


Community Health Needs Assessment

Temple Region Health Community

2022

Baylor Scott & White HEALTH

Temple Region health community hospitals

- **Baylor Scott & White Medical Center – Temple** (includes Baylor Scott & White McLane Children's Medical Center under same license)
- **Baylor Scott & White Continuing Care Hospital**

Approved by: Baylor Scott & White Health – Central Texas Operating, Policy and Procedure Board on May 13, 2022
Posted to **BSWHealth.com/CommunityNeeds** on June 30, 2022

Baylor Scott & White HEALTH

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Baylor Scott & White Health mission

Our commitment to the communities we serve

As the largest not-for-profit healthcare system in Texas and one of the largest in the United States, Baylor Scott & White Health was born from the 2013 combination of Baylor Health Care System and Scott & White Healthcare. Today, Baylor Scott & White includes 51 hospitals, 1,100 access points, more than 7,300 active physicians, and over 49,000 employees and the Baylor Scott & White Health Plan.

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

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

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

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

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

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

Community Health Needs Assessment (CHNA) report

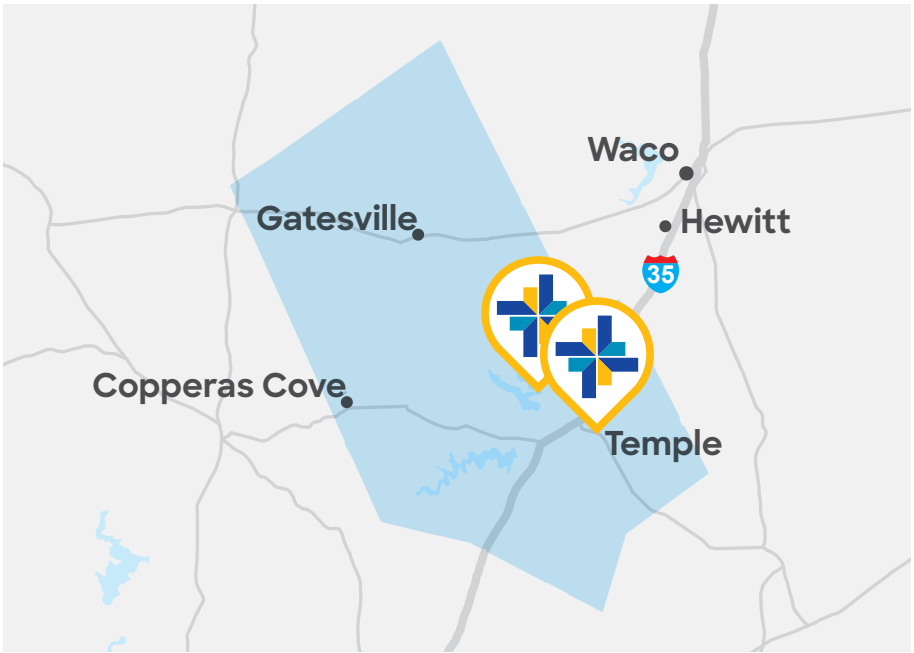
Baylor Scott & White Health (BSWH) owns and operates numerous individually licensed hospital facilities serving the residents of North and Central Texas.

The Temple Region Health Community is home to a number of these hospitals with overlapping communities, including:

- Baylor Scott & White Medical Center – Temple (includes Baylor Scott & White McLane Children's Medical Center under same license)
- Baylor Scott & White Continuing Care Hospital

The community served by the hospital facilities listed above is Bell and Coryell Counties. All of these owned hospital facilities are located in Bell County, and more than 70% of the admitted patients live in these two counties according to the hospital facilities' inpatient admissions over the 12-month period of FY20. Those facilities with overlapping counties of patient origin collaborated to provide a joint CHNA report in accordance with the Internal Revenue Code Section 501 (r) (3) and the US Treasury regulations thereunder. All of the collaborating hospital facilities included in a joint CHNA report define their communities to be the same for the purposes of the CHNA report.

Temple Region 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 Temple Region Health Community CHNA are:

- The community is outpacing the rate of growth of the US but not the state of Texas
- The median age of the population is younger than Texas overall and the national average.
- The median household income is significantly lower than both the state and the US.
- The community served has a higher percentage of uninsured and underinsured people than Texas and the US.

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

Health community data summary

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

- Inpatient discharges in the community are expected to grow by over 4% by 2030 with the largest growing product lines to include:
  - Pulmonary Medical
  - General Medicine
  - Cardiovascular Diseases
- Outpatient procedures are expected to increase by 31% by 2030 with the largest areas of growth including:
  - General & Internal Medicine
  - Labs
  - Physical & Occupational Therapy
  - Psychiatry
- Emergency Department visits are expected to grow by almost 8% by 2025.
- Hypertension represents about 72% of all heart disease cases.
- Cancer incidence is expected to increase by 8.6% by 2025.

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

No health professional shortage areas (HPSAs) or medically underserved areas or populations (MUA/Ps) were identified in the community.

Total population

435,281

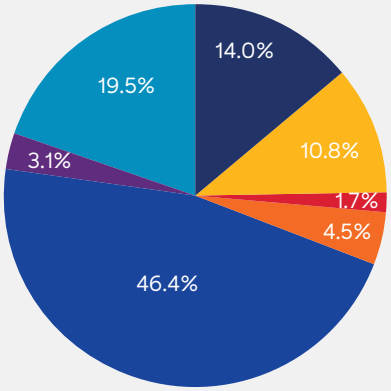
Average income

$57,613

Underserved ZIP codes

5

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	Obesity/physical inactivity	Conditions/diseases
2	Access to mental healthcare (providers and resources)	Mental health
3	Health literacy	Language/social
4	Access to primary healthcare providers	Access to care
5	Food insecurity/limited access to healthy foods	Environment
6	Access to care: insurance	Access to care

Priority 1: Obesity/Physical Inactivity

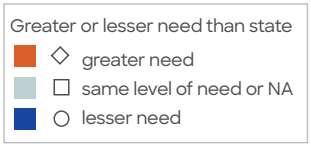
Category	Data shows greater need	Key informants indicate greater need
Conditions/ diseases	• Adult obesity • Physical inactivity	• High prevalence of obesity • Struggle to find affordable activities and connecting to resources for activity

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

Conditions/diseases: physical inactivity (% of adults reporting no leisure time physical activity in past month by county)



Counties are listed in alphabetical order within CTX-Temple Region Health Community.
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 one of the community's challenges is the high prevalence of obesity. They also shared that the community lacks safe outdoor walking paths.

In the prioritization session, hospital leadership agreed that adult obesity is an issue in the community. Obesity and its related conditions drive up healthcare costs, including equipment, medication, increasing hospital days, etc., and therefore, it is an important need to prioritize.

