Brazosport Regional Health System

Lake Jackson, Texas

QUORUM | HEALTH RESOURCES®

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution December 16th, 2015

[1]Response to Schedule h (Form 990) Part V B 4 & Schedule h (Form 990) Part V B 9

Dear Community Member:

In compliance with the Affordable Care Act, all not-for-profit hospitals are now required to develop a report on the medical and health needs of the communities they serve. At Brazosport Regional Health System (BRHS), we have spent more than 70 years providing high-quality compassionate healthcare to the greater Lake Jackson community. We welcome you to review this document not just as part of our compliance with federal law, but of our continuing efforts to meet your health and medical needs.

The "2015 Community Health Needs Assessment" identifies local health and medical needs and provides a plan of how BRHS will respond to such needs. This document suggests areas where other local organizations and agencies might work with us to achieve desired improvements and illustrates one way we, BRHS, are meeting our obligations to efficiently deliver medical services.

BRHS will conduct this effort at least once every three years. The report produced three years ago is also available for your review and comment. As you review this plan, please see if, in your opinion, we have identified the primary needs of the community and if you think our intended response will lead to needed improvements.

We do not have adequate resources to solve all the problems identified. Some issues are beyond the mission of the hospital and action is best suited for a response by others. Some improvements will require personal actions by individuals rather than the response of an organization. We view this as a plan for how we, along with other area organizations and agencies, can collaborate to bring the best each has to offer to support change and to address the most pressing identified needs.

The report is a response to a federal requirement of not-for-profit hospitals to identify the community benefit they provide in responding to documented community need. Footnotes are provided to answer specific tax form questions; for most purposes, they may be ignored. Most importantly, this report is intended to guide our actions and the efforts of others to make needed health and medical improvements in our area.

I invite your response to this report. As you read, please think about how to help us improve health and medical services in our area. We all live in, work in, and enjoy this wonderful community together. Together, we can make our community healthier for every one of us.

Thank You,

Al Guevara
Chief Executive Officer
Brazosport Regional Health System

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EXECUTIVE SUMMARY

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Brazosport Regional Health System ("BRHS" or the "Hospital") is organized as a not-for-profit hospital. A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. A CHNA assures BRHS identifies and responds to the primary health needs of its residents.

This study is designed to comply with standards required of a not-for-profit hospital.[2] Tax reporting citations in this report are superseded by the most recent 990 h filings made by the hospital.

In addition to completing a CHNA and funding necessary improvements, a not-for-profit hospital must document the following:

- Financial assistance policy and policies relating to emergency medical care
- Billing and collections
- Charges for medical care

Further explanation and specific regulations are available from Health and Human Services (HHS), the Internal Revenue Service (IRS), and the U.S. Department of the Treasury.[3]

Project Objectives

BRHS partnered with Quorum Health Resources (QHR) to:[4]

- Complete a CHNA report, compliant with Treasury – IRS
- Provide the Hospital with information required to complete the IRS – 990h schedule
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

Overview of Community Health Needs Assessment

Typically, non-profit hospitals qualify for tax-exempt status as a Charitable Organization, described in Section 501(c)(3) of the Internal Revenue Code; however, the term 'Charitable Organization' is undefined. Prior to the passage of Medicare, charity was generally recognized as care provided to the less fortunate who did not have means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

In response, IRS Revenue ruling 69-545 eliminated the Charitable Organization standard and established the Community Benefit Standard as the basis for tax-exemption. Community Benefit determines if hospitals promote the health of a broad class of individuals in the community, based on factors including:

- An Emergency Room open to all, regardless of ability to pay

[2] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602

[3] As of the date of this report all tax questions and suggested answers relate to 2014 Draft Federal 990 schedule h instructions i990sh—dft(2) and tax form

[4] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice & Schedule h (Form 990) V B 6 b

- Surplus funds used to improve patient care, expand facilities, train, etc.
- A board controlled by independent civic leaders
- All available and qualified physicians granted hospital privileges

Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c)(3) hospital facility is required to conduct a CHNA at least once every three taxable years and to adopt an implementation strategy to meet the community needs identified through such assessment.
- The assessment may be based on current information collected by a public health agency or non-profit organization and may be conducted together with one or more other organizations, including related organizations.
- The assessment process must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise of public health issues.
- The hospital must disclose in its annual information report to the IRS (Form 990 and related schedules) how it is addressing the needs identified in the assessment and, if all identified needs are not addressed, the reasons why (e.g., lack of financial or human resources).
- Each hospital facility is required to make the assessment widely available and downloadable from the hospital website.
- Failure to complete a CHNA in any applicable three-year period results in an excise tax to the organization of $50,000. For example, if a facility does not complete a CHNA in taxable years one, two, or three, it is subject to the penalty in year three. If it then fails to complete a CHNA in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four).
- An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.[5]

Community Health Needs Assessment Subsequent to Initial Assessment

The Final Regulations establish a required step for a CHNA developed after the initial report. This requirement calls for considering written comments received on the prior CHNA and Implementation Strategy as a component of the development of the next CHNA and Implementation Strategy. The specific requirement is:

> *"The 2013 proposed regulations provided that, in assessing the health needs of its community, a hospital facility must take into account input received from, at a minimum, the following three sources:*
>
> *(1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to*

[5] Section 6652

the health needs of the community;

(2) *members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations; and*

(3) *written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.*[6]

…the final regulations retain the three categories of persons representing the broad interests of the community specified in the 2013 proposed regulations but clarify that a hospital facility must ''solicit'' input from these categories and take into account the input ''received.'' The Treasury Department and the IRS expect, however, that a hospital facility claiming that it solicited, but could not obtain, input from one of the required categories of persons will be able to document that it made reasonable efforts to obtain such input, and the final regulations require the CHNA report to describe any such efforts."

Representatives of the various diverse constituencies outlined by regulation to be active participants in this process were actively solicited to obtain their written opinion. Opinions obtained formed the introductory step in this Assessment.

[6] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602 P. 78963 and 78964

APPROACH

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To complete a CHNA:

> *"… the final regulations provide that a hospital facility must document its CHNA in a CHNA report that is adopted by an authorized body of the hospital facility and includes:*
>
> *(1) A definition of the community served by the hospital facility and a description of how the community was determined;*
>
> *(2) a description of the process and methods used to conduct the CHNA;*
>
> *(3) a description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;*
>
> *(4) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and*
>
> *(5) a description of resources potentially available to address the significant health needs identified through the CHNA.*
>
> *… final regulations provide that a CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA."*[7]

Additionally, a CHNA developed subsequent to the initial Assessment must consider written commentary received regarding the prior Assessment and Implementation Strategy efforts. We followed the Federal requirements in the solicitation of written comments by securing characteristics of individuals providing written comment but did not maintain identification data.

> *"…the final regulations provide that a CHNA report does not need to name or otherwise identify any specific individual providing input on the CHNA, which would include input provided by individuals in the form of written comments."*[8]

QHR takes a comprehensive approach to the solicitation of written comments. As previously cited, we obtained input from the required three minimum sources and expanded input to include other representative groups. We asked all participating in the written comment solicitation process to self-identify themselves into any of the following representative classifications, which is detailed in an Appendix to this report. Written comment participants self-identified into the following classifications:

(1) Public Health – Persons with special knowledge of or expertise in public health

(2) Departments and Agencies – Federal, tribal, regional, State, or local health or other departments or agencies,

[7] Federal Register Op. cit. P 78966 As previously noted the Hospital collaborated and obtained assistance in conducting this CHNA from Quorum Health Resources (QHR). & Response to Schedule h (Form 990) B 6 b

[8] Federal Register Op. cit. P 78967 & Response to Schedule h (Form 990) B 3 h

with current data or other information relevant to the health needs of the community served by the hospital facility

(3) Priority Populations – Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs in the community served by the hospital facility. Also, in other federal regulations the term Priority Populations, which include rural residents and LGBT interests, is employed and for consistency is included in this definition

(4) Chronic Disease Groups – Representative of or member of Chronic Disease Group or Organization, including mental and oral health

(5) Represents the Broad Interest of the Community – Individuals, volunteers, civic leaders, medical personnel and others to fulfill the spirit of broad input required by the federal regulations

Other (please specify)

QHR also takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor[9] opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. We rely on secondary source data, and most secondary sources use the county as the smallest unit of analysis. We asked our local expert area residents to note if they perceived the problems or needs identified by secondary sources existed in their portion of the county.[10]

Most data used in the analysis is available from public Internet sources and QHR proprietary data from Truven. Any critical data needed to address specific regulations or developed by the Local Expert Advisor individuals cooperating with us in this study are displayed in the CHNA report appendix.

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Macon County compared to all State counties	March 15, 2015	2005 to 2013
www.communityhealth.hhs.gov	Assessment of health needs of Macon County compared to its national set of "peer counties"	March 15, 2015	1996 to 2009
Truven (formerly known as Thomson) Market Planner	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion	March 15, 2015	2012 to 2014

[9] "Local Expert" is an advisory group of at least 15 local residents, inclusive of at least one member self-identifying with each of the five QHR written comment solicitation classifications, with whom the Hospital solicited to participate in the QHR/Hospital CHNA process. Response to Schedule h (Form 990) V B 3 h

[10] Response to Schedule h (Form 990) Part V B 3 i

[11] The final regulations clarify that a hospital facility may rely on (and the CHNA report may describe) data collected or created by others in conducting its CHNA and, in such cases, may simply cite the data sources rather than describe the ''methods of collecting'' the data. Federal Register Op. cit. P 78967 & Response to Schedule h (Form 990) Part V B 3 d

	of each group in the entire area; and, to access population size, trends and socio-economic characteristics		
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	March 15, 2015	2014
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the county	March 15, 2015	2014
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	March 15, 2015	2000 to 2010
www.dataplace.org	To determine availability of specific health resources	March 15, 2015	2006
www.cdc.gov	To examine area trends for heart disease and stroke	March 15, 2015	2008 to 2010
http://svi.cdc.gov/map.aspx?txtzipcode=37083&btnzipcode=Submit	To identify the Social Vulnerability Index value	June 17, 2015	2010
www.CHNA.org	To identify potential needs from a variety of resource and health need metrics	March 15, 2015	2003 to 2014
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	March 15, 2015	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	March 15, 2015	CDC official final deaths 2013 published 1/26/2015

Federal regulations surrounding CHNA require local input from representatives of particular demographic sectors. For this reason, QHR developed a standard process of gathering community input. In addition to gathering data from the above sources:

- We deployed a CHNA "Round 1" survey to our Local Expert Advisors to gain written comments on the 2012 Significant Needs, provide input on current local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. We received community input from 15 Local Expert Advisors. Survey responses started April 21, 2015 and ended with the last response on May 11, 2015. All written comments are presented verbatim in the Appendix to this report.[12] No unsolicited written comments have been received by the hospital.
- Information analysis augmented by local opinions showed how Brazoria relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help

[12] Response to Schedule h (Form 990) Part V B 3 h

to improve their condition, and if so, who needs to do what to improve the conditions of these groups.[13]

- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
  - Access to care remains a problem
  - Many low-income have literacy barriers limiting access to care
  - Lack of substance abuse services

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors[14] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need, and new needs did emerge from this exchange.[15] Consultation with 18 Local Experts occurred again via an internet-based survey (explained below) beginning June 16, 2016 and ending July 18, 2015.

Having taken steps to identify potential community needs, the Local Experts then participated in a structured communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on a panel of experts with the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.[16]

In the BRHS process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, the vast majority of comments agreed with our findings. We developed a summary of all needs identified by any of the analyzed data sets. The Local Experts then allocated 100 points among the potential significant need candidates, including the opportunity to again present additional needs that were not identified from the data. A rank order of priorities emerged, with some needs receiving none or virtually no support, and other needs receiving identical point allocations.

