Baylor Scott & White Health
Community Health Needs Assessment

North & West Emergency Health Community

Baylor Scott & White Emergency Hospital - Colleyville
Baylor Scott & White Emergency Hospital - Keller
Baylor Scott & White Emergency Hospital - Aubrey
Baylor Scott & White Emergency Hospital - Murphy

Approved by: Baylor Scott & White Health - North Texas Operating, Policy and Procedure Board on June 25, 2019

Posted to BaylorScottandWhite.com/CommunityNeeds on June 30, 2019

Table of Contents

Baylor Scott & White Health Mission Statement ... ***4***

Executive Summary ... ***6***

Community Health Needs Assessment Requirement ... ***8***

CHNA Overview, Methodology and Approach ... ***9***

Consultant Qualifications & Collaboration ... **9**

Collaboration ... **9**

Community Served Definition ... **10**

Assessment of Health Needs ... **11**

Quantitative Assessment of Health Needs – Methodology and Data Sources ... **11**

Qualitative Assessment of Health Needs and Community Input – Approach ... **12**

Methodology for Defining Community Need ... **16**

Information Gaps ... **16**

Approach to Identify and Prioritize Significant Health Needs ... **17**

Existing Resources to Address Health Needs ... **18**

North and West Emergency Health Community CHNA ... ***19***

Demographic and Socioeconomic Summary ... **19**

Public Health Indicators ... **29**

Watson Health Community Data ... **29**

Focus Groups & Interviews ... **29**

Community Health Needs Identified ... **31**

Prioritized Significant Health Needs ... **33**

Description of Health Needs ... **33**

Non-Physician Primary Care Providers ... 33
Food Insecurity ... 34
Motor Vehicle Driving Deaths with Alcohol Involvement ... 34
Alzheimer's/Dementia in the Medicare Population ... 35
Health Care Costs ... 36

Summary ... **36**

Appendix A: Key Health Indicator Sources ... ***37***

Appendix B: Community Resources Identified to Potentially Address Significant Health Needs ... ***42***

Resources Identified ... **42**

Community Healthcare Facilities ... **44**

Appendix C: Federally Designated Health Professional Shortage Areas and Medically Underserved Areas and Populations 46

Appendix D: Public Health Indicators Showing Greater Need When Compared to State Benchmark.. 48

Appendix E: Watson Health Community Data.. 50

Appendix F: Evaluation of Prior Implementation Strategy Impact.......................... 54

Baylor Scott & White Health Mission Statement

Our Mission

Founded as a Christian ministry of healing, Baylor Scott & White Health promotes the well-being of all individuals, families and communities.

Our Ambition

To be the trusted leader, educator and innovator in value-based care delivery, customer experience and affordability.

Our Values

- We serve faithfully
- We act honestly
- We never settle
- We are in it together

Our Strategies

- Health – Transform into an integrated network that ambitiously and consistently provides exceptional quality care
- Experience – Achieve the market-leading brand by empowering our people to design and deliver a customer-for-life experience
- Affordability – Continuously improve our cost discipline to invest in our Mission and reduce the financial burden on our customers
- Alignment – Ensure consistent results through a streamlined leadership approach and unified operating model
- Growth – Pursue sustainable growth initiatives that support our Mission, Ambition, and Strategy

WHO WE ARE

As the largest not-for-profit healthcare system in Texas and one of the largest in the United States, Baylor Scott & White Health was born from the 2013 combination of Baylor Health Care System and Scott & White Healthcare. Today, Baylor Scott & White includes 50 hospitals, more than 900 patient care sites, more than 7,500 active physicians, and over 47,000 employees and the Scott & White Health Plan.

Founded as a Christian ministry of healing, Baylor Scott & White Health promotes the well-being of all individuals, families and communities.
Mission
Strategies
Health
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Values
To be the trusted leader, educator and innovator in value-based care delivery, customer experience and affordability.
Ambition

Executive Summary

As the largest not-for-profit health care system in Texas, Baylor Scott & White Health (BSWH) understands the importance of serving the health needs of its communities. In order to do that successfully, we must first take a comprehensive look at the systemic and local issues our patients, their families and neighbors face when it comes to having the best possible health outcomes and well-being.

Beginning in June of 2018, a BSWH task force led by the Community Health, Tax Services, and Marketing Research departments began the process of assessing the current health needs of the communities served for all BSWH hospital facilities. IBM Watson Health (formerly known as Truven Health Analytics) was engaged to help collect and analyze the data for this process and to compile a final report made publicly available in June of 2019.

BSWH owns and operates multiple individual licensed hospital facilities serving the residents of north and central Texas. Four hospitals with overlapping communities have collaborated to conduct this joint community health needs assessment. This joint community health needs assessment applies to the following BSWH hospital facilities:

- Baylor Scott & White Emergency Hospital - Colleyville
- Baylor Scott & White Emergency Hospital - Keller
- Baylor Scott & White Emergency Hospital - Aubrey
- Baylor Scott & White Emergency Hospital - Murphy

For the 2019 assessment, the community includes the geographic area where at least 80% of the hospital facilities' admitted patients live. These hospital facilities collaborated to conduct a joint CHNA report in accordance with Treasury Regulations and 501(r) of the Internal Revenue Code. All of the collaborating hospital facilities included in this joint CHNA report define their community, for purposes of the CHNA report, to be the same.

Hospital facilities and IBM Watson Health (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. A qualitative analysis included direct input from community, focus groups and key informant interviews. 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 an indicator for the community served was worse than the Texas state benchmark. A need differential analysis conducted on all the low performing indicators determined relative severity by using the percent difference from benchmark. The outcome of this quantitative analysis 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 which clarified the assignment of severity rankings to 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.

Hospital clinical leadership and/or other invited community leaders reviewed the top health needs in a meeting to select and prioritize the list of significant needs in this health community. The meeting, moderated by Watson Health, included an overview of the CHNA process for BSWH, the methodology for determining the top health needs, the BSWH prioritization approach, and discussion of the top health needs identified for the community.

Participants identified the significant health needs through review of data driven criteria for the top health needs, discussion, and a multi-voting process. Once the significant health needs were established, participants rated the needs using prioritization criteria recommended by the focus groups. 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 resulting prioritized health needs for this community include:

Priority	Need	Category of Need
1	Ratio of Population to One Non-Physician Primary Care Provider	Access to Care
2	Health Care Costs (Price-Adjusted Medicare Reimbursements (Parts A and B) Per Enrollee)	Access to Care
3	Food Insecure	Environment – Food
4	Alzheimer's Disease/Dementia in Medicare Population	Mental Health
5	Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse

The assessment process identified and included community resources abole to addres significant needs in the community. These resources, located in the appendix of this report, will be included in the formal implementation strategy to address needs identified in this assessment. The approved report is publicly available by the 15th day of the 5th month following the end of the tax year.

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

The prioritized list of significant health needs approved by the hospitals' governing body and the full assessment is available to anyone at no cost. To download a copy, visit **BSWHealth.com/CommunityNeeds**.

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 accounted for 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 and 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

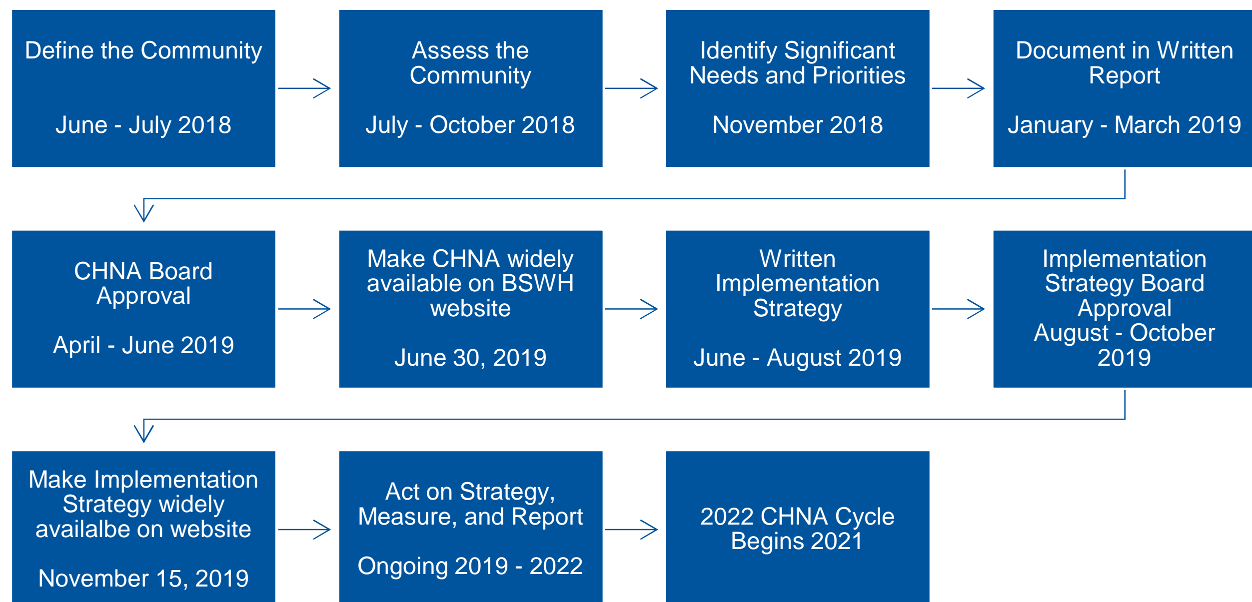
PPACA requires hospitals to adopt an Implementation Strategy to address prioritized community health needs identified through the assessment. An Implementation Strategy is a written plan that addresses each of the significant community health needs identified through the CHNA and is a separate but related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

The written Implementation Strategy must include the following:

- List of the prioritized needs the hospitals plan to address and the rationale for not addressing other significant health needs identified
- Actions the hospitals intend 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 hospitals plan to commit to address the health needs
- Describe any planned collaboration between the hospitals and other facilities or organizations in addressing the health needs

CHNA Overview, Methodology and Approach

BSHW began the 2019 CHNA process in June of 2018; the following is an overview of the timeline and major milestones.



BSWH partnered with Watson Health to complete a CHNA for qualifying BSWH hospital facilities.

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.

Collaboration

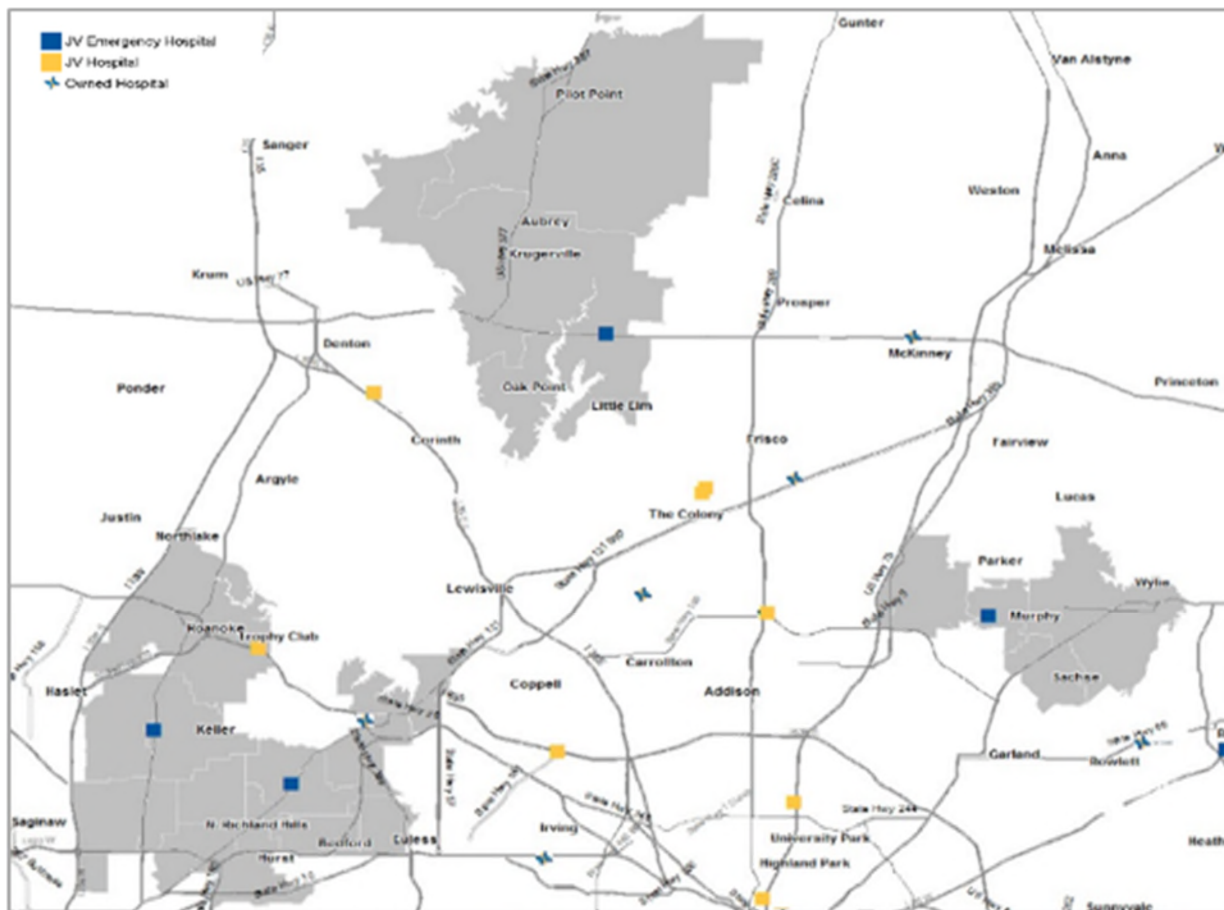
BSWH owns and operates multiple individually licensed hospital facilities serving the residents of north and central Texas. Four hospital facilities with overlapping communities have collaborated to conduct this joint community health needs assessment. This joint community health needs assessment applies to the following BSWH hospital facilities:

- Baylor Scott & White Emergency Hospital - Colleyville
- Baylor Scott & White Emergency Hospital - Keller
- Baylor Scott & White Emergency Hospital - Aubrey
- Baylor Scott & White Emergency Hospital - Murphy

Community Served Definition

The community served by the collaborating BSWH hospital facilities includes the ZIP codes listed below which spans multiple counties in the greater Dallas area including Collin, Dallas, Denton, and Tarrant counties. The community includes the geographic area where at least 75% of the hospital facilities' admitted patients live.

