Breast	*State Cancer Profiles, National Cancer Institute (CDC)*	*2013-2017 Age-Adjusted Female Breast Cancer Incidence Rate Cases Per 100,000 (All Races, includes Hispanic; Female; All Ages. Age Adjusted to the 2000 US Standard Population). Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex race category. If an average count of 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).*
Cancer Incidence: Lung	*State Cancer Profiles, National Cancer Institute (CDC)*	***2013-2017 Age-Adjusted Lung & Bronchus Cancer Incidence Rate Cases per 100,000 (All Races, includes Hispanic; Both Sexes; All Ages. Age Adjusted to the 2000 US Standard Population)***
Cancer Incidence: Prostate	*State Cancer Profiles, National Cancer Institute (CDC)*	***2013-2017 Age-Adjusted Prostate Cancer Incidence Rate Cases per 100,000 (All Races, includes Hispanic; Males; All Ages. Age Adjusted to the 2000 US Standard Population)***
Children in Poverty	***2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau***	***2019 Percentage of Children Under Age 18 in Poverty***
Children in Single-Parent Households	***2021 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)***	***2015-2019 Percentage of Children who Live in a Household Headed by Single Parent***
Children Uninsured	***2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau***	***2018 Percentage of Children Under Age 19 Without Health Insurance***
Diabetes Admission	***2018 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations***	***Number Observed/Adult Population Age 18 and Older. Risk Adjusted Rates not calculated for counties with fewer than 5 admissions.***

Diabetes Diagnoses in Adults	*CMS.gov Chronic Conditions 2007-2018*	*Prevalence of chronic condition across all Medicare beneficiaries*
Diabetes Prevalence	*County Health Rankings (CDC Diabetes Interactive Atlas)*	*2017 prevalence of diagnosed diabetes in a given county. Respondents were considered to have diagnosed diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes.*
Drug Poisoning Deaths	*2021 County Health Rankings & Roadmaps; CDC WONDER Mortality Data*	*2017-2019 Number of Drug Poisoning Deaths (Drug Overdose Deaths) per 100,000 Population. Death rates are NULL when the rate is calculated with a numerator of 20 or less.*
Elderly Isolation	*2018 American Community Survey 5-Year Estimates, US Census Bureau - American FactFinder*	*Percent of Non-family households - Householder living alone - 65 years and over*
English Spoken "Less than Very Well" in Household	*2015-2019 American Community Survey 5-Year Estimates, US Census Bureau, American FactFinder*	*2019 Percentage of households that 'speak English less than "very well"' within all households that 'speak a language other than English'*
Food Environment Index	*2021 County Health Rankings & Roadmaps; USDA Food Environment Atlas, Map the Meal Gap from Feeding America, United States Department of Agriculture (USDA)*	*2015 & 2018 Index of Factors that Contribute to a Healthy Food Environment, 0 (Worst) to 10 (Best)*
Food Insecure	*2021 County Health Rankings & Roadmaps; Map the Meal Gap, Feeding America*	*2018 Percentage of Population Who Lack Ade-quate Access to Food During the Past Year*
Food: Limited Access to Healthy Foods	*2021 County Health Rankings & Roadmaps; USDA Food Environment Atlas, United States Department of Agriculture (USDA)*	*2015 Percentage of Population Who are Low-Income and Do Not Live Close to a Grocery Store*

High School Graduation	*Texas Education Agency*	*2019 A four-year longitudinal graduation rate is the percentage of students from a class of beginning ninth graders who graduate by their anticipated graduation date, or within four years of beginning ninth grade.*
Household Income	*2021 County Health Rankings (Small Area Income and Poverty Estimates)*	*2019 Median Household Income is the income where half of households in a county earn more and half of households earn less.*
Income Inequality	*2021 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)*	*2015-2019 Ratio of Household Income at the 80th Percentile to Income at the 20th Percentile. Absolute Equality = 1.0. Higher ratio is greater inequality.*
Individuals Below Poverty Level	*2018 American Community Survey 5-Year Estimates, US Census Bureau, American FactFinder*	*Individuals below poverty level*
Low Birth Weight Rate	*2019 Texas Certificate of Live Birth*	*Number Low Birthweight Newborns / Number of Newborns. Newborn's birthweight – low or very low birthweight includes birthweights under 2,500 grams. Blanks indicate low counts or unknown values. A NULL value indicates unknown or low counts. The location variables (region, county, ZIP) refer to the mother's residence.*
Medicare Population: Alzheimer's Disease/Dementia	*CMS.gov Chronic conditions 2007-2018*	*Prevalence of chronic condition across all Medicare beneficiaries. A NULL value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complimentary cell suppression.*

Medicare Population: Atrial Fibrillation	*CMS.gov Chronic conditions 2007-2018*	*Prevalence of chronic condition across all Medicare beneficiaries. A NULL value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complimentary cell suppression.*
Medicare Population: COPD	*CMS.gov Chronic conditions 2007-2018*	*Prevalence of chronic condition across all Medicare beneficiaries. A NULL value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complimentary cell suppression.*
Medicare Population: Depression	*CMS.gov Chronic conditions 2007-2018*	*Prevalence of chronic condition across all Medicare beneficiaries*
Medicare Population: Emergency Department Use Rate	*CMS 2019 Outpatient 100% Standard Analytical File (SAF) and 2019 Standard Analytical Files (SAF) Denominator File*	*Unique patients having an Emergency Department visit / total beneficiaries, CY 2019*
Medicare Population: Heart Failure	*CMS.gov Chronic conditions 2007-2018*	*Prevalence of chronic condition across all Medicare beneficiaries. A NULL value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complimentary cell suppression.*
Medicare Population: Hyperlipidemia	*CMS.gov Chronic conditions 2007-2018*	*Prevalence of chronic condition across all Medicare beneficiaries*
Medicare Population: Hypertension	*CMS.gov Chronic conditions 2007-2018*	*Prevalence of chronic condition across all Medicare beneficiaries*
Medicare Population: Inpatient Use Rate	*CMS 2019 Inpatient 100% Standard Analytical File (SAF) and 2019 Standard Analytical Files (SAF) Denominator File*	*Unique patients being hospitalized / total beneficiaries, CY 2019*

Medicare Population: Stroke	*CMS.gov Chronic conditions 2007-2018*	*Prevalence of chronic condition across all Medicare beneficiaries. A NULL value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complimentary cell suppression.*
Medicare Spending Per Beneficiary (MSPB) Index	*CMS 2019 Medicare Spending Per Beneficiary (MSPB), Hospital Value-Based Purchasing (VBP) Program*	*Medicare Spending Per Beneficiary (MSPB): For each hospital, CMS calculates the ratio of the average standardized episode spending over the average expected episode spending. This ratio is multiplied by the average episode spending level across all hospitals. Blank values indicates missing hospitals or missing score. associated to the hospitals*
Mentally Unhealthy Days	*2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)*	*2018 Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)*
Mortality Rate: Cancer	*Texas Health Data, Center for Health Statistics, Texas Department of State Health Services*	*2017 Cancer (All) Age Adjusted Death Rate (Per 100,000 - All Ages. Age-adjusted using the 2000 U.S. Standard Population). Death rates are NULL when the rate is calculated with a numerator of 20 or less.*
Mortality Rate: Heart Disease	*Texas Health Data, Center for Health Statistics, Texas Department of State Health Services*	*2017 Heart Disease Age Adjusted Death Rate (Per 100,000 - All Ages. Age-adjusted using the 2000 U.S. Standard Population). Death rates are NULL when the rate is calculated with a numerator of 20 or less.*
Mortality Rate: Infant	*2021 County Health Rankings & Roadmaps, CDC WONDER Mortality Data*	*2013-2019 Number of All Infant Deaths (Within 1 year), per 1,000 Live Births. Blank values reflect unreliable or missing data.*

