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Regional Healthcare Partnership 7

2017 Community Needs Assessment

Final Report

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Central Health

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Executive Summary

Introduction and Background

Texas's 1115 Medicaid Waiver, known as the Texas Healthcare Transformation and Quality Improvement program, provides incentive payments through the implementation of health care delivery transformation projects as part of the Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program is administered in 20 distinct regions across Texas known as Regional Healthcare Partnerships or RHPs. RHP 7 in Central Texas consists of Bastrop, Caldwell, Fayette, Hays, Lee, and Travis counties and is led by the regional Anchor, Central Health. As regional Anchor, Central Health conducted a comprehensive community health needs assessment (CNA) in 2012 that served as the basis for the RHP 7's DSRIP project development. The initial CNA identified eighteen areas of critical need that fell into five broad categories:

- Access to primary, specialty, prenatal, and behavioral health care;
- Expansion of the continuum of behavioral health care;
- Coordination of health care services;
- Reduction of emergency department utilization; and
- Chronic disease prevention and treatment.

Scope and Purpose of the 2017 Community Needs Assessment

The goal of RHP 7's 2017 Community Needs Assessment is to update the findings of the 2012 CNA toward achieving the following goals:

- Identify pressing health issues, perceived needs, and barriers to health for low-income, uninsured, and Medicaid populations in RHP 7;
- Gain an understanding of the current health care delivery system for low-income, uninsured, and Medicaid populations in RHP 7;
- Explore impact of DSRIP activities on health and health care access in RHP 7 since 2012; and
- Identify areas of opportunity for RHP 7 to improve the health care delivery system moving forward.

Process and Methods

The 2017 CNA was undertaken with a broad definition of health, aligning with the Social Determinants of Health framework. The CNA process was informed by diverse perspectives using a participatory approach to help guide the research focus and methodology. Planning and development of the CNA was a collaborative effort between Anchor staff and lead DSRIP staff from all RHP 7 DSRIP performing provider organizations. Community stakeholders were engaged throughout the needs assessment process.

To achieve the goals of the assessment process, the 2017 CNA collected data from a variety of sources and used multiple methodologies. These included a thorough review of available secondary data, one stakeholder dialogue event, fifteen key informant interviews, two health and social service provider focus groups, two community member focus groups, and an online stakeholder survey targeting provider and community residents from across RHP 7. Results of all activities were aggregated by theme or topic area such that the report represents a synthesis and summary of all findings.

Key Themes

This section describes the overarching themes that emerged during the CNA process and highlights key data points or sub-themes for each.

Housing Affordability and Implications Migration out of Central Austin

The impacts of considerable growth in the RHP 7 region emerged as a key theme in this report, including rising housing costs, relocation towards more suburban and rural areas of RHP 7, and subsequent barriers to accessing needed health care or social services due to location, distance, and capacity.

Population Growth and Diversity

As of 2016, the total population of RHP 7 numbered over 1.5 million residents, representing 5.6% of the total population in Texas. As a region, RHP 7 has grown considerably since 2000. The populations of the six RHP 7 counties have also become increasingly diverse. Between 2010 and 2015, larger proportions of the populations in all six counties identified as Hispanic/Latino.

- Hays (30.1%), Travis (17.1%), and Bastrop (11.5%) counties had the highest population growth rates between 2010 and 2016.
- Hays County had a 30.2% increase in the size of its Hispanic/Latino population, and increases ranged between 10% and 18% in the other RHP 7 counties.
- Population growth is predicted to continue through 2020. Hays (19%), Bastrop (13%), and Caldwell (11%) counties are projected to have the highest growth rates between 2016 and 2020, all higher than the projected growth rate for Texas during the same period (8%).

Housing Affordability

Housing affordability was a one of the most consistent themes across all interviews and focus groups. Median monthly housing costs for renters increased since 2010 in every RHP 7 county. By 2015, a third or more of renters were cost burdened (defined as paying 35% or more of household income toward housing costs) across RHP 7.

- Median monthly housing cost for renter-occupied units increased in all RHP 7 counties between 2010 and 2015, with Lee and Hays counties having the largest increases.
- Hays County had the largest proportion of renters (54.8%) that were cost-burdened in 2015, followed by Travis (40.9%) and Caldwell (37.4%) counties. Approximately 20-25% of home owners in RHP 7 counties were housing cost burdened in 2015.

Migration

As the affordability of housing in Austin and Travis County has decreased, the common perception across key informant interviews and focus groups was that people were increasingly seeking more affordable housing options away from the center of Austin and into neighboring counties or the less urban areas of Travis County. Movement out of these areas was perceived to have resulted in individuals living further away from necessary services that are mostly centrally located in Travis County.

- Most RHP 7 counties had rates of in-migration that were higher than the state average.
- Hays (13.8%) and Caldwell (12.6%) counties had the highest proportions of residents that had moved into the county from elsewhere in the prior year.
- Caldwell (31.1%), Bastrop (14.8%), Hays (17.2%), and Lee (13.6%) counties had higher in-migration rates among those living in poverty than Travis County (10.7%).

Transportation and Location of Services

Secondary data, key informant interviews, focus groups, and the stakeholder survey consistently identified a lack of transportation as an issue that made it harder to access care in RHP 7. Participants indicated that health care providers and social services are concentrated in urban areas of Travis or Hays counties, presenting barriers related to transportation and timing of appointments and necessitating community members to cross county lines to access care. Participants noted that this was a growing concern as more community members move out of urban areas in order to find affordable housing. Provider focus group participants and key informants indicated that crossing county lines is not always an option, as community members may lose eligibility to services as their county of residence changes.

- 94.1% of provider respondents and 31.5% of community respondents to the stakeholder survey indicated that 'lack of transportation' was a barrier to accessing health care. This was the most frequently selected barrier for provider respondents.
- Of patients seeking services from safety net providers in RHP 7, 100% of patients living in Bastrop, Fayette, and Lee counties that received emergency department services did so outside their home county.
- Access to specialty care was highlighted as being particularly difficult for communities outside of Austin-Travis County by community focus groups, provider focus groups, and key informants. In the stakeholder survey, 97.4% of provider respondents and 56.1% of community member respondents indicated that access to specialty care was 'hard' or 'very hard.'

Economic and Health Inequality in the Region

Inequalities between racial and ethnic groups and between urban and rural areas in RHP 7 emerged as a theme across health and economic indicators in this report. A growing base of evidence has begun to show that living in communities with greater economic inequality is linked to poorer health outcomes, such as infant mortality, obesity, and stress.[1] Disparities were observed in RHP 7 between groups for economic indicators, as well as indicators of health outcomes and health care utilization.

Economic Inequality

Unemployment rates across RHP 7 have declined sharply over the past five years, mirroring trends at state and national levels. However, state data show stark differences in unemployment by race and ethnicity. The overall median household income increased between 2010 and 2015 across RHP 7. However, large income inequalities by race and ethnicity were also observed.

- Hispanic and Black individuals in Texas had unemployment rates that were 1.5 to 2 times higher than their Asian or White, non-Hispanic counterparts.
- Across all RHP 7 counties, Black residents had median household incomes that were an average of -$19,744 lower compared to White, non-Hispanic residents. Median household income for Hispanic residents were an average of -$15,139 lower compared to White, non-Hispanic residents.
- Larger proportions of Black residents (25.2%) and Hispanic residents (22.9%) were living in poverty compared to an average of 10.2% of White, non-Hispanic residents in RHP 7 counties.

[1] Inequality and Health, Institute for Policy Studies; https://inequality.org/facts/inequality-and-health/

Health Inequality

Secondary data aggregated across the RHP 7 counties illustrated some prominent health disparities by race and ethnicity. Health disparities, particularly among Black and Hispanic residents, were also discussed by key informants during interviews.

- Nearly 45% Black adults in RHP 7 reported having hypertension, compared to 28% of White, non-Hispanic adults.
- Diabetes was reported by 12% of Black and 11% of Hispanic adults, compared to 6% of White, non-Hispanic adults in RHP 7.
- Black adults (15.3%) in RHP 7 had higher rates of self-reported poor mental health compared to all other racial/ethnic groups, and to adults overall (9.1%).
- Half of Hispanic adults in RHP 7 reported that they did not have a personal doctor or provider, compared to 22.0% of White, non-Hispanic adults.
- Hispanic (43.0%) and multiracial/other (46.1%) adults were more likely to report they did not have a routine check-up in the prior year than White, non-Hispanic or Black adults in RHP 7.

Health Outcomes, Chronic Conditions, and Social Determinants of Health

Several health outcomes arose as key areas of concern for RHP 7 based upon secondary data. These included sexually transmitted infections (STIs) and prenatal care. Additionally, the prevention and management of chronic health conditions consistently emerged as a concern for RHP 7 from secondary data, key informant interviews, focus groups, and the stakeholder survey. Key informant interviewees and provider focus group participants also frequently discussed a number of upstream factors or social determinants of health that presented challenges to the prevention or management of these health conditions.

Sexually Transmitted Infections

Several participants in the stakeholder dialogue activity highlighted education around STIs as a gap in in the current delivery system. Stigma around seeking testing was also mentioned as a barrier. The 2012 CNA had noted some evidence of high rates of chlamydia in Travis and Hays counties and a high level of gonorrhea in Travis County. Data for 2015 showed these conditions were a growing problem and were now impacting a much larger population across RHP 7.

- Bastrop, Caldwell, Hays, and Travis counties experienced increases in chlamydia rates between 2012 and 2015.
- Caldwell County had the highest rate of chlamydia cases (809.4 per 100,000) in 2015, followed by Travis (661.8) and Bastrop (608.5) counties.
- Gonorrhea rates in Bastrop (151.5 per 100,000), Caldwell (155.5), and Travis (206.6) counties exceeded the state average (136.7).

Prenatal Care

While infant mortality rates across RHP 7 remained low, secondary data on premature births, low-birth weight, and smoking during pregnancy suggested that there may be some gaps in care for some areas of RHP 7. Key informant interviewees indicated that it was harder to access maternity care for community members in more rural areas.

- Premature and low-birth births increased in Caldwell and Fayette counties between 2012 and 2014, while they remained steady or decreased in all other counties.

- The proportions of births with prenatal care in the first trimester was lowest in Caldwell County (55.5%). The percent of births without any prenatal care had increased between 2012 and 2014 in Caldwell (1.9% to 2.5%) and Fayette (0.5 to 1.2%) counties.
- Among providers that responded to the stakeholder survey, 63% rated access to prenatal/material care as 'hard' or 'very hard' for the low-income community in RHP 7.

Chronic Conditions

Key informants, providers, and community members consistently identified chronic diseases (hypertension, diabetes, obesity, etc.) as leading health issues in their communities and pointed to physical activity and access to healthy food as important contributing factors. High housing costs and challenges around transportation were also noted by providers as factors that made it hard for patients to manage their chronic conditions. Secondary data related to chronic conditions further highlighted that chronic disease risk factors were common in RHP 7.

- Hypertension was found to affect over a quarter of adults in RHP 7, and over a third reported having high blood cholesterol.
- 8.1% of adults in RHP 7 reported having been diagnosed with diabetes. Black (11.9%) and Hispanic (10.8%) residents had higher proportions of diabetes compared to other groups.
- Over half of adults were categorized as overweight or obese in RHP 7. Overweight or obesity affected closer to 3 out of every 4 Black or Hispanic adults.
- Half of all adults (51.1%) in RHP 7 reported meeting aerobic recommendations, slightly higher than the state average (45.2%).
- Many census tracts within each of the RHP 7 counties were identified as food deserts. Approximately 13-16% of individuals in RHP 7 counties were food insecure. Lee (16.1%) and Travis (16.1%) counties had the highest proportions of food insecure populations, while Bastrop County (13.2%) had the lowest proportion.

Behavioral Health

One of the strongest and most consistent themes to emerge from the 2017 CNA was concern about behavioral health in the region. This concern was echoed throughout the provider focus groups and key informant interviews, with participants sharing their perceptions that behavioral health issues were increasing and services were lacking across the continuum of care. Providers highlighted substance use as a continued and growing concern in the region, particularly in rural areas. However, key informants from both rural and urban areas perceived the need for more substance use services throughout the region. Secondary data suggested alcohol abuse was prevalent in the region.

- Nearly 80% of providers responding to the stakeholder survey identified mental/behavioral health as a leading health concern for the low-income population in RHP 7. 45.1% identified substance use and abuse as a health condition of concern.
- Binge alcohol consumption among adults was observed to be more common in RHP 7 than the state (21.9% vs. 16.8%). Binge alcohol was more common among White, non-Hispanic adults (24.2%) and less common among Black adults (11.1%) in RHP 7.

Accessibility of Health Care is a Persistent Concern and Barriers are Multifaceted

Access to health care was a major concern for the low-income and Medicaid population in RHP 7, consistently named by stakeholders, key informants, providers, and community members alike. Barriers to care were multifaceted and included insurance, shortages of providers, particularly ones that accepted Medicaid or indigent health programs, and the timeliness and navigability of services. Providers and key informants further identified the lack of knowledge or awareness of services by community members and as another aspect of accessibility.

Access to Care

Key informant interviewees, provider focus group participants and community member focus group participants frequently identified access to health care as a key issue in their communities. Interviewees and provider focus group participants noted that DSRIP had helped to remove some barriers, highlighting projects that enhanced co-location and wrap-around services.

- Provider and community member survey respondents most frequently rated specialty care, inpatient psychiatric care, and inpatient alcohol/substance use treatment as health care services that were 'hard' or very hard' to access.
- A majority (89.0%) of providers and nearly half (45.9%) of community members that responded to the stakeholder survey rated 'access to dental care' as 'hard' or 'very hard.'
- 'Access to behavioral/mental health care' was the top focus area for improving delivery in RHP 7 most frequently selected by provider survey respondents and the third most frequently selected focus area by community member respondents. The most frequently selected focus area for community members was 'access to dental care.'

Insurance Coverage

Despite some progress in coverage since the launch of the Affordable Care Act in 2010, insurance remained a barrier to care in RHP 7 and most low-income adults under age 65 remain uninsured. Insurance problems such as lack of coverage or not enough coverage, high cost of co-pays, and not understanding insurance were frequently identified as barriers to care by community member and provider respondents to the stakeholder survey.

- Caldwell County had the highest uninsured rate (22.7%) in RHP 7, followed Bastrop (20.7%) and Lee (20.4%) counties. Hays County (16.0%) had the lowest uninsured rate in the region.
- Caldwell County was the only county in RHP 7 to experience an increase in the rate of uninsured children between 2012 and 2015 (12.3% to 13.5%). However, Fayette County had the highest percentage of uninsured children (15.5%).

Workforce Shortages

All RHP 7 counties were designated in whole or in part as Health Professional Shortage Areas (HPSAs) or Medically Underserved Areas (MUAs). Shortages of primary care providers and behavioral health providers were identified by interviewees, providers, and community members as impacting the ability to access needed care in the region. Community members voiced the need for more dentists in the region.

- Bastrop (29 providers per 100,000 population) and Lee (28 providers per 100,000 population) counties had the lowest rate of primary care providers in RHP 7. Travis County had the highest rate (97 providers per 100,000 population).

- Fayette County had the lowest rate of behavioral health care providers (26 providers per 100,000 population), while Travis County had the highest rate of behavioral health providers (354 providers per 100,000 population).
- Lee County had the lowest rate of dentists (22 per 100,000 population) in RHP 7, while Travis County had the highest rate (64 per 100,000 population). Fayette County experienced the biggest decrease in rate of dentists between 2010 and 2016 (32 to 26 per 100,000).

Positive Impacts of 1115 Waiver and DSRIP

Over the course of the 1115 Waiver period, many health care infrastructure expansions occurred in RHP 7. Key informants and stakeholders that were familiar with DSRIP projects described many positive impacts the programming had on their communities. These included increased access to services for low-income communities, growth in collaboration and communication between organizations doing complimentary work, and the recognition that the social determinants of health were important factors for the health care delivery system to consider.

Communication, Collaboration, and Data Sharing

Growing collaboration between social service and health care providers was frequently noted by stakeholders as one of the most positive impacts of the 1115 Waiver and DSRIP projects. Despite successes, many shared that more work was needed to increase communication between organizations and providers. They suggested that there was a specific need for more data sharing between health care delivery systems and social service agencies/community organizations to help community members navigate these systems easily and to prevent people from falling through the gaps.

