Methodist Richardsons Medical Center

Community Health Needs Assessment

Methodist
RICHARDSON

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Methodist Health System

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. This assessment applies to the following Methodist hospital facility:

- Methodist Richardson Medical Center

For the 2019 assessment, the community includes the geographic area where at least 75% of the hospital facility admitted patients live. Methodist Richardson Medical Center defined their community as the geographical area of Dallas and Collin Counties. This hospital facility 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 facility. 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 facility on or before February 15, 2020. The needs to be addressed by Methodist Richardson Medical Center are as follows:

- Chronic Heart Failure
- Cancer
- Stroke

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 Richardson Medical Center 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 Richardson Medical Center.

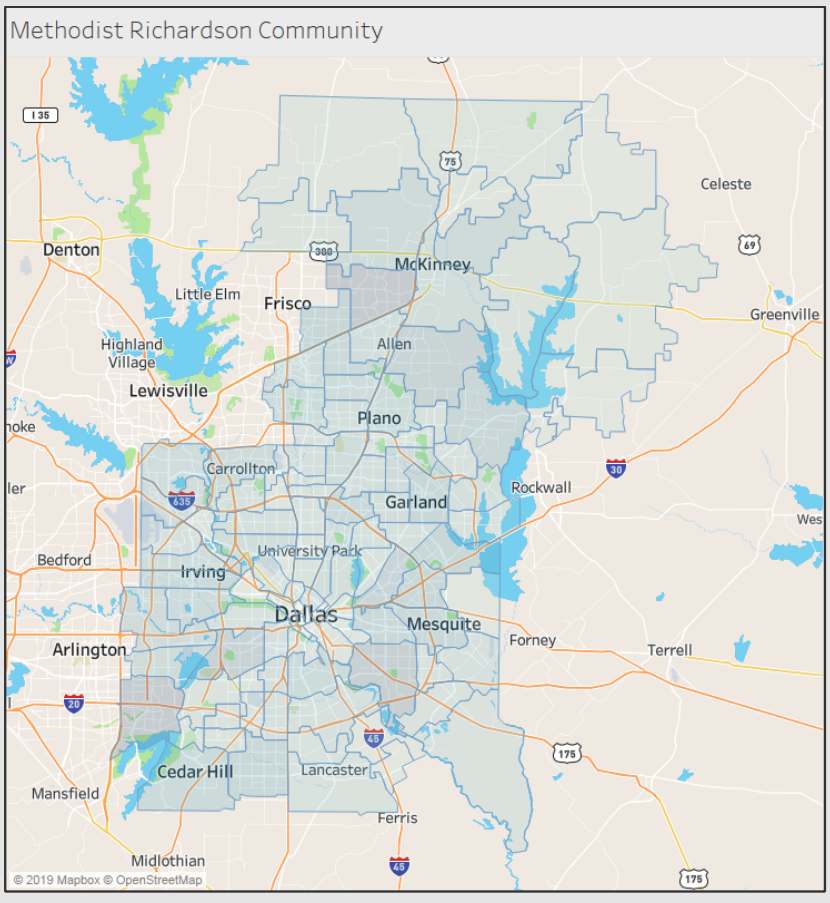
Consultant Qualifications & Collaboration

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 Richardson Medical Center defined the facility's community using the county in which at least 75% of patients reside. Using this definition, Methodist Richardson Medical Center has defined their community to be the geographical area of Dallas and Collin Counties for the 2019 CHNA.

Community Served Map



Source: Watson Health, 2019

Assessment of Health Needs

To identify the health needs of the community, the hospital facility 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**.

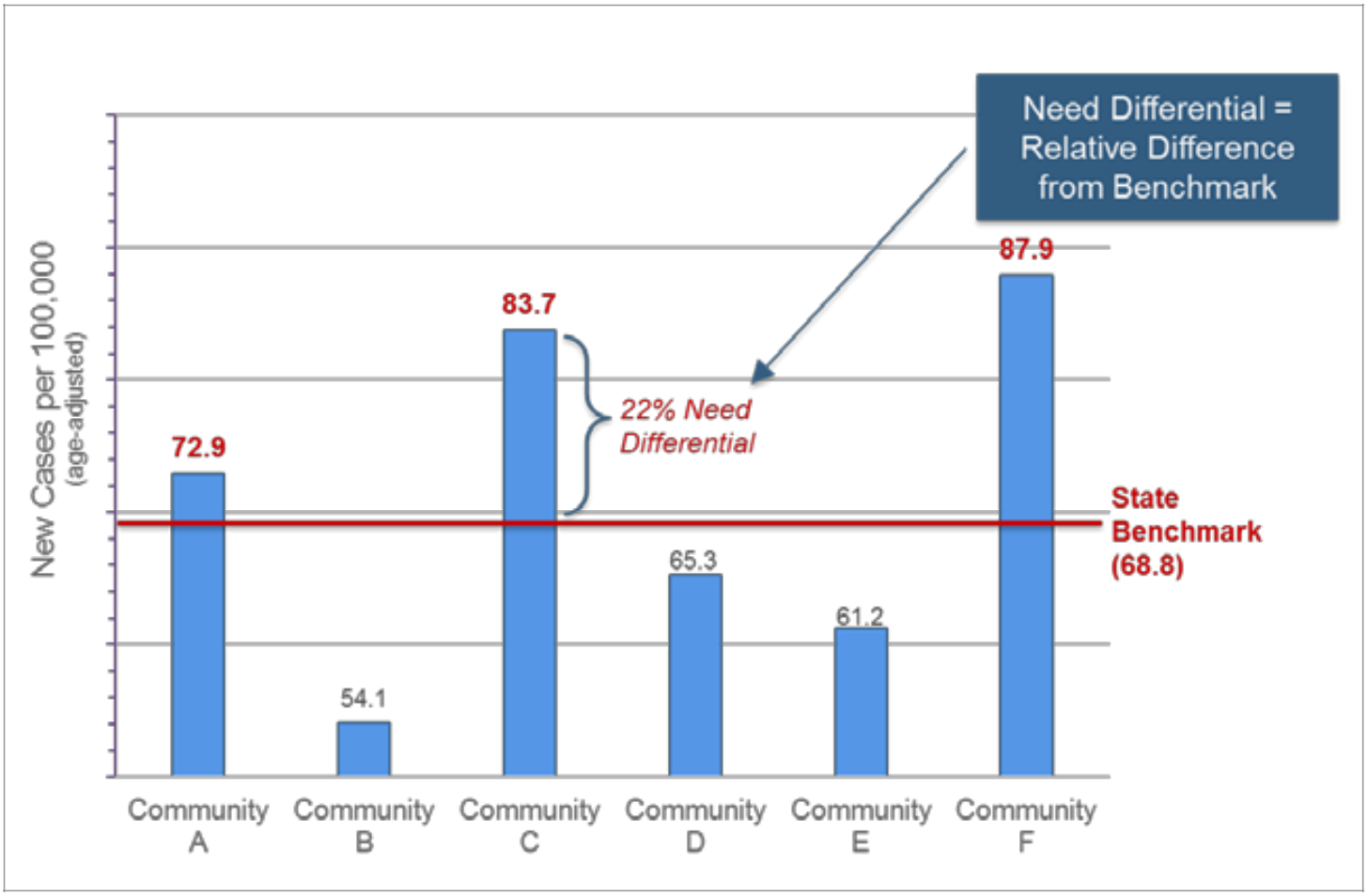
A benchmark analysis, conducted for each indicator collected for the community served, determined which public health indicators demonstrated a community health need from a quantitative perspective. Benchmark health indicators collected included (when available): overall U.S. values; state of Texas values; 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 were 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, three (3) focus groups with a total of 33 participants, as well as eight (8) 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 hospital. 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,

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
City of Plano	X	X	X	X	X		
CitySquare	X	X	X	X	X		X
Community Council							
Community Lifeline Center		X	X	X	X		
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				
Frisco Family Services		X	X				
Genesis Women's Shelter & Support		X	X		X		X
Goodwill Industries of Dallas			X	X			
Hope Clinic		X	X	X	X		
Hope Clinic of McKinney		X	X	X	X		
Legal Aid of Northwest Texas			X				
LifePath Systems	X		X	X			X
Los Barrios Unidos Community Clinic	X	X	X	X	X		X
Many Helping Hands Ministry	X	X	X	X			
McKinney City Council					X		
North Texas Food Bank			X				X
Office of the County Judge - Dallas County	X	X	X	X	X		X
Plano Fire-Rescue	X	X	X	X	X		X
Project Access-Collin County			X				

Participant Organization Name	Public Health	Medically Under-served	Low-income	Chronic Disease Needs	Minority Populations	Governmental Public --Health Dept.	Public Health Knowledge -- Expertise
Sharing Life Community Outreach Inc			X				
Society of St. Vincent de Paul of North Texas		X	X	X	X		
Texas Muslim Women's Foundation					X		
The Samaritan Inn			X				
United Way Metropolitan Dallas		X	X	X	X		X
Urban Inter-Tribal Center of Texas		X	X	X	X		X
Veterans Center of North Texas			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
PCI ProComp Solutions, LLC		X	X				
University of Texas - Dallas		X	X				
Assistance Center of Collin County		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

