BaylorScott&White

HEALTH

Community Health Needs Assessment 2016

Baylor Scott & White Medical Center – Llano

Baylor Scott & White Medical Center – Marble Falls

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 and 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 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 – Llano
- Baylor Scott & White Medical Center – Marble Falls

For the 2016 assessment, Baylor Scott & White Medical Center - Llano and Baylor Scott & White Medical Center - Marble Falls have defined their community to be the geographical area of Blanco, Burnet, Llano, and San Saba counties. The community served was determined based on the counties that make up at least 75 percent of the hospitals' 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 a joint CHNA report define their community, for purposes of this 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. Cancer
2. Heart disease deaths
3. Prenatal care
4. Car crash deaths
5. Mental health
6. Diabetes

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.

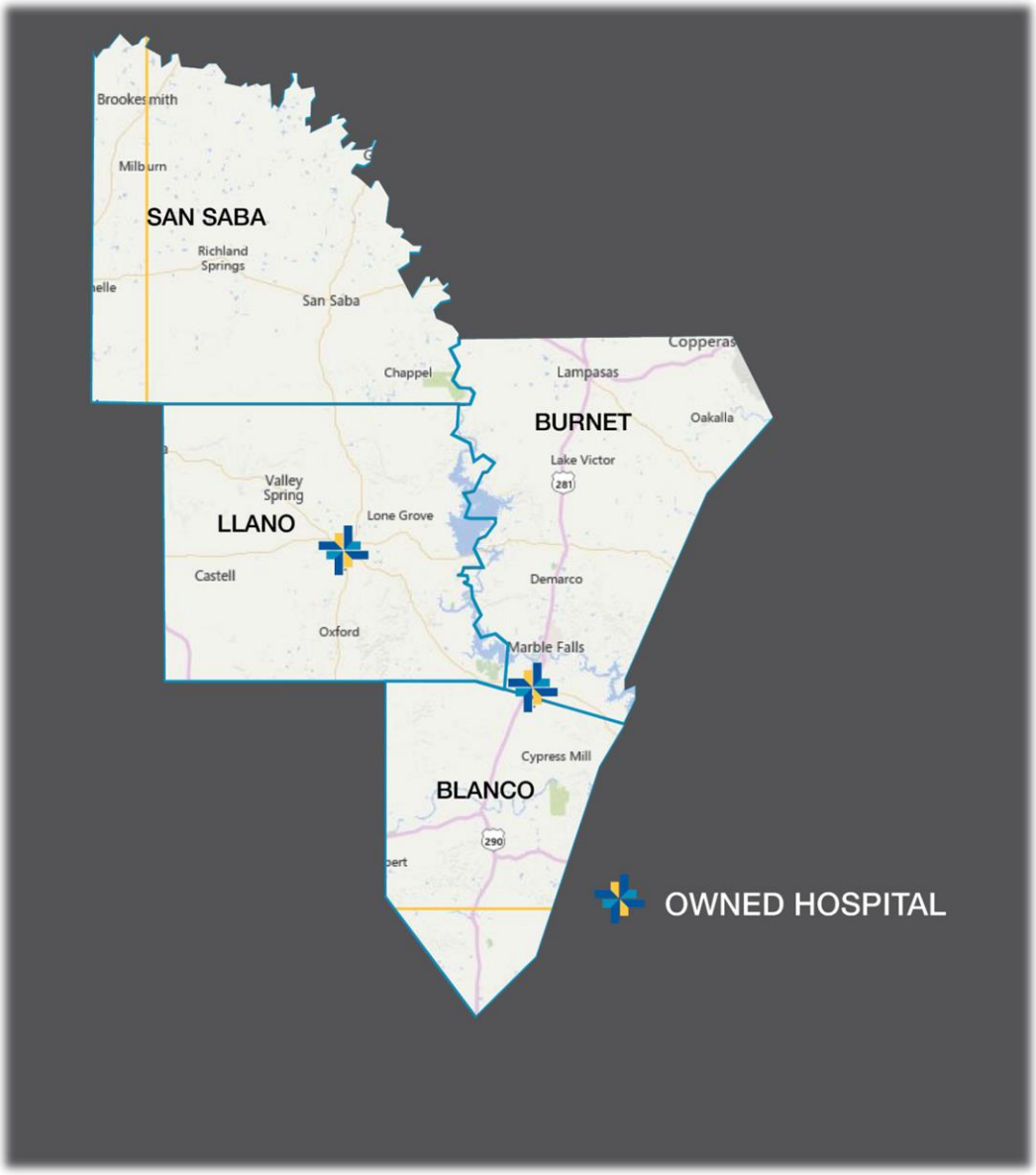
The community served definitions used in this current assessment differ from those used by the legacy Baylor Health Care System and the legacy Scott & White Healthcare in their 2013 CHNAs.

BSWH, has chosen a common methodology and approach to define the communities served for each of its licensed hospital 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 a 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 hospital facilities have defined their community to be the geographical area of Blanco, Burnet, Llano, and San Saba counties. The community served was determined based on the counties that made 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

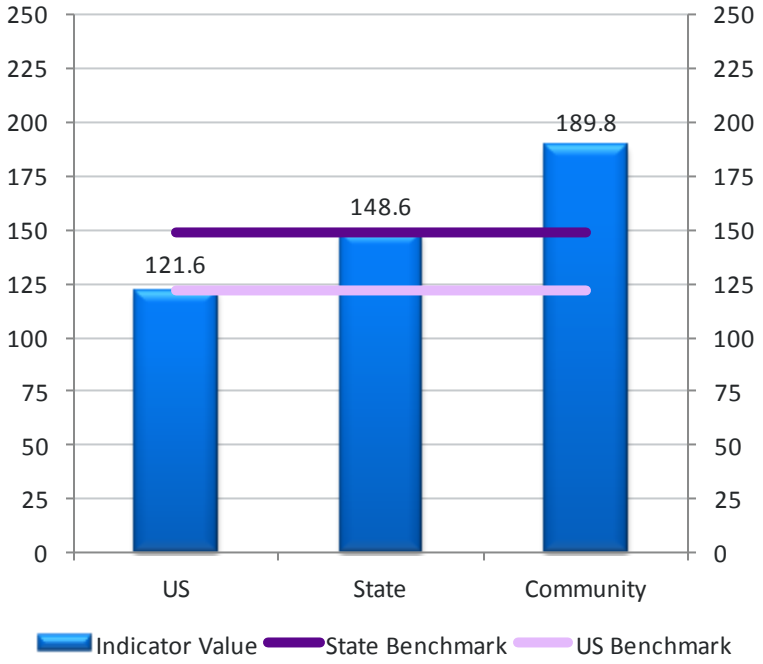
Health Behaviors
- Obesity
- Childhood Obesity
- Physical Inactivity
- No Exercise
- Adult Smoking
- Excessive Drinking
- Teen Birth Rate
- Sexually Transmitted Infections
- Alcohol Impaired Driving Deaths
- Drug Poisoning Deaths

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.

Health Indicator Benchmark Analysis Example



According the America's Health Rankings, Texas ranked 34th out of the 50 states. The health status of Texas compared to other states in the nation identifies many opportunities to impact health within local communities even for those communities that rank highly within the state. Therefore, the benchmark for the community served was set to the state value. Needs were identified when one or more of the indicators for the community served 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 nine (9) participants, as well as five (5) 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).

