Community Health Needs Assessment

Waco – McLennan Health Community

2022

Waco - McLennan health community hospitals

- **Baylor Scott & White Medical Center - Hillcrest**

Hillcrest Baptist Medical Center Board of Directors on May 6, 2022
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BaylorScott&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.

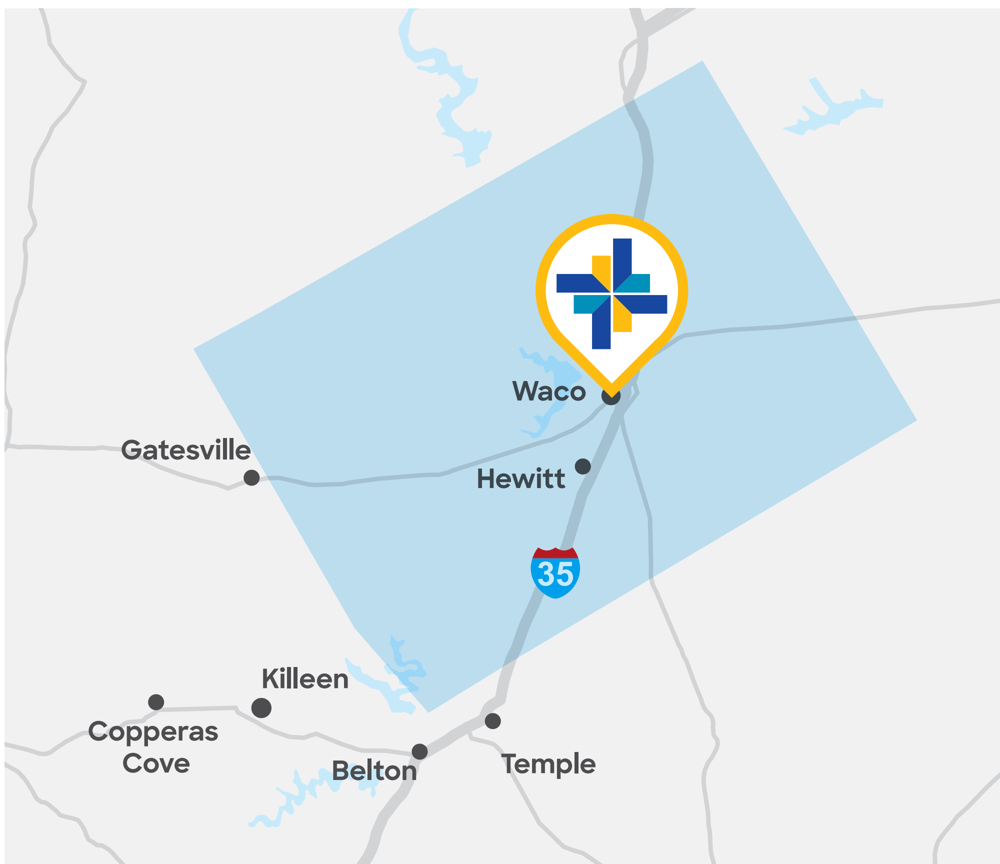
Community Health Needs Assessment (CHNA) report

The Waco – McLennan Health Community is home to one of these hospitals:

- Baylor Scott & White Medical Center – Hillcrest

The community served by the hospital listed above is McLennan County. BSWH has at least one hospital facility or a provider-based clinic in the county, and it comprises where more than 70% of the admitted patients live according to the hospital facility's 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.

Waco - McLennan 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 Waco - McLennan Health Community CHNA are:

- The community population growth outpaces the rate of growth of the US but is not as fast as the state of Texas.
- The median age of the population is younger than the US and Texas overall.
- The median household income is below both the state and the US.
- The community served has a higher % of uninsured people on average than Texas and the US.

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

Health community data summary

IBM Watson Health's utilization estimates and forecasts indicate the following for the Waco – McLennan Health Community:

- Inpatient discharges in the community are expected to grow by 0.5% by 2030 with the largest growing product lines to include:
  - Pulmonary Medical
  - Cardiovascular Diseases
  - General Medicine
- Outpatient procedures are expected to increase by over 28% by 2030 with the largest areas of growth including:
  - Labs
  - General and Internal Medicine
  - Physical & Occupational Therapy
  - Hematology and Oncology
  - Psychiatry
- Emergency Department visits are expected to grow by almost 11% by 2025.
- Hypertension represents 71% of all heart disease cases.
- Cancer incidence is expected to increase by over 5% by 2025.

Further health community information for the Waco – McLennan 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
McLennan	1	2	2	5	1

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

Total population

262,721

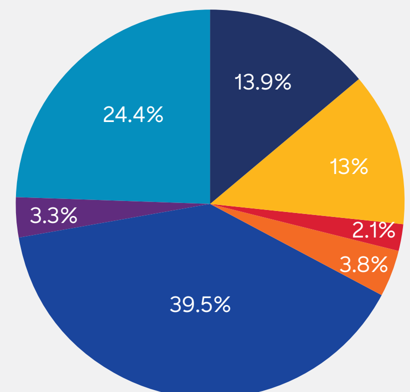
Average income

$55,959

Underserved ZIP codes

8

Insurance coverage



- Medicaid – pre-reform
- Medicare
- Medicare dual eligible
- Private – direct
- Private – ESI
- Private – exchange
- Uninsured

Priority health needs

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

Priority	Need	Category of need
1	Food insecurity/limited access to healthy foods	Environment
2	Access to healthcare/resources	Access to care
3	Infant mortality rate	Injury and death
4	Access to mental healthcare (providers/resources)	Mental health
5	Household income/poverty	Population and income
6	Diabetes	Conditions/diseases
7	Obesity	Conditions/diseases
8	Language barriers	Population and income

Priority 1: Food Insecurity/Limited Access to Healthy Foods

Category	Data shows greater need	Key informants indicate greater need
Environment	• Food insecure • Food environment index • Limited access to healthy foods	• Food insecurity • Lack of healthy food options/ lack of fresh foods

The **food insecure measure** is defined as **the percentage of population who lack adequate access to food during the past year.** The indicator is based on data from County Health Rankings & Roadmaps, Map the Meal Gap, Feeding America.

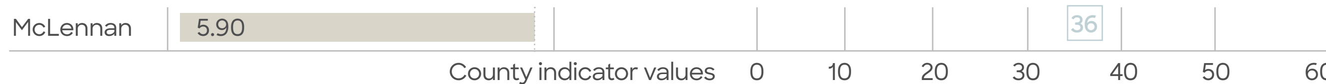
Environment: food insecure (% who lack adequate access to food in county)

Greater or lesser need than state
- ◇ greater need
- ☐ same level of need or NA
- ○ lesser need

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 **food environment index measure** is defined as measure is defined as **index of factors that contribute to a healthy food environment.** A value of zero "0" is worst and a value of ten "10" is best in the county. The indicator is based on data from County Health Rankings & Roadmaps, USDA Food Environment Atlas, Map the Meal Gap from Feeding America, United States Department of Agriculture (USDA).

