



COMMUNITY HEALTH NEEDS ASSESSMENT



TARRANT COUNTY HEALTH COMMUNITY

**METHODIST MANSFIELD MEDICAL CENTER
METHODIST SOUTHLAKE MEDICAL CENTER**

Approved by: Methodist Health System Board of Directors on July 12, 2022
Posted to <http://www.methodisthealthsystem.org> by September 30, 2022

TABLE OF CONTENTS

METHODIST HEALTH SYSTEM	3
COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) REPORT	5
DEMOGRAPHIC AND SOCIOECONOMIC SUMMARY	7
HEALTH COMMUNITY DATA SUMMARY	7
PRIORITY HEALTH NEEDS	8
PRIORITY 1: ACCESS TO MENTAL HEALTH RESOURCES	9
PRIORITY 2: DIABETES MANAGEMENT	11
PRIORITY 3: ACCESS TO PRIMARY CARE PROVIDERS/SERVICES	12
PRIORITY 4: INCREASING HEALTH NEEDS OF AGING COMMUNITY	14
PRIORITY 5: CANCER INCIDENCE	15
PRIORITY 6: MANY NON-ENGLISH SPEAKERS	17
APPENDIX A: CHNA REQUIREMENT DETAILS	20
APPENDIX B: KEY PUBLIC HEALTH INDICATORS	26
APPENDIX C: COMMUNITY INPUT PARTICIPATING ORGANIZATIONS	35
APPENDIX D: DEMOGRAPHIC AND SOCIOECONOMIC SUMMARY	36
APPENDIX E: PROPRIETARY COMMUNITY DATA	43
APPENDIX F: 2019 METHODIST CHNA EVALUATION	47
APPENDIX G: COMMUNITY RESOURCES IDENTIFIED TO POTENTIALLY ADDRESS SIGNIFICANT HEALTH NEEDS	48

METHODIST HEALTH SYSTEM

COMPASSIONATE HEALTHCARE IN NORTH TEXAS

The Methodist ministers and civic leaders who opened their doors in 1927 could not have imagined where Methodist Health System would be today. From humble beginnings, their renowned health system has become one of the leading healthcare providers in North Texas, with several locations across the region.

But all of their growth, advancements, accreditation, awards, and accomplishments have been earned under the guidance of their founding principles: life, learning, and compassion. They are still growing, learning, and improving — grounded in a proud past and looking ahead to an even brighter future.

MISSION, VISION, AND VALUES OF METHODIST HEALTH SYSTEM

MISSION

To improve and save lives through compassionate quality healthcare.

VISION

To be the trusted choice for health and wellness.

CORE VALUES

Methodist Health System core values reflect our historic commitment to Christian concepts of life and learning:

- **Servant Heart** - compassionately putting others first
- **Hospitality** - offering a welcoming and caring environment
- **Innovation** - courageous creativity and commitment to quality
- **Noble** - unwavering honesty and integrity
- **Enthusiasm** - celebration of individual and team accomplishment
- **Skillful** - dedicated to learning and excellence

Where compassion is our compass. Where hearts and minds operate as one. Where a glass half empty is filled with hope. Where healing is believing.

Whatever the medical need, Methodist Health System is honored that patients entrust them with their health and safety. They understand that Methodist has a solemn responsibility to each patient and patient families, and they can trust that the Methodist team takes that commitment very seriously.

Methodist Health System further illustrates this commitment through periodic community health needs assessments which include plans on addressing those needs with a wide range of outreach initiatives. These Community Health Needs Assessment (CHNA) activities also satisfy federal requirements outlined in the Patient Protection and Affordable Care Act.

Methodist Health conducts periodic reviews of public health indicators and benchmark analyses 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, Methodist gains a clearer understanding of the 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**.

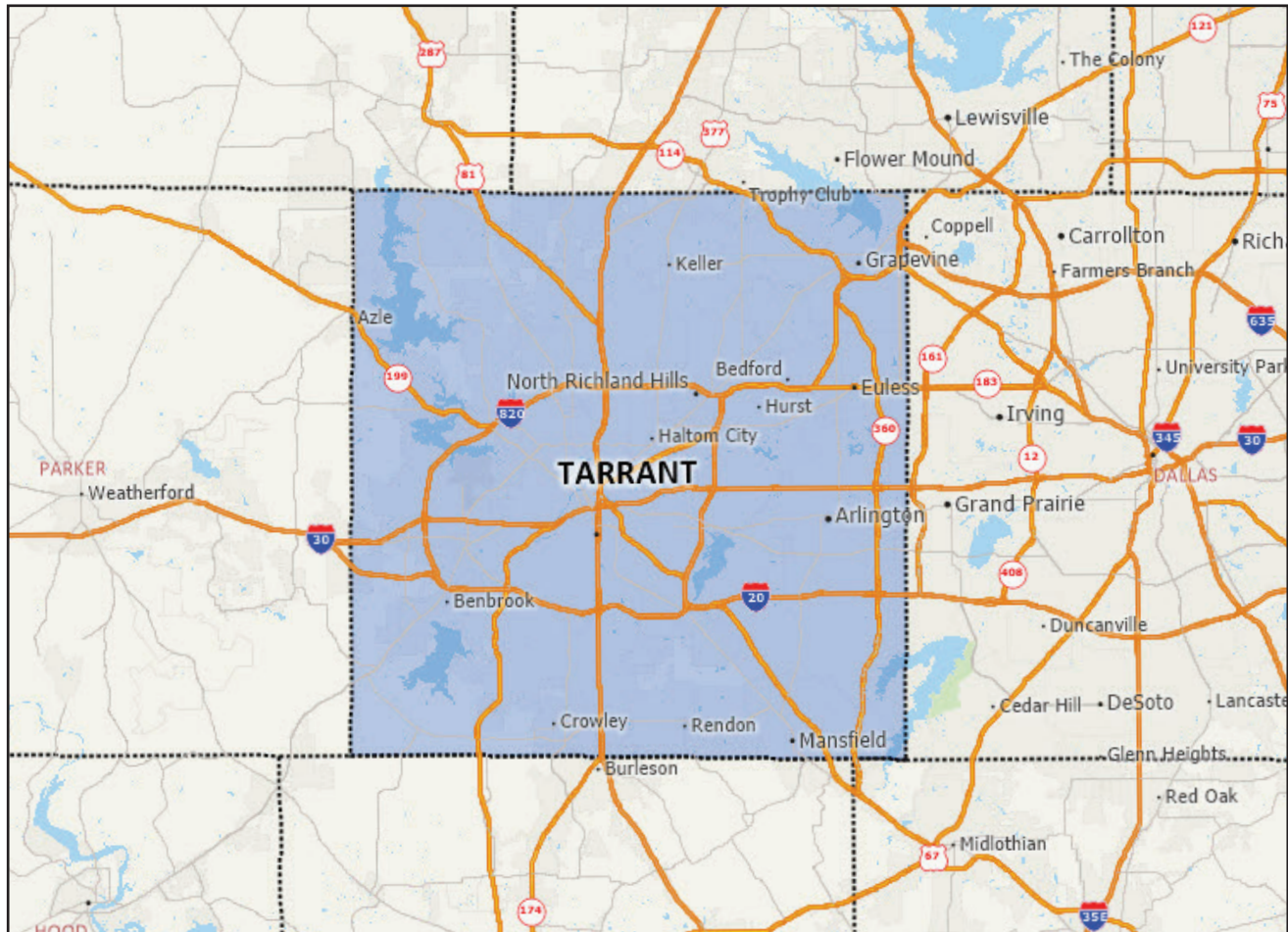
The CHNA serves as the foundation for community health improvement planning efforts over the next three years, while the implementation plans will be evaluated annually.

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) REPORT

Methodist owns and operates multiple individually licensed hospital facilities serving the residents of North Texas. This assessment applies to the following Methodist hospital facilities:

- **Methodist Mansfield Medical Center**
- **Methodist Southlake Medical Center**

The community served includes Tarrant County. The community includes the geographic area where more than 60 percent of the admitted patients live according to the hospital facilities' in-patient admissions over the twelve-month period of 2019Q2-2020Q1. Those facilities with overlapping counties of patient origin collaborated to provide a joint CHNA report in accordance with the U.S. Treasury regulations and 501(r)(3) of the Internal Revenue Code. 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.



Tarrant County Health Community Map

Methodist engaged with IBM Watson Health, a nationally-respected consulting firm, to conduct a Community Health Needs Assessment (CHNA) in accordance with the requirements of the Patient Protection and Affordable Care Act (PPACA) for the health communities they serve.

THE CHNA PROCESS INCLUDED:



- 1 Gathering and analyzing 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**.
- 2 Creating a benchmark analysis comparing the communities to overall state of Texas and United States (US) values.
- 3 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 each of the communities.

Demographic and Socioeconomic Summary

The most important demographic and socioeconomic findings for the Tarrant County Health Community CHNA are:

- 1 The community is growing faster than the U.S. and the State of Texas.
- 2 The median age of the population is younger than the U.S. but slightly older than the state of Texas.
- 3 The median household income is higher than both the State and the U.S.
- 4 The community served has a lower percentage of uninsured and Medicaid than Texas.

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

Health Community Data Summary

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

- 1 Inpatient discharges in the community are expected to grow by 8.5% by 2030 with the largest growing product lines to include:
 - Pulmonary Medical
 - Cardiovascular Diseases
 - General Medicine
- 2 Outpatient procedures are expected to increase by 34.3% by 2030 with the largest areas of growth including:
 - Labs
 - General & Internal Medicine
 - Physical & Occupational Therapy
 - Psychiatry
- 3 Emergency Department visits are expected to grow by 13.2% by 2025.
- 4 Hypertension represents 72.8% of all heart disease cases.
- 5 Cancer incidence is expected to increase by 10.7% by 2025.

Further health community information for the Tarrant County Health Community is included in **Appendix E**.

Priority Health Needs

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

<i>Priority</i>	<i>Need</i>	<i>Category of Need</i>
1	Access to Mental Health Resources	Access to Care
2	Diabetes Management	Conditions/Diseases
3	Access to Primary Care Providers/ Services	Access to Care
4	Increasing Health Needs of Aging Community	Utilization
5	Cancer Incidence	Conditions/Diseases
6	Many Non-English Speakers	Population

PRIORITY 1: ACCESS TO MENTAL HEALTH RESOURCES

The following data indicates greater need in accessing mental health resources to address mentally unhealthy days in the health community.

