COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION:

Diabetes

Parkland
Care. Compassion. Community.

TABLE OF CONTENTS

COMMUNITY HEALTH NEEDS ASSESSMENT
PROGRAM DESCRIPTION

Diabetes

A. PROBLEM STATEMENT

There is a high prevalence of diabetes among residents living in CHNA target ZIP Codes 75210, 75211, 75215, 75216, 75217 and 75241.

B. STRATEGY

Deploy primary, secondary and tertiary interventions as described in the activity section that focuses on individuals from CHNA target ZIP Codes.

C. METRICS

1. Number of patients from the targeted population screened for diabetes and receiving targeted follow-up based on screening results

2. Percentage of patients with diabetes from the targeted population who performed an HbA1c test

3. Percentage of patients with diabetes from the targeted population whose most recent HbA1c level is > 9.0%

4. Percentage of patients with diabetes from the targeted population with HbA1c level > 9.0% and PSAM score < 60%

5. Percentage of patients with diabetes from the targeted population who received a foot exam

6. Percentage of patients with a diagnosis of a diabetic foot problem from the targeted population who experienced an amputation

D. BUDGET (as of August 31, 2020)

Diabetes
Financial Summary

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Gross Revenue	$0	$0	$0	**$0**	**$0**	**$0**
Deductions from Revenue	-	-	-			**-**
Net Revenue	-	-	-			**-**
Expenses						
Salaries	289,194	301,176	313,618	326,535	336,331	**1,566,854**
Benefits	62,466	65,054	67,741	70,532	72,647	**338,440**
Med/Surg Supplies-Baxter	7,200	4,000	11,200	6,800	8,800	**38,000**
Lab Costs	3,000	10,000	13,000	17,000	22,000	**65,000**
IT Cost	15,500	6,700	7,900	5,500	9,100	**44,700**
Screen Toolkit Equipment	2,300	-	2,300	600	600	**5,800**
Supplies COPC Podatric Team	-	-	18,000	-	-	**18,000**
Transportation Options (Est. $50 p/patient)	1,500	5,000	6,500	8,500	11,000	**32,500**
Management Platform Diabetes Device	-	3,000	3,000	3,000	3,000	**12,000**
Marketing and Educational Materials	4,595	6,595	6,595	7,595	7,595	**32,795**
Miscellaneous Supplies	4,100	7,200	7,200	8,200	9,200	**35,900**
Total Expenses	**389,855**	**408,726**	**457,054**	**454,261**	**480,273**	**2,190,169**
Net Income	(389,855)	(408,726)	(457,054)	(454,261)	(480,273)	**(2,190,169)**
Indirect Expense Allocation (0% of Total Expenses)	-	-	-	-	-	**-**
Net Income after Indirect Expenses	**$ (389,855)**	**$ (408,726)**	**$ (457,054)**	**$ (454,261)**	**$ (480,273)**	**$ (2,190,169)**
Capital	-	-	-	-	-	-
Total	**$ (389,855)**	**$ (408,726)**	**$ (457,054)**	**$ (454,261)**	**$ (480,273)**	**$ (2,190,169)**
FTEs	**3.70**	**3.80**	**3.90**	**4.00**	**4.00**	**3.88**
Total Direct Expenses	**389,855**	**408,726**	**457,054**	**454,261**	**480,273**	**2,190,169**

E. STAFFING (as of 8/31/20)

#	FTE Description	Scope of Service	Year 1
1	Diabetes Care and Education Specialist (CDCES)	The overall scope of services of this position is: 1. CHW training, ongoing oversight / support 2. Developing curriculum for Diabetes education and community awareness programs 3. Act as community liaison between CHW and community partners 4. Connecting patients to Parkland Health & Hospital Systems care – COPC, OPC, and hospital 5. Metric / Data collection support 6. Participates in providing training/resources to multidisciplinary health care team PRN on diabetes community initiatives	2.0
2	Social Worker (LMSW)	1. Assist in patient screening, SDOH assessment completion, and Psychosocial needs evaluation 2. Function as a clinical extension of CHW, particularly for high risk stratification 3. Counsels - Emotional, social, and financial consequences of illness and/or disability 4. Connecting patients to Parkland Health & Hospital Systems care – COPC, OPC, and hospital	1.0
3	Registered Nurse - RN II	1. Provide guidance and support to on-site screening staff 2. Responsible for logistics and risk stratification for community screening 3. Support CDCES and CHW in providing basic education and awareness to screened patients 4. Coordinate and schedule follow-up within Parkland	0.5
	Medical Assistant	1. Communicates effectively with patients and their families regarding the care plan 2. Provides clinical and administrative support to community screening events 3. Ensure patients' follow-ups are scheduled in a timely manner 4. Serves as a patient advocate, focusing on patient needs, confidentiality, and preferences. 5. Monitors ongoing patient status and responds to any change in patient's condition by notifying the care team members.	0.2
	Total FTEs		**3.7**

