Baylor Scott & White Health
Community Health Needs Assessment

West Fort Worth Health Community

Baylor Scott & White All Saints Medical Center - Fort Worth
Baylor Scott & White Institute for Rehabilitation - Fort Worth
Baylor Scott & White Surgical Hospital - Fort Worth

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

Posted to BSWHealth.com/CommunityNeeds on June 30, 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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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. This joint community health needs assessment applies to the following BSWH hospital facilities:

- Baylor Scott & White All Saints Medical Center - Fort Worth
- Baylor Scott & White Institute for Rehabilitation - Fort Worth
- Baylor Scott & White Surgical Hospital - Fort Worth

For the 2019 assessment, the community served by these hospital facilities (Hood, Tarrant, Johnson, and Parker counties) 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 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 and clarified the assignment of severity rankings to the needs. The matrix shows the

convergence of needs identified in the qualitative data (interview and focus group feedback) and quantitative data (health indicators) and identifies the top health needs for this community.

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

Participants identified the significant health needs through review of data driven criteria for the top health needs, discussion, and a multi-voting process. Once the significant health needs were established, participants rated the needs using prioritization criteria recommended by the focus groups. The sum of the criteria scores for each need created an overall score 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	Ratio of Population to One Mental Health Provider	Mental Health
2	Uninsured Children	Access to Care
3	Ratio of Population to One Non-Physician Primary Care Provider	Access to Care
4	Alzheimer's Disease/Dementia in Medicare Population	Mental Health
5	Depression in Medicare Population	Mental Health

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

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

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

Consultant Qualifications & Collaboration

Watson Health delivers analytic tools, benchmarks, and strategic consulting services to the healthcare industry, combining rich data analytics in demographics, including the Community Needs Index, planning, and disease prevalence estimates, with experienced strategic consultants 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. This joint community health needs assessment applies to the following BSWH hospital facilities:

- Baylor Scott & White All Saints Medical Center - Fort Worth
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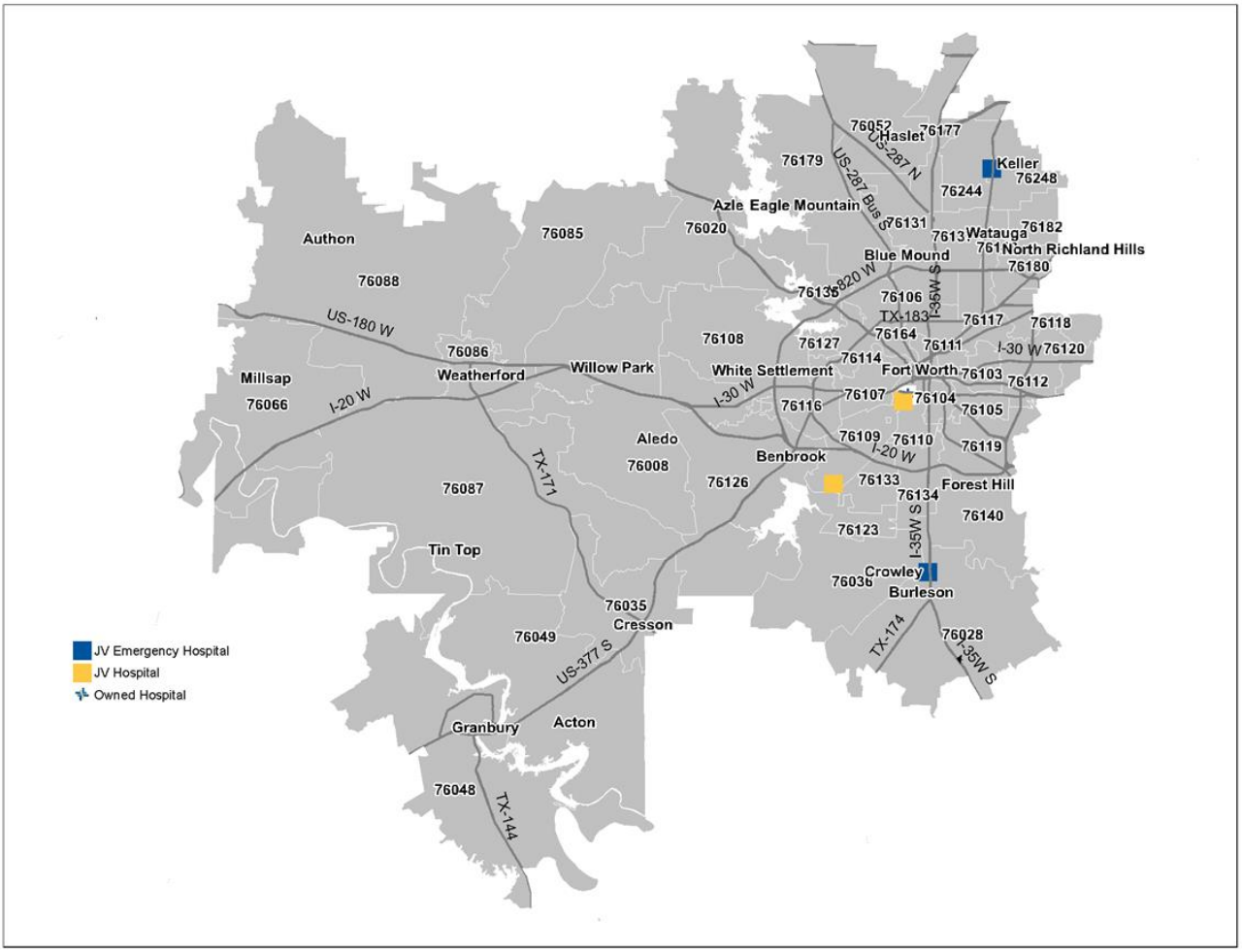
Community Served Definition

The community served by the collaborating BSWH hospital facilities includes Hood, Tarrant, Johnson, and Parker counties and includes the geographic area where at least 75% of the hospital facilities' admitted patients live.

BSWH Community Health Needs Assessment
West Fort Worth Health Community Map



Source: Baylor Scott & White Health, 2019

76035 76048 76049 76106 76111 76117 76131 76136 76137 76148 76161 76164 76179 76190 76192
76008 76020 76028 76036 76037 76066 76085 76086 76087 76088 76097 76098 76101 76102 76103
76104 76105 76107 76108 76109 76110 76112 76113 76114 76115 76116 76119 76120 76121 76122
76123 76124 76125 76126 76127 76128 76129 76130 76132 76133 76134 76135 76140 76147 76150
76151 76162 76163 76166 76185 76191 76193 76194 76195 76196 76197 76198 76199 76439 76485
76052 76177 76178 76244 76248 76080 76118 76180 76181 76182

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**.

Although this community definition is by ZIP codes, public health indicators are most commonly available by county. Therefore, a patient origin study determined which counties principally represent the community's residents receiving hospital services. The principal counties for the West Fort Worth Health Community needs analysis are Tarrant, Johnson, and Parker counties.

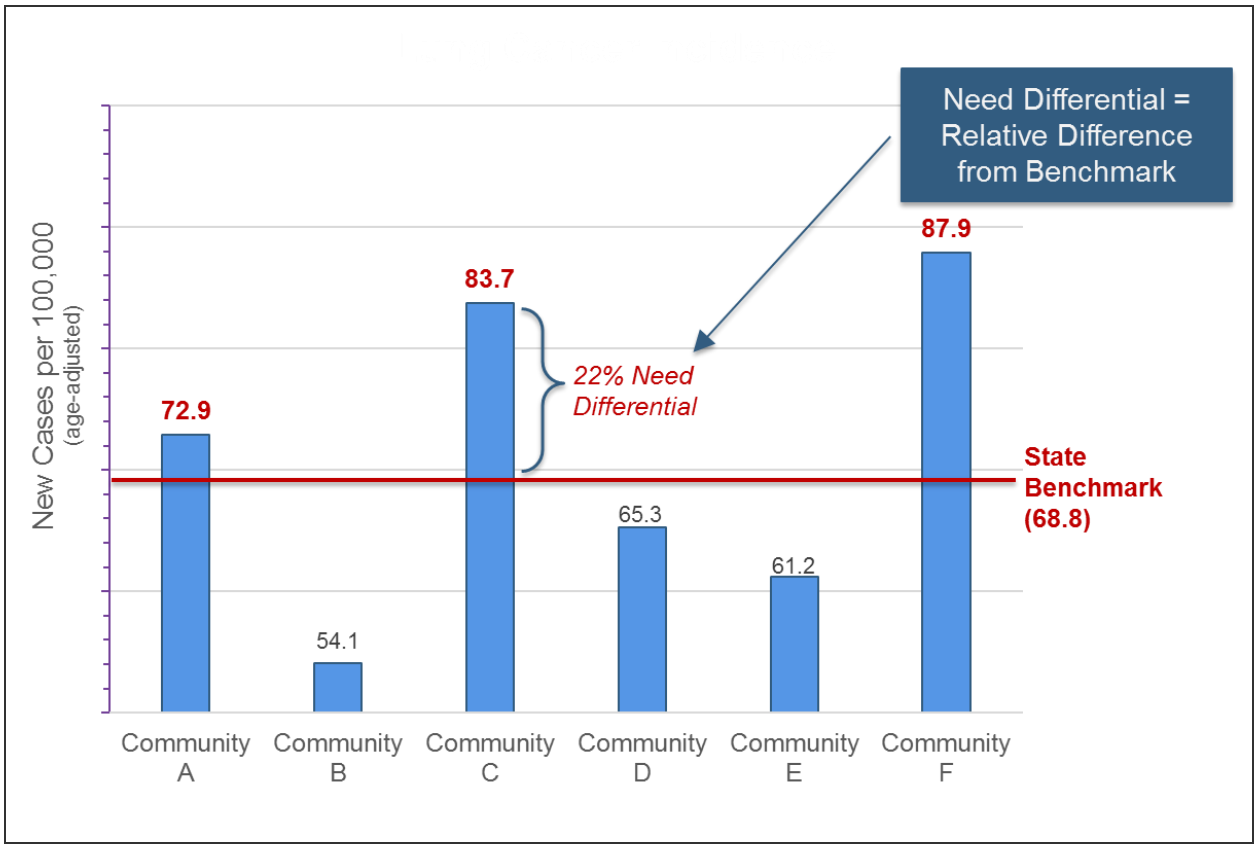
A benchmark analysis conducted for each indicator collected for the community served, determined which public health indicators demonstrated a community health need from a quantitative perspective. Benchmark health indicators collected included (when available): overall U.S. values; state of Texas values; 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 19 participants, and two (2) key informant interviews, gathered to account for 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 held with hospital clinical leadership or 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. Barriers and social determinants were new topics added to the 2019 community input sessions.

Watson Health conducted key informant interviews for the community served by the hospital 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 who served and/or represented the interests of medically underserved, low-income and minority populations in the community.

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

Community Input Participants

Participant Organization Name	Public Health	Medically Under-served	Low-income	Chronic Disease Needs	Minority Populations	Governmental Public --Health Dept.	Public Health Knowledge --Expertise
Area Agency on Aging/United Way of Tarrant County	X	X	X	X	X		X
Arlington Life Shelter		X	X	X			
Baylor Scott & White Health	X	X	X	X	X		X
Cancer Care Services	X	X	X	X	X		X
Eastside Ministries			X		X		
Epidemiology Associates							
Fort Worth Housing Solutions			X		X		
Grace		X	X	X	X		
Grace		X					
JPS Health	X					X	X
Metrocare	X	X	X	X	X		X
MHMR Tarrant County	X	X	X	X	X		
Mount Olive Baptist Church					X		
My Health My Resources (MHMR) of Tarrant County	X	X	X	X	X		
North Texas Area Community Health Centers	X	X	X	X	X		X
Project Access Tarrant County		X	X		X		

Participant Organization Name	Public Health	Medically Under-served	Low-income	Chronic Disease Needs	Minority Populations	Governmental Public --Health Dept.	Public Health Knowledge --Expertise
Salvation Army			X				
Tarrant Area Food Bank			X				
Tarrant County Public Health	X					X	X
Texas Rehabilitation Hospital of Fort Worth		X	X	X			
Union Gospel Mission		X	X				
United Way of Tarrant County	X	X	X	X	X		

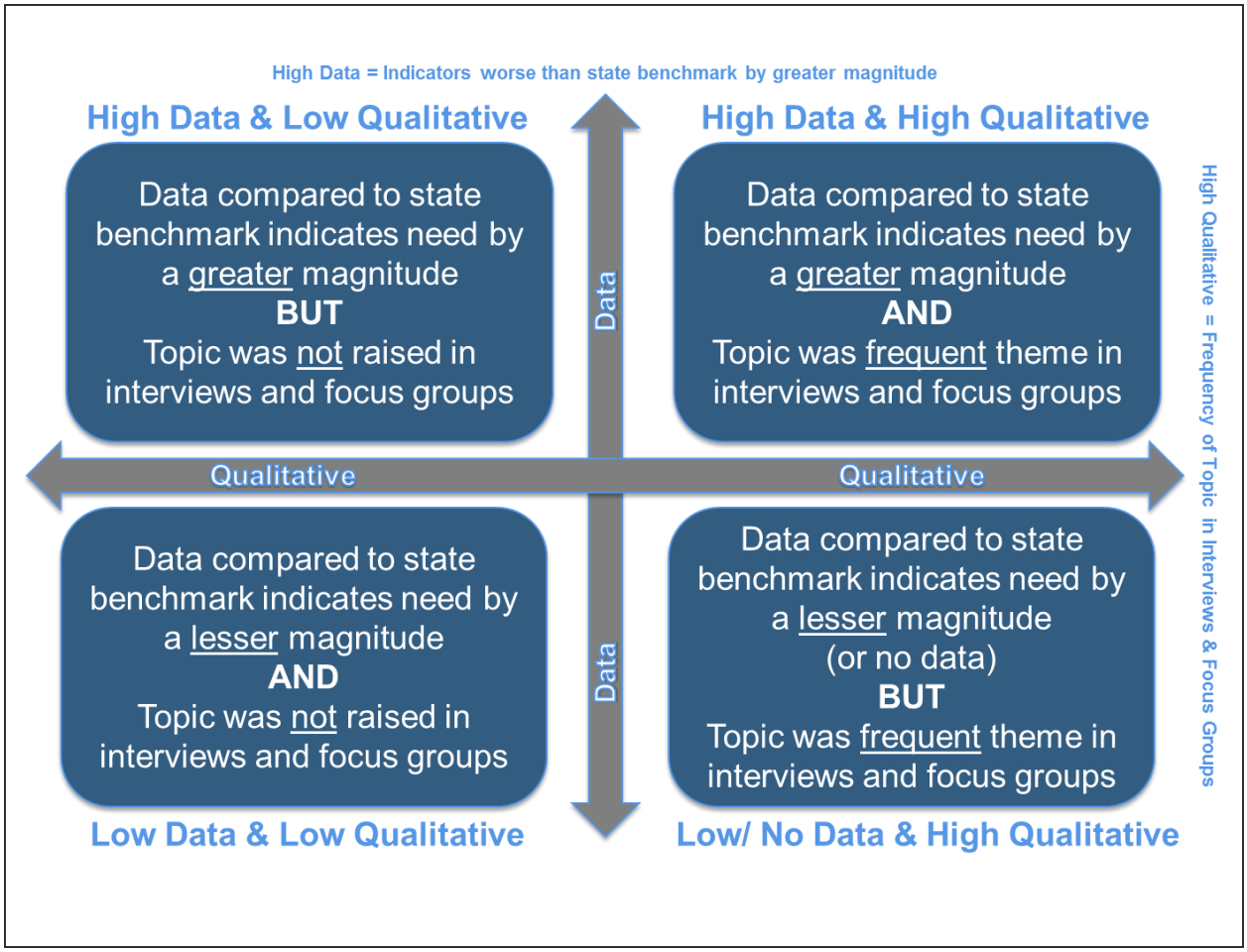
In addition to soliciting input from public health and various interests of the community, the hospital facilities were also required to consider written input received on their most recently conducted CHNA and subsequent implementation strategies. The assessment is available to receive public comment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

Methodology for Defining Community Need

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

The Health Needs Matrix



Source: IBM Watson Health, 2018

Information Gaps

In some areas of Texas, health indicators were not available due to the impact small population size has on reporting and statistical significance. Most public health indicators were available only at the county level. Evaluating data for entire counties versus more localized data, made it difficult to understand the health needs for specific population pockets within a county. It could also be a challenge to tailor programs to address

community health needs, as placement and access to specific programs in one part of the county may or may not actually affect the population who truly need the service.