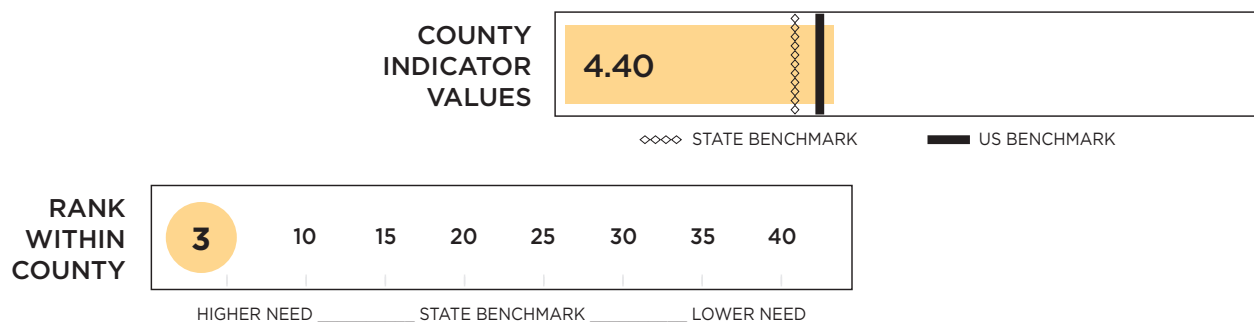
Category	Data Shows Greater Need	Key Informants Indicate Greater Need
Access to Care	<ul style="list-style-type: none"> • <i>Population to one primary care physician</i> • <i>Population to one non-physician primary care provider</i> 	<ul style="list-style-type: none"> • <i>Limited health care work force</i> • <i>Shortage of physicians and healthcare personnel</i> • <i>Limited health service hours</i>

Mental Health Conditions/Diseases: Mentally Unhealthy Days

(Average Number of Mentally Unhealthy Days Reported in Past 30 Days by County)

The Mentally Unhealthy Days measure is defined as the average number of mentally unhealthy days reported in the past 30 days. The indicator is based on data from County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS).

Tarrant County has a reported 4.40 days per month which is 17.1% higher than the state benchmark of 3.76 days per month. This indicates a higher need than the state and a larger vulnerable population. This indicator ranked as the third (3rd) among all 59 public indicators within Tarrant County and indicates greater need and a larger vulnerable population.



The key informants of the focus group recognize that there are gaps in mental health resources. They stated that there is limited access and a shortage of mental health services especially for the uninsured. For those that are insured, there is still insufficient insurance coverage for mental health services.

In the prioritization session, hospital leadership agreed that there is a need to address the gaps in mental and behavioral health services in the community. They added that there is a need to increase awareness of available resources.

PRIORITY 2: DIABETES MANAGEMENT

The following data indicates greater need for diabetes management in the health community.

Category	Data Shows Greater Need	Key Informants Indicate Less Need or Not Mentioned
Conditions/ Diseases	<ul style="list-style-type: none"> Diabetes Admission 	<ul style="list-style-type: none"> Not specifically mentioned

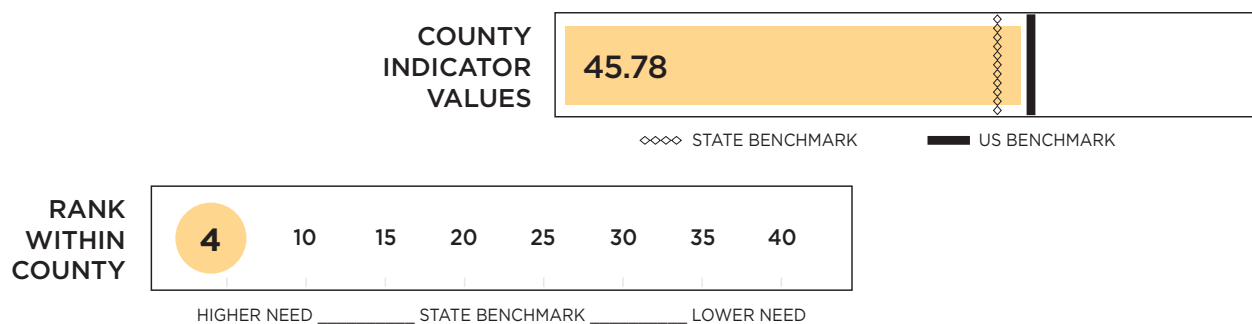
Conditions/Diseases: Diabetes Admission

(Number Diabetes Patients Observed/ Adult Population Age 18+ by County)

The indicator of diabetes admission is defined as the number of diabetes admissions observed divided by the adult population (age 18 and older) and is based on data from Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations.

Tarrant County has 45.78 diabetes patients per 100,000 adult individuals which is 15.9% higher than the state benchmark of 39.50. This indicates a slightly greater need than the state and a slightly larger vulnerable population.

This indicator ranked as the fourth indicator (4th) among all 59 public indicators within Tarrant County which indicates greater need and a larger vulnerable population.



The focus group participants did not discuss diabetes specifically.

In the prioritization session, the hospital and community leaders agreed that there is insufficient diabetes management in the community. They added that there is a need in the community to increase coordination of care, monitoring and medication assistance.

PRIORITY 3: ACCESS TO PRIMARY CARE PROVIDERS/SERVICES

The following data indicates greater need in accessing primary care providers and services in the health community.

Category	Data Shows Greater Need	Key Informants Indicate Less Need or Not Mentioned
Access to Care	<ul style="list-style-type: none"> • <i>Population to one primary care physician</i> • <i>Population to one non-physician primary care provider</i> 	<ul style="list-style-type: none"> • <i>Insufficient number of primary care providers</i> • <i>Insufficient number of primary care physicians</i>

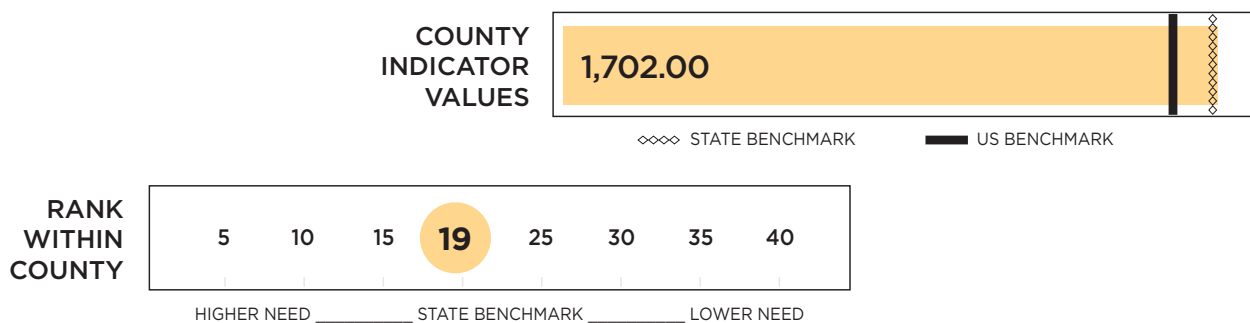
Access to Care: Population to One Primary Care Physician

(Number of Individuals Served by One Physician by County)

The population to one primary care physician indicator is defined as the ratio of population to one primary care physician 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.

Tarrant County has 1,702 individuals per every one primary care physician which is 3.7% higher than the state benchmark of 1,642. This indicates a greater need than the state and a larger vulnerable population.

This indicator ranked nineteenth (19th) among all 59 public indicators within Tarrant County which indicates higher need and a larger vulnerable population.



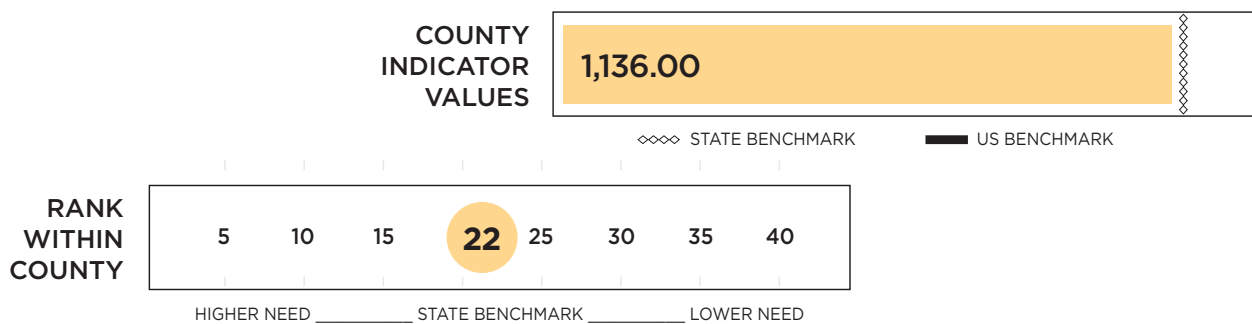
Access to Care: Population to One Non-Physician Primary Care Resource

(Number of Individuals Served by One Non-Physician Primary Care Resource by County)

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

Tarrant County has 1,136 individuals per every one non-physician primary care resource which is 0.7% higher than the state benchmark of 1,128. This indicates a greater need than the state and a larger vulnerable population.

This indicator ranked twenty-second (22nd) among all 59 public indicators within Tarrant County which indicates higher need and a larger vulnerable population.



The focus group participants cited that there is limited access to primary care physicians and non-physician primary care providers due to a shortage of resources and limited-service hours.

In the prioritization session, the hospital and community leaders agreed that there is a need to add primary care providers and resources in Tarrant County.

PRIORITY 4: INCREASING HEALTH NEEDS OF AGING COMMUNITY

The following data indicates greater need in the area of escalating health needs of the aging community and specifically Medicare spending per beneficiary (MSPB) index among the Medicare population.

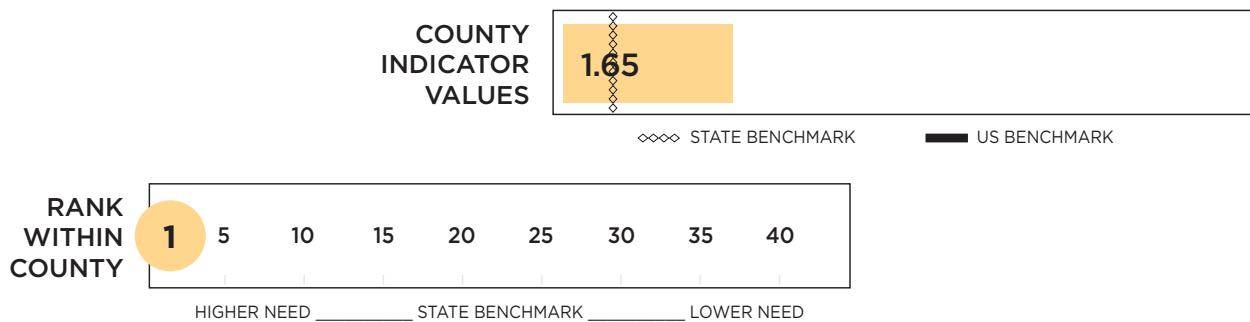
Category	Data Shows Greater Need	Key Informants Indicate Less Need or Not Mentioned
Utilization	<ul style="list-style-type: none"> Medicare spending per beneficiary (MSPB) index 	<ul style="list-style-type: none"> Not specifically mentioned

Utilization: Medicare Spending Per Beneficiary (MSPB) Index

(Average Episode Spending per Medicare Beneficiary by County)

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. This value is based on data from CMS Medicare Spending Per Beneficiary (MSPB), Hospital Value-Based Purchasing (VBP) Program.

