Baylor Scott & White Health
Community Health Needs Assessment

Waxahachie Health Community

Baylor Scott & White Medical Center - Waxahachie

Approved by: Baylor Scott & White Health – North Texas Operating, Policy and Procedure Board on June 25, 2019

Posted to BSWHealth.com/CommunityNeeds on June 30, 2019

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Baylor Scott & White Health Mission Statement

Our Mission

Founded as a Christian ministry of healing, Baylor Scott & White Health promotes the well-being of all individuals, families and communities.

Our Ambition

To be the trusted leader, educator and innovator in value-based care delivery, customer experience and affordability.

Our Values

- We serve faithfully
- We act honestly
- We never settle
- We are in it together

Our Strategies

- Health – Transform into an integrated network that ambitiously and consistently provides exceptional quality care
- Experience – Achieve the market-leading brand by empowering our people to design and deliver a customer-for-life experience
- Affordability – Continuously improve our cost discipline to invest in our Mission and reduce the financial burden on our customers
- Alignment – Ensure consistent results through a streamlined leadership approach and unified operating model
- Growth – Pursue sustainable growth initiatives that support our Mission, Ambition, and Strategy

WHO WE ARE

As the largest not-for-profit healthcare system in Texas and one of the largest in the United States, Baylor Scott & White Health was born from the 2013 combination of Baylor Health Care System and Scott & White Healthcare. Today, Baylor Scott & White includes 50 hospitals, more than 900 patient care sites, more than 7,500 active physicians, and over 47,000 employees and the Scott & White Health Plan.


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Executive Summary

As the largest not-for-profit health care system in Texas, Baylor Scott & White Health (BSWH) understands the importance of serving the health needs of its communities. In order to do that successfully, we must first take a comprehensive look at the systemic and local issues our patients, their families and neighbors face when it comes to having the best possible health outcomes and well-being.

Beginning in June of 2018, a BSWH task force led by the Community Health, Tax Services, and Marketing Research departments began the process of assessing the current health needs of the communities served for all BSWH hospital facilities. IBM Watson Health (formerly Truven Health Analytics) collected and analyzed the data for this process and compiled a final report made publicly available in June of 2019.

BSWH owns and operates multiple individual licensed hospital facilities serving the residents of north and central Texas. This community health needs assessment applies to the following BSWH hospital facility:

- Baylor Scott & White Medical Center – Waxahachie

For the 2019 assessment, the community includes the geographic area where at least 80% of the hospital facilities' admitted patients live.

The hospital and IBM Watson Health (Watson Health) examined over 102 public health indicators and conducted a benchmark analysis of the data comparing the community to overall State of Texas and United States (U.S.) values. A qualitative analysis included direct input from the community through focus groups and key informant interviews. Interviews included input from state, local, or regional governmental public health departments (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community, and individuals or organizations serving or representing the interests of medically underserved, low-income, and minority populations in the community

Needs were first identified when an indicator for the community served was worse than the Texas state benchmark. A need differential analysis conducted on all the low performing indicators determined relative severity by using the percent difference from benchmark. The outcome of this quantitative analysis aligned with the qualitative findings of the community input sessions to create a list of health needs in the community. Each health need received assignment into one of four quadrants in a health needs matrix, this clarified the assignment of severity rankings to the needs. The matrix shows the convergence of needs identified in the qualitative data (interview and focus group feedback) and quantitative data (health indicators) and identifies the top health needs for this community.

Hospital clinical leadership and/or other invited community leaders reviewed the top health needs in a meeting to select and prioritize the list of significant needs in this health community. The meeting, moderated by Watson Health, included an overview of the CHNA process for BSWH, the methodology for determining the top health needs, the BSWH prioritization approach, and discussion of the top health needs identified for the community.

Participants identified the significant health needs through review of data driven criteria for the top health needs, discussion, and a multi-voting process. Once the significant health needs were established, participants rated the needs using prioritization criteria recommended by the focus groups. The sum of the criteria scores for each need created an overall score that became the basis of the prioritized order of significant health needs. The resulting prioritized health needs for this community include:

Priority	Need	Category of Need
1	Ratio of Population to One Non-Physician Primary Care Provider	Access to Care
2	Ratio of Population to One Primary Care Physician	Access to Care
3	Ratio of Population to One Mental Health Provider	Mental Health
4	Uninsured Children	Access to Care
5	Ratio of Population to One Dentist	Access to Care

The assessment process identified and included community resources able to address significant needs in the community. These resources, located in the appendix of this report, will be included in the formal implementation strategy to address needs identified in this assessment. The approved report is publicly available by the 15th day of the 5th month following the end of the tax year.

An evaluation of the impact and effectiveness of interventions and activities outlined in the implementation strategy drafted after the prior assessment is included in **Appendix F** of this document.

The prioritized list of significant health needs approved by the hospitals' governing body and the full assessment is available to anyone at no cost. To download a copy, visit **BSWHealth.com/CommunityNeeds**.

This assessment and corresponding implementation strategy meet the requirements for community benefit planning and reporting as set forth in state and federal laws, including but not limited to: Texas Health and Safety Code Chapter 311 and Internal Revenue Code Section 501(r).

Community Health Needs Assessment Requirement

As a result of the Patient Protection and Affordable Care Act (PPACA), all tax-exempt organizations operating hospital facilities are required to assess the health needs of their community through a Community Health Needs Assessment (CHNA) once every three years.

The written CHNA Report must include descriptions of the following:

- The community served and how the community was determined
- The process and methods used to conduct the assessment including sources and dates of the data and other information as well as the analytical methods applied to identify significant community health needs
- How the organization took into account input from persons representing the broad interests of the community served by the hospital, including a description of when and how the hospital consulted with these persons or the organizations they represent
- The prioritized significant health needs identified through the CHNA as well as a description of the process and criteria used in prioritizing the identified significant needs
- The existing healthcare facilities, organizations, and other resources within the community available to meet the significant community health needs
- An evaluation of the impact of any actions that were taken, since the hospital facility(s) most recent CHNA, to address the significant health needs identified in that last CHNA

PPACA requires hospitals to adopt an Implementation Strategy to address prioritized community health needs identified through the assessment. An Implementation Strategy is a written plan addressing each of the significant community health needs identified through the CHNA in a separate but related document to the CHNA report.

The written Implementation Strategy must include the following:

- List of the prioritized needs the hospital plans to address and the rationale for not addressing other significant health needs identified
- Actions the hospital intends to take to address the chosen health needs
- The anticipated impact of these actions and the plan to evaluate such impact (e.g. identify data sources that will be used to track the plan's impact)
- Identify programs and resources the hospital plans to commit to address the health needs
- Describe any planned collaboration between the hospital and other facilities or organizations in addressing the health needs

CHNA Overview, Methodology and Approach

BSWH began the 2019 CHNA process in June of 2018; the following is an overview of the timeline and major milestones.

BSWH partnered with Watson Health to complete a CHNA for qualifying BSWH hospital facilities.

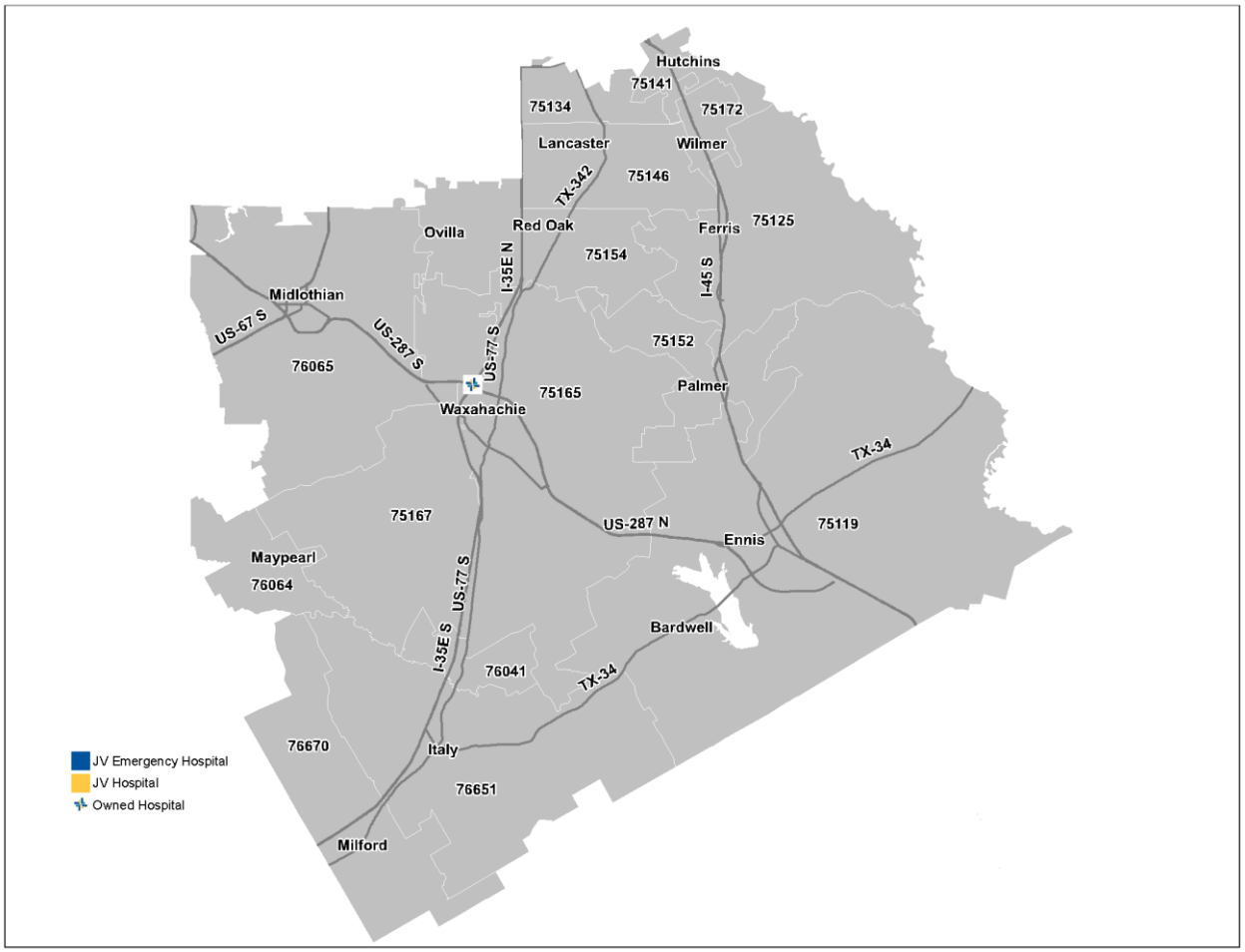
Consultant Qualifications & Collaboration

Watson Health delivers analytic tools, benchmarks, and strategic consulting services to the healthcare industry, combining rich data analytics in demographics, including the Community Needs Index, planning, and disease prevalence estimates, with experienced strategic consultants delivering comprehensive and actionable Community Health Needs Assessments.

Community Served Definition

Based on the review of patient admission records, the hospital facility has defined its community to include the ZIP codes listed below which spans multiple counties in the Waxahachie area of north Texas including Dallas and Ellis counties. The community includes the geographic area where at least 80% of the hospital facilities' admitted patients live.

BSWH Community Health Needs Assessment
Waxahachie Health Community Map



Source: Baylor Scott & White Health, 2019

75134, 75141, 75146, 75172, 75101, 75119, 75120, 75125, 75152, 75154, 75165, 75167, 75168, 76065, 76041, 76064, 76623, 76651, 76670

Assessment of Health Needs

To identify the health needs of the community, the hospital facility established a comprehensive method of accounting for all available relevant data including community input. The basis of identification of community health needs was the weight of qualitative and quantitative data obtained when assessing the community. Surveyors conducted interviews and focus groups with individuals representing public health, community leaders/groups, public organizations, and other providers. Data collected from several public sources compared to the state benchmark indicated the level of severity.

Quantitative Assessment of Health Needs – Methodology and Data Sources

Quantitative data collection and analysis in the form of public health indicators assessed community health needs, including collection of 102 data elements grouped into 11 categories, and evaluated for the counties where data was available. Since 2016, the identification of several new indicators included: addressing mental health, health care costs, opioids, and social determinants of health. The categories and indicators are included in the table below. The sources are in **Appendix A**.

Although this community definition is by ZIP codes, public health indicators are most commonly available by county. Therefore, a patient origin study determined which counties principally represent the community's residents receiving hospital services. The principal county for the Waxahachie Health Community needs analysis is Ellis County.

