


Community Health Needs Assessment

West Fort Worth Health Community

2022

Baylor Scott & White HEALTH

West Fort Worth health community hospitals

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

Approved by: Baylor Scott & White Health - North Texas Operating, Policy and Procedure Board on May 31, 2022
Posted to **BSWHealth.com/CommunityNeeds** on June 30, 2022

Baylor Scott & White HEALTH

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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.

Community Health Needs Assessment (CHNA) report

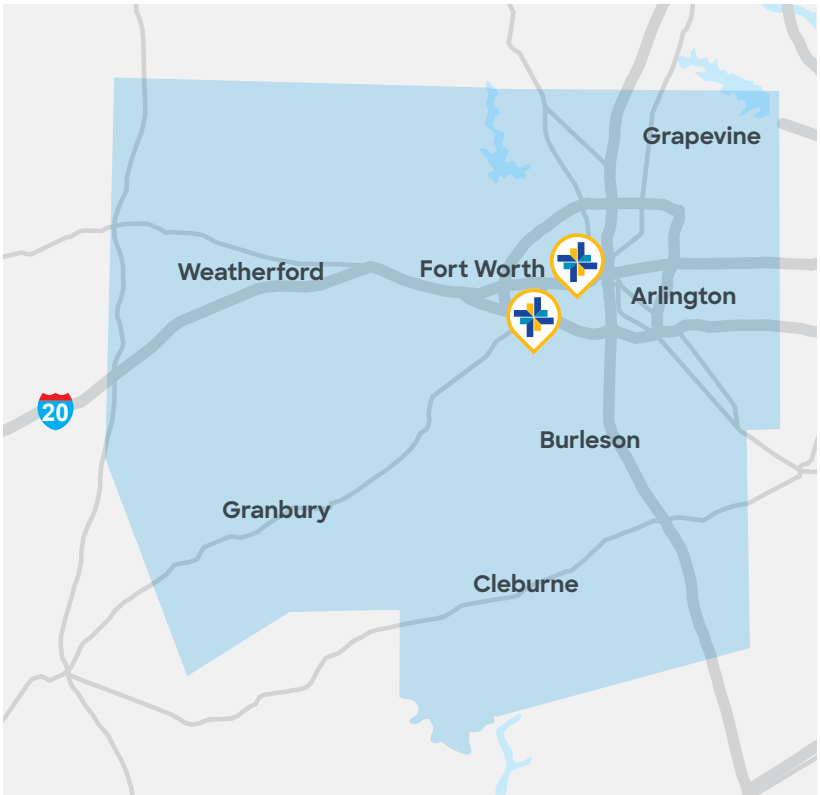
Baylor Scott & White Health (BSWH) owns and operates numerous individually licensed hospital facilities serving the residents of North and Central Texas.

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

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

The community served by the hospital facilities listed above is Hood, Johnson, Parker and Tarrant Counties and was determined 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.

West Fort Worth 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 West Fort Worth 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 but older than Texas overall.
- The median household income is higher than both the state and the US.
- The community served has a smaller percentage of uninsured and underinsured than Texas.

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

Health community data summary

IBM Watson Health's utilization estimates and forecasts indicate the following for the West Fort Worth 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 almost 34% by 2030 with the largest areas of growth including:
  - Labs
  - General & internal medicine
  - Physical & occupational therapy
  - Psychiatry
  - Hematology & oncology
- Emergency department visits are expected to grow by 13% by 2025.
- Hypertension represents 72% of all heart disease cases.
- Cancer incidence is expected to increase by 10.3% by 2025.

Further health community information for the West Fort Worth 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.

	Health professional shortage areas (HPSA)				Medically underserved area/ population (MUA/P)
County	Dental health	Mental health	Primary care	Grand total	MUA/P
Hood		1		1	
Johnson		1		1	
Parker	1	2	2	5	
Tarrant	3	4	3	10	3

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

Total population

2,438,658

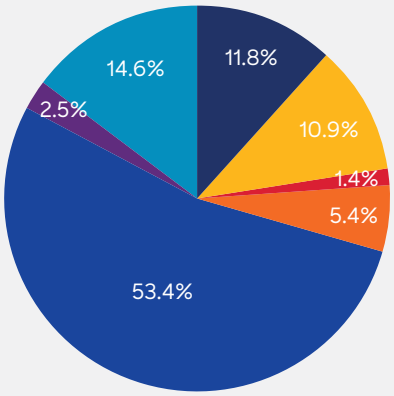
Average income

$73,530

Underserved ZIP codes

18

Insurance coverage



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	Access to healthy food/food insecurity	Environment
2	Access to mental healthcare providers/ behavioral healthcare services	Mental health
3	Uninsured/underinsured/poverty	Access to care
4	Adult and child obesity	Conditions/diseases
5	Lack of appropriate transportation	Environment
6	Physical inactivity/physically unhealthy days	Healthy behaviors
7	Access to healthcare providers (primary care and dental)	Access to care

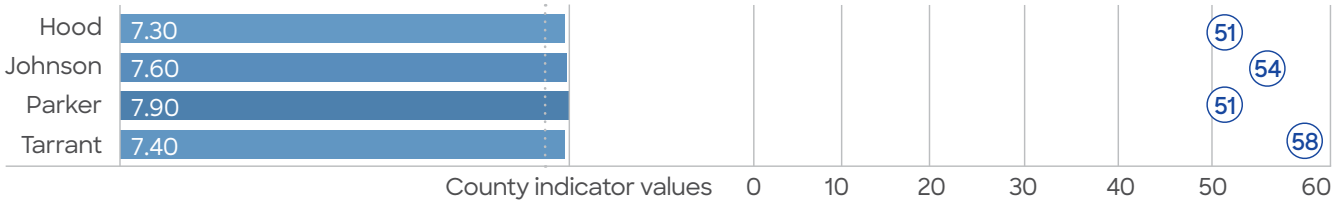
Priority 1: Access to Healthy Food/Food Insecurity

Although the data did not indicate a greater need, the key informants discussed the needs of the community for access to healthy foods and food security.

Category	Data shows less need or no data	Key informants indicate greater need
Environment	• Food environment index • Food insecure • Limited access to healthy food	• Healthy choices not affordable • Food deserts in some areas • Lack of healthy food in some areas

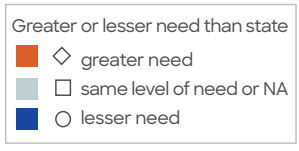
The **food environment index** measure is defined as **index of factors that contribute to a healthy food environment**. A value of zero "0" is worst and a value of ten "10" is best in the county. The indicator is based on data from County Health Rankings & Roadmaps, USDA Food Environment Atlas, Map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

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



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.

