


Community Health Needs Assessment

Waxahachie Health Community

2022

Baylor Scott & White HEALTH

Waxahachie health community hospital

- Baylor Scott & White Medical Center – Waxahachie

Approved by: Baylor Scott & White Health – North Texas Operating, Policy and Procedure Board on May 31, 2022
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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

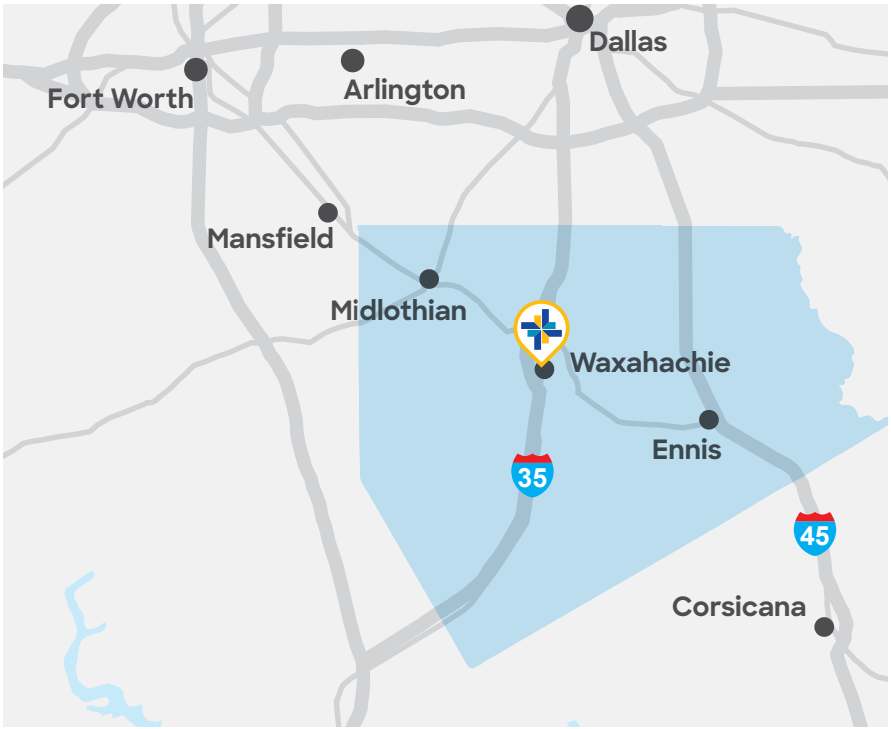
Baylor Scott & White Health (BSWH) owns and operates numerous individually licensed hospital facilities serving the residents of North and Central Texas.

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

- Baylor Scott & White Medical Center – Waxahachie

The community served by the hospital listed above is Ellis 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.

Waxahachie 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 Waxahachie Health Community CHNA are:

- The community is growing as fast as the state of Texas, and both are outpacing the rate of growth of the US.
- The average age of the population is younger than the US and slightly younger than Texas overall.
- The median household income is significantly higher than both the state and the US.
- The community served has a lower percentage of uninsured and underinsured than the state of Texas.

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

Health community data summary

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

- Inpatient discharges in the community are expected to grow by 12.7% by 2030 with the largest growing product lines to include:
  - Pulmonary medical
  - General medicine
  - Cardiovascular diseases
- Outpatient procedures are expected to increase by 38% by 2030 with the largest areas of growth including:
  - Labs
  - General & internal medicine
  - Physical & occupational therapy
- Emergency department visits are expected to grow by 10.4% by 2025.
- Hypertension represents 72.5% of all heart disease cases.
- Cancer incidence is expected to increase by 11.7% by 2025.

Further health community information for the Waxahachie 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
Ellis	1	1	1	3	1

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

Total population

194,892

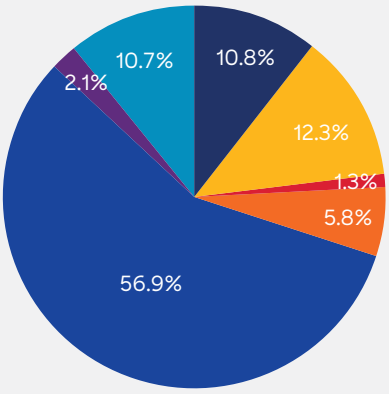
Average income

$80,656

Lowest income ZIP code

76670 Milford

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:

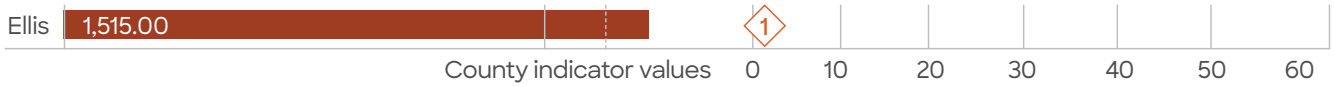
Priority	Need	Category of need
1	Access to mental healthcare (providers/services)	Mental health
2	Access to primary healthcare	Access to care
3	Diabetes	Conditions/diseases
4	Obesity/physical inactivity	Conditions/diseases Health behaviors
5	Rate of uninsured in general population	Access to care
6	Binge drinking and substance abuse/ access to treatment	Conditions/diseases
7	Lack of affordable housing	Environment
8	Emergency department use rate in all populations	Utilization

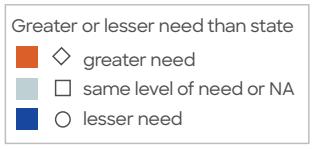
Priority 1: Access to Mental Healthcare (Providers/Resources)

The following data indicates greater need for **access for the population to one mental healthcare provider**. 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 greater need	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)





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The focus group participants stated that needs are high for mental health because mental health/substance abuse services are limited in the county. They felt that isolation is contributing to substance abuse/mental health/domestic abuse and other challenges. In addition, stigma and small-town mentality create resistance to mental health support.

In the prioritization session, the hospital leadership group stated that mental health need is high in schools as students deal with anxiety and depression, and parents are unsure of where to seek care for them. In addition, COVID has taken a toll on residents emotionally, contributing to increased rates of depression and suicide.

