

Ascension Seton Northwest

2021 Community Health Needs Assessment Ascension Seton

**Travis, Williamson, Hays, Bastrop, Burnet, Caldwell, Fayette,
Lee, Llano, Gonzales, and Blanco Counties, Texas**



Ascension

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The goal of this report is to offer a meaningful understanding of the most significant health needs across Ascension Seton, as well as to inform planning efforts to address those needs. Special attention has been given to the needs of individuals and communities who are more vulnerable, unmet health needs or gaps in services, and input gathered from the community. Findings from this report can be used to identify, develop, and focus hospital, health system, and community initiatives and programming to better serve the health and wellness needs of the community.

Ascension Seton Northwest

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The 2021 Community Health Needs Assessment report was approved by the Ascension Seton Board of Directors on May 24, 2022 (2021 tax year), and applies to the following three-year cycle: July 2022 to May 2025. This report, as well as the previous report, can be found at our public website.

We value the community's voice and welcome feedback on this report. Please visit our public website (<https://healthcare.ascension.org/chna>) to submit your comments.

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Executive Statement

The 2021 community health needs assessment (CHNA) represents a true collaborative effort in order to gain a meaningful understanding of the most pressing health needs across Ascension Seton's service area. Ascension Seton is exceedingly thankful to the many community organizations and individuals who shared their views, knowledge, expertise, and skills with us. A complete description of community partner contributions is included in this report. We look forward to our continued collaborative work to make this a better, healthier place for all people.

We would also like to thank you for reading this report, and your interest and commitment to improving the health of Ascension Seton's service area.

Executive Summary

The goal of the 2021 Community Health Needs Assessment report is to offer a meaningful understanding of the most significant health needs across Ascension Seton. Findings from this report can be used to identify, develop, and focus hospital, health system, and community initiatives and programming to better serve the health and wellness needs of the community.

Purpose of the CHNA

As part of the Patient Protection and Affordable Care Act of 2010, all not-for-profit hospitals are required to conduct a community health needs assessment (CHNA) and adopt an implementation strategy every three years. The purpose of the CHNA is to understand the health needs and priorities of those who live and/or work in the communities served by the hospital, with the goal of addressing those needs through the development of an implementation strategy plan.

Community Served

Ascension Seton has defined its 11-county service area as its service area for the 2021 CHNA, which includes the following counties: Bastrop, Blanco, Burnet, Caldwell, Fayette, Gonzales, Hays, Lee, Llano Travis, and Williamson. Dell Children's Medical Center serves a 46-county area for pediatric care which is noted later in this report, but for purposes of this CHNA the region is limited to the geographic area that serves both adults and children. The community served for Ascension Seton was defined as such because most of the population served from the hospitals in the Seton region are from Austin and the surrounding areas including the counties identified. Ascension Seton hospitals included in this region coordinate to offer services across it. Community health data is readily available at the county level.

Data Analysis Methodology

The 2021 CHNA was conducted from July 2021 to January 2022, and utilized processes which incorporated data from both primary and secondary sources. Primary data sources, sometimes called qualitative data, included information provided by groups/individuals, e.g., community residents, health care consumers, health care professionals, community stakeholders, and multi-sector representatives. Special attention was given to the needs of individuals and communities who are more vulnerable, and to unmet health needs or gaps in services. Together with the efforts of our hospital partners and consultants, an estimated total of 230 individuals participated in focus groups or interviews, held between July 2021 and December 2021. Populations represented by participants included medically underserved, low-income, minority groups, and rural, urban and suburban groups.

Secondary data, sometimes called quantitative data, was compiled and reviewed to understand the health status of the community. Measures reviewed included chronic disease, social and economic factors, and healthcare access and utilization trends in the community and were gathered from reputable and reliable sources.

Community Needs

Ascension Seton analyzed secondary data of over 56 indicators and gathered community input through focus groups, key informant interviews, and a survey to identify the needs in the Ascension Seton service area. In collaboration with community partners, Ascension Seton used a phased prioritization approach to determine the most crucial needs for community stakeholders to address. The significant needs are as follows:

- **Mental and Behavioral Health** - This need was selected because a number of key indicators reveal the significant and growing concerns over mental and behavioral health needs in our region. Many of these concerns are long standing, including reported numbers of poor mental health days and upward trending suicide rates and substance use and abuse. Coupled with the effects of the pandemic, concerns around isolation, anxiety and depression heightened needs around mental and behavioral health.
- **Access to Care** - This need was selected because both qualitative and quantitative data revealed significant and increasing needs around issues of accessing care, particularly regarding affordability and insurance coverage for care, transportation- especially in the rural parts of Ascension's service area, telemedicine and access to sufficient broadband infrastructures, and navigation of the complex medical system and services..
- **Social Determinants of Health** - This need was selected because many of the counties in the Ascension Seton service area have multiple indicators related to social needs that are significantly worse than averages for Texas and the United States, including lower access to exercise opportunities, lower rates of home ownership, very high rates of childhood poverty and low median household incomes, among others. Focus groups also mentioned food security and housing as significant barriers to healthy living.
- **Health Equity** - This need was selected because significant gaps in health indicators and outcomes exist in the Ascension Seton service region according to County Health Rankings data and focus groups revealed narratives of cultural and language barriers to receiving care.



About Ascension

As one of the leading non-profit and Catholic health systems in the United States, Ascension is committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable.

Ascension

Ascension is a faith-based healthcare organization dedicated to transformation through innovation across the continuum of care. The national health system operates more than 186 sites of care – including 146 hospitals and more than 40 senior living facilities – in 19 states and the District of Columbia, while providing a variety of services including clinical and network services, venture capital investing, investment management, biomedical engineering, facilities management, risk management, and contracting through Ascension's own group purchasing organization.

Ascension's Mission provides a strong framework and guidance for the work done to meet the needs of communities across the U.S. It is foundational to transform healthcare and express priorities when providing care and services, particularly to those most in need.

Mission: Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually-centered, holistic care which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words.

For more information about Ascension, visit <https://www.ascension.org/>.

Ascension Seton

As a Ministry of the Catholic Church, Ascension Seton is a non-profit hospital governed by a local board of trustees represented by residents, medical staff, and sister sponsorships, and provides medical care to patients from Central Texas and beyond. Ascension Seton operates 12 hospital campuses, five joint ventures that are certified as hospitals, 120 related healthcare facilities, and employs more than 3,000 primary and specialty care clinicians.

Serving Texas since 1902, Ascension Seton is continuing the long and valued tradition of addressing the health of the people in our community, following in the footsteps of legacy Seton Hospitals. Seton was and continues to be, a faith-based nonprofit healthcare system founded by the Daughters of Charity. Called to be a sign of God's unconditional love for all, Seton has consistently strived to expand access to high-quality, low-cost, person-centered medical care and services.

For more information about Ascension Seton, visit <https://healthcare.ascension.org/patient-resources/texas/txaus>



About the Community Health Needs Assessment

A Community Health Needs Assessment, or CHNA, is essential for community building and health improvement efforts, and directing resources where they are most needed. CHNAs can be powerful tools that have the potential to be catalysts for immense community change.

Purpose of the CHNA

A CHNA is “a systematic process involving the community to identify and analyze community health needs and assets in order to prioritize, plan, and act upon unmet community health needs.”¹ The process serves as a foundation for promoting the health and well-being of the community by identifying the most pressing needs, leveraging existing assets and resources, developing strategic plans, and mobilizing hospital programs and community partners to work together. This community-driven approach aligns with Ascension Seton’s commitment to offer programs designed to address the health needs of a community, with special attention to persons who are underserved and vulnerable.

This report outlines the process and methods for the collection and analysis of data about community health, identifies the priority community health needs of Ascension Seton for 2022 - 2025 and reflects the progress made on the prioritized health needs of the last CHNA, conducted in 2019.

IRS 501(r)(3) and Form 990, Schedule H Compliance

The CHNA also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection and Affordable Care Act of 2010, more commonly known as the Affordable Care Act (ACA). As part of the ACA, all not-for-profit hospitals are required to conduct a CHNA and adopt an implementation strategy every three years. Requirements for 501(c)(3) Hospitals Under the Affordable Care Act are described in Code Section 501(r)(3), and include making the CHNA report (current and previous) widely available to the public. In accordance with this requirement, electronic reports of both the CHNA and the implementation strategy can be found at <https://healthcare.ascension.org/CHNA> and paper versions can be requested in the Administrative Offices at each hospital.

¹ Catholic Health Association of the United States (<https://www.chausa.org>)

Community Served and Demographics

A first step in the assessment process is clarifying the geography within which the assessment occurs and understanding the community demographics.

Community Served

For the purpose of the 2021 CHNA, Ascension Seton has defined its community as Travis, Williamson, Hays, Bastrop, Burnet, Caldwell, Fayette, Gonzales, Llano, Lee and Blanco Counties. Ascension Texas includes Ascension Seton, Ascension Providence and Dell Children's and serves a larger area of Central Texas. The community served for Ascension Seton was defined as such because most of the population served from the hospitals in the Seton region are from Austin and the surrounding areas including the counties identified. Ascension Seton hospitals included in this region coordinate to offer services across it.

Located in Central Texas, Ascension Seton serves a population of 2,256,426 and includes the Austin-Round Rock Metropolitan Statistical Area (MSA). The most populated counties in the Ascension Seton service area are along the Interstate-35 (I-35) corridor and include Travis County, Williamson County and Hays County. These three counties include seven cities each with populations over 65,000, listed in Table 1 below.

Table 1: Cities in Ascension Seton Region

County	City	City Population
Travis	Austin	979,263
	Pflugerville	65,124
Williamson	Round Rock	133,435
	Cedar Park	77,419
	Georgetown	79,609
Hays	San Marcos	64,053
Source: American Community Survey Demographic and Housing Estimates 2019 1-year estimates, Table DP05 Hays County: 2020 5-year estimates (not available in 1-year estimates)		

Austin, Texas has been one of the fastest growing cities in the United States for a decade. The surrounding cities on the I-35 corridor have also seen immense population growth, as have the surrounding rural areas.

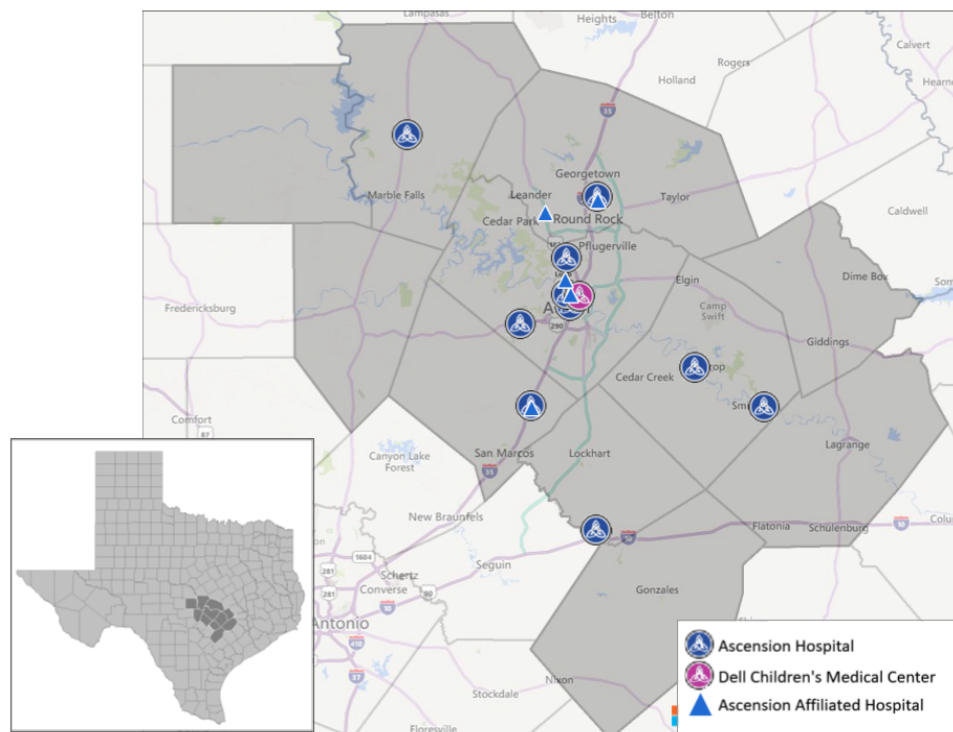
The Ascension Seton service region has two large State Universities, The University of Texas at Austin with over 50,000 students and Texas State University in San Marcos with over 38,000. The region also has several smaller universities including St. Edward's University, and Huston-Tillotson (an historically Black college, HBCU) in Austin and Southwestern University in Georgetown.

Many large technology companies are located in Central Texas. Some, like Dell Technologies, have called the Austin area home for decades while others, like Tesla and Oracle, have recently moved their headquarters to Austin. Additionally, many technology companies like Samsung, Amazon, Google and Facebook have a large and growing presence in Central Texas.

The region hosts many large events that bring tourism from around the country and even the world. Circuit of the Americas (COTA), located in Austin, is the only Formula 1 and MotoGP race track in the United States and the largest permanent outdoor amphitheater in Central Texas bringing many large sporting events and concerts to the area. Other large events hosted in Austin include South by Southwest, an annual conference hosted in March for music, comedy, film, and technology and Austin City Limits, a large music festival hosted over two weekends in October. While these are three of the largest events in the region, there are many more attractions that bring millions of people to the area each year.

Camp Mabry is located in Austin and houses the headquarters of Texas Military Forces which includes the Texas State Guard, Texas Army National Guard, and Texas Air National Guard. While there are no permanent residents at Camp Mabry, the location of Texas Military Force offices in the area brings a presence of military members and veterans to the area.

Figure 1: Map of Community Served



Demographic Data

Below are demographic data highlights for Ascension Seton, see more in Table 2 at the end of this chapter:

- Eleven percent of the residents of Ascension Seton are 65 or older, compared to 13 percent in Texas. In general, the most rural counties of the 11- county region have a larger proportion of residents who are 65 or older with the highest percentage in Llano County where 37 percent of the population are 65 or older.
- Thirty two percent of residents are Hispanic or Latino (any race).
- Seventy seven percent of residents are White; seven percent are Black or African American; six percent are Asian.
- The total population increase from 2010 to 2019 was +28 percent. Every county in the 11 county region experienced positive population growth in the last decade.
- The three most urban counties have the highest median household income of the eleven county region (\$80,690 for Travis; \$92,661 for Williamson, and \$72,890 for Hays), all of which are above the state of Texas median income (\$64,044). The lowest median household income in the region is in Gonzales County (\$48,425). Overall seven of the eleven counties in the region have a lower median household income than the Texas median household income.
- The percent of all ages of people in poverty was lower than the state (11 percent for Ascension Seton; 15 percent for Texas). Figure 2 below shows the percentage of families living below poverty by Census block group in the region to illustrate the distribution of poverty, Figure 3 shows further detail in the most populated area of the map.

Block groups are statistical divisions of census tracts defined to contain between 600 and 3,000 people used to present data²

- The uninsured rate for the Ascension Seton is lower than the state (15 percent for Ascension Seton; 20 percent for Texas).

² United States Census Bureau, Glossary. Retrieved March 2022 from:
https://www.census.gov/programs-surveys/geography/about/glossary.html#par_textimage_4

Figure 2: Percent of Families Living Below Poverty by Block Group

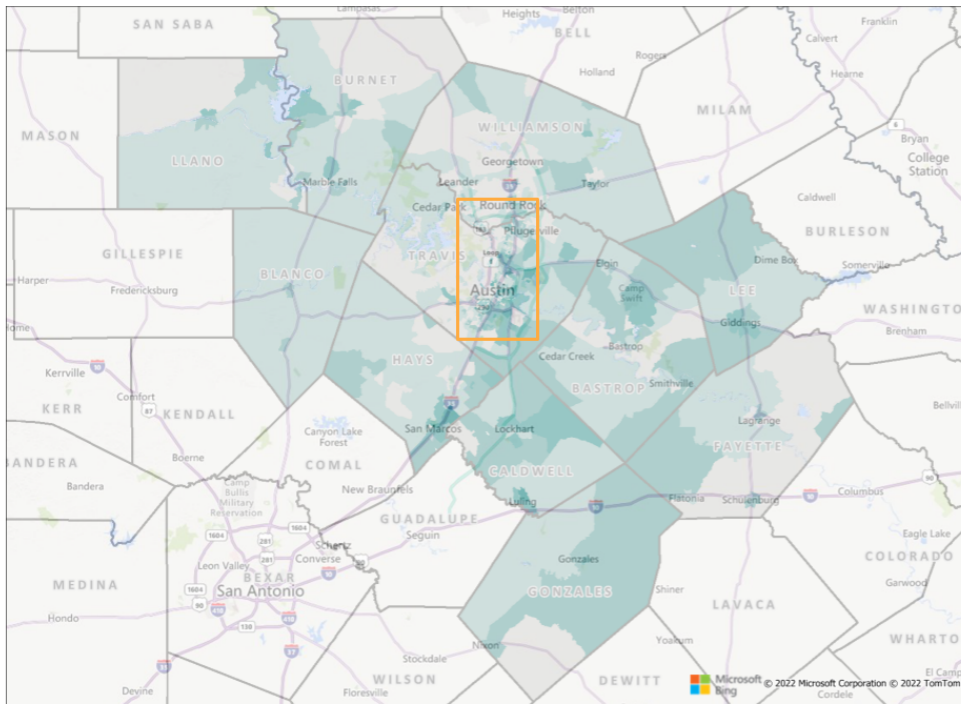


Figure 3: Percent of Families Living Below Poverty by Block Group

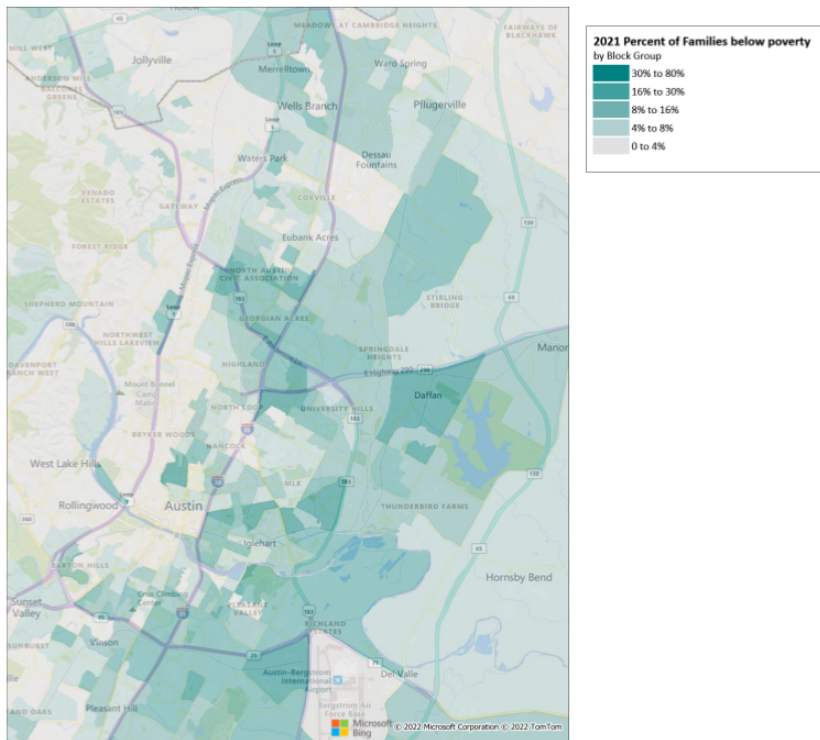


Table 2: Description of the Community

Demographic Highlights		
Indicator	Ascension Seton	Description
Population		
% Living in rural communities	13.5%	Percentage of population living in a rural area, 2010
% below 18 years of age	23.2%	Percent population below 18 years of age, 2019
% 65 and older	11.3%	Percent population ages 65 and over, 2019
% Hispanic	31.9%	Percentage of population that is Hispanic, 2019
% Asian	5.6%	Percentage of population that is non-Hispanic Asian, 2019
% Non-Hispanic Black	7.1%	Percentage of population that is non-Hispanic Black, 2019
% Non-Hispanic White	76.6%	Percentage of population that is non-Hispanic White, 2019
% Some Other Race	6.7%	Percentage of population that is non-Hispanic and Some Other Race than those listed, 2019
Social and Community Context		
English Proficiency	4.7%	Proportion of community members that speak English "less than well"
Median Household Income	\$75,624	Income where half of households in a county earn more and half of households earn less.
Percent of Children in Poverty	12.3%	Percentage of people under age 18 in poverty.
Percent of Uninsured	15.2%	Percentage of population under age 65 without health insurance.
Percent of Educational Attainment	89.6%	Percentage of adults ages 25 and over with a high school diploma or equivalent.
Percent of Unemployment	2.7%	Percentage of population ages 16 and older unemployed but seeking work

To view Community Demographic Data in its entirety, see Appendix B (page 46)

Process and Methods Used

Ascension Seton is committed to using national best practices in conducting the CHNA. Health needs and assets for the 11-county service region were determined using a mixed-methods approach which included a combination of data collection and analysis for both secondary and primary data, as well as community input on the identified and significant needs for adults and children.

Collaborators and Consultants

Ascension Seton collaborated with St. David's Foundation to conduct focus groups and interviews in Williamson, Bastrop, Caldwell and Hays counties. St. David's Foundation engaged Texas Health Institute (THI) to conduct 11 focus groups in these counties with a total of 58 participants. These participants represented populations who are or work with those who are medically underserved, low-income or minority populations. THI also sought participation from community leaders, other healthcare organizations and healthcare providers.

Ascension Seton also participated in the Austin/Travis County collaboration that produced the 2022 Austin Travis Community Health Assessment (CHA). Ascension Seton was an official partner for the development of the CHA, along with the Austin Transportation Department, the Capital Metropolitan Transit Authority, Central Health, Integral Care, St. David's Foundation, Travis County Health and Human Services, The University of Texas at Austin Dell Medical School and The University of Texas Health Science Center at Houston School of Public Health in Austin. Ascension Seton associates participated in multiple meetings and discussions related to the creation of the CHA.

Similarly, Ascension Seton was an official partner in the collaboration that produced the 2022 Williamson County Community Health Assessment, along with Baylor Scott & White Health, Bluebonnet Trails Community Services, Georgetown Health Foundation, Healthy Williamson County Coalition, Lone Star Circle of Care Opportunities for Williamson and Burnet Counties, St. David's Foundation, United Way of Williamson County, along with Williamson County.

For both the Travis and Williamson county reports, two Ascension Seton associates were active participants: Ingrid Taylor and Kelli Lovelace attended meetings and assisted in planning and reviewing the reports.

Ascension Seton contracted with Alpinista Consulting to complete some of the qualitative data requirements, specifically with regard to focus groups. Ascension Seton also collaborated with the following organizations and individuals.

- Austin Public Health coalition supporting the Community Health Assessment
- Williamson County Task Force
- St. David's Foundation
- Baylor Scott and White Health

Alpinista Consulting, founded in 2014, is based in Austin, Texas, specializing in facilitative work, collaborative learning, strategy development and implementation, capacity building, and program design. Consultants Anna Jackson and Fisher Qua work with a wide range of organizations in different geographies as they implement participatory approaches called Liberating Structures, which are aimed to draw forward ideas and insights from people across a wide range of roles. Jackson and Qua share backgrounds in social services, healthcare, government, and community-based organizational settings. Alpinista has worked with Ascension Seton on a variety of projects since 2014, including several DSRIP (Medicaid 1115 Waiver)-related initiatives, the Dell Children's Comprehensive Care Clinic, and the Leadership Development Institute (LDFR).

Data Collection Methodology

In collaboration with various community partners, Ascension Seton collected and analyzed primary and secondary data for the Ascension Seton 11-county service area.

Multiple methods were used to gather community input, including key stakeholder interviews, community focus groups and a community survey. These methods provided additional perspectives on how to select and address top health issues facing communities within the Ascension Seton service area. See Appendix C, and the "Community focus group" section below for detailed information about the collaboratives that contributed to data analysis in Travis, Williamson, Bastrop, Caldwell and Hays counties.

As noted in other parts of this report, quantitative data was organized by categories included in the County Health Rankings Report (Health Outcomes, Social and Economic Factors that Impact Health, Physical Environment, Access to Healthcare, and Health Behaviors, and Disparities), and then reviewed to determine trends of persistent and poor indicators of health county by county. Over 56 indicators were reviewed and analyzed. Once those trends and pockets of communities with poor health were identified, filters were established to highlight the greatest needs (e.g., long-term trends, significant statistical variances from experiences at the state and national level, and notable disparities due to geography, socio-economic status, race, and ethnicity).

Where possible, gaps and the resulting needs of communities were identified by reviewing which county indicators had gaps greater than one standard deviation, however, for cases where the standard deviation was not available, the absolute value of the indicator and the historical experience of that indicator was used to determine significance.

Results of the gaps, trends and themes that emerged from the quantitative data analysis were validated against the themes and feedback received from focus groups, interviews and surveys.

The validated themes and findings (that is, themes that were documented in both qualitative and quantitative analyses) were brought forward to a series of sensemaking sessions (six for Ascension Seton, including three groups of external stakeholders and three groups of internal stakeholders), to identify the needs through targeted criteria (including which needs most align with the mission of Ascension Seton and which it has capacity to impact), and then those needs were brought forward to the CHNA Steering Committee of Ascension Texas for final decisions about which needs would be prioritized.

Summary of Community Input

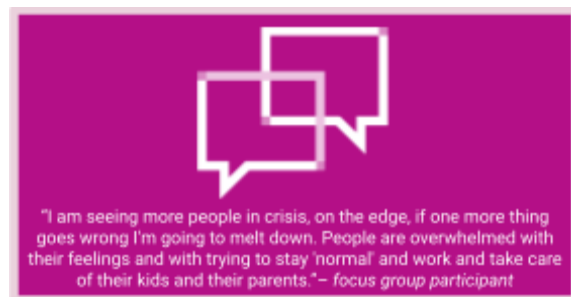
Recognizing its vital importance in understanding the health needs and assets of the community, Ascension Seton, in collaboration with hospital partners at St. David's Foundation, Baylor Scott and White, and public health leaders for Travis and Williamson counties solicited input from a range of public health and social service providers that represent the broad interest of Ascension Seton service area. A concerted effort was made to ensure that the individuals and organizations represented the needs and perspectives of: 1) public health practice and research; 2) individuals who are medically underserved, are low-income, or considered among the minority populations served by the hospital; and 3) the broader community at large and those who represent the broad interests and needs of the community served.

A summary of the process and results is outlined below.

Community focus groups

Ascension Seton drew from a number of sources to complete the qualitative analysis for this CHNA. A series of 19 focus groups with approximately 100 participants were conducted by Alpinista Consulting to gather input from community members in the following counties: Burnet, Llano, Blanco, Fayette, Lee and Gonzales, along with Travis and Williamson for focus groups that focused on children's needs.

Ascension Seton also received feedback from community members in Bastrop, Caldwell, Hays and Williamson counties from the Texas Health Institute (THI) through a partnership agreement with hospital partner St. David's Foundation. THI conducted a total of 11 focus groups in these four counties, with three each (two in English and one in Spanish) in Bastrop, Caldwell and Hays counties, and two (both in English) in Williamson county. A total of 58 community residents participated in those across



the counties. Findings from those focus groups are included in Appendix C, along with the full reports from the Texas Health Institute made available through Ascension Seton's partnership with hospital partner St. David's Foundation.

Finally, as part of collaborations led by public health departments in Travis and Williamson counties, Ascension Seton received reports from the community focus groups conducted in each of those counties. As part of the CHA Task Force, hospital partner Baylor Scott and White contracted with IBM Watson to conduct a focus group which included representatives from county government, church organizations, providers, local non-profits, and other community-based organizations. Most of the participants work with at-risk populations; the group at-large serve low-income populations, minorities, the medically under-served and homeless populations. These reports are included in Appendix C.

Together with the efforts of our hospital partners and contractors, an estimated total of 210 individuals participated in the focus groups, held between July 2021 and December 2021. Populations represented by participants included medically underserved, low-income, minority groups, and rural, urban and suburban groups.

Community Focus Groups	
Key Summary Points	
• Focus group participants from across regions spoke about the lack of availability of mental and behavioral health services as a long standing, chronic challenge that has been exacerbated by increased demand during the COVID-19 pandemic. • Key informants and focus group participants identified several factors that limit access to health care including affordability of healthcare, provider shortages for residents who are either publicly insured or uninsured, and lack of culturally and linguistically-appropriate care. • Multiple and layered social and structural determinants of health contribute to poor health outcomes. Focus group participants and interviewees noted several factors that affect health outcomes including housing and homelessness, lack of transportation, food insecurity, limited broadband or internet access, and racism and discrimination. • Navigating the healthcare and social services systems is complex both for people with resources and even more for those without. • Among the most commonly identified barriers to health was the cost of healthcare and the lack of insurance to cover costs, especially for children. • The result of population and economic growth has been a cascade of affordability and infrastructure pressures. Housing in particular across the entire region is in a crisis state. People who make a living wage can not afford to live in many of the communities where they work.	
Sectors Represented	Common Themes
• Public health • Health clinics • Education and School Health • Social Services • Research	• Opportunities to optimize organizational partnerships • Lack of behavioral and primary health services and resources • Population growth, infrastructure and affordability

- Emergency Response
- Community Collaborations
- Chambers of Commerce
- Hospital Leadership

Meaningful Quotes

- “A lot of people among our population have either poor access to health care, or no access to health care, because of financial reasons.”
- “Financial restrictions are a real challenge. Do people have paid time off? Can they afford to go to the doctor, especially if it means taking a full day off to travel to see someone an hour or more away?”
- “I think anybody can see on a map that the area east of I-35 has less access to grocery stores and fresh foods.”
- “There’s a huge Hispanic population that’s underrepresented, and they don’t have the means to get the information translated into Spanish to help them better understand how they can get services that are available to them.”
- “Sometimes we [immigrants] do feel very abandoned. Like we don’t exist. Like we are always in the shadows for everything.”
- “To assume that you don’t have people in the community that would comprehend or understand, that’s a misconception. When information is broken down and explained to people, they can really add a lot to what’s going on.”

Key stakeholder interviews

A series of 14 one-on-one interviews were conducted by the Ascension Texas Community Benefit team to gather feedback from key stakeholders on the health needs and assets of Ascension Texas. These interviews represented 14 different organizations and agencies. Some agencies also participated in the focus groups, held between September 2021 and October 2021. Sectors represented by participants included community non-profits, foundations, social service providers and health organizations.

Key Stakeholder Interviews

Key Summary Points

- Social determinants of health, including transportation, housing and employment, have a significant impact on peoples’ abilities to be and stay healthy.
- Accessing care is a challenge for many. Challenges include the cost of care and lack of insurance, ability to understand and navigate systems of care, and the logistics of access, whether related to limited options for transportation or restricted access due to broadband.
- Interviewees noted chronic conditions and quality of life issues including mental and behavioral health, potential lasting effects of COVID-19, and the impact of undiagnosed conditions or delayed treatment for existing conditions as particular areas of concern.
- Many participants noted health equities as a particular and significant concern, related to trust of healthcare workers and systems, cultural competence and humility of providers, language barriers, and ability to access health services especially for families in vulnerable conditions with multiple health and social needs.

Sectors Represented	Common Themes
• Mental Health Providers, Researchers and Policy Advocates • Federally Qualified Health Centers (FQHCs) • Health Foundation • Youth and Senior Activity Centers • Hospital Leadership	• Population growth, infrastructure and affordability • Cost of healthcare and lack of insurance • Effects of the pandemic on health and wellness • Opportunity to optimize organizational partnerships • Lack of behavioral health services and resources
Meaningful Quotes	
• “Biggest obstacle to health is poverty.. Poverty is the “evil empire.” [Poverty] defines people when they aren’t able to afford care. We need health care when we aren’t well but also when we are not sick.” • “ We’re all individuals of our community conditions, and so all those things that we live breathe and grow up and can impact both our health and mental health, and our well-being overall access to quality care.” • “This whole idea of access to, whether it’s programs, organizations, as a whole in the community. I think there’s a deficit and people even knowing what is available to them.” • “....we have often been seeking to bring in the leadership and the voice of communities that we work with instead of trying to helicopter in solutions.”	

Surveys

A survey was conducted by Ascension Seton to gather the perceptions, thoughts, opinions, and concerns of the community regarding health outcomes, health care access, and social determinants of health for Ascension Seton. Fifty- one individuals participated in the survey, held between August 2021 and October 2021.

The two largest counties in the Ascension Seton service region (Travis and Williamson) conducted their own surveys, so to reduce duplication and confusion the Ascension Seton community survey was promoted only in the suburban and rural counties in the service area which include: Hays, Bastrop, Burnet, Caldwell, Fayette, Lee, Llano, Gonzales and Blanco counties.

The data gathered and analyzed provides insight into the issues of importance to the community; however due to a small sample size these survey results cannot be generalized to represent community indicators or perceptions. The results of this survey should be used with caution and as a supplement to other reliable data sources including quantitative data and community stakeholder input.

The survey contained 15 multiple-choice questions and was conducted online only. The survey was available in both English and Spanish and distributed by asking community stakeholders and leaders to share the survey with the individuals they served.

Survey

Key Summary Points

- The most common reason selected for why individuals did not receive healthcare when needed was because they could not afford it.
- Participants ranked access to healthcare, safety from violence and affordable housing as the top three factors that are important to a healthy community.
- Participants ranked mental health and suicide, diabetes and high blood sugar, and employment and job skills as the most important factors to address to improve community health.

Summary of Secondary Data

Secondary data is data that has already been collected and published by another party. Both governmental and non-governmental agencies routinely collect secondary data reflective of the health status of the population at the state and county level through surveys and surveillance systems. Secondary data was compiled from various sources that are reputable and reliable.

Health indicators in the following categories were reviewed:

- Health Outcomes
- Social and Economic Factors that Impact Health
- Physical Environment
- Access to Healthcare
- Health Behaviors
- Disparities

A summary of the secondary data collected and analyzed through this assessment is outlined below. As noted in other parts of this report, quantitative data was organized in the categories noted above, and then reviewed to determine trends of persistent and poor indicators of health. Once those trends and pockets of communities with poor health were identified, filters were established to highlight the greatest needs (e.g., long-term trends, statistically significant variances from experiences at the state and national level, and notable disparities due to geography, socio-economic status, race, and ethnicity).

Where possible, gaps and the resulting needs of communities were identified by reviewing which county indicators had gaps greater than one standard deviation, however, for cases where the standard deviation was not available, the absolute value of the indicator and the historical experience of that indicator was used to determine significance.

For each of the categories, since there were 11 counties and multiple indicators of health and social well-being in each category, the counties were sub-categorized by population into one of three charts:

Largest population:	Hays, Travis and Williamson counties
Medium population:	Bastrop, Burnet and Caldwell counties
Small population:	Blanco, Fayette, Gonzales, Lee, Llano counties

To view secondary data and sources in its entirety, see Appendix D (page 179).

As noted in Appendix D, data for over 56 indicators were analyzed for each of the 11 counties that comprise the Ascension Seton service area using data from County Health Rankings and Roadmaps in 2021. The summaries below represent a small portion of the analyses undertaken to produce this report.

Health Outcomes

Why this is important: Health outcomes reflect how healthy a county is right now. They reflect the physical and mental well-being of residents within a community.

Generally, indicators that showed particular areas of need related to mental and behavioral health as measured by the number of poor mental health days, as well as poor physical health and relatively high incidences of sexually transmitted diseases. These needs are especially evident in counties with smaller populations. In addition to the needs above, premature deaths in Llano county were significantly higher than surrounding counties, as well as rates in Texas and the United States.

This data shows evidence of the gaps in health indicators between urban and more rural counties. The largest counties in the service area - Travis, Williamson and Hays - generally show better outcomes on infant mortality, premature death and poor physical days than counties with smaller populations. Although overall the urban counties show better health outcomes, health disparities are still apparent among different geographies within the county as shown in the Travis County Community Health Assessment on various mapped outcomes including overall life expectancy.³

Social and Economic Factors that Impact Health

Why this is important: These factors have a significant effect on our health. They affect our ability to make healthy decisions, afford medical care, afford housing and food, manage stress and more.

These indicators reveal the deep and diverse experiences of lives in the Ascension Seton service area. The median household annual income ranges from a high of \$92,660 (Williamson County) to a low of \$48,400 (Gonzales County), about half of that high income mark. Counties with larger populations tend to have lower childhood poverty rates, higher levels of educational attainment, and general greater access to healthy foods.

³ Travis County Community Health Assessment. To be published in June 2022. Page to be retrieved: www.austintexas.gov/communityhealthplan

Counties with medium-sized populations generally show lower violent crime rates along with lower educational attainment. Counties with lower populations also have lower rates of educational attainment. Many counties in the region - highly populated or not - have better than typical means to access healthy foods.

Gonzales county, one of the lesser-populated counties in the region, has the most indicators with worse-than-average results on these indicators.

Physical Environment

Why this is important: The physical environment is where people live, learn, work, and play. The physical environment impacts our air, water, housing and transportation to work or school. Poor physical environment can affect our ability and that of our families and neighbors to live long and healthy lives.

Many counties in the region experience burdens associated with housing problems and/or carry high financial costs associated with housing. Twenty percent of families in Hays and Gonzales counties have high housing problems (which may be the result of one or more conditions including overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities). The same is true for 19 percent of adults in Travis county, and 17 percent in Bastrop, Caldwell and Lee counties.

In Travis and Williamson counties data show higher rates of air pollution than the average experience across Texas, with trends showing a positive trajectory in reducing the pollution.

Access to Healthcare

Why this is important: Access to affordable, quality care can help detect issues sooner and prevent disease. This can help individuals live longer and have healthier lives.

As noted throughout this report, access to care is a challenge for most of the counties in the Ascension Seton region for reasons including large numbers of un- and underinsured people - especially children - and especially in smaller counties, high ratios of providers to residents. Counties with lower and medium populations have much lower rates of availability of providers for mental and behavioral health and dentists than the bigger counties. Smaller counties show uniformly higher ratios of population to providers, with trends worsening and rates already worse than in Texas and the United States. Blanco County has an exceptionally poor ratio of mental health providers to population at 11,931:1 (one for the entire population of Blanco County), where the ratio for Texas is 827:1 and for the United States, 400:1.

Health Behaviors

Why this is important: Health behaviors are actions individuals take that can affect their health. These actions can lead to positive health outcomes or they can increase someone's risk of

disease and premature death. It is important to understand that not all people have the same opportunities to engage in healthier behaviors.

In almost all of the counties in the region, big and small, adult obesity is rising and in many counties, is already at a higher rate than Texas and the United States. In the counties with large populations, an indicator regarding physical inactivity is improving, but that experience is not reflected in counties with medium and smaller populations. Excessive drinking is noted as a significant indicator in the larger counties.

Motor vehicle crash deaths and smoking were notably higher (worse) in medium and small population counties.

Disparities

Why this is important: Differences in access to opportunities that affect health can create differences between groups of people in the community. A focus on equity is important to improving health for everyone in the community.

Disparities in health indicators are also noted throughout this report. Of note in this section are the significantly worse experiences of Black populations related to infant mortality (especially in counties with lower populations), premature deaths, and childhood poverty (most notably in Caldwell county with an unusually high rate of 56.5 percent, which is twice or more the rate of childhood poverty in nearby counties, the state, and the United States).

Black populations also have lower median household incomes in most of the counties in the region. White populations tend to have indicators of better health in the more urban counties.

Summary of COVID-19 Impact on Ascension Seton

The COVID-19 pandemic has had an impact on communities world-wide. In the United States, urban communities took the hardest hit for both COVID-19 cases and death. Profound disparities emerged as the pandemic grew. Older Americans have the highest risk of death from COVID-19 than any other age group with 81% of deaths from COVID-19 to people over 65 years of age. There are significant disparities by race and ethnicity as well. Americans of color have higher risk of exposure, infection, and death compared to non-Hispanic White Americans.⁴

Significant COVID-19 disparities include:

- Hispanic Persons at 2.3 times the risk of death
- Non-Hispanic Black persons at 1.9 times the risk of death
- American Indian or Alaska Native at 2.4 times the risk of death

Some reasons for these differences include:

⁴Centers for Disease Control and Prevention. Retrieved from:
<https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities>

- Multigenerational families
- Living in crowded housing with close physical contact
- Working in environments in which social distancing is not possible
- Inadequate access to health care
- Higher rates of underlying conditions⁵

The pandemic has drastically changed many elements of daily life. Stakeholders noted the ways in which work and the workforce have changed and have continued to change over the past two years and the dynamic and ongoing stress that these changes have caused. In March of 2020, many people were sent home from work and have still not returned, while others were asked to continue to work in-person in an environment of uncertainty and personal risk. Many workplaces were tasked with keeping employees safe in an environment of changing and emerging health safety recommendations and increasing displays of violence toward frontline workers.

Many of the stakeholders engaged in this CHNA represented healthcare and social service organizations, and the toll on clinical care and social workers was evident in their experience and observations. The ongoing stresses of caring for critically ill patients throughout multiple surges in infections has led to stress, anxiety, fear, and fatigue in the workforce.

COVID-19 Impact on Largest Population Counties (as of 3/25/22)				
Indicator	Travis	Williamson	Hays	Description
Total Cases	220,748	132,240	59,901	
Confirmed Cases per 100,000	16,913	20,565	23,454	
Total Deaths	1,700	873	496	
Deaths per 100,000	130	136	194	
Case Fatality Percentage	0.77%	0.66%	0.82%	Percent of total confirmed cases of individuals who died of COVID-19

Sources (applies to all three tables):

COVID-19 Data: New York Times, US Census Bureau (July 2021). County specific data pages. Retrieved from:

<https://www.nytimes.com/interactive/2021/us/travis-texas-COVID-19-cases.html>

Population used for calculations: Census QuickFacts Population Estimates, July 1 2021. Retrieved from:

<https://www.census.gov/quickfacts/fact/table/williamsoncountytexas,traviscountytexas/PST045221>

COVID-19 Impact on Medium Population Counties (as of 3/25/22)				
Indicator	Bastrop	Burnet	Caldwell	Description
Total Cases	21,673	10,807	14,142	
Confirmed Cases per 100,000	21,236	-	-	Not calculated for counties with a population less than 100,000.
Total Deaths	233	168	175	
Deaths per 100,000	228	-	-	Not calculated for counties with a population less than 100,000.
Case Fatality Percentage	1.07%	1.55%	1.23%	Percent of total confirmed cases of individuals who died of COVID-19

⁵Centers for Disease Control and Prevention. Retrieved from:

<https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities>

COVID-19 Impact on Smallest Population Counties (as of 3/25/22)						
Indicator	Blanco	Fayette	Gonzales	Lee	Llano	Description
Total Cases	2,525	4,756	4,719	4,237	3,876	
Confirmed Cases per 100,000	-	-	-	-	-	Not calculated for counties with a population less than 100,000.
Total Deaths	34	104	97	60	97	
Deaths per 100,000	-	-	-	-	-	Not calculated for counties with a population less than 100,000.
Case Fatality Percentage	1.34%	2.18%	2.05%	1.42%	2.5%	Percent of total confirmed cases of individuals who died of COVID-19

In the tables above, the COVID-19 cases per 100,000 were calculated for the counties that have a population above 100,000. Smaller and some medium population counties such as Burnet (50,954), Caldwell (46,791), Blanco (11,886), Fayette (24,687), Gonzales (19,641), Lee (17,706) and Llano (21,978) do not have a population of more than 100,000 therefore no data is available for COVID-19 cases per 100,000 people. Also of note are the variations in COVID-19 data for the largest population, medium population and smallest population counties. Although it looks like the smaller population counties such as Blanco, Fayette, Lee, Llano have fewer deaths in comparison to larger counties such as Travis and Williamson, comparing case fatality data reveals that Llano has the highest fatality rate (2.5%), while Williamson has the lowest (0.66%).

