# Community Health Needs Assessment

Frisco Health Community
2022

**Baylor Scott & White**
HEALTH

# Frisco health community hospitals

- **Baylor Scott & White Medical Center – Centennial**

- **Baylor Scott & White Medical Center – Frisco**

- **Baylor Scott & White Institute for Rehabilitation – Frisco**

**BaylorScott&White**
**HEALTH**

# Table of contents

# 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

STRATEGIES

**Health
Experience
Affordability
Alignment
Growth**

**We serve faithfully**

**We act honestly**

**We never settle**

**We are in it together**

VALUES

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

AMBITION

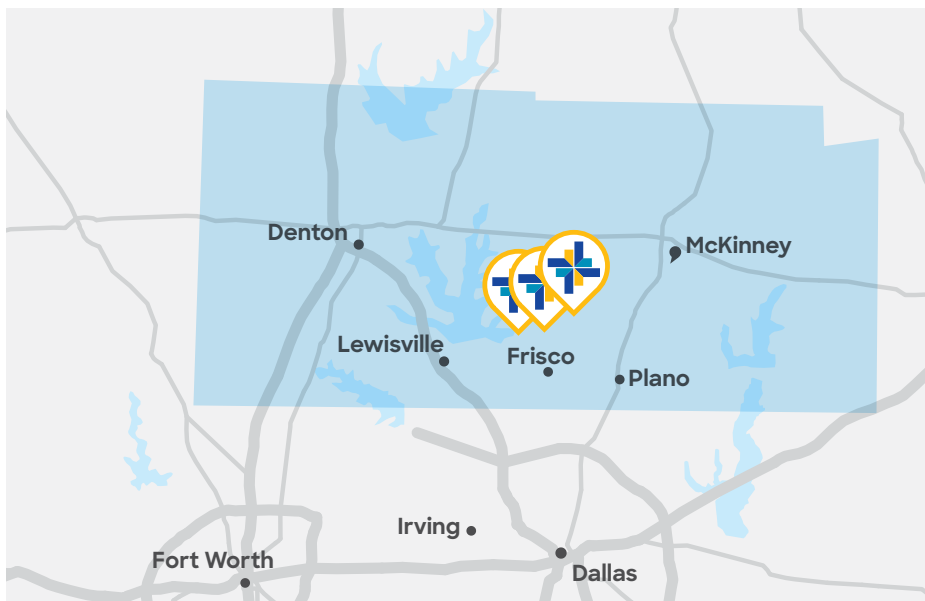# Community Health Needs Assessment (CHNA) report

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

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

• Baylor Scott & White Medical Center – Centennial

• Baylor Scott & White Medical Center – Frisco

• Baylor Scott & White Institute for Rehabilitation – Frisco

The community served by the hospital facilities listed above is Collin and Denton 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.

## Frisco 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.

| Define the community | → | Assess the community | → | Identify and prioritize "significant needs" |

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 Frisco 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 significantly lower percentage of uninsured and underinsured than Texas and significantly higher employer payer group.

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

# Health community data summary

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

- Inpatient discharges in the community are expected to grow by almost 18% by 2030 with the largest growing product lines to include:
  - Pulmonary medical
  - General medicine
  - Cardiovascular diseases
  - Orthopedics
- Outpatient procedures are expected to increase by over 38% by 2030 with the largest areas of growth including:
  - Labs
  - General & internal medicine
  - Physical & occupational therapy
  - Hematology & oncology
  - Psychiatry
- Emergency department visits are expected to grow by over 20% by 2025.
- Hypertension represents almost 74% of all heart disease cases.
- Cancer incidence is expected to increase by almost 16% by 2025.

Further health community information for the Frisco 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 | MUA/P |
|---|---|---|---|---|---|
| Collin | | 1 | | 1 | |
| Denton | 1 | 2 | 1 | 4 | 1 |

Source: US Department of Health and Human Services, Health Resources and Services Administration, 2021
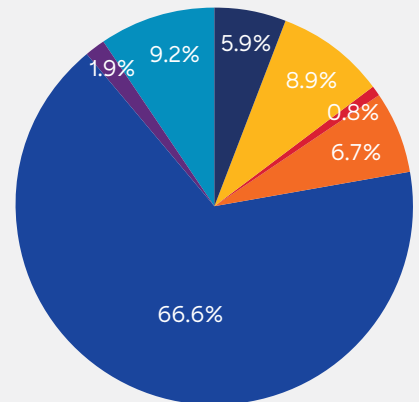
Total population
# 1,934,233

Average income
# $100,537

Underserved ZIP codes
# 2

## Insurance coverage



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

# Priority health needs

Using these and other data collection and interpretation methods, BSWH identified what it considers to be the community's key health needs. The resulting prioritized health needs for this community include:

| Priority | Need | Category of need |
|:---:|---|---|
| 1 | Access to mental health | Mental health |
| 2 | Mentally unhealthy days/depression Social isolation | Mental health/ environment |
| 3 | Access to primary care | Access to care |
| 4 | Diabetes/obesity | Conditions/diseases |
| 5 | Female breast cancer | Conditions/diseases |

# Priority 1: 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 |
|---|---|---|
| Mental health | • Population to one mental health provider | • Limited access to healthcare services especially in rural areas |

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



Collin 809.00   15
Denton 843.00   14

County indicator values   0   10   20   30   40   50

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

Counties are listed in alphabetical order within NTX-Frisco 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.

The focus group participants noted that there is a high demand in the community for mental/behavioral health services, but access is limited. The group anticipates further growth and increased severity of mental health in the future due to patients being underserved during COVID, which can only widen the access gaps that exist.

In the prioritization session, the hospital and community leaders agreed that mental health is a massive need and the importance of BSWH and other community stakeholders developing a more robust behavioral health strategy to ensure residents have adequate access.
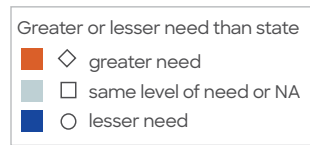
# Priority 2: Mentally Unhealthy/Depression/Social Isolation

The following indicates greater need in the areas of mentally unhealthy days, depression and isolation.

| Category | Data shows greater need | Key informants indicate greater need |
|---|---|---|
| Mental health | • Mentally unhealthy days<br>• Medicare population: depression | • Social isolation and loneliness caused increased depression and mental health needs |

