Baylor Scott & White HEALTH

Community Health Needs Assessment 2016

Baylor Scott & White Medical Center – Hillcrest

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 Medical Center – Hillcrest Board of Directors on May 6, 2016
Posted to BaylorScottandWhite.com/CommunityNeeds on June 30, 2016

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Baylor Scott & White Health Mission Statement

OUR MISSION

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

"Personalized health" refers to our commitment to develop innovative therapies and procedures focusing on predictive, preventive and personalized care. For example, we'll use data from our electronic health record to help us predict the possibility of disease in a person or a population. And with that knowledge, we can put measures in place to either prevent the disease altogether or significantly decrease its impact on the patient or the population. We'll tailor our care to meet the individual medical, spiritual and emotional needs of our patients.

"Wellness" refers to our ongoing effort to educate the people we serve, helping them get healthy and stay healthy.

"Christian ministry" reflects the heritage of Baylor Health Care's founders and Drs. Scott and White, who showed their dedication to the spirit of servanthood — to equally serve people of all faiths and those of none.

WHO WE ARE

In 2013, Baylor Health Care System and Scott & White Healthcare became one.

The largest not-for-profit health care system in Texas, and one of the largest in the United States, Baylor Scott & White Health (BSWH) was born from the 2013 combination of Baylor Health Care System and Scott & White Healthcare.

Known for exceptional patient care for more than a century, the two organizations serve adjacent regions of Texas and operate on a foundation of complementary values and similar missions. Baylor Scott & White Health includes 41 licensed hospitals, more than 900 patient care sites, more than 6,600 active physicians, 43,750+ employees and the Scott & White Health Plan.

Over the years, Baylor and Scott & White have worked together as members of the High Value Healthcare Collaborative, the Texas Care Alliance and Healthcare Coalition of Texas and are two of the best known, top-quality health care systems in the country, not to mention in Texas.

After years of thoughtful deliberation, the leaders of Baylor Health Care System and Scott & White Healthcare decided to combine the strengths of the two health systems and create a new model system able to meet the demands of health care reform, the changing needs of patients and extraordinary recent advances in clinical care.

With a commitment to and a track record of innovation, collaboration, integrity and compassion for the patient, Baylor Scott & White Health stands to be one of the nation's exemplary health care organizations.

OUR CORE VALUES & QUALITY PRINCIPLES

Our values define our culture and should guide every conversation, decision and interaction we have with each other and with our patients and their loved ones:

- *Integrity*: Living up to high ethical standards and showing respect for others
- *Servanthood*: Serving with an attitude of unselfish concern
- *Teamwork:* Valuing each other while encouraging individual contribution and accountability
- *Excellence*: Delivering high quality while striving for continuous improvement
- *Innovation*: Discovering new concepts and opportunities to advance our mission
- *Stewardship*: Managing resources entrusted to us in a responsible manner

Executive Summary

As the largest not-for-profit health care system in Texas BSWH understands the importance of serving the health needs of its communities. And in order to do that successfully, we must first take a comprehensive look at the issues our patients, their families, and neighbors face when it comes to making healthy life choices and health care decisions.

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

For the 2016 assessment, Baylor Scott & White Medical Center – Hillcrest has defined its community to be the geographical area of McLennan County. The community served was determined based on the county that makes up at least 75 percent of the hospital facility's 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, we conducted focus groups that included representation of minority, underserved, and indigent populations' needs and interviewed several key informants in the community that were community leaders and public health experts.

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

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

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

A dotmocracy[1] voting method was employed to identify the significant needs, and then to prioritize those needs. Each participant voted for only 5 of the health needs identified in

[1] "Dotmocracy" is an established facilitation method used to describe voting with dot stickers, also known as "multi-voting". In Dotmocracy participants vote on their favorite options using a limited number of

the matrix. The votes were tallied and priority needs were established by the highest number of votes and are displayed in order of number of votes received.

1. Mental health services
2. Chronic illness
3. Obesity
4. Access to care
5. Prenatal care
6. Tobacco use

Due to unplanned timing discrepancies, results from a telephone survey conducted by the Baylor Center for Community Research and Development were not available until after this report was nearly completed. The survey was commissioned by a task force made up of representatives from the Waco-McLennan County Public Health District, Providence Health Network, and Baylor Scott & White Medical Center-Hillcrest. The results of the telephone survey fully support the significant needs that have been identified in the community. A summary of the key findings is included in ***Appendix E*** of this document and the full supplemental report can be accessed at BaylorScottandWhite.com/CommunityNeeds

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).

stickers or marks with pens — dot stickers being the most common. This sticker voting approach is a form of cumulative voting.

Community Health Needs Assessment Requirement

As a result of the Patient Protection and Affordable Care Act (PPACA), all tax-exempt organizations operating hospital facilities are required to assess the health needs of their community through a Community Health Needs Assessment (CHNA) once every three years. A CHNA is a written document developed for a hospital facility that defines the community served by the hospital facility; the process used to conduct the assessment including how the hospital took into account input from community members including those from public health department(s) and members or representatives of medically underserved, low-income, and minority populations; identification of any organizations with whom the hospital has worked on the assessment; and the significant health needs identified through the assessment process.

The written CHNA Report must include descriptions of the following:

- The community served and how the community was determined
- The process and methods used to conduct the assessment including sources and dates of the data and other information as well as the analytical methods applied to identify significant community health needs
- How the organization took into account input from persons representing the broad interests of the community served by the hospital, including a description of when and how the hospital consulted with these persons or the organizations they represent
- The prioritized community health needs identified through the CHNA as well as a description of the process and criteria used in prioritizing the identified significant needs
- The existing health care facilities and other resources within the community available to meet the significant community health needs
- An evaluation of the impact of any actions that were taken, since the hospital facility(s) most recent CHNA, to address the significant health needs identified in that last CHNA

PPACA also requires hospitals to adopt an Implementation Strategy to address prioritized community health needs identified through the assessment. An Implementation Strategy is a written plan that addresses each of the significant community health needs identified through the CHNA and is a separate but related document to the CHNA report.

The written Implementation Strategy must include the following:

- List of the prioritized needs the hospital plans to address and the rationale for not addressing other significant health needs identified
- Actions the hospital intends to take to address the chosen health needs
- The anticipated impact of these actions and the plan to evaluate such impact (e.g. identify data sources that will be used to track the plan's impact)
- Identify programs and resources the hospital plans to commit to address the health needs

- Describe any planned collaboration between the hospital and other facilities or organizations in addressing the health needs

A CHNA is considered conducted in the taxable year that the written report of its findings, as described above, is approved by the hospital's governing body and made widely available to the public. The Implementation Strategy is considered adopted on the date it is approved by the governing body. Organizations must approve and make public their Implementation Strategy by the 15th day of the 5th month following the end of the tax year CHNA compliance is reported on IRS Form 990, Schedule H.

This assessment is also intended to meet the requirements for community benefit planning and reporting as set forth in the Texas Health and Safety Code Chapter 311 applicable to Texas nonprofit hospitals.

Baylor Scott & White Health: Community Health Needs Assessment Overview, Methodology and Approach

BSWH partnered with Truven Health Analytics (Truven Health) to complete a CHNA for Baylor Scott & White Medical Center - Hillcrest.

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

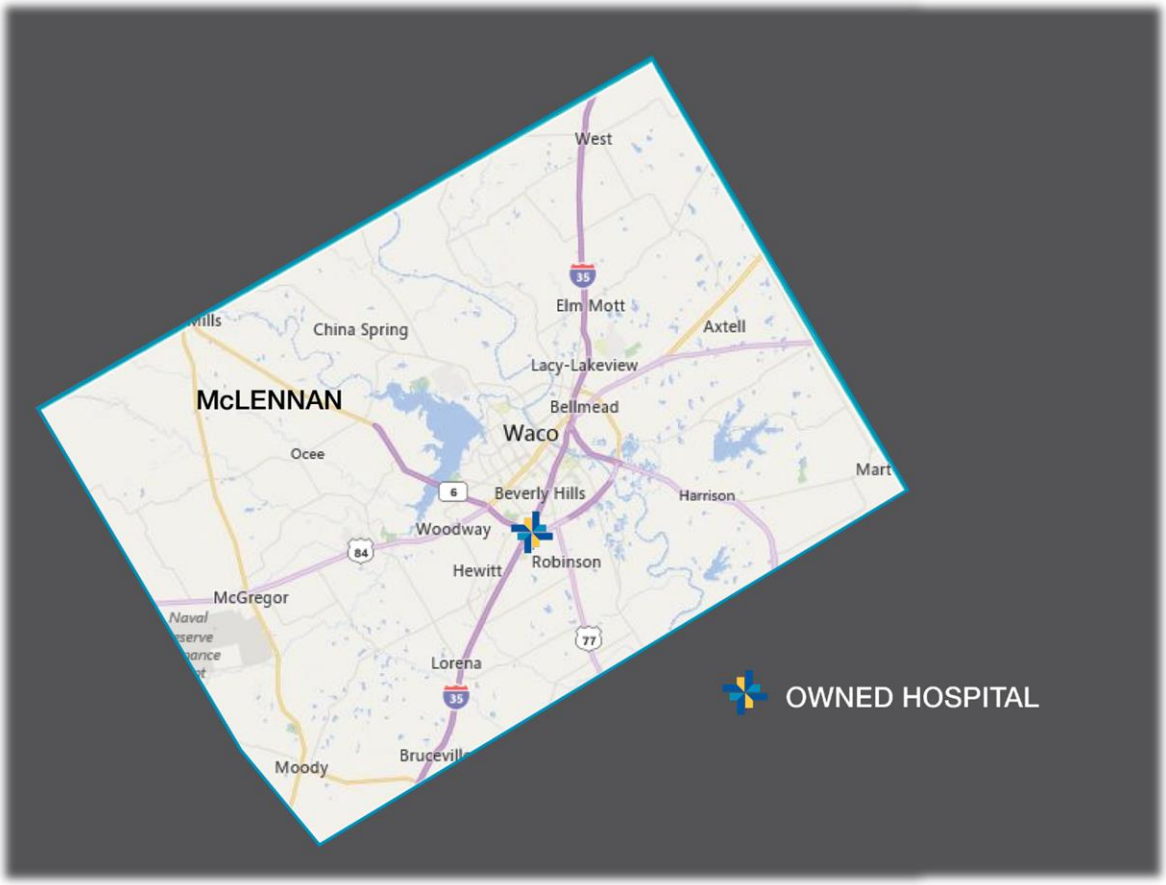
The community served definitions used in this current assessment differ from those used by the legacy Baylor Health Care System and the legacy Scott & White Healthcare in their 2013 CHNAs.