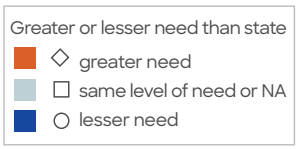
Environment: food insecure (% who lack adequate access to food by county)



Counties are listed in alphabetical order within NTX-West Fort Worth 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 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).

Environment: limited access to healthy foods (% population who are low-income and do not live close to grocery store by county)



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While the key informants acknowledged that the Tarrant Area Food Bank helped many communities within the county during the pandemic, many residents still have limited access to healthy food options. They cited limited transportation to access food. They noted opportunities to improve and increase access to healthy, affordable food and to continue successful collaborations for food delivery.

In the prioritization session, the hospital and community leaders agreed that food security is a basic need that should be addressed first as it is correlated to other healthcare needs.

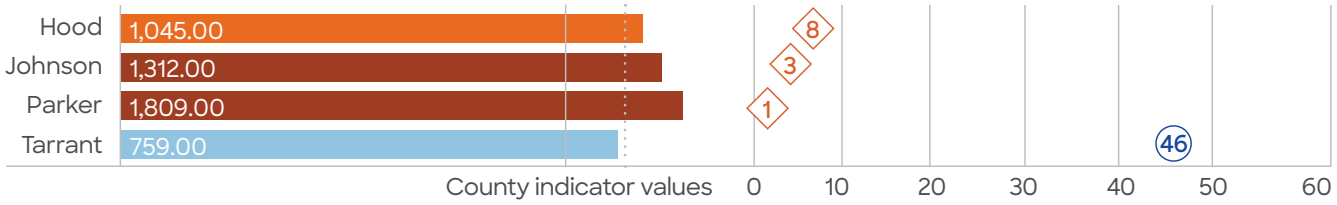
Priority 2: Access to Mental Healthcare Providers/Behavioral Healthcare Services

The following data indicates greater need for access for the population to one mental health provider.

Category	Data shows greater need	Key informants indicate greater need
Access to care	• Population to one mental health provider	• Insufficient access to mental/ behavioral health providers

The **population to one mental health provider** 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).

Access to care: population to one mental health provider (ratio of population to mental health providers by county)



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

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The focus group participants felt that the community suffered from a lack of mental/behavioral healthcare resources. They noted a shortage of mental health providers that accept Medicaid and uninsured. There is limited access to detoxification and addiction services as well.

In the prioritization session, the hospital leadership stated that West Fort Worth does not have the infrastructure to treat the growing number of patients with behavioral/mental health conditions. Without addressing this issue, mental and behavioral health issues will be a great cause of morbidity in the future. The group further discussed the distinction between behavioral and mental health. Behavioral health encompasses short-term or acute conditions such as depression, substance abuse, etc. Mental health can be viewed as more long-term with medical conditions such as schizophrenia, bipolar disorder, dementia, Alzheimer's, etc. Overall, the group agreed that healthcare providers must do a better job treating the patient as a whole—behavioral, mental, physiological, nutritional, spiritual, etc.

Priority 3: Uninsured/Underinsured/Poverty

The following indicates a greater need in the area of the uninsured.

Category	Data shows greater need	Key informants indicate greater need
Access to care	• Children uninsured	• Many uninsured

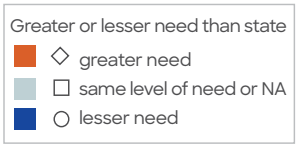
The indicator **children uninsured** is defined as **the percentage of children under age 19 without health insurance**. The indicator is based on data from County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau.

Access to care: children uninsured (% of children under age 19 without health insurance)

Category	Data shows less need or no data	Key informants indicate greater need
Access to care	• Population under age 65 without health insurance	• Many uninsured

The indicator **population under age 65 without health insurance** is defined as **the percentage of population under age 65 without health insurance**. The indicator is based on data from County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau.

Access to care: population under age 65 without health insurance (% of population under age 65 without health insurance)



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The focus group participants cited loss of health insurance as a top barrier in Tarrant County. Insufficient insurance coverage prevents members from seeking needed primary care, mental health services and prescription medication. Those who are employed in lower-wage jobs cannot afford health insurance or healthcare expenses.

In the prioritization session, the hospital and community leaders added that the underinsured are on the verge of becoming uninsured due to the high costs of premiums and copays. They acknowledged that the West Texas hospitals have programs to help the underinsured with subsidies to help pay high premiums, but some of these subsidies are part of the COVID recovery program and may lapse soon.

Priority 4: Adult and Childhood Obesity

Although the key informants did not mention it specifically, the data indicates a greater need in the area of obesity.

Category	Data shows greater need	Key informants indicate less need or not mentioned
Utilization	• Adult obesity (including childhood obesity)	• Not specifically mentioned

The indicator of **adult obesity** 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.

Conditions/diseases: adult obesity (% of adults with BMI =>30 by county)

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

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In the prioritization session, hospital leadership agreed that the community obesity concerns should include childhood obesity. Childhood obesity is a precursor to many chronic conditions, such as diabetes and hypertension. They agreed to add childhood and adult obesity as a significant need.

Priority 5: Lack of Appropriate Transportation

Although the data did not indicate a need, the key informants indicated a lack of transportation.

Category	Data shows less need or no data	Key informants indicate greater need
Environment	• No vehicle available	• Lack of 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.

Environment: no vehicle available (% of households with no vehicle available by county)

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

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According to key informants, there is limited public transportation throughout the community. In addition, there is much construction on the Tarrant highway system contributing to transportation delays. Even with reduced fees provided by Trinity Metro, public transportation is cost-prohibitive and not an effective way to get residents to their healthcare appointments. In Johnson County, the senior population's inability to access healthcare and food resources has a negative impact on their overall health.

In the prioritization session, the hospital and community leaders noted that transportation is key for all the significant needs discussed by the group; the nuance is the form of transportation. Transportation must be appropriate for the person and must consider the following items: non-emergent, accessible to the disabled, routes, hours, cost, etc. There are transportation options in the community; however, the options don't always meet the needs of the patient.

Priority 6: Physical Inactivity/Physically Unhealthy Days

The following indicates a greater need in the area of physical inactivity and physically unhealthy days.

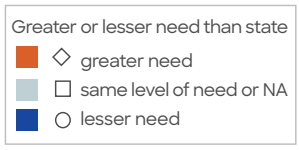
Category	Data shows greater need	Key informants indicate greater need
Health behaviors Health status	• Physical inactivity • Physically unhealthy days	• Lack of outdoor physical activity

The indicator of **physical inactivity** is defined as **the percentage of adults ages 20 and over reporting no leisure-time physical activity in the past month** and is based on County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System.

