Baylor Scott & White Health

Baylor Scott & White All Saints Medical Center – Fort Worth

Annual Report of Community Benefits

1400 8th Ave

Fort Worth, Texas 76104

Taxpayer ID # 75-1008430

For the Fiscal Year Ended June 30, 2016

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August 26, 2016

Dear Fellow Texan:

Since 1906, Baylor Scott & White All Saints Medical Center – Fort Worth has served the residents of Tarrant County and the surrounding areas. Originally founded as All Saints Episcopal Hospital, Baylor Scott & White - Fort Worth is a comprehensive medical center with 572 licensed beds located in the medical district of Fort Worth.

With areas of excellence including cardiology, neuroscience, transplantation, orthopedics, oncology, women's services, outpatient care, bariatrics, orthopedics and behavioral health, Baylor Scott & White – Fort Worth serves more than 195,000 people annually through its full-service hospital, primary care clinics, rehabilitation and fitness center and a variety of special medical services. Baylor Scott & White – Fort Worth is committed to fulfilling its mission**:**

> ***"Baylor Scott & White Health exists to serve all people by providing personalized health and wellness through exemplary care, education and research as a Christian ministry of healing.***

Enclosed is the community benefit report for Fiscal Year 2016. This will offer a better side-by-side comparison of what we planned versus what we actually did.

Our plans are developed according to community needs identified by the 2016 Baylor Scott & White Health Community Health Needs Assessment, North Texas Zone 3, as well as specific focus areas identified by Baylor Scott & White Health. Each year, our facilities spearhead a number of health fairs targeted at the underserved, supports local not-for-profit organizations with similar missions such as heart disease, oncology, stroke, chronic respiratory disease, diabetes, and Alzheimer's disease. As a preferred community partner, our commitment is to provide advanced health care for the ever-changing needs of our community. I encourage you to give me feedback for this report. Please address comments to me, in care of Jennifer Coleman, Senior Vice President, Public Affairs, Baylor Scott and White Health, 3500 Gaston Avenue, Suite 150, Dallas, Texas 75246.

Sincerely,

Janice Whitmire, MBA, HCM
Chief Operating Officer, Interim President
Baylor Scott & White All Saints Medical Center – Fort Worth

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1400 8th Ave
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I. Effective Dates of the Report

The annual report of community benefits provided is for the fiscal year ended June 30, 2016 (Fiscal Year 2016).

II. Hospital Description

Baylor Scott & White All Saints Medical Center – Fort Worth, an affiliate of Baylor Scott & White Health (BSWH), is a leading community and safety-net hospital in its service area. Located in downtown Fort Worth, the Hospital is a 572-bed medical facility offering the convenience and person attention of a local hospital, with the respected medical staff and advanced medical technology expected from a regional health care system. The hospital offers nearly twenty medical specialties, including programs of excellence in cardiology, neuroscience and oncology. It has an extensive transplant program in The Baylor Annette C. and Harold C Simmons Transplant Institute, the award winning Andrews Women's Hospital and the Joan Katz Breast Center.

The Hospital has received numerous awards and commendations for excellent care. Recent honors include: US News and World Report – Best Hospital for Common Care – Heart Failure and Chronic Obstructive Pulmonary Disease (COPD), Commission on Cancer Accreditation from the American College of Surgeons, National Accreditation Program for Breast Centers (NAPBC) and Cycle V Chest Pain Accreditation.

The Hospital uses its revenue after expenses to improve the health of Fort Worth and surrounding communities through patient care, education, research, and community service. In the fiscal year ending June 30, 2015, the Hospital had 17,743 total adult and special care nursery admits resulting in a total of 86,779 days of care; 5,621 babies were delivered and there were 43,545 emergency department visits.

As part of the Hospital's commitment to the community, the Hospital provides financial assistance in the form of charity care to patients who are indigent and satisfy certain requirements. Additionally, the Hospital is committed to treating patients who are eligible for means tested government programs such as Medicaid and other government sponsored programs including Medicare, which is provided regardless of the reimbursement shortfall, and thereby relieves the state and federal government of the burden of paying the full cost of care for these patients. Often, patients are unaware of the federal, state and local programs open to them for financial assistance, or they are unable to access them due to the cumbersome enrollment process required to receive these benefits. The Hospital offers assistance in enrollment to these government programs or extends financial assistance in

the form of charity care through the Hospital's Financial Assistance Policy which can be located on the Hospital's website at BaylorHealth.com/Financial Assistance.
In addition to the Hospital's Financial Assistance Policy, as part of a large faith based integrated health care delivery System the areas of medical education, research, subsidized services and community health education and screenings are initiatives that take place across the System, and also comprise a significant portion of the Hospital's community benefit program.