Mortality Rate: Stroke	*Texas Health Data, Center for Health Statistics, Texas Department of State Health Services*	*2017 Cerebrovascular Disease (Stroke) Age Adjusted Death Rate (Per 100,000 - All Ages. Age-adjusted using the 2000 U.S. Standard Population). Death rates are NULL when the rate is calculated with a numerator of 20 or less.*
No Vehicle Available	*U.S. Census Bureau, 2019 American Community Survey 1-Year Estimates*	*2019 Households with no vehicle available (percent of households). A NULL value entry indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest interval or upper interval of an open-ended distribution, or the margin of error associated with a median was larger than the median itself.*
Opioid Involved Accidental Poisoning Death	*U.S. Census Bureau, Population Division and 2019 Texas Health and Human Services Center for Health Statistics Opioid related deaths in Texas*	*Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2017. 2019 Accidental Poisoning Deaths where Opioids Were Involved are those deaths which include at least one of the following ICD-10 codes among the underlying causes of death: X40-X44, and at least one of the following ICD-10 codes identifying opioids: T40.0, T40.1, T40.2, T40.3, T40.4, T40.6. Blank values reflect unreliable or missing data.*
Physical Inactivity	*2021 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System*	*2017 Percentage of Adults Ages 20 and Over Reporting No Leisure-Time Physical Activity in the Past Month*
Physically Unhealthy Days	*2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)*	*2018 Average Number of Physically Unhealthy Days Reported in Past 30 Days (Age-Adjusted)*
Population to One Dentist	*2021 County Health Rankings & Roadmaps; Area Health Resource File/National Provider Identification file (CMS)*	*2019 Ratio of Population to Dentists*

Population to one Mental Health Provider	2021 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)	2020 Ratio of Population to Mental Health Providers
Population to One Non-Physician Primary Care Provider	2020 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)	2020 Ratio of Population to Primary Care Providers Other than Physicians
Population to One Primary Care Physician	2021 County Health Rankings & Roadmaps; Area Health Resource File/American Medical Association	2018 Number of Individuals Served by One Physician in a County, if the Population was Equally Distributed Across Physicians
Population under Age 65 without Health Insurance	2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau	2018 Percentage of Population Under Age 65 Without Health Insurance
Prenatal Care: First Trimester Entry into Prenatal Care	2020 Texas Health and Human Services, Vital statistics annual report	2016 Percent of births with prenatal care onset in first trimester
Renter-Occupied Housing	U.S. Census Bureau, 2019 American Community Survey 1-Year Estimates	2019 Renter-occupied housing (percent of households). A NULL value entry indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest interval or upper interval of an open-ended distribution, or the margin of error associated with a median was larger than the median itself.
Severe Housing Problems	2021 County Health Rankings & Roadmaps; Comprehensive Housing Affordability Strategy (CHAS) data, U.S. Department of Housing and Urban Development (HUD)	2013-2017 Percentage of Households with at Least 1 of 4 Housing Problems: Overcrowding, High Housing Costs, or Lack of Kitchen or Plumbing Facilities

Sexually Transmitted Infection Incidence	2021 County Health Rankings & Roadmaps; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)	2018 Number of Newly Diagnosed Chlamydia Cases per 100,000 Population
Smoking	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Percentage of the Adult Population in a County Who Both Report that They Currently Smoke Every Day or Most Days and Have Smoked at Least 100 Cigarettes in Their Lifetime
Suicide: Intentional Self-Harm	Texas Health Data Center for Health Statistics	2019 Intentional Self-Harm (Suicide) (X60-X84, Y87.0). Death rates are NULL when the rate is calculated with a numerator of 20 or less.
Teen Birth Rate	2021 County Health Rankings & Roadmaps; National Center for Health Statistics, Natality files, National Vital Statistics System (NVSS)	2013-2019 Number of Births to Females Ages 15-19 per 1,000 Females in a County (The Numerator is the Number of Births to Mothers Ages 15-19 in a 7 Year Time Frame, and the Denominator is the Sum of the Annual Female Populations, Ages 15-19)
Teens (16-19) Not in School or Work, Disconnected Youth	2021 County Health Rankings (Measure of America)	2015-2019 Disconnected youth are teenagers and young adults between the ages of 16 and 19 who are neither working nor in school. Blank values reflect unreliable or missing data.
Unemployment	2021 County Health Rankings & Roadmaps; Local Area Unemployment Statistics (LAUS), Bureau of Labor Statistics	2019 Percentage of Population Ages 16 and Older Unemployed but Seeking Work

APPENDIX C: COMMUNITY INPUT PARTICIPATING ORGANIZATIONS

Representatives from the following organizations participated in the focus group and a number of key informant interviews/surveys:

- **American Heart Association**
- **Baylor Scott & White Health**
- **Bridge Breast Network**
- **Brighter Tomorrows**
- **Baylor Scott & White Heart & Vascular**
- **Baylor University Medical Center**
- **Crossroads**
- **Dallas Area Interfaith**
- **Dallas Area Rape Crisis Center (DARCC)**
- **Dallas Area Rapid Transit (DART)**
- **Eligibility Consultants Inc.**
- **Empowering the Masses**
- **Family Promise of Living**
- **First United Methodist**
- **For Oak Cliff**
- **Frazier Revitalization**
- **Golden SEEDs**
- **Goodwill Dallas**
- **Methodist Dallas Medical Center**
- **Methodist Health Systemm**
- **Methodist Health System Golden Cross Academic Clinic**
- **Metrocare Services**
- **Sharing Life**
- **South Dallas Fair Park Faith Coalition**
- **Southern Methodist University**
- **Sr. Dir Business Ops**
- **State Fair of Texas**
- **The Bridge Homeless Recovery Center**
- **The Concilio**
- **The Stewpot**
- **United Way of Metropolitan Dallas (UWMD)**
- **Visiting Nurse Association (VNA)**
- **YMCA Dallas**

APPENDIX D: DEMOGRAPHIC AND SOCIOECONOMIC SUMMARY

According to population statistics, the community served is similar to Texas in terms of projected population growth; both outpace the country. The median age is younger than the US and the state of Texas. Median income is slightly higher than both the state and the country. The community served has a higher percentage of Medicaid beneficiaries than Texas but a lower percentage of uninsured than the state.