Health behaviors: physical inactivity (% of adults reporting no leisure time physical activity in past month by county)

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

Health status: physically unhealthy days (average number of physically unhealthy days reported in past 30 days by county)



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The focus group participants felt that the community lacks sufficient outdoor resources for residents to be physically active.

In the prioritization session, the hospital leadership questioned if the lack of outdoor physical activity options were due to not having an infrastructure in place.

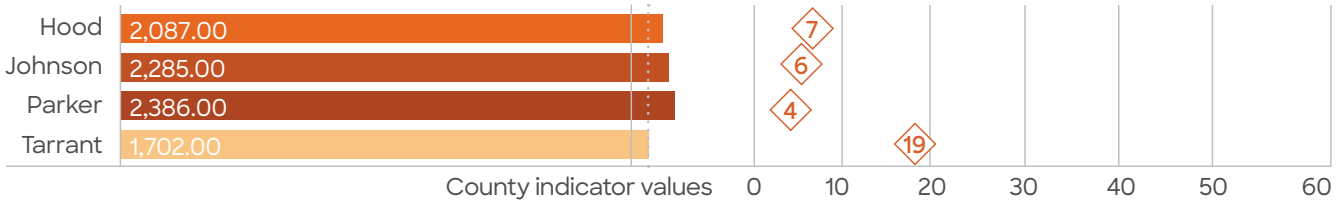
Priority 7: Access to Healthcare Providers (Primary Care and Dental)

The following indicates a greater need in the area of access for the population to one primary care physicians and access for the population to one dentist.

Category	Data shows greater need	Key informants indicate greater need
Access to care	• Population to one primary care physician • Population to one dentist	• Insufficient access to primary care providers • Insufficient access to dentists

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.

Access to care: population to one primary care physician (number of individuals served by one physician by county)



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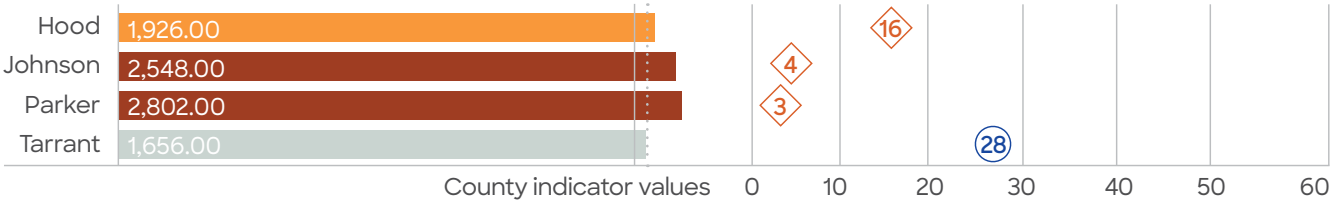
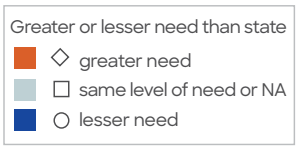
The **population to one dentist** is defined as **the ratio of population to dentists** and is based on data from County Health Rankings & Roadmaps; Area Health Resource File/National Provider Identification file (CMS).

Access to care: population to one dentist (ratio of population served by one dentist by county)





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The focus group participants felt that the overall community suffered from a lack of primary healthcare resources and dentists while experiencing a high demand for both.

In the prioritization session, the hospital leadership noted that when looking at access to primary care providers, there is a need to get better control of the workforce to find and educate the appropriate providers to take care of patients. In regard to dentists, they noted that dental care is important because dental care impacts physiological conditions.

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.

West Fort Worth community resources

Need	Organization	Address	Phone
Food insecurity/ access to healthy food	The Church on Rush Creek (food pantry)	2350 SW Green Oaks Boulevard Arlington, TX 76017	817.468.7729
	Mission Central (mobile food pantry)	521 W. Pipeline Road Hurst, TX 76053	817.595.0011
	Restoration Center (food pantry)	3452 Williams Road Benbrook, TX 76116	682.385.9189
	The Salvation Army of North Texas (food pantry)	3023 NW 24th Street Fort Worth, TX 76106	214.637.8100
	Midwest Food Bank	209 N. Industrial Boulevard Bedford, TX 76021	214.632.1343
Access to mental/ behavioral healthcare providers	Lena Pope (counseling and substance abuse services)	601 W. Sanford Street Arlington, TX 76011	817.255.2652
	Mission Arlington Metroplex (counseling services)	210 W. South Street Arlington, TX 76010	817.704.6144
	North Texas Area Community Health Centers Inc. (behavioral health services)	979 N. Cooper Street Arlington, TX 76011	817.801.4440
	Youth Advocate Programs, Inc. (YAP) (behavioral health)	1100 NW 18th Street, Annex D Fort Worth, TX 76106	817.945.2951
	Lifeologie Institute (counseling services)	1208 W. Magnolia Avenue Fort Worth, TX 76104	817.870.1087
Uninsured/ underinsured poverty	Texas HHSC	2220 Mall Circle Fort Worth, TX 76116	877.541.7905
	Mission Arlington Metroplex (emergency assistance)	210 W. South Street Arlington, TX 76010	817.277.6620
	Tarrant Area Food Bank (TAFB) (apply for food and financial assistance, healthcare)	2600 Cullen Street Fort Worth, TX 76107	866.430.6143
	Mission Ft. Worth (medical care)	4401 Vermont Avenue Fort Worth, TX 76115	817.207.0229
	Gill Children's Services (financial assistance for families with children)	555 Hemphill Street Fort Worth, TX 76104	817.332.5070

Need	Organization	Address	Phone
Obesity (adult/ childhood)	Northside Inter-Community Agency, Inc. (NICA) (health education/exercise and fitness)	1600 Circle Park Boulevard Fort Worth, TX 76164	817.626.1102
	Texas A&M AgriLife Extension Service - Extended Food Nutrition Education Program	200 Taylor Street Fort Worth, TX 76102	817.212.7501
	Meals On Wheels, Inc. of Tarrant County (nutrition counseling)	320 S. Freeway Fort Worth, TX 76104	817.336.0912
	Cornerstone Charitable Clinic (primary/preventive care, health education)	3500 Noble Avenue Fort Worth, TX 76111	817.632.6020
	Tarrant County - WIC	4200 S. Freeway Fort Worth, TX 76115	817.321.5400
Physical inactivity/ unhealthy days	Northside Inter-Community Agency, Inc. (NICA)	1600 Circle Park Boulevard Fort Worth, TX 76164	817.626.1102
	YMCA of Metropolitan Fort Worth	4750 Barwick Drive Fort Worth, TX 76132	817.292.9612
	Ryan Family YMCA	8250 McCart Avenue Fort Worth, TX 76132	817.346.8855
	McDonald Southeast Community YMCA	2801 Miller Avenue Fort Worth, TX 76105	817.534.1591
	Eastside YMCA	1500 Sandy Lane Fort Worth, TX 76112	817.451.8276

