Baylor Scott & White HEALTH

IMPLEMENTATION STRATEGY

For the 2016

Community Health Needs Assessment

Baylor Scott & White Medical Center – Hillcrest

Scott & White Clinic

Hillcrest Family Health Center

Hillcrest Physician Services

Approved by: Baylor Scott & White Medical Center – Hillcrest Board of Directors on November 4, 2016 and posted to http://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

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.

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 to meet the demands of health care reform, the changing needs of patients and extraordinary recent advances in clinical care.

Known for exceptional patient care for more than a century, the two organizations served adjacent regions of Texas and operated 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.

BSWH is a member of the High Value Healthcare Collaborative, the Texas Care Alliance and is one of the best known, top-quality health care systems in the country, not to mention in Texas.

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

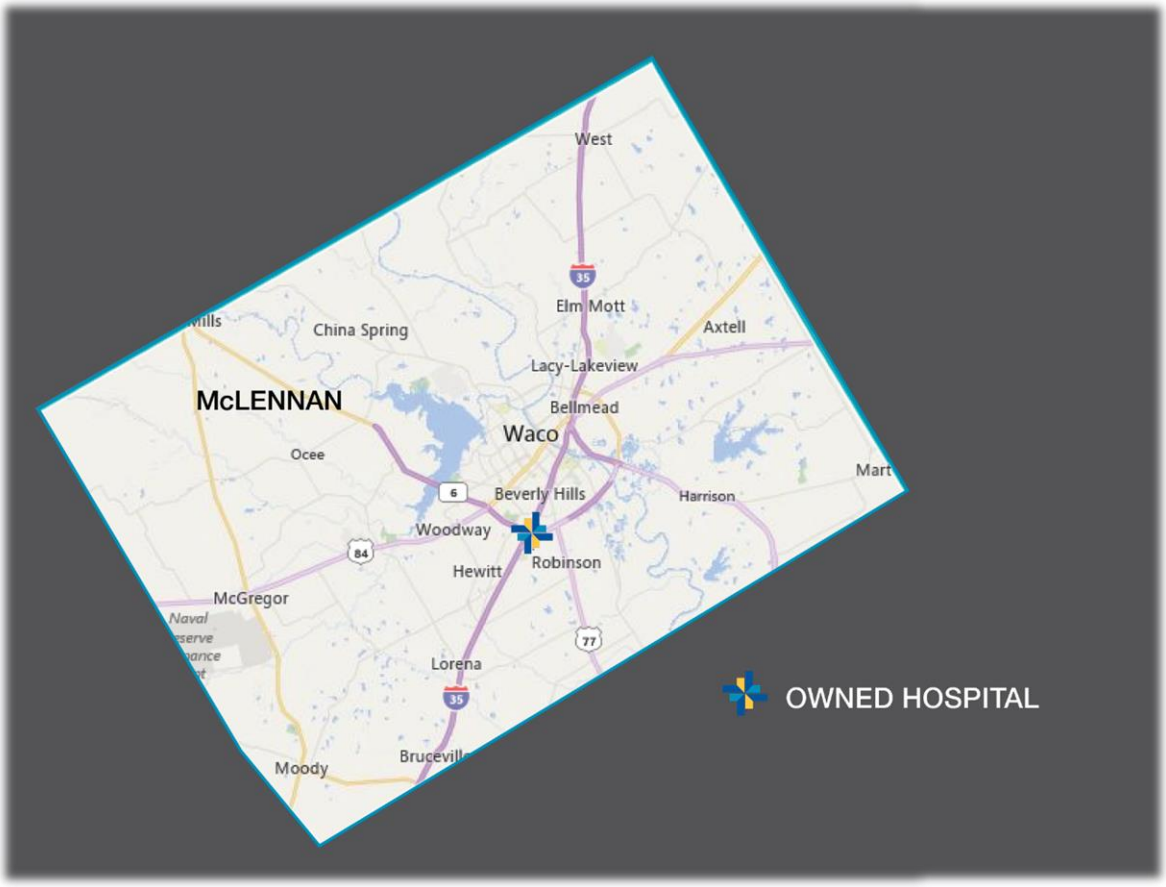
BSWH owns and operates multiple individual licensed hospital facilities serving the residents of North and Central Texas. For the 2016 assessment process, the below hospital facility defined its community to be the geographical area of McLennan County. The community served was determined based on the counties that make up at least 75 percent of the hospital's inpatient and outpatient admissions.

- Baylor Scott & White Medical Center - Hillcrest

This same hospital facility has chosen to do a joint implementation strategy to address the identified community health needs with other 501(c) 3 nonprofit organizations:

- Scott & White Clinic
- Hillcrest Family Health Center (HFHC)
- Hillcrest Physician Services (HPS)

Map of Community Served



Highlights of community characteristics include:

- 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 a 4% population growth of 6,800 people 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. Growth in this population will likely contribute to increased utilization of services as the population continues to age.
- 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.
- 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.
- 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.

