Baylor Scott & White Health
Community Health Needs Assessment

Bell County Health Community

Baylor Scott & White Medical Center – Temple (including Baylor Scott & White McLane Children's Medical Center)
Baylor Scott & White Continuing Care Hospital

Approved by: Baylor Scott & White Health – Central Texas Operating, Policy and Procedure Board on May 17, 2019

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Baylor Scott & White Health Mission Statement

Our Mission

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

Our Ambition

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

Our Values

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

Our Strategies

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

WHO WE ARE

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

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Mission
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Ambition

Executive Summary

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

Beginning in June of 2018, a BSWH task force led by the Community Health, Tax Services, and Marketing Research departments began the process of assessing the current health needs of the communities served for all BSWH hospital facilities. IBM Watson Health (formerly known as Truven Health Analytics) was engaged to help collect and analyze the data for this process and to compile a final report made publicly available in June of 2019.

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

- Baylor Scott & White Medical Center - Temple
- Baylor Scott & White Continuing Care Hospital

For the 2019 assessment, the community served by Baylor Scott & White Medical Center - Temple (includes Baylor Scott & White McLane Children's Medical Center) and the Baylor Scott & White Continuing Care Hospital is Bell County. All of these owned hospital facilities are located in Bell County and more than 75% of the admitted patients live in this community. These hospital facilities collaborated to provide a joint CHNA report in accordance with Treasury Regulations and 501(r) of the Internal Revenue Code. All of the collaborating hospital facilities included in this joint CHNA report define their community, for purposes of the CHNA report, to be the same.

Hospital facilities and IBM Watson Health (Watson Health) examined over 102 public health indicators and conducted a benchmark analysis of the data comparing the community to overall State of Texas and United States (U.S.) values. For a qualitative analysis, and in order to get input directly from the community, focus groups and key informant interviews were conducted. Interviews included input from state, local, or regional governmental public health departments (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community as well as individuals or organizations serving and/or representing the interests of medically underserved, low-income, and minority populations in the community.

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

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

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

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

Priority	Need	Category of Need
1	Food: Hunger and Access to Healthy Foods	Environment - Food
2	Physical Inactivity	Health Behaviors - Exercise
3	Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health
4	Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted
5	No Vehicle Available	Access to Care

As part of the assessment process, community resources were identified, including facilities/organizations, that may be available to address the significant needs in the community. These resources are located in the appendix of this report and will be included in the formal implementation strategy to address needs identified in this assessment, approved and made publicly available by the 15th day of the 5th month following the end of the tax year.

An evaluation of the impact and effectiveness of interventions and activities outlined in the implementation strategy drafted after the 2016 assessment is also included in **Appendix F** of this document.

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

This assessment and corresponding implementation strategy meet the requirements for community benefit planning and reporting as set forth in state and federal laws, including but not limited to: Texas Health and Safety Code Chapter 311 and Internal Revenue Code Section 501(r). A report of CHNA compliance is on the IRS Form 990, Schedule H.

Community Health Needs Assessment Requirement

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

The written CHNA Report must include descriptions of the following:

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

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

The written Implementation Strategy must include the following:

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

CHNA Overview, Methodology and Approach

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

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

Consultant Qualifications & Collaboration

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

Collaboration

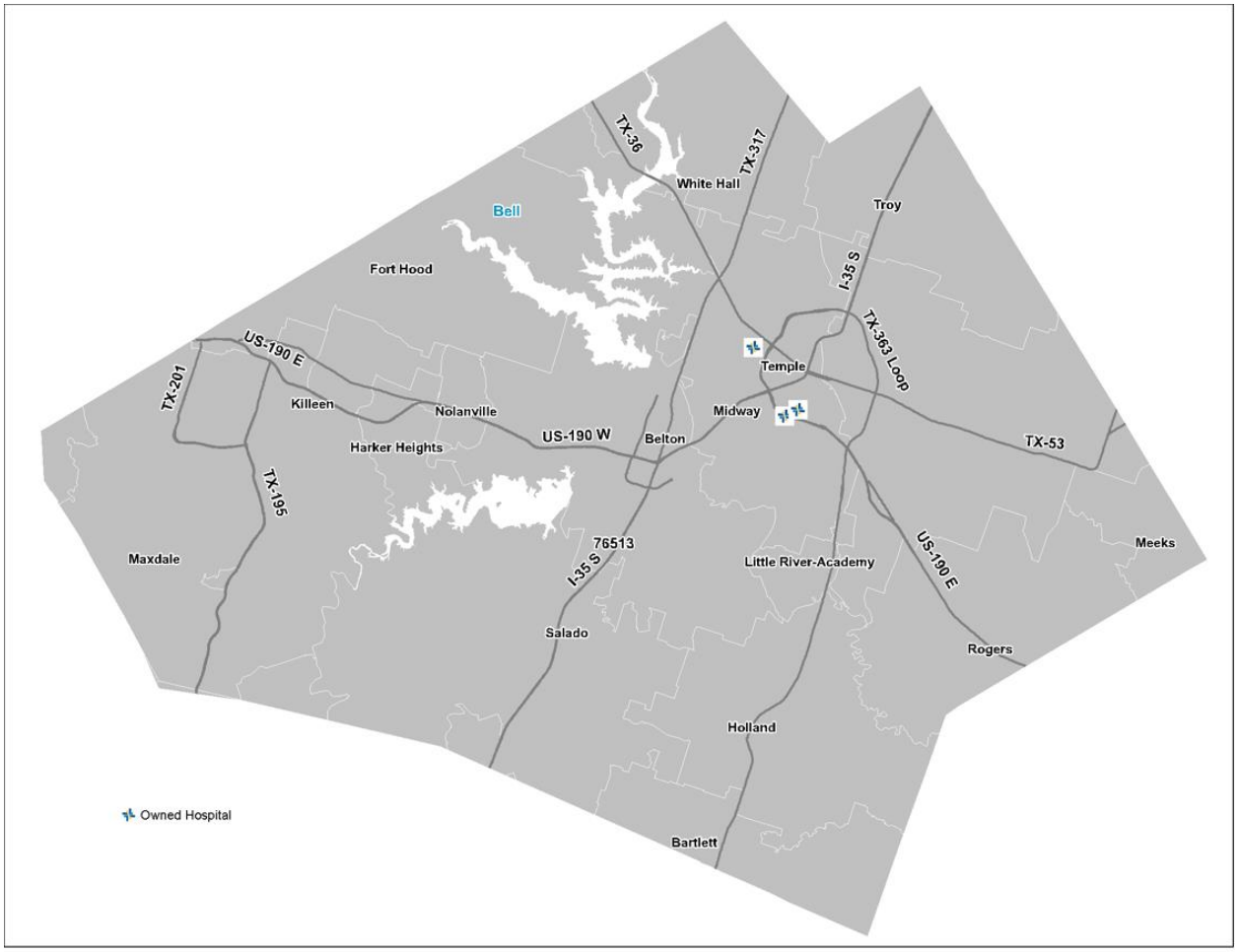
BSWH owns and operates multiple individually licensed hospital facilities serving the residents of north and central Texas. Two hospital facilities with overlapping communities have collaborated to conduct this joint community health needs assessment. This joint community health needs assessment applies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

- Baylor Scott & White Medical Center - Temple
- Baylor Scott & White Continuing Care Hospital

Community Served Definition

The community served by Baylor Scott & White Medical Center - Temple (includes Baylor Scott & White McLane Children's Medical Center) and the Baylor Scott & White Continuing Care Hospital is Bell County. All of these owned hospital facilities are located in Bell County and more than 75% of the admitted patients live in this community.

BSWH Community Health Needs Assessment
Bell County Health Community Map



Source: Baylor Scott & White Health, 2019

Assessment of Health Needs

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

Quantitative Assessment of Health Needs – Methodology and Data Sources

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

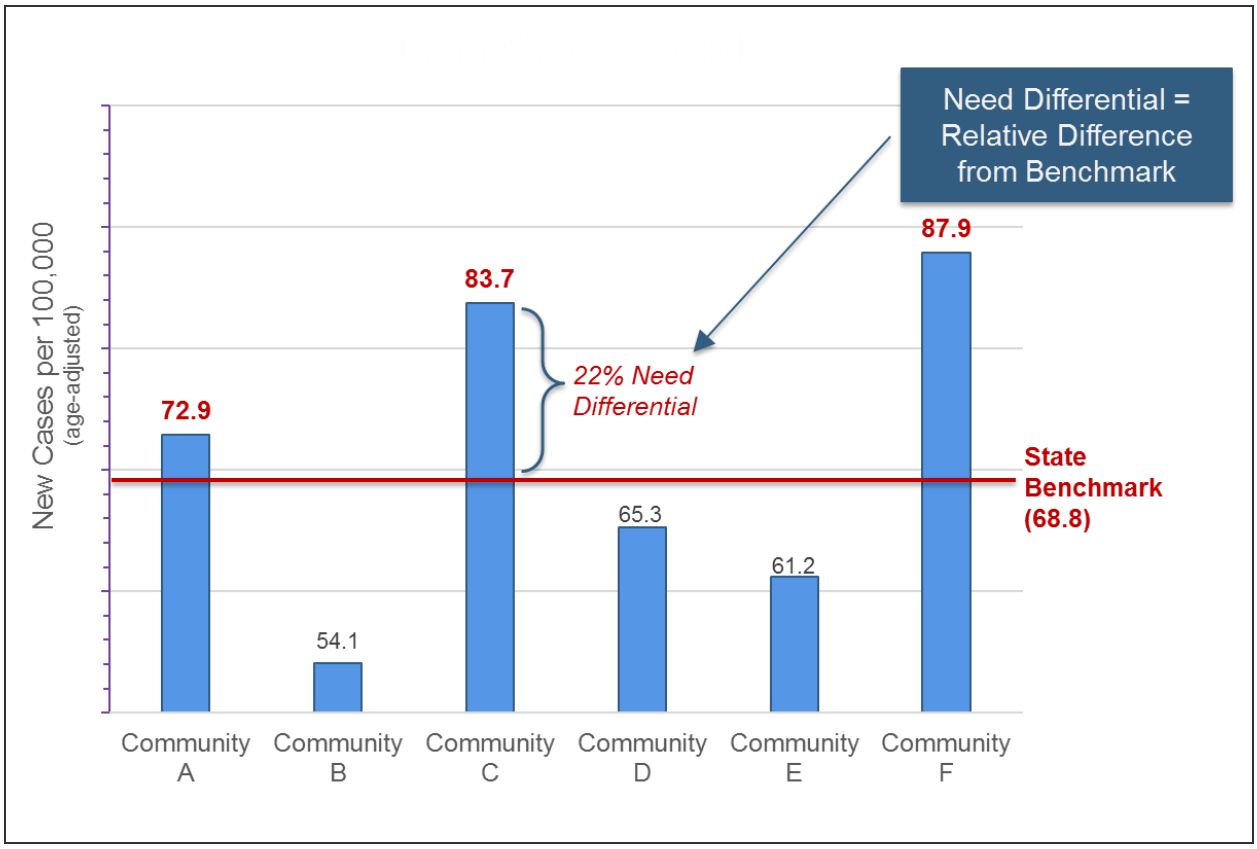
A benchmark analysis conducted for each indicator collected for the community served, determined which public health indicators demonstrated a community health need from a quantitative perspective. Benchmark health indicators collected included (when available): overall U.S. values, State of Texas values,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

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

Once the community benchmark was set to the state value, it was determined which indicators for the community did not meet the state benchmarks. This created a subset of indicators for further analysis. A need differential analysis was conducted to understand the relative severity of need for these indicators. The need differential established a standardized way to evaluate the degree each indicator differed from its benchmark; this measure is called the need differential. Health community indicators with need differentials above the 25th percentile, ordered by severity, and the highest ranked indicators were the highest health needs from a quantitative perspective. These data are available to the community via an interactive Tableau dashboard at **BSWHealth.com/CommunityNeeds** .

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

Health Indicator Benchmark Analysis Example



Source: IBM Watson Health, 2018

Qualitative Assessment of Health Needs and Community Input – Approach

In addition to analyzing quantitative data, one (1) focus group with a total of 15 participants, as well as eight (8) key informant interviews, were conducted to take into account the input of persons representing the broad interests of the community served. The focus group and interviews solicited feedback from leaders and representatives who serve the community and have insight into community needs. Prioritization sessions were also held with hospital clinical leadership and/or other community leaders to identify significant health needs from the assessment and prioritize them.

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

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

Participation in the qualitative assessment included at least one state, local, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community, as well as individuals or organizations who served and/or represented the interests of medically underserved, low-income and minority populations in the community.