GEOGRAPHY		Benchmarks		Community Served
		United States	Texas	Dallas County
Total Current Population		330,342,293	29,321,501	2,939,645
5 Yr Projected Population Change		3.3%	6.6%	6.5%
Median Age		38.6	35.2	34.5
Population 0-17		22.4%	25.7%	26.1%
Population 65+		16.6%	13.2%	11.4%
Women Age 15-44		19.5%	20.5%	21.6%
Hispanic Population		19.0%	40.7%	41.1%
INSURANCE COVERAGE	Uninsured	9.9%	18.8%	17.9%
	Medicaid	20.9%	13.0%	14.9%
	Private Market	8.3%	8.4%	7.7%
	Medicare	13.8%	12.7%	10.5%
	Employer	47.2%	47.1%	49.0%
Median HH Income		$65,618	$63,313	$66,577
No High School Diploma		12.2%	16.7%	20.8%

The community served expects to grow 6.5% by 2025, an increase by almost 180,000 people. The projected population growth is slightly lower than the state's 5-year projected growth rate (6.6%) but higher compared to the national projected growth rate (3.3%).

The ZIP Codes expected to experience the most growth in five years are:

- **75052 Grand Prairie – 8,690 additional people**
- **75217 Dallas – 6,315 additional people**
- **75115 Desoto – 5,150 additional people**

The community's population is younger with 51.5% of the population ages 18-54 and 26.1% under age 18. The age 65 plus cohort is expected to experience the fastest growth (24.4%) over the next five years. Growth in the senior population will likely contribute to increased utilization of services as the population continues to age.

Population statistics are analyzed by race and by Hispanic ethnicity. The community is primarily Hispanic. Diversity in the community will increase due to the projected growth of minority populations over the next five years. The expected growth rate of the Hispanic population (all races) is 123,356 people (10.9%) by 2025. The non-Hispanic white population is expected to decline by -4.9%.

POPULATION GROWTH

	National	Selected Area
2010 Total Population	308,745,538	2,421,572
2020 Total Population	330,342,293	2,760,309
2025 Total Population	341,132,738	2,939,645
2030 Total Population	353,513,931	3,135,014
% Change 2020 - 2025	3.27%	6.50%
% Change 2020 - 2030	7.01%	13.57%

POPULATION GENDER DISTRIBUTION

POPULATION GENDER DISTRIBUTION	Males All Ages	Females All Ages	Females Child Bearing
2010 Pop	1,197,496	1,224,076	542,633
2020 Pop	1,361,661	1,398,648	595,819
2025 Pop	1,450,885	1,488,760	613,225
2030 Pop	1,547,113	1,587,901	638,787
10Y Percent Change	13.62%	13.53%	7.21%
National	7.02%	7.01%	4.01%

2020 Race & Ethnicity w Total Population

Chart: Bar chart with y-axis from 0 to 1200000 (in increments of 200000). Categories: White Non-Hispanic (~760000), Black Non-Hispanic (~620000), Hispanic (~1140000), Asian & Pacific Is. Non-Hispanic (~190000), All Others (~55000). Legend: 2020 Pop
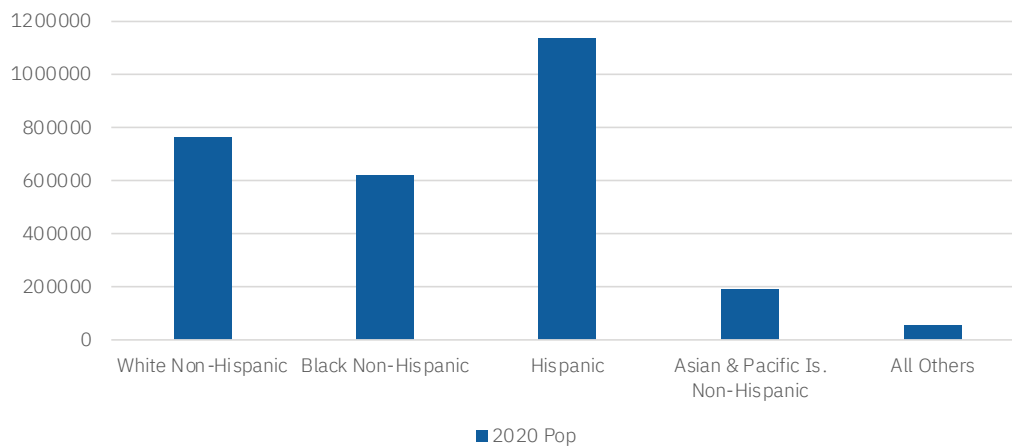
Population by Age Group 2010 - 2030

Chart: Bar chart with y-axis from 0 to 700000. Age groups along x-axis: 0-14, 15-17, 18-24, 25-34, 35-44, 45-54, 55-64, 65+. Legend: 2010, 2020, 2025, 2030
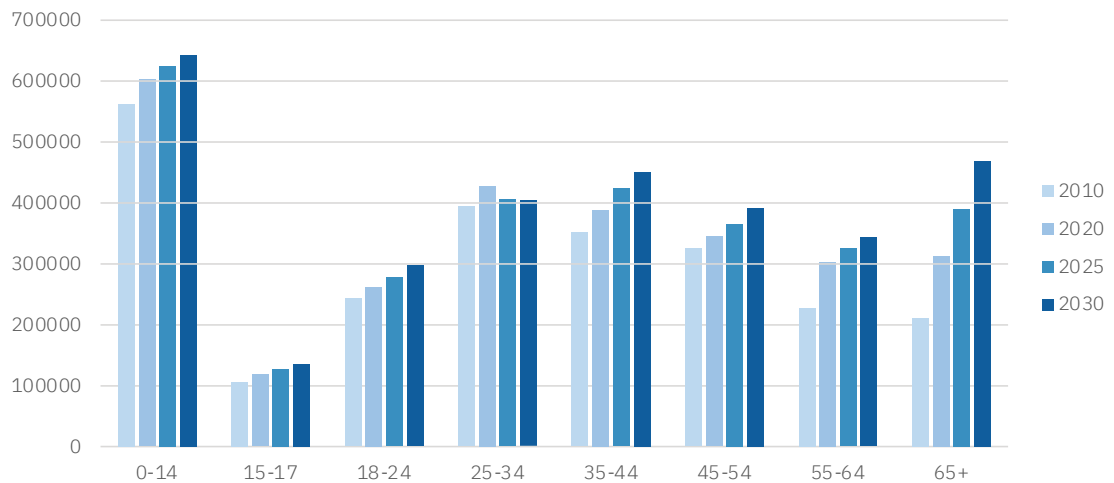
Population by Sex 2010 - 2030