F. INTERVENTION DEPLOYMENT

Goal 1: Increase the number of patients from the targeted population screened for diabetes and receiving targeted follow-up based on screening results by 2022 (2020: 2,838, 2021: 3,265, 2022: 3,998)						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
1	Identify Community Partners / stakeholders	Community Screening	• Identify and establish collaborative partnerships with community stakeholders – both clinical and nonclinical (eg. SDOH) to identify and coordinate community opportunities, build community capacity, reduce service duplication and optimize available resources	• Diabetes CHNA Team • Parkland Community Relations Team	# of community partners # of collaborative activities Community partner satisfaction	Community Partners 2020: 7 2021: 12 2022: 11

2	Patient Identification	Community Screening	• Administer Diabetes Screening Questionnaire
			• Perform Random Blood Glucose (RBG) screenings to identify patients with diabetes according to the following guidelines:
			  • RBG <140 mg/dL
			  • RBG >=140 mg/dL
			  • RBG > 400 mg/dL
			• SDOH screening & resource connection
			• Complete insurance coverage verification or referral to PFA
				• CHW
				• RN
				• PCP
				• PFA
					# of patients screened
					# of PFA enrollments
					# of patients referred to a Parkland PCP
					# of patients sent to ED
					# of SDOH assessments
					# of patients link to care
						Screenings
						2020: 2,838
						2021: 3,265,
						2022: 3,998
						PFA Referral
						2020: 539
						2021: 620
						2022: 770

[1] Assumption: 19% of Dallas County population is uninsured as noted in Community Health Needs Assessment

Goal 1: Increase the number of patients from the targeted population screened for diabetes and receiving targeted follow-up based on screening results by 2022 (2020: 2,838, 2021: 3,265, 2022: 3,998)

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact

3	Random capillary blood (RBG) glucose:
	RBG < 140 mg/dL
		Real Time during screening	Provide Healthy Living education to the patient that highlights the following:
			• Understanding diabetes[2]
			  • Understanding type of diabetes the patient has and its related symptoms
			• Healthy eating
			  • Emphasis on 3 planned meals that are low in carbohydrates
			• Exercise
			  • Promotes physical activity 30 minutes a day, 5 days a week
			• Taking medication
			  • Understanding the type of medication using timely administration. Also, focusing on medication refills
			• Monitoring blood glucose
			  • Promotes self-check of blood glucose at regular intervals
			• Lowering risk
			  • Understanding ways to avoid complications of the disease
			• Healthy coping
			  • Promotes change in the way to approach diabetes
			• No formal follow-up required when the RBG is <140 mg/dL:
			  • provide written resources
			  • consider Diabetes Prevention Program / alternate prevention resources
				• CHW
				• CDCES
				• RN
					# of patients with BG <140mg/dL
					# of patients receiving education
						Normal Screenings[3]
						2020: 2,540
						2021: 2,922
						2022: 3,578
						Education Sessions
						2020: 2,540
						2021: 2,922
						2022: 3,578

[2] Based on Parkland Health & Hospital System's Healthy Living with Diabetes Class Program - Recognized by the American Diabetes Association for Quality Self-Management Education and Support. https://www.parklandhospital.com/Uploads/Public/Documents/PDFs/Diabetes/Diabetes%20Book.pdf

[3] Data based on Texas data https://demographics.texas.gov/Resources/publications/2018/2018_12_17_DiabetesProfile.pdf

Goal 1: Increase the number of patients from the targeted population screened for diabetes and receiving targeted follow-up based on screening results by 2022 (2020: 2,838, 2021: 3,265, 2022: 3,998)

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact

4	Random capillary blood (RBG) glucose:
	RBG ≥ 140 mg/dL - Hi
		At the time of screening	Document recommendation for formal follow-up diabetes screening as follows:
			• Schedule established Parkland patient for confirmatory test
			  • Fasting Blood Glucose
			  OR
			  • HbA1c
			• Based on clinical assessment, schedule confirmatory test within the following timeframes:
			  • RBG 140-199mg/dl - 6 months
			  • RBG 200-399mg/dL - 3 months
			  • RBG 400mg/dL- ≤Hi - 14 days
			  • RBG 'Hi' - Emergent Assessment
			• Document recommendation for patient to go to Urgent Care or Emergency Department
			• Provide information / diabetes education to the community member / patient which may address the following:
			  • To include lifestyle information for BG<140mg/dL, as well as consider:
			  • **Taking medication**
			  Understanding medication, timely administration, medication refills
			  • **Monitoring blood glucose**
			  Self-blood glucose checks, glucose targets
			  • **Lowering risk**
			  Reducing complication risk, annual health screening recommendations
			  • **Healthy coping**
			  Disease acceptance, reducing distress
			• Recommend participation in and provide program resources for formalized diabetes self-management education program if not attended in previous year
			• When a patient has a PCP external to Parkland, he or she is advised to follow-up with PCP for confirmatory test in the same timeframe as above.
				• CHW
				• RN
				• CDCES
					# of patients with RBG: 140-199 mg/dl
					# of patients with RBG 200-399 mg/dL
					# of patients with RBG 400 mg/dL- <Hi
					# of patients with RBG 'Hi'
					# of patients with completed Fasting Blood Glucose
					# of patients with completed HbA1c
					# of patients who require a primary care connection
					# of patients with external primary care
					# of patients sent to ED
						TBD

5	Parkland diabetes screening	Real Time	• Identify at-risk for diabetes patients at Parkland • Perform lab HbA1c screening test (Not POC A1c) • Ensure timely care team follow-up	• MD/APP • Pharmacist	# of patients screened # of patients diagnosed with pre-diabetes and diabetes	TBD