- 31.3% of provider respondents to the stakeholder survey identified 'care coordination between providers' as a top area of focus for improving the delivery of health care.

Awareness of Social Determinants of Health

The growing recognition of the social determinants of health and their impact on individual and community members' health was discussed as a strength of the delivery system by stakeholder dialogue participants, focus group participants, and interviewees alike. However, participants perceived that the system faced challenges in addressing those factors and saw opportunities for health care providers to begin working on social determinants of health to improve population health across RHP 7.

Focus Areas for Improving the Delivery of Health Care in RHP 7

Key informant interviewees, provider and community member focus group participants, and respondents to the stakeholder survey identified access to care, as well as the many factors that can impact access, as key focus areas for improving the delivery of health care across RHP 7. Despite clear success around expanding services during the 1115 Waiver period, most stakeholders indicated that much remained to be done to increase access to health care and social services, especially to rural communities and communities experiencing the impacts of migration out of Austin. Key informants and provider focus group participants indicated that continued focus of increasing the availability and diversity of services in areas outside of Austin and bolstering programs like mobile health teams and telemedicine was important to continue to break down barriers to care.

Communication, collaboration, and information/data sharing were also identified as important focus areas for improving the delivery of care by stakeholder dialogue participants, key informants, and providers. They highlighted the need for more data sharing between health care delivery systems and

social service agencies in order to help community members navigate these systems more easily and prevent people from falling through gaps.

Community Needs Summary Table

The community needs summary table represents outliers in the community health needs data that show significant need for improvement in the region. In addition, the table incorporates the top five health conditions as identified by community members and by providers, where those were not already identified in secondary data. Finally, the list incorporates major social determinants of health outliers that have clear impact on achieving health outcomes.

UPDATED RHP 7 COMMUNITY NEEDS TABLE, 2017

Accidents and Injuries
Behavioral Health Care*
Chronic Conditions*
Dental Health*
Infectious and Vaccine Preventable Diseases*
Lack of Affordable Housing
Lack of Convenient Service Locations and Times*
Maternal and Child Health*
Preventive Care and Wellness*
Primary Care*
Racial and Ethnic Disparities*
Specialty Care
Transportation to Healthcare Services*

*Also identified in 2012 Community Needs Summary Table

Introduction

For the past five years, health care providers in Central Texas and across the state have been implementing health care delivery transformation projects as part of the Delivery System Reform Incentive Payment (DSRIP) program in Texas's 1115 Medicaid Waiver. The 1115 Waiver, known as the Texas Healthcare Transformation and Quality Improvement program, provides incentive payments to providers who successfully improve care delivery and health outcomes for primarily Medicaid, low-income, and uninsured people in Texas.

The DSRIP program is administered in 20 distinct regions across Texas known as Regional Healthcare Partnerships or RHPs. RHP 7 in Central Texas consists of Bastrop, Caldwell, Fayette, Hays, Lee, and Travis counties. These counties, with leadership and coordination from the region's Anchor, Central Health, came together in 2012 to develop a regional plan to transform health care delivery that addressed the health needs of the region. As one of its duties as regional Anchor, Central Health conducted a comprehensive community health needs assessment (CNA) that served as the basis for the RHP 7's DSRIP project development.

Today, as the 1115 Medicaid Waiver and the DSRIP program transition to the next phase of health care transformation work, regional Anchors are updating their original CNAs. This update will provide a fresh look at the region's health needs and community strengths so DSRIP providers can know best where and how to deploy their transformation resources in the future.

This 2017 CNA report provides a comprehensive assessment of RHP 7's health challenges and community strengths. A synthesis of health and disease status statistics with a comprehensive array of quantitative and qualitative information collected from RHP 7 stakeholders, providers, and community members offers RHP 7 DSRIP providers the foundation for continued health care transformation.

Regional Healthcare Partnership 7

There are nine DSRIP performing providers who conduct 76 DSRIP projects in the RHP 7 region. Providers include a public health department, three local mental health authorities (LMHA), and five hospitals. **Table 1** details these DSRIP performing partners and their local funding partners.

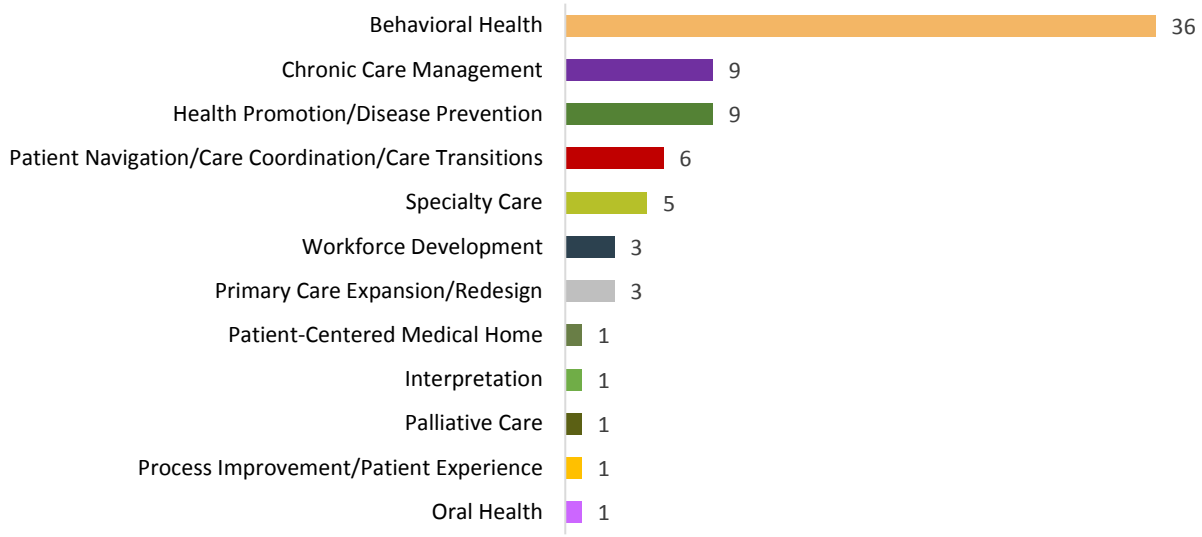
TABLE 1. RHP 7 DSRIP PERFORMING PROVIDERS AND LOCAL FUNDING PARTNERS, AS OF SEPTEMBER 30, 2015

RHP 7 DSRIP Performing Provider	Provider Type	Number of Projects	Local Funding Partner
Austin Travis County Integral Care	LMHA	11	Austin Travis County Integral Care
Bluebonnet Trails Community Services	LMHA	7	Bluebonnet Trails Community Services
Central Texas Medical Center	Hospital	1	City of San Marcos; Hays County; Hays County Emergency Services District 7
City of Austin Health and Human Services Department	Public Health Dept.	10	City of Austin Health and Human Services Department
Community Care Collaborative	Hospital - Atypical	15	Central Health
Dell Children's Medical Center	Hospital	4	Central Health; AISD
Hill Country MHDD Centers	LMHA	12	Hill Country MHDD Centers
St. David's HealthCare	Hospital	1	Central Health
University Medical Center Brackenridge	Hospital	15	Central Health
Total		**76**	

DATA SOURCE: Central Health RHP 7 Fast Facts 2015

DSRIP projects were designed to address community health and health care delivery needs. The focus areas addressed by DSRIP projects in RHP 7 are illustrated in **Figure 1**.

FIGURE 1. COUNT OF RHP 7 DSRIP PROJECTS, BY IDENTIFIED NEED ADDRESSED



DATA SOURCE: Central Health RHP 7 Fast Facts 2015

Previous Community Needs Assessment

In 2012, Central Health's initial CNA identified eighteen areas of critical need that fell into five broad categories:

- Access to primary, specialty, prenatal, and behavioral health care;
- Expansion of the continuum of behavioral health care;
- Coordination of health care services;
- Reduction of emergency department utilization; and
- Chronic disease prevention and treatment.

Scope and Purpose of the 2017 Community Needs Assessment

The goal of RHP 7's 2017 Community Needs Assessment is to update the findings of the 2012 CNA toward achieving the following goals:

- Identify pressing health issues, perceived needs, and barriers to health for low-income, uninsured, and Medicaid populations in RHP 7;
- Gain an understanding of the current health care delivery system for low-income, uninsured, and Medicaid populations in RHP 7;
- Explore impact of DSRIP activities on health and health care access in RHP 7 since 2012; and
- Identify areas of opportunity for RHP 7 to improve the health care delivery system moving forward.

The geographic focus of the 2017 CNA remained the six counties that comprise RHP 7: Bastrop, Caldwell, Fayette, Hays, Lee, and Travis counties.

Process and Methods

The following sections detail how the 2017 RHP 7 CNA was conducted, including the engagement of stakeholders and community members, methods for data collection and analyses, and the broader lens that was used to guide this process.

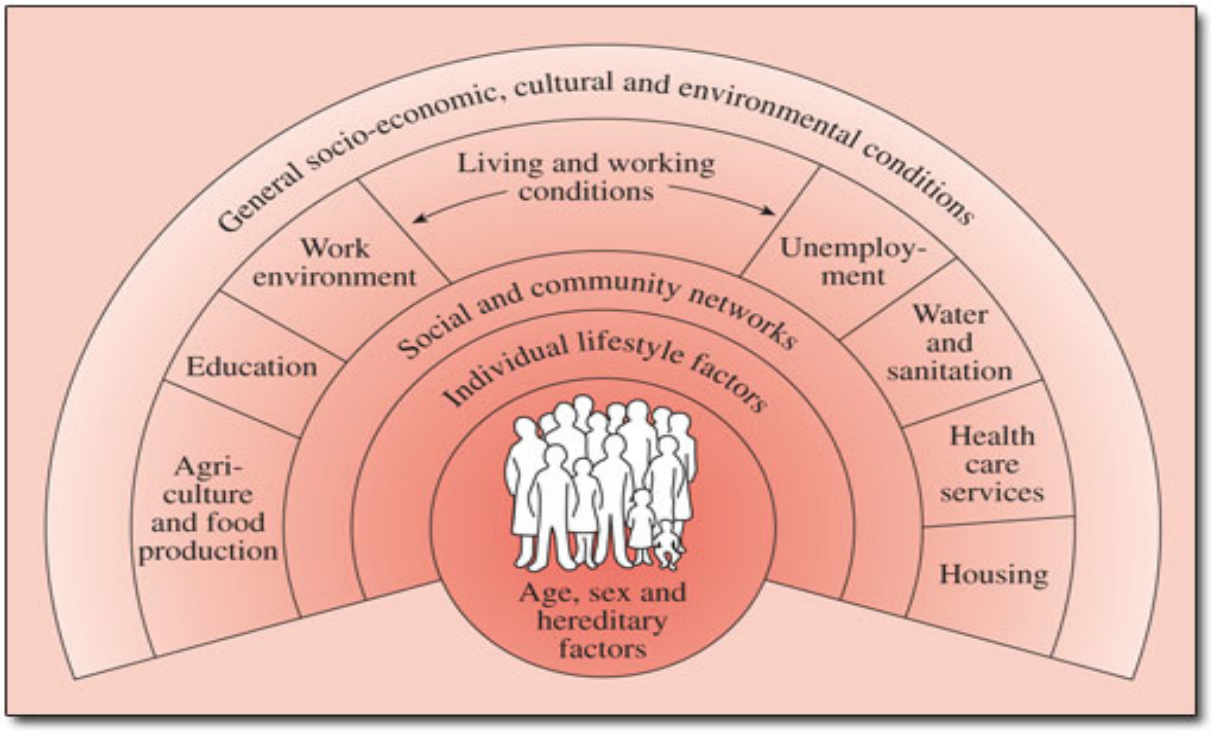
Social Determinants of Health Framework

The 2017 CNA was undertaken with a broad definition of health that recognized numerous factors at multiple levels impact individual, community, and regional health – from lifestyle behaviors (e.g., diet and exercise), to clinical care (e.g., access to medical services), to social and economic factors (e.g., employment opportunities). It is important to recognize these multiple factors have an impact on health and that there is a dynamic relationship between real people and their lived environments.

Where we are born, grow, live, work, and learn are all critical factors to consider. That is, not only do people's genes and lifestyle behaviors affect their health, but health is also influenced by more upstream factors such as employment status or quality of available housing. The social determinants of health framework addresses the distribution of wellness and illness among a population.

Figure 2 provides a visual representation of this relationship, demonstrating how individual lifestyle factors, which are closest to health outcomes, are influenced by more upstream factors such as education and the unemployment.

FIGURE 2. SOCIAL DETERMINANTS OF HEALTH FRAMEWORK



DATA SOURCE: World Health Organization, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health: Discussion paper for the Commission on the Social Determinants of Health, 2005

Community Engagement Process

To ensure that the CNA process was informed by diverse perspectives, a participatory approach was employed. This type of approach helps guide the research focus and methodology so that they are salient to the community and aid in building support at the community level for both the assessment and subsequent planning processes.

Planning and Development

Planning and development of the CNA was a collaborative effort between Anchor staff and lead DSRIP staff from all RHP 7 DSRIP performing provider organizations. This group gathers monthly at RHP 7's DSRIP Provider Exchange meetings. Prior to engaging HRiA, Anchor staff presented a proposed scope and process for the assessment to DSRIP Provider Exchange members for feedback. Anchor staff provided CNA progress updates at DSRIP Provider Exchange meetings and accepted guidance from members on assessment work. Participation of DSRIP Provider Exchange members was critical to the identification of stakeholders and key informants, the organization of focus groups, and the distribution of CNA surveys. Additionally, DSRIP Provider Exchange members supported small group discussions at the CNA kick-off meeting. A preliminary draft of the CNA report was available to Anchor staff and DSRIP Provider Exchange members for comment prior to the publication of the final report. See the **Data Sources** section for a list of DSRIP Provider Exchange members.

Community Stakeholder Involvement

Community stakeholders were engaged throughout the needs assessment process. The advisory committee, detailed above, provided oversight for the planning and execution of the needs assessment, including developing and finalizing a project scope, identifying additional stakeholders to engage through data collection methods like interviews and focus groups, and providing feedback on the CNA report. Community stakeholders participated in a stakeholder kick off meeting on July 20th, 2017. This meeting was attended by representatives from DSRIP Performing Provider organizations, community-based organizations and subcontractors, community members, and other stakeholders. Stakeholders were invited to provide feedback following a presentation of initial secondary data findings. Stakeholders were invited back for a presentation of the final report on October 19th, 2017 to gain validation and confirmation of findings. Feedback from stakeholders on the final report is presented in the conclusions section of the report.

Data Collection Activities

To develop a comprehensive portrait of the state of health and health care needs in the region and to achieve the goals of the assessment process, the 2017 CNA collected data from a variety of sources and used multiple methodologies. In addition to a thorough review of existing data, several primary data collection activities were designed to collect wide and diverse input from RHP 7 stakeholders: a stakeholder dialogue event, key informant interviews, health and social service provider and community member focus groups, and a stakeholder survey. Results of all activities were aggregated by theme or topic area such that the body of the 2017 CNA report represents a synthesis and summary of findings, incorporating all data types, sources, and methodologies. Detailed descriptions of all data collection activities and methodologies used in the 2017 CNA are provided in this section.

Stakeholder Dialogue

A stakeholder dialogue activity was conducted as part of the CNA kick-off meeting, held on July 20, 2017. Stakeholders worked in small groups to discuss and answer questions about the health care delivery system for low-income communities in the region. Stakeholders identified perceived gaps in the system, current state of the system in relation to identified gaps, ways that the system could be improved, and barriers to addressing the identified gaps. Results of the small group discussions were recorded and analyzed to identify salient themes across the topics that were covered.

Key Informant Interviews

Key informant interviews were conducted with community leaders from all six RHP 7 counties. Interviewees represented a variety of sectors, including county and city government, mental health, hospitals, community-based health care providers, and public health entities. DSRIP Provider Exchange members assisted the RHP 7 Anchor in identifying potential interview participants. A total of 15 interviews were conducted and included 23 individuals. Interviews sought to gain insight into the perceived impact of DSRIP projects on the local community and the RHP 7 region, the challenges and needs of low-income and Medicaid populations in the RHP 7 region, and the upstream factors impacting those challenges. Additionally, interviewees were asked to speak to the current state of the social service and health care delivery system in the region.