Chart: Bar chart with y-axis from 0 to 2,000,000 (in increments of 500,000). Categories: Males All Ages, Females All Ages, Females Child Bearing. Legend: 2010 Pop, 2020 Pop, 2025 Pop, 2030 Pop
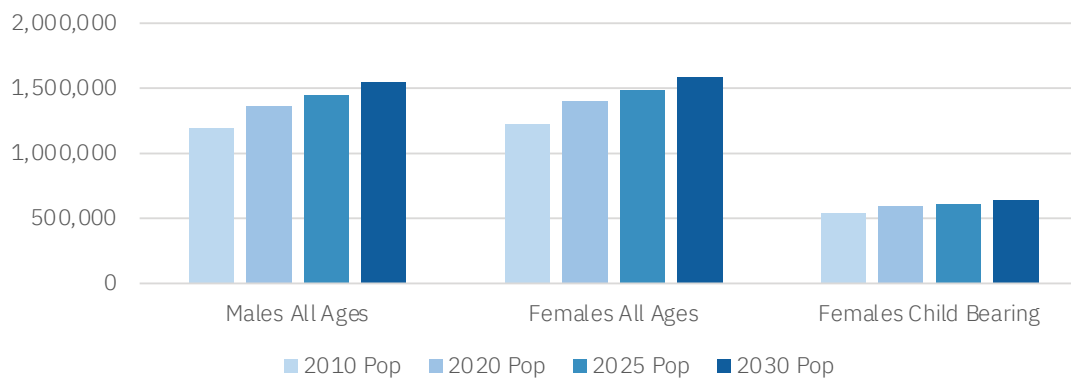
Source: IBM Watson Health / Claritas, 2020

POPULATION DISTRIBUTION

Age Group	Age Distribution				
	2020	% of Total	2025	% of Total	USA 2020 % of Total
0-14	602,889	21.8%	624,719	21.3%	18.5%
15-17	118,689	4.3%	127,654	4.3%	3.9%
18-24	261,613	9.5%	278,138	9.5%	9.5%
25-34	427,698	15.5%	405,939	13.8%	13.5%
35-54	732,726	26.5%	788,264	26.8%	25.2%
55-64	303,295	11.0%	325,214	11.1%	12.9%
65+	313,399	11.4%	389,717	13.3%	16.6%
TOTAL	**2,760,309**	**100%**	**2,939,645**	**100%**	**100%**

Source: IBM Watson Health / Claritas, 2020.

HOUSEHOLD INCOME DISTRIBUTION

2020 Household Income	Income Distribution		
	HH Count	% of Total	USA % of Total
<$15K	91,734	9.2%	10.0%
$15-25K	83,357	8.4%	8.6%
$25-50K	226,159	22.8%	20.7%
$50-75K	182,542	18.4%	16.7%
$75-100K	125,343	12.6%	12.4%
Over $100K	283,736	28.6%	31.5%
TOTAL	**992,871**	**100%**	**100%**

Source: IBM Watson Health / Claritas, 2020.

EDUCATION LEVEL

2020 Adult Education Level	Education Level Distribution		
	Pop Age 25+	% of Total	USA % of Total
Less than High School	197,703	11.1%	5.2%
Some High School	172,259	9.7%	7.0%
High School Degree	408,913	23.0%	27.2%
Some College/Assoc. Degree	454,874	25.6%	28.9%
Bachelor's Degree or Greater	543,369	30.6%	31.6%
TOTAL	**1,777,118**	**100%**	**100%**

Source: IBM Watson Health / Claritas, 2020.

RACE/ETHNICITY

Race/Ethnicity	Race/Ethnicity Distribution		
	2020 Pop	% of Total	USA % of Total
White Non-Hispanic	762,683	27.6%	59.3%
Black Non-Hispanic	618,082	22.4%	12.4%
Hispanic	1,135,347	41.1%	19.0%
Asian & Pacific Is. Non-Hispanic	189,577	6.9%	6.0%
All Others	54,620	2.0%	3.3%
TOTAL	2,760,309	100%	100%

Source: IBM Watson Health / Claritas, 2020.

The 2020 median household income for the United States was $65,618 and $63,313 for the state of Texas. The median household income for the ZIP codes within this community ranged from $165,935 for 75225 (Dallas) to $28,568 for 75210 (Dallas). There are twenty-eight (28) additional ZIP codes with median household incomes less than $52,400 – twice the 2020 Federal Poverty Limit for a family of four.

The median household income ZIP code map below illustrates ZIP codes that are lower or higher than twice the federal poverty level for a family of four in 2020.

Median Household Income is Lower or Higher than $52,400
Twice the Federal Poverty Limit for a Family of 4

$26,200 $52,400 $104,800

(a) **Methodist Charlton, Methodist Dallas, Methodist Rehab** Median Household Income

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METHODIST HEALTH SYSTEM
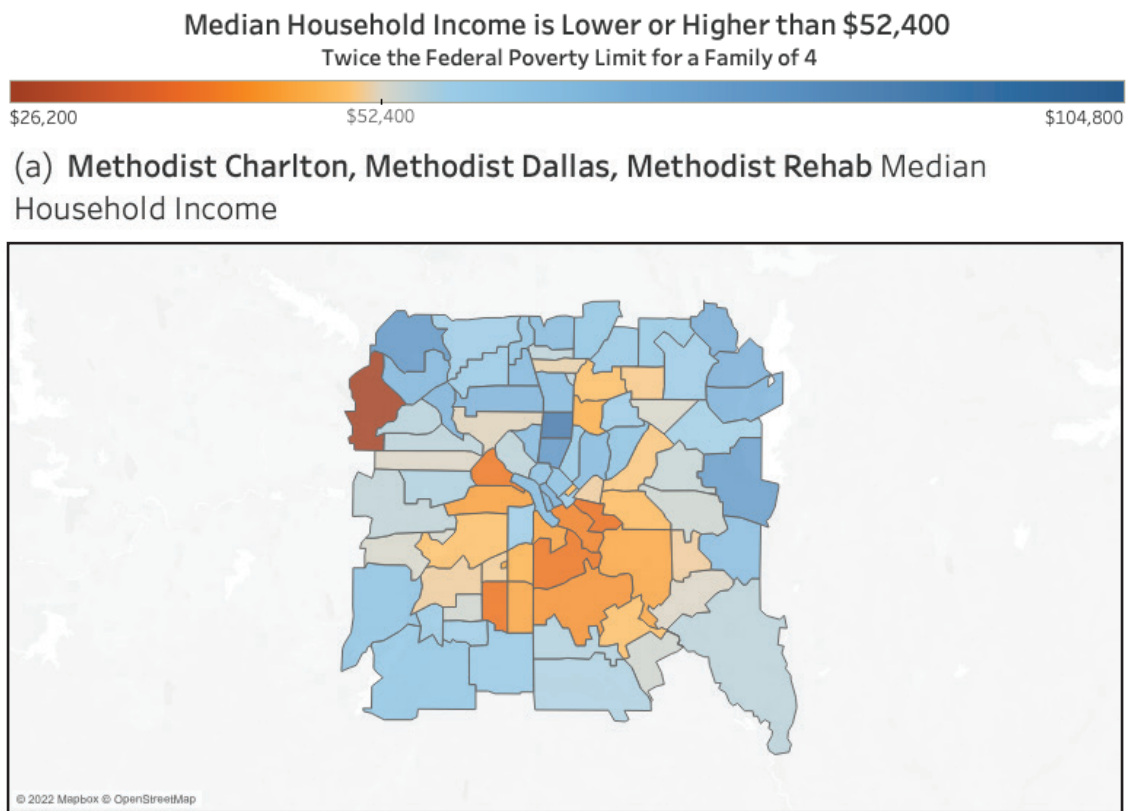
Insurance Coverage Estimates

Almost half of the population (49%) are insured through employer-sponsored health coverage. The remainder of the population was fairly equally divided between Medicaid, Medicare, and private market (the purchasers of coverage directly or through the health insurance marketplace).

