Community Health Needs Assessment 2016

North Texas Zone 4

Baylor Scott & White Medical Center – Waxahachie

The prioritized list of significant health needs has been presented and approved by the hospital facilities' governing body, and the full assessment must be made available to the public at no cost for download on our website at BaylorScottandWhite.com/CommunityNeeds or upon request. Retain this document through the fiscal year ending June 30, 2020.

Approved by: Baylor Scott & White Health – North Texas Operations Board on May 31, 2016

Posted to BaylorScottandWhite.com/CommunityNeeds on June 30, 2016

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Baylor Scott & White Health Mission Statement

OUR MISSION

Baylor Scott & White Health exists to serve all people by providing personalized health and wellness through exemplary care, education and research as a Christian ministry of healing.

"Personalized health" refers to our commitment to develop innovative therapies and procedures focusing on predictive, preventive and personalized care. For example, we'll use data from our electronic health record to help us predict the possibility of disease in a person or a population. And with that knowledge, we can put measures in place to either prevent the disease altogether or significantly decrease its impact on the patient or the population. We'll tailor our care to meet the individual medical, spiritual and emotional needs of our patients.

"Wellness" refers to our ongoing effort to educate the people we serve, helping them get healthy and stay healthy.

"Christian ministry" reflects the heritage of Baylor Health Care's founders and Drs. Scott and White, who showed their dedication to the spirit of servanthood — to equally serve people of all faiths and those of none.

WHO WE ARE

In 2013, Baylor Health Care System and Scott & White Healthcare became one.

The largest not-for-profit health care system in Texas, and one of the largest in the United States, Baylor Scott & White Health (BSWH) was born from the 2013 combination of Baylor Health Care System and Scott & White Healthcare.

Known for exceptional patient care for more than a century, the two organizations serve adjacent regions of Texas and operated on a foundation of complementary values and similar missions. BSWH includes 41 licensed hospitals, more than 900+ patient care sites, more than 6,600 active physicians, 43,750+ employees and the Scott & White Health Plan.

Over the years, Baylor and Scott & White worked together as members of the High Value Healthcare Collaborative, the Texas Care Alliance and Healthcare Coalition of Texas and were two of the best known, top-quality health care systems in the country, not to mention in Texas.

After years of thoughtful deliberation, the leaders of Baylor Health Care System and Scott & White Healthcare decided to combine the strengths of the two health systems and create a new model system able to meet the demands of health care reform, the changing needs of patients and extraordinary advances in clinical care.

With a commitment to and a track record of innovation, collaboration, integrity and compassion for the patient, BSWH stands to be one of the nation's exemplary health care organizations.

OUR CORE VALUES & QUALITY PRINCIPLES

Our values define our culture and should guide every conversation, decision and interaction we have with each other and with our patients and their loved ones:

- *Integrity*: Living up to high ethical standards and showing respect for others
- *Servanthood*: Serving with an attitude of unselfish concern
- *Teamwork:* Valuing each other while encouraging individual contribution and accountability
- *Excellence*: Delivering high quality while striving for continuous improvement
- *Innovation*: Discovering new concepts and opportunities to advance our mission
- *Stewardship*: Managing resources entrusted to us in a responsible manner

Executive Summary

As the largest not-for-profit health care system in Texas, BSWH understands the importance of serving the health needs of its communities. And in order to do that successfully, we must first take a comprehensive look at the issues our patients, their families, and neighbors face when it comes to making healthy life choices and health care decisions.

Beginning in the summer of 2015, a BSWH task force led by the community benefit, tax compliance, and corporate marketing departments began the process of assessing the current health needs of the communities we serve for all BSWH hospitals. Truven Health Analytics was engaged to help collect and analyze the data for this process and to compile a final report made publicly available in June of 2016.

For the 2016 assessment, Baylor Scott & White Medical Center – Waxahachie has defined its community to be the geographical area of Ellis County. The community served was determined based on the county that made up at least 75 percent of the hospital facility's inpatient and outpatient admissions over a period of the past 12 months.

With the aid of Truven Health Analytics, we examined nearly 70 public health indicators and conducted a benchmark analysis of this data comparing the community to overall state of Texas and U.S. values. For a qualitative analysis, and in order to get input directly from the community, we conducted focus groups that included representation of minority, underserved, and indigent populations' needs and interviewed several key informants in north Texas who were community leaders and public health experts.

Significant community health needs were identified through the weight of quantitative and qualitative data obtained when assessing the community. Needs which were supported by data showing the community to be worse than the state by a greater magnitude and also were a frequent theme during interviews and focus groups were determined to be significant.

These significant needs were prioritized based on input gathered from the focus groups and interviews. Participants of these focus groups and interviews were asked to rank the top three health needs of the community based on the importance they placed on addressing the need. Through this process, the health needs were prioritized based on the frequency they were listed as the top health care needs. The prioritized health needs of this community are below:

1. Physician and non-physician primary care providers to population ratio
2. Mental/behavioral health resources
3. Chronic disease
4. Heart failure
5. Excessive drinking

Also, as part of the assessment process, both internal resources and community resources and facilities were distinguished that may be available to address the significant needs in the community. They are identified in the body of this report and will be included in the formal implementation strategy to address needs identified in this

assessment that will be approved and made publicly available by the 15th day of the 5th month following the end of the tax year.

An evaluation of the impact and effectiveness of interventions and activities outlined in the implementation strategy drafted after the 2013 assessment was also completed and is included in Appendix C of this document.

The prioritized list of significant health needs has been presented and approved by the hospital facilities' governing body, and the full assessment is available to the public at no cost for download on our website at BaylorScottandWhite.com/CommunityNeeds.

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

Community Health Needs Assessment Requirement

As a result of the Patient Protection and Affordable Care Act (PPACA), all tax-exempt organizations operating hospital facilities are required to assess the health needs of their community through a Community Health Needs Assessment (CHNA) once every three years. A CHNA is a written document developed for a hospital facility that defines the community served by the hospital facility; the process used to conduct the assessment including how the hospital took into account input from community members including those from public health department(s) and members or representatives of medically underserved, low-income, and minority populations; identification of any organizations with whom the hospital has worked on the assessment; and the significant health needs identified through the assessment process.

The written CHNA report must include descriptions of the following:

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

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

The written Implementation Strategy must include the following:

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

- Describe any planned collaboration between the hospital and other facilities or organizations in addressing the health needs

A CHNA is considered conducted in the taxable year that the written report of its findings, as described above, is approved by the hospital's governing body and made widely available to the public. The Implementation Strategy is considered adopted on the date it is approved by the governing body. Organizations must approve and make public their Implementation Strategy by the 15th day of the 5th month following the end of the tax year in which the CHNA was performed. CHNA compliance is reported on IRS Form 990, Schedule H.

This assessment is also intended to meet the requirements for community benefit planning and reporting as set forth in the Texas Health and Safety Code Chapter 311 applicable to Texas nonprofit hospitals.

Baylor Scott & White Health: Community Health Needs Assessment Overview, Methodology and Approach

BSWH partnered with Truven Health Analytics (Truven Health) to complete a CHNA for Baylor Scott & White Medical Center – Waxahachie.

Consultant Qualifications & Collaboration

Truven Health and its legacy companies have been delivering analytic tools, benchmarks, and strategic consulting services to the healthcare industry for over 50 years. Truven Health combines rich data analytics in demographics (including the Community Needs Index, developed with Catholic Healthcare West, now Dignity Health), planning, and disease prevalence estimates with experienced strategic consultants to deliver comprehensive and actionable Community Health Needs Assessments.