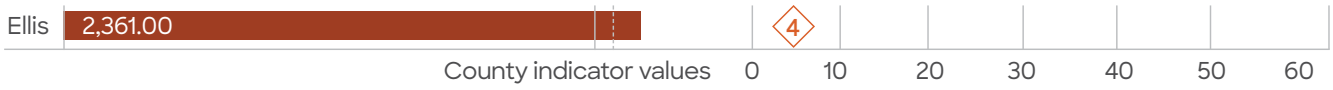
Priority 2: Access to Primary Healthcare

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

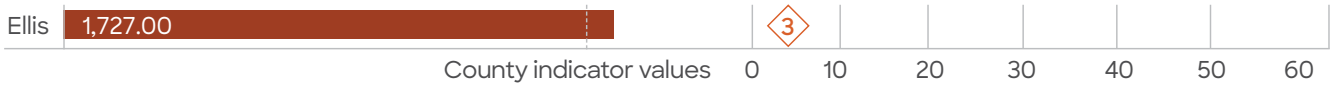
The **population to one primary care physician** indicator is defined as **the number of individuals served by one physician in a county if the population was equally distributed across physicians** and is based on data from County Health Rankings & Roadmaps and Area Health Resource File/American Medical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

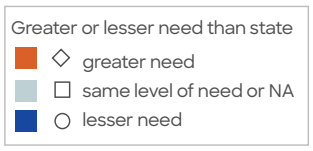
Access to care: population to one primary care physician (number of individuals served by one physician by county)



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)





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The focus group participants felt that the overall community has limited healthcare services for the population. Participants stated there is a high demand for primary care providers, leading to difficulty accessing primary care. In addition to limited providers, there is no publicly funded hospital in Ellis County, and therefore, indigent patients are directed to other counties.

In the prioritization session, the hospital leadership agreed that the uninsured population is limited in regard to accessing care. They also noted that some parents use emergency rooms for primary care services for their children. This could be because those fees are often later billed as charity care, and they are not otherwise incentivized to acquire insurance or Medicaid.

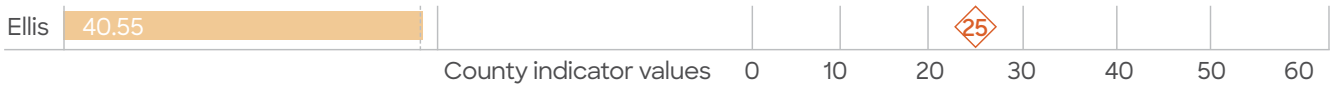
Priority 3: Diabetes

The following data indicates greater need in the area of diabetes admission, diabetes diagnoses in adults and diabetes prevalence.

Category	Data shows greater need	Key informants indicate greater need
Conditions/ diseases	• Diabetes admission • Diabetes diagnoses in adults • Diabetes prevalence	• Limited access to diabetes management medication • Chronic illness patient support is a big challenge

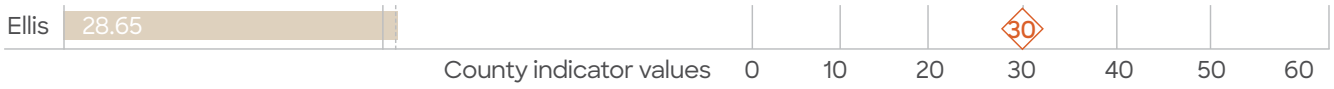
The indicator **diabetes admission** is defined as **the number observed/adult population age 18 and older**. Note that risk-adjusted rates are not calculated for counties with fewer than five admissions. The indicator is based on data from Texas Health and Human Services Center for Health Statistics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

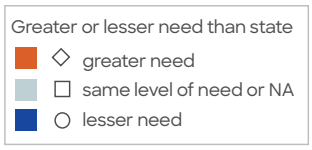
Conditions/diseases: diabetes admission (number observed/adult population in county)



The indicator **diabetes diagnoses in adults** is defined as **the prevalence of diabetes across all Medicare beneficiaries**. The indicator is based on data from CMS.gov Chronic Conditions 2007 - 2018.

Conditions/diseases: diabetes diagnoses in adults (% of adults with diabetes diagnoses in county)





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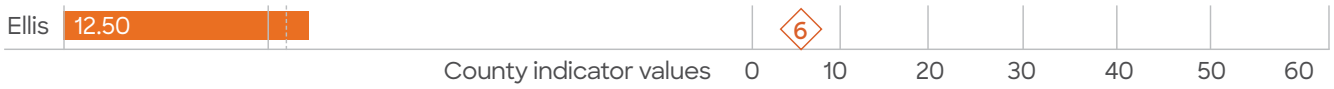
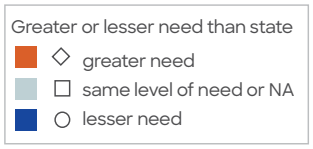
The indicator **diabetes prevalence** is defined as **the prevalence of diagnosed diabetes in a given county**. Note that respondents were considered to have diagnosed diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they 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)





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The focus group participants cited that there is limited access to diabetes management medication due to the high cost of medications. Mismanagement of diabetes leads to more unplanned admissions. They noted that all chronic illness patient support is a big challenge due to a lack of preventive education and patients unable to afford medication expenses.

In the prioritization session, the hospital leadership cited that diabetes management is a need. They added that doctors are seeing increases in cases of teenagers with Type 2 diabetes. They believed that addressing physical inactivity, obesity and poor diet in adolescents in the community before they lead to diabetes is important.

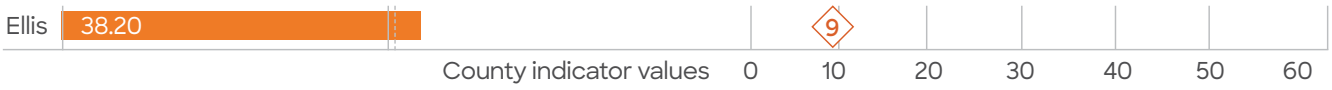
Priority 4: Obesity/Physical Inactivity

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 **adult obesity** indicator is defined as **the 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)

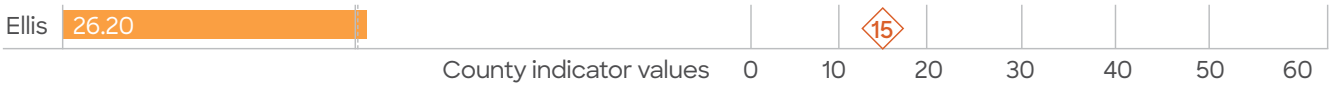


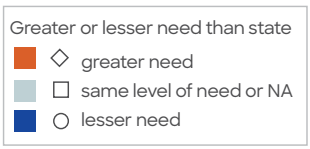
The following data indicates greater need in the area of physical inactivity.

