Community Health Needs Assessment

Greater Austin Region Health Community
2022

BaylorScott&White
HEALTH

Greater Austin Region health community hospitals

- **Baylor Scott & White Institute for Rehabilitation**

- **Baylor Scott & White Medical Center – Austin**

- **Baylor Scott & White Medical Center – Buda**

- **Baylor Scott & White Medical Center – Pflugerville**

- **Baylor Scott & White Medical Center – Round Rock**
  (Including Baylor Scott & White Medical Center – Lakeway and Baylor Scott & White Emergency Medical Center – Cedar Park)

- **Baylor Scott & White Medical Center – Taylor**

BaylorScott&White
HEALTH

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Baylor Scott & White Health mission

Our commitment to the communities we serve

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 51 hospitals, 1,100 access points, more than 7,300 active physicians, and over 49,000 employees and the Baylor Scott & White Health Plan.

Baylor Scott & White Health is a leading Texas healthcare provider with a proven commitment to patient and community health. Baylor Scott & White Health demonstrates this commitment through periodic community health needs assessments, then addresses those needs with a wide range of outreach initiatives.

These Community Health Needs Assessment (CHNA) activities also satisfy federal and state community benefit requirements outlined in the Patient Protection and Affordable Care Act and the Texas Health and Safety Code.

Baylor Scott & White Health conducts a thorough periodic examination of public health indicators and a benchmark analysis comparing communities it serves to an overall state of Texas value. In this way, it can determine where deficiencies lie and the opportunities for improvement are greatest.

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

STRATEGIES

**Health
Experience
Affordability
Alignment
Growth**

We serve faithfully

We act honestly

We never settle

We are in it together

VALUES

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

AMBITION

Through interviews, focus groups and surveys, the organization gains a clearer understanding of community needs from the perspective of the members of each community. This helps it identify the most pressing needs a community is facing and develop implementation plans to focus on those prioritized needs.

The process includes input from a wide range of knowledgeable people who represent the myriad interests of the community in compliance with 501 (r)(3) regulations. The CHNA process overview can be found in **Appendix A**.

The CHNAs serve as the foundation for community health improvement planning efforts over the next three years, while the implementation plans will be evaluated annually.

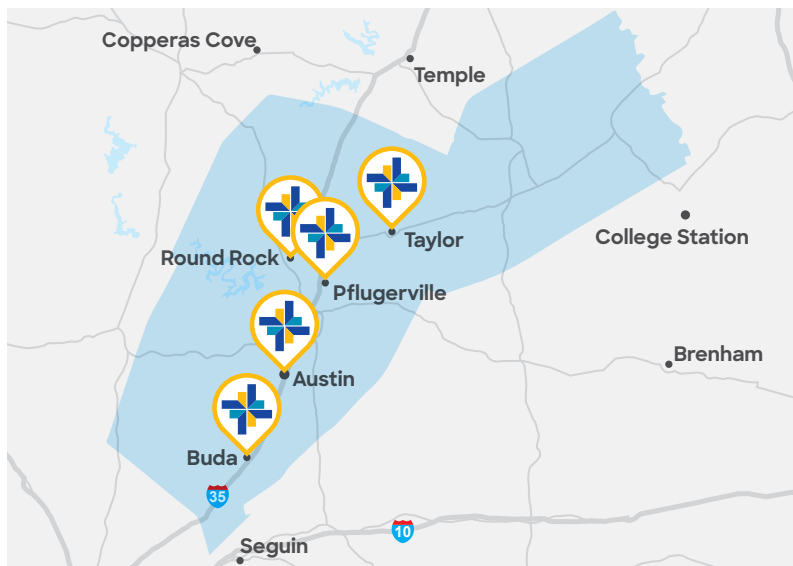# Community Health Needs Assessment (CHNA) report

Baylor Scott & White Health (BSWH) owns and operates numerous individually licensed hospital facilities serving the residents of North and Central Texas.

The Greater Austin Region Health Community is home to a number of these hospitals with overlapping communities, including:

- Baylor Scott & White Institute for Rehabilitation

- Baylor Scott & White Medical Center – Austin

- Baylor Scott & White Medical Center – Buda

- Baylor Scott & White Medical Center – Pflugerville

- Baylor Scott & White Medical Center – Round Rock (Including Baylor Scott & White Medical Center – Lakeway and Baylor Scott & White Emergency Medical Center – Cedar Park)

- Baylor Scott & White Medical Center – Taylor

The community served by the hospital facilities listed above is Hays, Milam, Travis and Williamson Counties. BSWH has at least one hospital facility or a provider-based clinic in each of these counties, and together they comprise more than 80% of admitted patients according to the hospital facilities' inpatient admissions over the 12-month period of FY20. Those facilities with overlapping counties of patient origin collaborated to provide a joint CHNA report in accordance with the Internal Revenue Code Section 501 (r) (3) and the US Treasury regulations thereunder. All of the collaborating hospital facilities included in a joint CHNA report define their communities to be the same for the purposes of the CHNA report.

Greater Austin Region Health Community map

BSWH engaged with IBM Watson Health, a nationally respected consulting firm, to conduct a Community Health Needs Assessment (CHNA) in accordance with the federal and state community benefit requirements for the health communities they serve.

Define the community	Assess the community	Identify and prioritize "significant needs"

The CHNA process included:

- Gathering and analyzing more than 59 public and 45 proprietary health data indicators to provide a comprehensive assessment of the health status of the communities. The complete list of health data indicators is included in **Appendix B**.

- Creating a benchmark analysis comparing the community to overall state of Texas and United States (US) values.

- Conducting focus groups, key informant interviews and stakeholder surveys, including input from public health experts, to gain direct input from the community for a qualitative analysis.

  - Gathering input from state, local and/or regional public health department members who have the pulse of the community's health.

  - Identifying and considering input from individuals or organizations serving and/or representing the interests of medically underserved low-income and minority populations in the community to help prioritize the community's health needs.

  - The represented organizations that participated are included in **Appendix C**.

IBM Watson Health provided current and forecasted demographic, socioeconomic and utilization estimates for the community.

Demographic and socioeconomic summary

The most important demographic and socioeconomic findings for the Greater Austin Region Health Community CHNA are:

- The community is outpacing the rate of growth of the state of Texas and the US.

- The median age of the population is older than Texas overall but younger than the national average.

- The median household income is significantly higher than both the state and the US.

- The community served has a higher percentage of privately insured people than Texas and the US.

Further demographic and socioeconomic information for the Greater Austin Region Health Community is included in **Appendix D**.

Health community data summary

IBM Watson Health's utilization estimates and forecasts indicate the following for the Greater Austin Health Community:

- Inpatient discharges in the community are expected to grow by 13.8% by 2030 with the largest growing product lines to include:
  - General Medicine
  - Pulmonary Medical
  - Cardiovascular Diseases
- Outpatient procedures are expected to increase by over 40% by 2030 with the largest areas of growth including:
  - General & Internal Medicine
  - Labs
  - Physical & Occupational Therapy
- Emergency Department visits are expected to grow by almost 19% by 2025.
- Hypertension represents 71% of all heart disease cases.
- Cancer incidence is expected to increase by almost 14% by 2025.

Further health community information for the Greater Austin Region Health Community is included in **Appendix E**.

The community includes the following health professional shortage areas and medically underserved areas as designated by the US Department of Health and Human Services Health Resources Services Administration. **Appendix D** includes the details on each of these designations.

County	Health professional shortage areas (HPSA)				Medically underserved area/ population (MUA/P)
	Dental health	Mental health	Primary care	Grand total	MUA/P
Hays	na	na	na	na	na
Milam		1	1	2	1
Travis	2	3	2	7	1
Williamson	1	1	1	3	1

Source: US Department of Health and Human Services, Health Resources and Services Administration, 2021
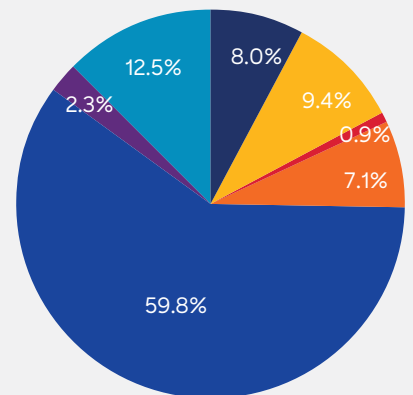
Total population

10,737,258

Average income

$86,818

Underserved ZIP codes

15

Insurance coverage

- Medicaid – pre-reform
- Medicare
- Medicare dual eligible
- Private – direct
- Private – ESI
- Private – exchange
- Uninsured

Pie chart values: 8.0%, 9.4%, 0.9%, 7.1%, 59.8%, 2.3%, 12.5%

Priority health needs

Using the data collection and interpretation methods outlined in this report, BSWH has identified what it considers to be the community's significant health needs. The resulting prioritized health needs for this community are:

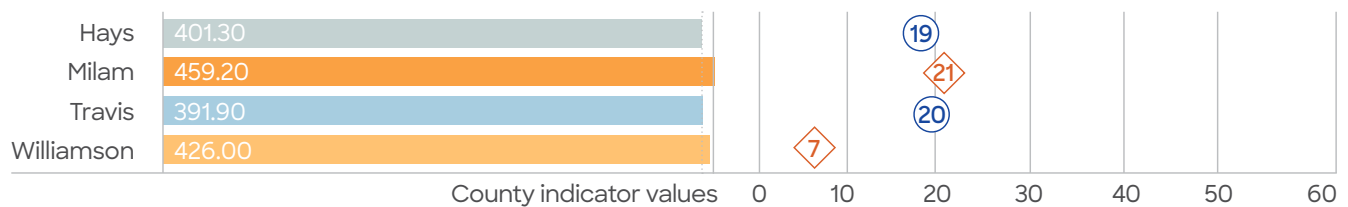| Priority	Need	Category of need
1	Preventive screenings	Conditions/diseases
2	Access to primary healthcare providers	Access to care
3	Adult obesity	Conditions/diseases
4	Access to mental healthcare (providers and resources)	Mental health
5	Severe housing problems	Housing/environment
6	Digital divide	Digital divide

Priority 1: Preventive Screenings (Cancer Incidence)

Category	Data shows greater need	Key informants indicate less need or not mentioned
Conditions/diseases	• Cancer incidence: all causes • Cancer incidence: female breast • Cancer incidence: prostate	• Not specifically mentioned, only discussed need for more cancer support

The following data indicates greater need for **preventive screenings for cancer around female breast, prostate and all causes**.

The cancer incidence: all causes measure is defined as **age-adjusted cancer (all) incidence rate cases per 100,000.** The indicator includes all races, all sexes and all ages. The indicator is based on data from State Cancer Profiles, National Cancer Institute (CDC).

Conditions/diseases: cancer incidence: all causes (incidence rate per 100,000 population in county)

	County indicator values
Hays	401.30
Milam	459.20
Travis	391.90
Williamson	426.00

Right panel ranks: Hays 19, Milam 21, Travis 20, Williamson 7

The cancer incidence: female breast measure is defined as **age-adjusted female breast cancer incidence rate cases per 100,000 population.** The indicator includes all races, females and all ages. Counts are suppressed if fewer than 16 records were reported in a specific area–sex–race category. The indicator is based on data from State Cancer Profiles, National Cancer Institute (CDC).