	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

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 McLennan County. 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.

Mental Health Services was identified as a priority need 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.

Data Collection supported these discussion. 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 4.9 in McLennan County compared to the 3.3 in the state and 2.3 among County Health Rankings Top Performer. 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.

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. 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.

According to the National Cancer Institute, the annual incidence of all cancers in McLennan County is higher than the state value. And the National Vital Statistics System reports the community's mortality rate exceeds the state rate for the following chronic conditions: heart disease, cancer, stroke, and chronic lower respiratory disease (CLRD).

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. According to the CDC, adult obesity rate in McLennan County is 28.6% which is just above the state's rate of 29%. 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.

Access to 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 2,322:1 in McLennan County which was significantly higher than 1,708 people per physician in the state.

Prenatal Care emerged as a need through extensive data collection. 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%.

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 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 21% in McLennan County, 17% in the state, and 14% among the County Health Rankings Top Performers. The medical community recognizes that tobacco use often impacts 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.

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 http://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 Medical Center – Hillcrest is a licensed not-for-profit hospitals and as such has 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 these clinics are not required by law to report their 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 Medical Center – Hillcrest and the Scott & White Clinic, Hillcrest Family Health Center and Hillcrest Physician Services hope to make a positive impact on the following significant community health needs:

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

The completed implementation strategy was adopted by the Baylor Scott & White Medical Center – Hillcrest Board of Directors on November 4, 2016.

Mental Health Services

Facility: Baylor Scott & White – Hillcrest and Hillcrest Physician Services
Program Name: Emergency Department Placement and Referrals
Program Description: The ED treats many patients that come in suffering from anxiety and depression. Due to the lack of resources to meet mental health needs it is not uncommon for patients to wait days or weeks before being able to secure available space for continued mental health care. The hospital is enlisting a TelePsych component to expedite placement and to help Trauma and ED providers determine need for a patient's placement in a mental health facility. Psychiatrists will also be able to guide ED physicians on more commonly occurring psychiatric medications. Hillcrest ED staff are working with local municipal judges to establish a more efficient process to assist with paperwork. The hospital will also continue to maintain an accurate database of community resources to which patients may be referred upon discharge as well as provision of educational information.
Anticipated Impact: Reduction in waiting time for the patient to establish continued mental health care and improved number of referrals to community resources.
Metrics: # of patient referrals # of community resources available to patients Time period between admission and discharge to continued mental health care # of TelePsych placements
Committed Resources: -ED nursing staff -cost of new TelePsych services

Facility: Baylor Scott & White - Hillcrest
Program Name: Prosper Waco – Mental Health Collaborative
Program Description: Prosper Waco is a community collaboration to impact the education, financial security and health (physical and mental) of McLennan County and in particular, the city of Waco. Monthly meetings of steering committees for each targeted area of impact occur and are open to the public for true community impact. OKAY TO SAY campaign: Developed by the Meadows Mental Health Policy Institute, is a community-wide campaign raises awareness about mental health and aims to erase the taboo of talking about mental health issues. Alongside Baylor Scott & White-Hillcrest, NAMI-Waco, Providence Healthcare Network, and Lowe's of Waco and a number of other local organizations, employers and clinics are working together to implement the Okay to Say campaign in the Waco community. On each piece of collateral placed in the partner sites around Waco, there is a 24/7 crisis text line referenced that people can use if they are having a mental health crisis. Callers will get an immediate response from a crisis counselor.
Anticipated Impact: The Hospital will work with this community collaborative to achieve 2 goals: (1) Decrease use of ER for mental health treatment by 25 percent. (2) Improve "poor mental health days" component of RWJF rankings to Texas average
Metrics:

-# of clients served by collaborating partners -improved long-term measurements of mental health needs identified in community assessment (number of mentally unhealthy days, # of providers per individual, etc). - use of local EDs for mental health treatment - # of poor mental health days
Committed Resources: -staff time in meetings and on collaborative projects -educational resources for community health -data acquisition, validation, and analysis

Facility: Baylor Scott & White - Hillcrest
Program Name: Behavioral Health Symposium
Program Description: Baylor Scott & White – Hillcrest hosts an annual symposium on behavioral health with Baylor University to help address the negative stigma of seeking mental health care services and the lack of resources in the community. The symposium is attended by healthcare providers, school counselors, faith community, University educators, and the general community.
Anticipated Impact: improved access to mental health services and stronger community collaborations.
Metrics: -# of symposium participants - use of local EDs for mental health treatment - # of poor mental health days
Committed Resources: -staff time speaking at event -promotional efforts