The Hospital is also committed to assisting with the preparation of future nurses at entry and advanced levels of the profession to establish a workforce of qualified nurses. Through the System's relationships with seven North Texas schools of nursing, the Hospital maintains strong affiliations with schools of nursing. In the fiscal year ending June 30, 2016, the Hospital invested in training 563 nurses. Total unreimbursed cost of these programs was $689,295. Like physicians, nursing graduates trained at a System entity are not obligated to join the staff although many remain in the North Texas area to provide top quality nursing services to many health care institutions.

III. Hospital Mission Statement

Baylor Scott & White Health exists to serve all people by providing personalized health and wellness through exemplary care, education and research as a Christian ministry of healing.

"Personalized health" refers to a commitment to develop innovative therapies and procedures focusing on predictive, preventive and personalized care. For example data from the electronic health record to helps to predict the possibility of disease in a person or a population. And with that knowledge, measures are put in place to either prevent the disease altogether or significantly decrease its impact on the patient or the population. Care is tailored to meet the individual medical, spiritual and emotional needs of the patients.

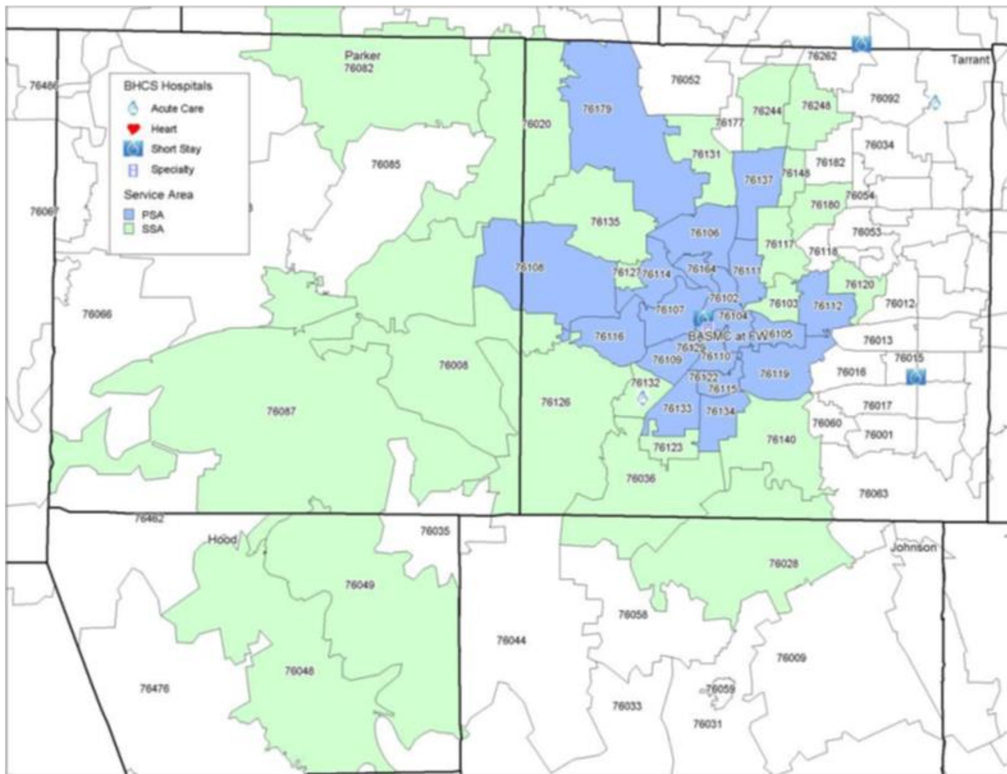
"Wellness" refers to ongoing efforts to educate the people served, helping them get healthy and stay healthy.

"Christian ministry" reflects the heritage of Baylor Health Care's founders and Drs. Scott and White, who showed their dedication to the spirit of servanthood — to equally serve people of all faiths and those of none.

IV. Description of Community Served

The System is committed to serving a vast array of neighborhoods comprising its service area and recognizes the importance of preserving a local community focus to effectively meet community needs.

Located in Tarrant County, Hospital serves the Western Region of the System and its total service area (TSA) includes ZIP codes from Tarrant, Parker, Hood and Johnson counties' It combines urban, suburban and rural areas with a total 2011 population of nearly 1.2 million residents.



