


Community Health Needs Assessment

Hill Country Health Community

2022

Baylor Scott & White HEALTH

Hill Country health community hospitals

- Baylor Scott & White Medical Center – Marble Falls

Approved by: Baylor Scott & White Health – Central Texas Operating, Policy and Procedure Board on May 13, 2022
Posted to **BSWHealth.com/CommunityNeeds** on June 30, 2022

Baylor Scott & White HEALTH

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Baylor Scott & White Health mission

Our commitment to the communities we serve

As the largest not-for-profit healthcare system in Texas and one of the largest in the United States, Baylor Scott & White Health was born from the 2013 combination of Baylor Health Care System and Scott & White Healthcare. Today, Baylor Scott & White includes 51 hospitals, 1,100 access points, more than 7,300 active physicians, and over 49,000 employees and the Baylor Scott & White Health Plan.

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

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

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

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

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

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

Community Health Needs Assessment (CHNA) report

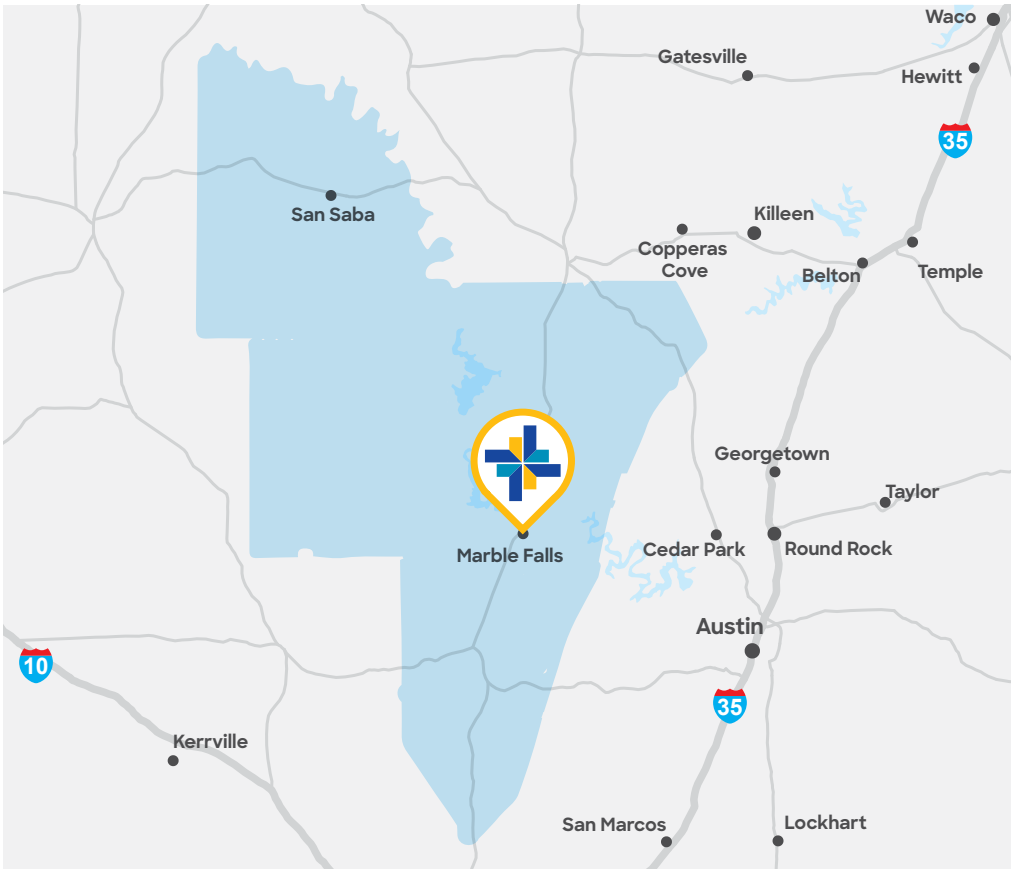
The Hill Country Health Community is home to one of these hospitals:

- Baylor Scott & White Medical Center – Marble Falls

The community served by the hospital listed above includes Blanco, Burnet, Llano and San Saba Counties. BSWH has at least one hospital facility or a provider-based clinic in these counties and the region comprises more than 70% of admitted patients according to the hospital facility's inpatient admissions over the 12-month period of FY20.

The facility completed a CHNA report in accordance with the Internal Revenue Code Section 501 (r)(3) and the US Treasury regulations thereunder.

Hill Country Health Community map



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

The CHNA process included:

- Gathering and analyzing more than 59 public and 45 proprietary health data indicators to provide a comprehensive assessment of the health status of the communities. The complete list of health data indicators is included in **Appendix B**.
- Creating a benchmark analysis comparing the community to overall state of Texas and United States (US) values.
- Conducting focus groups, key informant interviews and stakeholder surveys, including input from public health experts, to gain direct input from the community for a qualitative analysis.
  - Gathering input from state, local and/or regional public health department members who have the pulse of the community's health.
  - Identifying and considering input from individuals or organizations serving and/or representing the interests of medically underserved low-income and minority populations in the community to help prioritize the community's health needs.
  - The represented organizations that participated are included in **Appendix C**.

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

Demographic and socioeconomic summary

The most important demographic and socioeconomic findings for the Hill Country Health Community CHNA are:

- The community population growth outpaces the rate of growth of the US but is not as fast as the state of Texas.
- The median age of the population is significantly more than the US and Texas by a decade-plus.
- The median household income is below both the state and the US.
- The community served has a higher percentage of Medicare beneficiaries than Texas and the US.

Further demographic and socioeconomic information for the Hill Country Health Community is included in **Appendix D**.

Health community data summary

IBM Watson Health's utilization estimates and forecasts indicate the following for the Hill Country Health Community:

- Inpatient discharges in the community are expected to grow by 4.5% by 2030 with the largest growing product lines to include:
  - Pulmonary Medical
  - Cardiovascular Diseases
- Outpatient procedures are expected to increase by over 25% by 2030 with the largest areas of growth including:
  - General & Internal Medicine
  - Labs
  - Physical & Occupational Therapy
- Emergency Department visits are expected to grow by over 12% by 2025.
- Hypertension represents 61% of all heart disease cases.
- Cancer incidence is expected to increase by 3.7% by 2025.

Further health community information for the Hill Country Health Community is included in **Appendix E**.

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

	Health professional shortage areas (HPSA)				Medically underserved area/ population (MUA/P)
County	Dental health	Mental health	Primary care	Grand total	MUA/P
Blanco					1
Burnet		1		1	1
Llano		1	1	2	1
San Saba		1	1	2	1

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

Total population

83,311

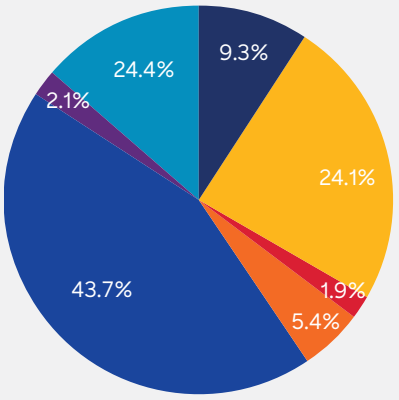
Average income

$61,040

Underserved ZIP codes

3

Insurance coverage



Priority health needs

Using these and other data collection and interpretation methods, BSWH identified what it considers to be the community's key health needs. The resulting prioritized health needs for this community include:

Priority	Need	Category of need
1	Food insecurity/limited access to healthy foods	Environment
2	Adult chronic illness	Conditions/diseases Health behaviors
3	Children in poverty/household income	Financial/income
4	Elderly isolation	Environment
5	Access to mental healthcare (providers/resources)	Environment
6	Language barrier/illiteracy	Population and income

Priority 1: Food Insecurity/Limited Access to Healthy Foods

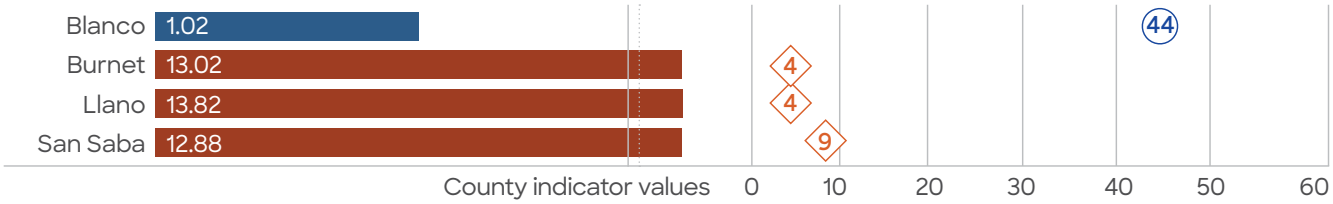
Category	Data shows greater need	Key informants indicate greater need
Environment	• Food insecure • Limited access to healthy foods	• Food insecurity • Lack of healthy food options

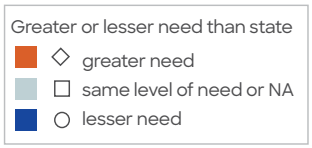
The **food insecure measure** is defined as **percentage of population who lack adequate access to food during the past year.** The indicator is based on data from County Health Rankings & Roadmaps, Map the Meal Gap, Feeding America.

Environment: food insecure (% who lack adequate access to food in county)

The indicator **limited access to healthy foods** is defined as **percentage of population who are low-income and do not live close to a grocery store.** The indicator is based on data from County Health Rankings & Roadmaps; USDA Food Environment Atlas, United States Department of Agriculture (USDA).

Environment: limited access to healthy foods





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

In addition, the focus group participants highlighted food insecurity challenges. They noted that there is a lack of healthy food options, a lack of fresh foods in the community and a lack of knowledge regarding where to access available food pantries. They recognized that transportation is a challenge to get food to people since those that rely on the bus know it is inefficient and timely, which is not ideal for transporting food that can spoil after a long bus ride. Ultimately, for some residents, their main source of food is a gas station.

In the prioritization session, the hospital and community leaders agreed that food insecurity is problematic. They recognize that many kids only get regular meals when they attend school.

Priority 2: Adult Chronic Illness

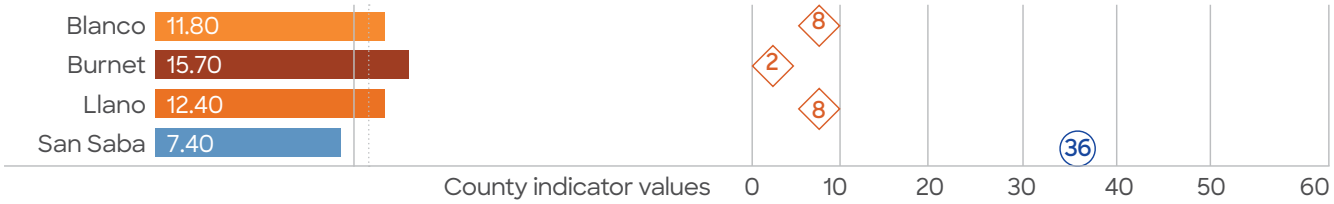
Category	Data shows greater need	Key informants indicate less need or not mentioned
Conditions/ diseases Health behaviors	• Adult obesity • Diabetes prevalence • Smoking	• Not specifically mentioned

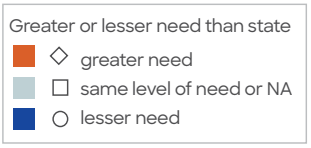
The **adult obesity** indicator is defined as **the percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2** and is based on data from County Health Rankings & Roadmaps, CDC Diabetes Interactive Atlas and The National Diabetes Surveillance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

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

The data below indicates greater need in the area of **diabetes prevalence**. The indicator is defined as **the prevalence of diagnosed diabetes in a given county.** Note that respondents were considered to have diagnosed diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes. The indicator is based on data from County Health Rankings (CDC Diabetes Interactive Atlas).

Conditions/diseases: diabetes prevalence (prevalence as % of diagnosed diabetes in county)





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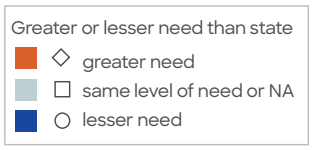
The data below indicates greater need in the area of **smoking**. The indicator is defined as **the percentage of the adult population in a county who both report that they currently smoke every day or most days and have smoked at least 100 cigarettes in their lifetime.** The indicator is based on data from County Health Rankings & Roadmaps; The Behavioral Risk Factor Surveillance System (BRFSS).

Health behaviors: smoking (% of adult smokers in county)



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In the prioritization session, hospital leadership agreed that adult chronic illness is an area of focus. While the data indicates adult obesity and diabetes prevalence, the group added that smoking is among them. They commented that smoking and vaping are further exacerbating the situation for congestive heart failure and COPD patients, although the data is not reflective of this yet.

Priority 3: Children in Poverty/Household Income

The following data indicates greater need in the area of children in poverty and household income.

Category	Data shows greater need	Key informants indicate greater need
Financial/ income	• Children in poverty • Household income	• Poverty in community

The **children in poverty** indicator is defined as **the percentage of children under age 18 in poverty.** The indicator is based on data from County Health Rankings & Roadmaps; Small Area Health Insurance Estimates (SAHIE), United States Census Bureau.

Financial/income: children in poverty (% of children under age 18 in poverty by county)

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

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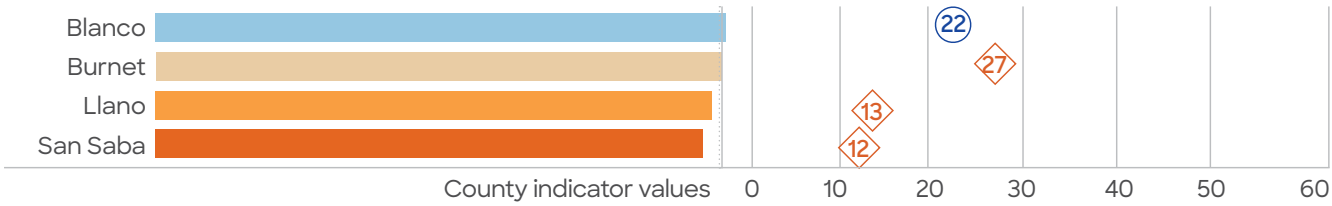
The **household income** measure is defined as **the median household income and is the income where half of households in a county earn more and half of households earn less.** The indicator is based on data from County Health Rankings (Small Area Income and Poverty Estimates).

Financial/income: household income (median household income in county)



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

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The focus group participants stated that there is much poverty in parts of the community. They scored poverty as one of the highest barriers in the community and also noted that there is a need to expand poverty definitions to increase funding for indigent care. They attributed some of the problem to the fact that many indigent people are coming over the border with no resources and that the low-income population is resistant to receiving help.

In the prioritization session, hospital leadership emphasized that there are several issues related to children in poverty. There are many homeless young adults and children left with grandparents to care for them on limited incomes. They feel the situation is complicated but an important issue to address. The group noted that it takes a communitywide effort to address some of the challenges for the children.

