Baylor Scott & White Health
Community Health Needs Assessment

Hill Country Health Community

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

Approved by: Baylor Scott & White Health – Central Texas Operating, Policy and Procedure Board, May 17, 2019
Posted to BSWHealth.com/CommunityNeeds on June 30, 2019

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Baylor Scott & White Health Mission Statement

Our Mission

Founded as a Christian ministry of healing, Baylor Scott & White Health promotes the well-being of all individuals, families and communities.

Our Ambition

To be the trusted leader, educator and innovator in value-based care delivery, customer experience and affordability.

Our Values

- We serve faithfully
- We act honestly
- We never settle
- We are in it together

Our Strategies

- Health – Transform into an integrated network that ambitiously and consistently provides exceptional quality care
- Experience – Achieve the market-leading brand by empowering our people to design and deliver a customer-for-life experience
- Affordability – Continuously improve our cost discipline to invest in our Mission and reduce the financial burden on our customers
- Alignment – Ensure consistent results through a streamlined leadership approach and unified operating model
- Growth – Pursue sustainable growth initiatives that support our Mission, Ambition, and Strategy

WHO WE ARE

As the largest not-for-profit healthcare system in Texas and one of the largest in the United States, Baylor Scott & White Health was born from the 2013 combination of Baylor Health Care System and Scott & White Healthcare. Today, Baylor Scott & White includes 50 hospitals, more than 900 patient care sites, more than 7,500 active physicians, and over 47,000 employees and the Scott & White Health Plan.


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Executive Summary

As the largest not-for-profit health care system in Texas, Baylor Scott & White Health (BSWH) understands the importance of serving the health needs of its communities. In order to do that successfully, we must first take a comprehensive look at the systemic and local issues our patients, their families and neighbors face when it comes to having the best possible health outcomes and well-being.

Beginning in June of 2018, a BSWH task force led by the Community Health, Tax Services, and Marketing Research departments began the process of assessing the current health needs of the communities served for all BSWH hospital facilities. IBM Watson Health (formerly known as 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 2019.

BSWH owns and operates multiple individual licensed hospital facilities serving the residents of North and Central Texas. Two hospitals with overlapping communities have collaborated to conduct this joint community health needs assessment. This joint community health needs assessment applies to the following BSWH hospital facilities:

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

For the 2019 assessment, the community served by these hospital facilities includes Blanco, Burnet, Llano, and San Saba Counties. BSWH has at least one hospital facility or a provider-based clinic in each of these counties and together they comprise where more than 80% of the clinic and hospitals' admitted patients live. These hospital facilities collaborated to conduct a joint CHNA report in accordance with Treasury Regulations and 501(r) of the Internal Revenue Code. All of the collaborating hospital facilities included in this joint CHNA report define their community, for purposes of the CHNA report, to be the same.

Hospital facilities and IBM Watson Health (Watson Health) examined over 102 public health indicators and conducted a benchmark analysis of the data comparing the community to overall State of Texas and United States (U.S.) values. For a qualitative analysis, and in order to get input directly from the community, focus groups and key informant interviews were conducted. Interviews included input from state, local, or regional governmental public health departments (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.

Needs were first identified when an indicator for the community served was worse than the Texas state benchmark. A need differential analysis conducted on all the low performing indicators determined relative severity by using the percent difference from benchmark. The outcome of this quantitative analysis aligned with the qualitative findings of the community input sessions to create a list of health needs in the community. Each health need received assignment into one of four quadrants in a health needs matrix, which clarified the assignment of severity rankings of the needs. The matrix shows the convergence of needs identified in the qualitative data (interview and focus group

feedback) and quantitative data (health indicators) and identifies the top health needs for this community.

Hospital clinical leadership and/or other invited community leaders reviewed the top health needs in a meeting to select and prioritize the list of significant needs in this health community. The meeting, moderated by Watson Health, included an overview of the CHNA process for BSWH, the methodology for determining the top health needs, the BSWH prioritization approach, and discussion of the top health needs identified for the community.

Participants identified the significant health needs through review of data driven criteria for the top health needs, discussion, and a multi-voting process. Once the significant health needs were established, participants rated the needs using prioritization criteria recommended by the focus groups. The sum of the criteria scores for each need created an overall score that was the basis of the prioritized order of significant health needs. The resulting prioritized health needs for this community include:

Priority	Need	Category of Need
1	Ratio of Population to One Mental Health Provider	Mental Health
2	Children in Poverty and Uninsured	SDH - Income / Access to Care
3	Diabetes Short-Term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes
4	Primary Care Providers (MD/Non-MD)	Access to Care
5	Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation

As part of the assessment process, community resources were identified, including facilities/organizations, that may be available to address the significant needs in the community. These resources are located in the appendix of this report and will be included in the formal implementation strategy to address needs identified in this assessment, 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 2016 assessment is also included in **Appendix F** of this document.

The prioritized list of significant health needs approved by the hospitals' governing body and the full assessment is available to anyone at no cost. To download a copy, visit **BSWHealth.com/CommunityNeeds** .

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

Community Health Needs Assessment Requirement

As a result of the Patient Protection and Affordable Care Act (PPACA), all tax-exempt organizations operating hospital facilities are required to assess the health needs of their community through a Community Health Needs Assessment (CHNA) once every three years.

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 significant 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 healthcare facilities, organizations, 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

CHNA Overview, Methodology and Approach

BSHW began the 2019 CHNA process in June of 2018; the following is an overview of the timeline and major milestones.

BSWH partnered with Watson Health to complete a CHNA for qualifying BSWH hospital facilities.

Consultant Qualifications & Collaboration

Watson Health delivers analytic tools, benchmarks, and strategic consulting services to the healthcare industry, combining rich data analytics in demographics, including the Community Needs Index, planning, and disease prevalence estimates, with experienced strategic consultants to deliver comprehensive and actionable Community Health Needs Assessments.

Collaboration

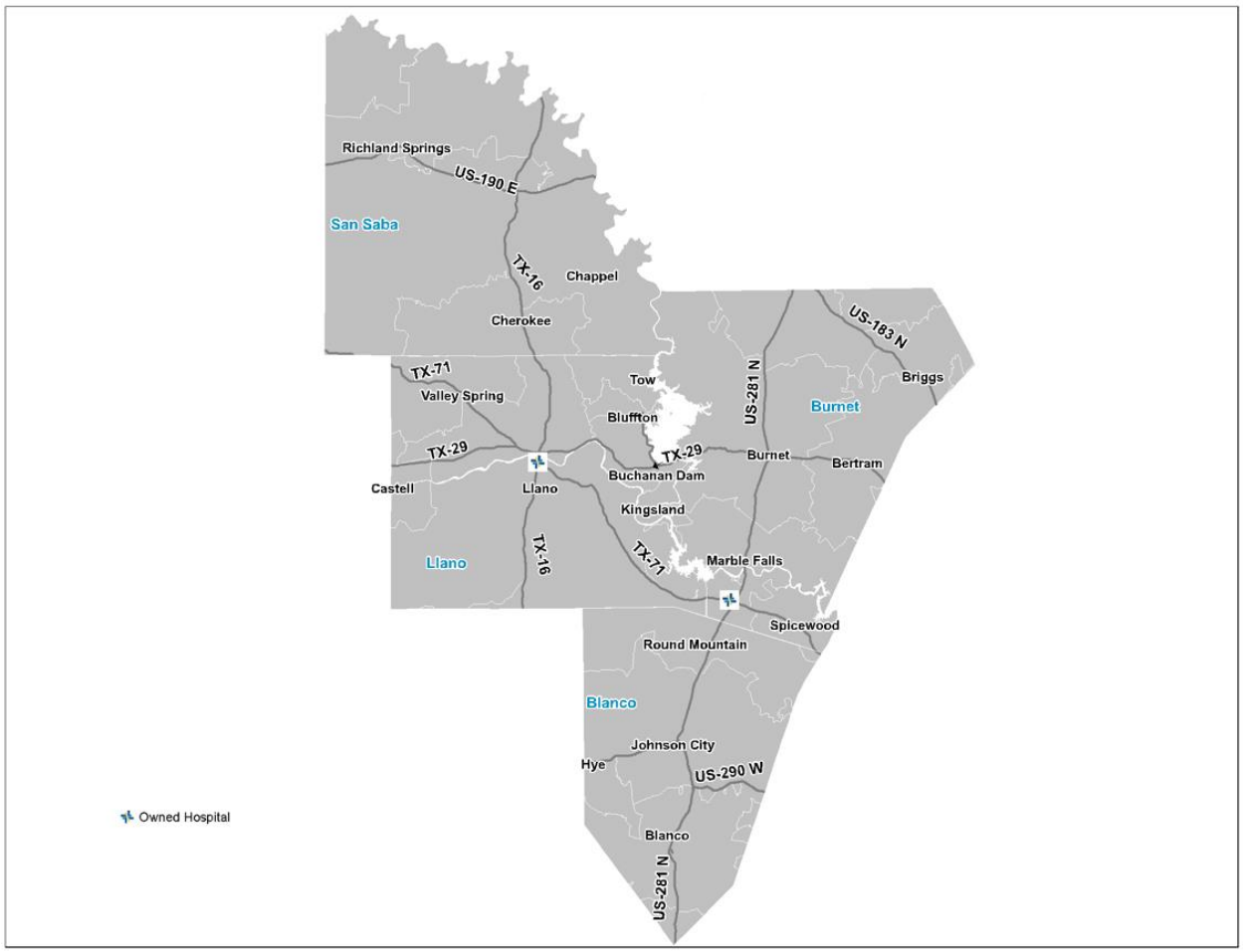
BSWH owns and operates multiple individually licensed hospital facilities serving the residents of North and Central Texas. Two hospital facilities with overlapping communities have collaborated to conduct this joint community health needs assessment. This joint community health needs assessment applies to the following BSWH hospital facilities:

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

Community Served Definition

The community served by Baylor Scott & White Medical Center - Llano and Baylor Scott & White Medical Center - Marble Falls includes Llano, Burnet, San Saba, and Blanco counties. Baylor Scott & White has at least one hospital facility or a provider based clinic in each of these counties and together they comprise where more than 80% of the hospitals admitted patients live.

BSWH Community Health Needs Assessment
Hill Country Health Community Map



Source: Baylor Scott & White Health, 2019

Assessment of Health Needs

To identify the health needs of the community, the hospital facilities established a comprehensive method of taking into account all available relevant data including community input. The basis of identification of community health needs was the weight of qualitative and quantitative data obtained when assessing the community. Surveyors conducted interviews and focus groups with individuals representing public health, community leaders/groups, public organizations, and other providers. In addition, data collected from several public sources compared to the state benchmark indicated the level of severity.

Quantitative Assessment of Health Needs – Methodology and Data Sources

Quantitative data collection and analysis in the form of public health indicators assessed community health needs, including collection of 102 data elements grouped into 11 categories, and evaluated for the counties where data was available. Since 2016, the identification of several new indicators included: addressing mental health, health care costs, opioids, and social determinants of health. The categories and indicators are included in the table below, the sources are in **Appendix A**.

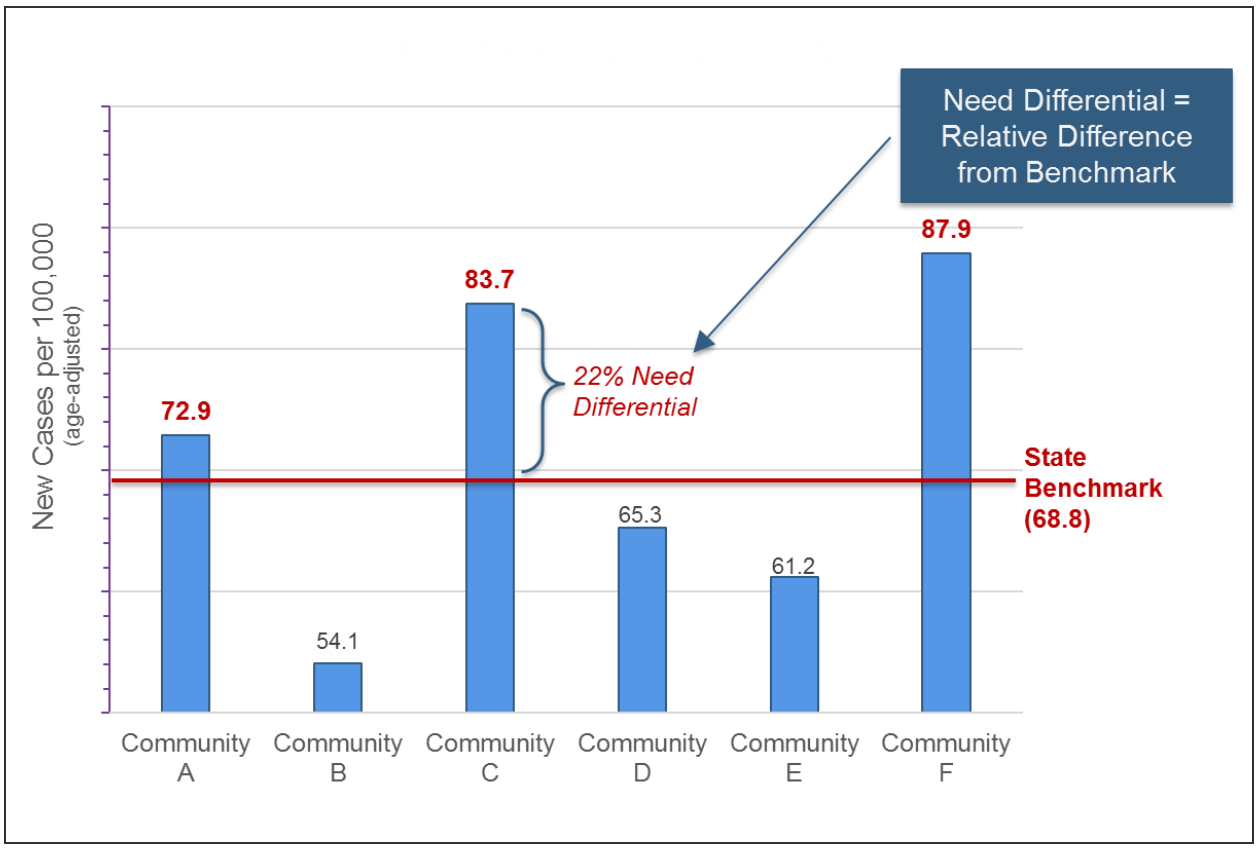
A benchmark analysis conducted for each indicator collected for the community served, determined which public health indicators demonstrated a community health need from a quantitative perspective. Benchmark health indicators collected included (when available): overall U.S. values; State of Texas values; and goal setting benchmarks such as Healthy People 2020.

According to America's Health Rankings 2018 Annual Report, Texas ranks 37th out of the 50 states. The health status of Texas compared to other states in the nation identified many opportunities to impact health within local communities, including opportunities for those communities that ranked highly. Therefore, the benchmark for the community served was set to the state value.

Once the community benchmark was set to the state value, it was determined which indicators for the community did not meet the state benchmarks. This created a subset of indicators for further analysis. A need differential analysis was conducted to understand the relative severity of need for these indicators. The need differential established a standardized way to evaluate the degree each indicator differed from its benchmark; this measure is called the need differential. Health community indicators with need differentials above the 50th percentile, ordered by severity, and the highest ranked indicators were the highest health needs from a quantitative perspective. These data are available to the community via an interactive Tableau dashboard at **BSWHealth.com/CommunityNeeds** .

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

Health Indicator Benchmark Analysis Example



Source: IBM Watson Health, 2018

Qualitative Assessment of Health Needs and Community Input – Approach

In addition to analyzing quantitative data, one (1) focus group with a total of 13 participants, as well as six (6) key informant interviews, were conducted to take into account the input of persons representing the broad interests of the community served. The focus group and interviews solicited feedback from leaders and representatives who serve the community and have insight into community needs. Prioritization sessions were also held with hospital clinical leadership and/or other community leaders to identify significant health needs from the assessment and prioritize them.

The focus group familiarized participants with the CHNA process and solicited input to understand health needs from the community's perspective. Focus groups, formatted for individual as well as small group feedback, helped identify barriers and social determinants influencing the community's health needs. Barriers and social determinants were new topics added to the 2019 community input sessions.

