Baylor Scott & White
HEALTH

IMPLEMENTATION STRATEGY

for the 2016

Community Health Needs Assessment

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

Baylor Scott & White Continuing Care Hospital

Scott & White Clinic
(including Baylor Scott & White McLane Children's Clinic)

Approved by: Baylor Scott & White Health – Central Texas Operating, Policy and Procedure Board on August 19, 2016 and posted to www.BaylorScottandWhite.com/CommunityNeeds on November 15, 2016

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Baylor Scott & White Health Mission Statement

OUR MISSION

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

"Personalized health" refers to a commitment to develop innovative therapies and procedures focusing on predictive, preventive and personalized care. For example, data from the electronic health record helps predict the possibility of disease in a person or a population. And with that knowledge, measures are put into place to either prevent the disease altogether or significantly decrease its impact on the patient or the population. Care is tailored to meet the individual medical, spiritual and emotional needs of patients.

"Wellness" refers to ongoing efforts to educate the people served, 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. BSWH includes 41 licensed hospitals, more than 900+ patient care sites, more than 6,600 active physicians, 43,750+ employees and the Scott & White Health Plan.

Over the years, Baylor and Scott & White 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, BSWH stands to be one of the nation's exemplary health care organizations.

OUR CORE VALUES & QUALITY PRINCIPLES

Specific values define the BSWH culture and should guide every conversation, decision and interaction with each other and with 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

2016 Community Health Needs Assessment Summary

Community Served

BSWH owns and operates multiple individual licensed hospital facilities serving the residents of North and Central Texas. The following hospital facilities have defined their communities to be the same, and conducted a joint community health needs assessment.

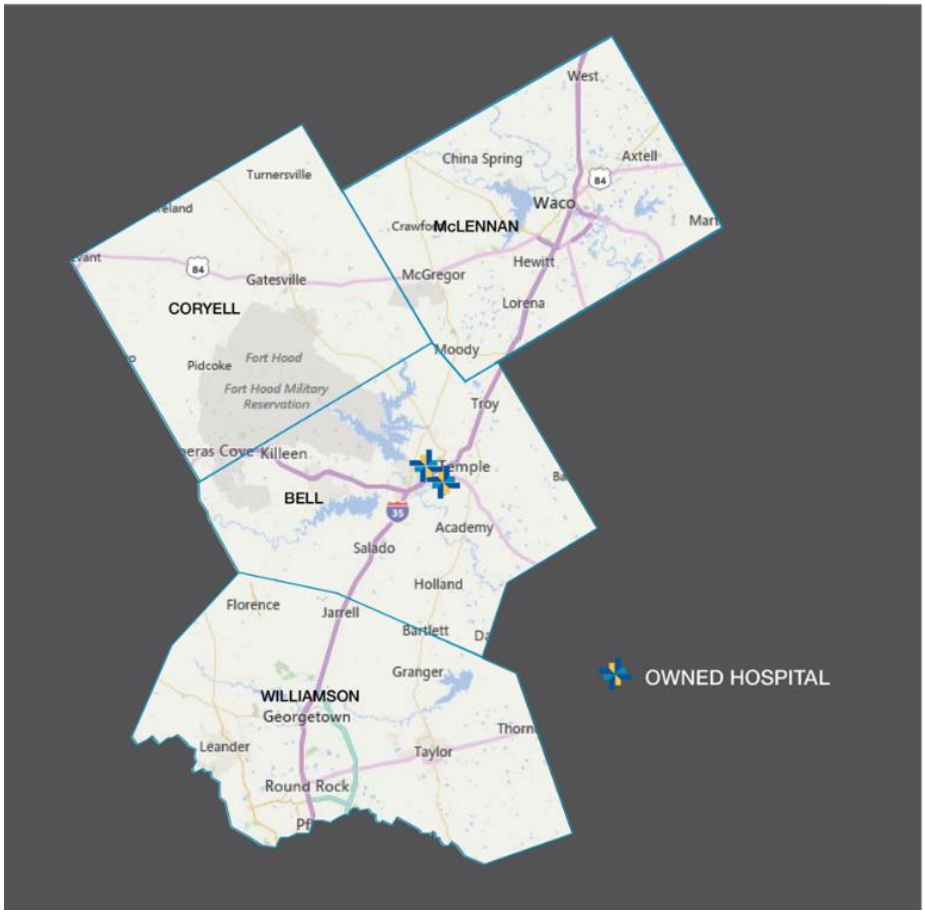
- Scott & White Memorial Hospital including Baylor Scott & White McLane Children's Medical Center
- Baylor Scott & White Continuing Care Hospital

These same hospital facilities have also chosen to do a joint implementation strategy with another 501(c) 3 nonprofit organizations:

- Scott & White Clinic including Baylor Scott & White McLane Children's Clinic

For the 2016 assessment process, the above facilities 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's inpatient and outpatient admissions.

Map of Community Served



Highlights of community characteristics include:

- The population is expected to grow 8% by 2020, an increase by more than 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.
- 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.
- 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.
- 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.

	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**

Community Health Needs Assessment Process

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

For the 2016 assessment, 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 counties that make up at least 75 percent of the hospital facilities' inpatient and outpatient admissions over a period of the past 12 months.

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

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

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

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

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

2016 Significant Health Needs

The identified significant needs are listed below in rank order. A complete description of the needs and how they were identified--including the data collected, community input obtained, analyzation process, and prioritization methods used—can be found in the 2016 CHNA report available at http://baylorscottandwhite.com/communityneeds.

Chronic Disease Management and Prevention: 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. The management and prevention of chronic diseases was identified as a leading health need in the community according to the focus group and interview participants. Specifically, the community identified the lack of public education to create awareness of chronic diseases and the factors that contribute, such as obesity, cardiac health and diabetes.

Mental Health Resources need was identified as a priority through the key informant interviews and focus groups in the assessment; 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 adequately 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.

Obesity and Poor Physical Health have 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. 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. Participants in community input sessions 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.