Tarrant County has a ratio of 1.65 for Medicare spending per beneficiary which is 58.7% higher than the state benchmark of 1.04. This indicates a greater need than the state and a larger vulnerable population. This indicator ranked as the top (1st) among all 59 public indicators within Tarrant County which indicates a greater need and a larger vulnerable population.



The key informants did not specifically discuss Medicare spending per beneficiary.

In the prioritization session, hospital leadership agreed that the health needs and spending of the aging population are escalating and need to be addressed.

PRIORITY 5: CANCER INCIDENCE

The following data indicates greater need in the areas of cancer incidence (all causes, female breast, lung and prostate) although it was not discussed by the key informants specifically.

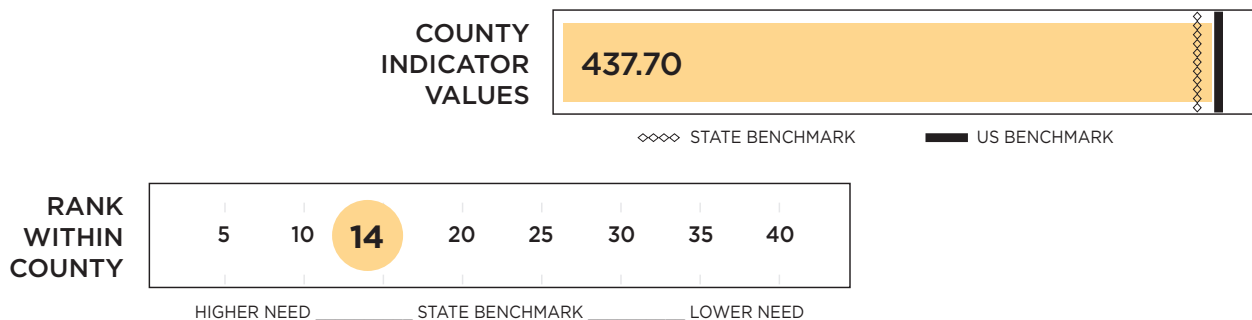
Category	Data Shows Greater Need	Key Informants Indicate Less Need or Not Mentioned
Conditions/ Diseases	<ul style="list-style-type: none"> • <i>Cancer incidence: All causes</i> • <i>Cancer incidence: Female Breast</i> • <i>Cancer incidence: Lung</i> • <i>Cancer incidence: Prostate</i> 	<ul style="list-style-type: none"> • <i>Not specifically mentioned</i>

Conditions/Diseases: Cancer Incidence: All Causes

(Cases per 100,000 Population in County)

The indicator Cancer Incidence: All Causes is defined as the age-adjusted cancer (all) incidence rate of cases per 100,000 population. It includes all races, including Hispanic; both sexes; and all ages. The measure is based on data from State Cancer Profiles, National Cancer Institute (CDC).

Tarrant County has 437.70 cancer cases per 100,000 population which is 7.4% higher than the state benchmark of 407.70. This indicates a higher need than the state and a larger vulnerable population. This indicator ranked fourteenth (14th) among all 59 public indicators within Tarrant County and indicates higher need and a larger vulnerable population.

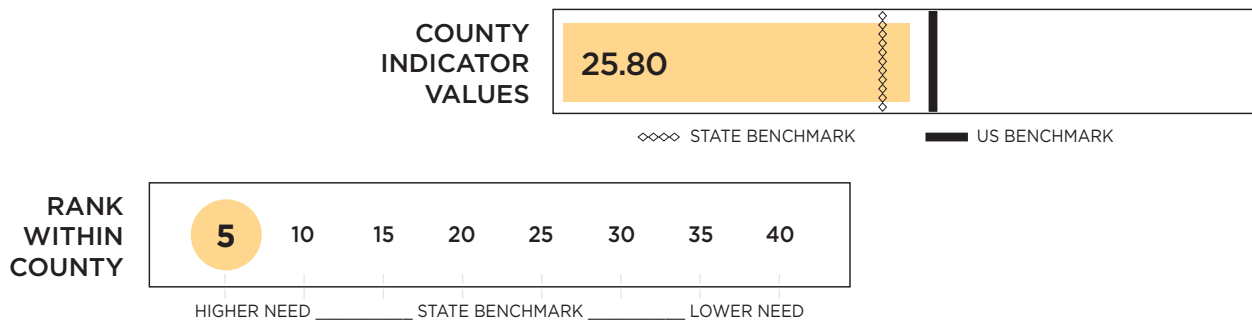


Conditions/Diseases: Cancer Incidence: Female Breast

(Female Breast Cancer Cases per 100,000 Female Population in County)

The indicator Cancer Incidence: Female Breast is defined as the age-adjusted breast cancer incidence rate of cases per 100,000 females. It includes all races, including Hispanic and all ages. The measure is based on data from State Cancer Profiles, National Cancer Institute (CDC).

Tarrant County has 25.80 female breast cancer cases per 100,000 population which is 14.7% higher than the state benchmark of 22.50. This indicates a greater need than the state and a larger vulnerable population. This indicator ranked fifth (5th) among all 59 public indicators within Tarrant County and indicates higher need and a larger vulnerable population.

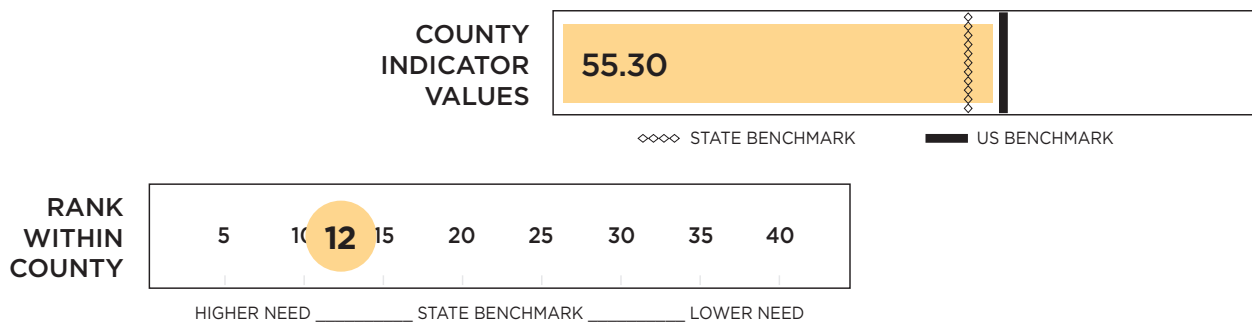


Conditions/Diseases: Cancer Incidence: Lung

(Lung Cancer Cases per 100,000 Population in County)

The indicator Cancer Incidence: Lung is defined as the age-adjusted lung cancer incidence rate of cases per 100,000 population. It includes all races, including Hispanic; both sexes; and all ages. The measure is based on data from State Cancer Profiles, National Cancer Institute (CDC).

Tarrant County has 55.30 lung cancer cases per 100,000 population which is 9.3% higher than the state benchmark of 50.60. This indicates a greater need than the state and a larger vulnerable population. This indicator ranked twelfth (12th) among all 59 public indicators within Tarrant County and indicates higher need and a larger vulnerable population.

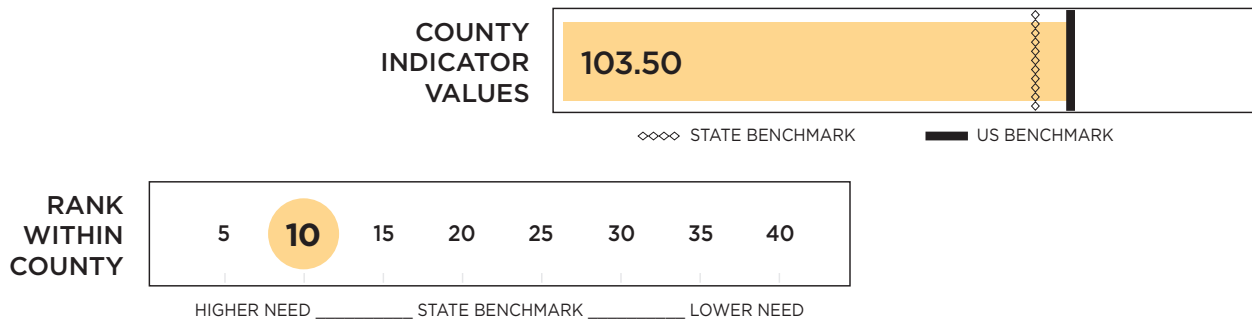


Conditions/Diseases: Cancer Incidence: Prostate

(Cases per 100,000 Male Population in County)

The indicator Cancer Incidence: Prostate is defined as the age-adjusted prostate incidence rate of cases per 100,000 males. It includes all races, including Hispanic and all ages. The measure is based on data from State Cancer Profiles, National Cancer Institute (CDC).

Tarrant County has 103.50 prostate cancer cases per 100,000 male population which is 10.1% higher than the state benchmark of 94. This indicates a greater need than the state and a larger vulnerable population. This indicator ranked tenth (10th) among all 59 public indicators within Tarrant County and indicates higher need and a larger vulnerable population.



Cancer incidence was not discussed by the key informants specifically.

In the prioritization session, hospital leadership agreed that there is a need to increase cancer screenings and increase outreach.

PRIORITY 6: MANY NON-ENGLISH SPEAKERS

The following data indicates greater need in the areas of cancer incidence (all causes, female breast, lung and prostate) although it was not discussed by the key informants specifically.