Watson Health conducted key informant interviews for the community served by the hospital facilities. The interviews aided in gaining understanding and insight into participants concerns about the general health status of the community and the various drivers that contributed to health issues.

Participation in the qualitative assessment included at least one state, local, 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 who served and/or represented the interests of medically underserved, low-income and minority populations in the community.

Participation from community leaders/groups, public health organizations, other healthcare organizations, and other healthcare providers (including physicians) ensured that the input received represented the broad interests of the community served. A list of the names of organizations providing input are in the table below.

Community Input Participants

Participant Organization Name	Public Health	Medically Under-served	Low-income	Chronic Disease Needs	Minority Populations	Governmental Public --Health Dept.	Public Health Knowledge/ --Expertise
Area Agency on Aging of The Capital Area		X	X	X	X		
Baylor Scott and White	X	X	X	X	X		X
Blanco County	X						
Celestecare of Horseshoe Bay	X						
Central Texas Catholic Charities	X	X	X	X	X	X	X
Central Texas Food Bank		X	X	X	X		X
City of Marble Falls	X						
Community Advocate Volunteer			X				
Community Resource Center of Texas Inc		X	X		X		X
Highland Lakes Family Crisis Center					X		
Marble Falls Area EMS	X	X	X	X	X		X
Marble Falls Independent School District		X	X		X		
Methodist Healthcare Ministries		X	X	X			
NAMI Texas	X	X	X	X	X		
Seton Highland Lakes		X	X	X	X		
Texas Department of State Health Services - HSR 7	X					X	X

Participant Organization Name	Public Health	Medically Under-served	Low-income	Chronic Disease Needs	Minority Populations	Governmental Public --Health Dept.	Public Health Knowledge/ --Expertise
Texas Home Health Group	X	X	X	X	X		

Note: multiple persons from the same organization may have participated

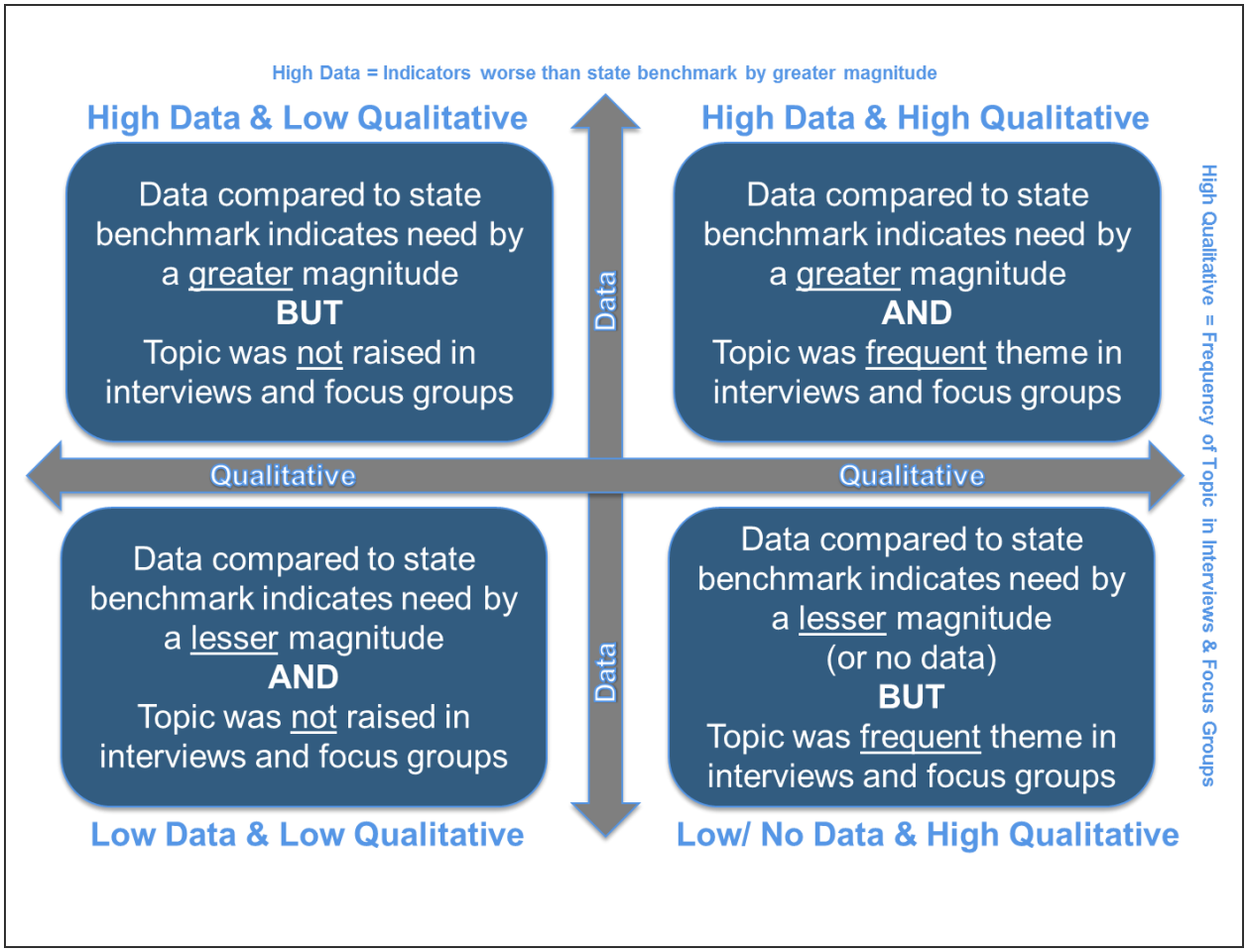
In addition to soliciting input from public health and various interests of the community, the hospital facilities were also required to consider written input received on their most recently conducted CHNA and subsequent implementation strategies. The assessment is available to receive public comment or feedback on the report findings on the BSWH website (**BSWHealth.com/CommunityNeeds)** or by emailing **CommunityHealth@bswhealth.org**. To date BSWH has not received such written input but continues to welcome feedback from the community.

Community input from interviews and focus groups organized the themes around community needs. These themes were compared to the quantitative data findings.

Methodology for Defining Community Need

Using qualitative feedback from the interviews and focus group, as well as the health indicator data, the consolidated issues currently affecting the community served assembled in the Health Needs Matrix below help identify the health needs for each community. The upper right quadrant of the matrix is where the needs identified in the qualitative data (interview and focus group feedback) and quantitative data (health indicators) converge to identify the top health needs for this community.

The Health Needs Matrix



Source: IBM Watson Health, 2018

Information Gaps

In some areas of Texas, health indicators were not available due to the impact small population size has on reporting and statistical significance. Additionally, most public health indicators were available only at the county level. In evaluating data for entire counties versus more localized data, it was difficult to understand the health needs for specific population pockets within a county. It could also be a challenge to tailor programs to address community health needs, as placement and access to specific programs in

one part of the county may or may not actually affect the population who truly need the service.

Approach to Identify and Prioritize Significant Health Needs

In a session held with Baylor Scott & White – Marble Falls hospital and clinic leadership and community leaders on November 29, 2018, significant health needs were identified and prioritized. The meeting, moderated by Watson Health, included an overview of the CHNA process for BSWH, the methodology for determining the top health needs, the BSWH prioritization approach, and discussion of the top health needs identified for the community.

Prioritization of the health needs took place in two steps. In the first step, participants reviewed the top health needs for their community with associated data-driven criteria to evaluate. The criteria included: health indicator value(s) for the community, how the indicator compared to the state benchmark, and potentially preventable ED visit rates for the community (if available). Participants then leveraged the professional experience and community knowledge of the group via discussion about which needs were most significant. With the data-driven review criteria and the discussion completed, a multi-voting method identified the significant health needs. Participants voted individually for the five (5) needs they considered as the most significant for this community. With votes tallied, five (5) identified needs ranked as significant health needs, based on the number of votes.

In the second step, participants ranked the significant health needs based on prioritization criteria recommended by the focus group conducted for this community:

1. Importance to the population served: the issue is important to the community and there is a willingness to address the issue; will be able to convene resources around initiatives.
2. Severity: the problem results in disability or premature death or creates burdens on the community, economically or socially.
3. Root Cause: the need is a root cause of other problems, thereby addressing it could possibly impact multiple issues.

Through discussion and consensus, the group rated each of the five (5) significant health needs on each of the three (3) identified criteria utilizing a scale of 1 (low) to 10 (high). The criteria scores summed for each need, created an overall score. The list of significant health needs was then prioritized based on the overall scores. For the scores that resulted in a tie, the need with the greater negative difference from the benchmark was ranked above the other need. The outcome of this process, the list of prioritized health needs for this community, is located in the "**Prioritized Significant Health Needs**" section of the assessment.

The prioritized list of significant health needs approved by the hospitals' governing body and the full assessment is available to anyone at no cost. To download a copy, visit **BSWHealth.com/CommunityNeeds** .

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. BSWH Community Resource Guides, and input from qualitative assessment participants, identified community resources that may assist in addressing the health needs identified for this community. A description of these resources is in **Appendix B**. In addition, an interactive asset map of various resources identified for all BSWH communities are located at: **BSWHealth.com/CommunityNeeds** .

Hill Country Health Community CHNA

Demographic and Socioeconomic Summary

According to population statistics, the community served shows a lower projected population growth compared to Texas but higher than the country. The median age was older than Texas or the United States. Median income was below both the state and the country. The community served had a smaller proportion of Medicaid beneficiaries than Texas and the U.S. and a smaller proportion of uninsured individuals than Texas overall.

Demographic and Socioeconomic Comparison: Community Served and State/U.S. Benchmarks

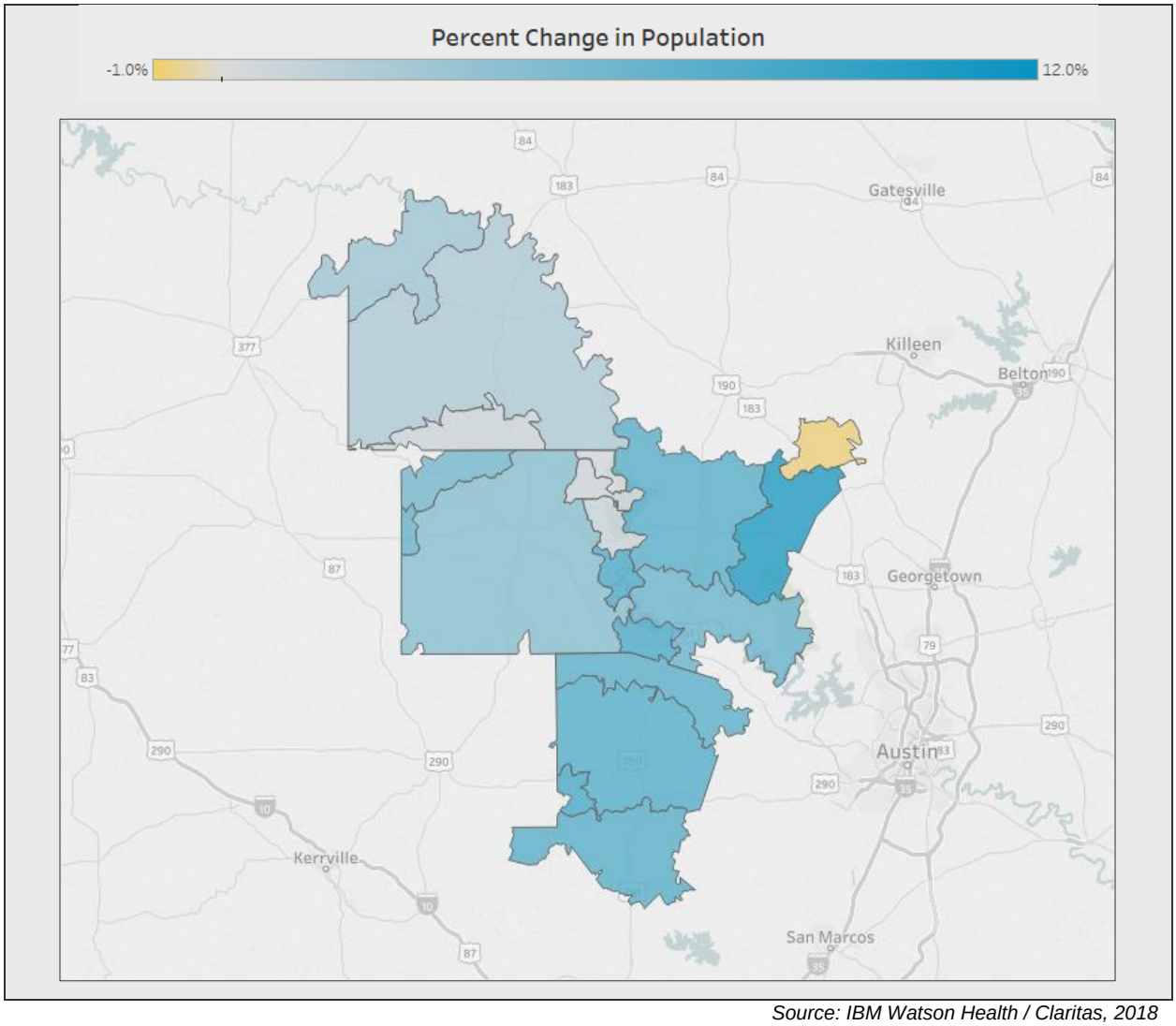
Geography		Benchmarks		Community Served
		United States	Texas	Hill Country Health Community
Total Current Population		326,533,070	28,531,631	80,757
5 Yr Projected Population Change		3.5%	7.1%	5.9%
Median Age		42.0	38.9	51.7
Population 0-17		22.6%	25.9%	19.2%
Population 65+		15.9%	12.6%	26.3%
Women Age 15-44		19.6%	20.6%	15.1%
Non-White Population		30.0%	32.2%	12.5%
Hispanic Population		18.2%	39.4%	20.6%
Insurance Coverage	Uninsured	9.4%	19.0%	13.5%
	Medicaid	14.9%	13.4%	9.8%
	Private Market	9.6%	9.9%	10.8%
	Medicare	16.1%	12.5%	26.4%
	Employer	45.9%	45.3%	39.6%
Median HH Income		$61,372	$60,397	$54,689
Limited English		26.2%	39.9%	17.8%
No High School Diploma		7.4%	8.7%	8.4%
Unemployed		6.8%	5.9%	5.4%

Source: IBM Watson Health / Claritas, 2018; US Census Bureau 2017 (U.S. Median Income)

The population of the community served is expected to grow 5.9% by 2023, an increase by more than 4,700 people. The 5.9% projected population growth is lower than the state's 5-year projected growth rate (7.1%) and higher compared to the national projected growth rate (3.5%). The ZIP codes expected to experience the most growth in five years are:

- 78654 Marble Falls – 1,084 people
- 78611 Burnet-Bertram – 953 people

2018 - 2023 Total Population Projected Change by ZIP Code



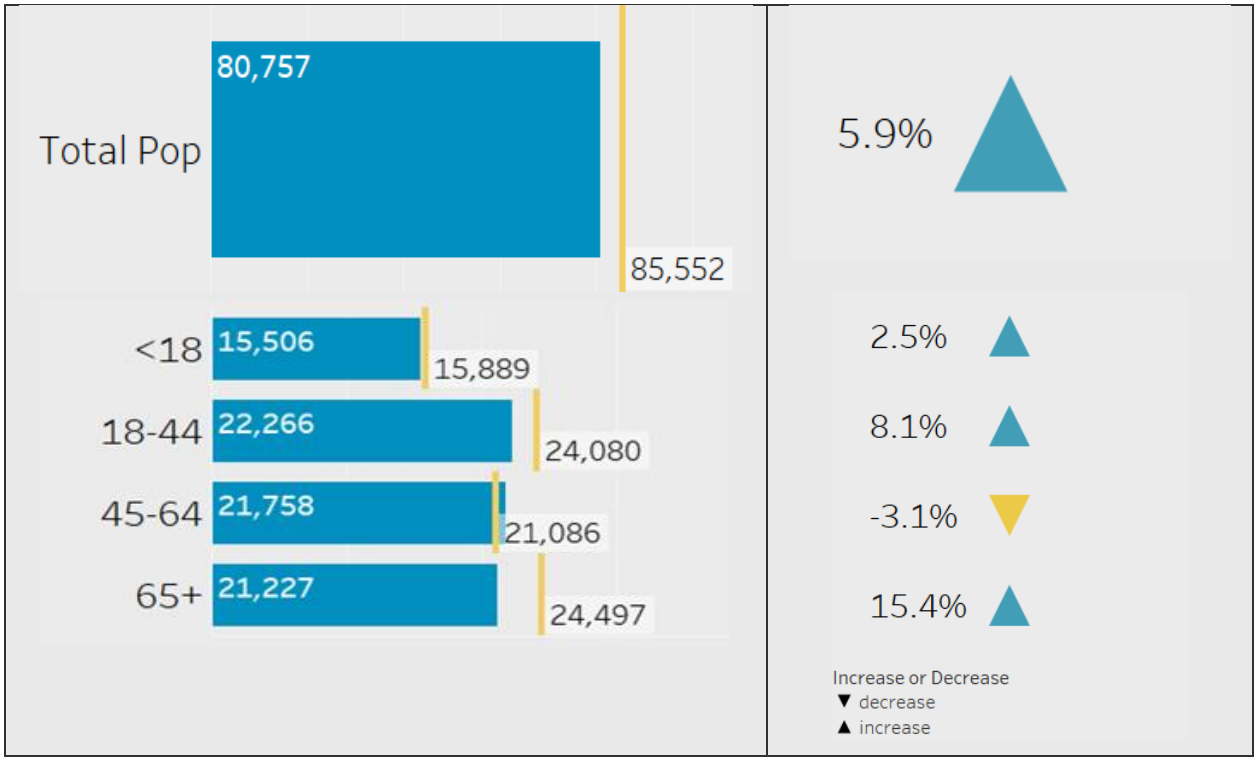
Source: IBM Watson Health / Claritas, 2018

The community's population was fairly distributed across four age groups with 27.6% of the population ages 18-44, 26.9% in the 45-64 age group, 26.3% age 65 plus and 19.2%

under age 18. The age 65 plus cohort is expected to grow the most adding 3,270 seniors by 2023 (15.4%). Meanwhile, the 45-64 cohort is expected to shrink by 3.1%.