Tobacco Use has been clearly linked to a number of diseases and is in fact the leading cause of preventable and premature death in the United States. The assessment process verified that a high percentage of the community 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. 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 emerged often in the community input sessions.

Affordable Access to Primary Care emerged frequently as a need 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. 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%. 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. 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.

Pediatric Asthma Hospitalization was a health need identified as a priority for the community. Asthma is a condition in which a person's air passages become inflamed, and the narrowing of the respiratory passages makes it difficult to breathe. Symptoms are often brought on by exposure to inhaled allergens, such as dust, pollen, mold, cigarette smoke and animal dander, or be exertion and stress. Reducing exposure to poor housing conditions, traffic pollution, secondhand smoke and other factors impacting air quality can help prevent asthma and asthma attacks. In the last 30 years, asthma has become one of the most common long-term diseases of children. 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).

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

Implementation Strategy Development and Adoption

A Community Benefit and Community Health Needs Assessment (CHNA) Task Force, made up of community benefit, tax compliance, and corporate marketing representatives was established to advise hospitals on the development of individual Implementation Strategies to address unmet community health needs. The Task Force is responsible for overseeing the CHNA process including the integration of the community benefit priorities into the system-wide strategic planning process.

The Task Force objectives include:

- Review and provide support for local hospital community benefit plans
- Ensure alignment of plans to System culture and strategies
- Provide guidance on tactics to address community health needs
- Ensure compliance with federal and state guidelines, regulations and filings
- Oversee program evaluation and tracking
- Secure successful adoption of plan by hospital board of directors

The Task Force relied on valuable input from key hospital, research, and strategic planning leaders throughout the process to support the Hospital in planning for implementation.

The following criteria were utilized to determine the priority areas to address:

- *Severity or prevalence of the issue*
- *Notable health disparities in specific populations*
- *Readiness of community population to change*
- *Resources available to impact the need*
- *Feasibility of possible interventions to affect change*
- *Ability to evaluate outcomes*

Our Corporate Structure and Efforts to Address Community Needs

Baylor Scott & White Memorial Hospital including Baylor Scott & White McLane Children's Medical Center and Baylor Scott & White Continuing Care Hospital are licensed not-for-profit hospitals and as such have completed an assessment of community health needs and developed a joint implementation strategy to meet federal requirements to maintain that status. BSWH has separate clinic facilities that are invaluable to our efforts to improve the health of our community both in treating patients as well as providing community benefits. Although the clinic is not required by law to report its own community benefit, we have included the clinic efforts around community health improvement in this plan as an extension of the work being done by the hospital for community benefit purposes.

By appropriately delegating resources within our facilities, strengthening local partnerships, and creating innovative programs both on the Hospital campus and within the community, Baylor Scott & White Memorial Hospital including Baylor Scott & White McLane Children's Medical Center, Baylor Scott & White Continuing Care Hospital, and the Scott & White Clinic including Baylor Scott & White McLane Children's Clinic hope to make a positive impact on the following significant community health needs:

1. Chronic Disease Management and Prevention
2. Mental Health Resources
3. Obesity and Poor Physical Health
4. Affordable Access to Primary Care
5. Pediatric Asthma Hospitalization

The completed implementation strategy was adopted by the Baylor Scott & White Health – Central Texas Operating, Policy and Procedure Board, the fiduciary board for the hospital facilities, on August 19, 2016.

Addressing Community Health Needs

CHRONIC DISEASE MANAGEMENT AND PREVENTION

Facility: Scott & White Memorial Hospital
Program Name: Vasicek Cancer Center's Community Outreach
Program Description: Cancer Center staff attend frequent community events to provide cancer care education materials and screening guidelines. - Support Groups for cancer patients and their family are provided monthly
Anticipated Impact: Reduction in unnecessary emergency room visits, readmissions, and better management of conditions due to people not being able to access their medications and/or health care coverage
Metrics: - Number of events supported - Number of attendees at events - Patient feedback from support groups - ED visits
Committed Resources: Educational materials supplied by American Cancer Society Staff time at events – approximately 40 hours/year Staff time at monthly support group – 3 hours/month

Facility: Scott & White Memorial Hospital
Program Name: BridgeS to Wellness and Health
Program Description: a collaborative strategy between Baylor Scott & White, United Way of Central Texas, Body of Christ Clinic, and the Temple Community Clinic. BridgeS works with underinsured and uninsured clients who are unable to afford the necessary prescriptions, equipment, and supplies to maintain or improve their health status. The goal is to bridge the gap while a client awaits approval or a long-term affordable prescription coverage.
Anticipated Impact: Reduction in unnecessary emergency room visits, readmissions, and better management of conditions due to people not being able to access their medications and/or health care coverage
Metrics: -Number of clients approved for BridgeS support -Total prescription/equipment savings for clients - Readmission rates - ED visits
Committed Resources: In kind- committee participation- quarterly meetings Physician Liaison Pharmacy Manager Continuum of care Social Work Director

Community Benefit Director	20 hours/month determining eligibility = approx. $6,000 annually

Facility: Scott & White Memorial Hospital
Program Name: Patient Navigation (DSRIP)
Program Description: To provide patient navigation services targeting patients who are at high risk of disconnect from health care including those with multiple chronic conditions, disabilities, limited English proficiency, uninsured, and those with low health literacy.
Anticipate Impact: To help community members managing chronic conditions avoid unnecessary visits to the ED
Metrics: Number of individuals receiving patient navigation service Rate of ED admits per 100,000
Committed Resources: Approximately $17,000 a quarter