A semi-structured interview guide was developed by HRiA in collaboration with Anchor staff and was used to ensure consistency in the topics covered in the interviews. Each interview was conducted by a trained HRiA staff member and detailed notes were taken during conversations. On average, interviews lasted 45 minutes. Interview notes were coded and analyzed thematically to identify the key themes that emerged across the discussions. Frequency and intensity of discussions on a specific topic were key indicators used for identifying main themes. Selected quotes, without personal identifying information, were included in the body of the 2017 CNA report to further illustrate points within topic areas. The final list of interviewees can be found in the **Data Sources** section and the interview guide is provided in the **RHP 7 CNA Appendix**.

Health and Social Service Providers Focus Groups

In addition to interviews, two focus groups were conducted with health and social service providers from across RHP 7. One focus group was conducted at Central Health with DSRIP performing providers and one focus group was conducted immediately after the CNA Kickoff event at the Central Health Southeast Health and Wellness Center with social service providers working with the low-income population across RHP 7. Provider focus group discussions focused on perceptions of the strengths, challenges, and needs of the low-income or Medicaid population in RHP 7, perceptions of the current state of the social service and health care delivery system in the region, and the perceived impact of the 1115 Waiver on that system.

A semi-structured focus group guide was developed by HRiA in collaboration with Anchor staff and was used to ensure consistency in the topics covered in the provider focus group groups. Each was facilitated by trained HRiA staff and detailed notes were taken during conversations. On average, focus groups lasted 60 minutes and included 8 to 10 participants. Provider focus group notes were coded and analyzed thematically to identify the key themes that emerged across the discussions. Frequency and intensity of discussions on a specific topic were key indicators used for identifying main themes. Selected quotes, without personal identifying information, were included in the body of the 2017 CNA report to further illustrate points within topic areas. The provider focus group guide can be found in the **RHP 7 CNA Appendix.**

Community Members Focus Groups

To obtain the perspectives of community members and patients, two focus groups were conducted with community members/patients in Bastrop and Hays counties. Both community member focus groups were coordinated by the Anchor in collaboration with local clinical providers (Bluebonnet Trails Community Services in Bastrop and Live Oak Health Partners Community Clinic in San Marcos). These sites were chosen based upon their counties relatively large population size outside of Travis County and

the willingness of DSRIP provider organizations to coordinate the focus group and recruit participants. The RHP 7 assessment also relied on a recently completed Travis County-specific community health needs assessment for community stakeholder input on health needs in RHP 7's most populous county. The community member/patient discussions explored perceptions of the community, priority health concerns in the community, and participants' experiences accessing health care and social services in community.

A semi-structured focus group guide was developed by HRiA in collaboration with Anchor staff and was used to ensure consistency in the topics covered in focus groups. Each was facilitated by trained HRiA staff and detailed notes were taken during conversations. On average, focus groups lasted 60 minutes and included 8 to 10 participants and all were conducted in English. Community member were provided a meal and received a $20 gift card to a local grocery store as an incentive. Community member focus group notes were coded and analyzed thematically to identify the key themes that emerged across the discussions. Frequency and intensity of discussions on a specific topic were key indicators used for identifying main themes. Selected quotes, without personal identifying information, were included in the body of the 2017 CNA report to further illustrate points within topic areas. The community member focus group guide can be found in the **RHP 7 CNA Appendix.**

Secondary Data Review

A comprehensive review of existing data drawn from national, state, and local sources was conducted. Data sources included, but were not limited to, the U.S. Census Bureau, the Centers for Disease Control and Prevention, the Texas Department of State Health Services, and the Texas Department of Public Safety, among others. Types of data included demographics, vital statistics, public health surveillance, as well as self-report of health behaviors from large, population-based surveys such as the Texas Behavioral Risk Factor Surveillance Survey (BRFSS). The selection of secondary data points was generally based on the prior CNA to allow for examination of trends over time. However, additional secondary data sources were explored when new themes or issues were identified in key informant interviews or focus groups. When available, data were stratified by race/ethnicity group or by income/poverty level to identify areas of disparity.

While mortality data for specific conditions are typically very accessible through state reporting of vital records, estimates of the numbers or proportions of individuals living with different health conditions or engaging in specific behaviors are more challenging to obtain. The Texas BRFSS is a population based survey that asks state residents about their health-related risk behaviors, chronic health conditions, and use of preventive services. As such, the Texas BRFSS is the primary source of population-level estimates of health and health behaviors. BRFSS indicators were aggregated across the six RHP 7 counties as data were not consistently available at the county-level.

In addition to the review of secondary data from their original source, previously published reports relating to the health or health needs of RHP 7 communities were also reviewed as part 2017 CNA to allow for the comparisons of themes that emerged from these previous assessments.

Stakeholder Survey

A brief online survey was developed and distributed across RHP 7 to broadly capture and quantify the perspective of stakeholders. The survey focused on providers and community members' perceptions of health issues, healthcare access, and focus areas for improving healthcare delivery in the region. The survey was developed by HRiA in collaboration with Anchor staff and included 11-items, using both Likert-type scales and closed-ended response categories. Skip patterns were embedded within the

survey so that questions could be tailored to the respondent (i.e. provider or community member). English and Spanish versions of the survey were made available to all respondents. The English and Spanish versions of the survey can be found in the **RHP 7 CNA Appendix**

Survey Distribution

The stakeholder survey was distributed by e-mail or in hard copy to providers and community members across the region. A variety of methods and modes of outreach were used: community members were provided hard copies within clinical settings in Bastrop, Travis, and Hays counties; providers and community members were targeted through e-mailed links or hard copies sent to a number of regional or county-level advisory, planning, and policy groups or committees; e-mailed links to the online survey were also distributed by the Anchor to its stakeholder distribution list of 800+ individuals which included providers and community members from across RHP 7. Providers and stakeholders were also asked to forward the survey link on to their own distribution lists and networks to further expand the reach of the survey. The period of data collection was between August 1 and August 22, 2017.

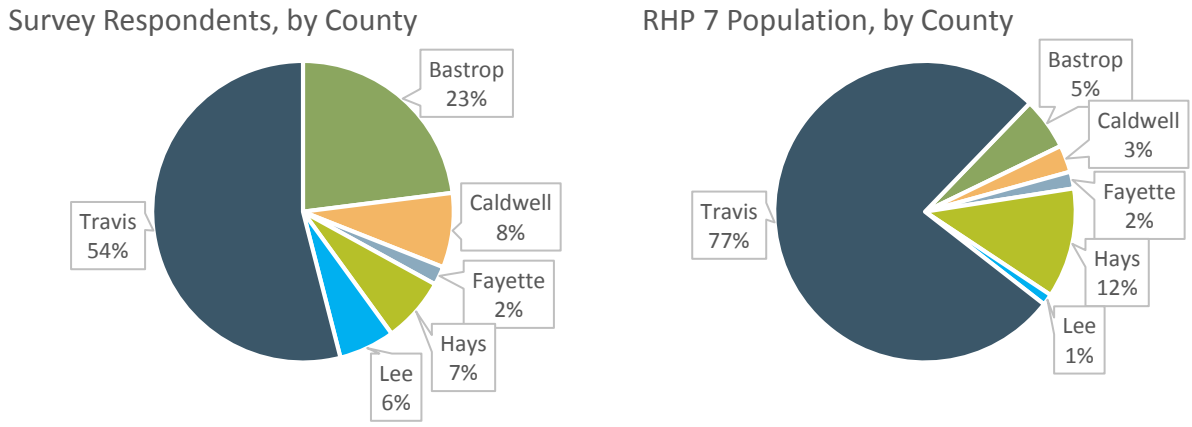
Survey Data Analyses

Stakeholder survey data were analyzed using Statistical Package for the Social Sciences software (IBM SPSS Statistics for Windows, Version 21.0. Armonk, NY: IBM Corp). Frequencies were calculated for all survey questions. However, not all respondents answered each question and non-answers were omitted from calculations. The final survey sample was restricted to providers who worked and community members who lived in RHP 7 counties. Analyses of provider and community member survey responses were conducted separately to preserve the independence of their perspectives.

Description of Survey Respondents

A total of 354 respondents (144 providers and 210 community members) completed the stakeholder survey. The survey was distributed broadly across RHP 7 using multiple methods to ensure representation from all six RHP 7 counties and a balanced response between the more/less populated counties. This aim was achieved for both providers and community members. Overall, the clear majority of providers (90%) that responded to the survey indicated they worked in Travis County. However, many providers (27.7%) indicated they worked in multiple counties. Nearly a quarter reported they worked in Bastrop (24%) or Hays (23%) counties, while Caldwell, Fayette, and Lee counties were each represented by about 15% of respondents. Thus, the provider survey results can be considered applicable and relevant for RHP 7 as a whole.

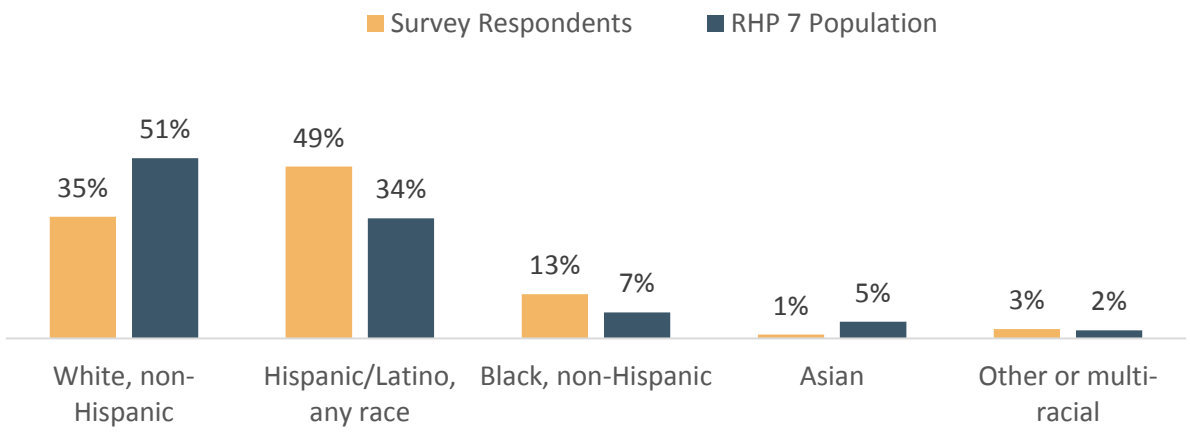
FIGURE 3. COMMUNITY MEMBER SURVEY RESPONDENTS, BY COUNTY AND COMPARED TO RHP 7 POPULATION



DATA SOURCE: RHP 7 Community Needs Assessment Stakeholder Survey, 2017 and U.S. Census Bureau, Population Division, Annual Estimates of the Resident Population: 2016

Stakeholder survey results for community members achieved a balanced representation of community members residing inside/outside of Travis County. As illustrated in **Figure 3**, just over half (54%) of respondents lived in Travis County which is smaller than Travis County's population as a percent the RHP 7 total population (77%). Thus, the community member survey results can be considered applicable and relevant for RHP 7 as a whole and with clear representation of the perspectives of those residing outside of Travis County and the urbanized central core of the region.

FIGURE 4. COMMUNITY MEMBER SURVEY RESPONDENTS, BY RACE/ETHNICITY AND COMPARED TO RHP 7 POPULATION

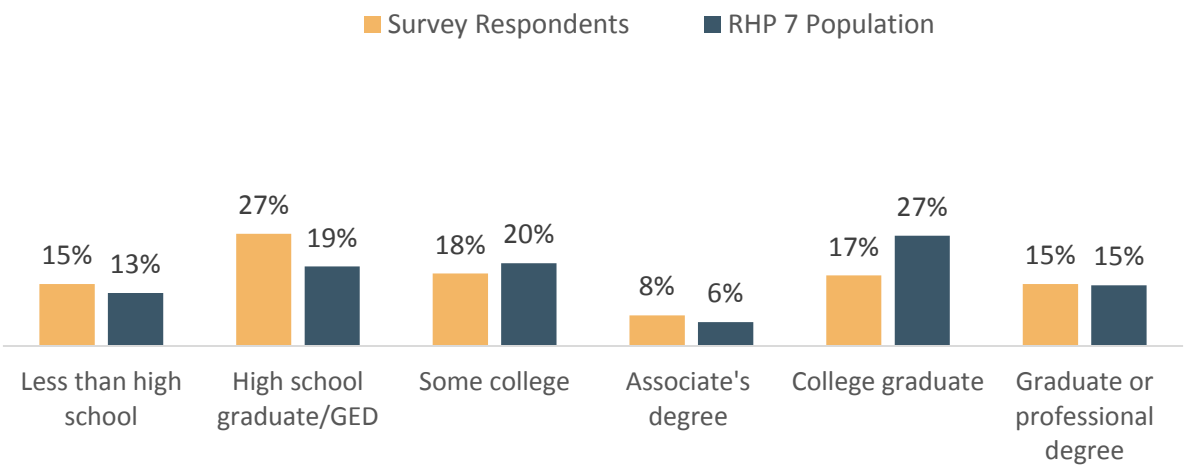


DATA SOURCE: RHP 7 Community Needs Assessment Stakeholder Survey, 2017 and U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015
NOTE: Proportions are based upon a total of 210 community member survey respondents and a total RHP 7 population of 1,457,015

A comparison of community member survey respondents and the overall RHP 7 population further demonstrated the survey achieved a sample that was inclusive of the perspective of populations that are particularly likely to be impacted by 1115 Waiver activities (**Figure 4**). This specifically included Hispanic and Black individuals who were represented at higher rates in the stakeholder survey than they are as a percent the RHP 7 total population. It should be noted that 21.4% of respondents opted to complete the Spanish version of the stakeholder survey which suggests many Hispanic/Latino

respondents were likely bilingual or English-only speakers. The low proportion of community members that identified as Asian may be partially explained by the limited language options for the survey.

FIGURE 5. COMMUNITY MEMBER SURVEY RESPONDENTS, BY EDUCATION AND COMPARED TO RHP 7 POPULATION



DATA SOURCE: RHP 7 Community Needs Assessment Stakeholder Survey, 2017 and U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015
NOTE: Proportions are based upon a total of 210 community member survey respondents and a total RHP 7 population age 25 or older of 951,103

The community member survey respondents and the overall RHP 7 population were also found to be similar in terms of educational attainment (**Figure 5**). Results of the community member survey can therefore be considered representative of the total RHP 7 population based on education level.

Providers that responded to the stakeholder survey (N=144) represented a wide range of organizations and sectors, and included community clinics (26.1% of respondents), mental health (23.2% of respondents), and social services (17.4%). Public health (9.4%), patient advocates (8.0%), hospitals (8.0%), health plans (8.0%) were also represented. Further details on survey respondents, both providers and community members, can be found in the **RHP 7 CNA Appendix**.

Data Limitations

While efforts were made to engage a diverse and representative cross-section of individuals, interview, focus group, and stakeholder survey participants only represent a sub-set of community members and stakeholders. While the data do provide valuable insights and important context, results may be limited in their generalizability to the overall population. Lastly, it is important to note that interview, focus group, and survey data were collected at a single point in time; so findings, while directional and descriptive, should not be interpreted as definitive.

As with all data collection efforts, there are several limitations that should be acknowledged. A number of secondary data sources were drawn upon in creating this report. Although all (e.g., U.S. Census, Texas Department of State Health Services, etc.) are considered highly credible, each source may use different methods and assumptions when tabulating data. Additionally, due to the collection of data from multiple sources, data presented in this report may cover multiple time periods. Therefore, figures and tables may not be directly comparable with each other. It should also be noted that in several instances county-level data were not available due to small sample sizes or data suppression rules. In these cases, data from multiple years or multiple counties may have been aggregated to allow for data estimates at the county- or regional-level.

Findings

Demographics

Demographic data include basic descriptive indicators, such as population size and the population's racial/ethnic composition, as well as economic-related characteristics like educational attainment, income, and employment status. Together, these indicators provide a detailed portrait of who resides in each of the RHP 7 counties, allowing for the identification of vulnerable sub-populations.

Key Themes

Population Growth and Diversity

As a region, RHP 7 has grown considerably since 2000 and population growth was one of the key themes that arose from the 2012 RHP 7 CNA. At that time, Texas Demographic Center had projected double-digit growth in all counties but Travis County. Actual growth rate data for 2016 showed growth was generally lower than expected in most RHP 7 counties, while greater than expected in Travis County. Current projections do show population growth is likely across RHP 7 through 2020. Projected rates pick up slightly in the rural counties and slowdown in Travis and Hays counties, although Hays County is still projected to experience the greatest growth.