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).

BSWH Community Health Needs Assessment Community Served Definition

For the 2016 assessment, Baylor Scott & White Medical Center - Hillcrest has defined its community to be the geographical area of McLennan County. The community served was determined based on the county that makes up at least 75 percent of the hospital's inpatient and outpatient admissions.

BSWH Community Health Needs Assessment
Map of Community Served



Assessment of Health Needs – Methodology and Data Sources

To assess the health needs of the community served, a quantitative and qualitative approach was taken. In addition to collecting data from a number of public and Truven Health proprietary sources, interviews and focus groups were conducted with individuals representing public health, community leaders/groups, public organizations, and other providers.

Quantitative Assessment of Health Needs

Quantitative data in the form of public health indicators were collected and analyzed to assess community health needs. Eight categories of seventy-nine indicators were collected and evaluated for the counties where data was available. The categories and indicators are included in the table below and the sources of these indicators can be found in ***Appendix A***.

Population
- High School Graduation Rate
- High School Drop Outs
- Some College
- Births to Unmarried Women
- Children in Poverty
- Children in Single-Parent Households
- Income Inequality
- Poverty
- Disability
- Social Associations
- Children Eligible for Free Lunch
- Homicides
- Violent Crime

Injury & Death
- Heart Disease Death Rate
- Overall Cancer Death Rate
- Chronic Lower Respiratory Disease (CLRD) Death Rate
- Stroke Death Rate
- Infant Mortality
- Child Mortality
- Premature Death
- Motor Vehicle Crash Mortality Rate

Mental Health
- Mental Health Providers
- Poor Mental Health Days

Prevention
- Diabetic Screening
- Mammography Screening
- Flu Vaccine 65+

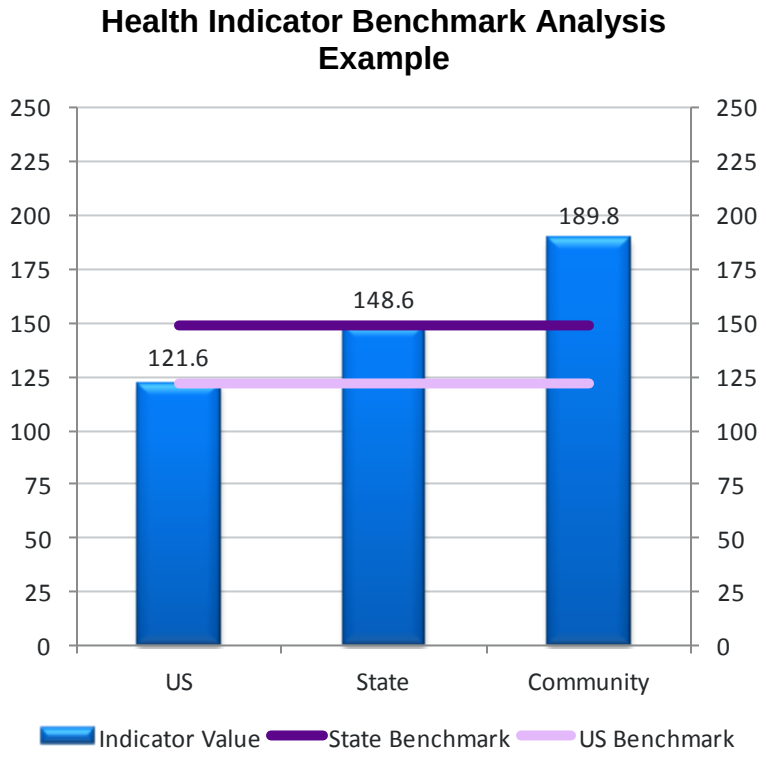
Health Outcomes
- Poor or Fair Health
- Average Number of Poor Physical Unhealthy Days in Past Month
- Cancer (all causes) Incidence
- Breast Cancer
- Colon Cancer
- Lung Cancer
- Prostate Cancer
- Diabetes
- Stroke
- Arthritis
- Alzheimer's/ Dementia
- Atrial Fibrillation
- COPD
- Kidney Disease
- Depression
- Heart Failure
- Hyperlipidemia
- Heart Disease
- Schizophrenia
- Osteoporosis
- HIV Prevalence
- Prenatal Care
- Smoking During Pregnancy
- Low Birth Rate
- Very Low Birth Rate
- Preterm Births

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

Access to Care
- Uninsured
- Uninsured Children (<17)
- Could Not See a Doctor Due to Cost
- Other Primary Care Providers
- Dentists
- Preventable Hospital Stays
- Affordability of Healthcare
- Healthcare Costs

Environment
- Limited Access to Healthy Foods
- Food Insecurity
- Food Environment Index
- Access to Exercise Opportunities
- Air Quality/ Pollution
- Drinking Water
- Housing
- Commute/ Long
- Commute/ Alone

In order to determine which public health indicators demonstrate a community health need, a benchmark analysis was conducted for each indicator collected for the community served. Benchmark health indicators collected included (when available); overall US values, state of Texas values, and goal setting benchmarks such as Healthy People 2020 and/or County Health Rankings Best Performer values.



According the America's Health Rankings, Texas ranks 34th out of the 50 states. The health status of Texas compared to other states in the nation identifies many opportunities to impact health within local communities even for those communities that rank highly within the state. Therefore, the benchmark for the community served was set to the state value. Needs are identified when one or more of the indicators for the community served do not meet state benchmarks. An index of magnitude analysis was then conducted on those indicators that did not meet state benchmarks in order to understand to what degree they differ from benchmark in order to understand their relative severity of need.

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

Qualitative Assessment of Health Needs (Community Input)

In addition to analyzing quantitative data, a focus group with eighteen (18) participants, as well as four (4) 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 hospital has 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.

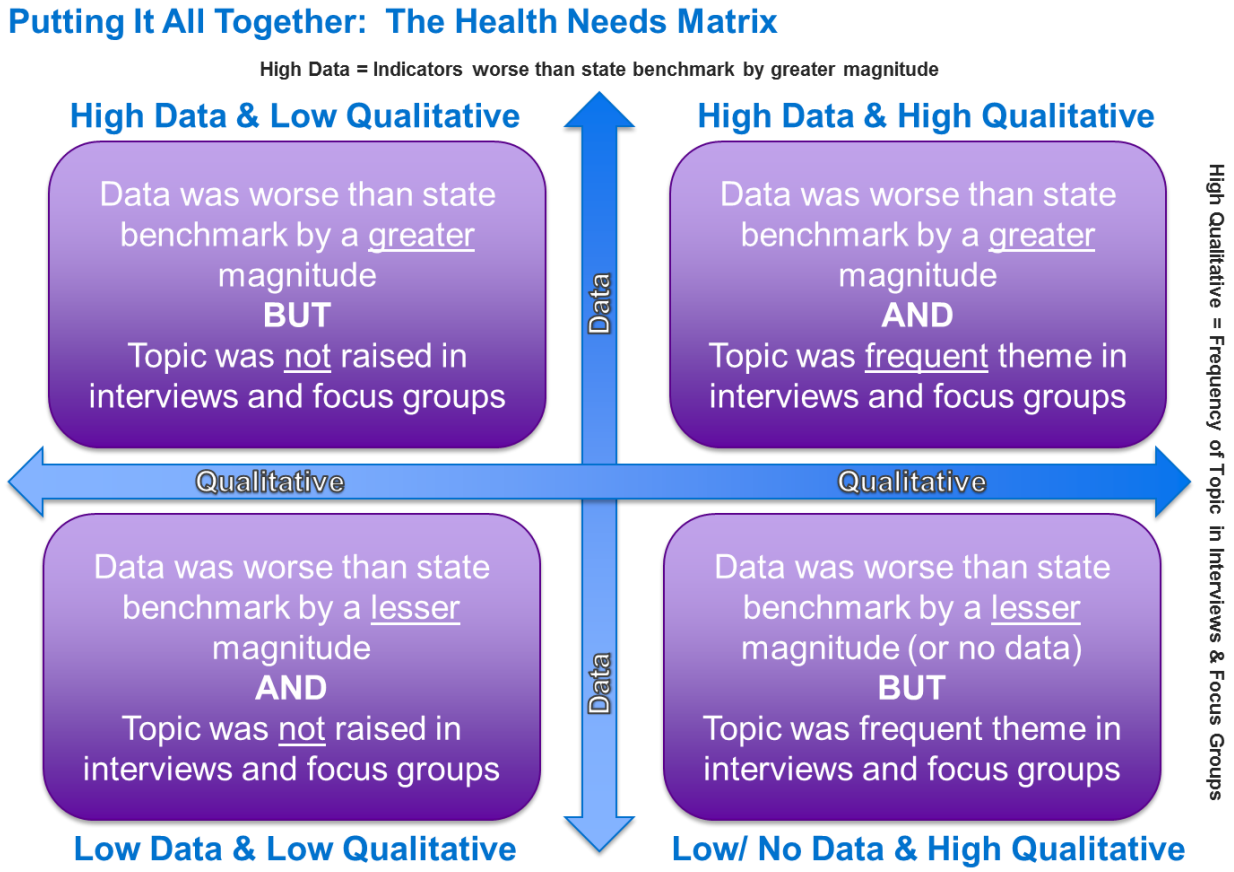
Input collected from the participants during the interviews and focus groups were organized into themes around community needs and compared to the quantitative data findings.

Additional findings from a separate community survey conducted by the Baylor Center for Community Research and Development are included in ***Appendix E*** and provide further validation of the health needs identified.

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

Existing Resources to Address Health Needs

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

Prioritizing Community Health Needs

The prioritization of community health needs identified through the assessment was based on the weight of quantitative and qualitative data obtained when assessing the community and included an evaluation of the severity of each need as it pertains to the state benchmark, value the community places on the need, and prevalence of the needs within the community. A thorough description of the process can be found in the "Prioritizing Community Health Needs" section of the assessment.