Facility: Scott & White Memorial Hospital
Program Name: Social Worker Assistance/Education for Advanced Heart Failure
Program Description: Social workers will assist with evaluation and application to pharmaceutical assistance programs, in depth evaluation of strengths and needs requested by medical team, counseling sessions directed at behavior modification, and referral and application to community resources. Development and implementation of additional teaching materials and classes to help patients better manage their disease. Action steps: - Effective July 2017 – Social worker began seeing heart failure patients in cardiology. - Heart failure team nurse practitioners have put together a mock up booklet for heart failure patients to take home with them explaining their disease and how to manage it. . - Offering weekly heart failure education classes in an outpatient setting: The classes are as follows: (1) What is Heart Failure? (2) Medication Management (3) Nutrition (4) Exercise - Projecting late FY17 –incorporating additional outpatient heart failure education classes to coincide with heart failure patients enrolled in cardiac rehab program. - Projecting FY18 – Heart Failure classes sent to patients via MyChart in a hyperlink for patients unable to attend class. - Projecting FY18 – Heart Failure classes available to send on a DVD to patients unable to attend class and no internet access. - Projecting FY17 – Living with Heart Failure event that is free of charge and open to the community. Event is set up much like the current weekly heart failure education classes.
Anticipated Impact: Improved outcomes in our Heart Failure patient population
Metrics: - volume of patients scheduled with social worker - Volume of patients attending classes and Living with Heart Failure Event
Committed Resources: $92,466 (includes cost of course material development and printing, staff time at events, and salary for 1 full-time Social Worker)

Facility: Scott & White Memorial Hospital

Program Name: Diabetes Education for the Community

Program Description:

- Por Tu Familia The hospital plans to host a series of Spanish diabetes education classes for the community in partnership with the American Diabetes Association. 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.

- Wellness Lives Here: Healthy Living Lunch n Learn Program BSWH dieticians and diabetes educators provide free lunch n learn sessions at local businesses in partnership with the American Diabetes Association to educate their employees about living a healthy lifestyle in an effort to prevent diabetes. The presentation provides general information on why and how to live a healthier lifestyle and how that will reduce risk of developing diabetes. Employees will walk away with tips, suggestions and tools to get started.

Anticipated Impact: Participants will have a better understanding of how to manage the condition or prevent it from affecting themselves or their family**.**

Metrics:

- # of participants
- Monitoring BMI at beginning and end or course and A1C levels where possible
- Pre/Post knowledge surveys

Committed Resources:

$15-20,000 corporate sponsorship annually
staff time planning and executing programs

Facility: Scott & White Memorial Hospital

Program Name: Community Events/Health Fairs

Program Description: BSWH staff donate time and materials to participate in local health fairs and community events to provide educational materials, answer questions, and advise on screening recommendations for various chronic diseases including chest pain, heart attack, hypertension, and heart failure.

Anticipated Impact: Successful ongoing maintenance of various chronic diseases

Metrics:

- # of staff hours at community events
- number of people reached at events

Committed Resources:

Staff time planning and participating in events such as the following:

- American Cancer Society Relay for Life
- Celebrate Killeen Healthcare Diversity Event
- It's a Guy Thing
- Georgetown Heart Failure Event
- Heart Failure Seminars
- Community Health Fair in Killeen
- For Women For Life

Facility: Scott & White Memorial Hospital

Program Name: Stroke Program

Program Description: The Certified Joint Commission Primary Stroke Center commits to participating in multiple community health education events each year as well as doing a hard push on stroke education inside the hospital during the month of May for patients, families and visitors.

Anticipated Impact: to enhance public knowledge of stroke signs/symptoms and risk factors

Metrics:
-# of people attending community events
-# of flyers/materials distributed
-# of ED patients that arrive within the time frame to receive medication (IV tPA) for acute ischemic strokes

Committed Resources:
2 FTEs in Stroke Program
52 hours/year at community events

Facility: Scott & White Clinic

Program Name: Patient Centered Medical Homes (PCMH)

Program Description: Every BSWH Primary Care Clinic in Central Texas has adopted the PCMH model of operation and has been recognized by the National Committee for Quality Assurance (NCQA) as a Patient-Centered Medical Home. This model changes how primary care is organized and delivered. It is one central place for a patient to get all their primary care as well as have specialty care coordinated. The goal is to have one team of medical professionals orchestrate all medical needs for an individual.
BSWH Primary Care Clinics are focusing heavily on impacting 3 adult chronic disease conditions (hypertension, diabetes, and depression).
The PCMH encompasses 6 main functions and attributes:

I. Patient-Centered Access- PCMH practices provide access to team-based care for both routine and urgent needs of patients and families. This includes same-day appointment availability, 24-hour access to clinical advice (both by telephone and secure electronic messaging), two-way communication between the care team and the patient, and online access to health information for patients (including the ability to request appointments, prescription refills, referrals, and test results).

II. Team-Based Care – PCMH practices focus on meeting the majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators.

III. Population Health Management- Each PCMH clinic site addresses the health of its population as a whole by reviewing clinical data about the panel it serves and sending reminders to patients about overdue preventive or chronic health services.

IV. Care Management and Support- PCMH providers recognize that patients and families are core members of the care team and work to incorporate their preferences when establishing goals and treatment plans. PCMH provides health

care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture, values, and preferences. The medical home practice actively supports patients in learning to manage and organize their own care at the level the patient chooses.

V. Care Coordination – PCMH practices serve as the hub of patient care needs by tracking and following up on tests, labs, and referrals. These practices also coordinate care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports.

VI. Quality and Safety – the PCMH demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, and measuring and responding to patient experiences and patient satisfaction surveys.

Anticipated Impact: improved quality of care, patient satisfaction, and better management of conditions due to continuity of care and establishment of trust with medical provider teams

Metrics:

Diabetes Management (D3 metrics)

- percentage of diabetic patients whose last A1c was less than 8
- percentage of diabetic patients whose last blood pressure reading was less than 140/90
- Percentage of diabetic patients who do not use tobacco

Healthy Planet Population Health Metrics

Adult Diabetes Registry Dashboard:

- Percentage diabetic patients who had a foot exam in the last 12 months
- Percentage of diabetic patients whose last A1c was less than 8
- Percentage of diabetic patients who had A1c testing done within the last 12 months
- Percentage of diabetic patients with last blood pressure less than 140/90
- Percentage of diabetic patients who had at least one lipid profile in the last 12 months
- Percentage of diabetic patients whose last LDL was in control (less than 100 mg/dl)
- Percentage of diabetic who received a urine protein screening or medical attention for nephropathy during at least one office visit within the last 12 months.