Facility: Scott & White Clinic, Hillcrest Family Health Center, and Hillcrest Physician Services
Program Name: Mental Health Services in Primary Care
Program Description: Five mental health service providers have been embedded into the **Scott & White** Waco regional family medicine clinic. 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. We anticipate achieving value 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. The **Hillcrest Family Health Center** recognizes the need for added mental health services in the primary care setting and is evaluating adding mental health providers to some of the primary care locations over the next few years. **Hillcrest Physician Services** currently has a mental health social worker embedded in the MacArthur Clinic which primary treats senior citizens.
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: - Retail Value Units (RVUs) - # of Patient Visits
Committed Resources: Salaries for 5 FTEs

Chronic Illness

Facility: Baylor Scott & White - Hillcrest
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**: Through the 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. -**CDE**: A newly hired certified diabetes educator (CDE) will be focused on providing diabetes management care and services in the outpatient setting.
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 -full time Certified Diabetes Educator (CDE)

Facility: Baylor Scott & White – Hillcrest, Hillcrest Family Health Center, and Hillcrest Physician Services
Program Name: Chronic Care Management
Program Description: Participants can either be self-referred or referred by a physician or nurse. With all chronic disease processes, participants are evaluated by hospital staff and set up with individual goals for improvement. An intervention plan of education and exercise is established. Followup discussions are held between the patient and the provider to assess progress on meeting personal goals.
Anticipated Impact: Participants have an increased knowledge and awareness of community members on achieving and living a healthy lifestyle
Metrics: -improved scores on diet survey -participant demonstrates competency or understanding in areas taught

Committed Resources: -staff time (160 hours/month)

Facility: Baylor Scott & White - Hillcrest
Program Name: Lung and Breast Cancer Screenings
Program Description: CT Lung CA Screening – Low dose Computed Tomography (CT) chest ordered for patients who meet the criteria of age 55-77, current or history of smoking, asymptomatic. High Risk breast cancer screening – – Women obtaining annual mammograms complete a personal and family history form; if genetic risk-factors are evident and after provider assessment and discussion, a genetic cancer screening may be completed to indicate if women at higher-risk of breast cancer need more frequent breast cancer screenings or other care." 2D and 3D Tomo Mammography - Screening or diagnostic exam performed with 2D mammography for detection of breast cancer.
Anticipated Impact: Improve rate of early detection of cancer incidence.
Metrics: -Track volumes -CT - Track % of positive results -MyRisk - Track % of high risk -MyRisk – Track % of genetically positive cancers
Committed Resources: -$481,950 in FY17 for purchase of 3D Tomo Mammography

Facility: Baylor Scott & White – Hillcrest
Program Name: McClinton Cancer Center Education and Outreach
Program Description: The cancer center staff dedicates time to advocating and bringing awareness to the prevention, detection, and treatment of various cancers in the community. This includes information about proper screening guidelines and where to seek help when needed, particularly for breast, lung, colorectal, prostate, and skin cancers.
Anticipated Impact: Increased knowledge and awareness in community members around prevention and detection of various types of cancer.
Metrics: -staff hours at community events -# of people reached -# of community events
Committed Resources: -staff time (20 hours/month)

Facility: Baylor Scott & White – Hillcrest and Hillcrest Physician Services
Program Name: McClinton Cancer Center Comprehensive Care
Program Description: The Baylor Scott & White McClinton Cancer Center is a Commission on Cancer accredited program through the American College of Surgeons and provides medical oncology, radiation oncology, supportive oncology, integrative oncology, lab, pharmacy, and lymphedema care in one location. At the cancer center, support groups or awareness events occur each month. Ongoing evaluation of the need for additional providers is done to provide the best cancer care. The Baylor Scott & White McClinton Cancer Center partners with the following organizations in various ways: American Cancer Society; Susan G. Komen for the Cure; LIVESTRONG Foundation; Leukemia & Lymphoma Society; Waco Family Health Center; Hillcrest Family Health Centers; Hillcrest Physician Services; MD Anderson Cancer Center; Baylor University (numerous disciplines/schools/programs); Gourmet Gallery. **HPS** Specialists participate regularly in tumor boards and hold community screening events for various cancers including prostate, colorectal and breast.
Anticipated Impact: Central Texans in the Waco Region will have high-quality, comprehensive cancer care locally.
Metrics: -number of patients receiving care -number of patient appointments -number of community outreach events
Committed Resources: $35 million annually

Facility: Baylor Scott & White - Hillcrest
Program Name: Hillcrest Breast Center Outreach
Program Description: Hillcrest's Breast Center staff dedicate time to advocating and bringing awareness to breast health in the community. This includes information about current screening recommendations, self-breast exams, the new genetics and high risk breast program and where to seek help when needed.
Anticipated Impact: Reduction in the incidence of late state cancers going undetected. -Women at high-risk of developing breast cancer will learn steps they can take to reduce their risk.
Metrics: -staff hours at community events -# of women reached -# of high-risk women identified -# of women that meet criteria to be genetically tested
Committed Resources: -staff time 100 hours/year

