



**St. David's  
Medical Center  
and  
St. David's South Austin  
Medical Center**

**Community Health Needs Assessment  
December 2019**



**Community Health Needs Assessment –  
*Hospital Facility Geography*  
December 2019**

The following spreadsheet shows the county of residence of patients served by St. David's HealthCare facilities. Based on this data, the four St. David's facilities include the following county Community Health Needs Assessments:

**St. David's Medical Center** – Travis, Williamson, Bastrop, Hays, Caldwell

**St. David's South Austin Medical Center** – Travis, Williamson, Bastrop, Hays, Caldwell

**St. David's North Austin Medical Center** – Travis, Williamson, Hays, Bastrop

**St. David's Round Rock Medical Center** – Travis, Williamson, Bastrop

## CY 2017 St. David's Patients by County

County	ST. DAVID'S MEDICAL CENTER		SOUTH AUSTIN MEDICAL CENTER		NORTH AUSTIN MEDICAL CENTER		ROUND ROCK MEDICAL CENTER		TOTALS	Percent	% Excl. Unk.
Travis	98,603	53%	89,205	65%	95,481	69%	16,261	23%	299,550	56.30%	57.44%
Williamson	47,302	25%	2,385	2%	29,045	21%	45,239	65%	123,971	23.30%	23.77%
Bastrop	8,385	4%	23,249	17%	4,105	3%	636	1%	36,375	6.84%	6.97%
Hays	8,928	5%	9,620	7%	1,525	1%	243	0%	20,316	3.82%	3.90%
Caldwell	2,177	1%	2,350	2%	429	0%	99	0%	5,055	0.95%	0.97%
All Other Counties	18,203	10%	6,724	5%	5,515	4%	5,829	8%	36,271	6.82%	6.95%
None/Unknown	3,356	2%	3,496	3%	2,456	2%	1,242	2%	10,550	1.98%	n/a
	<b>186,954</b>		<b>137,029</b>		<b>138,556</b>		<b>69,549</b>		<b>532,088</b>		

Notes:  
 St. David's Medical Center includes Georgetown and Heart Hospital. Surgical Center excluded.  
 Counties highlighted in yellow are included in that facility's CHNA due to at least 1% of patients residing in that county  
 Each of the counties that make up "All Other Counties" represent less than 1% of total patients across hospital facilities



## **Community Health Needs Assessment December 2019**

### **Definition of the Community Served**

St. David's Foundation, in collaboration with other healthcare entities in Central Texas, conducted Community Health Needs Assessments for the following 5 counties: Bastrop, Caldwell, Hays, Travis and Williamson Counties. These counties were selected because they represent the county of residence for the majority of patients receiving care at St. David's Hospital facilities. The purpose of the assessments was to identify and prioritize health needs so that healthcare organizations can better serve their communities.

### **Description of Process & Methodology**

The assessments included several components, including: a review of previously published community needs assessments and quantitative data from secondary sources, interviews, and focus groups. The data collection team gathered input from people who represent the broad interests of each county 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 with lived experience of health inequities, including people representing rural geographic areas, and representing certain ethnic/racial groups. (For a detailed description of methodology, please refer to the attached reports.)

### **Prioritized Description of Significant Health Needs**

Based on the findings from these five county-level assessments, St. David's has determined the following five areas to be the priority health needs to be addressed in our hospitals' Implementation Plans. The rationale for selecting the following needs is included in the attached pages:

1. Need for improved health and well-being of children
2. Need for improved health and well-being of women
3. Need for improved health and well-being of older adults
4. Need for improved health and well-being in rural communities
5. Need for health clinics to become community hubs for health

### **Description of Resources Potentially Available to Address these Needs**

St. David's will utilize a variety of resources to address these needs, including distributions from St. David's HealthCare Partnership, income from investments, and capacity of staff, including expertise in public health, grantmaking, strategic communications, evaluation, and organizational capacity building.



# Rationale for Selection as Community Health Need

## GOAL 1: FOSTER THE CONDITIONS THAT CREATE POSITIVE EARLY EXPERIENCES FOR YOUNG CHILDREN, KNOWING THESE EARLY EXPERIENCES ARE THE FOUNDATION FOR LATER HEALTH, SOCIAL, AND ECONOMIC OUTCOMES

### HOW WILL WE ADDRESS THIS GOAL? (OBJECTIVES)

1. **Inform the public by promoting the science of brain development to guide clinical practice, public policy, and resource decisions.**
2. **Screen at key intercept points such as pediatric clinics for childhood adversity, relational health, and other related factors.**
3. **Treat children through a strong therapeutic web that includes specialized treatments that incorporate research on the effects of trauma and adversity, as well as tools to build resiliency, such as parenting supports.**
4. **Prevent adversity and build resiliency, using avenues such as parent engagement and education campaigns, and engaging children and their communities in their own healing.**

### WHY THESE AREAS?

#### The Issue

The majority of human brain development occurs by age five. Our early experiences shape not just our behavior, but also our biology. Children who are exposed to high levels of adversity (e.g., abuse, neglect, domestic violence, etc.) are more likely to become adults who face a large burden of disease and social problems, such as depression, alcoholism, lung disease, and heart disease. To promote child resilience, St. David's Foundation aims to create the conditions for a thriving childhood and optimal brain development. Research in this area points to one major factor that creates child resilience, even in the face of high adversity: the presence of a stable, caring adult. Therefore, we strive to create the conditions for healthy relationships to flourish.

#### Change for Children and Families

To build resilience, all children need at least one stable, caring adult present in their lives. Parents and caregivers need the bandwidth to play, support, and talk to their children and the skills to know that this behavior is critical. To prevent ACEs, families need access to high-quality, affordable childcare; affordable and accessible healthcare; safe, affordable, and convenient transportation; quality food and water; and safe, stable, and affordable housing. Under optimal conditions, neighborhoods would have communal open spaces that promote social connectedness, and neighbors would know and help each other, making mutual support the norm rather than the exception. Additionally, children would be screened for ACEs in their pediatric offices and be referred to easily accessible and appropriate treatment as necessary, and they would have ample opportunities at school to engage in social-emotional development.

#### Change for the Field

Under optimal conditions, systems that interact with young children and families would have an understanding and shared commitment to preventing ACEs and building resilience. These systems include childcare centers and schools, pediatric practices, and prenatal and parenting programs. To help children thrive and foster resilient communities, it is vital that these systems use trauma-informed approaches and that the people within them know the science behind brain development. Schools should offer opportunities for social-emotional development; pediatric providers should have the knowledge and tools to address social determinants of health; and prenatal and parenting programs should promote caregiver networking, parent-child attachment, and universal screening and education about trauma. The systems that interact with children must be connected. For example, when pediatricians screen for ACEs, they need the knowledge and resources to refer children to treatment services as necessary.

# Rationale for Selection as Community Health Need

## GOAL 2: ENSURE WOMEN AND GIRLS ARE SUPPORTED WITH RESOURCES, RESPECT, AND CONDITIONS VITAL FOR EQUITABLE HEALTH AND WELL-BEING

### HOW WILL WE ADDRESS THIS GOAL? (OBJECTIVES)

1. **Establish Central Texas as a women's health and perinatal safe zone. Lead and join in a shared community commitment to protecting women's resources, respect, and conditions regardless of what happens in the broader environment.**
2. **Center women of color (e.g., listen to them, step back while they drive the agenda, include them at key tables, enable them to tell their own stories, invest in their leadership).**
3. **Fill gaps in the fragmented safety net women's health system and fund select innovations.**

### WHY THESE AREAS?

#### The Issue

Healthy women are a cornerstone of healthy families, communities, and economies. Women are often gatekeepers to the health of their children, partners, and aging relatives. Therefore, investing in women's health, rights, and well-being produces benefits that can empower entire communities.

Currently, women and girls in Central Texas do not have adequate access to the resources they need to care for their health and well-being. This issue is largely due to a **fragmented health system**, which leads to barriers in obtaining continuous, comprehensive women's health services. Women struggle to access contraception, comprehensive sex education, prevention and care for sexually transmitted infections, alternative birth options, and adequate pregnancy care.

When women and girls do access health services, they often are not trusted to make decisions about their own needs. Women of color especially experience this distrust and other forms of **discrimination**, both in health settings and in their everyday lives. Black women experience high rates of **toxic stress**, which a growing body of evidence suggests is a potent contributor to the alarming rates of morbidity and maternal mortality among this population.

#### Change for women and girls

Under optimal conditions, women's lives would not be more difficult because they are women, nor because they are members of other historically disenfranchised groups. Women should have access to childcare, family-friendly workplaces, and health services. Furthermore, all women deserve the human right to personal bodily autonomy, to have or not have children, and to raise the children they have in safe communities with social connections that support their parenting efforts and overall well-being. Ideally, women would not experience gender-based violence, discrimination, or wage inequality. Meanwhile, they need access to services that alleviate the effects of these stressors and enable them to care for their health and well-being, as well as that of their families.

#### Change for the Field

Underserved women must be at the center of driving change for their communities and defining what they need. Only with this foundational element in place will change for the women's health field meet their diverse needs. Cross-sector collaborations among medical providers, governments, community organizing groups, direct service providers, and philanthropy, are needed to bridge the gaps in services for women and connect the dots of the health system. Additionally, public and private sector partners must come together to create family-friendly workplaces, provide affordable and high-quality childcare, and combat gender-based violence. Finally, women and girls live intersectional lives—race, income, sexual orientation, citizenship status, and other factors all contribute to inequities in women's health. To create community momentum, we must forge connections with related groups and causes, and strengthen the field to support all women. Ultimately, we envision players from across the field coming together to dismantle the structural inequities that lead to poor health outcomes.

# Rationale for Selection as Community Health Need

## GOAL 3: INCREASE SUPPORT FOR OLDER ADULTS TO LIVE SAFELY AND INDEPENDENTLY IN THEIR OWN COMMUNITY

### HOW WILL WE ADDRESS THIS GOAL? (OBJECTIVES)

1. **Directly fund services and support the health of organizations providing services.**
2. **Bring services to scale in ways beyond grantmaking.**
3. **Engage and activate community around aging issues.**

### WHY THIS AREA?

#### The Issue

Central Texas has one of the fastest growing aging populations in the country and it is predicted to double over the next 20 years. As they age, older adults become more vulnerable to chronic conditions and functional disabilities that make it challenging for them to remain safe and independent in their homes and connected to their communities. Older adults often desire to remain living in their communities, and support services are critical in helping them to achieve this goal. To meet the growing demand, St. David's Foundation is working to increase services that support aging in place at a large scale appropriate for our five-county region.

#### Change for Older Adults

Aging adults need access to services that enable them to remain safe and independent in their homes and connected to their communities. These services must be easy to navigate, geographically accessible, and covered by Medicaid or affordable for those just over the Medicaid income threshold. The care older adults receive should be of high-quality and, for those at the end of their life, it should enable them to have a better death.

#### Change for the Field

Central Texas has an inadequate supply of services for older adults. To address this issue, governments, managed care organizations (MCOs), and other philanthropists must coordinate their efforts and implement public policy changes, changes in legislative appropriations, new benefit coverage by MCOs, and new investments (philanthropy, government, private sector) that create sustainable change for older adults in Central Texas. These changes could include MCOs and legislators adopting cost-effective, evidence-based aging services; governments increasing appropriations for Medicaid services for older adults; and foundations collectively establishing a fund to increase public support and awareness around aging issues.

# Rationale for Selection as Community Health Need

## GOAL 4: BUILD COMMUNITY CAPACITY WHILE CO-CREATING AND INVESTING IN LONG-TERM, PLACE-BASED SOLUTIONS

### HOW WILL WE ADDRESS THIS GOAL? (OBJECTIVES)

1. **Engage and empower rural communities to strengthen networks and transform policies, practices, and alignment of resources to address prioritized social determinants of health.**
2. **Build the capacity of people and places including formal and informal leaders within communities and organizations.**
3. **Strategically invest in solutions that harness community assets to support innovation, ecosystem building, and other promising rural-relevant approaches that can be scaled.**

### WHY THESE AREAS?

#### The Issue

Rural communities in Central Texas experience significant health disparities. On average rural residents are older, more impoverished, and in worse health than their urban counterparts. They are less likely to have health insurance (employer-based or Medicare/Medicaid), and often experience barriers in obtaining specialty care services. Furthermore, encroaching population growth from urban and suburban communities has led to longer commutes to work, increased pollution, rising home prices, increased taxes, increased crime rates, fewer agriculture-based industries, and less farmland. The loss of key community institutions, such as farms, rural hospitals, banks, and schools, has led to cultural fragmentation in these communities. Finally, demographic shifts have increased the number and diversity of low-income residents in rural communities, creating a higher level of need in these areas.

Despite these challenges, rural communities in Central Texas possess several key assets. They have a strong sense of community, a culture of caring, and a commitment to strengthening local capacity. This often translates into a shared responsibility to address issues, community resilience, and an innovative spirit to do more with less.

We believe that in working *with* the community to amplify voices least engaged and by elevating community driven solutions we could collectively, over time, improve rural health and well-being through targeted investments with other public and private co-investors to support thriving rural communities. psychiatric services can all inhibit rural residents' willingness and ability to seek care.

#### Change for Residents of Rural Communities

People living in rural counties need the resources and conditions to care for their health. Under optimal conditions, they would have economic stability, including steady employment; neighborhoods and physical environments supportive of their health, including access to safe and affordable housing, transportation, parks, and walkable spaces; access to the education needed to support their goals; access to healthy food; social support systems and connection; and easy access to high-quality health care.

#### Change for the Field

For community-level change to take root, rural communities must be the drivers of change and robust networks must exist among stakeholders from across sectors. Networks are sets of relationships and the patterns they create that influence the quality of communication and the likelihood of collaboration and innovation. The relationships within networks can shift group dynamics from hierarchy to peers, from conformity to appreciation of differences, and from control to a web of support. In rural communities, networks can create change across several areas. Three of the five counties in Central Texas—Bastrop, Caldwell and Hays—have been designated Health Professional Shortage Areas because the population-to-provider ratio is significantly above the national average, measuring at 1,320 people for every one doctor. Rural communities have more older adults, a higher prevalence of mental and behavioral health issues among children, a lack of OB/GYNs leading to long travel times for deliveries, high-risk pregnancies, and high rates of teen pregnancy. In short, the needs in rural communities are great, the resources are limited, and solutions are complex and dependent upon collaboration of multisector stakeholders.

# Rationale for Selection as Community Health Need

## GOAL 5: FACILITATE THE GROWTH OF CLINIC INFRASTRUCTURE AND CAPACITY AS THEY TRANSITION TO SERVE AS COMMUNITY HUBS FOR HEALTH

### HOW WILL WE ADDRESS THIS GOAL? (OBJECTIVES)

- 1. Provide access to primary care and behavioral health services for the uninsured.**
- 2. Expand capacity of clinics to provide activities, processes, and strategies to improve the care delivery model.**
- 3. Encourage clinics to look outside of their four walls and develop and strengthen community linkages to improve community health and wellbeing.**

### WHY THESE AREAS?

#### The Issue

St. David's Foundation believes that when Central Texans get sick or need medical attention, all people should be able to *easily* access the care they need. Community Health Clinics (CHCs) provide medical care to low-income and uninsured Central Texans and have been a key partner in ensuring community members have access to healthcare. While providing access to care continues to be important, we also recognize the major transition across the healthcare system to payment models that are tied to value, quality, and/or health outcomes rather than fee-for-service reimbursement. Our funding approach supports CHCs as they incorporate necessary changes to their care models to be able to succeed in new payment approaches that reward value over volume. In addition to serving the preventive and urgent healthcare needs of lower-income community members, clinics in our community are well-positioned to address and influence the non-clinical factors that impact the health outcomes of the larger community. Because we know that an estimated 80% of health is shaped by factors outside of the medical setting, the Foundation has increasingly prioritized funding for social determinants of health (SDoH) across our grantmaking portfolio. Because community clinics have not traditionally be designed or incentivized to accommodate this expanded scope, there are many challenges to be addressed. CHCs have many of the right pieces in place, but they will need additional support to prepare for the next steps.

#### Change for the Individual

Individuals under a community hub model engage with their local clinic very differently. Clinics serves as an "anchor" institution that individuals can look to as an opportunity to connect with their neighbors and the broader community. While participating in health-promoting activities at the clinic, individuals may also strengthen their informal networks of support. In very practical terms, clinics are uniquely positioned to identify the needs of patients, both medical and non-medical, and assist patients with acquiring that assistance. In order to do this, clinics must strengthen their ability to screen for social needs and develop workflows to connect patients with social services and follow-up with those patients. A few examples of SDoH needs that clinics can assist with include transportation, housing, and food security issues.

#### Change for the Field

The healthcare funding landscape is evolving in complex and uncertain ways, particularly concerning how public resources will be allocated and what clinics will have to accomplish to preserve funding streams. Clinical organizations, specifically Federally Qualified Health Clinics (FQHCs), find themselves continuing to serve their patients as they adapt to ongoing changes in how they are paid for these services and what payers are incentivizing them to do. What is certain is that clinics are being asked to be responsible for not only the health and well-being of their own patients, but for the broader population's as well. If accomplished, this move to focusing on population health could benefit the entire community. The Foundation seeks to learn with our clinical partners how best to transition from a fee-for-service model to a community hub for health. In other words, a model that incentivizes keeping communities healthy rather than one that promotes increased procedures for sick patients.



# 2019 COMMUNITY HEALTH NEEDS ASSESSMENT TRAVIS COUNTY, TEXAS



# ACKNOWLEDGEMENTS

The 2019 Travis County Community Health Needs Assessment (CHNA) represents the commitment of numerous partners that have contributed their expertise, resources, and time in support of a shared mission – to make Central Texas the healthiest community for all its residents. The data collection methodology was co-created through a partnership of health system partners to ensure that authentic community input and existing quantitative data would be combined to provide a comprehensive assessment of the conditions and opportunities that exist to improve health in Travis County. We recognize all of our CHNA partners including Georgetown Health Foundation, Ascension Seton, Austin Public Health, and of course the St. David’s Foundation in this important effort. Most importantly, we appreciate the many community organizations, churches, mothers, youth, fathers, advocates, leaders, and community members that shared their time, experiences, and hopefulness to help us complete this assessment. The list below is shared in appreciation of the many contributors of the Travis County CHNA project:

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## COMMUNITY INPUT PARTNERS

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William Cannon Apartment Homes	Cardinal 360, LLC
Booker T. Washington Terraces Public Housing Complex North	The College of Health Care Professions
Austin / Rundberg YMCA	CareBOX Program
Pflugerville Public Library	Greater Austin Hispanic Chamber of Commerce
Texas Department of State Health Services	Regarding Cancer
Central Texas Food Bank	Austin Clubhouse, Inc.
Lake Travis Independent School District	Women’s Health and Family Planning Association of Texas
Central Texas Catholic Charities	The Arc of the Capital Area
Austin Child Guidance Center	GO! Austin / VAMOS! Austin (GAVA)
People’s Community Clinic	Community Care Collaboration
Housing Authority of the City of Austin	

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# EXECUTIVE SUMMARY

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## OVERVIEW

Our understanding of what health means as a public condition, approach and system is evolving. Clinical interventions were once the primary solution for keeping people healthy. Adherence to regimens, healthy eating, physical activity and ways to support healthy behaviors were understood as the path to a healthy life. But as health practitioners now know, prevention goes beyond healthy behaviors and what happens within the traditional health system. The health of an individual is primarily determined by where they live, work and play. The CHNA Action Team along with SHARED Strategy Group co-created a data gathering process that engaged community members as experts in their experience living in Travis County. The anecdotal stories and authentic feedback provided the context necessary to understand and interpret quantitative data. The totality of information – both stories and statistics – are represented in this report as an assessment of health needs in Travis County, TX.

## METHODOLOGY

The methodology for the assessment of community health needs in Travis County used the framework from the National Association of County and City Health Officials (NACCHO) Mobilizing Action through Planning and Partnerships (MAPP) process. The MAPP process includes four key assessments of 1) Community Health Status Assessment, 2) Community Themes and Strengths, 3) Forces of Change and 4) Local Public Health System. This CHNA is designed to highlight health disparities and root causes of local conditions and describe the health system infrastructure. Both qualitative and quantitative data were used in the completion of this assessment.

## CHANGES IN COUNTY PROFILE

***The Travis County poverty rate has decreased 4% while the population of residents 65 and older has increased 29% since 2013.***

The population of Travis County is estimated at 1,226,698 (U.S. Census, 2017).<sup>1</sup> This represents a 1.84% growth rate over 2016. Since 2013, the Travis County total population has increased by 9% compared to 7% nationally. For the same period, the population of Travis County aged 65 years and older had the largest population increase by 29% compared to 17% statewide and 14% nationally. During the same comparison period, the reported median household income increased more than \$9,000 with Travis County realizing a greater increase in median household income than Texas and the U.S. For Travis County, the overall poverty rate decreased from 16% to 12%.<sup>2</sup> Travis County data revealed a heavy concentration of poverty within 10 zip code tabulation areas.<sup>3</sup>

## COMMUNITY HEALTH STATUS

***Cancer and heart disease are the top two leading causes of death in Travis County.***

According to the 2017 Critical Health Indicators Report released by Austin Public Health, Epidemiology and Public Health Preparedness Division, the top 10 leading causes of death in Travis County were: cancer, heart disease, accidents, stroke, lung disease, Alzheimer's Disease, suicide, diabetes, liver disease and kidney disease.<sup>4</sup>

When asked to rate their community's health, focus group participants rated their health as poor=1 or fair=2. Conversely, for key informant interview participants, which represented social service providers and organizational leaders, the perception of health was much higher with participants providing a rating of 3 and 4 on a 5-point scale.

<sup>1</sup> U.S. Census, 2017.

<sup>2</sup> American Community Survey 2013-2017 1-Year Estimates.

<sup>3</sup> American Community Survey, Travis County Poverty Brief, April 2018.

<sup>4</sup> Austin Public Health 2017 Critical Health Indicators Report, Epidemiology and Public Health Preparedness Division.

## HEALTH DISPARITIES

***Black residents in Travis County die sooner and more frequently and experience higher rates of chronic diseases and STIs than other race/ethnic groups in the County.***

Blacks are disproportionately impacted by higher mortality rates, chronic diseases and sexually transmitted infections (STIs) than all other race/ethnic groups. The disparities exist in cancer, diabetes, human immunodeficiency virus (HIV), chlamydia, syphilis and gonorrhea.

## COMMUNITY THEMES: STRENGTHS AND CONCERNS

***Participants identified mental health as one of the top two health challenges in the County.***

Community focus group participants were asked to provide input on perceptions of quality of life, community uniqueness, assets, and their perception of their ability to influence change in the community. Participants described a number of strengths and assets in the community including diversity - ethnic/racial diversity as well as age diversity as a positive; livability and family friendliness - a desirable place to live with family friendly amenities; community growth - rapid community growth creates new opportunities; and infrastructure in terms of educational and training advancement and health care. Many concerns for Travis County, particularly for poor and marginalized communities, were noted by participants and generally represented inequities associated with the social determinants of health (SDOH) such as access to high quality health care that is culturally and linguistically appropriate, lack of affordable and safe housing, income inequalities, lack of access to healthy foods and high levels of food insecurity,<sup>5</sup> transportation and lack of voice and power of community residents with County decision makers. There were also a number of comments from health care and social service providers of the many undocumented and immigrant populations that feared accessing government services in the current anti-immigrant climate.

Other concerns expressed by participants included a growing prevalence of chronic diseases such as asthma, diabetes, hypertension, liver disease as well as rabies associated with the bat population in central Texas. Tobacco is the leading cause of preventable death in Austin and Travis County.

Participants highlighted concerns with health disparities between white adults and black and Hispanic adults for diabetes. Black adults are more than twice as likely to be obese compared with white adults, a disparity that has persisted for years. In Travis County, three out of every 100 babies born is to a mother 15-17 years of age. Whites have the lowest percent while Hispanics have the highest percentage of births to females 15-17 and females under 20 years of age. The percentage of teen births among Hispanics is ten times higher than the percentage of teen births among whites.<sup>6</sup> Data also shows that premature births are more likely for black mothers in Travis County. Low birth weight is more frequently seen in black infants. Infant mortality rates are higher for blacks than whites and Hispanics. Though the rates for blacks have been on the decline for the past 10 years, the rate remains higher than the rates for whites and Hispanics.

Concerns around mental and behavioral health included issues surrounding both stigma and access. Community members identified mental health as one of the top two health challenges in the County. Community members perceived that maternal mental health was not a priority for decision makers. Concern for children exposed to trauma and adverse experiences, epigenetic and ongoing trauma of poor residents was expressed through comments regarding ongoing financial pressures, fear, day-to-day stressors, feelings of frustration, and feelings of lack of choice. While males comprise 51% of the city's population, males comprise 74% of those who die by suicide. The suicide rate for males is almost three times higher compared with females.

<sup>5</sup> Davis et al., "Food For All: Inclusive Neighborhood Food Planning in North Austin." Edited by Lyndon B. Johnson School of Public Affairs, Sustainability Office of the City of Austin, 5 July 2016, [issuu.com/atxsustainability/docs/food\\_for\\_all\\_final\\_070616.compre](http://issuu.com/atxsustainability/docs/food_for_all_final_070616.compre).

<sup>6</sup> Austin Public Health 2017 Critical Health Indicators Report, Epidemiology and Public Health Preparedness Division.

## ROOT CAUSE AND FORCES OF CHANGE

*Social determinants and race-based inequities in access to food, insurance coverage and care, housing and power are root causes of poor health in Travis County.*

Community input participants were asked to provide perspectives on the causes of poor health in their communities and the factors that ultimately influence quality of life. Identifying these factors provides potential change levers for improving health in Travis County. While the number of root causes for community health in Travis County is long, the core drivers are associated with the social determinants of health: food insecurity, cost of living, insurance coverage for adults, anti-immigration beliefs and practices, historical race-based inequities in access to housing (e.g., redlining policies), shifting population trends that have triggered issues of gentrification of neighborhoods and accelerating housing prices, and lastly access to services and care. Many community focus group participants saw access as a form of power – having the information on how to access resources, having the relationships to navigate the system, and access to places of influence where decisions are made.

## LOCAL PUBLIC HEALTH CARE INFRASTRUCTURE

*Travis County residents have a robust healthcare infrastructure for both insured and uninsured residents. Problems with accessing services are associated with the social determinants of health including transportation, reimbursement plans, available appointment slots, costs and cultural/linguistic barriers.*

The health care infrastructure in Travis County is extensive: 24 acute care and psychiatric hospitals; 43 Federally Qualified Health Centers (FQHCs) and 35 community health clinics<sup>7</sup>; six neighborhood health centers and three outreach sites; 38 mental and behavioral mental health centers or clinics; and 6 Women, Infants and Children (WIC) store sites per 100,000 population. There is a network of additional nonprofits and charitable organizations addressing various health and social service needs for vulnerable populations.

Provider-patient ratios are all significantly better than the state. Utilization rates vary across population centers in the County and 17% of the County's low-income population uses the emergency department instead of a primary care physician. Twelve percent of Travis County's population remain uninsured, even as the uninsured rate in the County dropped significantly from 28% in 2013.

## CONCLUSIONS ON HEALTH IMPROVEMENT PRIORITIES

**THE TOP HEALTH PRIORITIES FOR TRAVIS COUNTY IN 2018:**

*Data suggest that Travis County should focus on improving social inequities that drive poor health and dramatically improve the mental and behavioral health infrastructure and access to services.*

Based on input from community members, data on current health conditions, and data on social determinants of health, the following priorities were identified as top priorities for improving health in Travis County in order of perceived importance.

**MAKE INVESTMENTS IN IMPROVING THE SOCIAL DETERMINANTS OF HEALTH (SDOH)** – Improving community conditions by expanding economic opportunities and living wage jobs; expanding access to quality parks and green spaces, walking and biking trails, playgrounds, and facilities like the YMCA to support family health; subsidizing quality, affordable housing; expanded transportation solutions (especially for remote rural residents, and infrastructure to support safe biking and walking); and increase services to address the needs of the growing homeless population, including programs to secure stable transitional and permanent housing, availability of shelter beds, free health care and transportation services to health care services, and employment and job search services. We know that poverty limits access to healthy foods and safe neighborhoods and that more education is a predictor of better health. We also know that health suffers in communities with poor SDOH such as low-quality housing, low income, unsafe neighborhoods and schools, or substandard educational opportunities.<sup>8</sup>

<sup>7</sup> Texas Association of Community Health Centers

<sup>8</sup> Centers for Disease Control and Prevention, 2018.

**BEHAVIORAL AND MENTAL HEALTH** – Improve access to services across the continuum of behavioral and mental health needs (e.g., mental illness, substance use disorder, social connectedness). Participants noted the negative impacts on community health of the opioid epidemic and the need for increased mental health services, particularly for the most vulnerable and disconnected youth. A recent study sponsored by the National Council for Behavioral Health, America’s Mental Health 2018, found that the lack of access to behavioral health services is the root cause for the mental health crisis in America. Access to mental and behavioral health services, especially for children and youth, should be among the most important priority actions considered by Travis County.

**ACCESS AND AFFORDABILITY OF HEALTH CARE** – Improve access to be responsive to the needs of families and children. Increase access by removing barriers to care such as flat rate fees for office visits, transportation and lack of insurance coverage, and expand programs which show promising outcomes or community response (e.g., a kiosk to promote services was referenced), ensure information on accessing resources is widely available through health care roadmaps and other visual explanations of where and how to access services. Solutions might include extended after-hours appointments, free or sliding scale health clinics in neighborhood schools staffed by nurse practitioners, free public transportation that runs directly to FQHCs and FQHC look-alikes, additional FQHC access points in the most impoverished community locations, specialty care services focused on the top chronic diseases and necessary services such as maternal and child health care in the Travis County population. Adults in worse health, those with low incomes, and the uninsured are much more likely than others to delay or forgo health services due to costs.<sup>9</sup>

**CHRONIC DISEASE RISK FACTORS** – Chronic diseases are defined broadly as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both. Chronic diseases such as heart disease, cancer and diabetes are the leading causes of death and disability in the United States<sup>10</sup>. A risk factor is any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury.<sup>11</sup> In order to reduce the risk of developing a chronic illness such as heart disease, cancer or diabetes we recommend that Travis County improve access to affordable, healthy food options, eliminate food deserts, increase opportunities for free or affordable physical activity for all ages. Today, seven of the 10 leading causes of death in the United States are chronic diseases, and almost 50% of Americans live with at least one chronic illness. People who suffer from chronic diseases experience limitations in function, health, activity and work, all affecting the quality of their lives. Underlying these conditions are significant health risks such as tobacco use, poor nutrition, and physical inactivity. Increasing opportunities to engage in healthy behaviors reduces the risk for illness and death due to chronic diseases.<sup>12</sup>

**POWER DYNAMIC AND INFLUENCE: OUTREACH AND ENGAGEMENT** – Expanding leadership opportunities for marginalized community members, increase culturally appropriate messaging and outreach, create opportunities for personal development, promote a positive narrative, highlight positive community assets and efforts, identify and execute ways in which visible quick wins can be demonstrated that are driven by community voices and input.

<sup>9</sup> Gary Claxton, Bradley Sawyer and Cynthia Cox, Kaiser Family Foundation, 2019.

<sup>10</sup> Centers for Disease Control and Prevention, 2019.

<sup>11</sup> World Health Organization, 2019.

<sup>12</sup> Centers for Disease Control and Prevention, 2013.

# 2020-2022 TRAVIS COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT

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## INTRODUCTION

The health of a community can be measured many different ways. Personal and collective health encompasses well-being, social connectedness, personal agency, access to resources, built environment, economic security, practices, and beliefs. The understanding of the comprehensive nature of health means looking beyond individual disease conditions to assess the environments and circumstances in which a person lives, works and plays as well as what health care resources are available to them.

The CHNA Action Team, and their partners SHARED Strategy Group, co-created a data gathering process that engaged community members as experts in their experience living in Travis County. The goals of the Community Health Needs Assessment (CHNA) team were to:

- Identify existing and emerging community health needs
- Identify strengths and assets available to improve health
- Determine the issues affecting the quality of life of residents
- Understand the key forces of change influencing health in the community
- Evaluate the local public health system and determine priorities for improvement; and
- Identify top health priorities for future health improvement efforts

The anecdotal stories and authentic feedback provided the context necessary to understand and interpret numerical data. The totality of information – both stories and statistics, are represented in this report as an assessment of health needs in Travis County, TX.

## METHODOLOGY

The assessment of community health needs in Travis County used the assessment framework from the National Association of County and City Health Officials (NACCHO) Mobilizing Action through Planning and Partnerships (MAPP) process. Where the MAPP process includes four key assessments of 1) Community Health Status Assessment, 2) Community Themes and Strengths, 3) Forces of Change and 4) Local Public Health System, this CHNA was designed to specifically highlight health disparities and root causes and describe the health system infrastructure.

Both qualitative and quantitative data were used in the completion of this assessment. Primary qualitative data was collected to capture community input through focus group sessions and key informant interviews. Quantitative data such as key health indicators, social determinants of health and the community profile were based on secondary data analysis.

The methodology for collecting qualitative data or community input was designed to capture perspectives from representatives from each of the key community input sectors. These included:

- Representatives or members of medically underserved, low income and minority populations
- Populations with chronic disease needs
- Practitioners with expertise in public health
- Health care and mental health care providers
- Organizations serving low-income populations

- Agencies with information and data relevant to the health needs of the community
- Nonprofit organizations / Community-based organizations / Faith-based organizations
- Local public agencies

Six community focus groups were conducted in Travis County engaging a total of 55 community members. Focus group sessions were scheduled to provide opportunities for facilitated discussion in English and Spanish. Neighborhoods in which focus groups were held were selected based on poverty level, whether they had been engaged in other input efforts, community input sector representation, geographic location, and diversity of potential participants. Based on this, criteria, focus groups were held in the Bluff Springs, East Austin, Pflugerville, Rosewood, and Rundberg neighborhoods. For the East Austin focus group, the question format varied slightly from the other five focus group sessions. Participants in this focus group were primarily organization or agency representatives. The same questions were used for key informant interviews. Questions for all focus groups and interviews can be located in the Appendix. A community input summary report also is included in the Appendix.



For the remaining five focus groups participants were individuals not participating as representatives of an organization and were residents of the community, low-income, minority, or medically underserved populations. As a result, the questions were designed to build participant comfort level, reinforce validity of their experiences and encourage them as valued community members to share personal information. To ensure consistency across focus groups facilitators used a standardized facilitation guide. Questions were framed around four discussions; 1) Community Identity, 2) Access to Healthcare and Social Services, 3) Root Causes, and 4) Priorities and Recommendations. As participants arrived, they were asked to complete an anonymous demographic card.

Community members were provided a \$25 grocery store gift card for their participation. The demographics represented by the focus group participants (n=40) indicate that 38% were Hispanic, Latino or of Spanish origin. A quarter were Black or African American; 5% were Asian and 2.5% were Native American or Alaskan Native. The remainder were White or self-identified as "Other." About 5% reported their age as under 18 and more than three-quarters were aged 25-64 (see figure below).

Age Stratification of Community Input Participants*	
Under 18	5.1%
18-24	12.8%
25-44	46.1%
45-64	30.7%
65	5.1%

\*N=39, total may not add up to 100% based on rounding. One participant chose not to respond.

Participants lived in their neighborhoods...*	
Less than 1 year	15.3%
1 to 5 years	51.2%
6 to 10 years	12.8%
More than 10 years	20.5%

\*N=39, total may not add up to 100% based on rounding. One participant chose not to respond.

More than two-thirds of focus group participants reported living in Travis County for five years or less. About one-fifth lived in Travis County for 10 years or more.



# COUNTY PROFILE: TRAVIS COUNTY

## Geographic Boundaries

Travis County is the fifth-most populous county in Texas and includes Austin, Texas, which is the county seat and capital of Texas. Travis County encompasses 23 separate communities:

- Bee Cave
- Jonestown (pt)\*
- Lago Vista city
- Lakeway
- Manor city
- Briarcliff village
- Point Venture village
- The Hills village
- Volente village
- Webberville village
- San Leanna village
- Cedar Park city (pt)
- Creedmoor city
- Rollingwood city
- Sunset Valley city
- West Lake Hills city
- Austin (pt)
- Elgin city (pt)
- Leander city (pt)
- Mustang Ridge city (pt)
- Pflugerville city (pt)
- Round Rock city (pt)

\* (pt) means a portion of the area is located in another county



Travis County has an estimated population of 1,226,698 (2017) which represents a 1.84% growth over 2016. Seventy-three percent of the population for the county is located in the City of Austin. In 2010 the U.S. Census population for Travis County was reported at 1,024,266 (a population growth rate of approximately 20% from 2000). Trends project continued population growth with people out of state relocating to Austin and current residents moving outside the city limits to surrounding suburban and rural areas. Residents ages 25 to 44 years make up the highest percentage of the population at 36%. Though residents 65 and over only make up 10% of the current population, this represents a 29% increase in population from 2013. Population trends project continued population shifts with people out of state relocating to Austin and current residents moving outside the city limits to surrounding suburban and rural areas.

# SOCIAL DETERMINANTS OF HEALTH

*Nearly half of the population of Travis County identifies as Non-Hispanic White (49%) and disparities in levels of education, poverty, employment and income differ by race and ethnicity.*

Our health is largely determined by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships.<sup>13</sup>

## Race, Ethnicity, and Nativity

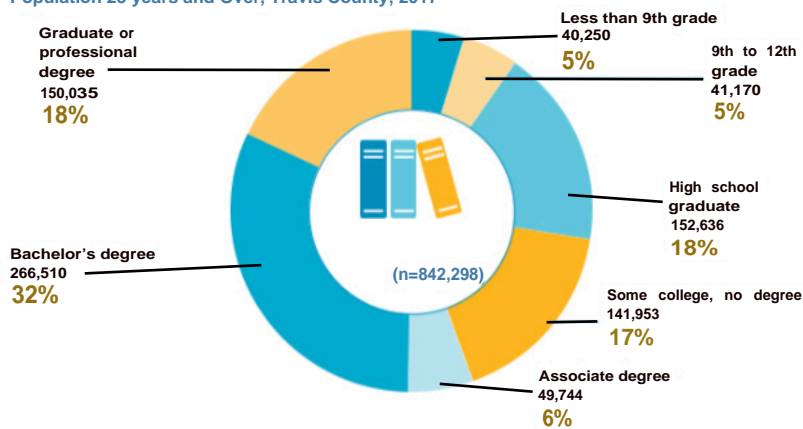
Non-Hispanic whites represent 49% of the Travis County population; Hispanic or Latino residents make up 34% of population followed by Non-Hispanic Black or African Americans representing 8% of the population. Smaller populations include Non-Hispanic Asian (7%) and Non-Hispanic 'Other' (3%). From 2013 to 2017, the number of Non-Hispanic Asians increased by 25%.

In reviewing population data on nativity and citizenship, 82% of Travis County residents are native, meaning anyone who was a U.S. citizen at birth, and 18% are foreign-born. Of the residents who are born outside of the U.S., 44% are naturalized U.S. citizens. It is important to note that representation in community input focus groups closely aligned with the diversity of the County as a whole. Focus group participants were not asked about their immigration status.

## Educational Attainment

According to the 2017 American Community Survey, Travis County has a highly educated population with 49% of adults holding a bachelor's degree or higher, compared to the state percentage of 30%. According to *Healthy People 2020*, the percentage of 9th graders that complete their high school diploma in four years is a leading indicator of the future health status of a community. The 2018 County Health Rankings for Travis County indicated that the high school graduation rate was 90%. Though data was not available to track the percentage of students entering 9th grade and completing in four years, County profile data indicated that five percent (5%) of residents had less than 9th grade education, and 5% had completed some high school education.

**FIGURE 3: EDUCATION ATTAINMENT LEVEL**  
Population 25 years and Over, Travis County, 2017



## Disability Status

Residents with a disability represent 8% of the population of Travis County. Residents 65 years or over have the highest rate of disability with 28% of that group living with some form of disability.

<sup>13</sup> ODPHP, 2019.



## Poverty

***Poverty is one of the leading determinants of health along with where one lives (zip code), race/ethnicity, and educational attainment.***

In 2012 – 2016, 15% of Travis County residents lived below the Federally Designated Poverty Level. For 2013 – 2017 the overall poverty rate decreased from 16% to 12%. Of the number of residents in poverty, 63% are adults age 18 to 64 and 29% are children. In expanding the definition of poverty to 200% of federal poverty level (FPL), the percent of residents increases to 27% (1 in 4 residents) which is a decrease from 32% reflected in the ACS 2016 reporting. Ten zip code tabulation areas (ZCTA) exist where 50% or more of the population live below 200% of the FPL. Nine of the ten zip codes are located east of I-35. This demarcation reflects the historical effects of inequitable transportation/development planning practices in communities of color.<sup>14</sup> The figure below shows the zip codes with the highest percentage of population living below 200% of the poverty threshold.

### NEIGHBORHOOD ZIP CODES WITH OVER 50% OF INDIVIDUALS LIVING BELOW 200% OF POVERTY IN TRAVIS COUNTY, 2012-2016

ZCTA	Estimate	Percent	ZCTA	Estimate	Percent
78705 (central/UT area)	15,163	76%	78744 (southeast)	25,583	54%
78724 (east)	14,678	62%	78721 (east)	6,551	54%
78741 (southeast)	31,382	61%	78617 (southeast)	12,277	50%
78752 (northeast)	11,266	57%	78723 (east)	16,124	50%
78753 (northeast)	30,545	55%	78719 (southeast)	881*	50%*

Another standard of measure of children in poverty or children facing food insecurity is the percentage of disadvantaged students. For the 2017-2018 school year, 50.6% of students in Travis County were considered economically disadvantaged. This is a decrease from 58.3% for the 2010-2011 school year.

<sup>14</sup> footnote from map

## Employment

***Though unemployment is near a record-low in Travis County, residents shared concerns that a gap exists between the skills desired by employers and the skills held by those seeking employment.***

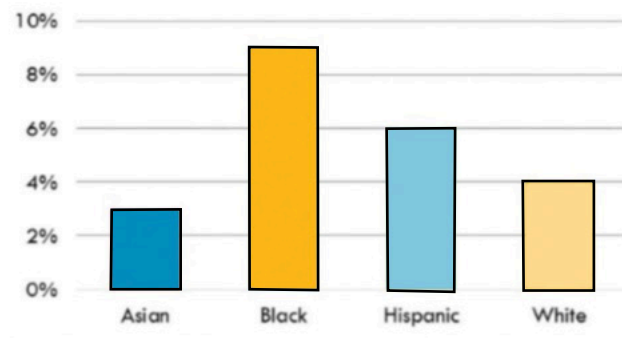
In May 2018, the unemployment rate for Travis County was 2.7%. This represents a slight decrease from the 2017 rate of 3.0%. Since 2013 there has been a gradual decline from 5.0%.<sup>15</sup> As reflected in the 2017 ACS Survey, 27% of the Travis County population age 16 and over were not in the labor force. Individuals between the ages 25 and 44 constitute 53% of Travis County's labor force. Slightly over half of Travis County's civilian employed population age 16 and over is employed in five industries: professional, scientific, and technical services; educational services; healthcare and social assistance; retail trade; and accommodation and food service workers.

According to the Greater Austin Chamber of Commerce, 60% of the area's job openings in 2017 required post-high school education or certification which eliminated approximately 63% of the unemployed job seekers.<sup>16</sup> For Travis County, it is estimated that the livable wage for one adult and one child is \$25.13 which is slightly over \$52,000 a year.

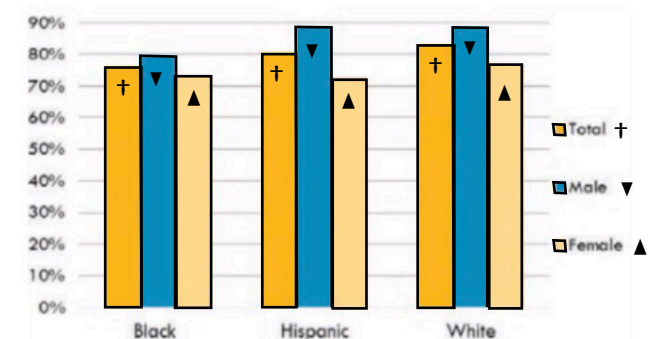
In 2016 legislation was proposed to increase the minimum wage to \$10.10 which would mean 99,894 workers in the workforce would receive a pay increase. If this legislation were to pass, workers with families would still earn well below a livable wage.

For the state of Texas, it is estimated that 38% of families earned less than \$47,000 a year for a family of four.<sup>17</sup> Unemployment rates were different for different populations. Data indicate that 9.1% of mothers with more than one child do not have a job and are actively seeking employment. For individuals with less than a high school diploma, the rate of unemployment is 7.1%.<sup>18,19</sup>

UNEMPLOYMENT BY RACE/ETHNICITY, TRAVIS COUNTY, 2012-2016



PERCENT EMPLOYED BY SEX, RACE/ETHNICITY, AGES 25-64, TRAVIS COUNTY, 2016



## Food Insecurity

***Data from a variety of Federal and national sources consistently indicate that food insecurity, lack of affordable, healthy food, and food deserts are a barrier to health in Travis County.***

The USDA defines food insecurity as a lack of consistent access to enough food for an active, healthy life.<sup>19</sup> Community input identified lack of access to healthy affordable food as a barrier to good health in the community.

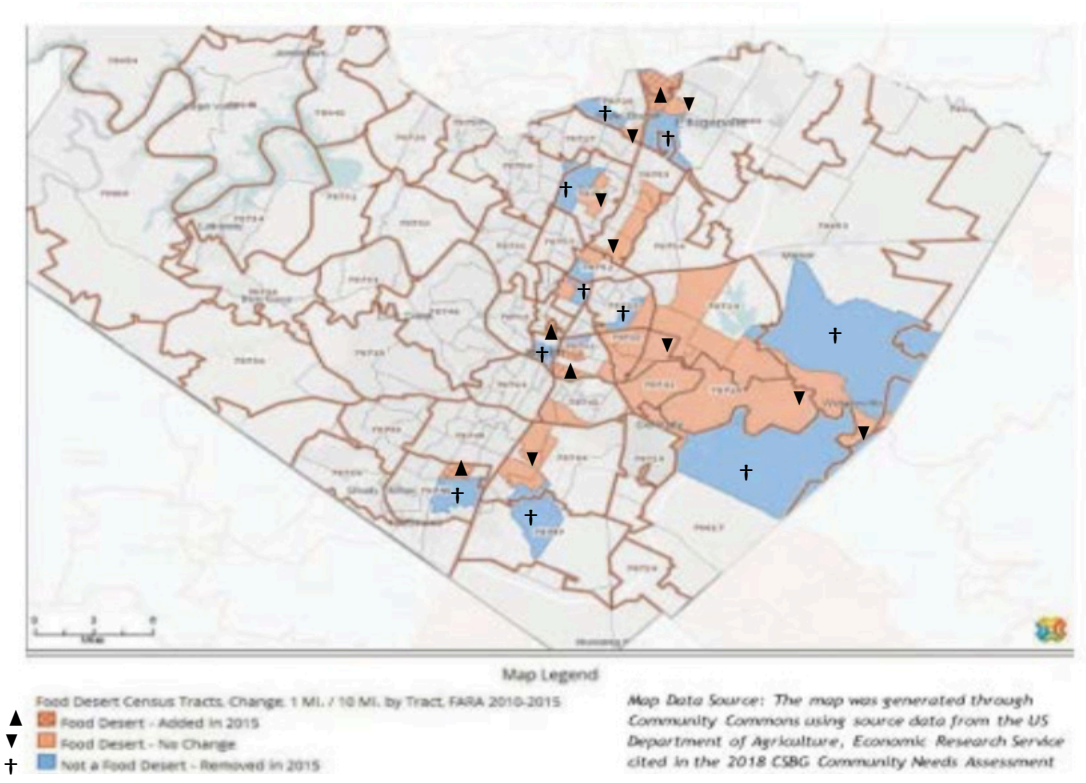
<sup>15</sup> Texas KIDS Count at the Center for Public Policy Priorities 2018 retrieved from <https://datacenter.kidscount.org/data/tables/8224- economically-disadvantaged-students>.  
<sup>16</sup> Neely, Christopher; "Why is Austin's near record-low unemployment a concern to some economists and officials?"; Community Impact Newspaper; April 24, 2018 found at <https://communityimpact.com/austin/economic-development/2018/04/24/why-is- austins-near- record-low-unemployment-a-concern-to-some-economists-and-officials/>  
<sup>17</sup> Center for Public Policy Priorities. "Time to Raise the Minimum Wage: Analysis of Who Would Benefit from a Minimum Wage Increase in Texas", 2016.  
<sup>18</sup> Austin Public Health, 2018 Community Services Block Grant Community Needs Assessment found at <http://www.austintexas.gov/edims/document.cfm?id=300035>  
<sup>19</sup> American Community Survey 5 Year Estimates 2016 found at <http://canatx.org/dashboard/we-achieve-our-full-potential/unemployment/>

Sector and organizational representatives specifically identified food deserts in urban areas and the over-availability of fast food options as barriers. Based on the most recently available healthy food access mapping data (2015) Travis County had a lower rate of food access than the State. Approximately, three in ten Travis County residents live in areas with low food access, which means reduced quality, variety, or desirability of diet or limited ease of access to large grocery stores.

***“We have a lot of fast food. Maybe that’s the biggest challenge. Grab-and-go, something that would be easy for the working community. To have healthy food options would be nice.”***  
 – Pflugerville resident

Connected to the issue of food insecurity is the issue of food deserts. Food deserts are defined as parts of the country lacking fresh fruit, vegetables, and other healthy food options. The following map provides the locations of food deserts throughout Travis County in 2015. The majority of large, full-service grocery stores are located in the Western part of the County while concentrated populations of low-income residents are located to the east of I-35.

**FOOD DESERT CHANGE BY CENSUS TRACT, 2010-2015<sup>20</sup>**



According to the most recent data (2015) from the Annie E. Casey Foundation, Kids Count Data Center, for Travis County, a total of 20,443 children ages zero to four were identified as participating in the Special Supplemental Nutrition Program for Woman, Infants, and Children (WIC). Access to WIC stores is then a critical resource is increasing food security for young children. WIC utilization data indicates that there is limited access to WIC stores for the Travis County population. Travis County residents accessing Supplemental Nutrition Assistance Program (SNAP) benefits was 9.3% between the months of July 2014 and July 2015.

<sup>20</sup>United States Department of Agriculture, Economic Research Service; Definitions of Food Insecurity retrieved from: <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx>

# COMMUNITY HEALTH STATUS

According to the World Health Organization (WHO), health is a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” The Community Health Status Assessment (CHSA) is a comprehensive summary representing the aggregate disease burden and health status of Travis County residents.

The Community Health Status Assessment (CHSA) provides a population level snapshot of the current condition of a community’s health. The design of this section is slightly different from the traditional MAPP assessment framework in that information on health resource availability is included in the section focused on Local Public Health Infrastructure. The data in this section is based on secondary data analysis of key health indicators for comparison and identification of health trends. The source of the secondary data is based on the 2017 Critical Health Indicators Report prepared by Austin Public Health, Epidemiology and Public Health Preparedness Division for Travis County and the County Health Rankings Health Indicators Report for Travis County. Additionally, primary data was obtained from the survey assessment of 504 HACA residents across three public housing properties, Chalmers, Booker T Washington, and Lakeside housing communities. Surveys were administered door-to-door by a survey assessment team that secured a response rate of over 70% of residents from each of the participating properties.

## Quality of Life

Quality of life is a holistic index of the human condition based on multiple factors that influence the standard of living or life experienced by a person, family, or community. Quality of life is influenced by factors such as housing burden, commuting, civic engagement, social or spiritual connections and of course physical and mental health.

## HOUSING BURDEN

**Almost forty-five percent of Travis County renters, for whom housing information was obtained, are experiencing some level of housing burden compared to 22% of homeowners.**

The U.S. Department of Housing and Urban Development defines housing burden or cost-burdened families as those “who pay more than 30 percent of their income for housing,” which may cause financial difficulties in affording other necessities such as food, transportation, clothing, and medical care. Further, those that are paying more than 50% of their income on rent are considered as experiencing a severe rent burden.<sup>21</sup> In Travis County, homeowners make up 52% of occupancy while 48% of occupied housing is renter-occupied. Renters experience a greater housing burden than homeowners with only 51% of renters spending less than 30% of their income on housing compared to 77% of homeowners. Additionally, 23% of renters were experiencing housing burden with nearly the same percent (21%) experiencing a severe housing burden.

## TRANSPORTATION

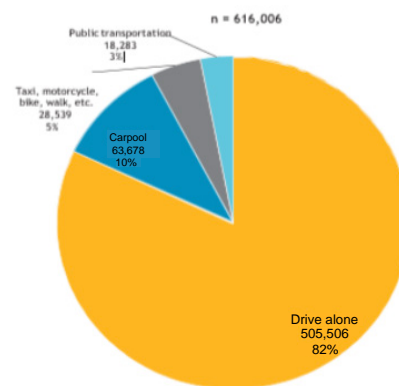
**Access to public transportation is an increasing challenge in Travis County as sustained population growth continues. Only 3% of participants report using public transportation.**

Throughout the community input discussions, transportation was a common theme as an increasing challenge with the population growth of the area over the last few years. For this assessment, we will use the common factor of commuting time to identify influence on quality of life.

The majority of residents 16 years and older in Travis County drive alone as the means of commuting to work (82%) while only 3% report using public transportation. In Travis County, sixty-two percent (62%) of commuters travel under 30 minutes to get to work, while 6% travel more than one hour.

FOR TRAVIS COUNTY (16 OR OLDER), 2017

Workers 16 years and over who do not work at home, Travis County, 2017



Created by: Travis County HHS, Research & Planning Division, 2018

<sup>21</sup> U.S. Housing and Urban Development; Rental Burdens: Rethinking Affordability Measures, found at [https://www.huduser.gov/portal/pdredge/pdr\\_edge\\_featd\\_article\\_092214.html](https://www.huduser.gov/portal/pdredge/pdr_edge_featd_article_092214.html)

## **CIVIC PARTICIPATION AND POLITICAL ENGAGEMENT**

### ***Recent elections saw higher rates of registered voter turnout in Travis County.***

The inclusion of civic participation in this assessment as an indicator of quality of life is relevant because some of the same barriers that impede health also impede civic engagement: many Americans do not vote due to lack of transportation to the polls, voter registration problems, inability to take off from work, and the perception that individual voice or vote does not influence political (or community) outcomes or decisions. This sentiment was reflected in comments from community residents in one public housing complex where the widely held perception was that decision makers would do what they wanted regardless of public input. According to 2018 research published by National Public Radio, during the 2016 election almost 50% of Texans did not turn out to vote.<sup>22</sup> For Travis County 38.7% of registered voters did not participate in the 2018 midterm. This represented a significant increase from voting rates in 2014 where an estimated 58% of registered voters did not vote.<sup>23</sup>

## **Behavioral Risk Factors**

### **TOBACCO**

#### ***Travis County adults smoke at rates lower than the statewide rate.***

The Travis County 2011-2015 prevalence estimates of current smoking adults (13.5%) and ever smoking adults (34.8%) are lower than that of adults in Texas. Both had been trending downward until 2015.

### **OBESITY**

#### ***One in five Travis County adults are obese and more than one-third are overweight.***

The prevalence of overweight or obesity among adults in Travis County has remained fairly constant at about 58% from 2011 to 2015. The rates of obesity are lower in Travis County as compared to Texas (21.9% vs. 31.0% respectively), and the prevalence of being overweight in Travis County is similar to that of Texas (36.1% vs. 35.7%, respectively (BRFSS, 2011-2015). Over half of Travis County youth are reaching the BMI fitness achievement levels, with high school boys and girls achieving the highest rates compared to elementary and middle school youth.

### **PHYSICAL ACTIVITY**

#### ***Continuing a consistent trend, Travis County adults are more active than adults across the state.***

According to the 2018 County Health Rankings data for the period of 2004 - 2014, Travis County adults were more physically active than adults across the state. Sixteen percent (16%) of Travis County adults age 20 and over reported no leisure-time physical activity compared to 24% of adults for the state of Texas. This has been a trend for the previous ten-year period.

<sup>22</sup> Leila Fadel, Don Gonyea, Asma Khalid; On the Sidelines of Democracy: Exploring Why So Many Americans Don't Vote; NPR September 10, 2018 found at <https://www.npr.org/2018/09/10/645223716/on-the-sidelines-of-democracy-exploring-why-so-many-americans-dont-vote>

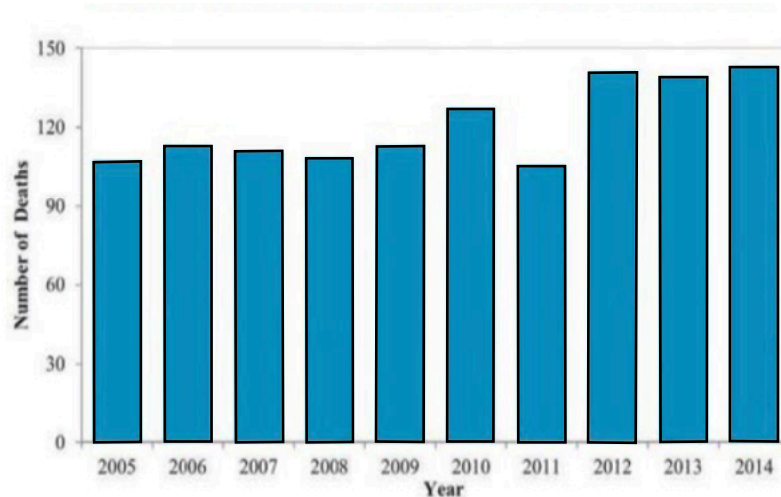
<sup>23</sup> Buchanan, Taylor Jackson; Data: 61.3percentofregisteredTravisCountyvotersparticipatedinthe2018midterm; Community Impact Newspaper, November 7, 2018, found at <https://communityimpact.com/austin/editors-pick/2018/11/07/data-61-3-percent-of-registered-travis-county-voters-participated-in-the-2018-midterm/>

## Social and Mental Health

### SUICIDE

**Travis County suicide mortality in 2014 was the highest in ten years. Austin experienced 132 suicides in 2015.**

During the ten-year period between 2005 and 2014, 1,207 deaths by suicide occurred in Travis County, with 2014 having the highest yearly suicide rate. The figure below depicts the suicide mortality by year from 2005-2014 in the County.



## Maternal and Child Health

### INFANT MORTALITY

**Mortality among Black infants is twice as high as for White and Hispanic infants.**

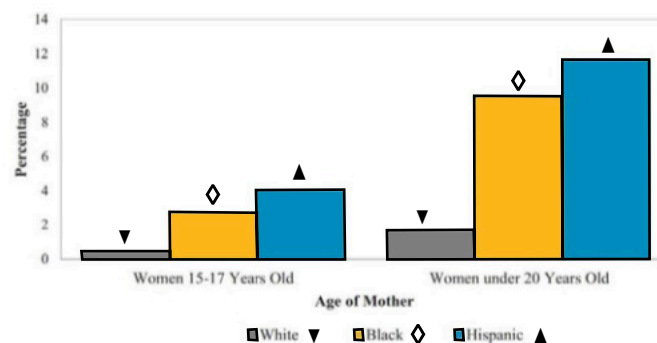
The average infant mortality rate for Travis County in 2014 was 4.4 per 1,000 live births. This is lower than the rate for Texas at 5.8 per 1,000 live births. Average infant mortality for the period 2012-2014 in Travis County and for the state was twice as high for Blacks (Travis: 9.0 per 1,000 live births; State: 11.5) as for Whites (Travis: 3.9; State: 5.1) and Hispanics (Travis: 4.3; State: 5.3).<sup>24</sup> Overall, in the previous ten-year period, Travis County has varied between 3.8 and 6.4 deaths per 1,000 live births.

### BIRTH TO TEEN MOTHERS

**Births to teen mothers are four times lower in Travis County than across the state.**

The percent of births to teen mothers for all races/ethnicities in Travis County is at or below the state average for 2012 to 2014. The average percent of births to women 15-17 years of age in Travis County was 2.2% during the period of 2012-2014.

**BIRTHS TO WOMEN UNDER THE AGE OF 20 YEARS OLD AND 15-17 YEARS OF AGE FOR TRAVIS COUNTY AND TEXAS 2012-2014**



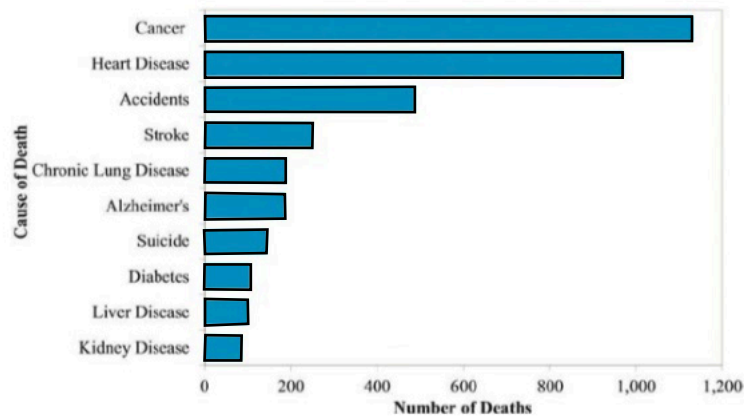
Data Source: Center for Health Statistics, Texas Department of State Health Services

<sup>24</sup> Center for Health Statistics, Texas Department of State Health Services, Texas Births 2012-2014.



## Death, Illness, and Injury

In 2017 the top three causes of death in Travis County were cancer, heart disease and accidents.

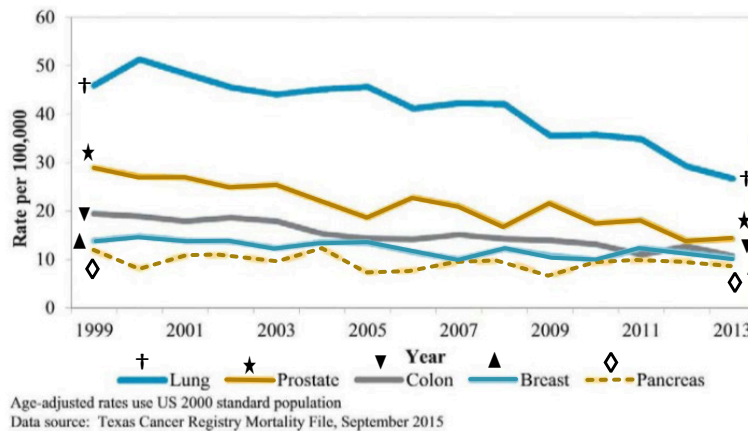


### CANCER

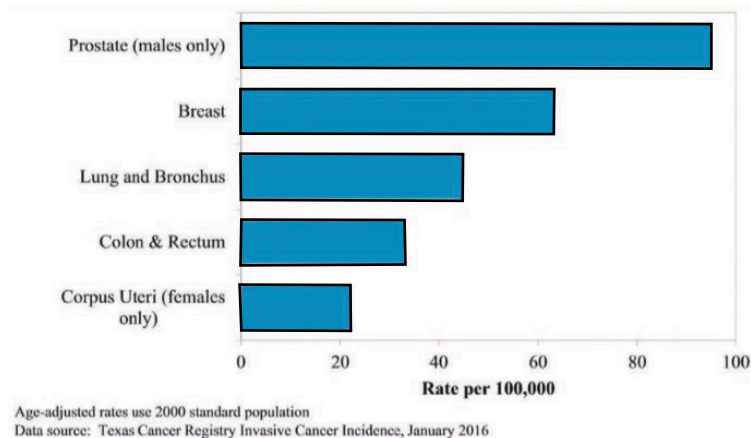
While cancer remains the leading cause of death in Travis County, the mortality rate due to the most common forms of cancer has declined over time.

Between 1999-2013 the leading cause of cancer related death was lung cancer. While the incidence of Prostate cancer remains high, the mortality rate has declined over time and is similar to other common forms of cancer.

AGE-ADJUSTED CANCER MORTALITY RATES IN TRAVIS COUNTY

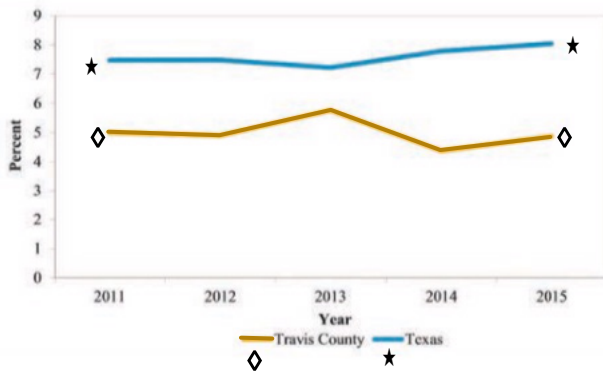


AGE-ADJUSTED INCIDENCE RATES FOR COMMON CANCERS IN TRAVIS COUNTY, 2009-2013, based on 2017 Critical Health Indicators Reporting



## CARDIOVASCULAR DISEASE

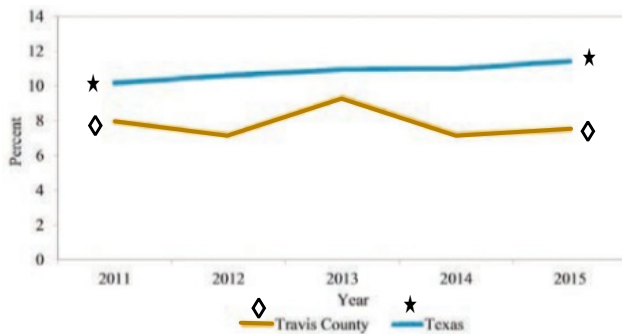
The prevalence of cardiovascular disease of Travis County adults between 2011 and 2015 remained lower than the state's average.



Data Source: Texas Behavioral Risk Factor Surveillance System (BRFSS), 2011-2015.

## DIABETES

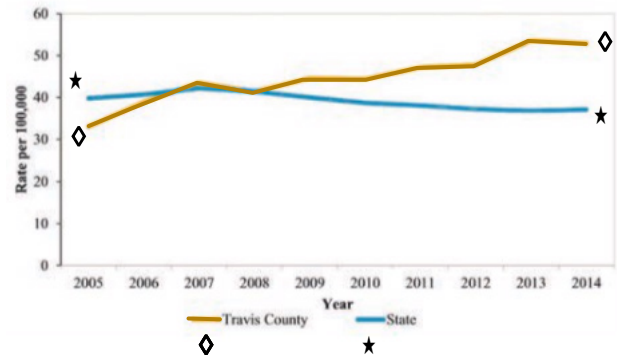
The prevalence of diabetes in Travis County, according to the Texas Behavioral Risk Factor Surveillance System (BRFSS), affects approximately 67,000 adults or 7.8% of the population. Between 2011 and 2015, the prevalence of diabetes in Travis County remains lower when compared to the state.



Data Source: Texas Behavioral Risk Factor Surveillance System (BRFSS), 2011-2015.

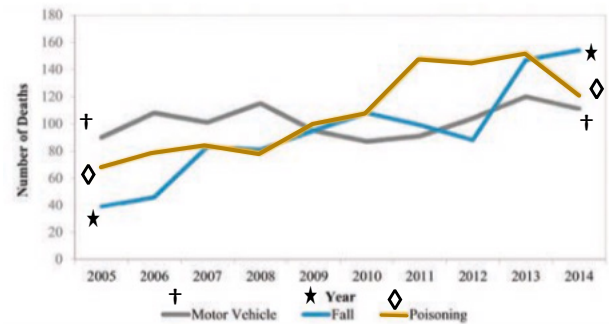
## INJURY

After the age was adjusted, the rate of deaths by unintentional injury between 2005 and 2014 increased in Travis County at the same time it decreased across Texas.



Data Source: Center for Health Statistics, Texas Department of State Health Services

The leading causes of unintentional injury deaths in Travis County from 2005-2014 were motor vehicle, falls, and poisoning. In 2013, rates for falls sharply increased as a leading cause of unintentional death.



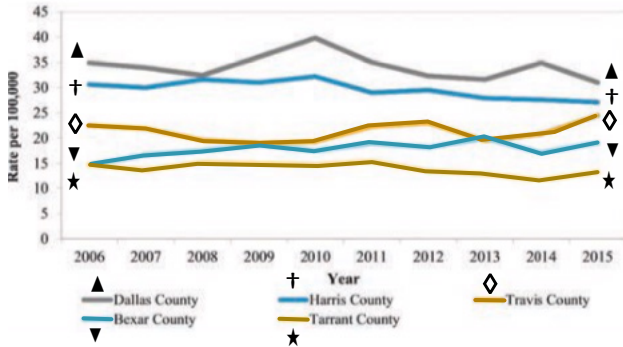
Data Source: Center for Health Statistics, Texas Department of State Health Services



## Communicable Disease

### HIV

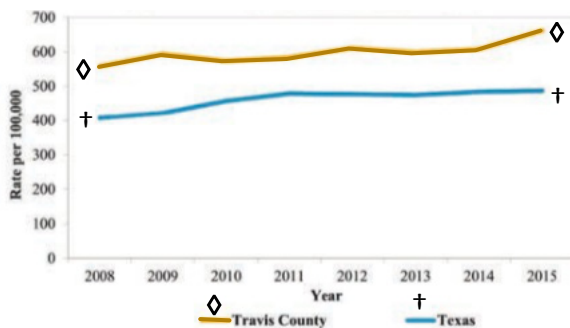
Over a ten-year period, the incidence rates for new HIV infection diagnoses in Travis County remained fairly constant until 2014 and 2015. During these years, there was a spike in reported new cases. The graphic below compares Travis County to Dallas, Bexar, Harris, and Tarrant counties.



Data Source: TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services

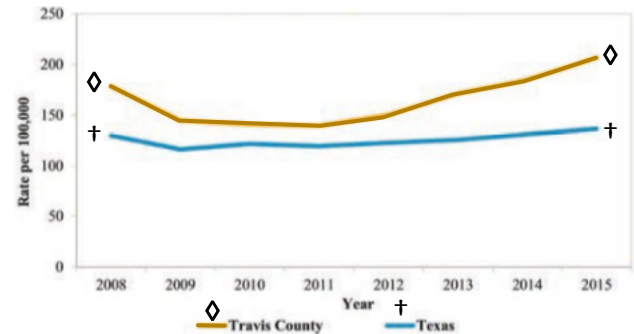
### CHLAMYDIA

Rates of chlamydia between 2008 and 2015 remained higher than the state's average. The following graphic shows how incidence rates are higher each year than the state's average, while also experiencing a spike in 2015 while the incidence rates across the state declined.



### GONORRHEA

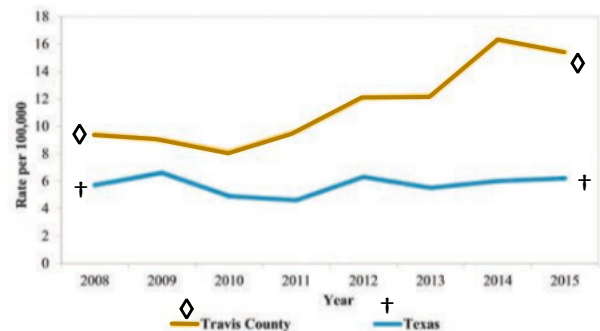
The figure below shows rates of incidence for gonorrhea in Travis County between 2008 and 2015. The County rates spiked between 2013 and 2015, while the state rates remained relatively constant.



Data Source: TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services

### SYPHILIS

Rates of syphilis between 2008 and 2015 was higher in Travis County than compared to the state. The figure indicates that Travis County had an increase in reported incidences around the same time that the state reported a decline in overall incidence rates (2013).



## HEALTH DISPARITIES

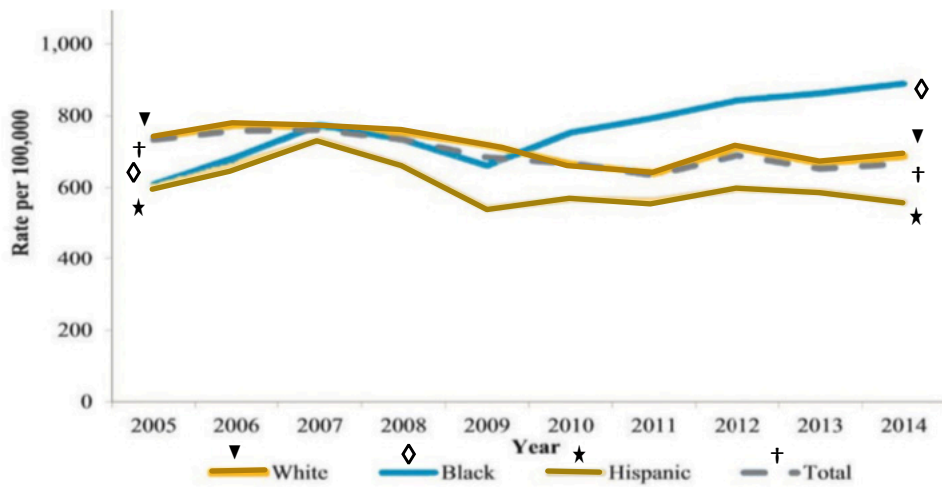
**Black residents in Travis County die sooner and more frequently and experience higher rates of chronic diseases and STIs than other race/ethnic groups in the County.**

According to the CDC, health disparities are preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups, and communities. In the Travis County CHNA we examined mortality, chronic disease burden, and STIs for differences between different race / ethnic groups.

### Mortality Rate

**Travis County's age-adjusted all-cause mortality rate and chronic disease incidence rates for Blacks has increased dramatically since 2019.**

MORTALITY BY RACE / ETHNICITY IN TRAVIS COUNTY, 2005-2014



Age-adjusted rates use US 2000 standard population  
 Source: Center for Health Statistics, Texas Department of State Health Services

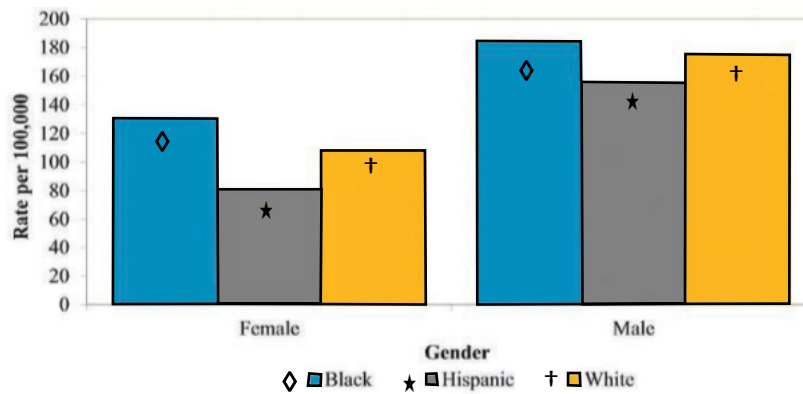
### MORTALITY RATE DISPARITIES

**Blacks living in Travis County experience higher mortality rates than other racial/ethnic groups from five of the seven leading causes of death.**

According to the Center for Health Statistics at the Texas Department of State Health Services, age-adjusted mortality rates for the leading causes of death in Travis County indicate that Whites had a greater prevalence of death from Alzheimer's Disease and Lung Disease than do Blacks and Hispanics. Blacks experience a higher rate of death compared to Whites and Hispanics from Heart Disease, Cancer, Stroke, and Diabetes. Hispanics experience a higher rate of death than Whites from Diabetes and Stroke.

## CANCER DISPARITIES

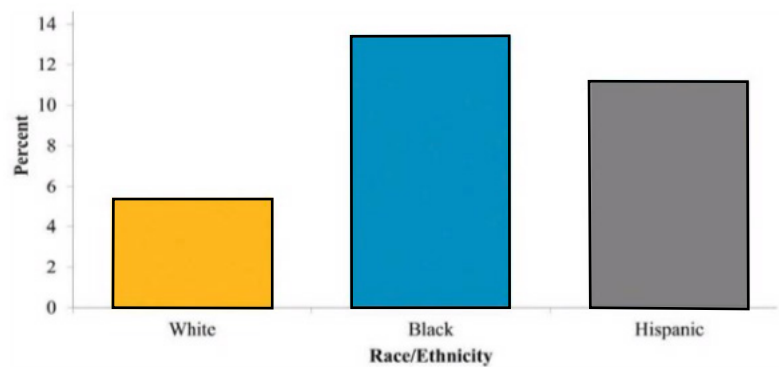
*Cancer-related mortality in 2013 disproportionately affected Black males and females.*



Source: Texas Cancer Registry Cancer Mortality File

## DIABETES DISPARITIES

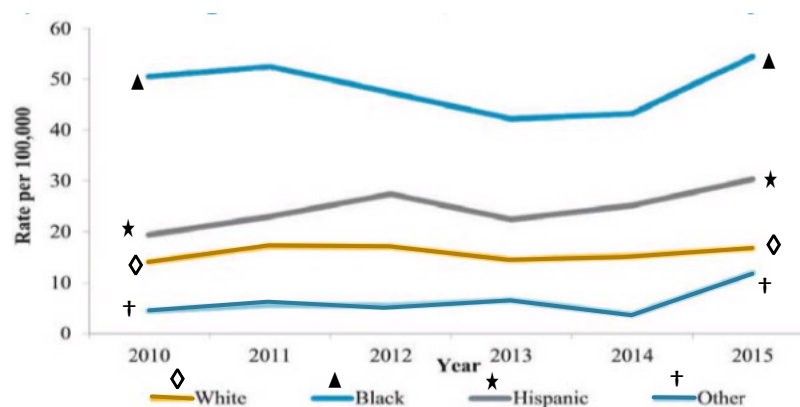
*Black and Hispanic adults in Travis County are more likely to have Diabetes.*



Source: Texas Behavioral Risk Factor Surveillance System (BRFSS), 2011-2015.

## HIV DISPARITIES

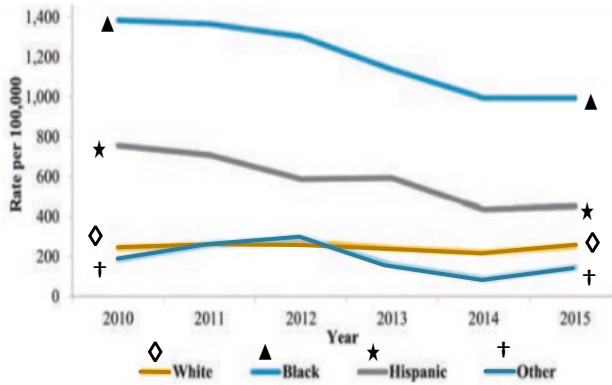
*Travis County Blacks, Hispanics and other race/ethnic groups have experienced a higher rate of new HIV diagnoses since 2013; White trend relatively unchanged.*



Source: TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services

### CHLAMYDIA DISPARITIES

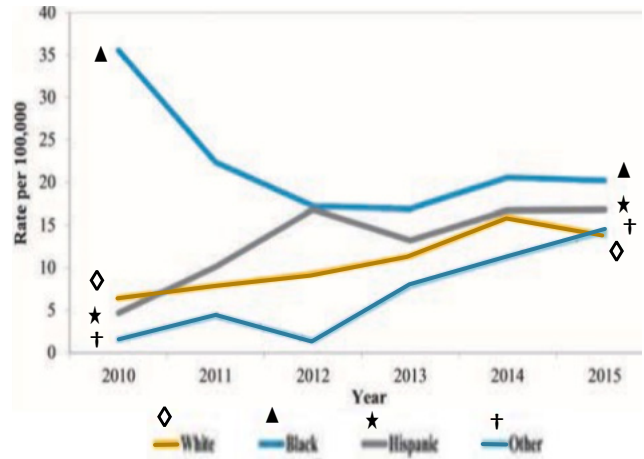
*Chlamydia incidence in Travis County is higher than the state's rate, disproportionately affecting Blacks.*



Source: TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Service

### SYPHILIS DISPARITIES

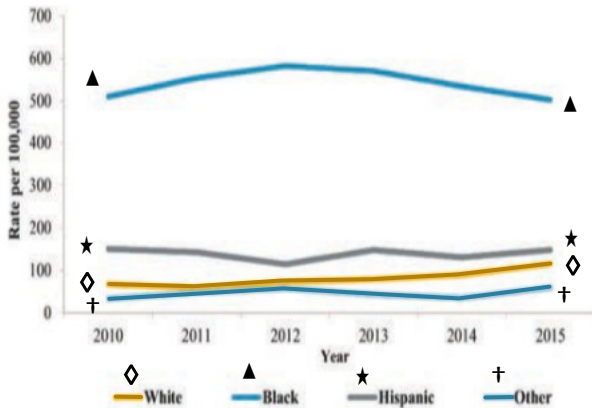
*Syphilis incidence rates for Blacks since 2010 are consistently higher than other races /ethnicities.*



Source: TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services

### GONORRHEA DISPARITIES

*Gonorrhea incidence rates between 2010 and 2015 disproportionately affect Black residents.*



Source: TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services

# COMMUNITY THEMES: STRENGTHS AND CONCERNS

Community input for the CHNA included a Community Themes and Strengths Assessment (CTSA) to gather perceptions of community assets and concerns and barriers that impact the quality of life of residents. Through focus groups, interviews, and surveys community residents were provided the opportunity to comment about their lived experiences. The approach allowed participants to gain confidence in contributing to the discussion by beginning with depersonalized observations of the community in general and progressing to reflective discussions around their own personal experience. Six community input focus groups were conducted in Travis County engaging a total of 55 community members; five community sector interviews were completed; and responses from the HACA interviews included 504 unique door- to-door surveys of HACA property residents 18 years or older.

## STRENGTHS AND ASSETS

*Travis County residents reported many strengths and assets for their community. Among the most frequently mentioned were community diversity, family friendliness and supports, livability, continued community growth, and existing infrastructure that supports education and career advancement and health care.*

- **DIVERSITY:** Community members view ethnic/racial diversity as well as age diversity as a positive characteristic of the County.
- **LIVABILITY:** Community members noted Travis County's array of amenities such as parks, stores, gyms, and libraries.
- **COMMUNITY GROWTH:** Focus group participants acknowledged rapid community growth in terms of new housing and businesses and saw this as a hopeful sign of opportunity.
- **COLLEGE AND TECHNICAL/CAREER READINESS INFRASTRUCTURE:** Community participants in organizational or leadership roles view Travis County as having many different opportunities for educational and training advancement.
- **HEALTH CARE INFRASTRUCTURE:** Travis County, particularly Austin, was viewed by community participants as a hub for health care with teaching hospitals and specialty care. Texans living outside of Travis often travel into Austin to seek specialty care.

*"There is a diversity of politics, age, culture... 'a blue dot in a red state'."*

## BARRIERS AND CHALLENGES

*Travis County residents have many different concerns for their communities. Prominent barriers and challenges cluster around a lack of access to important services such as affordable and culturally competent health care, affordable and safe housing, a safe community, healthy food options, public transportation, and family and youth activities. This perception is reinforced by an overarching belief that healthy communities are tied to political influence and power—the essential type of access that unlocks more opportunities for a better quality of life.*

- **GROWTH AND TRANSITION:** Growth was expressed as both a strength and challenge. Participants expressed concerns about community identity and how growth is pushing native Travis County residents out of the area.
- **DIFFERENCES IN AND LACK OF ACCESS TO CARE:** Physical places for health care exist but there is a challenge of accessing those places for service, particularly for those who are uninsured or on Medicaid/Medicare. Specialty care such as podiatry, mental health, or pain management were viewed as extremely difficult to access.
- **INADEQUATE CULTURAL COMPETENCY:** Lack of access to culturally and linguistically appropriate care and providers competent in the culture of the community was seen as a barrier. Outreach efforts to diverse communities were viewed as infrequent or not at all.
- **COST OF LIVING AND FINANCIAL STRESS:** Community members saw County growth increasing economic gaps, with some populations not benefitting from the growth while the influx of new residents contributed to an increase in the cost of living. In addition, community members shared that they experienced ongoing stress in finances and employment as growth accelerated.
- **LACK OF AFFORDABLE AND SAFE HOUSING:** Community participants, particularly those living in publicly subsidized housing expressed significant concerns around housing safety and the challenge of finding safe and affordable housing in areas that offer amenities for families.
- **TRANSPORTATION ACCESS:** Barriers related to transportation access had several nuances. The first was access to public transportation and inadequate routes to handle day-to-day travel needs in low-income communities. The second was cost of transportation and time associated with commuting and traffic.
- **POWER DYNAMICS AND INFLUENCE:** Community residents not in leadership positions expressed a lack of confidence in whether decision makers considered them in their decisions. Focus group participants commented that there was a lack of minority representation on boards and other business leadership positions.

*“People who live in Travis County are no longer from here. People who grew up here move out due to taxes.”*

*“We have access to services, but it’s not just what you know, it’s who you know to help you get in...”*

*“If you have a referral, it is going to take forever and if you have a referral for pain management, you can forget that.”*

*“Affordable housing, the cost of living and salaries have not kept up. If you’re a tech person and you have tons of money, you’re going to do great...but I think it’s still a big struggle for most people.”*

*“I’ve lived in the Austin area for quite some time and I love Austin, but I couldn’t afford to live in Austin.”*

– Pflugerville Resident

*“The highways [traffic] are big barriers .... if you wanted to incorporate a healthy lifestyle with your commuting, I don’t know how easy it would be.”*

*“A person can participate in community planning, but in the end, officials are going to do what they want to do regardless of what we say.”*

- **LACK OF AFFORDABLE HEALTHY FOOD ACCESS:** Community members felt food initiatives focused on healthy eating and obesity were good, but not effective if affordable healthy food options were not available in local restaurants or grocery stores.

*“I understand [businesses] making money, but how is it they want obesity to come down – healthier food is really not available to people.”*

- **LACK OF ACCESS TO FAMILY / YOUTH ACTIVITIES:** Community members perceive that Travis County is a good place to raise a family but there is a need for more family and youth activities. Some HACA property residents would like to see more positive activities for families that would curb negative behaviors in children and youth.

*“They are closing the Boys and Girls Club across the street. What are kids going to do without that club?”*

- **CRIME AND SAFETY:** Community concerns were voiced around crime and feeling unsafe when the environment includes loitering, homeless adults sleeping in the parks, and adults using drugs.

*“When you say ‘helps people be healthy,’ I think about safety first.”*

## COMMUNITY RECOMMENDATIONS AND PROPOSED SOLUTIONS

### Challenge: Lack of Access to Health Care

#### **Recommendation: Provide on-site social and health services in HACA communities**

HACA community residents recommended on-site health care services. Ninety percent (90%) indicated that they would be likely to use immediate medical care if offered at their housing project. Other recommendations included onsite group counseling; onsite pharmacy counseling and medication delivery; satellite clinics with free or affordable health screenings, support from a community wellness navigator.

### Challenge: Lack of Family Activities and Community Amenities

#### **Recommendation: Increase Community Activities**

Community members suggested activities to support positive family engagement. Suggestions most helpful to members include: Free or affordable exercise classes; family friendly cooking classes; saving the Boys and Girls Club (100% of BTW residents only); new or improved parks and walking trails; art classes; community gardens; a farmer’s market; religious/spiritual activities; neighborhood gatherings; sidewalks and bike lanes; and neighborhood groups or sports teams.

### Challenge: Lack of Access to Social Services

#### **Recommendation: Meet People Where They Are**

Community residents recommended solutions that would reach people where they are: Improving marketing and outreach to ensure everyone has access to information on available resources; and creating one-stop resource centers at the neighborhood level in the areas where people that access them the most live or work.



### **Challenge: Addressing Health Equity**

#### ***Recommendation: Increase Opportunities and Improve Access to Community Amenities***

During community input conversations, participants shared experiences of financial challenges and saw increased financial security as one of (and in some cases the most) critical solution to addressing most of the challenges in communities. This included providing financial education, supporting workforce development opportunities, and increasing opportunities for families to earn a better living. Community amenities such as high quality, state of the art parks and playgrounds, creative transportation options, sidewalks, and recreational paths only exist in higher income or trendy neighborhoods and are not available in lower income communities.



### **Challenge: Food Insecurity**

#### ***Recommendation: Increase Affordable Healthy Food Outlets and Nutrition Education***

Community residents recommended increasing the number of farmers markets and community gardens. Additionally, residents of HACA communities expressed the need for healthy cooking classes to teach them to prepare healthy meals on a budget. HACA community residents recommended providing access to a dietician in their community that could provide them with nutrition education to help them make better choices.



### **Challenge: Crime and Safety**

#### ***Recommendation: Prevention, Mental Health Resources, and Financial Security***

Community members provided several recommendations to combat crime and improve safety. Suggestions included creating economic opportunities for community members that have been left out of the growing economy. Additionally, community members saw the lack of positive activities or alternatives that would engage youth as a major contributor to crime and recommended increasing enrichment activities for youth. The provision of substance abuse and behavioral health services where people live is critical to stem the growing mental health crisis in Travis County. Several HACA property residents expressed the need for increased lighting as a way to make residents feel safer.



# ROOT CAUSES AND FORCES OF CHANGE

*The root causes influencing poor health in Travis County include the negative consequences of racial and ethnic discrimination and the ongoing stress for many Latinos associated with the upsurge in anti-immigration sentiment and the chaotic policy climate in the US and Texas. For many residents, the continuing stress associated with the cost of living and the living wage gap contribute to a poor quality of life. This is further exacerbated by challenges accessing needed services in the ever-changing landscape of community growth and expansion.*

## ROOT CAUSES

**XENOPHOBIA AND ANTI-IMMIGRATION:** In the current social and political climate anti-immigration, xenophobia, and other practices of racial or ethnic mistreatment impact the health and well-being of minority populations. Opportunities to promote cross-cultural relationship building; promoting diverse representation in leadership; culturally competent outreach and meaningful engagement; asset-based communications related to low-income populations and communities of color; and partnerships with faith-based and cultural organizations can help to promote a positive shift.

**COST OF LIVING AND LIVABLE WAGE:** The data provided illustrates the gap between cost of living and income for low-income wage earners. Actions that can trigger positive outcomes for under-resourced families include: providing free workforce development training applicable to advance low-income wage earners to better jobs and careers that meet them where they are in their skill-level; addressing childcare, transportation, and other barriers to securing workforce training and travel necessary to access higher paying employment; promoting and supporting small business entrepreneurship; increasing minimum wage and then working with major employers to set livable wage goals for their employees; ensure cost of living adjustments based on place-based economic growth.

## FORCES OF CHANGE

**POLICIES AND PROGRAMS TO IMPROVE FOOD ACCESS:** Both quantitative data and community input illustrated food access as a critical change lever in improving health. Noted actions to improve access include: expansion of farmers markets, WIC food stores, and community gardens; policies to incentivize and reinforce quality full-service grocery store in food deserts; partnerships to subsidize and promote participation in healthy meal prep delivery services to food deserts; use of mobile or pop-up markets as a temporary measure until permanent quality, healthy food outlets are made available.

**POPULATION GROWTH / COMMUNITY DEVELOPMENT / GENTRIFICATION:** With continued growth projected for Travis County over the next 10 years, measures that can help ensure low-income communities benefit from this growth can be a change lever to moving people out of poverty. Decision makers can intentionally implement an equity lens in planning and governance actions by using tools like policy impact assessments, health impact assessments, community advisory/monitoring committees, community benefits agreements with developers and new businesses to ensure no disproportionate benefit or burden is placed on any community. Travis County leaders are encouraged to explore models around the country that maximize the health system community benefits requirement to promote affordable housing development; and provide leadership training to build the capacity of low-income residents to serve on decision making bodies to build local leadership in underrepresented communities.

### **CENTRALIZED / DECENTRALIZED HEALTH CARE AND SOCIAL SERVICES:**

Community input participants indicated that they experience challenges accessing health care and social services due to the location of services. With transportation limitations and other barriers, strategies to centralize multiple services and/or decentralize health care services into neighborhood level sites will expand opportunities for residents to access necessary services.

# LOCAL PUBLIC HEALTH INFRASTRUCTURE

## HEALTH RESOURCE AVAILABILITY

For this CHNA the development team used in its assessment approach the County health infrastructure instead of the measurement of public health essential services. The rationale for this decision is that the presence of essential services does not necessarily mean those services are accessible. Therefore, for this CHNA health care infrastructure is used to identify current health care capacity, health system gaps, and possible areas in which improvements can be made to increase access. There is a network of additional nonprofits and charitable organizations addressing various health and social service needs for vulnerable populations.

### Hospitals

According to the Texas Department of State Health Services, 2016 Annual Hospital Survey there were 24 listed acute care and psychiatric hospitals in Travis County. This reflected a total of 3,139 acute care beds and 749 psychiatric beds (see Appendix for list of acute care and psychiatric hospitals in Travis County).

### Federally Qualified Health Centers (FQHCs)

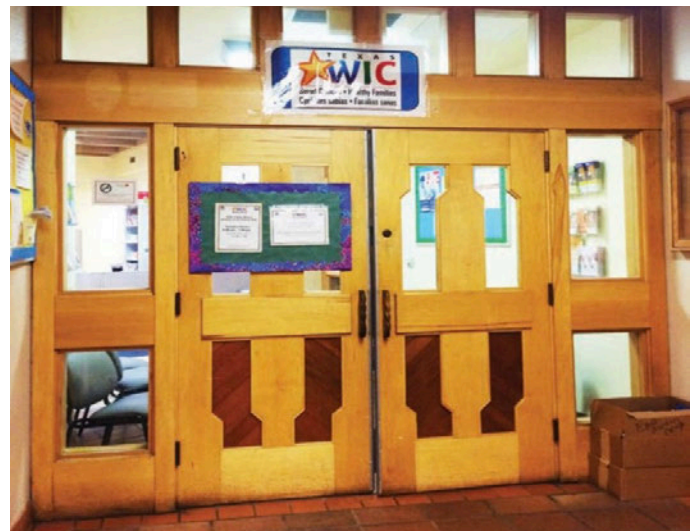
There are 35 community health center clinics (CHCs) in the County and a total of 43 FQHCs in and within 20 miles of Travis County. CHCs represent the safety net for local health care (see Appendix for a listing of the FQHCs in and surrounding Travis County). In addition to hospitals and CHCs, Austin Public Health operates six Neighborhood Centers and three outreach sites. These centers and sites offer a broad spectrum of social services and health care services including flu shots, health education classes, pregnancy testing, reproductive counseling, and preventive health screenings.

### Behavioral Health

There are 38 clinics or centers offering behavioral or mental health services which includes community health centers.<sup>25</sup>

### WIC Centers

Travis County has a significantly lower store to population ratio than the U.S and Texas. In Travis County there were six authorized WIC store sites for every 100,000 in population compared to 9.1 for Texas and 15.6 for the U.S. The WIC program not only provides food store sites but also has clinic locations that provide additional services to support pregnant mothers, women, infants, and children zero to 4 years of age. All WIC centers with the exception of Elgin Clinic and Oak Hill Clinic provide after hours or Saturday services (see Appendix for a listing of WIC store locations and service centers).



<sup>25</sup> Data Source: Texas Association of Community Health Centers.

## PATIENT-PROVIDER RATIOS

According to the County Health Rankings 2016 data, Travis County had a primary care physician/ patient ratio of 1,180 to 1, is significantly better than the state ratio. For dentists, the patient ratio is even greater at 1,470 patients for every one dentist. For mental health providers the ratio is 420 to 1 which is significantly better than the state ratio of 1,010 to 1. As noted, in the community input data, participants viewed the healthcare infrastructure as a community asset.

### Utilization

**Utilization of health care and pharmacy services vary across geography, demographics, and operator with 17% of low-income patients seeking emergency department care but not seeking primary care.**

Included in the 2018 HACA survey were questions about participants' healthcare system usage. Preliminary results revealed that Lakeside respondents were more likely to have visited primary care in the past year (73%,  $p < 0.01$ ) when compared to respondents from BTW (57%) and Chalmers (56%). Emergency Room (ER) use was similar across sites with 47% of respondents reporting having visited the ER one or more times in the past year. Overall, 17% of respondents visited the ER and did not go to primary care in the past year. Lakeside residents were more likely to be hospitalized in the past year ( $p < 0.05$ ) with 24% reporting one or more hospitalizations compared to 19% at BTW and 11% at Chalmers.

The most commonly utilized health clinic reported overall was CommUnity Care Health Centers (46%). The clinic utilization was different across sites ( $p < 0.001$ ). Lakeside residents were less likely to report not having a primary care clinic (2%) as compared to 13% at Chalmers and 17% at BTW. Lakeside residents were more likely to report going to a non-community clinic (27%) compared to 19% at Chalmers and 12% at BTW. The most common pharmacy used was HEB (62%) followed by Walgreens (20%). Utilization patterns also provide insight into how people access and navigate systems and practices to obtain the care they need. In one focus group, community residents discussed appointments and the challenge or ease some had in getting appointments to see a physician, particularly for specialty referral. One resident shared that the way to expedite getting a referral appointment was to go to the emergency room and that would move you up on the priority list from your primary care provider to a specialist referral. Examples such as this may shed light on system capacity issues and ways in which users have to navigate systems to receive timely care.

### Insurance Coverage

**Insurance coverage remains a key driver in whether an individual has access to care or will seek care when needed.**

According to U.S. Census Bureau, American Community Survey for 2017, 12% of Travis County residents are uninsured. Of the total uninsured population, 83% are adults ages 18 to 64, and 15% are under the age of 18. From 2013 to 2017, the number of uninsured Travis County residents decreased by 28% due to increased availability of insurance coverage through the ACA ("ObamaCare"). Travis County's proportion of uninsured residents is lower than the state level at 17% uninsured.

#### UNINSURED POPULATION COMPARISON

Health Insurance Coverage Status by Age in Travis County, 2013 & 2017				
	2013	2017	Change	Percent Change
Insured	911,698	1,073,782	162,084	18%
Uninsured	202,261	145,465	-56,796	-28%
Uninsured, under 18 years	23,256	22,042	-1,214**	-5%*
Uninsured, 18 to 64 years	177,521	121,388	-56,133	-32%
Uninsured, 65 and older	1,484*	2,035*	551**	37%

\*The estimate is not reliable at a 90% confidence level.

\*\*The difference between the 2013 & 2017 estimates is not statistically significant.

Created by: Travis County, HHS Research & Planning Division, 2017  
Source data: 2013 & 2017 American Community Survey 1-Year Estimates, C27001

# COMMUNITY HEALTH PRIORITIES

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## ***2-1-1 data reveal that assistance with medical appointments transportation and medical care expense assistance are the two top unmet health need requests to 2-1-1.***

2-1-1 is a free and confidential service that helps people across the country identify the local resources they need. The 2-1-1 program is administered by United Way and is available 24 hours a day, 7 days a week. Through the 2-1-1 service, local United Way affiliates are able to track the type of services or resources requested and whether the need was met or unmet. The most common unmet health needs requested through the 2-1-1 service are listed in the Appendix. Unmet needs for the 10 ZCTAs with over 50% of individuals living below 200% of poverty indicate that electricity payment assistance, rent assistance, automobile payment assistance, health insurance, medical appointments transportation, and food pantry locations were most often mentioned (see Appendix for more information).

## **COMMUNITY RECOMMENDATIONS FOR IMPROVING HEALTH AND WELL-BEING**

Community members were asked to provide their vision for what positive change would look like for their community. Members were also asked to provide recommendations on the priorities decision makers should focus on that would have the greatest impact in helping them achieve and maintain a healthy life. Focus group participants expressed that they would know positive changes were happening in their community if they saw more people getting jobs, improvements in built environments such as quality parks and activities for youth of all ages (decrease in disconnected youth), and churches and social service organizations visibly and proactively serving the needs of residents in the community. Additionally, community leaders would include meaningful engagement of community members throughout the decision-making process. Specifically, being perceived more as part of the solution and sharing in the benefits experienced in communities where improvements or development has occurred.

Community members were asked to provide a recommendation on the priorities decision makers should focus on to improve the lives of people in their community. Of the 40 total community participants in Travis County, the top priorities for improving lives were: Higher paying employment opportunities; access to education (as a pathway to improving quality of life not just access to information); access to affordable, quality, safe housing; and affordable healthy food access.

## **THE TOP HEALTH PRIORITIES FOR TRAVIS COUNTY IN 2018**

### ***Data suggest that Travis County should focus on improving social inequities that drive poor health and dramatically improve the mental and behavioral health infrastructure and access to services. Significant barriers to access exist for care, insurance coverage, housing, food, transportation, physical activity, and community voice.***

Based on input from community members, data on current health conditions, and data on social determinants of health, the following were identified as top priorities for improving health in Travis County:

**MAKE INVESTMENTS IN IMPROVING THE SOCIAL DETERMINANTS OF HEALTH (SDOH)** - Improving community conditions by expanding economic opportunities and living wage jobs; expanding access to quality parks and green spaces, walking and biking trails, playgrounds, and facilities like the YMCA to support family health; subsidizing quality, affordable housing; expanded transportation solutions (especially for remote rural residents, and infrastructure to support safe biking and walking); and increased services to address the needs of the growing homeless population, including programs to secure stable transitional and permanent housing, availability of shelter beds, free health care and transportation services to health care services, and employment and job search services. We know that poverty limits access to healthy foods and safe neighborhoods and that more education is a predictor of better health. We also know that health suffers in communities with poor SDOH such as low-quality housing, low income, unsafe neighborhoods and schools, or substandard educational opportunities.<sup>26</sup>

<sup>26</sup> CDC, 2018.

**BEHAVIORAL AND MENTAL HEALTH** – Improve access to services across the continuum of behavioral and mental health needs (e.g., mental illness, substance use disorder, social connectedness). Participants noted the negative impacts on community health of the opioid epidemic and the need for increased mental health services, particularly for the most vulnerable and disconnected youth. A recent study sponsored by the National Council for Behavioral Health; America’s Mental Health 2018 found that the lack of access to behavioral health services is the root cause for the mental health crisis in America. Access to mental and behavioral health services, especially for children and youth, should be among the most important priority actions considered by Travis County.

**ACCESS AND AFFORDABILITY OF HEALTH CARE** – Improve access to be responsive to the needs of families and children. Increase access by removing barriers to care such as flat rate fees for office visits, transportation and lack of insurance coverage, and expand programs which show promising outcomes or community response (e.g., a kiosk to promote services was referenced), ensure information on accessing resources is widely available through health care roadmaps and other visual explanations of where and how to access services. Solutions might include extended after-hours appointments, free or sliding scale health clinics in neighborhood schools staffed by nurse practitioners, free public transportation that runs directly to FQHCs and FQHC look-alikes, additional FQHC access points in the most impoverished community locations where people live and work, specialty care services focused on the top chronic diseases and necessary services such as maternal and child health care in the Travis County population. Adults in worse health, those with low incomes, and the uninsured are much more likely than others to delay or forgo health services due to costs.<sup>27</sup>

**CHRONIC DISEASE RISK FACTORS** – Improve access to affordable, healthy food options, eliminate food deserts, increase opportunities for free or affordable physical activity for all ages. Today, 7 of the 10 leading causes of death in the United States are chronic diseases, and almost 50% of Americans live with at least one chronic illness. People who suffer from chronic diseases experience limitations in function, health, activity, and work, affecting the quality of their lives. Underlying these conditions are significant health risks such as tobacco use, poor nutrition, and physical inactivity. Increasing opportunities to engage in healthy behaviors reduces the risk for illness and death due to chronic diseases.<sup>28</sup>

**OUTREACH, ENGAGEMENT, AND INFLUENCE** – Expanding leadership opportunities for marginalized community members, increase culturally appropriate messaging and outreach, create opportunities for personal development, promote a positive narrative, highlight positive community assets and efforts, identify and execute ways in which visible quick wins can be demonstrated that are driven by community voice and engagement in the decision-making process.

<sup>27</sup> Gary Claxton, Bradley Sawyer and Cynthia Cox, Kaiser Family Foundation, 2019.

<sup>28</sup> CDC, 2013.

# CONCLUSIONS

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The 2019 CHNA process sheds light on the opportunities and challenges that exist in improving health outcomes in Travis County. Community conversations helped to provide insight into the lived experiences that tell the story behind the data. This assessment provides a new baseline from which the CHNA partners and other decision makers will begin to develop a community health improvement plan for the next three years.

In addition to identified health priorities, the CHNA process helped partners broaden relationships with community members across sectors and neighborhoods. Many community members expressed a desire to be more involved and welcomed the opportunity to be a resource in the health improvement planning process. These new community relationships help promote accountability and will ensure that the decisions made as a result of this CHNA will represent the true needs of those most impacted. With this information, decision makers can confidently work towards becoming a healthier community.

To improve the health of Travis County citizens, it is essential to work collaboratively in the spirit that community participants envisioned for a healthy community and to focus County resources and engaged leadership on the priorities noted above. Their vision is both inspiring and possible with intention and commitment to a community that works for all its residents.



# APPENDICES

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**2018**

COMMUNITY HEALTH NEEDS ASSESSMENT

# TRAVIS COUNTY, TEXAS

Community Input Summary Report



**StDavid's**  
**FOUNDATION**



Ascension



Seton

# TRAVIS COUNTY, TEXAS



# TRAVIS COUNTY COMMUNITY INPUT AT-A-GLANCE

## Communities Engaged in Input Conversations

### Bluff Springs

- ◆ Pleasant Hill Branch Public Library
- ◆ William Cannon Apartment Homes

### Rosewood

- ◆ Booker T. Washington Terraces Public Housing Complex

### Rundberg

- ◆ North Austin YMCA

### Pflugerville

- ◆ Pflugerville Public Library



## Top Overall Community Challenge

Growth and Economics / Affordability (finding “well-paying” jobs, access to affordable housing)

## Causes of or Contributors to Community Challenges

Community participants attributed crime, obesity, addiction, abuse, and homelessness to a lack of economic resources, low paying jobs, high cost of quality foods/activities, and limited individual development opportunities for economic growth for the poor.

## 40 Community Residents Engaged In Conversations

### Community Input Participants Self-Identified as...

◆ Hispanic, Latino, or Spanish Origin	37.5%
◆ Black or African American	25%
◆ White or Caucasian	20%
◆ Asian	5%
◆ American Indian / Native or Alaska Native	2.5%
◆ Other	1%

### Age Stratification of Community Input Participants\*

◆ Under 18	5.1%
◆ 18 - 24	12.8%
◆ 25 - 44	46.1%
◆ 45 - 64	30.7%
◆ 65	5.1%

\*N = 39, totals may not add up to 100% based on rounding. One participant chose not to respond.

### Participants lived in their neighborhoods...\*

◆ Less than 1 year	15.3%
◆ 1 to 5 years	51.2%
◆ 6 to 10 years	12.8%
◆ More than 10 years	20.5%

\*N = 39, totals may not add up to 100% based on rounding. One participant chose not to respond.

## Positive attributes that make Travis County unique...

- ◆ Diversity
- ◆ Desirable place to live
- ◆ Broad offering of amenities (parks, stores, health care, gyms, libraries)
- ◆ Family-friendly
- ◆ Rapid community growth (both a positive and a challenge)



## Perceptions of Community Change

Rapid community growth was the #1 change cited by community residents. This is perceived to have both positive and negative affects:

### Pros

- ◆ Increased diversity
- ◆ Construction/building/business expansion
- ◆ New amenities (new homes, waterpark, new doctors, neighborhood restoration projects - in some areas)

### Cons

- ◆ Strain or demand on access to day-to-day resources
- ◆ Increase in cost of living

## Power and Influence in Community

Residents expressed a lack of confidence in whether decision makers considered them in their decisions. Though not confident in decision-making processes, many residents expressed wanting to be engaged in conversations. (Sign in sheets collected)

*"A person can participate in community planning, but in the end officials are going to do what they want to do regardless of what we say."* —Travis County Resident

## What change would look like...

- ◆ More people securing livable wage employment
- ◆ Improvements in built environments, beautification of poor neighborhoods, quality/state of the art parks in poor neighborhoods
- ◆ Community connectedness (decrease in disconnected youth, social service and faith-based organizations actively supporting community needs)
- ◆ Examples of decision makers actively engaging and considering resident feedback then seeing the actual results

## Community Expressed Priorities for Impact in Travis County

- ◆ Livable wage employment
- ◆ Access to education
- ◆ Access to housing
- ◆ Healthy food hubs with on-site resource centers
- ◆ Targeted help for those with extreme burdens

## Describing Community Health

# #1

## Poor Health

RESPONSE

No participants described community health as excellent

## Top Health Challenges

- ◆ Asthma/Allergies/Respiratory
- ◆ Mental Health Issues

## Causes or Contributors to Poor Health

Combination of lack of education and limited access to quality resources to support health (quality, affordable health care and healthy food options)

## Access to Health Care and Services

Community participants expressed challenges with timeliness in getting appointments, particularly for specialty care such as podiatry, mental health, and pain management. One resident provided an example of waiting three years for podiatry specialty care, while another resident expressed that it is often shared by primary care offices that an emergency room visit will move the patient up on the appointment list. Residents did feel that services are "out there," but were not easily accessible. For those with insurance, cost was still a concern due to co-pays and high deductibles.

*"If you have to have a referral it is going to take forever and if you have a referral for pain management you can forget that."* —Travis County Resident



## 2018 COMMUNITY HEALTH NEEDS ASSESSMENT

# TRAVIS COUNTY, TEXAS

## COMMUNITY INPUT SUMMARY REPORT

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### OVERVIEW

According to the 2010 census, Travis County has a population of 1,024,266 with 320,766 households. For 2017, the population is estimated at 1,226,698 which reflects a nearly 20% increase. Travis County is the fifth-most populous county in Texas and includes Austin, Texas, which is the county seat and capital of Texas. Communities identified for input sessions in Travis County were selected to engage residents in low-income neighborhoods, Spanish-speaking residents, and those in neighborhoods that had not been engaged through previous outreach efforts, such as Pflugerville. Five (5) community input sessions were conducted within Rosewood, Rundberg, Bluff Springs, and Pflugerville.

#### Community Conversations Locations

- ◆ Pleasant Hill Branch Public Library
- ◆ William Cannon Apartment Homes
- ◆ Booker T. Washington Terraces Public Housing Complex
- ◆ North Austin/Rundberg YMCA
- ◆ Pflugerville Public Library



Community input was gathered through face-to-face, small group, and individual conversations conducted in July and August of 2018. Conversations were designed to gain resident input on four primary areas of focus: community identity; access to health care and social services; root causes and determinants; and lastly, priorities and recommendations. Conversations were based on a series of 13 open-ended questions and two rated questions. Rated questions used a scale of poor, fair, good, and excellent to measure perception of community health and quality of life.

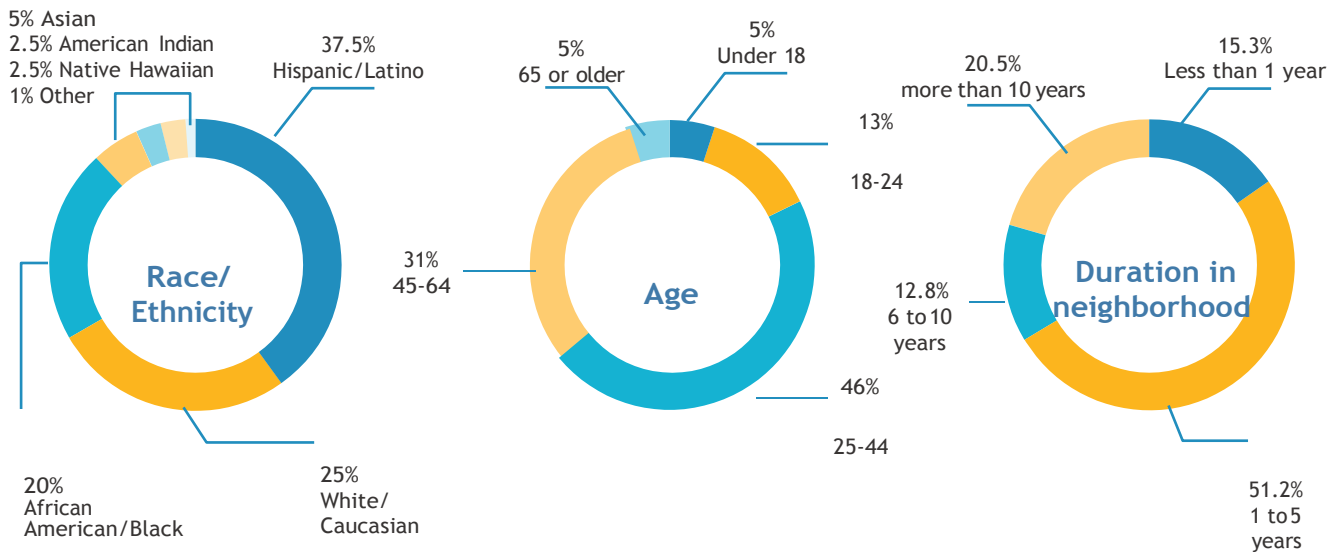
### DESCRIPTION OF COMMUNITY PARTICIPATION

A total of 40 Travis County residents were engaged during the community health needs assessment, community input process. Community members engaged in input sessions reflected the following demographics:

- ◆ The 2017 census estimates for the population of Travis County includes the following racial/ethnic groups: White- 80.2%, Black- 8.9%, American Indian and Alaska Native Alone- 1.2%, Asian- 7.1%, Native Hawaiian and Other Pacific Islander-0.1%. Ethnicity for Travis county includes Hispanic - 33.9%.



- ◆ Of the Travis County community members engaged, 37.5% were Hispanic/Latino, 25% were White/Caucasian, 20% were African American/Black, 5% were Asian, 2.5% American Indian, 2.5% Native Hawaiian, and 1% Other based on how participants self-identified their race/ethnicity.
- ◆ The age distribution for community input participants in Travis County included: 5% under 18 years of age , 13% were age 18-24, 46% were age 25-44, 31% were age 45-64, and 5% were 65 or older.
- ◆ Engaged Travis county residents represented individuals new to the community as well as those who were long-time residents. The full distribution of participants by the duration lived in their neighborhoods reflected: less than 1 year - 15.3%. 1 to 5 years - 51.2%, 6 to 10 years - 12.8%, and more than 10 years - 20.5%.



## NARRATIVE ON COMMUNITY IDENTITY

### What Makes Us Unique

Community members generally described Travis County as a diverse community with the elements (libraries, good schools, convenient shopping) that make it a desirable place to live. Members also saw Travis County as a hopeful place with evidence of the potential for opportunities.

Responses to the question of uniqueness varied among community locations. For example, community residents from the Bluff Springs conversations described the parks, trails, and natural spaces as part of the uniqueness, while residents engaged in Pflugerville saw their uniqueness in being a family-friendly community with day-to-day amenities easily accessible, which



I've lived in Austin and lived in Pflugerville and to me, Pflugerville has more of a family-friendly feeling than Austin. Austin was fun to be in my 20s, but Pflugerville feels more grounded to have a family in. It seems that the community does come together more than maybe I felt in Austin. I feel pretty connected. - Pflugerville Resident



improves their quality of life. Residents from the Rosewood Booker T. Washington Terraces conversation saw their community as a smaller unit, associating their responses to the housing complex and very immediate surrounding area.

## Top Two Community Challenges

Across all community conversations in Travis County, the most common community challenge identified by respondents was related to economic security or affordability. This included more specific issues such as finding livable wage jobs, affordable housing, taxes, and cost of living. The issue of homelessness was highlighted by participants in several community conversations with the perception of the issue encompassing both an economic issue and a perceived issue of crime or safety. Community members in Bluff Springs expressed challenges with addressing homelessness, drug addiction, suicide, and enhancements to built environments such as the need for more street lighting and shelters at bus stops. Residents participating in Rosewood conversations prioritized the issues that they saw having an impact on their children as the greatest challenges. These included a lack of positive activities for youth of all ages and the exposure to negative behaviors or elements such as adults using drugs and occupying the nearby park. In Pflugerville, participants expressed the challenges associated with growth, including traffic and a perceived burden on the public infrastructure not yet equipped to handle the growth.

Additionally, Pflugerville residents expressed a concern with losing the neighborly sense of connectedness as growth continues and the lack of healthy food options versus unhealthy, fast food options. Additional challenges expressed from the county participants as a whole included crime (prostitution, fights, burglary, violence), automobile accidents, and lack of ease in accessing day-to-day needs.

## Causes and Contributors to Community Challenges

Community members were also asked to identify what they believed were the root causes or contributors to the community challenges they identified. Low paying jobs or lack of economic security was seen as a driver for issues such as drug abuse, mental health issues, crime, and homelessness. Additionally, community members saw the lack of access to education resources or resources to improve educational achievement and work training opportunities as a contributor to community challenges. Residents in both Bluff Springs and Rundberg saw government processes, bureaucracy, and the slow pace of change or public action as a notable reason for the challenges in their community. One participant in the Pflugerville conversation didn't view the community as having any truly significant issues, stating that "it's not that bad. There's not a lot of poverty, I'm guessing. I mean there certainly are pockets of town that are lower-income, but I'm assuming that we're mostly middle-class income." Other contributors or causes included:



They are closing the Boys and Girls Club across the street. What are the kids going to do without that club?

-Rosewood BTW Terraces Resident

We have a lot of fast food. Maybe that's the biggest challenge. Grab-and-go food - something that would be easy for a dual-income, working community. To have healthy options for food would be nice.



- ◆ Lack of education
- ◆ Language barriers
- ◆ Lack of walkability/not pedestrian friendly (in relation to accidents)
- ◆ Lack of insurance coverage
- ◆ Lack of affordable quality childcare (as a barrier to economic security and employment)
- ◆ Perceptions about low-income communities

## Perceptions of Community Change in the Past Five Years

Across all conversations, community members agreed that rapid community growth was the biggest change over the past five years. Residents expressed seeing substantial growth in the number of people moving in, racial diversity, a boom in construction and building, new homes, increased community amenities, and increased bike lanes and sidewalks as examples of change. Residents in Rosewood highlighted that the increased cost of food and noticeable change in pricing, particularly with the trends toward healthy or organic foods, made the affordability of fast food more evident. Rundberg community members shared observations of community revitalization efforts with noticed efforts in

“ When we moved to Pflugerville there was a police chief and two assistants, only three schools and probably not even a major stop light. ”

cleaning up neighborhoods, more sidewalks and bike lanes, less visible homelessness, better bus stop lighting, and perception of lower crime/increased safety. In conversations in Bluff Springs, one participant shared the observation that there seemed to be an increased awareness of community issues and that more talks and discussions were taking place.



Ranked  
**1st**  
Poor Health

Ranked  
**2nd**  
Fair Health

Ranked  
**3rd**  
Good Health

## Describing Our Community’s Health

Participants were asked to describe or rate their community’s health using a scale of poor, fair, good, or excellent. The majority of conversation participants rated their community as having poor or fair health. Though perceptions of health were low, participants acknowledged that there were programs to help people get healthy. However, the focus of the health programs was more geared towards children than adults. This included summer feeding programs and sports activities.

“ I’m a retired teacher. We’re in Central Texas, we’re the allergy capital of the state. ”  
-Pflugerville Resident

## Greatest Community Health Challenges

When asked specifically about health challenges, the immediate response in several of the conversations was access. This included not having full-service hospitals, specialty care, and mental health care. In continuing the conversations, community members identified specific conditions they felt were health burdens in their community. Across the conversations, obesity, asthma/allergies, hypertension, and drug addiction were the most commonly referenced conditions. For Rosewood, poor nutrition and ADHD were also noted. Bluff Springs participants shared their concerns regarding diabetes and kidney failure, while in Pflugerville, allergies and just having the time for self-care and physical activity were the shared challenges. Rundberg participants saw obesity and lack of knowledge as the primary health challenges with alcoholism, diabetes, heart attacks, disability, and drug abuse rounding out their list. It is important to mention that in reporting on community responses around challenges we did not want to change



People work so much that they can't take off to go to a doctor. You got bills to pay. Some jobs don't want you to take off. You can't miss work if you need to take off you will be fired ... Employers may not say it directly, but they will make little threats.



the terminology or language used by participants in referring to substance use. Therefore, in the reporting drug use, substance abuse, drug abuse, and drug addiction are noted to reflect community participants' use of terminology.

## Causes and Contributors to Community Health

Interestingly, across all communities, participants identified during their discussions that some of the same causes or contributors to overall community challenges were also contributors to health challenges, particularly as it relates to economic insecurity (needing multiple jobs, under/unemployment, and low wages). Additionally, community residents saw a lack of knowledge/information/health education as a significant contributor as well lack of access and factors such as access to healthy food and access or time for physical activity as contributors. In speaking about access issues, an example of the barriers to seeking care came from a resident in the Rosewood community that worked in the food/fast food industry. The resident described the challenge of being unable to go to the doctor or seek medical care if you are employed in hourly wage positions or certain labor industries. Other contributors or causes of health challenges expressed included:

- ◆ The fact that neighborhoods are low-income
- ◆ Government processes (“the way government works”)
- ◆ Language barriers
- ◆ If the individual suffers from substance abuse that is a contributor for other health challenges or vice versa
- ◆ Lack of walkability of neighborhoods

## Raising Our Families

Most residents felt that Travis County overall was a good place to raise a family. Residents added that though it is a good place to raise a family, there was a need to be actively involved and aware of what children were experiencing or exposed to. This was of significant concern for Rosewood parents. Travis County residents also felt that to provide a good quality of life for their families they had to commute longer distances to find better-paying jobs not available in their community. This supported their ability to earn a higher income, but added to overall stress and put a strain on family time. Some Bluff Springs community members disagreed and felt that people were divided. This issue of divisiveness came up as a response to another question regarding community challenges in Bluff Springs. In Pflugerville, community participants agreed that overall the community was a good place to raise a family. One participant active in her child's school expressed that she did not see a strong level of volunteer support in the schools and saw this as a missing component. This could be due to work obligations or other limitations. For example, parents commuting to work in Austin may not have the ability to leave work, commute to Pflugerville in the middle of the day and get back to work in a timely manner. Rosewood residents at Booker T. Washington expressed some sense of community or connection with neighbors, but acknowledged that they could not respond yes because of lack of resources for children and the negative behaviors or elements to which children are exposed. Rosewood residents were extremely complimentary of the management staff at the complex and cited on numerous occasions how management actively kept them informed of employment opportunities and other wrap-around services.