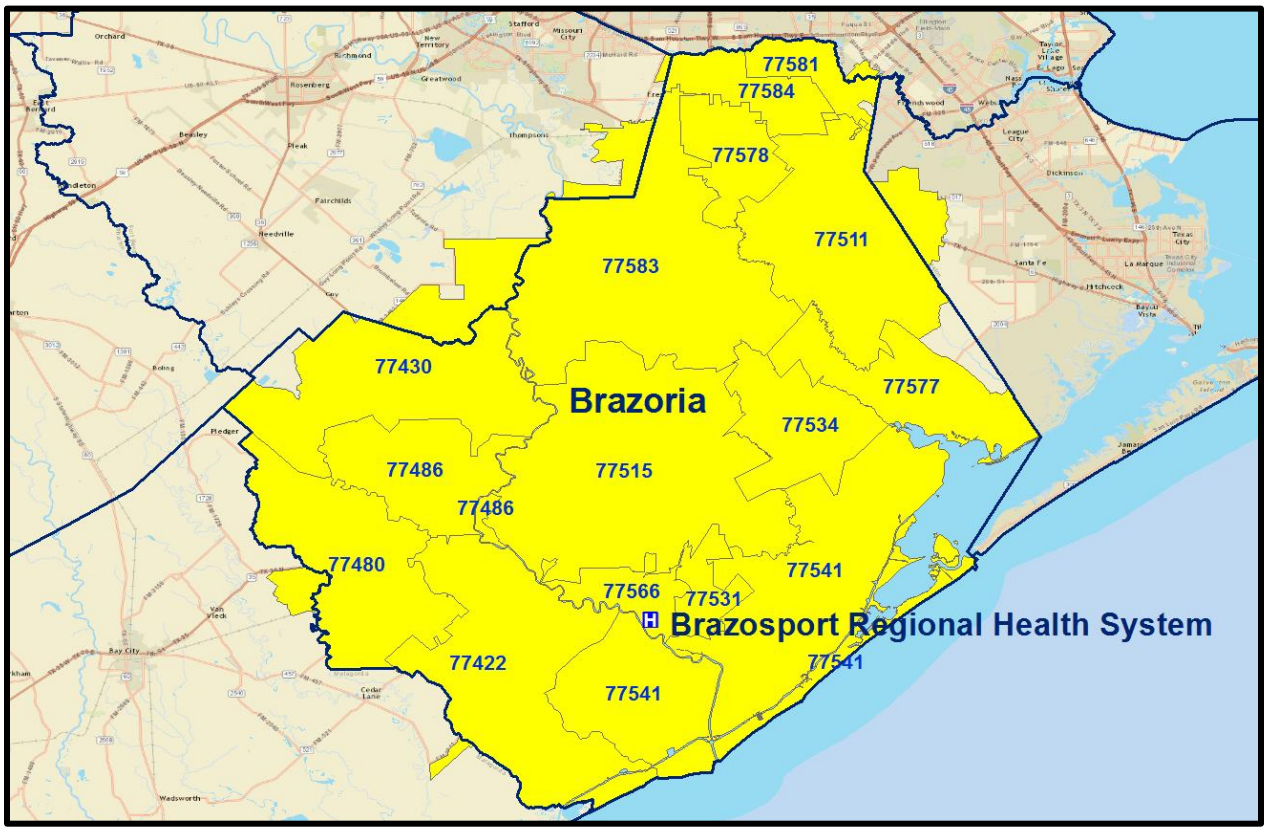
We dichotomized the rank order of prioritized needs into two groups: "Significant" and "Other Identified Needs." Our criteria for identifying and prioritizing Significant Needs was based on a descending frequency rank order of the needs based on total points cast by the Local Experts, further ranked by a descending frequency count of the number of local experts casting any points for the need. By our definition, a Significant Need had to include all rank ordered needs until at least fifty percent (50%) of all points were included and to the extent possible, represented points allocated by a majority of voting local experts. The determination of the break point — "Significant" as opposed to "Other" — was a qualitative interpretation by QHR and the BRHS executive team where a reasonable break point in rank order occurred.[17]

[13] Response to Schedule h (Form 990) Part V B 3 f
[14] Response to Schedule h (Form 990) Part V B 3 h
[15] Response to Schedule h (Form 990) Part V B 3 h
[16] Response to Schedule h (Form 990) Part V B 5
[17] Response to Schedule h (Form 990) Part V B 3 g

FINDINGS

FINDINGS

Definition of Area Served by the Hospital[18]



BRHS, in conjunction with QHR, defines its service area as Brazoria County in TX, which includes the following ZIP codes:[19]

77422	Brazoria	77541	Freeport
77430	Damon	77566	Lake Jackson
77480	Sweeny	77577	Liverpool
77486	West Columbia	77578	Manvel
77511	Alvin	77581	Pearland
77515	Angleton	77583	Rosharon
77531	Clute	77584	Pearland
77534	Danbury		

In 2013, the Hospital received 92.5% of its patients from this area.[20]

[18] Responds to IRS Schedule h (Form 990) Part V B 3 a
[19] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below
[20] Truven MEDPAR patient origin data for the hospital; Responds to IRS Schedule h (Form 990) Part V B 3 a

Demographic of the Community[21] [22]

The 2014 population for Brazoria County is estimated to be 350,055[23] and expected to increase at a rate of 8.2%. This is higher than the 3.5% national rate of growth, while Texas's population is expected to increase by 7.6%. Brazoria County in 2019 anticipates a population of 378,892.

According to the population estimates utilized by Truven, provided by The Nielsen Company, the 2014 median age for the county is 35.9 years, older than the Texas median age (34.3 years) and the national median age of 37.7 years. The 2014 Median Household Income for the area is $68,369, higher than the Texas median income of $50,418 and the national median income of $51,423. Median Household Wealth value is significantly higher than the National and the Texas value. Median Home Values for Brazoria ($149,913) is between the comparison values, above the Texas median of $136,121 and below the national median of $179,326. Brazoria's unemployment rate as of December, 2014 was 4.5%,[24] which is higher than the 4.4% statewide and the 5.5% national civilian unemployment rate.

The portion of the population in the county over 65 is 10.7%, compared to Texas (11.4%) and the national average (14.2%). The portion of the population of women of childbearing age is 19.8%, slightly lower than the Texas average of 20.8%, but in line with the national rate of 19.8%. 50% of the population is White non-Hispanic. The largest minority is Hispanic population which comprises 29.7% of the total.[25]

[21] Responds to IRS Schedule h (Form 990) Part V B 3 b
[22] The tables below were created by Truven Market Planner, a national marketing company
[23] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner
[24] http://research.stlouisfed.org/fred2/series/IDLATA7URN; http://research.stlouisfed.org/fred2/series/IDUR
[25] The tables below were created by Truven Market Planner, a national marketing company.

DEMOGRAPHIC CHARACTERISTICS

	Brazoria County	USA
2010 Total Population	328,045	308,745,538
2014 Total Population	350,055	317,199,353
2019 Total Population	378,892	328,309,464
% Change 2014 - 2019	8.2%	3.5%
Average Household Income	$85,404	$71,320

	2014	2019	% Change
Total Male Population	177,158	191,399	8.0%
Total Female Population	172,897	187,493	8.4%
Females, Child Bearing Age (15-44)	69,214	72,047	4.1%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2014	% of Total	2019	% of Total	USA 2014 % of Total
0-14	79,940	22.8%	83,648	22.1%	19.3%
15-17	15,624	4.5%	17,283	4.6%	4.1%
18-24	31,165	8.9%	36,765	9.7%	10.0%
25-34	44,603	12.7%	44,670	11.8%	13.2%
35-54	100,669	28.8%	102,178	27.0%	26.6%
55-64	40,444	11.6%	46,261	12.2%	12.6%
65+	37,610	10.7%	48,087	12.7%	14.2%
Total	350,055	100.0%	378,892	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

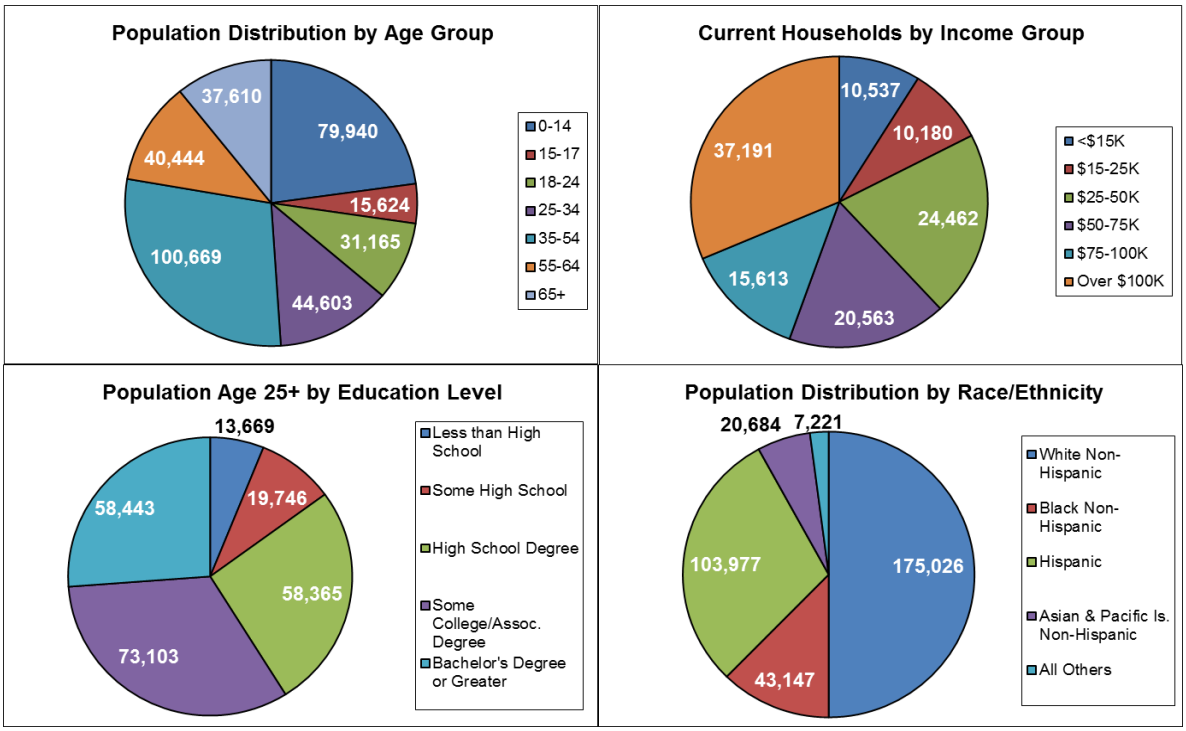
	Income Distribution		
2014 Household Incom	HH Count	% of Total	USA % of Total
<$15K	10,537	8.9%	13.3%
$15-25K	10,180	8.6%	11.2%
$25-50K	24,462	20.6%	24.4%
$50-75K	20,563	17.3%	17.9%
$75-100K	15,613	13.2%	11.9%
Over $100K	37,191	31.4%	21.3%
Total	118,546	100.0%	100.0%

EDUCATION LEVEL

	Education Level Distribution		
2014 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	13,669	6.1%	6.0%
Some High School	19,746	8.8%	8.2%
High School Degree	58,365	26.1%	28.4%
Some College/Assoc. Degree	73,103	32.7%	29.0%
Bachelor's Degree or Greater	58,443	26.2%	28.4%
Total	223,326	100.0%	100.0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2014 Pop	% of Total	USA % of Total
White Non-Hispanic	175,026	50.0%	62.1%
Black Non-Hispanic	43,147	12.3%	12.3%
Hispanic	103,977	29.7%	17.6%
Asian & Pacific Is. Non-Hispanic	20,684	5.9%	5.1%
All Others	7,221	2.1%	3.0%
Total	350,055	100.0%	100.0%



Area	2014-2019 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2014-2019	Females 15-44 % of Total Population	Females 15-44 % Change 2014-2019	Median Household Income	Median Household Wealth	Median Home Value
USA	3.5%	37.7	14.2%	18.0%	19.8%	1.0%	$51,423	$53,606	$179,326
Texas	7.6%	34.3	11.4%	24.2%	20.8%	4.7%	$50,418	$46,152	$136,121
Selected Area	8.2%	35.9	10.7%	27.9%	19.8%	4.1%	$68,369	$93,419	$149,913

The population was also examined according to characteristics presented in the Claritas Prizm customer segmentation data. This system segments the population into 66 demographically and behaviorally distinct groups. Each group, based on annual survey data, is documented as exhibiting specific health behaviors.

The makeup of the service area, according to the mix of Prizm segments and its characteristics, is contrasted to the national population averages to determine probable lifestyle and medical conditions present in the population. The national average, or norm, is represented as 100%. Where Brazoria varies more than 5% above or below that norm (that is, less than 95% or greater than 105%), it is considered significant.

Items in the table with red text are viewed as statistically important adverse potential findings—in other words, these are health areas that need improvement in the Brazoria area. Items with blue text are viewed as statistically important potential beneficial findings—in other words, these are areas in which Brazoria is doing better than other parts of the country. Items with black text are viewed as either not statistically different from the national norm or neither a favorable nor unfavorable finding—in other words more or less on par with national trends.

Health Service Topic	Demand as % of National	% of Population Effected
Weight / Lifestyle		
BMI: Morbid/Obese	94.5%	29.1%
Vigorous Exercise	106.0%	60.8%
Chronic Diabetes	86.2%	10.8%
Healthy Eating Habits	96.9%	28.7%
Ate Breakfast Yesterday	101.1%	80.0%
Slept Less Than 6 Hours	97.9%	13.4%
Consumed Alcohol in the Past 30 Days	104.6%	56.4%
Consumed 3+ Drinks Per Session	95.2%	26.9%
Behavior		
I Will Travel to Obtain Medical Care	99.7%	22.7%
I am Responsible for My Health	103.4%	67.5%
I Follow Treatment Recommendations	103.4%	53.7%
Pulmonary		
Chronic COPD	68.3%	2.7%
Tobacco Use: Cigarettes	88.0%	22.4%
Heart		
Chronic High Cholesterol	88.5%	19.3%
Routine Cholesterol Screening	105.5%	53.6%
Chronic Heart Failure	75.4%	3.0%

Health Service Topic	Demand as % of National	% of Population Effected
Cancer		
Mammography in Past Yr	97.7%	44.6%
Cancer Screen: Colorectal 2 yr	98.5%	25.2%
Cancer Screen: Pap/Cerv Test 2 yr	107.8%	64.6%
Routine Screen: Prostate 2 yr	103.1%	33.1%
Orthopedic		
Chronic Lower Back Pain	80.6%	19.0%
Chronic Osteoporosis	84.2%	8.3%
Routine Services		
FP/GP: 1+ Visit	100.5%	88.6%
Used Midlevel in last 6 Months	110.3%	45.6%
OB/Gyn 1+ Visit	107.5%	49.6%
Medication: Received Prescription	100.5%	60.6%
Internet Usage		
Use Internet to Talk to MD	110.3%	13.4%
Facebook Opinions	107.8%	11.1%
Looked for Provider Rating	111.7%	15.8%
Emergency Service		
Emergency Room Use	96.3%	32.6%
Urgent Care Use	116.8%	27.2%

Leading Causes of Death

Cause of Death			Rank among all counties in TX (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation
TX Rank	Brazoria Rank	Condition		TX	Brazoria	
1	1	Heart Disease	149 of 247	107.7	216.9	As expected
2	2	Cancer	96 of 247	156.9	189.6	As expected
3	3	Lung	114 of 247	42.4	50.9	As expected
5	4	Stroke	160 of 247	40.2	48.2	As expected
4	5	Accidents	201 of 247	40.0	42.1	As expected
6	6	Alzheimer's	47 of 247	24.3	33.5	Higher than expected
7	7	Diabetes	170 of 247	21.6	23.7	As expected
9	8	Kidney	91 of 247	15.9	16.3	As expected
11	9	Flu - Pneumonia	211 of 246	14.4	15.3	Lower than expected
8	10	Blood Poisoning	65 of 247	16.5	14.8	Higher than expected
12	11	Suicide	144 of 247	11.7	12.5	As expected
10	12	Liver	111 of 243	12.9	12.2	Higher than expected
13	13	Hypertension	119 of 242	8.5	7.1	As expected
14	13	Parkinson's	65 of 242	7.9	7.1	Higher than expected
15	15	Homicide	143 of 229	5.1	3.8	As expected

National Healthcare Disparities Report – Priority Populations[26]

Information about Priority Populations in the service area of the Hospital is difficult to encounter if it exists. Our approach is to understand the general trends of issues impacting Priority Populations and to interact with our Local Experts to discern if local conditions exhibit any similar or contrary trends. The following discussion examines findings about Priority Populations from a national perspective.