Facility: Baylor Scott & White - Hillcrest
Program Name: Getterman Chronic Disease Wellness Programs
Program Description: The hospital provides a variety of evidence-based community programs through the Getterman Wellness Center to help community members get in shape and stay fit. – Stroke: created out of necessity for patients in need of therapy after their P.T. had been completed &/or exhausted – Orthopedic: focus is to decrease pain and postpone the inevitable joint replacement General Wellness: MS, Diabetes, PVD, Fibromyalgia, Osteoporosis, Pulmonary Dysfunction, Obesity, Hypertension, Congestive Heart Failure, and Risk Reduction
Anticipated Impact: Program participants learn how to manage their disease and maintain appropriately healthy lifestyles.
Metrics: - # of patients participating in programs - sustained participation in maintenance programs - patients demonstrate understanding in areas taught
Committed Resources: -staff time (1 FTE)

Facility: Baylor Scott & White – Hillcrest and Hillcrest Physician Services
Program Name: Advanced Care Planning
Program Description: Provide advanced care planning for patients with high risk and chronic illness, and underserved populations. The palliative care professionals are experts in discussing with patients their future health care options such as advanced directives, living will, power of attorney, and end-of-life discussion.
Anticipated Impact: Provide access to advanced care planning for patients and families with high risk and chronic Illness populations.
Metrics: -Increase percent of discharges seen by Supportive and Palliative Care. -Increase number of unique patient visits.
Committed Resources: - $600,000 annually - 1 FTE Nurse Practitioner

Facility: Baylor Scott & White – Hillcrest, Hillcrest Family Health Center, and Hillcrest Physician Services
Program Name: Community Events/Health Fairs
Program Description: Baylor Scott & White - Hillcrest 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. Southwest Sports Medicine conducts high school athlete physicals, as well as first-responder screenings and physicals
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
-It's a Guy Thing
-For Women For Life

Facility: Scott & White Clinic, Hillcrest Family Health Center, and Hillcrest Physician Services

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. **HFHC** has also adopted the PCMH model and **HPS** has one clinic operating this way and is moving towards establishing all their clinics in the PCMH model. 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 and Hillcrest Physician Services
Program Name: Pneumonia Vaccinations
Program Description: This is a clinic initiative across all Scott & White sites (Hemingway Pulmonary Clinic, Temple Sleep Clinic, Temple Pulmonary Clinic, and Hillcrest Pulmonary Clinic) as well as HPS clinic locations 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 Staff time

Facility: Baylor Scott & White– Hillcrest, Scott & White Clinic, Hillcrest Family Health Center, and Hillcrest Physician Services
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: Hillcrest Family Health Center

Program Name: HFHC Division of Clinical Research

Program Description: Hillcrest Family Health Center maintains a clinical research office that operates as an adjunct to the Family Practice offices at The Bosque Clinic.
In 2014, Dr Allison obtained his Certified Physician Investigator status and currently serves as a Global Investigator Panel expert member for a large Pharmaceutical company.
The operation is led by Dr. Crawford Allison, and supported by three Clinical Research coordinators. The department has participated in more than 30 clinical trials in a variety of areas of medicine including Diabetes, Pain, Dermatology, Respiratory, Kidney Disease, Eczema, Influenza, Chronic Pain, Hypertension.
Research trials offer opportunities for the community to have treatment that may otherwise not be available in a practice setting. It also provides education to the community about the process of bringing a medication to the market and the role the FDA plays in that process. The department also encourages our patients to consider the benefits of research in regards to the greater good. Participating in a clinical trial today could potentially affect the outcome of a lifesaving medication or device tomorrow. The clinical research division provides invaluable services to our community and patients by seeking to be on the breaking edge of new treatment options for diseases for those who may feel they have run out of more traditional choices and that could potentially change lives.

Anticipated Impact: Research often provides patient centered education on disease process, treatment options and insights to the future that allow the patient greater autonomy, and often makes them feel more knowledgeable regarding their health care decisions. Enabling the patient in this manner often leads to better overall compliance and in turn, better health.