Population Distribution by Age

2018 Population by Age Cohort *Percent Change by 2023*

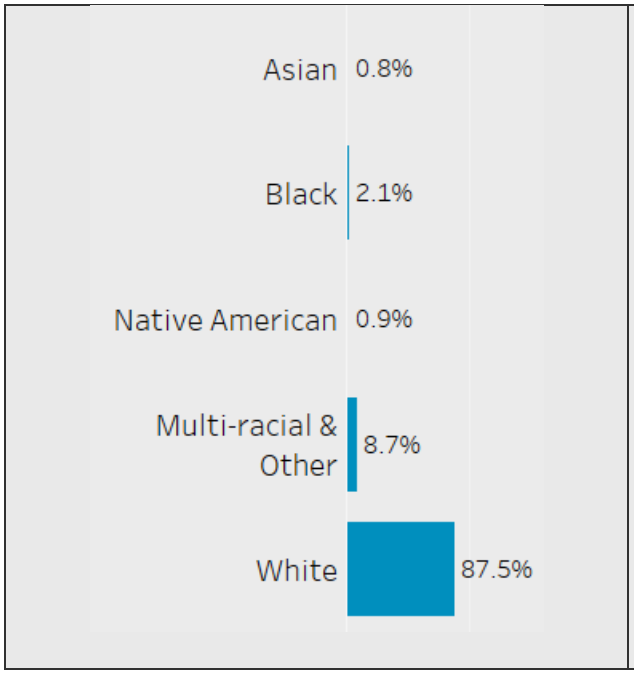


Source: IBM Watson Health / Claritas, 2018

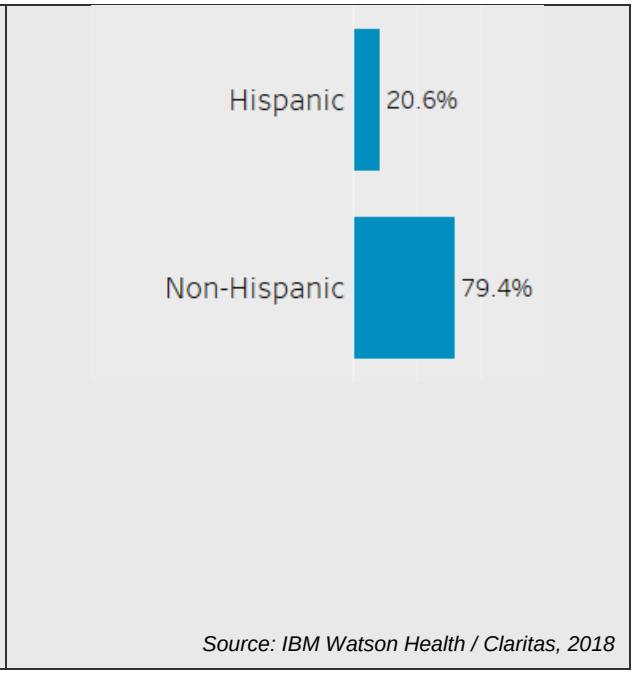
Population statistics are analyzed by race and by Hispanic ethnicity. The community was primarily white and non-Hispanic (74.9%). The Hispanic population (all races) also comprised a large population group (20.6%) and is expected to add the greatest number of people (2,447) by 2023. Other non-white, non-Hispanic races are expected to increase slightly over the next five years adding just under 1,000 people by 2023.

Population Distribution by Race and Ethnicity

2018 Population by Race

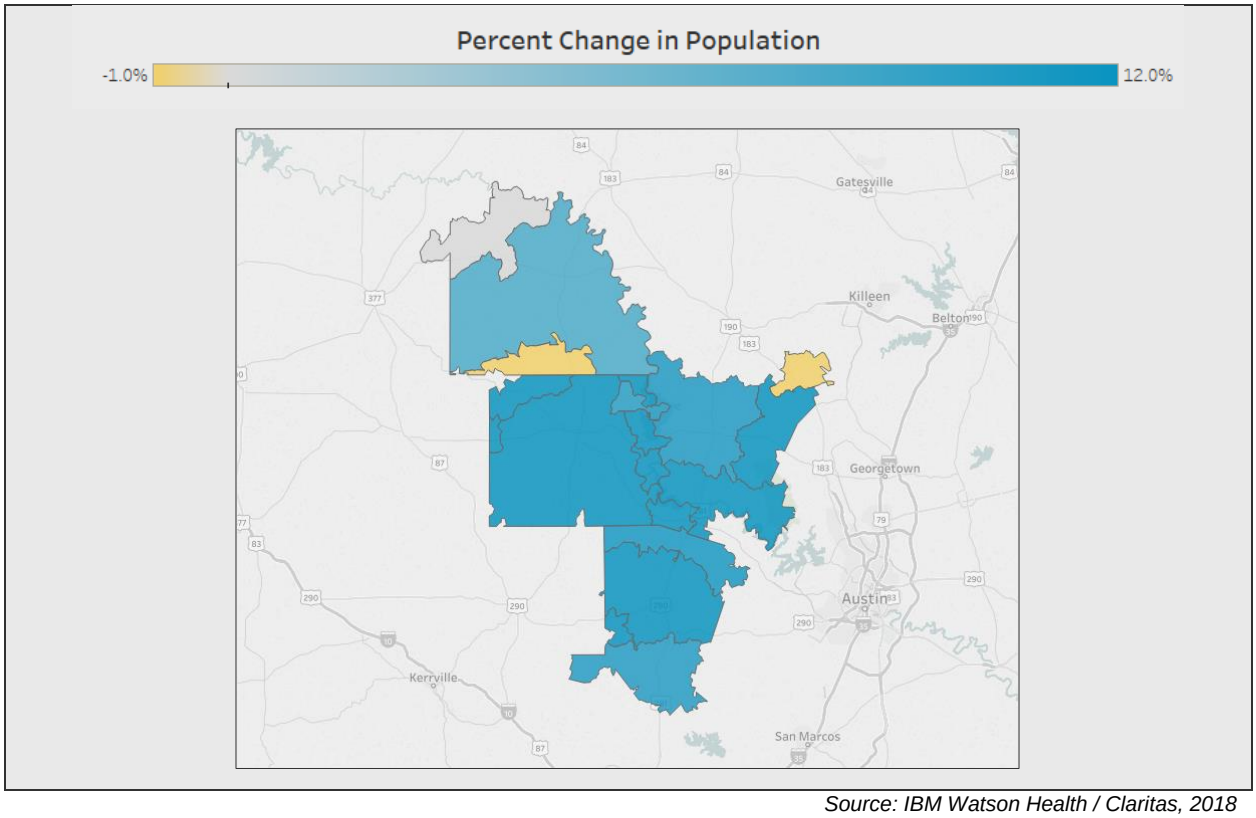


2018 Population by Ethnicity



Source: IBM Watson Health / Claritas, 2018

2018 - 2023 Hispanic Population Projected Change by ZIP Code

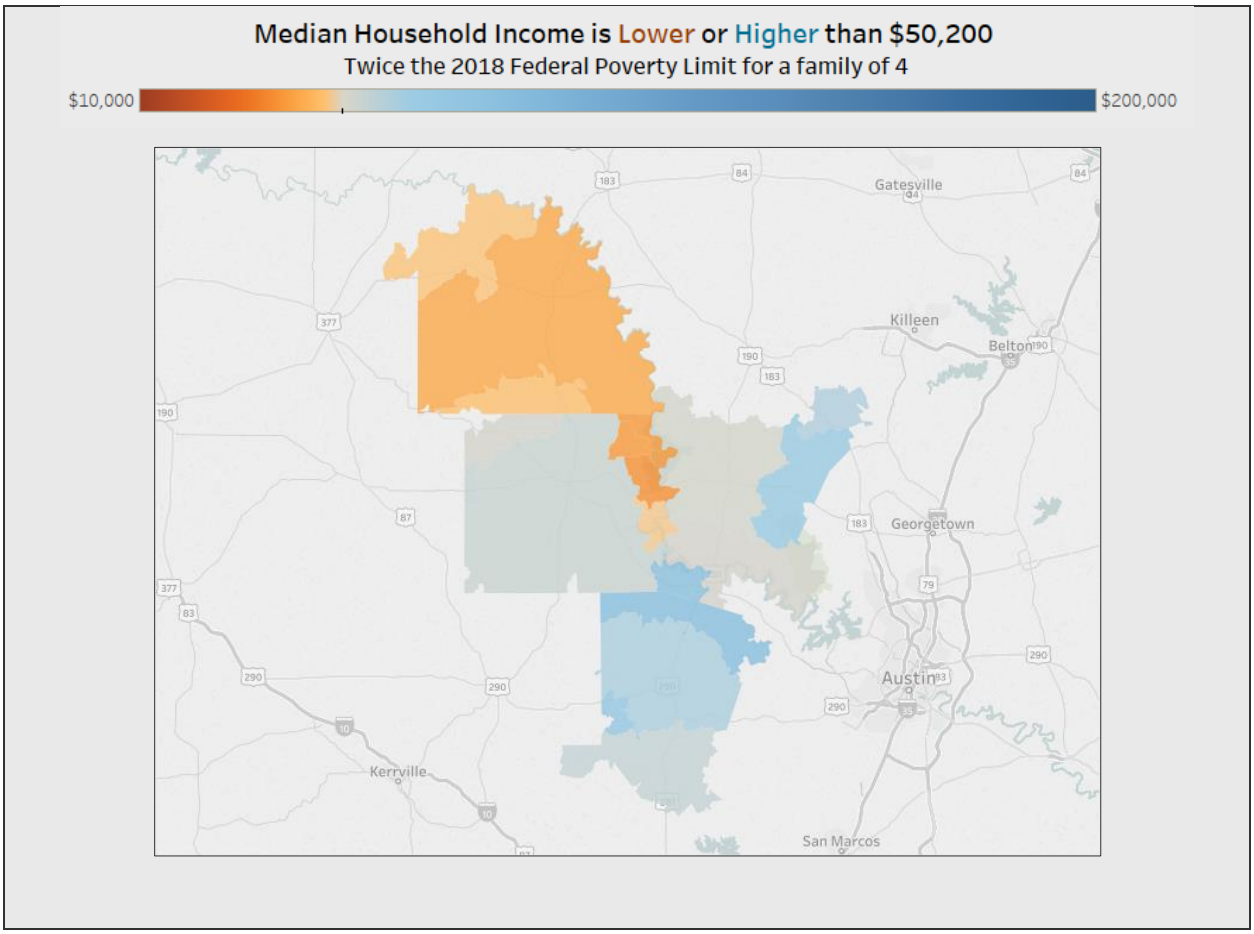


Source: IBM Watson Health / Claritas, 2018

The 2018 median household income for the United States was $61,372 and $60,397 for the state of Texas. The median household income for the ZIP codes within this community ranged from $36,716 for 78609 – Buchanan Lake to $82,813 for 78663 – North Blanco County. There were seven ZIP codes with median household incomes less than $50,200 – twice the 2018 Federal Poverty Limit or a family of four.

- 78639 Kingsland - $47,827
- 76871 San Saba County - $46,983
- 76832 San Saba County - $46,250
- 76877 San Saba County - $41,667
- 78672 Buchanan Lake - $38,438
- 78607 Buchanan Lake - $38,333
- 78609 Buchanan Lake - $36,716

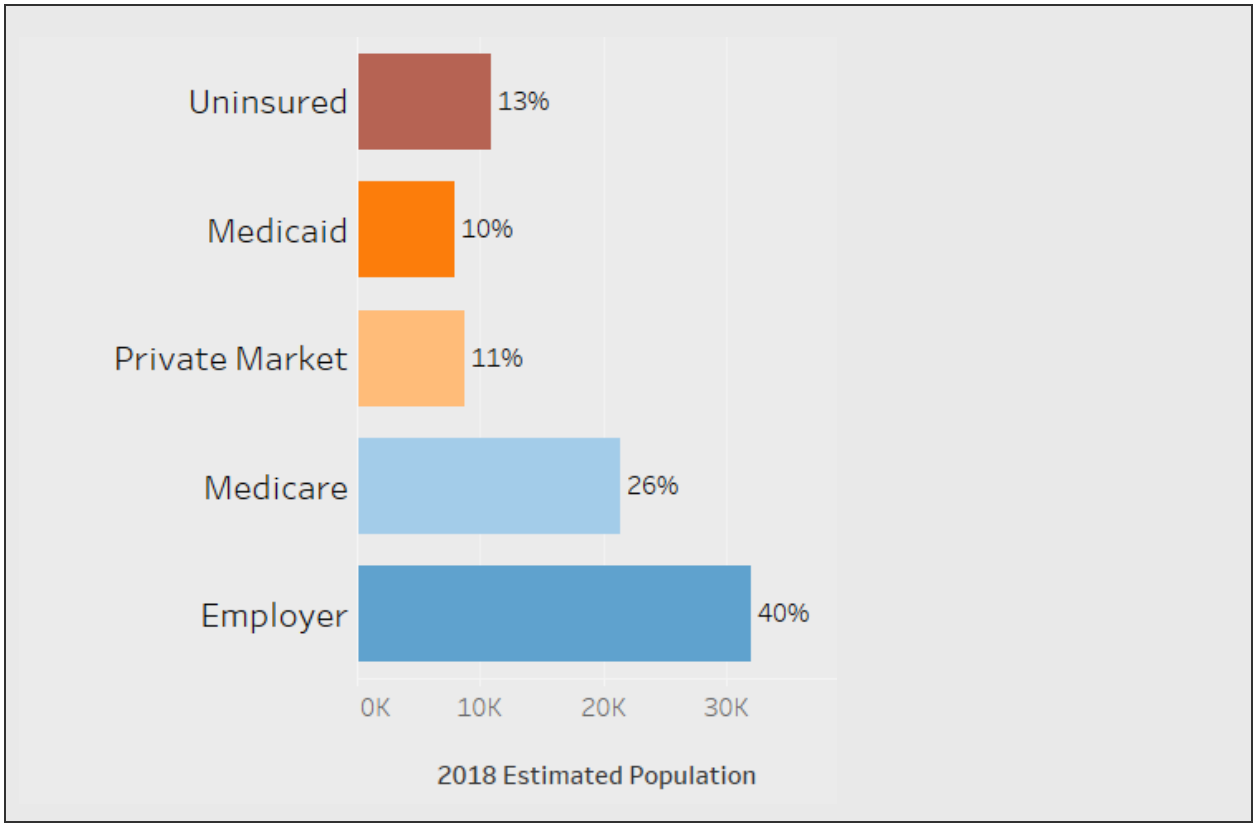
2018 Median Household Income by ZIP Code



Source: IBM Watson Health / Claritas, 2018

Most of the population (40%) was insured through employer sponsored health coverage while a quarter of the population (26%) was on Medicare. The remainder of the population was fairly equally divided between Uninsured (13%), Medicaid (10%), and private market (11%). The private market are those purchasing coverage directly or through the health insurance marketplace.

