Central Texas Medical Center*

2019 COMMUNITY HEALTH NEEDS ASSESSMENT

*Adventist Health System/Sunbelt, Inc.

Approved by the Hospital Board on: October 23, 2019

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Extending the Healing Ministry of Christ

AdventHealth

2019 Community Health Needs Assessment

Table of Contents

Acknowledgements

This report was prepared by Jessica Pizana with contributions from members of the Central Texas Medical Center Community Health Needs Assessment Committee representing health leaders in our community and Central Texas Medical Center leaders.

A special thanks to SHARED Strategy Group, LLC for their expertise and support in the collection and analysis of the data.

We are especially grateful to all those who participated in our household surveys and key informant interviews. Their contributions made this report possible and lay the groundwork as we continue to fulfill our mission of *Extending the Healing Ministry of Christ*.

1. EXECUTIVE SUMMARY

Goals

Adventist Health System/Sunbelt, Inc., d/b/a Central Texas Medical Center, will be referred to in this document as Central Texas Medical Center (CTMC) or "The Hospital". Central Texas Medical Center in San Marcos, Texas conducted a community health needs assessment in 2019. The goals of the assessment were to:

- Engage public health and community stakeholders including low-income, minority and other underserved populations
- Assess and understand the community's health issues and needs
- Understand the health behaviors, risk factors and social determinants that impact health
- Identify community resources and collaborate with community partners
- Publish the Community Health Needs Assessment
- Use assessment findings to develop and implement a 2020-2022 Community Health Plan based on Central Texas Medical Center's prioritized issues

Community Health Needs Assessment Committee

In order to ensure broad community input, Central Texas Medical Center created a Community Health Needs Assessment Committee (CHNAC) to help guide the Hospital through the assessment process. The CHNAC included representation from the Hospital, public health experts, and the broad community. This included intentional representation from low-income, minority and other underserved populations.

The CHNAC met and reviewed the primary and secondary data, helped define the priority issues to be addressed by the Hospital, and helped develop the Community Health Plan to address the priority issues. *See Section 5 for a list of CHNAC members*.

Data

Central Texas Medical Center collected both primary and secondary data. The primary data included stakeholder interviews, community member focus groups and an online survey.

Secondary data sources included internal Hospital utilization data (inpatient and emergency department). This utilization data showed the top reasons for visits to Central Texas Medical Center over the past year. In addition, we utilized publicly available data from state and nationally recognized data sources. *See Section 7 for a list of data sources.*

Primary and secondary data was then compiled and analyzed in order to identify the top 6 aggregate issues from the various sources of data.

Community Asset Inventory

The next step was a Community Asset Inventory. This inventory was designed to help Central Texas Medical Center and the CHNAC to:

- Understand existing community efforts to address the six identified issues from aggregate primary and secondary data
- Prevent duplication of efforts as appropriate. *See Section 9 for the Community Asset Inventory*

Selection Criteria

Using the data findings and the Community Asset Inventory, the CHNAC narrowed the list of six issues to three priority issues. The CHNAC used a priority selection tool that uses clearly defined criteria to select the top issues to address. *See Section 10 for the Priority Selection Report.*

The priority selection criteria included:

A. Relevance: How important is this issue?
B. Impact: What will we achieve by addressing this issue?
C. Feasibility: Can we adequately address this issue?

Priority Issues to be Addressed

The priority issues to be addressed include:

1. Access to affordable healthcare
2. Healthier management of lifestyle
3. Chronic disease management

See Section 11-12 for an explanation of priority issues which were chosen as well as those not chosen.

Approvals

In October 23, 2019, the Central Texas Medical Center Board approved the Community Health Needs Assessment findings, priority issues and final report. A link to the 2019 Community Health Needs Assessment was posted on the Hospital's website as well as https://www.adventhealth.com/community-health-needs-assessments prior to December 31, 2019.

Next Steps

The CHNAC will work with Central Texas Medical Center to develop a measurable 2020-2022 Community Health Plan to address the priority issues. The plan will be completed and posted on the Hospital's website prior to May 15, 2020.

2. ABOUT CENTRAL TEXAS MEDICAL CENTER

Central Texas Medical Center is part of AdventHealth. With a sacred mission of *Extending the Healing Ministry of Christ*, AdventHealth is a connected system of care for every stage of life and health. More than 80,000 skilled and compassionate caregivers in physician practices, hospitals, outpatient clinics, skilled nursing facilities and hospice centers provide individualized, wholistic care. A Christian mission, shared vision, common values, focus on whole-person health and commitment to making communities healthier unify the system's 46 hospital campuses and hundreds of care sites in diverse markets throughout nine states.

Central Texas Medical Center, which originated in 1923 as Hays County Soldiers, Sailors and Marines Memorial Hospital, opened at its current Wonder World Drive location in 1983. The CTMC staff of more than 700 employees works with over 300 active and consulting physicians to provide quality services to patients and their families. For more than 20 consecutive years, CTMC has been named "The Best Hospital in Hays County" in the annual "Best of Hays" publication released by the San Marcos Daily Record. In addition to interventional cardiac services, CTMC is a Certified Chest Pain Center and an accredited Primary Stroke Center. CTMC leads the region in da Vinci robotic-assisted surgery and offers a variety of specialty care services including medical imaging, rehabilitation, hospice, women's services and more.

3. CHOOSING THE COMMUNITY

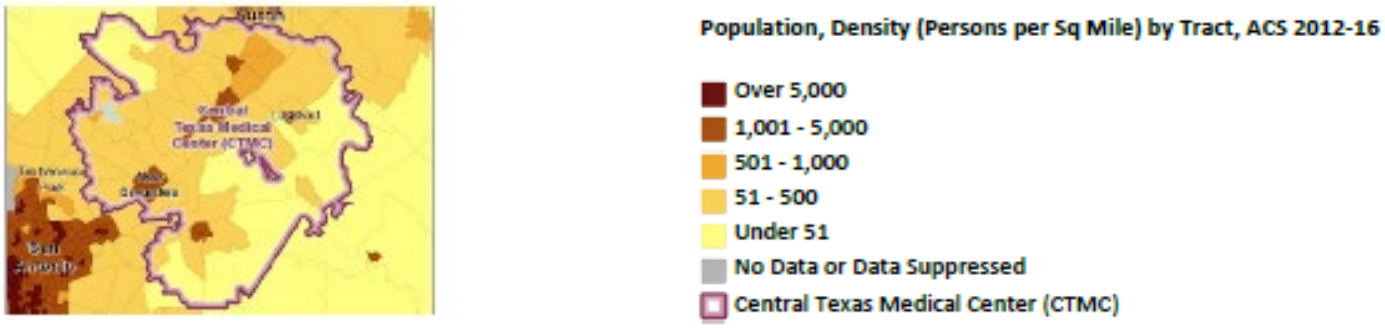
Central Texas Medical Center defined its community as its Primary Service Area (PSA) from which 75% of its patients come. This includes Hays and Caldwell counties and the zip codes 78640, 78644, 78655, 78666 and 78676.

4. COMMUNITY DESCRIPTION AND DEMOGRAPHICS

In order to understand our community and the challenges faced, Central Texas Medical Center looked at both demographic information for the service area population, as well as available data on social determinants of health. According to the Center for Disease Control and Prevention, social determinants of health include conditions in the places where people live, learn, work, and play which affect a wide range of health risks and outcomes. A snapshot of our community demographics and characteristics is included below. *Secondary report data can be found in Appendix B.*

A total of 366,191 people live in the 1,898 square mile report area defined for this assessment according to the U.S. Census Bureau American Community Survey 2012-2016 5-year estimates. The population density for this area, estimated at 192.91 persons per square mile, is greater than the national average population density of 90.19 persons per square mile.

The map below represents the service area where 75% of Central Texas Medical Center's patients come from.



Source: US Census Bureau, American Community Survey. 2013-17.

COMMUNITY DEMOGRAPHICS

Female 50.32%

Male 49.68%

AGE	0-4	5-17	18-24	25-34	35-44	45-54	55-64	65+
%	6.36%	17.4%	13.8%	13.69%	12.47%	12.19%	11.26%	12.83%

RACE	Caucasian	African-American	Asian	Native American / Alaska Native	Native Hawaiian /Pacific Islander	Other Race	Multiple Races
%	84.46%	3.96%	1.05%	0.34%	0.06%	7.66%	2.47%

ETHNICITY	Hispanic Latino	Non-Hispanic
%	40.13%	59.87%

Source: US Census Bureau, American Community Survey. 2013-17.

DATA INDICATOR	DESCRIPTION	CENTRAL TEXAS MEDICAL CENTER SERVICE AREA	TEXAS AVERAGE
Poverty[1]	% Population in Poverty (Below 100% FPL)	15.3%	16.7%
Unemployment Rate[2]	Unemployment Rate	4.7%	3.9%
Violent Crime[3]	Violent Crime Rate (Per 100,000 Pop.)	247.3	406.2
Population with No High School Diploma[1]	% Population Age 25+ with No High School Diploma	13.7%	17.65%
Insurance[4]	Uninsured Adults-% Without Medical Insurance	18.45%	22.6%
Insurance[4]	Uninsured Children-% Without Medical Insurance	9.21%	9.72%
Food Insecurity Rate[5]	Food Insecurity Rate	14.9%	17%
Population with Low Food Access[6]	% Population with Low Food Access	22.8%	27.07%
Use of Public Transportation[1]	% Population Using Public Transit for Commute to Work (Age 16+)	0.58%	1.5%
Alcohol Consumption[7]	Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	18.8%	15.8%
Tobacco Usage[7]	% Population Smoking Cigarettes (Age-Adjusted)	16.5%	16.5%

[1]US Census Bureau, American Community Survey. 2013-17. [2] US Department of Labor, Bureau of Labor Statistics. 2019 - June. [3] Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2019. [4] US Census Bureau, Small Area Health Insurance Estimates. 2016. [5] Feeding America. 2017. [6] US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2015. [7] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.