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

Community Input Participants

Participant Organization Name	Public Health	Medically Under-served	Low-income	Chronic Disease Needs	Minority Populations	Governmental Public --Health Dept.	Public Health Knowledge/ --Expertise
Area Agency on Aging of Central Texas		X	X	X	X		
Baylor Scott & White Health	X	X	X	X	X		X
Bell County Indigent Health Svc Department	X	X	X	X	X		
Bell County Public Health District	X	X	X		X	X	X
Bell/Lampasas Counties Community Supervision and Corrections Department				X			
Belton Independent School District	X	X	X	X	X		X
Body of Christ Community Clinic		X	X	X	X		
Central Texas Catholic Charities	X	X	X	X	X	X	X
Central Texas Food Bank		X	X	X	X		X
Christ Episcopal Church			X		x		X
CTLC and Feed My Sheep		X	X		X		
Greater Killeen Community (Free) Clinic		X	X	X	X		X
Lulac Council 4971					X		
Temple Independent School District	X	X	X		X		
Texas A&M Agrilife Extension Service			X	X			X
Texas Christian Community Development Network			X		X		

Participant Organization Name	Public Health	Medically Under-served	Low-income	Chronic Disease Needs	Minority Populations	Governmental Public --Health Dept.	Public Health Knowledge/ --Expertise
Texas Department of State Health Services Region 7	X	X	X	X	X	X	X
United Way of Central Texas	X	X	X	X	X		
Workforce Solutions of Central Texas			X				

Note: multiple persons from the same organization may have participated

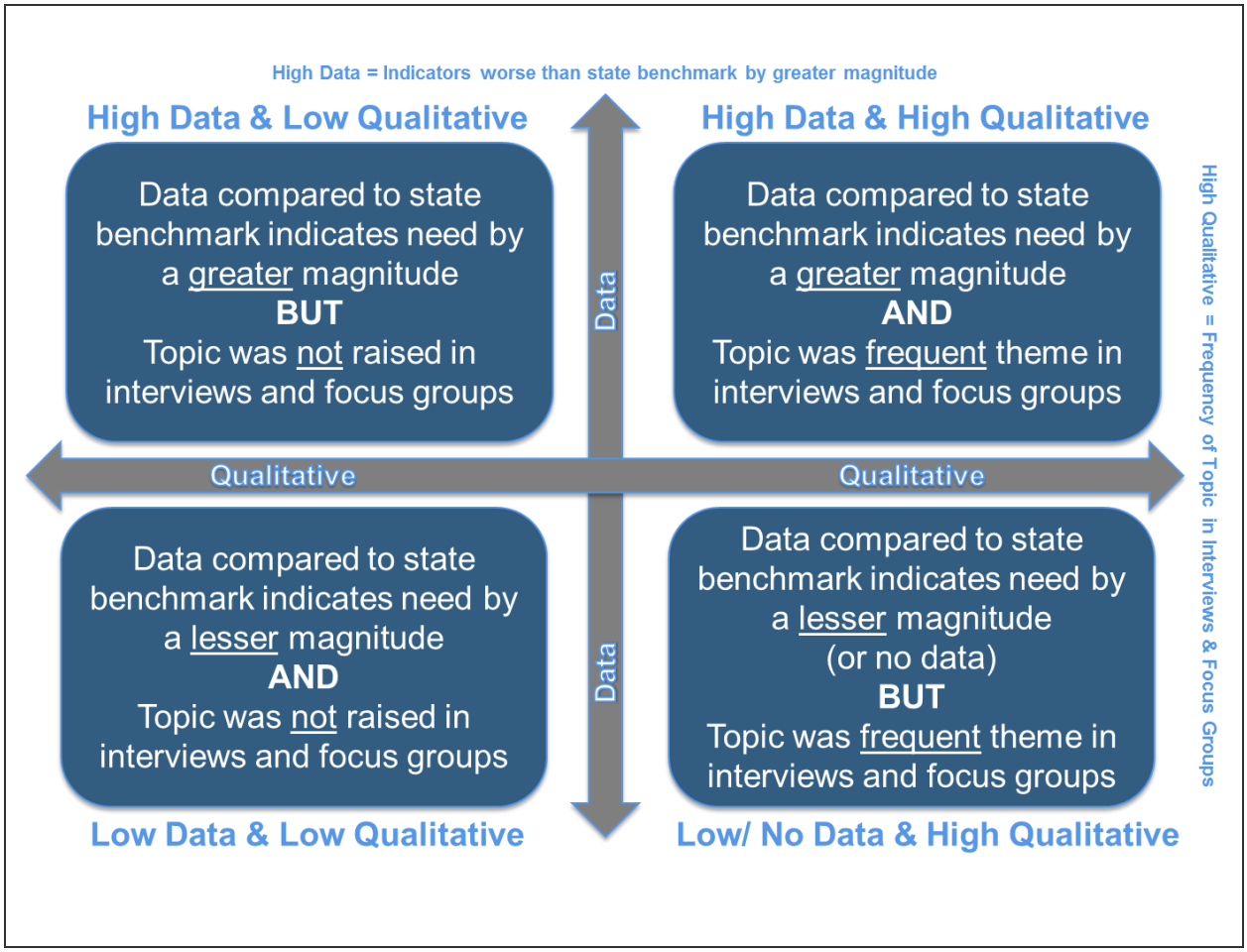
In addition to soliciting input from public health and various interests of the community, the hospital facilities were also required to consider written input received on their most recently conducted CHNA and subsequent implementation strategies. The assessment is available to receive public comment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

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

Methodology for Defining Community Need

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

The Health Needs Matrix



Source: IBM Watson Health, 2018

Information Gaps

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

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

Approach to Identify and Prioritize Significant Health Needs

In a session held with Baylor Scott & White Medical Center - Temple and Baylor Scott & White Continuing Care Hospital leadership and community leaders on November 26, 2018, significant health needs were identified and prioritized. The meeting, moderated by Watson Health, included an overview of the CHNA process for BSWH, the methodology for determining the top health needs, the BSWH prioritization approach, and discussion of the top health needs identified for the community.

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

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

1. Severity: the problem results in disability or premature death or creates burdens on the community, economically or socially
2. Root Cause: the need is a root cause of other problems, thereby addressing it could possibly impact multiple issues
3. Magnitude: the need impacts a large number of people, actually or potentially

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

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

Existing Resources to Address Health Needs

Part of the assessment process included gathering input on community resources potentially available to address the significant health needs identified through the CHNA. BSWH Community Resource Guides, and input from qualitative assessment participants, identified community resources that may assist in addressing the health needs identified for this community. A description of these resources is in **Appendix B**. In addition, an interactive asset map of various resources identified for all BSWH communities are at: **BSWHealth.com/CommunityNeeds** .

Bell County Health Community CHNA

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 was younger than Texas overall and median income was below both the state and the country. The community served has more uninsured individuals and more unemployed people than Texas and the U.S...

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

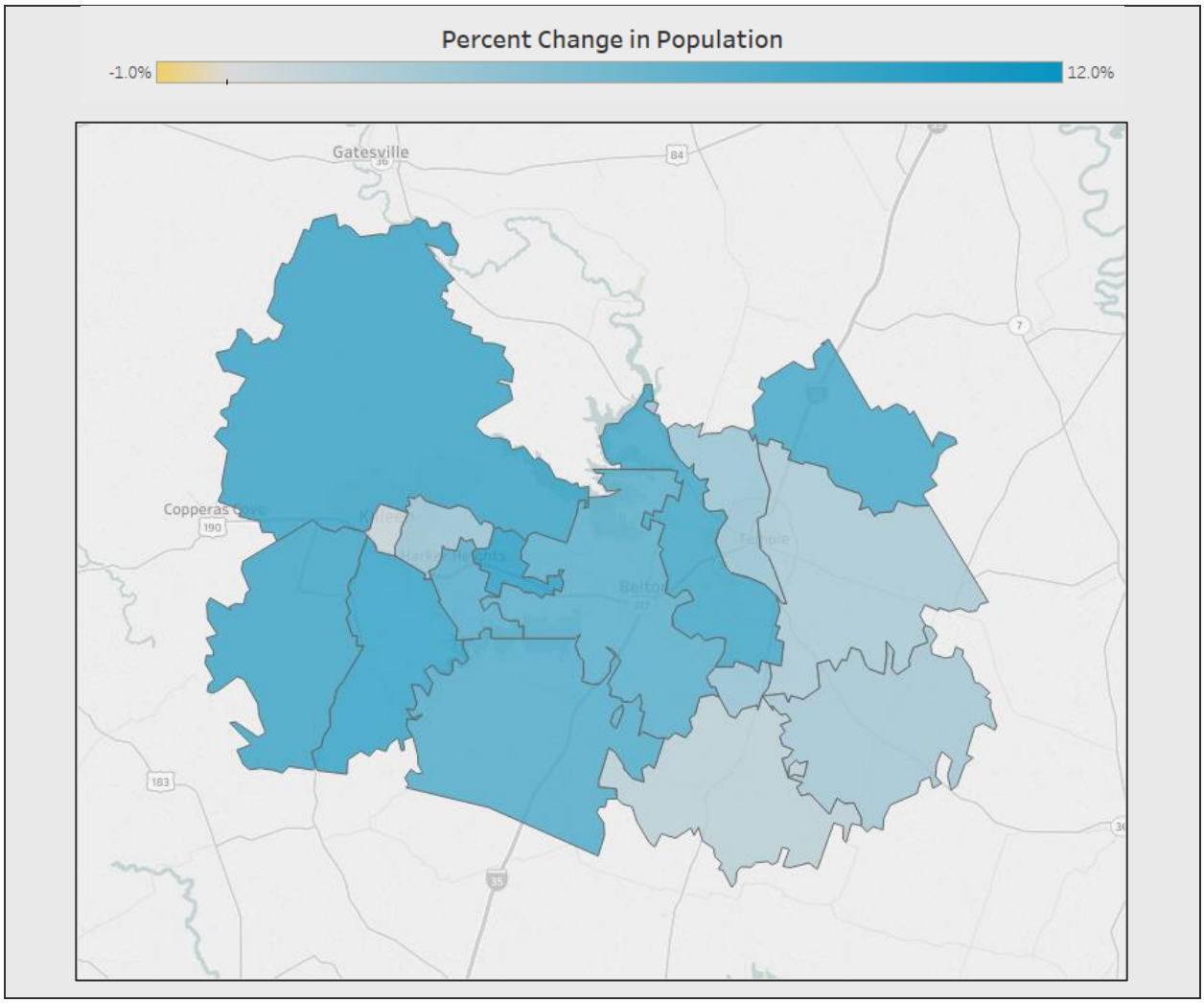
Geography		Benchmarks		Community Served
		United States	Texas	Bell County Health Community
Total Current Population		326,533,070	28,531,631	359,046
5 Yr Projected Population Change		3.5%	7.1%	7.0%
Median Age		42.0	38.9	34.3
Population 0-17		22.6%	25.9%	28.2%
Population 65+		15.9%	12.6%	10.1%
Women Age 15-44		19.6%	20.6%	21.9%
Non-White Population		30.0%	32.2%	41.9%
Hispanic Population		18.2%	39.4%	25.3%
Insurance Coverage	Uninsured	9.4%	19.0%	23.2%
	Medicaid	14.9%	13.4%	13.4%
	Private Market	9.6%	9.9%	7.9%
	Medicare	16.1%	12.5%	12.1%
	Employer	45.9%	45.3%	43.3%
Median HH Income		$61,372	$60,397	$51,970
Limited English		26.2%	39.9%	27.1%
No High School Diploma		7.4%	8.7%	4.9%
Unemployed		6.8%	5.9%	9.1%

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

The population of the community served is expected to grow 7.0% by 2023, an increase of more than 25,000 people. The 7.0% projected population growth is slightly lower than the state's 5-year projected growth rate (7.1%) and higher compared to the national projected growth rate (3.5%). The ZIP codes expected to experience the most growth in five years are:

- 76549 Killeen – 4,760 people
- 76542 Killeen – 4,559 people
- 76544 Fort Hood – 3,202 people
- 76502 Temple – 3,149 people

2018 - 2023 Total Population Projected Change by ZIP Code



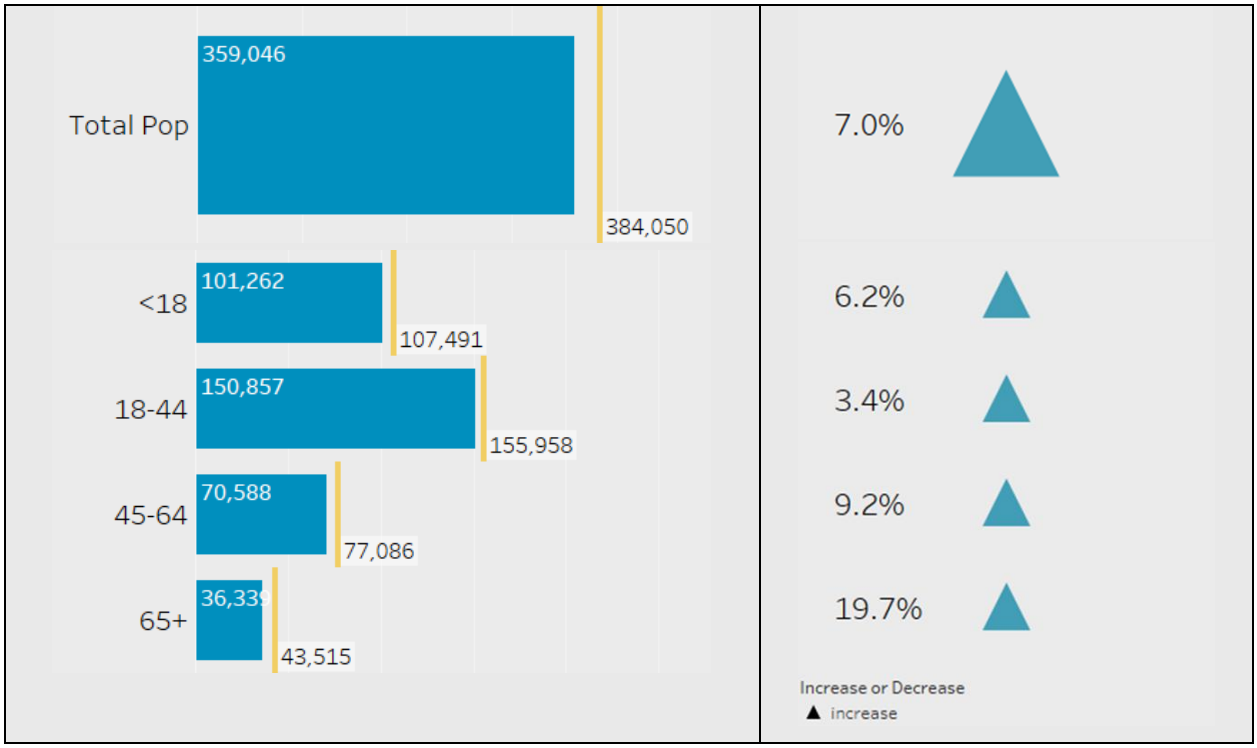
Source: IBM Watson Health / Claritas, 2018

The community's population skewed younger with 42.0% of the population ages 18-44 and 28.2% under age 18. The largest cohort (18-44) is expected to grow the least (5,101 people by 2023). Meanwhile, the age 65 plus cohort was the smallest but is expected to

experience the fastest growth (19.7%) over the next five years, adding 7,176 seniors to the community. Growth in the senior population will likely contribute to increased utilization of services as the population continues to age.