Conditions/diseases: cancer incidence: female breast (incidence rate per 100,000 female population in county)

	County indicator values
Hays	32.20
Milam	
Travis	32.50
Williamson	30.70

Right panel ranks: Hays 2, Travis 1, Williamson 1

Greater or lesser need than state
- ◇ greater need (orange)
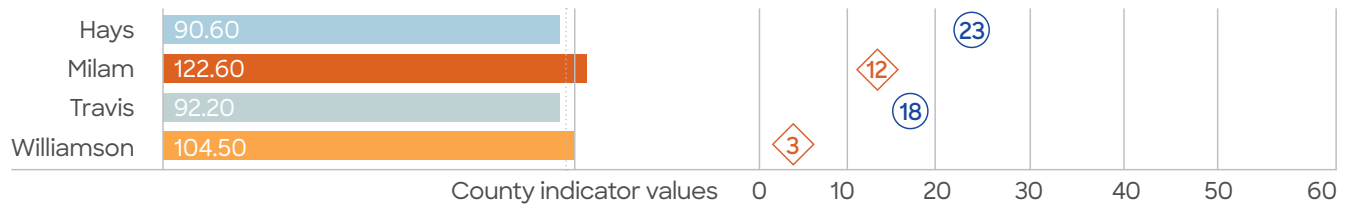- □ same level of need or NA (light blue)
- ○ lesser need (dark blue)

Counties are listed in alphabetical order within the Greater Austin Region Health Community.
LEFT PANEL: Indicator Values horizontal bar and label shows the county score. Vertical dotted line shows the state benchmark. Solid line is US score. Orange colors indicate a greater need and potentially larger vulnerable population in the county relative to the state benchmark. Blue indicates a lesser need and potentially smaller vulnerable population. Darker intense colors indicate greater differences.
RIGHT PANEL: Rank within county marks show how the indicator ranks compared to other indicators within the county. Indicators are ranked from 1 to 59, where low numbers show higher need and potentially larger vulnerable population relative to the state benchmark. Color and shape compare county performance to the state benchmark; orange diamonds show greater need and blue circles lesser need.

The cancer incidence: prostate measure is defined as **age-adjusted male prostate incidence rate cases per 100,000 population.** The indicator includes all races, males and all ages. The indicator is based on data from State Cancer Profiles, National Cancer Institute (CDC).

Conditions/diseases: cancer incidence: prostate (incidence rate per 100,000 male population in county)

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Although the focus group participants did not discuss cancer screenings specifically, they did agree that there was a need or opportunity to provide more community-based cancer support. They highlighted the high prevalence of chronic conditions in low-income populations.
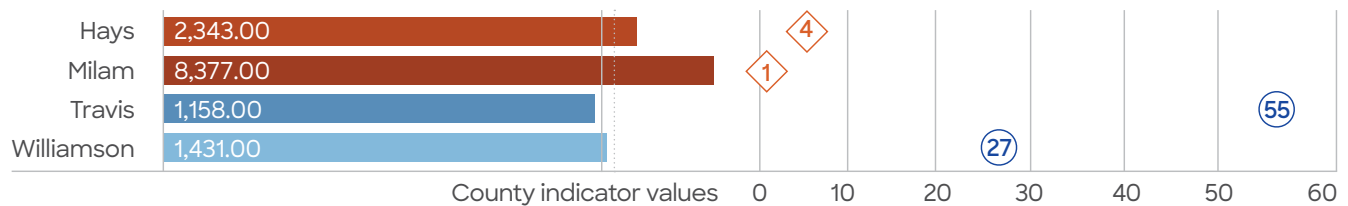
In the prioritization session, the hospital and community leaders agreed that cancer mortality is a great concern in Central Texas, and there is a racial disparity component to higher cancer incidence. They further cited that it is challenging for patients to access screenings. Easier access to screenings through expanded hours or more locations would contribute to higher screening rates.

Priority 2: Access to Primary Healthcare Providers

Category	Data shows greater need	Key informants indicate greater need
Access to care	• Population to one primary care physician	• Limited access to primary healthcare providers

The data below indicates greater need for **population to one primary care physician**. The indicator is defined as **the number of individuals served by one physician in a county if the population was equally distributed across physicians** and is based on data from County Health Rankings & Roadmaps and Area Health Resource File/American Medical Association.

Access to care: population to one primary care physician (number of individuals served by one physician by county)

Counties are listed in alphabetical order within the Greater Austin Region Health Community.
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RIGHT PANEL: Rank within county marks show how the indicator ranks compared to other indicators within the county. Indicators are ranked from 1 to 59, where low numbers show higher need and potentially larger vulnerable population relative to the state benchmark. Color and shape compare county performance to the state benchmark; orange diamonds show greater need and blue circles lesser need.

The focus group participants stated that the health community lacks sufficient numbers of primary healthcare providers, along with other specialties, to adequately serve the population, especially the growing underinsured patient population. They agreed that some of the healthcare access issues are tied to transportation but that cost and lack of insurance are also culprits. Regardless of the cause, there is a low ratio of healthcare providers to people in need.

In the prioritization session, hospital leadership prioritized Access to Primary Healthcare Providers as the second-highest ranked need to be addressed. They mentioned transportation difficulties as one of the challenges patients have in accessing providers.

Priority 3: Obesity

Category	Data shows greater need	Key informants indicate less need or not mentioned
Conditions/diseases	• Adult obesity	• Not specifically mentioned

The data below indicates greater need in the area of **adult obesity**. The indicator is defined as **the percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2** and is based on data from County Health Rankings & Roadmaps, CDC Diabetes Interactive Atlas and The National Diabetes Surveillance System.

Conditions/diseases: adult obesity (% of adults with BMI =>30 by county)

	Greater or lesser need than state
◇ (orange)	greater need
□ (grey)	same level of need or NA
○ (blue)	lesser need

Counties are listed in alphabetical order within the Greater Austin Region Health Community.
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The focus group participants did not specifically discuss obesity, but they did state that healthy food options were very limited in the health community, which is a contributor to conditions such as diabetes and obesity.

In the prioritization session, hospital leadership agreed that adult obesity is an issue in the community. Obesity and its related conditions drive up healthcare costs, including equipment, medication, increasing hospital days, etc., and therefore, it is an important need to prioritize.

Priority 4: Access to Mental Healthcare (Providers and Resources)

Category	Data shows greater need	Key informants indicate greater need
Mental health	• Mentally unhealthy days • Medicare population: depression	• Social isolation and depression brought on by COVID

The following data indicates greater need in the area of mental health, specifically in the measures of mentally unhealthy days and Medicare population: depression.

The **mentally unhealthy days** indicator is defined as **the average number of mentally unhealthy days reported in past 30 days (age-adjusted).** The indicator is based on data from County Health Rankings & Roadmaps, The Behavioral Risk Factor Surveillance System (BRFSS), CMS and National Provider Identification Registry (NPPES).

Mental health: mentally unhealthy days (average number of mentally unhealthy days reported in past 30 days by county)

The **Medicare population: depression** indicator is defined as **prevalence of the chronic condition of depression across all Medicare beneficiaries.** The indicator is based on data from CMS.gov Chronic Conditions.

Mental health: Medicare population: depression (prevalence of depression by county)

Greater or lesser need than state
◇ greater need
□ same level of need or NA
○ lesser need

Counties are listed in alphabetical order within the Greater Austin Region Health Community.
LEFT PANEL: Indicator Values horizontal bar and label shows the county score. Vertical dotted line shows the state benchmark. Solid line is US score. Orange colors indicate a greater need and potentially larger vulnerable population in the county relative to the state benchmark. Blue indicates a lesser need and potentially smaller vulnerable population. Darker intense colors indicate greater differences.
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The focus group participants stated that there is a demand for mental health services in the community, and patients are underserved. They further elaborated that mental health is on the decline, there is increased violence in the home, and drug abuse and child abuse are increasing.
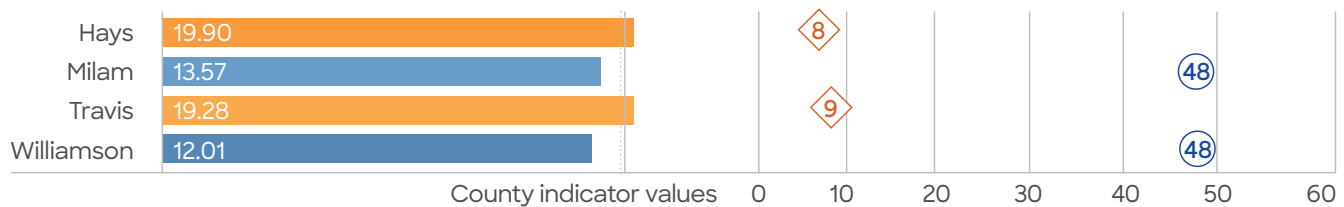
In the prioritization session, hospital leadership voted access to mental healthcare, both providers and resources, as the fourth-highest prioritized need in the community.

Priority 5: Severe Housing

Category	Data shows greater need	Key informants indicate greater need
Housing/ environment	• Severe housing problems	• Housing options and affordability are a challenge

The data below indicates greater need in the case of housing, specifically in the measure of **severe housing problems**. The indicator is defined as **the percentage of households with at least one of four housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities.** The indicator is based on data from County Health Rankings & Roadmaps; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP).

Housing: severe housing problems (% of households with 1 of 4 housing problems)

Counties are listed in alphabetical order within the Greater Austin Region Health Community.
LEFT PANEL: Indicator Values horizontal bar and label shows the county score. Vertical dotted line shows the state benchmark. Solid line is US score. Orange colors indicate a greater need and potentially larger vulnerable population in the county relative to the state benchmark. Blue indicates a lesser need and potentially smaller vulnerable population. Darker intense colors indicate greater differences.
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Legend — Greater or lesser need than state
- ◇ greater need
- ☐ same level of need or NA
- ○ lesser need

The focus group participants stated that housing options and affordability are a challenge in the health community. Gentrification has occurred, and the resulting impact is residents are being priced out of neighborhoods where they have lived for a long time. The participants cited that there is no visible plan across the county to provide affordable housing. They stated that there are people living in tents in many parts of the community and that some affordable housing options have a six-year waiting list. In addition, restrictions requiring all residents over 18 to have good credit have made it more difficult for many to find housing. Other requirements such as criminal background checks that prohibit people with a history of substance abuse rehabilitation or incarceration also add to the housing challenge. Participants felt strongly that there was an opportunity to advocate locally for more affordable housing and to reform the restrictions placed on applicants.

In the prioritization session, hospital leadership prioritized severe housing problems as the fifth-ranked need to be addressed.