Rates of chronic disease and disability tend to increase with the age of a population, contributing to greater demand for health care resources and services and increased health care costs.[2] The 2012 CNA had predicted that the population throughout RHP 7 would age, particularly in Hays County. Data showed that while population growth generally impacted all age groups proportionally, the numbers of adults age 65 and older grew at notable rates in Bastrop, Hays, and Travis counties between 2010 and 2015.

The populations of the six RHP 7 counties have also become increasingly diverse. Between 2010 and 2015, larger proportions of the populations in all six counties identified as Hispanic/Latino. While growth rates were more modest than projected in the 2012 CNA for this sub-population, Hays County had a notably high growth rate of 30.2% in Hispanic/Latino residents and growth ranged between 10% and 18% in the other RHP 7 counties. Excluding Bastrop County which did not have in increase, the percentage increases in the size of the Black population ranged from 6.3% in Lee County to a high of 13.3% in Hays County.

Bastrop and Hays counties also had notable growth in the size of their non-English speaking population between 2010 and 2015. Travis County continued to have the largest proportion of residents speaking languages other than English or Spanish, primarily reflecting larger sub-populations speaking languages such as Chinese, Vietnamese, and Korean.

Education is considered a key social determinant of health.[3] Key informant interviewees and provider focus group participants consistently connected educational attainment with health outcomes in their communities and linked low educational attainment to lower levels of health literacy. Despite rising high school graduation rates in recent years, as of 2015, nearly 1 in 5 residents age 25 or older in Bastrop,

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[2] The Rising Cost of Living Longer: Analysis of Medicare Spending by Age for Beneficiaries in Traditional Medicare, Kaiser Family Foundation, 2015; http://www.kff.org/medicare/report/the-rising-cost-of-living-longer-analysis-of-medicare-spending-by-age-for-beneficiaries-in-traditional-medicare/

[3] Education and Health, Exploring the Social Determinants of Health, Robert Wood Johnson Foundation, Issue Brief #5, 2011; http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70447

Caldwell, and Fayette counties did not have a high school diploma suggesting low educational attainment remains a pressing issue for the adult population in some RHP 7 counties.

Economics and Inequality

Unemployment rates across RHP 7 have declined sharply since 2009, mirroring trends at the state and national level. However, state data show stark disparities by race and ethnicity. As of 2015, Hispanic and Black individuals had unemployment rates that were 1.5 to 2 times higher than their Asian or White, non-Hispanic counterparts.

Consistent with a decline in unemployment, the overall median household income increased by an average of $4,585 between 2010 and 2015 across RHP 7. However, also consistent with differences in unemployment by race and ethnicity, large income inequalities were also observed. As of 2015, Black residents in RHP 7 counties had median household incomes that were an average of -$19,744 less than White, non-Hispanic residents. Hispanic residents in RHP 7 counties had median household incomes that were an average of -$15,139 less than White, non-Hispanics residents.

These income differences varied by county, with the largest inequalities observed in Travis County. A growing base of evidence has begun to show that living in communities with greater economic inequality is linked to poorer health outcomes, such as infant mortality, obesity, and stress,[4] which underscores the importance of these findings for RHP 7.

Discussions of poverty among provider focus group participants and key informant interviewees tended to emphasize the vulnerability of low-income individuals in terms of population growth, housing costs, and migration outward from the urban core of Travis County to more suburban and rural areas.

Housing Affordability and Migration

Housing is a social determinant of health that, when it is safe, stable, and affordable, can have positive impacts on health outcomes for individuals and communities.[5] Housing affordability, or the lack thereof, was a one of the clearest overarching themes across all interviews and focus groups. Median monthly housing costs for renters has increased since 2010 in every RHP 7 county and a third or more of renters are housing cost burdened in RHP 7. Affordability of rent was particularly an issue for Hays County, where over half of renters devoted 35% or more of household income toward housing costs.

Migration out of Travis County by low-income individuals and families was consistently discussed by key informants, providers and community members. Reportedly driven by higher housing costs, many individuals and families were perceived to be moving outward from Austin and Travis County seeking more affordable options. Secondary data do show relatively higher in-migration rates in Bastrop, Caldwell, Hays, and Lee counties among individuals living in poverty, compared to Travis County.

The implications of migration out of the central Austin-Travis County core was perceived by key informants and providers to have far reaching effects on the health care and social service systems of these outlying counties. Not only were individuals moving further away from centralized health care infrastructure and social service resources, but at the same time, due to capacity and infrastructure limits, outlying counties have found it challenging to meet the growing demand for services. Several

[4] Inequality and Health, Institute for Policy Studies; https://inequality.org/facts/inequality-and-health/
[5] Housing and Health, Exploring the Social Determinants of Health, Robert Wood Johnson Foundation, Issue Brief #7, 2011; http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70451

provider focus group participants also noted than many who have moved find they are no longer eligible for county-specific medical assistance programs because they have moved across county lines.

The sub-sections that follow, explore in greater depth the data that were examined around each of these themes. Specific data are discussed in terms of trends and differences between counties and within particularly vulnerable sub-populations.

Population

As of 2016, the total population of RHP 7 numbered over 1.5 million residents, representing 5.6% of the total population in Texas. Hays and Travis counties, together, represent the majority of the RHP 7 population (89.4%). Bastrop, Caldwell, Fayette, and Lee counties had relatively smaller populations.

TABLE 2. TOTAL POPULATION, BY COUNTY AND STATE, 2000, 2010, AND 2016

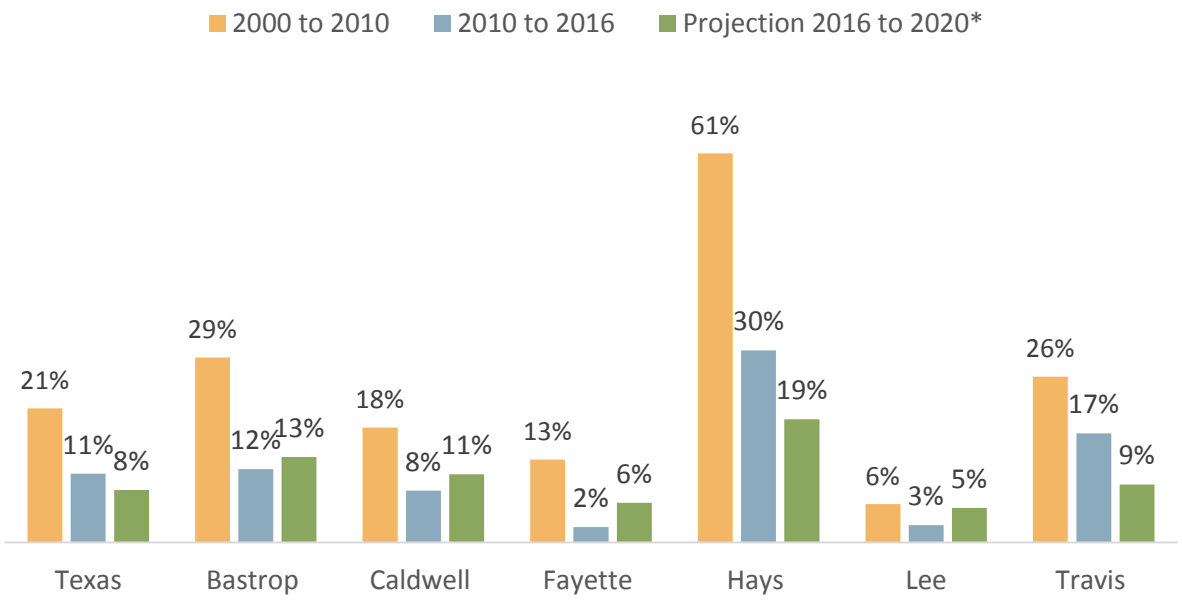
	2000	2010	2016	Projected % Growth 2010 to 2016*	Actual % Growth 2010 to 2016
Texas	20,851,820	25,145,561	27,862,596	*14%*	10.8%
Bastrop County	57,733	74,171	82,733	*34%*	11.5%
Caldwell County	32,194	38,066	41,161	*13%*	8.1%
Fayette County	21,804	24,554	25,149	*13%*	2.4%
Hays County	97,589	157,107	204,470	*36%*	30.1%
Lee County	15,657	16,612	17,055	*18%*	2.7%
Travis County	812,280	1,024,266	1,199,323	*7%*	17.1%
RHP 7 Total	1,037,257	1,334,776	1,569,891	*n/a*	17.6%

*DATA SOURCE: U.S. Census Bureau, Population Division, Annual Estimates of the Resident Population: 2000, 2010, 2016; *Texas State Data Center Population Projections, as cited in 2012 RHP 7 CNA*

Table 2 shows the total populations of each county and the actual growth rates for 2010 to 2016. Hays County experienced the greatest population increase between 2010 and 2016, increasing 30% from 157,107 to 204,470 residents. Travis County had the second highest population growth at 17.1%. The percentage of population growth in Travis County was comparable to the growth in RHP 7 overall, which increased by 17.6%.

Also detailed in **Table 2,** are the projected growth rates from the 2012 RHP 7 CNA that were anticipated for the 2010 to 2016 period. The 2012 CNA accurately projected the most growth taking place in Hays County, though the projected percent increase was slightly higher than the actual increase (36% compared to 30.1%). The previous CNA over-projected growth for Bastrop, Caldwell, Fayette, and Lee counties and under-projected growth for Travis County, which grew at more than double the rate that was projected.

FIGURE 6. POPULATION GROWTH RATES, BY COUNTY AND STATE, 2000 TO 2020



DATA SOURCE: U.S. Census Bureau, Population Division, Annual Estimates of the Resident Population: 2000, 2010, 2016 and Texas Demographic Center, Migration Scenario Data Tool, 2016-2020
*NOTE: Growth rates calculated as (Present #) - (Past#) / (Past#); *population projection assume net immigration from 2010 to 2030 to be equal to that from 2000 to 2010*

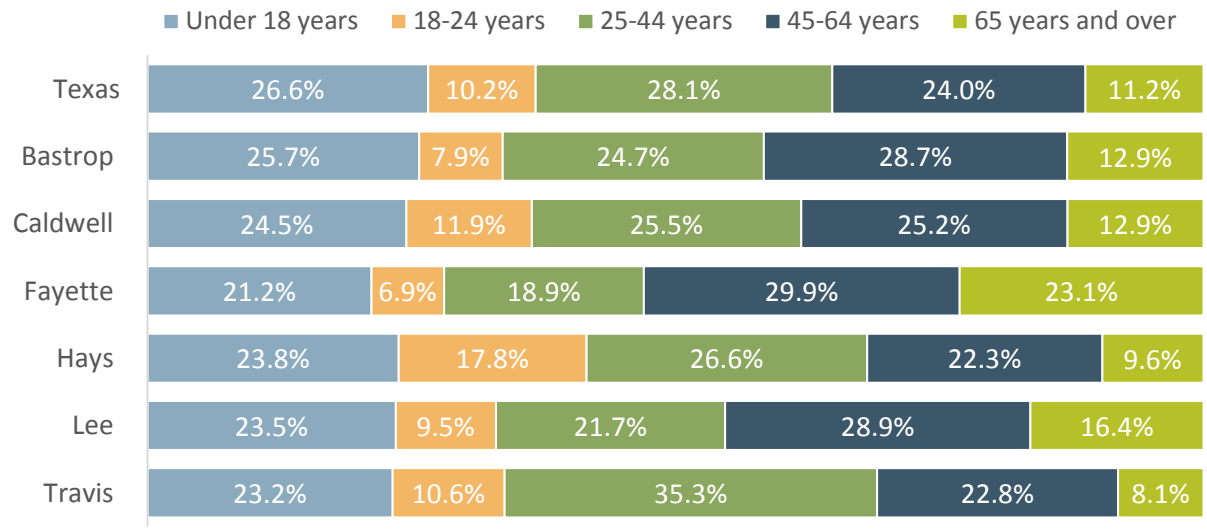
Figure 6 illustrates actual population growth rates for 2000 to 2010 and 2010 to 2016, as well as the current projected growth rate from 2016 to 2020. To date, Hays County had experienced the highest percentage increases in population size (61% increase between 2000 and 2010 and 30% increase between 2010 and 2016). Bastrop and Travis counties also grew at relatively high rates between 2000 and 2016. Current projections through 2020 show population growth will continue across RHP 7. The more rural counties (Bastrop, Caldwell, Fayette, and Lee) are projected to have slightly higher rates of growth by 2020 compared to actual growth rates between 2010 and 2016. In contrast, Hays and Travis counties have projected growth rates that are lower than actual growths in the earlier period. Despite this projected slowdown, Hays County is still projected to have greatest population growth in RHP 7.

Age Distribution

When examined as a proportion of the total population, data suggest that population growth was occurring in all age groups. However, based upon population counts, Bastrop, Hays, and Travis counties had notable increases in the number of residents that were aged 65 or older.

In Bastrop County, this population grew 24.8% from 7,952 in 2010 to 9,926 in 2015, in Hays County this population grew 40.2% from 12,154 in 2010 to 17,046 in 2015, and in Travis County this population grew 32.5% from 68,580 in 2010 to 90,853 in 2015.

FIGURE 7. AGE DISTRIBUTION, BY COUNTY AND STATE, 2015



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2006-2010 and 2011-2015

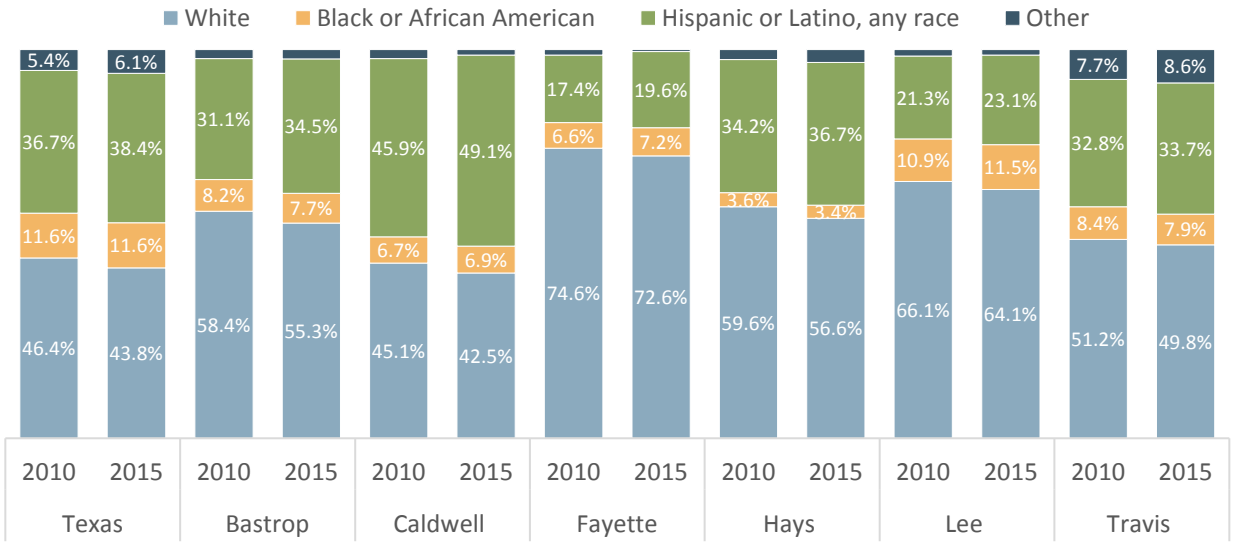
Figure 7 shows the age distribution for the RHP 7 counties as of 2015. Similar to state proportions, about a quarter of the population in RHP 7 counties was under 18 years old. Hays County had a larger proportion of young adults (18-24), while Travis County had a larger proportion of midlife adults (25-44) and Fayette and Lee counties had larger proportions of older adults (65 and older).

Demographic Diversity

Race and Ethnicity

The 2012 CNA had predicted that the population throughout RHP 7 would become increasingly diverse with larger proportions of the population identifying as Hispanic or Latino. In 2012, the Texas Demographic Center projected a 41% increase in the proportion of Hispanic or Latino residents by 2016.