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).
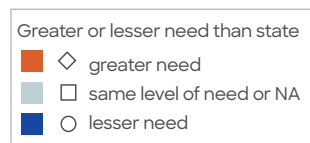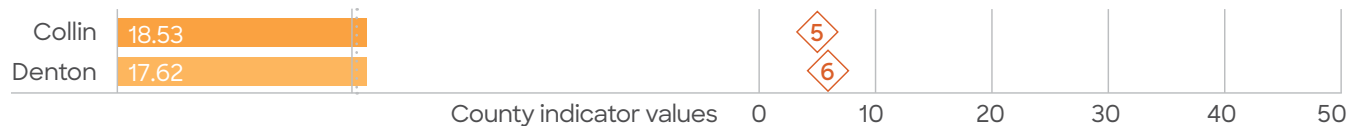
### Mentally unhealthy days (average days reported as mentally unhealthy in past 30 days by county)

| County | Value | | | | |
|---|---|---|---|---|---|
| Collin | 3.45 | | | | ⑳ |
| Denton | 3.88 | | | ◇13 | |
| County indicator values | | 0  10  20  30  40  50 | | | |

**Greater or lesser need than state**
- ◇ greater need (orange)
- ☐ same level of need or NA
- ○ lesser need (blue)

Counties are listed in alphabetical order within NTX-Frisco 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.

The **Medicare population: depression** indicator is defined as **the prevalence of depression across all Medicare beneficiaries** and is based on data from CMS.gov Chronic Conditions.

### Medicare population: depression (percent of Medicare beneficiaries with depression by county)

| County | Value | | | | |
|---|---|---|---|---|---|
| Collin | 18.53 | | ◇5 | | |
| Denton | 17.62 | | ◇6 | | |
| County indicator values | | 0  10  20  30  40  50 | | | |

**Greater or lesser need than state**
- ◇ greater need (orange)
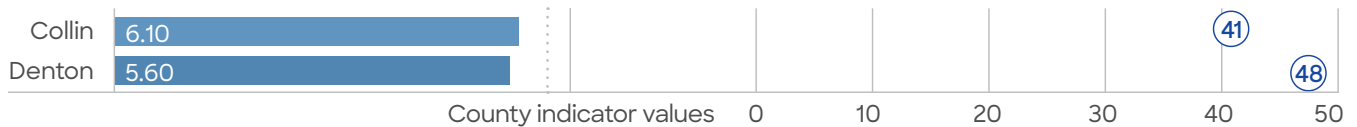- ☐ same level of need or NA
- ○ lesser need (blue)

Counties are listed in alphabetical order within NTX-Frisco 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.

| Category | Data shows less need or no data | Key informants indicate greater need |
|---|---|---|
| Environment | • Elderly isolation | • Elderly isolation due to COVID |

The **elderly isolation** measure is defined as **the percent of non-family households (householder living alone) age 65 years and over**. The indicator is based on data from American Community Survey Five-Year Estimates, US Census Bureau – American FactFinder.

### Elderly isolation (% householder age 65+ living alone by county)



Collin 6.10    41
Denton 5.60    48
County indicator values    0   10   20   30   40   50

**Greater or lesser need than state**
- greater need
- same level of need or NA
- lesser need

Counties are listed in alphabetical order within NTX–Frisco 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.

The focus group participants stated that mental health issues are a problem in the health community. The growing aging population brings with it an increase in cases of dementia and altered mental health. In addition, COVID caused a negative impact on the mental health of people from divisiveness and fear. It also increased social isolation, unease, separation and loneliness, which in turn increased depression and mental health needs in the community.

In the prioritization session, the hospital and community leaders agreed that mental health needs exist in the community and discussed the value of supporting the basic needs of the community members. They added that pressures from social media and isolation throughout the pandemic have impacted substance abuse in teenagers and young adults as well.

# Priority 3: Access to Primary Care

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.

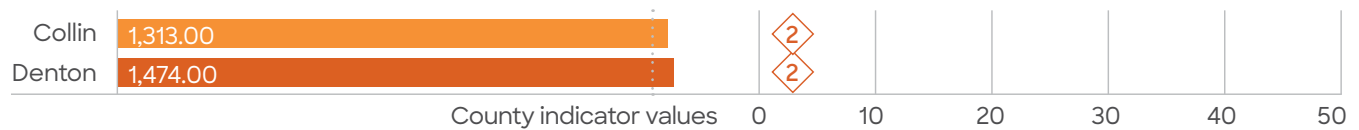| Category | Data shows greater need | Key informants indicate greater need |
|---|---|---|
| Access to care | • Population to one primary care physician<br>• Population to one non-physician primary care provider | • Limited access to healthcare services especially in rural areas<br>• High demand for primary care and limited number of primary care providers |

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)

| | |
|---|---|
| Collin | 986.00 |
| Denton | 1,851.00 |

County indicator values: 0 10 20 30 40 50 60

(Denton: 3 — greater need) (Collin: 51 — lesser need)

The **population to one non-physician primary care provider** 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)

| | |
|---|---|
| Collin | 1,313.00 |
| Denton | 1,474.00 |

County indicator values: 0 10 20 30 40 50

(Collin: 2 — greater need) (Denton: 2 — greater need)

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

Counties are listed in alphabetical order within NTX-Frisco 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.

The focus group participants felt that the overall community area has limited access to primary care providers, especially for those covered by Medicaid. High demand for primary care and a limited number of primary care providers leads to difficulty accessing primary care.

In the prioritization session, the hospital leadership noted that barriers in the Frisco Health Community include difficulty making same-day appointments with established primary care physicians, rapid urban sprawl contributing to a lack of providers, particularly in the Celina and Prosper communities, and a large influx of corporate headquarters moving to the Frisco area with employees who would like to access care close to work versus home.

# Priority 4: Diabetes/Obesity

The following indicates a need in the areas of diabetes and adult obesity.

| Category | Data shows greater need | Key informants indicate greater need |
|---|---|---|
| Conditions/ diseases | • Diabetes admission | • Chronic illnesses are not managed well and patients don't access necessary care regularly |

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 measure is based on data from Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations.

### Diabetes admission (number observed/adult population in county)

| | | County indicator values | 0 | 10 | 20 | 30 | 40 | 50 |
|---|---|---|---|---|---|---|---|---|
| Collin | 51.41 | | 1 | | | | | |
| Denton | 53.65 | | 1 | | | | | |

| Category | Data shows greater need | Key informants indicate less need or not mentioned |
|---|---|---|
| Conditions/ diseases | • Adult obesity | • 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)

| | | County indicator values | 0 | 10 | 20 | 30 | 40 | 50 |
|---|---|---|---|---|---|---|---|---|
| Collin | 25.40 | | | | | 33 | | |
| Denton | 32.00 | | | 15 | | | | |

**Greater or lesser need than state**
- ◇ greater need
- ☐ same level of need or NA
- ○ lesser need

Counties are listed in alphabetical order within NTX–Frisco 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.

