


Community Health Needs Assessment

Sherman Health Community

2022

Baylor Scott & White HEALTH

Sherman health community hospital

- Baylor Scott & White Surgical Hospital at Sherman

Approved by: Baylor Scott & White Health – North Texas Operating, Policy and Procedure Board on May 31, 2022
Posted to **BSWHealth.com/CommunityNeeds** on June 30, 2022

Baylor Scott & White HEALTH

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Baylor Scott & White Health mission

Our commitment to the communities we serve

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 51 hospitals, 1,100 access points, more than 7,300 active physicians, and over 49,000 employees and the Baylor Scott & White Health Plan.

Baylor Scott & White Health is a leading Texas healthcare provider with a proven commitment to patient and community health. Baylor Scott & White Health demonstrates this commitment through periodic community health needs assessments, then addresses those needs with a wide range of outreach initiatives.

These Community Health Needs Assessment (CHNA) activities also satisfy federal and state community benefit requirements outlined in the Patient Protection and Affordable Care Act and the Texas Health and Safety Code.

Baylor Scott & White Health conducts a thorough periodic examination of public health indicators and a benchmark analysis comparing communities it serves to an overall state of Texas value. In this way, it can determine where deficiencies lie and the opportunities for improvement are greatest.

Through interviews, focus groups and surveys, the organization gains a clearer understanding of community needs from the perspective of the members of each community. This helps it identify the most pressing needs a community is facing and develop implementation plans to focus on those prioritized needs.

The process includes input from a wide range of knowledgeable people who represent the myriad interests of the community in compliance with 501 (r)(3) regulations. The CHNA process overview can be found in **Appendix A**.

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

Community Health Needs Assessment (CHNA) report

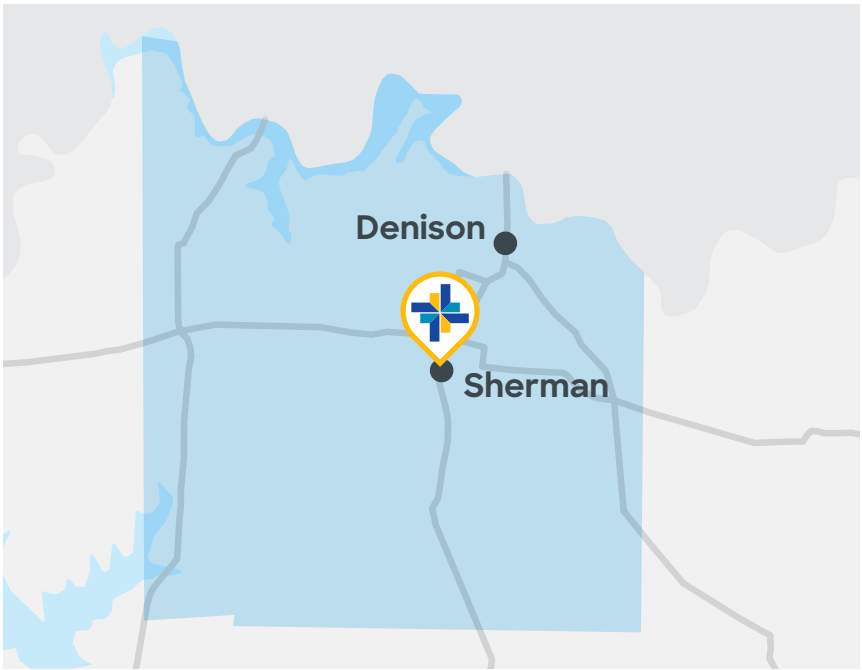
Baylor Scott & White Health (BSWH) owns and operates numerous individually licensed hospital facilities serving the residents of North and Central Texas.

The Sherman Health Community is home to one of these hospitals:

- Baylor Scott & White Surgical Hospital at Sherman

The community served by the hospital listed above is Grayson County and was determined based on the contiguous ZIP codes within the associated counties that made up nearly 80% of the hospital facilities' inpatient admissions over the 12-month period of FY20. The facility completed a CHNA report in accordance with the Internal Revenue Code Section 501 (r) (3) and the US Treasury regulations thereunder.

Sherman Health Community map



BSWH engaged with IBM Watson Health, a nationally respected consulting firm, to conduct a Community Health Needs Assessment (CHNA) in accordance with the federal and state community benefit requirements for the health communities they serve.

The CHNA process included:

- Gathering and analyzing more than 59 public and 45 proprietary health data indicators to provide a comprehensive assessment of the health status of the communities. The complete list of health data indicators is included in **Appendix B**.
- Creating a benchmark analysis comparing the community to overall state of Texas and United States (US) values.
- Conducting focus groups, key informant interviews and stakeholder surveys, including input from public health experts, to gain direct input from the community for a qualitative analysis.
  - Gathering input from state, local and/or regional public health department members who have the pulse of the community's health.
  - Identifying and considering input from individuals or organizations serving and/or representing the interests of medically underserved low-income and minority populations in the community to help prioritize the community's health needs.
  - The represented organizations that participated are included in **Appendix C**.

IBM Watson Health provided current and forecasted demographic, socioeconomic and utilization estimates for the community.

Demographic and socioeconomic summary

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

- The community is outpacing the rate of growth of the US but growing slower than the state of Texas.
- The average age of the population is older than both the US and Texas overall.
- The median household income is lower than both the state and the US.
- The community served has a slightly lower percentage of uninsured and underinsured than Texas.

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

Health community data summary

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

- Inpatient discharges in the community are expected to grow by 3.5% by 2030 with pulmonary medical as the product line growing the fastest.
- Outpatient procedures are expected to increase by almost 27% by 2030 with the largest areas of growth including:
  - Labs
  - General & internal medicine
  - Physical & occupational therapy
- Emergency department visits are expected to grow by 9.5% by 2025.
- Hypertension represents 65% of all heart disease cases.
- Cancer incidence is expected to increase by 5.1% by 2025.

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

The community includes the following health professional shortage areas and medically underserved areas as designated by the US Department of Health and Human Services Health Resources Services Administration. **Appendix D** includes the details on each of these designations.

	Health professional shortage areas (HPSA)				Medically underserved area/ population (MUA/P)
County	Dental health	Mental health	Primary care	Grand total	MUA/P
Grayson		1	1	2	1

Source: US Department of Health and Human Services, Health Resources and Services Administration, 2021

Total population

139,011

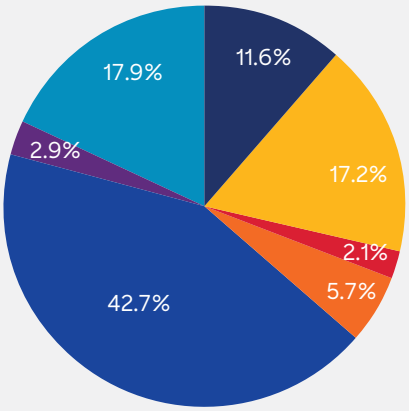
Average income

$61,067

Underserved ZIP codes

0

Insurance coverage



Priority health needs

Using the data collection and interpretation methods outlined in this report, BSWH has identified what it considers to be the community's significant health needs. The resulting prioritized health needs for this community are:

Priority	Need	Category of need
1	Access to primary healthcare providers	Access to care
2	Household income	Population & income
3	Mentally unhealthy days	Mental health
4	Infant mortality rate/lack of OB care	Injury & death/ maternal & child health
5	Children uninsured	Access to care

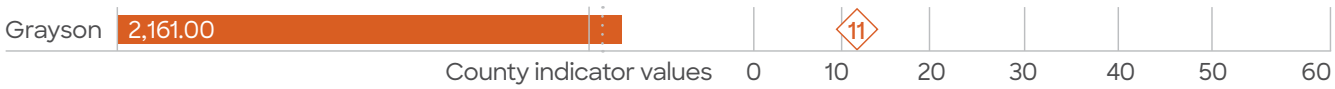
Priority 1: Access to Primary Healthcare Providers

The following data indicates greater need for access for the population to one primary care provider and access for the population to one non-physician primary care provider.

