BaylorScott&White
HEALTH

Community Health Needs Assessment 2016

Baylor Scott & White Medical Center – Round Rock

Baylor Scott & White Medical Center – Taylor

Baylor Scott & White Medical Center – Cedar Park

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– Central Texas Operating Policy and Procedure Board on April 22, 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 operate on a foundation of complementary values and similar missions. Baylor Scott & White Health 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 have worked together as members of the High Value Healthcare Collaborative, the Texas Care Alliance and Healthcare Coalition of Texas and are 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 recent advances in clinical care.

With a commitment to and a track record of innovation, collaboration, integrity and compassion for the patient, Baylor Scott & White Health 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.

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. This joint community health needs assessment applies to the following BSWH hospital facilities:

- Baylor Scott & White Medical Center – Round Rock
- Baylor Scott & White Medical Center – Taylor
- Baylor Scott & White Emergency Medical Center – Cedar Park

For the 2016 assessment, Baylor Scott & White Medical Center – Round Rock, Baylor Scott & White Medical Center – Taylor and Baylor Scott & White Emergency Medical Center – Cedar Park have defined their community to be the geographical area of Travis and Williamson counties. The community served was determined based on the counties that make up at least 75 percent of the hospital facilities' inpatient and outpatient admissions over a period of the past 12 months. Once the counties were identified those facilities with overlapping counties of patient origin collaborated to provide a joint CHNA report in accordance with the Treasury regulations. All of the collaborating hospital facilities included in this joint CHNA report define their community, for purposes of the CHNA report, to be the same.

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 the community that were community leaders and public health experts.

Needs were first identified when an indicator for the community served did not meet state benchmarks. An index of magnitude analysis was then conducted on all the indicators that did not meet state benchmarks to determine the degree of difference from benchmark in order to indicate the relative severity of the issue. The outcomes of this quantitative analysis were aligned with the qualitative findings of the community input sessions to bring forth a list of health needs in the community. These health needs were then

classified into one of four quadrants within a health needs matrix; high data low qualitative, low data low qualitative, low data high qualitative, or high data high qualitative.

The matrix was reviewed by hospital and clinic leadership in a session to establish a list of significant needs and to prioritize them. The meeting was moderated by BSWH – Central Texas Director of Community Benefit and included an overview of the community demographics, summary of health data findings and an explanation of the quadrants of the health needs matrix.

Participants all agreed that the health needs indicated in the quadrant labeled "high qualitative, high quantitative" deserved the most attention, and there was discussion around which indicators from that quadrant should be identified as significant.

A dotmocracy[1] voting method was employed to identify the significant needs, and then to prioritize those needs. Each participant voted for only 5 of the health needs identified in the matrix. The votes were tallied and priority needs were established by the highest number of votes and are displayed in order of number of votes received.

1. Chronic illness
2. Cancer
3. Primary care access
4. Mental health services

Also as part of the assessment process, we have distinguished both internal resources and community resources and facilities 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).

[1] "Dotmocracy" is an established facilitation method used to describe voting with dot stickers, also known as "multi-voting". In Dotmocracy participants vote on their favorite options using a limited number of stickers or marks with pens — dot stickers being the most common. This sticker voting approach is a form of cumulative voting.

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

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. 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 the BSWH facilities.

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.

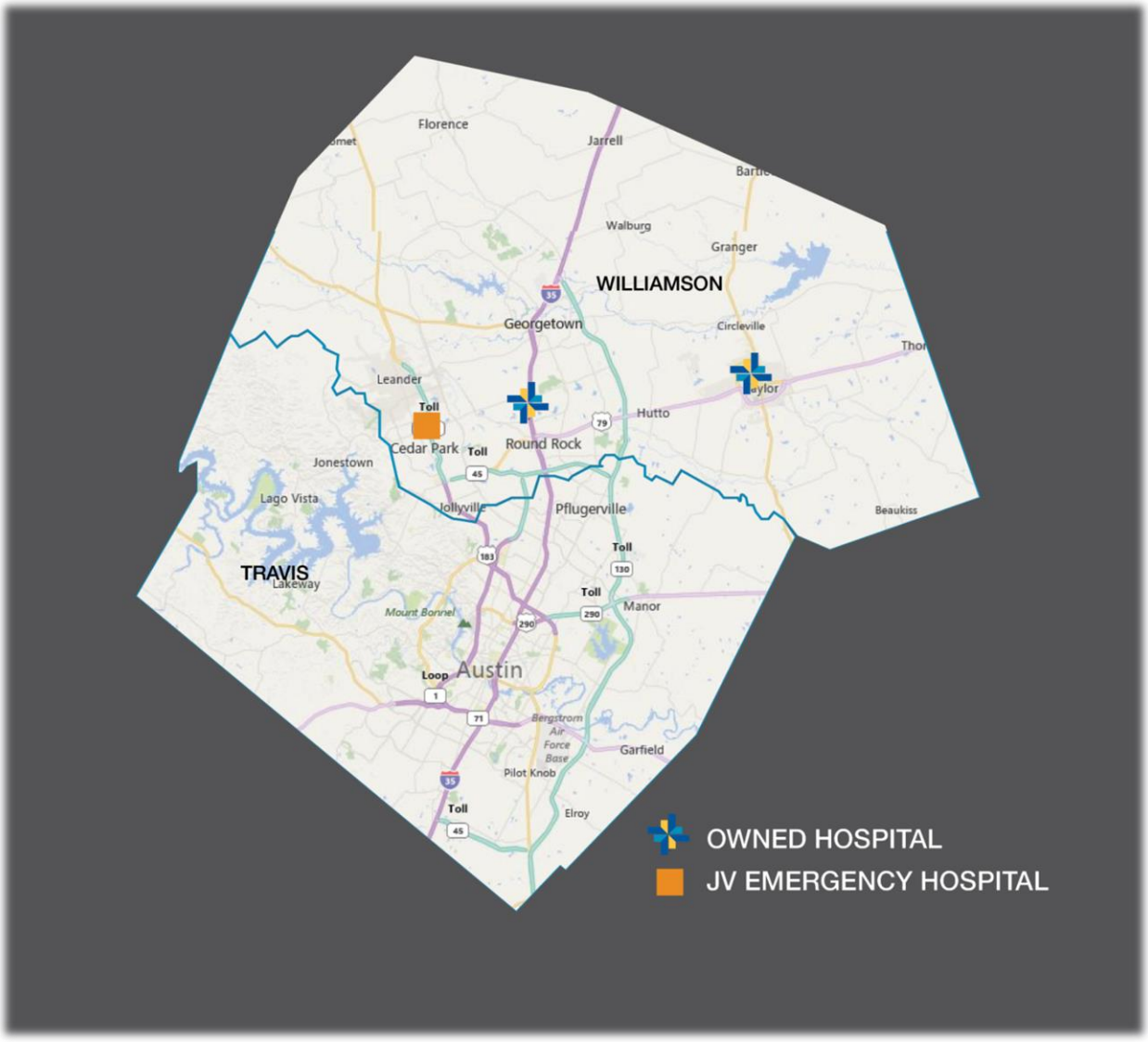
The community served definitions used in this current assessment differ from those used by the legacy Baylor Health Care System and the legacy Scott & White Healthcare in their 2013 CHNAs.

BSWH, has chosen a common methodology and approach to define the communities served for each of its facilities. BSWH identified the counties accounting for at least 75 percent of each facility's total volume (based on the most recent 12 months of inpatient and outpatient data). Once the counties were identified, those facilities with overlapping counties of patient origin collaborated to produce a joint CHNA report, in accordance with the Treasury regulations. All of the collaborating hospital facilities included in this joint CHNA report define their community for purposes of the CHNA report to be the same.

BSWH Community Health Needs Assessment Community Served Definition

For the 2016 assessment, the facilities have defined their community to be the geographical area of Travis and Williamson counties. The community served was determined based on the counties that make up at least 75 percent of the hospital'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 counties where data was 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+

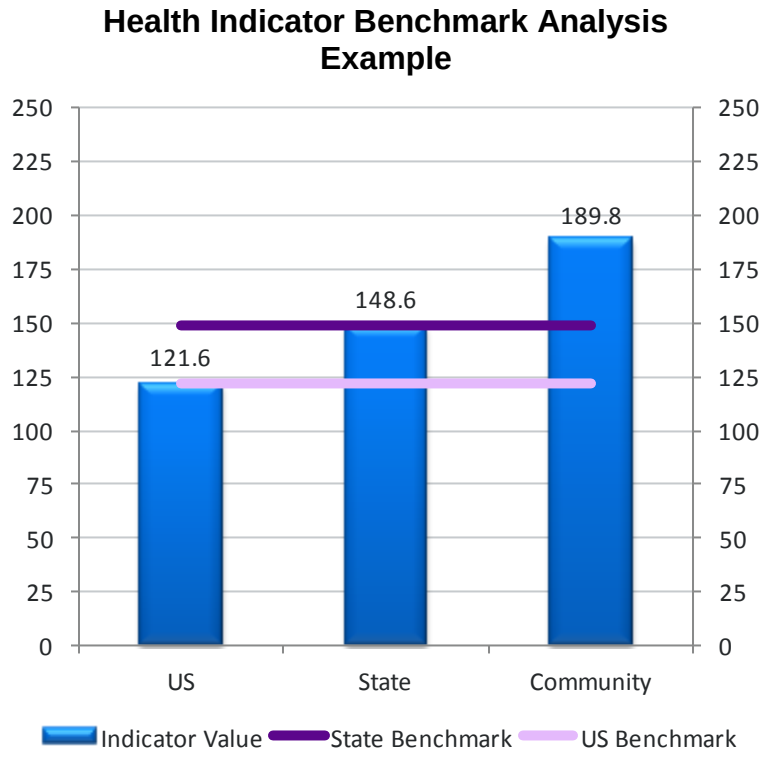
Health Outcomes
- Poor or Fair Health
- Average Number of Poor Physical Unhealthy Days in Past Month
- Cancer (all causes) Incidence
- Breast Cancer
- Colon Cancer
- Lung Cancer
- Prostate Cancer
- Diabetes
- Stroke
- Arthritis
- Alzheimer's/ Dementia
- Atrial Fibrillation
- COPD
- Kidney Disease
- Depression
- 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 demonstrate a community health need, a benchmark analysis was conducted for each indicator collected for 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.