2018 Estimated Distribution of Covered Lives by Insurance Category



Source: IBM Watson Health / Claritas, 2018

The community includes twelve (12) Health Professional Shortage Areas and four (4) Medically Underserved Areas as designated by the U.S. Department of Health and Human Services Health Resources Services Administration.[1] **Appendix C** includes the details on each of these designations.

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, 2018

Health Professional Shortage Areas and Medically Underserved Areas and Populations

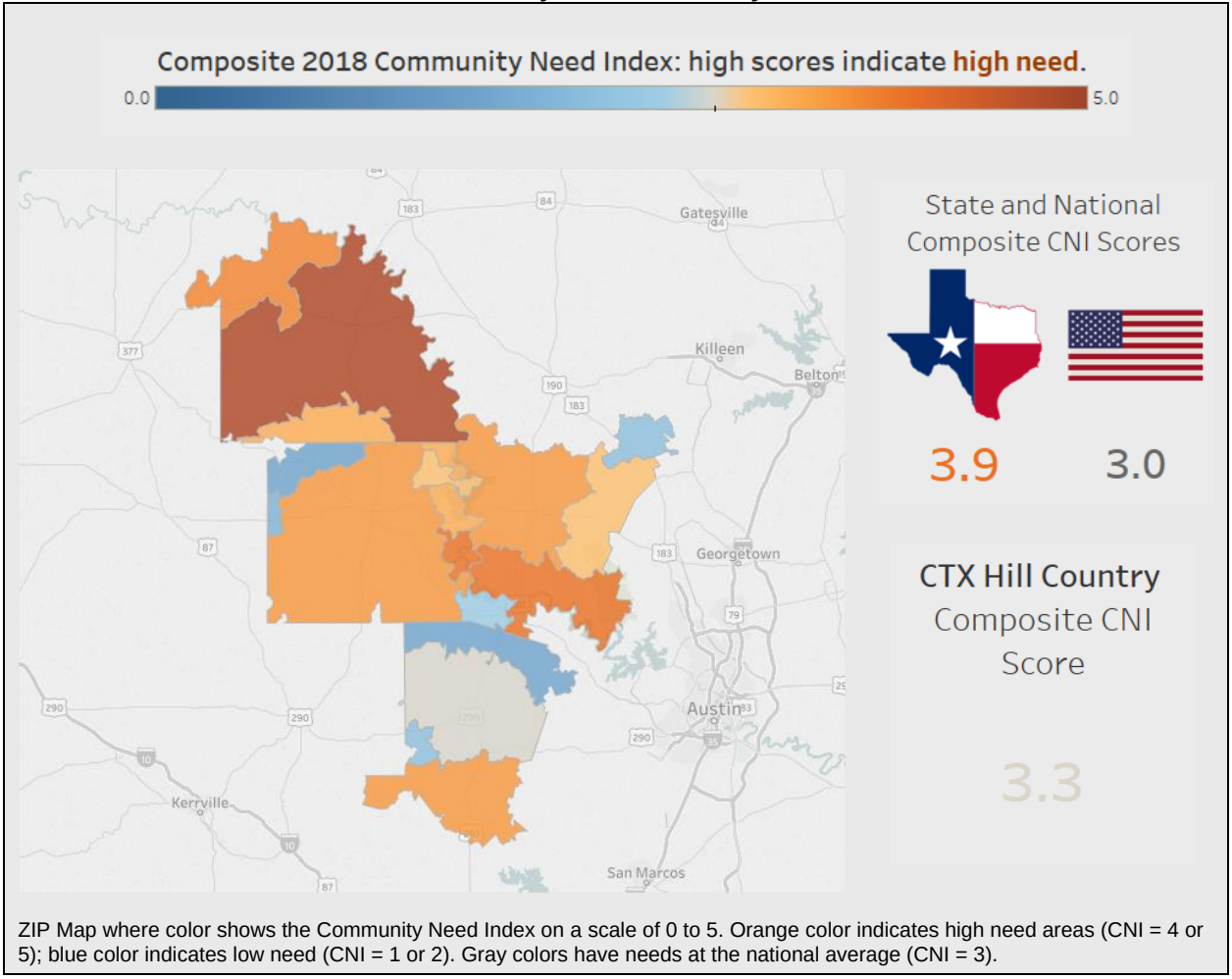
	Health Professional Shortage Areas (HPSA)				Medically Underserved Area/Population (MUA/P)
CTX Hill Country Health Community	**Dental Health**	**Mental Health**	**Primary Care**	**Grand Total**	**MUA/P**
Blanco	0	1	1	2	1
Burnet	0	1	2	3	1
Llano	1	2	2	5	1
San Saba	0	1	1	2	1
Total	**1**	**5**	**6**	**12**	**4**

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, 2018

The Watson Health Community Need Index (CNI) is a statistical approach to identifying areas within a community where health disparities may exist. 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 strongly linked to variations in community healthcare needs and is an 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 CNI score for the community served was 3.3 which is just slightly higher than the CNI national average of 3.0. In a portion of the community (Zip code 76877 - San Saba County) the CNI score was greater than 4.5, pointing to potentially more significant health needs among the population of this area.

2018 Community Need Index by ZIP Code



ZIP Map where color shows the Community Need Index on a scale of 0 to 5. Orange color indicates high need areas (CNI = 4 or 5); blue color indicates low need (CNI = 1 or 2). Gray colors have needs at the national average (CNI = 3).

CNI High Need ZIP Codes

City	Community	County	ZIP Code	2018 CNI Score
San Saba	San Saba County	San Saba	76877	4.8
Kingsland	Kingsland	Llano	78639	4.0
Marble Falls	Marble Falls	Burnet	78654	4.0

Source: IBM Watson Health / Claritas, 2018

Public Health Indicators

Public health indicators were collected and analyzed to assess community health needs. Evaluation for the community served used 102 indicators. For each health indicator, a comparison between the most recently available community data and benchmarks for the same/similar indicator was made. The basis of benchmarks was available data for the U.S. and the State of Texas.

Where the community indicators showed greater need when compared to the State of Texas comparative benchmark, the difference between the community values and the state benchmark was calculated (need differential). Those indicators with need differentials in the 50th percentile of greater severity pinpointed community health needs from a quantitative perspective. These indicators are located in **Appendix D**.

Watson Health Community Data

Watson Health supplemented the publicly available data with estimates of localized disease prevalence of heart disease and cancer as well as emergency department visit estimates. This information is located in **Appendix E**.

Focus Groups & Interviews

BSWH worked jointly with Seton Healthcare in collecting and sharing qualitative data (community input) on the health needs of this community.

In the focus group sessions and interviews, participants identified and discussed the factors that contribute to the current health status of the community, and then identified the greatest barriers and strengths that contribute to the overall health of the community. For this health community, there were 13 participants in the focus group held in Marble Falls, and six (6) interviews were conducted July through September 2018.

In this health community, the top health needs identified in the discussions included:

- Lack of public and alternative transportation options
- High cost of care
- Insurance coverage
- Behavioral Health
- Motivation to prioritize health

Participants described this hilly area west of Austin as rural with a small-town feel; the type of community where you know your neighbors and word of mouth is still an effective method to disseminate information. Hill Country had become a tourist destination and a popular place to retire, which caused a growth in the senior population and housing prices to increase significantly. These demographic shifts widened the income gap, and demand for healthcare services and infrastructure had surpassed supply. The top health needs in the health community centered around access to care issues (i.e. high cost of care, insurance coverage, lack of behavioral health resources, and provider shortages), environmental factors that negatively impact the health of the health community, and poor health outcomes.

The rising cost of healthcare and insurance coverage posed significant barriers to health in a health community that lacked free and low-cost healthcare options. The uninsured population continued to grow, driven by young adults and seniors who did not qualify for Medicaid or Medicare and were unable to afford insurance coverage. Those that did have insurance were faced with high copays and deductibles. Combined with a shortage of local physicians and dearth of public transit, patients without vehicles were left with few options to access healthcare resources. Patients de-prioritized their health needs due to high cost and instead prioritized basic needs like food and housing. The focus group suggested that increasing the availability of healthcare resources should be coupled with affordability, accessibility, and health education to improve the overall health status of the health community, especially for the most vulnerable senior, handicapped, and pediatric residents.

Behavioral health providers and resources were scarce in the health community. Both focus group and interview participants repeatedly identified mental health as the biggest gap, with needs for both more affordable providers, substance abuse treatment options, and access in rural areas. Pediatric and inpatient psych services were limited and identified by participants as a high need in the health community. Telehealth had been tested to expand coverage of behavioral health services; however, these efforts had been largely unsuccessful due to mistrust and privacy concerns. The health community lacked 24-hour clinics, so residents used the emergency department for basic care, including dental care and primary services to offset provider shortages and long wait times to obtain appointments.

The community participants shared that the health community was faced with high rates of both chronic and infectious disease, including cancer, obesity, and diabetes. A lack of healthy food options combined with primary care physician shortages may have been contributing to the prevalence of chronic illness. Infectious disease rates and substance abuse were on the rise, and demanded more interventions and resources to treat opioid, illegal drug, and alcohol misuse. Health literacy was relatively low in the health community, and many patients had language barriers to improving their health literacy and access to health care services.

Community Health Needs Identified

A Health Needs Matrix identified the health needs that resulted from the community health needs assessment (see Methodology for Defining Community Need section). The matrix shows the convergence of needs identified in the qualitative data (interview and focus group feedback) and quantitative data (health indicators) and identifies the top health needs for this community.

Top Community Health Needs Identified

Hill Country Health Community		
Top Needs Identified	**Category of Need**	**Public Health Indicator**
Children in Poverty	SDH - Income	2016 Percentage of Children Under Age 18 in Poverty
Diabetes Lower-Extremity Amputation Admission: Adult (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Number Observed / Adult Population Age 18 and older
Diabetes Short-term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Number Observed / Pediatric Population Under Age 18
Drug Poisoning Deaths Rate	Health Behaviors - Substance Abuse	2014-2016 Number of Drug Poisoning Deaths (Drug Overdose Deaths) per 100,000 Population
Elderly isolation. 65+ Householder living alone	SDH - Social Isolation	2012 Percent of Non-family households - Householder living alone - 65 years and over
Gastroenteritis Admission: Pediatric (Risk-Adjusted-Rate)	Preventable Hospitalizations	Number Observed / Pediatric Population Under Age 18
Limited Access to Healthy Foods (Percent of Low Income)	Environment - Food	2015 Percentage of Population Who are Low-Income and Do Not Live Close to a Grocery Store
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors - Substance Abuse	2012-2016 Percentage of Motor Vehicle Crash Deaths that had Alcohol Involvement
Perforated Appendix Admission: Adult (Risk-Adjusted-Rate per 100 Admissions for Appendicitis)	Preventable Hospitalizations	Number Observed / Adult Population Age 18 and older
Population with Adequate Access to Locations for Physical Activity	Health Behaviors - Exercise	2010 & 2016 Percentage of Population with Adequate Access to Locations for Physical Activity
Ratio of Population to One Dentist	Access To Care	2016 Ratio of Population to Dentists
Ratio of Population to one Mental Health Provider	Mental Health	2017 Ratio of Population to Mental Health Providers
Ratio of Population to One Non-Physician Primary Care Provider	Access To Care	2017 Ratio of Population to Primary Care Providers Other than Physicians
Ratio of Population to One Primary Care Physician	Access To Care	2015 Number of Individuals Served by One Physician in a County, if the Population was Equally Distributed Across Physicians
Uninsured Children	Access To Care	2015 Percentage of Children Under Age 19 Without Health Insurance

Note: Listed alphabetically, not in order of significance

Source: IBM Watson Health, 2018

Prioritized Significant Health Needs

Using the prioritization approach outlined in the overview section of this report, the following needs from the proceeding list were determined to be significant and then prioritized. Note that prioritization participants grouped together "Percentage of Children Under Age 18 in Poverty" and "Percentage of Children Under Age 19 Without Health Insurance" prior to scoring the significant health needs.

The resulting prioritized health needs for this community were:

Priority	Need	Category of Need
1	Ratio of Population to One Mental Health Provider	Mental Health
2	Children in Poverty and Uninsured	SDH - Income / Access to Care
3	Diabetes Short-Term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes
4	Primary Care Providers (MD/Non-MD)	Access to Care
5	Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation

Session participants emphasized need existed for diabetes in general and not just the pediatric population. Participants also emphasized mental health need was more than provider shortage, it includes addressing the stigma of seeking mental health care as well as a need locally for better understanding and education of the secondary effects of not taking care of your mental health (e.g. jobs, education).

Description of Significant Health Needs

Hill Country focus groups identified several major health concerns in their community related to mental health, access to care, social determinants of health, and pediatric chronic condition management. Regionalized health needs affected all age levels to some degree; however, often the most vulnerable populations were negatively affected. Community health gaps helped to define the resources and access to care within the county or region. Health and social concerns were validated through key informant interviews, focus groups and county data. Availability of providers for mental health and primary care; children in poverty, uninsured children, elderly isolation, and pediatric diabetes management were significant areas of concern.

Note: The difference between county and state values are relative. The calculation is (county-state)/state. This creates a standard comparison across indicators of the county value relative to the state.

Mental Health Provider Access

Access to mental health providers and services is an issue nationally. Nine million adults (or 1 in 5) report having an unmet mental health need and mental health provider shortages across the country continue to exist.[2]

Rural areas face challenges with accessing mental health care services. Primary Care Providers (PCPs) are often relied upon to treat patients with mental health needs. These providers experience expertise, time, and financial reimbursement constraints. Communities that have a lack of primary care providers are even more vulnerable.

According to the CMS National Provider Identification File, the number of residents in the community served for each mental health provider was 11,392 in Blanco County, per 5,944 residents in San Saba County, per 2,948 residents in Llano County, and per 1,595 residents in Burnet County. These values were compared to the overall state of Texas mental health provider ratio of one provider for every 1,012 residents. This was respectively a difference of 1,025.7%, 487.4%, 123.5% and 57.6% relative to the state value (relative difference).[3]

The mental health provider ratio values for Blanco, San Saba and Llano counties were ranked in the top ten needs out of 107 indicators measured when compared to the state of Texas. The best performing county in this community, Burnet, was three times higher than County Health Rankings top performers ratio of one mental health provider for every 470 residents.[4] The participants from the prioritization session discussed the mental health need was greater than just a provider shortage. The mental health need in this community should also include addressing the stigma of seeking mental health care as well education around consequences of not addressing mental health issues (i.e. jobs, education).

Primary Care Physician Providers

Primary care included family medicine, internal medicine, nursing, nurse practitioners, pharmacy, pediatrics, general obstetrics/gynecology, gerontology, behavioral health, community health, and the other people and professions who fulfilled the general medical needs of patient populations.

Primary care professionals served on the front lines of healthcare. For many individuals, they were the first point of contact with the healthcare system. They were often the first to recognize signs of depression, early signs of cancer or chronic disease, and other health concerns. Primary care providers ensured patients received the right care, in the right setting, by the most appropriate provider, and in a manner consistent with the patient's desires and values. Primary care was also important because it lowered costs. Access to primary care helped to keep people out of emergency rooms, where care costs were much higher than other outpatient care. Annual check-ups could catch and treat problems earlier, which was also less costly than treating severe or advanced illness.[5]

[2] **Mental Health America**, 2019
[3] CMS, National Provider Identification Registry (NPPES); County Health Rankings & Roadmaps, 2018
[4] County Health Rankings & Roadmaps, 2018
[5] **Primary Care Progress**, The Case for Primary Care, 2019

The focus group participants expressed perceived lack of health care providers including primary care physicians and non-physicians, and mental health care providers within the Hill Country Health Community. The health community has rural components which could present additional challenges to access to care. Transportation to disparate care sites across the counties may have been difficult, if not impossible.