Category	Data shows greater need	Key informants indicate greater need
Access to care	• Population to one primary care physician • Population to one non-physician primary care provider	• Shortage of physicians • Limited healthcare workforce

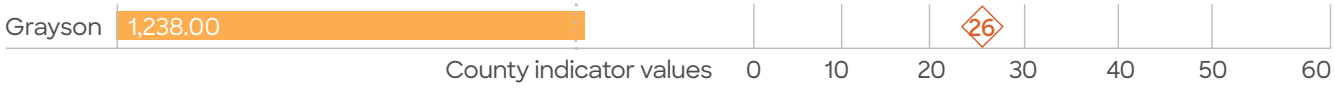
The **population to one primary care physician** indicator is defined as **the number of individuals served by one physician in a county if the population was equally distributed across physicians** and is based on data from County Health Rankings & Roadmaps and Area Health Resource File/American Medical Association.

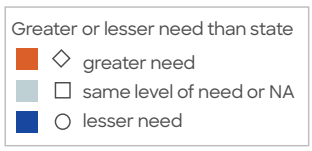
Access to care: population to one primary care physician (number of individuals served by one physician by county)



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

Access to care: population to one non-physician primary care provider (ratio of population to primary care providers other than physicians by county)





LEFT PANEL: Indicator Values horizontal bar and label shows the county score. Vertical dotted line shows the state benchmark. Solid line is US score. Orange colors indicate a greater need and potentially larger vulnerable population in the county relative to the state benchmark. Blue indicates a lesser need and potentially smaller vulnerable population. Darker intense colors indicate greater differences. **RIGHT PANEL:** Rank within county marks show how the indicator ranks compared to other indicators within the county. Indicators are ranked from 1 to 59, where low numbers show higher need and potentially larger vulnerable population relative to the state benchmark. Color and shape compare county performance to the state benchmark; orange diamonds show greater need and blue circles lesser need.

The focus group participants felt that the overall community area has limited access to primary care providers. The overall community area has limited healthcare treatment and preventive services for the underinsured and uninsured populations.

In the prioritization session, the hospital leadership agreed that primary care access is limited in the community. They also mentioned the downstream effects of limited access to primary care, such as cancer incidence, heart disease and overutilization of emergency departments.

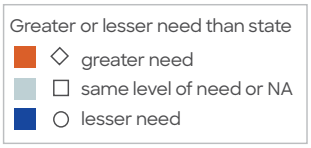
Priority 2: Household Income

The following data indicates greater need in the area of household income.

Category	Data shows greater need	Key informants indicate greater need
Population & income	• Household income	• High cost of living, more than current income levels can afford

The **household income** indicator is defined as **the median household income, which is the income where half of households in a county earn more and half of households earn less**. The measure is based on data from County Health Rankings (Small Area Income and Poverty Estimates).

Population & income: household income (median household income $USD by county)



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The focus group participants stated that there is a concern that many residents in the community cannot afford to receive needed healthcare services because they are unable to pay for services. They attribute a loss of income and lower incomes earned as a result of the financial impact COVID had on the community,

In the prioritization session, the hospital leadership group did not discuss household income specifically but voted it as the second-highest significant need because they attribute homelessness and other financial issues to be caused by low wages earned by residents in the community.

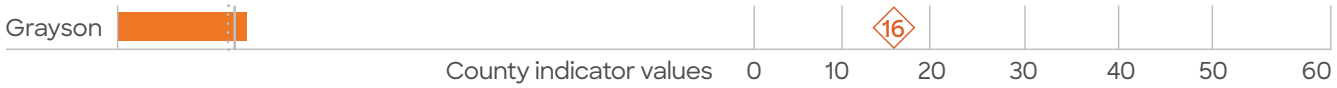
Priority 3: Mentally Unhealthy Days

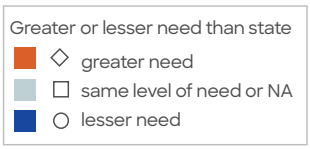
The following data indicates greater need around mentally unhealthy days.

Category	Data shows greater need	Key informants indicate greater need
Mental health	• Mentally unhealthy days	• Declining mental health status

The **mentally unhealthy days** indicator is defined as **the average number of mentally unhealthy days reported in past 30 days (age-adjusted)** and is based on data from County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS).

Mental health conditions/diseases: mentally unhealthy days (number of mentally unhealthy days reported in past 30 days by county)





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The focus group participants felt that the mental health status among residents is declining. They added that the community is suffering an overwhelming impact of substance abuse and mental health issues and lacks proactive mental health services, which contribute to the downfall of the physical well-being of residents as well.

In the prioritization session, the hospital and community leaders agreed that the mental health state of the community is declining. They added that mental health challenges are increasing year over year. They felt that increased isolation and inactivity among residents contribute to the poor mental health of the community.

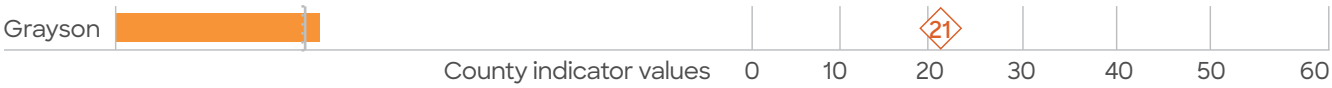
Priority 4: Infant Mortality Rate/Lack of OB Care

The following data indicates greater need in the area of infant mortality rate, although it was not discussed by the key informants specifically.

Category	Data shows greater need	Key informants indicate less need or not mentioned
Injury & death Maternal & child health	• Mortality rate: infant • Prenatal care: first trimester entry into prenatal care	• Not specifically mentioned

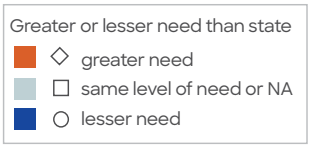
The **mortality rate: infant** indicator is defined as **the number of all infant deaths (within one year), per 1,000 live births**. The indicator is based on data from County Health Rankings & Roadmaps, CDC WONDER Mortality Data.

Injury & death: mortality rate: infant (number of all infant deaths per 1,000 live births by county)



The **prenatal care: first trimester entry into prenatal care** indicator is defined as **the percent of births with prenatal care onset in first trimester** and is based on data from Texas Health and Human Services - Vital statistics annual report.

Maternal & child health: prenatal care: first trimester entry into prenatal care (percent of births with prenatal care in first trimester by county)



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In the prioritization session, hospital leadership shared that obstetricians/gynecologists are increasingly leaving their practices due to challenges with the specialty. They believe that this attrition leads to decreased access to prenatal care among community mothers. As the market continues to grow, they fear that this problem will continue to worsen.

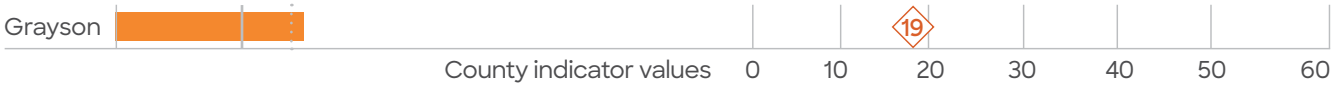
Priority 5: Children Uninsured

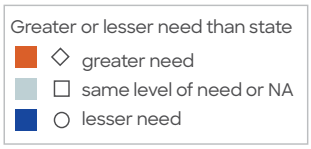
The following data indicates greater need in the area of uninsured children.

Category	Data shows greater need	Key informants indicate greater need
Access to care	• Children uninsured	• Lack of health insurance coverage

The indicator **children uninsured** is defined as **the percentage of children under age 19 without health insurance**. The indicator is based on data from County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau.

Access to care: children uninsured (% of children under age 19 without health insurance)





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The focus group participants noted that many members of the community lack health insurance. This lack of insurance coverage prevents many from seeking needed healthcare services as preventive measures and leads to patients with higher severity cases when they do seek care.

In the prioritization session, the hospital and community leaders cited many challenges for the children in the community. The children age out of foster programs as they grow older but then are left homeless and uninsured. Homelessness and a lack of insurance are challenges for other teens in the community as well.

The Community Health Dashboards data referenced above can be found at **BSWHealth.com/About/Community-Involvement/Community-Health-Needs-Assessments**.

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

Existing resources to address health needs

One part of the assessment process includes gathering input on potentially available community resources. The community is served by several large healthcare systems and multiple community-based health clinics. Below is a list of some of the community resources available to address identified needs in the community.