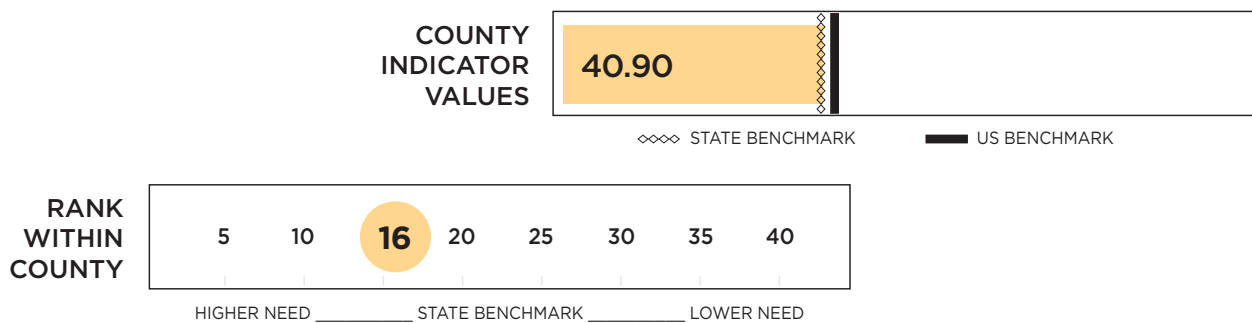
Category	Data Shows Greater Need	Key Informants Indicate Greater Need
<i>Population</i>	<ul style="list-style-type: none"> <i>English spoken "less than very well" in household</i> 	<ul style="list-style-type: none"> <i>Language barriers</i>

Population: English Spoken “Less Than Very Well” in Household

(Percent of Households That ‘Speak English Less Than “Very Well” by County)

The indicator Population: English Spoken “Less Than Very Well” in Household is defined as the percentage of households that ‘speak English less than “very well” within all households that ‘speak a language other than English.’ This value is based on data from American Community Survey 5-Year Estimates, US Census Bureau - American FactFinder.

Tarrant County has 40.90% of households that speak English less than “very well” among households that speak a language other than English. This value is 5.7% higher than the state benchmark of 38.70%. This indicates a greater need than the state and a larger vulnerable population. This indicator ranked sixteenth (16th) among all 59 public indicators within Tarrant County which indicates higher need and a larger vulnerable population.



The key informants noted that language barriers exist in the Tarrant County community. Language gaps between patient and provider lead to limited understanding of both parties.

In the prioritization session, hospital leadership agreed that the language barriers exist and bi-lingual staff and translation services are important to maintain and grow.

The Community Health Dashboards data referenced above, the prioritized list of significant health needs approved by the hospitals’ governing body and the full assessment can be found at <https://www.methodisthealthsystem.org/about/community-involvement>

Existing Resources to Address Health Needs

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

The available community's resources can be referenced in **Appendix G**.

Next Steps

Methodist Mansfield and Methodist Southlake started the Community Health Needs Assessment process in March 2021. Using both qualitative community feedback as well as publicly available and proprietary health indicators, Methodist Mansfield and Methodist Southlake were able to identify and prioritize community health needs for their facilities. 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 Methodist Mansfield and Methodist Southlake choose to address for the community served.

APPENDIX A: CHNA REQUIREMENT DETAILS

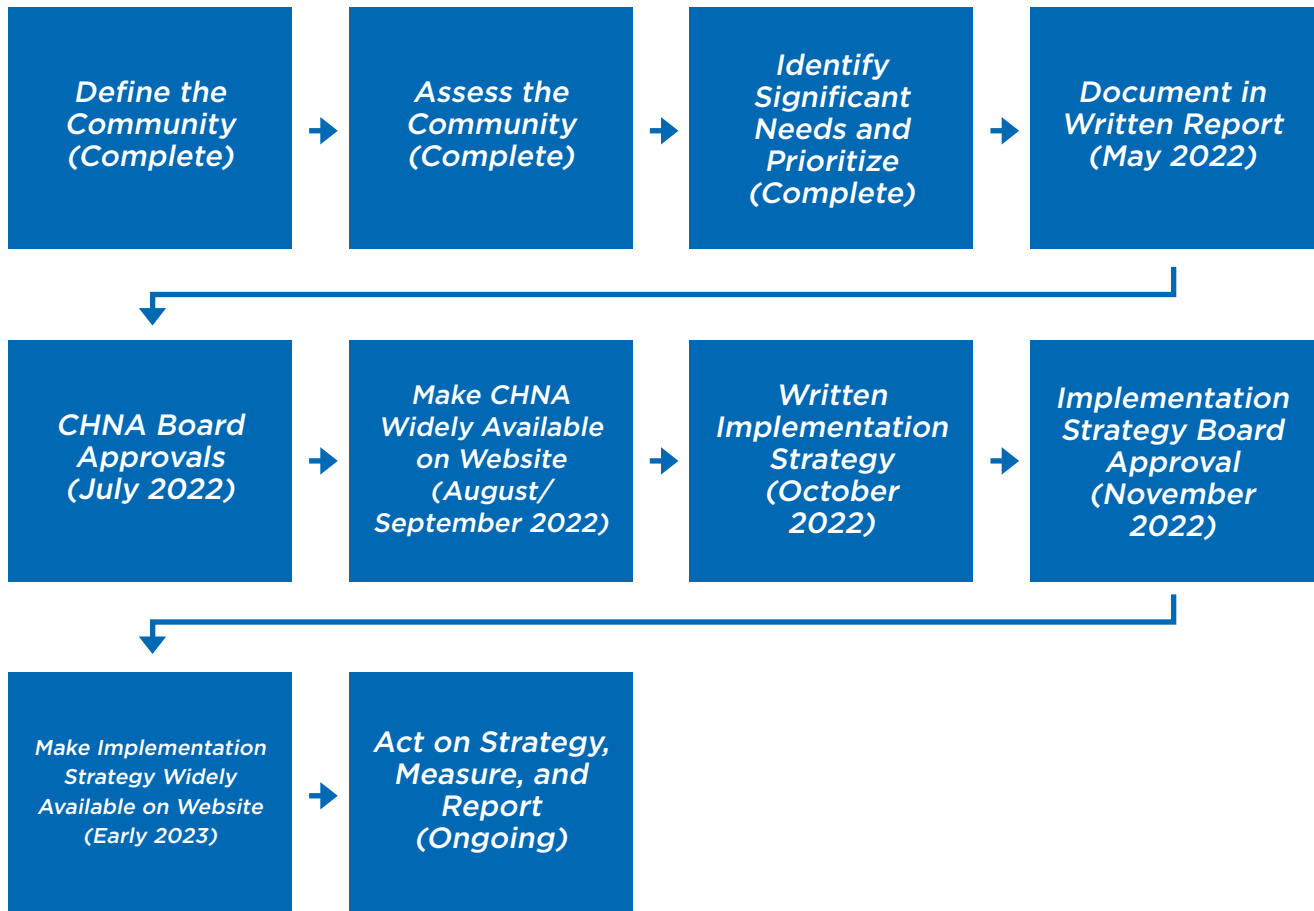
The Patient Protection and Affordable Care Act (PPACA) requires all tax-exempt organizations operating hospital facilities to assess the health needs of their community every three years. The resulting Community Health Needs Assessment (CHNA) report must include descriptions of the following:

- **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 hospital(s) 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

Methodist Health System began the 2022 CHNA process in March 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

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.

Data Gathering: Quantitative Assessment of Health Needs – Methodology and Data Sources

The team used quantitative data collection and analysis obtained 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, regulations 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 is in **Appendix B**.

A benchmark analysis of each indicator determined which public health indicators demonstrated a community health need. Benchmark health indicators included overall U.S. 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 preventative services).

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

- **Benchmarks were set for each health community using State value for comparison.**
- **Community indicators not meeting State benchmarks were identified.**
- **From this, a need differential analysis of the indicators was completed, which helped bring additional understanding of the community's relative severity of need.**
- **Using the need differentials, a standardized way to evaluate the degree each indicator differed from its benchmark was established.**

- **This quantitative analysis showed which health community indicators were below the 25th percentile in order of severity and, therefore, 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 Methodist Midlothian 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.

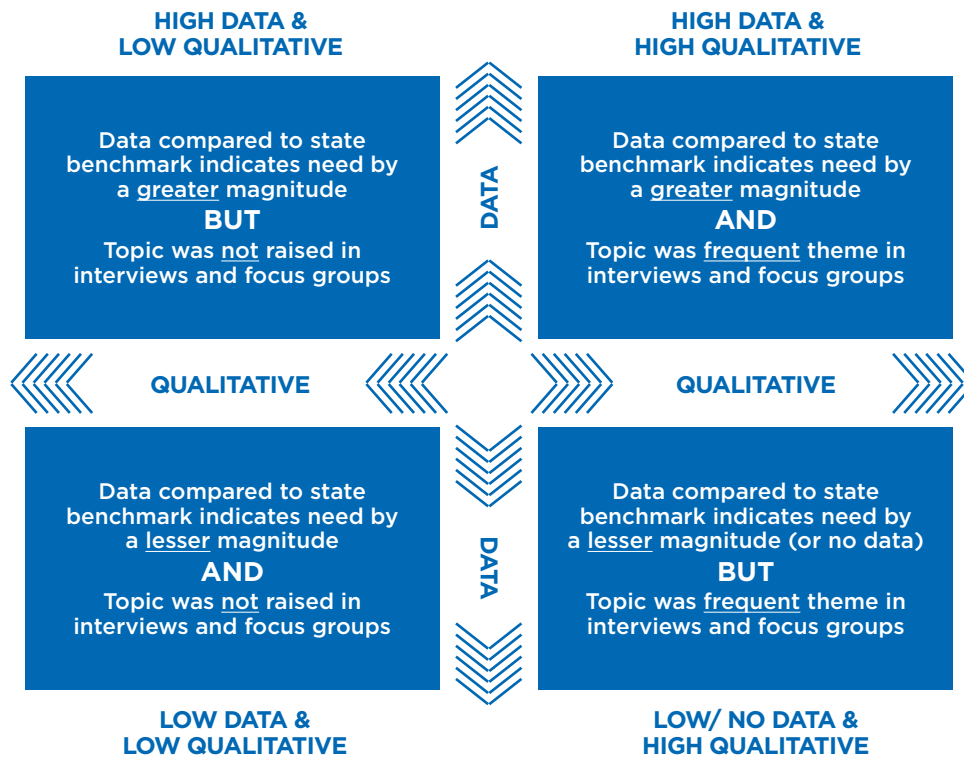
Multiple governmental public health department individuals were asked to contribute their knowledge, information, and expertise relevant to the health needs of the community. Individuals or organizations that served and/or represented the interests of medically underserved, low-income and minority populations 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. Input that has been received to date was reviewed and considered. The assessment is available for public comment or feedback on the report findings by emailing CHNAfeedback@mhd.com.

The CHNA assessment is available on the Methodist website at <https://www.methodisthealthsystem.org/about/community-involvement>

Approach to Prioritizing Significant Health Needs

On January 14, 2022, a session with key leaders from Methodist Mansfield and Methodist Southlake along with community leaders was convened 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 input from focus groups, interviews and survey participants.



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.