Need	Organization	Address	Phone
Access to primary care/ access to dental care	Cornerstone Charitable Clinic (primary/preventive care, health education)	3500 Noble Avenue Fort Worth, TX 76111	817.632.6020
	Catholic Charities of Fort Worth (dental clinic)	249 Thornhill Drive Fort Worth, TX 76115	817.600.1461
	Mission Fort Worth	4401 Vermont Avenue Fort Worth, TX 76115	817.207.0229
	Dental Health Arlington	501 W. Sanford Street Arlington, TX 76011	817.277.1165
	Crowley House of Hope	208 N. Magnolia Street Crowley, TX 76036	817.297.6495

There are many other community resources and facilities serving the West Fort Worth Health Community 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:

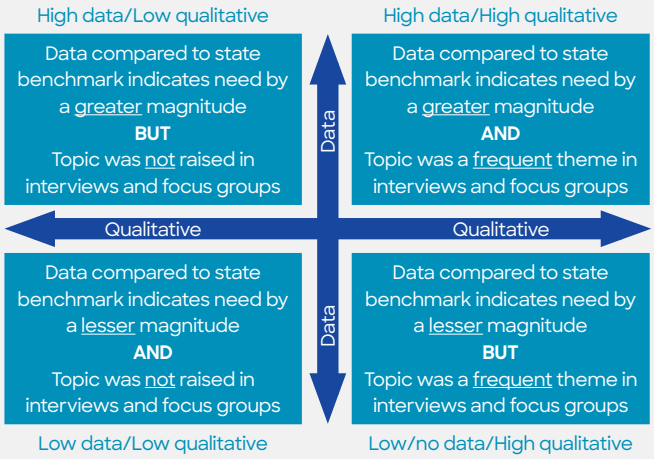
- Assembled a focus group representing the broad interests of the community served;
- Conducted interviews and surveys with key informants—leaders and representatives who serve the community and have insight into its needs; and
- Held prioritization sessions with hospital clinical leadership and community 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**.

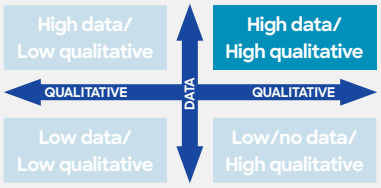
Approach to prioritizing significant health needs



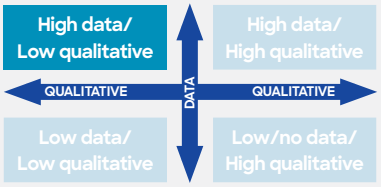
High data = Indicators worse than state benchmark by greater magnitude
High qualitative = Frequency of topic in interviews and focus groups

On January 24, 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.

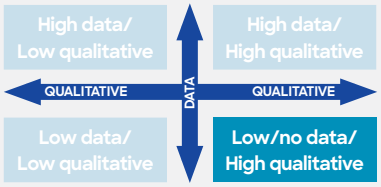
In the first step, participants reviewed the top health needs for their community using associated data-driven criteria. The criteria included health indicator value(s) for the community and how the indicator compared to the state benchmark.



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:

- **Community capacity or strengths:** The community may or may not have the capacity to act on the issue with regard to economic, social, cultural or political consideration. It should be considered whether current initiatives exist to help address the health issue that can be built upon to bolster existing resources.
- **Severity (outcome if ignored):** The problem results in disability or premature death or creates burdens on the community, economically or socially.
- **Root cause:** The need is a root cause of other problems. If addressed, it could possibly impact multiple issues.

The group rated each of the seven 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 healthy food/food insecurity	Environment
2	Access to mental healthcare providers/ behavioral healthcare services	Mental health
3	Uninsured/underinsured/poverty	Access to care
4	Adult and child obesity	Conditions/diseases
5	Lack of appropriate transportation	Environment
6	Physical inactivity/physically unhealthy days	Healthy behaviors
7	Access to healthcare providers (primary care and dental)	Access to care

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).

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:

- Brittain Kalish Group Project Access
- Baylor Scott & White Health
- Callier Center for Communication Disorders
- Fort Worth Housing Solutions
- Granbury Chamber of Commerce
- Mansfield Mission Center Linda Nix Clinic
- Meals on Wheels North Central Texas
- MedStar
- Methodist Mansfield Advisory Board
- One Safe Place
- Project Access Tarrant County
- Tarrant Area Food Bank
- Tarrant County Public Health
- United Way of Tarrant County
- Visiting Nurse Association of Texas - Dallas/Fort Worth

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 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 Texas.

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

Geography		Benchmarks		Community served
		United States	Texas	West Fort Worth health community
Total current population		330,342,293	29,321,501	2,438,658
Five-year projected population change		3.3%	6.6%	7.1%
Median age		38.6	35.2	36.3
Population 0 - 17		22.4%	25.7%	25.7%
Population 65+		16.6%	13.2%	12.9%
Women age 15 - 44		19.5%	20.5%	20.7%
Hispanic population		19.0%	40.7%	28.3%
Insurance coverage	Uninsured	9.9%	18.8%	14.6%
	Medicaid	20.9%	13.0%	11.8%
	Private market	8.3%	8.4%	7.9%
	Medicare	13.8%	12.7%	12.3%
	Employer	47.2%	47.1%	53.4%
Median HH income		$65,618	$63,313	$73,530
No high school diploma		12.2%	16.7%	14.6%

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

The community served expects to grow 7.1% by 2025, an increase of almost 172,000 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:

- 76244 Keller – 8,072 additional people
- 76063 Mansfield – 7,296 additional people
- 76028 Burleson – 6,198 additional people
- 76179 Fort Worth – 6,059 additional people

The community's population is younger with about half of the population ages 18 - 54 and 25.7% under age 18. The age 65-plus cohort is expected to experience the fastest growth (24%) 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 96,400 people (14%) by 2025. The non-Hispanic white population is expected to decline by -0.3%.