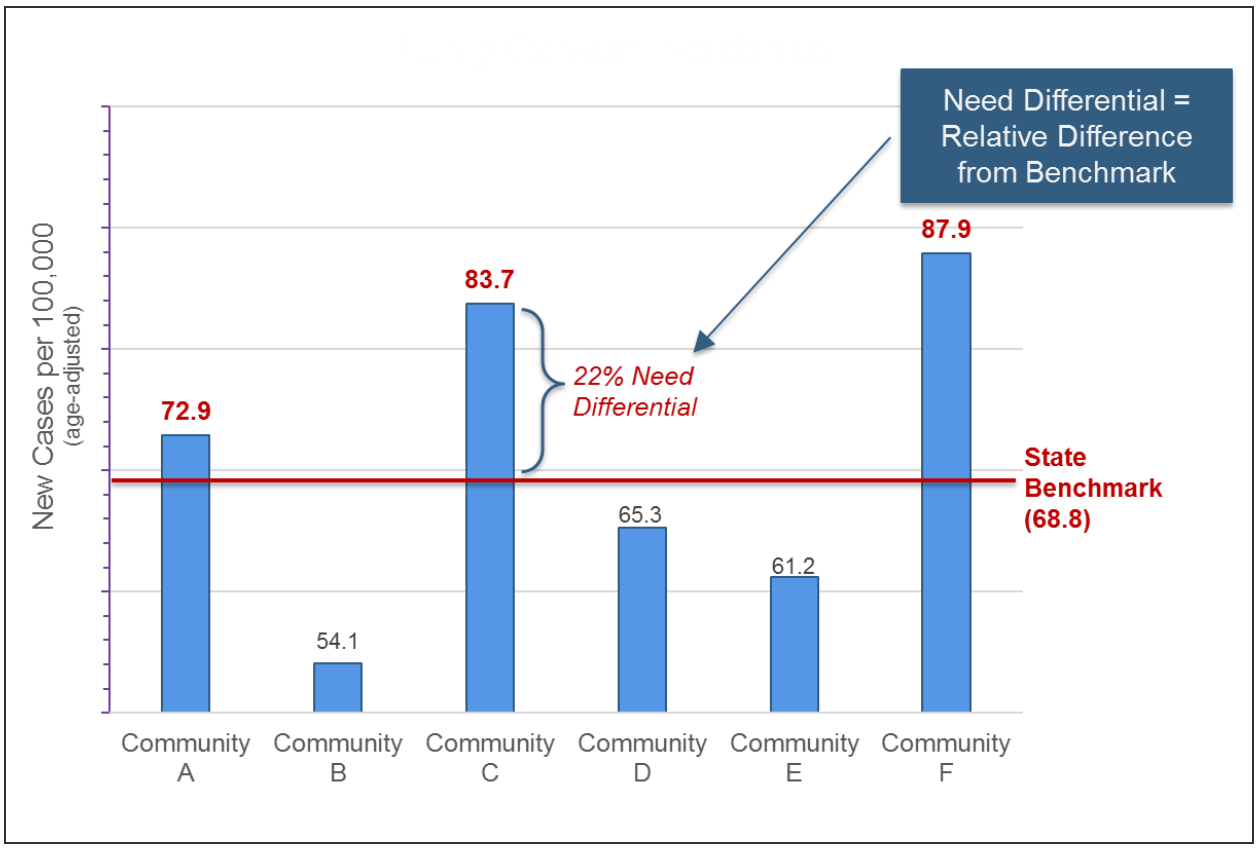
A benchmark analysis conducted for each indicator collected for the community served, determined which public health indicators demonstrated a community health need from a quantitative perspective. Benchmark health indicators collected included (when available): overall U.S. values; state of Texas values; and goal setting benchmarks such as Healthy People 2020.

According to America's Health Rankings 2018 Annual Report, Texas ranks 37th out of the 50 states. The health status of Texas compared to other states in the nation identified many opportunities to impact health within local communities, including opportunities for those communities that ranked highly. Therefore, the benchmark for the community served was set to the state value.

When the community benchmark was set to the state value, it was determined which indicators for the community did not meet the state benchmarks. This created a subset of indicators for further analysis. A need differential analysis clarified the relative severity of need for these indicators. The need differential standardized the method for evaluating the degree each indicator differed from its benchmark; this measure is called the need differential. Health community indicators with need differentials above the 50th percentile, ordered by severity, and the highest ranked indicators were the highest health needs from a quantitative perspective. These data are available to the community via an interactive Tableau dashboard at **BSWHealth.com/CommunityNeeds**.

Outcomes of the quantitative data analysis were compared to the qualitative data findings.

Health Indicator Benchmark Analysis Example



Source: IBM Watson Health, 2018

Qualitative Assessment of Health Needs and Community Input – Approach

In addition to analyzing quantitative data, two (2) focus groups with a total of 23 participants, and three (3) key informant interviews, gathered the input of persons representing the broad interests of the community served. The focus groups and interviews solicited feedback from leaders and representatives who serve the community and have insight into community needs. Prioritization sessions held with hospital clinical leadership and other community leaders identified significant health needs from the assessment and prioritized them

The focus group familiarized participants with the CHNA process and solicited input to understand health needs from the community's perspective. Focus groups, formatted for individual as well as small group feedback, helped identify barriers and social determinants influencing the community's health needs. Barriers and social determinants were new topics added to the 2019 community input sessions.

Watson Health conducted key informant interviews for the community served by the hospital. The interviews aided in gaining understanding and insight into participants concerns about the general health status of the community and the various drivers contributing to health issues.

Participation in the qualitative assessment was included from at least one state, local, or regional governmental public health department (or equivalent department or agency)

with knowledge, information, or expertise relevant to the health needs of the community, as well as individuals or organizations serving or representing the interests of medically underserved, low-income and minority populations in the community.

Participation from community leaders/groups, public health organizations, other healthcare organizations, and other healthcare providers (including physicians) ensured that the input received represented the broad interests of the community served. A list of the names of organizations providing input are in the table below.

Community Input Participants

Participant Organization Name	Public Health	Medically Under-served	Low-income	Chronic Disease Needs	Minority Populations	Governmental Public --Health Dept.	Public Health Knowledge --Expertise
Baylor Scott & White Health	X	X	X	X	X	X	X
Cancer Care Services	X	X	X	X	X		X
City of Waxahachie		X	X	X	X		
Daniel's Den			X				
Dallas County Health and Human Services	X		X			X	
Hope Clinic (Federally Qualified Health Clinic)	X	X	X	X	X	X	
Manna House			X				
Meals on Wheels of Johnson and Ellis Counties	X	X	X	X	X		
Metrocare	X	X	X	X	X		X
Presbyterian Children's Homes and Services			X	X	X		
Salvation Army			X				
Waxahachie Care Services			X				X
Waxahachie Senior Center					X		

Note: multiple persons from the same organization may have participated

In addition to soliciting input from public health and various interests of the community, the hospital was required to consider written input received on their most recently conducted CHNA and subsequent implementation strategies. The assessment is

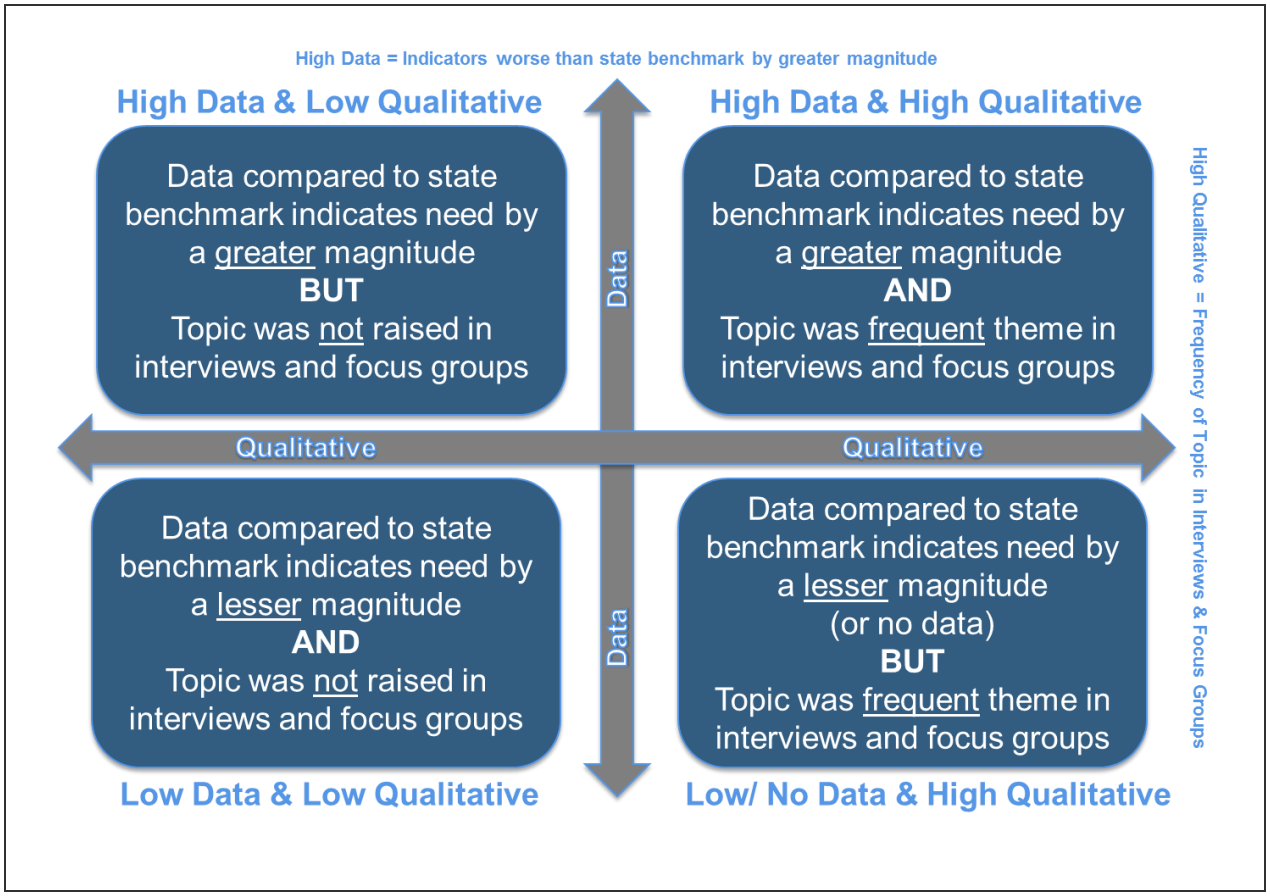
available to receive public comment or feedback on the report findings on the BSWH website (**BSWHealth.com/CommunityNeeds**) or by emailing **CommunityHealth@BSWHealth.org**. To date BSWH has not received such written input but continues to welcome feedback from the community.

Community input from interviews and focus groups organized the themes around community needs, and compared them to the quantitative data findings.

Methodology for Defining Community Need

Using qualitative feedback from the interviews, focus groups, and the health indicator data, the consolidated issues affecting the community served assembled in the Health Needs Matrix below helps identify the health needs for each community. The upper right quadrant of the matrix is where the needs identified in the qualitative data (interview and focus group feedback) and quantitative data (health indicators) converge to identify the top health needs for this community

The Health Needs Matrix



Source: IBM Watson Health, 2018

Information Gaps

In some areas of Texas, health indicators were not available due to the impact small population size has on reporting and statistical significance. Most public health indicators were available only at the county level. Evaluating data for entire counties versus more localized data, made it difficult to understand the health needs for specific population pockets within a county. It could also be a challenge to tailor programs to address community health needs, as placement and access to specific programs in one part of the county may or may not affect the population who truly need the service.

Approach to Identify and Prioritize Significant Health Needs

In a session held November 7, 2018, Baylor Scott & White – Waxahachie leadership, and community leaders met and identified and prioritized significant health needs. The meeting, moderated by Watson Health, included an overview of the CHNA process for BSWH, the methodology for determining the top health needs, the BSWH prioritization approach, and discussion of the top health needs identified for the community.

Prioritization of the health needs took place in two steps. In the first step, participants reviewed the top health needs for their community with associated data-driven criteria to evaluate. The criteria included health indicator value(s) for the community, how the indicator compared to the state benchmark, and potentially preventable ED visit rates for the community (if available). Participants then leveraged the professional experience and community knowledge of the group via discussion about which needs were most significant. With the data-driven review criteria and the discussion completed, a multi-voting method identified the significant health needs. Participants voted individually for the five (5) needs they considered as the most significant for this community. With votes tallied, five (5) identified needs ranked as significant health needs, based on the number of votes.

In the second step, participants ranked the significant health needs based on prioritization criteria recommended by the focus group conducted for this community:

1. Magnitude: the need impacts a large number of people, actually or potentially
2. Vulnerable Populations: there is a high need among vulnerable populations and/or vulnerable populations are adversely impacted
3. Feasibility: the problem is amenable to interventions; technology, knowledge, or resources can effect a change; or the problem is preventable

Through discussion and consensus, the group rated each of the five (5) significant health needs on each of the three (3) identified criteria utilizing a scale of one (low) to 10 (high). The criteria scores summed for each need created an overall score and became the basis for prioritizing the significant health needs. For the scores resulting in a tie, the need with the greater negative difference from the benchmark ranked above the other need. The outcome of this process, the list of prioritized health needs for this community, is located in the "**Prioritized Significant Health Needs**" section of the assessment.

The prioritized list of significant health needs approved by the hospitals' governing body and the full assessment is available to anyone at no cost. To download a copy, visit **BSWHealth.com/CommunityNeeds**.

Existing Resources to Address Health Needs

Part of the assessment process included gathering input on community resources potentially available to address the significant health needs identified through the CHNA. BSWH Community Resource Guides, and input from qualitative assessment participants, identified community resources that may assist in addressing the health needs identified for this community. A description of these resources is in **Appendix B**. An interactive asset map of various resources identified for all BSWH communities is located at **BSWHealth.com/CommunityNeeds**.

Waxahachie Health Community CHNA

Demographic and Socioeconomic Summary

According to population statistics, the community served was similar to Texas in terms of projected population growth; both outpace the country. The median age was younger than Texas overall and younger than the United States. Median income was above both the state and the country.