Approach to Identify and Prioritize Significant Health Needs

In a session held November 7, 2018 with Baylor Scott & White All Saints Medical Center - Fort Worth leadership met with community leaders, identified, and prioritized significant health needs. Inviting community leaders to participate in the prioritization sessions was a new approach for the 2019 CHNA. The meeting, moderated by Watson Health, included an overview of the CHNA process for BSWH, the methodology for determining the top health needs, the BSWH prioritization approach, and discussion of the top health needs identified for the community.

Prioritization of the health needs took place in two steps. In the first step, participants reviewed the top health needs for their community with associated data-driven criteria to evaluate. The criteria included health indicator value(s) for the community, how the indicator compared to the state benchmark, and potentially preventable ED visit rates for the community (if available). Participants then leveraged the professional experience and community knowledge of the group via discussion about which needs were most significant. With the data-driven review criteria and the discussion completed, a multi-voting method identified the significant health needs. Participants voted individually for the five (5) needs they considered as the most significant for this community. With votes tallied, five (5) identified needs ranked as significant health needs, based on the number of votes.

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

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

Through discussion and consensus, the group rated each of the five (5) significant health needs on each of the three (3) identified criteria utilizing a scale of one (low) to 10 (high). The criteria scores summed for each need, created an overall score. 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 potentially available to address the significant health needs identified through the CHNA. BSWH Community Resource Guides, and input from qualitative assessment participants, identified community resources that may assist in addressing the health needs identified for this community. A description of these resources is in **Appendix B**. An interactive asset map of various resources identified for all BSWH communities is located at **BSWHealth.com/CommunityNeeds**.

West Fort Worth Health Community CHNA

Demographic and Socioeconomic Summary

According to population statistics, the community served was similar to Texas in terms of projected population growth; both outpace the country. The median age was younger than Texas overall and younger than the United States. Median income was above both the state and the country.

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

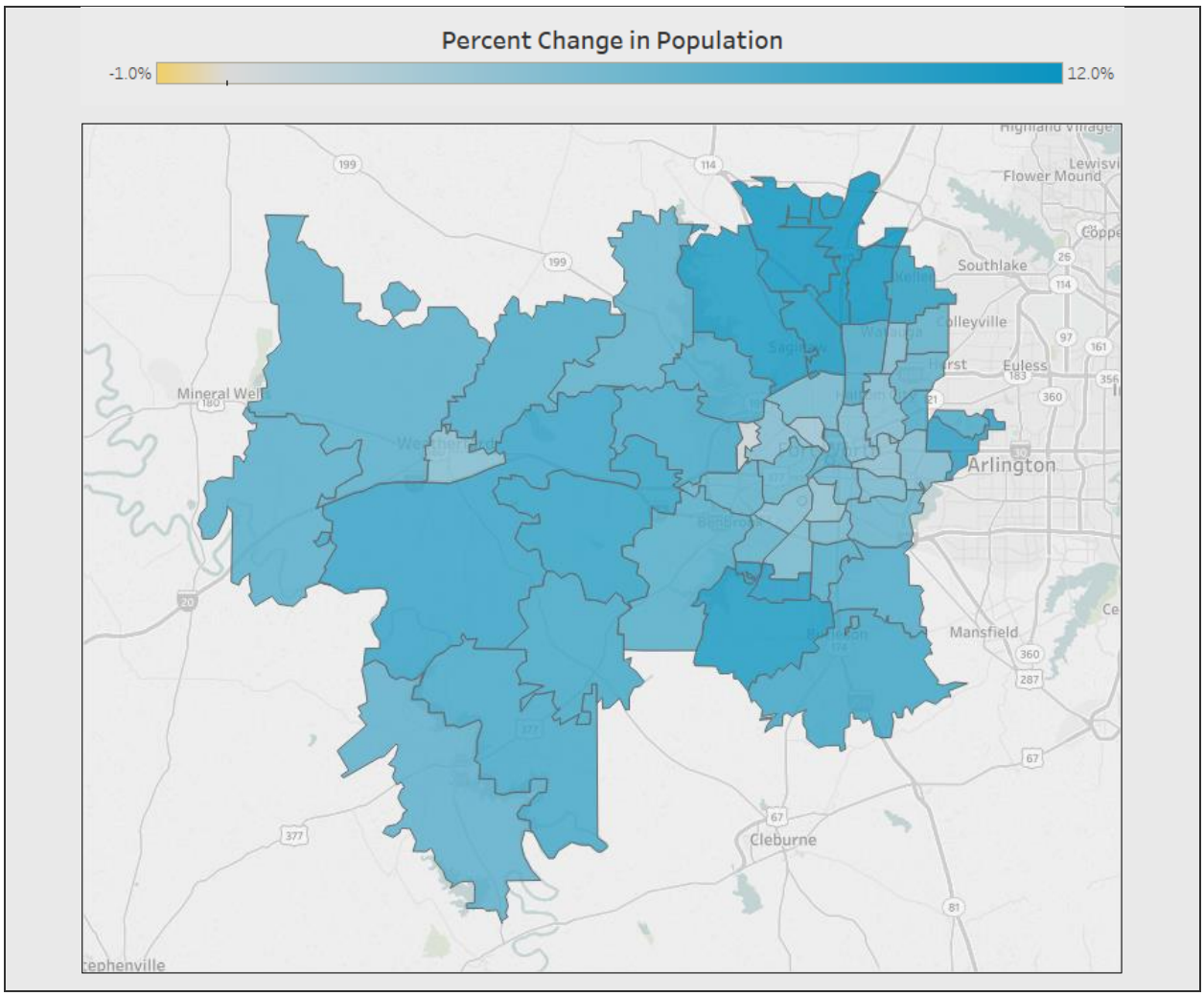
Geography		Benchmarks		Community Served
		United States	Texas	West Fort Worth Health Community
Total Current Population		326,533,070	28,531,631	1,448,606
5 Yr Projected Population Change		3.5%	7.1%	7.7%
Median Age		42.0	38.9	35.8
Population 0-17		22.6%	25.9%	26.7%
Population 65+		15.9%	12.6%	12.5%
Women Age 15-44		19.6%	20.6%	20.7%
Non-White Population		30.0%	32.2%	31.7%
Hispanic Population		18.2%	39.4%	29.6%
Insurance Coverage	Uninsured	9.4%	19.0%	16.8%
	Medicaid	14.9%	13.4%	13.0%
	Private Market	9.6%	9.9%	9.6%
	Medicare	16.1%	12.5%	11.9%
	Employer	45.9%	45.3%	48.8%
Median HH Income		$61,372	$60,397	$65,984
Limited English		26.2%	39.9%	31.5%
No High School Diploma		7.4%	8.7%	8.6%
Unemployed		6.8%	5.9%	5.6%

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

The population of the community served projects to grow 7.7% by 2023, an increase by more than 111,000 people. The 7.7% projected population growth is slightly less than the state's 5-year projected growth rate (7.1%) but higher when compared to the national projected growth rate (3.5%). The ZIP codes experiencing the most growth in five years are:

- 76244 Alliance-Keller – 9,222 people
- 76179 Northside-Blue Mound – 6,648 people
- 76028 Burleson – 6,350 people

2018 - 2023 Total Population Projected Change by ZIP Code

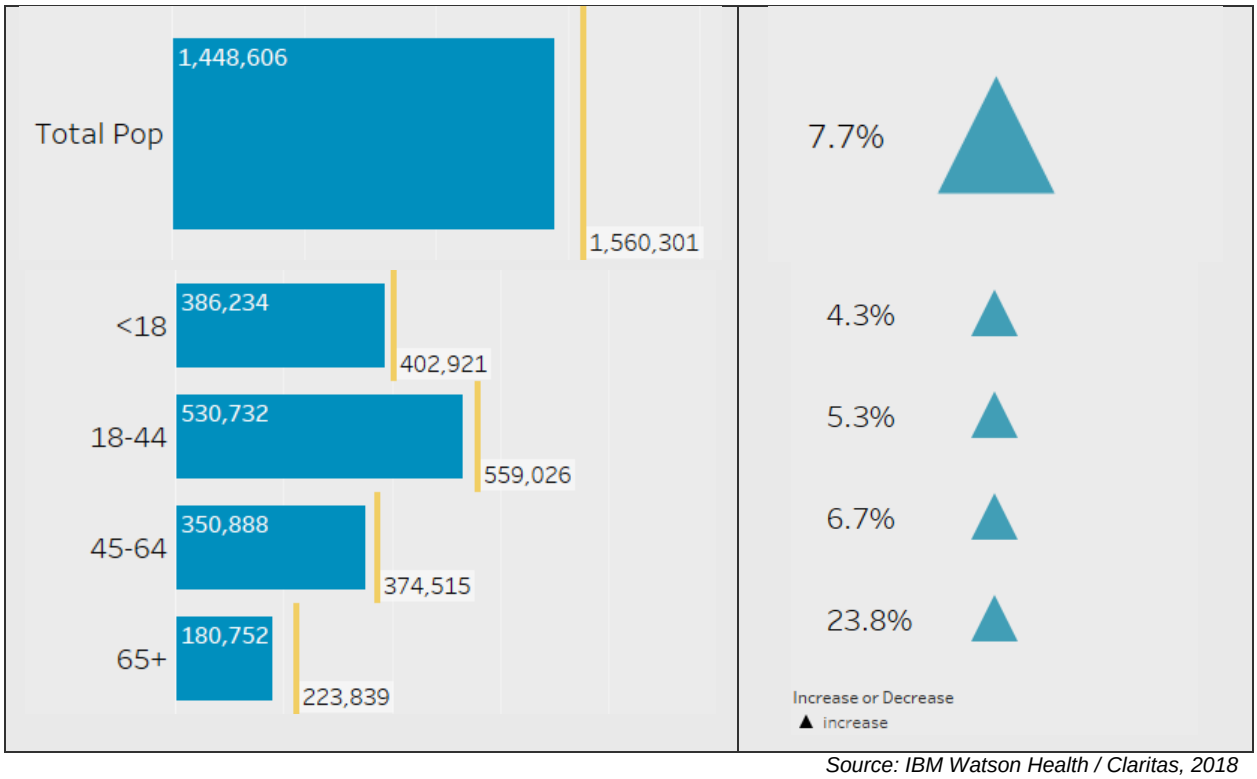


Source: IBM Watson Health / Claritas, 2018

The community's population skewed younger with 36.6% of the population ages 18-44 and 26.7% under age 18. The largest cohort (ages 18-44) projects the growth of 28,924 people by 2023. The age 65 plus cohort was the smallest, but is expected to experience the fastest growth (23.8%) over the next five years, adding 43,087 seniors to the community. Growth in the senior population will likely contribute to increased utilization of services as the population continues to age.

Population Distribution by Age

2018 Population by Age Cohort *Percent Change by 2023*

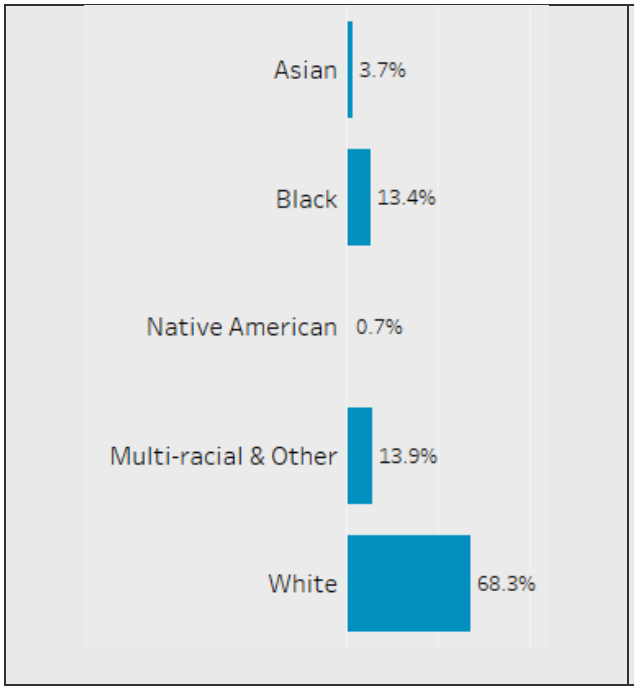


Source: IBM Watson Health / Claritas, 2018

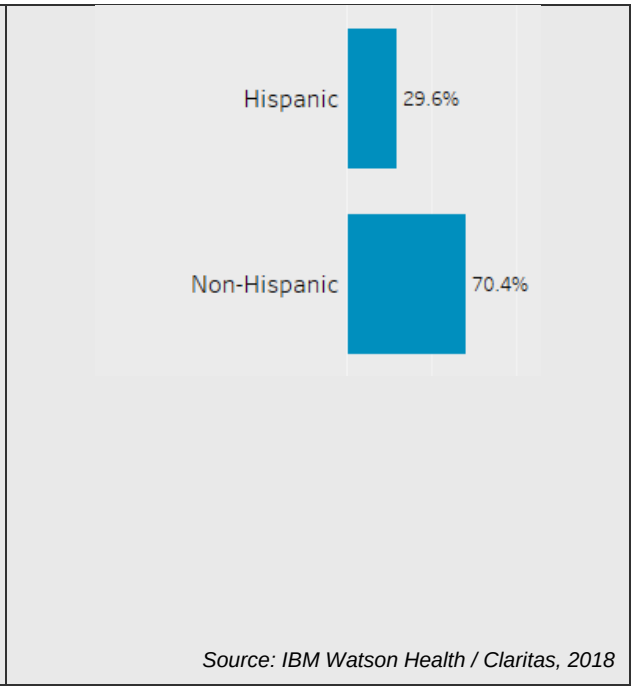
Analyzed by race and by Hispanic ethnicity, population statistics indicates the community was primarily non-Hispanic White (51.4%) but projects to be the slowest growing population segment and will only be 48.6% of the population by 2023. Thirty percent of the market identify as Hispanic, with projected growth to 31.2% in five years.