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 are identified when one or more of the indicators for the community served do 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 differ from benchmark in order to understand their relative severity of need.

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, a focus group with forty (40) participants, as well as eight (8) key informant interviews, were conducted September through November 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 is 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 feel about the general health status of the community and the various drivers contributing 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).

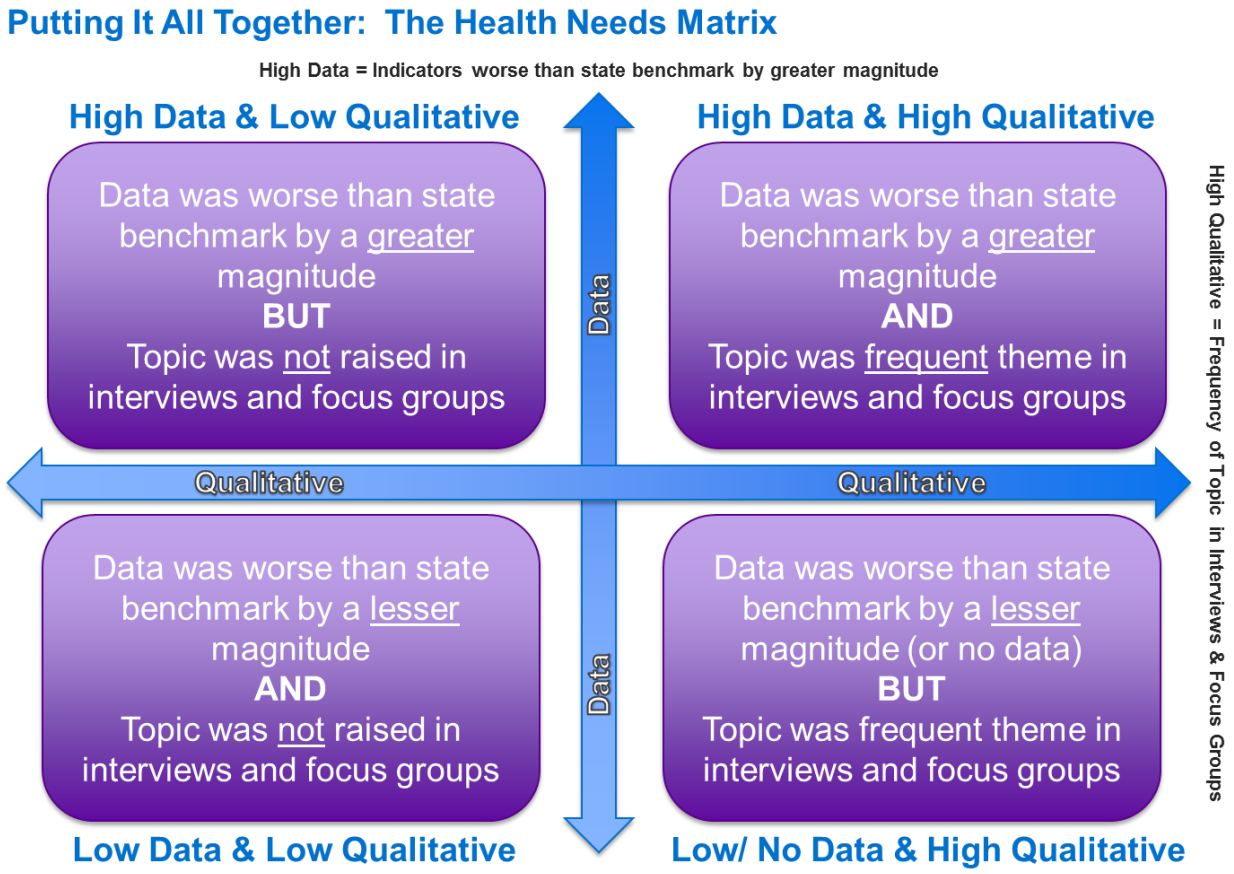
In addition to soliciting input from public health and various interests of the community, hospitals are also required to take into consideration written input received on their most recently conducted CHNA and subsequent implementation strategies. The facilities have an active portal on the website (CHNA.sw.org) where the assessment has been made available asking for public comment or feedback on the report findings. 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 were organized into themes around community needs and compared to the quantitative data findings.

Methodology for Defining Community Need

Quantitative and qualitative data were analyzed and displayed as a health needs matrix to help identify the most significant community health needs. Below is the matrix for the community served by the BSWH facilities in this community.

The upper right quadrant of the matrix is where the qualitative data (interview and focus group feedback) and quantitative data (health indicators) converge.



Source: Truven Health Analytics, 2016

Information Gaps

The majority of public health indicators are only available at the county level and in Texas health indicators are 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 challenging 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, Baylor Scott & White Medical Center - Round Rock, Baylor Scott & White Medical Center - Taylor and Baylor Scott & White Emergency Medical Center - Cedar Park chose to address the following identified needs:

- Obesity
- Breast cancer incidence rate
- Diabetes

Implementation strategies were put into place in 2013 to address the above needs. Those strategies have been evaluated as to their effectiveness and impact. Details for that evaluation can be found in ***Appendix C***.

Demographic and Socioeconomic Summary

According to population statistics, the community served was fairly representative of Texas overall. The projected population growth rate by 2020 and median income will be higher than the state and national benchmarks. The community served has lower socioeconomic barriers when compared to the state, specifically in Williamson County.

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	1,620,861
5 Yr Proj Pop Chg	4%	7%	9%
Population 0-17	23%	26%	25%
Population 65+	15%	12%	9%
Women Age 15-44	20%	21%	23%
Non-White Population	29%	31%	29%
Insurance Coverage: Medicaid	19%	14%	10%
Insurance Coverage: Uninsured	10%	20%	17%
Median Household Income	$56,682	$56,653	$62,071
Limited English	5%	8%	7%
No High School Diploma	14%	19%	12%
Unemployed	10%	8%	8%
Poverty	16%	18%	Travis Co: 18% Williamson Co: 8%

Source: Truven Health Analytics / The Nielsen Company, 2015

The population of the community served is expected to grow over 9% (152,000 people) by 2020. The 9% population growth is higher compared to the state growth rate of 7%

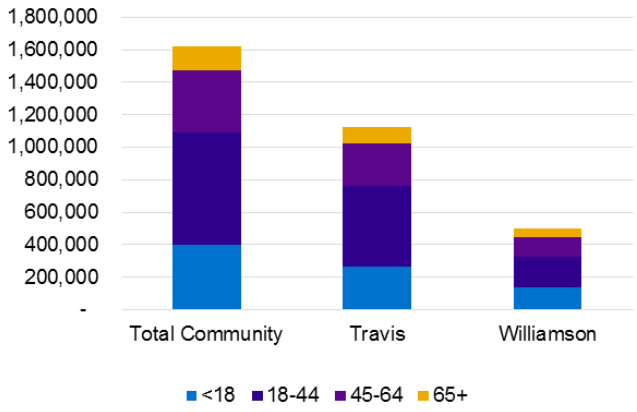
and the national growth rate of 4%. The ZIP Codes expected to experience the most growth in five years:

- 78732 Austin – 15.7%
- 78738 Austin – 15.1%
- 78747 Austin – 14.5%
- 78754 Austin – 15.3%
- 78634 Hutto - 14.6%

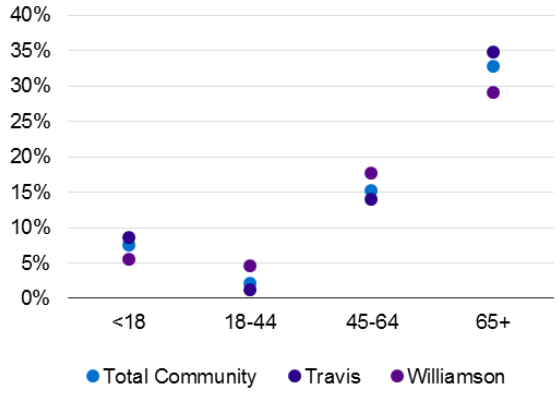
The sixty-five plus age cohort was the fastest growing at 33%, and is expected to increase by nearly 50,000 seniors over the next five years. Growth in this population will likely contribute to an increase in healthcare utilization as the population continues to age. Moreover, those from 45 to 64 years of age are projected to grow by nearly 58,000 individuals, which will also contribute to an increase in the utilization of healthcare.

Population by Age Cohort

2015 Total Population



5 Year Projected Population Growth Rate



Source: Truven Health Analytics / The Nielsen Company, 2015

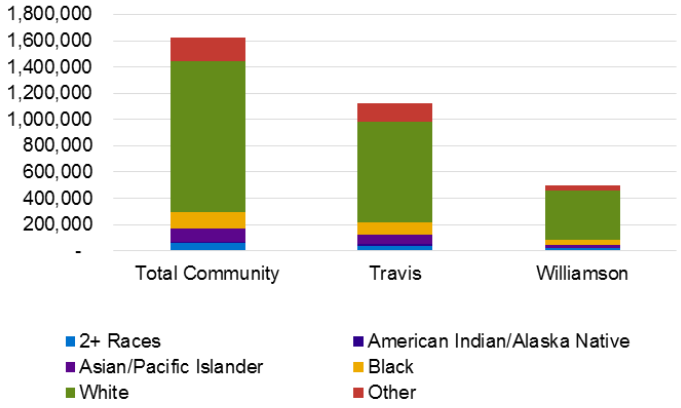
Diversity in the community will increase as minority populations are expected to grow the fastest. The majority of citizens resided in Travis County (69%). Also, Travis County was slightly more diverse than Williamson County due to a lower proportion of residents being identified as white. Within the community served, one-third of the population was Hispanic with Travis County being 35% Hispanic and Williamson County being 24% Hispanic. The Hispanic population in Williamson County is expected to grow more quickly than that of Travis County. Overall, faster growth is expected among the Hispanic population compared to the non-Hispanic population.

