2019 Community Benefit Report

Mission Regional Medical Center

Table of Contents

Mission Regional Medical Center

June 26, 2020

Dear Fellow Texans and Neighbors,

Ever since 1954, the main priority for Mission Regional Medical Center (formerly known as Mission Hospital) is to help and serve the Mission community. Mission Regional Medical Center (MRMC) fulfills their commitment to always provide exceptional healthcare by providing a highly skilled medical team, a hardworking supporting staff, and an award-winning state-of-the-art healthcare facility. In 2017, MRMC was acquired by Prime Healthcare Foundation Inc. (PHFI) This acquisition created a continuing growth of specialized care within the community of Mission and surrounding areas as well.

PHFI, our local leadership team, and the employees of MRMC have continuously dedicated their time and efforts into improving the health of the community we serve. MRMC has successfully been able to get our community much more involved by re-vamping and creating new events that strengthen the bond within our community even more than before. Some events that promote community gatherings include: health screenings, safety tips for parents and children, and even safety tips during the holidays.

Included in this Community Benefits Report is a copy of the 2020 Community Health Needs Assessment (CHNA) that outlines our priorities. These are comprised of community access to care including primary care and specialists, awareness of chronic disease, health knowledge and education, awareness of obesity and health nutrition as well as preventative care and services for the aging. A separate report on the status of the implementation of our priorities from the CHNA is also included as an attachment.

MRMC is your perfect community resource for health services. Once you review the enclosed reports, it can be found that MRMC provides a lot to our community. If you have been unable to attend any previous programs, stay on the lookout for future programs that can, and will, benefit your health.

Sincerely,

Kane Dawson

CEO, Mission Regional Medical Center

What is Community Benefit?

Community benefit encompasses programs or activities that provide treatment or promote health and healing in direct response to identified community needs.

Community benefit programs and activated meet at least one of these objectives:

- Improve access to health care services
- Enhance the health of the community
- Advance medical or health care knowledge
- Service for the aging generation
- Relieve or reduce the burden of government or other efforts

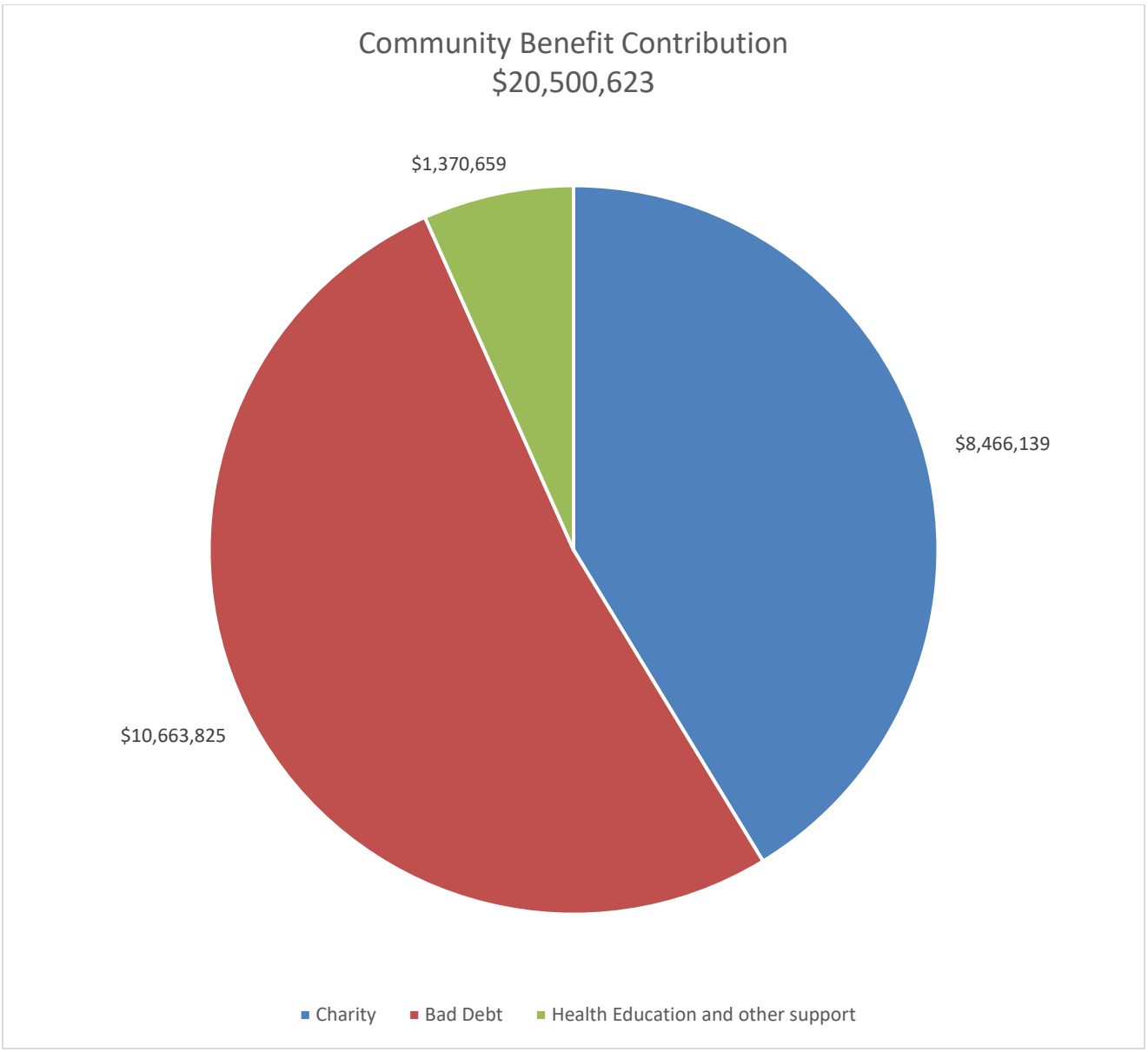
Creating healthier communities, together

Through outreach, programs, health education, donations, free or discounted care and more, we give back to our communities.

Community Benefit: Investments to support those in need

MRMC's community benefit investments not only support the health and well-being of each person we serve, but the whole community:

- Community health services: Free services such as patient education, health screenings immunizations and support groups as well as grants and donations to support community partners.
- Education and research: Education of medical conditions for the whole community, to be able to find and recognize issues that can be treated early on.
- Care and services operated at a loss: Clinical and social services provided despite a financial loss because they meet identified needs not met elsewhere in the community.
- Free and low-cost care: Financial assistance for those who are uninsured, underinsured, or otherwise unable to pay for their healthcare.


Community Benefit Contribution
$20,500,623
$1,370,659
$8,466,139
$10,663,825
Charity
Bad Debt
Health Education and other support

Our Commitment

Mission Regional Medical Center has served the people of our region since 1954 by providing healthcare services to all, crossing barriers of age, education and income levels.

As a non-profit community hospital, we continuously identify and utilize new and more effective ways to improve community health. Through outreach, programs, collaboration, health education, donations, free or discounted care, and more, we give back to our communities.

Not only does MRMC provide outreach and community access to care including primary care and specialists, awareness of chronic disease, health knowledge and education, awareness of obesity and health nutrition as well as preventative care and services for the aging, our doctors and nurses and staff also provide community-based care to patients and help educate the next generation of healthcare professionals.

The services we provide are essential to not only the community's overall health, but also to the quality of life for community residents. This focus is hardwired in our culture, from our volunteer Board of Directors to our physicians, volunteers and staff members.

MRMC has been actively involved in the community for decades. Since its beginning, this safety net hospital's philosophy has reflected the belief that effective preventive health care does not begin and end with an individual's well-being, but also includes promoting and supporting healthy, stable conditions.

Our Community

MRMC serves the City of Mission and its surrounding communities in the central and western parts of Hidalgo and eastern Starr County. As a non-profit hospital MRMC has a longstanding commitment to the health and well-being of the community. Our facilities were established to address a crucial need for health services, which to this day, continues stronger than ever.

Hidalgo and Starr County represent one of the poorest and most underserved regions of the State. High rates of uninsured and a higher-than-average prevalence of chronic diseases such as diabetes and all its co-morbidities have plagued this region and made it more difficult and challenging not only for our hospital, but also for our State and Federal agencies.

Community Needs Assessment Process

The following Community Benefit Report features highlights illustrating each of the five Priority Areas identified through the CHNA, as well as a compilation of progress made in 2019 on the implementation strategies associated with each Priority Area. As the Report clearly illustrates, Mission Regional Medical Center has made significant progress on each Priority Area in the first year of the Implementation Plan, in keeping with the hospital's strong commitment to provide better healthcare to the communities it serves.

The prioritized needs are:

1. **Access to Care Including Primary Care and Specialists:** To improve access to care for uninsured or underinsured population.

2. **Chronic Disease:** Improved the health of population with chronic diseases and related complications.

3. **Health Knowledge and Education:** Improve the overall knowledge level of the population toward general health to reduce of care in a hospital setting.

4. **Obesity:** Improve life choices of obese persons to reduce chronic side effects impacting the health of the population.

5. **Preventative Care and Services for the Aging:** Improve the healthy life span of the elderly patient and reduce the need for acute intervention

The activities addressing these community health needs during 2018 are outlined below:

Priority 1: Access to Care Including Primary Care and Specialists

Goal: To improve access to care for uninsured or underinsured population.

Mission Regional Medical Center is located in Hidalgo County, one of the most medically underserved counties in the nation. According to the Robert Wood Johnson Foundation, the county has one primary care physician per 2,220 people, which is nearly double the national ratio of 1,325 to 1. Adding to the lack of access is a high 31% uninsured rate, and the absence of a comprehensive public transportation system which hinders patients accessing preventive and follow-up medical care. The result is that significant numbers of residents experience serious negative health outcomes.

Mission Regional Medical Center has undertaken several initiatives to increase access to both both primary and specialist care. Among these efforts in 2019 were coordination with Help America to enroll more than 4,500 patients in Medicaid and other services to cover medical expenses. Additionally, in 2019 the hospital began providing a list of Federally Qualified Health Centers (FQHC) and the services each provides to patients served through the Emergency Department. Discussions also started with a FQHC on establishing an “after-hours” clinic to provide non-emergent care for uninsured patients who would normally be admitted through the Emergency Department. Finally, in 2019 MRMC began developing the infrastructure to provide telehealth services to help non-acute patients access care they are currently unable to receive due to the lack of public transportation.

Coordination with community partners is essential to the continued expansion of access to primary care and early intervention by specialists in our medically underserved region. Mission

Regional Medical Center remains committed to these efforts to head off more serious health outcomes for our population.

Priority 2: Chronic Disease

Goal: Improved the health of population with chronic diseases and related complications.

The historical lack of access to primary and specialty care in the region has contributed to high rates of diabetes and obesity which, in turn, trigger other serious chronic diseases. These conditions include kidney disease, heart and circulatory problems, and pressure on the heart and lungs that cause other chronic ailments including congestive heart failure, shortness of breath, and other respiratory issues.

In order to assist those already affected by chronic disease, in 2019 Mission Regional Medical Center initiated new educational and support services to targeted groups, such as Better Breathers for those with respiratory problems and a Congestive Heart Failure support and education group.

Another strategy, aimed at providing those with chronic disease improved regular monitoring of their condition, as well as identifying those at risk for chronic conditions, are wellness screenings offered to the general public upon request. The wellness screenings consist of basic men's and women's laboratory panels that patients can take to their primary care physician or specialist for interpretation and consideration in managing their care. In 2019, the MRMC Laboratory performed 13,463 wellness screenings, a 14% increase over 2018.

Priority 3: Health knowledge and education

Goal: Improve the overall knowledge level of the population toward general health to reduce episodes of care in a hospital setting.

Community health education is essential to positively influence the health behavior of individuals and their communities, as well as to advance improvements in the social determinants of health at home, in the workplace, and in the community. Mission Regional Medical Center utilizes several means to advance health knowledge and education in the City of Mission and surrounding communities, including the offering of educational seminars, coordination with strategic partner agencies, and outreach through larger scale community events.

In 2019 Mission Regional Medical Center provided seminars on a range of topics. Monthly CPR training sessions were offered to the community, resulting in 83 people being certified. Dr. Mario del Pino provided monthly weight loss seminars to the general public, while diabetes education was provided in the community through a partnership with Texas A&M University's School of Public Health. The month of October focused on breast cancer awareness and early detection, including the involvement of thousands in the Rio Grande Valley's largest "pink" event, the 10th Annual Mission Pink Run, in partnership with the American Cancer Society. The

year also saw the formation of a Senior Panel to develop and promote a series of educational seminars of interest to older members of the community in 2020.

The promotion of widespread health knowledge and education requires partnerships with significant stakeholders, a role that Mission Regional Medical Center gladly embraces on behalf of the community it serves. Leading examples of this commitment in 2019 were the annual Mission Community Health Fair held in January in partnership with the Greater Mission Chamber of Commerce, and the August 2019 health fair for school district and city employees in partnership with the Mission Consolidated Independent School District (Mission CISD) and the City of Mission.

Priority 4: Obesity and Healthy Nutrition

Goal: Improve life choices of obese persons to reduce chronic side effects impacting the health of the population.

A leading cause of the region's poor health outcomes is the high incidence of obesity, estimated at over one-third of the adult population in Hidalgo County by the Robert Wood Johnson Foundation. As noted in the Priority Area on Chronic Disease, Mission Regional Medical Center has implemented several strategies to assist those affected by conditions where obesity plays a major factor. In addition to these strategies, the hospital is also committed to preventing the onset of adult obesity through the promotion of healthy nutrition and the importance of exercise.

Under the leadership of our Director of Food Services, who is a licensed registered dietitian, Mission Regional Medical Center has initiated joint planning with Mission CISD to implement health food policies within the school district and thereby ensure that the school district's nearly 16,000 students receive good nutrition. Additionally, the Food Services department participates actively in all community health fairs and other events to promote information to the general public about making healthy nutrition choices in their daily life.

Priority 5: Preventative Care and Elderly

While the median age in Hidalgo County is fairly young, we have a growing senior population, which grows significantly in the winter months thanks to the thousands of "Winter Texans" from throughout the United States and Canada who make Mission their home for several months. In addition to special outreach programs targeting RV parks where many Winter Texans reside and through community events to reach permanent senior residents, Mission Regional Medical Center is on track to create a Senior Services Department to provide in-patient and out-patient experiences aligned with the specific needs of seniors.

As a first step, in 2019 Mission Regional Medical Center applied to the American College of Emergency Physicians for Geriatric Emergency Department Accreditation, and was notified in early 2020 of its accreditation, making it the only hospital south of San Antonio to earn this honor. Already in place is a pharmacist who is available to assist all seniors served by the

hospital with review and reconciliation of their medications and provide guidance on potential side effects. With the added input of an advisory Senior Panel of community members created in 2019, the hospital will continue implementing additional services to ensure that seniors have a seamless experience from admission to discharge that is tailored to their needs, eventually leading to the creation of a dedicated Senior Services Department.

Current Goals

In 2019, MRMC conducted a new Community Health Needs Assessment (CHNA). This CHNA is the most recent report to measure community input and relevant health data from the hospital, county, state, the community and national sources to assess the health status of the community and determine its needs based on multiple variables.

Five significant community health needs were identified by assessing the issues from the health data findings combined with the frequency and severity of mentions in community input. The CHNA Team later participated in a roundtable discussion to rank the community health needs based on three characteristics: prevalence of the issue, effectiveness of interventions and the hospital's capacity to address the need. Once this prioritization process was complete, the CHNA Team discussed the results and elected to address the following needs in various capacities through hospital-specific implementation plans and partnerships.

The prioritized needs are:
1. **Access to Care including Primary Care and Specialists:** To improve access to care for uninsured or underinsured population.
2. **Chronic Disease:** To improve the health of population with chronic diseases and related complications.
3. **Health Knowledge and Education:** To improve the overall knowledge level of the population toward general health to reduce episodes of care in a hospital setting.
4. **Obesity and Healthy Nutrition:** To improve life choices of obese persons to reduce chronic side effects impacting the health of the population.
5. **Preventative Care and Services for the Aging:** Improve the healthy life span of the elderly patient and reduce the need for acute intervention in the Emergency Department setting.

Mission Regional Medical Center in collaboration, engagement and partnership with our communities, will address these priorities with a specific focus on health and wellness, and disease prevention.

Maternity Outreach Clinic

Mission Regional Medical Center's Maternity Outreach Clinic provides early and continuous prenatal care to underserved women who don't have the resources needed to obtain medical treatment. Staffed by nurses and medical assistants, an estimated 1,527 patients were seen in 2019 at the clinic. While in 2018, an estimated of 2,050 patients were seen.

Services provided at the clinic include:

- Prenatal care
- Laboratory and ultrasound testing
- Instruction on normal physical change and common discomforts
- Symptoms to look for during pregnancy that should be reported to the clinic team
- Nutritional information and counseling
- Prenatal vitamins
- Easy access to many specialty services
- Assistance with referrals for smoking cessations, WIC or addiction counseling

Over the years, the clinic has made a tremendous difference in our community by bringing care to pregnant women who otherwise wouldn't get any medical attention. Running the clinic- including human resources and repairs- is expensive but bringing healthy babies to the world is priceless.

Hospital Education Community Benefits

Mission Regional Medical Center actively engages in a broad array of educational programs, many which are designed to serve healthcare professionals, colleges with health field programs and the community.

MRMC is an American Heart Association Training Center. It is a contracted provider for Life Support classes such as CPR with AED certification, Advanced Cardiac Life Support -ACLS, and Pediatric Advanced Life Support-PALS.

In order to meet the needs of our student population wishing to enter the Nursing, Medical and Allied Health fields of study, we offer CPR classes. In following our Mission & Vision for MRMC to "Educate the Community" the education department provides the students with a discount of $30.00 and the public $40.00 to take these classes here in our facility.

As a community based hospital, we also host and place up to 400 students in clinical areas rotations for courses such as Nursing (LVN, Associate Degree in Nursing, and Bachelors Degree in Nursing), Ultrasonography, Health Information Management, Imaging, Cardiopulmonary, Pharmacy, Laboratory, Physical Therapy, and Pharmacy.

Our employees receive many educational programs at no cost, making them well versed and educated in their areas of specialty.

Such courses and programs are CPR, ACLS, PALS, Cardiac Rhythm Class, Neonatal Resuscitation, and other online continuing education specific to all areas of healthcare in the hospital field.

June 2019 American Heart Assoc. Heart Saver class for the Junior Volunteers.

Emergency Department staff participates in annual Safety Fairs where car seats and bicycle helmets are issued out to the public along with safety awareness educational sessions.

Our online educational courses are through Healthstream and which offer hundreds of healthcare topics and certification preparation courses. With these programs the Evidence Based Best Practice concept of healthcare delivery can continue here at MRMC.

3/29/2019 Educators participated in the La Joya School Career fair for Seniors out information on Healthcare careers and promoting Mission Regional Medical Center.

October 2019 Assisted with the Halloween Safety Fair for the community.

November 2019 Educators participate at community health fairs administering flu shots to the public and City of Mission employees.