Adult Hypertension Registry Dashboard:

- Percentage of patients with hypertension whose last blood pressure was less than 140/90
- Percentage of patients with hypertension who have had a blood pressure measurement within the last 12 months
- Percentage of patients with hypertension who have received ambulatory medication therapy within the past 180 days for a select therapeutic agent (ACEI/ARB/Diuretics) and had a serum potassium and either a BUN or a serum creatinine lab done within the last 12 months

Adult Wellness Registry Dashboard:

- Percentage of patients who have received tobacco use screening and cessation intervention

Committed Resources:

- Time for primary care clinic nurses, providers, and administrative staff to complete 6-8 training modules for PCMH applications
- Time to complete training for clinic leadership, staff and physicians to prepare for maintenance of PCMH-recognized status

-208 hours/month for all clinic sites for preventive care and chronic condition care outreach with patients

Facility: Scott & White Clinic
Program Name: Better Breathers Club
Program Description: Better Breathers Club is a quarterly support group recognized through the American Lung Association that brings past and current patients with various lung disease together to listen to a speaker on certain topics and for fellowship. The topics range from information regarding specific pulmonary diseases or general diet and exercise. Three staff members in the Pulmonary Rehab department coordinate these sessions.
Anticipated Impact: Patients with COPD are able to better manage their condition
Metrics: # of class participants
Committed Resources: staff hours/month coordinating support group

Facility: Scott & White Clinic
Program Name: Respiratory Therapy Educator and Providers
Program Description: In FY2017 budget, the Division of Pulmonary plans to hire a Respiratory Therapist/educator (RT). This FTE would be dedicated to continuity of care for COPD patients. Responsibilities include: -Educate patients on medications and disease state -Ensure follow up with Pulmonary clinic and to obtain proper testing to follow progression of disease (Pulmonary Function Tests, CT (computed tomography), and chest X-rays) -Goal, when staffed appropriately, would be to have access for all patients that are hospitalized with COPD to automatically be seen in Pulmonary Clinic within 1-2 weeks. -Provide resources for COPD patients that have questions during transitions of care from hospital to clinic -Offer smoking cessation education -Provider Recruitment –Recruiting additional providers is needed to accomplish overall COPD strategies. Currently, we are understaffed as a Division and this initiative will require access into the clinic.
Anticipated Impact: Enhanced continuity of care for COPD patients
Metrics: time lapse from date of hospitalization due to COPD to scheduled appointment in Pulmonary Clinic.
Committed Resources: Salary of 1 FTE RT/educator

Facility: Scott & White Clinic
Program Name: Pneumonia Vaccinations
Program Description: This is a clinic initiative across all sites (Hemingway Pulmonary Clinic, Temple Sleep Clinic, Temple Pulmonary Clinic, and Hillcrest Pulmonary Clinic) to increase the number of community members that receive pneumonia vaccinations.
Anticipated Impact: Reduction in hospitalization rates due to pneumonia
Metrics: -# of vaccinations -Pneumonia vaccination rate
Committed Resources:

Cost of vaccines

Facility: Scott & White Clinic
Program Name: Chronic Kidney Disorder Education
Program Description: Educational classes provided to the community patients and a family member with chronic kidney disease aimed at slowing the progression to End Stage Renal Disease. This service was expanded from Temple to Killeen and Round Rock at the start of FY17. In addition, outreach clinics in Waco, Killeen, and Round Rock provide more access points to community members who might otherwise be forced to travel to Temple or elsewhere, or forego treatment altogether. Evaluate possibility of expansion to educating primary care providers to identify conditions before reaching a critical state as scheduling permits Plans for FY18 or FY19 to expand outreach efforts to include general community
Anticipated Impact: Reduction in admission rates due to poor management of chronic diseases
Metrics: -Number of participants that received education -Number of classes billed to Medicare - Patient knowledge and comprehension test administered post education
Committed Resources: 1 APP in Temple 1 APP in Killeen 1 APP in Round Rock

Facility: Scott & White Clinic
Program Name: Ostomy Support Group
Program Description: The Clinic intends to start a chapter of the Ostomy Support group to help community members who will be receiving or who have already had ostomy surgery. The program would be run by participants or families of participants who have ostomies. The Wound Ostomy Team will support them by being the "go to" expert in the field and the consultant.
Anticipated Impact: The program will help those who have recently undergone ostomy surgery learn how to troubleshoot some of the most common problems with ostomy pouching. This will likely will cut down on times they may require an appointment related to ostomy pouching.
Metrics: -# of clinic visits due to pouching issues - # of support group participants with pouching issues - # of pre-op educational sessions given - Patient satisfaction
Committed Resources: $30/ year membership to United Ostomy Association of America Staff time at support group

Facility: Scott & White Clinic
Program Name: In Kind Specialty Care at Local Free Clinics and Community Organizations
Program Description: BSWH physicians donate their time and talent to serve at local community free clinics serving the community members with little or no health insurance as well as providing physicals for high school athletes.
Anticipated Impact: Reduction in unnecessary Emergency Room visits
Metrics: - ED Visits - Patients treated at free clinics
Committed Resources: Cardiology – 20 hours/year Internal Medicine – 48 hours/month