With the exception of the Caucasian population, all races are expected to exceed a 10% growth rate over the next 5 years. The Asian / Pacific Islanders and multi-racial populations are expected to experience significant growth over the next 5 which will increase the population by 182,000 people. The African American population in Williamson County is expected to grow at twice the rate of Travis County. Total population

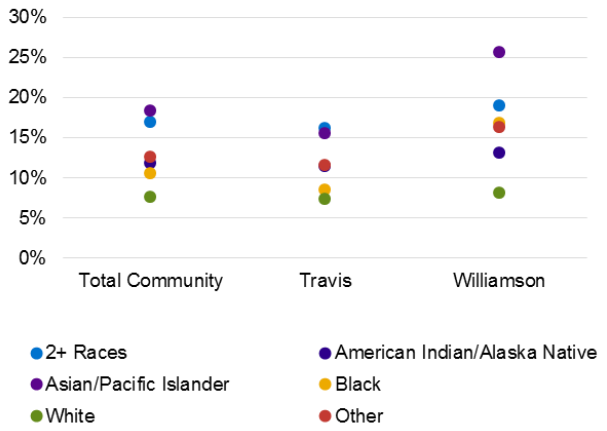
can be analyzed by race or by Hispanic ethnicity. The graphs below display the community's total population breakdown by race (including all ethnicities) and also by ethnicity (including all races).

Population by Race

2015 Total Population



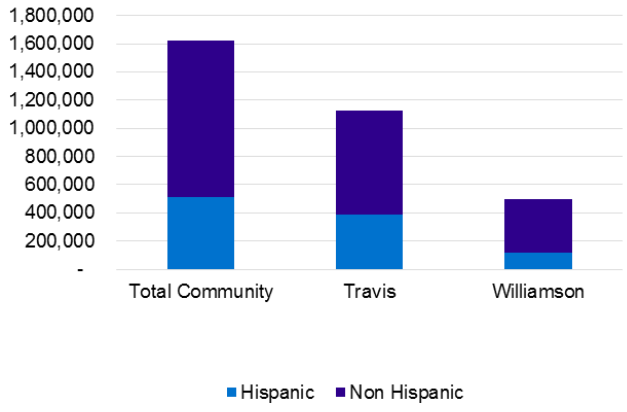
5 Year Projected Population Growth Rate



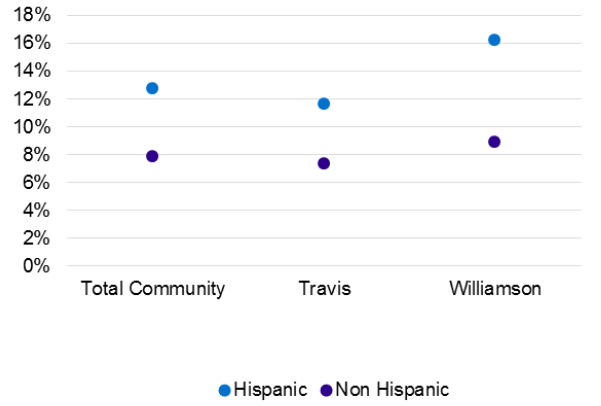
Source: Truven Health Analytics / The Nielsen Company, 2015

Population by Hispanic Ethnicity

2015 Total Population



5 Year Projected Population Growth Rate

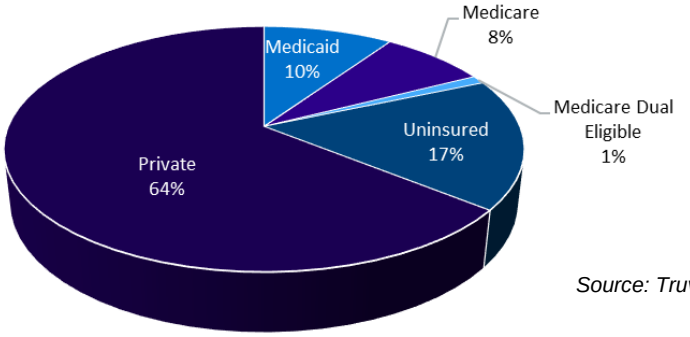


Source: Truven Health Analytics / The Nielsen Company, 2015

The median household income for the community served was $62,071. Sixty-four percent (64%) of the community was commercially insured. The population purchasing insurance through the health insurance exchange marketplace is expected to increase 65% by 2020. Within the community, up to 7% of the population are expected to purchase

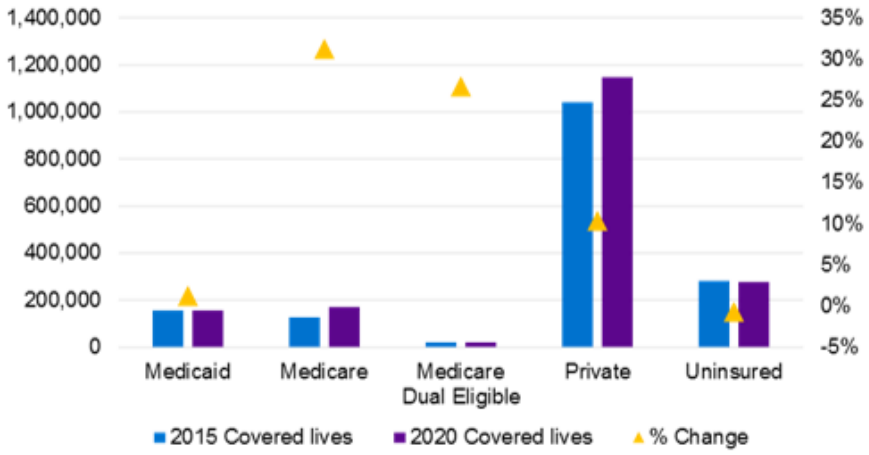
insurance on the exchanges by 2020. Over the next 5 years, Medicaid enrollment is projected to remain flat. Medicare and dual eligible enrollment will increase more in Travis County. Both counties are expected to experience a minimal decline in the number of uninsured individuals.

2015 Estimated Distribution of Covered Lives by Insurance Category



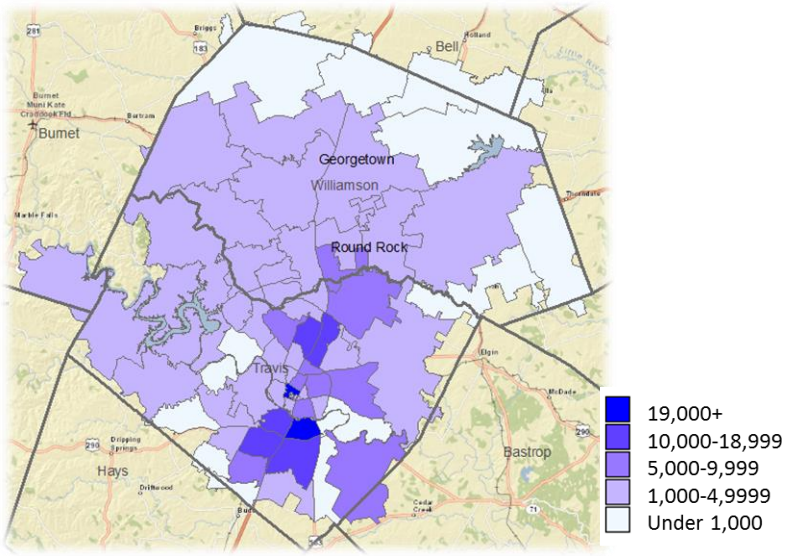
Source: Truven Health Analytics, 2015

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 thirteen (13) Health Professional Shortage Areas and two (2) Medically Underserved Areas as designated by the U.S. Department of Health and Human Services Health Resources Services Administration.[2] ***Appendix D*** includes the details on each of these designations.

Health Professional Shortage Areas and Medically Underserved Areas and Populations

	Health Professional Shortage Area (HPSA)				Medically Underserved Area/Population (MUA/P)
COUNTY	**Dental Health**	**Mental Health**	**Primary Care**	**TOTAL HPSA**	**TOTAL MUA/P**
Travis County	2	2	3	7	1
Williamson County	2	2	2	6	1
TOTAL	**4**	**4**	**5**	**13**	**2**

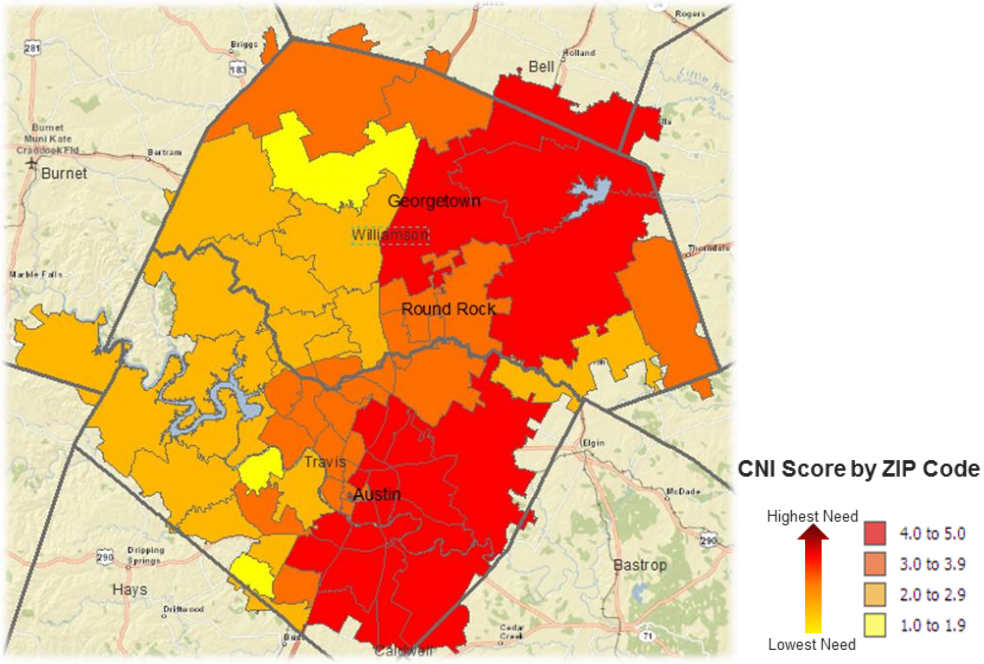
The Truven Health Community Need Index (CNI) is a statistical approach to identifying health needs in a community. The CNI takes into account vital socio-economic factors (income, cultural, education, insurance and housing) about a community to generate a CNI score for every populated ZIP code in the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

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

demand for various healthcare services. The CNI score by ZIP code identifies specific areas within a community where healthcare needs may be greater.