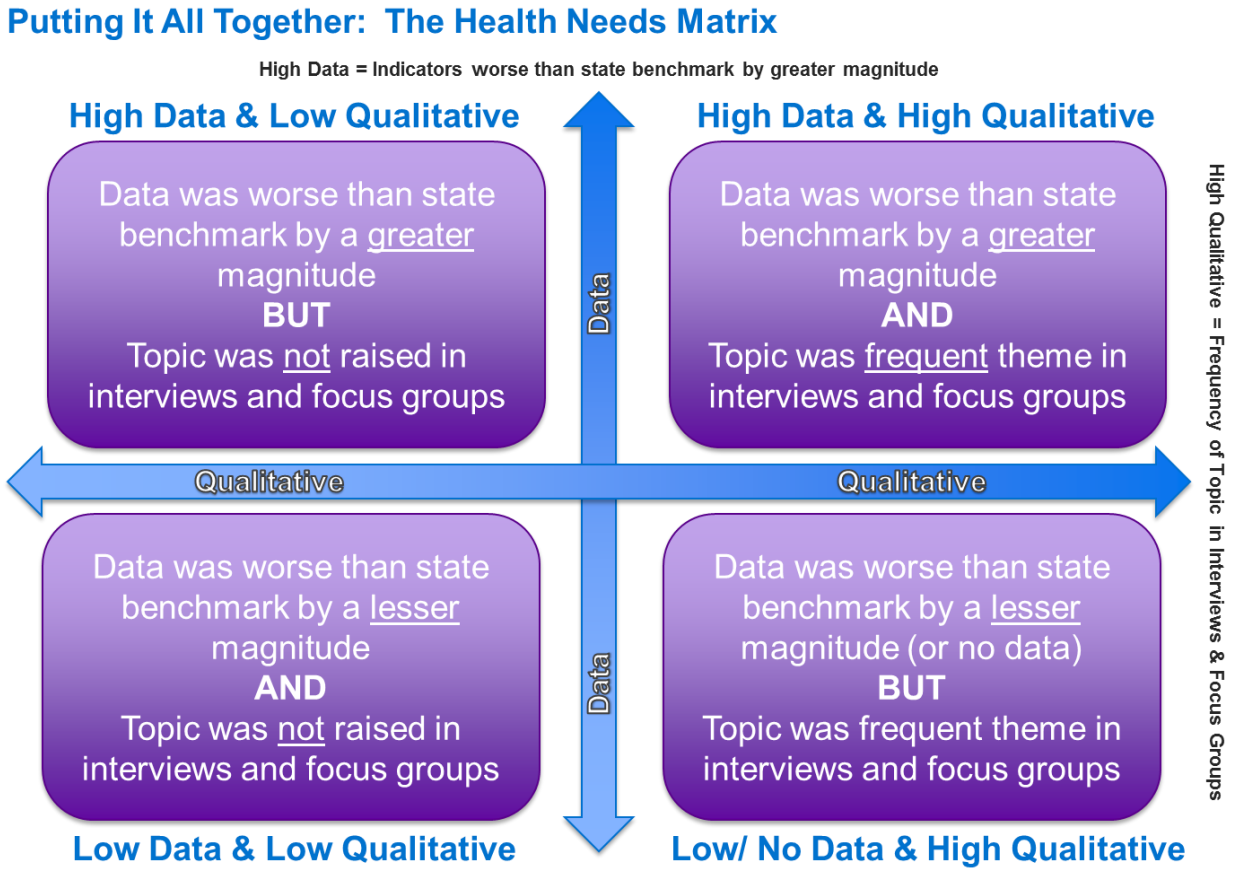
In addition to soliciting input from public health and various interests of the community, hospitals are also required to take into consideration written input received on their most recently conducted CHNA and subsequent implementation strategies. The facilities have an active portal on the website (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

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

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



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 a challenge to tailor programs to address community health needs as placement, and access to those programs in one part of the county may or may not actually impact the population who truly need the service. Truven Health supplemented health indicator data with Truven Health's ZIP code estimates to assist in identifying specific populations within a community where health needs may be greater.

Existing Resources to Address Health Needs

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

Prioritizing Community Health Needs

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

The prioritized needs were reviewed and/or approved by senior management, hospital advisory board members, governing board members and BSWH governing board.

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 - Llano chose to address the following identified needs:

1. Obesity
2. Adults with diabetes
3. Cancer death rates

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

Baylor Scott & White Medical Center – Marble Falls became a licensed hospital facility in 2015. With this being the first CHNA performed by Baylor Scott & White Medical Center – Marble Falls, there are no implementation strategies of prior identified needs to evaluate.

Demographic and Socioeconomic Summary

This community was older and less diverse when compared to other the overall state of Texas and the nation. The community had a lower unemployment rate than the other benchmarks but also a lower median income. The population of this community was on par with the benchmarks for other social barriers (limited English and no high school diploma).

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	76,995
5 Yr Proj Pop Chg	4%	7%	5%
Population 0-17	23%	26%	20%
Population 65+	15%	12%	25%
Women Age 15-44	20%	21%	15%
Non-White Population	29%	31%	12%
Insurance Coverage: Medicaid	19%	14%	11%
Insurance Coverage: Uninsured	10%	20%	14%
Median Household Income	$56,682	$56,653	$48,657
Limited English	5%	8%	4%
No High School Diploma	14%	19%	15%
Unemployed	10%	8%	6%
Poverty	16%	18%	Blanco Co: 10%
			Burnet Co: 17%
			Llano Co: 15%
			San Saba Co: 15%

Source: Truven Health Analytics / The Nielsen Company, 2015

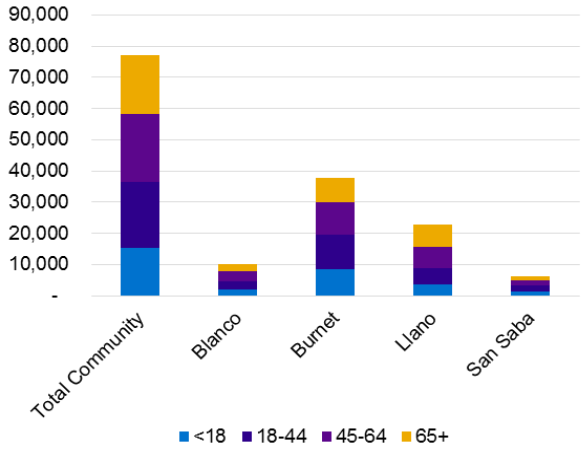
The population in the community served is expected grow almost 5% by 2020, increasing the population by just over 3,700 people. This growth rate is lower than Texas overall (6.7%) but higher than the entire U.S. (3.5%). The largest increases will be in Bertram (9.6%), Kingsland (6.8%), and Horseshoe Bay (6.6%). A few markets are projected to have a slight population decline by 2010, including Briggs, Tow, and Bluffton.

The sixty-five plus cohort made up 25% of this market, more than double the percentage for Texas (12%). The senior population is also expected to experience the most growth over the next five years, estimated to increase 28,000 over the next five years. Growth in this population will likely contribute to increased utilization of services as the population continues to age.