Facility: Scott & White Clinic
Program Name: **Physician Speakers/Community Health Lectures and Education**
Program Description: Physicians provide expert content in the form of lectures, presentations, interviews, and written articles on various health topics year-round. Utilizing the Physician information, the Public Relations Team produces opportunities for free health and wellness education for all people – whether they are insured, uninsured or under insured patients – through well-developed relationships with news media outlets. The goal of the team's work is to educate the public about health issues. The team uses news media and social media efforts to equip the community with the latest health and wellness information as well as information on when and how to connect with health care professionals, hospitals, and other health care institutions. The scope of the efforts includes but is not limited to: • public health • disease-specific or injury-specific information • identifying community resources for meeting health needs • the development of tools and resources needed to get credible information to patients This is accomplished through: • publishing educational and diagnostic opportunities • providing timely, relevant health content on social media sites • hosting electronic education events • maintaining health education blogs • promoting the System health library • monitoring and engaging government agencies and industry associations relative to connecting providers and patients • promoting the tools and resources needed to improve the quality, cost-effectiveness, efficiency, patient-centeredness, safety and access to health care.
Anticipated Impact: By providing quality information and education to the community on popular health topics and current health concerns, residents will have increased knowledge and be better able to make decisions regarding improving their health.
Metrics: - # of physician hours - # of interviews -# of articles made publicly available -# of blog posts accessed

- # of speaking engagements/presentations
- # of attendees at community presentations

Committed Resources:
Physician prep time
Public Relations Staff time managing content = 12 hours/month

Facility: Baylor Scott & White Continuing Care Hospital

Program Name: Bringing Awareness to Chronic Illness

Program Description: a program that will include information that applies to chronic illness prevention and maintenance at the accessible communications board in the lobby of the hospital as well as at a Healthy Living display available to the community. The hospital will use ChooseMyPlate.gov teaching for the communication board and healthy living table. The focus on the communication board will be adult men and women and the board will be updated quarterly (Obesity 2 times and Chronic Disease 2 times). Also included will be information about portion distortion and dietary guidelines (Quarter 1); eating on a budget and recipes and menus (Quarter 3); Chronic Disease focus will be on diabetes and the 2 boards will be Living with Diabetes (Quarter 2) and Are you at Risk (Quarter 4).

- The Healthy Living table will be completed twice per year in the hospital lobby will include further information in regards to the quarterly communication board topics and will be manned by hospital providers or staff during normal business hours.

- Hospital staff will participate in at least one community health fair each year held at University of Mary Hardin-Baylor. The display will be focused on ChooseMyPlate.gov and Are You at Risk for Diabetes.

Anticipated Impact: Community members will be able to verbalize their understanding of chronic disease prevention and maintenance

Metrics:
-number of visitors to health fair booth
-attendance at Healthy Living Table

Committed Resources: 40 hours/year

MENTAL HEALTH RESOURCES

Facility: Scott & White Memorial Hospital

Program Name: Mental Health Support

Program Description: The Social Work part of CCM is very involved in mental health for patients who present to our hospital, ED, outpatient clinics, and post-acute areas like home care. Master's prepared social workers are the primary mental health providers of care nationally by a huge margin – actually more social workers doing mental health work than all other professions combined.
Emergency Department - In the ED, the social workers do the initial psychiatric consultation and assessment (determining DTS, DTO, and other psychiatric conditions) with psychiatric residents and attending's doing follow up as indicated.

Inpatient Support/Referrals- The acute care social workers on the floors are doing the bulk of the psychosocial assessments and interventions plus referrals to follow-up services after discharge. **Outpatient Support** - In the outpatient clinics, social workers see patients in medical clinics along with functioning as psychotherapists in the mental health clinic. There is a social work clinic set up to provide a variety of services including getting mental health patients their medications and helping determine which financial aid criteria they meet.
Anticipated Impact: patients are provided necessary medications and referrals to community resources to various community agencies – MRHR, ADVRC, Killeen and Temple Community Clinics, Pharmacy Company Assistance Programs (PAP), Body of Christ Clinic in Belton
Metrics: # of referrals to community resources
Committed Resources:16 FTE Social Workers

Facility: Scott & White Memorial Hospital
Program Name: Community Collaborations and Partnerships
Program Description: The Hospital collaborates with community agencies in a variety of settings including the court system. BSWH staff members serve as hospital representatives on various committees, task forces, and collaborative partnerships to help bring together available resources in the community. Bell County Mental Health Task Force, monthly meetings, and weekly phone calls with Bell County Attorney to fully support transitional care needs of Bell County Notice of Emergency Detention (NED) and Order of Protective Custody (OPC) patients, are an example of these. Home care social workers are often the only mental health professional who makes home visits, along with hospice social workers.
Anticipated Impact: A successful partnership between the hospital and local organizations to best serve the members of our community in need of mental health services.
Metrics: **-** # of home care visits/month -# of OPC and NED patients assisted/month - # of referrals to community resources
Committed Resources: Bell County Mental Health Task Force – monthly meeting – 2 hours Weekly phone calls with County – 3 hours Staff time making Home Care Visits as needed

Facility: Scott & White Memorial Hospital
Program Name: **Mental Health Task Force**
Program Description: Works to solve mental health deficits with community resources. Partnerships include: a. Cenikor Foundation which provides follow up care, HIV kits to opiate dependent child bearing-aged females as referred to the program b. Alcoholics Anonymous – provides services 2 times a week on inpatient unit c. Narcotics Anonymous – a support group that meets weekly for people dealing with overcoming substance abuse
Anticipated Impact: To foster regular communication between the hospital and community resources and provide immediate substance abuse treatment

Metrics: -# of people met that met with Alcoholics Anonymous or Narcotics Anonymous on in-patient unit
Committed Resources: Unit Director and social worker attendance at Task Force meetings (8 staff hours)

Facility: Scott & White Memorial Hospital
Program Name: Mental Health Awareness
Program Description: The Department of Psychiatry is planning free events to occur throughout the month of May for Mental Health Awareness. An open house is planned for mental health awareness month with the intent of stopping the stigma for patients. The department also participates in other community events as available.
Anticipated Impact: To reduce the stigma in the community for people who have a mental health condition in order decrease the effects of that stigma (examples are: people being reluctant to seek treatment, lack of understanding by family, friends, co-workers of someone who has a mental illness.)
Metrics: - # of participants - # of giveaways distributed at community events
Committed Resources: $5,000 annually

