



Community Health Needs Assessment

Dallas Metropolitan Health Community
2022

Dallas Metropolitan health community hospitals

- Baylor Scott & White Institute for Rehabilitation – Dallas
- Baylor Scott & White Heart & Vascular Hospital – Dallas
- Baylor Scott & White Medical Center – Uptown
- Baylor University Medical Center
- North Central Surgical Center
- Baylor Scott & White Medical Center – Sunnyvale

Approved by: Baylor Scott & White Health – North Texas Operating, Policy and Procedure Board on May 31, 2022
Posted to [BSWHealth.com/CommunityNeeds](https://www.bswhealth.com/CommunityNeeds) on June 30, 2022

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Baylor Scott & White Health mission

Our commitment to the communities we serve

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 51 hospitals, 1,100 access points, more than 7,300 active physicians, and over 49,000 employees and the Baylor Scott & White Health Plan.

Baylor Scott & White Health is a leading Texas healthcare provider with a proven commitment to patient and community health. Baylor Scott & White Health demonstrates this commitment through periodic community health needs assessments, then addresses those needs with a wide range of outreach initiatives.

These Community Health Needs Assessment (CHNA) activities also satisfy federal and state community benefit requirements outlined in the Patient Protection and Affordable Care Act and the Texas Health and Safety Code.

Baylor Scott & White Health conducts a thorough periodic examination of public health indicators and a benchmark analysis comparing communities it serves to an overall state of Texas value. In this way, it can determine where deficiencies lie and the opportunities for improvement are greatest.

Through interviews, focus groups and surveys, the organization gains a clearer understanding of community needs from the perspective of the members of each community. This helps it identify the most pressing needs a community is facing and develop implementation plans to focus on those prioritized needs.

The process includes input from a wide range of knowledgeable people who represent the myriad interests of the community in compliance with 501 (r)(3) regulations. The CHNA process overview can be found in **Appendix A**.

The CHNAs serve as the foundation for community health improvement planning efforts over the next three years, while the implementation plans will be evaluated annually.

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

MISSION

We serve faithfully

We act honestly

We never settle

We are in it together

VALUES

STRATEGIES

**Health
Experience
Affordability
Alignment
Growth**

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

AMBITION

Community Health Needs Assessment (CHNA) report

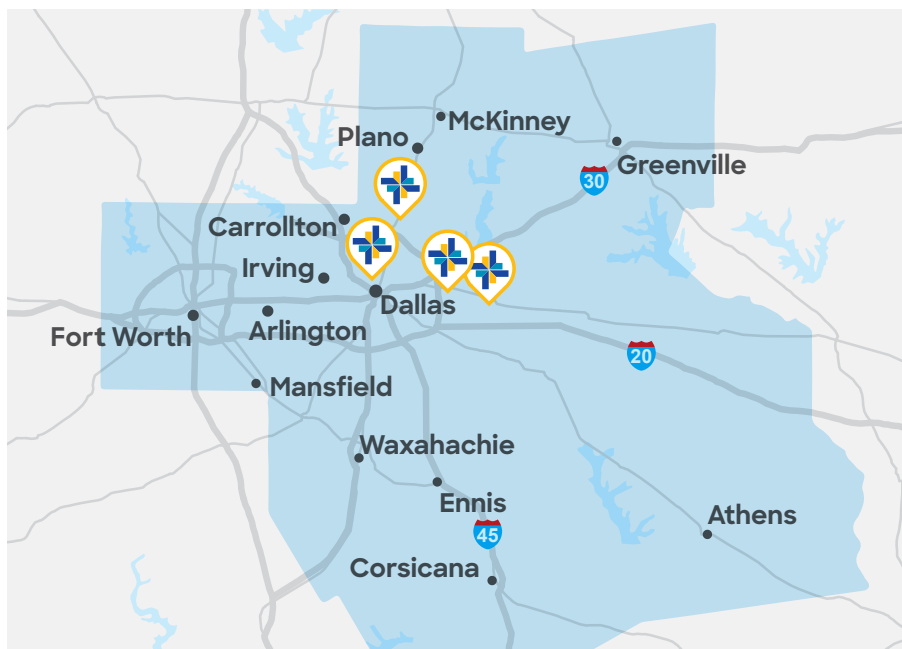
Baylor Scott & White Health (BSWH) owns and operates numerous individually licensed hospital facilities serving the residents of North and Central Texas.

The Dallas Metropolitan Health Community is home to a number of these hospitals with overlapping communities, including:

- Baylor Scott & White Institute for Rehabilitation – Dallas
- Baylor Scott & White Heart & Vascular Hospital – Dallas
- Baylor Scott & White Medical Center – Uptown
- Baylor University Medical Center
- North Central Surgical Center
- Baylor Scott & White Medical Center – Sunnyvale

The community served by the hospital facilities listed above is Collin, Dallas, Ellis, Henderson, Hunt, Kaufman, Navarro, Rockwall, Tarrant and Van Zandt Counties. The community served was based on the contiguous ZIP codes within the associated counties that made up nearly 80% of the hospital facilities' inpatient admissions over the 12-month period of FY20. Those facilities with overlapping counties of patient origin collaborated to provide a joint CHNA report in accordance with the Internal Revenue Code Section 501 (r) (3) and the US Treasury regulations thereunder. All of the collaborating hospital facilities included in a joint CHNA report define their communities to be the same for the purposes of the CHNA report.

Dallas Metropolitan Health Community map



BSWH engaged with IBM Watson Health, a nationally respected consulting firm, to conduct a Community Health Needs Assessment (CHNA) in accordance with the federal and state community benefit requirements for the health communities they serve.



The CHNA process included:

- Gathering and analyzing more than 59 public and 45 proprietary health data indicators to provide a comprehensive assessment of the health status of the communities. The complete list of health data indicators is included in **Appendix B**.
- Creating a benchmark analysis comparing the community to overall state of Texas and United States (US) values.
- Conducting focus groups, key informant interviews and stakeholder surveys, including input from public health experts, to gain direct input from the community for a qualitative analysis.
 - Gathering input from state, local and/or regional public health department members who have the pulse of the community's health.
 - Identifying and considering input from individuals or organizations serving and/or representing the interests of medically underserved low-income and minority populations in the community to help prioritize the community's health needs.
 - The represented organizations that participated are included in **Appendix C**.

IBM Watson Health provided current and forecasted demographic, socioeconomic and utilization estimates for the community.

Demographic and socioeconomic summary

The most important demographic and socioeconomic findings for the Dallas Metropolitan Health Community CHNA are:

- The community is growing at a rate higher than both the state of Texas and the US.
- The average age of the population is younger than the US and slightly older than Texas overall.
- The median household income is significantly higher than both the state and the US.
- The community served has a lower percentage of uninsured and underinsured than the state of Texas.

Further demographic and socioeconomic information for the Dallas Metropolitan Health Community is included in **Appendix D**.

Health community data summary

IBM Watson Health's utilization estimates and forecasts indicate the following for the Dallas Metropolitan Health Community:

- Inpatient discharges in the community are expected to grow by almost 9% by 2030 with the largest growing product lines to include:
 - Pulmonary medical
 - General medicine
 - Cardiovascular diseases
- Outpatient procedures are expected to increase by 34% by 2030 with the largest areas of growth including:
 - Labs
 - General & internal medicine
 - Physical & occupational therapy
 - Psychiatry
- Emergency department visits are expected to grow by over 13% by 2025.
- Hypertension represents almost 73% of all heart disease cases.
- Cancer incidence is expected to increase by over 11% by 2025.

Further health community information for the Dallas Metropolitan Health Community is included in **Appendix E**.

The community includes the following health professional shortage areas and medically underserved areas as designated by the US Department of Health and Human Services Health Resources Services Administration. **Appendix D** includes the details on each of these designations.

County	Health professional shortage areas (HPSA)				Medically underserved area/ population (MUA/P)
	Dental health	Mental health	Primary care	Grand total	
Collin		1		1	
Dallas	7	14	9	30	10
Ellis	1	1	1	3	1
Henderson		1	1	2	
Hunt	1	2	2	5	1
Kaufman	na	na	na	na	na
Navarro		1	1	2	
Rockwall	na	na	na	na	na
Tarrant	3	4	3	10	3
Van Zandt		1	1	2	1

Source: US Department of Health and Human Services, Health Resources and Services Administration, 2021

Total population

6,555,451

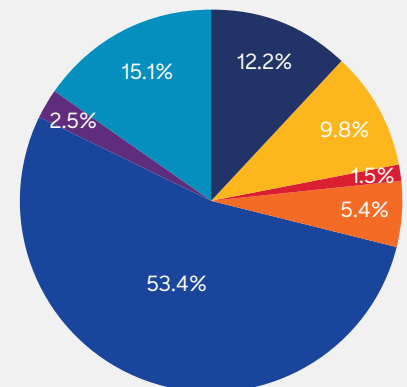
Average income

\$75,314

Underserved ZIP codes

64

Insurance coverage



- Medicaid - pre-reform
- Medicare
- Medicare dual eligible
- Private - direct
- Private - ESI
- Private - exchange
- Uninsured

Priority health needs

Using the data collection and interpretation methods outlined in this report, BSWH has identified what it considers to be the community's significant health needs. The resulting prioritized health needs for this community are:

Priority	Need	Category of need
1	Obesity/physical inactivity	Conditions/diseases
2	Diabetes	Conditions/diseases
3	Access to primary healthcare	Access to care
4	Gaps in behavioral health/ substance abuse services	Health behaviors/mental health conditions/diseases
5	Access to mental healthcare (providers/services)	Access to care/mental health
6	Food insecurity/access to healthy food	Environment
7	Infant mortality rate	Injury and death
8	Transportation	Environment

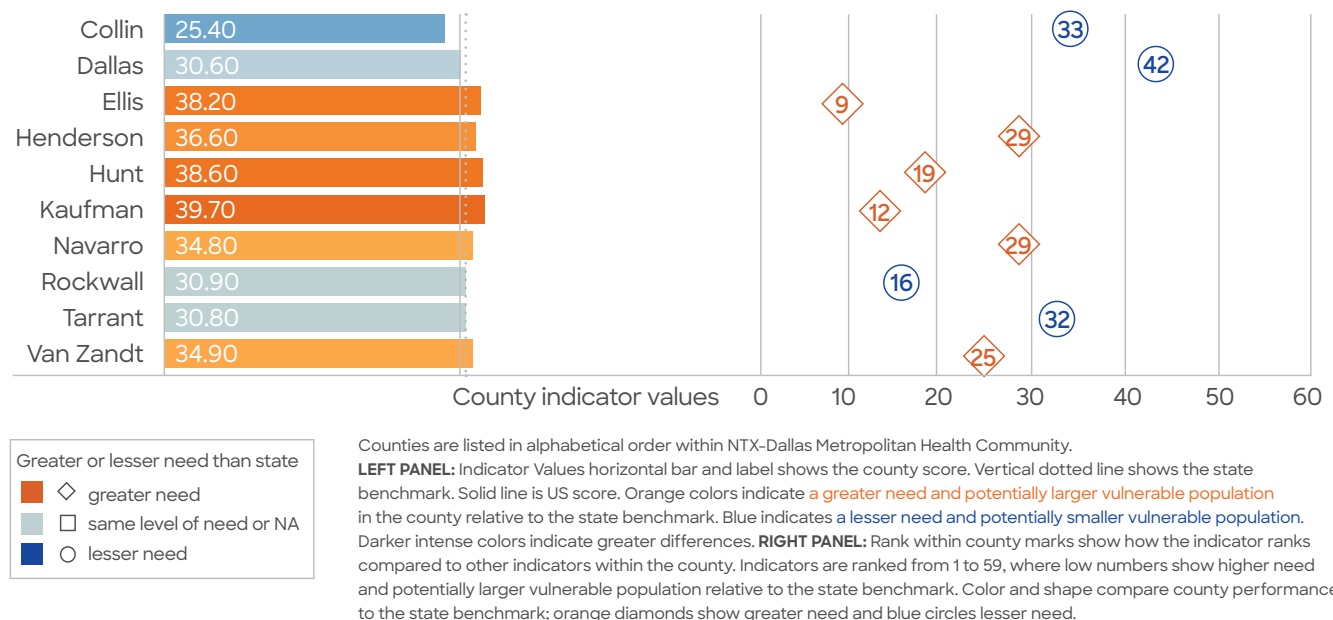
Priority 1: Obesity/Physical Inactivity

The following data indicates greater need in the area of **adult obesity**.

Category	Data shows greater need	Key informants indicate less need or not mentioned
Conditions/ diseases	<ul style="list-style-type: none"> Adult obesity 	<ul style="list-style-type: none"> Not specifically mentioned

The **adult obesity** indicator is defined as **the percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m²** and is based on data from County Health Rankings & Roadmaps, CDC Diabetes Interactive Atlas and The National Diabetes Surveillance System.

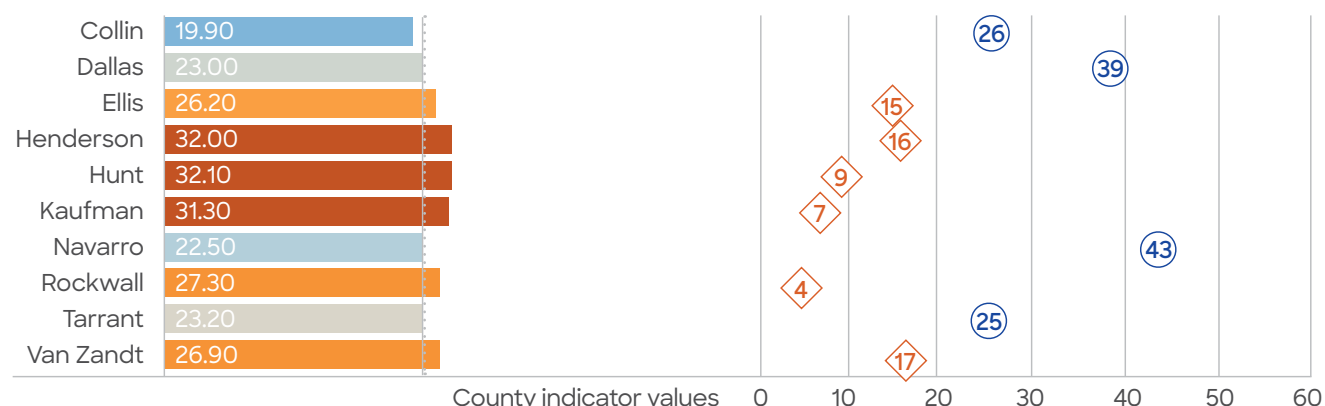
Adult obesity (% of adults with BMI =>30 by county)



The following data indicates greater need in the area of **physical inactivity**.

Category	Data shows greater need	Key informants indicate greater need
Health behaviors	<ul style="list-style-type: none"> Physical inactivity 	<ul style="list-style-type: none"> No sidewalks for outdoor walking Lack of awareness of access to outdoor public parks or events happening

Physical inactivity (% of adults reporting no leisure-time physical activity by county)



Greater or lesser need than state
◇ greater need
□ same level of need or NA
○ lesser need

Counties are listed in alphabetical order within NTX-Dallas Metropolitan Health Community.