Priority 6: Digital Divide

Category	Data shows less need or no data	Key informants indicate greater need
Digital divide	• No data	• Digital disparities

While there is no data indicator for digital divide collected or available, the focus group participants stated that digital inequity exists in the health community. They noted that many people assume that everyone can access the internet, but not all residents of rural communities have access. They believe that the digital divide is due to a lack of connectivity and that poor connections exist because people may not have equipment to access the internet or may not be able to pay for internet access.

In the prioritization session, hospital leadership prioritized digital divide as the sixth-ranked need to be addressed. They explored the meaning of digital divide and how it correlated to access care.

The Community Health Dashboards data referenced above can be found at **BSWHealth.com/About/ Community-Involvement/Community-Health-Needs-Assessments**.

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

Existing resources to address health needs

One part of the assessment process includes gathering input on potentially available community resources. The community is served by several large healthcare systems and multiple community-based health clinics. Below is a list of some of the community resources available to address identified needs in the community.

Greater Austin Region community resources

Need	Organization	Address	Phone
Preventive screenings	C.D. Doyle Clinic – Travis County	304 E. 7th Street Austin, TX 78701	409.571.9362
	Planned Parenthood of Greater Texas – Travis County	1823 E. 7th Street Austin, TX 78702	512.477.5846
	The Austin Diagnostic Clinic – Williamson County	1401 Medical Parkway Cedar Park, TX 78613	512.901.1111
	Williamson County and Cities Health District	350 Discovery Boulevard Cedar Park, TX 78613	512.260.4240
	HealthPoint – Milam County	1701 Pecos Avenue Rockdale, TX 76567	512.883.1070
	Little River Healthcare – Milam County	1700 Brazos Avenue Rockdale, TX 76567	512.446.4500
	CommuniCare Health Centers – Hays County	2810 Dacy Lane Kyle, TX 78640	210.233.7000
	Community Action, Inc. of Central Texas – Hays County	611 Martin Luther King Drive San Marcos, TX 78666	512.392.5816
Access to primary healthcare	C.D. Doyle Clinic – Travis County	304 E. 7th Street Austin, TX 78701	409.571.9362
	CommUnityCare ATCIC – Travis County	1631 E. 2nd Street Austin, TX 78702	512.978.9000
	Lone Star Circle of Care (LSCC) – Williamson County	2423 Williams Drive Georgetown, TX 78626	877.800.5722
	Carousel Pediatrics – Williamson County	1201 S. Interstate 35 Round Rock, TX 78664	512.744.6000
	HealthPoint – Milam County	1701 Pecos Avenue Rockdale, TX 76567	512.883.1070
	Little River Healthcare – Milam County – Internal Medicine/Family Medicine	1700 Brazos Avenue Rockdale, TX 76567	512.446.4500
	Live Oak Health Partners Primary & Specialty Care – Hays County	177b Kirkham Circle Kyle, TX 78640	512.405.0077
	Community Action, Inc. of Central Texas – Hays County	611 Martin Luther King Drive San Marcos, TX 78666	512.392.5816

Need	Organization	Address	Phone
Obesity	Sustainable Food Center (SFC) – Travis County	2921 E. 17th Street Austin, TX 78702	512.220.1083
	Austin Public Health (WIC – Travis County)	405 W. Stassney Lane Austin, TX 78745	512.972.4942
	Walk with a Doc (physical activity/health education – Williamson County)	445 E. Morrow Street Georgetown, TX 78626	614.714.0407
	Williamson County and Cities Health District (WCCHD) (WIC)	350 Discovery Boulevard Suite 102 Cedar Park, TX 78613	512.260.4241
	Milam County (WIC)	211 S. Houston Avenue Cameron, TX 76520	254.697.4913
	Milam County Health Department – Rockdale (WIC)	313 N. Main Street Rockdale, TX 76567	512.446.6245
	Seton Diabetes Education Center – Hays County	7900 FM 1826 Austin, TX 78737	512.324.1891 ext. 2
	CommuniCare Health Centers – Hays County (health education)	2810 Dacy Lane Kyle, TX 78640	210.233.7000
Access to mental healthcare (resources/ providers)	Integral Stonegate Clinic – Travis County	1631 E. 2nd Street Austin, TX 78702	512.472.4357
	Austin Area Mental Health Consumers Inc. (AAMHC) – Travis County	3205 S. 1st Street Austin, TX 78704	512.442.3366
	Community Resource Centers of Texas, Inc. – Williamson County	155 Hillcrest Lane Liberty Hill, TX 78642	512.548.5091
	Samaritan Center – Williamson County	3613 Williams Drive Georgetown, TX 78628	512.451.7337 ext. 8
	Central Counties Services, Inc. – Milam County – Cameron	708 N. Crockett Avenue Cameron, TX 76520	254.697.6631
	Central Counties Services–Marc Center – Milam County	1705 Pecos Avenue Rockdale, TX 76567	254.298.7171
	CommuniCare Health Centers–Kyle Campus (behavioral services – Hays County)	2810 County Road 205 Kyle, TX 78640	512.268.8900
	Samaritan Center – Hays County	129 W. Hutchison Street San Marcos, TX 78666	512.451.7337

Need	Organization	Address	Phone
Severe housing	The Salvation Army of Austin – Travis County	501 E. 8th Street Austin, TX 78701	512.476.1111
	The Salvation Army of Austin–Austin Shelter for Women and Children–Trav.	4613 Tannehill Lane Austin, TX 78721	512.933.0600
	Hope Alliance Emergency Shelter – Williamson County	1011 Gattis School Road Round Rock, TX 78664	800.460.7233
	The DMA Companies – Williamson County	300 Carl Stern Drive Hutto, TX 78634	512.846.4014
	Pioneer Property Management Inc. – Milam County	1501 E. Belton Avenue Rockdale, TX 76567	512.446.2322
	Cameron Housing Authority	704 W. 6th Street Cameron, TX 76520	254.697.6523
	Greater San Marcos Youth Council (GSMYC) (children's shelter – Hays County)	1402 N. Interstate 35 San Marcos, TX 78666	512.754.0500
	San Marcos Housing Authority – Hays County	1201 Thorpe Lane San Marcos, TX 78666	512.353.5058
Digital divide	Computer Class – Manos De Christo – Travis County	4911 Harmon Avenue Austin, TX 78751	512.270.1375
	Refugee Services of Texas (RST) (digital literacy –Travis County)	500 E. St. Johns Avenue Austin, TX 78752	512.472.9472
	Texas HHSC – Williamson County-TANF (help pay for phone)	2500 N. Austin Avenue Georgetown, TX 78626	512.942.4030
	HIREDTexas – Williamson County (training/help with digital literacy)	1705 Gattis School Road Round Rock, TX 78664	800.939.6631
	Texas HHSC–TANF (help pay for phone – Milam County)	201 Lafferty Avenue Cameron, TX 76520	254.697.6695
	Texas HHSC–TANF (help pay for phone – Milam County)	313 N. Main Street Rockdale, TX 76567	512.446.2543
	Community Action, Inc. of Central Texas (computer class – Hays County)	1301 Old Goforth Road Buda, TX 78610	512.392.1161
	Education Based Housing (computer skills and training – Hays County)	1506 S. Interstate Highway 35 San Marcos, TX 78666	512.392.8452

There are many other community resources and facilities serving the Greater Austin area that are available to address identified needs and can be accessed through a comprehensive online resource catalog called Find Help (formerly known as Aunt Bertha). It can be accessed 24/7 at **BSWHealth.FindHelp.com**.

Next steps

BSWH started the Community Health Needs Assessment process in April 2021. 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.

Appendix A: CHNA requirement details

The Patient Protection and Affordable Care Act (PPACA) requires all tax-exempt organizations operating hospital facilities to assess the health needs of their community every three (3) years. The resulting Community Health Needs Assessment (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 used 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; and

- An evaluation of the impact of any actions that were taken since the hospitals' most recent CHNA to address the significant health needs identified in that report.

  ○ Hospitals also must adopt an implementation strategy to address prioritized community health needs identified through the assessment.

CHNA process

BSWH began the 2022 CHNA process in April of 2021. The following is an overview of the timeline and major milestones:

Define the community
▼
Assess the community
▼
Identify "significant needs" and "prioritize"
▼
Document in written report
▼
CHNA board approvals
▼
Make CHNA widely available on website
▼
Written implementation strategy
▼
Implementation strategy board approval
▼
Make implementation strategy widely available on website
▼
Act on strategy, measure and report

Consultant qualifications

IBM 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.

Health needs assessment process overview

To identify the health needs of the community, the hospitals established a comprehensive method using all available relevant data including community input. They used the qualitative and quantitative data obtained when assessing the community to identify its community health needs. Surveyors conducted interviews and focus groups with individuals representing public health, community leaders/groups, public organizations and other providers. In addition, data collected from public sources compared to the state benchmark indicated the level of severity. The outcomes of the quantitative data analysis were compared to the qualitative data findings.

These data are available to the community via an interactive dashboard at **BSWHealth.com/ CommunityNeeds**.

Data gathering: quantitative assessment of health needs – methodology and data sources

The IBM team used quantitative data collection and analysis garnered from public health indicators to assess community health needs. This included over 100 data elements grouped into over 11 categories evaluated for the counties where data was available. Recently, indicators expanded to include new categories addressing mental health, healthcare costs, opioids and social determinants of health. A table depicting the categories and indicators and a list of sources are in **Appendix B**.

A benchmark analysis of each indicator determined which public health indicators demonstrated a community health need. Benchmark health indicators included overall US values, state of Texas values and other goal-setting benchmarks, such as Healthy People 2020.

According to America's Health Rankings 2021 Annual Report, Texas ranks 22nd out of the 50 states in the area of Health Outcomes (which includes behavioral health, mortality and physical health) and 50th in the area of Clinical Care (which includes avoiding care due to cost, providers per 100,000 population and preventive services). When the health status of Texas was compared to other states, the team identified many opportunities to impact community health.

The quantitative analysis of the health community used the following methodology:

- The team set benchmarks for each health community using state value for comparison.

- They identified community indicators not meeting state benchmarks.

- From this, they determined a need differential analysis of the indicators, which helped them understand the community's relative severity of need.

- Using the need differentials, they established a standardized way to evaluate the degree that each indicator differed from its benchmark.

- This quantitative analysis showed which health community indicators were above the 25th percentile in order of severity—and which health indicators needed their focus.

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

Information gaps

In some areas of Texas, the small population size has an impact on reporting and statistical significance. The team has attempted to understand the most significant health needs of the entire community. It is understood that there is variation of need within the community, and BSWH may not be able to impact all of the population who truly need the service.

Community input: qualitative health needs assessment – approach

To obtain a qualitative assessment of the health community, the team:

- Assembled a focus group representing the broad interests of the community served;

- Conducted interviews and surveys with key informants—leaders and representatives who serve the community and have insight into its needs; and

- Held prioritization sessions with hospital clinical leadership and community leaders to review collection results and identify the most significant healthcare needs based on information gleaned from the focus groups and key informants.

Focus groups helped identify barriers and social factors influencing the community's health needs. Key informant interviews gave the team even more understanding and insight about the general health status of the community and the various drivers that contributed to health issues.