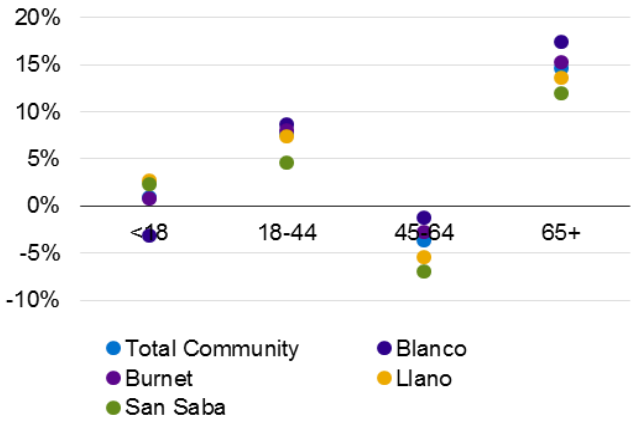
Children were the smallest age cohort and 5 year projected growth is flat, while the age 18-44 population is anticipated to increase by 1,500 people in the same timeframe. The age 45-64 cohort is expected to decline over the next 4 years

Population by Age Cohort

2015 Total Population



5 Year Projected Population Growth Rate



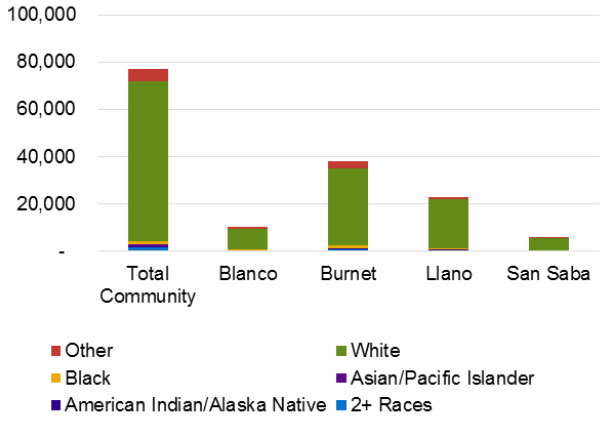
Source: Truven Health Analytics / The Nielsen Company,

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).

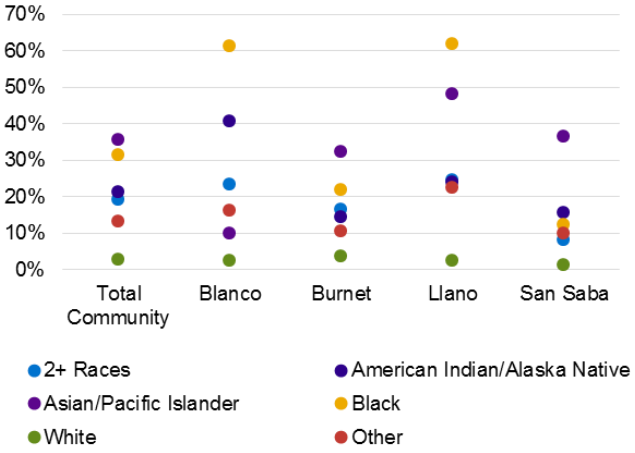
The community was 88% white in 2015, and the population growth rate is expected to remain relatively flat. Diversity in the community will increase as minority populations are expected to have the highest growth rates.

Population by Race

2015 Total Population



5 Year Projected Population Growth Rate

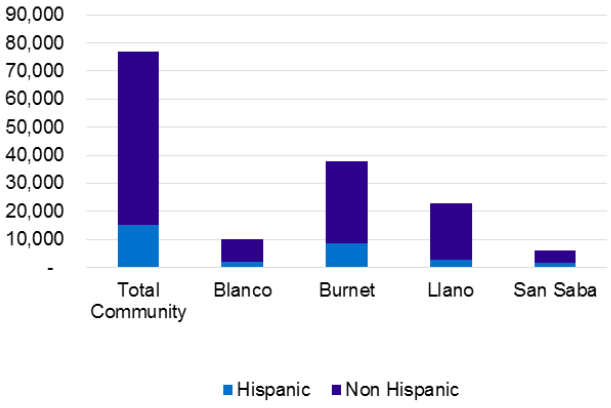


Source: Truven Health Analytics / The Nielsen Company, 2015

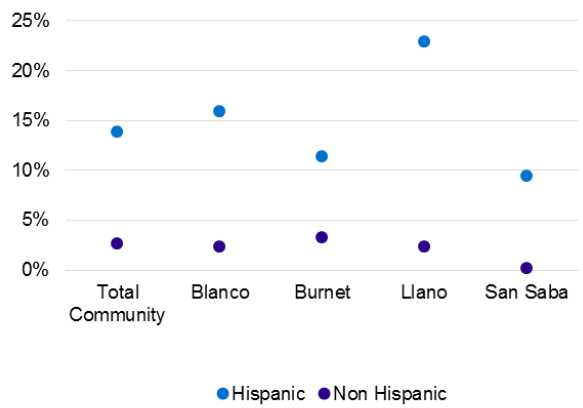
The Hispanic population is expected to grow more than five times faster than the non-Hispanic population. In 2015, 20% of the population identified as Hispanic and 80% of the Hispanic population resided in Burnet and Llano counties. The projected growth rate of minority populations is much greater than that of the white population, but the overall proportion of minorities will only increase by 2% in 2020 (from 11% of total population to 13%).

Population by Hispanic Ethnicity

2015 Total Population



5 Year Projected Population Growth Rate

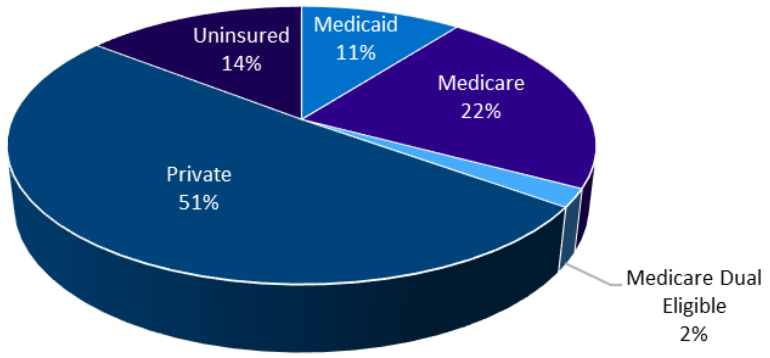


Source: Truven Health Analytics / The Nielsen Company, 2015

The median household income for the community served was $42,657. In 2015, 51% of the community was commercially insured, 11% was covered by Medicaid, 14% was uninsured, and 24% was covered by Medicare or Medicare dual eligible. The population purchasing insurance through the health insurance exchange marketplace is expected to increase from 3% to 5% by 2020. The uninsured is not expected to change over the next 5 years.

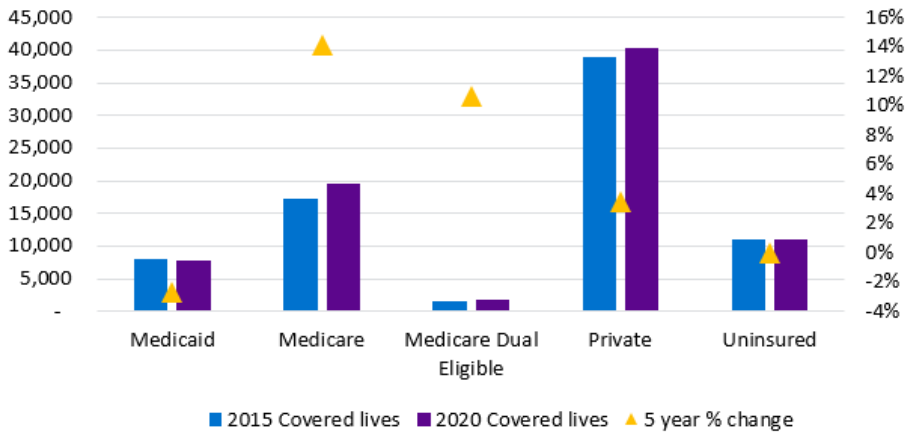
The largest growth in any one insurance category for all counties will be in Medicare, which is driven by the aging population.