2019 American Heart Association Classes & Attendance

ACLS Class Date	Number of Attendees
1/22/19	4
2/15/2019	5
3/23/19	7
4/17/19	6
4/24/2019	5
6/8/2019	8
6/22/19	8
7/20/2019	6
8/17/2019	7
9/28/2019	7
10/26/19	6
12/15/2019	9
Totals	78

BLS Class Date	Number of Attendees
1/12/19	9
1/19/19	8
2/16/19	11
4/13/19	9
5/11/19	8
6/28/19	9
7/27/19	8
8/24/19	6
9/21/19	4
10/19/19	5
11/23/19	9
Total	88

PALS Class Date	Number of Attendees
2/14/19	3
3/30/19	6
4/27/19	6
7/22/19	6
9/29/19	5
11/24/19	7
Totals	**33**

EKG Class	Number of Attendees
1/25/19	6
2/22/19	5
3/28/19	6
5/28/19	5
8/22/19	8
10/30/19	14
Totals	**44**

MRMC 2019 Student Clinical Rotations

School & Program	# of Students	Unit/Dept
College of Health Care Professionals - Diagnositic Medical Sonography	2	Ultrasound
College of Health Care Professionals - Radiologic Technologist Program	2	Imaging
Concorde Career Colleges: PTA Program	1	5T-RehabCare
Elite Medical Training Solutions	43	ED
Laredo Community Colloge - OTA Program	2	5T-RehabCare
Meridian Institute of Surgical Assisting: Surgical First Assistant	2	Surgery
RGV Careers - ADN	44	Nursing: Womens & Childrens; ICU; 5T-Rehab
RGV Careers - LVN	380	Nursing: 2T Tele; 3S Post Surgical; 3T& 4T Med-Tele; Women's & Children's Services
RGV - Pharmacy Tech	1	Pharmacy
Roseman University: Pharmacy Program	1	Pharmacy
Sharyland ISD: Pioneer High School Health Science Clinicals - CCMA Program	28	Hospital Wide
STC - ADN	360	Nursing: ED; ICU; 2T- Intermediate; 3T Med-Tele; 4T Med-Tele; Women's & Childrens
STC - Computed Tomography	5	CT
STC - LVN	55	Nursing: 2T - Tele, 5T Rehab
STC - Occupation Assistant Program	4	5T-RehabCare
STC - PTCA Program	5	Nursing: 3T & 4T med-Tele, Outpatient Lab
STC - Pharmacy Tech	3	Pharmacy
STC - Phlebotomy	5	Lab
STC - Radiology Program	12	Imaging
STC - Radiololgy DMS Program	3	Imaging

STC - Respiratory Therapy	18	CP
STC Mission Veterans HighSchool - PTCA	13	Lab, Imaging & Nursing Units
Texas A&M - Pharmacy	4	Pharmacy
Texas Southmost College - Medical Laboratory Program	3	Lab
University of Texas - Pharmacy	4	Pharmacy
UTRGV - BSN	32	Nursing: 3T & 4T Med-Tele
UTRGV - CLS	4	Lab
University of St. Augustine for Health Services: PT/OT	1	5T-RehabCare
University of St. Augustine for Health Services: Communication Sciences & Disorders (COMD)	1	SLP - Hospital Wide
TOTAL Students	**1036**	

Hospital Education January 2019-December 2019

BLS Provider Classes 88 attendees x ($30.00 per hour x 4 hours) Instructor: 11 Classes x $200/class: BLS Online Access Keys 114 x $21.00 BLS ecards 202 x $2.40 BLS supplies 325.00	$10,560.00 $2,200.00 $2,394.00 $484.40 $325.00
ACLS classes 78 attendees x ($30.00 per hour x 8 hours) Instructor: 13 classes x $300 per class ACLS Online Access Keys 12 x $103 ACLS ecards 90 x $ 5.40 ACLS supplies $300.00	$18,72000 $3,900.00 $1,236.00 $486.00 $300.00
PALS Classes 42 attendees x ($30.00 per hour x 8 hours) Instructor: 8 classes x $300 per class PALS Online Access Keys 16 x $114 PALS ecards 58 x $ 5.40 PALS supplies $300.00	$10,080.00 $2,400.00 $1,824.00 $313.00 $300.00
EKG Classes 44 attendees x ($30.00 per hour x 6 hours)	$ 7,920.00

COMMUNITY OUTREACH

Mission Regional Medical Center goes beyond its walls providing healthcare expertise to the community it serves. Medical and allied staff reach out to inform and educate residents on a variety of health topics. The outreach is in keeping with the hospital Mission: To improve the health of the community we serve.

Annual Mission Community Health Fair

The annual community health fair ensures the community has access to healthcare screenings they may not have otherwise. Through these screenings, the community is able to find and treat any medical issues early on.

Hundreds of people gathered to receive free health screenings at the Mission Event Center for the for the 25th Annual Mission Community Health Care

Halloween Safety Fair

MRMC's Halloween safety fair attracts thousands of people from the Mission community each year to learn safety tips from the Mission Fire and Police Department. Parents and children also get to enjoy dressing up and learning how to make their Halloween night a safe and candy-filled one.

Thousands gathered at the Halloween Safety Fair where attendees were treated to snacks, candy, music and safety tips.

Mission Pink

Mission Regional Medical Center hosts an Annual Mission Pink 5 K Walk/Run for Breast Care Awareness in October. An estimated 3,000 people participate in Mission Pink. The purpose of the walk is to remind women of the importance of mammograms and early detection.

Walkers and runners take off at the 10th Annual Mission Pink Walk/Run for Breast Cancer Awareness at Mission Regional Medical Center.

Infant Care Seat Program

Parents around the Mission community are able to join the Infant Care Seat program to learn safety tips for their infant children while riding in a car. Parents are also provided a car seat for attending.

Winter Texans

Every October, the Rio Grande Valley becomes the temporary home to thousands of people from the northers parts of the country who migrate to areas with warmer climates during the winter months. They are warmly called “Winter Texans”.

Mission Regional Medical Center has been serving our Winter Texans for as long as they’ve been visiting the Rio Grande Valley. Our Marketing and Business Development Team coordinates health presentations, health screenings, flu shots, as well as educational presentations and interactive discussions with local physicians at community meetings.

Community Partnerships

Year after year, we have the privilege of working with our community partners to build a healthier community. MRMC has formed invaluable partnerships with many organizations throughout the area we serve. Our partners include:

City of Mission

We provide clinical screenings at their health fairs and educational seminars on worksite wellness, breast cancer, heart disease, kidney health, diabetes, nutrition, blood pressure, cholesterol and exercise. We also support the City with various projects for the good of the community. Every year, a team of MRMC employees volunteer to help clean up part of the city during the annual Trash Bash.

Mission Consolidated Independent School District

We provide health and wellness information to the faculty and staff. We support their health Occupations Students of America (HOSA) program.

Mission Chamber of Commerce

We coordinate and support events with the Mission Chamber of Commerce including the Annual Community Health Fair, Winter Texan Fiesta, and Buenas Tardes Luncheon.

Leadership Mission

MRMC sponsors employee participation in the Community Leadership Development Program and hosts one of the required meetings at our hospital.

Philippine Nurses Association

We support the Philippine Nurses Association in several community projects to enhance their profession and collegiality.

United Blood Services

MRMC donates and helps encourage blood donations to United Blood services throughout the year.

Mission Boys & Girls Club

We make financial donations for programs and operations to this important community resource.

Mission Police Department

MRMC supports our local police department in various activities throughout the year, including collecting toys around Christmas time and community neighborhood watch projects.

Community Speakers Bureau

MRMC Mammographers speak at various community events on breast cancer and early detection.

Mayor's International Brunch

The Mayor of Mission coordinates the Mayor's International Brunch to foster goodwill with our neighbors to the South- Mexico. This is part of our US Sister City Program. MRMC attends and supports the brunch and its goodwill efforts.

South Texas Community College

MRMC hospital staff helps as adjunct faculty at South Texas Community College to educate future healthcare professionals.

Part 1

ANNUAL STATEMENT OF COMMUNITY BENEFITS STANDARD 2019 TEXAS NONPROFIT HOSPITALS

Part I

Please Check "one" your ownership: *

(x) Not-For-Profit

( ) For-Profit (received Medicaid Disproportionate Share Funds)

( ) Public

( ) For-Profit

Are you reporting as part of a hospital system? ( ) Yes (x) No

III HOSPITAL SYSTEMS - List all the hospitals included in this system report. Refer to the instructions on the back of this page in completing this section.

III	Community Benefits Contribution*	Net Patient Revenue (NPR)**	Miles From System Office	Name of Hospital	Physical Address, City, State, Zip
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
TOTAL:					

* The sum of these contributions should equal the entry in II.E (Section II follows Worksheet 5).

** The sum of net patient revenue should equal the entry in STDI1 (Standards Section follows Section II).

ESTIMATED UNREIMBURSED COSTS OF INPATIENT AND OUTPATIENT CHARITY CARE PROVIDED - 2019

Total Billed Charges for Charity Care Provided (based on 2019 audited fiscal year): (exclude bad debt)

.

W1A.	**Financially Indigent**	**Medically Indigent**	**Total Charity Care Charges**
Inpatient	39,061,019	0	39,061,019
Outpatient	35,899,831	0	35,899,831
Total	74,960,850	0	(a) 74,960,850

Cost to Charge Ratio Calculation (based on 2018 audited fiscal year):

W1B1. **2018** Gross Patient Service Revenue1, 2;..... (b) 724,174,335

W1B2. **2018** Total Patient Care Operating Expenses1,3.....(**Bad Debt should be treated as a Deduction**) ..... (c) 102,105,908

W1B3. **Cost to Charge Ratio (Divide (c) by (b)) (please report the ratio as a decimal 0.0000)**
*****THIS IS A PRE-CALCULATED FIELD.** (d) 0.141

W1C. **Estimated Costs of Charity Care Provided ((a) x (d))** ..... (e) 10,569,479

Payments Received for Charity Care Provided: (based on 2019 audited fiscal year)

W1D1. Third-Party Payments..... 228,756

W1D2. Payments from Patients..... 1,874,584

W1D3. Other Payments (4) (Public hospitals report tax appropriations relative to charity care here) 0

W1D4. **Total Payments Received for Charity Care Provided**.....
*****THIS IS A PRE-CALCULATED FIELD.** (f) 2,103,340

W1E. **Estimated Unreimbursed Costs of Charity Care Provided ((e) - (f))5**..... * (g) 8,466,139

1 Use audited data for FY 2018 to complete the Cost to Charge Ratio Calculation section of this worksheet for FY 2019.

2 Gross Patient Service Revenue excludes Medicaid Disproportionate Share Hospital payments.

3 Total Patient Care Operating Expenses -**(Bad Debt should be treated as a deduction) excludes contractual adjustments.**

4 Do not include charitable contributions and grants received by the hospital.

5 Report zero (0) in (g) if total estimated costs of charity care provided (e) minus total payments (f) is a negative value.

***Please take a brief second to fill out the four question feedback survey in the link below.**

https://tcnws.co1.qualtrics.com/jfe/form/SV_0lENJ4LgFt35DDv

CALCULATION OF THE RATIO OF COST TO CHARGE - 2018

C alculation of initial Ratio of Cost to Charge

W1AA1. Total Patient Revenues (from **2018** Medicare Cost Report1, Worksheet G-3, Line 1) (a) 724,174,335

W1AA2. Total Operating Expenses (from **2018)** Medicare Cost Report1, Worksheet A, Line 118, Col. 7 (b) 96,298,509

W1AA3. **Initial Ratio of Cost to Charge ((b) divided by (a))**
*****THIS IS A PRE-CALCULATED FIELD.** (c) 0.133

Application of Initial Ratio of Cost to Charge to 2019 Bad-Debt Expense

W1AB1. Bad-Debt Expense2 (from **2019** audited financial statement covering your reporting period) (d) 72,913,579

W1AB2. Multiply "Bad-Debt Expense" by "Initial Cost to Charge Ratio" to determine allowable Bad-Debt Expense ((d) x (c))
*****THIS IS A PRE-CALCULATED FIELD.** (e) 9,697,506

W1AB3. **Add the allowable "Bad-Debt Expense" to " Total Operating Expenses" ((b) + (e))**
*****THIS IS A PRE-CALCULATED FIELD.** (f) 105,996,015

W1AC. **Calculation of Ratio of Cost to Charge ((f) divided by (a)) (Please report the ratio as a decimal)** (g) 0.1464

NOTE:This is Worksheet 1-A from the 1994 Annual Statement of Community Benefits Standard form.

1. Use the **PRIOR** year cost report regardless of status of review. For example, use Medicare Cost Report data for FY 2018 to complete the calculation of initial Ratio of Cost to Charge section of this worksheet.

2. Bad debt expense is defined as the provision for actual or expected uncollectibles resulting from the extension of credit.

Additional cost areas that are not reflected in the above calculations may be identified on the back of this form. Do not include these costs in worksheet computations.

Worksheet 1-A (continued)

Cost Area	Medicare Cost Report Reference*	**Amount**

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY.
To navigate the worksheet pages of the Annual Statement of community benefits standards for Texas non profit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.

Support to Financially Indigent Patients Provided Through Others 2019

Funding to: W2A

W2A.	Other Nonprofit	Public	Total
Outpatient Clinic	0	0	0
Hospital	0	0	0
Other Health Care Organizations	0	705,692	705,692
Total Funding to Others	0	705,692	705,692

Financial Support to:

W2B.

W2B	Other Nonprofit	Public	Total
Outpatient Clinic	0	0	0
Hospital	0	0	0
Other Health Care Organizations	0	0	0
Total Other Financial Support	0	0	0

.

W2C.	Other Nonprofit	Public	Total
Total Support Provided Through Others:	0	705,692	705,692

W2D. **Less: Payments allocated** (c) 0

W2E. **Total Unreimbursed Support Provided Through Others ((a.3. + b.3.) - (c))** (d) 705,692

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY. DO NOT LEAVE ANY SECTION BLANK, REPORT ZERO (0).

To navigate the worksheet pages of the Annual Statement of community benefits standards for Texas non profit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.

ESTIMATED UNREIMBURSED COSTS OF GOVERNMENT-SPONSORED INDIGENT HEALTH CARE - 2019

Worksheet 3

Billed Charges for Government-sponsored Indigent Health Care Provided:(Do not include Medicare or Non-government charges.)

W3A.	**Inpatient**	**Outpatient**	**Total**
Medicaid(include Medicaid Managed Care charges; exclude Medicaid Disproportionate Share AND 1115 WAIVER PAYMENTS payments)	130,243,332	78,703,853	208,947,185
State Government (CSHCN, Primary Care, Kidney Health, etc.)	3,301,413	3,457,490	6,758,903
Local Government (County Indigent Health Care, other)	0	0	0
Other Government	0	0	0
Total Billed Charges	133,544,745	82,161,343	215,706,088

W3B1. **Ratio of Cost to Charge (Worksheet 1, Item d)** (Please report the ratio as a decimal) *****THIS IS A PRE-CALCULATED FIELD.** (b) 0.141

W3B2. **Estimated Costs of Government-sponsored Indigent Health Care Provided ((a) x (b)) ***THIS IS A PRE-CALCULATED FIELD.** (c) 30,414,558

Payment Received for Government-sponsored Indigent Health Care Provided:(Do not include Medicare or non-government payments received.)

W3C1. Medicaid (include Medicaid Managed Care payments; exclude Medicaid Disproportionate Share Hospital payments) 25,719,351

W3C2. Medicaid Disproportionate Share Hospital payments 3,390,677

w3c22. Uncompensated Care Payments

8,599,438

W3C3. State Government (CSHCN, Primary Care, Kidney Health, etc.) 488,787

W3C4. Local Government (County Indigent Health Care, other). 0

W3C5. Other Government. **(Include Local Provider Participation Fees (LPPF); Champus Payments and DSRIP should not be reported here; report Champus Payments in Worksheet 4B only)(Champus Payments and DSRIP "SHOULD NOT" be reported here; report "CHAMPUS Payments only in Worksheet 4b.)** 0

W3C5A. Please specify source of Other Government payments

_____

W3C6. **Total Payments ***THIS IS A PRE-CALCULATED FIELD.** (d) 38,198,253

W3D. **Estimated Unreimbursed Costs of Government-sponsored Indigent Health Care ((c) - (d))1** 0

(e)

(1) Report zero (0) in (e) if estimated costs of government-sponsored indigent health care provided (c) minus total payments (d) is a negative value.

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY. DO NOT LEAVE ANY SECTION BLANK, REPORT ZERO (0).

To navigate the worksheet pages of the Annual Statement of community benefits standards for Texas non profit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.

UNREIMBURSED COSTS OF PROVIDING COMMUNITY BENEFITS -2019

Worksheet 4-A

Unreimbursed Costs of Subsidized Health Services:

W4AA1.	Emergency Care		0
W4AA2.	Trauma Care		0
W4AA3.	Neonatal Intensive Care		0
W4AA4.	Freestanding Community Clinics, e.g., rural health clinics		81,884
W4AA5.	Collaborative effort with local government(s) and/or private agency in preventive medicine, e.g., immunization program		0
W4AA6.	Other Services		0
W4AA7.	**Total** *****THIS IS A PRE-CALCULATED FIELD.**	(a)	81,884
W4AB1.	**Donations Made by the Hospital**	(b)	60,863
W4AB2.	**Unreimbursed Research-Related Costs**	(c)	0

Unreimbursed Education - Related Costs:

W4AC1.	Education of physicians, nurses, technicians and other medical professionals and health care providers	356,224
W4AC2.	Scholarships and funding to medical schools, colleges and universities for health professions education	60,266
W4AC3.	Education of patients concerning diseases and home care in response to community needs	0
W4AC4.	Community health education through informational programs, publications and outreach activities in response to community needs	105,730
W4AC5.	Other educational services	0

W4AC6. **Total**
*****THIS IS A PRE-CALCULATED FIELD.** (d) 522,220

W4AD. **Total Unreimbursed Costs of Providing Community Benefits ((a) + (b) + (c) + (d))**
*****THIS IS A PRE-CALCULATED FIELD***.** (e) 664,967

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY. DO NOT LEAVE ANY SECTION BLANK, REPORT ZERO (0).
To navigate the worksheet pages of the Annual Statement of community benefits standards for Texas non profit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.

EST. UNREIMBURSED COSTS OF INPAT./OUTPAT. MEDICARE, CHAMPUS AND OTHER GOV'T-SPONSORED PROGRAMS - 2019

Worksheet 4-B

Total Billed Charges for Medicare *(INCLUDE MEDICARE MANAGED CARE)*, CHAMPUS, and Other Government (DO NOT REPORT DSRIP)-sponsored

Health Care Provided: (Do not include Medicaid charges or other government charges previously reported on worksheet 3.)

W4BA1.	Inpatient	254,577,965	
W4BA2.	Outpatient	103,169,761	
W4BA3.	**Total Billed Charges ***THIS IS A PRE-CALCULATED FIELD***.**	(a) 357,747,726	
W4BB1.	**Ratio of Cost to Charge (Worksheet 1, Item d) (Please report the ratio as a decimal 0.0000) ***THIS IS A PRE-CALCULATED FIELD***.**		(b) 0.141
W4BB2.	**Estimated Costs of Government-sponsored Health Care Provided (a x b) ***THIS IS A PRE-CALCULATED FIELD***.**		(c) 50,442,429

Payments Received for Care Provided: (Do not include Medicaid payments received.)

W4BC1.	Government Payments	54,790,824	
W4BC2.	Payments from Patients	197,324	
W4BC3.	Other Payments	1,066,825	
W4BC4.	**Total Payments ***THIS IS A PRE-CALCULATED FIELD***.**	(d) 56,054,973	
W4BD.	**Estimated Unreimbursed Costs of Government-sponsored Health Care Provided ((c) - (d))2**		(e) 0

1. Do not include charitable contributions and grants.

2. Report zero (0) in (e) if estimated cost of government-sponsored health care provided (c) minus total payments (d) is a negative value.

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY. DO NOT LEAVE ANY SECTION BLANK, REPORT ZERO (0).
To navigate the worksheet pages of the Annual Statement of community benefits standards for Texas non profit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.

ESTIMATED VALUE OF TAX EXEMPT BENEFITS
2019

Worksheet 5

Franchise Tax:

W5A. The greater of Fund Balance x 0.25 percent (.0025); -OR-

Net Income plus Officers' and Directors' Compensation x 4.5 percent (.045) (a) 878,874

Ad Valorem Taxes

.