Environment: food environment index (index of factors that contribute to a healthy food environment in county, 0 = worst and 10 = best)



Greater or lesser need than state
- ◇ greater need
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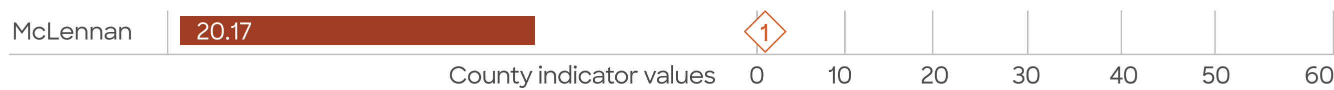
The indicator **limited access to healthy foods** is defined as **the percentage of population who are low-income and do not live close to a grocery store.** The indicator is based on data from County Health Rankings & Roadmaps; USDA Food Environment Atlas, United States Department of Agriculture (USDA).

Environment: limited access to healthy foods



County indicator values 0 10 20 30 40 50 60

Greater or lesser need than state
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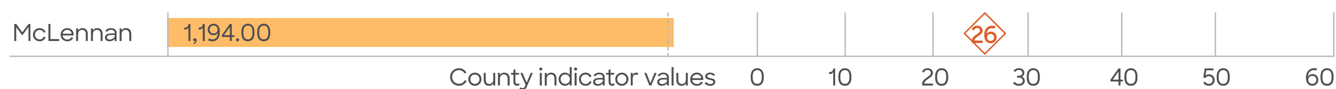
In addition, the focus group participants highlighted food insecurity challenges. They noted that there is a lack of healthy food options/lack of fresh foods in the community. They also recognized that transportation is a challenge to get food to people since they can't take it on the bus.

In the prioritization session, the hospital and community leaders agreed that there is a large number of food deserts in the community. There is also a lack of healthy and affordable food options for members of the community. They cited higher food costs in rural communities, which is unfortunate as those rural residents lack easy access to bigger markets in the city. They recognized that when healthy food is inaccessible due to cost or availability, it greatly impacts patients with chronic medical conditions, thus increasing hospital admissions. The group concluded that education is also needed to teach individuals and families how to prepare affordable, healthy meals.

Priority 2: Access to Healthcare/Resources

Category	Data shows greater need	Key informants indicate greater need
Access to care	• Population to one non-physician primary care provider	• Limited access to healthcare and resources in general

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



Greater or lesser need than state
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- lesser need

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The focus group participants stated the community has limited healthcare services. They further stated that access is cut by insufficient accessible hours of service for working residents who are unable to leave work to seek care.

In the prioritization session, even though the hospital leadership group was surprised to learn that access to care was a significant need for the community, they knew that the issue existed. They agreed that the barriers to access care included affordability, lack of education about the available resources, transportation issues, limited providers accepting new patients and difficulty obtaining appointments.

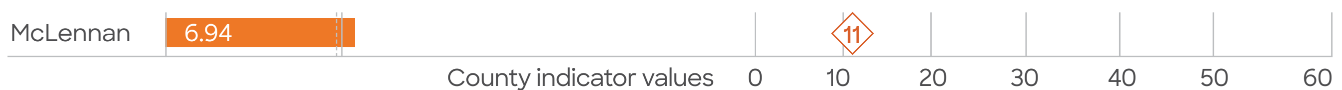
Priority 3: Infant Mortality Rate

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 and death	• Mortality rate: infant	• 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 and death: mortality rate: infant (number of all infant deaths per 1,000 live births by county)



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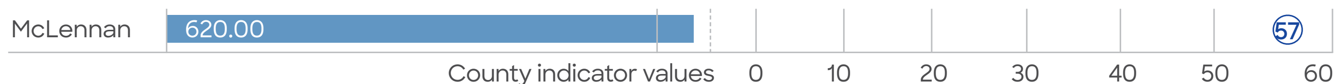
In the prioritization session, hospital leadership discussed the prenatal and maternal health data that was shared. The group identified that there are underlying systemic issues experienced by Hispanics and African Americans that impact prenatal care, infant mortality and low birth weight.

Priority 4: Access to Mental Healthcare (Providers/Resources)

Although the data did not indicate greater need for access for the population to one mental healthcare provider, key informants indicated there is a need. The indicator is defined as **the ratio of population to mental health providers** and is based on data from County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES).

Category	Data shows less need or no data	Key informants indicate greater need
Mental health	• Population to one mental health provider	• Limited mental health providers

Access to care: population to one mental health provider (ratio of population to mental health providers by county)



Greater or lesser need than state
greater need
same level of need or NA
lesser need

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The focus group participants stated the community has limited mental healthcare services. They noted that mental health and substance abuse/addictions are problems, and treatment is difficult to obtain. They cited that the state has 40% vacancies for mental health providers, and the majority of patients end up in the emergency room. They also noted that adolescent mental health has grown significantly with high suicide rates, but there are no adolescent psychiatrists in town.

In the prioritization session, the hospital leadership group shared that there is a substantial increase in mental health issues over recent years, and it has been compounded by the pandemic. They concurred that the emergency department is seeing a high volume of patients presenting with mental health issues. They agreed that there is a lack of access to mental health providers because most providers require a funding source to access those services.

They also confirmed that although efforts are made in schools, mental health issues are increasing in the adolescent population. A recent survey of school counselors showed that the need is acutely increasing. Another group lacking mental health services is the perinatal population. The group also mentioned that providers are not always representative of the community. There is a need for Spanish-speaking individuals, African Americans, and those with other racial and ethnic backgrounds to serve the diverse Waco population.

Priority 5: Household Income/Poverty

The following data indicates greater need in the community in the issue of household income, income inequality and individuals below poverty level.

Category	Data shows greater need	Key informants indicate greater need
Population and income	• Population and income • Income inequality • Individuals below poverty level	• Two extremes with the population–poor and wealthy

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

Financial/income: household income (median household income in county)

Greater or lesser need than state
- ◇ greater need
- ☐ same level of need or NA
- ○ lesser need

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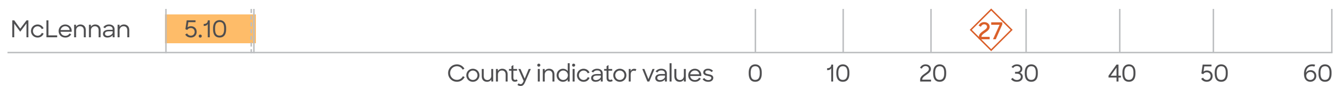
The **income inequality** measure is defined as **the ratio of household income at the 80th percentile to income at the 20th percentile.** Absolute equality is when the measure is equal to 1.0. A higher ratio indicates greater inequality. The indicator is based on data from County Health Rankings & Roadmaps, American Community Survey (ACS), Five-Year Estimates (United States Census Bureau).