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

Evaluation of Implementation Strategy Impact

As part of the current assessment, BSWH conducted an evaluation of the implementation strategies adopted as part of the 2013 CHNAs. In 2013, Baylor Scott and White Medical Center – Hillcrest (fka Hillcrest Baptist Medical Center) chose to address the following identified needs:

1. Obesity
2. Diabetes
3. Breast cancer death rate
4. Colorectal cancer incidence
5. Hospitalization due to pediatric asthma
6. Children with health insurance

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

Demographic and Socioeconomic Summary

According to population statistics, the community served was fairly representative of Texas overall; having a slightly slower projected population growth rate over the next 5 years as well as a lower median income. The community served was also similar to the overall state as it relates to socioeconomic barriers, with the exception of having a lower proportion of the population facing language barriers and a lower median income.

Demographic and Socioeconomic Comparison: Community Served and State/US

Demographic / Socioeconomic Variable	Benchmarks		Community Served
	United States	Texas	
Total Current Population	319,459,991	27,037,393	248,903
5 Yr Proj Pop Chg	4%	7%	5%
Population 0-17	23%	26%	25%
Population 65+	15%	12%	14%
Women Age 15-44	20%	21%	21%
Non-White Population	29%	31%	31%
Insurance Coverage: Medicaid	19%	14%	12%
Insurance Coverage: Uninsured	10%	20%	19%
Median Household Income	$56,682	$56,653	$42,817
Limited English	5%	8%	4%
No High School Diploma	14%	19%	18%
Unemployed	10%	8%	8%
Poverty	16%	18%	22%

Source: Truven Health Analytics / The Nielsen Company, 2015

Benchmarks

The population of the community served is expected to grow 5% (12,500 people) by 2020. The 5% population growth is lower compared to the state growth rate (6.7%) and higher compared to the national growth rate (4%). The ZIP Codes expected to experience the most growth in five years:

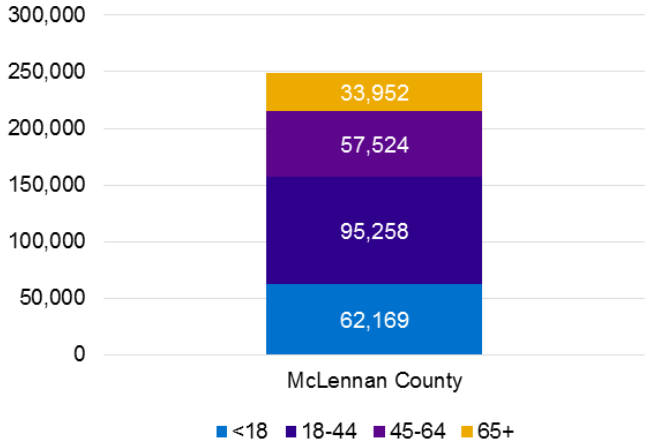
- 76706 Waco – 2,293 people (6%)
- 76709 Waco – 1,535 people (6%)
- 76705 Waco – 1,205 people (4%)
- 76643 Hewitt – 1,167 people (8%)

Overall, the city of Waco is projected to experience 4% population growth of 6,800 people in the next five years.

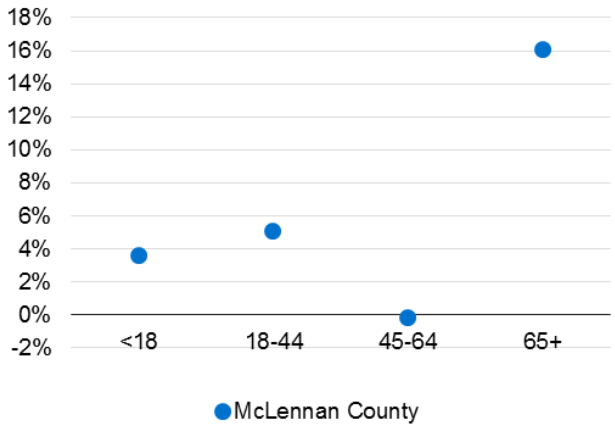
The sixty-five plus cohort was the smallest but is expected to experience the most growth over the next five years. Growth in this population will likely contribute to increased utilization of services as the population continues to age.

Population by Age Cohort

2015 Total Population



5 Year Projected Population Growth Rate

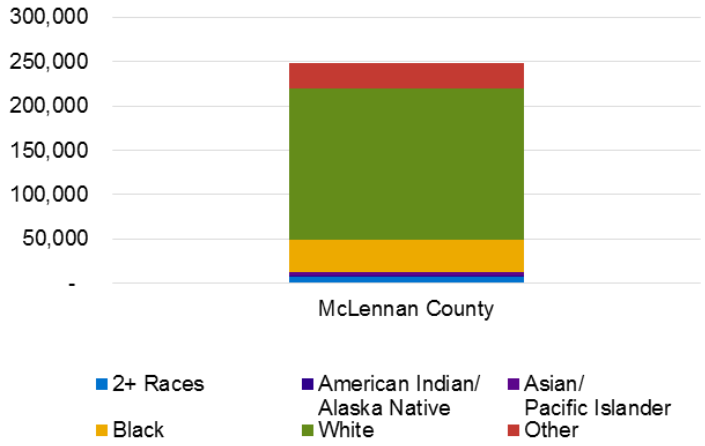


Source: Truven Health Analytics / The Nielsen Company, 2015

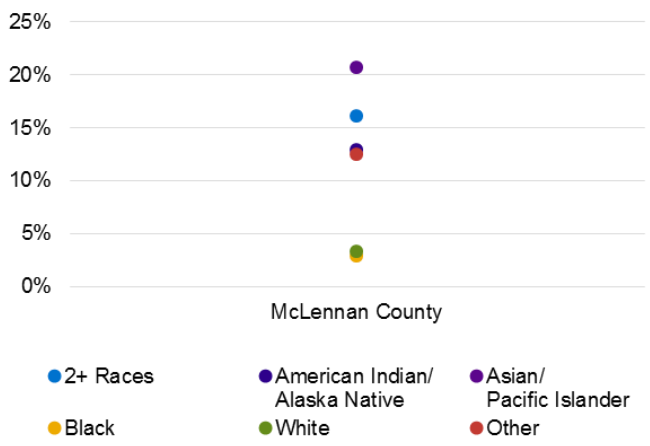
Diversity in the community will increase as minority populations are expected to grow the fastest. The community will experience significant growth in the Asian/Pacific Islander (21%), Multi-racial (16%) and American Indian (13%) communities. African American and Caucasian populations are expected to remain relatively flat. Total population can be analyzed by race or by Hispanic ethnicity. The graphs below display the community's total population breakdown by race (including all ethnicities) and also by ethnicity (including all races).

Population by Race

2015 Total Population



5 Year Projected Population Growth Rate

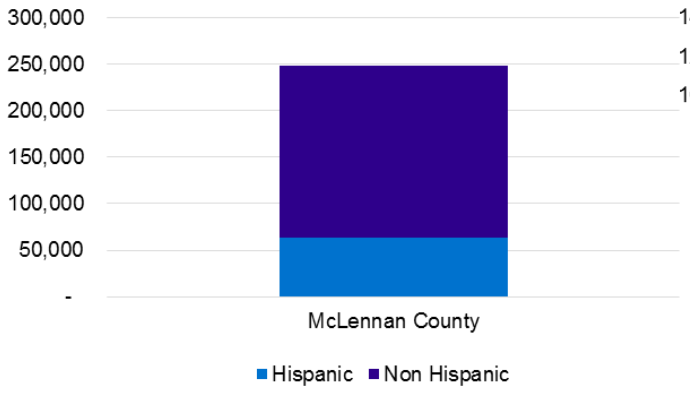


Source: Truven Health Analytics / The Nielsen Company, 2015

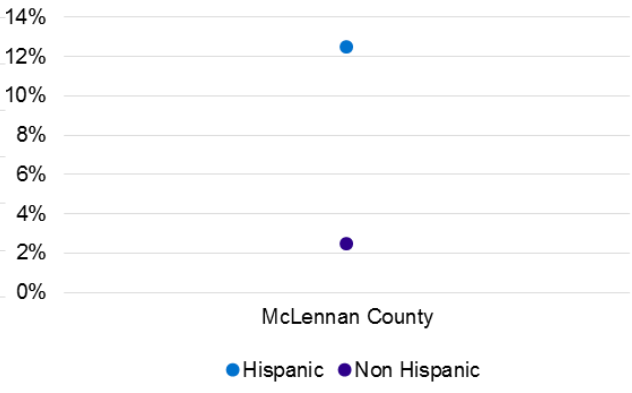
The Hispanic population is expected to grow more than five times faster than the non-Hispanic population. Currently twenty-five percent of the population identified as Hispanic.