Demographic and Socioeconomic Comparison: Community Served and State/U.S. Benchmarks

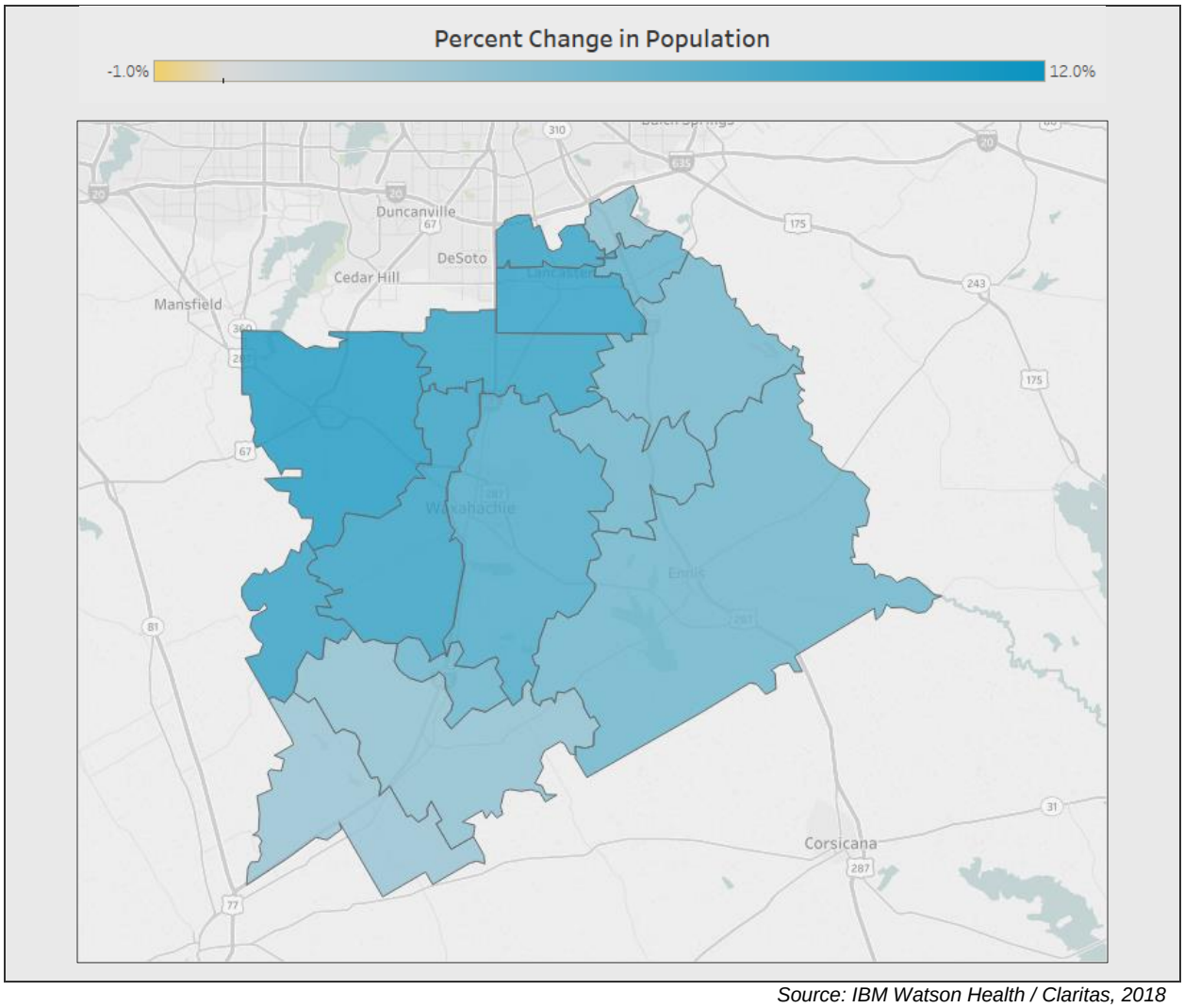
Geography		Benchmarks		Community Served
		United States	Texas	Waxahachie Health Community
Total Current Population		326,533,070	28,531,631	237,186
5 Yr Projected Population Change		3.5%	7.1%	8.1%
Median Age		42.0	38.9	35.8
Population 0-17		22.6%	25.9%	26.5%
Population 65+		15.9%	12.6%	12.0%
Women Age 15-44		19.6%	20.6%	20.5%
Non-White Population		30.0%	32.2%	38.7%
Hispanic Population		18.2%	39.4%	25.8%
Insurance Coverage	Uninsured	9.4%	19.0%	13.1%
	Medicaid	14.9%	13.4%	12.1%
	Private Market	9.6%	9.9%	9.6%
	Medicare	16.1%	12.5%	13.6%
	Employer	45.9%	45.3%	51.7%
Median HH Income		$61,372	$60,397	$64,524
Limited English		26.2%	39.9%	26.0%
No High School Diploma		7.4%	8.7%	8.1%
Unemployed		6.8%	5.9%	5.2%

Source: IBM Watson Health / Claritas, 2018; US Census Bureau 2017 (U.S. Median Income)

The population of the community served is expected to grow 8.1% by 2023, an increase by more than 19,000 people. The 8.1% projected population growth is slightly less than the state's 5-year projected growth rate (7.1%) but higher when compared to the national projected growth rate (3.5%). The ZIP codes expected to experience the most growth in five years are:

- 75154 Red Oak – 3,844 people
- 76065 Midlothian – 3,723 people
- 75165 Waxahachie – 3,393 people

2018 - 2023 Total Population Projected Change by ZIP Code

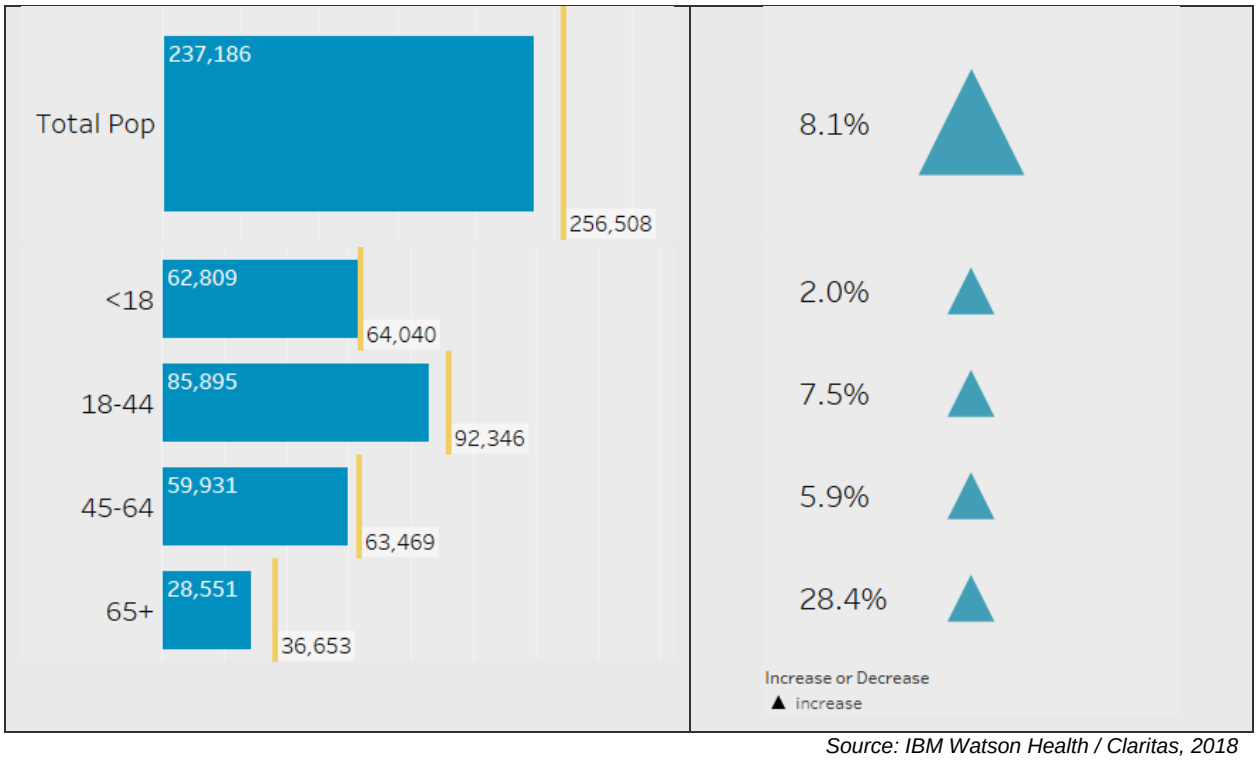


Source: IBM Watson Health / Claritas, 2018

The community's population skewed younger with 36.2% of the population ages 18-44 and 26.5% under age 18. The largest cohort (ages 18-44) projects a growth of 6,451 people by 2023. The age 65 plus cohort was the smallest but projects to experience the fastest growth (28.4%) over the next five years, adding 8,102 seniors to the community. Growth in the senior population will likely contribute to increased utilization of services as the population continues to age.

Population Distribution by Age

2018 Population by Age Cohort *Percent Change by 2023*

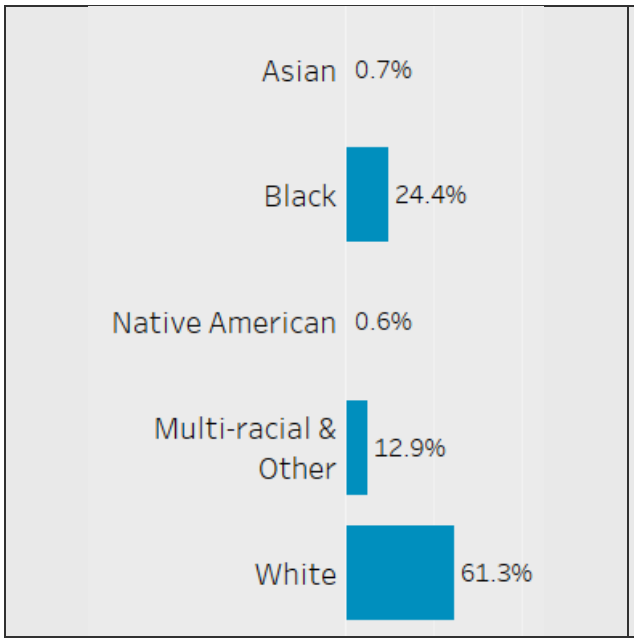


Source: IBM Watson Health / Claritas, 2018

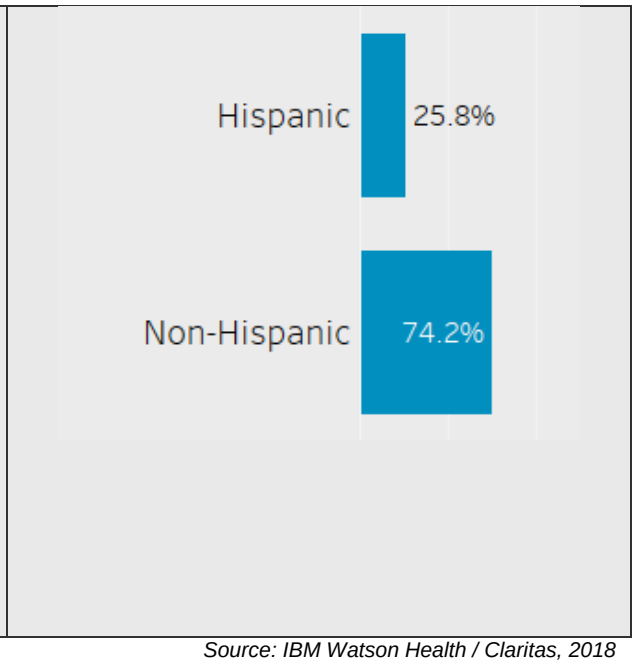
Population statistics are analyzed by race and by Hispanic ethnicity. The community was primarily non-Hispanic White (47.4%) and non-Hispanic Black (24.1%). The Hispanic population (all races) made up 25.8% of the health community, and is expected to increase 14.9% by 2023, an increase of 9,116 people. This exceeds the growth rate of non-Hispanics (all races), which was 5.8%.