5. COMMUNITY HEALTH NEEDS ASSESSMENT COMMITTEE

A Community Health Needs Assessment Committee (CHNAC or the Committee) was formed to help Central Texas Medical Center conduct a comprehensive assessment of the community. The Committee included representation from the Hospital, public health officials and the broad community as well as representation from low-income, minority and other underserved populations. Current CHNAC members include:

Community Members

Name	Title	Organization	Description of Services	Low-Income	Minority	Other Underserved Populations
Emilio Carranco, MD	Director, Student Health	Texas State Student Health Center	Provides primary, women's and psychiatric healthcare services to university students		x	x
DerryAnn Krupinsky	Assistant Director	Women, Infants & Children (WIC)	Serves to safeguard the health of low-income pregnant, postpartum and breastfeeding women, infants and children up to age 5	x	x	x
Lydia Perez	Director	Community Action, Inc.	Provide planning, support, vision and leadership to communities in their efforts to address the needs of low-income residents	x	x	x
Jim Swisher	Deputy Chief	San Marcos – Hays County EMS	Provides 9-1-1 emergency medical response to Hays County residents	x	x	x
Dyanna Eastwood, RN	Lead District Nurse	San Marcos CISD	Supports student's success by providing healthcare through assessment, intervention and follow-up for all children within the school district	x	x	x

Amy Lowrie	Clinical Director	Scheib Mental Health	Provides mental health and mental disability services to residents in San Marcos and Hays County mainly to those without insurance and those on Medicaid	x	x	x
Debbie G. Ingalsbe	County Commissioner, Pct. 1	Hays County	Exercises broad policy-making authority. Typically, responsible for building and maintaining county roads and bridges within the precinct	x	x	x
April Harris	Manager, Hays County	CommuniCare Health Centers	Provides full-service primary healthcare to Hays County	x	x	x

Central Texas Medical Center Members

The following CTMC Team Members provided guidance and leadership throughout the CHNA process.

- **Anthony Stahl,** President/CEO, Administration
- **Catherine Amitrano**, CNO, Administration
- **Karen Morris**, Administrative Director, Ancillary Services
- **Jessica Pizana**, Director, Marketing/PR/Business Development
- **Nahum Melendez**, Chaplain, Spiritual Care
- **Kathleen Chomel**, Director, Live Oak Health Partners
- **Brian Betsworth**, Manager, Marketing/PR

6. PUBLIC HEALTH

Public health was represented throughout the Community Health Needs Assessment by participating in review of the primary and secondary data, as well as helping to prioritize data. The following public health employees provided guidance and leadership throughout the data review process.

- **Emilio Carranco, MD,** Director of Student Health, Texas State University Student Health Center - Provides primary, women's and psychiatric healthcare services to university students
- Kathleen Chomel, Director, Live Oak Health Partners Clinic- Live Oak Health Partners is a trade name for Specialty Physicians of Central Texas, Inc., a 501(c)(3) related organization to Central Texas Medical Center. Beginning January 1, 2013, the Live Oak Health Partners Community Clinic took over services at the Hays County Local Health Department.
- **DerryAnn Krupinsky,** Assistant Director, Women, Infants & Children (WIC) - Serves to safeguard the health of low-income pregnant, postpartum and breastfeeding women, infants and children up to age 5
- **Lydia Perez,** Executive Director, Community Action, Inc. - Provides planning, support, vision and leadership to communities in their efforts to address the needs of low-income residents
- **Jim Swisher,** Deputy Chief, San Marcos – Hays County EMS - Provides 9-1-1 emergency medical response to Hays County residents
- **Dyanna Eastwood,** Lead District Nurse, San Marcos CISD – Supports student's success by providing healthcare through assessment, intervention and follow-up for all children within the school district
- **Amy Lowrie,** Clinic Director, Scheib Mental Health – Provides mental health and mental disability services to residents in San Marcos and Hays County mainly to those without insurance and those on Medicaid
- **Debbie Ingalsbe,** County Commissioner, Pct. 1, Hays County - Exercises broad policy-making authority Typically, responsible for building and maintaining county roads and bridges within the precinct
- **April Harris,** Manager, CommuniCare - Provides full-service primary healthcare to Hays County

7. PRIMARY AND SECONDARY DATA SOURCES

Primary Data

a. Community online surveys
b. Stakeholder telephone interviews
c. Focus groups were conducted at the Dr. Eugene Clark Central Library, Hays County Library, WIC Program Center of Caldwell County and Hays County Community Action, Inc.

Secondary Data

a. Hospital Utilization Data: Top 10 inpatient and Emergency Department diagnoses by payer was provided by Central Texas Medical Center's Chief Financial Officer
b. The Engagement Network: Our secondary data was sourced from the Engagement Network. This is a national platform produced by the Center for Applied Research and Engagement Systems (CARES) at the University of Missouri. The Engagement Network hosts a national Map Room with 15,000+ data layers, a Community Health Needs Assessment reporting tool with 80+ health-related indicators, and a hub network with 30+ partner organizations using CARES technology.

Data Sources:

a. US Census Bureau, Decennial Census, 2000 - 2010
b. US Census Bureau, American Community Survey, 2013-2017
c. Feeding America, 2014
d. US Census Bureau, Small Area Health Insurance Estimates, 2016
e. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, US Department of Health & Human Services, Health Indicators Warehouse, 2006-2012
f. Centers for Disease Control and Prevention, National Vital Statistics System, US Department of Health & Human Services, Health Indicators Warehouse, 2006-2012
g. US Department of Labor, Bureau of Labor Statistics, 2018 – August
h. Federal Bureau of Investigation, FBI Uniform Crime Reports, 2012-2014
i. US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2015
j. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2015
k. Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Healthcare, 2015
l. US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration, April 2016
m. US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, March 2018
n. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2011-2012
o. Centers for Disease Control and Prevention, National Vital Statistics System, Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research, 2007-2010
p. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2015
q. State Cancer Profiles, 2011-2015
r. State Cancer Profiles, 2009-2013
s. Centers for Medicare and Medicaid Services, 2015
t. Centers for Disease Control and Prevention, National Vital Statistics System, US Department of Health & Human Services, Health Indicators Warehouse, 2006-2012
u. Centers for Disease Control and Prevention, National Vital Statistics System, 2012-2016

8. COMMUNITY COLLABORATION

For primary data collection, St. David's Foundation, Seton Healthcare Family and Central Texas Medical Center collaborated to conduct a Community Health Needs Assessment for Hays and Caldwell Counties. The purpose of the joint assessment is to identify and prioritize health needs so that these organizations can better serve their communities.

As part of the assessment, SHARED Strategy Group, LLC gathered input from people who represented the broad interests of Hays and Caldwell Counties and who have special knowledge of or expertise in the community's health issues. The key stakeholders included nonprofit leaders, health department authorities, public school leaders, healthcare providers or leaders, elected officials and people representing distinct geographic areas.

Consultants conducted 14 interviews and four focus groups between July through September 2018. After completing the interviews and focus groups, we administered an online survey in May 2019 to help prioritize needs previously identified in the assessment.

Funders

- **St. David's Foundation**- The St. David's Foundation reinvests proceeds from St. David's HealthCare to help build the healthiest community in the world. The Foundation helps people in every corner of the community through signature programs and collaborations with more than 60 nonprofit partners.
- **Seton Healthcare:** The Seton Healthcare Family is a faith-based nonprofit healthcare system founded in 1902 by the Daughters of Charity. Called to be a sign of God's unconditional love for all, Seton strives to expand access to high-quality, low-cost, person-centered care and services. Seton is a part of Ascension, the largest non-profit health system in the U.S. and the world's largest Catholic health system.
- **Central Texas Medical Center**- Central Texas Medical Center is a faith-based nonprofit hospital part of AdventHealth. With a sacred mission of Extending the Healing Ministry of Christ, AdventHealth is a connected system of care for every stage of life. The Central Texas Medical Center staff of more than 700 employees works with over 300 active and consulting physicians to provide quality services to patients and their families.

Other Coalition Partners

- **Texas State University Student Health Center -** Provides primary, women's and psychiatric healthcare services to university students
- **Women, Infants & Children (WIC) -** Serves to safeguard the health of low-income pregnant, postpartum and breastfeeding women, infants and children up to age 5
- **Community Action -** Provides planning, support, vision and leadership to communities in their efforts to address the needs of low-income residents
- **San Marcos – Hays County EMS -** Provides 9-1-1 emergency medical response to Hays County residents
- **San Marcos CISD -** Supports student's success by providing healthcare through assessment, intervention and follow-up for all children within the school district
- **Scheib Mental Health -** Provides mental health and mental disability services to residents in San Marcos and Hays County mainly to those without insurance and those on Medicaid
- **Hays County -** Exercises broad policy-making authority. Typically, responsible for building and maintaining county roads and bridges within the precinct
- **CommuniCare -** Provides full-service primary healthcare to Hays County

9. DATA SUMMARY

Primary and Secondary Data: High Level Findings

Once all primary and secondary data was collected, this was then analyzed and categorized into top 6 priorities per source of data. These results are listed by source in the tables below.

Primary and secondary data was presented to the CHNAC. Each Committee member received copies of the reports. The Central Texas Medical Center representative presented admission data for inpatient and the Emergency Department including diagnosis for 2018.