FIGURE 8. RACIAL AND ETHNIC DISTRIBUTION, BY COUNTY AND STATE, 2010 AND 2015



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2006-2010 and 2011-2015

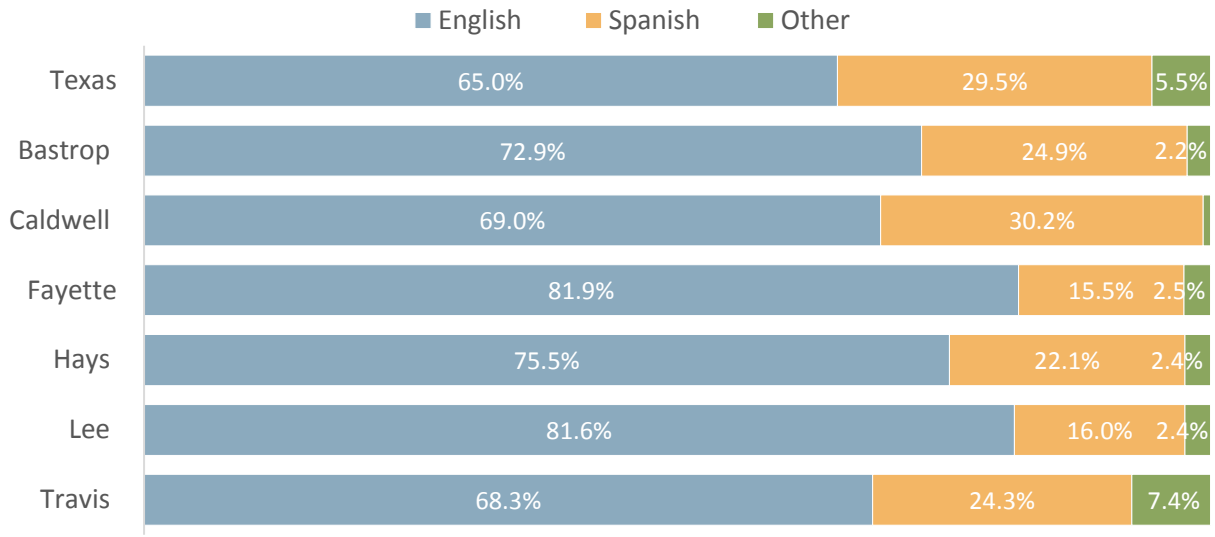
Each RHP 7 county did experience an increase in the proportion of their population that identified as Hispanic/Latino between 2010 and 2015 (**Figure 8**). Growth rates (based on population counts) were

more modest than was projected in 2012. Hays County had the highest growth rate in its Hispanic/Latino population, from 50,082 in 2010 to 65,165 in 2015 (30.2% growth rate). Growth rates were lower in Bastrop (18.1% growth rate), Caldwell (12.5% growth rate), Fayette (16.2% growth rate), Lee (9.7% growth rate), and Travis (17.8% growth rate) counties.

As of 2015, U.S. Census Data show that Bastrop, Fayette, Hays, Lee and Travis counties each had 50% or more of their population who identified as White, non-Hispanic. In contrast, nearly half of Caldwell County's population identified as Hispanic/Latino in 2015. Each county had a proportion of Black residents, ranging from 3.4% in Hays County to 11.5% in Lee County. Residents who identified as other races made up a small proportion of the population in most RHP 7 counties. Of these, the largest group was Asian (6.0% in Travis County and 1.2% in Hays County).

Language

FIGURE 9. LANGUAGE SPOKEN AT HOME FOR POPULATION 5 YEARS AND OLDER, BY COUNTY AND STATE, 2015



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015

As of 2015, most residents in RHP 7 reported speaking English at home (**Figure 9**). The proportion ranged from a low of 68.3% in Travis County to a high of 81.9% in Fayette County. Spanish was the primary language spoken by non-English speakers across the region, making up approximately a quarter of residents in Bastrop, Caldwell, Hays, and Travis counties.

For most RHP 7 counties, the proportion of the population speaking a language other than English at home did not materially change since 2010 (data not shown). However, Bastrop and Hays counties did have some notable growth rates in their non-English speaking populations between 2010 and 2015 (10.2% growth in Bastrop County and 7% growth in Hays County) which was higher than for the state overall (2.3% growth).

Travis County had the highest proportion of residents that reported speaking languages other than English or Spanish (7.4%); of these 3.7% were Asian languages including Chinese, Vietnamese, and Korean.

Education

Education is considered a key social determinant of health.[6] Across all racial and ethnic groups, individuals lacking a high school diploma typically earn substantially less than their graduating counterparts which may reduce their access to healthy foods, adequate housing, or needed health care services. Low educational attainment is strongly related to poorer health outcomes and a shorter life expectancy.[7]

Key informant interviews and provider focus group participants connected educational attainment with health outcomes in their communities and perceived that increasing opportunities for educational achievement leads to increased stability and better health outcomes for individuals and communities.

Several interviewees that worked in health care identified the need for health care agencies to work on education, with one interviewee stressing that education was the most important social determinant of health, while another stressed the impact of education on health literacy. Interview and focus group participants consistently stated that low health literacy affected health outcomes and community members' ability to access appropriate, timely health care.

> "[Education] is the single most important social determinant of health we should be investing in."
>
> -Key Informant Interviewee
>
> "[Half] of folks have a high school degree or less…[that] impacts things like health literacy, [which is] an expensive undertaking. It's easier to just hand someone a patient plan and say 'Well, I hope you can read this or find someone who can read this to you.'"
>
> -Key Informant Interviewee (Bastrop County)

Health literacy includes a patient's ability to understand their personal health and related medical options, as well as their ability to identify necessary information and services and make the best decisions for themselves and their health. Low levels of health literacy can create barriers to accessing health care and contribute to poorer health outcomes.[8] Providers that participated in focus groups discussed the connection between health literacy with health care access in RHP 7. They shared that higher levels of health literacy helped patients know *"where to go and why you need to go there"* and helped patients advocate for themselves.

Focus groups conducted as part of the recently completely Travis County Community Health Assessment[9] echoed this perception. In it, Travis County participants talked about difficulties navigating their health insurance, finding doctors, and understanding medical terminology and paper work. A lack

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[6] Education and Health, Exploring the Social Determinants of Health, Robert Wood Johnson Foundation, Issue Brief #5, 2011; http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70447

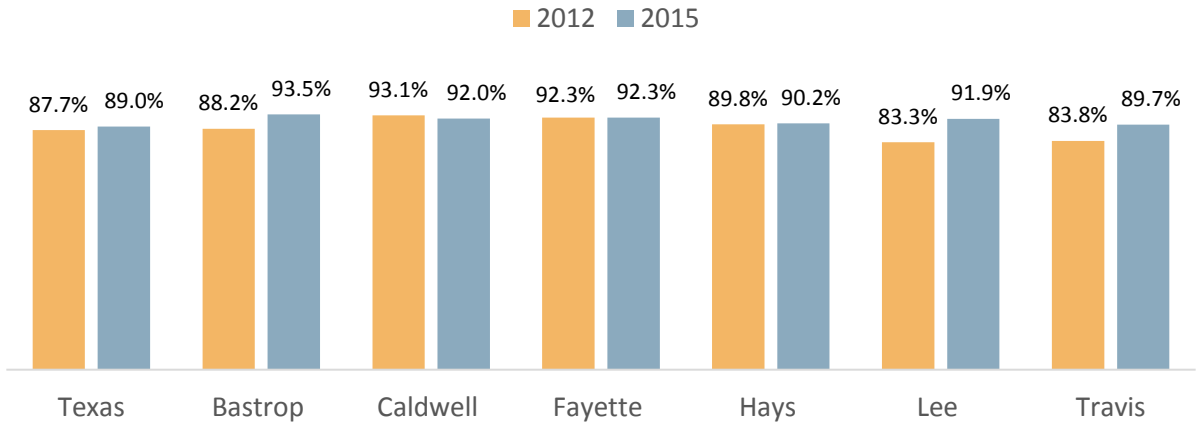
[7] Education and Health, Exploring the Social Determinants of Health, Robert Wood Johnson Foundation, Issue Brief #5, 2011; http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70447

[8] Health Literacy, Centers for Disease Control and Prevention, 2017; https://www.cdc.gov/healthliteracy/basics.html

[9] Community Health Assessment – Austin/Travis County, September 2017 Draft; http://austintexas.gov/sites/default/files/files/Health/CHA-CHIP/ATC_CHA_DRAFT_09_26_17__002_.pdf

of understanding and managing medical diagnoses, such as diabetes or hypertension was also mentioned. The general lack of awareness of service availability among the community was also stressed by Travis County focus group participants.

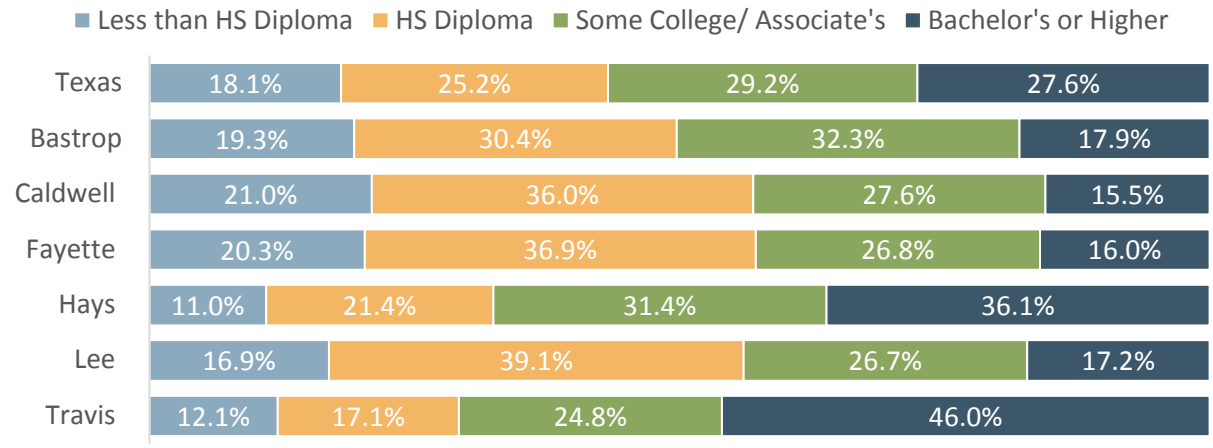
FIGURE 10. HIGH SCHOOL GRADUATION RATE, BY COUNTY AND STATE, 2012 AND 2015



DATA SOURCE: Texas Education Agency, Completion, Graduation, and Dropouts Data Search, Grade 9 Four-Year Longitudinal Graduation and Dropout Rates, Class of 2012 and 2015

High school graduation rates increased between 2012 and 2015 in Texas and each RHP 7 county **(Figure 10**). The largest improvements were observed in Lee (83.3% to 91.9%), Bastrop (88.2% to 93.5%), and Travis (83.8% to 89.7%) counties.

FIGURE 11. EDUCATIONAL ATTAINMENT FOR POPULATION 25 YEARS AND OLDER, BY COUNTY AND STATE, 2015



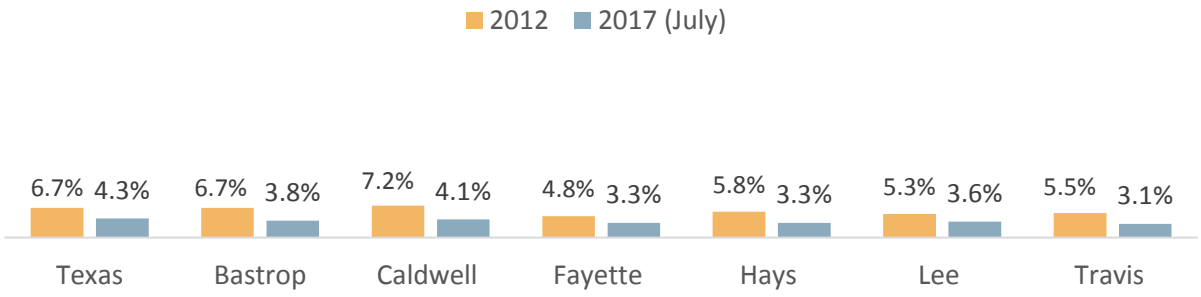
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates 2011-2015
NOTE: Proportions based upon the population aged 25 years or older

As of 2015, nearly 1 in 5 residents age 25 or older in Bastrop, Caldwell, and Fayette counties did not finish high school, a rate that is slightly higher than the state (**Figure 11**). At the higher end of the educational attainment spectrum, just over a quarter of Texans reported their highest level of education to be at least a bachelor's degree. Bastrop, Caldwell, Fayette, and Lee counties all had rates that were slightly below this rate, ranging from 15.5% in Caldwell County to 17.9% in Bastrop County. In contrast, Hays and Travis counties each had rates that were markedly higher than the state (36.1% in Hays and 46.0% in Travis).

For most counties, educational attainment in 2015 was similar to 2010, however some changes were observed in two counties. The proportion population in both Lee and Caldwell counties with at least a bachelor's degree had increased between 2010 and 2015 (Lee County from 14.5% to 17.2% and Caldwell County from 14.4% to 15.4%).

Employment

FIGURE 12. UNEMPLOYMENT RATE, BY COUNTY AND STATE, 2012 AND 2017



DATA SOURCE: U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics, 2012 and 2017
NOTE: Unemployment rate for 2017 is based on data through July 2017

The national unemployment rate has declined steadily since its recent peak in 2009 and unemployment in Texas has declined similarly to a current rate of 4.3%. Each RHP 7 county has experienced declining unemployment rates over the course of the 1115 Waiver period, with relatively larger declines in Bastrop and Caldwell counties (**Figure 12**). While current unemployment rates are low overall, clear differences exist between racial and ethnic groups.

According to state level data from Bureau of Labor Statistics, in 2015 unemployment in Texas was lower among Asian (2.6%) and White residents (3.6%) and it was higher among Hispanic (5.1%) and Black (7.6%) residents[10].

Income

TABLE 3. MEDIAN HOUSEHOLD INCOME, BY COUNTY AND STATE, 2010 AND 2015

	All Households (2010 and 2015)			By Race/Ethnicity (2015)			
	2010	2015	% Change	White	Black	Hispanic	Asian
Texas	$49,646	$53,207	7.2%	$65,714	$39,345	$41,248	$75,796
Bastrop County	$51,829	$54,821	5.8%	$60,669	$47,545	$41,443	$79,063
Caldwell County	$41,594	$47,233	13.6%	$55,786	$29,816	$41,705	n/a
Fayette County	$45,450	$47,808	5.2%	$49,928	$36,714	$45,453	n/a
Hays County	$56,353	$58,583	4.0%	$66,581	$56,134	$46,510	$56,364
Lee County	$46,986	$53,902	14.7%	$57,065	$33,060	$55,409	n/a
Travis County	$54,074	$61,451	13.6%	$74,110	$42,404	$42,788	$77,831

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2006-2010 and 2011-2015

[10] Economic Policy Institute, analysis of Bureau of Labor Statistics Local Area Unemployment Statistics (LAUS) data and Current Population Survey (CPS) data; http://www.epi.org/publication/state-unemployment-rates-by-race-and-ethnicity-at-the-end-of-2015-show-a-plodding-recovery/

Consistent with reductions in unemployment, median household incomes increased in Texas and each RHP 7 county between 2010 and 2015 (**Table 3**). The largest percentage change in median household incomes were observed in Caldwell, Lee, and Travis counties (approximately 14% change), while percent change was lower in Bastrop, Fayette, and Hays counties (approximately 5% change). As of 2015, Travis County had the highest median household income of the RHP 7 counties ($61,451) followed closely by Hays County ($58,583). The counties with the lowest median household incomes were Caldwell ($47,233) and Fayette ($47,808) counties.

Large income inequalities were observed across RHP 7 when the 2015 median household income data was stratified by race/ethnicity (**Table 3**)**.** On average, Black residents in RHP 7 counties had median household incomes that were -$19,744 less than White residents. The disparity between Black and White residents was particularly high in Caldwell (-$25,972), Lee (-$24,005), and Travis (-$31,706) counties.

Similarly, Hispanic residents in RHP 7 counties on average had median household incomes that were -$15,139 less than White residents. The disparity between Hispanic and White residents was particularly high in Bastrop (-$19,225), Hays (-$20,071), and Travis (-$31,322) counties.