Facility: Scott & White Clinic
Program Name: Mental Health Services in Primary Care
Program Description: Nine Mental Health service providers have been embedded into 4 of the regional family medicine clinics. There are 5 in the Waco clinic, 1 at in Temple, 2 in Killeen clinics, 1 in South Belton and plans for a 2nd provider coming to Santa Fe clinic soon. It is our intent and goal to eventually add mental health providers into all family medicine clinic locations. The clinics that have embedded mental health have built a valuable working relationship between the primary care providers and mental health providers that enhances the overall patient care model. This is difficult to quantify through metrics (other than RVU's/visits), but the value comes from better provider relationships and stronger coordination of care for the patient. These visits are mostly done on a one on one basis for privacy.
Anticipated Impact: The goal is to provide better access and care for the community through population health, expanding into the community for easier and more convenient access.
Metrics: - RVUs - # of Patient Visits
Committed Resources: Salaries for 9 FTEs

OBESITY & POOR PHYSICAL HEALTH

Facility: Baylor Scott & White Continuing Care Hospital
Program Name: Healthy Living for Life

Program Description: A program that will provide general information on ways to live healthy for life that applies to all ages and incomes. Information will be available at the accessible communications board in the lobby of the hospital as well as at a Healthy Living display. The hospital will use ChooseMyPlate.gov teaching for the communication board and healthy living table. The focus on the communication board will be adult men and women and the board will be updated quarterly (Obesity 2 times and Chronic Disease 2 times). Also included will be information about portion distortion and dietary guidelines (Quarter 1); eating on a budget and recipes and menus (Quarter 3); Chronic Disease focus will be on diabetes and the 2 boards will be Living with Diabetes (Quarter 2) and Are you at Risk (Quarter 4).

- The Healthy Living table will be completed twice per year in the hospital lobby will include further information in regards to the quarterly communication board topics and will be manned by hospital providers or staff during normal business hours.

- Hospital staff will participate in at least one community health fair each year held at University of Mary Hardin-Baylor. The display will be focused on ChooseMyPlate.gov and Are You at Risk for Diabetes.

Anticipated Impact: Community members will be able to verbalize their understanding of chronic illness prevention and maintenance

Metrics:
-Number of visitors to health fair booth
-Attendance at Healthy Living Table

Committed Resources: 40 hours/year

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

Program Name: Farmers Market (at Memorial and McLane Children's Hospitals)

Program Description: providing easy access on site to fresh local fruits and vegetables to patients, their families, staff, and the entire community. In addition to food vendors, a bouncy house is managed by volunteers to add extra elements of fun and exercise for kids.

Anticipated Impact: Morale of visitors will be boosted because of access to healthy foods produced by local farmers and community will acknowledge benefits of having access to these options

Metrics:
- Number of vendors that participate
- Number of visitors to the market each week

Committed Resources:
- 16 hours/month during market (McLane)
- 44 hours/month (Memorial)
- 20 staff hours planning program
- Promotional signs and advertising

Facility: Baylor Scott & White McLane Children's Clinic (part of Scott & White Clinic)

Program Name: Family, Food, Fun

Program Description: Community based wellness program, provided Free to the public, for children 9-15 years old which incorporates the entire family. This partnership with the City of Killeen, program provides nutritional and physical fitness education as well as culinary instruction. The goal is promote

physical activity and healthy nutrition within a family unit, to provide sustainable health improvements. The program meets once weekly for 5 weeks and is offered repeatedly throughout the year. The program includes: hands on cooking demonstrations, budget friendly recipes, cooking competitions, fitness demonstrations for home, park and gym, and interactive technology that encourages family meal time and physical activity.
Anticipated Impact: Through community collaboration, bring awareness to fun, healthy activities that can be shared by the whole family Objectives of the wellness program include: - OBJ1: Increase number of family dinners to 5 - 7 days of the week. - OBJ2: Increase selection of healthier items (low sugar, low salt, review nutrition label for nutrition facts and portions, more fruit and vegetable options at home, meals prepared at home.) - OBJ3: Increase physical activity to meet or exceed national guidelines (adults 30-60 minutes most days of the week, children 60 minutes most days of the week). - OBJ4: Observe FFF participants on weekly basis to measure attendance and level of participation. - OBJ5: Measure and analyze physical activity in FFF child participants and control group child participants.
Metrics: - Number of program participants - Increased activity levels of kids measured in pre and post assessments. - Demographics: Parent and child names, child date of birth, and zip code - Fitness Assessments: Family, Food, & Fun! Participants will be asked to complete a physical assessment to demonstrate progress over the 4 week program. This assessment will be completed on Week 1 and Week 4 of the four week program. 1) Walk .52 mile. Timed. 2) Jumping jacks. Quantity in 1 minute. 3) Sit ups. Quantity in 30 seconds. - Biometrics: Family, Food, & Fun! Participants will have their height, weight, and waist circumference measured at the beginning of the 4-week course (pre), the end of the 4-week course (post), and 3, 6, 9, 12-month post.
Committed Resources: - $63,000 annual program budget - 30 staff hrs/week

Facility: Scott & White Memorial Hospital (including Baylor Scott & White McLane Children's Medical Center
Program Name: Community Health Financial and In – Kind Contributions
Program Description: the hospitals will collaborate with local, statewide, and national organizations whose work aligns with BSWH goals to impact health concerns. The hospitals will provide financial assistance to these organizations and in return, health services and or programs to encourage healthy living are made available to the community.
Anticipated Impact: Increased opportunities in the community that promote healthy living
Metrics: - Number of program participants - Total value of contributions
Committed Resources: - Scott & White Memorial Hospital – $290,000 annually - Baylor Scott & White McLane Children's Medical Center- $35,000 annually