The overall Texas provider ratio was one primary care physician to every 1,670 residents. San Saba County had a ratio of one primary care physician to every 2,951 residents and Blanco County had a ratio of 1:2,751. These were different from the state value by 76.7% and 64.7% respectively.[6]

Non-Physician Primary Care Providers

There is a nationwide scarcity of physicians, particularly in small towns and cities. This shortage is accentuated in rural areas across the country. Only about 11% of the nation's physicians work in rural areas, despite nearly 20% of Americans living there.[7] Demographic shifts, such as growth in the elderly or near elderly populations increase the need for primary care access. Estimates of the scope of the provider shortage in rural America vary, however it is generally agreed upon that thousands of additional Primary Care Providers are needed to meet the current demand in rural America and that tens of thousands of additional caregivers will be needed to meet the growing rural population. Recruiting physicians to rural areas is particularly challenging and it could take years to secure a vacant position.

Primary care physician extenders (e.g. nurse practitioners, physician assistants, and clinical nurse specialists) could help close the gap in access to primary care services when they are located in a community. Non-physician providers or physician extenders are typically licensed professionals such as Physician Assistants or Nurse Practitioners who treat and see patients. Dependent upon state regulations, extenders may practice independently, or in physician run practices. Physician extenders expand the scope of primary care providers within a geographic area and help to bridge the gap to both access to care and management of healthcare costs.

Non-Physician Primary Care provider access in Blanco, San Saba, and Llano counties were worse than the Texas state threshold of one provider to 1,497 residents. The Blanco County ratio was 3,797 residents to one non-physician primary care provider, San Saba County ratio was 2,972:1, and Llano County ratio was 2,545:1.[8]

Children in Poverty

Children in poverty is measured as the percentage of children under age 18 living in poverty. Poverty status is defined by family; either everyone in the family is in poverty or no one in the family is in poverty. The characteristics of the family used to determine the

[6] Area Health Resource File/American Medical Association, County Health Rankings and Roadmaps **National Statistics**, 2018
[7] J. Cromartie, Population & Migration (Washington, D.C,: **U.S. Department of Agriculture, Economic Research Service, May 26, 2012**)
[8] CMS, National Provider Identification Registry (NPPES), County Health Rankings & Roadmaps, 2018

poverty threshold are: number of people, number of related children under 18, and whether or not the primary householder is over age 65. Family income is then compared to the federal poverty threshold; if that family's income is below that threshold, the family is in poverty.[9]

Poverty can result in an increased risk of mortality, morbidity, depression, and poor health behaviors. A 2011 study found that poverty and other social factors contribute to a number of deaths comparable to leading causes of death in the U.S. like heart attacks, strokes, and lung cancer. While repercussions resulting from poverty are present at all ages, children in poverty may experience lasting effects on academic achievement, health, and income into adulthood. Low-income children have an increased risk of injuries from accidents and physical abuse and are susceptible to more frequent and severe chronic conditions and their complications such as asthma, obesity, and diabetes than children living in higher income households. [10]

Overall the state of Texas had a rate of 22.4% of children living in poverty which was above the U.S. value of 20.0%. The San Saba County value of 33.2% indicated a need relative to the State of Texas. Beginning in early childhood, poverty takes a toll on mental health and brain development, particularly in the areas associated with skills essential for educational success such as cognitive flexibility, sustained focus, and planning. Low income children are more susceptible to mental health conditions like ADHD, behavior disorders, and anxiety which can limit learning opportunities and social competence leading to academic deficits that may persist into adulthood.[11]

Uninsured Children

Lack of health insurance coverage is a significant barrier to accessing needed health care services and to maintaining financial security. Dependent groups, such as children, are often the most vulnerable and at risk to changes in financial situations as they are most affected by lack of insurance, transportation, parental knowledge, and secure housing. Lack of preventative care often places children in precarious and dangerous healthcare situations.

The Kaiser Family Foundation released a report in 2017 concerning the uninsured crisis facing the nation. One key finding was that "Going without coverage can have serious health consequences for the uninsured because they receive less preventative care, and delayed care often results in serious illness or other health problems. Being uninsured can also have serious financial consequences, with many unable to pay their medical bills, resulting in medical debt."[12] Growing populations of uninsured in any community can easily stress social agencies and healthcare providers. Schools often become de facto primary care healthcare providers, which taxes the school system and its health care staff.

[9] **County Health Rankings**, 2018
[10] McCarty AT. Child poverty in the United States: A tale of devastation and the promise of hope. Soc. Compass. 2016;10(7):623-639.
[11] McCarty AT. Child poverty in the United States: A tale of devastation and the promise of hope. Soc. Compass. 2016;10(7):623-639.
[12] Kaiser Family Foundation. The Uninsured: A Primer - Key Facts about Health Insurance and the Uninsured Under the Affordable Care Act. December 2017.

The overall Texas percent of uninsured children was 10.0%. The percentage of uninsured children in Blanco County was 18.7% which was 87.0% greater than the Texas state benchmark of 10.0%; while the San Saba County value was 17.2% and 71.7% higher relative to the State of Texas.[13] These findings from the Hill Country CHNA indicate a need and a potentially vulnerable population with the community.

Isolation of Elderly over 65 years of age

The elderly population, 65 years of age and older, were expected to experience the fastest growth (20.8%) over the next five years, adding nearly 9,000 elderly to the community.[14] Growth among this age group will likely contribute to increased utilization of healthcare services. Over time, the community must be able to provide adequate services to care for the aging population.

Elderly who live alone is a growing challenge for communities across the nation. People who are aging alone in impoverished areas with degraded social infrastructure would benefit from neighborhood revitalization, requiring considerable investment from the public and private sectors. Rural areas that are not highly connected, may have residents who would be at a higher risk of isolation. Elderly, frail, and reclusive people who live alone may require home care and specialized services such as meal delivery and social visits. Identification and support of this marginalized population is essential. Integrated social services to engage, support and positively challenge their elderly populations will improve the overall health and well-being of the community.

In all four counties that make up the Hill Country Health Community, the percentage of elderly who lived alone indicated a significant health need. In Texas overall, the percent of individuals living alone that were age 65 and older was 8.0%. The overall value for the U.S. was 10.4%. In Llano County the value was 18.6%, in San Saba County 15.5%, Burnet County 12.1%, and in Blanco County 12.1%.[15] These values ranked in the top 11 health needs for the Hill Country Health Community.

Diabetes Short-term Complications Admission: Pediatric (Risk-Adjusted-Rate)

Type 1 or Childhood Onset Diabetes afflicts children from early ages such as two years of age through teenage years. This diagnosis can be devasting to a family as it requires daily insulin, blood sugar monitoring, nutrition, education on preparing and purchasing healthy foods. This can be an overwhelming and daunting task for any family. Children are growing continually and are generally active and all these circumstances can require frequent monitoring and changing of insulin amounts.

Hospital admission for diabetes short-term complications is considered an avoidable event. Diabetes when properly controlled through health management and outpatient care should not result in the need for inpatient care. When a community has elevated rates for hospital admissions due to uncontrolled diabetes, it points to challenges in health education, behavior modification, and the outpatient care system. Additional challenges

[13] Small Area Health Insurance Estimates (SAHIE), United States Census Bureau; County Health Rankings & Roadmaps, 2018
[14] IBM Watson Health / Claritas, 2018
[15] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2012-2016

such as limited English speaking, lack of education and poverty levels can easily sabotage a family's resources and put a child at risk for hospitalization or worse.

Blanco County pediatric admissions for diabetes short-term complication admissions was the top ranked indicator of the 107 indicators evaluated for the Hill Country Health Community, indicating a significant issue for the community. The number of admissions for Blanco County was 312.8 per 100,000 (risk-adjusted).[16] The overall Texas benchmark rate was 23.6 per 100,000. Communities with an identified risk should plan to care for pediatric diabetes patients in aspects along the continuum of care, from basic needs to clinical care.

While the admission rate for diabetes short-term complication admissions in Blanco County was the top ranked indicator for the Hill Country Health Community, the participants from the prioritization session wanted to acknowledge a need around diabetes in general not just the pediatric population. While the indicators did not rank as severe as others in this community, diabetes prevalence was higher than the state benchmark in all four counties and the rate of adult admissions for lower-extremity amputations, another avoidable event, was higher than the state benchmark for Llano County.

Summary

BSWH conducted its Community Health Needs Assessments beginning June 2018 to identify and begin addressing the health needs of the communities they serve. Using both qualitative community feedback as well as publicly available and proprietary health indicators, BSWH was able to identify and prioritize community health needs for their healthcare system. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed for the health needs BSWH chooses to address for the community served.

[16] Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations, 2016

Appendix A: Key Health Indicator Sources

Category	Public Health Indicator	Source
Access to Care	Hospital Stays for Ambulatory-Care Sensitive Conditions-Medicare	2018 County Health Rankings & Roadmaps; Dartmouth Atlas of Health Care, CMS
	Percentage of Population under age 65 without Health Insurance	2018 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau
	Price-Adjusted Medicare Reimbursements per Enrollee **NEW 2019**	2018 County Health Rankings & Roadmaps; Dartmouth Atlas of Health Care, CMS
	Ratio of Population to One Dentist	2018 County Health Rankings & Roadmaps; Area Health Resource File/National Provider Identification file (CMS)
	Ratio of Population to One Non-Physician Primary Care Provider	2018 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)
	Ratio of Population to One Primary Care Physician	2018 County Health Rankings & Roadmaps; Area Health Resource File/American Medical Association
	Uninsured Children	2018 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau
Conditions/Diseases	Adult Obesity (Percent)	2018 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System
	Arthritis in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Atrial Fibrillation in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Cancer Incidence - All Causes	2011-2015 State Cancer Profiles, National Cancer Institute (CDC)
	Cancer Incidence - Colon	2011-2015 State Cancer Profiles, National Cancer Institute (CDC)
	Cancer Incidence - Female Breast	2011-2015 State Cancer Profiles, National Cancer Institute (CDC)
	Cancer Incidence - Lung	2011-2015 State Cancer Profiles, National Cancer Institute (CDC)
	Cancer Incidence - Prostate	2011-2015 State Cancer Profiles, National Cancer Institute (CDC)
	Chronic Kidney Disease in Medicare Population	CMS.gov Chronic conditions 2007-2015
	COPD in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Diabetes Diagnoses in Adults	CMS.gov Chronic conditions 2007-2015
	Diabetes prevalence	2018 County Health Rankings (CDC Diabetes Interactive Atlas)
	Frequent physical distress	2016 Behavioral Risk Factor Surveillance System (BRFSS)
	Heart Failure in Medicare Population	CMS.gov Chronic conditions 2007-2015
	HIV Prevalence	2018 County Health Rankings & Roadmaps; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)
	Hyperlipidemia in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Hypertension in Medicare Population	CMS.gov Chronic conditions 2007-2015

Category	Public Health Indicator	Source
	Ischemic Heart Disease in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Osteoporosis in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Stroke in Medicare Population	CMS.gov Chronic conditions 2007-2015
Environment	Air Pollution - Particulate Matter daily density	2018 County Health Rankings & Roadmaps; Environmental Public Health Tracking Network (CDC)
	Drinking Water Violations (Percent of Population Exposed)	2018 County Health Rankings & Roadmaps; Safe Drinking Water Information System (SDWIS), United States Environmental Protection Agency (EPA)
	Driving Alone to Work	2018 County Health Rankings & Roadmaps; American Community Survey, 5-Year Estimates, United States Census Bureau
	Elderly isolation. 65+ Householder living alone **NEW 2019**	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
	Food Environment Index	2018 County Health Rankings & Roadmaps; USDA Food Environment Atlas, Map the Meal Gap from Feeding America, United States Department of Agriculture (USDA)
	Food Insecure	2018 County Health Rankings & Roadmaps; Map the Meal Gap, Feeding America
	Limited Access to Healthy Foods (Percent of Low Income)	2018 County Health Rankings & Roadmaps; USDA Food Environment Atlas, United States Department of Agriculture (USDA)
	Long Commute Alone	2018 County Health Rankings & Roadmaps; American Community Survey, 5-Year Estimates, United States Census Bureau
	No vehicle available **NEW 2019**	U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates
	Population with Adequate Access to Locations for Physical Activity	2018 County Health Rankings & Roadmaps; Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files (ArcGIS)
	Renter-occupied housing **NEW 2019**	U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates
	Residential segregation - black/white **NEW 2019**	2018 County Health Rankings (American Community Survey, 5-year estimates)
	Residential segregation - non-white/white **NEW 2019**	2018.County Health Rankings (American Community Survey, 5-year estimates)
	Severe Housing Problems	2018 County Health Rankings & Roadmaps; Comprehensive Housing Affordability Strategy (CHAS) data, U.S. Department of Housing and Urban Development (HUD)
Health Behaviors	Adult Smoking	2018 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)
	Adults Engaging in Binge Drinking During the Past 30 Days	2018 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)
	Disconnected youth **NEW 2019**	2018 County Health Rankings (Measure of America)
	Drug Poisoning Deaths Rate	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Insufficient sleep **NEW 2019**	2016 Behavioral Risk Factor Surveillance System (BRFSS)
	Motor Vehicle Driving Deaths with Alcohol Involvement	2018 County Health Rankings & Roadmaps; Fatality Analysis Reporting System (FARS)
	Physical Inactivity	2018 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System
	Sexually Transmitted Infection Incidence	2018 County Health Rankings & Roadmaps; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)
	Teen Birth Rate per 1,000 Female Population, Ages 15-19	2018 County Health Rankings & Roadmaps; National Center for Health Statistics - Natality files, National Vital Statistics System (NVSS)

Category	Public Health Indicator	Source
Health Status	Adults Reporting Fair or Poor Health	2018 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)
	Average Number of Physically Unhealthy Days Reported in Past 30 days (Age-Adjusted)	2018 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)
Injury & Death	Cancer Mortality Rate	2013 Texas Health Data, Center for Health Statistics, Texas Department of State Health Services
	Child Mortality Rate	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Chronic Lower Respiratory Disease (CLRD) Mortality Rate	2013 'Texas Health Data, Center for Health Statistics, Texas Department of State Health Services
	Death rate due to firearms **NEW 2019**	2018 County Health Rankings (CDC WONDER Environmental Data)
	Heart Disease Mortality Rate	2013 Texas Health Data, Center for Health Statistics, Texas Department of State Health Services
	Infant Mortality Rate	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Motor Vehicle Crash Mortality Rate	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Number of deaths due to injury **NEW 2019**	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Premature Death (Potential Years Lost)	2018 County Health Rankings & Roadmaps; National Center for Health Statistics - Mortality Files, National Vital Statistics System (NVSS)
	Stroke Mortality Rate	2013 Texas Health Data, Center for Health Statistics, Texas Department of State Health Services
Maternal & Child Health	First Trimester Entry into Prenatal Care	2016 Texas Health and Human Services - Vital statistics annual report
	Low Birth Weight Percent	2018 County Health Rankings & Roadmaps; National Center for Health Statistics - Natality files, National Vital Statistics System (NVSS)
	Low Birth Weight Rate	2016 Texas Health and Human Services - Vital statistics annual report - Preventable Hospitalizations
	Preterm Births <37 Weeks Gestation	2015 Kids Discount Data Center
	Very Low Birth Weight (VLBW)	Centers for Disease Control and Prevention WONDER
Mental Health Conditions/Diseases	Accidental poisoning deaths where opioids were involved **NEW 2019**	U.S. Census Bureau, Population Division and 2015 Texas Health and Human Services Center for Health Statistics Opioid related deaths in Texas
	Alzheimer's Disease/Dementia in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Average Number of Mentally Unhealthy Days Reported in Past 30 days (Age-Adjusted)	2018 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)
	Depression in Medicare Population	CMS.gov Chronic conditions 2007-2015
	Frequent mental distress	2016 Behavioral Risk Factor Surveillance System (BRFSS)
	Intentional Self-Harm; Suicide **NEW 2019**	2015 Texas Health Data Center for Health Statistics
	Ratio of Population to one Mental Health Provider	2018 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)
	Schizophrenia and Other Psychotic Disorders in Medicare Population	CMS.gov Chronic conditions 2007-2015
Population	Children Eligible for Free Lunch Enrolled in Public Schools	2018 County Health Rankings & Roadmaps, The National Center for Education Statistics (NCES)