Although adult obesity was not specifically discussed by the key informants, they did note chronic illnesses and conditions, such as diabetes and obesity, are not managed well, and patients do not access necessary care regularly. They anticipate that the problem will only worsen due to patients being underserved during COVID. They also added that although food banks and Meals on Wheels are available to the community, the chronically ill are not helped by these sources because they lack the options for restricted diets, such as low sodium, etc., that these conditions require.

In the prioritization session, hospital leadership felt that the problems of high diabetes and obesity in the community are due to negative life habits. They discussed the direct link they see between adult obesity and diabetes. As the population ages, they expect the community incidence of diabetes to increase.
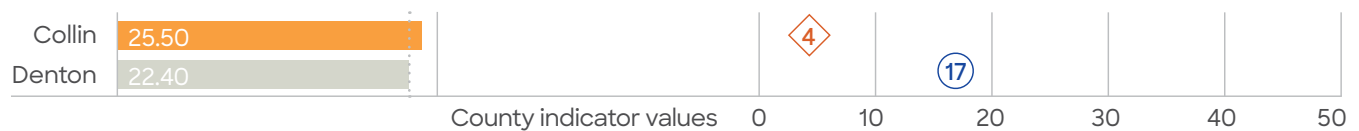
# Priority 5: Female Breast Cancer

Although the data indicates greater need to address female breast cancer incidence, the key informants did not mention it specifically.

| Category | Data shows greater need | Key informants indicate less need or not mentioned |
|---|---|---|
| Conditions/ diseases | • Cancer incidence: female breast | • Not specifically mentioned |

The **cancer incidence: female breast** measure is defined **as age-adjusted female breast cancer incidence rate cases per 100,000 population**. The indicator is based on data from State Cancer Profiles, National Cancer Institute (CDC).

## Cancer incidence: female breast (rate of breast cancer among females per 100,000 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-Frisco 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.

The incidence of female breast cancer was not discussed by the key informants.

In the prioritization session, hospital leadership agreed that as the population ages in Frisco, community incidence of breast cancer will also increase and needs to be identified as a significant need.

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 included gathering input on potentially available community resources. A statewide Community Resource Guide and suggestions from some of our assessment participants helped identify community resources that may help address this community's known health needs.

## Frisco community resources

| Need | Organization | Address | Phone |
|---|---|---|---|
| Access to mental healthcare providers/ resources | SMU Counseling | 5228 Tennyson Parkway Plano, TX 75024 | 972.473.3456 |
| | LifePath Systems (behavioral health services) | 7308 Alma Drive Plano, TX 75025 | 877.422.5939 |
| | CK Family Services (CK) (youth behavioral health services) | 710 E. Park Boulevard Plano, TX 75074 | 817.516.9100 |
| | Grace Counseling, Inc. | 105 Kathryn Drive Lewisville, TX 75067 | 844.564.0712 |
| | Child & Family Guidance Center (CFGC) | 4031 W. Plano Parkway Plano, TX 75093 | 866.695.3794 |
| Mentally unhealthy days/social isolation/ depression | Custer Road United Methodist Church (pastoral care/ spiritual support) | 6601 Custer Road Plano, TX 75023 | 972.618.3450 ext. 227 |
| | Lifeologie Institute (counseling) | 3600 Shire Boulevard Richardson, TX 75082 | 214.556.0996 |
| | Plano Family YMCA (social isolation/health education) | 3300 McDermott Road Plano, TX 75025 | 214.705.9459 |
| | Prelude Clubhouse – Psychosocial Rehabilitation Clubhouse | 1947 K Avenue Plano, TX 75074 | 972.424.2990 |
| | NAMI North Texas (virtual support groups) | Virtual – covers: Dallas County, Collin County, Denton County | 214.341.7133 |
| Access to primary healthcare | Carevide | 111 N. Johnson Street Farmersville, TX 75442 | 903.455.5958 |
| | Community Healthcare Center | 1620 W. Virginia Street McKinney, TX 75069 | 940.766.6306 |
| | Community Health Clinic | 120 Central Expressway McKinney, TX 75070 | 972.547.0606 |
| | Hope Clinic | 103 E. Lamar Street McKinney, TX 75069 | 469.712.4246 |
| | Collin County Primary Care Services (PrimaCare program) | 1920 Eldorado Parkway McKinney, TX 75069 | 469.952.3737 |

| Need | Organization | Address | Phone |
|------|-------------|---------|-------|
| Diabetes/ obesity | Plano Family YMCA | 3300 McDermott Road Plano, TX 75025 | 214.705.9459 |
| | Collin County Health Care Services (WIC – nutrition education) | 900 E. Park Boulevard Plano, TX 75074 | 972.633.3350 |
| | McKinney Family YMCA | 300 Ridge Road McKinney, TX 75072 | 972.529.2559 |
| | Denton County Health Department (WIC – nutrition education) | 3044 Old Denton Road Carrollton, TX 75007 | 940.349.2930 |
| | Community Health Clinic (diabetic care) | 120 Central Expressway McKinney, TX 75070 | 972.547.0606 |
| Female breast cancer | Planned Parenthood of Greater Texas (Cancer screenings – Plano Health Center) | 600 N. Central Expressway Plano, TX 75074 | 972.424.6311 |
| | Health Services of North Texas (HSNT) (women's wellness and family planning) | 2540 K Avenue Plano, TX 75074 | 972.424.1480 |
| | HSNT at Denton South Center | 3537 S. Interstate 35 Suite 201 Denton, TX 76210 | 940.381.1501 |
| | Carevide (preventive care, disease screenings, disease management) | 111 N. Johnson Street Farmersville, TX 75442 | 903.455.5958 |
| | Community Health Clinic (women's wellness exams) | 120 Central Expressway McKinney, TX 75070 | 972.547.0606 |

There are many other community resources and facilities serving the Frisco 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 its 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:

Define the community

▼

Assess the community

▼

Identify "significant needs" and "prioritize"

▼

Document in written report

▼

CHNA board approvals

▼

Make CHNA widely available on website

▼

Written implementation strategy

▼

Implementation strategy board approval

▼

Make implementation strategy widely available on website

▼

Act on strategy, measure and report

## 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 December 15, 2021, 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.