2015 Estimated Distribution of Covered Lives by Insurance Category



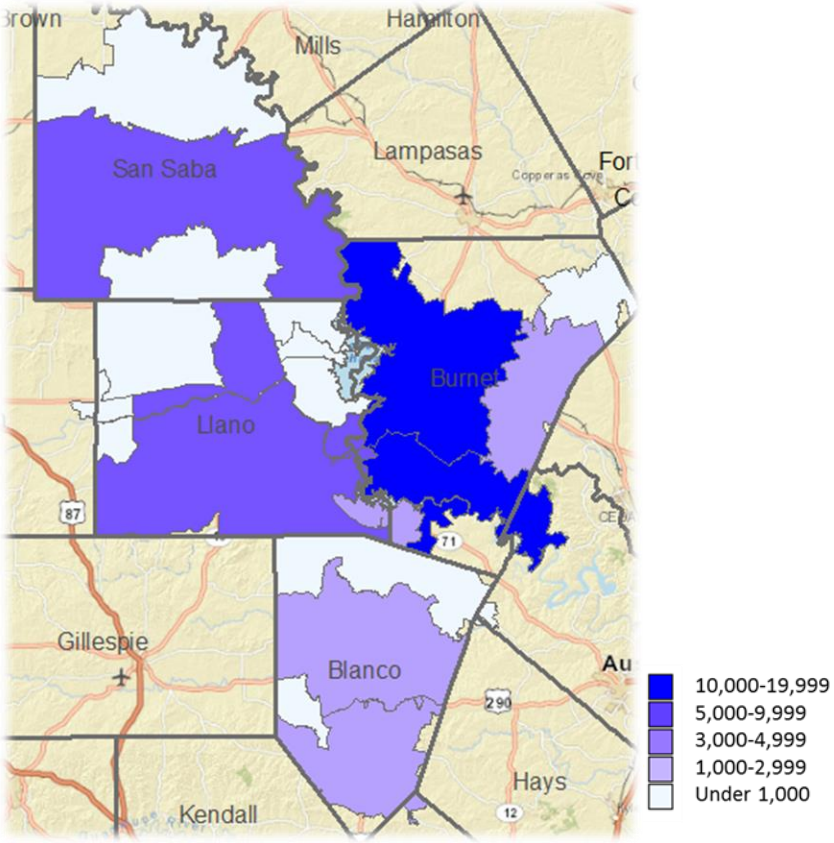
Source: Truven Health Analytics / The Nielsen Company, 2015

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 seventeen (17) Health Professional Shortage Areas and four (4) 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

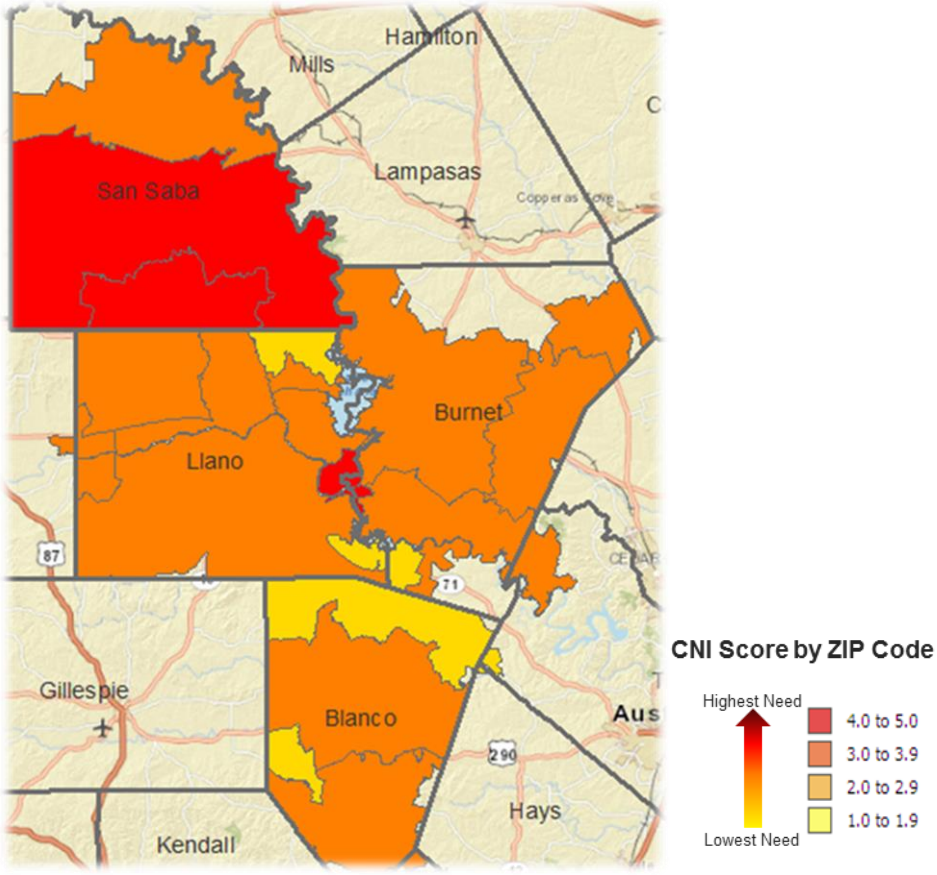
	Health Professional Shortage Area (HPSA)				Medically Underserved Area/Population (MUA/P)
COUNTY	**Dental Health**	**Mental Health**	**Primary Care**	**TOTAL HPSA**	**TOTAL MUA/P**
Blanco County	0	1	1	2	1
Burnet County	3	4	4	11	1
Llano County	0	1	1	2	1
San Saba County	0	1	1	2	1
TOTAL	**3**	**7**	**7**	**17**	**4**

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

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 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 above the average community need with significant variation in different parts of the market. Cherokee, San Saba, and Kingsland showed the greatest need; Horseshoe Bay, Round Mountain, and Tow showed fewer barriers to health. 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	Percentage of population under age 65 without health insurance
Access to Care	Percent Uninsured Children (<17)
Access to Care	Ratio of population to one primary care physician
Access to Care	Ratio of population to one non-physician primary care provider
Access to Care	Ratio of population to one dentist
Access to Care	Number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees
Environment	Food Insecure Households (percent)
Environment	Limited access to healthy foods (percent of low income)
Environment	Food environment index
Environment	Population with adequate access to locations for physical activity (percent)
Environment	Drinking water violations (percent of population exposed)
Environment	Long commute - driving alone (percent of workers who community by car)
Health Behaviors	Adult Obesity (percent)
Health Behaviors	Physical Inactivity (percent)
Health Behaviors	No Exercise (percent)
Health Behaviors	Adult Smoking (percent)
Health Behaviors	Driving deaths with alcohol involvement (percent)
Health Behaviors	Number of drug poisoning deaths (per 100,000)
Health Behaviors	Teen birth rate per 1,000 female population, ages 15-19
Health Outcomes	Cancer (all causes) Incidence
Health Outcomes	Lung Cancer Incidence (per 100,000)
Health Outcomes	Prostate Cancer Incidence (per 100,000)
Health Outcomes	Adults Reporting Diagnosed w/ Diabetes (percent)
Health Outcomes	Atrial Fibrillation: Medicare Population (percent)
Health Outcomes	Hyperlipidemia: Medicare Population (percent)
Health Outcomes	Pediatric Perforated Appendix Admission Risk-Adjusted-Rate (per 100 Admissions for Appendicitis)
Health Outcomes	First trimester entry into prenatal care
Health Outcomes	Births to Mothers Who Smoked During Pregnancy (New Birth Certificate)
Health Outcomes	Low Birth Weight Rate (per 100 births)
Health Outcomes	Preterm Births <37 weeks gestation
Injury & Death	Heart Disease Death Rate (per 100,000)
Injury & Death	Cancer Deaths total (per 100,000)
Injury & Death	Chronic Lower Respiratory Disease (CLRD) Death Rate (per 100,000)
Injury & Death	Stroke Death Rate (per 100,000)

Category	Indicator
Injury & Death	Premature Death (potential years lost)
Injury & Death	Infant Mortality (rate per 1,000)
Injury & Death	Child Mortality Rate (per 100,000)
Injury & Death	Motor Vehicle Crash Mortality Rate (per 100,000)
Injury & Death	Ratio of population to one mental health provider.
Population	Some College (percent)
Population	Children in Poverty (Percent)
Population	Children in Single-parent Households
Population	Unemployment (percent)
Population	Income inequality
Population	Individuals Who Report Being Disabled (percent)
Population	Percentage of children enrolled in public schools that are eligible for free lunch
Prevention	Diabetic monitoring: Medicare Enrollees
Prevention	Mammography Screening: Medicare Enrollees

Truven Health Community Data

Truven Health Analytics supplemented 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, with 17,000 estimated cases of hypertension in the community overall. Approximately 400% higher than other heart diseases.