2020 Population by Payor

Legend:
- Medicaid - Pre Reform
- Medicaid Expansion
- Medicare
- Medicare Dual Eligible
- Private - Direct
- Private - ESI
- Private - Exchange
- Uninsured

Data labels: 14.9%, 8.8%, 1.7%, 4.9%, 49.0%, 2.8%, 17.9%
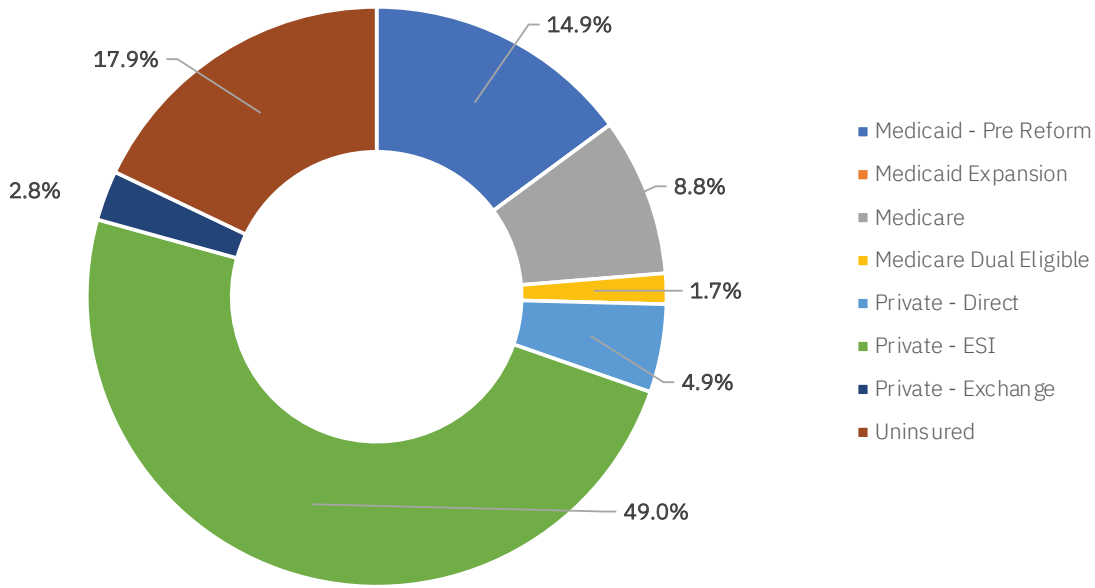
Source: IBM Watson Health Insurance Coverage Estimates, 2020.

Health Professional Shortages

The health community includes thirty (30) Health Professional Shortage Area and ten (10) Medically Underserved Areas as designated by the U.S. Department of Health and Human Services Health Resources Services Administration.

	HEALTH PROFESSIONAL SHORTAGE AREAS (HPSA)				MEDICALLY UNDERSERVED AREA/ POPULATION (MUA/P)
County	Dental Health	Mental Health	Primary Care	Grand Total	MUA/P
Dallas	7	14	9	30	10

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, 2021.

The detail of the HPSA and MUA/P designations are listed below:

Health Professional Shortage Areas (HPSA)

COUNTY NAME	HPSA ID	HPSA ID NAME	HPSA DISCIPLINE CLASS	DESIGNATION TYPE
Dallas	1487790622	OFAC-Parkland Center for Internal Medicine (PCIM)	Primary Care	Other Facility
Dallas	7486259744	LI - Irving	Mental Health	Low-Income Population HPSA
Dallas	7482835384	LI - South Central Dallas	Mental Health	Low-Income Population HPSA
Dallas	7482563929	LI - Southeast Dallas	Mental Health	Low-Income Population HPSA
Dallas	7486982533	LI - Grand Prairie-West Dallas	Mental Health	Low-Income Population HPSA
Dallas	7483797081	LI - Central Dallas County	Mental Health	Low-Income Population HPSA
Dallas	7484799626	LI - North Dallas County	Mental Health	Low-Income Population HPSA
Dallas	7482166324	LI - Northeast Dallas Countyy	Mental Health	Low-Income Population HPSA
Dallas	14899948OZ	MISSION EAST DALLAS AND METROPLEX PROJECT	Primary Care	Federally Qualified Health Center
Dallas	74899948MN	MISSION EAST DALLAS AND METROPLEX PROJECT	Mental Health	Federally Qualified Health Center
Dallas	64899948MO	MISSION EAST DALLAS AND METROPLEX PROJECT	Dental Health	Federally Qualified Health Center
Dallas	14899948Q0	Healing Hands Ministries, Inc.	Primary Care	Federally Qualified Health Center
Dallas	74899948O2	Healing Hands Ministries, Inc.	Mental Health	Federally Qualified Health Center
Dallas	64899948NX	Healing Hands Ministries, Inc.	Dental Health	Federally Qualified Health Center
Dallas	148999485F	Martin Luther King Jr. Family Clinic Inc.	Primary Care	Federally Qualified Health Center
Dallas	748999481V	Martin Luther King Jr. Family Clinic Inc.	Mental Health	Federally Qualified Health Center
Dallas	6489994897	Martin Luther King Jr. Family Clinic Inc.	Dental Health	Federally Qualified Health Center
Dallas	14899948P6	Dallas County Hospital District	Primary Care	Federally Qualified Health Center
Dallas	748999482V	Dallas County Hospital District	Mental Health	Federally Qualified Health Center
Dallas	64899948C2	Dallas County Hospital District	Dental Health	Federally Qualified Health Center

COUNTY NAME	HPSA ID	HPSA ID NAME	HPSA DISCIPLINE CLASS	DESIGNATION TYPE
Dallas	1488622370	Urban Inter-Tribal Center Of Texas	Primary Care	Indian Health Service, Tribal Health, and Urban Indian Health Organizations
Dallas	7485754448	Urban Inter-Tribal Center Of Texas	Mental Health	Indian Health Service, Tribal Health, and Urban Indian Health Organizations
Dallas	6485188079	Urban Inter-Tribal Center Of Texas	Dental Health	Indian Health Service, Tribal Health, and Urban Indian Health Organizations
Dallas	14899948D3	Los Barrios Unidos Community Clinic, Inc.	Primary Care	Federally Qualified Health Center
Dallas	748999481L	Los Barrios Unidos Community Clinic, Inc.	Mental Health	Federally Qualified Health Center
Dallas	6489994889	Los Barrios Unidos Community Clinic, Inc.	Dental Health	Federally Qualified Health Center
Dallas	1489814978	FCI - Seagoville	Primary Care	Correctional Facility
Dallas	6481843658	FCI - Seagoville	Dental Health	Correctional Facility
Dallas	7483425946	FCI - Seagoville	Mental Health	Correctional Facility
Dallas	1487991263	LI - Central Dallas County	Primary Care	Low Income Population HPSA