Spotlight: Children in the Ascension Seton region

Ascension Texas' commitment to serving children and families in Central Texas inspired specific research and engagement with stakeholders related to children's health. Children in the Ascension Seton region, as across Texas, face profound barriers to wellness, all of which were exacerbated throughout the pandemic and economic recession. Across Texas, the unmet needs of children are well documented, including rising experiences (on top of already high experiences) with suicide and mental and behavioral health needs, shortages of homes for foster children, lack of access to care due to loss of health insurance, and moreover, greater disparities in the experiences of health of children who are White compared to those who are Black and/or Hispanic.

Since opening in 2007, Dell Children's has been the only dedicated freestanding pediatric facility in the region, serving 46 counties. To keep up with the population growth in Central Texas, the new Dell Children's Medical Center North hospital, along with expansions at Dell Children's Medical Center's central campus, and Dell Children's Specialty Pavilion, are part of a comprehensive plan by Ascension Texas to continue expanding pediatric care in the region over the next five years. In response to the growing health demands in our community, Ascension Texas is building programs to address children's needs.

Children

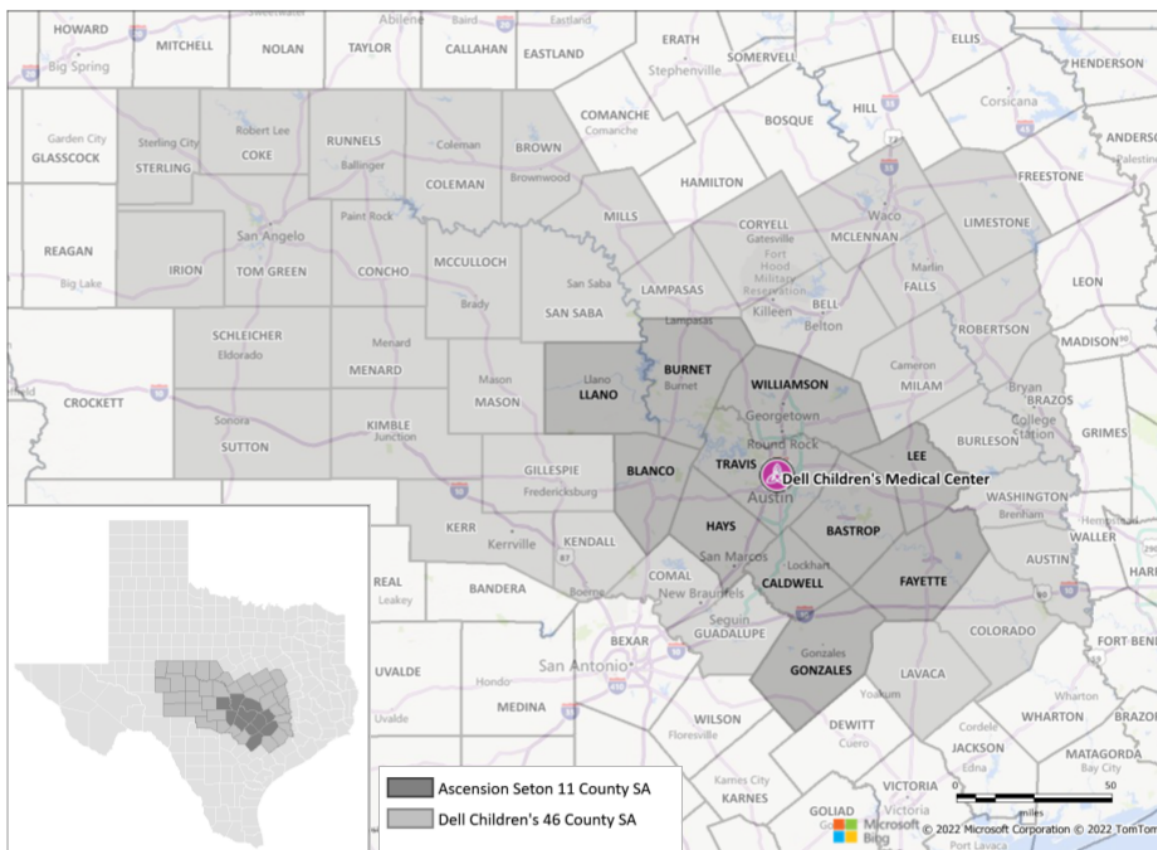
Key Summary Points

- Navigating services for children, especially those who are economically disadvantaged and/or are Black or Hispanic, is a significant barrier to health, given the multiple points of entry into an often uncoordinated system of care for children and their families.
- Mental and behavioral health needs of children and adolescents are more visible and more critical as a result of the pandemic, racial reckoning and unrest, and already existing challenges in accessing professionals trained in this specialty.
- Disparities in the health, social and safety conditions for children and families vary significantly by geography, race, ethnicity and income level.

Meaningful Quotes

- “Who are the institutions families engage with before school districts? Preschool; and that isn’t relevant for families that are doing kin-based care, informal network childcare.”
- “Complexity [of children’s needs] cuts across sectors and most solutions are going to be local and built off the partnerships and capacities of those communities”
- “Text messaging and social media campaigns led by and for youth and families with the highest needs are a critical opportunity that we’ve been missing for more than a decade. These strategies are particularly helpful for people in rural areas who are disconnected from resources, but need information and support for their health and wellbeing.”
- “[Foster] youth who are going out into the world don’t have a chance to find community where they are living.”
- “Even before the pandemic, children in our community were in pain. The number of Travis County children and youth who died due to suicide over the last five years was twice as high as the number who died in the two previous five-year periods.ⁱ One-third of Texas high school students report feeling so sad or depressed that they could not carry on with their usual activities, and 29% report drinking alcohol or taking other drugs.”
(Quote from the Travis County Plan for Children’s Mental Health and Substance Misuse, 2021 report, citing Texas Youth Risk Behavior Survey, Texas Department of State Health Services, 2019.
<https://www.dshs.texas.gov/chs/yrbs/default.shtm>)

Figure 4: Ascension Seton 11-County Service Area and Dell Children's 46 County Service Area



Mirroring experiences across the United States, children in the Ascension Seton service region are more likely to live in poverty than adults, and there are large differences in childhood poverty by race and ethnicity. In Travis county, 30 percent of Black children and 27 percent of Hispanic children live below the federal poverty level, compared to seven percent of Asian children and five percent of White children.

The number of uninsured children in the Ascension Seton service area is staggering. All of the counties in the Ascension Seton service area have a higher rate of uninsured children than the rate for the United States. Half of the counties served by Ascension Texas have higher rates of child food insecurity than Texas, and almost all of the counties in the region have higher child food insecurity rates than the United States.

It is well documented that living in poverty is linked to poor health, both physical and mental, and there are a number of indicators documenting the correlation between higher rates of uninsured and low-income children and families with poorer health experiences.

According to the Annie E. Casey Foundation's 2021 Kids County Profile, the state of Texas ranks 49th in the United States, in Health, based on indicators including the number of low-birth

weight babies, the number of children with no health insurance, the number of children and teens aged 10-17 who are overweight or obese, and the number of children and teen deaths per 100,000.

Focus groups convened specifically to discuss the needs of children focused on themes related to access to trauma-informed and culturally responsive quality care and coordination among and between service providers. They discussed how children are a subpopulation who experience health disparities and are affected by a lack of access to care and saw that children appear to be struggling with weight gain and obesity more during the pandemic. Children and teens have less control over their diet and lifestyle compared to adults, making it harder to address health issues such as high cholesterol, diabetes, and hypertension.

Focus group participants noted that there are not many providers and practitioners who have the skills and experience necessary to work restoratively with young people who have experienced significant trauma. Housing for young people in these situations (with particularly complex needs) is also nearly unavailable, with many of the service providers describing young people staying at their offices with no other place to go and be safe. Age-related eligibility criteria for services often results in young people losing contact with secure, stable conditions or resources at a particularly vulnerable time in their lives (early adulthood). This is exacerbated by the difficulty in getting current organizations to coordinate successfully.

For children and family health more generally, the themes that stood out were related to mental health (increased need with little skill, training, or specialized experience), obesity and access to healthy foods, housing insecurity and affordability, limitations on the availability of quality child-care options, and then specific needs around things like immunizations and cross cultural communication.

Some significant Texas-wide findings related to children include:

- Two-thirds of Texas children with major depression receive no treatment.⁶
- One in three Texas children experience a mental health disorder in a given year.⁷
- The second leading cause of death among youth ages 10 - 24 is suicide.⁸
- About a quarter (24%) of parents of Texas children indicated that their child had no preventive care visits in the past 12 months in the 2019-2020 National Survey of Children's Health.⁹

⁶ Meadows Mental Health Policy Institute. Mental Health Statistics, children in Texas. Retrieved 1/12/22 from <https://mmhpi.org/>

⁷ Meadows Mental Health Policy Institute. Children, youth & families, did you know? Retrieved 1/12/22 from <https://mmhpi.org/work/children-youth/>

⁸ Meadows Mental Health Policy Institute. Children, youth & families, did you know? Retrieved 1/12/22 from <https://mmhpi.org/work/children-youth/>

⁹ 2019-2020 National Survey of Children's Health. Child and family measures nationwide vs. Texas. Retrieved 1/14/2022 from <https://www.childhealthdata.org/browse/survey/results?q=8604&r=1&r2=45> (survey asked among children who had a medical care visit within the past 12 months)

- Over half (59%) of parents surveyed said that their child did not have a medical home in the 2019-2020 National Survey of Children's Health.¹⁰

Spotlight: Health Disparities in the Ascension Seton Region

Health disparities are noted and documented throughout this Community Health Needs Assessment. While obviously an issue that is embedded in other health and social needs discussed in this report, noting it as a standalone need appropriately calls attention to the pervasive and persistent challenges associated with achieving health equity.

Health Disparities
Key Summary Points
• Factors like race, income level, ethnicity, environment and geography should not determine how healthy a person is, but there is a plentiful and growing body of data - both qualitative and quantitative – that provides consistent and evidence of strong correlations between social conditions and health and wellness. • Disparities in health care occur in the context of broader inequality. • There are many conditions within health systems, providers, patients, administrators and programs that contribute to disparities. • The pandemic, national reckoning with race and discriminatory practices, and the economic recession have heightened awareness of racial inequalities and health disparities.
Meaningful Quotes
• "I think cultural norms surrounding health behavior is something that is not studied..., and [I] feel like it can only be increased by, like, increasing the amount of diverse physicians and nurse practitioners we have in the field." • "Erasing income disparity as the determinant for quality of healthcare is the way to level the playing field."

Focus group participants described feeling intimidated by medical providers and hesitant to seek out medical care due to negative experiences. These community members fear deportation or other consequences associated with their or their family member's immigration status. In addition to costs, participants described that health care services often feel inaccessible because they are not culturally or linguistically appropriate. Focus group participants shared that they faced barriers related to language, noting an insufficient number of Spanish-speaking providers. In addition, they shared experiences where providers refused to find accommodations for patients who needed translation. Participants also mentioned that health care language, including language used on pamphlets or educational materials, is confusing and difficult to understand or apply.

¹⁰ 2019-2020 National Survey of Children's Health. Child and family measures nationwide vs. Texas. Retrieved 1/14/2022 from <https://www.childhealthdata.org/browse/survey/results?q=8632&r=1&r2=45>

In addition, focus groups shared how children and grandchildren often feel pressured to provide interpretation and assist senior populations with complex paperwork, because health care language, including language used on pamphlets or educational materials, is confusing and difficult to understand or apply. Furthermore, participants described how the inability to adapt to the predominant culture or navigate the healthcare system as an immigrant is a source of ongoing stress. Participants noted that many also forego both health care services and other services due to the fear of deportation based on immigration laws.

Specific county-by-county data related to health disparities is included in Appendix D. Some significant Ascension Seton findings related to health disparities include:

- Hispanic and Black populations have much higher incidences of “Preventable Hospital Stays” across the Ascension Seton service area than Texas averages.
- Black populations in the Ascension Seton service area have statistically significantly higher rates of “Childhood Poverty” and “Infant Mortality” than Texas averages.
- Black populations in the Ascension Seton service area also have statistically significantly higher rates of “Premature Death” than Texas averages.
- Hispanic populations in the Ascension Seton service area have statistically significantly higher rates of “Teen Births” than Texas averages.

In Travis County, the Community Advancement Network (CAN) creates a dashboard of 17 socio-economic indicators to track and follow the social and health conditions of Austin and Travis County. Among their findings in the 2020 CAN Dashboard, using data from 2018 in their “Equity Analysis,” the following are noted:

- Black residents are over-represented among those who smoke, those who are obese, and those reporting poor mental health.
- According to Austin Public Health, Black residents also have the highest rates of cardiovascular disease and diabetes—diseases more prevalent among those who are overweight or obese.
- Health disparities by income are even greater than disparities by race or ethnicity for mental health, smoking, and those with no health insurance.
- In Travis County, 26% of all people under the age of 65 who are low-income have no health insurance. This is almost twice the rate overall.
- Hispanics are more likely to be uninsured than people of other races and ethnicities. According to the Texas Behavioral Risk Factor Surveillance System, 23% of Hispanics under the age of 65 are uninsured. Much of the overall increase in the number of people who have health insurance is due to implementation of the Affordable Care Act, which is not available to people who are undocumented.

Spotlight: Differences Between Rural, Urban and Suburban Communities within the Region

The community as defined for this Community Health Needs Assessment is large, encompassing urban, suburban and rural communities and diverse populations within the larger Ascension Seton service area. Many participants in the focus groups remarked on the significant variations in health and social conditions and quantitative data affirm that significant gaps in health and social circumstances exist depending on where a person lives.

Rural, Urban and Suburban Communities
Key Summary Points
• Rural areas often lack or have less physical access to services of all kinds including health clinics, mental and behavioral health services, hospitals, grocery stores, and social service offices. • Personal vehicles are often the only transportation option in rural areas. • Digital infrastructure for the internet is lacking in many rural areas. This has been a persistent issue over the years as the world digitizes, and COVID-19 highlighted the disparities in many ways with the sudden need to access high speed internet at home for work or to access telehealth appointments. • Many rural areas in the Ascension Seton region are experiencing unprecedented growth as the Austin metro area continues to grow. Infrastructure of all kinds in small towns in Central Texas need updates to keep up with growth. • Rural communities operate differently than urban and suburban counties in many ways including community organizing, funding, and resident beliefs. Collaborations with rural communities should take into consideration community norms and engage local leadership.
Meaningful Quotes
• “We spend a lot of time in this [rural] county coaching & educating patients. It’s one of the things there. We try to get down to the personal level with them. We try to take time while we’re on scene with them to help educate them and help them understand (like medications).” • “Financial restrictions are a real challenge. Do people have paid time off? Can they afford to go to the doctor, especially if it means taking a full day off to travel to see someone an hour or more away?” • “Cities like La Grange have just one or two clinics that are just so packed.”

Focus groups and interviewees shared that getting licensed professionals to serve in a rural community is very difficult, especially if there isn't quality infrastructure in place.

Quantitative data analysis showed that rural counties, including Gonzalez, Caldwell, Blanco, Bastrop, Lee, Fayette and Llano have statistically significantly worse experiences on most health indicators than the Texas averages. Conversely, suburban and urban counties, including Williamson, Travis, and Hays) have statistically significantly better health experiences on most indicators than Texas averages. Even so, as noted in the Williamson County Community Health

Assessment¹¹, while rated as a generally healthy county in the County Health Rankings model, there are neighborhoods within the county that tend to have higher-than-average health risks and burdens. These variances are true throughout the Ascension Seton service area that is used as the region for the Community Health Needs Assessment.

Written Comments on Previous CHNA and Implementation Strategy

Ascension Seton's previous CHNA and implementation strategy were made available to the public and open for public comment via the website: <https://healthcare.ascension.org/chna>.

Ascension Seton has received a total of five responses from the public. Of those, one was from a reporter with questions regarding the availability of mental health services in Hays County, Two appeared to be communication errors as the comment section was left blank, and one shared information about a misspelling in the 2019 CHNA report that included Gonzales county. All questions were answered and corrections made in response to these comments.

Data Limitations and Information Gaps

Although it is quite comprehensive, this assessment cannot measure all possible aspects of health and cannot represent every possible population within Ascension Seton. This constraint limits the ability to fully assess all the community's needs.

For this assessment, three types of limitations were identified:

- Some groups of individuals may not have been adequately represented through the community input process. Those groups, for example, may include individuals who are transient, who speak a language other than English, or who are members of the lesbian/gay/bisexual/transgender+ community.
- Secondary data is limited in a number of ways, including timeliness, reach, and descriptive ability with groups as identified above.
- All focus groups and interviews were held virtually due to concerns about COVID-19. The virtual nature of these meetings, held via zoom, may have shaped the interactions and feedback received in a way that differs from in-person meetings.

Despite the data limitations, Ascension Seton is confident of the overarching themes and health needs represented through the assessment data. This is based on the fact that the data collection included multiple methods, both qualitative and quantitative, and engaged the hospital as well as participants from the community.

¹¹ 2022 Williamson County Health Assessment. Published April 2022. Retrieved from: https://www.healthywilliamsoncounty.org/content/sites/wcchd/2022cha/2022WilliamsonTXCHA_FINAL.pdf

Prioritization of Community Needs

Based on the data collected and presented in the previous sections, Ascension Seton Northwest with contracted assistance from Alpinista Consulting, applied a phased prioritization process, described below, to identify the priority needs in the Ascension Seton service area.

The first step was to gather data from a variety of quantitative and qualitative sources to understand the raw data in terms of trends, gaps, perceptions and opinions. Quantitative needs were categorized into groups such as health behaviors, social determinants of health, length of life, quality of life, clinical care, and systemic issues in order to better develop measures and evidence-based interventions that respond to the determined condition.

From there, with guidance from Alpinista consulting, quantitative and qualitative data were reviewed and analyzed through a “validation” process, whereby themes that emerged from the qualitative data gathering process were matched against analysis of trends and stark gaps in key indicators of the County Health Rankings Data (the primary source of the quantitative data). Specifically, Ascension Seton compared themes that emerged from the qualitative data gathering activities to various data “filters” of quantitative data, including: 1) Quantitative indicators of health and social needs that were worse by greater than one standard deviation compared to Texas and/or national indicators, 2) Analysis of trends over time that revealed worsening conditions related to health and social needs, 3) Analysis of significant gaps in health and social indicators among geographies within the service region as well as socio-economic and demographic (including racial and ethnic) indicators.

Next, “sensemaking” teams were convened with internal and external stakeholders to review the validated data and identify, through the lens of impact and alignment with Ascension Seton capacities and strategic priorities, which of the data points, or themes might be appropriate for prioritization. The sensemaking process, completed through a series of six sessions with three internal groups and three external groups, asked participants to consider the identified needs through various criteria, including the following:

- Alignment of problem with Ascension Seton’s strengths, capacities and priorities
- Impact on vulnerable populations
- Importance of problem to the community
- Organizational resources available to address problem

Based on the results of the sensemaking sessions, the CHNA Steering Committee¹² prioritized

¹² The CHNA Steering Committee is comprised of internal leaders Ray Anderson (Chief Strategy Officer), Lauren Baker (VP of Academic Integration & Chief of Staff), Derek Covert (Chief Mission Integration Officer and VP Canonical Affairs), and Kate Henderson (President - Regional Hospitals and Strategic Community Partnerships), and community partners Dr. Jewel Mullen (Associate Dean for Health Equity and Associate Professor, Department of Population Health at The University of Texas), and Dr. Andrew Springer (Associate Professor, Health Promotion and Behavioral Sciences at The University of Texas School of Public Health).



which of the identified needs were most significant

Ascension Seton has selected those needs determined by the CHNA Steering Committee as the prioritized needs to develop a three-year implementation strategy for each of the 12 hospitals in the Ascension Seton network, as well as the six joint ventures in its service area. Although each hospital may address many more needs, the prioritized needs will be at the center of a formal CHNA implementation strategy and corresponding tracking and reporting.

Through the prioritization process for the 2021 CHNA, the prioritized needs are as follows:

- Mental and Behavioral Health
- Access to Care
- Social Determinants of Health/Social Needs
- Health Equity

Ascension Seton understands the importance of all the health needs of the community and is committed to playing an active role in improving the health of the people in the communities it serves. For the purposes of this CHNA, Ascension Seton has chosen to focus its efforts on the priorities listed above.

To view health care facilities and community resources available to address the significant needs, please see Appendix E (page 205).

A description (including data highlights, community challenges & perceptions, and local assets & resources) of each prioritized need is on the following pages.

Mental and Behavioral Health	
Why is it Important?	Data Highlights
The individual and societal benefits of achieving mental wellness are significant. The need for mental health services is high. The economic value of providing appropriate mental health services can be measured in the avoided costs of hospital admissions, emergency department visits, criminal and juvenile justice involvement, homelessness, and more. Providing appropriate mental health services has been shown to reduce lost workdays and improve workplace productivity... access to the right services at the right time offers hope to individuals that they can achieve recovery and live meaningful lives.*	A number of key indicators reveal the significant and growing concerns over mental and behavioral health needs in our region. Over half of the counties in the Ascension Seton service area report a statistically significant average number of “mentally unhealthy days,” higher than the average in Texas, along with higher incidences of suicide and excessive drinking. According to the Behavioral Risk Factor Surveillance System survey (BRFSS), more adults in the Ascension Seton service region report that they have “ever been told you have a form of depression” by a health professional than the average in Texas and in the United States.
Local Assets & Resources	Significant societal events layered on top of the pandemic also impacted mental and behavioral health, resulting in increasing reports of anxiety and depression and suicide especially for young people (e.g., per CDC, emergency room visits for suspected suicide attempts increase by 31% among 12-17 year olds in 2020 compared to 2019), rising reports of challenges associated with isolation, and increasing reports of substance use and abuse (as of June 2020, CDC reported that 13% of Americans reported starting or increasing substance use as a way of coping with stress or emotions related to COVID-19, and overdoses have also spiked since the onset of the pandemic).
• Austin County Integral Care • Bluebonnet Trails • Ascension Seton Shoal Creek • Austin State Hospital • Ascension Seton Psychiatric Emergency Department • Ascension Seton Mind Institute • Grace Grego Maxwell Mental Health Unit at Dell Children’s Medical Center • Texas Children’s Study Center/University of Texas at Austin • Ascension Seton Health Services at Austin ISD • Central Texas Mental Health	
Community Challenges & Perceptions	Individuals Who Are More Vulnerable
• Big service gaps for those who don’t qualify for Local Mental Health Authorities (LMHAs) services and can’t access private pay therapy • Enduring behavioral health workforce shortages across Texas • Few providers with the same linguistic, cultural, and racial identities as those served • Lack of mental health services for an already long standing, chronic challenge exacerbated by increased demand during the COVID-19 pandemic.	• Medicaid-eligible families, since very few therapists or psychiatrists that work outside the LMHA system accept Medicaid payment. • Children and adolescents living in low-resource areas. • Older adults with limited incomes and fewer social networks. • Rural communities with limited access to health facilities coupled with limited broadband access that limits ability to use telehealth services.

*Source: Hogg Foundation 2016 Report *The Texas Mental Health Workforce: Continuing Challenges and Sensible Strategies*

Access to Care	
Why is it Important?	Data Highlights
Together, health insurance, local care options and a trusted and ongoing source of care help to ensure access to health care. Access to care allows individuals to enter the health care system, find care easily and locally, pay for care and get their health needs met.*	Seven of the eleven counties in the Ascension Seton service area are designated a Health Professional Shortage Service Area by the U.S. Health Resources & Services Administration (HRSA) for either primary, mental or dental care. Five of the 11 counties in the Ascension Seton service area have statistically significantly worse ratios of providers to patients for primary care and seven of the 11 counties have worse ratios for mental health care than averages for Texas, which is already worse than average ratios for the United States. A February 2021 report from the Texas Comptroller found that almost 90% of non-Hispanic Whites in Texas have broadband access, compared to 80% of Black Texans and 78% of Hispanic Texans.**
Local Assets & Resources	
• Ascension Seton Adult Hospitals • Dell Children's Medical Center • Ascension Medical Group • St. Davids, HCA, Hospital System • Baylor Scott & White Hospital System • McCarthy Community Health Clinic • People's Community Clinic • Lone Star Circle of Care • Communicare • RediClinics	
Community Challenges & Perceptions	Individuals Who Are More Vulnerable
Community members discussed four concerns related to accessing care: • <i>Transportation</i>: especially in rural counties, health facilities can be far away (50+ miles or more); in other counties, the lack of public transportation was noted as a barrier. • <i>Telemedicine</i>: Telemedicine became more commonplace during the pandemic, but some areas still lack broadband. • <i>Affordability and Insurance</i>: Understanding the systems around and ability to access insurance limits care. • <i>Healthcare System Navigation</i>: Many community members highlighted the complexity of health systems and their need to get assistance from navigators, social workers, case managers and others to get the care they need.	Individuals and families with lower incomes People with lower digital literacy skills and/or no access to devices Persons who live in rural areas People with limited English proficiency Focus group participants noted several sub-populations who experience greater health disparities and barriers to accessing health care. These populations include people who are immigrants, disabled, LGBTQ+, children and older adults.

*Source: County Health Rankings definition of "Access to Care"

**Source: [Comptroller FiscalNotes](#): Broadband Expansion in Texas, published February 2021

Social Determinants of Health/Social Needs	
Why is it Important?	Data Highlights
Social Determinants of Health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship and age. These are important because these conditions have a major impact on a person's health, functioning and quality-of-life. SDOH also contributes to wide health disparities and inequities.*	Many of the counties in the Ascension Seton service area have indicators related to social needs with statistically significantly worse outcomes than averages for Texas, including lower access to exercise opportunities, lower rates of home ownership, very high rates of childhood poverty and low median household incomes, among others. The Central Texas Food Bank notes that more than one in four children in Central Texas is food insecure. The national average is slightly higher than one in five.
Local Assets & Resources	
• Capital Area Food Bank • ECHO • Meals on Wheels Central Texas • Caritas • Refugee Services of Texas • Life Works Street Outreach • Front Steps • Any Baby Can • Foundation for the Homeless • Safe Alliance	Data from the United Way of Greater Austin, who manages the 2-1-1 help hotline, reported that the number one call for help in 2021 was related to food stamps. Help from food pantries was the fifth most requested call. According to its Community Health Assessment, one of its "Key Findings" is that one out of three households in Williamson county, ranked overall as one of the healthiest counties in the state overall, works but cannot afford basic needs. "These households struggle to manage even their most basic needs - housing, food, transportation, childcare, health care, and necessary technology."
Community Challenges & Perceptions	Individuals Who Are More Vulnerable
• Multiple social and structural determinants of health contribute to poor health outcomes in all of the Ascension Seton service area counties. • Related to issues of accessing care, many community members specifically noted transportation and broadband, along with the rising costs of housing and food security as critical needs.	Focus group participants noted several sub-populations who experience greater health disparities and barriers to accessing health care. These populations include people who are immigrants, disabled, LGBTQ+, children and older adults. Individuals who are uninsured People living in geographic areas that have fewer physical resources including health facilities, grocery stores, and public transportation (occurs in both rural and urban settings) Individuals and families with lower incomes

*Source: [Healthy People 2030, Social Determinants of Health](#)

Health Equity	
Why is it Important?	Data Highlights
Gaps in health are large, persistent and increasing. Health equity means increasing opportunities for everyone to live the healthiest life possible, no matter who we are, where we live or how much money we make.*	Significant gaps in health indicators and health outcomes exist in the Ascension Seton service region according to County Health Rankings data, including: • Every county in the service region shows a higher infant mortality rate for Black populations that is worse than the average across Texas • A majority of counties in the service region show substantially worse experiences for Hispanic and Black populations related to indicators of household incomes, childhood poverty and premature deaths • Significant gaps exist in health indicators between populations who live in rural areas versus suburban or urban areas. The 2022 Travis County Community Health Assessment shows Black individuals are overrepresented in the population of people experiencing homelessness. While the overall population has approximately eight percent Black individuals, 37 percent of the people experiencing homelessness in Travis County are Black. The report shows that, “In Travis County, census tracts with higher proportions of the population who are Black/African American have heightened levels of all community-level homelessness risk factors analyzed, lower median income, greater proportion experiencing rent burden and overcrowded rental units, higher eviction rates, higher likelihood of gentrification, and lower percent with health insurance.”¹³
Local Assets & Resources	
• Travis County Health Equity Alliance • Central Health Equity Policy Council • Division of Community Engagement & Health Equity at Dell Medical School • Maternal Health Equity Collaborative • Community Health Champions at Central Health • The Alliance of African American Health in Central Texas • Austin Black Physicians Associations • Latino Healthcare Forum • Austin Community Foundation • Hispanic Health Coalition	
Community Challenges & Perceptions	Individuals Who Are More Vulnerable
• There is a lack of providers who share the same linguistic, cultural and racial identities with the people they serve. • Focus groups also brought up issues of trust, safety and familiarity with providers. • Focus groups identified institutional racism as a driver of health inequities.	Populations with limited English proficiency, immigrants and persons unfamiliar with systems of care available in the Ascension Seton service area Racial and ethnic groups who experience racism and discrimination

* Source: [Robert Wood Johnson Foundation](#)

¹³ Travis County Community Health Assessment. To be published June 2022. To be retrieved at: www.austintexas.gov/communityhealthplan

Summary of Impact from the Previous CHNA Implementation Strategy

An important piece of the three-year CHNA cycle is revisiting the progress made on priority needs set forth in the preceding CHNA. By reviewing the actions taken to address the significant needs and evaluating the impact those actions have made in the community, it is possible to better target resources and efforts during the next CHNA cycle.

Ascension Seton conducted its last CHNAs in 2019. At the time, seven regions comprised the Ascension Seton service area as noted below:

Central Region: Travis County

North Region: Williamson County

East Region: Bastrop, Gonzales, Lee and Fayette Counties

West Region: Burnet, Blanco and Llano Counties

South 1 Region: Hays County

South 2 Region: Caldwell County

The CHNA identified the following prioritized needs in each of the seven regions for FY 2019-FY 2021.

- Mental and behavioral health
- Chronic diseases
- Access to Care

Ascension Seton facilities have worked to address these needs. The information below includes a summary of the impact Ascension Seton has made on these community needs over the past three years.

Ascension Seton operates the primary teaching hospitals where Dell Medical School at The University of Texas at Austin undergraduate and graduate medical students train. Ascension Seton has collaborated on medical resident training as medical students and residents have completed rotations in different specialties at many of the Ascension Seton facilities, including Dell Seton Medical Center at The University of Texas (DSMCUT), Ascension Seton Medical Center Austin, Dell Children's Medical Center, and Ascension Seton Shoal Creek. In addition, research is conducted at multiple Ascension Seton facilities including 42 cardiovascular trials covering the region from Williamson to Kyle. These studies include investigational drugs and devices, post approval devices, as well as investigator-initiated studies. Studies include 216 current patients.

DSMCUT initiated the B-Team, which is a hospital-based consultation service for patients with Opioid Use Disorder (OUD) to establish Medication-Assistance Treatment (MAT). Specifically, the team screens patients, identifies those eligible for MAT, initiates therapies, and facilitates

outpatient follow-up. MAT is an evidence-based intervention that combines medication with psychosocial services including cognitive therapy, counseling and social work. Interprofessional collaboration plays a critical role in the success of this program. Our team of nurses, social workers, physicians, pharmacists, physician assistants and chaplains offer varied and unique perspectives that allow for optimal care. Since establishing the program, DSMCUT has trained over 1,190 physicians to screen for OUD and expanded a continuum of care for just under 300 patients.

Services such as Ascension Contact Center's remote care program have been critical during the COVID-19 pandemic, adjusting to connect with families via zoom, Facetime, and Skype to provide primary and specialty care physicians. Clinicians work with individuals suffering from chronic illness or individuals who are preparing for surgery via telehealth. Navigators tailor each care pathway based on the individual's personal needs. This program has been live for six years.

COVID-19 had significant impacts on the ability of Ascension Seton to engage the community as intended with the strategies developed in 2019. As all in-person screenings, education, and support groups were put on hold, the organization quickly shifted to virtual opportunities for education and support meetings. Ascension Seton has continued to provide perinatal classes weekly, lunch and learns on various topics including chronic disease management, weight management, understanding the different levels of emergency health care offered (telemedicine, urgent care, and emergency care) in the community, and ongoing support groups (Very Important Hearts, Parkinson's, Easy Breathers, etc). Health screenings have also been adjusted to offer appointment times and follow proper COVID-19 safety protocols.

Focus has also been shifted to improve clinical training for mental and behavioral health and substance abuse conditions allowing for improved diagnosis, treatment and referrals.

Written input received from the community and a full evaluation of our efforts to address the significant health needs identified in the 2019 CHNA can be found in Appendix F (*page 218*).

Approval by Ascension Seton Board of Directors

To ensure the Ascension Seton's efforts meet the needs of the community and have a lasting and meaningful impact, the 2021 CHNA was presented to the Ascension Seton Board of Directors for approval and adoption on May 24, 2022. Although an authorized body of the hospital must adopt the CHNA and implementation strategy reports to be compliant with the provisions in the Affordable Care Act, adoption of the CHNA also demonstrates that the board is aware of the findings from the community health needs assessment, endorses the priorities identified, and supports the strategy that has been developed to address prioritized needs.

Conclusion

The purpose of the CHNA process is to develop and document key information on the health and wellbeing of the communities Ascension Seton serves. This report will be used by internal stakeholders, non-profit organizations, government agencies, and other community partners of Ascension Seton's to guide the implementation strategies and community health improvement efforts as required by the Affordable Care Act. The 2021 CHNA will also be made available to the broader community as a useful resource for further health improvement efforts.

Ascension Seton hopes this report offers a meaningful and comprehensive understanding of the most significant needs for residents of Ascension Seton. As a Catholic health ministry, Ascension Seton is dedicated to spiritually centered, holistic care that sustains and improves the health of not only individuals, but the communities it serves. With special attention to those who are poor and vulnerable, we are advocates for a compassionate and just society through our actions and words. Ascension Seton is dedicated to serving patients with compassionate care and medical excellence, making a difference in every life we touch. The hospital values the community's voice and welcomes feedback on this report. Please visit this public website (<https://healthcare.ascension.org/chna>) to submit your comments.

Appendices

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Appendix A: Definitions and Terms

Acute Community Concern

An event or situation which may be severe and sudden in onset, or newly affects a community. This could describe anything from a health crisis (e.g., COVID-19, water poisoning) or environmental events (e.g. hurricane, flood) or other event that suddenly impacts a community. The framework is a defined set of procedures to provide guidance on the impact (current or potential) of an acute community concern.

Source: Ascension Acute Community Concern Assessment Framework

Collaborators

Third-party, external community partners who are working with the hospital to complete the assessment. Collaborators might help shape the process, identify key informants, set the timeline, contribute funds, etc.

Community Focus Groups

Group discussions with selected individuals. A skilled moderator is needed to lead focus group discussions. Members of a focus group can include internal staff, volunteers and the staff of human service and other community organizations, users of health services and members of minority or disadvantaged populations.

Source: CHA Assessing and Addressing Community Need, 2015 Edition II

Community Forums

Meetings that provide opportunities for community members to provide their thoughts on community problems and service needs. Community forums can be targeted towards priority populations.

Community forums require a skilled facilitator.

Source: CHA Assessing and Addressing Community Need, 2015 Edition II

Community Served

A hospital facility may take into account all the relevant facts and circumstances in defining the community it serves. This includes: The geographic area served by the hospital facility; Target populations served, such as children, women, or the aged; and Principal functions, such as a focus on a particular specialty area or targeted disease.

Consultants

Third-party, external entities paid to complete specific deliverables on behalf of the hospital (or coalition/collaborators); alternatively referred to as vendors.

Demographics

Population characteristics of your community. Sources of information may include population size, age structure, racial and ethnic composition, population growth, and density.

Source: CHA Assessing and Addressing Community Need, 2015 Edition II

Identified Need

Health outcomes or related conditions (e.g., social determinants of health) impacting the health status of the community served

Key Stakeholder Interviews

A method of obtaining input from community leaders and public health experts one-on-one. Interviews can be conducted in person or over the telephone. In structured interviews, questions are prepared and standardized prior to the interview to ensure consistent information is solicited on specific topics. In less structured interviews, open-ended questions are asked to elicit a full range of responses. Key informants may include leaders of community organizations, service providers, and elected officials. Individuals with

a special knowledge or expertise in public health may include representatives from your state or local health department, faculty from schools of public health, and providers with a background in public health. See Section V for a list of potential interviewees. Could also be referred to as Stakeholder Interviews.

Source: CHA Assessing and Addressing Community Need, 2015 Edition II

Medically Underserved Populations

Medically Underserved Populations include populations experiencing health disparities or that are at risk of not receiving adequate medical care because of being uninsured or underinsured, or due to geographic, language, financial, or other barriers. Populations with language barriers include those with limited English proficiency. Medically underserved populations also include those living within a hospital facility's service area but not receiving adequate medical care from the facility because of cost, transportation difficulties, stigma, or other barriers.

Source:

<https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospitalorganizations-section-501r3>

Prioritized Need

Significant needs which have been selected by the hospital to address through the CHNA implementation strategy

Significant Need

Identified needs which have been deemed most significant to address based on established criteria and/or prioritization methods

Surveys

Used to collect information from community members, stakeholders, providers, and public health experts for the purpose of understanding community perception of needs. Surveys can be administered in person, over the telephone, or using a web-based program. Surveys can consist of both forced-choice and open-ended questions.

Source: CHA Assessing and Addressing Community Need, 2015 Edition II

Underinsured

A person whose health coverage is inadequate for various reasons including experiencing a gap in coverage in the prior year or high out-of-pocket costs and deductibles

Appendix B: Community Demographic Data and Sources

The tables below provide a description of the community's demographics. The description of the importance of the data is largely drawn from the County Health Rankings and Roadmaps website.

Population

Why it is important: Knowing who lives in the community can inform decisions about the challenges and opportunities to ensure all community members have the opportunity to be healthy.

Population	Ascension Seton	Texas	United States	Description
Total Population	2,256,426	28,995,881	328,239,523	Resident population, 2019
Population Change 2010 - 2019	+28%	+16%	+7%	Calculated using ACS 5-year Estimates for total population in 2010 and 2019
Rural	13.5%	15.3%	19.3%	Percentage of population living in a rural area, 2010
Female	49.9%	50.3%	50.8%	Percentage of population that is female according to the Census, 2019
Male	50.1%	49.7%	49.2%	Percentage of population that is male according to the Census, 2019
<i>Data sources:</i> Total Population, M/F: American Community Survey 5-year estimate 2019, Table DP05 Population Change 2010 - 2019: Calculated from American Community Survey 5-year estimates 2010 and 2019, Table DP05 Rural: County Health Rankings pulled 2020, Census Estimates from 2010				

Population by Race or Ethnicity

Why it is important: The race and ethnicity composition of a population is important in understanding the cultural context of a community. The information can also be used to better identify and understand health disparities.

Race/Ethnicity	Ascension Seton	Texas	United States	Description
White	76.6%	74.0%	72.5%	Percentage of population that is non-Hispanic White, 2019
Hispanic	31.9%	39.3%	18.4%	Percentage of population that is Hispanic, 2019
Black	7.1%	12.1%	12.7%	Percentage of population that is non-Hispanic Black, 2019
Some Other Race	6.7%	5.8%	4.9%	Percentage of population that is non-Hispanic and Some Other Race than those listed, 2019
Asian	5.6%	4.8%	5.5%	Percentage of population that is non-Hispanic Asian, 2019
Two or More Races	3.4%	2.7%	3.3%	Percentage of population that is non-Hispanic and Two or More Races, 2019
American Indian & Alaska Native	0.5%	0.5%	0.8%	Percentage of population that is non-Hispanic American Indian & Alaska Native, 2019

Native Hawaiian & Pacific Islander	0.1%	0.1%	0.2%	Percentage of population that is non-Hispanic Native Hawaiian & Pacific Islander, 2019
<i>Data source: American Community Survey 5-year Estimate 2019, Table DP05</i>				

Language

Why it is important: The languages spoken in the community are important in understanding the cultural context of a community. The information can also be used to better identify and understand health access needs.

Language	Ascension Seton	Texas	United States	Description
English Proficiency	9.4%	13.7%	8.4%	Population 5 years and over who speak a language other than English at home who speak English "less than very well". Census, 5 year estimate 2019
Spanish	7.3%	11.6%	12.3%	Percent of the population over 5 years old who speak Spanish at home and speak English "less than very well". Census, 5 year estimate 2019
Asian and Pacific Islander Languages	1.2%	1.3%	1.6%	Percent of the population over 5 years old who speak Asian and Pacific Islander languages at home and speak English "less than very well". Census, 5 year estimate 2019
Other Indo-European Languages	0.6%	0.6%	1.1%	Percent of the population over 5 years old who speak other Indo-European languages at home and speak English "less than very well". Census, 5 year estimate 2019
<i>Data source: American Community Survey 5-year Estimate 2019, Table DP02</i>				

Population by Age

Why it is important: The age structure of a population is important in planning for the future of a community, particularly for schools, community centers, healthcare and child care. A population with more youths will have greater education needs and child care needs, while an older population may have greater healthcare needs.

Ages	Ascension Seton	Texas	United States	Description
Median Age	35.2	34.6	38.1	The age which half the people are younger than this and half are older, 2019
Under 18	23.2%	25.5%	22.2%	Percent population below 18 years of age, 2019
65+	11.3%	12.9%	16.5%	Percent population ages 65 and over, 2019
<i>Data source: American Community Survey 5-year Estimate 2019, Table DP05</i>				

Income

Why it is important: Median household income and the percentage of children living in poverty, which can compromise physical and mental health, are well-recognized indicators. People with higher incomes tend to live longer than people with lower incomes. In addition to affecting access to health insurance, income affects access to healthy choices, safe housing, safe neighborhoods and quality schools. Chronic stress related to not having enough money can have an impact on mental and physical health. ALICE, an acronym for Asset Limited, Income Constrained, Employed, are households that earn more than the U.S. poverty level, but less than the basic cost of living for the county. Combined, the number of poverty and ALICE households equals the total population struggling to afford basic needs.