Metrics:
-Efficacy of individual medications
-A1c levels maintained under trial conditions
-# of subjects per trial
-# of trials per year
-all established measurements for each trial pertaining to the disease

Committed Resources:
- 1 physician
- 3 clinical researchers

OBESITY

Facility: Baylor Scott & White - Hillcrest
Program Name: Farmers Market /Veggie Van
Program Description: Provide easy access on site to fresh local fruits and vegetables to patients, their families, staff, and the entire community.
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: - 8 hours/month planning and coordinating market - Promotional signs and advertising

Facility: Baylor Scott & White – Hillcrest
Program Name: Getterman Wellness Programs
Program Description: The hospital provides a variety of free evidence-based community programs through the Getterman Wellness Center to help community members get in shape and stay fit. The Getterman Wellness Center hosts weekly fitness classes for employees and community members. Classes occur weekly throughout the year, or biannually for 6 to 8 week sessions. The following classes are offered to employees at no cost, and community members can participate for a nominal fee. - Yoga (weekly) - Zumba (weekly) - Tai Chi (biannually) - Cardiac Yoga (biannually)
Anticipated Impact: Improve the overall health and wellness of employees and community members in Central Texas in a fun, consistent and accessible group atmosphere.
Metrics: - number of participants - number of classes offered annually
Committed Resources: - instructor hours (1 hour/week/instructor) - instructor fees ($25/hour) - staff hours planning, coordinating, and advertising (8 hours/month)

Facility: Baylor Scott & White - Hillcrest
Program Name: Community Nutrition Outreach for at risk clients of Caritas
Program Description: This program will provide quarterly healthy eating education and Medical Nutrition Therapy disease management to those in our community seeking Caritas services.
Anticipated Impact: Caritas clients will make healthier nutrition choices to help prevent and control nutrition related diseases
Metrics: - client knowledge with regards to nutrition in pre and post surveys -client reported behavior changes in nutrition choices
Committed Resources: - 10 staff hours/ month

Facility: Baylor Scott & White - Hillcrest
Program Name: Healthy Choices with Supplemental Nutrition Assistance Program (SNAP)
Program Description: This program will provide budget conscious healthy eating education for Care Net of Central Texas clients. We will also teach Care Net clients how to make healthy choices with their SNAP benefits.
Anticipated Impact: Care Net clients will like to learn how to provide healthy meals to their families on a budget.
Metrics: - client knowledge with regards to nutrition in pre and post surveys -client reported behavior changes in nutrition choices
Committed Resources: - 10 staff hours/ month

Facility: Baylor Scott & White - Hillcrest
Program Name: Community Health Financial and In – Kind Contributions
Program Description: The hospital 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: - approximately $200,000 annually

Facility: Baylor Scott & White – Hillcrest, Scott & White Clinic, and Hillcrest Physician Services
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**
Anticipated Impact: These programs 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

Facility: Baylor Scott & White - Hillcrest
Program Name: YMCA Partnership
Program Description: Annual service on the YMCA of Central Texas's Medical Advisory Board
Anticipated Impact: To leverage the healthcare-related resources and programs of other non-governmental organizations, particularly physical fitness, emotional health, and obesity and diabetes-prevention programs, to serve patients and family members who may also be receiving care within BSWH Waco Region facilities and needing free or low-cost community services.
Metrics: -Number of meetings attended -Number of programs in operation through YMCA
Committed Resources: - Staff time to attend monthly YMCA Medical Advisory Board meetings and share information among the Hillcrest campus related to YMCA programs, approximately 20 hours annually.

ACCESS TO CARE

Facility: Baylor Scott & White – Hillcrest, Hillcrest Family Health Center, Hillcrest Physician Services
Program Name: Medicaid 1115 Waiver (Limestone Specialty Clinic)
Program Description: The hospital helps provides service to rural communities that do not have direct access to specialty services that is provided in larger communities. Services such as general surgery, orthopedics, OB-GYN, and pediatrics rotate times at Limestone Medical Center, a community hospital, which is not able to provide services currently needed in the rural communities. Pediatricians from the Hillcrest Family Health Clinic are on regular rotations to care for patients at the specialty clinic. HPS also provides wound care at the specialty clinic in Limestone. HPS treats patients in Hamilton through the Southwest Sports Medicine to help provide additional care to rural areas.
Anticipated Impact: Improve access of specialty care for the rural areas of our community including underserved population.
Metrics: -Number of patients seen -Number of new services offered
Committed Resources: -Hospital: $100,000 annually -HPS: 2 physicians in Hamilton - HPS: 8 providers for specialty clinic (MD, APP)

Facility: Baylor Scott & White - Hillcrest
Program Name: Faith Community Health
Program Description: Faith Community Health pairs at risk patients with Faith Community Caregivers, volunteers that agree to visit with the patient 1 hour per week. The volunteer aims to help the patient become more compliant with their medical regimen and discharge instructions. Case managers and BS&W Navigators also help them reach the resources they need including transportation. As the program develops, and in partnership with Prosper Waco, more opportunities will be developed to help patients. Community partners include: Prosper Waco, Faith Communities (i.e. churches), and Faith Community Caregivers (trained community volunteers). Faith Community Caregivers will be assigned to highest risk patients as available and utilized in every way possible in cooperation with other programs and services provided by Hillcrest including but not limited to: (Chronic Disease Wellness Programs, Diabetes Education, McClinton Cancer Center, and Chronic Kidney Disorder Education).
Anticipated Impact: Reduction in readmission rates of patients.
Metrics: -readmission rates -Number of volunteers -Number of patients served by Faith Community Caregivers -specify some health outcomes being measured of those receiving help with transportation services

Committed Resources:
- $66,000 annually for staff and expenses

Facility: Baylor Scott & White - Hillcrest

Program Name: Nurse Family Partnership (NFP)

Program Description: Nurse-Family Partnership is an evidence-based community healthcare program that empowers low-income, first-time mothers to become confident parents and strong women by partnering with nurse home visits. Nurse home visits begin early in the mother's pregnancy and continue visitation until the child's second birthday. Nurses provide support, resource connections, education and counseling on health, behavioral and self-sufficiency issues.