High data/Low qualitative — High data/High qualitative

| High data/Low qualitative | High data/High qualitative |
|---|---|
| Data compared to state benchmark indicates need by a <u>greater</u> magnitude **BUT** Topic was <u>not</u> raised in interviews and focus groups | Data compared to state benchmark indicates need by a <u>greater</u> magnitude **AND** Topic was a <u>frequent</u> theme in interviews and focus groups |
| Data compared to state benchmark indicates need by a <u>lesser</u> magnitude **AND** Topic was <u>not</u> raised in interviews and focus groups | Data compared to state benchmark indicates need by a <u>lesser</u> magnitude **BUT** Topic was a <u>frequent</u> theme in interviews and focus groups |

Low data/Low qualitative — Low/no data/High qualitative

High data = Indicators worse than state benchmark by greater magnitude
High qualitative = Frequency of topic in interviews and focus groups

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.
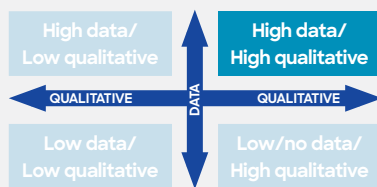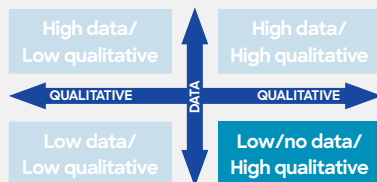


**High data and high qualitative:** The community indicators that showed a greater need in the health community overall when compared to the state of Texas comparative benchmark and were identified as a greater need by the key informants.
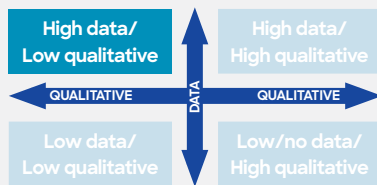


**High data and low qualitative:** The community indicators showed a greater need in the health community overall when compared to the state of Texas comparative benchmark but were not identified as a greater need or not specifically identified by the key informants.



**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.

- **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?

- **Severity:** The problem results in disability or premature death or creates burdens on the community, economically or socially.

The group rated each of the five 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 | Access to mental health | Mental health |
| 2 | Mentally unhealthy days/depression Social isolation | Mental health/ environment |
| 3 | Access to primary care | Access to care |
| 4 | Diabetes/obesity | Conditions/diseases |
| 5 | Female breast cancer | Conditions/diseases |

# 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/m2 |
| 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). |
| 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). |

| Indicator name | Indicator source | Indicator definition |
|---|---|---|
| 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 |
| 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 |

| Indicator name | Indicator source | Indicator definition |
|---|---|---|
| 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. |
| 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. |
| 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. |

| Indicator name | Indicator source | Indicator definition |
|---|---|---|
| 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 |
| 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 |

| Indicator name | Indicator source | Indicator definition |
|---|---|---|
| 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. |
| 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:

- Baylor Scott & White Health
- Baylor Scott & White The Heart Hospital – Denton
- Baylor Scott & White Medical Center – McKinney
- Baylor Scott & White Medical Center – Plano
- Collin County RHP 18
- Callier Center for Communication Disorders
- Church of Jesus Christ of LDS
- City of Denton
- Collin County Coalition Charitable Clinics
- Collin County Health Care Services
- Collin County Health Department
- Collin County Public Health
- Collin College Homeless Coalition
- Community Lifeline Center
- Community Services, Inc.

- Denton County MHMR Center
- First Refuge Ministries
- First United Methodist, Richardson
- Health Services of North Texas
- Julia's Center
- Metroport Meals on Wheels
- My Possibilities
- North Central Texas Health Care Center Comm.
- North Texas Food Bank
- Plano Fire-Rescue
- Texas Health Resources
- United Way
- Visiting Nurse Association of Texas – Dallas/Fort Worth
- Wellness Center for Older Adults

# 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 slightly older than Texas but younger than the United States. Median income is significantly 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 and the US.

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

| Geography | | Benchmarks | | Community served |
|---|---|---|---|---|
| | | **United States** | **Texas** | **Frisco health community** |
| Total current population | | 330,342,293 | 29,321,501 | 1,934,233 |
| Five-year projected population change | | 3.3% | 6.6% | 8.9% |
| Median age | | 38.6 | 35.2 | 37.6 |
| Population 0 – 17 | | 22.4% | 25.7% | 24.6% |
| Population 65+ | | 16.6% | 13.2% | 11.4% |
| Women age 15 – 44 | | 19.5% | 20.5% | 21.0% |
| Hispanic population | | 19.0% | 40.7% | 17.9% |
| Insurance coverage | Uninsured | 9.9% | 18.8% | 9.2% |
| | Medicaid | 20.9% | 13.0% | 5.9% |
| | Private market | 8.3% | 8.4% | 8.6% |
| | Medicare | 13.8% | 12.7% | 9.7% |
| | Employer | 47.2% | 47.1% | 66.6% |
| Median HH income | | $65,618 | $63,313 | $100,537 |
| No high school diploma | | 12.2% | 16.7% | 6.9% |

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

The community served expects to grow 8.9% by 2025, an increase of almost 173,000 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:

- 75002 Allen – 7,402 additional people

- 75035 Frisco – 7,244 additional people

- 75098 Wylie – 7,020 additional people

The community's population is younger with 52.2% of the population ages 18 - 54 and 24.6% under age 18. The age 65-plus cohort is expected to experience the fastest growth (31%) 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 distribution

| Age group | Age distribution | | | | |
| | 2020 | % of total | 2025 | % of total | USA 2020 % of total |
| --- | --- | --- | --- | --- | --- |
| 0 – 14 | 389,622 | 20.1% | 389,674 | 18.5% | 18.5% |
| 15 – 17 | 86,897 | 4.5% | 93,708 | 4.4% | 3.9% |
| 18 – 24 | 180,720 | 9.3% | 210,268 | 10.0% | 9.5% |
| 25 – 34 | 248,153 | 12.8% | 254,638 | 12.1% | 13.5% |
| 35 – 54 | 581,357 | 30.1% | 597,611 | 28.4% | 25.2% |
| 55 – 64 | 227,783 | 11.8% | 273,179 | 13.0% | 12.9% |
| 65+ | 219,701 | 11.4% | 287,989 | 13.7% | 16.6% |
| **Total** | **1,934,233** | **100.0%** | **2,107,067** | **100.0%** | **100.0%** |