BSWH Community Health Needs Assessment
North & West Emergency Health Community Map



Source: Baylor Scott & White Health, 2019

76034, 76244, 76227, 75098, 76051, 76248, 75068, 75094, 76182, 76137, 76258, 75074, 76021, 76148, 75048, 76054, 76262, 76180, 76039, 76053

Assessment of Health Needs

To identify the health needs of the community, the hospital facilities established a comprehensive method of accounting for 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 sources are in **Appendix A**.

Although this community was defined by ZIP codes, public health indicators are most commonly available by county. Therefore, a patient origin study determined which counties principally represent the community's residents receiving the hospitals services. The principal counties for the North & West Emergency Health Community needs analysis are Collin, Denton and Tarrant counties.

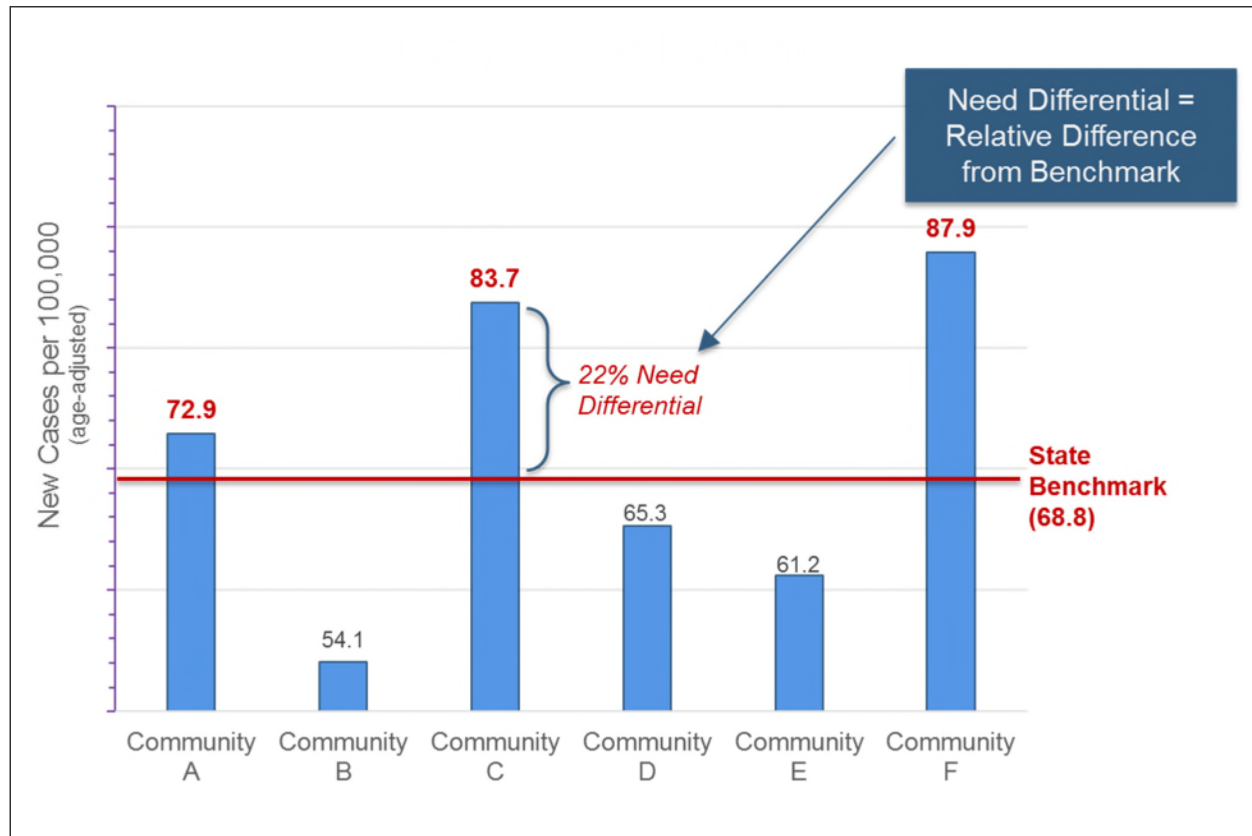
A benchmark analysis conducted for each indicator collected for the community served, determined which public health indicators demonstrated a community health need from a quantitative perspective. Benchmark health indicators collected included (when available): overall U.S. values; state of Texas values;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

When 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 clarified the relative severity of need for these indicators. The need differential standardized the method for evaluating the degree each indicator differed from its benchmark; this measure is called the need differential. Health community indicators with need differentials above the 50th percentile, ordered by severity, and the highest ranked indicators were the highest health needs from a quantitative perspective. These data are available to the community via an interactive Tableau dashboard at **BSWHealth.com/CommunityNeeds**.

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

Health Indicator Benchmark Analysis Example



Source: IBM Watson Health, 2018

Qualitative Assessment of Health Needs and Community Input – Approach

In addition to analyzing quantitative data, four (4) focus groups with a total of 42 participants, and four (4) key informant interviews, gathered 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. Prioritization sessions were held with hospital clinical leadership and/or other community leaders to identify significant health needs from the assessment and prioritize them.

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.

Watson Health conducted key informant interviews for the community served by the hospital facilities. 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 included at least one state, local, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community, as well as individuals or organizations who served and/or represented the interests of medically underserved, low-income and minority populations in the community.

Participation from community leaders/groups, public health organizations, other healthcare organizations, and other healthcare providers (including physicians) ensured that the input received represented the broad interests of the community served. A list of the names of organizations providing input are 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
Area Agency on Aging/United Way of Tarrant County	X	X	X	X	X		X
Arlington Life Shelter		X	X	X			
Baylor Scott & White Health	X	X	X	X	X		
Cancer Care Services	X	X	X	X	X		X
City of Denton			X	X	X		
City of Plano	X	X	X	X	X		
Community Lifeline Center		X	X	X	X		
Denton Community Food Center			X				
Denton County Public Health	X	X	X	X	X	X	X
Eastside Ministries			X		X		
Epidemiology Associates							
First Refuge Ministries		X	X	X			
Fort Worth Housing Solutions			X		X		
Frisco Family Services		X	X				
Giving Hope, Inc.		X	X	X			X
Goodwill Industries of Fort Worth		X	X		X		

Participant Organization Name	Public Health	Medically Under-served	Low-income	Chronic Disease Needs	Minority Populations	Governmental Public --Health Dept.	Public Health Knowledge/ --Expertise
Grace		X	X	X	X		
Grace		X					
Health Services of North Texas		X	X	X	X		
Hope Clinic of McKinney		X	X	X	X		
JPS Health	X					X	X
Lifepath Systems	X		X	X			X
McKinney City Council					X		
Metrocare	X	X	X	X	X		X
MHMR Tarrant County	X	X	X	X	X		
Mount Olive Baptist Church					X		
My Health My Resources (MHMR) of Tarrant County	X	X	X	X	X		
North Texas Area Community Health Centers	X	X	X	X	X		X
Our Daily Bread		X	X				
PCI Procomp Solutions, LLC		X	X				
Plano Fire-Rescue	X	X	X	X	X		X
Project Access Tarrant County		X	X		X		
Project Access-Collin County			X				
Refuge For Women North Texas					X		
Salvation Army			X				
Serve Denton			X				
Tarrant Area Food Bank			X				
Tarrant County Public Health	X					X	X
Texas Muslim Women's Foundation					X		

Participant Organization Name	Public Health	Medically Under-served	Low-income	Chronic Disease Needs	Minority Populations	Governmental Public --Health Dept.	Public Health Knowledge/ --Expertise
Texas Rehabilitation Hospital of Fort Worth		X	X	X			
The Samaritan Inn			X				
Union Gospel Mission		X	X				
United Way		X	X	X	X		
United Way of Tarrant County	X	X	X	X	X		
University of North Texas	X		X		X		X
University of Texas – Dallas		X	X				
Veterans Center of North Texas			X				X

Note: multiple persons from the same organization may have participated

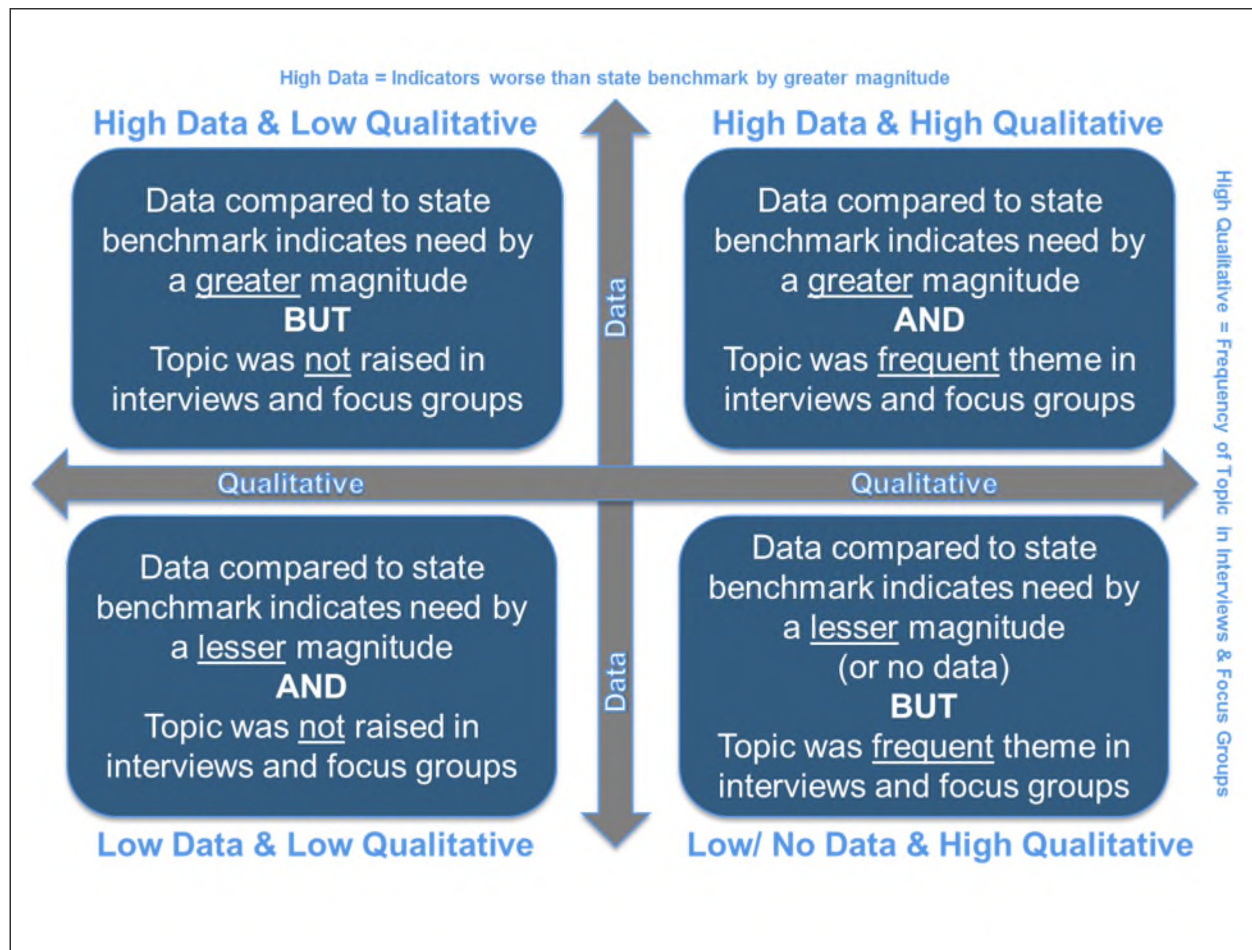
In addition to soliciting input from public health and various interests of the community, the hospital facilities considered written input received on their most recently conducted CHNA and subsequent implementation strategies. The assessment is available to receive public comment or feedback on the report findings on the BSWH website (**BSWHealth.com/CommunityNeeds**) or by emailing **CommunityHealth@BSWHealth.org**. To date BSWH has not received such 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 group, as well as the health indicator data, the consolidated issues currently affecting the community served assembled in the Health Needs Matrix below help identify the health needs for each 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 top health needs for this community.