Population Distribution by Race and Ethnicity

2018 Population by Race

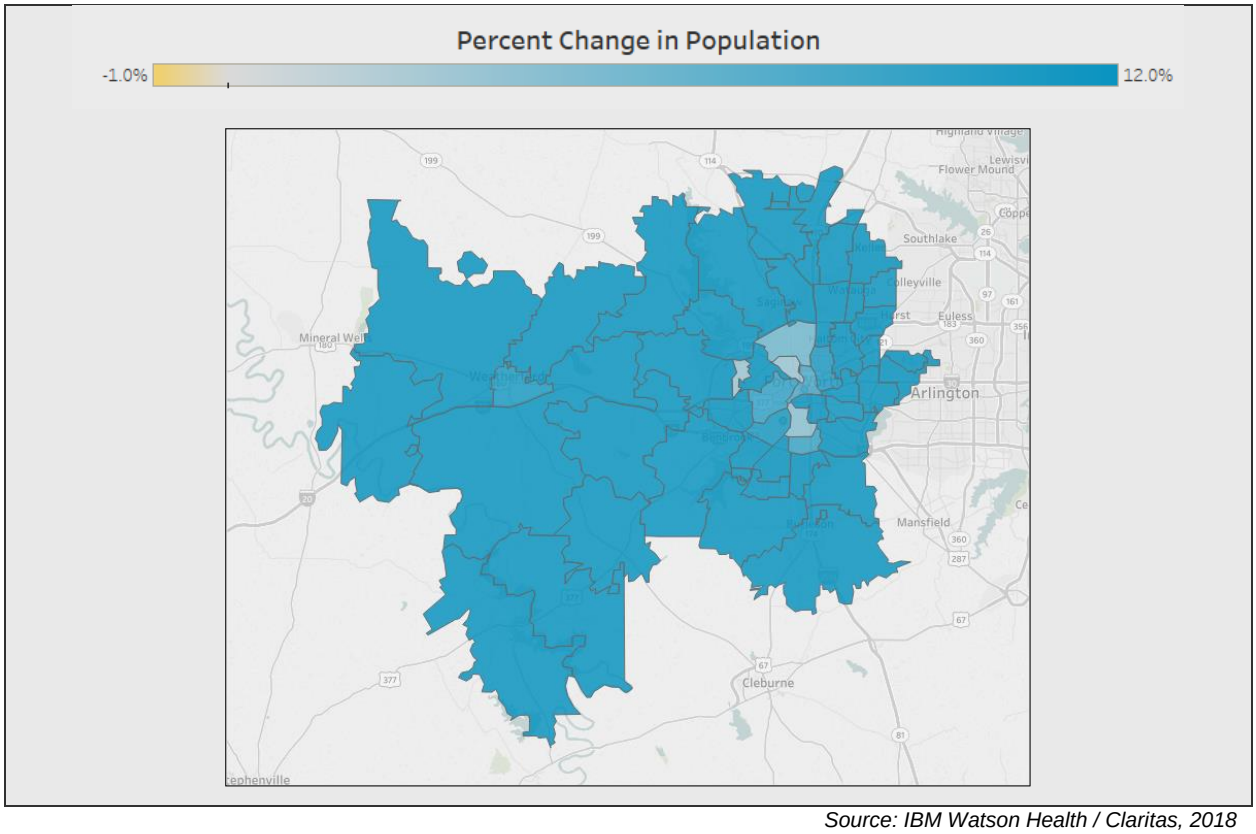


2018 Population by Ethnicity



Source: IBM Watson Health / Claritas, 2018

2018 - 2023 Hispanic Population Projected Change by ZIP Code

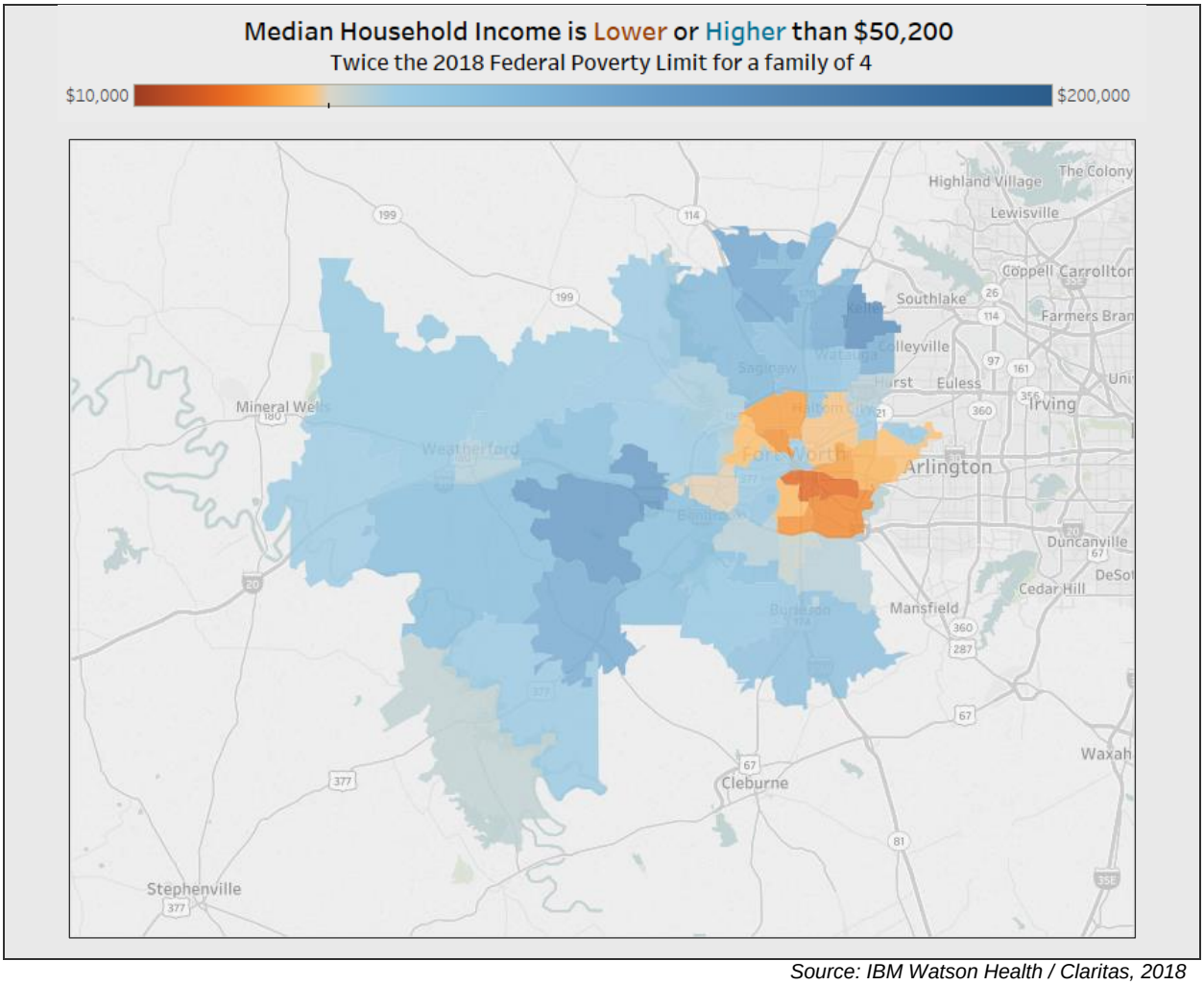


Source: IBM Watson Health / Claritas, 2018

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 $27,977 for 76104 – Meadowbrook to $134,346 for 76248 – Alliance-Keller. Fifteen (15) ZIP Codes had median household incomes less than $50,200 – twice the 2018 Federal Poverty Limit for a family of four:

- 76116 TCU-Tanglewood - $49,400
- 76111 Northside - Blue Mound - $47,382
- 76117 Watauga-Haltom City - $47,265
- 76120 Meadowbrook - FW CBD - $46,695
- 76114 Azle - River Oaks - $46,039
- 76110 EdgeCliff - Seminary - $44,841
- 76112 Meadowbrook - FW CBD - $43,799
- 76122 EdgeCliff - Seminary - $41,000
- 76103 Meadowbrook - FW CBD - $39,948
- 76106 Northside - Blue Mound - $39,790
- 76115 EdgeCliff - Seminary - $37,339
- 76164 Northside - Blue Mound - $36,716
- 76119 EdgeCliff - Seminary - $35,142
- 76105 Meadowbrook - FW CBD - $28,390
- 76104 Meadowbrook - FW CBD - $27,977

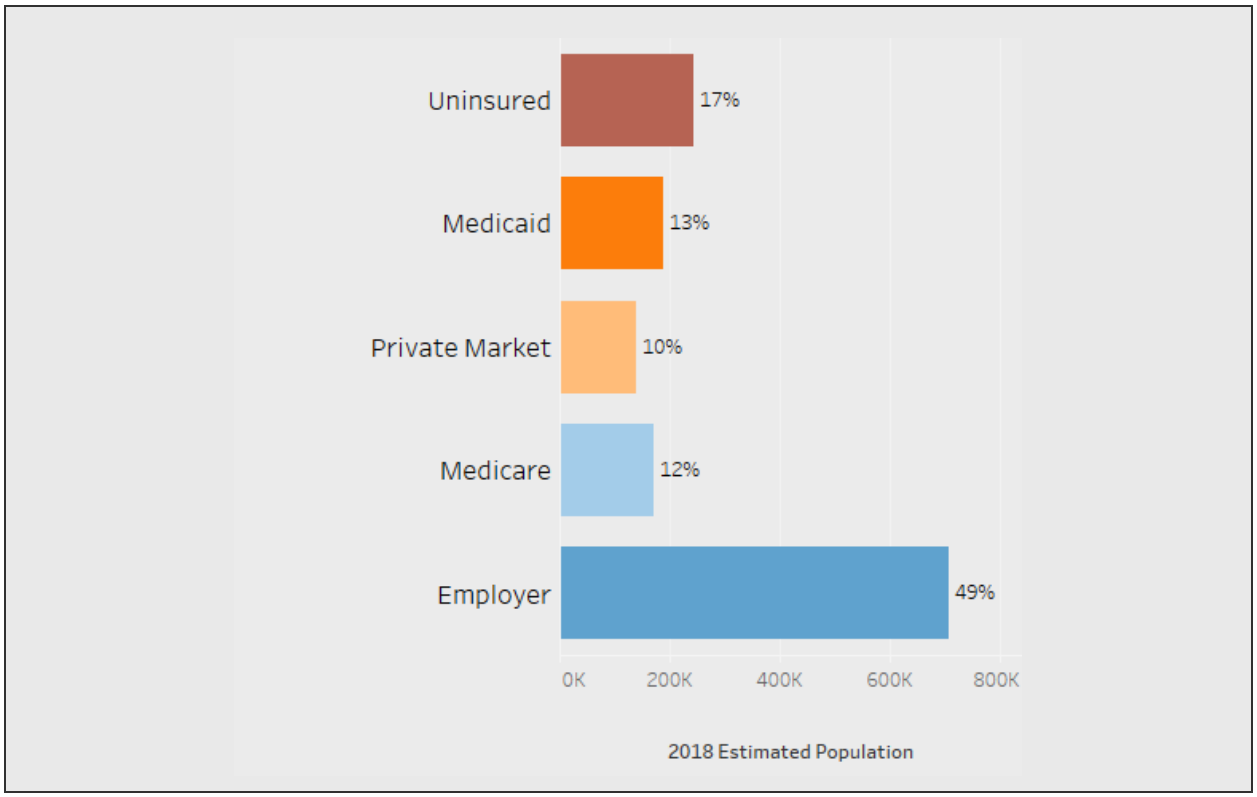
2018 Median Household Income by ZIP Code



Source: IBM Watson Health / Claritas, 2018

Forty nine percent (49%) of the population received insurance through sponsored health coverage, but a significant portion of the population were uninsured (17%). The remainder of the population was fairly equally divided between Medicaid, Medicare, and private market insurance (the purchasers of coverage directly or through the health insurance marketplace).

2018 Estimated Distribution of Covered Lives by Insurance Category



Source: IBM Watson Health / Claritas, 2018

The community includes nine (9) Health Professional Shortage Areas and four (4) 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 West Fort Worth Health Community	**Dental Health**	**Mental Health**	**Primary Care**	**Grand Total**	**MUA/P**
Johnson	0	1	0	1	1
Tarrant	3	2	3	8	3
Total	**3**	**3**	**3**	**9**	**4**

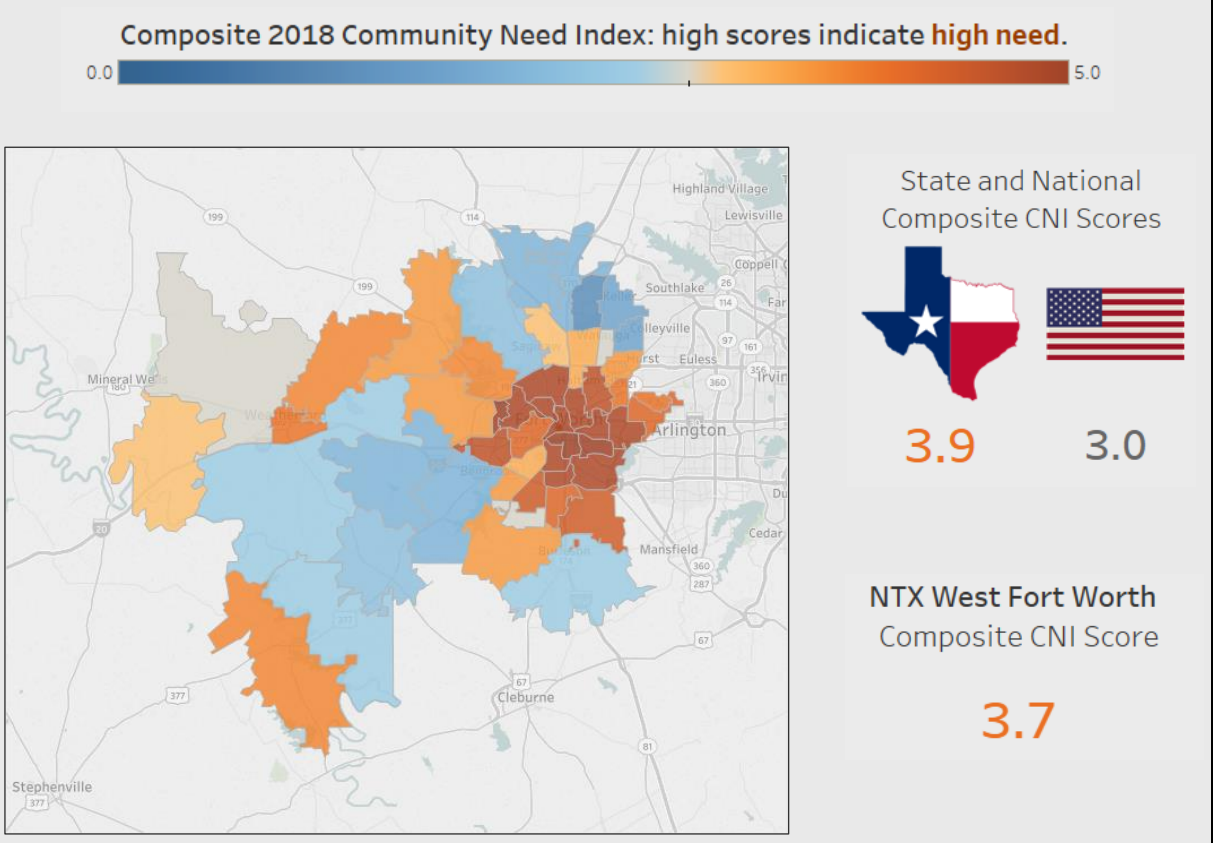
Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, 2018

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

The Watson Health Community Need Index (CNI) is a statistical approach to identifying areas within a community where health disparities may exist. The CNI accounts for vital socio-economic factors (income, cultural, education, insurance and housing) about a community to generate a CNI score for every populated ZIP code in the United States. The CNI strongly links to 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 3.7, this was higher than the CNI national average of 3.0, potentially indicating greater health care needs in this community. There were portions of the community (Meadowbrook, Azle-River Oaks, Northside-Blue Mound, EdgeCliff - Seminary) where the CNI score was greater than 4.5, pointing to potentially more significant health needs among the population.