Population distribution

	Age distribution				
Age group	2020	% of total	2025	% of total	USA 2020 % of total
0 - 14	518,944	21.3%	531,322	20.4%	18.5%
15 - 17	108,122	4.4%	115,373	4.4%	3.9%
18 - 24	229,690	9.4%	255,742	9.8%	9.5%
25 - 34	335,483	13.8%	332,046	12.7%	13.5%
35 - 54	641,074	26.3%	673,615	25.8%	25.2%
55 - 64	289,723	11.9%	310,142	11.9%	12.9%
65+	315,622	12.9%	392,414	15.0%	16.6%
Total	**2,438,658**	**100.0%**	**2,610,654**	**100.0%**	**100.0%**

Household Income distribution

	Income distribution		
2020 Household income	HH count	% of total	USA % of total
<$15K	67,310	7.7%	10.0%
$15 - 25K	62,981	7.2%	8.6%
$25 - 50K	182,279	20.8%	20.7%
$50 - 75K	160,725	18.3%	16.7%
$75 - 100K	117,377	13.4%	12.4%
Over $100K	287,131	32.7%	31.5%
Total	**877,803**	**100.0%**	**100.0%**

Education level

	Education level distribution		
2020 Adult education level	Pop age 25+	% of total	USA % of total
Less than high school	105,258	6.7%	5.2%
Some high school	125,323	7.9%	7.0%
High school degree	399,808	25.3%	27.2%
Some college/assoc. degree	483,964	30.6%	28.9%
Bachelor's degree or greater	467,549	29.6%	31.6%
Total	**1,581,902**	**100.0%**	**100.0%**

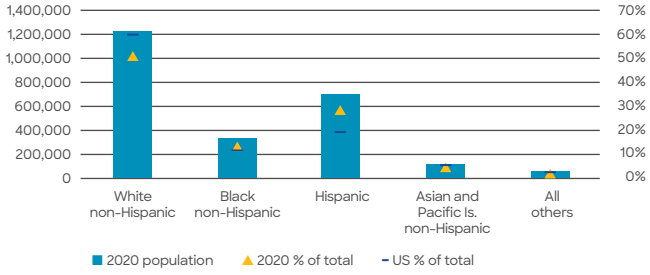
Race/ethnicity

	Race/ethnicity distribution		
Race/ethnicity	2020 pop	% of total	USA % of total
White non-Hispanic	1,224,954	50.2%	59.3%
Black non-Hispanic	340,080	13.9%	12.4%
Hispanic	690,766	28.3%	19.0%
Asian & Pacific is. non-Hispanic	120,092	4.9%	6.0%
All others	62,766	2.6%	3.3%
Total	**2,438,658**	**100.0%**	**100.0%**

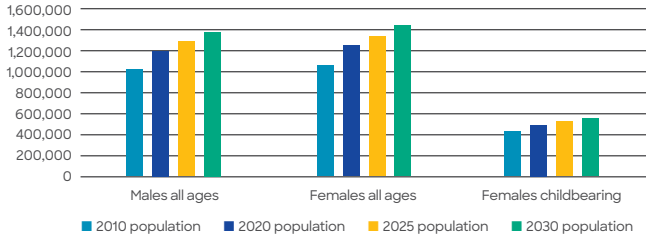
Population estimates		
Population	National	Selected area
2010 total	308,745,538	2,080,067
2020 total	330,342,293	2,438,658
2025 total	341,132,738	2,610,654
2030 total	353,513,931	2,809,038
% change 2020 - 2025	3.27%	7.05%
% change 2020 - 2035	7.01%	15.19%

Population	Males all ages	Females all ages	Females childbearing
2010 total	1,023,146	1,056,921	442,918
2020 total	1,195,866	1,242,792	504,326
2025 total	1,280,326	1,330,328	527,563
2030 total	1,377,645	1,431,393	559,002
10Y %	15.20%	15.18%	10.84%
National	7.02%	7.01%	4.01%

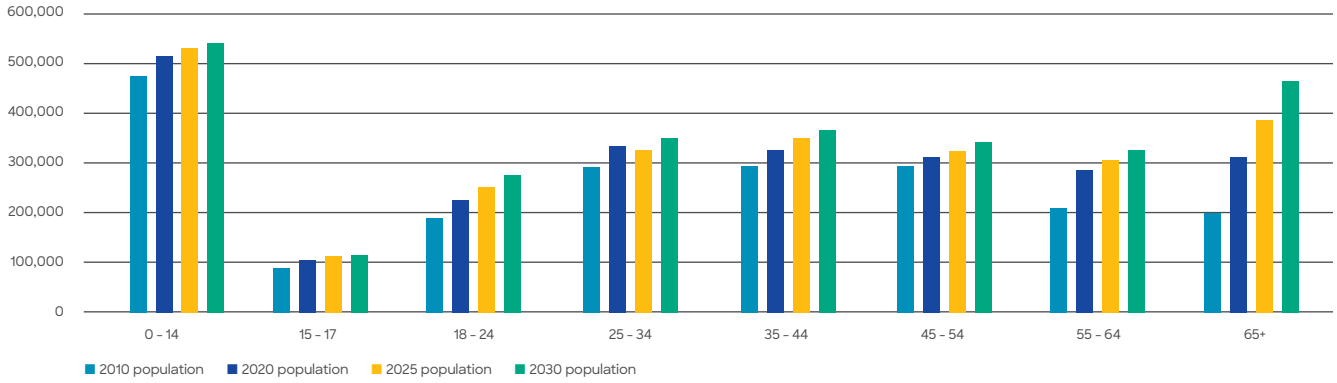
2020 race and ethnicity with total population