Category	Data shows greater need	Key informants indicate greater need
Health behaviors	• Physical inactivity	• Insufficient outdoor places to exercise/trails to walk

The indicator **physical inactivity** is defined as **the percentage of adults ages 20 and over reporting no leisure-time physical activity in the past month**. The indicator is based on data from County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System.

Health behaviors: physical inactivity (% of adult reporting no leisure-time physical activity in county)





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While the focus group participants did not specifically discuss obesity, they noted there is an opportunity to provide community education for chronic conditions, services and prevention. They did discuss that the community is not conducive to healthy living because there are insufficient outdoor places to exercise/trails in some parts of the county.

In the prioritization session, hospital leadership agreed that obesity and lack of physical activity are areas of concern and need to be prioritized.

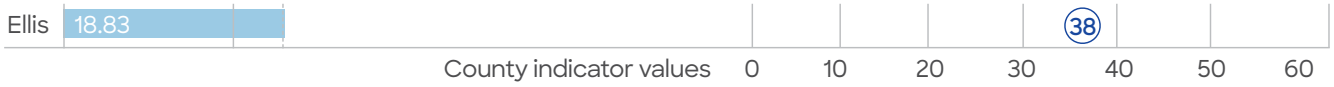
Priority 5: Rate of Uninsured in General Population

Although the data does not indicate a high need relative to other indicators to address the measure of population under age 65 without health insurance, the key informants felt that the community is challenged by the lack of insurance coverage.

Category	Data shows less need or no data	Key informants indicate greater need
Access to care	• Population under age 65 without health insurance	• Community lacks health insurance coverage

The indicator **population under age 65 without health insurance** is defined as **the percentage of population under age 65 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: population under age 65 without health insurance (% of population under age 65 without health insurance)



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

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The focus group participants noted that many residents in the county lack insurance coverage. They added that even those who are insured suffer from rising healthcare costs and drop their insurance plans because they can no longer afford the premiums, copays and out-of-pocket payments.

In the prioritization session, the hospital and community leaders agreed that lack of insurance is a barrier in the health community and needs to be a priority. Use of the emergency department by parents was mentioned as a means to avoid payment for services for the uninsured as those bills are written off as charity care based on low-income and lack of insurance.

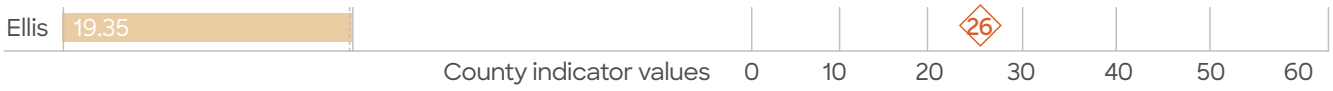
Priority 6: Binge Drinking and Substance Abuse/Access to Treatment

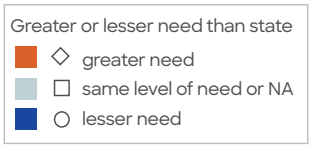
The following data indicates greater need in the area of binge drinking and substance abuse/access to treatment.

Category	Data shows greater need	Key informants indicate greater need
Condition/ diseases	• Binge drinking	• Access to alcohol and drinking enhanced by COVID • Difficult to access alcohol abuse services

The **binge drinking** indicator is defined as **the percentage of a county's adult population that reports binge or heavy drinking in the past 30 days** and is based on data from County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS).

Conditions/diseases: binge drinking (% of adults binge or heavy drinking in past 30 days by county)





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The focus group participants noted that the use of alcohol increased during the pandemic. Unfortunately, alcohol abuse services are difficult to access. There is also a stigma and small-town mentality to resist services such as substance abuse support.

In the prioritization session, the hospital and community leaders agreed that substance abuse has likely increased in the last two years. More importantly, they felt that the community needs a detoxification center so they can avoid sending patients to the emergency department to get needed care.

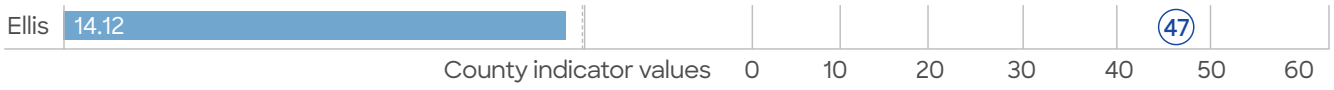
Priority 7: Lack of Affordable Housing

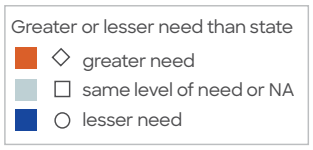
Although the data does not indicate a high need relative to other indicators to address the lack of affordable housing, the key informants and focus group participants felt strongly that the community is challenged in this area.

Category	Data shows less need or no data	Key informants indicate greater need
Environment	• Severe housing problems	• Lack of affordable housing

The indicator **severe housing problems** is defined as **the percentage of households with at least one of four housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities**. The indicator is based on data from County Health Rankings & Roadmaps; Comprehensive Housing Affordability Strategy (CHAS) data, U.S. Department of Housing and Urban Development (HUD).

Environment: severe housing problems (% of population with one of four problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities by county)





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The focus group participants noted that the community lacks both sufficient housing and affordable housing. They added that includes increasing affordable housing options for senior citizens. Many felt strongly that COVID had a financial impact on residents through the loss of jobs or reduced incomes, which led to a loss of housing or problems with affordability of housing.

In the prioritization session, the hospital and community leaders believed that affordable housing is almost non-existent for anyone earning less than $50,000 a year in Ellis County. It is causing an increase in the homeless population. They also noted that people are moving out of Waxahachie in search of affordable housing elsewhere.

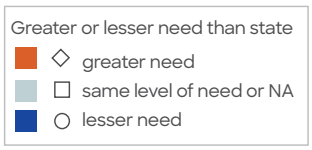
Priority 8: Emergency Department Use Rate in All Populations

The following data indicates greater need in terms of high use of the emergency department.