The Health Needs Matrix



Source: IBM Watson Health, 2018

Information Gaps

In some areas of Texas, health indicators were not available due to the impact small population size has on reporting and statistical significance. Most public health indicators were available only at the county level. Evaluating data for entire counties versus more localized data, made it 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.

Approach to Identify and Prioritize Significant Health Needs

In a session held November 7, 2018 with Baylor Scott & White hospital facility leadership and community leaders met with community leaders, and identified and prioritized significant health needs. The meeting, moderated by Watson Health, included an overview of the CHNA process for BSWH, the methodology for determining the top health needs, the BSWH 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 with associated data-driven criteria to evaluate. The criteria included health indicator value(s) for the community, how the indicator compared to the state benchmark, and potentially preventable ED visit rates for the community (if available). Participants then leveraged the professional experience and community knowledge of the group via discussion about which needs were most significant. With the data-driven review criteria and the discussion completed, a multi-voting method identified the significant health needs. Participants voted individually for the five (5) needs they considered as the most significant for this community. With votes tallied, five (5) identified needs ranked as significant health needs, based on the number of votes.

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

1. Root Cause: the need is a root cause of other problems, thereby addressing it could possibly impact multiple issues
2. Severity: the problem results in disability or premature death or creates burdens on the community, economically or socially
3. Vulnerable Populations: there is a high need among vulnerable populations and/or vulnerable populations are adversely impacted

Through discussion and consensus, the group rated each of the five (5) significant health needs on each of the three (3) identified criteria utilizing a scale of one (low) to 10 (high). The criteria scores summed for each need created an overall score and became the basis for prioritizing the significant health needs. For the scores resulting in a tie, the need with the greater negative difference from the benchmark was ranked above the other need. 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 approved by the hospitals’ governing body and the full assessment is available to anyone at no cost. To download a copy, visit **BSWHealth.com/CommunityNeeds**.

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. BSWH Community Resource Guides, and input from 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**. In addition, an interactive asset map of various resources identified for all BSWH communities are located at: **BSWHealth.com/CommunityNeeds**.

North and West Emergency Health Community CHNA

Demographic and Socioeconomic Summary

According to population statistics, the community showed a higher projected population growth compared to Texas and the Country. The median age was slightly younger than Texas overall and much younger than the United States. Median income was significantly higher than both the state and the nation. The community served had fewer Medicaid beneficiaries and uninsured individuals than Texas and the U.S..

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

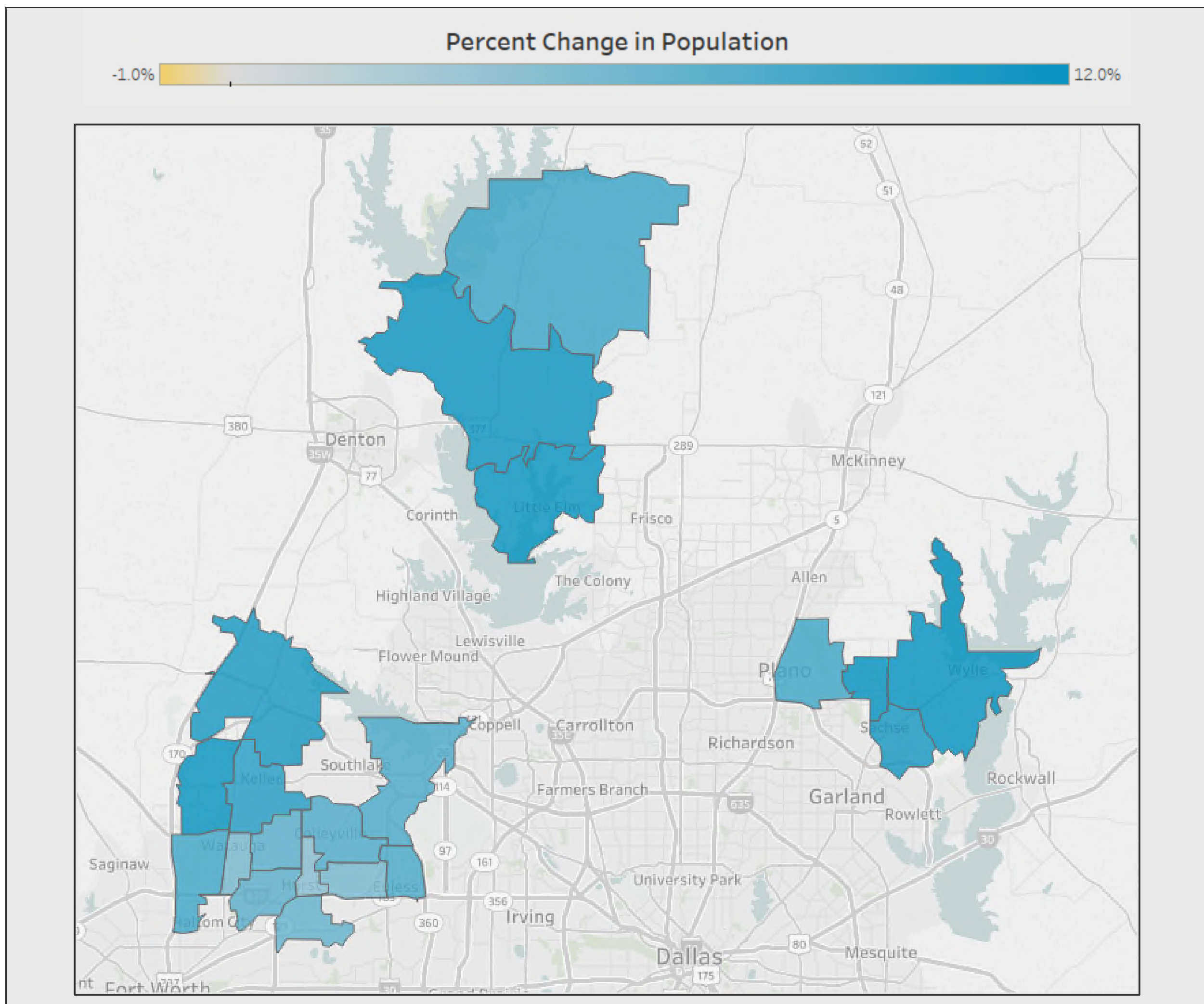
Geography		Benchmarks		Community Served
		United States	Texas	North & West Emergency Health Community
Total Current Population		326,533,070	28,531,631	766,538
5 Yr Projected Population Change		3.5%	7.1%	9.1%
Median Age		42.0	38.9	38.2
Population 0-17		22.6%	25.9%	25.9%
Population 65+		15.9%	12.6%	10.9%
Women Age 15-44		19.6%	20.6%	20.8%
Non-White Population		30.0%	32.2%	28.4%
Hispanic Population		18.2%	39.4%	18.8%
Insurance Coverage	Uninsured	9.4%	19.0%	8.2%
	Medicaid	14.9%	13.4%	5.9%
	Private Market	9.6%	9.9%	10.6%
	Medicare	16.1%	12.5%	9.8%
	Employer	45.9%	45.3%	65.5%
Median HH Income		$61,372	$60,397	$92,518
Limited English		26.2%	39.9%	27.1%
No High School Diploma		7.4%	8.7%	4.2%
Unemployed		6.8%	5.9%	4.2%

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

The community served expects to grow 9.1% by 2023, an increase by more than 69,000 people. The 9.1% projected population growth is much higher than the state's 5-year projected growth rate (7.1%) and the national projected growth rate (3.5%). The ZIP Codes expected to experience the most growth in five years are:

- 76244 Alliance-Keller – 9,222 people
- 75098 Sachse-Wylie-Murphy – 7,536 people
- 75068 Northeast Dent – 6,232 people

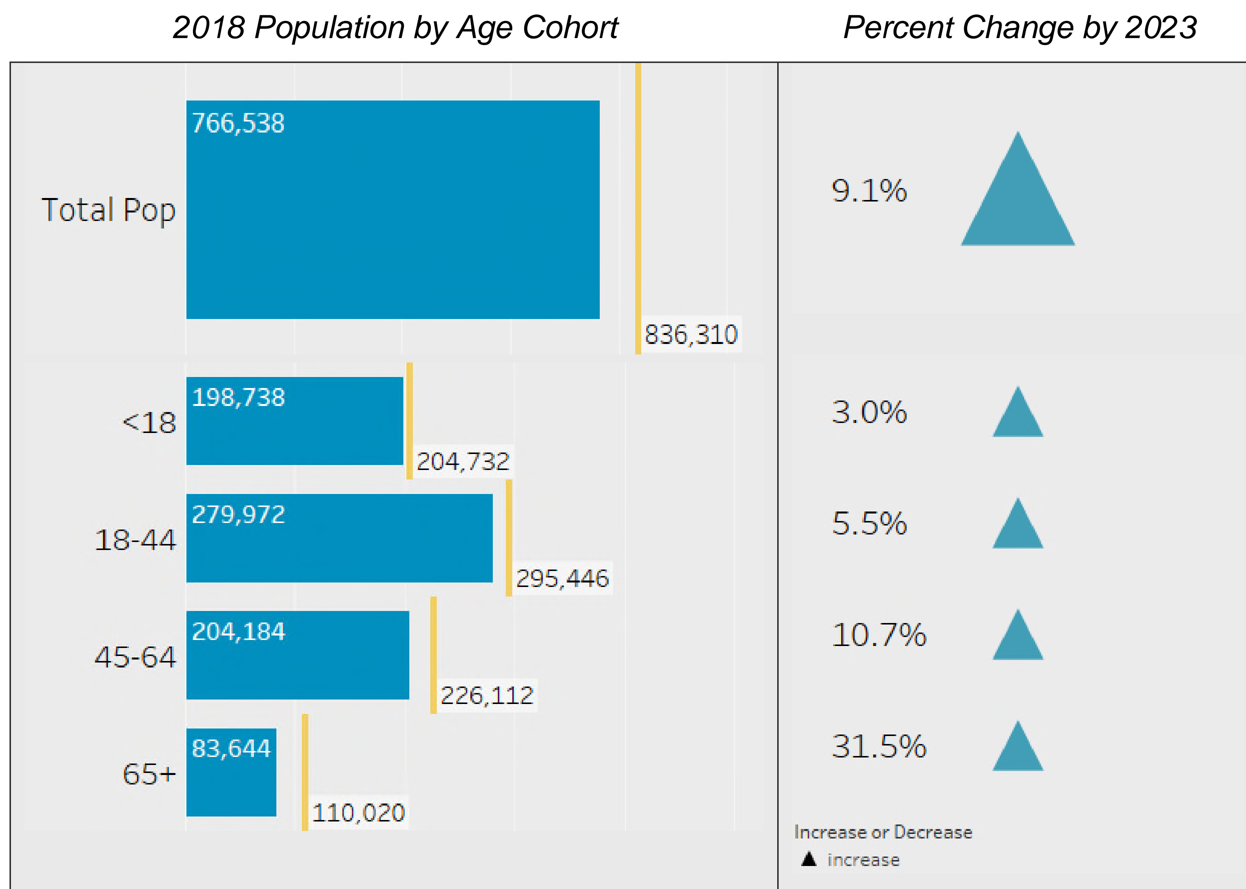
2018 - 2023 Total Population Projected Change by ZIP Code



Source: IBM Watson Health / Claritas, 2018

The community's population skewed younger with 36.5% of the population ages 18-44 and 25.9% under age 18. The largest cohort (ages18-44) expects a growth of 15,474 people (5.5%) by 2023. The age 65 plus cohort was the smallest, but projects the fastest growth (31.5%) over the next five years, adding 26,376 seniors to the community. Growth in the senior population will likely contribute to increased utilization of services as the population continues to age.