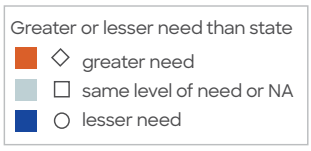
Priority 2: Access to Mental Healthcare (Providers and Resources)

Category	Data shows greater need	Key informants indicate greater need
Mental health	• Mentally unhealthy days • Medicare population: depression • Suicide: intentional self-harm	• Mental health resources overwhelmed with cases

The following data indicates greater need in the area of mental health, specifically in the measures of mentally unhealthy days, Medicare population: depression and suicide: intentional self-harm.

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

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



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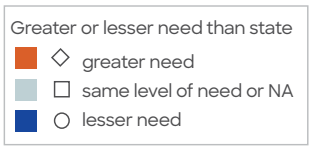
The **Medicare population: depression** indicator is defined as **prevalence of the chronic condition of depression across all Medicare beneficiaries**. The indicator is based on data from CMS.gov Chronic Conditions.

Mental health: Medicare population: depression (prevalence of depression by county)



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The **suicide: intentional self-harm** indicator is defined as **intentional self-harm (suicide) (X60-X84, Y87.0)**. The indicator is based on data from Texas Health Data Center for Health Statistics.

Mental health: suicide: intentional self-harm (rate of suicide by county)

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

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The focus group participants stated that the overall community has limited mental health and substance abuse services for the population, which leads to difficulty accessing care. The community felt mental and behavioral health is the most underserved area when looking at the services needed. They noted that if you have a suicidal child, there are no crisis services in the community. The child must be treated at or transported to another county.

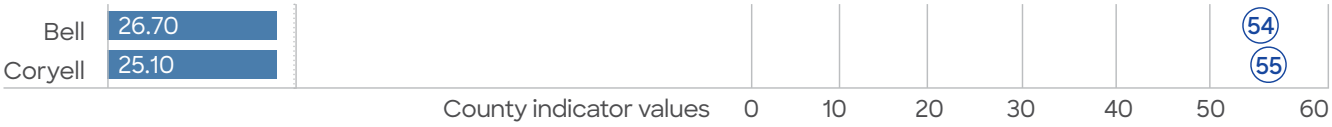
In the prioritization session, hospital leadership voted access to mental healthcare, both providers and resources, as the second-highest prioritized need in the community. All participants agreed that suicide should be included in the mental health category. Participants noted suicides have become more prominent since COVID, and the demographic of younger adults has increased. Some speculated that the military community is a contributing factor.

Priority 3: Health Literacy

Category	Data shows less need or no data	Key informants indicate greater need
Language/ social	• English spoken "less than very well" in household	• Language barriers exist

Although the data does not indicate a need in the area of **English spoken "less than very well" in household**, the key informants indicate that there was indeed a greater need because language barriers exist. The indicator is defined as **the percentage of households that "speak English less than very well" within all households that "speak a language other than English"** and is based on data from American Community Survey Five-Year Estimates, US Census Bureau - American FactFinder.

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



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

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The focus group participants stated that language barriers exist and that residents perceive using a language line as very demeaning.

In the prioritization session, hospital leadership concluded that health literacy is an important indicator and prioritized it in third place. They clarified that health literacy means dealing with individuals' knowledge of how to access their care as well as how to manage their healthcare conditions.

Priority 4: Access to Primary Healthcare Providers

Category	Data shows greater need	Key informants indicate greater need
Access to care	• Population to one primary care physician	• Limited access to primary healthcare providers

The data below indicates **greater need for population to one primary care physician**. The 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)

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

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The focus group participants stated that access to behavioral health services is the need for primary healthcare and preventive care. The limited access is due to a combination of an insufficient number of providers as well as residents' inability to access care in parts of the community due to transportation, insurance or funding limitations.

In the prioritization session, hospital leadership prioritized Access to Primary Healthcare Providers as the fourth-highest ranked need to be addressed. They questioned how the number of providers was insufficient as they make great strides to hire and employ primary care physicians to decrease the primary care physician to population ratios. They ultimately recognized that lack of insurance and lack of transportation hinder access to primary care.

Priority 5: Food Insecurity/Limited Access to Healthy Foods

The following data indicates greater need to address the limited access to healthy foods and the food insecure indicator.

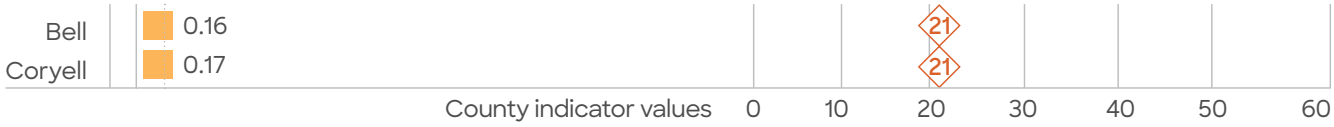
Category	Data shows greater need	Key informants indicate greater need
Environment	• Limited access to healthy foods • Food insecure	• Food desert–little to no access to fruit and vegetables/healthy food options

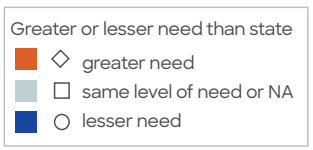
The indicator **food: limited access to healthy foods** is defined as **the percentage of population who are low-income and do not live close to a grocery store**. The indicator is based on data from County Health Rankings & Roadmaps; USDA Food Environment Atlas, United States Department of Agriculture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

Environment: food: limited access to healthy foods (% of low-income population not living close to grocery store)

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

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





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The focus group participants noted that the community is a food desert, specifically with little to no access to fruit and vegetables/healthy food options. They cited that many elderly located in the east side of the county must pay more for fresh foods. Even if they had access to fresh foods, there is a lack of health education around healthy cooking and eating.

In the prioritization session, the hospital and community leaders agreed that there is limited access to healthy foods in the community. They recognized that when healthy food is inaccessible, it greatly impacts patients with chronic medical conditions such as obesity and creates a domino effect for further health needs.

Priority 6: Access to Care: Insurance

Category	Data shows lesser need	Key informants indicate greater need
Access to care	• Children uninsured • Population under age 65 without health insurance	• Lack of insurance coverage—Bell County especially has been challenged with COVID

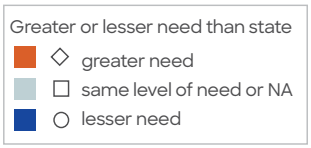
Although the data does not indicate a need to address the measures of children uninsured and the population under age 65 without health insurance, the key informants felt that the community is challenged by the lack of insurance coverage, especially since the pandemic.

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

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

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: % of population under age 65 without health insurance



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The focus group participants noted that many members of the community lack health insurance. Even those who are employed in lower-skill jobs are not offered insurance coverage by their employers. Lack of health insurance and the inability to afford care are top barriers to accessing needed services.

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.

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.