Medically Underserved Areas and Populations (MUA/P)

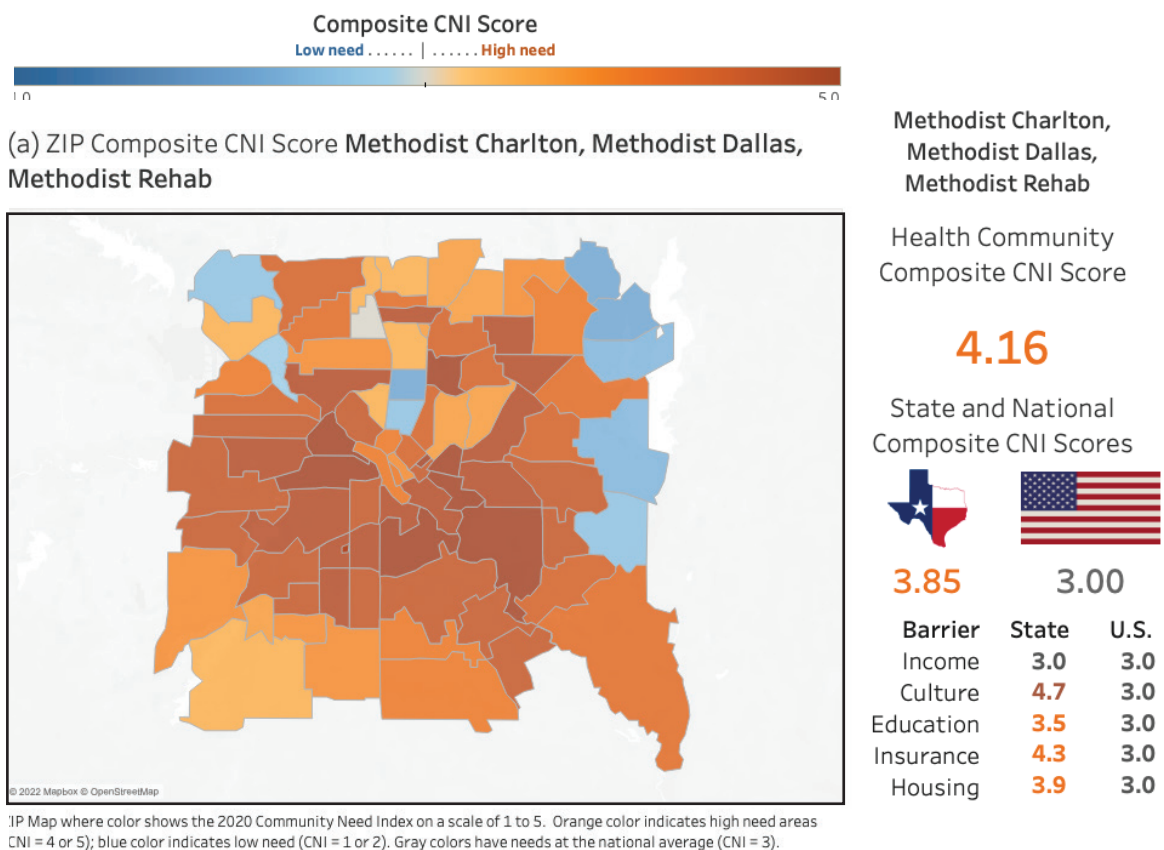| COUNTY NAME	MUA/P SOURCE IDENTIFICATION NUMBER	SERVICE AREA NAME	DESIGNATION TYPE	RURAL STATUS
Dallas	1485024236	Dallas County - Dallas South	Medically Underserved Area	Non-Rural
Dallas	03469	Dallas Service Area	Medically Underserved Area	Non-Rural
Dallas	1487043129	East Dallas County	Medically Underserved Area	Non-Rural
Dallas	05213	Forest Glenn Service Area	Medically Underserved Area	Non-Rural
Dallas	07959	Lillycare Dallas	Medically Underserved Area	Non-Rural
Dallas	1484709099	Southeast Dallas County	Medically Underserved Area	Non-Rural
Dallas	1486572106	Dallas County - Dallas Southwest	Medically Underserved Population	Non-Rural
Dallas	1489157042	LI - Grand Prairie	Medically Underserved Population	Non-Rural
Dallas	1483247641	LI - Irving	Medically Underserved Population	Non-Rural
Dallas	07753	Mission East Dallas Area	Medically Underserved Population	Non-Rural

Community Needs Index

The IBM Watson Health Community Need Index (CNI) is a statistical approach that identifies areas within a community where there are likely gaps in healthcare. The CNI takes into account vital socio-economic factors, including income, culture, education, insurance, and housing, about a community to generate a CNI score for every population ZIP code in the U.S.

The CNI is strongly linked to variations in community healthcare needs and is a good indicator of a community's demand for a range of healthcare services. Not-for-profit and community-based hospitals, for whom community need is central to the mission of service, are often challenged to prioritize and effectively distribute hospital resources. The CNI can be used to help them identify specific initiatives best designed to address the health disparities of a given community.

The CNI score by ZIP code shows specific areas within a community where healthcare needs may be greater.

Dallas County Health Community

Composite CNI Score
Low need . . . . . . | . . . . . . High need

(a) ZIP Composite CNI Score **Methodist Charlton, Methodist Dallas, Methodist Rehab**

ZIP Map where color shows the 2020 Community Need Index on a scale of 1 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).

Methodist Charlton, Methodist Dallas, Methodist Rehab

Health Community Composite CNI Score

4.16

State and National Composite CNI Scores

3.85   **3.00**

Barrier	State	U.S.
Income	3.0	3.0
Culture	4.7	3.0
Education	3.5	3.0
Insurance	4.3	3.0
Housing	3.9	3.0

The overall CNI score for the Dallas County Health Community is 4.16. The difference in the numbers indicates both a strong link to community healthcare needs and a community's demand for various healthcare services. In portions of the community the CNI score was greater than 4.5, indicating more significant health needs among the population.

APPENDIX E: PROPRIETARY COMMUNITY DATA

IBM Watson Health supplemented the publicly available data with estimates of localized inpatient demand discharges, outpatient procedures, emergency department visit, heart disease, as well as cancer incidence estimates.

Social determinants of health are the structural determinants and conditions in which people are born, grow, live, work and age; all of which can greatly impact healthcare utilization and play a major role in the shifting healthcare landscape. Social determinants, such as education, income and race are factored into Inpatient Demand Estimates and Outpatient Procedure Estimates utilization rate creation methodologies.

Inpatient Demand Estimates

Inpatient Demand Estimates provides the total volume of annual acute care admissions by ZIP code and DRG product line for every market in the United States. IBM uses all-payor state discharge data for publicly available states and Medicare (MEDPAR) data for the entire U.S. These rates are applied to demographic projections by ZIP code to estimate inpatient utilization for 2020 through 2030.

The following summary is reflective of the inpatient utilization trends for the Dallas County health community. Total discharges in the community are expected to grow by 7.2% by 2030, with pulmonary medical, general medicine, and cardiovascular diseases projecting the largest growth.