Financial/income: income inequality (ratio of household income at the 80th percentile to income at the 20th percentile in county)



Greater or lesser need than state
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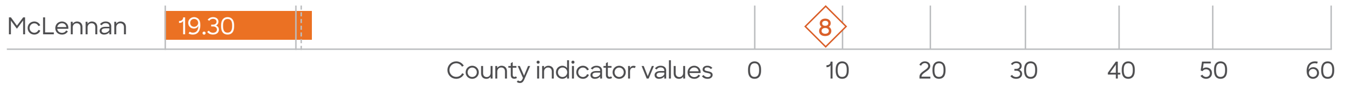
The **individuals below poverty level** measure is defined as **individuals below poverty level.** The indicator is based on data from American Community Survey Five-Year Estimates, US Census Bureau - American FactFinder.

Financial/income: individuals below poverty level (individuals below poverty level in county)



Greater or lesser need than state
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The focus group participants noted that there are two extremes within the community—poor and wealthy. The poorer residents can't afford to pay their rent.

In the prioritization session, the hospital and community leaders noted that members of the community experience income inequality and, therefore, are more inclined to have issues accessing healthy food and mental health services and experience language barriers.

Priority 6: Diabetes

The following data indicates greater need to address diabetes admission and diabetes prevalence.

Category	Data shows greater need	Key informants indicate less need or not mentioned
Conditions/ diseases	• Diabetes admission • Diabetes prevalence	• Not specifically mentioned

The data below indicates greater need for **diabetes admission**. The indicator is defined as **the number observed/adult population age 18 and older.** Note that risk-adjusted rates are not calculated for counties with fewer than five admissions. The indicator is based on data from Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations.

Conditions/diseases: diabetes admission (number observed/adult population in county)

The data below indicates greater need for **diabetes prevalence**. The indicator is defined as **prevalence of diagnosed diabetes in a given county.** Note that 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. The indicator is based on data from County Health Rankings (CDC Diabetes Interactive Atlas).

Conditions/diseases: diabetes prevalence (prevalence as % of diagnosed diabetes in county)

Greater or lesser need than state
- greater need
- same level of need or NA
- lesser need

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In the prioritization session, hospital leadership agreed that diabetes is a top health concern for the Hispanic population. Diabetes is the top diagnosis and medication need for the indigent populations. Diabetes readmission rate is a top five indicator for the health community.

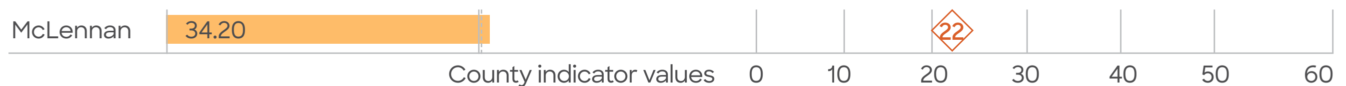
Priority 7: Obesity

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

Category	Data shows greater need	Key informants indicate less need or not mentioned
Conditions/ diseases	• Adult obesity	• Not specifically mentioned

The indicator is defined as **percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2** and is based on data from County Health Rankings & Roadmaps, CDC Diabetes Interactive Atlas and The National Diabetes Surveillance System.

Conditions/diseases: adult obesity (% of adults with BMI =>30 by county)



County indicator values 0 10 20 30 40 50 60

Greater or lesser need than state
- greater need
- same level of need or NA
- lesser need

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In the prioritization session, hospital leadership agreed that obesity is also a top health concern for the Hispanic population.

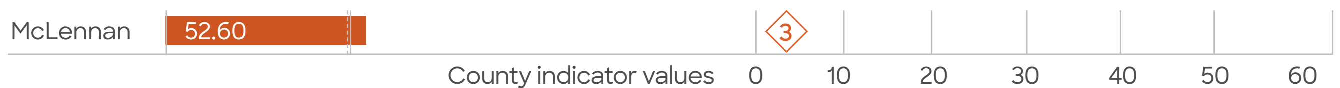
Priority 8: Language Barriers

The data below indicates greater need in the case of the indicator **language: English spoken "less than very well"** in household.

Category	Data shows greater need	Key informants indicate greater need
Population and income	• English spoken "less than very well" in household	• Language barriers

The indicator is defined as **"percentage of households that speak English 'less than very well' within all households that speak a language other than English."** The indicator is based on data from American Community Survey Five-Year Estimates, US Census Bureau - American FactFinder.

Language/social: English spoken "less than very well" in household (% of households speaking less than very well English by county)



Greater or lesser need than state
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- same level of need or NA
- lesser need

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The focus group participants stated that there are language barriers in the community. The barriers include those community members who are Spanish-speaking as well as those that speak other languages besides Spanish.

In the prioritization session, hospital leadership mentioned that language is a barrier for non-English speaking patients. It is difficult for the community to fully understand the directives from physicians when they don't understand the language used.

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 hospital's 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.

Waco – McLennan community resources

Need	Organization	Address	Phone
Food insecurity/ access to healthy food	Salvation Army of Waco Food Pantry	4721 W. Waco Drive Waco, TX 76710	254.756.7271
	Hands of Mercy Food Pantry – First Spanish Assembly of God	3301 Clay Avenue Waco, TX 76711	254.752.2293
	Antioch Community Church Pantry	505 N. 20th Street Waco, TX 76707	254.754.0386
	Mt. Lebanon Seventh Day Adventist Food Pantry	4298 Meyers Lane Waco, TX 76705	254.799.2979
	First Baptist Church Waco – Gospel Café	825 S. 10th Street Waco, TX 76706	254.753.5916
Access to primary healthcare	Clínica Hispana	3833 Franklin Avenue Waco, TX 76710	254.298.8926
	Waco Family Medicine	2201 MacArthur Drive Waco, TX 76708	254.313.4610
	Meyer Center Community Health Clinic	1226 Washington Avenue Waco, TX 76701	254.714.1579
	Austin Avenue Clinic	110 S. 12th Street Waco, TX 76701	254.313.4200
	(VHA) – Central Texas Veterans Health Care System – Doris Miller Medical Center	4800 Memorial Drive Waco, TX 76711	254.752.6581
Infant mortality rate	City of Waco Public Health Department – WIC	225 W. Waco Drive Waco, TX 76707	254.750.5474
	Waco Family Medicine (prenatal care, maternity care, reproductive health)	2201 MacArthur Drive Waco, TX 76708	254.313.4610
	Meyer Center Community Health Clinic	1226 Washington Avenue Waco, TX 76701	254.714.1579
	AVANCE-Waco – Parent-Child Education Program	3005 Edna Avenue Waco, TX 76708	254.296.0449
	Texas HHSC – STAR Medicaid Managed Care	612 Austin Avenue Waco, TX 76701	254.752.4839