Defining the Community Served

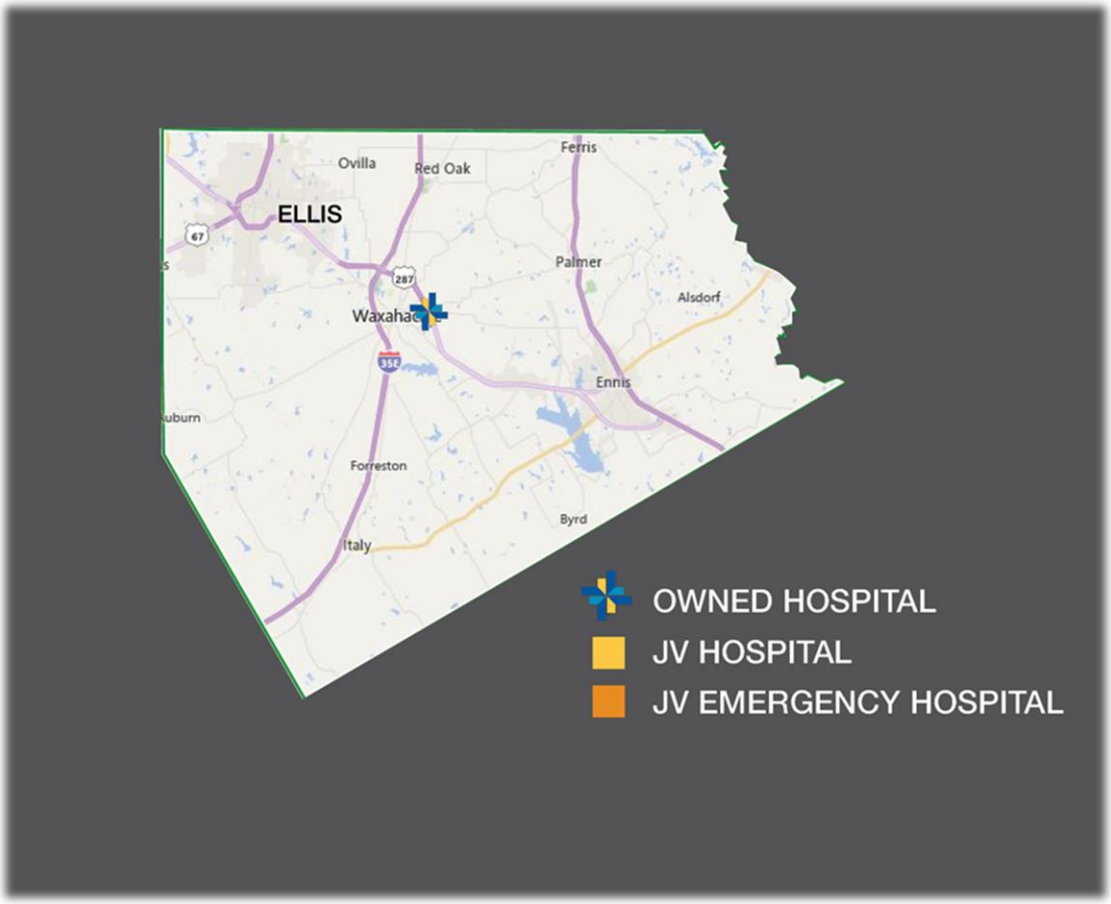
BSWH owns and operates multiple individual licensed hospital facilities serving the residents of North and Central Texas. Certain of these hospital facilities have overlapping communities and have collaborated to conduct a joint community health needs assessment. The community served definitions used in this current assessment differ from those used by the legacy Baylor Health Care System and the legacy Scott & White Healthcare in their previously conducted (2013) CHNAs. The current organization, BSWH, has chosen a common methodology and approach to define the communities served for each of its facilities.

For the current assessment, to define the community served by the BSWH hospital facility listed above, BSWH identified the county accounting for at least 75 percent of the facility's total volume (based on the most recent 12 months of inpatient and outpatient data).

BSWH Community Health Needs Assessment Community Served Definition

For the 2016 assessment, Baylor Scott & White Medical Center – Waxahachie has defined their community to be the geographical area of Ellis County. The community served was determined based on the county that made up at least 75 percent of the hospital facility's inpatient and outpatient admissions.

BSWH Community Health Needs Assessment
Map of Community Served



Assessment of Health Needs – Methodology and Data Sources

To assess the health needs of the community served, a quantitative and qualitative approach was taken. In addition to collecting data from a number of public and Truven Health proprietary sources, interviews and focus groups were conducted with individuals representing public health, community leaders/groups, public organizations, and other providers.

Quantitative Assessment of Health Needs

Quantitative data in the form of public health indicators were collected and analyzed to assess community health needs. Eight categories of seventy-nine indicators were collected and evaluated for the county where data were available. The categories and indicators are included in the table below and the sources of these indicators can be found in ***Appendix A***.

Population
- High School Graduation Rate
- High School Drop Outs
- Some College
- Births to Unmarried Women
- Children in Poverty
- Children in Single-Parent Households
- Income Inequality
- Poverty
- Disability
- Social Associations
- Children Eligible for Free Lunch
- Homicides
- Violent Crime

Injury & Death
- Heart Disease Death Rate
- Overall Cancer Death Rate
- Chronic Lower Respiratory Disease (CLRD) Death Rate
- Stroke Death Rate
- Infant Mortality
- Child Mortality
- Premature Death
- Motor Vehicle Crash Mortality Rate

Mental Health
- Mental Health Providers
- Poor Mental Health Days

Prevention
- Diabetic Screening
- Mammography Screening
- Flu Vaccine 65+

Health Outcomes
- Poor or Fair Health
- Average Number of Poor Physical Unhealthy Days in Past Month
- Cancer (all causes) Incidence
- Breast Cancer
- Colon Cancer
- Lung Cancer
- Prostate Cancer
- Diabetes
- Stroke
- Arthritis
- Alzheimer's/ Dementia
- Atrial Fibrillation
- COPD
- Kidney Disease
- Depression
- Heart Failure
- Hyperlipidemia
- Heart Disease
- Schizophrenia
- Osteoporosis
- HIV Prevalence
- Prenatal Care
- Smoking During Pregnancy
- Low Birth Rate
- Very Low Birth Rate
- Preterm Births

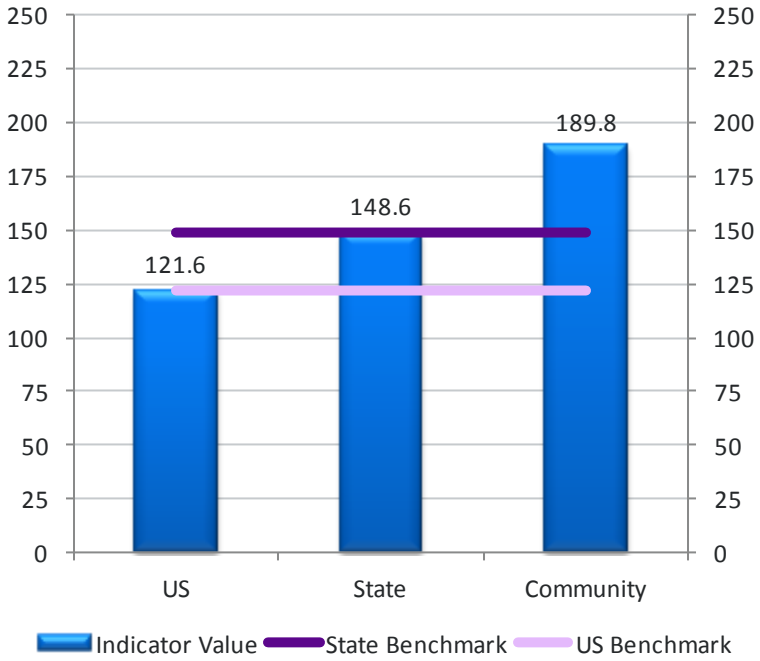
Health Behaviors
- Obesity
- Childhood Obesity
- Physical Inactivity
- No Exercise
- Adult Smoking
- Excessive Drinking
- Teen Birth Rate
- Sexually Transmitted Infections
- Alcohol Impaired Driving Deaths
- Drug Poisoning Deaths

Access to Care
- Uninsured
- Uninsured Children (<17)
- Could Not See a Doctor Due to Cost
- Other Primary Care Providers
- Dentists
- Preventable Hospital Stays
- Affordability of Healthcare
- Healthcare Costs

Environment
- Limited Access to Healthy Foods
- Food Insecurity
- Food Environment Index
- Access to Exercise Opportunities
- Air Quality/ Pollution
- Drinking Water
- Housing
- Commute/ Long
- Commute/ Alone

In order to determine which public health indicators demonstrated a community health need, a benchmark analysis was conducted for each indicator collected in the community served. Benchmark health indicators collected included (when available): overall US values, state of Texas values, and goal setting benchmarks such as Healthy People 2020 and/or County Health Rankings Best Performer values.

Health Indicator Benchmark Analysis Example



Source: Truven Health Analytics, 2016

According the America's Health Rankings, Texas ranks 34th out of the 50 states. The health status of Texas compared to other states in the nation identifies many opportunities to impact health within local communities, even for those communities that rank highly within the state. Therefore, the benchmark for the community served was set to the state value. Needs were identified when one or more of the indicators for the community served did not meet state benchmarks. An index of magnitude analysis was then conducted on those indicators that did not meet state benchmarks in order to understand to what degree they differed from the benchmark and in order to understand their relative severity of needs.

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

Qualitative Assessment of Health Needs (Community Input)

In addition to analyzing quantitative data, focus groups with ten (10) participants, as well as eight (8) key informant interviews, were conducted September through November of 2015 in order to take into account the input of persons representing the broad interests of the community served. The focus groups and interviews were conducted to solicit feedback from leaders and representatives who serve the community and have insight into community needs.

The focus group was designed to familiarize participants with the CHNA process and gain a better understanding of priority health needs from the community's perspective. Focus groups were formatted for individual as well as small group feedback and also helped identify other community organizations already addressing health needs in the community.

Truven Health also conducted key informant interviews for the community served. The interviews were designed to help understand and gain insight into how participants felt about the general health status of the community and the various drivers which contributed to health issues.

In order to qualitatively assess the health needs for the community, participation was solicited from at least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community; as well as individuals or organizations serving and/or representing the interests of medically underserved, low-income, and minority populations in the community.