## Influencing Community Decision

In general, residents did not feel that their feedback was considered when officials made decisions about their communities. Many residents expressed that even if they can and do actively participate in community planning, in the end, officials are going to do what they want regardless of the input. Some felt that public notices were the only instances in which someone's opinion really was needed and this may be only due to an obligation. One of the residents from Rundberg shared that although Restore Rundberg always encouraged community members to voice their ideas or concerns, the group never did anything with the feedback given. As a result, almost all participants felt that their interest and effort had no value. Residents in Rosewood did see this discussion as a positive step and wanted to see the follow up as well as other opportunities for groups to come to them for meaningful conversations. Additionally, this conversation sparked discussions in the room related to challenges residents were experiencing with their housing, such as mold that one resident stated caused her child with asthma to have an attack. Housing officials were in attendance and noted these concerns for response.

“A person can participate in community planning, but in the end, officials are going to do what they want to do regardless of what we say.”



Rosewood shared that pain management was almost impossible to access and accessing women's health services was also a significant challenge, particularly as it related to the referral process to a gynecologist. Pflugerville participants provided an example of a popular Ascension Seton physician [Dr. Freeman] who was considered stellar in her care and likely experiencing a patient overload. Dental care services were considered to be more accessible than other types of health care. Residents across areas were familiar with St. David's Foundation mobile dental units that are available in schools. Rosewood residents felt the frequency of mobile units visits to schools could even be increased in their community. Military veterans who self-identified during one conversation stated that although they did have access through VA benefits, those services were not easily accessible.

## PRIORITIES AND RECOMMENDATIONS

### Suggestions for Improving Community Health and Health of Families

Travis County community participants were asked to provide suggestions on those actions or resources that would help them and their communities achieve and maintain a healthy life. The three most commonly referenced suggestions were:

- ◆ Improving affordability/increasing family earnings
- ◆ Providing affordable healthy food options, coupled with access to dietitian education services and meal prep education (cooking demonstration classes)
- ◆ Increasing outreach and activities for children and youth of all ages

Travis County community members also strongly identified with suggestions around access to free, safe places for a variety of physical activities and opportunities for social and civic connectedness as ways in which they felt their health could be improved. Additional comments that rounded out the suggestions for what actions or resources would be needed to improve health included:

- ◆ Providing opportunities for intergenerational education for all family members
- ◆ Expanding or establishing mental health services
- ◆ Establishing one-stop resource centers at the neighborhood level
- ◆ Improving marketing and information sharing on existing resources

### What Positive Change Would Look Like for Travis County

In conducting community conversations, it was important to identify what community members felt needed to be visible or experienced in order to know that positive changes were occurring in their community. For members of Travis County, participants felt they would know positive changes were happening in their community if they saw more people getting jobs, improvements in built environments such as quality parks and activities for youth of all ages (decrease in disconnected youth), and churches and social service organizations visibly in community proactively serving the needs of residents. This proactive service would include streamlined



processes to support increased access. Additionally, community leaders would include meaningful engagement of community members throughout decision making processes. Specifically, community members envisioned being perceived more as part of the solution and sharing in the benefits experienced in communities where improvements or development has occurred.

Other positive changes residents would like to see include:

- ◆ More community activities and events to bring people together
- ◆ Better food stores and affordable healthy food options
- ◆ Increased accessibility for individuals with disabilities
- ◆ A St. David's hospital in Bluff Springs
- ◆ A closer VA clinic
- ◆ Lower crime rate
- ◆ A one-stop resource center
- ◆ Less drug abuse
- ◆ More support for the YMCA
- ◆ A revitalized downtown area
- ◆ A nice entrance for Pflugerville
- ◆ A new rec center with a pool and gym
- ◆ Better weather emergency preparedness
- ◆ More investments in solar, water-wise lawns and less chemical lawn treatment
- ◆ Tax incentives for new businesses to come into the area

## Priorities for the Greatest Impact

As a final question, community members were asked to provide a recommendation on the priorities decision makers should focus on to improve the lives of people in their community. Of the 40 total community participants in Travis County, the top priorities for improving lives were: **well-paying jobs, access to education, access to housing, and affordable healthy food access.**



Other priorities provided by community members include:

More cultural acceptance of people | More focus on health

More outreach services | Access to insurance | More access to the dental bus

Increasing the frequency of the dental bus that comes in the community (Rosewood)

Use of renewable energy sources/increased environmental focus (Pflugerville)

Keeping residents aware of what's happening in communities/giving enough notice

Group sessions like our community conversation where people can talk

More community activities, events, and classes | Hotline for mental health counseling

Spanish-speaking representatives | More engagement of churches

For city representatives to hold community activities and get people involved

More help for people that have nothing



## COMMUNITY INPUT SESSION QUOTES

“We have access to services, but it's not just what you know it's who you know to help you get in.”

– **Booker T. Washington Terraces Resident,  
Rosewood Neighborhood, Travis County**

“People work so much they can't take off to go to a doctor.”

– **Booker T. Washington Terraces Resident,  
Rosewood Neighborhood, Travis County**

“You can be a part of it [decision-making], but they are going to do what they want to do in the end regardless.”

– **Booker T. Washington Terraces Resident,  
Rosewood Neighborhood, Travis County**

“I understand making money, but how is it they want obesity to come down when healthier food is not really available to people.”

– **Booker T. Washington Terraces Resident,  
Rosewood Neighborhood, Travis County**

“When you say helps people be healthy, I think about safety first.”

– **Booker T. Washington Terraces Resident,  
Rosewood Neighborhood, Travis County**

“...kids see a lot of stuff so its hard to protect them from everything.”

– **Booker T. Washington Terraces Resident,  
Rosewood Neighborhood, Travis County**

“If you have special needs it's not easy. I had to wait three years to get an appointment to see a podiatrist.”

– **Booker T. Washington Terraces Resident,  
Rosewood Neighborhood, Travis County**

“If you have to have a referral it is going to take forever and if you have a referral for pain management you can forget that.”

– **Booker T. Washington Terraces Resident,  
Rosewood Neighborhood, Travis County**

“The highways are big barriers so 130, 45, I-35, you're basically stuck here so if you wanted to incorporate a healthy lifestyle with your commute, I don't know how easy it would be.”

– **Pflugerville Resident, Travis County**

“I've lived in the Austin area for quite some time and I loved Austin, but I couldn't afford to live in Austin. Maybe we should talk about affordability, because that's why we're here.”

– **Pflugerville Resident, Travis County**

“The thing is if you don't have insurance, you have to come out of pocket and more than likely you're not going to the doctor.”

– **Pflugerville Resident, Travis County**

“It was important to me that my daughter grow up in a diverse place and Pflugerville definitely is. People are always happy and smiling here, it feels like Pleasantville.”

– **Pflugerville Resident, Travis County**

“I think people are stressed, I think its economic stress even though we're living in a very abundant, the most abundant place in the country, there are people that are really suffering economically.”

– **Pflugerville Resident, Travis County**

“Things have changed so much. There is so much growth and things are not as affordable.”

– **Pflugerville Resident, Travis County**

“Affordable housing, the cost of living and salaries have not kept up. If you're a tech person and you have tons of money, you're going to do great and you'll do great where ever you are, or you'll be able to make it, but I think it's still a big struggle for people.”

– **Pflugerville Resident, Travis County**

# FACILITATOR'S GUIDE



## CENTRAL TEXAS CHNA COMMUNITY INPUT QUALITATIVE DATA COLLECTION

### Facilitator's Guide

*(Designed for lay community conversations with a primary target audience of those in marginalized communities, those experiencing the greatest health burden, and those living in areas of high health risk factors. The conversations should last no more than an hour and 30 minutes max.)*

#### GROUP DISCUSSION #1 – INTRODUCTION & COMMUNITY IDENTITY (30 minutes)

- 1. What would you say are the positive things that make this community unique, for example, people feel connected, sidewalks, clean streets, people talking to each other, churches?** *(Write responses on flipchart "Unique/ Positive" flip chart header)*
- 2. What would you say are the top two challenges (problems) your community faces? These do not have to be health related.** *(Write responses on flipchart "Top Two Challenges" flipchart header and denote by hash marks the number of people giving that answer)*
- 3. What are the two most critical health problems in your community? Think about what concerns you about your community?** *(Write responses on flipchart "Health Problems" flipchart header and denote by hash marks the number of people giving that answer)*
- 4. How has your community changed in the past five-years?** *(Write responses on a flipchart "Community Change" flipchart header)*
- 5. How would you describe your community's health and the ways your community helps people be healthy? You can respond using poor, fair, good, or excellent. Then ask for those that said poor, why. For those that voted fair, why. For those that voted good, why. Last, if any for those that voted poor, why.)**
- 6. Do you consider this community a good place to raise a family? (Think about is it safe, does it provide you with the economic opportunities to earn a living that supports a healthy life?)** *(Write responses on flipchart "Quality of Life" flipchart header)*
- 7. How would you describe decision making in the community? Do you feel like there are opportunities to be involved in decision making for what happens in your community?** *(Write responses on flipchart "Community Decision Making" flipchart header)*

#### GROUP DISCUSSION 2 – ACCESS TO HEALTHCARE AND SOCIAL SERVICES (15 minutes)

- 8. Is it easy to get appointments to see the doctor or to access healthcare?** *(If they are just answering yes or no ask prompting questions to get them to describe where they go for healthcare, how long it takes to see a doctor or other examples that illustrate the ease or difficulty of accessing healthcare)*
- 9. If I am new to community how do I know where to go to get the services I need? Where do people get information?** *(Write responses on flipchart "Information & Social Services" flipchart header). If you need to give examples of services consider, utility bill assistance, food assistance, employment assistance)*

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

*(Looking for how many people say no and write on the flipchart the health or social services they feel are not accessible/available in their community, what is the impact on life)*

**GROUP DISCUSSION 3 – ROOT CAUSES AND DETERMINANTS (15 minutes)**

**11. Think about how you described your community’s health. What do you think are the reasons or causes?** *(Refer to the flipchart sheet posted from the community health responses and write their responses to what they feel are the causes “Reasons and Causes-Health” flipchart header)*

**12. What do you think are the causes or reasons for the community challenges you mentioned?** *(Refer to the flipchart sheet posted from the community challenges responses and write their responses to what they feel are the causes for the community challenges/problems. Write the responses “Causes of Community Challenges”).*

**GROUP DISCUSSION 4 – PRIORITIES AND SUGGESTIONS (20 minutes)**

**13. What are some of your suggestions to improve the health in your community? What would make it easier for you and your family to stay healthy?** *(Write the responses on flipchart “Suggestions to Improve Health”)*

**14. What would you have to see or experience in order to feel like positive changes are happening in the community? What would positive change look like in this community?** *(Write responses on flipchart “Change for Our Community Is...”)*

**15. I will go around the room and ask each of you to provide a final comment on what two priorities should decision-makers focus on first that would have the greatest impact on improving the lives of people in the community? Consider that your comments will help influence decisions on how to support (improve) your** *(Write responses on the flipchart and capture the number of votes/people that responded)*

# COMMUNITY INPUT SESSIONS AND INTERVIEWS



## Central Texas Community Health Needs Assessment Community Input Sessions & Interviews

### Travis County

COMMUNITY INPUT FOCUS GROUP SESSIONS		
Location	Community Input Sector	Number of Participants
Pleasant Hill Branch Public Library	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	3 participants
William Cannon Apartment Homes	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	6 participants
Booker T. Washington Terraces Public Housing Complex	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	14 participants
North Austin YMCA	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	11 participants
Pflugerville Library	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	5 participants
East Austin Stakeholder Focus Group	Health providers, public agencies, and representatives from nonprofit organizations service low-income populations, minority populations, medically under-served, and populations with chronic diseases.	16 participants

Key Informant Interviews		
Name	Organization name	Title/Role
Sharon K. Melville	Texas Department of State Health Services - HSR 7	Regional Medical Director
Angela Henry	Central Texas Food Bank	Director of Community Health and Nutrition
Brad Lancaster	Lake Travis Independent School District	Superintendent
Louri O'Leary	Central Texas Catholic Charities	Executive Director
Nancy Mangham	St. John Episcopal Church	Church Administrator

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## LOCATIONS AND SECTORS REPRESENTED IN FOCUS GROUP SESSIONS

### COMMUNITY INPUT FOCUS GROUP SESSIONS – July & August 2018

Location	Community Input Sector	Number of Participants
Pleasant Hill Branch Public Library	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	3
William Cannon Apartment Homes (Spanish and English facilitator)	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	6
Booker T. Washington Terraces Public Housing Complex	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	14
North Austin YMCA (Spanish and English facilitator)	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	11
Pflugerville Library	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	5
East Austin Community	Health providers, public agencies, organizations serving low-income, minorities and medically underserved populations	16
<b>Total</b>		<b>55 Community Focus Group Participants</b>



# ORGANIZATIONS AND SECTORS REPRESENTED IN KEY INFORMANT INTERVIEWS

## COMMUNITY INPUT KEY INFORMATION INTERVIEWS – July & August 2018

Organization or Agency	Community Input Sector
St. John Episcopal Church	Nonprofit Organization Faith-Based Organization
Texas Department of State Health Services - HSR 7	Public health expertise State agency with data or information
Central Texas Food Bank	Nonprofit organization Organization serving minority, low-income or medically under-served populations
Lake Travis Independent School District	Organization serving targeted population Educational system / local public system
Central Texas Catholic Charities	Nonprofit organization Organization serving minority, low-income or medically under-served populations

## EAST AUSTIN FOCUS GROUP AND KEY INFORMANT INTERVIEW QUESTIONS

1.	Describe the community and score the current health status on a scale of 1 - 5. (1 worst-5 best)
2.	Identify the factors for the score and separate into strengths and weaknesses.
3.	Discuss the underlying barriers to health that contribute to the weaknesses.
4.	Discuss community strengths that can create opportunities for improving health.
5.	Identify and rank the criteria for prioritization.

## COMMUNITY INPUT FOCUS GROUP QUESTIONS

(low-income, medically underserved, and minority populations)

### Group Discussion 1 Community Identity

1. What would you say are the positive things that make your community unique?
2. What would you say are the top two problems or challenges your community faces?
3. What are the two most critical health problems in your community?
4. How has your community changed in the past five years?
5. Think about your community. What do you see or notice? Describe it?
6. How would you rate your community's health? (5 point scale = poor, fair, average, good, excellent)
7. Do you consider this community a good place to raise a family?
8. How would you describe decision making in your community? Is it easy for residents to be involved?

### Group Discussion 2: Access to Health Care and Social Services

1. Is it easy to get appointments to see the doctor or to access health care?
2. If I am new to community how do I know where to go to get the services I need?
3. Do the people in your community have access to the health care and social services they need?

### Group Discussion 3: Root Causes

1. Think about how you described your community's health. What do you think are the reasons or causes?
2. Think about the other community challenges you mentioned. What do you think are the causes or reasons for those challenges?

### Group Discussion 4: Priorities and Recommendations

1. What are your suggestions for improving health in your community? Another way to look at it is what would make it easier for you to stay healthy?
2. What would you have to see or experience in order to feel like positive changes are happening in your community? Another way to think about it is what would positive change look like?
3. What two priorities should decision-makers focus on first that would have the greatest impact on improving the health and well-being of people in this community?

## COMMUNITY INPUT QUESTIONS TO CAPTURE THEMES AND STRENGTHS

1.	What are the positive things in your community?
2.	What are the challenges in your community?
3.	What are the barriers to good health?
4.	How has your community changed in the past three years (or five years)?
5.	Do you consider this community a good place to raise a family?
6.	Describe decision-making in your community? Has your community made it easy or difficult for you to participate in decision-making?
7.	If I am new to community how do I know where to go to get the services I need?

## LIST OF HOSPITALS IN TRAVIS COUNTY, TX

HOSPITAL NAME	HOSPITAL TYPE	ACUTE BEDS	PSYCHIATRIC BEDS
Austin State Hospital	State	0	314
Ascension Seton Shoal Creek	Church	0	147
University Medical Center at Brackenridge	Church	339	0
St. David's Medical Center	Other NFP	595	0
Ascension Seton Medical Center Austin	Church	530	0
St. David's South Austin Medical Center	Other NFP	300	0
Texas Neurorehab Center	Partnership	47	0
Austin Lakes Hospital	Corporation	0	58
Ascension Seton Southwest	Church	33	0
Arise Austin Medical Center	Partnership	19	0
The Hospital at Westlake Medical Center	Partnership	23	0
Dell Children's Medical Center	Church	248	0
Central Texas Rehabilitation Hospital	Corporation	50	0
Lakeway Regional Medical Center	Corporation	106	0
HEALTHSOUTH Rehabilitation Hospital of South Austin	Partnership	60	0
Austin Oaks Hospital	Partnership	0	80
Cross Creek Hospital	Corporation	0	90
HEALTHSOUTH Rehabilitation Hospital of Austin	Corporation	83	0
Cornerstone Hospital of Austin	Corporation	157	0
Texas Neurorehab Center	Partnership	0	60
Northwest Hills Surgical Hospital	Partnership	8	0
North Austin Medical Center	Other NFP	424	0
Ascension Seton Northwest	Church	117	0
Vibra Rehabilitation Hospital of Lake Travis	Corporation	36	0

Source: <https://www.dshs.texas.gov/chs/hosp/hosplis2016.pdf>

## FEDERALLY QUALIFIED HEALTH CENTERS IN AND SURROUNDING TRAVIS COUNTY, TX

1	Health Center Name	Operated By
2	Ben White Health Clinic	Lone Star Circle Of Care
3	Ben White Health Clinic	Lone Star Circle Of Care
4	Ben White Health Clinic	Lone Star Circle Of Care
5	Care Connections Clinic	TRAVIS COUNTY HEALTHCARE DISTRICT
6	CommUnityCare Blackstock	TRAVIS COUNTY HEALTHCARE DISTRICT
7	CommuniCare Health Centers - Kyle	BARRIO COMPREHENSIVE FAMILY HEALTH CARE CENTER, INC.
8	Community Care ATCIC at Rundberg	TRAVIS COUNTY HEALTHCARE DISTRICT
9	Community First Health Center	TRAVIS COUNTY HEALTHCARE DISTRICT
10	CommUnityCare - North Central	TRAVIS COUNTY HEALTHCARE DISTRICT
11	CommUnityCare Arbor Terrace	TRAVIS COUNTY HEALTHCARE DISTRICT
12	CommUnityCare at Austin Recovery	TRAVIS COUNTY HEALTHCARE DISTRICT
13	CommUnityCare at Austin Transitional Center	TRAVIS COUNTY HEALTHCARE DISTRICT
14	CommUnityCare at Sunrise Church	TRAVIS COUNTY HEALTHCARE DISTRICT
15	CommUnityCare ATCIC	TRAVIS COUNTY HEALTHCARE DISTRICT
16	CommUnityCare ATCIC-Dove Springs	TRAVIS COUNTY HEALTHCARE DISTRICT
17	CommUnityCare Austin Resource Center for the Homeless	TRAVIS COUNTY HEALTHCARE DISTRICT
18	CommUnityCare Ben White Dental	TRAVIS COUNTY HEALTHCARE DISTRICT
19	CommUnityCare David Powell	TRAVIS COUNTY HEALTHCARE DISTRICT
20	CommUnityCare Del Valle	TRAVIS COUNTY HEALTHCARE DISTRICT
21	CommUnityCare East Austin	TRAVIS COUNTY HEALTHCARE DISTRICT
22	CommUnityCare Hancock	TRAVIS COUNTY HEALTHCARE DISTRICT
23	CommUnityCare Manor	TRAVIS COUNTY HEALTHCARE DISTRICT
24	CommUnityCare Oak Hill	TRAVIS COUNTY HEALTHCARE DISTRICT
25	CommUnityCare Pflugerville	TRAVIS COUNTY HEALTHCARE DISTRICT
26	CommUnityCare Rundberg	TRAVIS COUNTY HEALTHCARE DISTRICT
27	CommUnityCare Sandra Joy Anderson Community Health and Wellness Center	TRAVIS COUNTY HEALTHCARE DISTRICT
28	CommUnityCare South Austin	TRAVIS COUNTY HEALTHCARE DISTRICT
29	CommUnityCare Southeast Health and Wellness Center	TRAVIS COUNTY HEALTHCARE DISTRICT
30	CommUnityCare Spring Terrace	TRAVIS COUNTY HEALTHCARE DISTRICT
31	CommUnityCare William Cannon	TRAVIS COUNTY HEALTHCARE DISTRICT
32	Lone Star Circle of Care at Collinfield	Lone Star Circle Of Care
33	Lone Star Circle of Care at Stassney	Lone Star Circle Of Care
34	LSCC Family Care Center at Northwest	Lone Star Circle Of Care
35	LSCC Family Care Center at Northwest	Lone Star Circle Of Care

36	LSCC Family Care Center at Northwest	Lone Star Circle Of Care
37	Manor	PEOPLE'S COMMUNITY CLINIC
38	Manor Women's Health Center	TRAVIS COUNTY HEALTHCARE DISTRICT
39	Northeast Health Resource Center	TRAVIS COUNTY HEALTHCARE DISTRICT
40	PCC - Camino	PEOPLE'S COMMUNITY CLINIC
41	People's Community Clinic	PEOPLE'S COMMUNITY CLINIC
42	Riverside Women's Health Center	TRAVIS COUNTY HEALTHCARE DISTRICT
43	Springdale Women's Health Center	TRAVIS COUNTY HEALTHCARE DISTRICT

Source: <https://findahealthcenter.hrsa.gov/?zip=Travis%2BCounty%252C%2BTX%252C%2BUSA&radius=20&incrementalsearch=true>



## WIC SERVICES AND CLINIC LOCATIONS

WIC CLINIC	HOURS	LOCATION
Rosewood-Zaragosa Clinic Neighborhood Center	Mondays and Tuesdays 7:30am-12pm; 1pm-6:30pm Wednesdays and Thursdays 7:30am-12pm; 12:30-4pm *Closed second Wednesday of the month Fridays 7:30am-11:30am *Open second Saturday of the month 8am-12pm	2800 Webberville Rd., Austin, 78702
South Austin Clinic Multipurpose Center	Mondays and Tuesdays 7:30am-12pm; 1pm-6:30pm *Closed Wednesdays Thursdays 7:30-12pm; 12:30-4pm *Closed Fridays *No Saturday hours	2508 Durwood Dr., Austin, 78704
St. John Clinic Community Center	Mondays and Tuesdays 7:30am-12pm; 1pm-7pm Wednesdays and Thursdays 7:30am-12pm; 12:30-4:30pm *Closed second Wednesday of the month Fridays 7:30am-12pm *Open second Saturday of the month 8am-12pm	7500 Blessing Ave., Austin, 78752
Northwest Clinic	Mondays and Tuesdays 7:30am-12pm; 1pm-7pm Wednesdays and Thursdays 7:30am-12pm; 12:30-4:30pm *Closed second Wednesday of the month Fridays 7:30am-12pm *Open second Saturday of the month 8am-12pm	8701 Research Blvd., Suite A, Austin, 78758
Montopolis Clinic	Mondays and Tuesdays 7:30am-12pm; 1pm-7pm Wednesdays and Thursdays 7:30am-12pm; 12:30-4:30pm *Closed second Wednesday of the month Fridays 7:30am-12pm *Open second Saturday of the month 8am-12pm	2901 Montopolis Dr. Suite 1300, Austin, 78741
Far South Clinic	Mondays and Tuesdays 7:30am-12pm; 1pm-7pm Wednesdays and Thursdays 7:30am-12pm; 12:30-4:30pm *Closed second Wednesday of the month Fridays 7:30am-12pm *Open second Saturday of the month 8am-12pm	405 W. Stassney, Austin, 78745
Dove Springs Clinic	Mondays and Tuesdays 7:30am-12pm; 1pm-7pm Wednesdays and Thursdays 7:30am-12pm; 12:30-4:30pm *Closed second Wednesday of the month Fridays 7:30am-12pm *Open second Saturday of the month 8am-12pm	6801 South IH-35, Suites I & J, Austin, 78744

WIC CLINIC	HOURS	LOCATION
Manor Clinic East Rural Community Center	Tuesdays 7:30am-12pm; 1pm-6:30pm Thursdays 7:30am-12pm; 12:30-5pm *No Saturday hours	600 West Carrie Manor, Manor, TX 78653
Pflugerville Clinic North Rural Community Center	Mondays and Tuesdays 7:30am-12pm; 1pm-6:30pm Wednesdays and Thursdays 7:30am-12pm; 12:30-4:00pm *Closed second Wednesday of the month Fridays 7:30am-11:30am	15822 Foothill Farms Loop, Pflugerville, TX 78660
Oak Hill Clinic West Rural Community Center	Wednesdays 8am-12pm; 12:30-4:30pm *Closed second Wednesday of the month Fridays 8am-12pm *Closed the Friday before the second Saturday of the month *No Saturday hours	8656 State Hwy. 71 West, Bldg. A, Ste. B, Austin 78735
Del Valle Clinic South Rural Community Center	Mondays 7:30am-12pm; 1pm-6:30pm Thursdays 7:30am-12pm; 12:30pm-4:00pm *No Saturday hours	3518 FM 973, Del Valle, TX, 78617
Bastrop Clinic	Mondays 8:00am-12:00pm, 1pm-7pm Tuesdays 8:00am-12:00pm, 12:30pm-7:00pm Wednesdays 8:00am-12:00pm, 12:30pm-4:30pm Thursdays 8:00am-12:00pm, 12:30pm-4:30pm Fridays 8:00am-12:00pm *No Saturday hours	443 Highway 71, Bastrop, TX 78602
Elgin Clinic	Mondays and Wednesdays 8am-12pm; 12:30-5pm *Closed second Wednesday of the month Fridays 8am-12pm *No Saturday hours	218 South Main St., Elgin, TX, 78621
Mom's Place 512-972-6700	Mondays, Tuesdays, Wednesdays, Thursdays, and Fridays 8:30am-12pm; 12:30pm-4:30pm *Closed second Wednesday of the month *Open first and third Saturdays of the month 8am-12pm	701 Research Blvd, Suite B, Austin, TX, 78758

## RECOMMENDATIONS FOR WAYS HEALTH SYSTEMS CAN ENGAGE EXISTING COMMUNITY GROUPS IN ADDRESSING BEHAVIORAL HEALTH

### Travis County Key Informant Interviews



*A hospital system with more resources could help the local organizations with funding*

*Assistance with efficiently navigating specialty care, I don't have time to travel around to see generalists and then specialists (multiple visits needed to address issues)*

*Sustainable funding; hard to keep momentum with a program if there are funding issues*

*Have behavioral healthcare in the same location as primary healthcare*

*Partner with hospitals that are seeing repeat patients to coordinate post-discharge care; faith based, and community organizations could provide follow-up services and job placement*

*Public sector doesn't have money, so we need partnerships*

*We are having initial conversations with hospitals to try working together; however, funding is an issue.*

*We've tried to have forums for mental health issues (town halls), it's a good start. Funding is an issue to continue these efforts. Each community was left to pursue follow up issues on their own. If funding were available, the state would have been able to follow up more effectively. (Texas Department of State Health Services representative)*



## 2-1-1 MOST PREVALENT UNMET HEALTH NEEDS IN TRAVIS COUNTY, 2017

UNMET HEALTH NEED	NUMBER OF OCCASIONS THE NEED WAS UNMET ACROSS TRAVIS COUNTY
Medical Appointments Transportation	41
Medical Care Expense Assistance	33
General Dentistry	27
Prescription Expense Assistance	19
Community Clinics	14
Incidental Medical Expense Assistance	13
Adult State/Local Health Insurance Programs	10
Dental Insurance	6

## OVERALL UNMET NEEDS IN TRAVIS COUNTY FOR 10 ZCTAS WITH OVER 50% LIVING BELOW 200% POVERTY

ZIP CODE	TOP UNMET NEED 1	TOP UNMET NEED 2	TOP UNMET NEED 3
78617 (southeast)	Electric Service Payment Assistance	Adult State/Local Health Insurance Programs	Air Conditioners
78705 (central / UT area)	none	none	none
78719 (southeast)	Electric Service Payment Assistance	Medical Appointments Transportation	none
78721 (east)	Electric Service Payment Assistance	Automobile Payment Assistance	none
78723 (east)	Rent Payment Assistance	Electric Service Payment Assistance	Motel Bill Payment Assistance
78724 (east)	Electric Service Payment Assistance	Food Pantries	Motel Bill Payment Assistance

## SUMMARY OF KEY INFORMANT INTERVIEWS

### TOP HEALTH NEEDS IN COMMUNITY



*From a public health standpoint, regionally there are a large number of rabies cases - due in part to the number of bats*

*Behavioral healthcare*

*For overall region: access to care and lack of insurance*

*Public health funding*

*Introduced virtual therapy to address shortage in mental health providers*

*Lack of chronic medical condition management*

*Schools not required to teach sex education or health education*

*Southwest portion of central Texas (including Travis County): mental health care access, access to affordable care, injury/violence prevention, obesity prevention*

*The need to use state provided services as the last resort, adults with coverage (e.g. Medicare and Medicaid) cannot use Texas State Health Services facilities*

*Regionally, the incidence of Tuberculous among undocumented workers (such as truckers and farm workers)*

*Very high incidence of non-HIV sexually transmitted diseases*



## KEY INFORMANT INTERVIEWS - UNMET NEEDS

### GREATEST UNMET NEEDS AND GAPS IN HEALTHCARE SERVICES



*Regionally (Travis County and other central Texas counties) any specialty care is a problem, cardiology, tuberculosis care, dermatology, substance abuse, mental health.*

*Chronic disease management, diabetes management*

*Education is needed for behavioral healthcare.*

*Family planning education.*

*From a public health perspective, Hepatitis C care is missing from most counties regionally, there is no state program for treatment. It is very treatable but expensive.*

*Lack of insurance prevents people from getting care.*

*Mental health, substance abuse treatment, more need exists in the community than resources to address*

*People don't know that they need certain care,*

*Pregnancy and prenatal care access, especially in rural areas.*



### VULNERABLE GROUPS/ POPULATIONS FOR SPECIAL FOCUS



*All populations need support*

*Transportation issues exist for all residents in the region.*

*Anti-immigrant rhetoric out there, fear to pursue services.*

*Young people are vulnerable to drug issues*

*Those with issues addressing basic needs such as housing, food, and employment are important. Health takes a second priority compared to those.*

*Men's health, in general, is overlooked (focus on elderly and children).*

*Neighborhoods further south and east from the city are more vulnerable as the poverty level increases.*

*Those in poverty.*

*Those with no financial means to access healthcare.*

*Uninsured individuals; Texas did not expand Medicaid due to the political climate, so we have one of the highest uninsured populations.*

*Children and elderly are impacted more by social factors.*





## FOCUS GROUPS - COMMUNITY INPUT

Other priorities provided by community members include:



*More cultural acceptance of people*

*More focus on health and mental health*

*More outreach services*

*Access to insurance*

*Increasing the dental bus that comes in the community (Rosewood)*

*Use of renewable energy sources/ increased environmental focus (Pflugerville)*

*More community activities, events, and classes*

*Keeping residents aware of what's happening in communities/giving enough notice*

*Group sessions like these community conversations where people can talk*

*Hotline for mental health counseling*

*Spanish-speaking representatives | More engagement of churches*

*For city representatives to hold community activities and get people involved*

*More help for people that have nothing*





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# COMMUNITY HEALTH ASSESSMENT 2019



WILLIAMSON COUNTY, TEXAS

## Acknowledgements

The dedication, expertise, and leadership of a large number of agencies and people made the 2019 Williamson County Community Health Assessment (CHA) possible. This collaboratively developed plan engaged the community to produce a comprehensive assessment that will be used to develop the 2020-2022 Community Health Improvement Plan (CHIP). The Williamson County and Cities Health District (WCCHD) led this CHA effort in collaboration with strong community partners including Ascension Seton, Baylor Scott & White Health, Bluebonnet Trails Community Services, Georgetown Health Foundation, Lone Star Circle of Care, Opportunities for Williamson and Burnet Counties, St. David's Foundation, and the WilCo Wellness Alliance. The opportunity provided for collaboration between hospital systems and local public health agencies to collectively assess the health needs of the community we all serve was an important aspect of this project. This shared ownership of community health among diverse stakeholders enhances coordination and utilization of resources across entities to achieve improvements in the community's health. The following organizations and individuals graciously provided support for this project:



### 2019 CHA Task Force

#### Name

Jana Whitaker  
Ingrid Taylor  
Tara Stafford  
Andrea Richardson  
Suzy Pukys

Ray Langlois  
Tracy Angelocci  
Jim Ellis  
Kim Munoz  
Becky Pastner  
Jesse Simmons  
Jodee O'Brien  
Kelli Becerra  
Shelbi Snyder  
Deb Strahler  
Melissa Tung  
Justine Price

#### Organization

Ascension Providence  
Ascension Seton  
Baylor Scott & White Health  
Bluebonnet Trails Community Services  
Georgetown Health Foundation  
Langlois Consultant Services LLC  
(on behalf of Eastern Williamson County Collaborative)  
Lone Star Circle of Care  
Opportunities for Williamson and Burnet Counties  
Opportunities for Williamson and Burnet Counties  
St. David's Foundation  
St. David's Foundation  
United Way of Williamson County  
WilCo Wellness Alliance  
Williamson County and Cities Health District  
Williamson County and Cities Health District  
Williamson County and Cities Health District  
Williamson County and Cities Health District

## 2019 CHA Support Team

Name

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 Nicole Evert  
 Zeal Gandhi  
 Emily Hayes  
 Elise Huebner  
 Jay Rimel  
 George Strebel

Organization

Williamson County and Cities Health District  
 Williamson County and Cities Health District  
 Williamson County and Cities Health District  
 Williamson County and Cities Health District  
 Williamson County and Cities Health District  
 Williamson County and Cities Health District  
 Williamson County GIS

## WWA Leadership Team

Working Group

Coalition Coordinator  
 Support Staff  
 Support Staff  
 Support Staff  
 Behavioral Health Task Force  
 Child Youth Behavioral Task Force  
 Alan's Hope  
 Healthy Living  
  
 Maternal and Infant Health  
 Public Health and Medical Preparedness  
 School Health  
 Substance Abuse Collaborative

Name, Organization

Kelli Becerra, Williamson County and Cities Health District  
 Deb Strahler, Williamson County and Cities Health District  
 Shelbi Snyder, Williamson County and Cities Health District  
 Melissa Tung, Williamson County and Cities Health District  
 Kathy Pierce, Williamson County Precinct Two  
 Matt Smith, Williamson County Juvenile Services  
 Tammy Smith, Williamson County Precinct Two  
 Courtney Alcott, One Life Health Coaches  
 Chelsea Stevens, Texas A&M Agrilife Extension Service  
 Vinita Magoon, Baylor Scott & White Health  
 Toby Hatton, One Texas (Ascension Seton and Ascension  
 Providence)  
 Sherry Stamp, Georgetown ISD  
 Laurie Born, LifeSteps Council on Alcohol and Drugs  
 Rosana Sielaff, LifeSteps Council on Alcohol and Drugs

## WCCHD Leadership Team

Name

Dr. Virginia Headley  
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 Michelle Broddrick  
 Karina Martinez  
 Bryan Damis  
 Teresa Galindo  
 Ivah Sorber  
 Caroline Hilbert  
 Deb Strahler  
 Victoria Lippman  
 Justine Price  
 Tina Horkey

Division

Interim Executive Director  
 Medical Director/Health Authority  
 Administration and Finance  
 Clinical Services  
 Disease Control and Prevention  
 Environmental Health  
 Human Resources  
 Immunization Advocacy  
 Marketing and Community Engagement  
 Program Eligibility and Social Services  
 Quality and Strategic Management  
 WIC and Community Nutrition

## Board of Health

Name

Edward Strout, RN, CEN, LP, Vice-Chair  
 Mary Faith Sterk, MSW, LCSW, Secretary  
 Ehab Kwar  
 Dr. Luis Egelsee  
 Selicia Sanchez-Adame  
 Carole Bachmayer  
 Marlene McMichael, Chair  
 Joanne Land

City

Cedar Park  
 Georgetown  
 Hutto  
 Leander and Liberty Hill  
 Round Rock  
 Taylor  
 Williamson County  
 Williamson County

### Organizations that participated in Key Informant Interviews and Stakeholder focus groups

Baylor Scott & White Health	Round Rock Area Serving Center
Bluebonnet Trails Community Services	Sacred Heart Community Clinic
Boys and Girls Club	Shepherd's Heart Food Pantry and Community Ministries
Central Texas Catholic Charities	Taylor City Council
Central Texas Food Bank	Taylor Housing Authority
Christ Fellowship Church	Taylor Press
Community Resource Center of Texas Inc.	Texas Department of State Health Services Region 7
Eastern Williamson County Collaborative	The Caring Place
Georgetown Health Foundation	The Pavilion Clubhouse of Round Rock
Georgetown Public Library	Tripp Center
Interagency Support Council of Eastern Williamson County	United Seniors of Taylor
LifePark Center	United Way of Williamson County
Lone Star Circle of Care	Williamson County and Cities Health District
	Williamson County EMS Mobile Outreach Team

### Community Survey Distributors

AGE of Central Texas	LifeSteps Council on Alcohol and Drugs
Allen R. Baca Center	Muirfield Property Owners Association, Inc.
Avery Ranch Owners Association, Inc	Neighborhood Association of Southwestern Williamson County
Baylor Scott & White Medical Center - Taylor	Opportunities for Williamson and Burnet Counties
Bluebonnet Trail Community Services	Parmer Village Condominium Community
Christ Fellowship Church	Round Rock Public Library
City of Round Rock	Salvation & Praise Tabernacle Ministries
Cottages at Lake Creek Homeowners Association	Shepherd's Heart Food Pantry & Thrift Shop
Davis Spring Homeowners Association	Southeast Georgetown Community Council
Eastern Williamson County Collaborative	Southwestern University
Hill Country Community Ministries	Taylor Housing Authority
Hutto Has Heart	Texas State University Round Rock
Indian Oaks Neighborhood Association	The Caring Place
Interagency Support Council of Eastern Williamson County, Inc.	United Way
Intervention Services	WilCo Wellness Alliance
Lakeline Station, Foundation Communities	Williamson County
Liberty Hill Community Resource Center	Williamson County and Cities Health District

### Organizations that participated in Stakeholder Facilitated Activity

AGE of Central Texas	Dell Children's Health Plan
American Foundation for Suicide Prevention	Eastern Williamson County Collaborative
American Heart Association	Family Eldercare
Annunciation Maternity Home	First Baptist Church Georgetown
April Lopez and Associates	Fort Hood Behavioral Health
Ascension Seton	Frost Insurance
Baylor Scott & White Health	Georgetown Behavioral Health Institute
BCFS Common Thread	Georgetown Gospel Justice Center
Blackland Food Co-op	Georgetown ISD
Bluebonnet Trails Community Services	Girls Empowerment Network
Boys and Girls Club	Girls with Grit
Brighter Days Food Pantry	Heidi Group
Cedar Crest Hospital and Residential Treatment Center	Hill Country Community Ministries
Celebration Church	Hope Alliance
Cenikor	Hutto Has Heart
City of Georgetown Library	Hutto ISD
City of Georgetown Parks and Recreation	



Interagency Support Council of Eastern Williamson  
 County, Inc.  
 Intervention Services  
 IT'S TIME TEXAS  
 Keep Hutto Beautiful  
 Langlois Consultant Services LLC  
 LifeSteps  
 Lone Star Circle of Care  
 Lone Star Justice Alliance  
 Mature Driver Program  
 MAXIMUS  
 Mommie Support Network  
 NAMI Austin  
 Onestep Life Coach  
 Opportunities for Williamson and Burnet Counties  
 Palace Theatre  
 Profile by Sanford  
 Rock Springs  
 Round Rock ISD  
 Samaritan Center  
 Senior Access  
 Southeast Georgetown Community Council  
 Southwestern University  
 Spirit Reins  
 STARRY  
 Taylor Housing Authority  
 Taylor ISD

#### CASPER Organizations

Austin Public Health  
 Texas Department of State Health Services Region 7  
 Texas State University  
 Texas A&M University School of Public Health

#### Community Focus Group Convening Organizations

God's Way Christian Baptist Church  
 Opportunities for Williamson and Burnet Counties  
 Regarding Cancer  
 The NEST

Texas Department of Agriculture  
 Texas Department of State Health Services  
 Texas Health Steps  
 Texas State Technical College  
 Texas State University  
 The Arc of Texas  
 The Christi Center  
 The Georgetown Project  
 The Key 2 Free  
 The Pavilion Clubhouse of Round Rock  
 The Volunteer Center  
 TMF Health Quality  
 United Seniors of Taylor  
 United Way of Williamson County  
 Upward Bound  
 WCCHD WIC  
 WGU  
 WilCo Wellness Alliance  
 Williamson County  
 Williamson County and Cities Health District  
 Williamson County EMS  
 Williamson County Juvenile Services  
 Williamson County Sherriff's Office  
 WIOA Youth Workforce Solutions  
 Wonders and Worries  
 YMCA of GWC  
 Yoga Yoga

WilCo Medical Reserve Corps  
 Williamson County Office of Emergency Management  
 Williamson County GIS

The Pavilion Clubhouse of Round Rock  
 Tripp Center  
 Williamson County and Cities Health District

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## Executive Summary

### Overview

In order to strategically address health issues within the community, it is vital to sustain broad community partnerships first and develop a shared vision and goals for the future. Led by the Williamson County and Cities Health District (WCCHD), the 2019 Williamson County Community Health Assessment (CHA) was developed by a strong task force of community partners (CHA Task Force): Ascension Seton, Baylor Scott & White Health, Bluebonnet Trails Community Services (BTCS), Eastern Williamson County Collaborative, Georgetown Health Foundation, Lone Star Circle of Care (LSCC), Opportunities for Williamson and Burnet Counties (OWBC), St. David's Foundation, United Way of Williamson County, and the WilCo Wellness Alliance. The 2019 CHA is designed to collect, analyze, and use data to educate and mobilize communities, develop priorities, gather resources, plan actions to improve population health, and provide a foundation of data to be used for evidence-based goal setting and decision making for Williamson County, Texas.

### Methodology

The CHA Task Force used the National Association of County and City Health Officials (NACCHO) Mobilizing for Action through Planning and Partnerships (MAPP) process as a proven systematic framework for identifying community health needs and the resources for meeting those needs.(1) The MAPP process consisted of four assessments – the Community Health Status Assessment (CHSA), the Community Themes and Strengths Assessment (CTSA), the Forces of Change Assessment (FoCA), and the Local Public Health Systems Assessment (LPHSA).(2) The findings from each assessment are included as individual sections in the report. Together, the four assessments provide a comprehensive view of the factors influencing the health of the community and guide the community's determination of priority areas. Through the process, the CHA Task Force engaged over 2,600 community members and stakeholders and 182 households.

**The assessment process involved gathering both quantitative data (e.g. “numbers”) and qualitative data (e.g. “voices of the community”) through a variety of methods:**

- Community Health Survey
- Facilitated activities at community meetings
- Community focus groups
- Stakeholder focus groups
- Key informant interviews
- Mom's Community Listening Forum
- Local Public Health Systems Assessment
- Community Assessment for Public Health Emergency Response (CASPER)
- Primary and secondary data analysis

### Community Health Status Assessment

The CHSA explores aggregated, population-level data to define the health status of the county and provide key findings to residents and stakeholders. Indicators are divided into eleven broad categories based on the MAPP framework's “Core Indicator List.” The CHSA draws comparisons between Williamson County and Texas health indicators, as well as applicable Healthy People 2020 (HP2020) targets. The CHA Task Force obtained data from many primary and secondary sources at the local, state, and national level. Significant secondary data sources include American Community Survey, Behavioral Risk Factor Surveillance System, Texas Department of State Health Services, and U.S. Department of Agriculture. Local organizations, including BTCS, Hill Country Community Ministries, and LSCC, also provided primary data.

In 2017, the TOP 10 CAUSES OF DEATH in Williamson County were:

- |                        |                           |
|------------------------|---------------------------|
| 1. Cancer              | 6. Unintentional Injuries |
| 2. Heart Disease       | 7. Kidney Disease         |
| 3. Alzheimer's Disease | 8. Suicide                |
| 4. Stroke              | 9. Diabetes Mellitus      |
| 5. Lung Disease        | 10. Parkinson's Disease   |

## Community Themes and Strengths Assessment

The CTSA focuses on identification of current community issues, perceptions about quality of life, and community assets through feedback from community stakeholders and the general public.

### Strengths and Assets

Through the CTSA, nine strengths and assets in the county were identified by residents and stakeholders and can continue to be leveraged to improve the health and wellness of the community:

- **GOOD EDUCATION SYSTEM:** Residents identified good schools as the #1 strength of the county. Fifteen Independent School Districts and multiple higher education campuses provide resources and services.
- **LOW CRIME AND SAFE NEIGHBORHOODS:** Residents identified low crime and safe neighborhoods as the #2 strength of the county. However, focus group participants noted higher crime areas and unsafe neighborhoods in rural communities.
- **ACCESS TO HEALTHCARE:** Residents identified access to healthcare as the #3 strength of the county. There is a general perception that available healthcare is of high quality, especially for the insured.
- **PARKS, TRAILS, AND RECREATION FACILITIES:** Residents identified use of parks and recreation as the #4 strength of the county. The county has many parks, facilities, and over 208.6 miles of trails.
- **CLEAN ENVIRONMENT:** Residents identified a clean environment as the #5 strength of the county. A clean environment is essential to the health and well-being of residents.
- **RELIGIOUS OR SPIRITUAL VALUES:** Residents identified religious or spiritual values as the #2 strength in the East. Churches, a place of trust, play a key role in community support and delivery of services.
- **COMMUNITY PARTNERSHIPS AND COLLABORATIONS:** Stakeholders identified community partnerships as the #1 solution to improving health in the county. Many organizations that provide essential services have formed partnerships to provide wrap-around services and to meet gaps in service delivery.
- **COMMUNITY RESOURCES:** Residents perceive the county to have an abundance of available resources. Aunt Bertha listed 149 claimed organizations and 329 claimed programs in the county.
- **COMMUNITY SUPPORT:** The community is supportive of one another, especially in times of need. As one focus group participant noted, "we all pull together in the community and make miracles happen."

### Concerns Identified

The CHA Task Force identified two cross-cutting themes and ten health concerns in the county.

#### Cross-Cutting Themes

- **LACK OF CULTURAL COMPETENCY:** Residents and stakeholders identified the need for translation and bilingual services among community and healthcare organizations and information disseminated in multiple languages. The local public health system should ensure a culturally competent workforce.
- **LACK OF HEALTH EQUITY:** Residents and stakeholders frequently mentioned differences in income, wealth, employment, access, and resources. Decision makers should prioritize underserved populations in the East and in rural areas that tend to have less access and worse health outcomes.

## Social Determinants of Health

- **LACK OF AFFORDABLE HEALTHCARE:** Uninsured, low-income, and underserved populations tend to lack access to affordable healthcare. Residents listed multiple contributing factors, including rising medical bills, copays, deductibles, and cost to referral services.
- **LACK OF AWARENESS OF COMMUNITY RESOURCES:** Even though community resources are abundant, access and awareness differ by region and population. Decision makers should prioritize increasing access and awareness in the East, in rural communities, and in underserved populations.
- **LACK OF (PUBLIC) TRANSPORTATION:** Only about 4% of households had problems getting transportation in the past six months; however, access remains a major concern for residents and stakeholders. Decision makers should seek alternative solutions to improve transportation options.
- **LACK OF AFFORDABLE AND SAFE HOUSING:** Housing and rental prices have steadily increased making it less affordable for those that have always lived in the county. The county has no homeless shelters and few transitional services for individuals facing homelessness.
- **LACK OF COMMUNITY TRUST:** East residents and stakeholders mentioned distrust of local government by minority groups due to political, historical, and cultural issues. To become a more resilient Williamson County, decision makers should focus on the community resiliency framework.

## Behavioral Health

- **MENTAL HEALTH, STRESS, AND WELL-BEING:** Mental health and stress affect all populations in the county and were ranked the #1 and #4 health problems, respectively. About one in ten households reported that a member of the household had been diagnosed with psychosocial or mental illness.
- **SUBSTANCE USE AND ABUSE:** Residents identified drug abuse as the #3 health problem in the East. The rate of excessive drinking among adults is higher in the county than the state, and tobacco use continues to remain high because of the increased prevalence of e-cigarette use.

## Chronic Disease and Risk Factors

- **CHRONIC DISEASE (OBESITY AND DIABETES):** Following cancer, heart disease is the #2 cause of death in the county. Residents identified obesity as the #1 and diabetes as the #5 health problem in the county. Improving healthy food access and increasing physical activity rates will improve chronic disease rates.
- **LACK OF HEALTHY FOOD ACCESS:** Stakeholders identified healthy food access as the #3 health problem. The county contains multiple food deserts. Decision makers should increase grocery store access for low-income populations and households with no vehicle.
- **PHYSICAL INACTIVITY:** Adults who are sedentary are at an increased risk of many serious health conditions. One in five households reported having barriers or challenges that prevent physical activity, such as injury, illness, or disability.

## Forces of Change Assessment

The FoCA identifies trends, factors, or events that influence the health and quality of life of the community and the Williamson County public health system. These external factors create many opportunities and challenges for the community and are categorized into eight forces of change.

- **AFFORDABILITY AND COST OF LIVING INCREASES:** As the cost of living increases and the county becomes a more affordable alternative to Austin, many current residents are being priced out of the housing market.

- **CITY DEVELOPMENT:** Cities are being developed to keep up with demand and the influx of new residents. While cities may have good intentions to develop new community resources for new residents, attention should also be placed on taking care of current residents and their needs.
- **CURRENT EVENTS:** Current events such as recent suicides and school shootings in the nation continue to affect the behavioral, emotional, and physical health and wellness of residents.
- **DEMOGRAPHIC CHANGES:** The Hispanic population and the aging population are each expected to double by 2050. Decision-makers should prioritize these populations in future planning efforts.
- **POLITICAL CLIMATE:** Due to shifting priorities at the state and national level, there have been funding cuts for social services, access to healthcare, and access to affordable health insurance.
- **POPULATION GROWTH:** Between 2010 and 2017 the county's population grew by 29.5%, adding about 20,000 residents per year, more than double the growth in Texas. Liberty Hill, Leander, and Hutto lead the county in growth.
- **SOCIAL MEDIA AND CHANGES IN TECHNOLOGY:** Social media use continues to become more pervasive in the county, mirroring nationwide trends. Social media affects how children and youth connect with one another other, while older adults are struggling to adapt to technological changes.
- **URBANIZATION AND GENTRIFICATION OF RURAL AREAS:** Growing numbers of the population are moving to traditionally rural areas. Rapid gentrification of areas in the county exacerbates income disparity and growing health inequity which is related to worse health outcomes.

## Local Public Health Systems Assessment

The LPHSA provides an understanding of how the Williamson County public health system is performing and can help local partners make more effective policy and resource decisions to improve the community's health. The CHA Task Force identified the highest- and lowest-ranked performance measures of the public health system.

**HIGHEST RANKED:** Two of the five highest measures were related to establishing and assessing community partnerships.

- 4.2.1. Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community
- 4.2.3. Assess how well community partnerships and strategic alliances are working to improve community health

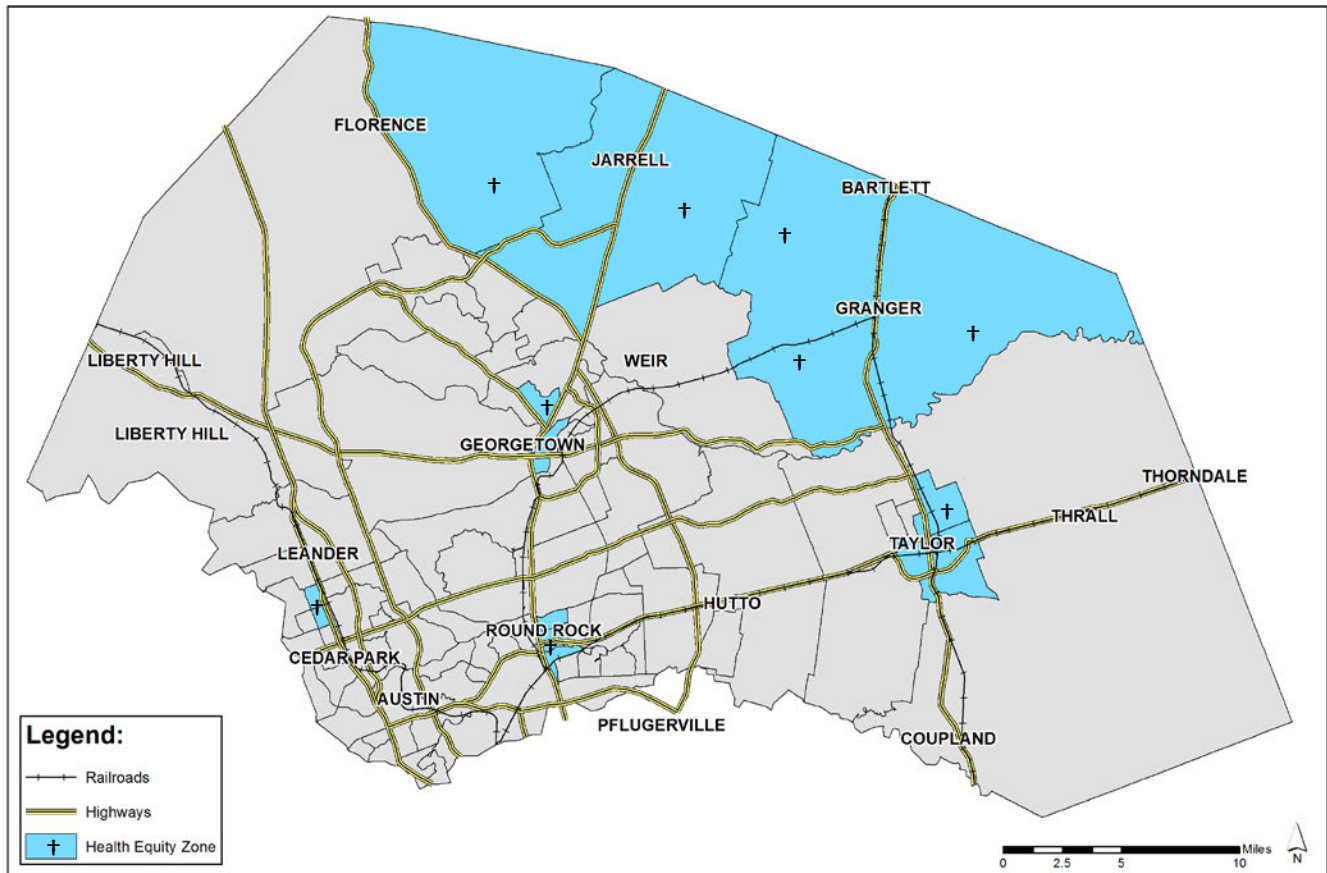
**LOWEST RANKED:** Three of the five lowest measures were related to assuring a culturally-competent health care workforce.

- 8.3.1. Identify education and training needs and encourage the public health workforce to participate in available education and training
- 8.3.5. Continually train the public health workforce to deliver services in a culturally competent manner and understand the social determinants of health
- 8.4.4. Provide opportunities for the development of leaders who represent the diversity of the community

## Health Equity Zones

According to the Robert Wood Johnson Foundation (RWJF), health equity “means that everyone has a fair and just opportunity to be as healthy as possible.”(3) Health equity is a critical factor that contributes to the economic prosperity, safety, and security of all county residents.(4) As of 2018, Williamson County ranked in the top three healthiest counties in Texas for the eighth consecutive year.(5) Overall, quality of life ranks high.(6) Despite being the second healthiest county in Texas, disparities in health and wellness continue to persist.(6) The CHA Task Force identified five Health Equity Zones in Williamson County. Health Equity Zones are census tract areas in the county that tend to have higher than average health risks and burdens.(7)





### Williamson County, Texas Health Equity Zones






This map identifies five health equity zones in Williamson County, Texas. Health equity zones are census tract areas in the county that tend to have higher than average health risks and burdens.  
 Data Source: 2019 Williamson County Community Health Assessment  
 Date Created: 2/6/2019



## Top Five Health Priorities

The CHA is just the first step of the community health improvement process. The companion document, the Community Health Improvement Plan (CHIP), will be the community's action plan for addressing the top five health priorities and coordinating county-wide efforts for the next three years. Through feedback and prioritization from residents and stakeholders, the CHA Task Force identified the following five health focus areas for decision makers in Williamson County to prioritize and to improve health and wellness for all residents.

Residents and stakeholders are highly invested in improving behavioral health, access to healthcare, and chronic disease in Williamson County. Behavioral health, stress, and well-being (with a focus on decreasing poor mental health, stress, and substance abuse) remain the #1 health priority in the county. Access to and affordability of healthcare (with a focus on increasing dental care and improving access to affordable health insurance for vulnerable populations) and chronic disease risk factors (with a focus on increasing healthy food access and physical activity) continue to remain in the top five. Social determinants of health (with a focus on increasing affordable and safe housing, access to transportation, and workforce development) is a new health priority for the county. These priorities highlight the need to build capacity in the county to tackle issues that require long-term solutions. Lastly, the CHA Task Force identified "Building a resilient Williamson County" as the #5 health priority of the county. Recent research and public health evidence have shown the impact of community resiliency on the health and wellness of a community and the necessity of this priority to improving the other four health priorities.

ICON	RANK	HEALTH PRIORITY
	1	<b>Behavioral health, stress, and well-being</b> <i>Focus on decreasing poor mental health, stress, and substance abuse</i>
	2	<b>Chronic disease risk factors</b> <i>Focus on increasing healthy food access and physical activity</i>
	3	<b>Social determinants of health</b> <i>Focus on increasing affordable and safe housing, access to transportation, and workforce development</i>
	4	<b>Access and affordability of healthcare</b> <i>Focus on increasing dental care and improving access to affordable health insurance for vulnerable populations</i>
	5	<b>Building a resilient Williamson County</b> <i>Focus on increasing the community's ability to utilize available resources to respond to, withstand, and recover from adverse situations</i>

## Conclusion and Implications for Williamson County

The 2019 CHA provides a comprehensive snapshot into the health and quality of life of Williamson County residents. Though the county consistently ranks among the healthiest in Texas, health inequities continue to exist. Community partners will use this assessment to guide the development of the CHIP, the community's action plan to address the top health priorities and areas of need in the county. The CHA Task Force hopes this assessment will increase engagement in supporting health for all who live, learn, work, play, worship, and age in the county and spur on efforts to building a resilient Williamson County.



## Introduction

Many factors shape the health and wellness of an individual and of a community. The five major determinants of health are biology and genetics, individual behavior, social factors, policy making, and health services.(8) Healthy People 2020 emphasizes the importance of addressing the social determinants of health to achieving health equity. Social determinants of health are “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”(9) To improve the health of all Williamson County residents, the county must improve the places and the conditions in which people live in.

Sustained and widespread community involvement is necessary to strategically address the health issues within the community. These efforts require the resources of multiple agencies and individuals. This shared ownership of community health offers better mobilization and utilization of resources to achieve improvement. The first step in this community health improvement process is the Community Health Assessment (CHA).(1)

### **The CHA is designed to:**

1. Collect, analyze, and use data to educate and mobilize communities, develop priorities, gather resources, and plan actions to improve population health
2. Provide a foundation of data to be used for evidence-based goal setting and decision-making

## Williamson County CHA

The Williamson County and Cities Health District (WCCHD) led this CHA effort in collaboration with strong community partners. The 2019 Williamson County CHA Task Force (hereafter known as the CHA Task Force) included Ascension Seton, Baylor Scott & White Health (BSWH), Bluebonnet Trails Community Services (BTCS), Eastern Williamson County Collaborative (EWCC), Georgetown Health Foundation (GTHF), Lone Star Circle of Care (LSCC), Opportunities for Williamson and Burnet Counties (OWBC), St. David’s Foundation (SDF), United Way of Williamson County, and the WilCo Wellness Alliance (WWA).

### **The goals of the CHA Task Force were to:**

1. Identify existing and emerging community health needs
2. Identify the strengths and assets available to improve health
3. Determine key issues that affect quality of life
4. Understand key forces of change influencing health in the community
5. Evaluate the local public health system and determine priorities for improvement
6. Identify top health priorities for future health improvement efforts

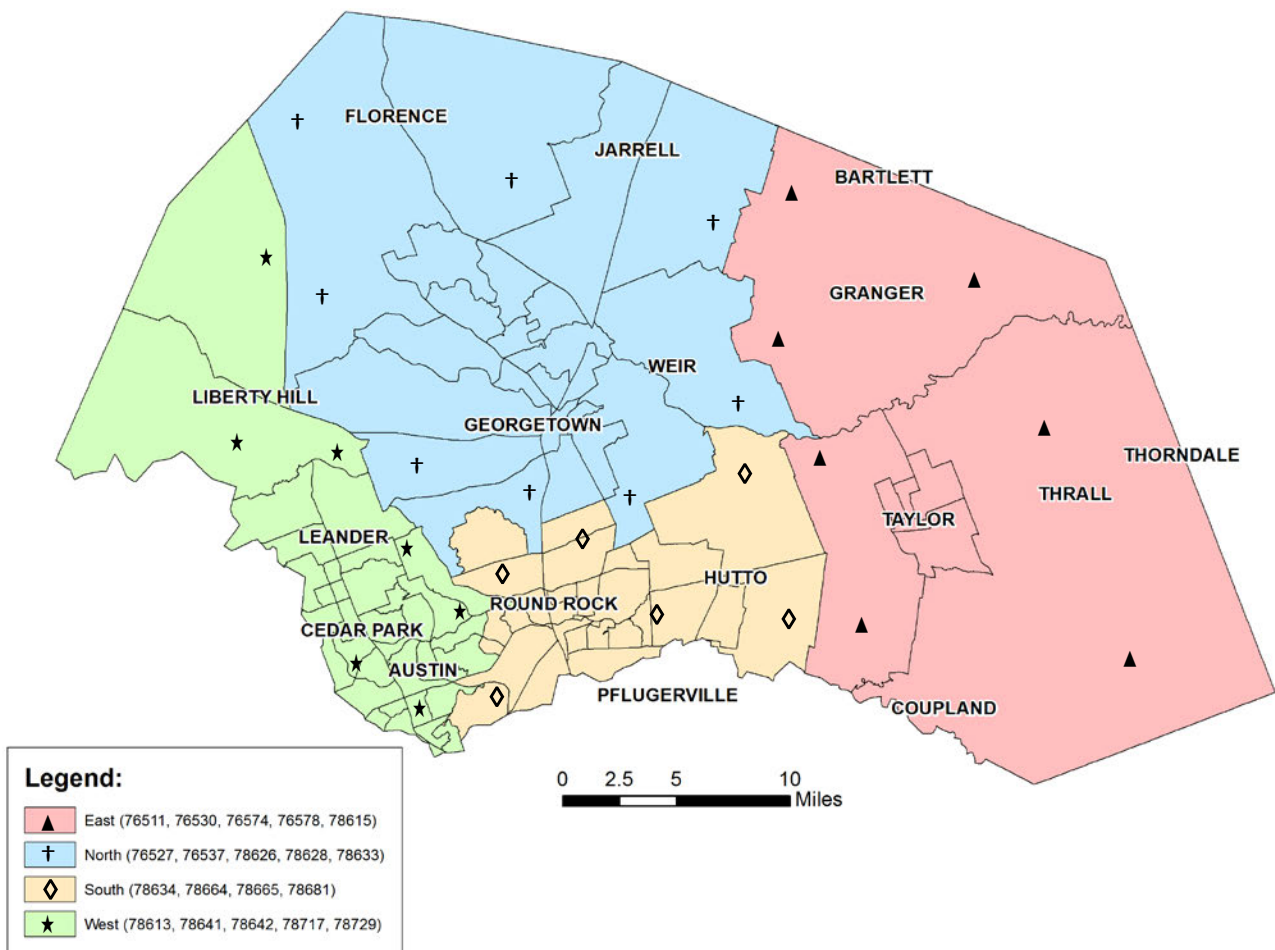
## Community Description

Williamson County, Texas is bounded by Burnet County to the West, Bell County to the North, Milam and Lee Counties to the East, and Travis and Bastrop Counties to the South. Williamson County has an estimated population of 547,828 residents and this number has grown by about 30% over the past 10 years.(10) Austin’s continued increase in population and development has fueled local growth, with greater and greater numbers of Williamson County residents commuting into Austin for work each day. Williamson County is an economic magnet, with major employers such as Dell, Sears Teleserv, Emerson, Round Rock Premium Outlets, Baylor Scott & White Healthcare, St. David’s Round Rock Medical Center and Georgetown Hospital, Ascension Seton Medical Center Williamson, Cedar Park Regional Medical Center, Southwestern University, Texas A&M Health Science Center Round Rock, Texas State University, and TECO Westinghouse.

Overall, households were satisfied with the quality of life in Williamson County. Nine out of ten households reported that they were either very satisfied or satisfied with quality of life in the county.(6) As of 2018, the county ranked in the top three healthiest counties in Texas for the eighth consecutive year.(5) Out of 241 ranked counties, the county was second overall in health outcomes and fifth overall in health factors. Compared to 2016, the county increased in rank for clinical care from #4 to #2 and dropped in rank from #3 to #4 for social and economic factors. Compared to 2016, the county dropped in rank from #8 to #17 for health behaviors and #135 to #189 for physical environment. Adult obesity in the county is higher than the state. Sexually transmitted infections are higher than top performers in the United States. Percentage of households with at least one of four housing problems (overcrowding, high housing costs, or lack of kitchen or plumbing facilities) is lower than the state, but higher than top performers. Most residents (81%) are driving alone to work, which is about the state rate, and 43% of residents have long commute times of more than 30 minutes which is higher than the state rate.

Williamson County can be divided into four distinct geographic regions: North, East, South, and West (Figure 1).

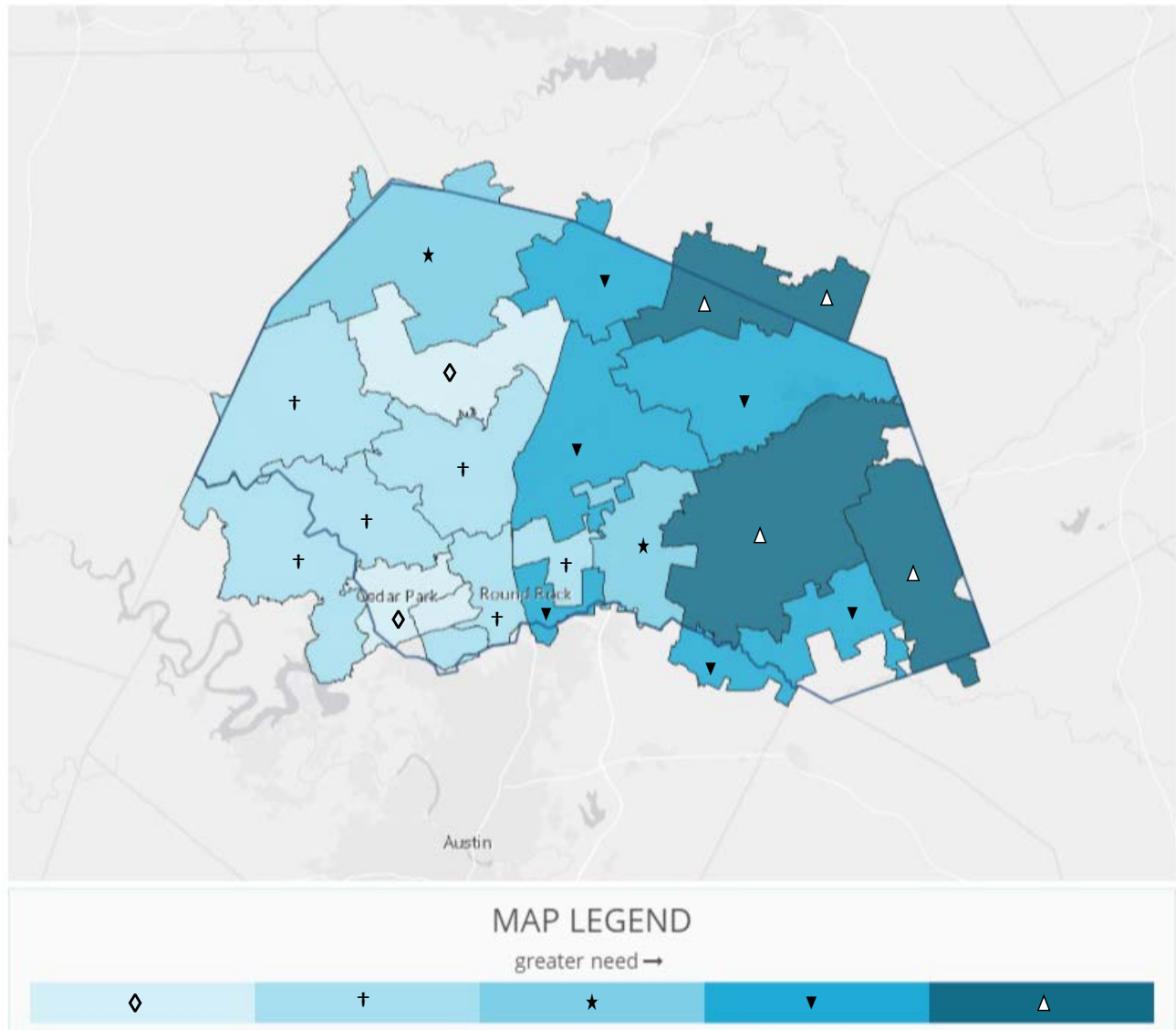
**Figure 1: Map of Williamson County, Texas**



Areas of highest needs move from West to East. The 2018 SocioNeeds Index is a measure of socioeconomic need that is correlated with poor health outcomes (Figure 2).(11) All zip codes, counties, and county equivalents in the United States are given an Index Value from 0 (low need) to 100 (high need). Areas with greatest need are in zip codes in the East and in dark blue: 76511 (73.9), 76574 (64.8), and 76578 (64.3).

**Figure 2: SocioNeeds Index by Zip Code**

**Data Source:** Conduent Healthy Communities Institute  
**Measurement Period:** 2018





## Methodology

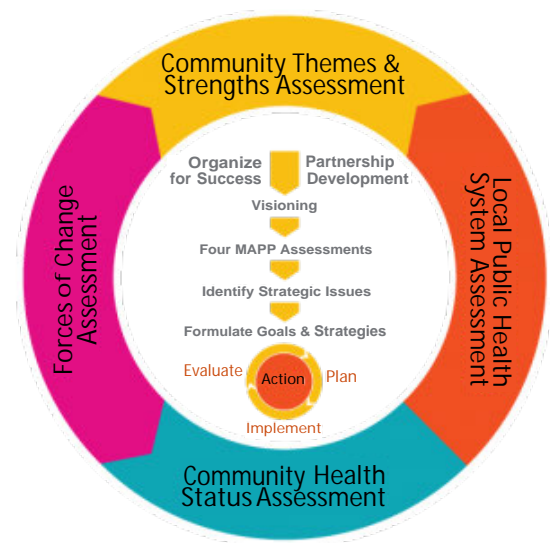
### The Mobilizing for Action through Planning and Partnerships Framework

The Mobilizing for Action through Planning and Partnerships (MAPP) framework from the National Association of County and City Health Officials (NACCHO) is a proven, systematic, and outcome-oriented process for the ongoing engagement of community stakeholders. MAPP provides a method to help communities prioritize public health issues, identify resources available, and take action. The CHA Task Force used this process to provide an update to the 2016 report. MAPP includes four assessments, each of which offer important information for improving community health. Together, the four assessments provide a comprehensive understanding of the health of the community.(2)

The four assessments are (Figure 3):










- The **Community Health Status Assessment (CHSA)** identifies priority health issues in the community and looks at health outcomes and health behaviors. Questions answered by this assessment include “How healthy are Williamson County residents?” and “What does the health status of our community look like?”
- The **Community Themes and Strengths Assessment (CTSA)** identifies important issues in the community and answers the questions “What is important to our community?” and “What assets do we have that can be used to improve community health?”
- The **Forces of Change Assessment (FoCA)** identifies factors that affect the context of the community such as legislation, technology, and other changes. The assessment answers the question “What is occurring or might occur that affects the health of our community or the local public health system?”
- The **Local Public Health System Assessment (LPHSA)** looks at the organizations and agencies that constitute the Williamson County public health system and answers the questions “What are the components, activities, competencies, and capacities of the local public health system?” and “How are the Ten Essential Services being provided to the community?”

**Figure 3: MAPP Framework**



## Data Collection Methods

The CHA Task Force used both quantitative and qualitative data from primary and secondary data sources to compile the four MAPP assessments and determine health priorities.

	METHOD	TIME FRAME	PARTICIPANTS	RESULTS	ASSESSMENT
	Community Health Survey	4/24/2018-5/31/2018	2,272 Community residents	Appendix F: Community Health Survey Results	CTSA
	Facilitated Activities at Community Meetings	4/19/2018-6/5/2018	262 Stakeholders, Community organizations	Appendix H: Community Meeting Facilitated Activities Results	CTSA
	Community Focus Groups	5/23/2018-9/19/2018	62 Community residents	Appendix J: Community Focus Groups Results	CTSA, FoCA
	Stakeholder Focus Groups	7/25/2018	26 Stakeholders (Williamson County, East)	Appendix K: Truven Stakeholder Focus Group Results	CTSA, FoCA
	Key Informant Interviews	8/1/2018-9/30/2018	9 Key informants (Williamson County, East)	Appendix L: Truven Key Informant Interview Notes	CTSA, FoCA
	Mom's Community Listening Forum	8/10/2018	50 Community residents and mothers, Community organizations	Appendix M: Mom's Community Listening Forum Report	CTSA
	Local Public Health Systems Survey and Fishbone Diagram	8/14/2018-9/17/2018	CHA Task Force/WCCHD District Leadership Team	Local Public Health Systems Assessment	LPHSA
	Community Assessment for Public Health Emergency Response (CASPER)	10/12-13/2018	182 Households in clusters	Appendix N: CASPER Report	CTSA
	Primary and Secondary Data Analysis	Dependent on data source	Dependent on data source	Community Health Status Assessment	CHSA

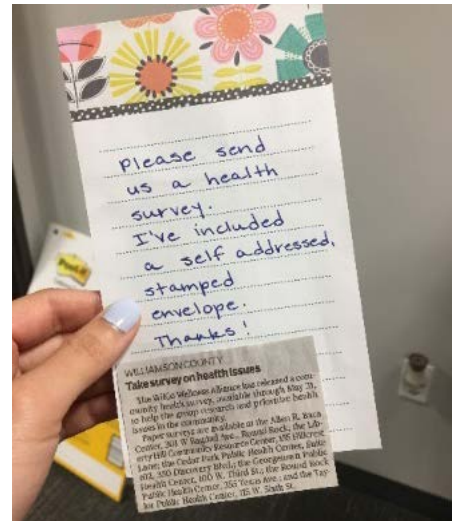


## Community Health Survey



A county-wide Community Health Survey kicked off the first phase of data collection between April and May of 2018. The purpose of the survey was to understand resident perspectives on health and health-related needs, and the results guided topics for subsequent CHA data collection. Survey questions were adapted from the NACCHO example community health survey. The CHA Task Force piloted the community survey and adjustments were made based upon feedback. A copy of the Community Health Survey (English and Spanish) can be found in Appendix D: Community Health Survey. The survey consisted of five required questions and three optional demographic questions. Surveys were disseminated through multiple methods (group administration, convenience sampling, media distribution, paper surveys with drop boxes at local sites, and through the NextDoor App). Historically underrepresented groups were oversampled to ensure representation in the CHA. The CHA Task Force also partnered with EWCC to oversample Eastern Williamson County. All survey distribution locations are listed in Appendix E: Community Health Survey Locations of Distribution.

1. Group administration – Paper surveys in English and Spanish were distributed to all stakeholders who attended the EWCC May meeting.
2. Convenience Sampling – English surveys were distributed to participants through a booth at the WWA Health Equity Summit held on April 24, 2018 at the Georgetown Public Safety Operations and Training Center. The CHA Task Force partnered with organizations such as BTCS, OWBC, Hill Country Community Ministries (HCCM), and organizations in the EWCC to distribute paper surveys in English and Spanish to under-reached populations at Head Starts, Senior Centers, food pantries, and churches.
3. Media Distribution – Links to the electronic survey in English and Spanish were made available on the [HealthyWilliamsonCounty.org/CHA](http://HealthyWilliamsonCounty.org/CHA) website. Links to the electronic survey were distributed by different organizations through press releases, newsletters, and social media.
4. Drop boxes – Drop boxes for paper surveys in English and Spanish were held at Allen R. Baca Center, Liberty Hill Community Resource Center, Round Rock Public Library, and all four WCCHD Public Health Centers.
5. NextDoor App – NextDoor App is the private social network for neighborhoods. Individuals can connect with their neighbors and engage their local community. Links to the electronic survey in English and Spanish were posted as an update that reached all neighborhoods in Williamson County by the Williamson County Public Information Office.

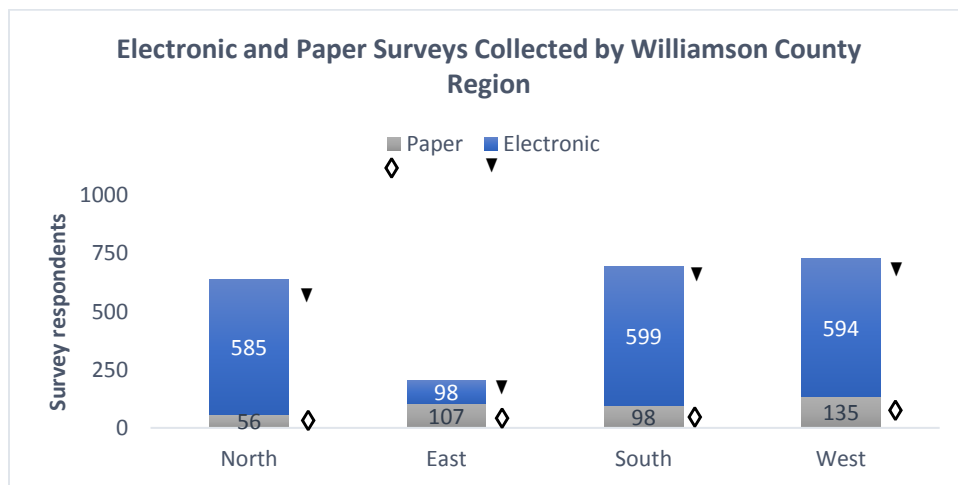


The CHA Task Force collected 2,272 surveys (94.3% of total collected) with a Williamson County zip code. Four out of five surveys were electronic, and one out of five surveys was paper. Almost all the surveys (98.3%) collected were in English (Table 1). About 3% of households in Williamson County are linguistically isolated and have difficulty accessing services that are available to fluent English speakers.(12) When separated out by region, the West provided the most surveys (729), followed closely by the South (697) and the North (641). Paper surveys constituted over half of surveys collected in the East (Figure 4). Percentage of surveys collected was higher in the North (28.2%) and the East (9.0%) and lower in the South (30.7%) and West (32.1%) compared to the total percentage of individuals living in those regions (Figure 5). Additional survey results are in Appendix F: Community Health Survey Results.

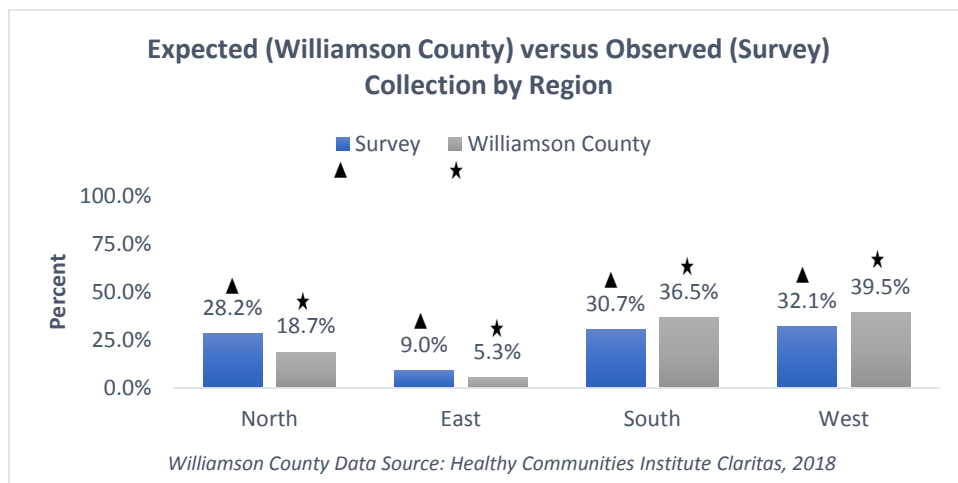
**Table 1: Total Surveys Collected in Williamson County**

SURVEY TYPE	COUNT	PERCENT
<b>Electronic</b>	1,876	82.6%
English	1,873	82.4%
Spanish	3	0.1%
<b>Paper</b>	396	17.4%
English	360	15.9%
Spanish	36	1.6%
<b>Total</b>	2,272	100%

**Figure 4: Electronic and Paper Surveys Collected by Williamson County Region**



**Figure 5: Expected (Williamson County) versus Observed (Survey) Collection by Williamson County Region**



**Facilitated Activities at Community Meetings**



Facilitated activities were conducted at coalition meetings to gain feedback from stakeholders. Stakeholders rotated around stations to answer five questions. The number of responses per question were later summarized and averaged across the various coalitions. These activities are detailed in

Appendix G: Community Meeting Facilitated Activity Guide. Approximately 262 stakeholders participated in ten

facilitated activities conducted among coalitions throughout Williamson County (Table 2). Results from facilitated activities are in Appendix H: Community Meeting Facilitated Activities Results.

**Table 2: Facilitated Activities Conducted at Community Meetings at Williamson County Coalitions**

ORGANIZATION	GEOGRAPHICAL REGION	DATE	PARTICIPANTS
<b>Williamson County Coalitions</b>			
Hutto Resource Center (formerly known as Hutto Has Heart)	Hutto	4/19/2018	20
Round Rock Non-Profit Meeting	Round Rock	6/5/2018	~30
The Georgetown Project	Georgetown	5/2/2018	43
Interagency Support Council of Eastern Williamson County, Inc.	Taylor, East Williamson County	5/8/2018	25
Eastern Williamson County Collaborative	East Williamson County	4/26/2018	19
West WilCo Community Resources	Cedar Park, Leander, West Williamson County	5/23/2018	13
<b>WilCo Wellness Alliance</b>			
Maternal and Infant Health	Williamson County	5/1/2018	13
Healthy Living (Active Living, Employee Wellness, and Healthy Eating)	Williamson County	5/15/2018	19
Behavioral Health Task Force (Subcommittees: Child Youth Behavioral Health Task Force, Alan's Hope)	Williamson County	5/31/2018	63
LifeSteps Substance Abuse Coalition	Williamson County	5/16/2018	17



### Community Focus Groups



The CHA Task Force conducted eight focus groups of eight to ten individuals to capture lived experiences and voices of residents from July to September of 2018. The team identified focus groups from populations that were either underrepresented or at-risk for worse health outcomes. The CHA Task Force partnered with trusted organizations in the community to recruit participants. Participants in the focus groups each received a \$20 gift card for participating. To ensure consistency, facilitators used a standardized guide

that was adapted from GTHF's Southeast Georgetown Needs Assessment Focus Group Protocol.(13) The focus group guide is found in Appendix I: Community Focus Group Guide. Facilitators asked open-ended questions to allow participants to share their stories of health and wellness in the community. Results of the focus groups are in Appendix J: Community Focus Groups Results.

A total of 62 community residents participated across the county. Focus groups were conducted among the following population groups:

- African American/Black
- Hispanic/Latino
- High risk youth
- Individuals affected by cancer
- Individuals living in rural cities in East Williamson County (Bartlett and Granger)
- Individuals in recovery for substance abuse
- Aging population

### Stakeholder Focus Groups



An outside consultant, Truven Analytics, conducted two stakeholder focus groups of ten to fourteen stakeholders. One stakeholder focus group was conducted for the whole county and one stakeholder focus group was conducted for the East. Stakeholders discussed strengths and challenges of the health of the community, access and barriers to good health, community partnerships, and opportunities to improve health in the community, and prioritized community health needs. Summaries are in Appendix K: Truven Stakeholder Focus Group Results.

### Key Informant Interviews



An outside consultant, Truven Analytics, conducted ten key informant interviews. Key informant interviews were conducted for all of Williamson County and for the East. Key informants discussed strengths and challenges of the health of the community, access and barriers to good health, community partnerships, and opportunities to improve health in the community, and prioritized community health needs. Key Informant Notes are in Appendix L: Truven Key Informant Interview Notes.

### Mom's Community Listening Forum



The Maternal and Infant Health working group of the WWA hosted the Mom's Community Listening Forum on August 10th, 2018. The Mother's Listening Forum gave the community a chance to hear directly from mothers, whose voices may sometimes go unheard. An open forum stimulated community conversation about the service gaps that exist for mothers in Williamson County. The forum consisted of 1) a speaker panel of mothers to discuss their primary health concerns, challenges, and needs; 2) a listening panel of community organizations to discuss the services their organizations provide; and 3) an audience of community members to ask questions. The final report is linked in Appendix M: Mom's Community Listening Forum Report.



**MOMS COMMUNITY**  
LISTENING FORUM

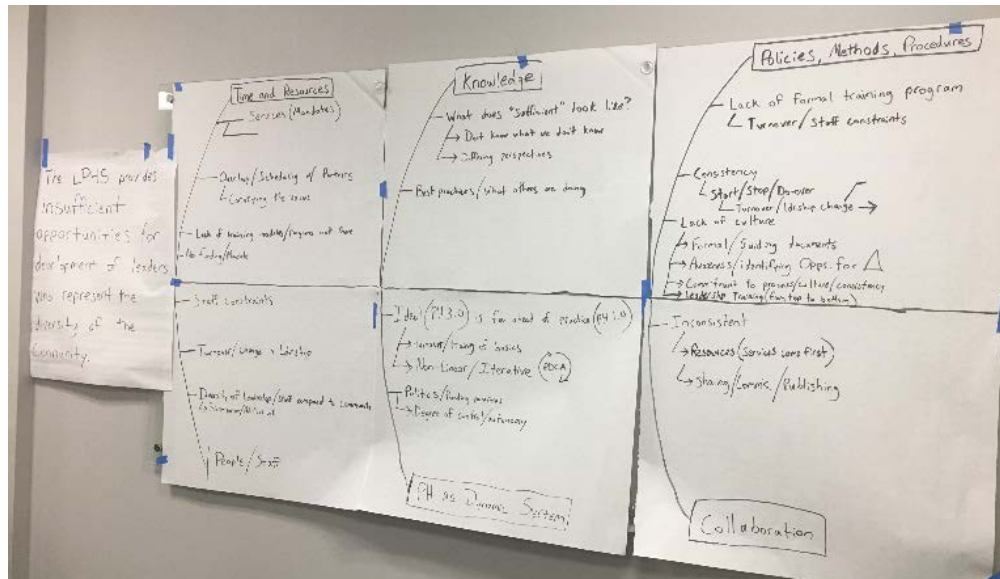
### Local Public Health Systems Survey and Fishbone Diagram



The CHA Task Force assessed the Williamson County public health system by 1) administering a survey adapted from the National Public Health Performance Standards (NPHPS) Local Assessment Instrument to organizations that represented the local public health system; and 2) conducting a facilitated activity among WCCHD leadership to understand the root cause of the lowest ranked performance measure. Due to limited time and resources, the CHA Task Force modified the NPHPS Local Assessment Instrument into a survey.



The CHA Task Force identified 33 performance measures from the instrument to evaluate delivery of the Ten Essential Public Health Services.(14) The survey can be found in Appendix O: Local Public Health Systems Survey. Results were ranked and averaged and can be found in Appendix P: Local Public Health System Assessment Results. Each of the Ten Essential Public Health Services was given a score by averaging the relevant performance measures. The lowest-ranked measure was addressed in detail during a subsequent facilitated activity. The WCCHD District Leadership Team (DLT) participated in an hour-long facilitated activity using quality improvement tools such as the fish bone diagram and the 5 Whys to better understand the root causes of the lowest ranked performance measure.



### Community Assessment for Public Health Emergency Response (CASPER)



The CHA Task Force conducted a CASPER on October 12-13, 2018 to obtain household-level data about the health status, behaviors, and needs of Williamson County residents. A CASPER is an epidemiological technique designed to provide quick, reliable, and accurate household-based information about community needs. The CASPER provides additional details about key issues in the county and identifies root causes of challenges faced by residents. The main goal of the CASPER was to gather household-level public health information to contribute to the 2019 CHA in Williamson County. The CHA Task Force surveyed 182 households in Williamson County. The report is in Appendix N: CASPER Report.



The CASPER had four objectives:

1. To assess awareness of resources and services in Williamson County
2. To explore health behaviors regarding obesity, mental health, and chronic disease in Williamson County
3. To evaluate access and barriers to healthcare, transportation, and community resources in Williamson County
4. To describe the types of medical needs and equipment used in Williamson County

## Primary and Secondary Data Analysis



The CHA team obtained data from many secondary sources at the local, state, and national level.

Significant secondary data sources included:

- American Community Survey (ACS)
- Area Health Resource File (AHRF)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Centers for Medicare & Medicaid Services (CMS)
- County Business Patterns (CBP)
- Dartmouth College Institute for Health Policy & Clinical Practice
- Feeding America
- Healthy Communities Institute
- National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)
- National Vital Statistics System (NVSS)
- Nielsen Claritas and SiteReports
- Safe Drinking Water Information System (SDWIS)
- Surveillance, Epidemiology, and End Results Program State Cancer Profiles (SEER SCP)
- Texas Department of Family and Protective Services
- Texas Department of State Health Services (DSHS)
- Texas Education Agency (TEA)
- Texas Office of the State Demographer (OSD)
- Uniform Crime Reporting – FBI
- U.S. Census Bureau (Census)
- U.S. Department of Agriculture (USDA)

Primary data was also obtained from our local organizations.

- Bluebonnet Trails Community Services (BTCS)
- Hill Country Community Ministries (HCCM)
- Lone Star Circle of Care (LSCC)

### Prioritization of Health Equity Zones and Top Five Health Priorities.

The CHA Task Force identified Health Equity Zones from available census-tract level measures that were related to lower health outcomes. Health priorities were selected based on themes identified through the four MAPP assessments and prioritization by the community through the Community Health Survey and Community Focus Group sticker activity and by stakeholders through the Facilitated Activities at community meetings.

## Data Limitations

### Community Health Status Assessment

The availability of data sources was the largest limitation to the CHSA. The lengthy process of data collection, aggregation, and publication by multiple sources prevented access to comprehensive, up-to-the-minute data for the CHSA. For some health indicators, the available data can be several years old and may no longer be representative of the community. Data may be suppressed and/or limited for certain race and ethnic groups due to small numbers of significant health events. This restricts the ability to identify disparities among subgroups, namely Asian Americans, American Indian/Alaskan Natives, and Native Hawaiian/Pacific Islanders. The CHA Task

Force strived to include the most up-to-date data available, incorporating local data from the most recent full calendar year and certain secondary data from the past two years. However, some secondary data sources are only available more than two years in the past, limiting the ability to draw full conclusions based on recent data. While there was a solid representation of local data from community organizations compared to past CHAs, the CHA Task Force would like to include more local data to provide a truly comprehensive snapshot of health status in Williamson County.

#### Community Themes and Strengths Assessment

For the CTSA, assuring representation from all population groups and sectors in Williamson County proved to be challenging. For the Community Health Survey, survey respondents tended to be older, female, and White compared to the demographics of Williamson County. The Community Health Survey lacked representation from vulnerable populations and minority groups. To ensure representation in the 2019 CHA, the Task Force conducted community focus groups among these population groups. However, the CHA Task Force did not conduct a community focus group among any Asian population groups. The Task Force could not identify a community organization from which to recruit participants. Moreover, the Task Force did conduct a community focus group among the Hispanic population; however, no focus group was conducted among only Spanish-speaking participants. To ensure representation from stakeholders, the Task Force conducted stakeholder focus groups and key informant interviews in the county, but some representatives were missing from the process, including those from the business community and media.

#### Forces of Change Assessment

The CHA Task Force decided not to conduct a prioritization activity and a traditional opportunities and threats analysis due to limited time and resources. The CHA Task Force identified the most prevalent forces of change indirectly through results of the various data collection methods.

#### Local Public Health Systems Assessment

The survey was adapted from a NACCHO instrument that was meant to be conducted as a facilitated discussion. According to the Local Instrument Guide, each performance measure would be compared to a “gold standard” and relevant participants to the Essential Service would discuss and classify the activity. Due to limited time and resources, no “gold standard” was identified for each performance measure, and no facilitated discussion took place to identify the percentage of activity met for each performance measure. Therefore, each survey respondent had a different perspective on what the “gold standard” is for optimal activity for that performance measure. Each organization that participated in the survey plays an active role in the local public health system; however, each organization is not responsible for delivering all the Essential Services or is knowledgeable and able to evaluate all aspects of the local public health system. In addition, participants had differences in knowledge about the public health system. This may have led to some interpretation differences and issues for some of the questions, potentially introducing a degree of response variability.

#### Other Community Assessments

Five additional community assessments were identified in Williamson County and can be used as references when evaluating the health of the county. A matrix of topics addressed by the assessments is in Appendix Q: Community Health Assessment Matrix.





# Community Health Status Assessment

## CORE INDICATORS

*Based on the NACCHO MAPP Framework*

- C1. Demographic Characteristics
- C2. Socioeconomic Characteristics
- C3. Health Resource Availability
- C4. Quality of Life
- C5. Behavioral Risk Factors
- C6. Environmental Health Indicators
- C7. Social and Mental Health
- C8. Maternal and Child Health
- C9. Death, Illness, and Injury
- C10. Communicable Disease
- C11. Sentinel Events

## Overview

The Community Health Status Assessment (CHSA) presents aggregate population-level data in the form of statistics, graphs, charts, and maps to define the health status of Williamson County. Data were obtained from many primary and secondary sources at the local, state, and national level. The CHA Task Force collected primary data through online and household surveys, as well as focus groups. Quotes from focus groups are included to provide lived experiences and real-world context to supplement quantitative findings. Secondary data include health indicators, which have been analyzed to compare rates or trends of health outcomes and determinants.<sup>(15)</sup> The most up-to-date secondary data can be found at [www.healthywilliamsoncounty.org](http://www.healthywilliamsoncounty.org).

The CHSA divides indicators into eleven broad categories based on the MAPP framework's "Core Indicator List." Comparisons are drawn between Williamson County and Texas health indicators, as well as applicable Healthy People 2020 (HP2020) targets. HP2020 is a nationwide set of 10-year health promotion and disease prevention goals established by the United States Department of Health and Human Services.<sup>(9)</sup> Achievements and gaps in health status are

identified among race, ethnicity, age, gender, or socioeconomic groups within the county. Key findings are summarized at the end of each section to help stakeholders plan, implement, and establish evidence-based health improvements for specific geographic areas and residents of Williamson County. For the purposes of this assessment, the non-Hispanic White population was referred to as "White," the non-Hispanic African American population was referred to as "Black," and the Asian American population as "Asian." The term "Hispanic" is used and does not distinguish by race, although the definition by the U.S. Census is "Hispanic White."

### C1. Demographic Characteristics

*"TAYLOR IS GOING TO START TO GROW, SO WE HAVE TO BE READY TO HANDLE THAT GROWTH."*

The population in Williamson County continues to grow and expand as more people move to Central Texas. This rapid population growth results in a changing population landscape, which will influence the availability of health resources and services. The tables, maps, and discussions in this section examine three key topic areas: demographic distribution, population change, and population projection. Demographic distribution describes gender, age, race, and ethnicity of Williamson County residents. Population change identifies growth and migration in the county, specifically by city and zip code. Lastly, population projection predicts county growth by 2050 for gender, age, race, and ethnicity. The continuous tracking of demographic trends will assist strategic planning and program development to address the health status of all Williamson County residents.

#### Demographic Distribution

The gender distribution in Williamson County is comparable to the gender distribution in Texas, with slightly more females (50.9%) than males (49.1%) in the county (Table 3).

Individuals ages 25 to 44 years make up the largest age group in the county (28.3%) and in Texas (27.4%) (Table 3). Additionally, the younger generation less than 18 years of age comprise 25.7% of the county's population, which is similar to Texas (25.9%). Williamson County and Texas have similar proportions of individuals ages 18 to 24 years and 65 years and older.

In 2018, the largest racial and ethnic group in Williamson County is White (74.7%), followed by Hispanic (24.6%), Asian (6.9%) and Black (6.6%) (Table 3). Compared to Texas, Williamson County has a higher percentage of White and Asian populations, and a smaller percentage of Black and Hispanic populations.

**Table 3: Demographic Characteristics of Williamson County and Texas, 2018**

<b>Demographic Characteristics of Williamson County and Texas, 2018</b>		
<b>Population</b>	<b>Williamson County</b>	<b>Texas</b>
Population Count	547,828	28,531,603
Percent Growth from April 1, 2010 to July 1, 2018	29.6%	13.5%
<b>Gender</b>		
Male	49.1%	49.6%
Female	50.9%	50.4%
<b>Age</b>		
<18	25.7%	25.9%
18-24	9.0%	10.1%
25-44	28.3%	27.4%
45-64	24.8%	23.9%
65+	12.1%	12.6%
<b>Race/Ethnicity</b>		
White	74.2%	67.5%
Hispanic/Latino	24.6%	39.6%
Black/African American	6.7%	12.2%
Asian American	7.2%	5.0%
American Indian/Alaskan Native	0.7%	0.7%
Native Hawaiian/Pacific Islander	0.1%	0.1%
Other	7.4%	11.2%

*Data Source: Healthy Communities Institute, 2018*

When examining the age and gender distribution of Williamson County residents, there is a higher percentage of males in the county less than 24 years old and a higher percentage of females in the county ages 25 and older (Table 4). Females ages 25 to 44 comprise the largest group at 14.4%, followed by males ages 25 to 44 at 14.0%, and males under 18 years old at 13.1%.

**Table 4: Age and Gender Distribution in Williamson County, 2018**

Age and Gender Distribution in Williamson County, 2018			
Age	Male	Female	Total
Under 18	13.1%	12.7%	25.7%
18 to 24	4.5%	4.4%	9.0%
25 to 44	14.0%	14.4%	28.3%
45-64	12.2%	12.7%	24.8%
65 and over	5.3%	6.8%	12.1%
Total	49.1%	50.9%	N/A

*Data Sources: Healthy Communities Institute, 2018*

The combined gender and racial/ethnic group with the highest median age is White females (39.9 years), followed by White males (38.2 years), and Asian females (35.7 years) (Table 5).

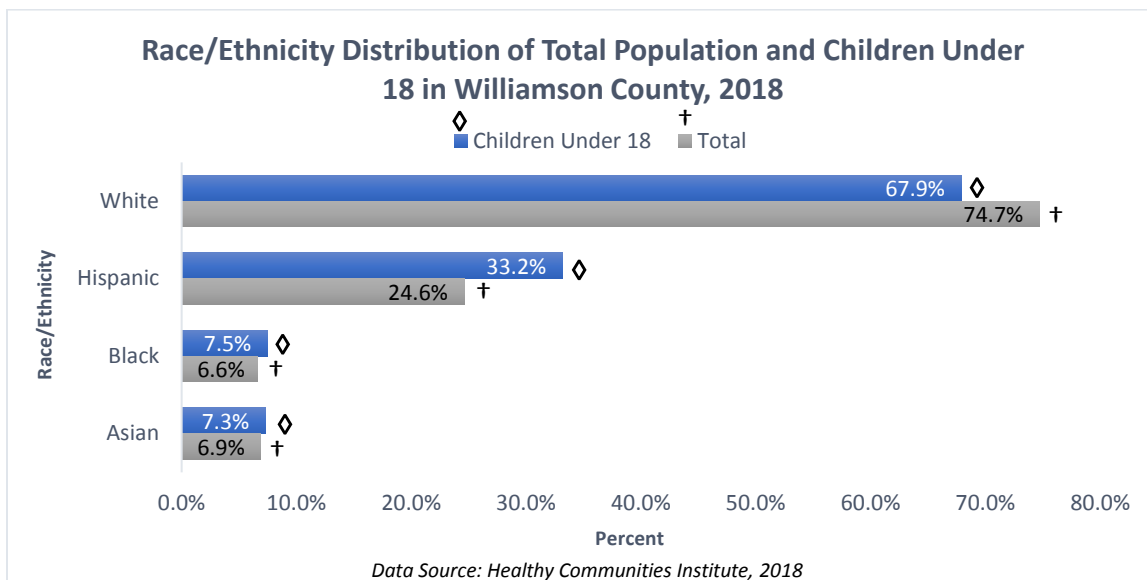
**Table 5: Median Age Among Gender and Race/Ethnicity Groups in Williamson County, 2018**

Median Age among Gender and Race/Ethnicity Groups in Williamson County, 2018			
Race/Ethnicity	Male	Female	Median Age
White	38.2	39.9	39.1
Hispanic	26.6	28.4	27.5
Black	31.7	34.5	33.1
Asian	35.2	35.7	35.4
Total	35.9	37.5	36.7

*Data Source: Healthy Communities Institute, 2018*

In Williamson County, the distribution of the younger generation is similar to the overall county distribution, with the White population as the largest group, followed by the Hispanic population, the Black population, and the Asian population (Figure 6).

**Figure 6: Race/Ethnicity Distribution of Total Population and Children Under 18 in Williamson County, 2018**



Life Expectancy

Table 6 displays life expectancy for both females and males in Williamson County and Texas. Life expectancy is the average number of years a person can expect to live, describing a population's longevity and general health.(16)

Both males and females in Williamson County have longer life expectancies than their Texas counterparts. Females in Williamson County having a higher life expectancy (83.3 years) compared to males (80 years).

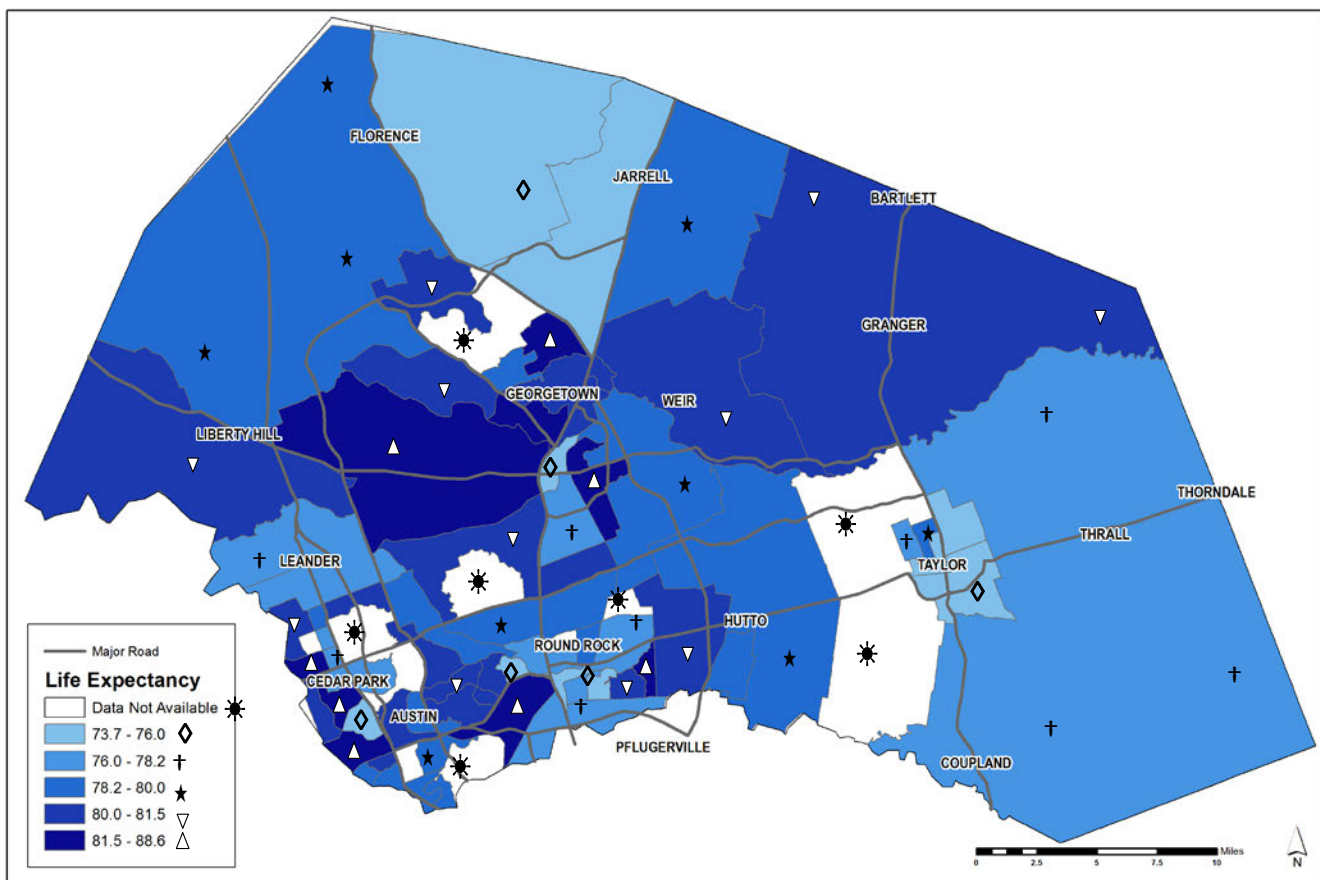
**Table 6: Life Expectancy by Gender in Williamson County and Texas, 2018**

Life Expectancy by Gender in Williamson County and Texas, 2018		
Gender	Williamson County	Texas
Male	80.0	76.2
Female	83.3	80.8

*Data Source: Institute for Health Metrics and Evaluation, 2014*

Figure 7 below displays life expectancy by census tract in Williamson County. Research has shown that life expectancy varies by geography, especially at the county level.(17) Tracking inequality at the county level over time is an important means of assessing progress toward more equitable health outcomes, as stated in the Healthy People 2020 objective: “Achieve health equity, eliminate disparities, and improve the health of all groups.”(17) In Williamson County, the census tract with the longest life expectancy is 88.6 years (Cedar Park), while the census tract with the shortest life expectancy is 73.8 years (Jarrell), which is a difference of 14.8 years. Census tracts with the shortest life expectancy (less than 76 years) include parts of Round Rock, Cedar Park, Taylor, Georgetown, Jarrell, and Florence.

**Figure 7: Life Expectancy by Census Tract in Williamson County, 2010-2015**



**Life Expectancy by Census Tract in Williamson County, 2010-2015**

This map illustrates life expectancy at birth in years. This represents the average number of years a person can expect to live from 2010 to 2015 for each census tract in Williamson County.

Data Source: U.S. Small-Area Life Expectancy Estimates Project, 2010-2015

Date Created: 2/12/2019



## Population Change

Between 2010 and 2017, the county's population grew by 29.5%, which is more than double the growth within Texas (12.6%) (Table 6). Hutto, Leander, and Liberty Hill lead the county in growth, with Liberty Hill reaching growth that is three times more than the county growth rate and seven times more than the state growth rate.

**Table 7: Population Change in Williamson County and Texas, 2010-2017**

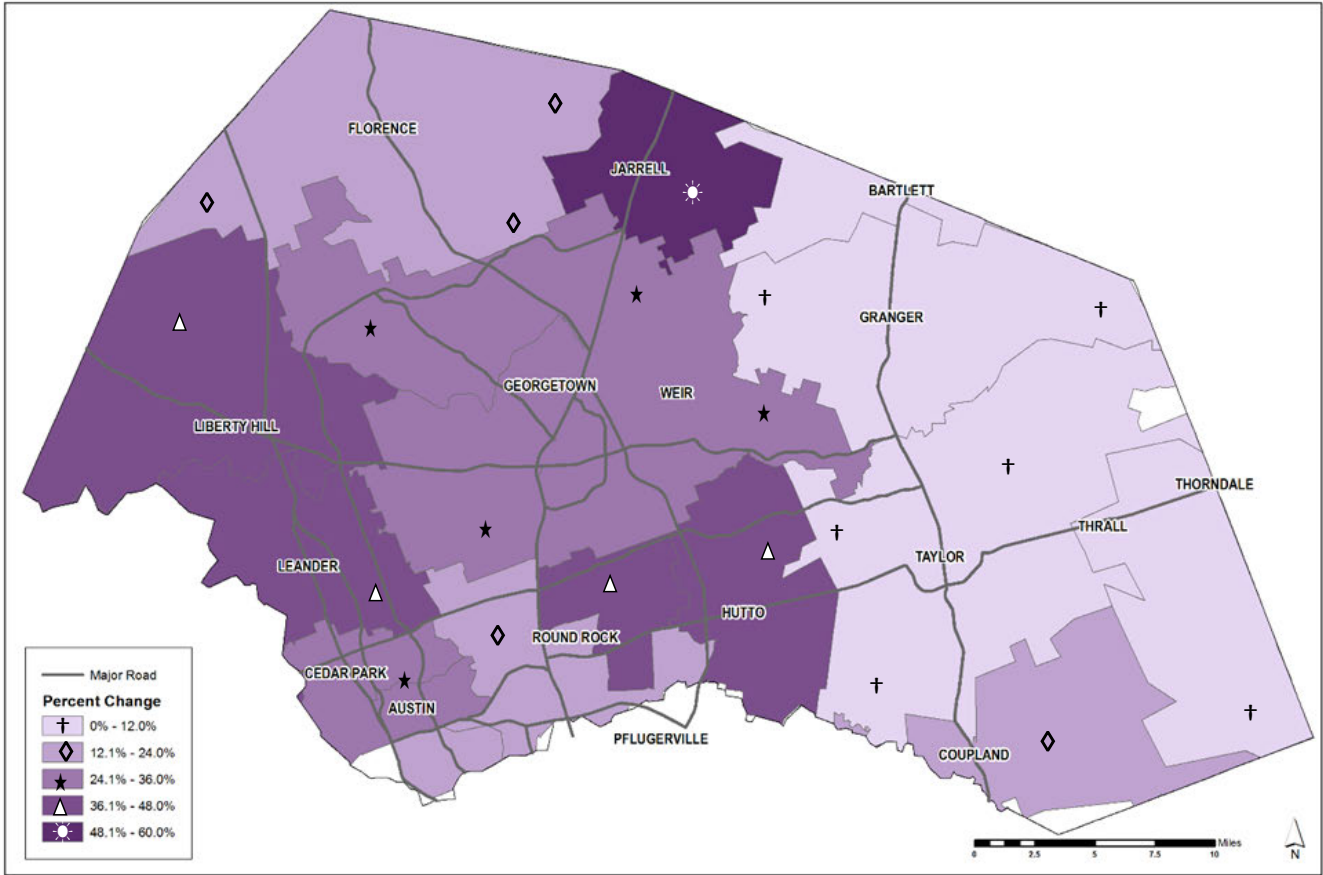
Population Change in Williamson County and Texas, 2010-2017			
Geographic Area	2010 Pop. <sup>1</sup>	2017 Pop. <sup>2</sup>	% Growth 2010-2017*
Texas	25,145,561	28,304,596	12.6%
Williamson County	422,679	547,545	29.5%
Cedar Park	48,937	75,704	54.7%
Georgetown	47,400	70,685	49.1%
Hutto	14,698	25,367	72.6%
Liberty Hill	967	1,905	97.0%
Leander	26,521	49,234	85.6%
Round Rock	99,887	123,678	23.8%
Taylor	15,191	16,982	11.8%

Notes: \*Growth from April 1, 2010 to July 1, 2017

Data Sources: <sup>1</sup>Census 2010; <sup>2</sup>Census, 2017

Population change in Williamson County is broken down by zip code, as shown in Figure 8. All zip codes within Williamson County have experienced population growth from 2010 to 2018, ranging from 5.6% in 76511 (Bartlett) to 56.8% in 76527 (Jarrell). Other growing zip codes include 78634 (Hutto) at 45.1%, 78665 (Round Rock) at 44.7%, 78641 (Leander) at 39.7%, and 78642 (Liberty Hill) at 36.7%.

Figure 8: Population Change by Zip Code in Williamson County, 2010-2018



**Population Change by Zip Code in Williamson County from 2010-2018**

This map illustrates population change from 2010 to 2018 for each zip code in Williamson County.  
Data Source: Healthy Communities Institute, 2018  
Date Created: 12/3/2018

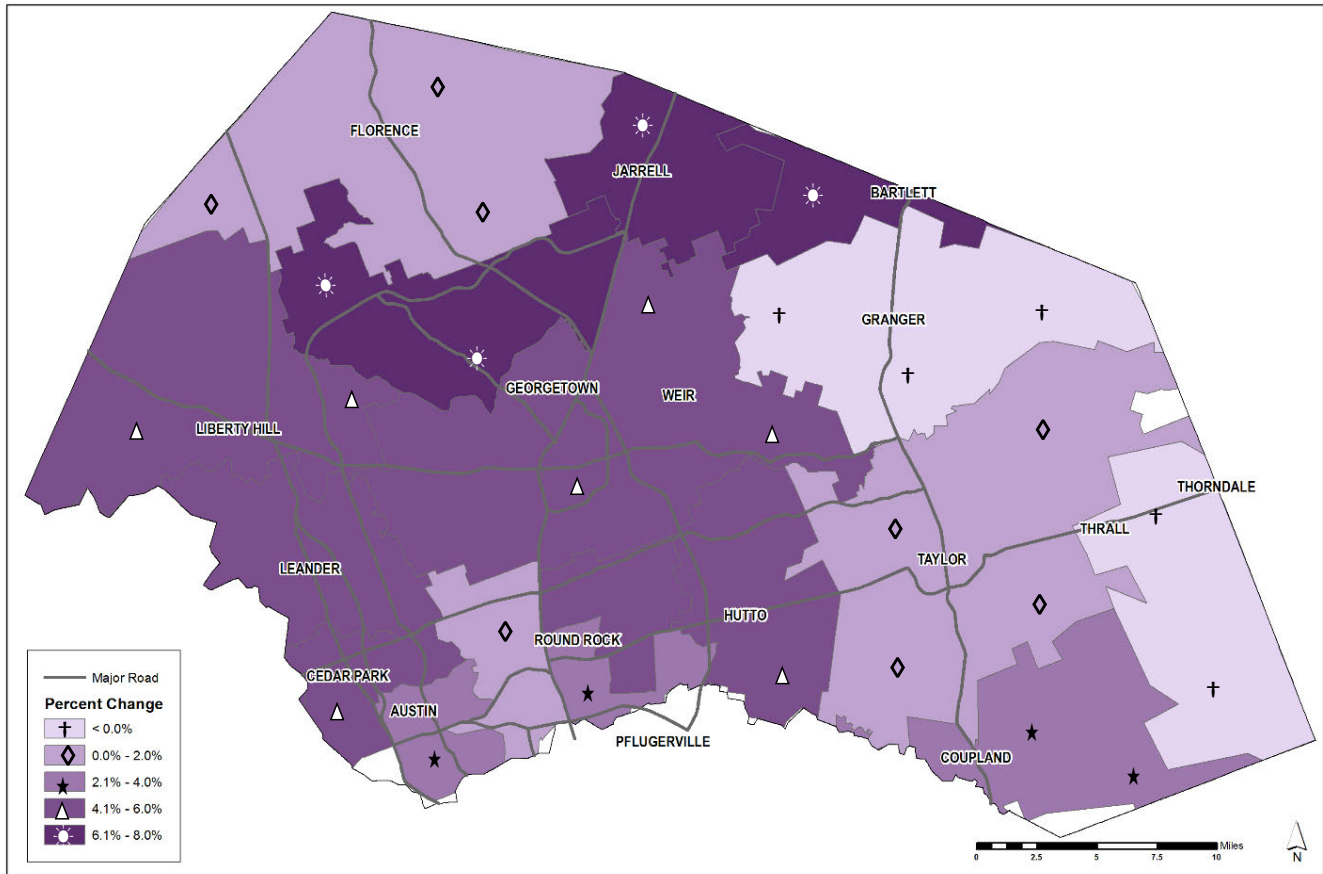




The CHA Task Force mapped population growth and migration from 2011 to 2016 among White (Figure 9), Hispanic (Figure 10), Black (Figure 11), and Asian (Figure 12) populations across the county by zip code.

The White population has experienced the largest growth at 7.9% in 76511 (Bartlett), followed by 7.1% in 76537 (Jarrell), and 7.0% in 78633 (Georgetown). Moderate growth has occurred in 78641 (Leander), 78665 (Round Rock), and 78634 (Hutto). Migration occurred in 76578 (Thrall) at -2.8% and 76530 (Granger) at -0.9%.

**Figure 9: Non-Hispanic White Population Change by Zip Code in Williamson County, 2011-2016**



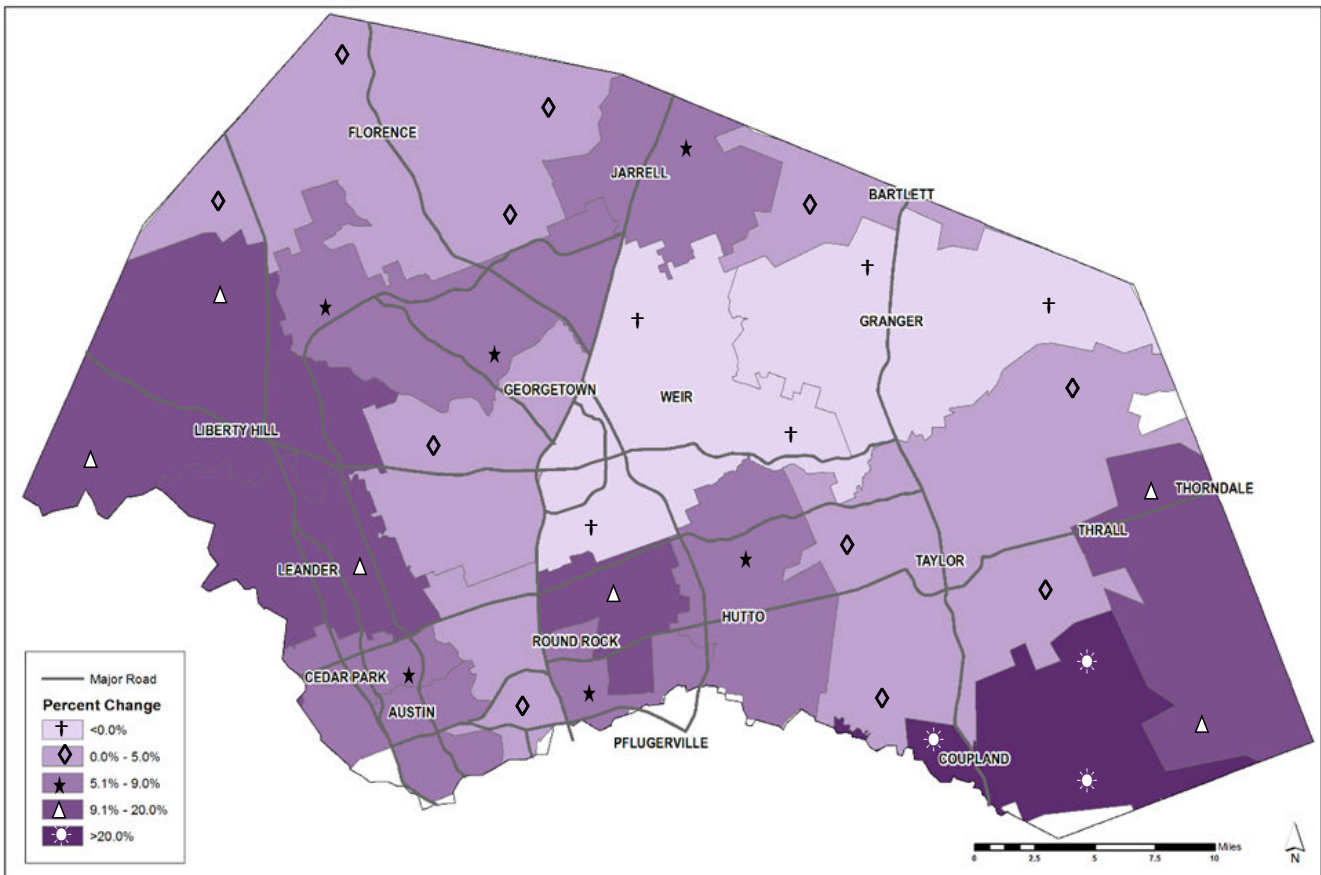
**Non-Hispanic White Population Change by Zip Code in Williamson County from 2011-2016**

This map illustrates population change among Non-Hispanic Whites from 2011 to 2016 for each zip code in Williamson County.  
 Data Source: American Community Survey, 2011-2016  
 Date Created: 12/3/2018



The Hispanic population has experienced the largest growth of any group at 752.5% in 78615 (Coupland). Moderate growth has occurred in 76578 (Thrall), 78642 (Liberty Hill), 78641 (Leander), and 78665 (Round Rock). Emigration reduced populations in 76530 (Granger) at -2.5% and 78626 (Georgetown) at -0.7%.