Category	Public Health Indicator	Source
	Children in Poverty	2018 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau
	Children in Single-Parent Households	2018 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)
	Civilian veteran population 18+ **NEW 2019**	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
	Disabled population, civilian noninstitutionalized	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
	High School Dropout	2016 Texas Education Agency
	High School Graduation	2017 Texas Education Agency
	Homicides	2018 County Health Rankings & Roadmaps, CDC WONDER Mortality Data
	Household income, median **NEW 2019**	2018 County Health Rankings (2016 Small Area Income and Poverty Estimates)
	Income Inequality	2018 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)
	Individuals Living Below Poverty Level	2012-2016 US Census Bureau - American FactFinder
	Individuals Who Report Being Disabled	2012-2016 US Census Bureau - American FactFinder
	Non-English-speaking households **NEW 2019**	U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
	Social/Membership Associations	2018 County Health Rankings & Roadmaps; 2015 County Business Patterns, United States Census Bureau
	Some College	2018 County Health Rankings & Roadmaps; American Community Survey (ACS), 5 Year Estimates (United States Census Bureau)
	Unemployment	2018 County Health Rankings & Roadmaps; Local Area Unemployment Statistics (LAUS), Bureau of Labor Statistics
	Violent Crime Offenses	2018 County Health Rankings & Roadmaps; Uniform Crime Reporting (UCR) Program, United States Department of Justice, Federal Bureau of Investigation (FBI)
Preventable Hospitalizations	Asthma Admission: Pediatric (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Diabetes Lower-Extremity Amputation Admission: Adult (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Diabetes Short-term Complications Admission: Pediatric (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Gastroenteritis Admission: Pediatric (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Perforated Appendix Admission: Adult (Risk-Adjusted-Rate per 100 Admissions for Appendicitis)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Perforated Appendix Admission: Pediatric (Risk-Adjusted-Rate for Appendicitis)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Uncontrolled Diabetes Admission: Adult (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
	Urinary Tract Infection Admission: Pediatric (Risk-Adjusted-Rate)	2016 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations
Prevention	Diabetic Monitoring in Medicare Enrollees	2018 County Health Rankings & Roadmaps; Dartmouth Atlas of Health Care, CMS

Category	Public Health Indicator	Source
	Mammography Screening in Medicare Enrollees	2018 County Health Rankings & Roadmaps; Dartmouth Atlas of Health Care, CMS

Appendix B: Community Resources Identified to Potentially Address Significant Health Needs

Below is a list of resources available in the community with the ability to address the significant health needs identified in the assessment. For a continually updated list of the resources available to address these needs as well as other social determinants of health, please visit our website (**BSWHealth.com/CommunityNeeds)**.

Resources Identified

COMMUNITY HEALTH NEED	CATEGORY	SERVICE	FACILITY NAME	ADDRESS	CITY	PHONE NUMBER
Primary Care Providers (MD/Non-MD)	Access to Care	Primary Care	Burnet County Indigent Health Program - Burnet	309 Industrial Boulevard	Burnet	512-755-1558
Primary Care Providers (MD/Non-MD)	Access to Care	Primary Care	Burnet County Indigent Health Program - Marble Falls	1016 Broadway Street	Marble Falls	830-693-0700
Primary Care Providers (MD/Non-MD)	Access to Care	Primary Care	Community Resource Center	1016 Broadway Street	Marble Falls	830-693-0700
Primary Care Providers (MD/Non-MD)	Access to Care	Primary Care	Lone Star Circle of Care Family Care Center	802 Avenue J	Marble Falls	877-800-5722
Primary Care Providers (MD/Non-MD)	Access to Care	Primary Care	Methodist Healthcare Ministries of South Texas - Wesley Nurse	800 Wright Street	Llano	325-247-4011
Diabetes Short-Term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Health Education	Boys and Girls Club - Burnet Teen Center	601 North Wood Street	Burnet	512-756-1444
Diabetes Short-Term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Health Education	Boys and Girls Club - Burnet Unit	709 Northington Street	Burnet	512-756-1444
Diabetes Short-Term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Health Education	Boys and Girls Club - Granite Shoals Extension	505 South Phillips Ranch Road	Granite Shoals	830-798-2582
Diabetes Short-Term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Health Education	Boys and Girls Club - Kingsland Unit	3435 West RR 1431	Kingsland	325-388-2800
Diabetes Short-Term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Health Education	Boys and Girls Club - Marble Falls Unit	1701 Broadway Street	Marble Falls	830-798-2582

COMMUNITY HEALTH NEED	CATEGORY	SERVICE	FACILITY NAME	ADDRESS	CITY	PHONE NUMBER
Diabetes Short-Term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Health Education	Methodist Healthcare Ministries of South Texas - Wesley Nurse	800 Wright Street	Llano	325-247-4011
Diabetes Short-Term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Home Health Services	Encompass Home Health	503 FM 1431, Suite 202	Marble Falls	830-693-2657
Diabetes Short-Term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Home Health Services	Granite Mesa Health Center	1401 Max Copeland Drive	Marble Falls	830-693-0022
Diabetes Short-Term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Home Health Services	Jordan Health Services	705 Highway 281, Suite 201	Marble Falls	830-798-2989
Diabetes Short-Term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Home Health Services	Outreach Health Services-Home Care	503 FM 1431, Suite 102	Marble Falls	830-693-1963
Diabetes Short-Term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Home Health Services	Seton Highland Lakes Home Health and Hospice	401 Industrial Boulevard	Burnet	512-756-7511
Diabetes Short-Term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Home Health Services	Texas Home Health Group	1100 Mission Hills Drive	Marble Falls	930-798-8272
Diabetes Short-Term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Home Medical Social Services	Encompass Home Health	503 FM 1431, Suite 202	Marble Falls	830-693-2657
Diabetes Short-Term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Home Nursing	Seton Highland Lakes Home Health and Hospice	401 Industrial Boulevard	Burnet	512-756-7511
Diabetes Short-Term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Nutrition Education	Lakes Area Care, Inc.	507 West Buchanan Drive	Burnet	512-756-4422
Ratio of Population to One Mental Health Provider	Mental Health	Crisis Services	Bluebonnet Trails Community Services	4606 Innovation Loop	Marble Falls	830-798-2902
Ratio of Population to One Mental Health Provider	Mental Health	Family Counseling	Llano Alliance for Drug Intervention (LADI)	1203 Ford Street	Llano	325-247-4573
Ratio of Population to One Mental Health Provider	Mental Health	Family Counseling	Llano Alliance for Drug Intervention (LADI)	711 South Water Street, Suite B	Burnet	830-613-6526

COMMUNITY HEALTH NEED	CATEGORY	SERVICE	FACILITY NAME	ADDRESS	CITY	PHONE NUMBER
Ratio of Population to One Mental Health Provider	Mental Health	General Psychiatry	Bluebonnet Trails Community Services	4606 Innovation Loop	Marble Falls	830-798-2902
Ratio of Population to One Mental Health Provider	Mental Health	General Psychiatry	Lone Star Circle of Care Family Care Center	802 Avenue J	Marble Falls	877-800-5722
Ratio of Population to One Mental Health Provider	Mental Health	Mental Health Services	Cross Hope Clubhouse	1315 Broadway Street	Marble Falls	830-596-3453
Children in Poverty and Uninsured	SDH - Income / Access to Care	Baby and Toddler Clothes	Highland Lakes Pregnancy Resource Center - Kingsland	266 Nob Hill	Kingsland	325-388-0354
Children in Poverty and Uninsured	SDH - Income / Access to Care	Baby and Toddler Clothes	Highland Lakes Pregnancy Resource Center - Marble Falls	1016 Broadway Street	Marble Falls	325-388-0354
Children in Poverty and Uninsured	SDH - Income / Access to Care	Baby Supplies	Highland Lakes Pregnancy Resource Center - Kingsland	266 Nob Hill	Kingsland	325-388-0354
Children in Poverty and Uninsured	SDH - Income / Access to Care	Baby Supplies	Highland Lakes Pregnancy Resource Center - Marble Falls	1016 Broadway Street	Marble Falls	325-388-0354
Children in Poverty and Uninsured	SDH - Income / Access to Care	Child Life Services	Hill Country Children's Advocacy Center	1001 North Hill Street	Burnet	512-756-2607
Children in Poverty and Uninsured	SDH - Income / Access to Care	Child Welfare	Hill Country Children's Advocacy Center	1001 North Hill Street	Burnet	512-756-2607
Children in Poverty and Uninsured	SDH - Income / Access to Care	Clothing	Anchor of Hope Church	906 King Road	Marble Falls	830-693-7937
Children in Poverty and Uninsured	SDH - Income / Access to Care	Clothing	First United Methodist Church	1101 Bluebonnet Drive	Marble Falls	830-693-4341
Children in Poverty and Uninsured	SDH - Income / Access to Care	Clothing	King's Closet	3455 RR 1431	Kingsland	325-388-0620
Children in Poverty and Uninsured	SDH - Income / Access to Care	Clothing	The Good Neighbor Thrift Shop	502 FM 1431	Marble Falls	830-798-1512
Children in Poverty and Uninsured	SDH - Income / Access to Care	Clothing	The Helping Center	1315 Broadway Street	Marble Falls	830-693-5689
Children in Poverty and Uninsured	SDH - Income / Access to Care	Clothing Vouchers	Anchor of Hope Church	906 King Road	Marble Falls	830-693-7937
Children in Poverty and Uninsured	SDH - Income / Access to Care	Crisis Services	Bluebonnet Trails Community Services	4606 Innovation Loop	Marble Falls	830-798-2902

COMMUNITY HEALTH NEED	CATEGORY	SERVICE	FACILITY NAME	ADDRESS	CITY	PHONE NUMBER
Children in Poverty and Uninsured	SDH - Income / Access to Care	Early School Preparedness	Burnet Head Start	803 North Vanderveer Street	Burnet	512-756-4777
Children in Poverty and Uninsured	SDH - Income / Access to Care	Early School Preparedness	Highland Lakes Head Start	8200 West FM 1431	Granite Shoals	830-598-7667
Children in Poverty and Uninsured	SDH - Income / Access to Care	Early School Preparedness	Hill Country Community Action Association	2905 West Wallace Street	San Saba	254-519-3360
Children in Poverty and Uninsured	SDH - Income / Access to Care	Early School Preparedness	Marble Falls Head Start	901 Avenue U	Marble Falls	830-693-2887
Children in Poverty and Uninsured	SDH - Income / Access to Care	Education Assistance	Afterschool Centers on Education	607 North Vanderveer	Burnet	512-715-5191
Children in Poverty and Uninsured	SDH - Income / Access to Care	Education Assistance	Afterschool Centers on Education	2101 Mustang Drive	Marble Falls	830-798-3690
Children in Poverty and Uninsured	SDH - Income / Access to Care	Education Assistance	Afterschool Centers on Education	1401 North Main Street	Burnet	512-715-5193
Children in Poverty and Uninsured	SDH - Income / Access to Care	Education Assistance	Afterschool Centers on Education	1511 Pony Circle	Marble Falls	830-798-3689
Children in Poverty and Uninsured	SDH - Income / Access to Care	Education Assistance	Afterschool Centers on Education	8200 West FM 1431	Granite Shoals	830-798-3688
Children in Poverty and Uninsured	SDH - Income / Access to Care	Education Assistance	Afterschool Centers on Education	500 East Graves	Burnet	512-715-5190
Children in Poverty and Uninsured	SDH - Income / Access to Care	Education Assistance	Afterschool Centers on Education	315 Main Street	Bertram	512-715-5192
Children in Poverty and Uninsured	SDH - Income / Access to Care	Education Assistance	Boys and Girls Club - Burnet Teen Center	601 North Wood Street	Burnet	512-756-1444
Children in Poverty and Uninsured	SDH - Income / Access to Care	Education Assistance	Boys and Girls Club - Burnet Unit	709 Northington Street	Burnet	512-756-1444
Children in Poverty and Uninsured	SDH - Income / Access to Care	Education Assistance	Boys and Girls Club - Granite Shoals Extension	505 South Phillips Ranch Road	Granite Shoals	830-798-2582
Children in Poverty and Uninsured	SDH - Income / Access to Care	Education Assistance	Boys and Girls Club - Kingsland Unit	3435 West RR 1431	Kingsland	325-388-2800
Children in Poverty and Uninsured	SDH - Income / Access to Care	Education Assistance	Boys and Girls Club - Marble Falls Unit	1701 Broadway Street	Marble Falls	830-798-2582
Children in Poverty and Uninsured	SDH - Income / Access to Care	Education Financial Aid and Loans	DMC Grants & Consulting	PO Box 646	Marble Falls	830-385-4672
Children in Poverty and Uninsured	SDH - Income / Access to Care	Financial Aid and Loans	DMC Grants & Consulting	PO Box 646	Marble Falls	830-385-4672

COMMUNITY HEALTH NEED	CATEGORY	SERVICE	FACILITY NAME	ADDRESS	CITY	PHONE NUMBER
Children in Poverty and Uninsured	SDH - Income / Access to Care	Financial Aid and Loans	First United Methodist Church	1101 Bluebonnet Drive	Marble Falls	830-693-4341
Children in Poverty and Uninsured	SDH - Income / Access to Care	Financial Aid and Loans	Hill Country Community Action Association	2905 West Wallace Street	San Saba	254-519-3360
Children in Poverty and Uninsured	SDH - Income / Access to Care	Financial Assistance	Central Texas Council of Governments- San Saba County	500 East Wallace St.	San Saba	254-770-2300
Children in Poverty and Uninsured	SDH - Income / Access to Care	Financial Assistance	First Baptist Church	902 LeVantana Drive	Marble Falls	830-693-4381
Children in Poverty and Uninsured	SDH - Income / Access to Care	Financial Assistance	First United Methodist Church	1101 Bluebonnet Drive	Marble Falls	830-693-4341
Children in Poverty and Uninsured	SDH - Income / Access to Care	Financial Assistance	First United Methodist Church	1101 Bluebonnet Drive	Marble Falls	830-693-4341
Children in Poverty and Uninsured	SDH - Income / Access to Care	Financial Assistance	Hill Country Community Action Association	2905 West Wallace Street	San Saba	254-519-3360
Children in Poverty and Uninsured	SDH - Income / Access to Care	Financial Assistance	The Helping Center	1315 Broadway Street	Marble Falls	830-693-5689
Children in Poverty and Uninsured	SDH - Income / Access to Care	Financial Education	DMC Grants & Consulting	PO Box 646	Marble Falls	830-385-4672
Children in Poverty and Uninsured	SDH - Income / Access to Care	Free Meals	Meals on Wheels - Burnet	602 North Wood Street	Burnet	512-715-9717
Children in Poverty and Uninsured	SDH - Income / Access to Care	Free Meals	Meals on Wheels - Kingsland	200 Winwood Drive	Kingsland	325-388-4608
Children in Poverty and Uninsured	SDH - Income / Access to Care	Free Meals	Meals on Wheels - Marble Falls	200 highway 1431 East	Marble Falls	512-715-9717
Children in Poverty and Uninsured	SDH - Income / Access to Care	Free Meals	St. Frederick Baptist Church	301 Avenue N	Marble Falls	830-693-4499
Children in Poverty and Uninsured	SDH - Income / Access to Care	Government Benefits	Highland Lakes Pregnancy Resource Center - Kingsland	266 Nob Hill	Kingsland	325-388-0354
Children in Poverty and Uninsured	SDH - Income / Access to Care	Government Benefits	Highland Lakes Pregnancy Resource Center - Marble Falls	1016 Broadway Street	Marble Falls	325-388-0354
Children in Poverty and Uninsured	SDH - Income / Access to Care	Help Understanding Government Programs	Highland Lakes Pregnancy Resource Center - Kingsland	266 Nob Hill	Kingsland	325-388-0354