### Household Income distribution

| 2020 Household income | Income distribution | | |
| | HH count | % of total | USA % of total |
| --- | --- | --- | --- |
| <$15K | 33,231 | 4.8% | 10.0% |
| $15 – 25K | 29,194 | 4.2% | 8.6% |
| $25 – 50K | 102,009 | 14.7% | 20.7% |
| $50 – 75K | 101,285 | 14.6% | 16.7% |
| $75 – 100K | 90,000 | 13.0% | 12.4% |
| Over $100K | 337,676 | 48.7% | 31.5% |
| | | | |
| **Total** | **693,395** | **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 | 42,071 | 3.3% | 5.2% |
| Some high school | 45,662 | 3.6% | 7.0% |
| High school degree | 206,129 | 16.1% | 27.2% |
| Some college/assoc. degree | 362,829 | 28.4% | 28.9% |
| Bachelor's degree or greater | 620,303 | 48.6% | 31.6% |
| **Total** | **1,276,994** | **100.0%** | **100.0%** |

### Race/ethnicity

| Race/ethnicity | Race/ethnicity distribution | | |
| | 2020 pop | % of total | USA % of total |
| --- | --- | --- | --- |
| White non-Hispanic | 1,080,391 | 55.9% | 59.3% |
| Black non-Hispanic | 196,176 | 10.1% | 12.4% |
| Hispanic | 346,786 | 17.9% | 19.0% |
| Asian & Pacific is. non-Hispanic | 250,778 | 13.0% | 6.0% |
| All others | 60,102 | 3.1% | 3.3% |
| **Total** | **1,934,233** | **100.0%** | **100.0%** |

Source: IBM Watson Health / Claritas, 2020.

## Population estimates

| Population | National | Selected area |
|---|---|---|
| 2010 total | 308,745,538 | 1,442,426 |
| 2020 total | 330,342,293 | 1,934,233 |
| 2025 total | 341,132,738 | 2,107,067 |
| 2030 total | 353,513,931 | 2,329,860 |
| % change 2020 – 2025 | 3.27% | 8.94% |
| % change 2020 – 2035 | 7.01% | 20.45% |

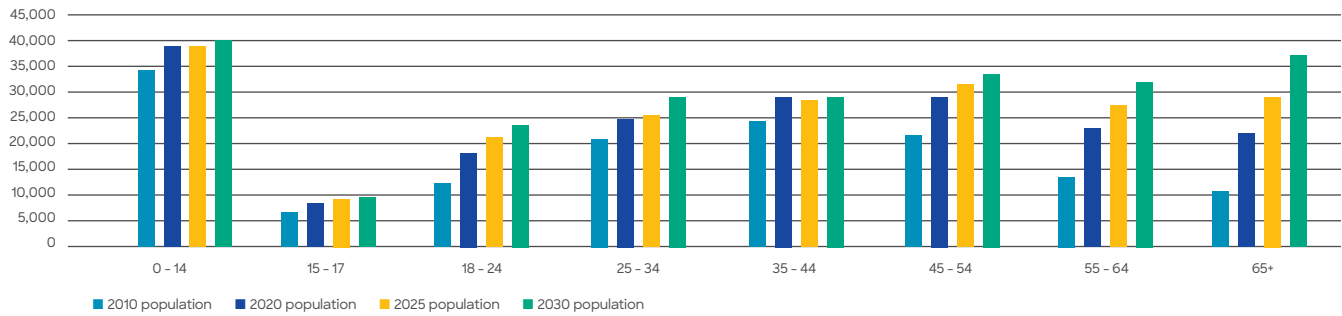| Population | Males all ages | Females all ages | Females childbearing |
|---|---|---|---|
| 2010 total | 708,910 | 733,516 | 326,036 |
| 2020 total | 950,997 | 983,236 | 406,446 |
| 2025 total | 1,034,882 | 1,072,185 | 423,103 |
| 2030 total | 1,142,686 | 1,187,174 | 457,066 |
| 10Y % | 20.16% | 20.74% | 12.45% |
| National | 7.02% | 7.01% | 4.01% |

## 2020 race and ethnicity with total population
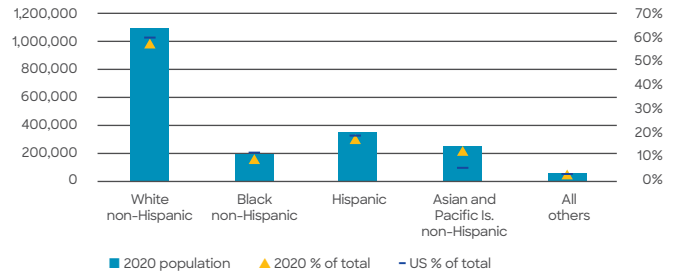


## Population by sex 2010 – 2030
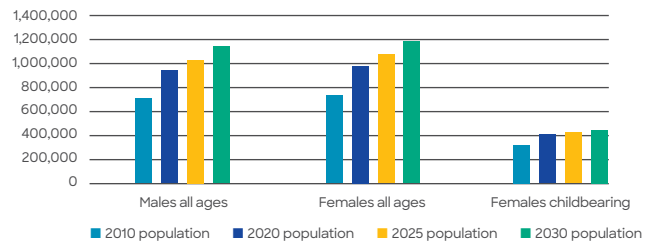


## Population by age group 2010 – 2030



Source: IBM Watson Health / Claritas, 2020.

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 $173,555 for 75022 Flower Mound to $33,629 for 76201 Denton. The only other ZIP code with a median household income less than $52,400—twice the 2020 federal poverty limit for a family of four—was 76205 Denton with $48,554.

A majority of the population (67%) is insured through employer sponsored health coverage. The remainder of the population is 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.