**Figure 10: Hispanic Population Change by Zip Code in Williamson County, 2011-2016**



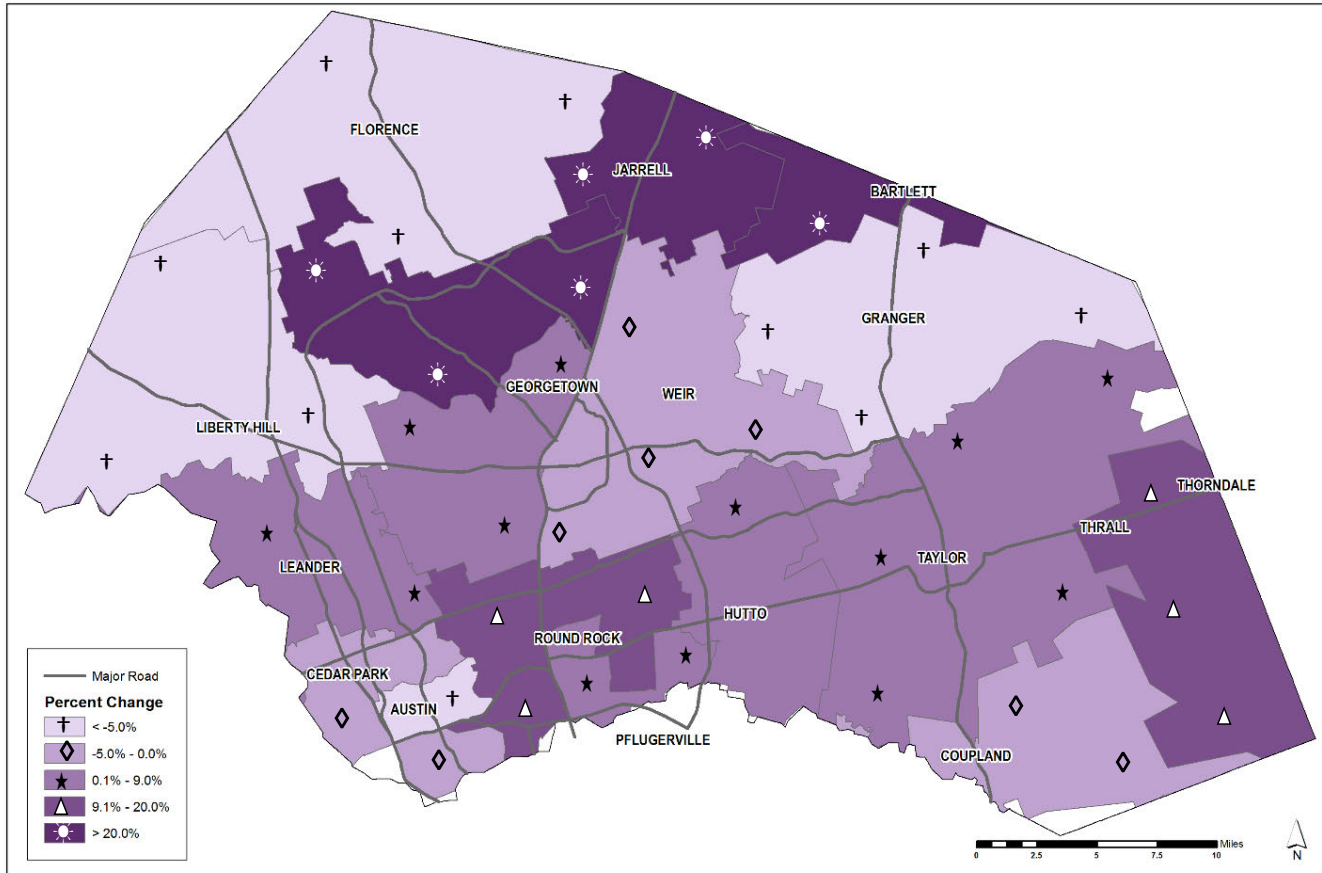
**Hispanic Population Change by Zip Code in Williamson County from 2011-2016**

This map illustrates population change among Hispanics from 2011 to 2016 for each zip code in Williamson County.  
 Data Source: American Community Survey, 2011-2016  
 Date Created: 12/3/2018



The Black population has experienced the largest growth at 97.6% in 78633 (Georgetown), followed by 59.0% in 76537 (Jarrell), and 30.2% in 76511 (Bartlett). Moderate growth has occurred in 76578 (Thrall), 78665 (Round Rock), and 78681 (Round Rock). The highest emigration rates occurred in 76527 (Florence) at -20.0%, 76530 (Granger) at -9.9%, and 78717 (Austin) at -6.0%.

**Figure 11: African American Population Change by Zip Code in Williamson County, 2011-2016**



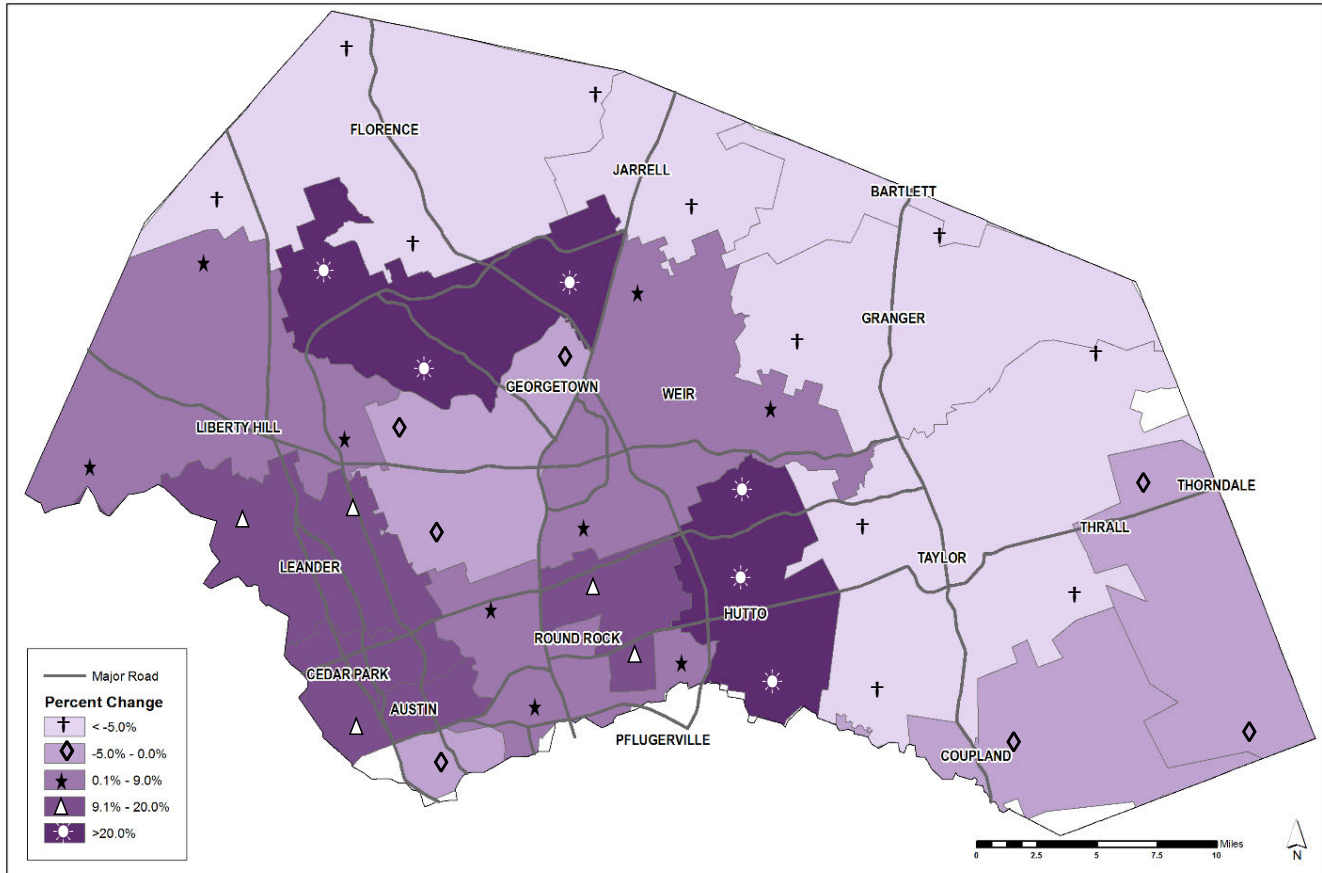
**African American Population Change by Zip Code in Williamson County from 2011-2016**

This map illustrates population change among African Americans from 2011 to 2016 for each zip code in Williamson County  
 Data Source: American Community Survey, 2011-2016.  
 Date Created: 12/3/2018



The Asian population has experienced significant growth at 158.2% in 78634 (Hutto) and 39.0% in 78633 (Georgetown). Moderate growth has occurred in 78665 (Round Rock), 78613 (Cedar Park), 78641 (Leander), and 78717 (Austin). The highest emigration rates occurred in 76527 (Florence) and 76530 (Granger) at -20.0%, and in 76574 (Taylor) at -10.2%.

**Figure 12: Asian Population Change by Zip Code in Williamson County, 2011-2016**



**Asian Population Change by Zip Code in Williamson County from 2011-2016**

This map illustrates population change among Asian Americans from 2011 to 2016 for each zip code in Williamson County.  
 Data Source: American Community Survey, 2011-2016  
 Date Created: 12/3/2018



**Population Projection**

At the current rate of growth, the Office of the State Demographer predicts that the county’s population will reach almost 2 million residents by 2050 (Table 8). Williamson County is projected to experience population growth among multiple age, gender, and racial/ethnic groups. The percentage of females is projected to increase from 50.7% to 53% by 2050. Among racial and ethnic groups, the Hispanic population is projected to more than double by 2050, from 23.8% to 48.2%.

**Table 8: Population Projection by Demographic Characteristics in Williamson County, 2018 and 2050**

<b>Population Projection by Demographic Characteristics in Williamson County, 2018 and 2050</b>		
	<b>2018</b>	<b>2050*</b>
<b>Population</b>	547,828	1,976,958
<b>Gender</b>		
Male	49.1%	47.0%
Female	50.9%	53.0%
<b>Age</b>		
<18	25.7%	20.5%
18-24	9.0%	8.3%
25-44	28.3%	25.9%
45-64	24.8%	23.3%
65+	12.1%	21.9%
<b>Race/Ethnicity</b>		
White	74.7%	32.3%
Hispanic/Latino	24.6%	48.2%
Black/African American	6.6%	6.5%
Asian American	6.6%	N/A
American Indian/Alaskan Native	N/A	N/A
Native Hawaiian/Pacific Islander	N/A	N/A
Other	3.0%	13.0%

*Notes: \*Population Projections: 1.0 Migration Rate; N/A: Population Percentages and Projections Not Available.*

*Data Sources: Healthy Communities Institute, 2018; \*Office of the State Demographer, 2050*

The figures shown below display population pyramids for Williamson County in 2017 (Figure 13) and 2050 (Figure 14). Population pyramids are used to predict population growth by gender and age groups. As seen in Figure 13, the triangular pyramid shape represents a population that has a high proportion of younger and working-class age groups. Most of the population is clustered around the middle of the pyramid, which represents those ages 25 to 44 years. As this “reproductive” group ages over time, they will become the “post-reproductive” group of those ages 65 years and older. This population shift can be seen in Figure 14; the pyramid is more rectangular shaped, indicating a higher proportion of elderly residents compared to younger and working-class populations. By 2050, the post-reproductive group is expected to comprise 21.9% of the overall county population, which is nearly double the current proportion of 11.9%, and is a larger proportion compared to the same age group in Texas (17.4%) (Table 8). Simultaneously, a decrease is expected to occur in the number of younger residents, specifically those less than 18 years of age. By 2050, the percentage of those less than 18 years of age is expected to shift from 26.0% to 20.5%.

Figure 13: Population Pyramid of Williamson County by Age and Sex, 2017

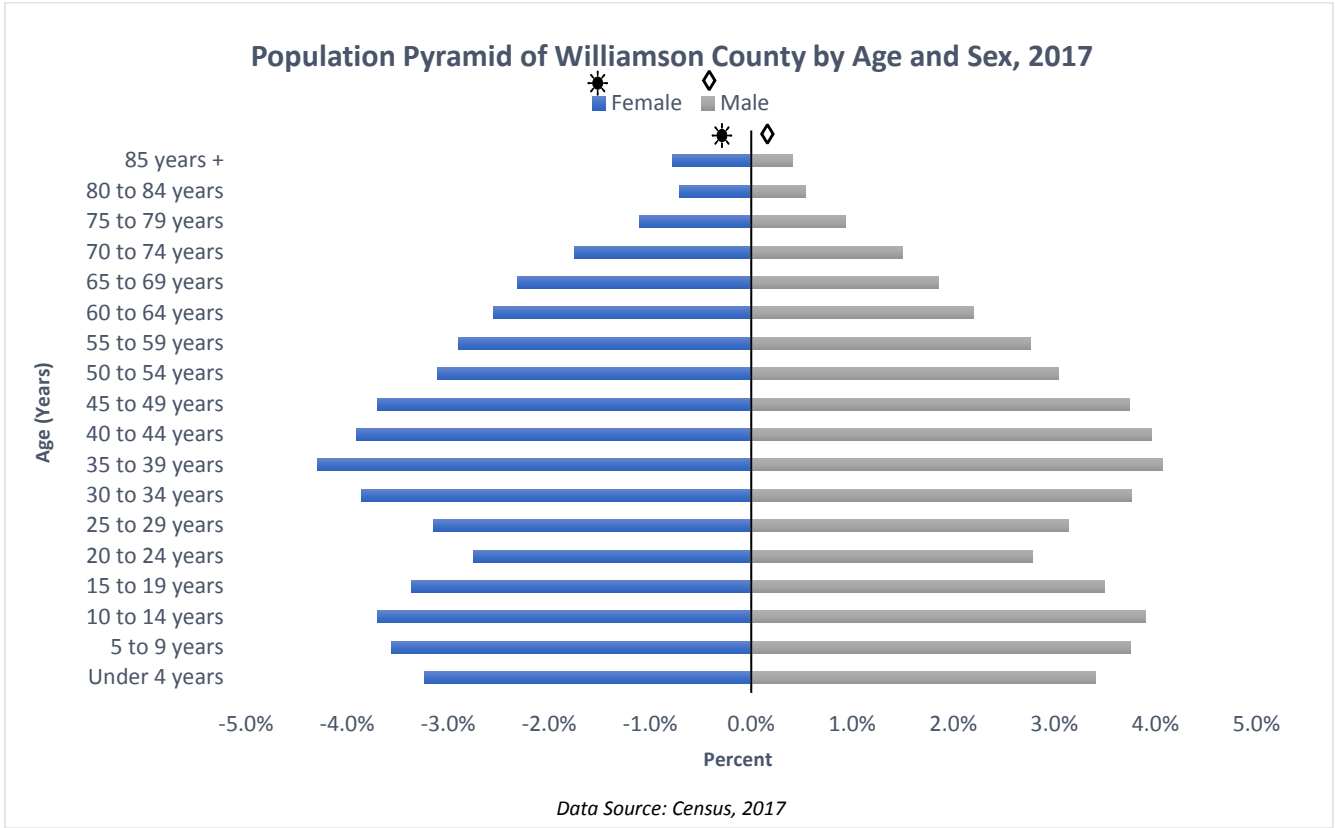
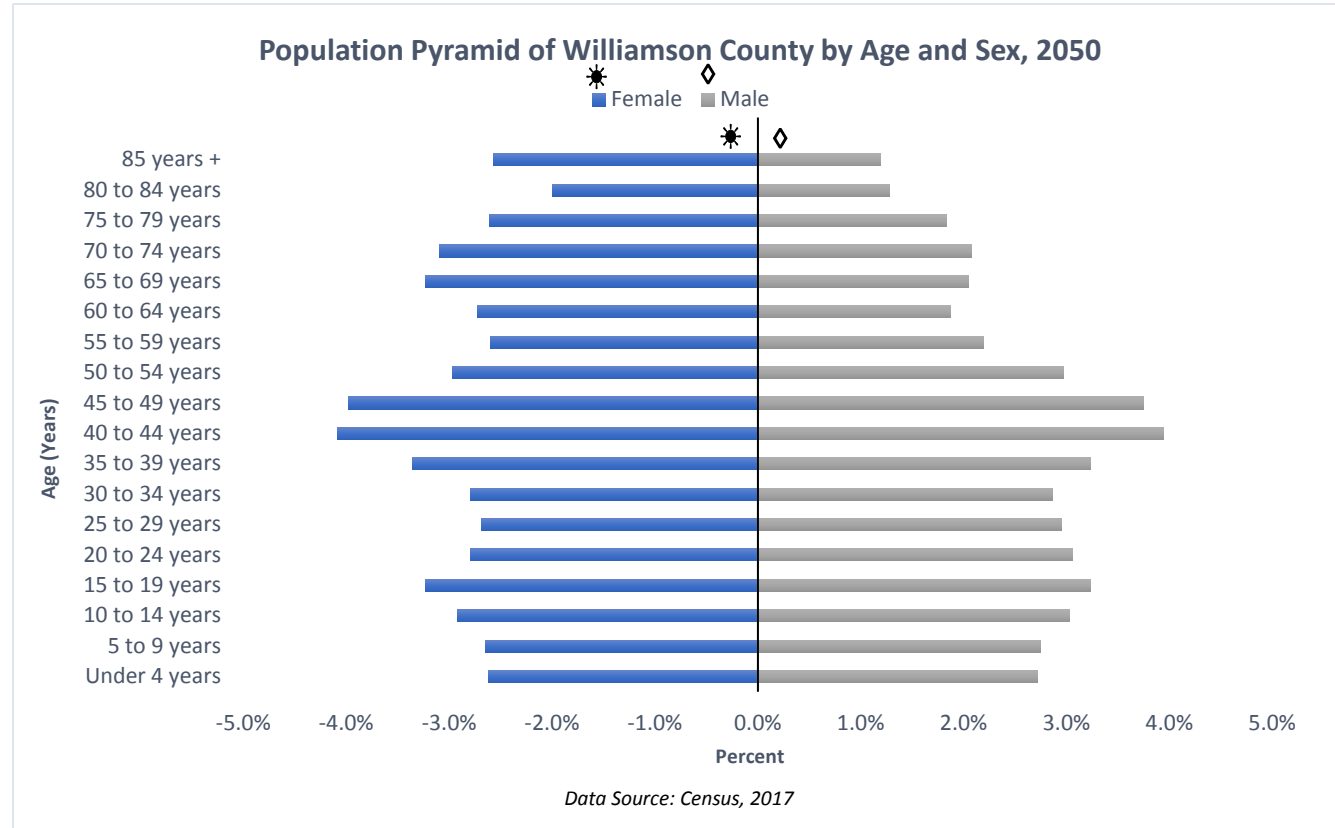


Figure 14: Population Pyramid of Williamson County by Age and Sex, 2050





## Language Spoken at Home

A large majority (79.0%) of residents over the age of 5 years old spoke English at home, as compared to 64.7% of Texas residents (Table 9). Of the Williamson County residents who spoke a language other than English at home, 14.3% spoke Spanish.

**Table 9: Language Spoken at Home (Ages 5 and Over) in Williamson County and Texas, 2013-2017**

Language Spoken at Home (Ages 5 and Over) in Williamson County and Texas, 2013-2017		
Indicator	Williamson County	Texas
Speak only English	79.0%	64.7%
Speak a language other than English	21.0%	35.3%
Spanish	14.3%	29.5%

*Data Source: American Community Survey, 2013-2017*

## Key Findings

Williamson County has experienced rapid growth over the past eight years and will continue to experience significant growth over the next three decades. This growth has the potential to cause a shortage of providers and services, placing greater demands on the health care system. In addition, health resources and programs will need to be structured around age, race, ethnicity, culture, language, and geography to accommodate residents of Williamson County. Below are key considerations for stakeholders responsible for healthcare system planning and development.

- **Major population growth is expected for those ages 65 and older.** This will increase the prevalence of chronic diseases in Williamson County, since older adults often have more chronic conditions than other age groups.(18) Additionally, an aging population places burden upon the working-age population to support the large number of elderly dependents. (17) Future planning should consider chronic disease management, quality of life resources, and preventative health care for the aging population.
- **The Hispanic population is expected to more than double by 2050.** Certain chronic health conditions and risk factors, such as obesity and diabetes, disproportionately affect this population.(19) These findings should be considered when planning health improvement and intervention strategies. Moreover, the rates of individuals who speak Spanish or another language other than English is growing and needs to be addressed. Culturally competent programs that address language disparities are necessary to strengthen awareness, knowledge, and access to health resources and services.
- **Growing numbers of the population are moving to rural areas of the county, specifically Jarrell, Georgetown, Hutto, and Coupland.** Those living in rural areas cite transportation as a major barrier to healthcare access. Lack of adequate transportation may result in rescheduled or missed appointments, delayed care, and missed or delayed medication use.(20) This ultimately leads to poor management of chronic illness and health outcomes.(20) Programs should strongly consider expanding their services to these areas to increase health care coverage and access.

## C2. Socioeconomic Characteristics

---

*“IF THERE WAS SOME SORT OF VOCATIONAL TRAINING FOR ADULTS, THAT WOULD BE VERY HELPFUL, LIKE ELECTRICAL – LIKE WHATEVER – PLUMBING, ELECTRICAL, WHATEVER, BUT SOMETHING THAT SOME OF OUR ADULTS WHO JUST MAYBE DIDN'T GO TO SCHOOL RIGHT AWAY OR WANT TO GO BACK OR WHATEVER. WE JUST DON'T HAVE ANYTHING FOR THEM AS WELL.”*

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Socioeconomic characteristics include indicators that affect health status, such as median household income, poverty, unemployment, and education. When examined together, these indicators describe an individual's socioeconomic status (SES). Research shows that SES is a consistent and reliable predictor of many health outcomes across the life span.(21)

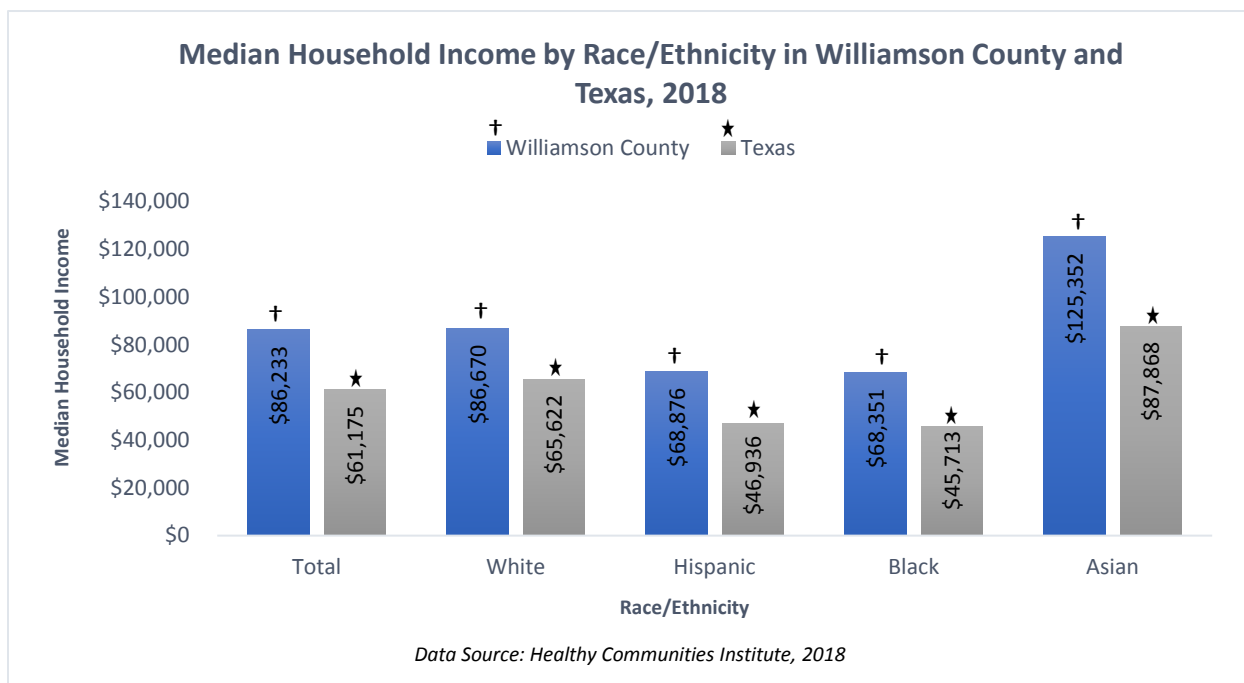
### Median Household Income

#### *Why is this important?*

“Median household income reflects the relative affluence and prosperity of an area. Areas with higher median household incomes are likely to have more educated residents and lower unemployment rates. Areas with higher median household incomes also have higher home values and their residents enjoy more disposable income.”(12)

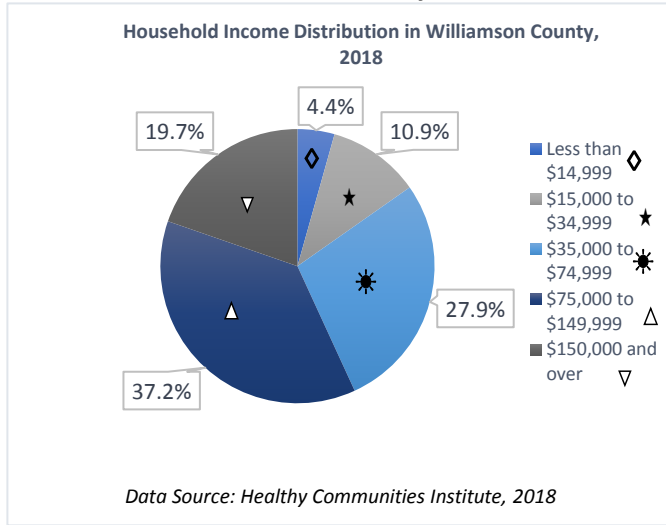
Williamson County has a median household income of \$86,233, which is \$20,000 more than the median household income for Texas (Figure 15). Moreover, the median household income for each racial and ethnic group is higher in Williamson County compared to the same groups for Texas. The White (\$86,670) and Asian (\$125,352) populations earn above the Williamson County total median household income. The Hispanic (\$68,876) and Black/African American (\$68,351) populations earn below the total median household income compared to the county, but still earn above the median compared to the state.

**Figure 15: Median Household Income by Race/Ethnicity in Williamson County and Texas, 2018**

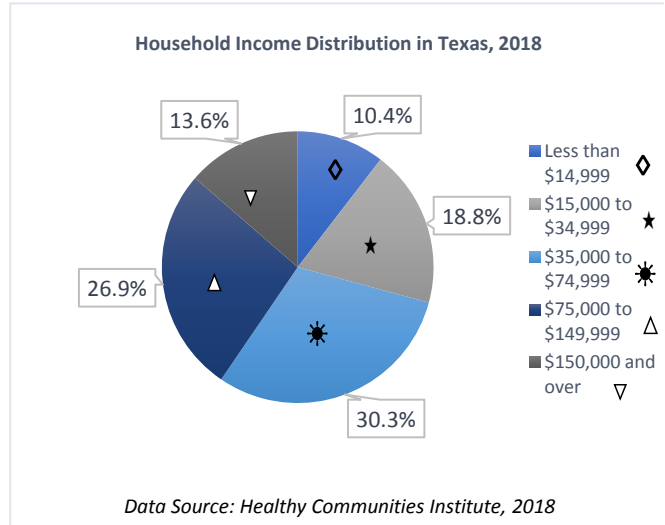


About one in five (19.7%) Williamson County households earn more than \$150,000, while almost one in ten (8.9%) households earn less than \$25,000 (Figure 16). Additionally, two in five (40.5%) households earn between \$75,000 and \$149,000 and one in three (29.4%) households earns between \$35,000 and \$74,999. When compared to Texas, Williamson County has a higher percentage of households who earn \$75,000 or more, while Texas has a higher percentage of households who earn less than \$75,000 (Figure 16 and Figure 17).

**Figure 16: Median Household Income Distribution in Williamson County, 2018**



**Figure 17: Median Household Income Distribution in Texas, 2018**



Poverty

*Why is this important?*

“A high poverty rate is both a cause and a consequence of poor economic conditions. A high poverty rate indicates that local employment opportunities are not sufficient to provide for the local community. Through decreased buying power and decreased taxes, poverty is associated with lower quality schools and decreased business survival.”(22)

Williamson County has a lower percentage (7.0%) of individuals living below the Federal Poverty Line (FPL) compared to Texas (16.0%) (Table 10). The percentage of adults aged 65 and older who are living in poverty is 5.1% (Williamson County) and 10.7% (Texas). Of adults ages 18-64 with any disability, 15.0% (Williamson County) and 24.6% (Texas) are living in poverty. The percentage of youth under the age of 18 who are living in poverty is 8.4% (Williamson County) and 22.9% (Texas).

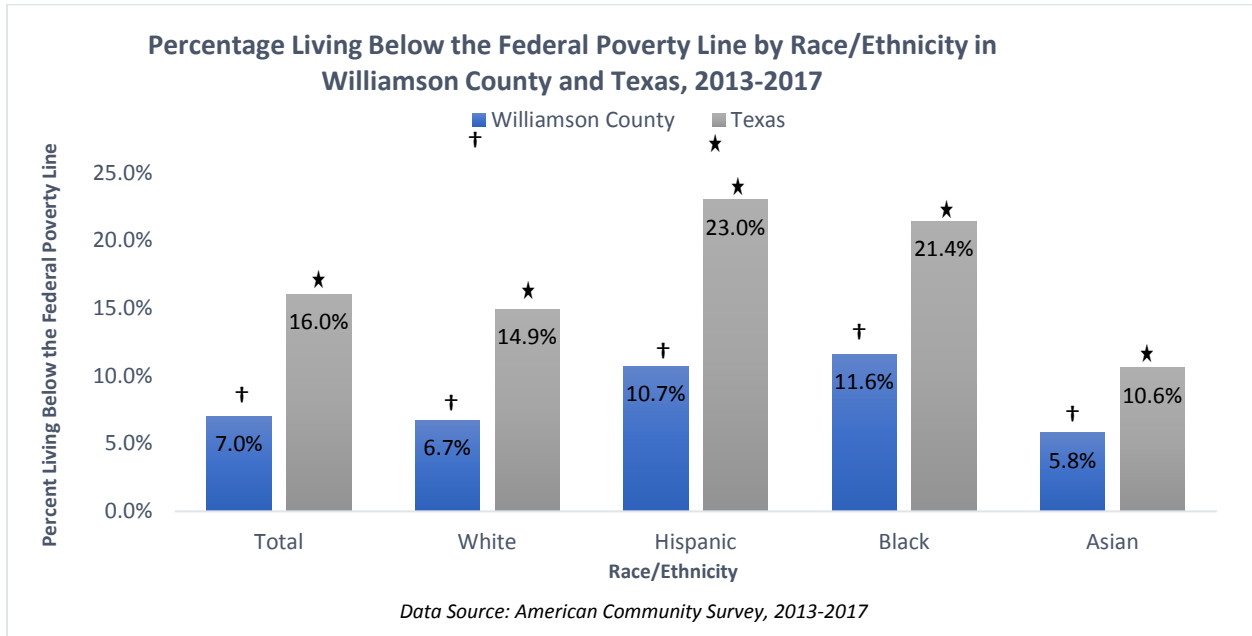
**Table 10: Percent of Residents Living Below the Federal Poverty Line (FPL) in Williamson County and Texas, 2013-2017**

Indicator	Williamson County	Texas
People Living Below FPL	7.0%	16.0%
People 65+ Living Below FPL	5.1%	10.7%
People with a Disability Living Below FPL	15.0%	24.6%
Children Under 18 Living Below FPL	8.4%	22.9%

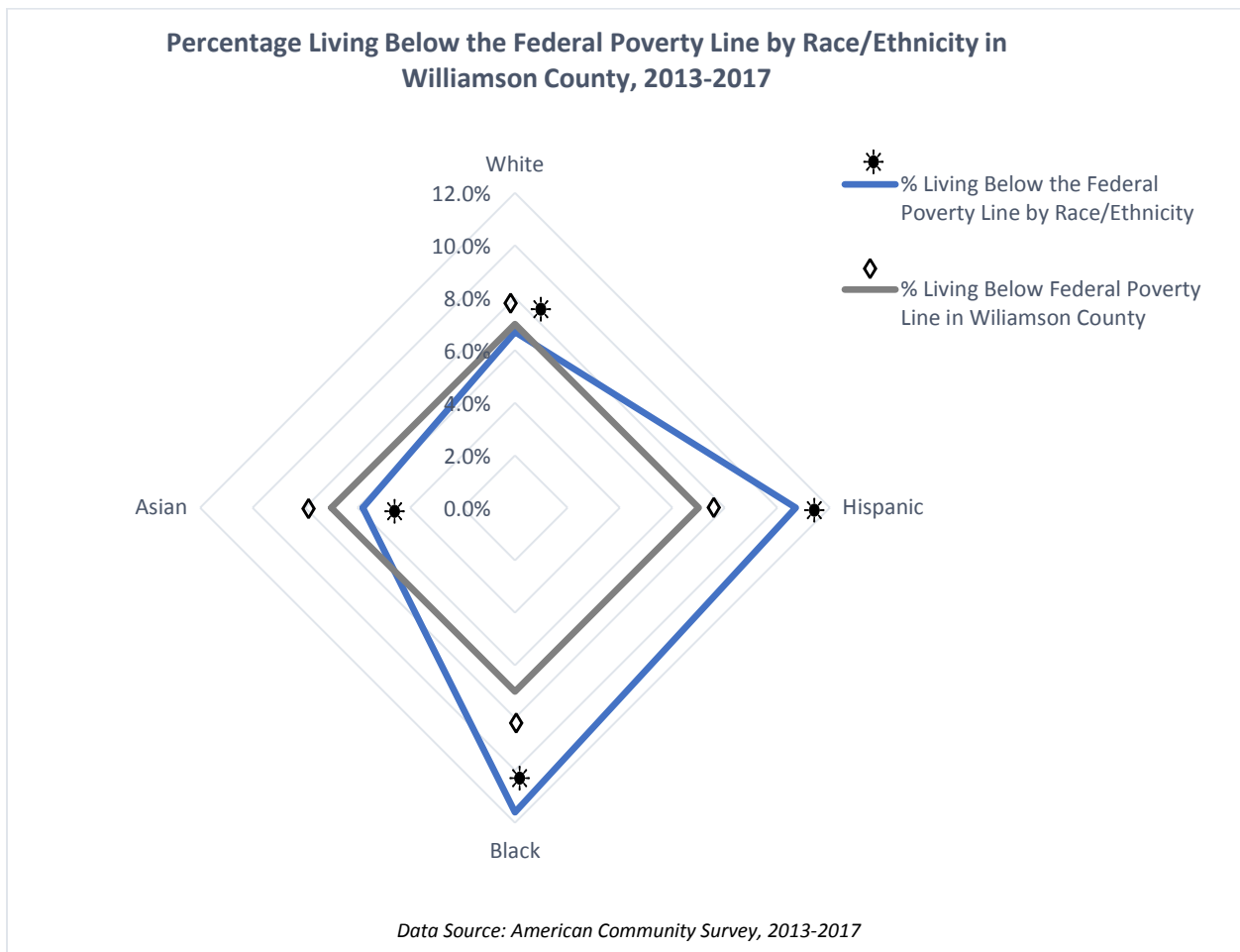
Data Source: American Community Survey, 2013-2017

Across all racial and ethnic groups, Williamson County had lower percentages of residents living below the FPL compared to Texas (Figure 18). In Williamson County, the percentage of residents living in poverty among White (6.7%) and Asian (5.8%) populations is less than the overall county value of 7.0% (Figure 19). In contrast, poverty among Hispanic and Black populations in Williamson County is higher than the overall county value, at 10.7% and 11.6% respectively.

**Figure 18: Percentage Living Below the Federal Poverty Line by Race/Ethnicity in Williamson County and Texas, 2013-2017**



**Figure 19: Percentage Living Below the Federal Poverty Line by Race/Ethnicity in Williamson County, 2013-2017**



Unemployment

Why is this important?

“The unemployment rate is a key indicator of the local economy. Unemployment occurs when local businesses are not able to supply enough appropriate jobs for local employees and/or when the labor force is not able to supply appropriate skills to employers. A high rate of unemployment has personal and societal effects. During periods of unemployment, individuals are likely to feel severe economic strain and mental stress. Unemployment is also related to access to health care, as many individuals receive health insurance through their employer. A high unemployment rate places strain on financial support systems, as unemployed persons qualify for unemployment benefits and food stamp programs.”(23)

About three percent (3.2%) of the Williamson County workforce 16 years of age and older are unemployed, compared to 3.9% in Texas (Table 11). When looking at veterans specifically, Williamson County has a lower percentage of veterans unemployed (2.8%) compared to Texas (4.4%).

**Table 11: Percentage of Civilian Workforce Unemployed in Williamson County and Texas, 2018**

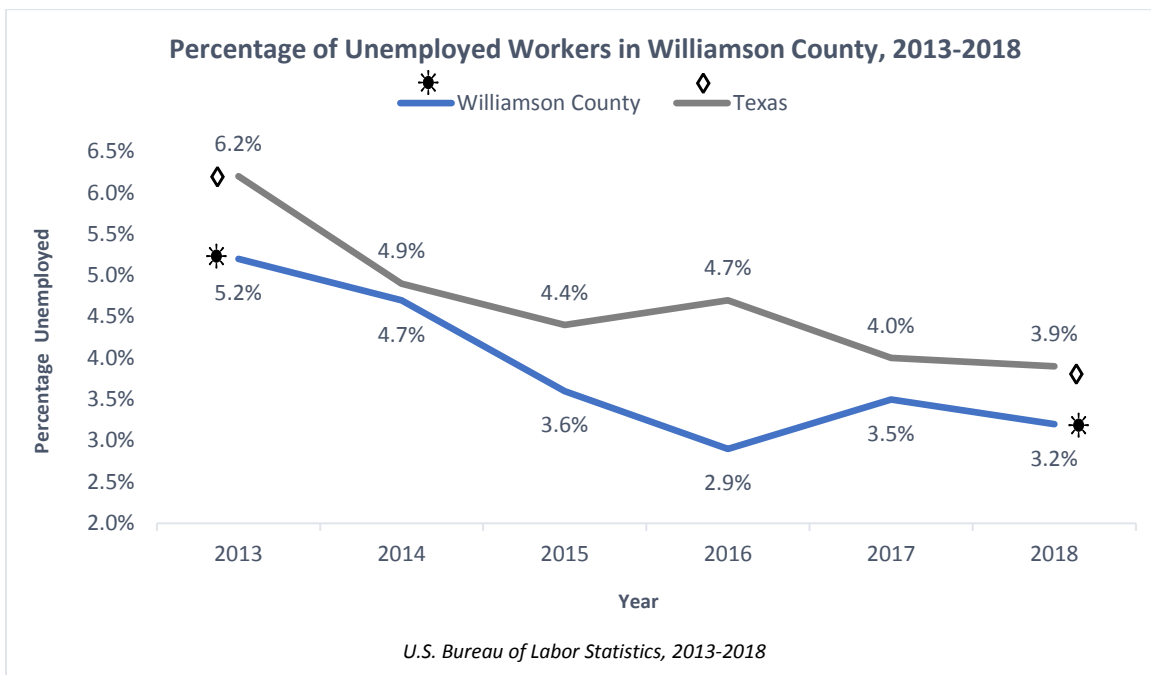
Percentage of Civilian Workforce Unemployed in Williamson County and Texas, 2018		
Indicator	Williamson County	Texas
Unemployment* <sup>1</sup>	3.2%	3.9%
Unemployment-Veterans <sup>2</sup>	2.8%	4.4%

Notes: \*Unemployment Rate as of August 1st, 2018

Data Sources: <sup>1</sup>U.S. Bureau of Labor Statistics, 2018; <sup>2</sup>American Community Survey, 2012-2016

Between 2013 and 2018, unemployment rates among the civilian workforce have been less in Williamson County compared to Texas (Figure 20). The percentage of unemployed workers in Williamson County has decreased from 5.2% in 2013 to 3.2% in 2018.

**Figure 20: Percentage of Unemployed Workers in Williamson County and Texas, 2013-2018**



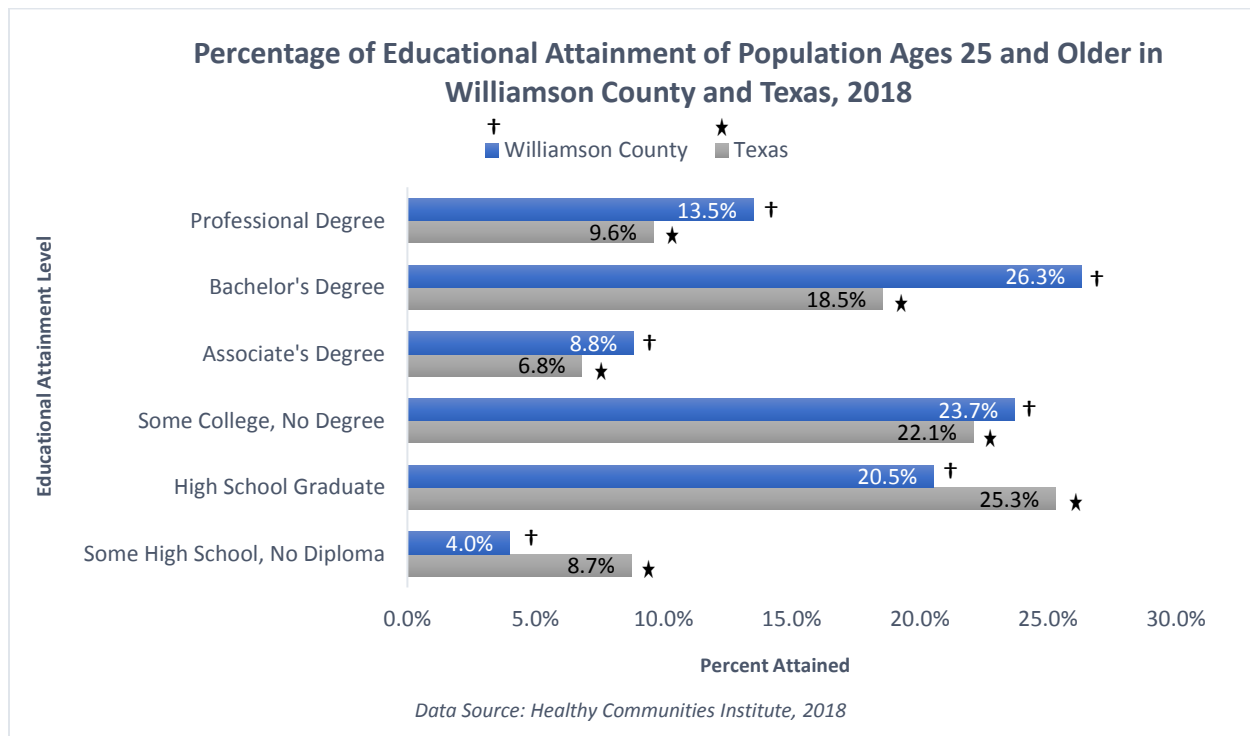
## Educational Attainment

### Why is this important?

“Graduating high school is an important personal achievement and is essential for an individual's social and economic advancement. Graduation rates are also an important indicator of the performance of the educational system.”(24) Furthermore, “the college experience develops cognitive skills, and allows learning about a wide range of subjects, people, cultures, and communities. Having a degree also opens up career opportunities in a variety of fields and is often the prerequisite to a higher-paying job. It is estimated that college graduates earn about \$1 million more per lifetime than non-graduate peers.”(25)

About 70% of Williamson County adults ages 25 years and older have some form of college or higher (combined percentages of those who have a professional, bachelor’s, associate’s some college), which is higher than Texas (57%) (Figure 21). In Williamson County, about one in 25 residents have some high school education but no college degree (4.0%), about one in five residents have obtained a high school diploma (20.5%), about one in four have some college experience but no degree (23.7%), about one in ten have an Associate’s degree (8.8%), about one in four have a Bachelor’s degree (26.3%), and about one in eight have a Master’s or Doctoral degree (13.5%).

**Figure 21: Percentage of Educational Attainment of Population Ages 25 and Older in Williamson County and Texas, 2018**



### Key Findings

Although Williamson County fares better than Texas concerning median household income, poverty, unemployment, and education, many socioeconomic factors should still be considered and addressed. Certain populations have substantially worse socioeconomic status compared to others, which is described in further detail below.

- The percentage of disabled adults who experience poverty is higher than the overall county value.**

“Persons with a disability are more likely to live in poverty as compared to the rest of the population. The poverty rate is especially high among persons with long-term disabilities. Without adequate income, individuals with disabilities may not be able to afford necessary expenses, such as rent or mortgage, utility



bills, medical and dental care, and food. People with disabilities living below the poverty level are more likely to experience material hardship in comparison to others living in poverty.”(26)

- **About one in ten youth experience poverty, which equates to 11,209 children under 18 years old.** “Compared to their peers, children in poverty are more likely to have physical health problems like low birth weight or lead poisoning and are also more likely to have behavioral and emotional problems. Children in poverty also tend to exhibit cognitive difficulties, as shown in achievement test scores, and are less likely to complete basic education.”(27)
- **Approximately 5% of the senior population experiences poverty.** “Seniors who live in poverty are an especially vulnerable group due to increased physical limitations, medical needs, and social isolation. Seniors often live on a fixed income from pensions or other retirement plans and social security. If this income is insufficient in the face of increasing prescription costs and other costs of living, most seniors have no way to supplement their income.”(28)
- **Historically, minority populations have a higher rate of poverty compared to other racial groups.** In Williamson County, poverty is significantly worse among Hispanic and Black populations compared to the overall county value. Additionally, both groups have a median household income that is below the overall county value. Income inequality is the largest factor contributing to higher poverty rates.(29)

The findings in this section provide evidence for increased intervention efforts to reduce poverty among high-risk groups. Research shows that increased educational attainment and income growth decreases poverty rates, therefore priorities and policies should be developed concerning these factors.

### C3. Health Resource Availability

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*“BIG DISTINCTION BETWEEN INSURANCE AND HEALTH CARE. AND EVERYTHING NOWADAYS IS INSURANCE, INSURANCE, INSURANCE WHEN THE FOCUS SHOULD BE ON HEALTHCARE.”*

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Indicators in this section include availability of health care providers, Federally Qualified Health Centers (FQHCs), as well as preventable hospitalizations and health insurance rates covering the cost of the care provided. Deficiencies in these areas of the healthcare system may cause delayed or missed care, leading to serious and potentially fatal health outcomes.

#### Provider Access

##### *Why is this important?*

Access to healthcare providers, specifically primary care physicians, mental health providers, and dentists, increases the likelihood that individuals will receive preventative care that mitigates long-term health complications.

**Table 12: Provider Access in Williamson County and Texas**

Provider Access in Williamson County and Texas		
Indicator	Williamson County	Texas
Primary Care Provider Ratio <sup>1</sup>	1,510:1	1,670:1
Dentist Ratio <sup>2</sup>	1,850:1	1,790:1
Mental Health Provider Ratio <sup>3</sup>	1,110:1	1,010:1

*Data Sources: <sup>1</sup>Area Health Resource File, 2015; <sup>2</sup>Area Health Resource File, 2016; <sup>3</sup>CMS, National Provider Identification, 2017*

*Findings based on Table 12:*

- For every primary care provider in Williamson County, there are 1,510 residents, which is lower than the ratio in Texas (1,670:1).
- For every dentist in Williamson County, there are 1,850 residents, which is higher than the ratio in Texas (1,790:1).
- For every mental health provider in Williamson County, there are 1,110 residents, which is higher than the ratio in Texas (1,010:1).

## Federally Qualified Health Centers

*Why is this important?*

Federally Qualified Health Centers (FQHCs) “provide care to underserved and vulnerable populations in settings like community health centers, migrant health centers, health care for the homeless centers, public housing primary care centers, and other settings.”(30) Additionally, they help lower health care costs and reduce the need for hospitalizations.

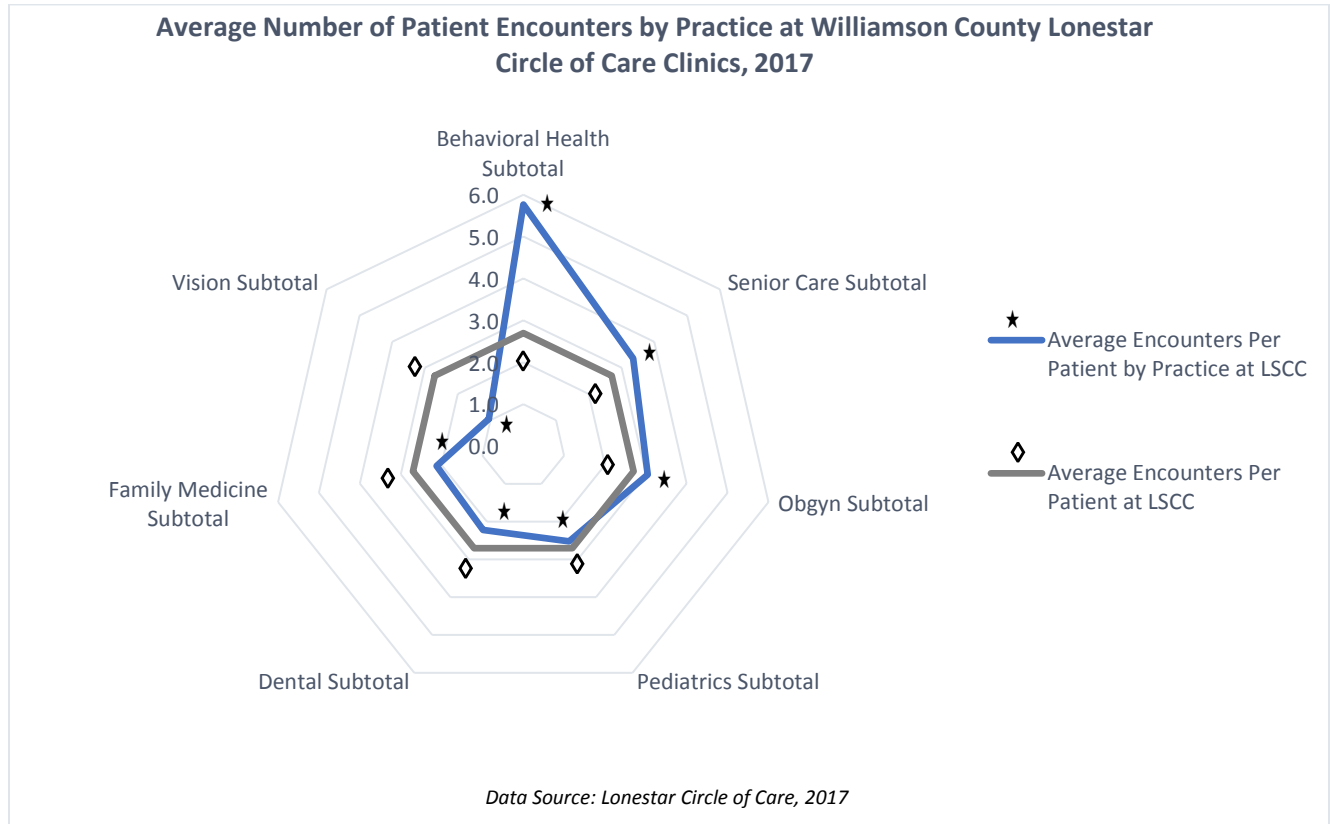
Compared to Texas, Williamson County has a higher rate of coverage by Federally Qualified Health Centers (FQHCs). For every 100,000 population, there are 2.1 FQHC locations in the county compared to 1.8 in Texas.(31)

## Local Spotlight: Lone Star Circle of Care

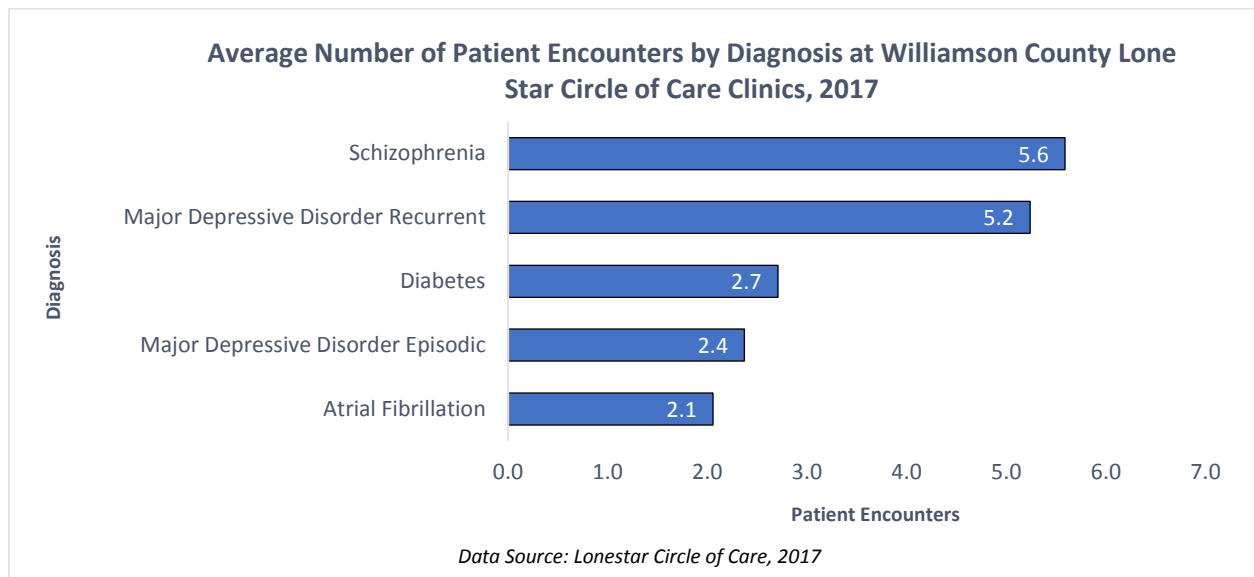
In Williamson County, Lone Star Circle of Care (LSCC) is the local FQHC provider with nine locations across the county. Below is an overview of LSCC, which includes the average number of encounters per patient by type of practice and diagnosis.

In 2017, the practice with the highest number of patient encounters was behavioral health (5.8), which was significantly higher than the overall rate (2.7) (Figure 22). Senior Care (3.4) and Ob-Gyn (3.0) also had patient encounters that were higher than the overall rate. At LSCC, a patient diagnosed with schizophrenia was seen almost six times (5.6) on average, followed by major depressive recurrent disorder (5.2), diabetes (2.7), major depressive episodic disorder (2.4) and atrial fibrillation (2.1) (Figure 22).

**Figure 22: Average Number of Patient Encounters by Practice at Williamson County Lone Star Circle of Care Clinics, 2017**



**Figure 23: Average Number of Patient Encounters by Diagnosis at Williamson County Lone Star Circle of Care Clinics, 2017**



## Preventable Hospitalizations

### Why is this important?

Hospitalization for diagnoses treatable in outpatient services suggests that the quality of care provided in the outpatient setting was less than ideal. The measure may also represent a tendency to overuse hospitals as a main source of care.(32)

In Williamson County, there were 38 preventable hospital stays per 1,000 fee-for-service Medicare enrollees, which is lower than the rate in Texas (53 per 1,000 fee-for-service Medicare enrollees).(33)

## Health Insurance

### Why is this important?

“Medical costs in the United States are extremely high, so people without health insurance may not be able to afford medical treatment or prescription drugs. They are also less likely to get routine checkups and screenings, so if they do become ill, they will not seek treatment until the condition is more advanced and therefore more difficult and costlier to treat. Many small businesses are unable to offer health insurance to employees due to rising health insurance premiums.”(34)

Figure 24 displays the percentage of total persons without health insurance in Williamson County (10.0%) and Texas (18.2%). When stratified by race/ethnicity, almost eighteen percent (17.5%) of the Hispanic population in Williamson County did not have health insurance as compared to 10.1% of the White population, 8.7% of the Asian population, and 8.4% of the Black population.

**Figure 24: Percentage of Population without Insurance by Race/Ethnicity in Williamson County and Texas, 2013-2017**

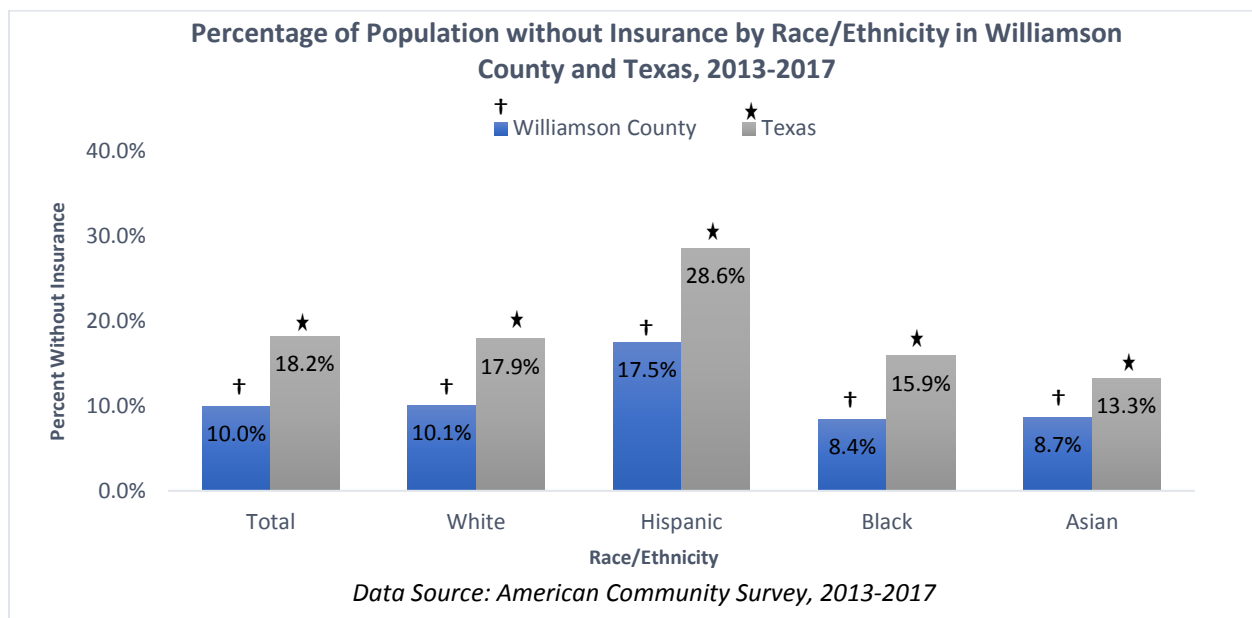


Figure 25 displays the percentage of individuals under age 18 without health insurance in Williamson County (6.7%) and Texas (11.0%). This equates to 9,428 children in Williamson County and 836,178 children in Texas who do not have any form of health insurance.

**Figure 25: Percentage of Population without Insurance for Children and Persons in Williamson County and Texas, 2013-2017**

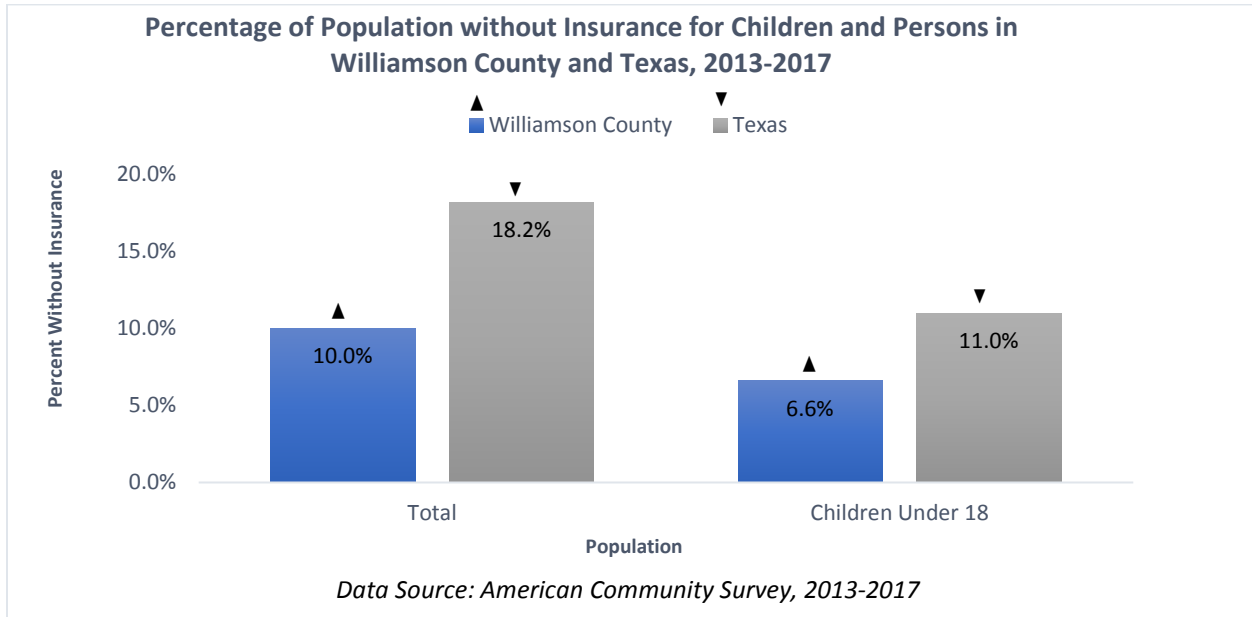


Figure 26 examines the total population without health insurance across various income levels in Williamson County and Texas. Almost twenty percent (20.7%) of those with a median household income of less than \$25,000 do not have health insurance in Williamson County, compared to 27.9% in Texas. As median household income increases, the percentage of those uninsured decreases; the uninsured rates in Williamson County for those who have a median household income of \$25,000-49,999, \$50,000-74,999, \$75,000-99,999, and over \$100,000 are 19.4%, 14.1%, 7.9%, and 4.5% respectively.

**Figure 26: Percentage of Population without Insurance by Median Household Income in Williamson County and Texas, 2013-2017**

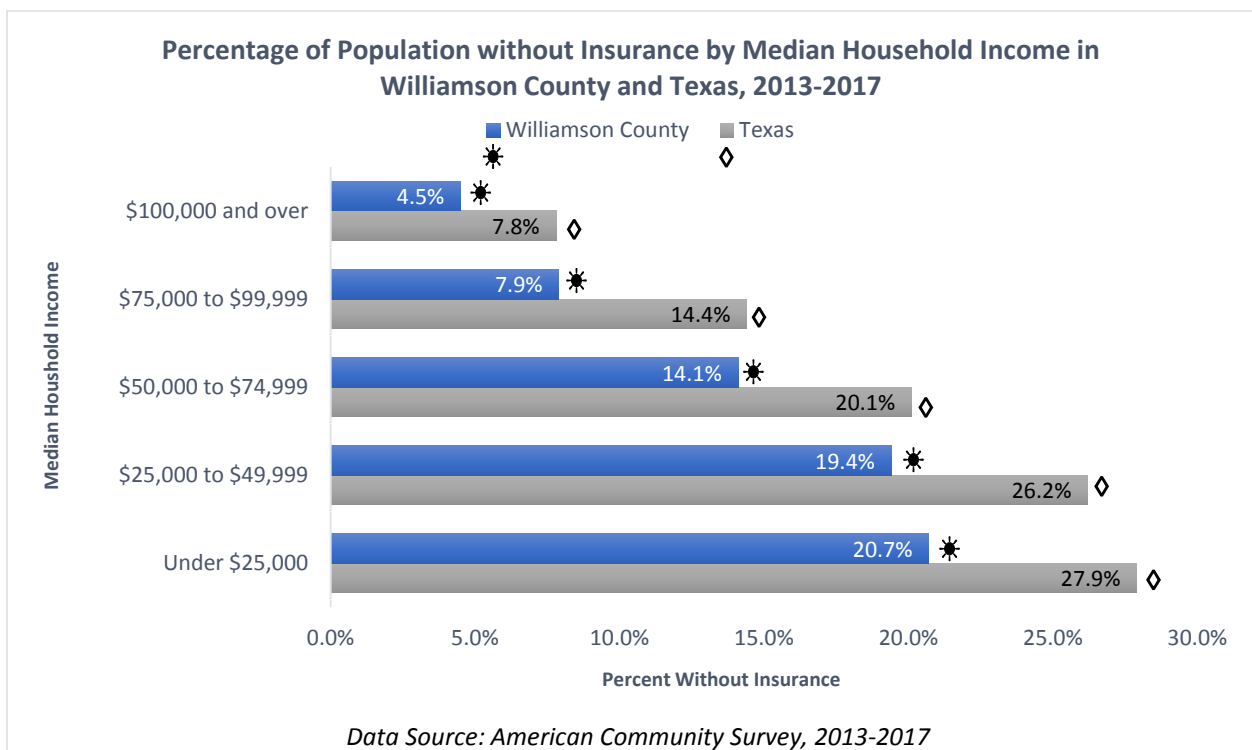


Figure 27 compares the insured and uninsured populations by federal poverty level (FPL) in Williamson County. Each year, the Census Bureau updates the FPL to define and quantify poverty in America; the further below the official poverty line one falls, the more vulnerable one is.(35) For example, a family of four living on an annual median household income of \$25,100 or less would fall below the 100% FPL; a family of four living on an annual median household income of less than \$34,638 would fall below the 138% FPL; a family of four living on an annual median household income less than \$100,400 would fall below the 400% FPL. In Texas, full coverage government health insurance plans or lower monthly premiums are available to households that fall below the 400% FPL. However, many of these households have incomes are too high to qualify for government health insurance plans or lower premiums, and income alone doesn't qualify a household for these insurance plans.

Williamson County households who fall below the 400% FPL have higher rates of not having health insurance. Over half (51.9%) of households who fall between the 138 to 399% FPL do not have health insurance, over ten percent (11.1%) of households who fall between 100-137% FPL do not have health insurance, and almost twenty percent (17.4%) of households who fall below the 100% FPL do not have health insurance.

**Figure 27: Percentage of Population without Insurance by Poverty in Williamson County and Texas, 2013-2017**

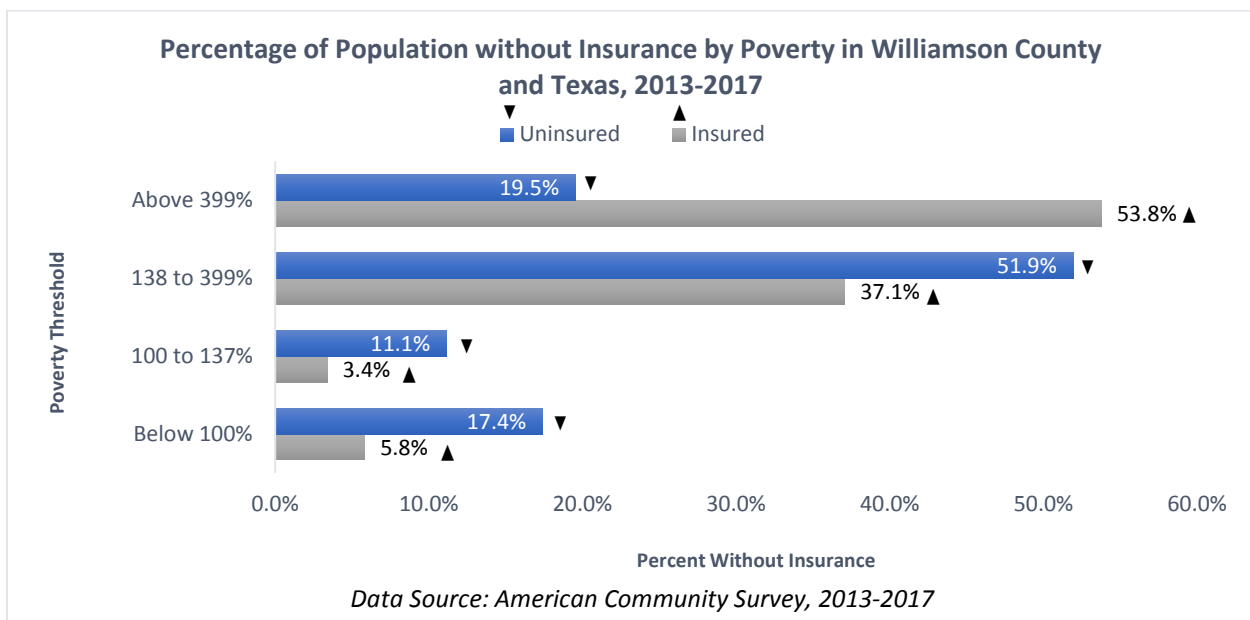
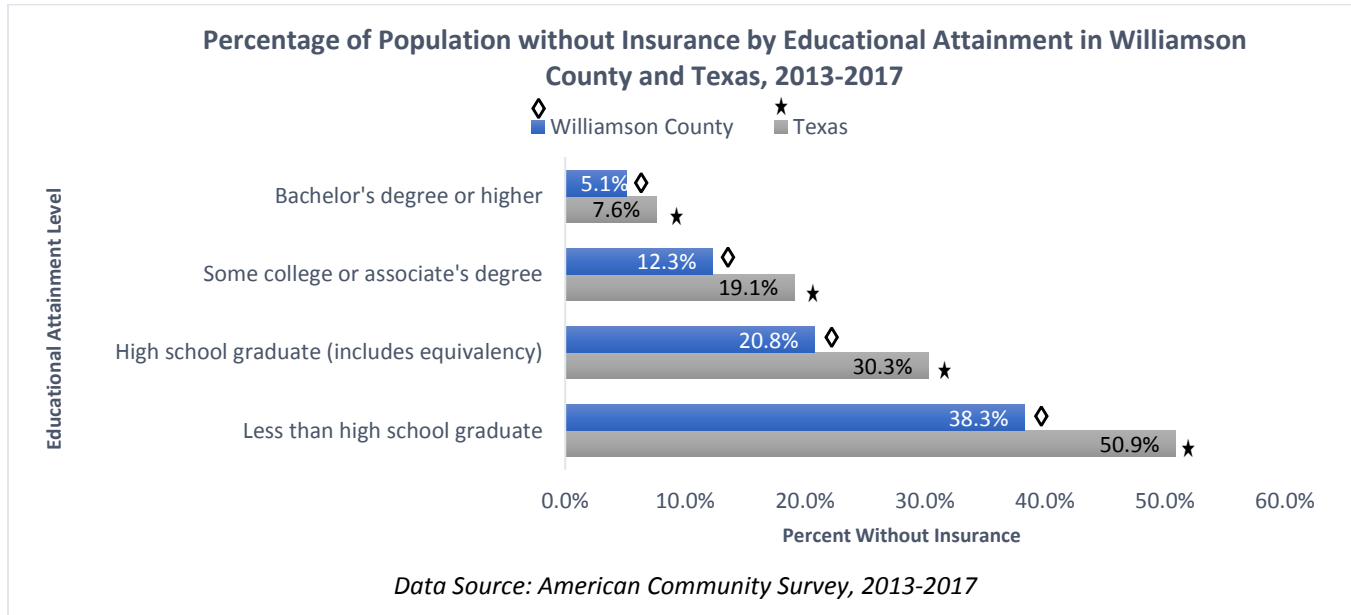


Figure 28 below examines the adult population (ages 26-64) without health insurance across various education levels in Williamson County and Texas. Almost forty percent (38.3%) of those with less than a high school diploma do not have health insurance in Williamson County, compared to 50.9% in Texas. As the population attains higher levels of education, the percentage of uninsured persons decreases. The uninsured rates in Williamson County for those who have attained a high school diploma, some college or Associate's degree, or a Bachelor's degree or higher is 20.8%, 12.3% and 5.1% respectively.

**Figure 28: Percentage of Population without Insurance by Educational Attainment in Williamson County and Texas, 2013-2017**



#### Key Findings

When the CHA Task Force examined healthcare resource availability in Williamson County, several gaps stood out. These should be addressed by stakeholders within the healthcare system, as well as those who develop policies regarding health care and health insurance.

- **The ratio of dental providers is worse in the county compared to Texas.** “Studies have linked oral infections with diabetes, heart disease, stroke, and premature, low-weight births.”(36) “Professional dental care helps to maintain the overall health of the teeth and mouth and provides for early detection of pre-cancerous or cancerous lesions. People living in areas with low rates of dentists may have difficulty accessing the dental care they need.”(37)
- **In conjunction with a low mental health provider ratio, the county’s local FQHC sees the most encounters per patient for mental health disorders.** “Psychological distress is important to recognize and address before issues become serious. Mental disorders are common across the United States, but only a fraction of those affected receive treatment. Although occasional down days are normal, persistent mental and emotional health problems should be evaluated and treated by a qualified professional.”(38)
- **Many Williamson County residents do not have health insurance.** The Hispanic population has the highest uninsured rate compared to other racial and ethnic groups. Moreover, those with low median household income, no high school diploma, and living in poverty are more likely to not have health insurance.

#### C4. Quality of Life

*“WELL, I HEAR A LOT OF INDIVIDUALS TALKING ABOUT THE FACT THAT THEY’RE ON SOME FORM OF DISABILITY. AND YOU’D LIKE TO BETTER YOURSELF SO MAYBE GET A JOB OR SOMETHING LIKE THAT. AND THAT SOUNDS SIMPLE. WANT MORE MONEY? GO GET A JOB, RIGHT? BUT IT AFFECTS YOU SO NEGATIVELY... THERE’S A PERIOD OF TIME AT WHICH ONE IS VERY MUCH FINANCIALLY AT RISK WHICH PUTS EVERYTHING AT RISK, YOUR HOUSING, YOUR FOOD, YOUR MEDICAL, TRANSPORTATION. ALL OF THESE AREAS ARE IN JEOPARDY IF SOMEBODY IS ON SOME FORM OF DISABILITY AND WOULD LIKE TO BETTER THEMSELVES.”*



Health-related quality of life is defined as “an individual’s or group’s perceived physical and mental health over time.”(39) Although health is one of the important domains of overall quality of life, there are other domains such as jobs, housing, schools, and neighborhood.(39) The data in this section describe individual-level quality of life indicators (health status, and physical/mental health perceptions), and community-level quality of life indicators (disability, transportation, housing, social/civic engagement, and Head Start facilities).

### Self-Reported Health

#### *Why is this important?*

Self-reported health status is based on survey responses to the question: “In general, would you say that your health is excellent, very good, good, fair, or poor?”

Poor Physical Health Days is based on survey responses to the question: “Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?”

Poor Mental Health Days is based on survey responses to the question: “Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?”

Together, these measures determine health-related quality of life. Self-reported quality of life data is a reliable estimate of one’s recent health.(40)

**Table 13: Self-Reported Health of Adults in Williamson County and Texas, 2016**

<b>Self-Reported Health of Adults in Williamson County and Texas, 2016</b>		
<b>Indicator</b>	<b>Williamson County</b>	<b>Texas</b>
Poor or fair health	13%	18%
Poor physical health days	3	3.5
Poor mental health days	3.1	3.4

*Data Source: Behavioral Risk Factor Surveillance System, 2016*

#### *Findings based on Table 13:*

- Adults in Williamson County reported a better health status than adults in Texas. Approximately 13% of adults in the county rated their health as “poor” or “fair” as compared to 18% in the state.
- Adults in Williamson County reported an average of 3 poor physical health days in the past 30 days, while adults in Texas reported an average of 3.5 days.
- Adults in Williamson County reported an average of 3.1 poor mental health days in the past 30 days, while adults in Texas reported an average of 3.4 days.

### Disability

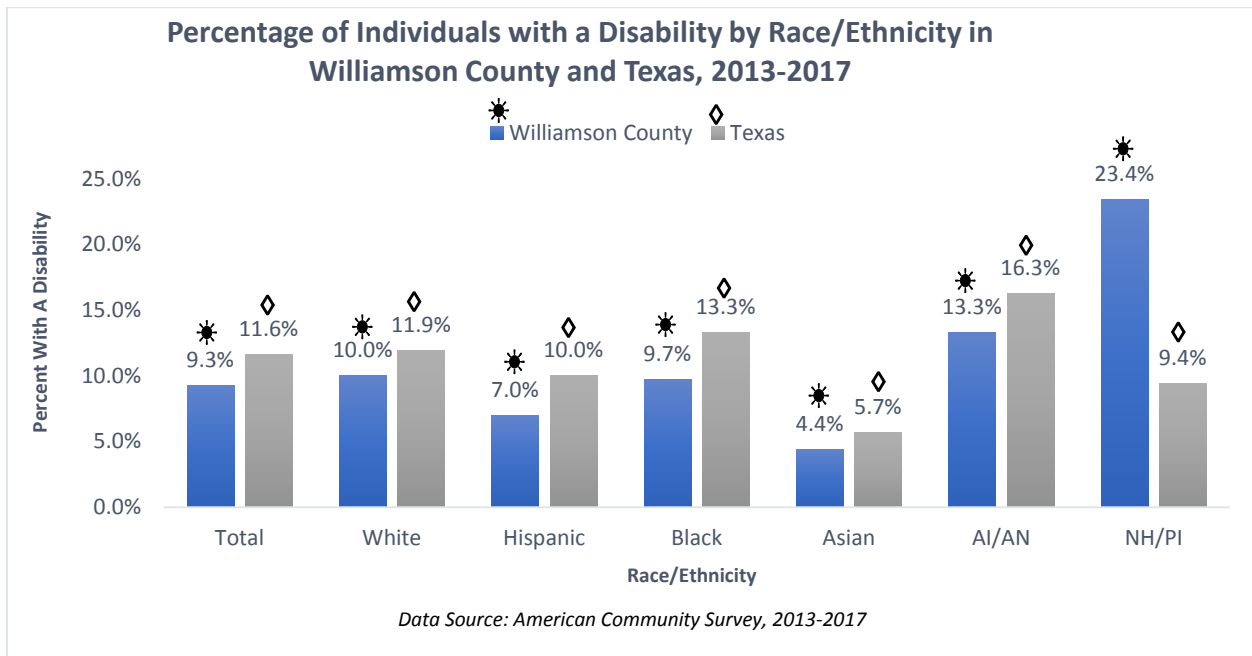
#### *Why is this important?*

“People with a disability have difficulties performing activities due to a physical, mental, or emotional condition. The extent to which a person is limited by a disability is heavily dependent on the social and physical environment in which he or she lives. Without sufficient accommodations, people with disabilities may have difficulties living independently or fulfilling work responsibilities.”(41)

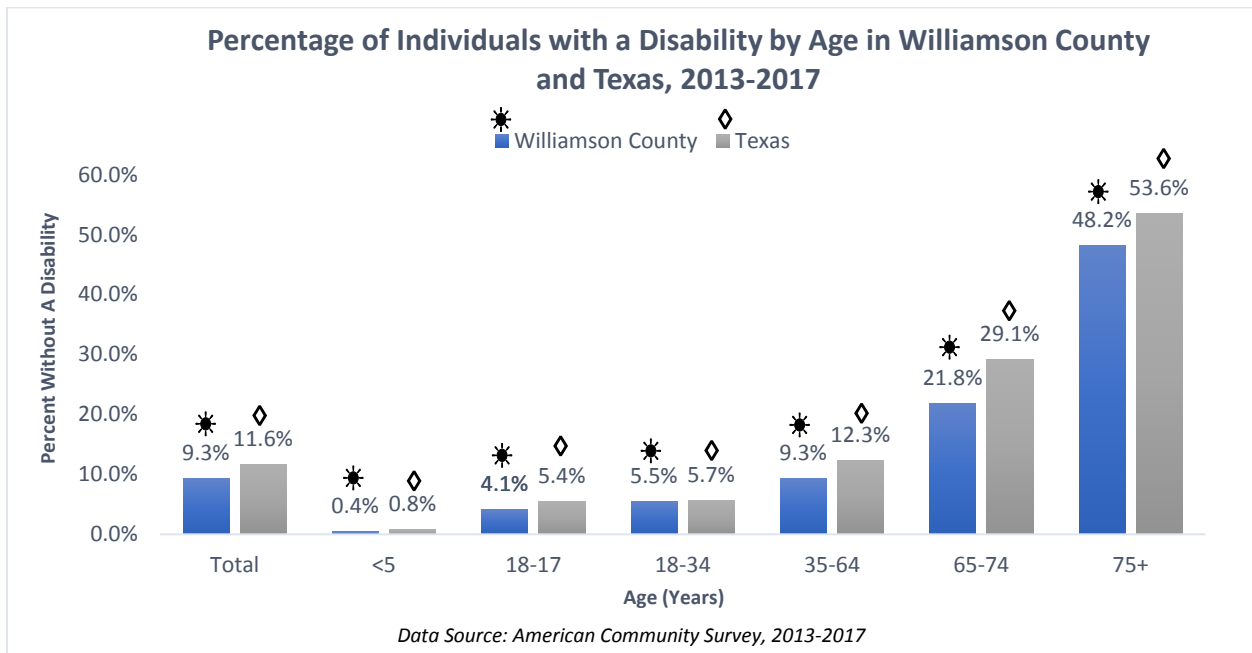
In 2017, the percentage of Williamson County’s population with a disability was 9.3%, compared to 11.6% in Texas (Figure 29). In Williamson County, the Native Hawaiian/Pacific Islander population had the highest percentage of disabilities (23.4%), followed by the American Indian/Alaskan Native population (13.3%). Moreover, these populations had higher percentages of disability compared to the overall county and Texas values. As individuals

age, their percentage of disability increases, as seen in Figure 30. Residents ages 75 and older have the highest percentage of disability (48.2%), followed by those ages 65-75 years (21.8%) and those ages 35-64 years (9.3%).

**Figure 29: Percentage of Individuals with a Disability by Race/Ethnicity in Williamson County and Texas, 2013-2017**



**Figure 30: Percentage of Individuals with a Disability by Age in Williamson County and Texas, 2013-2017**



Transportation

*Why is this important?*

There are many options for travel to work—the most common include driving alone in a personal vehicle, walking, or using public transportation. Driving alone “increases traffic congestion, especially in areas of greater population density,” while also causing “decreased levels of physical activity and cardiorespiratory health, and increased BMI

and hypertension.”(42) Moreover, “a lengthy commute to work cuts into one’s free time and can contribute to health problems such as headaches, anxiety, and increased blood pressure. Longer commutes require workers to consume more fuel which is both expensive for workers and damaging to the environment.”(43)

Alternatively, public transportation and walking to work offer more benefits, which include lowering commute costs, traffic congestion, and air pollution. Public transportation “offers mobility to U.S. residents, particularly people without cars. Transit can help bridge the spatial divide between people and jobs, services, and training opportunities. Public transportation is also beneficial because it reduces fuel consumption, minimizes air pollution, and relieves traffic congestion.”(44) “Walking to work is a good way to incorporate exercise into a daily routine. In addition to the health benefits, walking helps people get in touch with their communities, reduces commute costs, and helps protect the environment by reducing air pollution from car trips. Furthermore, studies have shown that walking to work improves employees' overall attitude and morale and reduces stress in the workplace.”(45)

Many households do not have a vehicle, which “is directly related to the ability to travel.” “In general, people living in a household without a car make fewer than half the number of journeys compared to those with a car. This limits their access to essential local services such as supermarkets, post offices, doctors' offices, and hospitals. Most households with above-average incomes have a car while only half of low-income households do.”(46)

**Table 14: Transportation Indicators in Williamson County and Texas, 2013-2017**

Indicator	Williamson County	Texas
Mean Travel Time to Work (minutes)	27.9	26.1
Percentage of Workers Who Drive to Work Alone	80.3%	80.5%
Percentage of Workers Who Walk to Work	0.9%	1.6%
Percentage of Workers Who Commute to Work by Public Transportation	0.8%	1.5%
Percentage of Households without a Vehicle	1.2%	2.2%

*Data Source: American Community Survey, 2013-2017*

*Findings based on Table 14:*

- In Williamson County, average daily travel time to work for workers ages 16 and older is 27.9 minutes, which is longer than Texas (26.1 minutes).
- The percentage of workers ages 16 and older who drive alone to work in Williamson County is 80.3% or roughly 400,000 persons, compared to 80.5% or roughly 21.6 million persons in Texas.
- The percentage of workers ages 16 and older who walk to work in Williamson County is 0.9% or roughly 4,400 persons, compared to 1.6% or roughly 430,000 persons in Texas. Both Williamson County and Texas fall below the HP2020 target of 3.1%.
- The percentage of workers ages 16 and older who commute to work by public transportation in Williamson County is 0.8% or roughly 3,900 persons, compared to 1.5% or roughly 400,000 persons in Texas. Both Williamson County and Texas fall below the HP2020 target of 5.5%.
- The percentage of households without a vehicle in Williamson County is 1.2% or roughly 3,037 households, compared to 2.2% or roughly 300,000 households in Texas.

## Housing

### *Why is this important?*

Quality of housing determines health outcomes and is one of the most significant social determinants of health. When home and rent values substantially increase, this can cause people to move more frequently, fall behind on housing payments, or not have a stable place to live.(47) Housing instability is associated with increased risk of teen pregnancy, early drug use, and depression among youth.(47) Housing foreclosures are associated with

depression, anxiety, increased alcohol use, psychological distress, and suicide.(47) Additionally, spending a high percentage of household income on housing may result in less income towards basic needs, such as food, clothing, transportation, medicine, and healthcare.

Between 2011 and 2016, rent in Williamson County increased by 10.6%, compared to 11.9% in Texas (Figure 30). However, Williamson County had a higher increase in home values compared to Texas, at 19.4% and 12.9% respectively.

From 2011 to 2016, all zip codes in Williamson County had a lower percent change in rent and home values compared to their respective county values (Figure 32 and Figure 33). The zip code with the highest percent change in rent value was 76511 (Bartlett) at 5.9% (Figure 32). Other zip codes with high percent changes in rent include 76578 (Thrall) and 78717 (Austin). Regarding home values, 76578 (Thrall) had the highest percent change at 5.8%, followed by 78613 (Cedar Park) at 4.5%, 78626 (Georgetown) at 4.4%, and 76537 (Jarrell) at 4.1% (Figure 33). Health Equity Zones reside in Bartlett, Jarrell, and parts of Georgetown.

**Figure 31: Percent Increase in Rent and Home Values in Williamson County and Texas, 2011-2016**

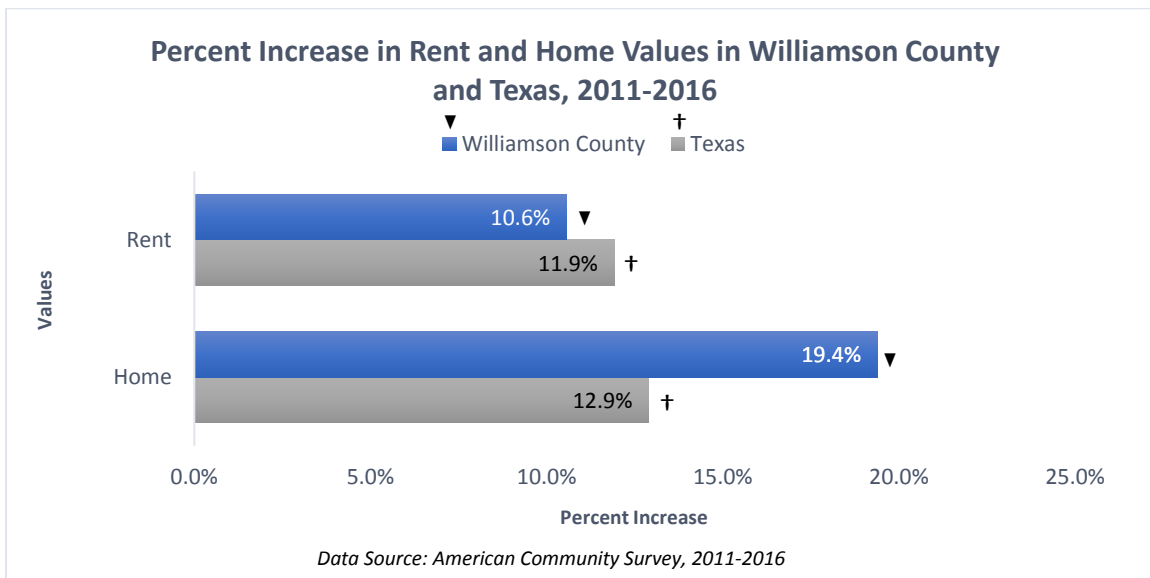
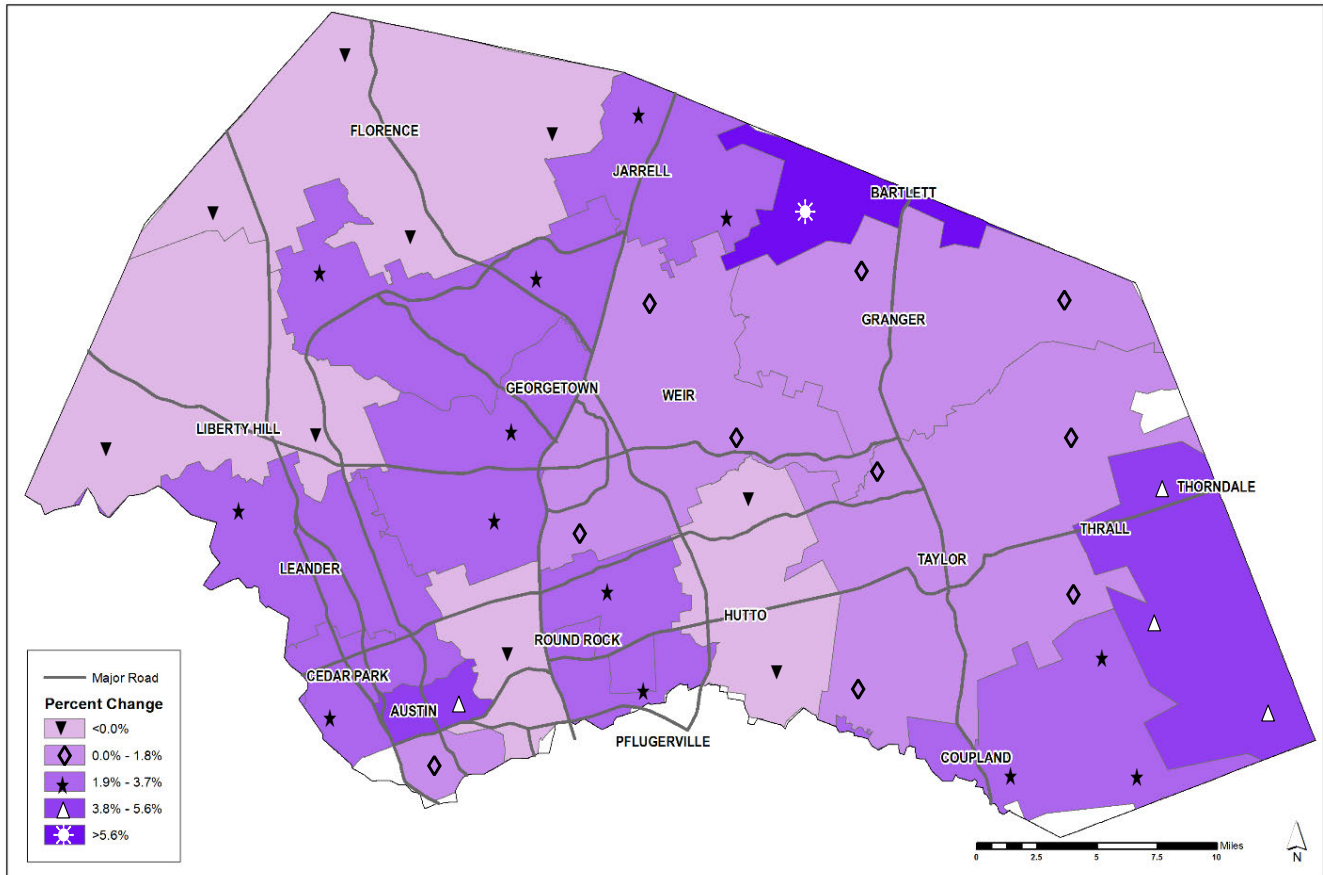


Figure 32: Percent Change in Rent Value by Zip Code in Williamson County, 2011-2016

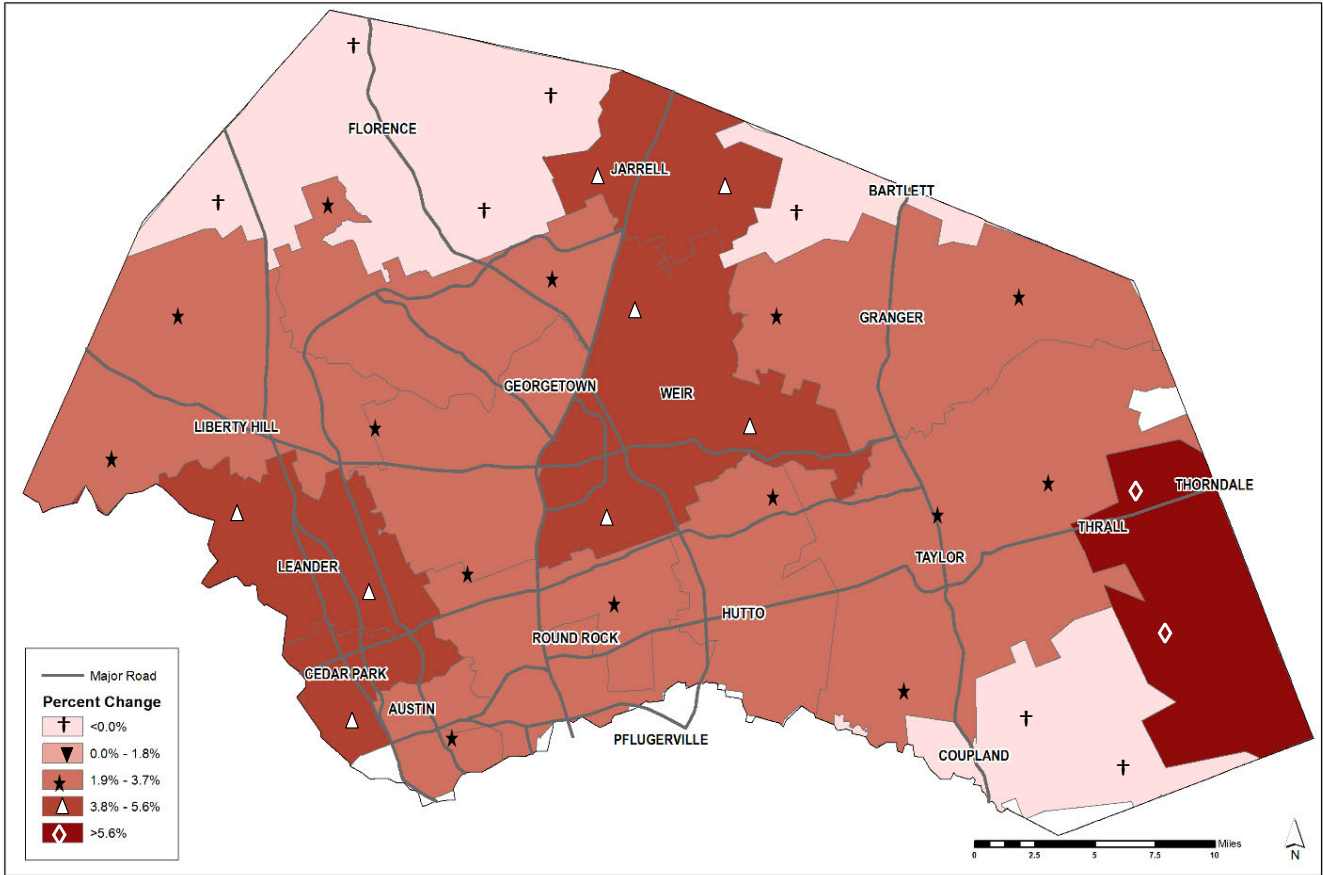


**Percent Change in Rent Value by Zip Code in Williamson County, 2011-2016**

This map illustrates the percent change in median rent value from 2011 to 2016 for each zip code in Williamson County.  
 Data Source: American Community Survey, 2011-2016  
 Date Created: 12/3/2018



Figure 33: Percent Change in Home Value by Zip Code in Williamson County, 2011-2016



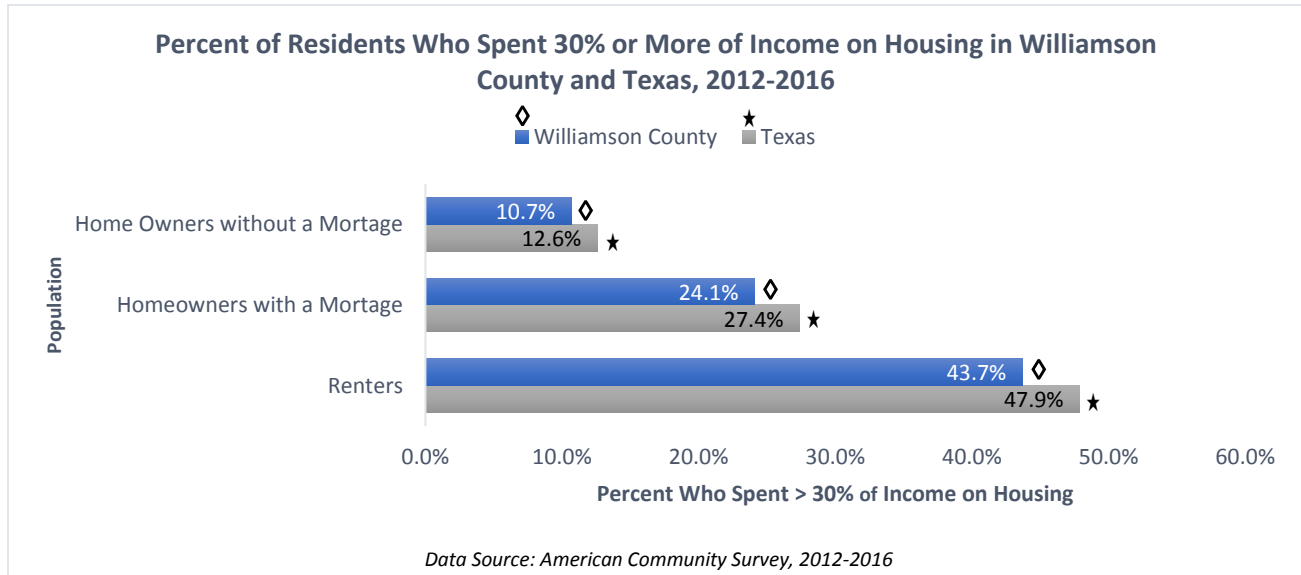
**Percent Change in Home Value by Zip Code in Williamson County, 2011-2016**

This map illustrates the percent change in median home value from 2011 to 2016 for each zip code in Williamson County.  
Data Source: American Community Survey, 2011-2016  
Date Created: 12/3/2018



Compared to Texas, there are fewer renters and homeowners in Williamson County who spent 30% or more of their household income on housing costs (Figure 34). Almost half (43.7%) of renters in Williamson County spend 30% or more of their income on housing, which is much higher than homeowners with a mortgage (24.1%) and homeowners without a mortgage (10.7%).

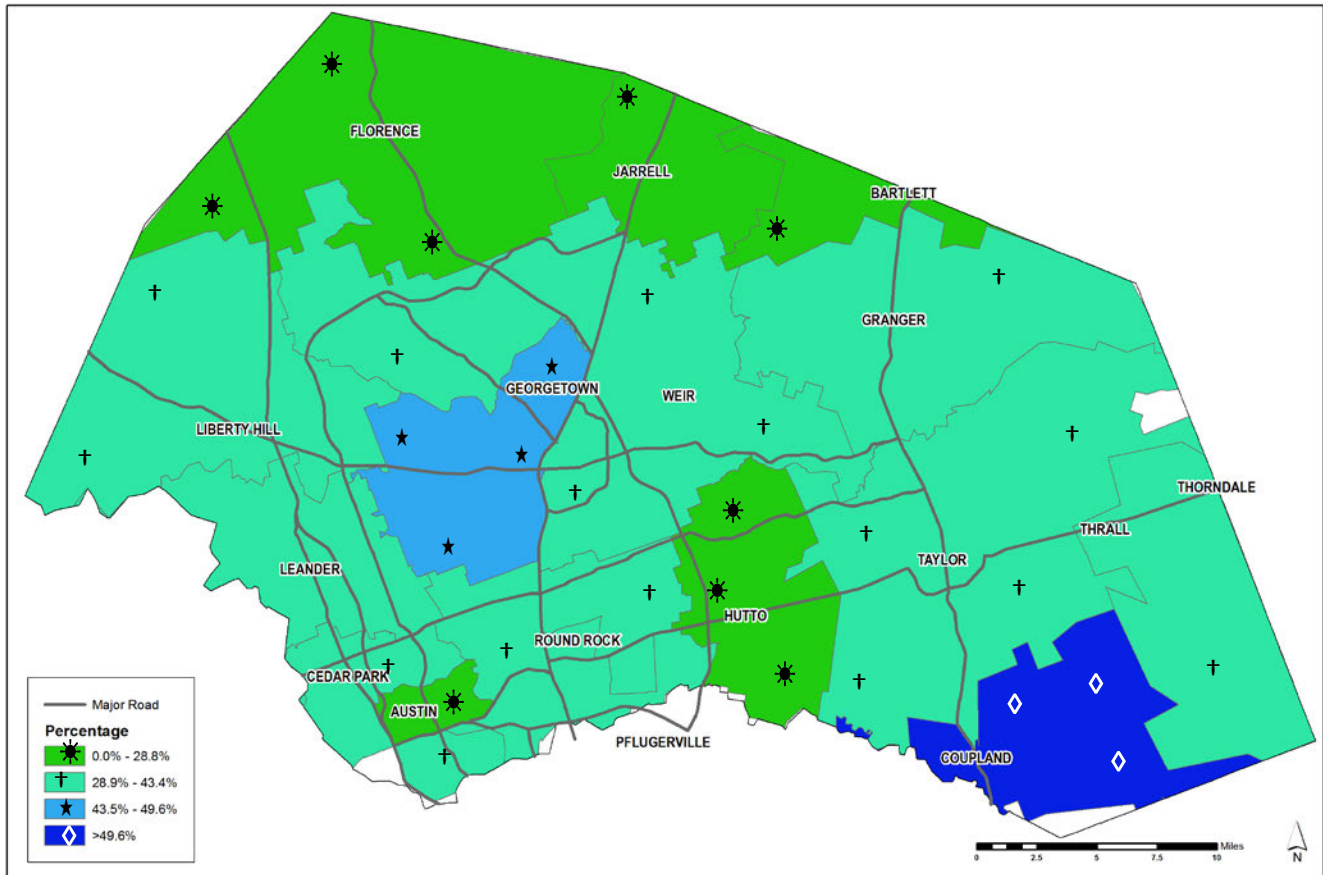
**Figure 34: Percent of Residents Who Spent 30% or More of Income on Housing in Williamson County and Texas, 2012-2016**



Over half of renters (54.8%) in 78615 (Coupland) and 47.4% of renters in 78628 (Georgetown) spent 30% or more of their income on housing (Figure 35). Both zip codes have percentages higher than the overall county value (43.7%). In addition, 43.1% of renters in 78633 (Georgetown) and 41.1% of renters in 78641 (Leander) spent 30% or more of their income on housing. Part of a Health Equity Zone resides in Georgetown and Leander.



Figure 35: Rent as a Percentage of Household Income by Zip Code in Williamson County, 2016



Rent as a Percentage of Household Income by Zip Code in Williamson County, 2012-2016

This map illustrates the percentage of residents whose monthly rental costs are more than 30% of their household income for each zip code in Williamson County from 2012-2016. Data Source: American Community Survey, 2012-2016 Date Created: 12/3/2018



Social and Civic Engagement

Why is this important?

Poor or lack of social interaction with those in your community is associated with increased morbidity and early mortality (48). Research has found that people living in areas with high levels of social trust are less likely to rate their health status as fair or poor than people living in areas with low levels of social trust.(48) “Voting is one of the most fundamental rights of a democratic society. Exercising this right allows a nation to choose elected officials and hold them accountable. Voting ensures that all citizens can voice their opinions on issues such as the use of tax dollars, civil rights and foreign policy. By voting, individuals shape their communities and influence the next generation of society. A high level of turnout indicates that citizens are involved and interested in who represents them in the political system.”(49)

Table 15: Social and Civic Engagement in Williamson County and Texas

Indicator	Williamson County	Texas
Presidential Voter Turnout <sup>1</sup>	67.7%	58.8%
Midterm Voter Turnout <sup>2</sup>	62.5%	52.7%
Number of social associations per 10,000 population <sup>3</sup>	6.2	7.6

Data Sources: Texas Secretary of State, <sup>1</sup>2016 and <sup>2</sup>2018; <sup>3</sup>County Business Patterns, 2015

*Findings based on Table 15:*

- The number of social associations per 10,000 population is 6.2 in Williamson County, compared to 7.6 in Texas. Associations include civic organizations, bowling centers, golf clubs, fitness centers, sports organizations, religious organizations, political organizations, labor organizations, business organizations, and professional organizations.
- Compared to Texas, Williamson County had higher voter turnout in the most recent presidential and midterm elections. In the 2016 presidential election, 67.7% of registered voters in Williamson County voted, compared to 58.8% in Texas. In the 2018 midterm election, 62.5% of registered voters in Williamson County voted, compared to 52.7% in Texas.

### Head Start Facilities

*Why is this important?*

Head Start is a federal program that promotes the school readiness of children from birth to age five from low-income families by enhancing their cognitive, social, and emotional development. Head Start programs provide a learning environment that supports children's growth in many areas such as language, literacy, and social and emotional development.(50)

Compared to Texas, there are more Head Start centers in Williamson County for families who qualify based on income and poverty status. Williamson County has 5.2 Head Start centers for every 1,000 families with children under the age 5, which is higher than the rate in Texas (4.0).(51)

### Key Findings

According to the CDC, health-related quality of life indicators make it possible to scientifically demonstrate the impact of health on quality of life and is a valid measure of unmet needs and intervention outcomes.(39) Self-reported health status, as well as physical and mental health perceptions of Williamson County residents, indicate that individual-level quality of life is above satisfactory. However, certain community-level quality of life indicators may require additional surveillance and prioritization:

- **The percentage of individuals affected by disability will most likely continue to increase as population growth occurs for those over the age of 65.** The aging population, as well as racial and ethnic groups with higher percentages of disability, should be considered when implementing policies, distributing funds, and developing programs for those with disabilities.
- **Transportation indicators are worse in Williamson County compared to Texas and applicable HP2020 Targets.** Alternatives to driving alone to work, such as public transportation and walking, should be promoted and prioritized to decrease traffic congestion, air pollution, and risk of chronic disease. Moreover, increasing public transportation options will assist households who do not own a vehicle.
- **A large majority of those who rent in Williamson County spend 30% or more of their income on housing, especially those in zip codes 78615, 78628, 78633, and 78641.** More affordable housing options for low-income residents should be established in Williamson County, with placement in geographic areas affected by increases in home and rent values. Part of Georgetown resides in a Health Equity Zone.

## C5. Behavioral Risk Factors

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*“FOR ME, MY WIFE, WE’RE EMPTY NESTERS. ALL OUR KIDS HAVE MOVED OUT. WE’RE BOTH 58 YEARS OLD. I GUESS FOR US, IT’S THE CONCERNS OF FINDING WAYS TO STAY ACTIVE AS WE GROW OLDER.”*

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Certain health-related behaviors, known as behavioral risk factors, contribute to injury and chronic disease, resulting in increased risk of morbidity and mortality. In this section, significant risk factors will be outlined, which include obesity and overweight, physical inactivity, unhealthy eating, tobacco use, and excessive drinking.

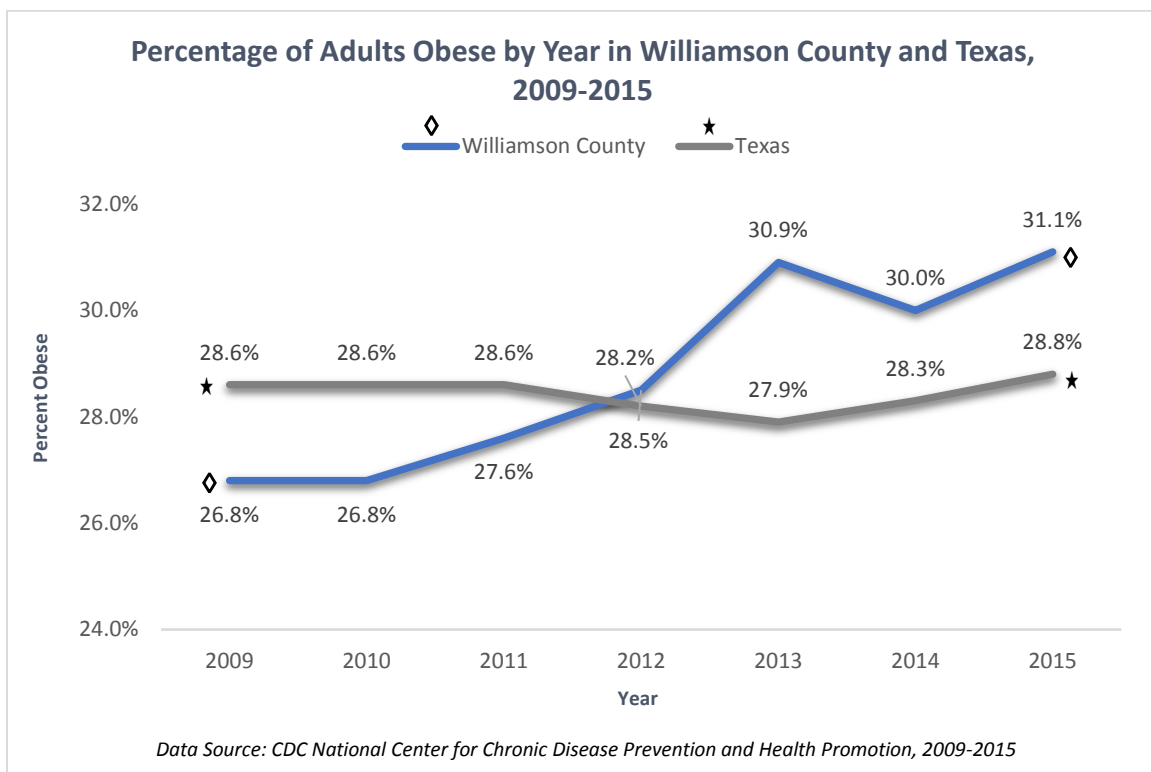
### Obese and Overweight Adults

#### *Why is this important?*

“The percentage of obese adults (those with a Body Mass Index greater than or equal to 30) is an indicator of the overall health and lifestyle of a community. Being overweight or obese increases the risk of many diseases and health conditions, including heart disease, type 2 diabetes, cancer, hypertension, stroke, liver and gallbladder disease, respiratory problems, and osteoarthritis. Losing weight and maintaining a healthy weight help to prevent and control these diseases. Being obese also carries significant economic costs due to increased healthcare spending and lost earnings.”(52)

Williamson County has experienced an increasing trend of obese adults, increasing from 26.8% in 2009 to 31.1% in 2015 (Figure 36). In 2012, the percentage of obese adults (28.5%) in Williamson County surpassed the Texas value (28.2%). Moreover, the percentage of obese adults in Williamson County in 2013 (30.9%) and 2015 (31.1%) surpassed the HP2020 target of 30.5%. As of 2016, both Williamson County and Texas had high percentages of adults who are overweight or obese, at 64.5% and 68.4% respectively.(53)

**Figure 36: Percentage of Adults Obese by Year in Williamson County and Texas, 2009-2015**



### Physical Inactivity

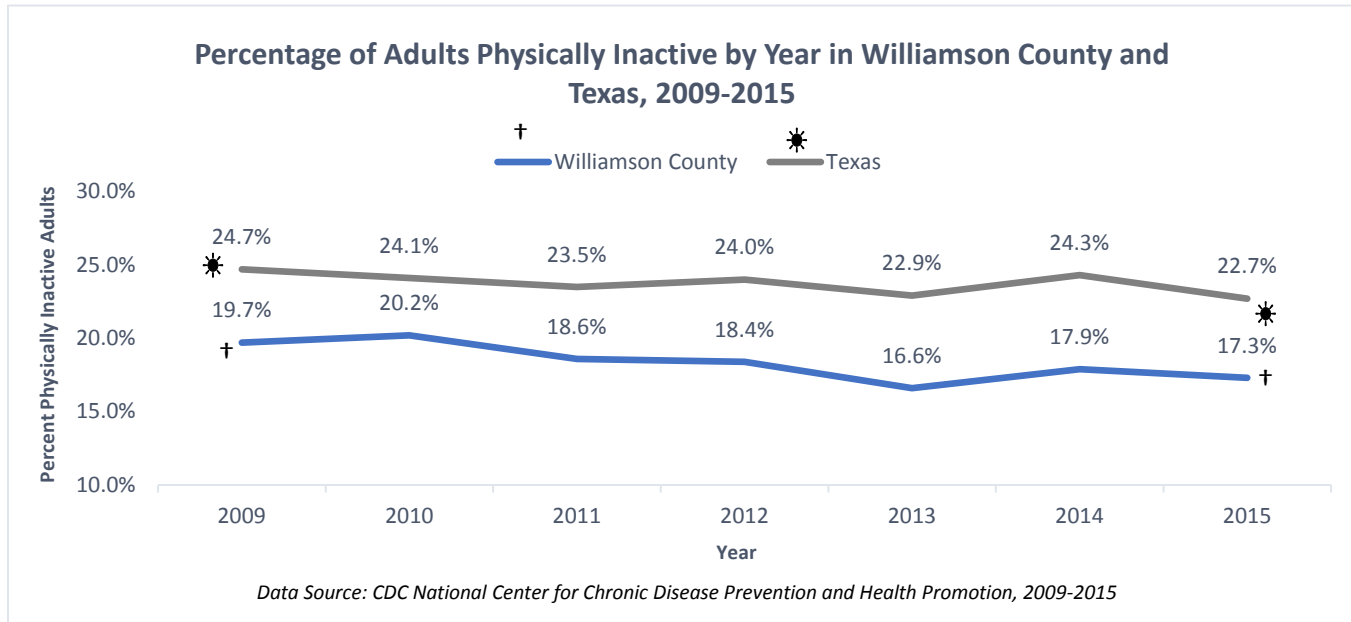
#### *Why is this important?*

“Adults who are sedentary are at an increased risk of many serious health conditions. These conditions include obesity, heart disease, diabetes, colon cancer, and high blood pressure. In addition, physical activity improves mood and promotes healthy sleep patterns. The American College of Sports Medicine (ACSM) recommends that

adults perform physical activity three to five times each week for 20 to 60 minutes at a time to improve cardiovascular fitness and body composition.”(54)

The percentage of adults in Williamson County and Texas who are physically inactive has remained relatively stagnant from 2009 to 2015 (Figure 37). Both the county and the state met the HP 2020 target of having less than 32.6% physically inactive adults. As of 2016, 19.3% of adults in Williamson County and 25.2% of adults in Texas do not participate in any physical activity or exercise.(53)

**Figure 37: Percentage of Adults Physically Inactive by Year in Williamson County and Texas, 2009-2015**



## Unhealthy Eating

### *Why is this important?*

“It is essential to eat a fresh, healthy and balanced diet in order to maintain a healthy weight and prevent chronic disease. Numerous studies have shown a clear link between the amount and variety of fruits and vegetables consumed and rates of chronic diseases, especially cancer. According to the World Cancer Research Fund International, about one third of all cancers can be prevented through a nutritious diet that includes fruits and vegetables, physical activity, and maintaining a healthy weight. The US Department of Agriculture (USDA) recommends making healthy daily food choices that include fruits and vegetables, although the recommended daily amounts depend on age, sex, and level of physical activity. Despite the benefits, many people still do not eat recommended levels of fruits and vegetables.”(55)

In 2015, about seventeen percent (16.6%) of adults ages 18 and older in Williamson County reported consuming fruits and vegetables five or more times per day, which is comparable to Texas (17.2%).(55)

## Tobacco Use

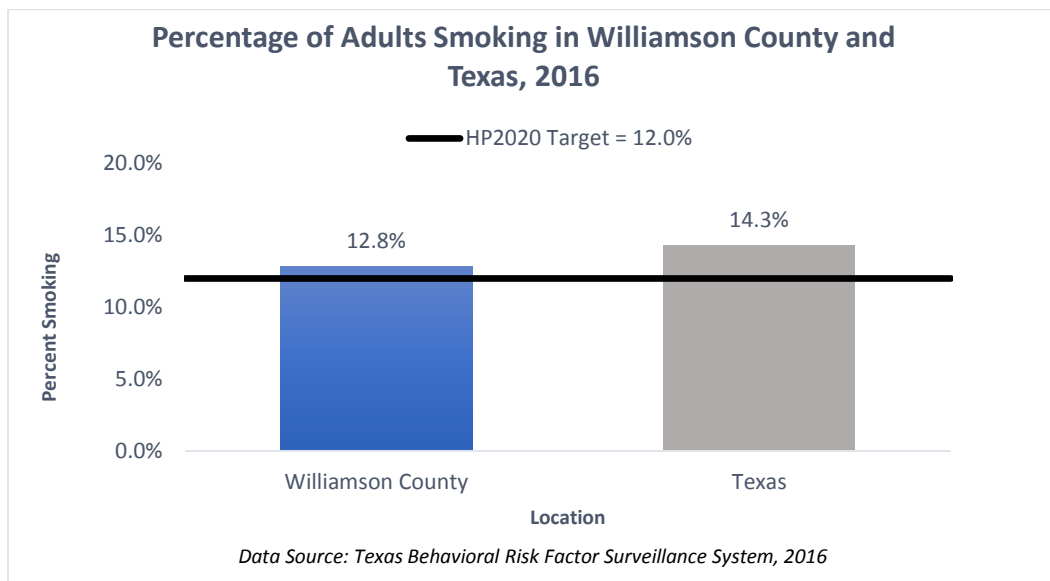
### *Why is this important?*

“Tobacco is the agent most responsible for avoidable illness and death in America today. According to the Centers for Disease Control and Prevention, tobacco use brings premature death to almost half a million Americans each year, and it contributes to profound disability and pain in many others. The World Health Organization states that approximately one-third of all tobacco users in this country will die prematurely because of their dependence on tobacco. Areas with a high smoking prevalence will also have greater exposure to secondhand smoke for non-

smokers, which can cause or exacerbate a wide range of adverse health effects such as cancer, respiratory infections, and asthma.”(56)

Adults ages 18 and older had lower rates of smoking in Williamson County (12.8%) compared to Texas (14.3%) (Figure 38). Both Texas and Williamson County have smoking rates that surpass the HP2020 target of 12.0%. The reported rate from the CASPER survey in Williamson County indicated that 19.2% of households have used tobacco products, which is significantly higher than the individual level percentage in Williamson County. However, this may be due to the inclusion of e-cigarettes and vaping on the CASPER survey question.

**Figure 37: Percentage of Adults Smoking in Williamson County and Texas, 2016**

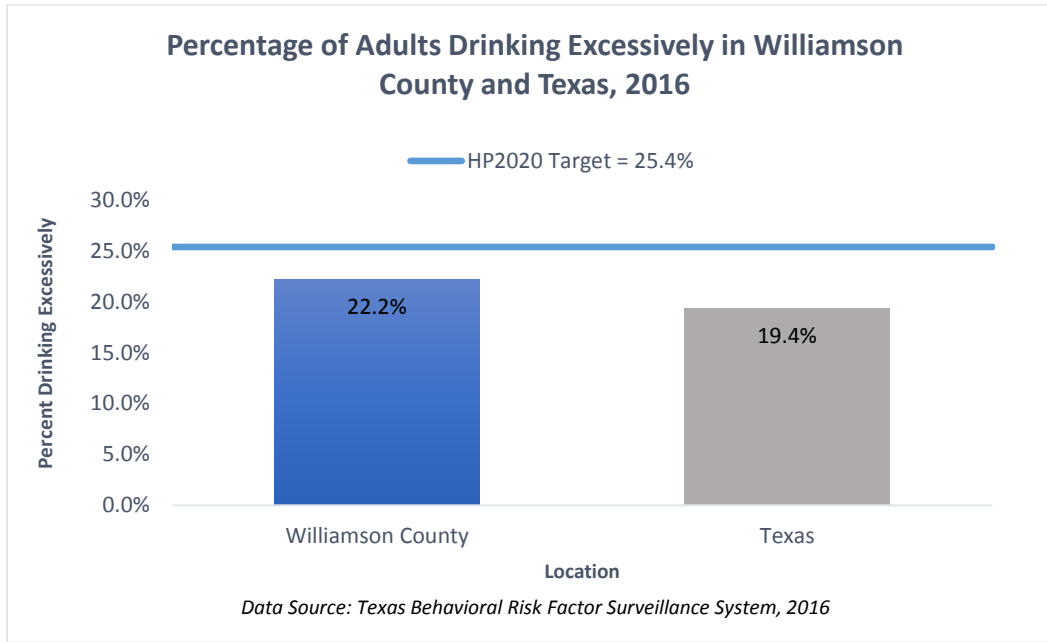


### Drinking Excessively

#### *Why is this important?*

“Drinking alcohol has immediate physiological effects on all tissues of the body, including those in the brain. Alcohol is a depressant that impairs vision, coordination, reaction time, judgment, and decision-making, which may in turn lead to harmful behaviors. According to the Centers for Disease Control and Prevention, excessive alcohol use, either in the form of heavy drinking (drinking more than 15 drinks per week on average for men or more than eight drinks per week on average for women), or binge drinking (drinking more than five drinks during a single occasion for men or more than four drinks during a single occasion for women), can lead to increased risk of health problems, such as liver disease and unintentional injuries. Alcohol abuse is also associated with a variety of other negative outcomes, including employment problems, legal difficulties, financial loss, family disputes, and other interpersonal issues.”(57)

The percentage of adults ages 18 and older that drink excessively was higher in Williamson County (22.2%) compared to Texas (19.4%) (Figure 39). Both Texas and Williamson County have rates of excessive drinking that are below the HP2020 target of 25.4%.