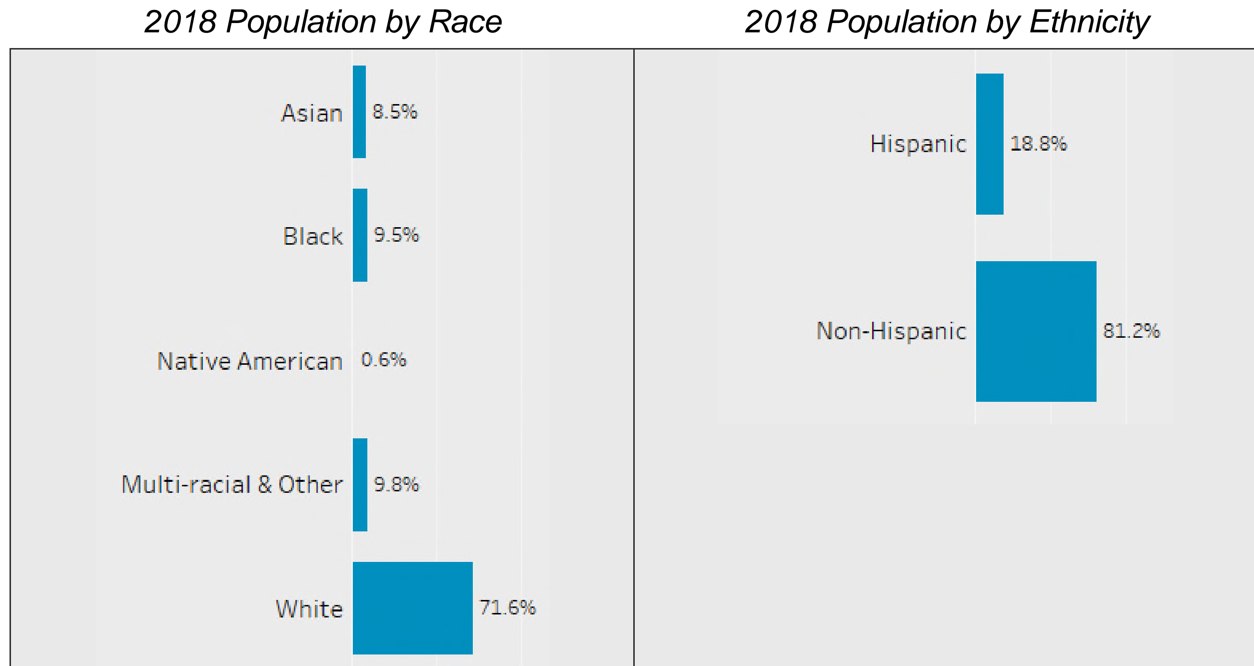
Population Distribution by Age



Source: IBM Watson Health / Claritas, 2018

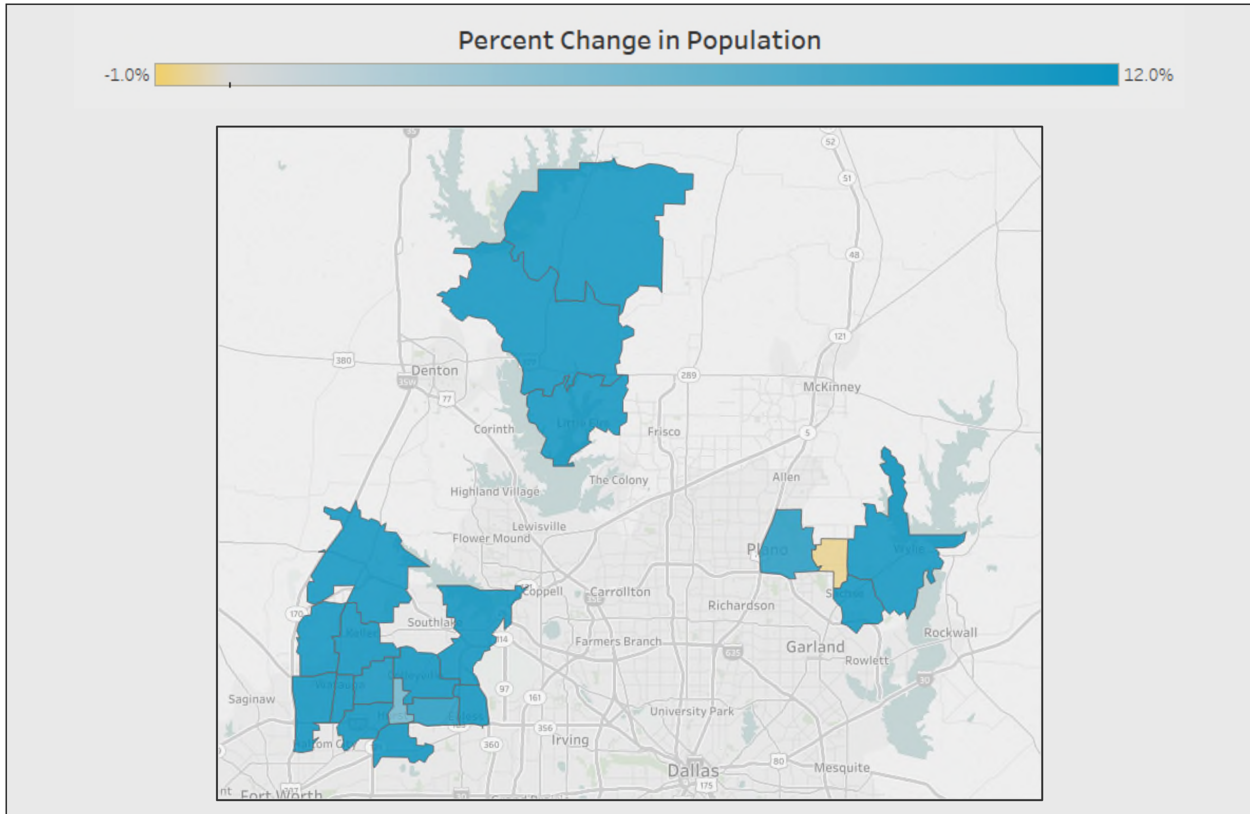
Population statistics are analyzed by race and by Hispanic ethnicity. The community was primarily white and non-Hispanic (60.6%), but diversity in the community will increase due to the projected growth of minority populations over the next five years. The expected growth rate of the Hispanic population (all races) is over 20,000 people (14.2%) by 2023. The non-Hispanic white and Native American populations project the slowest growth (2.2% and 2.1% respectively) while the non-Hispanic Asian / Black and multi-racial populations project the highest percentages in growth.

Population Distribution by Race and Ethnicity



Source: IBM Watson Health / Claritas, 2018

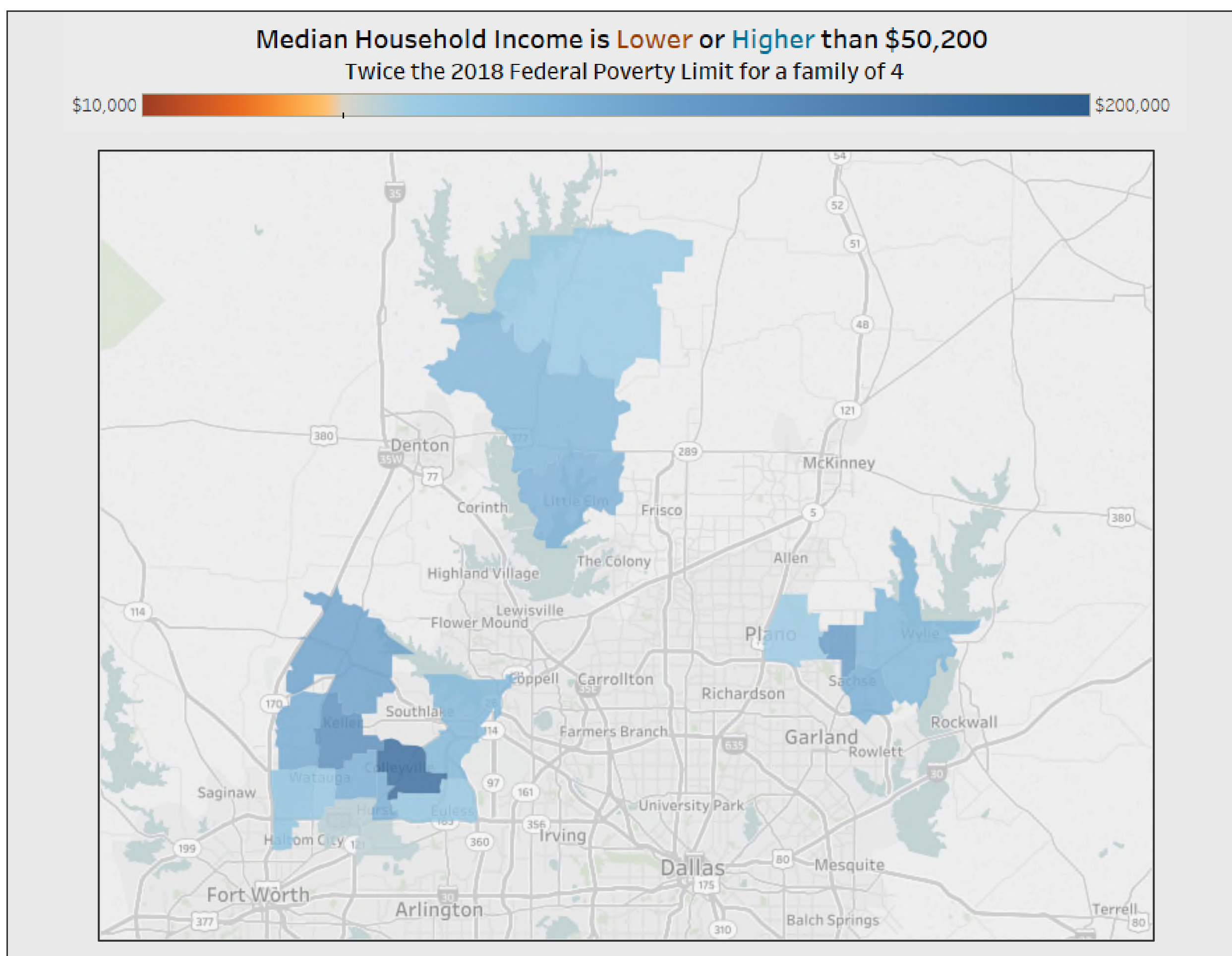
2018 - 2023 Hispanic Population Projected Change by ZIP Code



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 $56,641 for 76053 – HEB to $176,949 for 76034 – Colleyville-Southlake. There were no ZIP codes with median household incomes less than $50,200 – twice the 2018 Federal Poverty Limit for a family of four.