Need	Organization	Address	Phone
Access to mental healthcare (providers/ resources)	Mission Waco Health Clinic (psychiatry services)	1226 Washington Avenue Waco, TX 76701	254.296.9866 ext. 206
	Family Abuse Center	PO Box 20395 Waco, TX 76702	254.772.8999
	A Children At Heart Ministries - STARRY Counseling	3001 W. Waco Drive Waco, TX 76707	254.399.6552
	The Grace Alliance - Living Grace Groups	201 Old Hewitt Road Waco, TX 76712	254.235.0616
	Leslie Hunt, LPC, LCDC	5006 Lakeland Circle Waco, TX 76710	214.616.3771
Household income/ poverty	Caritas of Waco (case management)	300 S. 15th Street Waco, TX 76701	254.753.4593 ext.227
	Economic Opportunities Advancement Association	500 Franklin Avenue Waco, TX 76701	254.756.0954
	Texas HHSC	612 Austin Avenue Waco, TX 76701	254.752.4839
	Public Health Department WIC	225 W. Waco Drive Waco, TX 7670	254.750.5474
	Esther's Closet - Cen-Tex African American Chamber of Commerce	1020 Elm Avenue Waco, TX 76704	254.235.3204
Diabetes	VHA - Weight Management Program	4800 Memorial Drive Waco, TX 76711	254.752.6581
	Agape Meal Program	500 Webster Avenue Waco, TX 76706	254.752.3000
	Just as I am Ministries Inc. (meals)	1415 Chapel Hill Drive Waco, TX 76712	254.666.4051
	Waco Family Medicine	2201 MacArthur Drive Waco, TX 76708	254.313.4610
	Meyer Center Community Clinic	1226 Washington Avenue Waco, TX 76701	254.714.1579

Need	Organization	Address	Phone
Obesity	VHA – Weight Management Program	4800 Memorial Drive Waco, TX 76711	254.752.6581
	City of Waco Public Health Department WIC	225 W. Waco Drive Waco, TX 76707	254.750.5474
	Meyer Center Community Clinic	1226 Washington Avenue Waco, TX 76701	254.714.1579
	Waco Family Medicine	2201 MacArthur Drive Waco, TX 76708	254.313-4610
	Agape Meal Program (healthy meals)	500 Webster Avenue Waco, TX 76706	254.752.3000
Language barriers	Clínica Hispana	3833 Franklin Avenue Waco, TX 76710	254.298.8926
	VHA Medical Center (supports Spanish-speaking patients)	4800 Memorial Drive Waco, TX 76711	254.752.6581
	City of Waco Public Health Department WIC (Spanish)	225 W. Waco Drive Waco, TX 76707	254.750.5474
	Texas HHSC (Spanish)	612 Austin Avenue Waco, TX 76701	254.752.4839
	SSA Office (American Sign Language, Arabic, Chinese, English, French, Greek, Interpretation Services Available, Italian, Korean, Polish, Portuguese, Russian, Spanish, Vietnamese)	1700 Lake Air Drive Waco, TX 76710	866.964.6304

There are many other community resources and facilities serving the Waco – McLennan 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 its 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:

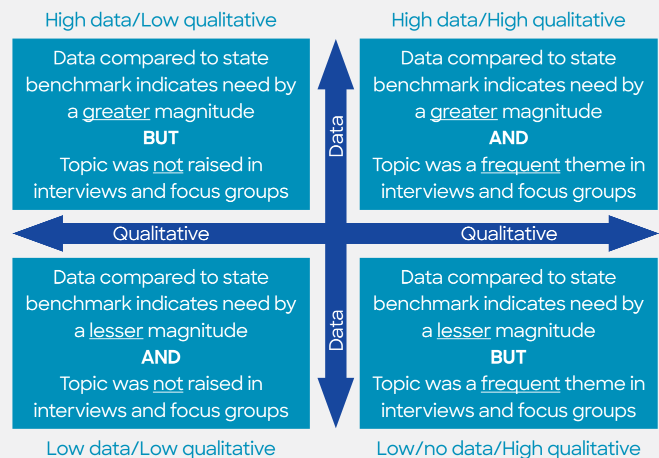
- Assembled a focus group representing the broad interests of the community served;
- Conducted interviews and surveys with key informants—leaders and representatives who serve the community and have insight into its needs; and
- Held prioritization sessions with hospital clinical leadership and community 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**.

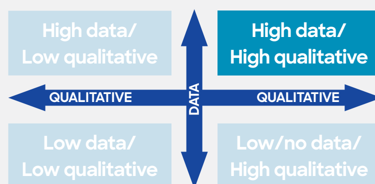
Approach to prioritizing significant health needs



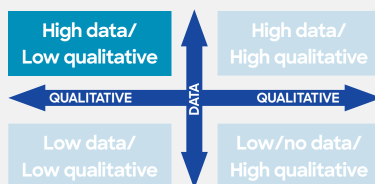
High data = Indicators worse than state benchmark by greater magnitude
High qualitative = Frequency of topic in interviews and focus groups

On January 13, 2022, a session was conducted with key leadership members from Baylor Scott & White Medical Center – Hillcrest 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.

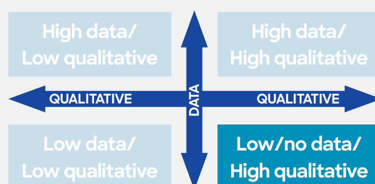
In the first step, participants reviewed the top health needs for their community using associated data-driven criteria. The criteria included health indicator value(s) for the community and how the indicator compared to the state benchmark.



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:

- **Root cause:** Is the issue a root cause of other problems—thereby possibly affecting multiple issues?
- **Social justice:** Severity: Is the problem more concentrated to a specific vulnerable population? Does addressing this issue lead to unfair social benefit? Are we equitable to all vulnerable populations in our approach?
- **Feasibility/cost:** Is the problem amenable to interventions? What technology, knowledge or resources are necessary to effect a change? Is the problem preventable? Is it too expensive for the community to tackle?