Temple Region community resources

Need	Organization	Address	Phone
Obesity/ physical inactivity	VHA MOVE! Weight Management Program	1901 Veterans Memorial Drive Temple, TX 76504	800.423.2111
	Bell County Public Health District WIC	201 N. 8th Street Temple, TX 76501	254.778.1511
	Body of Christ Community Clinic (nutrition education)	2210 Holland Road Belton, TX 76513	254.939.9500
	Focus on Hope Outreach Services (free summer meals/health education)	2802 W. Avenue M Temple, TX 76504	866.942.4003
	Bell County Public Health District WIC	213 W. Avenue D Copperas Cove, TX 76522	254.547.9571
Access to mental healthcare (providers/ resources)	Presbyterian Children's Homes and Services (PCHAS)	12 W. French Avenue Temple, TX 76501	800.888.1904
	Lone Star Circle of Care (LSCC)	2112 SW H K Dodgen Loop Temple, TX 76504	877.800.5722
	A Children At Heart Ministries - STARRY Counseling	2027 S. 61st Street Temple, TX 76504	254.773.5802
	Central Counties Services, Inc. (mental health services)	304 S. 22nd Street Temple, TX 76501	844.815.6221
	VHA SUD Program	1901 Veterans Memorial Drive Temple, TX 76504	800.423.2111
Health literacy	Temple Community Clinic	1905 Curtis B Elliot Drive Temple, TX 76501	254.771.3374
	Hope Pregnancy Centers, Inc.	601 S. Main Street Copperas Cove, TX 76522	254.518.4673
	Helping Hands Ministry of Belton Education Classes	2210 Holland Road Belton, TX 76513	254.939.7355
	Bell County Public Health District - Health Education	509 S. 9th Street Temple, TX 76504	254.939.2091
	Body of Christ Community Clinic - Belton	2210 Holland Road Belton, TX 76513	254.939.9500

Need	Organization	Address	Phone
Access to primary healthcare	Coryell Memorial Healthcare System	1507 W. Main Street Gatesville, TX 76528	254.865.8251
	Body of Christ Community Clinic - Belton	2210 Holland Road Belton, TX 76513	254.939.9500
	Temple Community Clinic	1905 Curtis B Elliot Drive Temple, TX 76501	254.771.3374
	Lone Star Circle of Care (LSCC)	2112 SW H K Dodgen Loop Temple, TX 76504	877.800.5722
	Waco Family Medicine - Temple Location	600 S. 25th Street Temple, TX 76504	254.313.4610
Food insecurity/ access to healthy food	St. Vincent de Paul of Greater Temple, Inc.	106 W. Avenue D Temple, TX 76501	254.773.7591
	The Salvation Army of Bell County - Food Pantry	419 W. Avenue G Temple, TX 76504	254.774.9996
	Churches Touching Lives for Christ Food Pantry	702 W. Avenue G Temple, TX 76504	254.778.6885
	Taylor's Valley Baptist Church - Food Pantry	2497 Farm to Market Road 93 Temple, TX 76502	254.939.0503
	Texas HHSC - SNAP benefits	4501 S. General Bruce Drive Temple, TX 76502	254.778.6751
Population under 65 without health insurance	Texas HHSC	4501 S. General Bruce Drive Temple, TX 76502	254.778.6751
	Body of Christ Community Clinic - Belton	2210 Holland Road Belton, TX 76513	254.939.9500
	Temple Community Clinic	1905 Curtis B Elliot Drive Temple, TX 76501	254.771.3374
	DSHS Public Health Region 7 - Temple	2408 S. 37th Street Temple, TX 76504	254.778.6744
	Coryell Memorial Healthcare System	1507 W. Main Street Gatesville, TX 76528	254.865.8251

There are many other community resources and facilities serving the Temple region 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 hospitals' most recent CHNA to address the significant health needs identified in that report.
    - Hospitals also must adopt an implementation strategy to address prioritized community health needs identified through the assessment.

CHNA process

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

Consultant qualifications

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

Health needs assessment process overview

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

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

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

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

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

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

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

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

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

Information gaps

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

Community input: qualitative health needs assessment - approach

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

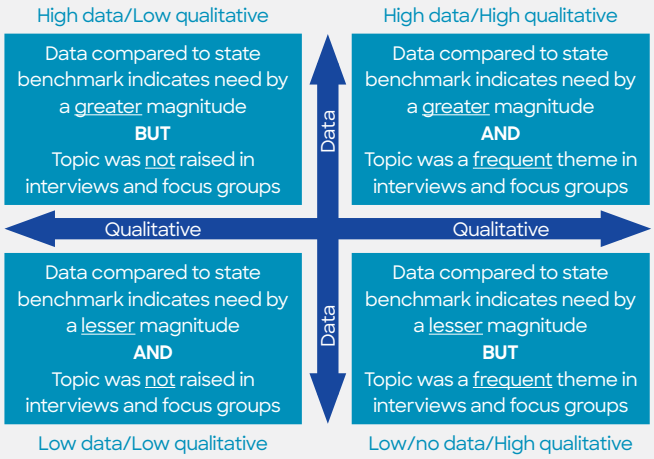
- Assembled a focus group representing the broad interests of the community served;
- Conducted interviews and surveys with key informants—leaders and representatives who serve the community and have insight into its needs; and
- Held prioritization sessions with hospital clinical leadership and community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

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

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

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

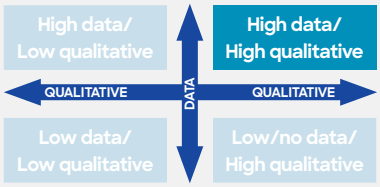
Approach to prioritizing significant health needs



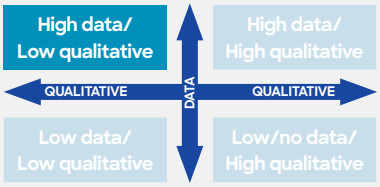
High data = Indicators worse than state benchmark by greater magnitude
High qualitative = Frequency of topic in interviews and focus groups

On January 13, 2022, a session was conducted with key leadership members from Baylor Scott & White along with community leaders to review the qualitative and quantitative data findings of the CHNA to date, discuss at length the significant needs identified, and complete prioritization exercises to rank the community needs. Prioritizing health needs was a two-step process. The two-step process allowed participants to consider the quantitative needs and qualitative needs as defined by the indicator dataset and focus group/interview/survey participant input.

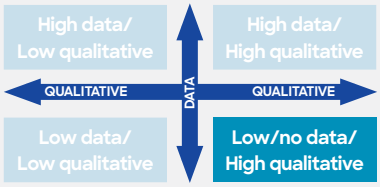
In the first step, participants reviewed the top health needs for their community using associated data-driven criteria. The criteria included health indicator value(s) for the community and how the indicator compared to the state benchmark.