1. High Data & 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 also identified as a greater need by the key informants.



2. High Data & Low Qualitative: The community indicators that 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.



3. Low/No Data & High Qualitative: The community indicators that 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.

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:

- 1** Severity: What degree of disability or premature death occurs because of the problem? What are the potential burdens to the community, such as economic or social burdens?
- 2** Social Justice: Is the problem more concentrated to a specific vulnerable population? Does addressing this issue lead to unfair social benefit? Are we equitable to all vulnerable populations in our approach?
- 3** Root Cause: Is the issue a root cause of other problems - thereby possibly affecting multiple issues?

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. 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.

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 U.S. and the State of Texas.

The indicators used and the sources are listed below:

Indicator Name	Indicator Source	Indicator Definition
<i>Adult Obesity</i>	<i>2021 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System</i>	<i>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</i>
<i>Adults Reporting Fair or Poor Health</i>	<i>2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)</i>	<i>2018 Percentage of Adults Reporting Fair or Poor Health (Age-Adjusted)</i>
<i>Binge Drinking</i>	<i>2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)</i>	<i>2018 Percentage of a County's Adult Population that Reports Binge or Heavy Drinking in the Past 30 Days</i>
<i>Cancer Incidence: All Causes</i>	<i>State Cancer Profiles, National Cancer Institute (CDC)</i>	<i>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)</i>
<i>Cancer Incidence: Colon</i>	<i>State Cancer Profiles, National Cancer Institute (CDC)</i>	<i>2013-2017 Age-Adjusted Colon & 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 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).</i>

Cancer Incidence: Female Breast	State Cancer Profiles, National Cancer Institute (CDC)	<i>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 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).</i>
Cancer Incidence: Lung	State Cancer Profiles, National Cancer Institute (CDC)	<i>2013-2017 Age-Adjusted Lung & Bronchus Cancer Incidence Rate Cases per 100,000 (All Races, includes Hispanic; Both Sexes; All Ages. Age Adjusted to the 2000 US Standard Population)</i>
Cancer Incidence: Prostate	State Cancer Profiles, National Cancer Institute (CDC)	<i>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)</i>
Children in Poverty	2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau	<i>2019 Percentage of Children Under Age 18 in Poverty.</i>
Children in Single-Parent Households	2021 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)	<i>2015-2019 Percentage of Children that Live in a Household Headed by Single Parent</i>
Children Uninsured	2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau	<i>2018 Percentage of Children Under Age 19 Without Health Insurance</i>
Diabetes Admission	2018 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations	<i>Number Observed / Adult Population Age 18 and older. Risk Adjusted Rates not calculated for counties with fewer than 5 admissions.</i>

<i>Diabetes Diagnoses in Adults</i>	<i>CMS.gov Chronic conditions 2007-2018</i>	<i>Prevalence of chronic condition across all Medicare beneficiaries</i>
<i>Diabetes Prevalence</i>	<i>County Health Rankings (CDC Diabetes Interactive Atlas)</i>	<i>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.</i>
<i>Drug Poisoning Deaths</i>	<i>2021 County Health Rankings & Roadmaps, CDC WONDER Mortality Data</i>	<i>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.</i>
<i>Elderly Isolation</i>	<i>2018 American Community Survey 5-Year Estimates, US Census Bureau - American FactFinder</i>	<i>Percent of Non-family households - Householder living alone - 65 years and over</i>
<i>English Spoken “Less than Very Well” in Household</i>	<i>2015-2019 American Community Survey 5-Year Estimates, US Census Bureau - American FactFinder</i>	<i>2019 Percentage of households that ‘speak English less than “very well”’ within all households that ‘speak a language other than English’</i>
<i>Food Environment Index</i>	<i>2021 County Health Rankings & Roadmaps; USDA Food Environment Atlas, Map the Meal Gap from Feeding America, United States Department of Agriculture (USDA)</i>	<i>2015 & 2018 Index of Factors that Contribute to a Healthy Food Environment, 0 (Worst) to 10 (Best)</i>
<i>Food Insecure</i>	<i>2021 County Health Rankings & Roadmaps; Map the Meal Gap, Feeding America</i>	<i>2018 Percentage of Population Who Lack Ade-quate Access to Food During the Past Year</i>
<i>Food: Limited Access to Healthy Foods</i>	<i>2021 County Health Rankings & Roadmaps; USDA Food Environment Atlas, United States Department of Agriculture (USDA)</i>	<i>2015 Percentage of Population Who are Low-Income and Do Not Live Close to a Grocery Store</i>

<i>High School Graduation</i>	<i>Texas Education Agency</i>	<i>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.</i>
<i>Household Income</i>	<i>2021 County Health Rankings (Small Area Income and Poverty Estimates)</i>	<i>2019 Median Household Income is the income where half of households in a county earn more and half of households earn less.</i>
<i>Income Inequality</i>	<i>2021 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)</i>	<i>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.</i>
<i>Individuals Below Poverty Level</i>	<i>2018 American Community Survey 5-Year Estimates, US Census Bureau - American FactFinder</i>	<i>Individuals below poverty level</i>
<i>Low Birth Weight Rate</i>	<i>2019 Texas Certificate of Live Birth</i>	<i>Number Low Birthweight Newborns / Number of Newborns. Newborn's birthweight - low or very low birthweight includes birthweights 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.</i>
<i>Medicare Population: Alzheimer's Disease/Dementia</i>	<i>CMS.gov Chronic conditions 2007-2018</i>	<i>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 complimentary cell suppression.</i>

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 complimentary 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 complimentary cell suppression.
Medicare Population: Depression	CMS.gov Chronic conditions 2007-2018	Prevalence of chronic condition across all Medi-care 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
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 complimentary 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

<p><i>Medicare Population: Stroke</i></p>	<p><i>CMS.gov Chronic conditions 2007-2018</i></p>	<p><i>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 complimentary cell suppression.</i></p>
<p><i>Medicare Spending Per Beneficiary (MSPB) Index</i></p>	<p><i>CMS 2019 Medicare Spending Per Beneficiary (MSPB), Hospital Value-Based Purchasing (VBP) Program</i></p>	<p><i>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 indicates missing hospitals or missing score. associated to the hospitals</i></p>
<p><i>Mentally Unhealthy Days</i></p>	<p><i>2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)</i></p>	<p><i>2018 Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)</i></p>
<p><i>Mortality Rate: Cancer</i></p>	<p><i>Texas Health Data, Center for Health Statistics, Texas Department of State Health Services</i></p>	<p><i>2017 Cancer (All) Age Adjusted Death Rate (Per 100,000 - All Ages. Age-adjusted using the 2000 U.S. Standard Population). Death rates are NULL when the rate is calculated with a numerator of 20 or less.</i></p>
<p><i>Mortality Rate: Heart Disease</i></p>	<p><i>Texas Health Data, Center for Health Statistics, Texas Department of State Health Services</i></p>	<p><i>2017 Heart Disease Age Adjusted Death Rate (Per 100,000 - All Ages. Age-adjusted using the 2000 U.S. Standard Population). Death rates are NULL when the rate is calculated with a numerator of 20 or less.</i></p>
<p><i>Mortality Rate: Infant</i></p>	<p><i>2021 County Health Rankings & Roadmaps, CDC WONDER Mortality Data</i></p>	<p><i>2013-2019 Number of All Infant Deaths (Within 1 year), per 1,000 Live Births. Blank values reflect unreliable or missing data.</i></p>

<i>Mortality Rate: Stroke</i>	<i>Texas Health Data, Center for Health Statistics, Texas Department of State Health Services</i>	<i>2017 Cerebrovascular Disease (Stroke) Age Adjusted Death Rate (Per 100,000 - All Ages. Age-adjusted using the 2000 U.S. Standard Population). Death rates are NULL when the rate is calculated with a numerator of 20 or less.</i>
<i>No Vehicle Available</i>	<i>U.S. Census Bureau, 2019 American Community Survey 1-Year Estimates</i>	<i>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 falls 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.</i>
<i>Opioid Involved Accidental Poisoning Death</i>	<i>U.S. Census Bureau, Population Division and 2019 Texas Health and Human Services Center for Health Statistics Opioid related deaths in Texas</i>	<i>Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2017. 2019 Accidental Poisoning Deaths where Opioids Were Involved are those deaths which 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.</i>
<i>Physical Inactivity</i>	<i>2021 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System</i>	<i>2017 Percentage of Adults Ages 20 and Over Reporting No Leisure-Time Physical Activity in the Past Month</i>
<i>Physically Unhealthy Days</i>	<i>2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)</i>	<i>2018 Average Number of Physically Unhealthy Days Reported in Past 30 Days (Age-Adjusted)</i>
<i>Population to One Dentist</i>	<i>2021 County Health Rankings & Roadmaps; Area Health Resource File/National Provider Identification file (CMS)</i>	<i>2019 Ratio of Population to Dentists</i>

<i>Population to one Mental Health Provider</i>	<i>2021 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)</i>	<i>2020 Ratio of Population to Mental Health Providers</i>
<i>Population to One Non-Physician Primary Care Provider</i>	<i>2020 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)</i>	<i>2020 Ratio of Population to Primary Care Providers Other than Physicians</i>
<i>Population to One Primary Care Physician</i>	<i>2021 County Health Rankings & Roadmaps; Area Health Resource File/American Medical Association</i>	<i>2018 Number of Individuals Served by One Physician in a County, if the Population was Equally Distributed Across Physicians</i>
<i>Population under Age 65 without Health Insurance</i>	<i>2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau</i>	<i>2018 Percentage of Population Under Age 65 Without Health Insurance</i>
<i>Prenatal Care: First Trimester Entry into Prenatal Care</i>	<i>2020 Texas Health and Human Services - Vital statistics annual report</i>	<i>2016 Percent of births with prenatal care onset in first trimester</i>
<i>Renter-Occupied Housing</i>	<i>U.S. Census Bureau, 2019 American Community Survey 1-Year Estimates</i>	<i>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 falls 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.</i>
<i>Severe Housing Problems</i>	<i>2021 County Health Rankings & Roadmaps; Comprehensive Housing Affordability Strategy (CHAS) data, U.S. Department of Housing and Urban Development (HUD)</i>	<i>2013-2017 Percentage of Households with at Least 1 of 4 Housing Problems: Overcrowding, High Housing Costs, or Lack of Kitchen or Plumbing Facilities</i>