Category	Data shows greater need	Key informants indicate greater need
Healthcare utilization	• Medicare population: emergency department use rate	• No space in emergency rooms for specialty care

The **Medicare population: emergency department use rate** indicator is defined as **the rate of unique patients having an emergency department visit divided by the total number of beneficiaries** and is based on data from CMS Outpatient 100% Standard Analytical File (SAF) and CMS Standard Analytical Files (SAF) Denominator File.

Healthcare utilization: Medicare population: emergency department use rate (unique patients with ED visit/total beneficiaries 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 noted that there is no space in emergency rooms for specialty care. The use of emergency departments is too high and cannot meet the demand.

In the prioritization session, the hospital and community leaders agreed that the emergency department is overutilized by all payer types, not just the Medicare population.

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.

Waxahachie community resources

Need	Organization	Address	Phone
Access to mental healthcare providers/ resources	Family Abuse Center	630 Farley Street Waxahachie, TX 75165	800.283.8401
	Hope Clinic	805 W. Lampasas Street Ennis, TX 75119	972.923.2440
	Lakes Regional Community Centers	2414 N. Preston Street Ennis, TX 75119	972.875.6375
	Child & Family Guidance Center (CFGC)	1505 W. Jefferson Street Waxahachie, TX 75165	866.695.3794
	Runnin' Free Ranch	1403 Old Bardwell Road Ennis, TX 75119	214.399.4270
Access to primary healthcare	Hope Clinic	411 E. Jefferson Street Waxahachie, TX 75165	972.923.2440
	Hope Clinic	805 W. Lampasas Street Ennis, TX 75119	972.923.2440
	Midlothian Senior Citizens Center (health assessments screening program)	4 Community Drive Midlothian, TX 76065	972.775.6401
	Region 10 Education Service Center (child health/ development screenings, nutrition)	301 Harris Street Italy, TX 76651	972.348.1626
	Ellis County Texas - Indigent Health Care Program (help pay for primary care)	207 S. Sonoma Trail Ennis, TX 75119	972.825.5085
Diabetes	Hope Clinic	411 E. Jefferson Street Waxahachie, TX 75165	972.923.2440
	Hope Clinic	805 W. Lampasas Street Ennis, TX 75119	972.923.2440
	Waxahachie Family YMCA (recreation center/nutrition education programs)	100 YMCA Drive Waxahachie, TX 75165	972.938.9826
	Midlothian Senior Citizens Center (diabetes screening)	4 Community Drive Midlothian, TX 76065	972.775.6401
	Guardian Healthcare (diabetes management services)	114 Park Place Boulevard Waxahachie, TX 75165	972.937.1560

Waxahachie community resources

Need	Organization	Address	Phone
Obesity/ physical inactivity	Hope Clinic (chronic disease)	411 E. Jefferson Street Waxahachie, TX 75165	972.923.2440
	Hope Clinic (chronic disease)	805 W. Lampasas Street Ennis, TX 75119	972.923.2440
	Waxahachie Family YMCA (recreation center/nutrition education programs)	100 YMCA Drive Waxahachie, TX 75165	972.938.9826
Binge drinking/ substance abuse/access to treatment	Lakes Regional Community Centers	2414 N. Preston Street Ennis, TX 75119	972.875.6375
	REACH Council	208 S. 4th Street Midlothian, TX 76065	972.723.1053
	Hope Clinic (adult health/behavioral health)	411 E. Jefferson Street Waxahachie, TX 75165	972.923.2440
	Hope Clinic (adult health/behavioral health)	805 W. Lampasas Street Ennis, TX 75119	972.923.2440
Population under 65 without health insurance	PCHAS Self-Sufficiency Program (assistance with obtaining health insurance)	300 Brookside Road Waxahachie, TX 75167	800.888.1904
	Hope Clinic	411 E. Jefferson Street Waxahachie, TX 75165	972.923.2440
	Hope Clinic	805 W. Lampasas Street Ennis, TX 75119	972.923.2440
	Texas HHSC	2707 N. Kaufman Street Ennis, TX 75119	972.875.6571
	Ellis County Texas - Indigent Health Care Program (help pay for primary care)	207 S. Sonoma Trail Ennis, TX 75119	972.825.5085

Waxahachie community resources

Need	Organization	Address	Phone
Affordable housing	Daniel's Den Inc. (Transitional housing)	507 W. Jefferson Street Waxahachie, TX 75165	972.938.0103
	Presbyterian Children's Homes and Services (PCHAS) (residential housing to achieve self-sufficiency)	300 Brookside Road Waxahachie, TX 75167	972.456.9460
	Ennis Housing Authority	300 Arnold Street Ennis, TX 75119	972.878.7451
	Ferris Housing Authority	401 W. 1st Street Ferris, TX 75125	972.842.2047
	The DMA Companies	991 Abigail Way Midlothian, TX 76065	469.324.0040
ED utilization	Hope Clinic	411 E. Jefferson Street Waxahachie, TX 75165	972.923.2440
	Hope Clinic	805 W. Lampasas Street Ennis, TX 75119	972.923.2440
	Midlothian Senior Citizens Center (health assessments screening program)	4 Community Drive Midlothian, TX 76065	972.775.6401
	Region 10 Education Service Center (child health/ development screenings, nutrition)	301 Harris Street Italy, TX 76651	972.348.1626
	Ellis County Texas - Indigent Health Care Program (help pay for primary care)	207 S. Sonoma Trail Ennis, TX 75119	972.825.5085

There are many other community resources and facilities serving the Waxahachie 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:

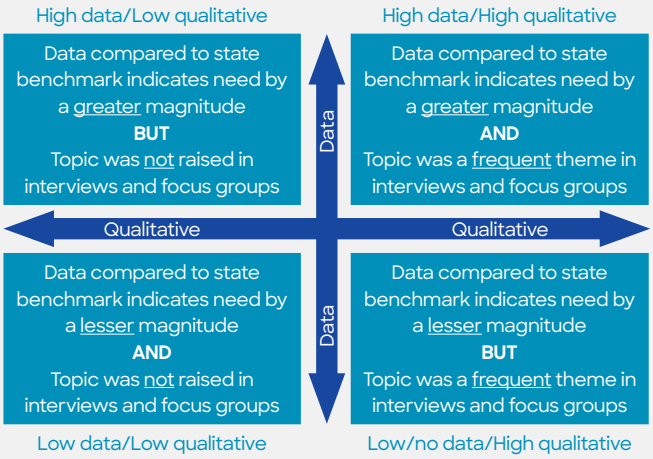
- Assembled a focus group representing the broad interests of the community served;
- Conducted interviews and surveys with key informants—leaders and representatives who serve the community and have insight into its needs; and
- Held prioritization sessions with hospital clinical leadership and community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