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



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



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

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

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

Prioritization of significant needs

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

- **Root cause:** The need is a root cause of other problems. If addressed, it could possibly impact multiple issues.
- **Severity:** The problem results in disability or premature death or creates burdens on the community, economically or socially.
- **Magnitude:** The need affects many people, either actually or potentially.

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

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

The resulting prioritized health needs for this community are:

Priority	Need	Category of need
1	Obesity/physical inactivity	Conditions/diseases
2	Access to mental healthcare (providers and resources)	Mental health
3	Health literacy	Language/social
4	Access to primary healthcare providers	Access to care
5	Food insecurity/limited access to healthy foods	Environment
6	Access to care: insurance	Access to care

Appendix B: key public health indicators

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

The indicators used and the sources are listed below:

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

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

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

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

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

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

Appendix C: community input participating organizations

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

- Altrusa International of Temple
- Baylor Scott & White Health
- Bell County Indigent Health Services Department
- Bell County Public Health District
- Bell/Lampasas Counties Community Supervision and Corrections Department
- Belton Independent School District
- Body of Christ Community Clinic
- Central Counties Services (MHMR)
- Central Texas Council of Governments
- Churches Touching Lives for Christ
- Coryell County Emergency Management
- Family Promise of Eastern Bell County
- Greater Killeen Community (Free) Clinic
- Helping Hands Ministry of Belton
- Hill County Transit District: "the HOP"
- Killeen ISD
- LULAC Council
- Regional Health Partner RHP 16
- Salado Independent School District
- St. Vincent de Paul
- Temple Community Clinic
- Temple Independent School District
- Temple National Association for the Advancement of Colored People (NAACP)
- Texas A&M AgriLife Extension Service - Bell County
- Texas A&M University Central Texas
- The Salvation Army
- United Way of Central Texas
- Workforce Solutions of Central Texas

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

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

Geography		Benchmarks		Community served
		United States	Texas	Temple Region health community
Total current population		330,342,293	29,321,501	435,281
Five-year projected population change		3.3%	6.6%	6.2%
Median age		38.6	35.2	32.8
Population 0 - 17		22.4%	25.7%	27.0%
Population 65+		16.6%	13.2%	11.1%
Women age 15 - 44		19.5%	20.5%	22.0%
Hispanic population		19.0%	40.7%	25.2%
Insurance coverage	Uninsured	9.9%	18.8%	19.5%
	Medicaid	20.9%	13.0%	14.0%
	Private market	8.3%	8.4%	7.6%
	Medicare	13.8%	12.7%	12.5%
	Employer	47.2%	47.1%	46.4%
Median HH income		$65,618	$63,313	$57,613
No high school diploma		12.2%	16.7%	9.0%

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

The community served expects to grow 6.2% by 2025, an increase by more than 27,113 people. The projected population growth is lower than the state's five-year projected growth rate (6.6%) but higher than the national projected growth rate (3.3%). The ZIP codes expected to experience the most growth in five years are:

- 76542 Killeen – 4,477 people
- 76549 Killeen – 4,781 people

The community's population is younger with about 53% of the population ages 18 - 54 and 27% under age 18. The age 65-plus cohort is expected to experience the fastest growth (18.2%) 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, and the white non-Hispanic population is expected to decline at a rate of -2.4%. The expected growth rate of the Hispanic population (all races) is 17,897 people (16.3%) by 2025. The black population is expected to grow by 10.6%.

Population distribution

	Age distribution				
Age group	2020	% of total	2025	% of total	USA 2020 % of total
0 - 14	99,493	22.9%	104,005	22.5%	18.5%
15 - 17	17,829	4.1%	19,848	4.3%	3.9%
18 - 24	48,451	11.1%	48,797	10.6%	9.5%
25 - 34	72,771	16.7%	71,181	15.4%	13.5%
35 - 54	107,163	24.6%	118,418	25.6%	25.2%
55 - 64	41,187	9.5%	42,945	9.3%	12.9%
65+	48,387	11.1%	57,200	12.4%	16.6%
Total	**435,281**	**100.0%**	**462,394**	**100.0%**	**100.0%**

Household Income distribution

	Income distribution		
2020 Household income	HH count	% of total	USA % of total
<$15K	15,534	10.0%	10.0%
$15 - 25K	13,864	8.9%	8.6%
$25 - 50K	39,860	25.6%	20.7%
$50 - 75K	32,876	21.1%	16.7%
$75 - 100K	20,625	13.2%	12.4%
Over $100K	33,030	21.2%	31.5%
Total	**155,789**	**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	9,670	3.6%	5.2%
Some high school	14,664	5.4%	7.0%
High school degree	70,114	26.0%	27.2%
Some college/assoc. degree	110,142	40.9%	28.9%
Bachelor's degree or greater	64,918	24.1%	31.6%
Total	**269,508**	**100.0%**	**100.0%**

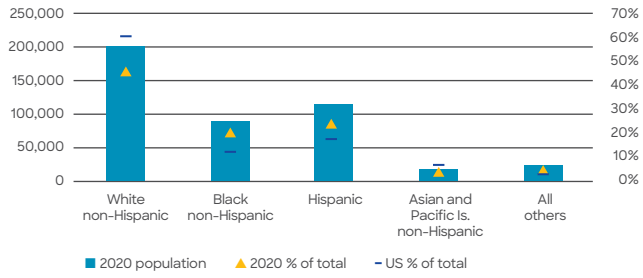
Race/ethnicity

	Race/ethnicity distribution		
Race/ethnicity	2020 pop	% of total	USA % of total
White non-Hispanic	198,343	45.6%	59.3%
Black non-Hispanic	92,503	21.3%	12.4%
Hispanic	109,527	25.2%	19.0%
Asian & Pacific is. non-Hispanic	15,498	3.6%	6.0%
All others	19,410	4.5%	3.3%
Total	**435,281**	**100.0%**	**100.0%**

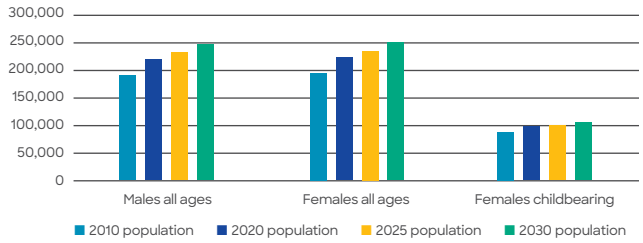
Population estimates		
Population	National	Selected area
2010 total	308,745,538	382,972
2020 total	330,342,293	435,281
2025 total	341,132,738	462,394
2030 total	353,513,931	493,085
% change 2020 - 2025	3.27%	6.23%
% change 2020 - 2035	7.01%	13.28%

Population	Males all ages	Females all ages	Females childbearing
2010 total	189,071	193,901	89,262
2020 total	216,786	218,495	95,957
2025 total	230,316	232,078	99,104
2030 total	245,391	247,694	103,532
10Y %	13.20%	13.36%	7.89%
National	7.02%	7.01%	4.01%