LEFT PANEL: Indicator Values horizontal bar and label shows the county score. Vertical dotted line shows the state benchmark. Solid line is US score. Orange colors indicate a greater need and potentially larger vulnerable population in the county relative to the state benchmark. Blue indicates a lesser need and potentially smaller vulnerable population. Darker intense colors indicate greater differences. **RIGHT PANEL:** Rank within county marks show how the indicator ranks compared to other indicators within the county. Indicators are ranked from 1 to 59, where low numbers show higher need and potentially larger vulnerable population relative to the state benchmark. Color and shape compare county performance to the state benchmark; orange diamonds show greater need and blue circles lesser need.

While the focus group participants did not specifically discuss obesity, they noted that a lack of physical activity is due in part to the community having insufficient outdoor places for residents to exercise or walk. They added that there is an opportunity to expand community recreation sites for safe, active and accessible activities as the community grows.

In the prioritization session, hospital leadership agreed that obesity and physical inactivity are areas of concern and need to be prioritized as they lead to conditions such as congestive heart failure.

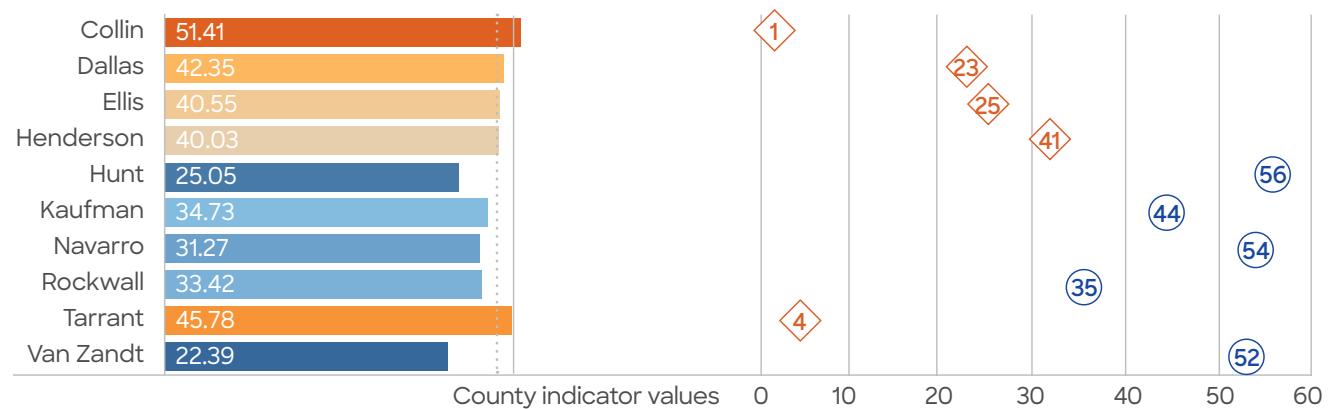
Priority 2: Diabetes

The following data indicates greater need in the area of **diabetes admission, diabetes diagnoses in adults and diabetes prevalence**.

Category	Data shows greater need	Key informants indicate less need or not mentioned
Conditions/ diseases	<ul style="list-style-type: none"> Diabetes admission Diabetes diagnoses in adults Diabetes prevalence 	<ul style="list-style-type: none"> Not specifically mentioned, diabetes only discussed as one of the health conditions concerning the community

The indicator **diabetes admission** is defined as the **number observed/adult population age 18 and older**. Note that risk-adjusted rates are not calculated for counties with fewer than five admissions. The indicator is based on data from Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations.

Diabetes admission (number observed/adult population by county)



Greater or lesser need than state	
Orange diamond	greater need
Grey square	same level of need or NA
Blue circle	lesser need

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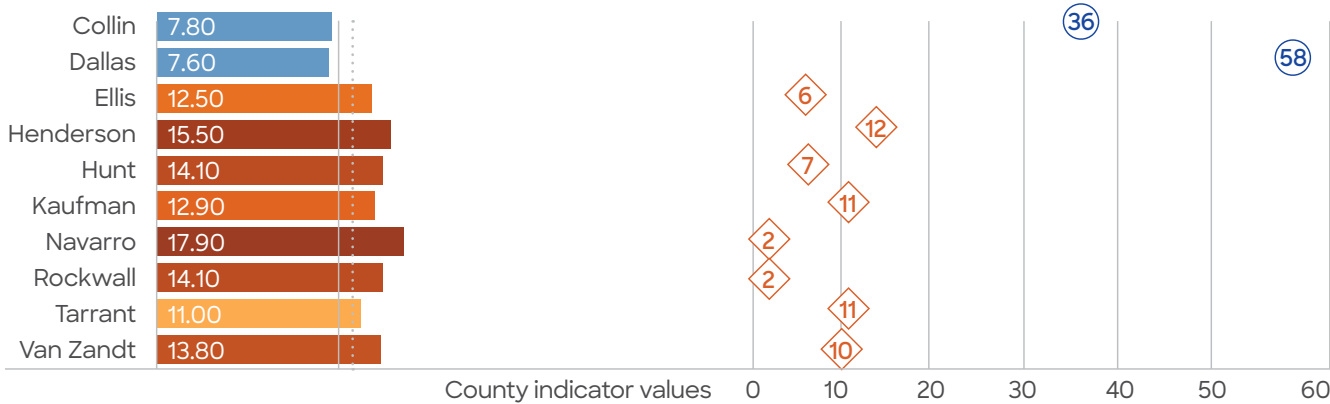
The indicator **diabetes diagnoses in adults** is defined as **the prevalence of diabetes across all Medicare beneficiaries**. The indicator is based on data from CMS.gov Chronic Conditions 2007–2018.

Diabetes diagnoses in adults (% of adults with diabetes diagnoses by county)



The indicator **diabetes prevalence** is defined as **prevalence of diagnosed diabetes in a given county**. Note that respondents were considered to have diagnosed diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes. The indicator is based on data from County Health Rankings (CDC Diabetes Interactive Atlas).

Diabetes prevalence (prevalence as % of diagnosed diabetes by county)



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The focus group participants cited that there is limited access to diabetes management medication due to the high cost of medications. They noted that diabetes was among the health conditions that are a cause of concern in the community.

In the prioritization session, the hospital leadership cited that diabetes and heart disease are health conditions that span across all income levels and races and demand attention to address in the community.

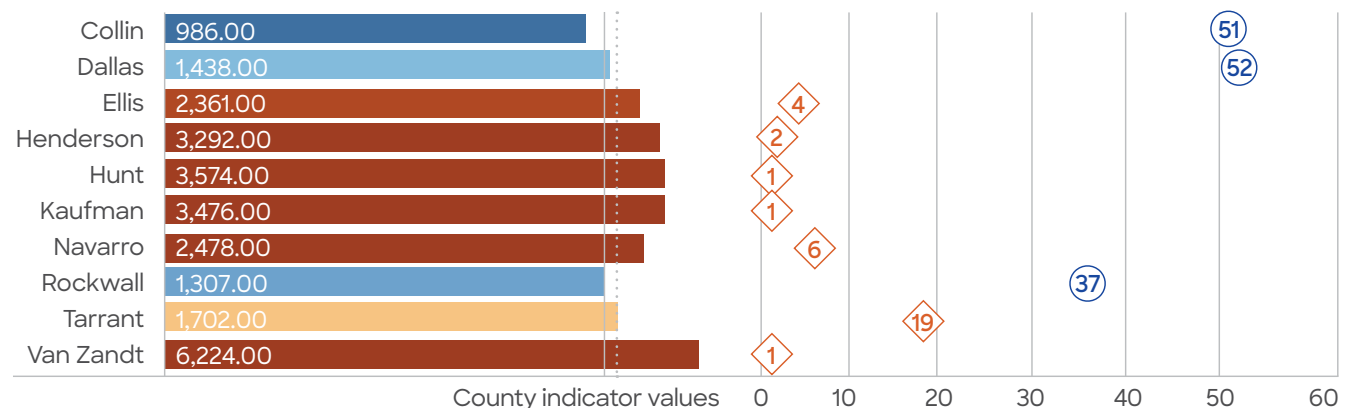
Priority 3: Access to Primary Healthcare

The following data indicates greater need for access for the population to one primary care provider and access for the population to one non-physician primary care provider.

Category	Data shows greater need	Key informants indicate greater need
Access to care	<ul style="list-style-type: none"> Population to one primary care physician Population to one non-physician primary care provider 	<ul style="list-style-type: none"> Limited access to primary care providers Limited access to social workers and care navigators

The **population to one primary care physician** indicator is defined as **the number of individuals served by one physician in a county if the population was equally distributed across physicians** and is based on data from County Health Rankings & Roadmaps and Area Health Resource File/American Medical Association.

Population to one primary care physician (number of individuals served by one physician by county)



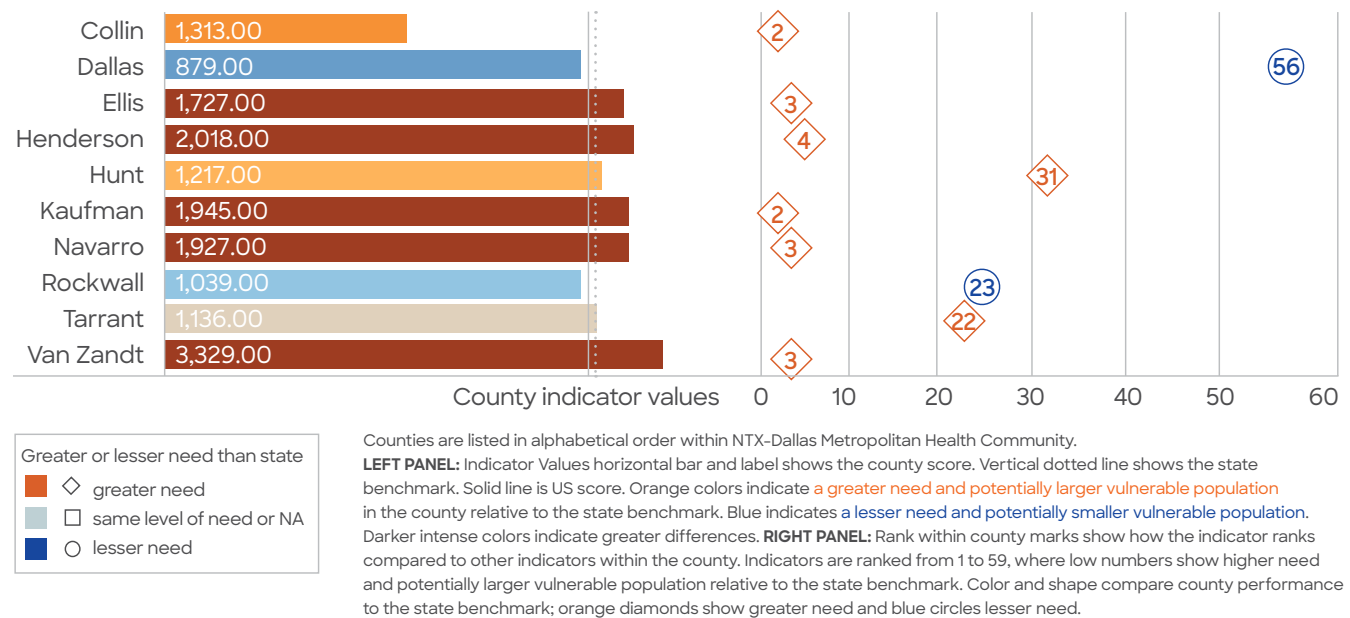
Greater or lesser need than state	
Orange diamond	greater need
Grey square	same level of need or NA
Blue circle	lesser need

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The data below indicates greater need for **access for the population to one non-physician primary care provider**. The indicator is defined as the **ratio of population to primary care providers other than physicians** and is based on data from County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES).

Population to one non-physician primary care provider (ratio of population to primary care providers other than physicians by county)



The focus group participants felt that the overall community area has limited access to primary care and a limited number of providers. Participants believed that the limited access is due to a combination of an insufficient number of providers as well as residents' inability to access care in parts of the community due to transportation, insurance or funding limitations.

In the prioritization session, the hospital leadership acknowledged that although great strides have been made to improve access to care, it is still a substantial need, particularly for the South Dallas community, which has been exacerbated by COVID.

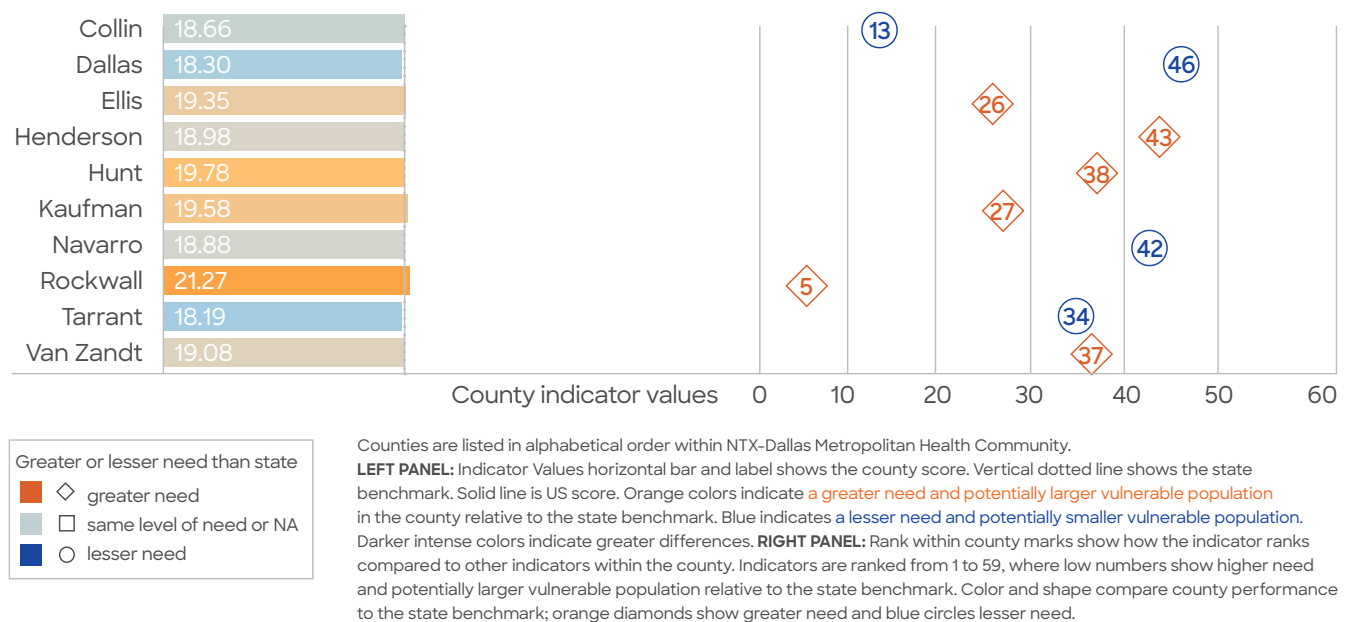
Priority 4: Gaps in Behavioral Health/Substance Abuse Services

The following data indicates greater need in the area of binge drinking and substance abuse/access to treatment.

Category	Data shows greater need	Key informants indicate greater need
Health behaviors	<ul style="list-style-type: none"> Binge drinking Drug poisoning deaths 	<ul style="list-style-type: none"> Negative life habits (smoking, drinking, etc.)
Mental health conditions/diseases	<ul style="list-style-type: none"> Mentally unhealthy days 	<ul style="list-style-type: none"> Gap in mental/behavioral health services and substance abuse services

The **binge drinking** indicator is defined as **the percentage of a county's adult population that reports binge or heavy drinking in the past 30 days** and is based on data from County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS).