Population Distribution by Age

2018 Population by Age Cohort *Percent Change by 2023*

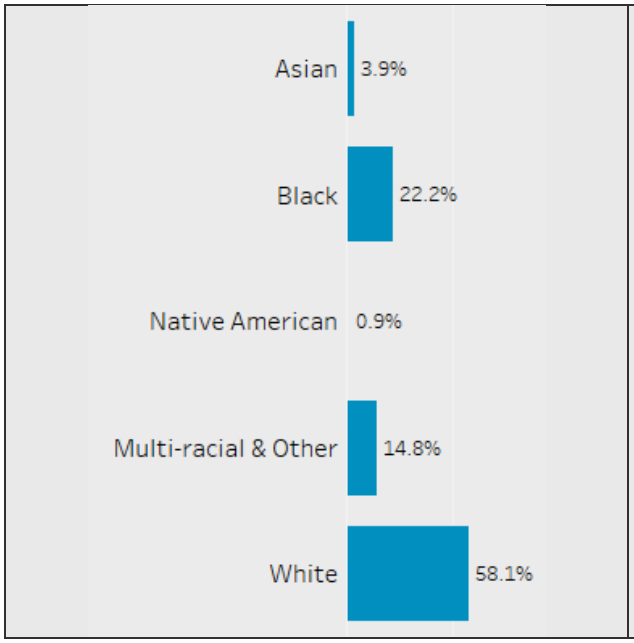


Source: IBM Watson Health / Claritas, 2018

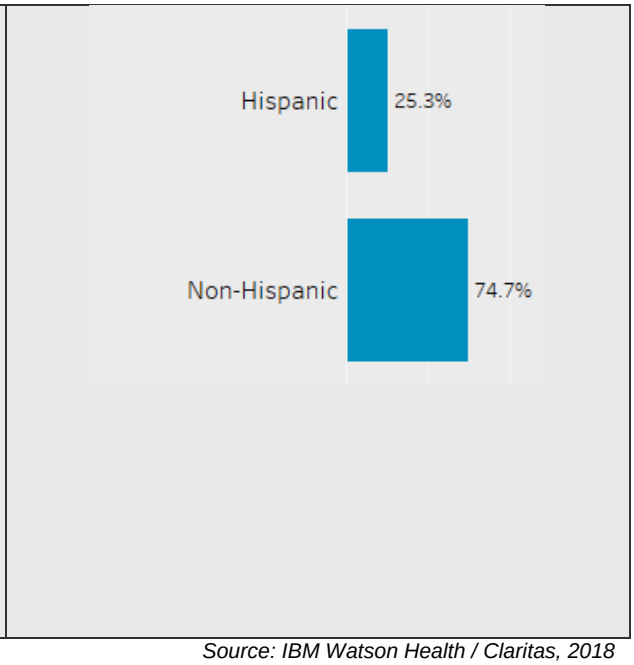
Population statistics can be analyzed by race and by Hispanic ethnicity. The community was primarily white non-Hispanic (45.6%), followed by the black non-Hispanic population (20.9%). The total non-Hispanic population is expected to grow just 3.5%, while the non-Hispanic population will grow 17.1% adding 15,508 Hispanic residents. The white non-Hispanic population is expected to slightly decrease (-0.3%).

Population Distribution by Race and Ethnicity

2018 Population by Race

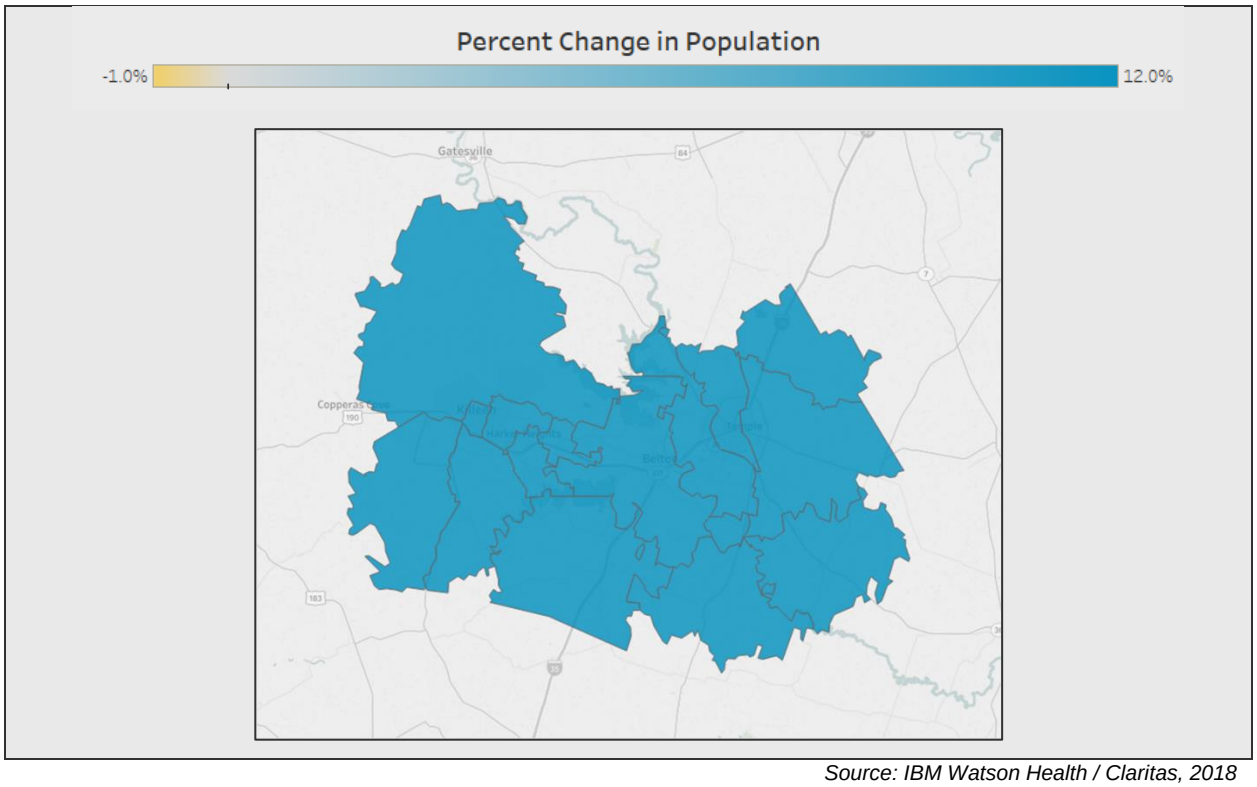


2018 Population by Ethnicity



Source: IBM Watson Health / Claritas, 2018

2018 - 2023 Hispanic Population Projected Change by ZIP Code

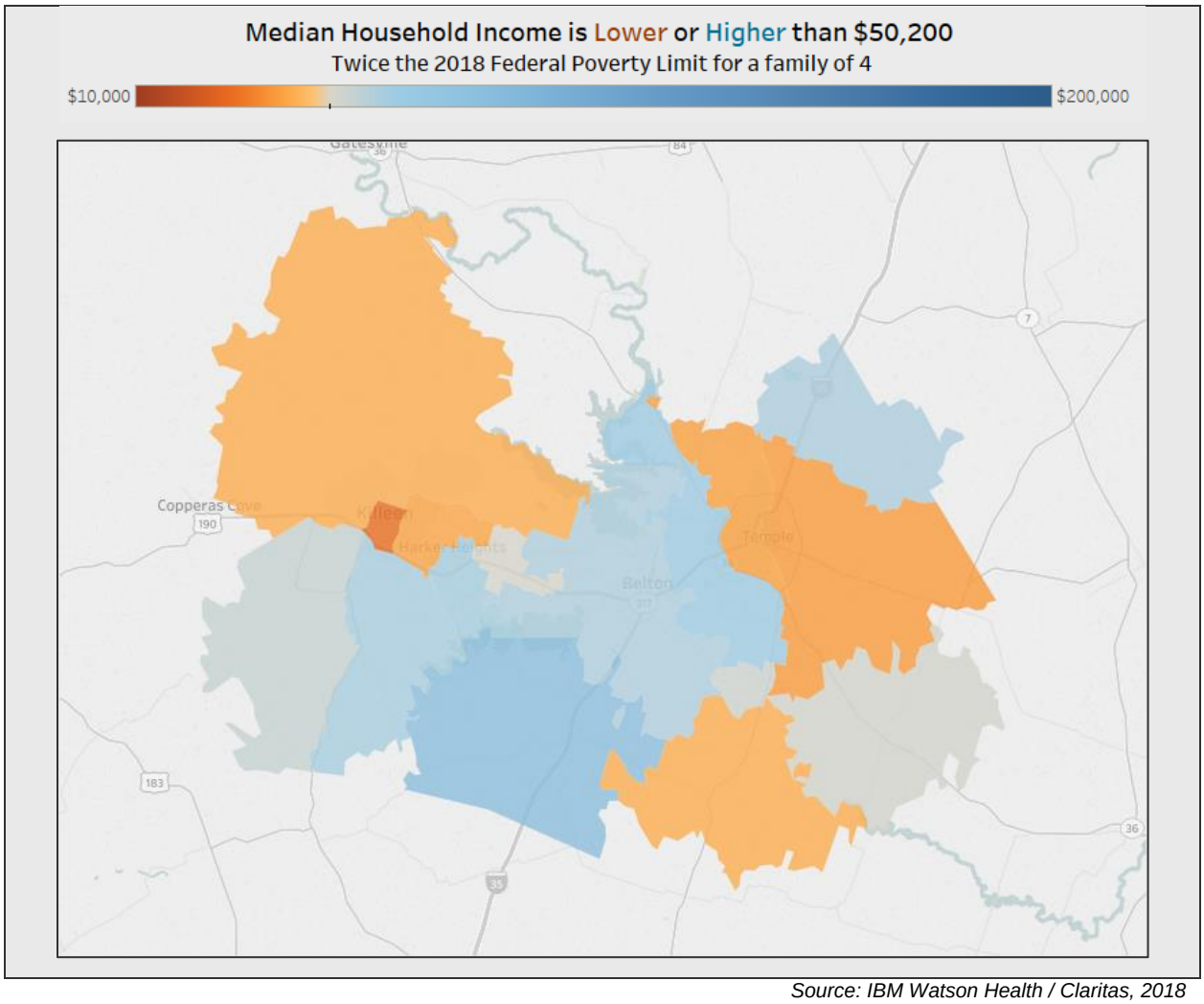


Source: IBM Watson Health / Claritas, 2018

The 2018 median household income for the United States was $61,372 and $60,397 for the state of Texas. The median household income for the ZIP codes within this community ranged from $30,247 for 76541-Killeen to $80,247 for 76571-Salado. There were eight ZIP codes with median household incomes less than $50,200, twice the 2018 Federal Poverty Limit for a family of four.

- 76569 East Bell County - $52,012
- 76559 Harker Heights - $50,256
- 76534 East Bell County - $42,557
- 76544 Fort Hood - $42,542
- 76543 Killeen - $40,707
- 76504 Temple - $39,729
- 76501 Temple - $38,717
- 76541 Killeen - $30,247

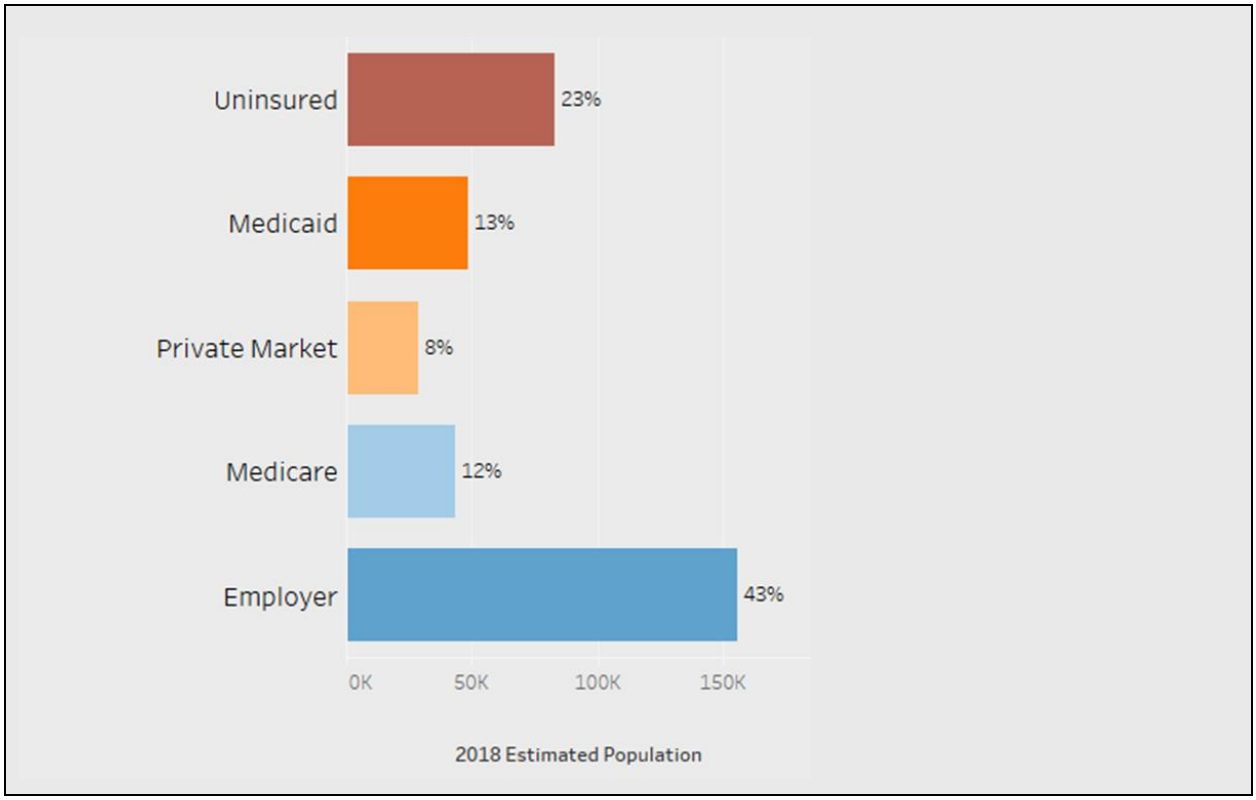
2018 Median Household Income by ZIP Code



Source: IBM Watson Health / Claritas, 2018

A majority of the population (43%) were insured through employer sponsored health coverage; followed by a group of those without health insurance (23%). The next largest groups of the population were Medicaid (13%) and Medicare (12%). The smallest group were those covered by private market plans (the purchasers of coverage directly or through the health insurance marketplace) at 8%.

