Methodist Charlton Medical Center

Methodist Dallas Medical Center

Methodist Rehabilitation Hospital

Community Health Needs Assessment

Methodist HEALTH SYSTEM

Approved by:
Methodist Dallas Medical Center and Methodist Charlton Medical Center
Board of Directors on September 24, 2019
Methodist Rehabilitation Hospital Board of Directors on August 6, 2019
Posted to:
www.methodisthealthsystem.org/about/communityinvolvement on
September 30, 2019

Table of Contents

Compassionate Healthcare

The Methodist ministers and civic leaders who opened our doors in 1927 couldn't have imagined where Methodist Health System would be today. From humble beginnings, our renowned health system has become one of the leading healthcare providers in North Texas.

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

Whatever your medical need, we are honored that you would entrust us with your health and safety. We understand that we have a solemn responsibility to you and your family, and you can trust that our team takes that commitment very seriously.

Mission, Vision, and Values of Methodist Health System

Mission

To improve and save lives through compassionate quality healthcare.

Vision for the Future

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:

- **S**ervant Heart – compassionately putting others first
- **H**ospitality – offering a welcoming and caring environment
- **I**nnovation – courageous creativity and commitment to quality
- **N**oble – unwavering honesty and integrity
- **E**nthusiasm – celebration of individual and team accomplishment
- **S**killful – dedicated to learning and excellence

Executive Summary

Methodist Health System (Methodist) understands the importance of serving the health needs of its communities. To do that successfully, we must first take a comprehensive look at the issues our patients, their families, and neighbors face when making healthy life choices and health care decisions.

Beginning in June 2018, the organization began the process of assessing the current health needs of the communities it serves. IBM Watson Health (Watson Health) was engaged to help collect and analyze the data for this process and to compile a final report made publicly available on September 30, 2019.

Methodist owns and operates multiple individually licensed hospital facilities serving the residents of North Texas. Several of Methodist's hospital facilities have overlapping communities in their service areas and therefore collaborated to conduct a joint CHNA. This joint assessment applies to the following Methodist hospital facilities:

- Methodist Charlton Medical Center
- Methodist Dallas Medical Center
- Methodist Rehabilitation Hospital

For the 2019 assessment, the community includes the geographic area where at least 75% of the hospital facilities' admitted patients live. Methodist Charlton Medical Center, Methodist Dallas Medical Center, and Methodist Rehabilitation Hospital defined their community as the geographical area of Dallas County. These hospital facilities provided a Community Health Needs Assessment (CHNA) report in accordance with Treasury Regulations and 501(r) of the Internal Revenue Code.

Watson Health examined over 102 public health indicators and conducted a benchmark analysis of the data comparing the community to overall state of Texas and United States (U.S.) values. For a qualitative analysis, and in order to get input directly from the community, focus groups and key informant interviews were conducted. Interviews included input from state, local, or regional governmental public health departments (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community as well as individuals or organizations serving and/or representing the interests of medically underserved, low-income, and minority populations in the community.

Needs were first identified when it was determined which indicators for the community did not meet the state benchmarks. A need differential analysis was conducted on all of the indicators not meeting benchmarks to determine relative severity by using the percent difference from benchmark. The outcome of this quantitative analysis was then aligned with the qualitative findings of the community input sessions to create a list of health needs in the community. Each health need received assignment into one of four quadrants in a health needs matrix, this clarified the assignment of severity rankings of the needs. The matrix shows the convergence of needs identified in the qualitative data (interview and focus group feedback) and quantitative data (health indicators) and identifies the top health needs for this community.

On May 2, 2019 a prioritization meeting was held with system and hospital leadership in which the health needs matrix was reviewed to establish and prioritize significant needs. The meeting was moderated by Watson Health and included an overview of the Methodist CHNA process, summary of qualitative and quantitative findings, and a review of the identified community health needs.

Participants identified the significant health needs through review of the health needs matrix, discussion, and a consensus process. Once the significant health needs were established, participants rated the needs using a set of prioritization criteria. The sum of the criteria scores for each need created an overall score that was the basis of the prioritized order of significant health needs.

The meeting participants subsequently evaluated the prioritized health needs against a set of selection criteria in order to determine which needs would be addressed by the hospital facilities. A description of the selected needs is included in the body of this report. Each facility developed an individual implementation strategy with specific initiatives aimed at addressing the selected health needs. The implementation strategy will be completed and adopted by the hospital facilities on or before February 15, 2020. The needs to be addressed by Methodist Charlton Medical Center, Methodist Dallas Medical Center, and Methodist Rehabilitation Hospital are as follows:

- Hypertension
- Stroke
- Diabetes
- HIV

As part of the assessment process, community resources were identified, including facilities/organizations, that may be available to address the significant needs in the community. These resources are in the appendix of this report.

An evaluation of the impact and effectiveness of interventions and activities outlined in the implementation strategy drafted after the prior assessment is also included in **Appendix E** of this document.

The CHNA for Methodist Charlton Medical Center, Methodist Dallas Medical Center, and Methodist Rehabilitation Hospital has been presented and approved by the Vice President of Strategic Planning, Methodist Health System Senior Executive Management team and Methodist Health System's Board of Directors. The full assessment is available for download at no cost to the public on Methodist's website, visit **www.methodisthealthsystem.org/about/communityinvolvement**.

This assessment and corresponding implementation strategy meet the requirements for community benefit planning and reporting as set forth in state and federal laws, including but not limited to: Texas Health and Safety Code Chapter 311 and Internal Revenue Code Section 501(r).

Community Health Needs Assessment Requirement

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

CHNA Overview, Methodology and Approach

Methodist began the 2019 CHNA process in June of 2018 and partnered with Watson Health to complete a CHNA for Methodist Charlton Medical Center, Methodist Dallas Medical Center, and Methodist Rehabilitation Hospital.

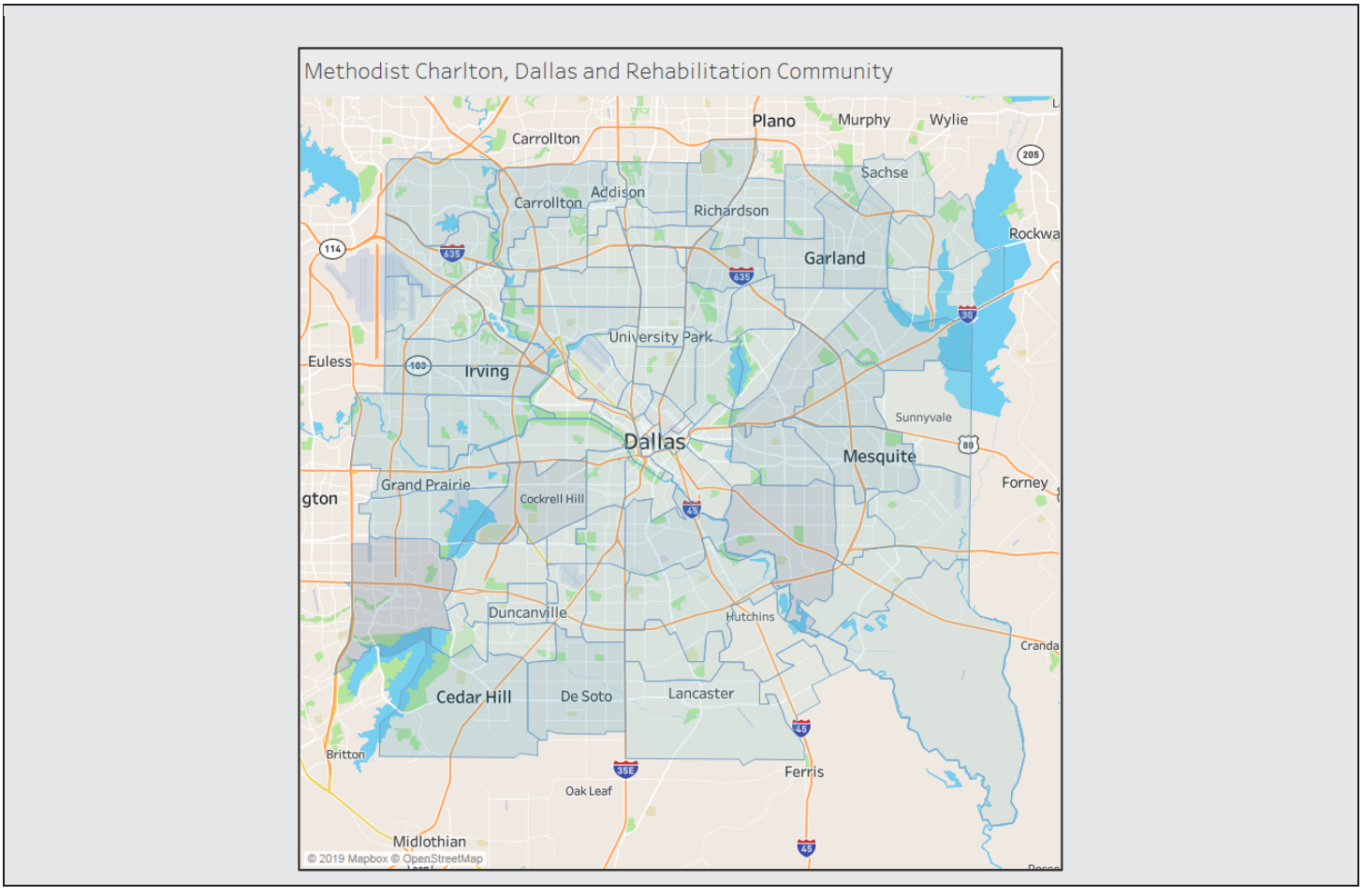
Consultant Qualifications & Collaboration

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.

Community Served Definition

For the purpose of this assessment, 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



Assessment of Health Needs

To identify the health needs of the community, the hospital facilities established a comprehensive method of taking into account all available relevant data including community input. The basis of identification of community health needs was the weight of qualitative and quantitative data obtained when assessing the community. Surveyors conducted interviews and focus groups with individuals representing public health, community leaders/groups, public organizations, and other providers. In addition, data collected from several public sources compared to the state benchmark indicated the level of severity.

Quantitative Assessment of Health Needs – Methodology and Data Sources

Quantitative data collection and analysis in the form of public health indicators assessed community health needs, including collection of 102 data elements grouped into 11 categories, and evaluated for the counties where data was available. Since 2016, the identification of several new indicators included: addressing mental health, health care costs, opioids, and social determinants of health. The categories, indicators, and sources are included in **Appendix A**.

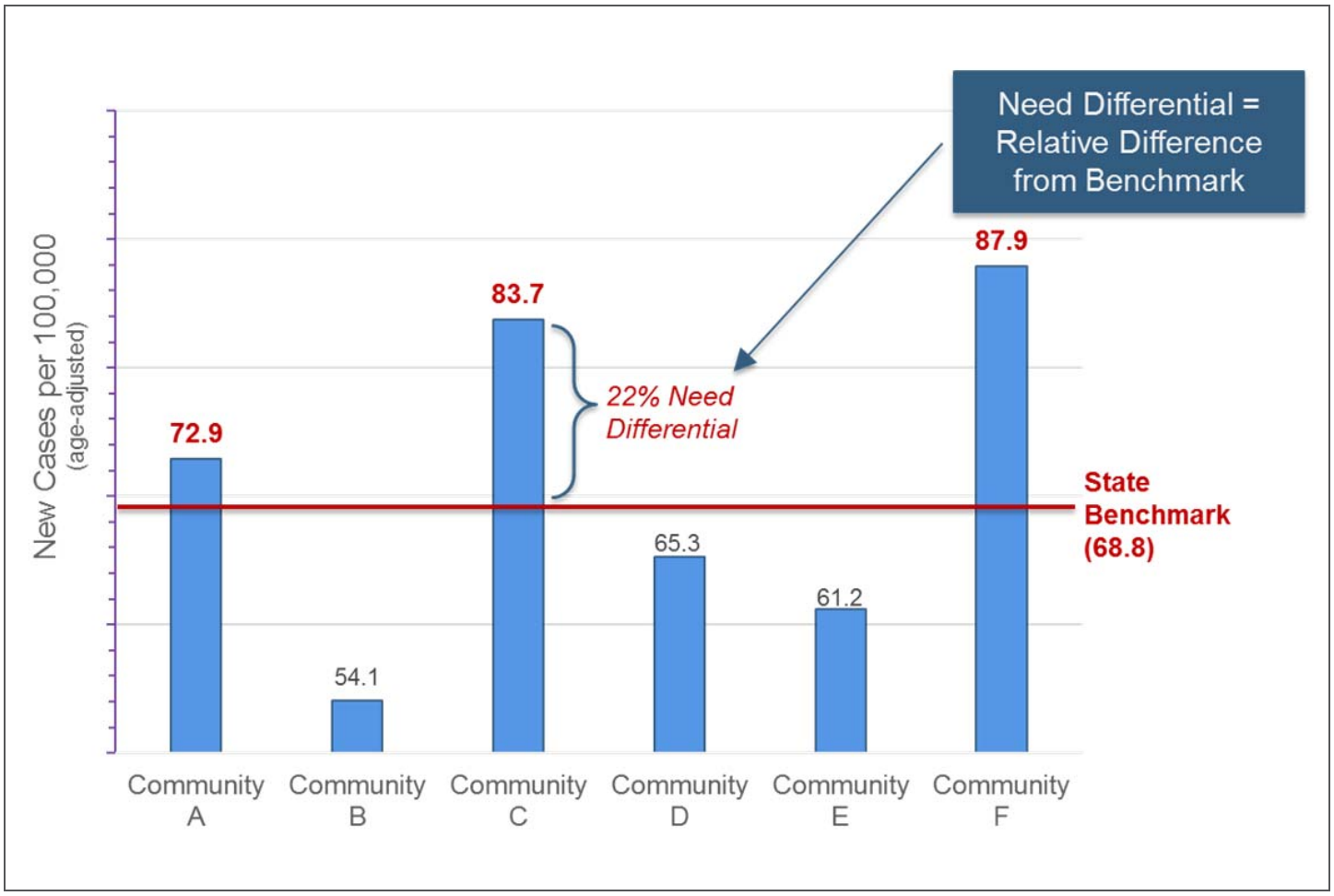
A benchmark analysis, conducted for each indicator collected for the community served, determined which public health indicators demonstrated a community health need from a quantitative perspective. Benchmark health indicators collected included (when available): overall U.S. values; state of Texas values; and goal setting benchmarks such as Healthy People 2020.