Population by Hispanic Ethnicity

2015 Total Population



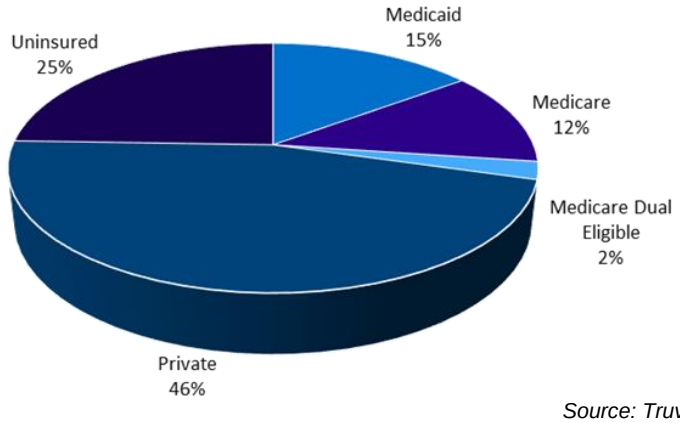
5 Year Projected Population Growth Rate



Source: Truven Health Analytics / The Nielsen Company, 2015

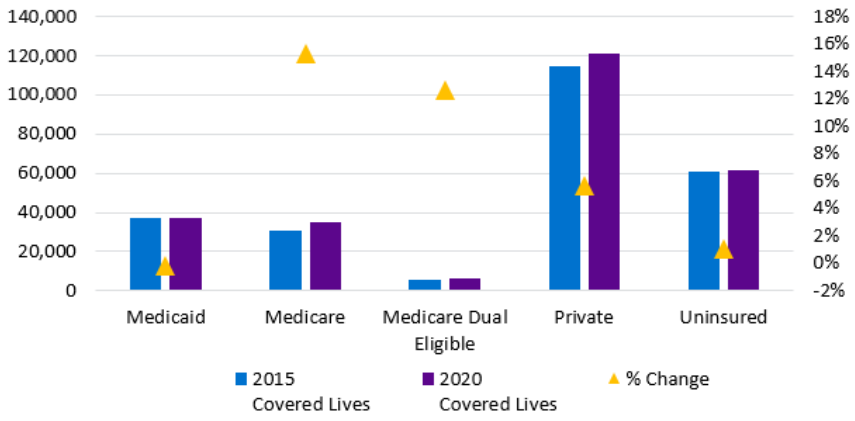
The median household income for the community served was $42,817. Forty-six percent (46%) of the community was commercially insured. The population purchasing insurance through the health insurance exchange marketplace is expected to increase 44% by 2020. This growth will have little effect on the total number of commercially insured as those receiving employer sponsored coverage are expected to decrease by similar number of lives. Fifteen percent (15%) were covered by Medicaid, 25% were uninsured and 14% were covered by Medicare or were Medicare Dual Eligible. The uninsured are currently expected to remain at approximately 25% of the population over the next five years

2015 Estimated Distribution of Covered Lives by Insurance Category



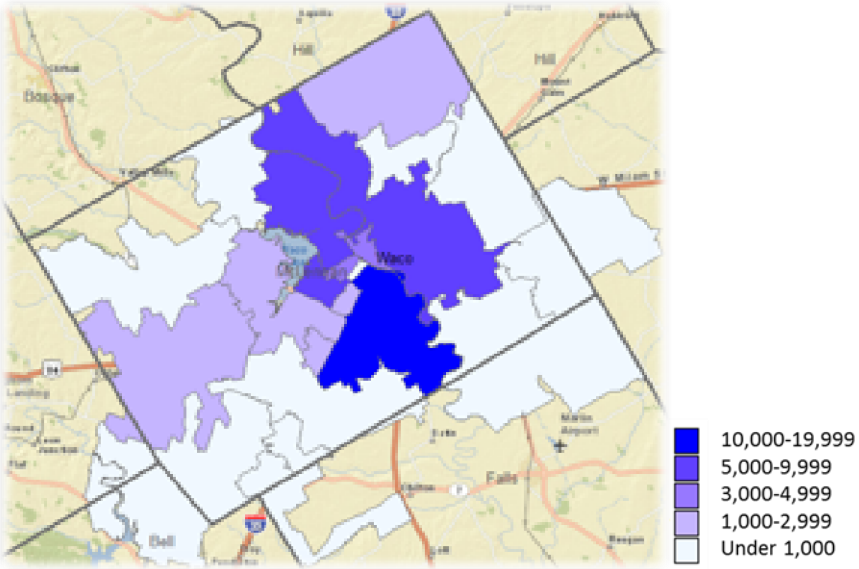
Source: Truven Health Analytics, 2015

Estimated Covered Lives and Projected Growth by Insurance Category



Source: Truven Health Analytics, 2015

2015 Estimated Uninsured Lives by ZIP Code



Source: Truven Health Analytics, 2015

The community includes six (6) Health Professional Shortage Areas and one (1) Medically Underserved Area as designated by the U.S. Department of Health and Human Services Health Resources Services Administration.[2] ***Appendix D*** includes the details on each of these designations.

Health Professional Shortage Areas and Medically Underserved Areas and Populations

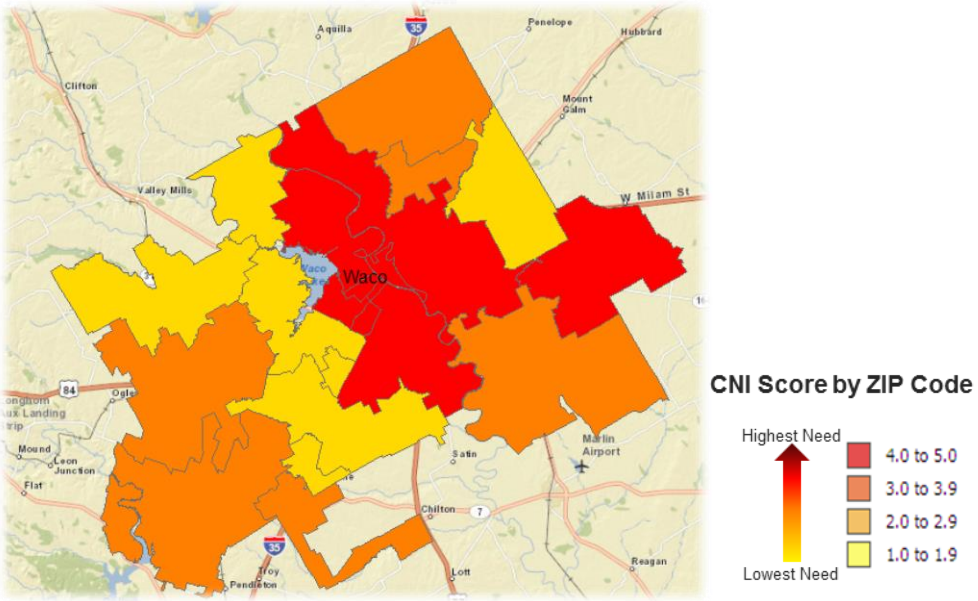
	Health Professional Shortage Area (HPSA)				Medically Underserved Area/Population (MUA/P)
COUNTY	Dental Health	Mental Health	Primary Care	TOTAL HPSA	TOTAL MUA/P
McLennan County	2	3	1	6	1

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

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

Overall, the community served was slightly above the CNI national average. However, there were portions of the community (Waco and Mart) where we anticipate greater healthcare needs based upon socioeconomic barriers. The community has an overall CNI Score of 3.7.

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 included the following:

Category	Indicator
Access To Care	Could not see doctor due to cost
Access To Care	Ratio of population to one non-physician primary care provider
Access To Care	Ratio of population to one dentist
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)
Health Behaviors	Physical Inactivity (percent)
Health Behaviors	No Exercise (percent)
Health Behaviors	Adult Smoking (percent)
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	Colon Cancer Incidence (per 100,000)
Health Outcomes	Lung Cancer Incidence (per 100,000)
Health Outcomes	Adults Reporting Diagnosed w/ Diabetes (percent)
Health Outcomes	Alzheimer's Disease/Dementia: Medicare Population (percent)
Health Outcomes	Depression: 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 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
Health Outcomes	Very Low Birth Weight (VLBW) (percent)
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	Average number of mentally unhealthy days reported in past 30 days (age-adjusted)
Population	Some College (percent)
Population	Children in Poverty (Percent)
Population	Children in Single-parent Households
Population	Income inequality
Population	Individuals Living Below Poverty Level

Category	Indicator
Population	Individuals Who Report Being Disabled (percent)
Population	Percentage of children enrolled in public schools that are eligible for free lunch
Population	Violent Crime Rate (offenses per 100,000 pop)
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, including 30,000 cases in Waco. Waco accounted for between 55-58% of the community cases for each heart disease type. There was a significant proportion of each heart disease type in the cities of Woodway, Hewitt, and McGregor.

2015 Estimated Heart Disease Cases

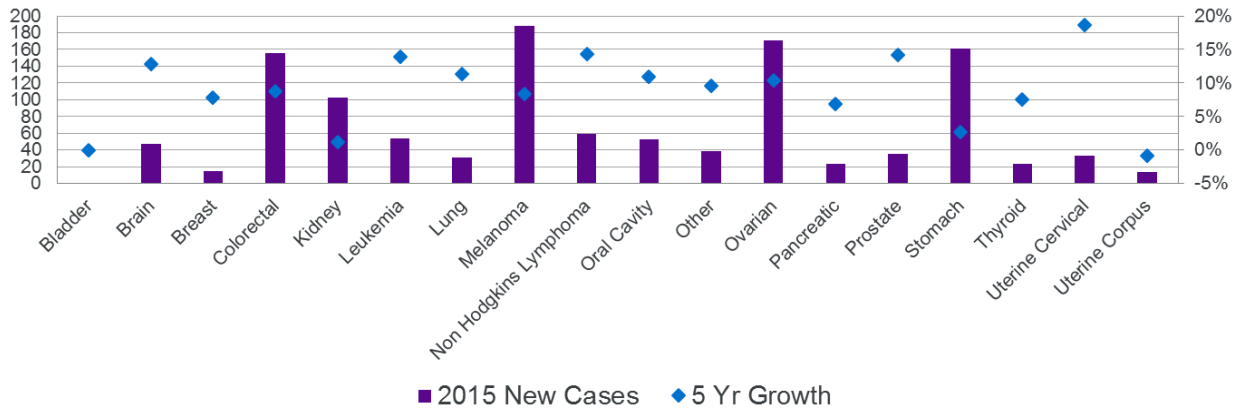
Heart Disease Type	Estimated Community Cases
ARRHYTHMIAS	8,767
CONGESTIVE HEART FAILURE	4,804
HYPERTENSION	52,880
ISCHEMIC HEART DISEASE	7,450

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 reveal the greatest growth rates are projected for thyroid, melanoma, pancreatic and kidney cancers in the community. Growth rates for all cancer types in the community served are projected to be lower than statewide rates; 7% lower in pancreatic cancer incidence, 6% lower in colorectal, lung and kidney cancer incidence, 5% lower in breast, bladder, leukemia, lymphoma, oral, and ovarian cancer incidence.