Top 6 Priorities determined from Community Interviews/Surveys					
1	Chronic disease management	3	Mental health services	5	Transportation
2	Access to affordable healthcare	4	Healthier management of lifestyle	6	Lack of affordable housing

Top 6 Priorities determined from Hospital Emergency Department Data					
1	Chest pain	3	Abdominal pain	5	Headache
2	Urinary tract infection	4	Respiratory disorders	6	Flu

Top 6 Priorities determined from Hospital Inpatient Admission Data					
1	Heart disease/heart failure	3	Pneumonia	5	Respiratory failure
2	Kidney failure	4	Heart attack	6	Stroke

Top 6 Priorities determined from Secondary Data provided by The Engagement Network/ Secondary Needs Assessment Tool					
1	Transportation	3	Hypertension/heart disease	5	Overweight
2	Alcohol consumption	4	Mortality suicide	6	Asthma prevalence

Primary and Secondary Data: Aggregate Community Health Needs

At the CHNAC meeting, the data was reviewed, and the Committee categorized and prioritized the issues based on importance, impact, and the ability to impact change. Groups were then asked to select their top six issues and share them with the larger group. Committee members voted on their top three priorities.

Top 6 Priorities				
	Priority Issue	Ethnic Group	Age Group	Specific Geographic Area
1	Access to affordable healthcare	All	All	Low-income population in Hays & Caldwell counties
2	Healthier management of lifestyle	All	All	Low-income population in Hays & Caldwell counties
3	Chronic disease management	All	All	Low-income population in Hays & Caldwell counties
4	Lack of affordable housing	All	All	Low-income population in Hays & Caldwell counties
5	Limited point-to-point transportation resources	All	All	Low-income population in Hays & Caldwell counties
6	Timely access to local mental health services	All	All	Low-income population in Hays & Caldwell counties

10. COMMUNITY ASSET INVENTORY

In order to help Central Texas Medical Center's CHNAC determine the community health priorities where they could make a meaningful difference, the hospital conducted a Community Asset Inventory related to the top six identified community health needs. The inventory was designed to help the CHNAC narrow the six needs to the three priority issues. Appendix C includes the full Asset Inventory.

COMMUNITY ASSET INVENTORY		
Top Issues Defined by Primary and Secondary Data	**Current Community Programs**	**Current Hospital Programs**
Access to affordable healthcare	CVS prescription drug program; CommuniCare; Community Action; Hays County Health Department Clinic; Hays/Caldwell County Indigent Programs; Integrated Medical Care Texas State Student Health Center; Women, Infants & Children (WIC)	HealthCheck screening and fair; Diabetes screenings vouchers for health screenings; Live Oak Health Partners* Community Clinic; Prescription drug program ** Live Oak Health Partners is a trade name for Specialty Physicians of Central Texas, Inc., a 501(c)(3) related organization to Central Texas Medical Center.*
Healthier management of lifestyle	Church Health Programs Farmers Markets; Hays County Food Bank; Retail fitness centers; San Marcos Community Activity Center and related programs; San Marcos and Hays County Parks Department; Take Off Pounds Sensibly (TOPS); Texas State Campus Recreation; Texas State health promotion services	Cardiac Rehabilitation Program; Annual HealthCheck Screening and Fair; Bariatric Support Group; Community Health/Fitness Events; Community Speaking Engagements; Cooking demo classes; Healthy meal options for patients and visitors; Nutritional counseling; Walking trail
Chronic disease management	Angels for Elders; CVS prescription drug program; CommuniCare; Community Action; HHC – Aged & Disability; Hays County Diabetes Coalition; Hays County Health Department Clinic; Hays/Caldwell County Indigent Programs; Integrated Medical Care; Texas State Student Health Center; Women, Infants & Children (WIC);	Annual HealthCheck Screening and Fair; CHF chronic care management program; Diabetes education; Diabetes support group; Live Oak Health Partners Community Clinic; Free blood pressure checks; Free glucose checks diabetes risk assessment; Nutritional counseling; Outpatient cardiac rehab program;
Lack of affordable housing	Chamber Housing Initiative; SMTX 4 ALL – City of San Marcos Housing Task Force; San Marcos Housing Authority; Southside Community Center; Supportive Housing	None
Limited point-to-point transportation resources	Capital Area Rural; San Marcos Transit Transportation System (CARTS)	MAP Rides – LOHP Community Clinic
Timely access to local mental health services	San Marcos CISD counseling staff; Texas State Student Health Center; San Marcos Police Officers; Schieb Mental Health Center; Wellbridge San Marcos; San Marcos Treatment Center; Mobile Crisis Outreach Team; CommuniCare Mental Health	None

11. PRIORITY SELECTION

Priority Selection using the Rating & Prioritizing Key Health Issues Worksheet

The top six issues identified from the CHNAC data review of household data, key informant survey responses, and the top inpatient and ED admissions data were reviewed and discussed again alongside the asset inventory to identify the top priorities.

Once the top 6 aggregate issues were selected, the CHNAC utilized a tool called the Rating & Prioritizing Key Health Issues Worksheet located in Appendix D to help identify which issues would be addressed.

This worksheet utilized the following criteria for each issue:

1. Relevance: How important is this issue?
2. Impact: What will we achieve by addressing this issue?
3. Feasibility: Can we adequately address this issue?

Each potential issue was rated based on the above criteria, with a scoring of 1 = lowest priority, to 4= highest priority.

Relevance How important is this issue?	**Impact** What will we achieve by addressing this issue?	**Feasibility** Can we adequately address this issue?
• Size of problem (e.g. % population) • Severity of problem (e.g. Cost to treat, lives lost) • Urgency to solve problem; community concern • Linked to other important issues	• Availability of solutions/proven strategies • Builds on or enhances current work • Significant consequences of not addressing issue now	• Availability of resources (staff, community partners, time, money) to address issue • Political capacity/will • Community/social acceptability • Appropriate socio-culturally • Can identify easy, short-term wins

Below are the six issues identified with composite scores for the participating CHNA Committee members.

Health Issue	Relevance	Impact	Feasibility	Composite Score for CHNAC
Chronic disease management	4	4	3	11
Access to affordable healthcare	4	4	3	11
Mental health services	3	3	2	8
Transportation	3	2	1	6
Lack of affordable housing	3	3	1	7
Healthier management of lifestyle	3	3	3	9

RATIONALE FOR COMMUNITY ISSUES THE HOSPITAL WILL ADDRESS		
Relevance How important is this issue?	**Impact** What will we achieve by addressing this issue?	**Feasibility** Can we adequately address this issue?
1. Chronic Disease Management		
33% of population have high blood pressure. By 2040, population diagnosed with diabetes in Hays County will increase by 343%. High cost to treat complications	Diabetes education; nutritional counseling; Live Oak Health Partners Community Clinic; diabetes support group; free glucose checks diabetes risk assessment; outpatient cardiac rehab program; free blood pressure checks; annual HealthCheck Screening and Fair; CHF chronic Increase healthcare costs and chronic disease	Community outreach team, funds Angels for Elders; Hays County Diabetes Coalition; Hays County Health Department Clinic; CVS prescription drug program; Community Action; Hays/Caldwell County Indigent Programs; CommuniCare; Women, Infants & Children (WIC); Texas State Student Health Center; Integrated Medical Care
2. Healthier management of lifestyle		
28.5% of adult population is considered obese. 15% of adult population is considered in poor general health. Estimated cost to treat complications	Walking trail; bariatric support group; cooking demo classes; community health/fitness events; community speaking engagements; healthy meal options for patients and visitors; nutritional counseling; annual HealthCheck Screening and Fair; Cardiac Rehabilitation Program Increase healthcare costs and chronic disease	Community outreach team, funds San Marcos Community Activity Center and related programs; San Marcos and Hays County Parks Department; Take Off Pounds Sensibly (TOPS); Retail fitness centers; Farmers' Markets; Hays County Food Bank; Texas State Student Health Center
3. Access to affordable healthcare		
18.5% of population is without medical insurance. 17.4% of population is below federal poverty level. Estimated cost to treat complications	Live Oak Health Partners Community Clinic Increase healthcare costs and chronic disease	Live Oak Health Partners Community Clinic Hays County Health Department Clinic; CVS prescription drug program; Community Action; Hays/Caldwell County Indigent Programs; CommuniCare; Women, Infants & Children (WIC); Texas State Student Health Center; Integrated Medical Care

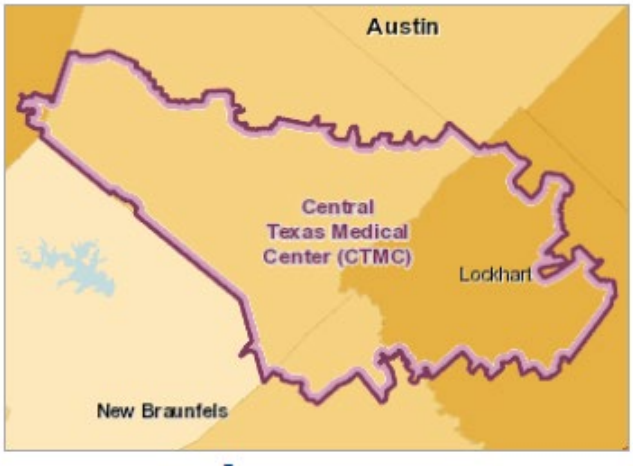
RATIONALE FOR COMMUNITY ISSUES THE HOSPITAL WILL NOT ADDRESS		
Relevance How important is this issue?	**Impact** What will we achieve by addressing this issue?	**Feasibility** Can we adequately address this issue?
1. Transportation		
Due to lack of transportation, less than 1% of population uses public transportation. As one of the fastest growing areas in the United States, strain on transportation infrastructure will continue to increase. Leads to access and health-related issues.	MAP Rides – LOHP Community Clinic Increase healthcare costs and chronic disease	The hospital does not have the resources for this priority. Capital Area Rural Transportation System (CARTS); San Marcos Transit;
2. Lack of affordable housing		
19% of households have severe housing problems. 14.5% of households spend 50% or more of their income on housing Affordable housing would allow income to be dedicated to healthcare.	The hospital does not have solutions for this priority. Increase healthcare costs and chronic disease	The hospital does not have the resources for this priority. SMTX 4 ALL – City of San Marcos Housing Task Force; Chamber Housing Initiative; Southside Community Center; San Marcos Housing Authority; Supportive Housing
3. Mental health services		
Per 100,000 population, the death rate is 14 due to suicide. 19% of population drinks excessively	The hospital does not have solutions for this priority. Increase healthcare costs and chronic disease	The hospital does not have the resources for this priority. San Marcos CISD counseling staff; Mental health office at Texas State Student Center; San Marcos Police Officers; Schieb Mental Health Center; Wellbridge San Marcos; San Marcos Treatment Center; Mobile Crisis Outreach Team

12. PRIORITY ISSUES TO BE ADDRESSED

ISSUE 1: ACCESS TO AFFORDABLE HEALTHCARE

Central Texas Medical Center recognizes the importance of removing cost as a prohibitive factor for community members accessing necessary care. Collaboration with community partners will be vital to the success of addressing this issue. Currently, 18.5% of the Hospital's primary service area lacks medical insurance according to the American Community Survey.