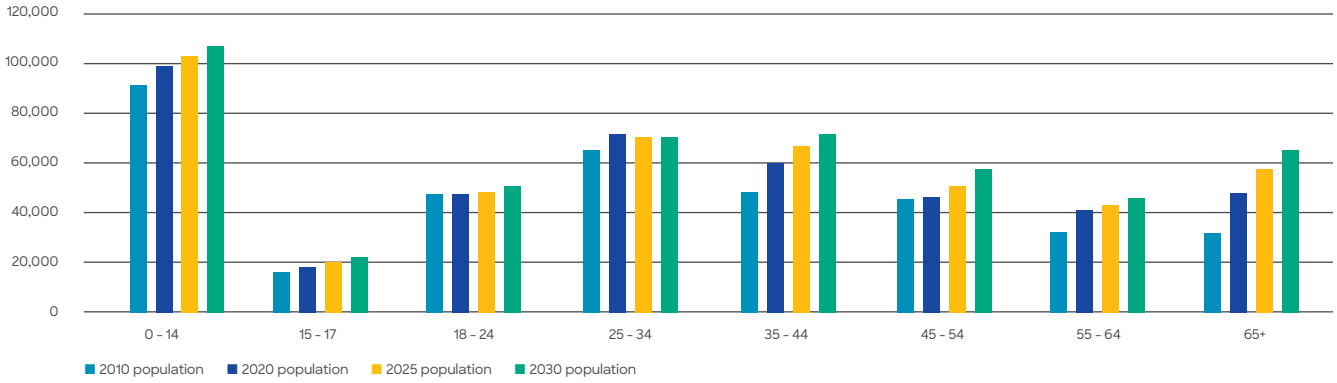
2020 race and ethnicity with total population



Population by sex 2010 - 2030



Population by age group 2010 - 2030

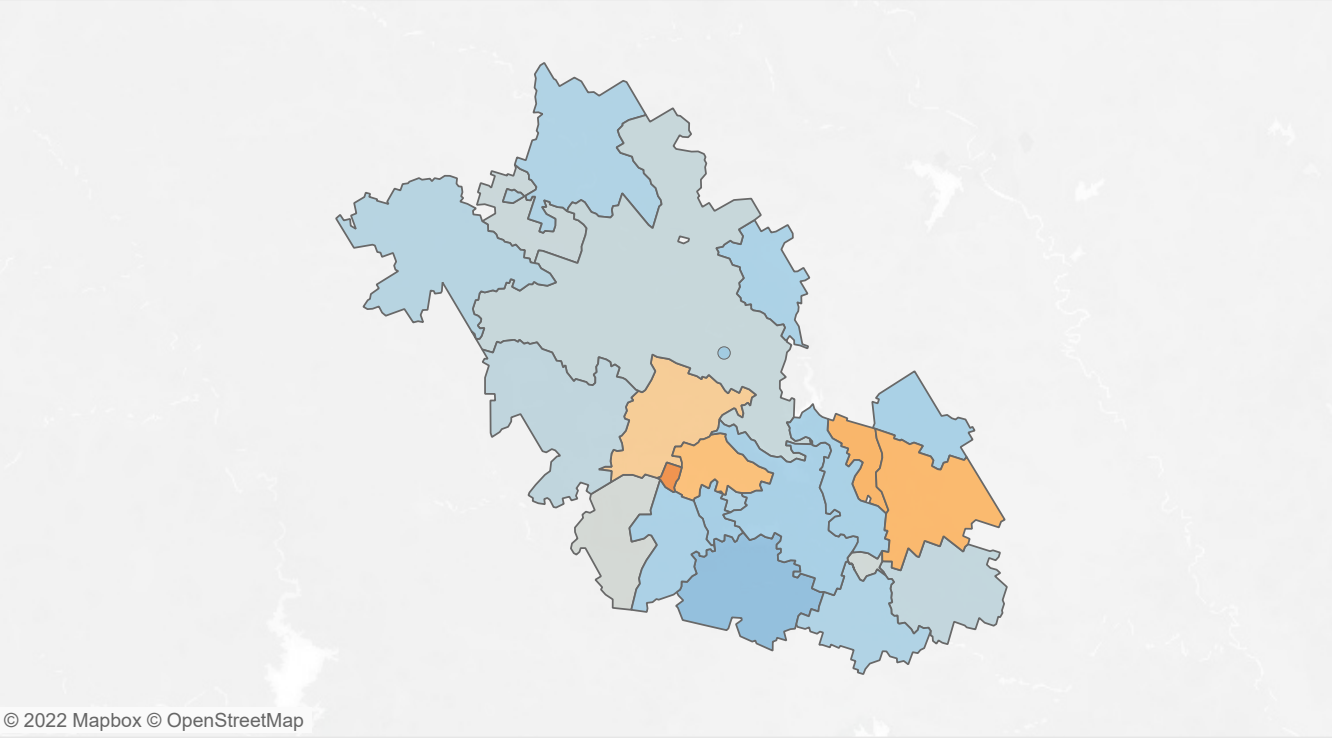


The 2020 median household income for the United States was $65,618 and $63,313 for the state of Texas. The median household income for the ZIP codes within this community ranged from $33,431 for 76541 in Killeen to $93,960 for 76571 in Salado. There were four (4) additional ZIP codes in the community with median household incomes less than $52,400—twice the 2020 federal poverty limit for a family of four.

- 76501 Temple
- 76504 Temple
- 76543 Killeen
- 76544 Fort Hood

A large portion of the population (46.4%) is insured through employer sponsored health coverage, closely followed by those without health insurance (12.5%). The remainder of the population is fairly equally divided between Medicaid, Medicare and private market (the purchasers of coverage directly or through the health insurance marketplace).