According to America's Health Rankings 2018 Annual Report, Texas ranks 37th out of the 50 states. The health status of Texas compared to other states in the nation identified many opportunities to impact health within local communities, including opportunities for those communities that ranked highly. Therefore, the benchmark for the community served was set to the state value.

Once the community benchmark was set to the state value, it was determined which indicators for the community did not meet the state benchmarks. This created a subset of indicators for further analysis. A need differential analysis was conducted to understand the relative severity of need for these indicators. The need differential established a standardized way to evaluate the degree each indicator differed from its benchmark. Health community indicators with need differentials above the 50th percentile are ordered by severity and the highest ranked indicators were the highest health needs from a quantitative perspective.

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

Health Indicator Benchmark Analysis Example



Source: IBM Watson Health, 2019

Qualitative Assessment of Health Needs and Community Input – Approach

In addition to analyzing quantitative data, two (2) focus groups with a total of 22 participants, as well as five (5) key informant interviews, were conducted to take into account the input of persons representing the broad interests of the community served. The focus groups and interviews solicited feedback from leaders and representatives who serve the community and have insight into community needs.

The focus groups familiarized participants with the CHNA process and solicited input to understand health needs from the community's perspective. Focus groups, formatted for individual as well as small group feedback, helped identify barriers and social determinants influencing the community's health needs. Barriers and social determinants were new topics added to the 2019 community input sessions.

Watson Health conducted key informant interviews for the community served by the hospitals. The interviews aided in gaining understanding and insight into participants' concerns about the general health status of the community and the various drivers that contributed to health issues.

Participation in the qualitative assessment was included from at least one state, local, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community,

as well as individuals or organizations who served and/or represented the interests of medically underserved, low-income and minority populations in the community.

Participation from community leaders/groups, public health organizations, other healthcare organizations, and other healthcare providers ensured that the input received represented the broad interests of the community served. A list of the organizations providing input is in the table below.

Community Input Participants

Participant Organization Name	Public Health	Medically Under-served	Low-income	Chronic Disease Needs	Minority Populations	Governmental Public -- Health Dept.	Public Health Knowledge -- Expertise
Agape Clinic		X	X	X	X		X
Bridge Breast Network		X	X		X		X
CitySquare	X	X	X	X	X		X
Community Council							
Cornerstone Baptist Church	X	X	X	X	X		X
D/FW Hindu Temple Society					X		
Dallas Area Interfaith		X	X		X		X
Family Promise of Irving		X	X				
Genesis Women's Shelter & Support		X	X		X		X
Goodwill Industries of Dallas			X	X			
Hope Clinic		X	X	X	X		
Legal Aid of Northwest Texas			X				
Los Barrios Unidos Community Clinic	X	X	X	X	X		X
Many Helping Hands Ministry	X	X	X	X			
North Texas Food Bank			X				X
Office of the County Judge - Dallas County	X	X	X	X	X		X
Sharing Life Community Outreach Inc			X				

Participant Organization Name	Public Health	Medically Under-served	Low-income	Chronic Disease Needs	Minority Populations	Governmental Public -- Health Dept.	Public Health Knowledge -- Expertise
Society of St. Vincent de Paul of North Texas		X	X	X	X		
United Way Metropolitan Dallas		X	X	X	X		X
Urban Inter-Tribal Center of Texas		X	X	X	X		X
YMCA	X	X	X	X	X		X
Cancer Care Services	X	X	X	X	X		X
Dallas County Health and Human Services	X		X			X	
Metrocare	X	X	X	X	X		X
Methodist Golden Cross Academic Clinic		X	X	X	X		X
The Visiting Nurse Association of North Texas (VNA)	X	X	X	X	X		X

Note: multiple persons from the same organization may have participated

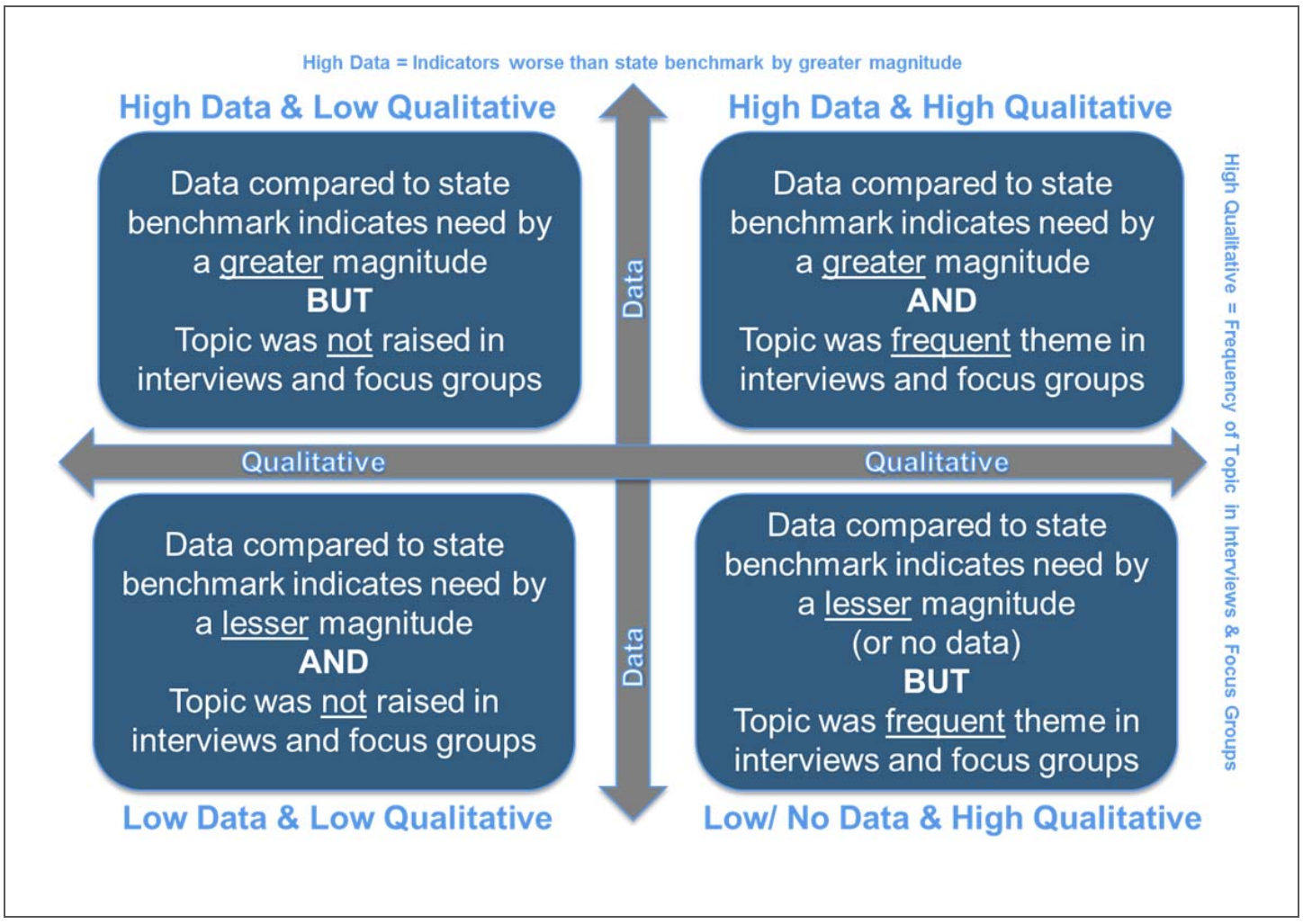
In addition to soliciting input from public health and various interests of the community, the hospital was also required to consider written input received on their most recently conducted CHNA and subsequent implementation strategies. The assessment is available to receive public comment or feedback on the report findings on the Methodist website (**www.methodisthealthsystem.org/about/communityinvolvement**) or by emailing **CHNAfeedback@mhd.com**. To date Methodist has not received written input but continues to welcome feedback from the community.

Community input from interviews and focus groups organized the themes around community needs. These themes were compared to the quantitative data findings.

Methodology for Defining Community Need

Using qualitative feedback from the interviews and focus groups, as well as the health indicator data, the issues currently affecting the community served are assembled in the Health Needs Matrix below to help identify the top health needs for the community. The upper right quadrant of the matrix is where the needs identified in the qualitative data (interview and focus group feedback) and quantitative data (health indicators) converge to identify the significant health needs for this community.

The Health Needs Matrix



Information Gaps

Most public health indicators were available only at the county level. In evaluating data for entire counties versus more localized data, it was difficult to understand the health needs for specific population pockets within a county. It could also be a challenge to tailor programs to address community health needs, as placement and access to specific programs in one part of the county may or may not actually affect the population who truly need the service. The publicly available health indicator data was supplemented with Watson Health's ZIP code estimates to assist in identifying specific populations within a community where health needs may be greater.

Approach to Identify and Prioritize Significant Health Needs

In a session held with system and hospital leadership representing Methodist Charlton Medical Center, Methodist Dallas Medical Center, and Methodist Rehabilitation Hospital on May 2, 2019, significant health needs were identified and prioritized. Moderated by Watson Health, the meeting included: an overview of the CHNA process for Methodist; the methodology for determining the top health needs; the Methodist prioritization approach; and discussion of the top health needs identified for the community.

Prioritization of the health needs took place in two steps. In the first step, participants reviewed the top health needs for their community based on the Health Needs Matrix. The group then reviewed the significant health needs as determined by the upper right quadrant of the matrix and identified other significant needs from other matrix quadrants by leveraging the professional experience and community knowledge of the group via discussion.

In the second step, participants ranked the significant health needs based on the following prioritization criteria:

1. Magnitude: The need impacts a large number of people, actually or potentially.
2. 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?
3. Vulnerable Populations: There is a high need among vulnerable populations and/or vulnerable populations are adversely impacted.
4. Root Cause: The issue is a root cause of other problems, thereby possibly affecting multiple issues.

Through discussion and consensus, the group rated each of the significant health needs on each of the four identified criteria utilizing a scale of 1 (low) to 10 (high). The criteria scores summed for each need created an overall score. The list of significant health needs was then prioritized based on the overall scores. The outcome of this process, the list of prioritized health needs for this community, is located in the "**Prioritized Significant Health Needs**" section of the assessment.

The prioritized list of significant health needs was approved by the hospitals' governing body and the full assessment is available to anyone at no cost. To download a copy, visit **www.methodisthealthsystem.org/about/communityinvolvement**.

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:

1. 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.
2. Feasibility: Ensure needs are amenable to interventions, acknowledge resources needed, and determine if need is preventable.
3. Quick Success & Impact: Ability to obtain quick success and make an impact in the community.

Through discussion and consensus, the group rated a subset of the prioritized health needs on each of the three identified criteria utilizing a scale of 1 (low) to 10 (high). The criteria scores summed for each need, created an overall score. The list of prioritized health needs was then ranked based on the overall scores. The health needs selected by participants, which will be addressed via implementation strategies, are located in the "**Health Needs to be Addressed by Methodist**" section of the assessment.

Existing Resources to Address Health Needs

Part of the assessment process included gathering input on community resources potentially available to address the significant health needs identified through the CHNA. Qualitative assessment participants identified community resources that may assist in addressing the health needs identified for this community. A description of these resources is in **Appendix B**.