Uninsured Adults

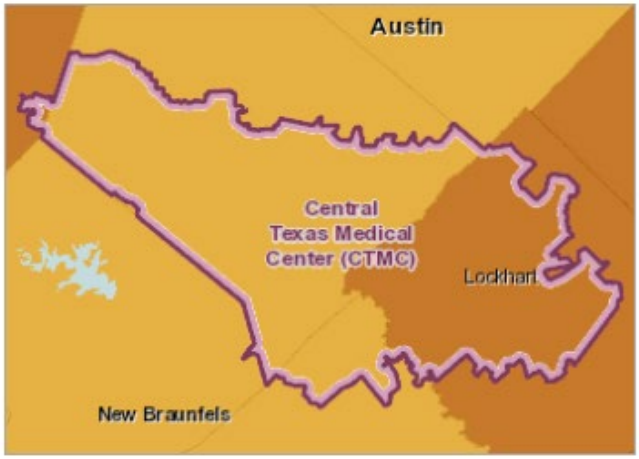


Uninsured Population, Age 18-64, Percent by County, SAHIE 2016

- Over 27.0%
- 22.1 - 27.0%
- 17.1 - 22.0%
- Under 17.1%
- No Data or Data Suppressed

Source: US Census Bureau, Small Area Health Insurance Estimates. 2016

Uninsured Children



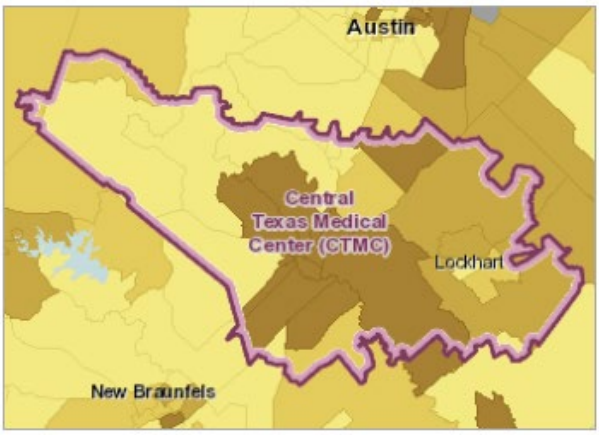
Uninsured Population, Age 0-18, Percent by County, SAHIE 2016

- Over 10.0%
- 8.1 - 10.0%
- 6.1 - 8.0%
- Under 6.1%
- No Data or Data Suppressed

Source: US Census Bureau, Small Area Health Insurance Estimates. 2016

Poverty

Poverty is an additional determining factor of affordability of healthcare. According to the US Census Bureau, 17.4% of the PSA is currently living below the federal poverty level. Healthcare is especially difficult to access for the population over 65 years of age. Key informant surveys vocalized the challenges faced by this population who is struggling to afford services, and avoiding doctor visits due to this barrier, which leads to worsening of health conditions.



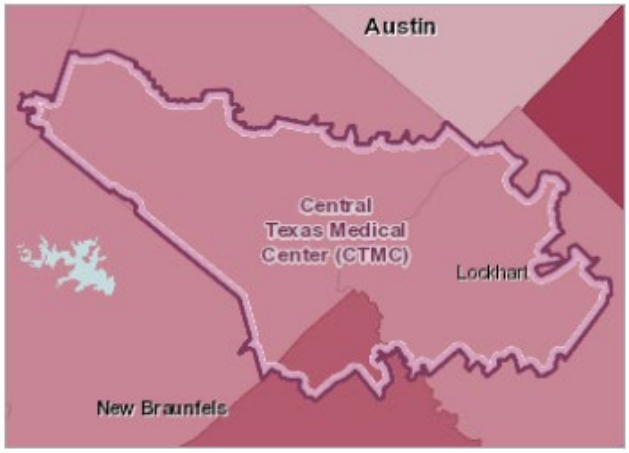
Source: US Census Bureau, Small Area Health Insurance Estimates. 2016

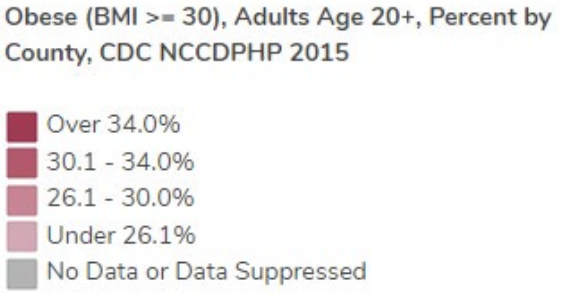
ISSUE 2: HEALTHIER MANAGEMENT OF LIFESTYLE

Both primary and secondary data showed a need to support healthier management of lifestyle for CTMC community members.

Obesity

According to the US Census Bureau, American Community Survey 2013-2017 28.5% of the adult population in Central Texas Medical Center's PSA is considered obese. This leads to increased risk for chronic disease, and poor overall health.





Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2015.

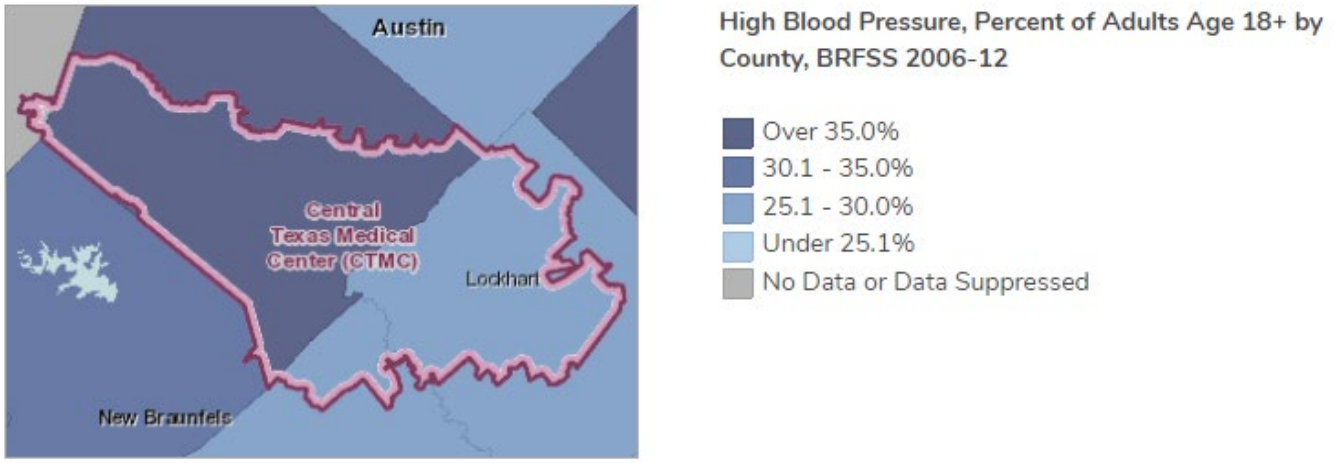
The survey also identified 15% of the adult population as considered to be in poor general health.
CTMC recognizes that investing resources into healthier management of lifestyle will help to also address additional issues such as chronic disease and mental health.

ISSUE 3: CHRONIC DISEASE MANAGEMENT

In addition to prevention, there is a large subset of the population already living and experiencing the effects of chronic disease.

High Blood Pressure

The American Community Survey identified 33% of the population has currently being diagnosed with high blood pressure.



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.

Diabetes

According to the Texas Health Institute, the population diagnosed with diabetes in Hay County will increase by 343% without intervention. Both chronic diseases lead to lower quality of life and higher costs for healthcare.

13. PRIORITY ISSUES THAT WILL NOT BE ADDRESSED

ISSUE 1: TRANSPORTATION

Both secondary data and community interviews/surveys identified transportation as a barrier to care and an issue for the community. CTMC participates in community initiatives to address this barrier already. The CHNAC agreed that this issue was not feasible for CTMC to identify as a priority while still acknowledging the importance of removing the barrier of transportation to accessing healthcare.

ISSUE 2: LACK OF AFFORDABLE HOUSING

Lack of affordable housing was identified in community interviews and surveys as an area of concern for the community. After discussion within the CHNAC, it was decided that the CTMC lacked the resources to best address this issue. Several initiatives were identified through the Community Asset Inventory which are already working to address this issue including city leadership-led efforts.

ISSUE 3: MENTAL HEALTH SERVICES

Secondary data and community interviews/surveys identified mental health services as an important issue to address. CTMC doesn't have existing programs to address this issue. The Community Asset Inventory identified several community initiatives which already exist. CTMC will continue to refer community members to these programs.