Binge drinking (% of adults binge or heavy drinking in past 30 days by county)



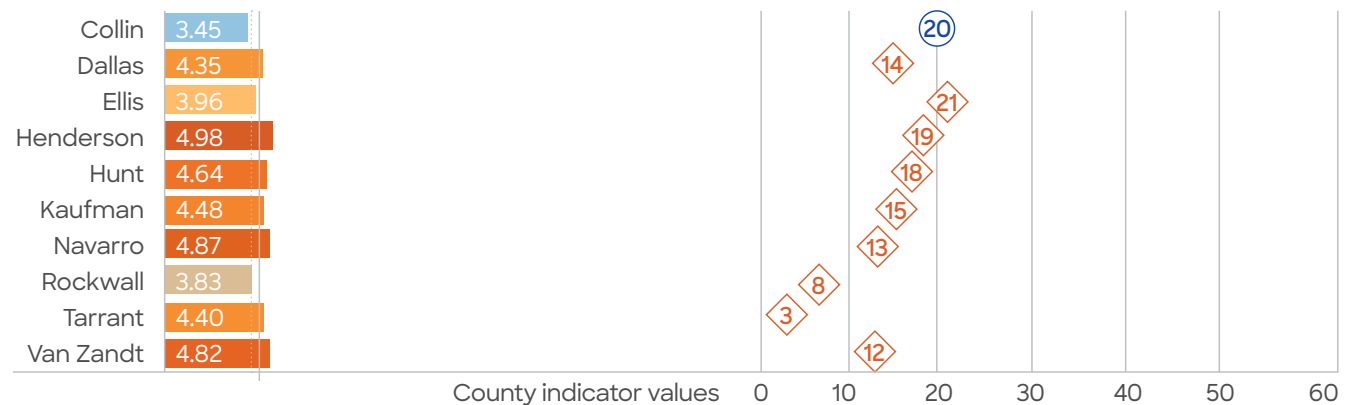
The **drug poisoning deaths** indicator is defined as **the number of drug poisoning deaths (drug overdose deaths) per 100,000 population**. Death rates are NULL when the rate is calculated with a numerator of 20 or less. The indicator is based on data from County Health Rankings & Roadmaps, CDC WONDER Mortality Data.

Drug poisoning deaths (number of drug poisoning deaths per 100,000 by county)



The **mentally unhealthy days** indicator is defined as **the average number of mentally unhealthy days reported in past 30 days (age-adjusted)** and is based on data from County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS).

Mentally unhealthy days (number of mentally unhealthy days reported in past 30 days by county)



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The focus group participants cited that COVID–19 increased the demand for mental health and substance abuse services and strained the already scarce resources. Isolation is contributing to substance abuse. Making matters worse, there is a stigma and resistance to substance abuse support.

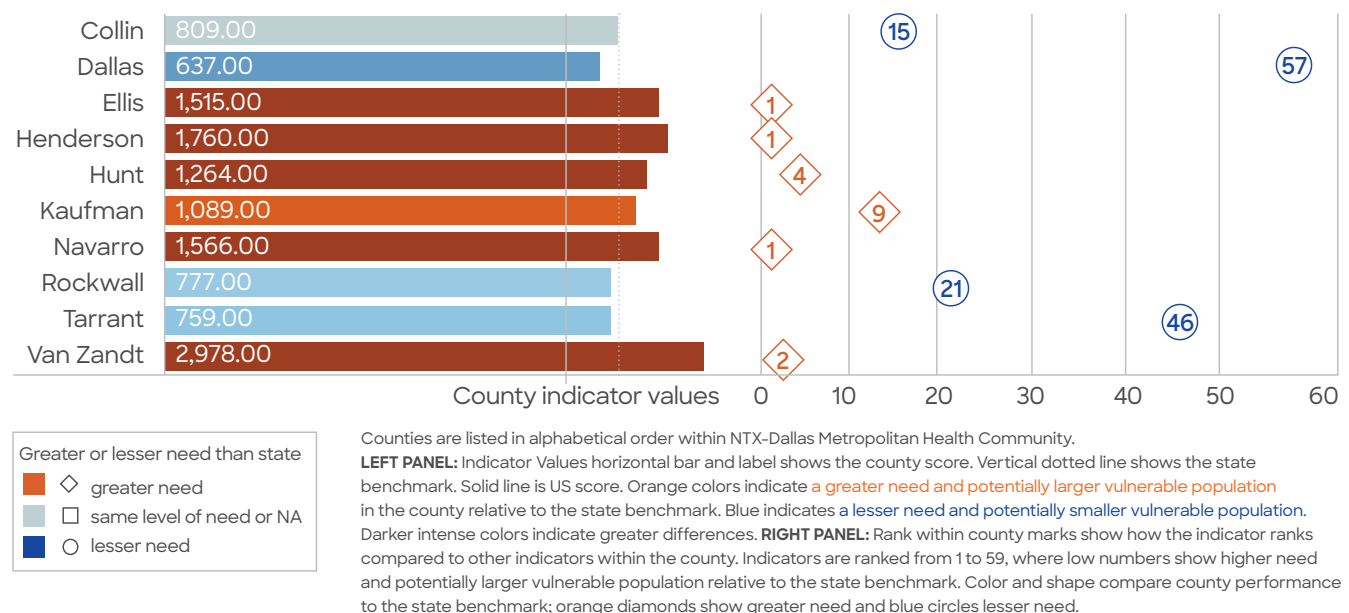
In the prioritization session, the hospital and community leaders were in agreement that the health community lacks access to mental health and substance abuse services. There is an insufficient number of providers, and the pandemic has made the problem even more acute. Emergency departments and hospitals are experiencing an increase in patients with mental and behavioral issues that are compounded with alcohol and drug use.

Priority 5: Access to Mental Healthcare (Providers/Resources)

The following data indicates greater need for **access for the population to one mental healthcare provider**. The indicator is defined as **the ratio of population to mental health providers** and is based on data from County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES).

Category	Data shows greater need	Key informants indicate greater need
Access to care/mental health	<ul style="list-style-type: none"> Population to one mental health provider 	<ul style="list-style-type: none"> Limited access to mental healthcare providers

Population to one mental health provider (ratio of population to mental health providers by county)



The focus group participants stated that needs are high for mental health, but there is limited access to providers. The demand for mental health services increased with COVID-19, and the group anticipates further growth and increased severity in future patients because they are underserved. In addition to not having enough mental health resources, some residents resist seeking care due to the stigma and small-town mentality around mental health issues.

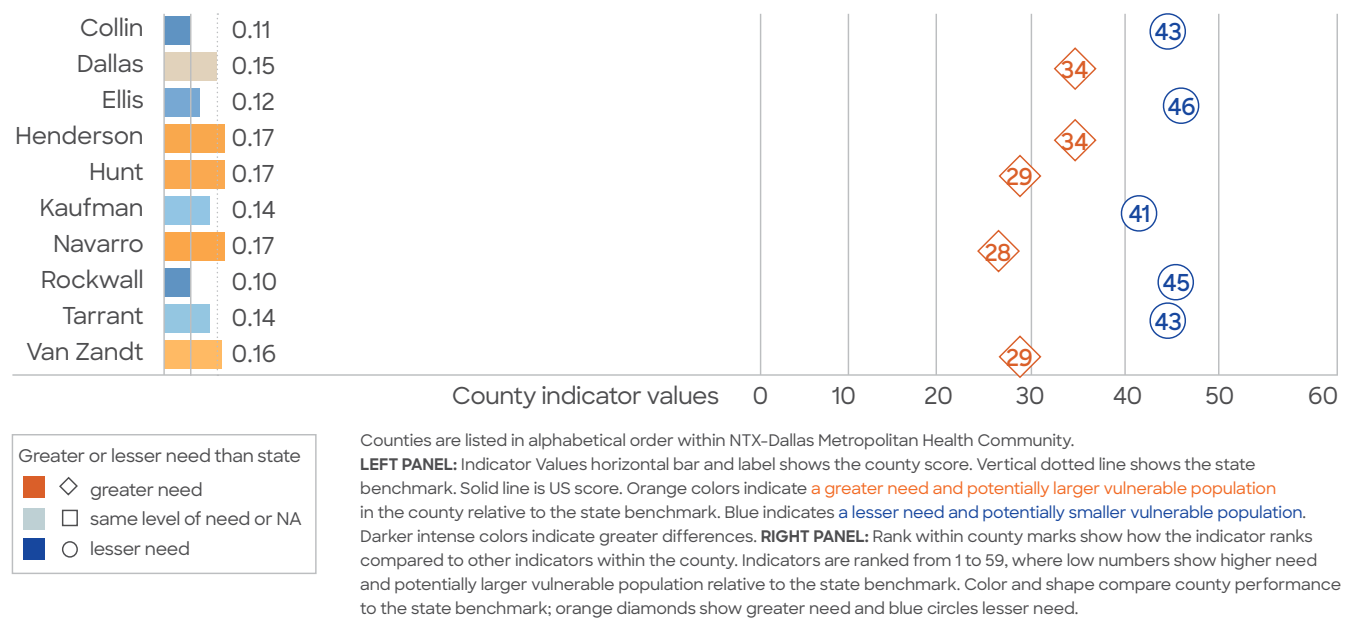
In the prioritization session, the hospital and community leaders were in agreement that the health community lacks access for mental health and substance abuse services. There are not enough psychiatrists and mid-level mental and behavioral health providers to keep up with the demand.

Priority 6: Food Insecurity/Access to Healthy Foods

Category	Data shows greater need	Key informants indicate greater need
Environment	<ul style="list-style-type: none"> Food insecure 	<ul style="list-style-type: none"> Food deserts

The **food insecure** measure is defined as **the percentage of population who lack adequate access to food during the past year**. The indicator is based on data from County Health Rankings & Roadmaps, Map the Meal Gap, Feeding America.

Food insecure (% who lack adequate access to food by county)

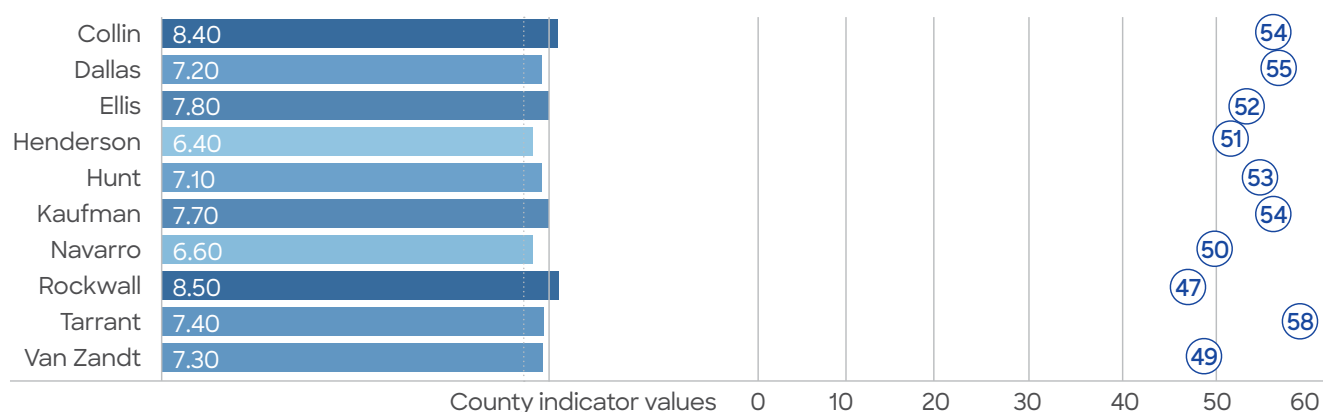


While the data did not indicate a need, the key informants cited a greater need in response to food deserts and the availability of fresh food or healthy food options.

Category	Data shows less need or no data	Key informants indicate greater need
Environment	<ul style="list-style-type: none"> Food environment index Limited access to healthy foods 	<ul style="list-style-type: none"> Food deserts No fresh food/no healthy foods options

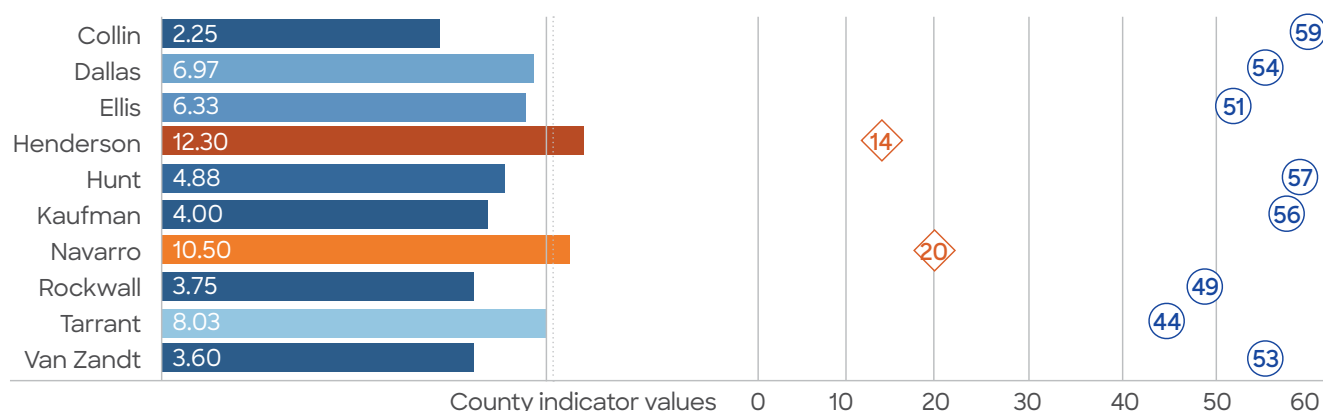
The **food environment index** measure is defined as **index of factors that contribute to a healthy food environment**. A value of zero “0” is worst and a value of ten “10” is best in the county. The indicator is based on data from County Health Rankings & Roadmaps, USDA Food Environment Atlas, Map the Meal Gap from Feeding America, United States Department of Agriculture (USDA).

Food environment index (index of factors that contribute to a health food environment by county, 0=worst – 10=best)



The indicator **limited access to healthy foods** is defined as **the percentage of population who are low-income and do not live close to a grocery store**. The indicator is based on data from County Health Rankings & Roadmaps; USDA Food Environment Atlas, United States Department of Agriculture (USDA).

Limited access to healthy foods (% population, low income and do not live close to grocery store by county)



Greater or lesser need than state
 ◊ greater need
 □ same level of need or NA
 ○ lesser need

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While the key informants acknowledged that COVID helped with food access in North Texas as more resources were made available, they expressed concern that once federal or state support comes to an end post-pandemic, there will be a negative impact on healthy food availability to residents. They added that there are food deserts in the community as well as limited fresh produce access in some areas.

In the prioritization session, the hospital and community leaders agreed that there are many food deserts in the community. They recognized that food insecurity and a lack of access to food, especially nutritious food, are huge problems.