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

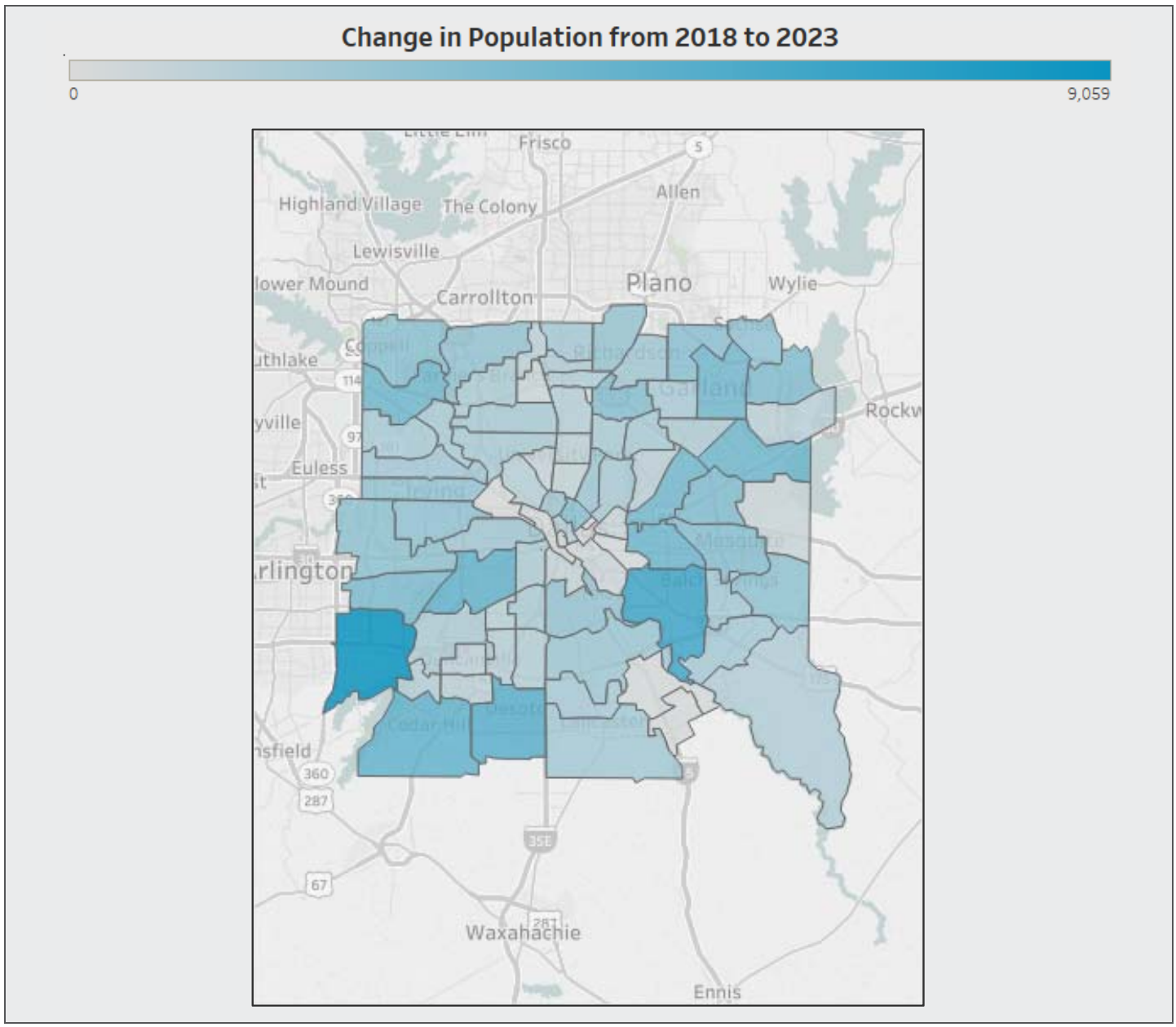
Geography		Benchmarks		Community Served
		United States	Texas	
Total Current Population		326,533,070	28,531,631	2,685,226
5 Yr Projected Population Change		3.5%	7.1%	6.6%
Median Age		42.0	38.9	34.7
Population 0-17		22.6%	25.9%	26.5%
Population 65+		15.9%	12.6%	10.7%
Women Age 15-44		19.6%	20.6%	21.6%
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

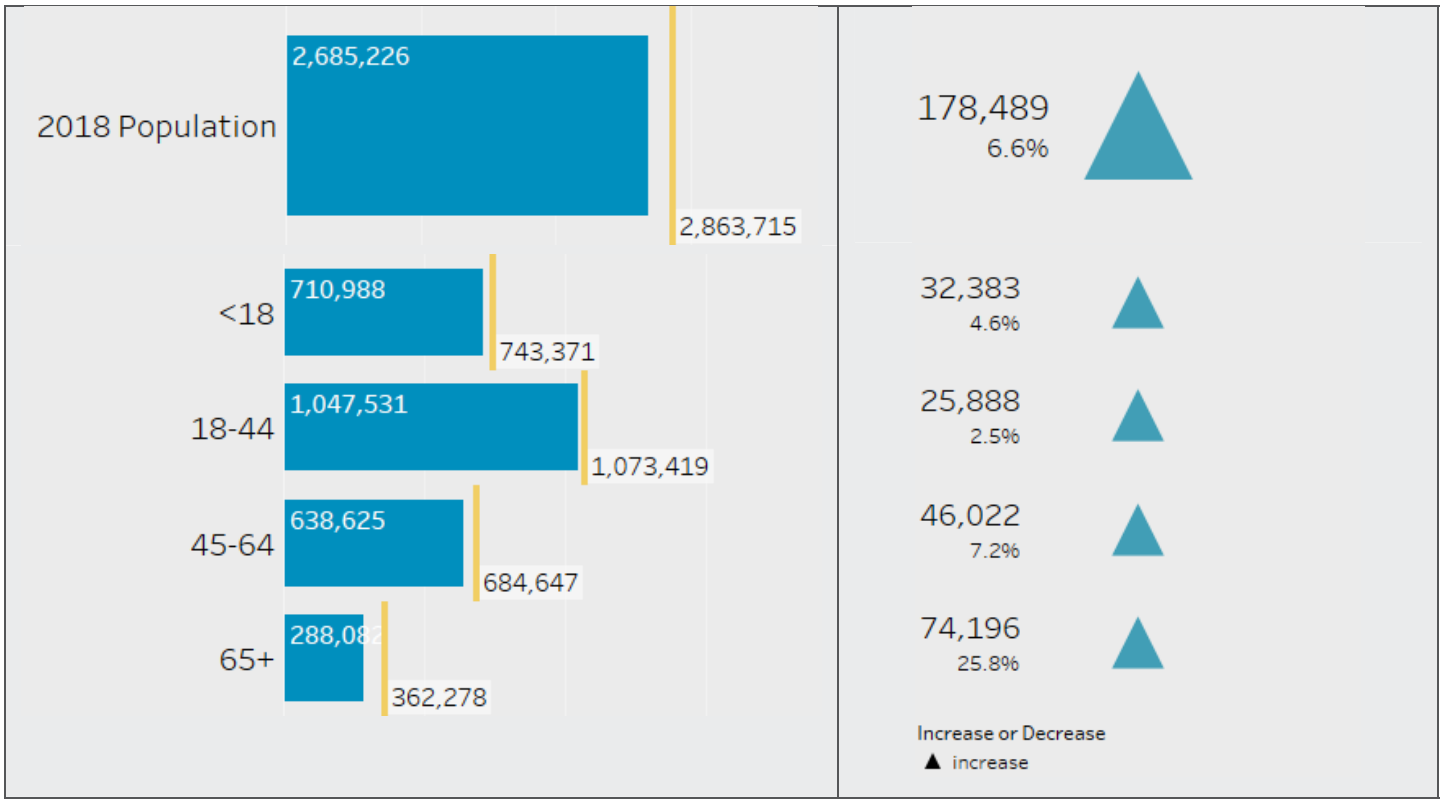


Source: IBM Watson Health / Claritas, 2018

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*

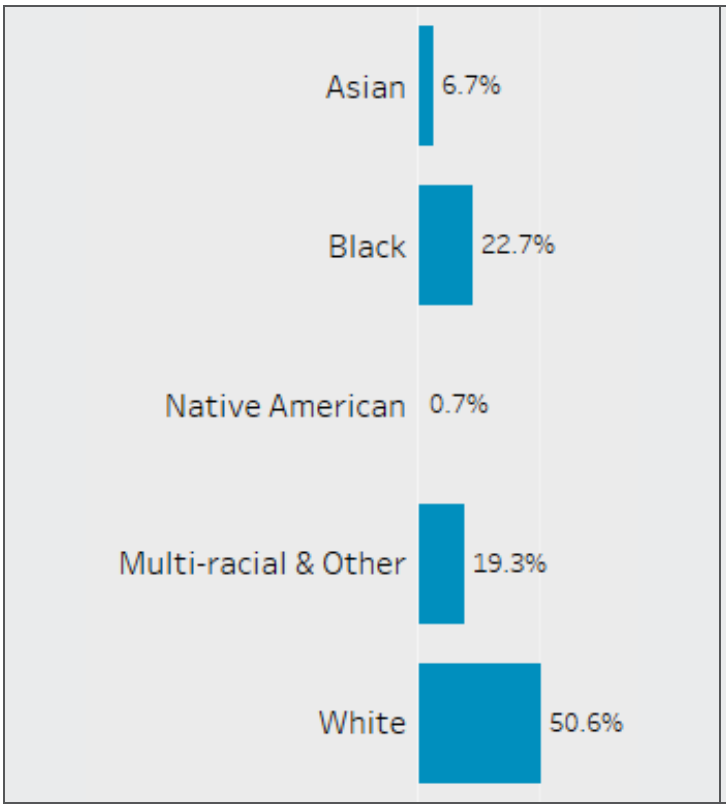


Source: IBM Watson Health / Claritas, 2018

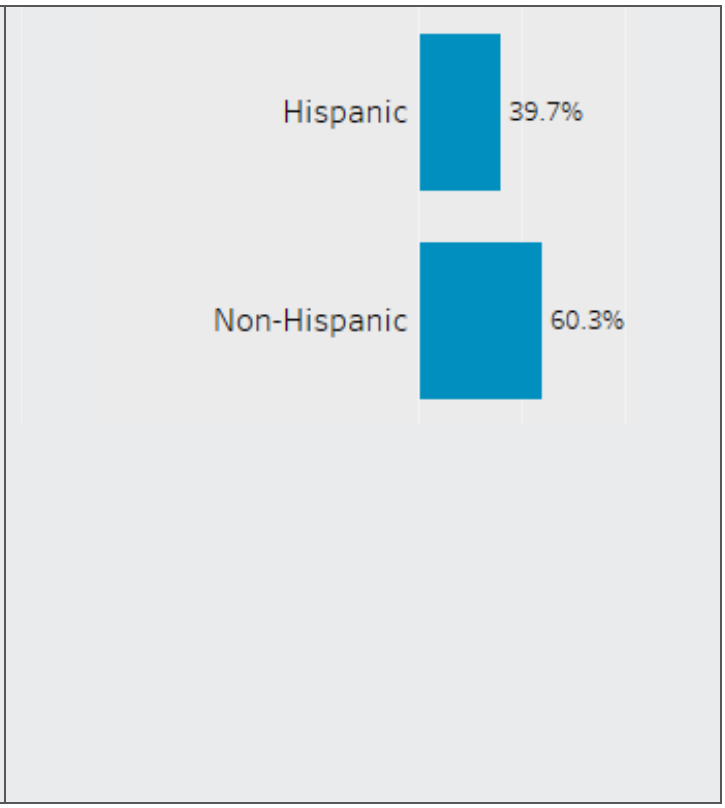
Population statistics are analyzed by race and by Hispanic ethnicity. The largest groups in the community were White Non-Hispanic (29.4%), Black Non-Hispanic (22.3%), and White Hispanic (21.2%). The expected growth rate of the Hispanic population (all races) is almost 106,000 people (9.9%) by 2023, while 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