14. NEXT STEPS

The CHNAC will work with Central Texas Medical Center and other community partners to develop a measurable Community Health Plan for 2020-2022 to address the priority issues. For each priority, specific goals will be developed including measurable outcomes, intervention strategies and the resources necessary for successful implementation.

Evidence-based strategies will be reviewed to determine the most impactful and effective interventions. For each goal, a review of policies that can support or deter progress will be completed with consideration of opportunities to make an impact. The plan will be reviewed quarterly with an annual assessment of progress. A presentation of progress on the plan will also be presented to the Hospital board annually.

A link to the Community Health Plan will be posted on AdventHealth.com prior to May 15, 2020.

15. WRITTEN COMMENTS REGARDING 2016 NEEDS ASSESSMENT

We posted a link to the most recently conducted CHNA and most recently adopted implementation strategy 2016 on our Hospital website as well as AdventHealth.com prior to May 15, 2017 and have not received any written comments.

16. REVIEW OF STRATEGIES UNDERTAKEN IN THE 2017 COMMUNITY HEALTH PLAN

The 2016 Central Texas Medical Center Community Health Needs Assessment was posted on Central Texas Medical Center's website. Since the completion of the 2016 CHNA, Central Texas Medical Center has transitioned to AdventHealth. The CHNA now appears on AdventHealth's website.

Activities and accomplishments from Central Texas Medical Center's Implementation Plan include the following:

Priority 1: Increase access to Primary Care

2016 Description of the Issue: In Hays and Caldwell counties, low-income, uninsured adult residents have limited or few options for accessing primary care services. When healthcare is inaccessible, many individuals are forced to forego care or delay care which can lead to avoidable complications, or overutilization care via hospital emergency departments (ED). This places a significant burden on hospital emergency departments within the counties. Patients that are medically screened and treated in an ED setting likely struggle with uncoordinated care and may not have the resources or funding to follow discharge instructions including access to prescriptions and appropriate follow up care. Our secondary data showed that Hays County had a significantly lower ratio of primary care physicians per 100,000 population (46.7) than the state of Texas (58.5) and the United States (74.5). As a result, access to primary care is challenging, especially for low-income residents.

Accomplishments:

Strategy 1: Recruit healthcare professionals and expand access at the Live Oak Health Partners Clinic

- Recruited one nurse practitioner for the Live Oak Health Partners clinic
- Expanded access at the Live Oak Health Partners clinic
- Increased Relative Value Units (RVU) in primary care by 4,573 from 2017 to 2018
- Trained clinics on redesigned physician schedules templates in order to create more bandwidth
- Shortened visits from 30- or 60- minute to 20- minute time slots, making it easier to schedule patients
- Standardized scheduling rules across all primary care clinics

Strategy 2: Increase use of clinic services and increase capacity of Live Oak Health Partners Clinic

- Provided ongoing community outreach activities to increase awareness of clinic services
- In 2018, the clinic exceeded their goal of 5,100 patient encounters by 7,889

Strategy 3: Increase number of patients declaring Live Oak Health Partner's Walk-in Clinic as their primary care provider

- In 2018, there were 1,213 new patients whom established care with the clinic which surpassed the goal of 300 new patients

Strategy 4: Improve access to those with limited mobility or lack of transportation with Texas State University

- In partnership with Texas State University, the clinic created a program to have students drop off patients for medical appointments. Program is slowly building as there has been a decrease of patients requesting transportation in the past year.

Priority 2: Healthier Management of Lifestyle

2016 Description of the Issue: Hays and Caldwell Counties exceed the averages for a number of key health indicators—most notably the lack of physical activity. In our primary service area, 23 percent of adults aged 20 and older self-report no leisure time for activity, based on the question "during the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?" This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues such as obesity and poor cardiovascular health.

Accomplishments:

Strategy 1: Develop programs built on the AdventHealth CREATION Health principles to promote the ideals of healthy living

- In 2018, clinic hosted eight CREATION Health classes which surpassed the goal of hosting five classes for the year

Strategy 2: Increase participation in Central Texas Medical Center's CREATION Health Fitness Day which is offered free for the community

- In 2018, they exceeded their goal to assist 450 attendees to 460 attendees

Strategy 3: to provide low income residents access to health screenings to provide a baseline for making healthier lifestyle choices

- In 2018, the goal was to distribute 325 vouchers and have 60 vouchers redeemed and the goal was exceeded with a total of 450 vouchers distributed and 124 redeemed

Priority 3: Management of Heart Disease/Congestive Heart Failure (CHF) and Related Conditions

2016 Description of the Issue: Within the report area, the rate of death due to coronary heart disease per 100,000 population is 167.25. In Caldwell County, it is 186.7 as compared to the state number of 175.7 and the national rate of 175. This indicator is relevant because heart disease is a leading cause of death in the United States. These statistics are especially revealing as many patients with cardiovascular disease generally have multiple chronic diseases including diabetes.

Accomplishments:

Strategy 1: Increase capacity of outpatient cardiac rehabilitation and provide services to un/underinsured patients

- The cardiac rehabilitation department was able to exceed their goal to provide services to at least five patients by extending it to nine patients and had one patient accept services.

Strategy 2: Offer free blood pressure screenings at Central Texas Medical Center and throughout the community with education on hypertension and heart disease

- In 2018, the goal for 2018 was to provide 425 blood pressure screenings and provided 520 blood pressure screenings.

Strategy 3: Collaborate with local organizations to distribute vouchers for free carotid artery and peripheral arterial disease screenings, including education

- In 2018, the goal was to distribute 20 carotid artery vouchers and 20 peripheral arterial disease vouchers. This goal was exceeded by distributing 25 carotid artery vouchers and 25 peripheral arterial disease vouchers.

Priority 4: Management of Diabetes

2016 Description of the Issue: It is projected that by 2040, 23.8 percent of Texans will have diabetes; 23.1 percent or 112,455 of Hays County residents and 25.2 percent or 12,436 of Caldwell County residents will be diagnosed with the disease. Research highlights that medical expenditures for people with diabetes is about 2.3 times higher than medical expenditures for those who are not diabetic. Expected population growth over the next several years is expected to exacerbate the prevalence of diabetes and associated complications, and consequently, the need for healthcare services and access to healthcare providers.

Accomplishments:

Strategy 1: To increase awareness and early detection of diabetes by offering free monthly blood glucose screenings and diabetes risk assessments based on American Diabetes Association guidelines

- In 2018, the goal was to average 54 blood glucose screenings and risk assessments and this goal was exceeded by averaging 73 per month.

Strategy 2: To provide all diabetes education class participants with up to four individualized follow-up visits with a Diabetes Educator focusing on lifestyle changes (over a 12-month period)

- In 2018, the goal was to have at least 43.8 percent of diabetes education participants receiving at least 2 follow-up visits over a 12-month period and this goal was exceeded by having 52 percent of diabetes education participants receiving at least 2 follow-up visits over a 12-month period.

Strategy 3: To provide individuals diagnosed with diabetes and their family members ongoing opportunities for education, accountability and encouragement to adopt and maintain successful diabetes management and control

- Began hosting a diabetes support group biweekly with an average attendance of eight attendees throughout the year

Priority 5: Education

2016 Description of the Issue: According to participants in the primary data collection phase, a lack of education and economic inequalities lead to poor lifestyle decisions such as unhealthy diets and a lack of exercise. Diabetes is a significant health problem partly due to lack of access to healthy foods and lack of knowledge about healthy eating. Many health problems are exacerbated by the challenges of finding providers, navigating the healthcare system and managing medication. Assessment participants stressed the need for community-based strategies and interventions at early ages that promote healthy behaviors.

Accomplishments:

Strategy 1: Improved management of hospitalized un/underinsured patients in an outpatient/home setting

- Central Texas Medical Center was able to provide 56 percent of un/underinsured patients a referral to a medical home prior to discharge from the facility. We will continue to strive towards the goal of 80% of un/underinsured patients receiving referrals prior to discharge.

Strategy 2: To establish a Patient Family Advisory Council (PFAC) that will advocate for community resources based on their experience with Central Texas Medical Center, Live Oak Health Partners and other associated clinics

- The 2018 goal was for PFAC members to develop an action plan that will address at least two identified Central Texas Medical Center and community needs. PFAC exceeded this goal by identifying 3 needs and executing initiatives addressing these needs.

Strategy 3: To develop support groups for individuals facing cancer, especially for our Spanish speaking population

- The 2018 goal was to provide 12 support group meetings but due to hiring the navigator in November 2018, we did not meet this goal. Moving forward, Central Texas Medical Center will work closely with the navigator to provide cancer-related support groups in 2019

Priority 6: Management of Mental and Behavioral Health

2016 Description of the Issue: Hays County specifically has a mental health shortage with 86 providers per 100,000 population as compared to the state average of 96.7 and the national average of 189. The county, hospital emergency rooms, police department and school counselors often must respond to crises. There are very few mental and behavioral healthcare resources aimed at serving the mental health needs of the community, especially children, before emergencies develop. Assessment participants raised concerns about residents with very serious mental health problems who often require extensive treatment and case management.

Accomplishments:

Strategy 1: To develop a cross-functional community committee including law enforcement, Central Texas Medical Center, Texas State University, Live Oak Health Partners and local mental health providers

- The 2018 goal was to provide two meetings and the facility exceeded with a total of seven meetings being held.

Strategy 2: To provide family members ongoing opportunities for education and encouragement

- In 2018, CTMC provided two support groups to help families with a loved one with mental/behavioral challenges and will continue services in 2019.

Strategy 3: To offer free, educational presentations at local churches, businesses, civic groups, etc.

- Central Texas Medical Center hosted four presentations in 2018 and will continue in the following years.