Sherman community resources

Need	Organization	Address	Phone
Access to primary healthcare providers	Grayson County Health Clinic (primary care)	1111 Gallagher Drive Sherman, TX 75090	903.771.2846
	Greater Texoma Health Clinic	900 N. Armstrong Avenue Denison, TX 75020	903.465.2440
	Callie Clinic	1521 Baker Road Sherman, TX 75090	903.891.1972
	VA North Texas Health Care System (VANTHCS)	3811 US 75 Sherman, TX 75090	903.487.0477
	Texas HHSC	2001 Loy Lake Road Sherman, TX 75090	877.541.7905
Household income	Four Rivers Outreach (educational, training, employment services)	210 S. Rusk Street Sherman, TX 75090	903.870.4000
	Texas HHSC	2001 Loy Lake Road Sherman, TX 75090	877.541.7905
	Salvation Army of Grayson County (emergency financial assistance)	5700 Texoma Parkway Sherman, TX 75090	903.868.9602
	North Texas 2nd Chance Lighthouse Inc. (Basic needs assistance)	502 N. 5th Street Gunter, TX 75058	903.816.3814
	Express Employment Professionals - Sherman, TX	4001 N. Highway 75 Sherman, TX 75090	903.893.1122
Mentally unhealthy days	Lakes Regional Community Centers (mental health services)	421 N. Sam Rayburn Freeway Sherman, TX 75090	903.892.8185
	TMC Behavioral Health Center	2601 Cornerstone Drive Sherman, TX 75092	903.416.3000
	Texoma Community Center (mental health services)	315 W. McLain Drive Sherman, TX 75092	903.957.4701
	Grayson County Children's Advocacy Center (CAC)	910 E. Cottonwood Road Sherman, TX 75090	903.957.0440
	Child & Family Guidance Center of Texoma	804 E. Pecan Grove Road Sherman, TX 75090	903.893.7768

Need	Organization	Address	Phone
Infant mortality/lack of obstetric care	Women Rock Inc. (obstetric care)	225 E. Houston Street Sherman, TX 75090	903.487.2528
	Grayson County Health Clinic (women's health)	1111 Gallagher Drive Sherman, TX 75090	903.771.2846
	Callie Clinic (family planning)	1521 Baker Road Sherman, TX 75090	903.891.1972
	True Options Pregnancy Center	105 W. Pecan Street Sherman, TX 75090	903.893.9099
	Texas HHSC	2001 Loy Lake Road Sherman, TX 75090	877.541.7905
Children uninsured	Texas HHSC	2001 Loy Lake Road Sherman, TX 75090	877.541.7905
	Grayson County Health Department - WIC (children/infants at nutritional risk)	205 N. Houston Avenue Denison, TX 75021	903.465.2878 ext.225
	Greater Texoma Health Clinic (pediatric primary care)	900 N. Armstrong Avenue Denison, TX 75020	903.465.2440
	Grayson County Health Clinic (pediatrics)	1111 Gallagher Drive Sherman, TX 75090	903.771.2846
	Grayson County WIC - Sherman (children/infants at nutritional risk)	515 N. Walnut Street Sherman, TX 75090	903.893.0131 ext. 1238

There are many other community resources and facilities serving the Sherman area that are available to address identified needs and can be accessed through a comprehensive online resource catalog called Find Help (formerly known as Aunt Bertha). It can be accessed 24/7 at **BSWHealth.FindHelp.com**.

Next steps

BSWH started the Community Health Needs Assessment process in April 2021. Using both qualitative community feedback as well as publicly available and proprietary health indicators, BSWH was able to identify and prioritize 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.

Appendix A: CHNA requirement details

The Patient Protection and Affordable Care Act (PPACA) requires all tax-exempt organizations operating hospital facilities to assess the health needs of their community every three (3) years. The resulting Community Health Needs Assessment (CHNA) report must include descriptions of the following:

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

CHNA process

BSWH began the 2022 CHNA process in April of 2021. The following is an overview of the timeline and major milestones:

Consultant qualifications

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

Health needs assessment process overview

To identify the health needs of the community, the hospitals established a comprehensive method using all available relevant data including community input. They used the qualitative and quantitative data obtained when assessing the community to identify its community health needs. Surveyors conducted interviews and focus groups with individuals representing public health, community leaders/groups, public organizations and other providers. In addition, data collected from public sources compared to the state benchmark indicated the level of severity. The outcomes of the quantitative data analysis were compared to the qualitative data findings.

These data are available to the community via an interactive dashboard at **BSWHealth.com/CommunityNeeds**.

Data gathering: quantitative assessment of health needs – methodology and data sources

The IBM team used quantitative data collection and analysis garnered from public health indicators to assess community health needs. This included over 100 data elements grouped into over 11 categories evaluated for the counties where data was available. Recently, indicators expanded to include new categories addressing mental health, healthcare costs, opioids and social determinants of health. A table depicting the categories and indicators and a list of sources are in **Appendix B**.

A benchmark analysis of each indicator determined which public health indicators demonstrated a community health need. Benchmark health indicators included overall US values, state of Texas values and other goal-setting benchmarks, such as Healthy People 2020.

According to America's Health Rankings 2021 Annual Report, Texas ranks 22nd out of the 50 states in the area of Health Outcomes (which includes behavioral health, mortality and physical health) and 50th in the area of Clinical Care (which includes avoiding care due to cost, providers per 100,000 population and preventive services). When the health status of Texas was compared to other states, the team identified many opportunities to impact community health.

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

- The team set benchmarks for each health community using state value for comparison.
- They identified community indicators not meeting state benchmarks.
- From this, they determined a need differential analysis of the indicators, which helped them understand the community's relative severity of need.
- Using the need differentials, they established a standardized way to evaluate the degree that each indicator differed from its benchmark.
- This quantitative analysis showed which health community indicators were above the 25th percentile in order of severity—and which health indicators needed their focus.

The outcomes of the quantitative data analysis were compared to the qualitative data findings.

Information gaps

In some areas of Texas, the small population size has an impact on reporting and statistical significance. The team has attempted to understand the most significant health needs of the entire community. It is understood that there is variation of need within the community, and BSWH may not be able to impact all of the population who truly need the service.

Community input: qualitative health needs assessment - approach

To obtain a qualitative assessment of the health community, the team:

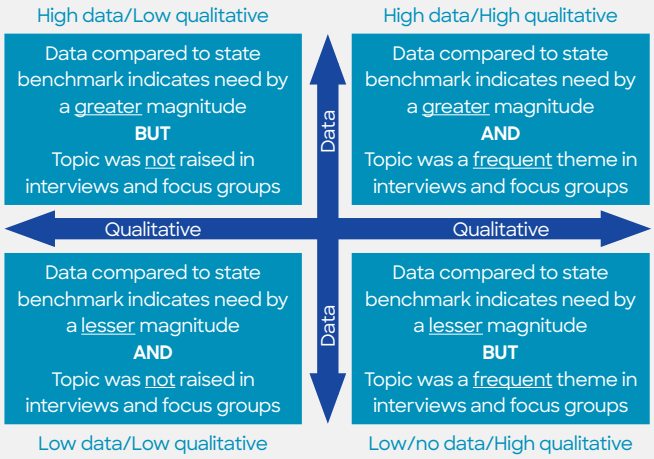
- Assembled a focus group representing the broad interests of the community served;
- Conducted interviews and surveys with key informants—leaders and representatives who serve the community and have insight into its needs; and
- Held prioritization sessions with hospital clinical leadership and community leaders to review collection results and identify the most significant healthcare needs based on information gleaned from the focus groups and key informants.

Focus groups helped identify barriers and social factors influencing the community's health needs. Key informant interviews gave the team even more understanding and insight about the general health status of the community and the various drivers that contributed to health issues.

Multiple governmental public health department individuals were asked to contribute their knowledge, information and expertise relevant to the health needs of the community. Individuals or organizations who served and/or represented the interests of medically underserved, low-income and minority populations in the community also took part in the process. NOTE: In some cases, public health officials were unavailable due to obligations concerning the COVID-19 pandemic.

The hospitals also considered written input received on their most recently conducted CHNA and subsequent implementation strategies if provided. The assessment is available for public comment or feedback on the report findings by going to the BSWH website (**BSWHealth.com/CommunityNeeds**) or by emailing **CommunityHealth@BSWHealth.org**.