The Hospital's TSA is fast growing, having grown 31 percent between 2000 and 2011. It is projected population increase of 9.6 percent between 2011 and 2016. (Table 1)

- Average household income, $64,678, is below the average for both Texas and the U.S.
- 12 percent of the population has household incomes under $12,000 and 11 percent have average household incomes between $15,000 and $25,000.
- 17 percent of the population has incomes over $100,000. (Table 5)
  Over half (54 percent) of the TSA population is White/Caucasian compared to 48 percent in Texas and 64 percent in the U.S. TSA minority populations include 28.5 percent Hispanic/Latino and 12.4 percent Black/African American. (Table 2)
- The TSA and Texas are similar in terms of age breakdown. In comparison to the U.S., the TSA has a larger percentage of children (age 0 -14 years) and smaller percentages in the 55 and older age ranges. (Table 3)
- Over 20 percent of TSA residents have not graduated from high school. This is a higher percentage than found in both Texas (19 percent) and the U.S. (15 percent). (Table 4)
- Considering insurance status, 18.5 percent of Tarrant County residents are uninsured compared to 24.7 percent of Texas residents and 15.5 percent of U.S. residents.

[1]The TSA is defined by the health care industry standard eighty percent rule (fifty percent of inpatient volume from the primary service area plus thirty per cent of the inpatient volume from secondary service area). To ensure that a true representation of the community is served, the outlier Zip codes are removed, missing Zip codes adjacent to the facility are included and Zip codes needed to complete the contiguous service area are included.

V. Identified Community Health Needs

During the fiscal year ending June 30, 2013, the Hospital conducted a CHNA to assess the health care needs of the community. The CHNA took into account input from persons who represent the broad interest of the community served by the Hospital, including those with special knowledge of or expertise in public health. The CHNA has been made widely available to the public and is located on the website at the following address, BaylorHealth.com/Community. A summary of the CHNA is outlined below including the list of the needs identified in the assessment.

Creating healthy communities requires a high level of mutual understanding and collaboration with community individuals and partner groups. The development of this assessment brings together information from community health leaders and providers along with local residents for the purposes of researching, prioritizing and documenting the community health needs for the geographies served by the Hospital. This health assessment will serve as the foundation for community health improvement efforts for next three years.

The FY 2013 CHNA brings together a variety of health status information. This assessment consolidates information from the recent community health needs assessment conducted for the Texas' Regional Healthcare Partnership Region 10 (Region 10 RHP), the Tarrant County Community Health Needs Assessment and the Consumer Health Report conducted by the National Research Corporation (NRC) for the Hospital each of which takes into account input from person who represent the broad interest of the community including those with special knowledge of or expertise in public health.

The identified community health needs as outlined below were reviewed and prioritized with input from the Baylor Scott & White Health (BSWH) Senior Leadership, the BSWH Mission and Community Benefit Committee and approved by the BSWH Board of Trustees. The methodology for prioritization can be found in the CHNA executive summary. Although each identified need is prioritized as high, medium or low, the Hospital will address all identified needs in the Plan.

The importance and benefits of compiling information from other recognized assessments are as follows: 1) Increases knowledge of community health needs and resources, 2) Creates a common understanding of the priorities of the community's health needs, 3) Enhances relationships and mutual understanding between and among stakeholders, 4) Provides a basis upon which community stakeholders can make decisions about how they can contribute to improving the health of the community, 5) Provides rationale for current and potential funders to support efforts to improve the health of the community, 6) Creates opportunities for collaboration in delivery of services to the community and 7) Provides guidance to the hospital how it can align its services and community benefit programs to best meet needs.
In developing a plan to address all identified community health needs, the Hospital and the System found that aggregating the needs allows for significant, crosscutting initiatives. Therefore, this community health implementation plan organizes the needs as follows:

A. Access to Care for Low Income/Underserved

B. Behavioral Health Services
C. Care Coordination and Care Transition
D. Emergency and Urgent Care
E. Multiple Chronic Conditions
F. Preventative Health Screenings
G. Dental Care

VI. Programs Addressing Identified Community Health Needs

Program Title: **Donations – In-Kind**

Description: The Hospital supports other not-for-profit organizations with in kind donations, such as serviceable equipment or supplies. Also provided are in kind donations such as meeting room overhead and space for not-for-profit organizations and social service networks; equipment and medical supplies for health related programs; emergency medical care at health-related community events; costs for coordinating events not sponsored by health care organizations; employee costs associated with board and community involvement on work time; food donations; other free ancillary services such as lab, and radiology and pharmacy services to other providers in the community, such as clinics or shelters. These donations extend the Baylor All Saints' services beyond the walls of the hospital.