Product line	2020 Discharges	2025 Discharges	2030 Discharges	2020-2025 Discharges Change	2020-2025 Discharges % Change	2020-2030 Discharges Change	2020-2030 Discharges % Change
Alcohol & Drug Abuse	3,272	3,321	3,621	49	1.5%	349	10.7%
Cardio-Vasc-Thor Surgery	7,168	7,509	7,798	341	4.8%	630	8.8%
Cardiovascular Diseases	16,492	17,893	20,310	1,401	8.5%	3,818	23.2%
ENT	1,359	1,234	1,159	(125)	-9.2%	(200)	-14.7%
General Medicine	40,231	41,965	44,809	1,734	4.3%	4,577	11.4%
General Surgery	17,985	18,059	18,826	75	0.4%	841	4.7%
Gynecology	1,521	754	439	(768)	-50.5%	(1,083)	-71.2%
Nephrology/Urology	9,885	10,458	11,351	573	5.8%	1,466	14.8%
Neuro Sciences	11,980	12,435	13,573	455	3.8%	1,593	13.3%
Obstetrics Del	33,504	30,318	29,529	(3,186)	-9.5%	(3,975)	-11.9%
Obstetrics ND	2,763	2,349	2,187	(414)	-15.0%	(576)	-20.8%
Oncology	4,751	4,802	4,993	51	1.1%	242	5.1%
Ophthalmology	276	257	244	(19)	-6.9%	(33)	-11.9%
Orthopedics	16,546	16,493	17,208	(53)	-0.3%	662	4.0%
Psychiatry	2,168	2,244	2,327	76	3.5%	159	7.3%
Pulmonary Medical	15,956	18,380	20,845	2,424	15.2%	4,889	30.6%
Rehabilitation	136	150	170	14	9.9%	34	24.6%
TOTAL	185,994	188,621	199,388	2,627	1.4%	13,394	7.2%

Source: IBM Watson Health Inpatient Demand Estimates, 2020.

Outpatient Procedures Estimates

Outpatient Procedure Estimates predict the total annual volume of procedures performed by ZIP Code for every market in the United States using proprietary and public health claims, as well as federal surveys. Procedures are defined and reported procedure codes and are further grouped into clinical service lines. The Dallas County Health Community outpatient procedures are expected to increase by almost 33% by 2030 with the largest growth in the categories of Labs, General & Internal Medicine and Physical & Occupational Therapy.

Clinical Service Category	2020 Procedures	2025 Procedures	2020-2025 Procedures % Change	2030 Procedures	2020-2030 Procedures % Change
Allergy & Immunology	601,643	653,077	8.5%	708,998	17.8%
Anesthesia	179,002	212,788	18.9%	244,335	36.5%
Cardiology	1,451,931	1,895,214	30.5%	2,486,483	71.3%
Cardiothoracic	1,452	1,666	14.8%	1,888	30.0%
Chiropractic	829,023	833,895	0.6%	823,222	-0.7%
Colorectal Surgery	16,059	17,084	6.4%	18,131	12.9%
CT Scan	450,483	628,524	39.5%	862,707	91.5%
Dermatology	389,422	455,674	17.0%	528,441	35.7%
Diagnostic Radiology	2,578,892	2,847,841	10.4%	3,127,220	21.3%
Emergency Medicine	1,475,487	1,635,756	10.9%	1,812,657	22.9%
Gastroenterology	160,085	185,952	16.2%	213,373	33.3%
General & Internal Medicine	20,812,123	24,300,508	16.8%	27,518,600	32.2%
General Surgery	144,358	163,759	13.4%	185,397	28.4%
Hematology & Oncology	4,402,884	5,277,039	19.9%	6,095,227	38.4%
Labs	26,917,230	30,255,116	12.4%	33,923,728	26.0%
Miscellaneous	1,131,526	1,282,616	13.4%	1,435,768	26.9%
MRI	211,481	239,945	13.5%	270,780	28.0%
Nephrology	736,227	876,309	19.0%	1,025,941	39.4%
Neurology	342,808	378,172	10.3%	415,367	21.2%
Neurosurgery	10,380	15,235	46.8%	18,103	74.4%
Obstetrics/Gynecology	506,991	528,174	4.2%	563,841	11.2%
Ophthalmology	1,240,084	1,490,613	20.2%	1,750,338	41.1%
Oral Surgery	15,412	17,016	10.4%	18,928	22.8%
Orthopedics	330,954	373,655	12.9%	417,497	26.1%
Otolaryngology	784,781	887,298	13.1%	989,147	26.0%
Pain Management	204,892	231,740	13.1%	257,190	25.5%
Pathology	377	424	12.6%	478	26.7%
PET Scan	10,217	11,833	15.8%	13,473	31.9%
Physical & Occupational Therapy	6,326,122	7,511,643	18.7%	8,811,096	39.3%
Plastic Surgery	19,446	22,569	16.1%	26,143	34.4%
Podiatry	99,592	109,126	9.6%	117,451	17.9%
Psychiatry	3,108,474	4,264,961	37.2%	5,560,181	78.9%
Pulmonary	462,214	525,323	13.7%	599,385	29.7%
Radiation Therapy	178,901	201,414	12.6%	224,411	25.4%
Single Photon Emission CT Scan (SPECT)	26,422	29,977	13.5%	34,430	30.3%
Urology	140,674	166,040	18.0%	193,519	37.6%
Vascular Surgery	67,913	77,881	14.7%	88,150	29.8%
TOTAL	76,365,964	88,605,860	16.0%	101,382,021	32.8%

Source: IBM Watson Health Outpatient Procedure Estimates, 2020.

Emergency Department Visits

2025 Visits

Emergency Department Estimates predict the total annual volume of emergency department (ED) visits by ZIP code and level of acuity for every market in the United States. IBM uses an extensive supply of proprietary claims, public claims, and Federal surveys to construct population-based use rates for all payors by age and sex. These use rates are then applied to demographic and insurance coverage projections by ZIP Code to estimate ED utilization for 2020 through 2030.
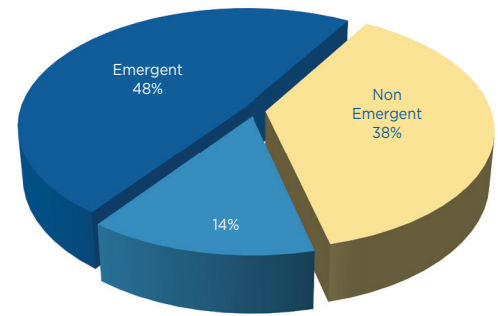
Visits are broken out into emergent and non-emergent ambulatory visits to identify the volume of visits that could be seen in a less-acute setting, for example, a fast-track ED or an urgent care facility. In addition, visits that result in an inpatient admission are broken out into a third, separate category. In the Dallas County Health Community, ED visits are expected to grow by 12.6% by 2025.