The group rated each of the 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	Food insecurity/limited access to healthy foods	Environment
2	Access to healthcare/resources	Access to care
3	Infant mortality rate	Injury and death
4	Access to mental healthcare (providers/resources)	Mental health
5	Household income/poverty	Population and income
6	Diabetes	Conditions/diseases
7	Obesity	Conditions/diseases
8	Language barriers	Population and income

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 Collaborative
- Baylor Scott & White – Hillcrest
- Baylor Scott & White – Hillcrest Nurse-Family Partnership
- Baylor Scott & White Health
- Caritas of Waco
- Compassion
- Family Abuse Center
- Heart of Texas Area Agency on Aging (HOTAAA)
- Heart of Texas Regional Advisory Council (HOTRAC)
- Jesus Said Love
- La Vega Independent School District
- Meals on Wheels
- Prosper Waco
- Waco Family Medicine
- Waco Independent School District
- Waco Police Department
- Waco-McLennan County Public Health District

Appendix D: demographic and socioeconomic summary

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

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

Geography		Benchmarks		Community served
		United States	Texas	Waco – McLennan health community
Total current population		330,342,293	29,321,501	262,721
Five-year projected population change		3.3%	6.6%	5.6%
Median age		38.6	35.2	34.4
Population 0 – 17		22.4%	25.7%	24.8%
Population 65+		16.6%	13.2%	15.0%
Women age 15 – 44		19.5%	20.5%	21.4%
Hispanic population		19.0%	40.7%	27.9%
Insurance coverage	Uninsured	9.9%	18.8%	24.4%
	Medicaid	20.9%	13.0%	13.9%
	Private market	8.3%	8.4%	7.1%
	Medicare	13.8%	12.7%	15.1%
	Employer	47.2%	47.1%	39.5%
Median HH income		$65,618	$63,313	$55,959
No high school diploma		12.2%	16.7%	16.3%

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

The community served expects to grow 5.6% by 2025, an increase of more than 14,700 people. The projected population growth is lower than the state's five-year projected growth rate (6.6%) but higher compared to the national projected growth rate (3.3%).

The community's population is younger with 51% of the population ages 18 - 34 and 24.7% under age 18. The age 65-plus cohort is expected to experience the fastest growth (15%) over the next five years. Growth in the senior population will likely contribute to increased utilization of services as the population continues to age.

Population statistics are analyzed by race and by Hispanic ethnicity. The community is primarily white and 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 14% by 2025. The non-Hispanic white and black populations are expected to have the slowest growth (1.1% and 3.4%).

Population distribution

	Age distribution				
Age group	2020	% of total	2025	% of total	USA 2020 % of total
0 - 14	53,907	20.5%	56,820	20.5%	18.47%
15 - 17	11,240	4.3%	11,623	4.2%	3.88%
18 - 24	35,056	13.3%	32,990	11.9%	9.5%
25 - 34	35,706	13.6%	40,083	14.4%	13.5%
35 - 54	58,369	22.2%	62,021	22.4%	25.2%
55 - 64	29,123	11.1%	28,675	10.3%	12.9%
65+	39,320	15.0%	45,209	16.3%	16.6%
Total	**262,721**	**100.0%**	**277,421**	**100.0%**	**100.0%**

Household Income distribution

	Income distribution		
2020 Household income	HH count	% of total	USA % of total
<$15K	12,609	12.9%	10.0%
$15 - 25K	9,560	9.8%	8.6%
$25 - 50K	24,560	25.1%	20.7%
$50 - 75K	15,789	16.2%	16.7%
$75 - 100K	10,904	11.2%	12.4%
Over $100K	24,334	24.9%	31.5%
Total	**97,756**	**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	10,998	6.77%	5.21%
Some high school	15,523	9.55%	7.04%
High school degree	43,865	27.0%	27.2%
Some college/assoc. degree	53,704	33.0%	28.9%
Bachelor's degree or greater	38,428	23.6%	31.6%
Total	**162,518**	**100.0%**	**100.0%**

Race/ethnicity

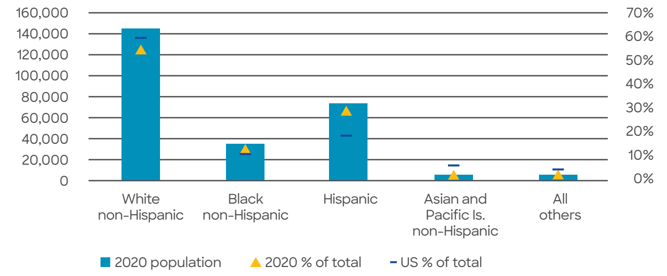
	Race/ethnicity distribution		
Race/ethnicity	2020 pop	% of total	USA % of total
White non-Hispanic	143,397	54.6%	59.3%
Black non-Hispanic	36,148	13.8%	12.4%
Hispanic	73,228	27.9%	19.0%
Asian & Pacific is. non-Hispanic	4,382	1.7%	6.0%
All others	5,566	2.1%	3.3%
Total	**262,721**	**100.0%**	**100.0%**

Source: IBM Watson Health/Claritas, 2020.

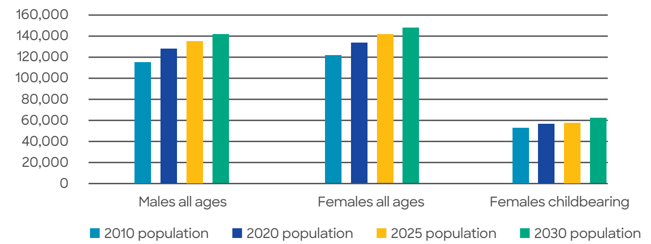
Population estimates		
Population	National	Selected area
2010 total	308,745,538	238,370
2020 total	330,342,293	262,721
2025 total	341,132,738	277,421
2030 total	353,513,931	292,861
% change 2020 - 2025	3.27%	5.60%
% change 2020 - 2035	7.01%	11.47%

Population	Males all ages	Females all ages	Females childbearing
2010 total	115,924	122,446	52,018
2020 total	128,304	134,417	56,340
2025 total	135,618	141,803	58,839
2030 total	143,239	149,622	61,959
10Y %	11.64%	11.31%	9.97%
National	7.02%	7.01%	4.01%

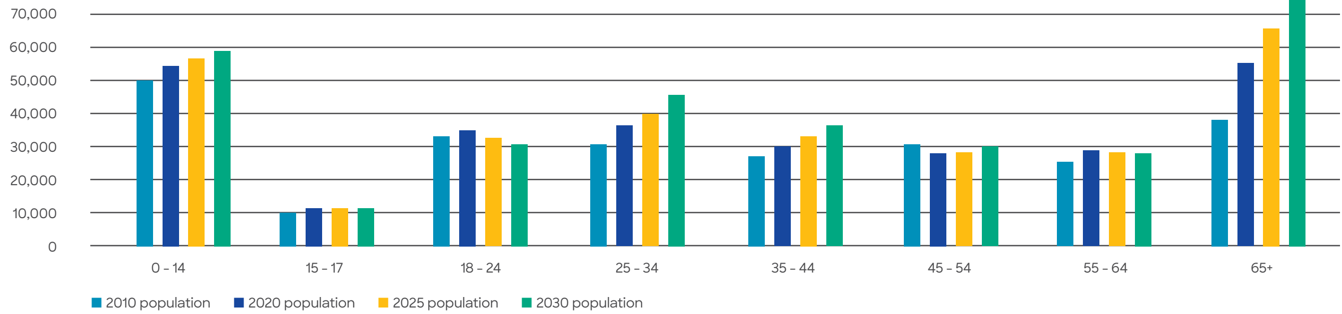
2020 race and ethnicity with total population