Persons Served: 70,306

Needs Addressed Under This Program:

- Access to Care for Low Income/Underserved
- Emergency and Urgent Care

Program Title: **Donations In-Kind - Faith in Action Initiatives**

Description: The Office of Faith in Action Initiatives 2nd Life program provides monetary and medical supplies and equipment reclamation from Baylor Scott and White Health System and community partners for the purpose of providing for the health care needs of populations both locally and internationally whose needs cannot be met through their own organization. 2nd Life provides recycled medical equipment to underserved health care organizations, and provides monetary supporting disaster situations in shipment of medical equipment in the U.S. and in third world countries.

Needs Addressed Under This Program:

- Access to Care for Low Income/Underserved

Program Title: **Fetal and Infant Mortality Review Program**

Description: The National Fetal and Infant Mortality Review (NFIMR) is a collaborative effort between the American College of Obstetricians and Gynecologists and the federal Maternal and Child Health Bureau. NFIMR serves as a national resource center for state and local fetal and infant mortality. Tarrant County Fetal Infant Mortality Review (TCFIMR) was developed in 2007 and uses the NFIMR model. The infant mortality rate in Tarrant County has been increasing since 2000 and is currently at 7.6 deaths per 1,000 live births (year 2006), which is higher that state and national rates, and much

higher than the national Healthy People 2010 goal of 4.5 per 1,000. Service on various boards in the community helps to serve the Tarrant County area.
Persons Served: 30
Needs Addressed Under This Program:

- Access to Care for Low Income/Underserved

Program Title: **Health Care Support Services**
Description: Health care support services are provided by the Hospital to increase access and quality of care in health services to individuals, especially persons living in poverty and those in vulnerable situations. The hospital provides staff to assist in the qualification of the medically underserved for programs that will enable their access to care, such as Medicaid, Medicare, SCHIP and other government programs or charity care programs for use in any hospital within or outside the Hospital.
Persons Served: 1,692
Needs Addressed Under This Program:

- Access to Care for Low Income/Underserved

Program Title: **Community Education and Outreach - Behavioral Health**
Description: The statistics concerning suicide, depression, eating disorders, binge drinking, drug use, bullying and other mental health issues are alarming. The Hospital provides education on behavioral health to increase awareness about mental disorders and to offer effective tools for seeking treatment. All but one county in the region served by the Hospital are recognized as health professions shortage areas for mental health providers.
Persons Served: 100
Needs Addressed Under This Program:

- Behavioral Health Services

Program Title: **Health Screenings - Behavioral Health**
Description: The Hospital conducts screening assessments to alert the community to depression and how individuals at increased risk for depression are considered to have increased risk throughout their lifetime. Groups at increased risk include persons with other psychiatric disorders, including substance misuse; persons with a family history of depression; persons with chronic medical diseases; and persons who are unemployed or of lower socioeconomic status. Also, women are at increased risk compared with men. Significant depressive symptoms are associated with common life events in older adults, including medical illness, cognitive decline, bereavement, and institutional placement in residential or inpatient settings.
Persons Served: 103
Needs Addressed Under This Program:

- Behavioral Services

Program Title: **Community Education and Outreach - Fall Prevention**
Description: Fall related injuries among older adults, especially among older women, are associated with substantial economic costs. As the number of older adults increases

dramatically over the next few decades, so will economic burden of falls. Falls are preventable. Today, there are effective fall prevention interventions that can be used in community settings. By offering effective fall prevention programs in our communities, the Hospital can be instrumental in reducing falls and helping older adults live better, longer lives.
Persons Served: 160
Needs Addressed Under This Program:

- Emergency and Urgent Care

Program Title: **Community Benefit Operations**
Description: The Hospital is represented through the Dallas/Fort Worth Hospital Council which produces an annual Community Needs Assessment. The Hospital also provides dedicated staff for managing or overseeing community benefit program activities not included in other categories of community benefit. This staff provides internal tracking and reporting of community benefit as well as managing or overseeing community benefit program activities.
Persons Served: 125,594
Needs Addressed Under This Program:

- Multiple Chronic Conditions

Program Title: **Community Education and Outreach**
Description: Community health education activities are carried out at the Hospital and in the community to improve community health and extend beyond patient care activities. These services do not generate patient care bills and include such activities as community health education, community-based clinical health services and screenings for under- insured and uninsured persons, support groups, and self -help programs.
Persons Served: 3,045
Needs Addressed Under This Program:

- Multiple Chronic Conditions

Program Title: **Community Education and Outreach – Diabetes**
Description: Diabetes education is the cornerstone of diabetes management, because diabetes requires day to day knowledge of nutrition, exercise, monitoring, and medication. Diabetes is unlike other diseases, such as cholesterol and hypertension, where medication alone can often times be successfully treated. There are many components to diabetes, such as: the diabetes disease process, nutritional management, physical activity, medications, glucose monitoring, and psycho/social adjustment. Diabetes education increases awareness of diabetes, what is required for its treatment, and enhances the power to control it. Diabetes education enhances incorporation of positive lifestyle changes.
Persons Served: 180
Needs Addressed Under This Program:

- Multiple Chronic Conditions

Program Title: **Community Education and Outreach - Oncology**

Description: The Hospital participates in community health education programs to provide information about the importance of maintaining a healthy lifestyle in an effort to increase awareness about the risk of cancer. The Hospital provides information to increase awareness about the risk of cancer. A blog published by the American Cancer Society stated the importance of cancer education citing that those with a higher educational level had fewer total cancer deaths and deaths from lung and colorectal cancer than those with a lower educational level. Those comparisons showed greater differences than comparing similar educational levels on a racial basis (for example, white men with 8 or less years of education compared to black men with less than 8 years of education). For these circumstances, education trumped race when it came to impact of risk of dying.
Persons Served: 200
Needs Addressed Under This Program:

- Multiple Chronic Conditions

Program Title: **Community Health Education - Aramark/Nutrition**
Description: Aramark provides a means to healthy living, disease prevention and disease management through nutrition education. The goals of this program include provoking life-long healthy eating and physical activity habits by using the principles of the Food Guide Pyramid; building nutrition knowledge and skills which encourage healthy eating and physical activity choices; to positively influence states of physical wellness, recovery from illness, disease prevention and chronic disease management through nutrition education; and to promote a healthy nutritional paradigm in the community. The education program includes: analysis of food nutrition labels; research referencing the benefits of nutrients, minerals and vitamins; food guide research; developing healthy eating habits via production of grocery lists, menu preparation, budgeting for food and creating a balanced diet; brainstorming about nutrition and making healthy choices with food consumption in relation to physical need and body requirements while emphasizing the results of poor long term nutritional decisions; and measuring body fat and muscle density and providing appropriate nutrition education for optimal health status achievement.
Persons Served: 2,150
Needs Addressed Under This Program**:**

- Multiple Chronic Conditions

Program Title: **Community Health Education - Breast Cancer**
Description: The Hospital participates in community health education to promote the importance of breast cancer screenings, avoiding risk factors, and the need for education, especially among minorities. Breast Cancer is the most prevalent cancer among American women. On average, every woman has a one in eight (12%) chance of developing breast cancer at some time in her life. According to the American Cancer Society, there will be an estimated 240,000 new cases of breast cancer diagnosed in the United States in 2007. About 180,000 of these will be invasive breast cancer.
Persons Served: 5,148
Needs Addressed Under This Program:

- Multiple Chronic Conditions

Program Title: **Community Health Education - Heart Disease**
Description: The Hospital participates in community health education by providing blood pressure screenings to improve cardiovascular health and quality of life through prevention, detection and treatment of risk factors. The focus of this education is on hypertension and cholesterol in men and women and minority groups at high risk for disease development.
Persons Served: 50
Needs Addressed Under This Program:
- Multiple Chronic Conditions

Program Title: **Donations -Financial**
Description: The Hospital provides funds in the community at large whose mission compliments the mission of the Hospital. These funds include gifts to other not for profit organizations, contributions to charity events after subtracting the fair market value of participation by employees or the organization and help to extend the services of the hospital beyond its walls.
Persons Served: 8,150
Needs Addressed Under This Program:
- Multiple Chronic Conditions

Program Title: **Health Screenings - Blood Pressure**
Description: The Hospital provides blood pressure screenings to improve cardiovascular health and quality of life through prevention, detection and treatment of risk factors through focusing particularly on hypertension and cholesterol in men and women and minority groups at high risk for disease development. The key to preventing cardiovascular disease, also called coronary artery disease (CAD), is managing risk factors such as high blood pressure high total cholesterol or high blood glucose. Regular cardiovascular screening is important because it helps detect risk factors in their earliest stages and identify lifestyle changes and pharmacotherapies, if appropriate, before it ultimately leads to the development of cardiovascular disease.
Persons Served: 3,125
Needs Addressed Under This Program:
- Preventative Health Screenings