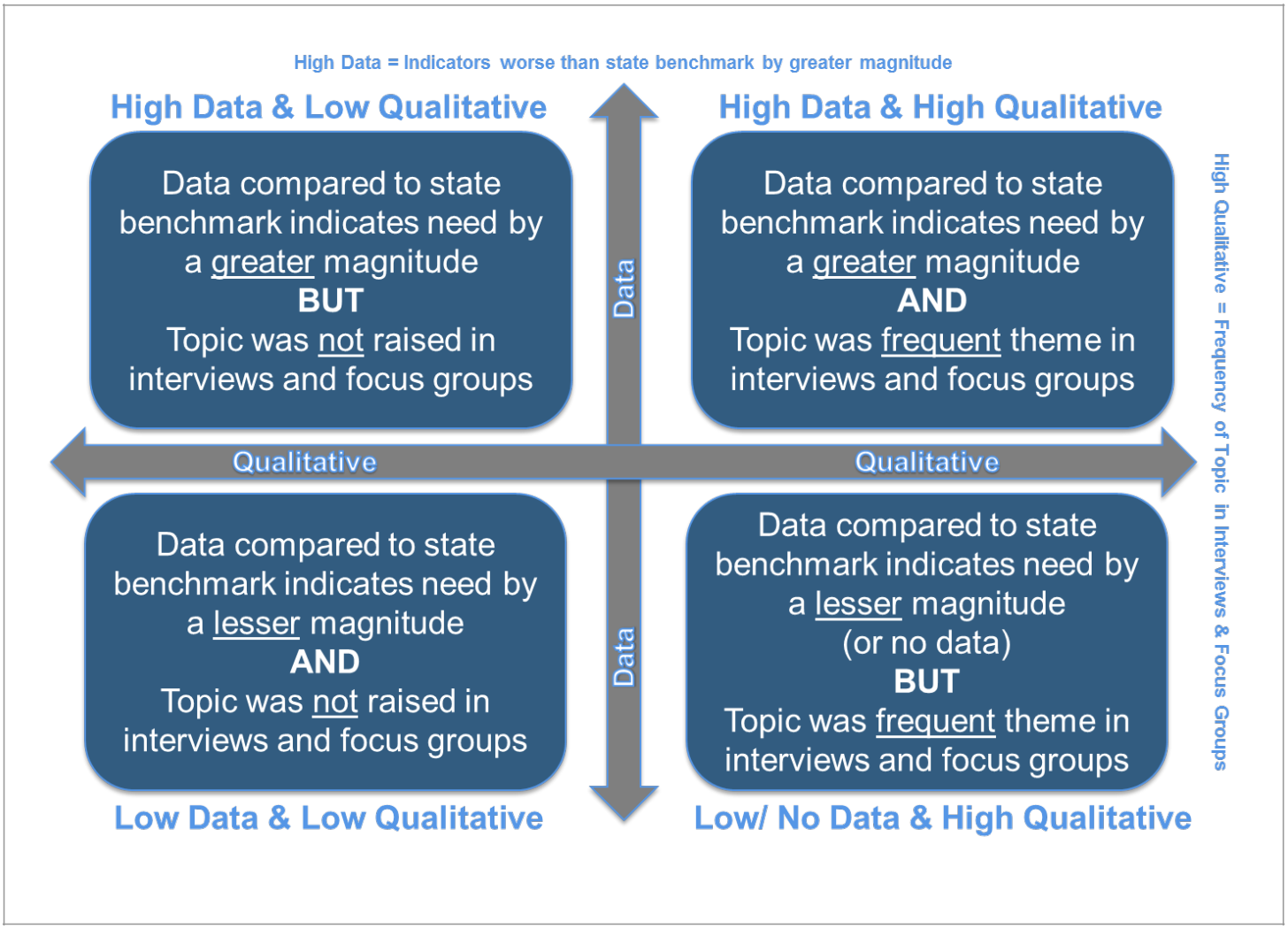
In addition to soliciting input from public health and various interests of the community, the hospital was also required to consider written input received on their most recently conducted CHNA and subsequent implementation strategies. The assessment is available to receive public comment or feedback 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



Source: IBM Watson Health, 2019

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 Richardson Medical Center 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 Richardson Medical Center 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 7.5% in five years, above the Texas growth rate of 7.1%. The median age of 35.5 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 Medicaid beneficiaries than the state of Texas.

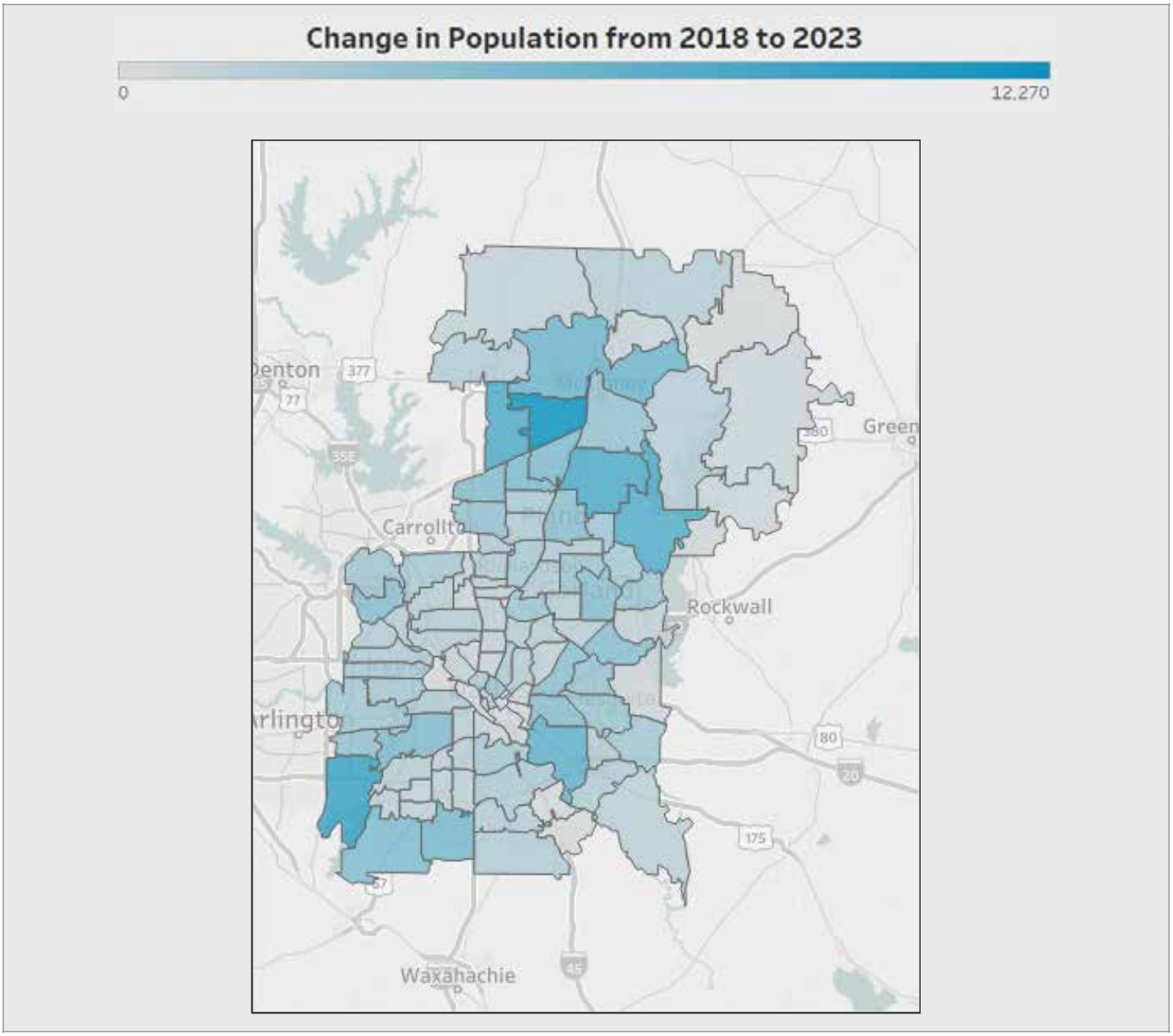
Demographic and Socioeconomic Comparison: Community Served and State/U.S. Benchmarks

Geography		Benchmarks		Community Served
		United States	Texas	
Total Current Population		326,533,070	28,531,631	3,601,164
5 Yr Projected Population Change		3.5%	7.1%	7.5%
Median Age		42.0	38.9	35.5
Population 0-17		22.6%	25.9%	26.3%
Population 65+		15.9%	12.6%	10.9%
Women Age 15-44		19.6%	20.6%	21.3%
Non-White Population		30.0%	32.2%	45.3%
Hispanic Population		18.2%	39.4%	33.5%
Insurance Coverage	Uninsured	9.4%	19.0%	16.7%
	Medicaid	19.0%	13.4%	13.1%
	Private Market	9.6%	9.9%	9.8%
	Medicare	16.1%	12.5%	10.8%
	Employer	45.9%	45.3%	49.6%
Median HH Income		$61,372	$60,397	$69,461
Limited English		26.2%	39.9%	42.7%
No High School Diploma		7.4%	8.7%	8.6%
Unemployed		6.8%	5.9%	5.4%

The population of the community served is expected to grow 7.5% by 2023, an increase of more than 268,000 people. The 7.5% projected population growth is more than the state's 5-year projected growth rate (7.1%) and higher when compared to the national projected growth rate (3.5%). The ZIP codes expected to experience the most growth in five years are:

- 75070 McKinney – 12,270 people
- 75052 Grand Prairie – 9,059 people
- 75002 Allen – 7,892 people