**Figure 38: Percentage of Adults Drinking Excessively in Williamson County and Texas, 2016**

### Cancer Screening

#### *Why is this important?*

“According to the Centers for Disease Control and Prevention (CDC), colorectal cancer is one of the most commonly diagnosed cancers in the United States and is the second leading cancer killer in the United States. The CDC estimates that if all adults aged 50 or older had regular screening tests for colon cancer, as many as 60% of the deaths from colorectal cancer could be prevented.”(58)

Additionally, the CDC states that “breast cancer is the second most common type of cancer among women in the United States.”(59) A mammogram is an X-ray of the breast used to detect breast cancer early, which ultimately lowers the risk of dying from breast cancer and increases option for treatment. The United States Preventative Services Task Force (USPSTF) recommends that women ages 50 to 74 years old should get a mammogram every two years.(59)

**Table 16: Routine Cancer Screening in Williamson County and Texas**

#### Routine Cancer Screening in Williamson County and Texas

Indicator	Williamson County	Texas
Colonoscopy <sup>1</sup>	70.8%	62.3%
Mammogram Among Female Medicare Enrollees <sup>2</sup>	68.0%	58.0%

Data Sources: <sup>1</sup>Texas Behavioral Risk Factor Surveillance System, 2016; <sup>2</sup>Dartmouth Atlas of Health Care, 2014

#### *Findings based on Table 16:*

- The percentage of adults ages 50 and older who have ever had a colonoscopy is 70.8%, which is higher than Texas (62.3%).
- Approximately 68% of female Medicare enrollees ages 67-69 in Williamson County have received at least one mammogram over a two-year period, compared to 58% in Texas.

## Key Findings

Research shows that unhealthy behaviors significantly increase the likelihood of injury, disease, and death. Fortunately, behavioral risk factors are modifiable with corrective action. The most concerning behavioral risk factors in Williamson County are discussed below, as well as recommendations for future data collection.

- **Two-thirds of adults are either obese or overweight, with an obesity trend that has continued to rise since 2004.** Limited data are available to examine correlated factors, such as high cholesterol and high blood pressure. Additionally, there is a lack of obesity and overweight data stratified by age, race/ethnicity, and social/economic factors. Increased surveillance and data collection are needed to identify long-term solutions to decrease the rate of overweight and obese adults in Williamson County.
- **Smoking among adults has surpassed the HP2020 goal.** As more tobacco-free and nicotine-containing products (e.g., e-cigarettes) become available, smoking rates have steadily increased. Although free of tobacco, smoking e-cigarettes increases the risk of using traditional cigarettes due to high levels of nicotine, an extremely addictive chemical.<sup>(60)</sup> E-cigarettes also contain chemicals that are highly toxic and cause irreversible lung damage and lung diseases.<sup>(60)</sup> The percentage of adults who have smoked tobacco products in Williamson County as measured by the Texas BRFSS is significantly less than what households reported as part of the CASPER survey. While there is a two-year difference in data collection and type of survey (individual v. household level), as well as the inclusion of e-cigarettes and vaping in survey questionnaires, the discrepancy in these smoking rates may indicate that the true smoking rate in Williamson County is underreported. Additionally, since the habit of smoking is usually established during teenage years, more data is needed to examine this emerging trend among the youth population.
- **The rate of excessive drinking among adults is higher in Williamson County compared to Texas.** There are many evidence-based strategies to reduce excessive drinking among adults, such as implementing effective prevention strategies and partnerships between law enforcement, health care agencies, and community organizations.<sup>(57)</sup> Ultimately, increased monitoring of excessive drinking is necessary to learn more about at-risk populations, such as underage adults and youth.

## C6. Environmental Health Indicators

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*“SO, FINALLY THE PARENT GETS TO A DOCTOR AND THEY SAY, “WELL, YOU NEED TO INCREASE MORE FRUITS AND VEGETABLES...” WELL, IN BARTLETT YOU HAVE ONE GROCERY STORE WITH FRUITS AND VEGETABLES THAT MOST OF THE TIME ARE ROTTEN.”*

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Environmental health indicators “impact a wide range of health, functioning, and quality of life outcomes.”<sup>(8)</sup> These indicators are part of the built environment, which include the location and amount of recreational facilities, fast food restaurants, grocery stores, Supplemental Nutrition Assistance Program (SNAP) retailers, and alcohol retailers. The built environment in a community will increase or decrease the likelihood of health behaviors, such as physical activity, healthy eating, and excessive drinking.

### Access to Exercise Opportunities

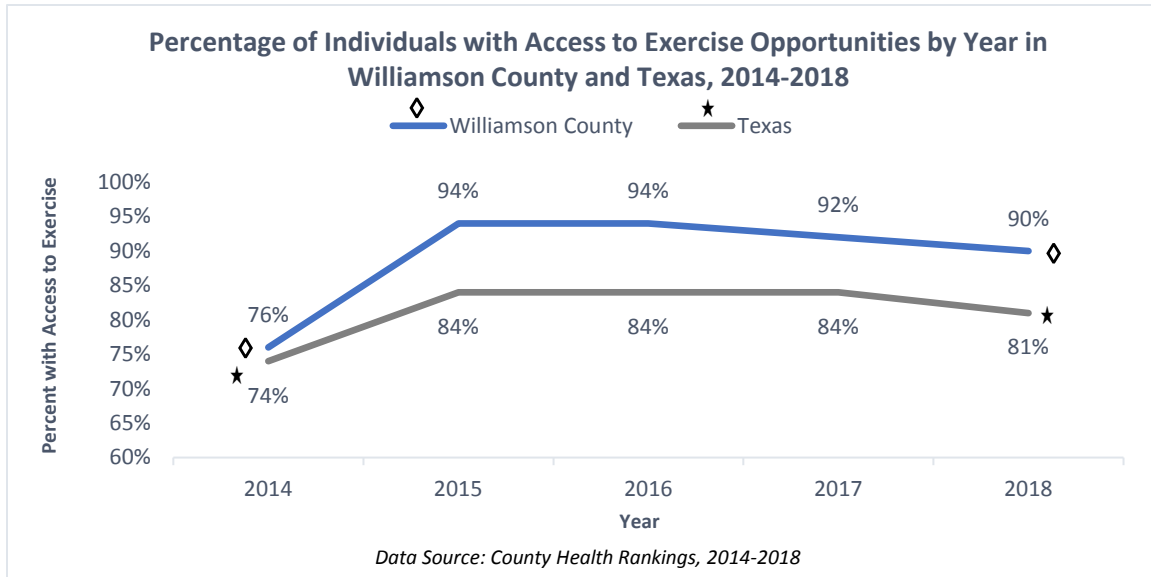
#### *Why is this important?*

“Proximity to exercise opportunities, such as parks and recreation facilities, has been linked to an increase in physical activity among residents. Regular physical activity has a wide array of health benefits including weight control, muscle and bone strengthening, improved mental health and mood, and improved life expectancy. Furthermore, exercise reduces the risk of cardiovascular disease, type 2 diabetes, and some cancers.”<sup>(61)</sup>



From 2014 to 2018, Williamson County and Texas have experienced similar trends regarding access to exercise opportunities (Figure 40). For both the county and the state, the percentage of individuals who live reasonably close to a physical activity location has decreased from 2016 to 2018. As of 2018, Williamson County has a higher percentage of exercise opportunities (90%) compared to Texas (81%).

**Figure 39: Percentage of Individuals with Access to Exercise Opportunities by Year in Williamson County and Texas, 2014-2018**



## Healthy Eating Environment

### Why is this important?

The accessibility, availability, and affordability of healthy and varied food options in the community increase the likelihood that residents will have a balanced and nutritious diet. A diet composed of nutritious foods, in combination with an active lifestyle, can reduce the incidence of heart disease, cancer, and diabetes, and is essential to maintain a healthy body weight and prevent obesity.(62)

**Table 17: Healthy Eating Environment Indicators in Williamson County and Texas, 2016**

Healthy Eating Environment Indicators in Williamson County and Texas, 2016		
Indicator	Williamson County	Texas
Food Insecurity <sup>1</sup>	13.0%	15.4%
Child Food Insecurity <sup>1</sup>	18.2%	23.0%
SNAP Authorized Retailer Rate* <sup>2</sup>	58.9	79.9
Fast Food Restaurants Rate* <sup>3</sup>	84.5	80.2
Grocery Store Rate* <sup>3</sup>	9.7	13.8

Notes: \*per 100,000 population

Data Sources: <sup>1</sup>Feeding America, 2016; <sup>2</sup>USDA- SNAP Retailer Locator, 2016; <sup>3</sup>County Business Patterns, 2016

### Findings based on Table 17:

- Thirteen percent of the population in Williamson County are experiencing food insecurity, compared to 15.4% in Texas.
- Almost one in five (18.2%) children in Williamson County experience food insecurity, compared to almost one in four (23%) in Texas.

- In Williamson County, there are 58.9 SNAP retailers per 100,000 population, which is less compared to Texas (79.9 per 100,000 population). Moreover, almost all SNAP retailers in Williamson County reside within convenience stores, gas stations, mini-marts, fast food restaurants, and pharmacies.
- Williamson County has 84.5 fast food restaurants per 100,000 population, which is higher compared to Texas (80.2 per 100,000 population).
- Compared to Texas, which has a grocery store rate of 13.8 per 100,000 population, Williamson County has a lower grocery store rate (9.7 per 100,000 population).

**Table 18: Grocery Store Access in Williamson County, 2015**

Grocery Store Access in Williamson County, 2015	
Indicator	Williamson County
Low Grocery Store Access	33.7%
Low Income and Low Access to Grocery Store	8.0%
No Car and Low Grocery Store Access	1.3%

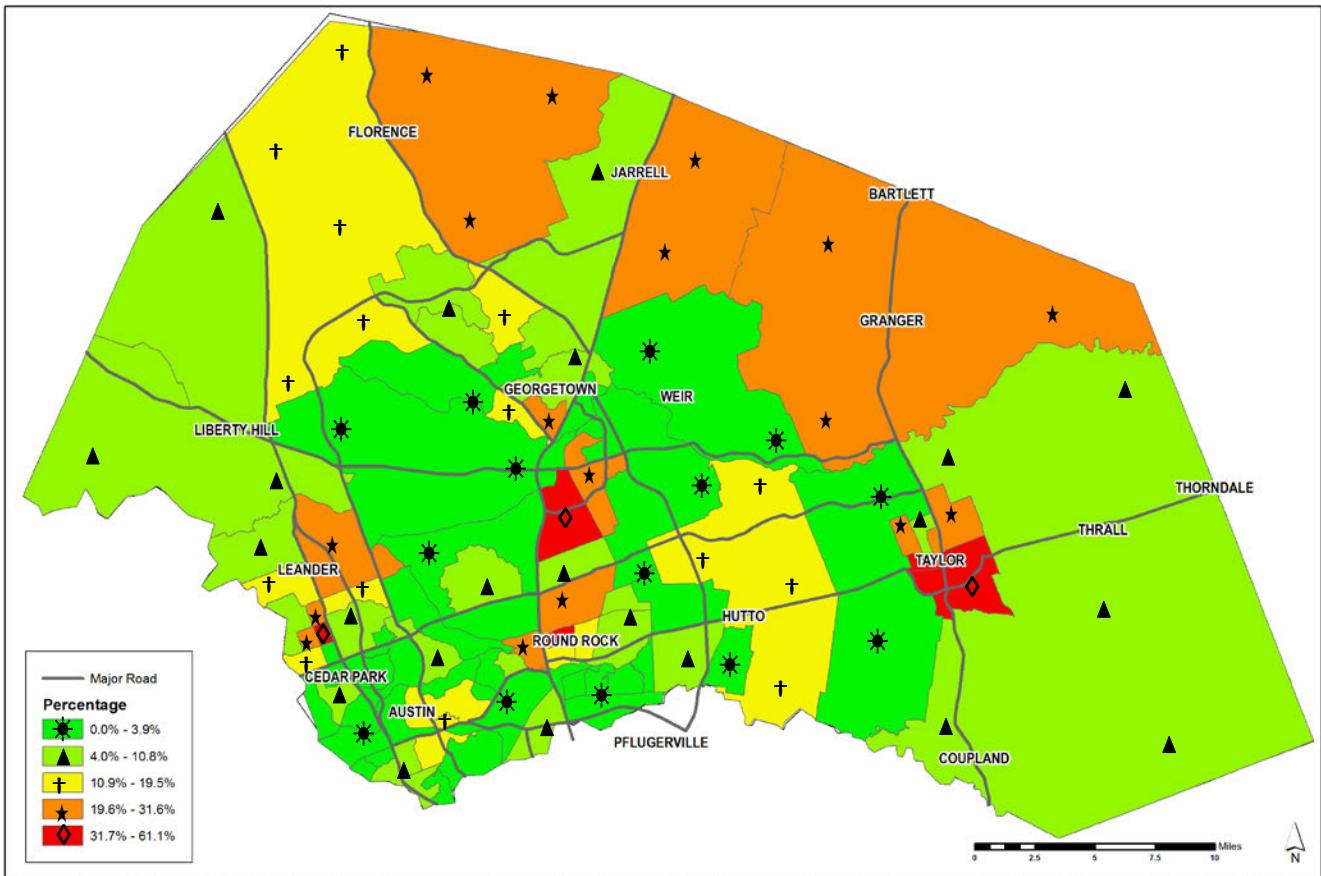
*Data Source: U.S. Department of Agriculture -- Food Environmental Atlas, 2015*

As of 2015, about one-third (33.7%) of Williamson County residents live far from a grocery store or supermarket (Table 18). If an individual resides in an urban area of the county, they have low grocery store access if they live more than one mile from a grocery store. If an individual resides in a rural area of the county, they have low grocery store access if they live more than 10 miles from a grocery store. The USDA defines a grocery store and/or supermarket as a storefront that reports at least 2 million dollars in annual sales, and contains all major food departments (i.e. meat, poultry, dairy, dry/package food, frozen food).

Approximately eight percent of the Williamson County population are live far from a grocery store *and* are low income (Table 18). Census tracts near Georgetown, Leander, Round Rock, and Taylor have the highest proportions (31.7% to 61.1%) of the population who are low income and have low grocery store access (Figure 40). Additionally, 19.6% to 31.6% of the populations in census tracts near Bartlett, Florence, Granger, and Jarrell are low-income and have low grocery store access.

A small percentage (1.3%) of households in Williamson County are living far from a grocery store *and* do not have a vehicle (Table 18). Of these households, most are from census tracts in Leander and Taylor, where the percentages of households without a car and low grocery access is 4.2-9.7% (Figure 41). Many of these census tracts are located within Health Equity Zones. Figure 42 maps the number of retailers and community resources that provide fresh food in Williamson County. Community resources such as food pantries, mobile food pantries, Meals on Wheels, and farmers' markets can provide grocery store-level accessibility to fresh food; however, they operate on very limited schedules.

**Figure 40: Percentage of Population that are Low-Income and have Low Access to a Grocery Store by Census Tract in Williamson County, 2015**



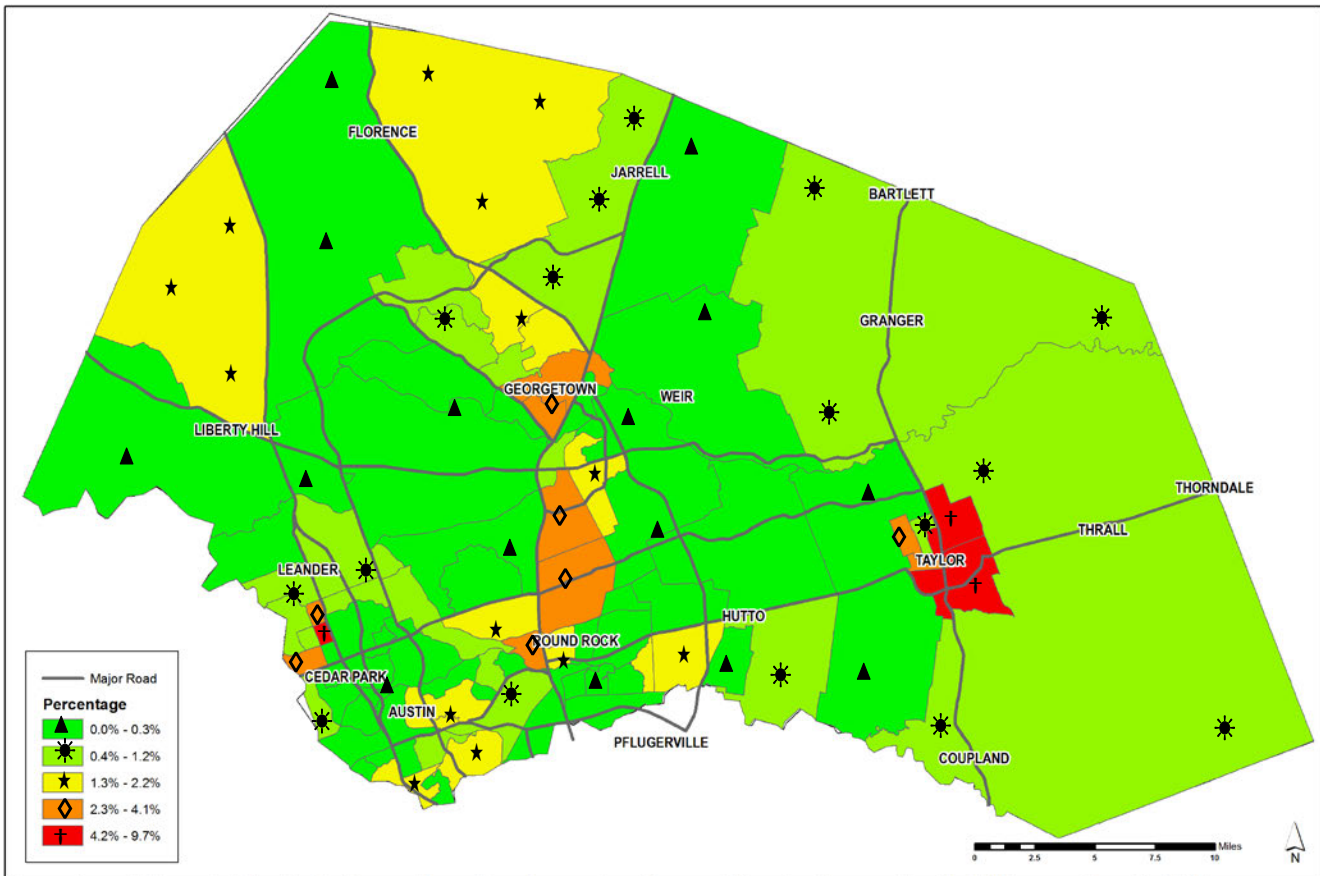
**Percentage of Population that are Low Income and have Low Access to a Grocery Store by Census Tract in Williamson County, 2015**

This map illustrates the percentage of the total population in Williamson County that is low income and living more than one mile from a supermarket or large grocery store if in an urban area, and more than 10 miles from a supermarket or large grocery store if in a rural area.

Data Source: U.S. Department of Agriculture – Food Environment Atlas, 2015  
 Date Created: 12/3/2018



**Figure 41: Percentage of Households with No Car and have Low Access to a Grocery Store by Census Tract in Williamson County, 2015**



**Percentage of Households with No Car and have Low Access to a Grocery Store by Census Tract in Williamson County, 2015**

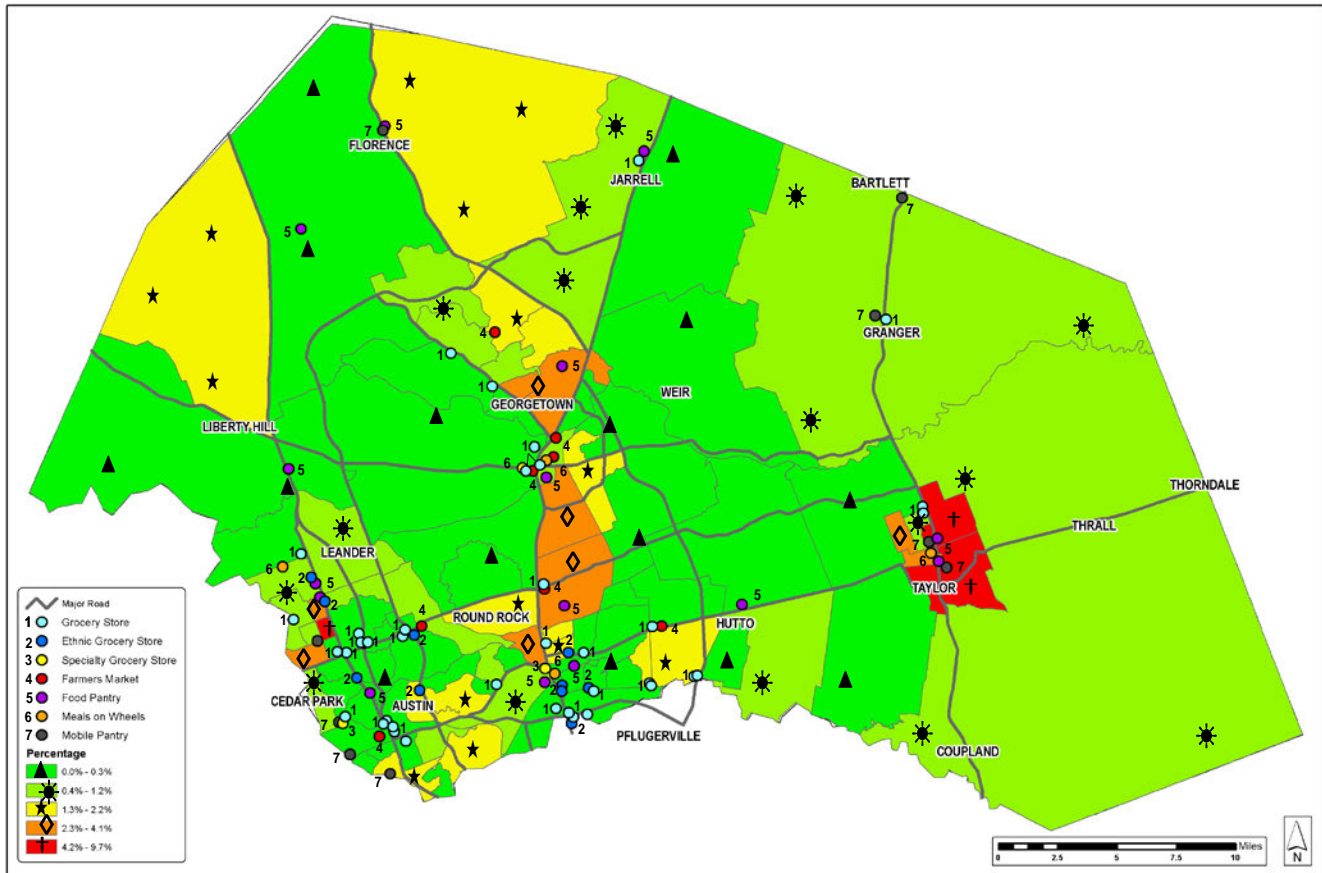
This map illustrates the percentage of housing units in Williamson County that do not have a car and are more than one mile from a supermarket or large grocery store if in an urban area, and more than 10 miles from a supermarket or large grocery store if in a rural area.

Data Source: U.S. Department of Agriculture – Food Environment Atlas, 2015

Date Created: 12/3/2018



**Figure 42: Retailers and Community Resources that Provide Fresh Food in Williamson County, 2019**



**Fresh Food Retailers and Community Resources in Williamson County, 2019**

This map illustrates the availability of fresh foods in Williamson County through retailers and community resources such as grocery stores, farmers markets, food pantries, mobile food pantries, and Meals on Wheels. Census tracts map the percentage of housing units in the county that do not have a car and are more than one mile from a supermarket or large grocery store if in an urban area, and more than 10 miles from a supermarket or large grocery store if in a rural area.

Data Source: USDA FNS SNAP Retail List, March 2019; USDA Food Environment Atlas, 2015 Date Created: 4/4/2019

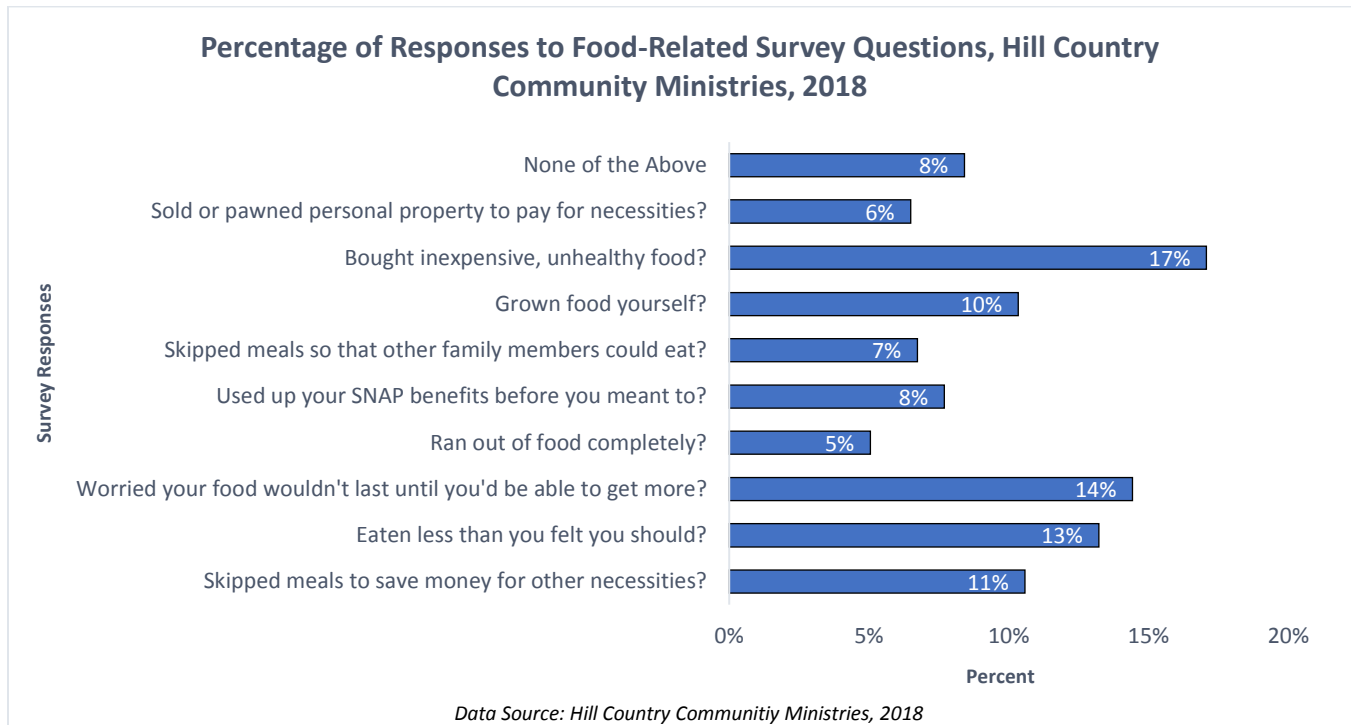


**Local Spotlight: Hill Country Community Ministries**

Hill Country Community Ministries (HCCM) is a local non-profit that is dedicated to serving Williamson County residents most in need, providing food, clothing, and other assistance. Those who received assistance from HCCM's Fresh Food for All program in certain Williamson County zip codes (78729, 78641, 78613, 76530, and 76527) were surveyed regarding food-related behaviors, perceptions, and barriers (Figure 43).

- 17% of respondents reported that in the past three months they had bought inexpensive, unhealthy food.
- 14% of respondents reported that in the past three months they worried their food wouldn't last until they'd be able to get more.
- 13% of respondents reported that in the past three months they had eaten less than they felt they should.

**Figure 43: Percentage of Responses to Food-Related Survey Questions, Hill Country Community Ministries, 2018**



#### Alcohol Retailers Rate

##### *Why is this important?*

The rate of beer, wine, and liquor stores in a geographic area increase the likelihood of certain health behaviors such as alcohol abuse and overdose, and alcohol-related motor vehicle accidents. These behaviors may result in chronic disease, unintentional injury, and death.(63)

In 2016, Williamson County had a rate of 8.0 beer, wine, and liquor stores per 100,000 population, which is higher than Texas (7.6 per 100,000 population).(64)

#### Key Findings

Many factors contribute to a healthy built environment in Williamson County. It is estimated that 9 out of 10 residents live within proximity to a recreational facility, creating an environment that promotes physical activity. However, improving the healthy eating environment in Williamson County remains a crucial element in decreasing outcomes such as obesity, heart disease, and diabetes. Below are gaps that should be addressed in reforming healthy food access in Williamson County:

- **Increase grocery store access for low-income populations and households with no vehicle.**
  - “People of all ages in Williamson County may experience food insecurity, which is limited or uncertain availability of nutritionally adequate foods or uncertain ability to acquire these foods in socially acceptable ways.”(65) Moreover, “people living farther away from grocery stores are less likely to access healthy food options on a regular basis and thus more likely to consume foods which are readily available at convenience stores and fast food outlets. Low-income individuals living in underserved areas often have limited numbers of stores that sell healthy foods. Additionally, vehicle ownership is directly related to the ability to travel. In general, people living in a household without a car make fewer than half the number of journeys compared to those



with a car.”(66) Specific areas of the county (Taylor and Leander/Cedar Park) should be targeted, since they reside within Health Equity Zones.

- **Increase the amount of SNAP retailers within grocery stores and farmer’s markets.**
  - “SNAP (Supplemental Nutrition Assistance Program), previously called the Food Stamp Program, is a federal-assistance program that provides low-income families with Electronic Benefit Transfers (EBTs) that can be used to purchase food. The purpose of the program is to assist low-income households in obtaining adequate and nutritious diets. According to the program, over 45 million people from over 20 million households receive SNAP benefits.”(67) Most SNAP retailers in Williamson County reside within convenience stores, gas stations, mini-marts, fast food restaurants, and pharmacies, rather than grocery stores and farmer’s markets. “Fast food is often high in fat and calories and lacking in recommended nutrients. Frequent consumption of these foods and an insufficient consumption of fresh fruits and vegetables increase the risk of overweight and obesity. Individuals who are overweight or obese are at increased risk for serious health conditions, including coronary heart disease, type-2 diabetes, multiple cancers, hypertension, stroke, premature death and other chronic conditions. Studies suggest that fast food strongly contributes to the high incidence of obesity and obesity-related health problems.” (68)

## C7. Social and Mental Health

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*“LIKE WE’RE STILL NOT GOING TO THE DOCTOR LIKE AT ALL. I CAN’T REMEMBER THE LAST TIME I’VE BEEN TO A DENTIST. ALL OF US HAVE UNADDRESSED MEDICAL ISSUES. BOTH OF MY PARENTS ARE DIABETIC. AND IT’S GOTTEN TO THE POINT WHERE LIKE IF I DO ANYTHING WRONG LIKE IF ANY MENTAL HEALTH PROBLEM FOR ME FLARES UP AND I HAVE TO GET SENT TO THE HOSPITAL AGAIN, THEN MY PARENTS ARE GOING TO BE IN DEBT FOR A LONG TIME.”*

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According to the U.S. Department of Health and Human Services, “mental health includes emotional, psychological, and social well-being.” Approximately 20% of American adults have experienced a mental health issue.(69) Many factors contribute to mental health problems. These factors include biological factors, life experiences, and family history.(69) Furthermore, mental health disorders increase the risk for other diseases such as diabetes, heart disease, and Human Immunodeficiency Virus (HIV).(70)

### Mental Health Indicators

**Table 19: Mental Health Indicators in Williamson County and Texas**

Mental Health Indicators in Williamson County and Texas		
Indicator	Williamson County	Texas
Percentage of Driving Deaths Involving Alcohol <sup>1</sup>	34.4%	28.3%
Drug Overdose Mortality Rate* <sup>2</sup>	6.4	9.8
Child Abuse Rate* <sup>3</sup>	410.0	850.0
Violent Crime Rate* <sup>4</sup>	146.6	407.6
Firearm Fatality Rate* <sup>5</sup>	9.0	11.0
Homicide Rate* <sup>6</sup>	2.0	5.0
Depression Among the Medicare Population <sup>7</sup>	18.1%	17.0%



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Notes: \*per 100,000 population

Data Sources: <sup>1</sup>FARS, 2012-2016; <sup>2</sup>CDC Compressed Mortality File, 2014-2016; <sup>3</sup>Texas Department of Family and Protective Services, 2017; <sup>4</sup>Uniform Crime Reporting-FBI; CDC Wonder, <sup>5</sup>2012-2016, <sup>6</sup>2010-2016; <sup>7</sup>Centers for Medicare and Medicaid Services, 2015

*Findings based on Table 19:*

- In Williamson County, the percentage of motor vehicle crash deaths involving alcohol was 34.4%, compared to 28.3% in Texas.
- Williamson County had a drug overdose mortality rate of 6.4 per 100,000 population, which was lower than the rate in Texas (9.8 per 100,000 population).
- In Williamson County, there were 410.0 children under 18 years of age that experienced abuse or neglect in cases per 100,000 children. This rate is lower than Texas, which has a rate of 850.0 child abuse cases per 100,000 children.
- Violent crime includes homicide, forcible rape, robbery, and aggravated assault. The total violent crime rate per 100,000 in Williamson County was 146.6 crimes per 100,000 population, which is significantly lower than the rate in Texas (407.6).
  - The rate of firearm deaths per 100,000 population in Williamson County was 9.0, compared to 11.0 in Texas.
  - The rate of homicide deaths per 100,000 population in Williamson County was 2.0, compared to 5.0 in Texas.
- Medicare is the federal health insurance program for persons aged 65 years or older, persons under age 65 years with certain disabilities, and persons of any age with end-stage renal disease (ESRD). As of 2015, an estimated 18.1% of Medicare beneficiaries in Williamson County were treated for depression, which is higher than in Texas (17.0%).

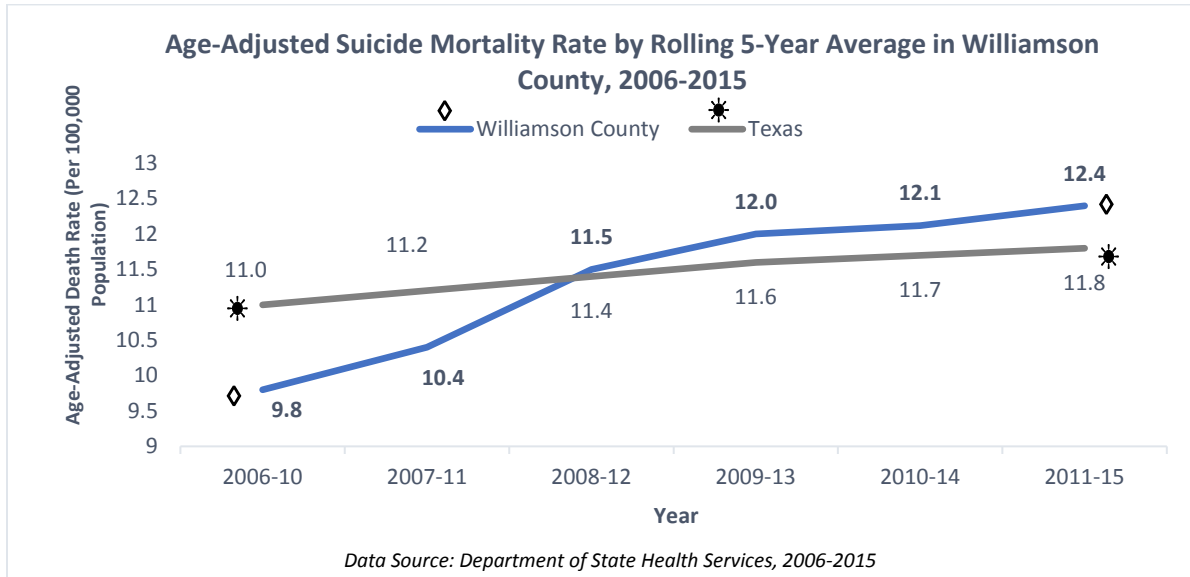
### Suicide Mortality

#### *Why is this important?*

“Suicide is a leading cause of death in America, presenting a major, preventable public health problem. More than 33,000 people kill themselves each year according to the Centers for Disease Control and Prevention, but suicide deaths only account for part of the problem. An estimated 25 attempted suicides occur per every suicide death, and those who survive suicide may have serious injuries, in addition to depression and other mental problems. Other repercussions of suicide include the combined medical and lost work costs on the community, totaling to over \$30 billion for all suicides in a year, and the emotional toll on family and friends.”(71)

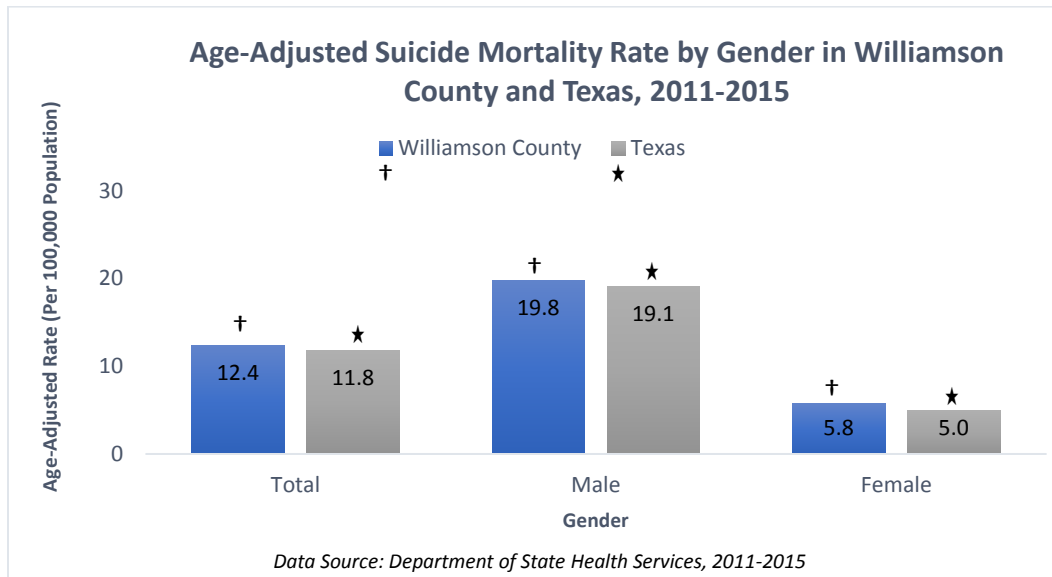
Suicide mortality rates in Williamson County have been rising since 2006 and surpassed the state rate in 2008 (Figure 44). Between 2011 and 2015, the age-adjusted suicide mortality rate was 12.4 deaths per 100,000 in Williamson County, comparable to 11.8 deaths per 100,000 in Texas. Both the Williamson County and Texas rates did not meet the HP2020 target (10.2 deaths per 100,000 population).

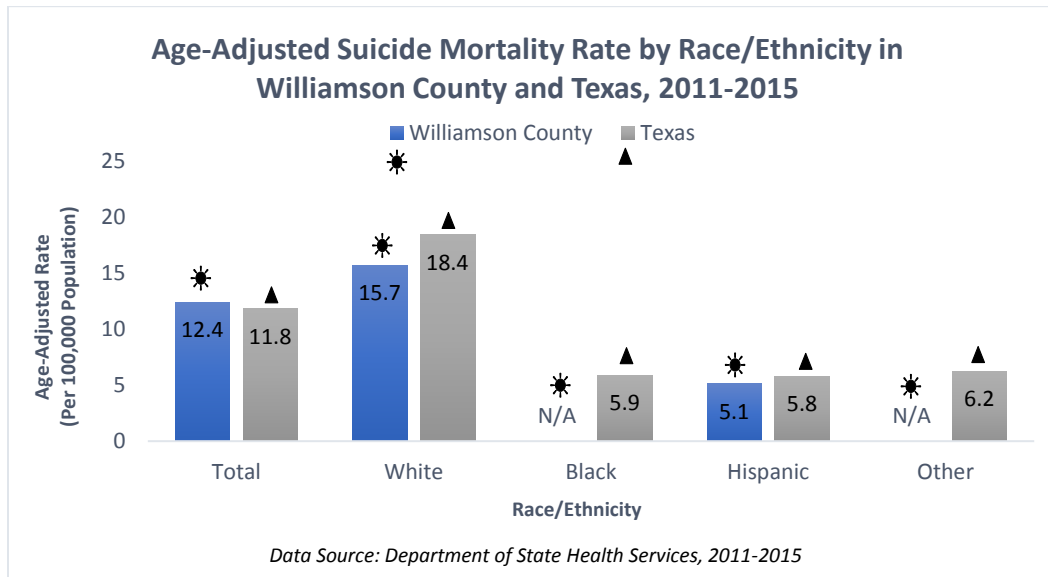
**Figure 44: Age-Adjusted Suicide Mortality Rate by Rolling 5-Year Average in Williamson County and Texas. 2006-2015**



Age-adjusted suicide mortality in Williamson County was highest among males (19.8 deaths per 100,000 population) and the White population (15.7 deaths per 100,000 population), with rates for both groups higher than the overall Texas value and the overall county value (Figure 45 and Figure 46).

**Figure 45: Age-Adjusted Suicide Mortality Rate by Gender in Williamson County and Texas, 2011-2015**



**Figure 46: Age-Adjusted Suicide Mortality Rate by Race/Ethnicity in Williamson County and Texas, 2011-2015**

### Mental Health Hospitalizations

**Table 20: Mental Health Hospitalizations in Williamson County and Texas, 2013-2015**

Mental Health Hospitalizations in Williamson County and Texas, 2013-2015		
Age-Adjusted Hospitalization Rate per 10,000	Williamson County	Texas
Due to Mental Health	23.7	41.2
Due to Pediatric Mental Health	36.7	45.1

*Notes: Hospitalizations include adjustment disorders; anxiety disorders; attention deficit conduct and disruptive behavior disorders; delirium, dementia, amnesic and other cognitive disorders; disorders usually diagnosed in infancy, childhood, or adolescence; mood disorders; personality disorders; schizophrenia and other psychotic disorders; and impulse control disorders not elsewhere classified.*

*Data Source: Department of State Health Services, 2013-2015*

### Findings based on Table 19:

- From 2013 to 2015, there were 23.7 mental health related hospitalizations per 10,000 population aged 18 years and older in Williamson County. This age-adjusted rate is lower compared to Texas, which has a rate of 41.2 mental health related hospitalizations per 10,000 population.
- From 2013 to 2015, there were 36.7 pediatric mental health related hospitalizations per 10,000 population under 18 years old in Williamson County. This age-adjusted rate is lower compared to Texas, which has a rate of 45.1 pediatric mental health related hospitalizations per 10,000 population.

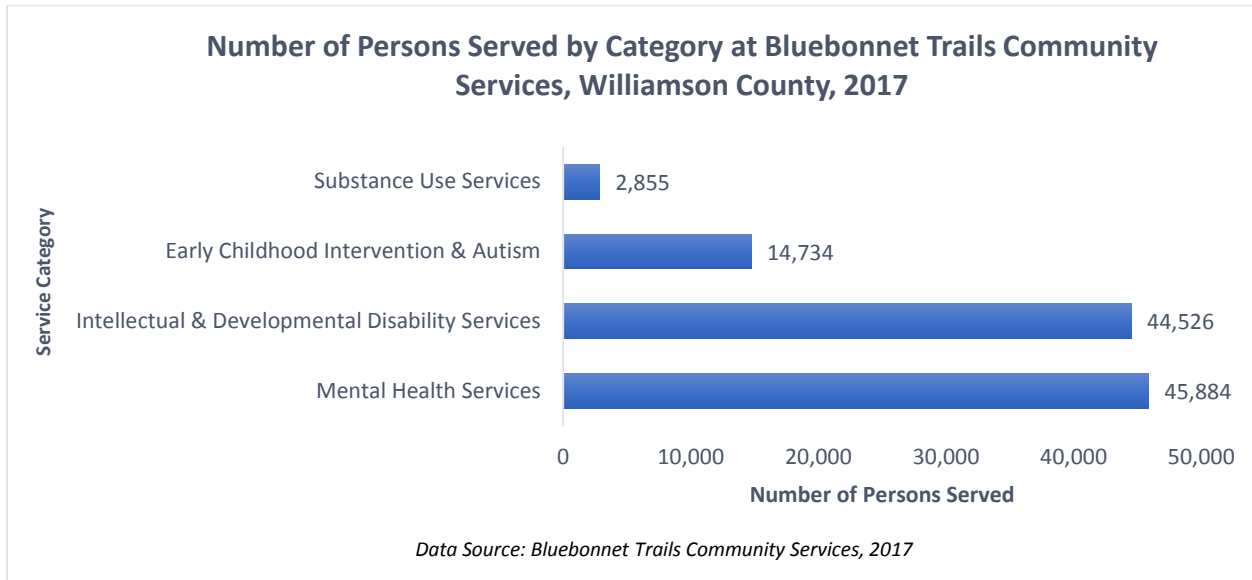
### Local Spotlight: Bluebonnet Trails Community Services (BTCS)

In Williamson County, the largest mental health provider is BTCS. Below is an overview of BTCS, which includes the number of services provided by category and the most diagnosed mental health disorders in 2017.

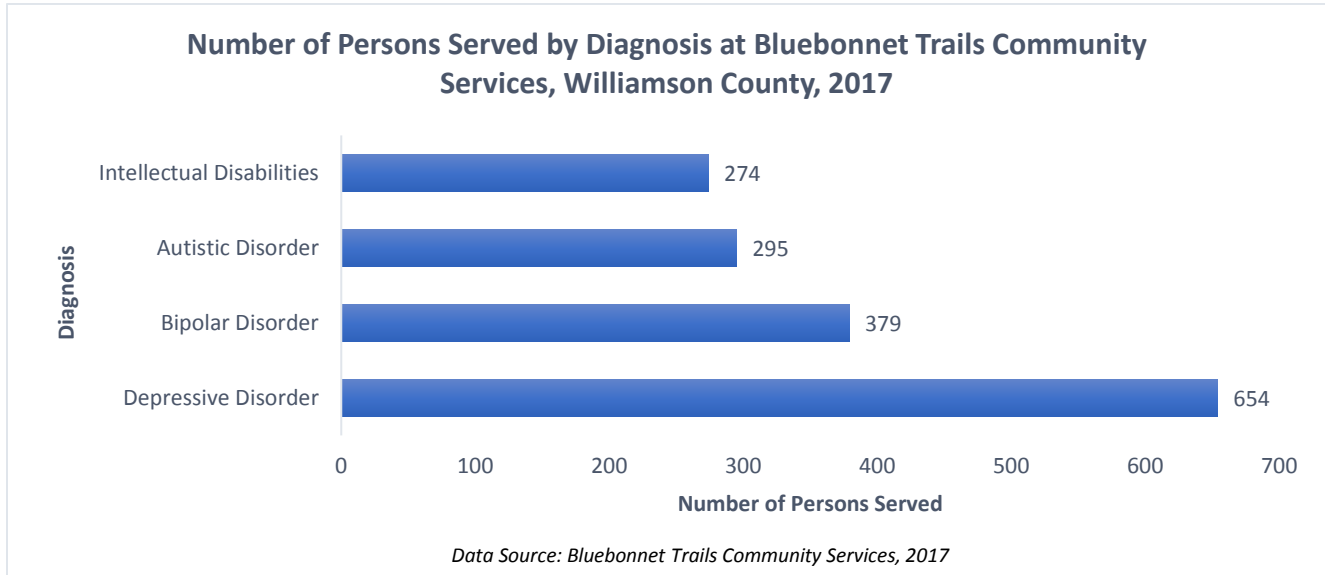
In 2017 at BTCS, there were 44,526 persons served for intellectual and developmental disability services, 45,884 for mental health services, 14,734 for early childhood intervention and autism, and 2,855 for substance abuse services (Figure 47). Within these encounters, BTCS served almost 700 persons experiencing a major depressive

disorder, almost 400 experiencing bipolar disorder, and almost 300 individuals living with an autistic disorder or an intellectual disability (Figure 48).

**Figure 47: Number of Persons Served by Category at Bluebonnet Trails Community Services, Williamson County, 2017**



**Figure 48: Number of Persons Served by Diagnosis at Bluebonnet Trails Community Services, Williamson County, 2017**



Key Findings

Certain mental health indicators stood out for having mortality rates that are not only high, but higher than the overall Texas value and the HP2020 target. These indicators are described in full detail, with future recommendations:

- **Over one-third of motor-vehicle fatal accidents were due to alcohol.** Evidence-based efforts should be made to decrease the number of alcohol-related motor-vehicle deaths in Williamson County. The National Highway Traffic Safety Administration recommends strategies that are proven to be effective in reducing

drinking and driving. These include: sobriety checkpoints, vehicle technology (e.g., ignition interlocks), mass media campaigns, school-based education, license suspension laws, and alcohol screening/interventions in various settings (e.g., health care, university).(72) Additional data is needed to examine drinking patterns among youth populations, since they are at higher risk of being involved in a motor vehicle crash.(72)

- **Suicide mortality has been rising in Williamson County, surpassing the HP2020 target. Deaths due to suicide disproportionately affect men compared to women and the White population compared to other racial/ethnic groups.** Ensuring that “government, public health, healthcare, employers, education, the media and community organizations are working together is important for preventing suicide.” When public health departments bring together community partners to tackle this issue, there is a greater likelihood of preventing suicide.(73) However, additional data is needed to determine the specific factors of at-risk groups in Williamson County.

## C8. Maternal and Child Health

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*“I CAN'T WORK. AND IT'S LIKE I'M GETTING ON MY FEET AND THEN I DON'T HAVE CHILD CARE SO I'M BACK IN A HOLE. AND THAT MESSES ME UP ALL THE TIME, WHERE IT'S ALWAYS VERY OVERWHELMING. IT'S HARD TO FIND CHILD CARE. AND EVEN IF WE DID, IT'S VERY EXPENSIVE. FOR ME, I HAVE FOUR KIDS, SO THAT'S REALLY HARD TO EVEN PAY FOR. IT'S LIKE YOU'RE WORKING JUST TO PAY.”*

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The prenatal care a mother receives heavily determines health outcomes of infants and children, an especially vulnerable population. According to the CDC, “safe motherhood begins before conception with proper nutrition and a healthy lifestyle and continues with appropriate prenatal care and the prevention and treatment of complications when possible.”(74) Prioritizing maternal health ensures full-term pregnancies without complications, delivery of a healthy infant, and creates a positive environment of support for the needs of mothers, infants, and families.(74)

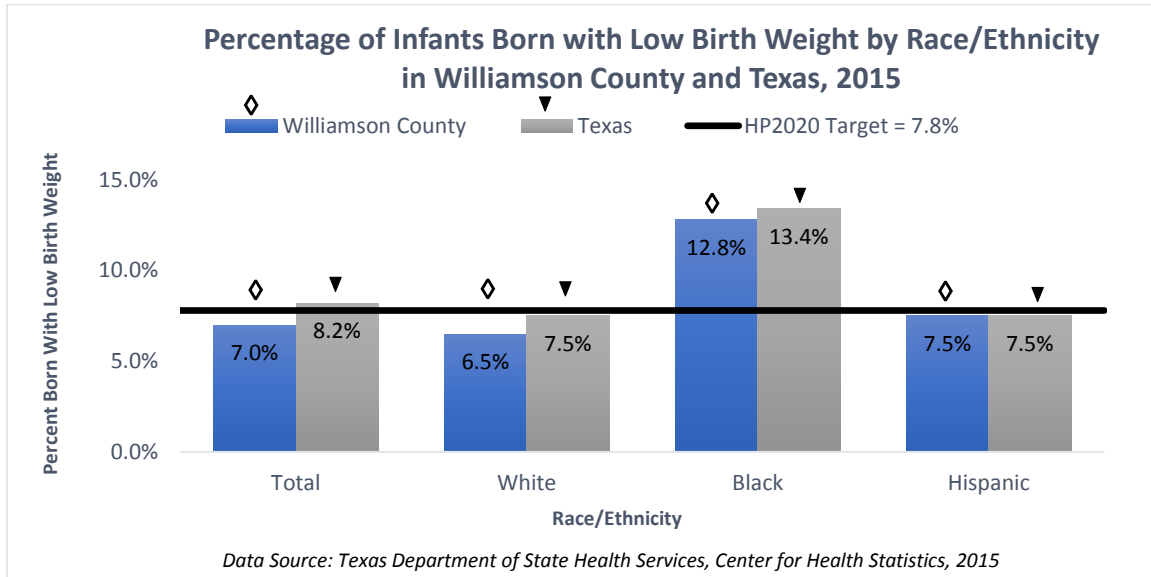
### Low Birth Weight

#### *Why is this important?*

“Babies born with low birth weight are more likely than babies of normal weight to have health problems and require specialized medical care in the neonatal intensive care unit. Low birth weight is typically caused by premature birth and fetal growth restriction, both are influenced by a mother's health and genetics.”(75)

In 2015, approximately seven percent of babies in Williamson County were born weighing less than 2500 grams, which is lower than the percentage in Texas (8.2%) and the HP2020 target (7.8%) (Figure 49). However, the percentage of babies born with a low birth weight among the Black population in Williamson County was 12.8%, which is higher compared to the overall Texas percentage and the HP2020 target.

**Figure 49: Percentage of Infants Born with Low Birth Weight by Race/Ethnicity in Williamson County and Texas, 2015**



### Infant and Child Mortality

#### Why is this important?

“Infant mortality rate continues to be one of the most widely used indicators of the overall health status of a community. The leading causes of death among infants are birth defects, preterm delivery, low birth weight, Sudden Infant Death Syndrome (SIDS), and maternal complications during pregnancy.”(76)

Child mortality rate has a large impact on years of potential life lost (YPLL). The leading causes of death among children ages 1 to 17 are unintentional injuries, specifically drowning and motor vehicle traffic accidents.(77)

**Table 21: Child and Infant Mortality in Williamson County and Texas, 2016**

Child and Infant Mortality in Williamson County and Texas, 2016		
Indicator	Williamson County	Texas
Infant Mortality Rate*	5.7	6.0
Child Mortality Rate^	18.1	21.5

\*per 1,000 live births; ^per 100,000 children

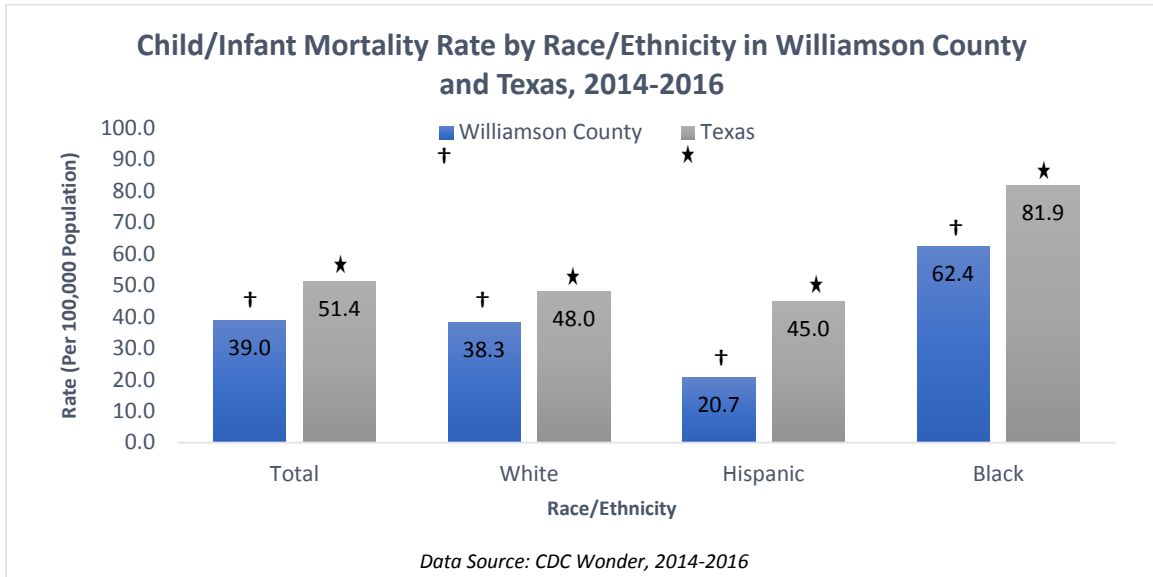
Data Source: CDC Wonder, 2016

#### Findings based on Table 20:

- Among infants less than 1 years old, the mortality rate in Williamson County (5.7 per 1,000 live births) is lower than both the Texas rate (6.0 per 1,000 live births) and the HP2020 target (6.0 per 1,000 live births).
- Among children ages 1 to 17, the mortality rate in Williamson County (18.1 per 100,000 population) is lower than the Texas rate (21.5 per 100,000 population).

The mortality rate for children less than 18 years of age in Williamson County (39.0 per 100,000 children) was lower compared to the state of Texas (51.4 per 100,000 children) (Figure 50). When stratified by race/ethnicity, mortality rates were higher in the state than in the county for all racial/ethnic groups. However, the mortality rate among the Black population (62.4 per 100,000 children) was higher than the overall rate for the county and the state.

**Figure 50: Child/Infant Mortality Rate by Race/Ethnicity in Williamson County and Texas, 2014-2016**



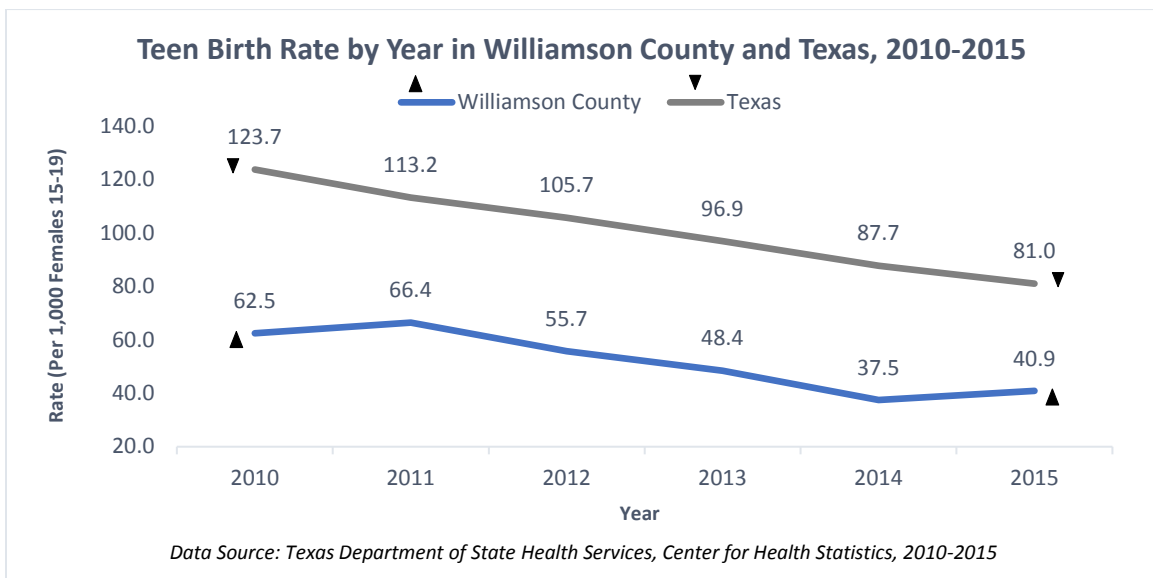
Teen Birth Rate

*Why is this important?*

Evidence suggests teen pregnancy significantly increases the risk of repeat pregnancy and of contracting a sexually transmitted infection (STI), both of which can result in adverse health outcomes for mothers, children, families, and communities. Teenage women who bear a child are less likely to graduate high school or college, more likely to be overweight/obese, and more likely to experience mental health distress.(78)

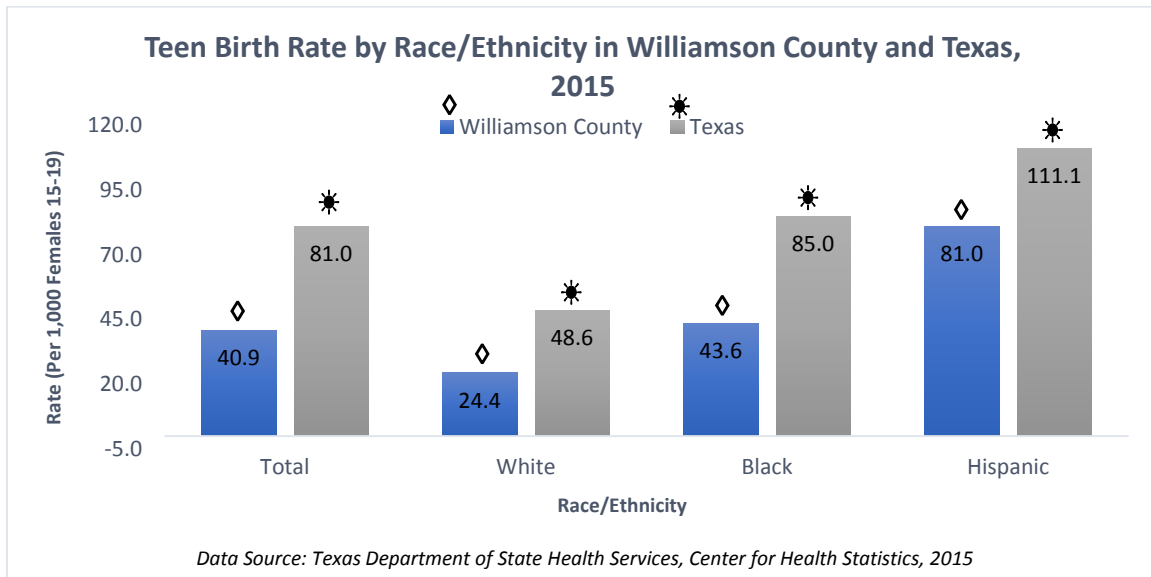
For both Williamson County and Texas, the birth rate among women ages 15 to 19 has tremendously decreased from 2010 to 2015 (Figure 51). In 2015, the teen birth rate in the county was 40.9 per 1,000 females, which is a thirty-five percent decrease from the rate in 2010 (62.5 per 1,000 females).

**Figure 51: Teen Birth Rate by Year in Williamson County and Texas, 2010-2015**



Across all racial/ethnic groups, Williamson County has lower teen birth rates compared to Texas (Figure 52). However, the rates of Williamson County Hispanic (81.0 per 1,000 females) and Black (43.6 per 1,000) populations are higher than the overall county rate (40.9 per 1,000).



**Figure 52: Teen Birth Rate by Race/Ethnicity in Williamson County and Texas, 2015**

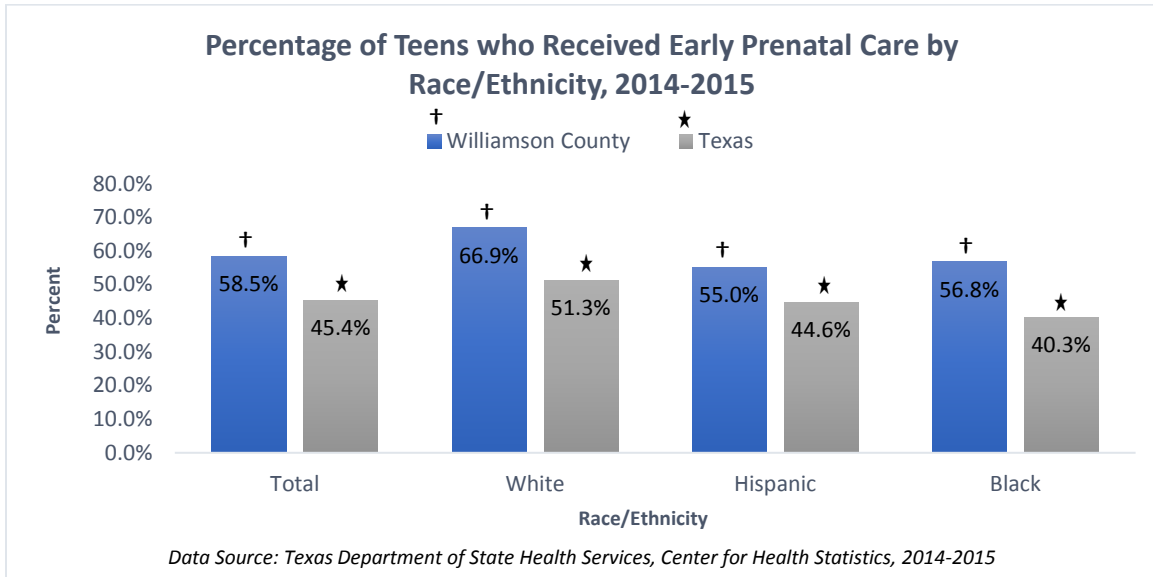
### Prenatal Care

#### *Why is this important?*

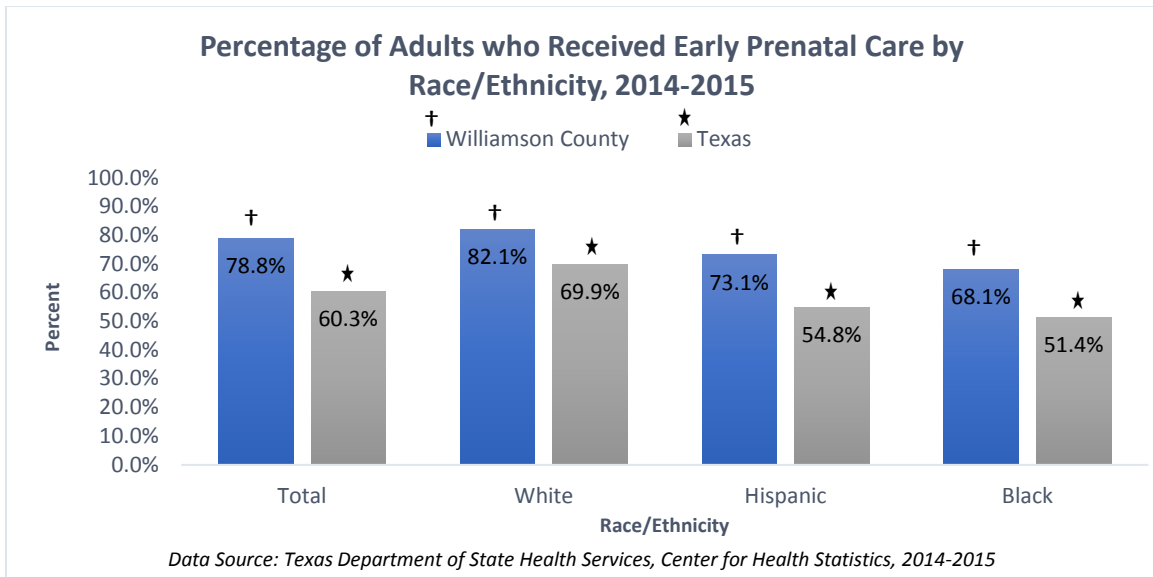
“Babies born to mothers who do not receive prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who do get care. Early prenatal care (i.e. care in the first trimester of a pregnancy) allows women and their health care providers to identify and, when possible, treat or correct health problems and health-compromising behaviors that can be particularly damaging during the initial stages of fetal development.”(79)

In Williamson County, the percentages of teenage and adult mothers who received early prenatal care was higher than Texas across all race/ethnicity groups (Figure 53 and Figure 54). Among teen mothers in Williamson County, the percentage for Hispanic (55.0%) and Black (56.8%) populations fell below the overall county value (58.5%) (Figure 53). A similar trend is seen among adult mothers in Williamson County; the percentages for Hispanic (73.1%) and Black populations (68.1%) are lower than the overall county value (78.8%) (Figure 54). In addition, the percentage of teenage mothers who received prenatal care is lower than adult mothers across all race/ethnic groups.

**Figure 53: Percentage of Teens who Received Early Prenatal Care by Race/Ethnicity, 2014-2015**



**Figure 54: Percentage of Adults who Received Early Prenatal Care by Race/Ethnicity, 2014-2015**



**Key Findings**

Williamson County has many notable strengths regarding maternal and infant health. These include low rates of child and infant mortality, low birth weight, and a declining teen birth rate. However, improvements should be made regarding maternal, infant, and child health outcomes for Hispanic and Black populations. Both groups have higher than average teen birth rates, as well as lower than average rates of receiving early prenatal care. Moreover, the Black population in Williamson County has a higher than average child/infant mortality rate and a high rate of infants born weighing less than 2,500 grams. Increasing prenatal care among teen and adult mothers who are Hispanic and/or Black can improve birth outcomes such as low birth weight and infant mortality.

## C9. Death, Illness, and Injury

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*“IF I COULD SPEAK FOR REGARDING CANCER, ONE OF THE BIGGEST ISSUES WE HAVE IS TRANSPORTATION FOR OUR CLIENTS TRYING TO GET IN FOR INFUSION THERAPY OR EVEN JUST A DOCTOR'S APPOINTMENT. IF THEY DON'T HAVE A FAMILY MEMBER, FRIEND, OR CAR, WE DON'T HAVE REALLY ANY TRANSPORTATION AT ALL. AND I THINK THAT'S REALLY LACKING IN WILLIAMSON COUNTY FOR PEOPLE IN NEED. SO THAT'S A MAJOR ISSUE.”*

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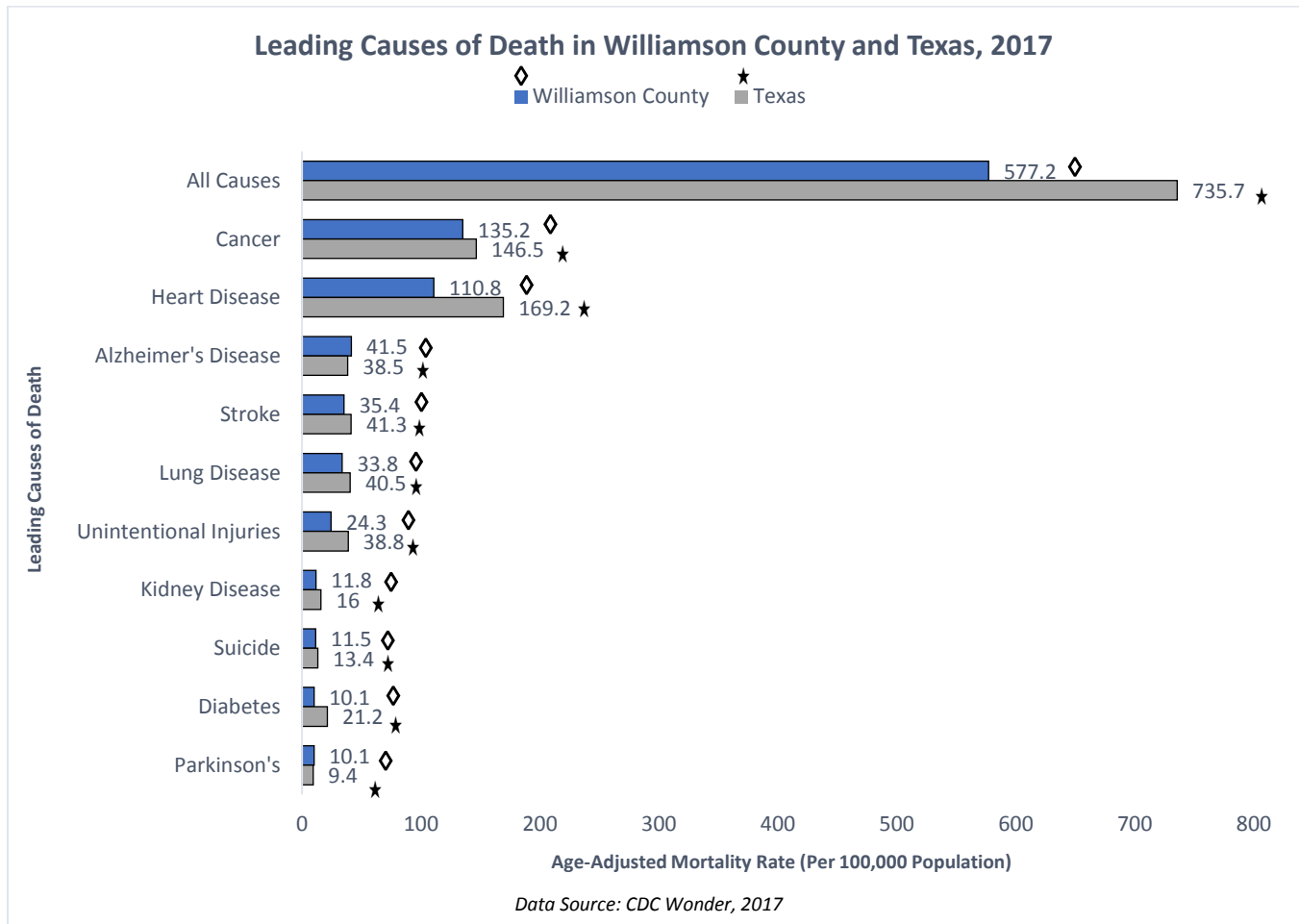
Mortality (rates of death within a population) and morbidity (rates of incidence and prevalence of disease) measure health status in a community.(80) In 2017, the top 10 causes of death in Williamson County were:

1. Cancer
2. Heart Disease
3. Alzheimer's Disease
4. Stroke
5. Lung Disease
6. Unintentional Injuries
7. Kidney Disease
8. Suicide
9. Diabetes Mellitus
10. Parkinson's Disease

This section further examines the relationship between gender, race/ethnicity, and mortality among the top five causes of death in Williamson County. Due to the low number of cases for Alzheimer's disease, stroke, and lung disease, the CHA team was not able to simultaneously examine gender and race/ethnicity for these diseases. Additionally, incidence data is only available for certain cancers, which include breast, lung, prostate, and colorectal cancers.

Figure 55 displays age-adjusted mortality rates for the top ten causes of death in Williamson County and Texas in 2017. For all causes of death, Williamson County (577.2 deaths per 100,000 population) had a lower age-adjusted death rate than Texas (735.7 deaths per 100,000 population). Compared to Texas, Williamson County had higher mortality rates for Alzheimer's (41.4 and 38.5 respectively) and Parkinson's (10.1 and 9.4 respectively) per 100,000 population. In 2017, the top cause of death in Williamson County was cancer, whereas in Texas it was heart disease.

**Figure 55: Leading Causes of Death in Williamson County and Texas, 2017**



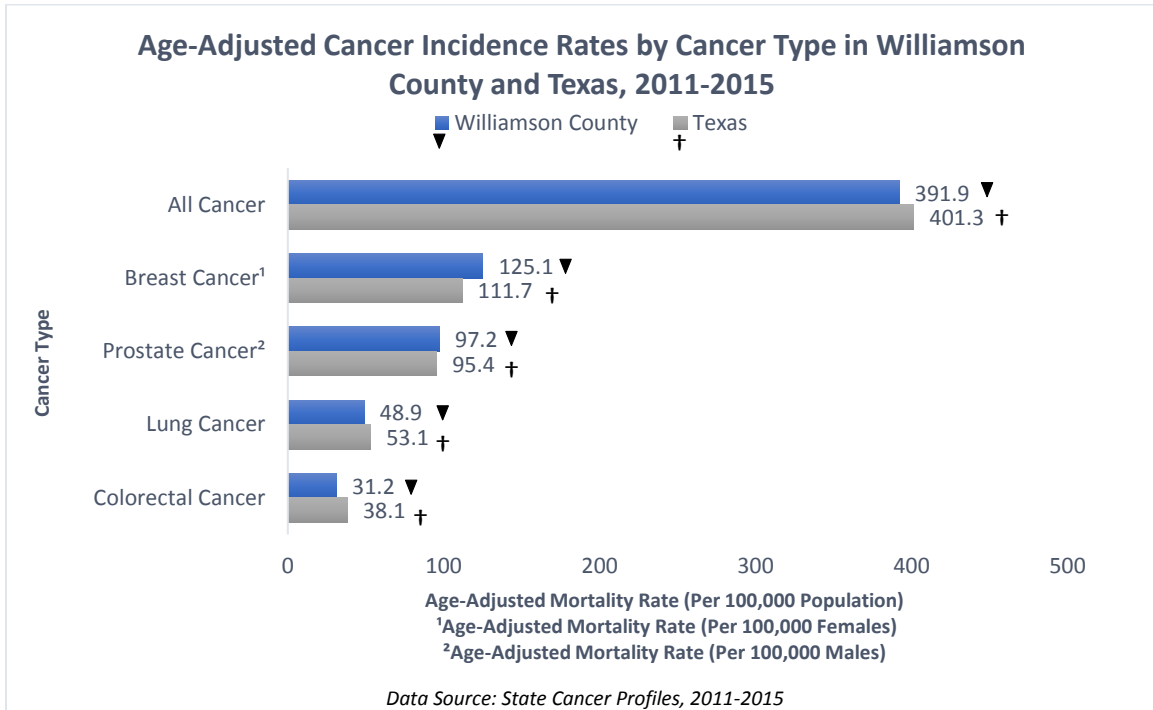
## Cancer

### *Why is this important?*

“The National Cancer Institute (NCI) defines cancer as a term used to describe diseases in which abnormal cells divide without control and are able to invade other tissues. According to the NCI there are over 100 different types of cancer, but breast, colon, lung, pancreatic, prostate, and rectal cancer lead to the greatest number of annual deaths. Risk factors of cancer include but are not limited to age, alcohol use, tobacco use, a poor diet, certain hormones, and sun exposure. Although some of these risk factors cannot be avoided--such as age--limiting exposure to avoidable risk factors may lower risk of developing certain cancers.”(81)

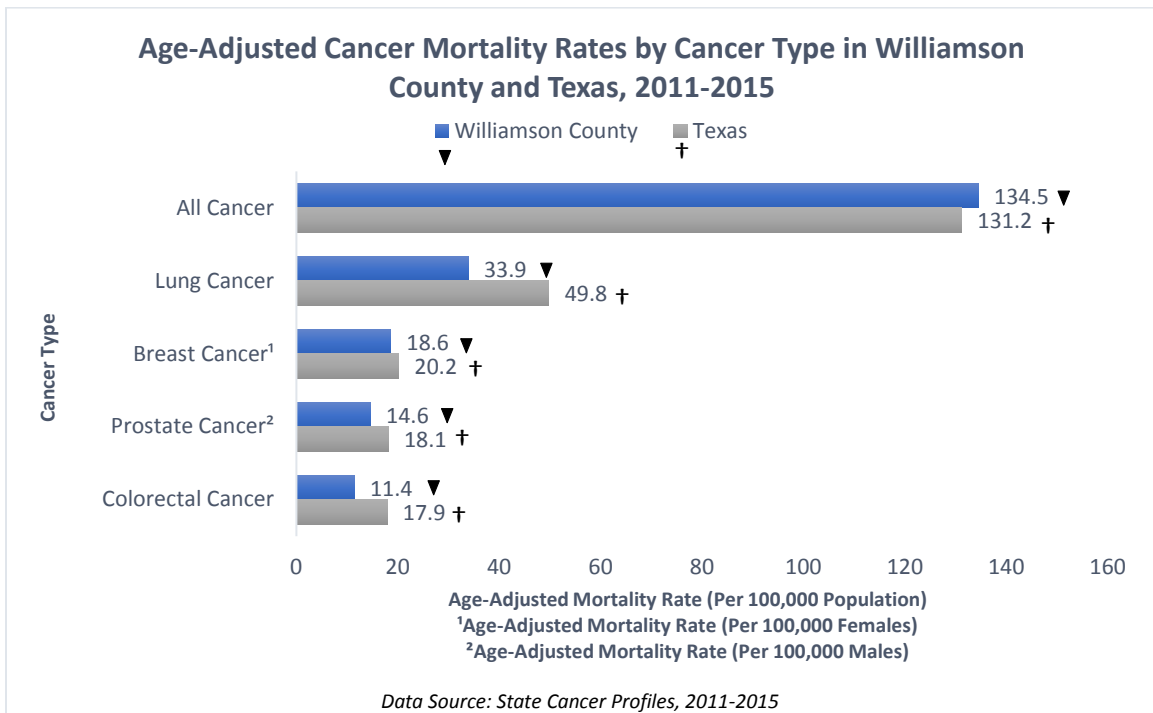
The age-adjusted cancer incidence rate, which describes newly diagnosed cases, was lower in Williamson County (391.9 per 100,000 population) compared to Texas (401.3 per 100,000 population) (Figure 56). However, incidence rates were higher in Williamson County compared to Texas for both breast and prostate cancer. Of all cancer types, breast cancer had the highest incidence rate in Williamson County (111.7 per 100,000 females), followed by prostate (97.2 per 100,000 males).

**Figure 56: Age-Adjusted Cancer Incidence Rates by Cancer Type in Williamson County and Texas, 2011-2015**



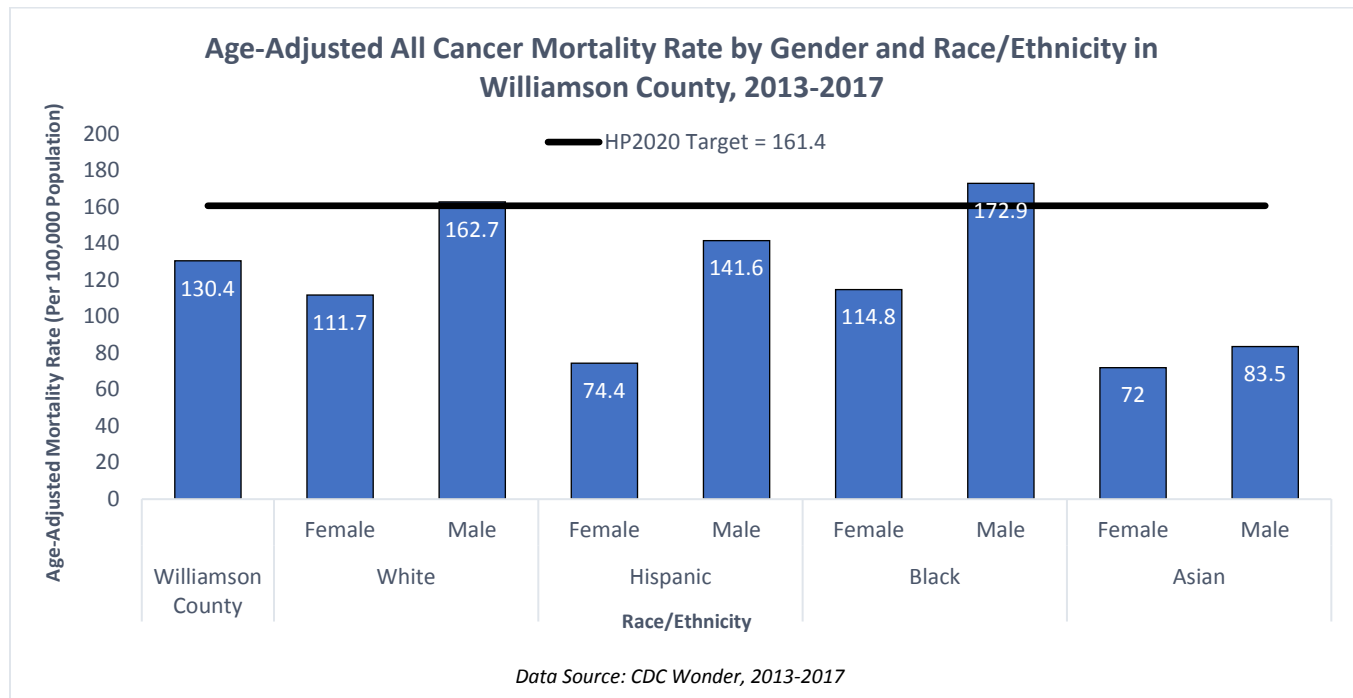
The age-adjusted cancer mortality rate was higher in Williamson County (134.5 per 100,000 population) compared to Texas (131.2 per 100,000 population) (Figure 57). In Williamson County, lung cancer has the highest mortality rate (33.9 per 100,000 population), followed by breast cancer (18.6 per 100,000 females).

**Figure 57: Age-Adjusted Cancer Mortality Rates by Cancer Type in Williamson County and Texas, 2011-2015**



When stratified by gender and race/ethnicity, Black males in Williamson County had the highest age-adjusted cancer mortality rate (172.9 per 100,000 population), followed by White males (162.7 per 100,000 population), and Hispanic males (141.6 per 100,000 population) (Figure 58). Additionally, these populations had cancer mortality rates above the overall county value (130.4 per 100,000 population), with rates for Black males and White males above the HP2020 target (161.4 per 100,000 population).

**Figure 58: Age-Adjusted All Cancer Mortality Rate by Gender and Race/Ethnicity in Williamson County, 2013-2017**



## Cardiovascular Diseases

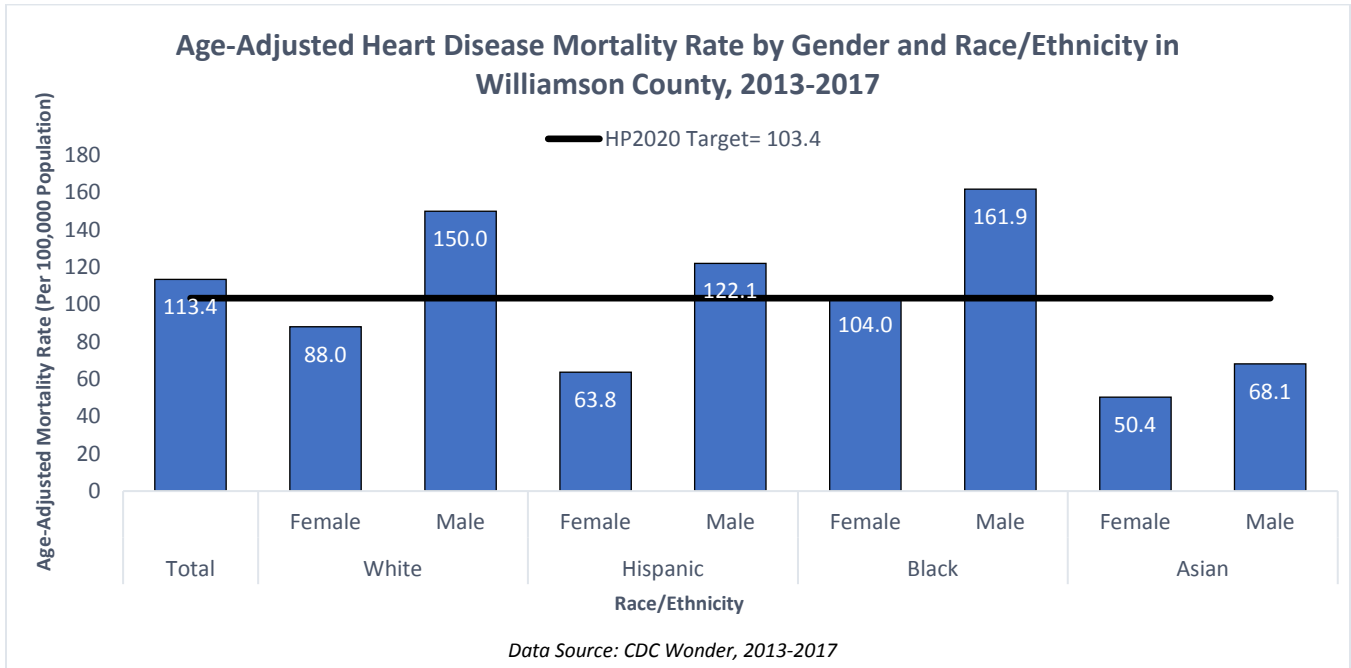
### Why is this important?

“Cardiovascular diseases, including heart disease and stroke, account for more than one-third of all U.S. deaths and a leading cause of disability. Heart disease is a term that encompasses a variety of different diseases affecting the heart. The most common type in the United States is coronary artery disease, which can cause heart attack, angina, heart failure, and arrhythmias. There are many modifiable risk factors for heart disease and stroke including tobacco smoking, obesity, sedentary lifestyle, and poor diet. Controlling high blood pressure and cholesterol are also important prevention strategies.”(82)

When stratified by gender and race/ethnicity, Black males in Williamson County had the highest age-adjusted heart disease mortality rate (161.9 per 100,000 population), followed by White males (150.0 per 100,000 population), and Hispanic males (122.1 per 100,000 population) (Figure 59).

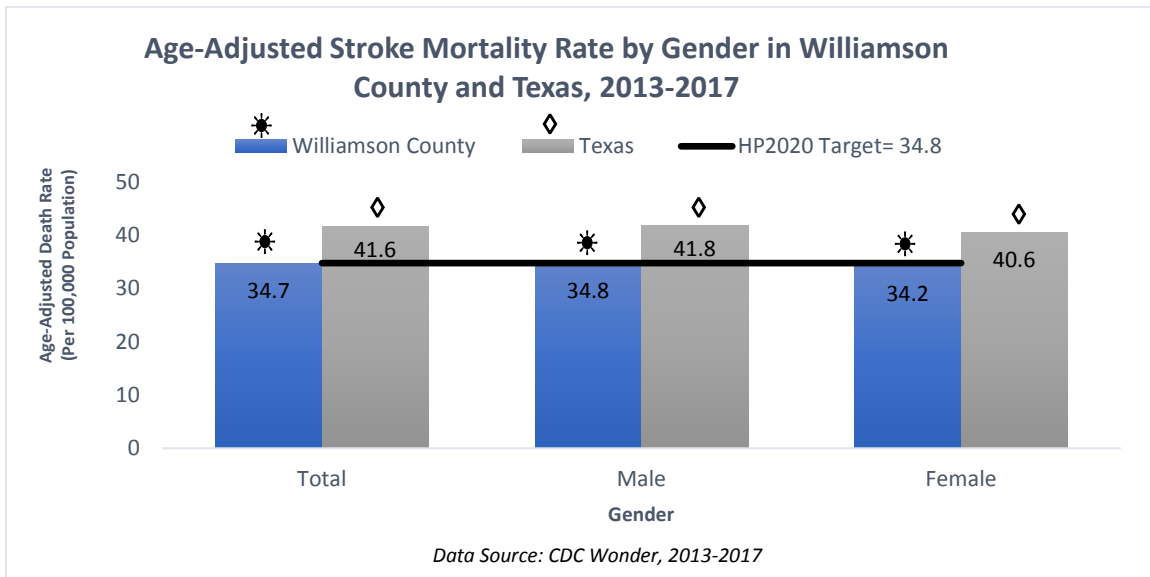
Additionally, these populations had heart disease mortality rates above the overall county value (113.4 per 100,000 population), and above the HP2020 target (103.4 per 100,000 population).

**Figure 59: Age-Adjusted Heart Disease Mortality Rate by Gender and Race/Ethnicity in Williamson County, 2013-2017**



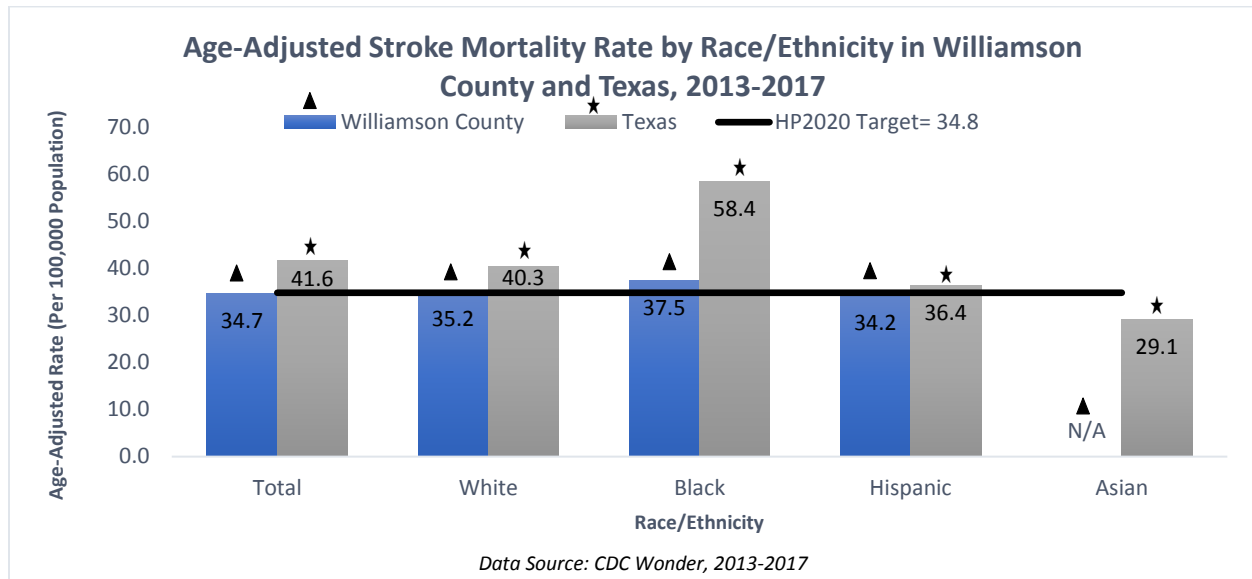
From 2013 to 2017, males and females in Williamson County had age-adjusted stroke mortality rates that were similar to one another and the overall county value (34.7 per 100,000 population) (Figure 60). Age-adjusted stroke mortality rates for Black (37.5 per 100,000 population) and White populations (35.2 per 100,000 population) in Williamson County were higher than the overall county value and the HP2020 target (34.8 per 100,000 population) (Figure 61).

**Figure 60: Age-Adjusted Stroke Mortality Rate by Gender in Williamson County and Texas, 2013-2017**





**Figure 61: Age-Adjusted Stroke Mortality Rate by Race/Ethnicity in Williamson County and Texas, 2013-2017**



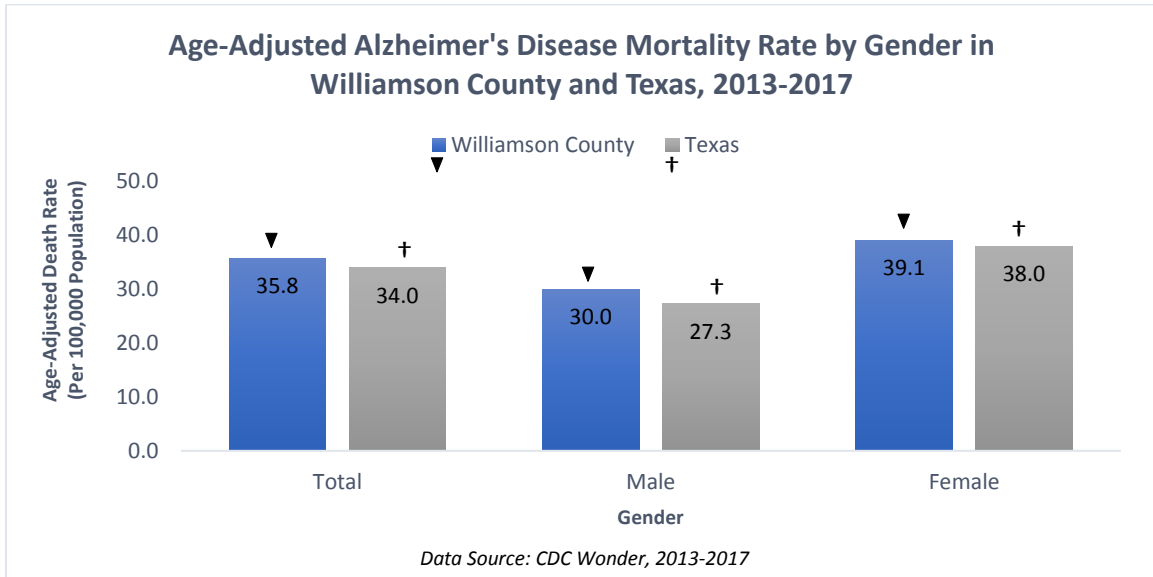
### Alzheimer's Disease

#### *Why is this important?*

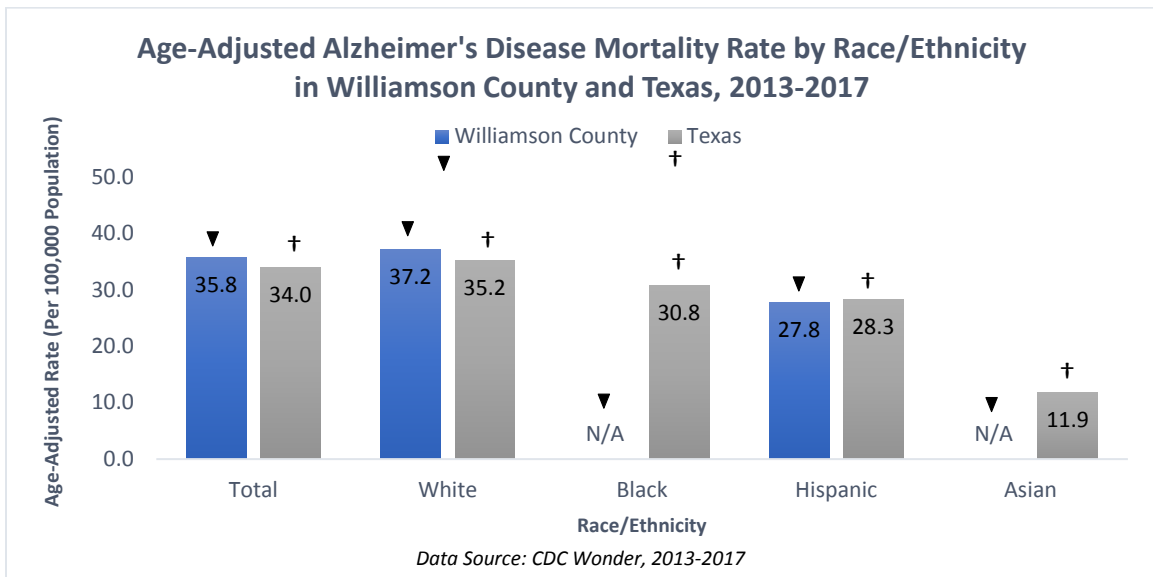
"Alzheimer's disease is the most common form of dementia among older people. It is a progressive and irreversible disease that impairs memory and affects thinking and behavior, to the point of eventually interfering with daily tasks. The greatest risk factor currently known is increasing age. After age 65, the likelihood of developing the disease doubles every five years; the risk is nearly 50% after age 85. Alzheimer's imposes heavy emotional and financial burdens on families. While there is currently no cure, there are treatments that can slow the progression of Alzheimer's and improve the quality of life for people with Alzheimer's and their caregivers."(83)

In Williamson County, the age-adjusted Alzheimer's disease mortality rate was higher among females (39.1 per 100,000 population) compared to males (30.0 per 100,000 population) (Figure 62). Moreover, the rate among females was higher than the overall county value (35.8 per 100,000 population). The White population in Williamson County had the highest age-adjusted Alzheimer's mortality rate (37.2 per 100,000 population), which also surpassed the overall county value (Figure 63).

**Figure 62: Age-Adjusted Alzheimer’s Disease Mortality Rate by Gender in Williamson County and Texas, 2013-2017**



**Figure 63: Age-Adjusted Alzheimer’s Disease Mortality Rate by Race/Ethnicity in Williamson County and Texas, 2013-2017**



Lung Disease

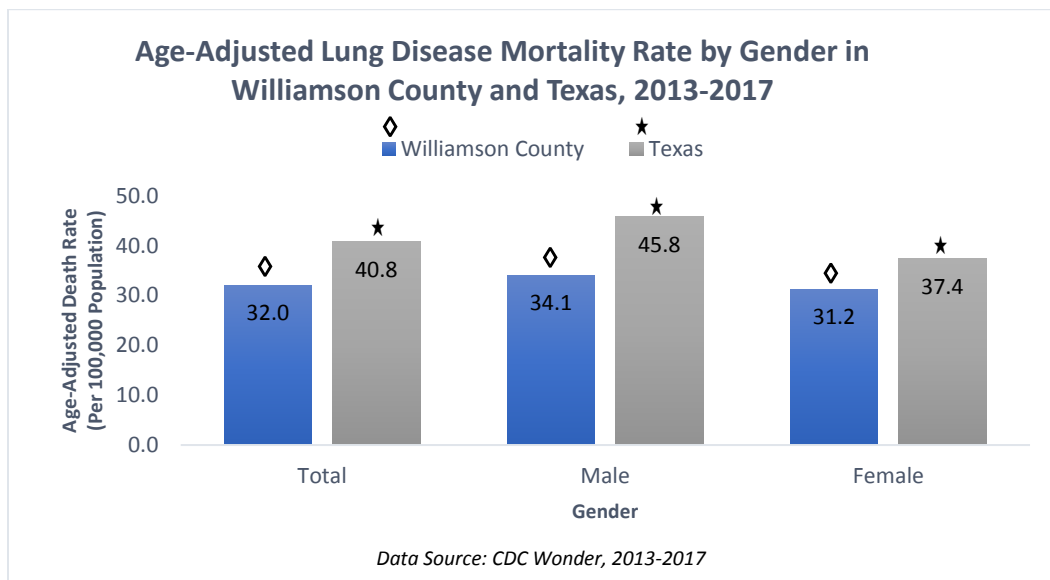
*Why is this important?*

According to the CDC, “chronic respiratory diseases are chronic disease of the airways and other structures of the lung.”(84) The most common types of lung disease are asthma, chronic obstructive pulmonary disease, occupational lung diseases, and pulmonary hypertension.(84) Tobacco smoke is the main risk factor for developing chronic respiratory diseases, followed by air pollutants in the home and workplace, genetic factors, and respiratory infections.(84)

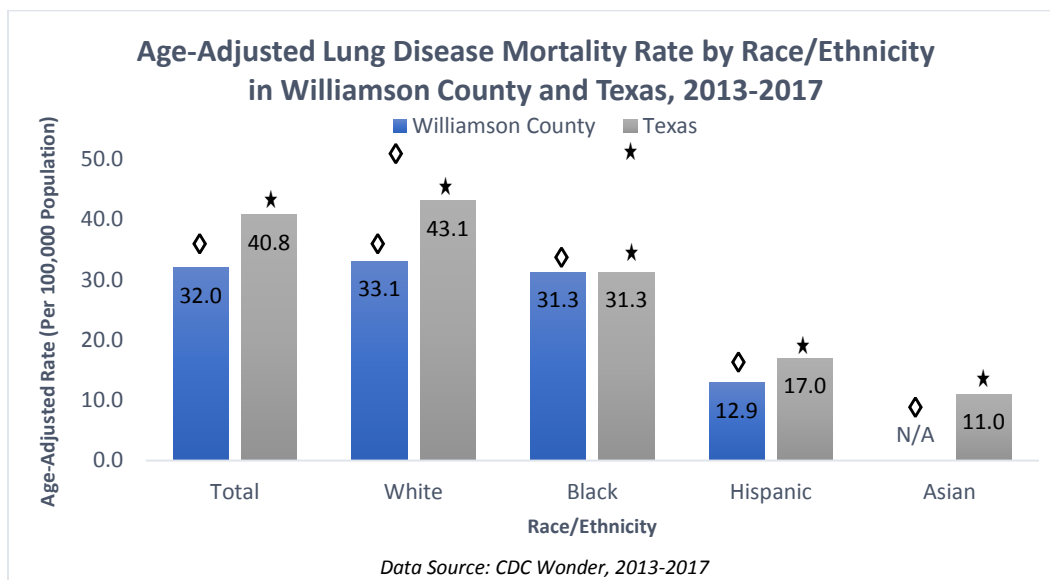
The age-adjusted lung disease mortality rate was higher among males (34.1 per 100,000 population) compared to females (31.2 per 100,000 population) (Figure 64). Moreover, the rate among males was higher than the overall county rate (32.0 per 100,000 population). Additionally, the age-adjusted mortality rate among the

White population (33.1 per 100,000) was the highest across all racial/ethnic groups and higher than the overall county value (Figure 65).

**Figure 64: Age-Adjusted Lung Disease Mortality Rate by Gender in Williamson County and Texas, 2013-2017**



**Figure 65: Age-Adjusted Lung Disease Mortality Rate by Race/Ethnicity in Williamson County and Texas, 2013-2017**



### Key Findings

Although Williamson County has lower rates of mortality compared to Texas, there are specific populations that carry a higher burden of disease and should be considered when developing interventions, programs, and services.

- **Cancer incidence rates are much higher than overall mortality rates for Williamson County.** Cancer screening should be prioritized to diagnose cancer during early stages before it becomes fatal. Recent incidence data are needed to inform early cancer detection and prevention activities in Williamson County.
- **Since cancer and heart disease are the leading causes of death in Williamson County,** program and service planning should consider high risk populations, which include Black, White, and Hispanic males.

- **Alzheimer’s disease is the third leading cause of death in the county, with mortality rates that are higher in Williamson County compared to Texas.** The disease disproportionately affects women and the White population.

## C10. Communicable Disease

Communicable diseases, which include sexually transmitted infections (STI) and tuberculosis (TB), pose a significant public health concern worldwide. Fortunately, there are ways to mitigate the spread of communicable diseases. Persons with Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), chlamydia, gonorrhea, and syphilis can prevent the spread of infection by using proper protection during sexual intercourse.(85) Individuals with tuberculosis should avoid physical contact with others, practice frequent handwashing, and take prescribed medicine as directed by a health professional.(86)

Most of the data in this section come from a passive disease surveillance system which collects diseases from the “Texas Notifiable Conditions List.” Texas law requires that health care providers, hospitals, laboratories, and others report select conditions to local health departments, who then submit data to DSHS, and ultimately to the CDC. Since this surveillance system only captures diseases reported to health departments, there are missing cases that go undetected or unreported. Consequently, the data in this section may not completely represent the actual burden of disease, but still offer insight regarding disease trends and affected population groups.

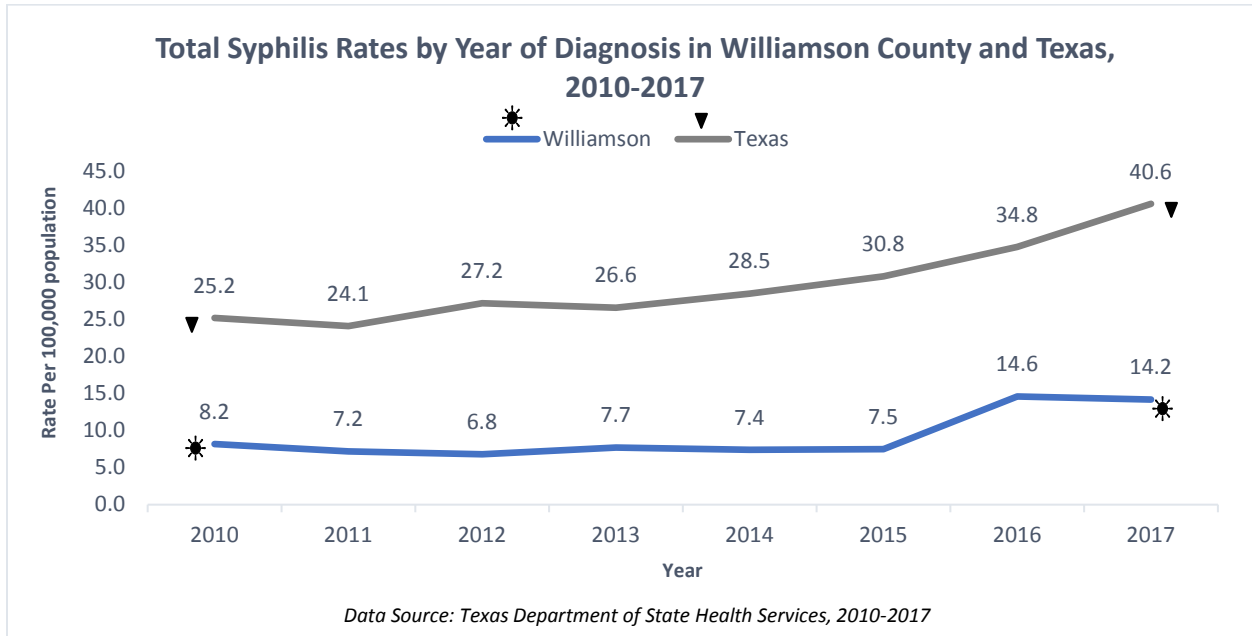
### Syphilis

#### *Why is this important?*

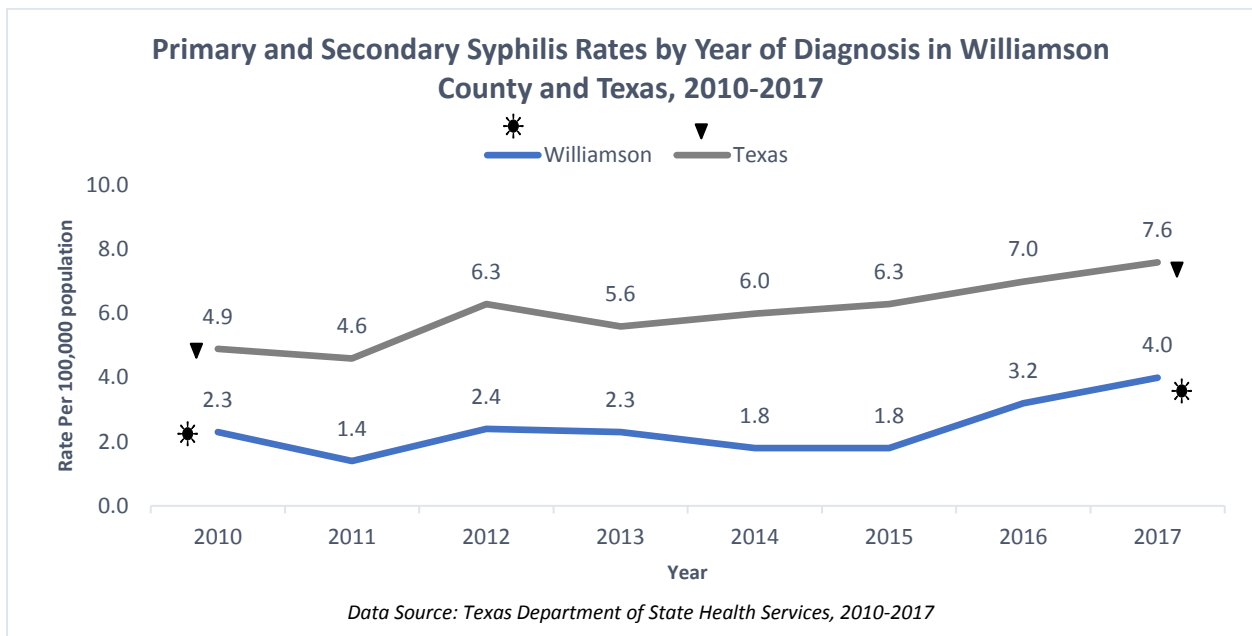
According to the CDC, “syphilis is a sexually transmitted infection that can cause serious health problems if not treated.”(87) Syphilis is divided into stages, which include primary and secondary (P&S, mild signs and symptoms), latent (no signs or symptoms), and tertiary (associated with severe medical complications). Pregnant women with untreated syphilis can pass the infection to their infant and have a higher risk for fetal death.(87)

Annual reported syphilis rates in Williamson County, which includes P&S and total (all stages), has remained lower than Texas rates from 2010 to 2017 (Figure 66 and Figure 67). However, the reported total syphilis rate in Williamson County has almost doubled between 2015 (7.5 infections per 100,000 population) and 2017 (14.2 infections per 100,000 population) (Figure 66). Moreover, reported P&S syphilis rates in Williamson County rose from 1.8 infections per 100,000 population in 2015 to 4.0 infections per 100,000 population in 2017 (Figure 67).

**Figure 66: Total Syphilis Rates by Year of Diagnosis in Williamson County and Texas, 2010-2017**

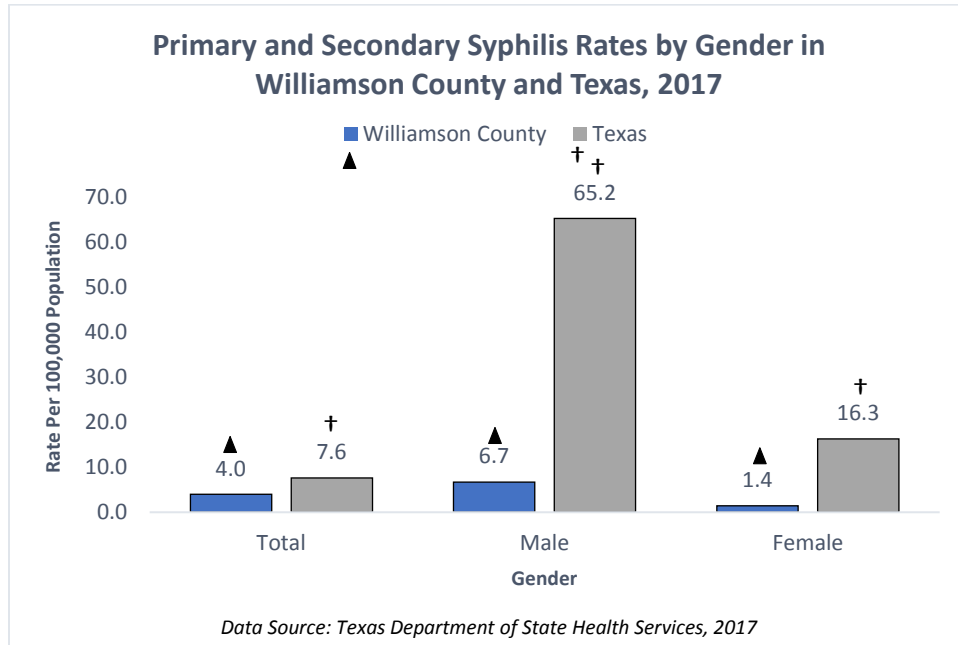


**Figure 67: Primary and Secondary Syphilis Rates by Year of Diagnosis in Williamson County and Texas, 2010-2017**

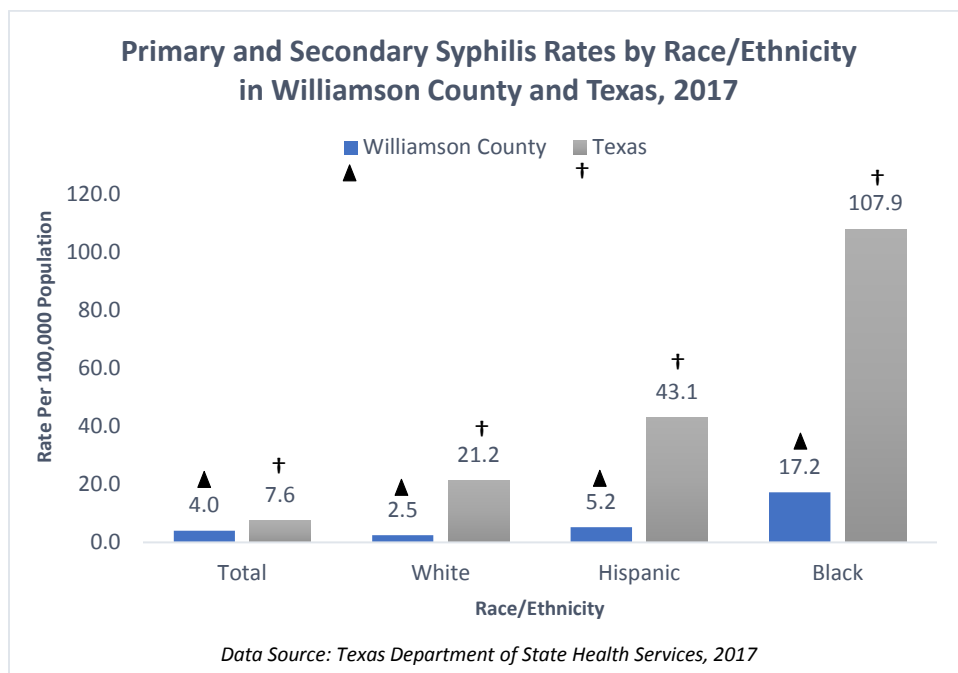


In Williamson County, reported rates of P&S syphilis in both males (6.7 per 100,000 population) and females (1.4 per 100,000 population) were lower compared to rates among Texas males (65.2 per 100,000 population) and females (16.3 per 100,000 population) (Figure 68). However, the reported syphilis rate for females in Williamson County (1.4 infections per 100,000 population) is slightly higher than the HP2020 target for females (1.3 infections per 100,000 population). Males in Williamson County met the HP2020 target of 6.7 infections per 100,000 males. When stratified by race and ethnicity, the Black population in Williamson County had the highest reported rate of P&S syphilis at 17.2 per 100,000 population (Figure 69). Furthermore, rates of reported syphilis were the highest among those ages 15 to 24 (10.3 infections per 100,000) (Figure 70).

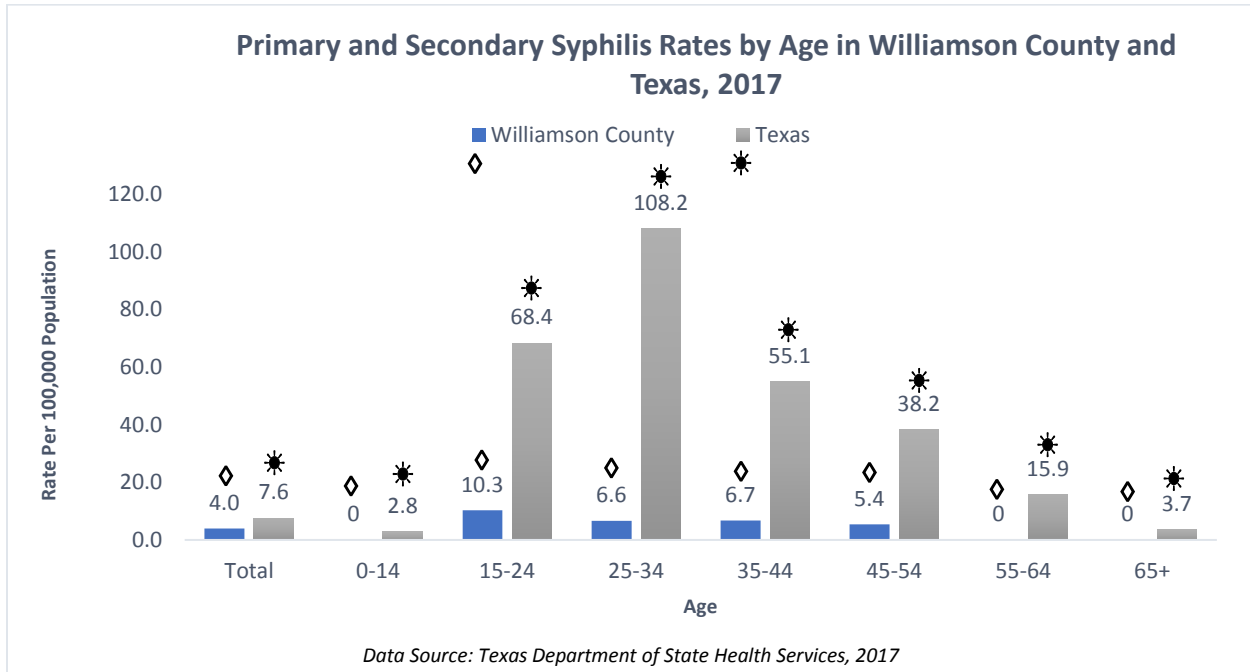
**Figure 68: Primary and Secondary Syphilis Rates by Gender in Williamson County and Texas, 2017**



**Figure 69: Primary and Secondary Syphilis Rates by Race/Ethnicity in Williamson County and Texas, 2017**



**Figure 70: Primary and Secondary Syphilis Rates by Age in Williamson County and Texas, 2017**



Chlamydia

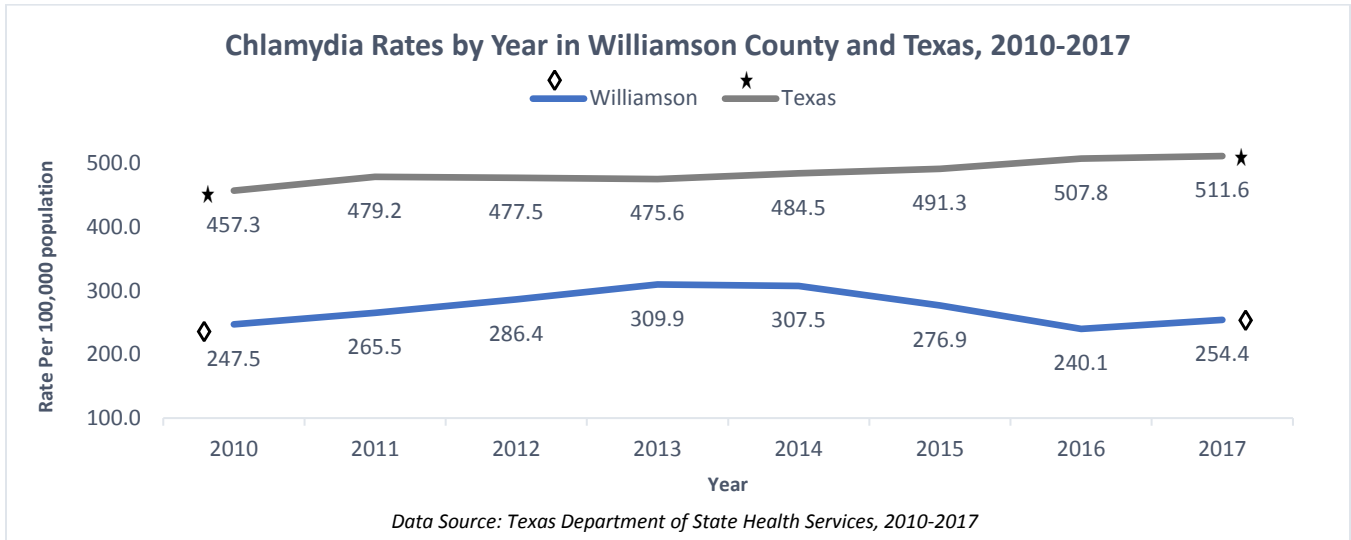
*Why is this important?*

According to DSHS, chlamydia is the most frequently reported bacterial STI in the United States. Most individuals with chlamydia do not display symptoms, resulting in many cases that go unreported. Moreover, lack of screening to identify the infection may result in serious complications such as pelvic inflammatory disease and ectopic pregnancy in women, and urethritis and proctitis in men.(88)

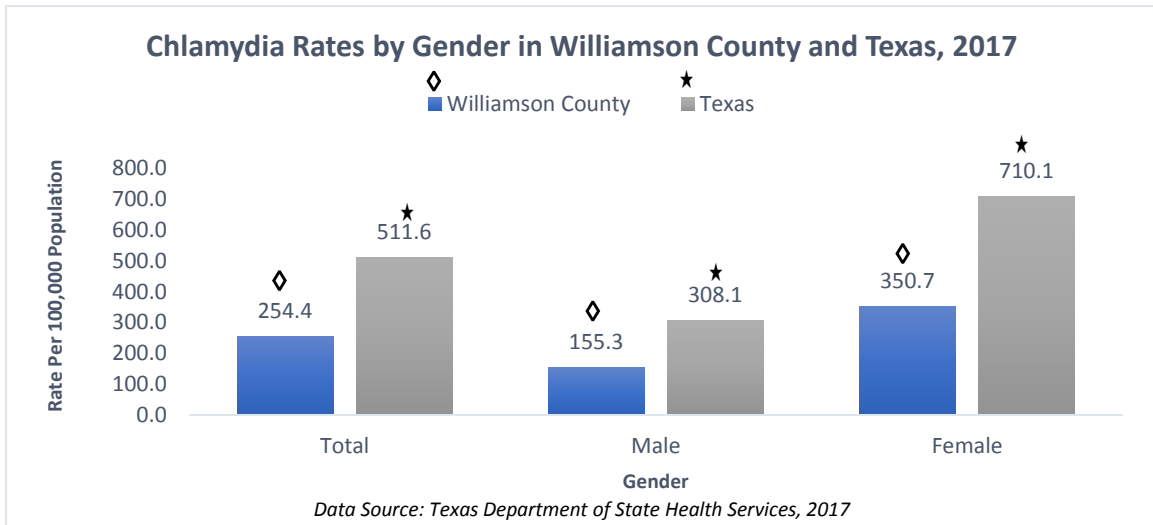
From 2010 to 2017, reported chlamydia rates in Williamson County have remained mostly constant and lower than rates in Texas (Figure 71). Females in Williamson County have a higher reported chlamydia rate (350.7 per 100,000 population) than males (155.3 per 100,000 population) and the overall county rate (254.4 per 100,000 population) (Figure 72). The Black population had the highest reported chlamydia rate (709.5 per 100,000 population), followed by the Hispanic population (295.7 per 100,000 population) and the White population (121.0 per 100,000 population) (Figure 73). Additionally, the 15 to 24-year-old group had the highest reported rate (1334.1 per 100,000 population) compared to other age groups (Figure 74).