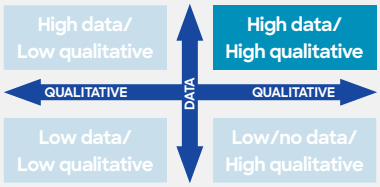
Approach to prioritizing significant health needs



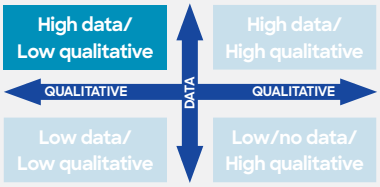
High data = Indicators worse than state benchmark by greater magnitude
High qualitative = Frequency of topic in interviews and focus groups

On January 21, 2022, a session was conducted with key leadership members from Baylor Scott & White along with community leaders to review the qualitative and quantitative data findings of the CHNA to date, discuss at length the significant needs identified, and complete prioritization exercises to rank the community needs. Prioritizing health needs was a two-step process. The two-step process allowed participants to consider the quantitative needs and qualitative needs as defined by the indicator dataset and focus group/interview/survey participant input.

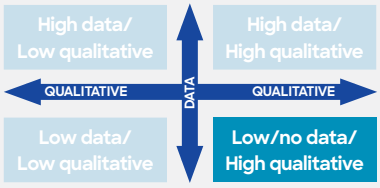
In the first step, participants reviewed the top health needs for their community using associated data-driven criteria. The criteria included health indicator value(s) for the community and how the indicator compared to the state benchmark.



High data and high qualitative: The community indicators that showed a greater need in the health community overall when compared to the state of Texas comparative benchmark and were identified as a greater need by the key informants.



High data and low qualitative: The community indicators showed a greater need in the health community overall when compared to the state of Texas comparative benchmark but were not identified as a greater need or not specifically identified by the key informants.



Low/no data and high qualitative:
The community indicators showed less need or had no data available in the health community overall when compared to the state of Texas comparative benchmark but were identified as a greater need by the key informants.

Participants held a group discussion about which needs were most significant, using the professional experience and community knowledge of the group. A virtual voting method was invoked for individuals to provide independent opinions.

This process helped the group define and identify the community's significant health needs. Participants voted individually for the needs they considered the most significant for this community. When the votes were tallied, the top identified needs emerged and were ranked based on the number of votes.

Prioritization of significant needs

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

- **Severity (outcome if ignored):** The problem results in disability or premature death or creates burdens on the community, economically or socially.
- **Magnitude (size of problem):** How many persons does the problem affect, either actually or potentially?
- **Community capacity or strengths:** The community may or may not have the capacity to act on the issue with regard to economic, social, cultural or political consideration. It should be considered whether current initiatives exist to help address the health issue that can be built upon to bolster existing resources.

The group rated each of the five significant health needs on each of the three identified criteria, using a scale of 1 (low) to 10 (high). The criteria score sums for each need created an overall score.

They prioritized the list of significant health needs based on the overall scores. The outcome of this process was the list of prioritized health needs for this community.

Priority	Need	Category of need
1	Access to primary healthcare providers	Access to care
2	Household income	Population & income
3	Mentally unhealthy days	Mental health
4	Infant mortality rate/lack of OB care	Injury & death/ maternal & child health
5	Children uninsured	Access to care

Appendix B: key public health indicators

IBM Watson Health collected and analyzed fifty-nine (59) public health indicators to assess and evaluate community health needs. For each health indicator, a comparison between the most recently available community data and benchmarks for the same/similar indicator was made. The basis of benchmarks was available data for the US and the state of Texas.

The indicators used and the sources are listed below:

Indicator name	Indicator source	Indicator definition
Adult obesity	2021 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System	2017 Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2
Adults reporting fair or poor health	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Percentage of adults reporting fair or poor health (age-adjusted)
Binge drinking	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Percentage of a county's adult population that reports binge or heavy drinking in the past 30 days
Cancer incidence: all causes	State Cancer Profiles National Cancer Institute (CDC)	2013 - 2017 Age-adjusted cancer (all) incidence rate cases per 100,000 (all races, includes Hispanic; both sexes; all ages. Age-adjusted to the 2000 US standard population)
Cancer incidence: colon	State Cancer Profiles National Cancer Institute (CDC)	2013 - 2017 Age-adjusted colon and rectum cancer incidence rate cases per 100,000 (all races, includes Hispanic; both sexes; all ages. Age-adjusted to the 2000 US standard population). Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of three is shown, the total number of cases for the time period is 16 or more, which exceeds suppression threshold (but is rounded to three).
Cancer incidence: female breast	State Cancer Profiles National Cancer Institute (CDC)	2013 - 2017 Age-adjusted female breast cancer incidence rate cases per 100,000 (all races, includes Hispanic; female; all ages. Age-adjusted to the 2000 US standard population). Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of three is shown, the total number of cases for the time period is 16 or more, which exceeds suppression threshold (but is rounded to three).

Indicator name	Indicator source	Indicator definition
Cancer incidence: lung	State Cancer Profiles, National Cancer Institute (CDC)	2013 - 2017 Age-adjusted lung and bronchus cancer incidence rate cases per 100,000 (all races, includes Hispanic; both sexes; all ages. Age-adjusted to the 2000 US standard population)
Cancer incidence: prostate	State Cancer Profiles, National Cancer Institute (CDC)	2013 - 2017 Age-adjusted prostate cancer incidence rate cases per 100,000 (all races, includes Hispanic; males; all ages. Age-adjusted to the 2000 US standard population)
Children in poverty	2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau	2019 Percentage of children under age 18 in poverty.
Children in single-parent households	2021 County Health Rankings & Roadmaps; American Community Survey (ACS), Five-Year Estimates (United States Census Bureau)	2015 - 2019 Percentage of children that live in a household headed by single parent
Children uninsured	2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau	2018 Percentage of children under age 19 without health insurance
Diabetes admission	2018 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations	Number observed/adult population age 18 and older. Risk-adjusted rates not calculated for counties with fewer than five admissions.
Diabetes diagnoses in adults	CMS.gov Chronic Conditions 2007 - 2018	Prevalence of chronic condition across all Medicare beneficiaries
Diabetes prevalence	County Health Rankings (CDC Diabetes Interactive Atlas)	2017 Prevalence of diagnosed diabetes in a given county. Respondents were considered to have diagnosed diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes.
Drug poisoning deaths	2021 County Health Rankings & Roadmaps, CDC WONDER Mortality Data	2017 - 2019 Number of drug poisoning deaths (drug overdose deaths) per 100,000 population. Death rates are null when the rate is calculated with a numerator of 20 or less.
Elderly isolation	2018 American Community Survey Five-Year Estimates, US Census Bureau - American FactFinder	Percent of non-family households - householder living alone - 65 years and over
English spoken "less than very well" in household	2015 - 2019 American Community Survey Five-Year Estimates, US Census Bureau - American FactFinder	2019 Percentage of households that 'speak English less than "very well"' within all households that 'speak a language other than English'
Food environment index	2021 County Health Rankings & Roadmaps; USDA Food Environment Atlas, Map the Meal Gap from Feeding America, United States Department of Agriculture (USDA)	2015 and 2018 Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)
Food insecure	2021 County Health Rankings & Roadmaps; Map the Meal Gap, Feeding America	2018 Percentage of population who lack adequate access to food during the past year

Indicator name	Indicator source	Indicator definition
Food: limited access to healthy foods	2021 County Health Rankings & Roadmaps; USDA Food Environment Atlas, United States Department of Agriculture (USDA)	2015 Percentage of population who are low-income and do not live close to a grocery store
High school graduation	Texas Education Agency	2019 A four-year longitudinal graduation rate is the percentage of students from a class of beginning ninth graders who graduate by their anticipated graduation date or within four years of beginning ninth grade.
Household income	2021 County Health Rankings (Small Area Income and Poverty Estimates)	2019 Median household income is the income where half of households in a county earn more and half of households earn less.
Income inequality	2021 County Health Rankings & Roadmaps; American Community Survey (ACS), Five-Year Estimates (United States Census Bureau)	2015 - 2019 Ratio of household income at the 80th percentile to income at the 20th percentile. Absolute equality = 1.0. Higher ratio is greater inequality.
Individuals below poverty level	2018 American Community Survey Five-Year Estimates, US Census Bureau - American FactFinder	Individuals below poverty level
Low birth weight rate	2019 Texas Certificate of Live Birth	Number low birth weight newborns /number of newborns. Newborn's birth weight – low or very low birth weight includes birth weights under 2,500 grams. Blanks indicate low counts or unknown values. A null value indicates unknown or low counts. The location variables (region, county, ZIP) refer to the mother's residence.
Medicare population: Alzheimer's disease/ dementia	CMS.gov Chronic Conditions 2007 - 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare population: atrial fibrillation	CMS.gov Chronic Conditions 2007 - 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare population: COPD	CMS.gov Chronic Conditions 2007 - 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare population: depression	CMS.gov Chronic Conditions 2007 - 2018	Prevalence of chronic condition across all Medicare beneficiaries
Medicare population: emergency department use rate	CMS 2019 Outpatient 100% Standard Analytical File (SAF) and 2019 Standard Analytical Files (SAF) Denominator File	Unique patients having an emergency department visit/total beneficiaries, CY 2019