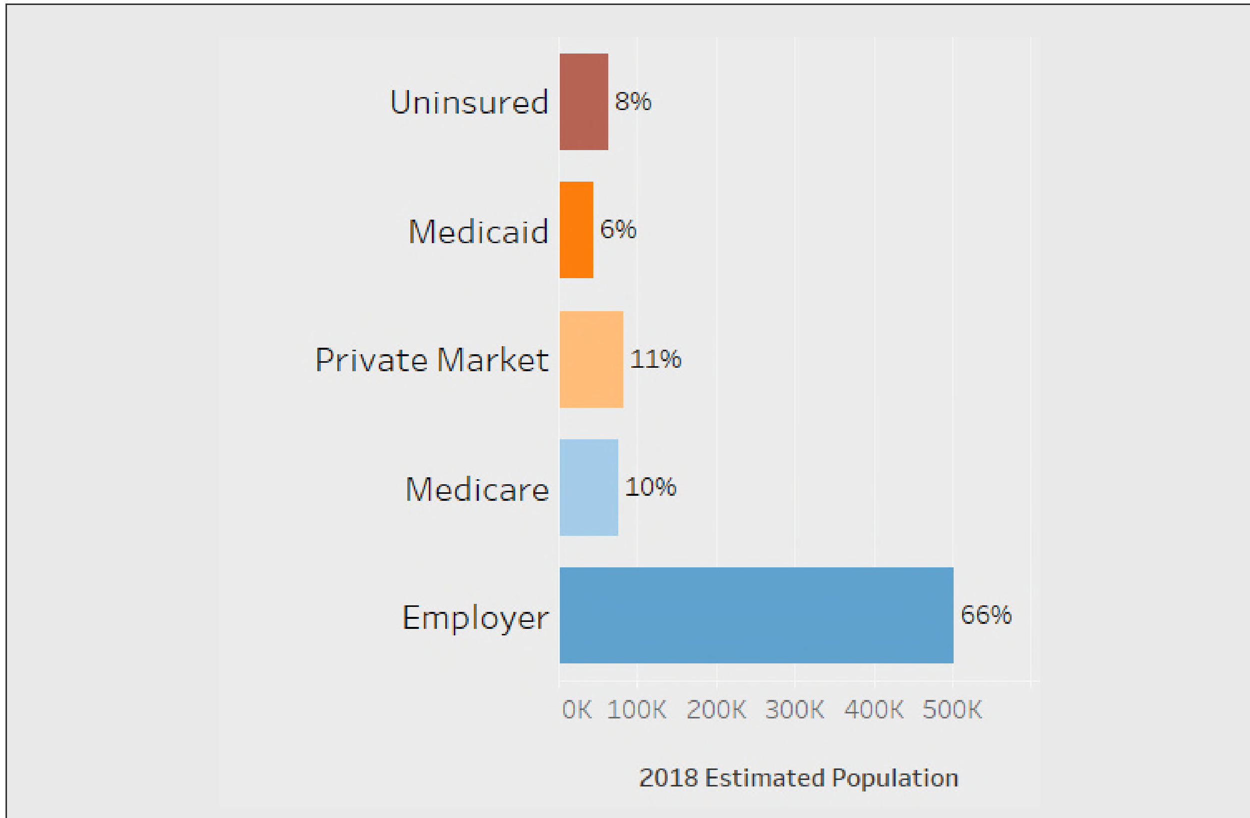
2018 Median Household Income by ZIP Code



Source: IBM Watson Health / Claritas, 2018

A majority of the population (66%) received insurance through employer sponsored health coverage, while the remainder of the population was fairly equally divided between Uninsured (8%), Medicaid (6%), Medicare (10%), 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 14 Health Professional Shortage Areas and five (5) Medically Underserved Areas as designated by the U.S. Department of Health and Human Services Health Resources Services Administration.[1] **Appendix C** includes the details on each of these designations.

Health Professional Shortage Areas and Medically Underserved Areas and Populations

	Health Professional Shortage Areas (HPSA)				Medically Underserved Area/Population (MUA/P)
NTX North & West Emergency Health Community	**Dental Health**	**Mental Health**	**Primary Care**	**Grand Total**	**MUA/P**
Collin	1	1	1	3	1
Denton	1	1	1	3	1
Tarrant	3	2	3	8	3
Total	**5**	**4**	**5**	**14**	**5**

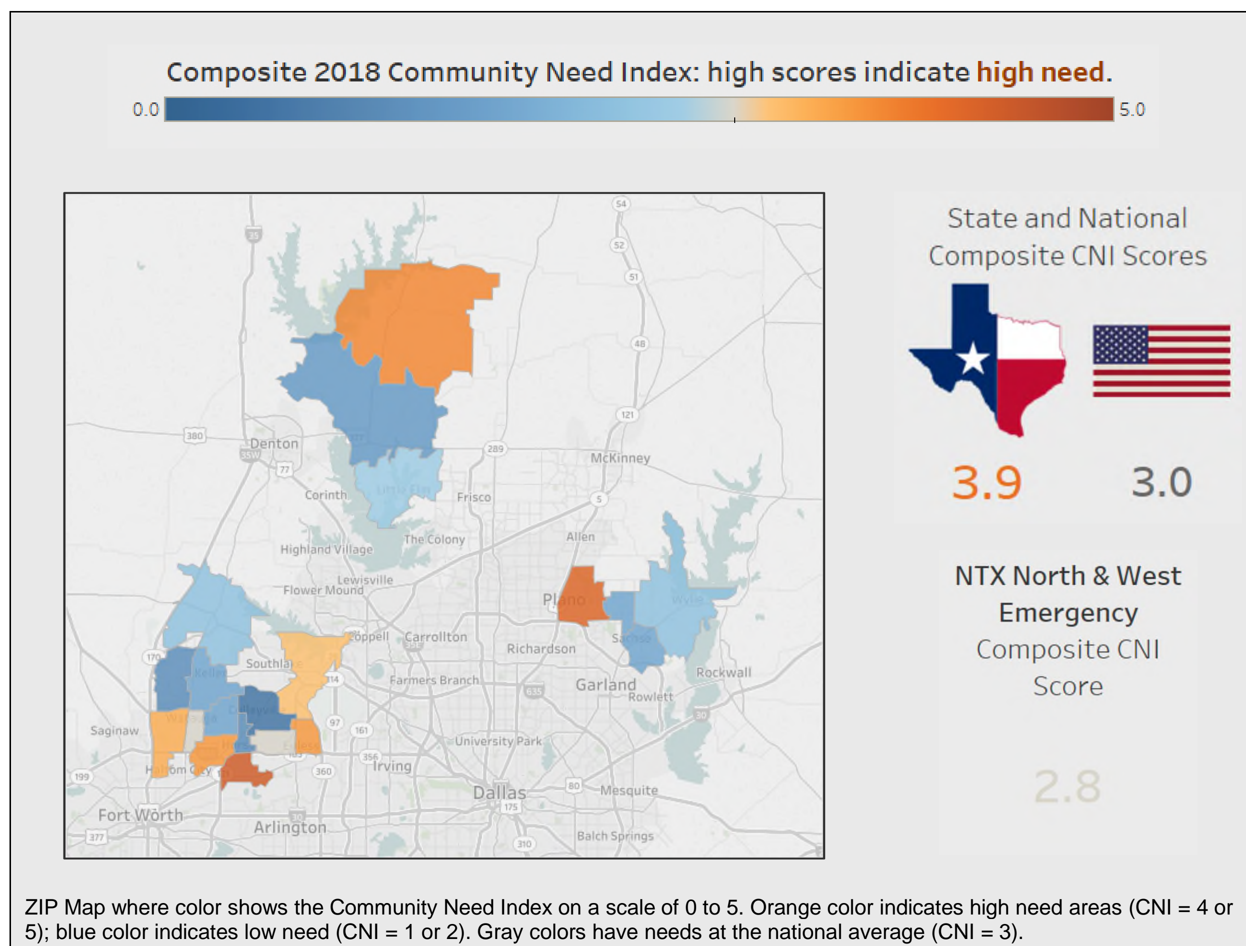
Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, 2018

[1] 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 accounts for vital socio-economic factors (income, cultural, education, insurance and housing) about a community to generate a CNI score for every populated ZIP code in the United States. The CNI strongly links to variations in community healthcare needs and is an indicator of a community's demand for various healthcare services. The CNI score by ZIP code identifies specific areas within a community where healthcare needs may be greater.

Overall, the CNI score for the community served was 2.8, lower than the CNI national average of 3.0. In portions of the community (HEB and Plano ZIP codes) the CNI score was greater than 4.0, 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).

CNI High Need ZIP Codes

City	Community	County	ZIP Code	2018 CNI Score
Hurst	HEB	Tarrant	76053	4.4
Plano	East Plano	Collin	75074	4.2

Source: IBM Watson Health / Claritas, 2018

Public Health Indicators

The analysis of public health indicators assessed 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 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. This information is located in **Appendix E**.

Focus Groups & Interviews

BSWH worked with Texas Health Resources and Methodist Health hospital facilities in collecting and sharing qualitative data (community input) on the health needs of this community.

In the focus group sessions and interviews, participants identified and discussed the factors contributing to the current health status of the community, and identified the greatest barriers and strengths that contribute to the overall health of the community. For this community there were four (4) focus group sessions with a total of 42 participants and four (4) interviews conducted July through September 2018.

This health community was described as a diverse community with both great wealth and significant poverty, and portions had designation as a “Blue Zone Community”. The fast growing area had many communities that were described as affluent, family friendly with good schools, many entertainment options, and very diverse. The population was described as well-educated, compassionate, artsy, diverse, but also fragmented. Part of the growth was driven by an increase in commuters, and participants noted that income disparity was high. Portions of this market were more rural and agricultural, and the increased cost of housing and taxes were putting longtime residents and fixed income seniors at risk for homelessness.

The group named multiple barriers to accessing health care, including gaps in services, shortage of behavioral health resources, access for uninsured, low health education and literacy, and need for more senior services. Participants noted the high rate of insured residents throughout the area, and the rate was further skewed by the requirement that all university and community college students have insurance. It was noted that the infrastructure for primary care and mental health was very low. Participants also said pediatric specialists were completely lacking in the Denton area, along with shortages for prenatal services, neonatal intensive care treatment, and OB/GYN care. Although the

community offered preventative care, participants recommended expanding these services. Transportation was available in a few areas but severely lacking throughout most of the area. Low-income residents often prioritized basic needs over health needs; prioritizing food and housing costs over health insurance and health costs.

The focus group discussed the challenges for low-income and immigrant populations to access health resources. Gaps in free and low-cost services exist for low-income African American moms until Medicaid eligibility kicked in for dental services, and preventive services. Many providers didn’t accept patients without insurance, and workers who were uninsured or undocumented could not afford the prohibitive cost of care. The fast growing immigrant population had unique challenges; only a few clinics treated female Muslims and those facilities needed guidance in delivering culturally sensitive care, and there were trust issues among some minority groups. Undocumented workers avoided using services fearing deportation and lack of translation services. Added translation services were needed in Spanish, Arabic, and Vietnamese to support the increasingly diverse community. Even with insurance, low- and middle-income residents couldn’t afford health or dental care.

Participants discussed the high need for mental health services in the area. Funding for mental health has decreased and psychiatric care was only available as cash pay, making services unavailable even to those with insurance. Denton County had more mental health providers than other parts of the Dallas Ft Worth area, but that amount is insufficient to meet demand. According to the participants the community needed more behavioral health providers and resources, including rehab services for alcohol and substance abuse. Wait times for psychiatric care often exceeded 6 months regardless of insurance status. Opioid addiction was on the rise and required additional counseling and support services in order to support area residents coping with addiction.

The focus group recognized their population was aging culminating in a growing need for navigation and support services that target seniors. The proportion of socially isolated seniors was increasing according to the participants, so the need for more transportation, navigation, and mental health services exists. Elderly and/or disabled residents without a support network often miss appointments and are at increased risk of opioid addiction. Stigma around mental health conditions prevented this population from seeking help for depression and other common conditions.

Community Health Needs Identified

A Health Needs Matrix identified the health needs that resulted from the community health needs assessment (see Methodology for Defining Community Need section). 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.

Top Community Health Needs Identified

North & West Emergency Health Community		
Top Needs Identified	Category of Need	Public Health Indicator
Adult Smoking	Health Behaviors - Substance Abuse	2016 Percentage Adults Who Report that They Currently Smoke Every Day or Most Days and Have Smoked at Least 100 Cigarettes in Their Lifetime
Adults Engaging in Binge Drinking During the Past 30 Days	Health Behaviors - Substance Abuse	2016 Percentage of a County's Adult Population that Reports Binge or Heavy Drinking in the Past 30 Days
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Prevalence of chronic condition across all Medicare beneficiaries
Cancer Incidence - All Causes	Cancer	2011-2015 Age-Adjusted Cancer (All) 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 - Lung	Cancer	2011-2015 Age-Adjusted Lung & Bronchus Cancer Incidence Rate Cases per 100,000
Cancer Incidence - Prostate	Cancer	2011-2015 Age-Adjusted Prostate Cancer Incidence Rate Cases per 100,000
Depression in Medicare Population	Mental Health	Prevalence of chronic condition across all Medicare beneficiaries
Food Insecure	Environment - Food	2015 Percentage of Population Who Lack Adequate Access to Food During the Past Year

North & West Emergency Health Community		
Top Needs Identified	Category of Need	Public Health Indicator
Health care costs	Access To Care	2015 Health Care Costs are the price-adjusted Medicare reimbursements (Parts A and B) per enrollee.
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	2012-2016 Percentage of Motor Vehicle Crash Deaths that had Alcohol Involvement
Price-Adjusted Medicare Reimbursements per Enrollee	Access To Care	2015 Amount of Price-Adjusted Medicare Reimbursements per Enrollee
Ratio of Population to One Non-Physician Primary Care Provider	Access To Care	2017 Ratio of Population to Primary Care Providers Other than Physicians
Schizophrenia and Other Psychotic Disorders in Medicare Population	Mental Health	Prevalence of chronic condition across all Medicare beneficiaries
Social/Membership Associations	SDH - Social Isolation	2015 Number of Membership Associations per 10,000 Population

Note: Listed alphabetically, not in order of significance

Source: IBM Watson Health, 2018

Prioritized Significant Health Needs

Using the prioritization approach outlined in the overview section of this report, the following needs from the proceeding list were determined to be significant and then prioritized.