In order to ensure the input received also represented the broad interests of the community served, participation was also sought from community leaders/groups, public health organizations, other healthcare organizations, and other healthcare providers (including physicians).

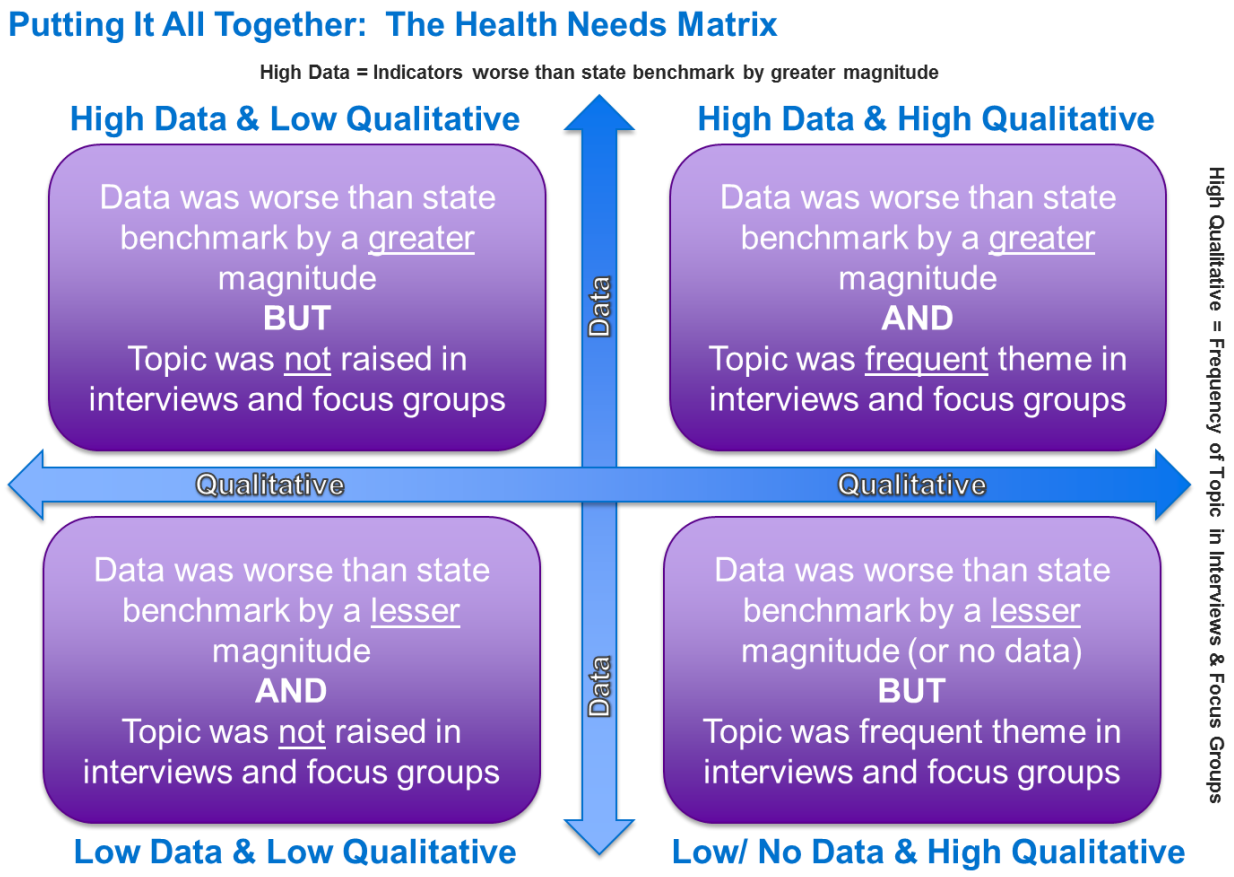
In addition to soliciting input from public health and various interests of the community, hospitals are also required to take into consideration written input received on their most recently conducted CHNA and subsequent implementation strategies. The facilities each have an active portal on the website where the assessment has been made available asking for public comment or feedback on the report findings. This information is located at BaylorHealth.com/CommunityNeeds. To date we have not received such written input but continue to welcome feedback from the community.

Input collected from the participants during the interviews and focus groups was organized into themes around community needs and compared to the quantitative data findings.

Methodology for Defining Community Need

Using qualitative feedback from the interviews and focus group, as well as the health indicator data, the issues currently impacting the community served were consolidated and assembled in the Health Needs Matrix below in order to identify the significant health needs for each community served.

The upper right quadrant of the matrix is where the qualitative data (interview and focus group feedback) and quantitative data (health indicators) converge. For the sake of this analysis, the upper right quadrant contains the most significant health needs identified.



Source: Truven Health Analytics, 2016

Information Gaps

The majority of public health indicators were only available at the county level; and in Texas, health indicators were not available for every county due to variation in population density. In evaluating data for entire counties versus more localized data, it was difficult to understand the health needs for specific population pockets within a county. It can also be a challenge to tailor programs to address community health needs as placement and access to those programs in one part of the county may or may not actually impact the population who truly need the service. Truven Health supplemented health indicator data with Truven Health's ZIP code estimates to assist in identifying specific populations within a community where health needs may be greater.

Existing Resources to Address Health Needs

Part of the assessment process included gathering input on community resources potentially available to address the significant health needs identified through the CHNA. A description of these resources is provided in ***Appendix B***.

Prioritizing Community Health Needs

The prioritization of community health needs identified through the assessment was based on the weight of quantitative and qualitative data obtained when assessing the community. A thorough description of the process can be found in the "Prioritizing Community Health Needs" section of the assessment.

Evaluation of Implementation Strategy Impact

As part of the current assessment, BSWH conducted an evaluation of the implementation strategies adopted as part of the 2013 CHNAs. In 2013, the facilities chose to address the following identified needs:

- Access to care for low income population/underserved
- Behavioral health
- Care coordination and care transitions
- Emergency and urgent care
- Dental care
- Multiple chronic conditions
- Prenatal care
- Preventive health screenings
- Patient safety and hospital acquired conditions

An implementation strategy was put into place in 2013 to address the above needs. That strategy has been evaluated as to its effectiveness and impact. Details for that evaluation can be found in ***Appendix C***.

Demographic and Socioeconomic Summary

According to population statistics, Ellis County is expected to grow 6%, or 10,029 people in the next five years. That population growth rate is lower than Texas overall (7%) but higher than the country (4%). The community had a slightly higher median household income than both state and national benchmarks, along with a less racially diverse population. Ellis County had slightly greater proportion of seniors than the other North Texas communities. The community, overall, appears to be at an advantage in terms of fewer social barriers experienced by its population with the exception of a slightly higher unemployment rate than the state benchmark.

Demographic and Socioeconomic Comparison: Community Served and State/US Benchmarks

Demographic / Socioeconomic Variable	Benchmarks		Community Served
	United States	Texas	
Total Current Population	319,459,991	27,037,393	167,158
5 Yr Proj Pop Chg	4%	7%	6%
Population 0-17	23%	26%	27%
Population 65+	15%	12%	12%
Women Age 15-44	20%	21%	20%
Non-White Population	29%	31%	26%
Median HH Income	$56,682	$56,653	$61,036
Limited English	5%	8%	4%
No High School Diploma	14%	19%	16%
Un-employed	10%	8%	9%
Insurance Coverage: Medicaid	19%	14%	12%
Insurance Coverage: Uninsured	10%	20%	14%
Poverty	16%	18%	12%

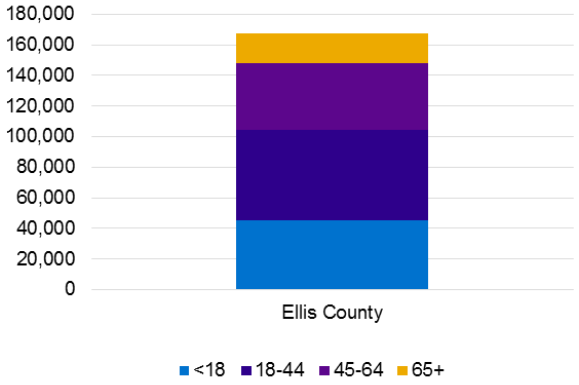
Source: Truven Health Analytics, 2015

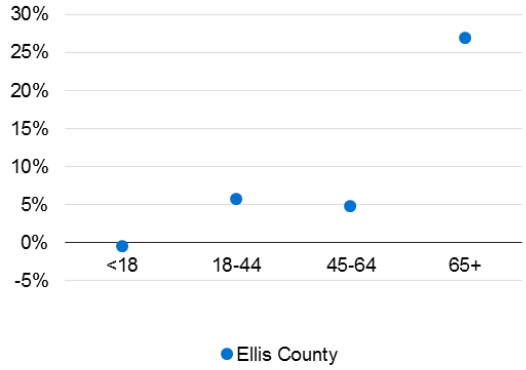
Ellis County is expected grow 6.4% (10,645 people) over the next five years. The ZIP codes with the highest expected growth rate in the next five years are:

- 76065 Midlothian – 3,119 people
- 75165 Waxahachie – 2,672 people

Growth is projected for every ZIP code in the county, but there is significant variation in the expected change between age groups. The population of children aged 0-17 will not change much, but Ellis County is expected to see a significant (27%) increase in 65+ population over the next 5 years, which is about 5,259 people. The 65+ senior cohort is expected to experience the most growth over the next five years in most markets. Growth in this population will likely contribute to increased utilization of services as the population continues to age.