Population by sex 2010 - 2030



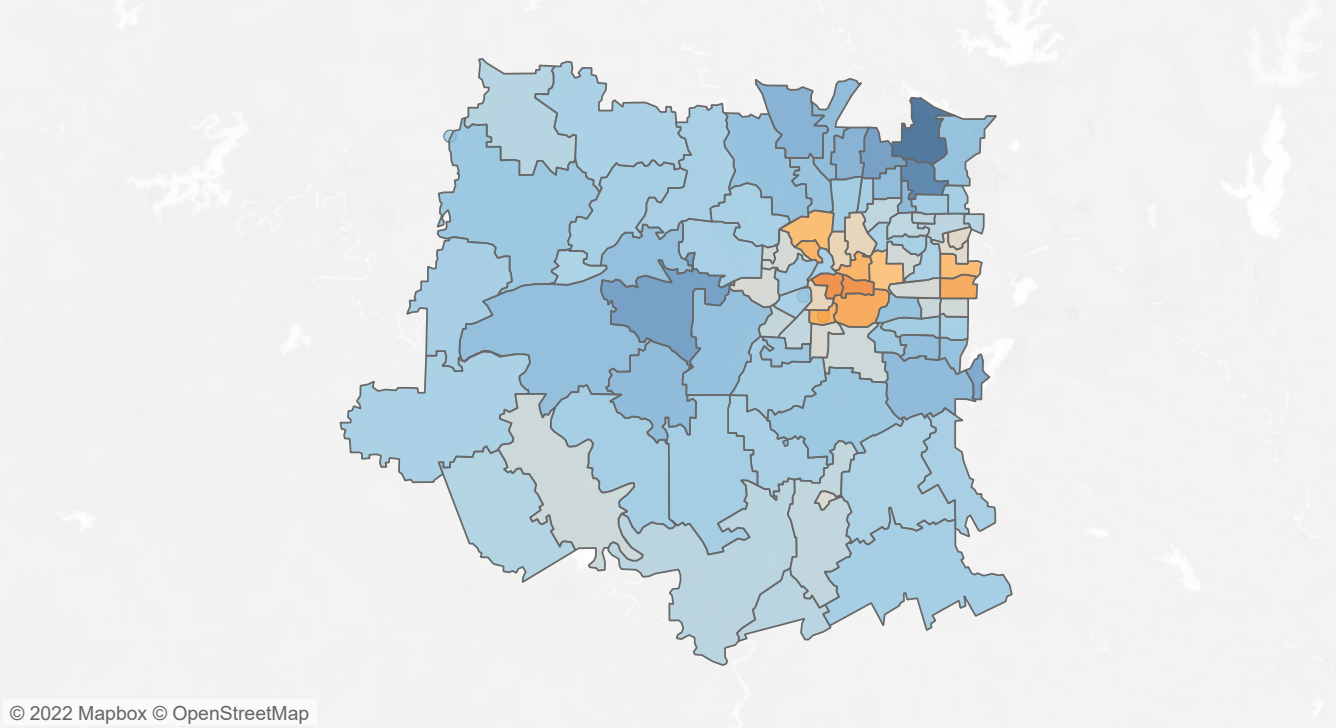
Population by age group 2010 - 2030



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 $33,035 for 76104 Fort Worth. There were eighteen (18) additional ZIP codes with median household incomes less than $52,400—twice the 2020 federal poverty limit for a family of four.

- 76105 Fort Worth – $33,276
- 76119 Fort Worth – $38,658
- 76010 Arlington – $39,158
- 76122 Fort Worth – $40,000
- 76115 Fort Worth – $40,552
- 76164 Fort Worth – $40,592
- 76103 Fort Worth – $41,363
- 76011 Arlington – $43,245
- 76106 Fort Worth – $43,387
- 76112 Fort Worth – $45,229
- 76111 Fort Worth – $48,837
- 76110 Fort Worth – $49,075
- 76117 Haltom City – $49,157
- 76005 Arlington – $49,944
- 76006 Arlington – $49,980
- 76059 Keene – $50,658
- 76134 Fort Worth – $51,749
- 76116 Fort Worth – $52,244

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.



A majority of the population (53%) 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).

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
Hood	7486865413	Hood County	Mental health	Geographic HPSA
Johnson	7482419760	LI - Johnson County	Mental health	Low-income population HPSA
Parker	1483688303	Parker County	Primary care	Geographic HPSA
Parker	7489602368	Parker County	Mental health	Geographic HPSA
Parker	1483608306	Campbell Clinic	Primary care	Rural health clinic
Parker	7482117716	Campbell Clinic	Mental health	Rural health clinic
Parker	6488663489	Campbell Clinic	Dental health	Rural health clinic
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

Medically underserved areas and populations (MUA/P)				
County	MUA/P source identification number	Service area name	Designation type	Rural status
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

Community Needs Index

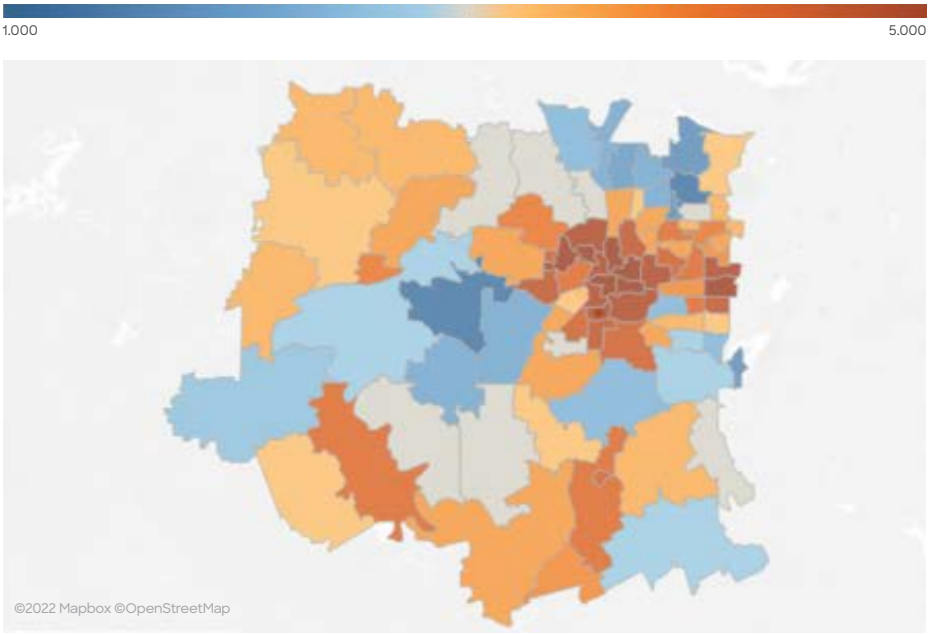
The IBM Watson Health Community Need Index (CNI) is a statistical approach that identifies areas within a community where there are likely gaps in healthcare. The CNI takes into account vital socio-economic factors, including income, culture, education, insurance and housing, about a community to generate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