Facility: Scott & White Memorial Hospital (including Baylor Scott & White McLane Children's Medical Center
Program Name: Community Health Education and Outreach
Program Description: The hospital hosts or sponsors a variety of community activities that promote healthy living/lifestyle including community events, health fairs, and health lectures. Several ongoing programs are listed below • It's a Guy Thing- annual men's health event featuring educational presentations, screenings and demonstrations • For Women For Life –annual women's health event featuring educational presentations, screenings and demonstrations • Health & Wellness Expos – provides blood pressure, BMI, grip strength, posture, vision, waist circumference and auricular therapy screenings • Educational Panels – BSWH staff speak as part of educational panels at institutions of higher learning • Website Education –information easily accessible to the public about how to make changes to live a healthy lifestyle is available at **http://wellness.sw.org**, topical information on certain diseases and health conditions affecting the community that is hosted on our blogsite **http://scrubbing.in** • Walk With a Doc - a free year-round monthly walking program. Each program starts with a volunteer doctor hosting a short discussion on a popular health topic like heart health, women's health, screening tips, etc. Then the conversation migrates into the walk, all the way back to the meeting point, where walkers can get water and a light healthy snack.
Anticipated Impact: to encourage healthy physical activity in people of all ages, and reverse the consequences of a sedentary lifestyle, which will improve the health and well-being of the community.
Metrics: -# of people attending events - # staff hours planning event
Committed Resources: Staff hours planning event Staff and volunteer hours in execution of events

ACCESS TO AFFORDABLE PRIMARY CARE

Facility: Baylor Scott & White McLane Children's Clinic (part of Scott & White Clinic)
Program Name: Drive-Thru Flu Clinics
Program Description: Regional events held in Temple, Killeen, and Waco, feature a convenient care delivery model for vaccinating families against the common flu virus. Patients are able to remain in their vehicles, with the clinic flow moving from station to station (to include registration, payment if needed, form review, vaccination, safety wait and release). Partnering with colleagues in Family and Internal Medicine, an entire family may be vaccinated in a matter of minutes without leaving their vehicle.
Anticipated Impact: To improve flu vaccination rates
Metrics: - Number of program participants - Better vaccination rates
Committed Resources: - Cost of vaccines - Staffing for flu clinic days

Facility: Baylor Scott & White McLane Children's Medical Center (part of Scott & White Memorial Hospital)
Program Name: Community Health Worker (PILOT)
Program Description: The position will serve as a patient navigator within the Children's ED. The position's primary focus will be to identify high utilizer patients (defined as more than 2 visits to the emergency department within 12 months) of ED services and link them with a Primary Care Physician for preventive services.
Anticipated Impact: Decrease the number of high utilizers in emergency department for non-emergent conditions.
Metrics: - Number of interventions - Successful linkage with PCP, post intervention -reduction of high utilizer ED visits -risk avoidance achieved through all of the above
Committed Resources: CHW salary, approximately $65,000 annual

Facility: Scott & White Memorial Hospital and Scott & White Clinic
Program Name: Enhancing Access through Scheduling and Availability
Program Description: The hospitals consistently look for opportunities to provide better access to care for the community in the form of locations, ease of scheduling, and number of providers available. Below is a list of some ongoing efforts to tackle the issue of access to primary care providers: • Same Day Access- Community members requesting an appointment to be seen that day will be provided an appointment. • Online Scheduling- Community members may schedule an appointment on-line to establish care, for follow-up and for acute visits.

- My Chart Scheduling – Via the patient portal within MyChart, patients may schedule appointments with providers with whom they have established care.
- E Visits – BSWH employees with BSWH Health Plan may schedule an E Visit with a nurse practitioner or physician assistant is being piloted within the region.
- Evaluate the possibility of expanding night and weekend availability

Anticipated Impact: Patients will be able to be seen sooner and scheduling will be easier.

Metrics:
- Number of new patients
- Number of participants
- 3rd available appointment report to show average length of time in days after appointment request
- Same Day Access Report

Committed Resources:
Memorial- IT staff for the development and enhancement of online scheduling
Memorial- software upgrades as needed
Clinic-The hiring of additional MD, NP and PA staff for manning the clinics

PEDIATRIC ASTHMA

Facility: Baylor Scott & White McLane Children's Medical Center (part of Scott & White Memorial Hospital)

Program Name: Pediatric Asthma Outreach

Program Description: Baylor Scott & White McLane Children's Medical Center in Temple uses a full-time asthma educator to coordinate outreach and education for asthma within the system and in the community. The educator identifies patients at risk for uncontrolled asthma and seeks to avoid recurrent emergency department visits and hospitalizations.

Action steps

a. Bimonthly life-threatening community asthma clinic: A pulmonologist and allergist jointly test for allergies and lung function, and educate attendees on how to manage severe asthma.

b. Quarterly community asthma class: Lunch is provided and the certified asthma educator instructs on how to properly use inhalers. A spacer and mask (if needed) is provided to every family for their asthmatic child, and the family is also taught how to use the spacer properly.

c. Camp Wheeze Away: The annual five-day overnight camp for patients referred by the pulmonologist or asthma educator. Camp includes a daily one-hour asthma education class.

d. Partnership with local school districts: Extend asthma education into the schools and provide school nurses and teachers with CEU's on asthma. Providing asthma education to families of asthmatics in the school district. Intervention starts with the school nurse assessing and finding the patient's in need of asthma education

e. Asthma Education in the Hospital: Asthma education is provided to every patient admitted to the hospital with a primary diagnosis of Asthma.

f. Asthma pathway: Developed for the in-patient asthmatics, it is a pathway developed by physicians, nurses, respiratory therapist to give direction of how we treat patients from the Emergency department all the way through the discharge process, so that all asthma patients are treated with the latest evidence based practice and collaboration of best care during the patient's hospital stay.

g. Asthma Action Plan: An Asthma Action Plan is given to an asthmatic patient at every out-patient and in-patient clinic, so that asthma symptoms are decreased. It also prevents fatality rates due to asthma by 70 %. The asthma action plan is being built in epic, so that it is easy to access in one area for the physician to make implementations to the plan and the patient is able to access on my chart from home.