Population by sex 2010 - 2030



Population by age group 2010 - 2030



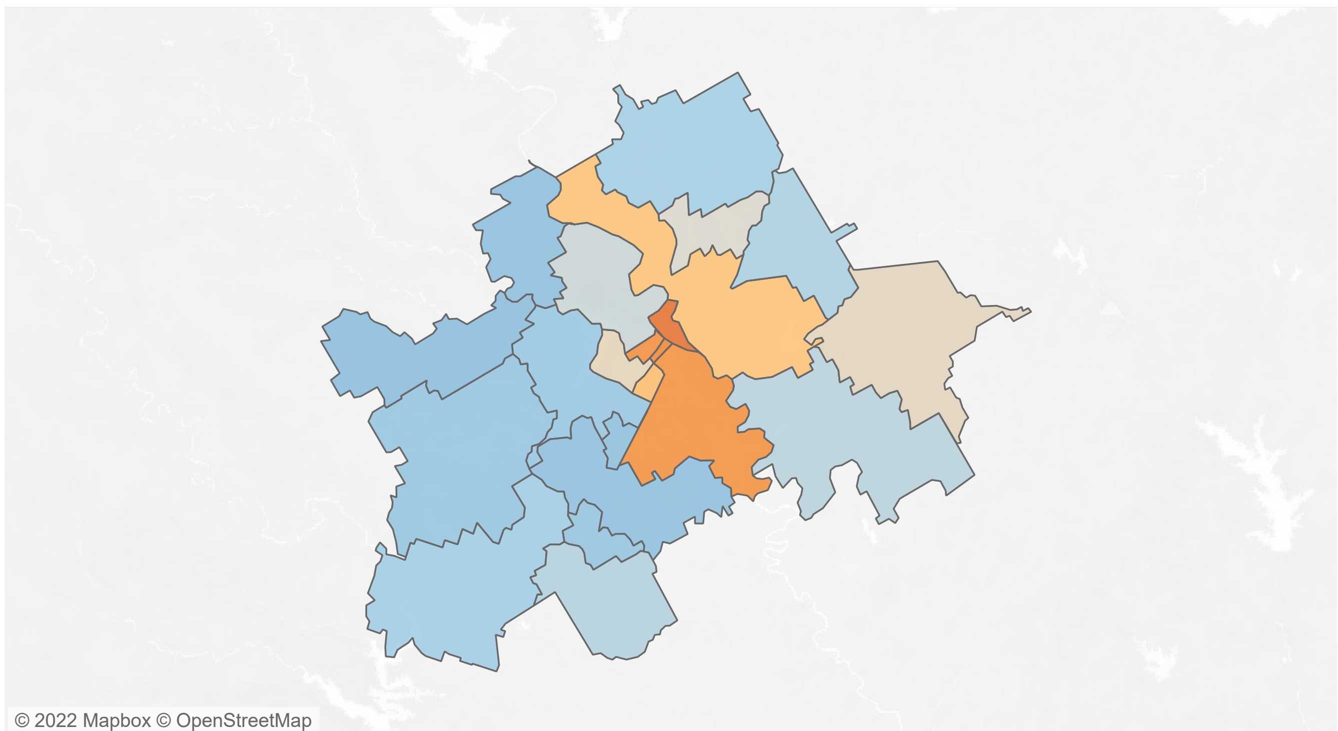
Source: IBM Watson Health/Claritas, 2020.

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 $27,604 for 76704 – Waco to $88,225 for 76638 – Crawford. There were eight (8) additional ZIP codes with median household incomes less than $50,200—twice the 2020 federal poverty limit for a family of four.

- 76704 Waco – $27,604
- 76701 Waco – $33,370
- 76707 Waco – $34,777
- 76706 Waco – $35,345
- 76711 Waco – $44,675
- 76705 Waco – $45,972
- 76710 Waco – $49,289
- 76664 Mart – $49,495

A majority of the population (40%) was insured through employer sponsored health coverage, closely followed by those without health insurance (24%). The remainder of the population was fairly equally divided between Medicaid, Medicare and private market (the purchasers of coverage directly or through the health insurance marketplace).

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.



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
McLennan	1485982391	LI - McLennan	Primary care	Low-income population HPSA
McLennan	7485788046	LI - McLennan County	Mental health	Low-income population HPSA
McLennan	148999485Z	Heart Of Texas Community Health Center, Inc.	Primary care	Federally qualified health center
McLennan	748999482U	Heart Of Texas Community Health Center, Inc.	Mental health	Federally qualified health center
McLennan	64899948C1	Heart Of Texas Community Health Center, Inc.	Dental health	Federally qualified health center

Medically underserved areas and populations (MUA/P)				
County	MUA/P source identification number	Service area name	Designation type	Rural status
McLennan	03507	McLennan service area	Medically underserved area	Non-rural

Community Needs Index

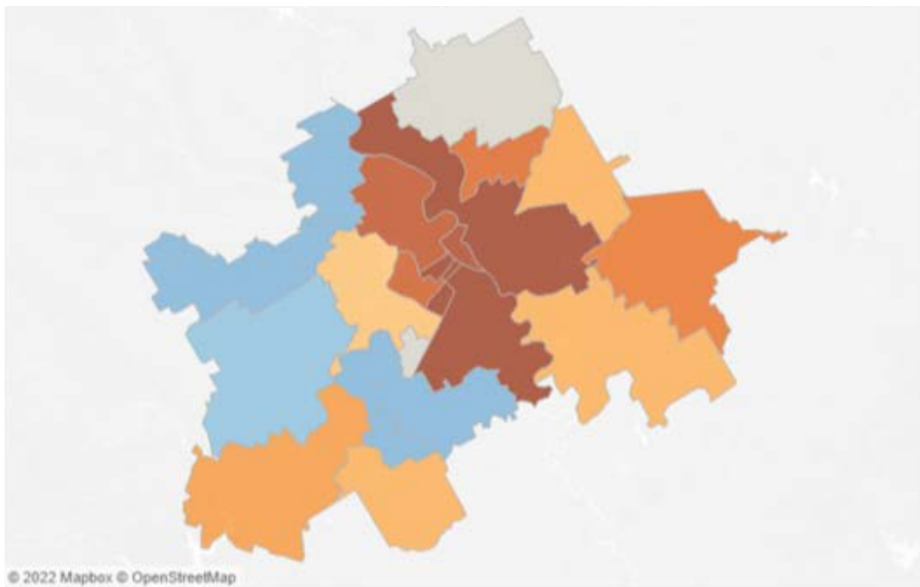
The IBM Watson Health Community Need Index (CNI) is a statistical approach that identifies areas within a community where there are likely gaps in healthcare. The CNI takes into account vital socio-economic factors, including income, culture, education, insurance and housing, about a community to generate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