© 2022 Mapbox © OpenStreetMap
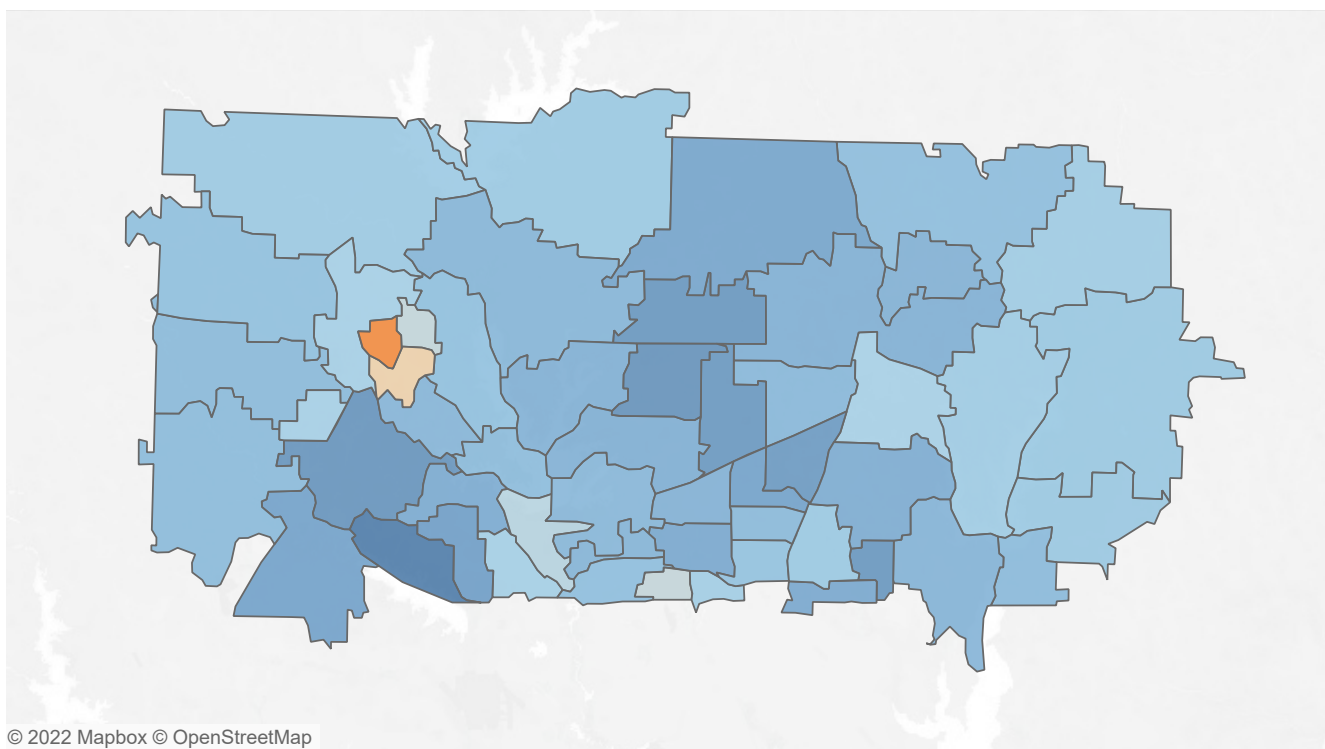
## Federally designated health professional shortage areas and medically underserved areas and populations

| 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 |
| Denton | 7487902282 | LI – MHCA – Denton County | Mental health | Low-income population HPSA |
| Denton | 14899948PA | Health Services of North Texas, Inc. | Primary care | Federally qualified health center |
| Denton | 74899948MQ | Health Services of North Texas, Inc. | Mental health | Federally qualified health center |
| Denton | 64899948MR | Health Services of North Texas, Inc. | Dental health | Federally qualified health center |

| Medically underserved areas and populations (MUA/P) | | | | |
|---|---|---|---|---|
| County | MUA/P source identification number | Service area name | Designation type | Rural status |
| Denton | 03463 | Poverty population | Medically underserved area – governor's exception | Non-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.

### Frisco Health Community

Composite CNI: high scores indicate high need.

1.000                                    5.000



©2022 Mapbox ©OpenStreetMap
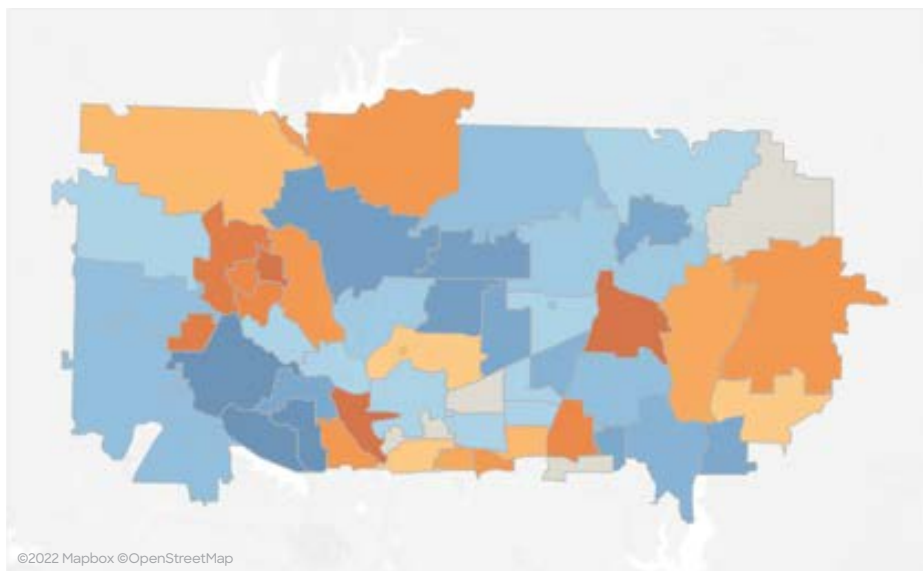
ZIP map where color shows the 2020 Community Need Index on a scale of 1 to 5. Orange color indicates high need areas (CNI = 4 or 5); blue color indicates low need (CNI = 1 or 2). Gray colors have needs at the national average (CNI = 3).

**Composite CNI score**
2.80

**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 Frisco Health Community is 2.80. 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-payor 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 Frisco Health Community. Total discharges in the community are expected to grow by 17.6% by 2030, with pulmonary medical, general medicine, cardiovascular diseases and orthopedics 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 | 1,616 | 1,668 | 1,886 | 52 | 3.2% | 270 | 16.7% |
| Cardio-Vasc-Thor Surgery | 5,340 | 5,892 | 6,404 | 552 | 10.3% | 1,063 | 19.9% |
| Cardiovascular Diseases | 8,783 | 9,932 | 11,788 | 1,149 | 13.1% | 3,005 | 34.2% |
| ENT | 809 | 771 | 769 | (37) | –4.6% | (39) | –4.9% |
| General Medicine | 23,238 | 25,034 | 27,830 | 1,796 | 7.7% | 4,592 | 19.8% |
| General Surgery | 10,528 | 10,840 | 11,696 | 312 | 3.0% | 1,168 | 11.1% |
| Gynecology | 963 | 472 | 281 | (491) | –51.0% | (682) | –70.8% |
| Nephrology/Urology | 6,015 | 6,650 | 7,548 | 635 | 10.6% | 1,533 | 25.5% |
| Neuro Sciences | 6,841 | 7,439 | 8,566 | 598 | 8.7% | 1,725 | 25.2% |
| Obstetrics Del | 18,331 | 17,206 | 17,812 | (1,125) | –6.1% | (519) | –2.8% |
| Obstetrics ND | 1,204 | 1,067 | 1,060 | (137) | –11.3% | (143) | –11.9% |
| Oncology | 2,858 | 3,053 | 3,355 | 195 | 6.8% | 497 | 17.4% |
| Ophthalmology | 166 | 162 | 162 | (4) | –2.5% | (4) | –2.5% |
| Orthopedics | 13,043 | 13,697 | 15,098 | 654 | 5.0% | 2,055 | 15.8% |
| Psychiatry | 1,773 | 1,899 | 2,059 | 126 | 7.1% | 286 | 16.1% |
| Pulmonary Medical | 9,692 | 11,890 | 14,368 | 2,198 | 22.7% | 4,676 | 48.2% |
| Rehabilitation | 204 | 237 | 284 | 33 | 16.1% | 80 | 39.1% |
| **TOTAL** | **111,406** | **117,911** | **130,966** | **6,505** | **5.8%** | **19,560** | **17.6%** |

