Baylor Scott & White HEALTH

Community Health Needs Assessment 2016

Scott & White Memorial Hospital
(including Baylor Scott & White McLane Children's Medical Center)

Baylor Scott & White Continuing Care Hospital

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

Table of Contents

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, Baylor Scott & White Health (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:

- Scott & White Memorial Hospital [including Baylor Scott & White McLane Children's Medical Center]
- Baylor Scott & White Continuing Care Hospital

For the 2016 assessment, Scott & White Memorial Hospital (including Baylor Scott & White McLane Children's Medical Center) and Baylor Scott & White Continuing Care Hospital have defined their community to be the geographical area of Bell, Coryell McLennan, 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.

Turning Point digital polling was employed to identify the significant needs, and then to prioritize those needs. Each participant voted for only 5 health needs in order of preferred significance. Responses were weighted based on the number of times they were voted for and by the rank they were given (1-5 with 1 being the highest and 5 being the lowest priority). The significant needs, which ranked in the top 5 more than 55% of the time, were prioritized in the following order.

1. Chronic Disease/Chronic Illnesses
2. Mental health services
3. Obesity/Poor Physical Health
4. Tobacco Use
5. Access to care
6. Pediatric asthma hospitalization

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).

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.

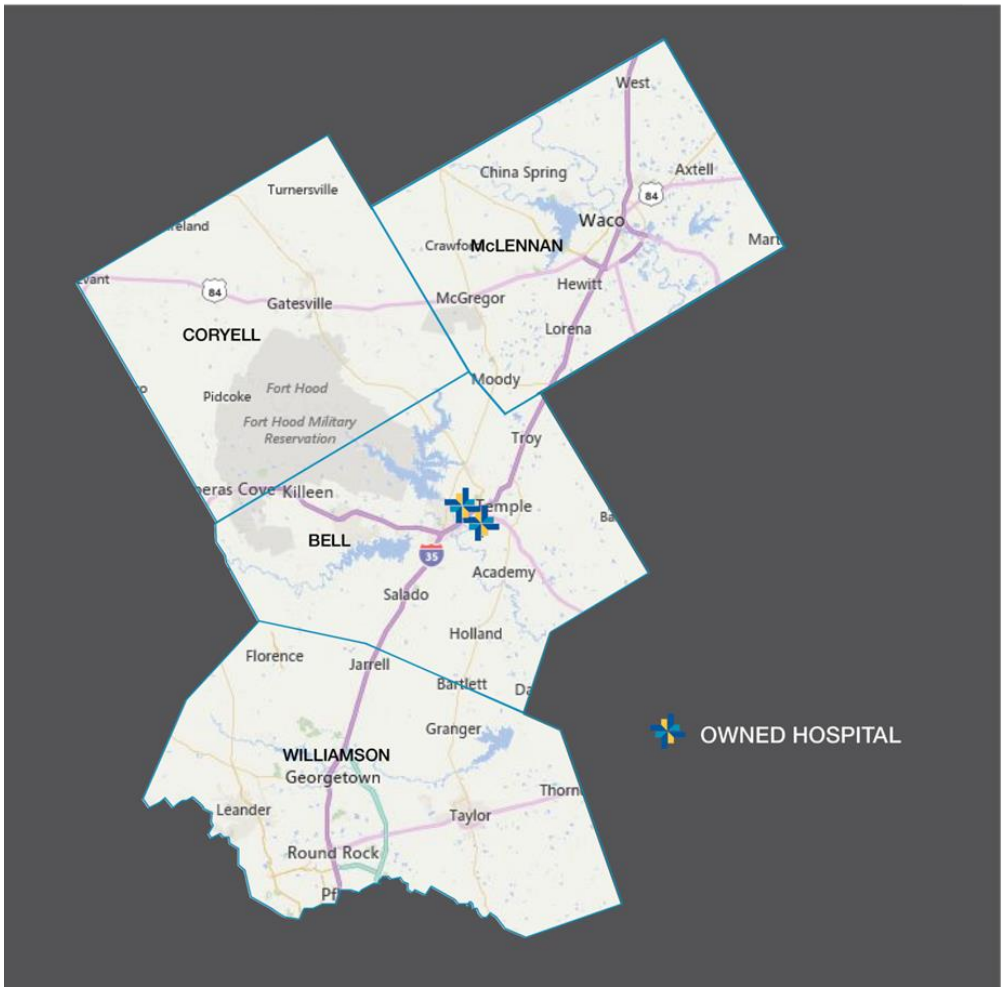
The community served definitions used in this current assessment differ from those used by the legacy Baylor Health Care System and the legacy Scott & White Healthcare in their 2013 CHNAs.

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 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 defined their community to be the geographical area of Bell, Coryell, McLennan, and Williamson counties. The community served was determined based on the county that makes up at least 75 percent of the hospitals' 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.

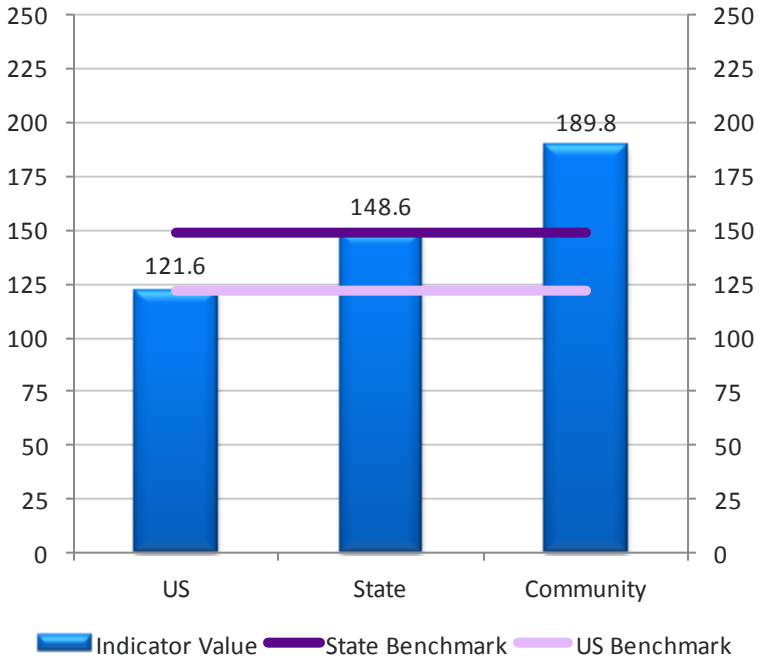
Quantitative Assessment of Health Needs

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 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, three (3) focus groups with a total of fifty-four (54) participants, as well as seven (7) 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).

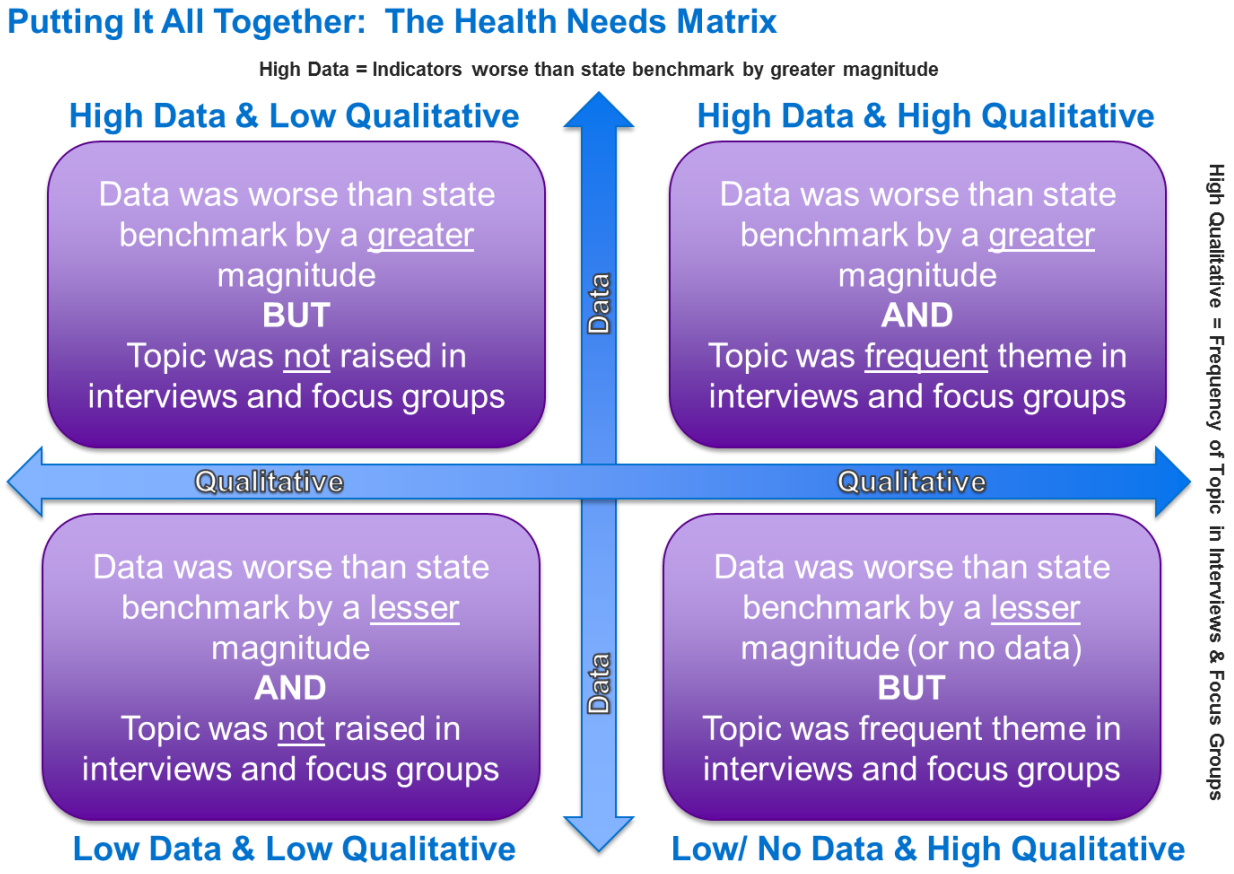
In addition to soliciting input from public health and various interests of the community, hospitals are also required to take into consideration written input received on their most recently conducted CHNA and subsequent implementation strategies. The facilities have an active portal on the website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

1. Obesity
2. Breast cancer death rate
3. STDs
4. Hospitalization due to pediatric asthma
5. Smoking
6. Linguistic isolation

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 with slightly higher median income. The population growth rate by 2020 is higher than state and national benchmarks. There were larger proportions of children and minorities compared to other communities in central Texas. The unemployment rate was similar to state and other central Texas communities. Social barriers such as the ability to speak only limited English and high school graduation rates provided a smaller challenge in the community served as compared to other communities.