The Nurse-Family Partnership program has a history of well documented success in working with First Time Pregnant women and then with their infant for the following two years in achieving 3 goals
*Improve Pregnancy Outcomes
*Improved Infant Health
*Improved Financial Stability for the Family

Our criteria for identifying clients:
Must live in McLennan County
Must be less than 29 weeks pregnant
Must meet income criteria of living at 185% below poverty level

Assessments/Access:
Our In-Home Curriculum delivered by Bachelor prepared RNs allows us to reduce problems with access to care. We provide education/information on chronic illnesses, obesity /general nutrition, smoking cessation, child development, parenting skills, appropriate immunizations, and planning for a healthier future.

The nurses perform regular assessments of mother and baby over the 30 months that the client is participating in our program.

These assessments include vitals on every visit, child development at 8 week intervals, and pre- and post-partum depression screenings.

Action Steps:
2017: Increase awareness of the program and benefits to the community. Client capacity at 150
2018: Increase our Nurse Home Visitor team by 2 nurses (1:25 case management ratio) to increase our client capacity to serve 200.
2019: Expand services to other counties – focusing on Bell, Limestone, Falls

Anticipated Impact: Low-income, first-time mothers will become confident parents and have increased full term births with normal weight babies.

Metrics:
- client retention
- client capacity
- % full term delivery rates
- maternal outcomes

- % breast feeding and continuation within 6 months
- # days in the Neonatal Intensive Care Unit after delivery
- child development scoring
- utilization of other health care providers
- % smoking
- incidence of domestic violence
- use of prescription and non-prescription drugs

Committed Resources:
-$718,000 5 year grant
-$200,000 operational dollars

Facility: Baylor Scott & White - Hillcrest and Hillcrest Physician Services

Program Name: Nurse Navigation (Oncology & Cardiology)

Program Description: Oncology Nurse Navigators and Cardiac Nurse Navigators connect patients without primary care providers within the areas of service to primary care providers.
This program will develop quick pathways of care between all specialty services and primary care networks to connect patients to primary care providers. Oncology Nurse Navigators and Cardiac Nurse Navigators partner with the following organizations in various ways to get patients the primary care they need: Hillcrest Family Health Centers; Waco Family Health Center; S&W Primary Care; Prosper Waco.

Anticipated Impact: Patients in sub-specialty care will have a primary care provider to care for primary care needs during or after acute care

Metrics:
-number of patients without primary care providers subsequently connected to a primary care provider

Committed Resources:
-staff time of all oncology and cardiac nurse navigators
-160 hours per week (2 full-time oncology nurse navigators and 2 full-time cardiac nurse navigators)

Facility: Baylor Scott & White - Hillcrest

Program: Prosper Waco – Community Health Worker (CHW) Program

Program Description: Community Health Workers (CHWs) are community members who undergo 160-hour state-approved training to understand health issues, the healthcare system and strategies for leading a healthy lifestyle. CHWs work at the grassroots level to connect their friends, family, and neighbors to local health resources and reinforce ways to lead a healthier lifestyle. Along with partnering on the CHW program, Family Health Center is training social workers to work alongside doctors and nurses to support patients in its clinics. These Integrated Health Managers (IHM) will provide support to patients on a variety of topics that busy doctors and nurses may not have the time to address. The IHM's can talk to patients about any mental or behavioral health concerns, help them understand their doctor's instructions and how to fill their prescriptions, and other health-related issues. This will provide patients a more personal level of attention so they can receive the best healthcare possible. Both the CHW and IHM programs are supported by an Episcopal Health Foundation grant of $586,735 divided over three years. Other financial support and in-kind donation is provided by the City of Waco, Family Health Center, Providence Healthcare Network and Baylor Scott & White - Hillcrest.