	Amount of Taxes
County Property Tax (Appraised Value of Property (Real andPersonal) x Tax Rate)	222,788
School District Tax (Appraised Value of Property x Tax Rate)	601,296
Hospital District Tax (Appraised Value of Property x Tax Rate)	0
Other Property Taxes (Appraised Value of Property x Tax Rate)	223,276

W5B5. **Total Estimated Ad Valorem Taxes** (b) 1,047,360

Sales Tax

W5C1. Supplies expense less pharmacy supplies expense 10,247,686

W5C2. Lease or rental expense 807,745

W5C3. Capital Purchases 3,906,015

W5C4. Total Estimated Taxable Purchases (1) 14,961,446

W5C5. Sales Tax Rate.....(**Please report RATE (.0000), not a percent**) (2) 0.0875

W5C6. **Total Estimated Sales Tax (Multiply (1) by (2)) ***THIS IS A PRE-CALCULATED FIELD.** (c) 1,309,126

Contributions

W5D1. Nondesignated and Charitable Cash Donations received by the hospital 7,228

W5D2. Fair Market Value of Nondesignated and Charitable In-Kind Donations 0

W5D3. **Total Contributions** (d) 7,228

Tax-Exempt Bond Financing

W5E1. Average Outstanding Bond Principal x Prevailing Interest Rate at Time of Issuance (1) 0

W5E2. Actual Interest Expense for the Reporting Period (2) 0

W5E3. Value of Tax-Exempt Bond Financing ((1) - (2)) (e) 0

W5F. **TOTAL ESTIMATED VALUE OF TAX EXEMPT BENEFITS ((a)+(b)+(c)+(d)+(e))** (f) 3,242,588

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY. DO NOT LEAVE ANY SECTION BLANK, REPORT ZERO (0).
To navigate the worksheet pages of the Annual Statement of community benefits standards for Texas non profit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.

II. CHARITY CARE, GOVERNMENT-SPONSORED INDIGENT HEALTH CARE, AND OTHER COMMUNITY BENEFITS INFORMATION - 2019

IIA. Unreimbursed costs of charity care

	Hospital	System Total
IIA1. Unreimbursed costs of providing care to financially and medically indigent (Worksheet 1, (g))	8,466,139	
IIA2. Support to financially indigent patients provided through others (Worksheet 2, (d))	705,692	
IIA3. Unreimbursed costs of charity care (A.1. + A.2.)	9,171,831	
IIB. Unreimbursed costs of providing Government-sponsored Indigent Health Care (Worksheet 3, (e))	0	
IIC. Total Charity Care and Government-sponsored Indigent Health Care (A.3. + B.)	9,171,831	
IID. Unreimbursed costs of providing Other Community Benefits (Worksheets 4-A, (e) + 4-B, (e))	664,967	
IIE. Total Charity Care, Government-sponsored Indigent Health Care, and Other Community Benefits (C. + D.)	9,836,798	

If you're reporting as a system, please provide system aggregate data for sections I, II, and III

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY.DO NOT LEAVE ANY SECTION BLANK, REPORT ZERO (0).
To navigate the worksheet pages of the Annual Statement of community benefits standards for Texas non profit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.

STD **STANDARDS - Please check the appropriate box (A, B or C) below and provide the requested information.**

TaxID. Taxpayer Number: 74-2206635

		Hospital	System
STDI1.	Net Patient Revenue (include Medicaid Disproportionate Share Hospital payments):**(exclude DSRIP= the incentive payments from "Net Patient Revenue) TREAT BAD DEBT AS A DEDUCTION FROM NET REVENUE**	119,169,436	

STDI2. The hospital has been designated as a**disproportionate share hospital** under the state Medicaid program in the period covered by this report (2014) or in either of its two previous fiscal years. Completion of section I-3. or I-4. is not required.

I-2
[x]

I3. STANDARDS - Please check the appopriate box (A, B, or C) below and provide the requested information.

A. Charity care and government-sponsored indigent health care are provided at a level which is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital, and the tax-exempt benefits received by the hospital.

A.[ ]

		Hospital
STDI3A1.	Tax exempt benefits (Worksheet 5)	
STDI3A2.	Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year	

B. Charity care and government-sponsored indigent health care are provided in an amount equal to at least 100 percent of the hospital's tax-exempt benefits, excluding federal income tax. (Standard B is met if B.4. is greater than or equal to B.3.)

[ ] B.

		Hospital	System
STDI3B1.	Tax-exempt benefits (Worksheet 5)		
STDI3B2.	Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year		
STDI3B3.	Total of B.1. and B.2. above		
STDI3B4.	Enter the total from item II.C		

C. Charity care and community benefits are provided in a combined amount equal to at least five (5) percent of the hospital s net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least four (4) percent of net patient revenue. (Standard C is met if C.4. is greater than or equal to C.3. and C.8. is greater than or equal to C.7.)

C.[ ]

	Hospital	System
STDI3C1. Multiply Net Patient Revenue (I-1.) by 5%		
STDI3C2. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year		
STDI3C3. Total of C.1. and C.2. above		
STDI3C4. Enter the amount recorded in item II.E.		
STDI3C5. Multiply Net Patient revenue (I-1.) by 4%		
STDI3C6. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year		
STDI3C7. Total of C.5. and C.6. above		
STDI3C8. Enter the amount recorded in item II.C.		

I4. Check this box if your hospital **did not meet** any of the standards in sections I-3. Please attach explanatory information.

[ ] I-4

I5. Certification Contact Information - Annual Statement of Community Benefits
*

Coordinator Name	Coordinator Title	Phone	Fax	Electronic/internet Mail address
Trish Van Matre	Controller	(956) 323-1025	(956) 323-1030	pvanmatre@primehealthcare.com

If you're reporting as a system, please provide system aggregate data

****

Part 2

Texas Nonprofit Hospitals*
Part II

Summary of Current Charity Care Policy and Community Benefits for Inclusion in DHSH Charity Care Manual as Required by Texas Health and Safety Code, 311.0461** 2019

Name of Hospital:	Mission Regional Medical Center
County:	Hidalgo
Mailing Address:	900 S. Bryan Road, Mission, Texas 78572
Physical Address if different from above:	_____
Effective Date of the current policy:	01/01/2019 (mm/dd/yyyy)
Date of Scheduled Revision of this policy:	12/31/2020 (mm/dd/yyyy)
How often do you revise your charity care policy?	Reviewed annually, revised as needed

Provide the following information on the office and contact person(s) processing requests for charity care.

Name of the office/department:	Patient Access
Mailing Address:	900 S. Bryan Road, Mission, Texas 78572
Contact Person:	Lupe Bautista
Title:	Patient Access Director
Phone:	(956) 323-1804
Fax:	(956) 323-1817
E-Mail: *	mbautista6@primehealthcare.com

Person completing this form if different from above:

Name: Trish Van Matre

Phone: (956) 323-1025

*This summary form is to be completed by each nonprofit hospital. Hospitals in a system must report on an individual hospital basis. Public hospitals, for-profit hospitals participating in the Medicaid disproportionate share hospital program and exempt hospitals are not required to complete this form. This form is also available in PDF format at DSHS web site: www.dshs.state.tx.us/chs/hosp under 2019 Annual Statement of Community Benefits Standard.

This information will be made available for public use. Please report most current information on the charity care policy and community benefits provided by the hospital.

I. Charity Care Policy:

1. Include your hospital's Charity Care Mission statement in the space below.

Mission Regional Medical Center (MRMC) provides care to individuals regardless of their ability to pay. The level of charity is determined in accordance with the attached Charity Care Policy.

2. Provide the following information regarding your hospital's current charity care policy.

a. Provide the definition of **charity care** for your hospital.	
Charity care is provided to those who meet the guidelines set forth in our Charity Care Policy based on financial income, family size and other considerations.	

b. What percentage of the federal poverty guidelines is financial eligibility based upon?

( ) Less then 100 %
( ) Less then 133 %
( ) Less then 150 %
(x) Less then 200 %
( ) Other, specify _____

c. Is eligibility based upon net or gross income?

( ) Net
(x) Gross

d. Does your hospital have a charity care policy for the Medically indigent?

(x) Yes ( ) No

If yes, provide the definition of the term **Medically Indigent**.

An individual who does not meet the poverty guidelines but has medical bills far exceeding their ability to pay.

e. Does your hospital use an Assets test to determine eligibility for charity care?

( ) Yes (x) No

If yes, please briefly summarize method:

_____

f. Whose income and resources are considered for income and/or assets eligibility determination?

[ ] 1. Single parent and children
[ ] 2. Mother, Father and Children
[x] 3. All family members
[ ] 4. All household members
[ ] 5. Other, please explain _____

g. What is included in your definition of income from the list below? Check all that apply.

[x] 1. Wages and salaries before deductions
[x] 2. Self-employment income
[x] 3. Social security benefits
[x] 4. Pensions and retirement benefits
[x] 5. Unemployment compensation
[x] 6. Strike benefits from union funds
[x] 7. Worker's compensation
[x] 8. Veteran's payments
[x] 9. Public assistance payments
[x] 10. Training stipends
[x] 11. Alimony
[x] 12. Child support
[x] 13. Military family allotments
[x] 14. Income from dividends, interest, rents, royalties
[x] 15. Regular insurance or annuity payments
[x] 16. Income from estates and trusts
[x] 17. Support from an absent family member or someone not living in the household
[x] 18. Lottery winnings
[ ] 19. Other, specify: _____

3. Does application for charity care require completion of a form?

(x) Yes ( ) No

If Yes:

a. **Please send a copy of the charity care application form.**

b. How does a patient request an application form? Check all that apply.

[x] 1. By telephone
[x] 2. In person
[x] 3. Other, please specify: Mail

c. Are charity care application forms available in places other than the hospital? *

(x) Yes ( ) No *

If Yes, please provide the name and address of the place:

Name: Alton Maternity Clinic

Address: 221 W. Dawes Ave., Mission, TX 78573

d. Is the application form available in language(s) other than English? *

(x) Yes ( ) No *

If yes, please check:

[x] Spanish

[ ] Other please specify: _____

4. When evaluating a charity care application:

a. How is the information verified by the hospital?

(x) 1. The hospital independently verifies information with third party evidence (W2, pay stubs)
( ) 2. The hospital uses patient self-declaration
( ) 3. The hospital uses both independent verification and patient self-declaration

b. What documents does your hospital use/require to verify income, expenses, and assets? Check all that apply.

[x] 1. W2-form
[x] 2. Wage and earning statement
[x] 3. Pay check remittance
[x] 4. Worker's compensation
[x] 5. Unemployment compensation determination letters
[x] 6. Income tax returns
[x] 7. Statement from employer
[x] 8. Social security statement of earnings
[x] 9. Bank statements
[x] 10. Copy of checks
[ ] 11. Living expenses
[ ] 12. Long term notes
[x] 13. Copy of bills
[ ] 14. Mortgage statements
[ ] 15. Document of assets
[x] 16. Documents of sources of income
[x] 17. Telephone verification of gross income with the employer
[x] 18. Proof of participation in govt assistance programs such as Medicaid
[x] 19. Signed affidavit or attestation by patient
[ ] 20. Veterans benefit statement
[ ] 21. Other, please specify: _____

5. When is a patient determined to be a charity care patient? Check all that apply.

[x] a. At time of admission
[x] b. During hospital stay
[x] c. At discharge
[x] d. After discharge
[ ] e. Other, please specify _____

6. How much of the bill will your hospital cover under the charity care policy? Check all that apply.

[ ] a. 100%
[x] b. A specified amount/percentage based on the patient's financial situation
[ ] c. A minimum or maximum dollar or percentage amount established by the hospital
[ ] d. Other, please specify _____

7. Is there a charge for processing an application/request for charity care assistance?

( ) Yes (x) No

8. How many days does it take for your hospital to complete the eligibility determination process?

45

9. How long does the eligibility last before the patient will need to reapply?

( ) a. Per admission
( ) b. Less than six months
( ) c. One year
(x) d. Other, specify 30 days

10. How does the hospital notify the patient about their eligibility for charity care? Check all that apply.

[x] a. In person
[x] b. By telephone
[x] c. By correspondence
[ ] d. Other, specify _____

11. Are all services provided by your hospital available to charity care patients?

( ) Yes (x) No

If NO, please list services not covered for charity care patients (e.g. transplant services, ER services, other outpatient services, physician's fees).

Elective procedures

12. Does your hospital pay for charity care services provided at hospitals owned by others?

( ) Yes (x) No

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). If more space is needed, please send additional information in a Word or PDF file. *

Based on information gathered through the 2018 CHNA conducted by MRMC, the following areas were identified as priorities and will be addressed through MRMC's Implementation Strategy for fiscal years 2019-2021. 1. Access to care, including access to primary care and specialists. 2. Chronic disease management (Heart Disease, Stroke, Diabetes, Cancer and Kidney Disease). 3. Lack of health knowledge and education. 4. Mental health and addiction. 5. Nutrition 6. Obesity 7. Preventative Care

Additional Information:

_____

***Please take a brief second to fill out the SIX question feedback survey in the link below.**

CLICK HERE

Appendix A

				Page(s):	**1 of 13**
Subject:	**Financial Assistance Policy (Non-Profit Facilities)**			**Formulated:**	**10/2016**
Manual:	**Patient Financial Services**			**Reviewed:**	**10/2016, 12/2018**
Corporate Board Approval		**Date:**		**Last Revised:**	**12/2018**

I. Policy:

Prime Healthcare nonprofit facilities, including Mission Regional Medical Center (the "Hospital"), offer a financial assistance program for those patients who meet the eligibility tests described below. The intent of this Financial Assistance Policy (the "Policy") is to satisfy the requirements of Section 501(r) of the Internal Revenue Code and Texas Health & Safety Code sections 311.031 to 311.048 and 324.101; all provisions should be interpreted accordingly.

A significant objective of Prime Healthcare nonprofit facilities is to provide care for patients in times of need. Prime Healthcare nonprofit facilities provide charity care and a discounted payment program as a benefit to the communities we serve as not-for-profit hospitals. To this end, Prime Healthcare nonprofit facilities are committed to assisting low-income and/or uninsured eligible patients with appropriate discount payment and charity care programs. All patients will be treated fairly, with compassion and respect. Notwithstanding anything else in this Policy, no individual who is determined to be eligible for financial assistance will be charged more for emergency or other medically necessary care than the Amounts Generally Billed to individuals who have insurance covering such care.

Financial assistance policies must balance a patient's need for financial assistance with the Hospital's broader fiscal stewardship. Financial assistance through discount payment and charity care programs is not a substitute for personal responsibility. It is the patients' responsibility to actively participate in the financial assistance screening process and where applicable, contribute to the cost of their care based upon their ability to pay. Outside debt collection agencies and the Hospital's internal collection practices will reflect the mission and vision of the Hospital.

This Policy applies to all emergency and other medically necessary care provided by the Hospital or a substantially-related entity working in the Hospital. This Policy applies only to charges for Hospital services and is not binding upon other providers of medical services who are not employed or contracted by Hospital to provide medical services, including physicians who treat Hospital patients on an emergency, inpatient or outpatient basis. A list of providers that deliver care in the hospital is available at www.missionrmc.org. This list specifies which providers are and are not covered by this Policy. Physicians not covered by this Policy who provide services to patients who are uninsured or cannot pay their medical bills due to high medical costs may have their own financial assistance policies to provide assistance.

II. Definitions:

"Amounts Generally Billed": The amounts generally billed ("AGB") for emergency or other medically necessary services to individuals eligible for the discounted payment program. The Hospital calculates the AGB for a patient using the prospective method as defined in the Treasury Regulations. Under the

prospective method, AGB is calculated using the billing and coding process the Hospital would use if the individual were a Medicare fee-for-service beneficiary using the currently applicable Medicare rates provided by the Centers for Medicare & Medicaid Services.

"Emergency and Medically Necessary": Any hospital emergency, inpatient, outpatient, or emergency medical care that is not entirely elective for patient comfort and/or convenience.

"Extraordinary Collection Actions": An Extraordinary Collection Action means any collection action involving certain sales of debt to another party, reporting adverse information to credit agencies or bureaus, or deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under the hospital's Financial Assistance Policy, or any action requiring a legal or judicial process, including placing a lien, foreclosing on real property, attaching or seizing of bank accounts or other personal property, commencing a civil action against an individual, taking actions that cause an individual's arrest, taking actions that cause an individual to be subject to body attachment, and garnishing wages, in each case as further described in Treasury Regulations Section 1.501(r)-6.

"Family": (1) for persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and (2) for persons under 18 years of age, parent, caretaker, relatives, and other children under 21 years of age of the parent or caretaker relative.

"Financially indigent": A financial indigent patient is a person who is uninsured or underinsured and is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the Hospital's eligibility criteria set forth in this policy.

"Medically Indigent": A medically indigent patient is a person whose medical or hospital bills, after payment by third-party payors, exceed a specified percentage of the patient's annual gross income, determined in accordance with the Hospital's eligibility criteria set forth in this policy, and the person is financially unable to pay the remaining bill.

"Plain Language Summary": The summary of the Financial Assistance Policy attached hereto as Exhibit 2, intended to comply with Treasury Regulations Section 1.501(r)-1(b)(24).

III. Procedure:

1. Eligibility for Financial Assistance

A. Self-Pay Patients

A patient qualifies for **charity care** as described in Section (III)2 below if all of the following conditions are met: (1) the patient does not have third party coverage from a health insurer, health care service plan, union trust plan, Medicare, or Medicaid, or is underinsured, as determined and documented by the hospital; (2) the patient's injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital; (3) the income of the Patient's Family does not exceed two hundred percent (200%) of the

current Federal Poverty Level; **and** (4) the patient has monetary assets of less than ten thousand dollars ($10,000.00).

A patient qualifies for the **discounted payment program** if all of the following conditions are met: (1) the income of the Patient's Family is greater than two hundred percent (200%) but less than four hundred percent (400%) of the current Federal Poverty Level; (2) the patient has monetary assets of less than ten thousand dollars ($10,000.00); **and** (3) the patient has out-of-pocket medical expenses in the prior twelve (12) months (whether incurred or paid in or out of any hospital) exceeding ten percent (10%) of Family income.

B. Insured Patients

A patient who has third party coverage or whose injury is a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital does not qualify for charity care, but may qualify for the discounted payment program if he or she (i) has a Family income greater than two hundred percent (200%) but less than four hundred percent (400%) of the current Federal Poverty Level; and (ii) has out-of-pocket medical expenses in the prior twelve (12) months (whether incurred or paid in or out of any hospital) exceeding ten percent (10%) of Family income. If eligible, the Medically Indigent patient's payment obligation will be an amount equal to the difference between what the Hospital receives from the insurance carrier and the Discounted Payment Maximum. If the amount paid by insurance exceeds the Discounted Payment Maximum, the patient will have no further payment obligation.

C. Other Circumstances

The Director of the Hospital's Patient Financial Services, (PFS) Department shall also have the discretion to extend charity care or the discounted payment program to patients under the following circumstances:

(i) The patient qualifies for limited benefits under the state's Medicaid program, i.e., limited pregnancy or emergency benefits, but does not have benefits for other services provided at the Hospital. This includes non-covered services related to:

- Services provided to Medicaid beneficiaries with restricted Medicaid (i.e., patients that may only have pregnancy or emergency benefits, but receive other care from the Hospitals);
- Medicaid pending applications that are not subsequently approved, provided that the application indicates that the patient meets the criteria for charity care;
- Medicaid or other indigent care program denials;
- Charges related to days exceeding a length of stay limit; and
- Any other remaining liability for insurance payments.

(ii) The patient qualifies for a County Indigent Health Care Program but no payment is received by the Hospital.

(iii) Reasonable efforts have been made to locate and contact the patient, such efforts have been unsuccessful, and the PFS Director has reason to believe that the patient would qualify for charity care or the discounted payment program, i.e., homeless.