Indicator name	Indicator source	Indicator definition
Medicare population: heart failure	CMS.gov Chronic Conditions 2007 - 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare population: hyperlipidemia	CMS.gov Chronic Conditions 2007 - 2018	Prevalence of chronic condition across all Medicare beneficiaries
Medicare population: hypertension	CMS.gov Chronic Conditions 2007 - 2018	Prevalence of chronic condition across all Medicare beneficiaries
Medicare population: inpatient use rate	CMS 2019 Inpatient 100% Standard Analytical File (SAF) and 2019 Standard Analytical Files (SAF) Denominator File	Unique patients being hospitalized/total beneficiaries, CY 2019
Medicare population: stroke	CMS.gov Chronic Conditions 2007 - 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare spending per beneficiary (MSPB) index	CMS 2019 Medicare Spending Per Beneficiary (MSPB), Hospital Value-Based Purchasing (VBP) Program	Medicare spending per beneficiary (MSPB): for each hospital, CMS calculates the ratio of the average standardized episode spending over the average expected episode spending. This ratio is multiplied by the average episode spending level across all hospitals. Blank values indicate missing hospitals or missing score. Associated to the hospitals
Mentally unhealthy days	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Average number of mentally unhealthy days reported in past 30 days (age-adjusted)
Mortality rate: cancer	Texas Health Data, Center for Health Statistics, Texas Department of State Health Services	2017 Cancer (all) age-adjusted death rate (per 100,000 - all ages. Age-adjusted using the 2000 US Standard population). Death rates are null when the rate is calculated with a numerator of 20 or less.
Mortality rate: heart disease	Texas Health Data, Center for Health Statistics, Texas Department of State Health Services	2017 Heart disease age-adjusted death rate (per 100,000 - all ages. Age-adjusted using the 2000 US Standard population). Death rates are null when the rate is calculated with a numerator of 20 or less.
Mortality rate: infant	2021 County Health Rankings & Roadmaps, CDC WONDER Mortality Data	2013 - 2019 Number of all infant deaths (within one year), per 1,000 live births. Blank values reflect unreliable or missing data.
Mortality rate: stroke	Texas Health Data, Center for Health Statistics, Texas Department of State Health Services	2017 Cerebrovascular disease (stroke) age-adjusted death rate (per 100,000 - all ages. Age-adjusted using the 2000 US Standard population). Death rates are null when the rate is calculated with a numerator of 20 or less.

Indicator name	Indicator source	Indicator definition
No vehicle available	US Census Bureau, 2019 American Community Survey One-Year Estimates	2019 Households with no vehicle available (percent of households). A null value entry indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates fall in the lowest interval or upper interval of an open-ended distribution, or the margin of error associated with a median was larger than the median itself.
Opioid involved accidental poisoning death	US Census Bureau, Population Division and 2019 Texas Health and Human Services Center for Health Statistics Opioid related deaths in Texas	Annual estimates of the resident population: April 1, 2010, to July 1, 2017. 2019 Accidental poisoning deaths where opioids were involved are those deaths that include at least one of the following ICD-10 codes among the underlying causes of death: X40 - X44, and at least one of the following ICD-10 codes identifying opioids: T40.0, T40.1, T40.2, T40.3, T40.4, T40.6. Blank values reflect unreliable or missing data.
Physical inactivity	2021 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System	2017 Percentage of adults ages 20 and over reporting no leisure-time physical activity in the past month
Physically unhealthy days	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Average number of physically unhealthy days reported in past 30 days (age-adjusted)
Population to one dentist	2021 County Health Rankings & Roadmaps; Area Health Resource File/National Provider Identification file (CMS)	2019 Ratio of population to dentists
Population to one mental health provider	2021 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)	2020 Ratio of population to mental health providers
Population to one non-physician primary care provider	2020 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)	2020 Ratio of population to primary care providers other than physicians
Population to one primary care physician	2021 County Health Rankings & Roadmaps; Area Health Resource File/American Medical Association	2018 Number of individuals served by one physician in a county, if the population was equally distributed across physicians
Population under age 65 without health insurance	2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau	2018 Percentage of population under age 65 without health insurance
Prenatal care: first trimester entry into prenatal care	2020 Texas Health and Human Services - Vital statistics annual report	2016 Percent of births with prenatal care onset in first trimester

Indicator name	Indicator source	Indicator definition
Renter-occupied housing	US Census Bureau, 2019 American Community Survey One-Year Estimates	2019 Renter-occupied housing (percent of households). A null value entry indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates fall in the lowest interval or upper interval of an open-ended distribution, or the margin of error associated with a median was larger than the median itself.
Severe housing problems	2021 County Health Rankings & Roadmaps; Comprehensive Housing Affordability Strategy (CHAS) data, US Department of Housing and Urban Development (HUD)	2013 - 2017 Percentage of households with at least one of four housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
Sexually transmitted infection incidence	2021 County Health Rankings & Roadmaps; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)	2018 Number of newly diagnosed chlamydia cases per 100,000 population
Smoking	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Percentage of the adult population in a county who both report that they currently smoke every day or most days and have smoked at least 100 cigarettes in their lifetime
Suicide: intentional self-harm	Texas Health Data Center for Health Statistics	2019 Intentional self-harm (suicide) (X60 - X84, Y87.0). Death rates are null when the rate is calculated with a numerator of 20 or less.
Teen birth rate	2021 County Health Rankings & Roadmaps; National Center for Health Statistics - Natality files, National Vital Statistics System (NVSS)	2013 - 2019 Number of births to females ages 15 - 19 per 1,000 females in a county (The numerator is the number of births to mothers ages 15 - 19 in a seven-year time frame, and the denominator is the sum of the annual female populations, ages 15 - 19.)
Teens (16 - 19) not in school or work - disconnected youth	2021 County Health Rankings (Measure of America)	2015 - 2019 Disconnected youth are teenagers and young adults between the ages of 16 and 19 who are neither working nor in school. Blank values reflect unreliable or missing data.
Unemployment	2021 County Health Rankings & Roadmaps; Local Area Unemployment Statistics (LAUS), Bureau of Labor Statistics	2019 Percentage of population ages 16 and older unemployed but seeking work

Appendix C: community input participating organizations

Representatives from the following organizations participated in the focus group and a number of key informant interviews/surveys:

- Baylor Scott & White Health
- Baylor Scott & White Surgical Hospital at Sherman
- Texoma Community Center
- Texoma Health
- Sherman Chamber of Commerce
- Sherman High School
- Sherman Independent School District
- Wells Fargo Advisors

Appendix D: demographic and socioeconomic summary

According to population statistics, the community served is similar to Texas in terms of projected population growth; both outpace the country. However, the median age is older than Texas and the United States. Median income is also lower than both the state and the country. The community served has a lower percentage of Medicaid beneficiaries and uninsured individuals than Texas but a higher percentage of Medicare beneficiaries.

Demographic and socioeconomic comparison: community served and state/US benchmarks

Geography		Benchmarks		Community served
		United States	Texas	Sherman health community
Total current population		330,342,293	29,321,501	139,011
Five-year projected population change		3.3%	6.6%	6.0%
Median age		38.6	35.2	40.3
Population 0 - 17		22.4%	25.7%	23.4%
Population 65+		16.6%	13.2%	18.6%
Women age 15 - 44		19.5%	20.5%	18.3%
Hispanic population		19.0%	40.7%	14.2%
Insurance coverage	Uninsured	9.9%	18.8%	17.9%
	Medicaid	20.9%	13.0%	11.6%
	Private market	8.3%	8.4%	8.6%
	Medicare	13.8%	12.7%	19.3%
	Employer	47.2%	47.1%	42.7%
Median HH income		$65,618	$63,313	$61,067
No high school diploma		12.2%	16.7%	11.6%

Source: IBM Watson Health Demographics, Claritas, 2020, Insurance Coverage Estimates, 2020.