Goal 2: Increase percentage of patients with diabetes from the targeted population who performed an HbA1c from 87.59% to 90% by 2022						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
	Identify Parkland patients with an existing ICD10 diagnosis of diabetes	Annually	• Identify Parkland patients with an ICD-10 diagnosis for diabetes across COPC, OPC and hospital locations who have not had a POC or lab A1c test completed in the reporting year via: • EPIC Problem List • EPIC Health Maintenance • EPIC Diabetes Overview Snapshot • Care gaps RWB • Other sources	• MD / APPs • Multi-disciplinary clinical team • Business staff	# of patients requiring an A1c in the reporting year # of patients who completed an A1c in the reporting year	
1	Community diabetes screening follow-up established Parkland patients with RBG 140-199 mm/dL	6 months from screening	• Conduct clinic visit with PCP/APP as per guidelines and perform confirmatory test HbA1c • Document the results and schedule follow-up visit according to patients' clinical assessment • Identifying opportunities to connect patients to community resources • Provide diabetes education materials and /or refer patients diagnosed with diabetes to multidisciplinary team members and / or Healthy Living with Diabetes (HLWD) education for any or all of the following diabetes relevant topics: • Understanding diabetes • Healthy eating recommendations • Physical activity • Understanding medication • Diabetes monitoring / glucose management • Reducing risk – maintaining health • Healthy coping	• MD/APP • RN • CHW • CDCES	# of patients who completed an A1c in the reporting year Time duration from screening date # of patients receiving education materials # of patients referred for multi- disciplinary visit # of patients referred for HLWD program # of patients connected with CBOs	**TBD**

Goal 2: Increase percentage of patients with diabetes from the targeted population who performed an HbA1c from 87.59% to 90% by 2022						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**

2	Community screening follow-up
	established Parkland patients with
	RBG 200-399 mm/dL
		3 months from screening	• Conduct clinic visit with PCP/APP as per guidelines and perform confirmatory test HbA1c
			• Document the results and schedule follow-up visit according to patients' clinical assessment
			• Identifying opportunities to connect patients to community resources
			• Provide diabetes education materials and /or refer patients diagnosed with diabetes to multidisciplinary team members and / or Healthy Living with Diabetes (HLWD) education for any or all of the following diabetes relevant topics:
			  • Understanding diabetes
			  • Healthy eating recommendations
			  • Physical activity
			  • Understanding medication
			  • Diabetes monitoring / Glucose management
			  • Reducing risk – maintaining health
			  • Healthy coping
				• MD/APP
				• RN
				• CHW
				• CDCES
					# of patients who completed an A1c in the reporting year
					Time duration from screening date
					# of patients receiving education materials
					# of patients referred for multi- disciplinary visit
					# of patients referred for HLWD program
					# of patients connected with CBOs
						TBD

3	Community screening follow-up
	established Parkland patients with
	RBG 400 - <= Hi mm/dL
		14 days from screening	• Conduct clinic visit with PCP/APP as per guidelines and perform confirmatory test HbA1c
			• Document the results and schedule follow-up visit according to patients' clinical assessment
			• Identifying opportunities to connect patients to community resources
			• Patients are educated on diabetes relevant topics such as:
			  • Maintaining healthy weight
			  • Eat healthy diet with low carbohydrates and sugar
			  • Increasing physical fitness
			  • Ways to manage stress
			  • Limiting alcohol
			  • Smoking cessation
			  • Take medications properly
			  • Working with healthcare team
				• MD/APP
				• RN
				• CHW
				• CDCES
					# of patients who completed an A1c in the reporting year
					Time duration from screening date
					# of patients receiving education materials
					# of patients referred for multi-disciplinary visit
					# of patients referred for HLWD program
					# of patients connected with CBOs
						TBD

Goal 2: Increase percentage of patients with diabetes from the targeted population who performed an HbA1c from 87.59% to 90% by 2022						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
4	Follow-up patients when RBG >= 140 mm/dL		• When a patient has a PCP external to Parkland, he or she is advised to follow-up with PCP / medical home for confirmatory test in the same timeframe as above	• CDCES • CHW • RN • SW	# of patients with an external PCP who performed confirmatory test	**TBD**
5	Education and training – Community and Parkland workforce	March 2021-Ongoing	• Develop, implement and evaluate community awareness campaign / education regarding importance of glucose monitoring and A1c completion • Develop, implement and evaluate workforce training activity on importance of glucose monitoring and A1c completion	• Diabetes CHNA team • CDCES • CHW • RN • SW	# of and impact of community awareness campaigns / education # of and impact of workforce training activities	**TBD**
6	Point of care data optimization (EPIC / Diabetes Dashboard)	2021	• Review Information Technology (IT) opportunities to enhance point of care decision tools for clinicians to identify need for A1c test completion	• Parkland IT team • Diabetes CHNA team	Data optimization activity # of patients who completed an A1c in the reporting year Care team satisfaction	**TBD**

Goal 3: Decrease the percentage of patients with diabetes from the targeted population whose most recent HbA1c level is > 9.0% from 37.7% to 32.3% by 2022						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**