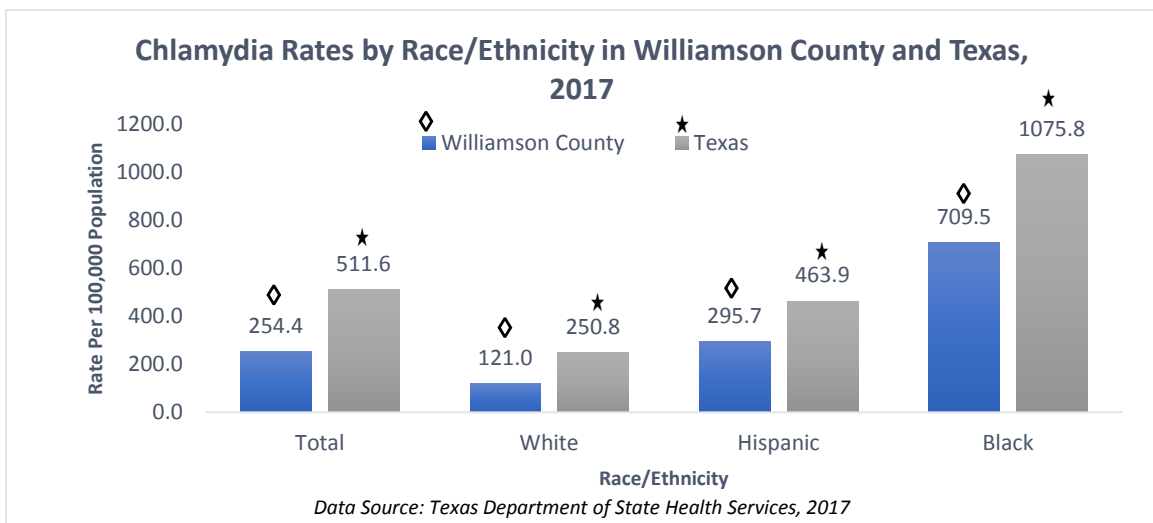
**Figure 71: Chlamydia Rates by Year in Williamson County and Texas, 2010-2017**



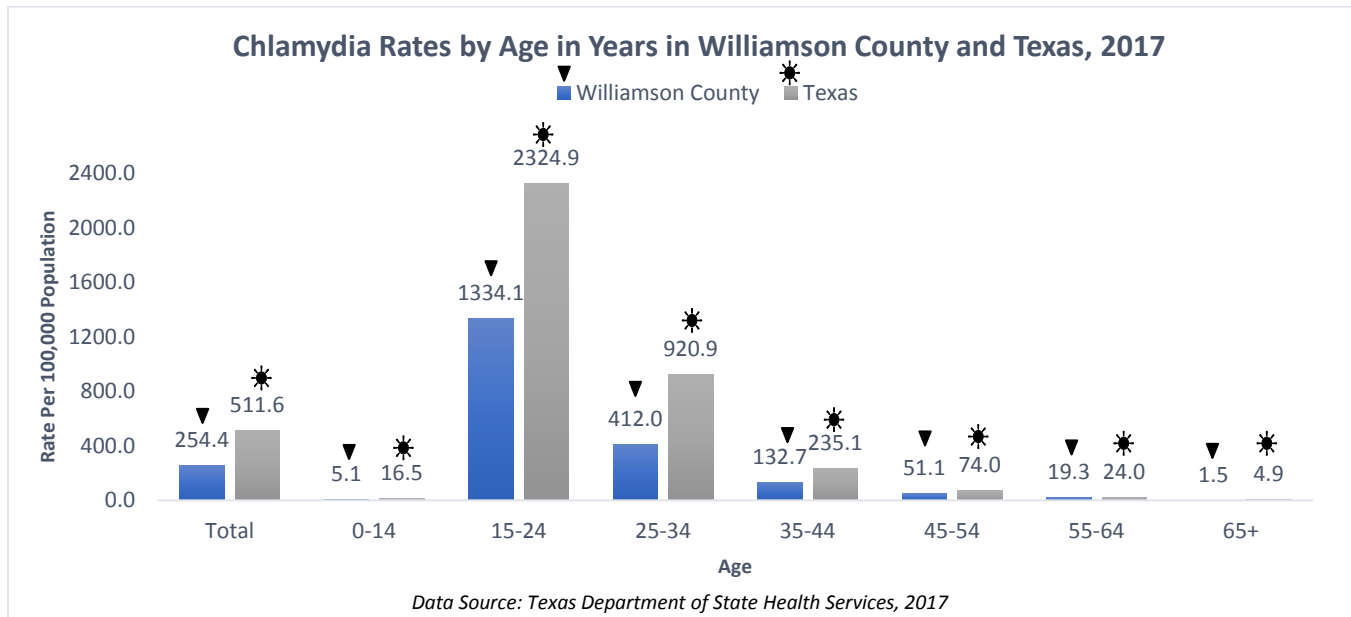
**Figure 72: Chlamydia Rates by Gender in Williamson County and Texas, 2017**



**Figure 73: Chlamydia Rates by Race/Ethnicity in Williamson County and Texas, 2017**



**Figure 74: Chlamydia Rates by Age in Years in Williamson County and Texas, 2017**



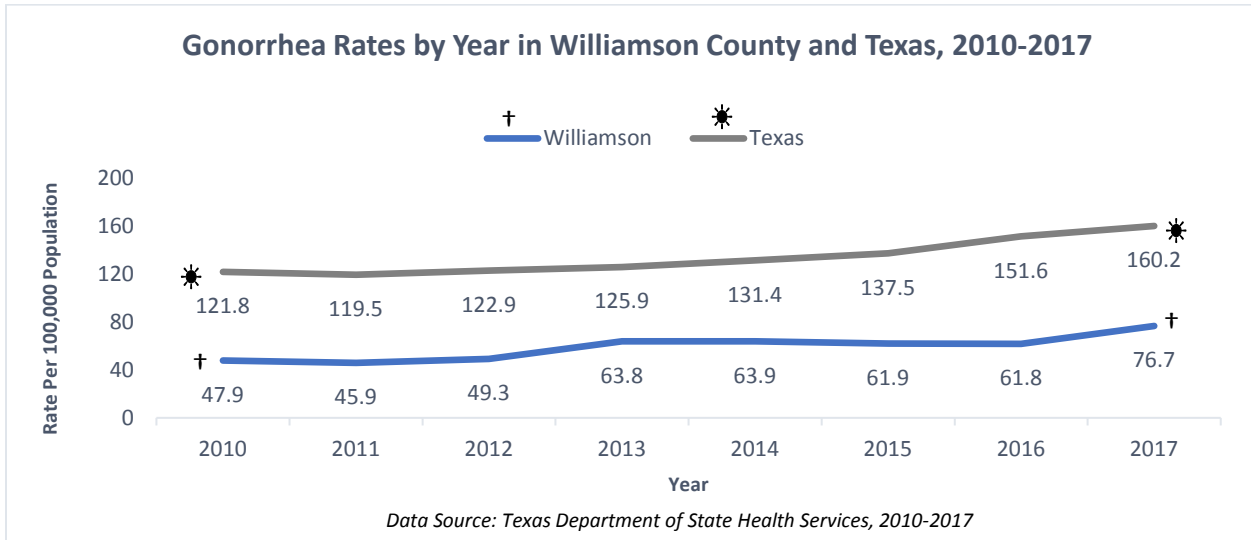
## Gonorrhea

### *Why is this important?*

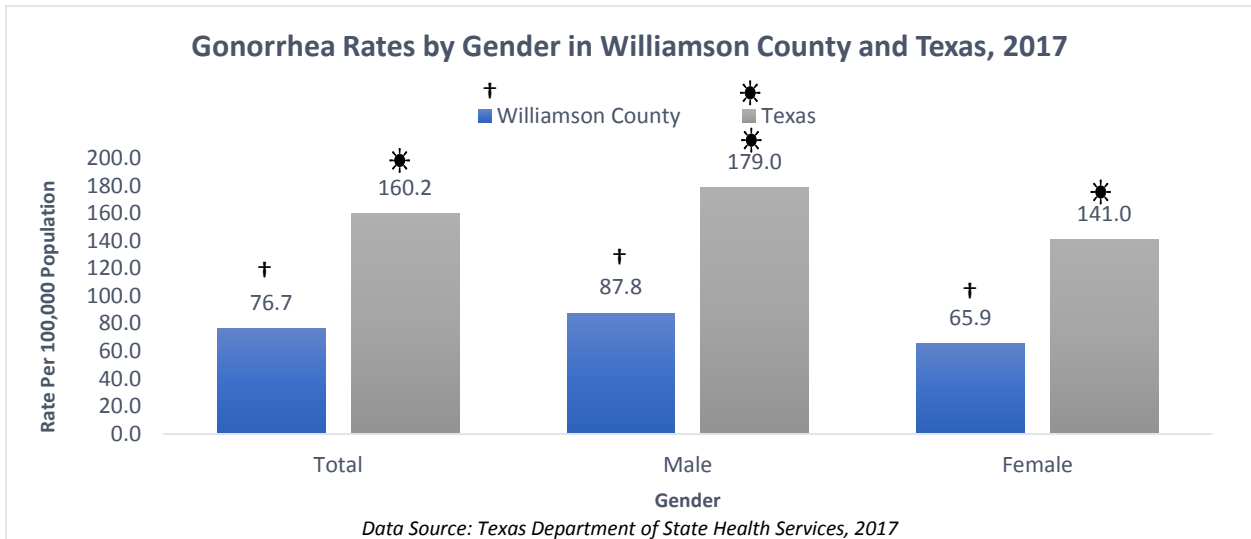
Gonorrhea is a very common sexually-transmitted infection that is treated using dual therapy (two drugs) to mitigate antibiotic resistance.(89) If not treated, gonorrhea can cause serious complications, such as infertility in both men and women.(89)

Reported rates of gonorrhea between 2010 to 2017 have been lower in Williamson County compared to Texas (Figure 75). However, Williamson County rates have steadily increased over this seven-year period, from 47.9 per 100,000 population to 76.7 per 100,000 population. Males in Williamson County have a higher reported gonorrhea rate (87.8 per 100,000 population) compared to females (65.9 per 100,000 population) and the overall county rate (76.7 per 100,000 population) (Figure 76). Reported gonorrhea rates for both males and females are lower than their respective HP2020 targets of 194.8 per 100,000 population and 259.18 per 100,000 population. The Black population in Williamson County have a significantly higher reported gonorrhea rate (327.4 per 10,000 population) compared to other racial/ethnic groups and compared to the overall county rate (Figure 77). Reported rates of gonorrhea were highest among the 15 to 24-year-old age group, at 305.1 per 100,000 population (Figure 78).

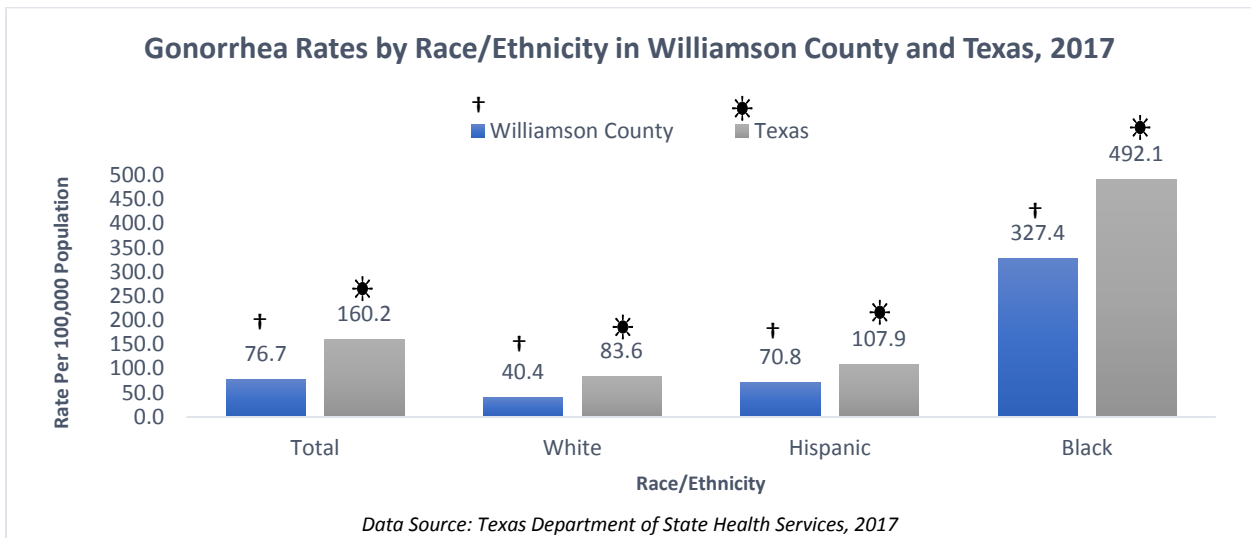
**Figure 75: Gonorrhea Rates by Year in Williamson County and Texas, 2010-2017**



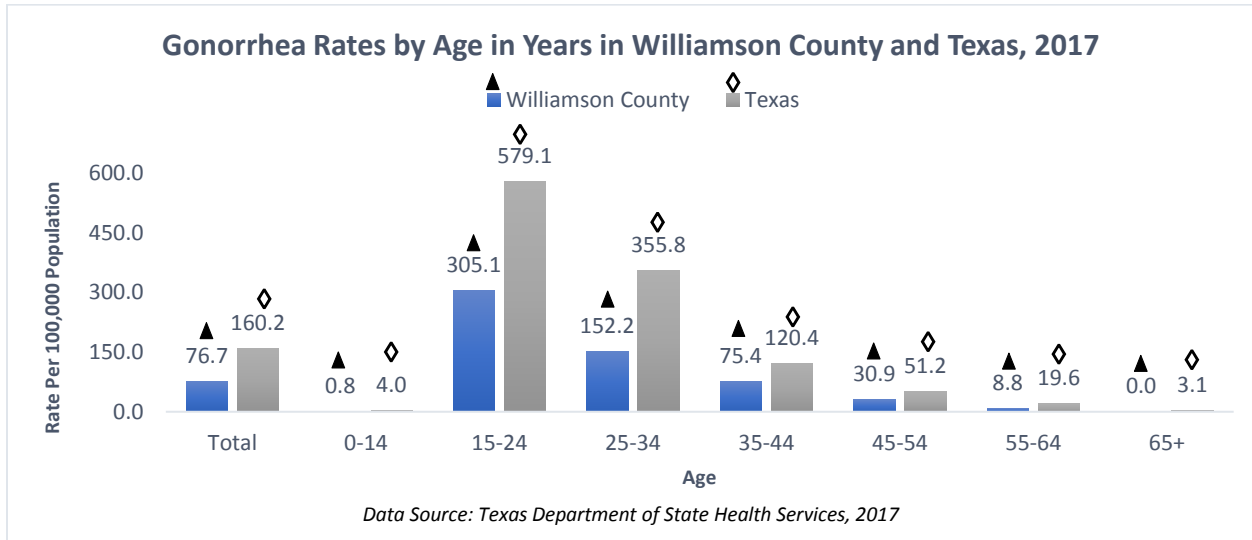
**Figure 76: Gonorrhea Rates by Gender in Williamson County and Texas, 2017**



**Figure 77: Gonorrhea Rates by Race/Ethnicity in Williamson County and Texas, 2017**



**Figure 78: Gonorrhea Rates by Age in Years in Williamson County and Texas, 2017**



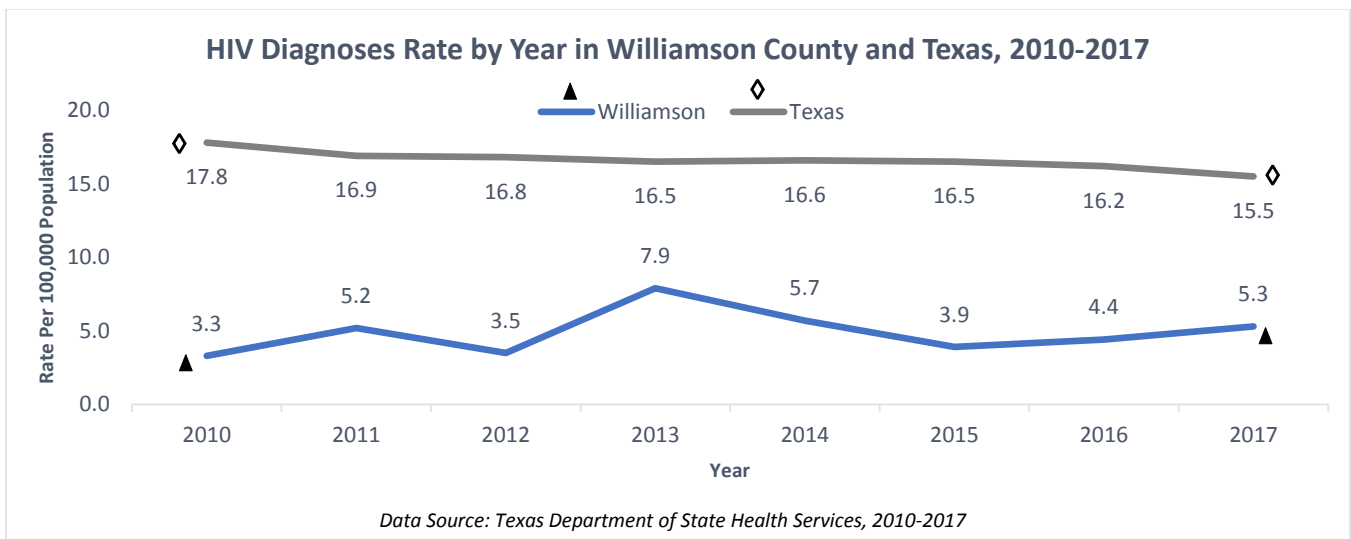
HIV and AIDS Diagnosis

*Why is this important?*

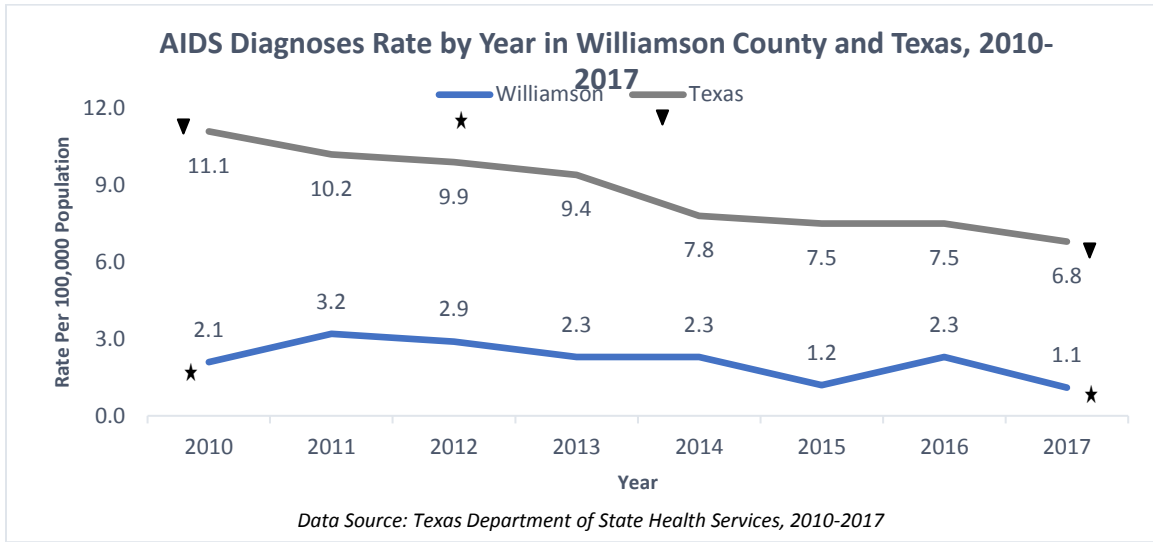
“HIV damages the immune system, eventually leading infected individuals to develop AIDS, a chronic and potentially life-threatening condition. People infected with HIV may develop mild infections or chronic symptoms like fever, fatigue, shortness of breath, and weight loss. If left untreated, HIV typically progresses to AIDS in about 10 years, at which point the immune system is weakened to the point of being unable to fight infections. When stratified by race and ethnicity, Blacks and Hispanics are disproportionately affected by HIV.” Additionally, men who have sex with men of all races are at a higher risk than others of contracting HIV.(90)

Due to advancements in treatment, people who have contracted HIV have a lower risk of mortality and are able to live longer. Despite the increase in the total number of people living with HIV in the U.S., the number of annual new HIV infections has remained stable in recent years.(90)

**Figure 79: HIV Diagnoses Rate by Year in Williamson County and Texas, 2010-2017**



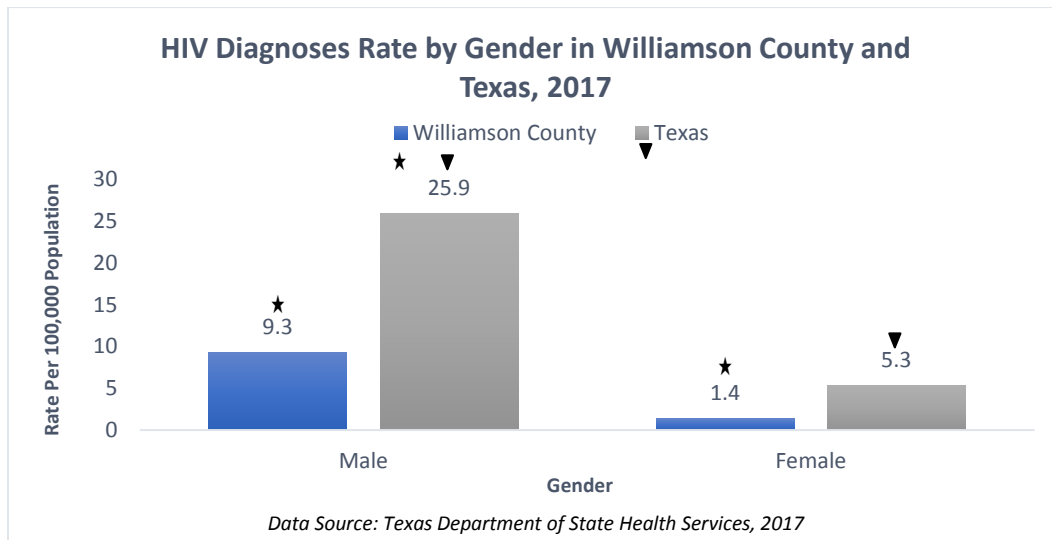
**Figure 80: AIDS Diagnoses Rate by Year in Williamson County and Texas, 2010-2017**



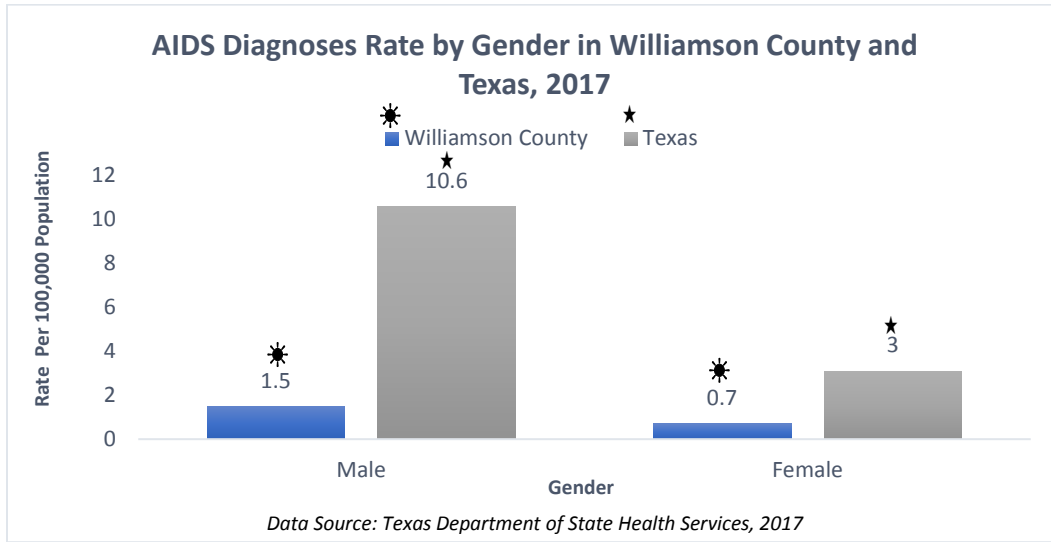
From 2010 to 2017, reported rates of newly diagnosed HIV infection and AIDS were lower in Williamson County compared to Texas (Figure 79 and Figure 80). In Williamson County, the rate of HIV diagnoses peaked at 7.9 per 100,000 population in 2013 but decreased to 5.3 per 100,000 population in 2017 (Figure 79). Across the same time period, 2013 to 2017, AIDS diagnoses in Williamson County have remained stable (Figure 80).

Males and the Black population in Williamson County have the highest reported rates of both HIV and AIDS, which also aligns with state and national rates (Figure 81, Figure 82, Figure 83, and Figure 84). When examining HIV and AIDS by age, the group with the highest rates were those ages 25 to 29 with HIV rates at 31.9 per 100,000 population (Figure 85) and AIDS rates at 11.6 per 100,000 population (Figure 86).

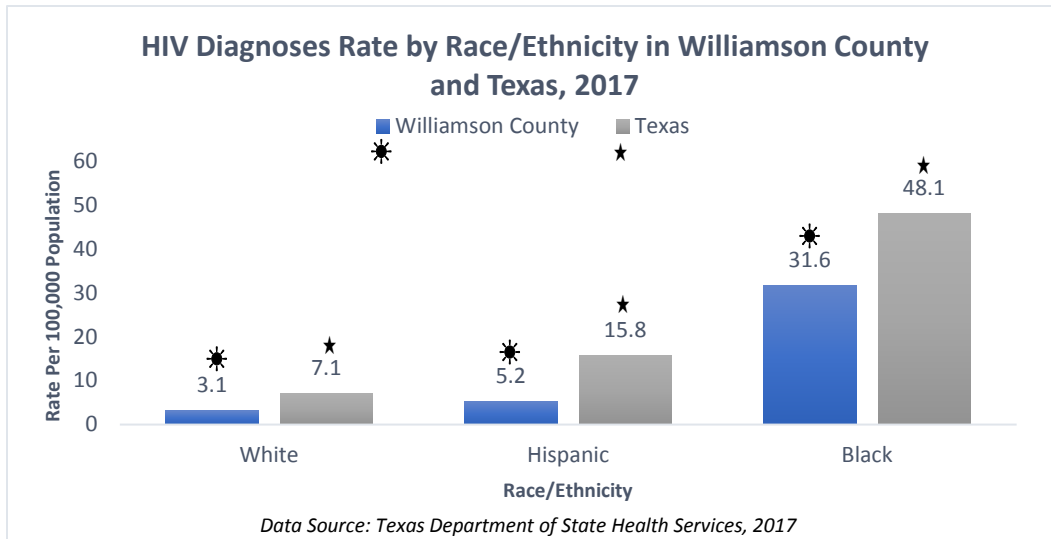
**Figure 81: HIV Diagnoses Rate by Gender in Williamson County and Texas, 2017**



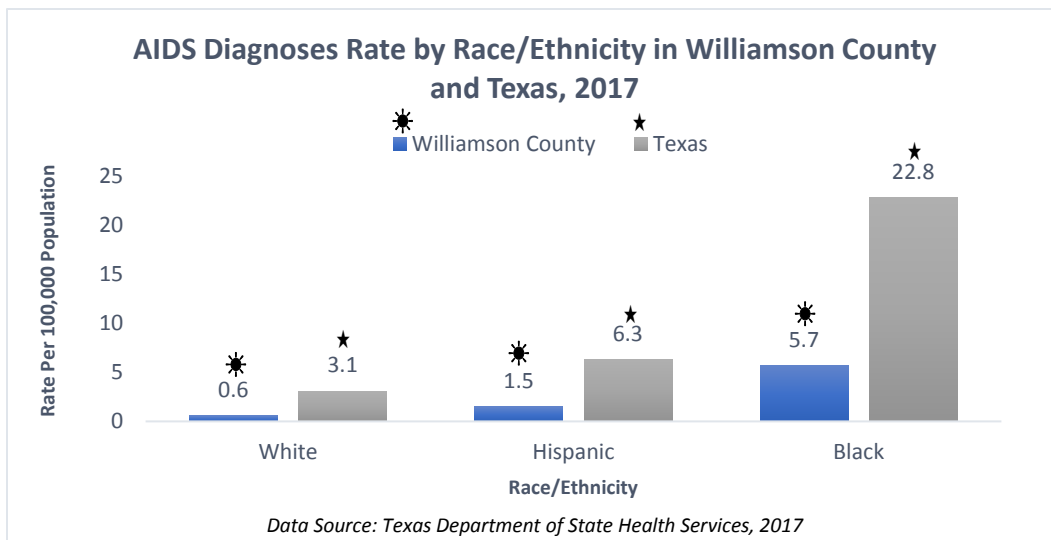
**Figure 82: AIDS Diagnoses Rate by Gender in Williamson County and Texas, 2017**



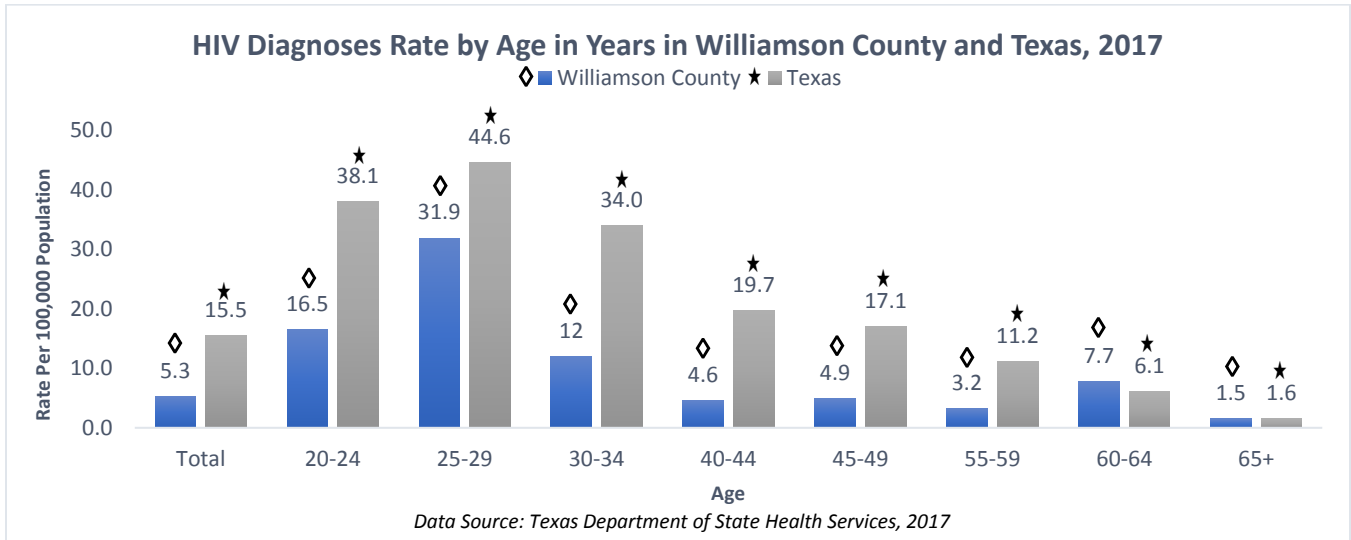
**Figure 83: HIV Diagnoses Rate by Race/Ethnicity in Williamson County and Texas, 2017**



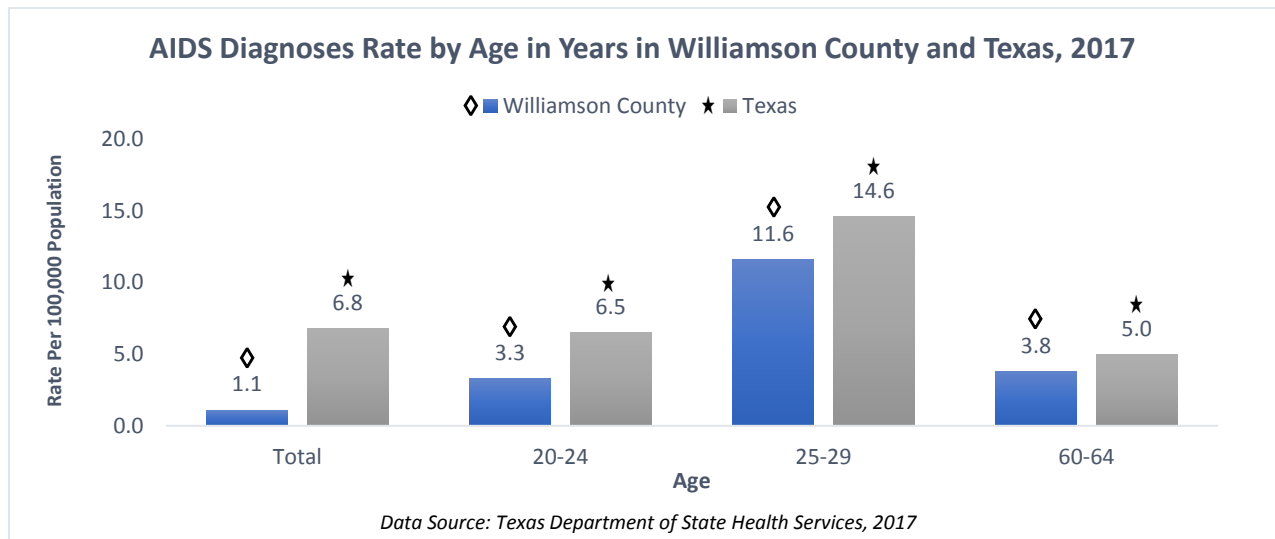
**Figure 84: AIDS Diagnoses Rate by Race/Ethnicity in Williamson County and Texas, 2017**



**Figure 85: HIV Diagnoses Rate by Age in Years in Williamson County and Texas, 2017**



**Figure 86: AIDS Diagnoses Rate by Age in Years in Williamson County and Texas, 2017**



Tuberculosis

*Why is this important?*

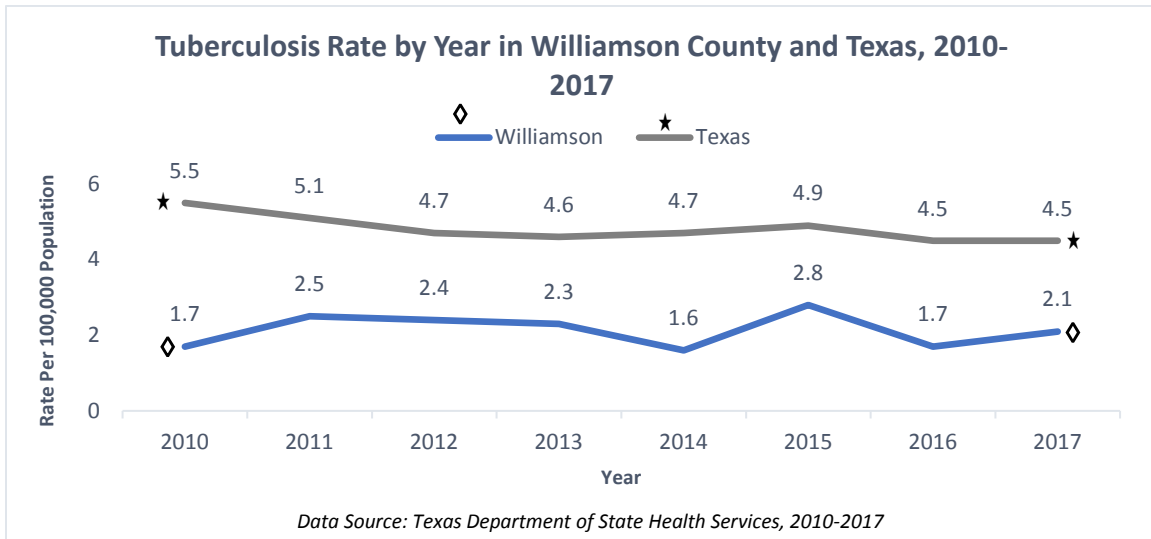
“Tuberculosis (TB) is a bacterial disease that usually affects the lungs, although other parts of the body can also be affected. The TB bacteria are spread through the air when a person with untreated pulmonary TB coughs or sneezes. Prolonged exposure to a person with untreated TB is usually necessary for infection to occur. In 9 out of 10 exposed people, the immune system halts the spread of the infection and the infected person does not become sick or spread disease to others. However, the bacilli remain dormant and these latent infections can be activated if the immune system becomes severely weakened by HIV, diabetes, chemotherapy cancer treatments, or other causes. A person with active TB disease is contagious until he/she has been on appropriate treatment for several days to weeks.”(91)

Compared to Texas, Williamson County had lower reported TB rates from 2010 to 2017 (Figure 87). Reported rates of TB in Williamson County peaked at 2.8 per 100,000 population in 2015 but decreased to 2.1 per 100,000 population in 2017. Williamson County males have a higher reported TB rate (2.2 per 100,000 population) compared to females (1.8 per 100,000 population) but have a reported rate that is similar to the overall county

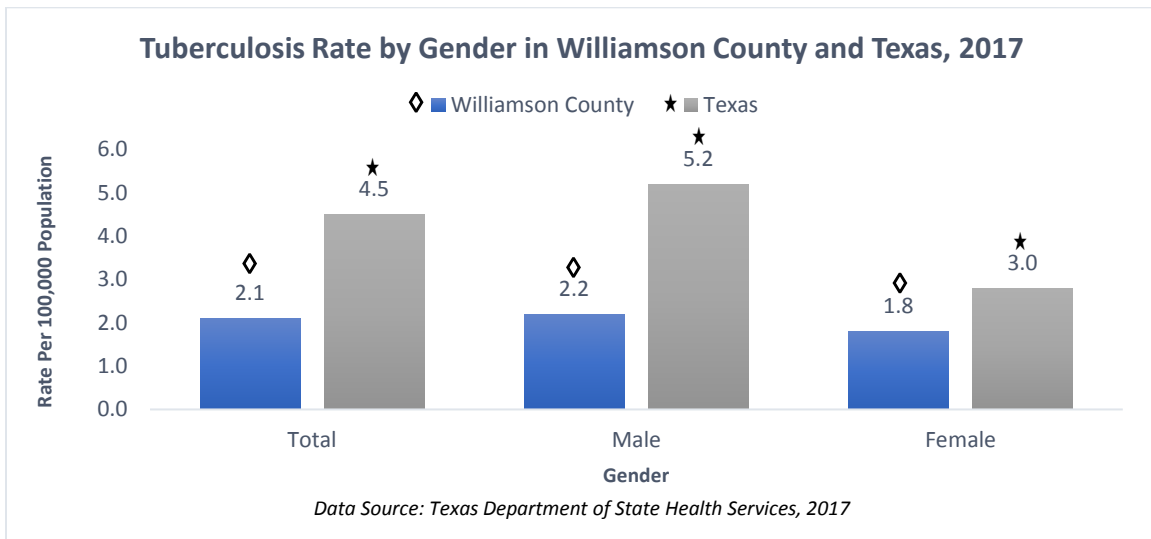


rate (2.1 per 100,000 population) (Figure 88). In Williamson County, Blacks (2.9 per 100,000 population), Hispanics (2.2 per 100,000 population), and Other racial/ethnic groups (14.9 per 100,000 population) have TB rates that are higher than the overall county value (Figure 89). Those aged 65 to 74 in Williamson County had the highest reported rate of tuberculosis (9.9 per 100,000 population) compared to other age groups and the overall value for both the county and the state (Figure 90). Moreover, those aged 18 to 24, 35 to 44, 55 to 64, and 75+ have reported TB rates that are higher than the overall county value.

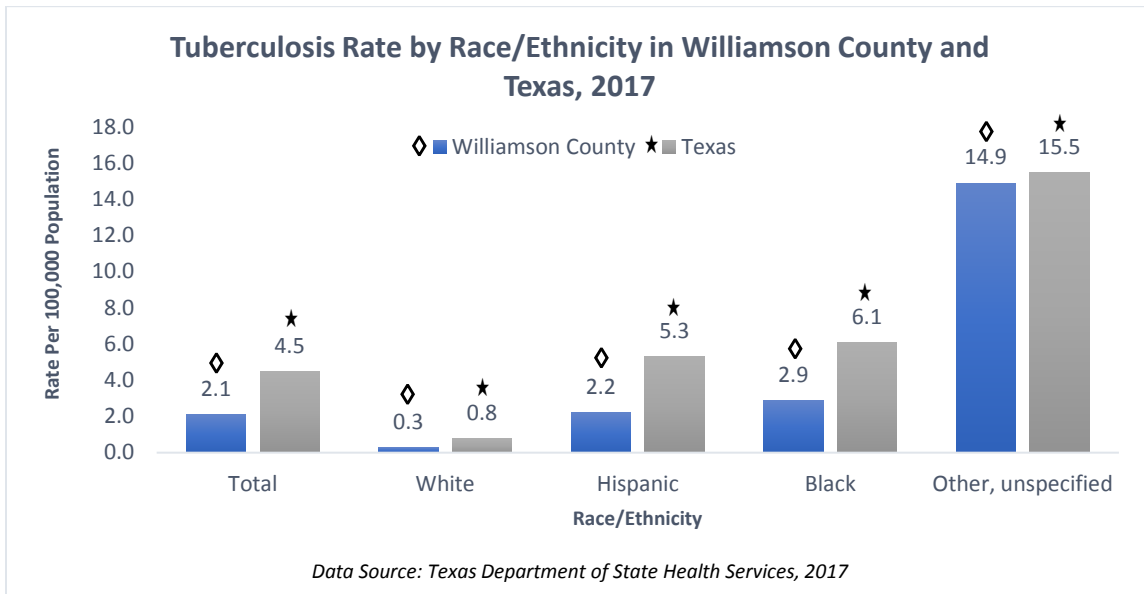
**Figure 87: Tuberculosis Rate by Year in Williamson County and Texas, 2010-2017**



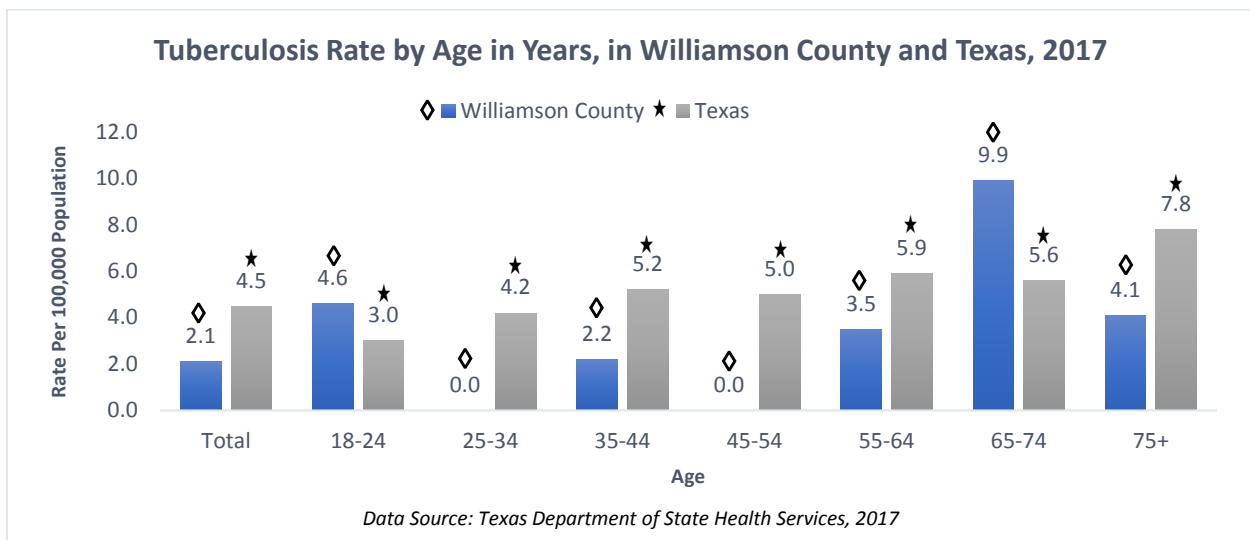
**Figure 88: Tuberculosis Rate by Gender in Williamson County and Texas, 2017**



**Figure 89: Tuberculosis Rate by Race/Ethnicity in Williamson County and Texas, 2017**



**Figure 89: Tuberculosis Rate by Age in Years Williamson County and Texas, 2017**



**Key Findings**

Despite stable reported rates of chlamydia, HIV, AIDS, and tuberculosis in Williamson County from 2010 to 2017, annual reported rates of total syphilis, P&S syphilis, and gonorrhea have increased. Many groups have remarkably high rates of communicable disease in Williamson County. Males have higher reported rates of gonorrhea, HIV, AIDS, and tuberculosis compared to females. Younger age groups, specifically those ages 15 to 24, have higher rates of syphilis, chlamydia, and gonorrhea compared to other age groups. Additionally, the 25 to 29-year-old cohort has the highest rate of HIV/AIDS. Tuberculosis is highest among the 65-74-year-old cohort. Across all diseases mentioned in this section (syphilis, chlamydia, gonorrhea, HIV, AIDS, and tuberculosis), Blacks have disproportionately-higher reported rates compared to other racial and ethnic groups.

**C11. Sentinel Events**

The data in this section highlight vaccine-preventable diseases, which include measles, mumps, rubella, tetanus, and pertussis. These diseases are classified as sentinel events, which are “cases of unnecessary disease, disability, or untimely death that could be avoided if appropriate and timely medical care or preventive services were

provided.” Additionally, this section will provide immunization data for adults and children, as well as the trend of conscientious exemptions in Williamson County and Texas.

## Vaccine-Preventable Diseases

### *Why is this important?*

The CDC recommends that people get MMR vaccine to protect against measles, mumps, and rubella. This is especially important for children, who should get one dose of MMR vaccine at 12 to 15 months of age, and the second dose at 4 to 6 years of age. Receiving both doses is 97% effective against measles and 88% effective against mumps.(92) Additionally, recommendations for pertussis and tetanus include DTaP vaccines for children younger than seven, and Tdap vaccines for older children and adults.(93)

**Table 22: Cases of Vaccine-Preventable Diseases in Williamson County, 2009-2016**

Cases of Vaccine-Preventable Diseases in Williamson County, 2009-2016								
	2009	2010	2011	2012	2013	2014	2015	2016
Measles	0	0	0	0	0	0	0	0
Mumps	0	0	1	0	0	0	0	3
Rubella	0	0	0	0	0	0	0	0
Tetanus	0	0	0	0	0	1	0	0
Pertussis	1,060	725	92	85	94	74	44	60

*Data Source: Texas Department of State Health Services, 2009-2016*

### *Findings based on Table 22:*

- **Measles** is an extremely contagious virus, with symptoms such as fever, cough, runny nose, red eyes, and sore throat.(94) There have been no confirmed cases of measles in Williamson County since 1999, which saw 2 cases reported. In Texas, one case of measles was reported in 2016.(94)
- **Mumps** is a virus with acute onset of parotitis (swollen salivary glands).(95) In 2011, Williamson County had 1 reported case of mumps, with no new cases until 2016, which saw 3 reported cases of mumps. In Texas, four outbreaks resulted in 191 reported cases of mumps in 2016, which is the highest amount of cases since 1994.(95)
- **Rubella** is a virus that causes symptoms such as rash, swollen glands, and a slight fever.(96) Complications of rubella include encephalitis and serious birth defects.(96) From 2010 to 2016, there have been no confirmed cases of rubella in Williamson County. In Texas, two cases of rubella were reported in 2015, with both cases originating from other countries. As of 2016, Texas resumed having zero cases of rubella.(96)
- **Tetanus** is a disease of the nervous system, causing lockjaw, breathing problems, severe muscle spasms and seizures, and death if left untreated.(97) In 2014, there was one reported case of tetanus in Williamson County. From 2012 to 2016, Texas had a total of 13 reported cases.(97)
- **Pertussis**, commonly known as whooping cough, is a very contagious disease that can cause serious illness in people of all ages.(93) Pertussis usually begins with cold-like symptoms and progresses to vomiting and exhaustion from frequent coughing fits. If not fully vaccinated, pertussis can result in hospitalization for pneumonia, convulsions, apnea, encephalopathy, and death.(93) Rates of pertussis in Williamson County have been stable until 2009 when WCCHD detected 1,060 cases. Since then, pertussis rates have decreased to 60 cases as of 2016. Texas saw a decrease in pertussis cases between 2013 to 2015, from 3,985 cases to 1,504 cases respectively.(93)

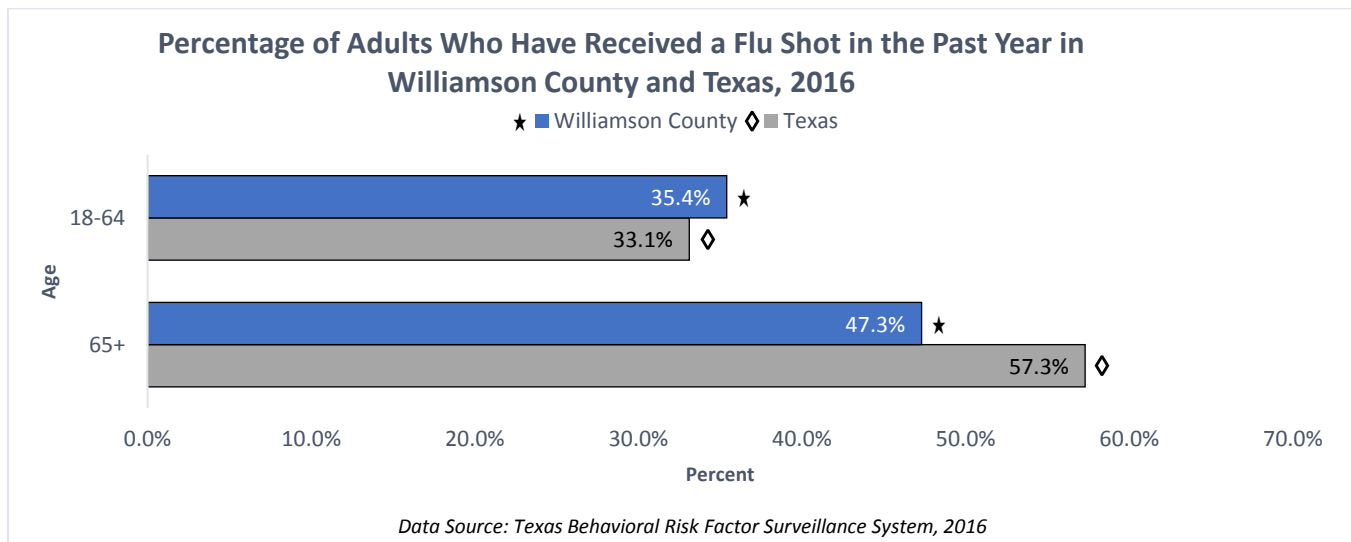
## Adult Immunizations

### Why is this important?

Influenza—also known as “flu”—is a “contagious disease caused by the influenza virus. The flu can cause severe illness and life-threatening complications particularly in older people, young children, pregnant women, and people with certain health conditions. It can lead to pneumonia and can be dangerous for people with heart or breathing conditions. The CDC estimates that in the United States, 5% to 20% of the population on average gets the flu and more than 200,000 people are hospitalized each year. The seasonal influenza vaccine can prevent serious illness and death. The CDC recommends annual vaccinations to prevent the spread of influenza.”(98)

In 2016, 35.4% of adults ages 18 to 64 reported that they had received a flu shot in the past year, which is comparable to Texas (33.1%) (Figure 91). However, the percentage of adults ages 65 and older who received a flu shot in the past year was lower in Williamson County (47.3%) compared to Texas (57.3%).

**Figure 90: Percentage of Adults Who Have Received a Flu Shot in the Past Year in Williamson County and Texas, 2016**



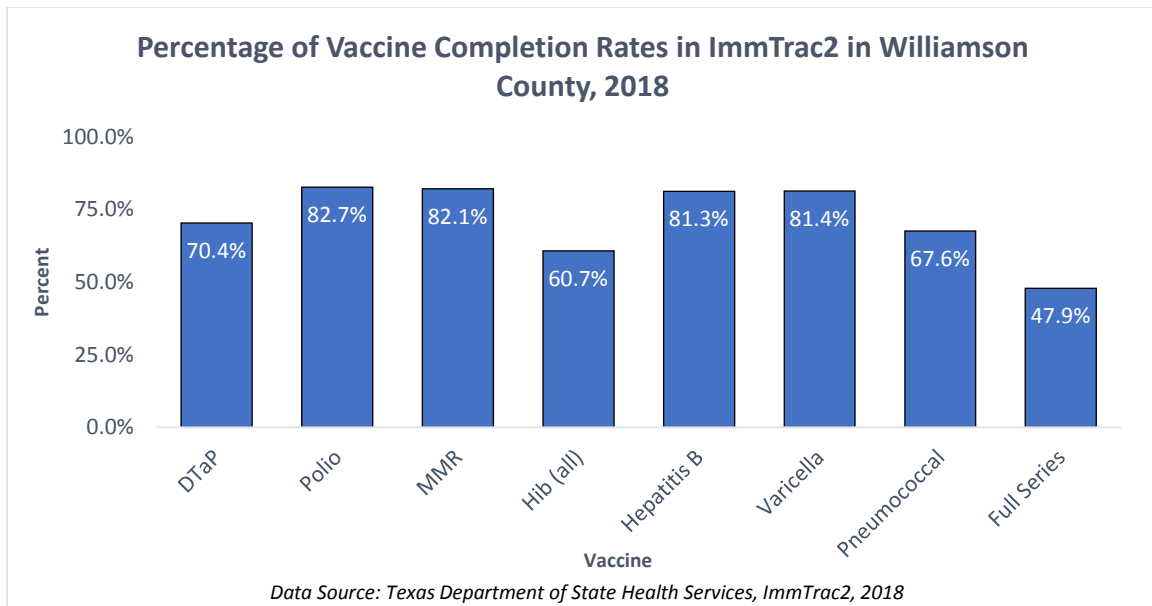
## Child Immunizations

### Why is this important?

The Advisory Committee on Immunization Practices (ACIP) recommends that all children receive routine vaccination prior to their second birthday, to protect against contracting fourteen vaccine-preventable diseases.(99) Completion of all doses of a vaccine on the recommended vaccine schedule provides the best protection for young children against harmful disease outbreaks.(99)

The data in Figure 92 are reported from ImmTrac2, which is the Texas immunization registry maintained by DSHS. ImmTrac2 is an opt-in registry that is free to use and provides a secure and confidential way to store vaccine information electronically for Texans of all ages.(100) Although healthcare providers are required to report childhood immunizations to ImmTrac2, they must also obtain parental consent, and registration of children is often missing from the system until the child’s admittance to kindergarten, where school requirements demand verification of a complete vaccination history. Due to this delay in entry and the incompleteness of vaccine records for children in ImmTrac2, the CHA team retrospectively examined vaccination rates of five-year old children to assess their status at two years of age. Although most children with data in ImmTrac2 who reside in Williamson County have received individual vaccines, such as Polio and MMR, less than half (47.9%) of five-year old children have received the full series of vaccines.

**Figure 91: Percentage of Vaccine Completion Rates in ImmTrac2 in Williamson County, 2018**



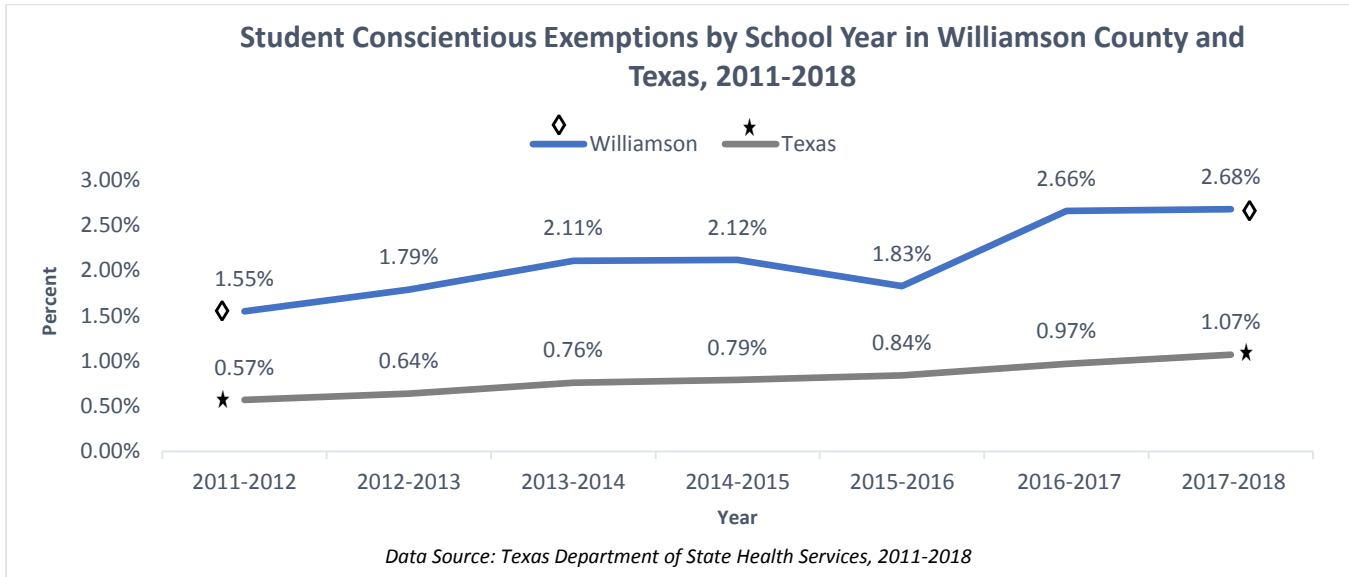
### Conscientious Exemptions

#### *Why is this important?*

Texas law stipulates that individuals can be exempt from vaccinations for reasons of conscience, which include religious beliefs.(101) As the percentage of conscientious exemptions increases, the percentage of individuals at risk for disease also increases. When a large percentage of the population is vaccinated, this indirectly offers a protective effect (“herd immunity”) to individuals who cannot be vaccinated for medical reasons or because vaccination was not successful.(102)

From 2011 to 2018, the percentages of conscientious exemptions among K-12 students has been higher in Williamson County compared to Texas (Figure 93). As of School Year 2017-18, the percentage of conscientious exemptions in Williamson County rose to 2.68%, which is the highest it’s been in the last eight years.

**Figure 92: Student Conscientious Exemptions by School Year in Williamson County and Texas, 2011-2018**



#### Key Findings

Although many vaccine-preventable diseases have been contained in Williamson County, it is crucial that immunization efforts focus on the key findings below to maintain progress and reduce the risk of future disease transmission. Additional data is needed to examine the perceptions and barriers surrounding vaccinations, specifically amongst parents and the senior population in Williamson County.

- **Increase the number of adults who receive an annual flu shot, especially for adults ages 65 and older.** This population has the highest flu-related mortality compared to other age groups, since the human immune system becomes weaker with age.(103)
- **Increase the vaccine full series completion rate for children under 2 years old.** Children this age are especially vulnerable to serious infectious diseases.(99)
- **Decrease the number of conscientious exemptions among K-12 students.** Children of all ages should receive vaccinations to help ensure their own long-term health, as well as the health of their classmates, teachers, and others in the community.(104)



## Community Themes and Strengths Assessment



**THIS ASSESSMENT AIMED TO ANSWER THE FOLLOWING QUESTIONS:**

What community barriers affect quality of life?

How is quality of life perceived in the community?

What assets are available to improve community health?

**Introduction**

The Community Themes and Strengths Assessment (CTSA) focuses on identification of current community issues, perceptions about quality of life, and community assets through feedback from community stakeholders and the general public. The questions posed in the sidebar are valuable for several reasons. First, community members become vested in the community health improvement process when they have a sense of ownership and responsibility for the outcomes. This occurs when their concerns are genuinely considered and visibly affect the process. Additionally, the themes and issues identified by asking these questions offer insight into the information and statistics identified in the other assessments. Furthermore, communities must leverage the strengths and assets of a community to improve health.

The CHA Task Force identified perceptions of quality of life, community barriers, and themes and strengths through a variety of data collection methods: the Community Health Survey, facilitated activities at community meetings, community focus groups, stakeholder focus groups, key

informant interviews, Mom’s Community Listening Forum, and the CASPER. In total, the CHA Task Force engaged over 2,681 community members and stakeholders and 182 households.

**Community Strengths and Assets**

Through the CTSA process, residents and stakeholders identified the following strengths and assets.

STRENGTHS AND ASSETS	REPRESENTATIVE QUOTE
<p><b>Access to healthcare</b></p> <p>Williamson County consists of a network of hospitals (e.g. St. David’s Georgetown, St. David’s Round Rock, Cedar Park Regional, Ascension Seton Medical Center Williamson, and BSWH Round Rock), community clinics (e.g. Samaritan Health Ministries, Sacred Heart Community Clinic, WCCHD), federally qualified health center (LSCC), and local mental health authority (BTCS). Texas A&amp;M Health Science Center College of Medicine and Nursing trains future doctors and nurses in Round Rock. Texas State University has committed to moving their entire college of Health Professions to Round Rock. In 2017, BSWH opened the first cancer center in the county. The county consists of two behavioral health treatment centers: Rock Springs and Georgetown Behavioral Health Institute. Survey respondents identified access to healthcare as the #1 factor that constituted a healthy Williamson County and the #3 strength of the county. Stakeholders cited access to healthcare as the third most important protective factor that helps people to be healthy. As the population grows, healthcare services will need to increase to meet the needs of its residents (especially for low-income underserved populations).</p>	<div data-bbox="1273 1339 1349 1417" data-label="Image"> </div> <p><i>“The cancer center, which I spend a lot of time there, which is right behind the hospital, and they’re associated with MD Anderson in Houston... the doctors over there are great...The nurses in the chemo lab are great.”</i></p>

### Clean environment

Survey respondents identified having a clean environment as the #4 factor that constituted a healthy Williamson County and the #5 strength of the county. A clean environment that includes air, water, land, and energy is essential to the health and well-being of residents. Williamson County is overall clean; however, residents in the East noted environmental factors that affected the health and well-being of its residents.



*“Yeah, and actually all the parks are well maintained. They’re clean. We have that walking trail from North Taylor all the way to South Taylor. And they keep adding new stuff.”*

### Community partnerships and collaborations

Williamson County has formed many community partnerships and collaborations over the years. Current health and wellness collaboratives include: Hutto Resource Center (formerly known as Hutto Has Heart), Round Rock Non-Profit Meeting, The Georgetown Project, Interagency Support Council of Eastern Williamson County, Inc., EWCC, West WilCo Community Resources, and the WWA. Through facilitated activities at community meetings, stakeholders identified partnerships as the #1 solution to improving health. Stakeholders noted the importance of involving residents directly affected by the issues in all aspects of decision-making. Moreover, stakeholders suggested leveraging coalitions to improve health by: 1) consolidating and providing wrap-around services at one stop shop facilities and community centers, 2) improving regional and local coordination and communication of resources and delivery of services, 3) coordinating data collection and data sharing, 4) reaching underserved and vulnerable populations, 5) breaking down silos within and outside of agencies, 6) focusing on social determinants of health, and 7) improving continuity of care for clients.



*“They had a lot of information to share with us as far as resources to help us and better our minds and stuff like that. But there’s still a disconnect I think from the community where we just didn’t get enough information out to help people know that these resources are available.”*

### Community resources

Many organizations provide community resources and services in the county. Aunt Bertha is the largest closed-loop referral network platform for social services in the United States. Service providers and individuals can search for free or reduced cost services such as medical care, food, job training, and more. As of November 6, 2018, 149 organizations have claimed 329 programs in the county. Through facilitated activities at community meetings, stakeholders identified community resources as the #1 protective factor in the county. Over half of responses answering the question “What are the things in this community that help people to be healthy?” were community resources. In addition, all community focus groups mentioned some level of satisfaction with community resources in their area. Over 50 resources related to physical activity, food pantries, behavioral health services, and afterschool programs were mentioned. For example, five out of eight focus groups mentioned access and knowledge about resources for the aging population.



*“The services here at the BACA Center has been the most blessed thing to seniors. Well, just the fact that the building is here, and it can be utilized by us seniors. We can come and socialize. You can do whatever you want to. You can play games...”*

### Community support

During community focus groups, residents frequently mentioned the community gathering together to meet the needs of its residents. During the Mom’s Community Listening Forum, the panel of moms mentioned that a strong support system from church, Facebook support groups, mother and child support groups, family and friends, and inpatient support was most important to the success of their family’s well-being. According to the Prevention Institute, “a resilient community is a community that can thrive in spite of adverse events or experiences” and a shift from community trauma to community well-being.”(105) To become more



*“Community support, feeling like they can call someone up any day and ask for help, ask for something. I think that to me from my perspective, the community support is strong.”*

resilient, the county will need to work to unite new populations as the county grows and demographics shift.

### Good education system

The county consists of 15 independent school districts fully or partially located in the county and many higher education campuses like Austin Community College, Southwestern University, Texas State University, and Texas A&M Health Science Center. Through the Community Health Survey, 1,012 respondents ranked good schools as the #1 strength. Five out of eight community focus groups mentioned the importance of school resources and the benefits of leveraging schools to deliver services to improve health of families. Focus group participants also mentioned the need to increase funding to support school activities. Stakeholders identified schools as a safe space to collocate healthcare, food, health education, afterschool, out of school, and mental health services.



*“So education opportunities I think are pretty good here in town.”*

### Low crime and safe neighborhoods

Through the Community Health Survey, residents identified low crime and safe neighborhoods as the #2 factor that constituted a healthy Williamson County and 920 respondents ranked low crime and safe neighborhoods as the #2 strength. However, focus group participants noted higher crime areas and unsafe neighborhoods in rural communities such as Bartlett and Granger.



*“Our kids can ride bikes and run around town with the other kids all day long and they’re perfectly safe.”*

### Parks, trails, and recreation facilities

The county consists of many parks, trails, and recreation facilities. According to the 2018 Comprehensive Parks Master Plan, “79% of survey respondents strongly agreed or agreed that parks, trails, and open space are a significant reason to live in Williamson County.”(106) The county consists of 208.6 miles of trails and 672.6 miles of proposed trails. Through the Community Health Survey, 737 respondents ranked use of parks and recreation as the #4 strength. Through facilitated activities at community meetings, stakeholders identified parks, trails, pools, and recreation facilities as the #2 most important factor to improve health in the county. Despite the wealth of resources, disparities still exist among the different regions. Trail growth follows population growth.(107) Precinct 1 consists of 52.5 miles of trails with 44.4 miles of proposed trails, Precinct 2 consists of 116 miles with 170.7 miles of proposed trails, Precinct 3 consists of 66.9 miles with 354.9 miles of proposed trails, and Precinct 4 consists of 45.2 miles with 102.6 miles of proposed trails. Additional resources should be allocated to the East and in smaller towns such as Granger and Jarrell. Moreover, focus group participants emphasized the priority of building connectivity between trails and communities.



*“Georgetown has awesome parks and recreation facilities. The hike and bike trails, the lake. It’s just it’s nice to be out in nature.”*

### Religious or spiritual values




Churches are an important part of the fabric of the community especially in the East. For the community, particularly among minority populations, churches are a place of security and trust. Churches like God’s Way Christian Baptist Church and Sacred Heart provide essential resources and services. Through the Community Health Survey, respondents identified religious or spiritual values as the #2 strength of the East and the #9 strength of the county. Through facilitated activities at community meetings, stakeholders identified religious or spiritual values as the #5 most important factor to improve health in the county. Focus group participants and stakeholders recommended leveraging churches to collocate and deliver services, provide programs, disseminate health information, and equip congregations to improve health of the county.



*“I feel like our church community here is really strong and does a lot to support youth and so many different aspects... I really feel like that people trust their churches and that it’s – sometimes in the community there’s some distrust of outsiders when people come in...”*

## Concerns Identified and Solutions Proposed

Through the CTSA process, residents and stakeholders identified the following concerns and proposed solutions.

CONCERNS IDENTIFIED AND SOLUTIONS PROPOSED	REPRESENTATIVE QUOTE
<b>Cross-cutting themes</b>	
<p><b>Lack of cultural competency</b></p> <p>Cultural competency is defined, as “the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.”(108) Examples of cultural competence include providing interpreter services, using community health workers, and providing training to increase cultural awareness, knowledge, and skills. Stakeholders and community residents identified the need for translation and bilingual services among community and healthcare organizations, as well as information disseminated in multiple languages.(109)</p> <p>Solutions proposed by stakeholders to improve cultural competency include:</p> <ul style="list-style-type: none"> <li>● Focus on inclusive health events, resources, and services</li> <li>● Hire more bilingual providers, staff, and translators</li> <li>● Build programming that teaches cultural competency</li> <li>● Educate on community need and empathy building</li> </ul>	<div style="text-align: center;"></div> <p><i>“We do have a population here that's Spanish-speaking, and I feel like they do get sometimes – not purposefully, excluded from... knowledge. I don't know how else to put it. And they're often – if they're undocumented, if they don't have legal status, that adds another layer of not being very protected....”</i></p>
<p><b>Lack of health equity</b></p> <p>Even though the county overall has a wealth of strengths and assets, population groups have different opportunities and resources that lead to health disparities and affect health outcomes. Both stakeholders and residents frequently mentioned differences in income, wealth, employment, access, and community resources. Residents had vastly different lived experiences depending on where they resided in the county. Vulnerable and underserved populations such as low-income, individuals with disabilities, uninsured/underinsured, and individuals experiencing homelessness especially in the East, south of Taylor, and in rural areas tend to have less access to community resources and services and worse health outcomes.</p> <p>Solutions proposed by stakeholders to improve health equity include:</p> <ul style="list-style-type: none"> <li>● Prioritize disenfranchised and minority populations</li> <li>● Address social determinants of health</li> </ul>	<div style="text-align: center;"></div> <p><i>“Everything is really to the north of town, all of the health providers north of town, all of the grocery stores are north of town, all of the schools with the exception of the high school are north of town. So that makes it hard for a lot of people in the community who don't have regular transportation.”</i></p>
<b>Social determinants of health</b>	
<p><b>Lack of affordable healthcare</b></p> <p>Lack of access and affordability of healthcare disproportionately affect individuals without healthcare insurance. Some households (6.2%) had problems getting healthcare in the past six months with most reporting barriers in accessing dental care and primary care. Six out of eight community focus groups mentioned a lack of access to healthcare.(6) Participants listed multiple contributing factors, including rising medical bills, copays, deductibles, and cost to referral services. Individuals could no longer continue to pay for long-term services such as therapy. Many families are uninsured or underinsured. The political climate continues to threaten cuts to Medicaid and Medicare. Many providers do not accept WilCo Care (the county's indigent healthcare) or Medicaid. Focus group participants noted that not all areas have the same type of access to healthcare services and resources. Individuals living in rural areas, and in the East must travel to the West to receive</p>	<div style="text-align: center;"></div> <p><i>“Mental healthcare insurance is not very fabulous... they're not getting mental health care if they don't have insurance. And if they don't have insurance... They start to isolate. And same with immigration issues and not having insurance. Like they are terrified to go</i></p>

healthcare. The East has a shortage of specialists and provider choices. Moreover, residents must spend significant time on long waiting lists to receive services at community clinics such as LSCC or BTCS. Because of such, many individuals turn to the emergency department for services, driving up the cost of uncompensated care.

*anywhere or do anything... and then they pay ungodly amounts of money for a lawyer and they have no money..."*

Cancer is the #1 cause of death in the county. Many residents (554) identified cancer as the #3 health problem of the county. In March 2017, uninsured residents with cancer were no longer able to seek cancer care services from an infusion center in Austin due to eligibility restrictions based on zip code of residence. The Williamson County cancer care system remains inaccessible for low income, uninsured, and those that lack transportation.

Solutions proposed by stakeholders to improve healthcare include:

- Increase after-hour availability to reduce waiting lists
- Provide access to telehealth services
- Offer services (dental, vision, and specialty care) in East Williamson County and in rural areas
- Lower cost of services for low-income and uninsured individuals
- Provide cancer care for the uninsured/underinsured

#### **Lack of awareness of community resources**

Even though community resources are abundant, access and awareness of resources differ by region and population. Five out of eight community focus groups mentioned a lack of access and awareness of resources. Focus group participants noted a lack of resources in the East and in rural areas such as Granger and Bartlett. Non-profits and community resources have eligibility requirements and varying hours and times that inadvertently prevent community members from accessing their services. For example, when community members graduate from programs, they can no longer receive the same services that have supported them in the past. Missing resources identified by stakeholders in the county included treatment centers, indigent care, senior services, green spaces, veteran services, social services, homeless shelters, resource centers, and recreational facilities.

Solutions proposed by stakeholders include:

- Increase coordination of services and resources
- Partner with local libraries to disseminate resources and services
- Improve inter-agency referral system through Aunt Bertha and 211, a Texas program committed to finding individuals local community resources
- Increase transitional services
- Focus on long-term support and follow-up
- Increase continuum of care and addition of community resources throughout the county
- Provide a recreational facility in Taylor



*"Because I've been here 20 something years but we never got that information. So finally, the lady she emailed me and she said she was sharing it with us so we can post it."*

#### **Lack of (public) transportation**

Since 2016, public transportation has improved in the county. Two new bus systems were established: GoGeo transit serves Georgetown and CapMetro serves Round Rock; however, problems still exist. The county is large, and resources and services are scattered across the county. About 3.9% of households had problems getting transportation in the past six months. The main barriers were "don't know how to



*"If I could speak for Regarding Cancer, one of the biggest issues we have is transportation for our*

use the bus system,” “not having a car,” and “no bus in my area.”(6) Lack of access to transportation and lack of transportation resources/options were mentioned by almost all community focus groups. Those most affected include the rural population, aging population, people with disabilities, individuals with healthcare problems, and persons with mental health issues. For example, focus group participants mentioned having to travel from Bartlett and Taylor to Round Rock for healthcare.

Solutions proposed by stakeholders to improve access include:

- Develop a low-income rideshare program and provide vouchers through the library
- Offer better and additional bus routes and schedules
- Offer a taxi service in Taylor
- Provide mobile resources and services for underserved and isolated areas

### Lack of affordable and safe housing

Housing prices in Williamson County continue to increase. According to the September 2018 Williamson County Housing Market Report, the median home price for all residential properties increased 2.1% to \$271,000 when compared to last year.(110) Focus group participants and stakeholders noted the tremendous growth of new construction across Williamson County; however, many new homes and rental properties are not affordable for current residents. As Williamson County becomes a more “affordable version of Austin,” many residents are becoming priced-out or become “stuck in the middle.” Moreover, no homeless shelters and few transitional services for individuals facing homelessness exist in the county.

Solutions proposed by stakeholders include:

- Provide emergency, transitional, and short-term supportive housing for persons in transition, homeless, and/or living with mental health and substance use
- Support local policies that aid individuals facing homelessness
- Increase subsidized housing and prioritize affordable housing for all income levels
- Offer housing that allows people with disabilities to live independently, but with support as needed
- Offer resources and navigators at affordable housing complexes

### Lack of community trust

“Community trauma is not just the aggregate of individuals in a neighborhood who have experienced trauma from exposures to violence. There are manifestations, or symptoms, of community trauma at the community level. The symptoms are present in the social-cultural environment, the physical/built environment and the economic environment.”(105) Focus group participants noted the changing community as new populations move into the county. Especially in the East, stakeholders and community members mentioned that minority groups mistrust government due to political, historical, and cultural issues. Barriers between cultures are still divisive for some areas; not everybody felt included.

Solutions proposed by stakeholders to improve trust include:

- Promote the community resiliency framework

*clients trying to get in for infusion therapy or even just a doctor's appointment. If they don't have a family member, friend, or car, we don't have really any transportation at all. And I think that's really lacking in Williamson County for people in need.”*



*“...every year I'm a piggy bank for the government. Then they say, 'Your house has increased. Then you are going to pay so much property tax.' I'm not working. So, I would be forced to sell the house.”*

*“That's the reason why we had to move here and then now they're changing housing a lot more... We used to pay \$900.00. Now it's \$1500.00.”*



*“What is Bartlett looking for now? Because those things felt really good and we would like to have some of those things back, but people are different. We've had different people move in. Some of their wants and needs may be a lot different. But the community piece is really*



- Increase family, peer, and social support
- Develop a culture of health and wellness

*missing. People are operating in silos.”*

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## Behavioral Health

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### Mental health, stress, and wellbeing

Mental health and stress affect all populations. Many survey respondents (854) ranked mental health issues as the #2 health problem and 543 residents ranked stress as the #4 health problem in the county. Through facilitated activities at community meetings stakeholders identified mental health as the #1 health problem in Williamson County. About one in ten households reported that a household member had been diagnosed by a healthcare professional with mental illness. About one in six households reported that a member of their household has sought help for mental, emotional, or behavioral health in the past six months.(6)

Community focus group participants determined several mental health, stress, and wellbeing needs in the community. These needs included an increase in resources that address ongoing therapy and counseling, funding for BTCS, affordable mental health care services, and awareness of mental health resources. Additionally, focus group participants mentioned the need to decrease the disconnect between the population and the importance of mental health, and reduce the stigma of mental health.

During the Mom’s Community Listening Forum, the panel identified managing mental and emotional health (such as post-partum depression, managing stress and anger) as the #1 concern for mothers. In addition, moms had concerns about providing for a child who has mental health issues or special needs.

Solutions proposed by stakeholders to improve mental health include:

- Improve the behavioral health system continuum of care
- Shift to trauma-informed care and resiliency model across systems
- Increase peer support groups
- Increase access to mental health services and providers that accept Medicaid and Medicare
- Decrease mental health stigma in the family, church, law enforcement, and in the community
- Improve awareness of mental health services and “warning” signs
- Reduce cost or consider sliding fee scale for mental health services
- Establish a formal mental health court
- Hire more diverse mental health professionals
- Offer resources after an event such as post-suicide
- Expand emergency mental health services such as Williamson County EMS Mobile Outreach Team (MOT) and Crisis Intervention Team (CIT)
- Increase local and state-funded beds for inpatient treatment for mental illness and substance use disorders, especially for low-income individuals
- Increase early intervention services and mental health care in schools
- Increase inpatient and outpatient rehabilitation services



*“Another big concern I have is ongoing therapy. So, I provide therapy in the school, but if there was ever a need for someone who wasn't associated with this school, then they are going to have to drive so far. And Bluebonnet Trails and Lone Star Circle of Care are both great organizations, but they – they're limited in funding. And so, it's hard – people can usually access a consultation for medication because they're not going in as often for that. But I feel like there's a real lack of kind of consistent – when people need weekly counseling, that doesn't end up happening unless it's through the school.”*

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### Substance abuse and use

Survey respondents identified drug abuse as the #3 health problem in the East. In addition, stakeholders identified substance abuse and use as the #2 health problem in the county. Focus group participants noted increase substance abuse in rural





areas, continued stigma about substance abuse, the relationship between substance abuse with mental health, the lack of awareness for substance abuse resources, and the need for more resources in East Williamson County.

People with mental and/or substance use disorders account for 40% of all cigarettes smoked in the United States. “Research shows that quitting smoking can improve mental health and addiction recovery outcomes.”(111) Through the CASPER, one in five (21.6%) households in the county reported that a member of their household uses tobacco products, which may include vaping and e-cigarettes.(6)

Solutions proposed by stakeholders to decrease substance abuse and use include:

- Increase substance abuse programs and resources especially for rural communities
- Consider a recovery-oriented system of care
- Consider alternative recovery support systems such as sober housing, housing for people with mental illness, and family recovery groups

*“My thought was about the substance use. We don't have any place for anyone to get detox, go into recovery, get any help, or even long-term help. And there does seem to be quite a bit of substance use in this town. And severe, significant substance use. And so, I think that's led to some of the theft over here...”*

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## Chronic Disease and Risk Factors

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### Chronic Disease (Obesity and Diabetes)

Obesity affects a large proportion of residents living in Williamson County. A majority of survey respondents (858) identified obesity as the #1 health problem. Stakeholders identified obesity as the #4 health problem. Focus group participants identified the need for a recreation center in Taylor, more community sport leagues and activities for children and adolescents, nutritional programs and outreach education, programs to address childhood obesity and tackle poverty, and more afterschool and summer activities.

Through the CASPER, more than one in seven households in the county (14.4%) reported a family member diagnosed with diabetes.(6) Residents identified diabetes as the #5 health problem in the county. Through activities at community meetings, stakeholders identified diabetes as the #5 health problem. Focus group participants mentioned concern for diabetes management and care, and the cost of diabetes.

Solutions proposed by stakeholders to decrease prevalence and incidence of diabetes include:

- Increase wellness and diabetes management classes
- Prescribe healthy diet regimens
- Partner between medical providers and food pantries to provide healthy foods for patients with chronic health conditions



*“I used to work in Taylor in the school district. And we – as school nurses we do screenings for high risk diabetes, and there were a lot of kids... from pre-K, kindergarten, first, third, and fifth she had 30 kids that were high risk for pre-diabetes and were already hypertensive.”*

### Lack of healthy food access

Several food deserts exist in Williamson County in Southeast Georgetown, Leander, Taylor, east of I35 in Round Rock, and in the rural areas of the North in Florence, Jarrell, Bartlett, and Granger. Stakeholders identified lack of access to healthy food as the #3 health problem and #2 risk factor in the county. Almost one in ten (9.7%) households reported having barriers that prevent them from eating healthfully. Of those households, most reported that healthy eating is “too expensive” (59.8%), followed by having “lack of interest” (24.2%), and “lack of time” (19.7%).(6) Focus group participants identified lack of access to healthy grocery stores, rotting



*“One of the things is the restaurants. All of them are hamburger, pizza. You have a few Mexican restaurants, but you know, kids... we do have Subway, but I wish we had other – We have*

vegetables at corner stores, unhealthy restaurants, and scarce healthy food options in the county.

Solutions proposed by stakeholders to improve healthy food access include:

- Increase access to healthy food pantries and community gardens
- Expand food pantries to offer fresh food for families
- Increase grocery store access in East Williamson County and rural areas

*McDonald's, we have Whataburger, and now they're making the Burger King. All burgers."*

### Physical inactivity

Almost one out of three households reported that they performed physical activity 4-6 days per week during the past week, followed by 1-3 days per week (30.6%), 0 days per week (18.6%), and 7 days per week (16.7%). In addition, households reported that they are most physically active at gyms/fitness centers (29.9%), parks/trails (18.8%), and at home (18.6%). Approximately 19% of households reported having barriers or challenges that prevent physical activity. Of those households, over half (55%) reported that injury/illness/disability prevents them from being physically active, and almost a third (30%) reported that lack of time prevents them from being physically active.<sup>(6)</sup> Focus group participants identified concerns about exercising while aging, safety concerns that prevent people from going out to exercise, and the lack of recreational facilities in the East and in rural areas.



*"For me, my wife, we're empty nesters. All our kids have moved out. We're both 58 years old. I guess for us, it's the concerns of finding ways to stay active as we grow older."*

Solutions proposed by stakeholders to improve physical activity include:

- Increase access points and parking for established trails
- Provide free, safe places to exercise
- Develop park for physically challenged individuals
- Increase sport leagues and activities for children and adolescents

## Underserved and Vulnerable Populations

Through the CTSA process, residents and stakeholders identified the following underserved populations.

### UNDERSERVED POPULATION

**Low income population:** *"I can't work... I'm getting on my feet and then I don't have child care so I'm back in a hole. And that messes me up all the time... It's hard to find child care. And even if we did, it's very expensive. For me, I have four kids, so that's really hard to even pay for. It's like you're working just to pay."*

**Aging population:** *"I used to take very good care of my teeth. But I cannot afford it. I don't have dental insurance. I'm paying now half of my Social Security for health insurance. And yes, it does affect your nutrition. I can't really chew some of the things... Yes, it's very hard to get dental care. Well, you can't afford it – I can't – when you're a senior."*

**Individuals living with disability:** *"I hear a lot of individuals talking about the fact that they're on some form of disability. You'd like to better yourself so maybe get a job... and that sounds simple. Want more money? Go get a job, right? But it affects you so negatively at least for a while unless your income was going to grow very quickly very in large amounts. There's a period of time at which one is very much financially at risk which puts everything at risk, your housing, your food, your medical, transportation. All of these areas are in jeopardy if somebody is on some form of disability and would like to better themselves."*

**Uninsured/underinsured population:** *"Living in a state that has no health insurance for anybody. Medicare you have to be over a certain age, and you have to be disabled or pregnant. There's no insurance here for anyone... There's no safety net in this state."*

**Individuals living with homelessness:** *“I got hit by 18-wheeler and had 5 blood clots... We’ve never been homeless in our lives... We have no help. I was paying \$300.00 to the Luxury Inn for two months. I exhausted all my money. I have nothing but our clothes on our backs. And all I dream is just to have a one bedroom. That’s all I want is a house, a home, we could call it a home and I could be happy and go to work once again, do my two jobs...”*

**Rural population:** *“It’s very challenging to navigate county services, because my students are divided between three counties: Williamson, Bell, and Milam... I’ll get a kid set up and then they’ll move one block and then I will have to completely get them set up again with the other county...understandably funding is very tight in these [rural areas]– mental health in particular – they are not going to keep a kid on their case load if they are not geographically in the right area...”*

## Implications for Williamson County

The CTSA identified nine strengths and assets, two cross cutting themes, and ten concerns.

STRENGTHS AND ASSETS	CONCERNS IDENTIFIED
<ul style="list-style-type: none"> <li>• Access to healthcare</li> <li>• Clean environment</li> <li>• Community partnerships and collaboration</li> <li>• Community resources</li> <li>• Community support</li> <li>• Good education system</li> <li>• Low crime and safe neighborhoods</li> <li>• Parks, trails, and recreation facilities</li> <li>• Religious or spiritual values</li> </ul>	<p><b>Cross-cutting themes</b></p> <ul style="list-style-type: none"> <li>• Lack of cultural competency</li> <li>• Lack of health equity</li> </ul> <p><b>Social determinants of health</b></p> <ul style="list-style-type: none"> <li>• Lack of affordable healthcare</li> <li>• Lack of awareness of community resources</li> <li>• Lack of (public) transportation</li> <li>• Lack of affordable and safe housing</li> <li>• Lack of community trust</li> </ul> <p><b>Behavioral health</b></p> <ul style="list-style-type: none"> <li>• Mental health, stress, and wellbeing</li> <li>• Substance abuse and use</li> </ul> <p><b>Chronic disease and risk factors</b></p> <ul style="list-style-type: none"> <li>• Chronic Disease (Obesity and Diabetes)</li> <li>• Lack of healthy food access</li> <li>• Physical inactivity</li> </ul>

Both the 2016 and 2019 CHAs identified similar strengths and assets in the county; however, the 2019 CHA identified three additional strengths (community support and resiliency, low crime and safe neighborhoods, and a clean environment) that can be leveraged to improve health. Both the 2016 and 2019 CHA identified similar concerns in the county; however, the 2019 CHA highlights two cross cutting themes and emphasizes the importance of improving social determinants of health, behavioral health, and chronic disease risk factors.

While the CTSA revealed many positive aspects and an overall good perception of quality of life in Williamson County, participants identified many areas for improvement. A major theme voiced by stakeholders and residents was that of disparity. Differences in income, wealth, access, and resources lead to highly varied lived experiences and health outcomes in the county. Vulnerable and underserved populations such as low-income, individuals with disabilities, uninsured/underinsured, aging population, and individuals experiencing homelessness tended to have less access to community resources and services. The following quotes from focus group participants highlight these differences:

### Access to healthcare

*"I think Georgetown Hospital is excellent... I think the personnel there are excellent. I think these two or three new facilities they've got out on Austin Avenue that have every doctor you can think of, just make the one stop, you don't have to go all over town. This is for the Georgetown area."*

*"Dental care. Everywhere I went they want thousands and thousands of dollars. And they're willing to finance it for you but then you can't pay for it. And I would be willing to pay a nominal amount but even with your health insurance through Medicare you only get a few things."*

### Clean environment

*"Yeah, and actually all the parks are well maintained. They're clean. We have that walking trail from North Taylor all the way to South Taylor. And they keep adding new stuff."*

*"People had asthma and emphysema and all that stuff that the cotton does... It's got that gin sitting there and then it's got cotton over there... we got a black person icon, Martin Luther King, named there and then they got cotton over there... the streets are dirty and it's got cotton laying on the side of the road because it blows off and it just litters the road from Martin Luther King and Walnut."*

### Healthy food access

*"I was going to say we've got a number of these fresh produce markets that come up three, four times a week. So you – local farmers bring in produce..."*

*"Finally, the parent gets to a doctor and they say, 'You need to increase more fruits and vegetables and have more activity.' In Bartlett you have one grocery store with fruits and vegetables that most of the time are rotten."*

### Parks, trails, and recreation facilities

*"Georgetown has awesome parks and recreation facilities. The hike and bike trails, the lake."*

*"You've got to go way across town. They're building all the parks. They're building parks over there four miles out and nobody can get to it. The kids over on this side can't get a ride over there."*

The CTSA process revealed multiple ways to leverage existing resources and provided a comprehensive understanding of the perceptions of values, concerns, and assets in the county. While most acknowledged the many challenges that lay ahead, community members, stakeholders, and leaders in this assessment anticipated improvements in the health and wellness where they live, work, worship, play, or learn in Williamson County.



# Forces of Change Assessment

**THIS ASSESSMENT AIMED TO ANSWER THE FOLLOWING QUESTIONS:**

What is occurring or might occur that affects the health of our community or the local public health system?

What specific threats or opportunities are generated by these occurrences?

**Introduction**

The purpose of the Forces of Change Assessment (FoCA) is to identify trends, factors, or events that influence the health and quality of life of the community and the local public health system. “Forces” include dynamic factors like legislation, technology, and other impending changes that affect the context in which the community and the local public health system operate. The health of a community is affected by many factors, or determinants. Social determinants of health include the complex, integrated, and overlapping social structures and economic systems. These systems include the social, physical, and built environments, as well as the intangible systems of *access* to necessities like food, water, housing, healthcare, education, and employment.

The CHA Task Force used a “Voice of the Customer” (VOC) approach to identify forces of change through active participation with community members. Stakeholder and community member feedback was captured through a variety of methods, including community focus groups, stakeholder focus groups, and key informant interviews.

The CHA Task Force identified forces of change that affect health and quality of life in residents and developed force field

diagrams to display some of the specific threats and opportunities generated by these forces. According to the American Society for Quality, a force field diagram assumes “that any situation is the result of forces for and against the current state being in equilibrium. Countering the opposing forces and/or increasing the favorable forces will help induce a change.”(112) Force field diagrams were developed for access to affordable housing (Table 23) and access to community resources (Table 24).

**Forces of Change**

Through the FoCA process, the CHA Task Force identified eight forces of change.

FORCES OF CHANGE	REPRESENTATIVE QUOTE
<p><b>Affordability and cost of living increases</b>                      Cost of living in the county continues to rise as more individuals (especially from Austin) move into the area and the county develops. Services and basic needs are becoming less affordable for residents that have always lived in the county. Focus group participants mentioned rising property taxes, annual taxes, and gas prices in the area.</p>	<div data-bbox="1143 1465 1227 1535" data-label="Image"> </div> <p><i>“My family is low income so it’s really hard for us... we have to go to the food bank every month. And they’re raising taxes... t’s been kind of hard for us to buy food because they’re raising food prices up so much that we barely get through.”</i></p>
<p><b>City development</b>                      The county continues to develop as more individuals move into the county. Neighborhoods, hospitals, restaurants, and schools are being developed to keep up with growth. Resources will continue to follow as the county grows.</p>	<div data-bbox="1146 1728 1224 1801" data-label="Image"> </div> <p><i>“Williams Drive is going to get even worse now that they’re building all the multiple housing units. 843 units are going in on Williamson, or Williams Drive.”</i></p>

### Current events

Current events such as recent suicides and school shootings in the nation continue to affect the behavioral, emotional, and physical health and wellness of residents.



*"It was super rare to have a school shooting. But now that we're having so many..."*

### Demographic changes

The population of the county is aging. Senior specific resources and services need to increase to match the needs of new residents. Minority populations (Hispanic/ Latino and Asian/South Asian) are increasing in the county. Culturally competent services and resources that address language barriers (in addition to Spanish) need to increase to match the needs of new residents.



*"I don't know if this is a change over the past few years or if it's just because I'm not used to it. It's probably because of how fast Georgetown is like growing and the demographics that tend to come in."*

### Political climate

Due to shifting priorities at the state and national level, there have been funding cuts for social services, access to healthcare, and access to affordable health insurance. Additionally, the political climate has led to greater fear of undocumented residents receiving resources and services. Issues such as homelessness and access to affordable services should be addressed by county officials and government leaders.



*"At the national level, things are happening, I think that may impact people to not want to inquire about services and things. It'll scare people away, and that'll just make things worse for them and for the community as a whole..."*

### Population growth

Population is rapidly growing. Many residents (who are primarily wealthy) are moving into the county from surrounding areas. While less populous areas are in greater need of resources for basic needs, more populous areas receive more attention and resources to accommodate increased growth.



*"Taylor is going to start to grow, so we have to be ready to handle that growth."*

### Social media and changes in technology

Social media use continues to increase in pervasiveness in the county and nationwide. Social media affects how individuals, especially children and youth, connect with one another. Many older adults are struggling to adapt to technological changes, and the impact that social media has had on individuals and the community.



*"Now it's like everybody just kind of wants to keep to themselves. And how do we bring that community back, the community involvement togetherness? I think a lot of it does have to do with social media. If I had one wish, I take away Snapchat, Instagram, all that stuff."*

### Urbanization and gentrification of rural areas

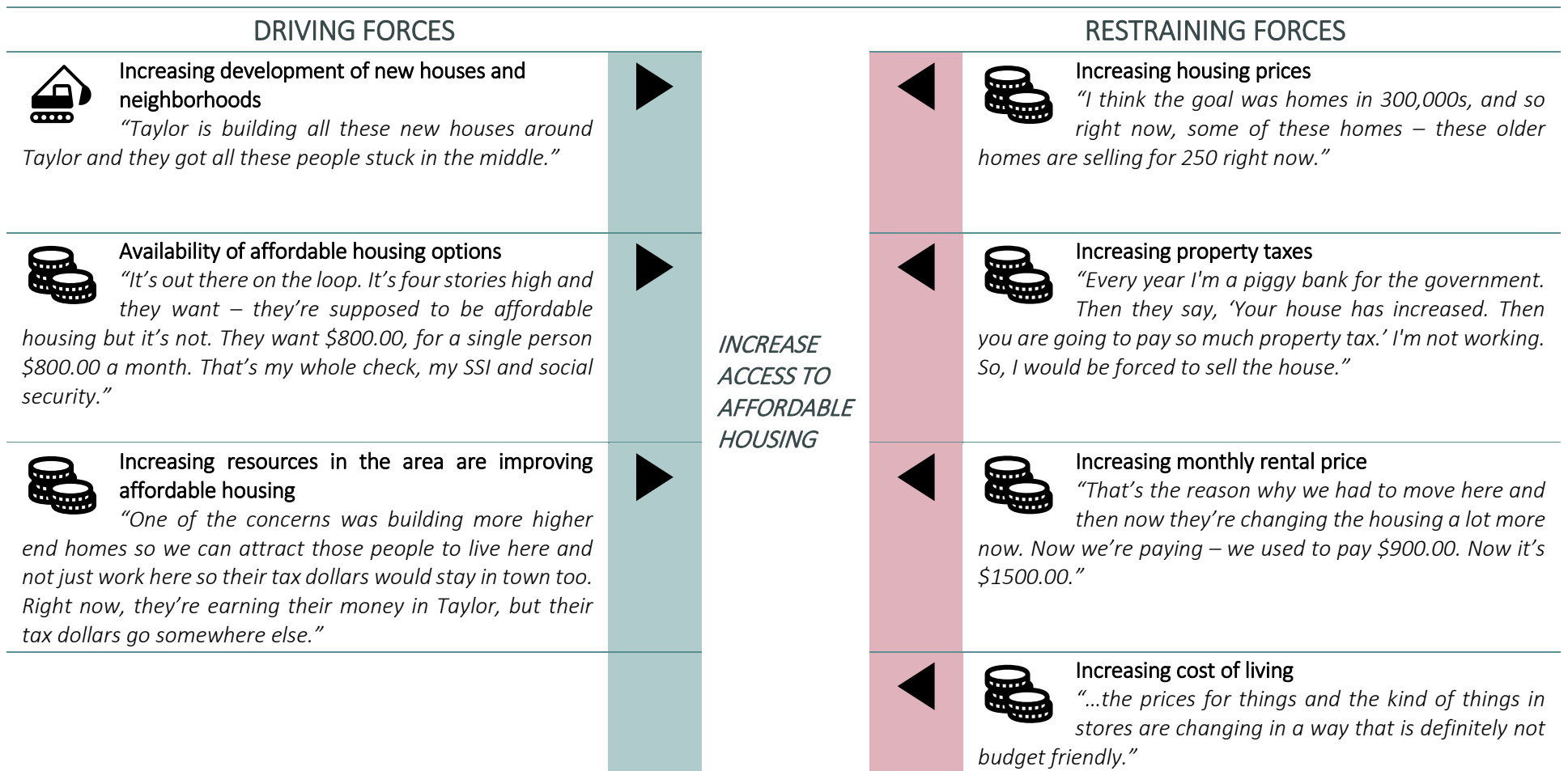
Individuals from surrounding counties continue to move in to traditionally rural areas in the county, especially in the East and in cities like Leander. Rapid gentrification exacerbates income disparity and health inequity. While cities may have good intentions to develop new community resources for new residents, attention should also be placed on taking care of current residents and their needs.



*"Well, the housing, seems like Taylor is building all these new houses around Taylor and they got all these people stuck in the middle. And they're not really just coming out trying to help them..."*









**Table 23: Access to Affordable Housing Force Field Diagram**



*INCREASE  
ACCESS TO  
AFFORDABLE  
HOUSING*

**Table 24: Access to Community Resources Force Field Diagram**

DRIVING FORCES		RESTRAINING FORCES
 <p><b>Increasing awareness of resources through social media</b>  <i>“Use the media to bombard people from every angle with information about health events and resources.”</i></p>	▶	 <p><b>Increasing fear in accessing community resources</b>  <i>“I put that one up there, and just because of at the national level, the things that are happening, I think that may impact people to not want to inquire about services and things. It’ll scare people away, and that’ll just make things worse for them and for the community as a whole... ”</i></p>
 <p><b>Increasing community resources because of population growth</b>  <i>“...hopefully there’s more things as Taylor grows, which it’s going to grow. Hopefully there’ll be things for more senior people to be.”</i></p>	▶	 <p><b>Lack of funding in rural communities</b>  <i>“With the economics being down the school just doesn't have funding to do that. And I think it involves creativity with finding funding sources in the summertime.”</i></p>
<p><b>Increasing support from community partners and organizations</b>  <i>“We have to find ways to make sure we let people know this is a safe haven and this is how this works. We’re not going to ask you are you illegal...”</i></p>	▶	 <p><b>Changes in access because of city development</b>  <i>“My dad was an addict, an alcoholic. They changed where the AA meetings were held. The city purchased the land that the former place was on and they lost that place and all of its memories and now have to give help to just as many if not more people in a much smaller area, a much smaller space which I don’t think is really going to help.”</i></p>
<p><b>Continued advocacy and support from the community especially from churches and other religious organizations</b>  <i>“Every church donates. All the churches donate to the food pantry, organizations like the Knights of Columbus or SBGST. They’ve donated to food banks money so that they can buy the groceries and things like that.”</i></p>	▶	 <p><b>Lack of resources and staff for rural communities</b>  <i>“I get so furious when the federal government and the state says oh, we’re going to do grants. Well, that automatically eliminates rural communities and rural schools because we don’t have the staffing to write the grant to go get it to bring it in. But that’s an easy way for the state government or the federal government. We’re doing these wonderful things for you but only the communities that have the resources and can write that are out there.”</i></p>

*INCREASE ACCESS TO COMMUNITY RESOURCES*

## Implications for Williamson County

The purpose of this assessment was to identify the *external* factors that affect the environment in which the Williamson County public health system operates, as well as the challenges and opportunities created by these factors. The eight forces of change identified through this assessment were:

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### FORCES OF CHANGE

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- Affordability and cost of living increases
  - City development
  - Current events
  - Demographic changes
  - Political climate
  - Population growth
  - Social media and changes in technology
  - Urbanization and gentrification of rural areas
- 

Forces of change that were identified both in 2016 and in 2019 were growth of the county, demographic changes, technology changes, political climate, and economic changes. In 2019, the CHA Task Force identified three new forces of change: affordability and cost of living increases, city development, and urbanization and gentrification of rural areas.

The information gathered through the FoCA was an important component of the MAPP process because it provided context for many of the key issues in the community. As community partners come together to identify key strategic issues and priorities for action in Williamson County, they will use these findings in conjunction with the other three MAPP assessments for a comprehensive picture of the community's health status.



# Local Public Health Systems Assessment

**THIS ASSESSMENT AIMED TO ANSWER THE FOLLOWING QUESTIONS:**

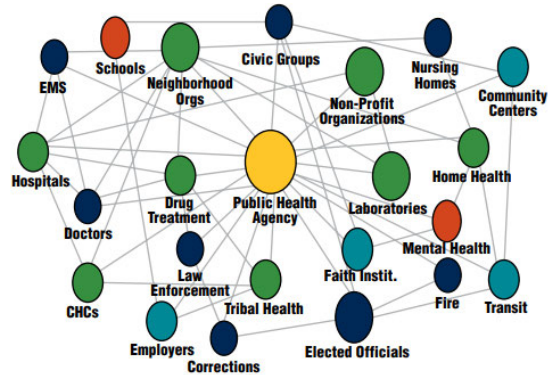
What are the components, activities, competencies, and capacities of our local public health system?

How are the Essential Services being provided to our community?

## Introduction

The Local Public Health Systems Assessment aims to answer two primary questions on the components of the system and the provision of essential services to the community. The information obtained from this assessment will be used to improve and to better coordinate public health activities at local levels. The results gathered provide an understanding of how the Williamson County public health system is performing and can help local partners make more effective policy and resource decisions to improve public health. The local public health system is defined as “all entities that contribute to the delivery of public health services within a local area.”(14) These entities include but are not limited to organizations indicated in Figure 94.

**Figure 93: Local Public Health System**



*Image Source: NPHPS (Performance Standards) Local Public Health System Performance Assessment Instrument (Local Instrument)*

The local public health system is responsible for delivering the Ten Essential Public Health Services (Figure 95), which describe the public health activities that all local communities should undertake:(113)

1. Monitor health status to identify and solve community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships and action to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure competent public and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

**Figure 94: Ten Essential Public Health Services**



*Image Source: Centers for Disease Control and Prevention*



The CHA Task Force assessed the local public health system by 1) administering a survey adapted from the National Public Health Performance Standards (NPHPS) Local Assessment Instrument to organizations that represented the local public health system; and 2) conducting a facilitated activity among WCCHD leadership to understand the root cause of the lowest-ranked performance measure.

Due to limited time and resources, the CHA Task Force modified the NPHPS Local Assessment Instrument into a survey. The CHA Task Force identified 33 performance measures from the instrument to evaluate delivery of the Ten Essential Public Health Services. Survey can be found in Appendix O: Local Public Health Systems Survey. The CHA Task Force selected measures for which they had limited knowledge on performance of service or where perception of delivery of service in the community was unclear. For each performance measure, respondents were asked two questions: 1) To what extent does your organization do this? and 2) How well is this done in the local public health system? Respondents were asked to rate the activity level using a five-item scale ranging from “No Activity” to “Optimal Activity.” The question “To what extent does your organization do this?” was adapted from the Austin Public Health System Assessment.(114)

According to the Local Assessment Instrument:

- Optimal Activity is defined as “greater than 75% of the activity described within the question is met.”
- Significant Activity is defined as “greater than 50% but no more than 75% of the activity described within the question is met.”
- Moderate Activity is defined as “greater than 25% but no more than 50% of the activity described within the question is met.”
- Minimal Activity is defined as “greater than zero but no more than 25% of the activity described within the question is met.”
- No Activity is defined as “0% or absolutely no activity.”

Respondents who were asked to take the survey represented the primary organizations involved in the Williamson County public health system. From August 14, 2018 to September 12, 2018, WCCHD DLT and the organizations representing the 2019 CHA Task Force completed the survey via Survey Monkey. Results were ranked and

averaged. Each of the Ten Essential Public Health Services was given a score by averaging the relevant performance measures.

The lowest-ranked measure was addressed in detail during a subsequent facilitated activity with DLT on September 17, 2018. DLT participated in an hour-long facilitated activity using quality improvement tools such as the fishbone diagram and the 5 Whys activity to better understand the root causes of the lowest ranked performance measure.

## Williamson County Public Health System

### Survey

The Task Force received 16 responses from the following seven organizations:

- Bluebonnet Trails Community Services
- Georgetown Health Foundation
- Langlois Consultant Services, LLC (on behalf of EWCC)
- Lone Star Circle of Care
- Opportunities for Williamson and Burnet Counties
- St. David's Foundation
- WCCHD

WCCHD completed ten surveys. Each of the WCCHD division directors and the WWA Coalition Coordinator were asked to complete the survey because each of the divisions are highly involved in delivering the Ten Essential Public Health Services.

The Ten Essential Public Health Services were ranked by the average LPHS scores for its related performance measures. All but one of the Ten Essential Public Health Services were ranked between moderate and significant activity. Table 25 displays the aggregated average scores for how well organizations believe that the essential service is being delivered in the local public health system at large, the extent to which organizations believe that *they* deliver the service, and the number of performance measures for each service. Disparities between how organizations ranked themselves versus the health system of which they are a part might reveal a perception of internal strengths or weaknesses relative to the LPHS at large. While this assessment lacks the data to investigate their underlying cause, these differences may be used to inform future assessments tools, in order to dive deeper into organizational perceptions and leverage those disparities to make collaborative improvements at the LPHS level. A complete ranking of performance measures can be found in Appendix P: Local Public Health System Assessment Results.

**Table 25: Essential Public Health Services Ranked by Average LPHS Score**

RANK	ESSENTIAL PUBLIC HEALTH SERVICE	LPHS	ORGANIZATION	NUMBER OF MEASURES
1	4: Mobilize community partnerships	3.57	4.17	2
2	2: Diagnose and Investigate	3.42	2.97	4
3	6: Enforce laws	3.38	3.19	3
4	3: Inform, educate, empower	3.38	3.14	5
5	7: Link to/provide care	3.26	3.40	3
6	1: Monitor Health	3.25	3.31	2
7	5: Develop policies	3.24	3.16	5
8	10: Research	3.15	3.51	3
9	9: Evaluate	3.03	3.44	3



Table 26 highlights the five performance measures that were rated the highest for the local public health system and the corresponding score for the organization. Two out of the five highest-ranked performance measures were related to Essential Service #4: Mobilize community partnerships and action to identify and solve health problems. The highest-ranked performance measure was *Measure 6.1.2. Stay up-to-date with current laws, regulations, and ordinances that prevent health problems or that promote or protect public health on the federal, state, and local levels.*

**Table 26: Top Five Highest Ranked LPHS Performance Measures**











RANK	PERFORMANCE MEASURE DESCRIPTION	LPHS	ORG
1	 6.1.2. Stay up-to-date with current laws, regulations, and ordinances that prevent health problems or that promote or protect public health on the federal, state, and local levels?	3.86	3.64
2	 4.2.1. Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?	3.60	4.27
3	 5.1.1. Support the work of the local health department (or other governmental local public health entity) to make sure the 10 Essential Public Health Services are provided?	3.57	3.79
4	 4.2.3. Assess how well community partnerships and strategic alliances are working to improve community health?	3.53	4.07
5	 2.1.2. Provide and collect timely and complete information on reportable diseases and potential disasters, emergencies, and emerging threats (natural and manmade)?	3.50	2.88

Table 26 highlights the five performance measures that were rated the lowest for the local public health system and the corresponding score for the organization. Three of the five lowest-ranked performance measures were related to Essential Service #8: Assure competent public and personal health care workforce. The lowest-ranked performance measure was *Measure 8.4.4. Provide opportunities for the development of leaders who represent the diversity of the community.* According to the RWJF, health equity “means that everyone has a fair and just opportunity to be healthier.”(3) To improve health equity, the Williamson County public health systems needs to improve the delivery of services in a culturally competent manner, engage the diversity of the community, and evaluate whether strategies taken improve county’s health.

**Table 27: Top Five Lowest Ranked LPHS Performance Measures**

RANK	PERFORMANCE MEASURE DESCRIPTION	LPHS	ORG
29	 9.1.2. Assess whether community members, including vulnerable populations, are satisfied with the approaches taken toward promoting health and preventing disease, illness, and injury?	2.92	3.23
30	 8.3.1. Identify education and training needs and encourage the public health workforce to participate in available education and training?	2.85	3.31
31	 10.3.3. Share findings with public health colleagues and the community broadly, through journals, Web sites, community meetings, etc.?	2.85	3.15

32		8.3.5. Continually train the public health workforce to deliver services in a culturally competent manner and understand the social determinants of health?	2.77	3.15
33		8.4.4. Provide opportunities for the development of leaders who represent the diversity of the community?	2.46	2.62

### DLT Facilitated Activity

From the survey results, the CHA Task Force identified the problem statement: The Local Public Health System provides insufficient opportunities for development of leaders who represent the diversity of the community. Using quality improvement tools (the fishbone diagram and the 5 Whys), WCCHD DLT identified root causes related to time and resources, knowledge, policies/methods/procedures, people and staff, public health as a dynamic system, and collaboration and partnerships as main topics for discussion.

Figure 96 is the fish bone diagram of the discussion. Ongoing turnover and leadership changes, as well, as a lack of time, resources, and staff in the public health system were root issues identified as barriers to leadership development. Because staff in the local public health system is responsible for delivering services and meeting deadlines, they have little time to develop and participate in the opportunities for development. Moreover, partners in the public health system need to improve communication, networking, and sharing of training and educational resources. Organizations will need to increase staff awareness of cultural competency and leadership development resources in the county. Results obtained from the survey and the facilitated activity will guide the health department to improve opportunities for development of leaders.

### Implications for Williamson County

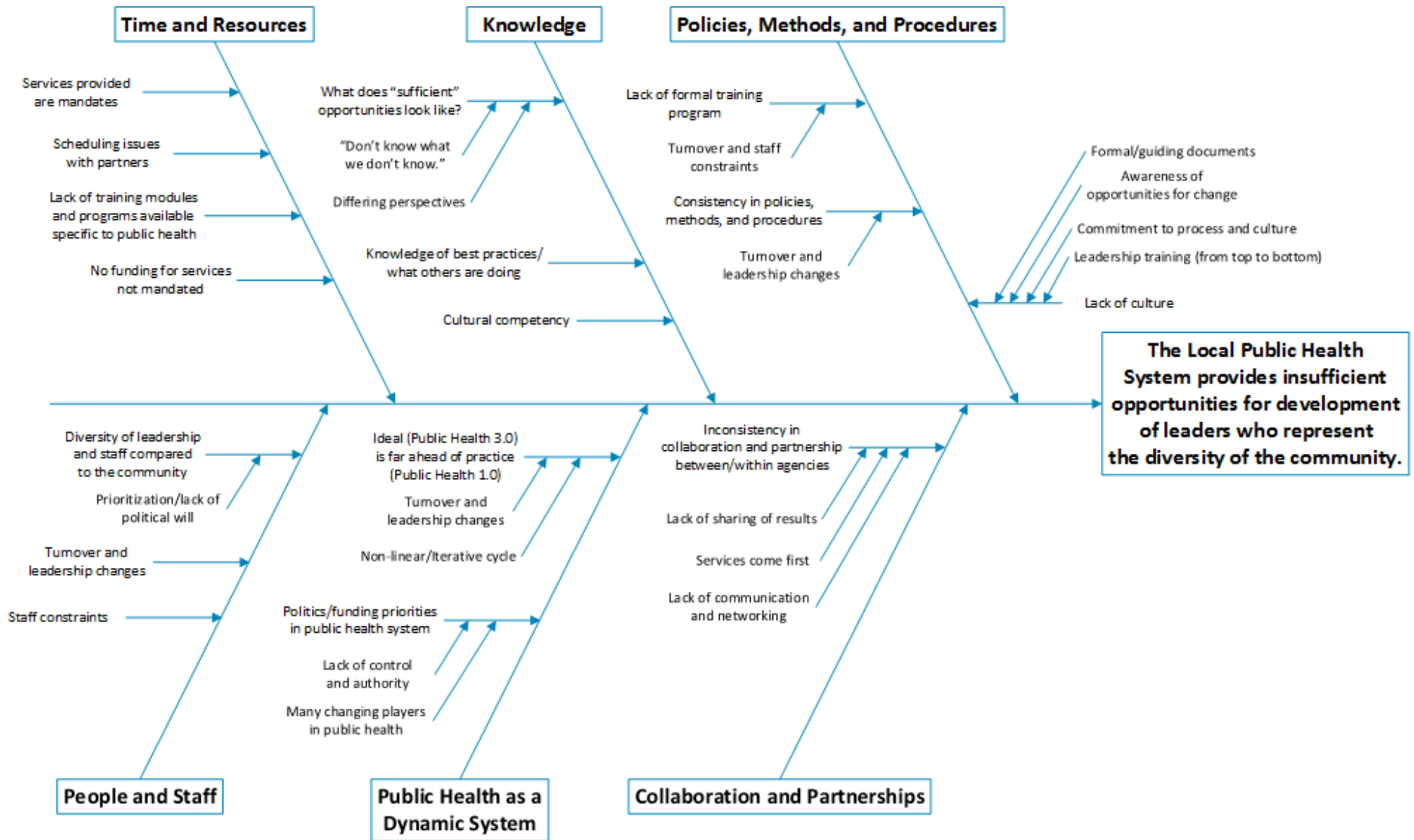
The local public health system has made significant improvements in community engagement since the 2016 CHA. Six out of eight of the recommendations identified in 2016 regarded community engagement such as identifying key partners and stakeholders in the community and improving coordination of the WWA. For the 2019 CHA, three out of the five highest-ranked performance measures were related to community partnerships and strategic alliances. Additionally, organizations ranked those performance measures higher for their own organization's efforts than the local public health system. It is unclear why there is a discrepancy in scores between the local public health system and for the organizations; however, results may mean a lack of coordination between organizations, a view that organizations do not see themselves as an integral part of the local public health system, or that the local public health system is not functioning optimally despite each organization's contributions.

The LPHSA was a useful process for both the CHA Task Force and the WCCHD DLT; however, additional follow-up is required to understand the root causes more thoroughly for each performance measure. The CHIP Task Force will use these findings to improve the local public health system's provision of the Ten Essential Public Health Services through the implementation of short- and long-term improvement recommendations from participants.

Based on the assessment results, the CHA Task Force recommends that the LPHS should:

- Continue to engage community partners and stakeholders in improving health equity
- Develop systems that provide opportunities for development of diverse leaders, despite expected leadership change and staff turnover
- Identify existing opportunities and trainings available in the community and share with the local public health system
- Improve delivery of culturally-competent services to improve health equity
- Hire leaders that represent the diversity of the community and provide opportunities to those leaders

Figure 95: Local Public Health Systems Assessment Fishbone Diagram



## PRIORITY AREAS AND ISSUES

With so many competing needs in the community, determining health priorities will help direct resources and collaborative efforts to the issues that matter most to the community and that will have the greatest impact on health status.

## Top Five Health Priorities

The CHA Task Force used the qualitative and quantitative data collected and analyzed by the four MAPP assessments to identify five Health Equity Zones and five health priorities.

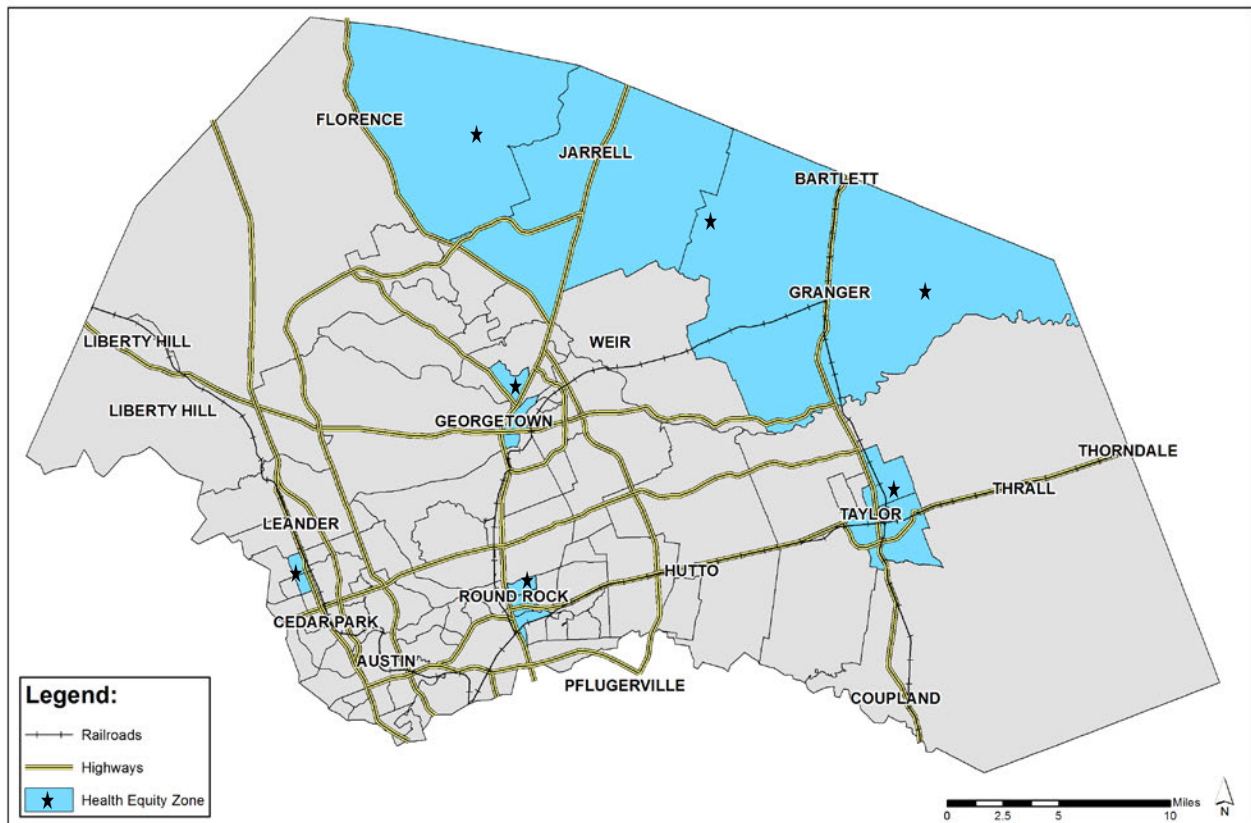
### Health Equity Zones

Health Equity Zones are census tract areas in the county that tend to have higher than average health risks and burdens.(7) Health equity zones were identified based off census-tract level measures that are related to health and wellness of a community and verified by stakeholders that serve these areas.