2018 Community Need Index by ZIP Code



ZIP Map where color shows the Community Need Index on a scale of 0 to 5. Orange color indicates high need areas (CNI = 4 or 5); blue color indicates low need (CNI = 1 or 2). Gray colors have needs at the national average (CNI = 3).

CNI High Need ZIP Codes

City	Community	County	ZIP Code	2018 CNI Score
Fort Worth	Meadowbrook - FW CBD	Tarrant	76104	5.0
Fort Worth	Meadowbrook - FW CBD	Tarrant	76105	5.0
Naval Air Station JRB	Azle - River Oaks	Tarrant	76127	5.0
Fort Worth	Azle - River Oaks	Tarrant	76114	4.8
Fort Worth	EdgeCliff - Seminary	Tarrant	76110	4.8
Fort Worth	EdgeCliff - Seminary	Tarrant	76115	4.8
Fort Worth	EdgeCliff - Seminary	Tarrant	76119	4.8
Fort Worth	EdgeCliff - Seminary	Tarrant	76122	4.8
Fort Worth	Meadowbrook - FW CBD	Tarrant	76102	4.8
Fort Worth	Meadowbrook - FW CBD	Tarrant	76103	4.8
Fort Worth	Meadowbrook - FW CBD	Tarrant	76112	4.8
Fort Worth	Northside - Blue Mound	Tarrant	76106	4.8
Fort Worth	Northside - Blue Mound	Tarrant	76111	4.8
Fort Worth	Northside - Blue Mound	Tarrant	76164	4.8
Fort Worth	TCU-Tanglewood	Tarrant	76116	4.6
Haltom City	Watauga-Haltom City	Tarrant	76117	4.6
Fort Worth	EdgeCliff - Seminary	Tarrant	76133	4.4
Fort Worth	EdgeCliff - Seminary	Tarrant	76140	4.4
Fort Worth	EdgeCliff - Seminary	Tarrant	76134	4.2
Fort Worth	Meadowbrook - FW CBD	Tarrant	76120	4.2
Fort Worth	TCU-Tanglewood	Tarrant	76107	4.2
Fort Worth	North Richland Hills	Tarrant	76118	4.0
Weatherford	Weatherford	Parker	76086	4.0

Source: IBM Watson Health / Claritas, 2018

Public Health Indicators

The analysis of Public health indicators assessed community health needs for the community served using 102 indicators. For each health indicator, a comparison between the most recently available community data and benchmarks for the same/similar indicator was made. The basis of benchmarks was available data for the U.S. and the state of Texas.

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

Watson Health Community Data

Watson Health supplemented the publicly available data with estimates of localized disease prevalence of heart disease and cancer 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.

For this community there were two (2) focus group sessions with a total of 19 participants and two (2) interviews conducted July through September 2018.

Focus group participants described Tarrant County as a diverse community with both great wealth and significant poverty with lots of country music and great BBQ. Fort Worth is a worldwide destination with recognized arts, theatre, shopping, dining, institutions of higher learning, and designation as a “Blue Zone Community”. The Grapevine and Southlake communities were described as affluent, family friendly, and a tourist destination. Tarrant County’s population growth was outpacing the rapid growth of the greater Dallas Metroplex area. Participants described a growing population across Tarrant County that were homeless or transient. Shelters were close to or over capacity and lacked health resources for low-income populations.

The focus group discussed the challenges for low income and immigrant populations to access health resources, especially for vulnerable populations like children and seniors. Low income residents often needed to prioritize basic needs over health needs and didn’t have access to affordable health insurance. Gaps in free and low-cost services were specifically noted for low-income African American moms until Medicaid eligibility kicked in, dental services, and preventive services. It was noted that health systems didn’t accept patients without insurance and redirected to community clinics, but often undocumented residents were afraid of to use unfamiliar providers or to use preventative healthcare services.

Focus group participants felt healthcare resources were limited for the expanding low-wage workforce commuting into the community. Many workers were uninsured or undocumented and could not afford the prohibitive cost of care. Cancer care, dialysis facilities, and dental care were key gaps despite high need. Undocumented workers avoided using services due for fear of deportation and lack of translation services. Added translation services were needed in Spanish, Arabic, and Vietnamese to support the increasingly diverse community.

Many members of the focus groups said that the lack of transportation was a major barrier to good health. Participants noted there was no reliable public transportation between cities and commented that “without a car you’re out of luck.” Many areas of the community didn’t have any health care facilities, and without public transportation, it was a challenge to access health services.

The community needed more behavioral health providers and resources according to the participants. Wait times for psychiatric care often exceeded six months regardless of insurance status. Funding for mental health has decreased and psychiatric care was only available as cash pay, making services unavailable even to those with insurance. Some suggested portions of the large homeless population contained individuals with untreated mental health issues. Substance abuse support was lacking despite the need for drug and alcohol rehabilitation services, and Opioid addiction was on the rise.

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

Community Health Needs Identified

A Health Needs Matrix identified the health needs that resulted from the community health needs assessment (see Methodology for Defining Community Need section). The matrix shows the convergence of needs identified in the qualitative data (interview and focus group feedback) and quantitative data (health indicators) and identifies the top health needs for this community.

Top Community Health Needs Identified

West Fort Worth Health Community		
Top Needs Identified	Category of Need	Public Health Indicator
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Prevalence of chronic condition across all Medicare beneficiaries
Depression in Medicare Population	Mental Health	Prevalence of chronic condition across all Medicare beneficiaries
Disconnected youth	SDH - Social Isolation	2010-2014 Disconnected youth are teenagers and young adults between the ages of 16 and 24 who are neither working nor in school.
Drug Poisoning Deaths Rate	Health Behaviors - Substance Abuse	2014-2016 Number of Drug Poisoning Deaths (Drug Overdose Deaths) per 100,000 Population
Hospital Stays for Ambulatory-Care Sensitive Conditions-Medicare	Access To Care	2015 Number of Hospital Stays for Ambulatory-Care Sensitive Conditions per 1,000 Medicare Enrollees
Ratio of Population to One Dentist	Access To Care	2016 Ratio of Population to Dentists
Ratio of Population to one Mental Health Provider	Mental Health	2017 Ratio of Population to Mental Health Providers
Ratio of Population to One Non-Physician Primary Care Provider	Access To Care	2017 Ratio of Population to Primary Care Providers Other than Physicians
Ratio of Population to One Primary Care Physician	Access To Care	2015 Number of Individuals Served by One Physician in a County, if the Population was Equally Distributed Across Physicians
Uninsured Children	Access To Care	2015 Percentage of Children Under Age 19 Without Health Insurance

Note: Listed alphabetically, not in order of significance

Source: IBM Watson Health, 2018

Prioritized Significant Health Needs

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

The resulting prioritized health needs for this community were:

Priority	Need	Category of Need
1	Ratio of Population to One Mental Health Provider	Mental Health
2	Uninsured Children	Access to Care
3	Ratio of Population to One Non-Physician Primary Care Provider	Access to Care
4	Alzheimer's Disease/Dementia in Medicare Population	Mental Health
5	Depression in Medicare Population	Mental Health

Description of Health Needs

A CHNA for the West Fort Worth Health Community identified significant community health needs categorized access to care as well as mental health. Regionalized health needs affect all age levels to some degree; however, it is often the most vulnerable populations that are negatively affected. Community health gaps help to define the resources and access to care within the county or region. Health and social concerns were validated through key informant interviews, focus groups and county data. Access to care; specifically, uninsured children and access to non-physician primary care providers; mental health issues of both depression and Alzheimer's disease/dementia among the Medicare population; as well as mental health provider access, were identified as significant areas of concern and noted in the data results for the West Fort Worth Health Community.

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

<u>Uninsured Children</u>

Lack of health insurance coverage is a significant barrier to accessing needed health care services and to maintaining financial security. Dependent groups, such as children, are often the most vulnerable and at risk to changes in financial situations as they are most affected by lack of insurance, transportation, parental knowledge, and secure housing. Lack of preventative care often places children in precarious and dangerous healthcare situations.

The Kaiser Family Foundation released a report in 2017 concerning the uninsured crisis facing the nation. One key finding was that "Going without coverage can have serious health consequences for the uninsured because they receive less preventative care, and

delayed care often results in serious illness or other health problems. Being uninsured can also have serious financial consequences, with many unable to pay their medical bills, resulting in medical debt".[2] The focus group participants discussed an increase in undocumented residents in the West Fort Worth Health Community. These groups often do not qualify for at risk programs and parents feared contact with healthcare entities, due to their status. Growing populations of uninsured in any community can easily stress social agencies and healthcare providers. Schools often become de facto primary care healthcare providers, taxing the school system and its health care staff.

Uninsured children were one of the top 10 ranked needs for the West Fort Worth Health Community based analysis of public indicator data. The percentage of uninsured children in Johnson County was 13.0% this was 29.6% difference relative to the Texas state benchmark of 10.0% (relative difference).[3] The portion of this health community that includes Johnson County had a greater relative need and a potentially vulnerable population.

Non-Physician Primary Care Providers

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

Primary care physician extenders (e.g. nurse practitioners, physician assistants, and clinical nurse specialists) could help close the gap in access to primary care services when they are 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.

Parker and Johnson counties had a need for non-physician primary care providers when compared to the overall Texas provider ratio of one provider to 1,497 residents. Johnson County had one provider to 2,592 residents. Parker County had one provider to 3,596.[4] The values for these counties are 73.1% and 140.2% higher than the state of Texas benchmark.

[2] Kaiser Family Foundation. The Uninsured: A Primer - Key Facts about Health Insurance and the Uninsured Under the Affordable Care Act. December 2017.
[3] Small Area Health Insurance Estimates (SAHIE), United States Census Bureau; County Health Rankings & Roadmaps, 2018
[4] CMS, National Provider Identification Registry (NPPES); County Health Rankings & Roadmaps, 2018

Depression in the Medicare Population

Depression is a true and treatable condition and not a normal result of aging. However, a myriad of 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. 80% of older adults have at least one chronic health condition and 50% have two or more.[5] 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.

The focus group participants noted that the 65 and older population in the West Fort Worth Health Community is growing and a data analysis estimates this age cohort is estimated to grow 23.8% by 2023, adding just over 43,087 seniors to the community. Johnson and Tarrant counties had higher percentages of depression in the Medicare population when compared to the Texas benchmark for this indicator. In Johnson County 19.0% of Medicare beneficiaries had depression; 27.7% higher than the Texas benchmark of 14.9%. Tarrant county had a rate of 17.9% this was 20.1% higher than state benchmark.[6] These portions of the community demonstrated a higher relative need and potential vulnerable population among seniors.

Alzheimer's/Dementia in the Medicare Population

Worldwide, 50 million people are living with Alzheimer's disease and other dementias including 5.7 million in the United States. Alzheimer's is a degenerative brain disease and the most common form of dementia. Dementia is not a specific disease; it is an overall term that describes a group of symptoms associated with a decline in memory and thinking skills. Between 2000 and 2015 deaths from heart disease have decreased 11% while deaths from Alzheimer's have increased 123%. Early and accurate diagnosis could save up to $7.9 trillion in medical and care costs. In 2018, Alzheimer's and other dementias will cost the nation $277 billion, by 2050 these costs could rise as high as $1.1 trillion.[7]

Alzheimer's/Dementia occurred at a rate of 13.0% amongst the Medicare population in the state of Texas overall. Johnson County had a rate of 16.2%, this was 24.4% higher than the state benchmark. This portion of the community had higher relative need and a potential vulnerable population. Concerns around the lack of availability of mental health services, especially for the elderly, was reinforced through community input.

The 65 and older population is living longer than previous generations due to improved healthcare outcomes and access, however we are still at the infancy of understanding mental health conditions and how they affect us as we age. Geographic distances of families place more burden on social programs and long-term care facilities when patients are no longer safe to live in their homes.

[5] **U.S. Center for Disease Control and Prevention**, 2019
[6] CMS Chronic Conditions Warehouse, 2007-2015
[7] **Alzheimer's Association**, 2019

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

Mental Health Provider Access

Access to mental health providers and services is an issue nationally. Nine million adults (or 1 in 5) report having an unmet mental health need and mental health provider shortages across the country continue to exist.[8]

Cities and rural areas both face challenges with accessing mental health care services. While more rural areas face additional issues in accessing providers; more urban areas have a greater number of people impacted. Primary care providers (PCP's) are often relied upon to help identify patients with mental health need and communities that have a lack of primary care providers face even more challenges in addressing that need.

According to the CMS National Provider Identification File, the ratio of residents in Parker County served by each mental health provider was 2,088 compared to the Texas state ratio of 1:1,012. Johnson County had a ratio of 1:1,471. These counties have a relative difference from the Texas state benchmark of 106.3% and 45.4% respectively.[9]

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 and publicly available and proprietary health indicators, BSWH identified and prioritized community health needs for their healthcare system. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed for the health needs BSWH chooses to address for the community served.