2018 Estimated Distribution of Covered Lives by Insurance Category



Source: IBM Watson Health / Claritas, 2018

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

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

Health Professional Shortage Areas and Medically Underserved Areas and Populations

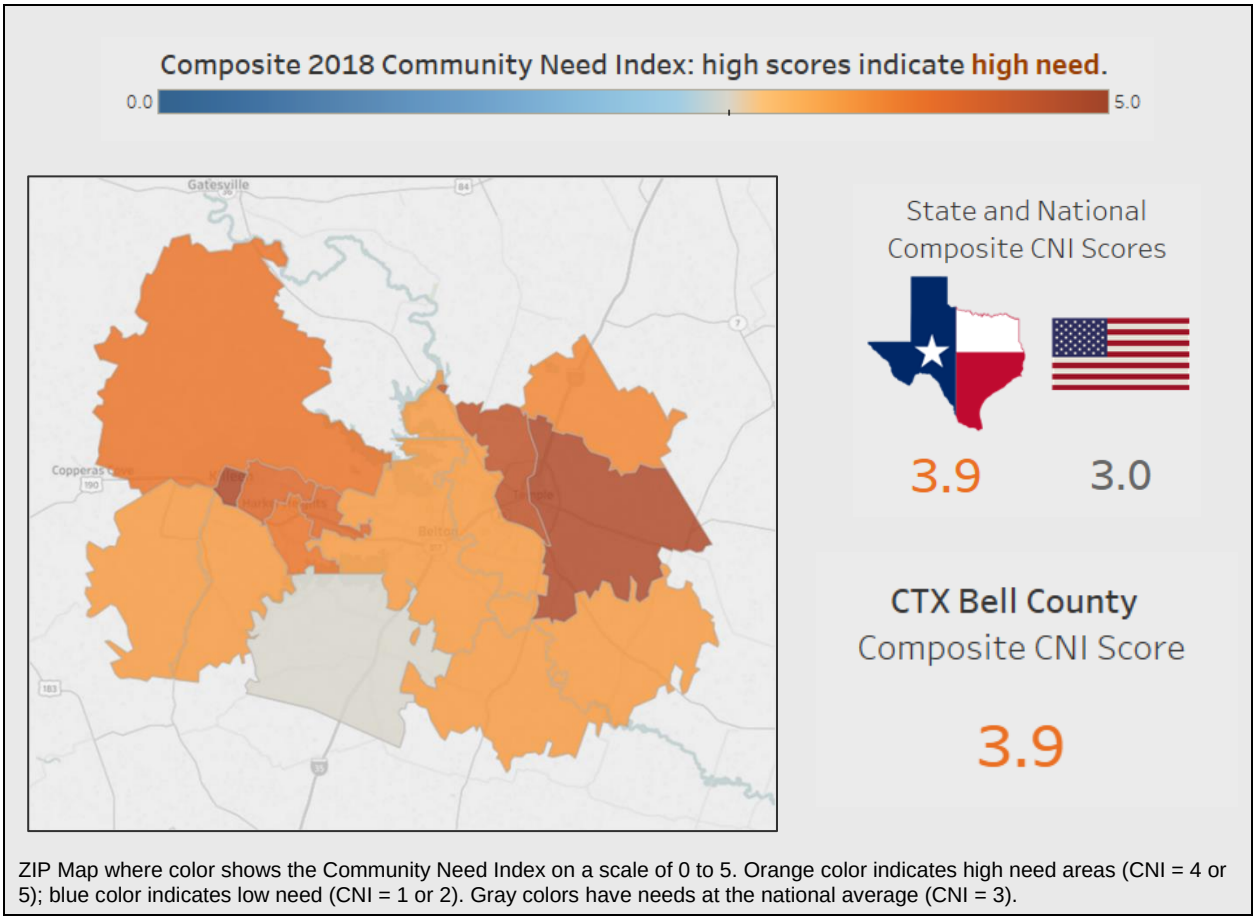
	Health Professional Shortage Areas (HPSA)				Medically Underserved Area/Population (MUA/P)
CTX Bell County Health Community	Dental Health	Mental Health	Primary Care	Grand Total	MUA/P
Bell	0	1	1	2	2
Total	**0**	**1**	**1**	**2**	**2**

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

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

Overall, the CNI score for the community served was 3.9, higher than the CNI national average of 3.0, potentially indicating greater health care needs in this community. In portions of the community (Killeen and Temple) the CNI score was greater than 4.5, pointing to potentially more significant health needs among the population.

2018 Community Need Index by ZIP Code



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

CNI High Need ZIP Codes

City	Community	County	ZIP Code	2018 CNI Score
Killeen	Killeen	Bell	76541	4.8
Temple	Temple	Bell	76501	4.8
Temple	Temple	Bell	76504	4.6
Killeen	Killeen	Bell	76543	4.2
Nolanville	Harker Heights	Bell	76559	4.2
Fort Hood	Fort Hood	Bell	76544	4.0
Harker Heights	Harker Heights	Bell	76548	4.0

Source: IBM Watson Health / Claritas, 2018

Public Health Indicators

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

Where the community indicators showed greater need when compared to the State of Texas comparative benchmark, the difference between the community values and the state benchmark was calculated (need differential). Those indicators with need differentials in the 25th percentile of greater severity pinpointed community health needs from a quantitative perspective. These indicators are located in **Appendix D**.

Watson Health Community Data

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

Focus Groups & Interviews

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

In the focus group sessions and interviews participants identified and discussed the factors that contribute to the current health status of the community; then identified the greatest barriers and strengths that contribute to the overall health of the community. For this health community, information was gathered through a focus group with 15 participants, eight (8) interviews, and a meeting with the Central Texas Council of Governments (including 30-60 local non-profit organization leaders); conducted July through September 2018.

For the health community served, the top health needs identified in these discussions included:

- Access to mental healthcare across the board, especially for uninsured populations, pediatric patients, crisis services, and non-acute services
- Transportation
- Lack of dental care
- Navigating the healthcare system/information
- Knowledge to self-manage chronic conditions

Participants described Bell County as a friendly and collaborative community with diverse resources and a low cost of living. Fort Hood's presence in the health community brought both benefits and challenges as one of the largest military bases in the world. The benefits included local jobs, but the challenges included a transient population of military and personnel with potentially more medical needs. The focus group shared that eastern Bell County was more rural with well-established farm families and skewed older, while

western Bell County was more diverse, skewed younger, and had a large Korean population. There was a significant homeless population and the number of residents without health insurance was growing.

Participants shared that there was significant inequality in healthcare access and services in the health community, often dependent on ability to pay and access to transportation. Significant services were provided through faith-based organizations, but a lack of overall coordination and communication led to some under/over-utilized services. The focus group discussed that the uninsured or low-income families, especially those with behavioral health issues, often did not follow up with post-inpatient care. Access to mental health services, transportation, and limited dental services were identified as the most significant healthcare challenges in Bell County, especially for the most vulnerable low-income residents.

Multiple factors limited access to healthy foods and physical activity options for area residents, especially for disabled seniors and families without a car. There were food pantries and kitchens operating in the area, but participants said health providers could be better trained to identify needy patients and recognize the health impact of food and housing insecurity. Limited public transportation compounded the difficulty for low income and rural residents to get to healthcare services and healthy food options. Participants argued that food and housing security are often the first steps to better manage chronic diseases and behavioral health issues.

There were considerable non-profit and faith-based services spread throughout the county, but many missed opportunities to coordinate services and transportation. Services were often not accessible due to a lack of available transportation, so there is an opportunity to share resources and improve communication between entities providing care. Throughout the discussion, it was apparent that the differences in the populations of eastern and western Bell County pose a significant challenge to improving coordination of services. The focus group suggested that strengthening, and increased utilization, of 211 from United Way would improve health care and coordination of services in the county.

Participants discussed that education is essential to break the cycle of poverty, along with increased healthcare access and improved follow-up of care. Offering mental health education in schools would provide health community residents with appropriate coping mechanisms. Development of a mentorship program will support the education initiatives and help to close the cycle of disparity, allowing health community residents to make choices that will enhance their lives.

Community Health Needs Identified

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

Top Community Health Needs Identified

Bell County Health Community		
Top Needs Identified	**Category of Need**	**Public Health Indicator**
Adults Reporting Fair or Poor Health	Health Status	2016 Percentage of Adults Reporting Fair or Poor Health (Age-Adjusted)
Average Number of Mentally Unhealthy Days Reported in Past 30 days (Age-Adjusted)	Mental Health	2016 Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)
Average Number of Physically Unhealthy Days Reported in Past 30 days (Age-Adjusted)	Health Status	2016 Average Number of Physically Unhealthy Days Reported in Past 30 Days (Age-Adjusted)
Civilian veteran population 18+	SDH - Veterans	2012 Percent of population 18 years and over - Civilian veterans
Diabetes Lower-Extremity Amputation Admission: Adult (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Number Observed / Adult Population Age 18 and older
Diabetes Short-term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Number Observed / Pediatric Population Under Age 18
Food Insecure	Environment - Food	2015 Percentage of Population Who Lack Adequate Access to Food During the Past Year
Frequent physical distress	Health Status	2016 Percentage of adults who reported ≥14 days to the question, “Thinking about your physical health, including physical illness and injury, for how many days during the past 30 days was your physical health not good?”
Adults Reporting Fair or Poor Health	Health Status	2016 Percentage of Adults Reporting Fair or Poor Health (Age-Adjusted)
Household income, median	SDH - Income	2016 Median Household Income is the income where half of households in a county earn more and half of households earn less.
Intentional Self-Harm; Suicide	Mental Health	2015 Intentional Self-Harm (Suicide) (X60-X84, Y87.0)

Bell County Health Community		
Top Needs Identified	**Category of Need**	**Public Health Indicator**
Limited Access to Healthy Foods (Percent of Low Income)	Environment - Food	2015 Percentage of Population Who are Low-Income and Do Not Live Close to a Grocery Store
No vehicle available	Access to Care	2017 Households with no vehicle available (percent of households)
Physical Inactivity	Health Behaviors - Exercise	2014 Percentage of Adults Ages 20 and Over Reporting No Leisure-Time Physical Activity in the Past Month
Premature Death (Potential Years Lost)	Health Status	2014-2016 Premature Death; Years of Potential Life Lost Before Age 75 per 100,000 Population (Age-Adjusted)
Renter-occupied housing	Environment - Housing	2017 Renter-occupied housing (percent of households)
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	2015 Number of Newly Diagnosed Chlamydia Cases per 100,000 Population
Uncontrolled Diabetes Admission: Adult (Risk-Adjusted-Rate)	Chronic Condition - Diabetes	Number Observed / Adult Population Age 18 and older

Note: Listed alphabetically, not in order of significance *Source: IBM Watson Health, 2018*

Prioritized Significant Health Needs

Using the prioritization approach outlined in the overview section of this report, the following needs from the proceeding list were determined to be significant and then prioritized.

The resulting prioritized health needs for this community were:

Priority	Need	Category of Need
1	Food: Hunger and Access to Healthy Foods	Environment - Food
2	Physical Inactivity	Health Behaviors - Exercise
3	Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health
4	Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted
5	No Vehicle Available	Access to Care

Description of Significant Health Needs

A CHNA for the Bell County Health Community identified several significant community health needs that can be categorized as issues related to: access to care, mental health, infectious disease, health behaviors and food. Regionalized health needs affect all age levels to some degree; however, it is often the most vulnerable populations that are often negatively affected. Community health gaps help to define the resources and access to care within the county or region. Health and social concerns were validated through key informant interviews, focus groups and county data. Access to care; specifically, transportation, hunger and access to healthy foods, physical inactivity, mental health status, and sexually transmitted infection rates were identified as significant areas of concern and noted in the data results for the Bell County Health Community.

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

No Vehicle Available

The state of Texas is second in the nation in terms of total square miles coming in behind Alaska.[2] Once outside of the large metropolitan areas in Texas, there are significant challenges in rural areas due to the distance from home to schools, shopping, healthcare, etc. The growing population of those over 65 years of age, across Texas, is intensifying the challenges associated with a lack of a personal transportation vehicle. In rural communities, social services, healthcare and access to food are typically spread out across considerable distances making it quite difficult for those without personal, reliable transportation.

In Bell County 5.7% of the population did not have access to a vehicle compared to the overall state of Texas benchmark of 5.3%. This was a difference of 7.5% relative to the state value (relative difference).[3] This indicates a potentially vulnerable population who likely face challenges accessing care and other basic needs. The Bell County focus group participants discussed concerns about residents who do not have access to a vehicle, noting it is a hardship to both the residents themselves and to the community providing services.

Food Insecurity and Limited Access to Healthy Foods

Food insecurity is a measurement of the prevalence of hunger in the community. It reflects the percentage of the population who do not have access to a reliable source of food. The Bell County CHNA identified consistent concerns around food insecurity. Lacking constant access to food is related to negative health outcomes such as weight-gain and premature mortality. Individuals and families with an inability to provide and eat balanced meals create additional barriers to healthy eating.[4]

[2] Ahern M, Brown C, Dukas S. A national study of the association between food environments and county-level health outcomes. The Journal of Rural Health. 2011;27:367379
[3] U.S. Census Bureau, American Community Survey 1-Year Estimates, 2017
[4] Gundersen C, Satoh A, Dewey A, Kato M, Engelhard E. Map the Meal Gap 2015: Food Insecurity and Child Food Insecurity Estimates at the County Level. Feeding America, 2015

It is equally important to eat a balanced diet that includes the consumption of fruits and vegetables as well as to have adequate access to a consistent supply of food. The community demonstrated a need related to food insecurity. Within Bell County 20.2% of the population lacked adequate access to food during the past year, indicating a potentially larger vulnerable population when compared to the overall Texas state benchmark at 15.7%. It is notable that the overall Texas proportion of food insecure population was also greater than the U.S. benchmark of 13%.[5]

In the United States, "food deserts", neighborhoods and communities that have limited access to affordable and nutritious foods, tend to be located in urban and rural low-income neighborhoods. People who live in these areas are less likely to have access to supermarkets or grocery stores that provide healthy choices for food. With limited or no access to food retailers or supermarkets that stock fresh produce, low-fat dairy, whole grains, and other healthy foods, these populations may be more likely to suffer from high rates of diabetes, cardiovascular disease, and obesity.[6]

Understanding how many people may be impacted by food deserts is measured by the percentage of the population who are low-income and do not live in close proximity to a grocery store. Living close to a grocery store is defined differently in rural and nonrural areas: in rural areas, it means living less than ten miles from a grocery store; in nonrural areas, less than one mile. "Low income" is defined as having an annual family income of less than or equal to 200% of the federal poverty threshold for the family size.[7]

In Bell County the percent of low-income population with limited access to healthy foods was 12.8% compared to the overall Texas value of 8.7%.[8] This difference indicates both a need and a potentially vulnerable population for health issues related to healthy eating.