Multiple governmental public health department individuals were asked to contribute their knowledge, information and expertise relevant to the health needs of the community. Individuals or organizations who served and/or represented the interests of medically underserved, low-income and minority populations in the community also took part in the process. NOTE: In some cases, public health officials were unavailable due to obligations concerning the COVID-19 pandemic.

The hospitals also considered written input received on their most recently conducted CHNA and subsequent implementation strategies if provided. The assessment is available for public comment or feedback on the report findings by going to the BSWH website (**BSWHealth.com/CommunityNeeds**) or by emailing **CommunityHealth@BSWHealth.org**.

Approach to prioritizing significant health needs

On January 11, 2022, a session was conducted with key leadership members from Baylor Scott & White along with community leaders to review the qualitative and quantitative data findings of the CHNA to date, discuss at length the significant needs identified, and complete prioritization exercises to rank the community needs. Prioritizing health needs was a two-step process. The two-step process allowed participants to consider the quantitative needs and qualitative needs as defined by the indicator dataset and focus group/interview/survey participant input.

High data/Low qualitative	High data/High qualitative
Data compared to state benchmark indicates need by a _greater_ magnitude **BUT** Topic was _not_ raised in interviews and focus groups	Data compared to state benchmark indicates need by a _greater_ magnitude **AND** Topic was a _frequent_ theme in interviews and focus groups
Data compared to state benchmark indicates need by a _lesser_ magnitude **AND** Topic was _not_ raised in interviews and focus groups	Data compared to state benchmark indicates need by a _lesser_ magnitude **BUT** Topic was a _frequent_ theme in interviews and focus groups
Low data/Low qualitative	Low/no data/High qualitative

High data = Indicators worse than state benchmark by greater magnitude
High qualitative = Frequency of topic in interviews and focus groups

In the first step, participants reviewed the top health needs for their community using associated data-driven criteria. The criteria included health indicator value(s) for the community and how the indicator compared to the state benchmark.
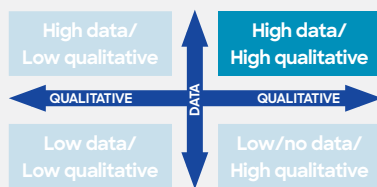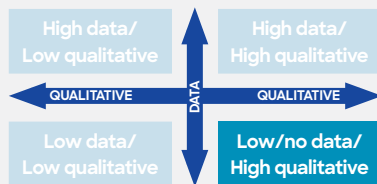

High data and high qualitative: The community indicators that showed a greater need in the health community overall when compared to the state of Texas comparative benchmark and were identified as a greater need by the key informants.
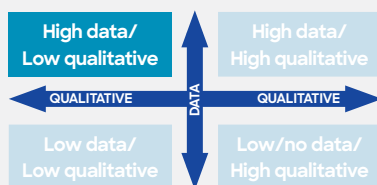
High data and low qualitative: The community indicators showed a greater need in the health community overall when compared to the state of Texas comparative benchmark but were not identified as a greater need or not specifically identified by the key informants.

Low/no data and high qualitative:
The community indicators showed less need or had no data available in the health community overall when compared to the state of Texas comparative benchmark but were identified as a greater need by the key informants.

Participants held a group discussion about which needs were most significant, using the professional experience and community knowledge of the group. A virtual voting method was invoked for individuals to provide independent opinions.

This process helped the group define and identify the community's significant health needs. Participants voted individually for the needs they considered the most significant for this community. When the votes were tallied, the top identified needs emerged and were ranked based on the number of votes.

Prioritization of significant needs

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

- **Severity:** The problem results in disability or premature death or creates burdens on the community, economically or socially.

- **Root cause:** The need is a root cause of other problems, if addressed, it could possibly impact multiple issues.

- **Magnitude:** The need affects many people, either actually or potentially.

The group rated each of the six significant health needs on each of the three identified criteria, using a scale of 1 (low) to 10 (high). The criteria score sums for each need created an overall score.

They prioritized the list of significant health needs based on the overall scores. The outcome of this process was the list of prioritized health needs for this community.

Priority	Need	Category of need
1	Preventive screenings	Conditions/diseases
2	Access to primary healthcare providers	Access to care
3	Adult obesity	Conditions/diseases
4	Access to mental healthcare (providers and resources)	Mental health
5	Severe housing problems	Housing/environment
6	Digital divide	Digital divide

Appendix B: key public health indicators

IBM Watson Health collected and analyzed fifty-nine (59) public health indicators to assess and evaluate community health needs. 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 US and the state of Texas.

The indicators used and the sources are listed below:

Indicator name	Indicator source	Indicator definition
Adult obesity	2021 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System	2017 Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2
Adults reporting fair or poor health	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Percentage of adults reporting fair or poor health (age-adjusted)
Binge drinking	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Percentage of a county's adult population that reports binge or heavy drinking in the past 30 days
Cancer incidence: all causes	State Cancer Profiles National Cancer Institute (CDC)	2013 – 2017 Age-adjusted cancer (all) incidence rate cases per 100,000 (all races, includes Hispanic; both sexes; all ages. Age-adjusted to the 2000 US standard population)
Cancer incidence: colon	State Cancer Profiles National Cancer Institute (CDC)	2013 – 2017 Age-adjusted colon and rectum cancer incidence rate cases per 100,000 (all races, includes Hispanic; both sexes; all ages. Age-adjusted to the 2000 US standard population). Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of three is shown, the total number of cases for the time period is 16 or more, which exceeds suppression threshold (but is rounded to three).
Cancer incidence: female breast	State Cancer Profiles National Cancer Institute (CDC)	2013 – 2017 Age-adjusted female breast cancer incidence rate cases per 100,000 (all races, includes Hispanic; female; all ages. Age-adjusted to the 2000 US standard population). Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of three is shown, the total number of cases for the time period is 16 or more, which exceeds suppression threshold (but is rounded to three).

Indicator name	Indicator source	Indicator definition
Cancer incidence: lung	State Cancer Profiles, National Cancer Institute (CDC)	2013 – 2017 Age-adjusted lung and bronchus cancer incidence rate cases per 100,000 (all races, includes Hispanic; both sexes; all ages. Age-adjusted to the 2000 US standard population)
Cancer incidence: prostate	State Cancer Profiles, National Cancer Institute (CDC)	2013 – 2017 Age-adjusted prostate cancer incidence rate cases per 100,000 (all races, includes Hispanic; males; all ages. Age-adjusted to the 2000 US standard population)
Children in poverty	2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau	2019 Percentage of children under age 18 in poverty.
Children in single-parent households	2021 County Health Rankings & Roadmaps; American Community Survey (ACS), Five-Year Estimates (United States Census Bureau)	2015 – 2019 Percentage of children that live in a household headed by single parent
Children uninsured	2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau	2018 Percentage of children under age 19 without health insurance
Diabetes admission	2018 Texas Health and Human Services Center for Health Statistics Preventable Hospitalizations	Number observed/adult population age 18 and older. Risk-adjusted rates not calculated for counties with fewer than five admissions.
Diabetes diagnoses in adults	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries
Diabetes prevalence	County Health Rankings (CDC Diabetes Interactive Atlas)	2017 Prevalence of diagnosed diabetes in a given county. Respondents were considered to have diagnosed diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes.
Drug poisoning deaths	2021 County Health Rankings & Roadmaps, CDC WONDER Mortality Data	2017 – 2019 Number of drug poisoning deaths (drug overdose deaths) per 100,000 population. Death rates are null when the rate is calculated with a numerator of 20 or less.
Elderly isolation	2018 American Community Survey Five-Year Estimates, US Census Bureau – American FactFinder	Percent of non-family households – householder living alone – 65 years and over
English spoken "less than very well" in household	2015 – 2019 American Community Survey Five-Year Estimates, US Census Bureau – American FactFinder	2019 Percentage of households that 'speak English less than "very well"' within all households that 'speak a language other than English'
Food environment index	2021 County Health Rankings & Roadmaps; USDA Food Environment Atlas, Map the Meal Gap from Feeding America, United States Department of Agriculture (USDA)	2015 and 2018 Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)
Food insecure	2021 County Health Rankings & Roadmaps; Map the Meal Gap, Feeding America	2018 Percentage of population who lack adequate access to food during the past year

Indicator name	Indicator source	Indicator definition
Food: limited access to healthy foods	2021 County Health Rankings & Roadmaps; USDA Food Environment Atlas, United States Department of Agriculture (USDA)	2015 Percentage of population who are low-income and do not live close to a grocery store
High school graduation	Texas Education Agency	2019 A four-year longitudinal graduation rate is the percentage of students from a class of beginning ninth graders who graduate by their anticipated graduation date or within four years of beginning ninth grade.
Household income	2021 County Health Rankings (Small Area Income and Poverty Estimates)	2019 Median household income is the income where half of households in a county earn more and half of households earn less.
Income inequality	2021 County Health Rankings & Roadmaps; American Community Survey (ACS), Five-Year Estimates (United States Census Bureau)	2015 – 2019 Ratio of household income at the 80th percentile to income at the 20th percentile. Absolute equality = 1.0. Higher ratio is greater inequality.
Individuals below poverty level	2018 American Community Survey Five-Year Estimates, US Census Bureau – American FactFinder	Individuals below poverty level
Low birth weight rate	2019 Texas Certificate of Live Birth	Number low birth weight newborns /number of newborns. Newborn's birth weight – low or very low birth weight includes birth weights under 2,500 grams. Blanks indicate low counts or unknown values. A null value indicates unknown or low counts. The location variables (region, county, ZIP) refer to the mother's residence.
Medicare population: Alzheimer's disease/ dementia	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare population: atrial fibrillation	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare population: COPD	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare population: depression	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries
Medicare population: emergency department use rate	CMS 2019 Outpatient 100% Standard Analytical File (SAF) and 2019 Standard Analytical Files (SAF) Denominator File	Unique patients having an emergency department visit/total beneficiaries, CY 2019

Indicator name	Indicator source	Indicator definition
Medicare population: heart failure	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare population: hyperlipidemia	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries
Medicare population: hypertension	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries
Medicare population: inpatient use rate	CMS 2019 Inpatient 100% Standard Analytical File (SAF) and 2019 Standard Analytical Files (SAF) Denominator File	Unique patients being hospitalized/total beneficiaries, CY 2019
Medicare population: stroke	CMS.gov Chronic Conditions 2007 – 2018	Prevalence of chronic condition across all Medicare beneficiaries. A null value indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell or for necessary complementary cell suppression.
Medicare spending per beneficiary (MSPB) index	CMS 2019 Medicare Spending Per Beneficiary (MSPB), Hospital Value-Based Purchasing (VBP) Program	Medicare spending per beneficiary (MSPB): for each hospital, CMS calculates the ratio of the average standardized episode spending over the average expected episode spending. This ratio is multiplied by the average episode spending level across all hospitals. Blank values indicate missing hospitals or missing score. Associated to the hospitals
Mentally unhealthy days	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Average number of mentally unhealthy days reported in past 30 days (age-adjusted)
Mortality rate: cancer	Texas Health Data, Center for Health Statistics, Texas Department of State Health Services	2017 Cancer (all) age-adjusted death rate (per 100,000 – all ages. Age-adjusted using the 2000 US Standard population). Death rates are null when the rate is calculated with a numerator of 20 or less.
Mortality rate: heart disease	Texas Health Data, Center for Health Statistics, Texas Department of State Health Services	2017 Heart disease age-adjusted death rate (per 100,000 – all ages. Age-adjusted using the 2000 US Standard population). Death rates are null when the rate is calculated with a numerator of 20 or less.
Mortality rate: infant	2021 County Health Rankings & Roadmaps, CDC WONDER Mortality Data	2013 – 2019 Number of all infant deaths (within one year), per 1,000 live births. Blank values reflect unreliable or missing data.
Mortality rate: stroke	Texas Health Data, Center for Health Statistics, Texas Department of State Health Services	2017 Cerebrovascular disease (stroke) age-adjusted death rate (per 100,000 – all ages. Age-adjusted using the 2000 US Standard population). Death rates are null when the rate is calculated with a numerator of 20 or less.