Overall, the community served was slightly higher than the U.S. CNI. However, there were portions of the community that identified significant health needs due to barriers to health. Georgetown, Bartlett, and Taylor in northeast Williamson County had the highest CNIs. Manor, Del Valle and portions of Austin were identified as having the greatest health needs. The community had an overall CNI Score of 3.5.

2015 Community Need Index by ZIP Code



Source: Truven Health Analytics, 2015

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 community indicators 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	Amount of price-adjusted Medicare reimbursements per enrollee
Access to care	Ratio of population to one non-physician primary care provider
Environment	Food Insecure Households (percent)
Environment	Severe housing problems (percent of households)
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 behaviors	Number of drug poisoning deaths (per 100,000)
Health behaviors	Sexually Transmitted Infection Incidence Rate (per 100,000)
Health outcomes	Female Breast Cancer Incidence
Health outcomes	Prostate Cancer Incidence (per 100,000)
Health outcomes	Atrial Fibrillation: Medicare Population (percent)
Health outcomes	Depression: Medicare Population (percent)
Health outcomes	Hyperlipidemia: Medicare Population (percent)
Health outcomes	Schizophrenia and Other Psychotic Disorders: Medicare Population (percent)
Health outcomes	Osteoporosis: Medicare Population (percent)
Health outcomes	HIV Prevalence
Health outcomes	Pediatric Asthma Admission Risk-Adjusted-Rate (per 100,000)
Health outcomes	Pediatric Perforated Appendix Admission Risk-Adjusted-Rate (per 100 Admissions for Appendicitis)
Health outcomes	Adult Perforated Appendix Admission Risk-Adjusted-Rate (per 100 Admissions for Appendicitis)
Health outcomes	Low Birth Weight Rate (per 100 births)
Mental health	Ratio of population to one mental health provider.
Population	High School Graduation Rate
Population	Social associations (membership associations per 10,000 population)
Population	Percentage of children enrolled in public schools that are eligible for free lunch

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 Heart Disease Estimates identified hypertension as the most prevalent heart disease diagnoses. The city of Austin accounted for two-thirds of the total cases for each heart disease type in the community served. The following cities accounted for less than 10% of heart disease cases for each individual illness:

- Round Rock, 8%
- Georgetown, 7%
- Pflugerville, 5%
- Cedar Park, 4%
- Leander, 4%

There were 320,000 cases of hypertension in the community; this was more than all other heart disease cases combined.

2015 Estimated Heart Disease Cases

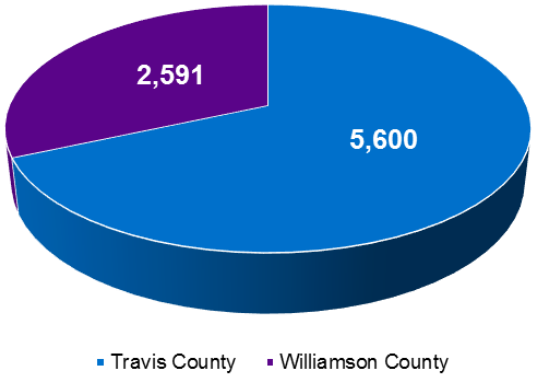
Disease Type	Travis County	Williamson County	Total Community
ARRHYTHMIAS	40,315	16,759	57,074
CONGESTIVE HEART FAILURE	15,119	6,874	21,994
HYPERTENSION	226,370	93,742	320,113
ISCHEMIC HEART DISEASE	33,456	14,159	47,615

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

Source: Truven Health Analytics, 2015

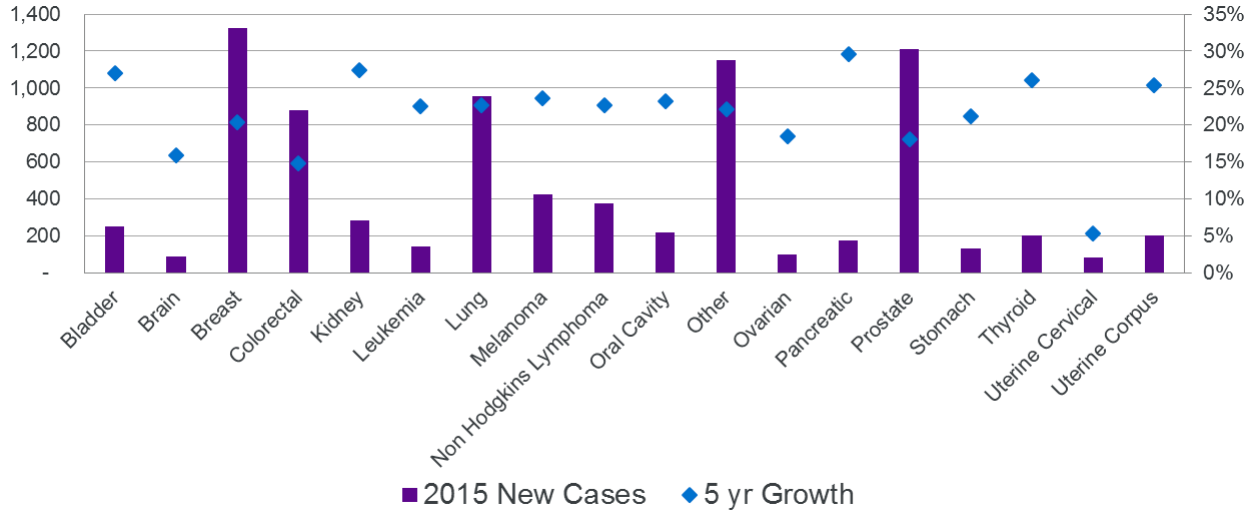
Truven Health's 2015 Cancer Incidence Estimates projected the greatest growth rates for bladder, kidney, pancreatic, thyroid, and uterine corpus cancers in the community. Breast, prostate, lung, and colorectal cancers continued to be the most prevalent cancer types. Incidence rates for the majority of cancers were higher than the state.

2015 Estimated New Cancer Cases



Source: Truven Health Analytics, 2015

New Cases and Projected Growth by Cancer Type

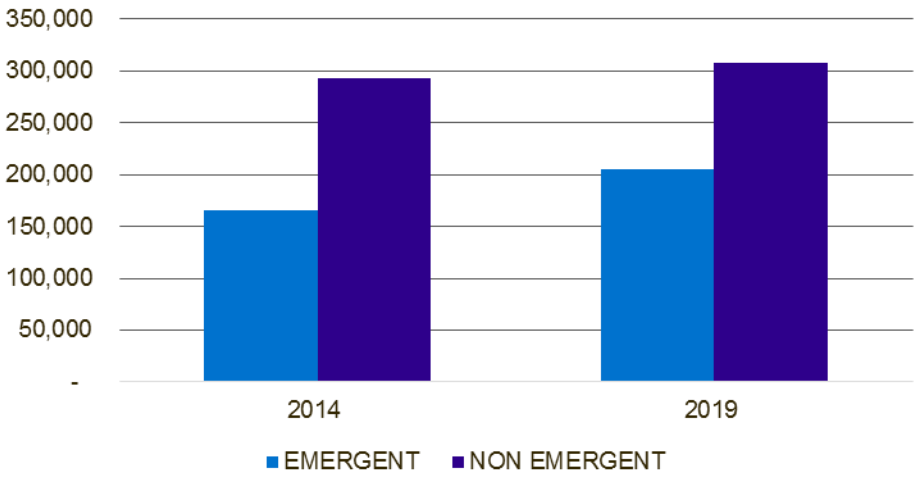


Source: Truven Health Analytics, 2015

Outpatient emergency department visits are those which are treated and released and therefore do not result in an inpatient admission. Truven Health estimated outpatient emergency department visits to increase 12% in the community over the next five years with a 24% growth in emergent visits alone.

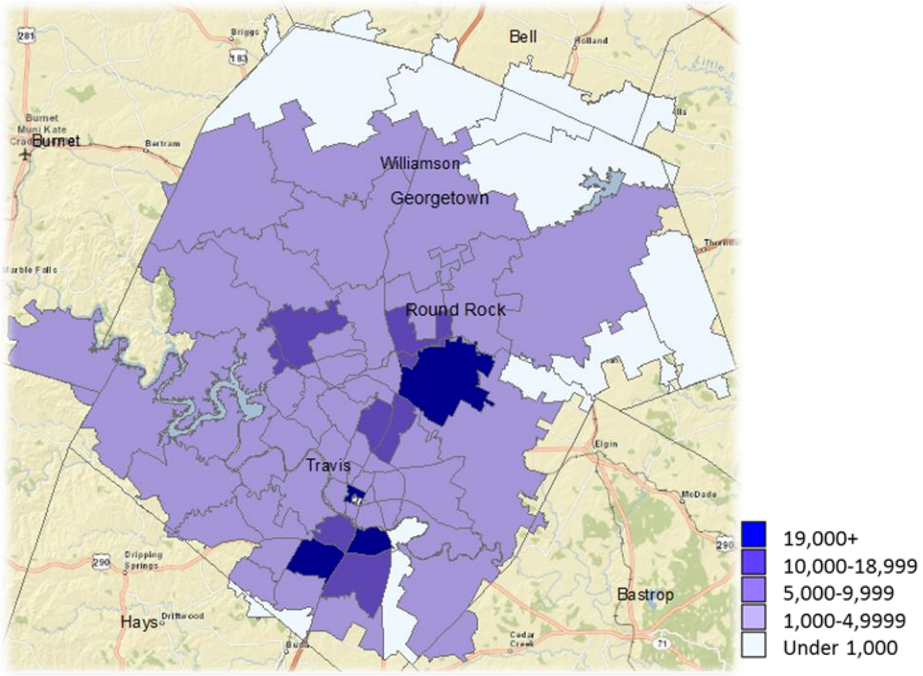
Non-emergent outpatient ED visits are lower acuity visits that present in the ED but can be treated in other more appropriate and less intensive outpatient settings. Non-emergent ED visits can be an indication that there are systematic issues with access to primary care or managing chronic conditions. There will be an increase of 5% in non-emergent visits in the community served over the next 5 years.