Population by Age Cohort



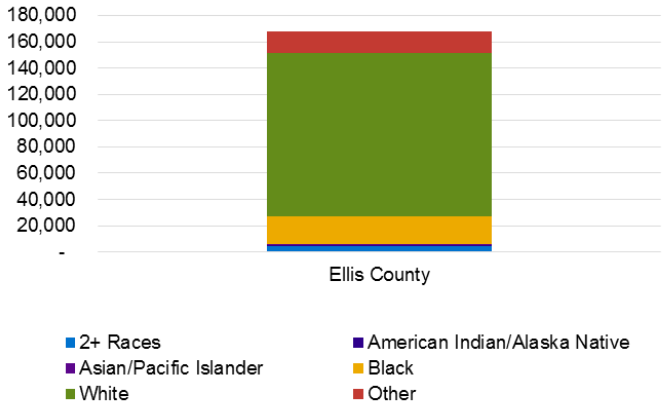


Source: Truven Health Analytics / The Nielsen Company, 2015

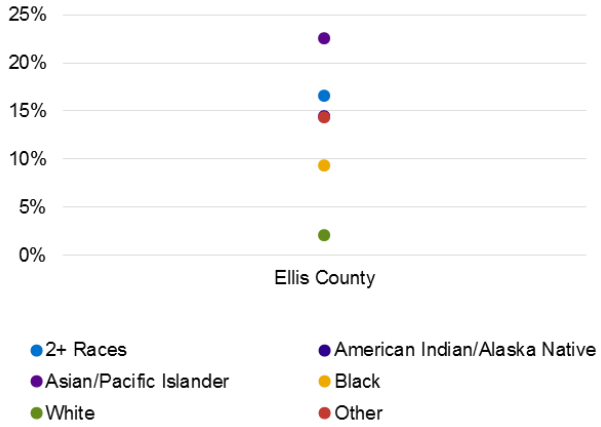
Diversity in the community is projected to increase. Currently in Ellis County, 70% of the population was white (124,379 people) and 25% were of Hispanic ethnicity (42,289 people). The projected growth of minority populations, including Asian/Pacific Islanders and Hispanics, is expected to outpace all other groups. The Hispanic population will increase by 5,872 people by 2020.

Population by Race

2015 Total Population



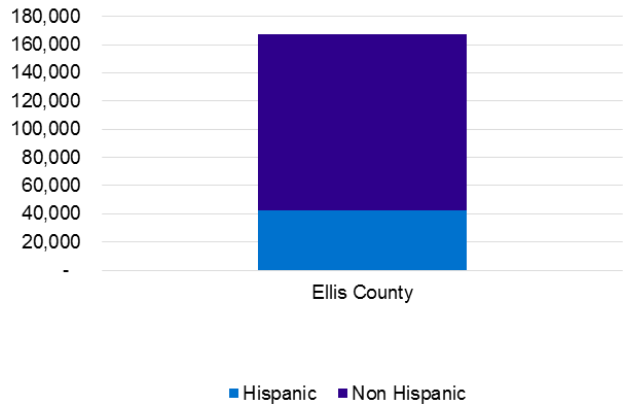
5 Year Projected Population Growth Rate



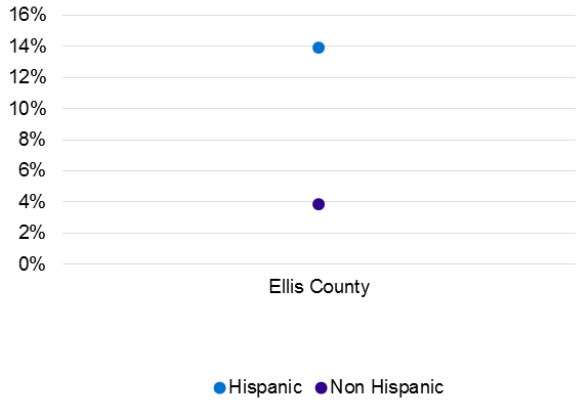
Source: Truven Health Analytics / The Nielsen Company, 2015

Population by Hispanic Ethnicity

2015 Total Population



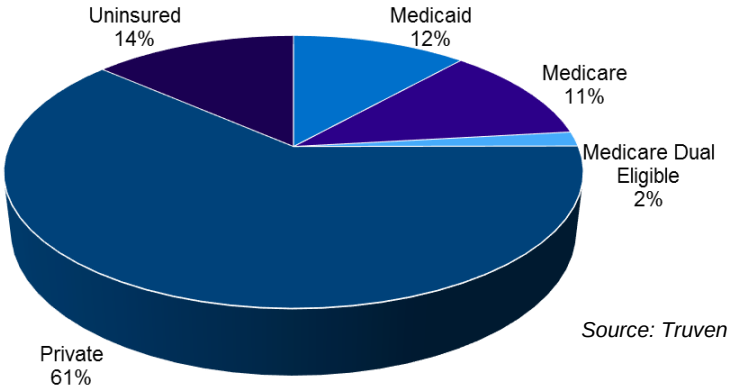
5 Year Projected Population Growth Rate



Source: Truven Health Analytics / The Nielsen Company, 2015

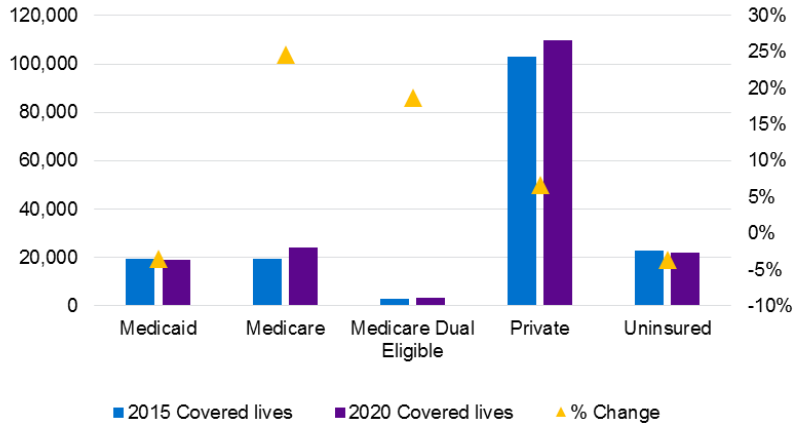
The median household income for the community served is $61,036, greater than both the state and U.S. benchmarks. The current insurance coverage mix in the market will shift significantly by 2020. Sixty-one percent of the population currently had private (commercial) insurance, and that's projected to increase 7% (7,000 people) over the next five years. Medicare and Dual Eligible insured people (those receiving both Medicare and Medicaid benefits) will see the largest percentage increases of 25% and 19%, respectively. Conversely, there will be decrease in the population of uninsured (-4%) and Medicaid (-3%) populations over the next 5 years.