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	1,158,104
5 Yr Proj Pop Chg	4%	7%	8%
Population 0-17	23%	26%	27%
Population 65+	15%	12%	11%
Women Age 15-44	20%	21%	22%
Non-White Population	29%	31%	32%
Insurance Coverage: Medicaid	19%	14%	11%
Insurance Coverage: Uninsured	10%	20%	16%
Median Household Income	$56,682	$56,653	$58,487
Limited English	5%	8%	3%
No High School Diploma	14%	19%	13%
Unemployed	10%	8%	8%
Poverty	16%	18%	Bell Co: 15% Coryell Co: 13% McLennan Co: 22% Williamson Co: 8%

Source: Truven Health Analytics / The Nielsen Company, 2015

The population of the community is expected to growth at 8%, which is over 90,000 people, by 2020. The cities of Hutto and Round Rock are growing faster than the state (7%) and the U.S. (4%) at rates of 15% and 13%, respectively. Round Rock was the largest city in the community served; the city's growth rates are very strong across all by ZIP Codes.

- 78664 Round Rock – 9% growth
- 78665 Round Rock – 13% growth
- 78681 Round Rock– 10% growth

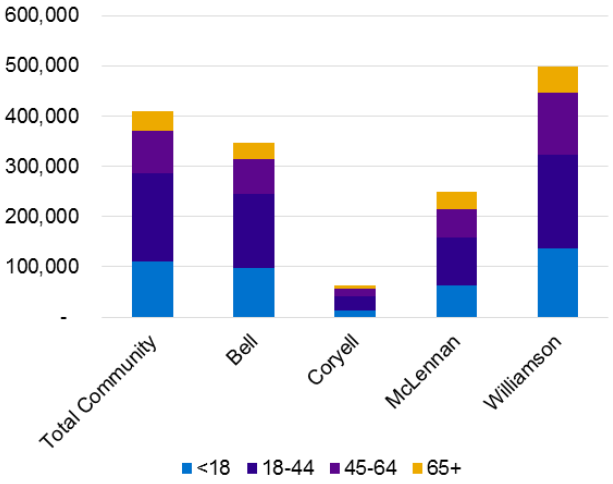
Overall, the city of Round Rock is projected to experience an 11% population growth over the next five years.

The sixty-five plus cohort was the smallest, but expected to experience the most growth over the next five years, which will add over 29,000 seniors to the community. Growth in this population will likely contribute to increased utilization of services as the population continues to age.

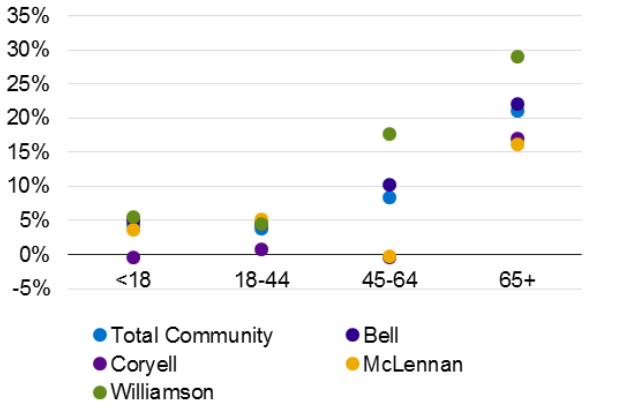
Women of childbearing age (18-44 years old) are expected to increase more quickly in Williamson County than in Bell and Coryell counties. The community's growth is equivalent to that of the state for this age cohort.

Population by Age Cohort

2015 Total Population



5 Year Projected Population Growth Rate

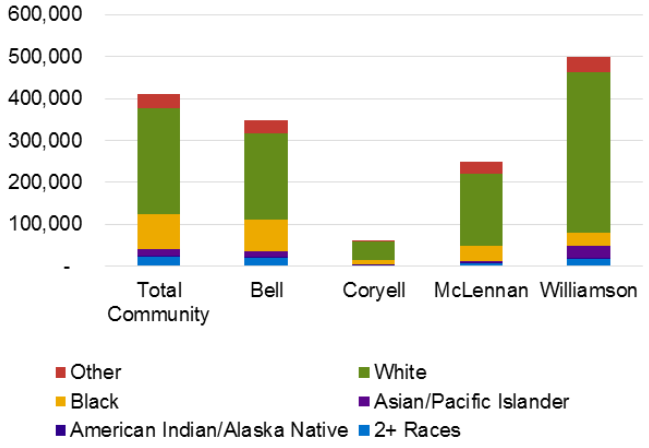


Source: Truven Health Analytics / The Nielsen Company, 2015

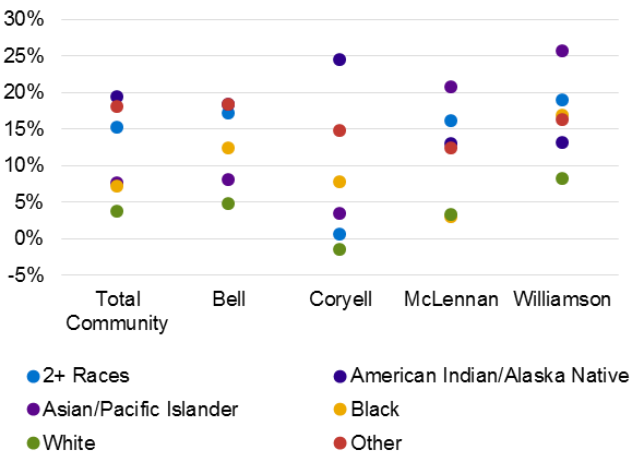
Diversity in the community will increase as minority populations are expected to grow the fastest. Bell County had a slightly higher percentage of minorities compared to the other counties in the community. Bell and Williamson counties were home to the majority of the minority population. Twenty-four percent (24%) of the population in the community served was Hispanic, with 43% living in Williamson County, 30% living in Bell County, and 23% living in McLennan County. Sixteen percent (16%) of the Coryell County population was Hispanic compared to 25% in Williamson County. The 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

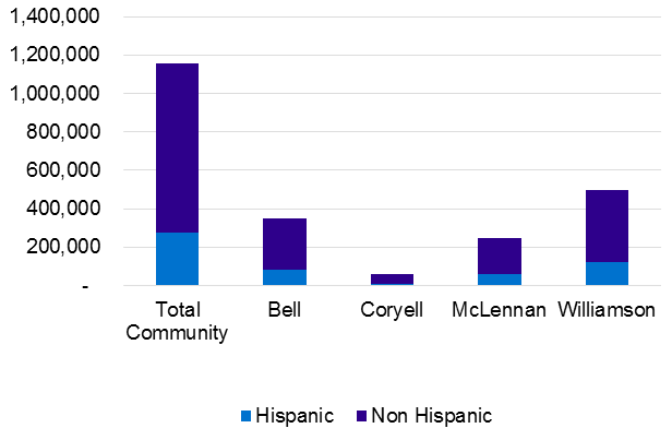


Source: Truven Health Analytics / The Nielsen Company, 2015

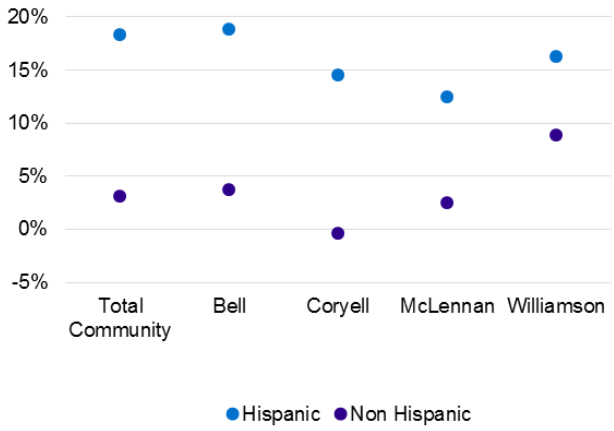
In the community, all counties are expected to experience significantly higher growth in Hispanic population. Coryell County was the least populated county and is expecting a slight decline in the non-Hispanic population. McLennan, Williamson and Bell Counties are estimated to experience more growth in all races.

Population by Hispanic Ethnicity

2015 Total Population



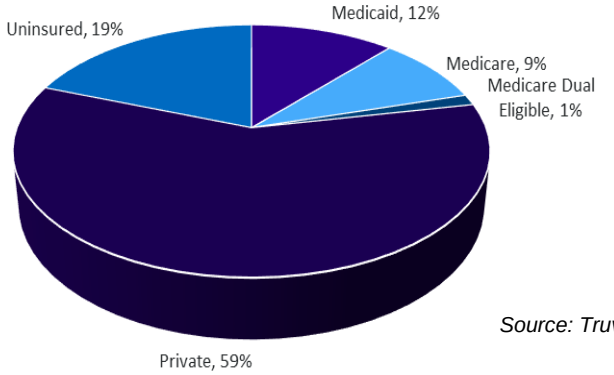
5 Year Projected Population Growth Rate



Source: Truven Health Analytics / The Nielsen Company, 2015

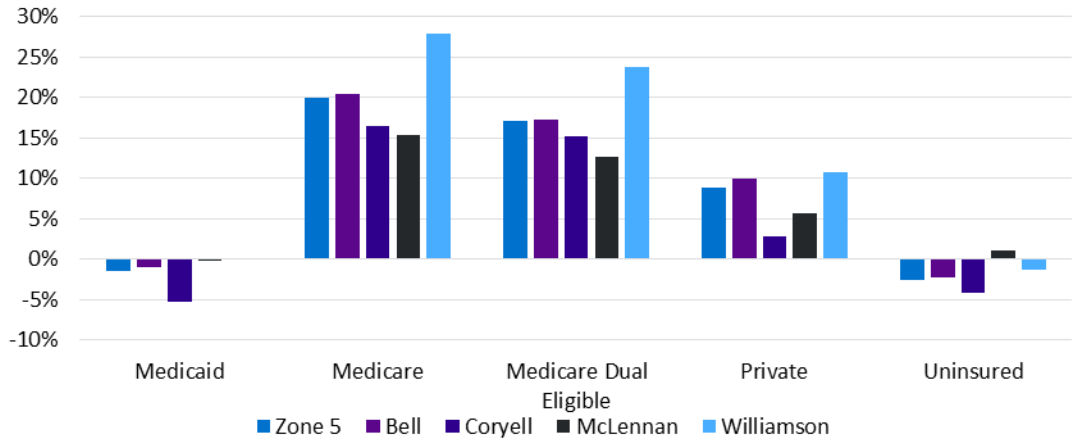
The median household income for the community served was $58,487. Fifty-nine percent (59%) of the community was commercially insured. Populations purchasing health insurance through the government exchanges is expected to grow 60% over the next 5 years, but will still comprise less than 5% of the commercial insurance market. The uninsured rate is expected to decline 3% in the community by 2020; however, 18% of the population in two of the counties is estimated to remain uninsured. Fifty-one percent (51%) of the population was enrolled in an employer sponsored insurance plan, and projected to increase by approximately 4% over the next five years. All counties are expected to experience a decline in the Medicaid and uninsured populations. Williamson County is expected to have higher growth in all other insurance types.