<i>Sexually Transmitted Infection Incidence</i>	<i>2021 County Health Rankings & Roadmaps; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)</i>	<i>2018 Number of Newly Diagnosed Chlamydia Cases per 100,000 Population</i>
<i>Smoking</i>	<i>2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)</i>	<i>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</i>
<i>Suicide: Intentional Self-Harm</i>	<i>Texas Health Data Center for Health Statistics</i>	<i>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.</i>
<i>Teen Birth Rate</i>	<i>2021 County Health Rankings & Roadmaps; National Center for Health Statistics, Natality files, National Vital Statistics System (NVSS)</i>	<i>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 7-Year Time Frame, and the Denominator is the Sum of the Annual Female Populations, Ages 15-19)</i>
<i>Teens (16-19) Not in School or Work - Disconnected Youth</i>	<i>2021 County Health Rankings (Measure of America)</i>	<i>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.</i>
<i>Unemployment</i>	<i>2021 County Health Rankings & Roadmaps; Local Area Unemployment Statistics (LAUS), Bureau of Labor Statistics</i>	<i>2019 Percentage of Population Ages 16 and Older Unemployed but Seeking Work</i>

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**
- **Fort Worth Housing Solutions**
- **Meals on Wheels**
- **Medstar**
- **Methodist Mansfield Advisory**
- **One Safe Place**
- **Project Access Tarrant County**
- **Tarrant Area Food Bank**
- **Tarrant County Public Health**
- **United Way of Tarrant County**

APPENDIX D: DEMOGRAPHIC AND SOCIOECONOMIC SUMMARY

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

GEOGRAPHY		Benchmarks		Community Served
		United States	Texas	Tarrant County
Total Current Population		330,342,293	29,321,501	2,050,322
5 Yr Projected Population Change		3.3%	6.6%	7.0%
Median Age		38.6	35.2	35.7
Population 0-17		22.4%	25.7%	25.9%
Population 65+		16.6%	13.2%	12.2%
Women Age 15-44		19.5%	20.5%	21.1%
Hispanic Population		19.0%	40.7%	30.3%
INSURANCE COVERAGE	Uninsured	9.9%	18.8%	15.3%
	Medicaid	20.9%	13.0%	12.2%
	Private Market	8.3%	8.4%	8.0%
	Medicare	13.8%	12.7%	11.3%
	Employer	47.2%	47.1%	53.2%
Median HH Income		\$65,618	\$63,313	\$73,266
No High School Diploma		12.2%	16.7%	15.0%

The community served expects to grow 7% by 2025, an increase by over 142,600 people. The projected population growth is higher than the state's 5-year projected growth rate (6.6%) and higher compared to 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**
- **76179 Fort Worth – 6,059 additional people**

The community's population is younger with 50.3% of the population ages 18-54 and 25.9% under age 18. The age 65 plus cohort is expected to experience the fastest growth (25.1%) 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 is primarily White Non-Hispanic. 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 83,220 people (13.4%) by 2025. The Non-Hispanic White population is expected to decline by -1.6%.

POPULATION DISTRIBUTION

Age Group	Age Distribution				
	2020	% of Total	2025	% of Total	USA 2020 % of Total
0-14	439,977	21.5%	450,111	20.5%	18.5%
15-17	91,299	4.5%	97,151	4.4%	3.9%
18-24	195,946	9.6%	216,021	9.9%	9.5%
25-34	290,681	14.2%	284,856	13.0%	13.5%
35-54	544,721	26.6%	575,729	26.3%	25.2%
55-64	238,255	11.6%	256,941	11.7%	12.9%
65+	249,443	12.2%	312,157	14.2%	16.6%
TOTAL	2,050,322	100%	2,192,966	100%	100%

HOUSEHOLD INCOME DISTRIBUTION

2020 Household Income	Income Distribution		
	HH Count	% of Total	USA % of Total
<\$15K	58,179	7.9%	10.0%
\$15-25K	53,121	7.2%	8.6%
\$25-50K	154,017	20.9%	20.7%
\$50-75K	134,709	18.3%	16.7%
\$75-100K	97,035	13.2%	12.4%
Over \$100K	238,748	32.4%	31.5%
TOTAL	735,809	100%	100%

Source: IBM Watson Health / Claritas, 2020.

EDUCATION LEVEL

2020 Adult Education Level	Education Level Distribution		
	Pop Age 25+	% of Total	USA % of Total
Less than High School	93,816	7.1%	5.2%
Some High School	104,485	7.9%	7.0%
High School Degree	318,663	24.1%	27.2%
Some College/Assoc. Degree	397,214	30.0%	28.9%
Bachelor's Degree or Greater	408,922	30.9%	31.6%
TOTAL	1,323,100	100%	100%

RACE/ETHNICITY

Race/Ethnicity	Race/Ethnicity Distribution		
	2020 Pop	% of Total	USA % of Total
White Non-Hispanic	929,276	45.3%	59.3%
Black Non-Hispanic	330,021	16.1%	12.4%
Hispanic	621,197	30.3%	19.0%
Asian & Pacific Is. Non-Hispanic	115,856	5.7%	6.0%
All Others	53,972	2.6%	3.3%
TOTAL	2,050,322	100%	100%

Source: IBM Watson Health / Claritas, 2020.

POPULATION GROWTH

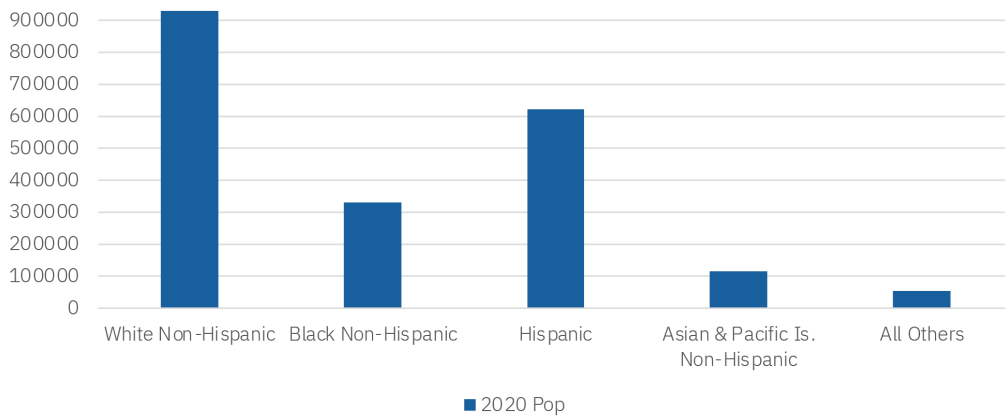
	National	Selected Area
2010 Total Population	308,745,538	1,756,877
2020 Total Population	330,342,293	2,050,322
2025 Total Population	341,132,738	2,192,966
2030 Total Population	353,513,931	2,356,099
% Change 2020 - 2025	3.27%	6.96%
% Change 2020 - 2030	7.01%	14.91%

POPULATION GENDER DISTRIBUTION

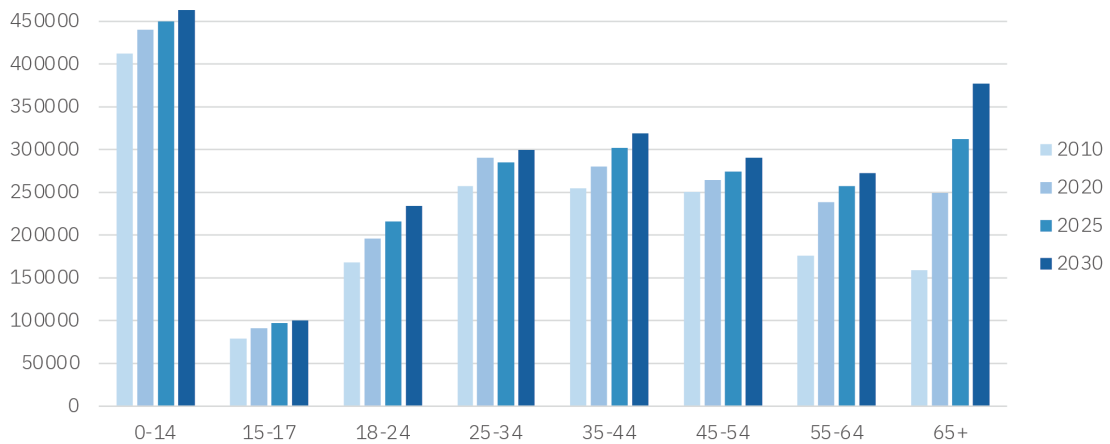
	Males All Ages	Females All Ages	Females Child Bearing
2010 Pop	861,908	894,969	383,085
2020 Pop	1,004,164	1,046,158	432,766
2025 Pop	1,074,287	1,118,679	450,893
2030 Pop	1,154,381	1,201,718	475,897
10Y Percent Change	14.96%	14.87%	9.97%
National	7.02%	7.01%	4.01%

Source: IBM Watson Health / Claritas, 2020.

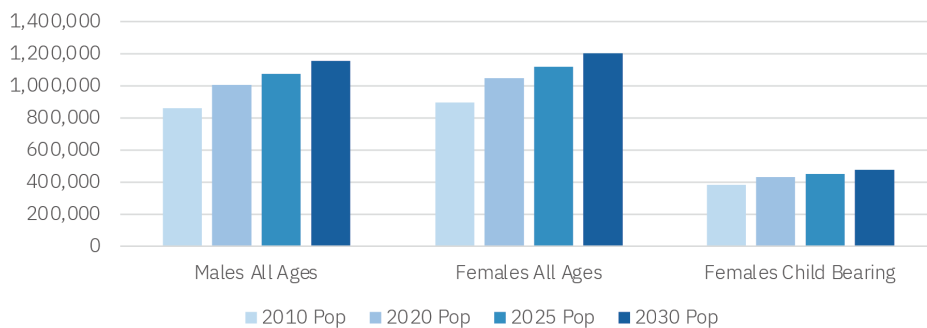
2020 Race & Ethnicity w Total Population