Indicator name	Indicator source	Indicator definition
No vehicle available	US Census Bureau, 2019 American Community Survey One-Year Estimates	2019 Households with no vehicle available (percent of households). A null value entry indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates fall in the lowest interval or upper interval of an open-ended distribution, or the margin of error associated with a median was larger than the median itself.
Opioid involved accidental poisoning death	US Census Bureau, Population Division and 2019 Texas Health and Human Services Center for Health Statistics Opioid related deaths in Texas	Annual estimates of the resident population: April 1, 2010, to July 1, 2017. 2019 Accidental poisoning deaths where opioids were involved are those deaths that include at least one of the following ICD-10 codes among the underlying causes of death: X40 – X44, and at least one of the following ICD-10 codes identifying opioids: T40.0, T40.1, T40.2, T40.3, T40.4, T40.6. Blank values reflect unreliable or missing data.
Physical inactivity	2021 County Health Rankings & Roadmaps; CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System	2017 Percentage of adults ages 20 and over reporting no leisure-time physical activity in the past month
Physically unhealthy days	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Average number of physically unhealthy days reported in past 30 days (age-adjusted)
Population to one dentist	2021 County Health Rankings & Roadmaps; Area Health Resource File/National Provider Identification file (CMS)	2019 Ratio of population to dentists
Population to one mental health provider	2021 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)	2020 Ratio of population to mental health providers
Population to one non-physician primary care provider	2020 County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES)	2020 Ratio of population to primary care providers other than physicians
Population to one primary care physician	2021 County Health Rankings & Roadmaps; Area Health Resource File/American Medical Association	2018 Number of individuals served by one physician in a county, if the population was equally distributed across physicians
Population under age 65 without health insurance	2021 County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau	2018 Percentage of population under age 65 without health insurance
Prenatal care: first trimester entry into prenatal care	2020 Texas Health and Human Services – Vital statistics annual report	2016 Percent of births with prenatal care onset in first trimester

Indicator name	Indicator source	Indicator definition
Renter-occupied housing	US Census Bureau, 2019 American Community Survey One-Year Estimates	2019 Renter-occupied housing (percent of households). A null value entry indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates fall in the lowest interval or upper interval of an open-ended distribution, or the margin of error associated with a median was larger than the median itself.
Severe housing problems	2021 County Health Rankings & Roadmaps; Comprehensive Housing Affordability Strategy (CHAS) data, US Department of Housing and Urban Development (HUD)	2013 – 2017 Percentage of households with at least one of four housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
Sexually transmitted infection incidence	2021 County Health Rankings & Roadmaps; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)	2018 Number of newly diagnosed chlamydia cases per 100,000 population
Smoking	2021 County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS)	2018 Percentage of the adult population in a county who both report that they currently smoke every day or most days and have smoked at least 100 cigarettes in their lifetime
Suicide: intentional self-harm	Texas Health Data Center for Health Statistics	2019 Intentional self-harm (suicide) (X60 – X84, Y87.0). Death rates are null when the rate is calculated with a numerator of 20 or less.
Teen birth rate	2021 County Health Rankings & Roadmaps; National Center for Health Statistics - Natality files, National Vital Statistics System (NVSS)	2013 – 2019 Number of births to females ages 15 – 19 per 1,000 females in a county (The numerator is the number of births to mothers ages 15 – 19 in a seven-year time frame, and the denominator is the sum of the annual female populations, ages 15 – 19.)
Teens (16 – 19) not in school or work - disconnected youth	2021 County Health Rankings (Measure of America)	2015 – 2019 Disconnected youth are teenagers and young adults between the ages of 16 and 19 who are neither working nor in school. Blank values reflect unreliable or missing data.
Unemployment	2021 County Health Rankings & Roadmaps; Local Area Unemployment Statistics (LAUS), Bureau of Labor Statistics	2019 Percentage of population ages 16 and older unemployed but seeking work

Appendix C: community input participating organizations

Representatives from the following organizations participated in the focus group and a number of key informant interviews/surveys:

- Affordable Central Texas
- AGE of Central Texas
- Austin Clubhouse
- Baylor Scott & White Health
- Boys & Girls Clubs of the Austin Area
- Catholic Charities
- Central Health
- Central Texas Food Bank
- City of Manor
- City of Pflugerville
- City of Taylor
- Community Care Board Member
- Faith in Action Georgetown
- Georgetown Health Foundation

- Integral Care
- Interagency Support Council of Eastern Williamson County, Inc.
- Lone Star Circle of Care
- Milam County Health Department
- Mobile Outreach Team Williamson County Emergency Services
- Partners in Hope
- Pavilion Clubhouse of Williamson County
- People's Community Clinic Austin
- Regarding Cancer
- The Caring Place
- United Way of Williamson County
- Williamson County and Cities Health District

Appendix D: demographic and socioeconomic summary

According to population statistics, the community served is similar to Texas in terms of projected population growth; both outpace the country. The median age is older than Texas but younger than United States. Median income is higher than both the state and the country. The community served has a lower percentage of Medicaid beneficiaries than both Texas and the US. The number of uninsured individuals in the community is higher than the US average but lower than the state.

Demographic and socioeconomic comparison: community served and state/US benchmarks

Geography		Benchmarks		Community served
		United States	**Texas**	**Greater Austin Region health community**
Total current population		330,342,293	29,321,501	10,737,258
Five-year projected population change		3.3%	6.6%	8.5%
Median age		38.6	35.2	36.4
Population 0 – 17		22.4%	25.7%	24.3%
Population 65+		16.6%	13.2%	11.7%
Women age 15 – 44		19.5%	20.5%	21.5%
Hispanic population		19.0%	40.7%	33.0%
Insurance coverage	Uninsured	9.9%	18.8%	12.5%
	Medicaid	20.9%	13.0%	8.0%
	Private market	8.3%	8.4%	9.4%
	Medicare	13.8%	12.7%	10.3%
	Employer	47.2%	47.1%	59.8%
Median HH income		$65,618	$63,313	$86,818
No high school diploma		12.2%	16.7%	9.5%

Source: IBM Watson Health Demographics, Claritas, 2020, Insurance Coverage Estimates, 2020.

The community served expects to grow 8.5% by 2025, an increase of more than 181,533 people. The projected population growth is higher than the state's five-year projected growth rate (6.6%) and the national projected growth rate (3.3%). The ZIP codes expected to experience the most growth in five years are:

- 78660 Pflugerville – 10,513 people

- 78613 Cedar Park – 8,246 people

The community's population is younger with about 53% of the population ages 18 – 54 and 22% under age 18. The age 65-plus cohort is expected to experience the fastest growth (24.3%) over the next five years. Growth in the senior population will likely contribute to increased utilization of services as the population continues to age.

Population statistics are analyzed by race and by Hispanic ethnicity. The community was primarily white non-Hispanic, but diversity in the community will increase due to the projected growth of minority populations over the next five years. The expected growth rate of the Hispanic population (all races) is over 84,664 people (12.0%) by 2025. The non-Hispanic white and black populations are expected to have the slowest growth (3.9% and 8.9%).

Population distribution

| Age group | Age distribution | | | | |
	2020	% of total	2025	% of total	USA 2020 % of total
0 – 14	431,592	20.2%	444,146	19.1%	18.5%
15 – 17	88,533	4.1%	98,881	4.3%	3.9%
18 – 24	223,243	10.4%	234,876	10.1%	9.5%
25 – 34	309,647	14.5%	310,131	13.4%	13.5%
35 – 54	600,664	28.1%	650,477	28.0%	25.2%
55 – 64	235,179	11.0%	262,231	11.3%	12.9%
65+	250,422	11.7%	320,071	13.8%	16.6%
Total	**2,139,280**	**100.0%**	**2,320,813**	**100.0%**	**100.0%**

Household Income distribution

| 2020 Household income | Income distribution | | |
	HH count	% of total	USA % of total
<$15K	53,085	6.5%	10.0%
$15 – 25K	45,070	5.5%	8.6%
$25 – 50K	143,498	17.5%	20.7%
$50 – 75K	134,093	16.4%	16.7%
$75 – 100K	110,603	13.5%	12.4%
Over $100K	333,482	40.7%	31.5%
Total	**819,831**	**100.0%**	**100.0%**

Education level

| 2020 Adult education level | Education level distribution | | |
	Pop age 25+	% of total	USA % of total
Less than high school	65,375	4.7%	5.2%
Some high school	66,730	4.8%	7.0%
High school degree	271,542	19.5%	27.2%
Some college/assoc. degree	367,959	26.4%	28.9%
Bachelor's degree or greater	624,306	44.7%	31.6%
Total	**1,395,912**	**100.0%**	**100.0%**

Race/ethnicity

| Race/ethnicity | Race/ethnicity distribution | | |
	2020 pop	% of total	USA % of total
White non-Hispanic	1,088,964	50.9%	59.3%
Black non-Hispanic	148,564	6.9%	12.4%
Hispanic	706,555	33.0%	19.0%
Asian & Pacific is. non-Hispanic	140,551	6.6%	6.0%
All others	54,646	2.6%	3.3%
Total	**2,139,280**	**100.0%**	**100.0%**

Population estimates

Population	National	Selected area
2010 total	308,745,538	1,640,049
2020 total	330,342,293	2,139,280
2025 total	341,132,738	2,320,813
2030 total	353,513,931	2,552,895
% change 2020 – 2025	3.27%	8.49%
% change 2020 – 2035	7.01%	19.33%