(iv) A third party collection agency has made efforts to collect the outstanding balance and has recommended to the Hospital's PFS Director that charity care or the discounted payment program be offered.

D. Determination of Family Income

For purposes of determining eligibility for the discounted payment program, documentation of income of the patient's Family shall be limited to recent pay stubs or income tax returns.

In determining a patient's monetary assets, the Hospital shall not consider retirement or deferred compensation plans qualified under the Internal Revenue Code, non-qualified deferred compensation plans, the first ten thousand dollars ($10,000.00) of monetary assets, and fifty percent (50%) of the patient's monetary assets over the first ten thousand dollars ($10,000.00).

E. Federal Poverty Levels

The measure of the Federal Poverty Level shall be made by reference to the most up to date Health and Human Services Poverty Guidelines for the number of persons in the patient's family or household. The Federal Poverty Levels as of 2018 are as follows:

SOURCE: Federal Register, Vol. 83, No. 12, January 18, 2018, pp. 2642-2644

2018 Poverty Guidelines for the 48 Contiguous States and the District of Columbia		
Persons in Family/Household	Poverty Guideline	400% of Poverty Guideline
1	$12,140	$48,560
2	$16,460	$65,840
3	$20,780	$83,120
4	$25,100	$100,400
5	$29,420	$117,680
6	$33,740	$134,960
7	$38,060	$152,240
8	$42,380	$169,520
For families/households with more than 8 persons, see https://aspe.hhs.gov/poverty-guidelines.		

2. Charity Care and Discounted Payment Program

Financial assistance may be granted in the form of full charity care or discounted care, depending upon the patient's level of eligibility as defined in this Policy.

The patient balances for those patients who qualify for charity care, as determined by the Hospital, shall be reduced to a sum equal to zero dollars ($0) with the remaining balance eliminated and classified as charity care.

The patient balances for those patients who qualify for the discounted payment program will be reduced; any discount will be applied against the gross charges for hospital services provided.

Discounted payments will be limited to the highest amount paid by Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or any other government-sponsored health program in which the Hospital participates (the "Discounted Payment Maximum"). The discount payment policy shall also include an interest-free extended payment plan to allow payment of the discounted price over time. The Hospital and the patient shall negotiate the terms of an extended payment plan, taking into consideration the patient's Family income and essential living expenses.

Once a complete financial assistance application is received, the Hospital must make a determination and provide a written notice of the decision and the basis relied on. If the patient is found eligible for assistance, a new billing statement will be sent which indicates how the discounted amount was calculated and states where to find the AGB. The Hospital will refund any amount collected in excess of the revised charges and reverse any Extraordinary Collection Actions that have been initiated. If a financial assistance application is received and is incomplete, the Hospital will provide written notice of the outstanding items and wait a reasonable period of time before initiating or resuming Extraordinary Collection Actions. If a complete application is received within the two hundred forty (240) day application period described below, any Extraordinary Collection Actions will be suspended while a determination of eligibility is made.

3. Application Process

Any patient who requests financial assistance will be asked to complete a financial assistance application. The financial assistance application form is attached as Exhibit 1 to this Policy. The application includes the office address and phone number to call if the patient has any questions concerning the financial assistance program or application process. The Hospital shall ensure that all employees likely to encounter patients that may need financial assistance are fully informed of and have access to this Policy, the Plain Language Summary, and the financial assistance application, and shall provide reasonable assistance to patients with the application process.

A patient is expected to submit the financial assistance promptly following care. A patient has up to two hundred forty (240) days following the date of first post-discharge statement in which to submit an application for financial assistance.

The financial assistance application requests patient information necessary for determining patient eligibility under the Financial Assistance Policy, including patient or family income and patient's family size. The Hospital will not request any additional information other than the information requested in the financial assistance application. A patient seeking financial assistance, however, may voluntarily provide additional information if they so choose. Qualification for financial assistance shall be determined solely by the patient's and/or patient family representative's ability to pay. Qualification for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.

4. Resolution of Disputes

Any disputes regarding a patient's eligibility to participate in the Charity Care Program shall be directed and resolved by the Hospital's Chief Financial Officer.

5. Publication of Policy

In order to ensure that patients are aware of the existence of the Financial Assistance Policy, the Hospital shall widely disseminate the existence and terms of this Policy throughout its service area. In addition to other appropriate efforts to inform the community about the Policy in a way targeted to reach community members most likely to need financial assistance, the following actions shall be taken:

A. Written Notice to All Patients

Each patient who is seen at a Prime Healthcare nonprofit facility, whether admitted or not, shall receive the Plain Language Summary, which is attached hereto as Exhibit 2. The notice shall be provided in non-English languages spoken by a substantial number of the patients served by the Hospital as provided in section III(5)(E) of this Policy.

B. Posting of Notices

The notices attached hereto as Exhibit 3:

- shall be clearly and conspicuously posted in locations that are visible to the patients in the following areas: (1) Emergency Department; (2) Billing Office; (3) Admissions Office; and (4) other outpatient settings.
- shall be printed in the Hospital's patient guide or other material that provides patients with information about the Hospital's admissions criteria.
- shall be provided in non-English languages spoken by a substantial number of the patients served by the Hospital as provided in section III(5)(E) of this Policy.

C. Notices to Accompany Billing Statements

Every post-discharge statement shall include a copy of the notice attached hereto as Exhibit 4. Each bill that is sent to a patient who has not provided proof of coverage by a third party at the time care is provided or upon discharge must include a statement of charges for services rendered by the Hospital and the notices attached hereto as Exhibits 4 and 5.

These notices shall be provided in non-English languages spoken by a substantial number of the patients served by the Hospital as provided in section III(5)(E) of this Policy.

D. Availability of Financial Assistance Documents

The Hospital shall post a copy of this Policy, the Plain Language Summary and the financial assistance application on its website and make all such documents available for free download. Such documents shall be available in the emergency room and admissions office and by mail upon request. The Hospital shall also annually publish notice of the Hospital's financial assistance program and this Policy in a local newspaper of general circulation in the county served by the Hospital. The documents shall be provided in non-English languages spoken by a substantial number of the patients served by the Hospital as provided in section III(5)(E) of this Policy and in language readily understandable to the average reader.

E. Accessibility to Limited English Proficient Individuals

The Hospital shall make translations of this Policy, the Plain Language Summary, and the financial assistance application available in any language that is the primary language of the lesser of one thousand (1,000) individuals or five percent (5%) of the population of the communities served by the Hospital.

6. Efforts to Obtain Information Regarding Coverage & Applications for Medicaid and CHIP

The Hospital shall make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the Hospital to a patient including, but not limited to, the following:

(1) private health insurance, including coverage offered through the federal health insurance marketplace; (2) Medicare; and/or (3) the Medicaid program, CHIP, the Texas Children with Special Health Care Needs Program, or other state-funded programs designed to provide health coverage.

If a patient does not indicate that he/she has coverage by a third party payor or requests a discounted payment program or charity care then the patient shall be provided with an application for the Medicaid program, CHIP, or other governmental program prior to discharge.

7. Collection Activities

Prime Healthcare nonprofit facilities may use the services of an external collection agency for the collection of patient debt. No debt shall be advanced for collection until the Director of the Hospital PFS or his/her designee has reviewed the account and approved the advancement of the debt to collection. Prime Healthcare nonprofit facilities shall obtain an agreement from each collection agency that it utilizes to collect patient debt that the agency will comply with the requirements of this Policy and applicable state law. For accounting purposes, any account that qualifies for bad debt under the Hospital's internal policy, but is not deemed as bad debt (resulting from revenue recognition accounting standards), will be considered and reported as patient financial assistance as a reduction to Hospital revenue.

If a patient does not apply for financial assistance or is denied financial assistance and fails to pay their bill, the patient may be subject to various collection actions, including Extraordinary Collection Actions. Notwithstanding the foregoing, neither the Hospital nor any collection agency with which it contracts shall engage in any Extraordinary Collection Actions (i) at any time prior to one hundred fifty (150) days following the first post-discharge statement sent to a patient or (ii) without first making reasonable efforts to determine whether a patient is eligible for financial assistance under this Policy. In addition, and even if the above two conditions are satisfied, Hospital or its contracted collection agencies must send a notice to the patient at least thirty (30) days before commencing any Extraordinary Collection Actions, which specifies the following: (i) collection activities the Hospital or contracted collection agency may take, (ii) the date after which such actions may be taken (which date shall be no earlier than thirty (30) days of the notice date, (iii) that financial assistance is available for eligible patients. A copy of the Plain Language Summary will be included with such notice. Reasonable efforts must be made (and documented) to orally notify patients of this Policy. If the patient applies for

financial assistance, any Extraordinary Collection Actions that may be in process will be suspended immediately pending the decision on the patient's application.

In addition, if a patient is attempting to qualify for eligibility under this Policy and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or making regular partial payments of a reasonable amount, the Hospital shall not send the unpaid bill to any collection agency.

The Hospital shall not, in dealing with patients eligible under this Policy, use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills.

Exhibit 1 [Financial assistance application]

Mission Regional Medical Center

Exhibit 2 [Financial Assistance Plain Language Summary]

Plain Language Summary of
Mission Regional Medical Center Financial Assistance Policy

Eligibility: Mission Regional Medical Center offers reduced or no charge services for emergency and other medically necessary care for individuals eligible under our Financial Assistance Policy. Eligibility is based on the Hospital's Financial Assistance Policy, which includes using the Federal Poverty Level guidelines, number of dependents, and gross annual income along with supporting income documents.

Income Guidelines: If meeting the Hospital's Financial Assistance Policy requirements, uninsured or underinsured patients with family income below 200% of the current Federal Poverty Level and less than $10,000 in monetary assets will qualify for a 100% discount on their qualifying Hospital services. Patients with family income greater than 200% but less than 400% of current Federal Poverty Level, less than $10,000 in monetary assets and excessive medical costs, and insured patients with family income less than 400% of current Federal Poverty Level and excessive medical costs, may qualify for partially discounted care and extended payment plans. Patients eligible for financial assistance will not be charged more than the amount generally billed for emergency or other medically necessary care to individuals having insurance coverage.

For More Information: The full Financial Assistance Policy and a Financial Assistance Application Form are available at our website, www.missionrmc.org, or by mail at no charge by calling 956-323-1800. Paper copies may be also obtained in person from our Billing Office at 900 S. Bryan Rd., Mission, TX, 78572. Applications are available in non-English languages spoken by large segments of the community. For further questions or assistance in completion of the Financial Assistance Application, please call our Billing Office at 956-323-1800.

Mission Regional Medical Center

Exhibit 3 [Notices to be posted in Emergency Department, Billing Office, Admissions Office, and other outpatient settings, and printed in hospital patient guide]

CHARITY CARE & DISCOUNTED PAYMENT PROGRAM

PATIENTS WHO LACK INSURANCE OR HAVE INADEQUATE INSURANCE AND MEET CERTAIN LOW- AND MODERATE-INCOME REQUIREMENTS MAY QUALIFY FOR DISCOUNTED PAYMENTS OR CHARITY CARE. THE EMERGENCY DEPARTMENT PHYSICIANS AND OTHER PHYSICIANS WHO ARE NOT EMPLOYEES OF THE HOSPITAL MAY ALSO PROVIDE CHARITY CARE OR DISCOUNTED PAYMENT PROGRAMS. PLEASE CONTACT 956-323-1800 FOR FURTHER INFORMATION.

REPORTING OF FINANCIAL ASSISTANCE

In keeping with its mission, Mission Regional Medical Center prepares and submits an annual report of the Hospital's financial assistance program and information relating to the provision of government-sponsored indigent health care and other community benefits to the Texas Department of State Health Services. This report is public information and is available upon request from the Texas Department of State Health Services.

Mission Regional Medical Center

Exhibit 4 [Notice to be included in *all* post-discharge billing statements]

Charity Care & Discounted Payment Program

Patients who lack insurance or who have inadequate insurance and meet certain low-and moderate-income requirements may qualify for discounted payments or charity care. Patients seeking discounted or free care must obtain and submit an application that will be reviewed by the Hospital. No patient eligible for financial assistance will be charged more for emergency or medically necessary care than amounts generally billed to individuals who have insurance covering such care. For more information, copies of documentation, or assistance with the application process, please contact the Hospital at 956-323-1800 or you may visit www.missionrmc.org or 900 S. Bryan Rd., Mission, TX, 78572 to obtain further information. Free copies of financial assistance documentation may also be sent to you by mail and are available in non-English languages spoken by a substantial number of the patients served by the Hospital. The Emergency Department physicians and other physicians who are not employees of the Hospital may also provide charity care or discounted payment programs. Please contact 956-323-1800 for further information.

Exhibit 5 [Notice to be included in post-discharge billing statements

to patients who have not provided proof of insurance]

Our records indicate that you do not have health insurance coverage or coverage under Medicare, Medicaid, CHIP, or other similar programs. If you have such coverage, please contact our office at 956-323-1800 as soon as possible so the information can be obtained and the appropriate entity billed.

If you do not have health insurance coverage, you may be eligible for Medicare, Medicaid, CHIP, coverage offered through the federal health insurance marketplace, the Texas Children with Special Health Care Needs Program, other state- or county-funded health coverage, or Prime Healthcare nonprofit facilities charity care or discounted payment program. For more information about how to apply for these programs, please contact the Prime Healthcare nonprofit facility PFS Designee at 956-323-1800 who will be able to answer questions and provide you with applications for these programs.

Patients who lack insurance or have inadequate insurance and meet certain low- and moderate-income requirements may qualify for discounted payments or charity care. Patients should contact the Prime Healthcare nonprofit facility or PFS Designee, at 956-323-1800 to obtain further information. If a patient applies, or has a pending application, for another health coverage program at the same time that he or she applies for a Prime Healthcare nonprofit facilities charity care or discounted payment program, neither application shall preclude eligibility for the other program.

Appendix B

Mission Regional Medical Center

Community Health Needs Assessment

2018

Table of Contents

Introduction

Internal Revenue Code (IRC) Section 501(r) requires health care organizations to assess the health needs of their communities and adopt implementation strategies to address identified needs. Per IRC Section 501(r), a byproduct of the Affordable Care Act, to comply with federal tax-exemption requirements, a tax- exempt hospital facility must:

- Conduct a community health needs assessment (CHNA) every three years.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how it is addressing the needs identified in the CHNA and a description of needs that are not being addressed with the reasons why such needs are not being addressed.

The CHNA must take into account input from persons including those with special knowledge of or expertise in public health, those who serve or interact with vulnerable populations and those who represent the broad interest of the community served by the hospital facility. The hospital facility must make the CHNA widely available to the public.

This CHNA, which describes both a process and a document, is intended to document Mission Regional Medical Center's (Medical Center) compliance with IRC Section 501(r). Health needs of the community have been identified and prioritized so that the Medical Center may adopt an implementation strategy to address specific needs of the community.

The process involved:

- An evaluation of the implementation strategy for calendar years ending December 31, 2016 through December 31, 2018, which was adopted by the Medical Center board of directors in 2016.
- Collection and analysis of a large range of data, including demographic, socioeconomic and health statistics, health care resources and hospital data.
- Obtaining community input through:
    - Interviews of key stakeholders who represent a) persons with specialized knowledge in public health, b) populations of need or c) broad interests of the community.

This document is a summary of all the available evidence collected during the CHNA conducted in tax year 2018. It will serve as a compliance document, as well as a resource, until the next

assessment cycle. Both the process and document serve as the basis for prioritizing the community's health needs and will aid in planning to meet those needs.

Summary of Community Health Needs Assessment

The purpose of the CHNA is to understand the unique health needs of the community served by the Medical Center and to document compliance with new federal laws outlined above.

The Medical Center engaged BKD, LLP to assist with conducting a formal CHNA. BKD, LLP is one of the largest CPA and advisory firms in the United States, with approximately 2,000 partners and employees in 38 offices. BKD serves more than 1,000 hospitals and health care systems across the country. The CHNA was conducted from September 2018 to December 2018.

Based on current literature and other guidance from the treasury and the IRS, the following steps were conducted as part of the Medical Center's CHNA:

- An evaluation of the impact of actions taken to address the significant health needs identified in the tax year 2016 CHNA was completed to understand the effectiveness of the Medical Center's current strategies and programs.
- The "community" served by the Medical Center was defined by utilizing inpatient and outpatient data regarding patient origin. This process is further described in Community Served by the Medical Center.
- Population demographics and socioeconomic characteristics of the community were gathered and reported utilizing various third parties (see references in Appendices). The health status of the community was then reviewed. Information on the leading causes of death and morbidity information was analyzed in conjunction with health outcomes and factors reported for the community by CountyHealthrankings.org. Health factors with significant opportunity for improvement were noted.
- Community input was provided through key stakeholder forums. Results and findings are described in the Community Input section of this report.
- Information gathered in the above steps was analyzed and reviewed to identify health issues of uninsured persons, low-income persons and minority groups and the community as a whole. Health needs were ranked utilizing a weighting method that weighs 1) the size of the problem, 2) the seriousness of the problem, 3) the impact of the issues on vulnerable populations, 4) the prevalence of common themes and 5) how important the issue is to the community.

- An inventory of health care facilities and other community resources potentially available to address the significant health needs identified through the CHNA was prepared and collaborative efforts were identified.

Health needs were then prioritized taking into account the perceived degree of influence the Medical Center has to impact the need and the health needs impact on overall health for the community.

Information gaps identified during the prioritization process have been reported.

General Description of the Medical Center

Mission Regional Medical Center is a 297-bed, not for profit, acute-care community hospital, and member of the Prime Healthcare Foundation. The Medical Center offers inpatient and outpatient acute medical care to all members of the community. The hospital is accredited by The Joint Commission and is recognized for excellence in orthopedic surgery and women's health care services.

At Mission Regional Medical Center, the goal is to provide patients the best medical care available and to identify the most appropriate setting and level of care for the patient. The Medical Center is committed to restoring our patients' health as quickly and compassionately as possible, and it has been consistently recognized for this dedication.

The Medical Center is rated one of the top hospitals in the country for clinical excellence in many services including maternity and orthopedic care. With more than 300 physicians, a highly trained medical staff, and the latest medical technology, Mission Regional Medical Center is committed to restoring patients' health as quickly and comfortably as possible.

The Medical Center's services include:

- Birthing Center
- Breast Care Center
- Heart Cath Lab for prevention, diagnosis and treatment of heart conditions
- Joint Replacement Institute and Orthopedics
- Diagnostic and Screening Imaging Services
- Surgery Center including a Pre-Operative Clinic
- Level III NICU
- Pediatric Care
- Wound Care Center

Mission Statement

To deliver compassionate, quality care to patients and better healthcare to communities.

Summary of Findings – 2018 CHNA

Health needs were identified based on information gathered and analyzed through the 2018 CHNA conducted by the Medical Center. These identified community health needs are discussed in greater detail later in this report and the prioritized listing is available at *Exhibit 25*.

As a result of the priority setting process, the identified priority areas that will be addressed through the Medical Center's Implementation Strategy for fiscal years 2019-2021 will be:

- Access to care / Access to primary care / Access to specialists
- Chronic diseases (Heart Disease, Stroke, Kidney, Cancer, Diabetes)
- Lack of health knowledge and education
- Mental health and addiction
- Nutrition
- Obesity
- Preventative care

The Medical Center's next steps include developing an implementation strategy to address these priority areas.

Community Served by the Medical Center

The Medical Center is located in Mission, Texas in Hidalgo County, located along the Texas-Mexico Border.

Defined Community

A community is defined as the geographic area from which a significant number of the patients utilizing hospital services reside. While the CHNA considers other types of health care providers, the Medical Center is the single largest provider of acute care services. For this reason, the utilization of hospital services provides the clearest definition of the community.