Income	Ascension Seton	Texas	United States	Description
Median Household Income	\$75,624	\$64,044	\$61,900	The income where half of households in a county earn more and half of households earn less.
Per Capita Income	\$39,292	\$31,277	\$34,103	Per capita income and benefits in inflation-adjusted dollars, 2019. Calculated as a weighted average using total population of counties in Ascension Seton region.
Poverty	11%	15%	13%	Percentage of population living below the Federal Poverty Line, 2019 (ACS 5-year est)
ALICE Households	29%	30%	29%	Asset Limited, Income Constrained, Employed households, 2018 (https://www.unitedforalice.org/)
Data sources: Median Household Income: County Health Rankings, 2021 - obtained from Small Area Population Estimates, 2019 Per Capita Income: American Community Survey 5-year Estimate 2019, Table DP03 Poverty: American Community Survey Table S1701, 2019 ALICE Households: Asset Limited, Income Constrained, Employed. United for ALICE. 2018. Obtained from UnitedforALICE.org				

Education

Why is it important: There is a strong relationship between health, lifespan and education. In general, as income increases, so does lifespan. The relationship between more schooling, higher income, job opportunities (e.g., pay, safe work environment) and social support, help create opportunities for healthier choices.

Education	Ascension Seton	Texas	United States	Description
High School Completion	90%	84%	88%	Percentage of adults ages 25 and over with a high school diploma or equivalent.
Bachelor's Degree or Higher	43%	30%	32%	Percentage of adults ages 25 and over with a Bachelor's degree or higher.
Data source: American Community Survey 5-year Estimate 2019, Table DP02				

Insured/Uninsured

Why it is important: Lack of health insurance can have serious health consequences due to lack of preventive care and delays in care that can lead to serious illness or other health problems.

Education	Ascension Seton	Texas	United States	Description
Uninsured	15.2%	19.9%	10.4%	Percentage of population under age 65 without health insurance.
<i>Data source: County Health Rankings, 2021. Obtained from Small Area Health Insurance Estimates, 2018.</i>				

Appendix C: Community Input Data and Sources

Focus Groups

Focus Groups	Description of Participants	Organizations & Sectors Represented	Number of Participants	Number of Focus Groups
Blanco, Burnet, Llano Counties	Public health nurse; Executive director of a chamber of commerce; EMS responder	Health Department; Chamber of commerce; County EMS	3	2
Fayette, Gonzalez, Lee Counties	School district nurse; Executive director of a large multi-county mental & behavioral health agency; Advanced practice community nurse; Community outreach & navigator for Medicaid plans	School District; Mental & behavioral health system; Community health provider & university education; Medicaid enroller	4	2
Children's Health	Executive director for a children's data sharing & analysis organization; Administrator & case manager for foster youth-serving organization; Outreach manager for organization focused on missing children; Administrator for Child Protective Services; COO for a children's healthcare respite organization; School nurse; CEO at children's wraparound service & advocacy agency	Data sharing and coordination organization; School district; Foster youth serving organization; CPS; Healthcare respite & families with medically fragile children; youth services & advocacy agency	7	2
All Counties	School health director at a school district; Community health worker; Executive Director for a foster youth serving organization; Director for a county indigent healthcare system; Community relations & outreach coordinator at a large health system	School district; Health system (x2); Foster youth service organization; County indigent care program	5	2
Internal	MPH student in healthcare	Children's hospital (x2);	9	2

	system community benefit; Injury prevention coordinator at children's hospital; Child abuse resource educator and coordinator at children's hospital; Injury prevention coordinator at hospital; Healthcare system external affairs officer; Healthcare system community development coordinator; Communications coordinator for a rural hospital; Language services provider for healthcare system & hospitals; Healthcare system community benefit & investments coordinator;	Major hospital; Health system administration (x4); Rural hospital; Central healthcare navigation services		
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Summary of Focus Groups

A series of 19 focus groups with approximately 100 participants were conducted by Alpinista Consulting to gather input from community members in the following counties: Burnet, Llano, Blanco, Fayette, Lee and Gonzales, along with Travis and Williamson for focus groups that focused on children's needs. Summaries of focus groups conducted by Alpinista Consulting are below.

Fayette, Lee and Gonzales Counties

The high level themes presented below are especially representative of the focus group discussions from this county cluster. The focus group participants for this group were particularly knowledgeable about the behavioral health dynamics across the region, so many sub-themes described under the Mental and Behavioral Health theme were articulated during these focus groups.

Assets

- Lee County has a program designed to reduce the crisis/acute response burden on Emergency Medical Services by having Advanced Practice Nurses trained in acute/crisis response that respond to calls (on-site/in-home)
- There is also a nurse training program in Lee that's coordinated with Texas A&M University College of Nursing with the focus on recruiting and retaining more nurses in rural counties.
- In rural counties, the school nurses often become hubs of information, service provision, health knowledge, and relationship/network building.

- Local networks tend to be strong, reliable, and functional ways to get things done - for instance, informal collaborations between the local pharmacies and school districts to get immunizations distributed
- In Gonzales County, the Hispanic Professionals Association is an organization that reaches across racial and cultural lines to coordinate resources in the region

Unique Challenges & Potential Solutions

- Older Adult Health: There are many retirees moving to Fayette county in particular. This is affecting both housing costs, as demand is increasing in a limited market, and healthcare services as there are not many providers or agencies dedicated to older adult health. Some concern was expressed about the long term implications of this as people who might be healthy in the short term continue to age and put pressure on the health services in the county.
- Provider Isolation: With such a rural and geographically dispersed region, providers are isolated from each other and therefore have to mostly be self-sufficient in their practice. This was expressed as a desire for more inter-professional learning rather than a critical challenge.

Burnet, Llano and Blanco Counties

The emphasis on population growth and the pressure that places on communities and public services infrastructure was acutely discussed by the participants from this cluster of counties. These counties may be a few years ahead of the surrounding region when it comes to facing these challenges - it is easy to imagine the east-side counties like Fayette, Lee, and Gonzales may also start noticing the challenges that come with unplanned growth.

Access to care, especially acute care, is tricky in these counties since they are geographically far from services. This means that provider choice is quite limited as well.

Reliable internet can be hard to get in these areas, so telehealth has been less than optimal.

The significant population of older adults means that there is high demand for in-home care, but not enough providers in the communities to serve the need.

Assets

- Sense of Community: There is a strong set of connections that exist in these communities that promotes belonging, health, and active involvement. It also means people show up for each other. This is accentuated by the presence of many spaces in the community that people convene at - from Gem of the Hills and the community resource centers to the music & event venues and the state parks.
- Use of Alternative Modes of Care to Increase Access: Whether this is an asset or a creative response to the need, people rely on unconventional forms of care. This was most creatively expressed in the wide ranging prevention & wellness work done by the EMS.

Unique Challenges and Solutions

- **Prevention:** The EMS participant in particular spoke about the need for prevention programs - for instance around strokes, falls, etc. They end up doing a lot of education and support (like picking up tripping hazards) when onsite with people who may call 911 in response to a fall. They also are developing a community paramedic program that should help meet less acute needs and preserve the availability of the ambulance for more severe emergencies. The geographic area that EMS needs to cover means that they can get stuck far from both the hospital and other calls.
- **Internet:** Coverage is spotty and unreliable in the region. Investment in better internet services is expensive and seems necessary not just from a telehealth perspective, but also simply due to the number of people moving to these counties who are likely to have jobs that enable some amount of remote work possibility.

Children's Health

The participants of the children's health focus groups represented two (or three) distinct points of view: People who work more closely with children in vulnerable situations and know about the social service ecosystem for young people and then people like school nurses or WIC staff whose experience and perspective is more about the general health of children and families.

When it comes to children in vulnerable situations, the themes that stand out most involve access to quality care that is trauma-informed and culturally responsive as well as coordination among and between service providers. There aren't many providers or practitioners who have the skill or experience necessary to work restoratively with young people who have experienced significant trauma. Housing for young people in these situations (with particularly complex needs) is also nearly unavailable, with many of the service providers describing young people staying at offices with no other place to go and be safe. Age-related eligibility criteria often means young people lose contact with secure, stable conditions or resources at a particularly vulnerable time in their lives (early adulthood). This is exacerbated by the difficulty in getting current organizations to coordinate successfully.

For children and family health more generally, the themes that stood out were related to mental health (increased need with little skill, training, or specialized experience to feel confident helping - this is especially true among the school nurses), obesity & access to quality food, housing insecurity and affordability puts pressures on families that may result in overall stress for children, an absence of quality child care options, and then specific needs around things like immunizations and cross cultural communication. Provider isolation is also a real challenge, especially for school nurses who might be the only healthcare professional in their setting or in the entire community.

Assets

Vulnerable Children:

- **Spirit of Cooperation:** Even though coordination is difficult, there seems to be a commitment to cooperating and figuring things out. This seems to be more difficult in the urban areas around Austin where the sheer number of service providers can be overwhelming. In the other counties, the networks seem to be closer and practitioners and service providers know where to go for support or help.

- **Technology Investment:** There are some growing efforts to invest in technology to help with the coordination challenges. Things like Aunt Bertha and other referral systems are meant to help young people stay connected to services across the different qualification thresholds they pass through.
- **Trauma-informed Care:** The providers and practitioners are all aware of the need for trauma-informed care and are doing what they can to provide it.

General Children & Family Health:

- **Schools:** The schools themselves are an important contributor to many of the counties and communities. They are a site of interaction, belonging, and connection.
- **Practitioners:** Many of the direct practitioners we talked with are deeply committed to their work. Whether that is someone in WIC who knows about the diverse needs of different families and speak in multiple forms of Spanish to communicate with them successfully or the school nurses who are trying to bring in professional development for other educators and teachers at their schools around mental health, preventing online abuse, and other complex health needs or who coordinate with the local pharmacies to set-up expanded vaccination programs.

Unique Challenges and Solutions

Vulnerable Children:

- **Age-related Transitions:** Young people who age out of services are often left without the critical stability and security they were able to develop through certain services and systems.
- **Policies:** Some policies at the state level mean that Texas simply does not have enough beds for foster youth with complex needs who need shelter and they are no longer placed in homes, so they sleep in provider offices or elsewhere.

General Children & Family Health:

- **Immunizations:** One of the more specific things that was mentioned by all the school nurses was the difficulty ensuring all incoming 7th graders have their state mandated immunizations. They are not allowed to even start school without them, and so every year there's a big effort for the first 1-2 weeks to get the kids vaccinated. This can be especially hard on families who may need to work and for whom English is not their primary language - so understanding what's required can be difficult to communicate successfully.
- **Obesity & Diabetes:** Many of the school nurses mentioned obesity as a particularly acute challenge in their districts. The reasons for this are complex, but many lamented the inability of the schools to provide at least one healthy meal a day.
- **Goodside Health:** This is a telehealth provider specifically for schools and seems to be a very good option to provide more comprehensive care to children on-call and in the context of their day. They also have mental health counselors available.
- **Early Childhood Health:** There isn't much data available on early childhood health, though there's an understanding of how important things like maternal and prenatal care, pre-K and head start programs, and things like childcare are to the long term health and wellbeing of the region.



Ascension Seton also received feedback from community members in Bastrop, Caldwell, Hays and Williamson counties from the Texas Health Institute (THI) through a partnership agreement with hospital partner St. David's Foundation. Reports from focus groups from each county are attached in the next pages.

COMMUNITY INPUT SUMMARY REPORT:

Bastrop County 2021-22 Community Health Needs Assessment



(I) Bastrop County 2021-22 Community Health Needs Assessment

ABOUT TEXAS HEALTH INSTITUTE

Texas Health Institute is a nonprofit, nonpartisan public health institute with the mission of advancing the health of all. Since 1964, we have served as a trusted, leading voice on public health and health care issues in Texas and the nation. Our expertise, strategies, and nimble approach makes us an integral and essential partner in driving systems change. We work across and within sectors to lead collaborative efforts and facilitate connections to foster systems that provide the opportunity for everyone to lead a healthy life. For more information, visit texashealthinstitute.org and follow us on Twitter, Facebook, and LinkedIn.

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THI

SDF	St. David's Foundation
AAPI	Asian American Pacific Islander
CHNA	Community Health Needs Assessments
CBO	Community-Based Organizations
ACE	Adverse Childhood Experience
CARTS	Capitol Area Rural Transportation System

BACKGROUND AND METHODS

As part of a collaboration of local hospital systems, St. David's Foundation (SDF) contracted with Texas Health Institute (THI) to conduct the qualitative research for the 2021-22 Community Health Needs Assessments (CHNAs) in Bastrop, Caldwell, Hays, and Williamson counties. The qualitative research and report are designed to meet the community input requirements of a CHNA for 501(c)(3) hospitals under the Affordable Care Act. As part of the CHNAs, THI staff used key informant interviews and focus groups to explore critical health issues in the four counties and how these issues are affected by COVID-19, structural factors, underlying causes, and community assets.

In addition to SDF, Ascension Seton and Georgetown Health were key collaborators in the Bastrop County CHNA process. Each of the collaborating organizations will also be using this summary report to support the development of their respective CHNAs.

METHODS

Between August and October 2021, THI virtually conducted eight key informant interviews and three community focus groups in Bastrop County. In addition, THI virtually conducted one targeted Photovoice project and associated discussion session.

A THI staff member served as the facilitator for all virtual interviews and focus groups. Audio recordings of the sessions were automatically transcribed using Otter.ai, and staff verified and cleaned transcripts for accuracy. Transcripts were coded and analyzed using Atlas.ti qualitative software.

Key Informant Interviews

SDF and other collaborating organizations helped identify potential Bastrop County key informants based on their leadership roles and experience working with medically underserved, low-income, and minority populations served by the hospital system. THI contacted and recruited key informants via email with an explanation of the project. The key informants for this project ([Table 1](#)) included representatives from health care organizations, community-based organizations (CBOs), and local government.

The key informant interview guide for organizational leaders covered critical health issues in the county, the impact of COVID-19 on these issues, structural factors that contribute to the critical health issues, assets and strengths of the community, and possible solutions ([Appendix A](#)). Each key informant interview lasted one hour.

Focus Groups

For the focus groups, THI worked collaboratively with Bastrop County Cares to identify individuals that represented or served low-income, medically underserved, and minority residents of Bastrop County. Bastrop County Cares initially notified community members about the community focus groups and the overall purpose of the CHNA. Prior to working with Bastrop County Cares, THI unsuccessfully reached out to a number of other agencies and organizations in the County regarding recruitment for the community focus groups ([Limitations](#)).

After community members expressed an interest in participating, THI coordinated with the participants to arrange meeting details. Each focus group participant self-identified as part of a medically underserved, low income, or minority population; as a person with chronic disease needs; or as someone who served this population ([Table 2](#)). Upon the conclusion of each focus group, THI compensated participants with a \$25 electronic gift card to a store of their choice.

The focus group guide covered participants' health concerns, underlying root causes of health issues that they see in their communities, community assets, proposed solutions, and specific strategies for addressing critical health needs ([Appendix B](#)). Community focus groups lasted approximately 75-90 minutes each.

Photovoice and Discussion

The Photovoice project and associated focus group consisted of participants recruited through the same processes as community focus group participants. THI worked specifically with a youth ministry leader at Ascension Catholic Church to identify youth interested in participating; participants were required to provide a signed parental consent form and received a \$50 electronic gift card after completion of the project.

The Photovoice project involved two sessions, starting with a 30-minute virtual training for youth participants ages 14-18. The facilitator asked participants to take and submit five photos—without faces or names—that represent factors that make it easy or difficult to be healthy in their community. Participants were encouraged to submit any photos they felt represented the prompt, including staged or candid photos, indoor or outdoor settings, and photos taken anywhere in their community (e.g., at home, school, church, work, etc.).

Approximately one week after the initial session, participants attended a 90-minute virtual discussion session during which the facilitator displayed photos via screenshare on Zoom. Participants discussed each other's photos and experiences using these prompt questions:

- What do you see?
- How does it make you feel?
- Why does this condition exist?

- What are some things that can be done about this condition, especially by local hospital systems?

HEALTH EQUITY

THI applied a health equity lens to the focus groups and key informant interviews. This was done by incorporating specific questions into the interview guides, including the following:

Key informant interview guide:

- Who do the top most critical health issues affect the most? (e.g., age groups, racial and ethnic groups, socioeconomic groups, geographic subsets, etc.)
- What factors contribute to the critical health issues?
- How does the critical health issue identified specifically impact low-income, underserved, or uninsured populations?
- What are some of the community's greatest strengths and assets? How could these be leveraged to address the health issues identified?
- What are your suggestions for ways to engage and build trust with community members, particularly low-income, underserved populations, ethnic and racial minorities, and limited English proficient residents to address the critical health issues of the county?

Focus group guide:

- What makes it easy or difficult to be healthy in your community and what factors, such as racism or discrimination, impact your ability to be healthy?
- Are there health services that you need but do not receive currently?
- What are some resources in the community that seem to be working to address health-related issues?

Additionally, THI used the following reflective questions to frame the analysis of the transcripts in order to draw out considerations of health equity:

- Who is disproportionately affected and impacted by critical health issues and by potential solutions?
- Who is included and excluded?
- What are the root causes and causal factors contributing to the community health needs?
- Are there assumptions taking place? If so, what are they?
- Who is potentially benefiting and who is being harmed?
- What are the interviews and focus groups telling us about what data might be missing? About who is and is not at the decision-making table?
- What changes are needed and what could be done differently?

THEMES

Among the focus groups and key informant interviews, three primary thematic categories emerged. The order presented below does not indicate priority or frequency of needs.

- Access to health care
- Structural and social determinants of health
- Priority health needs

In all interview contexts, participants identified barriers within the health care system that inhibit their ability to receive accessible, affordable, and culturally appropriate care, including specialty services and care for more complex health conditions. The participants also identified various social and structural barriers community members face that impact their wellness. Finally, critical health needs emerged as participants described the most commonly occurring chronic illnesses present in Bastrop County.

ACCESS TO HEALTH CARE

Key informants and focus group participants identified several factors that prevent access to health care in Bastrop County including affordability of health care, provider shortages for residents who are either publicly insured or uninsured, and lack of culturally and linguistically appropriate care.

Affordability of Health Care

Participants frequently mentioned the barrier of affordability of health care. This includes low-income, underserved, and minority residents not seeking treatment because they are unaware of where to access affordable care. Participants indicated that low-income families struggle to pay for medication, food, and transportation. One key informant mentioned that in the Hispanic/Latinx community, particularly among immigrants, people cannot afford to take time off work if they do not have full-time benefits or health insurance.

“Folks trust when they feel like they can afford the services ... They want to be able to afford services that brings them back again ... when they know that they're going to be able to pay, and therefore that it's sliding scale or no cost.”

– Key Informant

Sub-themes:

- Many community members travel distances of 20 or more miles to access affordable health care.
- Many community members—with or without insurance—are not able to afford medications, especially diabetes medication.
- Uninsured or underinsured community members often avoid preventive care due to cost.
- Dental care is expensive and many community members have significant dental needs but do not have dental insurance.

Primary and Specialty Care for Publicly Insured or Uninsured

“There's only a few groups that take Medicare. That is a huge barrier for folks, especially if you don't want to go to your federally qualified clinic, and you'd like to have a private physician.”

– Key Informant

Participants noted one of the significant barriers to accessing care in Bastrop County is the lack of primary and specialty care providers that accept public insurance. For example, few primary care or specialty care providers accept Medicare. In addition, since many county residents do not have a primary care physician, they tend to over-utilize emergency rooms for minor health issues. Participants also indicated that certain specialty care appointments are limited to specific days of the week.

Some Elgin residents travel to Smithville, Round Rock, Austin, College Station, Bryan, or Kyle to receive primary care services, care for more complex health conditions, or specialty care services, including for cardiology, obstetrics and gynecology, endocrinology, or pediatric care. Furthermore, the Bastrop County Indigent Health Care Program does not pay for specialty care if it is not available within the county. Additionally, focus group participants recalled difficulty in locating local mental health providers such as psychiatrists or psychologists who accept insurance to provide mental health care.

“Medical Access Program is paid for by Travis County, so the people from Bastrop County don't qualify. There are people who sometimes say they use the address of someone who lives in Austin to use that resource, because Bastrop doesn't have anything like it.”

– Key Informant

Sub-themes:

- There are not enough options for primary care; consequently, many community members will use the emergency room for minor health issues.
- Participants described needing care for more complex health conditions, including obstetrics and gynecology, pediatrics, endocrinology, cardiology, and dental care.
- Due to the unavailability of the Medical Access Program, a health coverage program for low-income residents, some Bastrop County residents falsify address information to receive MAP benefits from Travis County.
- Many community members travel to Austin or Round Rock to receive specialty care or primary care at Baylor Scott & White, St. David's Hospital in Austin, Ascension Seton in Austin, or other free or low-cost clinics.
- Key informants noted that existing physicians in Bastrop County, particularly those serving publicly insured and uninsured, manage an overwhelming caseload.

Culturally and Linguistically Appropriate Care

“People don't feel comfortable with their medical providers, and they don't trust them, because they don't have enough medical providers that look like them, nor speak their native language.”

– Focus Group Participant

Participants described that health care services often feel inaccessible, because they are not culturally or linguistically appropriate. Key informants and focus group participants shared barriers regarding the lack of health care workforce diversity and language, noting an insufficient number of Black/African American or Spanish-speaking providers.

Despite the growing population of Hispanic/Latinx residents in Stony Point and on the far southwestern edge of the county, there are limited services for those who speak Spanish. For example, Hispanic/Latinx populations in Bastrop County often encounter language barriers due to the lack of interpreters and translated material. Furthermore, participants noted that many people also forego both health care services and other services due to a lack of awareness of available resources and the fear of deportation based on immigration laws.

“She was the only black person when she walked [into the COVID vaccine clinic], and there was no black doctor, no black nurse, no one that was of color doing the reading or doing the intake. She immediately felt uncomfortable and decided not to get the COVID shot today. Representation is very, very important.”

– Key Informant

Sub-themes:

- Providers often do not understand the needs or cultural priorities of Black/African American, Hispanic/Latinx, or other minority communities and therefore prescribe treatment that is not accommodating or appropriate.
- There are not enough Black/African American physicians, psychiatrists, therapists, or fitness professionals in Bastrop County.
- Immigrant communities distrust health care providers, fearing deportation or risks to their citizenship process.
- Many community members are not proficient in speaking or reading English but most health care information and services are only in English.

“Some people may speak Spanish, but they may not be able to read it. [Or] Spanish is their second language. Maybe they speak an indigenous language, and then they speak Spanish and so on. Don't assume that just because the materials are translated into Spanish, that somebody can read them or fill them out.”

– Key Informant

SOCIAL AND STRUCTURAL DETERMINANTS OF HEALTH

Multiple compounding social and structural determinants of health cause poor health outcomes for Bastrop County residents. Key informants and focus group participants noted several factors that affect health outcomes including housing and homelessness, lack of transportation, food insecurity, limited broadband or internet access, and racism and discrimination.

Housing and Homelessness

Key informants and focus group participants revealed the lack of affordable housing available within the county is one of the most complicated issues for the community. The two public housing authorities within the county have long waiting lists. In addition, some populations experience poor housing conditions. For example, a high number of Hispanic/Latinx immigrants often live in overcrowded conditions, in homes or apartments with limited plumbing or no access to sewer systems. In addition, low-income seniors are in need of housing repairs to make their homes safer.

Furthermore, there is a growing population of homeless individuals with untreated mental health issues in Bastrop County. Participants noted that one of the biggest barriers among homeless populations is the inability to obtain proper identification documents. Lack of such documentation prohibits homeless individuals from receiving free or reduced price health care,

SNAP benefits, or any other services. One key informant mentioned that Black/African American residents are disproportionately impacted by homelessness in Elgin.

“It's just not affordable. I mean, you know, \$1,500, \$2000, \$2,500 a month is just not affordable for a low-income family. Then, the lack of Section 8 housing or housing authorities.... There's always waiting lists.... There's never enough to help people. I think when people don't have stable housing, maybe it's hard for them to have stable employment. Those kind of things all tie together.”

– Key Informant

Sub-themes:

- Population growth due to gentrification and the recent influx of Travis County residents in search of lower housing costs has caused housing costs to skyrocket in Bastrop County, making the current costs of living unaffordable for many long-time residents.
- Residents seeking housing vouchers experience long waitlists.
- Living in inadequate or dilapidated housing leads to multiple physical health and mental health issues.
- Homeless populations are often excluded from health care services or other social services due to the lack of proper identification.

Transportation

“If you don't have a vehicle, you're either trying to go on CARTS [Capitol Area Rural Transportation System]—which means you're going to spend a whole day for maybe a 30- or 40-minute appointment, because then you're on their transportation schedule—or you're having to pay somebody gas money to take you. You're never really on your own schedule. You're on someone else's schedule. There is usually some financial cost, even with CARTS. That means you're going to have to spend money eating or meeting your needs in the city for your one little doctor's appointment. It just has a ripple effect. It's other things people don't really think about if they don't have to experience them themselves.”

– Focus Group Participant

Participants frequently mentioned transportation as one of the leading structural barriers to health in Bastrop County. Community members expressed that transportation is an issue to attend doctor's appointments or visit grocery stores, as many residents often have to travel 20

miles to access those services. Despite having CARTS, Bastrop County residents still have difficulty navigating the complex transportation system, especially low-income residents and seniors. Even when residents have personal vehicles, the lack of money for gas prevents some from accessing primary care, specialty health care, or pharmacy visits.

Sub-themes:

- The lack of public transportation services inhibits people’s ability to get to grocery stores and health care appointments.
- For residents in Eglin or Stony Point, most grocery stores, doctors’ offices, and pharmacies are located 20 miles away (in Austin, Smithville, or the City of Bastrop), limiting many residents’ access to services due to the lack of public transportation options.
- There are several rural and isolated neighborhoods in Bastrop County, and many of them have a higher proportion of Hispanic/Latinx and senior residents.

Food Insecurity

“Some of the rural areas in Bastrop County, they probably have to drive 20 or 30 miles to even get to a grocery store. Then, when they get there, they don't have the money to buy the healthy things.”

– Key Informant

Participants mentioned inaccessibility of healthy food as a significant barrier to health, particularly the high costs of healthy food and the long distances traveled to access it. Residents noted that the unaffordability of healthy food affects residents’ ability to stay healthy. One key informant expressed that working families often have many challenges finding the time and resources to prepare healthy meals. When discussing options for people to access free or affordable food, such as food pantries, one key informant said, “We have a great food bank in Bastrop County, but they can’t get to everybody all the time.”

“People are kind of also in panic because there's been word of a food shortage going on. The price of groceries is going up.”

– Key Informant

Sub-themes:

- Transportation barriers directly affect food insecurity because many community members do not have the means to drive to grocery stores.
- Some rural areas of Bastrop County—such as Red Rock or Cedar Creek—are considered food deserts, disproportionately impacting Hispanic/Latinx and senior populations.
- There is a generational cycle of food insecurity. Multigenerational families seek emergency food from food pantries.

- The marketing and frequent promotion of unhealthy foods such as chips, candy and sweets creates an environment that makes it challenging to resist. This is particularly true among youth.

Broadband or Internet Access

Participants described the barriers associated with lack of access to broadband or internet services, particularly for seniors, families in more rural areas of Bastrop County, and homeless populations. Some seniors do not have access to computers and may be less comfortable using technology. Families residing in more rural areas of Bastrop County frequently do not have access to the internet or social media, which limits their awareness about available health care services or community events and creates a barrier to participation in telehealth appointments.

In addition, when schools transitioned to remote learning amid the pandemic, many students were not able to participate or submit homework assignments due to having no internet services. Participants noted that lack of internet access and computer literacy, particularly not having an email address, was a barrier to COVID-19 vaccine access.

“We tried to do a whole lot more telehealth for our folks. That was limited, mostly by the lack of internet accessibility. We were limited in a lot of areas just to phone conversations rather than actual tele-video. In Bastrop County, there's a lot of dead spots. Even with the phone, there's a lot of dead spots.”

– Key Informant

Sub-themes:

- Bastrop County residents who lack access to a computer are unable to participate in virtual doctor's appointments, limiting their access to health care.
- Senior populations in Bastrop County may lack computer literacy.
- Remote areas of Bastrop County often have poor internet access and Wi-Fi connectivity.

“People over 65 or people who had disabilities had so much trouble getting the vaccines, because the signup process was online through the internet and they didn't have email accounts.”

– Key Informant

Racism and Discrimination

Community participants also referenced challenges with racism and discrimination in Bastrop County. Participants mentioned witnessing racism in county hearings related to the symbolism

and removal of Confederate monuments and the hesitation of some residents to drive into Bastrop County due to experiences of being racially profiled and targeted by the county sheriff.

“We've been going through what people would call the second civil rights movement where some people are just uncomfortable when they don't see other people that look like them in the room. You often question: ‘Am I going to be treated differently? Am I going to be treated the same as everyone else?’ That is in the back of some individuals’ minds. We've even had people make comments about how the Black community unfortunately is really working in silos.”

– Key Informant

Participants noted that during the previous political administration, immigrant populations in Bastrop County became so fearful of U.S. Immigration and Customs Enforcement (ICE) seizures and possible deportations that many essentially went into hiding, and it was difficult for community organizations to reach them with information on available resources. Spanish-speaking focus group participants described feeling intimidated by medical providers and hesitant to seek out medical care due to negative experiences. These community members fear deportation or other consequences associated with their or their family member’s immigration status.

“It’s things other people don’t understand. It’s another thing for the same government or hospitals to try to intimidate you. Just a little while ago, someone made a terrible comment to me. They asked when my mom was going back to her country, and I told them that she had no plan to go back to her country. I asked why they were asking about her legal status. I just had an argument talking to that person.”

– Focus Group Participant

PRIORITY HEALTH NEEDS

Key informants and focus group participants acknowledged several top health priorities to address within Bastrop County including treatment for chronic health conditions, behavioral health needs—assistance with mental health and substance use—and dental care.

Chronic Diseases

The most common health conditions mentioned among key informants and focus group participants included obesity, hypertension, diabetes, heart disease, and cancer. Participants emphasized diabetes as most prominent in Black/African American communities and obesity as most prominent in Hispanic/Latinx communities. Participants cited the following as contributing

factors for diabetes and obesity: (a) lack of access to healthy food options and exercise facilities due to transportation barriers, (b) inability to afford healthy food options or medications due to poor socioeconomic status, (c) poor nutrition habits, (d) lack of nutrition education, and (f) foregoing doctor visits due to lack of insurance. Common cancers mentioned included breast cancer, prostate cancer, and lung cancer.

“A lot of people think, well, [chronic disease] it's hereditary. If you change your habits, you eat right, you exercise right, and you take care of your body, you can be the change agent.”

– Focus Group Participant

Sub-themes:

- Hispanic/Latinx and Black/African American populations have higher rates of diabetes and obesity possibly due to the lack of physical activity and poor nutrition.
- High costs of healthy food discourages residents from purchasing them, as quantity of food is preferred over quality of food to survive.
- The cost of medications to treat chronic diseases such as diabetes are very expensive and therefore a barrier to ongoing care.

“We don't have guidance on how to cook and prepare meals. We need guidance on some of that, because due to our customs or traditions, we tend to cook with a lot of oils. We fry a lot of food in our culture. So when one has reached a certain age, and they tell you that you have to change those traditions, you need to find recipes, foods, or someone to help guide you on how to cook the foods you like in a healthier way.”

– Focus Group Participant

Mental Health and Substance Use

Community members frequently mentioned the increasing need for mental health services within Bastrop County, particularly in Elgin. Common mental health concerns discussed included anxiety, depression, bipolar disorder, schizophrenia, and the overall negative impact of stress. Many mental health providers do not accept insurance, which makes mental health care difficult to afford. Participants noted that people experiencing homelessness often struggle the most with accessing mental health services. One community member mentioned that there is a “lack of a sustainable mental health service structure and a need to provide services on a consistent basis rather than on one visit.”

Another key informant stated that since mental health looks and feels different for Black/African American, Hispanic/Latinx, and other minority populations, the treatment approach must be culturally appropriate. For example, certain communities of color, especially Black/African American community members, have reservations about seeking mental health treatment due to fatal responses from law enforcement during mental health crises as seen in media.

“Mental health is, I think, under-utilized and under-available. Outpatient substance abuse treatment is non-existent. I think [it is] one of the biggest needs of our homeless population.”

– Key Informant

Community participants also discussed the increased need for mental health services for children due to increasingly frequent mental health crises. In addition, families with youth who may need a higher level of care have to travel to Austin to access residential services. Some youth Photovoice participants shared that they seldom utilize mental health services at school due to concerns about school counselors or social workers breaking their trust. Youth shared that rather than seeking outside support for their mental health needs, they prefer to try to manage things on their own.

Participants also highlighted increased substance use as a need in the community. One key informant mentioned that a high proportion of people experiencing homelessness frequently develop substance use disorders as a mechanism to self-medicate and cope with homelessness, which exacerbates mental health issues.

“If you didn't have a mental health issue, after you've been homeless you are going to have some because the situation causes mental health issues.”

– Key Informant

Sub-themes:

- The prevalence of mental illnesses has increased largely due to the impact of the COVID-19 pandemic.
- There is significant negative stigma about mental illnesses that inhibits individuals and families from seeking treatment and support.
- Homeless populations often struggle the most with mental illnesses and substance use disorders.
- There is a need to increase mental health crisis training among medical providers, police officers, first responders, school personnel, and families.

“Bluebonnet Trails have psychologists, psychiatrists, and people on staff. I think they do work on a sliding scale fee.... There's probably just not enough of those people on their staff to handle all the workload.”

– Key Informant

Dental Care

Participants also mentioned the need for and lack of access to affordable dental care in Bastrop County. Residents who do not have dental insurance face high out-of-pocket expenses for dental care. Participants mentioned that since there are no walk-in dentists that offer affordable antibiotics, pain relief, dental treatments, or even treatment plans, it is common for Hispanic/Latinx families to travel to Mexico for emergency dental appointments. Another key informant also mentioned the increase in dental patients seeking services for tooth decay attributed to the use of crystal methamphetamines.

“Dental health affects your physical health. A lot of times people can get their teeth pulled because of health-wise, but they can't get the replacement. That is a big setback. I don't want to go anywhere with my parents if I don't have my teeth.”

– Focus Group Participant

Sub-themes:

- Dental care is unaffordable for many low-income residents, and even people with dental insurance still have high out-of-pocket expenses.
- Low-cost dental services are often limited for people who are either uninsured or underinsured (e.g., services are limited to only one tooth or no root canals).

IMPACT OF COVID-19

The COVID-19 pandemic has had a multi-faceted impact on Bastrop County residents. Issues such as stress, anxiety, depression, and fear associated with social isolation, COVID-19 infections and the loss of friends and family members to COVID-19 have significantly affected the lives of all community members, irrespective of gender, age, socioeconomic status, or race.

Key informants and focus group participants noted the disproportionate impact of COVID-19 on low-income populations in Bastrop County. For example, participants described how

unemployment rates had increased as restaurants and retail organizations laid off their employees. Because of increasing unemployment, many residents struggled to pay rent or housing fees. Homeless shelters had to cut down on the number of people they could accept. In addition, widespread false information regarding the risks of COVID-19 vaccination has discouraged some community members from seeking vaccinations due to hesitancy.

“I think the mental health got worse since COVID.... There's a lot [of] underlying factors: children being home, being homeschooled, parents not working, the stressors of those things, no money, trying to find food, trying to find assistance.”

– Focus Group Participant

At the same time, some participants noted how the pandemic has had a bit of a “silver lining.” For example, some of the farmers markets and local farmers actively helped food banks distribute fresh produce to families in need in the county. In addition, several local churches and nonprofit organizations supported residents in need with necessary supplies, providing COVID-19 testing and vaccination sites.

“There were a couple of churches that did a lot. They did some outreach. I know my home church did a lot, especially when everything just shut down and toilet paper was a scarce commodity. We delivered to people, not just our church members, but anybody that contacted us.”

– Focus Group Participant

COMMUNITY ASSETS AND STRENGTHS

When asked to describe the assets and strengths of Bastrop County, participants frequently mentioned that the community is close-knit and has a strong sense of resiliency after natural disasters. One key informant expressed their gratitude for the tremendous impact of churches and faith-based organizations that participate in community outreach, advocacy, and support of homeless populations. Another key informant expressed excitement about the numerous nonprofit organizations and community-based organizations that have been instrumental in promoting community reconciliation and providing pandemic resources. Key informants and focus group participants also emphasized the tremendous support and impact of strong school districts. Furthermore, increasing population growth was also mentioned as an asset.

“I think there is a sense of rural community, that people are just friendly and willing to engage and just do these things right to help one another.”

– Key Informant

Participants named the following organizations as valuable resources for the community:

Health Care Organizations

A+ Lifestyle Medical Group	Community Health Center of Bastrop County
Ascension Seton Bastrop	Lone Star Circle of Care
Bastrop Community Health Center	Smithville Community Clinic
Bastrop County Indigent Health Care Program	Smithville Whole Health Partnership
Bastrop Independent School District Health Center	Texas Oncology – Bastrop
Bluebonnet Trails Community Services	WellMed at Elgin
	Bastrop First United Methodist Church (Wesley Nurse program)

Churches & Faith-Based Organizations

Bastrop Christian Ministerial Alliance	House of Ruth (Smithville Community Clinic)
Cedar Creek United Methodist Church	Iglesia San Juan Diego (Catholic church)
Central Texas Interfaith (Bastrop Interfaith)	Kingdom Harvest Ministries
Cowboy Church (multiple locations)	Sacred Heart Catholic Church in Elgin

Nonprofits & Community-Based Organizations

Area Agency on Aging (Austin)	Elgin and Bastrop Parks and Recreation Services (Fisherman's Park in Bastrop and Bryant Park)
Bastrop County Cares (Early Childhood Coalition and Network Weaving)	Hunger Free Communities – Bastrop
Bastrop County Emergency Food Pantry	IT'S TIME TEXAS
Capital Area Council of Governments	Master Gardeners
Capitol Area Rural Transportation System	Meals on Wheels Rural Capital Area
Drive a Senior Program	Sand Hollow Farm
Combined Community Action	Smithville Community Gardens
Community Cupboard (Elgin)	Smithville Food Pantry
	Smithville Workforce Training Center

(19) Bastrop County 2021-22 Community Health Needs Assessment

*“There is a pretty big collaborative spirit within the county....
There's a true investment at all levels, from the local
government to the different agencies, to really collaborate
and find ways to make a great impact on this community.”*

– Key Informant

PROPOSED SOLUTIONS AND ACTIONS FOR HOSPITALS

Participants were asked to identify potential solutions for the challenges discussed during the interviews and focus groups. Recommendations for hospital systems are listed below:

IMPROVE HEALTH CARE ACCESS

Affordable health care: Offer free or low-cost health care services such as preventative health screenings and dental screenings and cleanings.

Transportation: Increase the availability of transportation to health care appointments by collaborating with public transportation services and volunteers. Some key informants recommended providing shuttle buses to services or establishing mobile clinics with primary care and specialty services, mental health services, and dental care.

Knowledge and awareness: Provide additional community education by hosting fitness and nutrition classes, cooking demonstrations, and classes to demonstrate healthy grocery shopping on a budget. Disseminate information through pamphlets, booklets, or program flyers at community events.

Health care services at community events: Offer health care services on-site during community events (e.g., community celebrations, health fairs, church events, school events, etc.).

INCREASE CULTURALLY COMPETENT HEALTH CARE

Language and translation services: Increase the availability of Spanish translators during appointments and ensure materials are translated.

Culturally competent workforce: To increase compassionate and non-judgmental care, community members recommended expanding cultural sensitivity training for all providers and hospital staff to better equip them to serve underrepresented and minority populations. Participants also highlighted the need to diversify the workforce by hiring additional providers from underrepresented populations.

Proof of identification: To the extent that is feasible, do not require patients to show proof of identification or documentation of legal status.

“Increase recruitment for a diverse workforce, so that individuals and patients seeking services will be able to see people that look like them treat them.”

– Focus Group Participant

STRENGTHEN ENGAGEMENT AND OUTREACH

Trust: Reach out to traditionally disadvantaged communities that are distrustful of institutions using trusted community members to regain and build trust. Some key stakeholders and organizations mentioned by community participants included: local clergy or faith-based leaders and school district leaders.

Visibility: Increase community visibility and regularly engage with community members to understand their perspectives.

“To assume that you don't have people in the community that would comprehend or understand, that's a misconception. When information is broken down and explained to people, they can really add a lot to what's going on.”

– Key Informant

LIMITATIONS

There are several limitations to consider in the development of this report. First, THI conducted this project during the surge of COVID-19 cases related to the Delta variant, which occurred during the late summer and early fall of 2021. For the safety of staff and participants, all key informant interviews and focus groups were conducted virtually. This presented a challenge with both recruitment and facilitation of the interviews. Many of the community

leaders who helped recruit participants, or who served as key informants, were overwhelmed by responsibilities related to the pandemic. For example, some organizational leaders were coordinating clinical duties or responding to urgent needs from community members, limiting their ability to assist with this project. Similarly, it quickly became clear that community members were also experiencing fatigue from the pandemic, including fatigue regarding inquiry into their needs and the impact of COVID-19.

THI staff did extensive outreach to various CBO leaders in Bastrop County and potential participants, and organizational leaders and residents alike frequently declined participation for a variety of reasons, including research fatigue and fear of exploitation. In addition, THI staff experienced challenges with getting in contact with potential participants, even though multiple channels of communication were used (email, call, and text).

Furthermore, to participate virtually in focus groups, participants had to have access to a device that would allow them to use Zoom (a computer, tablet, or cell phone with data). While not a barrier for the majority of key informant interviews, this requirement likely inhibited some potential focus group participants from joining. In addition, although focus group participants could join Zoom by phone (dial-in), participants familiar with the video aspect of Zoom were frequently confused by the dial-in option, and consequently declined participation or did not show up to the focus group. Finally, virtual key informant interviews and focus groups could more easily be confounded by office or in-home distractions compared to in-person settings.

CONCLUSION

Between August and October 2021, THI conducted eight key informant interviews, three virtual community focus groups, and one targeted Photovoice project and associated discussion in Bastrop County. All participants identified either as stakeholders or representatives of medically underserved, low-income, and minority populations. Community members collectively identified the following categories as top health priorities:

- **Access to health care:** Examples included affordability of health care, provider shortages for residents that are either publically insured or uninsured, and lack of culturally and linguistically appropriate care.
- **Structural and social determinants of health:** Examples included housing and homelessness, lack of transportation, limited broadband or internet access, food insecurity, and racism and discrimination.
- **Priority health needs:** Top health needs included chronic conditions (e.g., obesity, hypertension, diabetes, heart disease, and cancer), mental health, behavioral health and substance use, and dental care.