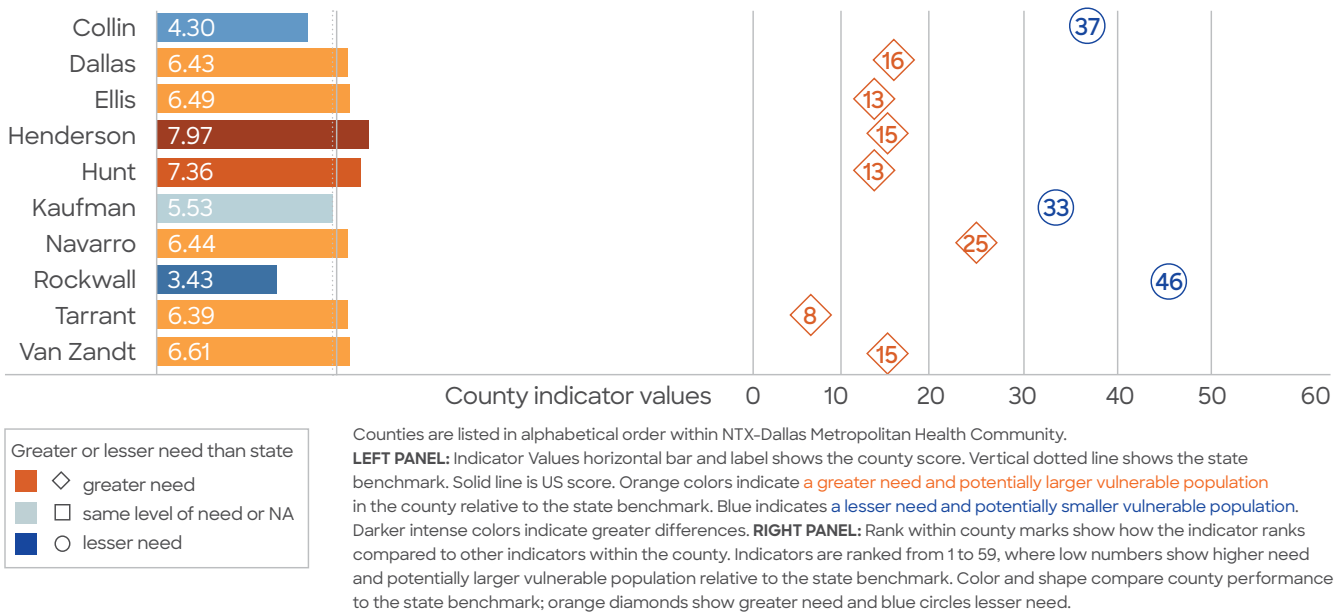
Priority 7: Infant Mortality Rate

The following data indicates greater need in the area of **infant mortality rate**, although it was not discussed by the focus groups specifically.

Category	Data shows greater need	Key informants indicate less need or not mentioned
Injury and death	<ul style="list-style-type: none"> Mortality rate: infant 	<ul style="list-style-type: none"> Not specifically mentioned

The **mortality rate: infant** indicator is defined as **the number of all infant deaths (within one year), per 1,000 live births**. The indicator is based on data from County Health Rankings & Roadmaps, CDC WONDER Mortality Data.

Mortality rate: infant (number of all infant deaths per 1,000 live births by county)



In the prioritization session, hospital leadership noted that some of the community counties have shockingly high infant mortality rates. They noted that it is particularly high amongst the African American population even with adequate prenatal care.

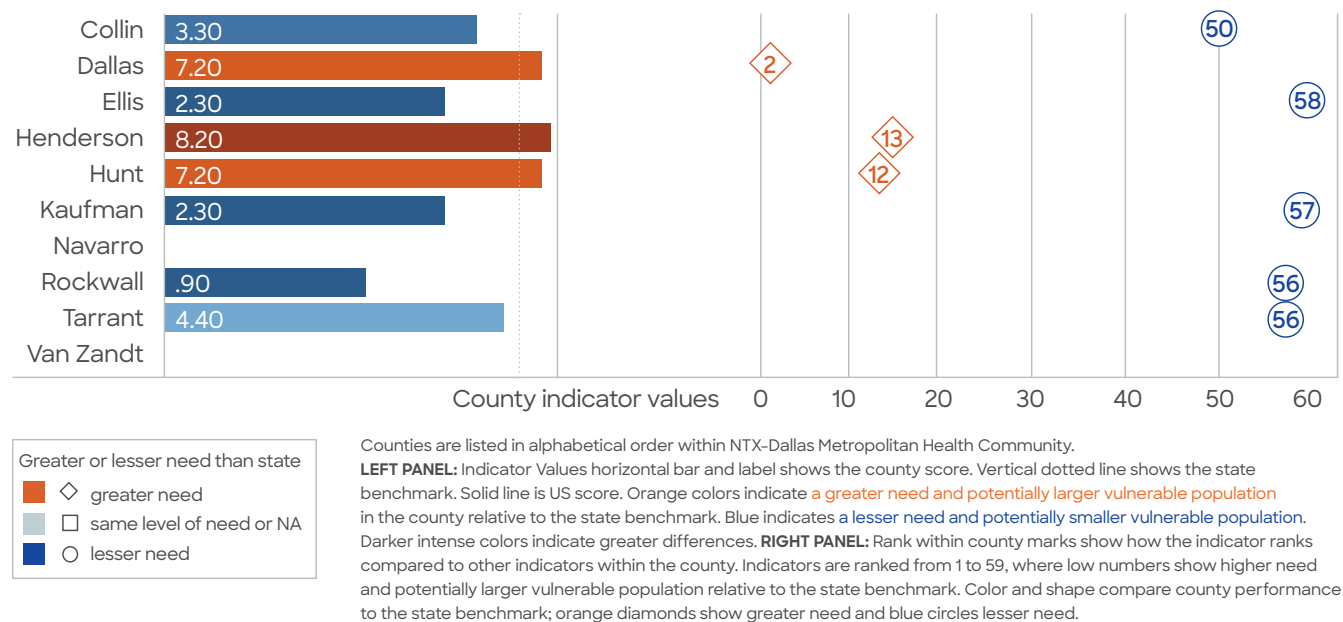
Priority 8: Transportation

The following data indicated greater need to address transportation needs and was supported by comments made by key informants.

Category	Data shows less need or no data	Key informants indicate less need
Environment	• No vehicle available	• Limited transportation

The **no vehicle available** measure is defined as **the percent of households with no vehicle available (percent of households)**. The indicator is based on data from US Census Bureau, American Community Survey One-Year Estimates.

No vehicle available (% of households with no vehicle available by county)



According to key informants, there is limited public transportation across the community. Even though there are programs in place to assist in transporting the population, public transportation is not convenient and can be cost-prohibitive. While some counties have transportation support for Medicare/Medicaid patients, access to public transportation for the remainder of the population is not sufficient. The participants noted that current voucher programs are still inefficient in getting residents to their healthcare appointments, and more needs to be done.

In the prioritization session, the hospital and community leaders agreed that transportation is a need but countered that it is not the highest need. They added that transportation still poses a challenge even with current programs in place.

The Community Health Dashboards data referenced above can be found at BSWHealth.com/About/Community-Involvement/Community-Health-Needs-Assessments.

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

Existing resources to address health needs

One part of the assessment process includes gathering input on potentially available community resources. The community is served by several large healthcare systems and multiple community-based health clinics. Below is a list of some of the community resources available to address identified needs in the community.

Dallas Metropolitan community resources

Need	Organization	Address	Phone
Obesity/ physical inactivity	Dallas Park and Recreation Department (recreation center)	16600 Park Hill Drive Dallas, TX 75248	214.670.6314
	YMCA of Metropolitan Dallas (fitness and recreation centers)	4332 Northaven Road Dallas, TX 75229	214.357.8431
	Adaptive Training Foundation	11837 Judd Court Dallas, TX 75243	214.432.1070
	MOVE! Weight Management Program	4500 S. Lancaster Road Dallas, TX 75216	800.849.3597
	YMCA Metro Dallas - Enhance Fitness Program	8920 Stults Road Dallas, TX 75243	469.276.8419
Diabetes	Los Barrios Unidos Community Clinic (prevention/treatment of diabetes)	809 Singleton Boulevard Dallas, TX 75212	214.540.0300
	YMCA of Metro Dallas (diabetes prevention program)	601 N. Akard Street Dallas, TX 75201	214.880.9622
	Baylor Scott & White Health and Wellness Center at Juanita J. Craft Recreation Center	4500 Spring Avenue Dallas, TX 75210	214.349.4325
	Christ's Family Clinic (diabetes education and prevention classes)	6409 Preston Road Dallas, TX 75205	214.261.9500
	Consultorio Medico Hispano (family medicine/ glucose test/hemoglobin A1C)	2626 S. Westmoreland Road Dallas, TX 75211	214.337.0565
Access to primary healthcare	HHM Health (family practice)	5750 Pineland Drive Dallas, TX 75231	214.379.4393 ext. 450
	Mission East Dallas (medical care clinic)	4550 Gus Thomasson Road Mesquite, TX 75150	972.682.8917 ext. 7009
	Texas Specialty Clinic (primary care-Medicaid/ Medicare)	2700 W. Pleasant Run Road Lancaster, TX 75146	888.871.1883
	Primary Care Clinic of North Texas	4001 McEwen Road Dallas, TX 75231	214.378.6005
	ICNA Relief - Dallas (medical clinic)	10874 Plano Road Dallas, TX 75238	469.291.7411

Need	Organization	Address	Phone
Gaps in behavioral health/ substance abuse services	First Step Counseling Center (addiction services)	16539 Addison Road Addison, TX 75001	214.942.8808
	Youth180 (addiction services)	7777 Forest Lane Dallas, TX 75230	972.566.4680
	HMM Health (behavioral health services)	8515 Greenville Avenue Dallas, TX 75243	214.221.0855
	Metrocare Services	1340 River Bend Drive Dallas, TX 75247	214.743.1200
	The Salvation Army of North Texas (voluntary alcohol/ substance abuse rehab)	5554 Harry Hines Boulevard Dallas, TX 75235	214.630.5611
Access to mental healthcare/ resources/ providers	Agape Medical Clinic (mental healthcare)	4104 Junius Street Dallas, TX 75246	972.707.7782
	The Stewpot (mental healthcare)	1835 Young Street Dallas, TX 75201	214.746.2785
	Counseling Institute of Texas (reduced cost)	3200 Southern Drive Garland, TX 75040	972.271.4300
	Metrocare Services (mental health services)	16160 Midway Road Addison, TX 75001	877.283.2121
	ChristianWorks - CounselingWorks	5440 Harvest Hill Road Dallas, TX 75230	972.960.9981
Food insecurity/ access to healthy food	Crossroads Community Services (food pantry)	4500 S. Cockrell Hill Road Dallas, TX 75236	214.560.2511
	North Dallas Shared Ministries (food pantry)	2875 Merrell Road Dallas, TX 75229	214.358.8700
	The Salvation Army of North Texas (food pantry)	5302 Harry Hines Boulevard Dallas, TX 75235	214.424.7050
	Metrocrest Services (food pantry)	13801 Hutton Drive Farmers Branch, TX 75234	972.446.2100
	St. Matthews Cathedral (food pantry)	5100 Ross Avenue Dallas, TX 75206	214.823.8134

Need	Organization	Address	Phone
Infant mortality rate	The Doctor Spot (mobile pediatric care)	Travels to different locations in Dallas County	972.834.2473
	Los Barrios Unidos Community Clinic (pediatrics program)	3111 Sylvan Avenue Dallas, TX 75212	214.540.0300
	Mission East Dallas - Medical Care Clinic (offer pediatric care)	4550 Gus Thomasson Road Mesquite, TX 75150	972.682.8917 ext. 7009
	HMM Health - Family Practice	5750 Pineland Drive Dallas, TX 75231	214.379.4393 ext. 450
	Texas Specialty Clinic (primary care/pediatric services - Medicaid)	2700 W. Pleasant Run Road Lancaster, TX 75146	888.871.1883
Transportation	Dallas Area Rapid Transit (DART)	1401 Pacific Avenue Dallas, TX 75202	214.979.1111
	Refugee and Immigration Center for Education and Legal Services (RAICES) - Texas	1910 Pacific Avenue Dallas, TX 75201	800.437.3071
	McKinney Avenue Transit Authority, Inc. - Dallas County	3153 Oak Grove Avenue Dallas, TX 75204	214.855.0006
	City of Mesquite (transportation for elderly and disabled)	1616 N. Galloway Avenue Mesquite, TX 75149	972.329.6833
	Metrocrest Services (transportation for seniors)	13801 Hutton Drive Farmers Branch, TX 75234	972.446.2100

There are many other community resources and facilities serving the Dallas Metropolitan area that are available to address identified needs and can be accessed through a comprehensive online resource catalog called Find Help (formerly known as Aunt Bertha). It can be accessed 24/7 at BSWHealth.FindHelp.com.

Next steps

BSWH started the Community Health Needs Assessment process in April 2021. Using both qualitative community feedback as well as publicly available and proprietary health indicators, BSWH was able to identify and prioritize community health needs for their healthcare system. 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.

Appendix A: CHNA requirement details

The Patient Protection and Affordable Care Act (PPACA) requires all tax-exempt organizations operating hospital facilities to assess the health needs of their community every three (3) years. The resulting Community Health Needs Assessment (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 used 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; and
 - An evaluation of the impact of any actions that were taken since the hospitals' most recent CHNA to address the significant health needs identified in that report.
- Hospitals also must adopt an implementation strategy to address prioritized community health needs identified through the assessment.

CHNA process

BSWH began the 2022 CHNA process in April of 2021. The following is an overview of the timeline and major milestones:



Consultant qualifications

IBM Watson Health delivers analytic tools, benchmarks and strategic consulting services to the healthcare industry, combining rich data analytics in demographics, including the Community Needs Index, planning and disease prevalence estimates, with experienced strategic consultants to deliver comprehensive and actionable Community Health Needs Assessments.

Health needs assessment process overview

To identify the health needs of the community, the hospitals established a comprehensive method using all available relevant data including community input. They used the qualitative and quantitative data obtained when assessing the community to identify its community health needs. Surveyors conducted interviews and focus groups with individuals representing public health, community leaders/groups, public organizations and other providers. In addition, data collected from public sources compared to the state benchmark indicated the level of severity. The outcomes of the quantitative data analysis were compared to the qualitative data findings.

These data are available to the community via an interactive dashboard at BSWHealth.com/CommunityNeeds.

Data gathering: quantitative assessment of health needs – methodology and data sources

The IBM team used quantitative data collection and analysis garnered from public health indicators to assess community health needs. This included over 100 data elements grouped into over 11 categories evaluated for the counties where data was available. Recently, indicators expanded to include new categories addressing mental health, healthcare costs, opioids and social determinants of health. A table depicting the categories and indicators and a list of sources are in **Appendix B**.

A benchmark analysis of each indicator determined which public health indicators demonstrated a community health need. Benchmark health indicators included overall US values, state of Texas values and other goal-setting benchmarks, such as Healthy People 2020.

According to America's Health Rankings 2021 Annual Report, Texas ranks 22nd out of the 50 states in the area of Health Outcomes (which includes behavioral health, mortality and physical health) and 50th in the area of Clinical Care (which includes avoiding care due to cost, providers per 100,000 population and preventive services). When the health status of Texas was compared to other states, the team identified many opportunities to impact community health.

The quantitative analysis of the health community used the following methodology:

- The team set benchmarks for each health community using state value for comparison.
- They identified community indicators not meeting state benchmarks.
- From this, they determined a need differential analysis of the indicators, which helped them understand the community's relative severity of need.
- Using the need differentials, they established a standardized way to evaluate the degree that each indicator differed from its benchmark.
- This quantitative analysis showed which health community indicators were above the 25th percentile in order of severity—and which health indicators needed their focus.