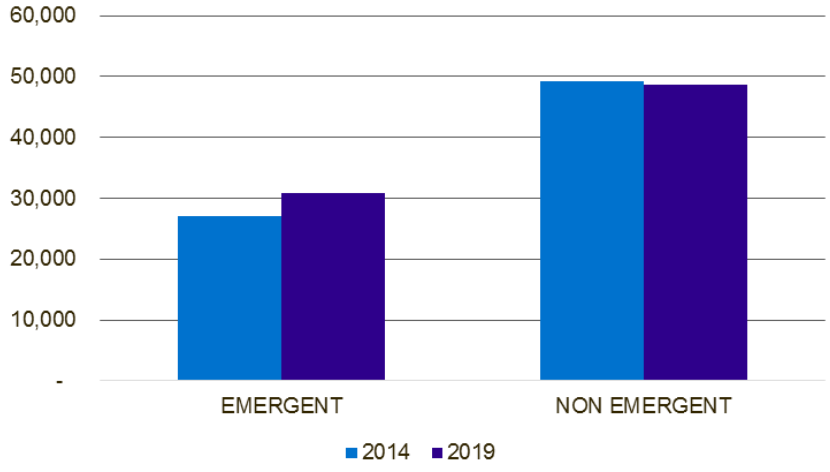
New Cases and Projected Growth by Cancer Type



Source: Truven Health Analytics, 2015

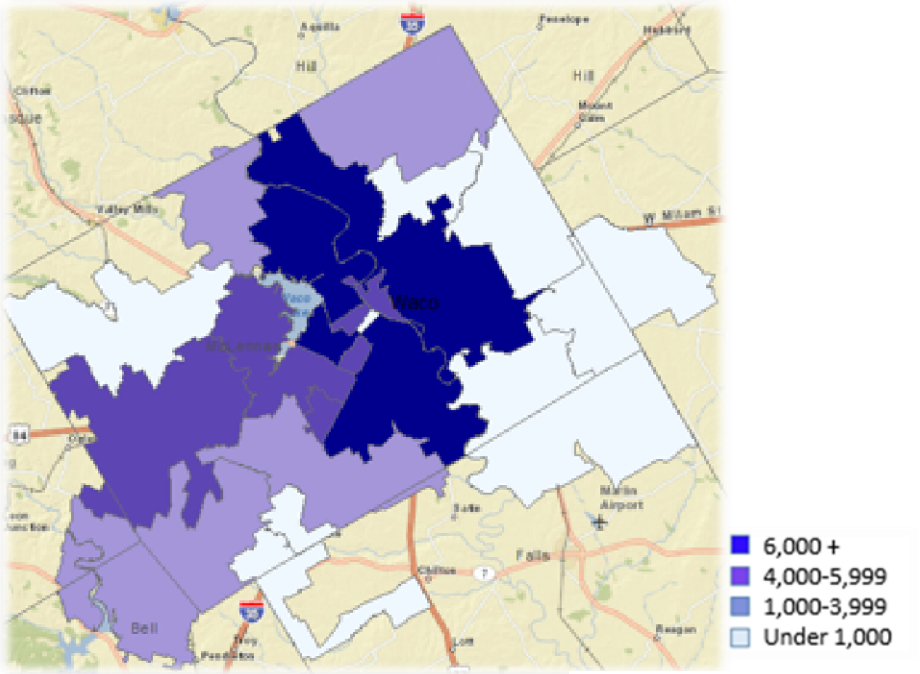
Outpatient emergency department visits are those which are treated and released and therefore do not result in an inpatient admission. Truven Health estimates outpatient emergency department visits are expected to increase 4% in the community over the next five years. Non-emergent outpatient ED visits 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 can be an indicating that there are systematic issues with access to primary care or managing chronic conditions. There will be a small decrease (-1%) in non-emergent visits while emergent visits are expected to increase 14%. In Waco alone, over 50,000 outpatient emergency department visits were expected.

Emergent and Non-Emergent ED Visits



Source: Truven Health Analytics, 2015

2014 Estimated Non-Emergent Visits by ZIP Code



Source: Truven Health Analytics, 2015

Interviews & Focus Groups

In the interview sessions, the participants were asked what factors contribute to the current health status of the community. The factors contributing to this perceived health status include chronic disease rates, socioeconomic disparity, poverty, health education, health disparities, healthy community and access to health care 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, heart disease, lung cancer)
2. Access challenges (public transportation, availability of women's healthcare, affordable healthcare, healthy food, dental services, mental health and specialty care services)
3. Mental/ Behavioral Health Services (uninsured, ADHD, substance abuse, depression, provider access, inpatient/ acute services)
4. Prevalence of Substance Abuse (prescription and illicit, homeless population impacted, tobacco use)
5. Community health and wellness (lack of health awareness and healthy choices, limited access to health foods)

Barriers to good health care in this community include lack of insurance coverage, poverty, lack of healthy food and exercise options, no public transportation and linguistic isolation.[3] The following populations were identified as vulnerable groups that will need special attention when addressing health needs:

- Low income
- Hispanic and African American
- Immigrants and Illegal immigrants
- Single mothers
- Seniors

Focus group participants were asked what factors contribute to the current health status of the community. Discussions focused on community mental health, health literacy and healthy living.

Mental health was a top priority for all three breakout groups. There are not enough resources (specialists and psychiatrists) to meet the needs of the community. The high rate of behavioral health issues within the homeless population is not well understood and difficult to manage. There is still a stigma attached to having a mental health condition which impacts community and cultural acceptance. Although crisis care is available, long term needs such as depression and life after substance abuse rehabilitation, are not being addressed. There is a need for care coordination to strengthen the network and break down the silos of care. Care Coordination would facilitate ongoing support for chronic behavioral health conditions and associated issues

[3] A linguistically isolated household is one in which no member 14 years old and over speaks only English or speaks a non-English language and speak English "very well". In other works all household members 14 years old and over have at least some difficulty with English., U.S. Census Bureau, 2000

such as medication availability and management. Education needs which the discussion groups identified for the community include: 1) for community members - how to be healthy and utilize the healthcare system and 2) for professionals - resources currently available for their clients/patients. Many resources that are available are underfunded; e.g. APS Healthcare Treatment Centers, Child Protective Services (CPS), and Health Literacy. The need for education about health permeates all communities due to a lack of available programs and affordability challenges (which impacts both the educator and the community members). There is a high incidence of the working poor who are not eligible for Medicaid, which provides access to educational programs. Still, such programs are challenged with obtaining funding to operate. The groups identified the need to provide better, frequent and easily accessible educational opportunities. Programs such as chronic disease management, medication management, vaccination requirements, how to navigate the healthcare system, cultural awareness, healthy living would benefit the community. The group noted that much of the education, such as healthy living, could start in grade school to build effective habits for life. Some of the positive feedback included the community's overall strength and resilience and the number of health resources available.

The focus group identified the following top health needs:

- Mental health
- Health education: chronic disease
- Health education: cultural awareness
- Health education: healthy lifestyle
- Care coordination
- Strengthen care and social services networks
- Adapting a healthy lifestyle

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.

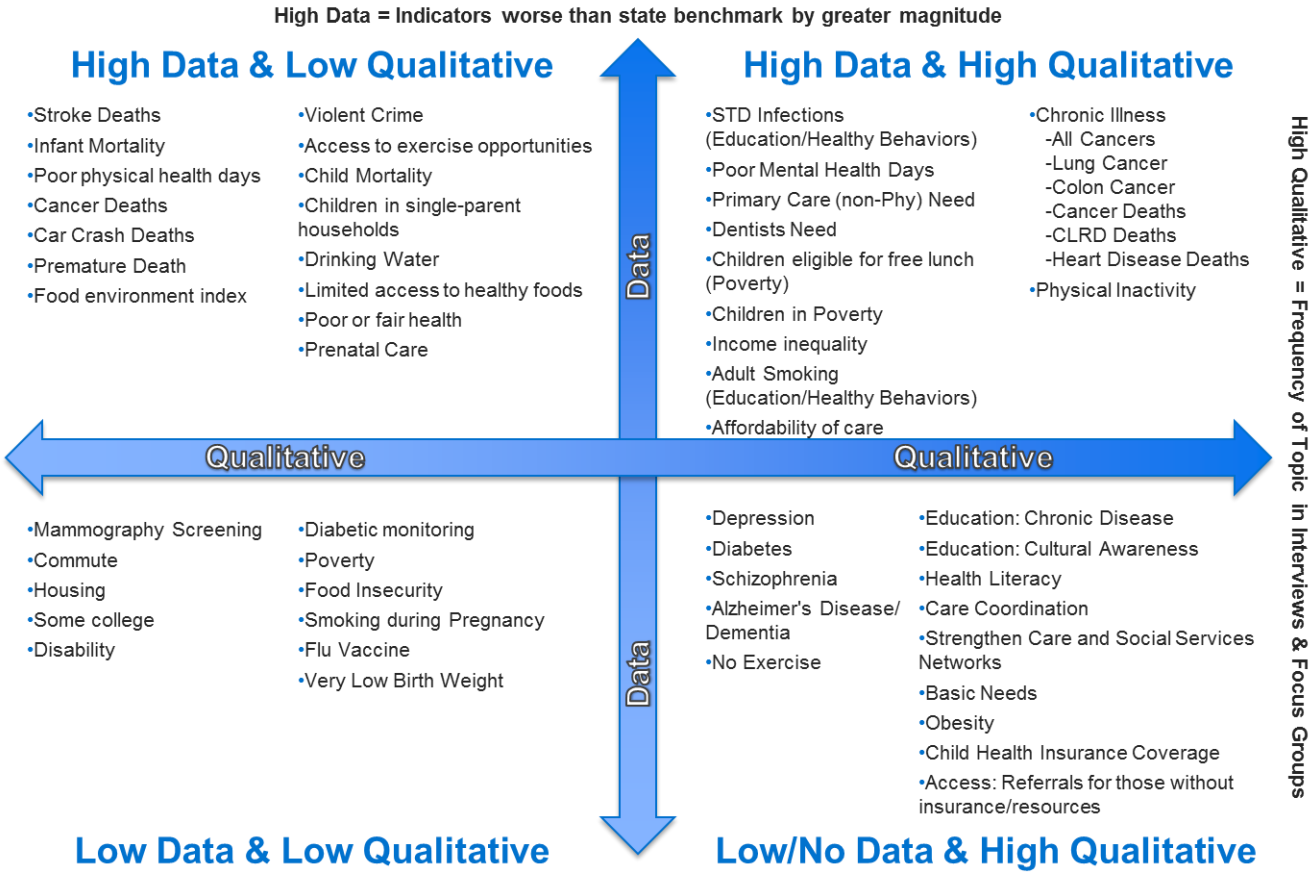
The interview and focus group participants and the populations they serve for this community are documented in the table below.