Physical Inactivity

Physical Inactivity is the percentage of adults age 20 and over reporting no leisure-time physical activity such as running, calisthenics, golf, gardening, or walking for exercise.[9] Decreased physical activity has been related to several disease conditions such as type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and premature mortality. Inactivity causes 11% of premature mortality in the United States and caused more than 5.3 million of the 57 million deaths that occurred worldwide in 2008.[10] Physical inactivity is linked to increased healthcare expenditures, particularly with circulatory system diseases.

[5] Map the Meal Gap, Feeding America; County Health Rankings & Roadmaps, 2018
[6] The National Academies of Sciences, Engineering, and Medicine; **Living in a Food Desert: How Lack of Access to Healthy Foods Can Affect Public Health**, 2019
[7] **Limited Access to Healthy Foods**; County Health Rankings, 2018
[8] USDA Food Environment Atlas, United States Department of Agriculture (USDA); County Health Rankings & Roadmaps, 2018
[9] **Physical Inactivity**, County Health Rankings & Roadmaps, 2018
[10] Lee IM, Shiroma EJ, Lobelo F, Puska P, Blair SN, Katzmarzyk PT, for the Lancet Physical Activity Series Working Group, Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy, The Lancet. 2012; 380.9838:219-229

In Bell County, 25.8% of residents do not get a healthy level of physical activity on a routine basis. The Bell County value was 7.5% higher than the overall Texas state value indicating a need from data perspective.[11] Participants in the community input sessions for Bell County validated the need for more physical activity to help improve the overall health status of their community.

Average Number of Mentally Unhealthy Days Reported in Past 30 days (Age-Adjusted)

Overall health depends on both physical and mental well-being. Measuring the number of days when people report that their mental health was not good (i.e. poor mental health days) represents an important facet of health-related quality of life. A study examining the validity of healthy days as a summary measure for mental health status found that counties with more unhealthy days were likely to have higher unemployment, poverty, percentage of adults who did not complete high school, mortality rates, and prevalence of disability.[12]

The results of the CHNA for the Bell County Health Community indicated a greater relative need and potentially larger vulnerable population given residents reported a higher number of days when they felt mentally unhealthy. Bell County residents reported an average of 3.6 mentally unhealthy days in the past 30. This was greater than the Texas benchmark by 6.8%.[13] This indicator is one of many measures of a community's mental health status and should be addressed along with housing, low income, access to healthcare, and education.

Sexually Transmitted Infection Incidence

The key health indicator of sexually transmitted infections (STI) is measured based on the incidence of chlamydia (number of new cases reported) per 100,000 population. Chlamydia is the most common bacterial STI in North America and is one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain.[14] Chlamydia incidence rates are also associated with unsafe sexual activity.

STIs are associated with a significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, infertility, and premature death. STIs also have a high economic burden on society. The direct medical costs of managing sexually transmitted infections and their complications in the U.S., for example, was approximately 15.6 billion dollars in 2018.[15] Chlamydia is only one of many STIs, hence screening in communities is essential.

[11] CDC Diabetes Interactive Atlas, The National Diabetes Surveillance System; County Health Rankings & Roadmaps, 2018
[12] **Poor Mental Health Days**, County Health Rankings, 2018
[13] The Behavioral Risk Factor Surveillance System (BRFSS); County Health Rankings & Roadmaps, 2018
[14] Genuis SJ, Genuis SK. Managing the sexually transmitted disease pandemic: A time for reevaluation. Am J Obstet Gynecol. 2004;191:1103-1112.
[15] Owusu-Edusei K Jr, Chesson HW, Gift TL, Tao G, Mahajan R, Ocfemia MC, Kent CK. The estimated direct medical cost of selected sexually transmitted infections in the United States, 2008. Sexually Transmitted Disease. 2013;40(3):197-201

Bell County's reported incidence of STIs indicate a greater relative need, and a population more vulnerable to other health risks. Bell County's rate of newly diagnosed Chlamydia cases per 100,000 population was 1,160.3 per 100,000 people. This rate was more than double the state of Texas (523.6 new cases/100,000) and the U.S. benchmark (478.8 new cases/100,000).[16] The STI rate for Bell County was one of the top ranked needs from a data perspective. The impact of STIs on the Bell County Health Community was significant given the proportion of younger people in the community as well as the presence of a large military base within the county.

Summary

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

[16] National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP); County Health Rankings & Roadmaps, 2018

Appendix A: Key Health Indicator Sources

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

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

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

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

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

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

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

Resources Identified

COMMUNITY HEALTH ED	CATEGORY	SERVICE	FACILITY NAME	ADDRESS	CITY	PHONE NUMBER
No Vehicle Available	Access to Care	Community Transportation Programs for Medical Appointments	Disabled American Veterans	607 E Veterans Memorial Blvd	Harker Heights	254-743-0880
No Vehicle Available	Access to Care	Food Delivery	Avenue T Church of Christ	2009 W. Avenue T	Temple	254-778-1708
No Vehicle Available	Access to Care	Food Delivery	Belton Senior Activity Center	842 South Mitchell Street	Belton	254-939-1170
No Vehicle Available	Access to Care	Food Delivery	Meals on Wheels	15 North 2nd Street	Temple	254-778-4221
No Vehicle Available	Access to Care	Public Transportation	Hill Country Transit District (HOP)	4515 W. US 190	Belton	1-800-791-96
No Vehicle Available	Access to Care	Social Services	Army Community Service	76020 Crockett St., Bldg. 76020	Fort Hood	254-287-3583
No Vehicle Available	Access to Care	Social Services	Baylor Scott and White Continuing Care Hospital	546 North Kegley Road	Temple	254-215-0900
No Vehicle Available	Access to Care	Social Services	Bring Everyone in the Zone	204 Prieset Drive	Killeen	254-423-7632
No Vehicle Available	Access to Care	Social Services	Central Counties Services for Mental Health	304 South 22nd Street	Temple	254-298-7000
No Vehicle Available	Access to Care	Social Services	Children's Advocacy Center of Central Texas, Inc.	402 North Main Street	Belton	254-939-2946
No Vehicle Available	Access to Care	Social Services	Healthy Homes- Harker Heights	305 Millers Crossing	Harker Heights	254-953-5439
No Vehicle Available	Access to Care	Social Services	New Century Hospice of Harker Heights	451 East Central Texas Expressway, Suite C,	Harker Heights	254-680-5500

COMMUNITY HEALTH ED	CATEGORY	SERVICE	FACILITY NAME	ADDRESS	CITY	PHONE NUMBER
No Vehicle Available	Access to Care	Social Services	Standards Home Health	2010 Southwest HK Dodgen Loop, Suite 200	Killeen	254-778-7000
No Vehicle Available	Access to Care	Social Services	Tex Med Home Health	1711 East Central Expressway, Suite 309	Killeen	800-839-4930
No Vehicle Available	Access to Care	Social Services	Texas Home Health Group	2010 Southwest HK Dodgen Loop	Temple	254-218-7070
No Vehicle Available	Access to Care	Subsidized Public Transportation	Hill Country Transit District (HOP)	4515 W. US 190	Belton	1-800-791-96
Physical Inactivity	Health Behaviors - Exercise	Daily Life Skills Training	Victory Gospel Chapel Spiritual Growth Center	1315 North Gray Street	Killeen	254-519-1118
Physical Inactivity	Health Behaviors - Exercise	Exercise and Fitness	Army Wellness Center	Bldg. 12019, 31st St and Old Ironsides Ave	Fort Hood	254-553-6169
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	Birth Control	The Bell County Public Health District Clinic	309 N. 2nd St	Killeen	254-526-8371
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	Birth Control	The Bell County Public Health District Clinic	509 S. 9th St	Temple	254-778-4766
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	Disease Screenings	Temple Community Clinic	1905 Curtis B. Elliott Drive	Temple	254-771-3374
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	Family Planning	Body of Christ Community Clinic	2210-B Holland Road	Belton	254-939-9500
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	Family Planning	Greater Killeen Community Clinic	718 N. 2nd Street, Ste A	Killeen	254-618-4211

COMMUNITY HEALTH ED	CATEGORY	SERVICE	FACILITY NAME	ADDRESS	CITY	PHONE NUMBER
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	Family Planning	Hope Pregnancy Center - Killeen	1211 Florence Road	Killeen	254-519-3343
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	Family Planning	Hope Pregnancy Center-Temple	2010 West Avenue H	Temple	254-773-2453
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	Family Planning	The Bell County Public Health District Clinic	509 S. 9th St	Temple	254-778-4766
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	Family Planning	The Bell County Public Health District Clinic	309 N. 2nd St	Killeen	254-526-8371
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	HIV and AIDS Services	Central Texas Support Services	2027 South 61st St., Suite 115	Temple	254-771-3352
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	Pregnancy Tests	Hope Pregnancy Center - Killeen	1211 Florence Road	Killeen	254-519-3343
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	Pregnancy Tests	Hope Pregnancy Center-Temple	2010 West Avenue H	Temple	254-773-2453
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	Pregnancy Tests	The Bell County Public Health District Clinic	509 S. 9th St	Temple	254-778-4766
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	Pregnancy Tests	The Bell County Public Health District Clinic	309 N. 2nd St	Killeen	254-526-8371
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	Sexual Health Services	The Bell County Public Health District Clinic	309 N. 2nd St	Killeen	254-526-8371

COMMUNITY HEALTH ED	CATEGORY	SERVICE	FACILITY NAME	ADDRESS	CITY	PHONE NUMBER
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	Sexual Health Services	The Bell County Public Health District Clinic	509 S. 9th St	Temple	254-778-4766
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	STI Prevention and Treatment	Central Texas Support Services	2027 South 61st St., Suite 115	Temple	254-771-3352
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	STI Prevention and Treatment	The Bell County Public Health District Clinic	309 N. 2nd St	Killeen	254-526-8371
Sexually Transmitted Infection Incidence	Infectious Disease - Sexually Transmitted	STI Prevention and Treatment	The Bell County Public Health District Clinic	509 S. 9th St	Temple	254-778-4766
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Bereavement	Hospice Compassus	2210 East Central Expressway, Suites 104 & 105	Killeen	888-928-4634
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Bereavement	Killeen Heights Veterans Center	302 Millers Crossing, Suite #4	Harker Heights	254-953-7100
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Bereavement	New Century Hospice of Harker Heighs	451 East Central Texas Expressway, Suite C,	Harker Heights	254-680-5500
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Crisis Services	Bring Everyone in the Zone	204 Prieset Drive	Killeen	254-423-7632
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Daily Life Skills Training	Victory Gospel Chapel Spiritual Growth Center	1315 North Gray Street	Killeen	254-519-1118
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Family Counseling	Aware Central Texas	903 N. Main St.	Belton	254-939-7582
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Family Counseling	Children's Advocacy Center of Central Texas, Inc.	402 North Main Street	Belton	254-939-2946

COMMUNITY HEALTH ED	CATEGORY	SERVICE	FACILITY NAME	ADDRESS	CITY	PHONE NUMBER
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Family Counseling	Olin E. Teague Veterans' Medical Center	1901 Veterans Memorial Drive	Temple	1-800-423-21
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Family Counseling	Starry Counseling	1711 East Central Expressway, Suite 203	Killeen	254-213-2035
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Family Counseling	Teach Them to Love Outreach Ministries	1519 Florence Road, Suite 5	Killeen	254-519-2222
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Family Counseling	Texas A&M Central Texas- Community Counseling and Family The	1001 Leadership Place	Killeen	254-519-5403
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	General Psychology	Daybreak Community Services	500 Sparta Rd	Belton	254-774-8511
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Help Hotlines	Central Counties Services for Mental Health	304 South 22nd Street	Temple	254-298-7000
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Help Hotlines	Central Texas Aging and Disability Resource Center	2180 North Main Street	Belton	254-770-2342
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Help Hotlines	Families in Crisis	1305 East Rancier Avenue	Killeen	254-634-1184
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Mental Health Education	Central Counties Services for Mental Health	304 South 22nd Street	Temple	254-298-7000
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Mental Health Evaluation	Central Counties Services for Mental Health	304 South 22nd Street	Temple	254-298-7000
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Mental Health Evaluation	Ingenia Behavioral Health	3901 E. Stan Schlueter Lp Suite 103	Killeen	254-768-2112
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Mental Health Hospital Treatment	Metroplex Behavioral Health Center	2407 South Clear Creek Road	Killeen	254-628-1000

COMMUNITY HEALTH ED	CATEGORY	SERVICE	FACILITY NAME	ADDRESS	CITY	PHONE NUMBER
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Mental Health Outpatient Treatment	Cedar Crest Hospital and Resident Treatment Center	3500 South Interstate 35	Belton	254-781-3217
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Mental Health Outpatient Treatment	Central Counties Services for Mental Health	304 South 22nd Street	Temple	254-298-7000
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Mental Health Outpatient Treatment	Christian Farms Tree House, Inc.	3804 Riverside Trail	Temple	254-933-9400
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Mental Health Outpatient Treatment	Metroplex Behavioral Health Center	2407 South Clear Creek Road	Killeen	254-628-1000
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Mental Health Outpatient Treatment	Metroplex Behavioral Health Center Integrated Health Clinic	2301 South Clear Creek Road, Suite 216	Killeen	254-519-8803
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Mental Health Residential Treatment	Cedar Crest Hospital and Resident Treatment Center	3500 South Interstate 35	Belton	254-781-3217
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Mental Health Residential Treatment	Victory Gospel Chapel Spiritual Growth Center	1315 North Gray Street	Killeen	254-519-1118
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Mental Health Residential Treatment	Women's Trauma Recovery Center	1901 Veterans Memorial Drive	Temple	800-423-2111
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Mental Health Services	Bell County Indigent Care	309 Priest Dr. Building 3	Killeen	877-516-8593
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Mental Health Services	Central Counties Services for Mental Health	304 South 22nd Street	Temple	254-298-7000
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Mental Health Services	Communities in Schools-Greater Central Texas	4520 East Central Texas Expressway, Suite 106	Killeen	254-554-2132
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Mental Health Services	Greater Killeen Community Clinic	718 N. 2nd Street, Ste A	Killeen	254-618-4211