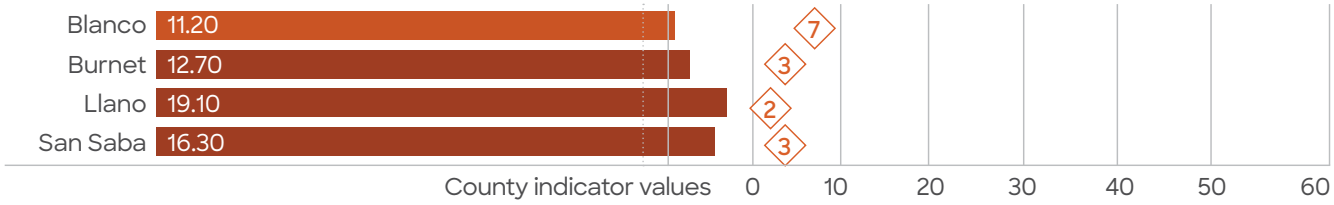
Priority 4: Elderly Isolation

The following data indicates greater need in elderly isolation in the community.

Category	Data shows greater need	Key informants indicate greater need
Environment	• Elderly isolation	• Older population suffering isolation

The **elderly isolation** measure is defined as **the percent of non-family households with the householder living alone and is 65 years and over.** The indicator is based on data from American Community Survey Five-Year Estimates, US Census Bureau - American FactFinder.

Environment: elderly isolation (% 65+ living alone in county)



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

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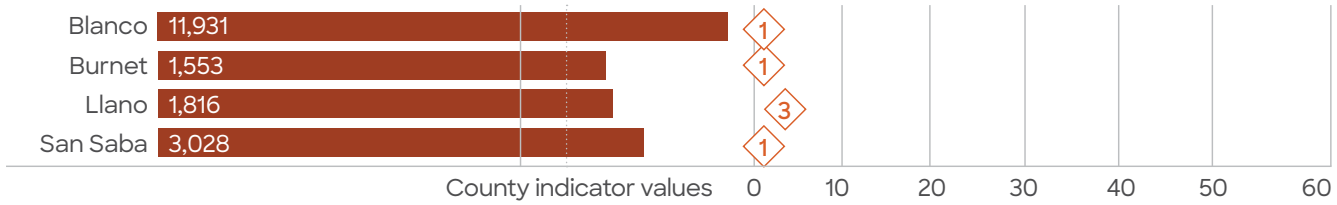
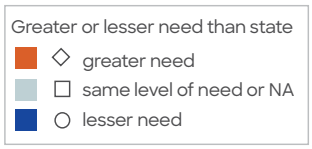
Priority 5: Access to Mental Healthcare (Providers/Resources)

Category	Data shows greater need	Key informants indicate greater need
Environment	• Population to one mental health provider	• Lack of access to behavioral/ mental health resources

The following data indicates greater need for **access for the population to one mental healthcare provider.** The indicator is defined as **the ratio of population to mental health providers** and is based on data from County Health Rankings & Roadmaps; CMS, National Provider Identification Registry (NPPES).

Access to care: population to one mental health provider (ratio of population to mental health providers by county)





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The focus group participants stated that needs are high for mental health and care, but access is very limited, especially for the uninsured. Participants stated there is a high demand for mental health providers, especially since mental health and substance abuse issues have escalated during the pandemic. Unfortunately, lack of insurance is a barrier as many mental health counselors do not accept uninsured patients. In addition, for those that can access services, the reaction time to get help from mental health counselors is long, which has led to the realization that staff members need more training in de-escalating stress in those patients. The community felt there was an opportunity to add physicians and mental health counselors and to increase patient knowledge on how to access resources.

In the prioritization session, the hospital leadership group agreed that mental health is a huge barrier to all that they do. They added that mental health patients are increasingly those who do not have insurance. They added that it takes longer to navigate and solve for care after an inpatient discharge for those patients.

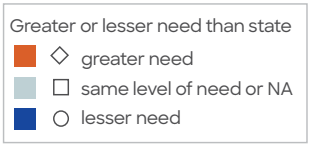
Priority 6: Language Barrier/Illiteracy

While the data did not indicate greater need in the case of the indicator **language: English spoken "less than very well" in household**, the key informants agreed that language barriers exist for the community's non-English speakers.

Category	Data shows less need or no data	Key informants indicate greater need
Population and income	• English spoken "less than very well" in household	• Language barriers

The indicator is defined as **the percentage of households that speak English "less than very well" within all households that speak a language other than English.** The indicator is based on data from American Community Survey Five-Year Estimates, US Census Bureau - American FactFinder.

Language/social: English spoken "less than very well" in household (% of households speaking less than very well English by county)



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In the prioritization session, hospital leadership mentioned that language barriers and illiteracy are a significant need in the community. They added that the need is frequently missed and is an underserved area. Some elderly are also illiterate in both English and their language, and this is a significant need.

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

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

Existing resources to address health needs

One part of the assessment process included gathering input on potentially available community resources. A statewide Community Resource Guide and suggestions from some of our assessment participants helped identify community resources that may help address this community's known health needs.

Hill Country community resources

Need	Organization	Address	Phone
Food insecurity/ access to healthy food	Lakes Area Care Incorporated (food pantry/nutrition classes)	507 Buchanan Drive Burnet, TX 78611	512.756.4422
	Central Texas Food Bank	507 Buchanan Drive Burnet, TX 78611	512.282.2111
	Chapel of the Hills Baptist Church - Chapel Food Bank	19135 Texas 29 Buchanan Dam, TX 78609	512.793.2453
	Jesus the Divine Teacher Ministries Church - Joseph's Food Pantry	706 N. Phillips Ranch Road Granite Shoals, TX 78654	830.220.2344
	Meals on Wheels of Williamson and Burnet Counties	602 N. Wood Street Burnet, TX 78611	512.715.9717
Adult chronic illness	Texas HHSC (Medicare/Medicaid)	1447 E. State Highway 71 Llano, TX 78643	855.937.2372
	Community Resource Centers of Texas, Inc. - Help Pay for Healthcare	100 Legend Hills Boulevard Llano, TX 78643	325.247.2703
	Family Medicine Clinic - Lampasas	187 Private Road 4060 Lampasas, TX 76550	512.556.3621
	Brownwood Regional Medical Center - One Source Health Center San Saba	403 W. Wallace Street San Saba, TX 76877	325.372.5701
	Healogics Inc. - Texas (care for patients with chronic wounds)	608 N. Key Avenue Lampasas, TX 76550	512.556.8700
Children in poverty/ household income	Central Texas Pregnancy Care Center (PCC) (baby supplies, understand government programs)	208 W. Wallace Street San Saba, TX 76877	325.646.5433
	Texas HHSC	1447 E. State Highway 71 Llano, TX 78643	855.937.2372
	Texas HHSC	421 E. Wallace Street San Saba, TX 76877	877.541.7905
	Cherokee Home for Children (housing, support system, faith based education)	PO Box 295 Cherokee, TX 76832	800.689.3292
	Workforce Solutions of Central Texas (child care services)	523 E. 3rd Street Lampasas, TX 76550	512.556.4055