The five Health Equity Zones are in the following areas:

- Georgetown (Figure 98)
- North Rural (Figure 99)
- Round Rock (Figure 100)
- Taylor (Figure 101)
- Leander / Cedar Park (Figure 102)

**Figure 96: Williamson County, Texas Health Equity Zones**



### Williamson County, Texas Health Equity Zones

This map identifies five health equity zones in Williamson County, Texas. Health equity zones are census tract areas in the county that tend to have higher than average health risks and burdens.

Data Source: 2019 Williamson County Community Health Assessment  
Date Created: 2/6/2019





Figure 97: Georgetown Health Equity Zone

Georgetown Health Equity Zone



Figure 98: North Rural Health Equity Zone

North Rural Health Equity Zone

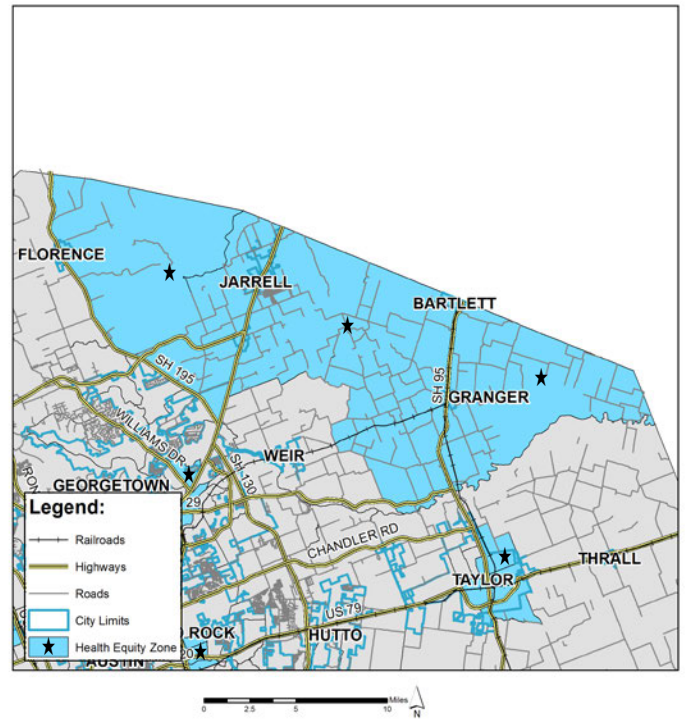


Figure 99: Round Rock Health Equity Zone

Round Rock Health Equity Zone

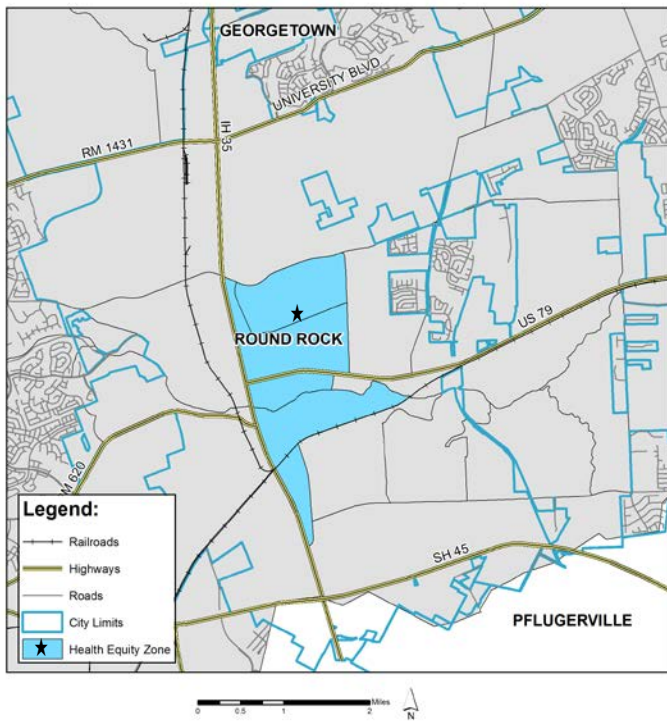


Figure 100: Taylor Health Equity Zone

Taylor Health Equity Zone

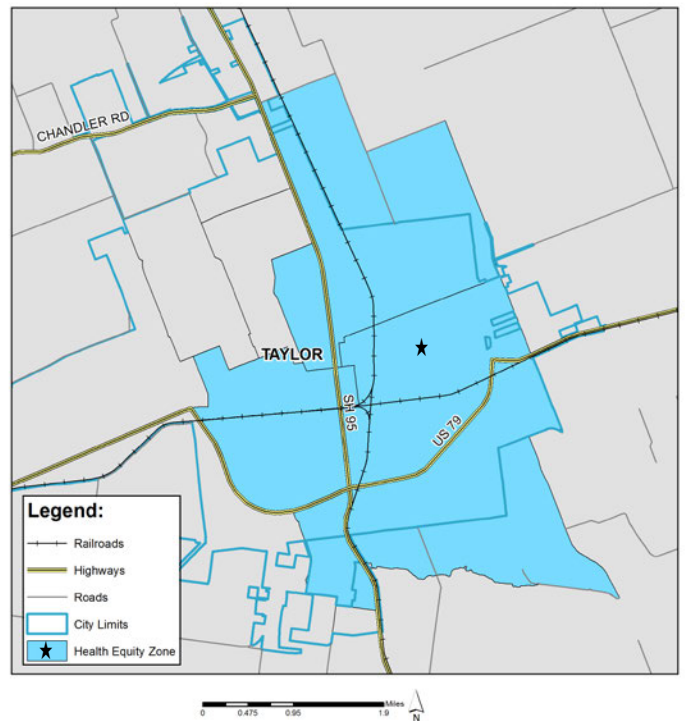
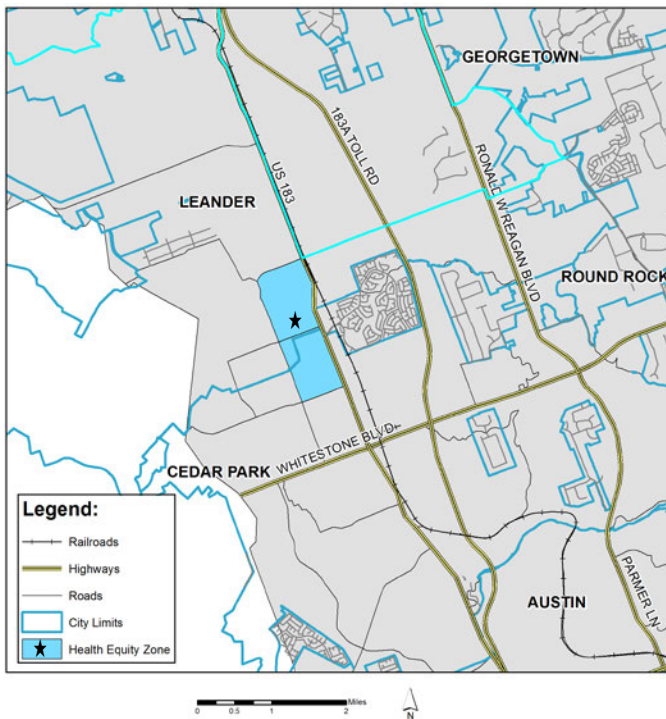


Figure 101: Leander/Cedar Park Health Equity Zone

Leander/Cedar Park Health Equity Zone



Measures for which the zone is worse than the county are highlighted in red. Measures with census tracts that are both better *and* worse than the county value are highlighted in yellow. (Table 28).

Table 28: Census-tract Level Measures for Health Equity Zones

MEASURE	GEORGETOWN	NORTH RURAL	TAYLOR	ROUND ROCK	LEANDER / CEDAR PARK	COUNTY
Population Impacted*	10,774	11,068	8,915	13,134	5,110	--
Life Expectancy**	◇ 76 to 83.2	★ 73.8 to 80.4	★ 74.5 to 75.1	★ 73.7 to 77.6	★ 77.9 to 78.6	81.7***
People Living Below Poverty Level*	★ 14.5% to 15.2%	◇ 6.0% to 22.4%	★ 13.8% to 23.7%	★ 20.7% to 23.1%	◇ 5.4% to 11.7%	7.2%
Median Household Income*	★ \$35,726 to \$48,259	★ \$40,955 to \$62,292	★ \$31,346 to \$48,313	★ \$34,100 to \$50,325	★ \$56,379 to \$56,552	\$75,935
Homeownership*	★ 26.5% to 38.5%	◇ 57.9% to 70.0%	★ 37.7% to 50.7%	◇ 28.2% to 82.6%	◇ 62% to 82.6%	64.3%
Low-Income and Low Access to a Grocery Store^	◇ 2.3% to 24.0%	◇ 1.4% to 25.2%	★ 27.0% to 61.1%	◇ 0% to 48%	★ 31.6% to 40.5%	8.0%
Adults with Health Insurance*	★ 68% to 80.4%	★ 68.4% to 82.1%	★ 66.3% to 71.6%	★ 68.5% to 72.0%	★ 75.2% to 82.9%	85.5%
Households without a Vehicle*	★ 5.6% to 8.8%	◇ 0.1% - 5.4%	★ 7.0% to 8.4%	◇ 2.4% to 9.1%	◇ 2.5% to 2.8%	2.5%
People 25+ with a High School Degree or Higher*	★ 79.2% to 90.3%	★ 77.8% to 91.8%	★ 69.2% to 83.7%	★ 73.4% to 89.6%	★ 80.6% to 84.1%	92.9%

Data Sources: \*American Community Survey, 2012-2016, \*\* U.S. Small-Area Life Expectancy Estimates Project (USALEEP), 2010-2015, \*\*\* Institute for Health Metrics and Evaluation, 2014, ^ U.S. Department of Agriculture - Food Environment Atlas, 2015

## Health Priorities

Through the four MAPP assessments and prioritization by residents and stakeholder, the CHA Task Force identified five health priorities to improve health and wellness in Williamson County from 2020-2022 (Table 29). Community members and stakeholders identified and ranked four out of the five health priorities through the Community Health Survey, the sticker activities at the Community Focus Groups, and facilitated activities at community meetings. During the Community Health Survey, survey respondents voted on the top health problems in the county. During the sticker activity at the Community Focus Groups, community members placed three green stickers on things that were going well in their lives and three red stickers on things that were not going well in their lives. During facilitated activities at community meetings, stakeholders identified the top health problems and risk factors through the number of responses for each topic. The Health Priority Matrix displays these rankings (Table 30).



The CHA Task Force identified the fifth health priority “Building a resilient Williamson County” based off public health evidence on the impact of community resiliency on the health and wellness of a community and the necessity of this priority to improving the other four health priorities for current and future generations. The Hogg Foundation for Mental Health identified resilience as “critical to health and mental health interventions.”(115) “Community resilience originates from buffers in communities and families to protect individuals from the accumulation of stress due to adverse childhood experiences, such as exposure to emotional and sexual abuse, maternal depression, neglect or incarceration.”(116, 117)

**Table 29: Health Priorities**

HEALTH PRIORITIES	
✱	Behavioral health, stress, and well-being (focus on decreasing poor mental health, stress, and substance abuse)
◇	Chronic disease risk factors (focus on increasing healthy food access and physical activity)
★	Social determinants of health (focus on increasing affordable and safe housing, access to transportation, and workforce development)
†	Access and affordability of healthcare (focus on increasing dental care and improving access to affordable health insurance for vulnerable populations)
▲	Building a resilient Williamson County (focus on increasing the community’s ability to utilize available resources to respond to, withstand, and recover from adverse situations)

**Table 30: Health Priority Matrix**






COMMUNITY HEALTH SURVEY		FOCUS GROUP STICKER ACTIVITY BY RESIDENTS		FACILITATED ACTIVITY AT COMMUNITY MEETINGS	
Health Problems		Health Problems		Risk Factors	
#1: Obesity ◇	#1: Behavioral Health ✱	#1: Mental Health issues ✱	#1: Lack of community resources ★		
#2: Mental health issues ✱	#2: Transportation ★	#2: Substance abuse ✱	#2: Lack of access to healthy foods ◇		
#3: Cancers ◇	#3: Housing ★	#3: Poor eating habits/choices ◇	#2: Lack of access to healthcare †		
#4: Stress ✱	#4: Healthcare †	#4: Obesity ◇	#3: Lack of access to public transportation ★		
#5: Diabetes ◇	#5: Jobs/Employment ★	#5: Disabilities ▲	#4: Unhealthy behaviors and lifestyles ▲		



## Conclusion and Implications for Williamson County

The 2019 CHA provides an updated analysis of available data to describe how the health and quality of life of Williamson County residents has changed since the last assessment in 2016. Throughout the 2019 assessment process, the CHA Task Force engaged with residents and stakeholders as active participants. Their feedback, paired with quantitative data, describes the current status and shared perceptions about the health and well-being of Williamson County, Texas. The 2019 CHA serves as the evidence-based foundational document for WCCHD, community partners, decision-makers, and most importantly residents to develop health-related policy. The document will be used to educate and mobilize community partners and residents, guide strategy, gather resources, and plan actions to improve health. Based on feedback from stakeholders across the county, the top five health priorities for future health improvement efforts are contained in Table 31 below.

**Table 31: Top Five Health Priorities for 2020-2022 in Williamson County, Texas**

ICON	RANK	HEALTH PRIORITY
	1	<b>Behavioral health, stress, and well-being</b> <i>Focus on decreasing poor mental health, stress, and substance abuse</i>
	2	<b>Chronic disease risk factors</b> <i>Focus on increasing healthy food access and physical activity</i>
	3	<b>Social determinants of health</b> <i>Focus on increasing affordable and safe housing, access to transportation, and workforce development</i>
	4	<b>Access and affordability of healthcare</b> <i>Focus on increasing dental care and improving access to affordable health insurance for vulnerable populations</i>
	5	<b>Building a resilient Williamson County</b> <i>Focus on increasing the community's ability to utilize available resources to respond to, withstand, and recover from adverse situations</i>

Identification of priorities is the first step in improving the health of the community. Future steps involve developing action plans with the community during the CHIP process to address each of these priorities. This collaborative effort provides a common agenda that the county will use to improve the health of all residents. Additionally, the 2019 CHA and recommendations can be used in the development of the following:

- Community health changes and trends
- Hospital-based community benefit and implementation strategy plans
- Organizational strategic planning
- Evidence base for grant applications

The Task Force hopes this CHA will increase engagement in supporting the health of the people of Williamson County and help further efforts to be the healthiest county in Texas. Sustained and broad community involvement is necessary to strategically address the health issues in Williamson County, and the solutions will require the combined resources and efforts of multiple partners across all sectors of the community. This shared ownership of community health among diverse stakeholders improves mobilization and utilization of resources to achieve our goals. Together, we can make Williamson County a healthy place for residents to live, work, worship, play, and learn.

## Appendices

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## Appendix C: List of Acronyms

BTCS: Bluebonnet Trails Community Services

BSWH: Baylor Scott & White Health

CASPER: Community Assessment for Public Health Emergency Response

CDC: Centers for Disease Control and Prevention

CHA: Community Health Assessment

CHIP: Community Health Improvement Plan

CHSA: Community Health Status Assessment

CTSA: Community Themes and Strengths Assessment

DLT: District Leadership Team

EWCC: Eastern Williamson County Collaborative

FoCA: Forces of Change Assessment

GTHF: Georgetown Health Foundation

HP2020: Healthy People 2020

HCCM: Hill Country Community Ministries

LPHSA: Local Public Health Systems Assessment

LSCC: Lone Star Circle of Care

MAPP: Mobilizing for Action through Planning and Partnerships

NACCHO: National Association of County and City Health Officials

NPHPS: National Public Health Performance Standards

OWBC: Opportunities for Williamson and Burnet Counties

RWJF: Robert Wood Johnson Foundation

SDF: St. David's Foundation

SES: Socioeconomic status

WWA: WilCo Wellness Alliance

WCCHD: Williamson County and Cities Health District

## Appendix D: Community Health Survey

Please take a minute to complete the survey below. The purpose of this survey is to get your opinions about health in Williamson County. The Williamson County Community Health Assessment Task Force will use the results of this survey and other information to identify the most pressing problems which can be addressed through community action. If you have previously completed a survey, please ignore this. Remember... your opinion is important! Thank you and if you have any questions, please visit our website at <http://www.healthywilliamsoncounty.org/cha>.

1. What is your zip code? \_\_\_\_\_

2. What are the three most important things that make a "Healthy Community?" Check three only:

- |  |  |
|--|--|
| <input type="checkbox"/> Access to health care (e.g., family doctor) | <input type="checkbox"/> Good schools                      |
| <input type="checkbox"/> Access to public transportation             | <input type="checkbox"/> Healthy behaviors and lifestyles  |
| <input type="checkbox"/> Affordable housing                          | <input type="checkbox"/> Low adult death and disease rates |
| <input type="checkbox"/> Clean environment                           | <input type="checkbox"/> Low crime / safe neighborhoods    |
| <input type="checkbox"/> Community and cultural events               | <input type="checkbox"/> Low infant deaths                 |
| <input type="checkbox"/> Community resources                         | <input type="checkbox"/> Use of parks and recreation       |
| <input type="checkbox"/> Excellent race relations                    | <input type="checkbox"/> Religious or spiritual values     |
| <input type="checkbox"/> Good jobs and healthy economy               | <input type="checkbox"/> Other _____                       |

3. What are the three most important "health problems" in our community? Check three only:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Arthritis                                 | <input type="checkbox"/> Self-harm (cutting)                        | <input type="checkbox"/> Rape / sexual assault                |
| <input type="checkbox"/> Hearing and visioning impairments or loss | <input type="checkbox"/> Mental health issues (depression, anxiety) | <input type="checkbox"/> Sexually Transmitted Diseases (STDs) |
| <input type="checkbox"/> Cancers                                   | <input type="checkbox"/> Alcohol abuse                              | <input type="checkbox"/> Worksite injuries                    |
| <input type="checkbox"/> Dental problems                           | <input type="checkbox"/> Drug abuse                                 | <input type="checkbox"/> Motor vehicle crash injuries         |
| <input type="checkbox"/> Diabetes                                  | <input type="checkbox"/> Senior falls (falling at home)             | <input type="checkbox"/> Lack of exercise                     |
| <input type="checkbox"/> Heart disease and stroke                  | <input type="checkbox"/> HIV / AIDS                                 | <input type="checkbox"/> Poor eating habits / choices         |
| <input type="checkbox"/> High blood pressure                       | <input type="checkbox"/> Suicide                                    | <input type="checkbox"/> Homelessness                         |
| <input type="checkbox"/> Lung disease (COPD, emphysema)            | <input type="checkbox"/> Homicide                                   | <input type="checkbox"/> Regular check-ups and shots          |
| <input type="checkbox"/> Anorexia / Bulimia                        | <input type="checkbox"/> Assault / Violence                         | <input type="checkbox"/> Tobacco use                          |
| <input type="checkbox"/> Stress                                    | <input type="checkbox"/> Domestic / family violence                 | <input type="checkbox"/> Not using seat belts                 |
| <input type="checkbox"/> Obesity                                   | <input type="checkbox"/> Adult abuse / neglect                      | <input type="checkbox"/> Other _____                          |

4. What are three "strengths" of our community? Check three only:

- |  |  |
|--|--|
| <input type="checkbox"/> Access to health care (e.g., family doctor) | <input type="checkbox"/> Good schools                      |
| <input type="checkbox"/> Access to public transportation             | <input type="checkbox"/> Healthy behaviors and lifestyles  |
| <input type="checkbox"/> Affordable housing                          | <input type="checkbox"/> Low adult death and disease rates |
| <input type="checkbox"/> Clean environment                           | <input type="checkbox"/> Low crime / safe neighborhoods    |
| <input type="checkbox"/> Community and cultural events               | <input type="checkbox"/> Low infant deaths                 |
| <input type="checkbox"/> Community resources                         | <input type="checkbox"/> Use of parks and recreation       |
| <input type="checkbox"/> Excellent race relations                    | <input type="checkbox"/> Religious or spiritual values     |
| <input type="checkbox"/> Good jobs and healthy economy               | <input type="checkbox"/> Other _____                       |

*The survey continues on the other side.*

**5. Who are the people who need the most help in our community? Check three only:**

- |   |                                    |                                      |
|---|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Homeless                 | <input type="checkbox"/> Rural     | <input type="checkbox"/> Veterans    |
| <input type="checkbox"/> Low income               | <input type="checkbox"/> Seniors   | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> People with disabilities | <input type="checkbox"/> Uninsured |                                      |

Please answer questions #6-8 so we can see how different types of people feel about local health issues. These questions are optional.

**6. What is your age?** \_\_\_\_\_

**7. What is your gender?**

- Female    Male

**8. What is the race/ethnic group you most identify with?**

- African American / Black  
 Asian / Asian American  
 Hispanic / Latino  
 Native American / Alaska Native  
 Native Hawaiian / Pacific Islander  
 White / Caucasian  
 Other \_\_\_\_\_

*Thank you very much for your response!*

## Appendix E: Community Health Survey Locations of Distribution

LOCATIONS OF SURVEY DISTRIBUTION	ELECTRONIC	PAPER
Allen R. Baca Center		×
Avery Ranch Owners Association, Inc Mailing List	*	
Bagdad Head Start/Early Head Start	*	•
Bartlett Head Start	*	•
Baylor Scott & White Medical Center - Taylor Mailing List	*	
Bluebonnet Trails Community Services - Cedar Park	*	•
Bluebonnet Trails Community Services - Georgetown	*	•
Bluebonnet Trails Community Services - Hutto	*	•
Bluebonnet Trails Community Services - Round Rock	*	•
Bluebonnet Trails Community Services - Taylor	*	•
Christ Fellowship Church Mailing List	*	
City of Round Rock Website	*	
Cottages at Lake Creek Homeowners Association Mailing List	*	
Davis Spring Homeowners Association Mailing List	*	
Eastern Williamson County Community Collaborative	*	□
Florence Head Start	*	•
Harris-Ross Head Start/Early Head Start	*	•
HealthyWilliamsonCounty.Org/CHA Webpage	*	
Hill Country Community Ministries		•
Hutto Has Heart Mailing List	*	□
Hutto Head Start	*	•
Indian Oaks Neighborhood Association	*	
Interagency Support Council of Eastern Williamson County, Inc. Mailing List	*	
Intervention Services	*	•
Lakeline Station, Foundation Communities Mailing List	*	
Liberty Hill Community Resource Center		×
Life Steps Mailing List	*	
Madella Hilliard Neighborhood Center	*	•
Mary Bailey Head Start	*	•
Muirfield Property Owners Association, Inc. Mailing List	*	
Neighborhood Association of Southwestern Williamson County Mailing List	*	
Next Door App	*	
Parmer Village Condominium Community Mailing List	*	
Rawleigh Elliott Head Start/Early Head Start	*	•
Round Rock Head Start	*	•
Round Rock Public Library		×
Salvation & Praise Tabernacle Ministries Mailing List	*	•
Shepherd's Heart Food Pantry & Thrift Shop Mailing List	*	•
Southeast Georgetown Community Council Mailing List	*	

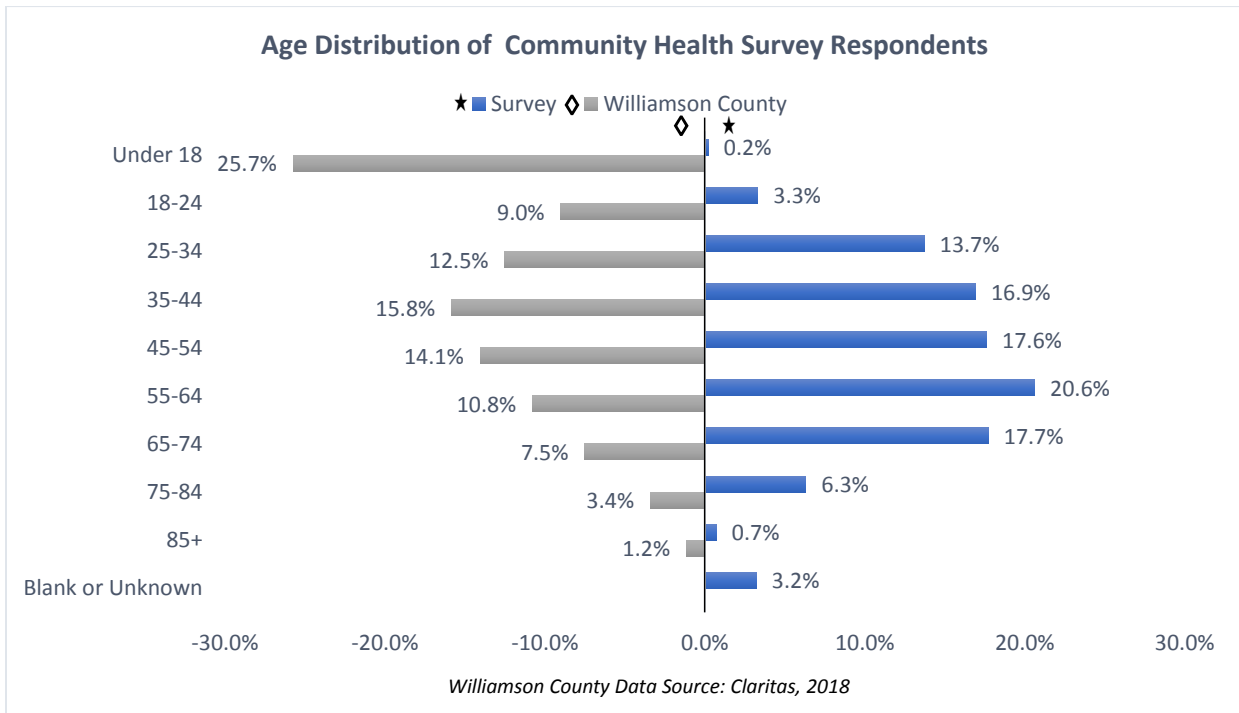
Southwestern University Mailing List	*	
T.H. Johnson Head Start	*	•
Taylor Housing Authority Mailing List	*	
Taylor Senior Center	*	•
Texas State University Round Rock Mailing List	*	
United Way of Williamson County Mailing List	*	
Williamson County and Cities Health District Press Release and Social Media	*	
Williamson County and Cities Health District Board of Health	*	
Williamson County and Cities Health District Cedar Park Public Health Center		×
Williamson County and Cities Health District Georgetown Public Health Center		×
Williamson County and Cities Health District Round Rock Public Health Center		×
Williamson County and Cities Health District Taylor Public Health Center		×
WilCo Wellness Alliance Newsletter and Social Media	*	
WilCo Wellness Alliance Health Equity Summit		•
Williamson County May Newsletter	*	
Notes: • Convenience Sampling, × Dropbox, ▫ Group Administration, * Media Distribution		

## Appendix F: Community Health Survey Results

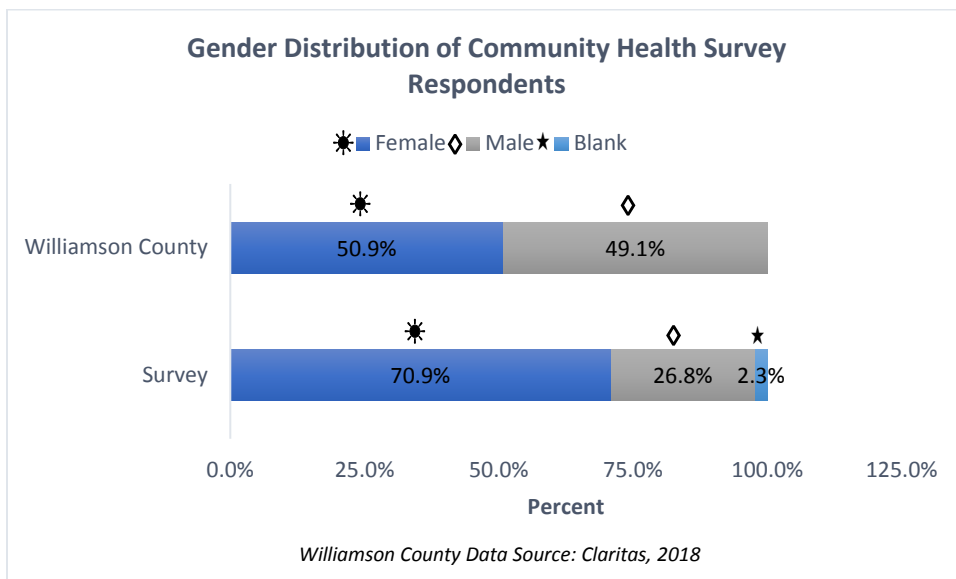
### Demographics

Survey respondents tended to be older than residents in Williamson County. The CHA Task Force focused on collecting surveys from individuals 18 years and older (Figure 103). Median age of survey respondents in the county was 52 compared to the median age of general population of 36.7. Median age in the North was higher than in the county at 61 years old. Median age in the East was lower than the county at 42 years old. More females than males responded to the survey (Figure 104). Seven out of ten survey respondents were female. A majority of respondents were White (Table 32).

**Figure 102: Age Distribution of Community Health Survey Respondents**



**Figure 103: Gender Distribution of Community Health Survey Respondents**





**Table 32: Race/Ethnicity of Community Health Survey Respondents**

RACE/ETHNICITY	SURVEY	WILLIAMSON COUNTY
White / Caucasian	73.1%	75%
African American / Black	4.8%	7%
Native American / Alaska Native	0.8%	1%
Asian / Asian American	2.2%	7%
Native Hawaiian / Pacific Islander	0.1%	0%
Other	0.2%	7%
Mixed Race	1.6%	4%
Unknown, Blank, Declined to Answer	4.5%	
Hispanic / Latino	12.8%	24.6%

*Williamson County Data Source: Claritas, 2018*

## Responses

### Factors of a Healthy Williamson County

Survey respondents were asked: “What are the three most important things that make a ‘Healthy Community?’”, and 2,247 individuals responded. More than half of all survey respondents indicated that access to healthcare was the most important thing that constitutes a “healthy community.” Two out of five voted on low crime/safe neighborhoods, and three out of ten voted on healthy behaviors and lifestyles (Table 33). Resident perceptions of what factors constituted a Healthy Williamson County are broken out by region in Figure 105.

**Table 33: Perceptions of Factors that Constitute a Healthy Williamson County**

RANK	HEALTHY WILLIAMSON COUNTY FACTORS	COUNT	PERCENT
1	Access to health care	1,253	55.8%
2	Low crime / safe neighborhoods	870	38.7%
3	Healthy behaviors and lifestyles	704	31.3%
4	Clean environment	680	30.3%
5	Good jobs and healthy economy	677	30.1%

*Notes: N=2,247*

**Figure 104: Perceptions of Factors that Constitute a Healthy Williamson County by Region**

	<p><b>North</b></p> <ol style="list-style-type: none"> <li>1. Access to health care</li> <li>2. Low crime / safe neighborhoods</li> <li>3. Healthy behaviors and lifestyles</li> <li>4. Good jobs and healthy economy</li> <li>5. Clean environment</li> </ol>	
<p><b>West</b></p> <ol style="list-style-type: none"> <li>1. Access to health care</li> <li>2. Low crime / safe neighborhoods</li> <li>3. Healthy behaviors and lifestyles</li> <li>4. Clean environment</li> <li>5. Good jobs and healthy economy</li> </ol>	<p><b>Williamson County</b></p> <ol style="list-style-type: none"> <li>1. Access to health care</li> <li>2. Low crime / safe neighborhoods</li> <li>3. Healthy behaviors and lifestyles</li> <li>4. Clean environment</li> <li>5. Good jobs and healthy economy</li> </ol>	<p><b>East</b></p> <ol style="list-style-type: none"> <li>1. Access to health care</li> <li>2. Good schools</li> <li>3. Low crime / safe neighborhoods</li> <li>3. Clean environment</li> <li>4. Good jobs and healthy economy</li> </ol>
	<p><b>South</b></p> <ol style="list-style-type: none"> <li>1. Access to health care</li> <li>2. Low crime / safe neighborhoods</li> <li>3. Clean environment</li> <li>4. Good jobs and healthy economy</li> <li>5. Healthy behaviors and lifestyles</li> </ol>	

**Strengths of Williamson County**

Survey respondents were asked: “What are three ‘strengths’ of our community?”, and 2,252 individuals responded. More than two out of five survey respondents voted on good schools. About two out of five survey respondents voted on low crime/safe neighborhoods. A little less than two out five survey respondents voted on access to healthcare (Table 34). Resident perceptions of top strengths in Williamson County are broken out by region in Figure 106.

**Table 34: Resident Perceptions of Strengths of Williamson County**

RANK	STRENGTHS IN COMMUNITY	COUNT	PERCENT
1	Good schools	1,012	44.9%
2	Low crime / safe neighborhoods	920	40.9%
3	Access to health care	873	38.8%
4	Use of parks and recreation	737	32.7%
5	Clean environment	579	25.7%

*Notes: n=2,252*

**Figure 105: Resident Perceptions of Strengths in Williamson County by Region**

	<p><b>North</b></p> <ol style="list-style-type: none"> <li>1. Low crime / safe neighborhoods</li> <li>2. Access to health care</li> <li>3. Use of parks and recreation</li> <li>4. Community and cultural events</li> <li>5. Good schools</li> </ol>	
<p><b>West</b></p> <ol style="list-style-type: none"> <li>1. Good schools</li> <li>2. Access to health care</li> <li>3. Low crime / safe neighborhoods</li> <li>4. Use of parks and recreation</li> <li>5. Clean environment</li> </ol>	<p><b>Williamson County</b></p> <ol style="list-style-type: none"> <li>1. Good schools</li> <li>2. Low crime / safe neighborhoods</li> <li>3. Access to health care</li> <li>4. Use of parks and recreation</li> <li>5. Clean environment</li> </ol>	<p><b>East</b></p> <ol style="list-style-type: none"> <li>1. Good schools</li> <li>2. Religious or spiritual values</li> <li>3. Access to health care</li> <li>4. Use of parks and recreation</li> <li>5. Low crime / safe neighborhoods</li> </ol>
	<p><b>South</b></p> <ol style="list-style-type: none"> <li>1. Good schools</li> <li>2. Low crime / safe neighborhoods</li> <li>3. Access to health care</li> <li>4. Use of parks and recreation</li> <li>5. Good jobs and healthy economy</li> </ol>	

**Health Problems in Williamson County**

Survey respondents were asked: “What are the three most important ‘health problems’ in our community?”, and 2,252 individuals responded. The #1 health problem identified in the community survey was obesity. Closely following by 4 votes was mental health issues (Table 35). Resident perceptions of health problems in Williamson County are broken out by region in Figure 107.

**Table 35: Resident Perceptions of Health Problems in Williamson County**

RANK	HEALTH PROBLEMS IN COMMUNITY	COUNT	PERCENT
1	Obesity	858	38.0%
2	Mental health issues	854	37.8%
3	Cancers	554	24.5%
4	Stress	543	24.0%
5	Diabetes	526	23.3%

*Note: n=2,252*

**Figure 106: Resident Perceptions of Health Problems in Williamson County by Region**

<b>North</b>		
<ol style="list-style-type: none"> <li>1. Obesity</li> <li>2. Mental health issues</li> <li>3. Cancers</li> <li>4. Heart disease and stroke</li> <li>5. Diabetes</li> </ol>		
<b>West</b>	<b>Williamson County</b>	<b>East</b>
<ol style="list-style-type: none"> <li>1. Mental health issues</li> <li>2. Obesity</li> <li>3. Stress</li> <li>4. Poor eating habits / choices</li> <li>5. Diabetes</li> </ol>	<ol style="list-style-type: none"> <li>1. Obesity</li> <li>2. Mental health issues</li> <li>3. Cancers</li> <li>4. Stress</li> <li>5. Diabetes</li> </ol>	<ol style="list-style-type: none"> <li>1. Mental health issues</li> <li>2. Obesity</li> <li>2. Diabetes</li> <li>3. Drug abuse</li> <li>4. Cancer</li> </ol>
<b>South</b>		
<ol style="list-style-type: none"> <li>1. Mental health issues</li> <li>2. Obesity</li> <li>3. Stress</li> <li>4. Diabetes</li> <li>5. Cancer</li> </ol>		

**Underserved Populations in Williamson County**

Survey respondents were asked: “Who are the people who need the most help in our community?”, and 2,238 individuals responded. The #1 underserved population identified in the community survey was low-income individuals, followed by seniors and people with disabilities (Table 36).

**Table 36: Resident Perceptions of Underserved Populations in Williamson County**

RANK	UNDERSERVED POPULATIONS	COUNT	PERCENT
1	Low income	1,394	62.3%
2	Seniors	1,282	57.3%
3	People with disabilities	1,117	49.9%
4	Uninsured	859	38.4%
5	Veterans	785	35.1%
6	Homeless	593	26.5%
7	Rural	181	8.1%
8	Other	125	5.6%
<i>N=2,238</i>			

## Appendix G: Community Meeting Facilitated Activity Guide

### Introduction

Thank you very much for joining us today! I am [your name] and [your name] from [name of organization]. We are working to conduct a Community Health Assessment, which is a process completed every 3 years with a collaborative group of community partners working toward the common goal of a healthy community. The previous assessment was completed in 2015. We want to get your perspective on the health of the community you work, live, worship, and play in and the health-related needs of your community. Your opinions will inform how we research and prioritize health issues in our communities. We will gather the data and bring back the results of this facilitated activity. In addition to this activity today, we are also conducting a community survey that can be completed on [www.healthywilliamsoncounty.org/](http://www.healthywilliamsoncounty.org/) or emailed out to this group to complete. (1 minutes)

### Procedure (20 minutes)

#### Question 1-4

- Divide into 4 groups.
- First group spend more time at first question. (5 minutes)
- Rotate. Read the question, read the responses, and add. (3 minutes, 3 minutes, 3 minutes)

#### Question 5

- On sticky notes, write down as many as resources you would suggest they are not currently available. Without discussion. (5 minutes)
- We will link later and provide information back to you.

### Questions

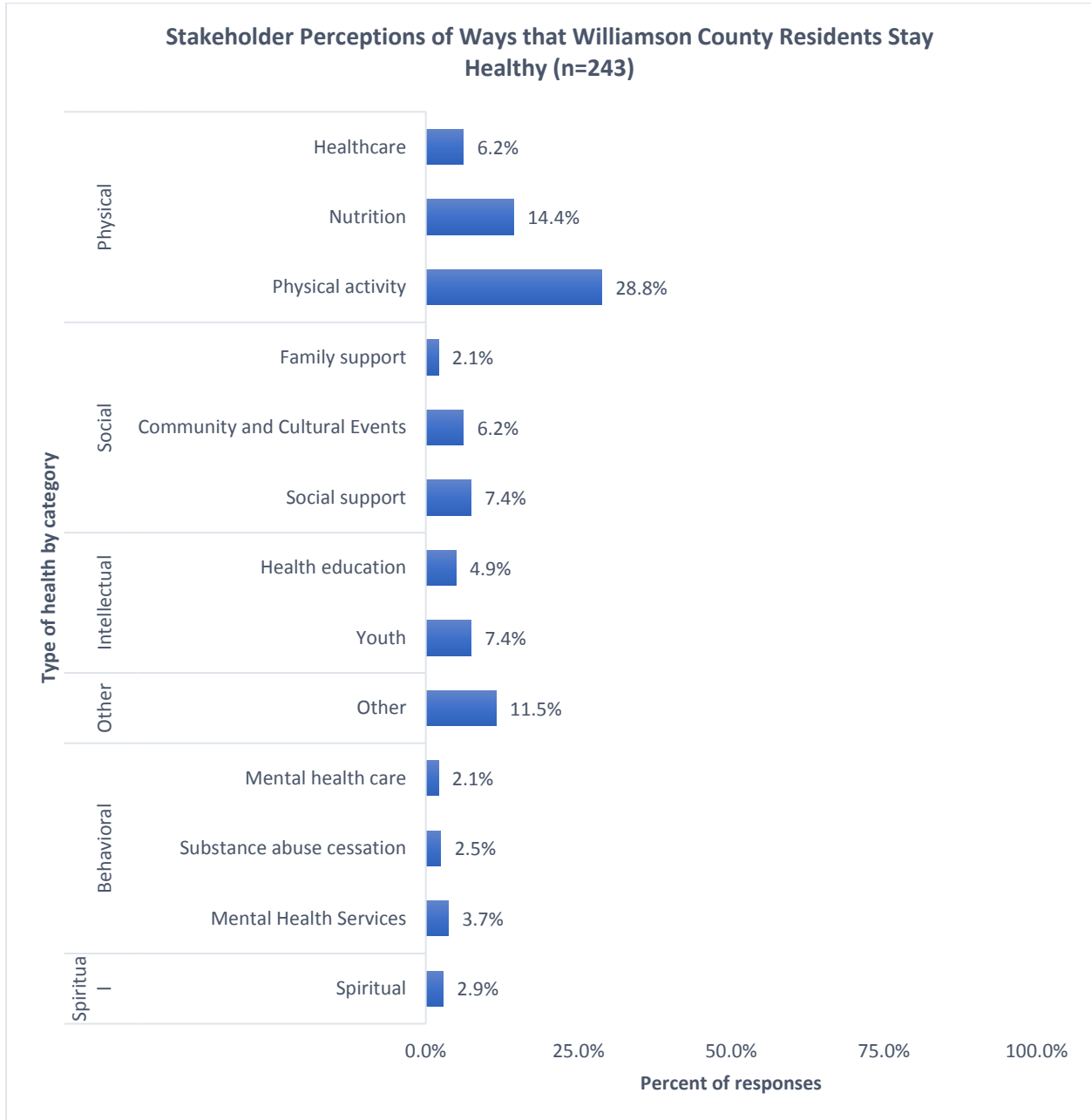
1. What are people doing to stay healthy in this community?
2. What do people see as major health related problems that impact this community?
3. Sometimes communities can help people to be healthy or prevent people from being healthy.
  - a. What are the things in this community that help people to be healthy?
  - b. What are the things in this community that make it harder for people to be healthy?
4. What are the greatest challenges to people accessing health services?
5. What other resources would you suggest that are not currently available? In other words, what are some solutions to these problems?

## Appendix H: Community Meeting Facilitated Activities Results

### Responses

Stakeholders were asked: “What are people doing to stay healthy in this community?” Stakeholders provided 243 responses (Figure 108). Stakeholders grouped the responses according to types of health (Physical, Social, Intellectual, Mental, and Spiritual Health).

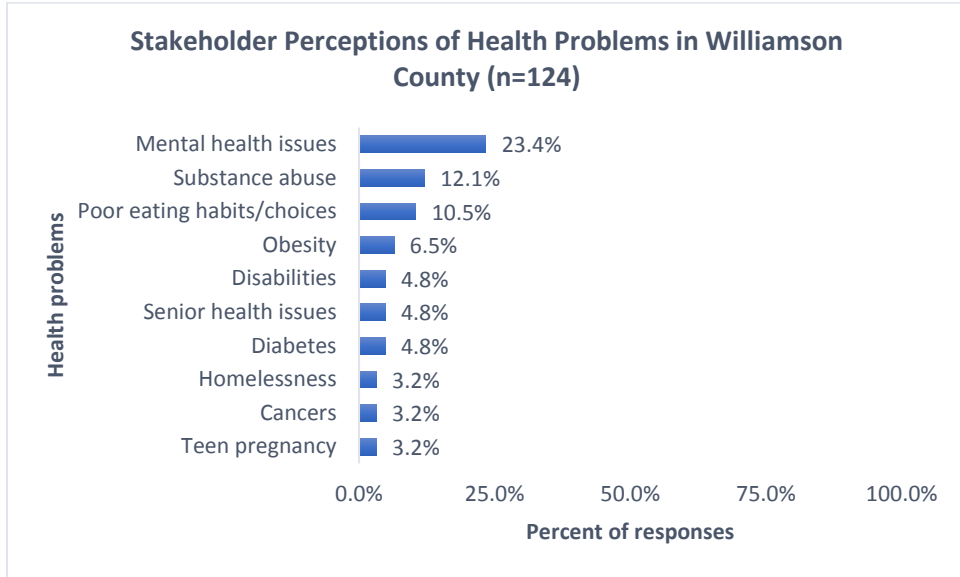
**Figure 107: Stakeholder Perceptions of Ways that Williamson County Residents Stay Healthy (n=243)**



### Health Problems in Williamson County

Stakeholders were asked: “What do people see as major health related problems that impact this community?” Stakeholders provided 124 responses (Figure 109).

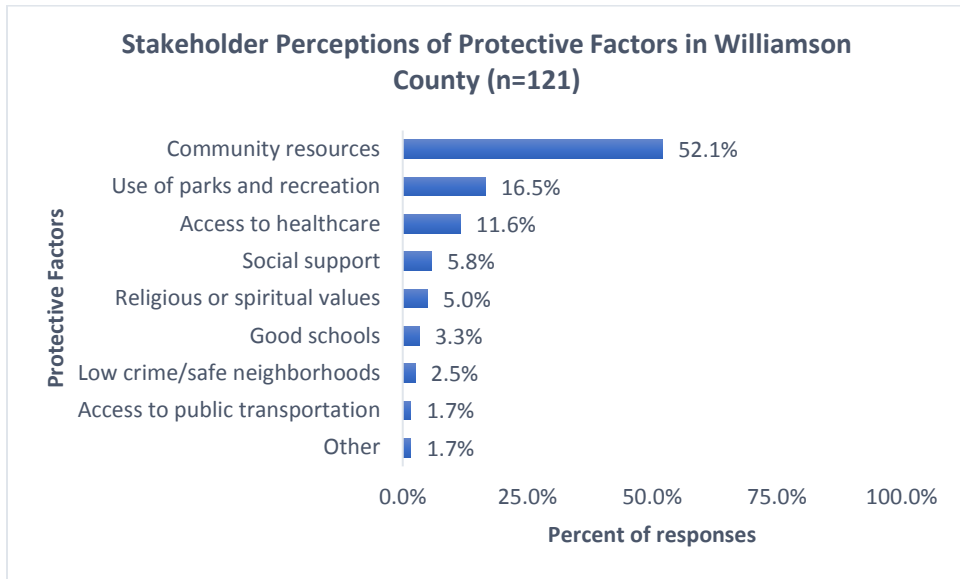
**Figure 108: Stakeholder Perceptions of Health Problems in Williamson County (n=124)**



**Protective Factors in Williamson County**

Stakeholders were asked: “Sometimes communities can help people to be healthy or prevent people from being healthy. What are the things in this community that help people to be healthy?” Stakeholders provided 121 responses (Figure 110).

**Figure 109: Stakeholder Perceptions of Protective Factors in Williamson County (n=121)**

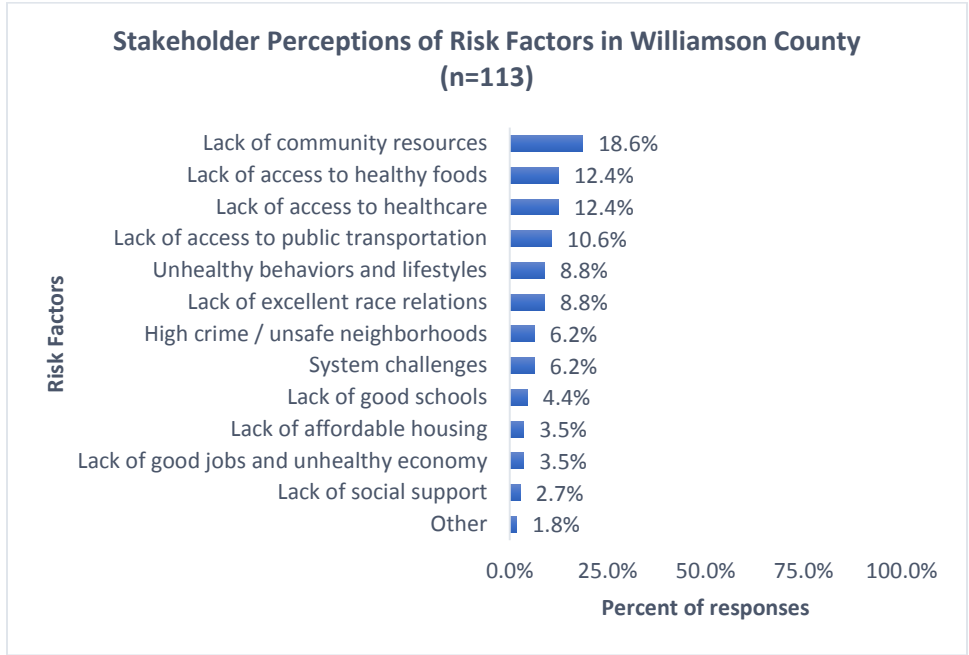


**Risk Factors in Williamson County**

Stakeholders were asked: “Sometimes communities can help people to be healthy or prevent people from being healthy. What are the things in this community that make it harder for people to be healthy?” Stakeholders provided 113 responses (Figure 111).



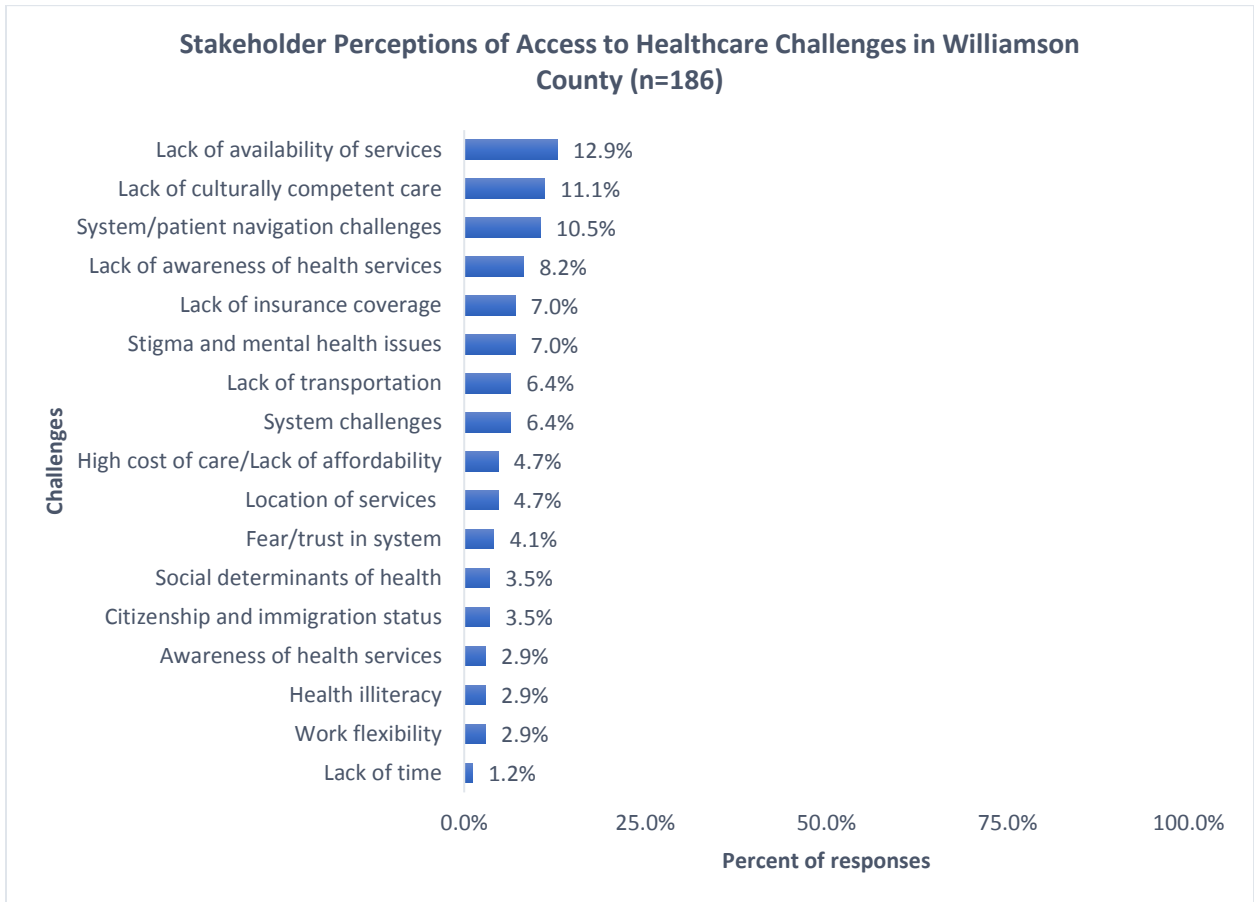
**Figure 110: Stakeholder Perceptions of Risk Factors in Williamson County (n=113)**



**Access to Healthcare Challenges in Williamson County**

Stakeholders were asked: “What are the greatest challenges to people accessing health services?” Stakeholders provided 186 responses (Figure 112).

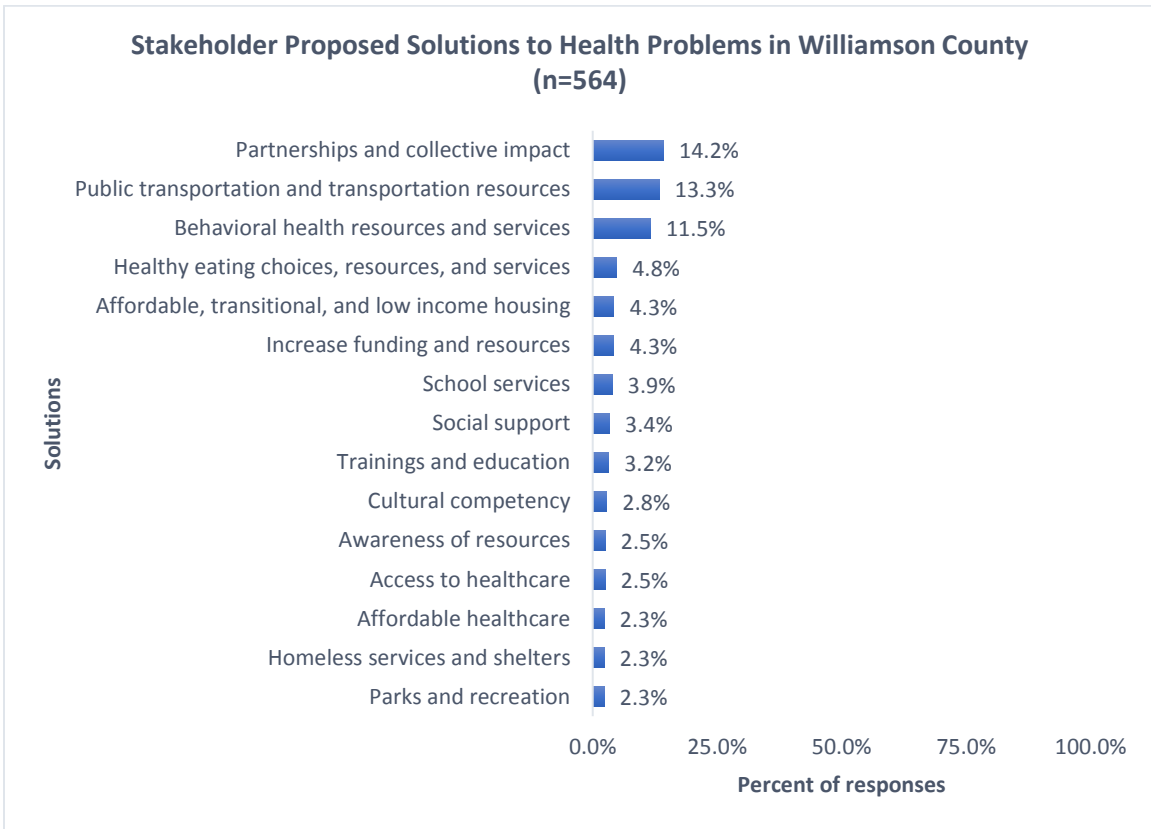
**Figure 111: Stakeholder Perceptions of Access to Healthcare Challenges in Williamson County (n=186)**



**Proposed Solutions and Resources in Williamson County**

Stakeholders were asked: “What other resources would you suggest that are not currently available? In other words, what are some solutions to these problems?” Stakeholders proposed 564 responses (Figure 113).

**Figure 112: Stakeholder Proposed Solutions to Health Problems in Williamson County (n=564)**



# Appendix I: Community Focus Group Guide



Date: \_\_\_\_\_ Location: \_\_\_\_\_ Facilitator: \_\_\_\_\_

1. Arrange room in circle.
2. Set up recorder.
3. Set up posters on wall.

\*Suggest organizer to step out or not speak during focus group\*

1. Pass out consent form for review
2. Distribute demographic survey for participants to fill out.
3. Distribute red and green stickers.
4. Get name tags for participants.
5. Let participant know that they can take a seat and eat snacks.

## I. Welcome – 10 minutes

Hi, my name is \_\_\_\_\_ and I am with [organization]. Thank you for taking the time to speak with me today.

In collaboration with community members and partners, Williamson County and Cities Health District and the WilCo Wellness Alliance is in the process of developing a community health assessment to understand the health of Williamson County. The purpose of the project is to explore the opportunities, challenges, wants, and needs facing residents in Williamson County. We want to get your perspective on the health of your community and the health-related needs of your community.

We would like this discussion to be pretty informal, honest, and thoughtful. We also want to hear from everyone in the room. Ideally, we will hardly talk at all. Our role is to ask questions, keep us on topic, and help keep the discussion flowing.

What is said in this room is confidential and will not be reported out except in general themes or anonymous comments. We are recording this conversation so we can listen again for context and clarity. What you tell us will be summarized into a report. However, no names will be attached to any of the experiences, opinions, or suggestions. The questions I will ask do not have right or wrong answers. They are about your experiences and opinions, so do not hesitate to speak. You are the expert of what it's like to live in [city/county/community] and we are here to learn from you. This is why we are giving you [gift card]. It is a small token of our appreciation for you sharing your experiences and time with us.

## II. Ground Rules and Consent Review

Before we get started with the focus group, we need your permission. So, we will begin by reviewing this consent form that outlines why we are doing the focus group, how it will affect you, what we will do with the information, and how you can contact us after today. Please take a couple of minutes to read over the consent form and sign. If you still would like to participate today, and we hope you do, then please sign the bottom of the form.

1. Receive consent form.
2. Give gift card and sign gift card acknowledgement form.

### III. Introduction Activity – 10 minutes

You should have three green and three red stickers. Around the room are posters titled with different areas of concerns or services. Please, place a green sticker under areas that you think are going well in your life and a red sticker under areas that are most difficult.

- Please state your first name, what city or town you live in, and how long you have lived here in the community.
- Tell us about one of your green stickers? Why do you see that as a positive for you and/or your community?
- Optional Follow-Up
  - There are a lot of green/red stickers on \_\_\_\_\_. Tell us more about that.
  - There is an outlier sticker on \_\_\_\_\_. Tell us more about that.

#### Poster headings:

Health care

Mental/behavioral health

Community resources

Food and nutrition

Physical activity

Housing

Transportation

Education

Youth

Child care/out of school programs

Senior services/Elderly concerns

Jobs/Employment

Neighborhood safety/Crime

Parks/Recreation

Immigration concerns/services

Legal concerns/services

Other

### IV. Questions – 60 minutes (10-12 minutes per question)

1. What do you want for yourself and your family?
  - a. (If health is not mentioned: Thinking about you and your family, how is your health and wellbeing? What would help your health and wellbeing?)
2. Sometimes the community people live in can help them to be healthy or prevent them from being healthy. Over the last 2-3 years, have you noticed any changes or challenges in your community? (For example: demographic shifts, aging population, migration, recession etc.)
  - a. Can you describe that experience?
3. Sometimes you need to seek services for help or support to be healthy. Who or where do you go to for help or support?
  - a. Can you describe that experience?
4. What services (programs, resources) have not been helpful? Why?
  - a. Can you describe that experience?
5. What services (programs, resources) are needed to better serve the needs of this community?

### V. Closing – 5 minutes

We want to thank you for the time you have taken out of your busy lives to be with us today. Thank you for participating in this focus group and for the information that you shared today.

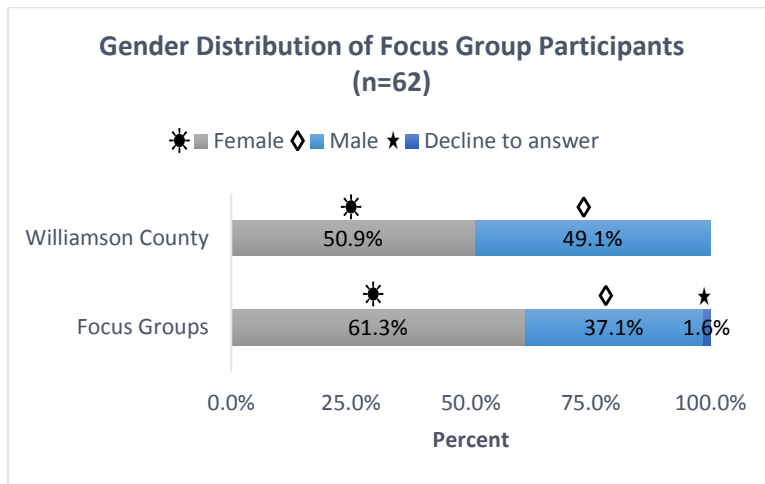
\*Adapted from [Southeast Georgetown Needs Assessment](#)

## Appendix J: Community Focus Groups Results

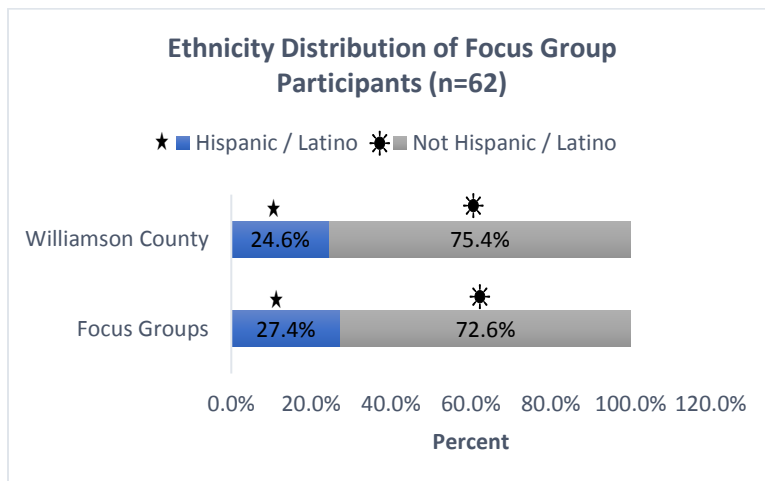
### Demographics

Focus group participants (n=62) tended to be more female than the general Williamson County Population (Figure 114). Median age of focus group participants was 53.5 years old. Participants tended to be less White and more Black/African American than the general population. No Asian, Native Hawaiian/Pacific Islander, and Other races participated in the focus group (Table 37). Percentage of Hispanic/Latino participants was like population in Williamson County (Figure 115).

**Figure 113: Gender Distribution of Focus Group Participants (n=62)**



**Figure 114: Ethnicity Distribution of Focus Group Participants (n=62)**



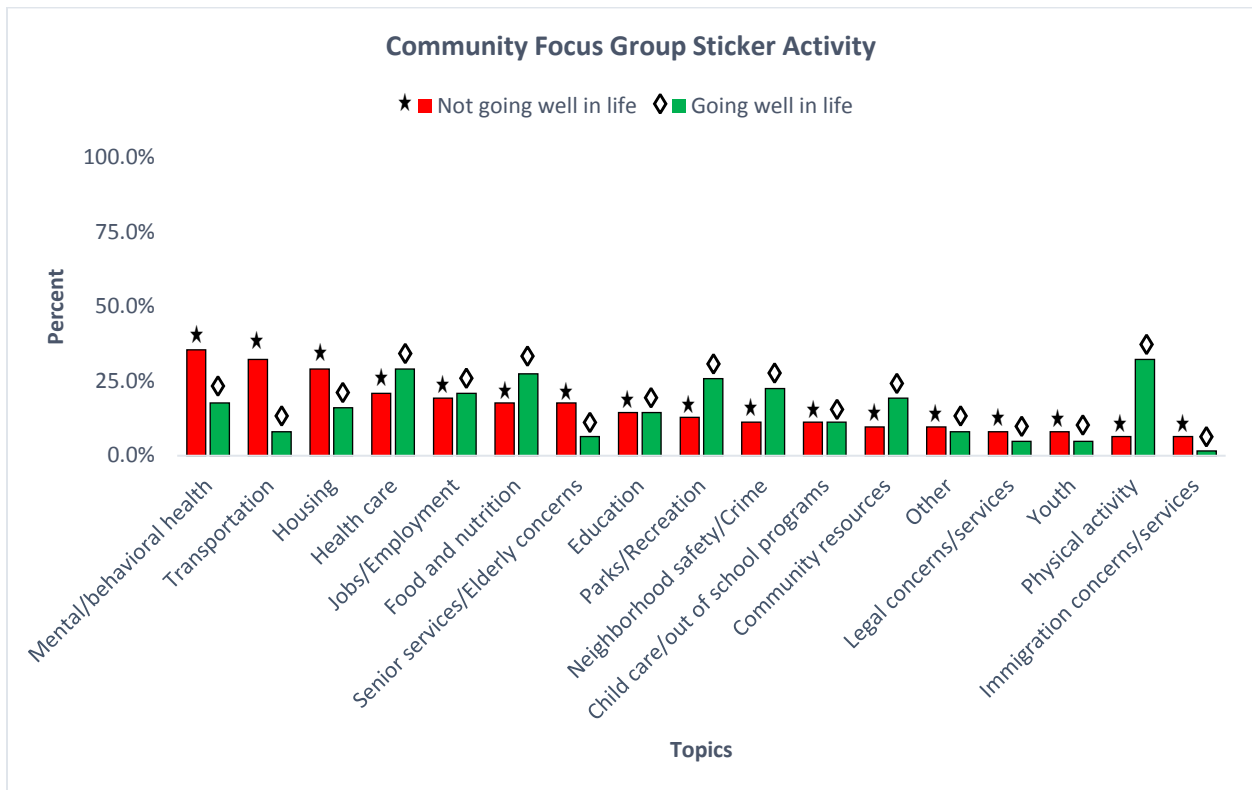
**Table 37: Race Distribution of Focus Group Participants (n=62)**

RACE	FOCUS GROUPS	WILLIAMSON COUNTY
White	56.5%	75%
Black/African American	14.5%	7%
American Indian/Alaskan Native	1.6%	1%
Asian	--	7%
Native Hawaiian/Pacific Islander	--	0%
Other	--	7%
Mixed Race	4.8%	4%
Blank/Decline to Answer	23%	

Sticker Activity

Focus group participants were each asked to place three red stickers on topics that weren't going well in their life and three green stickers on topics that were going well in their life (Figure 116). The top three topics that focus group participants identified as not going well in their life were 1) mental/behavioral health, 2) transportation, and 3) housing. The top three topics that focus group participants identified as going well in their life were 1) physical activity, 2) healthcare, and 3) food and nutrition.

**Figure 115: Community Focus Group Sticker Activity**



## Appendix K: Truven Stakeholder Focus Group Results



**IBM Watson Health™**

### BAYLOR SCOTT & WHITE HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT EAST WILLIAMSON COUNTY JULY 25, 2018

#### Overview

Baylor Scott & White Health, Ascension Seton, Williamson County and Cities Health District, and St. David's Foundation contracted IBM Watson Health to conduct a series of focus groups to assess the perceived health needs of the Williamson County residents they serve. Community members were invited to participate based on their involvement with public health or their work with medically underserved, chronic disease, low-income, or vulnerable populations. This focus group included organizations from the rural part of Williamson County, east of Interstate 35. The focus group consisted of ten participants from various local organizations, such as community collaboratives, faith-based institutions, mental health clinics, housing authorities, and food pantries.

The focus groups were facilitated by a team from IBM Watson Health and conducted in three parts. The sessions started with the entire group providing a description of the community and determining an overall health score. During the second part, participants were divided into smaller groups for more detailed discussions. The group then came back together for a final exercise.

Discussions were oriented around the following questions:

1. Describe the community and score the current health status on a scale of 1-5 (1 worst – 5 best).
2. Identify the factors for the score and separate into strengths and weaknesses.
3. Discuss the underlying barriers to health that contribute to the weaknesses.
4. Discuss community strengths that can create opportunities for improving health.
5. Identify and rank the criteria for prioritization.

#### Community Health Needs and Priorities Discussion Summary

The participants described the community as very compassionate with local churches providing many of the social services the community needed. The group emphasized that the community strongly prioritizes health and wellness. However, certain barriers pose challenges to organizations that serve the community. These include lack of access to transportation, healthcare, and recreation, as well as income inequality. They shared that many working residents make below a living wage, which contributes to other challenges the community faces. There is also a shortage of affordable housing, which results in transient housing situations for some low-income families.

The discussion of top health needs in the community centered around three areas: communication and education, access to services, and services for the low-income population. Certain segments of the population lack health literacy, which contributes to underutilization of available services. Additionally, lack of public transportation options in Eastern Williamson County causes underutilization of primary care services and overutilization of the emergency department. Where services are present and accessible, they are not always available to uninsured or low-income families. Participants suggested that health needs should be prioritized based on ability to address root causes, build on the community's strengths, focus on vulnerable populations, and the community's capacity to address needs.

#### *Communication and Education*



The participants noted that available services are underutilized, sometimes due to lack of health literacy, including an understanding of long-term consequences of their health choices. The lack of health literacy impacts the community’s understanding of alternatives to receiving care via the emergency department. The group also believe there is a lack of awareness regarding the services available to community members. Participants noted that a significant number of people in the community speak Spanish as their primary language and this poses a barrier to utilizing and navigating health care and services. In addition, the group said that the community consists of many undocumented residents who might fear accessing services.

**Access to Services and Services for Low-Income Populations**

The focus group discussed the limited public transportation in this health community. Population growth on the west side of Williamson County, specifically Round Rock and Georgetown, led to expansion of healthcare services, but the dearth of public transportation makes these services unavailable to the lower income population on the east side of the county. The closest urgent care facility is 20 miles away, so residents use the closer emergency department instead.

According to the participants, East Williamson County has insufficient healthcare services for low-income and uninsured residents, especially dental and behavioral healthcare, which contributes to over-utilization of the emergency department. Healthy food options are scarce and there are food deserts in the community. The low-income/uninsured population sometimes need to prioritize basic needs like food and housing costs over paying for healthcare services. The group also said that the size of the low-income population exceeds available affordable housing, which leads to many families living in hotels or other short-term housing options.

**Opportunities**

The group had several ideas for how the community could collaborate to address some of the aforementioned health needs discussed. Many of these ideas focused on using schools or churches as places for collocating services or as conduits for educating the community. There was also discussion of using food pantries or the local police department to connect vulnerable populations to assistance and resources.

**Focus Group Discussion Detail**

These are additional details and comments captured during the focus group participant discussions.

**EXERCISE 1A: HOW WOULD YOU DESCRIBE THIS COMMUNITY?**

- Many resources are faith based, and many social services come out of churches.
- The community has heart, compassion, and willingness to come together.
- There is a focus on wellness in the community.
- There is a disparity in access to health, education, transportation, and recreational activities for:
  - ◊ Children from low-income families, who have fewer options for recreational activity.
  - ◊ Working poor of all ages, especially seniors with incomes that are insufficient to meet basic needs.
- There is an absence of vocational training opportunities for jobs that pay a living wage.
- A shortage of affordable housing is a major issue, causing families to live in hotels and short-term housing.

**EXERCISE 1B: HOW DO YOU DESCRIBE THE HEALTH OF THIS COMMUNITY ON A SCALE OF 1-5 (1 WORST – 5 BEST)?**

Participants each gave the community a score based on their assessment of the health of the community. The average health score given by this group was 2.6. For comparison, the average score for the other Williamson County focus group was 3.2.

<b>Score</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2.5</b>	<b>2</b>	<b>1</b>
<b>Participants</b>	0	0	5	1	4	0

IN EXERCISE 2, PARTICIPANTS WERE ASKED TO IDENTIFY THE FACTORS FOR THE SCORE THEY GAVE, AND THEN SEPARATE THE FACTORS INTO STRENGTHS AND WEAKNESSES FOR THE NEXT DISCUSSIONS.

**EXERCISE 3: WHAT ARE THE BARRIERS TO GOOD HEALTH IN THIS COMMUNITY?**

- Health information is available, but portions of the population cannot or do not access it.
  - ◊ Taylor Press and schools both posts notices in both English and Spanish, but there is a large illiterate Spanish-speaking population.
  - ◊ There are generational differences in how people receive health information. Taylor Press began posting information via social media to engage younger audiences, but this created a barrier for seniors, who are more likely to read a hardcopy newspaper.
  - ◊ Some residents need a more robust method of referral than “just handing someone a pamphlet”, e.g., to connect patients to resources like Bluebonnet Trails.
- Health Illiteracy examples:
  - ◊ Disconnect between behavior and consequences, e.g., diabetic man goes to food pantry and gets sweets.
  - ◊ Lack of awareness of treatment for symptoms, e.g., patients don’t seek treatment until there is a health crisis and then goes to the emergency department.
- Trust and cultural differences:
  - ◊ Undocumented population fears accessing services.
  - ◊ Patients are unwilling to admit that they do not understand discharge instructions due to language barriers or hearing impairment.
  - ◊ “There is never a lack of healthcare because people just go to the ER - that is how they get healthcare.”
- Low income population of all ages face added challenges:
  - ◊ Need to prioritize food and other necessities over healthcare, including medications.
  - ◊ Lack of local dental services for the uninsured (requires travel to Round Rock.)
  - ◊ High numbers of uninsured residents in the health community, possibly correlated to undocumented residents.
  - ◊ Large senior population.
  - ◊ Food deserts and lack of access to healthy food.
- Substance abuse and mental health challenges:
  - ◊ Stigma
  - ◊ Prevalence of alcohol and drug use, e.g., marijuana, opioids, and methamphetamines.
  - ◊ Proximity to drug trafficking routes.
- Transportation considerations:
  - ◊ Public transportation is very limited and prevents the rural population from accessing available services, including pharmacies.
  - ◊ Williamson County is no longer deemed “rural” due to growth in the western part of the county, yet services are not accessible to the rural population on the east side.
  - ◊ The closest urgent care center is 20 miles away, so patients use the ER because it is closer.

Each participant voted for what they consider to be the 3 greatest barriers, ranked according to votes.

Barriers	Number of votes
Lack of awareness of services	7
Low income	7
Cultural barriers creating underuse	6

**EXERCISE 4: COMMUNITY PARTNERSHIPS AND OPPORTUNITIES**

- Hospital partnerships with schools and churches:
  - ◊ Supply health services, resources, and information to churches.
  - ◊ Provide nurses and EMTs to Parish Nurse program and the 65 churches in Taylor.

- ◇ Utilize health advocate peers to help explain discharge notes and instructions when the doctor can only spend 15 minutes with each patient.
- Schools as a resource:
  - ◇ Create collaboration between schools and healthcare services because undocumented families already have established relationships and feel safe there.
  - ◇ Educate children, who will spread the information to their parents.
  - ◇ Offer school-based services that are a conduit to families, such as food programs.
  - ◇ Work on legislation to expand school health services.
  - ◇ Provide school-based mental health for the entire school population, including teachers and staff.
  - ◇ Bartlett Schools are partnering with Literacy Council of Williamson to bring in secondary education resources for the community.
- Communication and coordination:
  - ◇ Use the media to bombard people from every angle with information about health events and resources.
  - ◇ Partner with private and public organizations, including food pantries, churches, schools, and employers to publicize information.
  - ◇ Utilize senior housing organization to reach low-income seniors.
  - ◇ Connect Bluebonnet Trails with the food pantry to provide psychiatric medication to food pantry clients.
  - ◇ Taylor Police Department has a network of agencies providing services.
  - ◇ Use cultural competence and language services to reach some populations.
  - ◇ Have a central location for services.
- Recreation:
  - ◇ Use local parks for fundraising walks.
  - ◇ Promote healthy eating through community garden.

Each participant voted for what they consider to be the 3 greatest opportunities, ranked according to votes.

Opportunity	Number of votes
Health education	7
Networking/word of mouth, network of local agencies	5
Co-located services	3

**EXERCISE 5: HOW TO PRIORITIZE THE NEEDS TO BE ADDRESSED**

Each participant voted for the top criteria to be used for prioritization of this community’s identified needs.

Top Criteria for Prioritization	Number of votes
Root Cause	7
Community Strengths	6
Community Capacity	4
Vulnerable Populations	4

**EXERCISE 6: BEHAVIORAL HEALTH**

Residents of Eastern Williamson County have mental and behavioral health needs which results in potentially increased opiate abuse. Participants noted gaps in the mental and behavioral health services continuum:

- Low income patients who cannot afford medications
- Lack of beds for mental health and substance abuse treatment, especially for low-income patients
- Need to educate law enforcement about handling of substance abuse cases
- Shortage of providers.

**PARTICIPATING ORGANIZATIONS**

Representatives from the following organizations participated in the focus group:

- Shepherd's Heart Food Pantry and Community Ministries
- Interagency of Eastern Williamson County
- East WilCo Collaborative
- Taylor Press
- Tripp Center
- United Seniors of Taylor
- Bluebonnet Trails Community Services
- LifePark Center
- Christ Fellowship Church
- Taylor Housing Authority



**BAYLOR SCOTT & WHITE HEALTH**  
**COMMUNITY HEALTH NEEDS ASSESSMENT**  
**WILLIAMSON COUNTY**  
**JULY 25, 2018**

## Overview

Baylor Scott & White Health engaged IBM Watson Health to conduct a series of focus groups to assess the perception of the health needs in the Texas communities they serve. Participants were invited to participate based on their involvement with public health or their work with medically underserved, chronic disease, low-income or minority populations. Participation was also sought from community leaders, other healthcare organizations, and other healthcare providers, including physicians.

The focus groups were facilitated by a team from IBM Watson Health and conducted in three parts. The sessions started with the entire group providing a description of the community and determining an overall health score. During the second part, participants were divided into smaller groups (if overall number of participants allowed) for more detailed discussions. The group then came back together for a final exercise. Discussions were oriented around the following questions:

1. Describe the community and score the current health status on a scale of 1-5 (1 worst – 5 best).
2. Identify the factors for the score and separate into strengths and weaknesses.
3. Discuss the underlying barriers to health that contribute to the weaknesses.
4. Discuss community strengths that can create opportunities for improving health.
5. Identify and rank the criteria for prioritization.

The Williamson County focus group was held in Georgetown and included thirteen participants. The group included service agency leaders, church representatives, providers, and representatives from various community agencies. Most of the participants worked with at-risk populations; the group at-large serve low-income populations, minorities, the medically under-served, and populations with chronic diseases.

## Community Health Needs and Priorities Discussion Summary

Participants described the community as a historically conservative, rural community where law and order dominated policies in the past. The community was undergoing an identity shift as people migrated from Austin into the area and shifting to be increasingly liberal, diverse, and urban. Due to the rapid population growth, resources in the community were at capacity and unable to keep up with demand. In addition to resource issues, the community lacked a central hub or epicenter of services which created challenges in coordinating efforts to address the health needs of the community. The focus group believes the top health needs in the community centered around poor coordination of services, access to care for low-income residents, and the growing homeless population. Participants felt that health needs should be prioritized with a focus on vulnerable populations, community capacity, and political feasibility/acceptability to address the issue.

### *Shifts in Population Demographics*

The focus group participants described the community demographics as having shifted significantly due to the rapid growth and influx of new residents. The immigrant population had increased as more people of South Asian and African descent moved into the area bringing extended family members as they established themselves. This resulted in many of the new immigrants being elderly, non-English speaking, and uninsured; which posed a unique set of challenges in addressing their health needs. Translation and bilingual healthcare services were particularly lacking, according to the group.

As Williamson became an increasingly desirable place to live, the community saw rapid gentrification and an increasing income gap, according to the focus group. The low income and homeless populations were growing, but funding and support for organizations serving these populations had not experienced a parallel growth. Local politics and policies created barriers for organizations to serve these populations whose health needs are significant.

### *Access and Coordination of Care*

The participants noted that recent growth was affecting the identity of the community, and its organizational structure was still evolving. This created challenges for organizations that were helping patients navigate the complex healthcare ecosystem, especially those patients who lacked insurance. Small charity organizations were overwhelmed with demand and could not support the needs of the uninsured and under-insured. Additional coordination across non-profit organizations, social services, and the local hospital systems was required. The entry point into services was unclear, which led to inefficiencies across organizations. Participants suggested using community vouchers to grant low-income patients access to all local agencies, expanding partnerships between the local library and Health and Human Services, and developing an intra-agency referral system as potential means to improve coordination in the community.

The group noted there were limited resources available for the homeless, uninsured, and poor. Resources that were particularly lacking in the community included low cost or free dental clinics, homeless shelters, and behavioral health providers and substance abuse treatment facilities that served the poor and indigent population. Additionally, participants stressed the importance of expanding transitional services to help patients move successfully from federal assistance programs to autonomy. This was especially important for healthcare as many patients could not transition from receiving free services or Medicaid to paying for their own insurance and medical bills. Lack of public transportation created an additional barrier for the low-income population and prevented patients from attending appointments and accessing healthcare services.

## Focus Group Discussion Detail

These are additional details and comments captured during the focus group participant discussions.

### EXERCISE 1A: HOW WOULD YOU DESCRIBE THIS COMMUNITY?

---

- Changing identity
  - ◊ Community had become an affordable version of Austin.
  - ◊ Collection of towns lacked a centralized hub or epicenter.
- Increasingly diverse:
  - ◊ growth of uninsured elderly immigrants relocated to reunite with family members
  - ◊ increased South Asian and African immigrant population
  - ◊ income disparity increased as low-income population continued to grow
  - ◊ rapid gentrification exacerbated income disparity.
- Increased tensions around growing diversity:
  - ◊ historically rural community with a small-town mentality rapidly converting to urban
  - ◊ historically conservative with growing liberal presence
  - ◊ resistance from residents to changing social landscape and diversity
  - ◊ law and order community.
- Lack of dependable public transportation was a major issue for rural parts of the community.
- Family friendly:
  - ◊ safe
  - ◊ food schools
  - ◊ sports- football.

- Services in the community were stretched thin and cannot keep pace with growth of population.

**EXERCISE 1B: HOW DO YOU DESCRIBE THE HEALTH OF THIS COMMUNITY ON A SCALE OF 1-5 (1 WORST – 5 BEST)?**

Overall community health score given by the group was 3.2

<b>Score</b>	5	4	3.5	3	2	1
<b>Participants</b>	0	2	2	6	1	0

**EXERCISE 3: WHAT ARE THE BARRIERS TO GOOD HEALTH IN THIS COMMUNITY?**

- Citizenship status. Undocumented immigrants were hesitant to access healthcare and social services due to fear of deportation.
- Linguistic barriers were increasing (i.e. South Asian population) but translation services limited and often only available in Spanish.
- Food deserts:
  - ◊ prevalent in rural parts
  - ◊ lacked grocery stores
  - ◊ access to healthy foods limited for low income residents.
- Local politics:
  - ◊ policies hindered local organizations from addressing health needs
  - ◊ lack of funding and support for social and healthcare services to support low income populations
  - ◊ failure to acknowledge social issues that faced the community (i.e. homelessness, domestic violence)
  - ◊ history as a law and order community discouraged patients in need from accessing resources for fear of prosecution.
- Homelessness:
  - ◊ lack of affordable housing
  - ◊ no homeless shelters in the community
  - ◊ local policies promoted a punitive attitude towards the homeless population.
- Lack of public transportation
- Resources not coordinated:
  - ◊ poor communication hindered coordination between NFPs and social services
  - ◊ resources siloed
  - ◊ information often unreliable or outdated
  - ◊ mental/behavioral health services particularly impacted
  - ◊ entry point into services unclear caused inefficiencies.
  - ◊ lack of transitional services
    - ◆ no transitional support for shifting off federal assistance
    - ◆ lack of long-term support and follow-up
    - ◆ cycle back through federal assistance programs.
- Rapid population shifts/growth were outpacing growth in healthcare services:
  - ◊ especially for low income residents
  - ◊ insufficient dental clinics for area demand
  - ◊ investment in healthcare resources was focused on higher income sectors
  - ◊ low income population was growing but investment in services for this population was declining.

Each person voted for what they consider to be the 3 greatest BARRIERS, ranked according to votes.



Challenge	Score
Lack of transitional services	7
Poor coordination and communication between NFPs and social services	7
Homelessness and lack of support services for this population	7
Local politics	6
Services cannot keep pace with population shifts and growth	4

**EXERCISE 4: COMMUNITY PARTNERSHIPS AND OPPORTUNITIES**

- Transportation programs to assist patients in accessing healthcare. No cost ride share program potentially coordinated through the local library to as an access point and information hub in the community.
- Healthy diet prescriptions. Partnership between medical providers and food pantries to provide healthy foods for patients with chronic conditions like diabetes, COPD, heart disease.
- Medicaid expansion
- Improve regional coordination and cooperation of social and healthcare services.
  - ◊ Develop community voucher that provides access to all locally available agencies.
  - ◊ Promote partnerships between the library and Health and Human Services.
    - ◆ Library can act as a key access point in the community due to presence of a licensed social worker. One successful example is that the library staff is trained in mental health first aid and has Narcan (anti-opioid overdose medication) on hand.
    - ◆ Intra-agency referral system. Enhance 2-1-1 United Way referral system.

Each person voted for what they consider to be the 3 greatest OPPORTUNITIES, ranked according to votes.

Opportunity	Score
Transportation programs to assist patients in accessing healthcare	10
Intra-agency referral system to improve coordination	9
Improving regional coordination and cooperation	7

**EXERCISE 5: HOW TO PRIORITIZE THE NEEDS TO BE ADDRESSED**

In discussion about criteria for prioritizing the needs of the community, the group identified one criteria in addition to those put forth as common criteria:

- political feasibility/acceptability/readiness

Each person voted for the top 3 criteria to be used for prioritization of this communities identified needs.

Top Criteria for Prioritization	Weight
Vulnerable populations	7
Community Capacity	7
Political feasibility/readiness/acceptability	7
Severity	5

**EXERCISE 6: BEHAVIORAL HEALTH**

Gaps in the mental/behavioral health services continuum:

- Lack of long-term support and psychiatric services
- Opioid users required additional intervention
  - ◊ Narcan availability limited for use in life threatening crisis situations.
  - ◊ Narcan is currently available in the local library which had hired a licensed social worker.

- Groups most need of services:
  - ◇ youth
  - ◇ rural populations
  - ◇ working poor
  - ◇ patients without transportation.

## PARTICIPATING ORGANIZATIONS

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Representatives from the following organizations participated in the focus group:

- Pavilion
- Christ Fellowship Church and Interagency of EWC
- Sacred Heart Community Clinic
- Williamson County and Cities Health District- PESS
- Taylor Housing Authority
- United Way of Williamson County
- Georgetown Public Library
- Georgetown Health Foundation
- Baylor Scott & White - Austin/Round Rock
- Mobile Outreach Team Williamson County Emergency Services
- Lone Star Circle of Care
- The Caring Place

## Appendix L: Truven Key Informant Interview Notes



**IBM Watson Health™**

### BAYLOR SCOTT & WHITE HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT EAST WILLIAMSON COUNTY KEY INFORMANT INTERVIEW NOTES

#### Overview

Baylor Scott & White Health, Ascension Seton, and Williamson County and Cities Health District contracted IBM Watson Health to conduct key informant interviews to assess the perception of the health needs in the Texas communities they serve. Community members were invited to participate based on their involvement with public health or their work with medically underserved, chronic disease, low-income, or minority populations. The phone interview topics included an overall health status score of the community, factors considered in the score, barriers to health, gaps in service, and opportunities for improving health. There were four interview participants for Eastern Williamson County, including representation from the Mayor's office, Boys & Girls Clubs of America, Life Park Board, East Williamson County Cooperative, and Interagency East. This is a summary of the comments and feedback collected during the key informant interviews. Similar responses by multiple respondents are indicated in parenthesis.

The discussion of top health needs in the community centered around the following themes: health education and navigation, access to services, and the need for mental health resources. These themes were like themes highlighted in the Eastern Williamson County focus group.

Interview participants repeatedly returned to the theme of health education, not just about healthy behaviors but also about understanding the resources available to the community and how to access them. This theme flowed into discussions about helping community members understand how to navigate the healthcare, especially those who face barriers to accessing care such as lack of healthcare insurance, low income, or language barriers.

Access to healthcare services was another frequent discussion point, with participants mentioning that specialty care was not readily available within the community and one needed to travel outside the community to access certain specialists (or to have a choice of providers). Low-income residents found this particularly burdensome as they may not have transportation, flexibility, or other means to access those services outside the community.

Mental health resources was another common topic that emerged from the interviews. Those who are dealing with mental health issues were recognized as a vulnerable population. There was discussion about a lack of mental health providers, especially for those without insurance. The participants acknowledged there were other types of mental health resources in the community, but they were limited and not consistently available due to lack of sustained funding.

#### Interview Feedback

1. How would you rate the current health status of this community (scale 1-5; 1=poor 5=excellent) and what are the factors you considered?

The scores given for this community were 3, 3, 3.5, and 4. Interview participants said these factors were considered when selecting their score:

- Investment in bike trails and amenities to encourage healthy living (2)

- High cost of health care and preventive medicine for low-income residents
- Threat of immigration issues
- Decent weather
- Diabetes and obesity (3)
- Health fairs
- Access to healthy eating and exercise
- Lack of access to health food for low income residents, especially Hispanic residents
- Limited access to specialists outside Taylor for those without insurance or low income
- Substance abuse
- Lack of childcare and healthcare options for the poor and elderly in Taylor
- Mental health
- Low socioeconomic groups in this area who choose not to access support for their health
- Families who don't know how to access what they need. (5)

## 2. What are the barriers to good health in this community?

- Culture and lack of health education
- Habits and ongoing patterns of unhealthy behavior
- Distance to see a specialist (2)
- Health education about available services
- Lack of mental health services
- Connection to people who don't seek information
- Language issues that limit information from reaching the whole community (information needs to be multiple languages)
- Lack of knowledge to navigate the health care system; barriers for lower income residents (3)
- Few exercise options, lack of sidewalks in rural areas outside Taylor
- Barriers between cultures that are divisive lead to social isolation; lack of trust among minority populations. (2)
- Transportation (3), especially in rural areas.

## 3. What are the largest unmet need and the gaps in healthcare services?

- Dental and vision for low income and uninsured
- Health education about available services
- Mental health (4) with family wraparound support
- Diabetes services
- Doctors that accept Medicare supplemental insurance
- Free health clinic options for drop in care instead of using emergency department
- Specialists of all types (5), including heart services, pediatrics, oncology, and obstetrics
- More choices in provider of services, especially for low income residents who can't leave the area.
- Mental health providers that take patients without insurance.

## 4. 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?

- Low income or residents with cultural barriers who underutilize preventive services
- Low socio-economics groups (2), especially the working poor who don't have insurance or are underinsured
- Rural residents who are less likely to travel far for access
- People with mental health issues
- Children without access to Head Start
- Low income seniors and older people with aging care needs (2)
- Residents on the south side of Taylor, where there are a greater number of lower income residents, special needs, language issues, large Hispanic populations, transportation challenges, and poor housing conditions.
- Groups with lower resources and less flexibility.

## 5. Where are there gaps in the mental/behavioral health services continuum?

- Bluebonnet services and programs that are more consistent
- Behavioral health assessment appointments for students in schools faster (currently multiple weeks)
- Family wraparound services for children, someone outside the school to determine overall needs of the family
- Additional staffing and resources for Blue Bonnet Trails Community Services to serve 8 counties
- Liaison between schools and services
- Alcohol and meth services in rural areas
- Funding for program changes to make services available long term.

6. What are 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?

- Bring in speakers for seniors.
- Need help on how to access services outside this market (that are not available locally).
- Determine in each community what are some of the groups that have good turnouts at events (Lions Club, Rotary) and connect with the community to help set up education sessions.
- Need navigators to help people find services.

7. How do community residents access their health information? What are the information gaps about health and healthcare services in this community?

- Churches or membership organizations
- Internet is easily accessible (3) but not available to everyone, especially seniors.
- Word of mouth in this rural community, with family members and friends is most common. (3)
- Library computers, but they're often full. Suggestion to get more computers and place them at hospitals and doctor offices.
- TV advertising
- 211 and Aunt Bertha (online resource to search by ZIP or topic)
- Newspaper
- Need to reach out to everyone in the community, especially those who can't read English.

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

- Have health classes in all languages; give information in multiple languages. (2)
- Teach about options in schools and involve the parents. (2)
- Be more inclusive and ensure that offerings are available to everyone, including different neighborhoods and churches.
- Everybody needs a doctor or medical professional, and check for certification and qualifications.
- People with resources don't experience any difficulty.
- Have churches sponsor events with BSWH or have hospitals reach out so people can understand the issues and spread the word.
- Improve transportation so people can access specialists and preventive care outside the community.
- The south side of Taylor has higher needs for better health, food options, and housing. Suggest that services in that community should be close by and easy to access.

9. How can the 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?

- Be out and more visible in the community.
- Build more opportunities for activity or healthy food.
- Have health fairs in parks on the south side for the community to walk there to learn about health care options and services.
- Understand the greater need in this area and brainstorm how to get people healthier.
- Hospital providers go the senior center, students, and housing authority.
- Use more mobile clinics. St. David's has a van for dental care, which is a great model.
- Provide physicians that can visit patient homes when they can't go to the hospital.
- Welcome people and make it more accessible. Offer more health fairs and make doctors available. Get to know people.

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

- Create a centralized location for low income services and promote healthy food and lifestyle. Makes it more accessible.
- Offer counselors to help people with paperwork. Get everybody involved and familiar with the process of navigating the health care system and make it a shared experience.
- One stop shop - centralized location with nurse practitioners, different specialties, food banks, budgeting, and healthy eating classes.
- Bring people together with different perspectives to share multifaceted input, understand what services are available, build relationships, and work together better.
- The county commissioner who oversees mental health services invited school people to a forum to listen about the mental health needs; this was very useful.
- Use churches to share information about programs, build on trust in those communities, especially minority ones.

## Appendix M: Mom's Community Listening Forum Report

Report can be accessed here:

[http://www.healthywilliamsoncounty.org/content/sites/wcchd/maternal\\_and\\_infant/2018/FINAL\\_Moms\\_Report.pdf](http://www.healthywilliamsoncounty.org/content/sites/wcchd/maternal_and_infant/2018/FINAL_Moms_Report.pdf)

## Appendix N: CASPER Report

Report can be accessed here: <http://www.healthywilliamsoncounty.org/casper>



## Appendix O: Local Public Health Systems Survey

This survey is part of the 2019 Williamson County Community Health Assessment (CHA) conducted by Williamson County and Cities Health District and community partners. The purpose of the survey is to measure the extent and reach of the local public health system in Williamson County. The survey is based on the 10 Essential Public Health Services, as defined by the Centers for Disease Control and Prevention (CDC), and the local public health system assessment guidelines developed by the National Association of County and City Health Officials (NACCHO). For more information about the essential services of Public Health, please see this link: <https://www.cdc.gov/nphpsp/essentialservices.html>.

Responses from this survey will be combined with other data sources and used to prioritize health needs in Williamson County. You received this survey because your organization has been identified as an important part of the local public health system in Williamson County.

The local public health system is commonly defined as all “public, private, and voluntary entities, individuals, and informal associations that contribute to the delivery of the essential health services within a jurisdiction.”

Please answer each question below about your organization’s role in the delivery of public health services and your perceptions of how well the local public health system is doing in delivering public health services.

We prefer that only one person from each organization, or each division within a larger organization, answer the survey.

NAME	
Title	
Organization	
Email	

Please select from the list below which areas your organization has a role in delivering services. Please select all that apply.

- Chronic disease prevention and control
- Communicable disease prevention and control
- Emergency preparedness, response and recovery
- Community engagement
- Mental health and substance abuse
- Preventive health services
- Primary care services
- Program eligibility and social services
- Specialty care services
- Surveillance/Epidemiology
- Other \_\_\_\_\_

<b>Optimal Activity (76–100%)</b>	Greater than 75% of the activity described within the question is met.
<b>Significant Activity (51–75%)</b>	Greater than 50% but no more than 75% of the activity described within the question is met.
<b>Moderate Activity (26–50%)</b>	Greater than 25% but no more than 50% of the activity described within the question is met.
<b>Minimal Activity (1–25%)</b>	Greater than zero but no more than 25% of the activity described within the question is met.
<b>No Activity (0%)</b>	0% or absolutely no activity.

ESSENTIAL SERVICE #1 – MONITOR HEALTH STATUS TO IDENTIFY COMMUNITY HEALTH PROBLEMS

**1.2.1 Use the best available technology and methods to display data on the public’s health?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**1.2.2 Analyze health data, including geographic information, to see where health problems exist?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ESSENTIAL SERVICE #2 – DIAGNOSE AND INVESTIGATE HEALTH PROBLEMS AND HEALTH HAZARDS

**2.1.1 Participate in a comprehensive surveillance system with national, state, and local partners to identify, monitor, and share information and understand emerging health problems and threats?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**2.1.2 Provide and collect timely and complete information on reportable diseases and potential disasters, emergencies, and emerging threats (natural and manmade)?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**2.2.2 Develop written rules to follow in the immediate investigation of public health threats and emergencies, including natural and intentional disasters?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**2.3.1 Have ready access to laboratories that can meet routine public health needs for finding out what health problems are occurring?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ESSENTIAL SERVICE #3—INFORM, EDUCATE, AND EMPOWER PEOPLE ABOUT HEALTH ISSUES

**3.1.1 Provide policymakers, stakeholders, and the public with ongoing analyses of community health status and related recommendations for health promotion policies?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
--	-------------	---------	----------	-------------	---------

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**3.1.2 Coordinate health promotion and health education activities at the individual, interpersonal, community, and societal levels?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**3.2.1 Develop health communication plans for media and public relations and for sharing information among LPHS organizations?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**3.3.1 Develop an emergency communications plan for each stage of an emergency to allow for the effective dissemination of information?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**3.3.2 Make sure resources are available for a rapid emergency communication response?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ESSENTIAL SERVICE #4—MOBILIZE COMMUNITY PARTNERSHIPS TO IDENTIFY AND SOLVE HEALTH PROBLEMS**

**4.2.1 Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**4.2.3 Assess how well community partnerships and strategic alliances are working to improve community health?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ESSENTIAL SERVICE #5—DEVELOP POLICIES AND PLANS THAT SUPPORT INDIVIDUAL AND COMMUNITY HEALTH EFFORTS**

**5.1.1 Support the work of the local health department (or other governmental local public health entity) to make sure the 10 Essential Public Health Services are provided?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal

**5.1.3 Ensure that the local health department has enough resources to do its part in providing essential public health services?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**5.2.1 Contribute to public health policies by engaging in activities that inform the policy development process?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**5.2.2 Alert policymakers and the community of the possible public health effects (both intended and unintended) from current and/or proposed policies?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**5.3.3 Connect organizational strategic plans with the Community Health Improvement Plan (CHIP)?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ESSENTIAL SERVICE #6—ENFORCE LAWS AND REGULATIONS THAT PROTECT HEALTH AND ENSURE SAFETY**

**6.1.2 Stay up-to-date with current laws, regulations, and ordinances that prevent health problems or that promote or protect public health on the federal, state, and local levels?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**6.2.1 Identify local public health issues that are inadequately addressed in existing laws, regulations, and ordinances?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**6.2.2 Participate in changing existing laws, regulations, and ordinances, and/or creating new laws, regulations, and ordinances to protect and promote public health?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ESSENTIAL SERVICE #7—LINK PEOPLE TO NEEDED PERSONAL HEALTH SERVICES AND ASSURE THE PROVISION OF HEALTHCARE WHEN OTHERWISE UNAVAILABLE

**7.1.2 Identify all personal health service needs and unmet needs throughout the community?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**7.2.2 Help people access personal health services in a way that takes into account the unique needs of different populations?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**7.2.4 Coordinate the delivery of personal health and social services so that everyone in the community has access to the care they need?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ESSENTIAL SERVICE #8—ASSURE A COMPETENT PUBLIC HEALTH AND PERSONAL HEALTHCARE WORKFORCE

**8.3.1 Identify education and training needs and encourage the public health workforce to participate in available education and training?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**8.3.5 Continually train the public health workforce to deliver services in a culturally competent manner and understand the social determinants of health?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**8.4.4 Provide opportunities for the development of leaders who represent the diversity of the community?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well is this done in the local public health system?	No Activity	Minimal	Moderate	Significant	Optimal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ESSENTIAL SERVICE #9—EVALUATE EFFECTIVENESS, ACCESSIBILITY, AND QUALITY OF PERSONAL AND POPULATION-BASED HEALTH SERVICES

**9.1.1 Evaluate how well population-based health services are working, including whether the goals that were set for programs and services were achieved?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?	NO ACTIVITY	MINIMAL	MODERATE	SIGNIFICANT	OPTIMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How well is this done in the local public health system?    No Activity    Minimal    Moderate    Significant    Optimal  
                                                                                       

**9.1.2 Assess whether community members, including vulnerable populations, are satisfied with the approaches taken toward promoting health and preventing disease, illness, and injury?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?    No Activity    Minimal    Moderate    Significant    Optimal  
                                                                                       

How well is this done in the local public health system?    No Activity    Minimal    Moderate    Significant    Optimal  
                                                                                       

**9.1.3 Identify gaps in the provision of population-based health services?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?    No Activity    Minimal    Moderate    Significant    Optimal  
                                                                                       

How well is this done in the local public health system?    No Activity    Minimal    Moderate    Significant    Optimal  
                                                                                       

**ESSENTIAL SERVICE #10—RESEARCH FOR NEW INSIGHTS AND INNOVATIVE SOLUTIONS TO HEALTH PROBLEMS**

**10.1.3 Keep up with information from other agencies and organizations at the local, state, and national levels about current best practices in public health?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?    No Activity    Minimal    Moderate    Significant    Optimal  
                                                                                       

How well is this done in the local public health system?    No Activity    Minimal    Moderate    Significant    Optimal  
                                                                                       

**10.2.2 Partner with colleges, universities, or other research organizations to conduct public health research, including community-based participatory research?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?    No Activity    Minimal    Moderate    Significant    Optimal  
                                                                                       

How well is this done in the local public health system?    No Activity    Minimal    Moderate    Significant    Optimal  
                                                                                       

**10.3.3 Share findings with public health colleagues and the community broadly, through journals, Web sites, community meetings, etc.?**

TO WHAT EXTENT DOES YOUR ORGANIZATION DO THIS?    No Activity    Minimal    Moderate    Significant    Optimal  
                                                                                       

How well is this done in the local public health system?    No Activity    Minimal    Moderate    Significant    Optimal

## Appendix P: Local Public Health System Assessment Results

MEASURE	DESCRIPTION OF PERFORMANCE MEASURE	LPHS AVERAGE SCORE	ORGANIZATION AVERAGE SCORE
6.1.2	Stay up-to-date with current laws, regulations, and ordinances that prevent health problems or that promote or protect public health on the federal, state, and local levels?	3.86	3.64
4.2.1	Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?	3.60	4.27
5.1.1	Support the work of the local health department (or other governmental local public health entity) to make sure the 10 Essential Public Health Services are provided?	3.57	3.79
4.2.3	Assess how well community partnerships and strategic alliances are working to improve community health?	3.53	4.07
2.1.2	Provide and collect timely and complete information on reportable diseases and potential disasters, emergencies, and emerging threats (natural and manmade)?	3.50	2.88
2.3.1	Have ready access to laboratories that can meet routine public health needs for finding out what health problems are occurring?	3.50	2.69
5.3.3	Connect organizational strategic plans with the Community Health Improvement Plan (CHIP)?	3.50	3.86
7.1.2	Identify all personal health service needs and unmet needs throughout the community?	3.50	3.50
10.1.3	Keep up with information from other agencies and organizations at the local, state, and national levels about current best practices in public health?	3.46	3.92
3.1.1	Provide policymakers, stakeholders, and the public with ongoing analyses of community health status and related recommendations for health promotion policies?	3.44	3.69
3.1.2	Coordinate health promotion and health education activities at the individual, interpersonal, community, and societal levels?	3.44	3.44
3.3.2	Make sure resources are available for a rapid emergency communication response?	3.44	2.75
1.2.2	Analyze health data, including geographic information, to see where health problems exist?	3.38	3.38
2.2.2	Develop written rules to follow in the immediate investigation of public health threats and emergencies, including natural and intentional disasters?	3.38	2.88
2.1.1	Participate in a comprehensive surveillance system with national, state, and local partners to identify, monitor, and share information and understand emerging health problems and threats?	3.31	3.44
3.3.1	Develop an emergency communications plan for each stage of an emergency to allow for the effective dissemination of information?	3.31	2.69
3.2.1	Develop health communication plans for media and public relations and for sharing information among LPHS organizations?	3.25	3.13



10.2.2	Partner with colleges, universities, or other research organizations to conduct public health research, including community-based participatory research?	3.15	3.46
5.2.1	Contribute to public health policies by engaging in activities that inform the policy development process?	3.14	2.79
6.2.1	Identify local public health issues that are inadequately addressed in existing laws, regulations, and ordinances?	3.14	3.14
6.2.2	Participate in changing existing laws, regulations, and ordinances, and/or creating new laws, regulations, and ordinances to protect and promote public health?	3.14	2.79
7.2.2	Help people access personal health services in a way that takes into account the unique needs of different populations?	3.14	3.50
7.2.4	Coordinate the delivery of personal health and social services so that everyone in the community has access to the care they need?	3.14	3.21
1.2.1	Use the best available technology and methods to display data on the public's health?	3.13	3.25
9.1.1	Evaluate how well population-based health services are working, including whether the goals that were set for programs and services were achieved?	3.08	3.62
9.1.3	Identify gaps in the provision of population-based health services?	3.08	3.46
5.1.3	Ensure that the local health department has enough resources to do its part in providing essential public health services?	3.00	2.71
5.2.2	Alert policymakers and the community of the possible public health effects (both intended and unintended) from current and/or proposed policies?	3.00	2.64
9.1.2	Assess whether community members, including vulnerable populations, are satisfied with the approaches taken toward promoting health and preventing disease, illness, and injury?	2.92	3.23
10.3.3	Share findings with public health colleagues and the community broadly, through journals, Web sites, community meetings, etc.?	2.85	3.15
8.3.1	Identify education and training needs and encourage the public health workforce to participate in available education and training?	2.85	3.31
8.3.5	Continually train the public health workforce to deliver services in a culturally competent manner and understand the social determinants of health?	2.77	3.15
8.4.4	Provide opportunities for the development of leaders who represent the diversity of the community?	2.46	2.62

## Appendix Q: Community Health Assessment Matrix

NAME OF ASSESSMENT	ORG	YEAR	DEMOGR APHICS	SOCIAL & PHYSICAL ENVIRONMENT	COMMUNITY STRENGTHS & RESOURCES	HEALTH BEHAVIORS	HEALTH OUTCOMES	HEALTH CARE ACCESS & AFFORDABILITY	EXTERNAL FACTORS	COMMUNITY'S VISION & IDENTIFIED OPPORTUNITIES	LINK
Williamson County Comprehensive Parks Master Plan	Williamson County	2018	X	X	X				X	X	<a href="http://www.willco.org/public-input-needed-on-updated-parks-master-plan">http://www.willco.org/public-input-needed-on-updated-parks-master-plan</a>
Community Coalition Partnerships, Community Needs Assessment	LifeSteps	2018	X		X	X	X		X	X	PDF Copy
Southeast Georgetown Needs Assessment	Georgetown Health Foundation	2015	X	X	X	X		X	X	X	<a href="http://gthf.org/Forms/GHF_NE EDS_ASSESSMENT_CV_Nov2015.pdf">http://gthf.org/Forms/GHF_NE EDS_ASSESSMENT_CV_Nov2015.pdf</a>
Community Health Needs Assessment	Baylor Scott & White Medical Center – Round Rock, Taylor, Cedar Park	2016	X	X	X	X	X	X			<a href="https://www.bswhealth.com/SiteCollectionDocuments/about/community-health-needs-assessments/BSW_CHNA_Final_Report_CTX3_AustinRR.pdf">https://www.bswhealth.com/SiteCollectionDocuments/about/community-health-needs-assessments/BSW_CHNA_Final_Report_CTX3_AustinRR.pdf</a>
Community Assessment	Opportunities for Williamson and Burnet Counties	2017	X	X	X			X		X	<a href="http://www.opportunitiesforwbc.org/wp-content/uploads/2017/05/2017-Community-Assessment.pdf">http://www.opportunitiesforwbc.org/wp-content/uploads/2017/05/2017-Community-Assessment.pdf</a>

# 2019 COMMUNITY HEALTH NEEDS ASSESSMENT BASTROP COUNTY, TEXAS





# ACKNOWLEDGEMENTS

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The 2019 Bastrop County Community Health Needs Assessment (CHNA) represents the commitment of numerous partners who have contributed their expertise, resources and time in support of a shared mission—to make Central Texas the healthiest community for all its residents. The data collection methodology was co-created through a partnership of health system partners to ensure authentic community input and existing qualitative data would be combined to provide a comprehensive assessment of conditions and opportunities that exist to improve health in Bastrop County. We recognize all of our CHNA partners including St. David’s Foundation, Georgetown Health Foundation, Ascension Seton and Bastrop County Cares. Most importantly, we appreciate the many community organizations, churches, mothers, fathers, youth, advocates, leaders and community members who shared their time, experience and hopefulness to help us complete this assessment. SHARED Strategy Group, LLC gratefully acknowledges the assistance of and/or contributions to this report by the following organizations:

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Krystal Grimes – Bastrop County Cares

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## COMMUNITY INPUT PARTNERS

Lost Pines Elementary School  
Bastrop Outreach Christian Center  
Red Rock Food Pantry  
Department of Veterans Affairs-Bastrop County  
Smithville Community Clinic  
Blue Bonnet Community Services  
Texas Association of Community Health Services  
Bastrop County Cares  
Ascension Catholic Church  
Smithville School District  
Texas A&M University Extension Services  
Bastrop Independent School District  
Lone Star Circle of Care  
Ascension Seton Smithville  
Combined Community Action

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# EXECUTIVE SUMMARY

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## OVERVIEW

Our understanding of what health means as a public condition, approach, and system is evolving. Clinical interventions were once the primary means for keeping people healthy. Adherence to regimens, healthy eating, physical activity, and ways to support healthy behaviors were understood as the path to a healthy life. But as health practitioners now know, prevention goes beyond healthy behaviors and what happens within the traditional health system. The health of an individual is largely determined by where they live, work, and play. The CHNA Action Team collaborated with SHARED Strategy Group to co-create a data gathering process which engaged community members as experts in their experience living in Bastrop County. The anecdotal stories and authentic feedback provided the context necessary to analyze and make sense of quantitative data. The totality of information – both stories and statistics – are represented in this report as an assessment of health needs in Bastrop County, TX.

## METHODOLOGY

The methodology for the assessment of community health needs in Bastrop County used the framework from the National Association of County and City Health Officials (NACCHO) Mobilizing Action through Planning and Partnerships (MAPP) process. The MAPP process includes four key assessments of 1) Community Health Status Assessment, 2) Community Themes and Strengths, 3) Forces of Change and 4) Local Public Health System. This CHNA is designed to highlight health disparities and root causes of local conditions and describe the health system infrastructure. Both qualitative and quantitative data were used in the completion of this assessment.

## CHANGES IN COUNTY PROFILE

***Bastrop County has experienced a demographic shift since 2012 with an increased population of Hispanics and a reduction in non-Hispanic whites***

The population of Bastrop County in 2018 is estimated at 84,761, based on the latest data from the U.S. Census, compared to 78,286 in 2016, and 74,023 in 2012. Since 2012, the Bastrop County population has increased by 5.7% compared to 7% nationally. When changes to racial, ethnic, and Hispanic origin were examined, population increases for Hispanics were most significant across all groups with an increase of 2.6% from 2012 to 2016. For that same period, non-Hispanic whites decreased by 2.7%. In 2016, non-Hispanic whites were the largest population group with 54.4% of the total Bastrop County population. The number of Bastrop County residents actually born in Texas increased by 10%, while the number of foreign-born residents increased by 9%. The reported median household income increased from \$54,821 in 2015, to \$59,185 in 2018.

## COMMUNITY HEALTH STATUS

***Most recently available public health data indicate that Bastrop County residents suffer from cancer and heart disease more than other conditions.***

According to the 2012 Bastrop Community Needs Assessment, the top 10 leading causes of death in Bastrop County were: cancer, heart disease, other diseases, accidents, chronic lower respiratory disease, stroke, Alzheimer's disease, suicide, diabetes and kidney disease.

Perceptions of community health varied between focus group participants and key informants (social service providers and organizational leaders) with focus group members rating their own health as “poor” and key informants rating community health higher.

## COMMUNITY THEMES: STRENGTHS AND CONCERNS

*Bastrop County residents and key informants identified faith, resilience, and law enforcement as several important community assets; concerns of residents focus on the lack of access to primary care, mental health services and chronic disease management services as well as the social determinants of health. Residents expressed concerns with an unhealthy power dynamic with county leaders.*

### Strengths and Assets

**STRENGTHS** – Bastrop County residents and stakeholders described several community strengths and positive cultural attributes they believe contribute to community health and quality of life for residents, including family friendliness and a positive place to raise a family, strong faith and faith-based organizations and churches as the foundation of the community, resilience in the face of natural disasters, effective law enforcement, and a commitment to community health.

**ASSETS** – Bastrop County residents and stakeholders identified community assets that can be leveraged to improve the quality of life and community health. These included a growing business community, health foundations actively investing in Bastrop County, a health care system of multiple agencies, and an active network of nonprofits and other community-based organizations.

### Community Concerns

The assessment also looked at the concerns of residents which most affect their quality of life in Bastrop County. Residents were most concerned with: access to healthcare; transportation; affordable housing; mental health and substance use; chronic diseases such as obesity, diabetes; and physical inactivity rates among residents. Lastly, community residents expressed the belief that there was a disconnect between leaders and community members that reflected an unhealthy power dynamic with little ability to influence community decisions leading to a lack of trust in community leaders. Additionally, some communities were concerned about racial/ethnic groups not being represented in decision making groups and the persistence of systemic racial inequities.

## ROOT CAUSE AND FORCES OF CHANGE

*Participants' perspectives of the causes of poor health in Bastrop County focused on low income, lack of access to care and coverage, and the effects of rapid population growth as causes and forces influencing community health.*

**COST OF LIVING & ECONOMIC WEALTH GAP** – Though the median income has increased in Bastrop County, there is still poverty. In 2017, 23.3% of people and 18.8% of children 18 and under were living below the poverty level.

**INSURANCE COVERAGE FOR ADULTS** – In Bastrop County, 19.2% of residents do not have health insurance. Although this represents a decrease from 21% in 2012, these numbers mean that 1 in 5 adults are still uninsured.

**POPULATION GROWTH** – Bastrop County's population is projected to significantly increase over the next few years as people move from Austin to surrounding counties for a more affordable cost of living and improved quality of life.

**ACCESS AND INFLUENCE** – Many community focus group participants saw access as a form of power – having information to know how to access resources, having relationships to be able to access resources timely, or access to spaces where decisions are made with the ability to influence decisions.

## LOCAL PUBLIC HEALTH CARE INFRASTRUCTURE

*Bastrop County's health system includes a hospital, Federally Qualified Health Centers (FQHCs) and an additional health care access point in a school district.*

There is one hospital (Ascension Seton Smithville) in Bastrop County with eight acute care beds and zero psychiatric care beds.<sup>1</sup> There are three Federally-Qualified Health Centers (FQHCs) in Bastrop County with one FQHC having an additional access point in the Elgin Independent School District.<sup>2</sup> There is a network of additional nonprofits and charitable organizations addressing various health and social service needs for vulnerable populations. In Bastrop County, there are 27.3 primary care physicians for every 100,000 people. Oral health patient ratios are slightly higher with 31.4 dentists for every 100,000 people.

## CONCLUSIONS ON HEALTH IMPROVEMENT PRIORITIES

### THE TOP HEALTH PRIORITIES FOR BASTROP COUNTY IN 2018

*Data suggests that Bastrop County should focus on improving access to healthcare and mental health services, and the social determinants of health that drive poor health – transportation, affordable housing and physical activity. Residents want a greater voice and influence with county decision makers.*

**MAKE INVESTMENTS IN IMPROVING THE SOCIAL DETERMINANTS OF HEALTH (SDOH)** – Improving community conditions by expanding economic opportunities and living wage jobs; expanding access to quality parks, green spaces, walking and biking trails, playgrounds, and facilities like the YMCA to reduce physical inactivity; subsidizing quality, affordable housing and expanded transportation solutions (especially for remote rural residents, and infrastructure to support safe biking and walking). Additionally, increase services to address the needs of the growing homeless population, including programs to secure stable transitional and permanent housing, availability of shelter beds, free health care and transportation services to health care services, and employment and job search services. We know that poverty limits access to healthy foods and safe neighborhoods and that more education is a predictor of better health. We also know that health suffers in communities with poor SDOH such as low-quality housing, low income jobs, unsafe neighborhoods and schools, or substandard educational opportunities.<sup>3</sup>

**BEHAVIORAL AND MENTAL HEALTH** – Improve access to services across the continuum of mental/behavioral health needs (e.g. mental illness, substance use disorder, social connectedness). Participants noted the negative impacts on community health from the opioid epidemic and the need for increased mental health services, particularly for the most vulnerable and disconnected youth. A recent study sponsored by the National Council for Behavioral Health; America's Mental Health 2018 found that the lack of access to behavioral health services is the root cause for the mental health crisis in America. Access to mental and behavioral health services, especially for children and youth, should be among the most important priority actions considered by Bastrop County.

**ACCESS AND AFFORDABILITY OF HEALTH CARE** – Improve access to primary care and mental health services to be responsive to the needs of families and children. Increase access by removing barriers to care such as flat rate fees for office visits, transportation, lack of insurance coverage, expand programs which show promising outcomes or community response (e.g. a kiosk to promote services was referenced), and ensure information on accessing resources is widely available through health care roadmaps and other visual explanations of where and how to access services. Solutions might include extended after-hours appointments, free or sliding scale health clinics in neighborhood schools staffed by nurse practitioners, free public transportation that runs directly to FQHCs, additional FQHC access points in the most impoverished community locations, specialty care services focused on the top chronic diseases, and necessary services such as maternal and child health care in the Bastrop County population. Adults in worse health, those with low incomes, and the uninsured are much more likely than others to delay or forgo health services due to costs.<sup>4</sup>

<sup>1</sup> Texas Department of State Health Services, 2016 Annual Hospitals Survey

<sup>2</sup> National Provider Registry

<sup>3</sup> CDC, 2018.

<sup>4</sup> Gary Claxton, Bradley Sawyer and Cynthia Cox, Kaiser Family Foundation, 2019



**CHRONIC DISEASE RISK FACTORS** – Bastrop County residents are experiencing more obesity and diabetes in their community, and CHNA participants know this is a growing community health concern. A risk factor is any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury.<sup>5</sup> In order to reduce the risk of developing a chronic illness such as heart disease, cancer or diabetes we recommend that Bastrop County consider improving access to affordable healthy food options, eliminate food deserts, and increase opportunities for free or affordable physical activity for all ages. Today, seven of the 10 leading causes of death in the United States are chronic diseases, and almost 50% of Americans live with at least one chronic illness. People who live with chronic diseases experience limitations in function, health, activity, and work, affecting the quality of their lives. Underlying these conditions are significant health risks such as tobacco use, poor nutrition, and physical inactivity. Increasing opportunities to engage in healthy behaviors reduces the risk for illness and death due to chronic diseases.<sup>6</sup>

**POWER DYNAMIC AND INFLUENCE: OUTREACH AND ENGAGEMENT** – Expanding leadership opportunities for marginalized community members, increasing culturally competent care, appropriate messaging and outreach, highlighting positive community cultural assets and efforts, identifying and executing ways in which visible quick wins can be demonstrated that are driven by community voice and input.



<sup>5</sup> World Health Organization, 2019.

<sup>6</sup> Centers for Disease Control and Prevention, 2013.

# 2020-2022 BASTROP COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT

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## INTRODUCTION

The health of a community can be measured many different ways. Personal and collective health encompasses well-being, social connectedness, personal agency, access to resources, built environment, economic security, practices, and beliefs. The understanding of the comprehensive nature of health means looking beyond individual disease conditions to assess the environments and circumstances in which a person lives, works, and plays as well as what health care resources are available to them.