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

Information gaps

In some areas of Texas, the small population size has an impact on reporting and statistical significance. The team has attempted to understand the most significant health needs of the entire community. It is understood that there is variation of need within the community, and BSWH may not be able to impact all of the population who truly need the service.

Community input: qualitative health needs assessment - approach

To obtain a qualitative assessment of the health community, the team:

- Assembled a focus group representing the broad interests of the community served;
- Conducted interviews and surveys with key informants—leaders and representatives who serve the community and have insight into its needs; and
- Held prioritization sessions with hospital clinical leadership and community leaders to review collection results and identify the most significant healthcare needs based on information gleaned from the focus groups and key informants.

Focus groups helped identify barriers and social factors influencing the community's health needs. Key informant interviews gave the team even more understanding and insight about the general health status of the community and the various drivers that contributed to health issues.

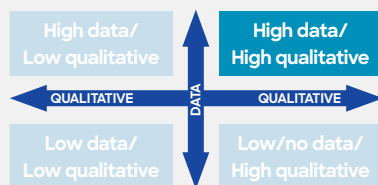
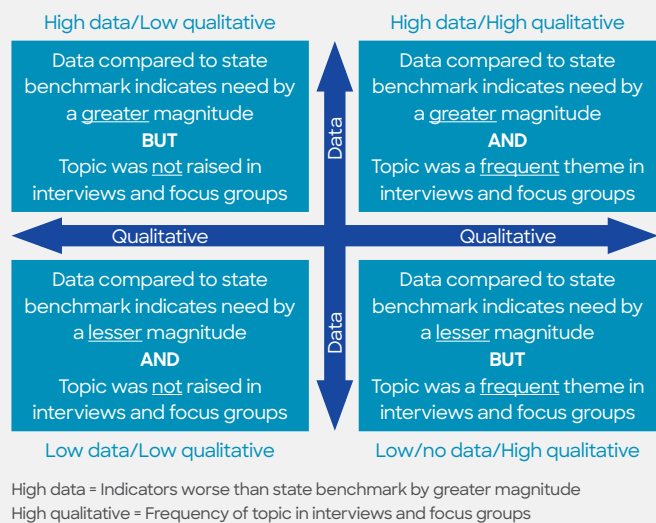
Multiple governmental public health department individuals were asked to contribute their knowledge, information and expertise relevant to the health needs of the community. Individuals or organizations who served and/or represented the interests of medically underserved, low-income and minority populations in the community also took part in the process. NOTE: In some cases, public health officials were unavailable due to obligations concerning the COVID-19 pandemic.

The hospitals also considered written input received on their most recently conducted CHNA and subsequent implementation strategies if provided. The assessment is available for public comment or feedback on the report findings by going to the BSWH website (BSWHealth.com/CommunityNeeds) or by emailing CommunityHealth@BSWHealth.org.

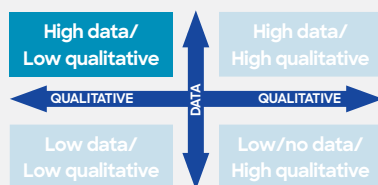
Approach to prioritizing significant health needs

On January 18, 2022, a session was conducted with key leadership members from Baylor Scott & White along with community leaders to review the qualitative and quantitative data findings of the CHNA to date, discuss at length the significant needs identified, and complete prioritization exercises to rank the community needs. Prioritizing health needs was a two-step process. The two-step process allowed participants to consider the quantitative needs and qualitative needs as defined by the indicator dataset and focus group/interview/survey participant input.

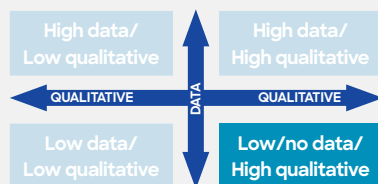
In the first step, participants reviewed the top health needs for their community using associated data-driven criteria. The criteria included health indicator value(s) for the community and how the indicator compared to the state benchmark.



High data and high qualitative: The community indicators that showed a greater need in the health community overall when compared to the state of Texas comparative benchmark and were identified as a greater need by the key informants.



High data and low qualitative: The community indicators showed a greater need in the health community overall when compared to the state of Texas comparative benchmark but were not identified as a greater need or not specifically identified by the key informants.



Low/no data and high qualitative:
 The community indicators showed less need or had no data available in the health community overall when compared to the state of Texas comparative benchmark but were identified as a greater need by the key informants.

Participants held a group discussion about which needs were most significant, using the professional experience and community knowledge of the group. A virtual voting method was invoked for individuals to provide independent opinions.

This process helped the group define and identify the community's significant health needs. Participants voted individually for the needs they considered the most significant for this community. When the votes were tallied, the top identified needs emerged and were ranked based on the number of votes.

Prioritization of significant needs

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

- **Root cause:** The need is a root cause of other problems. If addressed, it could possibly impact multiple issues.
- **Severity:** The problem results in disability or premature death or creates burdens on the community, economically or socially.
- **Feasibility/cost:** Is the problem amenable to interventions? What technology, knowledge or resources are necessary to effect a change? Is the problem preventable? Is it too expensive for the community to tackle?

The group rated each of the eight significant health needs on each of the three identified criteria, using a scale of 1 (low) to 10 (high). The criteria score sums for each need created an overall score. They prioritized the list of significant health needs based on the overall scores. The outcome of this process was the list of prioritized health needs for this community.

Priority	Need	Category of need
1	Obesity/physical inactivity	Conditions/diseases
2	Diabetes	Conditions/diseases
3	Access to primary healthcare	Access to care
4	Gaps in behavioral health/ substance abuse services	Health behaviors/mental health conditions/diseases
5	Access to mental healthcare (providers/services)	Access to care/mental health
6	Food insecurity/access to healthy food	Environment
7	Infant mortality rate	Injury and death
8	Transportation	Environment

Appendix B: key public health indicators

IBM Watson Health collected and analyzed fifty-nine (59) public health indicators to assess and evaluate community health needs. 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 US and the state of Texas.

The indicators used and the sources are listed below:

Indicator name	Indicator source	Indicator definition
Adult obesity	2021 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System	2017 Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m ²
Adults reporting fair or poor health	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Percentage of adults reporting fair or poor health (age-adjusted)
Binge drinking	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Percentage of a county's adult population that reports binge or heavy drinking in the past 30 days
Cancer incidence: all causes	State Cancer Profiles National Cancer Institute (CDC)	2013 - 2017 Age-adjusted cancer (all) incidence rate cases per 100,000 (all races, includes Hispanic; both sexes; all ages. Age-adjusted to the 2000 US standard population)
Cancer incidence: colon	State Cancer Profiles National Cancer Institute (CDC)	2013 - 2017 Age-adjusted colon and rectum cancer incidence rate cases per 100,000 (all races, includes Hispanic; both sexes; all ages. Age-adjusted to the 2000 US standard population). Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of three is shown, the total number of cases for the time period is 16 or more, which exceeds suppression threshold (but is rounded to three).

Indicator name	Indicator source	Indicator definition
Cancer incidence: female breast	State Cancer Profiles National Cancer Institute (CDC)	2013 - 2017 Age-adjusted female breast cancer incidence rate cases per 100,000 (all races, includes Hispanic; female; all ages. Age-adjusted to the 2000 US standard population). Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of three is shown, the total number of cases for the time period is 16 or more, which exceeds suppression threshold (but is rounded to three).
Cancer incidence: lung	State Cancer Profiles, National Cancer Institute (CDC)	2013 - 2017 Age-adjusted lung and bronchus cancer incidence rate cases per 100,000 (all races, includes Hispanic; both sexes; all ages. Age-adjusted to the 2000 US standard population)
Cancer incidence: prostate	State Cancer Profiles, National Cancer Institute (CDC)	2013 - 2017 Age-adjusted prostate cancer incidence rate cases per 100,000 (all races, includes Hispanic; males; all ages. Age-adjusted to the 2000 US standard population)
Children in poverty	2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau	2019 Percentage of children under age 18 in poverty.
Children in single-parent households	2021 County Health Rankings & Roadmaps; American Community Survey (ACS), Five-Year Estimates (United States Census Bureau)	2015 - 2019 Percentage of children that live in a household headed by single parent
Children uninsured	2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau	2018 Percentage of children under age 19 without health insurance
Diabetes admission	2018 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations	Number observed/adult population age 18 and older. Risk-adjusted rates not calculated for counties with fewer than five admissions.
Diabetes diagnoses in adults	CMS.gov Chronic Conditions 2007 - 2018	Prevalence of chronic condition across all Medicare beneficiaries

Indicator name	Indicator source	Indicator definition
Diabetes prevalence	County Health Rankings (CDC Diabetes Interactive Atlas)	2017 Prevalence of diagnosed diabetes in a given county. Respondents were considered to have diagnosed diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes.
Drug poisoning deaths	2021 County Health Rankings & Roadmaps, CDC WONDER Mortality Data	2017 - 2019 Number of drug poisoning deaths (drug overdose deaths) per 100,000 population. Death rates are null when the rate is calculated with a numerator of 20 or less.
Elderly isolation	2018 American Community Survey Five-Year Estimates, US Census Bureau - American FactFinder	Percent of non-family households - householder living alone - 65 years and over
English spoken "less than very well" in household	2015 - 2019 American Community Survey Five-Year Estimates, US Census Bureau - American FactFinder	2019 Percentage of households that 'speak English less than "very well"' within all households that 'speak a language other than English'
Food environment index	2021 County Health Rankings & Roadmaps; USDA Food Environment Atlas, Map the Meal Gap from Feeding America, United States Department of Agriculture (USDA)	2015 and 2018 Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)
Food insecure	2021 County Health Rankings & Roadmaps; Map the Meal Gap, Feeding America	2018 Percentage of population who lack adequate access to food during the past year
Food: limited access to healthy foods	2021 County Health Rankings & Roadmaps; USDA Food Environment Atlas, United States Department of Agriculture (USDA)	2015 Percentage of population who are low-income and do not live close to a grocery store
High school graduation	Texas Education Agency	2019 A four-year longitudinal graduation rate is the percentage of students from a class of beginning ninth graders who graduate by their anticipated graduation date or within four years of beginning ninth grade.
Household income	2021 County Health Rankings (Small Area Income and Poverty Estimates)	2019 Median household income is the income where half of households in a county earn more and half of households earn less.

Indicator name	Indicator source	Indicator definition
Income inequality	2021 County Health Rankings & Roadmaps; American Community Survey (ACS), Five-Year Estimates (United States Census Bureau)	2015 - 2019 Ratio of household income at the 80th percentile to income at the 20th percentile. Absolute equality = 1.0. Higher ratio is greater inequality.
Individuals below poverty level	2018 American Community Survey Five-Year Estimates, US Census Bureau - American FactFinder	Individuals below poverty level
Low birth weight rate	2019 Texas Certificate of Live Birth	Number low birth weight newborns /number of newborns. Newborn's birth weight - low or very low birth weight includes birth weights under 2,500 grams. Blanks indicate low counts or unknown values. A null value indicates unknown or low counts. The location variables (region, county, ZIP) refer to the mother's residence.
Medicare population: Alzheimer's disease/ dementia	CMS.gov Chronic Conditions 2007 - 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare population: atrial fibrillation	CMS.gov Chronic Conditions 2007 - 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare population: COPD	CMS.gov Chronic Conditions 2007 - 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare population: depression	CMS.gov Chronic Conditions 2007 - 2018	Prevalence of chronic condition across all Medicare beneficiaries
Medicare population: emergency department use rate	CMS 2019 Outpatient 100% Standard Analytical File (SAF) and 2019 Standard Analytical Files (SAF) Denominator File	Unique patients having an emergency department visit/total beneficiaries, CY 2019

Indicator name	Indicator source	Indicator definition
Medicare population: heart failure	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare population: hyperlipidemia	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries
Medicare population: hypertension	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries
Medicare population: inpatient use rate	CMS 2019 Inpatient 100% Standard Analytical File (SAF) and 2019 Standard Analytical Files (SAF) Denominator File	Unique patients being hospitalized/total beneficiaries, CY 2019
Medicare population: stroke	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare spending per beneficiary (MSPB) index	CMS 2019 Medicare Spending Per Beneficiary (MSPB), Hospital Value-Based Purchasing (VBP) Program	Medicare spending per beneficiary (MSPB): for each hospital, CMS calculates the ratio of the average standardized episode spending over the average expected episode spending. This ratio is multiplied by the average episode spending level across all hospitals. Blank values indicate missing hospitals or missing score. Associated to the hospitals
Mentally unhealthy days	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Average number of mentally unhealthy days reported in past 30 days (age-adjusted)
Mortality rate: cancer	Texas Health Data, Center for Health Statistics, Texas Department of State Health Services	2017 Cancer (all) age-adjusted death rate (per 100,000 – all ages. Age-adjusted using the 2000 US Standard population). Death rates are null when the rate is calculated with a numerator of 20 or less.

Indicator name	Indicator source	Indicator definition
Mortality rate: heart disease	Texas Health Data, Center for Health Statistics, Texas Department of State Health Services	2017 Heart disease age-adjusted death rate (per 100,000 - all ages. Age-adjusted using the 2000 US Standard population). Death rates are null when the rate is calculated with a numerator of 20 or less.
Mortality rate: infant	2021 County Health Rankings & Roadmaps, CDC WONDER Mortality Data	2013 - 2019 Number of all infant deaths (within one year), per 1,000 live births. Blank values reflect unreliable or missing data.
Mortality rate: stroke	Texas Health Data, Center for Health Statistics, Texas Department of State Health Services	2017 Cerebrovascular disease (stroke) age-adjusted death rate (per 100,000 - all ages. Age-adjusted using the 2000 US Standard population). Death rates are null when the rate is calculated with a numerator of 20 or less.
No vehicle available	US Census Bureau, 2019 American Community Survey One-Year Estimates	2019 Households with no vehicle available (percent of households). A null value entry indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates fall in the lowest interval or upper interval of an open-ended distribution, or the margin of error associated with a median was larger than the median itself.
Opioid involved accidental poisoning death	US Census Bureau, Population Division and 2019 Texas Health and Human Services Center for Health Statistics Opioid related deaths in Texas	Annual estimates of the resident population: April 1, 2010, to July 1, 2017. 2019 Accidental poisoning deaths where opioids were involved are those deaths that include at least one of the following ICD-10 codes among the underlying causes of death: X40 - X44, and at least one of the following ICD-10 codes identifying opioids: T40.0, T40.1, T40.2, T40.3, T40.4, T40.6. Blank values reflect unreliable or missing data.
Physical inactivity	2021 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System	2017 Percentage of adults ages 20 and over reporting no leisure-time physical activity in the past month

Indicator name	Indicator source	Indicator definition
Physically unhealthy days	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Average number of physically unhealthy days reported in past 30 days (age-adjusted)
Population to one dentist	2021 County Health Rankings & Roadmaps; Area Health Resource File/National Provider Identification file (CMS)	2019 Ratio of population to dentists
Population to one mental health provider	2021 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)	2020 Ratio of population to mental health providers
Population to one non-physician primary care provider	2020 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)	2020 Ratio of population to primary care providers other than physicians
Population to one primary care physician	2021 County Health Rankings & Roadmaps; Area Health Resource File/American Medical Association	2018 Number of individuals served by one physician in a county, if the population was equally distributed across physicians
Population under age 65 without health insurance	2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau	2018 Percentage of population under age 65 without health insurance
Prenatal care: first trimester entry into prenatal care	2020 Texas Health and Human Services - Vital statistics annual report	2016 Percent of births with prenatal care onset in first trimester
Renter-occupied housing	US Census Bureau, 2019 American Community Survey One-Year Estimates	2019 Renter-occupied housing (percent of households). A null value entry indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates fall in the lowest interval or upper interval of an open-ended distribution, or the margin of error associated with a median was larger than the median itself.