Five towns accounted for approximately 60% of cases in each heart disease type:

- Marble Falls (~21%)
- Burnet (~17%)
- Kingsland (~10%)
- Horseshoe Bay (~9%)
- Blanco (~8%)

2015 Estimated Heart Disease Cases

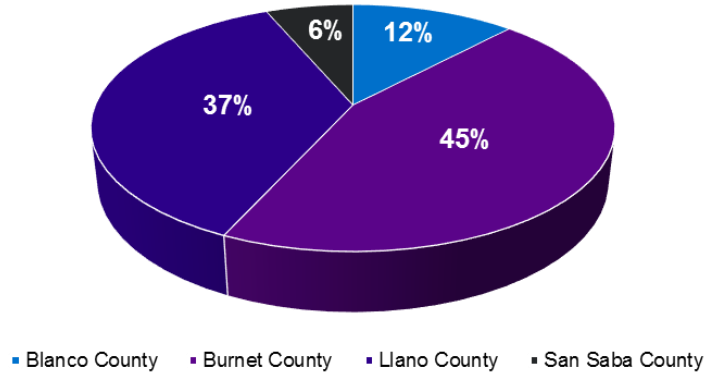
Disease Type	Blanco County	Burnet County	Llano County	San Saba County	Total Community
ARRHYTHMIAS	656	2,398	1,876	350	5,280
CONGESTIVE HEART FAILURE	252	823	678	139	1,892
HYPERTENSION	2,771	8,160	5,317	1,182	17,430
ISCHEMIC HEART DISEASE	667	1,935	1,639	301	4,542

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

Source: Truven Health Analytics, 2015

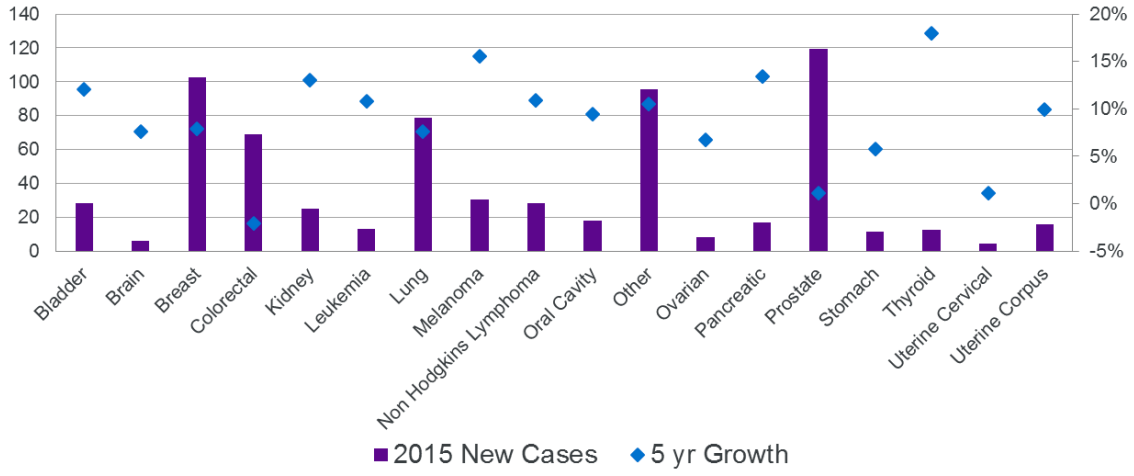
A total of 680 new cancer cases are estimated for the community. Prostate, breast, lung, and colorectal cancers accounted for 54% of the new cases. Projected growth rates are lower than Texas state benchmarks for most cancer types. For example, colorectal cancer incidence in the community is expected to decline by 2% while it is expected to increase 7% statewide, and prostate cancer incidence growth is 1% in the community but 9% across Texas.

2015 Estimated New Cancer Cases



Source: Truven Health Analytics, 2015

2015 Cancer Cases and Projected Growth by Type

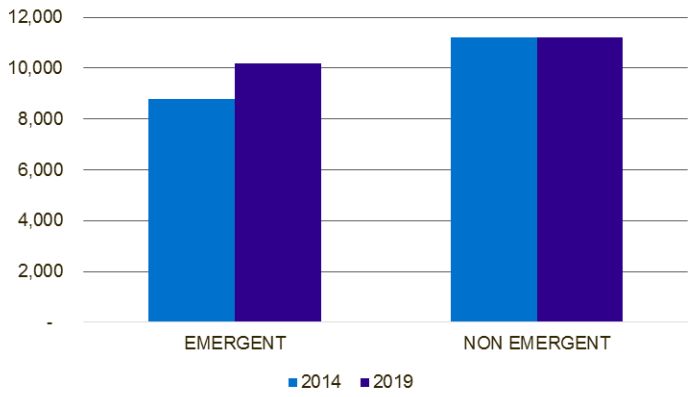


Source: Truven Health Analytics, 2015

Outpatient emergency department visits are those which are treated and released and therefore do not result in an inpatient admission. The largest volume of outpatient ED visits are expected to come from Burnet and Marble Falls.

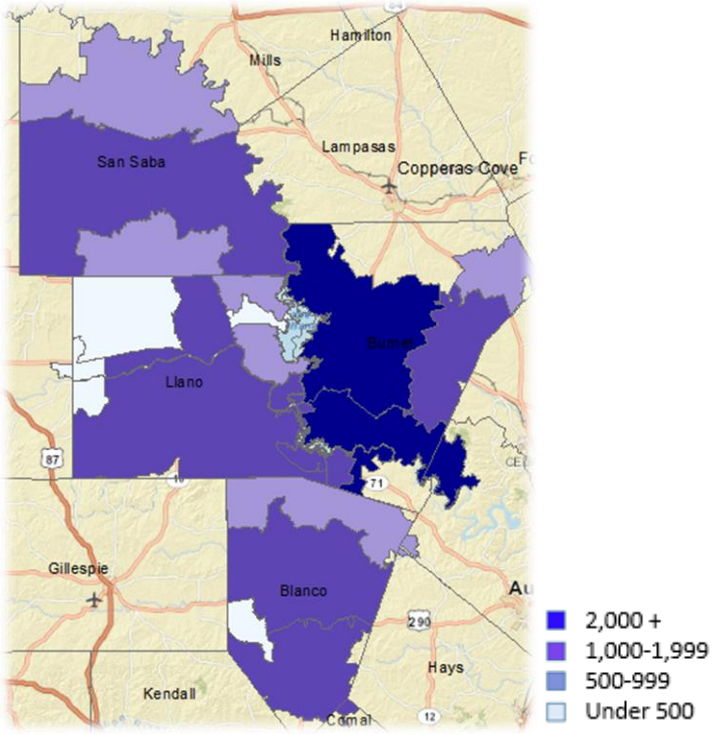
Non-emergent outpatient ED visits are lower acuity visits that present in the ED but can be treated in other more appropriate and less intensive outpatient settings. Non-emergent ED visits can be an indication that there are systematic issues with access to primary care or managing chronic conditions. Total outpatient ED visits are expected to increase 7% over the next five years, with non-emergent visits remaining flat and emergent visits growing at 16%.