The Community Health Needs Assessment (CHNA) Team, and their partners SHARED Strategy Group, co-created a data gathering process that engaged community members as experts in their experience living in Bastrop County. The goals of the CHNA team were to:

- Identify existing and emerging community health needs
- Identify strengths and assets available to improve health
- Determine the issues affecting the quality of life of residents
- Understand the key forces of change influencing health in the community
- Evaluate the local public health system and determine priorities for improvement; and
- Identify top health priorities for future health improvement efforts

The anecdotal stories and authentic feedback provided the context necessary to understand and interpret numerical data. The totality of information – both stories and statistics, are represented in this report as an assessment of health needs in Bastrop County, TX.



## METHODOLOGY

The assessment of community health needs in Bastrop County used the assessment framework from the National Association of County and City Health Officials (NACCHO) Mobilizing Action through Planning and Partnerships (MAPP) process. Where the MAPP process includes four key assessments of 1) Community Health Status Assessment, 2) Community Themes and Strengths, 3) Forces of Change and 4) Local Public Health System, this CHNA was designed to specifically highlight health disparities and root causes and describe the health system infrastructure.

Both qualitative and quantitative data were used in the completion of this assessment. Primary qualitative data was collected to capture community input through focus group sessions and key informant interviews. Quantitative data such as key health indicators, social determinants of health and the community profile is based on secondary data analysis. The methodology for collecting qualitative data or community input was designed to capture perspectives from representatives from each of the key community input sectors. These included:

- Representatives or members of medically underserved, low-income and minority populations
- Populations with chronic disease needs
- Practitioners with expertise in public health
- Health care and mental health care providers
- Organizations serving low-income populations
- Agencies with information and data relevant to the health needs of the community
- Nonprofit organizations / Community-based organizations / Faith-based organizations
- Local public agencies

With the assistance of Bastrop County Cares, St. David's Foundation, Ascension Seton, and the local public health system, SHARED Strategy Group, LLC, constructed five community focus groups with 40 community members. Participants included representation from faith-based communities, retirees, local elected officials, educational entities, health care providers, ethnic backgrounds, and home school parents. Focus group sessions provided opportunities for facilitated discussion in English and Spanish (see Appendix for the focus group protocol). Neighborhoods in which focus groups were held were selected based on their level of poverty, whether they had been engaged in other input efforts, community sector representation, geographic location, and diversity of potential participants. Based on these criteria, focus groups were held in Bastrop (city), Elgin, Red Rock and Smithville. Ten key informant interviews were conducted.

# COUNTY PROFILE: BASTROP COUNTY

*Bastrop County has experienced significant growth as the population has increased by more than 60,000 residents since 1980; adding 10,000+ residents in the last 8 years.*

## Geographic Boundaries

Bastrop County, Texas, includes three incorporated cities: Bastrop, Elgin and Smithville. McDade, Red Rock, Rockne, and Rosanky are also part of Bastrop County, but are unincorporated towns. Since 1980 the county population has grown by more than 60,000 residents, and from 2010-2018 the population swelled by more than 10,000 residents to an estimated 84,761.

Based on the U.S. Census Bureau the population was 78,286 in 2016 and 84,761 in 2018. Bastrop County is predominantly white (54.4% in 2016), but Hispanic, African American and Asian populations all showed slight increases in the county from 2012 to 2016. Children from 0-14 are 21.2% of the county's population (see Appendix).

*"The younger generation isn't coming back after college. They're moving away."*





## Community Description

Bastrop community members described their community as resilient, caring, friendly, and open to change. Bastrop community residents generally identified their schools as community anchor institutions with churches as the foundation of the community.

Recent natural disasters (flooding and fires) were identified as events catalyzing community members to work together, demonstrating resiliency and ability to respond as a community to challenges. Interviewees were, however, split on the issue of access to decision-makers. While 50% of community members felt no connection to local government, others felt like local government has an open-door policy to voice their opinion.

While there were many similarities among the focus groups, each group highlighted different concerns, as well as positive attributes of their communities (to be discussed later). For example, during the conversations at Lost Pines Elementary, community members said the community has a desire to grow, and partnerships are blossoming between school districts and the community, with a significant increase in parental involvement. Homeschooling parents at the Bastrop Christian Outreach Center expressed their concerns over the challenges they have faced in forming connections with various organizations: “We are not connected as a community” stated one respondent. Participants at the Smithville Free Clinic were quick to point out how friendly people were within their community. Respondents from Red Rock pointed out that they live in a food desert, but the food pantry distributes fresh fruits and vegetables daily. Each community expressed similar but also idiosyncratic concerns as well. This report focuses on the common concerns. Each community should explore their unique concerns with local leaders working on community health issues.

## SOCIAL DETERMINANTS OF HEALTH

***Thirty-six percent of Bastrop County residents identify as Hispanic with more than 10% foreign born. Poverty is unequally distributed across the county with Smithville having the highest rate of residents living at or below the Federal Poverty Level. Almost one-third of Bastrop County residents experience food insecurity.***

Social determinants of health are the multifaceted, integrated, and overlapping social structures and economic systems responsible for health inequities – unfair and avoidable, and often historical, differences in health status and health opportunity for different populations. These systems include social environment, physical environment, health services, and structural and societal factors. Social determinates of health are forged by the inequitable distribution of money, power, and resources throughout the community. To improve the health and quality of life in the community, it is necessary to not only address the social determinants of health but also to move from a focus on sickness and disease to one based on prevention and wellness. It is often the racial and ethnic minorities and those living in generational poverty that experience the most profound negative consequences of the social determinants of health.

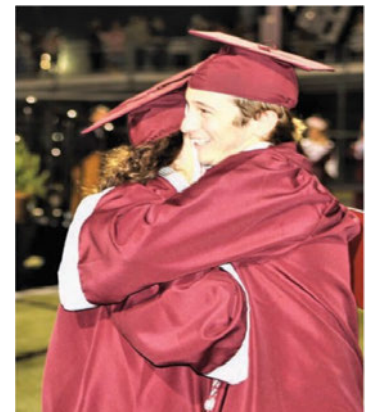
### Race, Ethnicity, and Hispanic Origin

More than one-third (36%) of Bastrop County’s population identifies as Hispanic/Latino and over half (54%) identify as non-Hispanic white. People identifying as Black or African American make up 8%, with Asians comprising less than 1% of the population. It is worth noting that the population of Elgin in 2016 was composed of 64% African American and Hispanic residents, substantially larger than the other cities and the county as a whole (see Tables in Appendix).

Eighty-nine percent of the Bastrop County population was native-born in 2012. A smaller percentage of county residents, 10.4%, were foreign born. This ratio shifted slightly in 2016, with 10.9% of the population foreign-born. Smithville has the lowest population of foreign-born residents, at 3%. Elgin has the highest population of foreign-born residents at 11.3%.

## Educational Attainment

Eighty-one percent of Bastrop County residents graduated from high school in 2012, and 16.5% earned a bachelor's degree. There was a slight increase in residents holding a college degree in 2016, up from 16.5% to 18.4%. Still, Bastrop County lags slightly behind the state (82.8%) in the percent of residents graduating from high school and holding college degrees (28.7%).



## Disability Status

Eleven percent of residents under age 65 have a disability. This is slightly higher than the statewide rate of 8%.

## Socioeconomic Characteristics

Socioeconomic characteristics are indicators describing individual or population economic status, work status, and social status. CDC measures economic status by how much money a person earns each year, work status by whether a person has a job, and social status by how many years a person spent in school. When measured together, these three indicators estimate socioeconomic status (SES). Research has demonstrated that individuals and populations with a higher SES have better health outcomes.

## Median Household Income

According to the US Census Quick Facts for Bastrop County, TX, the median household income was \$59,185 in 2017. Between 2015 and 2016 the median household income grew from \$54,821 to \$55,808, outpacing the median income in the U.S. In 2016, full-time male employees in Bastrop made 1.39 times more than female employees.

## Poverty

Poverty is the most powerful social determinant of health. Thirteen percent of the county-wide population lived at or below 100% of the Federal poverty level (FPL). Of note is relatively high poverty rate in Smithville compared to Bastrop City and Elgin.

POVERTY STATUS, BASTROP COUNTY, 2016

Poverty Status	Bastrop County	Bastrop	Smithville	Elgin
Total Population	75,916	7,375	8,952	3,884
<100% poverty	13%	9.6%	24.7%	13.7%
<200% poverty	33.2%	28.8%	42.2%	38.3%

## Employment

According to county-level data provided by Community Commons, the 2018 unemployment rate for Bastrop County is 3.7%. This is a decrease from 5.5% in 2015. When compared to Texas (4.6%), Bastrop County had a lower rate of unemployment in 2018. More than half (58.5%) of the Bastrop County population aged 16 years and older was in the labor force in 2017. The majority of Bastrop County's population is employed in five industries: educational services, health care and social assistance (19.6%); construction (14.6%); retail (11.2%); manufacturing (8.9%); and public administration (8.7%).

## Food Insecurity

Food insecurity is defined by the United States Department of Agriculture (USDA) as access by all people at all times to enough food for an active, healthy life. Research has consistently shown food insecurity to be related with poor health outcomes. In 2015, almost one-third (29.3%) of Bastrop County's population had low food access (or food insecurity). This level of poor food access is higher than the state (27.1%) and nation (22.4%) (see Table in Appendix).

# COMMUNITY HEALTH STATUS

According to the World Health Organization (WHO), health is a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” The Community Health Status Assessment (CHSA) is a comprehensive summary representing the aggregate disease burden and health status of Bastrop County residents. The CHNA Team obtained data for the CHSA from the most recently available secondary data sources at the local, state, and national levels. The CHSA presents statistics and trends of various health indicators to identify both improvements and gaps in health care availability among race, ethnicity, age, gender or socio-economic groups within the county. The CHNA Team analyzed available health status data from 2015-2018 for Bastrop County related to the following health status indicators: Quality of Life; Behavior Risk Factors; Social and Mental Health; Maternal and Child Health; Death, Illness, and Injury; and Communicable Disease.

## QUALITY OF LIFE

**Bastrop County residents have higher rates of obesity and lower rates of physical inactivity and tobacco use than previous years and in comparison, with the state.**

Quality of life is a holistic index of the human condition based on multiple factors that influence the standard of living or life experienced by a person, family, or community. Quality of life is influenced by factors such as housing burden, commuting, civic engagement, social or spiritual connections and of course physical and mental health.

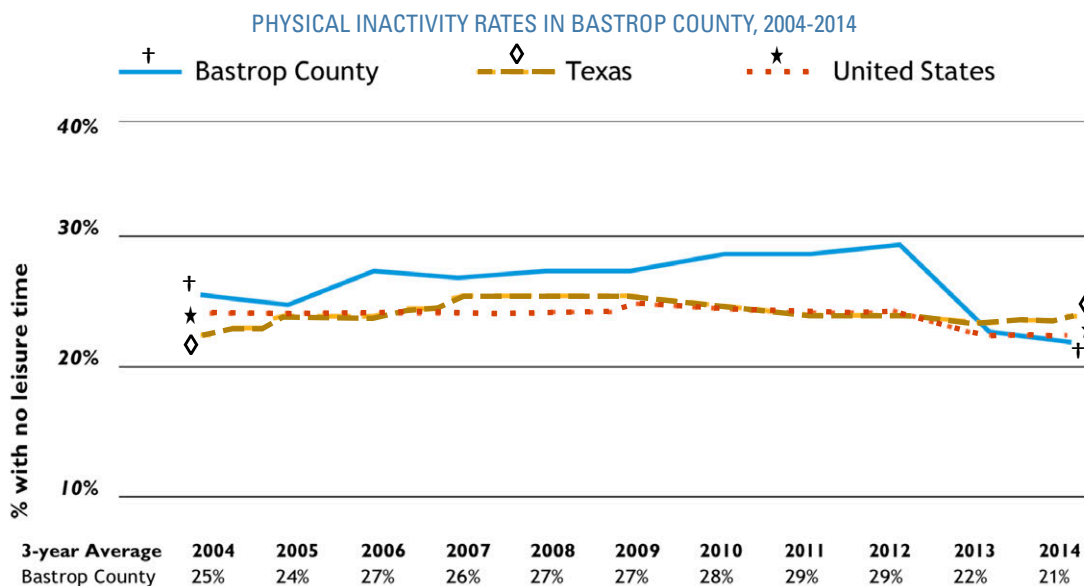
## Behavior Risk Factors

**TOBACCO** – Tobacco use in Bastrop County had been declining from 26% of adults in 2011 to 16% in 2017. The 2018 rate was slightly higher at 17% of the adult population.

*“People aren’t vested in their own health.”*  
– Community Resident

**OBESITY** – In 2016, 33.6% of adults 20 and older in Bastrop County were obese (a BMI of 30 or greater), compared to 28.4% of adults in Texas, and up from 31% in 2012. The figure includes data from 2004-2014, demonstrating a consistently upward trend in the rate of adult obesity. Since 2011, Bastrop County’s obesity rate has increased at twice the rate of the state and the nation (see Figure in Appendix).

**PHYSICAL INACTIVITY** – As of 2018, 21.1% of Bastrop County residents aged 20 and above reported no leisure time activity (i.e. physically inactive). Trend data from 2004-2014 indicate that the inactivity rate was relatively stable from 2004-2012, and then dropped markedly in 2013. The relationship between physical inactivity and obesity during the same time period should be examined more carefully.



Source: Robert Wood Johnson Foundation, County Health Rankings



## Social and Mental Health

**SUICIDE** – The 2018 age-adjusted suicide rate per 100,000 population in Bastrop County is 18.6 deaths. The 2018 Bastrop County suicide rate has increased by more than 3 percentage points since 2015 (15.2 deaths). Previous statewide suicide rates have been found to vary across reporting sources. For example, the CDC reported a rate of 13.4 deaths statewide in 2017, while the American Foundation for Suicide Prevention reported a rate of 12.4 deaths statewide.

## Maternal and Child Health

**INFANT MORTALITY** – Infant mortality, the probability of a child dying before age 1, in Bastrop County (4.6 deaths per 1,000 live births) is lower than the state (5.8 deaths per 1,000 live births).

**BIRTHS TO TEEN MOTHERS** – Teen birth rate, the number of births per 1,000 female population ages 15-19, in Bastrop County in 2018, is 33, lower than the state (41) and higher than the national average (15).

## Death, Illness, and Injury

When compared to the state, Bastrop County has a higher percentage of adult residents living with chronic obstructive pulmonary disease (COPD), diabetes, hypertension, and disability. Only among persons living with heart disease does Bastrop County have a lower percentage than the state.

HEALTH CONDITIONS IN BASTROP COUNTY, 2016

Condition	Bastrop	Texas	Population Used	Year
COPD	13.8%	4.9%	Age 18+	2016
Diabetes	9.8%	9.7%	Age 20+	2014
Heart Disease	1.3%	4.0%	Age 18+	2011-12
Hypertension	42.3%	30.0%	Age 18+	2006-12
Any Disability	14.3%	11.6%	All Ages	2006-12

Source: American Community Survey 5-year estimate.

Motor vehicle deaths and injury deaths in Bastrop County are greater than the national and state averages. There were 25.1 motor vehicle deaths per 100,000 population in Bastrop County and 83.4 injury-related per 100,000 population. Motor vehicle fatalities are twice as likely in Bastrop County compared to the state (13.2).

## Communicable Diseases

**HIV** – HIV prevalence in Bastrop County was 219.3 per 100,000 people. Compared to the state (368.9), Bastrop County has a lower rate of persons living with HIV.

## HEALTH EQUITY

***On all measures of equity, Bastrop County is less racially and ethnically equitable and integrated than the state or the nation.***

Health equity reflects the extent to which all persons have full access to equal opportunities to be healthy. In order to do that, communities must adopt an intentional approach to identify and eliminate disparities in access to care, quality of care, and health outcomes between racial and ethnic groups, socio-economic groups and others who live in marginalized and vulnerable conditions. Health disparities may be associated with social, economic or environmental circumstances, and may also be affected by behaviors, chronic diseases, and morbidity.

The *U.S News and World Report*, in conjunction with the Aetna Foundation, released Healthy Communities 2018, which ranked many indicators of health for all counties in the United States. The authors examine equity through a compilation of indicators in the following areas where inequities have historically and contemporaneously existed: education, health, income, and social justice.

### Educational Equity

Educational attainment has been shown to be a predictor of health outcomes (Hahn and Truman, 2015). Racial disparities for educational attainment are displayed in terms of a ratio from 0 to 1, with a lower score indicating there is a smaller difference among racial groups in attainment of a bachelor’s degree. Bastrop County’s racial disparity in educational attainment score is 0.42, which is much higher than the state ratio (0.22) and the nation (0.15).

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#### Educational Equity Score

Metric	County	State	U.S.
Racial Disparity in Educational Attainment	0.42	0.22	0.15

#### Education

The education category examines the strength of a community’s education system and the education level of its residents through measures of participation, capacity and achievement.

### Health Equity

The health equity category includes two indicators: racial disparities in exposure to air toxins and racial disparities in premature death. The quality of the physical environment can directly affect health outcomes. Poor air quality can play a role in various cancers and diseases of the respiratory and cardiovascular systems (see *Our Nation’s Air: Status and Trends Through 2017*). Air toxins exposure disparity is a ratio with a range of 0 to 100, with a lower score indicating a smaller gap in air pollution exposure between racial groups. Bastrop County has a ratio of 2.71, slightly higher than the state and the nation, both at 2.36.

Blacks/African Americans have historically experienced disparities in life expectancy and higher rates of mortality than other racial groups. Although this gap is narrowing, disparities persist (Cunningham et al, 2017). Premature death disparity is a ratio with a range of 0 to 1, with a lower score indicating a smaller gap in premature deaths among racial groups. Bastrop County has a ratio of 0.08, higher than the state (0.05) and the nation (0.01).

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#### Health Equity Score

Metrics	County	State	U.S.
Air Toxins Exposure Disparity Index Score	2.71	2.36	2.36
Premature Death Disparity Index Score	0.08	0.05	0.01

#### Health

The health category examines disparities in racial and ethnic groups to the exposure of environmental toxins and the extent to which residents die prematurely.

### Income Equity

Health outcomes, especially mortality rates, are strongly associated with income levels (Chokshi, 2018). The poverty disparity index score (PDI) is a ratio with a range of 0 to 1, with a lower score indicating a smaller difference in poverty rates between racial groups. Bastrop County has a ratio of 0.28, higher than the state (0.19) and that of the nation (0.13).

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## Income Equity Score

Metrics	County	State	U.S.
GINI Index Score	0.43	0.45	0.44
Poverty Disparity Index Score	0.28	0.19	0.13

### Income

The income category includes two metrics measuring the extent to which income and poverty are equally distributed across racial and ethnic groups. The PDI is described above. The GINI Index Score is a standard economic measure of income inequality. A community that scores 0.0 on the Gini scale has perfect equality in income distribution. The higher the number over 0 the higher the inequality, and a score of 1.0 indicates total inequality.

## Social Equity

Residential segregation, or the separation of racial and ethnic groups in communities, has been shown to limit access to health care and to negatively impact health outcomes (Williams and Collins, 2001). The segregation index score is a ratio with a range of 0 to 1, with a higher score indicating greater community racial integration, while a lower score indicates that a community is more racially segregated. Bastrop County has a ratio of 0.30, lower than that of the state (0.38) and the nation (0.41).

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## Social Equity Score

Metrics	County	State	U.S.
Segregation Index Score	0.30	0.38	0.41

### Social

Segregation caused by structural, institutional, and individual racism still exists in many parts of the country. The removal of discriminatory policies and practices has impacted acts of racism, but has had little effect on structural racism, like residential segregation - borne out of policies like housing stock redlining that formally ended decades ago, resulting in lingering structural inequalities in the quality of the housing stock in neighborhoods and the availability of quality, affordable housing in high poverty areas of a community.

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# COMMUNITY THEMES: STRENGTHS AND CONCERNS

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The Community Themes and Strengths Assessment (CTSA) focuses on the identification of current community issues, perceptions about quality of life, and community assets through feedback from community stakeholders. The diverse populations included in the CTSA shared perceptions of their communities and the county as a whole. While the CTSA revealed many positive aspects and an overall positive perception of quality of life in Bastrop County, it also identified several areas for improvement. For example, more than half of the community participants described the overall health of Bastrop County as fair (only 3% of the participants described the community health as excellent).

## COMMUNITY VALUES

According to the data collected, the most important values Bastrop County residents hold are family, health, safety, community connection, employment, and recreation opportunities.

## STRENGTHS AND ASSETS

### Strengths

Bastrop County residents and stakeholders described several community strengths and positive cultural attributes they believe contribute to community health and quality of life for residents, including family friendliness and a positive place to raise a family, strong faith and faith-based organizations and churches as the foundation of the community, resilience in the face of natural disasters, effective law enforcement, and a commitment to community health.

### Assets

Bastrop County residents and stakeholders identified community assets that can be leveraged to improve the quality of life and community health. These included a growing business community, health foundations actively investing in Bastrop County, a health care system of multiple agencies, and an active network of nonprofits and other community-based organizations. Key community partners working to improve the health and well-being of residents include Lone Star Circle of Care, St. David's Foundation, Smithville Free Clinic, Bastrop Independent School District, Bluebonnet Trails Community Service, Smithville Independent School District, Grace Baptist Church, Bastrop Outreach Christian Center, and Ascension Catholic Church. In the past five years, Bastrop County residents report experiencing positive community-wide changes in the health care system because:

- St. David's Foundation, with a mission to improve health outcomes for Central Texans, has a growing presence and investment priority for rural health;
- Bastrop County Cares is closing some of the gaps in well-being and social service needs;
- There is the beginning of collaboration and coordination among organizations that historically operated in silos; and
- Mental health services provided by Lone Star Circle of Care have increased.

## CONCERNS OR CHALLENGES

*Top concerns of Bastrop County residents focus on access to health and mental health services, transportation, affordable housing, increased prevalence of two chronic diseases, and the belief that government leaders are not listening to the community when important decisions are being made.*

The following sections examine in greater detail the concerns expressed by residents of Bastrop County.

### Access to Care

Uninsured, low-income, and underserved populations tend to lack access to affordable healthcare. Community members listed multiple contributing factors: 30-mile commute for quality healthcare, lack of public transportation options, delays in getting an appointment, lack of specialized care nearby, lack of women's health and prenatal care, limited office hours, inability to take off work for appointments, location of healthcare services, unemployment, providers not accepting new patients, and providers no longer accepting Medicare or Medicaid. Veterans are unable to access specialized health services due to a back log for specialty services.

### Transportation

Public transportation is available, however most families are unable to access CARTS (Capital Area Rural Transportation) because they live in the rural area of Bastrop County. Decisions about resource placement and location often don't consider the transportation challenges many residents face. Residents are aware that having access to a well-connected person, or someone who worked for the city, was necessary to be heard and for decisions about city and county resources to be informed by transportation considerations.

### Affordable Housing

The cost of housing has increased overall. In addition, the affordable housing issue has exacerbated homelessness. According to the 2018 Annual Bastrop County Head Start Report, affordable and safe housing was the third greatest concern for community members with 12% calling it a major challenge and 19% saying it is "somewhat" a challenge to purchase and maintain safe housing. Individuals selling property above the valued price, flipping houses for substantial profit, and the overcrowded housing authority list are contributing factors to successfully obtaining adequate housing.

### Power Dynamic and Influence

Bastrop community members described their community as resilient, open to change, caring and friendly. However, many participants expressed that they feel no connection with community and local government and their voices are not heard by decision makers. Participants shared their perception that systemic race-based injustice is persistent for persons of color.

### Mental Health

Seventy-five percent of the participants described mental health services as a vital concern in rural communities. A serious lack of resources and awareness of how to access services for individuals suffering with mental illness has increased dramatically as the county population has expanded. The recent suicide by a teenager highlighted the mental health challenges of school-aged youth. Psychiatric and mental health appointment slots are needed and the wait time for an appointment is usually several months.

### Behavioral Health/Substance Use/Abuse

The opioid epidemic raised concerns for community members. It was mentioned that 20 individuals died from an apparent drug overdose in one day. The rise of heroin and crystal methamphetamine use is a concern due to lack of behavioral health services to support these individuals.



## Chronic Diseases

**OBESITY, DIABETES** – Cancer and heart disease ranked #1 and #2 as top causes of death. Lack of quality food combined with poor eating habits are challenges that keep residents from having healthy diets. Resident said that the resources for those with diabetes were not adequately publicized.

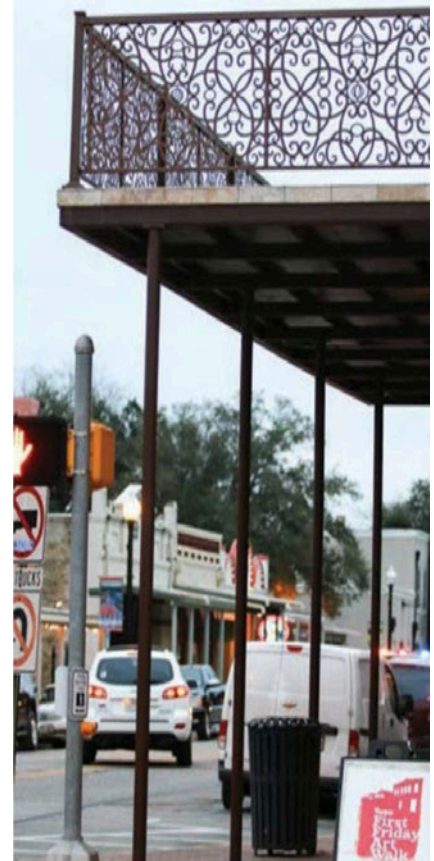
**ACCESS TO FOOD** – Participants shared that residents of some communities have to travel for quality food. There are limited healthy food choices offered at local restaurants.

**PHYSICAL INACTIVITY** – Parks, physical activity outlets, and recreational activities for youth are lacking. A fee being charged to use the school grounds is limiting the use of schools for organized sports.

## CONCLUSIONS AND IMPLICATIONS

The Community Themes and Strengths Assessment revealed positive attributes and an overall perception of quality of life in Bastrop County. Participants identified several areas for improvement. Participants reported that their most important community strengths include: family friendliness, strong faith and faith-based organizations and churches, resilience in the face of natural disasters, effective law enforcement, and a commitment to community health.

Residents were most concerned with: access to healthcare; transportation; affordable housing; mental health and substance use; chronic diseases – such as obesity and diabetes; physical inactivity rates among residents; and community and government power dynamics and lack of influence resulting in distrust of leaders. As an example, property taxes were increased for the new convention center with limited community input. This disconnect between the city and county decision makers and community residents has grown into a sense of distrust on the part of residents and a feeling that their voices and expressed needs are being discounted or ignored. Mending this relationship is an important priority for the community stakeholders included in the CTSA.



# ROOT CAUSES AND FORCES OF CHANGE

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*The main force of change in Bastrop County is the growth in population, which has resulted in an increased homeless population and decreased affordable housing.*

The purpose of the Forces of Change Assessment (FoCA) is to identify factors, trends, or events influencing the health and quality of life of the community and public health system. Through feedback from the community input groups, the data team identified challenges and opportunities associated with the Forces of Change in Bastrop County. Participants in the focus groups represented multiple sectors in the community: healthcare, local government, non-profit organizations, school districts, veterans, and faith-based organizations.

## FINDINGS – FORCES OF CHANGE

### Growth of Bastrop County

#### CHALLENGES:

- Increase in population has strained the level of infrastructure, including:
  - Transportation
  - Access to healthcare
  - Substance use disorders
  - Mental Health Services
  - Access to basic needs—quality food, affordable housing
- Property values are higher in Bastrop County leading to an increase in homelessness
- Provision of basic preventative health services

#### OPPORTUNITIES:

- Economic growth in expanding (CARTS) Capital Area Rural Transportation Services
- More businesses
- Health care services expanding
- More partnerships and collaboration

### Drug Abuse

#### CHALLENGES:

- Increase in substance use disorders
- Lack of mental health services

#### OPPORTUNITIES:

- More mental health services expanding to address the need
- Reduce the number of incidents relating to substance use disorder

### Technology

#### CHALLENGES:

- Limited internet service

#### OPPORTUNITIES:

- Social media promotes communication and provides an opportunity to reach more people
- Provides an opportunity for telemedicine
- Provides an opportunity to access available community resources



## Changes to Access in Healthcare

### CHALLENGES:

- Providers not taking new patients
- Appointment wait time being too long
- Providers not accepting Medicaid and Medicare as a payment source due to reimbursement time frame
- Travel time of 30 minutes to most healthcare providers
- Uninsured residents

### OPPORTUNITIES:

- Full-service hospital
- Increase in maternal and women's health care
- Increase in specialty care
- Expansion of public transportation

## Economic Change

### CHALLENGES:

- Increase in the cost of living including affordable housing
- Not enough large industries
- Long commutes necessary for better salary

### OPPORTUNITIES:

- Increase in local industries
- Increase in local business
- Increase in economic benefits and more property taxes for the county to use
- Decrease in children left at home alone during the late evenings (more family time)

# LOCAL PUBLIC HEALTH INFRASTRUCTURE

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For this CHNA, the development team used in its assessment approach the county health infrastructure instead of the measurement of public health essential services. The rationale for this decision is that the presence of essential services does not necessarily mean those services are accessible. Therefore, for this CHNA, health care infrastructure is used to identify current health care capacity, health system gaps, and possible areas in which improvements can be made to increase access.

From our community conversations, respondents indicated a priority need for dramatically increased access to health care. The lack of affordable oral health services, women's health (prenatal), specialty care, behavioral and mental health services, and primary health care is substantially worse in Bastrop County than the infrastructure across the state.

## Health Resource Availability

According to the Health Resources and Services Administration (HRSA), the entirety of Bastrop County is a Health Professional Shortage Area (HPSA), which means that an area has "shortages of primary care, dental care, or mental health providers and may be geographic (a county or service area), population-based (e.g. low income or Medicaid eligible) or associated with facilities (e.g. federally qualified health centers, state and federal prisons)."

Many barriers prevent access to health care such as a lack of health insurance coverage, limited availability of health care providers (e.g. dentists, mental health providers, physicians), lack of transportation, and inability to pay for health services. These barriers can lead to unmet needs, delays in care, failure to receive preventive services, and preventable hospitalization.

Indicators related to health resource availability are used to measure access, utilization, cost and quality of health care and prevention services in a population. Improving indicators related to health resource availability is one key to advancing health in Bastrop County.

**Facilities**

*While Bastrop County has a number of health care provider organizations, including Federally Qualified Health Centers that serve the uninsured and low-income populations, access remains difficult due to barriers such as transportation and limited appointments.*

There is a network of nonprofits and charitable organizations addressing various health and social service needs for vulnerable populations in Bastrop County. There are twelve dental service providers, one hospital (Ascension Seton Smithville) with 8 acute care beds and zero psychiatric care beds, 3 Federally-Qualified Health Centers (FQHCs) with one FQHC having an additional access point in the Elgin school district and nineteen clinics/urgent care services, access to care is limited due to lack of transportation from rural portions of the community, limited appointment slots, limited or no after-hours care, limited free or sliding scale payment fees, and limited numbers of providers accepting Medicaid and Medicare reimbursement. Feedback from focus group participants indicate that if more doctors would accept Medicaid and Medicare, the increase in the number of primary and specialty care physicians in Bastrop could potentially improve the overall health outcomes and decrease the gap for those seeking services.

According to the National Provider Registry, Bastrop County has 3 Federally Qualified Health Centers (FQHCs) and an additional FQHC access point in the Elgin ISD.

**Patient-Provider Ratios**

*Health care provider ratios in Bastrop County remain low compared to the state.*

As of 2016, there were 27.3 primary care physicians per 100,000 population in Bastrop County, compared to 59.9 statewide. There are 31.4 dentists per 100,000 population, compared to 55.9 statewide. In 2018, only 60.4% of the population had had a dental exam in the past 12 months, compared to 37.4% for the entire state.

**Utilization**

*Since 2016, preventable hospital stays declined significantly in Bastrop County with almost a quarter of residents unable to see a doctor when needed due to the cost of care.*

In 2018, there were 59 preventable hospital stays per 1,000 Medicare population, down from 68 per 1,000 in 2016. The percentage of diabetic Medicare enrollees (age 65-75) who receive Hemoglobin A1C monitoring was 83%, which was the same in 2016, but up from only 80% in 2012. Mammography screenings for female Medicare enrollees, were at 55%, a slight decrease from 55.7% in 2015. Twenty-three percent of Bastrop County residents could not see a doctor due to costs in 2015.

**Health Insurance Coverage**

*The rate of uninsured residents, including children, continued to drop in Bastrop County and stands at 21% in 2018.*

Having access to health insurance is paramount to improving health status. The percentage of uninsured adults in both Bastrop County and the State of Texas continues to decrease. Uninsured children decreased by 5.2% from 2015 to 2018 and uninsured adults decreased by 3.7% in the same time period.

HEALTH INSURANCE STATUS, 2015-2018, BASTROP

Bastrop	2015	2018	Change
Uninsured	25.0%	20.7%	-4.3%
Uninsured Adults	28.3%	24.6%	-3.7%
Uninsured Children	17.5%	12.4%	-5.2%

Source: American Community Survey 5-year estimate.

# COMMUNITY HEALTH PRIORITIES

## THE TOP HEALTH PRIORITIES FOR BASTROP COUNTY IN 2018

*Data suggest that Bastrop County should focus on improving the social determinants of health that drive poor health – access to health care and mental health services, transportation, affordable housing and physical activity. Additionally, residents want a greater voice and influence with county decision makers.*

### Community Recommendations on Improving Health and Well-Being

Respondents were asked to provide suggestions to improve the health and well-being of the people living in their communities. Community member suggestions included: access to affordable housing, transportation, physical activity through recreational opportunities for children and adults, free health care, access to healthier food choices, and access to mental and behavioral health services.

Others wanted health care providers to provide transportation to appointments for the homeless population. Others said that transportation options like walking and biking were unsafe, and the respondents want to see more opportunities for safe walking and biking. Lastly, community members were asked to provide priorities for decision makers to focus on to improve the health of Bastrop County residents for the greatest impact. Of the 24 members and 10 interviews conducted in Bastrop County, six major categories were identified.

**MAKE INVESTMENTS IN IMPROVING THE SOCIAL DETERMINANTS OF HEALTH (SDOH)** – Improving community conditions by expanding economic opportunities and living wage jobs; expanding access to quality parks, green spaces, walking and biking trails, playgrounds, and facilities like the YMCA to reduce physical inactivity; subsidizing quality, affordable housing and expanded transportation solutions (especially for remote rural residents, and infrastructure to support safe biking and walking). Additionally, increase services to address the needs of the growing homeless population, including programs to secure stable transitional and permanent housing, availability of shelter beds, free health care and transportation services to health care services, and employment and job search services. We know that poverty limits access to healthy foods and safe neighborhoods and that more education is a predictor of better health. We also know that health suffers in communities with poor SDOH such as low-quality housing, low income jobs, unsafe neighborhoods and schools, or substandard educational opportunities.<sup>7</sup>

**BEHAVIORAL AND MENTAL HEALTH** – Improve access to services across the continuum of mental/behavioral health needs (e.g. mental illness, substance use disorder, social connectedness). Participants noted the negative impacts on community health from the opioid epidemic and the need for increased mental health services, particularly for the most vulnerable and disconnected youth. A recent study sponsored by the National Council for Behavioral Health; America’s Mental Health 2018 found that the lack of access to behavioral health services is the root cause for the mental health crisis in America. Access to mental and behavioral health services, especially for children and youth, should be among the most important priority actions considered by Bastrop County.

**ACCESS AND AFFORDABILITY OF HEALTH CARE** – Improve access to be responsive to the needs of families and children. Increase access by removing barriers to care such as flat rate fees for office visits, transportation, lack of insurance coverage, and expand programs which show promising outcomes or community response (e.g. a kiosk to promote services was referenced), and ensure information on accessing resources is widely available through health care roadmaps and other visual explanations of where and how to access services. Solutions might include extended after- hours appointments, free or sliding scale health clinics in neighborhood schools staffed by nurse practitioners, free public transportation that runs directly to FQHCs, additional FQHC access points in the most impoverished community locations, specialty care services focused on the top chronic diseases, and necessary services such as maternal and child health care in the Bastrop County population. Adults in worse health, those with low incomes, and the uninsured are much more likely than others to delay or forgo health services due to costs.<sup>8</sup>

<sup>7</sup> CDC, 2018.

<sup>8</sup> Gary Claxton, Bradley Sawyer and Cynthia Cox, Kaiser Family Foundation, 2019.

**CHRONIC DISEASE RISK FACTORS** – Improve access to affordable, healthy food options, eliminate food deserts, increase opportunities for free or affordable physical activity for all ages. Today, 7 of the 10 leading causes of death in the United States are chronic diseases, and almost 50% of Americans live with at least one chronic illness. Bastrop County suffers from higher rates of obesity and diabetes. People who live with chronic diseases experience limitations in function, health, activity, and work, affecting the quality of their lives. Underlying these conditions are significant health risks such as tobacco use, poor nutrition, and physical inactivity. Increasing opportunities to engage in healthy behaviors reduces the risk for illness and death due to chronic diseases.<sup>9</sup>

**POWER DYNAMIC AND INFLUENCE: OUTREACH AND ENGAGEMENT** – Expanding leadership opportunities for marginalized community members, increasing culturally competent care, appropriate messaging and outreach, highlighting positive community cultural assets and efforts, and identifying and executing ways in which visible quick wins can be demonstrated that are driven by community voice and input.

**Priorities for Focused Populations for Bastrop County in 2018:**

- Veterans and service providers expressed the need for specialty care for Veterans
- African Americans in Elgin strongly felt they did not have voice or influence.
- Community members expressed the need for multi-sector services to address the complex issues of those experiencing chronic homelessness.

## CONCLUSIONS

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In conducting the community conversations and interviews, it was important to capture what the community members and interviewees felt change would look like for their community. Both groups wanted to see growth, resident inclusion in government decision making, and increased visibility of the decision makers and funding leaders at the community level. The community expressed the desire to see more conversations to improve the community's health, considerations for a full-service hospital, collaboration among organizations, teacher training to improve responsiveness and relationships with parents and students, a shared community vision, an increased focus on mental health, universal access to care, a healthy community, and expanded pharmacy services and programming.

Key informant interviewees wanted to see people with insurance, more connection to the rural communities, people of all ethnic backgrounds working together, honest and positive people working together, continued meetings to address the needs of the community, seeing the right people at the table, affordable housing for everyone, resources for individuals and families in any given situation, decreased duplication of effort among organizations, accessing data collected in the community, community leaders participating in community-level events, programs to address the needs of foster children and their caregivers, a movie theater, more communication between school superintendents and families, and better wages to decrease child labor. As one interviewee put it, "with all these positive changes taking place we will have healthy families, healthy communities, and the rate of mental health would be at an all-time low."

To improve the health of Bastrop County citizens, it is essential to work collaboratively in the spirit that community participants envisioned and to focus County resources and engaged leadership on the priorities noted above. Their vision is both inspiring and possible with intention and commitment to a community that works for all its residents. With this CHNA, decision makers can confidently work toward becoming a healthier community.

***"Positive change for me is a change from hopelessness to opportunity."***

<sup>9</sup> CDC, 2013.

# APPENDICES

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# 2018

COMMUNITY HEALTH NEEDS ASSESSMENT

# BASTROP COUNTY, TEXAS

Community Input Summary Report



**StDavid's**  
**FOUNDATION**



Ascension



Seton



# BASTROP COUNTY, TEXAS





# BASTROP COUNTY COMMUNITY INPUT

## AT-A-GLANCE

### Communities Engaged in Input Conversations

#### Bastrop City

- ◆ Lost Pine Elementary School
- ◆ Elgin
- ◆ Elgin Recreational Center (all participants were African American)
- ◆ Smithville
- ◆ Smithville Free Clinic (focus on conversations with veterans)
- ◆ Red Rock
- ◆ Grace Baptist Church

### Community Changes in the Past Five Years

- ◆ Seeing more people relocate and as a result, seeing housing waiting lists of two to three years
- ◆ Increased presence of the St. David's Foundation
- ◆ Bastrop County Cares closing some of the gap and decreasing organizations operating in silos
- ◆ Services provided by Lonestar Circle of Care have increased

### Positive attributes which make Bastrop County unique...

- ◆ Desire to grow
- ◆ Resilient
- ◆ Great place to raise a family
- ◆ Open to change
- ◆ Church is the foundation of the community

### 34 Community Residents Engaged In Conversations

#### Community Input Participants Self-Identified as...\*

◆ Hispanic, Latino, or Spanish Origin	4%
◆ Black or African American	7%
◆ White or Caucasian	79%
◆ Asian	5%
◆ American Indian / Native or Alaska Native	4%

\*One participant did not self-identify

#### Age Stratification of Community Input Participants

◆ Under 18	0%
◆ 18-24	8%
◆ 25-44	50%
◆ 45-64	30.7%
◆ 65+	38%

\*One participant did not self-identify

### Causes of or Contributors to Community Challenges

Community participants attributed low education, fear of being deported, poverty/socio-economic status, low-paying jobs, lack of affordable housing, homelessness, language barriers, population growth, generational gaps, culture, lack of access to physical activity, lack of access to quality food, and lack of insurance as the contributors to fair health.

### Top Overall Community Challenges

- ◆ Current hospital is small with limited healthcare services
- ◆ Affordable housing
- ◆ Transportation
- ◆ Prostitution and reintegration of victims of sex trafficking

## Power and Influence in Community

made to benefit those in the room at the time. As an example, property taxes were increased for the new convention center with limited community input. (Sign In sheets collected)

*“Local leaders are still talking about what they did 20 years ago.”* –Elgin Resident

## What change would look like...

- ◆ A full-service hospital
- ◆ Increased focus on mental health
- ◆ More connectedness with the rural community and people of other ethnic background
- ◆ Decrease duplication of efforts by organizations
- ◆ Universal access to health care
- ◆ Seeing the right people at the table

## Priorities for Focused Population Conversations

- ◆ Veterans in Smithville expressed concerns about access to specialty care and appointment wait times. Additionally, one female veteran demonstrated anger in expressing her personal frustrations with not having access to affordable, quality care.
- ◆ Homeschool parents’ primary concern was specific to the issue of lack of quality, safe public education. Parents did not feel the public-school system provided a positive learning environment for their children.
- ◆ African Americans in Elgin strongly felt that they did not have a voice or influence in Bastrop.

## Community Expressed Priorities for Impact in Bastrop County

Transportation, affordable housing, improved services to support the homeless population, access to health care that's responsive to the needs of families and children, more focus on mental health services, and comprehensive women's health will have the greatest impact.

## Describing Community Health

# #1

## Fair Health

RESPONSE

Three percent (3%) of participants described community health as excellent.

## Top Health Challenges

- ◆ Mental health, particularly substance use disorder and youth mental health services. The community has experienced several youth suicides.
- ◆ Obesity and diabetes were considered to be connected to each other.

## Causes or Contributors to Poor Health

- ◆ Lack of awareness about health care services. For example, there are several diabetes programs which are not visible or marketed to recruit those who need the services.
- ◆ Lack of care for the homeless
- ◆ Isolation/organizations unable to connect with those living in remote areas
- ◆ Fear remains a significant barrier to some families seeking services. “Moms are eligible for WIC, but don’t seek services due to fear of deportation.”

## Access to Health Care and Services

Based on the responses, 40% stated they have access to care; whereas 30% indicated that they have no access to care and cited several challenges. Some community members expressed that the appointment time for new patients is long. New patients may wait up to three (3) months for an appointment. Psychiatric and mental health appointments are needed, but the wait time for an appointment is usually months.

## 2018 COMMUNITY HEALTH NEEDS ASSESSMENT

# BASTROP COUNTY, TEXAS

## COMMUNITY INPUT SUMMARY REPORT

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### OVERVIEW

Bastrop County has a population of 84,761 residents with 25,822 households. The average household size is 2.5 people. Since 1980, Bastrop County has grown by more than 60,000 residents. Bastrop County includes three (3) incorporated cities including Smithville, Bastrop City, and Elgin. The county includes the additional unincorporated areas of Red Rock, McDade, Rockne, and Rosanky. Five (5) community input sessions were conducted at the following locations: Elgin Recreational Center; Lost Pines Elementary School; Bastrop Outreach Christian Center; Grace Baptist Church-Red Rock; and Smithville Free Clinic. These locations/communities were selected based on access to traditionally marginalized populations and identified special targeted populations, which included veterans, African Americans, and homeschool parents. Bastrop County Cares acted as the local outreach partner to support the recruitment of community residents for input sessions. Community input was gathered during the month of August 2018 with four primary areas of focus: community identity; access to health care and social services; root causes and determinants; and priorities and recommendations.

### DESCRIPTION OF COMMUNITY INPUT PARTICIPATION

- ◆ **Lost Pines Elementary School** conversation included the principal, two (2) school board members, and the school counselor. All participants identified themselves as White or Caucasian.
- ◆ **Elgin Recreational Center** community conversation included two (2) long-time residents and one (1) resident who moved within the last 5-7 years. They self-identified themselves as African Americans.
- ◆ **Bastrop Outreach Christian Center** included six (6) women who identified themselves as white. Two (2) participants lived in the community for 1-5 years; two (2) have been residents for 6-10 years; and two (2) more have been residents for 10 or more years. These women included homeschooling parents and the center director.
- ◆ **Red Rock Food Pantry**, which provides supplemental food to community members, is located at Grace Baptist Church. Four (4) participants attended this community conversation. They identified themselves as White/Caucasian and one American Indian.
- ◆ **Smithville Free Clinic** conversation included seven (7) community members, four (4) of whom were veterans. Six (6) community members self-identified as White/Caucasian and one (1) Hispanic/Latino.
- ◆ Communities included Elgin, Smithville, Bastrop City, and Red Rock. Of the Bastrop County members engaged, **79% were White**; 4% were Hispanic/Latino; 7% were Black/African American; 4% were Native American based on self-identification. Of the Bastrop County community members engaged, 8% were age 24-44, 50% were 45-64 and 38% were 65 and over. One respondent declined to provide age.
- ◆ According to Hearts of Texas *Head Start Annual Report*, Bastrop continues to grow as Austin residents move further from the city seeking affordable housing. The increase in population for Bastrop communities is: Bastrop City (10%); Elgin (8%); McDade (18%); Smithville (5%); and Wyldwood (52%).

## Key Informant Interviews

Ten (10) key informant interviews were conducted in August of 2018. Of these interviewees, 27% represented public health or the health care sector; 9% represented the faith-based sector; 18% represented community-based organizations or advocacy groups; and 27% represented local school districts. Key informant interviews were conducted with Smithville Hospital, Combined Community Action, Texas A&M Agrilife Extension Services, Veterans Affairs, Smithville School District, Blue Bonnet Trails, Bastrop Independent School District, Ascension Catholic Church, and Lone Star Circle of Care.

- ◆ **Ascension Seton Smithville**, located in Smithville, is an acute care facility providing in-patient and out-patient services to Bastrop and surrounding counties. **Ascension Seton Smithville** provides comprehensive, 24-hour, emergency services. Patients have the ability to schedule an ER visit for minor emergencies. This hospital is thirteen (13) miles away from the City of Bastrop.
- ◆ **Combined Community Action (CCA)** is a 501-(c)3 non-profit organization who has been providing services since March 1966. CCA is twenty-six (26) miles from the City of Bastrop and provides services to children and pregnant women, comprehensive energy assistance, Lee County cancer resources, emergency solutions, meals on wheels, tenant-based rental assistance, and weatherization programs. CCA has a partnership with the City of Bastrop to provide aid to the residents.
- ◆ **Veteran Affairs** provides general health care, mental health care, prescription fulfillment, and social services to returning service members (including homeless, LGBT, and women veterans), and their caregivers.
- ◆ **Blue Bonnet Trails Community Services** is located in Bastrop County and provides medical, dental, mental health, substance abuse, developmental services, and health care. Blue Bonnet Trails serves families, staff, faculty, and students in the Elgin Independent School District.
- ◆ **Bastrop Independent School District (BISD)** serves 11,000 students from the City of Bastrop, Cedar Creek, Paige, Red Rock and vast areas of rural Bastrop County. The BISD has two (2) comprehensive high schools, an early college high school, a non-traditional online high school, two (2) middle schools, two (2) intermediate schools, and six (6) elementary schools. The BISD also has two (2) licensed childcare facilities. According to BISD's Spring 2018 *Demographics of Study Report*, which is conducted to help the Board and administration make decisions regarding staff, facilities, and budgeting, the racial make-up of the district is as follows: Hispanic/Latino (66%); White (26%); Black/African American (4%). Additionally, 13% are bilingual, and 12% speak English as a second language, with 64% of students categorized as economically disadvantaged (Texas Academic Performance Report 2016-2017).
- ◆ **Community Health Centers of Southwest Texas** has locations in Bastrop and Elgin providing comprehensive preventive and primary health care. These services include dental, family medicine, WIC, optometry, pediatrics, behavior health, women's health, and diagnostic laboratory services.
- ◆ **Texas A&M Agrilife Extension Service** is an educational agency with a statewide network of professional educators, trained volunteers, and county offices. Texas A&M Extension Service provides programs, tools, and resources on a local and statewide level to teach people about agriculture and food production, advance health practices, protect the environment, strengthen the community, and enrich the youth.
- ◆ **Lone Star Circle of Care** provides services to the insured and uninsured population in Bastrop as well as surrounding counties in Texas. Those services include behavioral and mental health, dentistry, family medicine, obstetrics and gynecology, pediatrics, pharmacy services, and senior care.

- ◆ **Smithville Independent School District (SISD)** is located in Smithville and has 1,753 students enrolled. The teacher’s salary is \$7,516 less than the state average, and 44% of the students are considered at risk for dropping out of school according to findings completed by the Texas Tribune (2016-2017). Of the 1,753 students the racial make-up is as follows: African American (8%), Asian (1%), Hispanic (31%), Whites- (56%); two or more races (4%). 63% of the students were considered economically disadvantaged. 6% of the students were enrolled in bilingual and English language programs.
- ◆ **Ascension Catholic Church** is located in the City of Bastrop and provides a variety of religious services and activities for children and families. Ascension also provides an interpreter/advocate for the Spanish-speaking population.

## NARRATIVE ON COMMUNITY IDENTITY

### What Makes Us Unique

Community input sessions were designed using open-ended questions and an asset-based framing, to gain feedback specifically regarding the positive element(s) making communities unique. Bastrop county community members were engaged through small group conversations and interviews. Bastrop community members described their community as resilient, caring, friendly, and open to change. Bastrop community residents generally (with the exception of homeschool parents) identified the schools as strong anchors with churches as the foundation to the community. Recent flooding and fires were identified as events that catalyzed community members to work together. Interviewees were, however, split on the issue of access to decision-makers. While 50% of community members felt no connection to local government, others felt like local government has an open-door policy to voice their opinion.

There were some differences based on the location of the conversation. During the conversations at Lost Pines Elementary, community members said the community has a desire to grow, and partnerships are blossoming between school districts and the community, with a significant increase in parental involvement. Homeschool parents at the Bastrop Christian Outreach Center expressed their concern over the challenges they have faced in forming connections with various organizations: “We are not connected as a community” stated one respondent. Respondents from Red Rock pointed out that they [residents] live in a food desert, but the food pantry gives fresh fruits and vegetables daily. Participants at the Smithville Free Clinic were quick to point out how friendly people were within their community.



We are not connected as a community.

-Bastrop County Homeschool parent



### Top Two Community Challenges

The most common community challenges identified by participants were barriers to health care and transportation, including transportation to health care facilities. Seventy-five percent (75%) of the interviewees stated that mental health services are a vital concern in the rural communities. Residents recognized the growth in the Bastrop community and expressed excitement around the prospect of a new, local hospital facility which would eliminate what is now a 30-mile commute for quality health care. Both community conversation participants and key informants expressed significant concern regarding homelessness, lack of health care, and chronic disease prevalence in the community. Specific health care challenges include the lack of OBGYN/women’s health services as well as a lack of oral health/dental





We need dental care. I pulled a tooth for a guy with wire pliers . He didn't have insurance."

-Red Rock Community Member



services. Some residents have even gone so far as to take oral health into their own hands. Beyond the health care arena, there are many challenges faced by Bastrop residents. For the residents of Elgin, the justice system is perceived as unfair. Another concern is housing. According to the *Annual Head Start 2018 Report*, affordable and safe housing was the third greatest concern for community members, with 12% calling it a major challenge and 19% saying it is "somewhat" challenging to procure and maintain safe housing.

### Additional Challenges

Immigration | Drug abuse | Language barriers | Lack of education | Housing | Homelessness  
 Increase in the suicide rate | Difficulties in reaching the "hard to reach" populations | Gentrification  
 Lack of affordable health care | Lack of quality food | Injustice for people of color



Challenges identified by Bastrop residents varied across small group conversations. During the Lost Pines Elementary School conversation, residents raised concerns regarding family access to basic needs such as food, clothing, transportation, and being able to take care of basic personal needs. Elgin community residents were primarily concerned with social issues, resistance to change (e.g. "This is the way it's going to be. It has always been this way"), and the effects of generational privilege (e.g. "My dad was the mayor, so I'm going to be mayor also"). During the Bastrop Christian Outreach Center (homeschool parents), community members were concerned that people would think twice before moving to the City of Bastrop because of the school system. Red Rock community members expressed concerns about the drugs in the community. "Drugs are killing our community," said one respondent. Veteran respondents at the Smithville Free Clinic were in consensus that the lack of affordable housing is due to individuals selling property above the valued price, flipping houses, and the overcrowded housing authority list.



Folks don't want to change.

-Bastrop Homeschool Parent



## Causes and Contributors to Community Challenges

Health care and transportation were the top two challenges identified. Respondents were then asked to identify the causes and contributors to these community challenges. Responses varied from cultural differences to specialized health care services to the geographical distance to the limitation of available resources. Despite this variation, a major theme among all conversations was that the lack of education is a leading contributor to the challenges faced by communities. One interviewee shared that “a major contributor is fear of being deported.” Below is a list of all causes and contributors to the community challenges which were mentioned by respondents (separated by Key Informant Interviewees and Community Residents).

### Key Informant Interviews

Lack of education | Increased drop-out rates | Poverty/socio-economic status | Low paying jobs | Lack of social service programs focusing on daycare and vehicle repair services so people can get to work | Lack of accountability and rigor for students | Economy | Unemployment | Lack of affordable housing | Limited access to quality food | High cost of living | Families displacement | Population growth | Language barriers (e.g., assuming people know what you are saying) | Lack of communication | Generational gaps

### Community Resident Conversations

Culture | Lack of restaurants offering healthier choices | Lack of parks Bad habits | Lack of law enforcement | Lack of physical activity outlets Lack of recreational activities for children and adults | Lack of insurance Fees associated with using school grounds for organized sports | Lack of community volunteers | People not vested in their own health | Low academic rigor (underprepared students) | Lack of accountability students to further their education | Lack of the willingness to comply with providers’ orders and taking charge of your own health

“ Too many power-hungry people.  
-Bastrop  
Community Member ”



### 29% Describing Our Community’s Health

Poor  
53%  
Fair  
15%  
Good  
3%  
Excellent

Participants were asked to describe or rate their community’s health. Out of 34 responses, only one participant rated their community’s health as “excellent.” The majority of respondents rated the health of the community as “fair” or “poor.” The community had an overall impression of fair health because participants had access to care. Respondents noted, however; that while health is good inside the cities of Bastrop and Smithville, that status deteriorates outside city limits.

### Health Challenges

Lack of services for behavior health | Lack of access to mental health | Oral health | Diabetes care | Kidney disease | OBGYN care | Hypertension | Obesity



## Causes and Contributors to Community Health

The top two contributors to community health were **lack of health care** and **transportation**.

Respondents described their community's health based on:

- ◆ Lack of awareness for services (e.g., for diabetes)
- ◆ Malnutrition among children
- ◆ Low WIC participation
- ◆ Lack of care for the homeless population
- ◆ Individuals needing health care services falling through cracks in the system
- ◆ Organizations unable to locate people in remote areas
- ◆ Under-funded government and social service programs

“

We got to stop helping people.

People that's sick get free stuff and if you have insurance you can't get anything free.

-Smithville Residents

”

## Raising Our Families

Bastrop community input participants generally identified the county as a good place to raise a family, with key informants expressing more strongly that the community was an excellent place to raise a family. It is important to note that key informants represented more mainstreamed community leaders and sector representatives as opposed to members of a marginalized population. The low crime rate and the school system were key reasons why

people identified Bastrop as a good place to raise a family. The environment was perceived by participants as clean and safe. Residents expressed a culture of friendliness and saw neighbors coming together during a tragedy as a positive sign of sense of community. Though the community college provides opportunities for education, Bastrop is still viewed as having limited economic opportunities, making it a commuter county. Most residents commute to a nearby urban area for work because there are no major industries in Bastrop County. Another burden on the community is the opioid epidemic and the rise of heroin and crystal methamphetamine use. However, despite these challenges, respondents still saw Bastrop as a great place to live. It was noted, in fact, that many people come to Bastrop to retire.

“

Good Ole Boy System! Those who have money and those who don't.

-Bastrop City resident

Yes! 100%!

-Elgin resident

”



## Influencing Community Decision



We have no voice!  
-Bastrop resident

Local leaders are still  
talking about what they  
did 20 years ago.

-Elgin resident



Approximately 63% of the respondents felt they have no access to decision making in their communities. One resident stated that in his community, decisions for the local county and city governments are made by the county judge. When this question was asked at each community conversation location, the room fell silent. The facilitator reassured the respondents of their anonymity. Conversely, most of the key informant interviewees were comfortable with, and even welcomed, the opportunity to share their thoughts about decision making in their communities.

Though the atmosphere in the community conversations felt tense and uncertain around the question of decision making, the facilitator observed a willingness to participate in community change work if there was room at the table. Some participants felt the community had not achieved much progress through community organizing, but was heading in the right direction. One community resident suggested the organization of micro-communities as a voice for the community at large. In Smithville and Elgin, the community was welcome to attend monthly city government meetings, but only 20% of Smithville respondents stated involvement at the community level. In faith-based organizations, decisions were made by the congregants, but led by the Elders. Many community members felt decisions were made to benefit those in the room at the time. As an example, property taxes were increased for the new convention center with limited community input. As a result, the county has gone into debt. For this and other reasons, community members felt a gap between local government and the community

## ACCESS TO HEALTH CARE AND SOCIAL SERVICES

### Access to Primary and Specialty Care

In the next phase of questioning, participants were asked about specific experiences in their ability to access primary care (visit their main doctor) and their experience with specialty care. Based on the responses, 40% stated they have access to care; whereas 30% indicated that they have no access to care and cited several challenges. Some community members expressed that the appointment time for new patients is long. New patients may wait up to three (3) months for an appointment. Psychiatric and mental health appointments are needed, but the wait time is usually months.



We have a small-town doctor  
who cares for certain families.  
-Smithville Community Member

If you have money, you have  
access to care.

-Red Rock resident



A Smithville resident stated, “I’m stuck with the VA because I have no other way to pay for services, and the back log for special care is months behind at the VA.” Overall, community members felt that services were there, but there were significant barriers to access. Barriers included: long wait times, inability to take off work for appointments, limited clinic hours, the location of health care services/clinics, and transportation. A local health care organization responded, “it depends on the location and if an appointment is easy to get.”

Some clinics had limited capacity. Existing patients might get a same-week appointment, but new patients may have to wait longer. Most providers do not accept new patients, which was challenging for those having special health care needs. Lone Star Circle of Care was cognizant of the problems existing with appointment scheduling, and, as a result, has tried to improve the process of getting appointments. However, the general consensus was that there was not enough care. “We need a major hospital,” stated one organization representative.

Compounding the problem, many faith-based health care providers are no longer accepting Medicare or Medicaid due to the slow reimbursement rates. When it comes to emergency care, St. David’s Emergency Center has a limited number of beds, which forces people to travel to Austin for most emergencies. However, there are 3-4 urgent care units with full-time, walk-in services. In terms of utilization of local clinics and the FQHC, respondents from Elgin indicated that most children are seen by private providers.

## Accessing Information on Available Resources

In Bastrop County, community members and interviewees shared that new residents can receive information from the following sources (ranked in order): the school district, the chamber of commerce, city governments, and word of mouth. Additionally, community members felt social media, other web pages from local partners, the library, local organizations, billboards, some churches, and the general store in Red Rock were good places to go for information. One community member suggested using the post office as an outlet to disseminate information because it is another non-threatening location with no social stigma. There is a perceived disconnect between social service agencies and the communities who rely on them. One respondent felt that Food Stamps/SNAP was easy to access, but other services were more difficult. Respondents felt that there needed to be a better way of getting important information into the hands of community members. Lack of communication was identified as a root cause of people not utilizing services. A kiosk was suggested as a way to get information into communities. Another community resident stated that a hub is needed for micro- communities to access information and services. “Everyone does not have access to Facebook; nor does every family have internet access,” said one respondent.



Funerals homes are a good place to leave information. Someone is always there.

-Elgin Resident

Good luck finding resources in the community.

-Bastrop Community Member



## Accessing Quality Care or Social Services



No, we do not have access to needed quality care and social services.

-Bastrop Community Member



Generally speaking, community members were satisfied with their access to quality care and social services, however, they brought up several challenges faced by some residents. Bastrop County Cares and Lone Star Circle of Care were listed as places to obtain community information. One interviewee was unable to respond to this question. One disagreed and reiterated the challenges to access and that factors such as whether the individual is poor, educated, has insurance, has transportation, or has status absolutely impacted the ability to access quality care or services in Bastrop. According to one

organization, barriers to access to social services include fear of being deported. Chambers of commerce for Smithville, Elgin, and Bastrop were identified as a central point of contact for certain resources, such as workforce development or employment opportunities in the community. However, the person providing the information is not always knowledgeable about available services in the community. Military veterans shared access to the Bastrop Bar Association for legal counsel and the use of the Bastrop Bar Association library as a resource of great value to them.

A legal clinic is held twice a year for veterans and their caregivers. A benefit fair is conducted in the spring and fall to assist veterans with access to services in the county. Community participants expressed that they felt Lone Star Circle of Care, Blue Bonnet Trails, and the Federally Qualified Health Centers provided quality health care. It was noted that the FQHCs were the first to integrate the healthcare system.

“ The St. David’s Foundation funded a one-time dental care that was needed and appreciated for our community.  
-Smithville Resident ”

**Challenges to access quality health care and social services:**

Transportation | Providers no longer accepting new patients | Blue Bonnet Trails need more staff | Providers no longer accepting Medicaid and Medicare as a form of payment | Lack of a smart phone | Awareness of what is available | Lack of access to women's health and prenatal care | No internet

A common theme between the interviewees and the community conversations was that providers are no longer accepting new patients; nor are they accepting Medicaid and Medicare.

## PRIORITIES AND RECOMMENDATIONS

### Suggestions for Improving Community Health and Health of Families

Respondents were asked to provide suggestions to improve the health of the people living in their communities. Community member suggestions included: access to affordable housing, transportation, recreational activities for children and adults, free health care, access to healthier food choices, and access to mental health services. Others wanted health care providers to provide transportation to appointments for the homeless population. Others felt that the traffic situation makes healthy transportation options like walking and biking unsafe; and the respondents want to see more walking and bike trails.

Below is a list all recommendations provided by community members:

- ◆ More outreach
- ◆ Quality affordable housing
- ◆ Food for children all year
- ◆ School-based clinics
- ◆ Incentives for volunteers
- ◆ Free haircuts for children
- ◆ More people of color in the police and fire departments
- ◆ Banks and stores
- ◆ More specialty care—women's health, especially
- ◆ Multi-cultural events
- ◆ Educational campaign to reach the underserved population with an emphasis on the Spanish-speaking population
- ◆ Building patient and provider relationships
- ◆ Higher standards for high school students to improve education
- ◆ YMCA (indoor pool and track, mental health services—YMCA could be a “one stop shop”)
- ◆ More focus on children

- ◆ Satellite opportunities to bring resources to the community
- ◆ Places to check blood pressure and blood glucose - mobile health unit
- ◆ Regular presence in the community from health care providers
- ◆ More kitchen table talks to bring the community together
- ◆ Asking the community what the needs are instead of telling them what they need
- ◆ Provide new information (people are tired of hearing the same things)
- ◆ More changes through the St. David's Foundation
- ◆ Comprehensive plan structured to address the social determinants of health
- ◆ Work with employers to improve health care services
- ◆ SNAP campaign to bridge the gap for access to fresh fruits and vegetables
- ◆ Increase SNAP benefits and partner with

Walmart and local grocery stores to double dollars spent on fresh fruits and vegetables where people live

- ◆ Mechanisms to develop community leaders in different communities
- ◆ Develop community champions



We need proactive services.  
-Bastrop Community Member

I rather hear people say, I don't have transportation than to say never heard of you.  
-Bastrop Community Member

I want to see action from all these meetings.  
-Bastrop Residents

Focus more on the entire family.  
-Red Rock Residents

Stop using the same methods and getting the same results.



## What Positive Change Would Look Like for Bastrop County

In conducting the community conversations and interviews, it was important to capture what the community members and interviewees felt change should look like for their community. Both groups wanted to see growth, resident inclusion in government decision making, and increased visibility of the decision makers and funding leaders at the community level. The community expressed the desire to see more conversations to improve the community's health, a full-service hospital, more relationships, organizations working together, teacher training to improve responsiveness and relationships with parents and students, a shared community vision, an increased focus on mental health, universal access to care, a health community, and expanded pharmacy services and programming. Key Informant Interviewees saw positive change from a different lens. They wanted to see people with insurance, more connection to the rural communities, people of all ethnic backgrounds working together (Blacks, Whites, Asians, Hispanics, and others), honest and positive people working together, continued meetings to address the needs of the community, seeing the right people at the table, programming with the Hogg Foundation, affordable housing for everyone, resources for individuals and families in any given situation, decreased duplication of effort among organizations, accessing data collected in the community, community leaders participating in community-led events, programs to address the needs of foster children



Positive change for me is a change from hopelessness to opportunity.  
-Interviewee





and their caregivers, a movie theater, more communication between superintendents and families, and better wages to decrease child labor. As one interviewee put it, “with all these positive changes taking place we will have healthy families, healthy communities, and the rate of mental health would be at an all-time low.”

## Priorities for the Greatest Impact

Lastly, community members were asked to provide priorities that decision makers should focus on to improve the lives of people who live in Bastrop County. Of the 24 members and 10 interviews conducted in Bastrop County, six major priorities were identified: **access to affordable housing, access to mental health services, transportation, access to physical activity, improved services to address the homeless population, and access to health care which is responsive to the needs of families and children.** Below is a comprehensive list of priorities in order of importance:

- ↓ Transportation
- ↓ Hospital
- ↓ Education
- ↓ Women's health
- ↓ OBGYN services-prenatal care
- ↓ Improve CARTS (Capital Area Rural Transportation) to serve rural areas
- ↓ Oral health
- ↓ YMCA
- ↓ Obesity
- ↓ Cultural barriers
- ↓ Food access
- ↓ Funds
- ↓ Funds from the St. David's Foundation
- ↓ Focus on the next generation
- ↓ After school programs
- ↓ More focus on faith-based involvement
- ↓ Nutrition for children
- ↓ Veterans
- ↓ Law enforcement
- ↓ Solve the three unsolved murders



Some people are scared of certain people. We have to build trust to make a change. Popping in and out of the community doesn't work. We have to lay the groundwork for sustainability.



## COMMUNITY INPUT SESSION QUOTES TABLE

### Lost Pines Elementary School

"We have a desire to grow."

*"90% of our students are low-socio economic and come to school without the basic needs met."*

"We need long term resources. Resources are temporary. Some people have exhausted all resources and burned bridges."

*"Our doors are always open to people."*

### African American Community Elgin Recreation Center

"Elgin isn't Austin."

*"Since moving here five years ago, my breathing is better. I'm away from the congestion."*

"More diversity at the farmers market than in the past."

*"You're on one side, and they're on the other side."*

"There's a taco joint on every corner."

*"I don't want to blame Elgin for people being fat."*

### Homeschooling Parents Bastrop Outreach Christian Center

"I can contact any pastor and they're available."

*"I'm from the North East Boston area and I still have doctors there. We still go back to Boston in January and July for health."*

"People put up with waiting on the doctor for 45 minutes, likes it's no big deal. I'm not."

*"Bottom line is education."*

"Too many segments in the community, there needs to be more connection."

*"Folks are still in the same cycle. My goal and vision are children have a better future."*

"Good ole boy system ... those who have money and those who don't."

### Red Rock Community-Grace Baptist Church

"By no means are we a rich community."

*"I'm the gas can minister because I help people in need of any and everything."*

"We're flooded with drugs. Every drug dealer can somehow get here and set up shop."

*"Grace Baptist gives out fresh fruits and vegetables it makes people healthy and happy."*

"People stop by here with a toe nail off."

*"I'm not a doctor, but I have medical training."*

"I do minor first aid that will cost people \$500 at the emergency room."

*"Once I pulled a tooth with wire pliers because the person didn't have dental insurance and wanted it out."*

"If you have money, you have health care."

### Veterans Smithville Free Clinic

"20% of the people doing 80% of the work."

*"I don't grocery shop here."*

"The town closes at 7pm."

*"Houses sold for \$300,000 but were worth \$65,000."*

"Meth is going wild in Texas."

*"We are a big family."*

"Sometimes initiatives work against what you're to accomplish."

*"You can't enable people by running to rescue them."*

"I can't get a free aspirin and I pay my insurance, but people run to drug users consistently."

*"Sometimes free stuff doesn't get folks fully invested."*

"The big hole is education."



# FACILITATOR'S GUIDE



## CENTRAL TEXAS CHNA COMMUNITY INPUT QUALITATIVE DATA COLLECTION

### Facilitator's Guide

*(Designed for lay community conversations with a primary target audience of those in marginalized communities, those experiencing the greatest-health burden, and those living in areas of high health risk factors. The conversations should last no more than an hour and 30 minutes max.)*

#### GROUP DISCUSSION #1 – INTRODUCTION & COMMUNITY IDENTITY (30 minutes)

- 1. What would you say are the positive things that make this community unique, for example, people feel connected, sidewalks, clean streets, people talking to each other, churches?** *(Write responses on flip chart "Unique/ Positive" flip chart header)*
- 2. What would you say are the top two challenges (problems) your community faces? These do not have to be health related.** *(Write responses on flip chart "Top Two Challenges" flip chart header and denote by hash marks the number of people giving that answer)*
- 3. What are the two most critical health problems in your community? Think about what concerns you about your community?** *(Write responses on flip chart "Health Problems" flip chart header and denote by hash marks the number of people giving that answer)*
- 4. How has your community changed in the past five-years?** *(Write responses on a flip chart "Community Change" flip chart header)*
- 5. How would you describe your community's health and the ways your community helps people be healthy? You can respond using poor, fair, good, or excellent.** *Then ask for those who said poor, why. For those who voted fair, why. For those who voted good, why. Last, if any for those who voted poor, why.)*
- 6. Do you consider this community a good place to raise a family? (Think about is it safe, does it provide you with the economic opportunities to earn a living which supports a healthy life?)** *(Write responses on flip chart "Quality of Life" flip chart header)*
- 7. How would you describe decision making in the community? Do you feel like there are opportunities to be involved in decision making for what happens in your community?** *(Write responses on flip chart "Community Decision Making" flip chart header)*

#### GROUP DISCUSSION 2 – ACCESS TO HEALTHCARE AND SOCIAL SERVICES (15 minutes)

- 8. Is it easy to get appointments to see the doctor or to access healthcare?** *(If they are just answering yes or no ask prompting questions to get them to describe where they go for healthcare, how long it takes to see a doctor or other examples illustrating the ease or difficulty of accessing healthcare)*
- 9. If I am new to community how do I know where to go to get the services I need? Where do people get information?** *(Write responses on flip chart "Information & Social Services" flip chart header). If you need to give examples of services consider, utility bill assistance, food assistance, employment assistance)*

**10. Do you have access to the needed quality health or social services in your community?***(Looking for how many people say no and write on the flip chart the health or social services they feel are not accessible/available in their community, what is the impact on life)*

### **GROUP DISCUSSION 3 – ROOT CAUSES AND DETERMINANTS (15 minutes)**

**11. Think about how you described your community’s health. What do you think are the reasons or causes?** *(Refer to the flip chart sheet posted from the community health responses and write their responses to what they feel are the causes “Reasons and Causes-Health” flip chart header)*

**12. What do you think are the causes or reasons for the community challenges you mentioned?** *(Refer to the flip chart sheet posted from the community challenges responses and write their responses to what they feel are the causes for the community challenges/problems. Write the responses “Causes of Community Challenges”).*

### **GROUP DISCUSSION 4 – PRIORITIES AND SUGGESTIONS (20 minutes)**

**13. What are some of your suggestions to improve the health in your community? What would make it easier for you and your family to stay healthy?** *(Write the responses on flip chart “Suggestions to Improve Health”)*

**14. What would you have to see or experience in order to feel like positive changes are happening in the community? What would positive change look like in this community?** *(Write responses on flip chart “Change for Our Community Is...”)*

**15. I will go around the room and ask each of you to provide a final comment on what two priorities should decision-makers focus on first that would have the greatest impact on improving the lives of people in the community? Consider that your comments will help influence decisions on how to support (improve) your** *(Write responses on the flip chart and capture the number of votes/people who responded if there are repeats “Two Priorities”)*

## COMMUNITY INPUT SESSIONS

### Central Texas Community Health Needs Assessment Qualitative Data - Community Input Sessions & Interviews

COMMUNITY INPUT SESSIONS		
LOCATION	COMMUNITY INPUT SECTOR	NUMBER OF PARTICIPANTS
Lost Pines Elementary School	Academic experts	4 participants
Elgin Recreational Center - Targeted Population African American Population	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	3 participants
Bastrop Outreach Christian Center - Targeted Population Home-school Parents	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	6 participants
Grace Baptist Church (Red Rock Food Pantry)	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	4 participants
Smithville Community Clinic- Targeted Population Veterans	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	7 participants
Community Member Interviews - Targeted Population (Hispanic / Latino)	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	6 participants

## KEY INFORMANT INTERVIEWS

KEY INFORMANT INTERVIEWS	
LEADER / REPRESENTATIVE	COMMUNITY INPUT SECTOR
Richard Hutchins, Veteran Services Officer Veteran Affairs	Federal department or agency with current data or other information relevant to the health needs of the community served
Federal department or agency with current data or other information relevant to the health needs of the community served	Special knowledge of expertise in public health Mental health care provider
Henry Salas, Executive Director Rafael De La Puz, In-Transition/ Executive Director Texas Association of Community Health Centers	Special knowledge of expertise in public health Health care provider Community Health Center
Priscilla Ruiz, Youth Director Ascension Catholic Church	Community-based organization Faith-based organization
Cheryl Burns, Superintendent Smithville School District	Academic expert
Hillary Long, Family and Community Health Agent Texas A&M AgriLife Extension Service	Special knowledge of, or expertise in public health
Norma Mercado, Parent and Family Engagement Foster Care and Homeless Liaison Bastrop Independent School District	Local public agency representative with current data or other information relevant to the health needs of the community served
Lindsey Ripley, Program Design and Clinic Manager Lone Star Circle of Care	Health care provider Community Health Center
Robbie Rabe, Administrator Ascension Seton Smithville Hospital	Special knowledge of, or expertise in public health Healthcare provider
Kelly Franke, Executive Director Combined Community Action	Nonprofit organization Community-based organization

## DEMOGRAPHIC DISTRIBUTIONS (AGE & RACE/ETHNICITY) COMMUNITY INPUT SESSIONS

### AGE DISTRIBUTION 2016, BASTROP

Age	Bastrop County	Bastrop	Smithville	Elgin
0-14	21.2%	19.7%	19.5%	26.9%
15-44	37.0%	36.1%	30.5%	41.0%
45-64	28.4%	25.1%	24.7%	20.5%
65-84	11.7%	15.0%	20.4%	9.1%
85+.	1.7%	4.1%	5.0%	2.4%

### AGE DISTRIBUTION DIFFERENCE 2012-2016, BASTROP

Age	Bastrop County	Bastrop	Smithville	Elgin
0-14	-0.4%	-1.8%	-5.3%	3.5%
15-44	-0.6%	0.0%	-5.8%	0.1%
45-64	-0.6%	-1.5%	2.7%	-1.8%
65-84	1.4%	2.4%	5.4%	-2.3%
85+.	0.2%	0.8%	3.0%	0.5%

Source: American Community Survey 5-year estimates

### RACE/AND ETHNICITY DISTRIBUTION 2016, BASTROP

Race/Ethnicity	Bastrop County	Bastrop	Smithville	Elgin
African American	7.8%	12.4%	15.6%	21.2%
Asian	0.9%	0.1%	1.0%	0.0%
Hispanic	35.2%	17.7%	16.0%	41.3%
White	54.4%	67.2%	62.7%	36.3%
Other	1.7%	2.7%	4.8%	1.3%

### RACE/AND ETHNICITY DISTRIBUTION DIFFERENCE 2012-2016, BASTROP

Race/Ethnicity	Bastrop County	Bastrop	Smithville	Elgin
African American	0.0%	-1.5%	1.1%	4.4%
Asian	0.1%	-0.6%	-1.0%	-0.4%
Hispanic	2.6%	0.5%	-5.0%	-3.1%
White	-2.7%	0.6%	0.4%	-0.7%
Other	-0.1%	0.9%	4.5%	-0.2%

Source: American Community Survey 5-year estimates

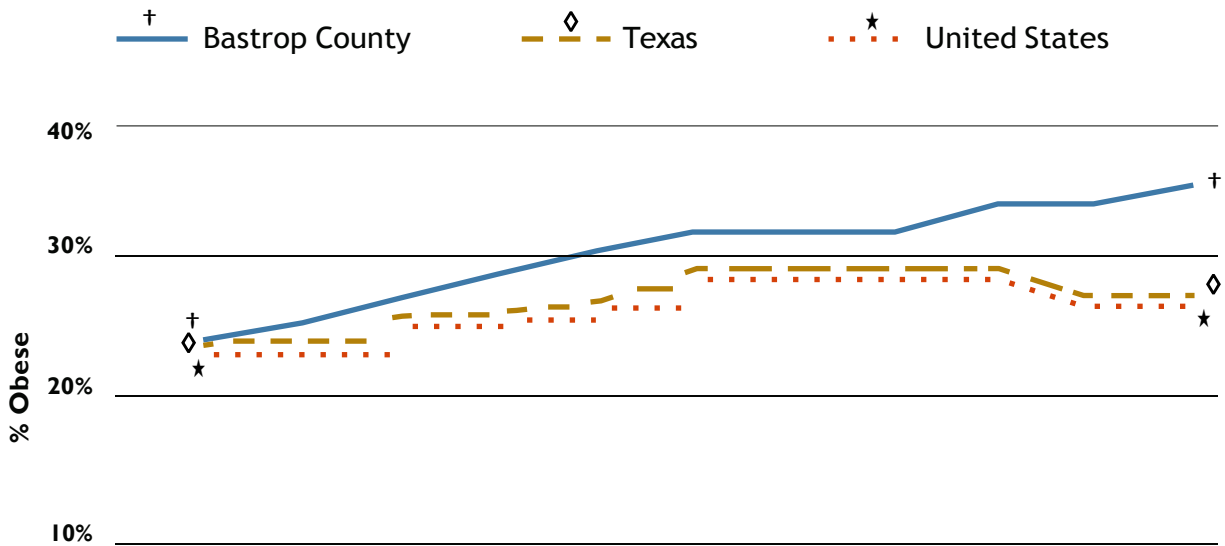
# HEALTH CHALLENGES FACING BASTROP COUNTY

## POPULATION WITH LOW FOOD ACCESS, BASTROP, TEXAS AND US, 2015

Report Area	Population	Population with Low Food Access	% Population with Low Food Access
Bastrop County	74,171	21,735	29.3%
Texas	25,145,561	6,807,728	27.1%
United States	308,745,538	69,266,771	22.4%

Source: US Department of Agriculture, Economic Research Service, Food Access Research Atlas, 2015

## OBESITY RATES IN BASTROP COUNTY, TEXAS AND THE US, 2004-2014



**0% Bastrop County's population obesity rate has increased at twice the rate of Texas, US**

3-year Average	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
United States	24%	24%	26%	26%	27%	28%	28%	28%	28%	28%	28%
Texas	24%	25%	26%	27%	27%	29%	29%	29%	29%	28%	28%
Bastrop County	25%	26%	27%	29%	30%	31%	31%	31%	33%	33%	34%

Please see Measuring Progress/Rankings Measures for more information on trends. Trends were measured using all years of data.

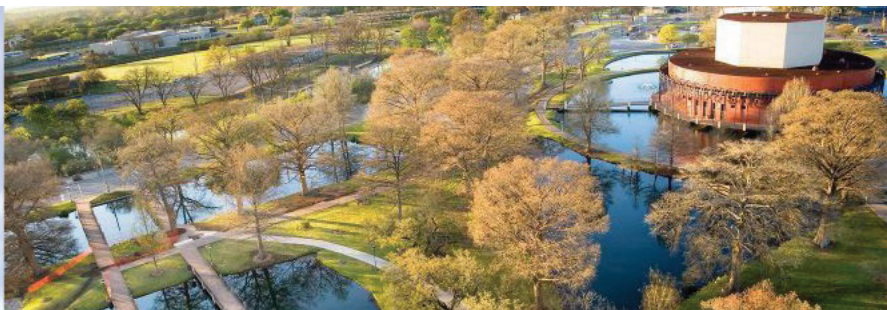
Source: Robert Wood Johnson Foundation, County Health Rankings



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# 2019 COMMUNITY HEALTH NEEDS ASSESSMENT HAYS COUNTY, TEXAS



# ACKNOWLEDGEMENTS

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The 2019 Hays County Community Health Needs Assessment (CHNA) represents the commitment of numerous partners who have contributed their expertise, resources, and time in support of a shared mission—to make Central Texas the healthiest community for all its residents. The data collection methodology was co-created through a partnership of health system partners to ensure that authentic community input and existing quantitative data would be combined to provide a comprehensive assessment of conditions and opportunities which exist to improve health in Hays County. We recognize all of our CHNA partners including Ascension Seton, Georgetown Health Foundation, Central Texas Medical Center, and of course the St. David's Foundation in this important effort. Most importantly, we appreciate the many community organizations, churches, mothers, youth, fathers, advocates, leaders, and community members that shared their time, experiences, and hopefulness to help us complete this assessment. The list below is shared in appreciation to the many contributors of the Hays County CHNA project:

## 2019 CHNA ACTION TEAM

Becky Pastner	St. David's Foundation
Jesse Simmons	St. David's Foundation
Abena Asante	St. David's Foundation
Angelica Ferrandino	St. David's Foundation
Elizabeth Krause	St. David's Foundation
Suzy Pukys	Georgetown Health Foundation
Tara Stafford	Baylor Scott and White Health
Jana Whitaker	Ascension Seton
Ingrid Taylor	Ascension Seton
Lolita M. Ross	SHARED Strategy Group, LLC
Samantha Lucas-Pipkorn	SHARED Strategy Group, LLC
Chanelle White	SHARED Strategy Group, LLC

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## COMMUNITY INPUT PARTNERS

San Marcos Public Library  
Ascension Seton Medical Center Hays  
City of Buda  
Hays County Food Bank  
Ascension Seton  
Hays County ISD  
Texas Department of State Health Services - HSR 7  
Central Texas Catholic Charities  
Central Texas Food Bank  
Community Action, Inc of Central Texas



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# EXECUTIVE SUMMARY

## OVERVIEW

Our understanding of what health means as a public condition, approach, and system is evolving. Clinical interventions were once the primary solution for keeping people healthy. Adherence to regimens, healthy eating, physical activity, and ways to support healthy behaviors were understood as the path to a healthy life. But as health practitioners now know, prevention goes beyond healthy behaviors and what happens within the traditional health system. The health of an individual is primarily determined by where they live, work, and play. The CHNA Action Team along with SHARED Strategy Group co-created a data gathering process that engaged community members as experts in their experience living in Hays County. The anecdotal stories and authentic feedback provided the context necessary to understand and interpret quantitative data. The totality of information – both stories and statistics – are represented in this report as an assessment of health needs in Hays County, TX.



## METHODOLOGY

The methodology for the assessment of community health needs in Hays County used the framework from the National Association of County and City Health Officials (NACCHO) Mobilizing Action through Planning and Partnerships (MAPP) process. The MAPP process includes four key assessments of 1) Community Health Status Assessment, 2) Community Themes and Strengths, 3) Forces of Change and 4) Local Public Health System. This CHNA is designed to highlight health disparities and root causes of local conditions and describe the health system infrastructure. Both qualitative and quantitative data were used in the completion of this assessment.

## CHANGES IN COUNTY PROFILE

***According to the U.S. Census Bureau, Hays County was named one of the fastest growing counties in Texas, with the Hispanic population growing faster than other racial/ethnic groups.***

Hays County has a population of 222,631 (2018) with an estimated 68,045 households, and is located between two major cities, Austin and San Antonio.<sup>1</sup> The land area is 678 square miles and the population density is 316.4 people per square mile. In 2017 the population was 214,4852 and in 2010 the estimated population was 157,107. Since 2010, the population has increased 29%.<sup>2</sup> Twenty-six percent of the county is between the ages of 25 and 44, making it the largest segment of the population. Eighty-seven percent of the population is Non-Hispanic White. However, year-over-year, the Hispanic population has grown faster than other populations. In 2010 the Hispanic population was estimated at 35%. By 2018, 38% were self-identified as Hispanic (all races). Poverty rates decreased between 2015 and 2018, dropping from 17.1% to 16.2%. Median household grew from \$59,260 in 2015 to \$64,864. Hays County adult unemployment decreased from 4.7% in 2015 to 3.3% in 2018.<sup>3</sup>

<sup>1</sup> US Census Bureau Quick Facts. Retrieved from <https://www.census.gov/quickfacts/fact/table/hayscountytexas>.

<sup>2</sup> US Census Reporter. <https://censusreporter.org/profiles/05000US48209-hays-county-tx/>

<sup>3</sup> Community Commons, Feb. 22, 2019). Retrieved from <https://www.communitycommons.org>

## COMMUNITY HEALTH STATUS

***Heart disease and cancer are the top two leading causes of death in Hays County; County rates for premature death and most chronic diseases are lower than the state.***

In Hays County, the top three causes of death are heart disease, cancer, and cerebrovascular disease (stroke)<sup>4</sup>. Each of these are related to lifestyle factors such as poor diet, physical inactivity, and smoking<sup>4</sup>. The adult obesity rate in Hays County is 26%, less than the overall state rate of 28%. Diabetes prevalence in 2018 was 8.6%, less than the state's prevalence of 9.7%.<sup>4</sup> The infant mortality rate for Hays County in 2018 was 3.4 per 1,000 live births, lower than the overall state rate. The teenage birth rate is 21 per 1,000 teens, also lower than the overall state rate for teen births. Premature death is a key indicator of a community's overall health and is measured by years of potential life lost. While the number of Years of Potential Life Lost for the county (YPLL- 4,900) is significantly lower than the state (6,700), the YPLL rate for black residents (6,500) is higher than non-Hispanic white residents (5,100) and Hispanic residents (4,700)<sup>4</sup>.

When asked to rate their community's health, 40% of focus group participants reported that their health was "excellent" and 46% described their health as "good." The most frequently mentioned vulnerable populations in Hays County were the working low income individuals and undocumented immigrants. Homelessness and housing insecurity were considered "invisible problems" that were not identified as priorities by community leaders.

## COMMUNITY THEMES: STRENGTHS AND CONCERNS

***Hays County is a family friendly community with many perceived strengths and assets, but there are urgent needs for behavioral health care, affordable housing and specialty care.***

Community focus group participants were asked to provide their perceptions of quality of life, community uniqueness, assets, and their perception of their ability to influence change in the community. Participants described a number of strengths and assets in the community including being a family friendly place to raise a family with good schools, parks, churches, libraries, and a close-knit community atmosphere. There were a number of suggestions from focus group participants for improving community health. More than half of all focus group participants identified mental health, behavioral health and substance abuse services, and affordable housing as the top two priorities. Other priorities identified by community members in order of greatest need included: point-to-point transportation, short-term and long-term homelessness supports, emergency oral health care, and frequent health fairs to connect residents to services and free health screenings. Key informant stakeholders spoke of the need for specialty care and education for Hays County residents. The most urgent specialty care needs include cardiology, mental health (substance abuse, behavioral health education), pediatrics, and chronic disease management.

## ROOT CAUSE AND FORCES OF CHANGE

***Social determinants of health (SDOH), such as lack of access to affordable housing and transportation, affordable and available specialty care and mental health services, and homelessness are root causes of poor health in Hays County.***

Community input participants were asked to provide their perspectives on the causes of poor health in their communities and the factors that ultimately influence quality of life. Identifying these factors provides potential change levers for improving health in Hays County. While the number of root causes for community health in Hays County is long, the core drivers are associated with the SDOH: affordability of health care, anti-immigration beliefs and practices, access to services and care due to barriers in transportation and distance to available specialists and other health care providers. Many community focus group participants also spoke about how challenging it can be to obtain specialty care in Hays County. Stakeholders described a larger problem of lack of commitment to improving community health on the part of funders, community leaders, and hospitals. Residents described attending meetings of community organizations and hospitals to explore partnerships. There have been forums/town halls on mental health issues. Lack of available funding was identified as a key barrier to continue these community health improvement interests. Each community was left to pursue their concerns on their own. Community members at the focus groups spoke at length about residents working so hard that there was not "any time to be healthy". The consequences for people lacking the energy to exercise or cook healthy meals leads many Hays County residents to lead an unhealthy life.

<sup>4</sup> Robert Wood Johnson Foundation County Health Rankings & Roadmap (2019, Feb. 24). Retrieved from <http://www.countyhealthrankings.org/>

## LOCAL PUBLIC HEALTH CARE INFRASTRUCTURE

*Hays County has three hospitals: Ascension Seton Medical Center Hays located in Kyle, Central Texas Medical Center located in San Marcos, and Baylor Scott & White.*

Hays County has Federally Qualified Health Centers (FQHC) in Wimberley, Kyle, San Marcos, and Buda with limited services. There are 12 other Community Health Centers within a 20-mile radius, located in Travis County. The percent of the population covered by Medicaid has remained at 12%, below the state average. The number of primary care and mental health providers lags behind that of the state. The dental provider to patient ratio is also below the state ratio.

## CONCLUSIONS ON HEALTH IMPROVEMENT PRIORITIES

### THE TOP HEALTH PRIORITIES FOR HAYS COUNTY IN 2018

Based on input from community members, data on current health conditions, and data on SDOH, the following priorities were identified as top priorities for improving health in Hays County:

**MAKE INVESTMENTS IN IMPROVING THE SOCIAL DETERMINANTS OF HEALTH (SDOH)** – Improve community conditions by addressing the availability of free or subsidized health care, expanding access to affordable housing, access to affordable mental health/behavioral health care due to barriers in cost, transportation and distance to available specialists and other health care providers, expanding economic opportunities and living wage jobs to reduce the number of individuals working multiple jobs that impact both quality of life and living a healthy balanced life, expanded transportation solutions, and increasing services to address the needs of the growing homeless population, including programs to secure stable transitional and permanent housing, free health care and transportation services to health care services, and employment and job search services. We know that poverty limits access to care, coverage, healthy foods and stable housing, and that more education is a predictor of better health. We also know that health suffers in communities with poor SDOH such as low-quality housing, low income jobs, and limited opportunities for further education.<sup>5</sup>

**BEHAVIORAL AND MENTAL HEALTH** – Improve access to services across the continuum of behavioral and mental health needs (e.g. mental illness, substance use disorder, social connectedness). Participants noted the negative impacts on community health of the opioid epidemic and the need for increased mental health services, particularly for the most vulnerable and disconnected youth. A recent study sponsored by the National Council for Behavioral Health; America’s Mental Health 2018 found that the lack of access to behavioral health services is the root cause for the mental health crisis in America. Access to mental and behavioral health services, especially for children and youth, should be among the most important priority actions considered by Hays County.

**ACCESS AND AFFORDABILITY OF HEALTH CARE** – Improve access to be responsive to the needs of families and children. Increase access by removing barriers to care such as flat rate fees for office visits, transportation and lack of insurance coverage, and expand programs which show promising outcomes or community response (e.g., a kiosk to promote services was referenced), ensure information on accessing resources is widely available through healthcare roadmaps and other visual explanations of where and how to access specialty care services. Solutions might include extended after-hours appointments, free or sliding scale health clinics in neighborhood schools staffed by specialty care nurse practitioners, free public transportation that run directly to FQHCs and FQHC look-alikes that provide specialty care services, additional FQHC access points in the most impoverished community locations, specialty care services focused on the top chronic diseases and necessary services such as maternal and child health care in the Hays County population. Adults in worse health, those with low incomes, and the uninsured are much more likely than others to delay or forgo health services due to costs and barriers to access.

<sup>5</sup> Centers for Disease Control and Prevention, 2018.

<sup>6</sup> Gary Claxton, Bradley Sawyer and Cynthia Cox, Kaiser Family Foundation, 2019.

**CHRONIC DISEASE RISK FACTORS** – Improve access to affordable healthy food options, eliminate food deserts, increase opportunities for free or affordable physical activity for all ages, and provide free smoking cessation services and medications. Today, seven of the ten leading causes of death in the United States are chronic diseases, and almost 50% of Americans live with at least one chronic illness. People who suffer from chronic diseases experience limitations in function, health, activity, and work, affecting the quality of their lives. Underlying these conditions are significant health risks such as tobacco use, poor nutrition, and physical inactivity. Increasing opportunities to engage in healthy behaviors reduces the risk for illness and death due to chronic diseases.<sup>7</sup>

**POWER DYNAMIC AND INFLUENCE: OUTREACH AND ENGAGEMENT** – Expand leadership opportunities for marginalized, vulnerable community members, increase culturally appropriate messaging and outreach, create opportunities to promote a positive narrative, highlight positive community assets and efforts, identify and execute ways in which visible quick wins can be demonstrated that are driven by community input. Create community responses to address the profoundly damaging anti-immigration rhetoric and actions that further marginalize and isolate members of the Hays County community.

<sup>7</sup> CDC, 2013.



# 2020-2022 HAYS COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT

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## INTRODUCTION

The health of a community can be measured many different ways. Personal and collective health encompasses well-being, social connectedness, personal agency, access to resources, built environment, economic security, practices, and beliefs. The understanding of the comprehensive nature of health means looking beyond individual disease conditions to assess the environments and circumstances in which a person lives, works, and plays as well as what health care resources are available to them. The Community Health Needs Assessment (CHNA) Action Team, and their partners SHARED Strategy Group, co-created a data gathering process that engaged community members as experts in their experience living in Hays County. The goals of the CHNA team were to:

- Identify existing and emerging community health needs
- Identify strengths and assets available to improve health
- Determine the issues affecting the quality of life of residents
- Understand the key forces of change influencing health in the community
- Evaluate the local public health system and determine priorities for improvement; and
- Identify top health priorities for future health improvement efforts

The anecdotal stories and authentic feedback provided the context necessary to understand and interpret numerical data. The totality of information – both stories and statistics, are represented in this report as an assessment of health needs in Hays County, TX.

## METHODOLOGY

The methodology for the assessment of community health needs in Hays County uses as a foundation the assessment element framework from the National Association of County and City Health Officials (NACCHO) Mobilizing Action through Planning and Partnerships (MAPP) process. Where the MAPP process includes four key assessments of 1) Community Health Status Assessment, 2) Community Themes and Strengths, 3) Forces of Change and 4) Local Public Health System, this CHNA is designed to highlight health disparities and root causes and present the health system infrastructure as opposed to essential services. Both qualitative and quantitative data were used in the completion of this assessment. Select quantitative data contained in this report were obtained from publicly available sources such as the U.S. Census, County Health Rankings, and Community Commons. The methodology for collecting qualitative data or community input was designed to capture perspectives from representatives from each of the key community input sectors. These included:

- Representatives or members of medically underserved, low-income and minority populations
- Populations with chronic disease needs
- Practitioners with expertise in public health
- Health care and mental health care providers
- Organizations serving low-income populations
- Agencies with information and data relevant to the health needs of the community
- Nonprofit organizations / Community-based organizations / Faith-based organizations
- Local public agencies

## COMMUNITY INPUT FOCUS GROUP SESSIONS

Community input was gathered in August of 2018 with four primary areas of focus: 1) community identity; 2) access to healthcare and social services; 3) root causes and forces of change; and 4) priorities and recommendations. One focus group was held at Community Action of Central Texas, and one was held at the San Marcos Library; both focus groups included representatives of medically underserved persons, low-income and minority populations, and populations with chronic disease needs. Community members were provided a \$25 grocery store gift card for their participation. To ensure consistency across focus groups, facilitators used a standardized facilitation guide.

These focus groups were designed, through open-ended questions and an asset-based frame, to get perspectives from residents about the positive element(s) of their community. As participants arrived, they were asked to complete an anonymous demographic form. This was voluntary, and no names or personally identifying information was shared. A Community Input summary report for the key informant interviews conducted by Ascension Seton and the summary report from the community focus groups conducted by SHARED Strategy Group, LLC are included in the appendix of this report.

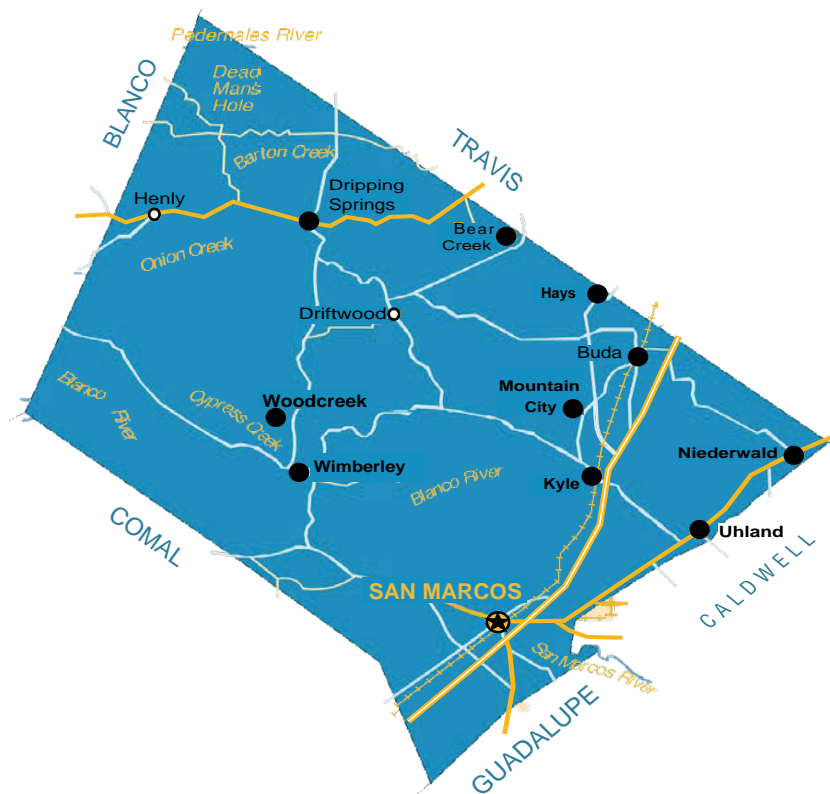
## KEY INFORMANT INTERVIEWS

Nine key informant interviews were conducted by our CHNA partner Baylor Scott & White with sector stakeholders. Interviews were conducted via phone and included representatives from the healthcare sector, social services, and local government.

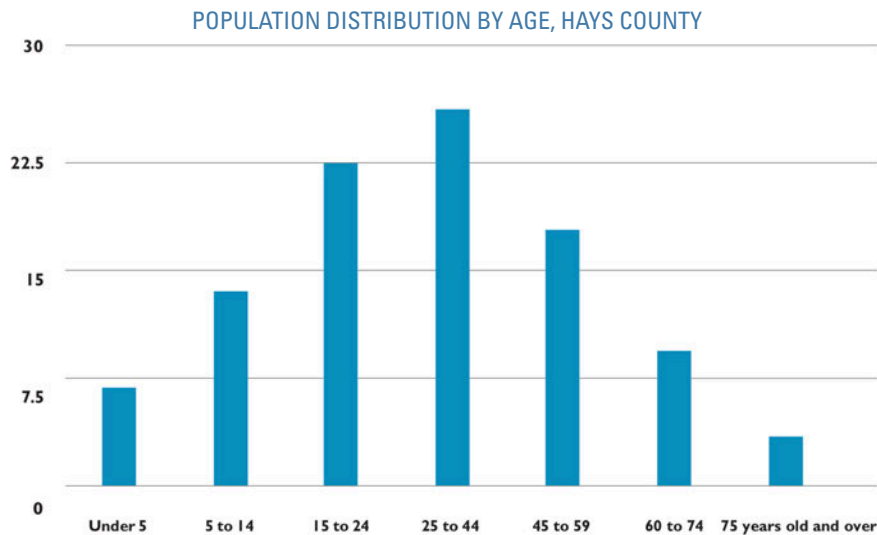
## COUNTY PROFILE: HAYS COUNTY

### *Geographic Boundaries*

Hays County is part of the Austin-Round Rock Metropolitan Statistical Area. San Marcos, the county seat of Hays County, is located along the southern border of the county and is nearly equidistant between Austin and San Antonio. Because of its proximity between two major cities, bedroom communities have formed around San Marcos. Hays County is composed of several small towns and cities including Buda, Dripping Springs, Hays, Kyle, Mountain City, Niederwald, San Marcos, Uhland, Wimberley and Woodcreek. Hays County experienced two massive floods in 2015, which devastated many families financially. The County has a relatively young population compared to the rural east and west regions of Texas; only 10% of Hays County is 65 years old or older.



Hays County has a population of 222,631 (2018) with an estimated 68,045 households. In 2017 the population was 214,485 and in 2010 the estimated population was 157,099. Since 2010 the population has increased 29%. The population is slightly more female than male with women comprising 51% of the population. The population in Hays County is much younger compared to the state with a median age of 30 years old. Twenty-six percent of the county is between the ages of 25 to 44 years of age group, making it the largest segment of the population.



Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimate

All racial and ethnic group populations in Hays County have increased over the last several years but one group is growing rapidly. The Hispanic population has increased from 37.2% of the total population in 2016 to 40.4%. As a share of the total county-wide population, White and Black populations are projected to decline over the next decade, Whites from 56.6% to 53.3% and Blacks from 3.1% to 2.8%<sup>8</sup> (see figure on next page).

During Community Input focus groups, community members described Hays County as a fast growing, close-knit community where neighbors help neighbors. The most commonly expressed descriptor for this community is that Hays County is a “river” community. Participants described how residents have spent their lives engaged in river-related recreational activities such as fishing. Prominent themes emerging from the key informant interviews and community focus groups centered around the impact of population growth in the county, lack of available mental/behavioral health services, challenges accessing health care, healthy foods, transportation, and affordable housing.

## SOCIAL DETERMINANTS OF HEALTH

***Hays County residents experience significant housing cost burdens and housing shortages with substandard housing present in almost 40% of the housing stock.***

Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes.<sup>9</sup> These conditions are known as social determinants of health (SDOH). The median household income for Hays County residents is \$64,864, higher than the state’s median income of \$56,583. The high school graduation rate of 90% and poverty of 16% are slightly better than the state rates of 89% and 17% respectively. However, a higher percent of households (22.6%) in Hays County experience severe housing problems compared to the state (18.3%). Substandard housing is present in Hays County (38.9%) more often than across the state (32.3%), and the percentage of households experiencing a housing cost burden (over 30% of their household income) is 38% in Hays County compared to 31% across the state. The table below presents the full data set on key measures of the social determinants of health.

Compared to the state, Hays County residents are more affluent with fewer residents receiving Medicaid support, less with limited healthy food access, and more residents employed.

<sup>8</sup> U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates.

<sup>9</sup> CDC, 2019.

# COMMUNITY HEALTH STATUS

The Community Health Status Assessment (CHSA) provides a population level snap-shot of the current condition of health for Hays County. The design of this section is slightly different from the traditional MAPP assessment framework in that information on health resource availability is included in the section focused on Local Public Health Infrastructure. The data in this section is based on secondary data analysis of key health indicators for comparison and identification of health trends. In addition, community comments on perceptions of health are included for additional context.

## QUALITY OF LIFE

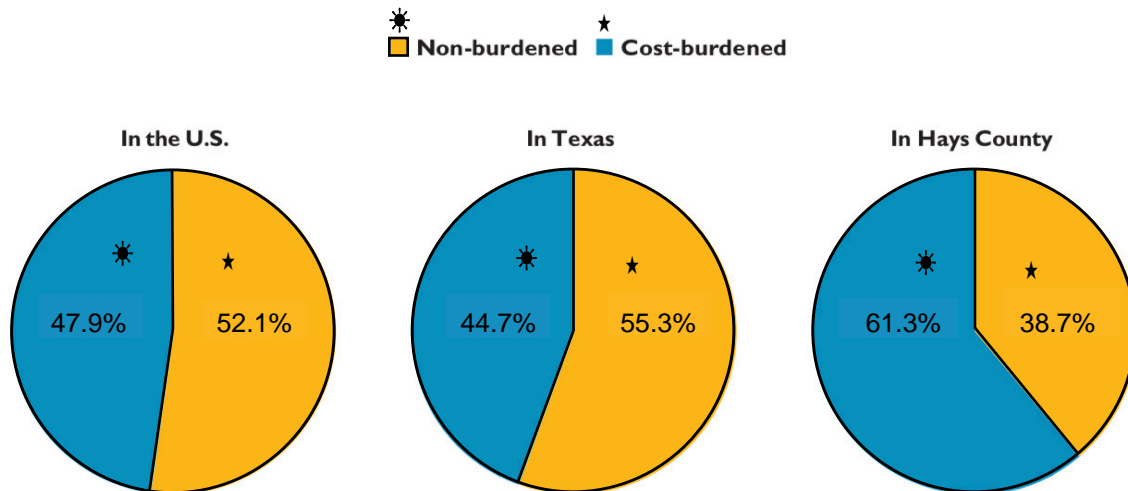
Quality of life is a holistic index of the human condition based on multiple factors that influence the standard of living or life experienced by a person, family, or community. Quality of life is influenced by factors such as housing burden, commuting, civic engagement, social or spiritual connections, and of course physical and mental health.

### HOUSING BURDEN

**More than half of Hays County residents who rent or own their own homes are experiencing significant housing burden as population growth drives up the price for homes.**

The U.S. Department of Housing and Urban Development defines housing burden or cost-burdened families as those “who pay more than 30 percent of their income for housing,” which may cause financial difficulties in affording other necessities such as food, transportation, clothing, and medical care<sup>10</sup>. Further, those that are paying more than 50% of their income on rent are considered as experiencing a severe rent burden.

Among renter households, in Hays County, 61.3% of renters experience a housing burden. This is slightly higher than the Texas housing burden rate of 56.3%. Homeowners in Hays County are also experiencing an increase in housing costs. According to the Austin Board of Realtors, home sale closing prices increased 52% in the last five years. In the city of Buda, in Hays County, the price increased by 63.2%.



Source: U.S. Census Bureau, 2015 American Community Survey 5-Year Estimates

### TRANSPORTATION

**Adequate, available, and affordable transportation was identified as one of the top two county challenges in 2018 and commute times for one-third of residents exceed 90 minutes.**

Based on the number of households, the largest percentage owned two automobiles at 46.3%. Of the total households, 1.3% did not own an automobile. In comparing commute time, Hays County workers commuted an average of 28 minutes. Additionally, 30% of the Hays workforce had commute times exceeding 90 minutes.

<sup>10</sup> [https://www.huduser.gov/portal/pdredge/pdr\\_edge\\_featd\\_article\\_092214.html](https://www.huduser.gov/portal/pdredge/pdr_edge_featd_article_092214.html)

## CIVIC PARTICIPATION AND POLITICAL ENGAGEMENT

**About 60% of Hays County voters participate in elections, comparable to the overall state rate. However, 40% of registered voters do not participate in elections – a sizable disengaged population.**

For the purpose of this assessment, civic participation is measured by participation in political processes, particularly voting. This is an important indicator of underlying power dynamics, community engagement, hope, disenfranchisement, and marginalization. Common barriers to voting include voter registration problems, inability to take time off from work, transportation challenges, and the perception of our ability to influence change. Some of these are also barriers to accessing health care services.

According to the Texas Secretary of State, in 2016 there were 121,326 registered voters in Hays County compared to 85,601 in 2004. Comparing those same years, the percentage of voters was consistent at approximately 59%. Another measure of civic engagement and resident transition or mobility is the Voter Suspense Rate. Suspense Rate reflects the percentage of registrants who had their Voter Certificate returned to the county office. This indicates that a resident no longer lives at their registered address and therefore, their voting state is changed to “suspense”. For Hays County, 7.8% of total voters were identified as “suspense”.

## BEHAVIORAL RISK FACTORS

**Smoking and excessive drinking have increased in Hays County since 2015.**

Since 2015 the percentage of adults living with obesity, excessively drinking, and smoking has increased. The number of physically inactive adults (21% to 18%) who lack access to exercise opportunities (93% to 88%) decreased. Food insecurity decreased from 16% to 14%. The adult smoking rate was 13% in 2015 and rose to 15% in 2018.

RISK FACTOR COMPARISON IN HAYS COUNTY, 2015 AND 2018

	2015		2018	
	Texas	Hays County	Texas	Hays County
Adult smoking	17%	13%	14%	15%
Physical inactivity	24%	21%	24%	18%
Excessive drinking	16%	18%	19%	22%
Food environment index	6	7	6	8
Lack of access to exercise opportunities	84%	93%	81%	88%
WIC authorized food store access	9.1	5.5	9.1	5.5
Food insecurity	18%	16%	16%	14%
Limited access to healthy foods	9%	7%	9%	6%

## IMPACT OF COUNTY-WIDE GROWTH

**Key stakeholders and community participants see the population growth occurring in Hays County as a “positive” challenge. Services and resources are stretched thin to meet increased demand, but new resources are beginning to help.**

Key stakeholders interviewed as part of this CHNA spoke at length about the impact of growth in Hays County. Rapid growth was an underlying theme that resulted in additional health care services established in the county. However, the pace that additional services have been introduced in the county has not kept up with the rate of growth and there is a need for more specialty care. Growth is perceived as something which has attracted a population that is unemployed and uninsured (presumably looking for work), which adds to the burden of the community.

Both key informants and community input participants described a community struggling with a lack of affordable fruits and vegetables, physical inactivity, and residents living with health conditions such as diabetes or obesity. Residents described the need for access to healthier foods and acknowledged that food insecurity exists across the region but that many residents and leaders are unaware of this fact. Participants noted that a geographic and social disparity exists in Hays County in terms of access to healthy food. The less affluent and more rural populations experience barriers to access to healthy food. Increased growth in the county has led to a new Walmart which has helped increase access to food.

## SOCIAL AND MENTAL HEALTH

*Hays County residents experience more poor mental health days per month, twice the suicide rate, but equal rates of depression when compared to the state.*

Data from the Centers for Disease Control and Prevention for the 25 most populous Texas counties show that the highest age-adjusted suicide rate per 100,000 population in the state was 16.7. The lowest county-wide rate of suicide was 5.5 per 100,000. Hays County experienced a rate of 12.5, higher than the reported rate for Texas (11.7) for the five-year reporting period (2011–2015).

	2015		2018	
	Texas	Hays County	Texas	Hays County
Poor mental health days	3.3	3.0	3.4	3.7
Depression	16%	15%	17%	17%
Suicide mortality	11.7	11.4	6.2	12.5

## MATERNAL AND CHILD HEALTH

*Infant and child mortality are substantially lower in Hays County than in the state.*

### INFANT MORTALITY

The 2018 infant mortality rate for Hays County was 3.4 per 1,000 live births. This is significantly lower than the rate for Texas (5.8). In addition, this represents a decrease in infant mortality from 2015. Child mortality rates were substantially higher than that of infant mortality rates.

	2015		2018	
	Texas	Hays County	Texas	Hays County
Low birthweight	8.4%	7.5%	8.3%	7.4%
Infant mortality	6.0	4.3	5.8	3.4
Child mortality	53.1	35	51.5	39.2

### TEEN BIRTHS

*Teen birth rates declined for both Texas and Hays County between 2015 and 2018; Hispanic teens have birth rates 4 times as high as White teens and 3 times as high as Black teens.*

Teen births is defined as the number of births to females ages 15 – 19 per 1,000 females in a county. Texas has an overall teen birth rate of 41 with county rates ranging from 14 in Collin to 109 in Brooks County. Hays County experienced a teen birth rate of 21 per 1,000 females, much lower than the state rate. Teen birth rates were significantly higher among Hispanics (38 per 1,000 females) compared to 9 for Whites and 13 for Blacks.

## DEATH, INJURY, AND ILLNESS

**Compared to Texas, Hays County experienced lower rates of death and illness. The exception is accidental deaths.**

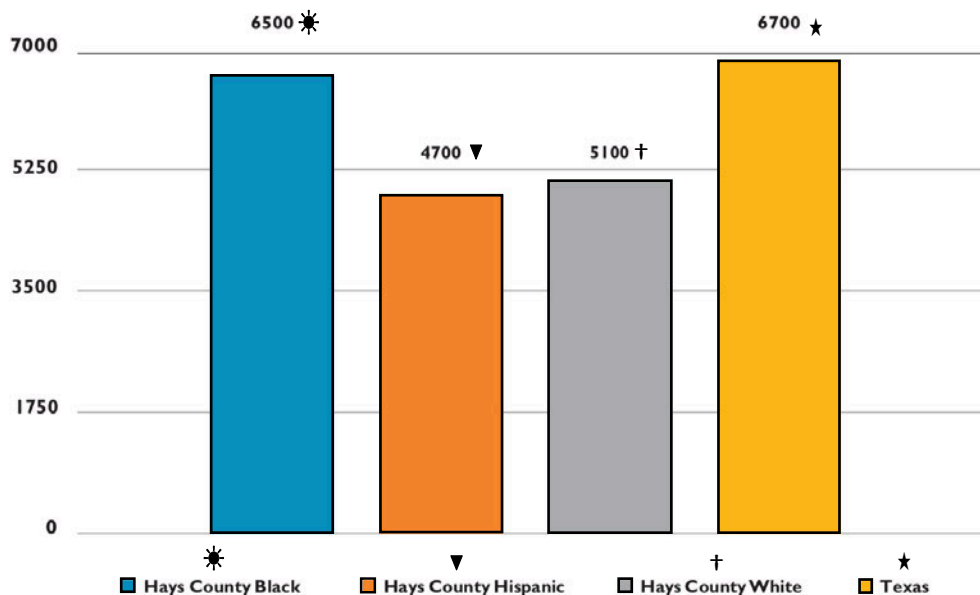
According to the most recent data published by the CDC National Center for Health Statistics (2016), the top five leading causes of death for Texas were; 1) Heart Disease 2) Cancer 3) Stroke 4) Accidents and 5) Chronic Lower Respiratory Disease.

Cause	Hays County Rate	Texas Rate
Heart Disease	151.6	178.1
Cancer	133.4	150.6
Accidents	43.0	37.8
Chronic Lower Respiratory Disease	40.6	42.4
Alzheimer's	39.8	41.3
Long commute	36.9%	47.3%

Age-adjusted death rates per 100,00 population (all ages).

Premature Death is measured by years of potential life lost (YPLL) before age 75. Every death occurring before the age of 75 contributes to the total number of years of potential life lost. According to the 2018 County Health Rankings, Hays County has a significantly lower rate of years of life lost at 4,900 compared to the state at 6,700.

YEARS OF POTENTIAL LIFE LOST (PREMATURE DEATH) IN HAYS COUNTY



## DIABETES

**In Hays County, both incidence (7.2 to 8.8) and prevalence (8% to 9%) of diabetes increased for the period 2015-2018.**

Nationally, diabetes represents one of the most-costly conditions not only in terms of the economic burden, but the burden it places on an individual's health. According to a 2019 report released by the American Diabetes Association (The Cost of Diabetes), total costs of diagnosed diabetes have increased to \$327 billion from \$245 billion in 2012. This represents a 26% increase during the five period. For Texas, the incidence of new diabetes diagnoses for the population over the age of 20 has decreased from 9.8 per 1,000 population in 2015 to 8.5 in 2018. The state also saw a slight decrease in the prevalence of diabetes among those 20 and older (11% to 10%). However, in Hays County both incidence (7.2 to 8.8) and prevalence (8% to 9%) of diabetes increased for the period 2015-2018. The adult obesity rate for Texas remained steady for the comparison period, while obesity rates increased from 24% to 26% in Hays County. In 2018, diabetes incidence in Hays County was slightly higher than the state average (8.8 vs 8.5).



## COMMUNICABLE DISEASE

### *Communicable disease data for Hays County for HIV prevalence had a significant increase in newly diagnosed HIV infections from 2015 to 2018*

Over a three-year period, prevalence of HIV and sexually transmitted infections (STIs) increased in Texas. In 2015 the prevalence rate of HIV was 318.6 (the number of new HIV diagnoses per 100,000 population). That rate increased in 2018 to 368.9. Prevalence of STIs is based on the measure of newly diagnosed chlamydia infections per 100,000 population. In 2018, the prevalence for STIs increased by 36.1 over 2015. Communicable disease data for Hays County showed a similar pattern for HIV prevalence with a significant increase from 101 in 2015 to 173 in the three-year comparison period. STIs were significantly higher in Hays County (641.5) compared to the state (523.6).

## COUNTY HEALTH RANKINGS

### *Hays County, as measured by the County Health Rankings, has better health outcomes than 92% of Texas counties*

The Robert Wood Johnson Foundation's County Health Rankings is a data tool used to report on the health status of a community by examining more than 30 measures for counties across the U.S. Hays County's overall health outcome ranking is 14 out of 242 counties in Texas. Total counties vary by measure, so rankings are not based on all 254 counties in Texas for each measure. Hays County, as measured by the County Health Rankings, has better health outcomes than 92% of Texas counties and is in the top 10% of counties when it comes to health, social, and economic factors (social determinants of health). Where Hays County appears to have much to improve upon is in the physical environment (e.g., housing and transportation).

COUNTY HEALTH RANKINGS FOR HAYS COUNTY, 2018

Category	Ranking
Length of Life (Premature death)	8
Quality of Life	75
Health Factors	24
Health Behaviors	41
Clinical Care	32
Social and Economic Factors	19
Physical Environment	232

Source: <http://www.countyhealthrankings.org/app/texas/2018/rankings/hays/county/outcomes/3/snapshot>

## HEALTH DISPARITIES

Social determinants of health are recognized as those social and economic health factors that have the greatest impact on health. These factors are key drivers in the health outcomes experienced by a particular population. Differences in health based on factors such as race or economic status are called disparities. Data on health disparities illustrate the undue, unfair, and disproportionate health burden a population experiences as a result of social determinants. In reviewing health outcomes data for Hays County, there were several health disparities or populations that experience this unfair health burden. For many health indicators, disaggregated data based on race or income level were not available. Most efforts towards eliminating health disparities were identified at the state level through institutions or organizations such as the Texas Health Institute, Texas Center for Health Disparities, Office of Minority Health Statistics, and the Texas Health Disparities Task Force. Numerous reports identified disparities in chronic disease prevalence in larger counties such as Travis or at the state level. For Hays County, the available disparities data were often presented based on gender (male and female). Health indicators such as premature death, teen birth, and low birth rate were identified by racial group. The following table illustrates the identified population health disparities for key health indicators.

SUMMARY OF POPULATION HEALTH DISPARITIES FOR HAYS COUNTY

Health Indicator	White	Black	Hispanic
Teen Birth Rate	9%	13%	38%
Premature Death/Years of life lost	5,100	6,500	4,700
Low Birth Rate ( <i>% of births</i> )	7%	14%	8%

Health Indicator	Males	Females
Life Expectancy (years)	78.7	82.4
Heart Disease Rate (per 100,000 population)	143.1	91.2
Chronic Respiratory Conditions (per 100,000 population)	46.9	32.9
Self-harm and interpersonal mortality (per 100,000 population)	23.1	6.9
Mental Health and Substance Use (per 100,000 population)	9.7	5.7

# COMMUNITY THEMES: STRENGTHS AND CONCERNS

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Input for this CHNA included a Community Themes and Strengths Assessment (CTSA) to gather perceptions of community assets and concerns and barriers that impact the quality of life of residents. Through focus groups and interviews community residents were provided the opportunity to comment about their lived experiences. The approach allowed participants to gain confidence in contributing to the discussion by beginning with depersonalized observations of the community in general and progressing to reflective discussions around their own personal experience. In Hays County, community members spoke with pride about how their community was not like any other—that the river made it unique. They described Hays County as a fast-growing, close-knit community where neighbors help neighbors. Although there are some challenges, many spoke of the benefits the Texas State University in San Marcos brought to the area, such as bike lanes and art-related events. The most commonly expressed descriptor for this community is that Hays County is a “river” community.

## STRENGTHS AND ASSETS

*Hays County residents reported many strengths and assets for their community. Among the most frequently mentioned were family friendliness and supports, continued community growth, and livability.*

### Family Friendly

Community members described how Hays County was a good place to raise a family. Good schools, parks, churches, libraries, and a close-knit atmosphere were all detailed by participants.

### Community Growth

Community members saw the addition of facilities such as the Hays YMCA which promotes a healthy lifestyle, stores such as Walmart, and new Urgent Care clinics that have appeared in recent years due to county growth.

### Livability

Community members described how Hays County is a great place to live because the river is a well-known and utilized resource that attracts many community social activities. Texas State University, located in San Marcos, was also mentioned as an asset.

### Community Collaborations

Key stakeholders identified the following collaborations at the local level: farmers markets integrated with hospitals; food pantry initiative for those in need of nutritional guidance; hospital partnerships with cities to build trails, especially exercise trails; injury prevention at football games, car seats; medical mobile truck for vaccinations and physicals; and partnerships with school districts.