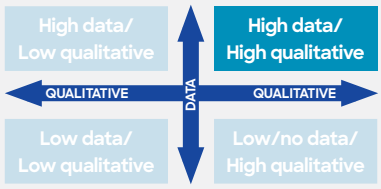
Approach to prioritizing significant health needs



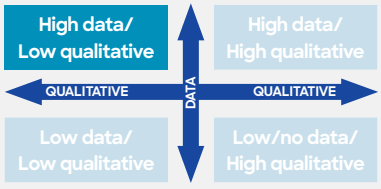
High data = Indicators worse than state benchmark by greater magnitude
High qualitative = Frequency of topic in interviews and focus groups

On January 19, 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.

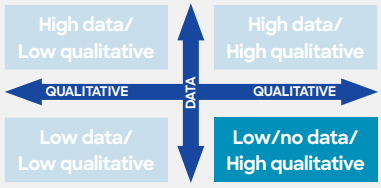
In the first step, participants reviewed the top health needs for their community using associated data-driven criteria. The criteria included health indicator value(s) for the community and how the indicator compared to the state benchmark.



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:

- **Feasibility/cost:** Is the problem amenable to interventions? Is the problem preventable? What technology, knowledge or resources are necessary to effect a change? Is it too expensive for the community to tackle?
- **Root cause:** The need is a root cause of other problems. If addressed, it could possibly impact multiple issues.
- **Severity (outcome if ignored):** The problem results in disability or premature death or creates burdens on the community, economically or socially.

The group rated each of the eight 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 mental healthcare (providers/services)	Mental health
2	Access to primary healthcare	Access to care
3	Diabetes	Conditions/diseases
4	Obesity/physical inactivity	Conditions/diseases Health behaviors
5	Rate of uninsured in general population	Access to care
6	Binge drinking and substance abuse/ access to treatment	Conditions/diseases
7	Lack of affordable housing	Environment
8	Emergency department use rate in all populations	Utilization

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).

Indicator name	Indicator source	Indicator definition
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).
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

Indicator name	Indicator source	Indicator definition
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
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.

Indicator name	Indicator source	Indicator definition
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.

Indicator name	Indicator source	Indicator definition
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.
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

Indicator name	Indicator source	Indicator definition
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
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.

Indicator name	Indicator source	Indicator definition
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
- Daniel's Den
- Emergency Management Midlothian Police Department
- Hope Clinic
- Meals on Wheels
- Mansfield Independent School District (MISD)
- Presbyterian Children's Homes & Services (PCHAS)
- REACH Council
- St. Joseph Church
- United Way
- Waxahachie Independent School District
- Waxahachie Care Services

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 slightly older than Texas but younger than the United States. Median income is significantly higher than both the state and the country. The community served has a lower percentage of Medicaid beneficiaries and a lower percentage of uninsured individuals than the state of Texas.

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

Geography		Benchmarks		Community served
		United States	Texas	Waxahachie health community
Total current population		330,342,293	29,321,501	194,892
Five-year projected population change		3.3%	6.6%	8.2%
Median age		38.6	35.2	36.3
Population 0 - 17		22.4%	25.7%	26.3%
Population 65+		16.6%	13.2%	13.4%
Women age 15 - 44		19.5%	20.5%	20.1%
Hispanic population		19.0%	40.7%	27.7%
Insurance coverage	Uninsured	9.9%	18.8%	10.7%
	Medicaid	20.9%	13.0%	10.8%
	Private market	8.3%	8.4%	7.9%
	Medicare	13.8%	12.7%	13.6%
	Employer	47.2%	47.1%	56.9%
Median HH income		$65,618	$63,313	$80,656
No high school diploma		12.2%	16.7%	14.5%

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

The community served expects to grow 8.2% by 2025, an increase of almost 16,000 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:

- 75154 Red Oak – 3,978 people
- 76065 Midlothian – 3,792 people
- 75165 Waxahachie – 3,607 people

The community's population is younger with 48.2% of the population ages 18 - 54 and 21.5% under age 18. The age 65-plus cohort is expected to experience the fastest growth (>26%) 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 8,558 people (16.7%) by 2025. The non-Hispanic white population is expected to have the slowest growth at 1.6%.

Population distribution

	Age distribution				
Age group	2020	% of total	2025	% of total	USA 2020 % of total
0 - 14	41,949	21.5%	42,709	20.3%	18.5%
15 - 17	9,224	4.7%	9,758	4.6%	3.9%
18 - 24	19,006	9.8%	21,763	10.3%	9.5%
25 - 34	24,284	12.5%	26,126	12.4%	13.5%
35 - 54	50,606	26.0%	52,148	24.7%	25.2%
55 - 64	23,790	12.2%	25,339	12.0%	12.9%
65+	26,033	13.4%	32,945	15.6%	16.6%
Total	**194,892**	**100.0%**	**210,788**	**100.0%**	**100.0%**

Household Income distribution

	Income distribution		
2020 Household income	HH count	% of total	USA % of total
<$15K	3,798	5.8%	10.0%
$15 - 25K	3,596	5.5%	8.6%
$25 - 50K	11,206	17.0%	20.7%
$50 - 75K	12,137	18.4%	16.7%
$75 - 100K	10,677	16.2%	12.4%
Over $100K	24,463	37.1%	31.5%
Total	**2,308,599**	**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	8,421	6.8%	5.2%
Some high school	9,710	7.8%	7.0%
High school degree	36,939	29.6%	27.2%
Some college/assoc. degree	42,080	33.7%	28.9%
Bachelor's degree or greater	27,563	22.1%	31.6%
Total	**124,713**	**100.0%**	**100.0%**