Program Title: **It's A Guy Thing**
Description: Regular health exams and tests can help find problems before they start. They also can help find problems early, when the chances for treatment and cure are better. Through It's A Guy Thing, the Hospital provides health services, screenings, and treatments, assisting men in taking steps that help their chances for living a longer, healthier life. This is annual event for men focusing on proactive health care including preventive health screenings, seminars and healthy lifestyle information.
Persons Served: 1,520
Needs Addressed Under This Program:

- Access to Care for Low Income/Underserved
- Behavioral Health Services
- Preventative Health Screenings

Program Title: **Health Screenings - Blood Pressure**
Description: The Hospital conducts screening assessments to alert the community to depression and how individuals at increased risk for depression are considered at risk throughout their lifetime. Groups at increased risk include persons with other psychiatric disorders, including substance misuse; persons with a family history of depression; persons with chronic medical diseases; and persons who are unemployed or of lower socioeconomic status. Also, women are at increased risk compared with men. Significant depressive symptoms are associated with common life events in older adults, including medical illness, cognitive decline, bereavement, and institutional placement in residential or inpatient settings.
Persons Served: 1,282
Needs Addressed Under These Programs:

- Preventative Health Screenings

Program Title: **Health Screenings - Cholesterol**
Description: The Hospital provides cholesterol screenings to help reduce the risk of heart related disease due to high cholesterol levels, and improve the quality of life for all persons who have or are at risk for the disease. Cholesterol buildup as plaque can prevent enough blood from flowing to the heart muscle. It is the most common cause of coronary heart disease, and happens so slowly that individuals may not be aware of it. This plaque can rupture, forming a blood clot that leads to a heart attack or stroke. The higher your LDL cholesterol, the greater the chance of heart attack or stroke. This is why cholesterol screening is so important. Cholesterol can build up for many years before any symptoms develop. Individuals may feel healthy and not realize they could be at risk for high cholesterol.
Persons Served: 1,420
Needs Addressed Under This Program:

- Preventative Health Screenings

Program Title: **Health Screenings - Multiple Diseases**
Description: Similar to national trends, residents in the Hospitals' service area exhibit increasing diagnoses of chronic conditions. It is common that the pathology for one condition may also affect other body systems, resulting in co-occurrence or multiple chronic conditions (MCC). The presence of MCC's adds a layer of complexity to disease management. The Hospital conducts screenings for MCC's including body fat analysis, BMI, and injury prevention.
Persons Served: 137
Needs Addressed Under This Program:

- Preventive Health Screenings
- Multiple Chronic Conditions

Program Title: **Health Screenings - Oncology**
Description: The Hospital participates in community health screenings to aid in reducing the number of undiagnosed cancer cases, as well as illness, disability, and death caused by cancer. Screening tests can help find cancer at an early stage, before symptoms appear. When abnormal tissue or cancer is found early, it may be easier to treat or cure.
Persons Served: 283
Needs Addressed Under This Program:

- Preventive Health Screenings

Program Title: **DSRIP Behavioral Health Services**
Description: The behavioral health project co-locates and integrates behavioral health services into the outpatient primary care setting. The model consists of providing a Licensed Clinical Social Worker (LCSW) to provide basic counseling services to address behavioral health needs such as: anxiety, depression, and substance abuse issues. The screening tools used are evidence based and will include (but not be limited to): PHQ2 or 9, GAD-7 and alcohol and substance abuse screens. Additionally, the LCSW will has the support of a Community Health Worker (CHW) to help with the screening and referral processes. The behavioral health program requires that the LCSW and CHW to work together with the primary care team to: 1) identify the patients who have behavioral health issues, 2) coordinate the patient's care and appointments to fit both the behavioral health and primary care appointment in the same visit and 3) help the primary care team to identify those patients whose behavioral health issues are impeding the management of their acute/chronic disease management models
Persons Served: 1,087
Needs Addressed Under This Program:

- Behavioral Health Services
- Multiple Chronic Conditions
- Preventative Health Screenings