APPENDIX A: PRIMARY DATA SURVEY & PRIMARY DATA RESULTS

Primary Data: Community Survey Questions

Audience: All

Please take a few minutes to fill out this survey to help Central Texas Medical Center identify and understand our current community health and how our organization can help provide resources needed to create a healthier community.

1. What county do you reside in?
2. How long have you lived in the community?
3. What would you say are the positive things that make your community unique? (for example, people feel connected, sidewalks, clean streets, people talking to each other, churches)
4. What would you say are the top two challenges your community faces?
5. What are the two most critical health problems in your community? Think about what concerns you about your community.
6. How has your community changed in the past five years?
7. How would you best describe your community's health and the ways your community helps people be healthy?
8. Do you consider your community a good place to raise a family?
9. How would you describe decision making in your community? Do you feel there are opportunities to be involved in decision making for what happens in your community?
10. Is it easy to get appointments to see the doctor or to access healthcare?
11. If I am new to the community, how do I know where to go to get the services I need? Where do people get information?
12. Do you have access to the needed quality health or social services in your community?
13. Think about how you described your community's health. What do you think are the reasons or causes?
14. What do you think are the causes or reasons for the community challenges you mentioned?
15. What are some of your suggestions to improve the health in your community? What would make it easier for you to stay healthy?
16. What would you have to see or experience in order to feel like positive changes are happening in your community?
17. What two priorities should decision makers focus on first that would have the greatest impact on improving the lives of people in the community?

SOCIAL DETERMINANT QUESTIONS

Questions 1-11 will help Central Texas Medical Center understand what challenges are faced beyond the hospital walls. Please indicate your answer by checking the correct box for each statement. ☑

Within the past 12 months, we worried whether our food would run out before we got money to buy more.	☐ Yes	☐ No
Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.	☐ Yes	☐ No
Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household?	☐ Yes	☐ No

In the past 12 months, has your utility company shut off your service for not paying your bills?	☐ Yes	☐ No	
In the past 12 months, was there a time you needed to see a doctor but could not because of cost?	☐ Yes	☐ No	
In the past 12 months, have you ever had to go without healthcare because you didn't have a way to get there?	☐ No	☐ No	
Are you afraid you might be hurt in your apartment building or house?	☐ No	☐ No	
Do problems getting child care make it difficult for you to work or study?	☐ No	☐ No ☐ N/A	
For questions 9-11, please check the box which reflects your experience the most.	1= Hardly ever	2= Some of the time	3= Often
How often do you feel that you lack companionship?	☐ 1	☐ 2	☐ 3
How often do you feel left out?	☐ 1	☐ 2	☐ 3
How often do you feel isolated from others?	☐ 1	☐ 2	☐ 3

DEMOGRAPHIC INFORMATION

Zip Code		
Languages Spoken	☐ English ☐ Spanish	☐ Creole ☐ Other:
Current Benefits Received	☐ Free/Reduced Lunch ☐ Medicaid ☐ Housing Assistance ☐ WIC	☐ SNAP ☐ Medicare ☐ Childcare Assistance ☐ Other:
Household Size		
Household Annual Income	☐ Less than $25,000 ☐ $25,000-$34,999 ☐ $35,000-$49,999 ☐ $50,000-$74,999	☐ $75,000-$99,999 ☐ $100,000-$149,999 ☐ $150,000-$199,000 ☐ $200,000 or more
Health Insurance Status	☐ Insured ☐ Uninsured	☐ Partially Insured
Employment Status	☐ Full-Time ☐ Part-Time ☐ Multiple Jobs	☐ Unemployed ☐ Full time-student
Marital Status	☐ Single (never married) ☐ Married ☐ Separated	☐ Divorced ☐ Widowed
Gender	☐ Female	☐ Male
Highest Education Level	☐ Some High School ☐ High School Graduate ☐ Some College ☐ Associate Degree	☐ Bachelor's Degree ☐ Graduate Degree ☐ Other:

Age	☐ 18-24 years ☐ 25-34 years ☐ 35-44 years	☐ 45-54 years ☐ 55-64 years ☐ 65 years or older
Ethnicity	☐ Hispanic	☐ Non-Hispanic
Race	☐ White ☐ African-American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander	☐ Asian ☐ Multiple Races ☐ Other

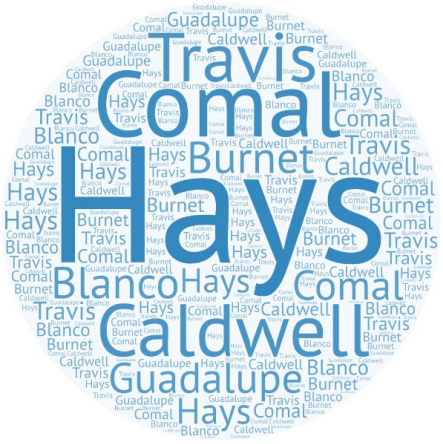
Primary Data: Community Survey Results

Community surveys were administered by the following and aggregate results are shown below.

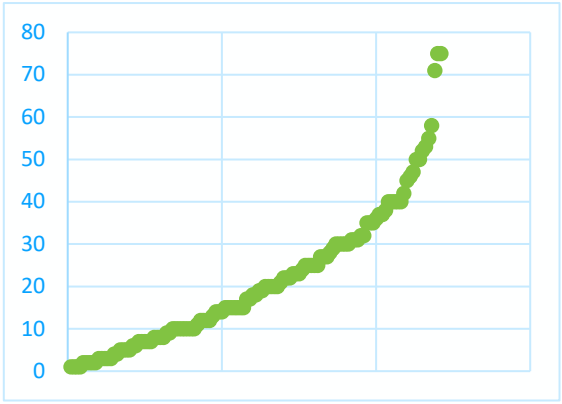
- 122 Online surveys
- 4 Focus groups

COMMUNITY SURVEY RESULTS

1. What County do you reside in?



2. How long have you lived in the community?



3. What would you say are the positive things that make your community unique?

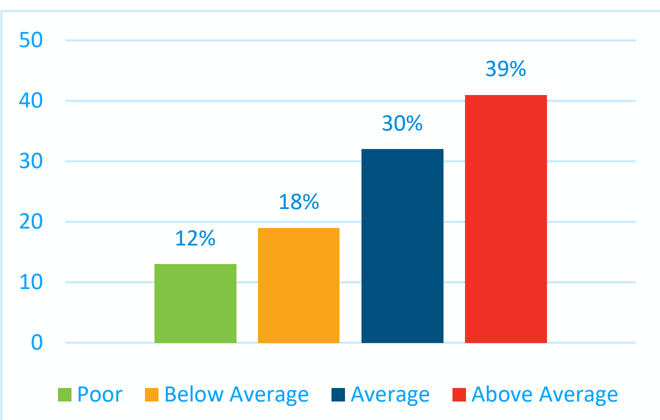
(e.g. people feel connected, sidewalks, clean streets, people talking to each other, churches)

4. What would you say are the top two challenges your community faces?

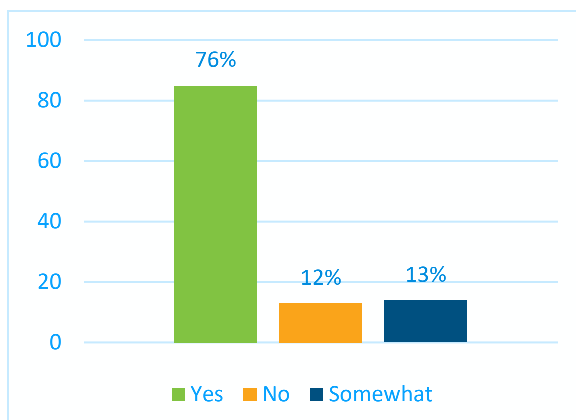
5. What are the two most critical health problems in your community? *Think about what concerns you have about your community*

6. How has your community changed in the past five years?

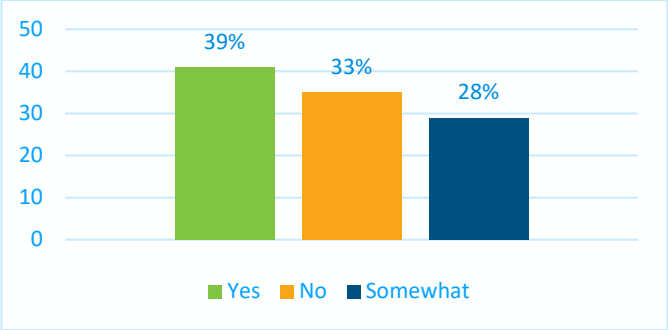
7. How would you describe your community's health and the ways your community helps people be healthy?



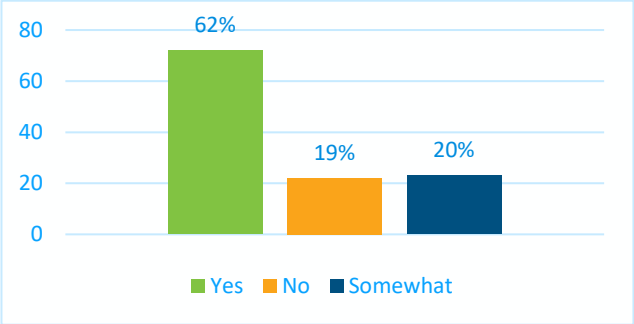
8. Do you consider your community a good place to raise a family?



9. How would you describe decision making in your community? Do you feel there are opportunities to be involved in your community?