The National Healthcare Quality and Disparities Reports (QDR) are annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129). These reports provide a comprehensive overview of the quality of health care received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups. The purpose of the reports is to assess the performance of our health system and to identify areas of strengths and weaknesses in the health care system along three main axes: access to health care, quality of health care, and priorities of the National Quality Strategy (NQS).

The reports are based on more than 250 measures of quality and disparities covering a broad array of health care services and settings. Data are generally available through 2012, although rates of uninsurance have been tracked through the first half of 2014. The reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality (AHRQ) and submitted on behalf of the Secretary of Health and Human Services (HHS).

Beginning with this 2014 report, findings on health care quality and health care disparities are integrated into a single document. This new National Healthcare Quality and Disparities Report (QDR) highlights the importance of examining quality and disparities together to gain a complete picture of health care. This document is also shorter and focuses on summarizing information over the many measures that are tracked; information on individual measures will still be available through chartbooks posted on the Web (www.ahrq.gov/research/findings/nhqrdr/2014chartbooks/).

The key findings of the 2014 QDR are organized around three axes: access to health care, quality of health care, and NQS priorities.

To obtain high-quality care, Americans must first gain entry into the health care system. Measures of access to care tracked in the QDR include having health insurance, having a usual source of care, encountering difficulties when seeking care, and receiving care as soon as wanted. Historically, Americans have experienced variable access to care based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, and residence location.

ACCESS: After years without improvement, the rate of uninsurance among adults ages 18-64 decreased substantially during the first half of 2014.

The Affordable Care Act is the most far-reaching effort to improve access to care since the enactment of Medicare and Medicaid in 1965. Provisions to increase health insurance options for young adults, early retirees, and Americans with pre-existing conditions were implemented in 2010. Open enrollment in health insurance marketplaces began in October 2013 and coverage began in January 2014. Expanded

[26] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule h (Form 990) Part V B 3 i

access to Medicaid in many states began in January 2014, although a few had opted to expand Medicaid earlier.

Trends

- From 2000 to 2010, the percentage of adults ages 18-64 who reported they were without health insurance coverage at the time of interview increased from 18.7% to 22.3%.
- From 2010 to 2013, the percentage without health insurance decreased from 22.3% to 20.4%.
- During the first half of 2014, the percentage without health insurance decreased to 15.6%.
- Data from the Gallup-Healthways Well-Being Index indicate that the percentage of adults without health insurance continued to decrease through the end of 2014,[27] consistent with these trends.

ACCESS: Between 2002 and 2012, access to health care improved for children but was unchanged or significantly worse for adults.

Trends

- From 2002 to 2012, the percentage of people who were able to get care and appointments as soon as wanted improved for children but did not improve for adults ages 18-64.

Disparities

- Children with only Medicaid or CHIP coverage were less likely to get care as soon as wanted compared with children with any private insurance in almost all years.
- Adults ages 18-64 who were uninsured or had only Medicaid coverage were less likely to get care as soon as wanted compared with adults with any private insurance in all years.

Trends

- Through 2012, most access measures improved for children. The median change was 5% per year.
- Few access measures improved substantially among adults. The median change was zero.

ACCESS DISPARITIES: During the first half of 2014, declines in rates of uninsurance were larger among Black and Hispanic adults ages 18-64 than among Whites, but racial differences in rates remained.

Trends

- Historically, Blacks and Hispanics have had higher rates of uninsurance than Whites.[28]

[27] Levy J. In U.S., Uninsured Rate Sinks to 12.9%. http://www.gallup.com/poll/180425/uninsured-rate-sinks. aspx.
[28] In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.

Disparities

- During the first half of 2014, the percentage of adults ages 18-64 without health insurance decreased more quickly among Blacks and Hispanics than Whites, but differences in uninsurance rates between groups remained.

- Data from the Urban Institute's Health Reform Monitoring System indicate that between September 2013 and September 2014, the percentage of Hispanic and non-White non-Hispanic adults ages 18-64 without health insurance decreased to a larger degree in states that expanded Medicaid under the Affordable Care Act than in states that did not expand Medicaid.[29]

ACCESS DISPARITIES: In 2012, disparities were observed across a broad spectrum of access measures. People in poor households experienced the largest number of disparities, followed by Hispanics and Blacks.

Disparities

- In 2012, people in poor households had worse access to care than people in high-income households on all access measures (green).

- Blacks had worse access to care than Whites for about half of access measures.

- Hispanics had worse access to care than Whites for two-thirds of access measures.

- Asians and American Indians and Alaska Natives had worse access to care than Whites for about one-third of access measures.

ACCESS DISPARITIES: Through 2012, across a broad spectrum of access measures, some disparities were reduced but most did not improve.

Disparity Trends

- Through 2012, most disparities in access to care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.

- I n four of the five comparisons shown above, the number of disparities that were improving (black) exceeded the number of disparities that were getting worse (green).

QUALITY: Quality of health care improved generally through 2012, but the pace of improvement varied by measure.

Trends

- Through 2012, across a broad spectrum of measures of health care quality, 60% showed improvement (black).

[29] Long SK, Karpman M, Shartzer A, et al. Taking Stock: Health Insurance Coverage under the ACA as of September 2014. http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of- September-2014.html

- Almost all measures of Person-Centered Care improved.
- About half of measures of Effective Treatment, Healthy Living, and Patient Safety improved.
- There are insufficient numbers of reliable measures of Care Coordination and Care Affordability to summarize in this way.

QUALITY: Through 2012, the pace of improvement varied across NQS priorities.

Trends

- Through 2012, quality of health care improved steadily but the median pace of change varied across NQS priorities:
    - Median change in quality was 3.6% per year among measures of Patient Safety.
    - Median improvement in quality was 2.9% per year among measures of Person-Centered Care.
    - Median improvement in quality was 1.7% per year among measures of Effective Treatment.
    - Median improvement in quality was 1.1% per year among measures of Healthy Living.
    - There were insufficient data to assess Care Coordination and Care Affordability.

QUALITY: Publicly reported CMS measures were much more likely than measures reported by other sources to achieve high levels of performance.

Achieved Success

Eleven quality measures achieved an overall performance level of 95% or better this year. At this level, additional improvement is limited, so these measures are no longer reported in the QDR. Of measures that achieved an overall performance level of 95% or better this year, seven were publicly reported by CMS on the Hospital Compare website (italic).

- *Hospital patients with heart attack given percutaneous coronary intervention within 90 minutes*
- Adults with HIV and CD4 cell count of 350 or less who received highly active antiretroviral therapy during the year
- *Hospital patients with pneumonia who had blood cultures before antibiotics were administered*
- *Hospital patients age 65+ with pneumonia who received pneumococcal screening or vaccination*
- *Hospital patients age 50+ with pneumonia who received influenza screening or vaccination*
- *Hospital patients with heart failure and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme or angiotensin receptor blocker at discharge*
- *Hospital patients with pneumonia who received the initial antibiotic dose consistent with current recommendations*

- *Hospital patients with pneumonia who received the initial antibiotic dose within 6 hours of arrival*
- Adults with HIV and CD4 cell counts of 200 or less who received Pneumocystis pneumonia prophylaxis during the year
- People with a usual source of care for whom health care providers explained and provided all treatment options
- Hospice patients who received the right amount of medicine for pain management

Last year, 14 of 16 quality measures that achieved an overall performance level of 95% or better were publicly reported by CMS. Measures that reach 95% and are no longer reported in the QDR continue to be monitored when data are available to ensure that they do not fall below 95%.

Improving Quickly

Through 2012, a number of measures showed rapid improvement, defined as an average annual rate of change greater than 10% per year. Of these measures that improved quickly, four are adolescent vaccination measures (italic).

- *Adolescents ages 16-17 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine*
- *Adolescents ages 13-15 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine*
- Hospital patients with heart failure who were given complete written discharge instructions
- *Adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine*
- *Adolescents ages 13-15 years who received 1 or more doses of meningococcal conjugate vaccine*
- Patients with colon cancer who received surgical resection that included 12+ lymph nodes pathologically examined
- Central line-associated bloodstream infection per 1,000 medical and surgical discharges, age 18+ or obstetric admissions
- Women with Stage I-IIb breast cancer who received axillary node dissection or sentinel lymph node biopsy at time of surgery

Worsening

Through 2012, a number of measures showed worsening quality. Of these measures that showed declines in quality, three track chronic diseases (italic). Note that these declines occurred prior to implementation of most of the health insurance expansions included in the Affordable Care Act.

- Maternal deaths per 100,000 live births

- Children ages 19-35 months who received 3 or more doses of Haemophilus influenzae type b vaccine
- People who indicate a financial or insurance reason for not having a usual source of care
- Suicide deaths per 100,000 population
- Women ages 21-65 who received a Pap smear in the last 3 years
- *Admissions with diabetes with short-term complications per 100,000 population, age 18+*
- *Adults age 40+ with diagnosed diabetes who had their feet checked for sores or irritation in the calendar year*
- Women ages 50-74 who received a mammogram in the last 2 years
- Postoperative physiologic and metabolic derangements per 1,000 elective-surgery admissions, age 18+
- *People with current asthma who are now taking preventive medicine daily or almost daily*
- People unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons

QUALITY DISPARITIES: Disparities remained prevalent across a broad spectrum of quality measures. People in poor households experienced the largest number of disparities, followed by Blacks and Hispanics.

Disparities

- People in poor households received worse care than people in high-income households on more than half of quality measures (green).
- Blacks received worse care than Whites for about one-third of quality measures.
- Hispanics, American Indians and Alaska Natives, and Asians received worse care than Whites for some quality measures and better care for some measures.
- For each group, disparities in quality of care are similar to disparities in access to care, although access problems are more common than quality problems.

QUALITY DISPARITIES: Through 2012, some disparities were getting smaller but most were not improving across a broad spectrum of quality measures.

Disparity Trends

- Through 2012, most disparities in quality of care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.

- When changes in disparities occurred, measures of disparities were more likely to show improvement (black) than decline (green). However, for people in poor households, more measures showed worsening disparities than improvement.

QUALITY DISPARITIES: Through 2012, few disparities in quality of care were eliminated while a small number became larger.

Disparities Trends

- Through 2012, several disparities were eliminated.
    - One disparity in vaccination rates was eliminated for Blacks (measles-mumps-rubella), Asians (influenza), American Indians and Alaska Natives (hepatitis B), and people in poor households (human papillomavirus).
    - Four disparities related to hospital adverse events were eliminated for Blacks.
    - Three disparities related to chronic diseases and two disparities related to communication with providers were eliminated for Asians.
    - On the other hand, a few disparities grew larger because improvements in quality for Whites did not extend uniformly to other groups.
    - At least one disparity related to hospice care grew larger for Blacks, American Indians and Alaska Natives, and Hispanics.
    - People in poor households experienced worsening disparities related to chronic diseases.

QUALITY DISPARITIES: Overall quality and racial/ethnic disparities varied widely across states and often not in the same direction.

Geographic Disparities

- There was significant variation in quality among states. There was also significant variation in disparities.
- States in the New England, Middle Atlantic, West North Central, and Mountain census divisions tended to have higher overall quality while states in the South census region tended to have lower quality.
- States in the South Atlantic, West South Central, and Mountain census divisions tended to have fewer racial/ethnic disparities while states in the Middle Atlantic, West North Central, and Pacific census divisions tended to have more disparities.
- The variation in state performance on quality and disparities may point to differential strategies for improvement.

National Quality Strategy: Measures of Patient Safety improved, led by a 17% reduction in hospital-acquired conditions.

Hospital-acquired conditions have been targeted for improvement by the CMS Partnership for Patients initiative, a major public-private partnership working to improve the quality, safety, and affordability of health care for all Americans. As a result of this and other federal efforts, such as Medicare's Quality Improvement Organizations and the HHS National Action Plan to Prevent Health Care-Associated Infections, as well as the dedication of practitioners, the general trend in patient safety is one of improvement.

Trends

- From 2010 to 2013, the overall rate of hospital-acquired conditions declined from 145 to 121 per 1,000 hospital discharges.
- This decline is estimated to correspond to 1.3 million fewer hospital-acquired conditions, 50,000 fewer inpatient deaths, and $12 billion savings in health care costs.[30]
- Large declines were observed in rates of adverse drug events, healthcare-associated infections, and pressure ulcers.
- About half of all Patient Safety measures tracked in the QDR improved.
- One measure, admissions with central line-associated bloodstream infections, improved quickly, at an average annual rate of change above 10% per year.
- One measure, postoperative physiologic and metabolic derangements during elective-surgery admissions, got worse over time.

Disparities Trends

- Black-White differences in four Patient Safety measures were eliminated.
- Asian-White differences in admissions with iatrogenic pneumothorax grew larger.

National Quality Strategy: Measures of Person-Centered Care improved steadily, especially for children.