The community served expects to grow 6% by 2025, an increase of 8,325 people. The projected population growth is higher than the state's five-year projected growth rate (6.6%) and higher than the national projected growth rate (3.3%). The ZIP codes expected to experience the most growth in five years are:

- 75092 Sherman - 1,640 additional people
- 75090 Sherman – 1,213 additional people
- 75020 Denison – 1,026 additional people

The community's population is younger with 44.5% of the population ages 18 - 54 and 23.4% under age 18. The age 65-plus cohort is expected to experience the fastest growth (18.5%) over the next five years. Growth in the senior population will likely contribute to increased utilization of services as the population continues to age.

Population statistics are analyzed by race and by Hispanic ethnicity. The community was primarily white non-Hispanic, but diversity in the community will increase due to the projected growth of minority populations over the next five years. The expected growth rate of the Hispanic population (all races) is 3,487 people (17.6%) by 2025. The non-Hispanic white population is expected to have the slowest growth at 2.7%.

Population distribution

	Age distribution				
Age group	2020	% of total	2025	% of total	USA 2020 % of total
0 - 14	26,991	19.4%	28,025	19.0%	18.5%
15 - 17	5,570	4.0%	5,975	4.1%	3.9%
18 - 24	12,371	8.9%	13,841	9.4%	9.5%
25 - 34	16,686	12.0%	16,972	11.5%	13.5%
35 - 54	32,740	23.6%	33,417	22.7%	25.2%
55 - 64	18,731	13.5%	18,400	12.5%	12.9%
65+	25,922	18.6%	30,706	20.8%	16.6%
Total	**139,011**	**100.0%**	**147,336**	**100.0%**	**100.0%**

Household Income distribution

	Income distribution		
2020 Household income	HH count	% of total	USA % of total
<$15K	5,672	10.6%	10.0%
$15 - 25K	4,938	9.2%	8.6%
$25 - 50K	12,262	22.8%	20.7%
$50 - 75K	8,732	16.3%	16.7%
$75 - 100K	7,428	13.8%	12.4%
Over $100K	14,652	27.3%	31.5%
Total	**53,684**	**100.0%**	**100.0%**

Education level

	Education level distribution		
2020 Adult education level	Pop age 25+	% of total	USA % of total
Less than high school	3,554	3.8%	5.2%
Some high school	7,386	7.9%	7.0%
High school degree	28,378	30.2%	27.2%
Some college/assoc. degree	36,248	38.5%	28.9%
Bachelor's degree or greater	18,513	19.7%	31.6%
Total	**94,079**	**100.0%**	**100.0%**

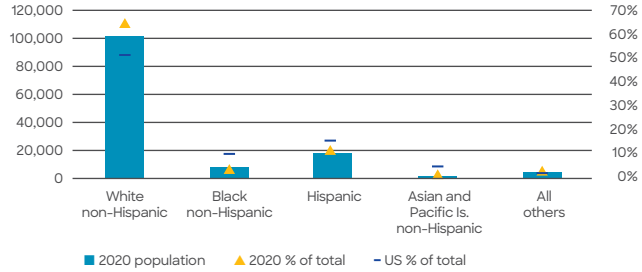
Race/ethnicity

	Race/ethnicity distribution		
Race/ethnicity	2020 pop	% of total	USA % of total
White non-Hispanic	103,620	74.5%	59.3%
Black non-Hispanic	8,111	5.8%	12.4%
Hispanic	19,773	14.2%	19.0%
Asian & Pacific is. non-Hispanic	2,079	1.5%	6.0%
All others	5,428	3.9%	3.3%
Total	**139,011**	**100.0%**	**100.0%**

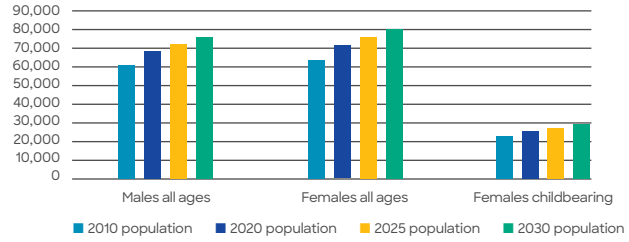
Population estimates		
Population	National	Selected area
2010 total	308,745,538	124,395
2020 total	330,342,293	139,011
2025 total	341,132,738	147,336
2030 total	353,513,931	156,180
% change 2020 - 2025	3.27%	5.99%
% change 2020 - 2035	7.01%	12.35%

Population	Males all ages	Females all ages	Females childbearing
2010 total	60,720	63,675	22,965
2020 total	67,993	71,018	25,375
2025 total	72,080	75,256	26,872
2030 total	76,507	79,673	28,537
10Y %	12.52%	12.19%	12.46%
National	7.02%	7.01%	4.01%

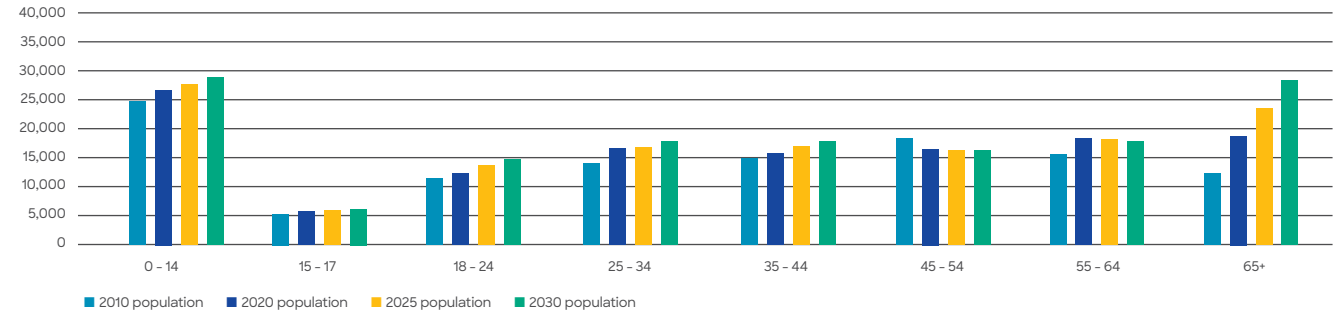
2020 race and ethnicity with total population



Population by sex 2010 - 2030



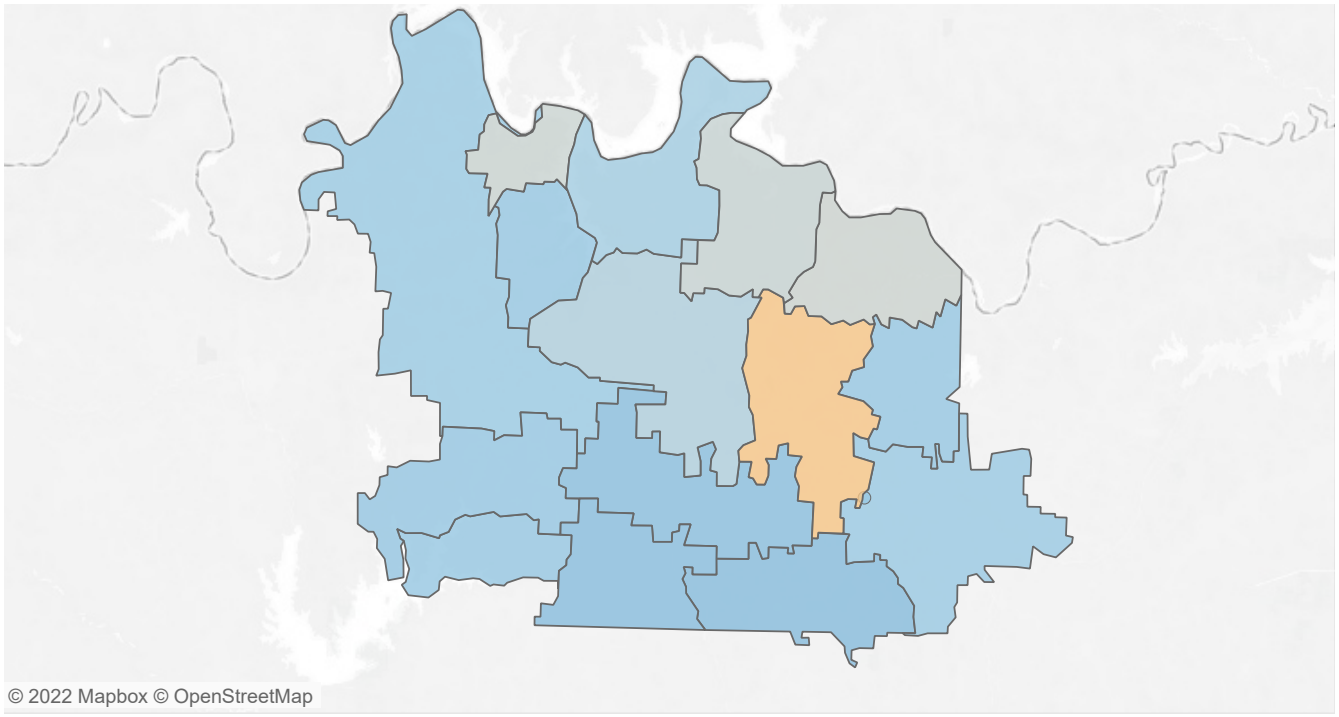
Population by age group 2010 - 2030



Source: IBM Watson Health/Claritas, 2020.