1	Identify and follow-up with established patients with HbA1c > 9%	Within 3 months from date of HbA1c > 9%	• Conduct clinic visit with PCP/APP/ Pharmacist as per guidelines to:
			  • Confirm HbA1c level
			  • Evaluate medication regimen and medication adherence
			• Schedule follow-up visit according to patients' clinical assessment
			• Patients are referred to multidisciplinary care team and / or HLWD program for education on any or all of the following topics:
			  • Understanding diabetes
			  • Healthy eating recommendations
			  • Physical activity
			  • Understanding medication
			  • Diabetes monitoring / glucose management
			  • Reducing risk – maintaining health
			  • Healthy coping
			• Identify opportunities to connect patients with appropriate community partners. For non-Parkland patients, provide information on available Diabetes Self-Management Education programs in the community
				• MD/APP
				• Pharmacist
				• RN
				• CDCES
				• CHW
					# of patients with HbA1c>9%
					# of patients scheduled for and who attended follow-up visit (multidisciplinary care team / HLWD program)
					# of completed patient visits
					# of patients connected to CBOs
						TBD

2	Follow-up with established patients with HbA1c ≤ 9%	In 6 months from HbA1c identification ≤ 9%	• Conduct clinic visit with PCP/APP/ Pharmacist as per guidelines to:
			  • Confirm HbA1c level
			  • Evaluate medication regimen and medication adherence
			• Schedule follow-up visit according to patients' clinical assessment
			• Patients are referred to a multidisciplinary care team and / or HLWD program for education on any or all of the following topics:
			  • Understanding diabetes
			  • Healthy eating recommendations
			  • Physical activity
			  • Understanding medication
			  • Diabetes monitoring / glucose management
			  • Reducing risk – maintaining health
			  • Healthy coping
			• Identify opportunities to connect patients with appropriate community partners
				• MD/APP
				• RN
				• CHW
				• CDCES
					# of patients with HbA1c ≤ 9%
					# of patients scheduled for and who attended follow-up visit (multidisciplinary care team / HLWD
					# of patients provided education materials
					# of patients connected to CBOs
						TBD

Goal 3: Decrease the percentage of patients with diabetes from the targeted population whose most recent HbA1c level is > 9.0% from 37.7% to 32.3% by 2022						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
3	Education and training – Community and Parkland workforce	March 2021 -ongoing	• Develop, implement and evaluate community awareness campaigns / education regarding importance of glucose control • Develop, implement and evaluate workforce training activity on importance of glucose control and ADA standards of diabetes care	• Diabetes CHNA team • CDCES • CHW • RN • SW	# of and impact of community awareness campaigns / education # of and impact of workforce training activities	**TBD**
4	Establish care management pathway for A1c>9%	December 2021	• Optimize multidisciplinary care team utilization to reduce A1c>9% • Establish streamlined care recommendations to reduce existing or risk of A1c>9%	• Diabetes CHNA team • MD/APP • Diabetes specialty care teams	Care management pathway development # of patients with an A1c >9% Care team satisfaction and engagement Patient satisfaction	
5	Optimize / Expand visit types	Ongoing – Real Time	• Provide expanded primary care access through alternate visit types (virtual, connected care, SMA, RN led clinic, multi-discipline Visits, etc.) – as part of Care Management Pathway	• MD/APP • Diabetes specialty care teams	# Visit types Care team engagement and satisfaction Patient satisfaction	
6	Point of care data optimization (EPIC / Diabetes Dashboard)	June 2022	• Review Information Technology (IT) opportunities to enhance point of care decision tools for clinicians to establish glucose control and adherence to ADA standards of diabetes care (patient, provider, clinic and system level)	• Parkland IT team • Diabetes CHNA team	Data optimization activity # of patients whose A1c > 9% in the reporting year Care team satisfaction	

Goal 4: Decrease the percentage of patients with diabetes from the targeted population with HbA1c level > 9.0% and PSAM score[4] < 60% from 20.6% to 15% by 2022

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact
1	Identifying patients with A1c > 9% and P-SAM < 60%	Real Time	• Conduct clinic visit with PCP/APP/ clinical pharmacist as per guidelines and confirm the HbA1c level • Utilize PSAM tool in EPIC to identify patients with PSAM < 60% - COPC, Diabetes Specialty Clinic, hospital	• PCP/APP • RN • CDCES • Pharmacist	# of patients with an HbA1c > 9 # of patients with a PSAM < 60% HbA1c and PSAM improvement results	**TBD**

2	Establish care management pathway for patients with HbA1c > 9 and PSAM < 60%	Real Time	• Develop and / or utilize medication adherence assessment tool to understand barriers and develop associated care management pathway for A1c > 9% and low medication adherence (PSAM < 60%) – COPC, Diabetes Specialty Clinic and hospital
			• Identifying and addressing barriers to medication adherence such as:
			  • Lack of understanding
			  • Cost
			  • Access
			  • Complexity of medication
			  • Health literacy
			  • Side effects
			  • Belief systems/culture
			  • Others
			• Schedule patients with relevant provider and / or multidisciplinary team member(s) based on identified barrier(s), optimizing alternate visit types:
			  • Virtual visit
			  • Shared Medical Appointments
			  • RN led clinic
			  • Specialty visits
			• Schedule follow-up visit according to patients' clinical assessment
				• Diabetes CHNA team
				• MD/APP
				• RN
				• SMA
				• SW
				• CDCES
				• Nurse Navigator
				• Pharmacist
					Care management pathway development, implementation and evaluation
					# of patients scheduled for virtual visits
					# of patients scheduled for SMA visit
					# of patients scheduled for RN-led clinic
					# of patients scheduled for specialty visits
					# of patients with medication adherence barriers
					# of patients scheduled for follow-up
						TBD