Trends

- From 2002 to 2012, the percentage of children whose parents reported poor communication significantly decreased overall and among all racial/ethnic and income groups.
- Almost all Person-Centered Care measures tracked in the QDR improved; no measure got worse.

[30] Agency for Healthcare Research and Quality. Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013. http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.html

Disparities

In almost all years, the percentage of children whose parents reported poor communication with their health providers was:

- Higher for Hispanics and Blacks compared with Whites.
- Higher for poor, low-income, and middle-income families compared with high-income families.

Disparities Trends

- Asian-White differences in two measures related to communication were eliminated.
- Four Person-Centered Care disparities related to hospice care grew larger.

National Quality Strategy: Measures of Care Coordination improved as providers enhanced discharge processes and adopted health information technologies.

Trends

- From 2005 to 2012, the percentage of hospital patients with heart failure who were given complete written discharge instructions increased overall, for both sexes, and for all racial/ethnic groups.
- There are few measures to assess trends in Care Coordination.

Disparities

- In all years, the percentage of hospital patients with heart failure who were given complete written discharge instructions was lower among American Indians and Alaska Natives compared with Whites.

National Quality Strategy: Many measures of Effective Treatment achieved high levels of performance, led by measures publicly reported by CMS on Hospital Compare.

Trends

- From 2005 to 2012, the percentage of hospital patients with heart attack given percutaneous coronary intervention within 90 minutes of arrival increased overall, for both sexes, and for all racial/ethnic groups.
- In 2012, the overall rate exceeded 95%; the measure will no longer be reported in the QDR.
- Eight other Effective Treatment measures achieved overall performance levels of 95% or better this year, including five measures of pneumonia care and two measures of HIV care.
- About half of all Effective Treatment measures tracked in the QDR improved.

- Two measures, both related to cancer treatment, improved quickly, at an average annual rate of change above 10% per year.
- Three measures related to management of chronic diseases got worse over time.

Disparities

- As rates topped out, absolute differences between groups became smaller. Hence, disparities often disappeared as measures achieved high levels of performance.

Disparities Trends

- Asian-White differences in three chronic disease management measures were eliminated but income-related disparities in two measures related to diabetes and joint symptoms grew larger.

National Quality Strategy: Healthy Living improved in about half of the measures followed, led by selected adolescent vaccines from 2008 to 2012.

Trends

- From 2008 to 2012, the percentage of adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine increased overall, for residents of both metropolitan and nonmetropolitan areas, and for all income groups.
- About half of all Healthy Living measures tracked in the QDR improved.
- Four measures, all related to adolescent immunizations, improved quickly, at an average annual rate of change above 10% per year (meningococcal vaccine ages 13-15 and ages 16-17; tetanusdiphteria-acellular pertussis vaccine ages 13-15 and ages 16-17).
- Two measures related to cancer screening got worse over time.

Disparities

- Adolescents ages 16-17 in nonmetropolitan areas were less likely to receive meningococcal conjugate vaccine than adolescents in metropolitan areas in all years.
- Adolescents in poor, low-income, and middle-income households were less likely to receive meningococcal conjugate vaccine than adolescents in high-income households in almost all years.

Disparities Trends

- Four disparities related to child and adult immunizations were eliminated.
- Black-White differences in two Healthy Living measures grew larger.

National Quality Strategy: Measures of Care Affordability worsened from 2002 to 2010 and then leveled off.

From 2002 to 2010, prior to the Affordable Care Act, care affordability was worsening. Since 2010, the Affordable Care Act has made health insurance accessible to many Americans with limited financial resources.

Trends

- From 2002 to 2010, the overall percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.
- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.[31]
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

Disparities

- I n all years, the percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines who indicated a financial or insurance reason for the problem was:
    - Higher among uninsured people and people with public insurance compared with people with any private insurance.
    - Higher among poor, low-income, and middle-income families compared with high-income families.

[31] Collins SR, Rasmussen PW, Doty MM, et al. The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf?la=en

CONCLUSION

The 2014 Quality and Disparities Reports demonstrates that access to care improved. After years of stagnation, rates of uninsurance among adults decreased in the first half of 2014 as a result of Affordable Care Act insurance expansion. However, disparities in access to care, while diminishing, remained.

Quality of health care continued to improve, although wide variation across populations and parts of the country remained. Among the NQS priorities, measures of Person-Centered Care improved broadly. Most measures of Patient Safety, Effective Treatment, and Healthy Living also improved, but some measures of chronic disease management and cancer screening lagged behind and may benefit from additional attention. Data to assess Care Coordination and Affordable Care were limited and measurement of these priorities should be expanded.

We asked a specific question to our Local Expert Advisors about unique needs of Priority Populations. We reviewed their responses to identify if any of the above trends were obvious in the service area. Accordingly, we place great reliance on the commentary received from our Local Expert Advisors to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized below:[32]

- Access to care remains a problem
- Many low-income have literacy barriers limiting access to care
- Lack of substance abuse services

[32] All comments and the analytical framework behind developing this summary appear in Appendix A

Consideration of Written Comments from Prior CHNA

A group of 15 individuals provided written comment in regard to the 2012 CHNA. Our summary of this commentary produced the following points, which were introduced in subsequent considerations of this CHNA.

Commenter characteristics:

Local Expert Classification	Yes (Applies to Me)	% Responding Yes	No (Does Not Apply to Me)	No Response	Total Response
1) **Public Health Expertise** (public health dept volunteers / employees, one holding an MPH degree and/or employed in a capacity where one is required)	**3**	**20%**	**8**	**4**	**15**
2) **Departments and Agencies** Federal, tribal, regional, State or local agencies with relevant data/information regarding health needs of the community served by the hospital	**4**	**27%**	**8**	**3**	**15**
3) **Priority Populations** (represented by public elected officials, religious officials, long term care / work shelter executives; and/or members of LGBT community, medically underserved, low income, minorities)	**9**	**60%**	**3**	**3**	**15**
4) Representative of or member of **chronic disease group** or organization	**1**	**7%**	**10**	**4**	**15**
5) **Broad Interest of the Community** (school system exec's, employers, leadership of civic organizations, voluntary health groups, Chamber of Commerce, Industrial Development)	**10**	**67%**	**2**	**3**	**15**

Priorities from the last assessment where the Hospital intended to seek improvement were:

- **Doctor Availability** Increase physician availability, lower wait time, increase doctors who take hospital call, increase the supply of primary care. The issue to address was to increase the supply of primary care physicians who will see patients in the BRHS primary service area.
- **Adverse Habits** Smoking, obesity and a lack of healthy eating habits are underlying conditions contributing to, adding complications to, and otherwise contributing to development of disease and disorder. The issue to address was to lower the prevalence of unhealthy habits.
- **Prevention** A lack of utilizing cancer prevention services, not checking cholesterol levels and generally not taking advantage of preventive efforts. The issue to address was to increase prevention service use.
- **Mental Health (including suicide)** Increase mental health resources (psychiatric and substance abuse; including physicians and other counselors or professionals), increase jail resources; provide resources for patients other than those in immediate harm to self or others. The issue to address was to increase the supply of mental health providers to serve residents in the BRHS primary service area.
- **Teen Births** Reducing births to women under age of 18. The issue to address was a reduction in the number of teen pregnancies.

BRHS received the following responses to the question: "*Comments or observations about this set of needs as being the most appropriate for the Hospital to take on in seeking improvements?"*

- Specific comments or observations about **Doctor Availability** as being among the most significant needs for the Hospital to work on to seek improvements?
    - Doctors that are rude, disrespectful, and arrogant are a drain on the community and should not be tolerated.
    - None
    - I have seen where they are working to find the right mix of Dr./ PA/ Nurse Practitioner.
    - See #3 above
    - None
    - I believe that doctor availability is a great issue with great financial requirements. I also believe that they are working hard to make changes and add Dr. availability where possible and practical.
    - See #3 above
    - Growing population with fewer GPs
    - It is critical that we have doctors in different fields to care for the citizens. Even more important now with the influx of thousands of new residents due to the many industry expansions underway in our area.
    - Definitely doctor availability is a must.
- Specific comments or observations about **Adverse Habits** as being among the most significant needs for the Hospital to work on to seek improvements?
    - Not focus for hospitals
    - Do not agree with the need to address this created habit
    - I have no specific comments
- Specific comments or observations about **Prevention** as being among the most significant needs for the Hospital to work on to seek improvements?
    - Not a focus
    - Information push
    - I have no specific comments
    - I know that the hospital has seminars concerning prevention.
    - I think work on prevention is extremely important through education of people to take responsibility for their health which could prevent disease in the future.
    - we need more education and assistance on drug and alcohol addiction.
- Specific comments or observations about **Mental Health (including suicide)** as being among the most significant needs for the Hospital to work on to seek improvements?
    - Access to care Education for parents/students especially school districts whom are normally the 1st that identify that the child/children have an issue. Affordable care
    - Telemedicine for the chronically mentally ill would facilitate routine follow up and monitoring
    - Do not agree to offer this care
    - The community has very few mental health specialist but has a large need for assistance in this area.
    - Mental health is lacking across the state. The hospital needs to recruit more mental health professionals for private practice as well as implementing mental health in the emergency room and designated beds for those needing additional care.
- Specific comments or observations about **Teen Births** as being among the most significant needs for the Hospital to work on to seek improvements?
    - Advocacy in the school districts and awareness from current/past teen parents. (peers)
    - Offering day of discharge birth control (long term), and financial planning info. The hospital cannot be accountable for all the ills of the world

    - Information push
    - I have no specific comments
    - I think education at a early age concerning avoiding teen births is critical.
    - At this time, there are no known programs for assistance in prevention and/or assistance with teen pregnancy situations
- Finally, after thinking about our questions and the information we seek, is there **anything else** you think important as we review and revise our thinking about significant health needs within the County?
    - Make the emergency room including exam rooms clean.
    - Continue educating the public about what all this hospital can do for different health concerns. There are so many people who are still not aware that treatment can be obtained here instead of else where.
    - a partnership with local schools to have a school based clinic may be beneficial in providing health prevention information to promote healthy lifestyles.

Conclusions from Public Input

Should the hospital continue to consider each need identified as most important in the 2012 CHNA report as the most important set of health needs currently confronting residents in the County?	Yes	No	No Opinion
Doctor Availability	14	1	0
Adverse Habits	8	4	3
Prevention	11	2	2
Mental Health (including Suicide)	12	1	2
Teen Births	8	4	3

Our group of 15 Local Expert Advisors participated in an online survey to offer opinions about their perceptions of community health needs and the potential needs of unique populations. Complete verbatim written comments appear in the Appendix to this report.

BRHS received the following responses to the question: "*What advice do you give us about written comments on maintaining the prior identified priority needs?"*

- There are limits to what any hospital can do or should do. A focus on the primary mission of a local community hospital is a gold mine. BRHS strives to be the hospital of choice and of course, hopes physicians and patients will report high satisfaction levels. The solution is very simple and never considered or implemented in any health system. Patients only stay in the hospital because they require nursing care. All other departments are fed by inpatients and outpatients, and only exist to serve patients. Changing the focus to the key delivery unit to meet everyone's goals is easy. Nurses should be the focus. Systems should be designed by and controlled by nurses. Adding teams of LVNs and RNs with assigned patient care technicians would dramatically lower cost, improve service, improve quality, improve patient and staff satisfaction. Staggering on and off shifts would eliminate the "change of shift" gaps. Turn over is very expensive and occurs because of the work environment. They key to wealth and satisfaction is nursing.
- Offering Mental health care would deplete our resources
- Preventive care needs to focus on health education.
- BMH has a significant issue with contract doctor billing our of the Emergency Room. A 1 hour 10 minute visit to the ER with 10-12 minutes of interface with the physician generated a bill of almost $3000 for ER physician services alone. We are actively working with our insurance provider and Altus to have Altus within our insurance network so as to provide competition to drive the ER physician costs down.

Summary of Observations: Comparison to Other Texas Counties

In general, Brazoria County residents are in good health compared to the healthiest in Texas.

In a health status classification termed "Health Outcomes", Brazoria ranks number 18 among the 237 Texas ranked counties (best being #1). Premature Death (deaths prior to age 75) presents better values (longer survivability) than on average for the US and TX.

In another health status classification "Health Factors", Brazoria County ranks number 23 among the 237 ranked Texas counties, with adult obesity and alcohol impaired driving deaths being above the TX average and the US best rates.

Smoking is below the TX average but above US best rates and also was an adverse finding in 2012.

In the “Clinical Care” classification, Brazoria County ranks number 39 among the 237 ranked TX counties. Uninsured rate, 22%, is basically unchanged for the last six years being above the US best rate of 11%, but is below the TX average of 25%. Diabetic Monitoring, 82%, is below the US best rate of 90%, and the TX rate of 83%. Mammogram screening rates are below US and TX averages.

In the “Social and Economic Factors” classification, Brazoria County ranks number 51 among the 237 ranked TX counties. Social Associations (# of organizations per 10,000) is 6.8, below the TX value of 7.8 and the US best of 22.0.

In the “Physical Environment” classification, Brazoria ranks 138 of the 237 ranked TX counties. Driving alone to work value, 85%, is higher than both the US, 71%, and TX, 80%, values.