The resulting prioritized health needs for this community were:

Priority	Need	Category of Need
1	Ratio of Population to One Non-Physician Primary Care Provider	Access to Care
2	Health Care Costs (Price-Adjusted Medicare Reimbursements (Parts A and B) Per Enrollee)	Access to Care
3	Food Insecure	Environment - Food
4	Alzheimer's Disease/Dementia in Medicare Population	Mental Health
5	Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse

Description of Health Needs

A CHNA for the North and West Emergency Health Community identified several significant community health needs categorized as issues related to access to care, mental health, hunger, and substance abuse. 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. Noted in the data results, significant areas of concern about access to care included non-physician provider availability and healthcare cost. Additional areas of concern included motor vehicle deaths involving alcohol, food insecurity (hunger), and Alzheimer's Disease/Dementia in the Medicare Population

Note: The difference between county and state values are relative. The calculation is (county-state)/state. This creates a standard comparison across indicators for the county relative to the state.

<u>Non-Physician Primary Care Providers</u>

There is a national wide scarcity of physicians across the United States, while particularly challenging in small towns and cities, metropolitan areas are not exempt. Demographic shifts, such as growth in the elderly or near elderly populations increase the need for primary care access. Estimates of the scope of the provider shortage in America vary, however, it is generally agreed upon that thousands of additional primary care providers (PCPs) are needed to meet the current demand and that tens of thousands of additional caregivers will be needed to meet the growing aging population across the country.

Primary care physician extenders (e.g. nurse practitioners, physician assistants, and clinical nurse specialists) could help close the gap in access to primary care services when they are in a community. Non-physician providers or physician extenders are typically licensed professionals such as Physician Assistants or Nurse Practitioners who treat and see patients. Dependent upon state regulations, extenders may practice independently or in physician run practices. Physician extenders expand the scope of primary care providers within a geographic area and help bridge the gap to both access to care and management of healthcare costs.

Non-physician primary care provider access in Denton and Collin counties fell short of the Texas state threshold of one provider to 1,497 residents. Denton County showed the greatest need of the two counties with one non-physician primary care provider to every 1,966 residents; Collin County had a ratio of one provider to every 1,828 residents. These were differences of 31.3% and 22.1% respectively relative to the state value (relative difference). It was also notable that the overall Texas number of residents to one non-physician provider was greater than the U.S. benchmark of one non-physician provider to 1,030 residents.[2]

Food Insecurity

Food insecurity is a measure of the prevalence of hunger in the community; it reflects the percentage of the population with no access to a reliable source of food. The North and West Emergency community health needs assessment identified concerns around food insecurity for Tarrant County. Lacking consistent access to food is related to negative health outcomes such as weight-gain and premature mortality. Individuals and families with an inability to provide and eat balanced meals create additional barriers to healthy eating.[3]

It is equally important to eat a balanced diet that includes the consumption of fruits and vegetables as well as to have adequate access to a consistent supply of food. Within Tarrant County 17.4% of the population lacked adequate access to food during the past year, indicating a potentially larger vulnerable population when compared to the overall Texas state benchmark at 15.7% (a 10.8% relative difference). It was notable that the overall Texas proportion of food insecure population was also greater than the U.S. benchmark of 13%.[4]

Motor Vehicle Driving Deaths with Alcohol Involvement

Motor vehicle driving deaths with alcohol involvement is measured as percentage of all motor vehicle crash deaths where alcohol was involved.[5] Approximately 17,000

[2] CMS, National Provider Identification Registry (NPPES), County Health Rankings & Roadmaps, 2018
[3] Gundersen C, Satoh A, Dewey A, Kato M, Engelhard E. Map the Meal Gap 2015: Food Insecurity and Child Food Insecurity Estimates at the County Level. Feeding America, 2015
[4] Map the Meal Gap, Feeding America; County Health Rankings & Roadmaps, 2018
[5] **Alcohol-impaired Driving Deaths**, County Health Rankings, 2018

Americans are killed annually in alcohol-related motor vehicle crashes.[6] Binge/heavy drinkers account for most instances of alcohol-impaired driving.[7] While not all fatal motor vehicle traffic accidents have a valid blood alcohol test, the data available likely undercounts instances of actual alcohol involvement. There can be a large difference in the degree that alcohol was responsible for the crash as blood alcohol may be minimally or significantly over the legal limit.

The Texas state benchmark for alcohol-impaired motor vehicle crash deaths was 28.3%, Collin County's rate of 35.8% was relatively 26.5% higher than the state benchmark.[8] Reliance on motor vehicles for primary transportation coupled with high alcohol consumption could increase both alcohol related accidents and deaths. Community education addressing the county rates and associated outcomes will be essential. Private/public partnerships to increase transportation options is another potential solution.

Alzheimer's/Dementia in the Medicare Population

Worldwide, 50 million people are living with Alzheimer's disease and other dementias including 5.7 million in the United States. Alzheimer's is a degenerative brain disease and the most common form of dementia. Dementia is not a specific disease; but an overall term describing a group of symptoms associated with memory decline and thinking skills. Between 2000 and 2015 deaths from heart disease have decreased 11%, while deaths from Alzheimer's have increased 123%. Early and accurate diagnosis could save up to $7.9 trillion in medical and care costs. In 2018, Alzheimer's and other dementias projects a cost to the nation of $277 billion, by 2050 these costs could rise as high as $1.1 trillion.[9]

Alzheimer's/Dementia occurred at a rate of 15.5% amongst the Medicare population in Tarrant County, a 19% relative difference to the Texas state benchmark of 13%. Concerns around availability of mental health services, especially for the elderly, was reinforced through community input.

The 65 and older population is living longer than previous generations due to improved healthcare outcomes and access. Advances in clinical care has allowed people to live longer. Geographic distances of families place more burden on social programs and long-term care facilities when patients are no longer safe to live in their homes.

While some dementias afflict those younger than age 65, Alzheimer's and other dementias primarily target the older than 65 population. The growing prevalence of these disorders places significant encumbrances on families, communities and health care providers. Health care systems and communities, who pro-actively identify their community needs, should plan and design for the projected increases in Alzheimer's patients' needs including healthcare, support systems, and long-term living facilities.

[6] Flowers NT, Naimi TS, Brewer RD, Elder RW, Shults RA, Jiles R. Patterns of alcohol consumption and alcohol-impaired driving in the United States. Alcohol Clin Exp Res. 2008;32:639-644.
[7] Centers for Disease Control and Prevention. Sociodemographic differences in binge drinking among adults-14 states, 2004. MMWR Morb Mortal Wkly Rep. 2009;58:301-304.
[8] Fatality Analysis Reporting System (FARS), County Health Rankings & Roadmaps, 2018
[9] **Alzheimer's Association**, 2019

Health Care Costs

Nationally, the subject of health care costs is a topic of concern and ultimately affects all age ranges. The burden of rising healthcare costs on populations with limited incomes and resources is a global issue. The number of Americans aged 65 and older projects to more than double, from 46 million in 2016 to over 98 million by 2060 across the United States.[10] Growth in the senior population will likely contribute to increased utilization of healthcare services and contribute to the national total of health care costs as the population continues to age.

Data on the cost of health care for the overall population can be difficult to gather. In some instances, only information about a subset of the population is available. For this community, reliable data about health care costs is available for the Medicare population. For the purposes of understanding health care costs, the CHNA utilized price-adjusted Medicare reimbursements (Parts A and B) per enrollee to understand the impact of health care costs.

Health Care costs per Medicare enrollee in Denton County were $11,956, this was 7.5% higher than the overall Texas per enrollee costs of $11,121.[11] The U.S. median value was $9,279.[12] These costs may be especially impact the North and West Emergency Health Community. The community has experiened population growth which projects continuation through 2023. In 2018, the community estimated to have 10.7% of its population covered by Medicare and the 65 and older age cohort projectd the most profound growth in the next five years. People over age 65 (those primarily enrolled in Medicare) expect growth of 31.5%, or almost 27,000 people by 2023.[13]

Summary

BSWH 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, BSWH was able to identify and prioritize community health needs for their healthcare system. The goal of improving the health of the community through the development of implementation plans employing specific tactics over a specified time, will address the BSWH chosen needs, and aid in addressing the health needs of the community served.

[10] **Population Reference Bureau**, 2016
[11] Dartmouth Atlas of Health Care, CMS; County Health Rankings & Roadmaps, 2018
[12] County Health Rankings & Roadmaps, 2018
[13] IBM Watson Health / Claritas, 2018

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

Category	Public Health Indicator	Source
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)
	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)

Category	Public Health Indicator	Source
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)
	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

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

Category	Public Health Indicator	Source
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 available in the community with the ability to address the significant health needs identified in the assessment. For a continually updated list of the resources available to address these needs as well as other social determinants of health, please visit our website (**BaylorScottandWhite.com/CommunityNeeds**).

Resources Identified

Community Health Need	Category	Service	Facility Name	Address	City	Phone Number
Health Care Costs (Price-Adjusted Medicare Reimbursements (Parts A and B) Per Enrollee)	Access to Care	Primary Care	Grace Grapevine	610 Shady Brook Drive	Grapevine	817-488-7009
Health Care Costs (Price-Adjusted Medicare Reimbursements (Parts A and B) Per Enrollee)	Access to Care	Primary Care	Muslim Community Center for Human Services Al-Shifa Clinic	7600 Glenview Drive	North Richland Hills	817-579-9165
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	Grace Grapevine	610 Shady Brook Drive	Grapevine	817-488-7009
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	Muslim Community Center for Human Services Al-Shifa Clinic	7600 Glenview Drive	North Richland Hills	817-579-9165
Food Insecure	Environment - Food	Emergency Food	Battered Women's Foundation	4166 Willman Ave	North Richland Hills	817-284-8464
Food Insecure	Environment - Food	Food Insecurity Services	Battered Women's Foundation	4166 Willman Ave	North Richland Hills	817-284-8464
Food Insecure	Environment - Food	Food Insecurity Services	Grace Grapevine	610 Shady Brook Drive	Grapevine	817-488-7009
Food Insecure	Environment - Food	Food Pantry	Battered Women's Foundation	4166 Willman Ave	North Richland Hills	817-284-8464

Community Health Need	Category	Service	Facility Name	Address	City	Phone Number
Food Insecure	Environment - Food	Food Pantry	Grace Grapevine	610 Shady Brook Drive	Grapevine	817-488-7009
Food Insecure	Environment - Food	Help Understanding Government Programs	MedData	2022 W Northwest Hwy #210,	Grapevine	866-534-6699
Food Insecure	Environment - Food	Social Services	Hope's Door	860 F Avenue, Suite 100	Plano	972-286-0423
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	Addiction Outpatient Treatment	Valley Hope of Grapevine	2300 William Tate	Grapevine	817-424-1305
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	Behavioral Health Services	1st Step Counseling	900 East Park Boulevard, Suite 15	Plano	972-633-5544
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	Behavioral Health Services	Hope's Door	860 F Avenue, Suite 100	Plano	972-286-0423
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	Behavioral Health Services	Valley Hope of Grapevine	2300 William Tate	Grapevine	817-424-1305
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	Social Services	Hope's Door	860 F Avenue, Suite 100	Plano	972-286-0423
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Mental Health Outpatient Treatment	Valley Hope of Grapevine	2300 William Tate	Grapevine	817-424-1305
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Mental Health Residential Treatment	Valley Hope of Grapevine	2300 William Tate	Grapevine	817-424-1305
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Short Term Housing	Grace Grapevine	610 Shady Brook Drive	Grapevine	817-488-7009

Community Health Need	Category	Service	Facility Name	Address	City	Phone Number
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Short Term Housing	Hope's Door	860 F Avenue, Suite 100	Plano	972-286-0423
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Short Term Housing	Mater Filius Dallas (1st pregnancy)		Plano	972-836-9378
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Social Services	Hope's Door	860 F Avenue, Suite 100	Plano	972-286-0423

Community Healthcare Facilities

Facility Name	Type	System	Street Address	City	State	ZIP
Baylor Emergency Medical Center	ED	Baylor Scott & White	26791 Highway 380	Aubrey	TX	76227
Baylor Emergency Medical Center	ED	Baylor Scott & White	511 FM 544 Suite 100	Murphy	TX	75094
Baylor Emergency Medical Center	ED	Baylor Scott & White	5500 Colleyville Boulevard	Colleyville	TX	76034
Baylor Emergency Medical Center	ED	Baylor Scott & White	620 South Main Suite 100	Keller	TX	76248
Baylor Medical Center At Trophy Club	ST	Baylor Scott & White	2850 East State Hwy 114	Trophy Club	TX	76262
Baylor Scott & White Medical Center - Grapevine	ST	Baylor Scott & White	1650 West College Street	Grapevine	TX	76051
Cook Childrens Northeast Hospital	KID	Cook Childrens	6316 Precinct Line Rd	Hurst	TX	76054
Exceptional ER Sachse	ED	Exceptional Emergency Room	7545 Murphy Road	Sachse	TX	75048
Healthsouth Rehabilitation Hospital Of The Mid-Cities	LT	HealthSouth	2304 State Highway 121	Bedford	TX	76021
Legacy ER	ED	Legacy	8950 N Tarrant Pkwy	North Richland Hills	TX	76182