Population by Age Group 2010 - 2030



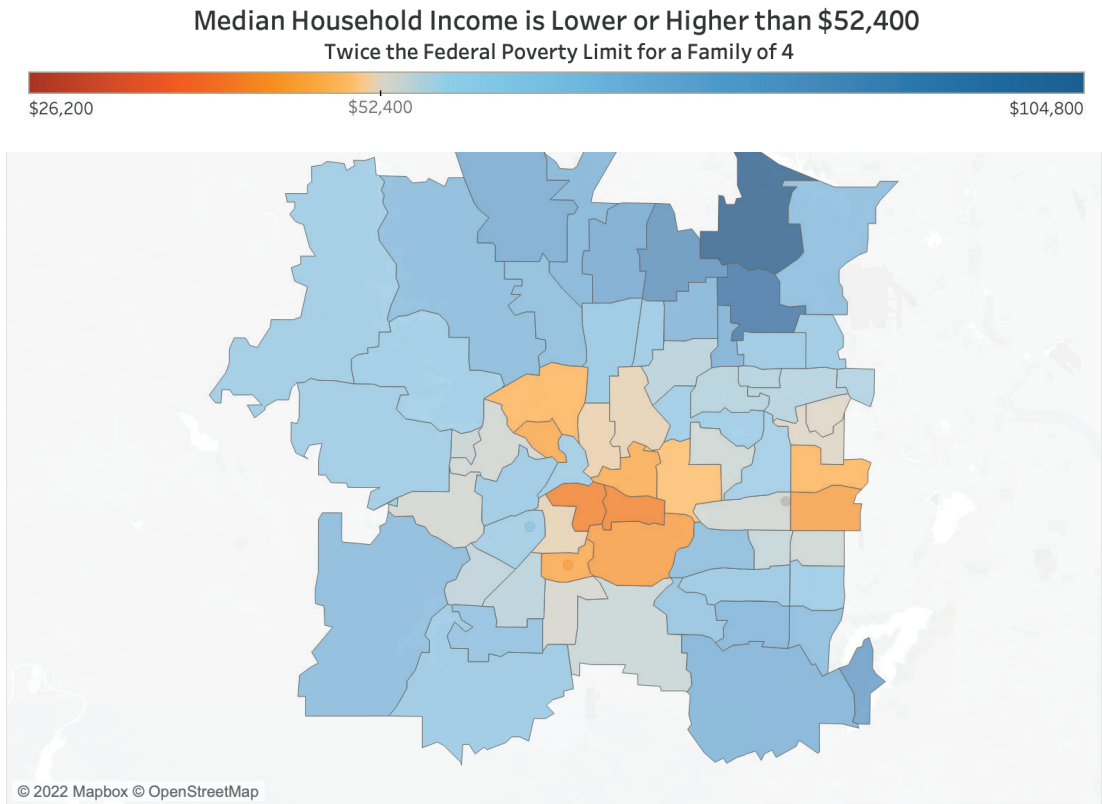
Population by Sex 2010 - 2030



Source: IBM Watson Health / Claritas, 2020.

The 2020 median household income for the United States was \$65,618 and \$63,313 for the State of Texas. The median household income for the ZIP codes within this community ranged from \$206,212 for 76092 (Southlake) to \$33,035 for 76104 (Fort Worth). There are seventeen (17) additional ZIP Codes with median household incomes less than \$52,400 – twice the 2020 Federal Poverty Limit for a family of four.

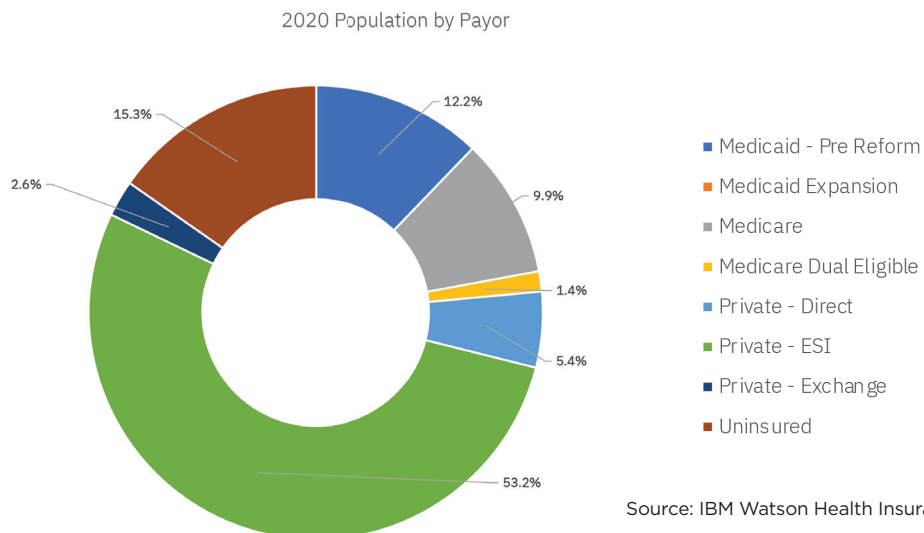
The Median Household Income ZIP code map below illustrates ZIP codes that are lower or higher than twice the Federal Poverty Level for a family of four in 2020.



ZIP code map color shows 2020 Median Household Income. ZIP codes are colored on a scale from orange to blue. Orange color indicates median income less than **twice the federal poverty level for a family of 4, which is \$52,400**, blue color indicates median is greater, and gray colors are similar to this benchmark.

Insurance Coverage Estimates

The majority of the population (53.2%) are insured through employer sponsored health coverage. The remainder of the population was fairly equally divided between Medicaid, Medicare, and private market (the purchasers of coverage directly or through the health insurance marketplace).



Source: IBM Watson Health Insurance Coverage Estimates, 2020.

Health Professional Shortages

The health community includes ten (10) Health Professional Shortage Area and three (3) Medically Underserved Areas as designated by the U.S. Department of Health and Human Services Health Resources Services Administration.

	HEALTH PROFESSIONAL SHORTAGE AREAS (HPSA)				MEDICALLY UNDERSERVED AREA/ POPULATION (MUA/P)
County	Dental Health	Mental Health	Primary Care	Grand Total	MUA/P
Tarrant	3	4	3	10	3

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, 2021.

The detail of the HPSA and MUA/P designations are listed below:

Health Professional Shortage Areas (HPSA)

COUNTY NAME	HPSA ID	HPSA ID NAME	HPSA DISCIPLINE CLASS	DESIGNATION TYPE
Tarrant	1482468046	Federal Medical Center - Fort Worth	Primary Care	Correctional Facility
Tarrant	6484046496	Federal Medical Center - Fort Worth	Dental Health	Correctional Facility
Tarrant	7483350268	Federal Medical Center - Fort Worth	Mental Health	Correctional Facility
Tarrant	1485279877	FMC-Carswell	Primary Care	Correctional Facility
Tarrant	6486448024	FMC-Carswell	Dental Health	Correctional Facility
Tarrant	7483623264	FMC-Carswell	Mental Health	Correctional Facility
Tarrant	7483111792	LI - MHCA - Tarrant County	Mental Health	Low Income Population HPSA
Tarrant	14899948H2	North Texas Area Community Health Centers Inc	Primary Care	Federally Qualified Health Center
Tarrant	748999483N	North Texas Area Community Health Centers Inc	Mental Health	Federally Qualified Health Center
Tarrant	64899948F5	North Texas Area Community Health Centers Inc	Dental Health	Federally Qualified Health Center

Medically Underserved Areas and Populations (MUA/P)

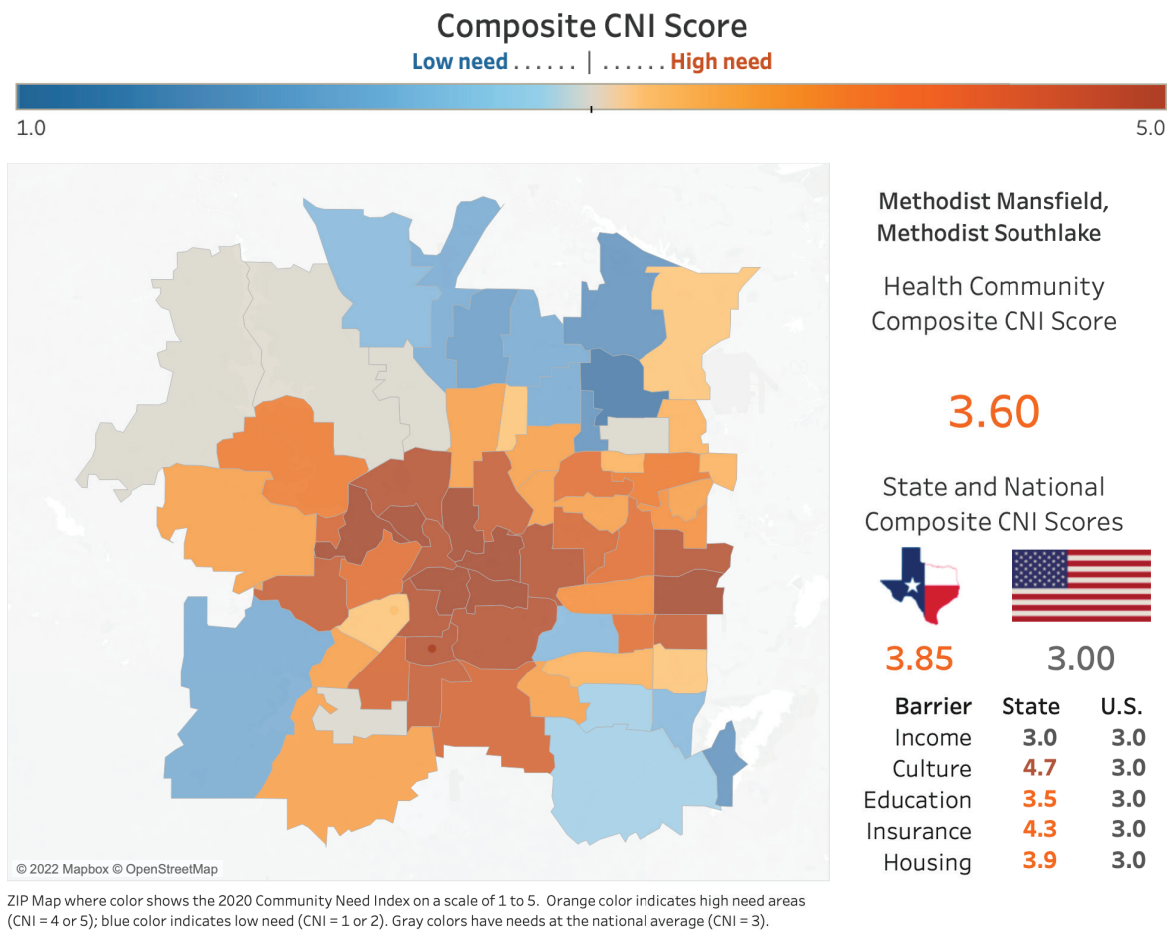
COUNTY NAME	MUA/P SOURCE IDENTIFICATION NUMBER	SERVICE AREA NAME	DESIGNATION TYPE	RURAL STATUS
Tarrant	07393	Central Service Area	Medically Underserved Area	Non-Rural
Tarrant	1481461749	Fort Worth-North	Medically Underserved Area	Non-Rural
Tarrant	07382	Low Inc - East Side	Medically Underserved Population	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 health care. 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 U.S.

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.