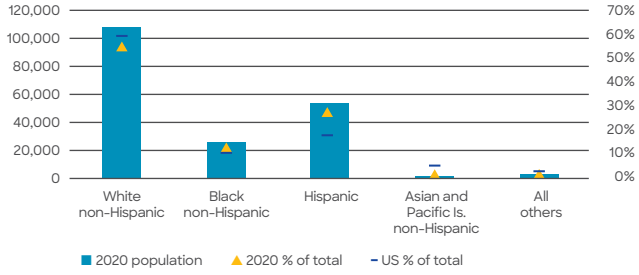
Race/ethnicity

	Race/ethnicity distribution		
Race/ethnicity	2020 pop	% of total	USA % of total
White non-Hispanic	108,456	55.6%	59.3%
Black non-Hispanic	26,704	13.7%	12.4%
Hispanic	54,068	27.7%	19.0%
Asian & Pacific is. non-Hispanic	1,611	0.8%	6.0%
All others	4,053	2.1%	3.3%
Total	**6,446,391**	**100.0%**	**100.0%**

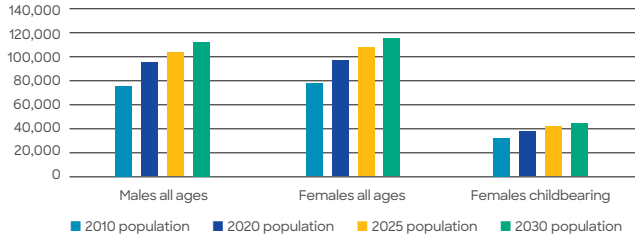
Population estimates		
Population	National	Selected area
2010 total	308,745,538	157,335
2020 total	330,342,293	194,892
2025 total	341,132,738	210,788
2030 total	353,513,931	230,703
% change 2020 - 2025	3.27%	8.16%
% change 2020 - 2035	7.01%	18.37%

Population	Males all ages	Females all ages	Females childbearing
2010 total	77,498	79,837	32,493
2020 total	95,875	99,017	39,088
2025 total	103,630	107,158	41,608
2030 total	113,356	117,347	45,026
10Y %	18.23%	18.51%	15.19%
National	7.02%	7.01%	4.01%

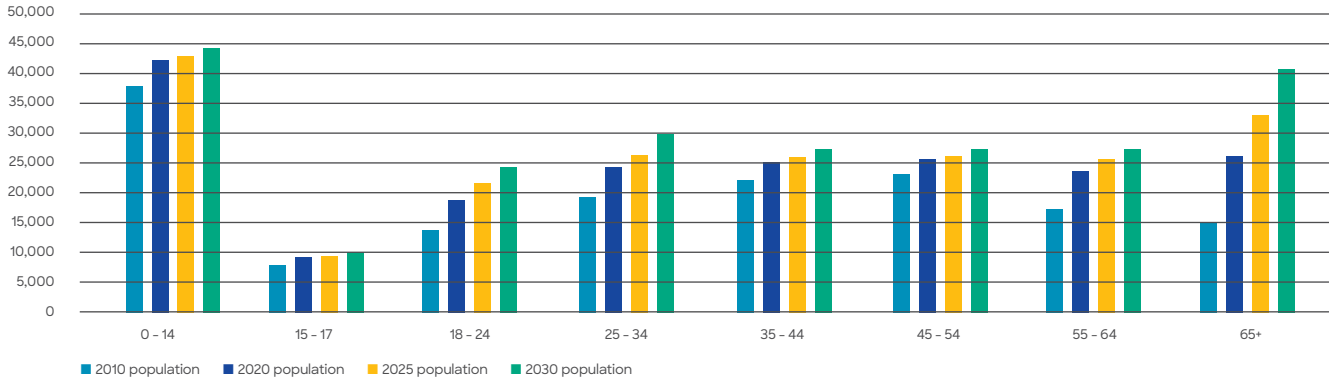
2020 race and ethnicity with total population



Population by sex 2010 - 2030

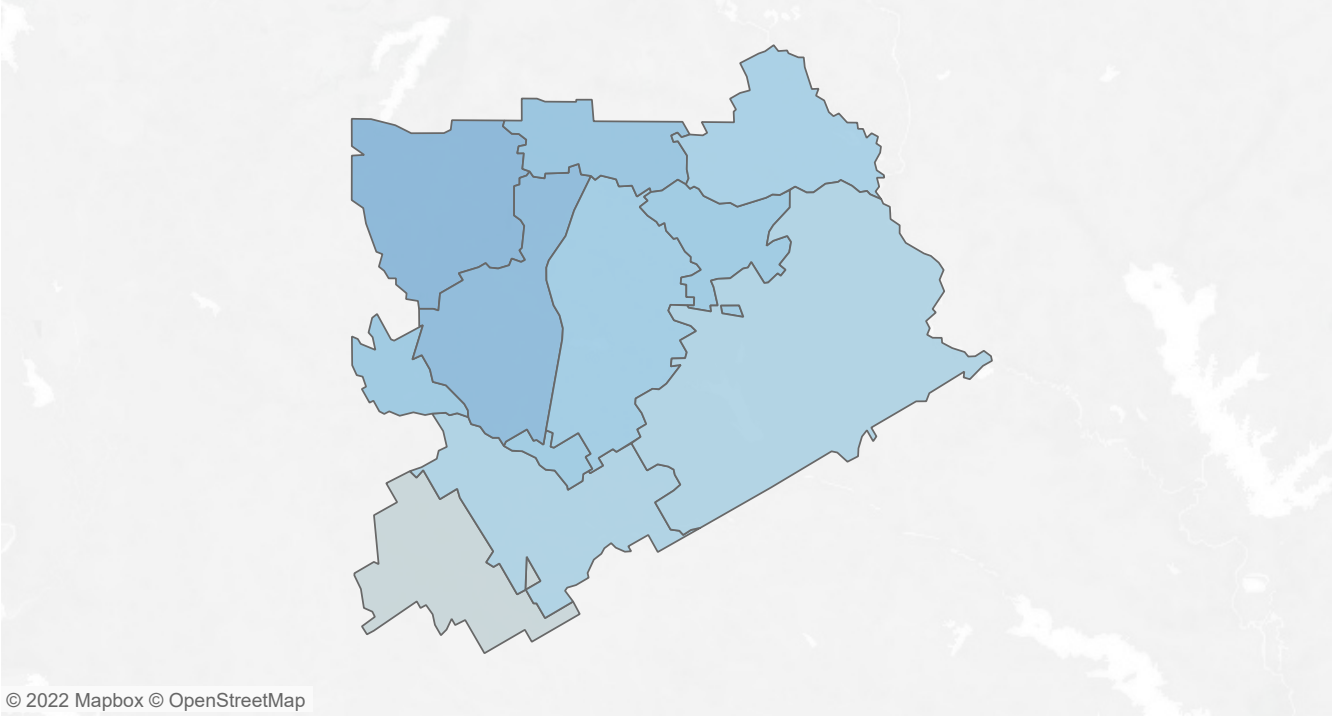


Population by age group 2010 - 2030



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 $55,851 for 76670 Milford to $100,990 for 76065 Midlothian. There were no 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 (57%) was insured through employer sponsored health coverage. 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).