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



Community Needs Index

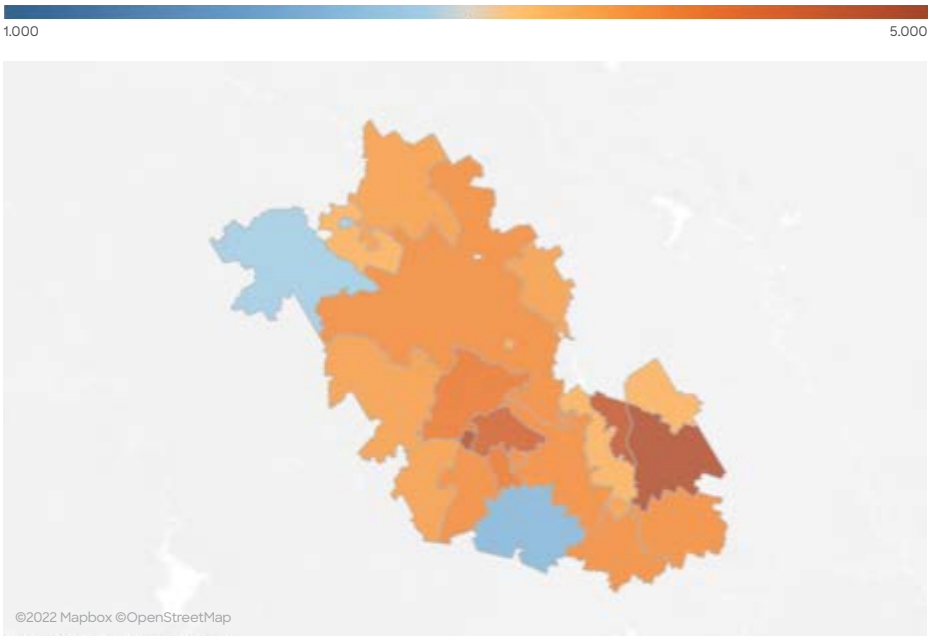
The IBM Watson Health Community Need Index (CNI) is a statistical approach that identifies areas within a community where there are likely gaps in healthcare. The CNI takes into account vital socio-economic factors, including income, culture, education, insurance and housing, about a community to generate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

Temple Region 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
3.89

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 Temple Region Health Community was 3.89. 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 the Temple Region Health Community. Total discharges in the community are expected to grow by over 4% by 2030, with pulmonary medicine, 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	539	545	597	6	1.0%	58	10.7%
Cardio-Vasc-Thor Surgery	1,175	1,185	1,193	10	0.9%	18	1.6%
Cardiovascular Diseases	2,887	2,949	3,210	62	2.2%	323	11.2%
ENT	196	173	158	(23)	-11.7%	(38)	-19.4%
General Medicine	6,847	6,924	7,208	78	1.1%	362	5.3%
General Surgery	2,777	2,761	2,853	(17)	-0.6%	76	2.7%
Gynecology	181	94	58	(87)	-47.9%	(123)	-68.1%
Nephrology/Urology	1,565	1,571	1,625	6	0.4%	61	3.9%
Neuro Sciences	2,124	2,114	2,261	(10)	-0.5%	137	6.5%
Obstetrics Del	3,916	3,549	3,475	(367)	-9.4%	(440)	-11.2%
Obstetrics ND	356	313	299	(43)	-12.2%	(57)	-16.1%
Oncology	643	637	653	(6)	-0.9%	10	1.5%
Ophthalmology	44	41	41	(2)	-5.3%	(3)	-7.0%
Orthopedics	2,715	2,627	2,678	(88)	-3.2%	(36)	-1.3%
Psychiatry	674	711	758	36	5.4%	83	12.4%
Pulmonary Medical	3,162	3,553	3,955	391	12.4%	793	25.1%
Rehabilitation	11	11	12	0	1.9%	1	9.0%
TOTAL	**29,810**	**29,757**	**31,033**	**(53)**	**-0.2%**	**1,223**	**4.1%**

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 Temple Region Health Community outpatient procedures are expected to increase by 31% by 2030 with the largest growth in the categories of general & internal medicine, labs, physical & occupational therapy and psychiatry.

Clinical service category	2020 procedures	2025 procedures	2020-2025 procedures % change	2030 procedures	2020 - 2030 procedures % change
Allergy & Immunology	54,752	57,960	5.9%	61,546	12.4%
Anesthesia	69,638	79,124	13.6%	88,822	27.5%
Cardiology	205,894	265,052	28.7%	347,973	69.0%
Cardiothoracic	235	262	11.3%	290	23.5%
Chiropractic	163,371	164,494	0.7%	164,397	0.6%
Colorectal Surgery	1,985	2,093	5.5%	2,213	11.5%
CT Scan	82,701	114,102	38.0%	156,474	89.2%
Dermatology	52,407	60,154	14.8%	68,509	30.7%
Diagnostic Radiology	376,210	411,302	9.3%	449,468	19.5%
Emergency Medicine	268,185	287,614	7.2%	310,493	15.8%
Gastroenterology	23,142	25,880	11.8%	28,950	25.1%
General & Internal Medicine	2,765,635	3,199,222	15.7%	3,625,643	31.1%
General Surgery	20,246	22,284	10.1%	24,694	22.0%
Hematology & Oncology	405,084	481,217	18.8%	570,362	40.8%
Labs	2,906,845	3,261,110	12.2%	3,677,691	26.5%
Miscellaneous	151,593	169,389	11.7%	188,468	24.3%
MRI	26,773	30,024	12.1%	33,633	25.6%
Nephrology	168,916	184,358	9.1%	206,025	22.0%
Neurology	31,376	35,763	14.0%	40,248	28.3%
Neurosurgery	1,482	2,193	48.0%	2,545	71.7%
Obstetrics/Gynecology	47,788	49,823	4.3%	52,512	9.9%
Ophthalmology	102,573	119,988	17.0%	138,234	34.8%
Oral Surgery	1,486	1,764	18.7%	2,085	40.3%
Orthopedics	45,210	50,223	11.1%	55,624	23.0%
Otolaryngology	93,853	102,840	9.6%	111,772	19.1%
Pain Management	29,023	31,623	9.0%	33,911	16.8%
Pathology	104	122	16.9%	142	36.6%
PET Scan	1,444	1,610	11.5%	1,789	23.9%
Physical & Occupational Therapy	498,848	604,259	21.1%	723,900	45.1%
Plastic Surgery	2,455	2,814	14.6%	3,242	32.1%
Podiatry	12,825	13,531	5.5%	14,137	10.2%
Psychiatry	267,198	353,429	32.3%	450,360	68.5%
Pulmonary	82,357	92,101	11.8%	105,000	27.5%
Radiation Therapy	19,109	21,831	14.2%	24,596	28.7%
Single Photon Emission CT Scan (SPECT)	3,257	3,593	10.3%	4,001	22.8%
Urology	21,636	24,748	14.4%	28,174	30.2%
Vascular Surgery	5,604	6,301	12.4%	7,059	26.0%
TOTAL	**9,011,241**	**10,334,195**	**14.7%**	**11,804,985**	**31.0%**

Source: IBM Watson Health Outpatient Procedure Estimates, 2020.

Emergency department visits

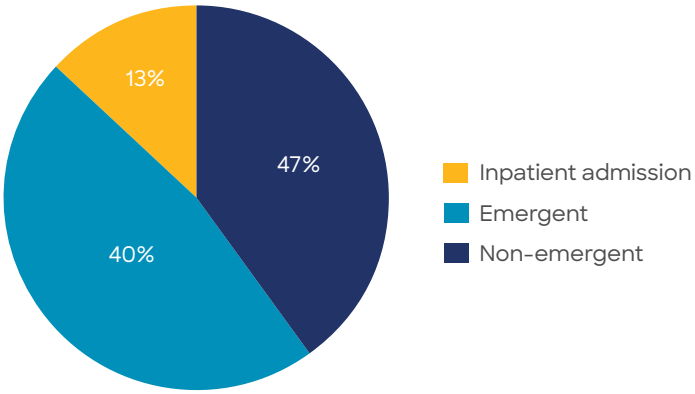
Emergency department estimates predict the total annual volume of emergency department (ED) visits by ZIP code and level of acuity for every market in the United States. IBM uses an extensive supply of proprietary claims, public claims and federal surveys to construct population-based use rates for all 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 Temple Region Health Community, ED visits are expected to grow by almost 8% by 2025.