West Fort Worth 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
3.52

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 West Fort Worth Health Community was 3.52. 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 West Fort Worth Health Community. Total discharges in the community are expected to grow by almost 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	2,690	2,741	3,002	51	1.9%	312	11.6%
Cardio-Vasc-Thor Surgery	7,639	7,957	8,185	318	4.2%	546	7.1%
Cardiovascular Diseases	17,081	18,315	20,646	1,234	7.2%	3,565	20.9%
ENT	1,319	1,217	1,151	(102)	-7.7%	(168)	-12.7%
General Medicine	38,182	39,439	41,817	1,258	3.3%	3,636	9.5%
General Surgery	16,926	16,799	17,351	(126)	-0.7%	425	2.5%
Gynecology	1,254	640	389	(614)	-49.0%	(864)	-68.9%
Nephrology/Urology	10,774	11,374	12,299	600	5.6%	1,525	14.2%
Neuro Sciences	11,141	11,442	12,547	300	2.7%	1,406	12.6%
Obstetrics Del	25,997	24,152	24,246	(1,845)	-7.1%	(1,751)	-6.7%
Obstetrics ND	2,236	1,955	1,870	(281)	-12.6%	(366)	-16.4%
Oncology	4,078	4,146	4,321	69	1.7%	243	6.0%
Ophthalmology	215	203	195	(12)	-5.5%	(20)	-9.4%
Orthopedics	18,259	18,185	18,998	(74)	-0.4%	739	4.0%
Psychiatry	2,748	2,874	3,027	127	4.6%	279	10.2%
Pulmonary Medical	17,587	20,486	23,475	2,899	16.5%	5,888	33.5%
Rehabilitation	138	149	167	11	8.1%	29	21.2%
TOTAL	**178,263**	**182,075**	**193,686**	**3,812**	**2.1%**	**15,423**	**8.7%**

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 West Fort Worth Health Community outpatient procedures are expected to increase by almost 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	617,106	676,826	9.7%	742,766	20.4%
Anesthesia	236,439	278,761	17.9%	319,105	35.0%
Cardiology	1,309,113	1,682,175	28.5%	2,171,870	65.9%
Cardiothoracic	1,451	1,675	15.5%	1,911	31.7%
Chiropractic	901,786	905,413	0.4%	885,898	-1.8%
Colorectal Surgery	16,435	17,683	7.6%	19,008	15.7%
CT Scan	491,629	661,465	34.5%	883,115	79.6%
Dermatology	414,820	488,150	17.7%	569,991	37.4%
Diagnostic Radiology	2,648,562	2,926,876	10.5%	3,223,940	21.7%
Emergency Medicine	1,278,490	1,421,941	11.2%	1,586,862	24.1%
Gastroenterology	186,242	209,755	12.6%	234,847	26.1%
General & Internal Medicine	19,550,795	22,715,510	16.2%	25,838,460	32.2%
General Surgery	138,336	155,545	12.4%	175,418	26.8%
Hematology & Oncology	4,481,421	5,292,790	18.1%	6,089,665	35.9%
Labs	22,991,190	26,096,724	13.5%	29,581,389	28.7%
Miscellaneous	1,100,766	1,237,148	12.4%	1,381,084	25.5%
MRI	235,604	264,741	12.4%	297,000	26.1%
Nephrology	589,115	699,493	18.7%	818,700	39.0%
Neurology	263,604	297,456	12.8%	332,671	26.2%
Neurosurgery	11,211	16,162	44.2%	18,726	67.0%
Obstetrics/Gynecology	339,157	363,153	7.1%	395,434	16.6%
Ophthalmology	1,208,781	1,463,881	21.1%	1,733,852	43.4%
Oral Surgery	12,309	14,059	14.2%	16,156	31.2%
Orthopedics	344,055	384,458	11.7%	426,952	24.1%
Otolaryngology	656,994	760,324	15.7%	866,464	31.9%
Pain Management	265,883	302,854	13.9%	338,356	27.3%
Pathology	584	692	18.4%	812	38.9%
PET Scan	12,401	14,443	16.5%	16,536	33.3%
Physical & Occupational Therapy	6,668,649	8,082,961	21.2%	9,678,724	45.1%
Plastic Surgery	18,278	21,177	15.9%	24,517	34.1%
Podiatry	99,006	105,294	6.4%	110,594	11.7%
Psychiatry	2,547,797	3,475,954	36.4%	4,531,455	77.9%
Pulmonary	416,203	471,170	13.2%	536,744	29.0%
Radiation Therapy	191,161	214,099	12.0%	237,680	24.3%
Single Photon Emission CT Scan (SPECT)	34,242	38,379	12.1%	43,525	27.1%
Urology	168,851	198,540	17.6%	231,016	36.8%
Vascular Surgery	56,150	63,908	13.8%	72,036	28.3%
TOTAL	**70,504,616**	**82,021,632**	**16.3%**	**94,433,277**	**33.9%**

Source: IBM Watson Health Outpatient Procedure Estimates, 2020.

Emergency department visits

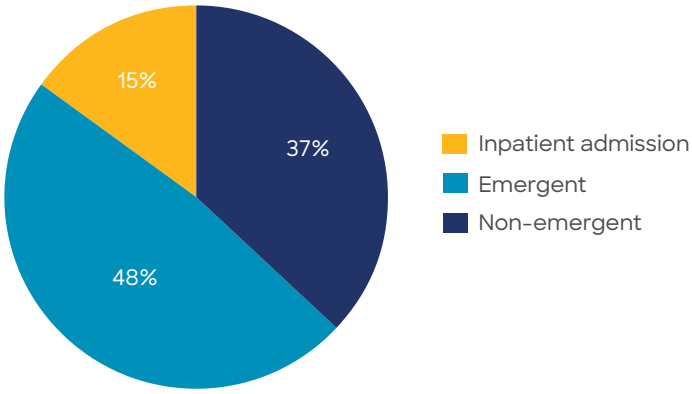
Emergency department estimates predict the total annual volume of emergency department (ED) visits by ZIP code and level of acuity for every market in the United States. IBM uses an extensive supply of proprietary claims, public claims and federal surveys to construct population-based use rates for all 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 West Fort Worth Health Community, ED visits are expected to grow by over 13% by 2025.

Emergent status	2020 visits	2025 visits	2020 - 2025 visits change	2020 - 2025 visits % change
Emergent	582,704	688,567	105,863	18.2%
Inpatient Admission	179,570	218,133	38,564	21.5%
Non-Emergent	501,623	522,486	20,863	4.2%
TOTAL	**1,263,897**	**1,429,187**	**165,290**	**13.1%**

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 West Fort Worth Health Community, the most common heart disease is hypertension at 72% of all heart disease cases.

Disease type	2020 prevalence	2020 % prevalence
Arrhythmia	110,164	12.3%
Heart Failure	51,725	5.8%
Hypertension	646,247	72.0%
Ischemic Heart Disease	89,013	9.9%
TOTAL	**897,149**	**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 10.3% in the West Fort Worth Health Community by 2025.