To address these top health priorities, participants recommended increasing community engagement and outreach and establishing a culturally competent workforce. The insight and recommendations shared in this report prioritize the perspectives of underserved communities within Bastrop County and may be leveraged to develop an efficient action plan to address the discussed top health needs.

TABLES

The following table describes each key informant and how their role in the community satisfied one of the IRS requirements for participation:

Table I
Description of Key Informants

Key Informant	Community Input Sector
Patricia Alford Project Coordinator for Accountable Communities Health Initiative Bastrop County Cares	• Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Edie Clark Leader Central Texas Interfaith	• Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Rafael De La Paz Chief Executive Officer Community Health Centers of South Central Texas	• Person with special knowledge or expertise in public health • Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility • Federal, tribal, regional, state, or local health or other department or agency, with current data or other information relevant to the health needs of the community served by the hospital facility
Kelly Franke Executive Director Combined Community Action, Inc.	• Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility • Federal, tribal, regional, state, or local health or other department or agency, with current data or other information relevant to the health needs of the community served by the hospital facility

Key Informant	Community Input Sector
Beth Rolingson Executive Director Advocacy Outreach	Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Jill Strube Director of Economic Development and Grants Administration City of Smithville	Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Monique Vasquez Organizer Central Texas Interfaith	Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility

The following table describes the focus group participants in aggregate:

Table 2
Description of Focus Group Participants

Focus Group	Community Input Sector	Description	Number	Language
1	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included female and male residents of ZIP codes 78602, 78621, and 78612 with ages ranging from 50-65+. Participants self-identified as Black/African American, White, and Not Hispanic/Latinx or Hispanic/Latinx.	5	English
2	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the	Participants included female residents of ZIP codes 78602 and 78621 with ages ranging from 18-65+. All participants self-identified as Black/African American.	5	English

	community served by the hospital facility			
3	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included female and male residents of ZIP codes 78602 and 78957 with ages ranging from 30-65. Participants self-identified as Hispanic/Latinx and Mexican, Mexican American or Chicano.	6	Spanish
Photovoice (Youth)	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included three female residents and one male, all of whom live in ZIP code 78602. Participants were between 15 and 16 years old. All participants self-identified as Mexican, Mexican American, or Chicano.	4	English

APPENDIX A: KEY INFORMANT INTERVIEW GUIDE

2021-22 Bastrop County SDF CHNA Key Informant Interview Guide

1. Please briefly describe your role in [organization] and who [organization] serves in Bastrop County.
2. Please describe how you are connected to St. David's Foundation, any of the St. David's Hospitals or Ascension Seton. If you are not connected, just indicate that.
 - a. Do you meet any of these criteria? *[Note: Participant does not necessarily have to meet any of these to participate.]*
 - i. Persons with special knowledge of or expertise in public health
 - ii. Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility
 - iii. Leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility.
3. What do you think are Bastrop County's three most critical health issues? *(Examples if needed: heart disease, diabetes, substance use, mental health, cancer, asthma, STIs, HIV, etc.)*
 - a. PROBE: Why are these the top priorities?
 - b. PROBE: Who do these health issues affect the most? *(e.g., age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)*
4. The top health issues identified in the 2019 Community Health Needs Assessment were [list top needs in previous CHNA]. How important are these issues today?
5. How has COVID-19 impacted the three critical health issues you identified?
 - a. PROBE: Are there some groups that have been more affected by COVID-19 than others in your community?
6. Now I am going to ask you about the factors that contribute to each of the top priority health issues you identified and how the issue impacts specific populations. *(Prompt: Note that a "factor" could be a health behavior like physical activity, SDOH such as food insecurity, insurance status, physical environment, etc.)*
 - a. Starting with [Name #1 critical health issue identified by interviewee]
 - i. What are the factors that contribute to making this a critical health issue?
 - ii. Which populations does the issue impact the most?
 - iii. How does this critical health issue specifically impact low-income, underserved/uninsured populations in Bastrop County?
 - iv. Are there organizations already addressing these issues in the county? If so, which ones? How do they address it?
 - b. Now thinking about [Name #2 critical health issue identified by interviewee]

- i. What are the factors that contribute to making this a critical health issue?
 - ii. How does this critical health issue specifically impact low-income, underserved/uninsured populations in Bastrop County?
 - iii. Which populations does the issue impact the most?
 - iv. Are there organizations already addressing these issues in the county? If so, which ones?
- c. Now thinking about [Name #3 critical health issue identified by interviewee]
 - i. What are the factors that contribute to making this a critical health issue?
 - ii. How does this critical health issue specifically impact low-income, underserved/uninsured populations in Bastrop County?
 - iii. Which populations does the issue impact the most?
 - iv. Are there organizations already addressing these issues in the county? If so, which organizations?
- 7. Based on your knowledge and expertise, what are the most effective strategies to address the top three health issues that you identified?
 - a. PROBE: What are some specific strategies that could help to address disparities between different populations for these health issues?
- 8. Beyond the top three health issues you've identified, what are the other critical health issues that are important to address?
- 9. How could St. David's Hospitals or Ascension Seton possibly partner with or enhance the efforts of organizations that are working to address the issues that you identified?
- 10. What are some of your community's greatest assets and strengths? (*Prompt: These often include social and human service agencies, community based organizations, nonprofit organizations, churches, but can also be cultural qualities*).
 - a. How do you think these strengths could be leveraged to address the top health issues in Bastrop County?
- 11. What are your suggestions for ways to engage and build trust with community members, particularly low-income, underserved populations, ethnic and racial minorities, and limited English proficient residents of Bastrop County to address these critical health issues?
- 12. Is there anything else you would like to share about the top health issues in Bastrop County?
- 13. Now I want you to think a little about a broader range of factors that could affect health. What do you think are the social and economic concerns facing your community? (*Prompt: affordable housing, unemployment, access to quality daycare, poverty*).
 - a. Who do these health needs or concerns affect the most (e.g., age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)?
 - b. PROBE: Are there organizations or available resources already addressing these needs? If so, which ones? How do they address the needs?

- c. PROBE: How important do you think it is that hospitals and health care systems work to connect patients with resources to support these factors affecting health? Why?
- 14. How could St. David's and local hospitals and Ascension Seton possibly partner with or enhance the efforts of these organizations to support factors affecting health?
- 15. Where do members of your community go to access primary health care?
 - a. What about specialty care?
 - b. What about access to emergency rooms or urgent care centers?
 - c. And mental and behavioral health care?
- 16. What challenges/barriers do low-income, underserved, and uninsured populations in your community face in access to health care?
 - a. What are two things that St. David's, local hospitals, St. David's Hospitals, and Ascension Seton could do to address these challenges?

Those are all of the questions I have for you today. Is there anything else you would like to add before I turn off the recorder? *[Allow time for comments]*

APPENDIX B: FOCUS GROUP GUIDE

2021-22 Bastrop County Focus Group Guide

1. When you think of the word “community,” what is the first thing that comes to mind?
2. What does health mean to you?
3. What do you do to stay healthy?
4. What are the things that **help you to be healthy** in your community? (e.g., *places to buy healthy food, safe places to walk and to exercise, community services and events, access to health care, affordable housing*)
5. What makes it **difficult to be healthy** in your community? (e.g., *lack of access to affordable health care, few grocery stores with fresh fruits and vegetables, affordable food, lack of transportation, language barriers, substance use, etc.*)
6. How does your race or ethnicity impact your ability to be healthy?
7. What do you think are the **two most important health issues** facing your community? Why? (e.g., *diabetes or cancer, unhealthy food or drug abuse, mental health, violence, or access to care*)
8. What are the **top two things that could be done** to fix these issues? (e.g., *What would it look like to fix the issues?*)
 - a. Who should be involved (people or organizations)?
9. Are there health services that you need but do not receive currently? If so, which services?
10. Where do you go for help when you need health services and cannot find them?
11. What are the strengths of the health services available in your community?
12. What resources do you have in the community that seem to be working to address the health-related issues that we talked about?
13. What could the hospital systems do to improve health and quality of life in the community?
14. What impact has the COVID-19 pandemic had in your life and in the community?
 - a. How has it affected your health, including your mental health?
 - b. How did COVID-19 impact the health challenges that we discussed earlier?
 - c. Are there community resources or agencies that have helped to support you during the pandemic? **If so, which organizations have been helpful?**
15. Are there any other issues that impact your physical or mental health that you would like to discuss?

COMMUNITY INPUT SUMMARY REPORT:

Caldwell County 2021-22 Community Health Needs Assessment



(I) Caldwell County 2021-22 Community Health Needs Assessment

ABOUT TEXAS HEALTH INSTITUTE

Texas Health Institute is a nonprofit, nonpartisan public health institute with the mission of advancing the health of all. Since 1964, we have served as a trusted, leading voice on public health and health care issues in Texas and the nation. Our expertise, strategies, and nimble approach makes us an integral and essential partner in driving systems change. We work across and within sectors to lead collaborative efforts and facilitate connections to foster systems that provide the opportunity for everyone to lead a healthy life. For more information, visit texashealthinstitute.org and follow us on Twitter, Facebook, and LinkedIn.

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THI	Texas Health Institute
SDF	St. David's Foundation
AAPI	Asian American Pacific Islander
CHNA	Community Health Needs Assessments
CBO	Community-Based Organizations
ACE	Adverse Childhood Experience
CARTS	Capitol Area Rural Transportation System

BACKGROUND AND METHODS

As part of a collaboration with local hospital systems, St. David's Foundation (SDF) contracted with Texas Health Institute (THI) to conduct the qualitative research for the 2021-22 Community Health Needs Assessments (CHNAs) in Bastrop, Caldwell, Hays, and Williamson counties. The qualitative research and report are designed to meet the community input requirements of a CHNA for 501(c)(3) hospitals under the Affordable Care Act. As part of the CHNAs, THI staff used key informant interviews and focus groups to explore critical health issues in the four counties and how these issues are affected by COVID-19, structural factors, underlying causes, and community assets.

In addition to SDF, Ascension Seton and Georgetown Health Foundation were key collaborators in the Caldwell County CHNA process. Each of the collaborating organizations will also be using the qualitative research to support the development of their respective CHNAs.

METHODS

Between August and October 2021, THI virtually conducted five key informant interviews and three community focus groups with Caldwell County residents. In addition, THI virtually conducted one targeted Photovoice project and associated focus group.

A THI staff member served as the facilitator for all virtual interviews and focus groups. Audio recordings of the sessions were automatically transcribed using Otter.ai, and staff verified transcripts for accuracy and cleaned. Spanish-language focus groups were first transcribed in Spanish and then translated into English. Transcripts were coded and analyzed using Atlas.ti qualitative software.

Key Informants

SDF and other collaborating organizations helped identify potential key informants, based on their leadership roles and experience working with medically underserved, low-income, or minority communities served by the hospital system. THI contacted and recruited key informants via email with an explanation of the project. The key informants for this project ([Table 1](#)) included representatives from health care organizations, community-based organizations, and the local government.

The key informant interview guide for organizational leaders covered the critical health issues in the county, the impact of COVID-19 on these issues, structural factors that contribute to the critical health issues, community assets, strengths of the community, and possible solutions to address these health issues ([Appendix A](#)). Each key informant interview lasted approximately one hour.

Focus Groups

For the focus groups, THI identified people from low-income, medically underserved, and minority populations in Caldwell County by working with community-based organizations (CBOs) and local institutions, including:

- Wesley Nurse program at First United Methodist Church of Luling
- Lockhart Independent School District
- District One Pride Association
- Golden Age Home - Lockhart
- St. John's Lutheran Church in Uhland

Community organizations and agencies initially notified community members about the community focus groups and the overall purpose of the CHNA. Once community members expressed an interest in participating, THI coordinated with the participants to arrange meeting details. In addition, THI used snowballing to identify additional participants through referrals to participants' friends and neighbors. Each participant self-identified as fitting one or more descriptions: medically underserved, low income, and minority, or living with chronic disease needs ([Table 2](#)). After each focus group, THI sent participants a \$25 electronic gift card to a store of their choice.

The focus group guide covered participants' health concerns, underlying root causes of health issues that they see in their communities, community assets, proposed solutions, and specific strategies for addressing critical health needs ([Appendix B](#)). Community focus groups lasted approximately 75-90 minutes each and were conducted in the early evening hours of weekdays.

Photovoice and Discussion

Photovoice participants were recruited through the same processes as community focus group participants. THI worked specifically with high school teachers to identify youth interested in participating; participants were required to provide a signed parental consent form and received a \$50 electronic gift card after completion of the project.

The project included two sessions, starting with a 30-minute virtual training for youth participants ages 14-18. The facilitator asked participants to take and submit five photos—without faces or names—that represent factors that make it easy or difficult to be healthy in their community. Participants were encouraged to submit any photos they felt represented the prompt, including staged or candid photos, indoor or outdoor settings, and photos taken anywhere in their community (e.g., at home, school, church, work, etc.).

Approximately one week after the initial session, participants attended a 90-minute virtual discussion session during which the facilitator displayed photos via screenshare on Zoom. Participants discussed each other's photos and experiences using the prompt questions:

- What do you see?
- How does it make you feel?
- Why does this condition exist?
- What are some things that can be done about this condition, especially by local hospital systems?

HEALTH EQUITY

THI applied a health equity lens to the focus groups and key informant interviews. This was done by incorporating specific questions into the interview guides, including the following:

Key informant interview guide:

- Who do the top most critical health issues affect the most? (e.g., age groups, racial and ethnic groups, socioeconomic groups, geographic subsets, etc.)
- What factors contribute to the critical health issues?
- How does the critical health issue identified specifically impact low-income, underserved, or uninsured populations?
- What are some of the community's greatest strengths and assets? How could these be leveraged to address the health issues identified?
- What are your suggestions for ways to engage and build trust with community members, particularly low-income, underserved populations, ethnic and racial minorities, and limited English proficient residents to address the critical health issues of the county?

Focus group guide:

- What makes it easy or difficult to be healthy in your community and what factors, such as racism or discrimination, impact your ability to be healthy?
- Are there health services that you need but do not receive currently?
- What are some resources in the community that seem to be working to address health-related issues?

Additionally, THI used the following reflective questions to frame the analysis of the transcripts in order to draw out considerations of health equity:

- Who is disproportionately affected and impacted by critical health issues and by potential solutions?
- Who is included and excluded?
- What are the root causes and causal factors contributing to the community health needs?
- Are there assumptions taking place? If so, what are they?
- Who is potentially benefiting and who is being harmed?

- What are the interviews and focus groups telling us about what data might be missing?
About who is and is not at the decision-making table?
- What changes are needed and what could be done differently?
- Are there assumptions taking place? If so, what are they?
- Who is potentially benefiting and who is being harmed?
- What are the interviews and focus groups telling us about what data might be missing?
About who is and is not at the decision-making table?
- What changes are needed and what could be done differently?

THEMES

Among the focus groups, key informant interviews, and Photovoice group discussion, there were four primary thematic categories that emerged. The order presented below does not indicate priority or frequency.

- Access to care
- Environmental, social, and structural barriers to community wellness
- Priority health needs
- Racism and discrimination

In all interview contexts, participants identified barriers within the health care system that inhibit their ability to receive affordable, culturally appropriate care that includes urgent care, care for complex health conditions, and specialty services. The participants also identified the various social, environmental, and structural barriers community members face that impact their wellness. Priority health needs emerged as participants described the most commonly occurring chronic illnesses present in Caldwell County. Finally, participants frequently described the impact of racism and discrimination based on immigration status.

ACCESS TO CARE

Participants described many issues relating to the accessibility of health care in Caldwell County. These included issues that make services inaccessible or insufficient, such as unaffordable costs, insurance-status, or general financial insecurity. Furthermore, participants described that health care services are often culturally inappropriate or insensitive, particularly to Hispanic/Latinx and Black/African American populations. Participants also described the lack of specialist providers in Caldwell County, including the lack of urgent care centers.

Affordability of Health Care

The most commonly described barrier was the lack of affordable health care. Participants mentioned that there are too few providers who accept Medicaid or have other reduced-cost programs for people who use self-pay or are uninsured. In identifying specific programs that do offer reduced costs, such as dental services, one focus group participant said, “Those clinics do help, they do... but it depends on how much you earn and things are expensive when one barely earns above the minimum.” Another focus group participant mentioned that they were turned away when they requested a payment plan. Participants specifically indicated that health care costs are most unaffordable for Hispanic/Latinx and Black/African American community members.

“It would be a good option to have a nearby clinic with accessible prices for the Hispanic community.”

– Focus Group Participant

Sub-themes:

- People who are uninsured or underinsured often avoid preventive care due to cost.
- Many low-income residents will travel to Austin, San Antonio, or Kyle to receive free or affordable health care, visiting providers such as CommuniCare.
- The wait times for appointments with Medicaid providers are long (sometimes multiple months long).
- Many community members cannot afford lab work or tests and so they forgo this type of health care, which can lead to complications and chronic issues.
- Dental care is too expensive and many community members do not have dental insurance.

Culturally and Linguistically Appropriate Care

In addition to costs, participants described that health care services often feel inaccessible because they are not culturally or linguistically appropriate. Focus group participants shared barriers regarding language, noting an insufficient number of Spanish-speaking providers. In addition, they shared experiences where providers refused to find accommodations for patients who needed translation. Participants also mentioned that health care language, including language used on pamphlets or educational materials, is confusing and difficult to understand or apply. Furthermore, participants described how community members have encountered health care providers who use “a very colonial...white supremacist approach to pathologizing Black bodies and bodies of color.” Overall, participants indicated a need for providers and services that are more accommodating and informed in serving underrepresented and minority populations and non-English-speaking patients.

Sub-themes:

- The Black/African American population of Caldwell County has been historically excluded from health care services, so many older Black/African American adults are hesitant or unsure of how to engage with health care.
- Many community members are not proficient in speaking or reading English but most health care information and services are only in English.
- Immigrant communities are distrusting of health care providers, fearing deportation or risks for their citizenship process.
- Many members of underrepresented and minority populations have experienced mistreatment by medical providers, such as physical roughness during services or prejudicial speech.
- Providers do not usually understand the needs, cultural priorities, or histories of Black/African American and Hispanic/Latinx communities and therefore the treatment is not accommodating or appropriate.

Urgent, Primary, and Specialty Care

Participants frequently indicated a lack of urgent care options and an insufficient number of care providers for more complex health conditions in Caldwell County, particularly in the areas of Luling, Dale, Fentress, and Prairie Lea. For example, focus group participants in Dale and Luling described a need for services that are available on evenings and weekends. Some participants indicated that a pediatrician with after-hours availability would be helpful, while others described how a general urgent care facility is most needed, as Caldwell County currently lacks one. The need for an urgent care facility was mentioned by participants from Lockhart, Dale, and Luling, indicating the need is felt across the entire county. Expanding on this, other participants indicated a general lack of services for more complex health needs, such as through OB-GYNs and pediatricians.

“[We need an] urgent care because sometimes ... it's Saturday and your kid's sick. What are you supposed to do? Okay, maybe take them to the ER, but it's gonna cost you thousands of dollars ... Some people don't get sick Monday through Friday, they get sick on the weekends. They need somewhere to go.”

– Focus Group Participant

Sub-themes:

- There are some services and provider types that are particularly difficult to access, these include:
 - Provider types: pediatricians, obstetricians/gynecologists, and podiatrists (particularly to treat foot-related conditions for people with diabetes).
 - Services: affordable prescription dispensaries, vaccinations (COVID-19 and general), urgent care, affordable and accessible vision screening and prescription glasses for children, affordable physicals for school aged kids.
- Waitlists for pediatricians and family practitioners at the hospital-based clinics are too long.
- There are not enough options for health care in general, so many community members will use the ER for non-emergent health care, often using ambulances to travel across the county.
- Many community members travel to Austin, San Antonio, or Kyle to receive specialty care and for primary care at free or low-cost clinics.

“I think one thing we can do is probably bring in a few more physicians, maybe an OB-GYN, more pediatricians for the children.”

– Focus Group Participant

ENVIRONMENTAL, SOCIAL, AND STRUCTURAL BARRIERS TO HEALTH

Both key informants and focus group participants were asked to identify factors that make it easy or difficult to be healthy in Caldwell County. Various environmental, social, and structural barriers were identified and discussed. The factors, explored below, were described as barriers that inhibit the ability of community members to fully participate in community life, stay healthy in general, or engage with health care services.

Transportation

Transportation barriers, specifically the lack of transportation services available, was the most frequently mentioned structural barrier by participants. Participants described how rural the county is—one key informant even mentioned it is 536 square miles—indicating that many of the health care services, food stores, and community members are very spread out. Despite the high rural residency of the county, many community members do not have personal vehicles.

When asked how residents typically get to doctor’s appointments, one focus group participant said, “We have to find an Uber or whatever we can each time, because we always need someone to take us. In reality, there is no transportation.” A key informant said, “The lack of

transportation impacts [people's] ability to get specialized care that maybe they need, and the ability to [do] follow-up care."

Furthermore, participants also described that the lack of transportation inhibits their access to fresh foods, employment, or social engagements, which ultimately impacts their overall health.

"We don't have public transportation here at all. I don't even know if we have a taxi service."

– Key Informant

Sub-themes:

- There are many neighborhoods in Caldwell County that are very remote and isolated, especially immigrant communities.
- The lack of public transportation services inhibits people's ability to get to grocery stores, jobs, social engagements, and health care appointments.
- Many community organizations host events in Lockhart, but this limits much of the county from attending due to the lack of transportation options to get there.
- It is common for community members to use ambulances to get to the hospital for non-emergent illnesses, primarily due to a lack of other transportation.

Food Access and Food Insecurity

Inaccessibility of healthy food was another frequently mentioned barrier to health. The primary themes that emerged around this topic were the costs of food and barriers to accessing free food.

Participants indicated that the cost of food in general is a barrier to many community members. Organic food options are especially cost-prohibitive. The unaffordability of food ultimately impacts people's ability to stay healthy.

"You can throw all the education and all the things at [people], but if they can't afford to buy the fruits and vegetables that you're telling them they need to eat for their diabetes, then you just wasted a piece of paper, because they cannot do that."

– Key Informant

When discussing options for people to access free or affordable food, such as food pantries, participants said that there are often too many barriers involved. For example, the food pantries have very limited hours or require identification and paperwork. One key informant said, "If you have a minority who may be in the process of becoming a U.S. citizen, or you have someone who was just incarcerated that is out and doesn't have an ID... I could give a whole

list of why someone would wouldn't feel comfortable providing their ID in order to receive those services.”

Sub-themes:

- Many community members find gas stations or dollar stores more accessible financially or transportation-wise, compared to grocery stores like H-E-B or Wal-Mart.
- Transportation barriers are directly related to food insecurity because community members do not have the means to drive to grocery stores.
- COVID-19 has limited free food services, like Meals on Wheels or school-based lunch programs.
- There are a lack of stores that offer fresh, organic food options.
- There are more fast food restaurants than there are healthy restaurant options.
- Food insecurity typically affects entire family systems (grandparents, parents, children) because many households are multigenerational.

Neighborhood and Built Environment

Participants also mentioned environmental factors that impact their health; for example, Caldwell County has few outdoor spaces, such as parks or walking trails, that feel safe and accessible. Existing parks were described as outdated, poorly-lit, or full of trash. Participants also described a desire for more air-conditioned indoor spaces, like gyms or a recreational center that could provide exercise classes, sports events, or cooking classes. Participants noted that such a center would need to be affordable for people with lower incomes.

Teen Photovoice participants also expressed concern for the health impact of environmental pollution from local oil factories and farmland. One said, “Every time we drive by a farm or somewhere that uses fertilizer, it has a very bad, strong smell, and it could get into your lungs.”

Finally, some participants mentioned that some areas of the county do not have reliable broadband access or mobile services that allow Internet connection. This inhibits people’s ability to stay connected in the increasingly virtual world, including for telehealth visits, virtual school, or social gatherings.

Sub-themes:

- Park spaces are hard to access: the State Park in Lockhart has a cost to enter; there are no parks in Prairie Lea; and the park in Lytton Springs is abandoned and run down.
- Participants described that there are many stray dogs, especially in Hispanic/Latinx neighborhoods, which makes community members feel unsafe; furthermore, there is not an affordable veterinary service nearby to help address the issue.
- Many roads have a lot of trash and generally feel unsafe for walking alongside.

Housing

The final structural barrier mentioned by participants was the lack of affordable housing available in Caldwell County. Participants noted the population growth due to the surge in the nearby Austin housing market. As that housing market grows, there have been more people moving into Caldwell County and purchasing properties at rates that make the property values and general costs of living unaffordable to long-time residents, especially Black/African American and Hispanic/Latinx community members.

“What I'm seeing going on in my community, where my mom's house still resides, is that they're building big two story houses next to your shack...to push you out, you know, because your taxes are going to rise.”

– Key Informant

A further consequence of the increasing costs of housing is that multiple generations commonly live together in one home. One key informant noted that this leads to the whole family struggling with similar health issues like food insecurity, lack of adequate A/C, or chronic diseases.

PRIORITY HEALTH NEEDS

The third overarching theme present throughout all of the interviews was a description of the most commonly identified health needs in Caldwell County. These needs were identified as chronic diseases, such as diabetes, hypertension, cancer, and obesity, as well as a high prevalence of mental illness, substance use, and issues related to oral health.

Chronic Disease

The most commonly mentioned health conditions were diabetes and hypertension, with cancer and obesity mentioned second most commonly. These conditions were noted to be most prevalent among the “African American populations, the Hispanic [populations], and minorities in the southern part of the county,” according to one key informant. Another key informant said that diabetes and hypertension “drive a lot of our E.D. [emergency department] visits, as well as hospitalizations.”

Furthermore, diabetes and cardiovascular disease were said to be present among many generations, with younger age groups showing early risk factors. These chronic diseases were frequently mentioned in relation to other issues within the county, such as lack of affordable preventative health care or lack of affordable, healthy food. Participants indicated that such barriers typically contribute to the high prevalence of diabetes, hypertension, obesity, and cancer.

Mental Health and Substance Use

Participants frequently mentioned concerns about mental illness, including depression, anxiety, or substance use disorders. Participants described how COVID-19 has increased the prevalence and severity of mental illnesses because of loneliness, desperation, trauma, and lack of support. Additionally, participants mentioned that there is a general stigma around mental health care, particularly among Black/African American and Hispanic/Latinx populations.

Regarding substance use, focus group participants mentioned seeing issues with prescription drugs and alcoholism most commonly. Participants also noted that there is a lack of mental health providers who offer affordable, culturally-informed care. For example, some participants noted the lack of mental health providers who accept Medicaid, and others described not having access to therapists who are Black/African American or Hispanic/Latinx.

“When I say accessible [mental health care], I'm talking about low cost or no cost. Because when you're talking about how I can access it if I have insurance, or if I have to get a referral from my physician, or I have a \$35 co-payment—that's not accessible.”

– Key Informant

Sub-themes:

- The prevalence of mental illnesses seems to be “worse than ever,” largely due to the impact of the pandemic.
- Younger community members, including children and teens, are experiencing depression and anxiety at very high rates.

Oral Health

Finally, the prevalence of oral health issues in Caldwell County was a common theme in the focus groups. Participants described the lack of sufficient dental providers in their community, particularly dentists with low-cost services. Costs for even routine dental cleanings are considered inaccessible for people without dental insurance or using self-pay. Some participants mentioned having to drive to Kyle or Austin to receive affordable oral care. Other participants noted that the free mobile dental clinic in Luling (no specific name given) is helpful, although its services have been reduced and canceled during the pandemic. One participant also described how these barriers to oral care in Caldwell County result in frequent emergency room visits related to dental issues and other chronic health conditions.

“Dental disease leads to cardiovascular disease ... and other kinds of health-related issues. Patients with diabetes, who maybe have poor oral care, can really suffer tremendously with infections.”

– Focus Group Participant

RACISM AND DISCRIMINATION

Another common theme present throughout all the interviews and focus groups was the pervasiveness of racism and discrimination based on immigration status faced by many community members in Caldwell County. Participants described the history of race-based discrimination throughout the community, which has included segregation, police brutality, and inadequate access to services like parks and hospitals in areas with more people of color. One participant described the negative impact of local leaders or organizations who are uneducated about cultural priorities and histories of Black/African American communities in Caldwell County. As an example, the participant observed that organizational leaders or health care providers who are white have acted “intimidated” by Black/African American communities or insisted on police presence at clinics in historically Black neighborhoods, which further erodes trust in health care providers among Black community members.

“This is also a community that has a confederate monument on the courthouse lawn ... you're literally confronting a very large, and intentionally present, romantic nod to the antebellum South.”

– Key Informant

Participants also described the frequency with which immigrant communities experience discrimination. Multiple key informants mentioned that people within immigrant communities often do not feel comfortable attending community events or resource fairs where they will be asked to provide identifying information. Focus group participants described feeling intimidated by medical providers for similar reasons. These community members fear deportation or other consequences associated with their or family member’s immigration status. Furthermore, one key informant mentioned that, as a consequence of these experiences with discrimination and fear, many immigrant communities “settle into a the most rural parts of Caldwell County,” making them further isolated.

“Sometimes we [immigrants] do feel very abandoned. Like we don’t exist. Like we are always in the shadows for everything.”

– Focus Group Participant

IMPACT OF COVID-19

Although mentioned throughout the previous sections, the impact of COVID-19 warrants its own discussion, as community members described specific ways in which the pandemic has affected the community's health. Participants noted that Caldwell County has struggled to get a majority of residents vaccinated, largely due to political influences creating resistance against vaccines. Similarly, participants mentioned that it is common for people to not wear masks in public places, which makes others feel unsafe. Participants also described experiencing confusion between local and state-level guidance related to the pandemic, saying that conflicting messages have created some tension in the community.

Additionally, over the course of the pandemic, community members have seen greater prevalence of food insecurity. Participants mentioned that services such as Meals on Wheels have had significantly less capacity, which has left many people without access to food. Similarly, participants described that many community members have lost their jobs or had reduced hours during the pandemic, creating financial vulnerabilities.

Participants also described the mental health implications of the pandemic, as previously mentioned in this report. For example, participants indicated that community members of all ages have been more isolated. Consequently, there has been an increase in depression and loneliness. Additionally, some key informants mentioned seeing increasing issues of obesity and worsening chronic illnesses due to community members staying at home most of the day.

COMMUNITY ASSETS AND STRENGTHS

When asked to describe the strengths of Caldwell County, participants mentioned that the community has a history of resiliency after experiencing fires, floods, displacement, police violence, and more. One key informant said that the community is full of individuals who see the needs of the area and genuinely desire to help. Focus group participants said another strength is the network of churches from many denominations that often work together to meet community needs, including by distributing food and clothing and conducting home visits to struggling or isolated community members.

Participants mentioned many local agencies and organizations that are helpful resources to community members. Notably, many participants mentioned the same organizations, rather than adding more to the list.

Organizations include:

Caldwell County Christian Ministries and
Caldwell County Foodbank
CommuniCare Clinics (Kyle, San Marcos,
and Austin)
Lamb and Sheep Ministries
First United Methodist Church of Luling
(Wesley Nurse program)
Lockhart Independent School District

Lockhart Learning Center
Meals on Wheels
St. Vincent DePaul ministry at St. Mary's
Catholic Church
St. John the Evangelist Catholic Church of
Luling
Texas Workforce Commission

PROPOSED SOLUTIONS AND ACTIONS FOR HOSPITALS

Participants were asked to identify potential solutions for the challenges they discussed during the interviews, with specific attention to actions that hospitals could take.

INCREASE CULTURALLY COMPETENT HEALTH CARE

Build trust: Engage grassroots organizations, including the school districts, in decision-making. Compensate local leaders or community members accordingly for their expertise and contributions.

Address racism and discrimination: Involve local council members to engage historically excluded communities in resource fairs, services, and decision-making.

Culturally competent workforce: Expand cultural sensitivity training for all providers and hospital staff to better equip them to serve underrepresented and minority populations, especially community members who are Black/African American, immigrants, or Hispanic/Latinx.

IMPROVE HEALTH CARE ACCESS

Mobile clinics: Offer easier ways to access general care, specialty care, and care for more complex health needs (e.g., through pediatricians, dentists), especially in rural communities. These would be most helpful if they are available frequently, such as once a week, and offer free or reduced-cost services.

Urgent care: Establish a way to meet the emergent, after-hours, and acute health care needs of community members.

Mental health services: Improve and increase access to services that are affordable, culturally sensitive, and accessible to underrepresented community members and younger people.

Public transportation: Improve services by working with local officials. Options may include Capital Area Rural Transportation System—CARTS—or other hospital-funded buses that link clinics and communities.

REDUCE BARRIERS IN THE COMMUNITY

Community education and recreational activities: Establish a recreation center with free or reduced price services like cooking classes, exercise classes, open gym time, job fairs, and other community events. Participants mentioned the need for this type of facility in Dale, Luling and Lockhart.

Nutrition: Expand access to affordable and healthy food by increasing capacity of the Caldwell County Foodbank, working with schools to expand the free lunch program, and/or establishing community gardens in historically underserved neighborhoods.

Public spaces: Clean up community parks from litter and improve lighting and walking trails.

LIMITATIONS

There are several limitations to consider in the development of this report. First, THI conducted this project during the surge of COVID-19 cases related to the Delta variant, which occurred during the late summer and early fall of 2021. For the safety of staff and participants, all key informant interviews and focus groups were conducted virtually. This presented a challenge with both recruitment and facilitation of the interviews. Many of the community leaders who helped recruit participants, or who served as key informants, were overwhelmed by responsibilities related to the pandemic. For example, some organizational leaders were coordinating clinical duties or responding to urgent needs from community members, limiting their ability to assist with this project. Similarly, it quickly became clear that community members were also experiencing fatigue from the pandemic, including fatigue regarding inquiry into their needs and the impact of COVID-19.

THI staff did extensive outreach to various CBO leaders in Caldwell County and potential participants. Organizational leaders and residents alike frequently declined participation for a

variety of reasons, including research fatigue and fear of exploitation. In addition, THI staff experienced challenges with getting in contact with potential participants, even though multiple channels of communication were used (email, call, and text).

Furthermore, to participate virtually in focus groups, participants had to have access to a device that would allow them to use Zoom (a computer, tablet, or cell phone with data or Wi-Fi access). While not a barrier for the majority of key informant interviews, this requirement likely inhibited some potential focus group participants from joining. In addition, although focus group participants could join Zoom by phone (dial-in only), participants familiar with the video aspect of Zoom were frequently confused by the dial-in option only, and consequently declined participation or did not show up to the focus group. Additionally, virtual key informant interviews and focus groups could more easily be confounded by office or in-home distractions compared to in-person settings.

Finally, one focus group had to be rescheduled because many of the participants were exposed to or infected with COVID-19 a few days prior to the originally scheduled date. This incident illustrates the challenges of coordinating and conducting interviews in the midst of the pandemic.

CONCLUSIONS

Between August and October 2021, THI conducted five virtual key informant interviews, three virtual community focus groups and one virtual Photovoice project and associated discussion in Caldwell County. Participants represented medically underserved, low-income, and/or minority populations. Community members collectively identified the following categories as top health priorities:

- **Access to care:** Examples included barriers within the system that inhibit the ability to receive affordable, culturally appropriate care that includes urgent and specialty care.
- **Environmental, social, and structural barriers to health:** Examples included insufficient public transportation, food insecurity, lack of green spaces, and unaffordable housing.
- **Priority health needs:** Examples included chronic illnesses such as diabetes and hypertension, mental illness and substance use, and oral health issues.
- **Racism and discrimination:** Participants identified prejudice against immigrant communities currently and historically, which pervades health care systems and the community in general.

To address these issues, participants recommended leveraging the strengths of their community, including the resiliency and expertise of community members, as well as the strong

network of churches and other trusted community organizations. The recommended solutions identified in this report represent the needs and priorities of communities most impacted by health disparities due to historical exclusion or discrimination. These findings can be used to improve the overall health of Caldwell County, especially its most vulnerable populations.

TABLES

The following table describes each key informant and how their role in the community satisfied one of the IRS requirements for participation.

Table I
Description of Key Informants

Key Informant	Community Input Sector
Amy Adams Nurse Texas Department of State Health Services	Federal, tribal, regional, state, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility
Margaret Carter Community Member	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Apryl Haynes (Germany) Chief Administrative and Nursing Officer Ascension Seton Edgar B. Davis Hospital	Persons with special knowledge or expertise in public health
Charity Kittrell Executive Director 4:12 Kids	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Lee Rust Ward 2 Council Member Luling City Council	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Dr. Skyller Walkes Chief of Staff Where We Thrive	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility

The following table describes the focus group participants in aggregate.

Table 2
Description of Focus Group Participants

Focus Group	Community Input Sector	Description of Participants	Number of Participants	Language
Lockhart, Texas	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included male and female residents of ZIP codes 78640 and 78644, ages 30-65+, with the majority of participants over 65. Participants self-identified as Mexican/Mexican American/Chicano, Hispanic/Latinx/Spanish origin, and White, Not Hispanic/Latinx.	12	English
Dale and Luling, Texas	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included male and female residents of ZIP codes 78648 and 78616, with ages ranging from 30-65. Participants self-identified as Mexican/Mexican American/Chicano, Hispanic/Latinx/Spanish origin, White, Not Hispanic/Latinx and Black/African American.	6	English

Spanish-speakers	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included female residents in ZIP codes 78616 and 78108, with ages ranging from 30-65. Four participants identified as Mexican, Mexican American, or Chicano and one as Hispanic/Latinx and Spanish origin.	5	Spanish
Photovoice (Youth)	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included female residents in ZIP codes 78644 and 78616. Participants were between 15 and 18 years old. One identified as Mexican, Mexican American or Chicano, one as Hispanic/Latinx and Spanish origin, and one as Black/African American.	3	English

APPENDIX A: KEY INFORMANT INTERVIEW GUIDE

2021-22 Caldwell County SDF CHNA Key Informant Interview Guide

1. Please briefly describe your role in [organization] and who [organization] serves in Caldwell County.
2. Please describe how you are connected to St. David's Foundation, any of the St. David's Hospitals, Ascension Seton, Baylor Scott & White Health. If you are not connected, just indicate that.
 - a. Do you meet any of these criteria? *[Note: Participant does not necessarily have to meet any of these to participate.]*
 - i. Persons with special knowledge of or expertise in public health
 - ii. Federal, tribal, regional, state, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility
 - iii. Leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility.
3. What do you think are Caldwell County's three most critical health issues? *(Examples if needed: heart disease, diabetes, substance use, mental health, cancer, asthma, STIs, HIV, etc.)*
 - a. PROBE: Why are these the top priorities?
 - b. PROBE: Who do these health issues affect the most? (e.g., age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)
4. The top health issues identified in the 2019 Community Health Needs Assessment were [list top needs in previous CHNA]. How important are these issues today?
5. How has COVID-19 impacted the three critical health issues you identified?
 - a. PROBE: Are there some groups that have been more affected by COVID-19 than others in your community?
6. Now I am going to ask you about the factors that contribute to each of the top priority health issues you identified and how the issue impacts specific populations. *(Prompt: Note that a "factor" could be a health behavior like physical activity, SDOH such as food insecurity, insurance status, physical environment, etc.)*
 - a. Starting with [Name #1 critical health issue identified by interviewee]
 - i. What are the factors that contribute to making this a critical health issue?
 - ii. Which populations does the issue impact the most?
 - iii. How does this critical health issue specifically impact low-income, underserved/uninsured populations in Caldwell County?
 - iv. Are there organizations already addressing these issues in the county? If so, which ones? How do they address it?

- b. Now thinking about [Name #2 critical health issue identified by interviewee]
 - i. What are the factors that contribute to making this a critical health issue?
 - ii. How does this critical health issue specifically impact low-income, underserved/uninsured populations in Caldwell County?
 - iii. Which populations does the issue impact the most?
 - iv. Are there organizations already addressing these issues in the county? If so, which ones?
 - c. Now thinking about [Name #3 critical health issue identified by interviewee]
 - i. What are the factors that contribute to making this a critical health issue?
 - ii. How does this critical health issue specifically impact low-income, underserved/uninsured populations in Caldwell County?
 - iii. Which populations does the issue impact the most?
 - iv. Are there organizations already addressing these issues in the county? If so, which organizations?
- 7. Based on your knowledge and expertise, what are the most effective strategies to address the top three health issues that you identified?
 - a. PROBE: What are some specific strategies that could help to address disparities between different populations for these health issues?
- 8. Beyond the top three health issues you've identified, what are the other critical health issues that are important to address?
- 9. How could St. David's Hospitals, Ascension Seton, Baylor Scott & White Health possibly partner with or enhance the efforts of organizations that are working to address the issues that you identified?
- 10. What are some of your community's greatest assets and strengths? *(Prompt: These often include social and human service agencies, community based organizations, nonprofit organizations, churches, but can also be cultural qualities).*
 - a. How do you think these strengths could be leveraged to address the top health issues in Caldwell County?
- 11. What are your suggestions for ways to engage and build trust with community members, particularly low-income, underserved populations, ethnic and racial minorities, and limited English proficient residents of Caldwell County to address these critical health issues?
- 12. Is there anything else you would like to share about the top health issues in Caldwell County?
- 13. Now I want you to think a little about a broader range of factors that could affect health. What do you think are the social and economic concerns facing your community? *(Prompt: affordable housing, unemployment, access to quality daycare, poverty).*
 - a. Who do these health needs or concerns affect the most (e.g., age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)?

- b. PROBE: Are there organizations or available resources already addressing these needs? If so, which ones? How do they address the needs?
 - c. PROBE: How important do you think it is that hospitals and health care systems work to connect patients with resources to support these factors affecting health? Why?
14. How could St. David's and local hospitals and Ascension Seton, Baylor Scott & White Health possibly partner with or enhance the efforts of these organizations to support factors affecting health?
15. Where do members of your community go to access primary health care?
- a. What about specialty care?
 - b. What about access to emergency rooms or urgent care centers?
 - c. And mental and behavioral health care?
16. What challenges/barriers do low-income, underserved, and uninsured populations in your community face in access to health care?
- a. What are two things that St. David's and local hospitals and St. David's Hospitals, Ascension Seton, Baylor Scott & White Health could do to address these challenges?