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 Frisco Health Community outpatient procedures are expected to increase by over 38% by 2030 with the largest growth in the categories of labs, general & internal medicine, physical & occupational therapy, hematology & oncology and psychiatry.

| Clinical service category | 2020 procedures | 2025 procedures | 2020-2025 procedures % change | 2030 procedures | 2020 – 2030 procedures % change |
|---|---|---|---|---|---|
| Allergy & Immunology | 595,173 | 670,082 | 12.6% | 761,452 | 27.9% |
| Anesthesia | 133,125 | 164,312 | 23.4% | 197,020 | 48.0% |
| Cardiology | 1,058,046 | 1,391,780 | 31.5% | 1,844,712 | 74.4% |
| Cardiothoracic | 1,167 | 1,427 | 22.3% | 1,720 | 47.4% |
| Chiropractic | 1,091,377 | 1,137,528 | 4.2% | 1,172,092 | 7.4% |
| Colorectal Surgery | 16,128 | 18,059 | 12.0% | 20,314 | 26.0% |
| CT Scan | 326,906 | 460,373 | 40.8% | 642,796 | 96.6% |
| Dermatology | 400,353 | 483,834 | 20.9% | 581,913 | 45.4% |
| Diagnostic Radiology | 1,983,480 | 2,271,633 | 14.5% | 2,603,107 | 31.2% |
| Emergency Medicine | 745,722 | 865,708 | 16.1% | 1,015,351 | 36.2% |
| Gastroenterology | 146,392 | 174,926 | 19.5% | 206,895 | 41.3% |
| General & Internal Medicine | 16,440,365 | 19,248,187 | 17.1% | 22,360,603 | 36.0% |
| General Surgery | 110,901 | 130,746 | 17.9% | 154,644 | 39.4% |
| Hematology & Oncology | 2,430,783 | 3,075,124 | 26.5% | 3,738,588 | 53.8% |
| Labs | 19,069,518 | 22,048,549 | 15.6% | 25,648,721 | 34.5% |
| Miscellaneous | 830,429 | 960,444 | 15.7% | 1,109,621 | 33.6% |
| MRI | 180,405 | 210,754 | 16.8% | 246,623 | 36.7% |
| Nephrology | 243,901 | 308,514 | 26.5% | 381,606 | 56.5% |
| Neurology | 301,567 | 329,642 | 9.3% | 363,943 | 20.7% |
| Neurosurgery | 8,569 | 12,803 | 49.4% | 15,662 | 82.8% |
| Obstetrics/Gynecology | 308,153 | 329,826 | 7.0% | 368,233 | 19.5% |
| Ophthalmology | 852,228 | 1,080,291 | 26.8% | 1,338,240 | 57.0% |
| Oral Surgery | 9,662 | 10,953 | 13.4% | 12,640 | 30.8% |
| Orthopedics | 289,261 | 338,070 | 16.9% | 392,809 | 35.8% |
| Otolaryngology | 800,546 | 869,940 | 8.7% | 956,346 | 19.5% |
| Pain Management | 146,266 | 170,975 | 16.9% | 196,571 | 34.4% |
| Pathology | 390 | 482 | 23.6% | 590 | 51.4% |
| PET Scan | 11,928 | 14,745 | 23.6% | 17,854 | 49.7% |
| Physical & Occupational Therapy | 6,760,880 | 8,216,085 | 21.5% | 9,977,233 | 47.6% |
| Plastic Surgery | 19,042 | 22,986 | 20.7% | 27,686 | 45.4% |
| Podiatry | 67,037 | 75,122 | 12.1% | 83,308 | 24.3% |
| Psychiatry | 2,794,077 | 3,341,267 | 19.6% | 4,005,499 | 43.4% |
| Pulmonary | 339,614 | 394,660 | 16.2% | 461,138 | 35.8% |
| Radiation Therapy | 179,265 | 213,999 | 19.4% | 251,986 | 40.6% |
| Single Photon Emission CT Scan (SPECT) | 22,850 | 27,398 | 19.9% | 33,044 | 44.6% |
| Urology | 105,402 | 130,061 | 23.4% | 159,129 | 51.0% |
| Vascular Surgery | 40,510 | 49,126 | 21.3% | 58,771 | 45.1% |
| **TOTAL** | **58,861,421** | **69,250,411** | **17.6%** | **81,408,462** | **38.3%** |

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 Frisco Health Community, ED visits are expected to grow by over 20% by 2025.

| Emergent status | 2020 visits | 2025 visits | 2020 – 2025 visits change | 2020 – 2025 visits % change |
|---|---|---|---|---|
| Emergent | 317,472 | 407,730 | 90,257 | 28.4% |
| Inpatient Admission | 98,811 | 131,475 | 32,664 | 33.1% |
| Non-Emergent | 267,089 | 282,389 | 15,300 | 5.7% |
| **TOTAL** | **683,372** | **821,593** | **138,222** | **20.2%** |

Source: IBM Watson Health Emergency Department Visits, 2020.