COMMUNITY HEALTH NEED	CATEGORY	SERVICE	FACILITY NAME	ADDRESS	CITY	PHONE NUMBER
Children in Poverty and Uninsured	SDH - Income / Access to Care	Help Understanding Government Programs	Highland Lakes Pregnancy Resource Center - Marble Falls	1016 Broadway Street	Marble Falls	325-388-0354
Children in Poverty and Uninsured	SDH - Income / Access to Care	Housing Advice	Community Resource Center	1016 Broadway Street	Marble Falls	830-693-0700
Children in Poverty and Uninsured	SDH - Income / Access to Care	Housing Insecurity Services	Central Texas Council of Governments- San Saba County	500 East Wallace St.	San Saba	254-770-2300
Children in Poverty and Uninsured	SDH - Income / Access to Care	Housing Insecurity Services	Habitat for Humanity at Highland Lakes	PO Box 1406	Marble Falls	830-693-0700
Children in Poverty and Uninsured	SDH - Income / Access to Care	Housing Insecurity Services	Habitat for Humanity at Highland Lakes	502 FM 1431	Marble Falls	830-693-3656
Children in Poverty and Uninsured	SDH - Income / Access to Care	Job Insecurity Services	Workforce Solutions of Rural Capital Area - Burnet	1001 West Buchanan Drive, Suite 1	Burnet	512-756-6769
Children in Poverty and Uninsured	SDH - Income / Access to Care	Job Insecurity Services	Workforce Solutions of Rural Capital Area - Llano	100 Legend Hills Boulevard	Llano	512-248-0275
Children in Poverty and Uninsured	SDH - Income / Access to Care	Job Placement	Workforce Solutions of Rural Capital Area - Burnet	1001 West Buchanan Drive, Suite 1	Burnet	512-756-6769
Children in Poverty and Uninsured	SDH - Income / Access to Care	Job Placement	Workforce Solutions of Rural Capital Area - Llano	100 Legend Hills Boulevard	Llano	512-248-0275
Children in Poverty and Uninsured	SDH - Income / Access to Care	Prescription Assistance	Burnet County Indigent Health Program - Burnet	309 Industrial Boulevard	Burnet	512-755-1558
Children in Poverty and Uninsured	SDH - Income / Access to Care	Prescription Assistance	Burnet County Indigent Health Program - Marble Falls	1016 Broadway Street	Marble Falls	830-693-0700
Children in Poverty and Uninsured	SDH - Income / Access to Care	Prescription Assistance	First United Methodist Church	1101 Bluebonnet Drive	Marble Falls	830-693-4341
Children in Poverty and Uninsured	SDH - Income / Access to Care	Prescription Assistance	Lakes Area Care, Inc.	507 West Buchanan Drive	Burnet	512-756-4422
Children in Poverty and Uninsured	SDH - Income / Access to Care	Prescription Assistance	Prescription Assistance Program	1016 Broadway Street	Marble Falls	830-693-0700
Children in Poverty and Uninsured	SDH - Income / Access to Care	Prescription Assistance	The Helping Center	1315 Broadway Street	Marble Falls	830-693-5689
Children in Poverty and Uninsured	SDH - Income / Access to Care	Social Services	Texas Home Health Group	1100 Mission Hills Drive	Marble Falls	930-798-8272

COMMUNITY HEALTH NEED	CATEGORY	SERVICE	FACILITY NAME	ADDRESS	CITY	PHONE NUMBER
Children in Poverty and Uninsured	SDH - Income / Access to Care	Transportation	Community Resource Center	1016 Broadway Street	Marble Falls	830-693-0700
Children in Poverty and Uninsured	SDH - Income / Access to Care	Vaccinations	Lakes Area Care, Inc.	507 West Buchanan Drive	Burnet	512-756-4422
Children in Poverty and Uninsured	SDH - Income / Access to Care	Winter Clothing	Anchor of Hope Church	906 King Road	Marble Falls	830-693-7937
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Assisted Living	CelesteCare of Horseshoe Bay	26409 State Highway 71 East	Horseshoe Bay	830-596-1711
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Assisted Living	CelesteCare of Llano	701 East Young Street	Llano	325-221-0797
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Assisted Living	Gateway Gardens/ Gateway Villas Retirement and Assisted Living	605 Gateway Central	Marble Falls	830-693-1903
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Assisted Living	Windchime at the Village Assisted Living	216 Covenant Lane	Kingsland	325-388-3502
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Fall Prevention	Encompass Home Health	503 FM 1431, Suite 202	Marble Falls	830-693-2657
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Food Delivery	Meals on Wheels - Burnet	602 North Wood Street	Burnet	512-715-9717
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Food Delivery	Meals on Wheels - Kingsland	200 Winwood Drive	Kingsland	325-388-4608
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Food Delivery	Meals on Wheels - Marble Falls	200 highway 1431 East	Marble Falls	512-715-9717
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Home Health Services	Encompass Home Health	503 FM 1431, Suite 202	Marble Falls	830-693-2657
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Home Health Services	Granite Mesa Health Center	1401 Max Copeland Drive	Marble Falls	830-693-0022
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Home Health Services	Jordan Health Services	705 Highway 281, Suite 201	Marble Falls	830-798-2989
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Home Health Services	Outreach Health Services-Home Care	503 FM 1431, Suite 102	Marble Falls	830-693-1963
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Home Health Services	Seton Highland Lakes Home Health and Hospice	401 Industrial Boulevard	Burnet	512-756-7511
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Home Health Services	Texas Home Health Group	1100 Mission Hills Drive	Marble Falls	930-798-8272

COMMUNITY HEALTH NEED	CATEGORY	SERVICE	FACILITY NAME	ADDRESS	CITY	PHONE NUMBER
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Home Living Aide Services	Visiting Angels	706 4th Street	Marble Falls	830-693-7118
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Home Medical Social Services	Encompass Home Health	503 FM 1431, Suite 202	Marble Falls	830-693-2657
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Home Nursing	Seton Highland Lakes Home Health and Hospice	401 Industrial Boulevard	Burnet	512-756-7511
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Prepared Food Delivery	Meals on Wheels - Burnet	602 North Wood Street	Burnet	512-715-9717
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Prepared Food Delivery	Meals on Wheels - Kingsland	200 Winwood Drive	Kingsland	325-388-4608
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Prepared Food Delivery	Meals on Wheels - Marble Falls	200 highway 1431 East	Marble Falls	512-715-9717
Elderly Isolation. 65+ Householder Living Alone	SDH - Social Isolation	Social Services	Texas Home Health Group	1100 Mission Hills Drive	Marble Falls	930-798-8272

Community Healthcare Facilities

Facility Name	Type	System	Street Address	City	State	ZIP
BAYLOR SCOTT & WHITE MEDICAL CENTER - LLANO	ST	Baylor Scott & White	200 W OLLIE ST	LLANO	TX	78643
BAYLOR SCOTT & WHITE MEDICAL CENTER - MARBLE FALLS	ST	Baylor Scott & White	810 W HIGHWAY 71	MARBLE FALLS	TX	78654
SETON HIGHLAND LAKES HOSPITAL	ST	Ascension Health	3201 SOUTH WATER STREET	BURNET	TX	78611

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

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

Health Professional Shortage Areas (HPSA)[17]

County Name	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type
Blanco	1487011249	Blanco County	Primary Care	Geographic HPSA
Blanco	7489026518	Blanco County	Mental Health	Geographic HPSA
Burnet	148999488N	Seton Highland Lakes Care-a-Van	Primary Care	Rural Health Clinic
Burnet	14899948OT	Seton Highland Lakes Dba Marble Falls Health Center	Primary Care	Rural Health Clinic
Burnet	74899948ME	Seton Highland Lakes Dba Marble Falls Health Center	Mental Health	Rural Health Clinic
Llano	1486640093	Low Income - Llano County	Primary Care	Low Income Population HPSA
Llano	7489383475	Llano County	Mental Health	Geographic HPSA
Llano	148999484U	Horseshoe Bay Clinic	Primary Care	Rural Health Clinic
Llano	648999480J	Horseshoe Bay Clinic	Dental Health	Rural Health Clinic
Llano	748999481F	Horseshoe Bay Clinic	Mental Health	Rural Health Clinic
San Saba	1481868316	San Saba County	Primary Care	Geographic HPSA
San Saba	7489559810	San Saba County	Mental Health	High Needs Geographic HPSA

[17] U.S. Department of Health and Human Services, Health Resources and Services Administration, 2018

Medically Underserved Areas and Populations (MUA/P)[18]

County Name	MUA/P Source Identification Number	Service Area Name	Designation Type	Rural Status
Blanco	03281	BLANCO SERVICE AREA	Medically Underserved Area	Rural
Burnet	03290	BLANCO SERVICE AREA	Medically Underserved Area	Rural
Llano	03381	Llano County	Medically Underserved Area	Rural
San Sabo	03418	SAN SABA SERVICE AREA	Medically Underserved Area	Rural

[18] U.S. Department of Health and Human Services, Health Resources and Services Administration, 201

Appendix D: Public Health Indicators Showing Greater Need When Compared to State Benchmark

Brazos Valley Health Community		
Public Health Indicator	**Category**	**Indicator Definition**
Diabetes Short-term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Preventable Hospitalizations	2016 Number Observed / Pediatric Population Under Age 18
Ratio of Population to one Mental Health Provider	Mental Health Conditions/Diseases	2017 Ratio of Population to Mental Health Providers
Ratio of Population to One Dentist	Access To Care	2016 Ratio of Population to Dentists
Gastroenteritis Admission: Pediatric (Risk-Adjusted-Rate)	Preventable Hospitalizations	2016 Number Observed / Pediatric Population Under Age 18
Ratio of Population to One Non-Physician Primary Care Provider	Access To Care	2017 Ratio of Population to Primary Care Providers Other than Physicians
Motor Vehicle Crash Mortality Rate	Injury & Death	2010-2016 Number of Motor Vehicle Crash Deaths per 100,000 Population
Motor Vehicle Driving Deaths with Alcohol Involvement	Health Behaviors	2012-2016 Percentage of Motor Vehicle Crash Deaths that had Alcohol Involvement
Elderly isolation. 65+ Householder living alone	Environment	2012 Percent of Non-family households - Householder living alone - 65 years and over
Individuals Who Report Being Disabled	Population	2012-2016 American Community Survey 5-Year Estimates, Population 65+ US
Disabled population, civilian noninstitutionalized	Population	2012 Percent Total Civilian Non-institutionalized Population with a disability
Drug Poisoning Deaths Rate	Health Behaviors	2014-2016 Number of Drug Poisoning Deaths (Drug Overdose Deaths) per 100,000 Population
Death rate due to firearms	Injury & Death	2012-2016 number of deaths due to firearms, per 100,000 population.
Civilian veteran population 18+	Population	2012 Percent of population 18 years and over - Civilian veterans
Population with Adequate Access to Locations for Physical Activity	Environment	2010 & 2016 Percentage of Population with Adequate Access to Locations for Physical Activity
Uninsured Children	Access To Care	2015 Percentage of Children Under Age 19 Without Health Insurance

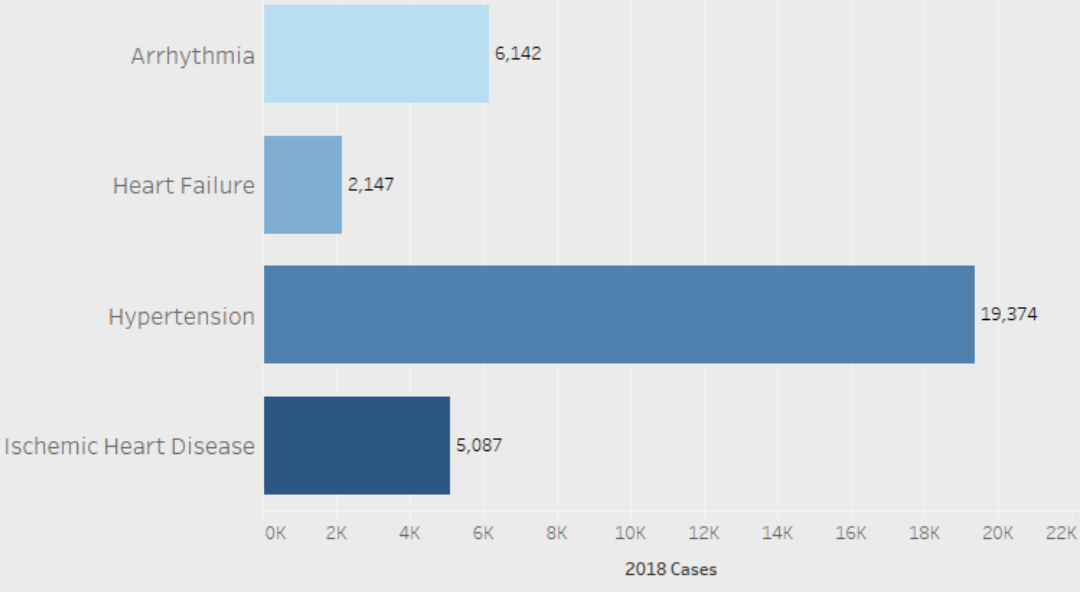
Brazos Valley Health Community		
Public Health Indicator	**Category**	**Indicator Definition**
Diabetes Lower-Extremity Amputation Admission: Adult (Risk-Adjusted-Rate)	Preventable Hospitalizations	2016 Number Observed / Adult Population Age 18 and older
Number of deaths due to injury	Injury & Death	2010-2016 Number of Motor Vehicle Crash Deaths per 100,000 Population
Ratio of Population to One Primary Care Physician	Access To Care	2015 Ratio of Population to Primary Care Providers
Limited Access to Healthy Foods (Percent of Low Income)	Environment	2015 Percentage of Population Who are Low-Income and Do Not Live Close to a Grocery Store
Perforated Appendix Admission: Adult (Risk-Adjusted-Rate per 100 Admissions for Appendicitis)	Preventable Hospitalizations	2016 Number Observed / Adult Population Age 18 and older
Children in Poverty	Population	2016 Percentage of Children Under Age 18 in Poverty

Appendix E: Watson Health Community Data

Watson Health supplemented the publicly available data with estimates of localized disease prevalence of heart disease and cancer as well as emergency department visit estimates.

Watson Health Heart Disease Estimates identified hypertension as the most prevalent heart disease diagnoses; there were over 19,000 estimated cases in the community overall. The Marble Falls ZIP code had the most estimated cases of each heart disease type, likely driven by population size. However, despite fewer number of cases, the ZIP codes of Buchanan Lake had some of the highest estimated prevalence rate for Arrhythmia (1,124 cases per 10,000 population), Heart Failure (403 cases per 10,000 population) and Ischemic Heart Disease (977 cases per 10,000 population). While North Blanco County had the highest prevalence for Hypertension (3,063 cases per 10,000 population).