Poverty

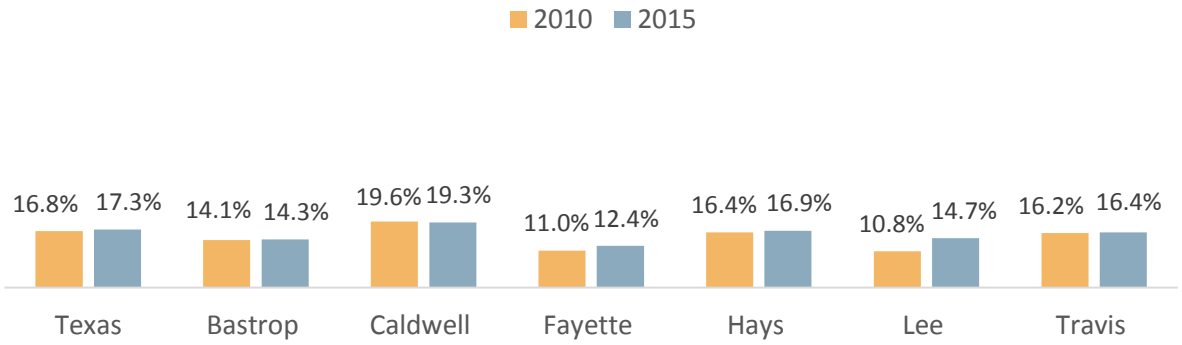
Household income is directly related to poverty status. The official measure of poverty, or Federal Poverty Level (FPL), is revised annually by the U.S. Department of Health and Human Services.[11] Key informant interview and provider focus group participants spoke frequently about the impact of poverty on the health of community members in the region. Participants indicated that low-income communities often have limited access to healthy, affordable food, opportunities for physical activity, and routine, timely health care and are often put in the position of making decisions between paying for health-related costs, like medications, or other costs, such as rent or gas.

> "Any time that you have low-income communities, they're making choices the best that they can."
>
> -Key Informant Interviewee

> "Children living in poverty is an important issue, so many resources and opportunities are not available to them and so they have worse long-term outcomes as a result."
>
> -Key Informant Interviewee

[11] The Federal Poverty Level (FPL) is based upon the total household income and the number of individuals in the household – currently this is equal to $12,060 for a single person and $24,600 for a family of 4. Those with incomes below this level are considered to be living in poverty or 'below 100% of FPL.'

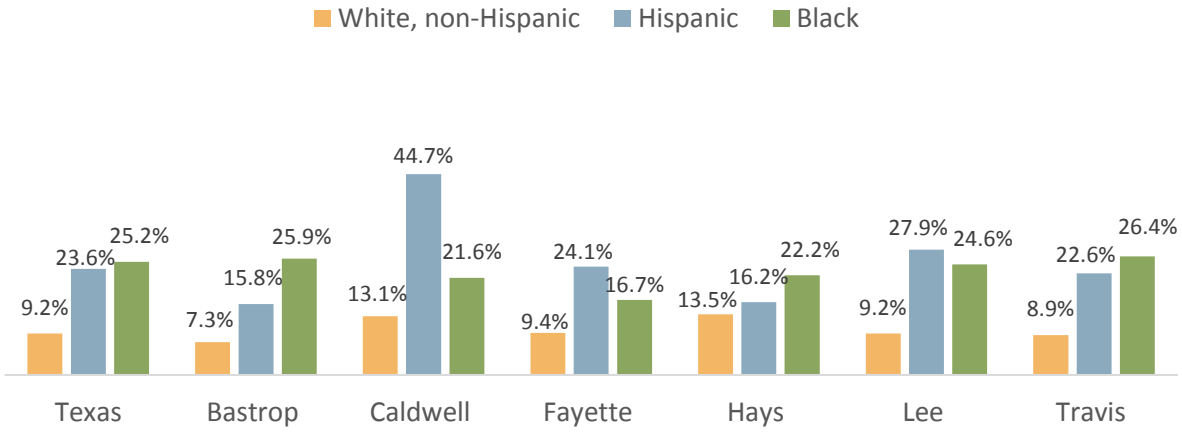
FIGURE 13. PERCENT OF INDIVIDUALS WITH INCOME BELOW 100% OF FEDERAL POVERTY LINE, BY COUNTY AND STATE, 2010 AND 2015



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2006-2010 and 2011-2015

Across RHP 7, between 12% and 19% of individuals were living in poverty as of 2015 (**Figure 13**). The poverty rate was highest in Caldwell County (19.3%) and lowest in Fayette County (12.4%). Between 2010 and 2015, rates remained steady in Bastrop, Caldwell, Hays, and Travis counties. However, the proportion of individuals living in poverty increased in Fayette (from 11.0% to 12.4%) and Lee (from 10.8% to 14.7%) counties between 2010 and 2015. The proportion of children (under age 18) living in poverty was higher than the overall poverty rate in each county. Further data from the Census Bureau shows that in 2015 the child poverty rate ranged from a low of 17.4% in Hays County to a high of 24.3% in Caldwell County.

FIGURE 14. PERCENT OF INDIVIDUALS BY RACE/ETHNICITY WITH INCOME BELOW 100% OF FEDERAL POVERTY LINE, BY COUNTY AND STATE, 2015



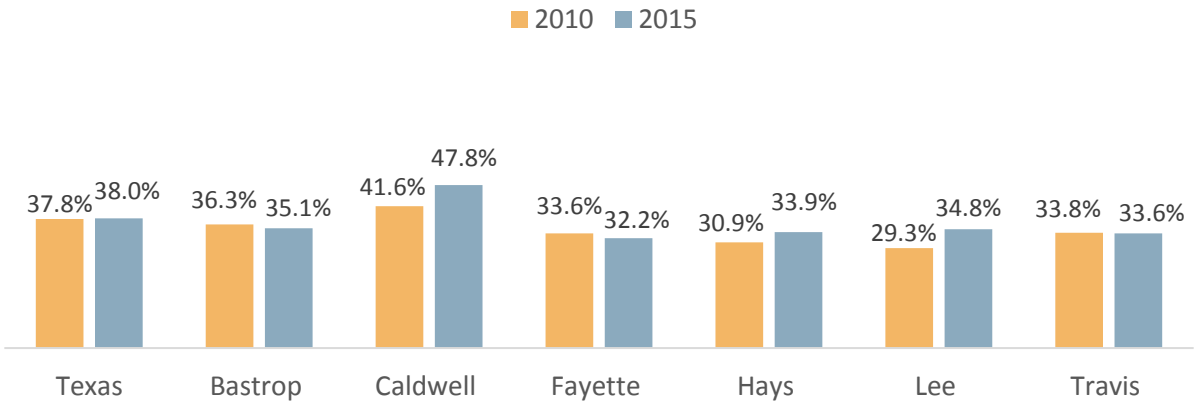
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015

Consistent the income inequalities described above, large differences in the poverty rates by race and ethnicity were observed in each of the RHP 7 counties. As illustrated in **Figure 14**, Hispanic and Black residents were between .5 to 3.5 times more likely to be living in poverty than their White, non-Hispanic counterparts in 2015.

On average, 25.2% of Black residents and 22.9% of Hispanic residents in RHP 7 counties were living in poverty compared to an average of 10.2% of White, non-Hispanic residents in RHP 7. The disparity between Black and White, non-Hispanic residents was particularly high in Bastrop, Lee, and Travis counties while the disparity between Hispanic and White, non-Hispanic residents was particularly high in Caldwell, Fayette, Lee, and Travis counties. The recent Travis County Community Health Assessment

report[12] also highlighted the widening wealth gap/disparity within Travis County, and stressed the negative impacts of economic inequality on a community's health.

FIGURE 15. PERCENT OF INDIVIDUALS WITH INCOME BELOW 200% OF FEDERAL POVERTY LINE, BY COUNTY AND STATE, 2010 AND 2015



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2006-2010 and 2011-2015

Across RHP 7, approximately one third of individuals had incomes that were below 200% of FPL as of 2015 (**Figure 15**). The rate remained stable between 2010 and 2015 in Bastrop, Fayette, and Travis counties. However, increases were observed in Caldwell (from 41.6% to 47.8%), Hays (from 30.9% to 33.9%) and Lee (from 29.3% to 34.8%) counties. The proportion of individuals living below 200% of FPL was generally higher for the population under age 18. This rate ranged from a low of 37.9% in Hays County to a high of 63.4% in Caldwell County. For more detailed data tables containing population counts for those living below 100% of FPL as well as below 200% of FPL, see **RHP 7 CNA Appendix**.

> "I think in one way, Austin-Travis County should be really proud for reducing poverty, but on the other hand how they've done it is basically to push out poverty. People that are in poverty can't afford the rent or cost of living and the middle class can't afford the tax burden being put on them."
>
> -Key Informant Interviewee
>
> "In Austin, the poor are getting shoved out to the outlying counties…which leads to the misperception that the city is getting healthier but it's really that the sick are getting pushed out"
>
> -Key Informant Interviewee

Many key informant interviewees and provider focus group participants specifically identified the population growth in the region, particularly in Austin, as a compounding issue for those living in poverty or with lower incomes. Some interviewees shared that while a common belief is that poverty and unemployment have decreased in Austin proper, this was only a result of lower income populations moving to outlying communities and counties. This perception was consistent with feedback from interviewees and providers that worked outside of Travis County who related during discussions that poverty had been increasing in their communities. This theme, and data related to housing and migration, are explored more fully in subsequent sections.

[12] Community Health Assessment – Austin/Travis County, September 2017 Draft; http://austintexas.gov/sites/default/files/files/Health/CHA-CHIP/ATC_CHA_DRAFT_09_26_17__002_.pdf

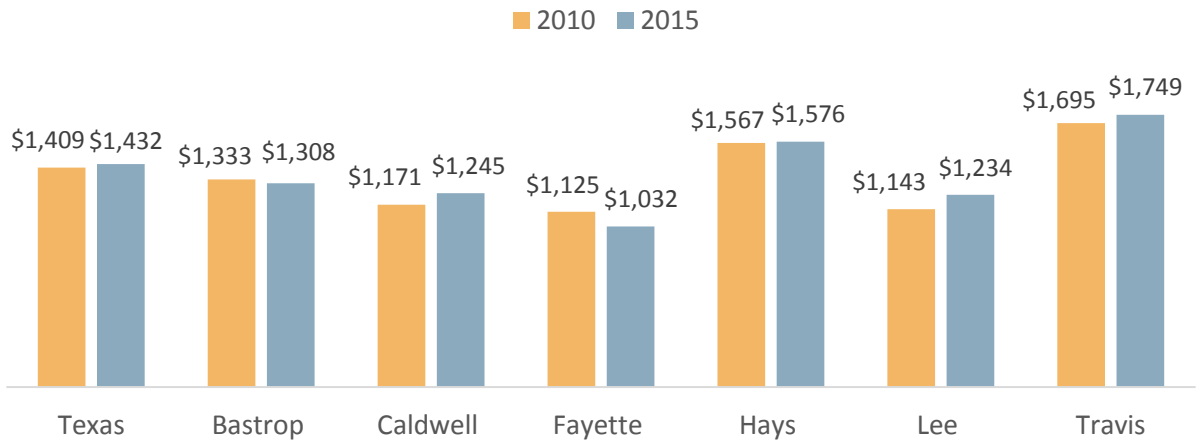
Housing and Homelessness

RHP 7 counties together account for over half a million occupied housing units and most lie within Travis County (approximately 400,000 units). As of 2015, the majority of occupied housing units were owner-occupied in Bastrop (62.2%), Caldwell (78.1%), Fayette (77.8%), Hays (63.9%), and Lee (74.5%) counties. In contrast, only about half of occupied housing units were owner-occupied in Travis County (51.7%).

> "The price of housing - If you're on a fixed income like me, they won't rent to you."
>
> -Community Member Focus Group Participant
>
> "It's the brick and mortar issue of housing but it's also how you cover the costs, including really high utility costs."
>
> -Key Informant Interviewee

Availability and location of affordable housing was a major theme that arose from key informant interviews and focus groups. Participants in community member focus groups consistently shared that the rising cost of living in the region was one of their major concerns. Several participants noted that high housing costs were particularly difficult for people with low or fixed incomes. Several community members and key informant interviewees raised the issue of high utility costs in the area, particularly for more rural communities.

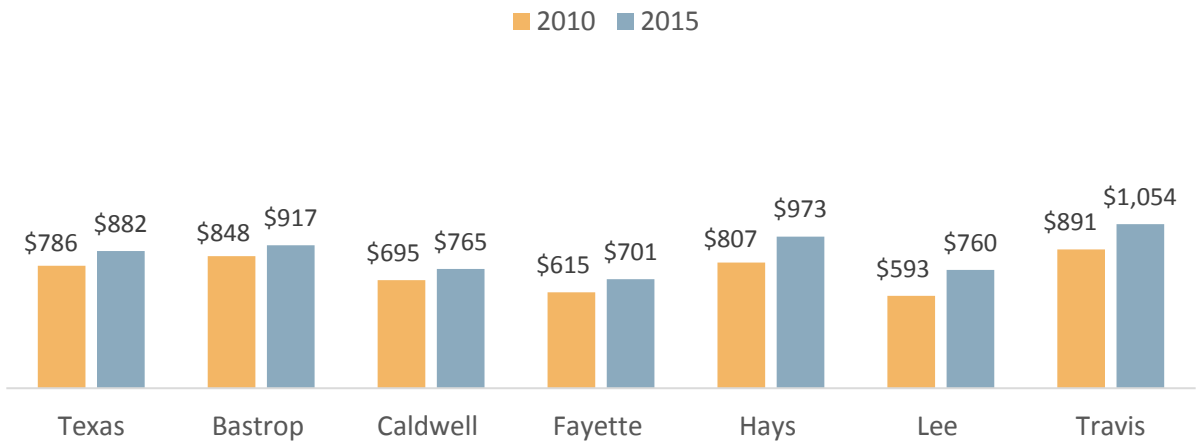
FIGURE 16. MEDIAN MONTHLY HOUSING COSTS FOR OWNER-OCCUPIED HOUSING UNITS, BY COUNTY AND STATE, 2010 AND 2015



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2006-2010 and 2011-2015
NOTE: Costs shown for owner-occupied housing units based only upon those with a mortgage (approximately 89% of all owner-occupied units)

Median monthly housing costs for owner-occupied units (those with mortgages) remained consistent between 2010 and 2015 (**Figure 16**). Owner housing costs were notably higher in Hays and Travis counties compared to the other RHP 7 counties in both years.

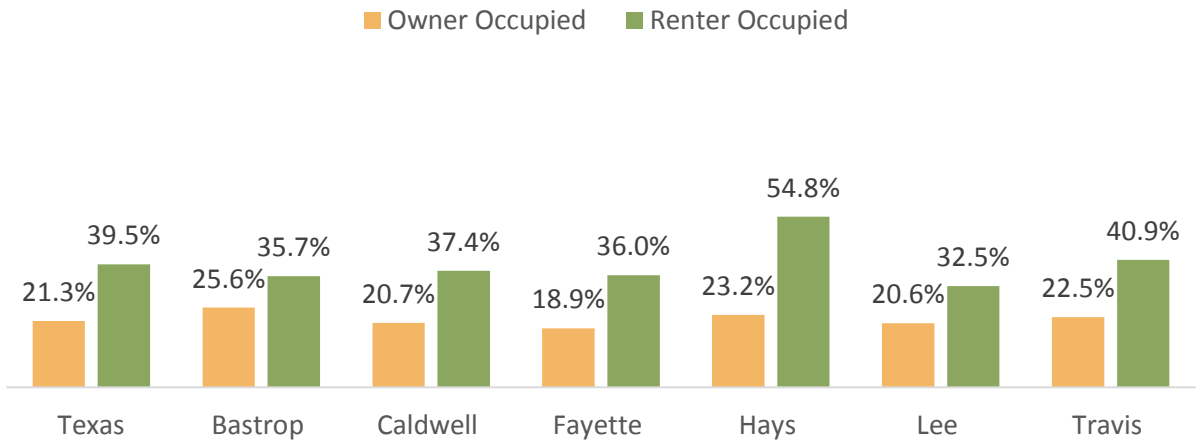
FIGURE 17. MEDIAN MONTHLY HOUSING COSTS FOR RENTER-OCCUPIED HOUSING UNITS, BY COUNTY AND STATE, 2010 AND 2015



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2006-2010 and 2011-2015

In contrast to owner-occupied units, median monthly housing costs for renter-occupied units increased between 2010 and 2015 for all counties in RHP 7 (**Figure 17**). Some counties increased to a lesser extent, such as Bastrop (8% increase) or Caldwell (10.1% increase) counties. However, several counties increased to a larger degree. Renters in Hays County experienced a 20.6% increase in median rental costs and renters in Lee County experienced a 28.2% increase in median rental costs. As of 2015, the median monthly cost for renters was highest in Hays and Travis counties.