Based on the patient origin of inpatient and outpatient discharges, management has identified the CHNA community to include Hidalgo and Starr Counties, hereafter referred to as the "CHNA Community". Based on analysis of patient discharge zip codes, the CHNA community represents 87.9% of total discharges. The zip code analysis is reflected in *Exhibit 1*.

Exhibit 1

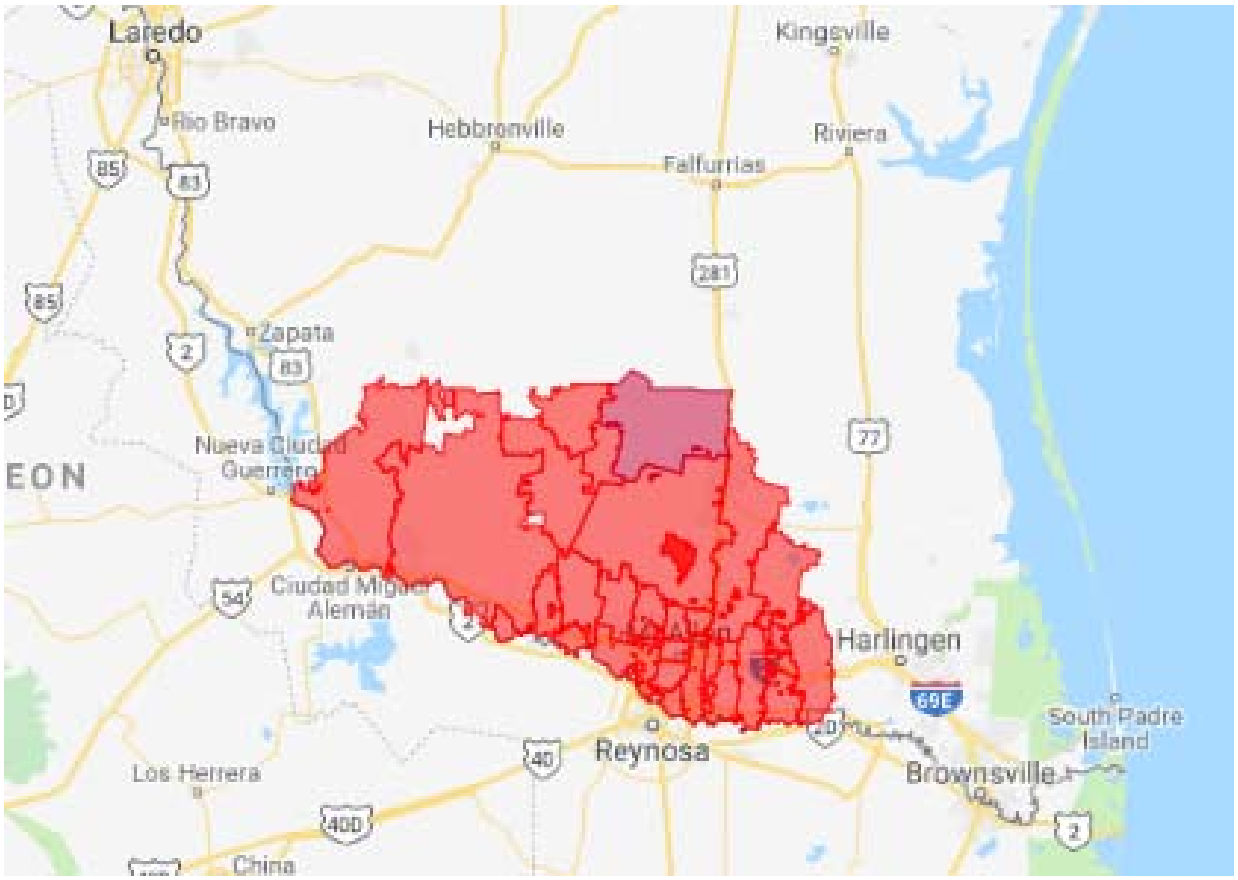
Zip Code	County (City)	Percent Discharges	Zip Code	County (City)	Percent Discharges
78572	Hidalgo (Mission)	31.5%	78577	Hidalgo (Pharr)	1.3%
78574	Hidalgo (Mission)	18.5%	78539	Hidalgo (Edinburg)	0.7%
78573	Hidalgo (Mission)	10.6%	78548	Starr (Grulla)	0.6%
78576	Hidalgo (Penitas)	5.1%	78589	Hidalgo (San Juan)	0.6%
78582	Starr (Rio Grande City)	4.3%	78542	Hidalgo (Edinburg)	0.5%
78501	Hidalgo (McAllen)	2.7%	78565	Hidalgo (Los Ebanos)	0.4%
78595	Hidalgo (Sullivan City)	2.5%	78557	Hidalgo (Hidalgo)	0.2%
78560	Hidalgo (La Joya)	1.9%	78516	Hidalgo (Alamo)	0.2%
78504	Hidalgo (McAllen)	1.6%		**CHNA Community**	**87.9%**
78541	Hidalgo (Edinburg)	1.6%		Total Other	12.1%
78584	Starr (Roma)	1.5%		Total	100.0%
78503	Hidalgo (McAllen)	1.5%			

Source: Mission Regional Medical Center

Community Details

Identification and Description of Geographical Community

The following map geographically illustrates the Medical Center's community. The map below displays the Medical Center's geographic relationship to the community, as well as significant roads and highways.



Community Population and Demographics

The U.S. Bureau of Census has compiled population and demographic data. *Exhibit 2* below shows the total population of the CHNA community compared to county, state and national population and demographic information. It also provides the breakout of the community between the male and female population, age distribution and race/ethnicity.

Exhibit 2

Demographic Characteristics

Gender	CHNA Community	Hidalgo County	Starr County	Texas	United States
Total Population	891,342	828,334	63,008	26,956,435	318,558,162
Total Male Population	434,668	404,079	30,589	13,379,165	156,765,322
Total Female Population	456,674	424,255	32,419	13,577,270	161,792,840
Percent Male	48.77%	48.78%	48.55%	49.63%	49.21%
Percent Female	51.23%	51.22%	51.45%	50.37%	50.79%

Population Age Distribution

Age Group	Percent of CHNA Community	Percent of Hidalgo County	Percent of Starr County	Percent of Texas	Percent of United States
0 - 4	9.72%	9.68%	10.15%	7.31%	6.24%
5 - 17	23.99%	24.05%	23.20%	19.15%	16.87%
18 - 24	11.09%	11.06%	11.56%	10.16%	9.82%
25 - 34	13.20%	13.24%	12.72%	14.53%	13.62%
35 - 44	12.95%	13.01%	12.17%	13.51%	12.73%
45 - 54	10.55%	10.54%	10.75%	12.88%	13.64%
55 - 64	8.07%	8.05%	8.30%	10.98%	12.58%
65+	10.43%	10.37%	11.15%	11.49%	14.50%
Total	100.00%	100.00%	100.00%	100.00%	100.00%

Total Population by Race Alone

Race	Percent of CHNA Community	Percent of Hidalgo County	Percent of Starr County	Percent of Texas	Percent of United States
White	90.19%	89.87%	94.43%	74.84%	73.35%
Black	0.55%	0.59%	0.06%	11.95%	12.63%
Asian and Pacific Island	0.92%	0.99%	0.08%	4.36%	5.22%
All Others	8.34%	8.55%	5.43%	8.85%	8.80%
Total	100.00%	100.00%	100.00%	100.00%	100.00%

Total Population by Ethnicity Alone

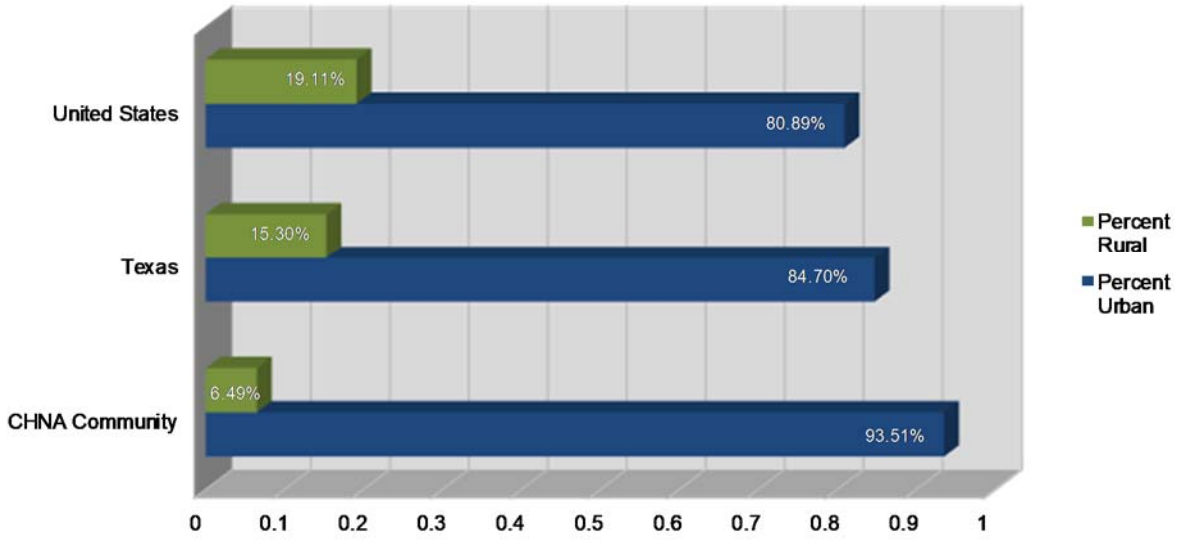
Ethnicity	Percent of CHNA Community	Percent of Hidalgo County	Percent of Starr County	Percent of Texas	Percent of United States
Hispanic or Latino	92.00%	91.48%	98.96%	38.63%	17.33%
Non-Hispanic or Latino	8.00%	8.52%	1.04%	61.37%	82.67%
Total	100.00%	100.00%	100.00%	100.00%	100.00%

Data Source: US Census Bureau, American Community Survey. 2012-16.

While the relative age of the community population can impact community health needs, so can the ethnicity and race of a population. The population of the community by race illustrates different categories of race, such as White, Black, Asian, other and multiple races.

Exhibit 3 reports the percentage of population living in urban and rural areas. Urban areas are identified using population density, count and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban. This table helps to understand why transportation may or may not be one of the highest ranking needs within the community.

Exhibit 3



Data Source: US Census Bureau, Decennial Census. 2010.

Socioeconomic Characteristics of the Community

The socioeconomic characteristics of a geographic area influence the way residents access health care services and perceive the need for health care services within society. The economic status of an area may be assessed by examining multiple variables within the community. The following exhibits are a compilation of data that includes median household income, employment rates, poverty, uninsured population and educational attainment for the community. These standard measures will be used to compare the socioeconomic status of the CHNA Community to the State of Texas and the United States.

Income and Employment

Exhibit 4 presents the median household income for the CHNA Community. This includes income of the householder and all other people 15 years and older in the household, whether or not they are related to the householder. The CHNA Community has a median household income that is below the State of Texas and the United States.

Exhibit 4

Area	Total Households	Median Household Income
CHNA Community	243,696	$ 51,702
Texas	9,286,554	$ 77,585
United States	11,716,237	$ 77,866

Data Source: US Census Bureau, Decennial Census. 2010.

Unemployment Rate

Exhibit 5 presents the average annual unemployment rate for the CHNA Community, as well as the State of Texas and the United States. The CHNA Community's unemployment rate of 6.8% is higher than the rates for the State of Texas and the United States which are 3.9% and 4.0% respectively.

Exhibit 5

Area	Number Unemployed	Unemployment Rate
CHNA Community	24,790	6.8%
Texas	539,409	3.9%
United States	6,469,456	4.0%

Data Source: US Department of Labor, Bureau of Labor Statistics. 2018 - August.

Poverty

Exhibit 6 presents the percentage of total population below 100% Federal Poverty Level (FPL). Poverty is a key driver of health status and is relevant because poverty creates barriers to access, including health services, healthy food choices and other factors that contribute to poor health. The CHNA Community poverty rate is significantly higher than the State of Texas and the United States.

Exhibit 6

Area	Population in Poverty	Percent of Population in Poverty
CHNA Community	291,257	33%
Texas	4,397,307	17%
United States	46,932,225	15%

Data Source: US Census Bureau, American Community Survey. 2012-16.

Uninsured

Exhibit 7 reports the percentage of the total civilian non-institutionalized population without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to health care access, including regular primary care, specialty care and other health services that contribute to poor health status. Approximately 291,930 persons are uninsured in the CHNA Community. The CHNA Community has an uninsured rate of 33.08%, which is higher than the State of Texas and the United States.

Exhibit 7

Area	Total Uninsured Population	Percent Uninsured Population
CHNA Community	291,930	33.08%
Texas	5,114,811	19.32%
United States	36,700,246	11.70%

Data Source: US Census Bureau, American Community Survey. 2012-16.

Education

Exhibit 8 presents percentage of the population with a Bachelor's level degree or higher in the CHNA Community versus the State of Texas and the United States.

Exhibit 8

Area	Population Age 25+ with Bachelor's Degree or Higher	Percent Population Age 25+ with Bachelor's Degree or Higher
CHNA Community	82,866	16.84%
Texas	4,800,677	28.10%
United States	64,767,787	30.32%

Data Source: US Census Bureau, American Community Survey. 2012-16.

Education levels obtained by community residents may impact the local economy. Higher levels of education generally lead to higher wages, less unemployment and job stability. These factors may indirectly influence community health. As noted in *Exhibit 8*, the percentage of residents within the CHNA Community obtaining a Bachelor's degree or higher is below the state and national percentage.

Physical Environment of the Community

A community's health is also affected by the physical environment. A safe, clean environment that provides access to healthy food and recreational opportunities is important to maintaining and improving community health. This section will touch on a few of the elements that relate to some needs mentioned throughout the report.

Grocery Store Access

Exhibit 9 reports the number of grocery stores per 100,000-population. Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods, fresh fruits and vegetables and fresh and prepared meats, fish and poultry.

Exhibit 9

Area	Number of Establishments	Establishments, Rate per 100,000 Population
CHNA Community	74	8.85
Texas	3,457	13.75
United States	65,399	21.18

Data Source: US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016.

Included are delicatessen-type establishments. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores, are excluded. This indicator is relevant because it provides a measure of healthy food access and environmental influences on dietary behaviors.

Food Access/Food Deserts

This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as a low-income census tract where a substantial number or share of residents has low access to a supermarket or large grocery stores. The information in *Exhibit 10* is relevant because it highlights populations and geographies facing food insecurity. The CHNA Community reports levels of food insecurity at a rate significantly higher than that of the State of Texas and the United States.

Exhibit 10

Area	Population with Low Food Access	Percent Population with Low Food Access
CHNA Community	325,369	38.9%
Texas	6,807,728	27.1%
United States	69,266,771	22.4%

Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2015.

Recreation and Fitness Facility Access

This indicator reports the number per 100,000-population of recreation and fitness facilities as defined by North American Industry Classification System (NAICS) Code 713940. It is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors. *Exhibit 11* shows that the CHNA Community has fewer fitness establishments per 100,000 than the State of Texas and the United States.

Exhibit 11

Area	Number of Establishments	Establishments, Rate per 100,000 Population
CHNA Community	31	3.71
Texas	2,347	9.33
United States	33,980	11.01

Data Source: US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016.

Exhibit 12 shows the percentage of adults who are physically inactive. The CHNA Community has a slightly lower percentage of adults who are physically inactive compared to both the State of Texas and the United States.

Exhibit 12

Area	Percent Population with No Leisure Time Physical Activity
CHNA Community	21%
Texas	23%
United States	22%

Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2015.

Clinical Care of the Community

A lack of access to care presents barriers to good health. The supply and accessibility of facilities and physicians, the rate of un-insurance, financial hardship, transportation barriers, cultural competency and coverage limitations affect access.

Rates of morbidity, mortality and emergency hospitalizations can be reduced if community residents access services such as health screenings, routine tests and vaccinations. Prevention indicators can call attention to a lack of access or knowledge regarding one or more health issues and can inform program interventions.

Access to Primary Care

Exhibit 13 shows the number of primary care physicians per 100,000-population. Doctors classified as "primary care physicians" by the American Medical Association include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Exhibit 13

Area	Primary Care Physicians	Primary Care Physicians, Rate per 100,000 Pop.
CHNA Community	427	47.8
Texas	18,511	68.7
United States	279,871	87.8

Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2014.

Lack of a Consistent Source of Primary Care

Exhibit 14 reports the percentage of adults aged 18 and older who self-report that they do not have at least one person who they think of as their personal doctor or health care provider. This indicator is relevant because access to regular primary care is important to preventing major health issues and emergency department visits.

Exhibit 14

Area	Total Adults Without Any Regular Doctor	Percent Adults Without Any Regular Doctor
CHNA Community	251,849	46.50%
Texas	5,946,509	32.36%
United States	52,290,932	22.07%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.

Population Living in a Health Professional Shortage Area

This indicator reports the percentage of the population that is living in a geographic area designated as a Health Professional Shortage Area (HPSA), defined as having a shortage of primary medical care, dental or mental health professionals. This indicator is relevant because a shortage of health professionals contributes to access and health status issues. As *Exhibit 15* shows, 7.3% of the residents within the CHNA Community are living in a health professional shortage area.

Exhibit 15

Area	Population Living in a HPSA	Percentage of Population Living in a HPSA
CHNA Community	60,968	7.30%
Texas	4,222,353	16.79%
United States	102,289,607	33.13%

Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. April 2016.

Preventable Hospital Events

Exhibit 16 reports the discharge rate (per 1,000 Medicare enrollees) for conditions that are ambulatory care sensitive (ACS). ACS conditions include pneumonia, dehydration, asthma, diabetes and other conditions which could have been prevented if adequate primary care resources were available and accessed by those patients. This indicator is relevant because analysis of ACS discharges allows demonstrating a possible "return on investment" from interventions that reduce admissions (for example, for uninsured or Medicaid patients) through better access to primary care resources.

Exhibit 16

Area	Total Medicare Part A Enrollees	Ambulatory Care Sensitive Condition Hospital Discharges	Ambulatory Care Sensitive Condition Discharge Rate
CHNA Community	30,428	1,838	60.4
Texas	1,497,805	79,741	53.2
United States	22,488,201	1,112,019	49.4

Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2015.

Health Status of the Community

This section of the assessment reviews the health status of the residents of Hidalgo and Starr Counties. As in the previous section, comparisons are provided with the state of Texas and the United States. This in-depth assessment of the mortality and morbidity data, health outcomes, health factors and mental health indicators of the county residents that make up the CHNA community will enable the Medical Center to identify priority health issues related to the health status of its residents.

Good health can be defined as a state of physical, mental and social well-being, rather than the absence of disease or infirmity. According to Healthy People 2020, the national health objectives released by the U.S. Department of Health and Human Services, individual health is closely linked to community health. Community health, which includes both the physical and social environment in which individuals live, work and play, is profoundly affected by the collective behaviors, attitudes and beliefs of everyone who lives in the community. Healthy people are among a community's most essential resources.

Numerous factors have a significant impact on an individual's health status: lifestyle and behavior, human biology, environmental and socioeconomic conditions, as well as access to adequate and appropriate health care and medical services.

Studies by the American Society of Internal Medicine conclude that up to 70% of an individual's health status is directly attributable to personal lifestyle decisions and attitudes. Persons who do not smoke, drink in moderation (if at all), use automobile seat belts (car seats for infants and small children), maintain a nutritious low-fat, high-fiber diet, reduce excess stress in daily living and exercise regularly have a significantly greater potential of avoiding debilitating diseases, infirmities and premature death.

The interrelationship among lifestyle/behavior, personal health attitude and poor health status is gaining recognition and acceptance by both the general public and health care providers. Some examples of lifestyle/behavior and related health care problems are presented below.