Anticipated Impact: Increased number of people covered by health insurance. Reduction in the number of people utilizing the ED as a source of primary care.
Metrics: -improved long-term numbers in community assessment identified needs -% of uninsured residents -# of people assisted by CHWs - ED use for non-emergencies
Committed Resources: -staff time in meetings and on collaborative projects -educational resources for community health -data acquisition, validation, and analysis

Facility: Scott & White Clinic and Hillcrest Family Health Center
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. **HFHC** does flu clinics for their patients as well as for specific employers in the area.
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: Scott & White Clinic, Hillcrest Family Health Center, and Hillcrest Physician Services
Program Name: Patient Centered Medical Home (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. **HFHC** has also adopted the PCMH model and **HPS** has one clinic operating this way and is moving towards establishing all their clinics in the PCMH model. 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

Facility: Baylor Scott & White– Hillcrest, Scott & White Clinic, Hillcrest Family Health Center, and Hillcrest Physician Services

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
- The **HPS** MacArthur Clinic accepts patients upon discharge from the hospital who need to establish primary care or be seen for continuing internal medicine care.

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

PRENATAL CARE

Facility: Baylor Scott & White - Hillcrest and Hillcrest Physician Services
Program: Women's and Children's Services
Program Description: Hillcrest Women's & Children's Center offers comprehensive women's health care in obstetrics and gynecology. One aspect of care provided is prenatal care. Prenatal care focuses on preventative healthcare with the goal of providing regular check-ups from Physicians to treat and prevent potential health problems throughout the course of the pregnancy. Women's Services at BSW Hillcrest works in collaboration with OB/GYN physicians and Family Medicine physicians to encourage early and regular access to prenatal care. Through this supportive care patients get advice on nutrition, exercise for a healthy pregnancy, controlling pre-existing conditions and/or treating pregnancy related conditions that may develop, and to make sure the baby is growing and developing appropriately. Education classes are taught by nursing staff and open to the community. We hold classes on prepared childbirth, breastfeeding classes, newborn care classes, and car seat safety.
Anticipated Impact: To ensure both mother and baby receive appropriate supportive care in order to have a healthy and safe delivery.
Metrics: -% of full term delivery rates - Maternal Outcomes - # of births that occur before 39 weeks gestation
Committed Resources: Hospital -100+ FTEs (L&D Nursing unit, Moth/Baby Nursing Unit) HPS – 6 FTE NPs ($500,000) for NICU

Facility: Baylor Scott & White - Hillcrest
Program: Prosper Waco – Well Woman Collaborative
Program Description: As a member of Prosper Waco's Women's Health Work Group, Hillcrest is working with other local healthcare providers and community organizations to develop a community-wide awareness campaign that will prompt women in our community to receive their annual well-woman exam. The awareness campaign will focus on the importance of women receiving preventative care to remain healthy and increase their chances of a healthy pregnancy. The campaign will educate women on their options for healthcare, regardless of insurance.
Anticipated Impact: -Reduction in disparities of poor birth outcomes. - Increase the number of women receiving annual preventative care. -Reduction in teen pregnancy rate across all racial groups.
Metrics: - improved long-term numbers in community assessment identified needs - % of women in McLennan County receiving well-women exams - individuals covered by health insurance - number of overweight/obese individuals - pre-term birth/low birth weight infants - number of women receiving annual preventive care

- rate of teen pregnancy

Committed Resources:
- staff time in meetings and on collaborative projects
- educational resources for community health
- data acquisition, validation, and analysis

Facility: Baylor Scott & White - Hillcrest

Program Name: Nurse Family Partnership (NFP)

Program Description: The Nurse-Family Partnership program is in place to provide a bachelor prepared nurse for home visitation on a non-clinical but educational visit to encourage healthy choices, prenatal care, smoking cessation, and empower meeting goals in career development to ensure financial independence. Nurse-Family Partnership is an evidence-based community healthcare program that empowers low-income, first-time mothers to become confident parents and strong women by partnering with nurse home visits. Nurse home visits begin early in the mother's pregnancy and continue visitation until the child's second birthday. Nurses provide support, resource connections, education and counseling on health, behavioral and self-sufficiency issues.

The Nurse-Family Partnership program has a history of well documented success in working with First Time Pregnant women and then with their infant for the following two years in achieving 3 goals
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The nurses perform regular assessments of mother and baby over the 30 months that the client is participating in our program.

These assessments include vitals on every visit, child development at 8 week intervals, and pre- and post-partum depression screenings.

Action Steps:
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2018: Increase our Nurse Home Visitor team by 2 nurses (1:25 case management ratio) to increase our client capacity to serve 200.
2019: Expand services to other counties – focusing on Bell, Limestone, Falls

Additional NFP Partners:

NFP is part of the Healthy Babies Coalition – a group of over 20 social service agencies and partners focused on Women and Children's health-- CareNet, Parents as Teachers, Avance, EOAC Head Start, Waco Public Health Department, WIC, Family Health Center residency and clinics, Providence Hospital, Baylor Scott & White, Superior, Amerigroup and Right Care.

NFP provides regular blood pressure screenings and education to the community through scheduled participation with Shepherd's Heart, Caritas and Family in Faith food pantries.

