Baylor Scott & White Health
Community Health Needs Assessment

Frisco Health Community

Baylor Scott & White Medical Center – Centennial
Baylor Scott & White Medical Center – Frisco
Baylor Scott & White Institute for Rehabilitation – Frisco

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

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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.


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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 Truven Health Analytics) collected and analyzed the data for this process and compiled 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. Three hospitals with overlapping communities have collaborated to conduct this joint community health needs assessment that applies to the following BSWH hospital facilities:

- Baylor Scott & White Medical Center - Centennial
- Baylor Scott & White Medical Center - Frisco
- Baylor Scott & White Institute for Rehabilitation - Frisco

For the 2019 assessment, the community includes the geographic area where at least 75% 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.

The 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 the community through 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 and 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; this 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 leadership and 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 became 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	Schizophrenia and Other Psychotic Disorders in Medicare Population	Mental Health
2	Depression in Medicare Population	Mental Health
3	Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse
4	Ratio of Population to One Non-Physician Primary Care Provider	Access to Care
5	Cancer Incidence - Female Breast	Cancer

The assessment process identified and included community resources able to address 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 took into account input from persons representing the broad interests of the community served by the hospital, including a description of when and how the hospital consulted with these persons or the organizations they represent
- The prioritized significant health needs identified through the CHNA as well as a description of the process and criteria used in prioritizing the identified significant needs
- The existing healthcare facilities, organizations, and other resources within the community available to meet the significant community health needs
- An evaluation of the impact of any actions that were taken, since the hospital facility(s) most recent CHNA, to address the significant health needs identified in that last CHNA

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

The written Implementation Strategy must include the following:

- List of the prioritized needs the hospital plans to address and the rationale for not addressing other significant health needs identified
- Actions the hospital intends to take to address the chosen health needs
- The anticipated impact of these actions and the plan to evaluate such impact (e.g. identify data sources that will be used to track the plan's impact)
- Identify programs and resources the hospital plans to commit to address the health needs
- Describe any planned collaboration between the hospital and other facilities or organizations in addressing the health needs

CHNA Overview, Methodology and Approach

BSWH 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 delivering comprehensive and actionable Community Health Needs Assessments.

Collaboration

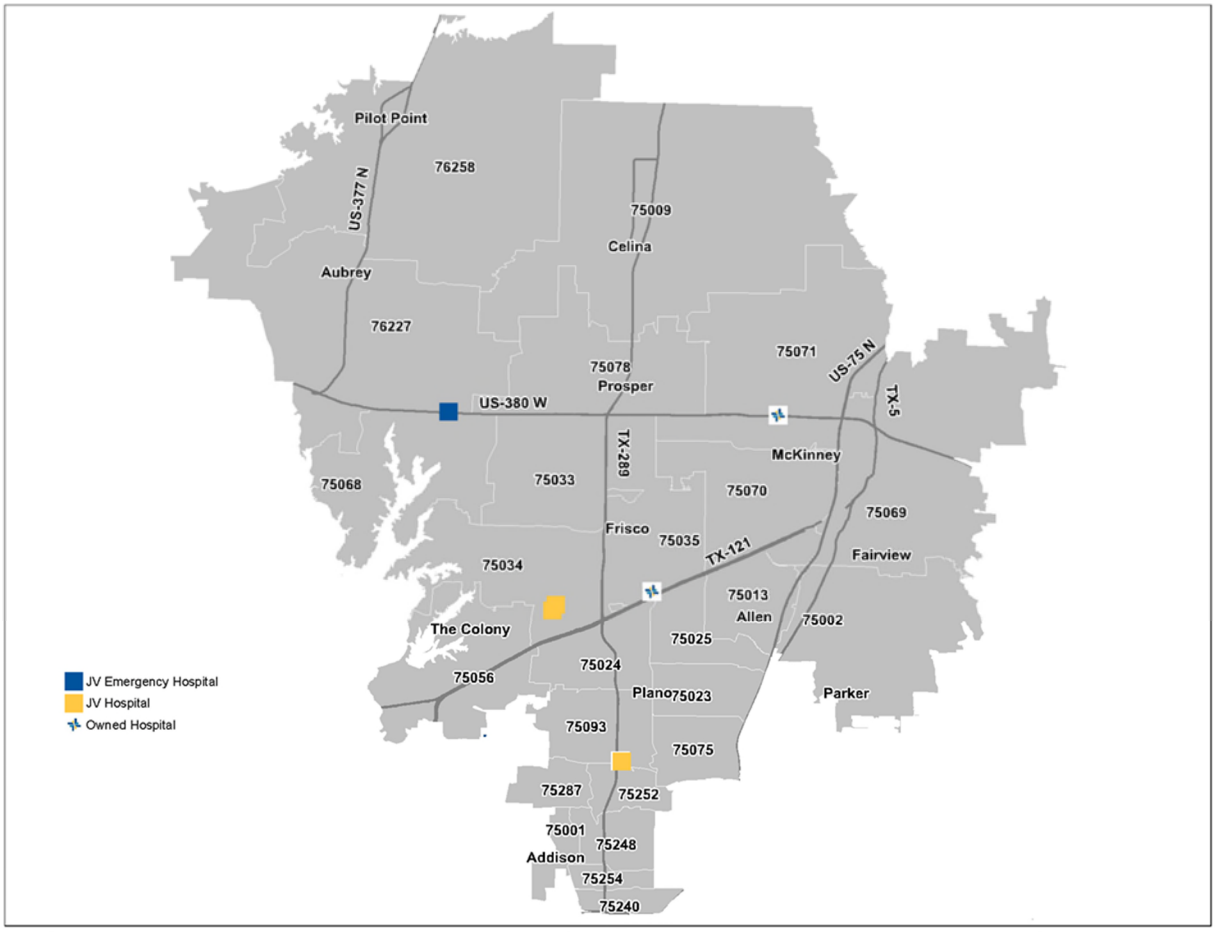
BSWH owns and operates multiple individually licensed hospital facilities serving the residents of north and central Texas. Three hospital facilities with overlapping communities have collaborated to conduct this joint community health needs assessment that applies to the following BSWH hospital facilities:

- Baylor Scott & White Medical Center – Centennial
- Baylor Scott & White Medical Center – Frisco
- Baylor Scott & White Institute for Rehabilitation – Frisco

Community Served Definition

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

BSWH Community Health Needs Assessment
Frisco Health Community Map



Source: Baylor Scott & White Health, 2019

75033 75034 75035 75068 76227 76258 75070 75009 75071 75078 75097 75069 75002 75013 75056 75001 75240 75248 75252 75254 75287 75294 75370 75380 75391 75023 75024 75025 75026 75075 75093

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. Data collected from several public sources compared to the state benchmark indicated the level of severity.

Quantitative Assessment of Health Needs – Methodology and Data Sources

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

ZIP codes defined this community however; public health indicators are most commonly available by county. Therefore, a patient origin study determined which counties principally represent the community's residents receiving hospital services. The principal counties for the Frisco Health Community needs analysis are Collin, and Denton counties.

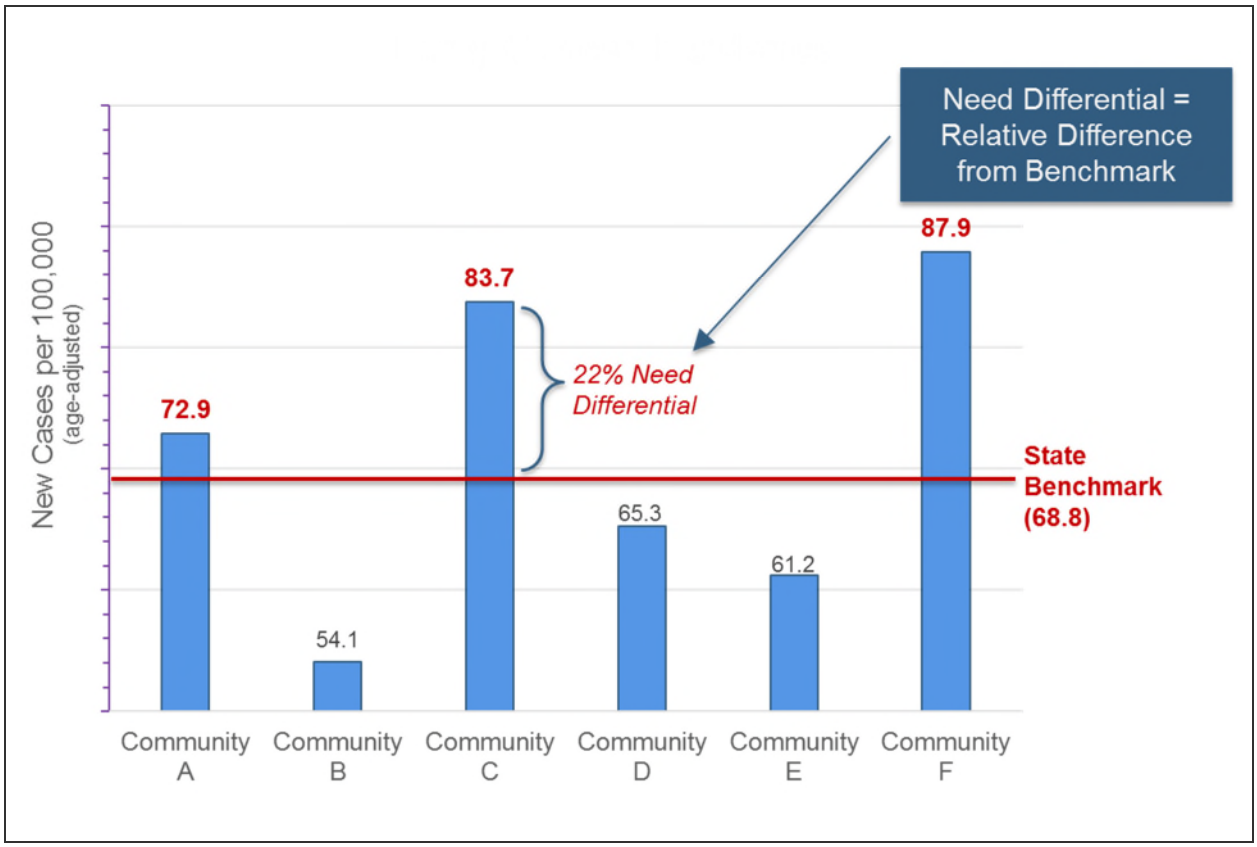
A benchmark analysis conducted for each indicator collected for the community served, determined which public health indicators demonstrated a community health need from a quantitative perspective. Benchmark health indicators collected included (when available): overall U.S. values; state of Texas values; 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, two (2) focus groups with a total of 23 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 also held with hospital clinical leadership and/ other community leaders identified significant health needs from the assessment and prioritized them.