Emergent and Non-Emergent ED Visits



Source: Truven Health Analytics, 2015

2014 Estimated Non-Emergent Visits by ZIP Code



Source: Truven Health Analytics, 2015

Interviews & Focus Groups

In the interview sessions, the participants were asked what factors contribute to the current health status of Blanco, Burnet, Llano, and San Saba counties. The factors contributing to the current health status included chronic disease rates, socioeconomic disparity, poverty, health education, health disparities, healthy community, and access to health care services. Interviewees acknowledged that access to care had improved with the new hospital in Marble Falls and associated physician specialties but noted that some access issues still exist. These issues included primary care for the uninsured, access to specialties for screening referrals and proximity of services to the population. Additional community health needs identified included need for preventative care and education, addressing the communities cancer rates, education around understanding the origins of chronic disease and factors supporting a healthy community such as eliminating food deserts and improving environmental factors.

The focus group included nine contributing participants with representation from organizations that work with the medically underserved, low-income, minorities, populations with chronic disease needs, and public health representatives. The group was asked to:

- Identify the top three health needs of the community.
- Discuss the similarities/differences between the needs identified in the 2013 CHNA.
- Identify other community resources that exist to address the priority health gaps.

In the community served, Baylor Scott & White opened a hospital in Marble Falls in July, 2015. This 46 bed facility was the first and only hospital available in the area. There were also several primary care and a few specialty care clinics spread out across the wider community. Challenges with healthcare access persisted within the overall community, especially in the aging, senior, indigent, uninsured, and Spanish speaking populations.

Transportation was identified as a major impediment to healthcare access in much of this market, especially Blanco County. Accessing care available in the community remained a challenge, as there were no public transportation options. There were no large employers in the area, which was an underlying cause for the significant population of uninsured and underinsured residents. Many who purchased insurance through the healthcare exchange could not afford the high deductibles and therefore, still lacked true access to health services.

Many without insurance were unaware of the resources available and found it difficult to navigate the system. Understanding and following the complex processes to access care were overly cumbersome and confusing for many community members. This was especially challenging for the senior and the underserved populations. There was not a process in place at the hospital or educational options to assist them with things like paperwork, language barriers, and computer skills. Recently, the food stamp and mental health office moved “up the hill” to an inaccessible location for those who required their services. The community was not aware of other resources in place to assist them. The group discussed the need to have bi-lingual support at the hospital to help senior and indigent clients navigate their available options. The group proposed placing computers

in the hospital lobby along with a support person to help patients access the patient portal and other applicable health information.

For the community served, the top five health needs identified in the focus group were:

1) Psychiatric and mental health services
2) Access to care
3) Pediatric specialists
4) Oncology specialists
5) Prevention

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.

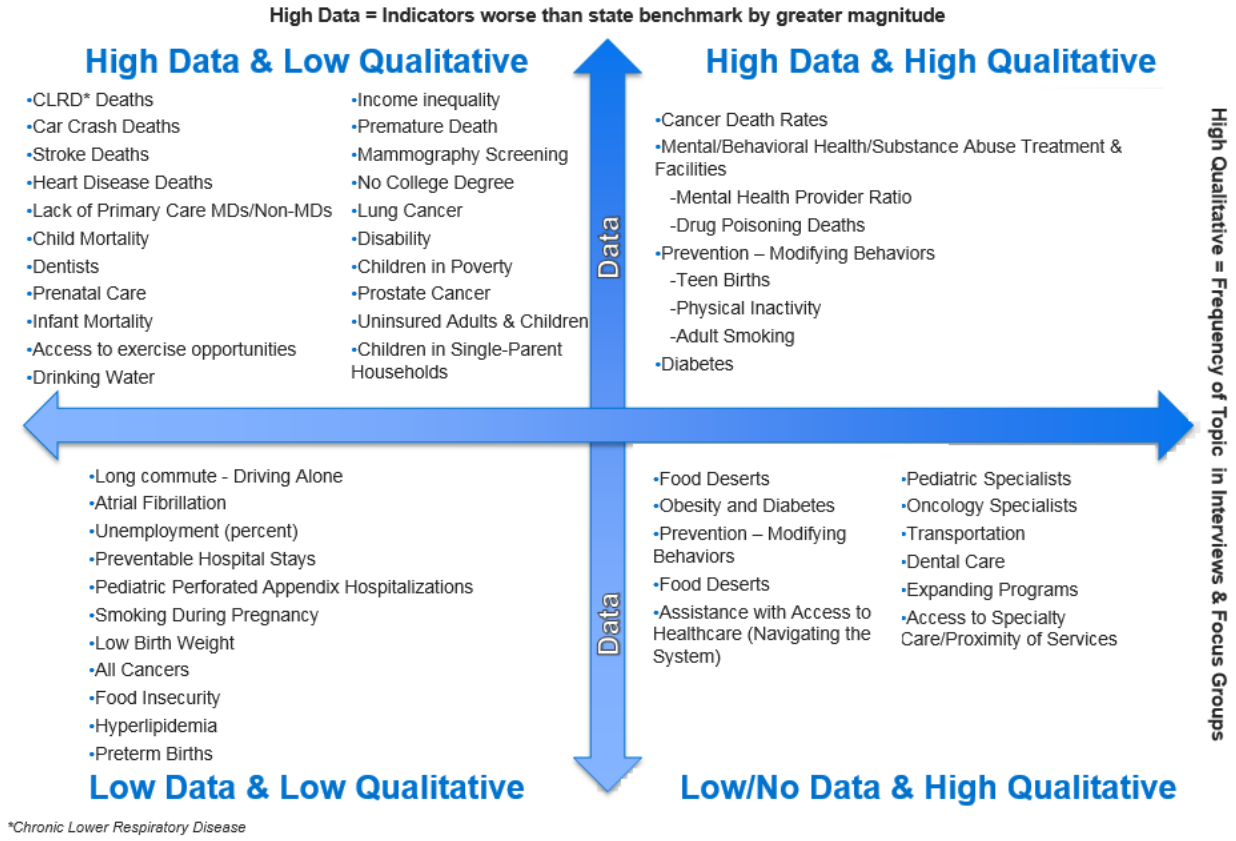
The interview and focus group participants and the populations they serve for this community are documented in the table below.