The overall CNI score for the Tarrant County Health Community is 3.60. 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 visit, 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 provides 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 U.S. 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 the Tarrant County Health Community. Total discharges in the community are expected to grow by 8.5% 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 & Drug Abuse	2,280	2,326	2,548	46	2.0%	268	11.8%
Cardio-Vasc-Thor Surgery	6,177	6,460	6,668	283	4.6%	491	8.0%
Cardiovascular Diseases	14,074	15,144	17,141	1,070	7.6%	3,067	21.8%
ENT	1,105	1,017	959	(89)	-8.0%	(147)	-13.3%
General Medicine	31,674	32,689	34,640	1,015	3.2%	2,966	9.4%
General Surgery	13,951	13,865	14,325	(87)	-0.6%	373	2.7%
Gynecology	1,072	546	331	(525)	-49.0%	(741)	-69.1%
Nephrology/Urology	9,008	9,545	10,350	537	6.0%	1,342	14.9%
Neuro Sciences	9,318	9,589	10,523	271	2.9%	1,205	12.9%
Obstetrics Del	22,388	20,662	20,626	(1,726)	-7.7%	(1,762)	-7.9%
Obstetrics ND	1,943	1,689	1,608	(254)	-13.1%	(335)	-17.2%
Oncology	3,360	3,425	3,577	65	1.9%	217	6.4%
Ophthalmology	182	172	165	(10)	-5.6%	(17)	-9.5%
Orthopedics	14,453	14,417	15,067	(36)	-0.2%	614	4.3%
Psychiatry	2,505	2,623	2,764	118	4.7%	259	10.4%
Pulmonary Medical	14,148	16,490	18,897	2,342	16.6%	4,749	33.6%
Rehabilitation	124	135	151	10	8.4%	27	21.8%
TOTAL	147,763	150,794	160,342	3,031	2.1%	12,579	8.5%

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 procedure codes and are further grouped into clinical service lines. The Tarrant County Health Community outpatient procedures are expected to increase by almost 34.3% by 2030 with the largest growth in the categories of Labs, General & Internal Medicine and Physical & Occupational Therapy.

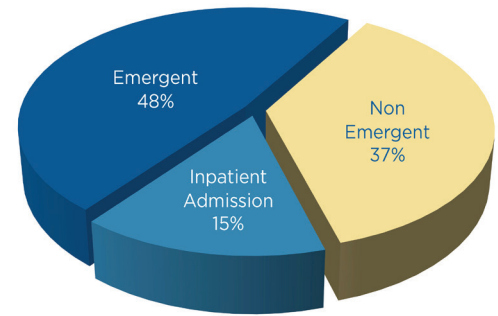
Clinical Service Category	2020 Procedures	2025 Procedures	2020-2025 Procedures % Change	2030 Procedures	2020-2030 Procedures % Change
Allergy & Immunology	525,678	577,658	9.9%	634,727	20.7%
Anesthesia	181,108	214,458	18.4%	246,106	35.9%
Cardiology	1,068,622	1,380,258	29.2%	1,789,797	67.5%
Cardiothoracic	1,190	1,377	15.7%	1,573	32.2%
Chiropractic	753,587	759,433	0.8%	747,859	-0.8%
Colorectal Surgery	13,924	15,045	8.1%	16,222	16.5%
CT Scan	393,705	532,162	35.2%	713,026	81.1%
Dermatology	329,020	388,197	18.0%	454,108	38.0%
Diagnostic Radiology	2,198,193	2,434,442	10.7%	2,685,538	22.2%
Emergency Medicine	1,074,494	1,195,835	11.3%	1,334,424	24.2%
Gastroenterology	154,439	173,818	12.5%	194,442	25.9%
General & Internal Medicine	16,213,748	18,863,665	16.3%	21,471,506	32.4%
General Surgery	110,282	124,362	12.8%	140,538	27.4%
Hematology & Oncology	3,811,885	4,512,081	18.4%	5,194,826	36.3%
Labs	19,155,818	21,773,616	13.7%	24,698,575	28.9%
Miscellaneous	955,762	1,076,273	12.6%	1,203,414	25.9%
MRI	192,116	216,133	12.5%	242,553	26.3%
Nephrology	510,233	606,957	19.0%	711,228	39.4%
Neurology	225,040	253,620	12.7%	283,136	25.8%
Neurosurgery	9,016	13,111	45.4%	15,157	68.1%
Obstetrics/Gynecology	296,294	316,243	6.7%	343,796	16.0%
Ophthalmology	989,683	1,202,365	21.5%	1,426,597	44.1%
Oral Surgery	10,388	11,866	14.2%	13,621	31.1%
Orthopedics	276,512	309,646	12.0%	344,304	24.5%
Otolaryngology	554,417	641,761	15.8%	730,827	31.8%
Pain Management	225,974	258,654	14.5%	290,246	28.4%
Pathology	482	570	18.2%	669	38.6%
PET Scan	9,439	11,020	16.8%	12,636	33.9%
Physical & Occupational Therapy	5,780,159	6,997,453	21.1%	8,363,825	44.7%
Plastic Surgery	14,790	17,218	16.4%	20,012	35.3%
Podiatry	78,368	83,298	6.3%	87,232	11.3%
Psychiatry	2,258,150	3,083,863	36.6%	4,018,897	78.0%
Pulmonary	345,678	392,111	13.4%	447,304	29.4%
Radiation Therapy	158,384	178,222	12.5%	198,504	25.3%
Single Photon Emission CT Scan (SPECT)	27,108	30,532	12.6%	34,748	28.2%
Urology	133,863	158,063	18.1%	184,539	37.9%
Vascular Surgery	44,578	50,821	14.0%	57,333	28.6%
TOTAL	59,082,130	68,856,206	16.5%	79,353,843	34.3%

Source: IBM Watson Health Outpatient Procedure Estimates, 2020.

Emergency Department Visits

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

2025 Visits



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 which result in an inpatient admission are broken out into a third, separate category. In the Tarrant County Health Community, ED visits are expected to grow by 13.2% by 2025.

<i>Emergent Status</i>	<i>2020 Visits</i>	<i>2025 Visits</i>	<i>2020-2025 Visits Change</i>	<i>2020-2025 Visits % Change</i>
Emergent	486,894	576,273	89,379	18.4%
Inpatient Admission	145,624	177,742	32,118	22.1%
Non Emergent	422,623	439,926	17,303	4.1%
TOTAL	1,055,141	1,193,941	138,800	10.4%

Source: IBM Watson Health Emergency Department Visits, 2020.

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.

<i>Disease Type</i>	<i>2020 Prevalence</i>	<i>2020 % Prevalence</i>
Arrhythmia	89,324	89,324
Heart Failure	41,655	41,655
Hypertension	535,320	535,320
Ischemic Heart Disease	69,407	69,407
TOTAL	735,706	100%

In the Tarrant County Health Community, the most common disease is hypertension at 72.8% of all heart disease cases.

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 10.7% in the Tarrant County Health Community by 2025.

Cancer Type	2020 Incidence	2025 Incidence	2020-2025 Change	2020-2025 % Change
Bladder	371	438	67	18.0%
Brain	189	209	20	10.3%
Breast	2,132	2,428	297	13.9%
Colorectal	1,015	963	-52	-5.1%
Kidney	356	422	67	18.8%
Leukemia	392	454	61	15.7%
Lung	968	1,090	123	12.7%
Melanoma	388	455	67	17.2%
Non Hodgkins Lymphoma	477	553	75	15.8%
Oral Cavity	278	321	43	15.6%
Other	1,009	1,175	167	16.5%
Ovarian	144	158	14	9.6%
Pancreatic	241	291	50	20.9%
Prostate	1,398	1,383	-15	-1.1%
Stomach	176	196	20	11.4%
Thyroid	303	346	43	14.2%
Uterine Cervical	66	67	1	2.2%
Uterine Corpus	234	272	38	16.3%
TOTAL	10,136	11,222	1,086	10.7%

Source: IBM Watson Health Cancer Estimates, 2020.

APPENDIX F: 2019 METHODIST CHNA EVALUATION

Many of the implementation strategy efforts were modified due to COVID as the facility reprioritized projects in response to the pandemic. Although many of the plans were halted, progress was made in several areas.

Atrial Fibrillation

In a continued effort to increase awareness of A-Fib with added treatment services and outreach, Methodist Mansfield enhanced existing A-Fib programs and services, increasing cryo-ablation procedures by 15% and EP procedures by 10%. In addition, Methodist Mansfield worked to increase awareness through education, reaching over 385 individuals with education seminars and training about A-Fib signs and symptoms.

Obesity and Diabetes

Methodist Mansfield worked to increase awareness of obesity prevention and treatment by reaching nearly 80 individuals and over 70 school nurses with educational presentations, and sponsoring the Run with Heart event reaching over 1,900 people as well as 8 sponsored runs with over 3,780 running participants.

To help increase awareness of diabetes prevention, Methodist Mansfield reached over 2,000 individuals with education and funding for the Mansfield Mission Center Wellness Clinic.

Opioid Addiction

Regarding opioid addiction prevention and treatment, Methodist Mansfield completed staff education on street and prescription drugs and established a drug disposal program for the convenient disposal of expired or no longer needed drugs through their pharmacy.

Cancer

Through the sponsorship of the Prettier in Pink event and other community education and awareness events, Methodist Mansfield reached over 1,600 participants with information about cancer prevention and the importance of early detection. In addition, the facility opened a comprehensive women's imaging center that completed over 12,000 mammograms for fiscal years 2020 and 2021.

APPENDIX G: COMMUNITY RESOURCES IDENTIFIED TO POTENTIALLY ADDRESS SIGNIFICANT HEALTH NEEDS

Below is a list of community resources that may help address this community's known health needs:

- **Aged and Disabled Resource Center**
- **Albert Galvan Health Clinic**
- **Area Agency on Aging**
- **Baylor Scott & White Community Care at Fort Worth**
- **Catholic Charities**
- **Catholic Charities Transportation Program**
- **CK Behavioral Health (CKBH)**
- **Community Health Center**
- **Cornerstone Assistance Network**
- **GRACE Food Pantry**
- **GRACE Free Community Clinic**
- **GRACE Friends & Family Senior Isolation Program**
- **Healing Shepherd Clinic**
- **JPS Clinic and Charitable Care Program**
- **JPS Health Network**
- **Mansfield Mission Center**
- **Meals on Wheels**
- **Mission Arlington**
- **My Health My Resources (MHMR)**
- **North Texas Area Community Health Care (Fort Worth Northside Community Health Center, Inc.)**
- **North Texas Community Health Centers, Inc**
- **Open Arms Health Clinic**
- **Project Access Tarrant County**
- **Sixty and Better**
- **South East Family Health Center**
- **Tarrant Area Food Bank**
- **Youth Advocate Programs, inc. (YAP)**