3	Point of care data optimization (EPIC / Diabetes Dashboard)	December 2021	• Review Information Technology (IT) opportunities to enhance point of care decision tools for clinicians to establish glucose control and medication adherence (patient, provider, clinic and system level) • Explore opportunities for PSAM optimization and provider utilization	• Parkland IT team • Diabetes CHNA team • Pharmacy team	Data optimization activity # of patients whose A1c > 9% in the reporting year and P-SAM < 60% Care team utilization / satisfaction	
4	Education and training: Community and Parkland workforce	Ongoing	Develop, implement and evaluate community awareness campaigns / education regarding importance of glucose control and medication adherence Develop, implement and evaluate workforce training activity on importance of glucose control and medication adherence	Diabetes CHNA team CDCES CHW RN SW	# of and impact of community awareness campaigns / education # of and impact of workforce training activities	

[4] Based on Parkland Score for Adherence to Medication (PSAM) Program https://www.parklandhospital.com/news-and-updates/did-you-take-your-meds-1533#:~:text=An%20innovative%20pilot%20program%20called,chronic%20diseases%20such%20as%20diabetes.

Goal 5: Increase percentage of patients with diabetes from the targeted population who received a foot exam from 52.2% to 76.7% by 2022						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
1	Patient Identification	Community screening	• Educate on performing self-foot assessments during community screening, education and awareness activities to alert individuals with diabetes to the risk of or identification of acute or chronic foot complications • Complete insurance coverage verification or referral to PFS if identified need for medical home or podiatry services at Parkland	• CDCES • CHW • RN • PFA	# of patients with diabetes who received at least annual foot exam # of patients with foot wound	**Screenings** 2020: 2,989 2021: 3,137 2022: 4,199

2	Patient Identification	Parkland Real Time	• All individuals with diabetes attending primary care, diabetes specialty service and where possible, hospital care at Parkland should be assessed for and receive an annual (at minimum) foot exam / screen:
			  • Workforce training on importance of a foot screening
			  • Training to ensure accurate completion of foot exam
			  • Optimize electronic capture of foot exam completion
				• Diabetes CHNA team
				• Primary care providers
				• Diabetes specialty team
				• RNs
					# of patients receiving at least annual foot exam in reporting year	

Goal 5: Increase percentage of patients with diabetes from the targeted population who received a foot exam from 52.2% to 76.7% by 2022						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**

2	Risk stratified approach to foot care	Real Time	• Based on foot risk screening / foot exam:
			  • Low foot risk – Primary care management
			  • Moderate foot risk – Community / COPC podiatry services
			  • High foot risk (wound) – Foot Wound Clinic / specialist team & potentially ED / hospital
			• Refer and schedule established Parkland patient for required initial and follow-up foot care visits:
			  • Primary care provider (Low risk)
			  • Community / COPC podiatry (Moderate risk)
			  • Foot Wound Clinic – High risk (Wound) (and potentially ED / Hospital)
			• Educating patients with diabetes on preventive foot care to avoid complications[5]:
			  • Daily feet check
			  • Regular feet washing
			  • Moisturizing feet daily
			  • Wearing appropriate footwear and socks
			  • Toenail care
			  • Diabetes control
			  • Smoking cessation
			  • Keeping active
			• Identify opportunities to connect patients with appropriate community resources (Podiatrists, footwear, etc.)
			• When a patient has a PCP external to Parkland, he or she is advised to follow-up with PCP as per clinical assessment
				• MD/APP
				• RN
				• Podiatrist
				• SMA
				• CHW
				• CBO
					# of diabetic patients who received a diabetes foot exam
					# of patients who received Podiatrist visit (Community/ COPC, Foot Wound Clinic)
					# of patients educated on self-foot care
					# of patients connected to community partners
						TBD

3	Point of care data optimization (EPIC / Diabetes Foot Dashboard)	December 2021	• Review Information Technology (IT) opportunities to enhance point of care decision tools for clinicians to establish foot exam activity and results (patient, provider, clinic and system level). • Develop broader foot service data dashboard	• Parkland IT team • Diabetes CHNA team • Podiatrists	Data optimization activity # of patients who received an annual foot exam Care team utilization / satisfaction	
4	Education and training: Community and Parkland workforce	Ongoing	• Develop, implement and evaluate community awareness campaigns / education regarding importance of self-foot care and examination • Develop, implement and evaluate workforce training activity on diabetes foot examination	• Diabetes CHNA team • Podiatrists • CDCES • CHW • RN • SW	# of and impact of community awareness campaigns / education # of and impact of workforce training activities	

[5] Based on Parkland's Twelve Tips For Healthy Feet For People With Diabetes https://www.parklandhospital.com/news-and-updates/twelve-tips-for-healthy-feet-for-people-with-diabe-643