Indicator name	Indicator source	Indicator definition
Severe housing problems	2021 County Health Rankings & Roadmaps; Comprehensive Housing Affordability Strategy (CHAS) data, US Department of Housing and Urban Development (HUD)	2013 - 2017 Percentage of households with at least one of four housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
Sexually transmitted infection incidence	2021 County Health Rankings & Roadmaps; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)	2018 Number of newly diagnosed chlamydia cases per 100,000 population
Smoking	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Percentage of the adult population in a county who both report that they currently smoke every day or most days and have smoked at least 100 cigarettes in their lifetime
Suicide: intentional self-harm	Texas Health Data Center for Health Statistics	2019 Intentional self-harm (suicide) (X60 - X84, Y87.0). Death rates are null when the rate is calculated with a numerator of 20 or less.
Teen birth rate	2021 County Health Rankings & Roadmaps; National Center for Health Statistics - Natality files, National Vital Statistics System (NVSS)	2013 - 2019 Number of births to females ages 15 - 19 per 1,000 females in a county (The numerator is the number of births to mothers ages 15 - 19 in a seven-year time frame, and the denominator is the sum of the annual female populations, ages 15 - 19.)
Teens (16 - 19) not in school or work - disconnected youth	2021 County Health Rankings (Measure of America)	2015 - 2019 Disconnected youth are teenagers and young adults between the ages of 16 and 19 who are neither working nor in school. Blank values reflect unreliable or missing data.
Unemployment	2021 County Health Rankings & Roadmaps; Local Area Unemployment Statistics (LAUS), Bureau of Labor Statistics	2019 Percentage of population ages 16 and older unemployed but seeking work

Appendix C: community input participating organizations

Representatives from the following organizations participated in the focus group and a number of key informant interviews/surveys:

- American Heart Association
- Baylor Scott & White Health
- Baylor Scott & White Heart & Vascular Hospital
- Baylor University Medical Center
- Bethesda Health Clinic
- Bridge Breast Network
- Brighter Tomorrows
- Brittain Kalish Group Project Access
- Baylor Scott & White – McKinney
- Baylor Scott & White – Plano
- Collin County RHP 18
- Church of Jesus Christ of LDS
- Collin College Homeless Coalition
- Collin County Coalition Charitable Clinics
- Collin County Health Care Services
- Collin County Health Department
- Collin County Public Health
- Community Lifeline Center
- Community Services, Inc.
- County of Navarro
- Crossroads
- Dallas Area Interfaith
- Dallas Area Rape Crisis Center (DARCC)
- Dallas Area Rapid Transit (DART)
- Daniel's Den
- Eligibility Consultants Inc.
- Emergency Management
- Midlothian Police Department
- Empowering the Masses
- Family Promise of Living
- First United Methodist
- First United Methodist, Richardson
- For Oak Cliff
- Fort Worth Housing Solutions
- Frazier Revitalization
- Golden SEEDS
- Goodwill Dallas
- Health Services of North Texas
- Hope Clinic
- Julia's Center
- Mansfield Independent School District (MISD)
- Meals on Wheels
- Meals on Wheels North Central Texas
- MedStar
- Methodist Dallas Medical Center
- Methodist Health System
- Methodist Health System Golden Cross Academic Clinic
- Methodist Mansfield Advisory Board
- Metrocare Services
- My Possibilities
- North Central Texas Health Care Center Comm.
- North Texas Food Bank
- One Safe Place
- Plano Fire-Rescue
- Presbyterian Children's Homes & Services (PCHAS)
- Project Access Tarrant County
- REACH Council
- Sharing Life
- South Dallas Fair Park Faith Coalition
- Southern Methodist University
- St. Joseph Church
- State Fair of Texas
- Tarrant Area Food Bank
- Tarrant County Public Health
- Texas Health Resources
- The Bridge Homeless Recovery Center
- The Concilio
- The Stewpot
- United Way
- United Way Hunt County
- United Way of Metropolitan Dallas (UWMD)
- United Way of Tarrant County
- Visiting Nurse Association (VNA)
- Visiting Nurse Association of Texas – Dallas/Fort Worth
- Waxahachie Care Services
- Waxahachie Independent School District
- Wellness Center for Older Adults
- YMCA Dallas

Appendix D: demographic and socioeconomic summary

According to population statistics, the community served is similar to Texas in terms of projected population growth; both outpace the country. The median age is older than Texas and younger than the United States. Median income is higher than both the state and the country. The community served has a lower percentage of Medicaid beneficiaries and a lower percentage of uninsured individuals than the state of Texas.

Demographic and socioeconomic comparison: community served and state/US benchmarks

Geography		Benchmarks		Community served
		United States	Texas	Dallas Metropolitan health community
Total current population		330,342,293	29,321,501	6,555,451
Five-year projected population change		3.3%	6.6%	7.1%
Median age		38.6	35.2	35.9
Population 0 - 17		22.4%	25.7%	25.8%
Population 65+		16.6%	13.2%	12.2%
Women age 15 - 44		19.5%	20.5%	21.0%
Hispanic population		19.0%	40.7%	31.6%
Insurance coverage	Uninsured	9.9%	18.8%	15.1%
	Medicaid	20.9%	13.0%	12.2%
	Private market	8.3%	8.4%	7.9%
	Medicare	13.8%	12.7%	11.3%
	Employer	47.2%	47.1%	53.4%
Median HH income		\$65,618	\$63,313	\$75,314
No high school diploma		12.2%	16.7%	16.0%

Source: IBM Watson Health Demographics, Claritas, 2020, Insurance Coverage Estimates, 2020.

The community served expects to grow 7.1% by 2025, an increase of over 456,000 people. The projected population growth is higher than the state's five-year projected growth rate (6.6%) and higher than the national projected growth rate (3.3%). The ZIP codes expected to experience the most growth in five years are:

- 75052 Grand Prairie – 8,690 people
- 76244 Keller – 8,072 people

The community's population is younger with 50.5% of the population ages 18 – 54 and 25.8% under age 18. The age 65-plus cohort is expected to experience the fastest growth (25%) over the next five years. Growth in the senior population will likely contribute to increased utilization of services as the population continues to age.

Population statistics are analyzed by race and by Hispanic ethnicity. The community was primarily white non-Hispanic, but diversity in the community will increase due to the projected growth of minority populations over the next five years. The expected growth rate of the Hispanic population (all races) is over 255,000 people (12.3%) by 2025. The non-Hispanic white population is expected to decline by -1.5%.

Population distribution					
Age group	Age distribution				
	2020	% of total	2025	% of total	USA 2020 % of total
0 – 14	1,402,006	21.4%	1,434,731	20.4%	18.5%
15 – 17	290,260	4.4%	310,388	4.4%	3.9%
18 – 24	617,866	9.4%	683,162	9.7%	9.5%
25 – 34	921,617	14.1%	908,993	12.9%	13.5%
35 – 54	1,771,999	27.0%	1,862,247	26.5%	25.2%
55 – 64	754,780	11.5%	825,496	11.8%	12.9%
65+	796,923	12.2%	996,360	14.2%	16.6%
Total	6,555,451	100.0%	7,021,377	100.0%	100.0%

Household Income distribution			
2020 Household income	Income distribution		
	HH count	% of total	USA % of total
<\$15K	187,128	8.0%	10.0%
\$15 – 25K	170,945	7.3%	8.6%
\$25 – 50K	477,519	20.4%	20.7%
\$50 – 75K	410,797	17.5%	16.7%
\$75 – 100K	304,712	13.0%	12.4%
Over \$100K	794,221	33.9%	31.5%
Total	2,345,322	100.0%	100.0%

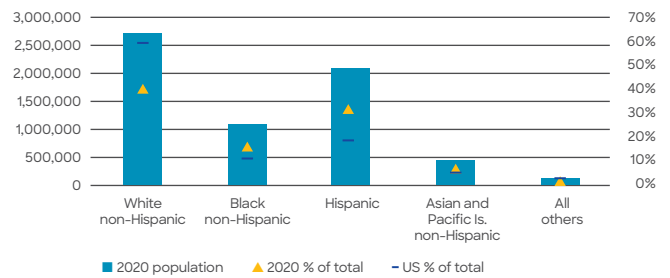
Education level			
2020 Adult education level	Education level distribution		
	Pop age 25+	% of total	USA % of total
Less than high school	340,020	8.0%	5.2%
Some high school	339,932	8.0%	7.0%
High school degree	970,377	22.9%	27.2%
Some college/assoc. degree	1,184,617	27.9%	28.9%
Bachelor's degree or greater	1,410,373	33.2%	31.6%
Total	4,245,319	100.0%	100.0%

Race/ethnicity			
Race/ethnicity	Race/ethnicity distribution		
	2020 pop	% of total	USA % of total
White non-Hispanic	2,727,211	41.6%	59.3%
Black non-Hispanic	1,116,716	17.0%	12.4%
Hispanic	2,072,574	31.6%	19.0%
Asian & Pacific is. non-Hispanic	480,828	7.3%	6.0%
All others	158,122	2.4%	3.3%
Total	6,555,451	100.0%	100.0%

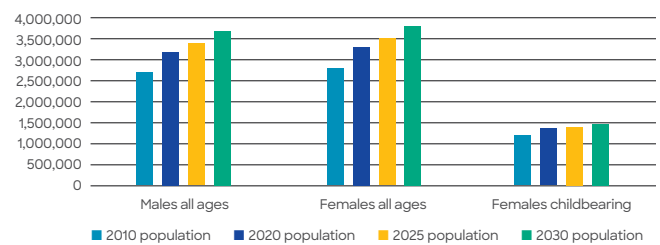
Population estimates		
Population	National	Selected area
2010 total	308,745,538	5,536,186
2020 total	330,342,293	6,555,451
2025 total	341,132,738	7,021,377
2030 total	353,513,931	7,561,369
% change 2020 - 2025	3.27%	7.11%
% change 2020 - 2035	7.01%	15.34%

Population	Males all ages	Females all ages	Females childbearing
2010 total	2,727,107	2,809,079	1,205,687
2020 total	3,223,566	3,331,885	1,374,220
2025 total	3,452,967	3,568,410	1,427,505
2030 total	3,717,539	3,843,830	1,508,407
10Y %	15.32%	15.37%	9.76%
National	7.02%	7.01%	4.01%

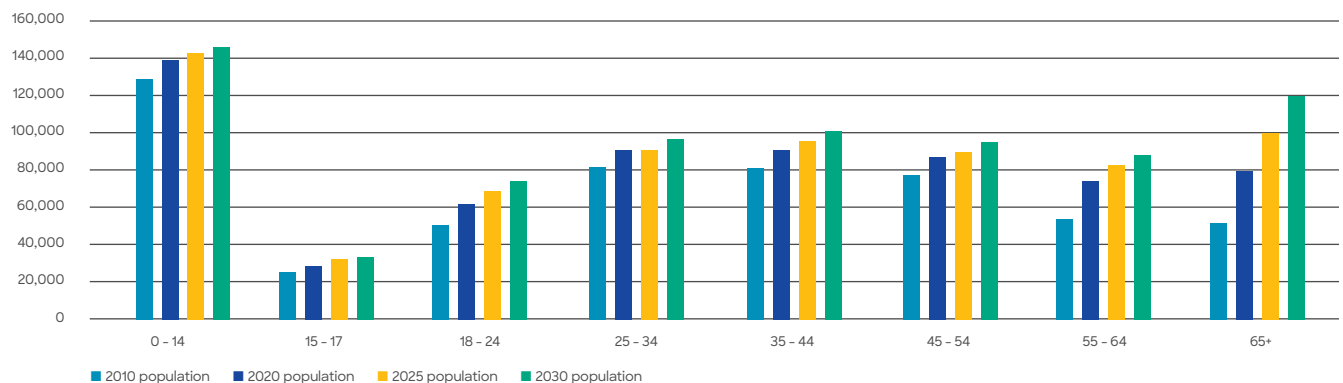
2020 race and ethnicity with total population



Population by sex 2010 - 2030



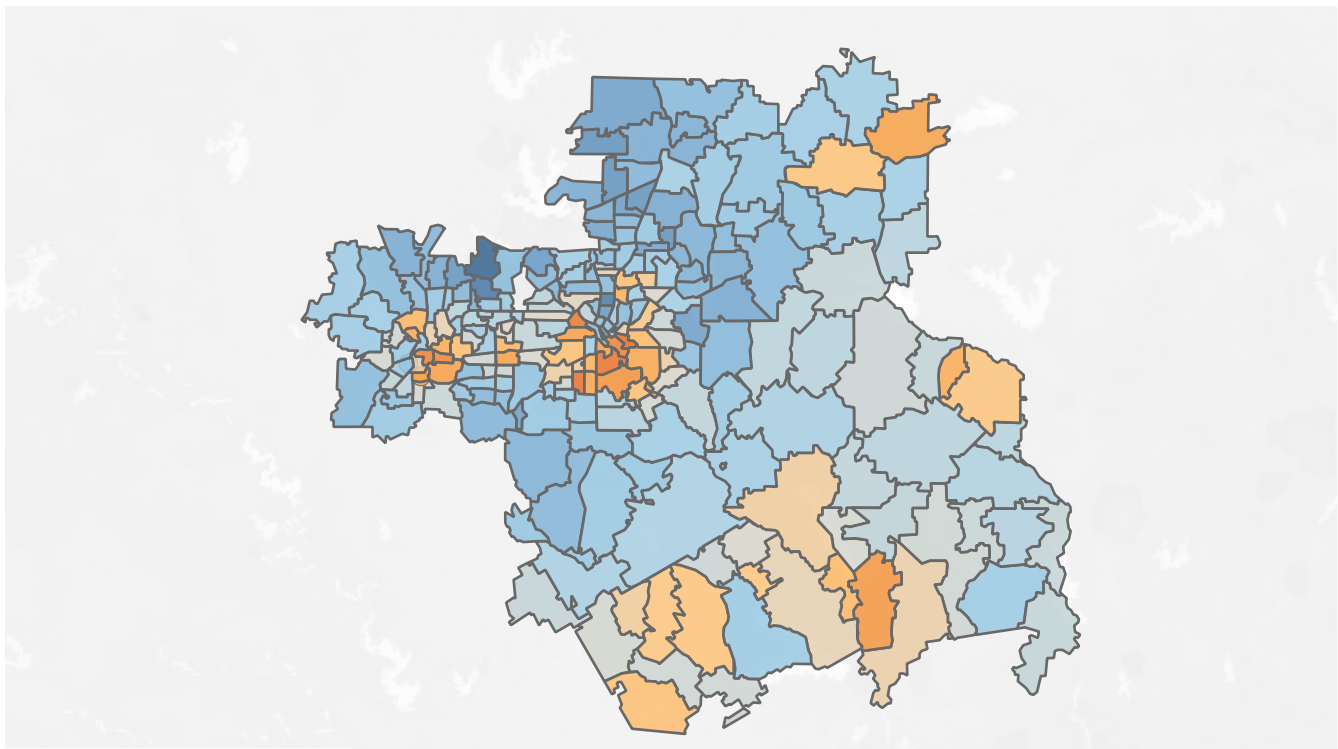
Population by age group 2010 - 2030



The 2020 median household income for the United States was \$65,618 and \$63,313 for the state of Texas. The median household income for the ZIP codes within this community ranged from \$206,212 for 76092 Southlake to \$28,568 for 75210 Dallas. There were sixty-four (64) ZIP codes with median household incomes less than \$52,400—twice the 2020 federal poverty limit for a family of four.