Focus Group and Key Informant Interview Participants					
Community Leaders/ Groups		**Public and Other Organizations**		**Other Providers**	
Town of Marble Falls (Focus Group)	Burleson County Health Resource Commission (Interview) **LI, CD**	Texas Housing Foundation (Focus Group) **MU, LI**	TX A&M Agrilife Extension Office (Interview) **MU, LI, CD**	Highland Lakes Family Crisis Center (Focus Group) **MU, LI**	Lake Falls Church (Focus Group) **MU, LI**
Catholic Charities of Central TX (Interview) **MU, LI, MP**		Community Resource Centers of Texas (Focus Group) **LI, CD, MP**	Texas Department of State Health Services (Interview) **PH**	Heart of Hope Counseling Mediation/ Highland Lakes Health Partnership (Focus Group) **MU, LI**	Seton Highland Lakes Hospital & Clinics/ HLHealth Partnership Board (Focus Group) **LI, CD**
		Department of State Health Services - Region 7, Highland Lakes Interagency (Focus Group) **PH**		Methodist Healthcare Ministry (Focus Group) **MU, LI**	Seton Healthcare (Interview) **MU**

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

Health Needs Matrix

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



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 1, 2016 by the BSWH Hill Country Regional Leadership members in a session to establish a list of significant needs and to prioritize them. The meeting was moderated by the Director of Community Benefit, BSWH-CTX Division 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 – Hill Country Region
- Vice President
- Chief Nursing Officer
- Administrative Resident
- Chief Medical Officer

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. Cancer
2. Heart disease deaths
3. Prenatal care
4. Car crash deaths
5. Mental health
6. Diabetes

[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

Cancer

According to the National Cancer Institute's State Cancer Profiles, the average annual incidence of all cancers per 100,000 people, when evaluated by county, was similar or lower when compared to the state incidence of 418.[4] However, three of the counties (Burnet, Llano and San Saba) had higher rates of lung cancer than the state incidence rate of 58 per 100,000 people.[5] Dartmouth Atlas of Healthcare provided information that two of the counties in the community had mammography screening rates less than the state. The two counties below the Texas 59% benchmark were Blanco (56.5%) and San Saba (50%).[6]

Cancer was identified as a top health priority for the community. It was discussed that oncology patients have to commute to Austin for the full spectrum of oncology services, including chemotherapy and access to more specialists. The most common types of cancer in this market are prostate, breast, lung, and colorectal, and these four types will make up more than half of the new cases in the next five years.

Heart Disease Deaths

The National Vital Statistics System tracked mortality rates by condition. The community's mortality rates far exceeded the state rates for the heart disease.[7] The heart disease mortality rate was 152 deaths per 100,000 people for the state. It was 205 in Blanco, 210 in Burnet, 271 in San Saba, and Llano was 130% higher than the benchmark at 350.

According to the USDA, Burnet (13.1%), Llano (12.7), and San Saba (11.8%) all had a higher percentage of low-income residents with limited access to healthy foods when compared to the state (8.3%).[8] Additionally, all found counties had less adequate access to locations for physical activity compared to the state value of 84%.[9]

Heart disease was identified as a significant health issue in the market, but it's a complex disease interdependent with other conditions such as obesity, diabetes, hypertension, and lack of exercise. Community input (gathered through key informant interviews and focus group sessions) validated the quantitative findings, indicating heart disease as a significant community health need. The community believed that preventative care

[4] National Cancer Institute, State Cancer Profiles, 2008-2012 average annual incidence of all cancer types per 100,000 people (age-adjusted)
[5] National Cancer Institute, State Cancer Profiles, 2008-2012 average annual incidence of lung cancer per 100,000 people (age-adjusted)
[6] Dartmouth Atlas of Healthcare, 2012, Percentage of female Medicare enrollees ages 67-69 that receive mammography screening
[7] National Vital Statistics System-Mortality (NVSS-M) (CDC/NCHS), 2013 deaths per 100,000 people
[8] USDA Food Environment Atlas
[9] Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files

services were lacking, especially for diabetes and obesity, and this continued to be a problem but had been overshadowed by the other challenges in the market.

Prenatal Care

According to the Texas Department of State Health Services Natality File, 65% of women in Texas entered into prenatal care within their first trimester of pregnancy compared to 56% in Blanco, 65% in Burnet, 68% in Llano, and 70% in San Saba.[10] Tobacco use was prevalent in this market and rates for births to mothers who smoked during pregnancy were much higher than Texas (4%) for the two counties with data (Burnet 9%, Llano 20%).[11] Llano and San Saba had higher rates of teen births (70 and 64 births respectively per 1,000 females aged 15-19) than the state of Texas (55 births per 1,000 females age 15-19).[12]

Access to prenatal care has been a challenge historically due to limited resources available in the community. The focus group observed that maternal health has been improving since prior assessments, which is a positive note. Additionally, there are services at the new hospital and more indigent care was available (but still limited). There are some free clinics to serve the population, but lack of awareness about prenatal services continues to persist.

Car Crash Deaths

All four counties in the community served had significantly higher motor vehicle crash mortality rates than the state average. The national average was 22 deaths per 100,000 population and the Texas rate of 14 deaths per 100,000 were far eclipsed by Blanco at 31, Burnet at 32, Llano at 18, and San Saba at 38 per 100,000 people.[13] In the United States, crash injuries result in about 500,000 hospitalizations and four million emergency department visits annually[14].

Mental Health Services

According to the County Health Rankings NPI file, there were fewer mental health providers per capita in this market when compared to Texas and national benchmarks. The U.S. ratio was 529 people per mental health provider and Texas was 1,034 per mental health provider. Burnet had 1,753 people for each mental health provider, and Llano had 1,620.[15] The Centers for Medicare & Medicaid Services (CMS) reported that the community's Medicare population had Alzheimer's disease/dementia and depression at a lower rate than Texas overall (12%).[16]

[10] Healthy Texas Babies Data Book, Center for Health Statistics, Texas Department of State Health Services; 2014, First Trimester Entry into Prenatal Care.
[11] 2007-2013 Population Reference Bureau analysis of Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). 2003-2006
[12] National Center for Health Statistics (NCHS), 2006-2012 birth rate per 1,000 female population, age 15-19
[13] County Health Rankings (NCHS) for 2006-2012 Motor vehicle crash deaths
[14] Healthy Communities Institute, Community Dashboard, 2015
[15] County Health Rankings (NPI file) for 2014 Ratio of population to one mental health provider
[16] Centers for Medicare & Medicaid Services (CMS), 2012 percentage of Medicare FFS Beneficiaries

According to focus group participants, sufficient early intervention, treatment services, and long term mental health services were not available within the community, and the community lacked enough professionals and a coordinated effort to provide appropriate crisis intervention. Gaps in mental health services contributed to the overutilization of the emergency department (ED) for mental health issues, and limited follow up care was available; often the patient returned to the same harmful environment. A suicide task force was in place, but the group believed it was underutilized. Substance abuse was widespread, and drug use among the school-aged population was a recognized problem. The community also needed educational services to address cultural bias and fear of seeking help for mental health issues.

Diabetes

Diabetes was closely linked to obesity and heart disease as well as lack of healthy food options and exercise. The obesity rate in Texas was 29%; Blanco and San Saba were both higher with 30%, Burnet was 29%, and Llano was 26%.[17] According to the USDA, Burnet (13.1%), Llano (12.7), and San Saba (11.8%) all had higher percentages of low-income residents with limited access to healthy foods when compared to the state (8.3%).[18] Additionally, all four counties had less adequate access to locations for physical activity compared to the state value of 84%.[19] Adult residents reported having no leisure-time physical activity at higher rates in all four counties compared to the state value of 23% (Blanco 24%, Burnet 28%, Llano 29%, and San Saba 24%).[20]

Obesity and diabetes were chronic diseases prevalent in the market with not enough preventive services available. The group discussions noted the need to increase community awareness of available services, health education, and additional local physicians. These issues were identified in prior assessments and remained a priority.

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.