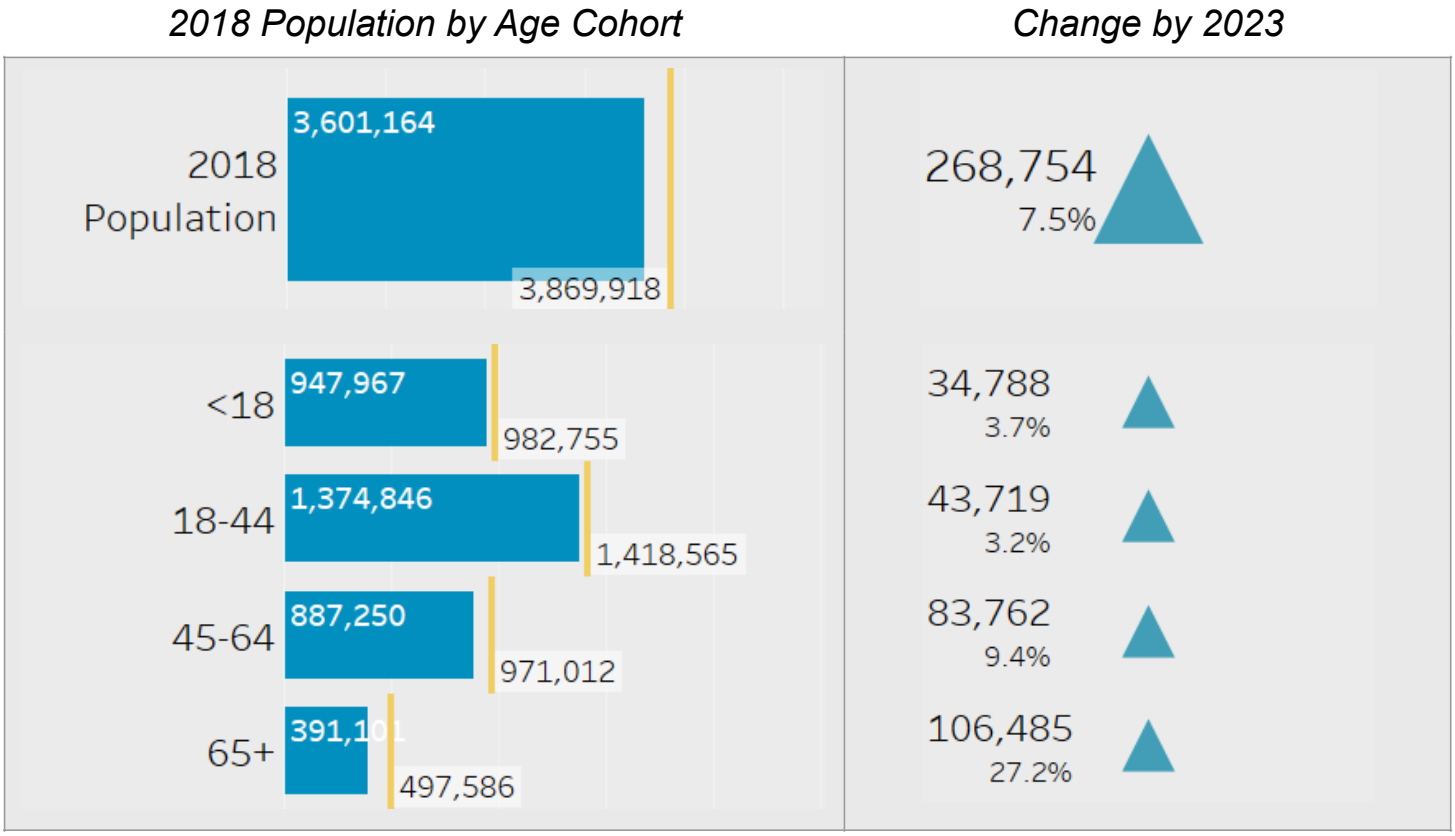
2018 - 2023 Total Population Projected Change by ZIP Code



Source: IBM Watson Health / Claritas, 2018

The community's population skewed younger with 38.2% of the population ages 18-44 and 26.3% under age 18. The largest cohort (18-44) is expected to grow by adding 43,719 people (3.2%) by 2023. The age 65 plus cohort was the smallest (10.9%) but is expected to experience the fastest growth (27.2%) over the next five years, adding 106,485 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

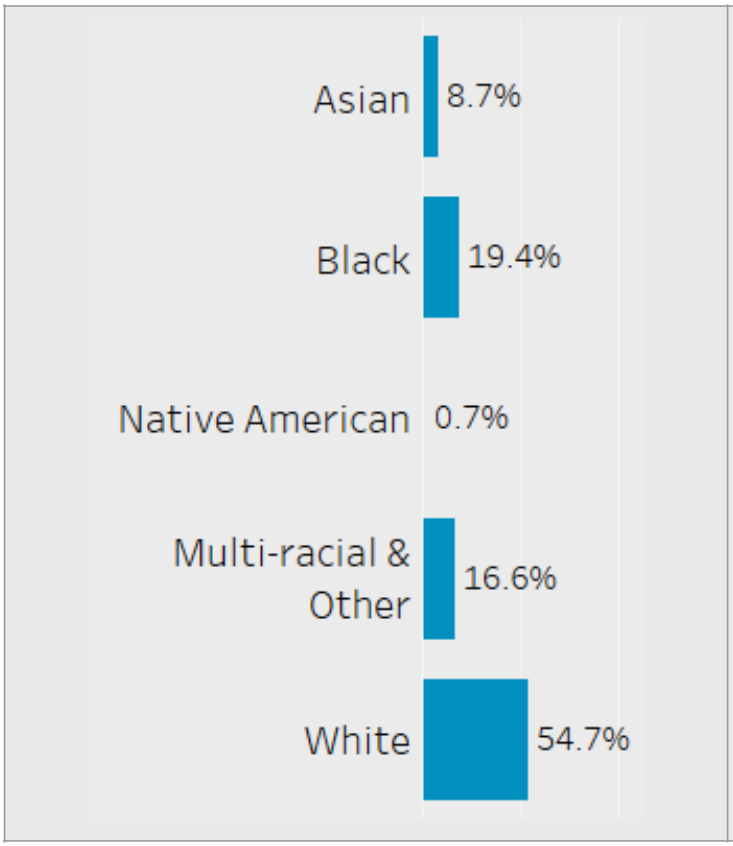


Source: IBM Watson Health / Claritas, 2018

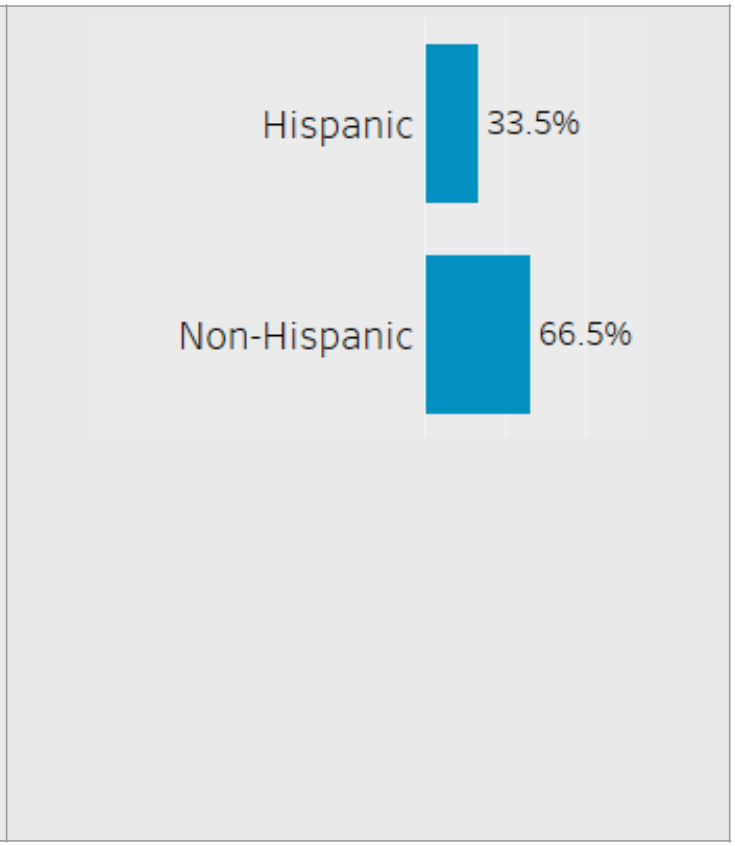
Population statistics are analyzed by race and by Hispanic ethnicity. The largest groups in the community were non-Hispanic White (36.58%), non-Hispanic Black (18.99%), White Hispanic (18.08%), and other Hispanic (13.09%). The expected growth rate of the Hispanic population (all races) is over 124,000 people (10.3%) by 2023, while the non-Hispanic population (all races) is expected to grow by over 144,000 people (6.0%) by 2023.