Lung cancer
Chronic bronchitis
Smoking
Cardiovascular disease
Emphysema
Cardiovascular disease
Lack of Exercise
Obesity
Depression
Cirrhosis of liver
Mental illness
Motor vehicle crashes
Alcohol/Drug Abuse
Homicide
Unintentional injuries
Suicide
Malnutrition
Obesity
Poor Nutrition
Depression
Digestive disease
Mental illness
Overstressed
Cardiovascular disease
Alcohol/drug abuse

Health problems should be examined in terms of morbidity as well as mortality. Morbidity is defined as the incidence of illness or injury, and mortality is defined as the incidence of death. Such information provides useful indicators of health status trends and permits an assessment of the impact of changes in health services on a resident population during an established period of time. Community attention and health care resources may then be directed to those areas of greatest impact and concern.

Leading Causes of Death and Health Outcomes

Exhibit 17 reflects the leading causes of death for the CHNA Community and compares the rates to Hidalgo County, Starr County, and the State of Texas and the United States.

Exhibit 17

Area	CHNA Community	Hidalgo County	Starr County	Texas	United States
Cancer	98.90	97.60	115.40	144.45	185.30
Heart Disease	92.70	90.10	127.20	89.93	115.30
Lung Disease	16.30	16.00	197.70	36.60	47.00
Stroke	22.60	22.30	26.40	36.83	42.20
Unintentional Injury	20.70	20.80	20.00	36.31	44.10
Motor Vehicle	11.80	11.80	13.00	13.87	11.60
Drug Poisoning	3.00	3.00	3.00	9.58	15.60
Homicide	3.20	3.20	3.80	5.40	5.40
Suicide	6.20	6.00	9.20	12.05	13.40

Note: Crude Death Rate (Per 100,000 Pop.)

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16.

The table above shows leading causes of death within the CHNA Community compared to Hidalgo County, Starr County, the State of Texas and also the United States. The crude rate is shown per 100,000 residents. As the table indicates, within the CHNA Community, only Heart Disease exceeds the rates for the State of Texas.

Health Outcomes and Factors

An analysis of various health outcomes and factors for a particular community can, if improved, help make the community a healthier place to live, learn, work and play. A better understanding of the factors that affect the health of the community will assist with how to improve the community's habits, culture and environment. This portion of the CHNA utilizes information from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project, a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

The County Health Rankings model is grounded in the belief that programs and policies implemented at the local, state and federal levels have an impact on the variety of factors that, in turn, determine the health outcomes for communities across the nation. The model provides a ranking method that ranks all 50 states and the counties within each state, based on the measurement of two types of health outcomes for each county: how long people live (mortality) and how healthy people feel (morbidity). These outcomes are the result of a collection of health factors and are influenced by programs and policies at the local, state and federal levels.

Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, e.g., 1 or 2, are considered to be the "healthiest." Counties are ranked relative to the health of other counties in the same state on the following summary measures:

- Health outcomes – rankings are based on an equal weighting of one length of life (mortality) measure and four quality of life (morbidity) measures.
- Health factors – rankings are based on weighted scores of four types of factors:
    - Health behaviors (nine measures)
    - Clinical care (seven measures)
    - Social and economic (nine measures)
    - Physical environment (five measures)

A more detailed discussion about the ranking system, data sources and measures, data quality and calculating scores and ranks can be found at the website for County Health Rankings (www.countyhealthrankings.org).

As seen in *Exhibit 18*, the relative health status of each county within the CHNA Community will be compared to the State of Texas as well as to a national benchmark. The current year information is compared to the health outcomes reported on the prior community health needs assessment and the change in measures is indicated. A better understanding of the factors that affect the health of the community will assist with how to improve the community's habits, culture and environment.

Exhibit 18.1

Health Outcomes	Hidalgo County: 2016	Hidalgo County: 2018	Change	Texas: 2018	Top US Performers: 2018
Mortality: State of Texas County Ranking	**16**	**15**	+		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)	5,500	5,700	-	6,700	5,300
Morbidity: State of Texas County Ranking	**214**	**212**	+		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)	30%	29%	+	18%	12%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)	4.7	4.4	+	3.5	3.0
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	3.5	3.9	+	3.4	3.1
Low birth weight – Percent of live births with low birth weight (<2500 grams)	8.0%	8.0%	NC	8.0%	6.0%

Data Source: Countyhealthrankings.org

Exhibit 18.2

Health Outcomes	Starr County: 2016	Starr County: 2018	Change	Texas: 2018	Top US Performers: 2018
Mortality: State of Texas County Ranking	**63**	**40**	+		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)	6,900	6,500	+	6,700	5,300
Morbidity: State of Texas County Ranking	**239**	**240**	-		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)	42%	41%	+	18%	12%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)	5.6	5.5	+	3.5	3.0
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	4.0	4.3	-	3.4	3.1
Low birth weight – Percent of live births with low birth weight (<2500 grams)	9.0%	9.0%	NC	8.0%	6.0%

Data Source: Countyhealthrankings.org

Exhibit 18.1 shows Hidalgo County's overall mortality and morbidity outcome rankings have improved from the 2016 rankings but are worse than the outcomes reported for the State of Texas, with the exception of premature death and low birth weight.

Exhibit 18.2 shows Starr County's overall mortality outcome rankings have improved from the 2016 rankings. However, the county's morbidity outcome rankings have worsened from the 2016 rankings. All outcome rankings are worse than the outcomes reported for the State of Texas with the exception of premature death.

A number of different health factors shape a community's health outcomes. The County Health Rankings model includes four types of health factors: health behaviors, clinical care, social and economic and the physical environment. The following summary shows some of the health outcomes that significantly improved or worsened from 2016 to 2018. The identified areas shown in *Exhibit 19.1* and *Exhibit 19.2* were determined using a process of comparing the rankings of each county's health outcomes in the current year (2018) to the rankings in the prior CHNA (2016). If the current year rankings showed an improvement or decline of 3% or three points, they were included in the charts below. Please refer to *Appendix D* for the full list of health factor findings and comparisons between prior CHNA information reported and current year information.

Exhibit 19.1

OUTCOMES IMPROVED: 2016 TO 2018		
Health Outcomes	Hidalgo County: 2016	Hidalgo County: 2018
Adult obesity – Percent of adults that report a BMI >= 30	37.0%	34.0%
Teen birth rate – Per 1,000 female population, ages 15-19	76.0	62.0
Uninsured adults – Percent of population under age 65 without health insurance	38.0%	32.0%
Dentists – Ratio of population to dentists	4,090:1	3,920:1
Mental health providers – Ratio of population to mental health providers	2,330:1	1,970:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	61.0	56.0
Children in poverty – Percent of children under age 18 in poverty	46.0%	43.0%

OUTCOMES WORSENED: 2016 TO 2018		
Health Outcomes	Hidalgo County: 2016	Hidalgo County: 2018
Primary care physicians – Ratio of population to primary care physicians	2,220:1	2,330:1

Exhibit 19.2

OUTCOMES IMPROVED: 2016 TO 2018		
Health Outcomes	Starr County: 2016	Starr County: 2018
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity	13.0%	28.0%
Sexually transmitted infections – Chlamydia rate per 100K population	323.0	279.6
Teen birth rate – Per 1,000 female population, ages 15-19	92.0	80.0
Uninsured adults – Percent of population under age 65 without health insurance	35.0%	31.0%
Primary care physicians – Ratio of population to primary care physicians	5,630:1	5,320:1
Dentists – Ratio of population to dentists	7,000:1	6,410:1
Mental health providers – Ratio of population to mental health providers	7,000:1	6,410:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	103.0	88.0

OUTCOMES WORSENED: 2016 TO 2018		
Health Outcomes	Starr County: 2016	Starr County: 2018
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity	24.0%	28.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement	31.0%	41.0%
Children in poverty – Percent of children under age 18 in poverty	44.0%	55.0%
Children in single-parent households – Percent of children that live in household headed by single parent	39.0%	43.0%
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)	265.0	281.0

As can be seen in *Exhibit 19.1* and *Exhibit 19.2*, there are several areas of the community that have room for improvement when compared to the state statistics; however, there are also significant improvements made within the counties from the prior year CHNA report.

The following exhibits show a more detailed view of certain health outcomes and factors. Detailed information was not available by zip codes; therefore Hidalgo and Starr Counties as a whole were used for the following indicators. The percentages for each county compared to the State of Texas and the United States.

Diabetes (Adult)

Exhibit 20 reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes. This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

Exhibit 20

Area	Population with Diagnosed Diabetes	Population with Diagnosed Diabetes, Age-Adjusted Rate
CHNA Community	56,265	10.02%
Texas	1,895,549	9.54%
United States	24,722,757	9.28%

Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2015.

High Blood Pressure (Adult)

Per *Exhibit 21*, 28.2% of CHNA Community residents aged 18 and older have ever been told by a doctor that they have high blood pressure or hypertension. This percentage of high blood pressure among adults is less than the percentage of the State of Texas but equal to the percentage for the United States.

Exhibit 21

Area	Total Adults with High Blood Pressure	Percent Adults with High Blood Pressure
CHNA Community	150,603	28.2%
Texas	5,399,918	30.0%
United States	65,476,522	28.2%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.

Obesity

Of adults aged 20 and older, 30.2% self-report that they have a body mass index (BMI) greater than 30.0 (obese) in the CHNA Community per *Exhibit 22*. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues. The CHNA Community has a BMI percentage greater than of the State of Texas and the United States.

Exhibit 22

Area	Adults with BMI > 30.0 (Obese)	Percent Adults with BMI > 30.0 (Obese)
CHNA Community	172,249	30.20%
Texas	5,632,512	28.80%
United States	67,983,276	28.30%

Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2015.

Poor Dental Health

This indicator is relevant because it indicates lack of access to dental care and/or social barriers to utilization of dental services. The CHNA Community reports 11.1% percent of adults with poor dental health as compared to 12.7% and 15.7% for the State of Texas and the United States respectively (*Exhibit 23*).

Exhibit 23

Area	Percent Adults with Poor Dental Health
CHNA Community	11.10%
Texas	12.70%
United States	15.70%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.

Low Birth Weight

Exhibit 24 below reports the percentage of total births that are low birth weight (under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities. The CHNA Community has a lower percent of low birth weight births compared to the State of Texas and the United States.

Exhibit 24

Area	Low Weight Births, Percent of Total Live Births
CHNA Community	7.90%
Texas	8.40%
United States	8.20%

Data Source: US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2006-12.

Community Input – Key Stakeholder Forums

Obtaining input from key stakeholders (persons with knowledge of or expertise in public health, persons representing vulnerable populations, or community members who represent the broad interest of the community, or) is a technique employed to assess public perceptions of the CHNA Community's health status and unmet needs. These key stakeholder forums are intended to ascertain opinions among individuals likely to be knowledgeable about the community and influential over the opinions of others about health concerns in the community.

Methodology

Key stakeholders forum participants were selected for participation based on their specialized knowledge or expertise in public health; their affiliation with local government, schools and industry; or their involvement with underserved and minority populations. Key stakeholders represent the following types of organizations:

- Mission Regional Medical Center
- Social service agencies
- Local school systems and universities
- Public health agencies
- Other medical providers
- Government officials
- Local businesses

All forums were conducted by BKD personnel. Two key stakeholder forums were conducted on October 29, 2018 and October 30, 2018.

Participants who participated in the survey provided input on the following issues:

- Health and quality of life for residents of the primary community
- Underserved populations and communities of need

- Barriers to improving health and quality of life for residents of the community
- Opinions regarding the important health issues that affect community residents and the types of services that are important for addressing these issues

This technique reveals community input for some of the factors affecting the views and sentiments about overall health and quality of life within the community.

Results from Community Input

The discussions in the key stakeholder forums were grouped into four major categories for discussion. A summary of the stakeholders' responses by each of the categories follows. This section of the report summarizes what the key stakeholders provided without assessing the credibility of their comments.

General opinions regarding health and quality of life in the community

The key stakeholders were asked to rate the health and quality of life in the community. They were also asked to provide their opinion whether the health and quality of life had improved, declined or stayed the same over the past few years. Lastly, key stakeholders were asked to provide support for their answers.

Key stakeholders rated the health and quality of life in their county as "average" to "below average". When asked whether the health and quality of life had improved, declined or stayed the same, the group expressed they thought the health and quality of life had improved over the last few years. When asked "why they thought the health and quality of life had improved", key stakeholders primarily noted that access to health services had increased.

Underserved populations and communities of need

Key stakeholders were asked to provide their opinions regarding specific populations or groups of people whose health or quality of life may not be as good as others. BKD also asked the key stakeholders to provide their opinions as to why they thought these populations were underserved or in need. BKD asked each key stakeholder to consider the specific populations they serve or those with which they usually work.

The group noted that persons living with low-incomes or unemployed are most likely to be underserved due to lack of access to services. The elderly were also identified as a population that is faced with challenges accessing care due to limited transportation. The group also identified "Winter Texans" and individuals living in the community with no legal immigration status as groups that are underserved.

Barriers

The key stakeholders were asked what barriers or problems keep community residents from obtaining necessary health services and improving health in their community. The majority of the key stakeholders noted barriers due to lack of funding for programs targeted at low-income/uninsured person and the inability for these persons to afford healthcare. Lack of transportation, language, immigration status, excessive wait times at physician appointments, and the current political climate relating to immigration were also noted as barriers.

Most important health and quality of life issues

Key stakeholders were asked to provide their opinion as to the most critical health and quality of life issues facing the county. Key stakeholders identified access and affordability of healthcare services as being the most important issue impacting health of the community. Additionally, there is a high rate of uninsured among this population and efforts should be made to connect community members to available resources.

Other noted important health and quality of life issues impacting the community include:

- Access to primary care and specialists
- Chronic diseases (Heart Disease, Stroke, Kidney, Cancer, Diabetes)
- Lack of health knowledge and education
- Mental health and addiction
- Poor nutrition / limited access to healthy food options
- Obesity
- Preventative care
- Services for the aging
- Transportation
- Language and cultural barriers
- Healthy behaviors / lifestyle choices.

The stakeholders felt the best way to address these needs was to continue to increase education and outreach to community members regarding the available services. Stakeholders also recommended collaboration in the community between the various healthcare resources.

The key stakeholders were also asked to identify the most critical issue the hospital should address over the next three to five years. Responses included:

- Improve access for uninsured and under-insured residents
- Expand services in the community
- Improve chronic disease (Heart Disease, Stroke, Cancer, Diabetes) management services

- Establishing clinics or providing extended service hours
- Increase health education in the education.

Key Findings

A summary of themes and key findings provided by the key stakeholders follows:

- The community's health and quality of life are generally seen to be very good, but there are certain groups of persons who have limited access to health such as those persons living in poverty and the elderly.
- Access to affordable healthcare for persons who are unemployed, uninsured, or who have low-income is seen as a major issue in the community.
- Mission Regional Medical Center should continue its outreach and education efforts on health and wellness.
- Heart disease, diabetes, cancer and obesity were noted health conditions negatively impacting the community.
- The community does not have adequate resources to treat patients suffering from Chronic Kidney Disease.
- Transportation was cited as a barrier to health. Transportation is an issue for people and prevents them from seeking care, making their appointments or receiving follow-up care.
- Over the last three years access to health services has improved due to additional services. However, expansion of services remains a need in the community.
- Access and services for mental health, especially services to children are limited.

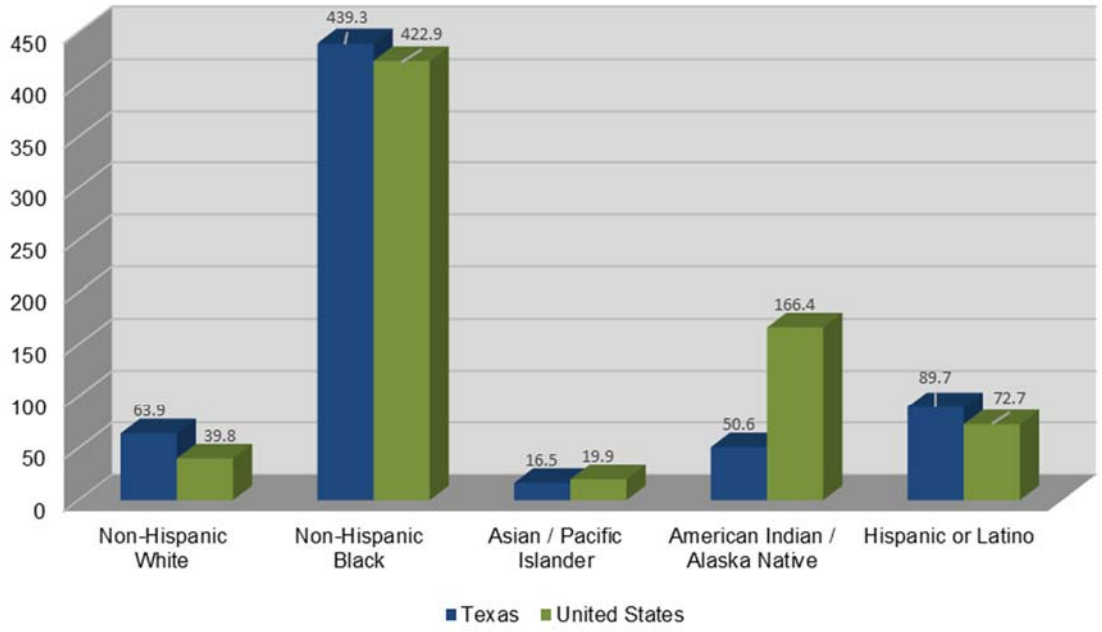
Health Issues of Vulnerable Populations

According to Dignity Health's Community Need Index (see *Appendices*), the Medical Center's CHNA Community has a high level of need. The CNI score is an average of five different barrier scores that measure socioeconomic indicators of each community (income, cultural, education, insurance and housing). The zip codes that have the highest need in the community are 78501 (McAllen), 78577 (Pharr), 78541 (Edinburg), and 78503 (McAllen).

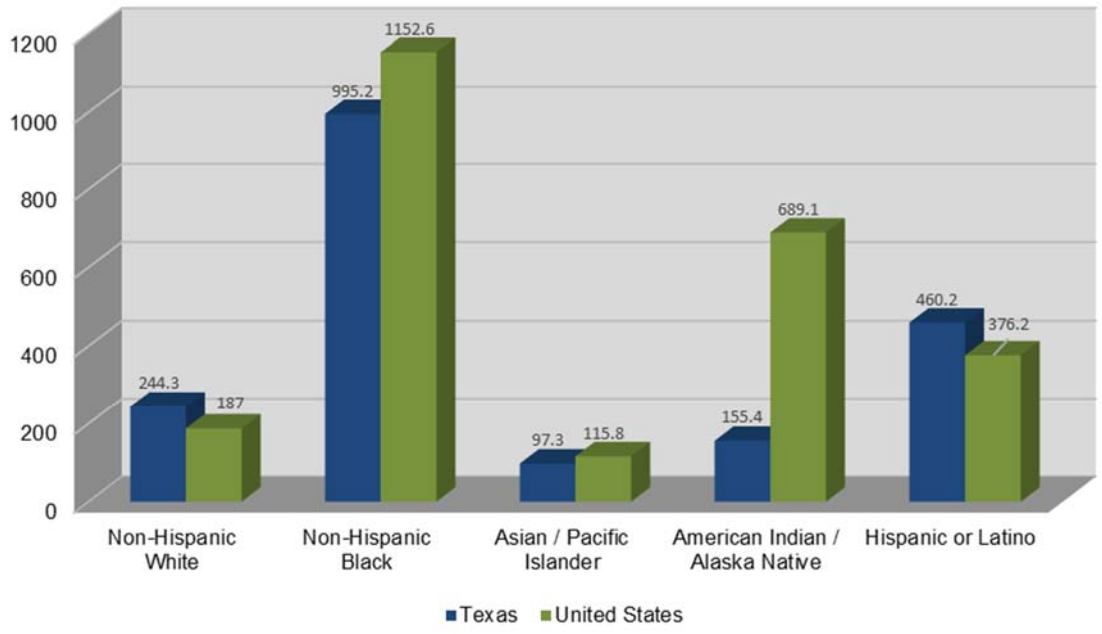
The following health disparities were noted per review of the secondary data from Community Commons and are based on age, race and ethnicity. Data is presented for the CHNA Community.