A majority of the population (53.4%) was insured through employer sponsored health coverage. The remainder of the population was fairly equally divided between Medicaid, Medicare and private market (the purchasers of coverage directly or through the health insurance marketplace).

The median household income ZIP code map below illustrates ZIP codes that are lower or higher than twice the federal poverty level for a family of four in 2020.



Federally designated health professional shortage areas and medically underserved areas and populations

Health professional shortage areas (HPSA)				
County	HPSA ID	HPSA name	HPSA discipline class	Designation type
Collin	7485109304	LI - MHCA - Collin County	Mental health	Low-income population HPSA
Dallas	1487790622	OFAC - Parkland Center for Internal Medicine (PCIM)	Primary care	Other facility
Dallas	7486259744	LI - Irving	Mental health	Low-income population HPSA
Dallas	7482835384	LI - South Central Dallas	Mental health	Low-income population HPSA
Dallas	7482563929	LI - Southeast Dallas	Mental health	Low-income population HPSA
Dallas	7486982533	LI - Grand Prairie - West Dallas	Mental health	Low-income population HPSA
Dallas	7483797081	LI - Central Dallas County	Mental health	Low-income population HPSA
Dallas	7484799626	LI - North Dallas County	Mental health	Low-income population HPSA
Dallas	7482166324	LI - Northeast Dallas County	Mental health	Low-income population HPSA
Dallas	14899948OZ	Mission East Dallas and Metroplex Project	Primary care	Federally qualified health center
Dallas	74899948MN	Mission East Dallas and Metroplex Project	Mental health	Federally qualified health center
Dallas	64899948MO	Mission East Dallas and Metroplex Project	Dental health	Federally qualified health center
Dallas	14899948Q0	Healing Hands Ministries, Inc.	Primary care	Federally qualified health center
Dallas	74899948O2	Healing Hands Ministries, Inc.	Mental health	Federally qualified health center
Dallas	64899948NX	Healing Hands Ministries, Inc.	Dental health	Federally qualified health center
Dallas	148999485F	Martin Luther King Jr. Family Clinic Inc.	Primary care	Federally qualified health center
Dallas	748999481V	Martin Luther King Jr. Family Clinic Inc.	Mental health	Federally qualified health center
Dallas	6489994897	Martin Luther King Jr. Family Clinic Inc.	Dental health	Federally qualified health center
Dallas	14899948P6	Dallas County Hospital District	Primary care	Federally qualified health center
Dallas	748999482V	Dallas County Hospital District	Mental health	Federally qualified health center
Dallas	64899948C2	Dallas County Hospital District	Dental health	Federally qualified health center

Health professional shortage areas (HPSA), continued				
County	HPSA ID	HPSA name	HPSA discipline class	Designation type
Dallas	1488622370	Urban Inter-Tribal Center of Texas	Primary care	Indian health service, tribal health and urban Indian health organizations
Dallas	7485754448	Urban Inter-Tribal Center of Texas	Mental health	Indian health service, tribal health and urban Indian health organizations
Dallas	6485188079	Urban Inter-Tribal Center of Texas	Dental health	Indian health service, tribal health and urban Indian health organizations
Dallas	14899948D3	Los Barrios Unidos Community Clinic, Inc.	Primary care	Federally qualified health center
Dallas	748999481L	Los Barrios Unidos Community Clinic, Inc.	Mental health	Federally qualified health center
Dallas	6489994889	Los Barrios Unidos Community Clinic, Inc.	Dental health	Federally qualified health center
Dallas	1489814978	FCI - Seagoville	Primary care	Correctional facility
Dallas	6481843658	FCI - Seagoville	Dental health	Correctional facility
Dallas	7483425946	FCI - Seagoville	Mental health	Correctional facility
Dallas	1487991263	LI - Central Dallas County	Primary care	Low-income population HPSA
Ellis	14899948J2	Ellis County Coalition for Health Options	Primary care	Federally qualified health center
Ellis	74899948A4	Ellis County Coalition for Health Options	Mental health	Federally qualified health center
Ellis	64899948L9	Ellis County Coalition for Health Options	Dental health	Federally qualified health center
Henderson	7485180550	LI - Henderson County	Mental health	Low-income population HPSA
Henderson	1488590383	LI - Henderson County	Primary care	Low-income population HPSA
Hunt	7486665870	LI - Hunt County	Mental health	Low-income population HPSA
Hunt	1489290274	LI - Hunt County	Primary care	Low-income population HPSA
Hunt	148999485C	Community Health Service Agency, Inc. of Hunt County	Primary care	Federally qualified health center
Hunt	748999481R	Community Health Service Agency, Inc. of Hunt County	Mental health	Federally qualified health center
Hunt	6489994894	Community Health Service Agency, Inc. of Hunt County	Dental health	Federally qualified health center
Navarro	1489990453	Navarro County	Primary care	Geographic HPSA
Navarro	7482306198	Navarro County	Mental health	Geographic HPSA

Health professional shortage areas (HPSA), continued				
County	HPSA ID	HPSA name	HPSA discipline class	Designation type
Tarrant	1482468046	Federal Medical Center - Fort Worth	Primary care	Correctional facility
Tarrant	6484046496	Federal Medical Center - Fort Worth	Dental health	Correctional facility
Tarrant	7483350268	Federal Medical Center - Fort Worth	Mental health	Correctional facility
Tarrant	1485279877	FMC - Carswell	Primary care	Correctional facility
Tarrant	6486448024	FMC - Carswell	Dental health	Correctional facility
Tarrant	7483623264	FMC - Carswell	Mental health	Correctional facility
Tarrant	7483111792	LI - MHCA - Tarrant County	Mental health	Low-income population HPSA
Tarrant	14899948H2	North Texas Area Community Health Centers Inc.	Primary care	Federally qualified health center
Tarrant	748999483N	North Texas Area Community Health Centers Inc.	Mental health	Federally qualified health center
Tarrant	64899948F5	North Texas Area Community Health Centers Inc.	Dental health	Federally qualified health center
Van Zandt	7489961368	LI - Van Zandt County	Mental health	Low-income population HPSA
Van Zandt	1486857060	LI - Van Zandt	Primary care	Low-income population HPSA

Medically underserved areas and populations (MUA/P)				
County	MUA/P source identification number	Service area name	Designation type	Rural status
Dallas	1485024236	Dallas County - Dallas South	Medically underserved area	Non-rural
Dallas	03469	Dallas service area	Medically underserved area	Non-rural
Dallas	1487043129	East Dallas County	Medically underserved area	Non-rural
Dallas	05213	Forest Glenn service area	Medically underserved area	Non-rural
Dallas	07959	Lillicare Dallas	Medically underserved area	Non-rural
Dallas	1484709099	Southeast Dallas County	Medically underserved area	Non-rural
Dallas	1486572106	Dallas County - Dallas Southwest	Medically underserved population	Non-rural
Dallas	1489157042	LI - Grand Prairie	Medically underserved population	Non-rural
Dallas	1483247641	LI - Irving	Medically underserved population	Non-rural
Dallas	07753	Mission East Dallas area	Medically underserved population	Non-rural
Ellis	03496	Ellis Service area	Medically underserved area	Non-rural
Hunt	03355	Western Hunt County	Medically underserved area	Non-rural
Tarrant	07393	Central Service area	Medically underserved area	Non-rural
Tarrant	1481461749	Fort Worth - North	Medically underserved area	Non-rural
Tarrant	07382	Low Inc. - East Side	Medically underserved population	Non-rural
Van Zandt	1484627193	Van Zandt County	Medically underserved area	Rural

Community Needs Index

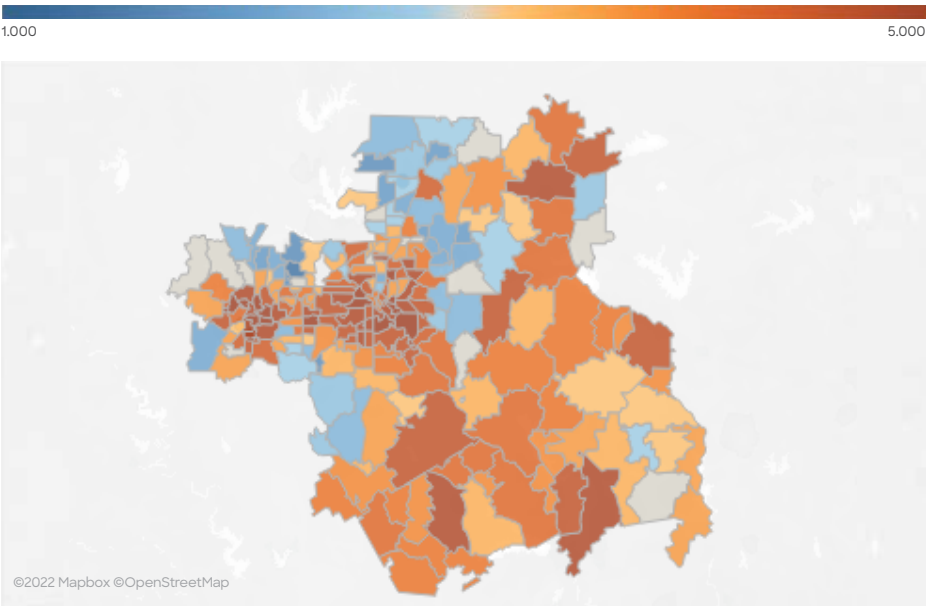
The IBM Watson Health Community Need Index (CNI) is a statistical approach that identifies areas within a community where there are likely gaps in healthcare. The CNI takes into account vital socio-economic factors, including income, culture, education, insurance and housing, about a community to generate a CNI score for every population ZIP code in the US.

The CNI is strongly linked to variations in community healthcare needs and is a good indicator of a community’s demand for a range of healthcare services. Not-for-profit and community-based hospitals, for whom community need is central to the mission of service, are often challenged to prioritize and effectively distribute hospital resources. The CNI can be used to help them identify specific initiatives best designed to address the health disparities of a given community.

The CNI score by ZIP code shows specific areas within a community where healthcare needs may be greater.

Dallas Metropolitan Health Community

Composite CNI: high scores indicate **high need**.



ZIP map where color shows the 2020 Community Need Index on a scale of 1 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).

Composite CNI score
3.85

Texas CNI score
3.85

US composite CNI score
3.00

Barrier	State	US
Income	3.0	3.0
Culture	4.7	3.0
Education	3.5	3.0
Insurance	4.3	3.0
Housing	3.9	3.0

The overall CNI score for the Dallas Metropolitan Health Community was 3.85. The difference in the numbers indicates both a strong link to community healthcare needs and a community’s demand for various healthcare services. In portions of the community, the CNI score was greater than 4.5, indicating more significant health needs among the population.

Appendix E: proprietary community data

IBM Watson Health supplemented the publicly available data with estimates of localized inpatient demand discharges, outpatient procedures, emergency department visits, heart disease, as well as cancer incidence estimates.

Social determinants of health are the structural determinants and conditions in which people are born, grow, live, work and age. All of which can greatly impact healthcare utilization and play a major role in the shifting healthcare landscape. Social determinants, such as education, income and race, are factored into Inpatient Demand Estimates and Outpatient Procedure Estimates utilization rate creation methodologies.

Inpatient demand estimates

Inpatient demand estimates provide the total volume of annual acute care admissions by ZIP code and DRG Product Line for every market in the United States. IBM uses all-payer state discharge data for publicly available states and Medicare (MEDPAR) data for the entire US. These rates are applied to demographic projections by ZIP code to estimate inpatient utilization for 2020 through 2030.

The following summary is reflective of the inpatient utilization trends for Dallas Metropolitan Health Community. Total discharges in the community are expected to grow by 9% by 2030, with pulmonary medical, general medicine and cardiovascular diseases projecting the largest growth.

Product line	2020 discharges	2025 discharges	2030 discharges	2020 - 2025 discharges change	2020 - 2025 discharges % change	2020 - 2030 discharges change	2020 - 2030 discharges % change
Alcohol and Drug Abuse	7,141	7,271	7,977	129	1.8%	836	11.7%
Cardio-Vasc-Thor Surgery	18,949	19,903	20,682	954	5.0%	1,733	9.1%
Cardiovascular Diseases	40,376	43,685	49,585	3,309	8.2%	9,209	22.8%
ENT	3,211	2,948	2,796	(263)	-8.2%	(415)	-12.9%
General Medicine	95,090	98,878	105,536	3,788	4.0%	10,446	11.0%
General Surgery	42,229	42,293	44,086	64	0.2%	1,857	4.4%
Gynecology	3,433	1,714	1,019	(1,719)	-50.1%	(2,414)	-70.3%
Nephrology/Urology	24,968	26,478	28,804	1,511	6.1%	3,836	15.4%
Neuro Sciences	28,497	29,631	32,606	1,135	4.0%	4,109	14.4%
Obstetrics Del	72,186	66,584	66,413	(5,603)	-7.8%	(5,773)	-8.0%
Obstetrics ND	5,837	5,060	4,817	(777)	-13.3%	(1,021)	-17.5%
Oncology	10,898	11,113	11,645	215	2.0%	747	6.9%
Ophthalmology	618	582	559	(35)	-5.7%	(59)	-9.5%
Orthopedics	43,975	44,224	46,569	249	0.6%	2,595	5.9%
Psychiatry	6,609	6,921	7,302	312	4.7%	692	10.5%
Pulmonary Medical	40,768	47,465	54,413	6,697	16.4%	13,645	33.5%
Rehabilitation	386	428	491	42	11.0%	105	27.3%
TOTAL	445,170	455,179	485,300	10,009	2.2%	40,130	9.0%

Source: IBM Watson Health Inpatient Demand Estimates, 2020.

Outpatient procedures estimates

Outpatient procedure estimates predict the total annual volume of procedures performed by ZIP code for every market in the United States using proprietary and public health claims, as well as federal surveys. Procedures are defined and reported by procedure codes and are further grouped into clinical service lines. The Dallas Metropolitan Health Community outpatient procedures are expected to increase by 34% by 2030 with the largest growth in the categories of labs, general & internal medicine, physical & occupational therapy and psychiatry.