Those are all of the questions I have for you today. Is there anything else you would like to add before I turn off the recorder? [Allow time for comments]

APPENDIX B: FOCUS GROUP GUIDE

2021-22 SDF CHNA Caldwell County Focus Group Guide

1. When you think of the word “community,” what is the first thing that comes to mind?
2. What does health mean to you?
3. What do you do to stay healthy?
4. What are the things that **help you to be healthy** in your community? (e.g., places to buy healthy food, safe places to walk and to exercise, community services and events, access to health care, affordable housing)
5. What makes it **difficult to be healthy** in your community? (e.g., lack of access to affordable health care, few grocery stores with fresh fruits and vegetables, affordable food, lack of transportation, language barriers, substance use, etc.)
6. How does your race or ethnicity impact your ability to be healthy?
7. What do you think are the **two most important health issues** facing your community? Why? (e.g., diabetes or cancer, unhealthy food or drug abuse, mental health, violence, or access to care)
8. What are the **top two things that could be done** to fix these issues? (e.g., What would it look like to fix the issues?)
 - a. Who should be involved (people or organizations)?
9. Are there health services that you need but do not receive currently? If so, which services?
10. Where do you go for help when you need health services and cannot find them?
11. What are the strengths of the health services available in your community?
12. What resources do you have in the community that seem to be working to address the health-related issues that we talked about?
13. What could the hospital systems do to improve health and quality of life in the community?
14. What impact has the COVID-19 pandemic had in your life and in the community?
 - a. How has it affected your health, including your mental health?
 - b. How did COVID-19 impact the health challenges that we discussed earlier?
 - c. Are there community resources or agencies that have helped to support you during the pandemic? **If so, which organizations have been helpful?**
15. Are there any other issues that impact your physical or mental health that you would like to discuss?

COMMUNITY INPUT SUMMARY REPORT:

Hays County 2021-22 Community Health Needs Assessment



(I) Hays County 2021-22 Community Health Needs Assessment

ABOUT TEXAS HEALTH INSTITUTE

Texas Health Institute is a nonprofit, nonpartisan public health institute with the mission of advancing the health of all. Since 1964, we have served as a trusted, leading voice on public health and health care issues in Texas and the nation. Our expertise, strategies, and nimble approach makes us an integral and essential partner in driving systems change. We work across and within sectors to lead collaborative efforts and facilitate connections to foster systems that provide the opportunity for everyone to lead a healthy life. For more information, visit texashealthinstitute.org and follow us on Twitter, Facebook and LinkedIn.

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THI	Texas Health Institute
SDF	St. David’s Foundation
AAPI	Asian American Pacific Islander
CHNA	Community Health Needs Assessments
CBO	Community-Based Organizations
ACE	Adverse Childhood Experience
CARTS	Capitol Area Rural Transportation System
SNAP	Supplemental Nutrition Assistance Program
ICE	U.S. Immigration and Customs Enforcement

BACKGROUND AND METHODS

As part of a collaboration of local hospital systems, St. David's Foundation (SDF) contracted with Texas Health Institute (THI) to conduct the qualitative research for the 2021-22 Community Health Needs Assessments (CHNAs) in Bastrop, Caldwell, Hays, and Williamson counties. The qualitative research and report are designed to meet the community input requirements of a CHNA for 501(c)(3) hospitals under the Affordable Care Act. As part of the CHNAs, THI staff used key informant interviews and focus groups to explore critical health issues in the four counties and how these issues are affected by COVID-19, structural factors, underlying causes, and community assets.

In addition to SDF, Ascension Seton and Georgetown Health Foundation were key collaborators in the Hays County CHNA process. Each of the collaborating organizations will also be using this community summary report to support the development of their respective CHNAs.

METHODS

Between August and October 2021, THI virtually conducted eight key informant interviews and two community focus groups in Hays County. In addition, THI virtually conducted one targeted Photovoice project and associated discussion session.

THI contacted several organizations to recruit key informants and focus group participants:

- Amigos de Jesús
- Austin Community College – Hays Campus
- Barnabas Connection
- CASA of Central Texas
- Community Action of Central Texas
- Dripping Springs Hill County Senior Center
- Eikon Church
- Hays County Government
- Hill Country Mental Health and Developmental Disabilities Centers
- Kyle Housing Authority
- San Marcos Activities Center
- San Marcos Housing Authority
- Southside Community Center
- Texas State University
- Texas State University Student Health Center
- Women of Unity

A THI staff member served as the facilitator, conducting and audio recording all virtual interviews and focus groups. Recordings were automatically transcribed using Otter.ai and transcripts were verified for accuracy and cleaned. Spanish-language focus groups were first transcribed in Spanish and then translated into English. Transcripts were coded and analyzed using Atlas.ti qualitative software.

Key Informant Interviews

SDF and collaborating organizations helped identify potential key informants in Hays County based on their role as leaders in organizations with current information regarding the health needs of communities served by the hospital system. THI contacted key informants via email with an explanation of the project, including that the emphasis was on interviewing community leaders who understand the needs of medically underserved, low-income, and minority populations. The key informants for this project ([Table I](#)) included representatives from health care organizations, community-based organizations, and local government.

The key informant interview guide asked organizational leaders about the critical health issues in the county, the impact of COVID-19 on these issues, structural factors that contribute to the critical health issues, assets and strengths of the community, and possible solutions ([Appendix A](#)). Each key informant interview lasted one hour.

Focus Groups

THI contacted 16 organizations to identify focus group participants who represented low-income, medically underserved, and minority residents of Hays County. Community organizations initially notified potential participants about the focus groups and the overall purpose of the CHNA.

Once community members expressed interest in participating, THI coordinated with the participants to arrange meeting details. In addition, THI used snowballing to identify additional participants through referrals to participants' friends and neighbors. Each participant self-identified as fitting one or more descriptions: medically underserved, low income, and minority, or living with chronic disease needs. After each focus group, THI sent participants a \$25 electronic gift card to a store of their choice. One community member attended the English-speaking focus group, and nine community members attended the Spanish-speaking focus group.

The focus group guide covered participants' health concerns, underlying root causes of health issues that they see in their communities, community assets, proposed solutions, and specific strategies for addressing critical health needs (see Appendix B). Community focus groups lasted approximately 75-90 minutes each and were conducted in the early evening hours of weekdays.

Photovoice and Discussion

Photovoice participants were recruited through the same processes as community focus group participants. THI worked specifically with high school teachers from Hays Independent School District and Barnabas Connection to identify participants; participants were required to provide a signed parental consent form and received a \$50 electronic gift card after completion of the project.

The project involved two sessions, starting with a 30-minute virtual training session for participants ages 14-18. The facilitator asked participants to take and submit five photos—without faces or names—that represent factors that make it easy or difficult to be healthy in their community. Participants were encouraged to submit any photos they felt represented the prompt, including staged or candid photos, indoor or outdoor settings, and photos taken anywhere in their community (e.g., at home, school, church, work, etc.).

Approximately one week after the initial session, participants attended a 90-minute virtual discussion session during which the facilitator displayed photos via screenshare on Zoom. Participants discussed each other's photos and experiences using the prompt questions:

- What do you see?
- How does it make you feel?
- Why does this condition exist?
- What are some things that can be done about this condition, especially by local hospital systems?

HEALTH EQUITY

THI applied a health equity lens to the analysis of the focus groups and key informant interviews. This was done by intentionally engaging community members from racial and ethnic minority population groups, conducting a focus group in Spanish, and by incorporating specific questions in the interview guides, including the following:

Key informant interview guide:

- Who do the top most critical health issues affect the most? (e.g., age groups, racial and ethnic groups, socioeconomic groups, geographic subsets, etc.)
- What factors contribute to the critical health issues?
- How does the critical health issue identified specifically impact low-income, underserved/uninsured populations?
- What are some of the community's greatest strengths and assets? How could these be leveraged to address the health issues identified?
- What are your suggestions for ways to engage and build trust with community members, particularly low-income, underserved populations, ethnic and racial minorities, and limited English proficient residents to address the critical health issues of the county?

Focus group guide:

- What makes it easy or difficult to be healthy in your community and what factors, such as racism or discrimination, impact your ability to be healthy?
- Are there health services that you need but do not receive currently?
- What are some resources in the community that seem to be working to address health-related issues?

Additionally, the following reflective questions were used to frame the analysis of the transcripts in order to draw out considerations of health equity:

- Who is disproportionately affected and impacted by critical health issues and by potential solutions?
- Who is included and excluded?
- What are the root causes and causal factors contributing to the community health needs?
- Are there assumptions taking place? If so, what are they?
- Who is potentially benefiting and who is being harmed?
- What are the interviews and focus groups telling us about what data might be missing? About who is and is not at the decision-making table?
- What changes are needed and what could be done differently?

THEMES

Among the key informant interviews, focus groups, and Photovoice group, three primary thematic categories emerged. The order presented below does not indicate priority or frequency.

- Priority health needs
- Barriers to health care and healthy lifestyles
- Sub-populations facing greater health disparities

In all interview contexts, participants identified the priority health issues in Hays County, including specific chronic diseases and categories of health. Additionally, participants described various social and structural barriers to accessing health care and living healthy lives. Participants also identified multiple sub-populations within Hays County who experience disproportionate health disparities and barriers. Several sub-themes emerged among each of these primary themes, which will be explored throughout the report as well.

PRIORITY HEALTH NEEDS

Key informants and focus group participants identified the top health priorities of Hays County, as well as the potential root causes for each priority. The most commonly listed health issues included diabetes, hypertension, obesity, and mental illnesses such as anxiety and depression. Participants also mentioned cancer and high cholesterol as prevalent, but to a lesser extent.

Diabetes

Participants mentioned diabetes as the most common health challenge in the community, noting a higher prevalence in both Hispanic/Latinx and Black/African American communities of the county. One key informant observed that diabetes affects “anyone over thirty” years old, indicating that it is a common issue. Participants said that diabetes is so common because of widespread challenges with nutrition and food insecurity, difficulty affording diabetes medications, and the prevalence of other similar chronic diseases.

Hypertension

The second most commonly identified health priority was hypertension. Participants noted hypertension is common among the entire population, including younger community members. As with diabetes, participants identified food insecurity, access to affordable care, and co-occurring chronic diseases as underlying reasons for the high prevalence of hypertension. Notably, the key informants could not identify any local organizations that are providing specific resources to mitigate the prevalence of hypertension.

Obesity

Participants mentioned obesity as another health priority in Hays County. One key informant said, “I’m seeing obesity a lot in the younger population. So they don’t have other conditions [like diabetes or hypertension] yet, but they will soon.” Other participants described increased incidences of weight gain among school-aged children specifically as a result of the COVID-19 pandemic, which has increased food insecurity, intensified chronic stress, and led to fewer activities being done outside the home.

Mental Health

Participants identified mental health as another health priority for Hays County, and specifically challenges with anxiety and depression. When asked to identify the root causes of mental health-related challenges, participants noted three factors. One, residents face general financial insecurity; one participant from the Spanish-speaking focus group said, “I think many people have depression because of the pressure they face in paying rent, bills, car insurance, and their phone bills.” Two, isolation increased due to COVID-19; one key informant noted that isolation

brought on by the pandemic “has been very difficult even for people who were previously pretty healthy.” Three, the lack of mental health providers in Hays County—especially providers who accept Medicaid or offer affordable self-pay options—reduces access to care. Furthermore, the waitlists for available providers are often multiple months long, making their services inaccessible for many community members.

“Even if people do have insurance, it's hard to get in to see [a mental health provider]. But for the people without insurance, it's pretty much not even an option.”

– Key Informant

Cancer

Participants also identified cancer as another health priority for Hays County, although it was mentioned less frequently than the above health conditions. When asked to identify root causes of cancer, participants noted that the prevalence of other health issues in Hays County, such as diabetes or obesity, are often associated with cancer. The lack of access to affordable preventive care was also mentioned as an underlying cause.

“[Our providers] usually find [patients] in their late stages [of cancer]. Because they don't have any insurance, they don't go to the doctor. And they haven't had an annual exam in 10 years ... then all of a sudden, they have a problem. And oh, lo and behold, you're in stage 4 for lung, pancreatic, liver [cancer].”

– Key Informant

Sub-themes:

- High cholesterol is a health problem seen among all age groups in Hays County.
- Transportation barriers complicate and deepen issues of isolation and make some mental and physical health issues worse.
- The most common types of cancers mentioned included liver, pancreatic, lung, and breast cancer.

BARRIERS TO HEALTH CARE AND HEALTHY LIFESTYLES

In identifying the top health priorities for Hays County, participants also described various social and structural barriers that medically underserved, low-income, and minority community members face that inhibit their access to health care and ability to live healthy lifestyles. The

most commonly identified barrier was the cost of health care. Participants also described the lack of transportation services, food insecurity, and unaffordable housing.

Cost of Health Care

Participants frequently identified lack of access to affordable health care as a main barrier to health and wellness. Multiple key informants mentioned that a significant portion of the Hays County population is uninsured or underinsured. One key informant described how common it is for low-income families to have disruptions in their health care due to irregular insurance access. The key informant said that families end up “running around, trying to get [their] files from this [provider] to that one.... Then, things fall through the crack.”

“A lot of people among our population have either poor access to health care, or no access to health care, because of financial reasons.”

– Key Informant

Participants also described the challenges that many underserved, low-income, and minority community members face regarding health care; while many receive lesser quality care due to financial insecurity or being un- or underinsured, many more will forgo care entirely because of the costs. Participants noted that people often avoid preventive care because the cost of regular lab tests is prohibitive.

Additionally, for these underserved and low-income community members, the opportunity costs associated with missing work to see a provider are too high. Consequently, many people rely on the emergency room for their health care needs, which ultimately results in large medical bills for treatment that could have been mitigated with more frequent health care access.

When asked about where low-income and uninsured residents go to receive free or affordable health care services, participants mentioned CommuniCare in Kyle. Participants from the Spanish-speaking group also mentioned CommuniCare Wimberley and CHRISTUS Trinity Clinic in San Marcos as clinics that provide affordable care for the Hispanic/Latinx community. Participants also noted the limitations of CommuniCare Wimberley (pediatrics only, does not treat adults), and the need for a low-cost clinic for uninsured, underinsured, and publicly insured adults in the area. Additionally, participants traveled to Austin or San Antonio to visit specialists with affordable, sliding-scale options. However, traveling even to San Marcos or Kyle is inaccessible for many due to not having a personal vehicle, expenses of travel (e.g., gas), or opportunity and financial costs associated with missing work.

“With just one consultation or one operation, one has to go multiple times. And let's not even talk about the price. It is way too high.”

– Spanish-speaking Focus Group Participant

Sub-themes:

- Affordable options for health care used by residents include the local health department, Live Oak Clinic, CommuniCare, and Corridor Primary Care in Kyle and San Marcos.
- Dental care is cost prohibitive for most; CommuniCare in Kyle offers basic oral care at lower costs.
- Many providers have stopped accepting Medicaid, which has reduced the number of options for affordable care.
- It is critical for low-cost providers to make it clear that their services are low or no cost, as this could mitigate the issue of people forgoing health care due to cost.

“Health insurance or the ability to pay for health care is the biggest barrier [to accessing to care].... Erasing income disparity as the determinant for quality of health care is the way to level the playing field.”

– Key Informant

Transportation

Participants identified transportation as another common barrier for many residents of Hays County. One key informant noted that, although Hays County is one of the fastest growing counties in the nation, there is extremely limited public transportation infrastructure. The Capital Area Service Transportation System (CARTS) service is limited, in both hours and available routes, and there are no other public options. Furthermore, one key informant noted, “There is no transportation available for someone with a wheelchair in Hays County to go the doctor.” Consequently disabled community members can struggle to receive appropriate services.

“There is no transportation so you miss your follow-up. You have to reschedule it for the next month, and then they can’t prescribe you your medicine. That’s where it becomes hard to stay healthy because you’re missing your medications. That makes it impossible to stay healthy.”

– Focus Group Participant

In addition to the lack of public transportation options, participants noted that many residents of Hays County do not have access to personal transportation. Focus group participants described having to rely on neighbors or friends to travel to work, grocery stores, or doctor’s appointments. A participant mentioned that it is not uncommon to have multiple households riding together to pick up food from the pantry, “We’ve stuffed four families’ worth of stuff into one car because only one person had access to a car that day.” For those who do have access to vehicles, gas and repairs are an additional financial burden. Therefore, needing to drive to San Marcos for affordable services at CommuniCare can be a barrier for many.

“Sometimes we are asking other people to do us the favor of taking us to the place we need to go to for medical assistance. It is not always possible to get ourselves all the way there.... For places outside of Wimberley, I do need help from another person in getting there.”

– Spanish-Speaking Focus Group Participant

Participants described how transportation barriers not only inhibit their ability to access health care services, but also affect other aspects of their ability to live a healthy life. For example, lack of transportation limits people’s ability to work, especially if multiple family members from one household need to travel to work. Additionally, transportation barriers often lead to people being isolated, which affects their mental and physical health. Even food access is inhibited by transportation barriers because community members need to be able to drive into more populous areas, like central Wimberley, Kyle, Buda, or San Marcos, to access grocery stores.

“With a clinic here in Wimberley, all of us who don’t have cars could walk to it.”

– Focus Group Participant

Food Insecurity

Participants noted that food insecurity is another common barrier to health in Hays County, and that many local nonprofits are actively working to improve food access. When asked about the root causes of this issue, participants identified the general financial insecurity of many residents. Participants also noted the geographic division of food access, with communities on the eastern side of I-35 having fewer grocery stores compared to the western side.

“I think anybody can see on a map that the area east of I-35 has less access to grocery stores and fresh foods.”

– Key Informant

Regarding the impact of financial insecurity on food access, participants noted that many residents could not afford healthy food or enough food for their family. One key informant said, “People are making hard choices between medications and eating, or whether or not their kids eat.” As a result, families often resort to buying cheaper food even though it is less healthy. One community member said, “What’s cheap is not good for you, but I can’t afford organic food. I can’t afford the better or good stuff that I should be eating.” Another said, “A lot of times, eating less expensive food is the way to fill your stomach.”

Participants mentioned that many people use the Hays County Food Bank, which makes an effort to include fresh produce and healthy options with each distribution. One key informant

noted that despite these efforts, “the quantity of the food available through food pantries is not completely sufficient” for larger families, which are common. Similarly, school districts distributed breakfast and lunches for families during remote learning for the 2020-21 school year, but many families struggled to take advantage of this because “there’s only one vehicle in the household, and whoever takes that to work has the vehicle,” according to one key informant.

In addition to the food pantries, some community members are able to get assistance with food through public benefits such as SNAP—Supplemental Nutrition Assistance Program. Yet, while some families qualify for benefits based on income, many families are not able to access SNAP due to their immigration status.

“There are several families where there’s mixed status and there’s a general fear of whoever has not got [citizenship] might get deported. So I would say immigration status affects access to food.”

– Key Informant

Unemployment

Unemployment also emerged as a sub-theme in relation to food insecurity. Participants noted the significant job loss in Hays County due to the pandemic. The prevalence of unemployment has intensified financial insecurity, especially in the Hispanic/Latinx population. Participants commented that there are also many barriers to gaining employment for particular populations. For example, people who are formerly incarcerated, low-income, or immigrants may not have social security cards or state IDs, which inhibits their ability to apply for jobs.

Affordable Housing

Participants also identified the lack of affordable housing as another prominent barrier to health in Hays County, especially in the last few years. One key informant said, “Affordable housing is just nonexistent in our area.” As a result, many community members live in multi-generational housing. According to one key informant, many families are “all crunched in somewhere because they can’t afford individual places.”

Furthermore, lot of housing conditions are poor, especially among immigrant communities, and the lack of affordable housing has increased homelessness. Participants noted that because housing is increasingly unaffordable, people’s ability to be healthy, engage with health care, or pay for other basic costs of living is inhibited. The cumulative impact of these stressors is increased mental stress.

“When 50% or 60% of your income is going towards rent or towards your mortgage, then you’re not able to put gas in the car or go to the doctor.”

– Key Informant

Population growth emerged as a sub-theme within the discussion of housing challenges in Hays County. Participants described the large influx of people moving into the area due to housing crises elsewhere. One key informant said people are coming from Austin and California, “buying up a lot of real estate” and causing property values to become unaffordable for long-time community members. Not only does this create barriers for home ownership, rent prices have increased exponentially as well.

SUB-POPULATIONS FACING GREATER HEALTH DISPARITIES

Participants identified five sub-populations in Hays County who experience greater health disparities and barriers to accessing health care. These populations include people who are immigrants, disabled, LGBTQ+, children, and older adults.

Immigrants

As discussed in previous sections of this report, immigrant communities in Hays County experience barriers such as lack of access to public programs like Medicaid or Children’s Health Insurance Program, SNAP, and Temporary Assistance for Needy Families. Additionally, immigrant communities often face barriers to employment. Cumulatively, these barriers create disproportionate financial insecurity among immigrant populations compared to the general population.

In addition to these structural barriers, participants noted that immigrant populations in Hays County experience discrimination both in health care settings and in general. Some participants described situations where they have encountered discriminatory speech and treatment from health care providers due to their immigration status. Other participants mentioned immigrants may be reluctant to give out personal information for health care or social services because of fears of deportation and consequently, will not visit doctors or social service agencies.

“We need to have an agency or medical service that doesn’t care if you are a citizen or not.”

– Focus Group Participant

Participants also noted the prevalence of discrimination in general. One key informant described incidences of U.S. Immigration and Customs Enforcement (ICE) raids at the H-E-B in Wimberley, saying that ICE agents would wait at the grocery store in unmarked vehicles to arrest people exiting the store. The key informant said that for many months after such events, many immigrant families would not “come to town to get food” or visit social service agencies that they normally felt comfortable to visit. Another key informant mentioned that there is a lot of stigma against organizations that help undocumented community members in general, making it complicated for them to garner support from the broader community.

People with Disabilities

People with disabilities in Hays County experience disproportionate barriers to health care access and are more affected by transportation barriers and access to services. One key informant noted the lack of accessible public transportation for people who use wheelchairs or need physical assistance. Additionally, people with visual impairments experience barriers to using telehealth platforms and social service agency websites. One key informant described how these populations rely on the 211 line to sign up for benefits or services but often face extremely long wait times for assistance over the phone. Finally, the lack of specialist providers in Hays County directly affects people with disabilities who often need specialty services.

LGBTQ+ People

Another sub-population identified as having greater health disparities and barriers is the LGBTQ+ community. For example, a key informant described the challenges that LGBTQ+ people face in Hays County, including harassment and homophobic treatment when they visit shops, restaurants, or gas stations. They noted how discrimination often leads to isolation and mental illness among those community members who are LGBTQ+.

Additionally, LGBTQ+ people in Hays County experience discrimination in health care settings, and transgender residents in particular face significant challenges in health care settings because “they will receive poor treatment, or no treatment, or inappropriate treatment.” This may include being misgendered, having hormone therapy disrupted “without any good reason,” or being ridiculed by providers. There is a need for more health care providers who are responsive to LGBTQ+ culture (e.g., knowledgeable about pronoun preference) and equipped to treat health issues specific to the LGBTQ+ community and transgender residents (e.g., hormone replacement therapy).

“[The LGBTQ+ community] really does need more LGBT-supportive medical providers—that could be dentists, it could be your primary care physician, or hospital staff.”

– Key Informant

Children

Participants described how children are a sub-population within Hays County who experience health disparities and are affected by a lack of access to care. As previously mentioned, children appear to be struggling with weight gain and obesity more during the pandemic. Additionally, children and teens have less control over their diet and lifestyle compared to adults, making it harder to address health issues such as high cholesterol, diabetes, and hypertension.

Furthermore, participants noted that many children are not able to get the health care services they need. For example, one key informant mentioned frequently seeing “young people not having access to vision screenings and corrective lenses as early as they could were they getting regular health care.” Participants also mentioned that children and teens are unable to get vaccines and physical exams required to attend school or participate in extracurricular activities.

Older Adults

Participants identified how isolation, financial insecurity, and technology barriers disproportionately affect older adults. For example, older adults have experienced greater isolation during COVID-19, affecting both their mental health as well as their ability to receive services. Participants also described how older adults in Hays County have been disproportionately affected by financial insecurity during the pandemic. One key informant said that rent in some senior living apartments has increased, creating significant financial challenges for people living on pensions. Furthermore, many social services, such as Meals on Wheels or senior luncheons, have been canceled or limited due to the pandemic, increasing food insecurity among older adults.

In addition to challenges brought on by the pandemic, participants noted that older adults in Hays County experience health disparities because of technology barriers. Many older adults face challenges with using virtual platforms, not just for accessing health care—which is increasingly moving toward virtual-based care—but also for meal delivery services or other social services. Additionally, barriers to using smart phones or video calling platforms can intensify social isolation among this population.

IMPACT OF COVID-19

Although mentioned throughout the previous sections, the impact of COVID-19 warrants its own discussion, as community members described specific ways in which the pandemic has affected the community’s health. The following are previously described negative impacts of the COVID-19 pandemic:

- Increased physical inactivity due to staying home
- Increased isolation, anxiety, and stress
- Increased food insecurity
- Increased financial insecurity due to job loss and reduced social services

In addition to these factors, participants described how the pandemic has directly impacted access to health care. For example, key informants noted that community members are hesitant to go to preventative health care appointments due to the prevalence of COVID-19. One key informant said, “I think there'll be a lot of both kids and adults who go a couple years without getting a regular physical because they don't want to have contact in that doctor's office [due to] the high rates of COVID-19 transmission in the community.”

Another key informant described how the hesitation extends beyond preventative appointments and also affects medical emergencies. The key informant said, “People are hesitating to go to the hospitals for heart palpitations, for heart attacks” because of fear of being infected with COVID-19. Community members also noted that precautions in the health care system related to COVID-19 have had the unintended consequence of limiting access for non-COVID health concerns.

“COVID also affects our diseases because if you go to an appointment and you have a fever that isn't related to COVID, they still don't want to help you because they think it is COVID.... You might have a check-up, but if you have fever or a runny nose, they think it is COVID and will cancel your appointment.”

– Focus Group Participant

COMMUNITY ASSETS AND STRENGTHS

When asked to describe the strengths of Hays County, participants mentioned a strong sense of community and a priority for taking care of each other. Individuals, local nonprofit organizations, and churches from various denominations are eager to network and coordinate with each other to distribute food and provide social services. One key informant said, “In rural populations, you really have to work with other people to survive. And I think that's what we are doing well. There's more we can do, but we're doing that pretty well.”

“I do think that the community has a strong sense of place and support for one another. And I think that is something that's really important.”

(17) Hays County 2021-22 Community Health Needs Assessment

More generally, participants noted that Hays County has a lot of natural space, which can provide opportunities for physical activity, time in nature, and places for community events. Additionally, participants noted that even though the county’s population growth has presented challenges, it has also brought in more financial resources. One key informant mentioned that the influx in people with higher incomes presents an opportunity to tap into private wealth for the greater good. Finally, participants noted that Hays County is home to a wide age range of people. With large populations of both college students and retirees, the generational diversity can be leveraged to strengthen the networking and mutual aid happening in the area.

Participants mentioned many local and regional organizations that are helpful resources to community members. These include:

Amigos de Jesús Ministry (in the Mercado)
Any Baby Can
Barnabas Connection
City of San Marcos
CHRISTUS Trinity Clinic (San Marcos)
CommuniCare (San Marcos and Kyle)
Community Action
The Connection Church
Greater San Marcos Youth Council
Hays-Caldwell Women’s Center
Hays County Food Bank
Hays Independent School District
Hill Country Mental Health and
Developmental Disabilities Centers

Live Oak Health Partners Community
Clinic (San Marcos)
Meals on Wheels
Out Youth (Austin)
Planned Parenthood
Santa Cruz Catholic Church (Buda)
Schreib Youth Crisis Respite Center
Southside Community Center
St. Vincent de Paul Society of St. Anthony
Marie de Claret Catholic Church
Women, Infants and Children program
(San Marcos)

PROPOSED SOLUTIONS AND ACTIONS FOR HOSPITALS

Participants were asked to identify potential solutions for the challenges they discussed during the interviews and focus groups.

BUILD TRUST TO IMPROVE OUTCOMES AMONG UNDERSERVED COMMUNITIES

Culturally competent workforce: Equip providers and hospital staff to better serve community members, especially people who are immigrants, Hispanic/Latinx, Black/African American or LGBTQ+ and those with disabilities.

Partnerships: Establish coalitions and partnerships with community-based organizations, churches, and schools to build trust and expand impact.

Community engagement and outreach: Work with community-based organizations to distribute information about health fairs or other hospital events and services, such as vaccine clinics.

Language and translation services: Ensure that materials are linguistically accessible and consider using non-print communication such as radio broadcasts. Increase the number of providers who speak Spanish or have accessible translation services. Include language on office doors and hospital marketing materials that explicitly welcomes historically excluded populations such as people who are LGBTQ+, immigrants, and Black/African American.

Proof of identification: Remove requirements for photo IDs, proof of citizenship, or other paperwork that may be a barrier for some populations to provide.

INCREASE AFFORDABILITY AND ACCESS

Affordable health care: Expand options such as free or low-cost clinics, sliding scale payment options, co-pay assistance for preventive health care (such as screenings or lab tests), and processes for nonprofits to easily pay for services on someone's behalf. Affordable services are especially needed for adults, as some available options only serve children.

Awareness: Ensure that free or low-cost services are explicitly advertised as such to increase likelihood that community members will use them.

Mobile clinics in rural areas: Offering mobile clinics would be most helpful if they are available frequently, such as once a week, and offer free or reduced-cost services.

Primary care and specialists: Expand access to providers, including pediatricians, OB/GYN, endocrinologists, ophthalmologists, and cardiologists. Specialists who offer free or low-cost services are especially needed.

Mental health services: Improve and expand access to services that are affordable, culturally sensitive, and accessible to older adults and minority community members.

REDUCE BARRIERS IN THE COMMUNITY

Community education: Prevention-focused classes or lifestyle change programs should be affordable or free and culturally appropriate. Programs that address the prevention of diabetes and hypertension are especially needed. Consider collaborating with community-based organizations, including churches, to host classes.

Transportation services: Work with local officials to improve options, such as expanding CARTS or establishing privately funded buses or vans that link clinics and communities. Transportation services should be accessible to community members with disabilities.

Affordable and healthy food: Expand access by increasing capacity of the Hays County Food Bank, working with churches to distribute food, and establishing affordable grocery stores in rural areas.

“I know the hospital here offers classes and stuff, but they're not affordable to most people. So just having affordable options for education I think would be really huge.”

– Key Informant

LIMITATIONS

There are several limitations to consider in the development of this report. First, THI conducted this project during the surge of COVID-19 cases related to the Delta variant, which occurred during the late summer and early fall of 2021. For the safety of staff and participants, all key informant interviews and focus groups were conducted virtually. This presented a challenge with both recruitment and facilitation of the interviews. Many of the community leaders who helped recruit participants, or who served as key informants, were overwhelmed by responsibilities related to the pandemic. For example, some organizational leaders were coordinating clinical duties or responding to urgent needs from community members, limiting their capacity to assist with this project. Similarly, community members were experiencing fatigue from the pandemic, including fatigue regarding inquiry into their needs and the effects of COVID-19.

THI staff did extensive outreach to various CBO leaders in Hays County and potential participants, and organizational leaders and residents alike frequently declined participation for a variety of reasons, including research fatigue and fear of exploitation. In addition, THI staff experienced challenges with getting in contact with potential participants, even though multiple channels of communication were used (email, call, and text).

Furthermore, to participate virtually in focus groups, participants had to have access to a device that would allow them to use Zoom (a computer, tablet, or cell phone with data). While not a barrier for the majority of key informant interviews, this requirement likely inhibited some potential focus group participants from joining. In addition, although focus group participants could join Zoom by phone (dial-in), participants familiar with the video aspect of Zoom were frequently confused by the dial-in option, and consequently declined participation or did not show up to the focus group. Finally, virtual key informant interviews and focus groups could more easily be confounded by office or in-home distractions compared to in-person settings.

CONCLUSIONS

Between August and October 2021, THI virtually conducted eight key informant interviews, two community focus groups, and one small-scale Photovoice project in Hays County. Participants represented or were leaders of medically underserved, low-income, and minority populations. They identified and discussed the top health priorities of their community, including:

- **Priority health needs:** Examples include diabetes, hypertension, mental illnesses such as anxiety and depression, obesity, and cancer.
- **Access to health care and healthy lifestyles:** Top concerns included costs of health care, transportation access, food insecurity, unemployment, housing, and population growth.
- **Sub-populations facing greater health disparities:** These sub-populations, including people who are immigrants, LGBTQ+, disabled, children, and older adults, face unique barriers.

To address these issues, participants recommended leveraging the strengths of their community, including the strong network of trusted community-based organizations and churches. The recommended solutions identified in this report represent the needs and priorities of communities most affected by health disparities due to historical exclusion or discrimination. These findings may be used to improve the overall health of Hays County, especially its most vulnerable populations.

TABLES

The following table identifies each key informant and details how their role in the community satisfied one of the IRS requirements for participation.

Table I
Description of Key Informants

Key Informant	Community Input Sector
Claire Bow Attorney and Transgender Advocate	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Debbie Gonzales Ingalsbe County Commissioner Precinct I	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Eleanor Owen Executive Director Hays County Food Bank	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Margie Rodriguez Clinic Manager Hays County Indigent Health Care Program	Federal, tribal, regional, state, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility
Albert Sander Director Amigos de Jesús	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Carrie Stolf Wesley Nurse First United Methodist Church San Marcos	Person with special knowledge or expertise in public health

Diana Woods Social Services Coordinator Buda Food Pantry	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Name withheld per request School District in Hays County	Persons with special knowledge or expertise in public health

The following table describes the focus group participants in aggregate:

Table 2
Description of Focus Group Participants

Focus Group	Community Input Sector	Description of Participants	Number	Language
Spanish-speakers	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included female and male residents in ZIP codes 78676, 78619, and 78737, with ages ranging from 30-65. All participants identified as Mexican, Mexican American, or Chicano.	9	Spanish
English-speakers	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Female resident of ZIP code 78610. Additional demographic data withheld to protect anonymity.	1	English

Photovoice (Youth)	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included female residents in ZIP codes 78640, 78619 and 78640. Participants were between 16 and 18 years old. Two identified as Mexican, Mexican American, or Chicano, one as Hispanic/Latinx and Spanish origin.	3	English
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APPENDIX A: KEY INFORMANT INTERVIEW GUIDE

2021-22 Hays County SDF CHNA Key Informant Interview Guide

1. Please briefly describe your role in [organization] and who [organization] serves in Hays County.
2. Please describe how you are connected to St. David's Foundation, any of the St. David's Hospitals, Ascension Seton, Baylor Scott & White Health. If you are not connected, just indicate that.
 - a. Do you meet any of these criteria? *[Note: Participant does not necessarily have to meet any of these to participate.]*
 - i. Persons with special knowledge of or expertise in public health
 - ii. Federal, tribal, regional, state, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility
 - iii. Leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility.
3. What do you think are Hays County's three most critical health issues? *(Examples if needed: heart disease, diabetes, substance use, mental health, cancer, asthma, STIs, HIV, etc.)*
 - a. PROBE: Why are these the top priorities?
 - b. PROBE: Who do these health issues affect the most? (e.g., age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)
4. The top health issues identified in the 2019 Community Health Needs Assessment were [list top needs in previous CHNA]. How important are these issues today?
5. How has COVID-19 impacted the three critical health issues you identified?
 - a. PROBE: Are there some groups that have been more affected by COVID-19 than others in your community?
6. Now I am going to ask you about the factors that contribute to each of the top priority health issues you identified and how the issue impacts specific populations. *(Prompt: Note that a "factor" could be a health behavior like physical activity, SDOH such as food insecurity, insurance status, physical environment, etc.)*
 - a. Starting with [Name #1 critical health issue identified by interviewee]
 - i. What are the factors that contribute to making this a critical health issue?
 - ii. Which populations does the issue impact the most?
 - iii. How does this critical health issue specifically impact low-income, underserved/uninsured populations in Hays County?
 - iv. Are there organizations already addressing these issues in the county? If so, which ones? How do they address it?

- b. Now thinking about [Name #2 critical health issue identified by interviewee]
 - i. What are the factors that contribute to making this a critical health issue?
 - ii. How does this critical health issue specifically impact low-income, underserved/uninsured populations in Hays County?
 - iii. Which populations does the issue impact the most?
 - iv. Are there organizations already addressing these issues in the county? If so, which ones?
 - c. Now thinking about [Name #3 critical health issue identified by interviewee]
 - i. What are the factors that contribute to making this a critical health issue?
 - ii. How does this critical health issue specifically impact low-income, underserved/uninsured populations in Hays County?
 - iii. Which populations does the issue impact the most?
 - iv. Are there organizations already addressing these issues in the county? If so, which organizations?
- 7. Based on your knowledge and expertise, what are the most effective strategies to address the top three health issues that you identified?
 - a. PROBE: What are some specific strategies that could help to address disparities between different populations for these health issues?
- 8. Beyond the top three health issues you've identified, what are the other critical health issues that are important to address?
- 9. How could St. David's Hospitals, Ascension Seton, Baylor Scott & White Health possibly partner with or enhance the efforts of organizations that are working to address the issues that you identified?
- 10. What are some of your community's greatest assets and strengths?
(Prompt: These often include social and human service agencies, community based organizations, nonprofit organizations, churches, but can also be cultural qualities).
 - a. How do you think these strengths could be leveraged to address the top health issues in Hays County?
- 11. What are your suggestions for ways to engage and build trust with community members, particularly low-income, underserved populations, ethnic and racial minorities, and limited English proficient residents of Hays County to address these critical health issues?
- 12. Is there anything else you would like to share about the top health issues in Hays County?
- 13. Now I want you to think a little about a broader range of factors that could affect health. What do you think are the social and economic concerns facing your community? *(Prompt: affordable housing, unemployment, access to quality daycare, poverty).*
 - a. Who do these health needs or concerns affect the most (e.g., age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)?

- b. PROBE: Are there organizations or available resources already addressing these needs? If so, which ones? How do they address the needs?
 - c. PROBE: How important do you think it is that hospitals and health care systems work to connect patients with resources to support these factors affecting health? Why?
14. How could St. David's and local hospitals and Ascension Seton, Baylor Scott & White Health possibly partner with or enhance the efforts of these organizations to support factors affecting health?
15. Where do members of your community go to access primary health care?
- a. What about specialty care?
 - b. What about access to emergency rooms or urgent care centers?
 - c. And mental and behavioral health care?
16. What challenges/barriers do low-income, underserved, and uninsured populations in your community face in access to health care?
- a. What are two things that St. David's and local hospitals and St. David's Hospitals, Ascension Seton, Baylor Scott & White Health could do to address these challenges?

Those are all of the questions I have for you today. Is there anything else you would like to add before I turn off the recorder? [Allow time for comments]

APPENDIX B: FOCUS GROUP GUIDE

2021-22 SDF CHNA Hays County Focus Group Guide

1. When you think of the word “community,” what is the first thing that comes to mind?
2. What does health mean to you?
3. What do you do to stay healthy?
4. What are the things that **help you to be healthy** in your community? (e.g., *places to buy healthy food, safe places to walk and to exercise, community services and events, access to health care, affordable housing*)
5. What makes it **difficult to be healthy** in your community? (e.g., *lack of access to affordable health care, few grocery stores with fresh fruits and vegetables, affordable food, lack of transportation, language barriers, substance use, etc.*)
6. How does your race or ethnicity impact your ability to be healthy?
7. What do you think are the **two most important health issues** facing your community? Why? (e.g., *diabetes or cancer, unhealthy food or drug abuse, mental health, violence, or access to care*)
8. What are the **top two things that could be done** to fix these issues? (e.g., *What would it look like to fix the issues?*)
 - a. Who should be involved (people or organizations)?
9. Are there health services that you need but do not receive currently? If so, which services?
10. Where do you go for help when you need health services and cannot find them?
11. What are the strengths of the health services available in your community?
12. What resources do you have in the community that seem to be working to address the health-related issues that we talked about?
13. What could the hospital systems do to improve health and quality of life in the community?
14. What impact has the COVID-19 pandemic had in your life and in the community?
 - a. How has it affected your health, including your mental health?
 - b. How did COVID-19 impact the health challenges that we discussed earlier?
 - c. Are there community resources or agencies that have helped to support you during the pandemic? **If so, which organizations have been helpful?**
15. Are there any other issues that impact your physical or mental health that you would like to discuss?

COMMUNITY INPUT SUMMARY REPORT:

Williamson County 2021-22 Community Health Needs Assessment



(I) Williamson County 2021-22 Community Health Needs Assessment

ABOUT TEXAS HEALTH INSTITUTE

Texas Health Institute is a nonprofit, nonpartisan public health institute with the mission of advancing the health of all. Since 1964, we have served as a trusted, leading voice on public health and health care issues in Texas and the nation. Our expertise, strategies, and nimble approach makes us an integral and essential partner in driving systems change. We work across and within sectors to lead collaborative efforts and facilitate connections to foster systems that provide the opportunity for everyone to lead a healthy life. For more information, visit texashealthinstitute.org and follow us on Twitter, Facebook, and LinkedIn.

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THI	Texas Health Institute
SDF	St. David’s Foundation
WCCHD	Williamson County and Cities Health District
AAPI	Asian American Pacific Islander
CHNA	Community Health Needs Assessment
CBO	Community-Based Organization
ACE	Adverse Childhood Experience

BACKGROUND AND METHODS

As part of a collaboration of local hospital systems, St. David's Foundation (SDF) contracted with Texas Health Institute (THI) to conduct the qualitative research for the 2021-22 Community Health Needs Assessments (CHNAs) in Bastrop, Caldwell, Hays, and Williamson counties. The qualitative research and report are designed to meet the community input requirements of a CHNA for 501(c)(3) hospitals under the Affordable Care Act. As part of the CHNAs, THI staff used key informant interviews and focus groups to explore critical health issues in the four counties and how these issues are affected by COVID-19, structural factors, underlying causes, and community assets.

In addition to SDF, Ascension Seton, Baylor Scott & White, Georgetown Health Foundation, and Williamson County and Cities Health District (WCCHD) were key collaborators in the Williamson County CHNA process. Each of the collaborating organizations will also be using this summary report to support the development of their respective CHNAs.

METHODS

Between August and October 2021, THI virtually conducted nine key informant interviews and two community focus groups with Williamson County residents. A THI staff member served as the facilitator for all virtual interviews and focus groups. Audio recordings of the sessions were automatically transcribed using Otter.ai, and staff verified and cleaned transcripts for accuracy. Transcripts were coded and analyzed using Atlas.ti qualitative software.

Key Informant Interviews

SDF and other collaborating organizations helped identify potential key informants based on their leadership roles and experience working with medically underserved, low-income, and minority populations served by the hospital system. THI contacted and recruited key informants via email with an explanation of the project. The key informants for this project ([Table 1](#)) included representatives from health care organizations, youth support organizations, and community-based organizations (CBOs).

The key informant interview guide for organizational leaders covered critical health issues in the county, the impact of COVID-19 on these issues, structural factors that contribute to the critical health issues, community assets, strengths of the community, and possible solutions to address these health issues ([Appendix A](#)). Each key informant interview lasted one hour.

Focus Groups

For the focus groups, THI identified people from low-income, medically underserved, and minority populations in Williamson County by working with Sacred Heart Community Clinic and identified school counselors that served these populations by working with WCCHD. Sacred Heart Community Clinic initially notified community members about the community focus groups and the overall purpose of the CHNA. Prior to working with Sacred Heart Community Clinic, THI unsuccessfully reached out to a number of other agencies and organizations in the county regarding recruitment for the community focus groups ([Limitations](#)).