2015 Estimated Distribution of Covered Lives by Insurance Category



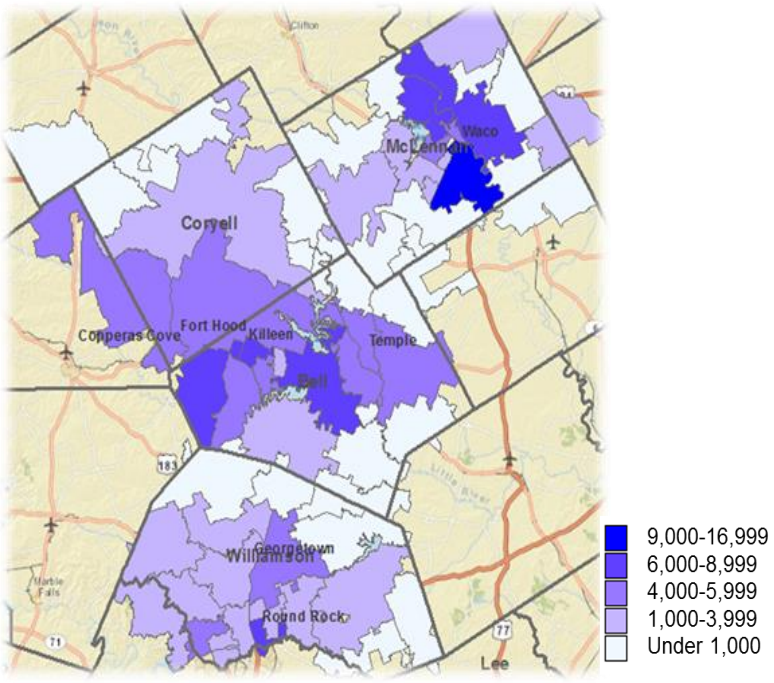
Source: Truven Health Analytics, 2015

Estimated Covered Lives and Projected Growth by Insurance Category



Source: Truven Health Analytics, 2015

2015 Estimated Uninsured Lives by ZIP Code



Source: Truven Health

The community includes thirteen (13) Health Professional Shortage Areas and five (5) Medically Underserved Areas as designated by the U.S. Department of Health and Human Services Health Resources Services Administration.[1] ***Appendix D*** includes the details on each of these designations.

Health Professional Shortage Areas and Medically Underserved Areas and Populations

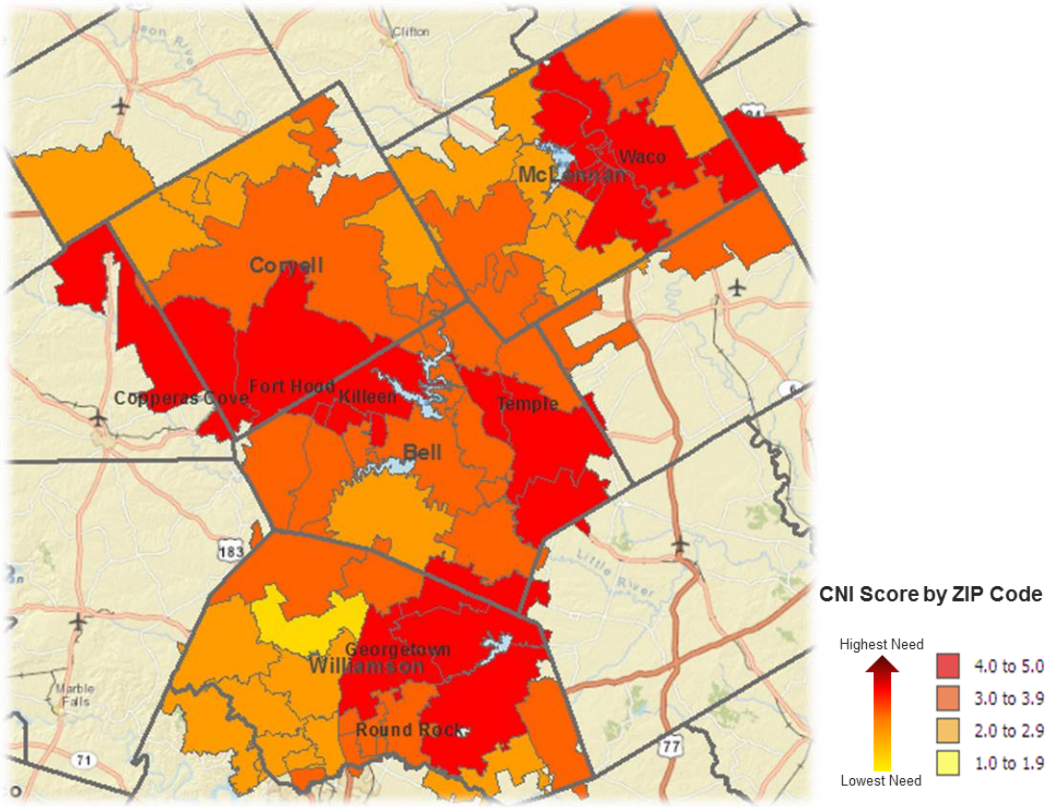
	Health Professional Shortage Area (HPSA)				Medically Underserved Area/Population (MUA/P)
COUNTY	**Dental Health**	**Mental Health**	**Primary Care**	**TOTAL HPSA**	**TOTAL MUA/P**
Bell County	0	0	0	0	2
Coryell County	0	0	1	1	1
McLennan County	2	3	1	6	1
Williamson County	2	2	2	6	1
TOTAL	**4**	**5**	**4**	**13**	**5**

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

The Truven Health's 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.

The community had an overall CNI Score of 3.5. The community was slightly higher than the average CNI for the U.S (3.0). The community encompassed a full range of needs spanning from those with very few needs to those with excessive needs. Waco, Temple, Killeen, Nolanville, Bartlett, Granger, Taylor, and Mart showed the greatest need and had higher CNI scores than the remaining portions of the community. Other areas such as Georgetown, Crawford and Purmela showed fewer barriers to health.

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:

Indicator Category	Indicator
Access to care	Could not see doctor due to cost
Access to care	Amount of price-adjusted Medicare reimbursements per enrollee
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	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	Adult Obesity (percent)
Health behaviors	Physical Inactivity (percent)
Health behaviors	No Exercise (percent)
Health behaviors	Adult Smoking (percent)
Health behaviors	Adults Engaging in Binge Drinking During the Past 30 Days (percent)
Health behaviors	Driving deaths with alcohol involvement (percent)
Health behaviors	Teen birth rate per 1,000 female population, ages 15-19
Health behaviors	Sexually Transmitted Infection Incidence Rate (per 100,000)
Health outcomes	Percentage of adults reporting fair or poor health (age-adjusted)
Health outcomes	Average number of physically unhealthy days reported in past 30 days (age-adjusted)
Health outcomes	Cancer (all causes) Incidence
Health outcomes	Female Breast Cancer Incidence
Health outcomes	Colon Cancer Incidence (per 100,000)
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	Alzheimer's Disease/Dementia: Medicare Population (percent)
Health outcomes	Atrial Fibrillation: Medicare Population (percent)
Health outcomes	COPD: Medicare Population (percent)
Health outcomes	Depression: Medicare Population (percent)

Indicator Category	Indicator
Health outcomes	Heart Failure: Medicare Population (percent)
Health outcomes	Hyperlipidemia: Medicare Population (percent)
Health outcomes	Schizophrenia and Other Psychotic Disorders: Medicare Population (percent)
Health outcomes	Pediatric Asthma Admission Risk-Adjusted-Rate (per 100,000)
Health outcomes	Pediatric Diabetes Short-term Complications Admission Risk-Adjusted-Rate (per 100,000)
Health outcomes	Pediatric Gastroenteritis Admission Risk-Adjusted-Rate (per 100,000)
Health outcomes	Pediatric Perforated Appendix Admission Risk-Adjusted-Rate (per 100 Admissions for Appendicitis)
Health outcomes	Pediatric Urinary Tract Infection Admission Risk-Adjusted-Rate (per 100,000)
Health outcomes	Adult Perforated Appendix Admission Risk-Adjusted-Rate (per 100 Admissions for Appendicitis)
Health outcomes	Adult Risk-Adjusted-Rate of Lower-Extremity Amputation Among Patients with Diabetes (per 100,000)
Health outcomes	First trimester entry into prenatal care
Health outcomes	Births to Mothers Who Smoked During Pregnancy (New Birth Certificate)
Health outcomes	Low Birth Weight Rate (per 100 births)
Health outcomes	Low Birth Weight (percent)
Health outcomes	Very Low Birth Weight (VLBW) (percent)
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)
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)
Mental health	Ratio of population to one mental health provider
Mental health	Average number of mentally unhealthy days reported in past 30 days (age-adjusted)
Population	High School Graduation Rate
Population	High School Dropouts (Percent)
Population	Some College (percent)
Population	Children in Poverty (Percent)
Population	Children in Single-parent Households
Population	Unemployment (percent)
Population	Income inequality
Population	Individuals Living Below Poverty Level
Population	Individuals Who Report Being Disabled (percent)
Population	Social associations (membership associations per 10,000 people)
Population	Children enrolled in public schools that are eligible for free lunch (percent)
Population	Violent Crime Rate (offenses per 100,000 people)
Prevention	Diabetic monitoring: Medicare Enrollees
Prevention	Mammography Screening: Medicare Enrollees
Prevention	Flu Vaccine 65+

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. There were more than 208,000 estimated case of hypertension in the community. The majority of heart disease cases occurred in the cities of Waco, Round Rock, and Georgetown; these cases accounted for almost 40% of the total for each heart disease type.