COMMUNITY HEALTH ED	CATEGORY	SERVICE	FACILITY NAME	ADDRESS	CITY	PHONE NUMBER
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Mental Health Services	Olin E. Teague Veterans' Medical Center	1901 Veterans Memorial Drive	Temple	1-800-423-21
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Social Services	Army Community Service	76020 Crockett St., Bldg. 76020	Fort Hood	254-287-3583
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Social Services	Baylor Scott and White Continuing Care Hospital	546 North Kegley Road	Temple	254-215-0900
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Social Services	Bring Everyone in the Zone	204 Prieset Drive	Killeen	254-423-7632
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Social Services	Central Counties Services for Mental Health	304 South 22nd Street	Temple	254-298-7000
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Social Services	Children's Advocacy Center of Central Texas, Inc.	402 North Main Street	Belton	254-939-2946
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Social Services	Healthy Homes- Harker Heights	305 Millers Crossing	Harker Heights	254-953-5439
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Social Services	New Century Hospice of Harker Heighs	451 East Central Texas Expressway, Suite C,	Harker Heights	254-680-5500
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Social Services	Standards Home Health	2010 Southwest HK Dodgen Loop, Suite 200	Killeen	254-778-7000
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Social Services	Tex Med Home Health	1711 East Central Expressway, Suite 309	Killeen	800-839-4930
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)	Mental Health	Social Services	Texas Home Health Group	2010 Southwest HK Dodgen Loop	Temple	254-218-7070

Community Healthcare Facilities

Facility Name	Type	System	Street Address	City	State	ZIP
BAYLOR SCOTT & WHITE CONTINUING CARE HOSPITAL	LT	Baylor Scott & White	546 NORTH KEGLEY ROAD	TEMPLE	TX	76502
BAYLOR SCOTT & WHITE MCLANE CHILDRENS MEDICAL CENTER	KID	Baylor Scott & White	1901 SW H.K. DODGEN LOOP	TEMPLE	TX	76502
CEDAR CREST HOSPITAL	PSY	Acadia Healthcare	3500 I-H 35 SOUTH	BELTON	TX	76513
EXPRESS ER	ED	Express ER	1551 W CENTRAL AVENUE	TEMPLE	TX	76504
EXPRESS ER	ED	Express ER	980 KNIGHTS WAY BLD 1	HARKER HEIGHTS	TX	76548
METROPLEX HOSPITAL	ST	Adventist Health	2201 SOUTH CLEAR CREEK ROAD	KILLEEN	TX	76549
METROPLEX PAVILION	ST	Adventist Health	2407 SOUTH CLEAR CREEK ROAD	KILLEEN	TX	76549
PREMIER ER PLUS - TEMPLE LLC	ED	Premier ER	7010 W ADAMS AVE SUITE 100	TEMPLE	TX	76502
SCOTT & WHITE MEDICAL CENTER - TEMPLE	ST	Baylor Scott & White	2401 SOUTH 31ST STREET	TEMPLE	TX	76508
SCOTT & WHITE PAVILION	ST	Baylor Scott & White	1815 SOUTH 31ST STREET	TEMPLE	TX	76504
SETON MEDICAL CENTER HARKER HEIGHTS	ST	Ascension Health	850 WEST CENTRAL TEXAS EXPRESSWAY	HARKER HEIGHTS	TX	76548

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

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

Health Professional Shortage Areas (HPSA)[17]

County Name	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type
Bell	1485053237	Low Income-Bell County	Primary Care	Low Income Population HPSA
Bell	7487290191	Low Income-Bell County	Mental Health	Low Income Population HPSA

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

County Name	MUA/P Source Identification Number	Service Area Name	Designation Type	Rural Status
Bell	07964	East Temple	Medically Underserved Area	Non-Rural
Bell	03517	South Bell Service Area	Medically Underserved Area	Non-Rural

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

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

Bell Valley Health Community		
Public Health Indicator	**Category**	**Indicator Definition**
Civilian veteran population 18+	Population	2012 Percent of population 18 years and over - Civilian veterans
High School Dropout	Population	2016 A four-year longitudinal dropout rate is the percentage of students from the same class who drop out before completing their high school education.
Sexually Transmitted Infection Incidence	Health Behaviors	2015 Number of Newly Diagnosed Chlamydia Cases per 100,000 Population
Asthma Admission: Pediatric (Risk-Adjusted-Rate)	Preventable Hospitalizations	2016 Number Observed / Pediatric Population Under Age 18
Perforated Appendix Admission: Adult (Risk-Adjusted-Rate per 100 Admissions for Appendicitis)	Preventable Hospitalizations	2016 Number Observed / Adult Population Age 18 and older
Limited Access to Healthy Foods (Percent of Low Income)	Environment	2015 Percentage of Population Who are Low-Income and Do Not Live Close to a Grocery Store
Death rate due to firearms	Injury & Death	2012-2016 number of deaths due to firearms, per 100,000 population.
Cancer Incidence - Lung	Conditions/Diseases	2011-2015 Age-Adjusted Lung & Bronchus Cancer Incidence Rate Cases per 100,000.
Diabetes Short-term Complications Admission: Pediatric (Risk-Adjusted-Rate)	Preventable Hospitalizations	2016 Number Observed / Pediatric Population Under Age 18
Child Mortality Rate	Injury & Death	2013-2016 Number of Deaths Among Children under Age 18 per 100,000
Infant Mortality Rate	Injury & Death	2010-2016 Number of All Infant Deaths (Within 1 year), per 1,000 Live Births
Food Insecure	Environment	2015 Percentage of Population Who Lack Adequate Access to Food During the Past Year
Low Birth Weight Rate	Maternal & Child Health	2016 Number Observed / Pediatric Population Under Age 18
Individuals Who Report Being Disabled	Population	2012-2016 American Community Survey 5-Year Estimates, Population 65+ US
Disabled population, civilian noninstitutionalized	Population	2012 Percent Total Civilian Non-institutionalized Population with a disability
Renter-occupied housing	Environment	2017 Renter-occupied housing (percent of households)

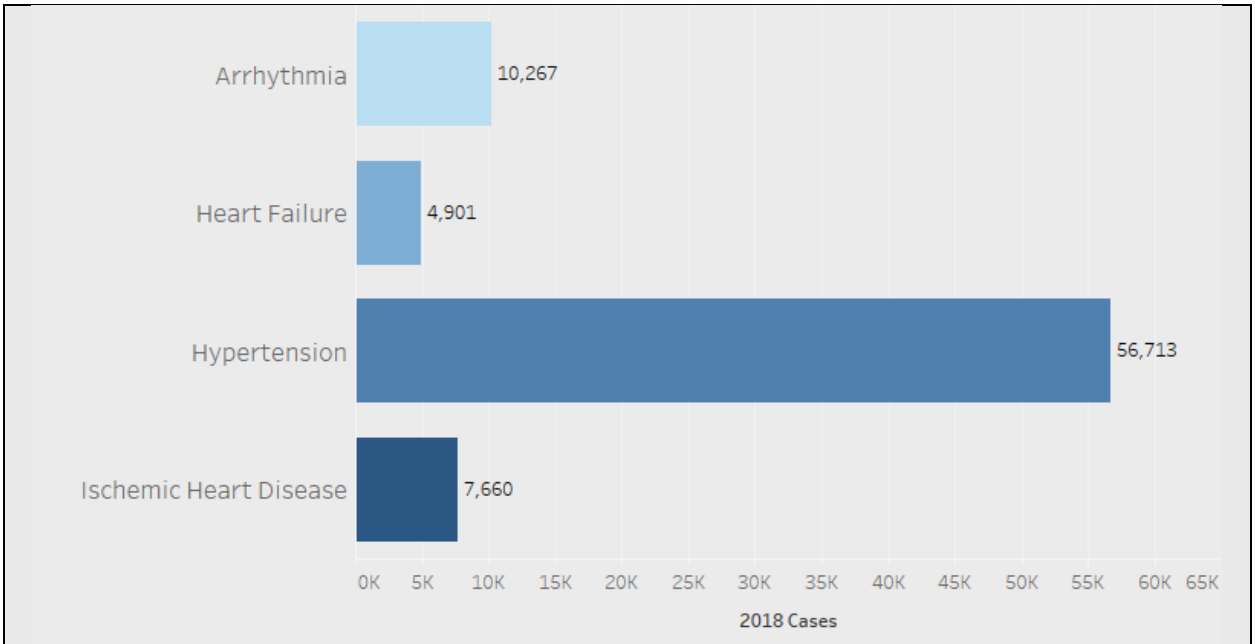
Bell Valley Health Community		
Public Health Indicator	**Category**	**Indicator Definition**
Adult Smoking	Health Behaviors	2016 Percentage of the Adult Population Report Currently Smoke Every Day/Most Days and Smoked at Least 100 Cigarettes in Their Lifetime.
Teen Birth Rate per 1,000 Female Population, Ages 15-19	Health Behaviors	2010-2016 Number of Births to Females Ages 15-19 per 1,000 Females in a County.
Homicides	Population	2010-2016 Number of Deaths Due to Homicide, Defined as ICD-10 Codes X85-Y09, per 100,000 Population
Cancer Incidence - All Causes	Conditions/Diseases	2011-2015 Age-Adjusted Cancer (All) Incidence Rate Cases Per 100,000.
Air Pollution - Particulate Matter daily density	Environment	2012 Average Daily Density of Fine Particulate Matter in Micrograms per Cubic Meter (PM2.5)
Cancer Incidence - Prostate	Conditions/Diseases	2011-2015 Age-Adjusted Prostate Cancer Incidence Rate Cases per 100,000.
Heart Failure in Medicare Population	Conditions/Diseases	2007-2015 Prevalence of chronic condition across all Medicare beneficiaries
Motor Vehicle Crash Mortality Rate	Injury & Death	2010-2016 Number of Motor Vehicle Crash Deaths per 100,000 Population
Cancer Incidence - Female Breast	Conditions/Diseases	2011-2015 Age-Adjusted Female Breast Cancer Incidence Rate Cases Per 100,000
High School Graduation	Population	2016 percentage of students from a class of beginning ninth graders who graduate by their anticipated graduation date.
Cancer Mortality Rate	Injury & Death	2013 Cancer (All) Age Adjusted Death Rate (Per 100,000 - All Ages. Age-adjusted using the 2000 U.S. Standard Population)
Diabetes Lower-Extremity Amputation Admission: Adult (Risk-Adjusted-Rate)	Preventable Hospitalizations	2016 Number Observed / Adult Population Age 18 and older
Insufficient sleep	Health Behaviors	2016 the percentage of adults who responded who stated they sleep less than 7 hours per night
Uncontrolled Diabetes Admission: Adult (Risk-Adjusted-Rate)	Preventable Hospitalizations	2016 Number Observed / Adult Population Age 18 and older
Preterm Births <37 Weeks Gestation	Maternal & Child Health	2015 number of babies born before 37 weeks gestation and that number as a percentage of all live births
Household income, median	Population	2016 Median Household Income is the income where half of households in a county earn more and half of households earn less.

Bell Valley Health Community		
Public Health Indicator	**Category**	**Indicator Definition**
Average Number of Physically Unhealthy Days Reported in Past 30 days (Age-Adjusted)	Health Status	2016 Average Number of Physically Unhealthy Days Reported in Past 30 Days (Age-Adjusted)
Premature Death (Potential Years Lost)	Injury & Death	2014-2016 Premature Death; Years of Potential Life Lost Before Age 75 per 100,000 Population (Age-Adjusted)
No vehicle available	Environment	2017 Households with no vehicle available (percent of households)
Physical Inactivity	Health Behaviors	2014 Percentage of Adults Ages 20 and Over Reporting No Leisure-Time Physical Activity in the Past Month
Average Number of Mentally Unhealthy Days Reported in Past 30 days (Age-Adjusted)	Mental Health Conditions/Diseases	2016 Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)
Frequent physical distress	Conditions/Diseases	2016 Percentage of adults self-reporting ≥14 days of poor physical health.
Hyperlipidemia in Medicare Population	Conditions/Diseases	2007-2015 Prevalence of chronic condition across all Medicare beneficiaries
Number of deaths due to injury	Injury & Death	2010-2016 Number of Motor Vehicle Crash Deaths per 100,000 Population
Intentional Self-Harm; Suicide	Mental Health Conditions/Diseases	2015 Intentional Self-Harm (Suicide) (X60-X84, Y87.0)
Adults Reporting Fair or Poor Health	Health Status	2016 Percentage of Adults Reporting Fair or Poor Health (Age-Adjusted)
Low Birth Weight Percent	Maternal & Child Health	2010-2016 Percentage of Live Births with Low Birthweight; < 2500 Grams

Appendix E: Watson Health Community Data

Watson Health Heart Disease Estimates identified hypertension as the most prevalent heart disease diagnoses; there were over 56,000 estimated cases in the community overall. Belton, Killeen and Temple communities had the most estimated cases of each heart disease type, likely driven by population size. However, despite fewer number of cases, the 76571 ZIP code in Salado had the highest estimated prevalence rates for Arrhythmia (516 cases per 10,000 population), Heart Failure (262 cases per 10,000 population), Hypertension (2,332 cases per 10,000 population) and Ischemic Heart Disease (447 cases per 10,000 population).