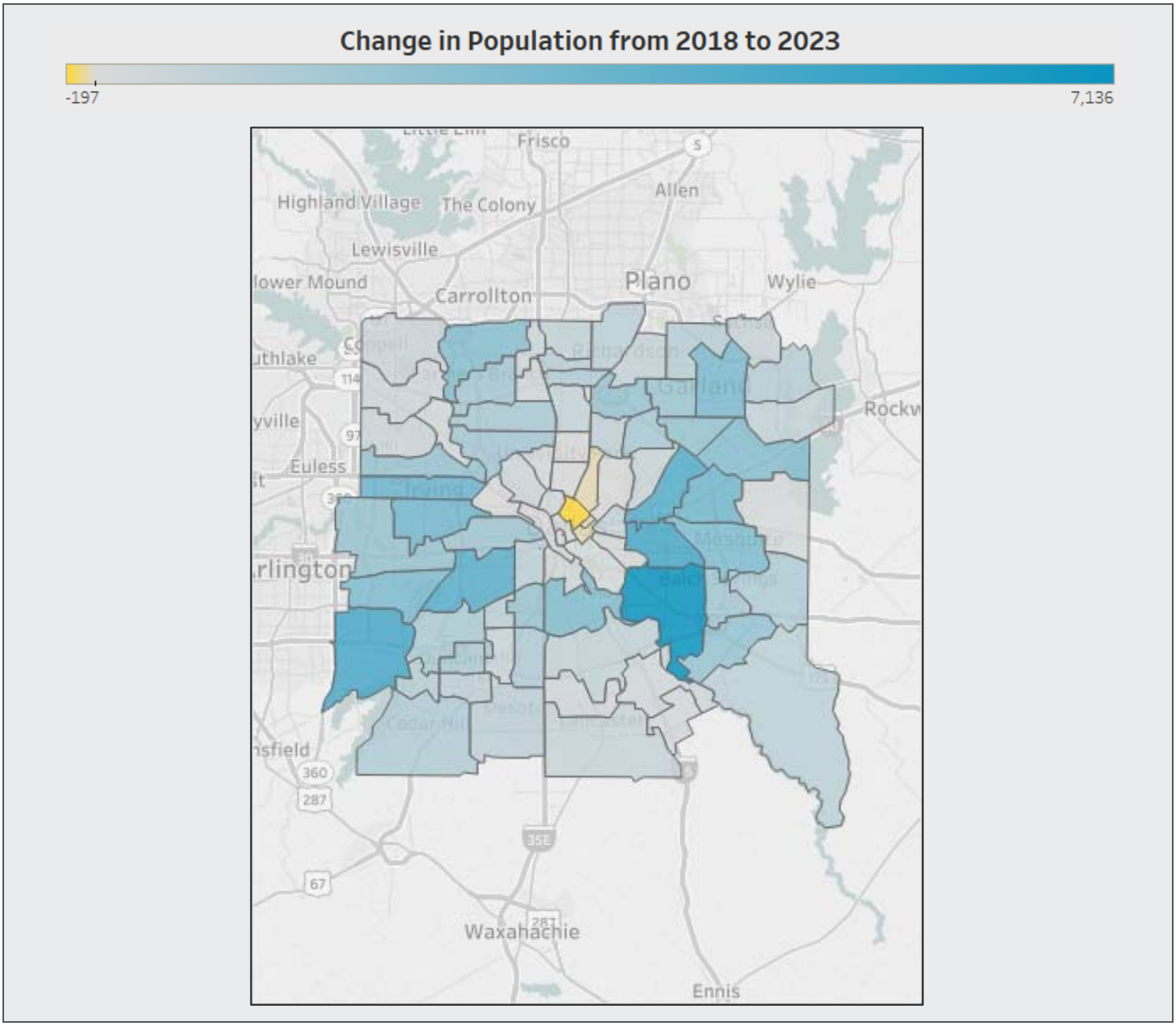


2018 Population by Ethnicity



Source: IBM Watson Health / Claritas, 2018

2018 - 2023 Hispanic Population Projected Change by ZIP Code

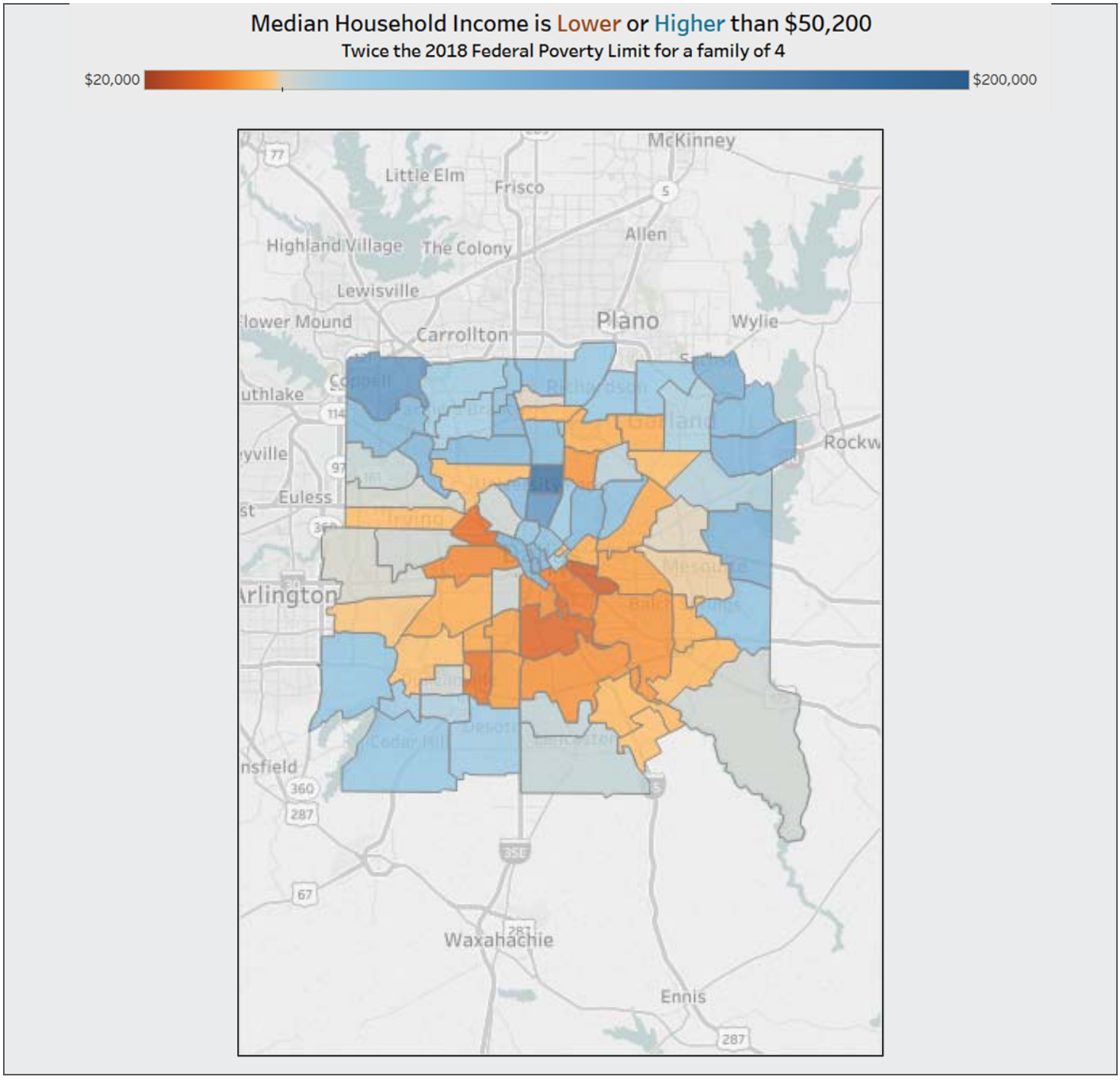


Source: IBM Watson Health / Claritas, 2018

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

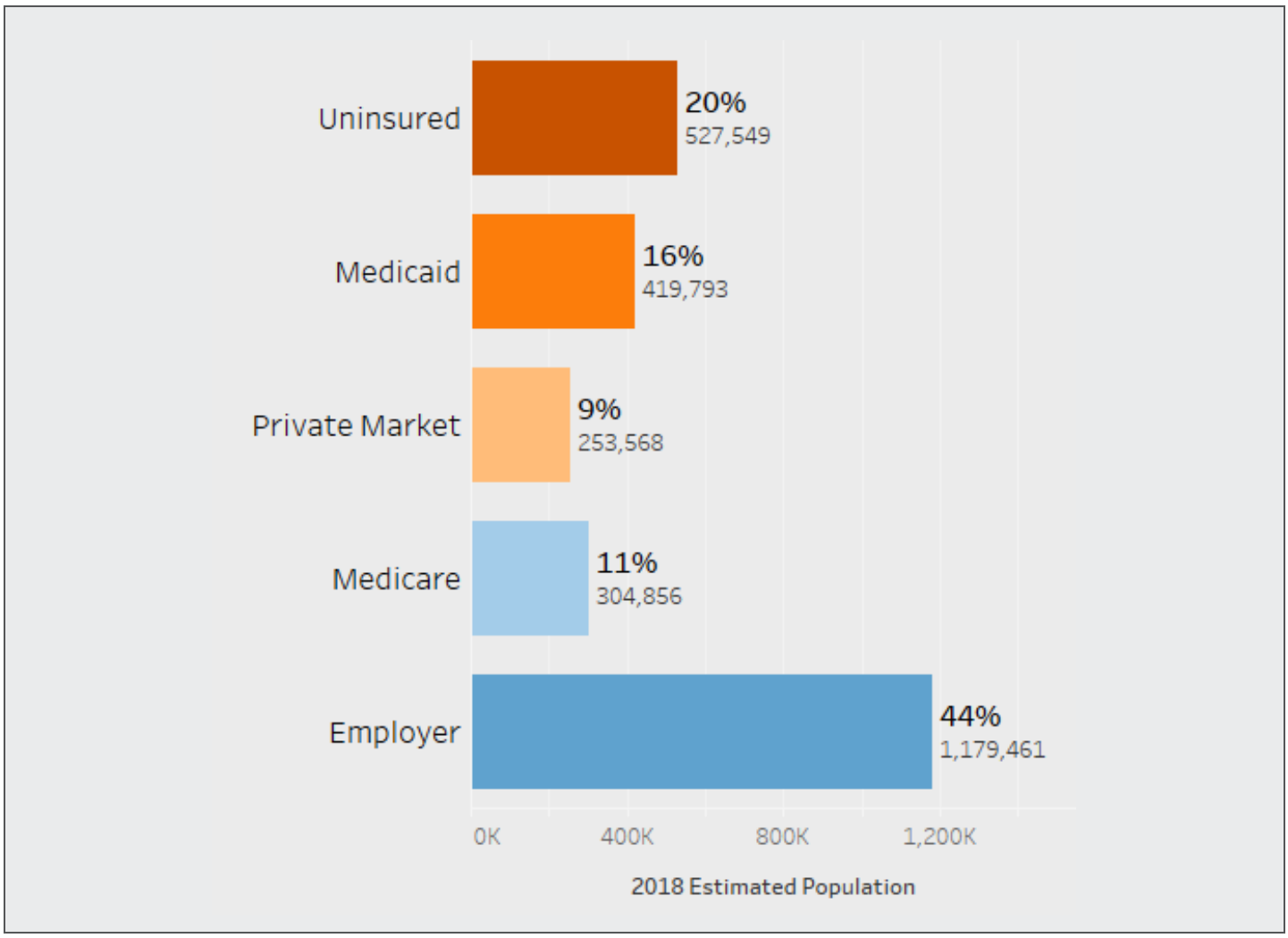
2018 Median Household Income by ZIP Code



Source: IBM Watson Health / Claritas, 2018

The largest segment of population (44%) were 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.[1] **Appendix C** includes the details on each of these designations.

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**

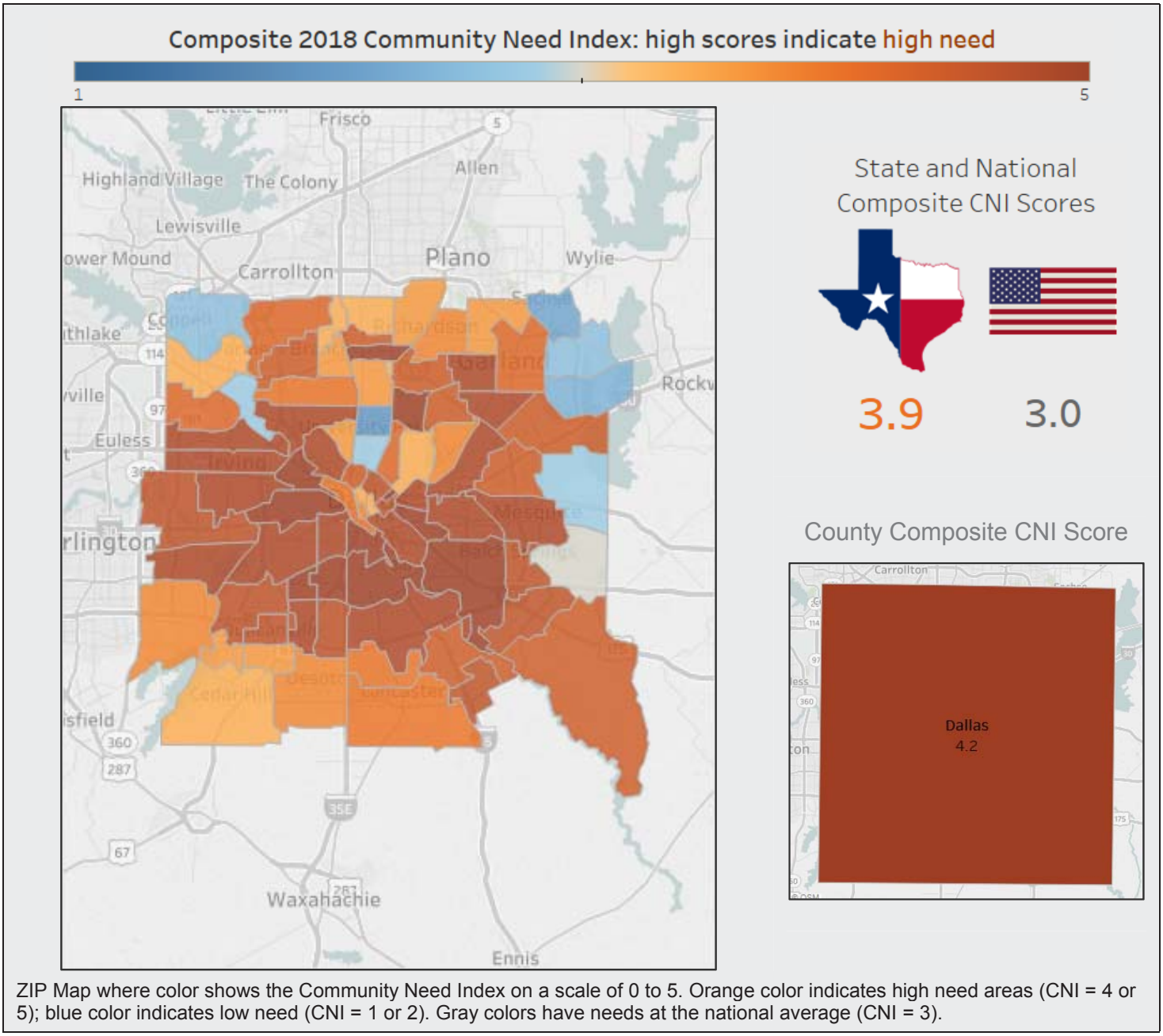
Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, https://data.hrsa.gov/tools/shortage-area

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.