[17] County Health Rankings (CDC) for 2011 Percentage of Adults that report BMI of 30 or more
[18] USDA Food Environment Atlas
[19] Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files
[20] CDC Diabetes Interactive Atlas, 2011 Percentage of adults aged 20 and over reporting no leisure-time physical activity

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

211	County Exchange – nutrition education	Hill Country Children's Advocacy Center	Rotary Club
Acton Crisis Center	County Groups for Healthcare Issues	Lonestar Circle of Care	Seton Caravan
Agri-Life – state extension office; "Do well, be well" diabetes education	DOVE Project	Methodist Healthcare Ministries	Seton Clinics
Baylor Scott & White Health	Food Banks	MHMR/MHDD/Veterans services	Seton health fairs
Care-a-van mobile health unit (asthma, obesity, pediatrics)	Free Clinics	Ministry Alliance	Suicide task force
Children's Advocacy Centers	Health Department	Mom Groups	Veterans Administration
Churches	Heart of Hope	Phoenix House for drug addiction/mental health	
Community Resource Center	Highland Lakes Health Partnership	Private practices and individuals	

Community Healthcare Facilities[21]

Hospitals – Three (3) hospitals serving the community

Facility Name	System	Type	Street Address	City	State	ZIP
Seton Highland Lakes Hospital	Ascension Health	ST	3201 SOUTH WATER STREET	BURNET	TX	78611
Baylor Scott & White Medical Center –Llano	Baylor Scott & White	ST	200 W OLLIE ST	LLANO	TX	78643
Baylor Scott & White Medical Center –Marble Falls	Baylor Scott & White	ST	810 W HIGHWAY 71	MARBLE FALLS	TX	78654

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

Baylor Scott & White Medical Center – Llano
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: Expand efforts of the Transforming Texas Initiative in Burnet and Williamson County to Llano County by collaborating with the Highland Lakes Healthcare Partnership

⃠ Use demographic maps to develop key contacts and stakeholders to participate in interventions that will assist target weight loss assistance for Hispanic population

⃠ Por Vida- collaboration with local restaurants to develop and advertise healthy choices on their menu

✘ Worksite wellness – institute programs in local businesses to encourage healthy choices among the employees

✔ Promote use of walking trails in collaboration with civic leaders and execute develop of safe pedestrian paths.

Strategy #2: Host and support local activities that encourage healthy activity and lifestyle choices

✔ Increase promotional efforts around local healthy activities

✔ Implement Walk Across Texas Program in community

✔ Support annual Fun Run for Heart Month

⃠ Host a Healthy Food Fare festival

✔ Engage with local businesses and civic organizations to do a Community Challenge around getting active and tracking physical activity for a pre-determined amount of time. Challenged other communities of similar size in competition.

✔ Host regular healthy cooking classes in partnership with Texas A&M AgriLife County Extension Office

Strategy #3: Enhance healthy living education

✔ Ensure hospital wellness site remains active and up to date with
🚫 Dedicate a dietician to participate in all ISD health committees
✔ Participate in more community health fairs and seek opportunities for community health lectures

Outcomes:

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: 2,761
Community Benefit Expense: $10,910

Community Health Education – School Based
BSWH recognizes the importance of teaching about health and healthy lifestyles to students in our school systems. Programs and services in this category 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 and are geared towards students K-12.

Persons Served: 797
Community Benefit Expense: $6,092

Financial Donations: 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: 1,470
Community Benefit Expense: $26,284

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: 1,165
Community Benefit Expense: $13,131

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: 700

Community Benefit Expense: $59,557

Subtotals For: Obesity

Number of Programs: 5 Persons Served: 6,893 Net Community Benefit: $115,974

Significant Need: Diabetes

Strategy #1: Educate the community on Type 2 diabetes on how to prevent and manage it

- ✔ Partner with American Diabetes Association to provide quality material
- ⃠ Offer Live Well Be Well diabetes education classes through nutrition department
- ✔ Provide regular glucose screenings and diabetes information at local health fairs
- ✔ Promote medical weight loss as a means to prevent and control chronic diseases such as diabetes

Strategy #2: determine whether need is prevalent enough to pursue recruitment of an Endocrinologist to join the hospital system in the Hill Country.

- ✔ Conduct analysis of diabetes related health indicators in the community
- ⃠ Identify geographic locations where risk of diabetes is high to determine growth of population most at risk
- ✔ Continue evaluation of current hospital and community resources to identify gaps in service

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.

Persons Served: 12
Community Benefit Expense: $302

Health Screenings: Eyes

BSWH offers screenings throughout the year to assist in the prevention and early identification of potential disease states like diabetes. 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: 63
Community Benefit Expenses: $1,435

Other 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: 700
Community Benefit Expense: $59,557

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: 2,761
Community Benefit Expense: $10,910

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: 1,165
Community Benefit Expense: $13,131

Subtotals For: Diabetes

Number of Programs: 5 Persons Served: 4,701 Net Community Benefit: $85,335

Significant Need: Cancer (Breast and Skin)

Strategy #1: Enhance community education efforts on breast health

- ✔ Provide material on frequency and recommendations for breast cancer screening at local health fairs
- ✔ Provide medical expert speaker on breast health information at annual women's health event
- ✔ Begin community outreach programs that focus on engaging women in understanding prevention and early detection of breast cancer
- ✔ Plan and promote opportunities for free screenings
- ✔ Establish procedure for navigating through the system if follow-up is required

Strategy #2: Provide access to affordable skin cancer screenings and updated information on guidelines

- ✔ Plan and promote biannual skin cancer screening event to community
- ✔ Include information on preventing skin cancer in health information provided at community health fairs

Outcomes:

Screenings: Skin Cancer

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: 137

Community benefit Expenses: $3,633

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: 1,165
Community Benefit Expense: $13,131

Subtotals For: Cancer

Number of Programs: 2 Persons Served: 1,302 Net Community Benefit: $16,764

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

Health Professional Shortage Areas (HPSA)[22]

County Name	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type
Blanco County	748031	Blanco County	Mental Health	HPSA Geographic
Blanco County	148031	Blanco County	Primary Care	HPSA Geographic
Burnet County	14899948OT	Seton Highland Lakes Dba Marble Falls Health Center	Primary Care	Rural Health Clinic
Burnet County	14899948B6	Seton Highland Lakes Clinic Marbles Fall	Primary Care	Rural Health Clinic
Burnet County	148999488N	Seton Highland Lakes Care-a-Van	Primary Care	Rural Health Clinic
Burnet County	148999484U	Horseshoe Bay Clinic	Primary Care	Rural Health Clinic
Burnet County	64899948ML	Seton Highland Lakes Clinic Marbles Fall	Dental Health	Rural Health Clinic
Burnet County	648999480J	Horseshoe Bay Clinic	Dental Health	Rural Health Clinic
Burnet County	74899948MF	Seton Highland Lakes Clinic Marbles Fall	Mental Health	Rural Health Clinic
Burnet County	74899948ME	Seton Highland Lakes Dba Marble Falls Health Center	Mental Health	Rural Health Clinic
Burnet County	748999481F	Horseshoe Bay Clinic	Mental Health	Rural Health Clinic
Burnet County	748053	Burnet County	Mental Health	HPSA Geographic
Burnet County	648053	Burnet County	Dental Health	HPSA Geographic
Llano County	748299	Llano County	Mental Health	HPSA Geographic
Llano County	148999486U	Low Income - Llano County	Primary Care	HPSA Population
San Saba County	748411	San Saba County	Mental Health	HPSA Geographic High Needs
San Saba County	148411	San Saba County	Primary Care	HPSA Geographic

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

Medically Underserved Areas and Populations (MUA/P)[23]

County Name	Service Area Name	MUA/P Source Identification Number	Designation Type
Blanco County	Blanco Service Area	3281	Medically Underserved Area
Burnet County	Burnet Service Area	3290	Medically Underserved Area
Llano County	Llano County	3381	Medically Underserved Area
San Saba County	San Saba Service Area	3418	Medically Underserved Area

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