After community members or school counselors expressed an interest in participating, THI coordinated with the participants to arrange meeting details. Each focus group participant—other than school counselors who serve these communities—self-identified as fitting one or more descriptions: medically underserved, low income, minority, or living with chronic disease needs ([Table 2](#)). Upon the conclusion of each focus group, THI compensated participants with a \$25 electronic gift card to a store of their choice.

The focus group guide covered participants' health concerns, underlying root causes of health issues that they see in their communities, community assets, proposed solutions, and specific strategies for addressing critical health needs ([Appendix B](#)). Community focus groups lasted approximately 75-90 minutes each.

HEALTH EQUITY

THI applied a health equity lens to the focus groups and key informant interviews. This was done by incorporating specific questions into the interview guides, including the following:

Key informant interview guide:

- Who do the top most critical health issues affect the most? (e.g., age groups, racial and ethnic groups, socioeconomic groups, geographic subsets, etc.)
- What factors contribute to the critical health issues?
- How does the critical health issue identified specifically impact low-income, underserved, or uninsured populations?
- What are some of the community's greatest strengths and assets? How could these be leveraged to address the health issues identified?
- What are your suggestions for ways to engage and build trust with community members, particularly low-income, underserved populations, ethnic and racial minorities, and limited English proficient residents to address the critical health issues of the county?

Focus group guide:

- What makes it easy or difficult to be healthy in your community and what factors, such as racism or discrimination, impact your ability to be healthy?
- Are there health services that you need but do not receive currently?
- What are some resources in the community that seem to be working to address health-related issues?

Additionally, THI used the following reflective questions to frame the analysis of the transcripts in order to draw out considerations of health equity:

- Who is disproportionately affected and impacted by critical health issues and by potential solutions?
- Who is included and excluded?
- What are the root causes and causal factors contributing to the community health needs?
- Are there assumptions taking place? If so, what are they?
- Who is potentially benefiting and who is being harmed?
- What are the interviews and focus groups telling us about what data might be missing? About who is and is not at the decision-making table?
- What changes are needed and what could be done differently?

THEMES

Among the focus groups and key informant interviews, four primary thematic categories emerged. The order presented below does not indicate priority or frequency of needs.

- Access to health care
- Structural and social determinants of health
- Priority health needs
- Children's health

Interview and focus group participants identified barriers within the health care system that inhibit their ability to receive accessible, affordable, and culturally appropriate care that includes specialty services. The participants also identified various social and structural barriers community members face that influence their wellness. Priority health needs emerged as participants described the most commonly occurring chronic illnesses present in Williamson County. Finally, participants frequently described the conditions that have a tremendous effect on children's health.

ACCESS TO HEALTH CARE

Key informants and focus group participants identified several factors that prevent access to health care in Williamson County including provider shortages for residents who are either publicly insured or uninsured, lack of culturally and linguistically appropriate care, and lack of medical system navigation support.

Access to Primary and Specialty Care for Publicly Insured or Uninsured

Community members frequently indicated an insufficient amount of primary and specialty care providers creates a barrier to accessing health care, particularly as it relates to providers that accept public insurance. One focus group participant said that, despite having four Federally Qualified Health Centers in Taylor, Round Rock, Cedar Park, and Georgetown, appointments are limited to certain days of the week, especially during the pandemic. Some Taylor residents travel to Round Rock and Georgetown to receive primary care services or x-rays.

Medicaid beneficiaries lack a sufficient number of primary care or specialty providers that accept their insurance, and people enrolled in WilCo Care (WCCHD's indigent care program) struggle to find physicians, particularly specialists. As a result, residents tend to over-utilize emergency rooms. One key informant stated that one of her recent clients enrolled in WilCo Care was referred to surgery after an emergency room visit but could not have the procedure due to the unavailability of specialty surgeons that accept the public insurance program. In addition, focus group participants recalled the difficulties in locating local mental health providers such as psychiatrists or psychologists who accept insurance to provide mental health care.

“When they're enrolled in the county program, we don't have a lot of providers that accept the WilCo Care card. Similar to Medicaid, we don't have a lot of providers.”

– Key Informant

Sub-themes:

- The wait times for appointments with providers at Lone Star Circle of Care who accept Medicaid or uninsured people are long (sometimes multiple months long).
- There are not enough options for health care in general, so many community members will use the emergency room for non-emergent health care.
- The types of specialty care or care for complex conditions that participants described needing included surgery, psychiatric services, affordable prescription dispensaries, optical care, podiatrists that can treat foot-related conditions for people with diabetes, and dental care.
- Many community members travel to Round Rock or Austin to receive specialty care and for primary care at free or low-cost clinics.

“If you are impoverished and only have Medicaid or no insurance, we have one Lone Star Circle of Care. That's it for the entire county.”

– Focus Group Participant

Insurance

Participants frequently shared challenges that residents have due to not having health insurance and not qualifying for the Medical Access Program. One focus group participant emphasized the large gap in health care services when residents cannot afford to pay privately. For example, without insurance, residents cannot receive access to preventive care or specialty services such as endoscopies or colonoscopies.

“Worrying about insurance, worrying about co-pays ... obviously, the transportation. I think all of the above would stop me from going unless I had to.”

– Focus Group Participant

Culturally and Linguistically Appropriate Care

Participants shared that health care services often feel inaccessible because they are not culturally or linguistically appropriate. Key informants and focus group participants shared barriers regarding language, noting an insufficient number of Spanish-speaking or Korean-speaking providers. For example, Hispanic/Latinx and Asian American Pacific Islander (AAPI) populations in Williamson County often encounter language barriers due to the lack of interpreters and translated material.

In addition, children and grandchildren often feel pressured to provide interpretation and assist senior populations with complex paperwork, because health care language, including language used on pamphlets or educational materials, is confusing and difficult to understand or apply. Furthermore, participants described how the inability to adapt to the predominant culture or navigate the health care system as an immigrant is a source of ongoing stress. Participants noted that many also forego both health care services and other services due to the fear of deportation based on immigration laws.

“There's a huge Hispanic population that's underrepresented, and they don't have the means to get the information translated into Spanish to help them better understand how they can get services that are available to them.”

– Key Informant

Sub-themes:

- Immigrant communities are distrusting of health care providers, fearing deportation or risks for their citizenship process.
- Many community members are not proficient in speaking or reading English but most health care information and services are only in English.
- Available interpretation services are limited and cannot assist non-English speaking patients with completing paperwork.
- Providers do not usually understand the needs or cultural priorities of Hispanic/Latinx communities and therefore the treatment is not accommodating or appropriate.

“A lot of times we do get calls of people who need food stamps, but because of the status of their immigration paperwork, they're afraid that if they apply for these benefits, then then they're not going to be able to become US citizens.”

– Key Informant

Support for Navigating the Health Care System

“Picking up the phone, knowing who to call, being intimidated or not even knowing where to start. You just don't even try.”

– Focus Group Participant

Community participants frequently mentioned the lack of awareness and support for navigating through the health care system as a barrier to accessing care. Many underrepresented populations with cultural and language barriers, such as Hispanic/Latinx and AAPI low-income residents, do not know about health facilities that provide services at a minimal cost. This lack of awareness of available resources also makes it difficult for patients, family members, and caregivers to advocate for their needs. In addition, strict HIPAA-related requirements on who can actually contact providers on behalf of the patient increases barriers to access, especially among non-English speaking patients.

While health navigators at the Williamson County City Health District can provide assistance, office closures prevented them from helping clients with documentation support during the COVID-19 pandemic, and many clients were unenrolled from support programs as a result.

“It's hard for the average person to navigate those systems, and then you're asking people that are disadvantaged to navigate systems.”

– Key Informant

SOCIAL AND STRUCTURAL DETERMINANTS OF HEALTH

Multiple compounding social and structural determinants of health cause poor health outcomes for Williamson County residents. Key informants and focus group participants acknowledged several factors including low socioeconomic status, housing and homelessness, lack of transportation, limited broadband or internet access, and community silos.

Low Socioeconomic Status

Low-income communities within Williamson County face the most barriers to accessing various services. Participants noted that Hispanic/Latinx residents tend to have higher rates of poverty, and wages for those with less than a high school education or GED are much lower and do not support the cost of living in the county. Furthermore, due to strict income eligibility criteria, even low-income families still may not qualify for WilCo Care. Having low or no income inhibits families' ability to afford healthy food options, medications, or transportation and fuel. The quality of health care and therapeutic services also declines when residents are not able to provide private-pay.

“Not having money really affects your mental health. You are trying to figure out, how I am going to pay this water bill, this gas bill, this light bill. I got electric due. I got car insurance. It's all rolling through your head, and there is no sleep, because you're trying to figure out how you're going to do it...I'm in a survival mode, and I need finances to just keep my head above water.”

– Focus Group Participant

Sub-themes:

- Residents who are uninsured or underinsured often avoid preventative care due to high co-pays or high overall costs.
- Dental care is expensive, and many community members have significant dental needs but do not have dental insurance.
- Mental health services are expensive, counselors often do not accept insurance, and many community members cannot afford counseling.

Housing and Homelessness

Recent economic development and population growth has caused housing prices to skyrocket in Williamson County over the last few years. Key informants and focus group participants revealed that the lack of affordable housing available within the county is probably one of the most complicated issues for the community. Despite the existence of local housing authorities

and Section 8 housing vouchers, people in need of low-income housing often experience long waiting lists. In addition, participants shared that emergency and transitional housing is unavailable in Williamson County. Furthermore, there is a growing population of people experiencing homelessness with untreated mental health issues.

“We don't even have emergency and transitional housing in Williamson County. When someone calls us and needs emergency shelter, we have to send them to Travis County or Bell County.”

– Key Informant

Sub-themes:

- Population growth due to the influx of Austin residents is making property values, cost of housing, and general cost of living rise, pushing out long-time Williamson County residents.
- Due to increased housing costs, multiple generations often live together in one home.
- Residents seeking housing vouchers experience 2-3 year waitlists.
- The Cedar Park area near the 183 corridor has a large population of people who are homeless.

Transportation

Participants frequently mentioned transportation as one of the leading structural barriers to health in Williamson County. Residents often have to travel many miles to get to the doctor, pharmacy, the grocery stores, or farmers markets. Even with personal vehicles, the lack of money to pay for gas prevents some residents from accessing services in Round Rock, Georgetown, or eastern Williamson County. Furthermore, participants also described how the lack of transportation inhibits access to good employment opportunities or higher education and training, which ultimately affects overall health outcomes.

“I couldn't find someone that was willing to serve [my son's] needs [in Taylor] without traveling literally an hour and a half ... for a 15-minute appointment. I also had to take a whole day off work to do that, and it came with a specialty co-pay.... I know my family needs this support. I know they need this care, but I can't get there.”

– Focus Group Participant

Sub-themes:

- The lack of public transportation services inhibits residents' ability to get to grocery stores, jobs, and health care appointments.

- For residents in more rural areas, doctors' offices can be 15-20 miles away in Round Rock and Georgetown, limiting much of the county's access to services due to the lack of transportation options to get there.
- There are many neighborhoods in Williamson County that are geographically isolated, especially within Hispanic/Latinx and senior communities.

"People forget that to go from one end of Williamson to the other is probably over an hour, and that's just not feasible."

– Focus Group Participant

Broadband or Internet Access

Participants described barriers associated with lack of access to broadband or internet, particularly for families in more rural areas of Williamson County. One key informant discussed frequent technical difficulties when attending virtual doctor's appointments including poor video quality, poor Wi-Fi, and poor phone reception. Participants noted how senior populations, AAPI populations, Hispanic/Latinx populations, and low-income families are often more disadvantaged when it comes to internet access. In addition, when organizations transitioned to remote services amid the pandemic, it became even more difficult for residents to access services due to the closure of public libraries—previously a primary point of access for many lower-income community members. Some people, including seniors, may also be less comfortable using technology or may not be computer literate.

"You don't have access to a computer. How can you do a virtual doctor's appointment?"

– Key Informant

Sub-themes:

- Williamson County residents who lack access to a computer are unable to participate in virtual doctor's appointments.
- Senior populations in Williamson County may lack computer literacy.
- Remote areas of Williamson County often have poor internet and Wi-Fi connectivity.

Ethnic and Racial Segregation

"They don't want to come be around certain people: African Americans, and I'm just going to really be honest."

– Key Informant

A number of key informants and focus group participants noted that Williamson County is ethnically and racially segregated. Participants noted specific residential areas have large populations of Hispanic/Latinx residents, and in general, people of color do not have equal access to community resources or culturally sensitive education about health. One participant pointed to the investment of resources in one area and not another: While public parks in affluent neighborhoods received adequate renovations, public parks within neighborhoods with higher populations of color did not receive equal renovations. Sometimes these neighborhoods are only a few miles apart, divided by a bridge.

“Instead of y'all just updating certain parks, you should be updating all the parks in the city.”

-Key Informant

PRIORITY HEALTH NEEDS

Key informants and focus group participants acknowledged several top health priorities to address within Williamson County including treatment for chronic health conditions, behavioral health needs—assistance with mental health and substance use—and dental care.

Chronic Disease

Hypertension, diabetes, obesity, and cancer were the most common health conditions mentioned among key informants and focus group participants, noting that diabetes and hypertension are common in Hispanic/Latinx and African American communities. Participants identified several factors that contribute to diabetes and obesity: (a) lack of access to healthy food options and exercise facilities due to transportation barriers, (b) inability to afford healthy food options or medications due to low socioeconomic status, (c) unhealthy nutrition habits, (d) lack of nutrition education, (e) foregoing doctor visits due to lack of insurance, (f) cultural values related to food in Hispanic/Latinx and Black/African American communities, and (g) lack of physical activity.

In addition, participants mentioned the common occurrence of cancer among AAPI residents, including ovarian cancer, lung cancer, and liver cancer.

Sub-themes:

- Hispanic/Latinx and Black/African American populations have higher rates of diabetes, obesity, and hypertension possibly due to the lack of physical activity and poor nutrition.
- The high cost of healthy food is a barrier for many community members, as quantity is prioritized over quality when resources are tight.
- Medications to treat chronic diseases such as diabetes are very expensive.

Mental Health and Substance Use

Community members identified the increasing need for and lack of affordable and available mental health services within Williamson County. Common mental illnesses discussed included stress, anxiety, and depression. Participants noted that low-income families, Medicaid recipients, or families seeking services on a sliding fee scale often struggle the most with navigating resources to address mental health concerns, because very few psychiatrists and psychologists accept insurance. One community member mentioned community crime has also increased due to stress as “people are crying and screaming for help and don't know how to go about getting it.” Participants also indicated the need to address negative stigma associated with mental illness through community education and advocacy.

Increased substance use and alcoholism was highlighted as a concern in the community as well. In addition to the lack of treatment providers available, community participants mentioned that it is very difficult to find recovery support services such as Alcoholics Anonymous, Narcotics Anonymous, or other support groups.

“There are hoops that people have to jump through.... I think it makes a lot of people, especially if they're having mental health and comprehension issues ... it can be a little bit more difficult for them to the point where they just give up, especially if they're not moving.”

– Key Informant

Sub-themes:

- The prevalence of mental illnesses seems to have increased largely due to the effects of the COVID-19 pandemic.
- Mental health is associated with a negative stigma that often discourages individuals and families from seeking treatment and support.
- Younger community members, including children and teens, are experiencing depression and anxiety at very high rates.
- Homeless populations often struggle the most with mental health and substance use disorders.

Dental Care

Participants also mentioned the need for and lack of access to affordable dental care in Williamson County. When seeking care, low-income, uninsured, and underinsured residents frequently travel from rural areas to find affordable dental care in Round Rock, Austin, or other urban areas. Participants also mentioned lack of awareness about where to seek low- or no-cost dental care within the county, the lack of availability of more complex dental services at low-cost clinics, and limitations of services per patient (e.g., services limited to one tooth per visit).

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“Even the free places ... a lot of times, they will still only work on one tooth, or they won't offer certain things like root canals.”

– Focus Group Participant

CHILDREN'S HEALTH

Childhood experiences have a tremendous influence on development and growth. Key informants and focus group participants acknowledged several key issues affecting Williamson County children and youth including child abuse, intellectual disabilities, and mental health.

Abuse

Participants mentioned the high prevalence of child abuse, including physical abuse and sexual abuse within Williamson County. They described how sexual abuse affected all children regardless of race, ethnicity, or socioeconomic status of the family, physical abuse tended to affect low-income families more, and noted that physical abuse usually peaks during the summer months and has significantly increased amid the pandemic due to higher unemployment rates. Due to limited free counseling in Williamson County, child abuse victims are often placed on long waiting lists for mental health providers. Additionally, participants mentioned the need for more training and awareness about adverse childhood experiences (ACEs) for all health care providers. Although Williamson County Juvenile Services provides advocacy for child abuse, intervention services, and ACEs education, limited grant funding only allocates those opportunities to residents in specific areas, such as Eastern Williamson County.

“These kids have been through significant abuse. They're always on a waitlist, which is not how you want to treat kids that have been sexually abused, physically abused, gone through, you know, the most horrible, horrific things. But it's what happens when you are limited on your free counseling services.”

– Key Informant

Sub-themes:

- Child abuse cases have increased amid the pandemic due to higher rates of stress, unemployment, and isolation.
- Victims of child abuse are often placed on long waiting lists due to limited treatment providers available.

Intellectual Disabilities

Participants also mentioned the need to increase special programs for youth with physical and intellectual disabilities such as cerebral palsy, deafness, blindness, autism, Down's syndrome, and dyslexia. Participants noted that there are few to no public programs available that facilitate talk therapy with autistic youth in Williamson County. They also mentioned that Rock Springs Behavioral Health Care in Georgetown frequently does not accept youth with intellectual disabilities for treatment. As a result, most families in Williamson County need to travel to Austin to access services. In addition, participants mentioned that local respite services or music therapy are not available in Williamson County to decrease burn out among families.

“I know a lot of our parents, especially with medically fragile children end up spending a lot more time in Austin.”

– Focus Group Participant

Mental Health

Participants highlighted the need to make both mental health services and education available, accessible, and destigmatized for youth. Not only is there a lack of resources for child and youth mental health services, but parents also lack the knowledge and awareness of their child's mental illness. Common youth mental illnesses mentioned among participants included suicidal ideation, attention deficit hyperactivity disorder, anxiety, depression, and bipolar disorder.

Additionally, amid the pandemic, participants noted an increase in severe mental health concerns among younger children, along with the difficulty of accessing mental health facilities and assistance for children under the age of thirteen. Although key informants expressed the benefits of integrating social emotional learning into the academic curriculum, they also underlined the school districts' opposition and resistance to providing platforms to discuss youth suicide prevention and social emotional learning.

“A lot of hospitals forget that if a parent has a child in a [mental health] crisis, that parent is in crisis too. They forget that they need to help the family navigate and advocate...It is not a rush-through system. Help them learn how to help their family member or their child.”

– Focus Group Participant

IMPACT OF COVID-19

The COVID-19 pandemic has had a multi-faceted impact on Williamson County residents. Issues such as stress, anxiety, depression, and fear associated with social isolation and the spread of COVID-19 have significantly affected the lives of all community members, irrespective of gender, age, socioeconomic status, or race. Key informants and focus group participants noted the disproportionate effects of COVID-19 on minority populations in Williamson County, including residents with lower educational attainment. For example, participants described how layoffs from restaurants and retail at the beginning of the pandemic significantly and disproportionately affected low-income residents, most of whom had a high school diploma or less and limited employment options.

Because of increasing unemployment, many residents struggled to pay rent or housing fees and had to move in with family members. Participants also described how Hispanic/Latinx and Black/African American populations experienced higher rates of COVID-19 diagnoses and death. Food insecurity worsened, and many school-aged children lacked breakfast, lunch, and snacks due to school closures.

At the same time, some participants noted how the pandemic has had a bit of a “silver lining” for some for some school-aged children. For example, in some cases, the pandemic has allowed parents and the school community to see a struggling child up-close, leading to students receiving the help they have needed for a long time. In addition, participants noted an increase in access to counseling, as many school counselors opened up private virtual counseling practices to meet the needs of students and families.

“A lot of them, because they're in multi-generational homes and stuff, a lot of people really got affected with the spread of COVID. A lot of them were afraid to go out there. I think a lot of them didn't have all the information they needed once vaccination things came out. They were afraid there might be consequences. They didn't know that you don't need any documentation to go get your vaccine or even the testing.”

– Key Informant

COMMUNITY ASSETS AND STRENGTHS

When asked to describe the assets and strengths of Williamson County, participants frequently mentioned that the community has a strong sense of altruism and members often come together to help each other. One key informant expressed their gratitude for the reliability of

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nonprofit agencies within the community. Another key informant expressed excitement about emerging diversification efforts that are promoting growth opportunities and resources for underrepresented populations. Key informants and focus group participants also emphasized the tremendous support and impact of strong school districts promoting social emotional learning and trauma-informed care as a strength. In addition, participants mentioned a strong network of churches with resources for food distribution, utility support, COVID-19 support, dental care, and other social services.

“I’m grateful that we do have in our community some nonprofit agencies that we can call and who we have good relationships with.”

– Focus Group Participant

Participants named the following organizations as valuable resources for the community:

Health Care Organizations

Ascension Medical Group	Lone Star Circle of Care
Austin Child Guidance Center	National Alliance on Mental Illness
Austin Public Health	Resilient WilCo
Austin Regional Clinic (e.g., Round Rock, Georgetown)	Rock Springs Behavioral Health in Georgetown
Baylor Scott & White Health	Sacred Heart Community Clinic
Bluebonnet Trails Community Services	STARRY Counseling in Georgetown
Child Mind Institute	Texas Health and Human Services
Early Childhood Intervention Services	WellMed Clinics
Georgetown Behavioral Health Institute	Williamson County and Cities Health District
Hana Care Texas	Williamson County Mobile Outreach Team
LifeCare (The Source)	
Lifepath Pharmacy	

Churches and Faith-Based Organizations

Gateway Church (food pantry)	St. William Catholic Church in Round Rock (Sacred Heart Clinic)
God's Way Christian Baptist Church	Ministerial Alliance (Georgetown, Taylor)
Samaritan Health Ministries	
St. Vincent DePaul Catholic Church (utility support and resource navigation)	

Nonprofits and Community-Based Organizations

Any Baby Can	Boys and Girls Club of East Williamson County
Aunt Bertha	

Child Protective Services
Community Action Inc. Central Texas
Community Resource Coordination
Groups
Court Appointed Special Advocates
Eastern WilCo Collaboration
Easterseals Central Texas
Faith in Action
Food Pantries (e.g., The Caring Place in
Georgetown, Shepherd's Heart in
Taylor, Round Rock Area Serving
Center)
Georgetown Chamber of Commerce
Georgetown Literacy Council
The Georgetown Project
Healthy Williamson County
Hutto Resource Center
Independent school districts

Korean Community Services
Law enforcement
Local housing authorities (e.g., Granger
Housing Authority)
Opportunities for Williamson-Burnet
Counties
Texas Parent to Parent
Texas Workforce Commission Child
Care Services
The Arc of Texas
Williamson County Children's Advocacy
Center
Williamson County Juvenile Justice
Alternative Education Program
Williamson County Meals on Wheels
Women, Infants, and Children Youth
Behavioral Health Task Force

“There’s a huge sense of community, of wanting to help each other.”

– Focus Group Participant

PROPOSED SOLUTIONS AND ACTIONS FOR HOSPITALS

Participants were asked to identify potential solutions for the challenges discussed during the interviews and focus groups. Recommendations for hospitals are listed below:

IMPROVE HEALTH CARE ACCESS

Transportation: Provide patients with transportation to appointments by collaborating with public transportation services and volunteers. Another option included providing mobile clinics with primary care services, mental health services, and dental care, especially in rural areas of Taylor.

Navigation support: Facilitate access to services including primary care, dental care, and mental health services in a single location. Other examples included providing case management services, increasing hospital social workers, and providing health care concierge services.

Affordable health care: Offer a free or discounted hospital program annually so that people who are unable to see a physician can schedule a visit at least once a year. Another option would be providing a low-cost community health clinic.

Community education and recreational activities: Provide free or affordable recreation and exercise activities for community residents in southeast Taylor. One key informant recommended revamping currently vacant community buildings to host dance classes, karate classes, or nutrition education classes.

INCREASE CULTURALLY COMPETENT HEALTH CARE

Language and translation services: Hire Spanish and Korean translators and interpreters. Provide dual-language websites, social media, pamphlets, etc.

Culturally competent workforce: To increase compassionate and non-judgmental care, community members recommended expanding cultural sensitivity training for all providers and hospital staff to better equip them to serve underrepresented and minority populations. Participants also recommended a need to diversify the workforce by hiring additional providers from underrepresented populations.

REDUCE SILOS AND INCREASE COLLABORATION

Partnerships: Build stronger relationships with faith-based organizations, independent school districts, nonprofits, and community-based organizations to provide holistic care. For example, utilize churches or schools to provide health fairs and health education to congregants and community members. Some key stakeholders and organizations mentioned by community participants included: local politicians, Williamson County and Cities Health District, the Ministerial Alliance, independent school districts, Austin Community College, and Community Action Inc. of Central Texas.

Community engagement and outreach: Increase community visibility and constantly engage with community members and grassroots organizations to understand their perspectives. For example, host a town hall meeting to share the community's insight with municipal/county leadership, funders, and hospital administrators. Distribute flyers to faith-based organizations, independent school districts, nonprofits, and community-based organizations.

Health data: Coordinate with other health care providers to establish a universal electronic health record database to streamline data access and enhance patient-centered treatment plans.

“I'd love to see some of those major players step in and see some of the silos come down and start seeing joint efforts with these large entities.”

– Focus Group Participant

LIMITATIONS

There are several limitations to consider in the development of this report. First, THI conducted this project during the surge of COVID-19 cases related to the Delta variant, which occurred during the late summer and early fall of 2021. For the safety of staff and participants, all key informant interviews and focus groups were conducted virtually. This presented a challenge with both recruitment and facilitation of the interviews. Many of the community leaders who helped recruit participants, or who served as key informants, were overwhelmed by responsibilities related to the pandemic. For example, some organizational leaders were coordinating clinical duties or responding to urgent needs from community members, limiting their capacity to assist with this project. Similarly, community members were experiencing fatigue from the pandemic, including fatigue regarding inquiry into their needs and the effects of COVID-19.

THI staff did extensive outreach to various CBO leaders in Williamson County and potential participants, and organizational leaders and residents alike frequently declined participation for a variety of reasons, including research fatigue and fear of exploitation. In addition, THI staff experienced challenges with getting in contact with potential participants, even though multiple channels of communication were used (email, call, and text).

Furthermore, to participate virtually in focus groups, participants had to have access to a device that would allow them to use Zoom (a computer, tablet, or cell phone with data). While not a barrier for the majority of key informant interviews, this requirement likely inhibited some potential focus group participants from joining. In addition, although focus group participants could join Zoom by phone (dial-in), participants familiar with the video aspect of Zoom were frequently confused by the dial-in option, and consequently declined participation or did not show up to the focus group. Finally, virtual key informant interviews and focus groups could more easily be confounded by office or in-home distractions compared to in-person settings.

CONCLUSION

Between August and October 2021, THI conducted nine virtual key informant interviews and two virtual community focus groups with people in Williamson County who identified either as stakeholders or representatives of medically underserved, low-income, and minority populations. Community members collectively identified the following categories as top health priorities:

- **Access to health care:** Examples included provider shortages for residents that are either publicly insured or uninsured, lack of culturally and linguistically appropriate care, and lack of support for navigating the health care system.
- **Social and structural determinants of health:** Examples included low socioeconomic status, housing and homelessness, lack of transportation, limited broadband or internet access, and community silos.
- **Priority health needs:** Top health needs included chronic conditions (e.g, diabetes, hypertension, obesity, and cancer), dental care, and mental health, behavioral health and substance use.
- **Children's health:** Top priorities for youth included child abuse, intellectual disabilities, and mental health.

To address these top health priorities, participants recommended increasing community engagement and outreach and establishing stronger partnerships with municipal and county leadership, faith-based organizations, independent school districts, nonprofits, and community-based organizations to provide community-centered holistic care. The insight and recommendations shared in this report prioritize the perspectives of underserved communities within Williamson County and may be leveraged to develop an efficient action plan to address the discussed top health needs.

TABLES

The following table identifies each key informant and details how their role in the community satisfied one of the IRS requirements for participation.

Table I
Description of Key Informants

Key Informant	Community Input Sector
Cara DiMattina-Ryan Chief Strategy Officer Workforce Solutions Rural Capital Area	Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Jennifer Harris President Dickey Museum & Multipurpose Center	Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Carlos Hernandez Leader of Hispanic Owned Business Circle Georgetown Chamber of Commerce	Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Dawn Jennings Special Education Parent Liaison Georgetown Independent School District	Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Yumi Kang Korean Community Health Navigator Austin Asian Community Health Initiative	- Person with special knowledge or expertise in public health - Leader, representative, or member of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility - Federal, tribal, regional, state, or local health or other department or agency, with current data or other information relevant to the health needs of the community served by the hospital facility

Key Informant	Community Input Sector
Aurora Maldonado Program Navigator Williamson County Indigent Care Program	• Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility • Federal, tribal, regional, state, or local health or other department or agency, with current data or other information relevant to the health needs of the community served by the hospital facility
Jessica Morales Program Navigator Supervisor Williamson County Indigent Care Program	• Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility • Federal, tribal, regional, state, or local health or other department or agency, with current data or other information relevant to the health needs of the community served by the hospital facility
Gloria Roberson Director Harris-Ross Head Start	• Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility
Kerrie Stannell Chief Executive Officer Williamson County Child Advocacy Center	• Leader, representative, or member of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility • Federal, tribal, regional, state, or local health or other department or agency, with current data or other information relevant to the health needs of the community served by the hospital facility

The following table describes the focus group participants in aggregate:

Table 2
Description of Focus Group Participants

Focus Group	Community Input Sector	Description	Number	Language
1	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included female residents of ZIP codes 78634 and 78628 with ages ranging from 30-65. Participants self-identified as Black/African American, White, and Not Hispanic/Latinx.	4	English
2	Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility	Participants included male and female residents of ZIP codes 78729, 78681, and 78634 with ages ranging from 40-65+. Participants self-identified as Mexican, Mexican American or Chicano, Hispanic/Latinx and Spanish origin, White, Not Hispanic/Latinx and Black/African American.	5	English

APPENDIX A: KEY INFORMANT INTERVIEW GUIDE

2021-22 Williamson County SDF CHNA Key Informant Interview Guide

1. Please briefly describe your role in [organization] and who [organization] serves in Williamson County.
2. Please describe how you are connected to St. David's Foundation, any of the St. David's Hospitals, Ascension Seton, Baylor Scott & White Health. If you are not connected, just indicate that.
 - a. Do you meet any of these criteria? *[Note: Participant does not necessarily have to meet any of these to participate.]*
 - i. Persons with special knowledge of or expertise in public health
 - ii. Federal, tribal, regional, state, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility
 - iii. Leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility.
3. What do you think are Williamson County's three most critical health issues? *(Examples if needed: heart disease, diabetes, substance use, mental health, cancer, asthma, STIs, HIV, etc.)*
 - a. PROBE: Why are these the top priorities?
 - b. PROBE: Who do these health issues affect the most? *(e.g., age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.)*
4. The top health issues identified in the 2019 Community Health Needs Assessment were [list top needs in previous CHNA]. How important are these issues today?
5. How has COVID-19 impacted the three critical health issues you identified?
 - a. PROBE: Are there some groups that have been more affected by COVID-19 than others in your community?
6. Now I am going to ask you about the factors that contribute to each of the top priority health issues you identified and how the issue impacts specific populations. *(Prompt: Note that a "factor" could be a health behavior like physical activity, SDOH such as food insecurity, insurance status, physical environment, etc.)*
 - a. Starting with [Name #1 critical health issue identified by interviewee]
 - i. What are the factors that contribute to making this a critical health issue?
 - ii. Which populations does the issue impact the most?
 - iii. How does this critical health issue specifically impact low-income, underserved/uninsured populations in Williamson County?

- iv. Are there organizations already addressing these issues in the county? If so, which ones? How do they address it?
- b. Now thinking about [Name #2 critical health issue identified by interviewee]
 - i. What are the factors that contribute to making this a critical health issue?
 - ii. How does this critical health issue specifically impact low-income, underserved/uninsured populations in Williamson County?
 - iii. Which populations does the issue impact the most?
 - iv. Are there organizations already addressing these issues in the county? If so, which ones?
- c. Now thinking about [Name #3 critical health issue identified by interviewee]
 - i. What are the factors that contribute to making this a critical health issue?
 - ii. How does this critical health issue specifically impact low-income, underserved/uninsured populations in Williamson County?
 - iii. Which populations does the issue impact the most?
 - iv. Are there organizations already addressing these issues in the county? If so, which organizations?
- 7. Based on your knowledge and expertise, what are the most effective strategies to address the top three health issues that you identified?
 - a. PROBE: What are some specific strategies that could help to address disparities between different populations for these health issues?
- 8. Beyond the top three health issues you've identified, what are the other critical health issues that are important to address?
- 9. How could St. David's Hospitals, Ascension Seton, Baylor Scott & White Health possibly partner with or enhance the efforts of organizations that are working to address the issues that you identified?
- 10. What are some of your community's greatest assets and strengths? *(Prompt: These often include social and human service agencies, community based organizations, nonprofit organizations, churches, but can also be cultural qualities).*
 - a. How do you think these strengths could be leveraged to address the top health issues in Williamson County?
- 11. What are your suggestions for ways to engage and build trust with community members, particularly low-income, underserved populations, ethnic and racial minorities, and limited English proficient residents of Williamson County to address these critical health issues?
- 12. Is there anything else you would like to share about the top health issues in Williamson County?
- 13. Now I want you to think a little about a broader range of factors that could affect health. What do you think are the social and economic concerns facing your community? *(Prompt: affordable housing, unemployment, access to quality daycare, poverty).*

- a. Who do these health needs or concerns affect the most (e.g. *age groups, racial/ethnic groups, socioeconomic groups, geographic subsets, etc.*)?
 - b. PROBE: Are there organizations or available resources already addressing these needs? If so, which ones? How do they address the needs?
 - c. PROBE: How important do you think it is that hospitals and health care systems work to connect patients with resources to support these factors affecting health? Why?
14. How could St. David's and local hospitals and Ascension Seton, Baylor Scott & White Health possibly partner with or enhance the efforts of these organizations to support factors affecting health?
15. Where do members of your community go to access primary health care?
- a. What about specialty care?
 - b. What about access to emergency rooms or urgent care centers?
 - c. And mental and behavioral health care?
16. What challenges/barriers do low-income, underserved, and uninsured populations in your community face in access to health care?
- a. What are two things that St. David's and local hospitals and St. David's Hospitals, Ascension Seton, Baylor Scott & White Health could do to address these challenges?

Those are all of the questions I have for you today. Is there anything else you would like to add before I turn off the recorder? *[Allow time for comments]*

APPENDIX B: FOCUS GROUP GUIDE

2021-22 Williamson County SDF CHNA Focus Group Guide

1. When you think of the word “community,” what is the first thing that comes to mind?
2. What does health mean to you?
3. What do you do to stay healthy?
4. What are the things that **help you to be healthy** in your community? (e.g., places to buy healthy food, safe places to walk and to exercise, community services and events, access to health care, affordable housing)
5. What makes it **difficult to be healthy** in your community? (e.g., lack of access to affordable health care, few grocery stores with fresh fruits and vegetables, affordable food, lack of transportation, language barriers, substance use, etc.)
6. How does your race or ethnicity impact your ability to be healthy?
7. What do you think are the **two most important health issues** facing your community? Why? (e.g., diabetes or cancer, unhealthy food or drug abuse, mental health, violence, or access to care)
8. What are the **top two things that could be done** to fix these issues? (e.g., What would it look like to fix the issues?)
 - a. Who should be involved (people or organizations)?
9. Are there health services that you need but do not receive currently? If so, which services?
10. Where do you go for help when you need health services and cannot find them?
11. What are the strengths of the health services available in your community?
12. What resources do you have in the community that seem to be working to address the health-related issues that we talked about?
13. What could the hospital systems do to improve health and quality of life in the community?
14. What impact has the COVID-19 pandemic had in your life and in the community?
 - a. How has it affected your health, including your mental health?
 - b. How did COVID-19 impact the health challenges that we discussed earlier?
 - c. Are there community resources or agencies that have helped to support you during the pandemic? **If so, which organizations have been helpful?**
15. Are there any other issues that impact your physical or mental health that you would like to discuss?



Finally, as part of collaborations led by public health departments in Travis and Williamson counties, Ascension Seton received reports from the community focus groups conducted in each of those counties.

In addition to the THI focus groups and interviews conducted for Williamson County, IBM Watson Health conducted an additional focus group of 13 individuals. To see Williamson Counties complete analysis of community input, refer to the 2022 Williamson County Community Health Assessment at the link provided:

https://www.healthywilliamsoncounty.org/content/sites/wcchd/2022cha/2022WilliamsonTXCHA_FINAL.pdf

Travis County engaged 112 participants including residents and professionals through key informant interviews, in-depth interviews, focus groups, community forums, radio talk-shows, and a photo outreach campaign. To see more detailed information about the qualitative input received by Travis County, refer to the 2022 Travis County Community Health Assessment at the link provided: www.austintexas.gov/communityhealthplan

Interviews

Key Informant	Sector
Andrea Richardson Executive Director, Bluebonnet Trails	Mental Health; Representative or member of medically underserved, low income and minority populations and populations with chronic disease needs in the community served
Vicki Coffee Director of Programs, Hogg Foundation for Mental Health	Mental Health; Representative or member of medically underserved, low income and minority populations and populations with chronic disease needs in the community served
Jon Calvin CEO, Lonestar Circle of Care	Primary Care; FQHC; Representative or member of medically underserved, low income and minority populations and populations with chronic disease needs in the community served
Karen Ranus Executive Director, National Alliance on Mental Illness (NAMI) Central Texas	Mental Health
Marisol Cortez Chief Marketing and Advancement Officer, Communicare	Primary Care; FQHC; Representative or member of medically underserved, low income and minority populations and populations with chronic disease needs in the community served
Dr. Aliya Hussaini, MD Health Portfolio Director, Michael and Susan Dell Foundation	Foundation; Chronic Disease; Representative or member of medically underserved, low income and minority populations and populations with chronic disease needs in the community served
Jeff Andresen CEO, Williamson County YMCA	Williamson County; Families and Children
Kathy Kuras CEO, Greater Austin YMCA	Travis County; Families and Children
Neal McMaster COO, Catholic Charities of Central Texas	Service area that mirrors Ascension Texas; Non-profit social services organization; Representative or member of medically underserved, low income and minority populations and populations with chronic disease needs in the community served
Dr. Leah Harris	Pediatrics; Families and Children

Chair of Pediatrics, Dell Children's Medical Center (Internal)	
Bess Searles and Population Health Team Community Care	Federally Qualified Health Center (FQHC)

Interview Questions

1. Tell us about yourself and your role, your background. For example, how long have you lived and worked in this region? How would you describe your professional-and-personal point of view -- the lenses you bring to this conversation?
2. Which part of the community, or the people in the community you feel you may be able to speak to best (in addition to your own)? (Sub-regions, particular cultural communities, people with particular kinds of needs, etc.)
3. What should we know about your community, in particular? For anyone who doesn't live there, what would be important to understand?
 - a. What are the particular assets, strengths, unique characteristics of the community, broadly (help us get a feel for the place)?
 - b. What are some of the particular challenges, globally, as you think about living there?
4. What are some of the obstacles, challenges, barriers, and complexities that interfere with your community's health & vitality?
5. What are some of the assets and strengths in your community that support vitality & health?
6. Topics we need more information on:
 - a. Cancer
 - b. Air & Water Quality
 - c. Tobacco Use
 - d. Community Safety
 - e. Family & Social Support
 - f. Infant & Child Mortality

Summary of Ascension Seton Interview Themes

Access to Care

Interviewees discussed access to care as it relates to physical, financial, language and literacy access. They noted limited access points despite the layered needs of individuals and families and the need for navigation assistance.

Quality of Life and Chronic Disease

Interviewees discussed both COVID-19 and Mental and Behavioral Health as diseases that are of critical importance at the time of this assessment in addition to other chronic disease management. Many mentioned the potential for lasting chronic effects of COVID-19 that are still unknown as well as challenges related to managing or diagnosing existing chronic conditions during the pandemic when people were reluctant to seek care. Interviewees noted an increased need for mental and behavioral health services as well as the need for prevention and early intervention in this space. Finally, conversation focused around the need for level-setting on data availability and the ability to track useful mental and behavioral health metrics.

Social Determinants of Health

Insurance rates were often discussed as a social determinant of health, with many people in the region uninsured or underinsured. Interviewees also noted transportation, housing, and income as social determinants that can affect health engagement and outcomes.

Health Equity

Issues of health equity discussed by interviewees are related to disproportionate poor health outcomes among groups of people. They discussed the issue of mistrust of the healthcare system, healthcare providers and fear due to previous experiences. Individuals noted systemic weaknesses in both healthcare and outside of healthcare (e.g. justice, immigration) as a major concern. Language access, cultural competency and humility were also topics often mentioned related to health equity.

Community Survey

Survey Distribution

A survey was conducted by Ascension Seton to gather the perceptions, thoughts, opinions, and concerns of the community regarding health outcomes, health care access, and social determinants of health for Ascension Seton. Fifty- one individuals participated in the survey, held between August 2021 and October 2021.

The two largest counties in the Ascension Seton service region (Travis and Williamson) conducted their own surveys, so to reduce duplication and confusion the Ascension Seton community survey was promoted only in the suburban and rural counties in the service area which include: Hays, Bastrop, Burnet, Caldwell, Fayette, Lee, Llano, Gonzales and Blanco counties.

The data gathered and analyzed provides insight into the issues of importance to the community; however due to a small sample size these survey results cannot be generalized to represent community indicators or perceptions. The results of this survey should be used with caution and as a supplement to other reliable data sources including quantitative data and community stakeholder input.

The survey contained 15 multiple-choice questions and was conducted online only. The survey was available in both English and Spanish and distributed by asking community stakeholders and leaders to share the survey with the individuals they served.

Survey Questions

Page 1

CHNA Community Survey 2021

Dear Residents of Hays, McLennan, Bastrop, Burnet, Caldwell, Coryell, Fayette, Lee, Llano, Gonzales, Hill, Limestone, Freestone, Blanco, Bosque, Falls and Hamilton Counties,

Ascension Texas is currently conducting a Community Health Needs Assessment. We would like to invite you to answer some questions about your community. Your perception and opinion about the strengths and areas of opportunity of your community is important to us and we would highly appreciate your input. The information you provide will be used to develop a plan that will help address the community health needs.