Population Distribution by Race and Ethnicity

2018 Population by Race

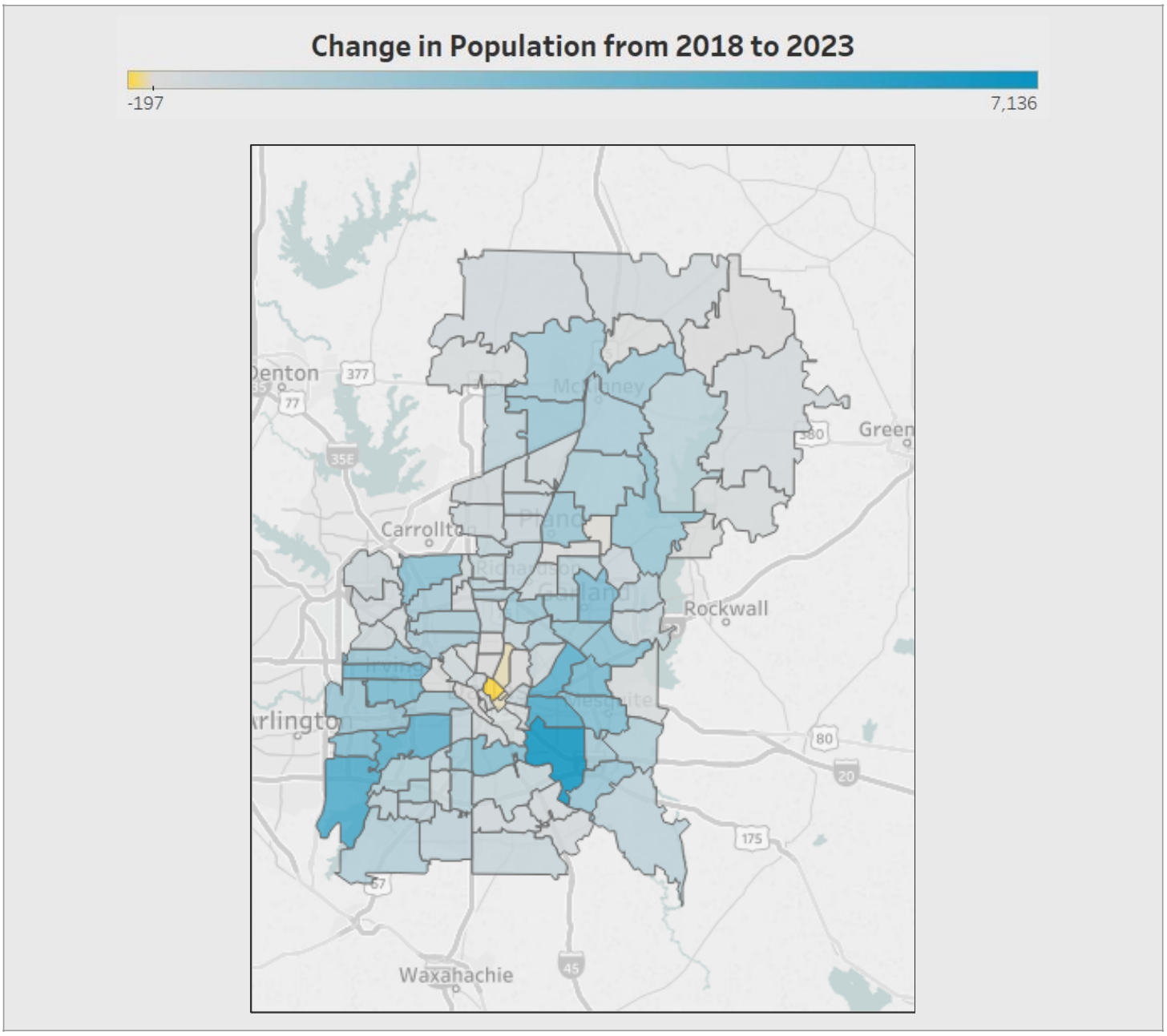


2018 Population by Ethnicity



Source: IBM Watson Health / Claritas, 2018

2018 - 2023 Hispanic Population Projected Change by ZIP Code

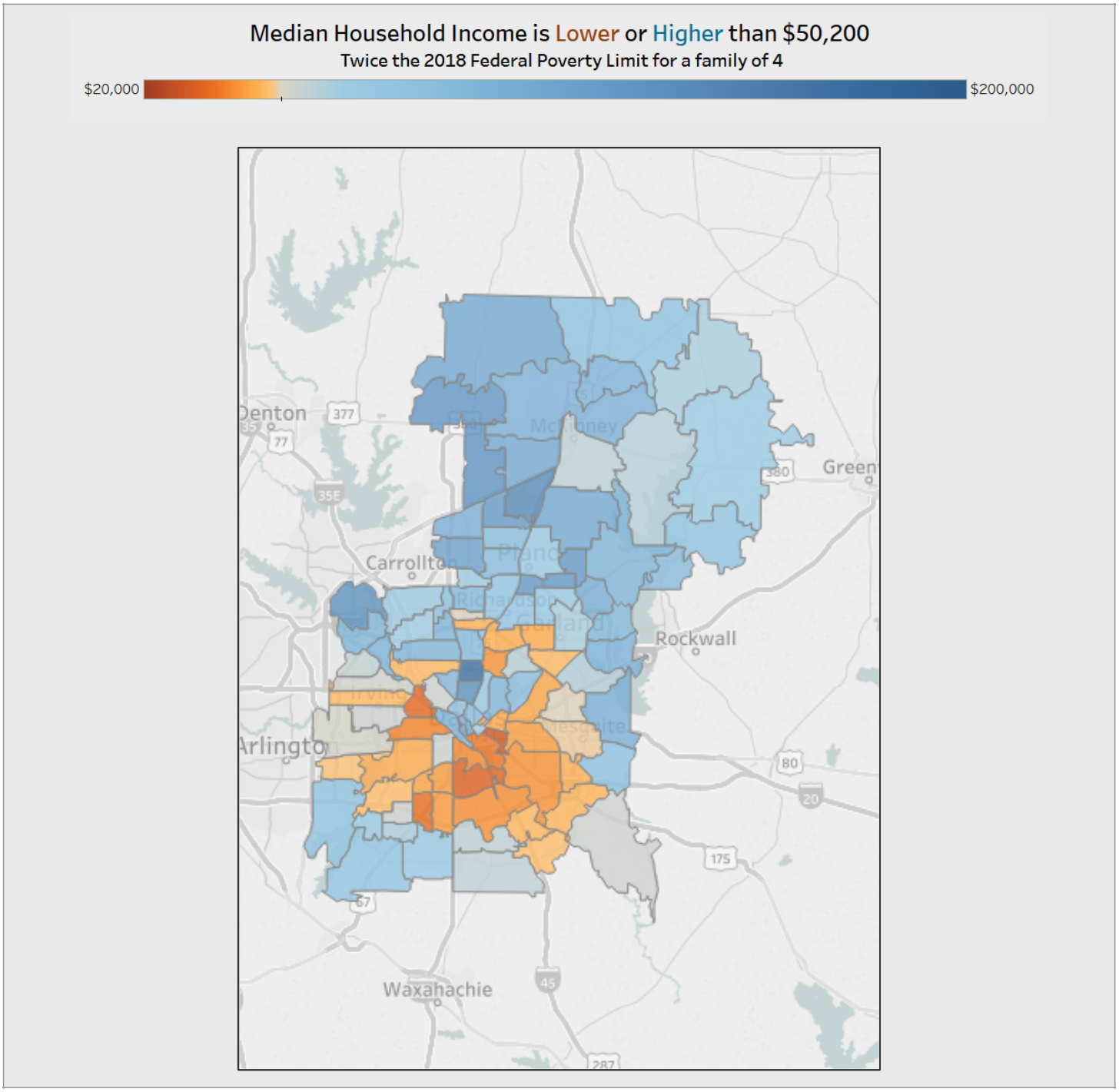


Source: IBM Watson Health / Claritas, 2018

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 33 ZIP codes with median household incomes less than $50,200, twice the 2018 Federal Poverty Limit for a family of four:

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

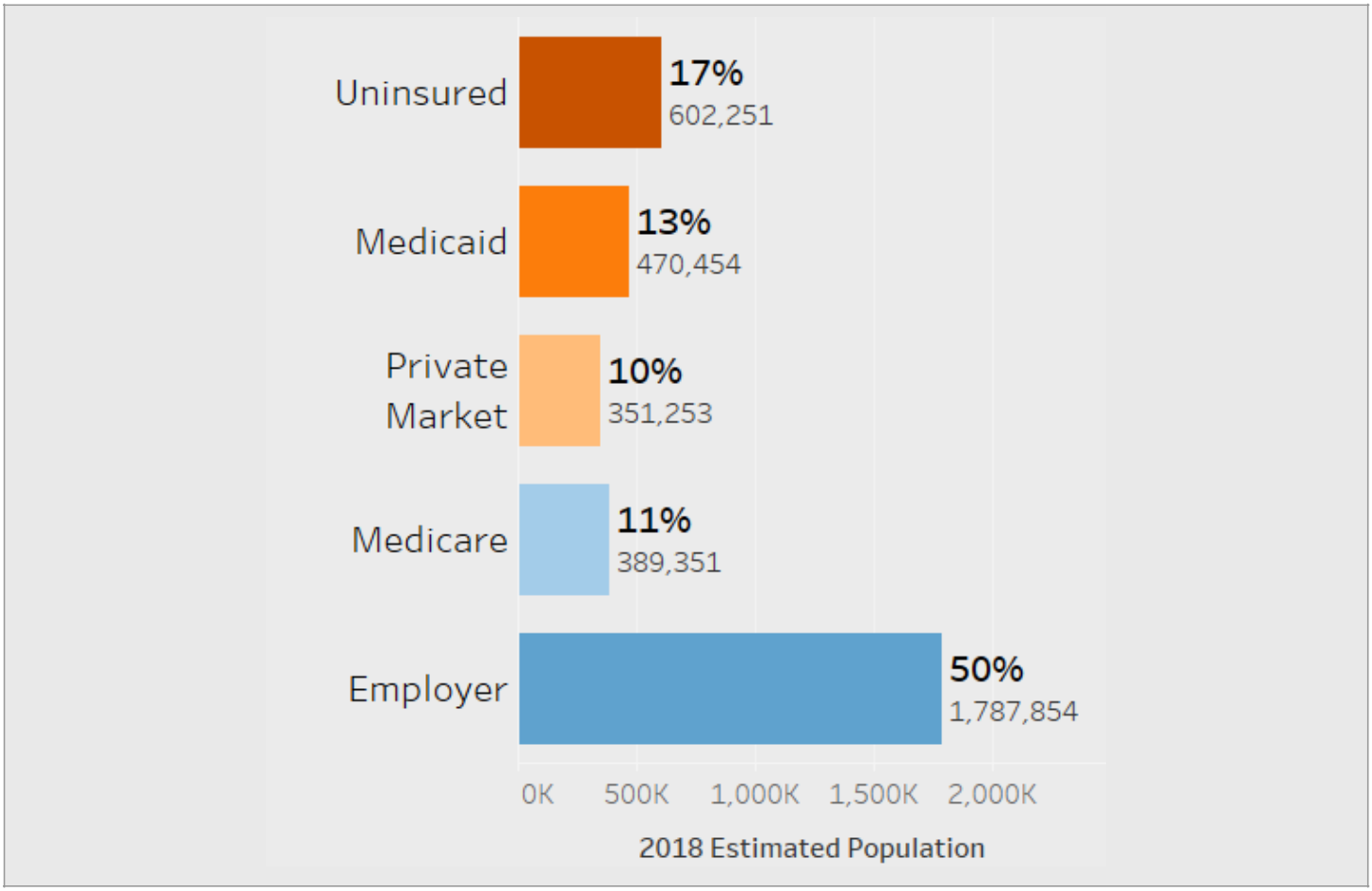
2018 Median Household Income by ZIP Code



Source: IBM Watson Health / Claritas, 2018

A majority of the population (50%) were insured through employer sponsored health coverage, 17% of residents did not have any health insurance. 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).

2018 Estimated Distribution of Covered Lives by Insurance Category



Source: IBM Watson Health / Claritas, 2018

The community includes 27 Health Professional Shortage Areas and 20 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

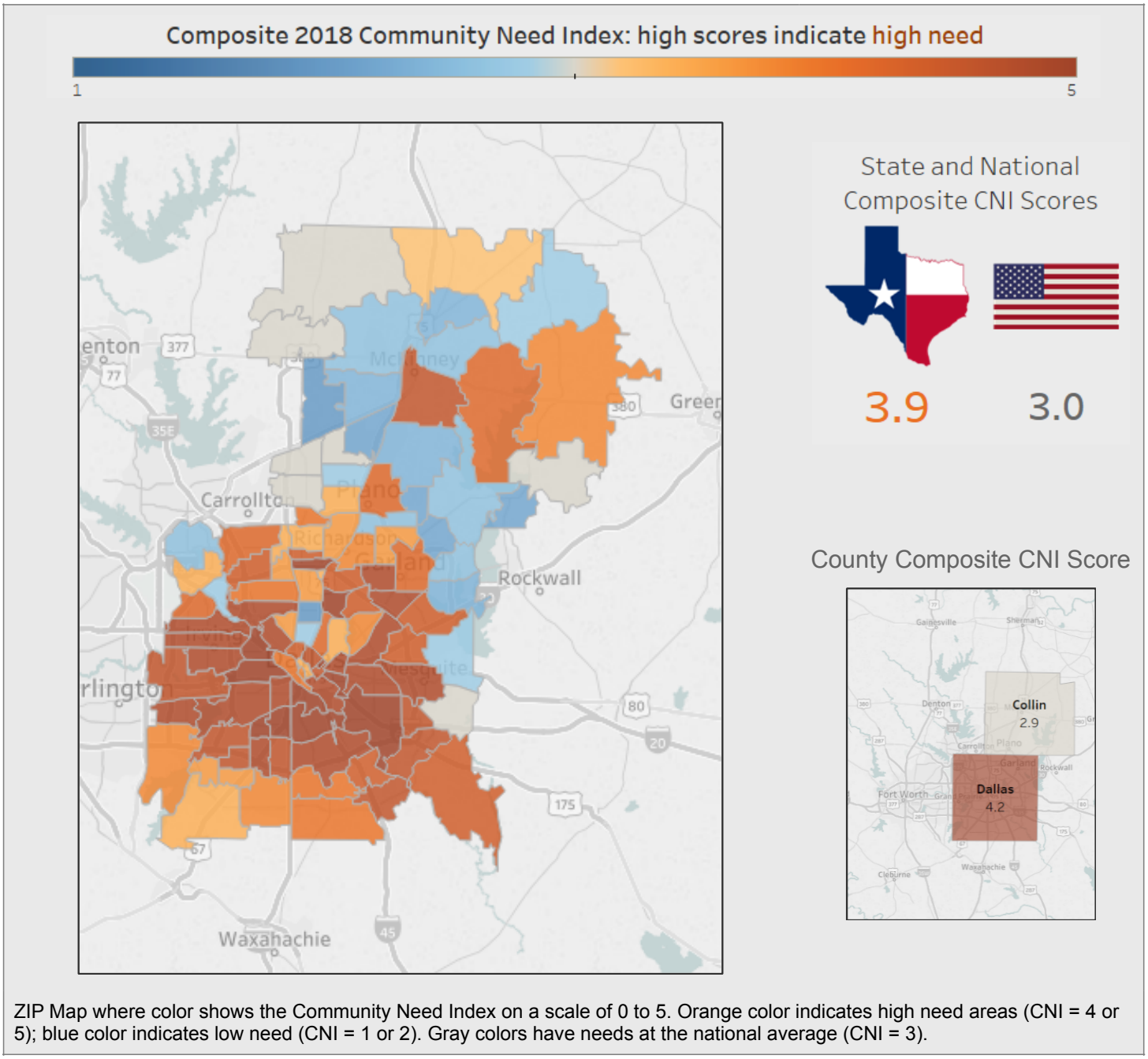
	Health Provessional Shortage Areas (HPSA)				Medically Underserved Area/Population (MUA/P)
5. Methodist Richardson MC	Dental Health	Mental Health	Primary Care	Grand Total	MUA/P
Collin		1		1	1
Dallas	8	8	10	26	19
Total	**8**	**9**	**10**	**27**	**20**

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, 2018

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.

The CNI score for the community served was 3.9 (4.2 for Dallas County and 2.9 for Collin County) which is higher than the CNI national average of 3.0, potentially indicating greater health care needs in this community. In portions of the community (Balch Springs, Dallas, Duncanville, Garland, Grand Prairie, Irving, McKinney, Mesquite, and Wilmer) the CNI score was greater than 4.5, pointing to potentially more significant health needs among the population.

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 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.

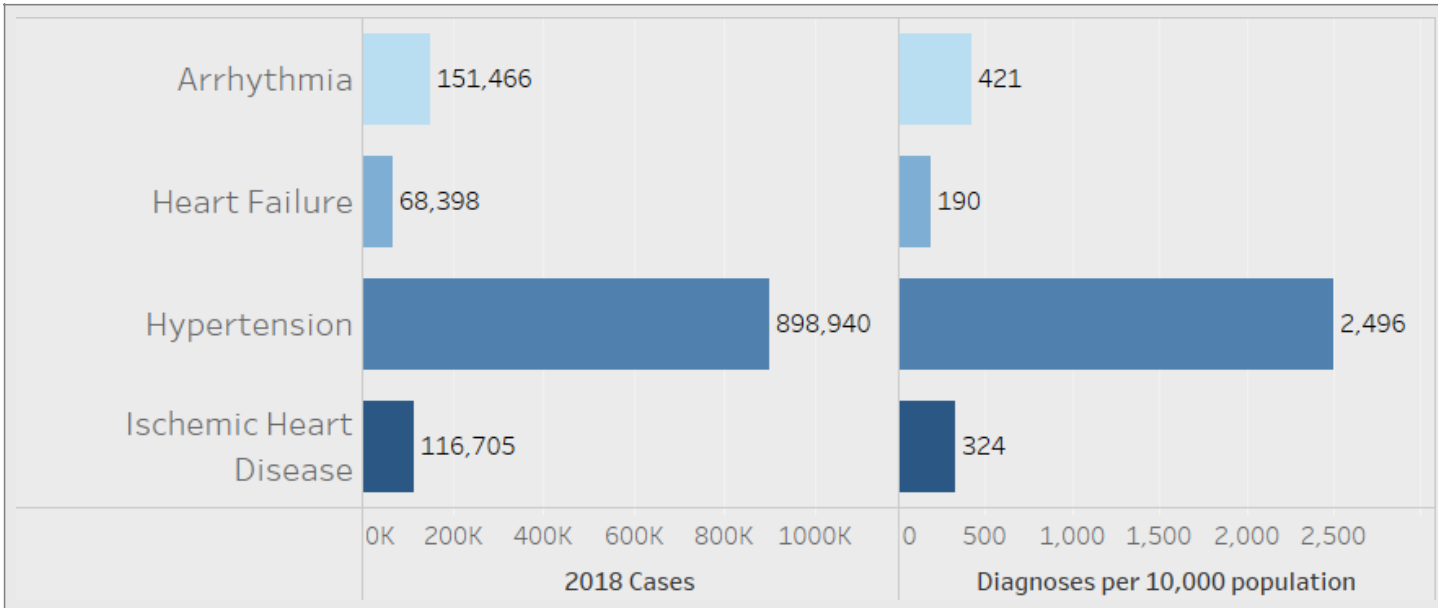
Where the community indicators showed greater need when compared to the state of Texas comparative benchmark, the difference between the community values and the state benchmark was calculated (need differential). Those highest ranked indicators with need differentials in the 50th percentile of greater 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 898,000 estimated cases in the community overall. McKinney ZIP code 75070 had the most estimated cases of Arrhythmia, Ischemic Heart Disease and Hypertension, while Grand Prairie ZIP code 75052 had the most estimated cases of Heart Failure. ZIP code 75075 in Plano had the highest estimated prevalence rates for Arrhythmia (705 cases per 10,000 population), Hypertension (3,332 cases per 10,000 population) and Ischemic Heart Disease (654 cases per 10,000 population). ZIP Code 75225 in Dallas was the highest rate for Heart Failure (341 cases per 10,000 population).