Program Title: **DSRIP Care Connect – Patient Care Navigation Program**
Description: Through the Patient Navigation Program the Hospital creates a fluid care navigation program located in the Emergency Department for patients who are identified (or proclaim) to not have a primary care physician and/or patient centered medical home to address their post-acute care needs. By having staff in these locations, patients can receive real time assistance in finding a provider and ensuring they are connected with the appropriate resources they would require once discharged home. Weekend staff coverage ensures that patients are seen and connected to resources 7 days/week. Additionally, in order to close the loop, staff conducts follow-ups with patients to make sure they have an appointment and that they attend their appointment. The staff is also responsible for ensuring that other barriers such as transportation are addressed and patients are able to attend their follow-up visits. The Care Connect staff receives e-mail notifications any time a patient revisits the hospital so they proactively visit with the patient to ensure the patient is able to access their PCP/PCMH appointment and/or recommended community resource(s). Care plans are developed for patients with high hospital utilization (especially patients with frequent

emergency department visits) and complex needs. Care plans include involvement with Social Work Supervisor, Hospital Medical Director and other hospital staff. Patients with care plans are contacted as often as needed to ensure continuity of the care.
Persons Served: 3,518
Needs Addressed Under This Program:

- Care Coordination and Care Transition

Program Title: **DSRIP Chronic Disease Management**
Description: Through the Patient Navigation Program the Hospital creates a fluid care navigation program located in the Emergency Department for patients who are identified (or proclaim) to not have a primary care physician and/or patient centered medical home to address their post-acute care needs. By having staff in these locations, patients can receive real time assistance in finding a provider and ensuring they are connected with the appropriate resources they would require once discharged home. Weekend staff coverage ensures that patients are seen and connected to resources 7 days/week. Additionally, in order to close the loop, staff conducts follow-ups with patients to make sure they have an appointment and that they attend their appointment. The staff is also responsible for ensuring that other barriers such as transportation are addressed and patients are able to attend their follow-up visits. The Care Connect staff receives e-mail notifications any time a patient revisits the hospital so they proactively visit with the patient to ensure the patient is able to access their PCP/PCMH appointment and/or recommended community resource(s). Care plans are developed for patients with high hospital utilization (especially patients with frequent emergency department visits) and complex needs. Care plans include involvement with Social Work Supervisor, Hospital Medical Director and other hospital staff. Patients with care plans are contacted as often as needed to ensure continuity of the care.
Persons Served: 210
Needs Addressed Under This Program:

- Access to Care for Low Income/Underserved
- Multiple Chronic Conditions

Program Title: **DSRIP Medication Management and Prescription Assistance**
Description: This project focuses on medication management and compliance in the ambulatory setting within the patient’s Baylor Clinic PCMH. The project utilizes a clinical pharmacist who reviews patient mediations on a regular basis to ensure that those patients who have multiple prescriptions medications are appropriate and to ensure the patient understands how and why they are taking the medications. Additionally, the patient is provided with assistance in obtaining the needed medications through a prescription assistance program to help patients who are eligible, qualify for medications and provide medications to those patients who cannot afford prescriptions. The project will attempt to provide medications at little to no cost for patients who are 150% below the federal poverty level, have one or more chronic diseases and remain compliant with their appointments and care regimens. Through this benefit and clinical pharmacist oversight and management, the expectation is that adherence and

compliance to medications will increase. The additional advantage to embedding this team within the PCMH is that patients receive comprehensive care management that addresses all of their needs in one care venue.
Persons Served: 755
Needs Addressed Under This Program:

- Access to Care for Low Income/Underserved
- Care Coordination and Care Transition
- Multiple Chronic Conditions

Program Title: **Primary Care Expansion**
Description: The Baylor Clinic at the Hospital expands current capacity by opening patient panels to non-Baylor patients and fully utilizes the space and providers' capacity. Additional support staff has been hired to better coordinate patient care, ensure transition from the hospital to a Baylor Clinic and help to facilitate the care of complex under-served patients. Additionally, the clinic provides high quality primary care services to a greater number of people. Essentially, through expanding the capacity of the current clinic, adding additional support staff and services, a patient can receive comprehensive and complete services in one primary care location. In addition to receiving primary care, this project also proposes that ancillary services such as labs, imaging (i.e.: CT scans, MRI, mammograms, ultrasound, echocardiograms, and interventional radiology) and diagnostics (i.e.: colonoscopy, stress tests, esophageal diagnostic, retinal screens) would also be provided upon physician request. This project aims to close the loop of care and increase patient compliance by co-locating/coordinating many of the essential services that the under-served population often has issues accessing and completing.
Persons Served: 5,628
Needs Addressed Under This Program:

- Access to Care for Low Income/Underserved
- Multiple Chronic Diseases

Program Title: **DSRIP Specialty Care Expansion**
Description: Patients (including Medicaid and uninsured) in an established Primary Care Medical Home (PCMH) receive specialty care services at the Baylor Clinic, including office visits with specialists, wound care, and facility based procedures such as cardiac catheterizations, certain surgeries (i.e., gallbladder/hernia), excision of masses (breast, lymphoma), and cataract removal and excluding transplants, oncology and perinatal services. Specialty care referral and coordination comes from the PCMH clinic per request by the patient's PCP.
Persons Served: 465
Needs Addressed Under This Program:

- Access to Care for Low Income/Underserved
- Multiple Chronic Diseases

Program Title: **Medical Education/Nurses**

Description: The Hospital is committed to assisting with the preparation of future nurses at entry and advanced levels of the profession to establish a workforce of qualified nurses. Through the System's relationships with many North Texas schools of nursing, the Hospital maintains strong affiliations with schools of nursing. Like physicians, nursing graduates trained at the Hospital are not obligated to join the staff although many remain in the North Texas area to provide top quality nursing services to many health care institutions.
Persons Served: 541
Needs Addressed Under This Program:

- Access to Care for Low Income/Underserved

VII. Charity Care and Government-Sponsored Indigent Health Care Provided

For Fiscal Year 2016, Baylor Scott & White All Saints Medical Center – Fort Worth provided $20,373,481 in unreimbursed costs of charity care and government-sponsored indigent health care.

VIII. Government-Sponsored Health Care Provided

For Fiscal Year 2016, Baylor Scott & White All Saints Medical Center – Fort Worth provided $37,552,019 in unreimbursed costs of government-sponsored health care.

IX. Other Types of Community Benefits Provided $1,669,020

Baylor Scott & White All Saints Medical Center – Fort Worth is committed to improving the quality of life for the many citizens living and working in its area. Baylor Scott & White – Fort Worth was pleased to allocate funds to the following community benefit activities.

A. Community Health and Wellness Improvement Services	$11,550
B. Community Benefit Operations	$58,600
C. Financial Donations	$44,535
D. In Kind Donations	$31,349
E. Health Care Support Services	$524,108
F. Health Screenings	$27,931
G. Medical Education	$689,295
H. Physician Recruitment	$47,557
I. Research	$193,141

J. Subsidized Health Services $40,954

X. Total Operating Expenses and Calculation of the Ratio of Cost to Charge

As required by Section 311.046 (a) (4), Baylor Scott & White – Fort Worth reports $307,707,847 in total operating expenses. As required by Section 311.046(1) (5), the ratio of cost to charges was 31.20%. Please see the attached worksheet for the full calculation.

XI. Report of Community Benefit Provided During Fiscal Year 2016

In a commitment to fulfill its mission, Baylor Scott & White – Fort Worth benefit to the community, conservatively estimated, was $59,594,520 for Fiscal Year 2016. Baylor Scott & White– Fort Worth is filing its Annual Statement of Community Benefits Standard (Statement) as a consolidated system with the other affiliated hospitals of BSWH excluding those that qualify as Medicaid disproportionate share hospitals).

Through community benefit activities, BSWH-affiliated hospitals provided: quality patient care and subsidized services otherwise not available in the community; medical education, training for medical technicians, hospital chaplains, nurses, and future physicians; and medical research that will speed the time between scientific finding and its application to improving medical care.

Any comments or suggestions in regard to the community benefit activities are greatly welcomed and may be addressed to Jennifer Coleman, Senior Vice President, Consumer Affairs, Baylor Scott and White Health, 3600 Gaston Avenue, Suite 150, Dallas, Texas 75246.

Baylor All Saints Medical Center

Total Operating Expenses
Section 311.046(a) (4)

For the Fiscal Year Ended June 30, 2015		307,707,847

Calculation of the Ratio of Cost to Charge
Section 311.046(a)(5)

Total Patient Revenues (from 2015 Medicare Cost Report, Worksheet G-3, Line 1)	(a)	949,623,519
Total Operating Expenses (from 2015 Medicare Cost Report, Worksheet A, Line 118, Col. 7)	(b)	288,154,687
Initial Ratio of Cost to Charge ((b) divided by (a))	(c)	30.34%
Application of Initial Ratio of Cost to Charge to Bad-Debt Expense		
Bad Debt Expense (from 2016 audited financial statements)	(d)	26,777,990
Multiply "Bad Debt Expense" by "Initial Ratio of Cost to Charge" ((d)*(c))	(e)	8,124,442
Add the allowable "Bad-Debt Expense" to "Total Operating Expenses" ((b) + (e))	(f)	296,279,129
Calculation of Ratio of Cost to Charge ((f) divided by (a))	(g)	31.20%