Anticipated Impact: A decline in the use of the emergency department and admission to the hospital for pediatric asthma

Metrics:
-Admission rates due to asthma
-Reduction in fatality rates due to asthma
-ED rates for asthma
-Monitoring how many participants attend asthma education classes.
-Monitor how many community members are reached by asthma outreach.

Committed Resources: $100,000 annually

Facility: Baylor Scott & White McLane Children's Clinic (Part of Scott & White Clinic)

Program Name: Primary Care Medical Home (PCMH)

Program Description: Every BSWH Pediatric Primary Care Clinic in Central Texas has adopted the Patient Centered Medical Home (PCMH) model of operation and has been recognized by the National Committee for Quality Assurance (NCQA) as a Patient-Centered Medical Home. This model changes how primary care is organized and delivered. It is one central place for a patient to get all their primary care as well as have specialty care coordinated. The goal is to have one team of medical professionals orchestrate all medical needs for an individual.
BSWH Primary Care Clinics are focusing heavily on impacting 3 pediatric disease conditions (asthma, ADHD, and obesity).

Anticipated Impact: improved quality of care, patient satisfaction, and better management of conditions due to continuity of care and establishment of trust with medical provider teams

Metrics:
Asthma Registry Dashboard:

- Percentage of patients with mild persistent, moderate or severe asthma who are on inhaled corticosteroid therapy.
- Percentage of asthma patients who have received an influenza vaccine in the past 12 months
- Percentage of asthma patients 13 years and older who have received tobacco cessation counseling in the last 12 months if identified as tobacco users.

Pediatric Wellness Registry Dashboard:

- Percentage of patients who have had a wellness visit in the last 13 months

Committed Resources:
- Time for primary care clinic nurses, providers, and administrative staff to complete 6-8 training modules for PCMH applications
- Time to complete training for clinic leadership, staff and physicians to prepare for maintenance of PCMH-recognized status
-208 hours/month for all clinic sites for preventive care and chronic condition care outreach with patients

Additional Metrics:

The hospital will monitor annual performance around actions taken, the number of people reached, and program outcome data when available as well internal system quality measures and indicator data assessed in the CHNA at the community level including:

- The % of the Medicare population diagnosed with depression through CMS
- The % of the Medicare population diagnosed with schizophrenia and other psychotic disorders through CMS
- The % of the Medicare population diagnosed with Alzheimer's Disease/Dementia through CMS
- Ratio of population to one mental health provider through County Health Rankings
- Average number of reported poor mental health days through County Health Rankings
- % of patients age 18 and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.
- # of patients age 18 and older with diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during a 4 month period in which there was a qualifying visit
- # of diabetic patients seen by a specialist in the last 12 months (pediatrics included)
- Improvement of Hgba1c in Diabetics seen in last 12 months
- # of patients with completed lipid panel for BMI>95%
- Obesity counseling in children
- Obesity screening/counseling for GYN and initial OB visits
- Tobacco cessation compliance
- % of adults aged 20 and above diagnosed with diabetes reported via BRFSS
- % of Medicare population according to CMS with the following conditions: hypertension, heart failure, hyperlipidemia, ischemic heart disease, atrial fibrillation, COPD, and stroke
- # of heart disease, stroke and CLRD deaths per 100,000 according to the National Vital Statistics System
- Total # of cancer deaths per 100,000 according to the National Vital Statistics System
- Incidences of all cancers, breast cancer, colon cancer, lung cancer, and prostate cancer according to the National Cancer Institute
- Adult Obesity Percent and Physical Inactivity Percent according to the CDC's County Health Rankings
- The ratio of the total population to one primary care physician according to the County Health Rankings
- The ratio of the total population to one non-physician primary care provider according to CMS

Planned Collaboration:

In addressing community needs, the Hospitals and Clinic plan to collaborate with:

- Temple Community Clinic
- Greater Killeen Free Clinic
- Bell County Indigent Health Care
- Bell County Navigator Program

- 30+ Farmers Market vendors
- City of Killeen
- City of Temple
- Boys & Girls Club of Killeen
- American Diabetes Association
- American Cancer Society
- American Heart Association
- United Way of Central Texas
- Local Independent School Districts

Community needs not being addressed and reasons why

Identified Needs Beyond the Hospitals Mission or Service Programs

BSWH is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization so that it can continue to provide a wide range of important health care services and community benefits.

The prioritization of needs was based on the weight of quantitative and qualitative data obtained when assessing the community. The prioritized needs were reviewed and/or approved by senior management, hospital advisory board members and the System's governing board.

The Hospitals will address significant community health needs based on their intersection with our mission and key clinical strengths. The following identified needs have not been addressed in the community benefit implementation plan because there are multiple other community and state agencies whose expertise and infrastructure are better suited for addressing:

- Tobacco Use

BSWH recognizes the importance of all needs identified by the community, but are unable to directly address the above need identified in the CHNA at this time.

Throughout the coming years, BSWH will regularly assess, evaluate, and report on the programs that have been put in place to address the significant needs in our community. It is our hope that through regular conversations with community members, feedback on this plan, and modification of programs and services, we will enhance the opportunities for patients to connect to community resources in ways that will improve community health, reduce unnecessary healthcare costs and improve the overall quality of care we deliver.

Please direct any feedback on the assessment or implementation plan to TaraStafford@BSWHealth.org

This document may be accessed at http://baylorscottandwhite.com/communityneeds

Appendix A: Facility Summary

This joint implementation strategy is intended to meet the requirements for community benefit planning and reporting as set forth in state and federal laws. This table is provided to help the reader easily identify which portions of the implementation strategy relate to each facility.

Facility	Chronic Disease	Mental Health	Obesity	Access to Primary Care	Pediatric Asthma
BS&W Continuing Care Hospital	✔		✔		
Scott & White Clinic including **Baylor Scott & White McLane Children's Clinic**	✔	✔	✔	✔	✔
Scott & White Memorial Hospital including **Baylor Scott & White McLane Children's Medical Center**	✔	✔	✔	✔	✔