Emergent Status	2020 Visits	2025 Visits	2020-2025 Visits Change	2020-2025 Visits % Change
Emergent	647,139	764,011	116,871	18.1%
Inpatient Admission	177,425	215,420	37,994	21.4%
Non Emergent	582,040	604,402	22,362	3.8%
TOTAL	**1.406,605**	**1,583,832**	**177,227**	**12.6%**

Source: IBM Watson Health Emergency Department Visits, 2020.

Heart Disease Estimates

The Heart Disease Estimates data set predicts the number of cases by heart disease type and ZIP Code for every market in the United States. IBM uses public and private claims data as well as epidemiological data from the National Health and Nutritional Examination Survey (NHANES) to build local estimates of heart disease prevalence for the current population. County-level models by age and sex are applied to the underlying demographics of specific geographies to estimate the number of patients with specific types of heart disease.

Disease Type	2020 Prevalence	2020 % Prevalence
Arrhythmia	113,651	12.0%
Heart Failure	56,200	5.9%
Hypertension	697,401	73.5%
Ischemic Heart Disease	81,498	8.6%
TOTAL	**948,750**	**100%**

In the Dallas County Health Community, the most common disease is hypertension at 73.5% of all heart disease cases.

Source: IBM Watson Heart Disease Estimates, 2020.

METHODIST HEALTH SYSTEM

Cancer Estimates

IBM Watson Health builds county-level Cancer Incidence models that are applied to the underlying demographics of specific geographies to estimate incidence (i.e., the number of new cancer cases annually) of all cancer patients. Cancer incidence is expected to increase by 10.5% in the Dallas County Health Community by 2025.

Cancer Type	2020 Incidence	2025 Incidence	2020-2025 Change	2020-2025 % Change
Bladder	413	484	71	17.2%
Brain	230	253	23	9.8%
Breast	2,715	3,078	364	13.4%
Colorectal	1,381	1,330	-51	-3.7%
Kidney	588	694	106	18.0%
Leukemia	370	424	54	14.7%
Lung	1,374	1,536	162	11.8%
Melanoma	483	559	76	15.7%
Non-Hodgkins Lymphoma	634	729	95	14.9%
Oral Cavity	384	441	57	14.9%
Other	1,568	1,813	245	15.7%
Overian	226	247	21	9.2%
Pancreatic	353	423	70	19.9%
Prostate	1,571	1,549	-22	-1.4%
Stomach	245	273	27	11.1%
Thyroid	372	424	51	13.8%
Uterine Cervical	107	107	0	-0.4%
Uterine Corpus	356	414	58	16.3%
TOTAL	13,371	14,778	1,407	10.5%

Source: IBM Watson Health Cancer Estimates, 2020.

APPENDIX F: 2019 METHODIST CHNA EVALUATION

Due to the COVID pandemic, progress was impeded on a number of initiatives for the community. Although the pandemic proved to be a barrier to initial progress, many of the initiatives have re-gained momentum through virtual offerings.

Hypertension, Stroke and Diabetes

As many patients experience diabetes, hypertension, and various infectious diseases, Methodist Dallas, Methodist Charlton, and Methodist Rehab Hospital have collectively aimed to improve the health of the members of the Dallas County community.

Methodist Dallas conducted monthly support groups, attended by physician guest speakers, to provide a forum for patients to connect with each other. Meetings were held virtually to increase accessibility.

Similarly to Methodist Dallas, Methodist Charlton also held support groups virtually, with an average attendance of 20 participants per month. Varied topics were discussed, including heart disease and diabetes. Additionally, Methodist Charlton held 12 monthly heart health and diabetes workshops throughout the year.

Two versions of the Methodist Health System newsletter, Shine and Shine Online, ran 10 articles about hypertension, stroke, and diabetes; reaching 25,000 homes and an additional 1,000 viewers through social media outreach in the Methodist Charlton service area.

The CardioMEMS program at Methodist Charlton has had steady growth over the past three years, with a total of 6 implantations since March 2019. The growth was facilitated when Medicare expanded their coverage criteria in 2020, which allowed for more Medicare patients to become eligible for CardioMEMS implantation.

Methodist Rehab Hospital continued their patient and provider education about rehab services. Due to COVID, a selection of provider education courses were conducted virtually. Patient and family rehab education took place prior to discharge, reaching 243 patients in 2020 and 278 patients in 2021.

APPENDIX G: COMMUNITY RESOURCES IDENTIFIED TO POTENTIALLY ADDRESS SIGNIFICANT HEALTH NEEDS

Below is a list of community resources that may help address this community's known health needs:

- **Agape Clinic/Baylor Community Care**
- **Austin Street Center**
- **Baylor College of Dentistry**
- **Baylor Community Care at Worth Street**
- **Baylor Irving Community Care Clinic**
- **Brother Bill's Helping Hand**
- **Care 365**
- **Catholic Charities of Metropolitan Dallas**
- **Christ's Family Clinic**
- **Churches**
- **City of Dallas**
- **City Square**
- **CK Behavioral Health (CKBH)**
- **Community Dental Care – East Dallas**
- **Community Dental Care – Vickery Meadow Dental Center**
- **Community Health Centers**
- **Crossroads**
- **Dallas Concilio**
- **Dallas Housing Authority**
- **Dallas Life Foundation**
- **DART**
- **DCHHS**
- **Diabetes Health and Wellness Institute at Juanita J. Craft Recreation Center**
- **DME Exchange of Dallas**
- **Food Pantries**
- **FQHCs or charity clinics (Agape, etc.)**
- **Garland Women's Health Center (Parkland)**
- **Genesis Women's Shelter**
- **Goodwill Industries of Dallas, Inc.**
- **Grand Prairie Women's Health Center (Parkland)**
- **Habitat for Humanity**
- **Healing Hands Ministries**
- **Hope Clinic Garland**
- **Hospital and Hospital Affiliated Clinics**
- **Irving Interfaith Clinic**
- **Irving Women's Health Center (Parkland)**
- **Islamic Association of North Texas Clinic**
- **Jefferson Dental**

- **Local Health Clinics**
- **Los Barrios Unidos Community Clinic**
- **Martin Luther King, Jr. Family Clinic, Inc.**
- **MetroCrest Family Medical Clinic**
- **Mission East Dallas**
- **Monday Clinic (UT Southwestern)**
- **Network of Community Ministries Adolescent and Children's Clinic**
- **North Texas Food Bank**
- **OB Complications Clinic**
- **Operation Community Care**
- **Parkland East Dallas Women's Health Center**
- **Parkland deHaro-Saldivar Women's Health Center**
- **Parkland Lakewest Women's Health Center**
- **Parkland Maple Women's Health Center**
- **Parkland Southeast Dallas Women's Health Center**
- **Parkland Vickery Women's Health Center**
- **Parkland Women's Health Centers**
- **Pearl Clinic**
- **Primary Care Clinic of North Texas – Dallas**
- **QuestCare Clinic**
- **RedBird Health Center**
- **Sharing Life Outreach**
- **Stewpot Dental Clinic**
- **The Bridge Homeless Shelter**
- **UT Southwestern - Dr. Nero (Sickle Cell)**
- **WIC Clinics**
- **Youth Advocacy Progarms, Inc. (YAP)**