Emergent and Non-Emergent ED Visits



Source: Truven Health Analytics, 2015

Emergent and Non-Emergent ED Visits



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. The factors contributing to this perceived health status include chronic disease rates, socioeconomic and health disparities, health education, and healthy community.

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

1. Prevention (vaccines and smoking cessation)
2. Cultural sensitivity
3. Expanding programs (preventing services for the uninsured, environmental health)
4. Health education (palliative & hospice care, health literacy)
5. Community health and wellness (access to healthy food, crime and violence, environment, dental care)

Barriers to good healthcare in this community include access to care issues, limited mental / behavioral health services, lack of specialty care, and the need for health education. The following populations were identified as vulnerable groups that will need special attention when addressing health needs:

- Minorities
- Lower socioeconomic status
- Immigrants
- Undocumented
- Hispanic teens
- Disabled elderly

Focus group participants were asked what factors contribute to the current health status of the community. Discussions focused on the growth of the community, community health and wellness, lack of public transportation, public health education, access to healthcare, having basic life needs met and cultural and language differences. The discussions focused on significant differences that existed between the urban and rural populations and how these differences impacted the community's healthcare challenges.

Access was a top priority for all breakout groups. There were not enough healthcare resources, which included specialists, primary care physicians, dental services, multi-lingual care givers and senior resources, to meet the needs of the growing community. Public transportation was not available in the rural areas, and it had limited availability in the urban areas. An inadequate number of sidewalks was also an issue for both locations which added additional burden to the transportation issues in the community served. High rates of uninsured residents impacted the availability of affordable healthcare options. Cultural barriers accompanied by linguistic isolation also contributed to the community's ability to access care.

The need for the community to focus on health and wellness was apparent in the focus group discussions. Environmental concerns such as the use of pesticides and reported air and water pollution were discussed; moreover, the risk environmental hazards placed

on health and the burden placed on the management of chronic disease impacted the community served. Health literacy and the awareness of the impact that healthy living had on physical well-being was lacking. The communication and education processes within the community were fragmented; therefore, information regarding programs and services focusing on healthy living were not disseminated throughout the community.

The stigma that surrounded mental health conditions impacted the cultural acceptance of those suffering from such illnesses. Limited mental health resources and services placed a burden on the community due to the lack of access to care. Services for depression, suicide, senior dementia, drug and substance abuse, general counseling, and long term monitoring and management are needed in the community served.

Lifestyle modifications in support of chronic disease management and prevention was also identified as a health need. The focus group identified the significance of diabetes and obesity and how they relate to chronic disease. With this being said, the community must prevent these conditions in an effort to remain healthy and free from chronic disease.

The focus groups identified the following top health needs:

- Chronic disease
    - Management of those with chronic conditions
    - Prevention, including lifestyle modification
- Obesity
- Mental /behavioral health
- Senior health
- Health literacy
- Access to care
    - Cost of care/insurance
    - Transportation
    - Rural communities
- Access to a healthy environment

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.

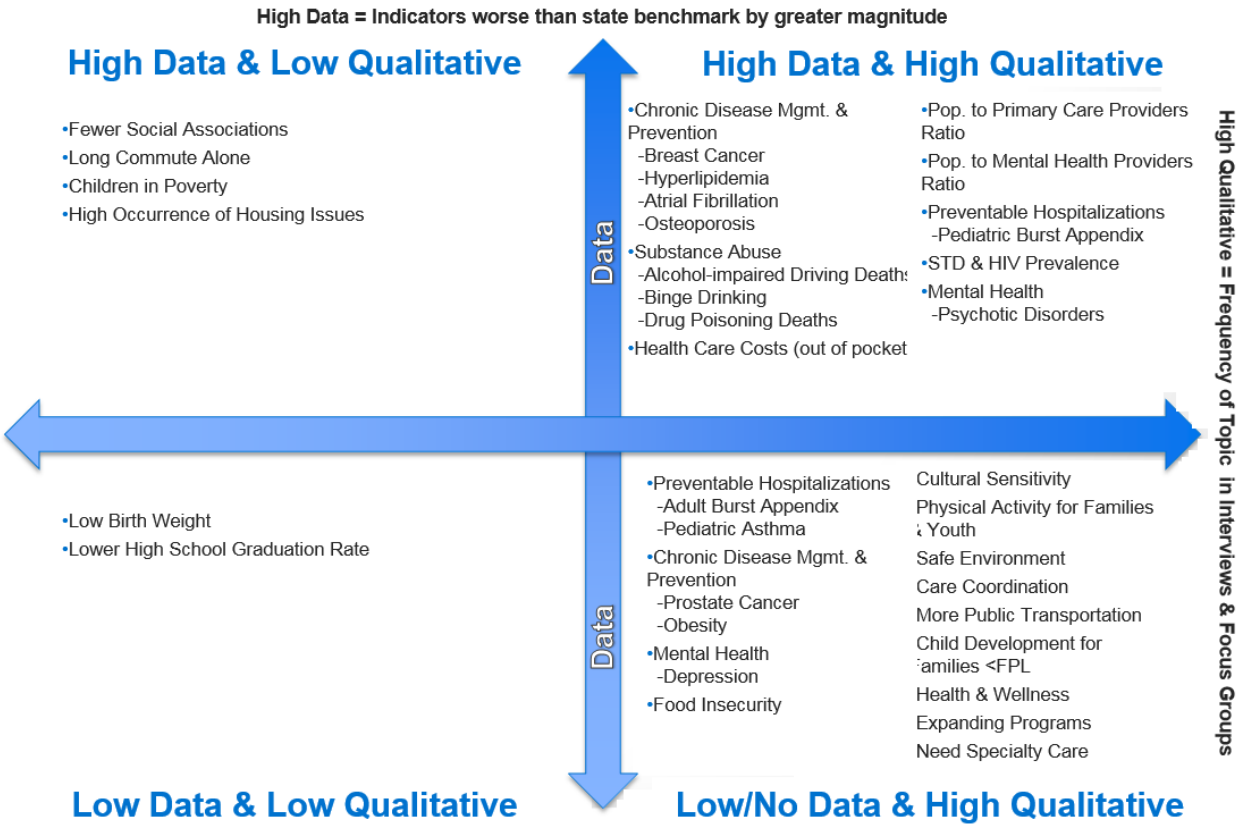
The interview and focus group participants and the populations they serve for this community are documented in the following table.

Focus Group and Key Informant Interview Participants				
Community Leaders/ Groups	**Public and Other Organizations**			**Other Providers**
Austin Interfaith (Interview) **LI, MP**	Texas A&M Agrilife Extension Services (Interview) **LI**	Texas A&M College of Medicine (Focus Group) **MU, CD**	Foundation Communities (Focus Group) **LI**	Gardner Chiropractic: Family and Wellness Center (Focus Group) **CD**
St. Davids Foundation (Interview) **MU**	Travis County Public Health Department, Health and Human Services Department (Interview) **PH**	Texas Health and Human Services Commission (Focus Group) **PH**	Round Rock ISD (Focus Group) **MU, LI, CD, MP**	Valence Health (Focus Group) **MU, LI**
American Heart Association (Focus Group) **MU, LI, CD, MP**	University of Texas School of Public Health (Interview)	Williamson County and Cities Health District (Focus Group) **PH, LI, CD, MP**	Hutto ISD (Focus Group) **MU, LI, CD, MP**	Texas NeuroRehab Center (Focus Group) **CD**
Bike Hutto (Focus Group)	It's Time Texas (Focus Group) **PH**	Williamson County HealthCare Link (Focus Group) **PH**	Lone Star Circle of Care (Focus Group) **MU, LI, CD, MP**	LifeSteps Council on Alcohol and Drugs (Focus Group) **MU, LI**
Catholic Charities of Central TX (Interview) **MU, LI, MP**	Georgetown ISD (Focus Group) **CD**	Williamson-Burnett County Opportunities (WBCO) (Focus Group) **PH**	WCCHD (Focus Group) **MU, LI**	Williamson County EMS (Focus Group) **MU**
Central Health (Interview) **MU, LI**	Leander ISD (Focus Group)	Williamson Counties and Cities Health District (WCCHD) (Focus Group) **PH**	Southwestern University (Focus Group)	WBCO (Focus Group) **MU, LI**
Smith&Nephew (Focus Group) **MU, LI, CD**	Texas Department of State Health Services (Interview & Focus Group) **PH**	FRIDAY & ADAPT (Focus Group)	Texas A&M Health Science Center Preventative Medicine (Focus Group)	
Literacy Council of Williamson County (Focus Group) **MU, LI**	Asian Chamber of Commerce (Interview) **MP**	Taylor ISD (Focus Group) **CD**		

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

Both the quantitative data and qualitative data were analyzed and assembled into a Health Needs Matrix in order to help identify the most significant community health needs. Below is the matrix for the community served the BSWH facilities.



Source: Truven Health Analytics, 2016

Prioritizing Community Health Needs

In order to identify and prioritize the significant needs of the community, the hospital facility established a comprehensive method of taking into account all available relevant data including community input.

First, specific needs were pinpointed when an indicator for the community served did not meet state benchmarks. Then an index of magnitude analysis was conducted on all those indicators to determine the degree of difference from the benchmark in order to indicate the relative severity of the issue. The outcomes of this quantitative analysis were aligned with the qualitative findings of the community input sessions to bring forth a list of health needs in the community. These health needs were then classified into one of four quadrants within a health needs matrix; high data low qualitative, low data low qualitative, low data high qualitative, or high data high qualitative.

The matrix was reviewed on February 8, 2016 by members of Baylor Scott & White Medical Center - Round Rock, Baylor Scott & White Medical Center - Taylor and Baylor Scott & White Emergency Center Cedar Park hospital and clinic leadership in a session to establish a list of significant needs and to prioritize them. The meeting was moderated by BSWH – Central Texas Director of Community Benefit and included an overview of the community demographics, summary of health data findings, and an explanation of the quadrants of the health needs matrix.

Session participants included:

President – Round Rock Region	Vice President Clinic Operations	Director, Project Management and Community Development
Regional Marketing Manager	Vice President Hospital Operations	

Participants all agreed that the health needs indicated in the quadrant labeled “high qualitative, high quantitative” deserved the most attention, and there was discussion around which indicators from that quadrant should be identified as significant.