## CONCERNS AND BARRIERS

*The top two community challenges consistently identified by community residents were affordable housing and transportation.*

Other challenges identified by participants included: Short-term and long-term homelessness; eligibility requirements for services; lack of mental health services; low level crimes (juvenile charges); immigration status; underinsured/uninsured or people with high deductible plans; chronic conditions like diabetes; juvenile diabetes and obesity; processed food; river upkeep and maintenance; outdoor recreation for the disabled and seniors; sidewalk repairs; help with social security benefits; trains (volume and noise); and pawn shops/predatory lending.

## RECOMMENDATIONS AND PROPOSED SOLUTIONS

In both community sessions, participants described several recommendations for improving community health and responding to pressing community problems.

### Challenge: Access to Transportation

#### ***Recommendation:***

One well-received suggestion was a point-to-point transportation system because people want to get on the bus at their home and get off the bus where they work. The public system is not currently able to do that.

### Challenge: Access to Resources and Navigating the Healthcare System

#### ***Recommendation:***

Community residents recommended solutions that would reach people where they live and work. Improving outreach to ensure everyone has access to information on available resources. Other recommendations included the creation of one-stop resource centers at the neighborhood level in the areas where people that access them the most live or work.

### Challenge: Support for Residents Experiencing Homelessness

#### ***Recommendation:***

Because homelessness was discussed as an issue, participants described the need for a shelter that is open to everyone. More broadly, homeless supports might include both short-term and long-term housing, transportation to food pantries, free health care services, mental and behavioral health supports, substance abuse counseling, and job training and retraining supports.

# ROOT CAUSES AND FORCES OF CHANGE

Stakeholders who were interviewed described how affordability was the biggest issue to access health care, that even if there was a specialist, people could not afford it. Transportation in Hays County is a barrier for residents since people have to travel to other communities to get specialty care. Stakeholders also spoke about how challenging it can be to obtain specialty care in Hays County.

Community members at the Focus Groups spoke at length about people working so hard that there is not any time to be healthy. The implications of people lacking energy to exercise or cook meals leads them down an unhealthy life. One participant said “People are working, but their income isn’t enough to make ends meet. They have no energy.”

***“People are working, but their income isn’t enough to make ends meet. They have no energy.”***

Participants expressed how hard it is to get by, let alone be healthy. When asked about the root cause of people not being healthy and one participant explained that “It’s all economic. The disparity just keeps growing between the haves and the have-nots. There are no or low-paying jobs, unaffordable housing, there are just so many things.” In one session, community members spoke about the connection between education and future income stating, “I see where people haven’t finished high school and maybe it’s [because] they’re having to drop out to get a minimum wage job to help support the family. So now they’ve dropped out of school and may be stuck in a minimum wage job. It’s part of a cycle.”

Participants in one of the Community Focus Groups described how leadership in San Marcos is made up of newer residents who don’t understand or appreciate the uniqueness of the town. One participant stated that it is a “small town mentality and history, but larger scale city development”. At another focus group, immigration was discussed at length as something that has been a recent change. One participant said, “The thing is that Kyle has a huge immigrant population, so there’s this whole neighborhood of people. There were concerns about people being too afraid to seek medical treatment for conditions or send their kids to school.”

***“It’s all economic. The disparity just keeps growing between the haves and the have-nots. There are no or low-paying jobs, unaffordable housing, there are just so many things.”***

# LOCAL PUBLIC HEALTH INFRASTRUCTURE

Hays County has three hospitals: Ascension Seton Medical Center Hays located in Kyle, Central Texas Medical Center located in San Marcos, and Baylor Scott & White Medical Center located in Buda. Ascension Seton Medical Center Hays serves the residents of Hays, Caldwell, and South Travis counties. The hospital opened in 2009 and is the largest medical campus in Hays County, with outpatient diagnostic and therapeutic services and a medical office building. The hospital is a certified Primary Stroke Center, offers a Level II Neonatal Intensive Care Unit (NICU), a 24-hour emergency department and serves the community as an Adult Level IV Trauma Center. Ascension Seton Medical Center Hays is part of the Ascension Seton system, which serves all of Central Texas and is the largest nonprofit health system in the U.S., and the world’s largest Catholic health system. Central Texas Medical Center began operations in 1923 as Hays County Soldiers, Sailors and Marines Memorial Hospital. Today, Central Texas Medical Center is a 178-bed hospital with over 700 employees, Level IV Emergency and Trauma; a birthing Center with Level II NICU, and hospice. Baylor Scott & White Medical Center in Buda is a full-service hospital and specialty clinic.

Hays County has Federally Qualified Health Centers in Wimberly, Kyle, San Marcos, and Buda. There are 12 other Community Health Centers within a 20-mile radius, located in Travis County.

Lack of health insurance is a growing problem in Hays County. In 2015, Hays County had lower than average rates of uninsured persons for both adults and children. In 2018, health insurance coverage increased and is now at state averages. The percent of the population covered by Medicaid has remained at 12%, below the state average. The number of primary care and mental health providers lags behind that of the state. The dental provider to patient ratio is also below the state ratio.

HEALTHCARE ACCESS COMPARISON FOR 2015 AND 2018

	2015		2018	
	Texas	Hays County	Texas	Hays County
Primary care physician to patient ratio	58.5	46.7	59.9	41.6
Mental health provider patient ratio	96.7	86.0	98.8	87.5
General Dentist patient ratio	36.2	26.0	55.9	34.2
Federally Qualified Health Centers (FQHCs)	1.4	1.3	1.8	3.8
Health Professional Shortage Area (HPSA)	24.3%	100%	16.8%	0%

## CHALLENGES IN ACCESSING HEALTH CARE SERVICES

### ***Hays County residents perceive inequities in securing health care appointments with providers giving priority to those who are privately insured.***

Among the healthcare access challenges identified by community input participants were eligibility requirements for services, lack of mental health services, underinsured or insured with high deductible plans, and chronic conditions like diabetes. During the community focus groups, participants spoke about how the level and type of care an individual receives is dependent upon income and insurance. One participant stated, “Care isn’t for the uninsured.” Community participants spoke of disparities in how appointments were scheduled, with privately insured individuals receiving priority in appointment setting over individuals with Medicaid.

Additionally, community members described how difficult it is to get mental health services and specialty care citing that residents often travelled to Austin when needing those services. For those with health insurance, care can also be varied. One participant shared, “I have insurance, and I get bad providers. It just depends. It can be hit or miss with providers.”

***“If you are on Medicaid, there are long wait times. The waiting list could be longer than six months.”***

## CHALLENGES IN ACCESSING SOCIAL SERVICES

### ***The administrative bureaucracy managing social services in Hays County is a significant barrier to health and well-being.***

When describing concerns with accessing social services, focus group participants described issues with silos, unfriendly administrators, and cumbersome bureaucracy. One participant shared, “It takes multiple calls. It’s like everybody needs a caseworker to find their way through the system. They need some sort of person to help them, and they don’t even know how it’s supposed to work when it does work. So, for some, it is the knowledge of how to do it and the aggressiveness to continue to pursue what you need because it doesn’t just happen the first time. There are multiple calls.”

## CHALLENGES ACCESSING MENTAL HEALTH SERVICES

### ***The lack of available mental health providers is a key barrier to health and well-being in Hays County.***

The lack of availability of mental and behavioral health services was a theme that emerged in the interviews and community focus groups. The Key Informant Interview participants noted that the need for these services far outpaced the availability of the services; lack of services related to Attention-deficit/hyperactivity disorder (ADHD), depression, and affordable outpatient therapy were also described. Community members who participated in the Focus Groups spoke of the impact of the lack of mental health services in their community, particularly for those who lack health insurance.

***“It’s when people have this attitude about low-income people. They think stinky, smelly, rude – they stereotype”***

Key stakeholders interviewed described the limited number of available mental health practitioners, especially for those with limited ability to pay. Many mental health conditions related to depression and suicide are being treated in the emergency room because outpatient mental health services are extremely limited. “While there has been rapid growth in Hays County, services have not caught up. There is a lack of follow up care and lack of rehab services if someone seeks assistance.”



# COMMUNITY HEALTH PRIORITIES

## THE TOP HEALTH PRIORITIES FOR HAYS COUNTY IN 2018

*Based on input from community members, data on current health conditions, and data on social determinants of health, the following priorities were identified as top priorities for improving health in Hays County: 1) better transportation options, 2) increasing affordable housing options, and 3) increasing access to specialty care and mental health/substance abuse services. In addition, related to these top three priorities, Hays County must consider how the social determinants of health (SDOH) are impacting the overall health and well-being of residents and their chronic diseases.*

**MAKE INVESTMENTS IN IMPROVING THE SOCIAL DETERMINANTS OF HEALTH (SDOH)** - Improve community conditions by addressing the availability of free or subsidized health care, expanding access to affordable housing, access to affordable mental health/behavioral health care due to barriers in cost, transportation and distance to available specialists and other health care providers, expanding economic opportunities and living wage jobs to reduce the number of individuals working multiple jobs that impact both quality of life and living a healthy balanced life, expanded transportation solutions, and increasing services to address the needs of the growing homeless population, including programs to secure stable transitional and permanent housing, free health care and transportation services to health care services, and employment and job search services. We know that poverty limits access to care, coverage, healthy foods and stable housing and that more education is a predictor of better health. We also know that health suffers in communities with poor SDOH such as low-quality housing, low income jobs, and limited opportunities for further education.<sup>11</sup>

**BEHAVIORAL AND MENTAL HEALTH** – Improve access to services across the continuum of behavioral and mental health needs (e.g. mental illness, substance use disorder, social connectedness). Participants noted the negative impacts on community health of the opioid epidemic and the need for increased mental health services, particularly for the most vulnerable and disconnected youth. A recent study sponsored by the National Council for Behavioral Health; America’s Mental Health 2018 found that the lack of access to behavioral health services is the root cause for the mental health crisis in America. Access to mental and behavioral health services, especially for children and youth, should be among the most important priority actions considered by Hays County.

**ACCESS AND AFFORDABILITY OF HEALTH CARE** – Improve access to be responsive to the needs of families and children. Increase access by removing barriers to care such as flat rate fees for office visits, transportation and lack of insurance coverage, and expand programs which show promising outcomes or community response (e.g., a kiosk to promote services was referenced), ensure information on accessing resources is widely available through health care roadmaps and other visual explanations of where and how to access specialty care services. Solutions might include extended after- hours appointments, free or sliding scale health clinics in neighborhood schools staffed by specialty care nurse practitioners, free public transportation that run directly to FQHCs that provide specialty care services, additional FQHC access points in the most impoverished community locations, specialty care services focused on the top chronic diseases and necessary services such as maternal and child health care in the Hays County population. Adults in worse health, those with low incomes, and the uninsured are much more likely than others to delay or forgo health services due to costs and barriers to access.<sup>11</sup>

**CHRONIC DISEASE RISK FACTORS** – Improve access to affordable, healthy food options, eliminate food deserts, increase opportunities for free or affordable physical activity for all ages, and provide free smoking cessation services and medications. Today, 7 of the 10 leading causes of death in the United States are chronic diseases, and almost 50% of Americans live with at least one chronic illness. People who suffer from chronic diseases experience limitations in function, health, activity, and work, affecting the quality of their lives. Underlying these conditions are significant health risks such as tobacco use, poor nutrition, and physical inactivity. Increasing opportunities to engage in healthy behaviors reduces the risk for illness and death due to chronic diseases.<sup>13</sup>

<sup>11</sup> CDC, 2018.

<sup>12</sup> Gary Claxton, Bradley Sawyer and Cynthia Cox, Kaiser Family Foundation, 2019.

<sup>13</sup> CDC, 2013.

**POWER DYNAMIC AND INFLUENCE: OUTREACH AND ENGAGEMENT** – Expand leadership opportunities for marginalized, vulnerable community members, increase culturally appropriate messaging and outreach, create opportunities to promote a positive narrative, highlight positive community assets and efforts, identify and execute ways in which visible quick wins can be demonstrated that are driven by community input. Create community responses to address the profoundly damaging anti-immigration rhetoric and actions that further marginalize and isolate members of the Hays County community.



## CONCLUSIONS

The 2019 CHNA process sheds light on the opportunities and challenges that exist in improving health outcomes in Hays County. Community conversations helped to provide insight into the lived experiences that tell the story behind the data. This assessment provides a new baseline from which the CHNA partners and other decision makers will begin to develop a community health improvement plan for the next three years.

In addition to identified health priorities, the CHNA process helped partners broaden relationships with community members across sectors and neighborhoods. Many community members expressed a desire to be more involved and welcomed the opportunity to be a resource in the health improvement planning process. These new community relationships help promote accountability and will ensure that the decisions made as a result of this CHNA will represent the true needs of those most impacted. With this information, decision makers can confidently work towards becoming a healthier community.

To improve the health of Hays County citizens, it is essential to work collaboratively in the spirit that community participants envisioned for a healthy community and to focus county resources and engaged leadership on the priorities noted above. Their vision is both inspiring and possible with intention and commitment to a community that works for all its residents.

# APPENDICES

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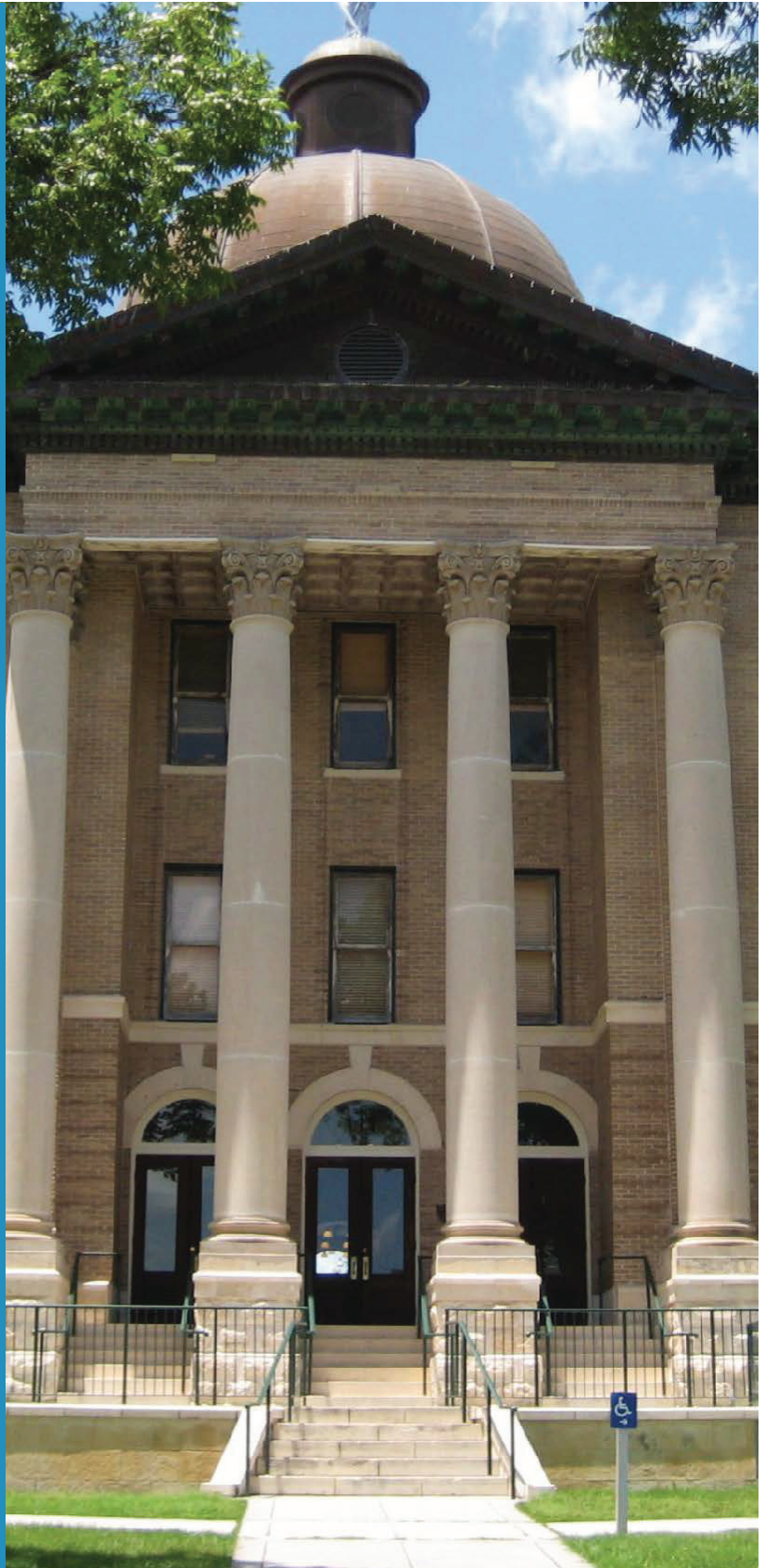


**2018**  
**COMMUNITY HEALTH**  
**NEEDSASSESSMENT**

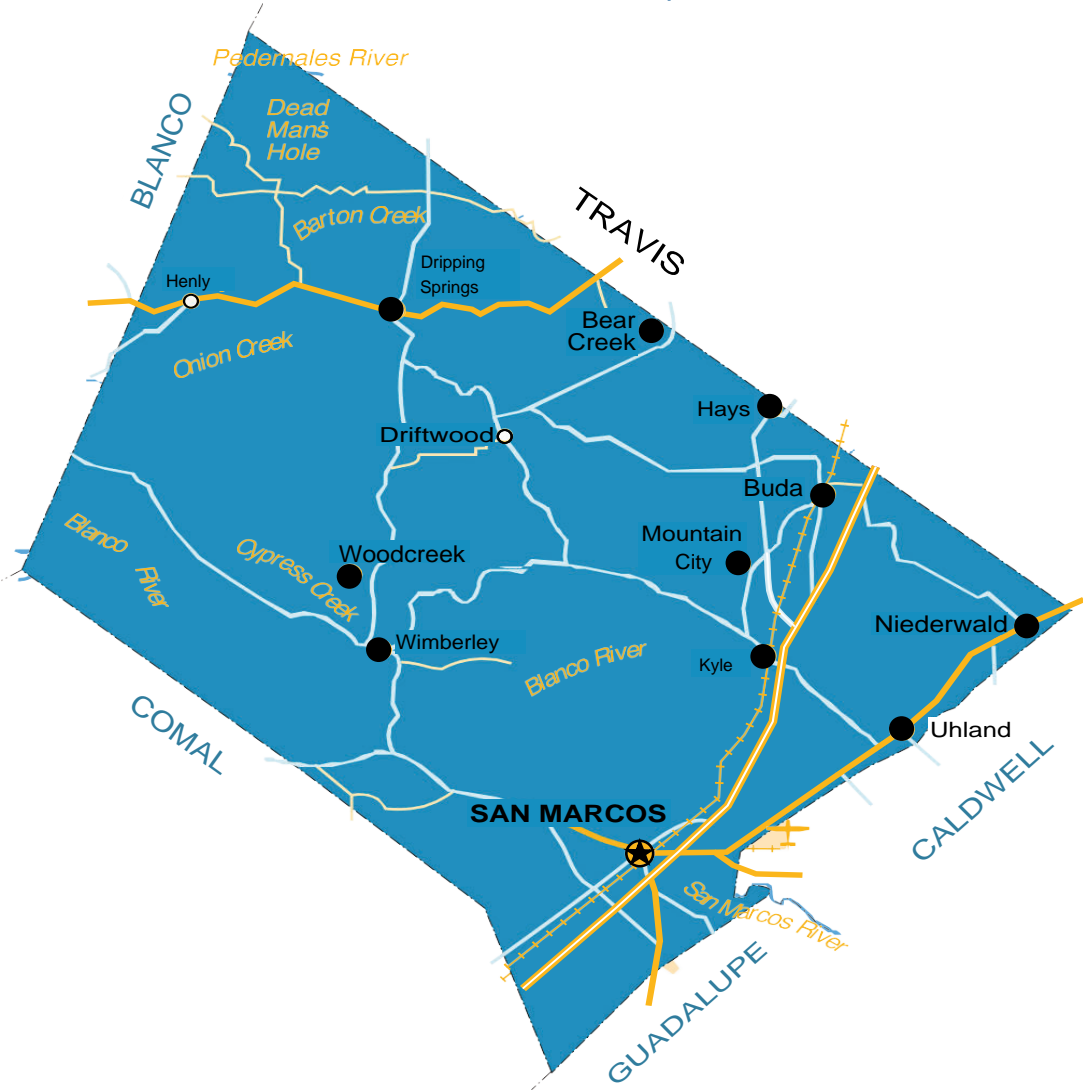


**HAYS**  
**COUNTY,**  
**TEXAS**

Community Input  
Summary Report



# HAYS COUNTY, TEXAS



## 2018 COMMUNITY HEALTH NEEDS ASSESSMENT

# HAYS COUNTY, TEXAS

## COMMUNITY INPUT SUMMARY REPORT

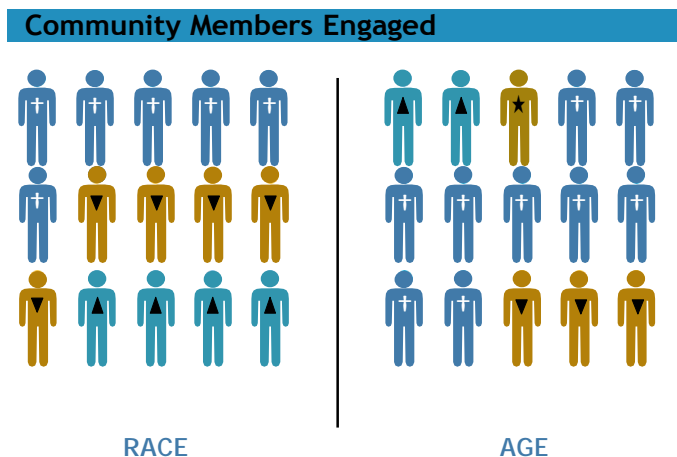
### OVERVIEW

Hays County has a population of 194,739 with an estimated 58,749 households. Community residents were invited to participate through local social service providers and the local public library to ensure that participants would have an understanding of community needs and personal experiences from which to draw their responses. Two (2) community input sessions were conducted for a total of fifteen (15) community members engaged. Sessions were conducted at Hays County Community Action, Inc. and the Hays County Library. Community input was gathered in August 2018 with four (4) primary areas of focus: community identity; access to health care and social services; root causes and determinants; and priorities and recommendations.



### DESCRIPTION OF COMMUNITY PARTICIPATION

For Hays County, the selected communities included San Marcos, Tyler, and Buda. Of the fifteen (15) Hays County community residents engaged, 42% were White, 37% were Hispanic/Latino, 5% were African American/Black, 5% were Asian, 5% were Middle Eastern, and 5% were Native Hawaiian. In terms of the age of the residents: 14% were 25-44 years of age; 7% were 35-44 years of age; 57% were 45-64 years of age, and 21% were 65 years old or older.





## NARRATIVE ON COMMUNITY IDENTITY

### What Makes Us Unique

Community input sessions were designed, through open-ended questions and an asset-based framing, to gain feedback regarding the positive element(s) that make the community unique. Fifteen (15) Hays County community members were engaged through small group conversations. They described Hays County as a fast growing, close-knit community where neighbors help neighbors and there have a high quality of life. The most commonly expressed descriptor for this community is that Hays County is a “river” community.



Neighbors take care of other neighbors, helping. I think even more now we continue to be a strong community through the crises that we have, most recently with the fire.



### Top Two Community Challenges

While many challenges were identified, the top two challenges were **affordable housing** and **transportation**. Other challenges discussed included:

- ◆ Short-term and long-term homelessness
- ◆ Eligibility requirements for services
- ◆ Lack of mental health services
- ◆ Low level crimes (juvenile charges)
- ◆ Immigration status
- ◆ Underinsured/uninsured or people with high deductible plans
- ◆ Chronic conditions like diabetes
- ◆ Juvenile diabetes and obesity
- ◆ Processed food
- ◆ River upkeep and maintenance
- ◆ Outdoor recreation for the disabled and seniors
- ◆ Lack of sidewalks (need repairs)
- ◆ Help with social security
- ◆ Trains (volume and noise)
- ◆ Pawn shops/predatory lending

### Causes and Contributors to Community Challenges

Participants in one of the sessions described how leadership in San Marcos is made up of newer residents who don't understand or appreciate the uniqueness of the town. One participant stated that it is a “small town mentality and history, but larger scale city development.” Another participant expressed difficulties with having a large university located in town.

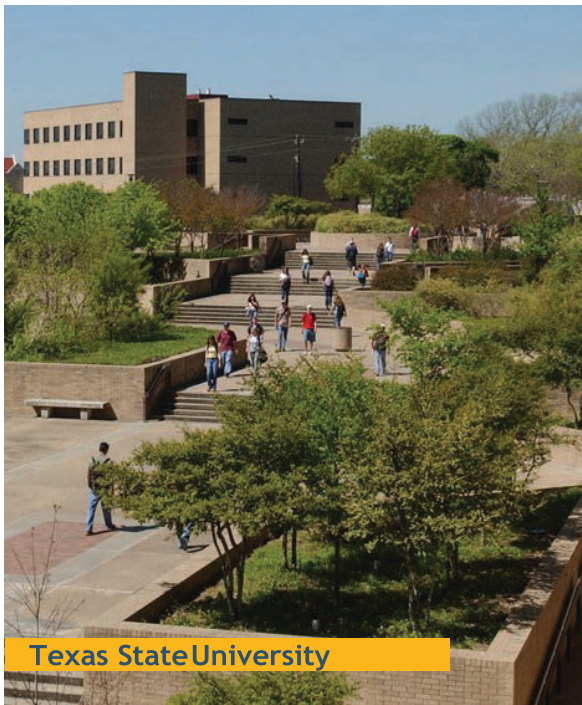


## Perceptions of Community Change in the Past Five Years

Hays County community members expressed seeing the community change over the past five (5) years. The consensus was that residents have seen growth, with new people and businesses moving into the area. The issue of immigration was discussed at length in one of the sessions as something that has been a recent change. One participant said, “the thing is that Kyle has a huge immigrant population, so there’s this whole neighborhood of people. And if you’ve ever seen their county department or sheriff’s vehicles, they’re green like immigration. Isn’t that interesting? I think the school district will be impacted, I don’t have a count, but I’m sure it will be. They are a prime target dropping their kids off at school.”



If you’ve ever seen [the] county department or sheriff’s vehicles, they’re green like immigration. Isn’t that interesting?”



Other changes included:

- ◆ People's manners are different
- ◆ Everything is moving fast
- ◆ People are moving more often
- ◆ Less opportunities for young adults
- ◆ New buildings
- ◆ University is taking over
- ◆ Drugs are more dangerous
- ◆ More housing that isn't necessarily affordable
- ◆ People are disconnected, more isolation
- ◆ More homelessness
- ◆ People are more depressed
- ◆ Multiple families in one home, housing insecure
- ◆ Kids transfer schools often

## Describing Our Community's Health

Generally, people described the community as having “good” health. Forty percent (40%) said that it was “excellent,” and forty-six percent (46%) of participants stated that it was “good.” Only thirteen percent (13%) described the health of their community as “fair.”

**40%**

Excellent

**46%**

Good

**13%**

Fair



## Causes and Contributors to Community Health

“ People [are] going into the workforce not looking to the future because they are short-sighted by necessity.

”

Participants spoke at length about people working so hard that there is not any time to be healthy. One participant said “people are working, but their income isn’t enough to make ends meet. They have no energy.” Participants expressed how hard it is to get by, let alone be healthy. One participant explained that “it’s all economic. The disparity just keeps growing between the haves and the have-nots. There are no or low-paying jobs, unaffordable housing, there are just so many things.” In one session, community members spoke about the connection between education and future income stating, “I see where people haven’t finished high school and maybe it’s [because] they’re having to drop out to get a minimum wage job to help support the family. So now they’ve dropped out of school and may be stuck in a minimum wage job. It’s part of a cycle.”

## Raising Our Families

At each session, participants agreed that Hays County was a good place to raise a family. There are activities for families, many art events, it has a small-town atmosphere, and there are a variety of churches. A few long-time residents described how there were neighborhood “eyes” on them as kids, and that it was a safe place to grow up.

“ Many people return back to San Marcos to raise their own children.

”



## Influencing Community Decision

Overall there seems to be fatigue when it comes to decision making. There was frequent discussion around how the people in charge are not originally from the area and that they do not have appreciation for the uniqueness of the area.



There is some connection to city leaders, they hear you. City Council is open, but whether or not they act just depends.

There are some opportunities to provide input, but all of the community engagement feels like they're just going through the motions. It is not a genuine input process.



## ACCESS TO HEALTH CARE AND SOCIAL SERVICES

### Access to Primary and Specialty Care

At both sessions, participants spoke about how the level and type of care an individual receives is dependent upon income and insurance. One participant said, “care isn’t for the uninsured.” Another participant shared that they have to drive to Kyle for urgent care services. Community participants spoke of disparities in how appointments were scheduled, with privately insured individuals receiving priority in appointment setting over individuals with Medicaid. One community member stated, “if you are on Medicaid, there are long wait times. The waiting list could be longer than six months.” Additionally, community members described how difficult it is to get mental health services. Another participant said, “specialty care is hard to find locally; you have to go to Austin.” For those with health insurance, care can also be varied. Another community member stated, “I have insurance, and I get bad providers. It just depends. It can be hit or miss with providers.”

In accessing social services, community participants described issues with silos, unfriendly administrators, and cumbersome bureaucracy. One participant shared, “it takes multiple calls. It’s like everybody needs a caseworker to find their way through the system. They need some sort of person to help them, and they don’t even know how it’s supposed to work when it does work. So for some it is the knowledge of how to do it and the aggressiveness to continue to pursue what you need because it doesn’t just happen the first time. There are multiple calls.” Discussions shifted in the room to perceptions of bias in treatment of people who are of low-income. “It’s when people have this attitude about low-income people. They think stinky, smelly, rude—they stereotype. Or if somebody drives up in a really nice vehicle, then people think



I think that does have to do with patience because people are so impatient with the people who are coming for help or services and stuff.

I don’t think they [social services] want to help.”



'oh well you don't need help,' but you don't know if their friend lent them that vehicle or they won it. You don't know." Another participant remarked that "you literally have to go pick up the application, and you can't give it to her there. They send you away to go fill it out, and then they wait two or three weeks to look at it, and then they give you an appointment. I mean it's just the process ... I don't think they want to help."

## Accessing Information on Available Resources

In Hays County, community members expressed that individuals new to the community most often receive information on available services or resources through word of mouth or the internet (Google).

## Accessing the Quality Health Care or Services Needed

For Hays County community members, access to services were varied. At one of the sessions, there was consensus among the group that you could have access to quality services if you had insurance. At another session, participants described the lack of urgent care and mental health services. One participant stated that mental health care "depends on the type of care you're trying to get—in-patient or speaking with a counselor. Everything depends on your insurance."

# PRIORITIES AND RECOMMENDATIONS

## Suggestions for Improving Community Health and Health of Families

In both community sessions, participants described a myriad of suggestions for improving community health. One well-received suggestion was a point-to-point transportation system because people want to get on the bus at their home and get off the bus where they work. The public system was not currently able to do that. Another suggestion was training for social services providers on cultural humility and customer service. At another session, participants expressed wanting assistance getting resources and navigating the healthcare system. Because homelessness was discussed as an issue, participants described the need for a shelter that is open to everyone.

Below is a list of all recommendations provided by community members:

- ◆ Social services directory
- ◆ City buses
- ◆ Walking more often with kids

“ Showing, modeling how to treat people with dignity and respect. Modeling for them, it's hard to ask for help and it makes it worse when there isn't good customer service. ”

“ [We need] health care advocates. It is so difficult to manage doctors and prescriptions, especially if you're sick. If there were trained volunteers that could help people navigate the system ... ”



- ◆ Affordable fitness center
- ◆ Roller-skating rink, even the bus circle
- ◆ More social opportunities for seniors
- ◆ Amphitheater
- ◆ Support for working parents who have a sick child at home with a daycare drop in or a home visiting nurse
- ◆ Exercise bikes on the river that are powered by an adult and create a little water spout when pedaled
- ◆ An accessible park for adults that has fitness stations and non-motorized routes/paths to get there
- ◆ Public art along the riverfront
- ◆ Incentives from the city for things like rock-climbing
- ◆ More sidewalks
- ◆ More summer programming for kids

## What Positive Change Would Look Like for Hays County

In conducting community conversations, facilitators prompted residents to identify what they needed to experience, or what they needed to see in their community, in order to feel that positive changes were occurring. For community members of Hays County, participants felt they would know positive changes were happening in their community if they saw outdoor art on the river; music in the park annually; community camaraderie (e.g., people saying “hello” on the sidewalk); a trail system that would connect Austin to San Marcos; free community college for all; and more bike-friendly lanes outside of downtown.



## Priorities for the Greatest Impact

As a final question, community members were asked to provide a recommendation on the priorities decision makers should focus on to improve the lives of people in their community. Of the fifteen (15) total community participants in Hays County, over half identified **mental health (including substance abuse services)** and **affordable housing** as top priorities. Below is a full list of priorities provided by community members in order of ranking:

- ◆ Point-to-point transportation
- ◆ Short-term and long-term homelessness
- ◆ Emergency dental care
- ◆ Educating social service staff
- ◆ Health fair

## TX CHNA Community Input Session Quotes - Hays County

“Well it's all economic. The disparity just keeps growing between the haves and the have-nots. There are no or low paying jobs, unaffordable housing, there are just so many things.”

– Hays County Resident, San Marcos

*“Some people are in such crisis mode that they don't have time to even see what's out there, They're just worried about today.”*

– Hays County Resident, San Marcos

“People are going into the workforce not looking to the future because they are short-sighted by necessity.”

– Hays County Resident, San Marcos

*“I feel like sometimes people run into people who are trying to keep them out [of services] and then there are other people who are trying every which way to bring people in.”*

– Hays County Resident, San Marcos

“People are working, but their income isn't enough to make ends meet. They have no energy.”

– San Marcos Resident, Hays County

*“We work with undocumented populations and sometimes my clients tell me, ‘I don't want to go to my doctor's appointments because I'm afraid of what's going to happen.’”*

– San Marcos Resident, Hays County

“People work so hard that there isn't time to be healthy.”

– San Marcos Resident, Hays County

# FACILITATOR'S GUIDE



## CENTRAL TEXAS CHNA COMMUNITY INPUT QUALITATIVE DATA COLLECTION

### Facilitator's Guide

*(Designed for lay community conversations with a primary target audience of those in marginalized communities, those experiencing the greatest-health burden, and those living in areas of high health risk factors. The conversations should last no more than an hour and 30 minutes max.)*

#### GROUP DISCUSSION #1 – INTRODUCTION & COMMUNITY IDENTITY (30 minutes)

- 1. What would you say are the positive things that make this community unique, for example, people feel connected, sidewalks, clean streets, people talking to each other, churches?** *(Write responses on flip chart “Unique/ Positive” flip chart header)*
- 2. What would you say are the top two challenges (problems) your community faces? These do not have to be health related.** *(Write responses on flip chart “Top Two Challenges” flip chart header and denote by hash marks the number of people giving that answer)*
- 3. What are the two most critical health problems in your community? Think about what concerns you about your community?** *(Write responses on flip chart “Health Problems” flip chart header and denote by hash marks the number of people giving that answer)*
- 4. How has your community changed in the past five-years?** *(Write responses on a flip chart “Community Change” flip chart header)*
- 5. How would you describe your community’s health and the ways your community helps people be healthy? You can respond using poor, fair, good, or excellent.** *Then ask for those that said poor, why. For those that voted fair, why. For those that voted good, why. Last, if any for those that voted poor, why.)*
- 6. Do you consider this community a good place to raise a family? (Think about is it safe, does it provide you with the economic opportunities to earn a living that supports a healthy life?)** *(Write responses on flip chart “Quality of Life” flip chart header)*
- 7. How would you describe decision making in the community? Do you feel like there are opportunities to be involved in decision making for what happens in your community?** *(Write responses on flip chart “Community Decision Making” flip chart header)*

#### GROUP DISCUSSION 2 – ACCESS TO HEALTHCARE AND SOCIAL SERVICES (15 minutes)

- 8. Is it easy to get appointments to see the doctor or to access healthcare?** *(If they are just answering yes or no ask prompting questions to get them to describe where they go for healthcare, how long it takes to see a doctor or other examples that illustrate the ease or difficulty of accessing healthcare)*
- 9. If I am new to community how do I know where to go to get the services I need? Where do people get information?** *(Write responses on flip chart “Information & Social Services” flip chart header). If you need to give examples of services consider, utility bill assistance, food assistance, employment assistance)*



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

*(Looking for how many people say no and write on the flip chart the health or social services they feel are not accessible/available in their community, what is the impact on life)*

**GROUP DISCUSSION 3 – ROOT CAUSES AND DETERMINANTS (15 minutes)**

**11. Think about how you described your community's health. What do you think are the reasons or causes?** *(Refer to the flip chart sheet posted from the community health responses and write their responses to what they feel are the causes "Reasons and Causes-Health" flip chart header)*

**12. What do you think are the causes or reasons for the community challenges you mentioned?** *(Refer to the flip chart sheet posted from the community challenges responses and write their responses to what they feel are the causes for the community challenges/problems. Write the responses "Causes of Community Challenges").*

**GROUP DISCUSSION 4 – PRIORITIES AND SUGGESTIONS (20 minutes)**

**13. What are some of your suggestions to improve the health in your community? What would make it easier for you and your family to stay healthy?** *(Write the responses on flip chart "Suggestions to Improve Health")*

**14. What would you have to see or experience in order to feel like positive changes are happening in the community? What would positive change look like in this community?** *(Write responses on flip chart "Change for Our Community Is...")*

**15. I will go around the room and ask each of you to provide a final comment on what two priorities should decision-makers focus on first that would have the greatest impact on improving the lives of people in the community? Consider that your comments will help influence decisions on how to support (improve) your** *(Write responses on the flip chart and capture the number of votes/people who responded if there are repeats "Two Priorities")*

## COMMUNITY INPUT TABLE



### Central Texas Community Health Needs Assessment Qualitative Data - Community Input Sessions & Interviews

#### Hays County

COMMUNITY INPUT SESSIONS		
Location	Community Input Sector	Number of Participants
Community Action of Central TX 101 Uhland Road Suite 107 San Marcos, TX	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	8 participants
San Marcos Library 625 E. Hopkins Street San Marcos, TX	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	7 participants

KEY INFORMANT INTERVIEWS		
Name	Organization name / Community Input Sector	Title/Role
Neal Kelley	Ascension Seton Medical Center Hays Healthcare provider / Health system	Chief Operating Officer
Chance Sparks	City of Buda Local government agency	City Manager – Community Development
Debbie Gonzales Ingalsbe	Hays County Local government agency	Hays County Commissioner
Denise Blok	Hays Food Bank Nonprofit organization serving low-income, minority, or health burdened community	CEO
Dr. Fausto Meza	Ascension Seton Healthcare provider / Health system	Vice President, Medical Affairs, South Market
Macie Walker	Hays County ISD Local education system serving target population	Director of Student Health Services
Sharon K. Melville	Texas Department of State Health Services - HSR 7 Public health expert	Regional Medical Director
Louri O'Leary	Central Texas Catholic Charities Nonprofit organization serving low-income, minority, or health burdened community	Executive Director
Angela Henry	Central Texas Food Bank Nonprofit organization serving low-income, minority, or health burdened community	Director of Community Health and Nutrition

## HAYS COUNTY KEY INFORMANT INTERVIEWS

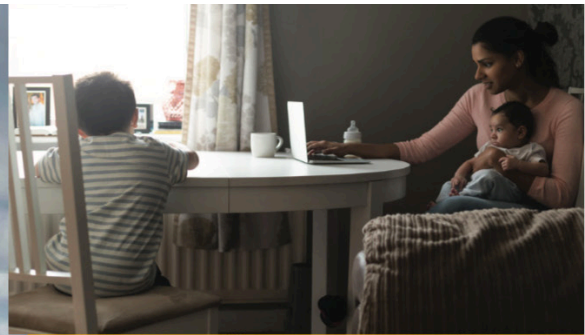
Name	Organization name	Title/Role
Neal Kelley	Ascension Seton Medical Center Hays (health care provider)	Chief Operating Officer
Chance Sparks	City of Buda (local public agency)	City Manager - Community Development
Debbie Gonzales Ingalsbe	Hays County (local public agency)	Hays County Commissioner
Denise Blok	Hays Food Bank (nonprofit organization serving low-income, population)	CEO
Dr. Fausto Meza	Ascension Seton (public health expert)	Vice President, Medical Affairs, South Market
Macie Walker	Hays County ISD (education system serving target population)	Director of Student Health Services
Sharon K. Melville	Texas Department of State Health Services - HSR 7	Regional Medical Director
Louri O'Leary	Central Texas Catholic Charities (nonprofit organization serving	Executive Director
Angela Henry	Central Texas Food Bank	Director of Community Health and Nutrition



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# 2019 COMMUNITY HEALTH NEEDS ASSESSMENT CALDWELL COUNTY, TEXAS



# ACKNOWLEDGEMENTS

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The 2019 Caldwell County Community Health Needs Assessment (CHNA) represents the commitment of numerous partners that have contributed their expertise, resources, and time in support of a shared mission—to make Central Texas the healthiest region for all its residents. The data collection methodology was co-created through a partnership of health system partners to ensure that authentic community input and existing quantitative data would be combined to provide a comprehensive assessment of conditions and opportunities that exist to improve health in Caldwell County. We recognize all of our CHNA partners including Ascension Seton, Georgetown Health Foundation, Central Texas Medical Center, and of course the St. David's Foundation in this important effort. Most importantly, we appreciate the many community organizations, churches, mothers, youth, fathers, advocates, leaders, and community members that shared their time, experiences, and hopefulness to help us complete this assessment. The list below is shared in appreciation of the many contributors of the Caldwell County CHNA project:

## 2019 CHNA ACTION TEAM

Becky Pastner – St. David's Foundation  
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Marianna Chauvin – SHARED Strategy Group, LLC  
Chanelle White – SHARED Strategy Group, LLC

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## COMMUNITY INPUT PARTNERS

Dr. Eugene Clark Central Library  
Lockhart WIC Program Clinic  
Community Health Centers of South Central Texas  
Texas A&M Extension Services  
Texas Association of Community Health Centers  
City of Luling, Texas – Office of the Mayor  
City of Luling, Texas – City Council

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# EXECUTIVE SUMMARY

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## OVERVIEW

Our understanding of what health means as a public condition, approach, and system is evolving. Clinical interventions were once the primary solution for keeping people healthy. Adherence to regimens, healthy eating, physical activity, and ways to support healthy behaviors were understood as the path to a healthy life. But as health practitioners now know prevention goes beyond healthy behaviors and what happens within the traditional health system. The health of an individual is primarily determined by where they live, work, and play. These conditions are often referred to as the social determinants of health (SDOH). The CHNA Action Team along with SHARED Strategy Group, co-created a data gathering process that engaged community members as experts in their experience living in Caldwell County. The anecdotal stories and authentic feedback provided the context necessary to understand and interpret quantitative data. The totality of information – both stories and statistics – are represented in this report as a place-based assessment of health needs in Caldwell County, TX.

## METHODOLOGY

The methodology for the assessment of community health needs in Caldwell County used the framework from the National Association of County and City Health Officials (NACCHO) Mobilizing Action through Planning and Partnerships (MAPP) process. The MAPP process includes four key assessments of 1) Community Health Status Assessment, 2) Community Themes and Strengths, 3) Forces of Change and 4) Local Public Health System. This CHNA is designed to highlight health disparities and root causes of local conditions and describe the health system infrastructure. Both qualitative and quantitative data were used in the completion of this assessment.

## CHANGES IN COUNTY PROFILE

Caldwell County has seen increases in both population and economic development in recent years; median household income has increased as well. More than half of the participants in Caldwell County community input sessions (focus groups) described seeing substantial growth and expansion within the community in the last five years in terms of population, residential housing, schools, and businesses.

Since the previous community health assessment in 2015, Caldwell County has experienced favorable change in some key health indicators. However, there are also areas where Caldwell has seen significant unfavorable change. Additionally, some measures reveal health disparities across racial and ethnic groups and the troubling consequences of poor SDOH.

Caldwell County has seen significant favorable change since the previous assessment in the following areas: increases in access to exercise opportunities, access to Federally Qualified Health Centers (FQHCs); decreases in the teen birth rate, child mortality, alcohol-impaired driving deaths, drug poisoning deaths, uninsured adults, preventable hospital stays, food insecurity, and unemployment. The County has experienced significant unfavorable change in the following areas: increases in premature death, premature age-adjusted mortality, human immunodeficiency virus (HIV) prevalence, sexually transmitted infections (STIs), and mortality from pedestrian accidents. As part of the analysis of health outcomes data, health disparities were analyzed where data was available by racial or ethnic group. The following are the top five health indicators with the greatest disparity based on race or ethnic group: premature death, premature age-adjusted mortality, teen birth, low birthweight, and population with any disability.

## COMMUNITY THEMES: STRENGTHS AND CONCERNS

Focus groups and interviews revealed several areas that residents and key informants consider to be positive aspects or strengths of Caldwell County. Residents also attributed some of the recent population growth to these community strengths. The major themes in the responses included: rurality, a sense of community, a strong sense of community history, a vibrant food culture, a sense of community safety, and easy access to nearby urban centers.

## LOCAL PUBLIC HEALTH INFRASTRUCTURE

Caldwell County has two hospitals (one general, one post-acute), two FQHCs, and two substance abuse facilities. However, Caldwell County is designated as a Health Professional Shortage Area (HPSA) with generally higher ratios for Primary Care Physicians, Oral Health providers, and Mental Health Professionals. Participants in community input sessions expressed frustration with frequent travel to urban centers for OB/GYN care and were dissatisfied with the availability of mental health services.

## ROOT CAUSE AND FORCES OF CHANGE

As part of our Community input sessions and key informant interviews, residents were asked to share their perspectives on the root causes and forces of change that lead to poor health in their communities. When speaking specifically of health outcomes, residents pointed to individual behaviors or choices, inadequate health systems, and access to health care services as root causes for poor health. Residents wanted to see improvements in the area of health fairs, free health screenings, affordable care, and environments that promote exercise and healthy eating. When speaking of the community in general, residents recommended improvements in community conditions reflected in the SDOH (e.g. transportation, programs for children, education). Many respondents focused on growth in the local economy. While some residents were slightly apprehensive about the growth in their communities, others recognized it as an opportunity. For more information on this topic, see the full report section.

## CONCLUSIONS ON HEALTH IMPROVEMENT PRIORITIES

### The Top Health Priorities for Caldwell County in 2018

*Data suggests that Caldwell County should focus on improving social inequities that drive poor health and dramatically improve access to chronic disease management resources as well as mental and behavioral health infrastructure.*

Based on input from community members, data on current health conditions, and data on social determinants of health, the following priorities were identified as top priorities for improving health in Caldwell County in order of perceived importance.

**MAKE INVESTMENTS IN IMPROVING THE SOCIAL DETERMINANTS OF HEALTH (SDOH)** – While available quantitative data focused primarily on health outcomes, the majority of focus group respondents wanted to see improvements in the SDOH and the built environment. This includes not only improved environments to promote healthy living and eating, but transportation concerns which affect the ability of residents in this commuter county to access the economic opportunity and social and health services they need. Improving community conditions by expanding economic opportunities and living wage jobs; expanding access to quality parks and green spaces, walking and biking trails, playgrounds, and facilities to support family health; subsidizing quality, affordable housing; expanded transportation solutions and infrastructure to support safe biking and walking; and increased services to address the needs of the homeless population, including programs to secure stable transitional and permanent housing, availability of shelter beds, free health care and transportation services to health care services, and employment and job search services. We know that poverty limits access to healthy foods and safe neighborhoods, and that more education is a predictor of better health. We also know that health suffers in communities with poor SDOH such as low-quality housing, low income, unsafe neighborhoods and schools, or substandard educational opportunities.<sup>1</sup>

**BEHAVIORAL AND MENTAL HEALTH** – Improve access to services across the continuum of behavioral and mental health needs (e.g., mental illness, substance use disorder, social connectedness). Participants noted the negative impacts on community health of the opioid epidemic and the need for increased mental health services, particularly for the most vulnerable and disconnected youth. A recent study sponsored by the National Council for Behavioral Health; America's Mental Health 2018 found that the lack of access to behavioral health services is the root cause for the mental health crisis in America. Access to mental and behavioral health services, especially for children and youth, should be among the most important priority actions considered by Caldwell County.

<sup>1</sup>Centers for Disease Control and Prevention, 2018.

**ACCESS AND AFFORDABILITY OF HEALTH CARE** – Provider ratios across the healthcare spectrum (whether it be for primary care, dentistry, or mental health) indicate there are opportunities for growth and expansion within the health care system in Caldwell County. Focus group respondents also communicated a desire for a more cohesive and communicative health care system that promotes patient navigation, as well as improved access to be responsive to the needs of families and children. Focus group respondents also suggested increasing access by removing barriers to care such as flat rate fees for office visits, transportation and lack of insurance coverage, and expand programs which show promising outcomes or community response (e.g., a kiosk to promote services was referenced), ensure information on accessing resources is widely available through health care roadmaps and other visual explanations of where and how to access services. Solutions might include extended after-hours appointments, free or sliding scale health clinics in neighborhood schools staffed by nurse practitioners, free public transportation that runs directly to FQHCs, additional FQHC access points in the most impoverished community locations where people live and work, specialty care services focused on the top chronic diseases and necessary services such as OB/GYN services, maternal and child health care in the Caldwell County population. Adults in worse health, those with low incomes, and the uninsured are much more likely than others to delay or forgo health services due to costs.<sup>2</sup>

**CHRONIC DISEASE RISK FACTORS** – Chronic diseases are defined broadly as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both. Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States.<sup>3</sup> A risk factor is any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury.<sup>4</sup> In order to reduce the risk of developing a chronic illness such as heart disease, cancer, or diabetes we recommend that Caldwell County consider these actions: Improve access to affordable healthy food options, eliminate food deserts, and increase opportunities for free or affordable physical activity for all ages. Today, 7 of the 10 leading causes of death in the United States are chronic diseases, and almost 50% of Americans live with at least one chronic illness. Where data was available by racial and ethnic backgrounds, all available measures indicated some type of disparity or increased burden in terms of chronic diseases. Racial or ethnic minorities constitute half of the population of Caldwell County. People who suffer from chronic diseases experience limitations in function, health, activity, and work, affecting the quality of their lives. Underlying these conditions are significant health risks such as tobacco use, poor nutrition, and physical inactivity. Increasing opportunities to engage in healthy behaviors, particularly for racial and ethnic minority populations reduces the risk of morbidity and death due to chronic disease.<sup>5</sup>

**SEXUAL HEALTH** – Whether it is increased STIs/HIV or teen birth rates, sexual health measures in Caldwell County have significantly worsened, lag behind the state average, or pose a racial or ethnic burden. In addition to these quantitative data around sexual health, focus group respondents were acutely aware of decreased access to reproductive health services.

**POWER DYNAMIC AND INFLUENCE: OUTREACH AND ENGAGEMENT** – Expanding leadership opportunities for marginalized community members, increase culturally appropriate messaging and outreach, create opportunities for personal development, promote a positive narrative, highlight positive community assets and efforts, identify and execute ways in which visible quick wins can be demonstrated that are driven by community voice and engagement in the decision making process.

These critical needs and final conclusions were determined through analysis of both quantitative and qualitative data. While conversations with residents focused primarily on making improvements across the entire spectrum of the SDOH and the built environment, the quantitative data were able to pinpoint specific chronic disease outcomes in Caldwell County that could benefit from targeted strategies for improvement.

<sup>2</sup> Gary Claxton, Bradley Sawyer and Cynthia Cox, Kaiser Family Foundation, 2019

<sup>3</sup> Centers for Disease Control and Prevention, 2019.

<sup>4</sup> World Health Organization, 2019.

<sup>5</sup> Centers for Disease Control and Prevention, 2013.

# 2020-2022 CALDWELL COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT

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## INTRODUCTION

The health of a community can be measured many different ways. Personal and collective health encompasses well-being, social connectedness, personal agency, access to resources, built environment, economic security, practices, and beliefs. An understanding of the comprehensive nature of health means looking beyond individual disease conditions to assess the environments and circumstances in which a person lives, works and plays as well as what health care resources are available to them. The CHNA Action Team, and their partners SHARED Strategy Group, co-created a data gathering process that engaged community members as experts in their experience living in Caldwell County. The goals of the Community Health Needs Assessment (CHNA) team were to:

- Identify existing and emerging community health needs
- Identify strengths and assets available to improve health
- Determine the issues affecting the quality of life of residents
- Understand the key forces of change influencing health in the community
- Evaluate the local public health system and determine priorities for improvement; and
- Identify top health priorities for future health improvement efforts

The anecdotal stories and authentic feedback provided the context necessary to understand and interpret numerical data. The totality of information – both stories and statistics, are represented in this report as an assessment of health needs in Caldwell County, TX.

## METHODOLOGY

The assessment of community health needs in Caldwell County used the assessment framework from the National Association of County and City Health Officials (NACCHO) Mobilizing Action through Planning and Partnerships (MAPP) process. Where the MAPP process includes four key assessments of 1) Community Health Status, 2) Community Themes and Strengths, 3) Root Causes and Forces of Change and 4) Local Public Health System, this CHNA was designed to specifically highlight health disparities and root causes and describe the health system infrastructure.

A dual approach was utilized to collect both quantitative and qualitative data to assess the health of the Caldwell County community. Primary source quantitative data were collected around key health indicators, social determinants of health, community profile data, demographics, and current conditions using county, state, and national data sources. When possible, recent data measures were compared to the same measures from the 2015 health assessment. The data team conducted key informant interviews and community input sessions (focus groups) with local residents to gain a better understanding of the numbers.

The data team conducted key informant interviews with representatives from local government and social service organizations. Additionally, community input sessions were conducted within Caldwell County in August of 2018 to gather information from local residents. Participants were invited through local social service providers and health clinics. This helped to ensure that participants carried an understanding of community needs as well as personal experiences from which to draw their responses. Social media was used to increase participation at community input sessions. The respondents who participated in community input sessions were located primarily within the Lockhart community. Sessions were held at two locations in the community: Lockhart Library and the WIC Center. A summary of the community input session meetings and the key informant stakeholder interviews is included in the Appendix.

# COUNTY PROFILE: CALDWELL COUNTY

## Geographic Boundaries

Caldwell County is part of the Greater Austin Metropolitan Area and is a rural county located south of Austin. The largest racial group in Caldwell County is White. However, half the population identifies their ethnicity as Hispanic. The county seat is Lockhart, approximately a 35-minute commute south of the city of Austin. Caldwell County shares a border with five other counties: Hays, Travis, Bastrop, Guadalupe, and Gonzales counties. The two largest population centers in Caldwell County include the City of Lockhart (13,319) and the City of Luling (5,709). These two cities constitute approximately 47% of the population of the county.

## SOCIAL DETERMINANTS OF HEALTH

***Caldwell County residents have experienced population growth, rising household income, increased commute times and challenging transportation conditions. Concerns with access to healthy foods, children on free and reduced lunches, and access to mental health and women’s health services have increased.***

The 2017 U.S. Census Bureau estimate for the total population of Caldwell County is 40,544, which includes the following racial groups: White (31,538); Black (2,665); Other (6,341). Roughly half of the population (50.7%) identifies as Hispanic or Latino (of any race). The age distribution of Caldwell County is: Under 18 years (9,773); 18 + years (30,771); and 65 + years (5,362).

***“Luling is a great retirement area with a slower pace. What is needed is nearby. Lockhart is growing much faster lately. There is more of a commercial boom.”***

– Key Informant

## Changes Since the Last Assessment

The U.S. Census Bureau estimates that the population in Caldwell County has increased from 39,347 in 2015 to 40,544 in 2017. More than half of the participants in Caldwell County community input sessions described marked growth

and expansion of population, residential housing, schools and businesses within their community in the last five years. Key informants reported that most of the population growth is occurring in Lockhart, while Luling is more of a retirement community.

***“I don’t believe it is a good place to raise a family because you cannot really make a living here.”***

– Resident

**SOCIOECONOMICS** – When speaking to residents during community input sessions, 24% of respondents indicated that they were concerned about the availability of high-paying jobs within the local economy. A review of the data for Caldwell County since the last assessment in 2015 indicates that the population below 100% of the Federal Poverty Level (FPL) has remained steady at 18.6%.

**QUALITY OF SCHOOLS** – Socioeconomic trends are often reflected in local school systems. Caldwell County has three school districts that serve residents. These districts are Lockhart ISD, Luling ISD, and Prairie Lea ISD. The state of Texas uses an A-F Accountability rating system, with single-campus districts receiving either a “Met Standard” or “Improvement Required” designation.

According to the Texas Education Agency, the 2018 district ratings for Caldwell County schools are: Lockhart ISD is rated a “C” district, Luling ISD is rated a “D” district, and Prairie Lea ISD has a “Met Standard” designation. The High school graduation rate for the county as a whole has increased from 91.6% to 92.0% since 2015, higher than the state of Texas at 89.0%.

**ACCESS TO HEALTHY FOOD** – The percentage of children eligible for free or reduced lunch has increased by 11% since 2015 (from 60.0% to 71.0%). Access to healthy food was a recurring theme in our discussions with Caldwell County residents. The Food Environment Index increased from 6.7 to 7.7 since 2015, and the measure of individuals with limited access to healthy food (percentage of population who are low-income and do not live close to a grocery store) decreased from 8.0% to 7.7% during that same time. The Food Environment Index measures a set of factors that contribute to a healthy food environment, 0 (worst) to 10 (best). The 2019 County Health Rankings used data from 2015 & 2016 for this measure.

## SOCIOECONOMIC MEASURES FOR CALDWELL COUNTY<sup>6</sup>

Measure	TX (2015)	TX (2018)	Caldwell (2015)	Caldwell (2018)
Poverty	17.6%	16.7%	18.7%	18.6%
Median Household Income	\$51,714	\$56,583	\$46,021	\$49,598
Unemployment	5.5%	4.6%	5.9%	4.3%
Children in Poverty	25.3%	22.4%	26.0%	24.0%
Single Parent Households	33.2%	33.3%	36.0%	31.3%
Food Environment Index	6.4	6.0	6.7	7.7
Limited Access to Healthy Food	9.3%	8.7%	8.0%	7.7%
HS Graduation	89.1%	89.0%	91.6%	92.0%
Children Eligible for Free/Red. Lunch	60.1%	58.9%	60.0%	71.0%

**HEALTH SYSTEM** – The most notable change in the health system in Caldwell County was decreased access to women’s health services due to the closing of a local OB/GYN clinic. All female participants in one of the focus groups indicated that they had to travel out of the county for their reproductive health care needs. Key informants from the Community Health Centers indicated that they are trying to fill the gap in women’s health that was created when they lost the only OB/GYN in Lockhart.

**HEALTH OUTCOMES** – Data from 2015 and 2018 reveal areas among different health measures that have increased or decreased significantly since the previous health assessment. Significant change is defined as a 20% or greater change in the measurement. Significant unfavorable changes since the previous health assessment include increases in the following areas: premature death, premature age- adjusted mortality, HIV prevalence, STIs, and mortality from pedestrian accidents. Significant favorable changes since the previous health assessment include: an increase in access to exercise opportunities and FQHCs; as well as decreases in the teen birth rate, child mortality, alcohol-impaired driving deaths, drug poisoning deaths, uninsured adults, preventable hospital stays (despite the fact that there is still significant progress to be made in this area compared to the State of Texas as a whole), food insecurity, and unemployment (see Table in Appendix for actual rates).

## COMMUNITY HEALTH STATUS

*Caldwell County residents have experienced declining health since 2015; rising rates of suicide, STIs, and physical inactivity combined with a growing mental health burden have residents concerned for the overall health of their community.*

### QUALITY OF LIFE

Quality of life is a holistic index of the human condition based on multiple factors that influence the standard of living or life experienced by a person, family, or community. Quality of life is influenced by factors such as physical and mental health, housing burden, commuting, and social or spiritual connections.

**PHYSICAL HEALTH BURDEN** – In Caldwell County, the prevalence of major health conditions is as follows: Hypertension (26.3%), Diabetes (10.5%); Heart Disease (0.8%). The percentage of individuals with any disability is 14.2%. Health challenges facing Caldwell County have gotten worse since 2015 and include increased suicide rates, increased STIs, increased poor physical health days, and more physically inactive residents. At the same time smoking rates among adults have declined slightly, there are slightly more primary care physicians and dentists, and fewer residents are experiencing solo long commutes. Most importantly, preventable hospital stays have declined markedly since 2015 (see Table in the Appendix for actual rates).

<sup>6</sup> <http://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/health-behaviors/diet-exercise/food-environment-index>



**MENTAL HEALTH BURDEN** – A health challenge for Caldwell County is the number of poor mental health days at 3.7 (avg. for past 30 days, age adjusted) compared to 3.4 for the state of Texas as a whole. Since the last assessment in 2015, depression (15.4% to 16.1%) and suicides (13.0 to 14.9 per 100,000) have increased. Excessive drinking is currently at 17.8% (data not available from 2015).

One participant in a community input session noted that “mental health needs of children and families really need to be stepped up... [a local provider] pays their counselors practically nothing and then wonder why there is such a huge turnover rate in providers. Clients do not get good care when they have to be introduced to a new counselor every 3 to 6 months.”

**HOUSING BURDEN AND TRANSPORTATION** – During community input sessions, several Caldwell County residents remarked about the growth of residential housing when they were asked to reflect on changes they had seen in the past few years. Data gathered as part of the assessment validate these stories, as Caldwell County has seen a decrease in severe housing problems (from 19.0% to 16.4%), substandard housing (from 33.7% to 29.2%), and housing cost burden (from 30.4% to 27.9%). Part of the appeal of living in Caldwell County is proximity to Austin. Residents described the county as a commuter county. In Caldwell County, 78.8% of workers drive alone to work, and 51.5% drive alone on a long commute to work. Commuting is not just a factor when it comes to access to work, but also access to the doctor and other social services. Lack of transportation in order to access health services was a concern raised by participants in our focus groups. Homelessness was an issue brought up in community input sessions as well as by key informants. However, there was a feeling that homelessness in Caldwell County, a more rural area, is different from the type of homelessness you see in the big cities in that it seems to be affecting families more than individual residents.

**AGING POPULATION** – In Caldwell County, 13.2% of the population (5,362) is 65 years or older. According to the Texas Department of Health and Human Services, in Caldwell County there are five (5) Assisted Living Facilities with a combined total of 92 beds, as well as five (5) Nursing Facilities with a combined total of 420 beds.

Caldwell County has experienced a significant unfavorable change in premature death and premature age-adjusted mortality since the last community health assessment in 2015. Premature death increased from (6,088.0 to 7,364.1); and premature age-adjusted mortality increased from (322.7 to 402.3). Life expectancy for women is between 80.8–86.2 years and between 77.3–86.8 years for men, depending on which end of the income spectrum they fall.

**SOCIAL ASSOCIATIONS** – A protective factor for the aging population is the degree of social associations. Over the course of small group discussions, most participants described Caldwell County as a “close-knit community, with friendly people.”

***“The growth can be misleading as well when you see a home it may not necessarily be a single family living there. They may be three families living in that home.”***

– Key Informant

***“As the cost of living rises in [larger cities] it pushes low income families to smaller areas.”***

– Key Informant

***“Transportation is an issue. There are people who post on different community Facebook pages, ‘Hey can someone give me a ride to the doctor,’ and I am thinking, you are going to ride with a stranger?”***

– Resident

***“There is a fee [for CARTS] and they limit the number of riders from my understanding. They only allow a mom to bring the one child who has an appointment so if you have three or four children what do you do?”***

– Key Informant

***“We do see some homelessness as well. It is different in Caldwell, small town it is families being homeless and not heavy concentrations so not as visible. Families may lose their homes and seek shelter, so it is a little different problem than a larger city.”***

– Key Informant



Approximately half of the respondents described a personal connection with community members. When compared to the State of Texas as a whole, residents of Caldwell County experience a relatively high degree of social associations, seeing an increase from 9.3 to 9.6 since 2015. Social associations in the state of Texas have decreased from 7.8 to 7.6 during that same time.

**BEHAVIORAL RISK FACTORS** – Since the previous health assessment in 2015, Caldwell County has seen a positive change in two key behavioral risk factors; adult smoking (16.7 to 16.2%) and adult obesity (28.2% to 26.6%) have both decreased. Concurrently, Caldwell County experienced an increase in physical inactivity (25.0 to 29.1) since 2015. This may be partially explained by the increase in the lack of access to exercise opportunities (from 49.0% to 60.9%) during the same time period. One of the recommendations participants in our community input sessions made was to improve the built environment to promote healthy lifestyles by providing more green spaces and bike lanes, increasing funding for parks and recreation, and giving residents more access to gym facilities. Excessive drinking is currently at 17.8% in Caldwell County (no data available for 2015). Caldwell is doing better on this measure than the state of Texas which is currently at 19.4% (see Table in Appendix on rates of Adult Risky Behaviors).

***“We have an elderly population here and housing is a challenge.”***

– Key Informant

***“Luling is a great retirement area with a slower pace.”***

– Key Informant

## **HEALTH DISPARITIES**

***Residents in Caldwell County differ in terms of their health based on income level, gender, race and ethnicity; Poorer residents, Blacks, and Hispanics have greater health burden .***

Of the 254 counties in the state of Texas, Caldwell County is ranked 130th for health outcomes and 134th for Health Factors.<sup>7</sup> Health outcomes for individuals in Caldwell County vary depending on race and income. For example, when examining life expectancy in Caldwell County, there is a 5.4-year gap between women based on income. For men, there is a 9.5-year gap. Additionally, the health burden for Blacks when it comes to any disability among all ages is 17.1%, compared to 10.2% for Hispanics and 14.8% for whites. The percentage of disability among Caldwell County Black residents is also significantly worse than the state of Texas.

Not all available data sets included information for each racial or ethnic group. However, when this information was available, Blacks and/or Hispanics showed an increased burden across all available measures. When compared to the general population of Caldwell County, Blacks experienced an increased health burden. Hispanics have an increased health burden for teen births. When compared to the general population of Caldwell County, both Blacks and Hispanics face an increased burden when it comes to economic factors like median household income, population below 100% of the FPL, and children in poverty.

<sup>7</sup> Robert Wood Johnson Foundation, County Health Rankings for 2019.

## DISPARITIES ACROSS RACE/ETHNICITY

Measure (Health Outcomes/Factors)	2018				
	Texas	Caldwell Co (all races/ ethnicities)	White	Black	Hispanic
Premature Death (Age - adjusted)	6,675	7,364	7,500	12,200	6,600
Teen Birth (births per 1,000 female population ages 15-19)	41	42	28	Not available	57
Low birthweight	8%	10%	10%	14%	9%
Population with any disability	12%	14%	15%	17%	10%
<b>Measure (Economic Factors)</b>					
Median Household Income	\$56,600	\$49,600	\$58,400	\$28,700	\$42,600
Poverty Population below 100% FPL	17%	19%	10%*	44%*	21%*
Children in Poverty	22%	24%	9%	41%	28%

Data in blue indicate elevated burden for racial/ethnic group compared to overall Caldwell County data

\* Source: <http://worldpopulationreview.com/us-counties/tx/caldwell-county-population/>

## SUMMARY OF CHANGE SINCE PREVIOUS HEALTH ASSESSMENT

The following areas have seen improvement in Caldwell County since 2015:

- The rate of drug poisoning deaths has improved from average to better than average
- The availability of fresh foods has improved from average to better than average
- Income inequality has lessened; moving from average to better than average
- The rate of alcohol-impaired driving deaths dropped from worse to average

The following areas have seen a decline in Caldwell County since the 2015:

- While poor physical health days reduced for the state, Caldwell saw an increase to worse than average
- The number of people diagnosed with sexually transmitted infections increased substantially and is now worse than average
- While the suicide rate decreased statewide, it increased in Caldwell: now worse than average
- Adult smoking did not drop as fast as the state and is now below average
- Lack of health insurance dropped but not as fast as the state and is now below average
- Access to primary care physicians and the number of preventable hospital stays are both now below average
- Persons with some college increased but not as fast as the state and is now below average

# COMMUNITY THEMES: STRENGTHS AND CONCERNS

## CULTURAL COMMUNITY NARRATIVE

Residents of Caldwell describe the county as a good place to raise a family, where everybody is neighborly. The Social Associations measure for Caldwell is 9.6 compared to 7.6 for Texas as a whole. Many residents choose Caldwell for the county's proximity to Austin while maintaining a small-town feel and low crime rate. Caldwell County boasts a violent crime rate of 293.4 compared to 407.6 for the state of Texas as a whole. Several respondents indicated that they have seen their small town growing in recent years, although some areas have seen more growth than others. Conversations with residents revealed that expansion is both a source of excitement and apprehension. While many are pleased with the fact there is more housing and economic development, others are uneasy about how to manage this growth and maintain a small-town feel with low crime. Food culture, particularly BBQ, is very much a part of the cultural narrative and a source of tourism. BBQ culture in Caldwell County includes heated rivalries that pit one community against another for BBQ supremacy.

*"It's part of our culture to eat BBQ"*  
– Key Informant

## STRENGTHS AND ASSETS

Community input for the CHNA included a Community Themes and Strengths Assessment (CTSA) to gather perceptions of community assets and concerns and barriers that impact the quality of life of residents. Through analysis of health outcomes and social determinants of health (SDOH) data, as well as community input sessions and key informant interviews, residents were provided the opportunity to comment about their lived experiences. The approach allowed participants to gain confidence in contributing to the discussion by beginning with depersonalized observations of the community in general and progressing to reflective discussions around their own personal experience.

Our quantitative analysis has determined that Caldwell County's community assets or strengths include relatively low rates compared to Texas as a whole: drug poisoning deaths, child mortality, adult obesity, income inequality, excessive drinking, food insecurity, and substandard housing. The county also has a relatively high food environment index. During community input sessions, respondents listed the quality of life afforded by a small, rural community as an asset. They also felt that the Lockhart Library and access to WIC services were something they valued in their communities.

- The Courthouse in Lockhart is lauded by key informants as a very active historical site, which is a source of tourism.
- Food culture, including BBQ and micro-breweries, is very much a part of the cultural narrative. There is a heated BBQ rivalry between the Lockhart and Luling communities.
- Caldwell County also has commuter access to larger economic centers such as the Austin Metropolitan Area and the oil fields located in the Eagle Ford Shale.



## BARRIERS AND CHALLENGES

The most common community challenges identified by participants in community input sessions were related to economic growth and development (identified by 29% of respondents) and lack of access to healthcare (identified by 19% of respondents), including specialty and mental health care services.

# ROOT CAUSES AND FORCES OF CHANGE

The top two health challenges identified by community input participants were obesity and diabetes. Respondents believe that the root causes of these two chronic diseases were a combination of lack of education, making poor health choices, and delaying medical care for one reason or another (age, documented status, access, cost, etc.). Key Informants from the community health center pointed to challenges with implementing integrated care in their rural community.

## DECISION-MAKING

Approximately one-third of community input participants reported that they had some degree of access to decision-makers or the decision-making process. The general reaction from Caldwell County residents when asked if they were involved in community decision-making was that of confusion. Many of the residents had important issues they wanted to raise, but did not know whom to ask, or felt that they would not be heard. Other residents felt disconnected from decision-makers. They did not feel as though they could directly reach those making decisions, but they knew someone who could make a connection. They were aware that having access to a well-connected person, or someone who worked for the city, was necessary to be heard.

***“There is not great connection between decision makers and poor community members.”***

– Key Informant

***“There is also a challenge with implementing an integrated care model, this is on the patient side and the system side.”***

– Key Informant

# LOCAL PUBLIC HEALTH INFRASTRUCTURE

## Quality and access to healthcare

The entirety of Caldwell County is designated as a Health Professional Shortage Area (HPSA). The majority of health services in Caldwell County are available in the Lockhart and Luling communities which are the two largest population centers (see Appendix for Health Care Access Measures).

***“Most doctors are here one or two days a week in Luling.”***

– Key Informant

**PRIMARY CARE PHYSICIANS AND FQHCs** – The ratio of Primary Care Physicians in Caldwell County has increased from 28.4 to 29.6 per 100,000 since 2015. However, despite modest gains, this ratio is still very low compared to the state of Texas (59.9 per 100,000). Caldwell County has two Federally Qualified Health Centers (FQHCs) in Caldwell County: Lockhart Family Practice Community Health Center as well as Luling Community Health and Dental Center.

**HOSPITALS AND EMERGENCY CARE** – Caldwell County has two hospitals: Central Texas Medical Center - Post-Acute Medical Specialty Hospital of Luling with 34 total beds and is a medical rehabilitation facility. Ascension

Seton Edgar B Davis hospital in Luling is a general acute care facility with 24 total beds. According to the CMS profile, the Emergency Department at Ascension Seton Edgar B. Davis hospital has an average ER wait time of 31 minutes, compared to a 45-minute average for the state of Texas.

**DENTISTS** – The ratio of general dentists in Caldwell County has increased from 28.4 to 34.0 per 100,000 since 2015; however, this ratio is still very low compared to the state of Texas (55.9 per 100,000). The number of individuals who have had no dental exam in the past 12 months has held steady at 37.6%, (comparable to the state - 37.4%). Key informants from the Community Health Centers indicate that they have seen a growing demand for dental health services among their patients.

**MENTAL HEALTH PROVIDERS AND FACILITIES** – The ratio of mental health providers in Caldwell County has increased from 59.0 to 63.2 per 100,000, which is still low compared to the state of Texas at 98.8 per 100,000. Caldwell County has two substance abuse treatment facilities. Both are located in Lockhart, and both are Bluebonnet Trails Community Centers with a combined total of 225 slots (no beds). Bluebonnet Trails is the Texas Health and Human Service (HHS) designated mental and behavioral health authority for Caldwell County. Behavioral health services are also available at one FQHC, Lockhart Family Practice Community Health Center. According to the Texas Department of State Health Services, none of the following types of medical facilities are available in Caldwell County: Narcotic Treatment Clinics, Birthing Centers, Ambulatory Surgical Centers, or free-standing emergency medical care facilities.

***“At the pediatrician’s office, they won’t see the baby unless it is an emergency and you have an appointment. The one time my daughter was having some kind of reaction, and I called ahead of the time I was coming in, and they denied me. They were like, ‘no we aren’t going to see you – you have to set an appointment and the next appointment is in two weeks!’”***

– Key Informant

***“Some of the barriers are with the public charge changes. This has caused the individuals to not participate for fear of deportation.”***

– Key Informant

***“A large demographic of the Hispanic community, who may or may not be of documented status, don’t want to go to the doctor because ‘what if?’”***

– Resident

During our community input sessions, 43% of participants felt that they had access to health services while 38% felt they did not (some participants did not respond). The responses were skewed based on the location where the community input session was held. Participants at the WIC Center tended to be younger and they discussed several challenges, while the participants at the Lockhart Library tended to be older and had an easier time accessing services and addressing their family’s health care needs. One resident was very concerned about the difficulty she and her family had experienced navigating what she described as a very disjointed, spread out, and non-communicative specialty healthcare system. Another resident was very disappointed in the availability of mental health services in the county. Access seems to vary around racial and ethnic groups as well. The issue of fear associated with undocumented status came up in both community input sessions and key informant interviews.



**QUALITY AND ACCESS TO SOCIAL SERVICES** – When community input participants were asked about access to healthcare and social services, 47% of participants felt that they had access to the services that they needed, 19% expressed that their access was limited, and 14% indicated that they did not have access at all.

A review of available data sets indicate that social workers have increased from 52.1 per 100,000 to 57.1 since 2015. However, this figure is still very low compared to the state of Texas at 80.3. Additionally, access to WIC authorized food stores remained steady at 5.2 in Caldwell County, compared to 9.1 in Texas as a whole (see Table Social Service Measures in Appendix).

*“Here I’ve found – because I didn’t have insurance for a while – I’ve found it to be cheaper when I didn’t have insurance because there are programs like the Patient Prescription Program with the sliding scale fee. There are resources, but you gotta know where to get them.”*

– Resident



## COMMUNITY HEALTH PRIORITIES

### Community Recommendations on Improving Health and Well-Being

Residents of Caldwell County would like the following issues to be prioritized by decision makers: Youth Recreational Facilities (14% of respondents); Afterschool Programs for Children (14% of respondents); Transportation including transportation to medical care (14% of respondents); Hospital open 24 hours (14% of respondents); Focus on Children and Families (14% of respondents); Education/Schools (10% of respondents); Women’s Clinic/OB/GYN (10% of respondents). The following suggestions were specific to improving community health: An Environment that Promotes Exercise (24% of respondents); An Environment that Promotes Healthy Eating (24% of respondents); and Health Fairs / Free Screenings (14% of respondents).

## The Top Health Priorities for Caldwell County in 2018

*Data suggests that Caldwell County should focus on improving chronic diseases and sexual health services, social inequities associated with income, race/ethnicity and gender that drive poor health, and dramatically improve the mental and behavioral health infrastructure and access to services. Significant barriers to access exist for care, food, transportation, physical activity, and community voice.*

Based on input from community members, data on current health conditions, and data on social determinants of health, the following were identified as top priorities for improving health in Caldwell County:

**MAKE INVESTMENTS IN IMPROVING THE SOCIAL DETERMINANTS OF HEALTH (SDOH)** – Focus on Community Input to address the Social Determinants of Health and the Built Environment. While available quantitative data focused primarily on health outcomes, the majority of focus group respondents wanted to see improvements in the social determinants of health and the built environment. This includes not only improved environments to promote healthy living and eating but transportation concerns which affect the ability of residents in this commuter county to access the economic opportunity and social and health services they need. Improving community conditions by expanding economic opportunities and living wage jobs; expanding access to quality parks and green spaces, walking and biking trails, playgrounds, and facilities to support family health; subsidizing quality, affordable housing; expanded transportation solutions and infrastructure to support safe biking and walking; and increased services to address the needs of the homeless population, including programs to secure stable transitional and permanent housing, availability of shelter beds, free health care and transportation services to health care services, and employment and job search services. We know that poverty limits access to healthy foods and safe neighborhoods and that more education is a predictor of better health.

We also know that health suffers in communities with poor SDOH such as low-quality housing, low income, unsafe neighborhoods and schools, or substandard educational opportunities.<sup>8</sup>

**BEHAVIORAL AND MENTAL HEALTH** – Improve access to services across the continuum of behavioral and mental health needs (e.g., mental illness, substance use disorder, social connectedness). Participants noted the negative impacts on community health of the opioid epidemic and the need for increased mental health services, particularly for the most vulnerable and disconnected youth. A recent study sponsored by the National Council for Behavioral Health; America's Mental Health 2018 found that the lack of access to behavioral health services is the root cause for the mental health crisis in America. Access to mental and behavioral health services, especially for children and youth, should be among the most important priority actions considered by Caldwell County.

**ACCESS AND AFFORDABILITY OF HEALTH CARE** – Provider ratios across the healthcare spectrum (whether it be for primary care, dentistry, or mental health) indicate there are opportunities for growth and expansion within the health care system in Caldwell County. Focus group respondents also communicated a desire for a more cohesive and communicative health care system that promotes patient navigation, as well as improved access to be responsive to the needs of families and children. Focus group respondents also suggested increasing access by removing barriers to care such as flat rate fees for office visits, transportation and lack of insurance coverage, and expand programs which show promising outcomes or community response (e.g., a kiosk to promote services was referenced), ensure information on accessing resources is widely available through health care roadmaps and other visual explanations of where and how to access services. Solutions might include extended after-hours appointments, free or sliding scale health clinics in neighborhood schools staffed by nurse practitioners, free public transportation that runs directly to FQHCs, additional FQHC access points in the most impoverished community locations where people live and work, specialty care services focused on the top chronic diseases and necessary services such as OB/GYN services, maternal and child health care in the Caldwell County population. Adults in worse health, those with low incomes, and the uninsured are much more likely than others to delay or forgo health services due to costs.<sup>9</sup>

<sup>8</sup> CDC, 2018

<sup>9</sup> Gary Claxton, Bradley Sawyer and Cynthia Cox, Kaiser Family Foundation, 2019.



**CHRONIC DISEASE RISK FACTORS** – Improve access to affordable, healthy food options, eliminate food deserts, increase opportunities for free or affordable physical activity for all ages. Today, 7 of the 10 leading causes of death in the United States are chronic diseases, and almost 50% of Americans live with at least one chronic illness. Where data was available by racial and ethnic backgrounds, all available measures indicated some type of disparity or burden in terms of chronic diseases and economic outcomes. In addition, racial or ethnic minorities constitute half of the population of Caldwell County. People who suffer from chronic diseases experience limitations in function, health, activity, and work, affecting the quality of their lives. Underlying these conditions are significant health risks such as tobacco use, poor nutrition, and physical inactivity. Increasing opportunities to engage in healthy behaviors, particularly for racial and ethnic minority populations reduces the risk for illness and death due to chronic diseases.<sup>10</sup>

**SEXUAL HEALTH** - Whether it is increased STIs/HIV or teen birth rates, sexual health measures in Caldwell County have significantly worsened, lag behind the state average, or pose a racial or ethnic burden. In addition to these quantitative data around sexual health, focus group respondents were acutely aware of decreased access to reproductive health services.

**OUTREACH, ENGAGEMENT, AND INFLUENCE** – Expanding leadership opportunities for marginalized community members, increase culturally appropriate messaging and outreach, create opportunities for personal development, promote a positive narrative, highlight positive community assets and efforts, identify and execute ways in which visible quick wins can be demonstrated that are driven by community voice and engagement in the decision making process.

## CONCLUSIONS

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The 2019 CHNA process sheds light on the opportunities and challenges that exist in improving health outcomes in Caldwell County. Community conversations helped to provide insight into the lived experiences that tell the story behind the data. This assessment provides a new baseline from which the CHNA partners and other decision makers will begin to develop a community health improvement plan for the next three years.

In addition to identified health priorities, the CHNA process helped partners broaden relationships with community members across sectors and neighborhoods. Many community members expressed a desire to be more involved and welcomed the opportunity to be a resource in the health improvement planning process. These new community relationships help promote accountability and will ensure that the decisions made as a result of this CHNA will represent the true needs of those most impacted. With this information, decision makers can confidently work towards becoming a healthier community.

To improve the health of Caldwell County residents, it is essential to work collaboratively in the spirit that community participants envisioned for a healthy community and to focus county resources and engaged leadership on the priorities noted above. Their vision is both inspiring and possible with intention and commitment to a community that works for all its residents.

<sup>10</sup> CDC, 2013.

# APPENDICES

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2018

COMMUNITY HEALTH  
NEEDS ASSESSMENT

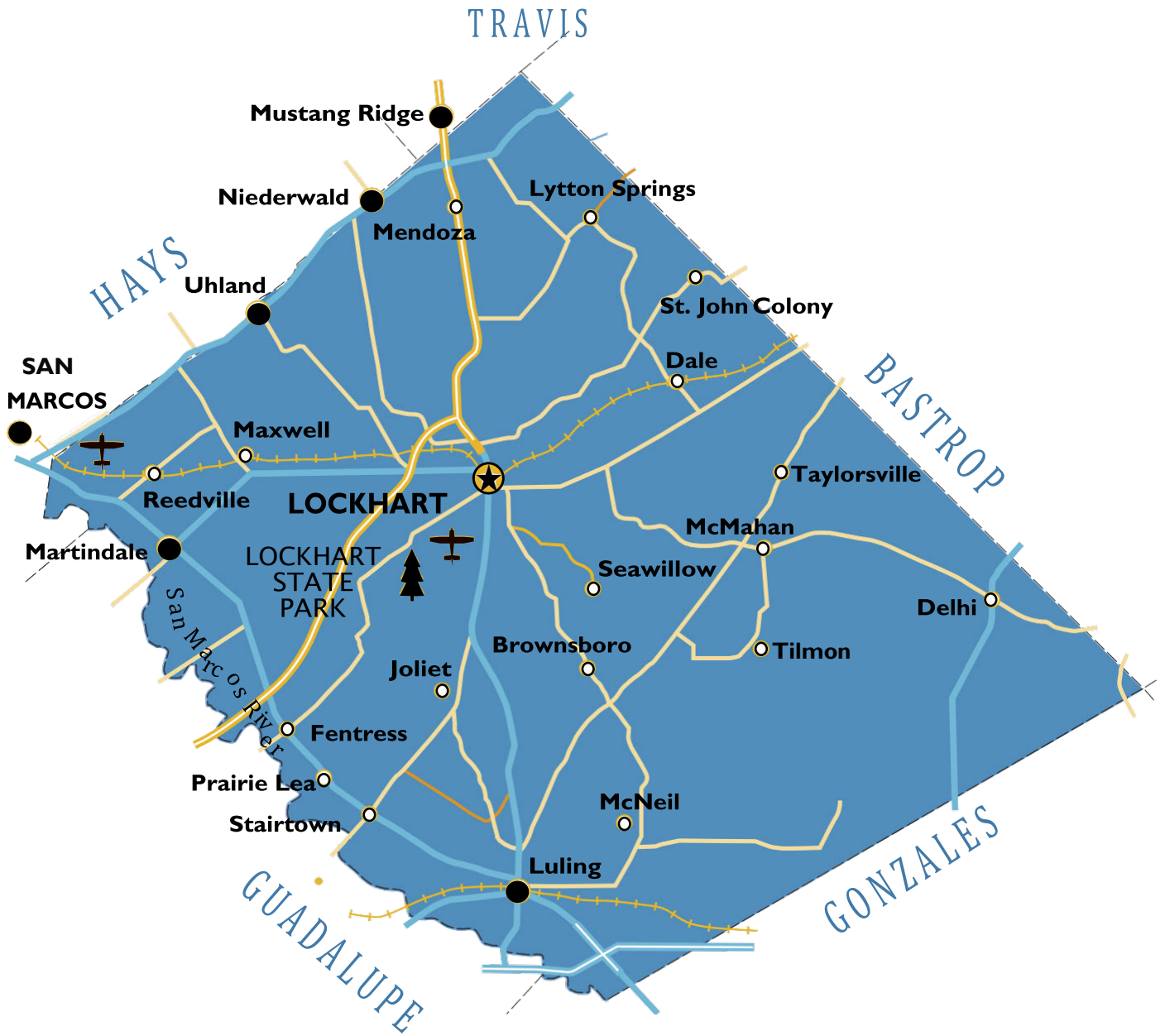


# CALDWELL COUNTY, TEXAS

Community Input  
Summary Report



# CALDWELL COUNTY, TEXAS





## 2018 COMMUNITY HEALTH NEEDS ASSESSMENT

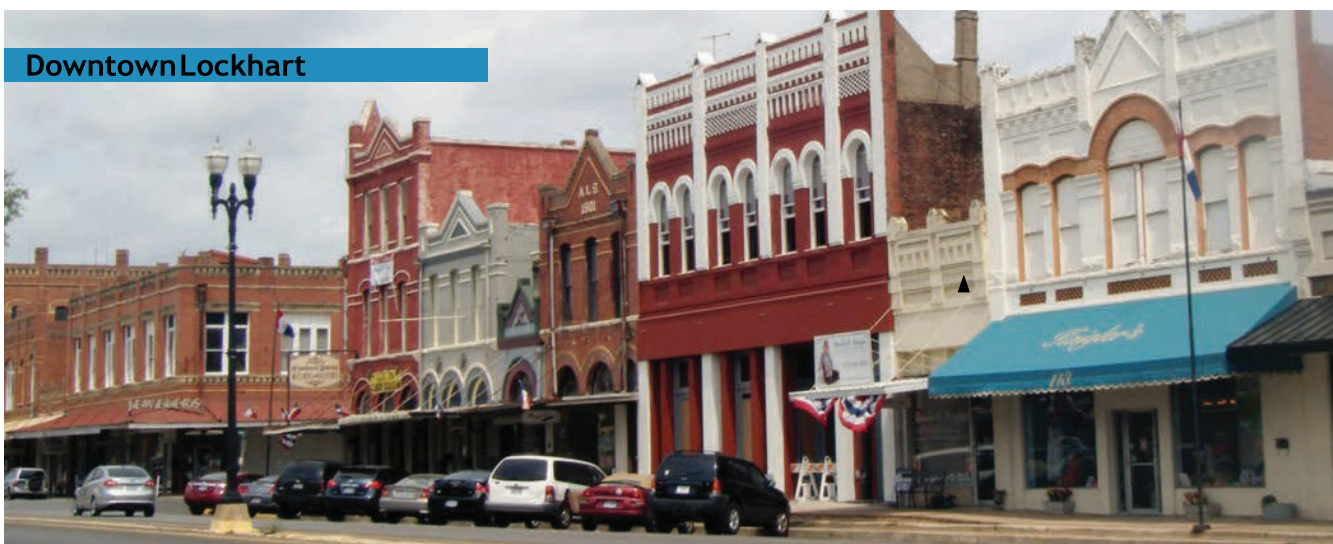
# CALDWELL COUNTY, TEXAS

## COMMUNITY INPUT SUMMARY REPORT

### OVERVIEW

Caldwell County has a population of 42,338 including approximately 12,664 households. Community input sessions were conducted within Caldwell County and participants were invited through local social service providers and health clinics. This helped to ensure that participants had an understanding of community needs and personal experiences from which to draw their responses. The participants were located primarily within the Lockhart community. Sessions were held at two locations in the community – the Dr. Eugene Clark Central Library and the WIC Program Center. The purpose of each session was to gather information based on four areas. These areas included community identity; access to health care and social services; root causes and determinants; and priorities and recommendations.

#### Downtown Lockhart

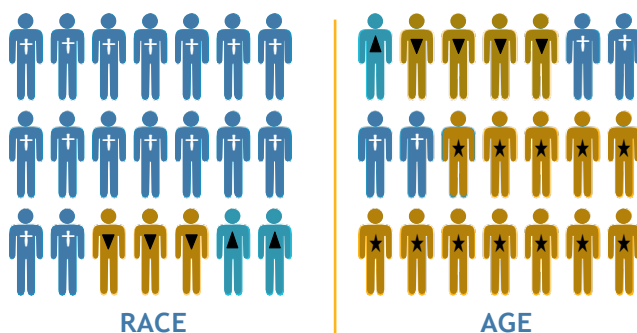


### DESCRIPTION OF COMMUNITY PARTICIPATION

For Caldwell County, community members engaged in input sessions reflected the following demographics:

- ◆ U.S. Census Bureau estimate (2017) for the population of Caldwell County includes the following racial groups: Hispanic – 22,127; White – 35,068; Black – 3,3027.
- ◆ Of the Caldwell County community members engaged, **76% were Hispanic/Latino**, and **14% were white**, and

#### Community Members Engaged



10% were African American/Black based on how participants self-identified their race/ethnicity.

- ◆ Of the Caldwell County community members engaged, 5% were under 18; 19% were 18-24; 24% were 25-44; 52% were 45-64; and 0% were 65+.

## NARRATIVE ON COMMUNITY IDENTITY

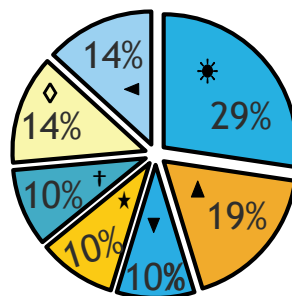
### What Makes Us Unique

The community input sessions were designed to obtain feedback on community characteristics using open-ended questions. Additionally, for questions used to determine perception of health and quality of life, participants were given a scale of poor, fair, good, or excellent. Participants were asked to identify the positive elements of their community that they perceived to be characteristics that describe the uniqueness of the community. During the course of small group discussions, most participants described Caldwell County as a “close knit community, with friendly people.” In addition, approximately half (50%) of respondents described a personal connection with community members. Sessions conducted at WIC indicated that an overwhelming number of participants thought the location of the WIC office was favorable. Individuals attending sessions conducted at the library considered the library to be a community gem and identified Lockhart as being a church community.

### Top Community Challenges

The most common community challenges identified by participants were related to economic growth and development and a lack of access to health care, including specialty and mental health services. Some residents expressed concern about the increase in population while others were excited and hopeful about the new developments which would be spurred by that growth. A full breakdown of community challenges expressed by participants is illustrated below. It is important to note that some community members provided multiple responses while others only contributed one response; therefore, the total will not reflect 100%.

#### Overall Community Challenges



- ◆ Growth and Economic Development
- ▲ Lack of Hospital
- ▼ Transportation
- Lack of Youth Facilities/Recreation
- + Lack of Jobs Paying Livable Wage
- Lack of Healthy Restaurants
- ◀ Homelessness

## Causes and Contributors to Community Challenges

Responses varied greatly when community members were asked to identify the root causes of community challenges. Some felt that challenges could be attributed to small town life, resistance to change, or low-paying (and physically-demanding) jobs.

## Perceptions of Community Change in the Past Five Years

Over half the participants (57%) of Caldwell County expressed seeing notable growth and expansion within the community in the last five years. Residents described growth in the areas of population, residential housing, schools, and businesses. During the discussion conducted at the WIC Center, there was one major concern, and that was decreased access to women's health services due to the closing of a local OBGYN office. All female participants indicated traveling out of the area (San Marcos, Austin, Kyle) for their health care needs.



## Describing Our Community's Health

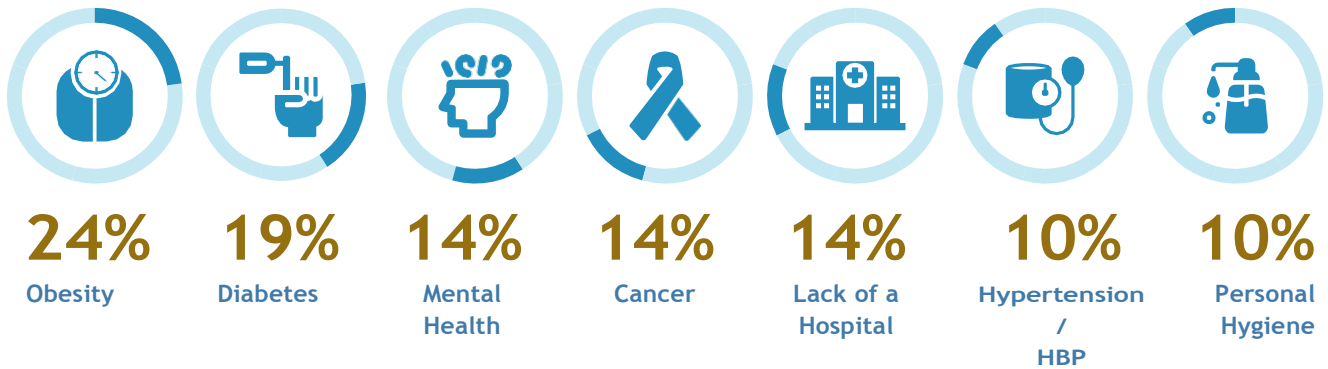


**24%** Participants were asked to describe or rate their community's health using a scale of poor, fair, good, or excellent. The majority of participants rated their community as having poor (24%) or fair (24%) health. The facilitator noted that participants who attended the WIC Center discussion (mostly younger women) were more aligned on the "poor" end of the health spectrum, while participants at the library (older demographic) tended to rate community health closer to the "good" end of the health spectrum. The remaining 30% were unsure and felt

it varied based on a person's resources. Percentages reflected may not total to 100% based on rounding.



## Health Challenges



### Causes and Contributors to Community Health

The top two health challenges identified by community input participants were obesity and diabetes. When it came to these health challenges, respondents felt that the root cause was a combination of lack of education, making poor health choices, or delaying medical care for one reason or another (age, documented status, cost, etc.). A full list of responses to this question are illustrated above. Not all respondents provided a single response so percentages will not total 100%.

### Raising a Family

Many Caldwell County residents felt that the rurality and insularity of their communities made Caldwell a good place to raise a family, especially in contrast to other urban areas in central Texas. Many residents expressed a concern that these same aspects create a barrier as well. For example, Caldwell County is a commuter county, and it is necessary to travel to nearby urban areas for employment or to access health and social services. The lack of high paying jobs was a concern raised by 24% of participants.

### Influencing Community Decision

Approximately one-third of the respondents felt they had some degree of access to decision makers or the decision-making process. The general reaction received from Caldwell residents when asked if they were involved in community decision making was that of confusion. Many of the residents had important issues they wanted to raise, but did not know who to ask, or felt that they would not be heard. Such was the case with one legally blind resident who wanted



The community is not blind friendly. I am legally blind and it is hard to get around. The curbs in the town are not marked. They should be painted a different color so they can be seen. **I would say something if I knew who to ask.**



brightly painted curbs in her community and said, “I would say something if I knew who to ask.” Other residents felt disconnected from decision makers. They did not feel as though they could directly reach decision makers, but they knew someone could make a connection. They were aware that having access to a well-connected person, or someone who worked for the city was necessary to be heard.

## ACCESS TO HEALTH CARE AND SOCIAL SERVICES

### Access to Primary and Specialty Care

In the next phase of questions, participants were asked about specific experiences in their ability to access primary and specialty care. Of all participants, 43% felt they had access to health services while 38% felt they did not (some participants did not respond). The responses were skewed based on the location of the session. Participants at the WIC Center discussed several challenges, while the participants at the library had an easier time accessing their health care needs. One resident was very concerned about the difficulty she and her family had experienced navigating what she described as a very disjointed, spread out, and non-communicative specialty healthcare system. Another resident was very disappointed in the availability of mental health services in the county. General barriers for accessing non-specialty care included: 1) Lack of insurance 2) Long wait times 3) Limited selection of doctors 4) High demand for pediatric doctors. In an effort to get receive access to pediatric care, one Lockhart resident utilized the services of a mobile unit rather than enduring the long wait times in a pediatrician’s office.

### Accessing Information on Available Resources

In Caldwell County, community members expressed that new residents often receive information on available services or resources from the library (33%) or city hall (24%). In addition, community members stated that the chamber of commerce, neighbors/long-time residents, and social media were other sources of information. One participant did note that she felt other communities did a better job of building a sense of community over social media. Another participant shared that she personally uses the automated telephone directory (211 service) to help her access social service.



## Accessing Quality Health Care and Services

When asked about access to health care and social services, 47% of participants felt they had access to the services they needed. Nineteen percent (19%) expressed that their access was limited and 14% indicated that they did not have access at all. Residents were concerned about the cost of medical care and the lack of access to a full-service hospital. Transportation was also considered to be a concern with one resident noting that ride sharing with strangers through social media had been used to access health care.

## PRIORITIES AND RECOMMENDATIONS

### Suggestions for Improving Community Health and Health of Families

Respondents were asked to provide suggestions to improve the health of their communities. Many suggestions revolved around access to care such as free check-ups, health screenings, and a local hospital. Others wanted to make exercise more accessible through fitness centers, green space, and bike lanes. Pricing and availability of healthy foods and access to farmers markets were also suggested to improve community health.

Below is a list all recommendations provided by community members

- ◆ Health fairs
- ◆ Job fairs
- ◆ Check-ups
- ◆ Free health screenings
- ◆ Activity center/gym/fitness center
- ◆ Free exercise camps
- ◆ Affordable health care
- ◆ Affordable healthy food or free food giveaways
- ◆ A hospital (open 24 hours)
- ◆ Multi-disciplinary, specialty medical care
- ◆ More green space
- ◆ Alternatives to driving (bikelanes)
- ◆ Farmer's market
- ◆ Personal care bags (hygiene items for homeless)



A lot of people don't have money. So they have to figure, 'do I go to the doctor or do I eat today?' At least I know I'll be alive. There is not one person that doesn't want to eat right, but eating right costs so much, and you can get fast food or junk food and it's 95% less.

- Lockhart Resident,  
Caldwell County



### What Positive Change Would Look Like for Caldwell County

In conducting community conversations, it was important to identify what community members felt needed to be visible or experienced to know that positive changes were occurring in their community. For members of Caldwell County, participants felt they would know positive changes were happening in their community if they saw signs of economic development, such as a bigger H-E-B, and more health food options. While they wanted to see growth, they wanted the community to continue to stay clean and maintain a low crime rate. Some residents expressed the desire to see change in schools while others wanted to see more accountability and responsiveness from city leaders.

## Priorities for the Greatest Impact

As a final question, community members were asked to provide a recommendation on the priority(ies) decision makers should implement to improve the lives of people in their communities. Of the 21 total community participants in Caldwell County, 14% identified each of the following priorities for improving lives: youth recreational facilities, afterschool programs for children, transportation, a hospital, and focusing on children and families.

Below is a full list of priorities provided by community members in order of ranking.

↓	<b>Youth recreational facilities</b>	<b>14%</b>
↓	<b>Afterschool for children</b>	<b>14%</b>
↓	<b>Transportation</b>	<b>14%</b>
↓	<b>Hospital</b>	<b>14%</b>
↓	<b>Focus on children and families</b>	<b>14%</b>
↓	Education/schools	10%
↓	Women's clinic	10%
↓	Child care	4%
↓	Safety	4%
↓	Access to services	4%
↓	Funding for parks and recreation	4%
↓	Accountability from elected officials	4%
↓	Diabetes	4%
↓	Cancer	4%
↓	Accessibility for the blind	4%
↓	Gym	4%



## COMMUNITY INPUT SESSION QUOTES TABLE

"I wish we had more of a medical center with multi-disciplinary specialized care where people didn't have to go to Austin or so far. I wish, I wish a lot. If I won the lottery, I would put up my own money to open my own medical facility. I would love to take care of all of our medical needs in Lockhart."

– Lockhart Resident, Caldwell County

*"A large demographic of the Hispanic community, who may or may not be of documented status, don't want to go to the doctor because 'what if?'"*

– Lockhart Resident, Caldwell County

"I don't believe it is a good place to raise a family because you cannot really make a living here."

– Lockhart Resident, Caldwell County

*"Transportation is an issue. There are people who post on different community Facebook pages, 'Hey can someone give me a ride to the doctor,' and I am thinking, you are going to ride with a stranger?"*

– Lockhart Resident, Caldwell County

"The community is not blind friendly. I am legally blind and it is hard to get around. The curbs in the town are not marked and are not blind friendly. They should be painted a different color so they can be seen. I would say something if I knew who to ask."

– Lockhart Resident, Caldwell County

*"I'm concerned with break-ins. One lady told me that there was a break-in at her apartment and she can't tell management because management is part of the problem. She tried to move further out but she can't."*

Lockhart Resident, Caldwell County

*"People don't have a way to get around. I've seen people out walking in the rain with strollers."*

– Lockhart Resident, Caldwell County

"At the pediatrician's office, they won't see the baby unless it is an emergency and you have an appointment. The one time my daughter was having some kind of reaction, and I called ahead of time that I was coming in, they denied me.

They were like, 'no we aren't gonna see you - you have to have a set appointment and the next appointment is in two weeks!'"

– Lockhart Resident, Caldwell County

*"Here I've found - because I didn't have insurance for a while - I've found it cheaper when I didn't have insurance because there are programs, like the Patient Prescription Program with the sliding scale fee. There are resources, but you gotta know where to get them."*

– Lockhart Resident, Caldwell County

"A lot of people don't have money. So they do have to figure, 'do I go to the doctor or do I eat today?' At least I know I'll be alive. There is not one person that doesn't want to eat right, but eating right cost so much, and you can get fast food or junk food and it's 95% less."

– Lockhart Resident, Caldwell County

*"Let me tell you the reason why a lot of people don't have driver's license here in Lockhart. It is so hard to get it! First you have to have an address, then you have to have a bill in your name, your social security ... so much documentation they just make it hard you know for a lot of people."*

– Lockhart Resident, Caldwell County



## FACILITATOR'S GUIDE



## CENTRAL TEXAS CHNA COMMUNITY INPUT QUALITATIVE DATA COLLECTION

### Facilitator's Guide

*(Designed for lay community conversations with a primary target audience of those in marginalized communities, those experiencing the greatest health burden, and those living in areas of high health risk factors. The conversations should last no more than an hour and 30 minutes max.)*

#### GROUP DISCUSSION #1 – INTRODUCTION & COMMUNITY IDENTITY (30 minutes)

- 1. What would you say are the positive things that make this community unique, for example, people feel connected, sidewalks, clean streets, people talking to each other, churches?** *(Write responses on flip chart "Unique/ Positive" flip chart header)*
- 2. What would you say are the top two challenges (problems) your community faces? These do not have to be health related.** *(Write responses on flip chart "Top Two Challenges" flip chart header and denote by hash marks the number of people giving that answer)*
- 3. What are the two most critical health problems in your community? Think about what concerns you about your community?** *(Write responses on flip chart "Health Problems" flip chart header and denote by hash marks the number of people giving that answer)*
- 4. How has your community changed in the past five-years?** *(Write responses on a flip chart "Community Change" flip chart header)*
- 5. How would you describe your community's health and the ways your community helps people be healthy? You can respond using poor, fair, good, or excellent.** *Then ask for those that said poor, why. For those that voted fair, why. For those that voted good, why. Last, if any for those that voted poor, why.)*
- 6. Do you consider this community a good place to raise a family? (Think about is it safe, does it provide you with the economic opportunities to earn a living that supports a healthy life?)** *(Write responses on flip chart "Quality of Life" flip chart header)*
- 7. How would you describe decision making in the community? Do you feel like there are opportunities to be involved in decision making for what happens in your community?** *(Write responses on flip chart "Community Decision Making" flip chart header)*

#### GROUP DISCUSSION 2 – ACCESS TO HEALTHCARE AND SOCIAL SERVICES (15 minutes)

- 8. Is it easy to get appointments to see the doctor or to access healthcare?** *(If they are just answering yes or no ask prompting questions to get them to describe where they go for healthcare, how long it takes to see a doctor or other examples that illustrate the ease or difficulty of accessing healthcare)*
- 9. If I am new to community how do I know where to go to get the services I need? Where do people get information?** *(Write responses on flip chart "Information & Social Services" flip chart header). If you need to give examples of services consider, utility bill assistance, food assistance, employment assistance)*

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

*(Looking for how many people say no and write on the flip chart the health or social services they feel are not accessible/available in their community, what is the impact on life).*

**GROUP DISCUSSION 3 – ROOT CAUSES AND DETERMINANTS (15 minutes)**

**11. Think about how you described your community’s health. What do you think are the reasons or causes?** *(Refer to the flip chart sheet posted from the community health responses and write their responses to what they feel are the causes “Reasons and Causes-Health” flip chart header).*

**12. What do you think are the causes or reasons for the community challenges you mentioned?** *(Refer to the flip chart sheet posted from the community challenges responses and write their responses to what they feel are the causes for the community challenges/problems. Write the responses “Causes of Community Challenges”).*

**GROUP DISCUSSION 4 – PRIORITIES AND SUGGESTIONS (20 minutes)**

**13. What are some of your suggestions to improve the health in your community? What would make it easier for you and your family to stay healthy?** *(Write the responses on flip chart “Suggestions to Improve Health”).*

**14. What would you have to see or experience in order to feel like positive changes are happening in their community? What would positive change look like in this community?** *(Write responses on flip chart “Change for Our Community Is...”).*

**15. I will go around the room and ask each of you to provide a final comment on what two priorities should decision-makers focus on first that would have the greatest impact on improving the lives of people in the community? Consider that your comments will help influence decisions on how to support (improve) your** *(Write responses on the flip chart and capture the number of votes/people that responded if there are repeats “Two Priorities”).*



## COMMUNITY INPUT SESSIONS TABLE/KEY INFORMANT INTERVIEWS



### Central Texas Community Health Needs Assessment Qualitative Data - Community Input Sessions & Key Informant Interviews Caldwell County

<b>COMMUNITY INPUT SESSIONS</b>		
<b>Location</b>	<b>Community Input Sector</b>	<b>Number of Participants</b>
Dr. Eugene Clark Central Library	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	12 participants
Lockhart WIC Program Clinic	Representatives or members of medically underserved, low-income and minority populations, populations with chronic disease needs	8 participants

<b>KEY INFORMANT INTERVIEWS</b>	
<b>Leader / Representative</b>	<b>Community Input Sector</b>
Joe Melgar Director of Client Services Community Health Centers of South Central Texas	Special knowledge or expertise in public health Health care provider Community Health Center
Elsie Lacey County Extension Agent Texas A & M Extension Services	University / Academic Special knowledge or expertise in public health Federal, state, or local agency with current data or other information relevant to the health needs of the community served
Rafael De La Puz, In-Transition/Executive Director Texas Association of Community Health Centers Community Health Centers of South Central Texas	Special knowledge or expertise in public health Health care provider Community Health Center
Mayor Mike Hendricks City of Luling, Texas	Local government official
Councilman John Wells City of Luling, Texas	Local government official

#### COMMUNITY PARTNERS ENGAGED IN NEEDS ASSESSMENT PROCESS

Lockhart WIC Program Clinic  
Dr. Eugene Clark Central Library, Lockhart Community Health Centers of South Central Texas Texas A & M University Extension Services  
City of Luling

# CALDWELL COUNTY COMMUNITY INPUT SUPPLEMENT KEY INFORMATION INTERVIEWS (KIIs)

### KIIs Community Participants

- ◆ Lockhart WIC Program Clinic
- ◆ Dr. Eugene Clark Central Library, Lockhart
- ◆ Community Health Centers of South Central Texas
- ◆ Texas A & M University Extension Services
- ◆ City of Luling

### Broad Interests of the Community Represented by KIIs

- ◆ Special knowledge or expertise in public health
- ◆ Health care provider
- ◆ Community health center
- ◆ State agency with current data or information relevant to the health needs of the community served
- ◆ University/Academic institution
- ◆ Local government official

### What Makes Caldwell County Unique...

- ◆ Strong sense of community
- ◆ Long-time residents with an openness towards new residents
- ◆ Strong sense of identity among municipalities in the county
- ◆ Luling and Lockhart are **not** the same - this was a common theme among interviewees

### Community Changes in the Past Five Years

- ◆ Luling (as opposed to Lockhart) is not viewed as a quick growth community; noticeable change is in new housing and commuting traffic
- ◆ Cost of living increases noticeable, particularly in housing pricing
- ◆ Population growth and shifts are driving planning for a potential new elementary school in the Luling School District near 130
- ◆ New health initiatives have been implemented in the past five years to address obesity, diabetes, memory health, and social support through the extension services
- ◆ New elementary school being built in the Mustang Ridge area

### Top Overall Community Challenges

- ◆ Traffic and multiple highways intersecting through Caldwell County, particularly in Luling
- ◆ Town of Luling is predominately landlocked, raising concerns for future growth
- ◆ Childhood poverty in the county is higher than that of the state
- ◆ Employment opportunities or opportunities to earn a livable wage to support a family are limited within Caldwell County
- ◆ Though there is a sense of community, there are not many instances of getting all county stakeholders together to have conversations on needs
- ◆ There is the perception that homelessness does not exist in small communities like those in Caldwell, which is not accurate - homelessness is more families living with other families or in shelters

### Decision Making in Communities

- ◆ Local elected officials expressed regular use of committees, group input, or community surveys before decisions are made
- ◆ Same people in decision making for some time; however, perception is that this is slowly changing
- ◆ New business owners are noticed in the town squares and a farm owned for generations is changing ownership to become a lavender farm - perception of growing new influencers in community
- ◆ Still a perception of a disconnect between decision makers and poor community



### Quality of Life - Raising A Family

- ◆ County is considered a safe place to raise a family overall
- ◆ Even in raising a family, the challenge is getting the young people to come back after graduating from college
- ◆ To earn a living the experience is that people do not work in Caldwell - most travel to San Marcos or Austin
- ◆ Programs such as 4-H are still viewed as critical to social connectedness and culture
- ◆ There is a significant number of parents that homeschool their children in Caldwell

### Where to Go for Information on Services...

- ◆ For local elected officials, this is seen as a challenge - no centralized source or “no wrong entry point” system for getting information on services
- ◆ Chamber of Commerce, WIC office, clinic nurses
- ◆ 211 perceived as the most centralized source
- ◆ Most CHC clinic patients learn about clinic services through word of mouth from family or friends
- ◆ Both elected officials and CHC interviewees saw information dissemination and access as an issue for improvement in the county - recurring response for several questions

### Rating Caldwell’s Health

**ALL** | **Poor or Fair Health**  
 RESPONSES

Data provided by the Texas A&M Extension Services showed 16% of adults in the US report their health as poor. For Caldwell, 23% of adults viewed their health as poor.

### Top Health Challenges

- ◆ There is a challenge with implementing an integrated care model on the patient side and the system side, i.e. referrals, coordination, providers, and access
- ◆ One in four (25%) in Luling do not have health insurance
- ◆ Though health facilities exist in the county, physicians are on-site average two days a week
- ◆ Noticed increase in demand for dental services for patients of Caldwell CHCs

### Causes or Contributors to Poor Health

- ◆ Some towns/cities in Caldwell have a significant percentage of elderly residents
- ◆ Healthy eating and exercise are a challenge as the food options and options for physical activity are limited
- ◆ Transportation is a barrier and contributes to whether individuals will seek care
- ◆ CARTS is available to provide transportation to appointments, but the rules for ridership are not supportive of families

#### Case Example:

*If a parent has four young children and needs to take one to the doctor, he/she is limited in being able to bring the other children along. So if you have no child care alternative, this is a barrier.*

## Access to Health Care and Services

- ◆ Appointments are a challenge because, most physicians do not have primary practices in Caldwell so they are on-site one or two days a week - this is for insured and uninsured
- ◆ If residents need care on “non-physician days” they seek care from the emergency department at Ascension Seton EdgarB. Davis Hospital
- ◆ For Lockhart and Luling, CHCs see patients come in and most can be seen in the same day, dental may be two days - other CHC sites longer wait time for appointment
- ◆ Many in Caldwell are sent to other towns for testing services
- ◆ Specialty care is extremely limited
- ◆ Ascension Seton and Heritage were identified as providing access to navigator support to identify services
- ◆ For social services, the perception is that those in poverty still had to go through an effort of “digging” to find services
- ◆ Public charge changes (immigration policy) are a barrier that has caused individuals not to seek care due to fear of deportation

## What Change Would Look Like...

- ◆ Seeing improvements in community facilities such as parks
- ◆ Attracting new businesses or industry that would allow people to earn a livable wage in Caldwell
- ◆ Seeing the connection between old residents and those new to community
- ◆ Establishing collaborative groups similar to Bastrop County Cares in Caldwell

## Suggested Priorities for Impact in Caldwell

- ◆ Improve access and ease of access (convenience and cost) of healthy food options - the increased commute time means families have less time to prepare meals in the evening
- ◆ Use the Extension Services Five Year Forum and similar platforms to bring together stakeholders to plan for health
- ◆ Improve outreach - increasing services without increasing outreach and marketing may still mean those in need will not receive care/services
- ◆ Build parks that are desirable/beneficial to all ages
- ◆ Attract more general practitioners to the community, i.e. increasing the number of days that providers are on-site in Caldwell clinics
- ◆ Inventory existing resources and services and create outreach plan that connects with different populations at their level - this was a common theme seen in response to several questions from interviewees
- ◆ City of Luling elected officials expressed a specific request of CHNA partners (St. David’s Foundation and Ascension Seton) seeking assistance in developing a strategy for improving outreach and information sharing on available services

## SIGNIFICANT CHANGES IN HEALTH OUTCOMES AND HEALTH FACTORS IN CALDWELL COUNTY (20% OR > CHANGE)

Measure	TX (2015)	TX (2018)	Caldwell (2015)	Caldwell (2018)*
Premature Death (Years of Potential Life Lost)	6,649.5	6,674.7	6,088.0	<b>7,364.1</b>
Premature Age-Adjusted Mortality	341.2	341.3	322.7	<b>402.3</b>
HIV Prevalence	318.6	368.9	167.0	<b>234.5</b>
STI Prevalence	487.5	523.6	522.0	<b>871.6</b>
Mortality from Pedestrian Accidents	2.0	3.6	1.8	<b>5.3</b>
Access to Exercise Opportunities	84.3%	80.6%	49.0%	<b>60.9%</b>
FQHCs	1.4	1.8	2.6	<b>5.3</b>
Teen Birth Rate	55.0	41.0	57.7	<b>42.4</b>
Child Mortality	53.1	51.5	54.7	<b>36.1</b>
Alcohol-impaired driving deaths	32.8%	28.3%	41.0%	<b>31.9%</b>
Drug Poisoning Deaths	9.4	9.7	8.0	<b>5.0</b>
Uninsured Adults	29.5%	23.3%	33.3%	<b>26.6%</b>
Preventable Hospital stays	62.9	53.2	106.9	<b>74.6</b>
Food Insecurity	18.3%	15.7%	17.0%	<b>13.0%</b>
Unemployment	5.5%	4.6%	5.9%	<b>4.3%</b>

\* **Yellow** indicates unfavorable change; **Blue** indicates favorable change.

## HEALTH CHALLENGES FACING CALDWELL COUNTY

Measure	TX (2015)	TX (2018)	Caldwell (2015)	Caldwell (2018)
Suicide	11.7	6.2	13.0	<b>14.9</b>
STIs	487.5	523.6	522.0	<b>871.6</b>
Poor Mental Health Days	3.3	3.4	N/A	<b>3.7</b>
Poor Physical Health Days	3.7	3.5	3.8	<b>4.1</b>
HPSA	24.3%	16.8%	100.0%	<b>100.0%</b>
Physical Inactivity	24.0%	24.3%	25.0%	<b>29.1%</b>
Some College	58.6%	60.4%	43.3%	<b>44.8%</b>
Adult Smoking	16.5%	14.3%	16.7%	<b>16.2%</b>
Primary Care Physicians	58.5	59.9	28.4	<b>29.6</b>
Driving Alone - Long Commute	35.1%	36.9%	54.0%	<b>51.5%</b>
Preventable Hospital Stays	62.9	53.2	106.9	<b>74.6</b>
General Dentists	36.2	55.9	28.4	<b>34.0</b>

## ADULT RISKY BEHAVIORS

Measure	TX (2015)	TX (2018)	Caldwell (2015)	Caldwell (2018)
Adult Smoking	16.5%	14.3%	16.7%	16.2%
Adult Obesity	28.2%	28.4%	28.2%	26.6%
Physical Inactivity	24.0%	24.3%	25.0%	29.1%
Lack of Exercise Opportunities	84.3%	80.6%	49.0%	60.9%
Excessive Drinking	16.0%	19.4%	N/A	17.8%

## HEALTHCARE ACCESS MEASURES/SOCIAL SERVICE MEASURES

### HEALTHCARE ACCESS MEASURES

Measure	TX (2015)	TX (2018)	Caldwell (2015)	Caldwell (2018)
Primary Care Physicians	58.5	59.9	28.4	29.6
FQHCs	1.4	1.8	2.6	5.3
Physical Inactivity	24.0%	24.3%	25.0%	29.1%
FQHCs	1.4	1.8	2.6	5.3
Mental Health Providers	96.7	98.8	59.0	63.2

### SOCIAL SERVICE MEASURES

Measure	TX (2015)	TX (2018)	Caldwell (2015)	Caldwell (2018)
Social Workers	71.9	80.3	52.1	57.1
Access to WIC Authorized Food Stores	9.1	9.1	5.2	5.2



## HEALTH DISPARITIES AND HEALTH IMPROVEMENT PRIORITIES IDENTIFIED THROUGH QUANTITATIVE DATA ANALYSIS

- ◆ Adult Smoking (County is at 16.2% compared to State at 14.3%)
- ◆ Adults with only Some College (County is at 44.8% compared to State at 60.4%)
- ◆ Health Professional Shortage Area (HPSA) (County is at 100.0% compared to State at 16.8%)
- ◆ HIV prevalence (Significant Unfavorable Change from 167.0 to 234.5 since last assessment)
- ◆ Low Birthweight (Racial/Ethnic Disparities)
- ◆ Mortality from Pedestrian Accidents (Significant Unfavorable Change from 1.8 to 5.3 since last assessment)
- ◆ Mortality: suicides (County is at 14.9 compared to State at 6.2)
- ◆ Physical Inactivity Among Adults (County is at 29.1% compared to State at 24.3%)
- ◆ Poor Mental Health Days (County is at 3.7 compared to State at 3.4)
- ◆ Poor Physical Health Days (County is at 4.1 compared to State at 3.5)
- ◆ Population with any disability (Racial/Ethnic Disparities)
- ◆ Premature Age-Adjusted Mortality (Racial/Ethnic Disparities; Significant Unfavorable Change from 322.7 to 402.3 since last assessment)
- ◆ Premature Death (Significant Unfavorable Change from 6088.0 to 7364.1 since last assessment; there are also Racial/Ethnic Disparities)
- ◆ Preventable Hospital Stays (County is at 74.6 compared to State at 53.2)
- ◆ Ratio of general dentists (County is at 34.0 compared to State at 55.9)
- ◆ Ratio of primary care physicians (County is at 29.6 compared to State at 59.9)
- ◆ Sexually Transmitted Infections (STIs) (Significant Unfavorable Change from 522.0 to 871.6 since last assessment; County is at 871.6 compared to State at 523.6)
- ◆ Teen Birth (Racial/Ethnic Disparities)
- ◆ Driving Alone - Long Commute (County is at 51.5% compared to State at 36.9%)

Priorities identified through **qualitative data analysis** include:

- ◆ Youth Recreational Facilities (14% of respondents)
- ◆ Afterschool Programs for Children (14% of respondents)
- ◆ Transportation (including transportation to medical care) (14% of respondents)
- ◆ Hospital (open 24 hours) (14% of respondents)
- ◆ Focus on Children and Families (14% of respondents)
- ◆ Education/Schools (10% of respondents)
- ◆ Women's Clinic (10% of respondents)



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