Facility Name	Type	System	Street Address	City	State	ZIP
Medical City North Hills	ST	Hospital Corporation of America	4401 Booth Calloway Road	North Richland Hills	TX	76180
Sagecrest Hospital Grapevine	LT	Freestanding	4201 William D Tate Avenue	Grapevine	TX	76051
Saint Camillus Medical Center	ST	Physician Synergy Group	1612 Hurst Town Center Dr	Hurst	TX	76054
Texas Health Harris Methodist Hospital Alliance	ST	Texas Health Resources	10864 Texas Health Trail	Ft Worth	TX	76244

**Type: St=Short-Term; Lt=Long-Term, Psy=Psychiatric, Kid = Pediatric, Ed = Freestanding Ed*

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
Collin	14899948PD	Collin County Adult Clinic	Primary Care	Federally Qualified Health Center Look-alike
Collin	64899948MU	Collin County Adult Clinic	Dental Health	Federally Qualified Health Center Look-alike
Collin	74899948MT	Collin County Adult Clinic	Mental Health	Federally Qualified Health Center Look-alike
Denton	14899948PA	Health Services of North Texas, Inc.	Primary Care	Federally Qualified Health Center
Denton	64899948MR	Health Services of North Texas, Inc.	Dental Health	Federally Qualified Health Center
Denton	74899948MQ	Health Services of North Texas, Inc.	Mental Health	Federally Qualified Health Center
Tarrant	1485279877	Federal Medical Center-Carswell	Primary Care	Correctional Facility
Tarrant	6486448024	Federal Medical Center-Carswell	Dental Health	Correctional Facility
Tarrant	6489994877	Federal Correctional Institution - Fort Worth	Dental Health	Correctional Facility
Tarrant	7483623264	Federal Medical Center-Carswell	Mental Health	Correctional Facility
Tarrant	148999484K	Federal Correctional Institution - Fort Worth	Primary Care	Correctional Facility
Tarrant	14899948H2	North Texas Area Community Health Center, Inc.	Primary Care	Federally Qualified Health Center
Tarrant	64899948F5	North Texas Area Community Health Center, Inc.	Dental Health	Federally Qualified Health Center

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

County Name	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type
Tarrant	748999483N	North Texas Area Community Health Center, Inc.	Mental Health	Federally Qualified Health Center

Medically Underserved Areas and Populations (MUA/P)[15]

County Name	MUA/P Source Identification Number	Service Area Name	Designation Type	Rural Status
Collin	3471	Collin Service Area	Medically Underserved Area	Non-Rural
Denton	3463	Poverty Population	MUA – Governor's Exception	Non-Rural
Tarrant	3509	Diamond Hill Service Area	Medically Underserved Area	Non-Rural
Tarrant	7382	Low Inc - East Side	MUP Low Income	Non-Rural
Tarrant	7393	Central Service Area	Medically Underserved Area	Non-Rural

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

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

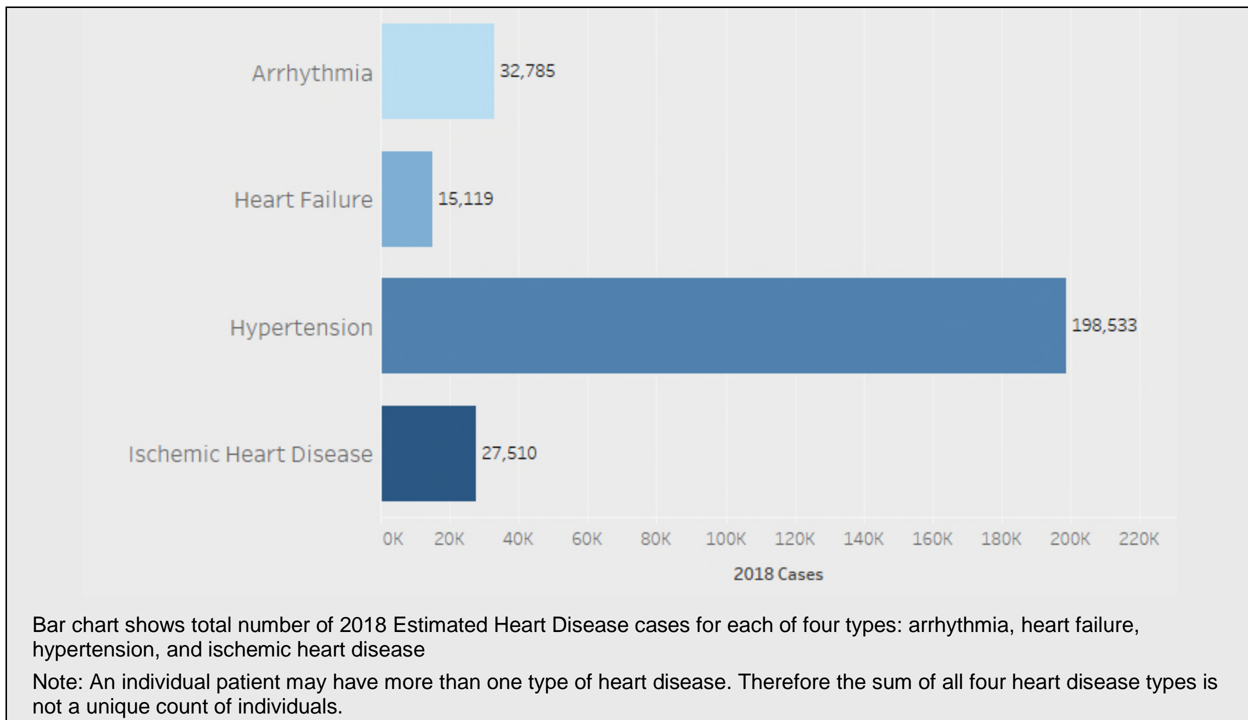
North & West Emergency Health Community		
Public Health Indicator	Category	Indicator Definition
Air Pollution - Particulate Matter Daily Density	Environment	2012 Average Daily Density of Fine Particulate Matter in Micrograms per Cubic Meter (PM2.5)
Ratio of Population to One Non-Physician Primary Care Provider	Access To Care	2017 Ratio of Population to Primary Care Providers Other than Physicians
Long Commute Alone	Environment	2012-2016 Among Workers Who Commute in Their Car Alone, the Percentage that Commute More than 30 Minutes
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors	2012-2016 Percentage of Motor Vehicle Crash Deaths that had Alcohol Involvement
Perforated Appendix Admission: Pediatric (Risk-Adjusted-Rate for Appendicitis)	Preventable Hospitalizations	2016 Number Observed / Pediatric Population Under Age 18
Social/Membership Associations	Population	2015 Number of Membership Associations per 10,000 Population
Chronic Lower Respiratory Disease (CLRD) Mortality Rate	Injury & Death	2013 Chronic Lower Respiratory Disease (CLRD) Age Adjusted Death Rate (per 100,000 - All Ages. Age-adjusted using the 2000 U.S. Standard Population)
Depression in Medicare Population	Mental Health	2007-2015 Prevalence of chronic condition across all Medicare beneficiaries
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	2007-2015 Prevalence of chronic condition across all Medicare beneficiaries
Infant Mortality Rate	Injury & Death	2010-2016 Number of All Infant Deaths (Within 1 year), per 1,000 Live Births
Cancer Incidence - Prostate	Conditions/Diseases	2011-2015 Age-Adjusted Prostate Cancer Incidence Rate Cases per 100,000.
Perforated Appendix Admission: Adult (Risk-Adjusted-Rate for Appendicitis)	Preventable Hospitalizations	2016 Number Observed / Adult Population Age 18 and older

North & West Emergency Health Community		
Public Health Indicator	Category	Indicator Definition
Cancer Incidence - Female Breast	Conditions/Diseases	2011-2015 Age-Adjusted Female Breast Cancer Incidence Rate Cases Per 100,000
Food Insecure	Environment	2015 Percentage of Population Who Lack Adequate Access to Food During the Past Year
Hyperlipidemia in Medicare Population	Conditions/Diseases	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
Chronic Kidney Disease in Medicare Population	Conditions/Diseases	2007-2015 Prevalence of chronic condition across all Medicare beneficiaries
Uncontrolled Diabetes Admission: Adult (Risk-Adjusted-Rate)	Preventable Hospitalizations	2016 Number Observed / Adult Population Age 18 and older
Adults Engaging in Binge Drinking During the Past 30 Days	Health Behaviors	2016 Percentage of a County's Adult Population that Reports Binge or Heavy Drinking in the Past 30 Days
Atrial Fibrillation in Medicare Population	Conditions/Diseases	2007-2015 Prevalence of chronic condition across all Medicare beneficiaries
Cancer Incidence - Lung	Conditions/Diseases	2011-2015 Age-Adjusted Lung & Bronchus Cancer Incidence Rate Cases per 100,000.
Diabetes Prevalence	Conditions/Diseases	2014 prevalence of self-reported diagnosed diabetes, not including pregnancy related.
Cancer Incidence - All Causes	Conditions/Diseases	2011-2015 Age-Adjusted Cancer (All) Incidence Rate Cases Per 100,000.
Price-Adjusted Medicare Reimbursements per Enrollee	Access To Care	2015 Amount of Price-Adjusted Medicare Reimbursements (Part A and B) per Enrollee
Adult Smoking	Health Behaviors	2016 Percentage of the Adult Population Report Currently Smoke Every Day/Most Days and Smoked at Least 100 Cigarettes in Their Lifetime.

Appendix E: Watson Health Community Data

Watson Health Heart Disease Estimates identified hypertension as the most prevalent heart disease diagnoses; 198,000 estimated cases in the community overall. Grapevine ZIP code 76051 had the most estimated cases of Arrhythmia, Heart Failure and Ischemic Heart Disease, while Alliance-Keller ZIP code 76244 had the most estimated cases of Hypertension. Despite fewer number of cases, the ZIP codes in HEB had some of the highest estimated prevalence rates for Arrhythmia (602 to 706 cases per 10,000 population) and Heart Failure (309 to 365 cases per 10,000 population). The ZIP code 76054 of HEB County had some of the highest prevalence for Hypertension (3,496 cases per 10,000 population) and Ischemic Heart Disease (648 cases per 10,000 population).

2018 Estimated Heart Disease Cases



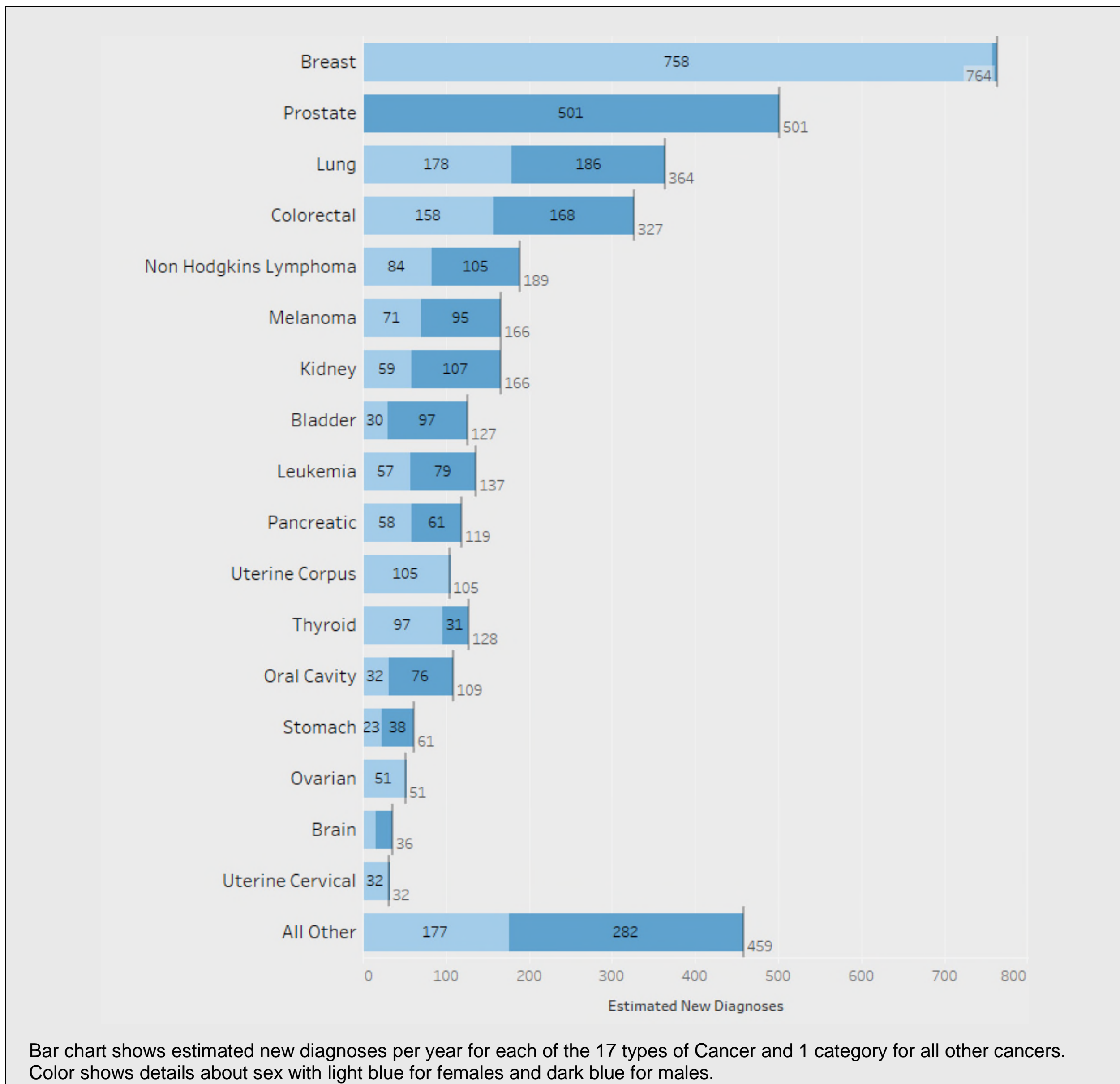
Bar chart shows total number of 2018 Estimated Heart Disease cases for each of four types: arrhythmia, heart failure, hypertension, and ischemic heart disease