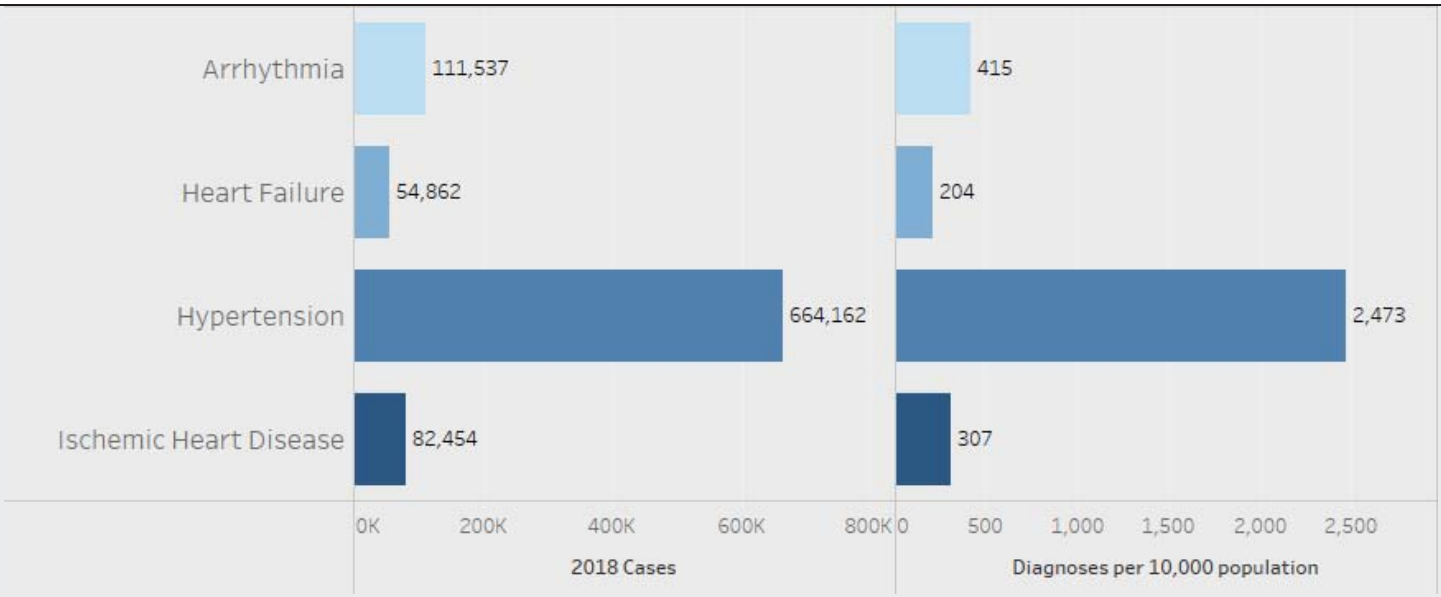
Where the community indicators showed greater need when compared to the state of Texas comparative benchmark, the difference between the community values and the state benchmark was calculated (need differential). Those highest ranked indicators with need differentials in the 50th percentile of greater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

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

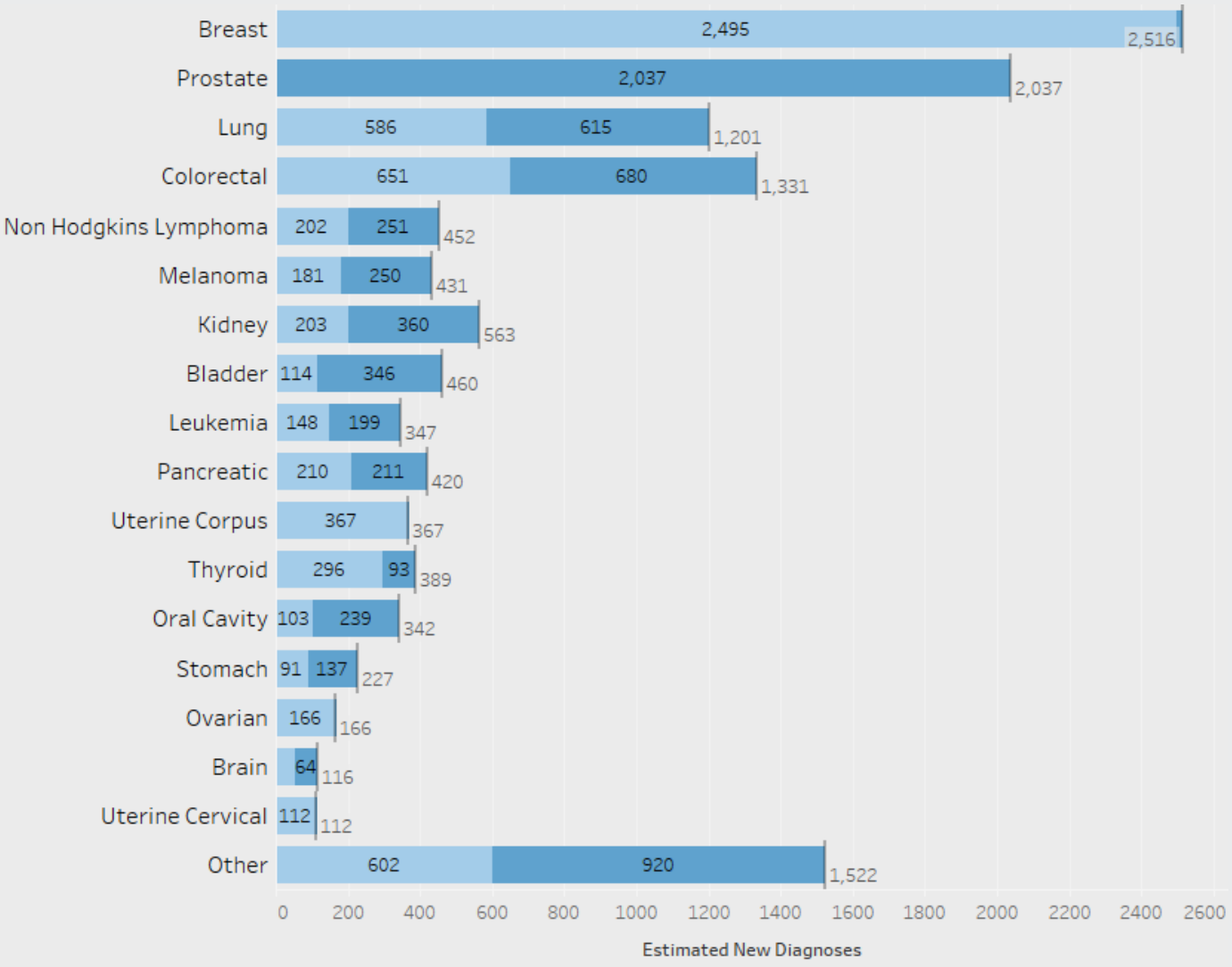


Bar chart shows total number and prevalence rate of 2018 Estimated Heart Disease cases for each of four types: arrhythmia, heart failure, hypertension, and ischemic heart disease

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

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%**

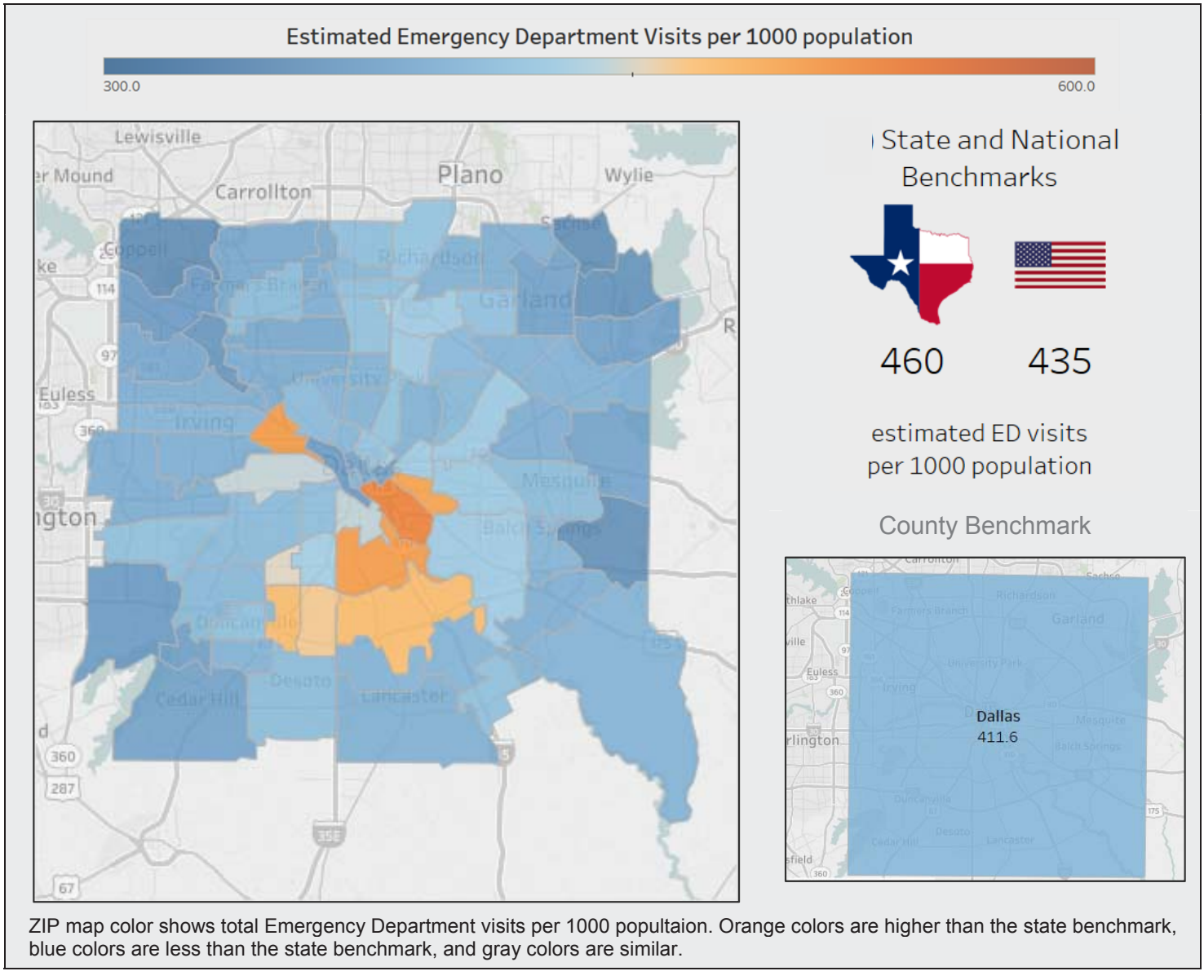
Source: IBM Watson Health, 2018

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.

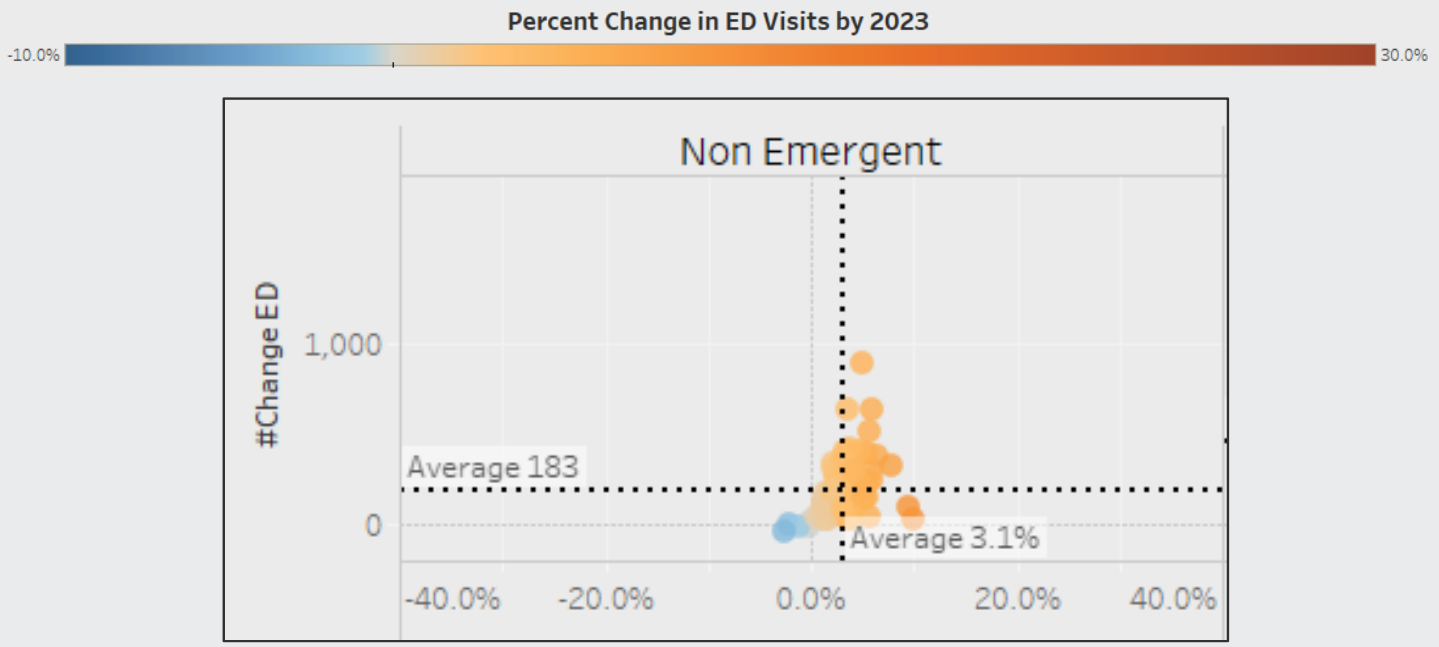
Non-emergent outpatient ED visits could be an indication of systematic issues within the community regarding access to primary care, managing chronic conditions, or other access to care issues such as ability to pay. Watson Health estimated non-emergent ED visits to increase by an average of 3.1% over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

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

Focus Groups & Interviews

Methodist worked jointly with Parkland Health & Hospital System, Texas Health Resources, and Baylor Scott & White Health hospital facilities in collecting and sharing qualitative data (community input) on the health needs of this community.

In the focus group sessions and interviews, participants identified and discussed the factors that contribute to the current health status of the community, and then identified the greatest barriers and strengths that contribute to the overall health of the community. For this health community there were two focus group sessions with a total of 22 participants and five (5) interviews were conducted July 2018 through March 2019.

In this health community, the top health needs identified in the discussions included:

- Lack of access to government healthcare, no Medicaid expansion
- Access to jobs and availability of living wage for patients
- Collaboration between providers, accountability of population
- Safe public transportation
- Navigating services
- Language barriers/cultural differences

Dallas was a melting pot of ethnicities and neighborhoods, each with different assets and health care needs. The predominantly urban area was a culturally and economically diverse area with strong community and networks but challenged with high poverty levels and growing homelessness. Companies were moving into the northern areas, such as Frisco and Plano, but the downtown area south of I40 lacked resources and was characterized by concentrated poverty and segregation. The area was rich with non-profits and service organizations, but services were often uncoordinated and underutilized. For those with insurance and means, there was access to high quality health care and specialists. The potential for infrastructure investment and coordination was high in this transitioning and gentrifying community.