Waco – McLennan 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
4.13

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 Waco – McLennan Health Community is 4.13. 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 Waco - McLennan Health Community. Total discharges in the community are expected to grow by 0.5% by 2030, with Pulmonary Medical, Cardiovascular Diseases and General Medicine 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	333	332	359	(0)	-0.1%	26	7.9%
Cardio-Vasc-Thor Surgery	729	718	702	(11)	-1.5%	(26)	-3.6%
Cardiovascular Diseases	1,315	1,311	1,391	(4)	-0.3%	76	5.8%
ENT	110	98	90	(12)	-10.7%	(20)	-18.3%
General Medicine	3,346	3,331	3,396	(15)	-0.5%	50	1.5%
General Surgery	1,558	1,494	1,496	(64)	-4.1%	(62)	-4.0%
Gynecology	89	47	30	(42)	-47.2%	(59)	-66.5%
Nephrology/Urology	866	873	900	7	0.8%	35	4.0%
Neuro Sciences	1,000	966	1,008	(34)	-3.4%	8	0.8%
Obstetrics Del	1,057	968	968	(89)	-8.4%	(89)	-8.4%
Obstetrics ND	99	86	81	(13)	-13.3%	(18)	-17.7%
Oncology	377	362	360	(15)	-3.9%	(17)	-4.4%
Ophthalmology	23	21	20	(2)	-7.6%	(3)	-13.0%
Orthopedics	1,487	1,412	1,400	(75)	-5.0%	(87)	-5.9%
Psychiatry	223	228	235	5	2.3%	12	5.5%
Pulmonary Medical	1,418	1,546	1,664	127	9.0%	246	17.3%
Rehabilitation	5	5	5	(0)	-2.7%	(0)	-0.4%
TOTAL	**14,033**	**13,797**	**14,105**	**(235)**	**-1.7%**	**72**	**0.5%**

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 Waco – McLennan Health Community outpatient procedures are expected to increase by almost 28% by 2030 with the largest growth in the categories of general and internal medicine, labs, physical & occupational therapy and psychiatry.

Clinical service category	2020 procedures	2025 procedures	2020-2025 procedures % change	2030 procedures	2020 - 2030 procedures % change
Allergy & Immunology	105,764	113,659	7.5%	121,683	15.1%
Anesthesia	31,561	36,054	14.2%	39,970	26.6%
Cardiology	151,768	190,564	25.6%	241,642	59.2%
Cardiothoracic	174	193	10.4%	210	20.4%
Chiropractic	58,989	56,649	-4.0%	52,013	-11.8%
Colorectal Surgery	1,306	1,348	3.2%	1,394	6.7%
CT Scan	52,817	72,277	36.8%	97,488	84.6%
Dermatology	35,397	39,874	12.6%	44,453	25.6%
Diagnostic Radiology	257,920	273,827	6.2%	290,063	12.5%
Emergency Medicine	146,344	160,067	9.4%	174,604	19.3%
Gastroenterology	16,399	18,182	10.9%	20,052	22.3%
General & Internal Medicine	1,910,892	2,182,473	14.2%	2,427,901	27.1%
General Surgery	16,126	17,527	8.7%	19,128	18.6%
Hematology & Oncology	392,898	455,869	16.0%	515,250	31.1%
Labs	1,973,763	2,196,845	11.3%	2,448,775	24.1%
Miscellaneous	91,953	98,538	7.2%	105,534	14.8%
MRI	18,333	19,988	9.0%	21,762	18.7%
Nephrology	53,026	58,774	10.8%	64,831	22.3%
Neurology	16,606	18,850	13.5%	21,119	27.2%
Neurosurgery	838	1,146	36.7%	1,302	55.4%
Obstetrics/Gynecology	22,665	24,043	6.1%	26,000	14.7%
Ophthalmology	101,129	117,318	16.0%	133,024	31.5%
Oral Surgery	938	1,090	16.2%	1,265	34.9%
Orthopedics	33,381	36,243	8.6%	39,110	17.2%
Otolaryngology	70,901	79,067	11.5%	87,055	22.8%
Pain Management	18,978	19,930	5.0%	20,398	7.5%
Pathology	66	75	14.3%	85	29.3%
PET Scan	2,043	2,282	11.7%	2,501	22.4%
Physical & Occupational Therapy	407,904	478,767	17.4%	554,278	35.9%
Plastic Surgery	1,927	2,151	11.7%	2,405	24.8%
Podiatry	14,809	15,660	5.7%	16,427	10.9%
Psychiatry	178,845	245,447	37.2%	322,781	80.5%
Pulmonary	47,411	52,075	9.8%	58,135	22.6%
Radiation Therapy	20,342	21,528	5.8%	22,690	11.5%
Single Photon Emission CT Scan (SPECT)	2,614	2,724	4.2%	2,902	11.0%
Urology	19,489	21,603	10.8%	23,767	22.0%
Vascular Surgery	5,478	5,916	8.0%	6,357	16.1%
TOTAL	**6,281,792**	**7,138,624**	**13.6%**	**8,028,355**	**27.8%**

Source: IBM Watson Health Outpatient Procedure Estimates, 2020.

Emergency department visits

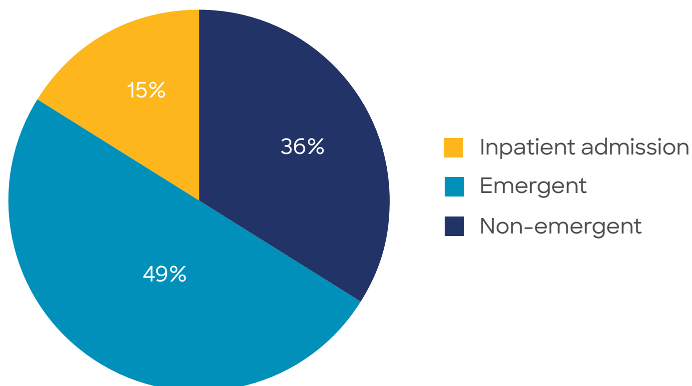
Emergency department estimates predict the total annual volume of emergency department (ED) visits by ZIP code and level of acuity for every market in the United States. IBM uses an extensive supply of proprietary claims, public claims and federal surveys to construct population-based use rates for all 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 Waco – McLennan Health Community, ED visits are expected to grow by 10.5% by 2025.

Emergent status	2020 visits	2025 visits	2020 - 2025 visits change	2020 - 2025 visits % change
Emergent	70,968	81,269	10,300	14.5%
Inpatient Admission	21,634	24,869	3,235	15.0%
Non-Emergent	58,173	60,406	2,233	3.8%
TOTAL	**150,776**	**166,544**	**15,768**	**10.5%**

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 Waco – McLennan Health Community, the most common disease is hypertension at almost 71% of all heart disease cases.

Disease type	2020 prevalence	2020 % prevalence
Arrhythmia	10,510	13.0%
Heart Failure	6,092	7.5%
Hypertension	57,145	70.6%
Ischemic Heart Disease	7,181	8.9%
TOTAL	**80,929**	**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 Waco – McLennan Health Community by 2025.