Need	Organization	Address	Phone
Elderly isolation	Daybreak Venture	2400 W. Brown Street San Saba, TX 76877	325.387.8123
	Hill Country Community Action	2905 W. Wallace Street San Saba, TX 76877	866.372.5167
	The Compassionate Friends (TCF) - Burnet County, Texas - Bereavement Support Group	204 E. Graves Street Burnet, TX 78611	512.756.8212
	Daybreak Venture	901 Plum Street Lampasas, TX 76550	512.556.8827
	Hill Country Children's Advocacy Center (HCCAC) (child and elder abuse victim services)	1001 N. Hill Street Burnet, TX 78611	512.756.2607
Access to mental healthcare (providers/ resources)	Hill Country Mental Health & Developmental Disabilities (MHDD) Center	102 E. Young Street Llano, TX 78643	877.466.0660
	Hill Country Children's Advocacy Center (HCCAC)	1001 N. Hill Street Burnet, TX 78611	512.756.2607
	Bluebonnet Trails Community Services	4606 Innovation Loop Marble Falls, TX 78654	844.309.6385
	Lone Star Circle of Care (mental health services)	802 Avenue J Marble Falls, TX 78654	877.800.5722
	Community Resource Centers of Texas, Inc. (connect with mental health resources)	100 Legend Hills Boulevard Llano, TX 78643	325.247.2703

Need	Organization	Address	Phone
Language barriers/ illiteracy	Texas HHSC (understand government programs, English/Spanish)	1447 E. State Hwy 71 Llano, TX 78643	855.937.2372
	Texas HHSC (understand government programs English/Spanish)	421 E. Wallace Street San Saba, TX 76877	877.541.7905
	Community Action, Inc. of Central Texas (adult education classes)	901 Avenue U Marble Falls, TX 78654	512.392.1161
	Literacy Highland Lakes	202 E. Brier Street Burnet, TX 78611	512.756.7337
	Bluebonnet Trails Community Services (American Sign Language, Amharic, Arabic, Armenian, Bengali, Burmese, Chinese, Croatian, Czech, Danish, Dutch, English, Esperanto, Finnish, French, German, Greek, Gujarati, Haitian, Hebrew, Hindi, Hungarian, Indonesian, Italian, Japanese, Javanese, Karen, Korean, Lao, Lithuanian, Malay, Malayalam, Navajo, Nepali, Norwegian, Panjabi, Persian, Polish, Portuguese, Romanian, Russian, Samoan, Serbian, Slovak, Somali, Spanish, Swahili, Swedish, Tagalog, Tamil, Thai, Turkish, Ukrainian, Urdu, Vietnamese, Yiddish)	4606 Innovation Loop Marble Falls, TX 78654	844.309.6385

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

Next steps

BSWH started the Community Health Needs Assessment process in April 2021. Using both qualitative community feedback as well as publicly available and proprietary health indicators, BSWH was able to identify and prioritize community health needs for its healthcare system. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed for the health needs BSWH chooses to address for the community served.

Appendix A: CHNA requirement details

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

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

CHNA process

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

Consultant qualifications

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

Health needs assessment process overview

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

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

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

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

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

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

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

- The team set benchmarks for each health community using state value for comparison.
- They identified community indicators not meeting state benchmarks.
- From this, they determined a need differential analysis of the indicators, which helped them understand the community's relative severity of need.
- Using the need differentials, they established a standardized way to evaluate the degree that each indicator differed from its benchmark.
- This quantitative analysis showed which health community indicators were above the 25th percentile in order of severity—and which health indicators needed their focus.

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

Information gaps

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

Community input: qualitative health needs assessment - approach

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

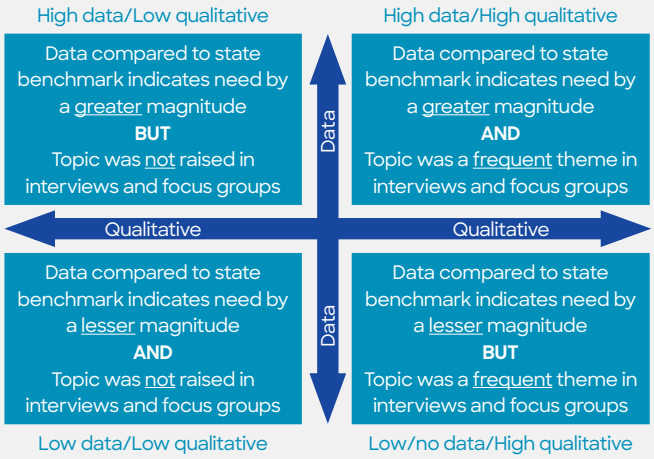
- Assembled a focus group representing the broad interests of the community served;
- Conducted interviews and surveys with key informants—leaders and representatives who serve the community and have insight into its needs; and
- Held prioritization sessions with hospital clinical leadership and community leaders to review collection results and identify the most significant healthcare needs based on information gleaned from the focus groups and key informants.

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

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

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

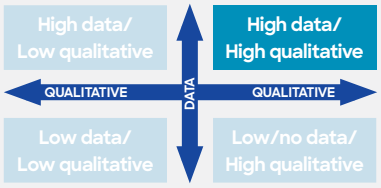
Approach to prioritizing significant health needs



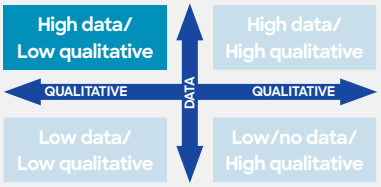
High data = Indicators worse than state benchmark by greater magnitude
High qualitative = Frequency of topic in interviews and focus groups

On January 5, 2022, a session was conducted with key leadership members from Baylor Scott & White Medical Center – Marble Falls along with community leaders to review the qualitative and quantitative data findings of the CHNA to date, discuss at length the significant needs identified, and complete prioritization exercises to rank the community needs. Prioritizing health needs was a two-step process. The two-step process allowed participants to consider the quantitative needs and qualitative needs as defined by the indicator dataset and focus group/interview/survey participant input.

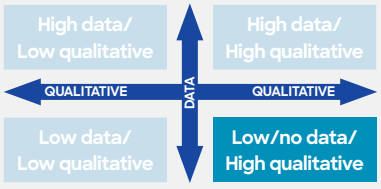
In the first step, participants reviewed the top health needs for their community using associated data-driven criteria. The criteria included health indicator value(s) for the community and how the indicator compared to the state benchmark.



High data and high qualitative: The community indicators that showed a greater need in the health community overall when compared to the state of Texas comparative benchmark and were identified as a greater need by the key informants.



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



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

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

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

Prioritization of significant needs

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

- **Community capacity or strengths:** Does the community have the capacity to act on the issue, including any economic, social, cultural or political consideration? Extent to which initiatives that address the health issue can build on the community's existing strengths and resources. Availability of local expertise regarding the health need.
- **Magnitude (size of problem):** How many people does the problem affect, either actually or potentially?
- **Severity (outcome if ignored):** What degree of disability or premature death occurs because of the problem? What are the potential burdens to the community, such as economic or social burdens?
- **Social justice:** Is the problem more concentrated to a specific vulnerable population? Does addressing this issue lead to unfair social benefit? Are we equitable to all vulnerable populations in our approach?

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

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

Priority	Need	Category of need
1	Food insecurity/limited access to healthy foods	Environment
2	Adult chronic illness	Conditions/diseases Health behaviors
3	Children in poverty/household income	Financial/income
4	Elderly isolation	Environment
5	Access to mental healthcare (providers/resources)	Environment
6	Language barrier/illiteracy	Population and income

Appendix B: key public health indicators

IBM Watson Health collected and analyzed fifty-nine (59) public health indicators to assess and evaluate community health needs. For each health indicator, a comparison between the most recently available community data and benchmarks for the same/similar indicator was made. The basis of benchmarks was available data for the US and the state of Texas.