Population Distribution by Race and Ethnicity

2018 Population by Race

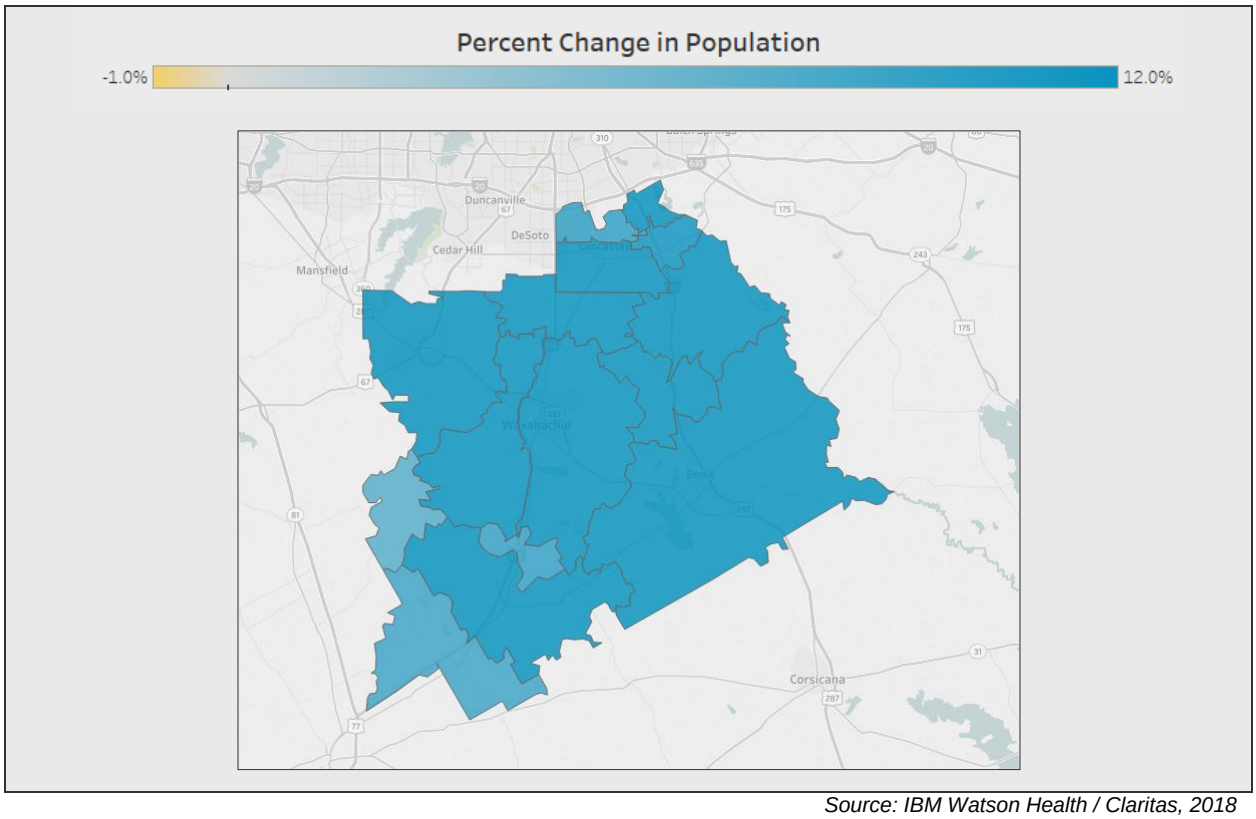


2018 Population by Ethnicity



Source: IBM Watson Health / Claritas, 2018

2018 - 2023 Hispanic Population Projected Change by ZIP Code

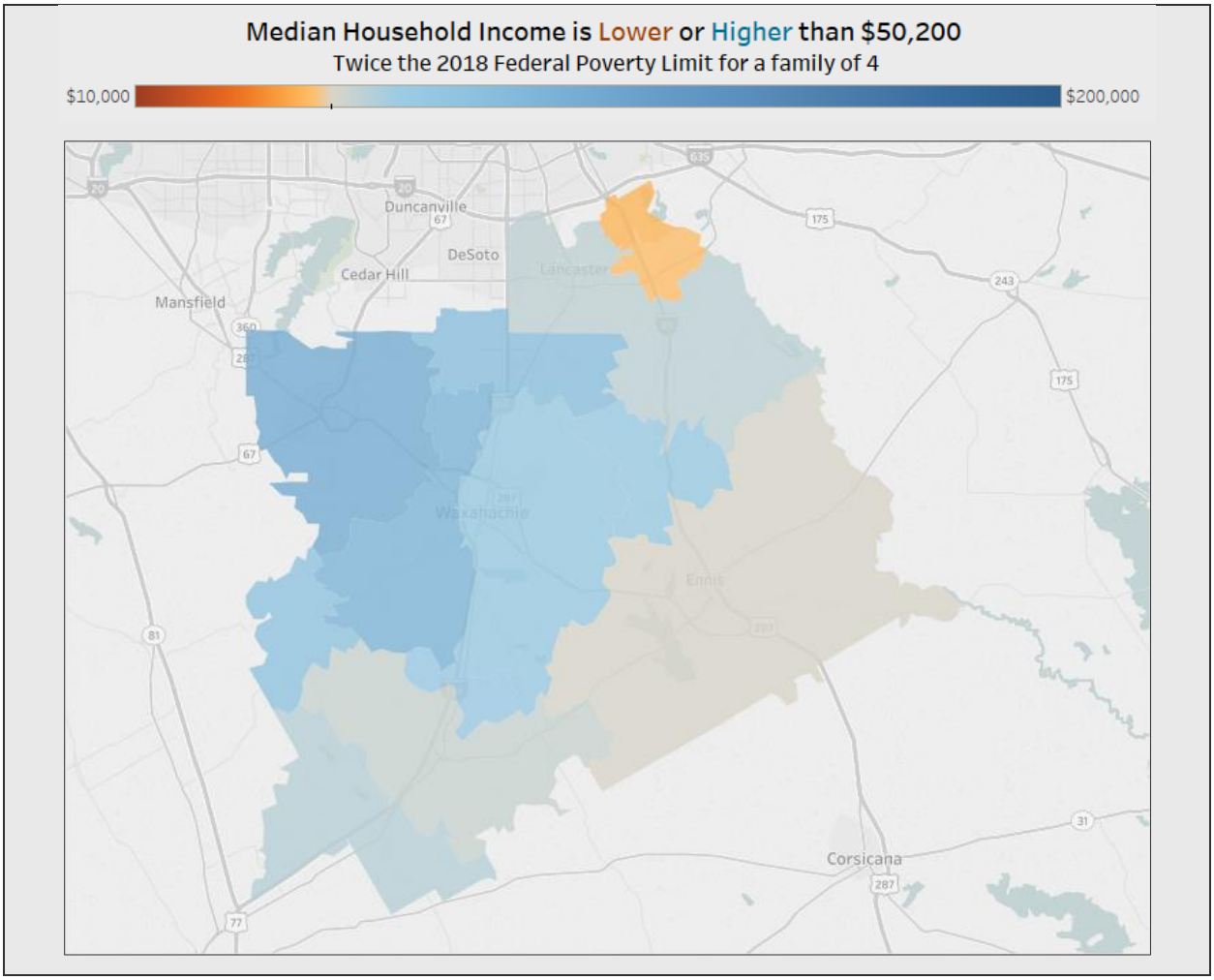


Source: IBM Watson Health / Claritas, 2018

The 2018 median household income for the United States was $61,372 and $60,397 for the state of Texas. The median household income for the ZIP codes within this community ranged from $43,968 for 75141 – Lancaster to $99,653 for 76065 – Midlothian. Two (2) ZIP Codes had median household incomes less than $50,200 – twice the 2018 Federal Poverty Limit for a family of four:

- 75172 Lancaster - $45,833
- 75141 Lancaster - $43,968

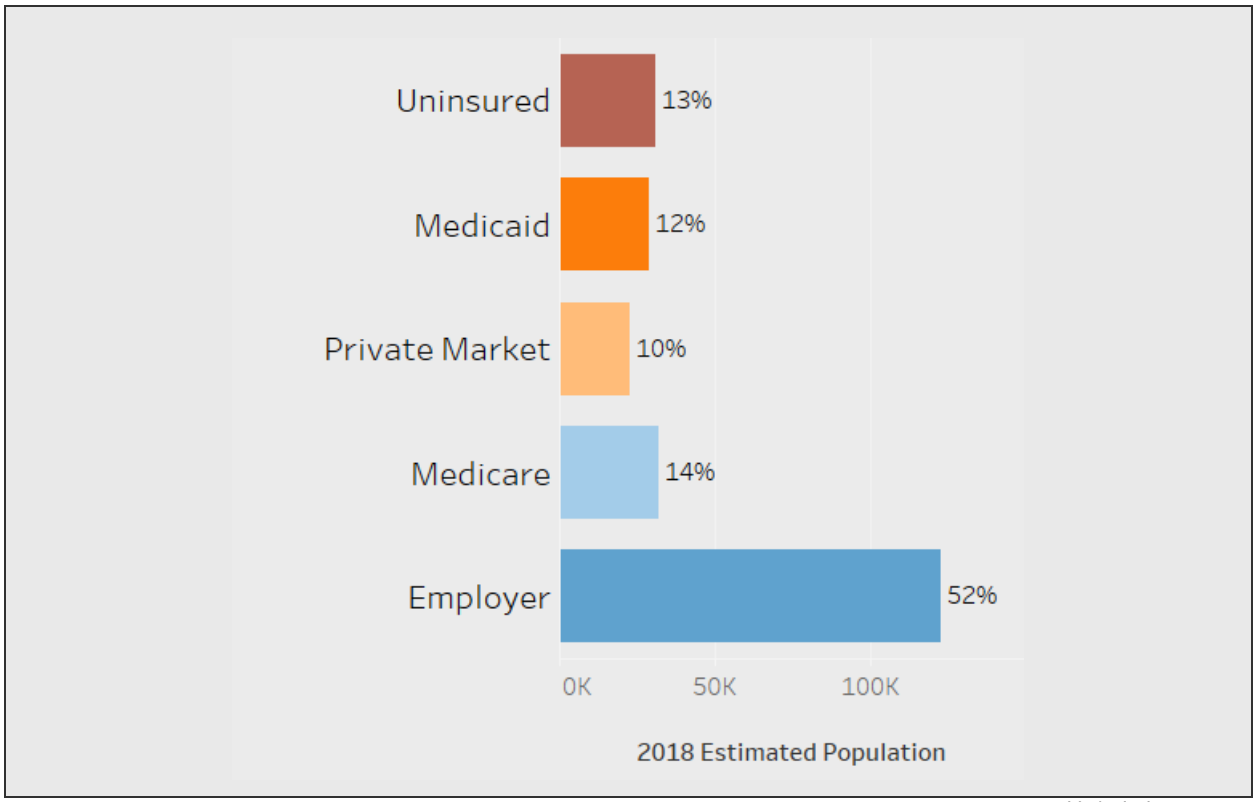
2018 Median Household Income by ZIP Code



Source: IBM Watson Health / Claritas, 2018

More than half of the population (52%) received insurance through employer sponsored health coverage. The remainder of the population was fairly equally divided between Medicaid, Medicare, private market (the purchasers of coverage directly or through the health insurance marketplace), and those without health care insurance.

2018 Estimated Distribution of Covered Lives by Insurance Category



Source: IBM Watson Health / Claritas, 2018

The community includes three (3) Health Professional Shortage Areas and one (1) Medically Underserved Areas as designated by the U.S. Department of Health and Human Services Health Resources Services Administration.[1] **Appendix C** includes the details on each of these designations.

Health Professional Shortage Areas and Medically Underserved Areas and Populations

	Health Professional Shortage Areas (HPSA)				Medically Underserved Area/Population (MUA/P)
NTX Waxahachie Health Community	**Dental Health**	**Mental Health**	**Primary Care**	**Grand Total**	**MUA/P**
Ellis	1	1	1	3	1
Total	**1**	**1**	**1**	**3**	**1**

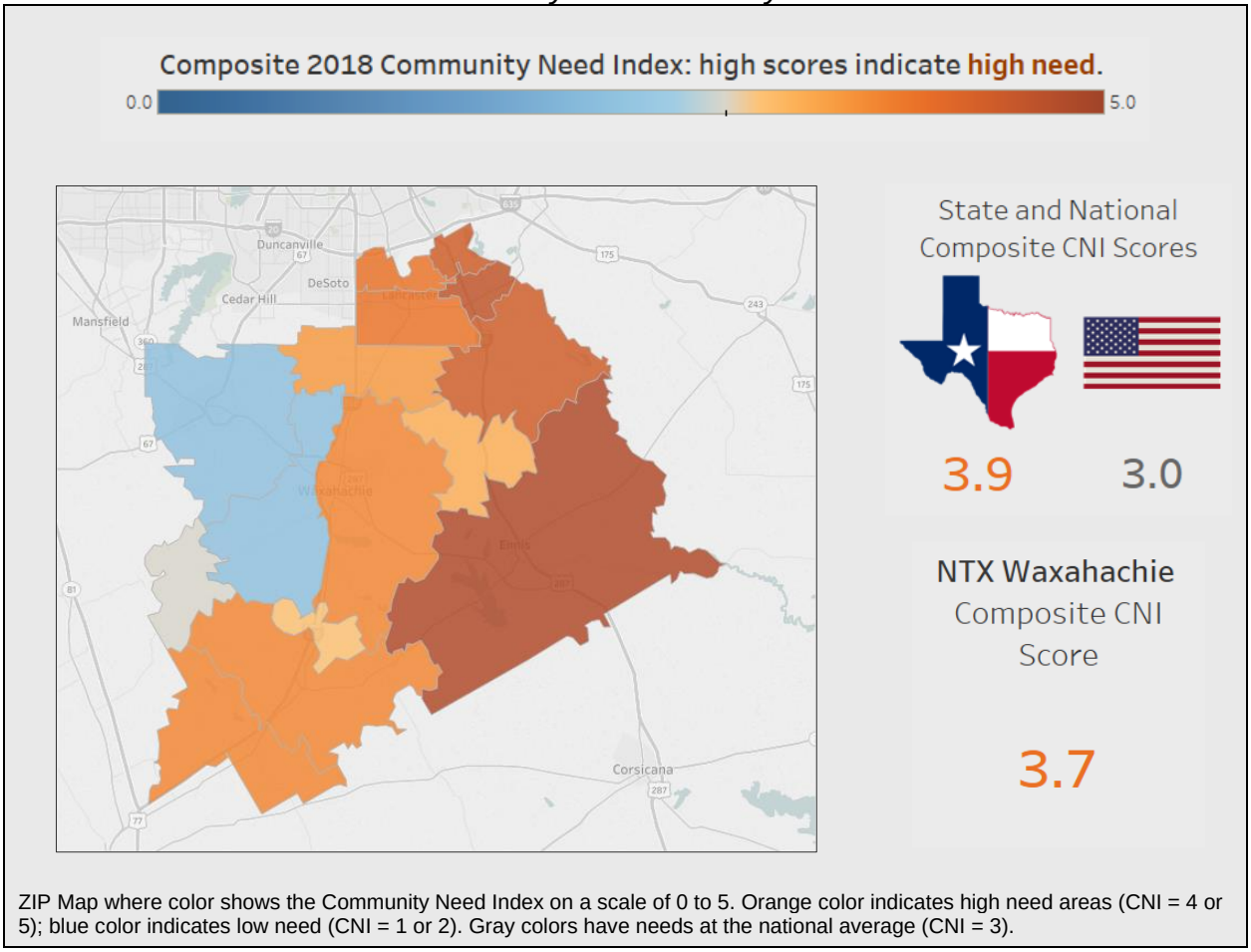
Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, 2018

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, 2018

The Watson Health Community Need Index (CNI) is a statistical approach to identifying areas within a community where health disparities may exist. The CNI accounts for vital socio-economic factors (income, cultural, education, insurance and housing) about a community to generate a CNI score for every populated ZIP code in the United States. The CNI strongly links to differences in community healthcare needs is an indicator of a community's demand for various healthcare services. The CNI score by ZIP code identifies specific areas within a community where healthcare needs may be greater.

Overall, the CNI score for the community served was 3.7, higher than the CNI national average of 3.0, potentially indicating greater health care needs in this community. In portions of the community (Ennis and Lancaster) the CNI score was greater than 4.5, pointing to potentially more significant health needs among the population.

2018 Community Need Index by ZIP Code



ZIP Map where color shows the Community Need Index on a scale of 0 to 5. Orange color indicates high need areas (CNI = 4 or 5); blue color indicates low need (CNI = 1 or 2). Gray colors have needs at the national average (CNI = 3).

CNI High Need ZIP Codes

City	Community	County	ZIP Code	2018 CNI Score
Ennis	Ennis	Ellis	75119	4.8
Wilmer	Lancaster	Dallas	75172	4.6
Ferris	Red Oak	Ellis	75125	4.4
Hutchins	Lancaster	Dallas	75141	4.4
Lancaster	Lancaster	Dallas	75134	4.0
Lancaster	Lancaster	Dallas	75146	4.0

Source: IBM Watson Health / Claritas, 2018

Public Health Indicators

The analysis of Public health indicators assessed community health needs for the community served using 102 indicators. For each health indicator, a comparison between the most recently available community data and benchmarks for the same/similar indicator was made. The basis of benchmarks was available data for the U.S. and the state of Texas.