The 2020 median household income for the United States was $65,618 and $63,313 for the state of Texas. The median household income for the ZIP codes within this community ranged from $84,856 for 75495 Van Alstyne to $47,452 for 75090 Sherman. There were no other ZIP codes with median household incomes less than $52,400—twice the 2020 federal poverty limit for a family of four.

The median household income ZIP code map below illustrates ZIP codes that are lower or higher than twice the federal poverty level for a family of four in 2020.



A majority of the population (43%) is insured through employer sponsored health coverage. The remainder of the population is fairly equally divided between Medicaid, Medicare and private market (the purchasers of coverage directly or through the health insurance marketplace).

Federally designated health professional shortage areas and medically underserved areas and populations

Health professional shortage areas (HPSA)				
County	HPSA ID	HPSA name	HPSA discipline class	Designation type
Grayson	7487593472	LI - Grayson County	Mental health	Low-income population HPSA
Grayson	1485849525	LI - Grayson County	Primary care	Low-income population HPSA

Medically underserved areas and populations (MUA/P)				
County	MUA/P source identification number	Service area name	Designation type	Rural status
Grayson	1481877977	LI - Grayson County	Medically underserved population	Partially rural

Community Needs Index

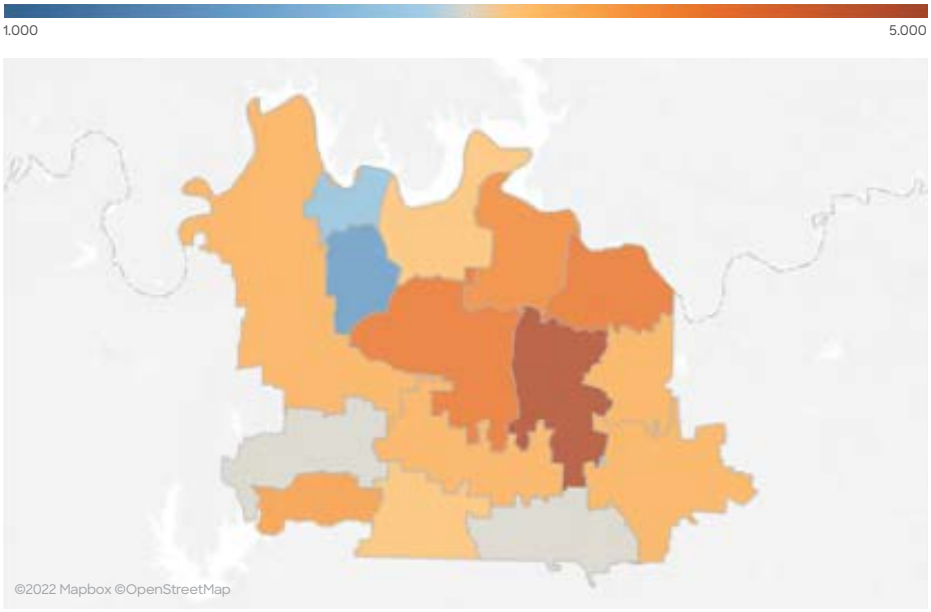
The IBM Watson Health Community Need Index (CNI) is a statistical approach that identifies areas within a community where there are likely gaps in healthcare. The CNI takes into account vital socio-economic factors, including income, culture, education, insurance and housing, about a community to generate a CNI score for every population ZIP code in the US.

The CNI is strongly linked to variations in community healthcare needs and is a good indicator of a community's demand for a range of healthcare services. Not-for-profit and community-based hospitals, for whom community need is central to the mission of service, are often challenged to prioritize and effectively distribute hospital resources. The CNI can be used to help them identify specific initiatives best designed to address the health disparities of a given community.

The CNI score by ZIP code shows specific areas within a community where healthcare needs may be greater.

Sherman Health Community

Composite CNI: high scores indicate high need.



ZIP map where color shows the 2020 Community Need Index on a scale of 1 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).

Composite CNI score
3.79

Texas CNI score
3.85

US composite CNI score
3.00

Barrier	State	US
Income	3.0	3.0
Culture	4.7	3.0
Education	3.5	3.0
Insurance	4.3	3.0
Housing	3.9	3.0

The overall CNI score for the Sherman Health Community was 3.79. The difference in the numbers indicates both a strong link to community healthcare needs and a community's demand for various healthcare services. In portions of the community, the CNI score was greater than 4.5, indicating more significant health needs among the population.

Appendix E: proprietary community data

IBM Watson Health supplemented the publicly available data with estimates of localized inpatient demand discharges, outpatient procedures, emergency department visits, heart disease, as well as cancer incidence estimates.

Social determinants of health are the structural determinants and conditions in which people are born, grow, live, work and age. All of which can greatly impact healthcare utilization and play a major role in the shifting healthcare landscape. Social determinants, such as education, income and race, are factored into Inpatient Demand Estimates and Outpatient Procedure Estimates utilization rate creation methodologies.

Inpatient demand estimates

Inpatient demand estimates provide the total volume of annual acute care admissions by ZIP code and DRG Product Line for every market in the United States. IBM uses all-payor state discharge data for publicly available states and Medicare (MEDPAR) data for the entire US. These rates are applied to demographic projections by ZIP code to estimate inpatient utilization for 2020 through 2030.

The following summary is reflective of the inpatient utilization trends for Sherman Health Community. Total discharges in the community are expected to grow by 3.5% by 2030, with pulmonary medical projecting the largest growth.

Product line	2020 discharges	2025 discharges	2030 discharges	2020 - 2025 discharges change	2020 - 2025 discharges % change	2020 - 2030 discharges change	2020 - 2030 discharges % change
Alcohol and Drug Abuse	168	167	178	(2)	-0.9%	10	5.7%
Cardio-Vasc-Thor Surgery	783	775	755	(8)	-1.1%	(29)	-3.7%
Cardiovascular Diseases	1,934	1,916	2,049	(18)	-0.9%	116	6.0%
ENT	96	84	75	(12)	-12.8%	(21)	-21.6%
General Medicine	4,140	4,109	4,184	(31)	-0.7%	44	1.1%
General Surgery	1,388	1,341	1,342	(47)	-3.4%	(46)	-3.3%
Gynecology	58	30	18	(29)	-49.2%	(40)	-68.8%
Nephrology/Urology	1,167	1,184	1,220	17	1.4%	53	4.6%
Neuro Sciences	1,139	1,092	1,152	(47)	-4.1%	13	1.2%
Obstetrics Del	1,382	1,300	1,294	(81)	-5.9%	(88)	-6.3%
Obstetrics ND	114	101	97	(13)	-11.3%	(17)	-15.0%
Oncology	318	314	315	(5)	-1.4%	(4)	-1.1%
Ophthalmology	15	14	13	(1)	-6.2%	(2)	-11.1%
Orthopedics	1,711	1,685	1,722	(26)	-1.5%	10	0.6%
Psychiatry	854	897	949	43	5.1%	95	11.1%
Pulmonary Medical	2,217	2,482	2,731	265	11.9%	514	23.2%
Rehabilitation	7	7	7	0	3.1%	1	10.4%
TOTAL	**17,491**	**17,497**	**18,101**	**6**	**0.0%**	**610**	**3.5%**

Source: IBM Watson Health Inpatient Demand Estimates, 2020.