## Emergency department visit estimates 2025



- Inpatient admission
- Emergent
- Non-emergent

16%
34%
50%
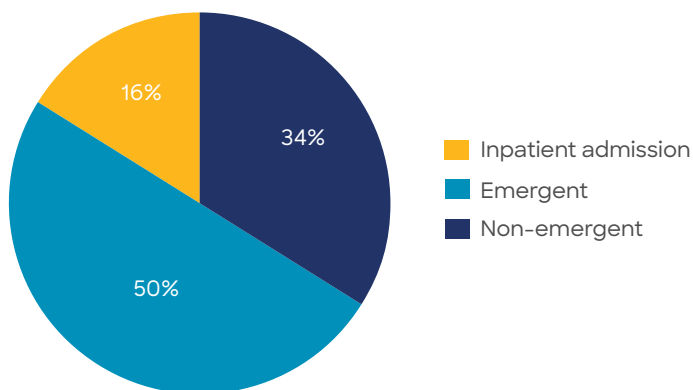
## Heart disease estimates

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 Frisco Health Community, the most common heart disease is hypertension at 73.6% of all heart disease cases.

| Disease type | 2020 prevalence | 2020 % prevalence |
|---|---|---|
| Arrhythmia | 85,176 | 12.4% |
| Heart Failure | 30,425 | 4.4% |
| Hypertension | 504,986 | 73.6% |
| Ischemic Heart Disease | 65,611 | 9.6% |
| **TOTAL** | **686,199** | **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 15.7% in the Frisco Health Community by 2025.

| Cancer type | 2020 incidence | 2025 incidence | 2020 – 2025 change | 2020 – 2025 % change |
|---|---|---|---|---|
| Bladder | 465 | 569 | 104 | 22.4% |
| Brain | 182 | 206 | 25 | 13.5% |
| Breast | 2,017 | 2,401 | 384 | 19.1% |
| Colorectal | 1,241 | 1,246 | 5 | 0.4% |
| Kidney | 381 | 471 | 90 | 23.5% |
| Leukemia | 344 | 411 | 67 | 19.4% |
| Lung | 994 | 1,171 | 178 | 17.9% |
| Melanoma | 535 | 645 | 110 | 20.5% |
| Non–Hodgkin's Lymphoma | 502 | 604 | 102 | 20.4% |
| Oral Cavity | 316 | 382 | 66 | 21.0% |
| Other | 1,349 | 1,634 | 285 | 21.1% |
| Ovarian | 156 | 179 | 23 | 14.5% |
| Pancreatic | 260 | 328 | 69 | 26.4% |
| Prostate | 1,326 | 1,382 | 57 | 4.3% |
| Stomach | 164 | 191 | 27 | 16.7% |
| Thyroid | 314 | 370 | 57 | 18.1% |
| Uterine Cervical | 67 | 72 | 5 | 7.1% |
| Uterine Corpus | 249 | 302 | 54 | 21.6% |
| **TOTAL** | **10,861** | **12,566** | **1,706** | **15.7%** |

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.

The 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

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

**Community served:** Collin, Dallas and Denton Counties

## Depression in the Medicare population

### Baylor Scott & White Medical Center – Centennial

| Action/tactics | Anticipated outcome | Evaluation of impact |
| --- | --- | --- |
| **Mental healthcare for veterans** A large percentage of veterans are faced with PTSD and depression. The hospital will partner with organizations and support groups to address mental health and depression issues for this population through cash and in-kind contributions to other not-for-profit community organizations existing to increase access to mental health for veterans. | Increased access to mental health care for veterans. | • **Persons served: 6,028** • **$90,800 community benefit** |
| **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. | • **Persons served: unknown** • **$100,106 community benefit** |

### Baylor Scott & White Medical Center – Frisco

| Action/tactics | Anticipated outcome | Evaluation of impact |
| --- | --- | --- |
| **Mental health services program** | Increased access to mental healthcare. | • The COVID-19 pandemic prohibited this strategy from being implemented. |

## Depression in the Medicare population, continued
### Baylor Scott & White Institute for Rehabilitation – Frisco

| Action/tactics | Anticipated outcome | Evaluation of impact |
|---|---|---|
| **Neuro support group** <br> Neuro support group for patients, families and community. Consults for depressed attendees will go to a neuropsychologist who does a clinical interview with the patient. | Increased access to mental healthcare. | • **Persons served: 180** <br> • **$1,200 community benefit** <br> • Limited numbers due to program suspension beginning in June 2019 and resuming in January 2022. |
| **Charity care** <br> Provide free and/or discounted care to financially or medically indigent patients as outlined in the financial assistance policy. | Increased access to primary care and/or specialty care for indigent persons regardless of their ability to pay. | • **$691,000 community benefit** |

## Motor vehicle driving deaths with alcohol involvement
### Baylor Scott & White Medical Center – Centennial
### Baylor Scott & White Institute for Rehabilitation – Frisco

| Action/tactics | Anticipated outcome | Evaluation of impact |
|---|---|---|
| **Community health education** <br> The hospital will educate students, parents and the community about the serious issue of underage drinking and driving, providing a realistic experience and encouraging them to make positive choices. | Increased awareness of the dangers and outcomes of drinking and driving. | **Centennial** <br> • Persons served: 1,078 <br> • $15,166 community benefit <br> **BSWIR – Frisco** <br> • The COVID-19 pandemic prohibited this strategy from being implemented. |

# Ratio of population to one non-physician primary care provider

## Baylor Scott & White Medical Center – Centennial

| Action/tactics | Anticipated outcome | Evaluation of impact |
|---|---|---|
| **Clinical training program**<br>To help address the state's healthcare workforce shortage, BSWH provides a clinical training program to prepare nurses for the medical workforce. | Increase access to free and low-cost healthcare by increasing the number of providers through medical education. | • **Persons served: 60**<br>• **$86,031 community benefit** |
| **Increase primary care access points**<br>One of the hospital's top initiatives is to add additional primary care access points to meet the community needs in our service area. Relocate and add non-physician primary care providers. | Increased access to free and low-cost healthcare. | • **Persons served: unknown**<br>• **$300,000 community benefit**<br>• Costs include the relocation of the Baylor Scott & White Douglass Community Clinic, a full-time community care navigator and a full-time nurse practitioner to help with growing community needs. |
| **Physician recruitment**<br>Physician recruitment in medically underserved areas to increase the number of providers available to serve the community. | Increase primary care providers in the community.<br>Reduction in shortage resulting in better health of the community. | • **$1,042,053 community benefit** |
| **Charity care**<br>Provide free and/or discounted care to financially or medically indigent patients as outlined in the financial assistance policy. | Increased access to primary care and/or specialty care for indigent persons regardless of their ability to pay. | • **$7.3 million community benefit** |

## Baylor Scott & White Medical Center – Frisco

| Action/tactics | Anticipated outcome | Evaluation of impact |
|---|---|---|
| **Charity care**<br>Provide free and/or discounted care to financially or medically indigent patients as outlined in the financial assistance policy. | Increased access to primary care and/or specialty care for indigent persons regardless of their ability to pay. | • **Persons served: unknown**<br>• **$388,951 community benefit**<br>• Since July 1, 2019, the hospital has recruited the following physicians: one internal medicine, three ortho, two OB/GYN, one ENT and one urology. |

## Total investment in adopted community needs since 2019 CHNA

| BSWMC – Centennial | BSWMC – Frisco | BSWIR – Frisco |
|---|---|---|
| **$8.9 million** | **$389,000** | **$692,000** |

BaylorScott&White
HEALTH