2018 Estimated Heart Disease Cases



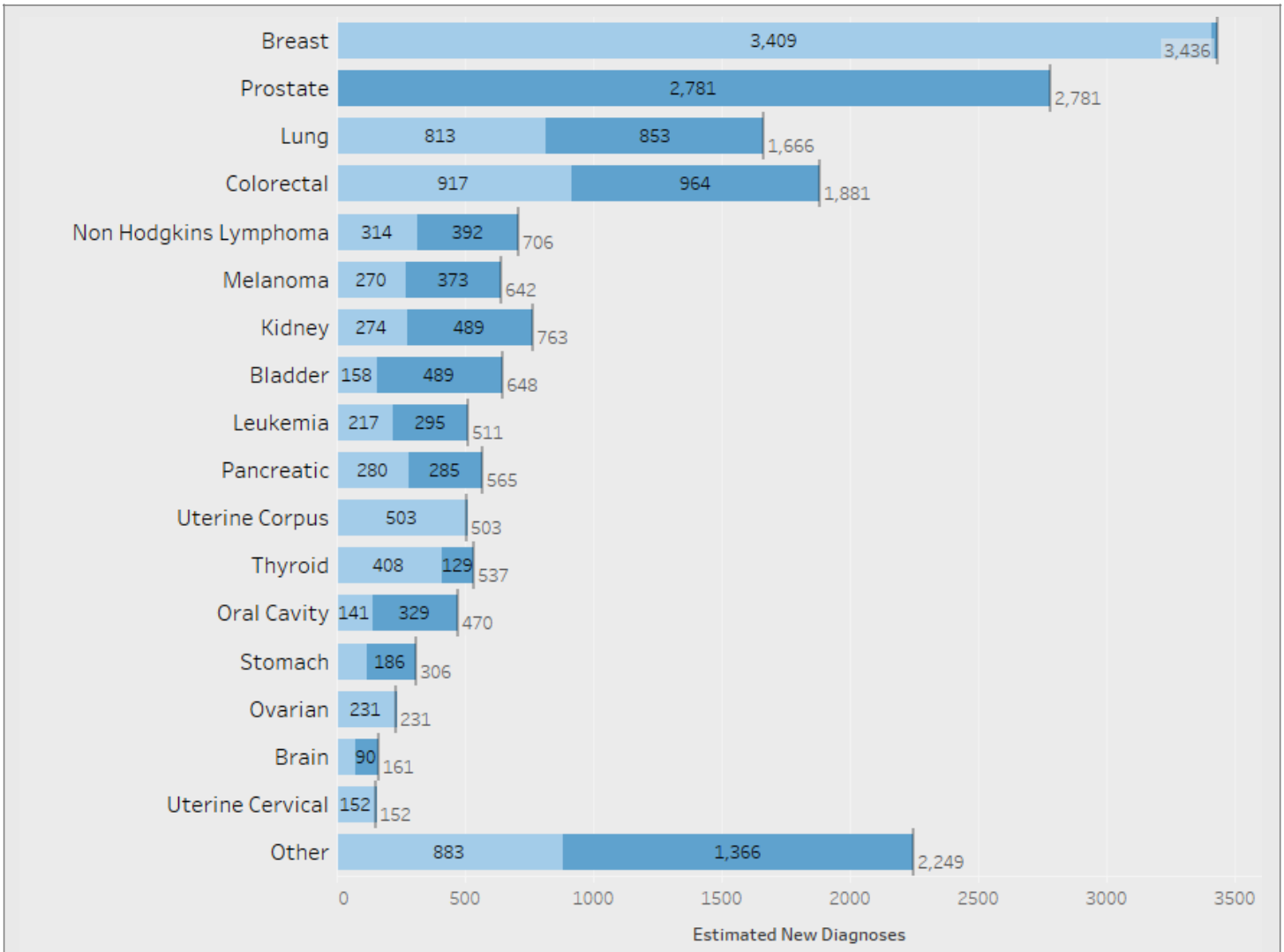
Bar chart shows total number and prevalence rate of 2018 Estimated Heart Disease cases for each of four types: arrhythmia, heart failure, hypertension, and ischemic heart disease

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

Source: IBM Watson Health, 2018

For this community, Watson Health's 2018 Cancer Estimates revealed the cancers projected to have the greatest rate of growth in the next five years were pancreatic, bladder, and kidney based on population changes and disease rates. The cancers estimated to have the greatest number of new cases in 2018 were breast, prostate, lung, and colorectal 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	648	779	20.3%
Brain	161	180	11.4%
Breast	3,436	3,978	15.8%
Colorectal	1,881	1,998	6.2%
Kidney	763	906	18.8%
Leukemia	511	597	16.7%
Lung	1,666	1,944	16.7%
Melanoma	642	750	16.8%
Non Hodgkins Lymphoma	706	829	17.5%
Oral Cavity	470	553	17.6%
Ovarian	231	262	13.6%
Pancreatic	565	690	22.0%
Prostate	2,781	3,071	10.4%
Stomach	306	359	17.1%
Thyroid	537	632	17.8%
Uterine Cervical	152	161	6.2%
Uterine Corpus	503	595	18.3%
All Other	2,249	2,658	18.2%
Grand Total	18,208	20,942	15.0%

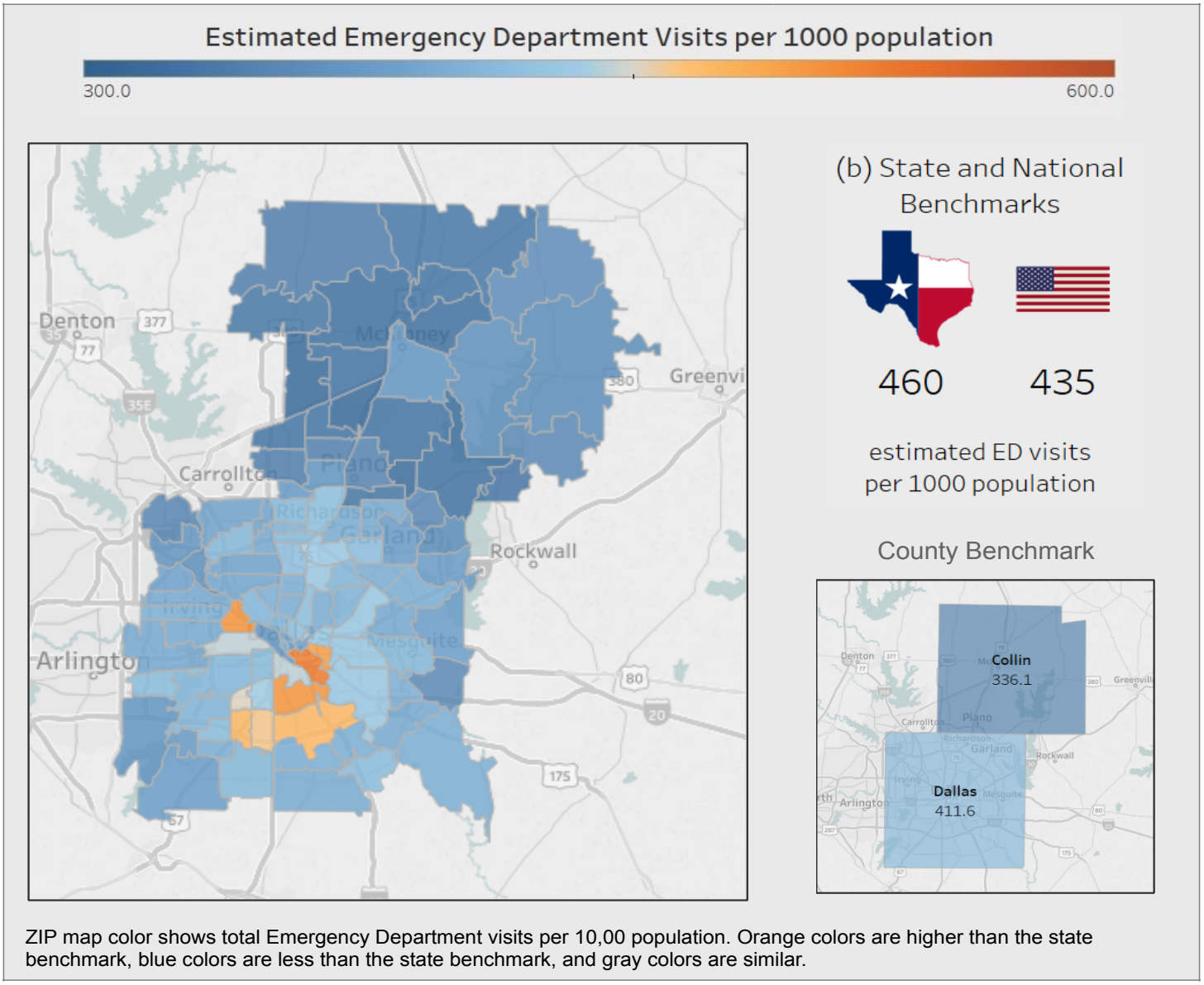
Source: IBM Watson Health, 2018

Based on population characteristics and regional utilization rates, Watson Health projected all emergency department (ED) visits in this community to increase by 7.9% over the next 5 years. The highest estimated ED use rates were in the ZIP codes of Dallas; 534 to 375.3 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 3.8% over the next five years in this community.