2018 Estimated Heart Disease Cases



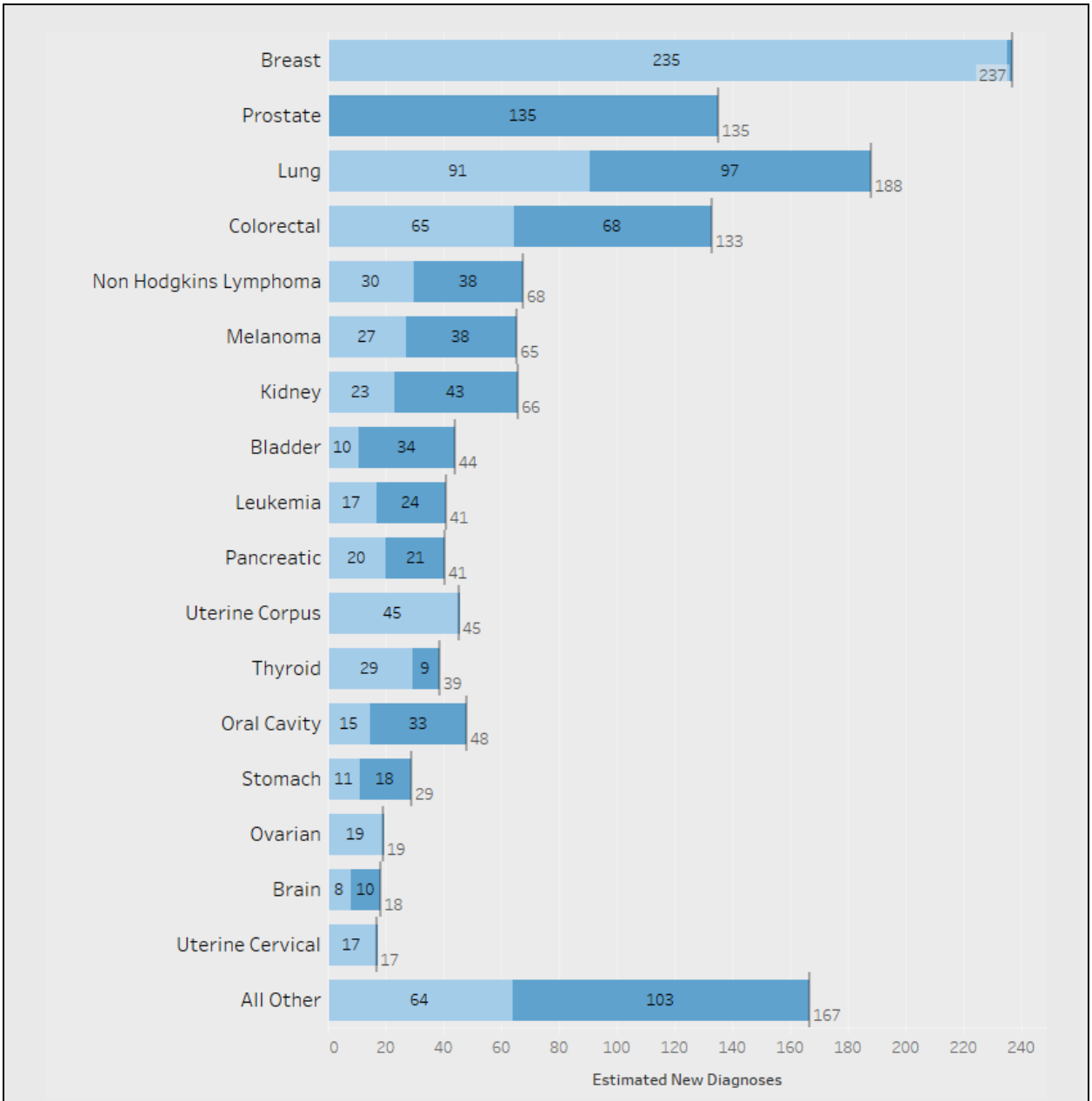
Bar chart shows total number of 2018 Estimated Heart Disease cases for each of four types: arrhythmia, heart failure, hypertension, and ischemic heart disease

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

Source: IBM Watson Health, 2018

For this community, Watson Health's 2018 Cancer Estimates revealed the cancers projected to have the greatest rate of growth in the next five years were pancreatic, thyroid, kidney, and uterine corpus; based on both population changes and disease rates. The cancers estimated to have the greatest number of new cases in 2018 were breast, lung and prostate cancers.

2018 Estimated New Cancer Cases



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

Source: IBM Watson Health, 2018

Estimated Cancer Cases and Projected 5 Year Change by Type

Cancer Type	2018 Estimated New Cases	2023 Estimated New Cases	5 Year Growth (%)
Bladder	44	51	15.0%
Brain	18	20	9.3%
Breast	237	268	13.2%
Colorectal	133	135	1.9%
Kidney	66	76	15.8%
Leukemia	41	46	13.0%
Lung	188	211	12.1%
Melanoma	65	74	13.9%
Non-Hodgkin's Lymphoma	68	77	13.3%
Oral Cavity	48	55	14.8%
Ovarian	19	21	11.0%
Pancreatic	41	48	17.6%
Prostate	135	145	7.0%
Stomach	29	32	12.4%
Thyroid	39	45	16.3%
Uterine Cervical	17	18	5.0%
Uterine Corpus	45	52	15.7%
All Other	167	191	14.3%
Grand Total	**1,399**	**1,565**	**11.9%**

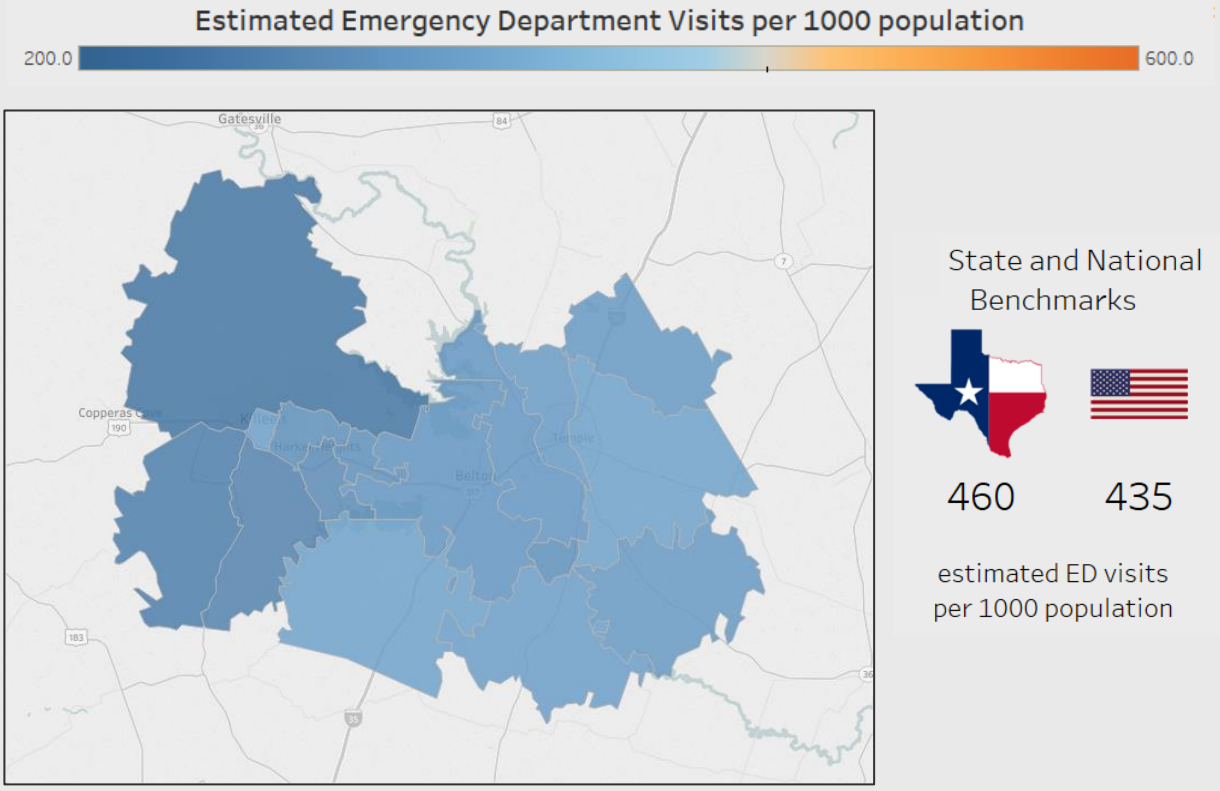
Source: IBM Watson Health, 2018

Based on population characteristics and regional utilization rates, Watson Health projected all emergency department (ED) visits in this community to increase by 7.5% over the next 5 years. Over 40% of ED visits were generated by the residents of Killeen ZIP codes, but the highest estimated ED use rates were in the ZIP codes of Temple; 348.7 ED visits per 1,000 residents, lower compared to the Texas state benchmark of 460 visits and the U.S. benchmark 435 visits per 1,000.

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

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

Estimated 2018 Emergency Department Visit Rate

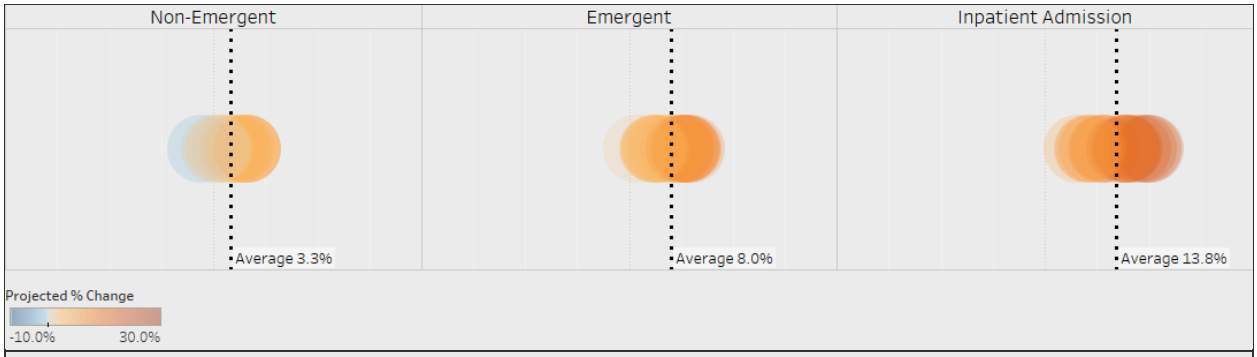


Zip map color shows total Emergency Department visits per 1000 popultaion. Orange colors are higher than the state benchmark, blue colors are less than the state benchmark, and gray colors are similar.

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

Source: IBM Watson Health, 2018

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



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

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

Source: IBM Watson Health, 2018

Appendix F: Evaluation of Prior Implementation Strategy Impact

This section provides a summary of the evaluation of the impact of any actions taken since the hospital facilities finished conducting their immediately preceding CHNA.

Total Resources Contributed to Addressing Needs: $4,909,880

Identified Need Addressed: Access to Care

Program Name: Mobile Integrated Health
Description: Through the use of community paramedics, telemedicine, and an integrated healthcare network to provide clinical interventions, clinical navigation support, and care transition assistance to our most at-risk population of patients Scott and White Emergency Medical Services (SWEMS) can reduce the number and frequency of unplanned readmissions to BSW Memorial. Paramedics will complete home visits for 30 day follow up for CHF discharges.
Impact/Outcomes: 60
Supported by: Baylor Scott & White Medical Center - Memorial
Resources Contributed: Resources valued at $45,508 of community benefit

Program Name: Poison Center Outreach
Description: Located at Scott & White Medical Center Temple, TX, the Central Texas Poison Center (CTPC) is a 24-hour poison emergency treatment and information resource for health care professionals and the public in Central Texas
Impact/Outcomes: 200,000
Supported by: Baylor Scott & White Medical Center - Memorial
Resources Contributed: Resources valued at $2,166,602 of community benefit

Program Name: Support of Community Clinics
Description: BS&W provides in kind donations in the form of volunteer support from both physicians and staff at local community clinics. Also included are hospital service fees (i.e. lab screenings, radiology services) that are significant to the operations of the Clinic patients. Expenses are reported at cost of service and not in lost revenue.
Impact/Outcomes: 2,000+
Supported by: Baylor Scott & White Medical Center – Memorial and Scott & White Clinic
Resources Contributed: $446,000

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

This program is designed to help our communities reach optimal health through education, spiritual support, and guidance by integrating faith and health.
Impact/Outcomes: 42 people engaged in the program. Unknown community wide impact at this point.
Supported by: Baylor Scott & White Medical Center – Memorial and Baylor Scott & White Continuing Care Hospital
Resources Contributed: $2,978

Program Name: Faith in Action – Second Life Resources
Description: In collaboration with other not for profit organizations, FIAI's Second Life Resources program has stretched medical resources and expertise to communities across the state of Texas which are underserved or in need due to natural disaster or economic and government-imposed burdens.
Impact/Outcomes: unknown people served
Supported by: Baylor Scott & White Medical Center - Memorial
Resources Contributed: Supplies valued at $43,372 were donated to other non-profits

Program Name: Embrace Health
Description: BSWH, TAMU College of Medicine and UMHB collaborative. Designed to teach medical and nursing students about the problems families encounter with respect to their own both health, as well as difficulties accessing health care.
Impact/Outcomes: 25
Supported by: Baylor Scott & White Medical Center - Memorial
Resources Contributed: Resources valued at $8,308 of community benefit

Program Name: Drive Thru Flu
Description: BS&W hosts an Annual Drive Thru Flu Clinic to provide easy access to vaccinations for the entire community.
Impact/Outcomes: 2,600 vaccines administered
Supported by: McLane Children's Clinic
Resources Contributed: $41,574

Program Name: DSRIP County Indigent Health Care Program
Description: As part of the 1115 Waiver BSWH was able to expand care to the most vulnerable in this community through providing navigation services to social and clinical services in our community. The navigators helped patients receive the care they needed through utilizing the network of clinics in the Baylor Scott & White clinic group as well as in other local free clinics. We partnered our psychiatric residency program to provide services in one of the free clinics in the area to better integrate primary care and behavioral health, using navigators to get patients appointments and connected to these services. As an extension of this work, BSWH empowers patients to engage in their preventive services and cancer screenings so we can continue to improve the health of our communities. BSWH continues several of these initiatives while building relationships with the community partners and agencies in the area to grow and sustain these initiatives.
Impact/Outcomes: 839 DSRIP program participants
Supported by: Baylor Scott & White Medical Center - Temple

Resources Contributed: Staff time and materials contributed as subsidized continuing care of Community Benefit

Identified Need Addressed: Chronic Disease Management and Prevention

Program Name: Community Health Fairs
Description: BS&W regularly participates in health fairs in the communities we serve in order to provide screening and access to educational materials that will help impact healthy lifestyle habits. Through *It's A Guy Thing and For Women for Life* the Hospitals provide health services, screenings, and treatments, assisting men and women in taking steps that help their chances for living a longer, healthier life and preventing the onset of some chronic conditions. These events for men and women focus on proactive health care including preventive health screenings, seminars and healthy lifestyle information.
Impact/Outcomes: 1,672
Supported by: Baylor Scott & White Medical Center – Memorial, Scott & White Clinic, and Baylor Scott & White Continuing Care Hospital
Resources Contributed: Staff time and materials valued at $108,929 of Community Benefit

Program Name: Health Screenings
Description: BS&W offers screenings throughout the year to assist in the prevention and early identification of potential disease states. Some screenings are provided on a onetime basis or as a special event in the community and are available to those who are underinsured, medically underinsured or for the broader community.
Impact/Outcomes: 528 people screened
Supported by: Baylor Scott & White Medical Center – Memorial
Resources Contributed: Staff time and screening resources