Sexually Transmitted Disease Disparities

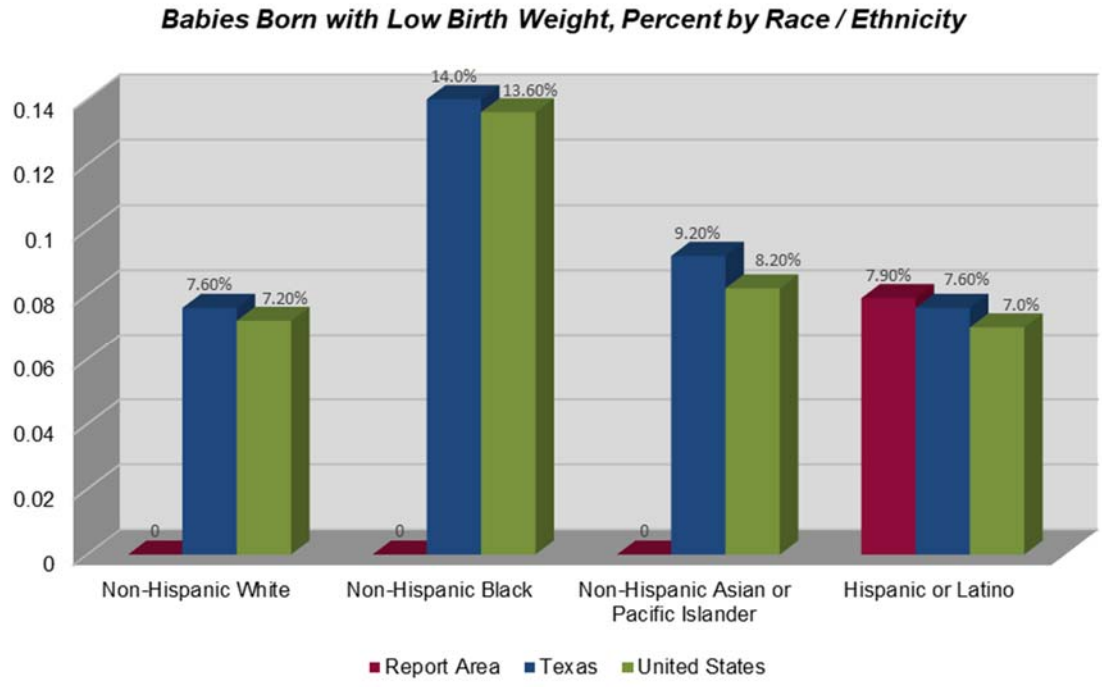
Gonorrhea Incidence Rate (Per 100,000 Pop.) by Race / Ethnicity



Chlamydia Incidence Rate (Per 100,000 Pop.) by Race / Ethnicity



Infant Health Disparities



Based on information obtained through key stakeholder forums, the following populations are considered to be vulnerable or underserved in the community and the identified needs are listed:

- Uninsured/Working Poor Population
  - Transportation
  - Access to specialty services
  - Health education
  - High cost of health care prevents needs from being met
  - Healthy lifestyle and health nutrition education
- Elderly
  - Transportation
  - Cost of prescriptions and medical care
  - Shortage of Physicians (limit on patients who are on Medicare)

- Hispanic Population
  - Language barriers
  - Transportation
  - Healthy living education
- Non-Hispanic/Black Population
  - Sexually Transmitted Diseases*
  - Low Birth Weight*

  ** Per secondary data report in graphs on previous pages.*

Information Gaps

This assessment was designed to provide a comprehensive and broad picture of the health in the overall community served by the Medical Center. However, there may be a number of medical conditions that are not specifically addressed in this report due to various factors, including but not limited to, publically available information or limited community input.

In addition, certain population groups might not be identifiable or might not be represented in numbers sufficient for independent analysis. Examples include homeless, institutionalized persons, undocumented residents and members of certain ethnic groups who do not speak English or Spanish. Efforts were made to obtain input from these specific populations through key stakeholder forums.

Prioritization of Identified Health Needs

Priority setting is a required step in the community benefit planning process. The IRS regulations indicate that the CHNA must provide a prioritized description of the community health needs identified through the CHNA and include a description of the process and criteria used in prioritizing the health needs.

Using findings obtained through the collection of primary and secondary data, the Medical Center completed an analysis of these inputs (see *Appendices*) to identify community health needs. The following data was analyzed to identify health needs for the community.

Leading Causes of Death

Leading causes of death for the community and the death rates for the leading causes of death for each county within the Medical Center's CHNA Community were compared to U.S. adjusted death rates.

Causes of death in which the county rate compared unfavorably to the U.S. adjusted death rate resulted in a health need for the Medical Center CHNA Community.

Health Outcomes and Factors

An analysis of the County Health Rankings health outcomes and factors data was prepared for each county within the Medical Center's CHNA Community. County rates and measurements for health behaviors, clinical care, social and economic factors and the physical environment were compared to state benchmarks. County rankings in which the county rate compared unfavorably (by greater than 30% of the national benchmark) resulted in an identified health need.

Primary Data

Health needs identified through key informant forums were included as health needs. Needs for vulnerable populations were separately reported on the analysis in order to facilitate the prioritization process.

Health Needs of Vulnerable Populations

Health needs of vulnerable populations were included for ranking purposes.

Ranking Process

To facilitate prioritization of identified health needs, a ranking process was used. Health needs were ranked based on the following five factors. Each factor received a score between 0 and 5.

1. How many people are affected by the issue or size of the issue? For this factor, ratings were based on the percentage of the community who are impacted by the identified need. The following scale was utilized: >25% of the community= 5; >15% and <25%=4; >10% and <15%=3; >5% and <10%=2 and <5%=1.
2. What are the consequences of not addressing this problem? Identified health needs which have a high death rate or have a high impact on chronic diseases received a higher rating.
3. The impact of the problem on vulnerable populations. Needs identified which pertained to vulnerable populations were rated for this factor.
4. How important the problem is to the community. Needs identified through community interviews and/or focus groups were rated for this factor.

5. Prevalence of common themes. The rating for this factor was determined by how many sources of data (leading causes of death, primary causes for inpatient hospitalization, health outcomes and factors and primary data) identified the need.

Each need was ranked based on the five prioritization metrics. As a result, the following summary list of needs was identified:

Exhibit 25

Identified Health Needs	How Many People Are Affected by the Issue?	What Are the Consequences of Not Addressing This Problem?	What is the Impact on Vulnerable Populations?	How Important is it to the Community?	How Many Sources Identified the Need?	Total Score *
Uninsured / Limited Insurance / Access	5	4	5	5	3	22
Chronic Diseases (Heart Disease, Stroke, Kidney, Cancer, Diabetes)	5	4	3	4	3	19
Lack of Primary Care Physicians / Hours	4	3	4	4	2	17
Lack of Specialists / Hours	4	3	4	4	2	17
Poor Nutrition / Limited Access to Healthy Food Options	5	3	3	3	2	16
Lack of Health Know ledge / Education	5	2	3	3	2	15
Transportation	3	1	5	4	2	15
Obesity	4	4	0	4	2	14
Preventative Care	5	3	2	3	1	14
Services for the Aging	3	3	4	2	1	13
Lack of Mental Health / Addiction Providers and Services	4	3	2	2	2	13
Healthy Behaviors / Lifestyle Choices	5	2	2	2	2	13
Services for Children	3	3	3	2	1	12
Need for Prenatal Care	2	3	4	2	1	12
Language and Cultural Barriers	2	2	3	3	2	12
Physical Inactivity / Lack of Exercise	2	3	2	2	1	10
Adult Smoking	2	3	2	2	1	10
Low Birth Weight	2	1	2	1	1	7
Teen Birth Rate	2	1	2	1	1	7
Medical Services to Winter Texans	1	2	2	1	1	7
Lack of Dentists	2	2	0	1	1	6
Sexually Transmitted Diseases	2	1	0	1	2	6
Excessive Drinking / Alcohol-Impaired Drinking Deaths	2	1	0	1	1	5

Management's Prioritization Process

For the health needs prioritization process, the Medical Center engaged a hospital leadership team to review the most significant health needs reported in the prior CHNA, as well as in *Exhibit 25*, using the following criteria:

- Current area of hospital focus
- Established relationships with community partners to address the health need
- Organizational capacity and existing infrastructure to address the health need

Based on the criteria outlined above, the leadership team ranked each of the health needs. As a result of the priority setting process, the identified priority areas that will be addressed through the Medical Center's Implementation Strategy for fiscal years 2019-2021 will be:

- Access to care / Access to primary care / Access to specialists
- Chronic diseases (Heart Disease, Stroke, Kidney, Cancer, Diabetes)
- Lack of health knowledge and education
- Mental health and addiction
- Nutrition
- Obesity
- Preventative care

The Medical Center's next steps include developing an implementation strategy to address these priority areas.

Health Care Resources

The availability of health care resources is a critical component to the health of a county's residents and a measure of the soundness of the area's health care delivery system. An adequate number of health care facilities and health care providers are vital for sustaining a community's health status. Fewer health care facilities and health care providers can impact the timely delivery of services. A limited supply of health resources, especially providers, results in the limited capacity of the health care delivery system to absorb charity and indigent care as there are fewer providers upon which to distribute the burden of indigent care.

Hospitals

The Medical Center is a 297 bed and is an acute-care community hospital facility located within the CHNA Community. Residents of the community can take advantage of services provided by other hospitals within the CHNA Community, as well as services offered by other facilities and providers.

Exhibit 26 summarizes hospitals available to the residents of the CHNA Community.

Exhibit 26

Facility	Address
Mission Regional Medical Center	900 South Bryan Road Mission, TX 78572-6613
McAllen Medical Center	301 West Expressway 83 Mcallen, TX 78503-3045
Solara Hospital McAllen	301 West Expressway 83 Mcallen, TX 78503-3045
Rio Grande Regional Hospital	101 East Ridge Road Mcallen, TX 78503-1299
Doctor's Hosp at Renaissance	5501 South Mccoll Road Edinburg, TX 78539
Cornerstone Regional Hospital	2302 Cornerstone Boulevard Edinburg, TX 78539-8471
Edinburg Regional Medical Center	1102 West Trenton Road Edinburg, TX 78539-6199
Weslaco Rehabilitation Hosp	906 South James Street Weslaco, TX 78596
Knapp Medical Center	1401 East Eighth Street Weslaco, TX 78596-6640

Source: http://www.ushospitalfinder.com

** Limited to Within 25 Miles of Medical Cen*

Other Health Care Facilities

Short-term acute care hospital services are not the only health services available to members of the Medical Center's CHNA Community. *Exhibit 27* provides a listing of community health centers within the Medical Center's CHNA Community.

Exhibit 27

Facility	Address	Facility	Address
Nuestra Clinica del Valle - Mission	611 N Bryan Road Mission, TX 78572-4245	Nuestra Clinica del Valle - Donna	301 S 17th Street Donna, TX 78537
Nuestra Clinica del Valle - Memorial	201 S Los Ebanos Blvd Alton, TX 78574-1139	Nuestra Clinica del Valle - Edcouch	1518 E Santa Rosa Edcouch, TX 78538-0355
Valley AIDS Council - Westbrook Clinic McAllen	300 S 2nd Street, Suite 101 McAllen, TX 79501	Nuestra Clinica del Valle - Mercedes	1500 First Street Mercedes, TX 78570-2551
Nuestra Clinica del Valle - Women's Health Clinic	806 W 3rd Street San Juan, TX 78589-2276	Nuestra Clinica del Valle - Rio Grande City	600 N Garza Street, Suite A Rio Grande City, TX 78582-3538
Nuestra Clinica del Valle - San Juan	801 W 1st Street San Juan, TX 78589-2276	Valley AIDS Council - Westbrook Clinic Harlingen	2306 Camelot Plaza Circle Harlingen, TX 78550
Nuestra Clinica del Valle - PSJA School Based Clinic	2900 N Raul Longoria Road San Juan, TX 78589-9727	Su Clinica - Harlingen Clinic	1706 Treasure Hills Blvd Harlingen, TX 78550
Nuestra Clinica del Valle - San Carlos	300 N 86th Street Edinburg, TX 78541-1838	Nuestra Clinica del Valle - Roma	2891 E Grant Roma, TX 78584-8053

Source: https://www.tachc.org/find_healthcare_center

The Medical Center's CHNA Community also has a number of clinics inside various retail facilities, including Walgreens and CVS. These clinics are expanding past providing only flu shots to providing checkups and treatments to a growing list of ailments.

Physicians

The Medical Center regularly monitors physician supply and demand. The key informant surveys indicated the need for additional primary care physicians and specialists.

Health Department

Hidalgo County Health & Human Services has eight Health Clinics located throughout Hidalgo County that provide a variety of clinical services for free or low cost; cost for clinical services is based on specific program requirements. Currently the Clinics accept the following medical coverage/insurances: Blue Cross Blue Shield of Texas, United Health, Superior, Driscoll, Molina, CHIP, and Medicaid.

The Health Clinic Staff is committed to serving the public health needs of Hidalgo County and to continue strengthening our outreach through local partnerships.

The following clinical services are provided:

- Immunizations
- Pregnancy Testing
- Well Child Checkups
- Tuberculosis Services
- Prenatal Care
- Family Planning
- Wellness Health
- Tuberculin Skin Test
- Newborn Screenings
- Case Management
- STD Clinics
- STD/HIV Testing & Counseling.

Appendices

Listing of Appendices:

A. Analysis of Data
B. Sources
C. Dignity Health Community Need Index (CNI) Report
D. County Health Rankings
E. Survey Instrument and Acknowledgements

Appendix A: Analysis of Data

Analysis of Health Status-Leading Causes of Death: Hidalgo County

Area	United States	(A) 10% of United States Crude Rate	Hidalgo County	(B) County Rate Less U.S. Adjusted Crude Rate	If (B)>(A), then "Health Need"
Cancer	185.30	18.53	97.60	-87.70	
Heart Disease	115.30	11.53	90.10	-25.20	
Lung Disease	47.00	4.70	16.00	-31.00	
Stroke	42.20	4.22	22.30	-19.90	
Unintentional Injury	44.10	4.41	20.80	-23.30	
Motor Vehicle	11.60	1.16	11.80	0.20	
Drug Poisoning	15.60	1.56	3.00	-12.60	
Homicide	5.40	0.54	3.20	-2.20	
Suicide	13.40	1.34	6.00	-7.40	

Note: Crude Death Rate (Per 100,000 Pop.)

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16.

Analysis of Health Status-Leading Causes of Death: Starr County

Area	United States	(A) 10% of United States Crude Rate	Starr County	(B) County Rate Less U.S. Adjusted Crude Rate	If (B)>(A), then "Health Need"
Cancer	185.30	18.53	115.40	-69.90	
Heart Disease	115.30	11.53	127.20	11.90	Health Need
Lung Disease	47.00	4.70	197.70	150.70	Health Need
Stroke	42.20	4.22	26.40	-15.80	
Unintentional Injury	44.10	4.41	20.00	-24.10	
Motor Vehicle	11.60	1.16	13.00	1.40	Health Need
Drug Poisoning	15.60	1.56	3.00	-12.60	
Homicide	5.40	0.54	3.80	-1.60	
Suicide	13.40	1.34	9.20	-4.20	

Note: Crude Death Rate (Per 100,000 Pop.)

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16.

Analysis of Health Outcomes: Hidalgo County

Health Outcomes	Top US Performers: 2018	(A) 30% of National Benchmark	Hidalgo County: 2018	(B) County Rate Less National Benchmark 2018	If (B)>(A), then "Health Need"
Adult smoking	14.0%	4.2%	15.0%	1.0%	
Adult obesity	26.0%	7.8%	34.0%	8.0%	Health Need
Food environment index	8.6	2.6	7.1	(1.5)	
Physical inactivity	20.0%	6.0%	25.0%	5.0%	
Access to exercise opportunities	91.0%	27.3%	62.0%	-29.0%	
Excessive drinking	13.0%	3.9%	14.0%	1.0%	
Alcohol-impaired driving deaths	13.0%	3.9%	28.0%	15.0%	Health Need
Sexually transmitted infections	145.1	43.5	407.3	262.2	Health Need
Teen birth rate	15.0	4.5	62.0	47.0	Health Need
Uninsured adults	6.0%	1.8%	32.0%	26.0%	Health Need
Primary care physicians	1,030	309	2,330	1,300	Health Need
Dentists	1,280	384	3,920	2,640	Health Need
Mental health providers	470	141	1,970	1,500	Health Need
Preventable hospital stays	35.0	10.5	56.0	21.0	Health Need
Diabetic screening	91.0%	27.3%	88.0%	-3.0%	
Mammography screening	71.0%	21.3%	58.0%	-13.0%	
Children in poverty	12.0%	3.6%	43.0%	31.0%	Health Need
Children in single-parent households	20.0%	6.0%	35.0%	15.0%	Health Need

Analysis of Health Outcomes: Starr County

Health Outcomes	Top US Performers: 2018	(A) 30% of National Benchmark	Starr County: 2018	(B) County Rate Less National Benchmark 2018	If (B)>(A), then "Health Need"
Adult smoking	14.0%	4.2%	20.0%	6.0%	Health Need
Adult obesity	26.0%	7.8%	31.0%	5.0%	
Food environment index	8.6	2.6	5.8	(2.8)	
Physical inactivity	20.0%	6.0%	28.0%	8.0%	Health Need
Access to exercise opportunities	91.0%	27.3%	28.0%	-63.0%	
Excessive drinking	13.0%	3.9%	14.0%	1.0%	
Alcohol-impaired driving deaths	13.0%	3.9%	41.0%	28.0%	Health Need
Sexually transmitted infections	145.1	43.5	279.6	134.5	Health Need
Teen birth rate	15.0	4.5	80.0	65.0	Health Need
Uninsured adults	6.0%	1.8%	31.0%	25.0%	Health Need
Primary care physicians	1,030	309	5,320	4,290	Health Need
Dentists	1,280	384	6,410	5,130	Health Need
Mental health providers	470	141	6,410	5,940	Health Need
Preventable hospital stays	35.0	10.5	88.0	53.0	Health Need
Diabetic screening	91.0%	27.3%	90.0%	-1.0%	
Mammography screening	71.0%	21.3%	44.0%	-27.0%	
Children in poverty	12.0%	3.6%	55.0%	43.0%	Health Need
Children in single-parent households	20.0%	6.0%	43.0%	23.0%	Health Need

Analysis of Primary Data – Key Informant Focus Groups

Need
Access and affordability of healthcare services
Access to primary care and specialists
Uninsured / Underinsured
Chronic diseases (Heart Disease, Kidney, Stroke, Cancer, Diabetes)
Lack of health knowledge and education
Mental health and addiction
Poor Nutrition / Limited Access to Healthy Food Options
Obesity
Preventative care
Services for the aging
Transportation
Language and Cultural Barriers
Healthy Behaviors / Lifestyle Choices

Issues of Uninsured Persons, Low-Income Persons and Minority/Vulnerable Populations

Population	Issues
Uninsured/Working Poor Population	Transportation Access to specialty services High cost of health care prevents needs from being met Healthy lifestyle and health nutrition education Prenatal care Services for children
Elderly	Transportation Cost of prescriptions and medical care Medical services to Winter Texans
Hispanic Population	Language and cultural barriers Transportation Immigration status Healthy living education
Non-Hispanic/Black Population	Sexually Transmitted Diseases* Low Birth Weight* ** Data Source: Community Commons*