Public transportation was extremely limited and compounded challenges to residents without a car. The focus groups described a local culture of generational habits and limited knowledge about healthy eating habits. The food pantries were working to alleviate hunger and to provide healthier and fresh food options; language and culture were barriers to developing trust and increased access. Culturally, the group noted that the Latino population would benefit from more nutritional education. There were food deserts in Dallas County, and some residents used local convenience stores and inexpensive fast food frequently, both poor nutrition options.

Focus groups shared that the diversity in the community also presented barriers to good health. Cultural and historical habits in the immigrant populations and lack of cultural sensitivity in providers contributed to a culture of distrust of outsiders. Combined with very limited public transportation, food deserts, and lack of insurance, many residents had no access to preventive services or primary care and used the ED for medical services. There was a need for education and resources to understand how to access care.

One of the primary barriers to good health in this community was the lack of living wage jobs to pay for insurance, health services, medications, housing, and healthy food. The focus group pointed to many areas of South Dallas that were available for development and investment. Lack of insurance was often mentioned by the focus group as a big issue in the area. Many residents worked but didn't have health insurance, part of the "working poor" population. Many hourly workers could not afford to take off work to attend to health needs.

Participants identified gaps in service in all clinical areas; primary care, maternal care, vision, dental, specialty, wellness clinics, geriatric specialists, and behavioral health care were the most acute. The needs for mental health services were frequently mentioned as a high need area; there was limited coordination of available services, the topic was highly stigmatized, very few services were available, and it affected all age groups. Focus group participants called out the need for increased space for residents to receive mental health treatment as well as increased funding.

Prioritized Significant Health Needs

The Health Needs Matrix identified through the community health needs assessment (see Methodology for Defining Community Need section) shows the convergence of needs identified in the qualitative data (interview and focus group feedback) and quantitative data (health indicators). The significant health needs for this community were identified, reviewed, and prioritized by Methodist leadership (see Approach to Identify and Prioritize Significant Health Needs section) and the resulting prioritized health needs for this community were:

Significant Community Health Needs Identified

Priority	Needs Identified	Category of Need	Public Health Indicator
1	Mental Health	Mental Health	Ratio of Population to One Mental Health Provider
1	Mental Health	Mental Health	Frequent Mental Distress
1	Mental Health	Mental Health	Intentional Self-Harm; Suicide
1	Diabetes	Chronic Conditions	Diabetes Prevalence
1	Obesity	Chronic Conditions	Adult Obesity (Percent)
1	HIV	Infectious Disease	HIV Prevalence
1	Food Insecurity	Environment	Food Insecurity (Hunger)
2	Poverty	Social Determinants of Health	Individuals Living Below the Poverty Level
2	Poverty	Social Determinants of Health	Children in Poverty
2	Stroke	Chronic Conditions	Stroke Mortality Rate
2	Hypertension	Chronic Conditions	Hypertension in Medicare Population
3	Diabetes	Chronic Conditions	Diabetes Short-term Complications Admission: Pediatric (Risk Adjusted)
4	Poverty	Social Determinants of Health	Children Eligible for Free Lunch Enrolled in Public Schools
5	Uninsured Population	Access to Care	Percent of Population under Age 65 without Health Insurance
6	Uninsured Population	Access to Care	Uninsured Children
7	Infant Mortality	Injury and Death - Children	Infant Mortality Rate
8	Housing	Environment	Severe Housing Problems
8	Drug Overdose Deaths	Health Behaviors - Substance Abuse	Drug Poisoning Death Rate
8	Drug Overdose Deaths - Opioids	Health Behaviors - Substance Abuse	Accidental Poisoning Deaths where Opioids were Involved

Priority	Needs Identified	Category of Need	Public Health Indicator
9	Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	Motor Vehicle Driving Deaths with Alcohol Involvement
9	Child Mortality	Injury and Death - Children	Child Mortality Rate
10	Transportation	Access to Care	No Vehicle Available
11	Perforated Appendix Admission	Preventable Hospitalizations	Perforated Appendix Admission: Pediatric (Risk-Adjusted Rate for Appendicitis)
11	Perforated Appendix Admission	Preventable Hospitalizations	Perforated Appendix Admission: Adult (Risk-Adjusted Rate per 100 Admissions for Appendicitis)
12	Housing	Environment	Renter-Occupied Housing
13	Language Barriers	Social Determinants of Health	Non-English Speaking Households

Source: IBM Watson Health, 2019

Health Needs to be Addressed by Methodist

Using the approach outlined in the methodology section of this report (see *Selecting the Health Needs to be Addressed by Methodist* section), participants from Methodist Charlton Medical Center, Methodist Dallas Medical Center, and Methodist Rehabilitation Hospital collectively rated, ranked, and selected the following significant needs to be addressed by implementation strategies:

1. Hypertension
2. Stroke
3. Diabetes
4. HIV

Description of Needs to be Addressed by Methodist

The CHNA process identified significant community health needs that can be categorized as chronic conditions and infectious diseases, specifically hypertension and heart disease, stroke, diabetes, and HIV prevalence. Regionalized health needs affect all age levels to some degree; however, it is often the most vulnerable populations that are negatively affected. Community health gaps help to define the resources and access to care within the county or region. Health and social concerns were validated through key informant interviews, focus groups and county data. The health needs selected by Methodist to be addressed are briefly described below with public health indicator and benchmark information.

Hypertension

Hypertension is another name for high blood pressure and the most common cardiovascular disease. Hypertension affects one in four adults in the United States. In Dallas County, Texas, 59% of adults under 65 years of age have had a hypertension diagnoses and 69% of those over 65 years old have hypertension.[2] Blood pressure is the force of blood pushing against the artery walls. High blood pressure will damage blood vessels similar to high pressure in tires, and hoses. High blood pressure can lead to life-threatening conditions like heart disease and stroke. In Dallas County, Texas, the mortality rate from heart disease is 180 per 100,000, or 5.3% higher than the state benchmark.[3]

Hypertension is more prevalent in people with a family history of high blood pressure and those with heart disease or diabetes. Hypertension is also more likely in African-Americans, those who are inactive or overweight, smokers and those who abuse alcohol.[4] Excess salt intake and taking anti-inflammatory medications, decongestants and cocaine can increase blood pressure.

Treatment of hypertension is multi-factorial and includes preventative health care visits, managing diet, stress, increased activity and including the use of anti-hypertensive medications, when prescribed by providers. Cities and states should monitor the incidence of hypertension in the communities and work with community health partners to improve the health of community members by providing routine health screenings, preventative care and access to activity and cost-effective medications.

Stroke

On average someone is the United States is having a stroke every 40 seconds. Strokes can and do occur at any age and nearly one fourth of strokes occur in people under the age of 65. Stroke is the third leading cause of death in the U.S. and in Texas.[5] Nearly three-quarters of all strokes occur in people over the age of 65. The risk of having a stroke more than doubles each decade after the age of 55. Stroke morbidity causes serious, long-term disability and each year over 795,000 people suffer a stroke and 140,000 die from the event.[6] In Dallas County, the stroke mortality rate is 43.9 per 100,000, almost 10% higher than the Texas state benchmark.[7]

A stroke is a sudden interruption in the blood supply of the brain. 80% of strokes are caused by an abrupt blockage of arteries leading to the brain; hemorrhagic stroke is when a blood vessel bursts leading to bleeding into brain tissue. All strokes are considered a medical emergency and people experiencing symptoms such as slurred speech, facial drooping, loss of balance or vision should seek medical attention immediately. Time is of the essence with stroke diagnosis and treatment.

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[2] https://www.countyhealthrankings.org/app/texas/2019/measure/outcomes/1/map
[3] 2013 Texas Health Data, Center for Health Statistics, Texas Department of State Health Services
[4] https://www.cdc.gov/bloodpressure/
[5] https://www.dshs.texas.gov/heart/Texas-Heart-Disease-and-Stroke-Program---Home.aspx
[6] http://www.strokecenter.org/patients/about-stroke/stroke-statistics/
[7] 2013 Texas Health Data, Center for Health Statistics, Texas Department of State Health Services

Identifying and eliminating risk factors associated with stroke are essential to decrease incidence of events. High blood pressure is the most common risk for stroke. Weight management, diet, exercise and the use of prescribed medications are essential for health. Stroke deaths are higher for African-Americans than whites, even at younger ages. Smokers have double the risk of having an ischemic stroke than non-smokers, even when risk adjusted for other factors. People experiencing atrial fibrillation (AF) have a five-fold increase in stroke risk. Stroke deaths and mortality have been decreasing over the last two decades and is highly correlated to education, awareness, and medical management improvement.[8]

Diabetes

Diabetes is the condition in which the body does not properly process food for use as energy. Most of the food we eat is turned into glucose, or sugar, for our bodies to use for energy. The pancreas makes a hormone called insulin to help glucose get into the cells of our bodies. When you have diabetes, your body either doesn't make enough insulin or can't use its own insulin as well as it should. There are several types of diabetes so treatments along with management vary by diagnosis. Diabetes can cause serious health complications including heart disease, blindness, kidney failure, and lower-extremity amputations.

Diabetes is a national crisis affecting more than 30 million Americans, another 84 million have pre-diabetes, high blood sugar levels but not high enough to cause type 2 diabetes. Diabetes was the seventh leading cause of death in the United States in 2015. In the last 20 years, the number of adults diagnosed with diabetes has more than tripled as the U.S. population has aged and become more overweight.[9] The risk-adjusted rate for pediatric hospital admissions due to complications from diabetes is 27 per 100,000 people, almost 15% higher than the Texas benchmark.[10]

The Centers for Disease Control (CDC) supports national, community, and faith organizations; state and local health departments; tribes; and other partners to prevent or delay type 2 diabetes, improve diabetes care and self-management, and prevent or reduce the severity of diabetes complications. Diabetes not only has significant health risks, economically the impact of diabetes is extraordinary.[11] The estimated cost of diagnosed diabetes in the U.S. in 2012 was $245 billion. Average medical expenditures attributed to diabetes care and management was $7,900 per year. The cost of diabetes medication and supplies is a struggle for people with the disease.[12]

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[8] http://www.strokecenter.org/patients/about-stroke/stroke-statistics/
[9] https://www.cdc.gov/chronicdisease/resources/publications/aag/diabetes.htm
[10] 2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
[11] https://gis.cdc.gov/grasp/diabetes/diabetesatlas.html
[12] American Diabetes Association. Economic costs of diabetes in the U.S. in 2012. Diabetes Care. 2013;36(4):1033–1046.

HIV

HIV stands for Human Immunodeficiency Virus. This particular virus can infect only humans and weakens your immune system by destroying important cells that fight disease and infection. At the end of 2012, about 1.2 million people in the United States were living with HIV. There are multiple factors that influence the risk of becoming infected with the HIV virus including the status of sex partners, risk behaviors, and where you live. In 2017, southern states had the highest rate of HIV per 100,000 people. Texas was 15.4 per 100,000 people and Georgia had the highest rate at 24.9.[13]

In Dallas County, the HIV prevalence rate is 798 per 100,000 people, which is 116% above the Texas state benchmark. This indicator was ranked the highest need from a data perspective in Dallas County.[14]

Overall in the U.S., the majority of people who receive an HIV diagnosis live in urban areas. However, in the south, 23% of new diagnoses are in suburban and rural areas. The South's larger and more geographically dispersed population of people living with HIV creates unique challenges for prevention and treatment. Understanding the places and populations that are most affected by HIV allows federal and local governments to allocate its resources to the geographic areas where they are needed most. It is essential for communities and healthcare providers to support a basic level of HIV education and prevention.

Overall, the number of people who have HIV has been increasing each year because people with HIV are now living longer and the number of new HIV diagnoses has been static the last few years. An HIV diagnosis requires proper medical care and medication that needs to be taken for the rest of your life. Antiretroviral therapy (ART) when taken as prescribed, dramatically prolongs the lives of those affected with HIV.[15] Today, someone diagnosed with HIV and treated before the disease is far advanced can live nearly as long as someone who does not have HIV.

Summary

Methodist conducted its Community Health Needs Assessments beginning June 2018 to identify and begin addressing the health needs of the communities they serve. Using both qualitative community feedback as well as publicly available and proprietary health indicators, Methodist was able to identify and prioritize community health needs for their healthcare system. 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 chose to address for the community served.