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
Ellis	14899948J2	Ellis County Coalition for Health Options	Primary care	Federally qualified health center
Ellis	74899948A4	Ellis County Coalition for Health Options	Mental health	Federally qualified health center
Ellis	64899948L9	Ellis County Coalition for Health Options	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
Ellis	03496	Ellis service area	Medically underserved area	Non-rural

Community Needs Index

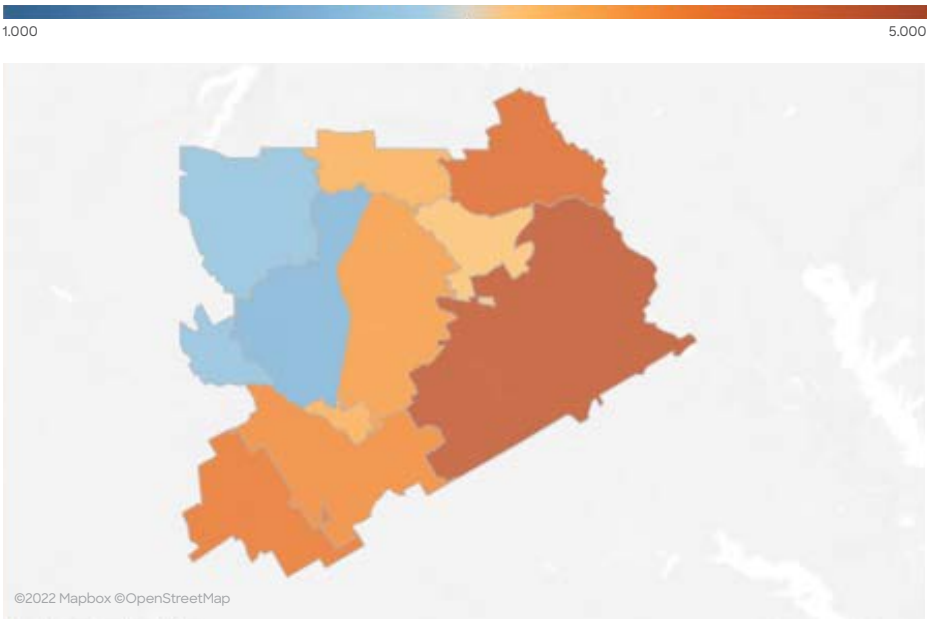
The IBM Watson Health Community Need Index (CNI) is a statistical approach that identifies areas within a community where there are likely gaps in healthcare. The CNI takes into account vital socio-economic factors, including income, culture, education, insurance and housing, about a community to generate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

Waxahachie 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
3.45

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 Waxahachie Health Community was 3.45. 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 Waxahachie Health Community. Total discharges in the community are expected to grow by 12.7% by 2030, with pulmonary medical, general medicine and cardiovascular diseases 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	201	206	229	5	2.5%	28	14.1%
Cardio-Vasc-Thor Surgery	539	567	594	28	5.2%	55	10.2%
Cardiovascular Diseases	1,224	1,349	1,555	125	10.2%	331	27.1%
ENT	94	88	86	(6)	-6.2%	(8)	-8.4%
General Medicine	2,855	2,974	3,204	119	4.2%	349	12.2%
General Surgery	1,351	1,358	1,428	7	0.5%	77	5.7%
Gynecology	111	54	32	(57)	-51.0%	(79)	-71.0%
Nephrology/Urology	703	742	808	39	5.6%	105	15.0%
Neuro Sciences	798	853	964	55	6.8%	165	20.7%
Obstetrics Del	2,009	1,940	2,006	(69)	-3.4%	(3)	-0.2%
Obstetrics ND	184	166	163	(18)	-9.8%	(21)	-11.5%
Oncology	328	338	359	9	2.8%	31	9.3%
Ophthalmology	17	16	16	(1)	-4.2%	(1)	-6.1%
Orthopedics	1,548	1,571	1,686	23	1.5%	138	8.9%
Psychiatry	63	66	68	3	4.1%	5	7.6%
Pulmonary Medical	1,393	1,647	1,929	253	18.2%	536	38.4%
Rehabilitation	5	5	6	0	7.1%	1	20.8%
TOTAL	**13,423**	**13,939**	**15,132**	**516**	**3.8%**	**1,709**	**12.7%**