Cancer type	2020 incidence	2025 incidence	2020 – 2025 change	2020 – 2025 % change
Bladder	42	46	5	10.8%
Brain	22	24	2	7.1%
Breast	170	184	14	8.4%
Colorectal	112	97	-15	-13.5%
Kidney	57	64	7	12.1%
Leukemia	46	50	5	10.3%
Lung	157	165	8	5.1%
Melanoma	59	67	8	14.1%
Non-Hodgkin's Lymphoma	62	68	6	9.9%
Oral Cavity	41	46	4	10.1%
Other	139	153	14	10.2%
Ovarian	23	24	1	4.4%
Pancreatic	38	43	5	12.9%
Prostate	120	108	-12	-10.0%
Stomach	24	25	1	3.5%
Thyroid	33	37	4	11.6%
Uterine Cervical	9	9	0	-1.0%
Uterine Corpus	47	51	5	10.4%
TOTAL	**1,201**	**1,262**	**61**	**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.

The 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
Facilities: BSWMC - Hillcrest, Baylor Scott & White Clinic
Community served: McLennan County

Limited access to healthy foods

Baylor Scott & White Medical Center – Hillcrest

Action/tactics	Anticipated outcome	Evaluation of impact
Farmer's market Held on-site at hospital to provide regular access to healthy fruits and vegetables.	Healthy produce is available to community in easily accessed locations.	The COVID-19 pandemic prohibited this strategy from being implemented to date.
Partnership through financial and in-kind donations Support of local partnerships and with community organizations aimed at increasing access to food and nutrition. (Caritas, Mission Waco, Food Pantries, Jubilee Market, etc.)	Relief for food insecurity and financial challenges due to economic impact of coronavirus and reducing stress and mental health issues arising from quarantining. Improved access to community resources.	• **5,000+ served** • **$174,833 community benefit**
Meals on Wheels Financial and food delivery support for homebound adults, disabled and elderly.	Maximized community resources to rural residents to improve their health and engage available post-acute providers, decreased overutilization of the emergency department and decreased readmissions.	• **750 served** • **$2,500 community benefit**
Charity care Provide free and/or discounted care to financially or medically indigent patients as outlined in the financial assistance policy.	Increased access to primary care and/or specialty care for indigent persons regardless of their ability to pay.	• **$39.1 million community benefit**

Access to mental health resources

Baylor Scott & White Medical Center – Hillcrest

Action/tactics	Anticipated outcome	Evaluation of impact
Nurse family partnership Connecting first-time mothers with nurse home visits.	Nurses provide support, resource connections, education, and counseling on health, behavioral and self-sufficiency issues. NFP demonstrates positive multigenerational outcomes for families and their communities. Mothers are stronger and better prepared, resulting in better school readiness, reduced crime, and less child abuse and neglect.	• **3,427 served** • **$328,198 community benefit**
TelePsych Increased use of technology like TelePsych, allowing for virtual care to expedite assessment and treatment in the ED. iPads are available in the ED and med/surg floors.	Improve access to mental health resources locally and reduce wait times.	• Reduced length of stay in ED. Patients no longer spend four to seven days in the ED. Receiving an immediate psych assessment sometimes can prevent patients from having to visit psychiatric facility. • **$2,400 community benefit**
Green gown initiative Patients at high risk of having urgent mental health need will receive a green gown to help healthcare workers identify them easily. Each unit will receive four to five gowns, as well as 12 gowns in the ED, and remove everything from the room that could be potentially dangerous for the patient once the patient is identified.	Improve access to mental health resources and patient satisfaction.	• Prevented misidentification issues—patients with psychiatric conditions had other medical issues and were not classified properly as having mental health issues. • **1,119 served** • **$1,082.25 community benefit**
Financial donations Support to community organizations working to address mental and behavioral health challenges, increasing access to resources and addressing the stigma of care.	Improved access to mental health resources. Assistance in addressing issues arising from quarantining/coronavirus. Reduction in stigma of receiving care for mental health.	• **700+ served** • **$18,650 community benefit**
Faith community health Encourages faith community wellness through establishment of health initiatives, assisting high-risk patients through social support and resource navigation, and fostering community engagement through local collaboration efforts.	Empowers local faith communities to foster health and wellness by providing more effective patient navigation, education and support.	• **251 clients served** through faith community connectors. • **$1,041 community benefit**
Behavioral health Specialists placed in primary care setting. Clinics will ensure P/T or F/T placement of at least one provider in Gatesville, Hewitt and Waco clinics.	Expeditious referral for treatment in primary care.	• Have placed three psychologists, one LPC and one LPSW in rotation available at clinics. Virtual during pandemic but now offering both virtual and in-person appointments. • **$1,690,000 community benefit**
Group therapy sessions	Identify patients at risk for behavioral health issues that keep them from achieving good quality of life.	Group sessions were stopped in early 2020 due to the pandemic. Anticipate starting again in Spring 2022.

Diabetes admissions

Baylor Scott & White Medical Center – Hillcrest
Baylor Scott & White Clinic

Action/tactics	Anticipated outcome	Evaluation of impact
Comprehensive chronic disease program Targeting low-income patients with diabetes and depression to help successfully manage diabetic care in the primary care setting. Monitoring of A1C levels, BP control, PQI93 Diabetes Composite scores, rates of ED visits for those with diabetes, and regular eye and foot exams performed.	Improved management of chronic conditions and patient outcomes related to diabetes. Managing depression and diabetes simultaneously will improve patient outcomes on both conditions.	• **7,214 served** • **$10 million community benefit**
Diabetes food box program Partnership with Central Texas Food Bank and Caritas providing diabetes-friendly food boxes for clients.	Clients with diabetes will receive diabetes-friendly food boxes.	Central Texas Food Bank discontinued program after year one due to logistical challenges.
Diabetes education Seminars and monthly group support sessions, inpatient education.	Provide regular sessions through inpatient and outpatient or community settings to help patients manage their diagnosis.	• Clinic offers face-to-face nurse visits to all patients with diabetes for counseling when needed. This service did not stop during the pandemic. It was offered throughout. Group sessions starting up again this spring (monthly). Led by providers. • **$2,000 benefit plus salary** • **12 patients per month**
Diabetic research studies at Bosque clinic	Ongoing research studies aimed at identifying better treatment options for patients with diabetes.	Shut down in 2020 due to pandemic.
Getterman Center diabetes program A free four-week education program.	Patients with diabetes are better able to manage their disease, lowering hospital admission rates.	• **550 served** • Patients regularly meet with a certified diabetes educator and have an opportunity to exercise at Getterman Wellness Center. • **$100,000 community benefit**
American Diabetes Association support in local community	ADA resources are made available to community and promoted so that community has better awareness of offerings.	• Regional ADA office was not responsive to Waco area needs and did not request for funding from BSWMC - Hillcrest. Budget dollars were repurposed for other diabetic support needs. • **$2,000 community benefit**

Total investment in adopted community needs since 2019 CHNA

BSWMC - Hillcrest	BSW Clinic
$49.7 million	**$1.7 million**

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