Program Name: DSRIP Cancer Screening Program
Description: As part of the HHSC 1115 Waiver to increase access to cancer screening in the primary care setting specific to the Medicaid, Low-Income, and Uninsured patient populations. Develop and implement cancer management interventions geared toward improving management of cancers and comorbidities, improving health outcomes and quality of life, preventing disease complications, and reducing unnecessary acute and emergency care utilization.
Impact/Outcomes: 23,463 program participants screened
Supported by: Baylor Scott & White Medical Center – Memorial
Resources Contributed: subsidized staff time and resources to conduct screenings and develop care plans for low income patients

Program Name: Cancer Registry
Description: The registry is used to identify areas where BSWH can improve health for our patients, at risk populations and the community as a whole and is integral to helping us achieve our mission of

serving the community and meeting identified needs. The cancer registry information is shared data and is not proprietary to BSWH. Expenses include staffing, software, and supplies to maintain the registry.
Impact/Outcomes: 8,100 people with cancer served
Supported by: Baylor Scott & White Medical Center – Memorial
Resources Contributed: $846,000 for program operations

Program Name: Community Health Education
Description: Baylor Scott & White Health consistently looks for opportunities to educate the community on prevention on managing chronic diseases including Cancer, Heart Disease, Stroke and Diabetes. The programs and services that fall into this category extend beyond patient care activities and include services directed to both individuals and larger populations in the community. They include such things as educational information about preventive health care, lectures, or presentations held by BSWH physicians and staff about health-related topics like understanding various conditions and diseases, when to seek treatment, and the treatment options available.
Impact/Outcomes: 12,118
Supported by: Baylor Scott & White Medical Center – Memorial, BSW McLane Children's Medical Center, Scott & White Clinic, McLane Children's Clinic, and Baylor Scott & White Continuing Care Hospital
Resources Contributed: $135,059 in staff time and resources

Program Name: Diabetes Education
Description: BSWH provides diabetes education seminars and presentations open to the public or for a specific group in need to educate the community about the signs and symptoms of diabetes and how to prevent diabetes from happening. The intent is to increase community knowledge of dangers and symptoms of diabetes to lower hospitalization rates due to the disease.
Impact/Outcomes: 158
Supported by: Baylor Scott & White Medical Center – Memorial
Resources Contributed: Staff time and materials valued at $30,835 of Community Benefit

Program Name: Wellness Lives Here (American Diabetes Collaboration)
Description: In partnership with the American Diabetes Association, BSWH diabetes educators provide free educational sessions at local businesses to their staff in order to help prevent the onset of diabetes and how to properly manage the disease.
Impact/Outcomes: 18
Supported by: Baylor Scott & White Medical Center – Memorial
Resources Contributed: Staff time and materials valued at $5,085 of Community Benefit

Program Name: Por Tu Familia
Description: Presented by Baylor Scott & White, Por tu Familia, or "for your family", is the signature comprehensive diabetes prevention and management program of the American Diabetes Association's Latino initiatives. It is a comprehensive program developed for and targeted to Latinos. It is geared towards people who have been diagnosed with diabetes or pre-diabetes, caregivers of people with diabetes, as well as anyone who believes they might be at risk.

Impact/Outcomes: 55 participants
Supported by: Baylor Scott & White Medical Center – Memorial
Resources Contributed: Staff time and materials valued at $5,120 of Community Benefit

Program Name: Diabetes Food Box Program
Description: BSW Memorial partnered with the Central Texas Food Bank and Churches Touching Lives for Christ to: (1) facilitate screening and enrollment of food insecure patients for diabetes; (2) prompt primary care referral from on-site food pantries and coordination of care; (3) distribution of diabetic-friendly food boxes, and (4) provision of diabetes education, including written materials, group classes, and one-on-one reinforcement of diabetes self-care behaviors.
Impact/Outcomes: 150 diabetics received food boxes
Supported by: Baylor Scott & White Medical Center – Memorial
Resources Contributed: Staff time and materials valued at $10,000 of Community Benefit

Program Name: Support Groups
Description: Baylor Scott & White Healthcare provides support group services for patients and their families for many chronic diseases and conditions including cancer, stroke and heart disease.
Impact/Outcomes: Dozens of patients and family members every month
Supported by: Baylor Scott & White Medical Center – Memorial
Resources Contributed: Staff time at meetings each month

Identified Need Addressed: Mental Health Resources

Facility: Scott & White Memorial Hospital
Program Name: Mental Health Support
Program Description: The Social Work part of CCM is very involved in mental health for patients who present to our hospital, ED, outpatient clinics, and post-acute areas like home care. Master's prepared social workers are the primary mental health providers of care nationally by a huge margin – actually more social workers doing mental health work than all other professions combined. Emergency Department - In the ED, the social workers do the initial psychiatric consultation and assessment (determining DTS, DTO, and other psychiatric conditions) with psychiatric residents and attending's doing follow up as indicated. Inpatient Support/Referrals- The acute care social workers on the floors are doing the bulk of the psychosocial assessments and interventions plus referrals to follow-up services after discharge. Outpatient Support - In the outpatient clinics, social workers see patients in medical clinics along with functioning as psychotherapists in the mental health clinic. There is a social work clinic set up to provide a variety of services including getting mental health patients their medications and helping determine which financial aid criteria they meet.
Impact/Outcomes: patients are referred and connected directly with community resources
Supported by: Baylor Scott & White Medical Center – Memorial and Scott & White Clinic
Committed Resources:16 FTE Social Workers

Program Name: TelePsych

Description: The ED treats many patients that come in suffering from anxiety and depression. Due to the lack of resources to meet mental health needs it is not uncommon for patients to wait days or weeks before being able to secure available space for continued mental health care. The hospital is utilizing a TelePsych component to expedite placement and to help Trauma and ED providers determine need for a patient's placement in a mental health facility by allowing patients in the unit to consult directly with a mental health provider remotely.
Impact/Outcomes: Achieved reduced wait times for patients to establish continued mental health care.
Supported by: Baylor Scott & White Medical Center – Memorial
Resources Contributed: TelePsych Implementation and ongoing support.

Program Name: Faith Community Health
Description: Faith Community Health is a branch of Faith In Action Initiatives in the Office of Mission and Ministries of Baylor Scott & White Health (BSWH). Faith Community Health strives to form relationships and collaborate with faith communities to improve the health of those people in their congregations and communities. Congregations and communities are supported by integrating faith and health through health educators, faith community nurses, home visits, and church volunteer members. This program is designed to help our communities reach optimal health through education, spiritual support, and guidance by integrating faith and health.
Impact/Outcomes: 42 people engaged in the program. Unknown community impact at this point.
Supported by: Baylor Scott & White Medical Center – Memorial and Baylor Scott & White Continuing Care Hospital
Resources Contributed: $2,978

Program Name: Community Health Education for Mental Health
Description: Baylor Scott & White Health consistently looks for opportunities to educate the community on health issues related to identified needs. These activities and events were offered to help provide access to resources or information on the growing issues around mental and behavioral health.
Impact/Outcomes: 157
Supported by: Baylor Scott & White Medical Center - Memorial
Resources Contributed: $2,703 of community benefit

Program Name: Mental Health Services in Primary Care
Description: Five mental health service providers have been embedded into the Scott & White regional family medicine clinics. It is our intent and goal to eventually add mental health providers into all family medicine clinic locations. The clinics that have embedded mental health have built a valuable working relationship between the primary care providers and mental health providers that enhances the overall patient care model.
Impact/Outcomes: improved access to mental health providers
Supported by: Baylor Scott & White Medical Center – Memorial and Scott & White Clinic
Resources Contributed: salaries for 5 FTE's

Identified Need Addressed: Obesity/Poor Physical Health

Program Name: Community Health Education in Community and Schools
Description: Baylor Scott & White Health consistently looks for opportunities to educate the community on health issues to support our mission and vision. The programs and services that fall into this category extend beyond patient care activities and include services directed to both individuals and larger populations in the community. They include such things as educational information about preventive health care, lectures, or presentations held by BSWH physicians and staff about health-related topics like understanding various conditions and diseases, when to seek treatment, and the treatment options available.
Impact/Outcomes: 10,716 people served
Supported by: Baylor Scott & White Medical Center – Memorial, McLane Children's Hospital, Scott & White Clinic and McLane Children's Clinic
Resources Contributed: Resources valued at $125,933 of Community Benefit

Program Name: Donations for Community Health Improvement
Description: BSWH donates funds often to local charitable, not for profit organizations whose efforts to improve community health align with the identified health needs in our community. We do so to support their efforts to improve the overall health of the community through education, prevention, health advocacy, or disease management education. Funds that go to improving the health infrastructure of our community are counted after subtracting the fair market value of participation by employees or the organization.
Impact/Outcomes: 36,104 people served
Supported by: Baylor Scott & White Medical Center – Memorial and McLane Children's Medical Center
Resources Contributed: Resources valued at $599,603 of Community Benefit

Program Name: Family, Food and Fun Program
Description: A free 4-week family wellness education program for kids 9 to 15 and their families. Each week families learn how to cook healthy, budget friendly meals and participate in fun fitness demonstrations designed to teach sustainable skills that support healthy lifestyles. **Program includes:** **1)hands on cooking demonstrations, budget friendly recipes, cooking competition** **2) fitness demonstrations for home, park and gym** **3) interactive technology that encourages family meal time and physical activity**
Impact/Outcomes: 604
Supported by: Baylor Scott & White McLane Children's Medical Center and McLane Children's Clinic
Resources Contributed: Resources valued at $98,428 of Community Benefit

Program Name: Family, Food and Fun Outreach
Description: A community event that serves as a recruitment or education opportunity, effectively demonstrating the educational content of Family, Food, & Fun! Examples will include community cooking demonstrations, fitness demonstrations, educational presentations, or guest lecturer
Impact/Outcomes: 7,930
Supported by: Baylor Scott & White McLane Children's Medical Center and McLane Children's Clinic
Resources Contributed: Resources valued at $25,428 of Community Benefit

Program Name: Farmers Markets
Description: BSWH hosts a weekly farmer's market in the spring/summer months. More than 16 vendors bring their healthy fruits and vegetables, BSWH nutrition occasionally offered a healthy cooking demonstration and provided healthy recipe cards.
Impact/Outcomes: 12,950 visitors
Supported by: Baylor Scott & White Medical Center – Memorial and McLane Children's Medical Center
Resources Contributed: Resources valued at $42,827 of Community Benefit

Program Name: Shopping for Wellness
Description: A physician on the medical staff at Baylor Scott & White Health and an H E B registered dietitian will help community participants navigate the grocery store aisles to find healthier options for the family. Health and wellness tips, recipe handouts, and personalized recommendations will be provided.
Impact/Outcomes: 120
Supported by: Baylor Scott & White Medical Center – Memorial and Scott & White Clinic
Resources Contributed: Resources and materials valued at $4,583 of Community Benefit

Program Name: Walk With a Doc
Description: Walk With a Doc is a year-round monthly walking program sponsored locally by Baylor Scott & White Health, Temple Mayor's Fitness Council, and the Scott & White Health Plan. The event is free and everyone is welcome. Our goal is to encourage healthy physical activity in people of all ages, and reverse the consequences of a sedentary lifestyle, which will improve the health and well-being of the community. Each program starts with a volunteer doctor hosting a short discussion on a popular health topic like heart health, women's health, screening tips, etc. Then the conversation migrates into the walk, all the way back to the meeting point, where walkers can get water and a light healthy snack.
Impact/Outcomes: 687 participants
Supported by: Baylor Scott & White Medical Center – Memorial
Resources Contributed: Resources valued at $39,020 of Community Benefit

Identified Need Addressed: Pediatric Asthma

Program Name: Community Education for Pedi Asthma
Description: McLane Children's Scott & White asthma outreach is geared towards helping patients, their families, health care providers and even the community work together to better understand asthma and how to better manage it. The goal is to improve the quality of life for these children and their families. The program's goal is to reduce clinic, emergency department visits and hospitalizations due to asthma, and to reduce the number of missed school days and work days due to asthma symptoms. The hospital provides free educational information classes and activities to parents and children on the causes and treatment of asthma symptoms as well as the importance of inhalers. Topics: What is asthma? How is it diagnosed? Signs and symptoms Triggers and trigger avoidance

Medications **Smoking cessation**
Impact/Outcomes: 6,790 served
Supported by: Baylor Scott & White McLane Children's Medical Center and Clinic
Resources Contributed: Staff time and resources valued at $19,723 of community benefit

Program Name: School Based Education for Pedi Asthma
Description: Asthma education provided in schools through partnerships with local ISDs
Impact/Outcomes: 6,463 students served
Supported by: Baylor Scott & White McLane Children's Medical Center and Clinic
Resources Contributed: Staff time and resources valued at $5,253 of community benefit

Program Name: Pediatric Asthma Education for Providers
Description: Information and activities that provide education for providers on asthma care including school nurses. (Open to all providers, not restricted to BSWH providers
Impact/Outcomes: 343 served
Supported by: Baylor Scott & White McLane Children's Medical Center and Clinic
Resources Contributed: Staff time and resources valued at $5,744 of community benefit

Program Name: Pediatric Asthma Inpatient Education
Description: Educational information provided in the hospital one on one consultation with parents and asthma educator before discharge for their children on the causes and treatment of asthma symptoms as well as the importance of inhalers.
Impact/Outcomes: 246 consultations given
Supported by: Baylor Scott & White McLane Children's Medical Center and Clinic
Resources Contributed: Staff time and resources valued at $31,287 of community benefit

Identified Need Addressed: Tobacco Cessation

Program Name: Texas *Quitline*
Description: The hospital implemented Quitline within our electronic health record system which offers free and confidential phone counseling services and resources such as nicotine patches, gums, or lozenges, to those who register desiring to quit smoking. The program is integrated into the hospital's EMR to allow for easy referral to the program.
Impact/Outcomes: hundreds of patients were referred to this resource
Supported by: Baylor Scott & White Medical Center – Memorial and Scott & White Clinic
Resources Contributed: $11,000 for implementation plus **-staff time for programming within Epic (estimated 31 hours)** **-staff time testing between BSWH and the QuitLine (estimated 13 hours)** **-Training Time (for docs, nurses, and support staff) estimated 81 hours**