Goal 6: Decrease percentage of patients with a diagnosis of a diabetic foot problem from the targeted population who experienced an amputation from 5.09% to 4% by 2022						
	Intervention	**Time of Services**	**Scope of Service**	**Staff**	**Outputs**	**Internal Capacity Impact**
1	Patient Identification	Community Screening	• Education on performing self-foot assessments during community screenings to alert people with diabetes to the risk of or identification of acute or chronic foot complications in order to reduce amputation risk • Complete insurance coverage verification or referral to PFS if identified need for medical home or podiatry services at Parkland	• CDCES • CHW • RN • PFs	# of patients with diabetes who received at least an annual foot exam # of patients with amputation or at-risk feet (e.g. wound)	**Screenings** 2020: 263 2021: 252 2022: 219
2	Patient Identification	Parkland Real Time	• All individuals with diabetes attending primary care or diabetes specialty service visits at Parkland should receive an annual (at minimum) foot exam / screen: • Workforce training on importance of and accurate completion of foot exam	• Diabetes CHNA team • Primary care providers • Diabetes specialty team • RNs	# of patients receiving at least annual foot exam in reporting year	

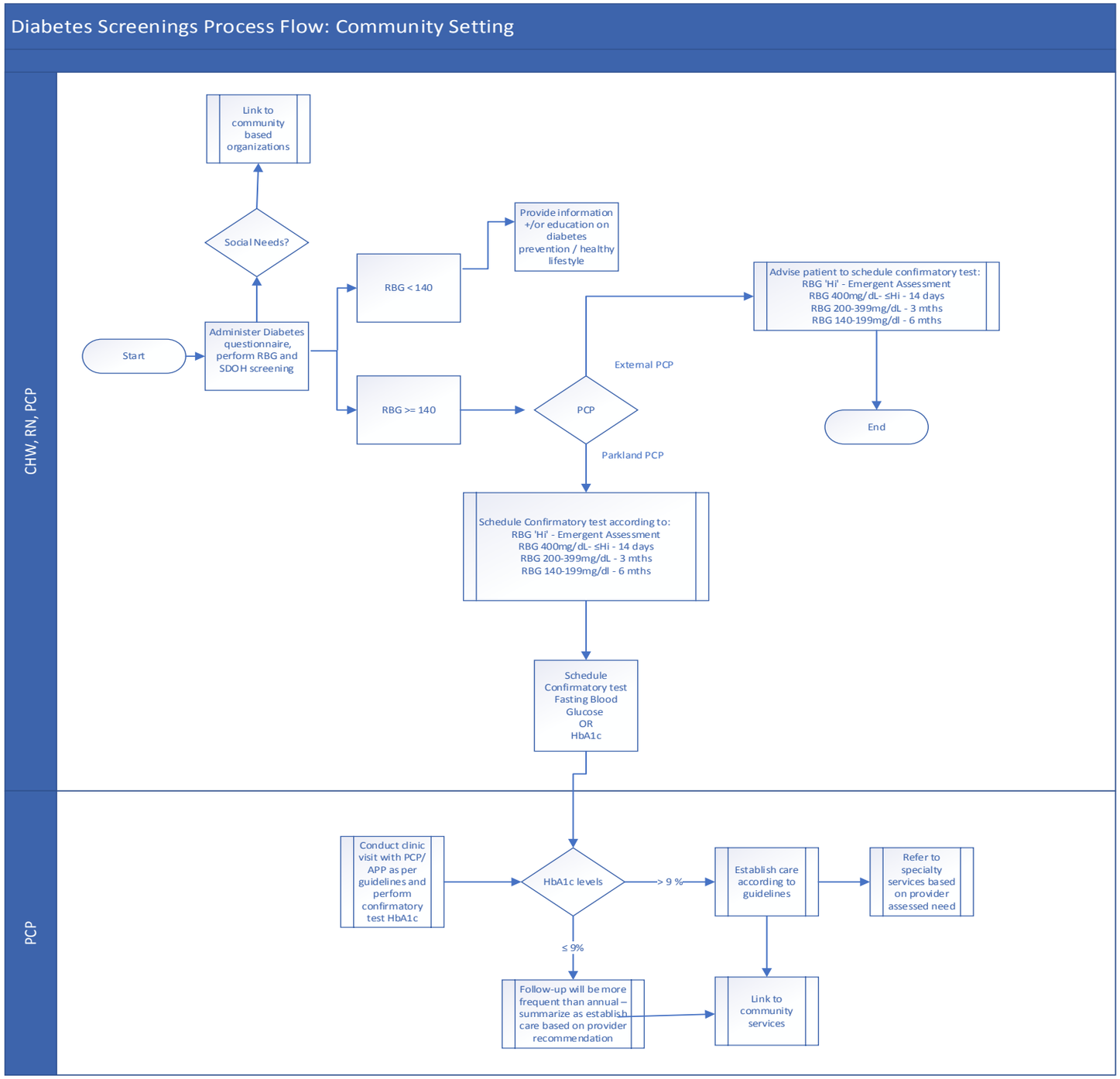
Goal 6: Decrease percentage of patients with a diagnosis of a diabetic foot problem from the targeted population who experienced an amputation from 5.09% to 4% by 2022