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 contributing 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 serving or representing 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
Baylor Scott & White	X	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
First Refuge Ministries		X	X	X			
Frisco Family Services		X	X				
Giving Hope, Inc.		X	X	X			X
Goodwill Industries of Fort Worth		X	X		X		
Health Services of North Texas		X	X	X	X		
Hope Clinic of McKinney		X	X	X	X		
Lifepath Systems	X		X	X			X
McKinney City Council					X		

Participant Organization Name	Public Health	Medically Under-served	Low-income	Chronic Disease Needs	Minority Populations	Governmental Public --Health Dept.	Public Health Knowledge --Expertise
Metrocare	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-Collin County			X				
Refuge For Women North Texas					X		
Serve Denton			X				
Texas Muslim Women's Foundation					X		
The Samaritan Inn			X				
United Way		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

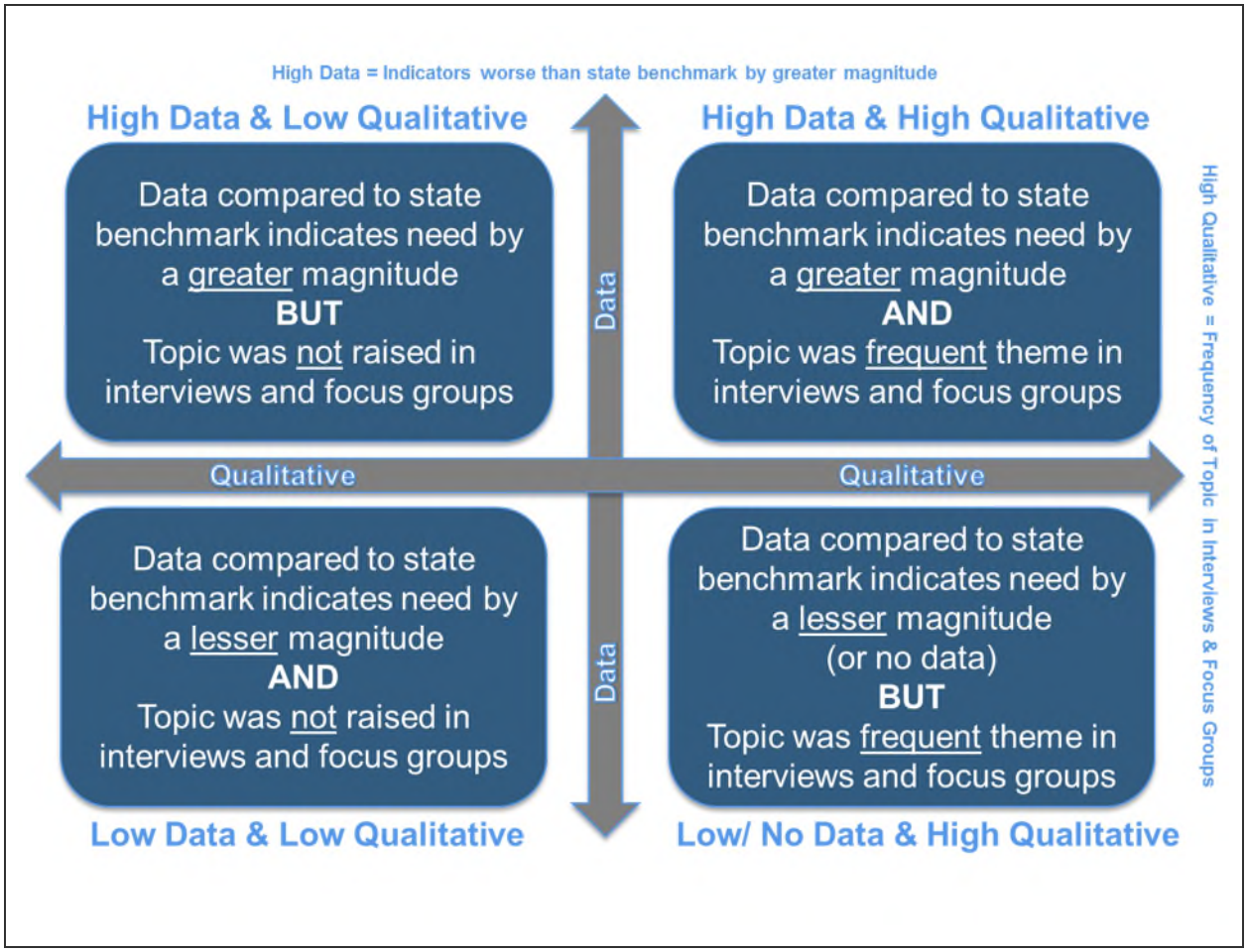
In addition to soliciting input from public health and various interests of the community, the hospital facilities considered written input received on their most recently conducted CHNA and subsequent implementation strategies. The assessment is available to receive public comment or feedback on the 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, and compared them to the quantitative data findings.

Methodology for Defining Community Need

Using qualitative feedback from the interviews and focus group, and 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 affect the population who truly need the service.

Approach to Identify and Prioritize Significant Health Needs

In a session held on November 6, 2018, Baylor Scott & White Medical Center – Centennial, Baylor Scott & White Frisco and Baylor Scott & White Institute for Rehabilitation leadership 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. Severity: the problem results in disability or premature death or creates burdens on the community, economically or socially
2. Vulnerable Populations: there is a high need among vulnerable populations and/or vulnerable populations are adversely impacted
3. Community Capacity: the community has the capacity to act on the issue, including any economic, social, cultural, or political consideration

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 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 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**. An interactive asset map of various resources identified for all BSWH communities is located at **BSWHealth.com/CommunityNeeds** .

Frisco Health Community CHNA

Demographic and Socioeconomic Summary

According to population statistics, the community served predicts growth exceeding the projected population growth in Texas and the country. The median age is younger, and the median income is significantly higher than both Texas and the United States. The community served has smaller proportion of Medicaid beneficiaries and uninsured individuals than Texas and the U.S...

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

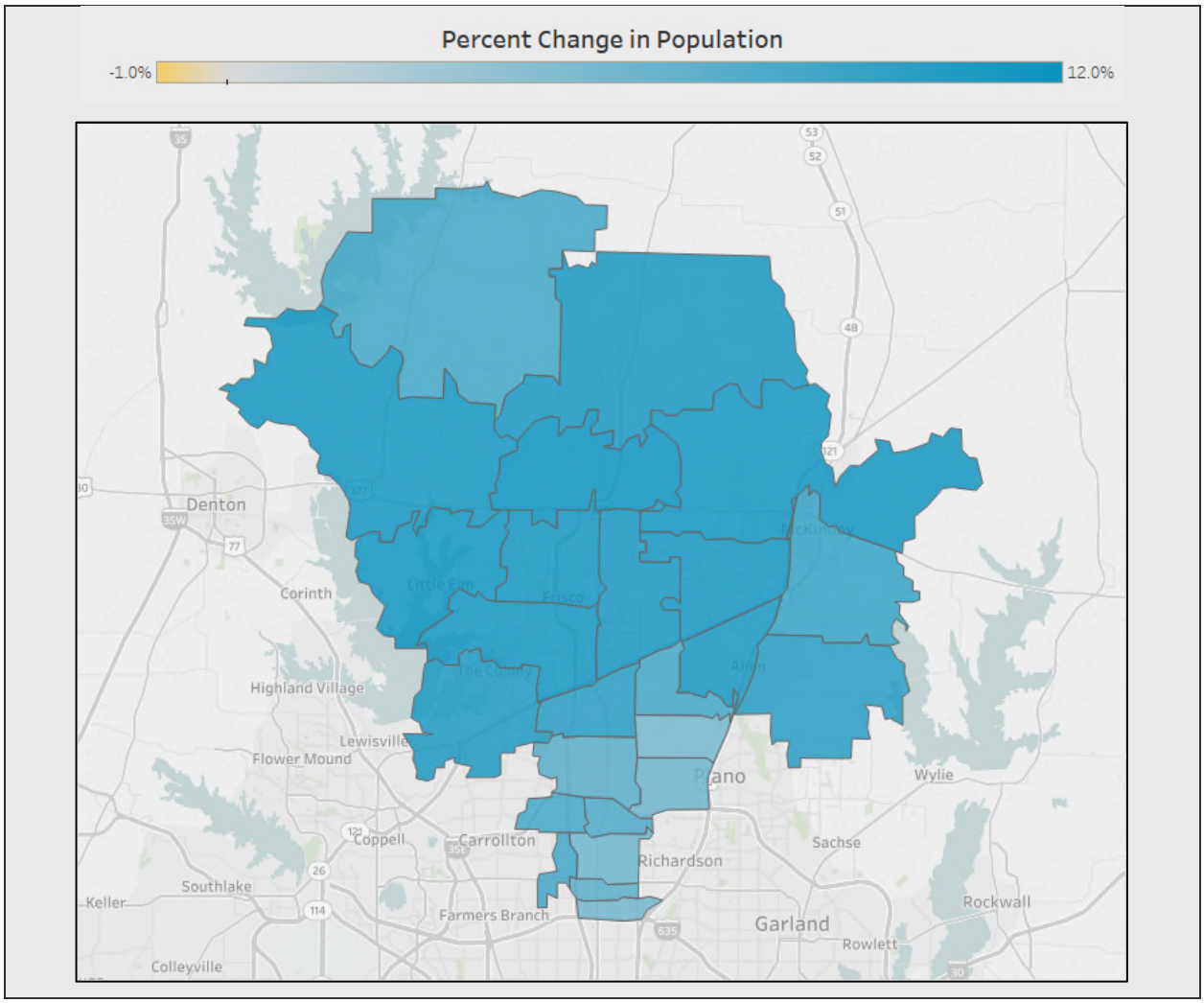
Geography		Benchmarks		Community Served
		United States	Texas	Frisco Health Community
Total Current Population		326,533,070	28,531,631	1,106,773
5 Yr Projected Population Change		3.5%	7.1%	9.7%
Median Age		42.0	38.9	37.4
Population 0-17		22.6%	25.9%	25.6%
Population 65+		15.9%	12.6%	10.6%
Women Age 15-44		19.6%	20.6%	21.2%
Non-White Population		30.0%	32.2%	34.4%
Hispanic Population		18.2%	39.4%	17.1%
Insurance Coverage	Uninsured	9.4%	19.0%	9.0%
	Medicaid	14.9%	13.4%	6.1%
	Private Market	9.6%	9.9%	10.7%
	Medicare	16.1%	12.5%	8.8%
	Employer	45.9%	45.3%	65.4%
Median HH Income		$61,372	$60,397	$92,339
Limited English		26.2%	39.9%	31.0%
No High School Diploma		7.4%	8.7%	3.2%
Unemployed		6.8%	5.9%	4.2%

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

The population of the community served predicts to grow 9.7% by 2023, an increase of more than 107,000 people; this is higher than the state's 5-year projected growth rate (7.1%) and much higher than the national projected growth rate (3.5%). The ZIP codes expected to experience the most growth in five years are:

- 75070 McKinney Westside – 12,270 people
- 75002 Allen – 7,892 people
- 75035 Frisco – 7,697 people
- 75034 Frisco – 7,567 people

2018 - 2023 Total Population Projected Change by ZIP Code

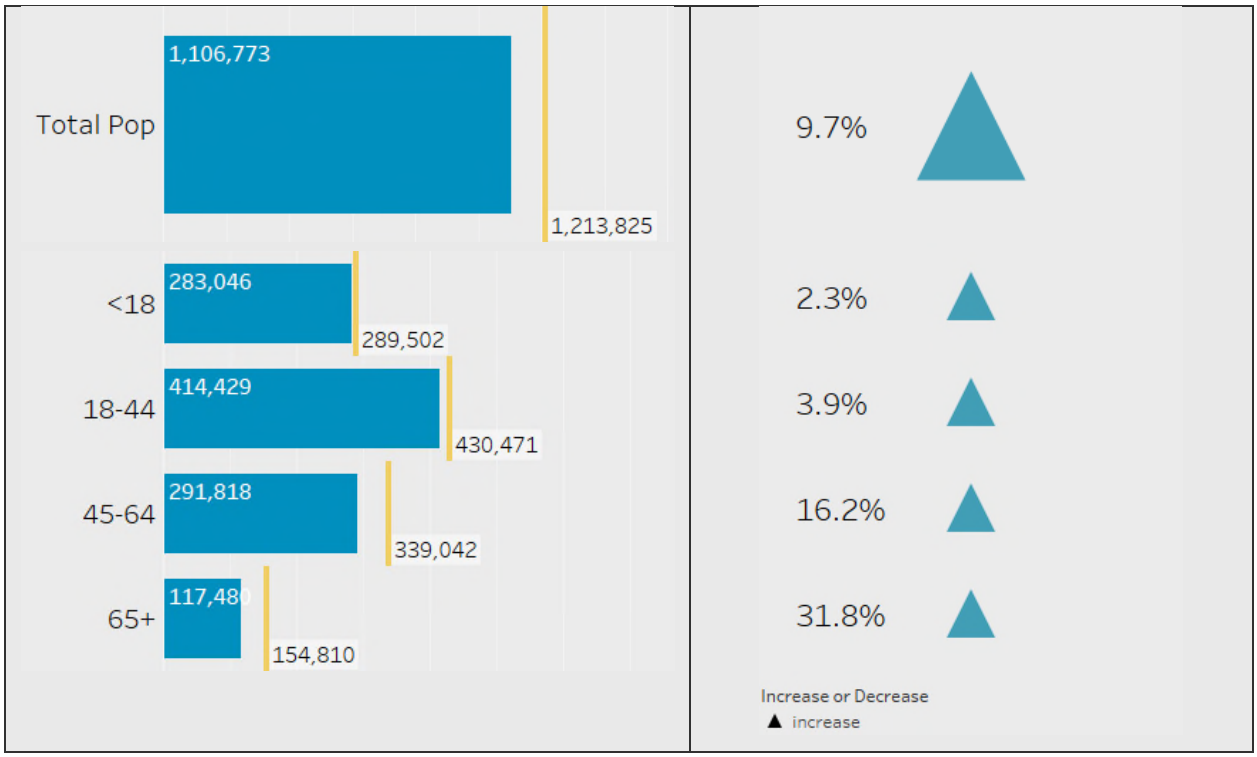


Source: IBM Watson Health / Claritas, 2018

The community's population skewed younger with 37.4% of the population ages 18-44 and 25.6% under age 18. The largest cohort (ages 18-44) predicts a growth of 16,042 people by 2023 (3.9%). The age 65+ cohort was the smallest (10.6%), but expects to experience the fastest growth (31.8%) over the next five years, adding 37,330 seniors to the community. Growth in the senior population will likely contribute to increased utilization of healthcare services as the population continues to age. The age 45-64 cohort (26.4%) is expected to have the second largest growth (16.2% increase) adding 47,224 people to the workforce.

Population Distribution by Age

2018 Population by Age Cohort *Percent Change by 2023*

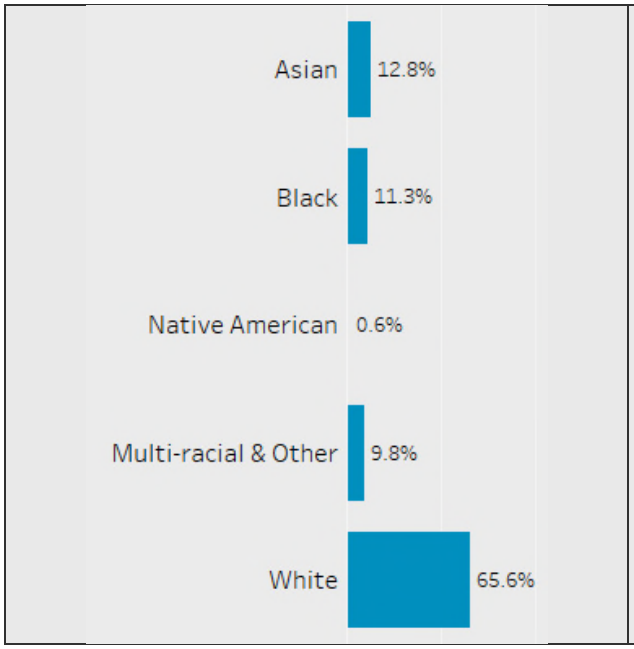


Source: IBM Watson Health / Claritas, 2018

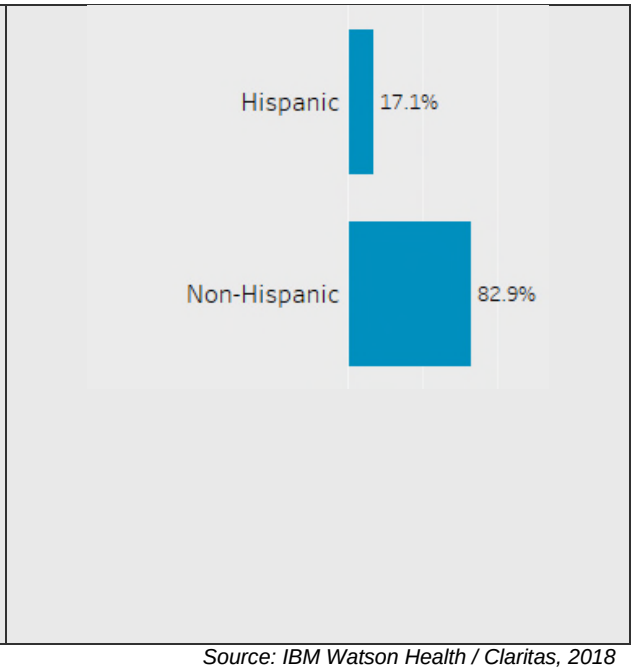
Analysis of population statistics is by race and Hispanic ethnicity. The community was primarily white and non-Hispanic (56.0%): the total non-Hispanic population represents the 82.9% of the entire population and e to grow by 82,042 people (8.9%). The non-Hispanic Asian and Black population will grow the most adding respectively 36,423 people (26% increase) and 26,554 people (22% increase). The expected growth rate of the Hispanic population (all races) is over 25,000 people (13.2%) by 2023. The Hispanic White population will experience the highest growth within the Hispanic ethnicity (13,353 additional people).