2015 Estimated Distribution of Covered Lives by Insurance Category



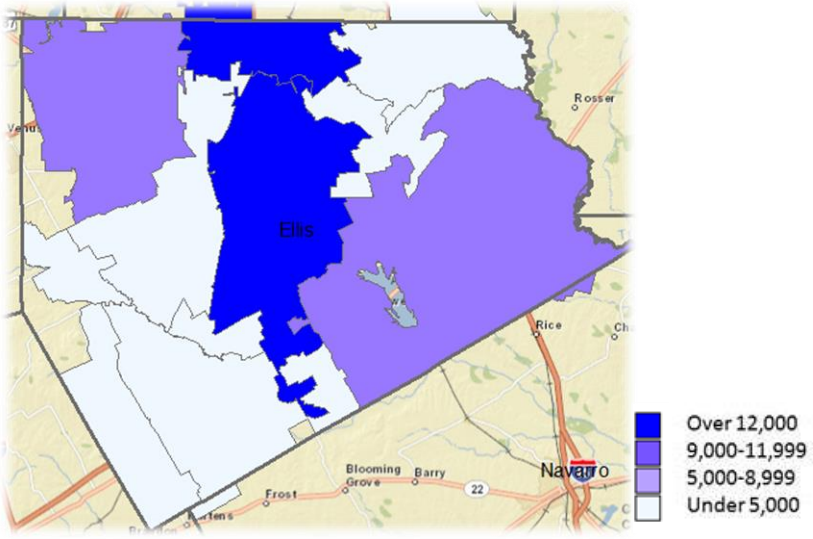
Source: Truven Health Analytics, 2015

Estimated Covered Lives and Projected Growth by Insurance Category



Source: Truven Health Analytics, 2015

2015 Estimated Uninsured Lives by ZIP Code



Source: Truven Health Analytics, 2015

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

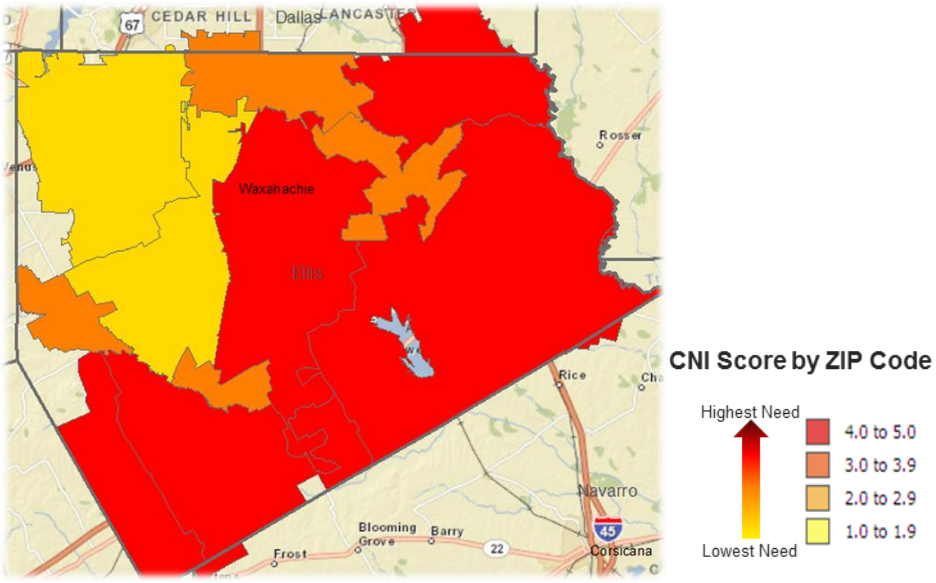
	Health Professional Shortage Area (HPSA)				Medically Underserved Area/Population (MUA/P)
COUNTY	Dental Health	Mental Health	Primary Care	TOTAL HPSA	TOTAL MUA/P
Ellis County	1	1	1	3	1

Health Professional Shortage Areas and Medically Underserved Areas and Populations

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

The community served was slightly above the community need index national average of 3.0, the overall county had a CNI of 3.5. Several areas of Ellis county scored 4.0 or higher on the index, especially the cities of Ennis, Ferris, Waxahachie, Italy, and Milford.

2015 Community Need Index by ZIP Code



Source: Truven Health Analytics, 2015

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, 2016

Public Health Indicators

Public health indicators were collected and analyzed to assess community health needs. Sixty-nine indicators were evaluated for the community served. For each health indicator, a comparison was made between the most recently available community data and benchmarks for the same/similar indicator. Benchmarks were based on available data and included the United States and the State of Texas. Health needs were identified where the county indicator did not meet the State of Texas comparative benchmark. The indicators that did not meet the state benchmark for this community include the following:

Category	Indicator
Access to Care	Ratio of population to one primary care physician
Access to Care	Ratio of population to one non-physician primary care provider
Access to Care	Ratio of population to one dentist
Environment	Population with adequate access to locations for physical activity (percent)
Environment	Air pollution - particulate matter (daily density)
Environment	Driving alone to work (percent of workforce)
Environment	Long commute - driving alone (percent of workers who commute by car)
Health Behaviors	Adults Engaging in Binge Drinking During the Past 30 Days (percent)
Health Behaviors	Driving deaths with alcohol involvement (percent)
Health Outcomes	Average number of physically unhealthy days reported in past 30 days (age-adjusted)
Health Outcomes	Cancer incidence
Health Outcomes	Female breast cancer incidence
Health Outcomes	Colon cancer incidence
Health Outcomes	Lung cancer incidence
Health Outcomes	Prostate cancer incidence
Health Outcomes	Adults reporting diagnosed with diabetes
Health Outcomes	Arthritis: Medicare Population (percent)
Health Outcomes	Alzheimer's Disease/Dementia: Medicare Population (percent)
Health Outcomes	Atrial Fibrillation: Medicare Population (percent)
Health Outcomes	Heart Failure: Medicare Population (percent)
Health Outcomes	Pediatric Diabetes Short-term Complications Admission Risk-Adjusted-Rate
Health Outcomes	Adult Risk-Adjusted-Rate of Lower-Extremity Amputation Among Patients with Diabetes (per 100,000)
Health Outcomes	First trimester entry into prenatal care
Health Outcomes	Births to Mothers Who Smoked During Pregnancy (New Birth Certificate)
Health Outcomes	Very Low Birth Weight (VLBW) (percent)
Health Outcomes	Preterm Births <37 weeks gestation
Injury & Death	Cancer Deaths total (per 100,000)
Injury & Death	Chronic Lower Respiratory Disease (CLRD) Death Rate (per 100,000)
Injury & Death	Stroke Death Rate (per 100,000)
Injury & Death	Infant Mortality (rate per 1,000)
Mental Health	Ratio of population to one mental health provider
Population	Some College (percent)

Population	Individuals Who Report Being Disabled (percent)

Truven Health Community Data

Truven Health Analytics supplemented the publically available data with estimates of localized disease prevalence of heart disease and cancer as well as emergency department visit estimates.

Unsurprisingly, Truven Health estimated hypertension as the most prevalent heart disease diagnoses in Ellis County with 39,867 cases. There are four cities in the community that accounted for almost 90% of each heart disease type within Ellis County: Waxahachie, Red Oak, Midlothian, and Ennis.

2015 Estimated Heart Disease Cases

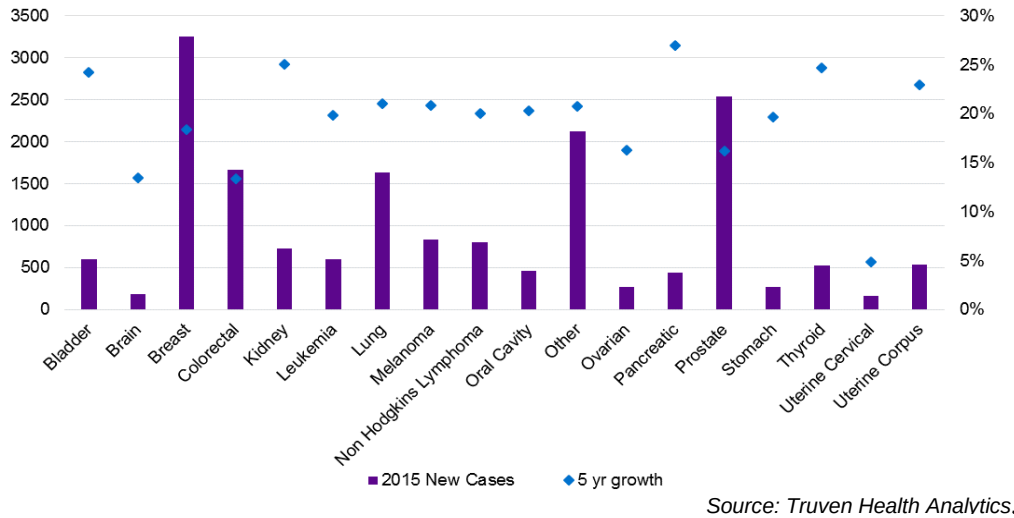
Disease Type	Ellis County
ARRHYTHMIAS	5,747
CONGESTIVE HEART FAILURE	3,513
HYPERTENSION	39,867
ISCHEMIC HEART DISEASE	5,934

Note: Prevalence cannot be aggregated across heart disease categories due to co-morbidity between heart disease types.

Source: Truven Health Analytics, 2015

Truven Health's 2015 Cancer Estimates showed the highest current cancer volumes are for bladder, kidney, melanoma, pancreatic and thyroid cancers, and growth over the next five years are expected to be greater than 20%. The greatest growth rates are projected for bladder, kidney, pancreatic and thyroid cancers. Overall, cancer incidence is currently higher than state benchmark.

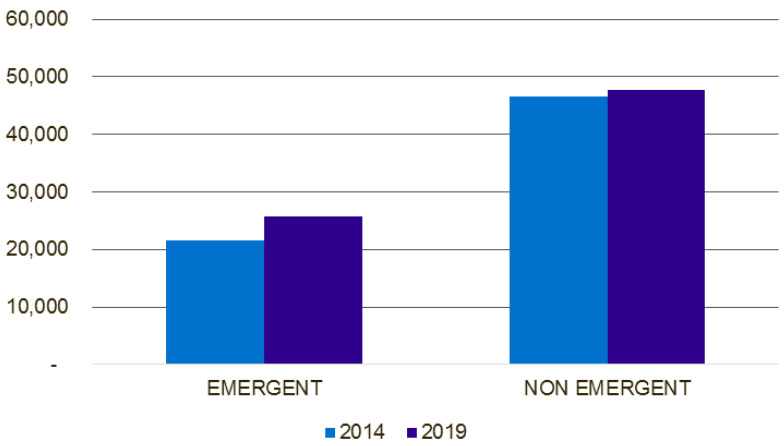
New Cases and Projected Growth by Cancer Type



Source: Truven Health Analytics.