Emergent status	2020 visits	2025 visits	2020 - 2025 visits change	2020 - 2025 visits % change
Emergent	130,739	143,285	12,546	9.6%
Inpatient Admission	35,672	40,155	4,483	12.6%
Non-Emergent	116,436	121,108	4,672	4.0%
TOTAL	**282,847**	**304,548**	**21,701**	**7.7%**

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.

Disease type	2020 prevalence	2020 % prevalence
Arrhythmia	13,094	12.8%
Heart Failure	6,390	6.3%
Hypertension	73,214	71.7%
Ischemic Heart Disease	9,345	9.2%
TOTAL	**102,044**	**100.0%**

Source: IBM Watson Heart Disease Estimates, 2020.

In the Temple Region Health Community, the most common disease is hypertension at 72% of all heart disease cases.

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 8.6% in the Temple Region Health Community by 2025.

Cancer type	2020 incidence	2025 incidence	2020 - 2025 change	2020 - 2025 % change
Bladder	52	58	7	12.8%
Brain	31	33	3	8.3%
Breast	244	273	29	11.9%
Colorectal	158	146	-11	-7.3%
Kidney	84	98	14	16.0%
Leukemia	57	64	7	12.2%
Lung	253	275	22	8.5%
Melanoma	81	93	11	13.7%
Non-Hodgkin's Lymphoma	102	115	13	12.3%
Oral Cavity	69	78	9	13.1%
Other	167	189	22	13.1%
Ovarian	34	36	3	7.6%
Pancreatic	47	54	8	16.8%
Prostate	166	160	-6	-3.6%
Stomach	34	37	3	8.0%
Thyroid	48	54	6	12.6%
Uterine Cervical	14	15	0	0.7%
Uterine Corpus	70	80	10	14.7%
TOTAL	**1,712**	**1,859**	**147**	**8.6%**

Source: IBM Watson Health Cancer Estimates, 2020.

Appendix F: 2019 community health needs assessment evaluation

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

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

Dates: Fiscal Years 2020 - March 2022
Facilities: BSWMC – Temple (including BSW McLane Children's), BSW Continuing Care Hospital – Temple, Baylor Scott & White Clinic (including BSW McLane Children's Clinic)
Community served: Bell County, Coryell County

Food insecurity

Baylor Scott & White Medical Center – Temple

Action/tactics	Anticipated outcome	Evaluation of impact
Food for Families Host the Food for Families Food Drive in Temple annually by serving as a collection site for canned foods and donations.	Local food pantries will have 25% more food for clients during the holiday season.	• **Persons served: 5,000+** • **$17,835 community benefit** investment of time and donations to three events (Fall of 2019, 2020 and 2021)
Living Well in Bell Community educational series in partnership with Temple Community Clinic.	Community members will learn steps from local providers and experts on how to improve their health and well-being.	• **Persons served: 1,000** • **$25,000 community benefit**
Faith Community Health Program Members of the Faith Community are trained to connect community members to health and social services available in the area. This is an effort to integrate faith workers and healthcare through health educators, faith community nurses, home visits and church volunteer members.	Help all populations reach optimal health by integrating faith communities with healthcare to increase effective patient navigation, education and support.	• **Persons served: 462** • **$714 community benefit**
Rural Health Initiative - Embrace Health Educating medical students and nursing students on the social determinants of health barriers that affect a person's ability to live a healthy life.	Students are better equipped to talk with patients about overcoming barriers to health.	• **Persons served: 90** • **$10,000 community benefit**
Cash donations Annual donations to local food pantries and other organizations improving access to food.	Homeless and hungry clients of local food banks receive necessary nutrition while in the care of the facility.	• **Persons served: 650** • **$278,559 community benefit**
Farmer's market Host a farmer's market for the community.	Healthy produce is available to the community, patients and staff.	• **Persons served: 1,500** • **$5,250 community benefit** The COVID-19 pandemic prohibited this strategy from being implemented after fiscal year 2019.

Food insecurity, continued

Baylor Scott & White Medical Center – Temple

Action/tactics	Anticipated outcome	Evaluation of impact
Connecting the Dots An annual program in partnership with the county and other healthcare providers focusing on solutions for social determinants of health and connecting local resources.	Awareness and adoption of programs and services to address SDOH. Improved community resources.	• **Persons served: 150** • **$8,000 community benefit**
Community health education Events and activities provided by BSWH through outreach efforts and in collaboration with community partners (i.e., Walk with a Doc, Health Fairs, Diabetes Education).	To encourage lifelong healthy eating and physical activity habits. To build nutrition knowledge and skills to positively influence states of wellness, recovery from illness, disease prevention and chronic disease management.	• **Persons served: 6,600+** • **$24,762 community benefit**

Baylor Scott & White Continuing Care Hospital

Action/tactics	Anticipated outcome	Evaluation of impact
Nutrition education Provide nutrition tips and healthy cooking suggestions through postings on community board and hospital newsletter.	Positive medical outcomes and fewer chronic conditions.	Due to COVID, the LTAC hospital did not receive visitors for a very long time. This has not been implemented to date.

Baylor Scott & White Clinic

Action/tactics	Anticipated outcome	Evaluation of impact
Accent Health Education content runs on clinic screens.	Community will have increased knowledge on healthy food choices resulting in improved community health.	Company has changed name to Outcome Health. Educational content is pushed on a regular basis in clinic lobbies. No expense to hospital for this service.
Provider education Provider education on social determinants of health (SDH), how to talk to patients about needs and where resources for referral can be found.	Providers are better equipped to provide resources to patients. Improved health outcomes.	• **Patient impact: countless** • **$1,000 community benefit** • Staff created a training tool for providers to learn how to use what is termed “the SDOH wheel,” which is accessible through all patient charts.