Population Distribution by Race and Ethnicity

2018 Population by Race

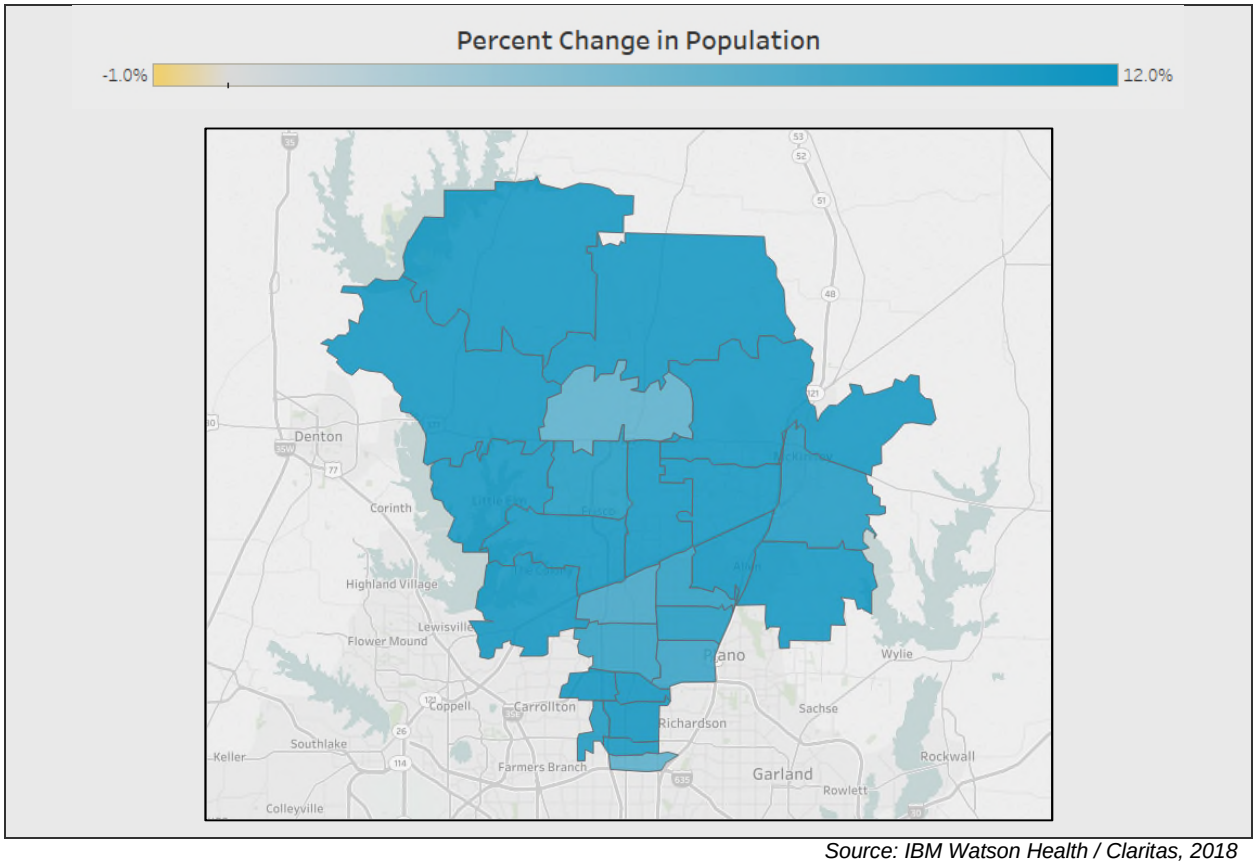


2018 Population by Ethnicity



Source: IBM Watson Health / Claritas, 2018

2018 - 2023 Hispanic Population Projected Change by ZIP Code

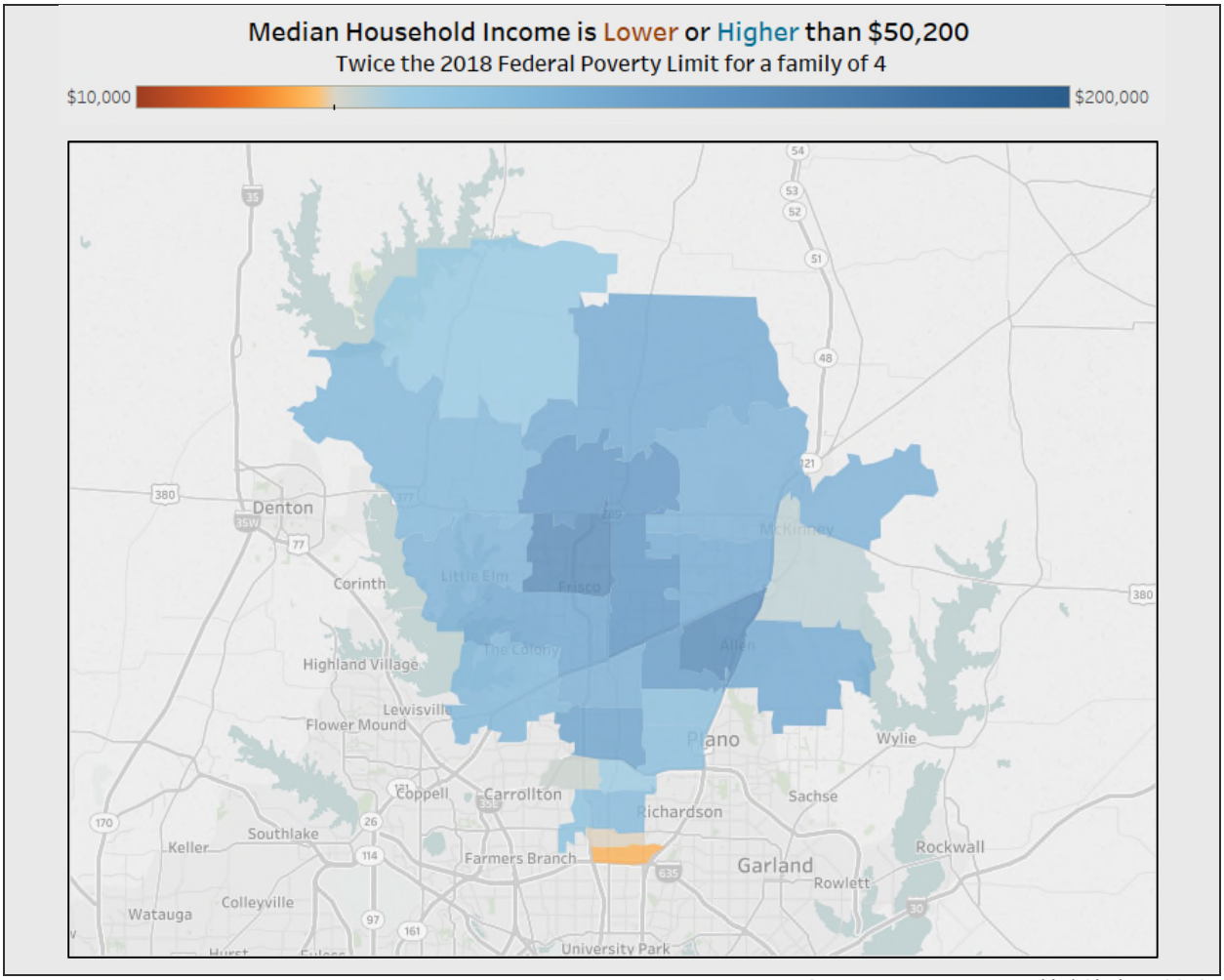


Source: IBM Watson Health / Claritas, 2018

The 2018 median household income for the United States was $61,372 and $60,397 for the state of Texas. The median household income for the ZIP codes within this community ranged from $43,473 for 75240 – Far North Dallas to $140,446 for 75033 – Frisco. There were two ZIP codes with median household incomes less than $50,200, twice the 2018 Federal Poverty Limit for a family of four:

- 75240 Far North Dallas – $43,473
- 75254 Far North Dallas – $49,817

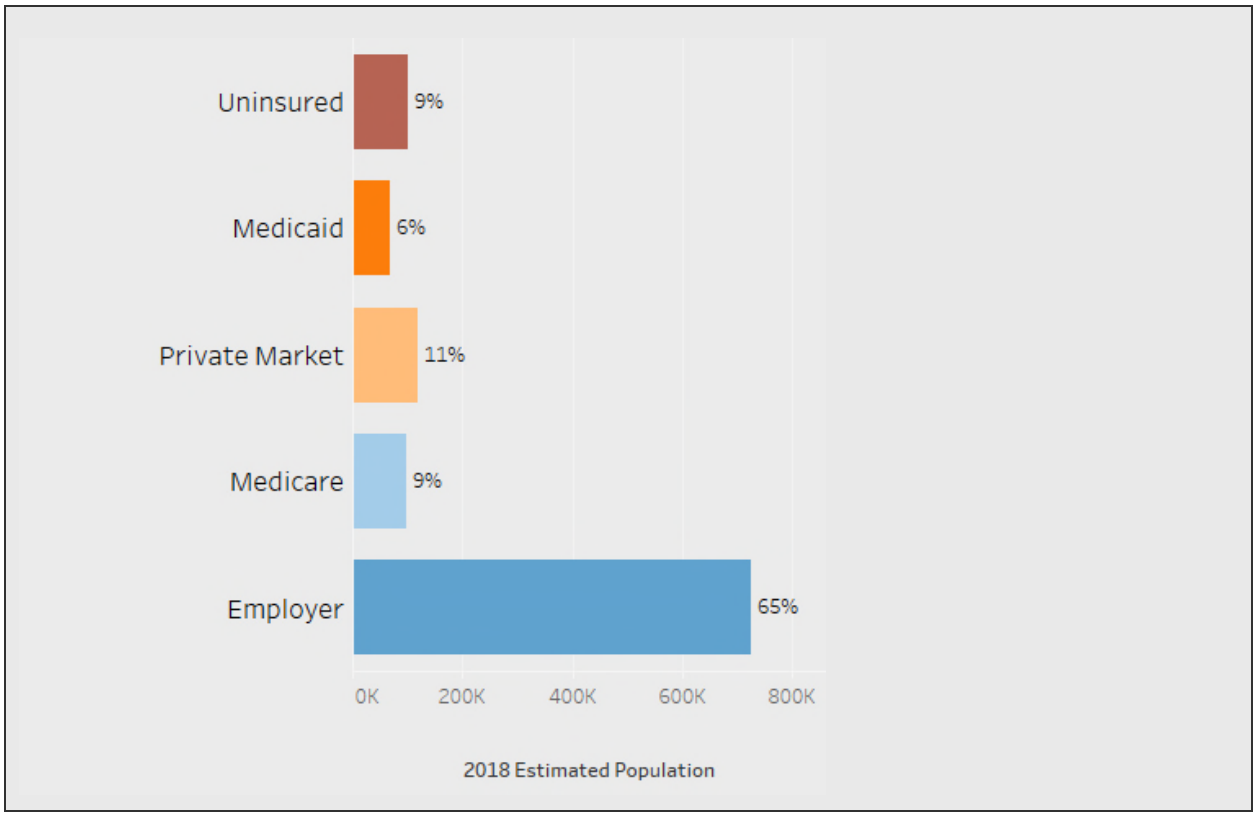
2018 Median Household Income by ZIP Code



Source: IBM Watson Health / Claritas, 2018

A majority of the population (65%) have insurance through employer sponsored health coverage. The remainder of the population was divided between those without health insurance (9%), Medicaid (6%), Medicare (9%), and private market (the purchasers of coverage directly or through the health insurance marketplace) (11%).

2018 Estimated Distribution of Covered Lives by Insurance Category



Source: IBM Watson Health / Claritas, 2018

The community includes six (6) Health Professional Shortage Areas and two (2) 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 Frisco Health Community	Dental Health	Mental Health	Primary Care	Grand Total	MUA/P
Collin	1	1	1	3	1
Denton	1	1	1	3	1
Total	2	2	2	6	2

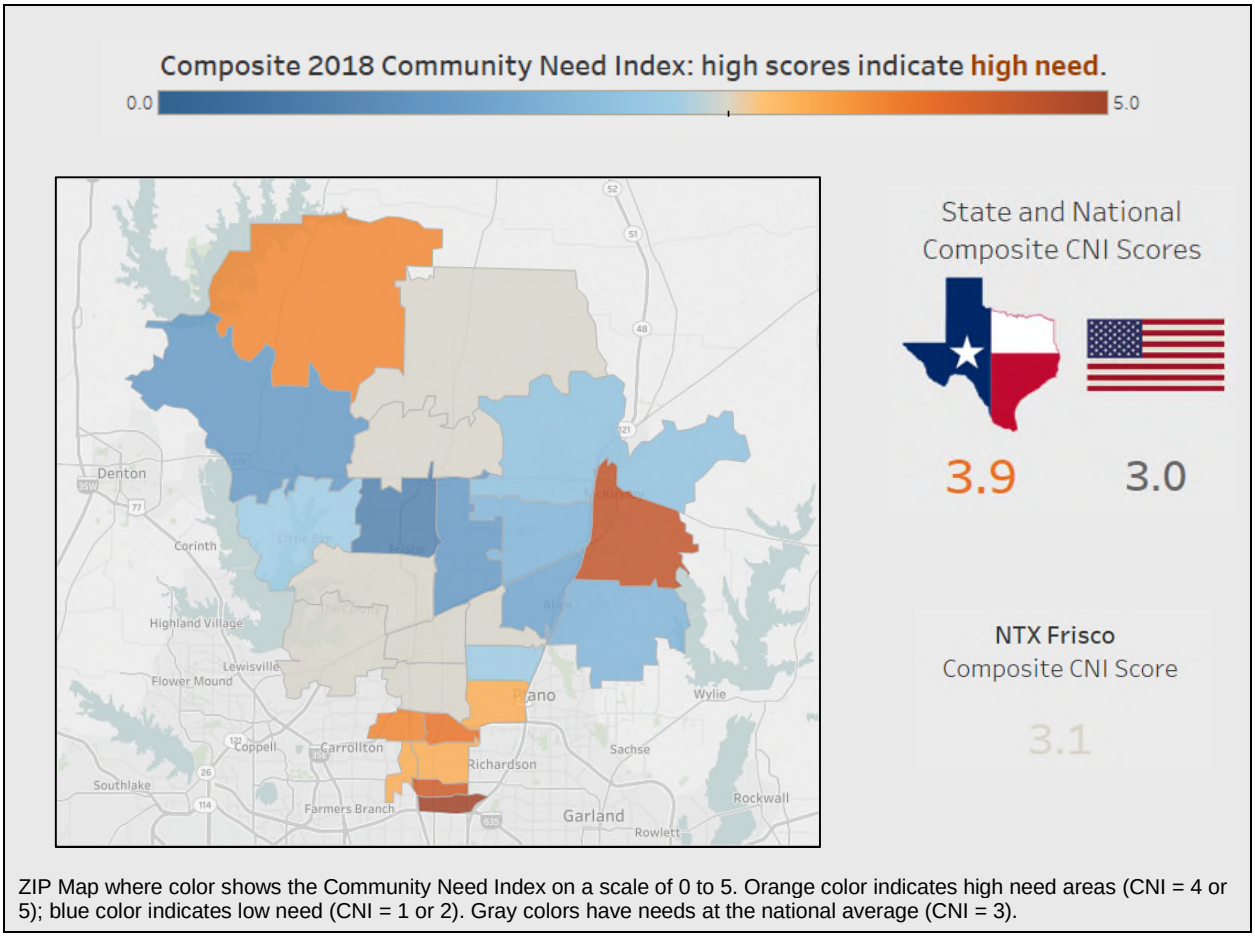
Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, 2018