Clinical service category	2020 procedures	2025 procedures	2020-2025 procedures % change	2030 procedures	2020 - 2030 procedures % change
Allergy & Immunology	1,587,849	1,743,492	9.8%	1,918,905	20.8%
Anesthesia	495,886	589,709	18.9%	679,857	37.1%
Cardiology	3,571,121	4,623,711	29.5%	6,025,048	68.7%
Cardiothoracic	3,778	4,392	16.2%	5,043	33.5%
Chiropractic	2,397,474	2,428,908	1.3%	2,415,828	0.8%
Colorectal Surgery	43,310	46,764	8.0%	50,547	16.7%
CT Scan	1,184,410	1,623,280	37.1%	2,201,727	85.9%
Dermatology	1,064,481	1,259,882	18.4%	1,479,401	39.0%
Diagnostic Radiology	6,581,771	7,305,699	11.0%	8,083,597	22.8%
Emergency Medicine	3,327,932	3,708,492	11.4%	4,145,981	24.6%
Gastroenterology	443,026	510,594	15.3%	583,398	31.7%
General & Internal Medicine	51,645,781	60,206,213	16.6%	68,564,815	32.8%
General Surgery	355,768	405,129	13.9%	461,814	29.8%
Hematology & Oncology	10,502,619	12,604,997	20.0%	14,645,542	39.4%
Labs	63,258,620	71,697,280	13.3%	81,245,484	28.4%
Miscellaneous	2,807,224	3,181,870	13.3%	3,578,171	27.5%
MRI	561,472	638,117	13.7%	723,577	28.9%
Nephrology	1,578,928	1,872,090	18.6%	2,191,354	38.8%
Neurology	822,177	909,539	10.6%	1,004,196	22.1%
Neurosurgery	27,251	39,845	46.2%	47,051	72.7%
Obstetrics/Gynecology	1,053,442	1,113,915	5.7%	1,207,578	14.6%
Ophthalmology	3,031,374	3,685,441	21.6%	4,379,420	44.5%
Oral Surgery	34,474	38,729	12.3%	43,895	27.3%
Orthopedics	871,881	986,153	13.1%	1,107,362	27.0%
Otolaryngology	1,988,604	2,239,512	12.6%	2,503,585	25.9%
Pain Management	583,599	665,604	14.1%	745,808	27.8%
Pathology	1,235	1,444	16.9%	1,680	36.0%
PET Scan	30,169	35,476	17.6%	41,013	35.9%
Physical & Occupational Therapy	17,149,219	20,664,584	20.5%	24,652,160	43.8%
Plastic Surgery	51,698	60,464	17.0%	70,606	36.6%
Podiatry	250,728	273,156	8.9%	293,368	17.0%
Psychiatry	7,496,759	9,877,263	31.8%	12,590,086	67.9%
Pulmonary	1,121,295	1,273,441	13.6%	1,454,033	29.7%
Radiation Therapy	494,235	562,109	13.7%	633,049	28.1%
Single Photon Emission CT Scan (SPECT)	77,814	88,488	13.7%	101,683	30.7%
Urology	379,853	449,695	18.4%	527,005	38.7%
Vascular Surgery	151,520	174,706	15.3%	199,104	31.4%
TOTAL	187,028,775	217,590,181	16.3%	250,602,769	34.0%

Source: IBM Watson Health Outpatient Procedure Estimates, 2020.

Emergency department visits

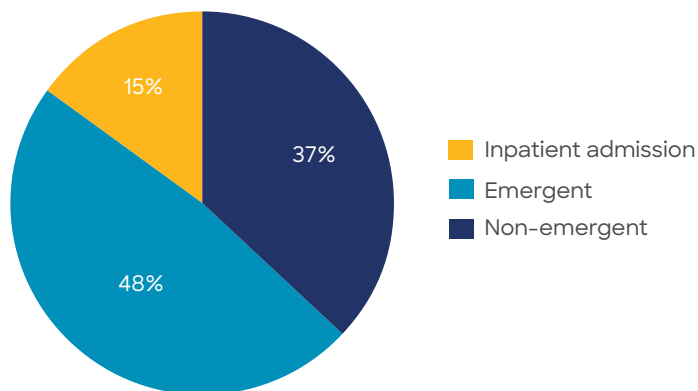
Emergency department estimates predict the total annual volume of emergency department (ED) visits by ZIP code and level of acuity for every market in the United States. IBM uses an extensive supply of proprietary claims, public claims and federal surveys to construct population-based use rates for all payors by age and sex. These use rates are then applied to demographic and insurance coverage projections by ZIP code to estimate ED utilization for 2020 through 2030.

Visits are broken out into emergent and non-emergent ambulatory visits to identify the volume of visits that could be seen in a less-acute setting, for example, a fast-track ED or an urgent care facility. In addition, visits that result in an inpatient admission are broken out into a third, separate category. In the Dallas Metropolitan Health Community, ED visits are expected to grow by 13.4% by 2025.

Emergent status	2020 visits	2025 visits	2020 - 2025 visits change	2020 - 2025 visits % change
Emergent	1,481,537	1,760,784	279,247	18.8%
Inpatient Admission	435,041	532,222	97,181	22.3%
Non-Emergent	1,303,559	1,358,002	54,443	4.2%
TOTAL	3,220,136	3,651,007	430,871	13.4%

Source: IBM Watson Health Emergency Department Visits, 2020.

Emergency department visit estimates 2025



Heart disease estimates

The heart disease estimates dataset predicts the number of cases by heart disease type and ZIP code for every market in the United States. IBM uses public and private claims data as well as epidemiological data from the National Health and Nutritional Examination Survey (NHANES) to build local estimates of heart disease prevalence for the current population. County-level models by age and sex are applied to the underlying demographics of specific geographies to estimate the number of patients with specific types of heart disease.

In Dallas Metropolitan Health Community, the most common heart disease is hypertension at 72.7% of all heart disease cases.

Disease type	2020 prevalence	2020 % prevalence
Arrhythmia	287,089	12.3%
Heart Failure	131,574	5.6%
Hypertension	1,700,631	72.7%
Ischemic Heart Disease	219,653	9.4%
TOTAL	2,338,947	100.0%

Source: IBM Watson Heart Disease Estimates, 2020.

Cancer estimates

IBM Watson Health builds county-level cancer incidence models that are applied to the underlying demographics of specific geographies to estimate incidence (i.e., the number of new cancer cases annually) of all cancer patients. Cancer incidence is expected to increase by almost 11.2% in the Dallas Metropolitan Health Community by 2025.

Cancer type	2020 incidence	2025 incidence	2020 - 2025 change	2020 - 2025 % change
Bladder	1,259	1,488	229	18.2%
Brain	589	651	62	10.6%
Breast	6,716	7,681	965	14.4%
Colorectal	3,531	3,381	-150	-4.2%
Kidney	1,338	1,589	252	18.8%
Leukemia	1,114	1,290	176	15.8%
Lung	3,454	3,891	437	12.6%
Melanoma	1,393	1,636	243	17.4%
Non-Hodgkin's Lymphoma	1,595	1,851	256	16.1%
Oral Cavity	973	1,129	156	16.1%
Other	3,835	4,479	644	16.8%
Ovarian	513	564	51	10.0%
Pancreatic	864	1,045	181	20.9%
Prostate	4,243	4,203	-40	-0.9%
Stomach	581	649	68	11.7%
Thyroid	959	1,102	142	14.8%
Uterine Cervical	239	244	5	1.9%
Uterine Corpus	880	1,027	147	16.7%
TOTAL	34,075	37,899	3,823	11.2%

Source: IBM Watson Health Cancer Estimates, 2020.

Appendix F: 2019 community health needs assessment evaluation

It is Baylor Scott & White Health's privilege to serve faithfully in promoting the well-being of all individuals, families and communities. Our 2019 Implementation Strategy described the various resources and initiatives we planned to direct toward addressing the adopted health needs of the 2019 CHNA.

Following is a snapshot of the impact of actions taken by Baylor Scott & White to address the below priority health issues.

Dates: Fiscal Years 2020 – March 2022

Facilities: BSW Institute for Rehabilitation, BSW Heart & Vascular Hospital – Dallas, BSWMC – Uptown, Baylor University Medical Center, North Central Surgical Center, BSWMC – Sunnyvale

Community served: Collin, Dallas, Denton, Ellis, Henderson, Hunt, Kaufman, Navarro, Rockwall, Tarrant and Van Zandt Counties

Ratio of Population to Primary Care Providers (Physician/Non-Physician)

Baylor University Medical Center

Action/tactics	Anticipated outcome	Evaluation of impact
Community education/outreach Provide free community education sessions on various health topics out in community, health fairs, health screenings, etc. Health & Wellness Center programs including: PEERS, Walk with a Doc, Healthy Cities, Group Lifestyle Balance, exercise program, diabetes management, cooking classes, community farm stand, etc.	Community members become more aware of the importance of regular doctor's visits to avoid having long-term complications and potentially high ED bills. Community members are given easy access to healthy lifestyle programs and education.	<ul style="list-style-type: none"> • Persons served: 24,853 • \$34,878 community benefit
Financial donations Financial donations to community organizations meeting identified needs, improving community health, or assisting with needs arising from community impacts, such as job loss due to closures or reduced/no income due to quarantines for families on limited incomes due to COVID-19.	Relief for food insecurity and homelessness due to the economic impact of the coronavirus and relief from mental health issues arising from quarantining/coronavirus economic defeat. Improved access to community resources.	<ul style="list-style-type: none"> • Persons served: 23,345 • \$815,655 community benefit
Physician recruitment Physician recruitment in medically underserved areas to increase the number of providers available to serve community.	Increase primary care providers in the community. Reduction in shortage resulting in better health of community.	<ul style="list-style-type: none"> • \$1,082,108 community benefit
Enrollment services Help enroll patients in public programs such as CHIP and Medicaid to increase access and quality of care.	Overcome access issues and reduce hospital expenses.	<ul style="list-style-type: none"> • Persons served: 2,568 • \$1,566,853 community benefit
Charity care Provide free/discounted care to financially or medically indigent patients as outlined in the financial assistance policy. Healthcare infrastructure; supplies; staff.	Increased access to primary care and/or specialty care for indigent persons regardless of their ability to pay.	<ul style="list-style-type: none"> • \$125,613,447 community benefit

Ratio of Population to Primary Care Providers (Physician/Non-Physician)

Baylor Scott & White Heart and Vascular Hospital – Dallas

Action/tactics	Anticipated outcome	Evaluation of impact
Enrollment services Conduct enrollment services to assist in the qualification of the medically underserved.	Enable access to care through Medicaid, Medicare, SCHIP, and other government programs or charity care programs.	<ul style="list-style-type: none"> • Persons served: 39 • \$18,457 community benefit
Clinical training program To help address the state's healthcare workforce shortage BSWH provides a clinical training program to prepare nurses for the medical workforce.	Increased access to care through preparation for the medical workforce.	<ul style="list-style-type: none"> • Persons served: 328 • \$1,906,699 community benefit
Community health education Provide free community education sessions on various health topics out in community, health fairs, health screenings, etc.	Free access to quality healthcare services, healthy lifestyle programs and education.	<ul style="list-style-type: none"> • Persons served: 5,761 • \$62,846 community benefit
Charity care Provide free/discounted care to financially or medically indigent patients as outlined in the financial assistance policy. Healthcare infrastructure; supplies; staff.	Increased access to primary care and/or specialty care for indigent persons regardless of their ability to pay.	<ul style="list-style-type: none"> • \$10,900,000 community benefit

Baylor Scott & White Institute for Rehabilitation – Dallas

Baylor Scott & White Medical Center – Sunnyvale

Baylor Scott & White Medical Center – Uptown

North Central Surgical Center

Action/tactics	Anticipated outcome	Evaluation of impact
Charity care Provide free/discounted care to financially or medically indigent patients as outlined in the financial assistance policy. Healthcare infrastructure; supplies; staff.	Increased access to primary care and/or specialty care for indigent persons regardless of their ability to pay.	BSW Institute for Rehabilitation <ul style="list-style-type: none"> • \$6,056,173 community benefit BSWMC – Sunnyvale <ul style="list-style-type: none"> • \$2,244,276 community benefit BSWMC – Uptown <ul style="list-style-type: none"> • \$90,933 community benefit North Central Surgical Center <ul style="list-style-type: none"> • \$137,826 community benefit

Ratio of population to one mental health provider

Baylor University Medical Center

Action/tactics	Anticipated outcome	Evaluation of impact
Depression screening Provide depression screening for all emergency department patients.	Increased likelihood of early diagnosis and referral for depression in the Medicare population.	<ul style="list-style-type: none"> • Persons served: 29,661 • Social determinants of health questions with questions surrounding depression and mental health were added into the BSW electronic health record, EPIC, in July 2021.
Arts in Medicine Art therapy, artist in residence, certified music practitioners, music therapy.	Creative expression and experiences provide social-emotional benefits to mental health by reducing stress and building self-awareness, empathy and community. Process is an antidote to pain, anxiety and boredom.	<ul style="list-style-type: none"> • 6 Arts in Medicine programs • Persons served: 209,624 • \$85,778 community benefit
Patient Education Center Support Groups	Cancer education and support are an important part of the cancer treatment process to help patients and families understand and manage physical, emotional and spiritual challenges.	<ul style="list-style-type: none"> • 13 Support groups • Persons served: 1,807 • \$2,260 community benefit
Faith Community Health	Empowers local faith communities to foster health and wellness by providing more effective patient navigation, education and support.	<ul style="list-style-type: none"> • Persons served: 81 • \$1,434 community benefit
DSRIP Behavioral Health Clinics Integrates behavioral health services into the outpatient primary care setting.	LCSW identifies, addresses and makes appropriate referrals for behavioral health needs, such as anxiety, depression and basic counseling services.	<ul style="list-style-type: none"> • Persons served: 7,473
Behavioral Health Sitter Services Utilizes nurses and patient care technicians as sitters for patients with altered mental status and/or suicidal ideation.	Sitters provide relief for patients' families when the patient is distressed, dying or suicidal. Reduces the risk of falling.	<ul style="list-style-type: none"> • Persons served - unknown • \$1,093,398 community benefit

Transportation

Baylor University Medical Center

Action/tactics	Anticipated outcome	Evaluation of impact
Transportation Program - Ride Health	Provide patients assistance with transportation to appointments to decrease inappropriate ED visits.	<ul style="list-style-type: none"> • Persons served: unknown • \$1,577,789 community benefit • Ride Health program set to go live in April 2022.

Transportation

Baylor Scott & White Heart and Vascular Hospital – Dallas

Action/tactics	Anticipated outcome	Evaluation of impact
Transportation Program Pre-admit, discharge and follow-up transportation needs.	Improved health outcomes.	<ul style="list-style-type: none"> • Persons served: unknown • \$11,583 community benefit
Ride Share Baylor Heart and Vascular Ride Share App—explore the potential to develop a platform for making ride appointments for patients in need within the Baylor Heart Center app.	Decreased no-shows and improved health outcomes.	Still in planning. Not yet implemented.

Baylor Scott & White Institute for Rehabilitation – Dallas

Baylor Scott & White Medical Center – Sunnyvale

Action/tactics	Anticipated outcome	Evaluation of impact
Transportation Program Pre-admit, discharge and follow-up transportation needs.	Improved health outcomes.	BSW Institute for Rehabilitation <ul style="list-style-type: none"> • Persons served: 70 • \$2,724 community benefit Sunnyvale <ul style="list-style-type: none"> • Persons served: 12 • \$272 community benefit

Ratio of Population to One Dentist

Baylor University Medical Center

Action/tactics	Anticipated outcome	Evaluation of impact
Dental Referrals Support Agape Dental and provide referrals for care to Agape Dental and Texas A&M College of Dentistry.	Improved access to dental care.	Implementation of this program was delayed due to COVID-19, but discussion on collaboration is still underway.

Total investment in adopted community needs since 2019 CHNA

Baylor University Medical Center \$131.8 million	BSW Institute for Rehabilitation – Dallas \$6 million	BSW Heart and Vascular Hospital – Dallas \$12.9 million
BSWMC – Uptown \$91,000	North Central Surgical Center \$138,000	BSWMC – Sunnyvale \$2.2 million



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