Baylor Scott & White McLane Children's Medical Center
Baylor Scott & White McLane Children’s Clinic

Action/tactics	Anticipated outcome	Evaluation of impact
Family, Food, and Fun! Engaging 60+ families every year to advise on healthy eating and physical activity program.	Increased awareness on shopping on a budget. Increase awareness on seasonal produce shopping. Provide information to local food pantries.	• **Persons served: 534** • **$30,921 community benefit**
Community health education Participate in community outreach/ community and school health fairs.	Reach 2,000+ people annually to provide information/increase awareness of available services and programs (i.e., Family, Food, and Fun!, Safe Kids, Safe Sitter, etc.)	• **Persons served: 2,000** • **$10,327 community benefit**
Social media Social media posts throughout the year on nutrition/healthy eating.	Inspire our 10K+ Facebook page followers to recognize the hospital as a resource for accessing nutrition tips and information.	• At least 1x month social media posting on nutrition and importance of healthy eating. • **Persons served: 10,000**

Physical inactivity

Baylor Scott & White Medical Center – Temple

Action/tactics	Anticipated outcome	Evaluation of impact
Walk with a Doc Monthly walking program to encourage regular physical activity. A different featured physician each month educates on various health topics.	Encourage healthy behavior change to include regular exercise and gaining knowledge on various health topics.	• **Persons served: 164** • **$3,083 community benefit** Program suspended beginning March 2020 due to the COVID-19 pandemic.
Mayors Fitness Council Program Providing regular physical activity/engagement opportunities like TrailBlazers Club, Corporate Challenge, Walking School Bus, etc.	Temple residents have access to regular free physical games and activities to engage in and promote healthy lifestyle.	• **Persons served: 10,000** • **$20,000 community benefit**
Community health education Participate in community education opportunities to promote healthy lifestyle changes and behaviors	Community members will have the tools and information they need to make healthier choices.	• **Persons served: 3,700** • **$14,341 community benefit**
Cash and in-kind donations Cash and in-kind contributions to other not-for-profit community organizations working to address obesity and improve physical activity in the community.	Improved community health overall and lower rates of physical inactivity.	• **Persons served: 650** • **$278,559 community benefit**

Baylor Scott & White Continuing Care Hospital

Action/tactics	Anticipated outcome	Evaluation of impact
Community health education Provide information about benefits of physical activity and how to make accommodations for exercise when in long-term recovery on community board and in hospital newsletter	Positive medical outcomes and fewer chronic health conditions.	Due to COVID, the LTAC hospital did not receive visitors for a very long time. This has not been implemented to date.

Baylor Scott & White Clinic

Action/tactics	Anticipated outcome	Evaluation of impact
Walk with a Doc Monthly walking program to encourage regular physical activity. A different featured physician each month educates on various health topics.	Encourage healthy behavior change to include regular exercise and gaining knowledge on various health topics.	• **Persons served: 164** • **$3,083 community benefit** Program suspended beginning March 2020 due to the COVID-19 pandemic.

Baylor Scott & White McLane Children's Medical Center
Baylor Scott & White McLane Children's Clinic

Action/tactics	Anticipated outcome	Evaluation of impact
Family, Food, and Fun! Engaging 60+ families every year to advise on healthy eating and physical activity program.	Increase family physical activity; increase awareness of physical activity benefits.	• **Persons served: 534** • **$30,921 community benefit**
Social media Posts throughout the year on physical activity.	Inspire our 10K+ Facebook page followers to recognize the hospital as a resource for accessing physical activity information.	• At least 1x month social media posting on nutrition and importance of healthy eating and staying active. • **Persons served: 10,000**
Cash and in-kind donations Cash and in-kind contributions to other not-for-profit community organizations working to address obesity and improve physical activity in the community.	Improved community health overall and lower rates of physical inactivity.	• **Persons served: 45** • **$35,251 community benefit**

Transportation

Baylor Scott & White Medical Center – Temple

Action/tactics	Anticipated outcome	Evaluation of impact
Transportation assistance BSWMC – Temple will provide shuttle transportation or pay for bus/taxi vouchers for qualifying patients being discharged from the hospital so they may return home, to rehab or to the nursing center.	Patients are able to get home faster after discharge.	• **$111,620 community benefit**
Telehealth Specialty care visits through the telehealth platform at the Temple Community Clinic.	Un/underinsured patients who have no transportation can still consult with specialists.	This was not implemented widely. However, some patients are able to see mental health providers via telehealth platform.
American Cancer Society Transportation Program Support of American Cancer Society's Transportation Program and expansion of Ride Health to needs outside of cancer care.	Cancer patients can get assistance with travel to and from appointments.	• **Persons served: 48** • **$7,807 community benefit**
Mobile Integrated Health Mobile Integrated Health (MIH) provides weekly in-home follow-up visits for CHF, COPD and some sepsis patients for 30 days post-discharge.	Reduce readmission to ER for chronic disease patients, saving them costly bills and inconvenience. Better outcomes for health conditions.	• **Persons served: 2,000** • **$45,508 community benefit** • Highest emergency department frequenters are visited in their home to avoid readmission. Savings are avoidance cost ~ $1M. • Program ended after fiscal year 2019.
Area Agency on Aging Transportation Dollars	Utilize federal grant dollars from AAA for qualifying BSWH patients to help get them to and from follow-up medical appointments.	• **$60,000 community benefit**
Bell County Transportation Collaborative	Regular community collaborative meetings led by BSWH with community partners to discuss and identify solutions to transportation challenges.	Four meetings were held before the pandemic hit, and priorities were reordered.
Cash and in-kind donations Cash and in-kind contributions to other not-for-profit community organizations working to address transportation and access challenges in the community.	Improved access to medical appointments and prescription pickup as well as jobs, school, grocery store, etc.	• **Persons served: 1,403** • **$925,729 community benefit**
Charity care Provide free and/or discounted care to financially or medically indigent patients as outlined in the financial assistance policy.	Increased access to primary care and/or specialty care for indigent persons regardless of their ability to pay.	• **$137,540,540 community benefit**

Transportation

Baylor Scott & White McLane Children's Medical Center
Baylor Scott & White McLane Children's Clinic

Action/tactics	Anticipated outcome	Evaluation of impact
School-based telehealth clinic Establish a school-based telehealth clinic that will consist of a virtual triage for acute care visits during the school day.	School nurses will consult directly with a McLane Children's provider to help determine whether a child's condition requires treatment. If the condition requires treatment, a clinic visit or immediate referral to the ED occurs, reducing unnecessary absences.	• Established in Salado ISD in FY21 at one school, then expanded to all district schools in FY22. • **Persons served: 12** • **$1,000 community benefit**
Community health worker in the emergency department	Patients will be connected to community resources before discharge from the hospital.	• **$20,000 community benefit** Program ended in early FY20 and has not been restarted.

Baylor Scott & White Continuing Care Hospital

Action/tactics	Anticipated outcome	Evaluation of impact
Charity Care Provide free and/or discounted care to financially or medically indigent patients as outlined in the financial assistance policy.	Increased access to primary care and/or specialty care for indigent persons regardless of their ability to pay.	• **$2,895,218 community benefit**

Total investment in adopted community needs since 2019 CHNA

BSWMC – Temple	BSW McLane Children's Medical Center	BSW Continuing Care Hospital	BSW Clinic (including BSW McLane Children's Clinic)
$139 million	**$96,500**	**$2.9 million**	**$35,000**