Where the community indicators showed greater need when compared to the State of Texas comparative benchmark, the difference between the community values and the state benchmark was calculated (need differential). Those highest ranked indicators with need differentials in the 50th percentile of greater severity pinpointed community health needs from a quantitative perspective. These indicators are located in **Appendix D**.

Watson Health Community Data

Watson Health supplemented the publicly available data with estimates of localized disease prevalence of heart disease and cancer and emergency department visit estimates. This information is located in **Appendix E**.

Focus Groups & Interviews

In the focus group sessions and interviews participants identified and discussed the factors that contribute to the current health status of the community, and then identified the greatest barriers and strengths that contribute to the overall health of the community. For this community there was one (1) focus group session with a total of eight (8) participants and three (3) interviews were conducted July through September 2018.

Participants described the strong sense of history, a small-town feel, and a strong connection to area churches in this growing community. Waxahachie Health Community covers most of Ellis County as well as the southeast section of Dallas County. As part of the community's growing pains, it struggled with the divide between old and new residents as well as poverty on the east side. Participants discussed how these factors impact the health of the community. They identified the community's top health care needs as access to health care, poverty, lack of financial resources, and health literacy. They noted that local service providers frequently worked together to coordinate services.

Many residents in the community lacked health insurance and transportation. As a result, the uninsured sought treatment in the area emergency rooms and lacked access to many medical specialists. Residents had to drive outside the region to see specialists, notably mental health providers, cardiologists, orthopedic physicians, neurologists, and home health professionals. The area had no mass transportation, people without cars relied on either family members for rides or had to walk to services. Health care clinics for low-income residents were available, including Hope Clinic, a federally mandated clinic, but required appointments and had no access to specialty care. Many area seniors and low-income residents lacked transportation and need to walk long distances to access jobs, the hospital, and the food bank.

Focus group participants shared that the community's east side was more impoverished than the rest of the service area, with more acute issues with hunger and homelessness.

Local churches provide food options, but have not solved the long-term issue. Participants shared that a culture of poverty was difficult to change, and some residents accessed services at multiple nonprofits. The focus group was concerned about hunger for the area's seniors and housing for families, especially children. The group suggested that a central location could be funded to function as a hub to provide and coordinate services.

There were very few treatment options for substance abuse and addiction in the community. Behavioral health needs were greatest for seniors, the uninsured, and the incarcerated population. Challenges with treating seniors included resistance to diagnosis, lack of health education, and accessing care without public transportation. Mental health issues were often prioritized below basic needs like food and shelter.

Community Health Needs Identified

A Health Needs Matrix identified the health needs that resulted from the community health needs assessment (see Methodology for Defining Community Need section). The matrix shows the convergence of needs identified in the qualitative data (interview and focus group feedback) and quantitative data (health indicators) and identifies the top health needs for this community.

Top Community Health Needs Identified

Waxahachie Health Community		
Top Needs Identified	Category of Need	Public Health Indicator
Depression in Medicare Population	Mental Health	Prevalence of chronic condition across all Medicare beneficiaries
Hospital Stays for Ambulatory-Care Sensitive Conditions- Medicare	Access To Care	2015 Number of Hospital Stays for Ambulatory-Care Sensitive Conditions per 1,000 Medicare Enrollees
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	2012-2016 Percentage of Motor Vehicle Crash Deaths that had Alcohol Involvement
Ratio of Population to One Dentist	Access To Care	2016 Ratio of Population to Dentists
Ratio of Population to one Mental Health Provider	Mental Health	2017 Ratio of Population to Mental Health Providers
Ratio of Population to One Non-Physician Primary Care Provider	Access To Care	2017 Ratio of Population to Primary Care Providers Other than Physicians
Ratio of Population to One Primary Care Physician	Access To Care	2015 Number of Individuals Served by One Physician in a County, if the Population was Equally Distributed Across Physicians
Uninsured Children	Access To Care	2015 Percentage of Children Under Age 19 Without Health Insurance

Note: Listed alphabetically, not in order of significance

Source: IBM Watson Health, 2018

Prioritized Significant Health Needs

Using the prioritization approach outlined in the overview section of this report, the following needs from the proceeding list were determined to be significant and then prioritized.

The resulting prioritized health needs for this community were:

Priority	Need	Category of Need
1	Ratio of Population to One Non-Physician Primary Care Provider	Access to Care
2	Ratio of Population to One Primary Care Physician	Access to Care
3	Ratio of Population to One Mental Health Provider	Mental Health
4	Uninsured Children	Access to Care
5	Ratio of Population to One Dentist	Access to Care

Description of Health Needs

A CHNA for the Waxahachie Healthcare Community identified two major categories of need in the community: mental health and access to care. Regionalized health needs affect all age levels to some degree; however, the most vulnerable populations often suffer more effects that are negative. Community health gaps helped to define the resources and access to care within the county or region. All groups in the age continuum were identified as having priority health needs. Health and social concerns were validated through key informant interviews, focus groups and county data. Access to care, specifically primary care providers, mental health providers, non-physician providers and dentists were significant areas of concern.

<u>Primary Care Physician Providers</u>

Primary care includes family medicine, internal medicine, nursing, nurse practitioners, pharmacy, pediatrics, general obstetrics/gynecology, gerontology, behavioral health, community health, and the other people and professions fulfilling the general medical needs of patient populations.

Primary care professionals serve on the front lines of healthcare. For many individuals, they are the first point of contact with the healthcare system, and often are the first to recognize signs of depression, early signs of cancer or chronic disease, and other health concerns. Primary care providers ensure patients receive the right care, in the right setting, by the most appropriate provider, and in a manner consistent with the patient's desires and values. Primary care is important because it lowers costs. Access to primary care helps to keep people out of emergency rooms, where care costs are much higher

than other outpatient care. Annual check-ups can catch and treat problems earlier; this is less costly than treating severe or advanced illness.[2]

The focus group participants perceived a lack of health care providers including primary care physicians and non-physicians, dentists, and mental health care providers within the Waxahachie Health Community. The community was largely comprised of rural components and could present additional challenges to access to care. Transportation to disparate care sites across the county may have been difficult, if not impossible. The ability to coordinate and co-mingle both access to care and social agencies would bolster the healthcare needs of the community.

Ellis County had primary care physician access of one physician to every 2,406 county residents. The Texas average of one primary care physician to every 1,670 residents means Ellis County was performing worse than the Texas state benchmark by 44%.[3] Primary Care Physician access was ranked in the top ten needs for the community when public health indicators were analyzed for the CHNA. Due to the length of time, effort and expense in recruiting physicians, it would serve the community to identify physicians in the community that are over 50 years old and then develop a comprehensive physician succession plan.

Non-Physician Primary Care Providers

There is a nationwide scarcity of physicians, particularly in small towns and cities. This shortage accentuates in rural areas across the country. Only about 11% of the nation's physicians work in rural areas, despite nearly 20% of Americans living there.[4] Demographic shifts, such as growth in the elderly or near elderly populations increase the need for primary care access. Estimates of the scope of the provider shortage in rural America vary, however, it is generally agreed upon that thousands of additional Primary Care Providers are needed to meet the current demand in rural America and that tens of thousands of additional caregivers will be needed to meet the growing rural population. Recruiting physicians to rural areas is particularly challenging and it could take years to secure a vacant position.

Primary care physician extenders (e.g. nurse practitioners, physician assistants, and clinical nurse specialists) could help close the gap in access to primary care services when they are located in a community. Non-physician providers or physician extenders are typically licensed professionals such as Physician Assistants or Nurse Practitioners who treat and see patients. Dependent upon state regulations, extenders may practice independently, or in physician run practices. Physician extenders expand the scope of primary care providers within a geographic area and help bridge the gap to both access to care and management of healthcare costs.

[2] **Primary Care Progress**, The Case for Primary Care, 2019
[3] Area Health Resource File/American Medical Association, County Health Rankings & Roadmaps, 2018
[4] J. Cromartie, Population & Migration (Washington, D.C,: **U.S. Department of Agriculture, Economic Research Service, May 26, 2012**)

Non-Physician Primary Care provider access in Ellis County, one provider to 2,308 people, was significantly worse (54%) than the Texas state threshold of one provider to 1,497 residents.[5]

Mental Health Provider Access

Access to mental health providers and services is an issue nationally. Nine million adults (or 1 in 5) report having an unmet mental health need and mental health provider shortages across the country continue to exist.[6]

Rural areas hold particular challenges with accessing mental health care services. Primary Care Providers (PCP's) often relied upon to treat patients with mental health needs, find lack of expertise, time, and financial reimbursement constraints. Communities lacking of primary care providers are particularly vulnerable.

According to the CMS National Provider Identification File, Ellis County had one mental health provider for every 1,636 people. The Ellis County ratio, from a data perspective, was significantly worse than the Texas state benchmark of one provider to 1,012 people.[7] There was considerable opportunity for improvement in the community served, compared to the state of Texas, in finding solutions for access to mental health providers.

Access to Dentists

Economic disparity, whether through poor diet, food deserts, lack of insurance or funding, may impact dental hygiene. Lack of appropriate dental hygiene and bad teeth reinforces economic disadvantage. People with poor dental hygiene find it difficult find employment or impossible to get past the interview stages. Entry-level jobs require service attitude and nice smiles, and immediate and often unfavorable assumptions are made when encountering persons with poor dentition. Oral health could contribute to various diseases and conditions such as endocarditis, cardiovascular disease, premature birth, and low birth weight. [8]

According to the analysis of public indicator data as part of the CHNA, access to dentists was the number one top ranked need for the Waxahachie Health community. The Ellis County ratio of residents to dentists was one dentist to 3,179 people, as compared to overall Texas ratio of one dentist to 1,790 people, and top US performers of 1,280 to one dentist.[9] Ellis County dentist to population ratio was nearly two times higher than the overall Texas ratio and two and a half times higher than top US performers. Social and economic constraints such as insurance, transportation, and poverty, compounded the access to dental care issue in the community.

[5] CMS, National Provider Identification Registry (NPPES), County Health Rankings & Roadmaps, 2018
[6] **Mental Health America**, 2019
[7] CMS, National Provider Identification Registry (NPPES), County Health Rankings & Roadmaps, 2018
[8] **Mayo Clinic**, 2019
[9] Area Health Resource File/National Provider Identification file (CMS), County Health Rankings & Roadmaps, 2018

Uninsured Children

Lack of health insurance coverage is a significant barrier to accessing needed health care services and to maintaining financial security. Dependent groups, such as children, are often the most vulnerable and at risk to changes in financial situations as they are most affected by lack of insurance, transportation, parental knowledge, and secure housing. Lack of preventative care often places children in precarious and dangerous healthcare situations.

The Kaiser Family Foundation released a report in 2017 concerning the uninsured crisis facing the nation. One key finding was that "Going without coverage can have serious health consequences for the uninsured because they receive less preventative care, and delayed care often results in serious illness or other health problems. Being uninsured can also have serious financial consequences, with many unable to pay their medical bills, resulting in medical debt."[10] The focus group participants discussed an increase in undocumented residents in the Waxahachie community. These groups often do not qualify for at risk programs and parents are afraid of contact with healthcare entities, due to their status. Growing populations of uninsured in any community can easily stress social agencies and healthcare providers. Schools often become de facto primary care healthcare providers, this taxes the school system and its health care staff.

Uninsured children were one of the top 10 ranked needs for Ellis County from analysis of public indicator data. The percentage of uninsured children in Ellis County was 12.5% this was 25% greater than the Texas state benchmark of 10.0%.[11] Children who are educated about health, nutrition and to maintain their health are more likely to carry on those healthy habits as adults.

Summary

BSWH conducted its Community Health Needs Assessments beginning June 2018 to identify and begin addressing the health needs of the communities they serve. Using both qualitative community feedback and publicly available and proprietary health indicators, BSWH identified and prioritized community health needs for their healthcare system. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed for the health needs BSWH chooses to address for the community served.

[10] Kaiser Family Foundation. The Uninsured: A Primer - Key Facts about Health Insurance and the Uninsured Under the Affordable Care Act. December 2017.

[11] Small Area Health Insurance Estimates (SAHIE), United States Census Bureau; County Health Rankings & Roadmaps, 2018

Appendix A: Key Health Indicator Sources

Category	Public Health Indicator	Source
Access to Care	Hospital Stays for Ambulatory-Care Sensitive Conditions- Medicare	2018 County Health Rankings & Roadmaps; Dartmouth Atlas of Health Care, CMS
	Percentage of Population under age 65 without Health Insurance	2018 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau
	Price-Adjusted Medicare Reimbursements per Enrollee **NEW 2019**	2018 County Health Rankings & Roadmaps; Dartmouth Atlas of Health Care, CMS
	Ratio of Population to One Dentist	2018 County Health Rankings & Roadmaps; Area Health Resource File/National Provider Identification file (CMS)
	Ratio of Population to One Non-Physician Primary Care Provider	2018 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)
	Ratio of Population to One Primary Care Physician	2018 County Health Rankings & Roadmaps; Area Health Resource File/American Medical Association
	Uninsured Children	2018 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau
Conditions/Diseases	Adult Obesity (Percent)	2018 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System
	Arthritis in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Atrial Fibrillation in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Cancer Incidence - All Causes	2011-2015 State Cancer Profiles, National Cancer Institute (CDC)
	Cancer Incidence - Colon	2011-2015 State Cancer Profiles, National Cancer Institute (CDC)
	Cancer Incidence - Female Breast	2011-2015 State Cancer Profiles, National Cancer Institute (CDC)
	Cancer Incidence - Lung	2011-2015 State Cancer Profiles, National Cancer Institute (CDC)
	Cancer Incidence - Prostate	2011-2015 State Cancer Profiles, National Cancer Institute (CDC)
	Chronic Kidney Disease in Medicare Population	CMS.gov Chronic conditions 2007-2015
	COPD in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Diabetes Diagnoses in Adults	CMS.gov Chronic conditions 2007-2015
	Diabetes prevalence	2018 County Health Rankings (CDC Diabetes Interactive Atlas)
	Frequent physical distress	2016 Behavioral Risk Factor Surveillance System (BRFSS)
	Heart Failure in Medicare Population	CMS.gov Chronic conditions 2007-2015
	HIV Prevalence	2018 County Health Rankings & Roadmaps; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)
	Hyperlipidemia in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Hypertension in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Ischemic Heart Disease in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Osteoporosis in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Stroke in Medicare Population	CMS.gov Chronic conditions 2007-2015