[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 linked differences 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 3.1, on par with the CNI national average of 3.0. In portions of the community (75240 – Far North Dallas and 75069 – Downtown McKinney-Eastside) the CNI score was greater than 4.5, pointing to potentially more significant health needs among that 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
Dallas	Far North Dallas	Dallas	75240	5.0
McKinney	Downtown McKinney-Eastside	Collin	75069	4.6
Dallas	Far North Dallas	Dallas	75254	4.4
Dallas	Far North Dallas	Collin	75252	4.0

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 served as the basis of benchmarks was available data for the U.S. and the state of Texas.

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

Watson Health Community Data

Watson Health supplemented the publicly available data with estimates of localized disease prevalence of heart disease and cancer and emergency department visit estimates. This information is located in **Appendix E**.

Focus Groups & Interviews

BSWH worked jointly 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 that contribute to the current health status of the community, and then identified the greatest barriers and strengths that contribute to the overall health of the community. For this health community there were 23 focus group participants in two sessions and four interviews conducted July through September 2018.

Focus group participants described both Denton and Collin counties as growing areas and among the healthiest in Texas. Denton County schools, and the university, attracted many foreign students and international residents. Collin County was a fast-growing, increasingly diverse area with a high cost of living. People moved to this community for its high quality of life, good schools, and job growth. Participants described the many outdoor activities, libraries, low crime rate, and abundant music venues that attracted new residents; but determined that the increased cost of housing and taxes were putting some longtime residents and fixed-income seniors at risk for homelessness.

In Collin County, the Asian and Indian populations were the fastest growing populations in the area. Cultural differences created challenges for local health care organizations when delivering services and participants suggested it would be helpful to educate health care providers to address trust issues. For example, only a few clinics treated female Muslims and those facilities needed guidance in delivering culturally sensitive inoffensive care for women or their families.

The area had limited health care services for the uninsured but an abundance of services for those with both insurance and a high income. The focus group participants noted that

Denton County had a high rate of insured residents, a rate skewed by the requirement that all university and community college students have insurance. The statistic on insurance coverage masked the fact that residents covered by Medicare or Medicaid often had trouble finding providers willing to accept those payers. Participants also said pediatric specialists were completely lacking in the 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. A need for Dentists exists, especially for low-income residents and people without a car. Limited public transportation created transportation “deserts”, and the lack of public transit interfered with ability to pursue follow up care. Public transportation that did exist and was ineffectual in assisting residents to get to their places of employment. Many participants noted that drunk driving was an issue and surmised the lack of public transportation contributed to this issue.

This area contained quickly growing bedroom communities, and impoverished areas east of the I-75 corridor. High housing costs contributes to a growing transient population who frequently use emergency departments for care. There were free clinics, but they are often inaccessible due to the lack of transportation. Low-income residents of Denton County had more mental health providers than other parts of the Dallas Ft. Worth area, but that amount is still insufficient to meet demand, especially for children.

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

Frisco Health Community		
Top Needs Identified	Category of Need	Public Health Indicator
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
Cancer Incidence - Female Breast	Cancer	2011-2015 Age-Adjusted Female Breast Cancer Incidence Rate Cases Per 100,000
Cancer Incidence - Prostate	Cancer	2011-2015 Age-Adjusted Prostate Cancer Incidence Rate Cases per 100,000
Depression in Medicare Population	Mental Health	Prevalence of chronic condition across all Medicare beneficiaries
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	2012-2016 Percentage of Motor Vehicle Crash Deaths that had Alcohol Involvement
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

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	Schizophrenia and Other Psychotic Disorders in Medicare Population	Mental Health
2	Depression in Medicare Population	Mental Health
3	Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse
4	Ratio of Population to One Non-Physician Primary Care Provider	Access to Care
5	Cancer Incidence - Female Breast	Cancer

Description of Health Needs

A CHNA for the Frisco Health Community identified several significant community health needs categorized as issues related to access to care, mental health, substance abuse and cancer. 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 received validation through key informant interviews, focus groups and county data. Access to care; specifically, non-physician primary care providers, schizophrenia and depression prevalence, motor vehicle deaths involving alcohol, and female breast cancer rates were identified as significant areas of concern and noted in the data results for Frisco Health Community of Collin and Denton counties.

<u>Schizophrenia and Other Psychotic Disorders in the Medicare Population</u>

Data on mental health diagnoses 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 mental health diagnoses is available for the Medicare population only and indicate a need among the Medicare population. This data, used as a proxy for need across the greater population, relates to the prevalence of mental health conditions within the community.

In the Frisco Health Community, the population age 65 and older (seniors) predicts the fastest growth of 31.8% by 2023. This projection adds approximately 37,330 seniors to the Frisco Health Community.[2] Growth among this age group will likely contribute to increased utilization of healthcare services. Over time, the community must grow their

[2] IBM Watson Health / Claritas, 2018

ability to provide adequate services to care for the aging population, including services related to mental health.

Both Collin and Denton counties had rates of 2.6% for schizophrenia and other psychotic disorders among their Medicare population. This was 10.1% greater than the overall Texas value for the same measure.[3] Seniors with either life-long mental health diagnoses or recent onset changes, face a multitude of challenges including access to specialized services, insurance, transportation, etc. Individuals with long-term mental health issues who have had access to therapy and medications may now face additional concerns as an aging senior. Isolation for adults 65 and older who are living alone is a growing challenge for communities across the nation, and compounds with serious mental health concerns. Integrating social services for engaging, supporting and positively challenging their 65 and older populations may improve the overall health and well-being of the community.

Depression in the Medicare Population

Depression not categorized as the normal result of aging is a true and treatable condition. However, conditions such as chronic illness, financial challenges, death, and a change of living situation, are some reasons why there are a growing number of people in the Medicare population with depressive diagnoses. Eighty percent of older adults have at least one chronic health condition and 50% have two or more.[4] Healthcare providers may mistake an older adult's symptoms of depression as just a natural reaction to illness or the life changes that may occur as we age, and therefore not see the depression as a condition to be treated.

Denton County, as part of the Frisco Health Community, had a rate of depression in the Medicare population of 17.6%; this was greater than the Texas state benchmark by 18.0%, indicating a greater need and a larger vulnerable population within the Frisco Health Community.[5]

Motor Vehicle Driving Deaths with Alcohol Involvement

Motor vehicle driving deaths with alcohol involvement measures as a percentage of all motor vehicle crash deaths where alcohol was involved.[6] There are approximately 17,000 Americans killed annually in alcohol-related motor vehicle crashes.[7] Binge (heavy) drinkers account for most instances of alcohol-impaired driving.[8] Not all fatal motor vehicle traffic accidents have a valid blood alcohol test, causing data available to likely undercount instances of actual alcohol involvement. Additionally, there can be a large

[3] CMS Chronic Conditions Warehouse, 2007-2015
[4] **U.S. Center for Disease Control and Prevention**, 2019
[5] CMS Chronic Conditions Warehouse, 2007-2015
[6] **Alcohol-impaired Driving Deaths**, County Health Rankings, 2018
[7] 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.
[8] 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.

difference in the degree 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%, the Collin County rate was 35.8%, and this is 26.5% higher than the state benchmark.[9] 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.

Ratio of Population to One Non-Physician Primary Care Provider

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 the U.S. vary, however a need of thousands of additional Primary Care Providers (PCPs) exists to meet the current demand and a need in the tens of thousands of additional caregivers exists 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 located 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.

Access to non-physician primary care providers is a need for both Denton and Collin counties. Of 107 indicators, this indicator ranked second for Denton County and fourth for Collin County. Access to care is as a critical issue within the focus group discussions. The Texas state benchmark for non-physician providers was one provider for every 1,497 residents. The Denton County ratio was one provider to 1,966 residents, or 31.3% higher than the state benchmark, and Collin County was one provider to every 1,828 residents, or 22.1% higher than the state benchmark.[10] The CHNA findings point to a greater need regarding access to non-physician primary care providers within the Frisco Health Community.

Cancer Incidence: Female - Breast

Breast cancer is responsible for more than 40,000 deaths in the United States each year, along with more than 265,000 new cancer diagnoses. According to M.D. Anderson research, new treatments have pushed the diseases five-year survival rate to nearly 90%.[11] Breast cancer is a complex disease with varied types, and risk factors such as

[9] Fatality Analysis Reporting System (FARS), County Health Rankings & Roadmaps, 2018
[10] CMS, National Provider Identification Registry (NPPES); County Health Rankings & Roadmaps, 2018
[11] https://www.mdanderson.org/cancer-types/breast-cancer.html

hereditary, body habitus, medical history, exposure to carcinogens, and other factors influence treatment outcomes. Early diagnosis and treatment are essential to long-term success and reduced mortality. Lack of access to care could delay both diagnosis and treatment. Communities with access to screening, education, primary care and specialized medical care can influence the incidence and outcomes of all types of cancer.

Both Denton and Collin counties' age-adjusted breast cancer rates were higher than the state of Texas benchmark of 111.7 new female breast cancer cases per 100,000 residents. Denton County was 13% higher at 125.9 new cases per 100,000 and Collin County was 11% higher with 123.7 new cases per 100,000 residents.[12] The data indicates a significant need and a greater vulnerable population.

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.

[12] State Cancer Profiles, National Cancer Institute (CDC), 2011-2015

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 (**BSWHealth.com/CommunityNeeds)**.