Outpatient procedures estimates

Outpatient procedure estimates predict the total annual volume of procedures performed by ZIP code for every market in the United States using proprietary and public health claims, as well as federal surveys. Procedures are defined and reported by procedure codes and are further grouped into clinical service lines. The Sherman Health Community outpatient procedures are expected to increase by almost 27% by 2030 with the largest growth in the categories of labs, general & internal medicine and physical & occupational therapy.

Clinical service category	2020 procedures	2025 procedures	2020-2025 procedures % change	2030 procedures	2020 - 2030 procedures % change
Allergy & Immunology	19,973	21,054	5.4%	22,190	11.1%
Anesthesia	12,491	14,747	18.1%	16,673	33.5%
Cardiology	103,366	125,662	21.6%	153,633	48.6%
Cardiothoracic	137	159	15.7%	179	30.3%
Chiropractic	64,867	62,739	-3.3%	58,518	-9.8%
Colorectal Surgery	905	949	4.8%	997	10.1%
CT Scan	33,581	43,679	30.1%	56,419	68.0%
Dermatology	29,393	34,003	15.7%	38,749	31.8%
Diagnostic Radiology	154,457	164,547	6.5%	174,592	13.0%
Emergency Medicine	75,364	81,723	8.4%	88,750	17.8%
Gastroenterology	11,381	12,398	8.9%	13,420	17.9%
General & Internal Medicine	1,208,410	1,360,424	12.6%	1,494,073	23.6%
General Surgery	7,902	8,558	8.3%	9,275	17.4%
Hematology & Oncology	275,056	306,322	11.4%	335,029	21.8%
Labs	1,227,416	1,360,174	10.8%	1,499,052	22.1%
Miscellaneous	55,365	61,094	10.3%	66,723	20.5%
MRI	12,995	14,230	9.5%	15,548	19.6%
Nephrology	27,588	31,207	13.1%	34,911	26.5%
Neurology	14,408	16,225	12.6%	17,973	24.7%
Neurosurgery	829	1,101	32.9%	1,250	50.8%
Obstetrics/Gynecology	22,540	24,077	6.8%	25,914	15.0%
Ophthalmology	71,477	84,666	18.5%	97,605	36.6%
Oral Surgery	817	892	9.2%	983	20.3%
Orthopedics	22,368	24,279	8.5%	26,150	16.9%
Otolaryngology	30,919	35,473	14.7%	39,875	29.0%
Pain Management	11,091	11,506	3.7%	11,388	2.7%
Pathology	37	43	17.1%	50	34.5%
PET Scan	1,268	1,440	13.6%	1,601	26.3%
Physical & Occupational Therapy	330,664	409,875	24.0%	496,323	50.1%
Plastic Surgery	1,136	1,244	9.5%	1,371	20.7%
Podiatry	7,882	8,341	5.8%	8,757	11.1%
Psychiatry	99,726	138,610	39.0%	182,969	83.5%
Pulmonary	32,893	35,392	7.6%	37,973	15.4%
Radiation Therapy	14,311	15,412	7.7%	16,456	15.0%
Single Photon Emission CT Scan (SPECT)	3,951	4,257	7.8%	4,622	17.0%
Urology	9,758	10,996	12.7%	12,219	25.2%
Vascular Surgery	4,040	4,545	12.5%	5,023	24.3%
TOTAL	**4,000,761**	**4,532,041**	**13.3%**	**5,067,232**	**26.7%**

Source: IBM Watson Health Outpatient Procedure Estimates, 2020.

Emergency department visits

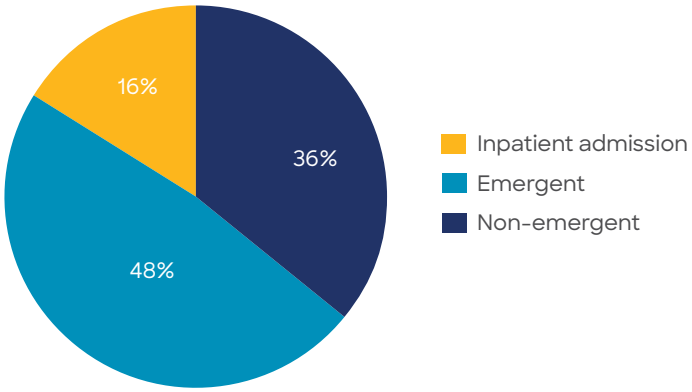
Emergency department estimates predict the total annual volume of emergency department (ED) visits by ZIP code and level of acuity for every market in the United States. IBM uses an extensive supply of proprietary claims, public claims and federal surveys to construct population-based use rates for all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

Visits are broken out into emergent and non-emergent ambulatory visits to identify the volume of visits that could be seen in a less-acute setting, for example, a fast-track ED or an urgent care facility. In addition, visits that result in an inpatient admission are broken out into a third, separate category. In the Sherman Health Community, ED visits are expected to grow by 9.5% by 2025.

Emergent status	2020 visits	2025 visits	2020 - 2025 visits change	2020 - 2025 visits % change
Emergent	37,302	42,103	4,802	12.9%
Inpatient Admission	12,651	14,517	1,866	14.8%
Non-Emergent	30,292	31,253	962	3.2%
TOTAL	**80,244**	**87,873**	**7,629**	**9.5%**

Source: IBM Watson Health Emergency Department Visits, 2020.

Emergency department visit estimates 2025



Heart disease estimates

The heart disease estimates dataset predicts the number of cases by heart disease type and ZIP code for every market in the United States. IBM uses public and private claims data as well as epidemiological data from the National Health and Nutritional Examination Survey (NHANES) to build local estimates of heart disease prevalence for the current population. County-level models by age and sex are applied to the underlying demographics of specific geographies to estimate the number of patients with specific types of heart disease.

In Sherman Health Community, the most common heart disease is hypertension at 65% of all heart disease cases.

Disease type	2020 prevalence	2020 % prevalence
Arrhythmia	9,563	15.0%
Heart Failure	4,441	7.0%
Hypertension	41,309	65.0%
Ischemic Heart Disease	8,259	13.0%
TOTAL	**63,572**	**100.0%**

Source: IBM Watson Heart Disease Estimates, 2020.

Cancer estimates

IBM Watson Health builds county-level cancer incidence models that are applied to the underlying demographics of specific geographies to estimate incidence (i.e., the number of new cancer cases annually) of all cancer patients. Cancer incidence is expected to increase by 5.1% in the Sherman Health Community by 2025.

Cancer type	2020 incidence	2025 incidence	2020 - 2025 change	2020 - 2025 % change
Bladder	51	57	7	13.6%
Brain	15	16	1	8.5%
Breast	153	167	14	9.3%
Colorectal	117	99	-18	-15.2%
Kidney	39	44	5	13.7%
Leukemia	37	42	5	12.5%
Lung	132	141	10	7.3%
Melanoma	56	65	9	16.6%
Non-Hodgkin's Lymphoma	43	49	5	12.1%
Oral Cavity	32	36	4	11.7%
Other	107	120	13	12.2%
Ovarian	13	14	1	5.2%
Pancreatic	29	34	5	15.4%
Prostate	148	134	-14	-9.2%
Stomach	14	15	1	4.7%
Thyroid	25	28	3	11.8%
Uterine Cervical	5	5	0	0.8%
Uterine Corpus	24	27	3	10.7%
TOTAL	**1,039**	**1,092**	**53**	**5.1%**

Source: IBM Watson Health Cancer Estimates, 2020.

Appendix F: 2019 community health needs assessment evaluation

It is Baylor Scott & White Health's privilege to serve faithfully in promoting the well-being of all individuals, families and communities. Our 2019 Implementation Strategy described the various resources and initiatives we planned to direct toward addressing the adopted health needs of the 2019 CHNA.

Following is a snapshot of the impact of actions taken by Baylor Scott & White to address the below priority health issues.

Dates: Fiscal Years 2020 - March 2022

Facility: Baylor Scott & White Surgical Hospital at Sherman

Community served: Grayson County

Healthcare costs (price-adjusted Medicare reimbursements - parts A&B per enrollee)

Action/tactics	Anticipated outcome	Evaluation of impact
Charity care Discounted care as outlined in the BSWH financial assistance policy. The hospital will provide the level of financial assistance consistent with certain state requirements applicable to non-profit hospitals.	Increased access to primary care and/or specialty care for indigent persons regardless of their ability to pay.	• **Persons served: unknown** • **$73,186 community benefit**

Total investment in adopted community needs since 2019 CHNA

BSW Surgical Hospital at Sherman

$73,000