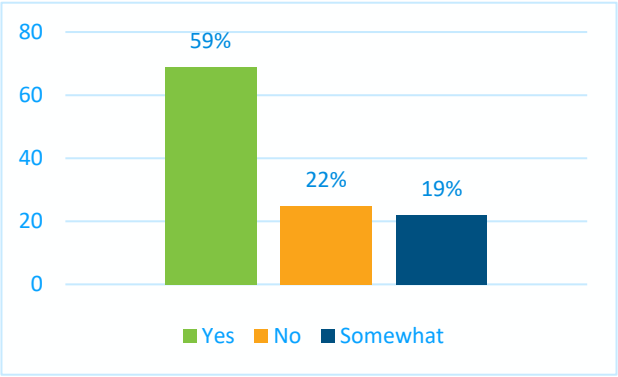


10. Is it easy to get appointments to see the doctor or to access healthcare?



11. If I am new to the community, how do I know where to go to get the services I need? Where do people get information?

12. Do you have access to the needed quality health or social services in your community?



13. Think about how you described your community's health. What do you think are the reasons or causes?

14. What do you think are the causes or reasons for the community challenges you mentioned?

15. What are some of your suggestions to improve the health in your community? What would make it easier for you to stay healthy?

16. What would you have to see or experience in order to feel like positive changes are happening in your community?

17. What two priorities should decision makers focus on first that would have the greatest impact on improving the lives of people in the community?

SURVEY QUESTION	SURVEY RESULTS	
Social Determinant Questions		
Within the past 12 months, we worried whether our food would run out before we got money to buy more.	14% Yes	86% No
Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.	11% Yes	89% No
Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household?	13% Yes	87% No
In the past 12 months, has your utility company shut off your service for not paying your bills?	6% Yes	94% No
In the past 12 months, was there a time you needed to see a doctor but could not because of cost?	28% Yes	72% No
In the past 12 months, have you ever had to go without healthcare because you didn't have a way to get there?	10% Yes	90% No
Are you afraid you might be hurt in your apartment building or house?	10% Yes	90% No
Do problems getting child care make it difficult for you to work or study?	12% Yes	18% No 70% N/A
How often do you feel that you lack companionship?	77% Hardly ever 18% Some of the time 5% Often	
How often do you feel left out?	73% Hardly ever 24% Some of the time 3% Often	
How often do you feel isolated from others?	72% Hardly ever 23% Some of the time 5% Often	

Primary Data: Stakeholder Interview Questions & Results

Interviews were administered to 14 stakeholders with the following aggregate results.

STAKEHOLDER INTERVIEW QUESTIONS & RESULTS

1. **How would you rate the current health status of this community and what are the factors you considered?**

2. **What are the BARRIERS to good health in this community?**

3. **What is the number one barrier to good healthcare in the community?**

4. **What are the top health needs of this community, and what concerns you most about the health of the community the hospital services?**

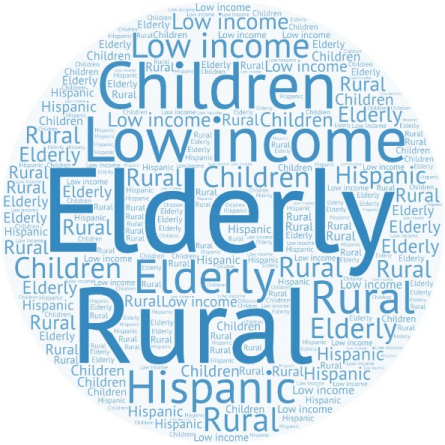
5. **What are the largest unmet needs and the gaps in healthcare services?**

6. **Is preventative care available in this community and do you think people are using those services?**

7. **What are the vulnerable groups/populations we should pay special attention to that might otherwise be overlooked in this health community, including leading social factors?**

8. **Where are there gaps in the mental/behavioral health services continuum?**

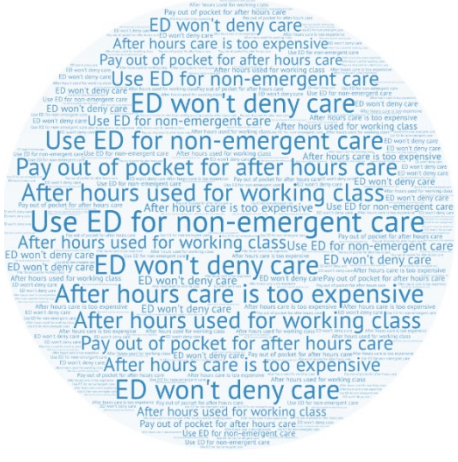
9. What specific populations need intervention most?



10. What are the ways that health system organizations (e.g. health departments, community clinics, and hospitals) can engage with existing groups in the community to address behavioral health issues, including faith-based organizations?

11. How do community residents access their health information?

12. Are there residents in the community that use the ED for non-emergent care? Are there after hour clinics, and are they utilized? If not, why?



13. What are the OPPORTUNITIES to improve health in this community?

14. How can health system organizations be active partners with you and your organizations, or what system changes need to take place to make health system organizations work together?

-

15. What are some examples of innovative collaborative models at the local, state, and/or national levels?

16. Are community-based (church, recreation center or school-based) clinics a potential solution for accessible care?

17. Are any community-based organizations that exist to address, alone or in partnership, the needs we discussed?

APPENDIX B: SECONDARY DATA REPORT

Central Texas Medical Center
Needs Assessment Report - Quick Facts

Location
Central Texas Medical Center (CTMC) (Service Area)

Demographics

Data Indicator	Indicator Variable	Location Summary	State Average
Population Age 65+	Total Population	366,192	26,956,435
	Population Age 65+	46,986	3,096,567
	Percent Population Age 65+	12.83%	11.49%
Population Age 0-18	Total Population	366,192	26,956,435
	Population Age 0-17	87,014	7,132,476
	Percent Population Age 0-17	23.76%	26.46%
Population Age 18-64	Total Population	366,192	26,956,435
	Population Age 18-64	232,192	16,727,392
	Percent Population Age 18-64	63.41%	62.05%
Total Population	Total Population	366,191	26,956,435
	Total Land Area (Square Miles)	1,898	261,249.64
	Population Density (Per Square Mile)	192.91	103.18
Change in Total Population	Total Population, 2000 Census	232,935	20,851,666
	Total Population, 2010 Census	322,060	25,145,561
	Total Population Change, 2000-2010	89,125	4,293,895
	Percent Population Change, 2000-2010	38.26%	20.59%
Female Population	Total Population	366,192	26,956,435
	Female Population	184,278	13,577,270

	Percent Female Population	50.32%	50.37%
Hispanic Population	Total Population	366,191	26,956,435
	Non-Hispanic Population	219,228	16,543,285
	Percent Population Non-Hispanic	59.87%	61.37%
	Hispanic or Latino Population	146,963	10,413,150
	Percent Population Hispanic or Latino	40.13%	38.63%
Male Population	Total Population	366,192	26,956,435
	Male Population	181,914	13,379,165
	Percent Male Population	49.68%	49.63%

Social & Economic Factors

Data Indicator	Indicator Variable	Location Summary	State Average
Violent Crime	Total Population	350,037	26,411,971
	Violent Crimes	866	107,267
	Violent Crime Rate (Per 100,000 Pop.)	**247.3**	406.2
Population with No High School Diploma	Total Population Age 25+	228,637	17,085,128
	Population Age 25+ with No High School Diploma	31,241	3,015,952
	Percent Population Age 25+ with No High School Diploma	**13.7%**	17.65%
Poverty - Population Below 100% FPL	Total Population	353,989.39	26,334,005
	Population in Poverty	54,316.82	4,397,307
	Percent Population in Poverty	**15.3%**	16.7%
Insurance - Uninsured Adults	Total Population Age 18 - 64	241,525	16,743,634
	Population with Medical Insurance	196,962	12,959,711
	Percent Population with Medical Insurance	81.5%	77.4%
	Population Without Medical Insurance	44,563	3,783,923
	Percent Population Without Medical Insurance	**18.45%**	22.6%
Insurance - Uninsured	Total Population Under Age 19	98,347	7,559,241

Children	Population with Medical Insurance	89,286	6,824,162
	Percent Population with Medical Insurance	90.8%	90.28%
	Population Without Medical Insurance	9,061	735,079
	Percent Population Without Medical Insurance	**9.21%**	9.72%
Income - Per Capita Income	Total Population	366,192	26,956,435
	Total Income ($)	$9,552,452,305.00	$750,156,282,800.00
	Per Capita Income ($)	**$26,086.00**	$27,828.00
Unemployment Rate	Labor Force	179,870	13,751,850
	Number Employed	171,379	13,212,441
	Number Unemployed	8,491	539,409
	Unemployment Rate	**4.7%**	3.9%
Lack of Social or Emotional Support	Total Population Age 18+	235,099	17,999,726
	Estimated Population Without Adequate Social / Emotional Support	40,338	4,139,937
	Crude Percentage	19.4%	23%
	Age-Adjusted Percentage	**18.7%**	23.1%
Teen Births	Female Population Age 15 - 19	12,943	914,438
	Births to Mothers Age 15 - 19	478	50,294
	Teen Birth Rate (Per 1,000 Population)	**36.97**	55
Food Insecurity Rate	Total Population	333,414	26,956,958
	Food Insecure Population, Total	49,703	4,578,670
	Food Insecurity Rate	**14.9%**	17%
Poverty - Children Below 100% FPL	Total Population	353,989	26,334,005
	Population Under Age 18	85,672	7,048,643
	Population Under Age 18 in Poverty	16,079	1,685,859
	Percent Population Under Age 18 in Poverty	**18.77%**	23.92%

Physical Environment

Data Indicator	Indicator Variable	Location Summary	State Average
Use of Public Transportation	Total Population Employed Age 16+	172,787	12,237,558
	Population Using Public Transit for Commute to Work	1,000	188,919
	Percent Population Using Public Transit for Commute to Work	**0.58%**	1.5%
Population with Low Food Access	Total Population	322,059	25,145,561
	Population with Low Food Access	73,444	6,807,728
	Percent Population with Low Food Access	**22.8%**	27.07%