NFP also partners with all the local school districts, many churches, and local service organizations like Lions Club and Rotary.

NFP representatives sit on the Women's Health initiative sub-committee for Prosper Waco- an initiative to bring business and health care providers together to improve our city.

NFP representatives sit on the board for Texas-AgriLife Extension offices for delivering education to the community on healthy living, diabetes and chronic disease management, and financial planning/life skills.

NFP representatives sit on the board for the Aging and Disability Resource Center (ADRC) of the Heart of Texas Council of Governments to help with education to the community on various resources and appropriate access to care and housing.

Anticipated Impact: Increased full term births with normal weight babies, and families less dependent on the county and government resources.

Metrics:

- client retention
- client capacity
- % full term delivery rates
- maternal outcomes
- % breast feeding and continuation within 6 months
- # days in the Neonatal Intensive Care Unit after delivery
- child development scoring
- utilization of other health care providers,
- % smoking
- incidence of domestic violence
- use of prescription and non-prescription drugs

Committed Resources:

-$718,000 5 year grant
-$200,000 operational dollars

Facility: Baylor Scott & White - Hillcrest ,and Hillcrest Physician Services

Program: Low-Birth Weight Clinic

Program Description: The hospital and healthcare specialists in the NICU make follow-up care available to all babies born at Hillcrest with a low-birth weight.

Goals of the Clinic:

- The identify problems early in growth, behavior and neuro-developmental issues
- To assist the primary care providers (PCP) in managing developmental issues unique to NICU graduates
- To assist in coordinating care with PCPs and specialists
- To assist in the coordination of assistance available to families of infants with disabilities
- To develop outcome studies for NICU populations
- Identify readmission rates and reasons for readmissions to develop strategies for prevention

Patient Criteria

- less than 35 weeks gestation
- 35 weeks to term and at risk for developmental delay

Frequency of visit (visits are in addition to regular pediatrician visits)

- Within one to two weeks of discharge
- At 1 month from discharge, then 3 months from discharge, then every 3 months until 18-24 months of age

More frequent visits are necessary if infant is not gaining weight or if there are other identified needs or concerns.

Anticipated Impact: To ensure all babies born with low birth weight grow and gain weight at a healthy rate through comprehensive medical care after leaving the NICU.

Metrics:

- growth rate
- infant weight gain
- # of visits
- # of NICU discharges
- readmission rates
- reason for readmission

Committed Resources:

-.75 FTE

Tobacco Use

Facility: Baylor Scott & White - Hillcrest
Program Name: Smoking Cessation Program at Getterman Wellness Center
Program Description: Community members can register themselves or join this program on referral from a physician. Participants are evaluated by staff and set up with individual goals. A quit day must be imminent in order for them to qualify to participate. Participants attend class (1 ½ hours) once a week for 6 weeks.
Anticipated Impact: community members are better able to manage health conditions health by eliminating tobacco use as a risk factor
Metrics: - Continued participation and working through their struggles through self-reporting - Days without smoking
Committed Resources: -approximately $285 per class for staff time and materials.

Facility: Baylor Scott & White - Hillcrest and Scott & White Clinic
Program Name: Texas *Quitline*
Program Description: The hospital is working to implement Quitline within our electronic health record system which offers free and confidential phone counseling services and resources such as nicotine patches, gums, or lozenges, to those who register desiring to quit smoking. The program is integrated into the hospital's EMR to allow for easy referral to the program.
Anticipated Impact: Reduction in #1 preventable risk factor for all chronic diseases
Metrics: - # of monthly referrals to Quitline - # of monthly referrals to Quitline through Oncology - services provided to patient from Quitline identified on HER - # of participants that quit smoking
Committed Resources: -staff time for programming within Epic (estimated 31 hours) -staff time testing between BSWH and the QuitLine (estimated 13 hours) -Training Time (for docs, nurses, and support staff) estimated 81 hours -Cost of implementation (estimated $11,000)

Additional Metrics for Identified Needs Where Applicable:

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 Clinics plan to collaborate with:

- Waco Prosper
- Baylor University
- City of Waco
- Waco McLennan County Public Health District
- Waco Family Health Center
- Farmers Market vendors
- American Diabetes Association
- American Cancer Society
- American Heart Association
- Local Independent School Districts
- Caritas
- Healthy Babies Coalition
- Limestone Medical Center
- Aging and Disability Resource Center

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 Tara.Stafford@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	Mental Health	Chronic Illness	Obesity	Access to Care	Prenatal Care	Tobacco Use
Baylor Scott & White - Hillcrest	✔	✔	✔	✔	✔	✔
Scott & White Clinic	✔	✔	✔	✔		✔
Hillcrest Family Health Center (HFHC)	✔	✔		✔		
Hillcrest Physician Services (HPS)	✔	✔	✔	✔	✔	