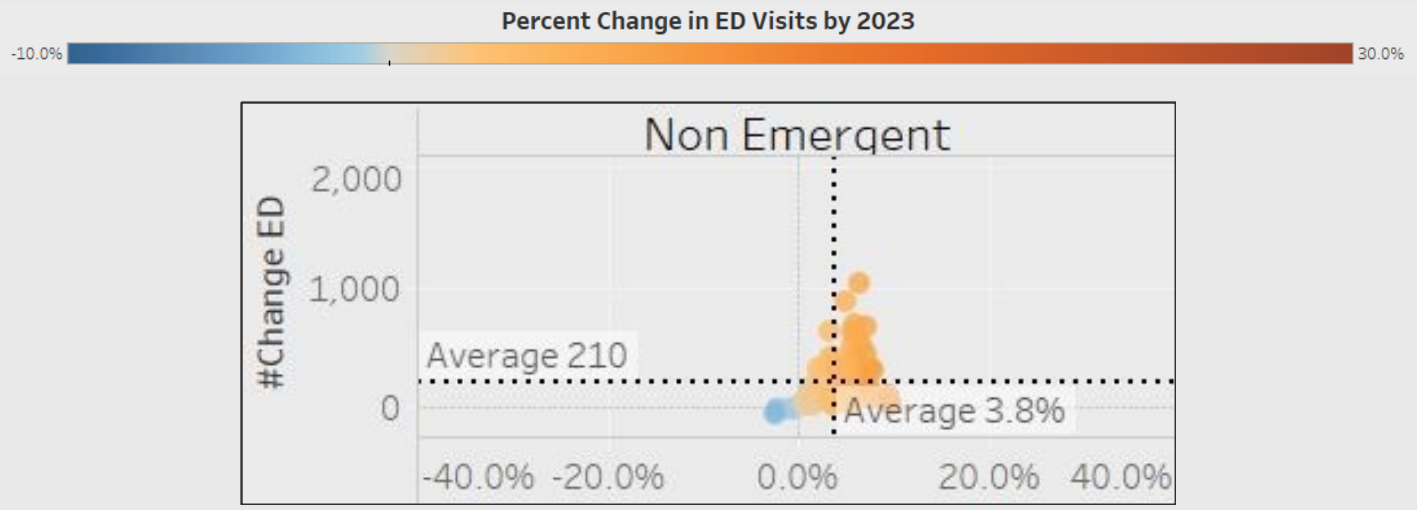
Estimated 2018 Emergency Department Visit Rate



ZIP map color shows total Emergency Department visits per 10,00 population. Orange colors are higher than the state benchmark, blue colors are less than the state benchmark, and gray colors are similar.

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

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 Baylor Scott & White Health, Parkland Health & Hospital System, and Texas Health Resources 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 three focus group sessions with a total of 33 participants and eight (8) interviews were conducted July 2018 through March 2019.

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

- Access to jobs and affordable housing
- Safe public transportation
- Lack of insurance and access to services
- Health care service gaps and navigating services
- Language barriers and 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. Participants described Collin County as a fast-growing, increasingly diverse area with a high cost of living. People moved to this community for its high quality of life, good schools, and job growth, but the increased cost of housing was putting some longtime residents and fixed-income seniors at risk for homelessness.

For those with insurance and means, there was access to high quality health care and specialists in the area, but there was a growing percentage that did not have equal access. Lack of insurance was often discussed as a major barrier to better health in the area. Many residents worked but didn't have health insurance, part of the "working poor" population. Parts of this health community were agricultural, and public transportation was extremely limited which created food and transportation "deserts". 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 lack of public transit interfered with follow up care and was also ineffectual in assisting residents get to their places of employment. It was suggested that centrally located health facilities with evening hours would help increase access.

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. There were food deserts, 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. For example, only a few clinics treated female Muslims and those facilities needed guidance in delivering culturally sensitive care as to not offend the women or their families. 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. The focus groups noted that minorities living in the area had an overall mistrust of authority (police, fire, hospitals). The group thought that outreach and education for health care providers to address trust issues would help tremendously.

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	Adolescent Behavioral Health	Health Behaviors	Teen Birth Rate per 1,000 Female Population, Ages 15-19
2	Language Barriers	Social Determinants of Health	Non-English Speaking Households
2	Hyperlipidemia	Chronic Conditions	Hyperlipidemia in Medicare Population
3	Schizophrenia and Other Psychotic Disorders	Mental Health	Schizophrenia and Other Psychotic Disorders in Medicare Population
3	Mental Health	Mental Health	Depression in Medicare Population
4	Atrial Fibrillation	Chronic Conditions	Atrial Fibrillation in Medicare Population
4	Chronic Heart Failure	Chronic Conditions	Hypertension in Medicare Population
4	Cancer	Cancer	Cancer Incidence - Female Breast
4	Stroke	Chronic Conditions	Stroke Mortality Rate
5	Uninsured Population	Access to Care	Percent of Population under Age 65 without Health Insurance
6	Poverty	Social Determinants of Health	Individuals Living Below the Poverty Level
7	Poverty	Social Determinants of Health	Children in Poverty
7	Food Insecurity	Environment	Food Insecurity (Hunger)
8	Drug Overdose Deaths - Opioids	Health Behaviors - Substance Abuse	Accidental Poisoning Deaths where Opioids were Involved
8	Drug Overdose Deaths	Health Behaviors - Substance Abuse	Drug Poisoning Death Rate
9	Poverty	Social Determinants of Health	Children Eligible for Free Lunch Enrolled in Public Schools
10	Social Isolation	Social Determinants of Health	Social Membership Associations
11	Child Mortality	Injury and Death - Children	Child Mortality Rate
11	Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	Motor Vehicle Driving Deaths with Alcohol Involvement
12	Infant Mortality	Injury and Death - Children	Infant Mortality Rate
12	Housing	Environment	Severe Housing Problems
12	Primary Care	Access to Care	Ratio of Population to one Non-Physician Primary Care Provider
13	Transportation	Access to Care	No Vehicle Available

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 Richardson Medical Center collectively rated, ranked, and selected the following significant needs to be addressed by implementation strategies:

1. Chronic Heart Failure
2. Cancer
3. Stroke

Description of Needs to be Addressed by Methodist

The CHNA process identified significant community health needs that can be categorized as chronic conditions, specifically chronic heart failure, cancer, and stroke. 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.

Chronic Heart Failure

Chronic Heart disease is an umbrella term which covers multiple conditions that affect the heart. Congestive heart failure (CHF) is another term for heart failure and occurs when your heart muscle doesn't pump blood as well as it should. Heart Disease can be chronic, ongoing, or acute where you experience a sudden onset of symptoms. Heart disease can, and does, occur at any age; however, it is most commonly seen as people age and have other co-morbidities that can increase the incidence of heart disease. In Dallas County, the mortality rate from heart disease is 180 per 100,000, or 5.3% higher than the state benchmark.[2]

Certain conditions, such as narrowed arteries in your heart (coronary artery disease) or high blood pressure, gradually leave your heart too weak or stiff to fill and pump efficiently. Dallas and Collin counties have a higher prevalence of Hyperlipidemia and Atrial Fibrillation compared to the state.[3] In Collin County, 54% of the Medicare population has a diagnosis of Hyperlipidemia which is 11% higher than the state benchmark. Not all conditions that lead to heart failure can be reversed, but treatments can improve the signs and symptoms of heart failure and help you live longer. Preventing heart failure may be possible by controlling conditions that cause heart failure, such as coronary artery disease, high blood pressure, diabetes or obesity. Lifestyle changes such as exercising, reducing sodium in your diet, managing stress and losing weight can improve quality of life.

Cancer

Cancer is a term used for diseases in which abnormal cells divide without control and can invade other tissues, when cancer spreads to other organs through the blood and lymph systems, it is considered malignant. Cancer is not just one disease, but many diseases and there are more than one hundred kinds of cancer.[4] Cancer is a genetic disease, it is caused by changes to genes that control the way our cells function, especially how they grow and divide.[5] Genetics play an important role in whether we are pre-ordained to develop a cancer; however, we have control over personal choices and environmental exposures that may modify risk.