The indicators used and the sources are listed below:

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

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

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

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

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

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

Appendix C: community input participating organizations

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

- Baylor Scott & White Health
- City of Marble Falls
- Community Resource Centers
- First Baptist Church Marble Falls
- Marble Falls Area EMS
- Marble Falls Senior Activity Center
- Phoenix Center

Appendix D: demographic and socioeconomic summary

According to population statistics, the community served is similar to Texas in terms of projected population growth; both outpace the country. The median age is older than both Texas and the United States. Median income is below both the state and the country. The community served has a higher percentage of Medicare beneficiaries than Texas and the US.

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

Geography		Benchmarks		Community served
		United States	Texas	Hill Country health community
Total current population		330,342,293	29,321,501	83,311
Five-year projected population change		3.3%	6.6%	6.1%
Median age		38.6	35.2	47.7
Population 0 - 17		22.4%	25.7%	19.4%
Population 65+		16.6%	13.2%	26.7%
Women age 15 - 44		19.5%	20.5%	15.1%
Hispanic population		19.0%	40.7%	21.4%
Insurance coverage	Uninsured	9.9%	18.8%	13.5%
	Medicaid	20.9%	13.0%	9.3%
	Private market	8.3%	8.4%	7.5%
	Medicare	13.8%	12.7%	26.0%
	Employer	47.2%	47.1%	43.7%
Median HH income		$65,618	$63,313	$61,040
No high school diploma		12.2%	16.7%	13.6%

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

The community served expects to grow 6.1% by 2025, an increase by more than 5,000 people. The projected population growth is lower than the state's five-year projected growth rate (6.6%) but higher compared to the national projected growth rate (3.3%).

The community's population is older with 42% of the population ages 55-plus. The age 65-plus cohort is expected to experience the fastest growth (15%) over the next five years. Growth in the senior population will likely contribute to increased utilization of services as the population continues to age.

Population statistics are analyzed by race and by Hispanic ethnicity. The community is primarily White and non-Hispanic, but diversity in the community will increase due to the projected growth of minority populations over the next five years. The expected growth rate of the Hispanic population (all races) is 15% by 2025, and the Black non-Hispanic population is 15.5%. The White non-Hispanic population is expected to have the slowest growth at 2.7%.

Population distribution

	Age distribution				
Age group	2020	% of total	2025	% of total	USA 2020 % of total
0 - 14	13,207	15.9%	13,846	15.7%	18.5%
15 - 17	2,963	3.6%	3,022	3.4%	3.9%
18 - 24	6,354	7.6%	7,146	8.1%	9.5%
25 - 34	8,420	10.1%	9,142	10.3%	13.5%
35 - 54	17,260	20.7%	17,048	19.3%	25.2%
55 - 64	12,874	15.5%	12,594	14.2%	12.9%
65+	22,233	26.7%	25,585	28.9%	16.6%
Total	**83,311**	**100.0%**	**88,383**	**100.0%**	**100.0%**

Household Income distribution

	Income distribution		
2020 Household income	HH count	% of total	USA % of total
<$15K	2,894	8.4%	10.0%
$15 - 25K	3,672	10.7%	8.6%
$25 - 50K	8,153	23.8%	20.7%
$50 - 75K	5,872	17.1%	16.7%
$75 - 100K	4,486	13.1%	12.4%
Over $100K	9,229	26.9%	31.5%
Total	**34,306**	**100.0%**	**100.0%**

Education level

	Education level distribution		
2020 Adult education level	Pop age 25+	% of total	USA % of total
Less than high school	3,646	6.0%	5.2%
Some high school	4,594	7.6%	7.0%
High school degree	17,885	29.4%	27.2%
Some college/assoc. degree	19,674	32.4%	28.9%
Bachelor's degree or greater	14,988	24.7%	31.6%
Total	**60,787**	**100.0%**	**100.0%**

Race/ethnicity

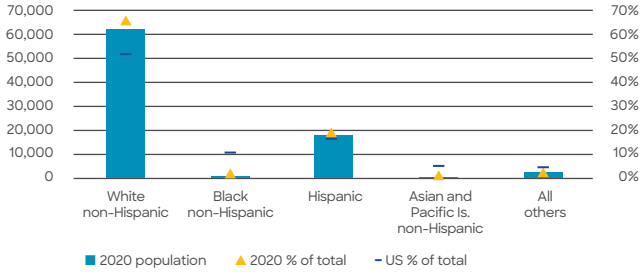
	Race/ethnicity distribution		
Race/ethnicity	2020 pop	% of total	USA % of total
White non-Hispanic	61,842	74.2%	59.3%
Black non-Hispanic	1,410	1.7%	12.4%
Hispanic	17,832	21.4%	19.0%
Asian & Pacific is. non-Hispanic	642	0.8%	6.0%
All others	1,585	1.9%	3.3%
Total	**83,311**	**100.0%**	**100.0%**

Source: IBM Watson Health/Claritas, 2020.

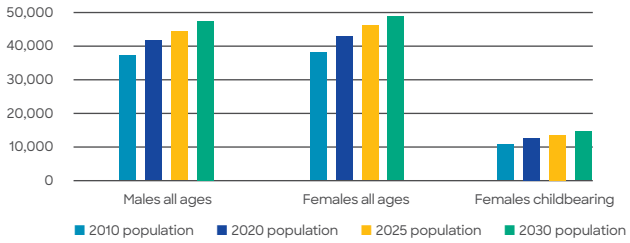
Population estimates		
Population	National	Selected area
2010 total	308,745,538	74,116
2020 total	330,342,293	83,311
2025 total	341,132,738	88,383
2030 total	353,513,931	93,819
% change 2020 - 2025	3.27%	6.09%
% change 2020 - 2035	7.01%	12.61%

Population	Males all ages	Females all ages	Females childbearing
2010 total	36,672	37,444	10,920
2020 total	41,048	42,263	12,586
2025 total	43,610	44,773	13,475
2030 total	46,307	47,512	14,512
10Y %	12.81%	12.42%	15.30%
National	7.02%	7.01%	4.01%

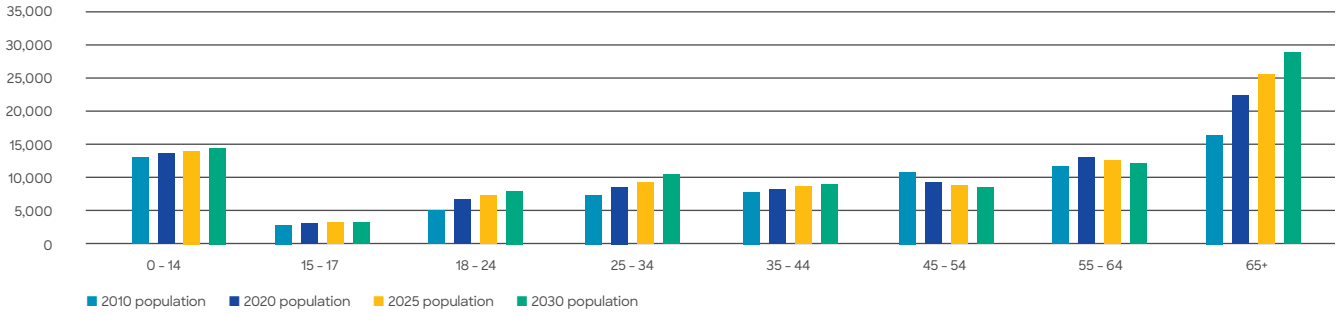
2020 race and ethnicity with total population