	Intervention	Time of Services	Scope of Service	Staff	Outputs	Internal Capacity Impact

2	Risk stratified approach to foot care	Real Time	• Based on foot risk screening / foot exam:
			  • Low foot risk – Primary care management
			  • Moderate foot risk – Community / COPC podiatry services
			  • High foot risk (wound) – Foot Wound Clinic / specialist team
			• Refer and schedule established Parkland patient for required initial and follow-up visits:
			  • Primary care provider (Low risk)
			  • Community / COPC podiatry (Moderate risk)
			  • Foot Wound Clinic – High risk (Wound)
			• Orders for and attainment of required foot supplies, equipment (e.g., boots, orthotics, walking aids, wound supplies)
			• Educating patients with diabetes on preventive foot care to avoid complications:
			  • Daily feet check
			  • Regular feet washing
			  • Moisturizing feet daily
			  • Wearing appropriate footwear and socks
			  • Toenail care
			  • Diabetes control
			  • Smoking cessation
			  • Keeping active
			• Identify opportunities to connect patients with appropriate community resources (Podiatrists, footwear, etc.)
			• When a patient has a PCP external to Parkland, he or she is advised to follow-up with PCP as per clinical assessment
				• MD/APP
				• RN
				• Podiatrist
				• SMA
				• CHW
				• CBO
					# of patients with diabetes referred community and specialty services podiatrists
					# of patients in low, moderate or high foot risk categories
					Time from podiatrist referral to visit across foot risk categories
					# of patients educated on self-foot care
					# of patients connected to community partners or resources
						TBD

3	Education and training: Community and Parkland workforce	Ongoing	• Develop, implement and evaluate community awareness campaigns / education regarding importance of self-foot care and examination • Develop, implement and evaluate workforce training activity on diabetes foot examination and prevention strategies for foot complications. As part, optimize Information Technology (IT) opportunities to enhance point of care decision tools for clinicians to establish foot exam activity and results, disease progression	• Diabetes CHNA team • Podiatrist • CDCES • CHW • RN • SW	# of and impact of community awareness campaigns / education # of and impact of workforce training activities	

G. SERVICE DELIVERY PROCESS FLOW



H. PARTNERSHIPS

	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status

1	Baylor Scott & White Health and Wellness Center at the Juanita J. Craft Recreation Center	Hatcher service area and CHNA ZIP Codes	• Primary care from integrated team of health professionals
			• Physician
			• Nurse Practitioner
			• Behavioral Health Therapist
			• Licensed Social Worker
			• Pharmacist
			• Diabetes Educators
			• Registered Dietitians
			• Referral Coordinator
			• Medical Assistants
			• Community Health Workers
				Hatcher service area and CHNA ZIP Codes	• GLB – Group Lifestyle Balance - 12-week weight loss program
					• HELP – Healthy Eating & Exercise Lifestyle Program
					• National Diabetes Prevention Program
					• CDC recognized
					• For people who have "pre-diabetes" or are at risk of developing type 2 diabetes
					• Year-long program
					  • DSMES – Diabetes Self-Management Education and Support classes taught by registered dietitians, requires physician referral
					  • MNT – Medical nutrition counseling by registered dietitians, requires physician referral
					  • Wrap-around services
					• Farm Stand
					• Cooking demos and classes
					• Fitness classes
						N/A

2	Inspired Vision Compassion Center	75217	IVCC is a non-profit that provides access to basic needs in a grocery store format to residents of Dallas in need. Services provided include: food, clothing, furniture, personal hygiene, animal supplies, emergency baby items, medical/first aid supplies, school supplies, etc. Each spring – they host a "Free Prom Store."	• All ages • Providing groceries for 1,400 – 1,900 families/day/5 days a week • Majority Hispanic population • No ZIP Code restrictions/no ID restrictions	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care	Negotiation Phase/Outlining Agreement

	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
3	City of Dallas – Parks & Recreation: Larry Johnson	75210	Recreation center features include: fitness center, gymnasium, kitchen, large meeting room, outdoor basketball court, parking, playground, small meeting room, youth programs, afterschool and summer camps, active adult and senior programs, adult sports programs	• Heavy senior concentration • 50-60 daily individuals (pre-COVID-19)	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services	Negotiation Phase/Outlining Agreement
4	City of Dallas – Parks & Recreation: John C. Phelps	75216	Recreation center features include: baseball field, fitness center, gymnasium, kitchen, large meeting room, outdoor basketball court, parking, playground, small meeting room, tennis court, walking trails, picnic area, youth dance instruction and cheerleading, after school programs, senior activities and adult fitness classes	• Larger senior population	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services	Negotiation Phase/Outlining Agreement
5	City of Dallas – Parks & Recreation: Janie C. Turner	75217	Recreation center features include: baseball field, fitness center, gymnasium, kitchen, large meeting room, outdoor basketball court, parking, small meeting room, tennis court, youth cheerleading & dance instruction, after school programs, adult fitness classes, senior activities, computer room, and popular boxing program for kids in partnership with DPD	• All ages	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care	Negotiation Phase/Outlining Agreement
6	Community Council of Greater Dallas	HQ: 75247, however serves all of Dallas County and immediate areas	Community action agency/social services organization focusing on poverty alleviation – increasing awareness and access to services. Current programs include: 1. serving seniors with benefits counseling, nutritional services, care coordination, caregiver support & advocacy, meals, transportation, and other senior assistance 2. Coordinating with a network of 1,000 agencies to deliver programs/services to low-income residents – removing barriers to employment and transitioning people out of poverty by providing job training, education, and wrap around services 3. 2-1-1- hotline information and referrals – fielding calls for meals, transportation, and assistance for aging, elderly, senior citizens, and people with disabilities	• Aging, elderly, senior citizens • Low-income • People with disabilities	PFA Training	Negotiation Phase/Outlining Agreement