A dotmocracy[3] voting method was employed to identify the significant needs, and then to prioritize those needs. Each participant voted for only 5 of the health needs identified in the matrix. The votes were tallied and priority needs were established by the highest number of votes and are displayed in order of number of votes received.

1. Chronic illness
2. Cancer
3. Primary care access
4. Mental health services

[3] “Dotmocracy” is an established facilitation method used to describe voting with dot stickers, also known as “multi-voting”. In Dotmocracy participants vote on their favorite options using a limited number of stickers or marks with pens — dot stickers being the most common. This sticker voting approach is a form of cumulative voting.

The significant needs were prioritized based on the severity of each need as it pertains to the state benchmark, value the community places on the need, and prevalence of the needs within the community.

Description of Significant Health Needs

Chronic Illness

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.[4]

The management and prevention of chronic diseases was identified as a leading health need in the community according to the focus group and interview participants. Specifically, the community identified the lack of public education to create awareness of chronic diseases and the factors that contribute, such as obesity, cardiac health and diabetes. The group noted the prevalence of obesity in children seeming to outpace that of obesity in adults. Growth of the community has impacted its health, especially as it pertains to chronic conditions. Urbanization has led to unhealthy diets due to the increasing availability of fast food options. The participants believed lifestyle modifications would need to be addressed in order to manage chronic disease in the community. Health education and assistance with managing chronic illnesses in all populations were common themes in the community discussions. In addition, the group specifically mentioned high rates of obesity, cardiac health and diabetes in the community.

According to the Centers for Medicare and Medicaid Services (CMS), a greater proportion of Williamson County Medicare recipients (47%) had hyperlipidemia compared to the state (45%) (Travis County was better than the state benchmark at 42%).[5] Hyperlipidemia is elevated blood lipid levels such as cholesterol and triglycerides and is associated with heart disease and stroke. Both counties have slightly higher rates of atrial fibrillation as well. In Travis County 7.5%, and in Williamson County 7.2%, of Medicare recipients have atrial fibrillation compared to a state value of 7.0%.[6] Hypertension and valvular heart disease are risk factors for atrial fibrillation. The proportion of osteoporosis is also slightly higher than the state in Travis County (7.5% compared to 7.0%).[7]

Cancer

Addressing the prevalence of all cancer types was identified as a need by the community input sessions. According to the National Cancer Institute's State Cancer Profiles, this community's female breast cancer incidence was 120 cases per 100,000 people in Travis

[4] http://www.medicinenet.com
[5] CMS, 2012 Percentage of Medicare FFS Beneficiaries with hyperlipidemia
[6] CMS, 2012 Percentage of Medicare FFS Beneficiaries with atrial fibrillation
[7] CMS, 2012 Percentage of Medicare FFS Beneficiaries with osteoporosis

County and 121 cases per 100,000 in Williamson County. Both Travis and Williamson counties were higher than the state value of 113 cases.[8] Breast cancer was an identified need in 2013, hospital leaders agreed it remained to be a need but also cancers of all types need to be an area of focus as well. Of the cancer rates analyzed, the Williamson County prostate cancer incidence rate also compares (slightly) unfavorably to the state benchmark falling just above the state incidence rate of 115.7 cases per 100,000 people with a rate of 115.9 cases.[9] Overall, the state of Texas has a cancer incidence rate of 418 per 100,000 people for all cancer types and both counties are favorable compared to the state on this measure. Travis County has a cancer incidence rate per 100,000 of 393 and Williamson County has a rate of 403.[10]

Primary Care Access

Barriers to accessing health care such as the cost of doctor visits/insurance, lack of transportation, and lack of health care infrastructure in outlying (more rural) areas were mentioned frequently in the community input sessions. Participants acknowledged the socioeconomic divide between urban/suburban and rural areas present challenges regarding access to healthcare services, specifically the increase in the disparity of access and quality of care between these areas of the community. Individuals living in rural areas often had no personal transportation and did not have public transportation. This provided challenges for these individuals to attend healthcare appointments. Cultural attitudes and beliefs also prevented some residents from seeking immediate care for an illness. Additionally, the lack of bilingual / multilingual resources impacted access to educational opportunities and community support. Uninsured patients and those covered by Medicaid encountered long physician appointment wait times; in some cases, patients could not get an appointment for up to a year. The cost to purchase insurance or pay out of pocket for health care is a significant barrier for those who are un/underinsured. Certain areas also encountered access issues due to a shortage of primary care physicians.

Non-physician primary care providers, such as nurse practitioners or physician assistants are one way to provide access to primary care at a lower cost. Health care costs in Williamson County are above the state average as measured by Medicare reimbursements.[11] The Centers for Medicare and Medicaid Services (CMS) identified that there was one non-physician primary care provider for every 2,264 residents in Williamson County. This was fewer providers per population than the 1,893 residents per non-physician primary care provider for the state as a whole.[9] Travis County was better than the state benchmark for both measures.

[8] National Cancer Institute, State Cancer Profiles, 2008-2012 average annual incidence per 100,000 people, female breast cancer (age-adjusted)
[9] National Cancer Institute, State Cancer Profiles, 2008-2012 average annual incidence per 100,000 people, male prostate cancer (age-adjusted)
[10] National Cancer Institute, State Cancer Profiles, 2008-2012 average annual incidence per 100,000 people, all cancer sites (age-adjusted)
[11] Dartmouth Atlas of Health Care, 2012 Amount of price-adjusted Medicare reimbursements per enrollee

Mental Health Services

The number of residents to one mental health provider was 1,101 in Williamson County compared to 1,034 in Texas. Travis County was lower than the state value with 449 residents per mental health provider.[12] CMS reports that 4.3% of the Medicare population in Travis County had been diagnosed with schizophrenia and other psychotic disorders; this is slightly higher than the Texas (3.6%).[13]

Mental Health was identified as a priority through the key informant interviews and focus group. Specifically needed was access to mental healthcare services to address issues such as depression, suicide, drug and substance abuse and tobacco usage. The need for education on the basics of mental health and counseling services was brought up by community members. Finally, the need to address the stigma associated with mental illness was identified due to the influence in often has on an individual's decision to seek treatment.

Summary

BSWH conducted its Community Health Needs Assessments 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 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 has chosen to address for the community served.

[12] CMS NPI file, 2014 Ratio of population to one mental health provider
[13] 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

American Diabetes Association	Central Health Policy Council	Community based youth athletics	Farmers Market
Any Baby Can	Chamber of Commerce	Community Care Collaborative / City Health District	Free Clinics
Austin Community College	Chiropractors	Community EMS	Grocery stores (healthy foods)
Baca Center (senior and community center)	Churches - Ministry Alliance	Community Gardens	Head Start
Baylor Scott & White Health	City based infrastructure available	Community Paramedics	Health Clinic (e.g. CVS, Walgreens, Urgent Care)
Behavioral Health Task Force	City Health District / FreeNet	Community Partnerships	H-E-B Grocery Stores
Blue Bonnet	Clay Madsen	County Health Department	Higher education and medical schools in the community
Capital Idea	Clinics	DSRIP (Delivery System Reform Incentive Payment)	Hospitals and clinics located in community
Caring Place	Colleges and Universities	Employers: large, locally based (e.g. Dell, ERCOT)	Independent School District (ISD) Alliance
Central Health Collation on Mental Health	Community Advancement Network (CAN)	Faith based programs	Leander Independent School District
Local Organizations	Philanthropy	Solid school systems	Veterans Administration

Lone Star Circle of Care	Recreation centers	St. David's Foundation	WIC Program
Marketing and advertisement	Retirement communities	STARRY mobile outreach for children	WilCo Wellness Alliance
Meals on Wheels	Round Rock Service Center	Strong non-profit community	Williamson Counties & Cities Health District (WCCHD)
Parks and Recreation	School Nurses	Texas Mobile Dentistry	YMCA
Partners in Austin Transforming Health (PATH)	Social services resources	United Way	

Community Healthcare Facilities[14]

Hospitals – Twenty-eight (28) hospitals serving the community

Facility Name	System	Type	Street Address	City	State	ZIP
Cedar Park Regional Medical Center	Ascension Health	ST	1401 MEDICAL PARKWAY	CEDAR PARK	TX	78613
Central Texas Rehabilitation Hospital	Ascension Health	LT	700 W 45TH STREET	AUSTIN	TX	78751
Dell Children's Medical Center	Ascension Health	KID	4900 MUELLER BLVD	AUSTIN	TX	78723
Seton Medical Center Austin	Ascension Health	ST	1201 WEST 38TH STREET	AUSTIN	TX	78705
Seton Medical Center Williamson	Ascension Health	ST	201 SETON PARKWAY	ROUND ROCK	TX	78665
Seton Northwest Hospital	Ascension Health	ST	11113 RESEARCH BOULEVARD	AUSTIN	TX	78759
University Medical Center At Brackenridge	Ascension Health	ST	601 EAST FIFTEENTH STREET	AUSTIN	TX	78701
Baylor Scott & White Emergency Medical Center Cedar Park	Baylor Scott & White	ST	900 EAST WHITESTONE BLVD	CEDAR PARK	TX	78613
Baylor Scott & White Medical Center - Round Rock	Baylor Scott & White	ST	300 UNIVERSITY BLVD	ROUND ROCK	TX	78665
Baylor Scott & White Medical Center - Taylor	Baylor Scott & White	ST	305 MALLARD LANE	TAYLOR	TX	76574
Cornerstone Hospital Austin	Cornerstone Healthcare Group	LT	4207 BURNET ROAD	AUSTIN	TX	78756
Cornerstone Hospital Austin - Round Rock	Cornerstone Healthcare Group	LT	4681 COLLEGE PARK DRIVE	ROUND ROCK	TX	78665
Lakeway Regional Medical Center	Freestanding	ST	100 MEDICAL PARKWAY	AUSTIN	TX	78738
The Hospital At Westlake Medical Center	Freestanding	ST	5656 BEE CAVES ROAD STE M-302	AUSTIN	TX	78746
HealthSouth Rehabilitation Hospital Of Austin	HealthSouth	LT	1215 RED RIVER	AUSTIN	TX	78701
HealthSouth Rehabilitation Hospital Of Round Rock	HealthSouth	LT	1400 HESTERS CROSSING	ROUND ROCK	TX	78681