Resources Identified

Community Health Need	Category	Service	Facility Name	Address	City	Phone Number
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	Metrocare at Midway — Center & Pharmacy	16160 Midway Rd. Suite 200	Addison	214-689-5196
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	Mi Doctor Family Clinic - Spring Valley Clinic	8112 Spring Valley Rd	Dallas	214-884-1705
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	PediPlace - Spring Creek Village	7989 Belt Line Rd, #120 Dallas	Dallas	214-420-8008
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	Primary Care Clinic of North Texas	3900 American Drive, #201	Plano	214-378-6005
Cancer Incidence - Female Breast	Cancer	Disease Screenings	Mi Doctor Family Clinic - Spring Valley Clinic	8112 Spring Valley Rd	Dallas	214-884-1705
Cancer Incidence - Female Breast	Cancer	Disease Screenings	Primary Care Clinic of North Texas	3900 American Drive, #201	Plano	214-378-6005
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	Behavioral Health Services	Jewish Family Services	6910 Dallas Parkway, Suite 116	Dallas	972-437-9950
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	Behavioral Health Services	Jewish Family Services	5402 Arapaho Rd	Dallas	972-437-9950

Community Health Need	Category	Service	Facility Name	Address	City	Phone Number
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	Behavioral Health Services	Metrocare at Midway — Center & Pharmacy	16160 Midway Rd. Suite 200	Addison	214-689-5196
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	Behavioral Health Services	Metrocare at Midway — Center & Pharmacy	5580 LBJ Freeway, Suite 615	Dallas	972-331-6363
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	Social Services	Jewish Family Services	6910 Dallas Parkway, Suite 116	Dallas	972-437-9950
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	Substance Use Services	Metrocare at Midway — Center & Pharmacy	16160 Midway Rd. Suite 200	Addison	214-689-5196
Depression in Medicare Population	Mental Health	Crisis Services	Jewish Family Services	5402 Arapaho Rd	Dallas	972-437-9950
Depression in Medicare Population	Mental Health	Family Counseling	Jewish Family Services	5402 Arapaho Rd	Dallas	972-437-9950
Depression in Medicare Population	Mental Health	Mental Health Services	Jewish Family Services	5402 Arapaho Rd	Dallas	972-437-9950
Depression in Medicare Population	Mental Health	Mental Health Services	Jewish Family Services	6910 Dallas Parkway, Suite 116	Dallas	972-437-9950
Depression in Medicare Population	Mental Health	Mental Health Services	Metrocare at Midway — Center & Pharmacy	5580 LBJ Freeway, Suite 615	Dallas	972-331-6363
Depression in Medicare Population	Mental Health	Mental Health Services	Metrocare at Midway — Center & Pharmacy	16160 Midway Rd. Suite 200	Addison	214-689-5196
Depression in Medicare Population	Mental Health	Social Services	Jewish Family Services	6910 Dallas Parkway, Suite 116	Dallas	972-437-9950

Community Health Need	Category	Service	Facility Name	Address	City	Phone Number
Depression in Medicare Population	Mental Health	Social Services	Metrocare at Midway — Center & Pharmacy	16160 Midway Rd. Suite 200	Addison	214-689-5196
Schizophrenia and Other Psychotic Disorders in Medicare Population	Mental Health	Crisis Services	Jewish Family Services	5402 Arapaho Rd	Dallas	972-437-9950
Schizophrenia and Other Psychotic Disorders in Medicare Population	Mental Health	Family Counseling	Jewish Family Services	5402 Arapaho Rd	Dallas	972-437-9950
Schizophrenia and Other Psychotic Disorders in Medicare Population	Mental Health	Mental Health Services	Jewish Family Services	5402 Arapaho Rd	Dallas	972-437-9950
Schizophrenia and Other Psychotic Disorders in Medicare Population	Mental Health	Mental Health Services	Jewish Family Services	6910 Dallas Parkway, Suite 116	Dallas	972-437-9950
Schizophrenia and Other Psychotic Disorders in Medicare Population	Mental Health	Mental Health Services	Metrocare at Midway — Center & Pharmacy	5580 LBJ Freeway, Suite 615	Dallas	972-331-6363
Schizophrenia and Other Psychotic Disorders in Medicare Population	Mental Health	Mental Health Services	Metrocare at Midway — Center & Pharmacy	16160 Midway Rd. Suite 200	Addison	214-689-5196
Schizophrenia and Other Psychotic Disorders in Medicare Population	Mental Health	Social Services	Jewish Family Services	6910 Dallas Parkway, Suite 116	Dallas	972-437-9950
Schizophrenia and Other Psychotic Disorders in Medicare Population	Mental Health	Social Services	Metrocare at Midway — Center & Pharmacy	16160 Midway Rd. Suite 200	Addison	214-689-5196

Community Healthcare Facilities

Facility Name	Type	System	Street Address	City	State	ZIP
Accel Rehabilitation Hospital Of Plano	LT	Accel Rehab	2301 Marsh Lane Suite 200	Plano	TX	75093
Baylor Scott & White Emergency Hospital - Aubrey	ED	Baylor Scott & White	26791 Highway 380	Aubrey	TX	76227
Baylor Scott & White Institute For Rehabilitation - Frisco	LT	Baylor Scott & White	2990 Legacy Drive	Frisco	TX	75034
Baylor Scott & White Medical Center - Centennial	ST	Baylor Scott & White	12505 Lebanon Road	Frisco	TX	75035
Baylor Scott & White Medical Center – Frisco	ST	Baylor Scott & White	5601 Warren Parkway	Frisco	TX	75034
Baylor Scott & White Medical Center – Mckinney	ST	Baylor Scott & White	5252 West University Drive	McKinney	TX	75071
Baylor Scott & White Medical Center – Plano	ST	Baylor Scott & White	4700 Alliance Boulevard	Plano	TX	75093
Childrens Medical Center Plano	KID	Children's Medical	7601 Preston Road	Plano	TX	75024
Eating Recovery Center	PSY	Freestanding	4708 Alliance Boulevard Third Floor	Plano	TX	75093
Elitecare 24 Hour Emergency Room	ED	Elite Care	2000 N Dallas Parkway Suite 100	Plano	TX	75093
Haven Behavioral Hospital Of Frisco	PSY	Haven Behavioral Healthcare	5680 Frisco Square Blvd Suite 3000	Frisco	TX	75034
Healthsouth Plano Rehabilitation Hospital	LT	HealthSouth	2800 West 15th Street	Plano	TX	75075
Icare Emergency Room	ED	iCare	2955 Eldorado Parkway Suite 100	Frisco	TX	75033
Legacy ER	ED	Legacy	1310 West Exchange Parkway	Allen	TX	75013

Facility Name	Type	System	Street Address	City	State	ZIP
Legacy ER	ED	Legacy	16151 Eldorado Pkwy Ste 100	Frisco	TX	75035
Legacy ER	ED	Legacy	2810 South Hardin Blvd Suite 100	McKinney	TX	75070
Legacy ER	ED	Legacy	9205 Legacy Drive	Frisco	TX	75034
Lifecare Hospitals Of Plano	LT	LifeCare	6800 Preston Road	Plano	TX	75024
Medical City Frisco A Medical Center Of Plano Facility	ST	Hospital Corporation of America	5500 Frisco Square Blvd	Frisco	TX	75034
Medical City Mckinney	ST	Hospital Corporation of America	4500 Medical Center Drive	McKinney	TX	75069
Medical City Mckinney - Wysong Campus	ST	Hospital Corporation of America	130 South Central Expressway	McKinney	TX	75070
Medical City Plano	ST	Hospital Corporation of America	3901 West 15th Street	Plano	TX	75075
Methodist Hospital For Surgery	ST	Methodist Health System	17101 Dallas Parkway	Addison	TX	75001
Methodist Mckinney Hospital LLC	ST	Methodist Health System	8000 West Eldorado Parkway	McKinney	TX	75070
Pam Rehabilitation Hospital Of Allen	LT	Post Acute Medical	1001 Raintree Circle	Allen	TX	75013
Plano Specialty Hospital	LT	Compass Pointe	1621 Coit Road	Plano	TX	75075
Plano Surgical Hospital	ST	Nobilis Health	2301 Marsh Lane Suite 100	Plano	TX	75093
Prestige ER	ED	Freestanding	7940 Custer Rd	Plano	TX	75025
Star Medical Center	ST	Freestanding	4100 Mapleshade Lane	Plano	TX	75075

Facility Name	Type	System	Street Address	City	State	ZIP
Texas Health Center For Diagnostics & Surgery Plano	ST	Texas Health Resources	6020 West Parker Road	Plano	TX	75093
Texas Health Presbyterian Hospital Allen	ST	Texas Health Resources	1105 Central Expressway North Suite 140	Allen	TX	75013
Texas Health Presbyterian Hospital Plano	ST	Texas Health Resources	6200 West Parker Road	Plano	TX	75093
Texas Health Seay Behavioral Health Hospital	PSY	Texas Health Resources	6110 West Parker Road	Plano	TX	75093
The Colony ER Hospital	ED	Nutex Health	4780 State Hwy 121	The Colony	TX	75056
The ER At Craig Ranch By Code 3	ED	Code 3	6045 Alma Road Suite 110	McKinney	TX	75070
The Heart Hospital Baylor Plano	ST	Baylor Scott & White	1100 Allied Drive	Plano	TX	75093
Wellbridge Hospital Of Plano	PSY	Wellbridge Health	4301 Mapleshade Lane	Plano	TX	75093

**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)[13]

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

Medically Underserved Areas and Populations (MUA/P)[14]

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

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

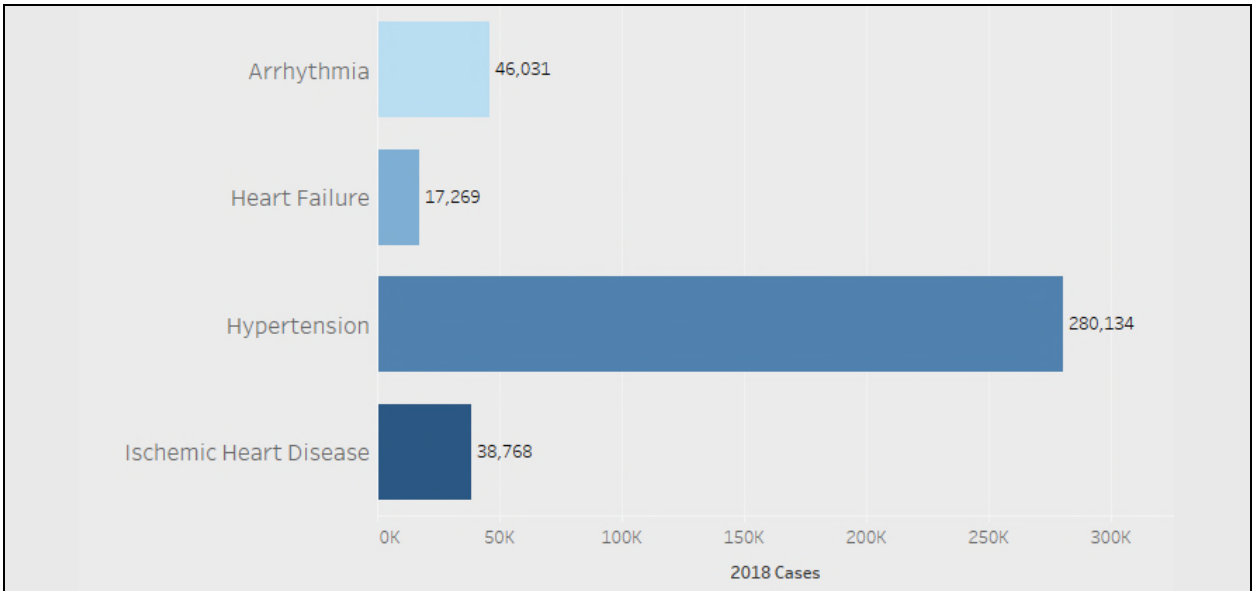
Frisco Valley Health Community		
Public Health Indicator	Category	Indicator Definition
Air Pollution - Particulate Matter daily density	Environment	2012 Average Daily Density of Fine Particulate Matter in Micrograms per Cubic Meter (PM2.5)
Ratio of Population to One Non-Physician Primary Care Provider	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
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
Perforated Appendix Admission: Adult (Risk-Adjusted-Rate per 100 Admissions for Appendicitis)	Preventable Hospitalizations	2016 Number Observed / Adult Population Age 18 and older
Cancer Incidence - Female Breast	Conditions/Diseases	2011-2015 Age-Adjusted Female Breast Cancer Incidence Rate Cases Per 100,000
Hyperlipidemia in Medicare Population	Conditions/Diseases	2007-2015 Prevalence of chronic condition across all Medicare beneficiaries