Focus Group and Key Informant Interview Participants					
Community Leaders/ Groups		**Public and Other Organizations**		**Other Providers**	
Community Bank and Trust (Focus Group)	Catholic Charities of Central TX (Interview)	Waco ISD, Greater Waco Academy, School District (Focus Group) **MU, LI, CD, MP**	Texas Department of State Health Services (Interview) **PH**	Heart of Texas Region MHMR (Focus Group) **MU, LI**	Hillcrest Medical Center (Interview) **CD**
Texas Document Solutions, Sales (Focus Group)		Baylor University *2 participants* (Focus Group)	Prosper Waco (Focus Group) **MU, LI, MP**	Family Health Center (Focus Group) **MU**	Waco Family Health Center (Interview) **MU, LI, CD, MP**
		McLennan Community College (Focus Group)	Waco-McLennan County Public Health Department (Focus Group) **MU, LI, CD, MP**	CareNet Pregnancy Center (Focus Group) **LI**	Hillcrest Family Health Center (Focus Group) **LI, CD**
		McLennan County Pack of Hope (Focus Group) **LI**		New Century Hospice (Focus Group) **CD**	Hillcrest Health Systems (Focus Group) **LI, CD**
		Waco Police Department (Focus Group) **MU, LI, CD, MP**		Providence Health Center, Care Management (Focus Group) **MU, CD, MP**	

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 Baylor Scott & White Medical Center - Hillcrest.



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 January 19, 2016 by Baylor Scott & White Medical Center - Hillcrest hospital and clinic leadership in a session to establish a list of significant needs and to prioritize them. The meeting was moderated by BSWH – Central Texas Director of Community Benefit and included an overview of the community demographics, summary of health data findings and an explanation of the quadrants of the health needs matrix.

Session participants included:

President – Waco Region	Chief Medical Officer	Chief Financial Officer
Vice President Operations	Director of Pharmacy	Director of Pathology and Respiratory Care
Director of Rehabilitation	Marketing Manager	Director of Philanthropy
Assistant Chief Nursing Officer	Director of Human Resources	Director of Trauma Services
Director of Clinic Operations	Director of Clinics	Director of Clinic Operations
Imaging Director	Director – Oncology & Cardiology	

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

1. Mental Health Services
2. Chronic Illness
3. Obesity
4. Access to Care
5. Prenatal Care
6. Tobacco Use

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.

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

Description of Significant Health Needs

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 needing access to services such as providers and acute inpatient services, especially for uninsured and/or homeless populations. The participants expressed a need for services to treat specific conditions such as ADHD, substance abuse and depression. The community input also focused on the need of addressing the stigma associated with having a mental health condition, which can influence an individual's decision to seek treatment. The input gathered acknowledged that mental health crisis care is currently available in the community but longer 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), in this community the average number of mentally unhealthy days, which includes stress, depression, and problems with emotions, reported by adults in the past month was 4.9 compared to the state value of 3.3 and the County Health Rankings Top Performer's value of 2.3.[5] The Centers for Medicare & Medicaid Services (CMS) report 12% of the community's Medicare population had Alzheimer's disease/ dementia and 17% suffered from depression.[6]

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.[7]

According to the National Cancer Institute's State Cancer Profiles, in this community the average annual incidence of all cancers was 433 per 100,000 people compared to the state value of 418.[8] The community's average annual lung cancer incidence per 100,000 people was 70, 22% higher than the state value of 58 people per 100,000.[3] The average annual colon and rectal cancer incidence per 100,000 people was 41 just slightly higher than to the state value of 40 people per 100,000.[3]

The National Vital Statistics System tracks mortality rates by condition. The community's mortality rates exceed the state rates for the following chronic conditions[9]:

[5] Behavioral Risk Factor Surveillance System (BRFSS), 2006-2012 average number of mentally unhealthy days reported in past 30 days (age-adjusted).
[6] Centers for Medicare & Medicaid Services (CMS), 2012 percentage of Medicare FFS Beneficiaries
[7] http://www.medicinenet.com
[8] National Cancer Institute, State Cancer Profiles, 2008-2012 average annual incidence per 100,000 people
[9] National Vital Statistics System-Mortality (NVSS-M) (CDC/NCHS), 2013 deaths per 100,000 people

- Heart disease mortality rate was 193 deaths per 100,000 people compared to the state rate of 152 deaths
- Cancer mortality rate was 181 deaths per 100,000 people compared to the state rate of 145 deaths
- Stroke mortality rates was 60 deaths per 100,000 people compared to the state rate of 35 deaths
- Chronic lower respiratory disease (CLRD) mortality rate was 50 deaths per 100,000 people compared to the state rate of 50 deaths

Community input (gathered through key informant interviews and focus group sessions) validated the quantitative findings, indicating chronic illness is a significant community health need. The participants noted the higher prevalence of diabetes and obesity in low income and pediatric populations. The participants believe the prevalence of diabetes is increasing, especially among children, and it is linked to obesity and other co-morbidities. The participants expressed a need for promoting health and wellness by increasing physical education opportunities and health friendly food options for children. The need for health education and support permeated discussions around chronic illnesses and all populations.

Obesity

Obesity and diabetes coupled with an unhealthy lifestyle were also a common themes among participants in the key informant interviews and focus group sessions. Participants noted the prevalence of a “food culture," not a “healthy life” culture in the community. Ethnic habits, which may be unhealthy, are difficult to modify and food deserts in the community contribute to unhealthy eating habits. Adult exercise options remain limited and not easily accessible. The ability to choose walking or biking as transportation method are limited as the community infrastructure does not support those alternatives. There is a need for more community activities and opportunities to exercise. High rates of obesity in the pediatric and low income populations were specifically called out. Diabetes is increasing among children and has an acknowledged link to obesity rates and other co-morbidities. The availability of education about the link between obesity, diabetes and a healthy lifestyle is limited.

According to the CDC, 28.6% of adults in McLennan County are reportedly obese compared to 29% of adults in the state. [10] An adult is considered obese if they have a Body Mass Index (BMI) of 30 or higher. Diet and lack of physical activity are some of the contributing factors to obesity. According to the USDA, in this community the percentage of low-income residents that had limited access to healthy foods is 12.5% compared to the state value of 8.3%.[11] Additionally, only 73% of the population had adequate access to locations for physical activity compared to the state value of 84%.[12] Twenty-six percent

[10] CDC, Behavior Risk Factor Surveillance System (BRFSS), 2012 percentage of adults reporting a BMI of 30 or more.
[11] 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.
[12] The Business Analyst, Delorme Map Data, 2010 & 2013, percentage of population with adequate access to locations for physical activity.

(26%) of adults over 20 years old reported no leisure-time physical activity, compared to the state value of 23%.[13] In a similar finding from the Behavioral Risk Factor Surveillance System (BRFSS), 28% of those 18 years of age and older reported no exercise in the past month as compared to the state value of 27%.[14] 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.[15]

Access to Care

Access to healthcare was a common theme which emerged through the key informant interviews and focus group session. Participants acknowledged the high quality healthcare that is available in the community, provided by Baylor Scott & White Medical Center - Hillcrest as well as Providence Health Center. However, the location of the facilities, lack of public transportation and/or walkability limit access to the care provided by these facilities in the more rural parts of the community. The current healthcare system is fragmented and does not adequately serve those areas impacted by poverty. There are individuals of lower socioeconomic status that do not have health insurance nor have the ability to pay out of pocket. Many of these individuals do not qualify for government programs/subsidies given their income levels, yet still face challenges in their ability to pay for their healthcare. Additionally, there are individuals who fall through the cracks of the current system due to a lack of care coordination. Strengthening existing networks of care could facilitate greater coordination of care for these individuals.

The quantitative analysis also identified/pointed to issues around access to care. According to the Behavioral Risk Factor Surveillance System (BRFSS), the percentage of adults in the community who could not see a doctor in the past 12 months due to cost was 22% compared to the state value of 19%.[16] Additionally the availability of physician extenders for primary care in the community was 23% below the state level; the ratio of population to one non-physician primary care provider was 2,322:1 compared to the state ratio of 1,893:1.[17] Access to dental care is also an issue, the community had a ratio of population to one dentist of 2,137:1 compared to the state ratio of 1,940:1.[18]

[13] CDC Diabetes Interactive Atlas, 2011 Percentage of adults aged 20 and over reporting no leisure-time physical activity

[14] Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention, Public Health Surveillance and Informatics Program Office (BRFSS, CDC/PHISIPO), 2016-2012, Adults that report no leisure time activity in the past month.

[15] Healthy People 2020, 2016, www. Healthypeople.gov/2020

[16] 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).

[17] CMS National Provider Identification File, 2014 Ratio of population to one non-physician primary care provider.

[18] Area Health Resource File/American Medical Association, 2013 ratio of population to one dentist.

Prenatal Care

Prenatal care did not emerge as a theme in the community input sessions but did emerge as a need from a data perspective. According to the Texas Department of State Health Services Natality File, in this community 62% of women entered into prenatal care within their first trimester of pregnancy as compared to the state value of 65%.[19]

Access to women's healthcare has been a challenge historically due to limited resources available in the community. However, recently new programs and community partnerships through Prosper Waco have been developed to address this need and the hospital wishes to continue focus on this area and drive momentum towards impacting the need for prenatal care in the community.

Tobacco Use

Tobacco use is a community health need identified through the hospital prioritization process. A high percentage of population smoke/chew tobacco or use vaping merchandise. According to the Behavioral Risk Factor Surveillance System (BRFSS), in this community, 21% of adults smoked tobacco as compared to the state value of 17%.[20] The hospital recognized that tobacco use impacts other chronic illness issues that are identified as needs such as lung cancer, heart disease and chronic lower respiratory disease. Also, the need for health education and support of healthy behaviors was a theme that emerged in the community input sessions.

Summary

BSWH conducted its Community Health Needs Assessments beginning July 2015 to identify and begin addressing the health needs of the communities they serve. Using both qualitative community feedback as well as publically available and proprietary health indicators, BSWH was able to identify and prioritize community health needs for their healthcare system. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed for the health needs BSWH has chosen to address for the community served.