It will take about 10 minutes to complete the survey. The first part of the survey will focus on collecting some demographic information that will help identify characteristics of your community. The second part will collect your opinion about health issues.

By taking this survey you certify that you are 18 years of age and have read this form, and are freely and voluntarily willing to participate in this survey.

Demographic Questions

Please type in the 5 digit zip code where you live

Which category includes your age?

- ☐ 18 - 24
- ☐ 25 - 34
- ☐ 35 - 44
- ☐ 45 - 54
- ☐ 55 - 64
- ☐ 65 and over

What gender do you identify with? Select all that apply.

- ☐ Female
- ☐ Male
- ☐ Non-binary
- ☐ Transgender
- ☐ Intersex
- ☐ Gender non-conforming
- ☐ Prefer not to answer
- ☐ Other

If Other, we welcome you to enter what best describes your gender identity here (not required)

Which of the following best describes your race?

- ☐ Black / African American
- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Hawaiian / Pacific Islander
- ☐ White
- ☐ Multi-racial
- ☐ Prefer not to answer
- ☐ Other

If Other, we welcome you to enter what best describes your race and ethnicity here (not required)

Which of the following best describes your ethnicity?

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Prefer not to answer

Access to Care

How do you pay for most of your healthcare?

- ☐ Pay cash (no insurance)
- ☐ An insurance plan that you or someone else buys on your own
- ☐ Health insurance through my employer
- ☐ Health insurance through someone else's employer
- ☐ Medicaid
- ☐ Medicare
- ☐ Veterans' Administration
- ☐ Indian Health Services
- ☐ Cobra
- ☐ Other

If you selected Other, please explain:

In the past 12 months, have you seen a medical doctor, dentist, nurse or other health professional?

- ☐ Yes
- ☐ No
- ☐ Don't know / not sure
- ☐ Prefer not to answer

Was there a time in the past 12 months when you needed medical care but did NOT get it?

- ☐ Yes
- ☐ No
- ☐ Don't know / not sure
- ☐ Prefer not to answer

If you struggled to access necessary medical care in the past 12 months, what is the main reason?

- ☐ Can't afford it / costs too much
- ☐ I don't have a doctor
- ☐ I had trouble getting an appointment
- ☐ I had transportation problems
- ☐ I don't know where to go
- ☐ I don't have health insurance
- ☐ Other

If you selected Other, please explain:

Community Health

In case of an emergency, my household has enough money saved up for how many months of expenses (rent, utilities, groceries, basic supplies)?

- ☐ Do not have enough saved for one month
- ☐ One month
- ☐ Two months
- ☐ Three months
- ☐ More than three months
- ☐ Not sure

In the following list, what do you think are the three most important factors for a healthy community?

- ☐ Good place to raise children
- ☐ Safety from violence
- ☐ Low level of child abuse
- ☐ Good schools
- ☐ Access to health care
- ☐ Parks and recreation
- ☐ Walkability and bikeability
- ☐ Clean environment
- ☐ Affordable housing
- ☐ Access to grocery stores that sell fresh foods
- ☐ Transportation options
- ☐ Arts and cultural events
- ☐ Excellent race / ethnic relations
- ☐ Good jobs and healthy economy
- ☐ Strong family life
- ☐ Healthy behaviors and lifestyles
- ☐ Low adult death and disease rates
- ☐ Low infant deaths
- ☐ Religious or spiritual values
- ☐ Emergency preparedness
- ☐ Other

If you selected Other, please describe the other factor you think is important for a healthy community:

What are the top 3 things you think should be addressed to improve the health of your community?

- ☐ Aging problems (for example: difficulty getting around, dementia, arthritis)
- ☐ Cancers
- ☐ Child abuse / neglect
- ☐ Dental problems
- ☐ Diabetes / High blood sugar
- ☐ Domestic violence / rape / Sexual assault
- ☐ Gun-related injuries
- ☐ Mental health problems including suicide
- ☐ Substance use
- ☐ Heart disease / stroke / high blood pressure
- ☐ Access to healthy foods
- ☐ Housing
- ☐ HIV / AIDS / Sexually transmitted diseases (STDs)
- ☐ Homicide
- ☐ Infectious diseases
- ☐ Motor vehicle crash injuries
- ☐ Infant death
- ☐ Respiratory / lung disease
- ☐ Teenage pregnancy
- ☐ Tobacco use / E-cigarettes / Vaping
- ☐ Education
- ☐ Employment and job skills
- ☐ Parks / Green space
- ☐ Other

If you selected Other, please describe what else you think is important to address to improve the health of your community:

What are three strengths in your neighborhood or community?

- ☐ Access to health care (e.g. family doctor)
- ☐ Access to public transportation
- ☐ Affordable housing
- ☐ Access to healthy foods
- ☐ Arts and cultural events
- ☐ Clean environment
- ☐ Community resources (e.g. non-profits, libraries, food pantries)
- ☐ Good jobs and healthy economy
- ☐ Good place to raise children
- ☐ Good relationships between different race/ethnic groups
- ☐ Good schools
- ☐ Health behaviors and lifestyles
- ☐ Overall good mental health
- ☐ Low crime / safe neighborhoods
- ☐ Parks and recreation
- ☐ Community emergency preparedness
- ☐ Religious or spiritual values
- ☐ Other

If you selected Other, please tell us what you think are other strengths in your community:

How would you rate the overall health of your community?

- ☐ Very unhealthy
- ☐ Unhealthy
- ☐ Somewhat healthy
- ☐ Healthy
- ☐ Very healthy
- ☐ Not sure

Has the COVID-19 (coronavirus) pandemic made any of these more difficult for you? Please select all that apply for each of the given time frames.

	March 2020 - February 2021	March 2021 - Present
Access to Food	☐	☐
Housing	☐	☐
Job security	☐	☐
Paying bills	☐	☐
Transportation	☐	☐
Caregiving duties	☐	☐
Other basic needs	☐	☐
None of these	☐	☐

How has your employment status changed since the COVID-19 pandemic (after March 1, 2020)?

- ☐ I am still going to my workplace for the same number of hours as before the pandemic
- ☐ I am still going to my workplace but am working reduced hours
- ☐ I am working from home
- ☐ I lost my job
- ☐ I had to quit my job to take care of people who depend on me
- ☐ Other

If you selected Other, please explain:

Have you experienced stress related to the pandemic?

- ☐ No, no stress at all
- ☐ Yes mild stress such as occasional worries or minor stress-related symptoms such as feeling a little anxious, sad, angry, or mild trouble sleeping
- ☐ Yes moderate stress with frequent worries, often feeling anxious, sad, or angry, or some trouble sleeping
- ☐ Yes severe stress with constant worries or feeling extremely anxious, sad, or angry, or frequent trouble sleeping

Have you been vaccinated for COVID-19?

- ☐ Yes fully vaccinated
- ☐ Yes partially vaccinated
- ☐ No

Appendix D: Secondary Data and Sources

The tables below are based on data vetted, compiled, and made available on the County Health Rankings and Roadmaps (CHRR) website (<https://www.countyhealthrankings.org/>), unless otherwise cited. The site is maintained by the University of Wisconsin Population Health Institute, School of Medicine and Public Health, with funding from the Robert Wood Johnson Foundation. CHRR obtains and cites data from other public sources that are reliable. CHRR also shares trending data on some indicators.

CHRR compiles new data every year and shares with the public in March. The data below is from the 2021 publication. It is important to understand that reliable data is generally two to three years behind due to the importance of careful analysis. NOTE: Data in the charts does not reflect the effects that the COVID-19 pandemic has had on communities.

How To Read These Charts

Why they are important: This section explains why we monitor and track these measures in a community and how it relates to health.

County vs. State: Describes how the county's most recent data for the health issue compares to state.

Top US Counties: The best 10 percent of counties in the country. It is important to compare not just with Texas but important to know how the best counties are doing and how our county compares.

Description: What the indicator measures, how it is measured and who is included in the measure.

" - ": Not available or not applicable. There might not be available data for the community on every measure. Some measures will not be comparable.

" * " : Indicators marked with a * indicate that standard deviation was not available for the given metric

Shading & Graphics Key:

Equal or greater than **one standard deviation worse than Texas**

Equal or greater than **two standard deviations worse than Texas**

Equal or greater than **one standard deviations better than Texas**

Equal or greater than **two standard deviations better than Texas**

● = trending better for this measure

● = staying the same for this measure

● = trending worse for this measure

Trends data obtained from County Health Rankings

Health Outcomes

Why they are important: Health outcomes reflect how healthy a county is right now. They reflect the physical and mental well-being of residents within a community.

Largest Population Counties

Indicators	Travis	Williamson	Hays	TX	US	Top US Counties	Description
Length of Life							
Premature Death	4,665 ●	4,248 ●	4,886 ●	6,620	6,900	5,500	Years of potential life lost before age 75 per 100,000 population (age-adjusted). Data from 2017-2019. Smaller is better.
Life Expectancy*	81.9	82.1	80.7	79.2	79.1	-	How long the average person can expect to live. Data from 2017-2019.
Infant Mortality	4.1	4.1	3.8	6	6	-	Number of all infant deaths (within 1 year) per 1,000 live births. Data from 2013-2019.
Physical Health							
Poor or Fair Health	16%	15%	18%	19%	17%	12%	Percent of adults reporting fair or poor health. Data from 2018.
Poor Physical Health Days	3.5	3.3	3.7	3.8	3.8	3.1	Average number of physically unhealthy days reported in past 30 days (age-adjusted). Data from 2018.
Frequent Physical Distress*	10%	10%	11%	12%	12%	-	Percent of adults 14 or more days of poor physical health per month. Data from 2018.
Low Birth Weight	8%	7%	7%	8%	8%	6%	The percent of babies born too small (less than 2,500 grams). Data from 2013-2019.
Mental Health							
Poor Mental Health Days	4.1	3.7	4.3	3.8	4.0	3.4	Average number of mentally unhealthy days self-reported in the past 30 days. Data from 2018.
Frequent Mental Distress*	12%	11%	13%	12%	12%	-	Percent of adults reporting 14 or more days of poor mental health per month. Data from 2018.

Suicide	13	14	13	13	14	-	Number of deaths due to suicide per 100,000. Data from 2015-2019.
Morbidity							
Diabetes prevalence	7%	9%	8%	10%	10%	-	Percent of adults aged 20 and above with diagnosed diabetes. Data from 2017.
Cancer Incidence*	391.9	426	401.3	409.5	449	-	New cases of cancer for every 100,000 people. Data from 2018.
Communicable Disease							
HIV Prevalence	470	164	180	393	366	-	Number of people aged 13 years and over with a diagnosis of HIV per 100,000. Data from 2018.
Sexually Transmitted Infections	733.0	247.7	555.3	517.6	524.6	161.4	Number of newly diagnosed chlamydia cases per 100,000. Data from 2018.
Data Sources for Health Outcomes Tables: - All metrics in this table were obtained from County Health Rankings & Roadmaps in 2021 unless otherwise noted. https://www.countyhealthrankings.org/explore-health-rankings - Cancer Incidence Data: U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2020 submission data (1999-2018): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; www.cdc.gov/cancer/dataviz, released in June 2021.							

Medium Population Counties

Indicators	Bastrop	Burnet	Caldwell	TX	US	Top US Counties	Description
Length of Life							
Premature Death	7,492 ●	7,137 ●	8,256 ●	6,620	6,900	5,500	Years of potential life lost before age 75 per 100,000 population (age-adjusted). Data from 2017-2019. Smaller is better.
Life Expectancy*	78.3	78.8	77.3	79.2	79.1	-	How long the average person can expect to live. Data from 2017-2019.
Infant Mortality	5	-	-	6	6	-	Number of all infant deaths (within 1 year) per 1,000 live births. Data from 2013-2019.
Physical Health							
Poor or Fair Health	22%	19%	26%	19%	17%	12%	Percent of adults reporting fair or poor health. Data from 2018.
Poor Physical Health Days	4.2	4.0	4.5	3.8	3.8	3.1	Average number of physically unhealthy days reported in past 30 days (age-adjusted). Data from 2018.

Frequent Physical Distress*	13%	12%	15%	12%	12%	-	Percent of adults 14 or more days of poor physical health per month. Data from 2018.
Low Birth Weight	8%	7%	9%	8%	8%	6%	The percent of babies born too small (less than 2,500 grams). Data from 2013-2019.
Mental Health							
Poor Mental Health Days	4.4	4.4	4.4	3.8	4.0	3.4	Average number of mentally unhealthy days self-reported in the past 30 days. Data from 2018.
Frequent Mental Distress*	14%	14%	15%	12%	12%	-	Percent of adults reporting 14 or more days of poor mental health per month. Data from 2018.
Suicide	15	16	14	13	14	-	Number of deaths due to suicide per 100,000. Data from 2015-2019.
Morbidity							
Diabetes prevalence	13%	16%	13%	10%	10%	-	Percent of adults aged 20 and above with diagnosed diabetes. Data from 2017.
Cancer Incidence*	432.9	425.7	375.9	409.5	449	-	New cases of cancer for every 100,000 people. Data from 2018.
Communicable Disease							
HIV Prevalence	236	116	239	393	366	-	Number of people aged 13 years and over with a diagnosis of HIV per 100,000. Data from 2018.
Sexually Transmitted Infections	973.3	282.0	1136.1	517.6	524.6	161.4	Number of newly diagnosed chlamydia cases per 100,000. Data from 2018.

Smallest Population Counties

Indicators	Fayette	Gonzales	Llano	Lee	Blanco	TX	US	Top US Counties	Description
Length of Life									
Premature Death	7,217 ●	7,599 ●	8,551 ●	8,060 ●	6,357 ●	6,620	6,900	5,500	Years of potential life lost before age 75 per 100,000 population (age-adjusted). Data from 2017-2019. Smaller is better.
Life Expectancy*	79.4	77.5	79.0	77.8	79.5	79.2	79.1	-	How long the average person can expect to live. Data from 2017-2019.
Infant Mortality	-	-	-	-	-	6	6	-	Number of all infant deaths (within 1 year) per 1,000 live births. Data from 2013-2019.
Physical Health									

Poor or Fair Health	21%	27%	19%	22%	17%	19%	17%	12%	Percent of adults reporting fair or poor health. Data from 2018.
Poor Physical Health Days	4.3	4.7	4.1	4.3	3.8	3.8	3.8	3.1	Average number of physically unhealthy days reported in past 30 days (age-adjusted). Data from 2018.
Frequent Physical Distress*	13%	15%	13%	14%	12%	12%	12%	-	Percent of adults 14 or more days of poor physical health per month. Data from 2018.
Low Birth Weight	7%	9%	8%	8%	6%	8%	8%	6%	The percent of babies born too small (less than 2,500 grams). Data from 2013-2019.
Mental Health									
Poor Mental Health Days	4.5	4.6	4.5	4.9	4.2	3.8	4.0	3.4	Average number of mentally unhealthy days self-reported in the past 30 days. Data from 2018.
Frequent Mental Distress*	15%	15%	15%	15%	13%	12%	12%	-	Percent of adults reporting 14 or more days of poor mental health per month. Data from 2018.
Suicide	11	12	24	19	32	13	14	-	Number of deaths due to suicide per 100,000. Data from 2015-2019.
Morbidity									
Diabetes prevalence	13%	17%	12%	15%	12%	10%	10%	-	Percent of adults aged 20 and above with diagnosed diabetes. Data from 2017.
Cancer Incidence*	389	360.4	372.2	498	389.3	409.5	449	-	New cases of cancer for every 100,000 people. Data from 2018.
Communicable Disease									
HIV Prevalence	110	125	135	138	78	393	366	-	Number of people aged 13 years and over with a diagnosis of HIV per 100,000. Data from 2018.
Sexually Transmitted Infections	368.0	382.9	80.2	133.9	903.1	517.6	524.6	161.4	Number of newly diagnosed chlamydia cases per 100,000. Data from 2018.

Social and Economic Factors

Why they are important: These factors have a significant effect on our health. They affect our ability to make healthy decisions, afford medical care, afford housing and food, manage stress and more.

Largest Population Counties

Indicator	Travis	Williamson	Hays	TX	US	Top US Counties	Description
Economic Stability							
Median Household Income	\$80,690	\$92,661	\$72,890	\$64,044	\$57,600	-	The income where half of households in a county earn more and half of households earn less. Data from 2019.
Unemployment*	2.6% 	2.8% 	2.8% 	3.5%	3.7%	2.6%	Percentage of population ages 16 and older unemployed but seeking work. Data from 2019.
Poverty	12%	6.4%	13.7%	14.7%	13.4%	-	Percentage of population living below the Federal Poverty Line. Data from 2015-2019.
Childhood Poverty	14% 	7% 	11% 	19%	18%	11%	Percentage of people under age 18 in poverty. Data from 2019.
Income Inequality	4.7	3.6	4.4	4.8	4.9	3.7	Ratio of household income at the 80th percentile to income at the 20th percentile. A higher inequality ratio indicates greater division between the top and bottom ends of the income spectrum. Data from 2015-2019.
Educational Attainment							
High School Completion	89%	93%	90%	84%	85%	96%	Percentage of adults ages 25 and over with a high school diploma or equivalent. Data from 2015-2019.
Some College	74%	75%	68%	62%	66%	73%	Percentage of adults ages 25-44 with some post-secondary education. Data from 2015-2019.
Social/Community							
Children in single-parent homes	23%	18%	17%	26%	33%	20%	Percentage of children that live in a household headed by a single parent. Data from 2015-2019.
Social Associations	9.2	6.4	5.9	7.5	9.3	18.4	Number of membership associations per 10,000 population. Data from 2018.

Disconnected Youth*	6%	7%	5%	8%	7%	-	Percentage of teens and young adults ages 16-19 who are neither working nor in school. Data from 2015-2019.
Juvenile Arrests*	21%	12%	20%	17%	-	-	Rate of delinquency cases per 1,000 juveniles. Data from 2018.
Violent Crime	370 	165 	244 	420	386	63	Number of reported violent crime offenses per 100,000 population. Data from 2014 & 2016.
Firearm Fatalities*	8	10	10	12	12	-	Number of deaths due to firearms per 100,000 population. Data from 2015-2019.
Access to Healthy Foods							
Food Environment Index	7.6	7.9	7.9	5.9	7.6	8.6	Index of factors that contribute to a healthy food environment, 0-worst 10-best. Data from 2015 & 2018.
Food Insecurity	13%	11%	12%	15%	13%	-	Percent of the population who lack adequate access to food. Data from 2018.
Limited Access to Healthy Foods	7%	8%	6%	9%	6%	-	Percent of population who are low-income and do not live close to a grocery store. Data from 2015.
<i>Data Sources for Social and Economic Factors Tables:</i> - All metrics in this table were obtained from County Health Rankings & Roadmaps in 2021. https://www.countyhealthrankings.org/explore-health-rankings - Poverty: American Community Survey Table DP03 5-year Estimates, 2019							

Medium Population Counties

Indicator	Bastrop	Burnet	Caldwell	TX	US	Top US Counties	Description
Economic Stability							
Median Household Income	\$62,627	\$62,827	\$55,301	\$64,044	\$57,600	-	The income where half of households in a county earn more and half of households earn less. Data from 2019.
Unemployment*	3.0% 	2.7% 	3.3% 	3.5%	3.7%	2.6%	Percentage of population ages 16 and older unemployed but seeking work. Data from 2019.
Poverty	11.2%	10.2%	18.9%	14.7%	13.4%	-	Percentage of population living below the Federal Poverty Line. Data from 2015-2019.
Childhood Poverty	24% 	16% 	21% 	19%	18%	11%	Percentage of people under age 18 in poverty. Data from 2019.
Income Inequality	4.5	4.0	4.4	4.8	4.9	3.7	Ratio of household income at the 80th percentile to income at the 20th percentile. A higher

							inequality ratio indicates greater division between the top and bottom ends of the income spectrum. Data from 2015-2019.
Educational Attainment							
High School Completion	82%	88%	78%	84%	85%	96%	Percentage of adults ages 25 and over with a high school diploma or equivalent. Data from 2015-2019.
Some College	50%	52%	38%	62%	66%	73%	Percentage of adults ages 25-44 with some post-secondary education. Data from 2015-2019.
Social/Community							
Children in single-parent homes	24%	21%	25%	26%	33%	20%	Percentage of children that live in a household headed by a single parent. Data from 2015-2019.
Social Associations	6.7	12.8	8.8	7.5	9.3	18.4	Number of membership associations per 10,000 population. Data from 2018.
Disconnected Youth*	6%	-	15%	8%	7%	-	Percentage of teens and young adults ages 16-19 who are neither working nor in school. Data from 2015-2019.
Juvenile Arrests*	21	17	37	17	-	-	Rate of delinquency cases per 1,000 juveniles. Data from 2018.
Violent Crime	407 ●	248 ●	219 ●	420	386	63	Number of reported violent crime offenses per 100,000 population. Data from 2014 & 2016.
Firearm Fatalities*	17	12	15	12	12	-	Number of deaths due to firearms per 100,000 population. Data from 2015-2019.
Access to Healthy Foods							
Food Environment Index	7.4	6.9	7.2	5.9	7.6	8.6	Index of factors that contribute to a healthy food environment, 0-worst 10-best. Data from 2015 & 2018.
Food Insecurity	12%	14%	15%	15%	13%	-	Percent of the population who lack adequate access to food. Data from 2018.
Limited Access to Healthy Foods	11%	13%	8%	9%	6%	-	Percent of population who are low-income and do not live close to a grocery store. Data from 2015.

Smallest Population Counties

Indicator	Fayette	Gonzales	Llano	Lee	Blanco	TX	US	Top US Counties	Description
Economic Stability									
Median Household Income	\$62,195	\$48,425	\$55,617	\$59,250	\$68,404	\$64,044	\$57,600	-	The income where half of households in a county earn more and half of households earn less. Data from 2019.
Unemployment*	2.6% 	2.7% 	3.4% 	2.6% 	2.4% 	3.5%	3.9%	2.6%	Percentage of population ages 16 and older unemployed but seeking work. Data from 2019.
Poverty	11.9%	14.1%	11%	12.3%	9%	14.7%	13.4%	-	Percentage of population living below the Federal Poverty Line. Data from 2015-2019.
Childhood Poverty	15% 	24% 	21% 	16% 	15% 	19%	18%	11%	Percentage of people under age 18 in poverty. Data from 2019.
Income Inequality	4.3	4.4	4.3	4.6	4.2	4.8	4.9	3.7	Ratio of household income at the 80th percentile to income at the 20th percentile. A higher inequality ratio indicates greater division between the top and bottom ends of the income spectrum. Data from 2015-2019.
Educational Attainment									
High School Completion	86%	77%	86%	85%	90%	84%	85%	96%	Percentage of adults ages 25 and over with a high school diploma or equivalent. Data from 2015-2019.
Some College	46%	30%	48%	51%	53%	62%	66%	73%	Percentage of adults ages 25-44 with some post-secondary education. Data from 2015-2019.
Social/Community									
Children in single-parent homes	21%	26%	20%	28%	23%	26%	33%	20%	Percentage of children that live in a household headed by a single parent. Data from 2015-2019.
Social Associations	17	12.0	11.5	11.1	12.8	7.5	9.3	18.4	Number of membership associations per 10,000 population. Data from 2018.
Disconnected Youth*	-	-	-	-	-	8%	7%	-	Percentage of teens and young adults ages 16-19 who are neither working nor in school. Data from 2015-2019.
Juvenile Arrests*	-	11	18	-	-	17	-	-	Rate of delinquency cases per 1,000 juveniles. Data from 2018.

Violent Crime	261 ●	652 ●	141 ●	253 ●	137 ●	420	386	63	Number of reported violent crime offenses per 100,000 population. Data from 2014 & 2016.
Firearm Fatalities*	10	12	20	-	23	12	12	-	Number of deaths due to firearms per 100,000 population. Data from 2015-2019.
Access to Healthy Foods									
Food Environment Index	7.5	7.0	6.3	7.8	8.1	5.9	7.6	8.6	Index of factors that contribute to a healthy food environment, 0-worst 10-best. Data from 2015 & 2018.
Food Insecurity	13%	15%	17%	14%	13%	15%	13%	-	Percent of the population who lack adequate access to food. Data from 2018.
Limited Access to Healthy Foods	8%	11%	14%	2%	1%	9%	6%	-	Percent of population who are low-income and do not live close to a grocery store. Data from 2015.

Physical Environment

Why they are important: The physical environment is where people live, learn, work, and play. The physical environment impacts our air, water, housing and transportation to work or school. Poor physical environment can affect our ability and that of our families and neighbors to live long and healthy lives.

Largest Population Counties

Indicator	Travis	Williamson	Hays	TX	US	Top US Counties	Description
Physical Environment							
Severe housing cost burden*	15%	10%	16%	13%	15%	-	Percentage of households that spend 50% or more of their household income on housing. Data from 2015-2019.
Severe Housing Problems*	19%	12%	20%	17%	18%	9%	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. Data from 2013-2017.
Homelessness*	2,506	12	102	27,229	580,466	-	The number of people experiencing homelessness on one particular night in 2020 as counted by a Point in Time count.

Air Pollution - Particulate Matter	9.2 	8.5 	8.2 	7.3	8.6	6.1	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5). Data from 2016.
Homeownership*	52%	68%	62%	62%	64%	-	Percentage of occupied housing units that are owned. Data from 2015-2019.
Data Sources for Physical Environment Tables: - All metrics in this table were obtained from County Health Rankings & Roadmaps in 2021 unless otherwise noted. https://www.countyhealthrankings.org/explore-health-rankings - Travis County Homelessness data: 2020 Point-in-Time Count Results, Ending Community Homelessness (ECHO). Obtained in 2021 from: https://www.austinecho.org/wp-content/uploads/2020/07/PIT-2020-Three-One-Pagers.Revised-7.9.2020.pdf - Other Counties Homelessness data: 2020 Point-in-Time Count Reports from Texas Homeless Network, PIT Count Reports by County. Obtained in 2021 from: https://www.thn.org/texas-balance-state-continuum-care/data/pit-count-and-hic/							

Medium Population Counties

Indicator	Bastrop	Burnet	Caldwell	TX	US	Top US Counties	Description
Physical Environment							
Severe housing cost burden*	11%	9%	14%	13%	15%	-	Percentage of households that spend 50% or more of their household income on housing. Data from 2015-2019.
Severe Housing Problems*	17%	13%	17%	17%	18%	9%	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. Data from 2013-2017.
Homelessness*	123 ^A	-	-	27,229	580,466	-	The number of people experiencing homelessness on one particular night in 2020 as counted by a Point in Time count.
Air Pollution - Particulate Matter	8.1 	7.4 	8.0 	7.3	8.6	6.1	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5). Data from 2016.
Homeownership*	78%	77%	67%	62%	64%	-	Percentage of occupied housing units that are owned. Data from 2015-2019.
Data Notes: ^A Bastrop County and Lee County Homeless data represents both counties together							

Smallest Population Counties

Indicator	Fayette	Gonzales	Llano	Lee	Blanco	TX	US	Top US Counties	Description
Physical Environment									
Severe housing cost burden*	8%	7%	12%	13%	8%	13%	15%	-	Percentage of households that spend 50% or more of their household income on housing. Data from 2015-2019.
Severe Housing Problems*	10%	20%	15%	17%	15%	17%	18%	9%	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. Data from 2013-2017.
Homelessness*	-	-	-	123 ^A	-	27,229	580,466	-	The number of people experiencing homelessness on one particular night in 2020 as counted by a Point in Time count.
Air Pollution - Particulate Matter	7.8 	7.7 	7.1 	7.9 	7.3 	7.3	8.6	6.1	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5). Data from 2016.
Homeownership*	82%	67%	78%	81%	79%	62%	64%	-	Percentage of occupied housing units that are owned. Data from 2015-2019.
<i>Data Notes:</i> ^A Bastrop County and Lee County Homeless data represents both counties together									

Clinical Care

Why it is important: Access to affordable, quality care can help detect issues sooner and prevent disease. This can help individuals live longer and have healthier lives.

Largest Population Counties

Indicator	Travis	Williamson	Hays	TX	US	Top US Counties	Description
Healthcare Access							
Uninsured	15% 	12% 	18% 	20%	10%	6%	Percentage of population under age 65 without health insurance. Data from 2018.
Uninsured Adults	17%	14%	20%	24%	12%	-	Percentage of adults under age 65 without health insurance. Data from 2018.

Uninsured children	8%	8%	11%	11%	5%	-	Percentage of children under age 19 without health insurance. Data from 2018.
Primary Care Physicians	1,158:1 	1,431:1 	2,343:1 	1,642:1	1,330:1	1,030:1	Ratio of population to primary care physicians. Data from 2018.
Mental Health Providers	343:1	828:1	971:1	827:1	400:1	290:1	Ratio of the population to mental health providers. Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and mental health providers that treat alcohol and other drug abuse, as well as advanced practice nurses specializing in mental health care. Data from 2020.
Psychiatrists*	5,359:1	10,726:1	15,660:1	12,804:1	No Data	-	Ratio of the population to psychiatrists in 2020. Source: Texas Primary Care Physicians & Psychiatrists
Dentists	1,385:1 	1,773:1 	2,616:1 	1,677:1	1,450:1	1,240:1	Ratio of population to dentists. Data from 2019.
Hospital Utilization							
Preventable Hospital Stays*	3,803 	3,776 	3,531 	4,793	4,535	2,761	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. Data from 2018.
Preventative Healthcare							
Flu Vaccinations*	50% 	52% 	48% 	46%	46%	53%	Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination. Data from 2018.
Mammography Screenings	40% 	46% 	37% 	37%	42%	50%	Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening. Data from 2018.
Data Sources for Clinical Care Tables - All metrics in this table were obtained from County Health Rankings & Roadmaps in 2021 unless otherwise noted. https://www.countyhealthrankings.org/explore-health-rankings - Psychiatrists Data: Texas Department of State Health Services, Health Professions Resource Center, Psychiatrists, 2020. Obtained in 2021 from: https://www.dshs.texas.gov/chs/hprc/tables/2020/psych20.aspx							

Medium Population Counties

Indicator	Bastrop	Burnet	Caldwell	TX	US	Top US Counties	Description
Healthcare Access							
Uninsured	22% 	23% 	22% 	20%	10%	6%	Percentage of population under age 65 without health insurance. Data from 2018.

Uninsured Adults	26%	27%	26%	24%	12%	-	Percentage of adults under age 65 without health insurance. Data from 2018.
Uninsured children	13%	13%	12%	11%	5%	-	Percentage of children under age 19 without health insurance. Data from 2018.
Primary Care Physicians	3,624:1 	2,264:1 	3,604:1 	1,642:1	1,330:1	1,030:1	Ratio of population to primary care physicians. Data from 2018.
Mental Health Providers	1,740:1	1,553:1	1,284:1	827:1	400:1	290:1	Ratio of the population to mental health providers. Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and mental health providers that treat alcohol and other drug abuse, as well as advanced practice nurses specializing in mental health care. Data from 2020.
Psychiatrists*	86,105:1	16,065:1	-	12,804:1	-	-	Ratio of the population to psychiatrists in 2020. Source: Texas Primary Care Physicians & Psychiatrists
Dentists	2,957:1 	2,293:1 	3,359:1 	1,677:1	1,450:1	1,240:1	Ratio of population to dentists. Data from 2019.
Hospital Utilization							
Preventable Hospital Stays*	4,211 	3,484 	6,002 	4,793	4,535	2,761	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. Data from 2018.
Preventative Healthcare							
Flu Vaccinations*	43% 	47% 	42% 	46%	46%	53%	Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination. Data from 2018.
Mammography Screenings	35% 	43% 	30% 	37%	42%	50%	Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening. Data from 2018.

Smallest Population Counties

Indicator	Fayette	Gonzales	Llano	Lee	Blanco	TX	US	Top US Counties	Description
Healthcare Access									
Uninsured	20% 	25% 	21% 	21% 	22% 	20%	10%	6%	Percentage of population under age 65 without health insurance. Data from 2018.
Uninsured Adults	22%	31% 	23%	24%	23%	24%	12%	-	Percentage of adults under age 65 without health insurance. Data from 2018.

Uninsured children	14%	15%	13%	12%	18%	11%	5%	-	Percentage of children under age 19 without health insurance. Data from 2018.
Primary Care Physicians	3,169:1 ●	2,603:1 ●	1,273:1 ●	3,429:1 ●	3,901:1 ●	1,642:1	1,330:1	1,030:1	Ratio of population to primary care physicians. Data from 2018.
Mental Health Providers	3,621:1	2,977:1	1,816:1	1,567:1	11,931:1	827:1	400:1	290:1	Ratio of the population to mental health providers. Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and mental health providers that treat alcohol and other drug abuse, as well as advanced practice nurses specializing in mental health care. Data from 2020.
Psychiatrists*	26,086:1	-	-	-	-	12,804:1	-	-	Ratio of the population to psychiatrists in 2020. Source: Texas Primary Care Physicians & Psychiatrists
Dentists	1,950:1 ●	2,605:1 ●	1,981:1 ●	3,448:1 ●	2,983:1 ●	1,677:1	1,450:1	1,240:1	Ratio of population to dentists. Data from 2019.
Hospital Utilization									
Preventable Hospital Stays*	2,900 ●	4,650 ●	4,227 ●	4,432 ●	3,014 ●	4,793	4,535	2,761	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. Data from 2018.
Preventative Healthcare									
Flu Vaccinations*	46% ●	39% ●	43% ●	47% ●	44% ●	46%	46%	53%	Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination. Data from 2018.
Mammography Screenings	37% ●	31% ●	42% ●	36% ●	35% ●	37%	42%	50%	Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening. Data from 2018.

Health Behaviors

Why they are important: Health behaviors are actions individuals take that can affect their health. These actions can lead to positive health outcomes or they can increase someone's risk of disease and premature death. It is important to understand that not all people have the same opportunities to engage in healthier behaviors.

Largest Population Counties

Indicator	Travis	Williamson	Hays	TX	US	Top US Counties	Description
Healthy Life							
Adult Obesity	23% 	31% 	32% 	31%	29%	26%	Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2. Data from 2017.
Physical Inactivity	15% 	19% 	17% 	23%	23%	20%	Percentage of adults age 20 and over reporting no leisure-time physical activity. Data from 2017.
Access to Exercise Opportunities	93%	87%	72%	81%	84%	91%	Percentage of population with adequate access to locations for physical activity. Data from 2010 & 2019.
Insufficient Sleep*	32%	34%	36%	34%	34%	-	Percentage of adults who report fewer than 7 hours of sleep on average. Data from 2018.
Motor Vehicle Crash Deaths	10	8	12	13	11	-	Number of motor vehicle crash deaths per 100,000 population. Data from 2013 - 2019.
Substance Use and Misuse							
Adult Smoking	13%	12% 	15%	14%	17%	14%	Percentage of adults who are current smokers. Data from 2018.
Excessive Drinking	22% 	19%	22% 	19%	19%	13%	Percentage of adults reporting binge or heavy drinking. Data from 2018.
Alcohol-Impaired Driving Deaths	23% 	27% 	38% 	26%	28%	11%	Alcohol-impaired driving deaths. Data from 2015-2019.
Drug Overdose Mortality Rate	13	6	8	11	21	-	Number of drug poisoning deaths per 100,000 population. Data from 2017-2019
Opioid Hospital Visits*	112	83	68	78	-	-	Rate of Opioid-related Hospital Visits per 100,000 Visits in 2020 (DSHS)

Sexual Health							
Teen Births	24	13	17	31	23	13	Number of births per 1,000 female population ages 15-19. Data from 2013-2019.
Data Sources for Health Behaviors Tables: - All metrics in this table were obtained from County Health Rankings & Roadmaps in 2021 unless otherwise noted. https://www.countyhealthrankings.org/explore-health-rankings - Opioid Hospital Visits data: Texas Department of State Health Services (DSHS), 2020. Obtained in 2021 from https://healthdata.dshs.texas.gov/dashboard/drugs-alcohol/opioids/opioid-rel-ed-visits							

Medium Population Counties

Indicator	Bastrop	Burnet	Caldwell	TX	US	Top US Counties	Description
Healthy Life							
Adult Obesity	42% ●	34% ●	39% ●	31%	29%	26%	Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2. Data from 2017.
Physical Inactivity	27% ●	25% ●	23% ●	23%	23%	20%	Percentage of adults age 20 and over reporting no leisure-time physical activity. Data from 2017.
Access to Exercise Opportunities	48%	63%	59%	81%	84%	91%	Percentage of population with adequate access to locations for physical activity. Data from 2010 & 2019.
Insufficient Sleep*	37%	35%	37%	34%	34%	-	Percentage of adults who report fewer than 7 hours of sleep on average. Data from 2018.
Motor Vehicle Crash Deaths	30	24	23	13	11	-	Number of motor vehicle crash deaths per 100,000 population. Data from 2013 - 2019.
Substance Use and Misuse							
Adult Smoking	18%	18%	19%	14%	17%	14%	Percentage of adults who are current smokers. Data from 2018.
Excessive Drinking	21%	20%	19%	19%	19%	13%	Percentage of adults reporting binge or heavy drinking. Data from 2018.
Alcohol-Impaired Driving Deaths	30% ●	33% ●	20% ●	26%	28%	11%	Alcohol-impaired driving deaths. Data from 2015-2019.
Drug Overdose Mortality Rate	9	13	-	11	21	-	Number of drug poisoning deaths per 100,000 population. Data from 2017-2019
Opioid Hospital Visits*	57	63	65	78	-	-	Rate of Opioid-related Hospital Visits per 100,000 Visits in 2020 (DSHS)

Sexual Health							
Teen Births	33	31	36	31	23	13	Number of births per 1,000 female population ages 15-19. Data from 2013-2019.

Smallest Populations

Indicator	Fayette	Gonzales	Llano	Lee	Blanco	TX	US	Top US Counties	Description
Healthy Life									
Adult Obesity	24% 	33% 	26% 	38% 	22% 	31%	29%	26%	Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2. Data from 2017.
Physical Inactivity	23% 	26% 	26% 	27% 	24% 	23%	23%	20%	Percentage of adults age 20 and over reporting no leisure-time physical activity. Data from 2017.
Access to Exercise Opportunities	58%	40%	80%	47%	50%	81%	84%	91%	Percentage of population with adequate access to locations for physical activity. Data from 2010 & 2019.
Insufficient Sleep*	36%	38%	35%	38%	35%	34%	34%	-	Percentage of adults who report fewer than 7 hours of sleep on average. Data from 2018.
Motor Vehicle Crash Deaths	26	26	20	34	18	13	11	-	Number of motor vehicle crash deaths per 100,000 population. Data from 2013 - 2019.
Substance Use and Misuse									
Adult Smoking	19.4%	19.5%	18.6%	19.4%	17%	14%	17%	14%	Percentage of adults who are current smokers. Data from 2018.
Excessive Drinking	20%	18%	20%	19%	21%	19%	19%	13%	Percentage of adults reporting binge or heavy drinking. Data from 2018.
Alcohol-Impaired Driving Deaths	20% 	20% 	35% 	23% 	23% 	26%	28%	11%	Alcohol-impaired driving deaths. Data from 2015-2019.
Drug Overdose Mortality Rate	-	-	-	-	-	11	21	-	Number of drug poisoning deaths per 100,000 population. Data from 2017-2019
Opioid Hospital Visits*	0	0	0	0	0	78	-	-	Rate of Opioid-related Hospital Visits per 100,000 Visits in 2020 (DSHS)
Sexual Health									
Teen Births	22	47	43	36	16	31	23	13	Number of births per 1,000 female population ages 15-19. Data from 2013-2019.

Disparities

Why they are important: Differences in access to opportunities that affect health can create differences between groups of people in the community. A focus on equity is important to improving health for everyone in the community. Any indicators compared using standard deviation are compared to the overall Texas metric.