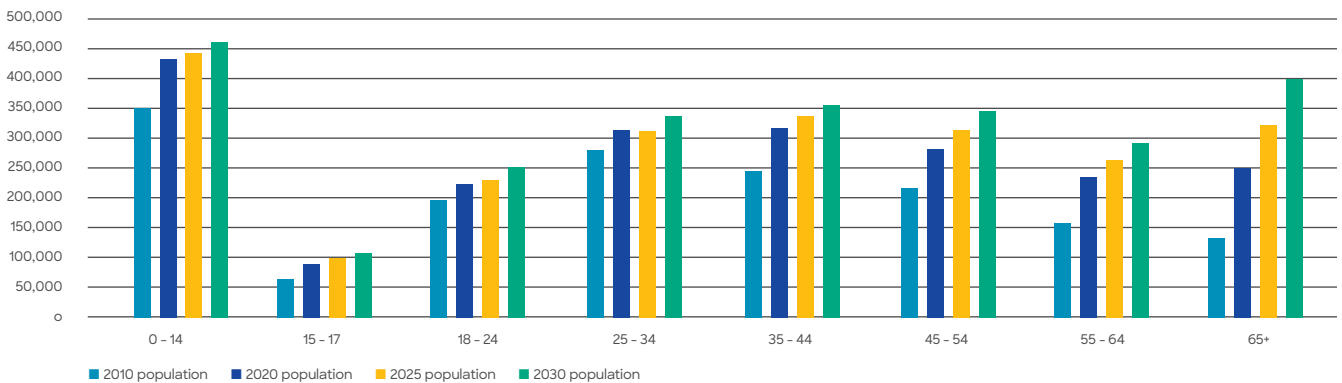| Population	Males all ages	Females all ages	Females childbearing
2010 total	821,174	818,875	385,517
2020 total	1,069,215	1,070,065	459,905
2025 total	1,158,246	1,162,567	479,168
2030 total	1,269,634	1,283,261	516,538
10Y %	18.74%	19.92%	12.31%
National	7.02%	7.01%	4.01%

2020 race and ethnicity with total population
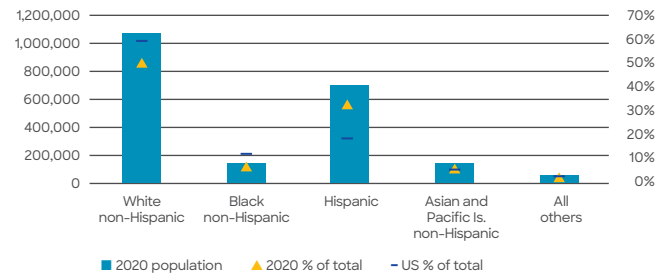
Population by sex 2010 – 2030
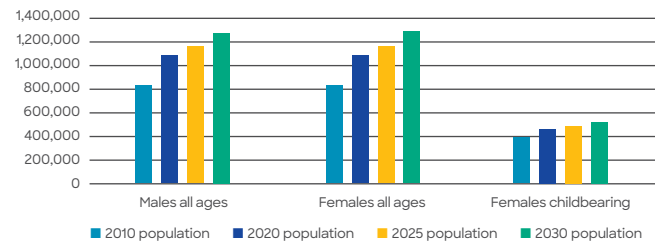

Population by age group 2010 – 2030

The 2020 median household income for the United States was $65,618 and $63,313 for the state of Texas. The median household income for the ZIP codes within this community ranged from $20,507 for 78705 Austin to $172,930 for 78739, which is also Austin. There were three (3) additional ZIP codes in Austin with median household incomes greater than $150,000.

- 78732 Austin – $157,591

- 78746 Austin – $153,657

- 78733 Austin – $171,924

A majority of the population (60%) was insured through employer sponsored health coverage, closely followed by those without health insurance (12.5%). The remainder of the population was fairly equally divided between Medicaid, Medicare and private market (the purchasers of coverage directly or through the health insurance marketplace).

The median household income ZIP code map below illustrates ZIP codes that are lower or higher than twice the federal poverty level for a family of four in 2020.

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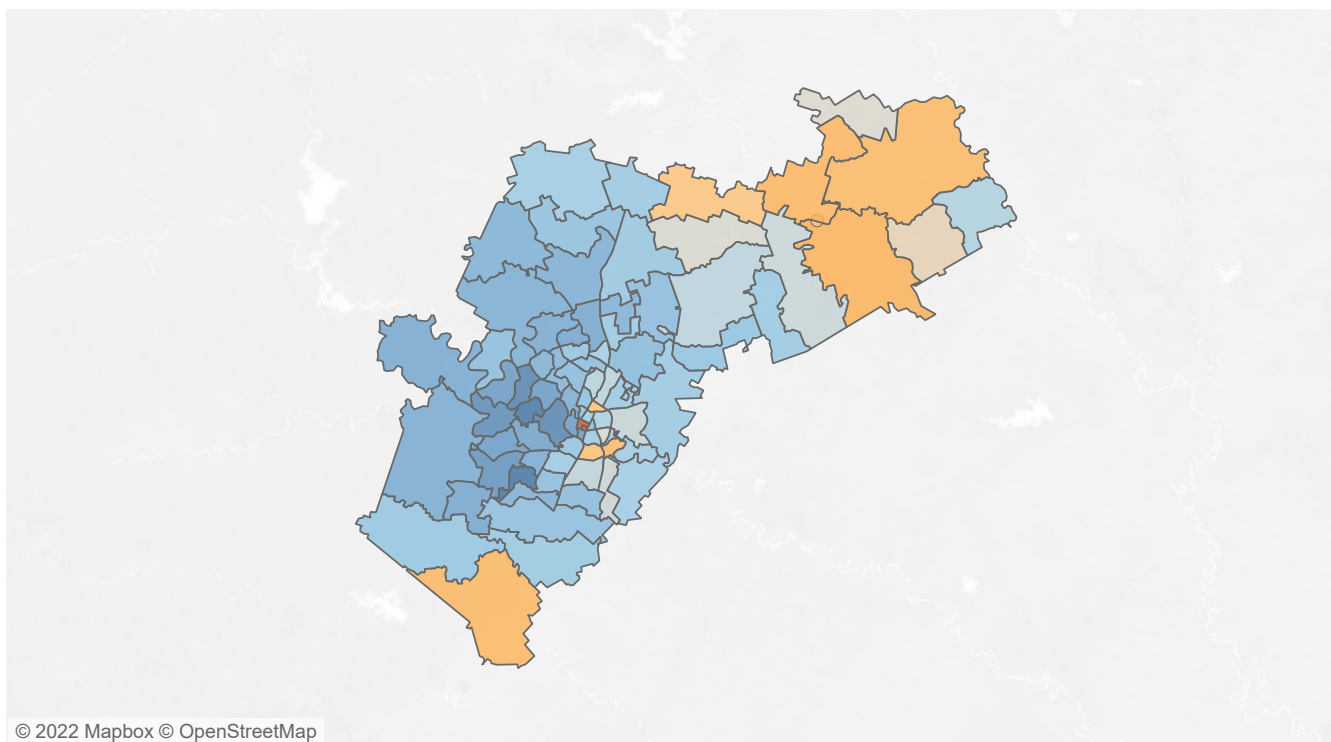
Federally designated health professional shortage areas and medically underserved areas and populations

Health professional shortage areas (HPSA)				
County	HPSA ID	HPSA name	HPSA discipline class	Designation type
Milam	1485783382	Milam County	Primary care	Geographic HPSA
Milam	7485618017	Milam County	Mental health	Geographic HPSA
Travis	7485886683	LI – Travis County	Mental health	Low-income population HPSA
Travis	14899948PB	People's Community Clinic	Primary care	Federally qualified health center
Travis	74899948MR	People's Community Clinic	Mental health	Federally qualified health center
Travis	64899948MS	People's Community Clinic	Dental health	Federally qualified health center
Travis	14899948OW	Travis County Healthcare District	Primary care	Federally qualified health center
Travis	74899948MI	Travis County Healthcare District	Mental health	Federally qualified health center
Travis	64899948MM	Travis County Healthcare District	Dental health	Federally qualified health center
Williamson	148999487E	Lone Star Circle Of Care	Primary care	Federally qualified health center
Williamson	748999484B	Lone Star Circle Of Care	Mental health	Federally qualified health center
Williamson	64899948H7	Lone Star Circle Of Care	Dental health	Federally qualified health center

| Medically underserved areas and populations (MUA/P)				
County	MUA/P source identification number	Service area name	Designation type	Rural status
Milam	1484459165	Milam County	Medically underserved area	Rural
Travis	03484	Travis service area	Medically underserved area	Non-rural
Williamson	03445	Williamson service area	Medically underserved area	Non-rural

Community Needs Index

The IBM Watson Health Community Need Index (CNI) is a statistical approach that identifies areas within a community where there are likely gaps in healthcare. The CNI takes into account vital socio-economic factors, including income, culture, education, insurance and housing, about a community to generate a CNI score for every population ZIP code in the US.

The CNI is strongly linked to variations in community healthcare needs and is a good indicator of a community's demand for a range of healthcare services. Not-for-profit and community-based hospitals, for whom community need is central to the mission of service, are often challenged to prioritize and effectively distribute hospital resources. The CNI can be used to help them identify specific initiatives best designed to address the health disparities of a given community.

The CNI score by ZIP code shows specific areas within a community where healthcare needs may be greater.

Greater Austin (Central Texas) Health Community

Composite CNI: high scores indicate high need.

1.000   5.000
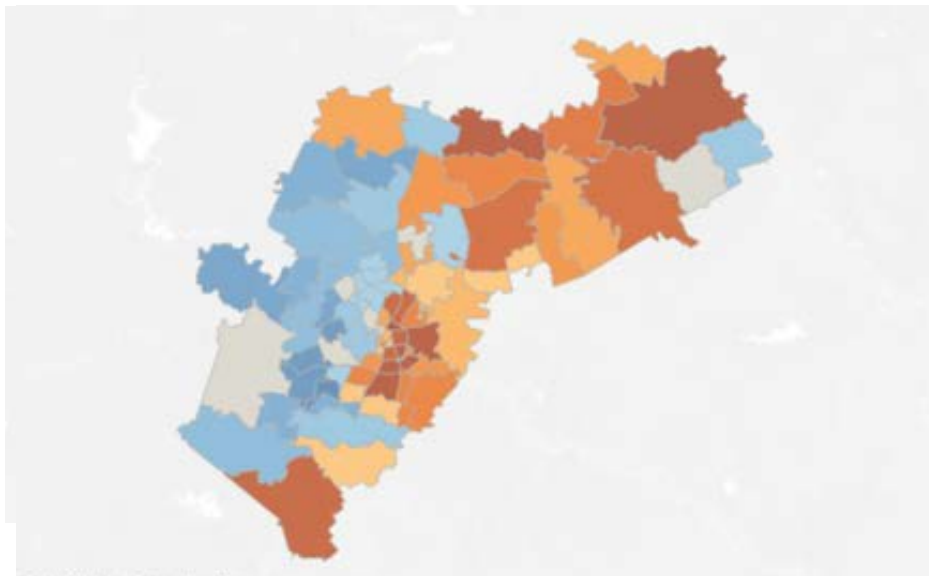
ZIP map where color shows the 2020 Community Need Index on a scale of 1 to 5. Orange color indicates high need areas (CNI = 4 or 5); blue color indicates low need (CNI = 1 or 2). Gray colors have needs at the national average (CNI = 3).