FIGURE 18. PERCENT OF HOUSING UNITS THAT ARE COST BURDENED, BY COUNTY AND STATE, 2015



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2006-2010 and 2011-2015
NOTE: Cost burdened is defined by housing costs that equal 35% or more of household income; among owner-occupied housing units based only upon those with a mortgage (approximately 89% of all owner-occupied units)

As of 2015, approximately 20-25% of home owners and over a third of renters met the definition of housing cost burdened[13] across RHP 7 (**Figure 18**). Hays County had the largest proportion of cost burdened renters compared to other RHP 7 counties. Over half of renters in Hays County devoted 35% or more of household income towards housing costs.

[13] U.S. Department of Housing and Urban Development (HUD) defines housing cost burdened as a household that pays more than 30% of their household income for housing costs. Cost burdened households may experience difficulties in paying for other basic needs such as food, transportation, or health care services.

This finding for Hays County is consistent with feedback from participants of the community member focus group held in Hays County. They specifically mentioned the impact Texas State University has on the cost and availability of rental units in the San Marcos area. Participants perceived that landlords in the area tended to have very high-income requirements, often 2 to 6 times the rent being asked, and prefer to cater to student populations.

Key informant interviewees and provider focus group participants consistently perceived that high housing costs greatly impacted the health of community members because it forced them to prioritize paying housing costs over accessing health care or healthy food, as one participant explained: *"The high percentage of their income that they have to spend on housing impacts the other areas of their lives because they have to make decisions about what to prioritize."*

An extensive report on homelessness in Austin,[14] identified 7,101 individuals as homeless in 2016, which was an increase from approximately 6,200 each year in 2013 and 2014, and stable from the count of 7,054 in 2015. It was also estimated that on any given day in 2016, approximately 41% of those experiencing homelessness were unsheltered.

> "You can't treat your mental health or substance abuse issue if you don't have a house."
>
> -Key Informant Interviewee
>
> "The issue of housing is huge – we can stabilize someone, we can divert them from jail but if they don't have secure housing they just cycle back through."
>
> -Provider Focus Group Participant

The report also identified specific health concerns for homeless populations including increased rates of substance use (17% of Austin's homeless reported daily use of drugs or alcohol in prior month) and mental health disorders (44% of Austin's homeless had a current mental health problem). Racial disparity is also evident in the Austin homelessness data. Although Black residents comprise 8% of the total population in Travis County, they made up 42% of Austin's homeless population in 2016.

A few key informant interviewees and provider focus group participants indicated a need for more programming around homelessness, particularly in Austin and Travis County. One interviewee shared that there needed to be more programming focused on getting people into housing and that additional factors could be addressed after that. Stakeholder dialogue participants further pointed out that in the current health care delivery system, patients are generally assumed to have homes and thus lacked the capacity or flexibility required to work effectively with homeless patients.

[14] Homelessness in Austin/Travis County: Current Needs and Gaps Report, Ending Community Homelessness Coalition (ECHO), 2017; http://www.austinecho.org/wp-content/uploads/2017/01/170901-Austin-Homelessness-Needs-Gaps-Analysis-2017.pdf

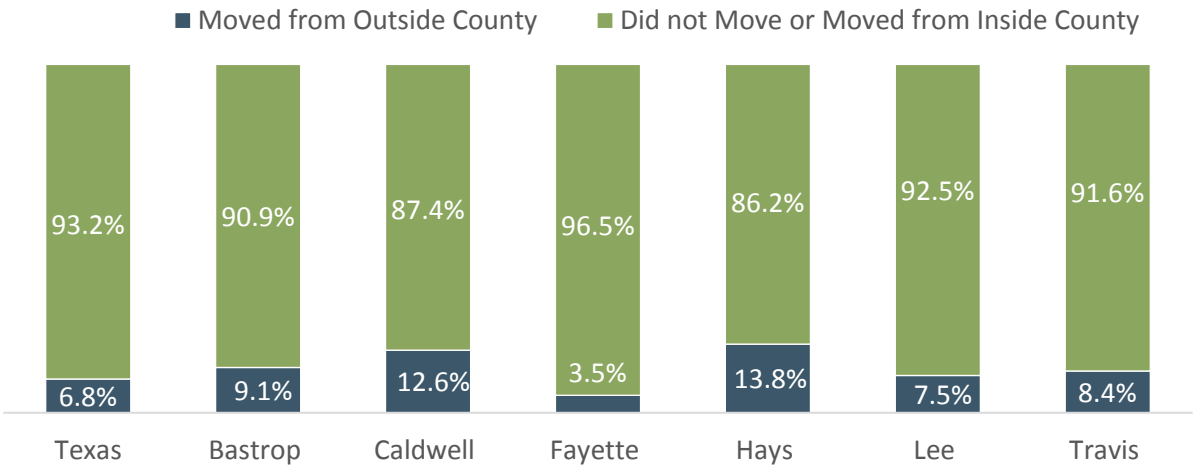
Migration

As the affordability of housing in Austin and Travis County has declined, the common perception across key informant interviews, provider focus groups, and community member focus groups was that individuals and families were increasingly seeking more affordable housing options outside of the urban center and in neighboring counties.

> "Finding affordable rental (or owner) opportunities is getting harder, the market here is very hot right now so families are having to move further and further out from the city (i.e. Austin)."
>
> -Key Informant Interviewee
>
> "If you want to live in a reasonably sized house, you have to move out of Austin and that's pushing people out which causes them to run into transportation issues."
>
> -Key Informant Interviewee

Housing affordability was also discussed in the recent Travis County Community Health Assessment.[15] In it, focus group participants viewed rising housing costs as a major factor in moving towards the outskirts of Austin or out into Travis County. This migration was observed to be common in East Austin, and thus disproportionately impacting the historically underserved Black and Hispanic communities. The Travis County report further noted that this migration served to disconnect residents from central services and increased transportation barriers.

FIGURE 19. IN-MIGRATION OF OVERALL POPULATION, BY COUNTY AND STATE, 2015



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015
NOTES: Proportions based upon population age 1 year and over

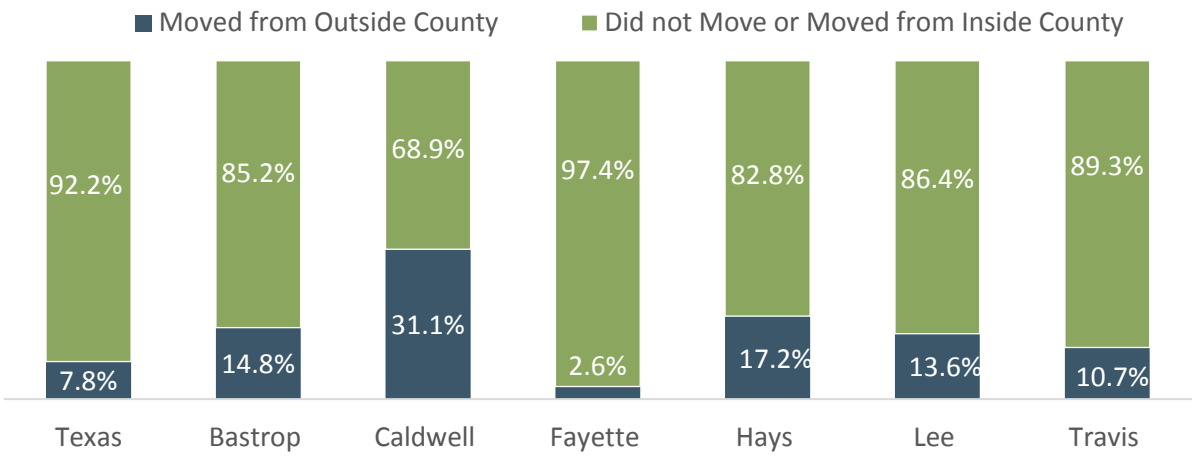
While secondary data demonstrated increased housing costs cost burden in RHP 7, particularly for renters and those in Hays and Travis counties, data quantifying actual population movement out of a county were unavailable. However, data on movement into a county, termed 'in-migration', was

[15] Community Health Assessment – Austin/Travis County, September 2017 Draft; http://austintexas.gov/sites/default/files/files/Health/CHA-CHIP/ATC_CHA_DRAFT_09_26_17__002_.pdf

available from the U.S. Census Bureau. Specifically, this is the proportion of persons who moved to a new household from outside of their current county of residence in the prior year.

As of 2015, the overwhelming majority of individuals (85% or more) reported they had not moved or had only moved within their current county of residence (**Figure 19**). In Texas, 6.8% of the population had relocated to a new county in year prior to the survey. Among the counties of RHP 7, most had rates of in-migration that were higher than the state average. Hays (13.8%) and Caldwell (12.6%) counties had the highest proportions of residents that had moved into the county from elsewhere. In contrast, Fayette County (3.5%) had the lowest in-migration rate.

FIGURE 20. IN-MIGRATION OF POPULATION WITH INCOME <100% FEDERAL POVERTY LINE, BY COUNTY AND STATE, 2015



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015
NOTES: Proportions based upon population age 1 year and over and for whom poverty status is determined

In-migration rates for the population living in poverty (**Figure 20**) were higher compared to the overall rates for most of the RHP 7 counties by an average of about 3 to 5 percentage points. The rate in Caldwell County was markedly high (31.1%), while Bastrop (14.8%), Hays (17.2%), and Lee (13.6%) counties also had in-migration rates among those living in poverty that were higher than Travis County (10.7%).

These findings do suggest that the population living in poverty is more mobile than the general population and that individuals living in poverty in many RHP 7 counties had recently relocated there from another county. While these findings are not definitive, the fact that in-migration rates were generally higher outside of Travis County does provide some support to the perception of key informants and providers that lower income individuals are migrating out of Travis County.

Implications of Migration

As described in the 2012 CNA, much of the health care infrastructure and many social service resources of RHP 7 are centrally located in Travis County. Movement out of Austin or Travis County due to high housing costs or cost of living was perceived by many key informants and providers to have resulted in individuals living further away from necessary health care and social services. At the same time, key informants and providers from outside of Travis stressed the perspective that it has become increasingly hard to meet the need for social health services in their communities due to capacity and funding issues.

Several providers emphasized that county boundaries further complicate the issue for individuals seeking services once they move into a new county. Many find they are no longer eligible to access services in their prior county, since most local health care support services have county-based funding. As one provider stated: *"If you live two miles in that direction, you're not eligible."* This results in vulnerable populations moving further away from needed services due to high cost of living, only to find they are no longer eligible for those services once they cross the county line.

"[The] population that we're attempting to support is moving away from the services that are most helpful to them. It's taken some time to build the infrastructure to support those needs outside of [Austin] – there's a lot of competing infrastructure needs in those communities."

-Key Informant Interviewee (Travis County)

"Compounded with Hays [County] being the fastest growing county, [there are] more and more people competing for limited services. As the population has grown, there's been some response, but it hasn't been proportional to the need."

-Key Informant Interviewee (Hays County)

"[There's] increased demand on our support service – the local food pantry is now at the lowest point in recent years. There's a big demand for support for struggling families."

-Key Informant Interviewee (Bastrop County)

"As soon as you put something in place, it's not enough because of growth"

-Stakeholder Dialogue Participant

Community Health Issues

This section focuses on the wide range of health issues which emerged from the 2017 CNA. This includes the review of secondary data and analyses of key informant interviews, provider and community member focus groups, and the stakeholder survey. The findings included in this section are intended to illustrate the distribution of health conditions and health-related behaviors in RHP 7 communities. Where appropriate and available, data are stratified by race/ethnicity to illustrate the disparities in health outcomes among different sub-populations.

Key themes

Chronic Conditions and Contributing Factors

Across RHP 7 and over the course of the 1115 Waiver period, the top two leading causes of mortality have remained heart disease and/or cancer. Other leading causes of death included chronic lower respiratory diseases, cerebrovascular diseases, accidents, and, increasingly, Alzheimer's disease. Key informants, providers, and community members consistently identified these chronic diseases as the leading issues in their communities, whether in interviews, focus groups, or the stakeholder survey.

Secondary data related to chronic conditions further supported this theme and highlighted that important risk factors were common. Hypertension was found to affect over a quarter of adults in RHP 7 and over a third reported high blood cholesterol. Over half of adults were categorized as overweight or obese, and diabetes was reported by 8% of adults in RHP 7. Racial and ethnic disparities in these chronic conditions and risk factors were prominent. Among Black adults living in RHP 7, nearly 45% reported having hypertension. Diabetes was reported by 12% of Black and 11% of Hispanic adults in RHP 7 and overweight or obesity affected closer to 3 out of every 4 Black or Hispanic adults. These findings were consistent with the recent Travis County Community Health Assessment[16] which reported high disparities in mortality due to a number of chronic conditions -- Black residents in Travis County had higher mortality rates for heart disease, cancer, stroke, and diabetes than White, non-Hispanic residents.

Many key informant interviewees pointed to upstream factors as important contributors to the problems of diabetes and obesity. These included physical activity, access to health food, and a lack of nutrition education. While adults in RHP 7 were more likely to meet aerobic physical activity recommendations than at the state level, still only about half of adults in RHP 7 met these recommendations. Many RHP 7 counties contain areas that have been identified as food deserts, which may impair individuals' access to healthy and nutritious foods. Bastrop County had the largest geographic area identified as food deserts (80.0% of census tracts) with Caldwell County not far behind (62.5%). However, over 40% of census tracts in Travis County were also identified as food deserts.

Key informants that were affiliated with Travis County acknowledged that access to fresh food was a known issue for low-income communities in Travis County. The rate of food insecure individuals in 2015 ranged from a low of 13.2% in Bastrop County, to a high of 16.1% in both Lee and Travis counties. The rate of food insecure individuals was higher among children, approximately 22.0% across RHP 7.

[16] Community Health Assessment – Austin/Travis County, September 2017 Draft; http://austintexas.gov/sites/default/files/files/Health/CHA-CHIP/ATC_CHA_DRAFT_09_26_17__002_.pdf

Behavioral Health and Substance Use

One of the strongest themes to emerge from the 2017 CNA was concern around behavioral health. Nearly 80% of providers responding to the stakeholder survey identified 'mental/behavioral health' as a leading health concern for the low-income population in RHP 7. This concern was further echoed throughout the provider focus groups and key informant interviews. Participants voiced their perceptions that behavioral health issues were increasing and services were lacking.

Secondary data were available to provide some insight into the mental health of the general adult population. Just under 10% of adults living in RHP 7 reported poor mental health and about 15% reported having received a depression diagnosis at some point in their life. Racial/ethnic differences were observed in both indicators. Black adults in RHP 7 had a higher rate of self-reported poor mental health compared to other groups, yet White, non-Hispanic adults were the group most likely to have received a diagnosis of depression.

Many key informants described substance use and abuse as an aspect of their concern around behavioral health in the region. 'Substance use' was identified was the 5th most frequently selected health issue of concern among providers that responded to the stakeholder survey. However, it was not a topic consistently discussed in community member focus groups. Furthermore, only a quarter of community member survey respondents identified 'substance use and abuse' as a Top 5 concern. Some of this inconsistency between the provider and community member perspective may be rooted in the fact that substance use is not as ubiquitous a problem as mental health.

Secondary data did suggest there were some population groups where tobacco or alcohol abuse were continuing concerns. The current smoking rate among adults in RHP 7 was 14.4% and below the state average of 16.5%. However, Black adults in RHP 7 were more likely to be current smokers (20.6%) than other racial/ethnic groups. Binge alcohol consumption among adults was observed to be more common in RHP 7 than the state (21.9% vs. 16.8%). However, binge alcohol was more common among White, non-Hispanic adults (24.2%) and less common among Black adults (11.1%) in RHP 7.