2018 Estimated Heart Disease Cases



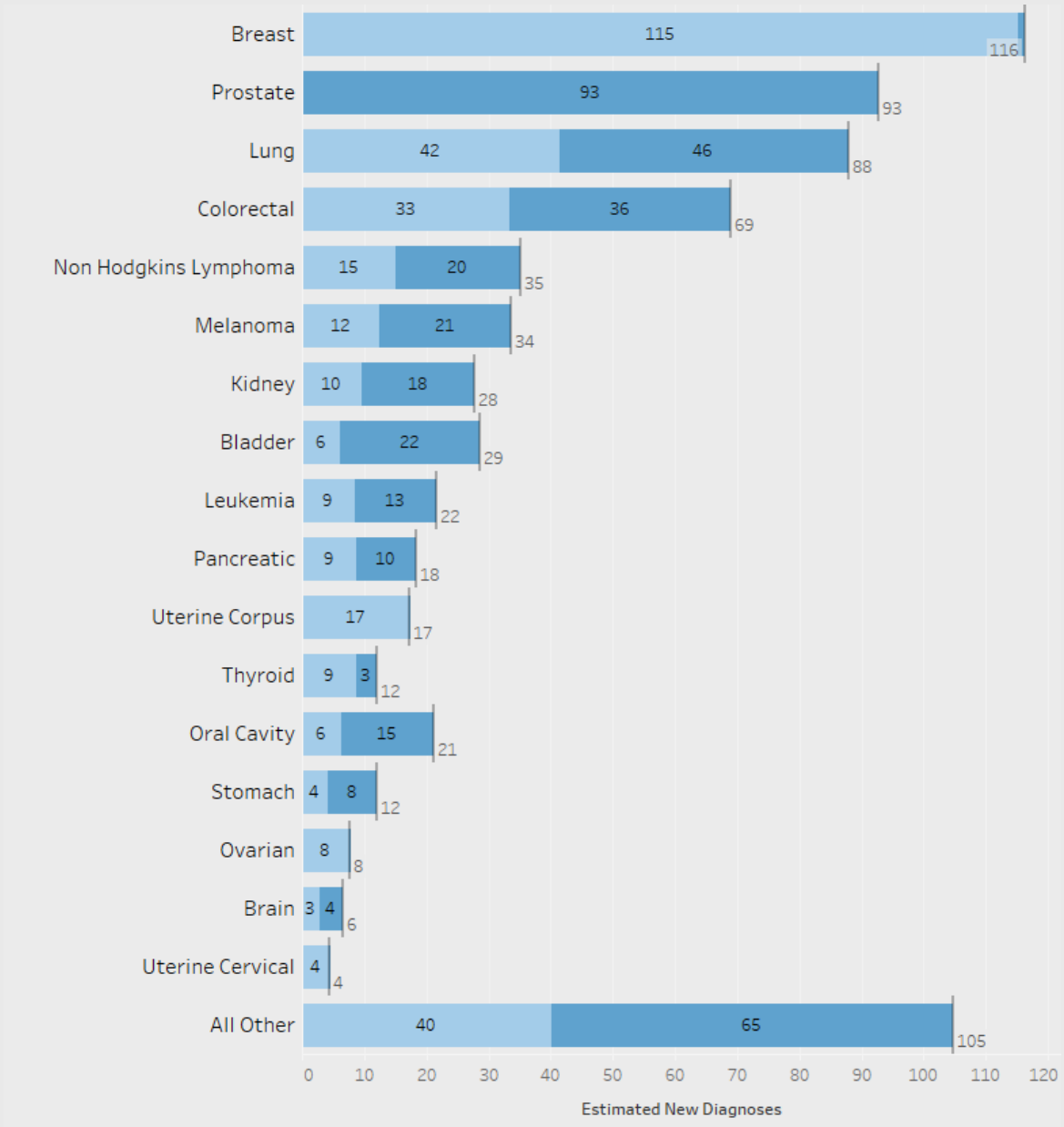
Bar chart shows total number of 2018 Estimated Heart Disease cases for each of four types: arrhythmia, heart failure, hypertension, and ischemic heart disease

Note: An individual patient may have more than one type of heart disease. Therefore the sum of all four heart disease types is not a unique count of individuals.

Source: IBM Watson Health, 2018

For this community, Watson Health's 2018 Cancer Estimates revealed the cancers projected to grow the greatest rate of growth in next 5 years were thyroid, pancreatic, and melanoma. Most new cancer cases in 2018 were estimated to be breast, lung, and prostate cancers.

2018 Estimated New Cancer Cases



Bar chart shows estimated new diagnoses per year for each of the 17 types of Cancer and 1 category for all other cancers. Color shows details about sex with light blue for females and dark blue for males.

Source: IBM Watson Health, 2018

Estimated Cancer Cases and Projected 5 Year Change by Type

Cancer Type	2018 Estimated New Cases	2023 Estimated New Cases	5 Year Growth (%)
Bladder	29	32	10.3%
Brain	6	7	16.7%
Breast	116	126	8.6%
Colorectal	69	63	-8.7%
Kidney	28	31	10.7%
Leukemia	22	24	9.1%
Lung	88	94	6.8%
Melanoma	34	39	14.7%
Non-Hodgkin's Lymphoma	35	39	11.4%
Oral Cavity	21	23	9.5%
Ovarian	8	8	0.0%
Pancreatic	18	21	16.7%
Prostate	93	93	0.0%
Stomach	12	13	8.3%
Thyroid	12	14	16.7%
Uterine Cervical	4	5	25.0%
Uterine Corpus	17	19	11.8%
All Other	105	117	11.4%
Grand Total	716	766	7.0%

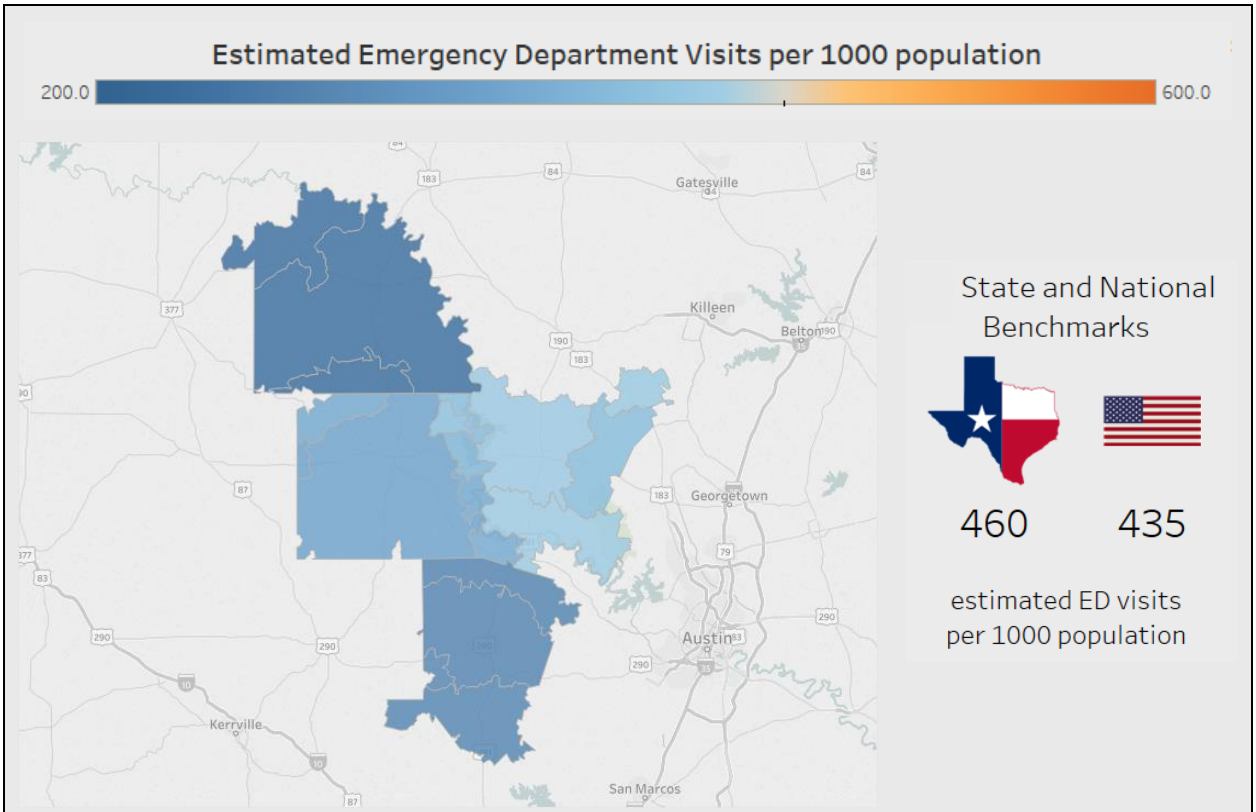
Source: IBM Watson Health, 2018

Based on population characteristics and regional utilization rates, Watson Health projected all emergency department (ED) visits in this community to increase by 8.8% over the next 5 years. About one-third of ED visits were generated by the residents of Marble Falls, where we also see the highest estimated ED use rates in this Health Community: 435.2 to ED visits per 1,000 residents compared to the Texas state benchmark of 460 visits and the U.S. benchmark 435 visits per 1,000.

These ED visits consisted of three main types: those resulting in an inpatient admission, emergent outpatient treated and released ED visits, and non-emergent outpatient ED visits that were lower acuity. Non-emergent ED visits present to the ED but can be treated in more appropriate and less intensive outpatient settings.

Non-emergent outpatient ED visits can be an indication of systematic issues within the community regarding access to primary care, managing chronic conditions, or other access to care issues such as ability to pay. Watson Health estimated non-emergent ED visits to increase by an average of 3.3% over the next 5 years in this community.

Estimated 2018 Emergency Department Visit Rate

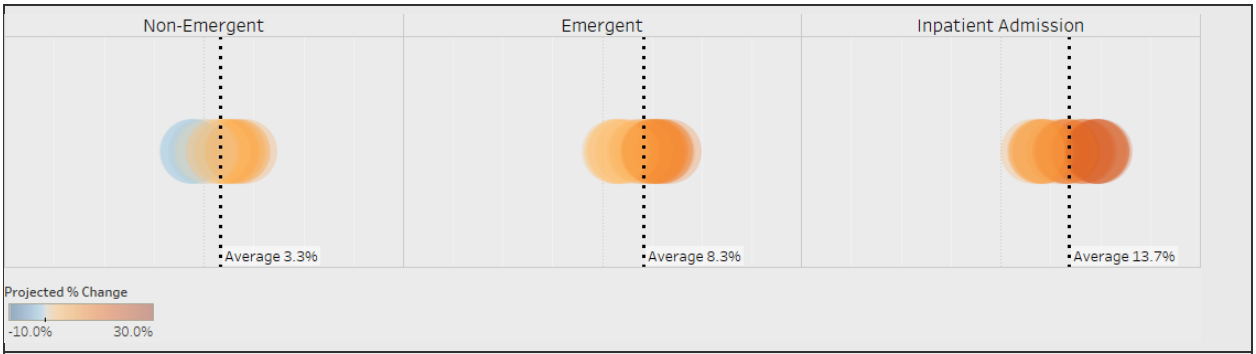


Zip map color shows total Emergency Department visits per 1000 popultaion. Orange colors are higher than the state benchmark, blue colors are less than the state benchmark, and gray colors are similar.

Note: These are not actual BSWH ED visit rates. These are statistical estimates of ED visits for the population.

Source: IBM Watson Health, 2018

Projected 5 Year Change in Emergency Department Visits by Type and ZIP Code



Three panels show the percent change in Emergency Department visits by 2013 at the ZIP level. The average for all ZIPs in the Health Community is labeled. ED visits are defined by the presence of specific CPT® codes in claims. Non-emergency visits to the ED do not necessarily require treatment in a hospital emergency department and can potentially be reated in a fast-track ED, an uregent care treatment center, or a clinical or a physician's private office. Emergent visits require immediate treatment in a hospital emergency department due to the severity of illness. ED visits that result in inpatient admissions do not receive a CPT® code, but typically can be assumed to have resulted from an emergent encounter.

Note: These are not actual BSWH ED visit rates. These are statistical estimates of ED visits for the population.

Source: IBM Watson Health, 2018

Appendix F: Evaluation of 2016 Implementation Strategy Impact

Evaluation of 2016 CHNA Implementation

Total Resources Contributed to Addressing Community Needs:

More than $71,000

Identified Needs **Chronic Disease, Cancer and Prenatal Care/Teen Births**

Addressed through: Community Education and Health Fairs

Program Name: COMMUNITY HEALTH EDUCATION – Community Based and Seniors
Description: Baylor Scott & White Health consistently looks for opportunities to educate the community on health issues to support our mission and vision. The programs and services that fall into this category extend beyond patient care activities and include services directed to both individuals and larger populations in the community. They include such things as educational information about preventive health care, lectures, or presentations held by BSWH physicians and staff about health-related topics like nutrition, breastfeeding, understanding various conditions and diseases, when to seek treatment, and the treatment options available.
Impact/Outcomes: 8643 Persons Served
Supported by: Baylor Scott & White Medical Center – Marble Falls, and Baylor Scott & White Medical Center - Llano
Resources Contributed: Staff time and resources valued at $13,225 of Community Benefit

Program Name: COMMUNITY HEALTH EDUCATION – School-Based and Teens
Description: BSWH recognizes the importance of teaching about health and health professions to students in our school systems. Programs and services in this category are geared towards students K-12 and provide educational opportunities for students in the local ISD's to learn about the importance of making healthy living choices starting at an early age.
Impact/Outcomes: 630 Persons Served
Supported by: Baylor Scott & White Medical Center – Marble Falls, and Baylor Scott & White Medical Center - Llano
Resources Contributed: Staff time and materials valued at $1,783 Community Benefit

Program Name: COMMUNITY BUILDING ACTIVITIES: Health Related
Description: Using BS&W expertise and resources, we can support community programs that address underlying causes of health problems in order to improve health status or quality of life. These efforts focus on the root causes of health problems such as poverty, homelessness and environmental problems.
Impact/Outcomes: 2879 Persons Served
Supported by: Baylor Scott & White Medical Center – Marble Falls, and Baylor Scott & White Medical Center - Llano
Resources Contributed: Staff time and resources valued at $17,535 of Community Benefit

Program Name: DONATION: Health Improvement
Description: BSWH donates funds often to local charitable, not for profit organizations whose efforts to improve community health align with the identified health needs in our community. We do so to support their efforts to improve the overall health of the community through education, prevention, health advocacy, or disease management education. Funds that go to improving the health infrastructure of our community are counted after subtracting the fair market value of participation by employees or the organization.
Impact/Outcomes: 30 Persons Served
Supported by: Baylor Scott & White Medical Center – Marble Falls, and Baylor Scott & White Medical Center - Llano
Resources Contributed: Staff time and materials valued at $18,793 of Community Benefit

Program Name: HEALTH FAIRS
Description: BS&W 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.
Impact/Outcomes: 1904 Persons Served
Supported by: Baylor Scott & White Medical Center – Marble Falls, and Baylor Scott & White Medical Center - Llano
Resources Contributed: Staff time and materials valued at $15,186 of Community Benefit

Identified Need Addressed: Cancer

Program Name: Community Health Education - Cancer
Description: BSWH supplies information and screenings on skin, cervical, colorectal, and breast health to organizations and at events across the community. Information includes proper screening guidelines or support groups, and how to access services to reduce the incidence of late stage cancer going undetected.
Impact/Outcomes: 338 Persons Served
Supported by: Baylor Scott & White Medical Center – Marble Falls, and Baylor Scott & White Medical Center - Llano
Resources Contributed: Staff time and materials valued at $4969 of Community Benefit

Identified Need Addressed: Chronic Disease Management

Program Name: DIABETES EDUCATION
Description: Educational outreach and other efforts done both in unit and out in the community targeting obesity and related chronic conditions to include Baylor Scott & White Health offering free and reduced cost services and programs geared towards enhancing well-being of individuals in the community.
Impact/Outcomes: 37 Persons Served
Supported by: Baylor Scott & White Medical Center – Marble Falls, and Baylor Scott & White Medical Center - Llano
Resources Contributed: Staff time and materials valued at $406 of Community Benefit

Program Name: DSRIP Comprehensive Chronic Disease Program
Description: As part of the HHSC 1115 Waiver and through the Regional Health Partnership needs assessment, BSWH Marble Falls identified the following key needs: (1) Improve the management of chronic conditions and patient outcomes specifically related to diabetes, heart disease and obesity, (2) Improve access to behavioral health providers and support systems, (3) Improve patient outcomes related to potentially preventable hospital admissions and readmissions, hospital acquired conditions and emergency room utilization, (4) Improve patient satisfaction in hospital and clinic locations, and (5) Continuously improve appropriate patient access by providing the right care at the right time in the right location. BSWH Marble Falls directly addressed these needs through the HHSC 1115 Waiver focusing on navigating patients to preventive care and patient centered medical home (PCMH) type work which coincides with the identified needs in the CHNA around helping with connection to services and resources, bolstering access to primary care and preventive services to the most vulnerable in this community.
Impact/Outcomes: 5,724 Persons Served
Supported by: Baylor Scott & White Medical Centers – Marble Falls and Llano
Resources Contributed: Staff time and materials contributed as subsidized continuing care of Community Benefit

Program Name: DSRIP ED Navigation
Description: As part of the HHSC 1115 Waiver, BSWH Llano seeks to expand care to the most vulnerable in this community through a focused navigation program to provide resource lists and support to patients to connect to social and clinical resources post discharge and also a paramedicine program for the highest risk patients in the community. These activities are augmented with a primary care strategy to help bring focus on the preventive services that patients need and often forgo due to resource and access constraints by using navigation and paramedicine to support the primary care practices in providing these services and change the focus to prevention, maintenance and well care and away from sick care and catastrophic events. We hope to improve the health of entire populations in the community through focusing on education, connectivity and support to establish care in primary care settings.
Impact/Outcomes: 473 Persons Served
Supported by: Baylor Scott & White Medical Center – Marble Falls, Llano
Resources Contributed: Staff time and materials contributed as subsidized continuing care of Community Benefit