Population by sex 2010 - 2030



Population by age group 2010 - 2030



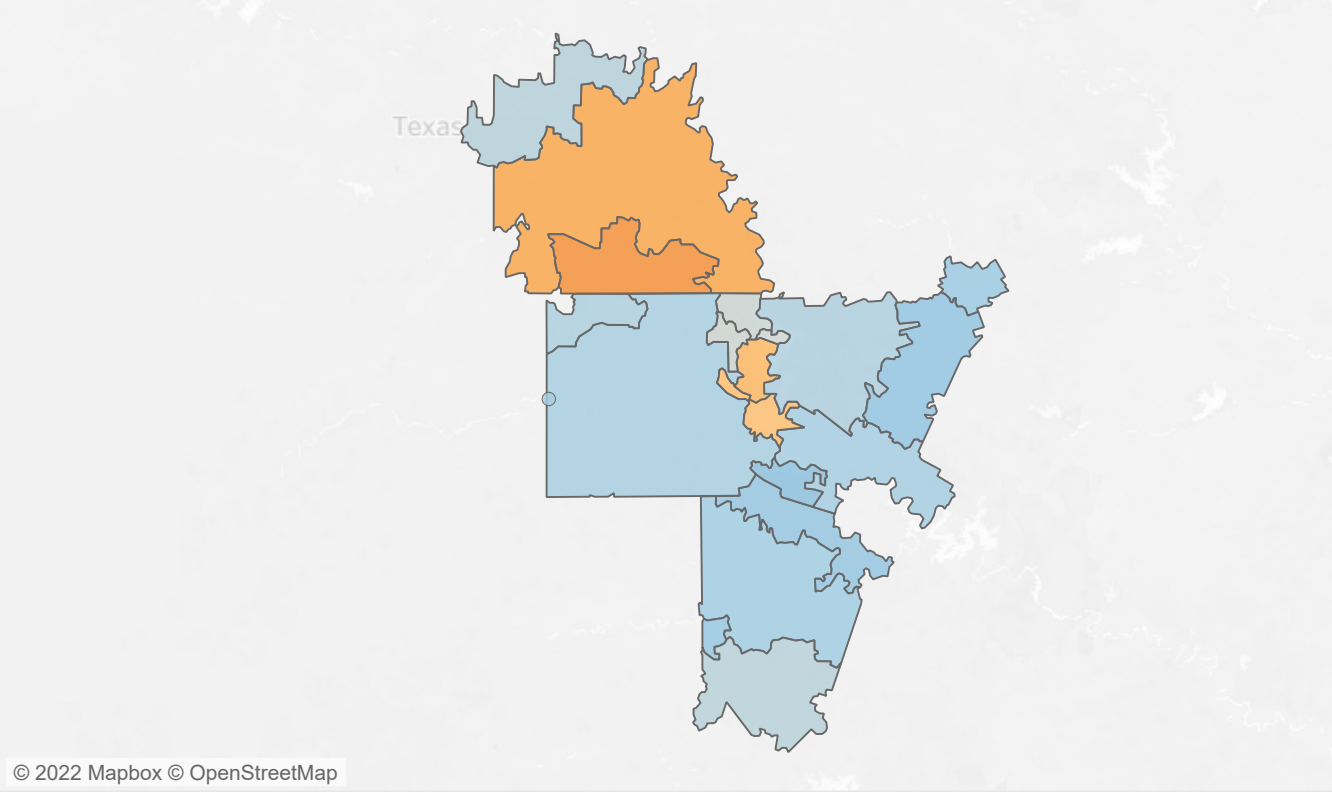
Source: IBM Watson Health/Claritas, 2020.

The 2020 median household income for the United States was $65,618 and $63,313 for the state of Texas. The median household income for the ZIP codes within this community ranged from $36,250 for 76832 – Cherokee to $82,875 for 78657 – Horseshoe Bay. There were three (3) additional ZIP codes with median household incomes less than $50,200—twice the 2020 federal poverty limit for a family of four.

- 76877 San Saba – $40,571
- 78609 Buchanan Dam – $44,034
- 78639 Kingsland – $45,823

A majority of the population (44%) were insured through employer sponsored health coverage, followed by those with Medicare (24%). The remainder of the population was fairly equally divided between Medicaid, uninsured and private market (the purchasers of coverage directly or through the health insurance marketplace).

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



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

Health professional shortage areas (HPSA)				
County	HPSA ID	HPSA name	HPSA discipline class	Designation type
Burnet	7481223298	LI - Burnet County	Mental health	Low-income population HPSA
Llano	7489383475	Llano County	Mental health	Geographic HPSA
Llano	1486640093	LI - Llano County	Primary care	Low-income population HPSA
San Saba	1481868316	San Saba County	Primary care	Geographic HPSA
San Saba	7489559810	San Saba County	Mental health	High-needs geographic HPSA

Medically underserved areas and populations (MUA/P)				
County	MUA/P source identification number	Service area name	Designation type	Rural status
Blanco	1483162891	Blanco County	Medically underserved area	Rural
Burnet	1484184472	Burnet service area	Medically underserved area	Rural
Llano	1488349559	Llano County	Medically underserved area	Rural
San Saba	1481315224	San Saba County	Medically underserved area	Rural

Community Needs Index

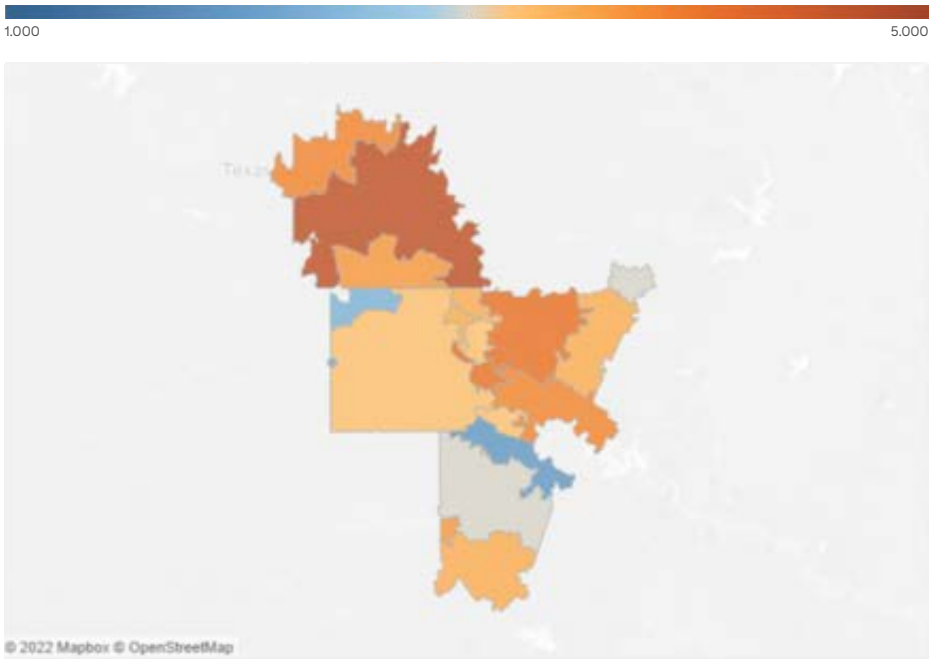
The IBM Watson Health Community Need Index (CNI) is a statistical approach that identifies areas within a community where there are likely gaps in healthcare. The CNI takes into account vital socio-economic factors, including income, culture, education, insurance and housing, about a community to generate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

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

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

Hill Country Health Community

Composite CNI: high scores indicate high need.