Frisco Valley Health Community		
Public Health Indicator	Category	Indicator Definition
Schizophrenia and Other Psychotic Disorders in Medicare Population	Mental Health	2007-2015 Prevalence of chronic condition across all Medicare beneficiaries
Perforated Appendix Admission: Pediatric (Risk-Adjusted-Rate for Appendicitis)	Preventable Hospitalizations	2016 Number Observed / Pediatric Population Under Age 18
Cancer Incidence - Prostate	Conditions/Diseases	2011-2015 Age-Adjusted Prostate Cancer Incidence Rate Cases per 100,000.
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

Appendix E: Watson Health Community Data

Watson Health Heart Disease Estimates identified hypertension as the most prevalent heart disease diagnoses; there were over 280,000 estimated cases in the community overall. The McKinney Westside ZIP code (75070) had the most estimated cases of each heart disease type, primarily driven by population size. However, despite fewer number of cases, the 75075 ZIP code in Plano had some of the highest estimated prevalence rates for Arrhythmia (705 cases per 10,000 population), Hypertension (3,332 cases per 10,000 population) and Ischemic Heart Disease (654 cases per 10,000 population). While the ZIP code 75248 in Far North Dallas had the highest prevalence of Heart Failure (314 cases per 10,000 population).

2018 Estimated Heart Disease Cases



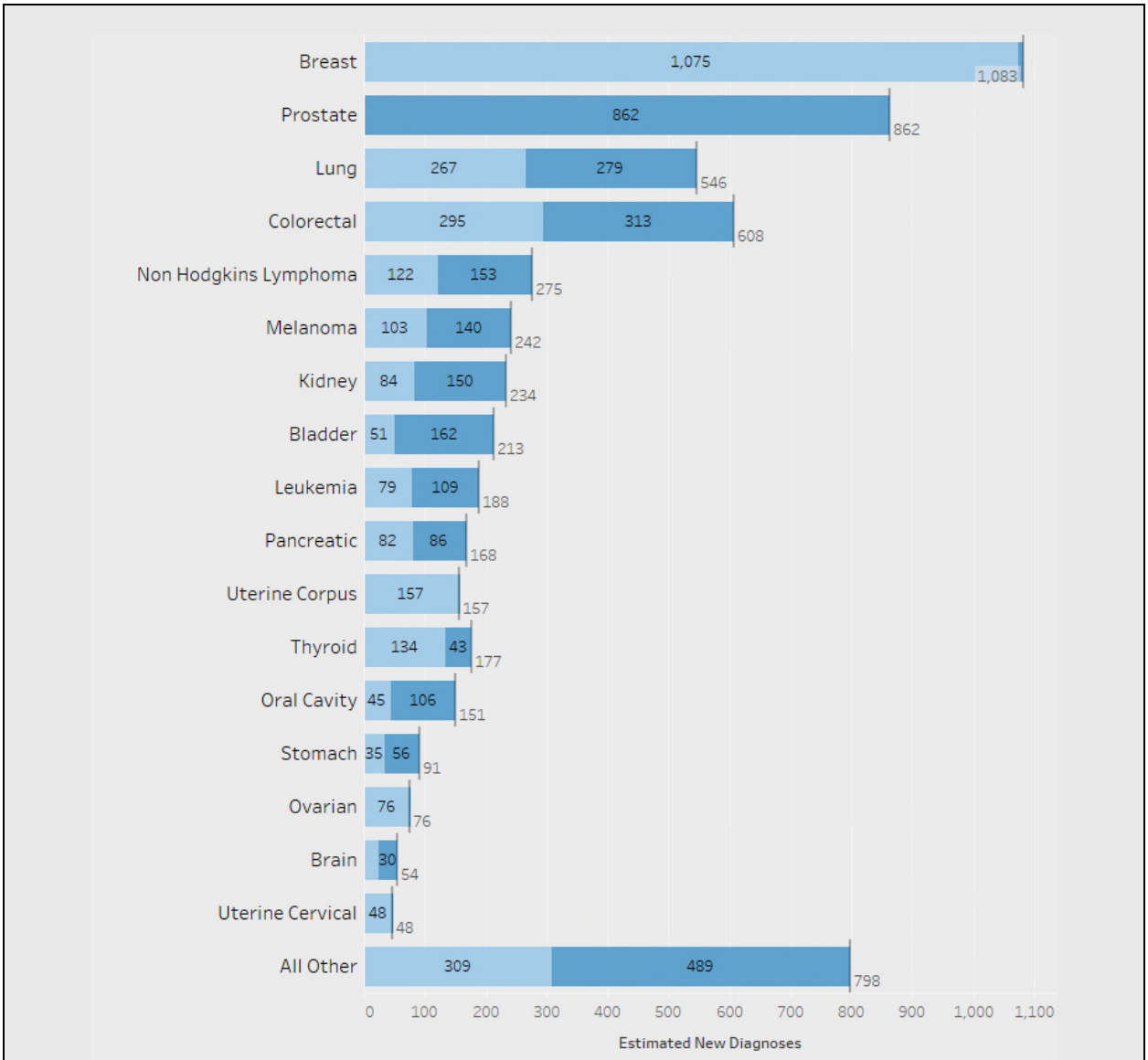
Bar chart shows total number of 2018 Estimated Heart Disease cases for each of four types: arrhythmia, heart failure, hypertension, and ischemic heart disease

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, kidney, uterine corpus, and oral cavity. Most new cancer cases in 2018 were estimated to be breast, prostate, and lung cancers.

2018 Estimated New Cancer Cases



Bar chart shows estimated new diagnoses per year for each of the 17 types of Cancer and 1 category for all other cancers. Color shows details about sex with light blue for females and dark blue for males.

Source: IBM Watson Health, 2018

Estimated Cancer Cases and Projected 5 Year Change by Type

Cancer Type	2018 Estimated New Cases	2023 Estimated New Cases	5 Year Growth (%)
Bladder	213	265	24.4%
Brain	54	62	14.8%
Breast	1,083	1,308	20.8%
Colorectal	608	669	10.0%
Kidney	234	289	23.5%
Leukemia	188	226	20.2%
Lung	546	664	21.6%
Melanoma	242	290	19.8%
Non Hodgkin's Lymphoma	275	335	21.8%
Oral Cavity	151	185	22.5%
Ovarian	76	90	18.4%
Pancreatic	168	214	27.4%
Prostate	862	1,002	16.2%
Stomach	91	111	22.0%
Thyroid	177	216	22.0%
Uterine Cervical	48	53	10.4%
Uterine Corpus	157	194	23.6%
All Other	798	979	22.7%
Grand Total	5,970	7,151	19.8%

Source: IBM Watson Health, 2018

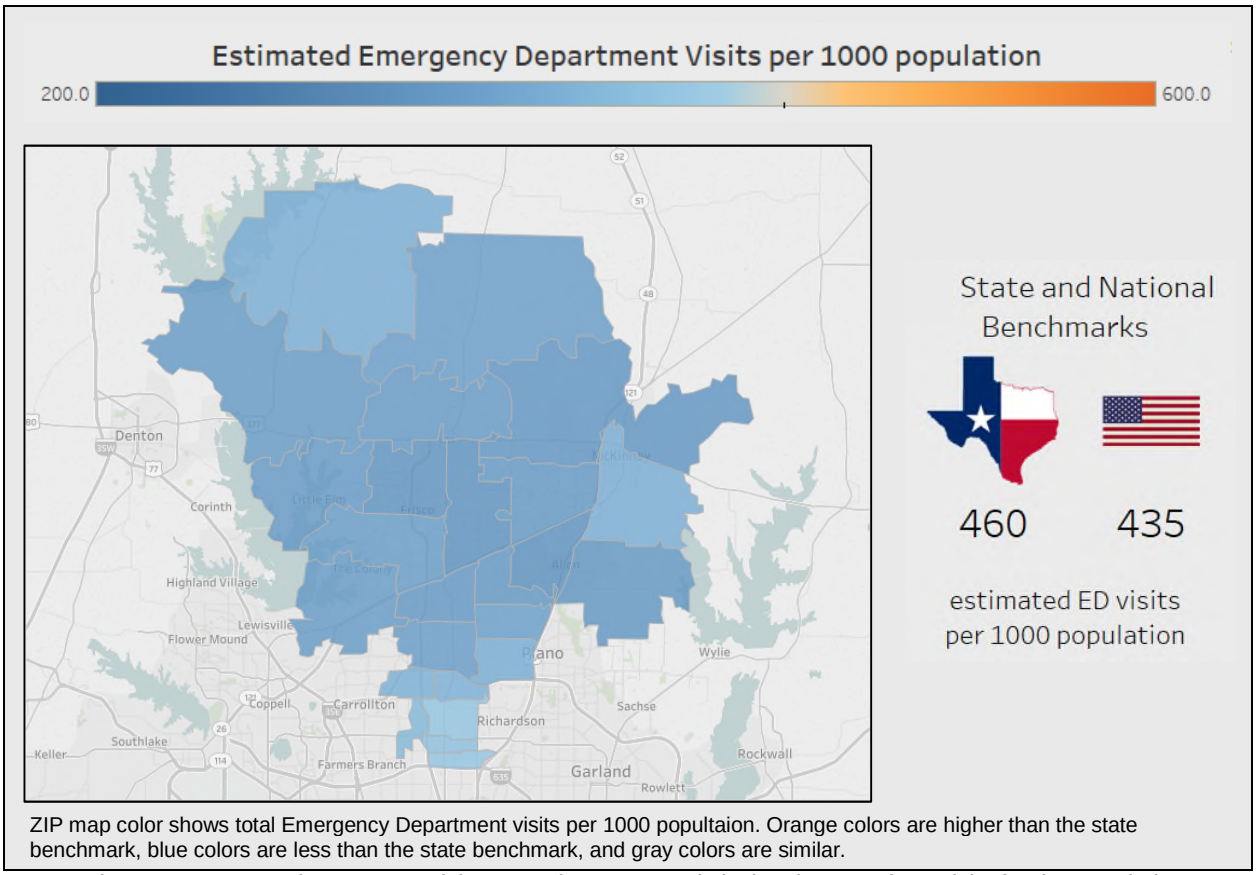
Based on population characteristics and regional utilization rates, Watson Health projected all emergency department (ED) visits in this community to increase by 10.1% over the next 5 years. The residents of Far North Dallas ZIP codes generated about 20% of the health community's ED visits. These ZIP codes also had the highest estimated ED use rates ranging from 378.1 to 419.3 ED visits per 1,000 residents; but still lower than the estimated Texas state benchmark of 460 visits and the estimated 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 require a more appropriate and less intensive outpatient treatment setting.