Category	Public Health Indicator	Source
Environment	Air Pollution - Particulate Matter daily density	2018 County Health Rankings & Roadmaps; Environmental Public Health Tracking Network (CDC)
	Drinking Water Violations (Percent of Population Exposed)	2018 County Health Rankings & Roadmaps; Safe Drinking Water Information System (SDWIS), United States Environmental Protection Agency (EPA)
	Driving Alone to Work	2018 County Health Rankings & Roadmaps; American Community Survey, 5-Year Estimates, United States Census Bureau
	Elderly isolation. 65+ Householder living alone **NEW 2019**	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
	Food Environment Index	2018 County Health Rankings & Roadmaps; USDA Food Environment Atlas, Map the Meal Gap from Feeding America, United States Department of Agriculture (USDA)
	Food Insecure	2018 County Health Rankings & Roadmaps; Map the Meal Gap, Feeding America
	Limited Access to Healthy Foods (Percent of Low Income)	2018 County Health Rankings & Roadmaps; USDA Food Environment Atlas, United States Department of Agriculture (USDA)
	Long Commute Alone	2018 County Health Rankings & Roadmaps; American Community Survey, 5-Year Estimates, United States Census Bureau
	No vehicle available **NEW 2019**	U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates
	Population with Adequate Access to Locations for Physical Activity	2018 County Health Rankings & Roadmaps; Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files (ArcGIS)
	Renter-occupied housing **NEW 2019**	U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates
	Residential segregation - black/white **NEW 2019**	2018 County Health Rankings (American Community Survey, 5-year estimates)
	Residential segregation - non-white/white **NEW 2019**	2018.County Health Rankings (American Community Survey, 5-year estimates)
	Severe Housing Problems	2018 County Health Rankings & Roadmaps; Comprehensive Housing Affordability Strategy (CHAS) data, U.S. Department of Housing and Urban Development (HUD)
Health Behaviors	Adult Smoking	2018 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)
	Adults Engaging in Binge Drinking During the Past 30 Days	2018 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)
	Disconnected youth **NEW 2019**	2018 County Health Rankings (Measure of America)
	Drug Poisoning Deaths Rate	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Insufficient sleep **NEW 2019**	2016 Behavioral Risk Factor Surveillance System (BRFSS)
	Motor Vehicle Driving Deaths with Alcohol Involvement	2018 County Health Rankings & Roadmaps; Fatality Analysis Reporting System (FARS)
	Physical Inactivity	2018 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System
	Sexually Transmitted Infection Incidence	2018 County Health Rankings & Roadmaps; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)
	Teen Birth Rate per 1,000 Female Population, Ages 15-19	2018 County Health Rankings & Roadmaps; National Center for Health Statistics - Natality files, National Vital Statistics System (NVSS)
Health Status	Adults Reporting Fair or Poor Health	2018 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)
	Average Number of Physically Unhealthy Days Reported in Past 30 days (Age-Adjusted)	2018 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)

Category	Public Health Indicator	Source
Injury & Death	Cancer Mortality Rate	2013 Texas Health Data, Center for Health Statistics, Texas Department of State Health Services
	Child Mortality Rate	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Chronic Lower Respiratory Disease (CLRD) Mortality Rate	2013 'Texas Health Data, Center for Health Statistics, Texas Department of State Health Services
	Death rate due to firearms **NEW 2019**	2018 County Health Rankings (CDC WONDER Environmental Data)
	Heart Disease Mortality Rate	2013 Texas Health Data, Center for Health Statistics, Texas Department of State Health Services
	Infant Mortality Rate	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Motor Vehicle Crash Mortality Rate	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Number of deaths due to injury **NEW 2019**	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Premature Death (Potential Years Lost)	2018 County Health Rankings & Roadmaps; National Center for Health Statistics - Mortality Files, National Vital Statistics System (NVSS)
	Stroke Mortality Rate	2013 Texas Health Data, Center for Health Statistics, Texas Department of State Health Services
Maternal & Child Health	First Trimester Entry into Prenatal Care	2016 Texas Health and Human Services - Vital statistics annual report
	Low Birth Weight Percent	2018 County Health Rankings & Roadmaps; National Center for Health Statistics - Natality files, National Vital Statistics System (NVSS)
	Low Birth Weight Rate	2016 Texas Health and Human Services - Vital statistics annual report - Preventable Hospitalizations
	Preterm Births <37 Weeks Gestation	2015 Kids Discount Data Center
	Very Low Birth Weight (VLBW)	Centers for Disease Control and Prevention WONDER
Mental Health	Accidental poisoning deaths where opioids were involved **NEW 2019**	U.S. Census Bureau, Population Division and 2015 Texas Health and Human Services Center for Health Statistics Opioid related deaths in Texas
	Alzheimer's Disease/Dementia in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Average Number of Mentally Unhealthy Days Reported in Past 30 days (Age-Adjusted)	2018 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)
	Depression in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Frequent mental distress	2016 Behavioral Risk Factor Surveillance System (BRFSS)
	Intentional Self-Harm; Suicide **NEW 2019**	2015 Texas Health Data Center for Health Statistics
	Ratio of Population to one Mental Health Provider	2018 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)
	Schizophrenia and Other Psychotic Disorders in Medicare Population	CMS.gov Chronic conditions 2007-2015

Category	Public Health Indicator	Source
Population	Children Eligible for Free Lunch Enrolled in Public Schools	2018 County Health Rankings & Roadmaps, The National Center for Education Statistics (NCES)
	Children in Poverty	2018 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau
	Children in Single-Parent Households	2018 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)
	Civilian veteran population 18+ **NEW 2019**	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
	Disabled population, civilian noninstitutionalized	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
	High School Dropout	2016 Texas Education Agency
	High School Graduation	2017 Texas Education Agency
	Homicides	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Household income, median **NEW 2019**	2018 County Health Rankings (2016 Small Area Income and Poverty Estimates)
	Income Inequality	2018 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)
	Individuals Living Below Poverty Level	2012-2016 US Census Bureau - American FactFinder
	Individuals Who Report Being Disabled	2012-2016 US Census Bureau - American FactFinder
	Non-English-speaking households **NEW 2019**	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
	Social/Membership Associations	2018 County Health Rankings & Roadmaps; 2015 County Business Patterns, United States Census Bureau
	Some College	2018 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)
	Unemployment	2018 County Health Rankings & Roadmaps; Local Area Unemployment Statistics (LAUS), Bureau of Labor Statistics
	Violent Crime Offenses	2018 County Health Rankings & Roadmaps; Uniform Crime Reporting (UCR) Program, United States Department of Justice, Federal Bureau of Investigation (FBI)
Preventable Hospitalizations	Asthma Admission: Pediatric (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Diabetes Lower-Extremity Amputation Admission: Adult (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Diabetes Short-term Complications Admission: Pediatric (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Gastroenteritis Admission: Pediatric (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Perforated Appendix Admission: Adult (Risk-Adjusted-Rate per 100 Admissions for Appendicitis)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Perforated Appendix Admission: Pediatric (Risk-Adjusted-Rate for Appendicitis)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Uncontrolled Diabetes Admission: Adult (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Urinary Tract Infection Admission: Pediatric (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations

Category	Public Health Indicator	Source
Prevention	Diabetic Monitoring in Medicare Enrollees	2018 County Health Rankings & Roadmaps; Dartmouth Atlas of Health Care, CMS
	Mammography Screening in Medicare Enrollees	2018 County Health Rankings & Roadmaps; Dartmouth Atlas of Health Care, CMS

Appendix B: Community Resources Identified to Potentially Address Significant Health Needs

Below is a list of resources available in the community with the ability to address the significant health needs identified in the assessment. For a continually updated list of the resources available to address these needs as well as other social determinants of health, please visit our website (**BSWHealth.com/CommunityNeeds)**.

Resources Identified

Community Health Need	Category	Service	Facility Name	Address	City	Phone Number
Ratio of Population to One Dentist	Access to Care	Dental Care	Daybreak Community Service Inc.	3901 North Dallas Avenue	Lancaster	972-228-5830
Ratio of Population to One Dentist	Access to Care	Dental Care	Ellis County Coalition for Health Options (Hope Clinic)	411 E Jefferson St	Waxahachie	972-923-2440
Ratio of Population to One Non-Physician Primary Care Provider	Access to Care	Primary Care	Ellis County Coalition for Health Options (Hope Clinic)	411 E Jefferson St	Waxahachie	972-923-2440
Ratio of Population to One Primary Care Physician	Access to Care	Primary Care	Ellis County Coalition for Health Options (Hope Clinic)	411 E Jefferson St	Waxahachie	972-923-2440
Uninsured Children	Access to Care	Child Welfare	SWAGG Program	1025 Ovilla Road	Waxahachie	972-213-8212
Uninsured Children	Access to Care	Prescription Assistance	Manna House	214 West Avenue F	Midlothian	972-775-1800
Uninsured Children	Access to Care	Vaccinations	Ellis County Coalition for Health Options (Hope Clinic)	411 E Jefferson St	Waxahachie	972-923-2440
Ratio of Population to One Mental Health Provider	Mental Health	General Psychology	Daybreak Community Service Inc.	3901 North Dallas Avenue	Lancaster	972-228-5830
Ratio of Population to One Mental Health Provider	Mental Health	General Psychology	Ellis County Coalition for Health Options (Hope Clinic)	411 E Jefferson St	Waxahachie	972-923-2440

Community Healthcare Facilities

Facility Name	Type	System	Street Address	City	State	ZIP
Altus Waxahachie LP	ED	Altus Health	1791 N Hwy 77	Waxahachie	TX	75165
Baylor Scott & White Medical Center At Waxahachie	ST	Baylor Scott & White	2400 N I-35 E	Waxahachie	TX	75165
Crescent Medical Center Lancaster	ST	Freestanding	2600 West Pleasant Run Road	Lancaster	TX	75146
Ennis Regional Medical Center	ST	Lifepoint	2201 West Lampasas Street	Ennis	TX	75119

**Type: ST=short-term; LT=long-term, PSY=psychiatric, KID = pediatric, ED = Freestanding ED*

Appendix C: Federally Designated Health Professional Shortage Areas and Medically Underserved Areas and Populations

Health Professional Shortage Areas (HPSA)[12]

County Name	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type
Ellis	14899948J2	Ellis County Coalition for Health Option	Primary Care	Federally Qualified Health Center
Ellis	64899948L9	Ellis County Coalition for Health Option	Dental Health	Federally Qualified Health Center
Ellis	74899948A4	Ellis County Coalition for Health Option	Mental Health	Federally Qualified Health Center

Medically Underserved Areas and Populations (MUA/P)[13]

County Name	MUA/P Source Identification Number	Service Area Name	Designation Type	Rural Status
Ellis	3496	Ellis Service Area	Medically Underserved Area	Partially Rural

[12] U.S. Department of Health and Human Services, Health Resources and Services Administration, 2018
[13] U.S. Department of Health and Human Services, Health Resources and Services Administration, 2018

Appendix D: Public Health Indicators Showing Greater Need When Compared to State Benchmark

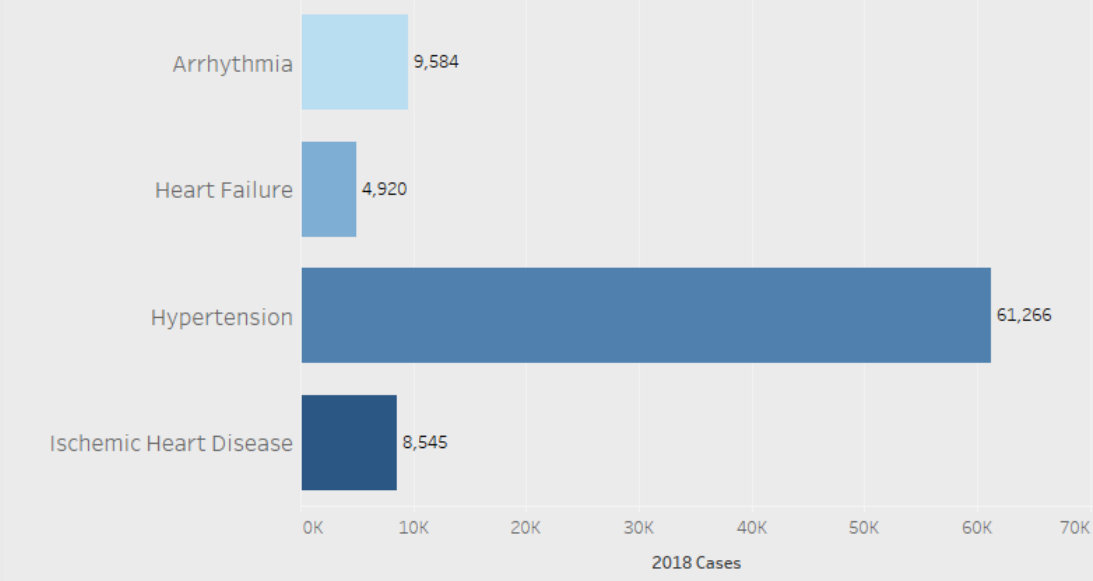
Waxahachie Health Community		
Public Health Indicator	**Category**	**Indicator Definition**
Gastroenteritis Admission: Pediatric (Risk-Adjusted-Rate)	Preventable Hospitalizations	2016 Number Observed / Pediatric Population Under Age 18
Ratio of Population to One Dentist	Access To Care	2016 Ratio of Population to Dentists
Ratio of Population to one Mental Health Provider	Mental Health	2017 Ratio of Population to Mental Health Providers
Urinary Tract Infection Admission: Pediatric (Risk-Adjusted-Rate)	Preventable Hospitalizations	2016 Number Observed / Pediatric Population Under Age 18
Ratio of Population to One Non-Physician Primary Care Provider	Access To Care	2017 Ratio of Population to Primary Care Providers Other than Physicians
Ratio of Population to One Primary Care Physician	Access To Care	2015 Ratio of Population to Primary Care Providers
Uncontrolled Diabetes Admission: Adult (Risk-Adjusted-Rate)	Preventable Hospitalizations	2016 Number Observed / Adult Population Age 18 and older
Air Pollution - Particulate Matter daily density	Environment	2012 Average Daily Density of Fine Particulate Matter in Micrograms per Cubic Meter (PM2.5)
Uninsured Children	Access To Care	2015 Percentage of Children Under Age 19 Without Health Insurance
Chronic Lower Respiratory Disease (CLRD) Mortality Rate	Injury & Death	2013 Chronic Lower Respiratory Disease (CLRD) Age Adjusted Death Rate (per 100,000 - All Ages. Age-adjusted using the 2000 U.S. Standard Population)
Long Commute Alone	Environment	2012-2016 Among Workers Who Commute in Their Car Alone, the Percentage that Commute More than 30 Minutes
Hospital Stays for Ambulatory-Care Sensitive Conditions- Medicare	Access To Care	2015 Number of Hospital Stays for Ambulatory-Care Sensitive Conditions per 1,000 Medicare Enrollees
Population with Adequate Access to Locations for Physical Activity	Environment	2010 & 2016 Percentage of Population with Adequate Access to Locations for Physical Activity
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors	2012-2016 Percentage of Motor Vehicle Crash Deaths that had Alcohol Involvement
Stroke Mortality Rate	Injury & Death	2013 Cerebrovascular Disease (Stroke) Age Adjusted Death Rate (Per 100,000 - All Ages. Age-adjusted using the 2000 U.S. Standard Population)