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

Composite CNI score
3.66

Texas CNI score
3.85

US composite CNI score
3.00

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

The overall CNI score for the Hill Country Health Community was 3.66. The difference in the numbers indicates both a strong link to community healthcare needs and a community's demand for various healthcare services. In portions of the community, the CNI score was greater than 4.5, indicating more significant health needs among the population.

Appendix E: proprietary community data

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

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

Inpatient demand estimates

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

The following summary is reflective of the inpatient utilization trends for Hill Country Health Community. Total discharges in the community are expected to grow by 4.5% by 2030, with pulmonary medical, cardiovascular diseases, general medicine and neuro sciences projecting the largest growth.

Product line	2020 discharges	2025 discharges	2030 discharges	2020 - 2025 discharges change	2020 - 2025 discharges % change	2020 - 2030 discharges change	2020 - 2030 discharges % change
Alcohol and Drug Abuse	85	84	88	(1)	-1.7%	3	3.8%
Cardio-Vasc-Thor Surgery	451	449	441	(2)	-0.4%	(10)	-2.3%
Cardiovascular Diseases	865	889	939	24	2.7%	74	8.5%
ENT	43	41	39	(3)	-6.1%	(4)	-9.6%
General Medicine	1,732	1,741	1,767	9	0.5%	35	2.0%
General Surgery	683	664	664	(19)	-2.7%	(19)	-2.8%
Gynecology	33	18	12	(15)	-45.4%	(21)	-63.4%
Nephrology/Urology	406	405	411	(1)	-0.1%	5	1.3%
Neuro Sciences	521	526	555	5	0.9%	34	6.5%
Obstetrics Del	622	604	623	(18)	-2.8%	1	0.1%
Obstetrics ND	60	59	61	(1)	-2.2%	1	1.6%
Oncology	162	159	158	(3)	-2.0%	(4)	-2.6%
Ophthalmology	9	8	8	(0)	-5.5%	(1)	-8.9%
Orthopedics	987	988	1,022	1	0.1%	35	3.5%
Psychiatry	44	44	43	(0)	-0.6%	(1)	-2.1%
Pulmonary Medical	931	1,044	1,149	113	12.2%	218	23.5%
Rehabilitation	6	7	7	0	4.7%	1	12.7%
TOTAL	**7,641**	**7,730**	**7,987**	**88**	**1.2%**	**346**	**4.5%**

Source: IBM Watson Health Inpatient Demand Estimates, 2020.

Outpatient procedures estimates

Outpatient procedure estimates predict the total annual volume of procedures performed by ZIP code for every market in the United States using proprietary and public health claims, as well as federal surveys. Procedures are defined and reported by procedure codes and are further grouped into clinical service lines. The Hill Country Health Community outpatient procedures are expected to increase by over 25% by 2030 with the largest growth in the categories of general and internal medicine, labs, physical & occupational therapy and psychiatry.

Clinical service category	2020 procedures	2025 procedures	2020-2025 procedures % change	2030 procedures	2020 - 2030 procedures % change
Allergy & Immunology	44,914	48,638	8.3%	52,329	16.5%
Anesthesia	15,071	17,195	14.1%	18,989	26.0%
Cardiology	77,419	93,191	20.4%	112,635	45.5%
Cardiothoracic	77	85	10.7%	92	20.5%
Chiropractic	39,295	37,205	-5.3%	33,043	-15.9%
Colorectal Surgery	576	605	5.0%	637	10.5%
CT Scan	26,651	32,921	23.5%	40,433	51.7%
Dermatology	38,638	43,016	11.3%	47,254	22.3%
Diagnostic Radiology	113,855	120,571	5.9%	126,799	11.4%
Emergency Medicine	38,230	42,402	10.9%	46,938	22.8%
Gastroenterology	7,100	7,773	9.5%	8,428	18.7%
General & Internal Medicine	727,702	822,719	13.1%	906,379	24.6%
General Surgery	4,873	5,372	10.2%	5,906	21.2%
Hematology & Oncology	116,183	131,880	13.5%	147,246	26.7%
Labs	847,830	928,703	9.5%	1,014,681	19.7%
Miscellaneous	23,624	26,359	11.6%	28,747	21.7%
MRI	9,009	9,889	9.8%	10,817	20.1%
Nephrology	15,763	17,247	9.4%	18,729	18.8%
Neurology	8,132	8,861	9.0%	9,657	18.8%
Neurosurgery	624	810	30.0%	924	48.2%
Obstetrics/Gynecology	10,201	11,065	8.5%	12,140	19.0%
Ophthalmology	63,086	72,723	15.3%	82,239	30.4%
Oral Surgery	248	299	20.6%	359	45.1%
Orthopedics	17,822	19,204	7.8%	20,574	15.4%
Otolaryngology	24,871	27,728	11.5%	30,678	23.3%
Pain Management	12,022	12,808	6.5%	13,459	12.0%
Pathology	42	47	10.8%	52	22.1%
PET Scan	750	831	10.9%	906	20.8%
Physical & Occupational Therapy	200,133	246,742	23.3%	297,541	48.7%
Plastic Surgery	1,037	1,178	13.6%	1,319	27.2%
Podiatry	7,492	8,085	7.9%	8,607	14.9%
Psychiatry	58,991	80,220	36.0%	104,580	77.3%
Pulmonary	19,341	20,761	7.3%	22,078	14.2%
Radiation Therapy	10,443	11,026	5.6%	11,521	10.3%
Single Photon Emission CT Scan (SPECT)	1,715	1,881	9.7%	2,054	19.7%
Urology	8,103	9,065	11.9%	10,012	23.6%
Vascular Surgery	2,028	2,262	11.5%	2,477	22.1%
TOTAL	**2,593,891**	**2,921,366**	**12.6%**	**3,251,259**	**25.3%**

Source: IBM Watson Health Outpatient Procedure Estimates, 2020.

Emergency department visits

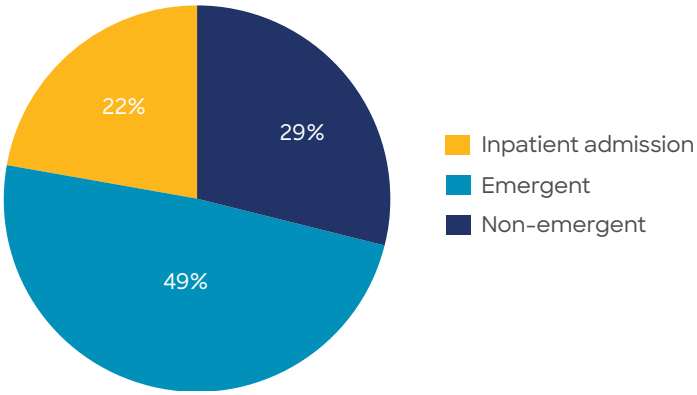
Emergency department estimates predict the total annual volume of emergency department (ED) visits by ZIP code and level of acuity for every market in the United States. IBM uses an extensive supply of proprietary claims, public claims and federal surveys to construct population-based use rates for all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

Visits are broken out into emergent and non-emergent ambulatory visits to identify the volume of visits that could be seen in a less-acute setting, for example, a fast-track ED or an urgent care facility. In addition, visits that result in an inpatient admission are broken out into a third, separate category. In the Hill Country Health Community, ED visits are expected to grow by 12% by 2025.

Emergent status	2020 visits	2025 visits	2020 - 2025 visits change	2020 - 2025 visits % change
Emergent	20,471	23,964	3,493	17.1%
Inpatient Admission	9,320	10,775	1,455	15.6%
Non-Emergent	13,724	14,050	326	2.4%
TOTAL	**43,515**	**48,788**	**5,274**	**12.1%**

Source: IBM Watson Health Emergency Department Visits, 2020.