[19] Healthy Texas Babies Data Book, Center for Health Statistics, Texas Department of State Health Services; 2014, First Trimester Entry into Prenatal Care.

[20] Behavioral Risk Factor Surveillance System (BRFSS,) 2006-2012, Percentage of adults who are current smokers

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	Family of Faith	Life Steps	Prosper Waco
Baylor School of Social Work	Farmers Market	Live Well Waco	Salvation Army
Baylor Scott and White Health	Food Pantries / Food Banks	Local Hospitals	Schools - ISDs
Baylor University Volunteer Network	Habitat for Humanity	McLennan Community College	SSA
Community Care Relationships Coalition	Health Department	MHMR	Tarlton State University
Community Gardens	Hispanic Chamber of Commerce	Mission Waco	United Way
Divine Nine (Baylor University)	Homeless Shelters	Mobile Vending	Veterans Administration
East Waco Park	HUD Section 8, Public Housing	National Alliance on Mental Illness (NAMI)	Waco Chapter of The Links, Inc.
Express Clinics	Indoor gym/walking trails	Police department	Waco Clinics
Family Counseling Center	Jack & Jill	Primary Care Doctors	YMCA

Community Healthcare Facilities[21]

Hospitals – Three (3) hospitals serving the community

Facility Name	System	Type*	Street Address	City	State	ZIP
DePaul Center	Ascension Health	PSY	301 LONDONDERRY DRIVE	WACO	TX	76712
Providence Health Center	Ascension Health	ST	6901 MEDICAL PARKWAY	WACO	TX	76712
Baylor Scott & White Medical Center - Hillcrest	Baylor Scott & White	ST	100 HILLCREST MEDICAL CENTER BLVD	WACO	TX	76702

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

Free-Standing Emergency Departments

Facility Name	Street Address	City	State	ZIP
PREMIER ER PLUS	9110 JORDAN LANE SUITE 100	WOODWAY	TX	76712

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

Appendix C: Evaluation of Implementation Strategy Impact

Baylor Scott & White Medical Center - Hillcrest
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: Cancer

Strategy #1: Achieve successful opening of a new comprehensive Cancer Treatment Center to help reduce health disparities related to cancer deaths and provide high-quality, culturally competent outreach, education, screenings, ambulatory treatment, and case management services.

✔ Cancer Center Opening in Fall 2013

Strategy #2: Enhance educational efforts on proper treatment and screenings for cancers affecting community (specifically breast and colon) to reduce the incidence of late stage cancers going undetected.

✔ Improve outreach efforts for cancer screenings to community including a focused treatment plan for potential diagnoses

✔ Continue screenings where possible at health fairs and community events

Strategy #3: Provide more opportunities for cancer screenings for underinsured to improve the number of early detection rates

Objectives/Activities:

✔ Identify opportunities to engage with representatives of minority populations to better collaborate and provide health information and services

Outcomes:

Breast Health - Community Education

The Hillcrest Breast Center supplies breast health information to organizations and 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: 3,075

Community Benefit Expenses: $2,756

McClinton Cancer Center

The Baylor Scott & White Health McClinton Cancer Center provides excellent care of cancer patients including focusing on the leading causes of cancer-related deaths for women and men in the Central Texas community.

Persons Served: 7,800

Community Benefit Expenses: $5,536 (education initiatives) plus $6,026,527 raised for construction of a facility to meet the needs of cancer patients

Financial Donations – Community Health Improvement

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

Persons Served: 10,575

Community Benefit Expenses: $139,725

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: 48

Community Benefit Expenses: $1,990

Health Fairs

Hillcrest 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: 3,183

Community Benefit Expenses: $3,040

Health Screenings

Hillcrest offers annual screening days to reach out to both men and women of Central Texas on the importance of early detection and preventive care of cancer.

Persons Served: 310

Community Benefit Expenses: $5,222

Subtotals For: Cancer

Number of Programs: 6 Persons Served: 17,383 Net Community Benefit: $6,184,799

Significant Need: Obesity

Strategy #1: Increase access to affordable fruits and vegetables

✔ Organize and host weekly farmers markets during spring/summer months, and provide healthy recipes utilizing produce available at farmer's market

Strategy #2: Improve access to and promotion of available affordable wellness activities provided by Hillcrest to the community

✔ Continue investing in and offering free community health and fitness programs at the Getterman Wellness Center

✔ Establish regular educational sessions on diabetes prevention and early detection

Strategy #3: Provide specific education of diabetes as a leading cause of obesity

Objectives/Activities:

⃠ Introduce new weight management and Diabetes Prevention programs to school children through partnerships with local YMCA and ISD

✔ Implement diabetes education program with the American Diabetes Association targeting Hispanic population to address health disparities

🚫 Diabetes Educators will formulate plans to provide appropriate in-service training to ED personnel and provide necessary material to newly diagnosed diabetics and caregivers

Outcomes:

Community Health Education

Baylor Scott & White Medical Center - Hillcrest 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 Hillcrest physicians and staff about health related topics like understanding various conditions and diseases, when to seek treatment and the treatment options available.

Persons Served: 5,440

Community Benefit Expense: $8,036

Financial Donation- Community Health Improvement

Baylor Scott & White Medical Center - Hillcrest donates funds to local charitable, not for profit organizations whose efforts to improve community health align with the identified health needs in our community. We do so to support their efforts to improve the overall health of the community through education, prevention, health advocacy, or disease management education.

Persons Served: 10,575

Community Benefit Expenses: $139,725

Faith Community Health

Faith Community Health is a branch of Faith In Action Initiatives in the Office of Mission and Ministries of BSWH. Faith Community Health strives to form relationships and collaborate with faith communities to improve the health of those people in their congregations and communities. Congregations and communities are supported by integrating faith and health through health educators, faith community nurses, home visits and church volunteer members.

Persons Served: 1,155

Community Benefit Expense: $3,129

Farmers Markets

Farmers Markets were held onsite weekly to offer fresh fruits and vegetables to the community throughout the summer months.

Persons Served: 2,000

Community Benefit Expense: unknown

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: 48

Community Benefit Expenses: $1,990

Health Fairs

Baylor Scott & White Medical Center - Hillcrest 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: 3,183

Community Benefit Expenses: $3,040

Health Screenings

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

Persons Served: 76

Community Benefit Expenses: $462

Por Tu Familia

Presented by Baylor Scott & White, 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.

Persons Served: 12

Community Benefit Expenses: $5,000

Wellness Programs

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

Persons Served: 2,666

Community Benefit Expenses: $648

Subtotals For: Obesity

Number of Programs: 9 Persons Served: 25,143 Net Community Benefit: $162,033

Significant Need: Pediatric Asthma Hospitalization

Strategy #1: Utilize a new full-time asthma educator to coordinate outreach and education and also to help identify "at risk" patients who may be in need of follow-up care.

Objectives/Activities:

✔ Increase education for parents and children on causes and treatment by providing standardized education material upon discharge and hosting community educational events

✘ Conduct in-home assessments of possible asthma triggers for families identified as "at risk"

✔ Establish partnership with ISDs to implement an asthma action plan and educate school nurses

✔ Enhance knowledge and education of hospital physicians and providers and establish better internal protocols

Outcomes:

Health Fairs

Baylor Scott & White Medical Center - Hillcrest 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: 3,183

Community Benefit Expenses: $3,040

Community Education for Pediatric Asthma

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: 10

Community Benefit Expenses: unknown

School Education for Pediatric Asthma

Asthma education provided in schools through partnerships with local ISDs.

Persons Served: 154

Community Benefit Expenses: $457

Subtotals For: Pediatric Asthma

Number of Programs: 3 Persons Served: 3,347 Net Community Benefit: $3,500

Total Number of Programs Addressing Needs:	18
Total Persons Served:	45,873
Total Net Community Benefit:	$6,345,332

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

Health Professional Shortage Areas (HPSA)[22]

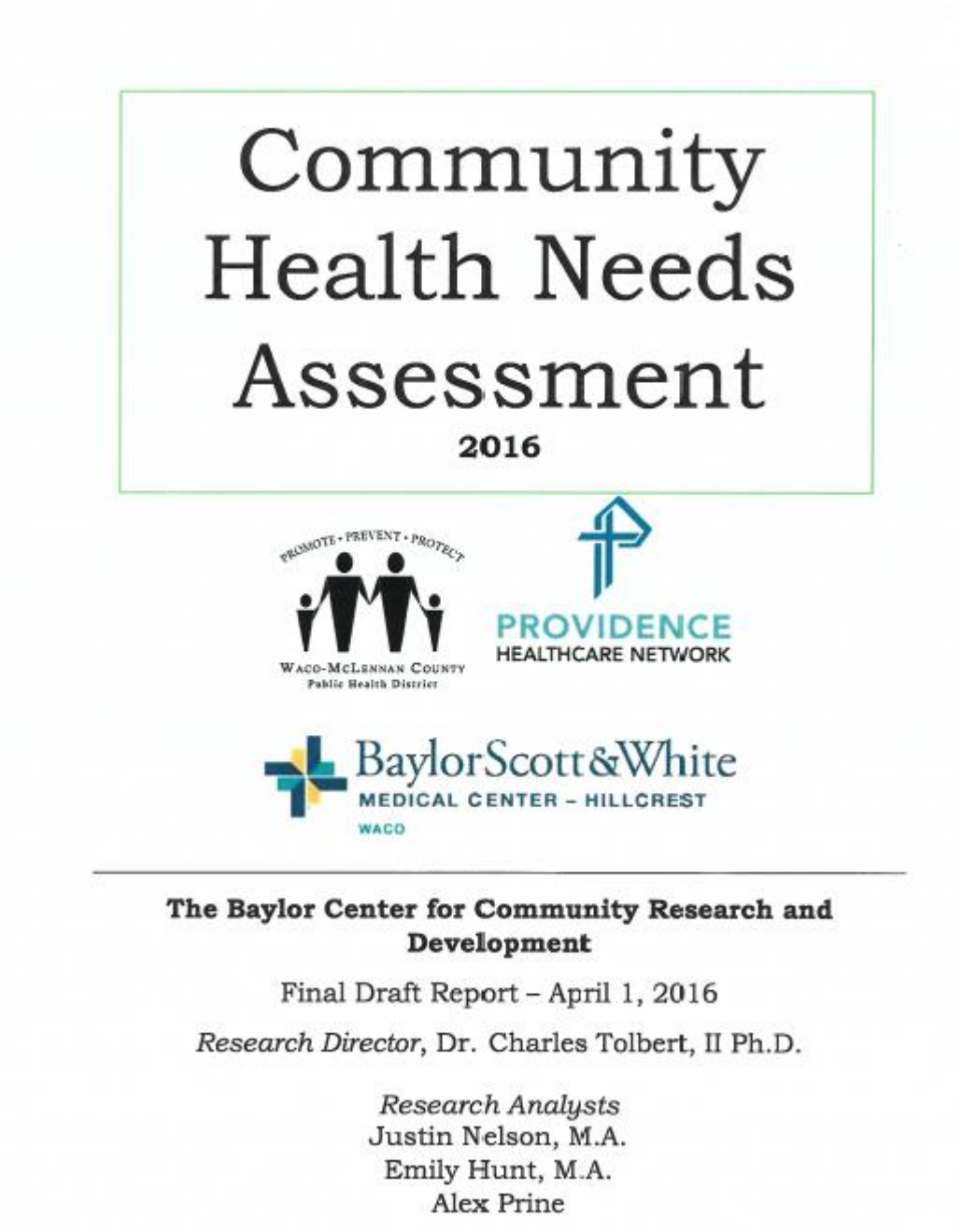
County Name	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type
McLennan County	148999485Z	Heart of Texas Community Health	Primary Care	Comprehensive Health Center
McLennan County	64899948C1	Heart of Texas Community Health	Dental Health	Comprehensive Health Center
McLennan County	748999482U	Heart 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