Health Outcomes

Large and Medium Population Counties

Indicator	Travis	Williamson	Hays		Bastrop	Burnet	Caldwell	Texas
Premature Death: Years of potential life lost before age 75 per 100,000 population (age-adjusted). Smaller is better.								
Overall	4,665	4,248	4,886		7,492	7,137	8,256	6,620
Asian*	2,355	1,872	-		-	-	-	3,002
Black	7,972	5,470	8,427		7,730	-	-	9,892
Hispanic	4,148	3,155	4,523		5,760	4,680	7,803	5,471
White	4,735	4,866	5,030		8,787	8,153	8,483	7,097
Infant Mortality Rate: Number of all infant deaths (within 1 year) per 1,000 live births.								
Overall	4	4	4		5	-		6
Black	9	7	-		-	-	-	11
Hispanic	4	3	3		-	-	-	5
White	3	4	4		-	-	-	5

Small Population Counties

Indicator	Fayette	Gonzales	Llano	Lee	Blanco	Texas
Premature Death: Years of potential life lost before age 75 per 100,000 population (age-adjusted). Smaller is better.						
Overall	7,217	7,599	8,551	8,060	6,357	6,620
Asian	-	-	-	-	-	3,002
Black	-	-	-	-	-	9,892
Hispanic	-	6,120	-	-	-	5,471
White	-	9,291	-	-	-	7,097
Infant Mortality Rate: Not available for these counties by Race						

Social and Economic Factors

Large and Medium Population Counties

Indicator	Travis	Williamson	Hays		Bastrop	Burnet	Caldwell	Texas	United States
Childhood Poverty: Percentage of people under age 18 in poverty.									
Overall	13.6%	6.5%	11.3%		23.8%	16.3%	20.5%	19.2%	17%
Asian*	5.5%	4.2%	5.9%		-	-	-	9.9%	-
Black	28.8%	15.4%	5.7%		23.4%	-	56.5%	27.1%	-
Hispanic	23.9%	14.1%	22.4%		18.1%	9.5%	28.1%	28.5%	-
White	4.6%	3.2%	5.6%		9.1%	16.3%	16.7%	9.1%	-

Median Household Income: The income where half of households in a county earn more and half of households earn less.									
Overall	\$80,690	\$92,661	\$72,890		\$62,627	\$62,827	\$55,301	\$64,044	\$65,712
American Indian and Alaskan Native*	\$58,354	\$69,063	\$74,313		-	\$39,815	-	\$56,394	\$43,825
Asian*	\$94,034	\$117,418	\$61,283		\$68,333	\$69,412	-	\$88,486	\$88,204
Black	\$50,582	\$68,900	\$58,417		\$49,836	\$68,152	\$51,265	\$46,572	\$41,935
Hispanic	\$54,833	\$73,082	\$59,625		\$62,212	\$49,097	\$52,200	\$49,260	\$51,811
White	\$92,366	\$90,759	\$75,082		\$69,055	\$60,726	\$55,831	\$75,879	\$66,536

Small Population Counties

Indicator	Fayette	Gonzales	Llano	Lee	Blanco	Texas	United States
Childhood Poverty: Percentage of people under age 18 in poverty.							
Overall	15.3%	23.7%	20.7%	16.1%	14.7%	19.2%	17%
Asian	-	-	-	-	-	9.9%	10%
Black	61.1%	47.5%	-	62.2%	-	27.1%	30%
Hispanic	13.1%	20.9%	23.5%	22.2%	27.6%	28.5%	23%
White	10.6%	8.3%	11.2%	2.9%	9.6%	9.1%	10%
Median Household Income: The income where half of households in a county earn more and half of households earn less.							
Overall	\$62,195	\$48,425	\$55,617	\$59,250	\$68,404	\$64,044	\$62,843
American Indian and Alaskan Native	-	\$118,438	-	-	\$110,354	\$56,394	\$43,825
Asian	\$220,724	-	-	-	-	\$88,486	\$88,204

Black	\$21,526	\$26,204	-	\$27,804	-	\$46,572	\$41,935
Hispanic	\$63,422	\$50,799	\$32,344	\$45,313	\$51,300	\$49,260	\$51,811
White	\$62,939	\$61,918	\$53,957	\$62,594	\$68,662	\$75,879	\$66,536

Physical Environment

Large and Medium Population Counties

Indicator	Travis	Williamson	Hays		Bastrop	Burnet	Caldwell	Texas	United States
Homelessness*: The 2020 Point in Time Count provides a snapshot of the number of people experiencing homelessness on one particular night . Travis County is conducted by ECHO, all other Seton counties are in Balance of State Continuum of Care and do not have county level data. The Overall indicator is the total count, the breakdown by race shows the percentage of the whole population experiencing homelessness of each race/ethnicity.									
Overall Count	2506	12	102		-	-	-	27,229	-
Black	35.1%	25%	5%		-	-	-	36.7%	-
Hispanic	24.8%	42%	29%		-	-	-	27.7%	-
White	52.5%	75%	72%		-	-	-	57.9%	-
Asian	0.4%	0%	0%		-	-	-	0.7%	-
Pacific Islander	0.2%	0%	0%		-	-	-	0.3%	-
Native American	1.4%	0%	6%		-	-	-	1.3%	-
Two or more Races	10.5%	0%	1%		-	-	-	3%	-
Homeownership*: Percentage of occupied housing units that are owned.									
Overall	52%	68%	62%		77.67%	77.19%	67%	62%	64%
American Indian or	47.31%	76.54%	72%		90.28%	55.74%	-	59%	54%

Alaskan Native									
Asian	50%	69%	61%		73.33%	77.00%	73%	63%	60%
Black	38%	51%	46%		58.86%	63.48%	64%	41%	42%
Hawaiian or Pacific Islander	24.77%	54.95%	-		-	-	-	43.46%	41.01%
Hispanic	42%	58%	56%		74.37%	69.58%	64%	57%	47%
White	55%	70%	63%		81.02%	77.28%	69%	66%	70%

Small Population Counties

Indicator	Fayette	Gonzales	Llano	Lee	Blanco	Texas	United States
Homeownership* : Percentage of occupied housing units that are owned.							
Overall	81.66%	67.30%	78%	80.55%	78.59%	62%	64%
American Indian or Alaskan Native	-	-	-	-	-	59%	54%
Asian	22.22%	54.55%	18%		94.03%	63%	60%
Black	46.94%	38.31%	-	69.52%	-	41%	42%
Hawaiian or Pacific Islander	-	-	-	-	-	43.46%	41.01%
Hispanic	79.34%	63.20%	49%	73.79%	75.89%	57%	47%
White	84.47%	73.21%	79%	82.94%	77.09%	66%	70%

Clinical Care

Large and Medium Population Counties

Indicator	Travis	Williamson	Hays		Bastrop	Burnet	Caldwell	Texas
Preventable Hospital Stays*: Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.								
Overall	3,803	3,776	3,531		4,211	3,484	6,002	4,793
Asian	1,916	3,704	2,409		-	-	-	7,270
Black	7,650	5,309	2,737		7,492	-	5,963	7,202
Hispanic	4,662	3,839	5,279		4,558	5,136	5,899	5,237
White	3,309	3,768	2,968		3,835	3,454	5,926	4,422

Small Population Counties

Indicator	Fayette	Gonzales	Llano	Lee	Blanco	Texas
Preventable Hospital Stays*: Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.						
Overall	2,900	4,650	4,227	4,432	3,014	4,793
Asian	-	-	-	-	-	7,270
Black	2,467	2,649	-	5,783	-	7,202
Hispanic	860	5,969	1,716	2,698	1,381	5,237
White	2,824	4,107	4,246	4,604	2,849	4,422

Health Behaviors

Large and Medium Population Counties

Indicator	Travis	Williamson	Hays		Bastrop	Burnet	Caldwell	Texas
Teen Births: Number of births per 1,000 female population ages 15-19.								
Overall	24	13	17		33	31	36	31
Asian	2	2	-				-	5
Black	29	15	10		26	-	-	32
Hispanic	43	22	30		42	48	49	43
White	5	9	7		24	22	21	19

Small Population Counties

Indicator	Fayette	Gonzales	Llano	Lee	Blanco	Texas
Teen Births: Number of births per 1,000 female population ages 15-19.						
Overall	22	47	43	36	16	31
Asian	-	-	-	-	-	-
Black	44	-	-	52	-	32
Hispanic	31	58	37	36	24	43
White	14	30	46	33	14	19

Appendix E: Health Care Facilities and Community Resources

As part of the CHNA process, Ascension Seton has cataloged resources available in Central Texas that address the significant needs identified in this CHNA. Resources may include acute care facilities (hospitals), primary and specialty care clinics and practices, mental health providers, and other non-profit services. State and national resources can also provide information regarding programs that can better serve the needs of a person experiencing a specific problem.

The resources listed under each significant need heading is not intended to be exhaustive.

Access to Care

Organization Name	Phone	Website
Dell Seton Medical Center at the University of Texas	(512) 324-7000	https://healthcare.ascension.org/locations/texas/txaus/austin-dell-seton-medical-center-at-the-university-of-texas
Ascension Seton Medical Center at Austin	(512) 324-1000	https://healthcare.ascension.org/locations/texas/txaus/austin-ascension-seton-medical-center-austin
Ascension Seton Southwest	(512) 324-9000	https://healthcare.ascension.org/locations/texas/txaus/austin-ascension-seton-southwest
Ascension Seton Northwest	(512) 324-6000	https://healthcare.ascension.org/locations/texas/txaus/austin-ascension-seton-northwest
Ascension Seton Williamson	(512) 324-4000	https://healthcare.ascension.org/locations/texas/txaus/round-rock-ascension-seton-williamson
Ascension Seton Hays	(512) 504-5000	https://healthcare.ascension.org/locations/texas/txaus/kyle-ascension-seton-hays
Ascension Seton Bastrop	(737) 881-7400	https://healthcare.ascension.org/locations/texas/txaus/bastrop-ascension-seton-bastrop
Ascension Seton Highland Lakes	(512) 715-3000	https://healthcare.ascension.org/locations/texas/txaus/burnet-ascension-seton-highland-lakes

Ascension Seton Smithville Regional Hospital	(512) 237-3214	https://healthcare.ascension.org/locations/texas/txaus/smithville-ascension-seton-smithville
Ascension Seton Edgar B. Davis	(830) 875-7000	https://healthcare.ascension.org/locations/texas/txaus/luling-ascension-seton-edgar-b-davis
Dell Children's Medical Center	(512) 324-0000	https://www.dellchildrens.net/
St. David's Hospital South Austin	(512) 447-2211	https://stdavids.com/locations/st-davids-south-austin-medical-center/about/
St. David's Medical Center	(512) 544-7111	https://stdavids.com/locations/st-davids-medical-center/
St. David's North Austin Medical Center	(512) 901-1000	https://stdavids.com/locations/st-davids-north-austin-medical-center/about/
St. David's Heart Hospital	(512) 407-7000	https://stdavids.com/locations/heart-hospital-of-austin/about/?utm_campaign=corp_listings_mgmt&utm_source=google&utm_medium=business_listing&com.dotmarketing.htmlpage.language=1
Baylor Scott & White Medical Clinic	(512) 654 - 4100	https://www.bswhealth.com/locations/austin-downtown-clinic?utm_source=google-mybusiness&utm_medium=organic&utm_campaign=yextlisting&y_source=1_MTM0MTE2NDUtNzE1LWxvY2F0aW9uLmdvb2dsZV93ZWJzaXRlX292ZXJyaWRI
Lakeway Regional Medical Center	(512) 654-5000	https://www.bswhealth.com/locations/lakeway/
Cornerstone Hospital of Austin	(512) 706-1900	https://www.chghospitals.com/location/cornerstone-specialty-hospitals-austin/
McCarthy Community Health Center	(512) 324-4930	https://www.healthgrades.com/group-directory/tx-texas/austin/seton-mc-carthy-community-health-center-oo7kdlk
University Physicians Group	(512) 324-9650	https://healthcare.ascension.org/locations/texas/txaus/austin-university-of-texas-physicians-downtown-austin?utm_campaign=gmb&utm_medium=

		organic&utm_source=local
Ascension Medical Group Family of Doctors at Balcones	(512) 324-6980	https://healthcare.ascension.org/locations/texas/txaus/austin-ascension-medical-group-seton-primary-care-balcones-woods
Ascension Medical Group at Jollyville	(512) 324-6975	https://healthcare.ascension.org/locations/texas/txaus/austin-seton-family-of-doctors-at-jollyville/our-specialties
Ascension Medical Group and Express Care at Davis Lane	(512) 324-9290	https://healthcare.ascension.org/?keyword=%2Bseton%20%2Bhealth%20%2Bcare&gclid=EAlaIqobChMI2LDnwLXr9AIVIRvUAR2wUgueEAAYASAAEgl7wfD_BwE
Ascension Medical Group at Stonehill	(512) 324-4875	https://healthcare.ascension.org/locations/texas/txaus/pflugerville-ascension-medical-group-sehttps://www.austinpcc.org/ton-primary-care-stone-hill
People's Community Clinic (Federally Qualified Health Center)	(512) 478-4939	https://www.austinpcc.org/
Lone Star Circle of Care (Federally Qualified Health Center)	(877) 800-5722	https://lonestarcare.org/
Communicare (Federally Qualified Health Center)	(210) 233-7000	https://communicaresa.org/
El Buen Samaritano Episcopal Mission	(512) 439-8900	https://elbuen.org/
RediClinics		https://www.rediclinic.com
UT Health Austin (clinical practice at Dell Medical School)	(833) 882-2737	https://uthealthaustin.org/
St. David's Foundation Dental Program	(512) 879-6240	https://stdavidsfoundation.org/our-programs/dental-program/
Hope Medical & Dental Clinics	(512) 766-9979	https://www.hopeclinicaustin.org/
Medical Assistance Program (MAP)	(512) 978-8000	https://www.centralhealth.net/map/
University of Texas at Austin Dell Medical School	(512) 495-5555	https://dellmed.utexas.edu/
Community Care Collaborative	(512) 978-8000	https://www.ccc-ids.org/about-us/visionmissionvalues/

Catholic Charities of Central Texas	(512) 651-6100	https://ccctx.org/
Foundation Communities	(512) 447-2026	https://foundcom.org/
Capital Metropolitan Transportation Authority (CAP Metro)	(512) 474-1200	https://www.capmetro.org/
Capital Area Rural Transportation System (CARTS)	(512) 478-7433	https://www.ridecarts.com/
United Way of Greater Austin	(512) 472-6267	https://www.unitedwayaustin.org/
Greater Austin Hispanic Chamber of Commerce Health and Wellness Committee	(512) 476-7502	https://www.gahccfoundation.org/home/
Austin Public Health Neighborhood Centers	(512) 972-5000	https://www.austintexas.gov/department/neighborhood-centers
Central Texas Medical Center	(512) 353-8979	https://www.christushealth.org/santa-rosa/san-marcos
Warm Springs Rehabilitation Hospital Kyle	(512) 262-0821	http://postacutemedical.com/facilities/find-facility/rehabilitation-hospitals/pam-rehabilitation-hospital-kyle
Hays Surgical Center	(512) 504-0202	https://hayssurgerycenter.com/
Ascension Seton Medical Group of Hays	(512) 504-0855	https://healthcare.ascension.org/locations/texas/txaus/kyle-ascension-medical-group-seton-at-hays
Live Oak Health Partner Clinics	(512) 396.3911	https://www.christushealth.org/trinity/clinic/locations-directions/san-marcos?utm_source=organic&utm_medium=GMB&utm_campaign=website&y_source=1_MTU5NjM4MjltNzE1LWxvY2F0aW9uLmdvb2dsZV93ZWJzaXRlX292ZXJyaWRI
Community Action Incorporated Of Hays County	(512) 392-1161	https://www.communityaction.com/
Warm Springs Specialty Hospital of Luling	(830) 875-8400	https://pamhealth.com/
Ascension Seton Luling Health Center	(830) 875-3445	https://healthcare.ascension.org/locations/texas/txaus/luling-seton-luling-health-center?utm_campaign=gmb&

		utm_medium=organic&utm_source=local
Seton Lockhart Internal Medicine	(512) 376-2999	https://healthcare.ascension.org/locations/texas/txaus/lockhart-seton-family-of-doctors-at-lockhart-209-south-church-st?utm_campaign=gmb&utm_medium=organic&utm_source=local
Ascension Seton Lockhart Medical Clinic	(512) 376-9690	https://healthcare.ascension.org/locations/texas/txaus/lockhart-ascension-seton-lockhart-family-healthcare-center?utm_campaign=gmb&utm_medium=organic&utm_source=local
Lockhart Family Medicine	(512) 376-5247	https://www.lockhartfamilymedicine.com/
Luling Community Dental	(830) 875-6603	https://www.dentalclinics.org/lis/tx-luling_community_dental_center
St. Marks Medical Center	(979) 242-2200	https://www.smmctx.org/getpage.php?name=index
St. Davids Emergency Center Bastrop	(512) 308-5900	https://stdavids.com/locations/st-davids-emergency-center-bastrop/?utm_campaign=corp_listings_mgmt&utm_source=google&utm_medium=business_listing&com.dotmarketing.htmlpage.language=1
Ascension Seton Bastrop Health Center	(512) 304-0313	https://healthcare.ascension.org/locations/texas/txaus/bastrop-seton-family-of-doctors-at-bastrop-seton-health-plaza?utm_campaign=gmb&utm_medium=organic&utm_source=local
Ascension Seton Smithville Health Center	(512) 360-5272	https://healthcare.ascension.org/locations/texas/txaus/smithville-seton-family-of-doctors-at-smithville?utm_campaign=gmb&utm_medium=organic&utm_source=local
CommUnity Care	(512) 978-9015	https://communitycaretexas.org/
Bastrop Community Health Center	(512) 321-7137	https://business.bastropchamber.com/list/member/bastrop-community-health-center-6627
Smithville Community Clinic	(512) 237-2772	https://www.smithvillecommunityclinic.org/

Tejas Health Care	(979) 968-2000	https://tejashealthcare.org/
Baylor Scott & White Medical Center Marble Falls	(830) 201-8000	https://www.bswhealth.com/locations/marble-falls?utm_source=google-mybusiness&utm_medium=organic&utm_campaign=yextlistings&y_source=1_MTM0MTE3MjAtNzE1LWxvY2F0aW9uLmdvb2dsZV93ZWJzaXRlX292ZXJyaWRI
Ascension Seton Burnet Healthcare Center	(512) 715-3118	https://www.seton.net/locations/seton-burnet-healthcare-center/?utm_campaign=gmb-website&utm_medium=organic&utm_source=google
Ascension Seton Bertram Healthcare Center	(512) 355-9233	https://healthcare.ascension.org/locations/texas/txaus/bertram-ascension-seton-bertram-healthcare-center?utm_campaign=gmb&utm_medium=organic&utm_source=local
Ascension Seton Kingsland Healthcare Center	(512) 715-3118	https://healthcare.ascension.org/locations/texas/txaus/kingsland-ascension-seton-kingsland-health-center?utm_campaign=gmb&utm_medium=organic&utm_source=local
Ascension Seton Lampasas Health Center	(512) 556-5362	https://healthcare.ascension.org/locations/texas/txaus/lampasas-ascension-seton-lampasas-health-center?utm_campaign=gmb&utm_medium=organic&utm_source=local
Ascension Seton Marble Falls Health Center	(830) 693-2600	https://healthcare.ascension.org/locations/texas/txaus/marble-falls-ascension-seton-highland-lakes-marble-falls-healthcare-center?utm_campaign=gmb&utm_medium=organic&utm_source=local
Cedar Park Regional Medical Center	(512) 528-7000	https://www.cedarparkregional.com/?utm_campaign=gmb&utm_medium=organic&utm_source=local
Baylor Scott & White Round Rock	(512) 509-0100	https://www.bswhealth.com/locations/round-rock?utm_source=google-mybusiness&utm_medium=organic&utm_campaign=yextlistings&y_source=1_MTM0MTE3MTAtNzE1LWxvY2F0aW9uLmdvb2dsZV93ZWJzaXRlX292ZXJyaWRI

Baylor Scott & White Taylor	(737) 888-3100	https://www.bswhealth.com/location/s/taylor?utm_source=google-mybusiness&utm_medium=organic&utm_campaign=yextlistings&y_source=1_MTM0MTE3MTEtNzE1LWxvY2F0aW9uLmdvb2dsZV93ZWJzaXRlX292ZXJyaWRI
Cornerstone Specialty Hospital of Round Rock	(512) 671-1100	https://www.chghospitals.com/location/cornerstone-specialty-hospitals-round-rock/
St. David's Round Rock Medical Center	(512) 341-1000	https://stdavids.com/locations/st-davids-round-rock-medical-center/?utm_campaign=corp_listings_mgmt&utm_source=google&utm_medium=business_listing&com.dotmarketing.htmlpage.language=1
St. David's Georgetown Hospital	(512) 943-3000	https://stdavids.com/locations/st-davids-georgetown-hospital/?utm_campaign=corp_listings_mgmt&utm_source=google&utm_medium=business_listing&com.dotmarketing.htmlpage.language=1
Ascension Seton Family of Doctors Chisholm Trail	(512) 324-4825	https://healthcare.ascension.org/locations/texas/txaus/round-rock-seton-family-of-doctors-at-chisolm-trail?utm_campaign=gmb&utm_medium=organic&utm_source=local
Ascension Medical Group Seton Express Care Round Rock	(512) 324-4780	https://healthcare.ascension.org/locations/texas/txaus/ascension-medical-group-seton-express-care-round-rock?utm_campaign=gmb&utm_medium=organic&utm_source=local
Ascension Medical Group Seton Primary Care Round Rock	(512) 324-4813	https://healthcare.ascension.org/locations/texas/txaus/round-rock-ascension-medical-group-seton-primary-care-round-rock?utm_campaign=gmb&utm_medium=organic&utm_source=local
Sacred Heart Community Clinic of Round Rock	(512) 716-3929	https://sacredheartclinic.org/
Austin Regional Clinic	(512) 272-4636	https://www.austinregionalclinic.com/

Mental and Behavioral Health

Organization Name	Phone	Website
Austin County Integral Care	(512) 472-4357	https://integralcare.org/en/home/
Ascension Seton Shoal Creek	(512) 324-2000	https://healthcare.ascension.org/?keyword=%2Bascension%20%2Bseton%20%2Bshoal%20%2Bcreek&gclid=EAlaQobChMlvMitmpz19AIVrxXUAR1blQ6FEAAYASAAEgLKQvD_BwE
Ascension Seton Psychiatric Emergency Department	(512) 324-2039	https://healthcare.ascension.org/?keyword=%2Bascension%20%2Ber&gclid=EAlaQobChMlp8ilvZz19AIVThXUAR0pRAMeEAAYASAAEgLBf_D_BwE
Ascension Seton Mind Institute	(512) 324-2000	https://healthcare.ascension.org/locations/texas/txaus/austin-ascension-seton-shoal-creek?utm_campaign=gmb&utm_medium=organic&utm_source=local
Grace Grego Maxwell Mental Health Unit at Dell Children's Medical Center	(512) 324-0029	https://www.dellchildrens.net/behavioral-health/about-us/?utm_campaign=gmb&utm_medium=organic&utm_source=local
Texas Children's Study Center/University of Texas at Austin	(512) 324-3315	https://healthcare.ascension.org/locations/texas/txaus/austin-texas-child-study-center-at-dell-childrens-medical-center?utm_campaign=gmb&utm_medium=organic&utm_source=local
Austin State Hospital	(512) 452-0381	https://www.hhs.texas.gov/services/mental-health-substance-use/state-hospitals/austin-state-hospital
Ascension Seton Health Services at Austin ISD	(512) 324-0195	https://www.austinisd.org/student-health
Bipolar Disorder Clinic at UT Health Austin (Dell Medical School)	(833) 882-2737	https://uthealthaustin.org/clinics/mulva-clinic-for-the-neurosciences/bipolar-disorder-center
Bluebonnet Trails	(844) 309-6385	https://bbtrails.org/
NAMI Central Texas	(512) 420-9810	https://namicentraltx.org/

Central Texas Mental Health	(512) 964-6992	https://www.centexmh.com/?gclid=EAlaQobChMIxLbEkaD19AlVvhvUAR1udgRAEAAAYAiAAEgJZRvD_BwE
Mental Health and Developmental Disabilities Center Hill Country	(830) 792-3300	https://www.hillcountry.org/
Communities for Recovery	(512) 758-7686	https://communitiesforrecovery.org/
Hill Country MHDD of Kyle	(512) 392-8953	https://www.hillcountry.org/
Oceans Behavioral Hospital	(254) 870-4874	https://oceanshealthcare.com/
Llano County Mental Health Center	(325) 247-5895	https://www.hillcountry.org/
Rock Springs Behavioral Health	(512) 883-1416	https://rockspringshealth.com/
Georgetown Behavioral Health Institute	(877) 500-9151	https://www.georgetownbehavioral.com/
STARRY Counseling	(512) 388-8290	https://www.starry.org/contact-us/
Cenikor	(737) 300-2968	https://www.cenikor.org/locations/austin-texas/

Chronic Conditions

Organization Name	Phone	Website
People's Community Clinic	(512) 478-4939	https://www.austinpcc.org/our-programs/adult/chronic-disease-management-program/
Live Tobacco - Free Austin	(512) 972-6464	https://www.livetobaccofreeaustin.org/
Ascension Seton Heart Specialty Care	(512) 681-0500	https://healthcare.ascension.org/locations/texas/txaus/austin-ascension-seton-heart-specialty-care-and-transplant-center?utm_campaign=gmb&utm_medium=organic&utm_source=local
Texas Heart and Vascular	(512) 623-5300	https://thandv.com/
Austin Heart	(512) 450-7241	https://austinheart.com/
Cardiovascular Specialists of Texas	(512) 807-3180	https://cstheart.com/
Texas Center for the Prevention and	(512) 324-9999	https://www.healthgrades.com/group-directory/tx-texas/austin/texas-cen

Treatment of Childhood Obesity		ter-for-the-prevention-and-treatment-of-childhood-obesity-oyxj7nd
Texas Pediatric Society	(512) 370-1506	https://txpeds.org/texas-pediatric-society-obesity-toolkit
Texas Diabetes	(512) 458-8400	https://texasdiabetes.com/
Diabetes Wellness	(210) 701-8890	https://www.centraltxdm.org/
Central Texas Diabetes Coalition	(512) 972-5222	https://www.austintexas.gov/department/central-texas-diabetes-coalition
American Heart Association of Austin	(512) 338-2400	https://www.heart.org/en/affiliates/texas/austin
Integral Health	(512) 472-4357	https://integralcare.org/program/tobacco-cessation/
Travis County Community Center	(512) 444-0071	https://austinaa.org/locations/travis-county-community-center/
Alcoholics Resource Center	(1-800) 839-1686	https://alcoholicsanonymous.com/aa-meetings/texas/austin-texas/page/5/
Austin AA Online		https://www.austinaaonline.org/
Sober Austin	(512) 444-0071	https://soberaustin.com/recovery/12-step-meetings-austin-tx/
Texas Oncology	(1-888) 864-4226	https://www.texasoncology.com/
Wonders and Worries	(512) 329-5757	www.wondersandworries.org
Breast Cancer Resources Center	(512) 524-2560	www.bcrc.org
American Cancer Society	(512) 919-1800	www.cancer.org
Regarding Cancer	(512) 213-4993	www.regardingcancer.org

Livestrong Foundation	(512) 279-8434	https://www.livestrong.org/
AIDS Services Of Austin	(512) 458-2437	https://viventhealth.org/

Social Determinants of Health

Organization Name	Phone	Website
Capital Area Food Bank	(512) 282-2111	https://www.centraltexasfoodbank.org/
ECHO	(512) 354-8012	https://liveatecho.com/
Mobile Loaves and Fishes	(512) 328-7299	https://mlf.org/
Meals on Wheels Central Texas	(512) 476-6325	https://www.mealsonwheelscentraltexas.org/
Caritas of Austin	(512) 479-4610	https://caritasofaustin.org/
Refugee Service of Texas	(512) 472-9472	https://www.rstx.org/
Any Baby Can	(512) 454-3743	https://anybabycan.org/
Casa De Dios	(512) 740-2983	https://casadedios.org/
Life Works Street Outreach	(512) 735-2400	https://www.lifeworksaustin.org/
Front Steps	(512) 305-4100	https://frontsteps.org/
Foundation for the Homeless	(512) 453-6570	https://www.foundationhomeless.org/
Casa Marianella	(512) 385-5571	https://www.casamarianella.org/
Hope Alliance	(512) 255-1212	https://www.hopealliancetx.org/
Family Crisis Center	(512) 303-7755	https://family-crisis-center.org/
Safe Alliance	(512) 267-7233	https://www.safeaustin.org/
HCWC	(512) 396-4357	https://www.hcwc.org/
County Indigent Health Care Program	(361) 645-8221	https://www.hhs.texas.gov/services/health/county-indigent-health-care-program
Hays County Food Bank	(512) 392-8300	https://haysfoodbank.org/home.aspx

Bastrop County Cares	(512) 581-4055	https://www.bastropcares.org/
Children's Care-a-Vans	(512) 738-0625	https://www.seton.net/locations/edgar-davis/services/careavan/?utm_campaign=gmb&utm_medium=organic&utm_source=local
Highland Lakes Health Partnership		https://www.facebook.com/HighlandLakesHealthPartnership/
Highland Lakes Family Crisis Center	(830) 201-4756	https://www.hlfcc.org/
The Helping Center	(830) 693-5689	https://www.helpingcenter.org/
Area Agency on Aging of the Capital Area	(512) 916-6062	https://www.capcog.org/divisions/area-agency-on-aging/
Healthy Williamson County		https://www.healthywilliamsoncountyy.org/
Williamson County Healthcare Hotline	(512) 943-3600	https://www.wcchd.org/
The Caring Place	(512) 987-2998	https://www.caringplacetx.org/
Round Rock Serving Center	(512) 244-2431	https://www.rrasc.org/
Travis County Housing Authority	(512) 480-8245	https://www.hatctx.com/

Health Equity

Organization Name	Phone	Website
Travis County Health Equity Alliance	(512) 972-5183	https://www.austintexas.gov/department/health-equity-unit-0
Central Health Equity Policy Council	(512) 978-8000	https://www.centralhealth.net/get-involved/central-health-equity-policy-council/#:~:text=About%20the%20Council&text=The%20CHEP%20Council%20provides%20recommendations,of%20the%20Federal%20Poverty%20Level
Division of Community Engagement & Health Equity at Dell Medical School		https://dellmed.utexas.edu/units/department-of-population-health/division-of-community-engagement-and-health-equity
Maternal Health Equity Collaborative		https://www.mhecatx.org/

Community Health Champions at Central Health	(512) 978-8000	https://www.centralhealth.net/get-involved/community-health-champions/#:~:text=Community%20Health%20Champions%20is%20an,the%20health%20of%20Central%20Texas.
The Alliance of African American Health in Central Texas	(512) 619-4280	https://aaahct.org/
Austin Black Physicians Associations	(512) 759-8110	https://www.austinbpa.com/
Latino Healthcare Forum	(512) 386-7777	https://www.lhcf.org/
Austin Community Foundation	(512) 472-4483	https://www.austincf.org/
Hispanic Health Coalition	(713) 666-5644	https://hispanic-health.org/

Appendix F: Evaluation of Impact from the Previous CHNA Implementation Strategy

Ascension Seton's previous CHNA implementation strategy was completed in May 2019, and addressed the following priority health needs: access to care, mental health, and chronic disease.

The tables below describe the actions taken during the 2020-2022 CHNA to address each priority need and indicators of improvement.

Note: At the time of the report publication (e.g., Spring), the third year of the cycle will not be complete.

Ascension Seton Medical Center Austin

PRIORITY NEED	Access to Care	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
The Women's Health and Perinatal NC3 approved and implemented a universal screening tool to assess for substance use disorder in pregnancy.	Ongoing	A screening tool was implemented at the end of FY21. A total of 1491 patients screened 48% of the patient population during that time
An Induction Protocol has been developed for inpatient treatment.	Implementation initiated/awaiting approval	Protocol is under the discovery phase of approval with AIS
Designated Level IV Maternal Care Facility	Completed	Expires 6/1/2025
Engage community in education, screening, and outreach around breast care.	Ongoing	Virtual education was provided. It was viewed 125 times and downloaded 13
Maintain or improve retention of women in the continuum of care assisting with navigating services around making appointments, attending appointments, and diagnosis and treatment plans.	Ongoing	Maintained over 540 patients per year—total of 1,145 patients in 2020 and 2021
Increase monthly mammogram screenings per month	Inactive	Strategy changed/canceled due to conflicting initiatives.

PRIORITY NEED	Chronic Disease	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Participate in professional development diabetes education courses.	Completed	Passed the Certification Examination for Diabetes Care and Education Specialists on May 15, 2021.
Hosting community support and education classes.	Ongoing	Monthly Very Important Hearts- Cardiac Support group meetings for the community averaged 8 in attendance and bi-monthly virtual high-risk maternity panels were conducted.

PRIORITY NEED	Mental Health	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Create a behavioral health consortium for mental health clinicians and hospital leadership.	Delayed due to COVID-19	Barriers to implementation due to COVID-19 and staffing changes

Dell Seton Medical Center at The University of Texas at Austin

PRIORITY NEED	Access to Care	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Train Clinicians on opioid addiction and treatment	Ongoing	1190 clinicians trained, quality improvement plan has been implemented, 530 healthcare workers have registered for stigma training
Expand continuum of care for opioid treatment	Ongoing	208 patients. This program has been expanded to other sites and peer recovery units deployed

PRIORITY NEED	Mental Health	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Create a behavioral health consortium for mental health clinicians and hospital leadership.	Delayed due to COVID-19	Barriers to implementation due to COVID-19 and staffing changes

Ascension Seton Hays

PRIORITY NEED	Access to Care	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Perform free mammograms	Ongoing	A total of 335 un- and underinsured patients
Provide Annual Flu Clinics	Ongoing	Three clinics hosted resulting in 178 shots distributed
Provide ongoing lunch and learns and chronic condition support groups, as well as participate in community health fairs	Ongoing–virtual	Monthly Very Important Hearts was conducted with an average of 8 participants each month. One health fair was conducted with 9 participants engaged with ASH

PRIORITY NEED	Mental Health	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Create a behavioral health consortium for mental health clinicians and hospital leadership.	Delayed due to COVID-19	Barriers to implementation due to COVID-19 and staffing changes

Ascension Seton Williamson

PRIORITY NEED	Access to Care	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Connect Navigators to Patients	Delayed due to COVID-19	Barriers to implementation due to COVID-19
Assist patients with scheduling appointments	Delayed due to COVID-19	Barriers to implementation due to COVID-19
Monitor completion of appointments	Delayed due to COVID-19	Barriers to implementation due to COVID-19
Participate in community preparedness program	Delayed due to COVID-19	None

PRIORITY NEED	Chronic Disease	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Host annual screening events, as well as chronic disease lunch and learns and support groups.	Ongoing	Two virtual lunch and learn events hosted and monthly Very Important Hearts-Cardiac Support group meetings with an average of 20 in attendance.

PRIORITY NEED	Mental Health	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Create a behavioral health consortium for mental health clinicians and hospital leadership.	Delayed due to COVID-19	Barriers to implementation due to COVID-19 and staffing changes

Ascension Seton Northwest

PRIORITY NEED	Access to Care	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Conduct Health fairs and weekly perinatal support groups	Ongoing	Two events were hosted where 60 men were screened and 20 women. Weekly perinatal support groups were hosted.

PRIORITY NEED	Chronic Disease	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Nutrition Classes	Delayed due to COVID-19	None
Increase five partnerships to improve diagnosis and treatment of chronic diseases	Delayed due to COVID-19	None

PRIORITY NEED	Mental Health	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Create a behavioral health consortium for mental health clinicians and hospital leadership.	Delayed due to COVID-19	Barriers to implementation due to COVID-19 and staffing changes

Ascension Seton Southwest

PRIORITY NEED	Access to Care	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Increase number of providers offering medical services	Delayed due to COVID-19	None
Conduct Community Health Screenings and flu clinics	Ongoing	210 participants participated in health and wellness fairs and one flu clinic was

		hosted where 10 vaccines were administered
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PRIORITY NEED	Chronic Disease	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Attend health fairs providing education and screenings for diabetes as well as conduct classes and consultation on diabetes care.	Delayed due to COVID-19	None

PRIORITY NEED	Mental Health	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Create a behavioral health consortium for mental health clinicians and hospital leadership.	Delayed due to COVID-19	Barriers to implementation due to COVID-19 and staffing changes

Ascension Seton Edgar B. Davis

PRIORITY NEED	Access to Care	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Provide pediatric care via the Children's Care-a-Van Program including pediatric immunizations.	Ongoing	Averaging 1700 patients annually with an average of 1200 vaccines administered annually.
Participate in Indigent Health Care Programs in Caldwell County	Ongoing	65 applicants for a total of 31 patients participated in the program – 7 currently on program. Provide PCP support, diabetes support, educational classes, dietitians, crisis (emergency health care support), and inpatient care - short term program support for patients– 3 returned to work, 1 received care from another resource, 1

PRIORITY NEED	Mental Health	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Create a behavioral health consortium for mental health clinicians and hospital leadership.	Delayed due to COVID-19	Barriers to implementation due to COVID-19 and staffing changes

Ascension Seton Highland Lakes

PRIORITY NEED	Access to Care	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Provide pediatric care via the Children's Care-a-Van Program including pediatric immunizations and flu shots clinics.	Ongoing	Averaging 1000 patients annually with an average of 1500 immunizations administered annually and one flu clinic providing 25 pediatric influenza vaccinations

PRIORITY NEED	Chronic Disease	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Blood Pressure Screenings	Delayed due to COVID-19	None
Provide education on chronic diseases and chronic disease support groups	Ongoing—virtual	300 participants in chronic disease education events and a weekly Parkinson's support group

PRIORITY NEED	Mental Health	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Create a behavioral health consortium for mental health clinicians and hospital leadership.	Delayed due to COVID-19	Barriers to implementation due to COVID-19 and staffing changes

Ascension Seton Smithville Regional Hospital

PRIORITY NEED	Access to Care	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Assist with Patient Prescription Assistance Program (PPAP) applications for indigent population to improve access to care	Ongoing	Processed 150 new patient applications and 360 refills. Average wholesale value of \$1,152,871

PRIORITY NEED	Chronic Disease	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Participate in Bastrop Cares Collaboration and Smithville Whole Health Partnership	Ongoing	Attend monthly community meetings to share resources and information
Participate in community events that address or prevent chronic disease	Ongoing	Completed "Walk Smithville" and ongoing community health fairs

PRIORITY NEED	Mental Health	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Create a behavioral health consortium for mental health clinicians and hospital leadership.	Delayed due to COVID-19	Barriers to implementation due to COVID-19 and staffing changes

Ascension Seton Shoal Creek

PRIORITY NEED	Access to Care	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Implement partial hospitalization program to expand continuum of care	Ongoing	200 patients have participated since December of 2019

PRIORITY NEED	Mental Health	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Create a behavioral health consortium for mental health clinicians and hospital leadership.	Delayed due to COVID-19	Barriers to implementation due to COVID-19 and staffing changes
Provide mental health and substance abuse assessments	Ongoing	Completed 2,839 total assessments
Expand video consultations	Ongoing	Video consultations expanded faster than planned due to COVID-19
Train clinicians on telemedicine psychiatric evaluations	Completed	Trained 30 social workers and 20 psychiatrists/psychologists

Dell Children's Medical Center

PRIORITY NEED	Access to Care	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Continue to operate Children's Medical Health Express Van	Ongoing	A total of 999 visits were conducted in 2020 and 2021. Volume picking up since March of 2021
Expand mental health access via the Children's Medical Health Express Van	Ongoing	- Added full time social worker to the clinic – increased referrals and continues to provide counseling. 16 referrals 4 counseling since March of 2021. A total of 126 telehealth visits were conducted. - Clinicians are attending mental health conferences.
Pediatric immunizations	Ongoing	Vaccination rate of patients is 84.7% providing 1930 vaccinations from 2020-2021
Increase Children's Health Express Van patients with insurance by screening for eligibility and assistance in applying.	Ongoing	Over 100 patients screened
Link patients to resources in the community.	In process	Working to identify a process to better screen patients for social determinants of

		health and expand community connections for referrals to resources.
Train child safety practitioners	Delayed due to COVID-19	None
Expand access to proper child safety seat assistance while enhancing access to child safety seats in order to reduce the number of children in car accidents who are unrestrained.	Delayed due to COVID-19	None
Reduce barriers of access to learn to swim programs, while expanding water safety training programs and reducing barriers to access to proper flotation devices.	Delayed due to COVID-19	None

PRIORITY NEED	Chronic Disease	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Obtain FQHC Patient Centered Medical Home Certification	Inactive.	Strategy changed/canceled due to conflicting initiatives.
Provide Primary Care via CollIN Grant utilizing shared plan for medically complex children.	Completed in 7/31/2021	The CCC program met this measure by providing families a shared web based platform to surface a shared care plan called STORY. This care plan is accessible via PC or mobile app for ease of use. Prior to this technology, care plans were embedded within the EMR encounter summary. The shift to utilizing technology permits parents/caregivers to have their child's care plan accessible and up to date with current medications, problem lists, etc. Since this platform is integrated with Athena EMR, realtime changes surface to the care plan, making it more accurate and useful. currently at 53% of patient/family participation.
Increase engagement with CollIN grant families	Completed in 7/31/2021	The CCC program met with measure by performing preventative visits with families that includes shared decision making, discussion about parent/caregiver/patient goals, and discussions about parameters of care. Below are 5 of the family engagement questions. In addition, the program developed a Family Workgroup to inform the CCC's service delivery model. It was recognized that the family work group composition did not adequately represent

		the population served at the clinic. The program continues to work to increase the number and diversity of parents/caregivers on the Family Workgroup. Increased engagement to 85%
Provide resiliency training for staff	Delayed due to COVID-19	Unable to provide, but staff have access to and have attended sessions at DSMCUT.

PRIORITY NEED	Mental Health	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Provide doctoral interns and fellows to provide ongoing mental health care	Ongoing	50-75 patients annually
Teleconsult programs to provide pediatric PCP's and schools assistance with diagnosis, assessment, and community referrals.	Ongoing	869 PCPs enrolled in CPAN FY 21-- 885 consultations and FY 22 – 1,066

Warm Springs Rehabilitation Hospital of Kyle

PRIORITY NEED	Access to Care	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Provide monthly stroke support groups for stroke survivors.	Ongoing	Monthly support groups shifted to virtual during the COVID-19 pandemic. Transitioned back to in person and departments are alternating months for presentation materials.
Provide facility space for nursing and therapy students and for professional organizations to support workforce development for rehabilitation services.	Ongoing	Hosted 15+ clinical rotations for PT, PTA, OT and COTA students. Additionally, WS Kyle hosts clinical rotations for LVN, RN and Accelerated BSN programs.
Warm Springs Rehabilitation Hospital of Kyle will host 4 professional association meetings annually.	Resuming	Unable to host events in facilities due to COVID-19 restrictions on visitors and inability to have gatherings in the hospital.

PAM Rehabilitation Hospital Round Rock

PRIORITY NEED	Access to Care	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Host 8 professional association meetings annually.	Delayed due to COVID-19	None

PRIORITY NEED	Chronic Disease	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Provide at least 10 stroke groups per calendar year with at least 15 survivors in attendance.	Ongoing	Monthly support groups hosted on the second Wednesday of every month virtually and call in options available with an average of 8-22 in attendance.

Central Texas Rehabilitation Hospital

PRIORITY NEED	Access to Care	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Host 8 professional association meetings annually.	Delayed due to COVID-19	None

PRIORITY NEED	Chronic Disease	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Engage 5 people in the stroke support group monthly to improve their quality of life after a stroke.	Delayed due to COVID-19	Support groups resumed in June of 2021.

Cedar Park Regional Medical Center

PRIORITY NEED	Mental and Behavioral Health	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Promote behavioral health, stress management, and wellbeing through education and partnerships in the community to improve the mental health care continuum.	Ongoing	Collaboration with Bluebonnet Trails and Rock Springs Hospital to optimize the continuum of care for ED patients presenting with mental health disorders. Collaboration with the Williamson County Child Advocacy Center to provide referral cards for ED caregivers whenever child abuse/ neglect is suspected. Collaboration with the Healthy Williamson County Coalition and provided information on free support groups and classes. Provided 24 free virtual breastfeeding support groups

		for patients which address wellbeing and stress management after childbirth. Provided resources promoting wellbeing to 9,000 Healthy Women affinity group members in 6 e-newsletters.
Provide education and stress management tools to 5,000 employees of local school districts.	Delayed due to COVID-19	In-person conferences have paused at this time. Have participated in the grant requests from the Leander Educational Excellence Foundation to approve teachers' request for funding to add programs to decrease students' stress and enhance wellbeing.

PRIORITY NEED	Chronic Disease	
ACTIONS TAKEN	STATUS OF ACTIONS	RESULTS
Provide education at 45 events annually.	Ongoing	6 virtual Bariatric Seminars and 6 Bariatric Support Groups were held from December 2020 through May 2021. Virtual seminars for Senior Circle resumed in April, 2021. Information on the prevention and treatment of chronic disease was provided in 24 Senior Circle e-newsletters and 6 Healthy Woman e-newsletters reaching 10,000 individuals. Hosted a booth at Leander Chamber Expo on 4/30/21 and provided information on chronic disease prevention to 500 people.
Provide 2,000 chronic health indicator screenings annually including blood pressure, blood glucose, and BMI.	Delayed due to COVID-19	None
Provide prenatal care for approximately 200 uninsured or underinsured women in 2020 through partnership with Lone Star Circle of Care.	Delayed due to COVID-19	12 virtual free Childbirth Education Classes were held from December, 2020 through May, 2021. 239 individuals attended and a total of 173 new OB patients at LoneStar during between 12/20 and 5/21