Emergency department visit estimates 2025



Heart disease estimates

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

In Hill Country Health Community, the most common disease is hypertension at almost 61% of all heart disease cases.

Disease type	2020 prevalence	2020 % prevalence
Arrhythmia	6,261	18.0%
Heart Failure	2,331	6.7%
Hypertension	21,231	61.1%
Ischemic Heart Disease	4,933	14.2%
TOTAL	**34,757**	**100.0%**

Source: IBM Watson Heart Disease Estimates, 2020.

Cancer estimates

IBM Watson Health builds county-level cancer incidence models that are applied to the underlying demographics of specific geographies to estimate incidence (i.e., the number of new cancer cases annually) of all cancer patients. Cancer incidence is expected to increase by almost 4% in the Hill Country Health Community by 2025.

Cancer type	2020 incidence	2025 incidence	2020 - 2025 change	2020 - 2025 % change
Bladder	27	31	3	11.8%
Brain	8	9	1	8.1%
Breast	129	139	10	8.0%
Colorectal	81	65	-16	-19.9%
Kidney	30	34	4	12.4%
Leukemia	25	28	3	11.3%
Lung	85	90	4	5.0%
Melanoma	38	44	6	16.8%
Non-Hodgkin's Lymphoma	39	44	4	10.9%
Oral Cavity	25	27	3	10.6%
Other	104	115	11	10.8%
Ovarian	11	12	0	3.6%
Pancreatic	17	20	2	13.4%
Prostate	93	82	-11	-12.2%
Stomach	11	12	0	2.1%
Thyroid	11	12	1	11.4%
Uterine Cervical	3	3	0	1.1%
Uterine Corpus	25	27	2	9.0%
TOTAL	**764**	**793**	**29**	**3.7%**

Source: IBM Watson Health Cancer Estimates, 2020.

Appendix F: 2019 community health needs assessment evaluation

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

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

Dates: Fiscal Years 2020 - March 2022
Facilities: BSWMC – Marble Falls, Baylor Scott & White Clinic, BSWMC – Llano*
Community served: Llano, Burnet, San Saba and Blanco Counties

*Sold January 1, 2021

Ratio of population to one mental health provider

Baylor Scott & White Clinic

Action/tactics	Anticipated outcome	Evaluation of impact
Telemedicine Implement telemedicine in clinical care.	High-need patients will be able to receive psychiatry consults faster and more efficiently.	We did implement telemedicine in several places. All of the outpatient clinics developed telemedicine capabilities during the pandemic. There was a four-week time frame where 100% of the visits were telemedicine. Now it is a part of all the care clinics provide. Marble Falls also added telemedicine to the emergency department and inpatient areas, specifically in neurology. We have 24/7 neurology coverage that has aided us in becoming a stroke center. Neurologists also do consults on our inpatient floor via telemedicine.

Ratio of population to one mental health provider

Baylor Scott & White Medical Center – Marble Falls

Baylor Scott & White Medical Center – Llano

Action/tactics	Anticipated outcome	Evaluation of impact
Mental health first aid Provide mental health first aid training to interested community organizations.	More lay people will be able to assist those struggling with mental health challenges.	**Marble Falls** • **Person served: 2,501** • **$3,675 community benefit** **Llano** • **$7,324 community benefit**
Addressing drug abuse Addressing drug abuse including opioids and methamphetamines by limiting prescriptions provided in the emergency department and after surgery. Identify ways to help families break the cycle of drug abuse.	Reduced number of prescribed opioids. Reduced number of complications due to meth use.	• We have implemented initiatives rolled out from the system to help mediate opioid abuse. • Mandatory training on chronic pain management required of providers. • Best practice alerts pop up when certain levels of opioids are being prescribed.
Coordination of resources Coordination of community health resources in a rural region for patient referrals.	Maximized community resources to rural residents to improve their health and engage available post-acute providers, decreased overutilization of the emergency department and decreased readmissions.	• The hospital has a strong collaboration with the Community Resource Center of Marble Falls. Patients are referred here regularly for assistance with needs post-discharge, including postpartum support, financial assistance, food and transportation. CRC has a program for CHF patients giving healthy food. Bluebonnet Trails also receives a lot of referrals. • Hospital representatives meet monthly with partners to discuss coordination of resources. • LoneStar Circle of Care is engaged to better assist unfunded patients with primary care, dental care and mental healthcare. • BSW provided walkers and other DME as well as COVID care kits by securing grant funds and funding from local churches. • **6,760+ served** • **$860,167 community benefit**

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

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

Action/tactics	Anticipated outcome	Evaluation of impact
Medical staff development Develop and implement a medical staff development plan and recruit new primary care providers.	Patients will have better access to primary care providers.	We have added substantially to our clinics across the area over the past few years: • **Johnson City** - two providers • **Burnet** - brand-new clinic and three providers • **Marble Falls clinic** - one physician, two NPs • **Horseshoe Bay clinic** - one physician, one NP • **Llano clinic** - one NP • **San Saba clinic** - one NP • **$2.82 million community benefit**
Charity care Provide free and/or discounted care to financially or medically indigent patients as outlined in the financial assistance policy.	Increased access to primary care and/or specialty care for indigent persons regardless of their ability to pay.	**Marble Falls** • **$16,883,297 community benefit (FY20 & 21)** **Llano** • **$1,863,237 community benefit**
Financial donations Cash and in-kind contributions to other not-for-profit community organizations existing to increase access to care for the community.	Improved access to care for uninsured and underinsured persons.	**Marble Falls** • **Persons served: 4,416** • **$14,900 community benefit**
In-kind donations In-kind medical supply and equipment donations to local non-profits supporting healthcare programs and identify better ways to assist outpatient care by connecting patients to underutilized resources and DME in the Faith in Action ministry.	Improved access to care for uninsured and underinsured persons.	**Marble Falls** • **$139,099 community benefit**
Faith community health Encourages faith community wellness through establishment of health initiatives, assisting high-risk patients through social support and resource navigation and fostering community engagement through local collaboration efforts.	Non-profit organizations are better able to help patients as a first touch point rather than having to send them to the hospital for care.	The COVID-19 pandemic prohibited this strategy from being implemented to date.

Elderly isolation: 65+ householder living alone

Baylor Scott & White Medical Center – Marble Falls

Action/tactics	Anticipated outcome	Evaluation of impact
Telemedicine Implement telemedicine in clinical care.	High-need patients will be able to receive psychiatry consults faster and more efficiently.	We were able to implement telemedicine in several places. All of the outpatient clinics developed telemedicine capabilities during the pandemic. There was a four-week period where 100% of the visits were provided via telemedicine. Now it is a part of all the care clinics provide. Marble Falls also added telemedicine to the emergency department and inpatient areas, specifically in neurology. We have 24/7 neurology coverage that has aided us in becoming a stroke center. Neurologists also do consults on our inpatient floor via telemedicine.
Faith community health Encourages faith community wellness through establishment of health initiatives, assisting high-risk patients through social support and resource navigation and fostering community engagement through local collaboration efforts	Non-profit organizations are better able to help patients as a first touch point rather than having to send them to the hospital for care.	The COVID-19 pandemic prohibited this strategy from being implemented to date.

Total investment in adopted community needs since 2019 CHNA

BSWMC – Marble Falls
$18 million

BSWMC – Llano
$1.9 million

BSW Clinic
$2.82 million