2015 Estimated Heart Disease Cases

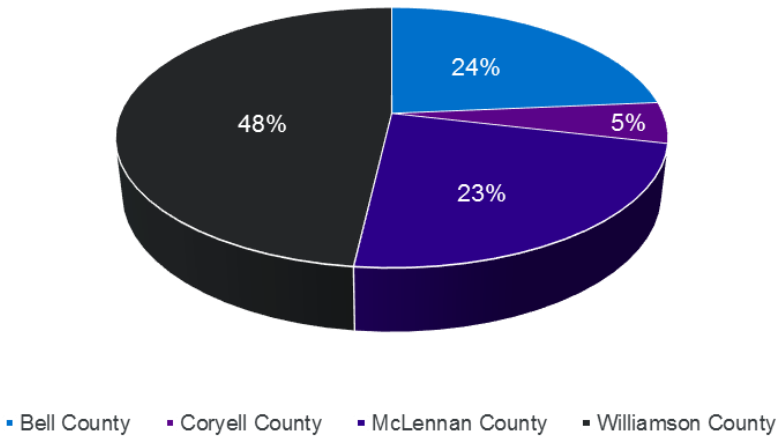
Disease Type	Bell County	Coryell County	McLennan County	Williamson County	Total Community
ARRHYTHMIAS	8,996	2,193	8,767	16,759	36,715
CONGESTIVE HEART FAILURE	4,218	931	4,804	6,874	16,827
HYPERTENSION	51,261	10,845	52,880	93,742	208,728
ISCHEMIC HEART DISEASE	6,794	1,509	7,450	14,159	29,912

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

Source: Truven Health Analytics, 2015

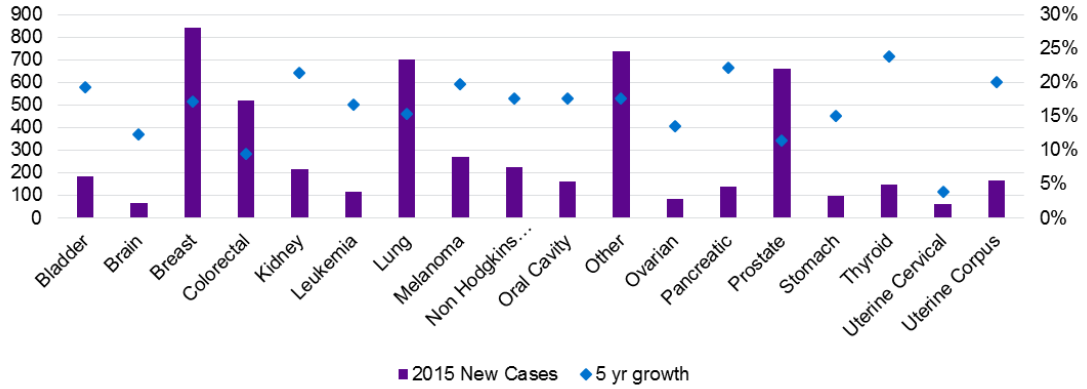
Truven Health's 2015 Cancer Estimates revealed the greatest growth rates were projected for thyroid, pancreatic, kidney and uterine cancers in the community. Growth rates for all cancer types were projected to be equal to or up to 2% higher than statewide rates.

2015 Estimated New Cancer Cases



Source: Truven Health Analytics, 2015

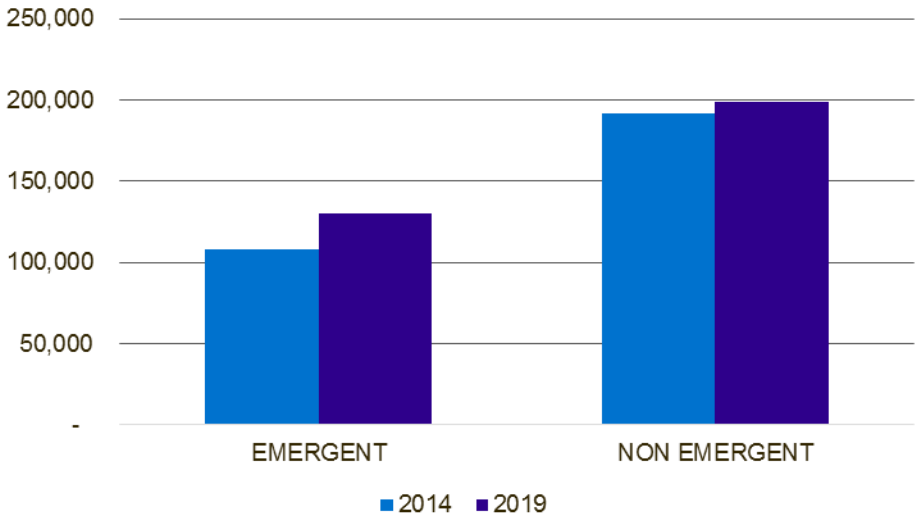
2015 Cancer Cases and Growth by Type



Source: Truven Health Analytics, 2015

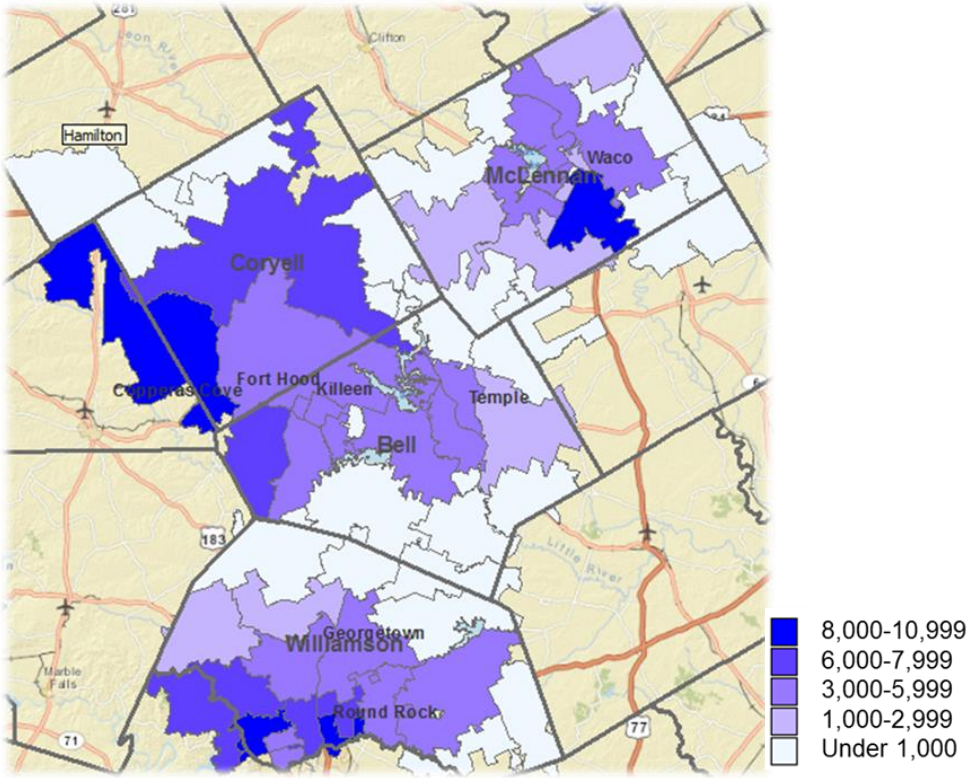
Outpatient emergency department visits are those which are treated and released and therefore do not result in an inpatient admission. Truven Health estimated outpatient emergency department (ED) visits to increase 7% in the community over the next five years. Non-emergent outpatient ED visits are lower acuity visits that present in the ED but can be treated in other more appropriate and less intensive outpatient settings. Non-emergent ED visits could have been an indication that there were systematic issues related to accessing primary care physicians or managing chronic conditions. Non-emergent visits are projected to increase by 4% while emergent visits are expected to increase 21%. Approximately 17% of visits were coming from the city of Waco, 12% from Round Rock, and 11% from the city of Killeen.

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 to identify the factors that contributed to the current health status of the community. The factors contributing to the perceived health status included socioeconomic disparity, poverty, health education, literacy, and coordination of healthcare services.

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

1. Prevalence of chronic conditions and diseases (childhood and adult obesity, childhood and adult diabetes and cancer)
2. Access to care (affordable healthcare / insurance, primary care for lower socio-economic populations, dental services and prescription assistance)
3. Prevention (smoking cessation and infectious disease)
4. Expanding programs (prevention and environment)
5. Mental / Behavioral Health (Substance abuse)

Barriers to good health care in this community included the lack of access to care, difficulty planning for the future, inadequate funding, the lack of resources in the community, and the cost of care. The following populations were identified as vulnerable groups that needed special attention when addressing health needs:

- Immigrants
- Spanish immigrants, specifically seniors
- African American
- Children of lower socio-economic status
- Teenagers
- Disabled elderly
- Homeless

Focus group participants were asked to identify the factors that contributed to the current health status of the community. Discussions focused on the prevalence of poverty and homelessness, linguistic isolation, care coordination, access to care challenges, and health and wellness limitations.

There were some discussions regarding ways the community could work together to achieve health for the community that would impact every individual in the community served. The group agreed that BSWH was in position to assist with defining and driving the vision for a healthy community and building on the current “culture of cooperation.” Mental / Behavioral health was a high priority; resources were limited for adults and non-existent for seniors. Children had some available services, but they did not provide adequate coverage. The group noted there was a shortage of providers, psychiatrists, and prescribers in both the public and private sectors. The situation was critical for the indigent. Medicaid limited the number of mental and behavioral health visits, and Texas did not fund the services needed. Funding was locally driven; therefore, it presented a significant challenge. Substance abuse was an issue that often led to other problems such as anxiety, aggression, family violence, and bouts with the criminal justice system. Depression and autism were widespread, and the demand for services from the lower

socioeconomic class was increasing. Lastly, the need for crisis treatment services was increasing.

Dental health was not related to socioeconomic issues; it was deficient across the community served. Preventative dental care was not available, and Medicaid did not cover services. Dental needs were often addressed when they became urgent. Lack of access to insurance, financial means, and transportation contributed to these challenges. There was a need for dental health coaching and education focusing on overall health. Dental issues were managed in the ED, and they were being addressed as an overall health issue.