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

County Name	Service Area Name	MUA/P Source Identification Number	Designation Type
McLennan County	McLennan Service Area	3507	Medically Underserved Area

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

Appendix E: The Baylor Center for Community Research and Development Assessment Findings



Community Health Needs Assessment

2016

PROMOTE • PREVENT • PROTECT

WACO-MCLENNAN COUNTY
Public Health District

PROVIDENCE
HEALTHCARE NETWORK

Baylor Scott & White
MEDICAL CENTER – HILLCREST
WACO

The Baylor Center for Community Research and Development

Final Draft Report – April 1, 2016

Research Director, Dr. Charles Tolbert, II Ph.D.

Research Analysts
Justin Nelson, M.A.
Emily Hunt, M.A.
Alex Prine

Background of the Community Health Needs Assessment

In this telephone survey, the Center for Community Research and Development (CCRD) assessed the overall health practices and health care needs of Waco-McLennan County residents with a focus on access, wellness, and health concerns. The questions were developed through meetings of Center researchers with the Community Health Needs Assessment (CHNA) team, made up of administrators from the Waco-McLennan County Public Health District, Providence Healthcare Network, and Baylor Scott & White Hillcrest Medical Center.

The CCRD conducted telephone interviews from January 4, 2016 to March 19, 2016. Residents of McLennan County were interviewed using a Computer Assisted Telephone Interviewing (CATI) system. The CATI technology allows more control over the interviewing process and automates the data entry. The sample was selected from a computer-generated set of random phone numbers. This random generation technique allows the inclusion of residents with unlisted numbers. Other steps taken to ensure the quality of this poll include: (1) testing and editing experimental versions of the questionnaire to increase the clarity and reliability of each question; (2) an intensive training session for each interviewer; (3) continual monitoring of interviews by research analysts; (4) daily review of work, interviewing procedures, and results by the CCRD staff; (5) calling during times established in previous studies to provide the most representative sample; (6) making up to five call-backs for each phone number to avoid distorting the sample toward more easily accessible residents; (7) using special "screens" to increase the number of male and minority respondents; (8) dedicating a portion of the sample to targeting cell phone users; and (9) conducting interviews in Spanish to a sample of Spanish speaking households.

The following report analyzes the responses of the over 1,150 (unweighted) adult McLennan County residents who completed the survey. Most demographic characteristics of this sample closely resemble those of previous CCRD polls and demographics available through external sources such as the United States Census. Though CCRD employed the best available methods for obtaining a representative sample, younger persons and members of minority ethnic groups were under-represented among respondents. To compensate, this analysis uses post-stratification sampling weights based on known local demographic factors as reported in the American Community Survey. All analysis in this document employs this weighted sample. Each respondent was asked several questions pertaining to access to healthcare, wellness practices, risks and diagnoses, as well as a variety of standard health indicators. The CHNA questions have been analyzed based on standard demographics, which include age, gender, race, marital status, household size, number of children, level of education, and household income.

In the detailed analysis that follows the Executive Summary, the presentation is formatted to represent the three main themes that developed during data collection: (1) Access and Affordability, (2) Wellness and Prevention, and (3) Health Concerns and Risks. These themes parallel those that emerged in focus groups and key informant interviews conducted by Truven Health Analytics. Survey questions within each section are presented as they were read to the respondents by our interviewers. Overall frequencies and cross-tabulations, as necessary, are provided for each question, and question summaries discuss factors that are related to each individual question. Should any additional issues be of particular concern or relevance to CHNA administration, the CCRD will provide original data material to the group for conducting further analyses.

Executive Summary

Section I. Access & Affordability

- The telephone survey results indicate that overall access to healthcare professionals was not a problem, though this finding varied by income level.
- While only 15 percent of respondents reported being without health insurance at the time of the interview, this number is slightly higher than the 12 percent that are uninsured nationally as reported by the American Community Survey in 2014. The primary means for receiving insurance are employment related with an additional 35 percent receiving insurance through Medicaid or public aid.
- While most adults in our sample were insured, the results of focus groups conducted by Truven note that income was a primary barrier to accessing healthcare because of the prohibitive cost of insurance.
- The focus groups discussed transportation as key concern to accessing healthcare, however survey results note that for those who had trouble with access, less than 10 percent of those respondents indicated that the problem was due to transportation.

Section II. Wellness & Prevention

- The focus groups and key informant interviews discussed the lack of health consciousness in the overall population. Survey results found only 17 percent of respondents reported participating in vigorous activities every day, but about 50 percent, or half of Waco residents report that they engage in vigorous physical activity throughout an average week. 1 in 4 respondents indicated that they engage in moderate physical activity every day.
- While approximately half of respondents get at least two cups of fruits or vegetables each day, poor diet choices were evident in that 14 percent of respondents report not eating any fruit on a daily basis. This finding illustrates diet concerns discussed in key informant interviews.
- 1 out of 4 respondents reported smoking regularly, with 20 percent of the sample indicating a daily smoking habit.
- The Truven focus groups discussed health literacy, or the navigation of the healthcare system as an educational need. Our survey results show that over 20 percent of respondents are not receiving any information related to improving their overall health.

Section III. Health Concerns & Risks

- Of those who reported health problems for themselves or their households, the main health problems reported in the survey sample were allergies and hypertension or high blood pressure.
- Approximately 1 out of 5 respondents have either personally been diagnosed with heart problems, or live with someone who has been diagnosed with heart problems in the past 12 months.
- The focus groups and key informant interviews expressed concern for mental health services in the community. Our survey results show that 25 percent of respondents who report having behavioral or emotional health concerns in their household do not find that these concerns are being addressed.

Key Findings

Section I. Access & Affordability

While healthcare reform has decreased the uninsured population in the Waco-McLennan County area, approximately 15 percent of respondents remain uninsured. Race was a factor in whether or not someone had health insurance and whether or not they or members of their household had gone without insurance in the past year. Most respondents indicated they were able to access health professionals without a problem, and the majority indicated having had a recent routine checkup. One theme discussed in the Truven focus groups and key informant interviews was access to health professionals, especially for individuals in rural areas. At least for McLennan County, this survey seems to contradict these results as only 12 percent of the sample report difficulty accessing health professionals.

The Truven focus group discussed a socioeconomic divide and cultural gap in Waco-McLennan County. Participants agreed that healthcare is not equally accessible for the socioeconomically challenged. Furthermore, there is very little access to health insurance for the poor. Without insurance, individuals do not have the ability to pay out of pocket. When there are challenges to the access of health facilities and insurance for the poor, it impacts Waco-McLennan County. Our survey results support this claim and show that over 40 percent of respondent's total annual household income is less than $35,000 a year, making it especially difficult to receive the same health benefits as individuals who are more socioeconomically prosperous.

Section II. Wellness & Prevention

The Truven focus groups and key informant interviews discussed the overall health of the community, saying that only a small part of the population is health focused. Our survey results show daily physical activity is limited and that eating habits do not reflect sufficient fruit and vegetable intake per health expert recommendations. The Truven focus groups and key informant interviews also discussed the overall health of the community, expressing poor

diet choices. Our survey results show that 11 percent of respondents report not eating any vegetables on a daily basis and that approximately 63 percent of respondents eat less than 3 cups per day. The Truven focus group and key informant interviews illustrate concerns regarding the overall lack of education about living a healthy lifestyle, the focus group suggests that schools and churches should provide education. Our survey results show that 1 out of every 5 respondents are not receiving health information from any source.

In regards to women's health concerns, most report using a general physician or gynecologist, though approximately 15 percent utilize the services of options such as Planned Parenthood, a family health center, or the health department clinic. Most women report having had a mammogram and well-woman exam at some point in their lifetime, but as key informant interviews indicate, routine wellness services for women remain a concern in the community.

Section III. Health Concerns & Risks

The Truven focus group identified health issues with obesity being a major concern. Our survey results reflect the focus group's identification, as 36.6 percent of respondents indicate that someone in their household has been told by a health professional in the last 12 months they were overweight. Heart problems and high blood pressure were of concern to respondents, as was diabetes. Over 20 percent of respondents report that someone in their household was diagnosed with heart problems in the past 12 months. And, close to 1 in 4 respondents reported having been personally diagnosed with diabetes, or reported living with someone who had been diagnosed with diabetes in the past year.

Additionally, emotional and behavioral health concerns were present in over ten percent of respondent's households, which was cited as concern by the focus groups and key informant interviews. According to survey results, approximately 10 percent of these cases resulted in hospitalization in the past year. Truven focus groups and key informant interviews indicate access to behavioral health professionals and services remains a challenge.