[8] **Mental Health America**, 2019
[9] CMS, National Provider Identification Registry (NPPES), County Health Rankings & Roadmaps, 2018

Appendix A: Key Health Indicator Sources

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

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

Category	Public Health Indicator	Source
Injury & Death	Cancer Mortality Rate	2013 Texas Health Data, Center for Health Statistics, Texas Department of State Health Services
	Child Mortality Rate	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Chronic Lower Respiratory Disease (CLRD) Mortality Rate	2013 'Texas Health Data, Center for Health Statistics, Texas Department of State Health Services
	Death rate due to firearms **NEW 2019**	2018 County Health Rankings (CDC WONDER Environmental Data)
	Heart Disease Mortality Rate	2013 Texas Health Data, Center for Health Statistics, Texas Department of State Health Services
	Infant Mortality Rate	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Motor Vehicle Crash Mortality Rate	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Number of deaths due to injury **NEW 2019**	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Premature Death (Potential Years Lost)	2018 County Health Rankings & Roadmaps; National Center for Health Statistics - Mortality Files, National Vital Statistics System (NVSS)
	Stroke Mortality Rate	2013 Texas Health Data, Center for Health Statistics, Texas Department of State Health Services
Maternal & Child Health	First Trimester Entry into Prenatal Care	2016 Texas Health and Human Services - Vital statistics annual report
	Low Birth Weight Percent	2018 County Health Rankings & Roadmaps; National Center for Health Statistics - Natality files, National Vital Statistics System (NVSS)
	Low Birth Weight Rate	2016 Texas Health and Human Services - Vital statistics annual report - Preventable Hospitalizations
	Preterm Births <37 Weeks Gestation	2015 Kids Discount Data Center
	Very Low Birth Weight (VLBW)	Centers for Disease Control and Prevention WONDER
Mental Health	Accidental poisoning deaths where opioids were involved **NEW 2019**	U.S. Census Bureau, Population Division and 2015 Texas Health and Human Services Center for Health Statistics Opioid related deaths in Texas
	Alzheimer's Disease/Dementia in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Average Number of Mentally Unhealthy Days Reported in Past 30 days (Age-Adjusted)	2018 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)
	Depression in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Frequent mental distress	2016 Behavioral Risk Factor Surveillance System (BRFSS)
	Intentional Self-Harm; Suicide **NEW 2019**	2015 Texas Health Data Center for Health Statistics
	Ratio of Population to one Mental Health Provider	2018 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)
	Schizophrenia and Other Psychotic Disorders in Medicare Population	CMS.gov Chronic conditions 2007-2015

Category	Public Health Indicator	Source
Population	Children Eligible for Free Lunch Enrolled in Public Schools	2018 County Health Rankings & Roadmaps, The National Center for Education Statistics (NCES)
	Children in Poverty	2018 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau
	Children in Single-Parent Households	2018 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)
	Civilian veteran population 18+ **NEW 2019**	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
	Disabled population, civilian noninstitutionalized	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
	High School Dropout	2016 Texas Education Agency
	High School Graduation	2017 Texas Education Agency
	Homicides	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Household income, median **NEW 2019**	2018 County Health Rankings (2016 Small Area Income and Poverty Estimates)
	Income Inequality	2018 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)
	Individuals Living Below Poverty Level	2012-2016 US Census Bureau - American FactFinder
	Individuals Who Report Being Disabled	2012-2016 US Census Bureau - American FactFinder
	Non-English-speaking households **NEW 2019**	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
	Social/Membership Associations	2018 County Health Rankings & Roadmaps; 2015 County Business Patterns, United States Census Bureau
	Some College	2018 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)
	Unemployment	2018 County Health Rankings & Roadmaps; Local Area Unemployment Statistics (LAUS), Bureau of Labor Statistics
	Violent Crime Offenses	2018 County Health Rankings & Roadmaps; Uniform Crime Reporting (UCR) Program, United States Department of Justice, Federal Bureau of Investigation (FBI)
Preventable Hospitalizations	Asthma Admission: Pediatric (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Diabetes Lower-Extremity Amputation Admission: Adult (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Diabetes Short-term Complications Admission: Pediatric (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Gastroenteritis Admission: Pediatric (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Perforated Appendix Admission: Adult (Risk-Adjusted-Rate per 100 Admissions for Appendicitis)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Perforated Appendix Admission: Pediatric (Risk-Adjusted-Rate for Appendicitis)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Uncontrolled Diabetes Admission: Adult (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Urinary Tract Infection Admission: Pediatric (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations

Category	Public Health Indicator	Source
Prevention	Diabetic Monitoring in Medicare Enrollees	2018 County Health Rankings & Roadmaps; Dartmouth Atlas of Health Care, CMS
	Mammography Screening in Medicare Enrollees	2018 County Health Rankings & Roadmaps; Dartmouth Atlas of Health Care, CMS

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

Below is a list of resources available in the community with the ability to address the significant health needs identified in the assessment. For a continually updated list of the resources available to address these needs as well as other social determinants of health, please visit our website (**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	Baylor Community Care at Fort Worth	1650 W. Magnolia, Suite 207	Fort Worth	817-912-8000
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	Beautiful Feet Ministries	1709 E. Hattie Street	Fort Worth	817-536-0505
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	Catholic Charities of Tarrant County	249 West Thornhill Drive	Fort Worth	817-534-0814
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	Cornerstone Assistance Network	3500 Noble Avenue	Fort Worth	817-632-6000
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	Crowley House of Hope Clinic	208 N. Magnolia	Crowley	817-297-6495
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	Healing Shepard Clinic (Union Gospel Mission)	1321 East Lancaster	Fort Worth	817-338-8432
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	JPS Health Center for Women & Children - Northwest	2200 Ephriham Ave.	Fort Worth	817-702-6500
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	JPS Health Network	1500 South Main Street	Fort Worth	817-702-1100
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	Muslim Community Center for Human Services Al-Shifa Clinic	7600 Glenview Drive	North Richland Hills	817-579-9165

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	North TX Area Community Health Center - Northside Comm Health	2332 Beverly Hills Drive	Fort Worth	817-625-4254
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	North TX Area Community Health Center - Southeast Comm Health	2909 Mitchell Blvd	Fort Worth	817-625-4254
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	Northside Community Health Center	2106 N. Main Street	Fort Worth	817-625-4254
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	Southeast Community Health Center	2909 Mitchell Blvd	Dallas	817-916-4333
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	Texas Health Arlington Memorial DSRIP Clinic	Arlington, TX 76012	Arlington	817-960-6100
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	Veteran's Administration Hospital – Outpatient Clinic	2201 SE Loop 820	Fort Worth	817-335-2202
Uninsured Children	Access to Care	Child Nutrition Programs	City of Fort Worth - Community Action Partners	3551 New York Avenue	Fort Worth	817-392-5790
Uninsured Children	Access to Care	Child Nutrition Programs	MHMR Tarrant County	3840 Hulen Street	Fort Worth	817-569-4300
Uninsured Children	Access to Care	Citizenship and Immigration	Catholic Charities of Tarrant County	249 West Thornhill Drive	Fort Worth	817-534-0814
Uninsured Children	Access to Care	Discounted Healthcare	Baylor Community Care at Fort Worth	1650 W. Magnolia, Suite 207	Fort Worth	817-912-8000
Uninsured Children	Access to Care	Help Understanding Government Programs	Tarrant Area Food Bank	2525 Cullen Street	Fort Worth	817-857-7100
Uninsured Children	Access to Care	Pediatric Social Services	MHMR Tarrant County	3840 Hulen Street	Fort Worth	817-569-4300

Community Health Need	Category	Service	Facility Name	Address	City	Phone Number
Uninsured Children	Access to Care	Prescription Assistance	Baylor Community Care at Fort Worth	1650 W. Magnolia, Suite 207	Fort Worth	817-912-8000
Uninsured Children	Access to Care	Prescription Assistance	Catholic Charities of Tarrant County	249 West Thornhill Drive	Fort Worth	817-534-0814
Uninsured Children	Access to Care	Prescription Assistance	Community Storehouse	4574 Keller Hicks Road	Keller	817-431-3340
Uninsured Children	Access to Care	Vaccinations	Baylor Community Care at Fort Worth	1650 W. Magnolia, Suite 207	Fort Worth	817-912-8000
Uninsured Children	Access to Care	Vaccinations	Crowley House of Hope Clinic	208 N. Magnolia	Crowley	817-297-6495
Uninsured Children	Access to Care	Vaccinations	North TX Area Community Health Center - Northside Comm Health	2332 Beverly Hills Drive	Fort Worth	817-625-4254
Uninsured Children	Access to Care	Vaccinations	North TX Area Community Health Center - Southeast Comm Health	2909 Mitchell Blvd	Fort Worth	817-625-4254
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Family Counseling	Catholic Charities of Tarrant County	249 West Thornhill Drive	Fort Worth	817-534-0814
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Family Counseling	Recovery Resource Council	2700 Airport Freeway	Fort Worth	817-332-6329
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	General Psychology	Daybreak Community Service Inc.	7401 West Cleburne Road	Fort Worth	817-293-9744
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	General Psychology	Daybreak Community Service Inc.	4100 International Plaza	Fort Worth	817-447-2700
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Long Term Housing	Fort Worth Housing Authority	1201 E 13th Street	Fort Worth	817-333-3400

Community Health Need	Category	Service	Facility Name	Address	City	Phone Number
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Long Term Housing	Promise House	3500 Noble Avenue	Fort Worth	817-632-6012
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Memory Care	Garden Terrace Alzheimer's Center of Excellence	7500 Oakmont Blvd	Fort Worth	817-346-8080
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Mental Health Evaluation	Mental Health Connection of Tarrant County	3200 Sanguinet Street	Fort Worth	817-927-5200
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Mental Health Hospital Treatment	Excel Center of Fort Worth	1220 W. Presidio	Fort Worth	817-335-6429
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Mental Health Outpatient Treatment	Excel Center of Fort Worth	1220 W. Presidio	Fort Worth	817-335-6429
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Mental Health Services	Excel Center of Fort Worth	1220 W. Presidio	Fort Worth	817-335-6429
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Mental Health Services	Mental Health Connection of Tarrant County	3200 Sanguinet Street	Fort Worth	817-927-5200
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Mental Health Services	Tarrant County Homeless Coalition	1201 E 13th Street	Fort Worth	817-409-3635
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Residential Housing	Fort Worth Housing Authority	1201 E 13th Street	Fort Worth	817-333-3400
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Short Term Housing	New Life Center	3500 Noble Avenue	Fort Worth	817-632-6012
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Short Term Housing	Promise House	3500 Noble Avenue	Fort Worth	817-632-6012

Community Health Need	Category	Service	Facility Name	Address	City	Phone Number
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Short Term Housing	Union Gospel Mission of Tarrant County	1321 East Lancaster Avenue	Fort Worth	817-339-2553
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Social Services	AIDS Outreach Center	400 North Beach Street, Suite 100	Fort Worth	817-795-3030
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Social Services	Baylor Community Care at Fort Worth	1650 W. Magnolia, Suite 207	Fort Worth	817-912-8000
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	Social Services	Catholic Charities of Tarrant County	249 West Thornhill Drive	Fort Worth	817-534-0814
Depression in Medicare Population	Mental Health	Family Counseling	Catholic Charities of Tarrant County	249 West Thornhill Drive	Fort Worth	817-534-0814
Depression in Medicare Population	Mental Health	Family Counseling	Recovery Resource Council	2700 Airport Freeway	Fort Worth	817-332-6329
Depression in Medicare Population	Mental Health	General Psychology	Daybreak Community Service Inc.	7401 West Cleburne Road	Fort Worth	817-293-9744
Depression in Medicare Population	Mental Health	General Psychology	Daybreak Community Service Inc.	4100 International Plaza	Fort Worth	817-447-2700
Depression in Medicare Population	Mental Health	Help Hotlines	Alzheimer's Association	2630 West Freeway #100	Fort Worth	800-272-3900
Depression in Medicare Population	Mental Health	Help Hotlines	United Way of Tarrant County & Area Agency On Aging	1500 North Main, Suite 200	Fort Worth	817-258-8081
Depression in Medicare Population	Mental Health	Mental Health Evaluation	Mental Health Connection of Tarrant County	3200 Sanguinet Street	Fort Worth	817-927-5200
Depression in Medicare Population	Mental Health	Mental Health Hospital Treatment	Excel Center of Fort Worth	1220 W. Presidio	Fort Worth	817-335-6429

Community Health Need	Category	Service	Facility Name	Address	City	Phone Number
Depression in Medicare Population	Mental Health	Mental Health Outpatient Treatment	Excel Center of Fort Worth	1220 W. Presidio	Fort Worth	817-335-6429
Depression in Medicare Population	Mental Health	Mental Health Services	Excel Center of Fort Worth	1220 W. Presidio	Fort Worth	817-335-6429
Depression in Medicare Population	Mental Health	Mental Health Services	Mental Health Connection of Tarrant County	3200 Sanguinet Street	Fort Worth	817-927-5200
Depression in Medicare Population	Mental Health	Mental Health Services	Tarrant County Homeless Coalition	1201 E 13th Street	Fort Worth	817-409-3635
Depression in Medicare Population	Mental Health	Social Services	AIDS Outreach Center	400 North Beach Street, Suite 100	Fort Worth	817-795-3030
Depression in Medicare Population	Mental Health	Social Services	Baylor Community Care at Fort Worth	1650 W. Magnolia, Suite 207	Fort Worth	817-912-8000
Depression in Medicare Population	Mental Health	Social Services	Catholic Charities of Tarrant County	249 West Thornhill Drive	Fort Worth	817-534-0814
Ratio of Population to One Mental Health Provider	Mental Health	Family Counseling	Catholic Charities of Tarrant County	249 West Thornhill Drive	Fort Worth	817-534-0814
Ratio of Population to One Mental Health Provider	Mental Health	Family Counseling	Recovery Resource Council	2700 Airport Freeway	Fort Worth	817-332-6329
Ratio of Population to One Mental Health Provider	Mental Health	General Psychology	Daybreak Community Service Inc.	7401 West Cleburne Road	Fort Worth	817-293-9744
Ratio of Population to One Mental Health Provider	Mental Health	General Psychology	Daybreak Community Service Inc.	4100 International Plaza	Fort Worth	817-447-2700
Ratio of Population to One Mental Health Provider	Mental Health	Mental Health Evaluation	Mental Health Connection of Tarrant County	3200 Sanguinet Street	Fort Worth	817-927-5200

Community Health Need	Category	Service	Facility Name	Address	City	Phone Number
Ratio of Population to One Mental Health Provider	Mental Health	Mental Health Hospital Treatment	Excel Center of Fort Worth	1220 W. Presidio	Fort Worth	817-335-6429
Ratio of Population to One Mental Health Provider	Mental Health	Mental Health Outpatient Treatment	Excel Center of Fort Worth	1220 W. Presidio	Fort Worth	817-335-6429
Ratio of Population to One Mental Health Provider	Mental Health	Mental Health Services	Excel Center of Fort Worth	1220 W. Presidio	Fort Worth	817-335-6429
Ratio of Population to One Mental Health Provider	Mental Health	Mental Health Services	Mental Health Connection of Tarrant County	3200 Sanguinet Street	Fort Worth	817-927-5200
Ratio of Population to One Mental Health Provider	Mental Health	Mental Health Services	Tarrant County Homeless Coalition	1201 E 13th Street	Fort Worth	817-409-3635

Community Healthcare Facilities

Facility Name	Type	System	Street Address	City	State	Zip
Baylor Emergency Medical Center	ED	Baylor Scott & White	12500 South Freeway, Suite 100	Burleson	TX	76028
Baylor Emergency Medical Center	ED	Baylor Scott & White	620 South Main, Suite 100	Keller	TX	76248
Baylor Scott & White All Saints Medical Center - Fort Worth	ST	Baylor Scott & White	1400 Eighth Avenue	Fort Worth	TX	76104
Baylor Scott & White Institute For Rehabilitation - Fort Worth	LT	Baylor Scott & White	6601 Harris Parkway	Fort Worth	TX	76132
Baylor Surgical Hospital At Fort Worth	ST	Baylor Scott & White	1800 Park Place Avenue	Fort Worth	TX	76110
Complete Care Camp Bowie	ED	Complete Care	6006 Camp Bowie	Fort Worth	TX	76116
Complete Care Chisholm Trail	ED	Complete Care	7445 Oakmont Blvd	Fort Worth	TX	76132
Complete Emergency Care Azle LLC	ED	Complete Care	611 Northwest Parkway	Azle	TX	76020
Cook Childrens Medical Center	KID	Cook Childrens	801 Seventh Avenue	Fort Worth	TX	76104
Excel ER - Weatherford	ED	Excel ER	730 Adams Drive	Weatherford	TX	76086
Exceptional Emergency Center	ED	Exceptional Emergency Room	1251 Eastchase Parkway	Fort Worth	TX	76120
Healthsouth City View Rehabilitation Hospital	LT	HealthSouth	6701 Oakmont Boulevard	Fort Worth	TX	76132
Healthsouth Rehabilitation Hospital Of Fort Worth	LT	HealthSouth	1212 West Lancaster Avenue	Fort Worth	TX	76102
Icare Emergency Room	ED	iCare	5500 Sycamore School Rd Suite 150	Fort Worth	TX	76123
John Peter Smith Hospital	ST	JPS	1500 South Main Street	Fort Worth	TX	76104