The lack of focus on community health and wellness played a significant role in chronic disease management. Access to healthy food was limited, and there were no local farmers markets. Opportunities for physical activity were limited due to a lack of green space and areas for walking and biking. Community engagement was lower in structured activities such as bowling and softball leagues, perhaps due to accessibility.

There was a high prevalence of obesity which correlated with diabetes, heart disease, and hypertension. These diseases were impacted by poverty and access to healthy food in the community. Classes were available; however, interest in attending was low. There were multiple efforts in place, but the counties were lacking a coordinated community plan.

STD rates were of significant concern to many of the participants. The city of Killeen was ranked among the top ten cities with the most STD cases in the U.S. Rates are on the rise which may be due to the growing population. Politics surrounded sex education limited early intervention. STDs were noted to be the most prevalent in those between the ages of 15 and 24 years. The group identified that there seemed to be an underlying issue pertaining to the lack of self-care which is similar to many health conditions. Education was suggested for both providers and community members.

The focus group identified the following health needs:

- Access to Care
- Mental health
- Dental health
- Long term care
- Chronic illness
- Community focus on health and wellness
- Obesity
- Sexually transmitted disease rate

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.

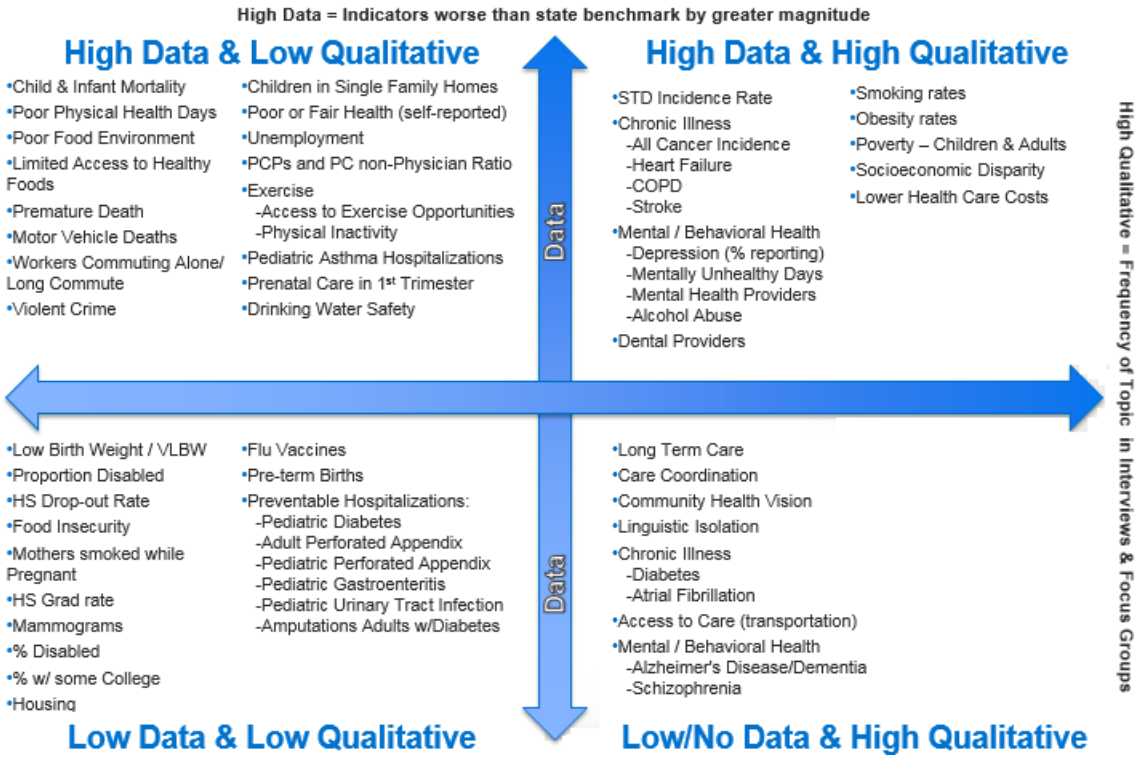
The interview and focus group participants and the populations they serve for this community are documented in the table below.

Focus Group and Key Informant Interview Participants							
Community Leaders/ Groups		**Public and Other Organizations**				**Other Providers**	
United Way of Central Texas (Focus Group) **MU, LI**	Center for Applied Health Research/ BSW, Central Texas United Way (Focus Group) **CD**	Area Agency on Aging (Focus Group) **CD**	Bell County Public Health District (Interview) **PH**	Williamson County HealthCare Link (Focus Group) **PH**	Lone Star Circle of Care (Focus Group) **MU, LI, CD, MP**	Central Counties Services and MHMR (Focus Group) **MU, LI**	Central Texas 4C, Inc. (Head Start) (Focus Group) **MU, LI**
Temple City Council, District 2 (Focus Group) **MP**	Catholic Charities of Central TX (Interview) **MU, LI, MP**	Texas Department of State Health Services(DSHS), Region 7, Temple (Focus Group) **PH**	Texas Department of State Health Services (Interview) **PH**	Williamson-Burnett County Opportunities (WBCO) (Focus Group) **PH**	WCCHD (Focus Group) **MU, LI**	Temple Community Clinic (Focus Group) **MU, LI, CD, MP**	Body of Christ Community Clinic (BOCCC) (Focus Group) **MU, LI**
American Heart Association (Focus Group) **MU, LI, CD, MP**	Smith&Nephew (Focus Group) **MU, LI, CD**	Temple Independent School District (ISD) ACE (Focus Group) **LI, MP**	Helping Hands Ministry-Belton (Interview) **LI**	Williamson Counties and Cities Health District (WCCHD) (Focus Group) **PH**	Southwestern University (Focus Group)	Greater Killeen Free Clinic (Focus Group) **MU, LI**	Community Partnerships, Helping Hands Ministry (Focus Group) **LI**
Bike Hutto (Focus Group)	Literacy Council of Williamson County (Focus Group) **MU, LI**	Bell County Indigent Health Services (Focus Group) **MU, LI**	Texas A&M Agrilife Extension Services (Interview) **LI**	FRIDAY & ADAPT (Focus Group)	Texas A&M Health Science Center Preventative Medicine (Focus Group)	Hillcrest Medical Center (Interview) **CD**	Waco Family Health Center (Interview) **MU, LI, CD, MP**
Community Bank and Trust (Focus Group)	Texas Document Solutions, Sales (Focus Group)	It's Time Texas (Focus Group) **PH**	Foundation Communities (Focus Group) **LI**	Hutto ISD (Focus Group) **MU, LI, CD, MP**	Texas Health and Human Services Commission (Focus Group) **PH**	Gardner Chiropractic: Family and Wellness Center (Focus Group) **CD**	LifeSteps Council on Alcohol and Drugs (Focus Group) **MU, LI**
		Georgetown ISD (Focus Group) **CD**	Round Rock ISD (Focus Group) **MU, LI, CD, MP**	Leander ISD (Focus Group)	Texas A&M College of Medicine (Focus Group) **MU, CD**	Valence Health (Focus Group) **MU, LI**	Williamson County EMS (Focus Group) **MU**
		Waco ISD, Greater Waco Academy, School District (Focus Group) **MU, LI, CD, MP**	Prosper Waco (Focus Group) **MU, LI, MP**	Baylor University *2 participants* (Focus Group)	Waco-McLennan County Public Health Department (Focus Group) **MU, LI, CD, MP**	Texas NeuroRehab Center (Focus Group) **CD**	WBCO (Focus Group) **MU, LI**
		McLennan Community College (Focus Group)	McLennan County Pack of Hope (Focus Group) **LI**	Waco Police Department (Focus Group) **MU, LI, CD, MP**		Gardner Chiropractic: Family and Wellness Center (Focus Group) **CD**	LifeSteps Council on Alcohol and Drugs (Focus Group) **MU, LI**
						Valence Health (Focus Group) **MU, LI**	Williamson County EMS (Focus Group) **MU**
						Texas NeuroRehab Center (Focus Group) **CD**	WBCO (Focus Group) **MU, LI**

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.



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 17, 2016 by Scott & White Memorial Hospital and Baylor Scott & White Continuing Care Hospital and on February 24, 2016 by Baylor Scott & White McLane Children's Medical Center leadership in sessions to establish a list of significant needs and to prioritize them. The meetings were 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.

February 17 - Session participants included:

President – Central Region	President / Chief Medical Officer	Nursing Director - ED
President – Continuing Care Hospital	Vice President - Laboratory	Director Clinical Operations – Surgery / Cardiology
Nursing Director - Obstetrics	Laboratory Director	Nursing Director
Ambulatory Nursing Director	Director of Human Resources	Nursing Director, Peri-operative Care
Director of Clinic Operations, Pulmonology / COPD	Vice President	Division Director
Nursing Director, Department of Medicine	Director, Regional Marketing	Vice President, HIM, MSS
Director of Physician Relations	Vice President Patient Care Services	Director of Clinic Operations
Regional Director of Supply Chain Operations	Director of Nursing Professional Development	Director of Operations, Central Regional Clinics
Entity Director	Chief Nursing Officer, Continuing Care Hospital	Manager, Post-Acute Care Services – Continuing Care Hospital/Home Care/Hospice
Director of Pastoral Care	Site Director for Central Regional Clinic	Vice President, Medical Specialties and Administrator for Cardiovascular Services
Director, Cancer Institute	Vice President Trauma and EMS Program, McLane Children's	Director, Trauma Program

Director of Cardiovascular Services	Hospitality Director	Director of Clinical Compliance and Accreditation
Director of Food and Nutritional Services, Memorial and CCH	Director of Clinic Operations, Psychiatry	HR Business Partner
Director, Radiation Oncology Killeen Clinic Director	Director of Finance, Memorial and CCH Chief Nursing Officer, Memorial	Director OB/Gyn
Director of Facilities, Temple Region	Director of Rehab Services	Director of Radiology
Director of Nursing	Director of Continuum of Care Management	Director of Pavilion Surgery Center
Vice President of Continuum of Care Management	Vice President of Finance, Memorial	

February 24 - Session participants included:

President/Chief Medical Officer	Chief Operations Officer/Chief Nursing Officer	Vice President, McLane Children's Administration
Vice President, Finance, Administration	Director of Pediatric Clinic Operations, Administration	Director, Critical Care Services, Administration
Director, Perioperative Services, Administration	Director, Patient & Family Support Services, Administration	Director, Hospitality Service, Administration
Director, Emergency & Acute Inpatient Services, Administration	Director, Diagnostic & Therapeutic Services, Administration	Director of Nursing for Ambulatory Care, Administration
Director of Pharmacy and Nutrition, Administration	Sr. Supervisor Pediatric Outpatient	Hospital Access Service Manager
Director of Access Service	Manager, Sterile Processing	Nurse Manager, Special Procedure Unit
Supervisor, Radiology/Ultrasound	Supervisor, Diagnostic Radiology	Clinical Manager, Rehabilitation PT/OT
Quality Training Manager	Hospitality Services Manager	PACU Charge Nurse
Nurse Manager, House Supervisors	Nurse Manager, NICU	Nurse Manager, Transport Team
Manager, Respiratory Care	Sr. Supervisor, Pediatric Clinic	Media Relations Manager
Human Resources Business Partner Manager, Operating Room	Nurse Manager, Emergency Services	Nurse Manager, Pediatric Medical / Surgical Manager, Operating Room

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.