Clinical Care

Data Indicator	Indicator Variable	Location Summary	State Average
Access to Dentists	Total Population, 2015	381,910	27,469,114
	Dentists, 2015	150	14,857
	Dentists, Rate per 100,000 Pop.	**39.3**	54.1
Cancer Screening - Sigmoidoscopy or Colonoscopy	Total Population Age 50+	70,759	5,055,051
	Estimated Population Ever Screened for Colon Cancer	38,456	3,058,306
	Crude Percentage	61.5%	60.5%
	Age-Adjusted Percentage	**55.3%**	57.3%
Cancer Screening - Mammogram	Total Medicare Enrollees	31,644	1,777,117
	Female Medicare Enrollees Age 67-69	3,289	172,456
	Female Medicare Enrollees with Mammogram in Past 2 Years	1,935	101,099
	Percent Female Medicare Enrollees with Mammogram in Past 2 Year	**58.8%**	58.6%
Cancer Screening - Pap Test	Female Population Age 18+	192,418	13,387,716
	Estimated Number with Regular Pap Test	135,450	10,188,052
	Crude Percentage	78%	76.1%
	Age-Adjusted Percentage	**77.4%**	76%
Facilities Designated as	Primary Care Facilities	1	181

Health Professional Shortage Areas	Mental Healthcare Facilities	1	147
	Dental Healthcare Facilities	1	150
	Total HPSA Facility Designations	3	478
Lack of Prenatal Care	Total Births	132.35	1,601,274
	Mothers Starting Prenatal Care in First Semester	83.73	947,636
	Mothers with Late or No Prenatal Care	48.25	632,269
	Prenatal Care Not Reported	0.37	21,369
	Percentage Mothers with Late or No Prenatal Care	**36.5%**	39.5%
Federally Qualified Health Centers	Total Population	249,043	25,145,561
	Number of Federally Qualified Health Centers	10	461
	Rate of Federally Qualified Health Centers per 100,000 Population	**4.02**	1.83
Lack of a Consistent Source of Primary Care	Survey Population (Adults Age 18+)	241,825	18,375,873
	Total Adults Without Any Regular Doctor	53,029	5,946,509
	Percent Adults Without Any Regular Doctor	**21.9%**	32.36%
Preventable Hospital Events	Total Medicare Part A Enrollees	25,708	1,497,805
	Ambulatory Care Sensitive Condition Hospital Discharges	11,908	79,741
	Ambulatory Care Sensitive Condition Discharge Rate	**46.3**	53.2

Health Behaviors

Data Indicator	Indicator Variable	Location Summary	State Average
Alcohol Consumption	Total Population Age 18+	235,099	17,999,726
	Estimated Adults Drinking Excessively	39,135	2,879,956
	Estimated Adults Drinking Excessively (Crude Percentage)	18.8%	16%
	Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	**18.8%**	15.8%
Physical Inactivity	Total Population Age 20+	277,358	19,469,060

	Population with no Leisure Time Physical Activity	56,156	4,435,423
	Percent Population with no Leisure Time Physical Activity	**20%**	22.7%
Tobacco Usage - Current Smokers	Total Population Age 18+	235,099.25	17,999,726
	Total Adults Regularly Smoking Cigarettes	34,173.07	3,005,954
	Percent Population Smoking Cigarettes (Crude)	16.4%	16.7%
	Percent Population Smoking Cigarettes (Age-Adjusted)	**16.5%**	16.5%

Health Outcomes

Data Indicator	Indicator Variable	Location Summary	State Average
Mortality - Lung Disease	Total Population	368,057	26,959,213
	Average Annual Deaths, 2007-2011	123	9,866
	Crude Death Rate (Per 100,000 Pop.)	33.5	36.6
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**34.8**	41.22
Mortality - Unintentional Injury	Total Population	368,057	26,959,213
	Average Annual Deaths, 2010-2014	133	9,789
	Crude Death Rate (Per 100,000 Pop.)	36.09	36.31
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**37.56**	37.57
Mortality - Heart Disease	Total Population	368,057	26,959,213
	Average Annual Deaths, 2010-2014	536	41,563
	Crude Death Rate (Per 100,000 Pop.)	145.56	154.17
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**152.25**	170.21
High Blood Pressure (Adult)	Total Population (Age 18+)	235,099	17,999,726
	Total Adults with High Blood Pressure	77,466	5,399,918
	Percent Adults with High Blood Pressure	**32.97%**	30%
Cancer Incidence - Lung	Estimated Total Population	35,686	2,474,387
	New Cases (Annual Average)	183	13,139

	Cancer Incidence Rate (Per 100,000 Pop.)	**51.5**	53.1
Mortality - Premature Death	Total Population	322,059	77,051,527
	Total Premature Death, 2014-2016	1,013	283,124
	Total Years of Potential Life Lost,2014-2016 Average	17,665	5,154,456
	Years of Potential Life Lost, Rate per 100,000 Population	**5,485**	6,690
Cancer Incidence - Prostate	Estimated Total Population (Male)	18,295	1,212,997
	New Cases (Annual Average)	139	11,572
	Cancer Incidence Rate (Per 100,000 Pop.)	**76.3**	95.4
Cancer Incidence - Breast	Estimated Total Population (Female)	19,172	1,365,890
	New Cases (Annual Average)	221	15,257
	Cancer Incidence Rate (Per 100,000 Pop.)	**115.4**	111.7
	Estimated Total Population (Female)	**14,313**	1,263,043
Cancer Incidence - Cervix	New Cases (Annual Average)	15	1,162
	Cancer Incidence Rate (Per 100,000 Pop.)	**10.8**	9.2
Cancer Incidence - Colon and Rectum	Estimated Total Population	35,200	2,538,057
	New Cases (Annual Average)	127	9,670
	Cancer Incidence Rate (Per 100,000 Pop.)	**36.1**	38.1
Obesity	Total Population Age 20+	277,133	19,451,593
	Adults with BMI > 30.0 (Obese)	79,674	5,632,512
	Percent Adults with BMI > 30.0 (Obese)	**28.5%**	28.8%
Overweight	Survey Population (Adults Age 18+)	227,390	17,157,497
	Total Adults Overweight	86,850	6,090,529
	Percent Adults Overweight	**38.2%**	35.5%
Diabetes (Adult)	Total Population Age 20+	277,643	19,455,240
	Population with Diagnosed Diabetes	26,282	1,895,549
	Population with Diagnosed Diabetes, Age-Adjusted Rate	**9%**	9.54%
Poor General Health	Total Population Age 18+	235,099	17,999,726

	Estimated Population with Poor or Fair Health	35,021	3,167,952
	Crude Percentage	14.9%	17.6%
	Age-Adjusted Percentage	**14%**	17.8%
Mortality - Suicide	Total Population	368,057	26,959,213
	Average Annual Deaths, 2010-2014	51	3,248
	Crude Death Rate (Per 100,000 Pop.)	13.84	12.05
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**13.88**	12.16
Mortality - Homicide	Total Population	368,057	26,959,213
	Average Annual Deaths, 2010-2014	12	1,455
	Crude Death Rate (Per 100,000 Pop.)	3.24	5.4
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**3.01**	5.39
Mortality - Cancer	Total Population	368,057	26,959,213
	Average Annual Deaths, 2010-2014	547	38,943
	Crude Death Rate (Per 100,000 Pop.)	148.73	144.45
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**147.81**	153.35
Mortality - Stroke	Total Population	368,057	26,959,213
	Average Annual Deaths, 2010-2014	130	9,929
	Crude Death Rate (Per 100,000 Pop.)	35.35	36.83
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**38.14**	41.66
High Cholesterol (Adult)	Survey Population (Adults Age 18+)	185,849	12,555,893
	Total Adults with High Cholesterol	65,583	5,245,959
	Percent Adults with High Cholesterol	**35.29%**	41.78%
Heart Disease (Adult)	Survey Population (Adults Age 18+)	242,385	18,337,915
	Total Adults with Heart Disease	13,490	726,947
	Percent Adults with Heart Disease	**5.6%**	4%
Depression (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	37,883	2,215,695
	Beneficiaries with Depression	5,825	377,096

	Percent with Depression	**15.4%**	17%
Poor Dental Health	Total Population (Age 18+)	226,749	17,999,726
	Total Adults with Poor Dental Health	25,133	2,279,845
	Percent Adults with Poor Dental Health	**11.1%**	12.7%
Infant Mortality	Total Births	21,443	2,014,555
	Total Infant Deaths	105	12,490
	Infant Mortality Rate (Per 1,000 Births)	**4.9**	6.2
Low Birth Weight	Total Live Births	156,051	2,759,442
	Low Weight Births (Under 2500g)	12,052	231,793
	Low Weight Births, Percent of Total	**7.72%**	8.4%
Asthma Prevalence	Survey Population (Adults Age 18+)	242,719	18,426,913
	Total Adults with Asthma	33,699	2,132,981
	Percent Adults with Asthma	13.9%	11.6%

Source: https://ahs.engagementnetwork.org, 1/9/2019

APPENDIX C: HOSPITAL UTILIZATION & EMERGENCY DEPARTMENT DATA

Below are the top diagnoses for Central Texas Medical Center in 2018.

Emergency Department

1. Chest pain
2. Urinary tract infection
3. Abdominal pain
4. Acute upper respiratory infection
5. Headache
6. Flu
7. Low back pain
8. Acute pharyngitis
9. Gastroenteritis and colitis
10. Fever

Inpatient Admissions

1. Heart disease
2. Sepsis
3. Kidney failure
4. Pneumonia
5. Respiratory failure
6. Urinary tract infection
7. Chronic obstructive pulmonary failure
8. Pancreatitis
9. Type 2 diabetes