Composite CNI score
3.32

Texas CNI score
3.85

US composite CNI score
3.00

Barrier	State	US
Income	3.0	3.0
Culture	4.7	3.0
Education	3.5	3.0
Insurance	4.3	3.0
Housing	3.9	3.0

The overall CNI score for the Greater Austin Health Community was 3.32. The difference in the numbers indicates both a strong link to community healthcare needs and a community's demand for various healthcare services. In portions of the community, the CNI score was greater than 4.5, indicating more significant health needs among the population.

Appendix E: proprietary community data

IBM Watson Health supplemented the publicly available data with estimates of localized inpatient demand discharges, outpatient procedures, emergency department visits, heart disease, as well as cancer incidence estimates.

Social determinants of health are the structural determinants and conditions in which people are born, grow, live, work and age. All of which can greatly impact healthcare utilization and play a major role in the shifting healthcare landscape. Social determinants, such as education, income and race, are factored into Inpatient Demand Estimates and Outpatient Procedure Estimates utilization rate creation methodologies.

Inpatient demand estimates

Inpatient demand estimates provide the total volume of annual acute care admissions by ZIP code and DRG Product Line for every market in the United States. IBM uses all-payor state discharge data for publicly available states and Medicare (MEDPAR) data for the entire US. These rates are applied to demographic projections by ZIP code to estimate inpatient utilization for 2020 through 2030.

The following summary is reflective of the inpatient utilization trends for the Greater Austin Health Community. Total discharges in the community are expected to grow by almost 14% by 2030, with general medicine, pulmonary medical and cardiovascular diseases projecting the largest growth.

Product line	2020 discharges	2025 discharges	2030 discharges	2020 – 2025 discharges change	2020 – 2025 discharges % change	2020 – 2030 discharges change	2020 – 2030 discharges % change
Alcohol and Drug Abuse	1,972	2,026	2,279	54	2.7%	307	15.5%
Cardio-Vasc-Thor Surgery	5,198	5,619	6,026	421	8.1%	828	15.9%
Cardiovascular Diseases	9,297	10,305	11,978	1,007	10.8%	2,681	28.8%
ENT	954	869	829	(85)	–8.9%	(125)	–13.1%
General Medicine	25,842	27,656	30,477	1,815	7.0%	4,635	17.9%
General Surgery	11,259	11,498	12,261	238	2.1%	1,001	8.9%
Gynecology	723	392	259	(331)	–45.8%	(464)	–64.1%
Nephrology/Urology	6,165	6,653	7,404	488	7.9%	1,238	20.1%
Neuro Sciences	7,689	8,187	9,207	498	6.5%	1,518	19.7%
Obstetrics Del	21,152	19,435	19,821	(1,716)	–8.1%	(1,331)	–6.3%
Obstetrics ND	1,684	1,475	1,445	(210)	–12.4%	(239)	–14.2%
Oncology	2,874	2,999	3,224	124	4.3%	350	12.2%
Ophthalmology	178	173	174	(5)	–2.9%	(4)	–2.4%
Orthopedics	12,035	12,591	13,834	556	4.6%	1,799	15.0%
Psychiatry	1,103	1,170	1,244	67	6.1%	141	12.8%
Pulmonary Medical	9,920	11,767	13,819	1,847	18.6%	3,899	39.3%
Rehabilitation	186	212	249	26	13.7%	63	33.6%
TOTAL	**118,233**	**123,027**	**134,530**	**4,794**	**4.1%**	**16,298**	**13.8%**

Source: IBM Watson Health Inpatient Demand Estimates, 2020.

Outpatient procedures estimates

Outpatient procedure estimates predict the total annual volume of procedures performed by ZIP code for every market in the United States using proprietary and public health claims, as well as federal surveys. Procedures are defined and reported by procedure codes and are further grouped into clinical service lines. The Greater Austin Health Community outpatient procedures are expected to increase by almost 41% by 2030 with the largest growth in the categories of general & internal medicine, labs, physical & occupational therapy and psychiatry.

Clinical service category	2020 procedures	2025 procedures	2020-2025 procedures % change	2030 procedures	2020 – 2030 procedures % change
Allergy & Immunology	609,310	675,113	10.8%	754,266	23.8%
Anesthesia	166,856	205,055	22.9%	244,732	46.7%
Cardiology	987,106	1,333,638	35.1%	1,812,840	83.7%
Cardiothoracic	1,274	1,532	20.3%	1,822	43.1%
Chiropractic	847,679	872,823	3.0%	882,347	4.1%
Colorectal Surgery	14,072	15,718	11.7%	17,607	25.1%
CT Scan	346,560	483,770	39.6%	672,155	94.0%
Dermatology	468,803	554,662	18.3%	656,001	39.9%
Diagnostic Radiology	1,926,314	2,173,546	12.8%	2,455,989	27.5%
Emergency Medicine	916,858	1,053,838	14.9%	1,224,822	33.6%
Gastroenterology	122,550	147,630	20.5%	176,671	44.2%
General & Internal Medicine	15,923,430	19,121,268	20.1%	22,416,849	40.8%
General Surgery	96,015	111,114	15.7%	129,690	35.1%
Hematology & Oncology	2,106,915	2,657,154	26.1%	3,229,776	53.3%
Labs	17,357,520	20,216,547	16.5%	23,673,922	36.4%
Miscellaneous	736,711	868,745	17.9%	1,018,687	38.3%
MRI	174,842	201,780	15.4%	233,568	33.6%
Nephrology	306,659	378,379	23.4%	460,422	50.1%
Neurology	228,924	258,537	12.9%	293,202	28.1%
Neurosurgery	10,360	14,247	37.5%	17,233	66.3%
Obstetrics/Gynecology	396,114	417,373	5.4%	460,330	16.2%
Ophthalmology	1,001,080	1,244,674	24.3%	1,521,928	52.0%
Oral Surgery	5,659	6,840	20.9%	8,345	47.5%
Orthopedics	245,904	286,740	16.6%	333,230	35.5%
Otolaryngology	745,062	840,998	12.9%	950,036	27.5%
Pain Management	105,433	122,465	16.2%	139,702	32.5%
Pathology	430	525	22.0%	635	47.7%
PET Scan	10,439	12,572	20.4%	14,929	43.0%
Physical & Occupational Therapy	5,735,874	7,079,652	23.4%	8,692,710	51.5%
Plastic Surgery	14,532	17,556	20.8%	21,205	45.9%
Podiatry	76,965	84,826	10.2%	92,484	20.2%
Psychiatry	2,739,054	3,325,411	21.4%	4,039,794	47.5%
Pulmonary	294,342	337,402	14.6%	391,666	33.1%
Radiation Therapy	183,436	213,304	16.3%	246,407	34.3%
Single Photon Emission CT Scan (SPECT)	19,776	24,104	21.9%	29,620	49.8%
Urology	142,865	172,502	20.7%	207,026	44.9%
Vascular Surgery	25,137	30,099	19.7%	35,639	41.8%
TOTAL	**55,090,860**	**65,562,138**	**19.0%**	**77,558,289**	**40.8%**

Source: IBM Watson Health Outpatient Procedure Estimates, 2020.

Emergency department visits

Emergency department estimates predict the total annual volume of emergency department (ED) visits by ZIP code and level of acuity for every market in the United States. IBM uses an extensive supply of proprietary claims, public claims and federal surveys to construct population-based use rates for all payors by age and sex. These use rates are then applied to demographic and insurance coverage projections by ZIP code to estimate ED utilization for 2020 through 2030.

Visits are broken out into emergent and non-emergent ambulatory visits to identify the volume of visits that could be seen in a less-acute setting, for example, a fast-track ED or an urgent care facility. In addition, visits that result in an inpatient admission are broken out into a third, separate category. In the Greater Austin Health Community, ED visits are expected to grow by almost 19% by 2025.

Emergent status	2020 visits	2025 visits	2020 – 2025 visits change	2020 – 2025 visits % change
Emergent	381,213	482,322	101,109	26.5%
Inpatient Admission	117,925	153,195	35,270	29.9%
Non-Emergent	311,874	328,243	16,368	5.2%
TOTAL	**811,012**	**963,760**	**152,748**	**18.8%**

Source: IBM Watson Health Emergency Department Visits, 2020.

Emergency department visit estimates 2025

- Inpatient admission
- Emergent
- Non-emergent
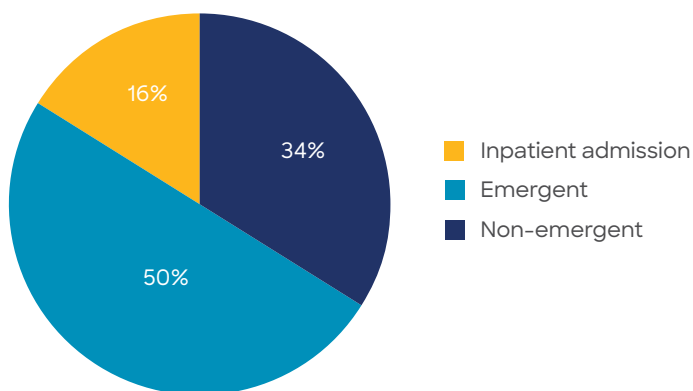
Heart disease estimates

The heart disease estimates dataset predicts the number of cases by heart disease type and ZIP code for every market in the United States. IBM uses public and private claims data as well as epidemiological data from the National Health and Nutritional Examination Survey (NHANES) to build local estimates of heart disease prevalence for the current population. County–level models by age and sex are applied to the underlying demographics of specific geographies to estimate the number of patients with specific types of heart disease.

In the Greater Austin Health Community, the most common disease is hypertension at 71% of all heart disease cases.

Disease type	2020 prevalence	2020 % prevalence
Arrhythmia	87,838	13.4%
Heart Failure	33,163	5.1%
Hypertension	464,849	71.1%
Ischemic Heart Disease	67,773	10.4%
TOTAL	**653,624**	**100.0%**

Source: IBM Watson Heart Disease Estimates, 2020.

Cancer estimates

IBM Watson Health builds county-level cancer incidence models that are applied to the underlying demographics of specific geographies to estimate incidence (i.e., the number of new cancer cases annually) of all cancer patients. Cancer incidence is expected to increase by 14% in the Greater Austin Health Community by 2025.

Cancer type	2020 incidence	2025 incidence	2020 – 2025 change	2020 – 2025 % change
Bladder	399	485	86	21.6%
Brain	155	176	21	13.5%
Breast	2,139	2,511	372	17.4%
Colorectal	1,296	1,258	–38	–2.9%
Kidney	461	561	100	21.7%
Leukemia	347	412	65	18.8%
Lung	865	1,000	134	15.5%
Melanoma	526	641	115	21.8%
Non-Hodgkin's Lymphoma	566	675	109	19.2%
Oral Cavity	388	466	78	20.0%
Other	1,473	1,755	282	19.1%
Ovarian	185	210	24	13.1%
Pancreatic	241	298	58	24.1%
Prostate	1,421	1,439	18	1.3%
Stomach	178	202	24	13.3%
Thyroid	238	278	41	17.2%
Uterine Cervical	66	70	4	5.5%
Uterine Corpus	454	544	90	19.8%
TOTAL	**11,398**	**12,980**	**1,582**	**13.9%**

Source: IBM Watson Health Cancer Estimates, 2020.