[13] https://www.cdc.gov/hiv/statistics/overview/geographicdistribution.html
[14] 2018 County Health Rankings & Roadmaps; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)
[15] https://www.cdc.gov/hiv/statistics/overview/ataglance.html

Appendix A: Key Health Indicator Sources

Category	Public Health Indicator	Source
Access to Care	Hospital Stays for Ambulatory-Care Sensitive Conditions- Medicare	2018 County Health Rankings & Roadmaps; Dartmouth Atlas of Health Care, CMS
	Percentage of Population under age 65 without Health Insurance	2018 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau
	Price-Adjusted Medicare Reimbursements per Enrollee **NEW 2019**	2018 County Health Rankings & Roadmaps; Dartmouth Atlas of Health Care, CMS
	Ratio of Population to One Dentist	2018 County Health Rankings & Roadmaps; Area Health Resource File/National Provider Identification file (CMS)
	Ratio of Population to One Non-Physician Primary Care Provider	2018 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)
	Ratio of Population to One Primary Care Physician	2018 County Health Rankings & Roadmaps; Area Health Resource File/American Medical Association
	Uninsured Children	2018 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau
Conditions/Diseases	Adult Obesity (Percent)	2018 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System
	Arthritis in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Atrial Fibrillation in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Cancer Incidence - All Causes	2011-2015 State Cancer Profiles, National Cancer Institute (CDC)
	Cancer Incidence - Colon	2011-2015 State Cancer Profiles, National Cancer Institute (CDC)
	Cancer Incidence - Female Breast	2011-2015 State Cancer Profiles, National Cancer Institute (CDC)
	Cancer Incidence - Lung	2011-2015 State Cancer Profiles, National Cancer Institute (CDC)
	Cancer Incidence - Prostate	2011-2015 State Cancer Profiles, National Cancer Institute (CDC)
	Chronic Kidney Disease in Medicare Population	CMS.gov Chronic conditions 2007-2015
	COPD in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Diabetes Diagnoses in Adults	CMS.gov Chronic conditions 2007-2015
	Diabetes prevalence	2018 County Health Rankings (CDC Diabetes Interactive Atlas)
	Frequent physical distress	2016 Behavioral Risk Factor Surveillance System (BRFSS)
	Heart Failure in Medicare Population	CMS.gov Chronic conditions 2007-2015
	HIV Prevalence	2018 County Health Rankings & Roadmaps; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)
	Hyperlipidemia in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Hypertension in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Ischemic Heart Disease in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Osteoporosis in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Stroke in Medicare Population	CMS.gov Chronic conditions 2007-2015
Environment	Air Pollution - Particulate Matter daily density	2018 County Health Rankings & Roadmaps; Environmental Public Health Tracking Network (CDC)
	Drinking Water Violations (Percent of Population Exposed)	2018 County Health Rankings & Roadmaps; Safe Drinking Water Information System (SDWIS), United States Environmental Protection Agency (EPA)

Appendix A: Key Health Indicator Sources

Category	Public Health Indicator	Source
	Driving Alone to Work	2018 County Health Rankings & Roadmaps; American Community Survey, 5-Year Estimates, United States Census Bureau
	Elderly isolation. 65+ Householder living alone **NEW 2019**	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
	Food Environment Index	2018 County Health Rankings & Roadmaps; USDA Food Environment Atlas, Map the Meal Gap from Feeding America, United States Department of Agriculture (USDA)
	Food Insecure	2018 County Health Rankings & Roadmaps; Map the Meal Gap, Feeding America
	Limited Access to Healthy Foods (Percent of Low Income)	2018 County Health Rankings & Roadmaps; USDA Food Environment Atlas, United States Department of Agriculture (USDA)
	Long Commute Alone	2018 County Health Rankings & Roadmaps; American Community Survey, 5-Year Estimates, United States Census Bureau
	No vehicle available **NEW 2019**	U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates
	Population with Adequate Access to Locations for Physical Activity	2018 County Health Rankings & Roadmaps; Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files (ArcGIS)
	Renter-occupied housing **NEW 2019**	U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates
	Residential segregation - black/white **NEW 2019**	2018 County Health Rankings (American Community Survey, 5-year estimates)
	Residential segregation - non-white/white **NEW 2019**	2018.County Health Rankings (American Community Survey, 5-year estimates)
	Severe Housing Problems	2018 County Health Rankings & Roadmaps; Comprehensive Housing Affordability Strategy (CHAS) data, U.S. Department of Housing and Urban Development (HUD)
Health Behaviors	Adult Smoking	2018 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)
	Adults Engaging in Binge Drinking During the Past 30 Days	2018 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)
	Disconnected youth **NEW 2019**	2018 County Health Rankings (Measure of America)
	Drug Poisoning Deaths Rate	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Insufficient sleep **NEW 2019**	2016 Behavioral Risk Factor Surveillance System (BRFSS)
	Motor Vehicle Driving Deaths with Alcohol Involvement	2018 County Health Rankings & Roadmaps; Fatality Analysis Reporting System (FARS)
	Physical Inactivity	2018 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System
	Sexually Transmitted Infection Incidence	2018 County Health Rankings & Roadmaps; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)
	Teen Birth Rate per 1,000 Female Population, Ages 15-19	2018 County Health Rankings & Roadmaps; National Center for Health Statistics - Natality files, National Vital Statistics System (NVSS)
Health Status	Adults Reporting Fair or Poor Health	2018 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)
	Average Number of Physically Unhealthy Days Reported in Past 30 days (Age-Adjusted)	2018 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)
Injury & Death	Cancer Mortality Rate	2013 Texas Health Data, Center for Health Statistics, Texas Department of State Health Services
	Child Mortality Rate	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Chronic Lower Respiratory Disease (CLRD) Mortality Rate	2013 'Texas Health Data, Center for Health Statistics, Texas Department of State Health Services
	Death rate due to firearms **NEW 2019**	2018 County Health Rankings (CDC WONDER Environmental Data)

Appendix A: Key Health Indicator Sources

Category	Public Health Indicator	Source
	Heart Disease Mortality Rate	2013 Texas Health Data, Center for Health Statistics, Texas Department of State Health Services
	Infant Mortality Rate	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Motor Vehicle Crash Mortality Rate	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Number of deaths due to injury **NEW 2019**	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Premature Death (Potential Years Lost)	2018 County Health Rankings & Roadmaps; National Center for Health Statistics - Mortality Files, National Vital Statistics System (NVSS)
	Stroke Mortality Rate	2013 Texas Health Data, Center for Health Statistics, Texas Department of State Health Services
Maternal & Child Health	First Trimester Entry into Prenatal Care	2016 Texas Health and Human Services - Vital statistics annual report
	Low Birth Weight Percent	2018 County Health Rankings & Roadmaps; National Center for Health Statistics - Natality files, National Vital Statistics System (NVSS)
	Low Birth Weight Rate	2016 Texas Health and Human Services - Vital statistics annual report - Preventable Hospitalizations
	Preterm Births <37 Weeks Gestation	2015 Kids Discount Data Center
	Very Low Birth Weight (VLBW)	Centers for Disease Control and Prevention WONDER
Mental Health	Accidental poisoning deaths where opioids were involved **NEW 2019**	U.S. Census Bureau, Population Division and 2015 Texas Health and Human Services Center for Health Statistics Opioid related deaths in Texas
	Alzheimer's Disease/Dementia in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Average Number of Mentally Unhealthy Days Reported in Past 30 days (Age-Adjusted)	2018 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)
	Depression in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Frequent mental distress	2016 Behavioral Risk Factor Surveillance System (BRFSS)
	Intentional Self-Harm; Suicide **NEW 2019**	2015 Texas Health Data Center for Health Statistics
	Ratio of Population to one Mental Health Provider	2018 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)
	Schizophrenia and Other Psychotic Disorders in Medicare Population	CMS.gov Chronic conditions 2007-2015
Population	Children Eligible for Free Lunch Enrolled in Public Schools	2018 County Health Rankings & Roadmaps, The National Center for Education Statistics (NCES)
	Children in Poverty	2018 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau
	Children in Single-Parent Households	2018 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)
	Civilian veteran population 18+ **NEW 2019**	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
	Disabled population, civilian noninstitutionalized	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

Appendix A: Key Health Indicator Sources

Category	Public Health Indicator	Source
	High School Dropout	2016 Texas Education Agency
	High School Graduation	2017 Texas Education Agency
	Homicides	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Household income, median **NEW 2019**	2018 County Health Rankings (2016 Small Area Income and Poverty Estimates)
	Income Inequality	2018 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)
	Individuals Living Below Poverty Level	2012-2016 US Census Bureau - American FactFinder
	Individuals Who Report Being Disabled	2012-2016 US Census Bureau - American FactFinder
	Non-English-speaking households **NEW 2019**	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
	Social/Membership Associations	2018 County Health Rankings & Roadmaps; 2015 County Business Patterns, United States Census Bureau
	Some College	2018 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)
	Unemployment	2018 County Health Rankings & Roadmaps; Local Area Unemployment Statistics (LAUS), Bureau of Labor Statistics
	Violent Crime Offenses	2018 County Health Rankings & Roadmaps; Uniform Crime Reporting (UCR) Program, United States Department of Justice, Federal Bureau of Investigation (FBI)
Preventable Hospitalizations	Asthma Admission: Pediatric (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Diabetes Lower-Extremity Amputation Admission: Adult (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Diabetes Short-term Complications Admission: Pediatric (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Gastroenteritis Admission: Pediatric (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Perforated Appendix Admission: Adult (Risk-Adjusted-Rate per 100 Admissions for Appendicitis)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Perforated Appendix Admission: Pediatric (Risk-Adjusted-Rate for Appendicitis)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Uncontrolled Diabetes Admission: Adult (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Urinary Tract Infection Admission: Pediatric (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
Prevention	Diabetic Monitoring in Medicare Enrollees	2018 County Health Rankings & Roadmaps; Dartmouth Atlas of Health Care, CMS
	Mammography Screening in Medicare Enrollees	2018 County Health Rankings & Roadmaps; Dartmouth Atlas of Health Care, CMS

Appendix A: Key Health Indicator Sources

Category	Public Health Indicator	Source
Population	Children Eligible for Free Lunch Enrolled in Public Schools	2018 County Health Rankings & Roadmaps, The National Center for Education Statistics (NCES)
	Children in Poverty	2018 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau
	Children in Single-Parent Households	2018 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)
	Civilian veteran population 18+ **NEW 2019**	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
	Disabled population, civilian noninstitutionalized	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
	High School Dropout	2016 Texas Education Agency
	High School Graduation	2017 Texas Education Agency
	Homicides	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Household income, median **NEW 2019**	2018 County Health Rankings (2016 Small Area Income and Poverty Estimates)
	Income Inequality	2018 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)
	Individuals Living Below Poverty Level	2012-2016 US Census Bureau - American FactFinder
	Individuals Who Report Being Disabled	2012-2016 US Census Bureau - American FactFinder
	Non-English-speaking households **NEW 2019**	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
	Social/Membership Associations	2018 County Health Rankings & Roadmaps; 2015 County Business Patterns, United States Census Bureau
	Some College	2018 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)
	Unemployment	2018 County Health Rankings & Roadmaps; Local Area Unemployment Statistics (LAUS), Bureau of Labor Statistics
	Violent Crime Offenses	2018 County Health Rankings & Roadmaps; Uniform Crime Reporting (UCR) Program, United States Department of Justice, Federal Bureau of Investigation (FBI)

Appendix B: Community Resources Identified to Potentially Address Significant Health Needs

Below is a list of resources identified via community input:

Resource	County
Churches	Dallas
City of Dallas	Dallas
City Square	Dallas
Community Health Centers	Dallas
Dallas Concilio	Dallas
Dallas Housing Authority	Dallas
Dallas Life Foundation	Dallas
DART	Dallas
DCHHS	Dallas
Food Pantries	Dallas
FQHCs or charity clinics (Agape, etc.)	Dallas
Genesis Women's Shelter	Dallas
Habitat for Humanity	Dallas
Hospital and Hospital Affiliated Clinics	Dallas
Local Health Clinics	Dallas
North Texas Food Bank	Dallas
Parkland	Dallas
Parkland Irving Health Center	Dallas
Sharing Life Outreach	Dallas
St. Vincent de Paul	Dallas
The Bridge Homeless Shelter	Dallas
WIC Clinics	Dallas

Appendix C: Federally Designated Health Professional Shortage Areas and Medically Underserved Areas and Populations

Health Professional Shortage Areas (HPSA)[16]

County Name	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type
Dallas	148999485F	MLK Jr Family Center	Primary Care	Federally Qualified Health Center

Medically Underserved Areas and Populations (MUA/P)[17]

County Name	MUA/P Source Identification Number	Service Area Name	Designation Type	Rural Status
Dallas	03453	Pleasant Grove Service Area	Medically Underserved Area	Non-Rural
Dallas	03468	Dallas Service Area	Medically Underserved Area	Non-Rural
Dallas	03469	Dallas Service Area	Medically Underserved Area	Non-Rural
Dallas	03490	Dallas Service Area	Medically Underserved Area	Non-Rural
Dallas	03491	Dallas Service Area	Medically Underserved Area	Non-Rural
Dallas	03526	Dallas Service Area	Medically Underserved Area	Non-Rural
Dallas	05210	Brooks Manor Service Area	Medically Underserved Area	Non-Rural
Dallas	05211	Cedar Glenn Service Area	Medically Underserved Area	Non-Rural

[16] U.S. Department of Health and Human Services, Health Resources and Services Administration, 2018
[17] U.S. Department of Health and Human Services, Health Resources and Services Administration, 2018

Appendix C: Federally Designated Health Professional Shortage Areas and Medically Underserved Areas and Populations

County Name	MUA/P Source Identification Number	Service Area Name	Designation Type	Rural Status
Dallas	05212	Cliff Manor Service Area	Medically Underserved Area	Non-Rural
Dallas	05213	Forest Glenn Service Area	Medically Underserved Area	Non-Rural
Dallas	05214	Cedar Glenn South Service Area	Medically Underserved Area	Non-Rural
Dallas	07294	Oak Cliff Service Area	Medically Underserved Area	Non-Rural
Dallas	07392	Grand Prairie	Medically Underserved Area	Non-Rural
Dallas	07631	Cockrell Hill Service Area	Medically Underserved Area	Non-Rural
Dallas	07753	Mission East Dallas Area	Medically Underserved Population	Non-Rural
Dallas	07921	Balch Springs	Medically Underserved Area	Non-Rural
Dallas	07942	Southwest Dallas	Medically Underserved Area	Non-Rural
Dallas	07959	Lillycare Dallas	Medically Underserved Area	Non-Rural
Dallas	07973	Hutchins-Wilmer	Medically Underserved Area	Non-Rural

Appendix D: Public Health Indicators Showing Greater Need When Compared to State Benchmark