Turning Point digital polling was employed to identify the significant needs, and then to prioritize those needs. Each participant voted for only 5 health needs in order of preferred significance. Responses were weighted based on the number of times they were voted for and by the rank they were given (1-5 with 1 being the highest and 5 being the lowest priority). The significant needs, which ranked in the top 5 more than 55% of the time, were prioritized in the following order.

1. Chronic disease/Chronic illness
2. Mental health services
3. Obesity/Poor physical health
4. Tobacco use
5. Access to care
6. Pediatric asthma hospitalization

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 Disease / 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[2].

According to the National Cancer Institute's State Cancer Profiles, in Bell, Coryell and McLennan Counties, the average annual incidence of all cancers was 475, 446, and 433 cases per 100,000 people, respectively, compared to 418 per 100,000 people in the state.[3] The community's average annual lung cancer incidence was significantly higher than the state benchmark. Bell County was 83 per 100,000 people, Coryell County was 84 per 100,000 people and McLennan County was 70 per 100,000 people compared to the 58 per 100,000 people in the state.[3] The average annual colon and rectal cancer incidence per 100,000 people was 42 in Bell County, 46 in Coryell County, and 41 in McLennan County; they were slightly higher than the state(40 per 100,000 people).[3] Prostate cancer incidence in Bell County was 132 per 100,000 people compared to the state value of 116.[4] According to CMS, the COPD rate in the Medicare population in Coryell County was 12%, and the state rate was11%. The Medicare population heart failure rate in Bell and Coryell Counties was 18% and 17% respectively, also slightly above the state's rate of 16%.[5]

The National Vital Statistics System tracks mortality rates by condition. The community's mortality rates exceeded the state rates for the following chronic conditions:[6]

- Cancer mortality rate in McLennan County was 181 deaths per 100,000 people compared to the state rate of 145 deaths
- Stroke mortality rates in McLennan County was 60 deaths per 100,000 people compared to the state rate of 35 deaths
- Heart Disease mortality rate in McLennan County was 193 deaths per 100,000 people compared to the state rate of 152 deaths

Community input validated the quantitative findings which indicated that chronic illness is a significant community health need. Higher rates of chronic illness and morbidity were identified in Bell, Coryell and McLennan Counties. The participants identified needs that are not being met such as a general lack of understanding around resources that are available to the community, access to continuous care options, and availability of healthy food choices. The participants agreed on the need to focus on community health and wellness and its significance in addressing chronic illness.

[2] http://www.medicinenet.com
[3] National Cancer Institute, State Cancer Profiles, 2008-2012 average annual incidence per 100,000 people
[4] National cancer Institute, 2008-2012 average annual incidence per 100,000 people
[5] CMS, 2012 Percentage of Medicare FFS Beneficiaries
[6] National Vital Statistics System-Mortality (NVSS-M) (CDC/NCHS), 2013 deaths per 100,000 people

Mental Health Services

Mental Health as a community health need was identified as a priority through the key informant interviews and focus groups; in fact, it was the topic most mentioned. Specifically, participants mentioned the lack of funding and the need for access to services, such as mental health providers and acute inpatient services, particularly for the uninsured and/or homeless populations. The participants expressed a need for services to treat specific conditions such substance abuse, depression, and long term needs. The community input also focused on addressing the stigma associated with having a mental health condition which could influence an individual's decision to seek treatment. The input gathered acknowledged that mental health crisis care was currently available in the community; however, long term needs, such as ongoing management of depression and life after substance abuse rehabilitation, are not being addressed.

According to the Behavioral Risk Factor Surveillance System (BRFSS), the average number of mentally unhealthy days, which includes stress, depression, and problems with emotions, reported by adults in the past month was 3.8 in Bell County, 4.8 in Coryell County, and 4.9 in McLennan County compared to the 3.3 in the state and 2.3 among County Health Rankings Top Performer.[7] The Centers for Medicare & Medicaid Services (CMS), National Provider Identification File provided the number of people per every mental health provider; in Coryell and Williamson Counties it was 2,617 and 1,101 respectively. This was compared to the 1,034 in the state and 370 among the County Health Rankings Top Performer.[8] CMS reported 12% of the Medicare population in McLennan County had Alzheimer's disease or dementia compared 11% in the state. In Bell County, 18% of the Medicare population suffered from depression. Both Coryell and McLennan Counties had a depression rate of 17% compared to the state value of 16%. In McLennan County the rate of Schizophrenia and other psychotic disorders was 4% which is slightly above the state's rate of 3.6%.[9]

Obesity

Obesity was a significant health need of the community that emerged through the key informant interviews and focus group sessions. The participants noted that obesity has not improved and the condition is expected to get worse among the population. Of significant concern were the co-morbidities and challenges of chronic disease brought on by obesity. The participants identified the need for additional resources in the community which support the health and wellness of the community's population. Specifically the group mentioned the community resources coordination efforts to increase physical activity, healthier eating, and educational needs of its population.

According to the CDC, adult obesity rates in Bell and Coryell Counties were at 30% and 31%, respectively; they were above the state's rate of 29% while McLennan and Williamson Counties were just below at 28.6% and 27.8% respectively.[10] Both Coryell

[7] Behavioral Risk Factor Surveillance System (BRFSS), 2006-2012 average number of mentally unhealthy days reported in past 30 days (age-adjusted).
[8] Centers for Medicare & Medicaid Services (CMS), 2014 Ratio of population to one mental health provider.
[9] Centers for Medicare & Medicaid Services (CMS), 2012 percentage of Medicare FFS Beneficiaries
[10] CDC, 2011 Percentage of Adults that report BMI of 30 or more

and McLennan Counties were significantly higher than the state's physical inactivity rate of 23.4%. Coryell was at 31% and McLennan was at 26% for physical inactivity; these rates are also higher than the 20% among County Health Rankings Top Performer.[11] According to the Behavioral Risk Factor Surveillance System (BRFSS), the percent of adult population that reported no exercise in the last month was 27% in Coryell County and 28% in McLennan County which was aligned with the state value of 27%.[12] Additionally, the USDA identified the percentage of low income residents that have limited access to healthy foods in Bell County to be15%, Coryell County was 11%, and McLennan County was 12%, this was significantly higher than the state (9%).[13] Obesity has been linked to many chronic diseases and individuals who are at a healthy weight are less likely to develop chronic illness risk factors such as high blood pressure and dyslipidemia as well as less likely to develop chronic diseases such as type 2 diabetes, osteoarthritis and some cancers.[14]

Poor Physical Health Days

Poor physical health days was identified as a priority need through the hospital prioritization process. According to the BRFSS, the number of poor physical health days, which includes physical illness and injury, reported in the last thirty days in Bell County was 4.3, Coryell County was 4.8, and McLennan County was 5.3 compared to the 3.7 in the state and 2.5 among County Health Rankings Top Performers.[15] The percentage of physical inactivity in Bell County was 4%, Coryell and McLennan Counties were 5%, the state was 4%, and the County Health Rankings Top Performers were 3%.

Tobacco Use

Tobacco use was a community health need identified through the hospital prioritization process. Although smoking was identified as a need in 2013, the group identified that it remained a problem. A high percentage of the population smoked, chewed tobacco, or used vaping merchandise.

According to the BRFSS, the percent of adults that smoke tobacco was 19% in Bell County, 21% in McLennan County, 17% in the state, and 14% among the County Health Rankings Top Performers.[16] The hospital recognized that tobacco use impacted other chronic illnesses that were identified as needs such as lung cancer, heart disease, and chronic lower respiratory disease. The need for health education and support of healthy behaviors was a theme that emerged in the community input sessions.

[11] National Center for Health Statistics (NCHS), 2011 Percentage of adults aged 20 and over reporting no leisure-time physical activity
[12] Behavioral Risk Factor Surveillance System (BRFSS), 2006-2012 18+ who report no exercise in past month
[13] United States Department of Agriculture (USDA) Food Environment Atlas, 2010 percentage of population who are low-income and do not live close to a grocery store
[14] Healthy People 2020, 2016, www. Healthypeople.gov/2020
[15] Behavioral Risk Factor Surveillance System (BRFSS), 2006-2012, Average number of physically unhealthy days reported in past 30 days (age-adjusted)
[16] Behavioral Risk Factor Surveillance System (BRFSS,) 2006-2012, Percentage of adults who are current smokers

Access to Care

Access to healthcare was a common theme which emerged through the key informant interviews and focus group session. Participants acknowledged the culture of cooperation, available resources, and opportunities to connect the community. However, care coordination remained a challenge and impacted access to care. There was a need to better communicate with the Hispanic and undocumented populations to help eliminate the fear of seeking services. The healthcare system was fragmented and did not adequately serve those areas impacted by poverty. It was agreed that the healthcare infrastructure was challenged with getting the right resources to the residents at the appropriate time throughout the continuum of care. Strengthening existing networks of care would facilitate greater coordination of care for the community.

The quantitative analysis also identified access to care issues. According to the BRFSS, the percentage of adults in the community who could not see a doctor in the past 12 months due to cost was 22% in McLennan County compared to the state value of 19%.[17] Additionally, the number of people per non-physician primary care provider was 4,010:1 in Coryell County, 2,322:1 in McLennan County and 2,264:1 in Williamson County compared to the state ratio of 1,893:1.[18] In Coryell County, the number of people per primary care provider was 4,827 which was significantly higher than 1,708 people per physician in the state and 1,045 among County Health Rankings Top Performers.[19]

Pediatric Asthma Hospitalization

Hospitalization for pediatric asthma was a community health need identified as a priority for the community. Although pediatric asthma was identified in 2013, the hospital leaders agreed that it remained an issue. The Pediatric Asthma Admission Risk-Adjusted-Rate (per 100,000) was 181 in Bell County and 218 in McLennan County, both higher than the state's admission rate (95/100,000).[20]

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 chooses to address for the community served.