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 4.8% over the next five years in this health community.

Estimated 2018 Emergency Department Visit Rate

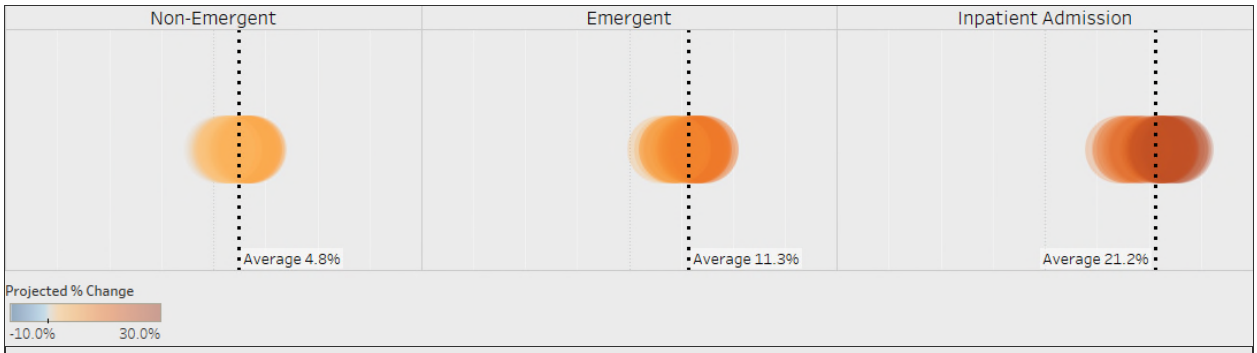


ZIP map color shows total Emergency Department visits per 1000 popultaion. Orange colors are higher than the state benchmark, blue colors are less than the state benchmark, and gray colors are similar.

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 Medical Center – Centennial
Baylor Scott & White Medical Center – Frisco
Baylor Scott & White Institute for Rehabilitation – Frisco

Prior Significant Health Needs Addressed by Facilities

Prior Identified Need Facility	Access to care for middle to lower socioecomic status	Mental/ Behavioral Health	Preventable Admissions: adult uncolntrolled diabetes	Lack of Dental Providers	Teen Pregnancy	Drug Abuse
Baylor Scott & White Medical Center - Centennial			√			
Baylor Scott & White Medical Center - Frisco	√					
Baylor Scott & White Institute for Rehabilitation - Frisco	√	√				

Total Resources Contributed to Addressing Needs: $19,404,259

Identified Need Addressed: Access to Care for Middle to Lower Socio- Economic

Program: Community Benefit Operations
Entity Name: Baylor Scott & White Medical Center – Centennial Baylor Scott & White Institute for Rehabilitation – Frisco
Description:
The Hospital regularly and formally assesses the needs of the community through a System conducted Community Health Needs Assessment. Strategies developed to address the CHNA's identified needs in an Implementation Plan guides community benefit efforts. The Hospital also provides dedicated staff for managing or overseeing community benefit program activities that are not included in other categories of community benefit. This staff provides internal tracking and reporting community benefit as well as managing or overseeing community benefit program activities.
Impact: 3,948 persons served**;** increased primary care and health education for under-served/under-insured community members
Committed Resources: Staff time; supplies/equipment; $54,781 net community benefit

Program: Community Education and Outreach - Screenings
Entity Name: Baylor Scott & White Medical Center - Centennial
Description:
The Hospital conducts screening assessments to alert the community to chronic medical diseases for persons who are unemployed or of lower socioeconomic status
Impact: 353 persons served; increased access to early detection of chronic diseases
Committed Resources: Staff time; supplies/equipment; $12,117 net community benefit

Program: Donations -Financial
Entity Name: Baylor Scott & White Medical Center – Centennial Baylor Scott & White Institute for Rehabilitation - Frisco
Description:
The Hospital provides funds in the community at large whose mission compliments the mission of the Hospital. These funds include gifts to other not for profit organizations, contributions to charity events after subtracting the fair market value of participation by employees or the organization and help to extend the services of the hospital beyond its wall. Community Partners • Byron Nelson Golf Classic • Dallas White Rock Marathon • National Multiple Sclerosis Society • Physical Medicine and Rehabilitation
Impact: # served unknown; increased access to healthcare through social service/health agencies
Committed Resources: Staff time; $80,956 net community benefit

Program: Enrollment Services
Entity Name: Baylor Scott & White Medical Center - Centennial
Description:
The hospital provides assistance to enroll in public programs, such as SCHIP and Medicaid. These health care support services provided by the hospital to increase access and quality of care in health services to individuals, especially persons living in poverty and those in vulnerable situations. The hospital provides staff to assist in the qualification of the medically under-served for programs that will enable their access to care, such as Medicaid, Medicare, SCHIP and other government programs or charity care programs for use in any hospital within or outside the hospital
Impact: 5,741 persons served; increase access and quality of care in health services to individuals, especially persons living in poverty and those in vulnerable situations.
Committed Resources: Eligibility Consultant's Inc., contract; $76,159 net community benefit

Program: Financial Assistance
Entity Name: Baylor Scott & White Medical Center – Frisco Baylor Scott & White Institute for Rehabilitation - Frisco
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 the hospital treat indigent patients.
Impact: 191 persons served
Committed Resources: $18,175,067 net community benefit

Program: Medical Education - Allied Health
Entity Name: Baylor Scott & White Medical Center - Centennial
Description:
The hospital is committed to assisting with the preparation of future health care professionals at entry and advanced levels of the profession to establish a workforce of qualified ancillary health service staff thereby affecting the documented shortage of health care providers. Like physicians, students trained at the hospital are not obligated to join the staff although many remain in the Community to provide top quality nursing services to many health care institutions.
Impact: 4 students trained; increased quality and size of health professional work force in the North Texas area
Committed Resources: Health service line educators; nurse educators; supervisory staff; $5,961 net community benefit

Program: Translation Services
Entity Name: Baylor Scott & White Medical Center - Centennial
Description:
The Hospital provides translation/interpreter services that go beyond what is required by state or federal rules or law or for accreditation. For example, translation services for a group that comprises less than 15% of the population.
Impact: 218 persons served; Improve systems for personal and public health.
Committed Resources: translation contract; $2,377 net community benefit

Program: Workforce Development
Entity Name: Baylor Scott & White Medical Center - Centennial
Description:
Workforce Development - Recruitment of physicians and other health professionals for areas identified as medically underserved areas (MUAs) or other community needs assessment. The age and characteristics of a state's population has a direct impact on the health care system. The hospitals seek to allay the physician shortage, thereby better managing the growing health needs of the community.
Impact: # persons served unknown; increase access to primary care providers in the community
Committed Resources: physician recruiting staff; $977,985 net community benefit

Identified Need Addressed: Mental / Behavioral Health

Program: Community Education and Outreach - Behavioral Health
Entity Name: Baylor Scott & White Medical Center - Centennial
Description:
The statistics concerning suicide, depression, eating disorders, binge drinking, drug use, bullying and other mental health issues are alarming. The Hospital provides education on behavioral health to increase awareness about mental disorders and to offer effective tools for seeking treatment.

Impact: 266 persons served; decreased health professions shortage areas for mental health providers.
Committed Resources: staff time; equipment/supplies; clinical experts

Program: Advance Directives Education
Entity: Baylor Scott & White Institute for Rehabilitation – Frisco
Description:
An Advance Healthcare Directive allows people to state what kind of medical care they want to receive should they become permanently unconscious or terminally ill. This gives patients the ability to state any healthcare instructions and limitations decisions concerning their care. The Chaplain provides Advance Directives education for patients in conjunction with the Case Management Department. This is a non-billed service
Impact: unknown number served; reduced stress associated with end of life care decisions.
Committed Resources: Chaplain services; $1000 net community benefit

Program: Donations -Financial
Entity: Baylor Scott & White Institute for Rehabilitation – Frisco
Description:
The Hospital provides funds in the community at large whose mission compliments the mission of the Hospital. These funds include gifts to other not for profit organizations, contributions to charity events after subtracting the fair market value of participation by employees or the organization, and help to extend the services of the hospital beyond its walls. Community Partners: • Neuro Assist Foundation • RISE- Adaptive Sports
Impact: unknown number of persons served; increased access to healthcare through social service/health agencies
Committed Resources: staff time; equipment/supplies; clinical experts; $1,868 net community benefit

Identified Need Addressed: Preventable Admits/Adult Uncontrolled Diabetes

Program: Community Education and Outreach - Diabetes
Entity Name: Baylor Scott & White Medical Center - Centennial
Description:
The hospital will provide a variety of diabetes education programs covering topics that teach keys to living successfully with diabetes. The hospital offers free diabetes screenings and support groups at annual community events. These services are at no charge and will be open to the public.
Impact: 154 persons served; Increase awareness of diabetes prevention, diagnosis and management
Committed Resources: staff time; equipment/supplies; clinical experts; $1,106 net community benefit

Identified Need Addressed: Teen Births

Program: Community Health Education - Parent Education
Entity Name: Baylor Scott & White Medical Center - Centennial
Description:
The Hospital participates in community health education by providing new parent educational series

addressing Baby Care, Breastfeeding, Car Seat Fitting, Childbirth, Infant CPR and Sibling Classes. Series also includes a tour of the Women & Infant Center.
Impact: 605 persons served; help the underserved in the community who are at risk for or receiving treatment through education and publication of healthy ways to parent.
Committed Resources: staff time; equipment/supplies; clinical experts; $14,882 net community benefit

Needs Not Addressed:

- Lack of Dental Providers
- Teen Pregnancy
- Drug Abuse

These identified needs not addressed in the Community Benefit Implementation plan were addressed through multiple other community and state agencies whose expertise and infrastructure are better suited for addressing these needs.