Summary of Observations: Peer Comparisons

The federal government administers a process to allocate all counties into "Peer" groups. County "Peer" groups have similar social, economic, and demographic characteristics. Health and wellness observations when Brazoria County is compared to its national set of Peer Counties and compared to national rates result in the following:

Mortality

- Better – Nothing
- Worse
    - **Alzheimer’s disease** deaths – 36.8 per 100,000; 11th worse among 44 peer counties, US average 27.3
    - **Female life expectancy** – 80.1 years; 11th worse among 44 peer counties, US avg. 79.8
    - **Motor vehicle accidents** – 17.5 deaths per 100,000; 7th worse among 43 peer counties, US avg. 19.2

Morbidity

- Better – **Adult overall health status; Older adult depression**
- Worse
    - **Alzheimer’s diseases/dementia** – 11.5% adults living with the condition; 11th worse among 44 peer counties, US avg. 10.3
    - **Preterm births** – 13.5% of live births are preterm; 4th worse among 44 peer counties, US avg. 12.1%

Health Care Access and Quality

- Better – **Primary care provider access**
- Worse
    - **Cost barrier to care** – 17.6% adults did not see a doctor due to cost; 2nd worse among 41 peer counties, US avg. 15.6
    - **Uninsured** – 21.4% of populations without health insurance; 3rd worse among 44 peers, US avg. 17.7%

Health Behaviors

- Better – Adult binge drinking; Adult smoking
- Worse
    - **Adult female pap tests** – 74.9% of adult women report having routine pap tests; 7th worse among 42 peer counties, US avg. 77.3%
    - **Teen births** – 48.3 per 1,000 births are teen births; worst among 44 peer counties, US avg. 42.1%

Social Factors

- Better – **High housing costs**
- Worse
    - **Inadequate Social Support** – 25.0% adults report inadequate social support; 2nd worse among 41 peer counties, US avg. 19.6%
    - **Poverty** – 11.7% individuals living in poverty; 6th worse among 44 peer counties, US avg. 16.3%
    - **Unemployment** – 6.6% unemployment; 10th worse among 44 peer counties, US avg. 7.1%

Physical Environment

- Better – **Living near highways**
- Worse
    - **Drinking water** – 3.0% potentially exposed to water exceeding a health violation limit; 11th worse among 43 peer counties, US avg. 0%
    - **Limited access to healthy food** – 6.6% of low income do not live close to a grocery store; 9th worse among 44 peer counties, US avg. 6.2%

Conclusions from Demographic Analysis Compared to National Averages

The 2014 population for Brazoria County is estimated to be 350,055 according to Truven and Claritas (Truven's demographic partner) and expected to increase at a rate of 8.2% to achieve 382,198 by 2020.

Alternatively, the State of Texas Demographer cites the 2015 population as 326,288, growing at a rate of 3.5% to 337,724 by 2020.

According to the population estimates utilized by Truven, the 2014 median age for the county is 35.9 years, older than

the Texas median age (34.3 years) and the national median age of 37.7 years. The 2014 Median Household Income for the area is $68,369, higher than the Texas median income of $50,418 and the national median income of $51,423. Median Household Wealth value is significantly higher than the National and the Texas value. Median Home Values for Brazoria ($149,913) is between the comparison values, above the Texas median of $136,121 and below the national median of $179,326.

Brazoria's unemployment rate as of December, 2014 was 4.5%, which is higher than the 4.4% statewide and the 5.5% national civilian unemployment rate.

The portion of the population in the county over 65 is 10.7%, compared to Texas (11.4%) and the national average (14.2%). The portion of the population of women of childbearing age is 19.8%, slightly lower than the Texas average of 20.8%, but in line with the national rate of 19.8%.

Both Truven and the TX Demographer place 50% to 52% of the population is White nonHispanic. The largest minority is the Hispanic population which comprises 28.4% to 29.7% of the total.

Brazoria County zip codes primarily fall into the "average" categories of Social Vulnerability. Social Vulnerability is a composite of fourteen census derived factors to provide a composite score of the area's ability to prepare for and respond to natural disaster, including disease outbreaks and human caused threats. The Clute zip code falls into the highest (adverse) category while Sweeny and Lake Jackson fall into the lowest (best) performing category of Social Vulnerability.

The population was also examined according to characteristics presented in the Claritas Prizm customer segmentation data. This system segments the population into 66 demographically and behaviorally distinct groups. Each group, based on annual survey data, is documented as exhibiting specific health behaviors.

Brazoria has one adverse health characteristic impacting more than 25% of the population:

- Urgent Care Use is 16.8% above average, impacting 27.2% of the population.

Brazoria has several beneficial health characteristics:

- Pap/Cervix Cancer screening is 7.8% above average impacting 64.6% of the population.
- Vigorous Exercise 6% above average impacting 60.8% of the population.
- Routine Cholesterol Screening 5.5% above average impacting 53.6% of the population.
- Obtained an OB/GYN visit is 7.5% above average impacting 49.6% of the population.
- Use of an Advanced Practice Practitioner in last year is 10.3% above average impacting 45.6% of the population.

Conclusions from Other Statistical Data

Among top 15 Leading Causes of Death, 10 of the 15 occurred at expected rates, Alzheimer's; Blood Poisoning; Liver; and, Parkinson's occurred at higher than expected rates, and Flue/Pneumonia occurred at a lower than expected rate. The top 10 Causes of Death are:

1. Heart Disease with Brazoria ranking #149 among TX 247 Counties (Where #1 is worst in State)
2. Cancer ranking #96 in TX
3. Lung ranking #114 in TX
4. Stroke ranking #160 in TX
5. Accidents ranking #201 in TX
6. Alzheimer's ranking #46 in TX
7. Diabetes ranking #170 in TX
8. Kidney ranking #91 in TX
9. Flu/Pneumonia ranking #211 in TX
10. Blood Poisoning ranking #65 in TX

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 US counties or equivalents applying small area estimation techniques to the most recent county information.

Unfavorable Brazoria County measures which are worse than the US avg. and had an unfavorable change:

- **Female Heavy Drinking** – ranking in 2012 at 53.2 percentile (1st percentile is best) among US counties; 5.4% of females are heavy drinkers and this value increased 1.6 percentage points since 2005

Unfavorable Brazoria County measures which are worse than the US avg. but had a favorable change:

- none

Desirable Brazoria County measures better than the US avg. but an unfavorable change:

- **Male Heavy Drinking** – ranking in 2012 at 34.7 percentile (1st percentile is best) among all US counties; 9.1% of males are heavy drinkers and this value increased 0.8 percentage points since 2005
- **Female Obesity** – ranking in 2011 at 27.4 percentile among all US counties; 35.9% of females are obese and this value increased 6 percentage points since 2001
- **Male Obesity** – ranking in 2011 at 14.6 percentile among all US counties; 33.9% of males are obese and this value increased 3.5 percentage points since 2001

Desirable Brazoria County measures better than the US avg. and had a favorable change:

- **Female Life Expectancy** – ranking in 2013 at 48.5 percentile among all US counties; 80.3 years of life and this value favorably increased 2.1 years since 1985
- **Male Binge Drinkers** – ranking in 2012 at 45.1 percentile among all US counties; 23.4% of males are binge drinkers and this value favorably decreased 2.2 percentage points since 2005
- **Female Recommended Physical Activity** – ranking in 2011 at 32.1 percentile among all US counties; 53.4% of females partake in recommended physical activity and this value favorably increased 3.8 percentage points since 2001
- **Male Life Expectancy** – ranking in 2013 at 29.5 percentile among all US counties; 76.6 years of life and this value favorably increased 5.5 years since 1985
- **Male Smokers** – ranking in 2012 at 18.7 percentile among all US counties; 22.1% of males smoke and this declined 6.4 percentage points since 1996
- **Male Recommended Physical Activity** – ranking in 2011 at 17.6% among all US counties; 58.6% of males partake in recommended physical activity and this value increased 1.5 percentage points since 2001
- **Female Binge Drinkers** – ranking in 2012 at 38.1% among all US counties; 5.4% of females are binge drinkers and this value declined 1.6 percentage points since 2005
- **Female Smokers** – ranking in 2012 at 4.6% among all US counties; 14.3% of females smoke and this declined 7.3 percentage points since 1996

Conclusions from Prior CHNA Implementation Activities

Worksheet 4 of Form 990 h can be used to report the net cost of community health improvement services and community benefit operations.

> *"Community health improvement services" means activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services.*
>
> *"Community benefit operations" means:*
>
> - *activities associated with community health needs assessments, administration, and*
> - *the organization's activities associated with fundraising or grant-writing for community benefit programs.*

Activities or programs cannot be reported if they are provided primarily for marketing purposes or if they are more beneficial to the organization than to the community. For example, the activity or program may not be reported if it is designed primarily to increase referrals of patients with third-party coverage, required for licensure or accreditation, or restricted to individuals affiliated with the organization (employees and physicians of the organization).

To be reported, community need for the activity or program must be established. Community need can be demonstrated through the following:

- A CHNA conducted or accessed by the organization.
- Documentation that demonstrated community need or a request from a public health agency or community group was the basis for initiating or continuing the activity or program.
- The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or program carried out for the express purpose of improving community health.

Community benefit activities or programs also seek to achieve a community benefit objective, including improving access to health services, enhancing public health, advancing increased general knowledge, and relief of a government burden to improve health. This includes activities or programs that do the following:

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial, or cultural barriers to accessing health services, and if they ceased would result in access problems (for example, longer wait times or increased travel distances).
- Address federal, state, or local public health priorities such as eliminating disparities in access to healthcare services or disparities in health status among different populations.
- Leverage or enhance public health department activities such as childhood immunization efforts.
- Otherwise would become the responsibility of government or another tax-exempt organization.
- Advance increased general knowledge through education or research that benefits the public.

Activities reported by the Hospital in its implementation efforts and/or its prior year tax reporting included:

PROMOTION OF COMMUNITY HEALTH:

Brazosport Regional participates in a number of community building activities that promote the health of the communities the organization services. Brazosport Regional provides a free monthly community education that covers a broad range of health related topics, such as allergies and asthma, diabetes, breast health and understanding epilepsy. Brazosport Regional has also developed and offers numerous support groups that are free for community members, including support for breast cancer, diabetes, stroke, weight loss and mental illness. Annually Brazosport Regional provides several community based free screening and immunization clinics, such as a free flu shot clinic that delivers over 1,000 free flu shots over a two day period, a free prostate screening exam for nearly 200 local men, and providing various health screenings (blood pressure, blood sugar, and cholesterol) at local community and business events such as the senior fest, the disabilities expo, the Dow retires reunion and the Clute festival. The Brazosport Regional Auxiliary also coordinates a community wide blood drive that occurs every two months in the classrooms at Brazosport Regional.

Brazosport Regional is a community owned 501(c)(3) that maintains as open medical staff, consisting of approximately 130 physicians and mid-level providers. The organization is governed by a 12 member board, comprised of local community members, and actively participates in furthering the health of the community by providing financial support for community activities and civic organizations, providing facilities for free community education, support groups, screenings and immunizations, and reinvesting all surplus funds in the expansion and improvement of medical equipment and facilities for the benefit of the community served.

EXISTING HEALTHCARE FACILITIES, RESOURCES, & IMPLEMENTATION STRATEGY

SIGNIFICANT HEALTH NEEDS

We used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by BRHS.[33] The following list:

- Identifies the rank order of each identified Significant Need
- Presents the factors considered in developing the ranking
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term
- Identifies BRHS current efforts responding to the need including any written comments received regarding prior BRHS implementation actions
- Establishes the Implementation Strategy programs and resources BRHS will devote to attempt to achieve improvements
- Documents the Leading Indicators BRHS will use to measure progress
- Presents the Lagging Indicators BRHS believes the Leading Indicators will influence in a positive fashion, and
- Presents the locally available resources noted during the development of this report as believed to be currently available to respond to this need.

In general, BRHS is the major hospital in the service area. BRHS is a 134-bed, acute care medical facility located in Lake Jackson, TX. The next closest facilities are outside the service area and include:

- Angleton Danbury Medical Center (now UTMB Health) in Angleton, TX, 13.2 Miles, 19 minutes
- Sweeny Community Hospital in Sweeny, TX, 19.5 miles, 31 minutes
- Matagorda Regional Medical Center in Bay City, TX, 38.4 miles, 57 minutes

All data items analyzed to determine significant needs are “Lagging Indicators,” measures presenting results after a period of time, characterizing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast, the BRHS Implementation Strategy uses “Leading Indicators.” Leading Indicators anticipate change in the Lagging Indicator. Leading Indicators focus on short-term performance, and if accurately selected, anticipate the broader achievement of desired change in the Lagging Indicator. In the QHR application, Leading Indicators also must be within the ability of the hospital to influence and measure.

[33] Response to IRS Schedule h (Form 990) Part V B 3 e

Texas Community Benefit Requirements

Texas requires nonprofit hospitals to provide community benefits as a condition of state tax exemption. Texas law requires that, in order to qualify as tax-exempt "charitable organizations," nonprofit hospitals and hospital systems must provide "charity care and government-sponsored indigent health care" or "charity care and community benefits" in at least the amount specified in accordance with one of four alternative standards. Nonprofit disproportionate share hospitals, nonprofit hospitals in counties with a population of less than 58,000, and hospitals that exclusively provide free care are exempt from this requirement.

The Texas Department of Health requires that each nonprofit hospital submit an "annual report of its community benefit plan" that includes a specification of: the hospital's mission statement; the health needs of the community considered in developing the hospital's community benefit plan; the amount and types of community benefits actually provided; total operating expenses; and the hospital's cost to charge ratio.[34]

II. Community Benefits Projects/Activities:

Provide information on name, brief description (3 lines), target population or purpose (3 lines) for each of the community benefits projects/activities CURRENTLY being undertaken by your hospital (example: diabetes awareness).