Facility Name	Type	System	Street Address	City	State	Zip
JPS Health Network - Trinity Springs North	ST	JPS	1000 St Louis Avenue	Fort Worth	TX	76104
Kindred Hospital - Fort Worth	LT	Kindred	815 Eighth Avenue	Fort Worth	TX	76104
Kindred Hospital -Tarrant County	LT	Kindred	7800 Oakmont Boulevard	Fort Worth	TX	76132
Lake Granbury Medical Center	ST	Community Health Sys	1310 Paluxy Road	Granbury	TX	76048
Legacy ER	ED	Legacy	8950 N Tarrant Pkwy	North Richland Hills	TX	76182
Lifecare Hospitals Of Fort Worth	LT	LifeCare	6201 Overton Ridge Blvd	Fort Worth	TX	76132
Medical City Alliance	ST	Hospital Corporation of America	3101 North Tarrant Parkway	Fort Worth	TX	76177
Medical City Fort Worth	ST	Hospital Corporation of America	900 Eighth Avenue	Fort Worth	TX	76104
Medical City North Hills	ST	Hospital Corporation of America	4401 Booth Calloway Road	North Richland Hills	TX	76180
Medical City Weatherford	ST	Hospital Corporation of America	713 E Anderson St	Weatherford	TX	76086
Mesa Springs	PSY	Springstone	5560 Mesa Springs Drive	Fort Worth	TX	76123
Texas Health Harris Methodist Hospital Alliance	ST	Texas Health Resources	10864 Texas Health Trail	Ft Worth	TX	76244
Texas Health Harris Methodist Hospital Azle	ST	Texas Health Resources	108 Denver Trail	Azle	TX	76020
Texas Health Harris Methodist Hospital Fort Worth	ST	Texas Health Resources	1301 Pennsylvania Avenue	Fort Worth	TX	76104
Texas Health Harris Methodist Hospital Southwest Fort Worth	ST	Texas Health Resources	6100 Harris Parkway	Fort Worth	TX	76132
Texas Health Hospital Clearfork	ST	Texas Health Resources	5400 Clearfork Main St	Fort Worth	TX	76109

Facility Name	Type	System	Street Address	City	State	Zip
Texas Health Huguley Hospital	ST	Texas Health Resources	11801 South Freeway	Burleson	TX	76028
Texas Health Specialty Hospital Fort Worth	ST	Texas Health Resources	1301 Pennsylvania Avenue 4th Floor	Fort Worth	TX	76104
Texas Rehabilitation Hospital Of Fort Worth	LT	Texas Health Resources	425 Alabama Avenue	Fort Worth	TX	76104
The Emergency Center At West 7th	ED	The Emergency Center	1101 University Drive	Fort Worth	TX	76107
Totalcare Emergency	ED	Total Care	8501 Benbrook Blvd Suite 103	Benbrook	TX	76126
Usmd Hospital At Fort Worth	ST	USMD	5900 Altamesa Boulevard	Fort Worth	TX	76132
Weatherford Rehabilitation Hospital Llc	LT	Maxim Management Group	703 Eureka St	Weatherford	TX	76086
Wellbridge Hospital Of Fort Worth	PSY	Wellbridge Health	6200 Overton Ridge Blvd	Fort Worth	TX	76132
Wise Health Surgical Hospital	ST	Wise Regional Health System	3200 North Tarrant Parkway	Fort Worth	TX	76177

**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)[10]

County Name	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type
Johnson	7486648435	CF-Sanders Estes Unit	Mental Health	Correctional Facility
Tarrant	1485279877	Federal Medical Center-Carswell	Primary Care	Correctional Facility
Tarrant	6486448024	Federal Medical Center-Carswell	Dental Health	Correctional Facility
Tarrant	6489994877	Federal Correctional Institution - Fort Worth	Dental Health	Correctional Facility
Tarrant	7483623264	Federal Medical Center-Carswell	Mental Health	Correctional Facility
Tarrant	148999484K	Federal Correctional Institution - Fort Worth	Primary Care	Correctional Facility
Tarrant	14899948H2	North Texas Area Community Health Center, Inc.	Primary Care	Federally Qualified Health Center
Tarrant	64899948F5	North Texas Area Community Health Center, Inc.	Dental Health	Federally Qualified Health Center
Tarrant	748999483N	North Texas Area Community Health Center, Inc.	Mental Health	Federally Qualified Health Center

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

Medically Underserved Areas and Populations (MUA/P)[11]

County Name	MUA/P Source Identification Number	Service Area Name	Designation Type	Rural Status
Johnson	3510	Johnson Service Area	Medically Underserved Area	Partially Rural
Tarrant	7393	Central Service Area	Medically Underserved Area	Non-Rural
Tarrant	3509	Diamond Hill Service Area	Medically Underserved Area	Non-Rural
Tarrant	7382	Low Inc - East Side	MUP Low Income	Non-Rural

[11] 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

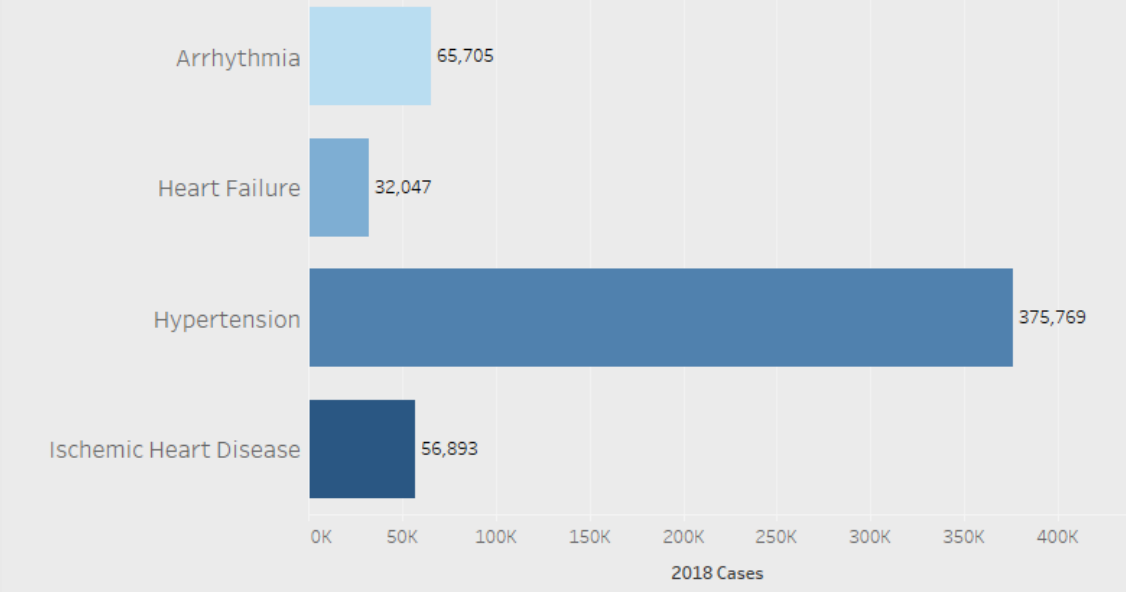
West Fort Worth Health Community		
Public Health Indicator	Category	Indicator Definition
Ratio of Population to One Non-Physician Primary Care Provider	Access To Care	2017 Ratio of Population to Primary Care Providers Other than Physicians
Ratio of Population to one Mental Health Provider	Mental Health	2017 Ratio of Population to Mental Health Providers
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)
Ratio of Population to One Dentist	Access To Care	2016 Ratio of Population to Dentists
Civilian veteran population 18+	Population	2012 Percent of population 18 years and over - Civilian veterans
Disconnected youth	Health Behaviors	2010-2014 Population between the ages of 16 and 24 who are neither working nor in school.
Perforated Appendix Admission: Pediatric (Risk-Adjusted-Rate for Appendicitis)	Preventable Hospitalizations	2016 Number Observed / Pediatric Population Under Age 18
Long Commute Alone	Environment	2012-2016 Among Workers Who Commute in Their Car Alone, the Percentage that Commute More than 30 Minutes
Motor Vehicle Crash Mortality Rate	Injury & Death	2010-2016 Number of Motor Vehicle Crash Deaths per 100,000 Population
Air Pollution - Particulate Matter daily density	Environment	2012 Average Daily Density of Fine Particulate Matter in Micrograms per Cubic Meter (PM2.5)
Death rate due to firearms	Injury & Death	2012-2016 number of deaths due to firearms, per 100,000 population.
Hospital Stays for Ambulatory-Care Sensitive Conditions- Medicare	Access To Care	2015 Number of Hospital Stays for Ambulatory-Care Sensitive Conditions per 1,000 Medicare Enrollees
Drug Poisoning Deaths Rate	Health Behaviors	2014-2016 Number of Drug Poisoning Deaths (Drug Overdose Deaths) per 100,000 Population
Ratio of Population to One Primary Care Physician	Access To Care	2015 Ratio of Population to Primary Care Providers

West Fort Worth Health Community		
Public Health Indicator	Category	Indicator Definition
Diabetes Short-term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Preventable Hospitalizations	2016 Number Observed / Pediatric Population Under Age 18
Uninsured Children	Access To Care	2015 Percentage of Children Under Age 19 Without Health Insurance
COPD in Medicare Population	Conditions/Diseases	2007-2015 Prevalence of chronic condition across all Medicare beneficiaries
Depression in Medicare Population	Mental Health	2007-2015 Prevalence of chronic condition across all Medicare beneficiaries
Uncontrolled Diabetes Admission: Adult (Risk-Adjusted-Rate)	Preventable Hospitalizations	2016 Number Observed / Adult Population Age 18 and older
Cancer Incidence - Lung	Conditions/Diseases	2011-2015 Age-Adjusted Lung & Bronchus Cancer Incidence Rate Cases per 100,000.
Infant Mortality Rate	Injury & Death	2010-2016 Number of All Infant Deaths (Within 1 year), per 1,000 Live Births
Alzheimer's Disease/Dementia in Medicare Population	Mental Health	2007-2015 Prevalence of chronic condition across all Medicare beneficiaries
Number of deaths due to injury	Injury & Death	2010-2016 Number of Motor Vehicle Crash Deaths per 100,000 Population
Stroke Mortality Rate	Injury & Death	2013 Cerebrovascular Disease (Stroke) Age Adjusted Death Rate (Per 100,000 - All Ages. Age-adjusted using the 2000 U.S. Standard Population)
Physical Inactivity	Health Behaviors	2014 Percentage of Adults Ages 20 and Over Reporting No Leisure-Time Physical Activity in the Past Month
Heart Failure in Medicare Population	Conditions/Diseases	2007-2015 Prevalence of chronic condition across all Medicare beneficiaries
Population with Adequate Access to Locations for Physical Activity	Environment	2010 & 2016 Percentage of Population with Adequate Access to Locations for Physical Activity

Appendix E: Watson Health Community Data

Watson Health Heart Disease Estimates identified hypertension as the most prevalent heart disease diagnoses. There were over 375,000 estimated cases in the community overall. The 76028 ZIP Code of Burleson had the most estimated cases of each heart disease type. The 76049 ZIP code of Granbury had the highest estimated prevalence rates for Arrhythmia (672 cases per 10,000 population), Hypertension (3,488 cases per 10,000 population), and Ischemic Heart Disease (725 cases per 10,000 population). While the 76126 ZIP code of Southwest Ft Worth had the highest estimated prevalence rates for Heart Failure (327 cases per 10,000 population).

2018 Estimated Heart Disease Cases



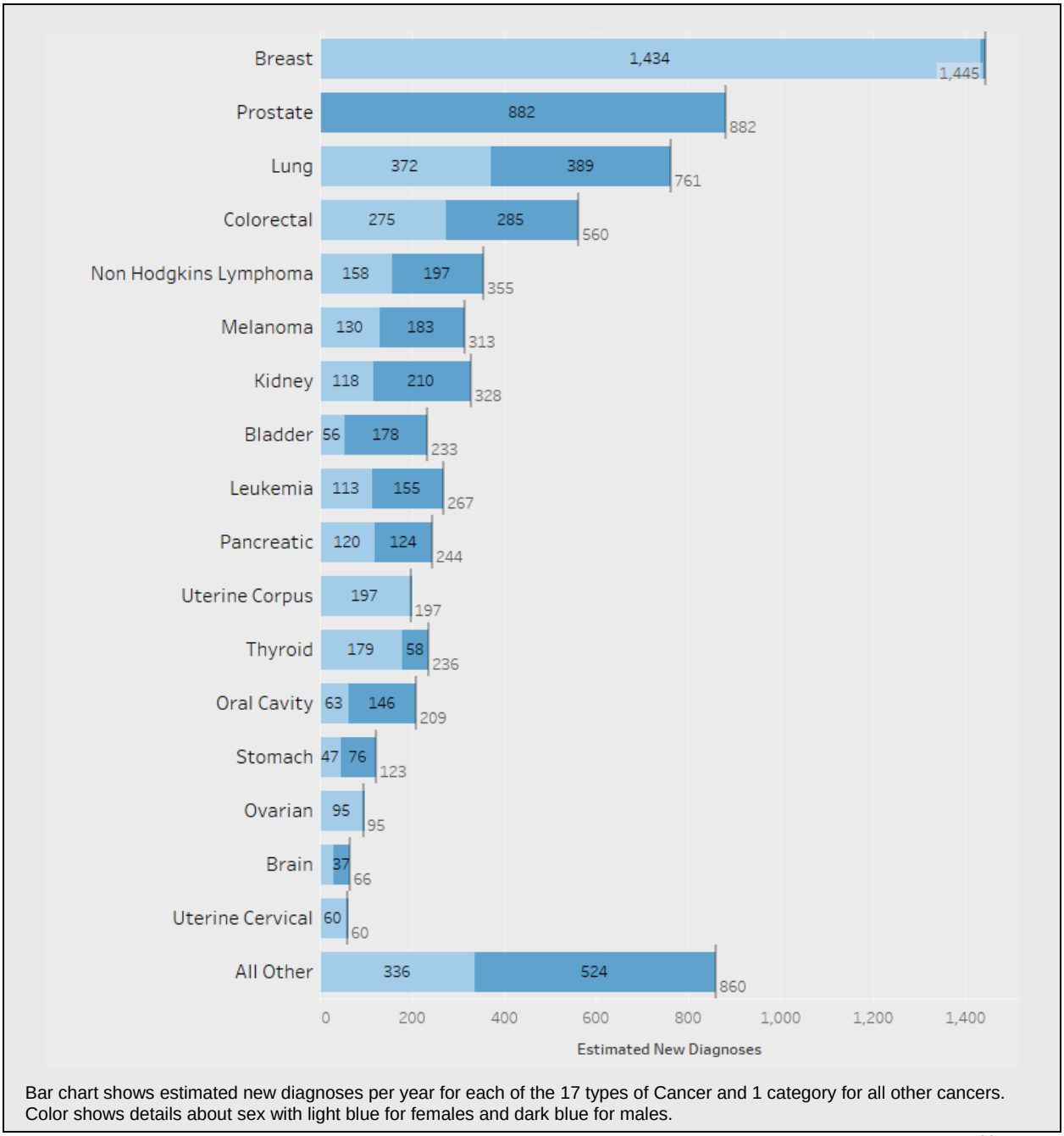
Bar chart shows total number of 2018 Estimated Heart Disease cases for each of four types: arrhythmia, heart failure, hypertension, and ischemic heart disease

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 and bladder; based on both population changes and disease rates. The estimates for the most new cases in 2018 were breast, prostate, lung cancers and colorectal.