Appendix B: Sources

Data Indicator	Source
Total Population	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Change in Total Population	Data Source: US Census Bureau, Decennial Census. 2000 - 2010. Source geography: Tract
Population Under Age 18	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Median Age	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Migration Patterns	Data Source: University of Wisconsin Net Migration Patterns for US Counties. 2000 to 2010. Source geography: County
Population Age 18-64	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Population Age 65+	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Population in Limited English Households	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Renter-Occupied Housing	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Household Composition	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Urban and Rural Population	Data Source: US Census Bureau, Decennial Census. 2010. Source geography: Tract
Children Eligible for Free/Reduced Price Lunch	Data Source: National Center for Education Statistics, NCES - Common Core of Data. 2015-16. Source geography: Address
Education - Bachelor's Degree or Higher	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Education - Head Start	Data Source: US Department of Health & Human Services, Administration for Children and Families. 2018. Source geography: Point
Education - High School Graduation Rate	Data Source: US Department of Education, EDFacts. Accessed via DATA.GOV. Additional data analysis by CARES. 2015-16. Source geography: School District
Education - No High School Diploma	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Education - Student Reading Proficiency (4th Grade)	Data Source: US Department of Education, EDFacts. Accessed via DATA.GOV. 2014-15. Source geography: School District
Households with No Motor Vehicle	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Income - Inequality (GINI Index)	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Income - Median Household Income	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Insurance - Uninsured Population	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Population Commuting to Work Over 60 Minutes	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Population Receiving SNAP Benefits (SAIPE)	Data Source: US Census Bureau, Small Area Income & Poverty Estimates. 2015. Source geography: County
Poverty - Children Below 100% FPL	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

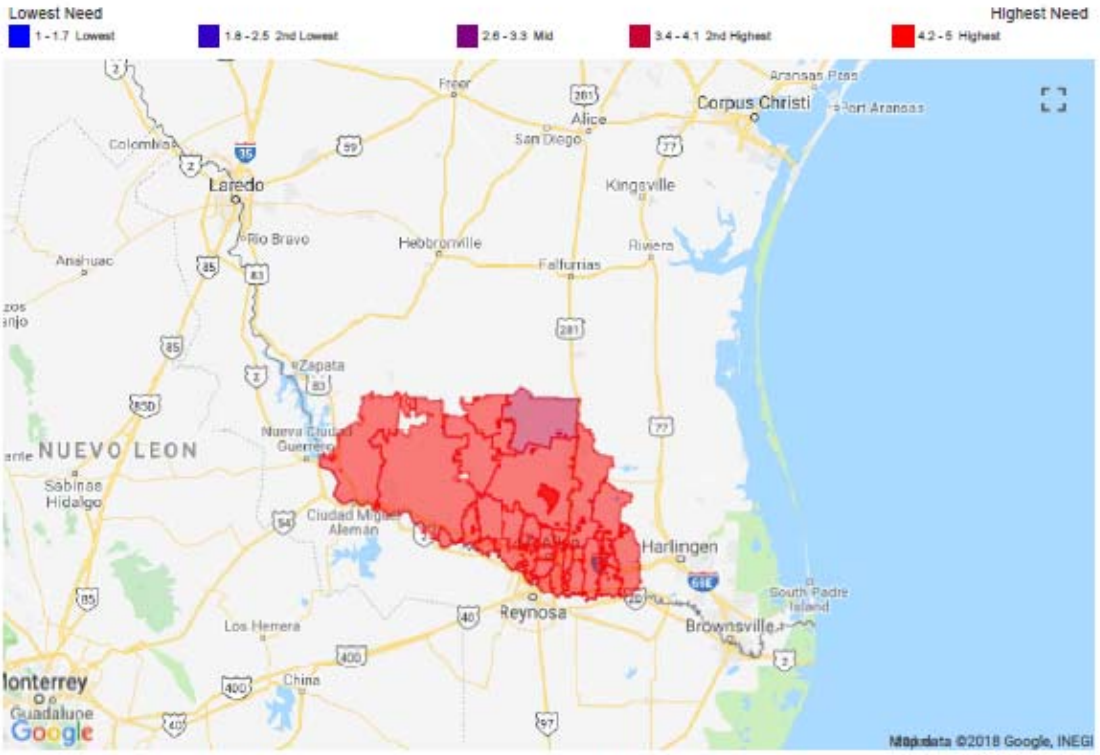
Data Indicator	Source
Poverty - Population Below 100% FPL	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Teen Births	Data Source: US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2006-
Unemployment Rate	Data Source: US Department of Labor, Bureau of Labor Statistics. 2018 - August. Source geography: County
Violent Crime	Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and
Young People Not in School and Not Working	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Air Quality - Particulate Matter 2.5	Data Source: Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2012. Source geography: Tract
Air Quality - Respiratory Hazard Index	Data Source: EPA National Air Toxics Assessment.
Built Environment - Broadband Access	Data Source: National Broadband Map. 2016. Source geography: Tract
Built Environment - Recreation and Fitness Facility Access	Data Source: US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016. Source geography: ZCTA
Climate & Health - High Heat Index Days	Data Source: National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS) . Accessed via CDC WONDER. Additional data analysis by CARES. 2014. Source
Climate & Health - Tree Canopy	Data Source: Multi-Resolution Land Characteristics Consortium, National Land Cover Database 2011. Additional data analysis by CARES. 2011. Source geography: Tract
Food Environment - Fast Food Restaurants	Data Source: US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016. Source geography: ZCTA
Food Environment - Food Desert Census Tracts	Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2015.
Food Environment - Grocery Stores	Data Source: US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016. Source geography: ZCTA
Food Environment - Low Food Access	Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2015. Source geography: Tract
Food Environment - Modified Retail Food Environment Index	Data Source: Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity. 2011. Source geography: Tract
Food Environment - SNAP-Authorized Food Stores	Data Source: US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator. Additional data analysis by CARES. 2017. Source geography: Tract
Housing - Housing Cost Burden (30%)	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Housing - Mortgage Lending	Data Source: Federal Financial Institutions Examination Council, Home Mortgage Disclosure Act. Additional data analysis by CARES. 2014.
Housing - Substandard Housing	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
Housing - Vacancy Rate	Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
30-Day Hospital Readmissions	Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care.
Access to Dentists	Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2015. Source geography: County
Access to Mental Health Providers	Data Source: University of Wisconsin Population Health Institute, County Health Rankings. 2018. Source geography: County

Data Indicator	Source
Access to Primary Care	Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2014. Source geography: County
Diabetes Management - Hemoglobin A1c Test	Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2015. Source geography: County
Federally Qualified Health Centers	Data Source: US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. March 2018. Source geography: Address
Health Professional Shortage Areas	Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. April 2016. Source geography: Address
Lack of Prenatal Care	Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for
Preventable Hospital Events	Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2015. Source geography: County
Prevention - Mammogram	Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2015. Source geography: County
Prevention - Recent Primary Care Visit	Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2015.
Alcohol Consumption	Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health
Alcohol Expenditures	Data Source: Nielsen, Nielsen SiteReports. 2014. Source geography: Tract
Breastfeeding - Ever	Data Source: Child and Adolescent Health Measurement Initiative, National Survey of Children's Health. Additional data analysis by CARES. 2016. Source geography: State
Fruit/Vegetable Expenditures	Data Source: Nielsen, Nielsen SiteReports. 2014. Source geography: Tract
Physical Inactivity	Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2015. Source geography: County
STI - Chlamydia Incidence	Data Source: US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
STI - Gonorrhea Incidence	Data Source: US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
STI - HIV Prevalence	Data Source: US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
Tobacco Expenditures	Data Source: Nielsen, Nielsen SiteReports. 2014. Source geography: Tract
Tobacco Usage - Current Smokers	Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health
Vegetable Consumption - All Vegetables	Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2015. Source geography: State
Asthma Prevalence	Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County
Cancer Incidence - All Sites	Data Source: State Cancer Profiles. 2011-15. Source geography: County
Cancer Incidence - All Sites	Data Source: State Cancer Profiles. 2011-15. Source geography: County
Cancer Incidence - Colon and Rectum	Data Source: State Cancer Profiles. 2011-15. Source geography: County
Cancer Incidence - Lung	Data Source: State Cancer Profiles. 2011-15. Source geography: County

Data Indicator	Source
Cancer Incidence - Prostate	Data Source: State Cancer Profiles. 2011-15. Source geography: County
Depression (Medicare Population)	Data Source: Centers for Medicare and Medicaid Services. 2015. Source geography: County
Diabetes (Adult)	Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2015. Source geography: County
Diabetes (Medicare Population)	Data Source: Centers for Medicare and Medicaid Services. 2015. Source geography: County
Heart Disease (Adult)	Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County
Heart Disease (Medicare Population)	Data Source: Centers for Medicare and Medicaid Services. 2015. Source geography: County
High Blood Pressure (Adult)	Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health
High Blood Pressure (Medicare Population)	Data Source: Centers for Medicare and Medicaid Services. 2015. Source geography: County
Infant Mortality	Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2006-10. Source geography: County
Low Birth Weight	Data Source: US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2006-
Mortality - Cancer	Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County
Mortality - Coronary Heart Disease	Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County
Mortality - Drug Poisoning	Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County
Mortality - Homicide	Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County
Mortality - Lung Disease	Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County
Mortality - Motor Vehicle Crash	Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County
Mortality - Pedestrian Motor Vehicle Crash	Data Source: US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2011-2015. Source geography: County
Mortality - Premature Death	Data Source: University of Wisconsin Population Health Institute, County Health Rankings. 2014-16. Source geography: County
Mortality - Stroke	Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County
Mortality - Suicide	Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County
Mortality - Unintentional Injury	Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County
Obesity	Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2015. Source geography: County
Obesity (Youth)	Data Source: Child and Adolescent Health Measurement Initiative, National Survey of Children's Health. 2016. Source geography: State
Poor Dental Health	Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10. Source geography: County
Poor General Health	Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health

Appendix C: Dignity Health Community Need Index (CNI) Report

Dignity Health.



Mean(zipcode): 4.6 / Mean(person): 4.7 CNI Score Median: 4.6 CNI Score Mode: 4.6

Zip Code	CNI Score	Population	City	County	State
78557	4.4	13659	Hidalgo	Hidalgo	Texas
78599	4.6	31831	Weslaco	Hidalgo	Texas
78570	4.8	34998	Mercedes	Hidalgo	Texas
78573	4.8	39791	Mission	Hidalgo	Texas
78574	4.6	62977	Mission	Hidalgo	Texas
78596	4.8	41907	Weslaco	Hidalgo	Texas
78516	4.6	35599	Alamo	Hidalgo	Texas
78501	5	63521	Mcallen	Hidalgo	Texas
78577	5	81193	Pharr	Hidalgo	Texas
78537	4.6	45989	Donna	Hidalgo	Texas
78541	5	47814	Edinburg	Hidalgo	Texas
78560	4.8	5988	La Joya	Hidalgo	Texas
78542	4.6	76071	Edinburg	Hidalgo	Texas
78572	4.8	84710	Mission	Hidalgo	Texas
78595	4.4	6696	Sullivan City	Hidalgo	Texas
78548	4.2	77	Grulla	Starr	Texas
78503	5	24911	Mcallen	Hidalgo	Texas
78576	4.2	11137	Penitas	Hidalgo	Texas
78538	4.6	19384	Edcouch	Hidalgo	Texas
78543	4.8	6076	Elsa	Hidalgo	Texas
78589	4.6	40768	San Juan	Hidalgo	Texas
78539	4.6	35498	Edinburg	Hidalgo	Texas
78504	4.2	55725	Mcallen	Hidalgo	Texas
78549	4.4	1174	Hargill	Hidalgo	Texas

	78591	4.2	312	Santa Elena	Starr	Texas
	78563	3.8	427	Linn	Hidalgo	Texas
	78588	4.2	322	San Isidro	Starr	Texas
	78536	4.2	195	Delmita	Starr	Texas
	78584	4.8	19634	Roma	Starr	Texas
	78582	4.6	43961	Rio Grande City	Starr	Texas

Source: http://cni.chw-interactive.org

Appendix D: County Health Rankings

County Health Rankings - Health Outcomes: Hidalgo County

Health Outcomes	Hidalgo County: 2016	Hidalgo County: 2018	Change	Texas: 2018	Top US Performers: 2018
Health Behaviors: State of Texas County Ranking	**172**	**131**	+		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke	15.0%	15.0%	NC	14.0%	14.0%
Adult obesity – Percent of adults that report a BMI >= 30	37.0%	34.0%	+	28.0%	26.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	5.3	7.1	+	6.0	8.6
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity	25.0%	25.0%	NC	24.0%	20.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity	61.0%	62.0%	+	81.0%	91.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days	14.0%	14.0%	NC	19.0%	13.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement	30.0%	28.0%	+	28.0%	13.0%
Sexually transmitted infections – Chlamydia rate per 100K population	407.3	407.3	NC	526.6	145.1
Teen birth rate – Per 1,000 female population, ages 15-19	76.0	62.0	+	41.0	15.0
Clinical Care: State of Texas County Ranking	**182**	**176**	+		
Uninsured adults – Percent of population under age 65 without health insurance	38.0%	32.0%	+	19.0%	6.0%
Primary care physicians – Ratio of population to primary care physicians	2,220:1	2,330:1	-	1,670:1	1,030:1
Dentists – Ratio of population to dentists	4,090:1	3,920:1	+	1,790:1	1,280:1
Mental health providers – Ratio of population to mental health providers	2,330:1	1,970:1	+	1,010:1	470:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	61.0	56.0	+	53.0	35.0
Diabetic screening – Percent of diabetic Medicare enrollees that receive HbA1c screening	87.0%	88.0%	+	84.0%	91.0%
Mammography screening – Percent of female Medicare enrollees that receive mammography screening	58.0%	58.0%	NC	58.0%	71.0%

County Health Rankings - Health Outcomes: Hidalgo County

Health Outcomes	Hidalgo County: 2016	Hidalgo County: 2018	Change	Texas: 2018	Top US Performers: 2018
Social and Economic Factors: State of Texas County Ranking	**235**	**232**	-		
High school graduation – Percent of ninth grade cohort that graduates in 4 years	85.0%	87.0%	+	89.0%	95.0%
Some college – Percent of adults aged 25-44 years with some post-secondary education	45.0%	47.0%	+	60.0%	72.0%
Unemployment – Percent of population age 16+ unemployed but seeking work	8.7%	7.8%	+	4.6%	3.2%
Children in poverty – Percent of children under age 18 in poverty	46.0%	43.0%	+	22.0%	12.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile	5.6	5.6	NC	4.9	3.7
Children in single-parent households – Percent of children that live in household headed by single parent	33.0%	35.0%	-	33.0%	20.0%
Social associations – Number of membership associations per 10,000 population	3.9	3.7	-	7.6	22.0
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)	310.0	312.0	-	408.0	62.0
Injury deaths – Number of deaths due to injury per 100,000 population	30.0	30.0	NC	55.0	55.0
Physical Environment: State of Texas County Ranking	**217**	**231**	-		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter	8.6	8.9	-	8.0	6.7
Severe housing problems – Percentage of household with at least one of four housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities	28.0%	28.0%	NC	18.0%	9.0%
Driving alone to work – Percentage of the workforce that drives alone to work	79.0%	80.0%	-	80.0%	72.0%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes	23.0%	22.0%	+	37.0%	15.0%

Data Source: Countyhealthrankings.org

County Health Rankings - Health Outcomes: Starr County

Health Outcomes	Starr County: 2016	Starr County: 2018	Change	Texas: 2018	Top US Performers: 2018
Health Behaviors: State of Texas County Ranking	**231**	**239**	-		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke	20.0%	20.0%	NC	14.0%	14.0%
Adult obesity – Percent of adults that report a BMI >= 30	30.0%	31.0%	-	28.0%	26.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	4.4	5.8	+	6.0	8.6
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity	24.0%	28.0%	-	24.0%	20.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity	13.0%	28.0%	+	81.0%	91.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days	14.0%	14.0%	NC	19.0%	13.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement	31.0%	41.0%	-	28.0%	13.0%
Sexually transmitted infections – Chlamydia rate per 100K population	323.0	279.6	+	526.6	145.1
Teen birth rate – Per 1,000 female population, ages 15-19	92.0	80.0	+	41.0	15.0
Clinical Care: State of Texas County Ranking	**236**	**231**	-		
Uninsured adults – Percent of population under age 65 without health insurance	35.0%	31.0%	+	19.0%	6.0%
Primary care physicians – Ratio of population to primary care physicians	5,630:1	5,320:1	+	1,670:1	1,030:1
Dentists – Ratio of population to dentists	7,000:1	6,410:1	+	1,790:1	1,280:1
Mental health providers – Ratio of population to mental health providers	7,000:1	6,410:1	+	1,010:1	470:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	103.0	88.0	+	53.0	35.0
Diabetic screening – Percent of diabetic Medicare enrollees that receive HbA1c screening	88.0%	90.0%	+	84.0%	91.0%
Mammography screening – Percent of female Medicare enrollees that receive mammography screening	46.0%	44.0%	-	58.0%	71.0%

County Health Rankings - Health Outcomes: Starr County

Health Outcomes	Starr County: 2016	Starr County: 2018	Change	Texas: 2018	Top US Performers: 2018
Social and Economic Factors: State of Texas County Ranking	**240**	**241**	-		
High school graduation – Percent of ninth grade cohort that graduates in 4 years	92.0%	92.0%	NC	89.0%	95.0%
Some college – Percent of adults aged 25-44 years with some post-secondary education	33.0%	32.0%	+	60.0%	72.0%
Unemployment – Percent of population age 16+ unemployed but seeking work	13.5%	13.6%	-	4.6%	3.2%
Children in poverty – Percent of children under age 18 in poverty	44.0%	55.0%	-	22.0%	12.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile	5.2	5.3	-	4.9	3.7
Children in single-parent households – Percent of children that live in household headed by single parent	39.0%	43.0%	-	33.0%	20.0%
Social associations – Number of membership associations per 10,000 population	2.7	2.7	NC	7.6	22.0
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)	265.0	281.0	-	408.0	62.0
Injury deaths – Number of deaths due to injury per 100,000 population	31.0	33.0	-	55.0	55.0
Physical Environment: State of Texas County Ranking	**60**	**130**	-		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter	8.6	8.0	+	8.0	6.7
Severe housing problems – Percentage of household with at least one of four housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities	21.0%	21.0%	NC	18.0%	9.0%
Driving alone to work – Percentage of the workforce that drives alone to work	71.0%	71.0%	NC	80.0%	72.0%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes	20.0%	22.0%	NC	37.0%	15.0%

Data Source: Countyhealthrankings.org

Appendix E: Key Stakeholder Acknowledgements

Key Stakeholder Acknowledgements

Thank you to the following individuals who provided input into the community health needs assessment.

Key Stakeholders

Name	Organization
Mayor Armando O'Caña	Mayor - City of Mission
Roberto Dominguez	Chief of Police - City of Mission
Jaime Acevedo	Planning Director - City of Mission
Noemi Munguia	Human Resources Director - City of Mission
Nereyda Pena	Assitant HR Director - City of Mission
Ruben Plata	City Council Member - City of Mission
Robert Hinojosa	Risk Management Director - City of Mission
Martin Garza, Jr.	City Manager - City of Mission
Omar Rodriguez	Manager of Communication - Food Bank
Lulu Rizalde	Case Management Director - MRMC
Diana Alcocer	Executive Director - Stream
Craig Verley	Director of Public Relations and Marketing - Mission CISD
Lorena Garcia	Assistant Superintendent
Dr. Carol G. Perez	Superintendent - Mission CISD
Dr. Gloria Ortiz	Endocrinologist
Dr. Humberto Nunez	Hospitalist
Dr. Sheila Calderon	Internal Medicine
Dr. Jaspreet Kaur	Primary Care Physician