Appendix F: 2019 community health needs assessment evaluation

It is Baylor Scott & White Health's privilege to serve faithfully in promoting the well-being of all individuals, families and communities. Our 2019 Implementation Strategy described the various resources and initiatives we planned to direct toward addressing the adopted health needs of the 2019 CHNA.

Following is a snapshot of the impact of actions taken by Baylor Scott & White to address the below priority health issues.

Dates: Fiscal Years 2020 – March 2022
Facilities: Baylor Scott & White Medical Center – Austin, Baylor Scott & White Medical Center – Buda, Baylor Scott & White Medical Center – Pflugerville, Baylor Scott & White Medical Center – Round Rock (including Baylor Scott & White Medical Center – Lakeway), Baylor Scott & White Medical Center – Taylor, Baylor Scott & White Clinic
Community served: Williamson, Travis and Hays Counties

Accidental poisoning deaths where opioids were involved
Baylor Scott & White Medical Center — Round Rock
(including Baylor Scott & White Medical Center – Lakeway and Baylor Scott & White Institute for Rehabilitation – Lakeway)

Action/tactics	Anticipated outcome	Evaluation of impact
Reduction of prescribed opioids The hospitals will reduce the number of prescribed opioids after surgery through: • Implementation of ERAS (Enhanced Recovery After Surgery) protocol for general surgery patients, orthopedics and spine surgery and expand into urology and gynecology • Consideration of using integrative medicine as an alternative	Accidental deaths through opioid abuse will decline; post-surgery prescriptions will decline; significant community participation in opioid abuse education program.	We have implemented several strategies at our local facilities based on system initiatives to help mediate opioid abuse. BSWH has implemented mandatory training on chronic pain management for providers. A best practices alert pops up when certain levels of opioids are being prescribed. Policies reflect TMB and DEA mandates that include the review of PMP AWARxE (controlled substance pharmacy tracking database) prior to issuing certain prescriptions.

Baylor Scott & White Clinic

Action/tactics	Anticipated outcome	Evaluation of impact
Community health education Provide free community education sessions on alternatives to opioids and the signs of abuse through programs like Walk with a Doc and HealthSpeak.	Community members become more aware of the danger of opioid abuse and how to prevent it.	• **8,615 served** through HealthSpeak series and other educational outreach activities • **$25,447 community benefit**

Intentional self-harm – suicide
Baylor Scott & White Medical Center — Austin

Action/tactics	Anticipated outcome	Evaluation of impact
Mental health first aid Implementation of mental first aid. Training laypeople to recognize signs of mental distress and equipping them to provide immediate assistance and referral to appropriate resources. HealthSpeak Education Series offers free educational seminars designed to provide information on disease and wellness topics.	Improved awareness of mental health needs and knowledge of local resources.	• **Persons served: 469** • **$7,102 community benefit**
Cash and in-kind contributions Cash and in-kind contributions to other not-for-profit community organizations existing to increase access to healthcare and services for the community.	Improved access to care. Number of suicide attempts will decline due to proactive programs targeting individuals at risk.	• **$24,100 community benefit**
Faith community health Members of the faith community are trained to connect community members to health and social services available in the area. This is an effort to integrate faith workers and healthcare through health educators, faith community nurses, home visits and church volunteer members.	The overall community's health will improve by integrating faith communities with healthcare to increase effective patient navigation, education and support.	This system-led program has not yet been initiated in the Greater Austin Region, but it is still planned for implementation in late summer/ early fall 2022.

Baylor Scott & White Medical Center — Buda

Action/tactics	Anticipated outcome	Evaluation of impact
Mental health first aid Implementation of mental first aid. Training laypeople to recognize signs of mental distress and equipping them to provide immediate assistance and referral to appropriate resources.	Improved awareness of mental health needs and knowledge of local resources.	Not implemented yet due to COVID-19, but hospital still plans to continue the conversation about bringing the program into the community.
Cash and in-kind contributions Cash and in-kind contributions to other not-for-profit community organizations existing to increase access to healthcare and services for the community.	Improved access to care. Number of suicide attempts will decline due to proactive programs targeting individuals at risk.	• **Persons served: 21,824** • **$35,329 community benefit** Community partners include Austin Child Guidance, Catholic Charities, Dripping Springs ISD and Equine Rehabilitation of Central Texas.

Intentional self-harm – suicide, continued
Baylor Scott & White Medical Center – Pflugerville

Action/tactics	Anticipated outcome	Evaluation of impact
Mental health first aid Implementation of mental first aid. Training laypeople to recognize signs of mental distress and equipping them to provide immediate assistance and referral to appropriate resources.	Improved awareness of mental health needs and knowledge of local resources.	• **Persons Served: 53** • **$1,913 community benefit**
Cash and in-kind contributions Cash and in-kind contributions to other not-for-profit community organizations existing to increase access to healthcare and services for the community.	Improved access to care. Number of suicide attempts will decline due to proactive programs targeting individuals at risk.	• **$26,000 community benefit**
Crisis intervention Partnership with crisis intervention team – Pflugerville Police Department.	Provide access to acute treatment of suicidal ideation/self-harm patients until patient is medically clear and able to transfer to appropriate facility.	The medical center continues to work with Pflugerville PD to improve our processes around mental healthcare in the ED. The Pflugerville ED manager continues to have a good line of communication with PD leadership to address opportunities as they arise. The ED manager is also working to restart meetings with PD leadership and mental health support in the community to allow for consistent in-person meetings and open dialogue to be proactive in improving the quality of care provided to our mental health patients.

Baylor Scott & White Medical Center – Round Rock (including Baylor Scott & White Medical Center – Lakeway)

Action/tactics	Anticipated outcome	Evaluation of impact
Community referrals Work with community non-profits and mental health providers to improve referral process and thereby access to mental healthcare resources in the Williamson County Area. Implement online therapy tool to enable anytime access to therapy for mentally ill. Partner with clinic to implement TalkSpace.com.	Community members will be referred to appropriate resources in a timely manner and will be connected to others sharing similar challenges to build a support network. Number of suicide attempts will decline due to proactive programs targeting individuals at risk.	• **$264,037 community benefit**
Mental health first aid Implementation of mental first aid. Training laypeople to recognize signs of mental distress and equipping them to provide immediate assistance and referral to appropriate resources. HealthSpeak Education Series offers free educational seminars designed to provide information on disease and wellness topics.	Improved awareness of mental health needs and knowledge of local resources.	• **Persons served: 578** • **$14,557 community benefit**
Cash and in-kind contributions Cash and in-kind contributions to other not-for-profit community organizations existing to increase access to healthcare and services for the community.	Improved access to care. Number of suicide attempts will decline due to proactive programs targeting individuals at risk.	• **Persons served: 16,557** • **$596,171 community benefit**

Intentional self-harm – suicide, continued
Baylor Scott & White Medical Center — Taylor

Action/tactics	Anticipated outcome	Evaluation of impact
Access to care Enhanced access to mental health providers through improved processes for scheduling and provider recruitment.	Appointments for mental health will become more available.	• New mental health provider onboarded to restart mental health services at the hospital. Provider is working on building up his practice. • **$422,000 community benefit**

Baylor Scott & White Clinic

Action/tactics	Anticipated outcome	Evaluation of impact
Community health education Provide community education on mental health to reduce the negative stigma around seeking help.	Reduction of negative stigma around seeking help for mental health. Improved community awareness of challenges faced by individuals struggling with mental illness and what resources are available.	• **8,615 served** through HealthSpeak series and other educational outreach activities. • **$25,447 community benefit**

Ratio of population to one physician primary care provider (physician/non-physician)

Baylor Scott & White Medical Center – Austin
Baylor Scott & White Medical Center – Buda
Baylor Scott & White Medical Center – Pflugerville
Baylor Scott & White Medical Center – Taylor

Action/tactics	Anticipated outcome	Evaluation of impact
Transportation Address transportation challenges for access to PCPs through collaboration with area agencies.	The community will see improved access to affordable, available transportation to healthcare services, reducing missed appointments due to transportation challenges.	• Transportation solutions and support dollars, including for Ride Health • **Austin $3,650 community benefit** • **Buda $3,650 community benefit** • **Lakeway $2,000 community benefit** • **Pflugerville $1,500 community benefit** • **Round Rock $3,000 community benefit** • **Taylor $7,000 community benefit** • **1,500 persons served**
Cash and in-kind donations Cash and in-kind contributions to other not-for-profit community organizations existing to increase access to healthcare and services for the community.	Improved access to care for un/underinsured.	• **Persons served: 38,381** • **Austin $24,100 community benefit** • **Buda $35,329 community benefit** • **Lakeway 77,120 community benefit** • **Pflugerville $26,000 community benefit** • **Round Rock $519,051 community benefit** • **Taylor $10,650 community benefit**
In-kind medical supply donations In-kind medical supply and equipment donations to local non-profits supporting healthcare programs.	Other non-profit organizations are better able to help patients at a first touch point rather than having to send them to the hospital for care.	• **Round Rock $345,000 community benefit**
Charity care Provide free and/or discounted care to financially or medically indigent patients as outlined in the financial assistance policy.	Increased access to primary care and/or specialty care for indigent persons regardless of their ability to pay.	• **Austin $2,993,995 community benefit** • **Buda $3,759,185 community benefit** • **Pflugerville $4,886,496 community benefit** • **Round Rock (including Lakeway) $29,273,039 community benefit** • **Taylor $6,064,835 community benefit**

Ratio of population to one physician primary care provider (physician/non-physician), continued
Baylor Scott & White Clinic

Action/tactics	Anticipated outcome	Evaluation of impact
Taylor clinic expansion project Operational plans to grow clinic space by 2021. Addition of primary care physician and non-physician providers to the hospital and clinic.	Residents have reliable access to PCPs, resulting in fewer visits to the ED due to earlier detection of major health problems. Reduced health problems/ positive medical outcomes (weight loss, conditions such as Type 2 diabetes, CHF, etc.). New patients will be able to access a primary care provider within seven days.	• Expansion completed in January 2022. Added six exam rooms. New APP starts in June. One physician added; however, one physician moved to PRN. Recruiting underway to fill FT physician position. • $450,000 building • $429,000 staffing • **$879,000 community benefit**
Transportation Address transportation challenges for access to PCPs through collaboration with area agencies.	The community will see improved access to affordable, available transportation to healthcare services, reducing missed appointments due to transportation challenges.	• CARTS added an on-demand service that seems to be increasing in popularity. Seeing their new vehicles arriving at the Taylor facilities frequently.

Total investment in adopted community needs since 2019 CHNA

BSWMC – Austin	BSWMC – Buda	BSWMC – Pflugerville
$3 million	**$3.8 million**	**$4 million**

BSWMC – Round Rock (including BSWMC – Lakeway and BSWIR – Lakeway)	BSWMC – Taylor	BSW Clinic
$30.5 million	**$6.5 million**	**$904,000**