2018 Estimated New Cancer Cases



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

Source: IBM Watson Health, 2018

Estimated Cancer Cases and Projected 5 Year Change by Type

Cancer Type	2018 Estimated New Cases	2023 Estimated New Cases	5 Year Growth (%)
Bladder	233	277	18.9%
Brain	66	74	12.1%
Breast	1,445	1,649	14.1%
Colorectal	560	571	2.0%
Kidney	328	384	17.1%
Leukemia	267	309	15.7%
Lung	761	870	14.3%
Melanoma	313	368	17.6%
Non Hodgkins Lymphoma	355	412	16.1%
Oral Cavity	209	243	16.3%
Ovarian	95	107	12.6%
Pancreatic	244	293	20.1%
Prostate	882	955	8.3%
Stomach	123	139	13.0%
Thyroid	236	278	17.8%
Uterine Cervical	60	63	5.0%
Uterine Corpus	197	229	16.2%
All Other	860	1,001	16.4%
Grand Total	7,234	8,222	13.7%

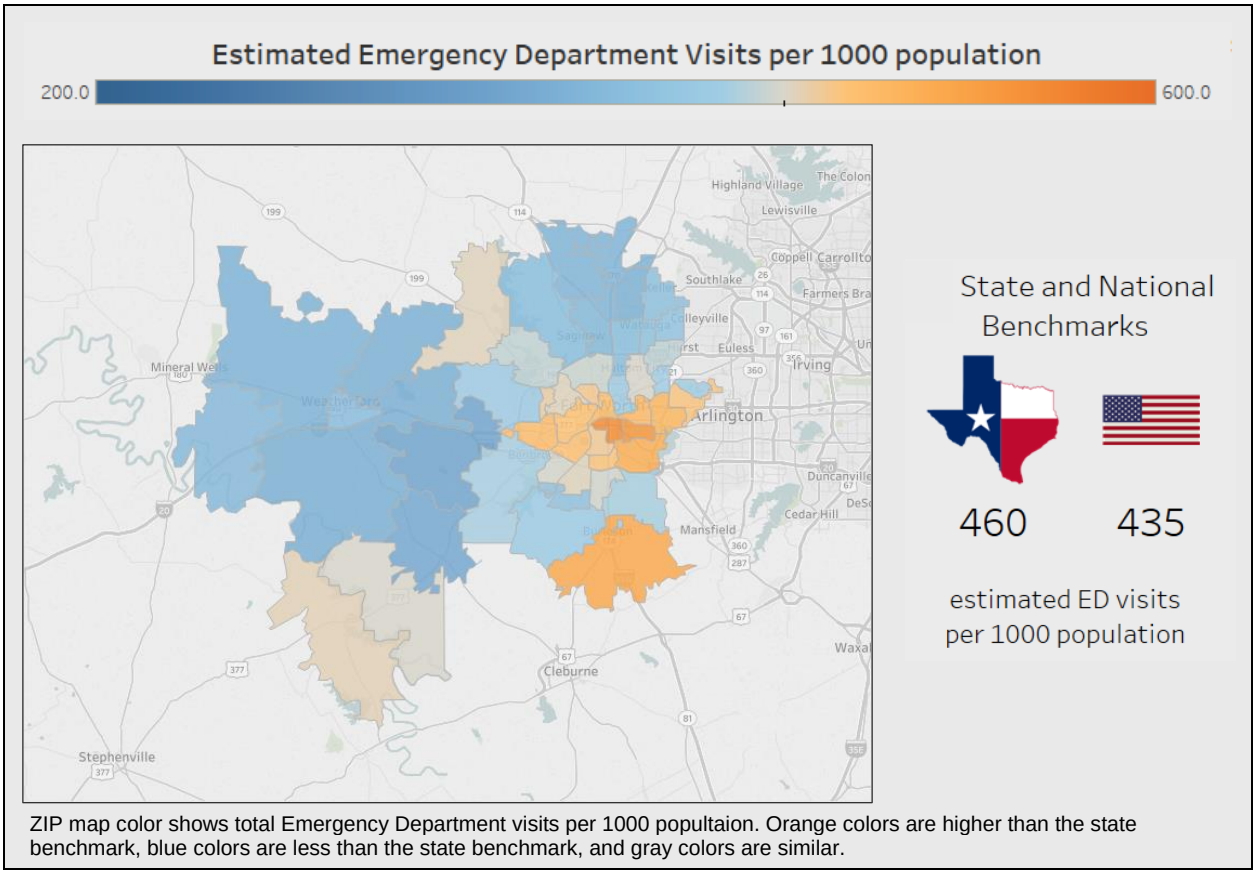
Source: IBM Watson Health, 2018

Based on population characteristics and regional utilization rates, Watson Health projected all emergency department (ED) visits in this community to increase by 8.4% over the next five years. The highest estimated ED use rates were in the ZIP codes of Meadowbrook; 480.4 to 554.9 ED visits per 1,000 residents compared to the Texas state benchmark of 460 visits and the U.S. benchmark 435 visits per 1,000.

These ED visits consisted of three main types: those resulting in an inpatient admission, emergent outpatient treated and released ED visits, and non-emergent outpatient ED visits that were lower acuity. Non-emergent ED visits present to the ED but can be treated in more appropriate and less intensive outpatient settings.

Non-emergent outpatient ED visits could be an indication of systematic issues within the community regarding access to primary care, managing chronic conditions, or other access to care issues such as ability to pay. Watson Health estimated non-emergent ED visits to increase by an average of 3.8% over the next five years in this community.

Estimated 2018 Emergency Department Visit Rate

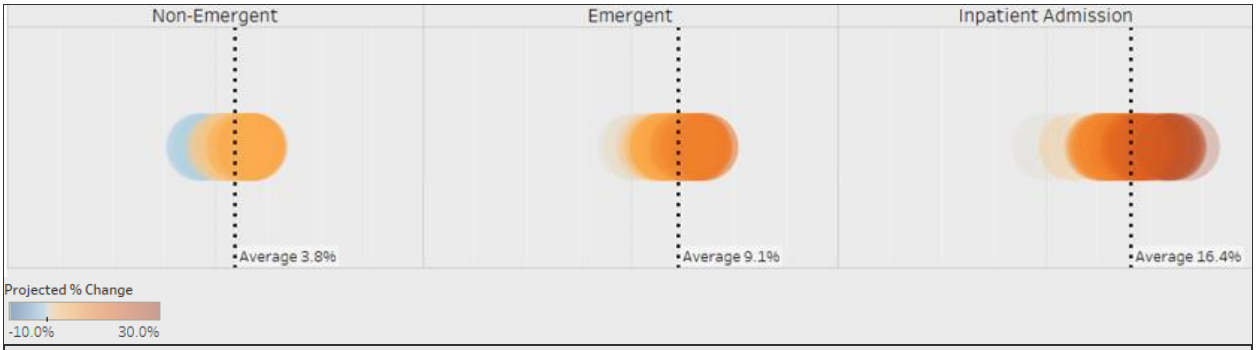


ZIP map color shows total Emergency Department visits per 1000 popultaion. Orange colors are higher than the state benchmark, blue colors are less than the state benchmark, and gray colors are similar.

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 All Saints Medical Center – Fort Worth

Baylor Scott & White Institute for Rehabilitation – Fort Worth

Baylor Surgical Hospital at Fort Worth

Evaluation of Prior CHNA Implementation

2016 Identified Need Facility	Access to care for middle to lower socio-economic status	MD& Non MD primary care provider to population ratio	Mental/ behavioral health	Chronic disease	Dentist to population ratio	Health and wellness promotion
Baylor Scott & White All Saints Medical Center - Fort Worth	√	√	√	√		√
Baylor Scott & White Institute for Rehabilitation - Fort Worth	√					
Baylor Surgical Hospital at Fort Worth	√					

Total Resources Contributed to Addressing Needs: $6,474,368

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

Program: Community Benefit Operations
Entity Name: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The Hospital produces a triennial Community Needs Assessment. 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: 575,377 persons served; increased access to healthcare services in the community
Committed Resources: Staff time; supplies/expenses; clinical experts; $180,289 net community benefit

Program: Donations- In Kind/Faith in Action Initiatives
Entity Name: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The Hospital donates retired medical supplies and equipment to the office of Faith in Action Initiatives 2nd Life program to provide for the health care needs of populations in the community and nation whose needs not met through their own organization.
Impact: unknown # persons served; increase infrastructure of healthcare access
Committed Resources: Staff time; warehouse space; volunteers; community partners; $442 net community benefit.

Program: DSRIP Cancer Screening Program.
Entity Name: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
Increase access to cancer screening in the primary care setting. Develop and implement disease management interventions geared toward improving management of cancers and commodities, improving health outcomes and quality of life, preventing disease complications, and reducing unnecessary acute and emergency care utilization.
Impact: 2,486 persons served; increased access to healthcare provision for underserved/**u**nderinsured
Committed Resources: advanced nurse practitioner (APRN) and LVN; social workers; Care Coordinators; Medical Director

Program: DSRIP Chronic Disease Management and Prevention Program
Entity Name: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
Develop and implement chronic disease management interventions geared toward improving management of diabetes and heart disease, comorbidities, improving health outcomes and quality of life, preventing disease complications, and reducing unnecessary acute and emergency care utilization.
Impact; 624 persons served; increase number of patients with at least one of four chronic diseases referred to and managed by a community health worker
Committed Resources: community health workers, nurse care managers and other hospital staff

Program: DSRIP Medication Management
Entity Name: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
This project combines to implement interventions that place teams, technology and processes to avoid medication errors. The project combines the components of both of these options but focuses on medication management and compliance in the ambulatory setting within the patient's Baylor Clinic Primary Care Medical Home (PCMH). Additionally, patients who qualify for medications and those patients who cannot afford prescriptions will receive help obtaining the medications they need through implementing a prescription assistance program. Medications have little to no cost for patients who are 150% below the federal poverty level, have one or more chronic diseases and remain compliant with their appointments and care regimens.
Impact: 755 persons served; improved clinical outcomes; increased patient compliance; access to affordable medications; reduced patient transportation needs
Committed Resources: clinical pharmacist; staff time; supplies/equipment;

Program: DSRIP Specialty Care Expansion
Entity Name: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
Patients (including Medicaid and uninsured) in an established Primary Care Medical Home (PCMH) will receive specialty care services through this DSRIP project, including office visits with specialists, wound care, and facility based procedures such as cardiac catheterizations, certain surgeries (i.e., gallbladder/hernia), excision of masses (breast, lymphoma), and cataract removal and excluding transplants, oncology and perinatal services. Specialty care referral and coordination comes from the PCMH clinic per request by the patient's PCP.
Impact: 465 persons served; increased access to specialty care for low/middle income population
Committed Resources: 12 physician specialists providers

Program: Enrollment Services
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
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: 3,933 persons served; increased access for under-served populations
Committed Resources: Eligibility Consultant Inc., contract; $1,549,428 net community benefit

Program: Faith Community Health
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
Faith Community Health (FCH) is a branch of Faith In Action Initiatives in the Office of Mission and Ministries of Baylor Scott & White Health (BSWH). FCH helps high-risk patients through the provision of resources and support, encourages congregational wellness through programs and screenings, and community engagement through resource navigation.
Impact: 285 persons served; improves health by combining the caring strengths of faith communities and the clinical expertise of trained Faith Community volunteers
Committed Resources: Staff time; clinical experts; volunteers; $150 net community benefit

Program: Fetal and Infant Mortality Review Program
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The National Fetal and Infant Mortality Review (NFIMR) is a collaborative effort between the American College of Obstetricians and Gynecologists and the federal Maternal and Child Health Bureau. NFIMR serves as a national resource center for state and local fetal and infant mortality. Tarrant County Fetal Infant Mortality Review (TCFIMR) developed in 2007, uses the NFIMR model. The infant mortality rate in Tarrant County has been increasing since 2000 and is currently at 7.6 deaths per 1,000 live births (year 2006), which is higher that state and national rates, and much higher than the national Healthy People 2010 goal of 4.5 per 1,000. Service on various boards in the community, which helps to serve the Tarrant County area.
Impact: 52 persons served; increased awareness of behaviors constituting health risks

Committed Resources: staff time; $218 net community benefit

Program: Financial Assistance
Entity Name: Baylor Surgical Hospital at Fort Worth
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: 200 person served
Committed Resources: net benefit $835,329.92

Program: Translation Services
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
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: unknown number of persons served; Improve systems for personal and public health
Committed Resources: contract services; $132,390 net community benefit

Identified Need Addressed: Chronic Disease

Program: Community Education and Outreach
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
Community education activities provided at the hospital and in the community improve community health, and extend the reach of the hospitals beyond patient care activities. These services do not generate patient care bills and include such activities as community health education; community based clinical health services and screenings for under insured and uninsured persons, support groups, and self-help programs.
Impact: 25,508 persons served; enhanced chronic disease prevention/disease management
Committed Resources: staffing; supplies; clinical experts; $2,492 net community benefit

Program: Community Education and Outreach - Diabetes
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
Diabetes education is the cornerstone of diabetes management, because diabetes requires day-to-day knowledge of nutrition, exercise, monitoring, and medication. Diabetes is unlike other diseases, such as cholesterol and hypertension, where medication alone is often successfully treated. There are many components to diabetes, such as the diabetes disease process, nutritional management, physical activity, medications, glucose monitoring, and psycho-social adjustment. Diabetes education increases awareness of diabetes, what is required for its treatment, and enhances the power to control it. Diabetes education

enhances incorporation of positive lifestyle changes.
Impact: 359 persons served**;** enhanced chronic disease prevention/disease management
Committed Resources: staffing; supplies; clinical experts; $394 net community benefit

Program: Community Education and Outreach - Oncology
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The Hospital participates in community education programs to provide information about the importance of maintaining a healthy lifestyle in an effort to increase awareness about the risk of cancer. The Hospital provides information to increase awareness about the risk of cancer. A blog published by the American Cancer Society stated the importance of cancer education citing that those with a higher educational level had fewer total cancer deaths and deaths from lung and colorectal cancer than those with a lower educational level. Those comparisons showed greater differences than comparing similar educational levels on a racial basis (for example, white men with 8 or less years of education compared to black men with less than 8 years of education). For these circumstances, education trumped race when it came to impact of risk of dying.
Impact: 3,668 persons served; enhanced chronic disease prevention/disease management
Committed Resources: staffing/supplies; clinical expert; $5,787 net community benefit