	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
7	Dallas Housing Authority (DHA)	Various; starting with 75212	DHA provides quality, affordable housing to low-income families and individuals through administration of housing assistance programs across North Texas. DHA is interested in providing access to supportive resources for families – creating housing solutions in healthy, inclusive communities that offer economic, educational, and social growth opportunities.	• 46% of clients are seniors or persons with disabilities • Average annual income: $14,000 • 83% female head of households • 86% African American • Average age: 49 • Serving ~55,000 individuals across 4,903 rental housing units	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care PFA Training	Negotiation Phase/Outlining Agreement
8	Los Barrios Unidos Community Clinic	75211, 75212	Los Barrios operates a Community health clinic in a high need area – known for having quality bilingual staff in English and Spanish. They do not turn away anyone for inability to pay, and accepts Medicaid, CHIP, Medicare, private insurance, and offers a sliding fee scale based on federal poverty level guidelines. The clinic is a federally qualified health center that provides comprehensive primary care services to prevent illness and promote health.	• Economically disadvantages, low-income, and poor people minorities • ~87,000+ annual patient visits	PFA Training	Negotiation Phase/Outlining Agreement
9	Healing Hands Ministries	75243, 75231	Healing Hands operates 7 clinics including a patient-centered community health center. It can serve as a permanent medical home for uninsured, underinsured, and has a goal to teach refugees how to care for their children. They also provide shared medical appointments where groups of 10-12 people are educated in a group setting allowing for peer discussion and support. They have 3 translators on staff and employ a language line.	• 20,000+ individual patients annually who speak 68 different languages • 61,000+ patient visits annually • Children and families • 67% of patients are women	PFA Training	Negotiation Phase/Outlining Agreement
10	Foremost Family Health Center	75215, 75180	Foremost is a federally qualified health center offering access to affordable and comprehensive medical, dental, and behaviorally health services, regardless of ability to pay.	• ~6,161 patients	PFA Training	Negotiation Phase/Outlining Agreement

	CBO Name	ZIP Codes	Scope of Service	Population	Services for Parkland Patients	MOU Status
11	Crossroads Community Services	HQ: 75236, however serves Dallas, Ellis, and Navarro Counties	Crossroads provides nutritious food and supportive education to low-income families and individuals. They have a main hub that serves as a food pantry, and also have partnered with 1200+ community distribution partners (CDPs) to expand their food assistance reach. Crossroads is also committed to meeting peoples basic needs and works with local partners to improve economic and health outcomes for their clients (UTSW, NTFB, Sharing Life Community Outreach, Parkland through BUILD Health Challenge project, DCHHS, University of Dallas)	• ~75,000 people including 26,500 children • Distributes ~9 million pounds of groceries annually • Low-income/economically disadvantaged people, dislocated people, unemployed/ underemployed	Virtual Care PFA Training	Executed
12	Cornerstone Crossroads Academy	75215	CCA's mission is to develop urban youth through education. They are a certified secondary/high school, and host youth development program. Their primary target are older students who need a 2nd change to earn a high school diploma or returning students. Many of CCA's students are transient. Tuition is free to students, and in lieu of tuition, students participate in community service opportunities. In addition to curriculum, students also meet 1:1 with a life coach weekly to identify areas of concern: social, emotional, and physical support for students who are on the verge or already homeless/in crisis. CCA has purchased The Phyllis Wheatley School, and plans to expand their services at its new location in the coming years. CCA also provides their community access to healthy foods by partnering with Crossroads Community Services.	• Ethnic/racial minorities • Ages 16+	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care	Negotiation Phase/Outlining Agreement
13	Voice of Hope	Physically located in 75212, but draws a large crowd from 75211	Voice of Hope is a non-profit seeking to provide character building, education support, life skills, and family support services to their clients. They work to equip families with resources and skills needed to overcome and break the poverty cycle. Youth programs include: ASPIRE after school program (homework help & a meal), Summer Day Camps, Kids Across America. Family and Community support programs include: Food Pantry as a community distribution partner with Crossroads Community Services, Fruits and Vegetables Outreach (with Hardies), holiday outreach, neighborhood watch groups, and activities for senior citizens including bible studies and knitting groups. Voice of Hope also partners with NTFB, DISD, World Vision, YMCA, Young Life, Mercy Street Dallas, and the West Dallas Initiative.	• All ages with a focus on school aged children and senior citizens	Community Hub: Health Screenings, SDOH Screenings, On-Site Financial Services, Virtual Care	Negotiation Phase/Outlining Agreement