1. Availability of doctors: Increase physician availability, lower waiting time, increase doctors who take hospital call, increase the supply of primary care; We are recruiting primary care physicians, and physician extenders. 2. Diabetes: Large diabetic population; Section 1115 waiver project to follow and teach diabetic patients; Expanded diabetic education classes.[35]

Significant Needs

1. **MENTAL HEALTH (including suicide)** – 2012 Significant Need, 2015 – Local Expert mixed support; depression 11th best among peers below US avg.; Social Associations (adverse); Inadequate Social Support (adverse)

Problem Statement: The issue to address is to increase the supply of mental health providers to serve residents in the BRHS primary service area

- ***Brazosport Regional is declining to address this community health need, primarily due to resource constraints. Several local agencies and private businesses are focused on meeting the community need and developing programs for this population.***

Public comments received on previously adopted implementation strategy:

- Places for the chronic mentally ill. Attempted suicide are treated poorly by the system. Mentally ill patients or otherwise at risk should not be asked if they will be admitted. They need intervention and a sound referral process with follow up. Hospitals are the start, but the community has to have the resources.
- Information only
- I have no specific comments

[34] http://www.hilltopinstitute.org/hcbpDocs/HCBP_CBL_tx.pdf
[35] http://www.dshs.state.tx.us/chs/hosp/2013-Part-II-Texas-Nonprofit-Hospital-Annual-Statement-of-Community-Benefits-Data/

- I have no specific comments
- More mental health care specialist are needed locally

BRHS services, programs, and resources available to respond to this need include:[36]

- Emergency Services provides emergency intervention and case management support

BRHS evaluation of impact of actions taken since the immediately preceding CHNA:

- A new outpatient mental health service has begun at Brazosport Medical Center in Freeport through Stephen F. Austin Community Health Network, which is partially funded by United Way.

Anticipated results from BRHS Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers		X
2. Reduces barriers to access services (or, if ceased, would result in access problems)		X
3. Addresses disparities in health status among different populations		X
4. Enhances public health activities		X
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization		X
7. Increases knowledge; then benefits the public		X

The strategy to evaluate BRHS intended actions is to monitor change in the following Leading Indicator:

- N/A

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- N/A

[36] This section in each need for which the hospital plans an implementation strategy responds to Schedule h (Form 990) Part V Section B 3 c

BRHS anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information

Other local resources identified during the CHNA process that are believed available to respond to this need:[37]

Organization	Contact Name	Contact Information
Stephen F. Austin – Freeport, TX Youth and Family Counseling Services Gulf Coast Center Brazoria County Counseling Center	Mark Young, CEO Mike Winburn, Executive Director	281-824-1480 979-849-7751 866-729-3848 979-549-0889

2. **DOCTOR AVAILABILITY & ACCESS/AWARENESS and WAIT TIME – 2012 Significant Need; 2015 – Local Experts support; 7th best among peers above US avg.; Urgent Care Use above (adverse); Advanced Practice Practitioner use (desirable)**

Problem Statement: The issue to address is to increase the supply of primary care physicians who will see patients in the BRHS primary service area

Public comments received on previously adopted implementation strategy:

- Not a major role for hospitals
- Raise funds to use for indigent care
- I have no specific comments
- From what I observe, the hospital is on the right track to encourage doctors to relocate to our area.
- It is very frustrating to call our family doctor when we are ill and find out we have to go to urgent care because an appointment is not available. We need more doctor availability.

BRHS services, programs, and resources available to respond to this need include:

- Brazosport Regional Family Medicine Centers are now offered in three locations throughout the service area.
- Brazosport Regional Physician Services offers employment opportunities for a number of primary care positions, including Family Practice, Pediatrics, Internal Medicine and Obstetrics and Gynecology.
- Brazosport Regional collaborates with local Primary Care Physicians in the recruitment process and, when

[37] This section in each need for which the hospital plans an implementation strategy responds to Schedule h (form 990) Part V Section B 3 c and Schedule h (Form 990) Part V Section B 11

appropriate, jointly recruits physicians to join existing physician practices in our service area.

- During the strategic planning process, Brazosport Regional Health System conducts a comprehensive Physician Manpower Analysis to determine recruitment needs by physician type.

BRHS evaluation of impact of actions taken since the immediately preceding CHNA:

- There is a marked increase in the number of primary care physicians in the service area from the time the preceding CHNA was conducted.

Anticipated results from BRHS Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	Yes	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	Yes	
3. Addresses disparities in health status among different populations		
4. Enhances public health activities		
5. Improves ability to withstand public health emergency		
6. Otherwise would become responsibility of government or another tax-exempt organization		
7. Increases knowledge; then benefits the public		

The strategy to evaluate BRHS intended actions is to monitor change in the following Leading Indicator:

- The total number of recruited Primary Care Physicians in the Brazosport Regional service area

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Improved community perception of physician availability and ease of access, as well as wait time to see a physician, as measured by the Community Image and Perception Analysis completed by BRHS.

BRHS anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Local Primary Care Physicians		

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
UTMB Health Angleton Danbury Campus	Dave Bleakney, Administrator	(979) 849-7721
Sweeny Community Hospital	William Barnes, CEO	(979) 548-1500

3. EMERGENCY – Local Expert identified need

Problem Statement: The area needs the ability to quickly access quality emergency services

Public comments received on previously adopted implementation strategy:

- This was not a Significant Need identified in 2012 so no written public comments about this need were solicited, however, two comments were received about emergency services, as follows
    - Crisis response in case of a plant emergency
    - Make the emergency room including exam rooms clean.

BRHS services, programs, and resources available to respond to this need include:

- Current Emergency Services Department at Brazosport Regional is staffed by Board Certified Emergency Medicine Physicians and is designated as a Level 3 Trauma Center.
- Brazosport Regional is constructing a new state of the art Emergency Services Pavilion which will double the patient capacity of the facility and continue to improve the hospital's ability to respond to crisis situations in the surrounding area.
- Brazosport Regional employs a Safety Officer/Emergency Manager who is responsible for coordinating emergency response services with local governmental agencies and corporations, including the plants.
- All Administrative Personnel at Brazosport Regional have been trained in the implementation of the FEMA National Incident Management Systems

BRHS evaluation of impact of actions taken since the immediately preceding CHNA:

- This need was not present on the preceding CHNA

Anticipated results from BRHS Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	Yes	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	Yes	
3. Addresses disparities in health status among different populations		
4. Enhances public health activities		
5. Improves ability to withstand public health emergency	Yes	
6. Otherwise would become responsibility of government or another tax-exempt organization		
7. Increases knowledge; then benefits the public		

The strategy to evaluate BRHS intended actions is to monitor change in the following Leading Indicator:

- Wait time from door to provider

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Improved community perception of availability and ease of access to high quality emergency services as measured by the Community Image and Perception Analysis completed by BRHS.

BRHS anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Dow Chemical Company		979-238-2011
BASF	Cindy Suggs, Manager, Community and Government Affairs	979-415-6273
EmCare Physician Group	Dr. Kevin Rittger	979-285-1485

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
Altus Emergency Center	Amir Bashiri	(979) 529-2000

4. **Access/Cost - Local Expert identified need; Adults not seeing Dr. due to cost (adverse); No health insurance (severe adverse) but below TX avg.**

Problem Statement: Cost of care deters utilization of local services.

Public comments received on previously adopted implementation strategy:

- This was not a Significant Need identified in 2012 so no written public comments about this need were solicited, however, two comments were received about emergency services, as follows
    - The patients with no intent of payment should still be exposed and reminded of the cost they incur. Specific referrals or on-call places to send patients for follow up, and then having access to the entire record so each encounter is a follow up.
    - Do not agree to offering assistance

BRHS services, programs, and resources available to respond to this need include:

- Brazosport Regional is a non-profit healthcare system that provides care regardless of an individual's ability to pay for services. As part of its commitment to serve the community, BRHS provides financial assistance in the form of charity care to citizens who are financially indigent and satisfy certain requirements.
- It is the policy of BRHS to promote the health and well being of the people in the Hospital service area. BRHS will provide medically necessary health care services to members of the Hospital service area who are unable to pay for such services. The Financial Assistance Policy provides guidelines for Financial Assistance based on financial need to self pay patients receiving emergency and other non-elective services for medical conditions that would cause patients harm without immediate attention. Assistance may range from full write-off to discounted care.
- The BRHS Financial Assistance (Charity Care) Policy is publicly available at www.brazosportregional.org

BRHS evaluation of impact of actions taken since the immediately preceding CHNA:

- This need was not present on the preceding CHNA

Anticipated results from BRHS Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	Yes	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	Yes	
3. Addresses disparities in health status among different populations	Yes	
4. Enhances public health activities		

5. Improves ability to withstand public health emergency		
6. Otherwise would become responsibility of government or another tax-exempt organization	Yes	
7. Increases knowledge; then benefits the public		

The strategy to evaluate BRHS intended actions is to monitor change in the following Leading Indicator:

- Number of Financial Assistance Screenings

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Total number of patients that qualified for discounted rates for services through the Financial Assistance Policy

BRHS anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Live Oak Clinic	Sanjay Aggarwal, M.D., Medical Director	979-388-0809
Stephen F. Austin Community Health Network	Mark Young, CEO	281-824-1480

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
Live Oak Clinic	Sanjay Aggarwal, M.D., Medical Director	979-388-0809
Stephen F. Austin Community Health Network	Mark Young, CEO	281-824-1480

5. **PREVENTION</u> – 2012 Significant Need; 2015 – Local Expert mixed support; Diabetic Monitoring (desirable); Cholesterol Screening (desirable); Female life span 11th worse among peers better US avg.; Male life span better and improved; Female and Male Physical Activity (desirable)**

Problem Statement: The issue to address is to increase prevention service use.

Public comments received on previously adopted implementation strategy:

- Access to care
- I have no specific comments
- Lack of medical attention for the uninsured.

BRHS services, programs, and resources available to respond to this need include:

- Diabetes Outpatient Training Site (DOTS)
- Diabetes Support Group
- Free Peripheral Artery Disease (PAD) Screenings

BRHS evaluation of impact of actions taken since the immediately preceding CHNA:

- Diabetes Outpatient Training is having a significant impact on patients who are recently diagnosed, resulting in decreased readmissions and preventing or reducing complications.
- Provided over 100 PAD Screens to local residents and scheduled follow up appointment with a Cardiologist when appropriate.

Anticipated results from BRHS Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	Yes	
2. Reduces barriers to access services (or, if ceased, would result in access problems)		
3. Addresses disparities in health status among different populations		
4. Enhances public health activities	Yes	
5. Improves ability to withstand public health emergency		
6. Otherwise would become responsibility of government or another tax-exempt organization		
7. Increases knowledge; then benefits the public	Yes	

The strategy to evaluate BRHS intended actions is to monitor change in the following Leading Indicator:

- Total number of PAD Screenings completed annually
- Total number of participants in the DOTS Program.

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Improved Male and Female life span rates

BRHS anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
American Diabetes Association Local Primary Care Physicians		(800) 342-2383

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
Stark Diabetes Center at UTMB Health		(888) 252-8212

6. Cancer - #2 cause of death; Brazoria ranks (adverse) TX

Problem Statement: Greater use of prevention and treatment services are needed

Public comments received on previously adopted implementation strategy:

- This was not a Significant Need identified in 2012 so no written public comments about this need were solicited nor were any unsolicited written comments received

BRHS services, programs, and resources available to respond to this need include:

- A comprehensive Cancer Treatment Center providing both Medical and Radiation Oncology Treatment Services
- Free Screenings for Oral, Head and Neck Cancer
- Mammography Screenings & Breast Health Initiatives through The Mermaid Project
- Cancer Support Group

BRHS evaluation of impact of actions taken since the immediately preceding CHNA:

- This need was not present on the preceding CHNA

Anticipated results from BRHS Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	Yes	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	Yes	
3. Addresses disparities in health status among different populations		

4. Enhances public health activities	Yes	
5. Improves ability to withstand public health emergency		
6. Otherwise would become responsibility of government or another tax-exempt organization		
7. Increases knowledge; then benefits the public	Yes	

The strategy to evaluate BRHS intended actions is to monitor change in the following Leading Indicator:

- Total number of participants in The Mermaid Project and in the Oral, Head and Neck Cancer Screenings

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Decrease in cancer related deaths in the primary service area

BRHS anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
MD Anderson Cancer American Cancer Society		(877) 632-6789 (713)-266-2877

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
MD Anderson Cancer		(877) 632-6789

Other Needs Identified During CHNA Process

8. **OBESITY**
9. **DIABETES**
10. **TEEN BIRTHS – 2012 Significant Need**
11. **ALZHEIMER's**
12. **STROKE**
13. **ALCOHOL - including alcohol abuse**
14. **WOMEN's HEALTH**
15. **ACCIDENTS**
16. **HEART DISEASE**
17. **ADVERSE HABITS – 2012 Significant Need**
18. **FLU/PNEUMONIA**
19. **SMOKING**
20. **KIDNEY**
21. **LIVER**
22. **LUNG**
23. **SOCIAL VULNERABILITY**
24. **BLOOD POISONING**
25. **PARKINSON's**
26. **ENVIRONMENTAL**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[38]

1. MENTAL HEALTH (including suicide) – 2012 Significant Need
2. DOCTOR AVAILABILITY/ACCESS/AWARENESS and WAIT TIME – 2012 Significant Need
3. EMERGENCY
4. ACCESS/COST
5. PREVENTION – 2012 Significant Need
6. CANCER

[38] Responds to Schedule h (Form 990) Part V B 8

Significant needs where hospital did not develop implementation strategy[39]

Mental Health

Other needs where hospital developed implementation strategy

None

Other needs where hospital did not develop implementation strategy

None

[39] Responds to Schedule h (Form 990) Part V Section B 8

APPENDIX

Appendix A – Written Commentary on Prior CHNA

Hospital solicited written comments about its 2012 CHNA.[40] 15 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

1. **Please indicate which (if any) of the following characteristics apply to you. If none of the following choices apply to you, skip the indication and please continue to the next question.**

Local Expert Classification	Yes (Applies to Me)	% Responding Yes	No (Does Not Apply to Me)	No Response	Total Response
1) **Public Health Expertise** (public health dept volunteers / employees, one holding an MPH degree and/or employed in a capacity where one is required)	**3**	**20%**	**8**	**4**	**15**
2) **Departments and Agencies** Federal, tribal, regional, State or local agencies with relevant data/information regarding health needs of the community served by the hospital	**4**	**27%**	**8**	**3**	**15**
3) **Priority Populations** (represented by public elected officials, religious officials, long term care / work shelter executives; and/or members of LGBT community, medically underserved, low income, minorities)	**9**	**60%**	**3**	**3**	**15**
4) Representative of or member of **chronic disease group** or organization	**1**	**7%**	**10**	**4**	**15**
5) **Broad Interest of the Community** (school system exec's, employers, leadership of civic organizations, voluntary health groups, Chamber of Commerce, Industrial Development)	**10**	**67%**	**2**	**3**	**15**

2. **In the last process, several data sets were examined and a group of local people were involved in advising the Hospital. While multiple needs emerged, the Hospital had to determine what issues were of high priority and where it would be a valuable resource to assist in obtaining improvements.**

   Priorities from the last assessment where the Hospital intended to seek improvement were:

   - Doctor Availability Increase physician availability, lower wait time, increase doctors who take hospital call, increase the supply of primary care. The issue to address was to increase the supply of primary care physicians who will see patients in the BRHS primary service area.
   - Adverse Habits Smoking, obesity and a lack of healthy eating habits are underlying conditions contributing to, adding complications to, and otherwise contributing to development of disease and disorder. The issue to address was to lower the prevalence of unhealthy habits.
   - Prevention A lack of utilizing cancer prevention services, not checking cholesterol levels and generally not taking advantage of preventive efforts. The issue to address was to increase prevention service use.
   - Mental Health (including suicide) Increase mental health resources (psychiatric and substance abuse; including physicians and other counselors or professionals), increase jail resources, provide resources for patients other

[40] Responds to IRS Schedule h (Form 990) Part V B 5

than those in immediate harm to self or others. The issue to address was to increase the supply of mental health providers to serve residents in the BRHS primary service area.