Program: Community Education and Outreach - Transplant
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
Community health education at the Hospital and in the community improve community health and extend beyond patient care activities. These services do not generate patient care bills and include such activities as community health education; community based clinical health services and screenings for under insured and uninsured persons, support groups, and self-help programs.
Impact: 1,955 persons served; enhanced chronic disease prevention/disease management
Committed Resources: staffing/supplies; clinical expert; $2,083 net community benefit

Program: Community Health Education - Breast Cancer
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The Hospital participates in community health education to promote the importance of breast cancer screenings, avoiding risk factors, and the need for education, especially among minorities. Breast Cancer is the most prevalent cancer among American women. On average, every woman has a one in eight (12%) chance of developing breast cancer at some time in her life. According to the American Cancer Society, there will be an estimated 240,000 new cases of breast cancer diagnosed in the United States in 2007. About 180,000 of these will be invasive breast cancer.
Impact: 9,173 persons served; enhanced chronic disease prevention/disease management
Committed Resources: staffing/supplies; clinical expert; $6,451 net community benefit

Program: Community Health Education - Heart Disease
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The Hospital participates in community health education by providing blood pressure screenings to improve cardiovascular health and quality of life through prevention, detection and treatment of risk

factors. The focus of this education is on hypertension and cholesterol in men and women and minority groups at high risk for disease development.
Impact: 1,550 persons served; enhanced chronic disease prevention/disease management
Committed Resources: staffing/supplies; clinical expert; $384 net community benefit

Program: Donations -Financial
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
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/programs 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.
Impact: 8,750 persons served; improve extension access to healthcare through donations of supplies and services to not-for-profit community social services provision agencies with missions similar to BSWH
Committed Resources: staff time; $164,366 net community benefit

Program: Donations- In Kind/Faith in Action Initiatives
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The Hospital donates retired medical supplies and equipment to the office of Faith in Action Initiatives 2nd Life program to provide for the health care needs of populations in the community and nation whose needs not met through their own organization.
Impact: unknown # persons served; increase infrastructure of healthcare access
Committed Resources: staff; physical home for warehousing donations; volunteer development; $442 net community benefit

Program: DSRIP Diabetes Bundle
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
Develop and implement chronic disease management interventions that are geared toward improving management of diabetes and comorbidities, improving health outcomes and quality of life, preventing disease complications, and reducing unnecessary acute and emergency care utilization
Impact: 362 persons served; enhanced chronic disease prevention/disease management
Committed Resources: staffing/supplies; clinical expert

Program: DSRIP Hepatitis Bundle
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
Implement screening program in high-risk populations to detect and treat Hepatitis C infections.
Impact: 362 persons served; enhanced chronic disease prevention/disease management
Committed Resources: staffing/supplies; clinical expert

Program: For Women For Life
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
Regular health exams and tests can help find problems before they start. They also can help find problems early, when the chances for treatment and cure are better. Through For Women For Life, the Hospital provides health services, screenings, and treatments, assisting women in taking steps that help their chances for living a longer, healthier life. This annual event for women focusing on proactive health care including preventive health screenings, seminars and healthy lifestyle information.
Impact: 8,976 persons served; enhanced chronic disease prevention/disease management
Committed Resources: staffing/supplies; clinical expert; $19,507 net community benefit

Program: Research
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description
The Hospital provides financial support for Baylor Research Institute (BRI) operating expenses and capital purchases. In addition to microscopic studies – BRI brings the research to the patient's bedside. BRI helps to improves the understanding of the basis of a disease, to identify potential
Impact: improves the understanding of the basis of a disease, to identify potential treatments or preventive therapies, and to enroll patients in research trials
Committed Resources: research staff; $682,409 net community benefit

Identified Need Addressed: Dentists to Population Ratio

Program: Health Screenings - Dental
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The hospital created partnerships with Cook's Children's' Medical Center and Tarrant County College Dental Hygiene Program and providers to screen economically challenged populations within the community. Various health screenings include: • General dental cleanings and check ups • Identification of further dental care such as fillings and or oral surgery as needed • Oral disease screenings for teeth and gum health
Impact: 36 persons served; increased access to dental care
Committed Resources: staff time; Dentist

Identified Need Addressed: Health and Wellness Promotion

Program: Community Education and Outreach - Fall Prevention
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
Fall-related injuries among older adults, especially among older women, are associated with substantial economic costs. As the number of older adults increases dramatically over the next few decades, so will economic burden of falls. Falls are preventable. Today, there are effective fall prevention interventions useful in community settings.
Impact: 749 persons served; reducing falls and helping older adults live better, longer lives.
Committed Resources: staffing/supplies; clinical expert; $1,333 net community benefit

Program: Community Education and Outreach - Pain Management
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The Hospital provides education and supportive pain management programs for predominantly poor and medically under-served. These programs aim to prevent re-admission and escalations of pain associated with their ailment due to mismanaged medications. The importance of pre-surgery patient communication is paramount and is not only a means of educating the patient but is also a method for preserving a patient's well-being after a surgical procedure.
Impact: 179 persons served; optimal patient communication can improve health outcomes in various ways including symptom resolution, emotional healing and recovery, and pain control
Committed Resources: staffing/supplies; clinical expert; $160 net community benefit

Program: Community Education and Outreach - Sleep Apnea
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The Hospital provides information to predominantly poor and medically under-served in an effort to improve their quality of life and prevent escalation of additional health issues resulting from sleep apnea. Obstructive sleep apnea is a sleep disorder in which interrupted breathing occurs during sleep. Sleep apnea, can cause fragmented sleep and low blood oxygen levels. For people with sleep apnea, the combination of disturbed sleep and oxygen starvation may lead to
Impact: 179 person served; reduced hypertension, heart disease and mood and memory problems. Sleep apnea also increases the risk of drowsy driving.
Committed Resources: staffing/supplies; clinical expert; $179 net community benefit

Program: Community Education and Outreach - Smoking Cessation
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The Hospital provides community health education to encourage smoking cessation. This information aids in improving quality of life in the community as well as aiding in preventing smoking related illness. Smoking cessation counselling is widely recognized as an effective clinical practice. Even a brief intervention by a health professional significantly increases the cessation rate. A smoker's likelihood of quitting increases when he or she hears the message from a number of health care providers from a variety of disciplines. Health professionals are perhaps the most credible source of health information.
Impact: 279 persons served; increased awareness of the importance of adopting a healthy lifestyle; increased awareness of behaviors constituting health risks
Committed Resources: staffing/supplies; clinical expert; $357 net community benefit

Program: Community Health Education - Aramark/Nutrition
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
Aramark provides a means to healthy living, disease prevention and disease management through nutrition education. The education program includes: analysis of food nutrition labels; research referencing the benefits of nutrients, minerals and vitamins; food guide research; developing healthy eating habits via production of grocery lists, menu preparation, budgeting for food and creating a balanced diet; brainstorming about nutrition and making healthy choices with food consumption in relation to physical need and body requirements. The program emphasizes the results of long-term nutritional decisions; and measuring body fat and muscle density and providing appropriate nutrition education for

optimal health status achievement.
Impact: 3,182 persons served; positively influence states of physical wellness, recovery from illness, disease prevention and chronic disease management through nutrition education.
Committed Resources: staffing/supplies; clinical expert; $6,892 net community benefit

Program: Health Screenings - Blood Pressure
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The Hospital provides blood pressure screenings to improve cardiovascular health and quality of life through prevention, detection and treatment of risk factors through focusing particularly on hypertension and cholesterol in men and women and minority groups at high risk for disease development. The key to preventing cardiovascular disease, also called coronary artery disease (CAD), is managing risk factors such as high blood pressure, high total cholesterol or high blood glucose. Regular cardiovascular screening is important because it helps detect risk factors in their earliest stages and identify lifestyle changes and pharmacotherapies, if appropriate, before it ultimately leads to the development of cardiovascular disease.
Impact: 11,338 persons served; enhanced chronic disease prevention/disease management
Committed Resources: staffing/supplies; clinical expert; $12,235 net community benefit

Program: Health Screenings - Cholesterol
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The Hospital provides cholesterol screenings to help reduce the risk of heart related disease due to high cholesterol levels, and improve the quality of life for all persons who have or are at risk for the disease. Cholesterol buildup as plaque can prevent enough blood from flowing to the heart muscle. It is the most common cause of coronary heart disease, and happens so slowly that individuals may not be aware of it. This plaque can rupture, forming a blood clot that leads to a heart attack or stroke. The higher your LDL cholesterol, the greater the chance of heart attack or stroke. This is why cholesterol screening is so important. Cholesterol can build up for many years before any symptoms develop. Individuals may feel healthy and not realize they could be at risk for high cholesterol.
Impact: 24,390 persons served; enhanced chronic disease prevention/disease management
Committed Resources: staffing/supplies; clinical expert; $32,062 net community benefit

Program: Health Screenings - Multiple Diseases
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
Similar to national trends, residents in the Hospitals' service area exhibit increasing diagnoses of chronic conditions. It is common that the pathology for one condition may also affect other body systems, resulting in co-occurrence or multiple chronic conditions (MCC). The presence of MCC's adds a layer of complexity to disease management. The Hospital conducts screenings for MCC's including body fat analysis, BMI, and injury prevention.
Impact: 283 persons served; enhanced chronic disease prevention/disease management
Committed Resources: staffing/supplies; clinical expert; $428 net community benefit

Program: Health Screenings - Oncology

Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The Hospital participates in community health screenings to aid in reducing the number of un-diagnosed cancer cases, as well as illness, disability, and death caused by cancer. Screening tests can help find cancer at an early stage, before symptoms appear.
Impact: 519 persons served; enhanced chronic disease prevention/disease management
Committed Resources: staffing/supplies; clinical expert; $1,413 net community benefit

Program: It's A Guy Thing
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
Regular health exams and tests can help find problems before they start. They also can help find problems early, when the chances for treatment and cure are better. Through For It's A Guy Thing, the Hospital provides health services, screenings, and treatments, assisting men in taking steps that help their chances for living a longer, healthier life. This annual event for men focusing on proactive health care including preventive health screenings, seminars and healthy lifestyle information.
Impact: 1,615 persons served; enhanced chronic disease prevention/disease management
Committed Resources: staffing/supplies; clinical expert; $3,380 net community benefit

Identified Need Addressed: Mental / MD and Non-MD Primary Care Providers to Population

Program: DSRIP Primary Care Expansion
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The Baylor Clinic at the Hospital expands current capacity by opening patient panels to non-Baylor patients and fully utilizes the space and providers' capacity. Additional support staff hired to coordinate patient care, ensure transition from the hospital to a Baylor Clinic helps to facilitate the care of complex under-served patients. Additionally, the clinic provides high quality primary care services to a greater number of people. Essentially, through expanding the capacity of the current clinic, adding additional support staff and services, a patient can receive comprehensive and complete services in one primary care location. In addition to receiving primary care, this project also proposes that ancillary services such as labs, imaging (i.e.: CT scans, MRI, mammograms, ultrasound, echocardiograms, and interventional radiology) and diagnostics (i.e.: colonoscopy, stress tests, esophageal diagnostic, retinal screens) would also be provided upon physician request. This project aims to close the loop of care and increase patient compliance by co-locating/coordinating many of the essential services that the under-served population often has issues accessing or completing.
Impact: 11,188 person served; comprehensive and complete services delivered in one location; increased patient compliance
Committed Resources: PCMH and PCP

Program: Medical Education - Allied Health Services
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The Hospital provides professional education services for students preparing for health professions at a variety of schools both intermediate and advanced levels.
Impact: 39 persons served; alleviate the shortage of medical professionals
Committed Resources: Nurse educators; Supervisory staff; $428,797 net community benefit;

Program: Medical Education - Nursing Students
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The hospital is committed to assisting with the preparation of future nurses at entry and advanced levels of the profession to establish a workforce of qualified nurses thereby affecting the documented shortage of non-primary care nurses and health care providers. Through the System's relationships with many North Texas schools of nursing, the hospital maintains strong affiliations with schools of nursing. Like physicians, nursing graduates 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: 1,129 nurses educated; increased quality and size of nursing work force in the North Texas area
Committed Resources: Nurse educators; Supervisory staff; $ 2,166,198 net community benefit;

Program Workforce Development
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
Workforce Development - The hospital will recruit physicians and other health professionals for areas identified as medically under-served. The Hospital seeks to allay the physician shortage, thereby better managing the growing health needs of the community.
Impact: # served unknown; increased access to primary care health providers
Committed Resources: cost of support for new physician start up; 104,449 net community benefit

Identified Need Addressed: Preventable Admits: Mental/ Behavioral Health

Program: Child Life Specialists Services
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
Palliative Care Child Life Program helps children "navigate" the illness of someone they love. Serious illnesses not only drastically affect patients but also affect the children in their lives. As the largest program of its kind in the nation, our Palliative Care Child Life Program is a pioneer in helping kids navigate a loved one's illness. When patients experience a serious or life-limiting illness or injury, the effects reach far beyond just their physical health. For those who have children, grandchildren or another close child in their lives, it can be difficult for those children to understand and navigate the situation.
Impact: 645 persons served; improved grief management; reduced length of stay
Committed Resources: palliative care department; $133,575 net community benefit

Program: Community Education and Outreach - Behavioral Health
Entity: Baylor Scott & White All Saints Medical Center – Fort Worth
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. All but one county in the region served by the Hospital is a recognized health professions shortage areas or mental health providers.
Impact: 279 person served; enhanced chronic disease prevention/disease management
Committed Resources: staffing/supplies; clinical expert; $348 net community benefit

Program: DSRIP Mental/ Behavioral Health Clinics
Entity Name: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
This project co-locates and integrates behavioral health services into the outpatient primary care letting. The screening tools used are evidence based and include PHQ2 or 9, GAD-7 and alcohol and substance abuse screens. This staff when triaged to clinics and community locations provides behavioral health services.
Impact: 1,087 person served; increased behavioral health services for underserved and underinsured populations
Committed Resources: Licensed Clinical Social Worker (LCSW); Community Health Worker (CHW)

Program: Health Screenings - Behavioral Health
Entity Name: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
The Hospital conducts screening assessments to alert the community to depression and how individuals at increased risk for depression, considered at risk throughout their lifetime. Groups at increased risk include persons with other psychiatric disorders, including substance misuse; persons with a family history of depression; persons with chronic medical diseases; and persons who are unemployed or of lower socioeconomic status. Women are at increased risk compared with men. Significant depressive symptoms are associated with common life events in older adults, including medical illness, cognitive decline, bereavement, and institutional placement in residential or inpatient settings.
Impact: 541 persons served; increased behavioral health services for underserved and underinsured populations
Committed Resources: Cost of clinical social workers, community health workers and other related cost

Program: Mission and Ministry Support Groups/Services
Entity Name: Baylor Scott & White All Saints Medical Center – Fort Worth
Description:
Baylor Chaplains are Committed to providing effective ministry to people and their families who receive medical care at a Baylor hospital. Pastoral care may work in close collaboration with physicians, nursing staff, administrative staff, local clergy and others involved in a patient's care.
Impact: 20 person served: decreased anxiety and better recovery
Committed Resources: staff

Needs Not Addressed:

- Dentist to Population Ratio

The identified need not addressed in the Community Benefit Implementation report was addressed through multiple other community and state agencies whose expertise and infrastructure are better suited for addressing these needs.