Cancer type	2020 incidence	2025 incidence	2020 - 2025 change	2020 - 2025 % change
Bladder	490	576	86	17.5%
Brain	234	259	24	10.4%
Breast	2,565	2,915	349	13.6%
Colorectal	1,271	1,187	-84	-6.6%
Kidney	460	543	84	18.2%
Leukemia	479	553	74	15.5%
Lung	1,208	1,355	147	12.1%
Melanoma	506	596	89	17.7%
Non-Hodgkin's Lymphoma	573	662	89	15.6%
Oral Cavity	349	403	54	15.4%
Other	1,297	1,506	209	16.1%
Ovarian	181	198	17	9.3%
Pancreatic	305	366	62	20.3%
Prostate	1,684	1,650	-34	-2.0%
Stomach	214	237	23	10.7%
Thyroid	367	420	52	14.3%
Uterine Cervical	79	81	2	2.6%
Uterine Corpus	292	339	46	15.8%
TOTAL	**12,554**	**13,845**	**1,290**	**10.3%**

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

Facilities: Baylor Scott & White All Saints Medical Center – Fort Worth
Baylor Scott & White Institute for Rehabilitation – Fort Worth
Baylor Scott & White Surgical Hospital – Fort Worth

Community served: Hood, Johnson, Parker and Tarrant Counties

Ratio of population to primary care providers (physician/non-physician)

Baylor Scott & White All Saints Medical Center – Fort Worth

Action/tactics	Anticipated outcome	Evaluation of impact
Financial donations Financial donations to community organizations meeting identified needs, addressing access to care or improving community health (i.e., community clinics).	Improved access to care.	• **Persons served: 13,214** • **$120,645 community benefit**
Clinical training program To help address the state's healthcare workforce shortage, BSWH provides a clinical training program to prepare physicians, nurses and allied health professionals for the medical workforce.	Number of nurses and ancillary service line staff educated in the community.	• **Persons served: 358** • **$5,345,841 community benefit**
Enrollment services The hospital will conduct enrollment services to assist in the qualification of the medically underserved for programs enabling access to care, such as Medicaid, Medicare, SCHIP and other government programs or charity care programs.	Overcome access issues and reduce hospital expenses.	• **Persons served: 3,404** • **$1,190,140 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.	• **Persons served: unknown** • **$31,741,112 community benefit**

Ratio of population to primary care providers (physician/non-physician), continued

Baylor Scott & White Surgical Hospital – Fort Worth

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.	• **Persons served: unknown** • **$176,297 community benefit**

Baylor Scott & White Institute for Rehabilitation – Fort Worth

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.	• **Persons served: unknown** • **$947,000 community benefit**

Access to mental health providers

Baylor Scott & White All Saints Medical Center – Fort Worth

Action/tactics	Anticipated outcome	Evaluation of impact
Mental health screenings Screen for mental health issues in emergency department and refer to appropriate services.	Increase access to mental health services for under/uninsured.	• **Persons served: 9,926**

Uninsured children

Baylor Scott & White All Saints Medical Center – Fort Worth

Action/tactics	Anticipated outcome	Evaluation of impact
Infant mortality prevention Provide sleep sacks to underserved/uninsured children who are less than one year old to decrease the chance of suffocation.	Reduction of infant mortality	• **Persons served: 9,152** • **$66,615 community benefit**
Wellness programs Provide wellness programs for children, including vaccinations, health screenings and general fitness education opportunities.	Increase access to services for uninsured.	• **Persons served: 470** • **$7,629 community benefit**
Child life specialist program Child life specialist helps children "navigate" the illness of someone they love. When patients experience a serious or life-limiting illness or injury, the effects reach far beyond just their physical health. For those who have children, grandchildren or other close children in their lives, it can be difficult for those children to understand and navigate the situation.	Improved grief management and reduced length of stay.	• **Persons served: unknown** • **$118,765 community benefit**

Depression in the Medicare population

Baylor Scott & White All Saints Medical Center – Fort Worth

Action/tactics	Anticipated outcome	Evaluation of impact
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** • **$130,441 community benefit**
Palliative care Palliative care provides relief of emotional pain that accompanies end-of-life care. Providing palliative care services addresses cultural, spiritual, ethnic and social needs in a manner respectful of patient's individuality and inherent human dignity and worth. This service is provided without regard to ability to pay.	Improved grief management and reduced length of stay.	• **Persons served: 6,164** • **$933,505 community benefit**
Support groups Provide support groups and art therapy for cancer survivors and caretakers.	Improved mental health.	• **Persons served: 13,875** • **$9,002 community benefit**

Baylor Scott & White Institute for Rehabilitation – Fort Worth

Action/tactics	Anticipated outcome	Evaluation of impact
Behavioral health screenings Begin new health screenings for behavioral health and order process for a neuro-psychologist's involvement on cases.	Increased access to mental health services.	• **Persons served: 219** • Social determinants of health questions surrounding depression and mental health were added into the BSW electronic health record, EPIC, in July 2021.
Support groups Refer patients and families into support group offerings and implement a brain injury support group.	Increased access to care for those suffering from depression following stroke.	• **Persons served: 180** • **$1,200 community benefit** Limited numbers due to program suspension beginning in June 2019 and resuming in January 2022.

Addressing more than one need

Baylor Scott & White All Saints Medical Center – Fort Worth

Action/tactics	Anticipated outcome	Evaluation of impact
Community education/outreach Community education/outreach activities provided at the hospitals and in the community improve community health and extend the reach of the hospitals beyond patient care. Services can include health screenings, chronic disease education, general wellness support, 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.	• **Persons served: 31,708** • **$108,225 community benefit**
Faith Community Health Faith Community Health encourages faith community wellness through establishment of health initiatives, assisting high-risk patients through social support and resource navigation, and fostering community engagement through local collaboration efforts.	Help all populations reach optimal health by integrating faith communities with healthcare to foster health and wellness by providing more effective patient navigation, education and support.	• **Persons served: 771** • **$2,492 community benefit**
Financial and in-kind donations Financial and in-kind donations to community organizations meeting identified needs, addressing access to care or improving community health.	Improved access to care, help with Medicaid enrollment, better referrals to community resources.	• **Persons served: 23,714** • **$246,613 community benefit**
Psychiatric consults Provide referrals for psychiatric consults for underserved and underinsured clinic patients with mental/behavioral health needs.	Improved access to mental health services.	• **Persons served: 4,121**

Total investment in adopted community needs since 2019 CHNA

BSWMC – Fort Worth
$40 million

BSWIR – Fort Worth
$948,000

BSW Surgical Hospital – Fort Worth
$176,000