- Teen Births Reducing births to women under age of 18. The issue to address was a reduction in the number of teen pregnancies.

3. Should the hospital continue to consider each need identified as most important in the 2012 CHNA report as the most important set of health needs currently confronting residents in the County?

Should the hospital continue to consider each need identified as most important in the 2012 CHNA report as the most important set of health needs currently confronting residents in the County?	Yes	No	No Opinion
Doctor Availability	14	1	0
Adverse Habits	8	4	3
Prevention	11	2	2
Mental Health (including Suicide)	12	1	2
Teen Births	8	4	3

- **Specific comments or observations about Doctor Availability as being among the most significant needs for the Hospital to work on to seek improvements?**
    - Doctors that are rude, disrespectful, and arrogant are a drain on the community and should not be tolerated.
    - None
    - I have seen where they are working to find the right mix of Dr./ PA/ Nurse Practitioner.
    - See #3 above
    - None
    - I believe that doctor availability is a great issue with great financial requirements. I also believe that they are working hard to make changes and add Dr. availability where possible and practical.
    - See #3 above
    - Growing population with fewer GPs
    - It is critical that we have doctors in different fields to care for the citizens. Even more important now with the influx of thousands of new residents due to the many industry expansions underway in our area.
    - Definitely doctor availability is a must.

- **Specific comments or observations about Adverse Habits as being among the most significant needs for the Hospital to work on to seek improvements?**
    - Not focus for hospitals
    - Do not agree with the need to address this created habit
    - I have no specific comments
- **Specific comments or observations about Prevention as being among the most significant needs for the Hospital to work on to seek improvements?**
    - Not a focus
    - Information push
    - I have no specific comments
    - I know that the hospital has seminars concerning prevention.
    - I think work on prevention is extremely important through education of people to take responsibility for their health which could prevent disease in the future.
    - we need more education and assistance on drug and alcohol addiction.
- **Specific comments or observations about Mental Health (including suicide) as being among the most significant needs for the Hospital to work on to seek improvements?**
    - Access to care Education for parents/students especially school districts whom are normally the 1st that identify that the child/children have an issue. Affordable care
    - Telemedicine for the chronically mentally ill would facilitate routine follow up and monitoring
    - Do not agree to offer this care
    - The community has very few mental health specialist but has a large need for assistance in this area.
    - Mental health is lacking across the state. The hospital needs to recruit more mental health professionals for private practice as well as implementing mental health in the emergency room and designated beds for those needing additional care.
- **Specific comments or observations about Teen Births as being among the most significant needs for the Hospital to work on to seek improvements?**
    - Advocacy in the school districts and awareness from current/past teen parents. (peers)
    - Offering day of discharge birth control (long term), and financial planning info. The hospital cannot be accountable for all the ills of the world
    - Information push

- I have no specific comments
- I think education at a early age concerning avoiding teen births is critical.
- At this time, there are no known programs for assistance in prevention and/or assistance with teen pregnancy situations

- **Finally, after thinking about our questions and the information we seek, is there anything else you think important as we review and revise our thinking about significant health needs within the County?**
  - Make the emergency room including exam rooms clean.
  - Continue educating the public about what all this hospital can do for different health concerns. There are so many people who are still not aware that treatment can be obtained here instead of else where.
  - a partnership with local schools to have a school based clinic may be beneficial in providing health prevention information to promote healthy lifestyles.

- **Do you have opinions about new or additional implementation efforts or community needs the Hospital should pursue?**
  - TO compete in the area wait times will be important.
  - Increase the supply of primary care
  - No
  - See comments in #3 above.
  - Can there be a reduced rate for low income people in need of emergency care.
  - I think the hospital is listening to the needs of the community and that is evident by the expansion currently going on now and in the recent past. It is also evident that the community is in agreement indicated by the donations made by industry and individuals for the improvement of different areas in the hospital.
  - substace abuse prevention and treatment efforts are needed locally
  - Nursing care is the focus for success, quality, and satisfaction. Systems are inefficient, expensive because nurses care for patients. The system is too expensive to provide adequate patient care providers, which is the key to success and big bonuses for admin.

Should the hospital continue to allocate resources to assist improving the needs?

Should the hospital continue to allocate resources to assist improving the needs identified in the 2012 Report?	Yes	No	No Opinion
Doctor Availability	13	1	3
Adverse Habits	3	7	5
Prevention	10	2	3
Mental Health (including Suicide)	12	1	2
Teen Births	6	4	5

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in Doctor Availability.**
    - Not a major role for hospitals
    - Raise funds to use for indigent care
    - I have no specific comments
    - From what I observe, the hospital is on the right track to encourage doctors to relocate to our area.
    - It is very frustrating to call our family doctor when we are ill and find out we have to go to urgent care because an appointment is not available. We need more doctor availability.
- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in Adverse Habits.**
    - Not a focus for hospitals
    - Getting people to recognize the value of prevention.
    - I have no specific comments
    - More community education programs for the public, along with public service ads to re-enforce new information.
- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in Prevention.**
    - Access to care
    - Places for the chronic mentally ill. Attempted suicide are treated poorly by the system. Mentally ill patients or otherwise at risk should not be asked if they will be admitted. They need intervention and a sound referral process with follow up. Hospitals are the start, but the community has to have the resources.
    - Do not agree to offering assistance
    - I have no specific comments

- lack of medical attention for the uninsured.

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in Mental Health (including suicide).**
  - Information only
  - I have no specific comments
  - I don't see how the hospital is responsible for reducing teen births; but if so, public education programs that teens will listen to.
  - I have no specific comments
  - More mental health care specialist are needed locally
  - Teen birth is not a problem the hospital can solve. Anyone entering the hospital should be asked for payment planning and assessed a fee. The patients with no intent of payment should still be exposed and reminded of the cost they incur. Specific referrals or on-call places to send patients for follow up, and then having access to the entire record so each encounter is a follow up.

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in Teen Births.**
  - Crisis response in case of a plant emergency
  - Forget about mental health needs. It will deplete your funds with no help provided to anyone.
  - Bring specialized services back to the hospital, Increase level of care available 24hrs a day
  - Community education programs on health issues related to teen pregnancies and healthcare issues related to teen sex.
  - a local clinic or program to assist with prevention and providing care for teen pregnancy situations would be helpful. This could also focus on alcohol and substance use that can lead to teen pregnancy.
  - Reviewing the actual mission as practical to location. BRHS cannot and never will be a medical center. Focusing money on pointless endeavors is costly. The open heart program is a great example. No reason to ever spend a dime on such a program. Millions lost by these ideas and fads. Patients will only go to BRHS is they receive excellent care. Excellent care is not a top down mandate or memo. Excellent patient care is nurses not tasked to provide direct care. RNs head teams adequately staffed to provide excellent care. Nurses control systems and are not subject to the needs of other departments that only exist because patients need nursing care. Turnover is not because BRHS trains nurses to work in Houston. Nurses leave because they are over worked, have no control over systems and processes, spend hours documenting in a pointless system instead of caring for patients, hours wasted because of other departments. The solution is simple and clear, but completely ignored by non-nursing administration. Nursing is not a cost to the organization. Patients need nursing care which then feeds other departments.

Appendix B – Identification & Prioritization of Community Needs

Need Topic	Total Votes	Number of Local Experts Voting for Need	Percent of Votes	Cumulative Votes	Need Determination
1. MENTAL HEALTH (including suicide) - 2012 Significant Need	320	13	21.33%		Significant Need
2. DOCTOR AVAILABILITY - 2012 Significant Need	267	13	17.80%	39.13%	
3. ACCESS/AWARENESS and WAIT TIME	116	9	7.73%	46.87%	
4. EMERGENCY	107	7	7.13%	54.00%	
5. ACCESS/COST	99	8	6.60%	60.60%	
6. PREVENTION - 2012 Significant Need	87	7	5.80%	66.40%	
7. CANCER	80	8	5.33%	71.73%	
8. OBESITY	63	5	4.20%	75.93%	Other Identified Need
9. DIABETES	55	5	3.67%	79.60%	
10. TEEN BIRTHS - 2012 Significant Need	51	4	3.40%	83.00%	
11. ALZHEIMER's	49	5	3.27%	86.27%	
12. STROKE	42	4	2.80%	89.07%	
13. ALCOHOL - including alcohol abuse	39	4	2.60%	91.67%	
14. WOMEN's HEALTH	27	4	1.80%	93.47%	
15. ACCIDENTS	25	4	1.67%	95.13%	
16. HEART DISEASE	24	3	1.60%	96.73%	
17. ADVERSE HABITS - 2012 Significant Need	12	2	0.80%	97.53%	
18. FLUE/PNEUMONIA	10	2	0.67%	98.20%	
19. SMOKING	10	2	0.67%	98.87%	
20. KIDNEY	4	1	0.27%	99.13%	
21. LIVER	4	1	0.27%	99.40%	
22. LUNG	4	1	0.27%	99.67%	
23. SOCIAL VULNERABILITY	3	2	0.20%	99.87%	
24. BLOOD POISONING	1	1	0.07%	99.93%	
25. PARKINSON's	1	1	0.07%	100.00%	
26. ENVIRONMENTAL	0	0	0.00%	100.00%	
Total	1500		100.00%		

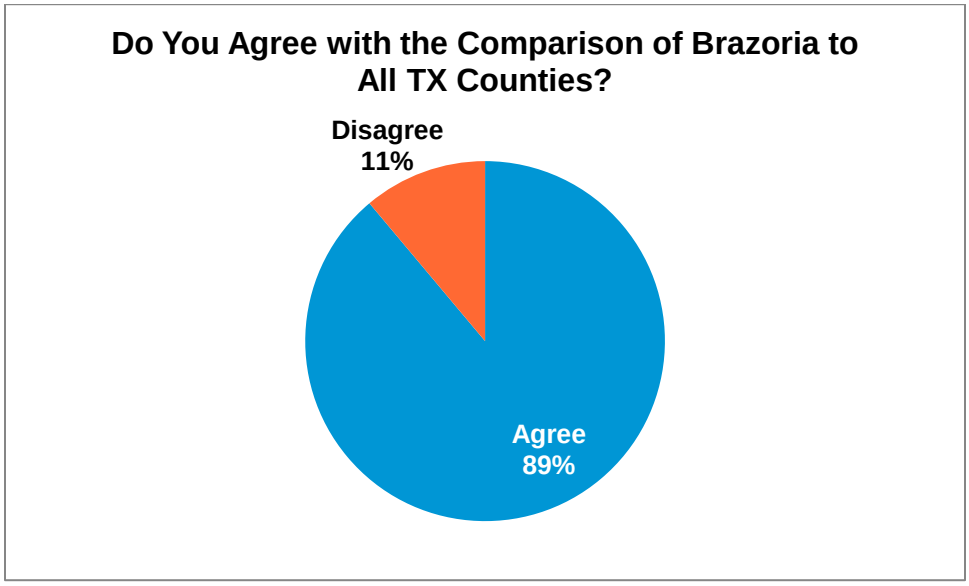
Individuals Participating as Local Expert Advisors[41]

Respondent Characteristics	Yes (Applies to Me)	% of Total Responses	No (Does Not Apply to Me)	No Comment	Total Responses
(1) **Public Health** - Persons with special knowledge of or expertise in public health	6	33%	8	4	18
(2) **Departments and Agencies** - Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility	3	17%	8	7	18
(3) **Priority Populations** - Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility. Also in other federal regulations the term Priority Populations, which include rural residents and LGBT interests, is employed and for consistency is included in this definition	5	28%	8	5	18
(4) **Chronic Disease Groups** - Representative of or member of Chronic Disease Group or Organization, including mental and oral health	1	6%	10	7	18
(5) **Represents the Broad Interest of the Community** - Individuals, volunteers, civic leaders, medical personnel and others to fulfill the spirit of broad input required by the federal regulations.	12	67%	2	4	18