Public Health Indicator	Category	Indicator Definition
Uninsured Children	Access to Care	2015 Percentage of Children Under Age 19 Without Health Insurance
Percentage of Population under age 65 without Health Insurance	Access to Care	2015 Percentage of Population Under Age 65 Without Health Insurance
No Vehicle Available	Access to Care	2017 Percentage of Households with no Vehicle Available
Cancer Incidence - All Causes	Cancer	2011-2015 Age-Adjusted Cancer (All) Incidence Rate Cases per 100,000
Cancer Incidence - Colon	Cancer	2011-2015 Age-Adjusted Colon & Rectum Cancer Incidence Rate Cases per 100,000
Cancer Incidence - Female Breast	Cancer	2011-2015 Age-Adjusted Female Breast Cancer Incidence Rate Cases per 100,000
Cancer Incidence - Prostate	Cancer	2011-2015 Age-Adjusted Prostate Cancer Incidence Rate Cases per 100,000
Cancer Mortality Rate	Cancer	2013 All Cancer Age-Adjusted Death Rate per 100,000 (Age-Adjusted using the 2000 U.S. Standard Population)
Arthritis in Medicare Population	Chronic Condition - Arthritis	2007-2015 Prevalence of Chronic Condition Across all Medicare Beneficiaries
Heart Disease Mortality Rate	Chronic Condition - Cardiovascular	2013 Heart Disease Age-Adjusted Death Rate per 100,000 (Age-adjusted using the 2000 U.S. Standard Population)
Atrial Fibrillation in Medicare Population	Chronic Condition - Cardiovascular	2007-2015 Prevalence of Chronic Condition Across all Medicare Beneficiaries
Hyperlipidemia in Medicare Population	Chronic Condition - Cardiovascular	2007-2015 Prevalence of Chronic Condition Across all Medicare Beneficiaries
Stroke Mortality Rate	Chronic Condition - Cerebrovascular	2013 Cerebrovascular Disease (Stroke) Age-Adjusted Death Rate per 100,000 (Age-adjusted using the 2000 U.S. Standard Population)
Stroke in Medicare Population	Chronic Condition - Cerebrovascular	2007-2015 Prevalence of Chronic Condition Across all Medicare Beneficiaries
Uncontrolled Diabetes Admission: Adult (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	2016 Number Observed / Adult Population Age 18 and Older
Diabetes Short-term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	2016 Number Observed / Adult Population Age 18 and Older
Chronic Kidney Disease in Medicare Population	Chronic Condition - Kidney Disease	2007-2015 Prevalence of Chronic Condition Across all Medicare Beneficiaries

Appendix D: Public Health Indicators Showing Greater Need When Compared to State Benchmark

Public Health Indicator	Category	Indicator Definition
Adult Obesity (Percent)	Chronic Condition - Obesity	2014 Percentage of the Adult Population (Age 20 and Older) that Reports a Body Mass Index (BMI) Greater than or Equal to 30 kg/m2
Osteoporosis in Medicare Population	Chronic Condition - Osteoporosis	2007-2015 Prevalence of Chronic Condition Across all Medicare Beneficiaries
Some College	Education	2012-2016 Percentage of Adults Ages 25-44 with Some Post-Secondary Education
High School Dropout	Education	2016 Percentage of Students from the Same Class who Drop out Before Completing their High School Education
High School Graduation	Education	2016 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
Air Pollution - Particulate Matter Daily Density	Environment	2012 Average Daily Density of Fine Particulate Matter in Micrograms per Cubic Meter (PM2.5)
Food Insecure	Environment - Food	2015 Percentage of Population Who Lacked Adequate Access to Food During the Past Year
Severe Housing Problems	Environment - Housing	2010-2014 Percentage of Households with at Least 1 of 4 Housing Problems: Overcrowding, High Housing Costs, or Lack of Kitchen or Plumbing Facilities
Renter-Occupied Housing	Environment - Housing	2017 Percentage of Households that are Renter-Occupied
Homicides	Environment - Violence	2010-2016 Number of Deaths Due to Homicide, Defined as ICD-10 Codes X85-Y09, per 100,000 Population
Violent Crime Offenses	Environment - Violence	2012-2014 Number of Reported Violent Crime Offenses per 100,000 Population
Death Rate Due to Firearms	Environment - Violence	2012-2016 Number of Deaths due to Firearms per 100,000 Population
Physical Inactivity	Health Behaviors - Exercise	2014 Percentage of Adults Ages 20 and Over Reporting No Leisure-Time Physical Activity in the Past Month
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	2012-2016 Percentage of Motor Vehicle Crash Deaths that had Alcohol Involvement
Drug Poisoning Deaths Rate	Health Behaviors - Substance Abuse	2014-2016 Number of Drug Poisoning Deaths (Drug Overdose Deaths) per 100,000 Population
Adult Smoking	Health Behaviors - Substance Abuse	2016 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
Accidental Poisoning Deaths where Opioids were Involved	Health Behaviors - Substance Abuse	2010-2017 Accidental Poisoning Deaths where Opioids were Involved (Underlying Causes of Death: X40-X44, and One of the Following ICD-10 Codes

Appendix D: Public Health Indicators Showing Greater Need When Compared to State Benchmark

Public Health Indicator	Category	Indicator Definition
		Identifying Opioids: T40.0, T40.1, T40.2, T40.3, T40.4, T40.6)
Teen Birth Rate per 1,000 Female Population, Ages 15-19	Health Behaviors - Teen Pregnancy	2010-2016 Number of Births to Females Ages 15-19 per 1,000 Females in a County
Long Commute Alone	Health Status	2012-2016 Among Workers Who Commute in Their Car Alone, the Percentage that Commute More than 30 Minutes
Premature Death (Potential Years Lost)	Health Status	2014-2016 Premature Death; Years of Potential Life Lost Before Age 75 per 100,000 Population (Age-Adjusted)
Adults Reporting Fair or Poor Health	Health Status	2016 Percentage of Adults Reporting Fair or Poor Health (Age-Adjusted)
Frequent Physical Distress	Health Status	2016 Percentage of Adults who Reported ≥14 Days of Poor Physical Health in the Past 30 Days
HIV Prevalence	Infectious Disease - HIV	2015 Number of Persons Aged 13 Years and Older Living with a Diagnosis of Human Immunodeficiency Virus (HIV) Infection per 100,000 Population
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	2015 Number of Newly Diagnosed Chlamydia Cases per 100,000 Population
Infant Mortality Rate	Injury & Death - Children	2010-2016 Number of All Infant Deaths (Within 1 year), per 1,000 Live Births
Child Mortality Rate	Injury & Death - Children	2013-2016 Number of Deaths Among Children under Age 18 per 100,000
Low Birth Weight Percent	Maternal and Child Health	2010-2016 Percentage of Live Births with Low Birthweight; < 2500 Grams
Very Low Birth Weight (VLBW)	Maternal and Child Health	2016 Live Births Weighing Less than 1,500 Grams (3.4 Pounds)
Low Birth Weight Rate	Maternal and Child Health	2016 Number Observed / Adult Population Age 18 and Older
First Trimester Entry into Prenatal Care	Maternal and Child Health	2014 Percent of Births with Onset of Prenatal Care within the First Trimester
Intentional Self-Harm; Suicide	Mental Health	2015 Intentional Self-Harm (Suicide) (X60-X84, Y87.0)
Average Number of Mentally Unhealthy Days Reported in Past 30 days (Age-Adjusted)	Mental Health	2016 Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)
Frequent Mental Distress	Mental Health	2016 Percentage of Adults who Reported ≥14 Days of Poor Mental Health in the Past 30 Days

Appendix D: Public Health Indicators Showing Greater Need When Compared to State Benchmark

Public Health Indicator	Category	Indicator Definition
Depression in Medicare Population	Mental Health	2007-2015 Prevalence of Chronic Condition Across all Medicare Beneficiaries
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	2007-2015 Prevalence of Chronic Condition Across all Medicare Beneficiaries
Schizophrenia and Other Psychotic Disorders in Medicare Population	Mental Health	2007-2015 Prevalence of Chronic Condition Across all Medicare Beneficiaries
Perforated Appendix Admission: Adult (Risk-Adjusted-Rate per 100 Admissions for Appendicitis)	Preventable Hospitalizations	2016 Number Observed / Adult Population Age 18 and Older
Perforated Appendix Admission: Pediatric (Risk-Adjusted-Rate for Appendicitis)	Preventable Hospitalizations	2016 Number Observed / Adult Population Age 18 and Older
Asthma Admission: Pediatric (Risk-Adjusted-Rate)	Preventable Hospitalizations	2016 Number Observed / Adult Population Age 18 and Older
Children in Single-Parent Households	SDH	2012-2016 Percentage of Children that Live in a Household Headed by Single Parent
Individuals Living Below Poverty Level	SDH - Income	2012-2016 American Community Survey 5-Year Estimates, Individuals below Poverty Level
Children Eligible for Free Lunch Enrolled in Public Schools	SDH - Income	2015-2016 Percentage of Children Enrolled in Public Schools that are Eligible for Free or Reduced Price Lunch
Household Income, Median	SDH - Income	2016 Income where Half of Households in a County Earn More and Half of Households Earn Less
Children in Poverty	SDH - Income	2016 Percentage of Children Under Age 18 in Poverty
Non-English Speaking Households	SDH - Language	2012 Percent of Households with Language other than English
Disconnected Youth	SDH - Social Isolation	2010-2014 Population Between the Ages of 16 and 24 who are Neither Working nor in School
Social/Membership Associations	SDH - Social Isolation	2015 Number of Membership Associations per 10,000 Population

Appendix E: Evaluation of Prior Implementation Strategy Impact

Identified Need	Implementation Strategy Response	Status
Access to care	Continue to provide care to uninsured or underinsured patients through existing programs and facilities; recruitment of primary care providers where appropriate; continued training of primary care and specialty care physicians through the residency program; provide providers and other support to local charity clinics; add access points throughout the service area (such as family health centers, imaging and urgent care locations); provide low-cost screenings and sports physicals; offering streamlined care for patients through various navigator programs and virtual visits; and provide assistance with getting insurance coverage as a CMS designated Champion of Coverage provider.	• $156.0M (FY2017) in unreimbursed cost of charity care (10.5% of net patient revenue) • Approval to build Midlothian Hospital bringing acute care and outpatient services to Midlothian and surrounding communities • Opened new Convenient Care Campus in Grand Prairie (primary & specialty care, UC, imaging, and lab) • Methodist Medical Group launched MethodistNOW (virtual visits with online diagnosis & treatment, accessible 24/7) • MHS trained 88 residents in the Graduate Medical Education program in 2017-2018 academic year • Folsom Wellness Center had 10,984 community visits, 3,006 employee visits, 1,254 personal training sessions, 229 exercise prescriptions for members and bariatric surgery patients, and 17 group exercise classes per week (3-20 per class) • FitZone Wellness Center had 17,970 community visits, 4,611 employee visits, and 4,173 cardiac/ pulmonary rehab patient visits • Over $500K given to various community agencies and groups to further MHS mission and outreach to communities served through sponsorships and events, marketing support, and outreach • Nearly 2,400 mammograms provided through MHS' mobile mammography program in the past 2 years • 570 educational classes and events provided through Generations program in 2017 with 10,645 attendees • Monthly ongoing support groups for Breast Cancer, HPB and Diabetes • Faith Community Nursing outreach includes programs that promote health and wellness (engaged over 20,000 members through programming and gave over 600 flu shots in the past two years) • 1115 Waiver/DSRIP program leverages ED patient navigators to guide patients seeking routine medical care in the ED to Primary Care Providers at Golden Cross and MCMC Family Medicine • Over 1,480 patients received one-on-one navigation & chronic disease services FYTD 2018 • MHS Diabetes Council works with the American Diabetes Association to raise awareness of diabetes prevention and treatment; Activities include participation in health fairs, hosting clinical education seminars and fund-raising efforts (Tour de Cure)
Diabetes	Provide ongoing educational classes and support groups with a focus on Diabetes; continue existing entity-based chronic disease programs such as the 1115 Waiver Projects; Continue to collaborate with community agencies such as the American Diabetes Association and the Texas Agri-life Extension office to increase access to services and improve awareness of risk factors and treatment.	
Heart Disease	Continue to provide education and treatment through existing and added area Methodist Family Health Centers; provide ongoing community education and support services; and collaborate with community agencies to improve awareness of risk factors and treatment.	
Awareness and collaboration of community resources	Improve awareness and collaboration of community resources through various navigator programs such as the ACO nurse navigator program and the ED Patient Navigation 1115 Waiver project and MHS Mobile mammography program; collaborating with local municipalities and coalitions to expand outreach and awareness of community resources such as charitable contribution to community agencies.	
Prevention	Provide health screenings and annual community education to area residents such as MHS' Mobile Mammography program, Senior Access Generations programming, congregational health Ministry efforts and the Folsom wellness center; and support community prevention efforts through the Nurse Clinical Advancement Program.	

Status continued
• Secured United Way funding for Diabetes Community Health Worker • Work with Brother Bills Helping Hand in West Dallas to provide clinical education for staff, reduced fees for select ancillary care services and operational support • Led collaboration with VNA/Meals on Wheels to provide meals in high risk zip codes • Participated in several community events hosted by DeSoto ISD, Duncanville ISD, Cedar Hill Parks & Recreation, City of Dallas, Dallas Parks & Recreation and GrowSouth (City of Dallas) • MCMC added free Congestive Heart Failure and Smoking Cessation classes in 2018Offer free community “Lunch & Learns” featuring health-related topics such as nutrition, emotional health, and chronic disease prevention • Collaboration with JPS, The Caring Place (charity clinic), Christ’s Family Clinic, Parkland and other local charity clinics to coordinate care for low income and Medicaid patients