Waxahachie Health Community		
Public Health Indicator	**Category**	**Indicator Definition**
Cancer Incidence - Lung	Conditions/Diseases	2011-2015 Age-Adjusted Lung & Bronchus Cancer Incidence Rate Cases per 100,000.
Adult Obesity (Percent)	Conditions/Diseases	2014 Percentage of the Adult Population (Age 20 and Older) that Reports a Body Mass Index (BMI) Greater than or Equal to 30 kg/m2
Civilian veteran population 18+	Population	2012 Percent of population 18 years and over - Civilian veterans
Cancer Incidence - Colon	Conditions/Diseases	2011-2015 Age-Adjusted Colon & Rectum Cancer Incidence Rate Cases per 100,000
Cancer Mortality Rate	Injury & Death	2013 Cancer (All) Age Adjusted Death Rate (Per 100,000 - All Ages. Age-adjusted using the 2000 U.S. Standard Population)
Depression in Medicare Population	Mental Health	2007-2015 Prevalence of chronic condition across all Medicare beneficiaries

Appendix E: Watson Health Community Data

Watson Health Heart Disease Estimates identified hypertension as the most prevalent heart disease diagnoses. There were over 61,000 estimated cases in the community overall. The 75165 ZIP code of Waxahachie had the most estimated cases of each heart disease type. The 76670 ZIP code of South Ellis had the highest estimated prevalence rates for Arrhythmia (540 cases per 10,000 population), Heart Failure (285 cases per 10,000 population), Hypertension (3,056 cases per 10,000 population), and Ischemic Heart Disease (537 cases per 10,000 population).

2018 Estimated Heart Disease Cases



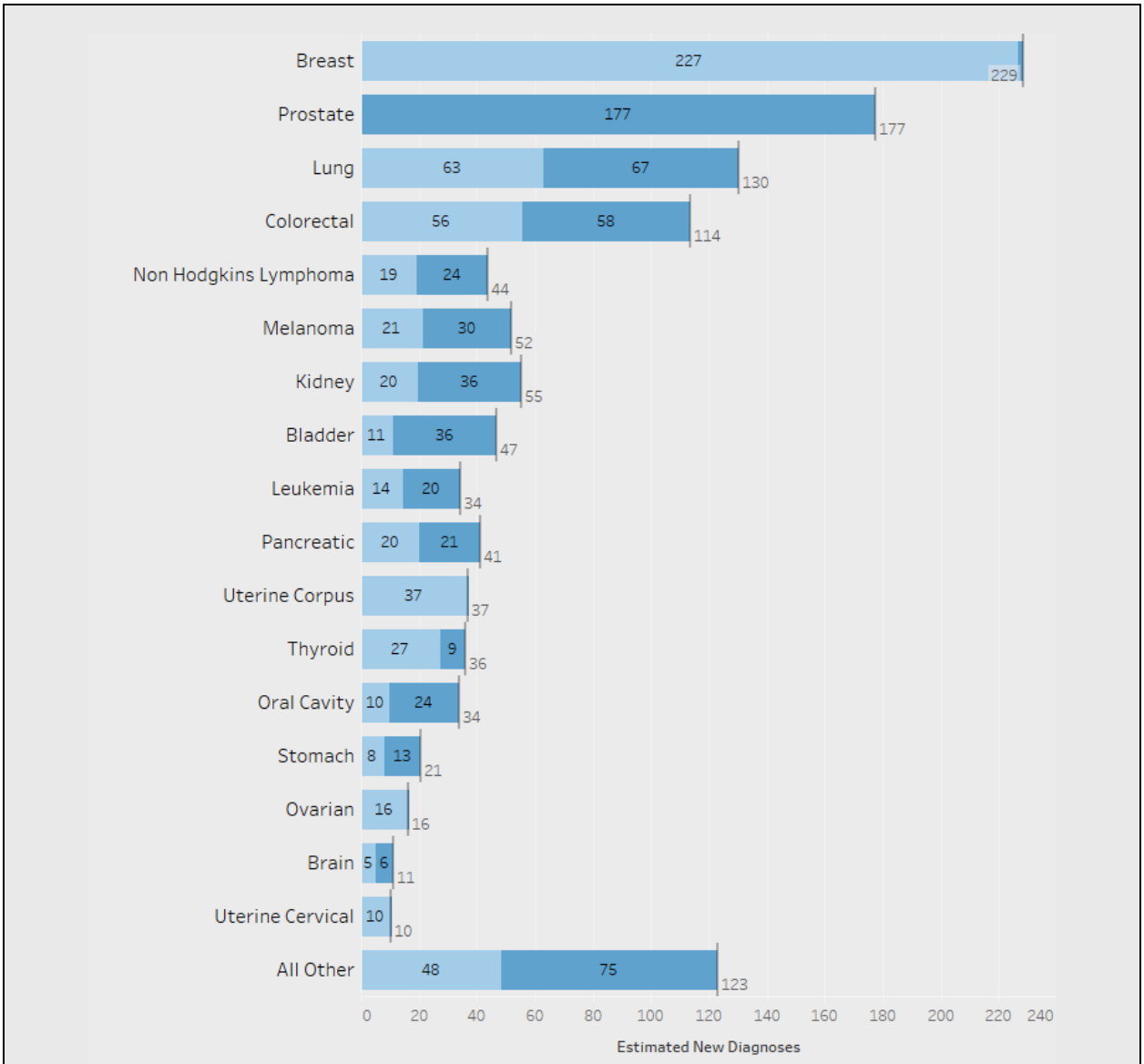
Bar chart shows total number of 2018 Estimated Heart Disease cases for each of four types: arrhythmia, heart failure, hypertension, and ischemic heart disease

Note: An individual patient may have more than one type of heart disease. Therefore the sum of all four heart disease types is not a unique count of individuals.

Source: IBM Watson Health, 2018

For this community, Watson Health's 2018 Cancer Estimates revealed the cancers projected to have the greatest rate of growth in the next five years were pancreatic, bladder, kidney, thyroid, and uterine corpus; based on both population changes and disease rates. The estimates for the most number of new cases in 2018 were breast, prostate, lung cancers, and colorectal.

2018 Estimated New Cancer Cases



Bar chart shows estimated new diagnoses per year for each of the 17 types of Cancer and 1 category for all other cancers. Color shows details about sex with light blue for females and dark blue for males.

Source: IBM Watson Health, 2018

Estimated Cancer Cases and Projected 5 Year Change by Type

Cancer Type	2018 Estimated New Cases	2023 Estimated New Cases	5 Year Growth (%)
Bladder	47	56	19.1%
Brain	11	13	18.2%
Breast	229	266	16.2%
Colorectal	114	119	4.4%
Kidney	55	66	20.0%
Leukemia	34	40	17.6%
Lung	130	152	16.9%
Melanoma	52	61	17.3%
Non Hodgkins Lymphoma	44	51	15.9%
Oral Cavity	34	40	17.6%
Ovarian	16	19	18.8%
Pancreatic	41	50	22.0%
Prostate	177	195	10.2%
Stomach	21	24	14.3%
Thyroid	36	43	19.4%
Uterine Cervical	10	11	10.0%
Uterine Corpus	37	44	18.9%
All Other	123	146	18.7%
Grand Total	1,211	1,396	15.3%

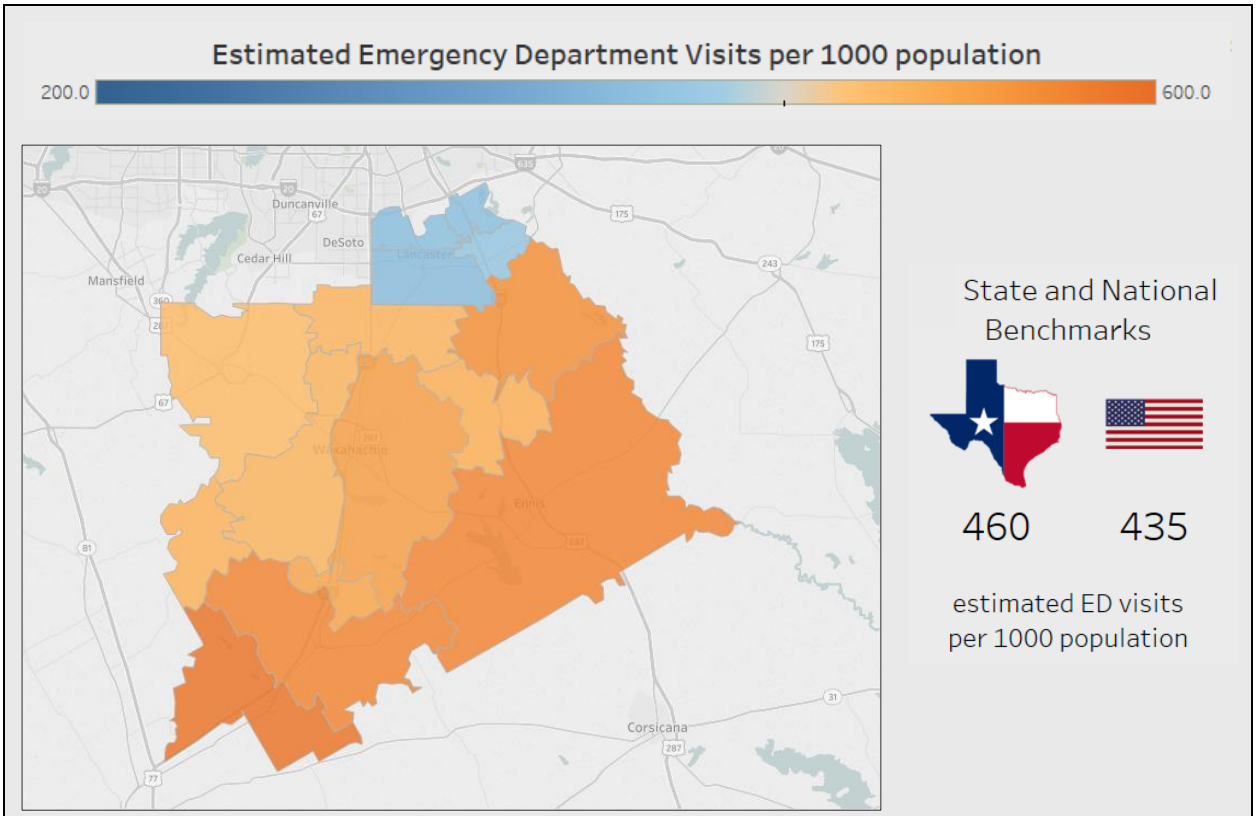
Source: IBM Watson Health, 2018

Based on population characteristics and regional utilization rates, Watson Health projected all emergency department (ED) visits in this community to increase by 9.2% over the next 5 years. The highest estimated ED use rates were in the ZIP code of Milford; 586.8 ED visits per 1,000 residents compared to the Texas state benchmark of 460 visits and the U.S. benchmark 435 visits per 1,000.

These ED visits consisted of three main types: those resulting in an inpatient admission, emergent outpatient treated and released ED visits, and non-emergent outpatient ED visits that were lower acuity. Non-emergent ED visits present to the ED but can be treated in more appropriate and less intensive outpatient settings.

Non-emergent outpatient ED visits could be an indication of systematic issues within the community regarding access to primary care, managing chronic conditions, or other access to care issues such as ability to pay. Watson Health estimated non-emergent ED visits to increase by 4.1% over the next five years in this community.

Estimated 2018 Emergency Department Visit Rate

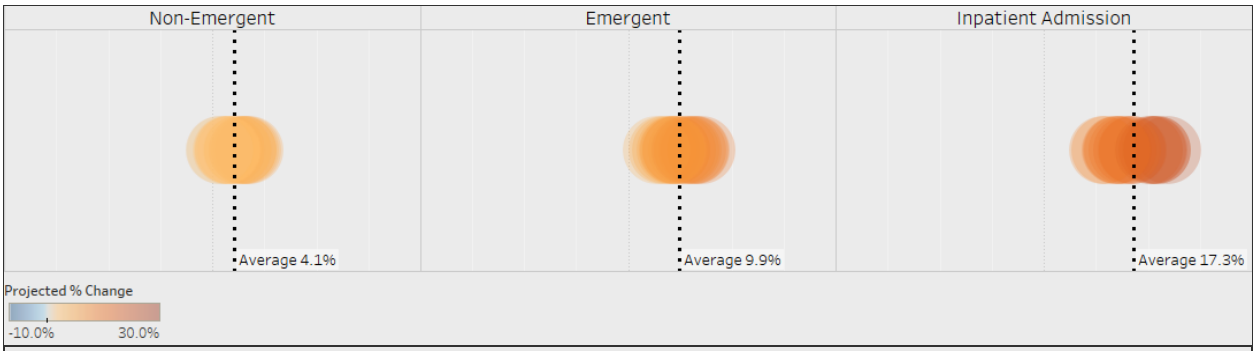


ZIP map color shows total Emergency Department visits per 1000 popultaion. Orange colors are higher than the state benchmark, blue colors are less than the state benchmark, and gray colors are similar.