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

Facility Name	System	Type	Street Address	City	State	ZIP
HealthSouth Rehabilitation Hospital Of South Austin	HealthSouth	LT	330 WEST BEN WHITE BLVD	AUSTIN	TX	78704
Heart Hospital Of Austin	Hospital Corporation of America	ST	3801 NORTH LAMAR	AUSTIN	TX	78756
North Austin Medical Center	Hospital Corporation of America	ST	12221 MOPAC EXPRESSWAY NORTH	AUSTIN	TX	78758
Round Rock Medical Center	Hospital Corporation of America	ST	2400 ROUND ROCK AVENUE	ROUND ROCK	TX	78681
St David's Georgetown Hospital	Hospital Corporation of America	ST	2000 SCENIC DRIVE	GEORGETOWN	TX	78626
St David's Medical Center	Hospital Corporation of America	ST	919 EAST 32ND STREET	AUSTIN	TX	78705
St David's Rehabilitation Hospital	Hospital Corporation of America	ST	1005 EAST 32ND STREET	AUSTIN	TX	78705
St David's South Austin Medical Center	Hospital Corporation of America	ST	901 WEST BEN WHITE BOULEVARD	AUSTIN	TX	78704
Arise Austin Medical Center	Surgery Partners	ST	3003 BEE CAVE ROAD	AUSTIN	TX	78746
Northwest Hills Surgical Hospital	Surgical Care Affiliates	ST	6818 AUSTIN CENTER BOULEVARD	AUSTIN	TX	78731
Texas Neurorehab Center	Universal Health Services	PSY	1106 WEST DITTMAR BUILDING 9	AUSTIN	TX	78745
Vibra Rehabilitation Hospital Of Lake Travis	Vibra Healthcare	LT	2000 MEDICAL DRIVE	LAKEWAY	TX	78734

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

Free-Standing Emergency Departments

Facility Name	Street Address	City	State	ZIP
Austin Emergency Center	4015 SOUTH LAMAR	AUSTIN	TX	78704
Austin Emergency Center	3563 FAR WEST BOULEVARD	AUSTIN	TX	78731
Austin Emergency Center Anderson Mill	13435 US HIGHWAY 183 N SUITE 311	AUSTIN	TX	78750
Cedar Park Emergency Center	3620 WHITESTONE BLVD EAST	CEDAR PARK	TX	78613
First Choice Emergency Room	15100 FM ROAD 1825	PFLUGERVILLE	TX	78660
First Choice Emergency Room	10407 JOLLYVILLE ROAD	AUSTIN	TX	78759
First Choice Emergency Room	9312 BRODIE LANE	AUSTIN	TX	78748
First Choice Emergency Room	1501 FM 685	PFLUGERVILLE	TX	78660
First Choice Emergency Room	2105 E PALM VALLEY BLVD	ROUND ROCK	TX	78665
Five Star ER	1700 ROUND ROCK AVE	ROUND ROCK	TX	78681
Five Star ER	8721 MANCHACA	AUSTIN	TX	78749
Five Star ER	21315 N SH 130 BLDG 4	PFLUGERVILLE	TX	78660
Neighbors Emergency Center	12701 RR 620 N	AUSTIN	TX	78750
Neighbors Emergency Center (Mueller)	1801 E 51ST STREET (BLDG H)	AUSTIN	TX	78723
Oncall Emergency Center Circle C	5701 W SLAUGHTER LANE BLDG G	AUSTIN	TX	78749

Psychiatric Facilities

Facility Name	Street Address	City	State	ZIP
Austin Lakes Hospital	1025 EAST 32ND STREET	AUSTIN	TX	78705
Austin Oaks Hospital	1407 WEST STASSNEY LANE	AUSTIN	TX	78745
Cross Creek Hospital	8402 CROSS PARK DRIVE	AUSTIN	TX	78754
Georgetown Behavioral Health Institute LLC	3101 S AUSTIN AVE	GEORGETOWN	TX	78626
Rock Springs	700 SOUTHEAST INNER LOOP	GEORGETOWN	TX	78626
Seton Shoal Creek Hospital	3501 MILLS AVENUE	AUSTIN	TX	78731
Texas Neurorehab Center	1106 WEST DITTMAR BUILDING 1 & 15	AUSTIN	TX	78745

Baylor Scott & White Medical Center – Round Rock

FY2014-FY2016 Implementation Evaluation

✔	*Successful strategies and activities.*
⊘	*Partially successful strategies. Ideas good but either funding or staffing prohibited proper execution.*
✘	*Unsuccessful strategies and activities. Were unable to implement*

Significant Need: Obesity

Strategy #1: Engage the community in regular activities that promote being active and making healthy choices

- ✔ hosting monthly Walk with a Doc programs in local parks
- ✔ provide cooking demonstrations, diet and nutrition information and medical experts to local media to address obesity and prevention methods
- ✔ Provide blood pressure and glucose screenings at health fairs throughout the community on request

Strategy #2: Increase community education around personal benefits to achieving and maintaining a healthy weight and lifestyle

- ✔ support community efforts targeting obesity through financial and in kind contributions,
- ✔ participate or host regular health fair events to share information on chronic illnesses related to being overweight as well as steps to correct bad habits
- ✔ Offer providers as medical experts at community health events, organizational meetings and to the media when requested

Outcomes

Community Health Education - Diabetes

BSWH provides diabetes education programs and presentations open to the public or for a specific group in need to educate the community about the signs and symptoms of diabetes and how to prevent diabetes from happening.

Persons Served: 257

Community Benefit Expenses: $14,847

Community Health Education - Heart

Heart disease is the leading cause of death in our communities as well as at a national level. Screenings and education assist in early detection and treatment.

Persons Served: 538

Community Benefit Expenses: $3,041

Community Health Education – General Wellness

BSWH consistently looks for opportunities to educate the community on health issues to support our mission and vision. The programs and services that fall into this category extend beyond patient care activities and include services directed to both individuals and larger populations in the community. They include such things as educational information about preventive health care, lectures, or presentations held by BSWH physicians and staff about health related topics like understanding various conditions and diseases, when to seek treatment, and the treatment options available.

Persons Served: 4,435

Community Benefit Expenses: $42,410

Community Health Education – In Schools

BSWH recognizes the importance of teaching about making healthy living choices starting at an early age. Programs and services are geared towards students K-12.

Persons Served: 1,253

Community Benefit Expenses: $1,690

For Women For Life

Regular health exams and tests can help find problems before they start. They also can help find problems early, when the chances for treatment and cure are better. Through For Women For Life the Hospital provides health services, screenings, and treatments, assisting women in taking steps that help their chances for living a longer, healthier life. This annual

event for women focusing on proactive health care including preventive health screenings, seminars and healthy lifestyle information.

Persons Served: 52

Community Benefit Expenses: $6,621

It's a Guy Thing

Regular health exams and tests can help find problems before they start. They also can help find problems early, when the chances for treatment and cure are better. Through It's a Guy Thing the Hospital provides health services, screenings, and treatments, assisting women in taking steps that help their chances for living a longer, healthier life. This annual event for women focusing on proactive health care including preventive health screenings, seminars and healthy lifestyle information.

Persons Served: 30

Community Benefit Expenses: $13,286

Financial Donation: Community Health Improvement

BSWH often donates funds to local charitable, not for profit organizations whose efforts to improve community health align with the identified health needs in our community. We do so to support their efforts to improve the overall health of the community through education, prevention, health advocacy, or disease management education.

Persons Served: 4,659

Community Benefit Expenses: $132,172

Health Fairs

BSWH regularly participates in health fairs all over the communities we serve in order to provide access to educational materials that will help impact healthy lifestyle habits.

Persons Served: 32,457

Community Benefit Expenses: $61,234

Health Screenings

BSWH offers screenings throughout the year to assist in the prevention and early identification of potential disease states. Some screenings are provided on a one-time basis or as a special event in the community and are available to those who are under insured, medically underserved or for the broader community.

Persons Served: 3,020

Community Benefit Expenses: $75,379

Health Screenings – Diabetes

BSWH regularly administers diabetes risk assessment tests, glucose screenings and one on one education and counseling when needed for events both on site and out in the community.

Persons Served: 98

Community Benefit Expenses: $1,508

Por Tu Familia

Presented by BSWH, Por tu Familia, or “for your family”, is the signature comprehensive diabetes prevention and management program of the American Diabetes Association’s Latino initiatives. It is a comprehensive program developed for and targeted to Latinos. It is geared towards people who have been diagnosed with diabetes or pre-diabetes, caregivers of people with diabetes, as well as anyone who believes they might be at risk.

Diabetes is an urgent health problem in the Latino community as their rates of diabetes are almost double those of non-Latino whites. Getting information to the community about the seriousness of diabetes, its risk factors and those who may be at risk and ways to help manage the disease is essential. According to the American Diabetes Association, many Latinos feel guilty spending time and money on personal health and feel selfish putting their own health care ahead of their families’ needs, when in truth, the opposite should be true.

Persons Served: 14

Community Benefit Expenses: $5,611

Walk With a Doc

BSWH hosts monthly walk sessions at San Gabriel Park. Community members are invited to join a provider for a 2-mile walk and brief health lecture.

Persons Served: 684

Community Benefit Expenses: $19,413

Wellness Programs: Community Based

BSWH offers free and/or reduced cost services and programs geared towards enhancing the well-being of individuals in the community.

Persons Served: 768

Community Benefit Expenses: $8,801

Subtotals For: Obesity

Number of Programs: 13 Persons Served: 48,266 Net Community Benefit: $386,013

Significant Need: Cancer

Strategy #1: Engage a targeted population in specific activities to provide education on prevention, early detection and treatment of breast cancer

✔ Host or provide support to support groups for people living with breast cancer throughout the community

✔ Increase participation in community health fairs and provide medical experts to provide information on breast health

✔ Partner with local municipalities during breast cancer awareness month to offer "group screening nights" which include annual mammograms

Outcomes

Community Health Education – Cancer

BSWH supplies information on breast health to organizations and at events across the community. Information includes proper screening guidelines and how to access services to reduce the incidence of late stage cancer going undetected.