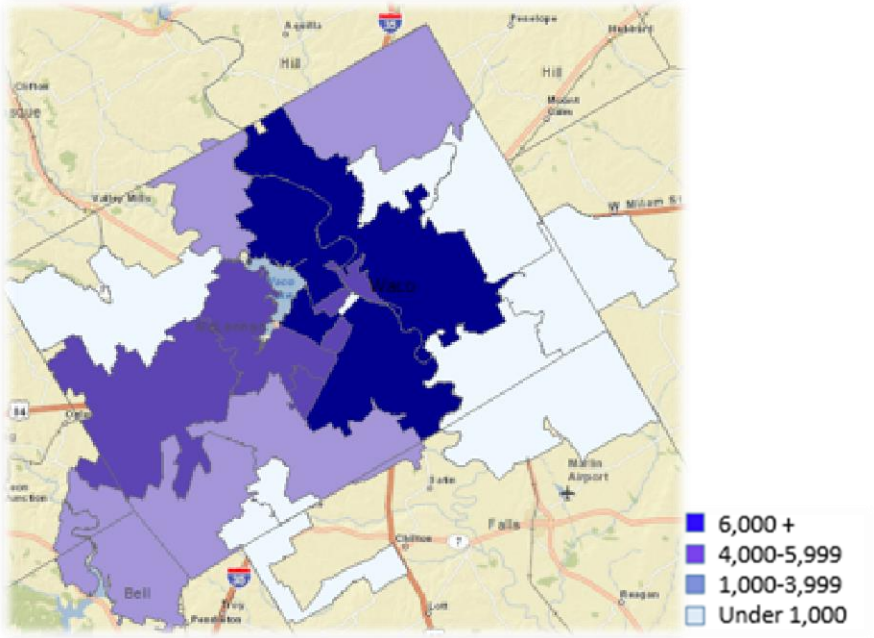
Outpatient emergency department visits are those that are treated and released and therefore do not result in an inpatient admission. Truven Health estimated the highest volume of outpatient emergency department visits in Ellis County was expected to come from the cities of Waxahachie and Red Oak, which will account for over 50% of the total volume in the community. The overall volume is expected to grow 8% over the next 5 years, including a 3% growth in non-emergent visits and a 20% growth in emergent visits. Non-emergent outpatient ED visits are lower acuity visits that present in the ED but can be treated in other more appropriate and less intensive outpatient settings. Non-emergent ED visits can be an indication that there are systematic issues with access to primary care or managing chronic conditions.

Emergent and Non-Emergent ED Visits



Source: Truven Health Analytics, 2015

2014 Estimated Non-Emergent Visits by ZIP Code



Source: Truven Health Analytics, 2015

Interviews & Focus Groups

In the interview sessions, the participants were asked what factors contribute to the current health status of the community. Factors the participants considered included access to care and providers, lack of preventative health and wellness among those in poverty, infant mortality rates, and challenges around serving those of different cultures.

For the community served, the top five health needs identified in the interview process included:

1. Prevalence of chronic conditions and diseases (diabetes, cardiac/CHF, vascular, obesity, hypertension, asthma)
2. Challenges with access to healthcare (affordability, provider capacity, behavior/ mental health services and resources, dental care, primary care, specialty care and medical homes)
3. Mental/ behavioral health services (access and resources, service availability)
4. Community health and wellness (adult obesity)
5. Service integration between primary care and behavioral/ mental health

Barriers to good healthcare in this community include socioeconomic status (poverty), lack of access to healthy food options, limited public transportation, delays in seeking/receiving care and linguistic isolation.[2] The following populations were identified as vulnerable groups that will need special attention when addressing health needs:

- Seniors
- Homeless
- Immigrants / refugees
- Non-English speaking
- Working poor / indigent
- LGBT

Focus group participants were asked what factors contribute to the current health status of the community. Factors discussed by the group included significant uninsured and underinsured population and access to physicians for that population. Other problems identified were inadequate mental health services, challenges with managing the growing homeless population and poor performance on most public health indicators.

The counties in north Texas range from low to high on the socioeconomic scale. All counties are experiencing significant population growth across the board with the Hispanic, African American and Asian populations showing notable changes. Public transportation has been identified as available but not meeting the needs of the indigent, low income and senior populations. Transportation to medical appointments and to support of other aspects of health (such as to stores for fruits and vegetables; to parks for exercise and recreation) is lacking.

[2] A linguistically isolated household is one in which no member 14 years old and over speaks only English or speaks a non-English language and speak English “very well”. In other works all household members 14 years old and over have at least some difficulty with English., U.S. Census Bureau, 2000

While there is a growing number of clinics and FQHCs, the group identified access as a significant problem for the low income, under and uninsured populations. A shortage of mental health providers, primary care physicians and bi-lingual physicians exacerbates the problem. Many specialty physicians will not take under-insured or uninsured patients, which magnifies the complexity to the issue. The lack of Medicaid expansion dollars has contributed to the low acceptance of Medicaid patients in Dallas, which causes a significant gap in the ability for the under-insured/uninsured to access quality medical care. The physician Medicaid acceptance rate is the lowest in the country at 18% (per the participants). The community is also seeing rising teen pregnancy rates, STD rates and homelessness. The homeless population faces many challenges including; limited or no transportation, access to medication, medical compliance, chronic illness and comorbidities. Some have not seen a physician for five to ten years or more. Clinics struggle with managing the care of the homeless population as they have no way to contact or follow up with these patients who do not have a permanent address.

The group believes that political parties in the area are not focused on the community health needs and there is no influential “lobby” for healthcare issues that impact the community. Additionally, there is polarization amongst political parties on certain health issues. For example, a very successful program was in place several years ago to reduce teen pregnancy. The program was very effective but unsustainable due changing political agendas and diminishing resources around to sex education. As a result, improved rates around teen pregnancy have regressed.

Some of the positive feedback included the community’s movement towards safe and walkable neighborhoods and quality hospital care. It was acknowledged that there have been efforts to retain new physicians in the community after graduation from local medical schools.

The focus group identified the following top community health needs:

- Mental health awareness – addressing stigma and cultural barriers around seeking care
- Access to care – especially for low to middle income population and seniors who lack transportation
- Preventative care – creating partnerships with community entities for education and awareness
- Preventative care – promoting wellness and healthy living by creating safe, healthy, holistic environments
- Promoting health and wellness
- Transportation – access to care and in support of healthy lifestyles
- Diabetes – addressing the rate of diabetes among the population and managing diabetic care
- Teens – pregnancies and drug abuse

Community resources were identified by the groups to address the top needs identified. ***Appendix B*** includes the list of existing community resources identified by the participants.

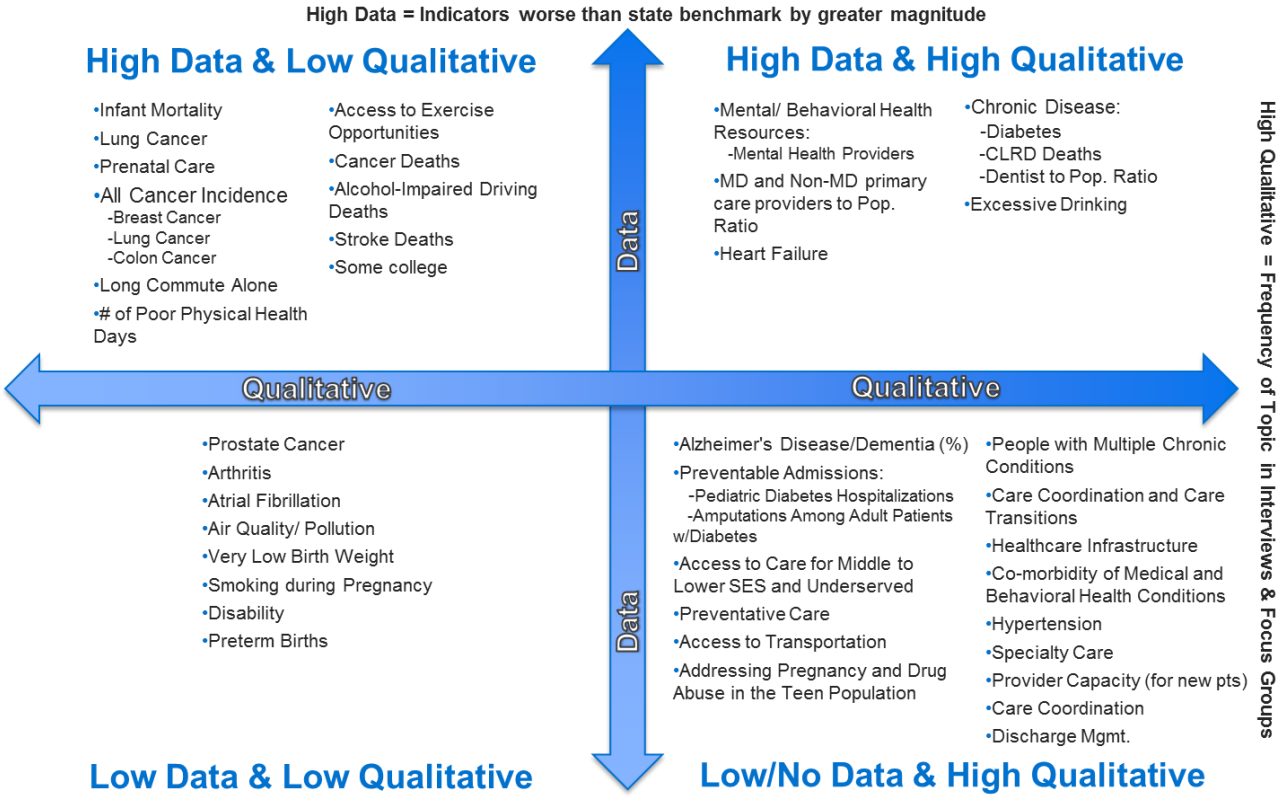
The interview and focus group participants and the populations they serve for this community are documented in the following table.