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

Source: IBM Watson Health, 2018

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

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	127	157	23.6%
Brain	36	41	13.9%
Breast	764	904	18.3%
Colorectal	327	353	8.0%
Kidney	166	202	21.7%
Leukemia	137	163	19.0%
Lung	364	437	20.1%
Melanoma	166	198	19.3%
Non Hodgkins Lymphoma	189	227	20.1%
Oral Cavity	109	131	20.2%
Ovarian	51	59	15.7%
Pancreatic	119	150	26.1%
Prostate	501	573	14.4%
Stomach	61	73	19.7%
Thyroid	128	153	19.5%
Uterine Cervical	32	35	9.4%
Uterine Corpus	105	127	21.0%
All Other	459	557	21.4%
Grand Total	**3,841**	**4,540**	**18.2%**

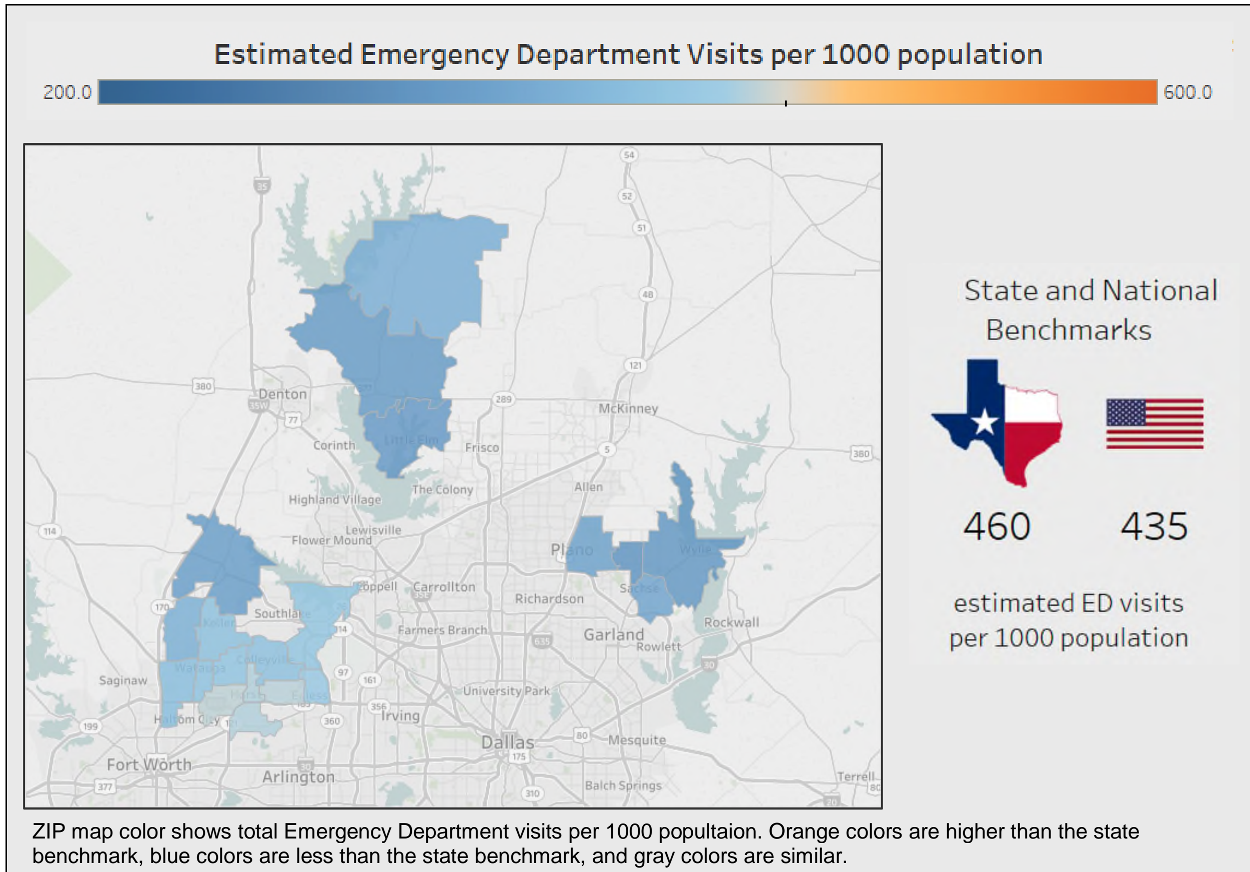
Source: IBM Watson Health, 2018

Based on population characteristics and regional utilization rates, Watson Health projected all emergency department (ED) visits in this community to increase by 10.2% over the next 5 years. About 16% of ED visits were generated by the residents of Alliance-Keller ZIP code 76244, but the highest estimated ED use rates were in the ZIP codes of North Richland Hills; 448.7 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 5.0% over the next five years in this community.

Estimated 2018 Emergency Department Visit Rate

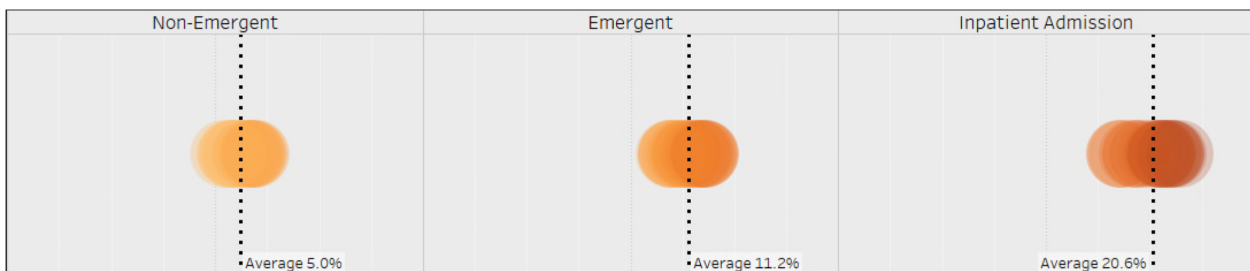


ZIP map color shows total Emergency Department visits per 1000 popultaion. Orange colors are higher than the state benchmark, blue colors are less than the state benchmark, and gray colors are similar.

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

Source: IBM Watson Health, 2018

Projected 5 Year Change in Emergency Department Visits by Type and ZIP Code



Three panels show the percent change in Emergency Department visits by 2013 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 uregent care treatment center, or a clinical or a physician's private office. Emergent visits require immediate treatment in a hospital emergency department due to the severity of illness. ED visits that result in inpatient admissions do not receive a CPT® code, but typically can be assumed to have resulted from an emergent encounter.

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

Source: IBM Watson Health, 2018

Appendix F: Evaluation of Prior Implementation Strategy Impact

This section provides a summary of the evaluation of the impact of any actions taken since the hospital facilities finished conducting their immediately preceding CHNA

Baylor Scott & White Emergency Hospital – Colleyville
Baylor Scott & White Emergency Hospital – Keller
Baylor Scott & White Emergency Hospital –Aubrey
Baylor Scott & White Emergency Hospital – Murphy

Prior Significant Health Needs Addressed by Facilities

Prior Identified Need Facility	Affordable Healthcare/Healthcare Costs	Mental/ Behavioral Health	Chronic Illness	Physical Inactivity	Dental Services	Hyperlipidemia
Baylor Scott & White Emergency Hospital - Aubrey	?					
Baylor Scott & White Emergency Hospital - Colleyville	?					
Baylor Scott & White Emergency Hospital - Keller	?					
Baylor Scott & White Emergency Hospital - Murphy	?					

Total Resources Contributed to Addressing Needs: $3,360,484

Identified Need Addressed: Affordable healthcare/healthcare costs

Program: Financial Assistance
Entity Name: Baylor Scott & White Emergency Hospital - Aubrey
Description:
As an affiliated for-profit joint venture hospital, the hospital expanded its provision of financial assistance to eligible patients by providing free or discounted care as outlined in the BSWH financial assistance policy. The hospital has agreed to provide the same level of financial assistance as other BSWH nonprofit hospitals and to be consistent with certain state requirements applicable to nonprofit hospitals. Certain hospitals not meeting minimum thresholds are required to make a contribution/grant to other affiliated nonprofit hospital to help hospital treat indigent patients.
Impact: 683 persons served;
Committed Resources: unreimbursed cost of providing financial assistance; $846,022 net community benefit

Program: Financial Assistance

Entity Name: Baylor Scott & White Emergency Hospital – Colleyville

Description:

As an affiliated for-profit joint venture hospital, the hospital expanded its provision of financial assistance to eligible patients by providing free or discounted care as outlined in the BSWH financial assistance policy. The hospital has agreed to provide the same level of financial assistance as other BSWH nonprofit hospitals and to be consistent with certain state requirements applicable to nonprofit hospitals. Certain hospitals not meeting minimum thresholds are required to make a contribution/grant to other affiliated nonprofit hospital to help hospital treat indigent patients.

Impact: 280 persons served

Committed Resources: unreimbursed cost of providing financial assistance; $803,592 net community benefit

Program: Financial Assistance

Entity Name: Baylor Scott & White Emergency Hospital - Keller

Description:

As an affiliated for-profit joint venture hospital, the hospital expanded its provision of financial assistance to eligible patients by providing free or discounted care as outlined in the BSWH financial assistance policy. The hospital has agreed to provide the same level of financial assistance as other BSWH nonprofit hospitals and to be consistent with certain state requirements applicable to nonprofit hospitals. Certain hospitals not meeting minimum thresholds are required to make a contribution/grant to other affiliated nonprofit hospital to help hospital treat indigent patients.

Impact: 883 persons served

Committed Resources: unreimbursed cost of providing financial assistance; $1,535,501 net community benefit

Program: Financial Assistance

Entity Name: Baylor Scott & White Emergency Hospital - Murphy

Description:

As an affiliated for-profit joint venture hospital, the hospital expanded its provision of financial assistance to eligible patients by providing free or discounted care as outlined in the BSWH financial assistance policy. The hospital has agreed to provide the same level of financial assistance as other BSWH nonprofit hospitals and to be consistent with certain state requirements applicable to nonprofit hospitals. Certain hospitals not meeting minimum thresholds are required to make a contribution/grant to other affiliated nonprofit hospital to help hospital treat indigent patients.

Impact: 600 persons served

Committed Resources: unreimbursed cost of providing financial assistance; $1,735,369 net community benefit

Baylor Scott & White is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization that continues to provide a wide range of important health care services and community benefits.

Needs Not Addressed:

These hospitals, committed to providing emergency care in the communities served, addressed significant community health needs based on their intersection with the stated mission and key clinical strengths. The following identified un-addressed needs are addressed through multiple other community and state agencies whose expertise and infrastructure are better suited for addressing these needs:

- Mental/behavioral health
- Chronic illness
- Physical inactivity
- Dental services
- Hyperlipidemia