Persons Served: 177

Community Benefit Expense: $1,417

For Women For Life

Regular health exams and tests can help find problems before they start. They also can help find problems early, when the chances for treatment and cure are better. Through For Women For Life the Hospital provides health services, screenings, and treatments, assisting women in taking steps that help their chances for living a longer, healthier life. This annual event for women focusing on proactive health care including preventive health screenings, seminars and healthy lifestyle information.

Persons Served: 52

Community Benefit Expenses: $6,621

Health Screenings - Breast

BSWH hosted a Mammo-Mixer for the employees of the cities of Round Rock and Georgetown to assist in the prevention and early identification of breast cancer.

Persons Served: 22

Community Benefit Expenses: $772

Support Groups

BSWH provides regular support group services for patients and their families that are specific to a disease or social concern including breast cancer.

Persons Served: 174

Community Benefit Expenses: $3,584

Subtotals For: Breast Cancer

Number of Programs: 4 Persons Served: 425 Net Community Benefit: $12,394

Total Number of Programs Addressing Needs:	17
Total Persons Served:	48,691
Total Net Community Benefit:	$398,407

Baylor Scott & White Medical Center – Taylor

FY2014-FY2016 Implementation Evaluation

✔	*Successful strategies and activities.*
⊘	*Partially successful strategies. Ideas good but either funding or staffing prohibited proper execution.*
✗	*Unsuccessful strategies and activities. Were unable to implement*

Prioritized Need: Diabetes

Strategy #1: Engage targeted population in specific activities to provide education on prevention and treatment of diabetes

Planned activities include: monthly support groups, special educational events at community locations, health screenings, and identifying community partners with which to collaborate.

✔ **Successful strategy and activities**

Outcomes

Diabetes Education

BSWH provides diabetes education seminars and presentations open to the public or for a specific group in need to educate the community about the signs and symptoms of diabetes and how to prevent diabetes from happening with intent to lower hospitalization rates due to the disease.

Persons Served: 152

Community Benefit Expense: $284

Diabetes Support Group

BSWH provides support group services for patients, family members and community members to give education, social and emotional support to those affected by diabetes.

Persons Served: 129

Community Benefit Expense: $3,214

Community Health Education

BSWH consistently looks for opportunities to educate the community on health issues to support our mission and vision. The programs and services that fall into this category extend beyond patient care activities and include services directed to both individuals and larger populations in the community. They include such things as educational information about preventive health care, lectures, or presentations held by BSWH physicians and staff about health related topics like understanding various conditions and diseases, when to seek treatment, and the treatment options available.

Persons Served: 1,641

Community Benefit Expense: $5,307

Donations to Health Improvement Activities

BSWH donates funds to local charitable, not for profit organizations whose efforts to improve community health align with the identified health needs in our community. We do so to support their efforts to improve the overall health of the community through education, prevention, health advocacy, or disease management education. Funds that go to improving the health infrastructure of our community are counted after subtracting the fair market value of participation by employees or the organization.

Persons Served: unknown

Community Benefit Expense: $2,500

Balance Food and Fitness Program at Taylor ISD

Due to the high rate of juvenile diabetes at Taylor ISD schools, BSWH formed a partnership with the after school program to create a program that provides education on proper eating and exercise.

Persons Served: 150

Community Benefit Expense $1,940

Subtotals For: Diabetes

Number of Programs: 4 Persons Served: 1,772 Net Community Benefit: $13,245

Prioritized Need: Obesity

Strategy #1: Engage the community in regular activities that promote being active and making healthy choices

- ✔ **Successful strategy and activities.**

Strategy #2: Increase community education around personal benefits to achieving and maintaining a healthy weight and lifestyle

Planned activities include hosting regular exercise programs, supporting community efforts that target obesity through financial donations and in kind services, participate in or host regular health fairs providing information on diet and nutrition, offer blood pressure and BMI testing at community events, maintain web content that can be accessed for health topics and tips.

- ✔ **Successful strategy and activities.**

Community Health Education

BSWH consistently looks for opportunities to educate the community on health issues to support our mission and vision. The programs and services that fall into this category extend beyond patient care activities and include services directed to both individuals and larger populations in the community. They include such things as educational information about preventive health care, lectures, or presentations held by BSWH physicians and staff about health related topics like understanding various conditions and diseases, when to seek treatment, and the treatment options available.

Persons Served: 1,641

Community Benefit Expense: $5,307

Donations to Health Improvement Activities

BSWH donates funds to local charitable, not for profit organizations whose efforts to improve community health align with the identified health needs in our community. We do so to support their efforts to improve the overall health of the community through education, prevention, health advocacy, or disease management education. Funds that go to improving the health infrastructure of our community are counted after subtracting the fair market value of participation by employees or the organization.

Persons Served: unknown

Community Benefit Expense: $2,500

Health Fairs

BSWH regularly participates in health fairs all over the communities we serve in order to provide access to educational materials that will help impact healthy lifestyle habits.

Persons Served: 1,126

Community Benefit Expense: $6,496

Health Screenings

BSWH offers screenings throughout the year to assist in the prevention and early identification of potential disease states. Some screenings are provided on a one-time basis or as a special event in the community and are available to those who are under insured, medically underserved or for the broader community.

Persons Served: 308

Community Benefit Expense: $3,635

Heart Disease Education

Heart disease is the leading cause of death in our communities as well as at a national level. Screenings and education assist in early detection and treatment and is also a common concern for men and women who are overweight or obese.

Persons Served: 300

Community Benefit Expense: $2,915

Community Wellness/Exercise Programs

BSWH offers free and/or reduced cost services and programs geared towards enhancing the well-being of individuals in the community. Most of these exercise classes are held at a local senior center and are free to all community members.

Persons Served: 780

Community Benefit Expense: $3,389

Subtotals For: Obesity

Number of Programs: 6 Persons Served: 4,155 Net Community Benefit: $26,182

Total Number of Programs Addressing Needs:	8
Total Persons Served:	6,077
Total Net Community Benefit:	$39,427

Baylor Scott & White Emergency Medical Center – Cedar Park

FY2014-FY2016 Implementation Evaluation

✔	*Successful strategies and activities.*
⃠	*Partially successful strategies. Ideas good but either funding or staffing prohibited proper execution.*
✘	*Unsuccessful strategies and activities. Were unable to implement*

Significant Need: Obesity

Strategy #1: Increase community awareness of the health risks and diseases associated with obesity and being overweight

✔ Participate in at least 2 community health fairs and n prevention of illness related to being overweight

✔ Increase efforts to provide awareness education to the community regarding early recognition of behaviors or health indicators that lead to being overweight

✘ supply medical providers as topic experts to share information with the public

Strategy #2: Educate and engage the community in regular activities promoting health and making healthy lifestyle choices

✔ Provide annual flu vaccination clinic

⃠ Participate in at least to BSWH sponsored community walks

⃠ Provide financial support to community efforts targeting obesity

Outcomes

Financial Donation: Community Health Improvement

BSWH often donates funds to local charitable, not for profit organizations whose efforts to improve community health align with the identified health needs in our community. We do so to support their efforts to improve the overall health of the community through education, prevention, health advocacy, or disease management education.

Persons Served: 2,000

Community Benefit Expense: $1,500

Health Fairs

BSWH regularly participates in health fairs all over the communities we serve in order to provide access to educational materials that will help impact healthy lifestyle habits.

Persons Served: 4,897

Community Benefit Expenses: $25,820

HealthSpeak

Free health seminars and lectures conducted by BSWH providers for community members covering a wide range of conditions and diseases.

Persons Served: 171

Community Benefit Expenses: $7,886

Health Screenings

BSWH offers screenings throughout the year to assist in the prevention and early identification of potential disease states. Some screenings are provided on a one-time basis or as a special event in the community and are available to those who are under insured, medically underserved or for the broader community.

Persons Served: unknown

Community Benefit Expenses: $127.24

Community Health Education – General Wellness

BSWH consistently looks for opportunities to educate the community on health issues to support our mission and vision. The programs and services that fall into this category extend beyond patient care activities and include services directed to both individuals and larger populations in the community. They include such things as educational information about preventive health care, lectures, or presentations held by BSWH physicians and staff

about health related topics like understanding various conditions and diseases, when to seek treatment, and the treatment options available.

Persons Served: 1,543

Community Benefit Expenses: $1,890

Health Education in Schools

BSWH recognizes the importance of teaching about health and health professions to students in our school systems. Programs and services in this category are geared towards students K-12 and provide educational opportunities for students in the local ISD's to learn about the importance of making healthy living choices starting at an early age.

Persons Served: 4,037

Community Benefit Expense: $865

Total Number of Programs Addressing Need: 6
Total Persons Served: 12,648
Total Net Community Benefit: $38,088

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

Health Professional Shortage Areas (HPSA)[15]

County Name	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type
Travis County	14899948PB	People's Community Clinic	Primary Care	Comprehensive Health Center
Travis County	14899948OW	Travis County Healthcare District/Dba Communitycar	Primary Care	Comprehensive Health Center
Travis County	64899948MS	People's Community Clinic	Dental Health	Comprehensive Health Center
Travis County	64899948MM	Travis County Healthcare District/Dba Communitycar	Dental Health	Comprehensive Health Center
Travis County	74899948MR	People's Community Clinic	Mental Health	Comprehensive Health Center
Travis County	74899948MI	Travis County Healthcare District/Dba Communitycar	Mental Health	Comprehensive Health Center
Travis County	148999482F	North West Service Area	Primary Care	HPSA Geographic
Williamson County	148999487E	Lone Star Circle of Care	Primary Care	Comprehensive Health Center
Williamson County	64899948H7	Lone Star Circle of Care	Dental Health	Comprehensive Health Center
Williamson County	748999484B	Lone Star Circle of Care	Mental Health	Comprehensive Health Center
Williamson County	14899948B8	Immigration and Customs Enforcement - Taylor	Primary Care	Correctional Facility
Williamson County	64899948MD	Immigration and Customs Enforcement - Taylor	Dental Health	Correctional Facility
Williamson County	74899948M7	Immigration and Customs Enforcement - Taylor	Mental Health	Correctional Facility

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

Medically Underserved Areas and Populations (MUA/P)[16]

County Name	Service Area Name	MUA/P Source Identification Number	Designation Type
Travis County	Travis Service Area	3484	Medically Underserved Area
Williamson County	Williamson Service Area	3445	Medically Underserved Area

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