[41] Responds to IRS Schedule h (Form 990) Part V B 3 g

Advice Received from Local Expert Advisors

Question: *Do you agree with the observations formed about the comparison of Brazoria to all otherTX counties?*



Comments:

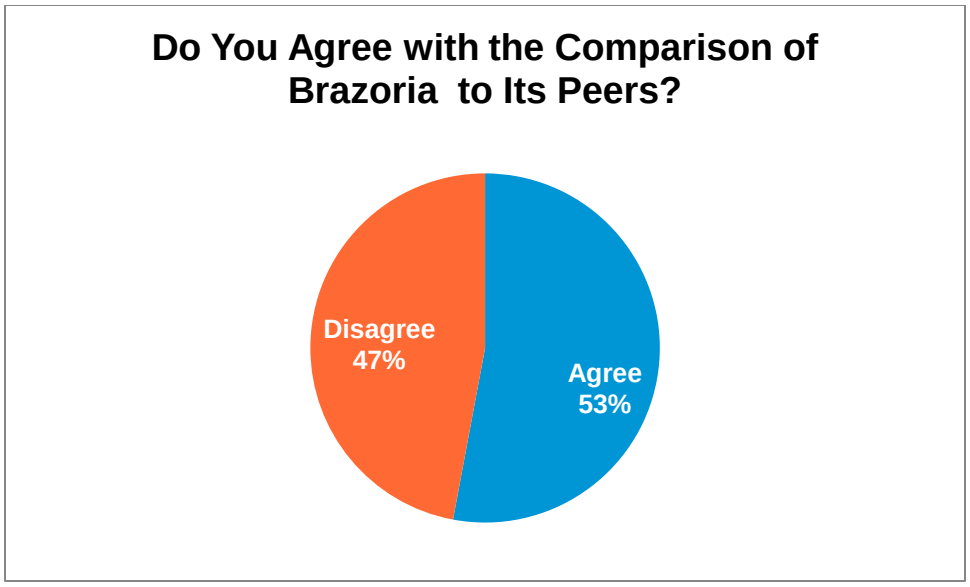
- Feel the uninsured rate (listed at 22%) is not an accurate number. I think it is higher. Also, question "Diabetic Monitoring" at 82%--don't think it's that good--based on the clients we see in Indigent program.
- I feel the uninsured rate is higher than 22% based on the local student population on free and reduced programs in the local school district.

Question: *Do you agree with the observations formed about the comparison of Brazoria to its peer counties?*

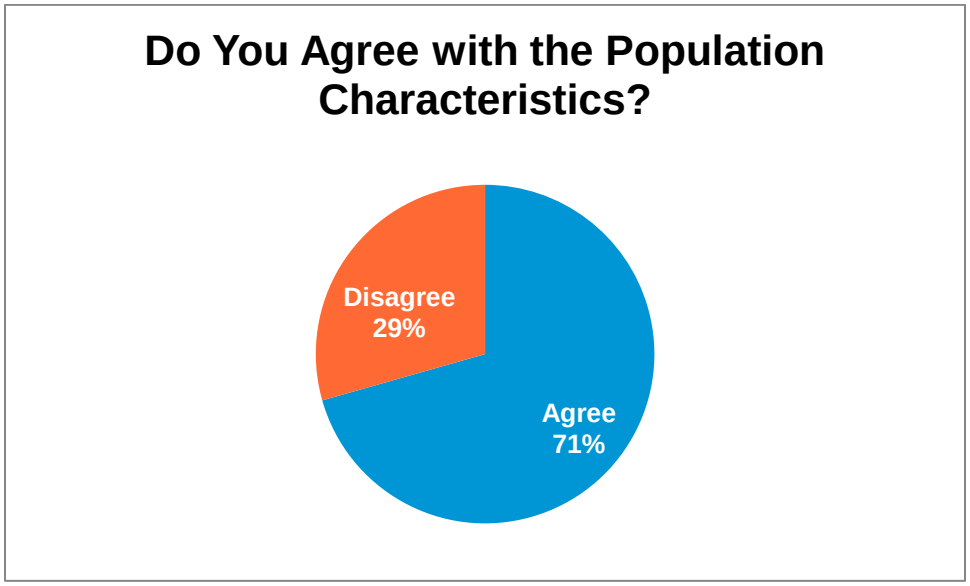
Comments:

- The unemployment rate, and thus part of the poverty portion of the equation, would appear to be a choice by those individuals. There is a shortage of work force members in many areas of our community. There are many high wage jobs available.
- Do not agree with Drinking water observations or limited access to healthy food findings.
- Don't know where this drinking water analysis came from. lake Jackson has a "superior" water system as determined by the State of Texas
- Primary care provider access continues to be a problem, especially for clients that are uninsured. County has too many homeless--need more social support for these people (especially children/adolescents). Obesity is problematic EVERYWHERE!!!!
- The unemployment data is a bit outdated. I believe it is just a little over 4% now.

- Unemployment number is badly dated.



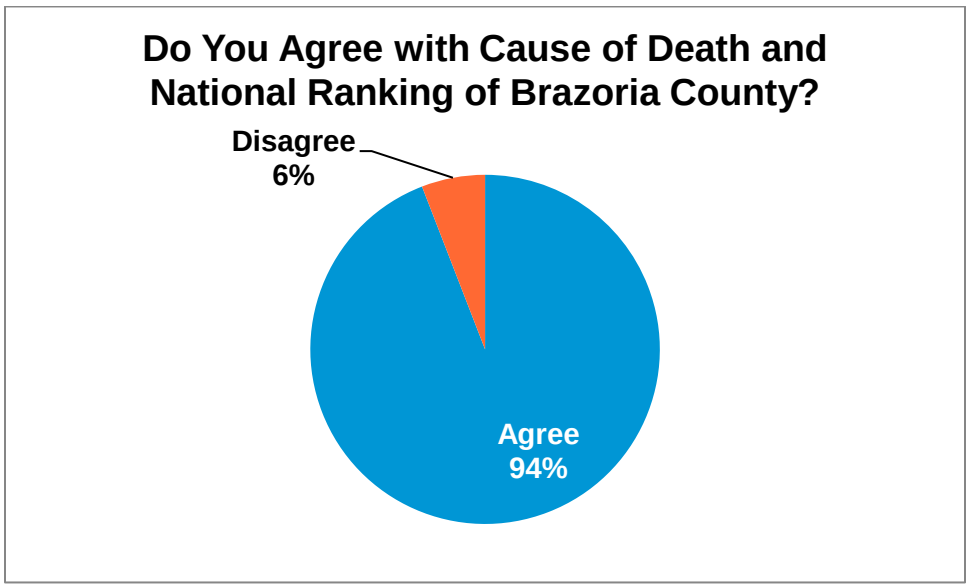
Question: *Do you agree with the observations formed about the population characteristics of Brazoria County?*



Comments:

- Don't feel the County as a whole has adequate resources for large scale events, like bioterrorism. There is also inadequate HAZMAT (Decontamination) services!!
- I think the population estimates' for 2020 are extremely low.
- unemployment number listed above is wrong. unemployment rate is lower now. the average price of a home is wrong. Values are much higher than listed.

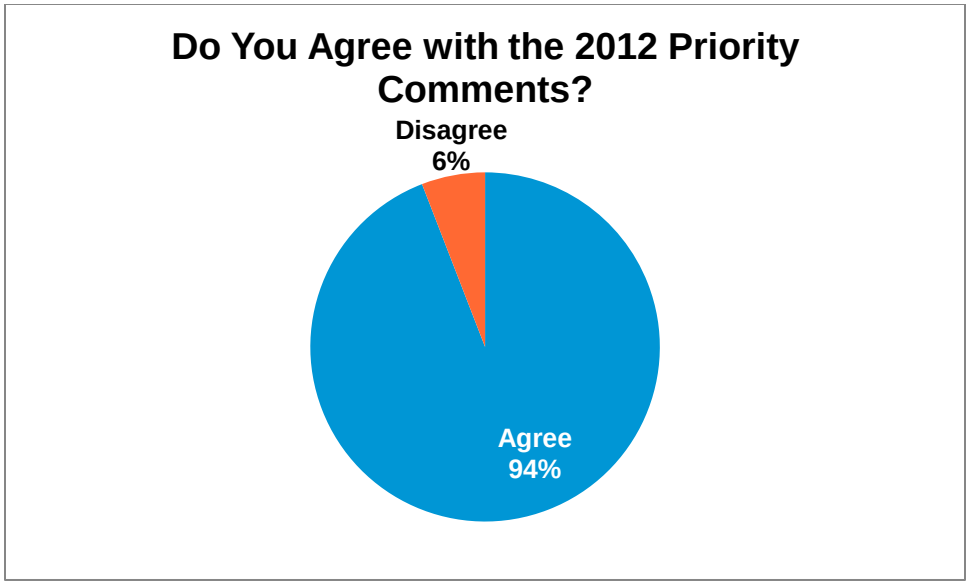
Question: *Do you agree with the observations formed about from Brazoria's national ranking and Causes of Death?*



Comments:

- (None)

Question: *Do you agree with the Written Comments Received on the 2012 CHNA?*

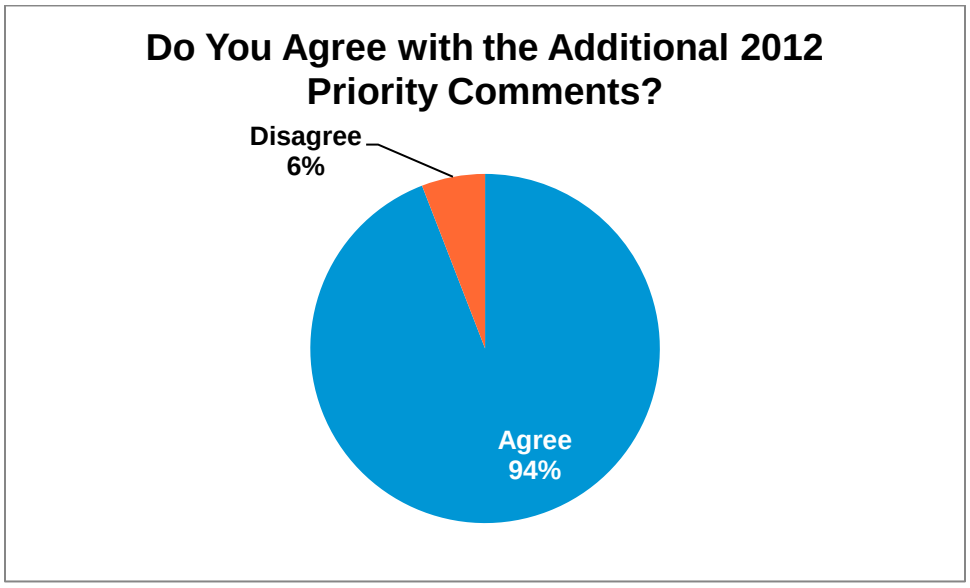


Comments:

- Access to mental health services continue to be problematic in Brazoria County. NO regular Psychiatrist (s) available!!!
- I would also add that there should be an initiative to encourage individuals to only use the emergency room in case of an emergency. Too often the emergency room is treated as a primary care physician. I also would

encourage substance-abuse treatment's become a priority as well as mental health. People suffering from those issues pose a danger to themselves and society.

Question: *Do you agree with the Additional Written Comments Received on the 2012 CHNA?*



- School districts also can not be accountable for all the ills of the world or to fix the ill wills of the world.
- the last bullet. There is a pregnancy help center in the area.

Appendix C – Illustrative Schedule h (Form 990) Part V B Potential Response

Illustrative IRS Schedule h Part V Section B (Form 990)[42]

Community Health Need Assessment Illustrative Answers

1. **Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?**

   Suggested Answer –

2. **Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C**

   Suggested Answer –

3. **During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply)**

   a. **A definition of the community served by the hospital facility**

      Suggested Answer –

   b. **Demographics of the community**

      Suggested Answer –

   c. **Existing health care facilities and resources within the community that are available to respond to the health needs of the community**

      Suggested Answer –

   d. **How data was obtained**

      Suggested Answer –

   e. **The significant health needs of the community**

      Suggested Answer –

   f. **Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups**

      Suggested Answer –

   g. **The process for identifying and prioritizing community health needs and services to meet the community health needs**

      Suggested Answer –

   h. **The process for consulting with persons representing the community's interests**

[42] Questions are drawn from 2014 Federal 990 schedule h.pdf and may change when the hospital is to make its 990 h filing

Suggested Answer –

i. **Information gaps that limit the hospital facility's ability to assess the community's health needs**

Suggested Answer –

j. **Other (describe in Section C)**

Suggested Answer –

4. **Indicate the tax year the hospital facility last conducted a CHNA: 20__**

Suggested Answer –

5. **In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted**

Suggested Answer –

6. **a. Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C**

Suggested Answer –

b. Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C

Suggested Answer –

7. **Did the hospital facility make its CHNA report widely available to the public?**

Suggested Answer –

If "Yes," indicate how the CHNA report was made widely available (check all that apply):

a. **Hospital facility's website (list URL)**

Suggested Answer –

b. **Other website (list URL)**

Suggested Answer –

c. **Made a paper copy available for public inspection without charge at the hospital facility**

Suggested Answer –

d. **Other (describe in Section C)**

Suggested Answer –

8. **Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11**

Suggested Answer –

9. **Indicate the tax year the hospital facility last adopted an implementation strategy: 20__**

   Suggested Answer –

10. **Is the hospital facility's most recently adopted implementation strategy posted on a website?**

    a. **If "Yes," (list url):**

       Suggested Answer –

    b. **If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?**

11. **Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed**

    Suggested Answer –

12. **a. Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r) (3)?**

    Suggested Answer –

    b. If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?

    Suggested Answer –

    c. If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form4720 for all of its hospital facilities?

    Suggested Answer –