[17] The Behavioral Risk Factor Surveillance System (BRFSS), 2006-2012, county-level measures, in almost all instances aggregated over seven years, from the National Center for Health Statistics (NCHS)/Centers for Disease Control and Prevention (CDC).
[18] CMS National Provider Identification File, 2014 Ratio of population to one non-physician primary care provider.
[19] Area Health Resource File/American Medical Association, 2012 Ratio of population to one primary care physician
[20] Center for Health Statistics Texas Health Care Information Collection, Texas Department of State Health Services, 2013 Pediatric Asthma Admission Risk-Adjusted-Rate (per 100,000 population)

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

Act Waco Newsletter	Care Networks (non-profits, clinics, faith-based service providers)	Community Paramedics	Farmers markets
ADA Classes	Cedar Crest Behavioral Healthcare System	Coryell Memorial	Food Pantries
Aging, Disability & Resource Center (ADRC)	Central County Services	County Health Department	Fort Hood
Area Aging/AAACT/211	Central Texas Youth Service	Divine Nine (Baylor University)	Greater Killeen Free Clinic
Baylor School of Social Work	Chamber of Commerce	East Waco Park	Habitat for Humanity
Baylor University Volunteer Network	Christian Farms Treehouse	Express Clinics	Head Start
Bell County Health	Churches	Family Counseling Center	Health Department
Body of Christ Community Clinic (BOCCC)	City/ local community development	Family Health Center	Higher education
Baylor Scott & White Health	Community Care Relationships Coalition	Family of Faith	Hispanic Chamber of Commerce
Baylor Scott & White DSRIP Waiver Project	Community Gardens	Farmers Market	Homeless Alliance
Homeless Shelters	Marketing and advertisement	Primary Care Doctors	Temple Community Clinic
HUD Section 8, Public Housing	McLennan Community College	Private medical clinics including free clinics	Texas A&M Central
Indoor gym/walking trails	Medical higher education campuses	Prosper Waco	UMHB

Jack & Jill	Metroplex Health System	Region 12 Services	United Way
Large employers	MHMR	Salvation Army	Veterans Administration
Law Enforcement	Mission Waco	Schools - ISDs	Waco Chapter of The Links, Inc.
Life Steps	Mobile Vending	Seton Healthcare	Waco Clinics
Live Well Waco	National Alliance on Mental Illness (NAMI)	SSA	WilCo Wellness Alliance
Local Hospitals	Parks and recreation	STARRY Counseling	Williamson County and Cities Health District (WCCHD)
Local Mental Health Authorities (LMHA's)	Police department	Tarlton State University	YMCA

Community Healthcare Facilities[21]

Hospitals – Twenty (20) hospitals serving the community

Facility Name	System	Type	Street Address	City	State	ZIP
Baylor Scott & White Continuing Care Hospital	Baylor Scott & White	LT	546 NORTH KEGLEY ROAD	TEMPLE	TX	76502
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 - Hillcrest	Baylor Scott & White	ST	100 HILLCREST MEDICAL CENTER BLVD	WACO	TX	76702
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
Cedar Park Regional Medical Center	Ascension Health	ST	1401 MEDICAL PARKWAY	CEDAR PARK	TX	78613
Cornerstone Hospital Austin - Round Rock	Cornerstone Healthcare Group	LT	4681 COLLEGE PARK DRIVE	ROUND ROCK	TX	78665
Coryell Memorial Hospital	Coryell Memorial Healthcare System	ST	1507 WEST MAIN STREET	GATESVILLE	TX	76528
DePaul Center	Ascension Health	PSY	301 LONDONDERRY DRIVE	WACO	TX	76712
Healthsouth Rehabilitation Hospital Of Round Rock	HealthSouth	LT	1400 HESTERS CROSSING	ROUND ROCK	TX	78681
McLane Children's Hospital - Scott & White	Baylor Scott & White	KID	1901 SW H.K. DODGEN LOOP	TEMPLE	TX	76502
Metroplex Hospital	Adventist Health	ST	2201 SOUTH CLEAR CREEK ROAD	KILLEEN	TX	76549
Metroplex Pavilion	Adventist Health	ST	2407 SOUTH CLEAR CREEK ROAD	KILLEEN	TX	76549
Providence Health Center	Ascension Health	PSY	6901 MEDICAL PARKWAY	WACO	TX	76712
Round Rock Medical Center	Hospital Corporation of America	ST	2400 ROUND ROCK AVENUE	ROUND ROCK	TX	78681
Scott & White Memorial Hospital	Baylor Scott & White	ST	2401 SOUTH 31ST STREET	TEMPLE	TX	76508
Scott & White Pavilion	Baylor Scott & White	ST	1815 SOUTH 31ST STREET	TEMPLE	TX	76504

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

Hospitals (cont.)

Facility Name	System	Type	Street Address	City	State	ZIP
Seton Medical Center Harker Heights	Ascension Health	ST	850 WEST CENTRAL TEXAS EXPRESSWAY	HARKER HEIGHTS	TX	76548
Seton Medical Center Williamson	Ascension Health	ST	201 SETON PARKWAY	ROUND ROCK	TX	78665
St David's Georgetown Hospital	Hospital Corporation of America	ST	2000 SCENIC DRIVE	GEORGE TOWN	TX	78626

**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 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	2105 E PALM VALLEY BLVD	ROUND ROCK	TX	78665
Five Star ER	1700 ROUND ROCK AVE	ROUND ROCK	TX	78681
Premier ER Plus	9110 JORDAN LANE SUITE 100	WOODWAY	TX	76712

Psychiatric Facilities

Facility Name	Street Address	City	State	ZIP
Cedar Crest Hospital	3500 I-H 35 SOUTH	BELTON	TX	76513
Georgetown Behavioral Health Institute LLC	3101 S AUSTIN AVE	GEORGETOWN	TX	78626
Rock Springs	700 SOUTHEAST INNER LOOP	GEORGETOWN	TX	78626

Appendix C: Evaluation of Implementation Strategy Impact

Scott & White Memorial Hospital
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 the amount and improve consistence and quality of education provided to the community on the personal benefits to achieving and maintaining a healthy weight and lifestyle.

✔ Maintain accurate website content to provide tips on kids getting and staying healthy

✔ Participate in more community health fairs to share information on prevention of chronic illnesses related to being overweight as well as steps to correct bad habits

✔ Seek new opportunities for healthcare providers to give community lectures with relative health topics

✔ Host a free Health Fair event targeting minorities and medically underserved population with content focused on major health priorities

✔ Work to address disparities among Black and Hispanic population by partnering with local churches and organizations that serve and are trusted by these targeted groups in order to provide appropriate educational materials on healthy living

Strategy #2: Partner with local organizations to provide and promote regular participation in free to low-cost healthy activities within the community.

✔ Maintain and cultivate community partnerships providing healthy activities through in kind and financial support

✔ Host regular farmers markets to provide access to healthy fruits and vegetables

✔ Expand partnership with members of the Temple Mayor's Fitness Council to create additional programming within the city that is affordable and encourage healthy behaviors

Outcomes

Community Health Education – Heart Disease

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: 2,925
Community Benefit Expense: $3,282

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: 416,665
Community Benefit Expense: $83,836

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 instruction on making healthy life choices starting at an early age.

Persons Served: 3,093
Community Benefit Expense: $6,783

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: 187
Community Benefit Expense: $6,632

Financial Donations for Health Improvement

BSWH donates funds often 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: 17,507
Community Benefit Expense: $424,420

Farmers Market

BSWH hosts a weekly farmer's market in the spring/summer months. More than 16 vendors bring their healthy fruits and vegetables, BSWH nutrition does a healthy cooking demonstration and provides healthy recipe cards.

Persons Served: 12,500
Community Benefit Expense: $20,346

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: 55
Community Benefit Expense: $23,511

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 men in taking steps that help their chances for living a longer, healthier life. This annual event for men focusing on proactive health care including preventive health screenings, seminars and healthy lifestyle information.

Persons Served: 34
Community Benefit Expense: $25,000

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: 4,714
Community Benefit Expense: $71,897

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: 72
Community Benefit Expense $10,726

Promotion for Community Education Events

Staff time from the marketing and PR team spent planning and promoting community health events

Persons Served: unknown
Community Benefit Expense: $733

Provided Media

BSWH staff and physicians provide regular educational pieces to various media entities. (i.e. local television stations and newspapers)

Persons Served: 40
Community Benefit Expense: $9,487

Speakers Bureau

BSWH providers regularly participate in community events or meetings to provide topical lectures on various health conditions.

Persons Served: 107
Community Benefit Expense $155

Subtotals For: Obesity

Number of Programs: 14 Persons Served: 457,899 Net Community Benefit: $686,808

Significant Need: Sexually Transmitted Infections

Strategy #1: Provide accurate and accessible information on prevention and treatment of sexually transmitted diseases.

🚫 evaluate and revise the current literature on sexual health that is distributed on behalf of the hospital for outreach purposes

✔ Investigate better ways to improve dialogue with patients and the broader community including social networks, web-based programs, and community forums

✔ Enhance partnerships with local ISDs to teach sexual education within the schools and expand into additional districts throughout the state of Texas.

✔ Host annual Teen Health Month activities

❌ Explore possibility of incorporating HPV testing into annual sports physicals

Strategy #2: Ensure BSWH and other local medical providers are aware of best practices for treatment and prevention of STDs though offerings of continuous education

🚫 Scott & White Wellness and Sexual Health Program will provide information to providers on best practices and educational materials for possible topics to cover with patients when STD or inappropriate behaviors are identified.

✔ Encourage CME for all family providers when opportunities are available

🚫 Incorporate a standard question to be part of annual health exam for PCP to help catch potential cases of STIs earlier.

Outcomes

Scott & White Adolescent Wellness and Sexual Health (aka Worth the Wait)

Scott & White Wellness and Sexual Health Program empowers teens with information necessary to develop healthy habits and relationships. Previously known as Scott & White Worth the Wait, the program continues with the all-inclusive, data-driven curriculum founded on the medical, legal, psychological and socioeconomic information regarding adolescent health risk behaviors. Based on the probable consequences of adolescent risk behaviors, the safest and healthiest choice for teens is to promote risk avoidance by establishing healthy habits and relationships. The in-school intervention program is offered for middle and high school students, with components for parents, healthcare providers and the community.