Focus Group and Key Informant Interview Participants					
Community Leaders/ Groups		**Public and Other Organizations**	**Other Providers**		
United Way of Tarrant County (Focus Group) **PH**	United Way of West Ellis County (Focus Group) **PH**	YWCA of Metropolitan Dallas (Focus Group) **MU**, **LI**	Metracrest Community Clinic (Focus Group) **MP**	Parkland Health & Hospital System (Interview) **MU**, **LI**	Christian Community Action (CCA) *2 participants* (Focus Group) **LI**
City Square (Interview) **MU**, **LI**	United Way of Denton County *2 participants* (Interview) **PH**	Collin County Health Care Services (Interview) **PH**, **LI**	Mental Health America of Greater Dallas (Focus Group) **MU**, **LI**, **CD**	JPS Health Network/ Regional Health Partnership District 10 (Interview) **LI**	AIDS Arms, Inc. (Focus Group) **LI**, **CD**
		Injury Prevention Center (IPC) of Greater Dallas, Parkland Health and Hospital System (Focus Group) **MU**, **MP**	Bridge-Breast Network (Focus Group) **LI**	Tarrant County Hospital District/ JPS Health Network Trinity Springs Pavilion for Psychiatric Services (Interview) **MU**, **LI**	Metrocare Services (Interview) **MU**, **LI**, **CD**, **MP**

Represents Public Health	Represents Medically Underserved Populations	Represents Low Income Populations	Represents Populations with Chronic Disease Needs	Represents Minority Populations
PH	**MU**	**LI**	**CD**	**MP**

Health Needs Matrix

Quantitative and qualitative data were analyzed and displayed as a health needs matrix to identify the most significant community health needs. Below is the matrix for the community served by Baylor Scott & White Medical Center – Waxahachie.



Source: Truven Health Analytics, 2016

Prioritizing Community Health Needs

Significant community health needs were identified through the weight of quantitative and qualitative data obtained when assessing the community. Criteria used to identify significant health needs were first, quantitative data about the need showed the community's results to be worse than the state's by a greater magnitude, and second, it was a frequent theme during the interviews and focus group.

These significant needs were prioritized based on input gathered from the focus groups and interviews. Participants of these focus groups and interviews were asked to rank the top three health needs of the community based on the importance they placed on addressing the need. Through this process, the health needs were prioritized based on the frequency they were listed as the top health care needs. The prioritized health needs of this community are below.

1. Physician and non-physician primary care providers to population ratio
2. Mental/behavioral health resources
3. Chronic disease
4. Heart failure
5. Excessive drinking

By addressing the above prioritized significant needs via an implementation strategy, BSWH hospitals aim to impact and elevate the overall health status of the community.

Description of the Health needs to be addressed

<u>Physician and non-physician primary care providers to population ratio</u>

A shortage of primary care physicians was identified as a priority need through key informant interviews and the focus group session. Specifically, there is an acute shortage of primary care providers and bilingual physicians. Many physicians will not take underinsured, uninsured or Medicaid patients, and this shortage of available doctors causes long wait times and limits access when care is needed.

The quantitative analysis validated the findings from the community's input. According to the Area Health Resource File, the population to primary care physician (PCP) ratio in Ellis County is 2,369:1, which is significantly above the state value of 1,708 and the County Health Rankings Top Performer's value of 1,045:1.[3] The ratio population to one non-physician primary care provider ratio was 3,058:1 in the county compared to the state value of 1,893:1.[4]

[3] Area Health Resource File / American Medical Association, 2012 Ratio of population to one primary care physician

[4] CMS, National Provider Identification File, 2014 Ratio of population to one non-physician primary care provider.

Mental/behavioral health resources and excessive drinking

Community input identified mental and behavioral health as a priority community health need, and it was reiterated through key informant interviews and the focus group session. Specifically, shortages in mental health providers significantly limit access to services. When compounded by delays in care and poor management of conditions, they often lead to a crisis situation for patients and their families. The participants expressed a need to address all categories of mental health, including substance abuse, behavioral health, psychiatric conditions and access to services. There are stigma and cultural barriers that surround the acknowledgment of mental health conditions and subsequent care; the community believes that efforts in these areas could make the biggest impact.

According to the CMS National Provider Identification File, the ratio of population to mental health providers is 1,529:1 in Ellis County. For reference, the state ratio is of 1,034:1 and the County Health Rankings Top Performer's value of 386:1.[5] Poor mental health days in Ellis County are at 2.9, lower than the state value of 3.3 but higher than the County Health Rankings Top Performer's value of 2.3.[6] The Behavioral Risk Factor Surveillance System (BRFSS) reports, in Ellis County, the percentage of adults who have engaged in binge drinking in the last 30 days is 20% compared to the state value of 16%.[7] The Centers for Medicare & Medicaid Services (CMS) report that among the Medicare population in Ellis County:

- 12% have Alzheimer's disease / dementia on par with the state value
- 16% have depression, which is slightly less than the state value
- 3% were identified with schizophrenia and other psychotic disorders, lower than the state value of 4%

Chronic disease and heart failure

A chronic illness or disease is a disease lasting 3 months or more, by the definition of the U.S. National Center for Health Statistics. Chronic diseases generally cannot be prevented by vaccines or cured by medication, nor do they just disappear. Health damaging behaviors - particularly tobacco use, lack of physical activity, and poor eating habits - are major contributors to the leading chronic diseases.[8] Chronic disease prevention and management was frequently discussed in the key informant interviews and focus group. Specifically, participants identified diabetes, chronic lower respiratory disease (CLRD) and heart failure as priorities in the community, and high rates for the community are confirmed by the quantitative data. The participants identified a need for better coordinated services. It was recognized that although there are numerous efforts and programs in place, communication and care coordination are limited.

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[5] CMS National Provider Identification File, 2014, Ratio of population to mental health providers.
[6] BRFSS/NCHS/CDC, 2006-2012 Average number of mentally unhealthy days reported in past 30 days (age-adjusted)
[7] The Behavioral Risk Factor Surveillance System, 2006-2012 Percentage of adults reporting binge or heavy drinking
[8] http://www.medicinenet.com

According to the Center for Disease Control (CDC) Diabetes Interactive Atlas, 10% of the adults in Ellis County have diabetes, which is above the state average of 9%.[9] Children with diabetes are hospitalized at a higher rate than the rest of the state (32 per 100,000 versus 25 per 100,000).[10]

The National Vital Statistics System identified the chronic lower respiratory disease (CLRD) mortality rate in Ellis County as 45 deaths per 100,000 people compared to the state rate of 37 deaths.[11] The Centers for Medicare and Medicaid Services (CMS) shows that the Medicare beneficiary heart failure rate and atrial fibrillation rates are slightly higher than the state value.[12]

Summary

BSWH conducted a Community Health Needs Assessment beginning July 2015 to identify and begin addressing the health needs of the communities they serve. Using both qualitative community feedback as well as publically available and proprietary health indicators, BSWH was able to identify and prioritize community health needs for their hospital system. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed to the health needs BSWH has chosen to address for the community served.