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 Waxahachie Health Community outpatient procedures are expected to increase by 38% 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	28,939	32,551	12.5%	36,829	27.3%
Anesthesia	17,307	20,587	19.0%	23,920	38.2%
Cardiology	103,795	136,017	31.0%	180,138	73.6%
Cardiothoracic	127	146	15.7%	169	33.6%
Chiropractic	70,132	70,791	0.9%	69,612	-0.7%
Colorectal Surgery	1,011	1,064	5.2%	1,132	12.0%
CT Scan	39,365	53,969	37.1%	73,589	86.9%
Dermatology	33,216	40,184	21.0%	48,365	45.6%
Diagnostic Radiology	201,611	224,838	11.5%	251,519	24.8%
Emergency Medicine	112,624	123,407	9.6%	136,909	21.6%
Gastroenterology	12,559	14,557	15.9%	16,823	34.0%
General & Internal Medicine	1,546,887	1,829,102	18.2%	2,114,414	36.7%
General Surgery	11,242	12,753	13.4%	14,594	29.8%
Hematology & Oncology	290,739	355,461	22.3%	422,885	45.5%
Labs	1,776,436	2,053,430	15.6%	2,381,941	34.1%
Miscellaneous	72,791	82,070	12.7%	92,060	26.5%
MRI	16,312	18,645	14.3%	21,428	31.4%
Nephrology	43,596	51,603	18.4%	61,013	40.0%
Neurology	24,205	26,480	9.4%	29,218	20.7%
Neurosurgery	882	1,209	37.0%	1,423	61.3%
Obstetrics/Gynecology	25,957	28,047	8.1%	30,658	18.1%
Ophthalmology	84,548	104,808	24.0%	127,755	51.1%
Oral Surgery	1,008	1,146	13.7%	1,323	31.3%
Orthopedics	36,020	41,071	14.0%	46,835	30.0%
Otolaryngology	53,185	60,848	14.4%	69,375	30.4%
Pain Management	26,458	30,679	16.0%	35,234	33.2%
Pathology	51	61	19.5%	73	42.8%
PET Scan	1,241	1,490	20.1%	1,764	42.2%
Physical & Occupational Therapy	485,128	585,523	20.7%	707,191	45.8%
Plastic Surgery	1,635	1,907	16.7%	2,242	37.2%
Podiatry	10,317	11,714	13.5%	13,212	28.1%
Psychiatry	119,077	169,735	42.5%	231,585	94.5%
Pulmonary	41,480	46,869	13.0%	53,418	28.8%
Radiation Therapy	18,767	21,687	15.6%	24,922	32.8%
Single Photon Emission CT Scan (SPECT)	2,314	2,652	14.6%	3,121	34.9%
Urology	13,678	16,134	18.0%	19,002	38.9%
Vascular Surgery	5,705	6,702	17.5%	7,819	37.1%
TOTAL	**5,330,344**	**6,279,939**	**17.8%**	**7,353,510**	**38.0%**

Source: IBM Watson Health Outpatient Procedure Estimates, 2020.

Emergency department visits

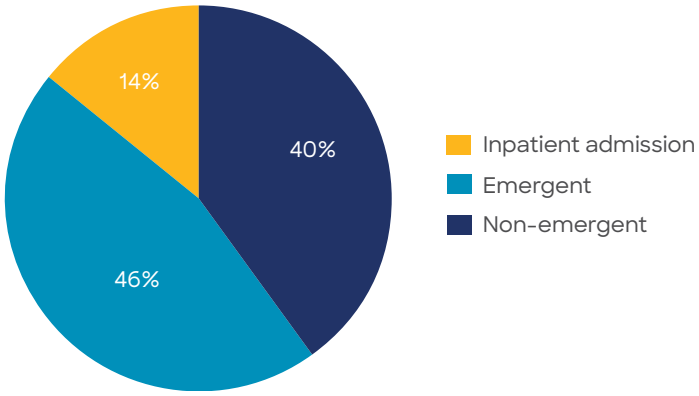
Emergency department estimates predict the total annual volume of emergency department (ED) visits by ZIP code and level of acuity for every market in the United States. IBM uses an extensive supply of proprietary claims, public claims and federal surveys to construct population-based use rates for all 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 Waxahachie Health Community, ED visits are expected to grow by 10% by 2025.

Emergent status	2020 visits	2025 visits	2020 - 2025 visits change	2020 - 2025 visits % change
Emergent	51,750	58,552	6,802	13.1%
Inpatient Admission	14,976	17,530	2,555	17.1%
Non-Emergent	48,812	51,440	2,629	5.4%
TOTAL	**115,537**	**127,523**	**11,985**	**10.4%**

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 Waxahachie Health Community, the most common heart disease is hypertension at 72.5% of all heart disease cases.

Disease type	2020 prevalence	2020 % prevalence
Arrhythmia	8,206	11.7%
Heart Failure	4,309	6.1%
Hypertension	50,865	72.5%
Ischemic Heart Disease	6,750	9.6%
TOTAL	**70,130**	**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 almost 12% in the Waxahachie Health Community by 2025.

Cancer type	2020 incidence	2025 incidence	2020 - 2025 change	2020 - 2025 % change
Bladder	42	50	8	19.3%
Brain	19	21	2	11.7%
Breast	213	245	32	15.2%
Colorectal	112	105	-7	-6.0%
Kidney	46	55	9	19.8%
Leukemia	29	34	5	17.2%
Lung	101	115	14	13.6%
Melanoma	45	54	9	19.5%
Non-Hodgkin's Lymphoma	47	55	8	17.1%
Oral Cavity	30	35	5	16.6%
Other	89	104	16	17.8%
Ovarian	16	17	2	10.9%
Pancreatic	28	34	6	22.1%
Prostate	121	119	-2	-1.5%
Stomach	17	19	2	12.2%
Thyroid	29	33	5	15.8%
Uterine Cervical	7	7	0	4.0%
Uterine Corpus	31	37	5	17.4%
TOTAL	**1,021**	**1,141**	**120**	**11.7%**

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

Facility: Baylor Scott & White Medical Center – Waxahachie

Community served: Dallas and Ellis Counties

Ratio of population to primary care providers (physician/non-physician)

Baylor Scott & White Medical Center – Waxahachie

Action/tactics	Anticipated outcome	Evaluation of impact
Cash and in-kind donations Cash and in-kind contributions to other not-for-profit community organizations existing to increase access to care for the community.	Increased access to care in the community.	• **Persons served: 80** • **$160,039 community benefit**
Clinical training program Train non-physicians and other non-physician staff to relieve the identified workforce shortage.	Number of nurses and ancillary service line staff educated in the community.	• **Persons served: 560** • **$844,848 community benefit**
Workforce development Plan to add additional staff to manage the identified medically underserved areas of family medicine, internal medicine, general obstetrics/gynecology, gerontology, behavioral health and community health.	Increased number of physicians available to the community.	• **Persons served: unknown** • **$1,019,875 community benefit**
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 healthcare for uninsured populations.	• **Persons served: unknown** • **$23,915,727 community benefit**

Action/tactics	Anticipated outcome	Evaluation of impact
Enrollment services The hospital will conduct enrollment services to assist in the qualification of the medically underserved for programs enabling access to care, such as Medicaid, Medicare, SCHIP and other government programs or charity care programs.	Increased access through qualifications for provision of services by those accepting means-tested government programs.	• **Persons served: 926** • **$96,226 community benefit**
Community health education Community health education programs for underserved and underinsured populations.	Increased awareness of health conditions/ illnesses, signs and symptoms.	• **Persons served: 3,062** • **$3,536 community benefit**

Total investment in adopted community needs since 2019 CHNA

BSWMC – Waxahachie

$26 million