Persons Served: 7,095
Community Benefit Expense: $55,474

Subtotals For: Sexually Transmitted Disease

Number of Programs: 1 Persons Served: 7,095 Net Community Benefit: $55,474

Significant Need: Breast Cancer

Strategy #1: Improve community outreach efforts on breast health

✔ Provide reliable information on cancer awareness issues

✔ Provide materials on appropriate screening measures in facility as well as make available in predetermined community locations

✔ Improve collaborative efforts with American Cancer Society to bring more awareness about cancer as well as programs and resources to the community

Strategy #2: Provide frequent opportunities for cancer screenings for the underinsured

✔ Host Fall Cancer Screening Event during Breast Cancer Awareness month

✔ Continue fostering partnerships with local community clinics to schedule free screenings for their clients

✔ Establish protocols for navigating patients through the system if follow up is required including financial assistance

Outcomes

Community Health Education – Breast 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: 22,523
Community Benefit Expense: $3,267

Community Health Education – Cancer

BSWH supplies information on various types of cancer 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: 14,215
Community Benefit Expense: $795

Screening and Services – Breast Cancer

BSWH offers mammography screenings throughout the year to assist in the prevention and early identification of breast cancer.

Persons served: 88
Community Benefit Expense: $3,817

Cancer Registry

The registry is used to identify areas where BSWH can improve health for our patients, at-risk populations and the community as a whole and is integral to helping us achieve our mission of serving the community and meeting identified needs. The cancer registry information is shared data and is not proprietary to BSWH. Expenses include staffing, software, and supplies to maintain the registry.

Persons Served: 5,400
Community Benefit Expense: $564,000

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: 55
Community Benefit Expense: $23,511

Provided Media

BSWH staff and physicians provide regular educational pieces to various media entities. (i.e. local television stations and newspapers)

Persons Served: 40
Community Benefit Expense: $9,487

Subtotals For: Breast Cancer

Number of Programs: 6 Persons Served: 42,321 Net Community Benefit: $604,877

Significant Need: Linguistic Isolation

Strategy #1: Enhance the translation services available to community members who speak little or no English

🚫 Explore potential technology options to better translation experience

✔ Assess existing resources to identify opportunities for improvement

✔ Build relationships with local agencies and organizations that are already serving the ESL community members and can assist with connecting them to healthcare resources.

Outcomes

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: 72
Community Benefit Expense $10,726

There are many additional efforts in place around addressing Linguistic Isolation through our translation services but proper metrics have not yet been attained by publication date of this report.

Subtotals For: Linguistic Isolation

Number of Programs: 1 Persons Served: 72 Net Community Benefit: $10,726

Additional Outcomes Addressing Significant Health Needs in the Community
Research: Improving Community Health

BSWH provides financial support for operating expenses and capital purchases for research in line with our mission and vision and in pursuit of improving community health.

Persons Served: unknown
Community Benefit Expense: $11,650,707

Total Number of Programs Addressing Needs:	21
Total Persons Served:	507,315
Total Net Community Benefit:	$12,997,866

Baylor Scott & White
McLane Children's Medical Center
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: Capitalize on opportunities to educate children and their parents in the community on the personal benefits to achieving and maintaining a healthy weight and lifestyle

✔ Maintain accurate website content to provide tips on kids getting and staying healthy

⃠ Host free Saturday seminars on preparing and purchasing healthy summer snacks

✔ Provide educational materials for achieving and maintaining a healthy lifestyle in all local school clinics

Strategy #2: Partner with local organizations to provide and promote regular participation in free to low-cost healthy activities within the community.

⃠ Expand MEND (Mind Exercise Nutrition Do It) program in partnership with the City of Temple modeled after another successful program in nearby city.

✔ Maintain and cultivate community partnerships providing healthy activities through in kind and financial support.

✔ Host regular farmers markets to provide access to healthy fruits and vegetables

✔ Host free community events at BSWH facilities. Cooking Classes, Safety Classes, etc.

Outcomes

Community Health Education – Diabetes

McLane Children's provides diabetes education seminars and presentations open to the public or for a specific group in need to educate the community kids and their parents about the signs and symptoms of diabetes and how to prevent diabetes from happening.

Persons Served: 200
Community Benefit Expense: $207

Community Health Education and Outreach

McLane Children's 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: 300
Community Benefit Expense: $2,437

Financial Donations for Health Improvement

McLane Children's donates funds often 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: 11,610
Community Benefit Expense: $55,876

Farmer's Market

BSWH hosts a weekly farmer's market in the spring/summer months. More than 16 vendors bring their healthy fruits and vegetables, BSWH nutrition does a healthy cooking demonstration and provides healthy recipe cards.

Persons Served: 2,450
Community Benefit Expense: $7,701

Health Fairs

McLane Children's 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: 300
Community Benefit Expense: $600

Subtotals For: Obesity

Number of Programs: 5 Persons Served: 14,860 Net Community Benefit: $66,731

Significant Need: Hospitalization due to Pediatric Asthma

Strategy #1: utilize a new full-time asthma educator to coordinate outreach and education. This person will also help identify children in the community who are "at risk" and may need additional follow up care.

✔ Increase education and outreach opportunities for parents through seminars, camps, wellness talks, etc.

❌ Have trained professionals conduct in home assessments of possible asthma triggers for "at risk" families

✔ Establish partnerships with local ISDs to teach asthma education within the schools and train school nurses how to properly follow an asthma action plan

✔ Enhance medical education of BSWH providers as well as other medical professionals in the community through adoption of new asthma action plan and establishment of new internal protocols.

🚫 Attempt to establish program in partnership with Scott & White Health Plan to provide essential controller medications at Tier 1 cost and make inhaler spacer available at all clinic sites for patients unable to afford them.

✔ Address disparities in access through cultivation of partnerships with local churches and organizations in lower income neighborhoods

Outcomes

Community Education and Outreach

Educational information and activities provided to parents and children on the causes and treatment of asthma symptoms as well as the importance of inhalers.

Persons Served: 880
Community Benefit Expense: $12,231

Education and Outreach in Schools

Asthma education provided in schools through partnerships with local ISDs.

Persons Served: 1,100
Community Benefit Expense: $1,285

Medical Provider Education

Information and activities that provide education for providers on asthma care.

Persons Served: 830
Community Benefit Expense: $1,540

Nursing Student Education

Teaching nursing students about caring for asthma patients whether in the hospital or in the community/schools.

Persons Served: 43
Community Benefit Expense: $231

Subtotals For: Pediatric Asthma

Number of Programs: 4 Persons Served: 2,853 Net Community Benefit: $15,287

Total Number of Programs Addressing Needs:	9
Total Persons Served:	17,713
Total Net Community Benefit:	$82,018

Baylor Scott & White Continuing Care Hospital
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: Obesity

Strategy #1: Conduct nutritional education in area schools to demonstrate to children the importance of starting healthy habits early to help prevent health complications that result from being overweight or obese.

✘ This strategy is better suited for our Children's Hospital. The CCH staff and hospital were not well-equipped to take this on and efforts failed before ever really getting off the ground.

Strategy #2: The hospital will increase participation in community health events.

✔ This was a new activity for CCH hospital and it was well received but participation was limited to 1-2 events per year. Would like to see an increase in future years.

Strategy #3: Secure and promote opportunities for family members of Hospital patients to access free or affordable exercise classes or health activities.

✔ This was a partial success. It was not feasible to host exercise classes on site, nor was the concept well received but the opportunity to utilize public boards for wellness information was beneficial and well utilized by patients.

Outcomes

Community Health Education Opportunities

CCH consistently looked 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 physicians and staff about health related topics like understanding various conditions and diseases, when to seek treatment, and the treatment options available.

Persons Served: 1,800
Community Benefit Expense: $2,595

Donations to Health Improvement Events/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: $5,000

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. Information supplied at health fairs includes making healthy lifestyle changes like quitting smoking, starting a nutritional diet, and increasing exercise.

Persons Served: 300
Community Benefit Expense: $275

Subtotals For: Obesity

Number of Programs: 3 Persons Served: 2,100 Net Community Benefit: $7,870

Prioritized Need: Smoking

Strategy #1: Offer smoking cessation programs, access to resources to decrease the incidence of smoking in Bell County.

- ✔ Cessation program made available but not utilized. Providing resources for quitting smoking was better received but no major changes occurred. Overall strategy worked but would like to see higher impact.

Strategy #2: Host physician led education sessions open to the public on the Continuing Care Hospital campus to discuss how smoking is a major contributor to lengthy hospital stays

- ✔ Concept was good but not fully integrated into planning efforts. May try again.

Outcomes

Smoking Cessation Outreach

Many of our patients and family members have addictions to tobacco. We provide materials on quitting smoking to our patients and offer a variety of resources to connect them to in order to aid in that journey.

Persons Served: 30
Community Benefit Expense: $916

Community Health Education Opportunities

CCH consistently looked 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 physicians and staff about health related topics like understanding various conditions and diseases, when to seek treatment, and the treatment options available.

Persons Served: 1,800
Community Benefit Expense: $2,595

Health Fairs

CCH participated in health fairs in order to provide access to educational materials that will help impact healthy lifestyle habits like quitting smoking.

Persons Served: 300
Community Benefit Expense: $275

Subtotals For: Smoking

Number of Programs: 3 Persons Served: 2,130 Net Community Benefit: $3,786

Total Number of Programs Addressing Needs:	4
Total Persons Served:	4,230
Total Net Community Benefit:	$11,656

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
Coryell County	148099	Coryell County	Primary Care	HPSA Geographic
McLennan County	148999485Z	Heart of Texas Community Health	Primary Care	Comprehensive Health Center
McLennan County	64899948C1	Heart of Texas Community Health	Dental Health	Comprehensive Health Center
McLennan County	748999482U	Heart of Texas Community Health	Mental Health	Comprehensive Health Center
McLennan County	748999481B	Low Income McLennan County	Mental Health	HPSA Population
McLennan County	74899948MM	McLennan County State Juvenile Correctional Facility	Mental Health	Correctional Facility
McLennan County	648309	McLennan County	Dental Health	HPSA Geographic High Needs
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

[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
Coryell County	Coryell Service Area	3307	Medically Underserved Area
McLennan County	McLennan Service Area	3507	Medically Underserved Area
Williamson County	Williamson Service Area	3445	Medically Underserved Area
Bell County	South Bell Service Area	3517	Medically Underserved Area
Bell County	East Temple	7964	Medically Underserved Area

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