Note: These are not actual BSWH ED visit rates. These are statistical estimates of ED visits for the population.

Source: IBM Watson Health, 2018

Projected 5 Year Change in Emergency Department Visits by Type and ZIP Code



Three panels show the percent change in Emergency Department visits by 2013 at the ZIP level. The average for all ZIPs in the Health Community is labeled. ED visits are defined by the presence of specific CPT® codes in claims. Non-emergency visits to the ED do not necessarily require treatment in a hospital emergency department and can potentially be reated in a fast-track ED, an uregent care treatment center, or a clinical or a physician's private office. Emergent visits require immediate treatment in a hospital emergency department due to the severity of illness. ED visits that result in inpatient admissions do not receive a CPT® code, but typically can be assumed to have resulted from an emergent encounter.

Note: These are not actual BSWH ED visit rates. These are statistical estimates of ED visits for the population.

Source: IBM Watson Health, 2018

Appendix F: Evaluation of Prior Implementation Strategy Impact

This section provides a summary of the evaluation of the impact of any actions taken since the hospital facilities finished conducting their immediately preceding CHNA.

Baylor Scott & White Medical Center – Waxahachie

Prior Significant Health Needs Addressed by Facility

Prior Identified Needs Facility	Physician & Non-Physician Care Providers to Population Ratio	Mental/ Behavioral Health Resources	Chronic Disease	Heart Failure	Exxesive Drinking
Baylor Scott & White Medical Center - Waxahachie	√	√	√	√	√

Total Resources Contributed to Addressing Needs: $5,450,042

Identified Need Addressed: Chronic Disease and Heart Failure

Program Name: **News Media Generated Community Health Education**
Description:
The Public Relations Team uses news media and social media efforts to equip the community with the latest health and wellness information as well as information on when and how to connect with health care professionals, hospitals, and other health care institutions. The scope of the efforts includes but is not limited to: • public health • disease-specific or injury-specific information • identifying community resources for meeting health needs • the development of tools and resources needed to get credible information to patients This is accomplished through: • publishing educational and diagnostic opportunities • providing timely, relevant health content on social media sites • hosting electronic education events • maintaining health education blogs • promoting the System health library • monitoring and engaging government agencies and industry associations relative to connecting providers and patients • promoting the tools and resources needed to improve the quality, cost-effectiveness, efficiency, patient-centeredness, safety and access to health care. These education opportunities produce free health and wellness education for all people – whether they are insured, uninsured or under insured patients – through well-developed relationships with news media outlets. The goal of the team's work is to educate the public about health issues.

Impact: 161,000 audience reach; 23 stories on a wide range of health topics
Resources Contributed: Staff time

Program Name: Community Benefit Operations
Description:
The Hospital produces a triennial Community Needs Assessment, and provides dedicated staff for managing or overseeing community benefit program activities that are not included in other categories of community benefit. This staff provides internal tracking and reporting community benefit as well as managing or overseeing community benefit program activities.
Impact: 205,718 persons served;
Resources Contributed: Staff time; $132,668 net community benefit

Program Name: Community Health Education:
Description:
Community education activities provided both at the Hospital and in the community improve community health and extend beyond patient care activities. These services do not generate patient care bills and include such activities as community health education, community-based clinical health services and screenings for under-insured and uninsured persons, support groups, and self -help programs.
Impact: 381 Persons Served;
Resources Contributed: Staff time; equipment/supplies; event cost; $2,725 net community benefit

Program Name: Donations - Financial
Description:
The Hospital provides funds in the community to other not for profit organizations whose mission compliments the mission of the Hospital. These funds include monetary gifts and contributions to charity events after subtracting the fair market value of participation by employees or the organization and help to extend the services of the hospital beyond its walls.
Impact: 26,028 persons served; 7 community partnerships developed; **Partnerships Reported Outcomes:** American Cancer - 22% decline in cancer mortality in the past 2 decades - preventing more than 1.5 million cancer deaths since 2007 - Community education, by 2018, 80% of 45 & older being screened for colorectal cancer therefore substantially reducing colorectal cancer as a major public health problem. - current estimated rate for colorectal cancer screening in the population in North Texas is around 2 million Ellis County Coalition for Health Options (Hope Clinic) - Increased access for Emergency Department follow ups for low-income patients to come to Hope Clinic and establish primary care provider to obtain preventive healthcare in the coming months and years. Drug Prevention Resources – Ellis County Smoking Cessation program provided 1,200 cessation kits - completed approximately 60 healthcare consultations to speak with physicians to make sure they asked cessation questions and gave resources
Resources Contributed: cost of program/sponsorship; staff time; $194,800 net community benefit

Program Name: Donations - In Kind

Description:
The Hospital supports other not for profit organizations with in kind donation, such as serviceable equipment or supplies. Also provided are in kind donations such as meeting room overhead and space for not for profit organizations and social service networks; equipment and medical supplies; costs for coordinating events not sponsored by health care organizations; employee costs associated with board and community involvement on work time; food donations; etc. These donations extend the hospitals services beyond the wall of the hospital.
Impact: 1,922 persons served;
Resources Contributed: Staff time; cost of equipment/supplies; $6,729 net community benefit

Program Name: Faith in Action Initiatives
Description:
The Hospital donates retired medical supplies and equipment to the office of Faith in Action Initiatives 2nd Life program provides for the health care needs of populations in the community and nation not met through their own organization.
Impact: 52 organizations served including medical missions; emergency/disaster community response teams; churches; rehabilitation facilities; social service organizations; start up clinics; and other hospitals;
Resources Contributed: staff time; equipment; volunteer recruitment; delivery; shipping costs; depreciated value of donated equipment; $30,231 net community benefit

Program Name: For Women For Life
Description:
Through For Women For Life annual program, the Hospital provides health services, screenings, and treatments, assisting women in taking steps that help their chances for living a longer, healthier life. This annual event for women focusing on proactive health care including preventive health screenings, seminars and healthy lifestyle information. These services are at no cost to the female population who might not otherwise seek preventive health care.
Impact: 357 persons served; $18,347 net community benefit; reduced readmission rates for congestive heart failure
Resources Contributed: staff time; clinical experts; educational web site; health literature; finances; $18,347 net community benefit

Program Name: It's A Guy Thing
Description:
Regular health exams and tests can help find problems before they start. They also can help find problems early, when the chances for treatment and cure are better. Through For It's A Guy Thing, the Hospital provides health services, screenings, and treatments, assisting men in taking steps that help their chances for living a longer, healthier life. This annual event for men focuses on proactive health care including preventive health screenings, seminars and healthy lifestyle information.
Impact: 157 persons served; detection and prevention of disease

Resources Contributed: staff time; clinical experts; educational web site; health literature; finances; $11,073 net community benefit

Program Name: Screenings
Description:
Cardiovascular - The Hospital provides blood pressure screenings to improve cardiovascular health and quality of life through prevention, detection and treatment of risk factors through focusing particularly on hypertension and cholesterol in men and women and minority groups at high risk for disease development. The key to preventing cardiovascular disease, also called coronary artery disease (CAD), is managing risk factors such as high blood pressure, high total cholesterol or high blood glucose. Regular cardiovascular screening is important because it helps detect risk factors in their earliest stages and identify lifestyle changes and pharmacotherapies, if appropriate, before it ultimately leads to the development of cardiovascular disease. Cancer - The Hospital participates in community health screenings to aid in reducing the number of un-diagnosed cancer cases, as well as illness, disability, and death caused by cancer. Screening tests can help find cancer at an early stage, before symptoms appear. Abnormal tissue or cancer found early may be easier to treat or cure. Injury Prevention - Violence and injuries kill more people ages 1–44 in the U.S.1 than any other cause, and costs more than $406 billion in medical care and lost productivity each year. The Hospital conducts injury prevention screenings to help the community understand the risks associated with preventable injury.
Impact: 4,511 persons served; early detection and prevention of disease;
Resources Contributed: staff time; equipment/supply costs; clinical experts; health literature $3,259 net community benefit

Program Name: Weight Loss Support Group
Description:
Attending support groups connects those undergoing bariatric surgery to peers and may improve weight loss efficacy. One of the most important habits to adopt in moving forward on a weight loss journey is regular participation in support groups. Many people find support groups especially helpful after weight loss surgery, which present a chance for patients to gain from hearing the perspective from others on similar issues; listening to challenges, others are experiencing, and to gain insight into obstacles that may be ahead. Participating in support groups goes well beyond sharing experiences and advice… in addition to the invaluable encouragement and support attendees receive, they also result in more weight loss.
Impact: 150 persons served;
Resources Contributed: staff time; clinical experts; health literature; $867 net community benefit

Identified Need Addressed: Mental/Behavioral Resources & Excess Drinking

Program Name: Behavioral Health Connections
Description:
The hospital contracts with Behavioral Health Connections to come to the hospital and interviews patients to determine what resources best meet patients' needs (inpatient or outpatient) and refers patients to those agencies. The hospital provides Licensed Clinical Social Workers (LCSW) who round on patients, as

well as chaplains and sitters who stay with patients to make sure the patient is not of harm to themselves (suicidal patients) while they are waiting for a bed to open up at a mental health facility.
Impact: 816 persons served; 372 persons transferred to outside agencies; 204 transferred for outpatient behavioral health services;
Resources Contributed: 5.3 FTE's; Contract cost for Behavioral Health Connections; staff time equivalent to $40,841 (net community benefit)

Program Name: Community Health Education - Alzheimer's Disease
Description:
Community education activities at the Hospital and in the community improve community health and extend beyond patient care activities. These services do not generate patient care bills and include such activities as community health education regarding Alzheimer's Disease. Theses community-based health education services for both the broader community and the under-insured and uninsured persons aid in creating awareness, to reinforce the importance of early detection and treatment, both key components in the battle against Alzheimer's disease.
Impact: 50 persons served; Early intervention and prevention
Resources Contributed: staff time; supplies; health experts; literature; $150 net community benefit

Program Name: Donations - Financial
Description:
The Hospital provides funds in the community to other not for profit organizations whose mission compliments the mission of the Hospital. These funds include monetary gifts and contributions to charity events after subtracting the fair market value of participation by employees or the organization and help to extend the services of the hospital beyond its walls.
Impact: 2,400 persons served; 4 community partners developed Partner Reported Outcomes: • Drug Prevention Resources: Impact Communities -Drug Prevention Resources – Ellis County Smoking Cessation program provided 1,200 cessation kits - completed approximately 60 healthcare consultations to speak with physicians to make sure they asked cessation questions and gave resources • Ellis County Children's Advocacy Center – heightened community awareness through quality legal, psychological, social, and medical services to abused children • Meals on Wheels of Johnson and Ellis County – 2,400 meals served; • American Cancer – Look Good Feel Better is a free service teachings women battling cancer beauty techniques to help them improve their appearance and self-image during chemotherapy and radiation treatments • Dinah Weable Breast Cancer Survivors - 364 screening mammograms • REACH Council Prevention Services – heightened awareness and encouragement to support safe and healthy choices vital to the well-being of our youth, families and community; purchased over 5000 informational rack cards/brochures • Boys and Girls Club -94% of youth mentored longer than six months improved or maintained in 5 of 7 youth development areas; 95% improvement in social acceptance;
Resources Contributed: Financial support (net benefit reported in previous section)

Identified Need Addressed: Physician & Non-Physician Care Providers to Population Ratio

Program Name: Enrollment Services
Description:
The hospital provides assistance to enroll in public programs, such as SCHIP and Medicaid. These health care support services provided by the hospital to increase access and quality of care in health services to individuals, especially persons living in poverty and those in vulnerable situations. The hospital provides staff to assist in the qualification of the medically under-served for programs that will enable their access to care, such as Medicaid, Medicare, SCHIP and other government programs or charity care programs for use in any hospital within or outside the hospital.
Impact: 8,166 persons served (for FY2018); increased access to physician/non-physician primary care providers
Resources Contributed: Contract; $98,293 net community benefit

Program Name: Medical Education - Allied Health Services
Description:
The Hospital provides medical education to students other than nursing education and residency program students to assist in attaining medical degrees, certifications or licenses. These education programs include students of ancillary service lines such as Echo techs and radiology students. These students require 100% of a supervisor's time.
Impact: 162 students educated; increased access to non-physician ancillary health care services
Resources Contributed: Nurse Educators; $180,799 net community benefit

Program Name: Medical Education - Nursing
Description:
The Hospital commits to assisting with the preparation of future nurses at entry and advanced levels of the profession to establish a workforce of qualified nurses. Through the System's relationships with many North Texas schools of nursing, the Hospital maintains strong affiliations with schools of nursing. Like physicians, nursing graduates trained at the Hospital are not obligated to join the staff although many remain in the North Texas area to provide top quality nursing services to many health care institutions.
Impact: 726 nurses educated; 12 partnerships developed with area colleges and universities; increased access to non-physician health care providers
Resources Contributed: Nurse Educator Staff; $1,480,506 net community benefit

Program Name: Workforce Development
Description:
The recruitment of physicians and other health professionals for areas identified as medically under-served (MUAs) or other community health needs as identified in the Community Health Needs Assessment (CHNA). The age and characteristics of a state's population has a direct impact on the health care system. The state's population is growing at an explosive pace –and, like the rest of the country, the Ellis County population is aging and in need of more health care services, which puts added demands on the system.

The Hospital seeks to allay the physician shortage, thereby better managing the growing health needs of the community.
Impact: 6 physicians recruited **;** increased access for women; increased access for primary care and orthopedic patients; Increased access for heart patients; increased access for surgical patients
Resources Contributed: Physician subsidies; $3,249,114 net community benefit

Needs Not Addressed:

All needs addressed in this report