[9] CDC Diabetes Interactive Atlas, 2011 Percentage of adults aged 20 and above with diagnosed diabetes (as reported via BRFSS)
[10] Center for Health Statistics Texas Health Care Information Collection, Texas Department of State Health Services, 2013 Pediatric Diabetes Short-Term Complications Admission Risk-Adjusted-Rate (per 100,000 population) Texas Hospital Inpatient Discharge Public Use Data File.
[11] National Vital Statistics System-Mortality (NVSS-M) (CDC/NCHS), 2013, deaths per 100,000 people
[12] Centers for Medicare and Medicaid Services (CMS), 2012 Percentage of Medicare FFS Beneficiaries

Appendix A: Key Health Indicator Sources

Key Health Indicator Sources	
CMS Chronic condition Data Warehouse (CCW)	Center for Public Policy Priorities/ Texas Education Agency
National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention	Texas Education Agency
Texas Department of state Health Services	2015 County Health Rankings
National Vital Statistics System	US Census Small Area Income and Poverty Estimates (SAIPE)
CDC Wonder mortality data Compressed Mortality File (CMF)	American Community Survey
Fatality Analysis Reporting System (FARS)	Bureau of Labor Statistics
Small Area Health Insurance Estimates	County Business Patterns
Dartmouth Atlas of Health Care	National Center for Education Statistics
Area Health Resource File/ American Medical Association	National Center for Health Statistics
CMS, National Provider Identification File	Uniform Crime Reporting, Federal Bureau of Investigation
Feeding America	Behavioral Risk Factor Surveillance System (BRFSS)
USDA Food Environment Atlas	National Cancer Institute
Safe Drinking Water Information System	CDC Diabetes Interactive Atlas
Comprehensive Housing Affordability Strategy (CHAS)	CMS

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

Resources Identified via Community Input

911 Services	Girls, Inc.	Mental Health Coalition	Obesity Coalition
Breast Bridge	Hospitals	Metrocrest	Public Health Departments
Catholic Charities	Injury Prevention Center of Greater Dallas	MHMR	Senior Source
CCA Community Clinics	Local Churches	NAMI Suicide Prevention	Transitional Care Services
City Governments	Meals on Wheels	Night Shelter	United Way
Free Clinics	Medstar	NTX Food bank	

Community Healthcare Facilities[13]

Hospitals – Two (2) hospitals serving the community

Facility Name	System	Type	Street Address	City	State	ZIP
Baylor Scott & White Medical Center - Waxahachie	Baylor Scott & White	ST	2400 N I-35 E	WAXAHACHIE	TX	75165
Ennis Regional Medical Center	Lifepoint	ST	2201 WEST LAMPASAS STREET	ENNIS	TX	75119

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

[13] Texas Department of State Health Services, 12/23/2015

Appendix C: Evaluation of Implementation Strategy Impact

As the largest not-for-profit health system in Texas, BSWH provides its patients and community with greater access to care directly through hospitals and in collaboration with other affiliates of BSWH through an array of initiatives that meet the identified community needs from the 2013CHNA.

Among the greatest need identified in the 2013CHNA was the need for access to more quality preventive health and sick care services to be provided in the communities served. These needs required improving the excellence of health care delivery through additional services with a continual focus on the patients, and compassion for their situation. These needs were met through the convenient locations across the community, and the cooperation and collaboration afforded the hospitals by the vast geography served through BSWH. BSWH affiliation makes a hospital a more robust service provider, including the advancement of medical education and research initiatives. Need is the basis for building new facilities and advancing and increasing services through physicians and caregivers drawn to BSWH in recognition of its quality standing in the community served. Categories of service in this Plan included:

- Community health education services
- Medical education
- Subsidized health services
- Research
- Financial and in kind donations
- Community benefit operations
- Health care support services

In addition to the tactics to meet the prioritized community health needs identified below, the community benefits from many BSWH initiatives which are funded and provided by both the hospitals and affiliates of the System.

- Behavioral health
- Access to care for low income/underserved
- Care coordination and care transitions
- Dental care
- Emergency and urgent care
- Multiple chronic conditions
- Preventive health screenings
- Patient safety and hospital acquired conditions

More in depth reporting for this period may be located at BaylorHealth.com/About/Community.

Categories of Outcomes and Impact

Financial Donations - Through financial donations to other not-for-profit organizations in the community at large whose missions compliment the mission of the hospitals in the community, the hospital's community reach is extended beyond its walls. These funds include gifts to other not for profit organizations, contributions to charity events after subtracting fair market value of participation by employees or the organization, and helped to extend the services of the hospital beyond its walls. Gifts for the fiscal years beginning July 2013 through June 2015 totaled $104,579 and assisted in addressing the needs of:

- Access to care for low income/underserved – Hope Clinic for underserved and underinsured; Dina Weeble breast cancer initiative providing mammograms for uninsured women.
- Behavioral health – Hope Clinic for underinsured and underserved
- Dental care - providing funding to a local FQHC clinic for underserved and under-insured /uninsured people
- Multiple chronic conditions - Providing Mammograms for uninsured women of the community; supporting nutritious feeding programs for under-served populations through Meals on Wheels; funding research and creating awareness of cancer prevention and potential cures through donations to the American Cancer Society; funding advocacy for children displaced from their homes and in the judicial system who have no one other than lawyers to represent their best interests through donations to CASA; and providing funds to defray the expenses of area transplant patients.

In-kind Donations/Faith in Action Initiatives - Through in-kind donations to the Office of Faith in Action Initiatives 2nd Life program provides monetary donations, and medical supplies and equipment repurposed from the hospitals in the community. This initiative provides for the health care needs of populations locally whose needs cannot be met through their own organization. 2nd Life provides recycled medical equipment to underserved health care organizations, and provides monetary support for disaster situations through the shipment of medical equipment. In the fiscal years beginning July 2013 and ending June 2015 the hospitals provided Medical supplies and equipment valued at approximately $41,800. Through this effort, the following needs were addressed:

- Multiple chronic conditions
- Access to care for low income/underserved
- Patient safety and hospital acquired conditions

The following projects were funded/supplied:

- Mission East Dallas
- Family and Child Guidance
- Threshold ministry
- Equal Heart
- Heart of the Fatherless

- Our Children's House
- Baylor House Calls
- Family Legacy
- Hope Clinic of Waxahachie
- Cornerstone Network
- His Bridge Builders

Community Health Improvement Services: The hospitals of BSWH provided health screenings, and services assisting the community in taking steps to help increase their chances for living a longer, healthier life. Through the provision of community health education and improvement services in including educational events, disease support groups and health screenings, the following needs were addressed:

- Preventive health screenings
- Multiple chronic conditions
- Emergency and urgent care
- Care coordination and care transitions
- Patient safety and hospital acquired conditions

In the fiscal years beginning July of 2013 and ending June 2015 the hospital served persons through 13,929 screenings, identified 1,937 persons as at risk and referred them to a physician or clinic for diagnosis. Through these efforts the hospital addressed

- Clinical services – Childhood immunization programs (11,206 persons served)
- Screenings - For Women for Life – 97 persons served; It's a Guy Thing – 78 persons served; Cancer; cardiovascular, diabetes and wellness screenings – served 999 persons
- Education - Asthma, behavioral health issues, diabetes, pain management, sleep apnea, smoking cessation, supportive and palliative care, transplant, nutrition, breast cancer and heart disease.
- Emergency and urgent care - falls prevention.
- Expansion of services - relocated to a new 300,000 square-foot facility located at the intersection of I-35 and Highway 287. The new campus includes expanded facilities to increase services for obstetrics, additional inpatient beds, operating rooms, and emergency and intensive care unit (ICU) rooms. The Baylor Scott & White Charles A. Sammons Cancer Center at Waxahachie provides inpatient and outpatient cancer services closer to home for the residents of Ellis County

The hospital expended $286,045 in physician recruitment efforts for the fiscal year beginning July 2014 and ending June of 2015.

Medical Education - The hospital in the community is committed to assisting with the preparation of future physicians and nurses at entry and advanced levels of the profession to establish a workforce of qualified health care professionals in an underserved area.

Through the System's relationships with many North Texas schools of nursing, the hospital maintained strong affiliations with schools of nursing. Like physicians, nursing graduates trained at community hospitals are not obligated to join the staff although many remain in the North Texas area to provide top quality nursing services to many health care institutions. The community hospital also provided recruitment assistance to physicians in order to relocate their practice into the community to satisfy a documented shortage of physicians in the total service area and other medically underserved areas. Through this effort the following need was addressed:

- Access to care for low income/underserved - 515 nurses received training at a cost of $2,285,787 through the fiscal years beginning July 1, 2013 and ending June 30, 2015; Community hospitals also expended $640,298 in physician recruitment efforts for the same period

Health Care Support Services are provided by BSWH to increase access and quality of care in health services to individuals, especially those living in poverty and those invulnerable situations. The hospital provided staff to assist in the qualification of the medically underserved for programs that will enable their access to care, through Medicaid, Medicare, SCHIP and to other government programs or charity care programs for use in any hospital within or outside of BSWH. This service addressed the following need:

- Access to Care for Low Income and Underserved – in the fiscal years beginning July 1, 2013 and ending in June 30, 2015 the community hospitals expended $47,314 in the commission of services including transportation programs for patients and families to enhance patient access to care; assistance to enroll in SCHIP & Medicaid; and translation and interpretation services to go beyond what is required by law for accreditation.

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

Health Professional Shortage Areas (HPSA)[14]

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

Medically Underserved Areas and Populations (MUA/P)[15]

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

[14] U.S. Department of Health and Human Services, Health Resources and Services Administration, 2016
[15] U.S. Department of Health and Human Services, Health Resources and Services Administration, 2016