In Texas in 2016, the age-adjusted rate of new cancer cases was 391.8 per 100,000 people and there were 109,083 cancer cases reported.[6] Nationally, there were 1,658,716 new cases of cancer reported in 2016 and 598,031 cancer diagnoses. There were 436 new cancer cases reported and 156 died per 100,000. Cancer is the second leading cause of death in the United States, exceeded only by heart disease. One of every four deaths in the U.S. is due to cancer.[7] In Dallas County, the incidence rate of prostate cancer, female breast cancer, and colon cancer are all higher than the Texas state benchmarks, and the cancer mortality rate of 163 per 100,000 people is 4.4% worse than the Texas benchmark.[8] Similarly, the breast cancer incidence rate in Collin County is 10.7% higher than the Texas benchmark (123.7 vs. 111.7 per 100,000).[9]

Cancer prevention, treatment and research are addressed on federal, state and local levels. Individuals can improve their odds of not receiving a cancer diagnosis by controlling their exposure to carcinogens, avoiding or quitting smoking, seeking preventative healthcare and living a healthy lifestyle, including nutritious foods and getting regular exercise.

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.[10] 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

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[4] https://www.cdc.gov/cancer/dcpc/prevention/index.htm

[5] https://www.cancer.gov/about-cancer/causes-prevention

[6] https://gis.cdc.gov/Cancer/USCS/DataViz.html

[7] https://gis.cdc.gov/Cancer/USCS/DataViz.html

[8] 2011-2015 Age-Adjusted Colon & Rectum Cancer Incidence Rate, National Cancer Institute (CDC); 2011-2015 Age-Adjusted Female Breast Cancer Incidence Rate, National Cancer Institute (CDC); 2011-2015 Age-Adjusted Prostate Cancer Incidence Rate, National Cancer Institute (CDC); 2013 Cancer Age Adjusted Death Rate, Texas Health Data, Center for Health Statistics, Texas Department of State Health Services

[9] 2011-2015 Age-Adjusted Female Breast Cancer Incidence Rate, National Cancer Institute (CDC)

[10] https://www.dshs.texas.gov/heart/Texas-Heart-Disease-and-Stroke-Program---Home.aspx

140,000 die from the event.[11] In Dallas County, the stroke mortality rate is 43.9 per 100,000, almost 10% higher than the Texas state benchmark.[12]

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 a 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.

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.[13]

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.

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[11] http://www.strokecenter.org/patients/about-stroke/stroke-statistics/

[12] 2013 Texas Health Data, Center for Health Statistics, Texas Department of State Health Services

[13] http://www.strokecenter.org/patients/about-stroke/stroke-statistics/

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 non-institutionalized	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
	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 B: Community Resources Identified to Potentially Address Significant Health Needs

Below is a list of resources identified via community input:

Resource	County
Assistance Center of Collin County	Collin
Collin County Adult Clinic	Collin
Collin County Alliance for Children	Collin
Collin County Social Services Association	Collin
Community Dental Care	Collin
Community Lifeline Center	Collin
Family Guidance	Collin
Family Health Center	Collin
Frisco Family Services	Collin
Geriatric Wellness Center	Collin
Grace to Change	Collin
Holy Family Day School	Collin
Hope Clinic of McKinney	Collin
LifePath Systems	Collin
Plano Adult Clinic	Collin
Plano Children's Medical Clinic	Collin
Plano Indigent Care Clinic	Collin
Project Access	Collin
Veterans Assistance Center	Collin
Wellness Center for Older Adults	Collin
Churches	Dallas
City of Dallas	Dallas
City Square	Dallas
Community Health Centers	Dallas
Dallas Concilio	Dallas
Dallas Housing Authority	Dallas

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

Below is a list of resources identified via community input:

Resource	County
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)[14]

County Name	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type
Dallas	148999485F	MLK Jr Family Center	Primary Care	Federally Qualified Health Center
Dallas	14899948D3	Los Barrios Unidos Community Health Center	Primary Care	Federally Qualified Health Center
Dallas	6489994889	Los Barrios Unidos Community Health Center	Dental Health	Federally Qualified Health Center
Dallas	6489994897	MLK Jr. Family Center	Dental Health	Federally Qualified Health Center
Dallas	748999481L	Los Barrios Unidos Community Health Center	Mental Health	Federally Qualified Health Center
Dallas	748999481V	MLK Jr. Family Center	Mental Health	Federally Qualified Health Center
Dallas	14899948P6	Dallas County Hospital District Homeless Programs	Primary Care	Federally Qualified Health Center
Dallas	64899948C2	Dallas County Hospital District Homeless Programs	Dental Health	Federally Qualified Health Center
Dallas	748999482V	Dallas County Hospital District Homeless Programs	Mental Health	Federally Qualified Health Center
Dallas	1482645075	Southeast Dallas	Primary Care	Geographic HPSA
Dallas	14899948OZ	Mission East Dallas (Medical) and Metroplex Project	Primary Care	Federally Qualified Health Center
Dallas	64899948MO	Mission East Dallas (Medical) and Metroplex Project	Dental Health	Federally Qualified Health Center
Dallas	74899948MN	Mission East Dallas (Medical) and Metroplex Project	Mental Health	Federally Qualified Health Center

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

[4] 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

Health Professional Shortage Areas (HPSA)[14]

County Name	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type
Dallas	14899948OY	Urban Inter-Tribal Center of Texas	Primary Care	Native American/Tribal Facility/Population
Dallas	64899948MP	Urban Inter-Tribal Center of Texas	Dental Health	Native American/Tribal Facility/Population
Dallas	74899948MP	Urban Inter-Tribal Center of Texas	Mental Health	Native American/Tribal Facility/Population
Dallas	7481857339	South Irving Service Area	Mental Health	Geographic HPSA
Dallas	14899948Q0	Healing Hands Ministries, Inc.	Primary Care	Federally Qualified Health Center
Dallas	64899948NX	Healing Hands Ministries, Inc.	Dental Health	Federally Qualified Health Center
Dallas	74899948O2	Healing Hands Ministries, Inc.	Mental Health	Federally Qualified Health Center
Dallas	1487790622	Ofac-Parkland Center for Internal Medicine (Pcim)	Primary Care	Other Facility
Dallas	1488147611	Simpson-Stuart	Primary Care	Geographic HPSA
Dallas	1487732421	Trinity Area	Primary Care	Geographic HPSA
Dallas	6488138803	Lisbon Service Area	Dental Health	Geographic HPSA
Dallas	6486350827	West Dallas/Cliff Hall	Dental Health	High Needs Geographic HPSA
Dallas	7482132665	West Dallas	Mental Health	High Needs Geographic HPSA
Collin	7485109304	Low Income-Collin County	Mental Health	Low Income Population HPSA

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

Public Health Indicator	Category	Indicator Definition
Price-Adjusted Medicare Reimbursements per Enrollee	Access to Care	2015 Amount of Price-Adjusted Medicare Reimbursements (Part A and B) per Enrollee
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
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	2017 Ratio of Population to Primary Care Providers Other than Physicians
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)
Hyperlipidemia in Medicare Population	Chronic Condition - Cardiovascular	2007-2015 Prevalence of Chronic Condition Across all Medicare Beneficiaries
Atrial Fibrillation 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

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

Public Health Indicator	Category	Indicator Definition
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 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)

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

Public Health Indicator	Category	Indicator Definition
Chronic Kidney Disease in Medicare Population	Chronic Condition - Kidney Disease	2007-2015 Prevalence of Chronic Condition Across all Medicare Beneficiaries
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)
Driving Alone to Work	Environment	2012-2016 Percentage of the Workforce that Drives Alone to Work
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

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

Public Health Indicator	Category	Indicator Definition
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 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
Ratio of Population to One Mental Health Provider	Mental Health	2017 Ratio of Population to Mental Health Providers

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
Schizophrenia and Other Psychotic Disorders 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
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; adding access points throughout the service area (such as family health centers, imaging and urgent care locations); providing low-cost screenings through programs such as MHS' Mobile Mammography program and low-dose screenings for lung cancer; offering streamlined care for patients through various navigator programs and virtual visits; and collaborating with community agencies such as City of Richardson to provide an immunization clinic and Collin County Project Access.	• $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) • $85M expansion at MRMC (adds 2 floors, 150 beds, OR & 500-space parking garage) • 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 • City of Richardson immunization clinics reached 1,097 children in 2017 with 2,623 vaccines given and YTD 2018 reached 608 children with 1,481 vaccines given • 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 • Cancer screenings – 2 screenings reached 100 community members • Low-dose cancer screenings – provided at low cost for those without insurance; working to screen City of Richardson employees • Over 1,000 people helped in the past two years through the Asian Breast Health outreach program • 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 • Over 100 patients with ongoing monitoring in the high risk assessment clinic at Richardson Cancer Center • Food for Life program 3-day class about changing diet to prevent cancer and other chronic illnesses • 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 Clinic
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 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 new 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	Continue various navigator programs such as the ED Patient Navigation 1115 Waiver project and MHS Mobile mammography program; collaborate with local municipalities and coalitions (such as Whole Foods Food for Life Program; RISH Health Science Tech rotational program and the Learning Lab for Health Sciences at the Continuing Care Campus to expand outreach and awareness of community resources; provide support with charitable contribution to community agencies to improve awareness of services.	
Cancer	Provide low-cost screening mammograms to area residents through MHS' Mobile Mammography program; provide ongoing community education and support services (such as Senior Access Generations programming; Asian Breast Health Outreach Project and high risk assessment clinic at the Richardson Cancer Center.	

Appendix E: Evaluation of Prior Implementation Strategy Impact

Status continued
• 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) • Offer 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