Prenatal Care

While infant mortality rates across RHP 7 remained extremely low (4.8 per 1,000 births in 2014), secondary data on premature births, low-birth weight births, and smoking during pregnancy suggested that there may be some gaps in care for some areas of RHP 7. Both premature births and low-birth weight births were observed to increase between 2012 and 2014 in Caldwell and Fayette counties. The proportions of births with prenatal care in the first trimester was lowest in Caldwell County and the percent of births without any prenatal care had increased between 2012 and 2014 in Caldwell and Fayette counties. These data echoed key informants who indicated that it was harder to access maternity care for community members in more rural areas. Among providers that responded to the stakeholder survey, 63% rated access to prenatal/material care as 'hard' or 'very hard' for the low-income community in RHP 7.

Sexually Transmitted Infections

Secondary data on the incidence of sexually transmitted infections (STIs) suggested a growing problem across RHP 7. The 2012 CNA had noted some evidence of high rates of chlamydia in Travis and Hays counties and a high level of gonorrhea in Travis County. Data for 2015 showed these conditions were now impacting a much larger population across RHP 7. Increases in many counties were dramatic between 2012 and 2015. As of 2015, chlamydia rates in all but Fayette and Lee counties exceeded the state average and gonorrhea rates in Bastrop, Caldwell, and Travis counties exceeded the state average.

Syphilis was also observed to increase in Bastrop, Caldwell, Hays, and Travis counties, though rates remained quite low. Some participants in the stakeholder dialogue activity did highlight education around STIs as a gap in current delivery system.

Connection to Preventive Care

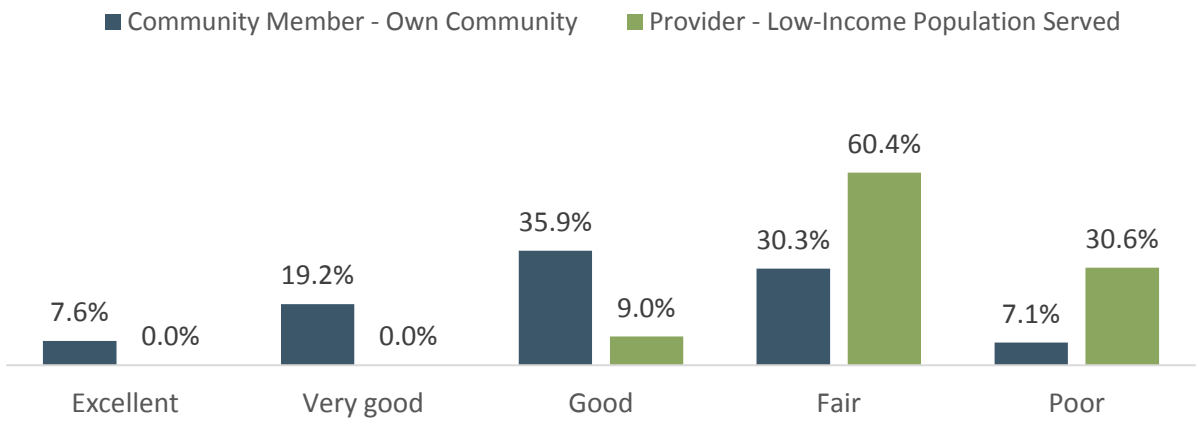
Utilization and engagement with primary care was also found to differ greatly by race and ethnicity. Almost half of Hispanic adults in RHP 7 counties did not have a personal provider, which was more than double the rate for White, non-Hispanic adults. Furthermore, Hispanic (43.0%) and multiracial/other (46.1%) adults were more likely to report they did not have a routine check-up in the prior year than White, non-Hispanic or Black adults in RHP 7. Key informants and provider focus group participants discussed that preventable hospitalizations were related to a lack of mental health care and primary care in the community.

Inadequate access to dental care was identified in the 2012 CNA as a key community need. Results from the 2017 CNA confirms that it remains a need. Providers and community members that responded to the stakeholder survey consistently identified dental care as an area of concern. In addition, the vast majority (89.0%) of providers and nearly half (45.9%) of community members rated access to dental care in the community as 'hard' or 'very hard.' Secondary data showed that 63.2% of adults in RHP 7 had a dental visit in the prior year. Black and Hispanic adults in RHP 7 were less likely than White, non-Hispanic adults to have had a dental visit.

The sub-sections that follow, explore in greater depth the data that were examined around each of these themes. Specific data are discussed in terms of trends and differences between counties and within particularly vulnerable sub-populations.

Perception of Community Health

FIGURE 21. GENERAL PERCEPTION OF THE OVERALL HEALTH OF THE COMMUNITY, 2017



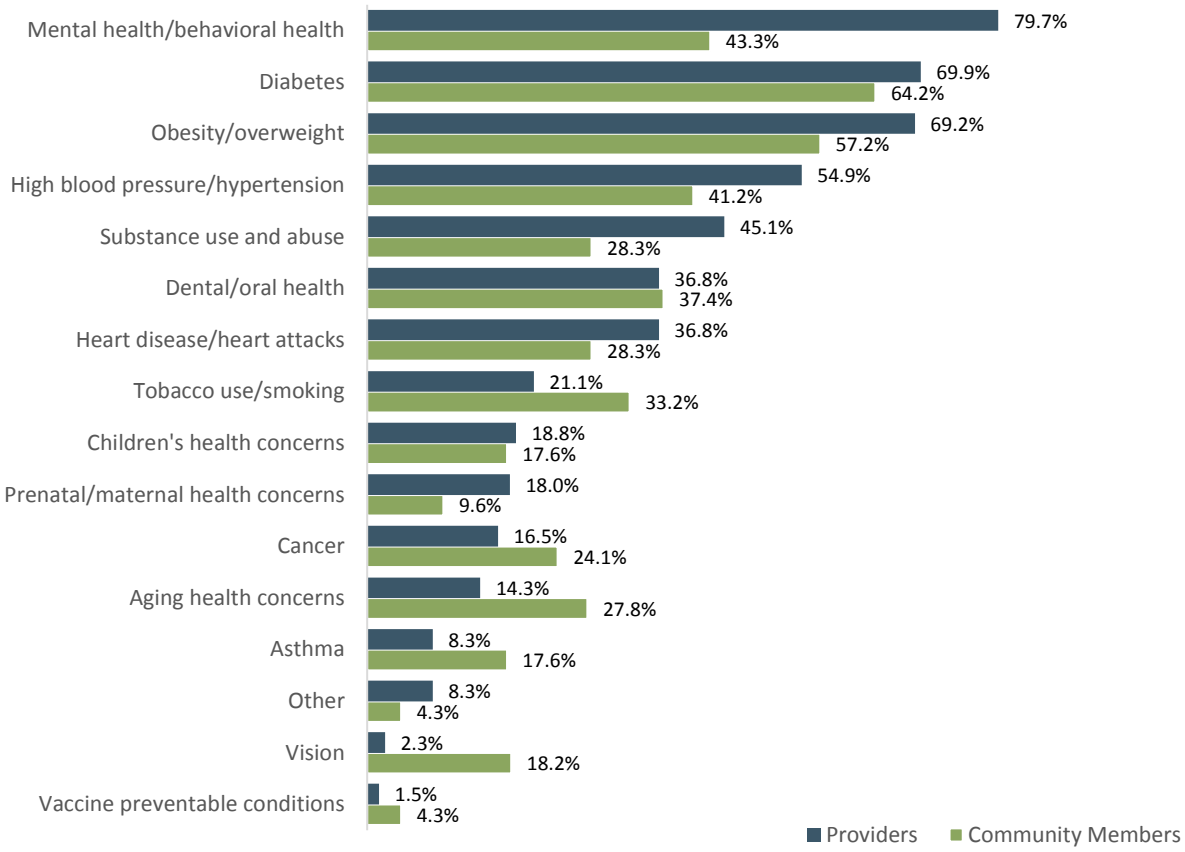
DATA SOURCE: RHP 7 Community Needs Assessment Stakeholder Survey, 2017
NOTE: Community Members responded based upon their own community while Providers responded based upon the low-income population served by their organization

The stakeholder survey asked both providers working in RHP 7 counties and community members living in RHP 7 counties to rate the general overall health of the community. Most community members rated the health of their community as either 'good' (35.9%) or 'fair' (30.3%) (**Figure 21**). Data were explored by county of residence, and community member survey respondents who lived in Bastrop County (n=48)

appeared to be a bit more likely to rate the overall health of their community as 'excellent' (17.4%) compared to respondents living in other counties.

In contrast, providers were asked to rate the overall health of the low-income community (i.e. the Medicaid or uninsured population) in the counties where they worked. Providers tended to rate the health of the community as 'fair' (60.4%) or 'poor' (30.6%). Data were explored by county in which providers worked, including those that worked in multiple counties, and results were similar.

FIGURE 22. HEALTH CONDITIONS RANKED BY FREQUENCY IDENTIFIED AS A "TOP 5" CONCERN BY RHP 7 STAKEHOLDER SURVEY RESPONDENTS, 2017



DATA SOURCE: RHP 7 Community Needs Assessment Stakeholder Survey, 2017
NOTE: Community members responded based upon their own community while providers responded based upon the low-income population served by their organization

The survey additionally asked providers and community members to select what they perceived were the 'Top 5' health concerns for community members from a comprehensive list of health conditions. The most frequently selected health concerns were consistent between community members and providers (**Figure 22**); these included mental health/behavioral health, diabetes, overweight/obesity, high blood pressure/hypertension, substance use and abuse, and dental/oral health.

There were health concerns that one group emphasized more than the other. Providers were more likely to select 'substance use and abuse' as a Top 5 health concern (45.1% of providers vs. 28.3% of community members), while community members selected tobacco use/smoking (33.2% of community members vs. 21.1% of providers), and aging health concerns (27.8% of community members vs. 14.3% of providers) more frequently than providers. Cancer, asthma, and vision were also issues that community members were more likely to select as a Top 5 concern compared to providers.

Leading Causes of Mortality

TABLE 4. TOP FIVE LEADING CAUSES OF MORTALITY, BY COUNTY AND STATE, 2012

	Texas	Bastrop	Caldwell	Fayette	Hays	Lee	Travis
1	Heart disease	Cancer	Heart disease	Heart disease	Cancer	Cancer	Cancer
2	Cancer	Heart disease	Cancer	Cancer	Heart disease	Heart disease	Heart disease
3	Chronic lower respiratory diseases	Chronic lower respiratory diseases	N/A	Cerebro-vascular diseases	Accidents	N/A	Accidents
4	Accidents	Accidents	N/A	N/A	Cerebro-vascular diseases	N/A	Cerebro-vascular diseases
5	Cerebro-vascular diseases	Cerebro-vascular diseases	N/A	N/A	Chronic lower respiratory diseases	N/A	Chronic lower respiratory diseases

DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, 2015
NOTE: Ranking based on age-adjusted rates; N/A denotes insufficient sample size to calculate a reliable rate or data suppressed due to confidentiality constraints; accidents include transportation related injuries (e.g. care accidents), falls, drowning or submersion, exposure to smoke, fire and flames, discharge of firearms, and poisoning or exposure to noxious substances.

The leading causes of mortality for 2012 and 2015 are shown in **Table 4** (above) and **Table 5** (below). Cancer and heart disease have consistently been the two leading causes of death for residents in all RHP 7 counties and this was persistent over time. Other leading causes of death ranking behind these top two included chronic lower respiratory diseases, cerebrovascular diseases (i.e. stroke), and accidents for both 2012 and 2015. By 2015, Alzheimer's disease had risen in both Bastrop and Hays counties as a leading cause of death. This is consistent with the growing number of residents that are age 65 or older in both Bastrop and Hays counties, and is a trend that is likely to continue in these and the other RHP 7 counties.

TABLE 5. TOP FIVE LEADING CAUSES OF MORTALITY, BY COUNTY AND STATE, 2015

	Texas	Bastrop	Caldwell	Fayette	Hays	Lee	Travis
1	Heart disease	Heart disease	Cancer	Heart disease	Heart disease	Cancer	Cancer
2	Cancer	Cancer	Heart disease	Cancer	Cancer	Heart disease	Heart disease
3	Cerebro-vascular diseases	Accidents	N/A	Cerebro-vascular diseases	Accidents	N/A	Accidents
4	Chronic lower respiratory diseases	Alzheimer's disease	N/A	N/A	Chronic lower respiratory diseases	N/A	Cerebro-vascular diseases
5	Alzheimer's disease	Chronic lower respiratory diseases	N/A	N/A	Alzheimer's disease	N/A	Chronic lower respiratory diseases

DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, 2015
NOTE: Ranking based on age-adjusted rates; N/A denotes insufficient sample size to calculate a reliable rate or data suppressed due to confidentiality constraints; accidents include transportation related injuries (e.g. care accidents), falls, drowning or submersion, exposure to smoke, fire and flames, discharge of firearms, and poisoning or exposure to noxious substances.

Chronic Disease and Contributing Factors

Chronic diseases and their associated risk factors came up consistently from community members, providers, and key informants alike. Community member focus group participants identified diabetes, hypertension, and chronic lung diseases as particularly prevalent in their communities. Provider focus group participants and stakeholders more consistently identified diabetes and obesity as leading issues for the communities where they work.

Key informants and providers also tended to connect the perceived prevalence of these chronic diseases with upstream factors, such as a lack of nutrition education programming and limited access to healthy, affordable food.

Consistent with these focus group findings, respondents to the stakeholder survey further emphasized chronic health conditions as the major concerns across the region. As noted earlier, diabetes, obesity and overweight, and high blood pressure/hypertension were all concerns that were among the most frequently selected by community members and providers as Top 5 health concerns.

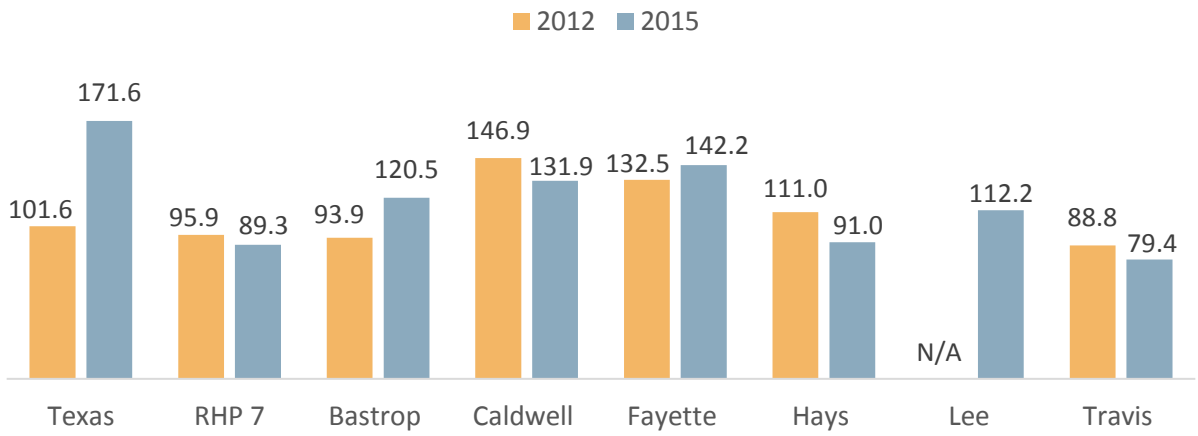
> "Obesity and diabetes really rise to the top for me and that is related to so many other conditions. It appears to be a regional issue too, but slightly lower in Travis County than others."
>
> -Key Informant Interviewee
>
> "There are a lot of issues around chronic diseases - these are particularly prevalent and relate to issues of nutrition and obesity."
>
> -Key Informant Interviewee
>
> "Some of the health problems are more related to healthy food, physical exercise – it's more related to socio-economic status."
>
> -Provider Focus Group Participant

Cardiovascular Disease and Related Conditions

Coronary heart disease is the main form of heart disease. It is a disease of the blood vessels the heart that can lead to the blockages of an artery or heart attack. Heart disease is one of several cardiovascular diseases, which affect the heart and blood vessel system. Other cardiovascular diseases include stroke, hypertension, angina (chest pain), and rheumatic heart disease, high blood pressure, diabetes, and high blood cholesterol are major risk factors for the development of heart disease. Lifestyle factors such as smoking, physical inactivity, and obesity also contribute to increased risk[17].

[17] Lower Heart Disease Risk, National Heart, Lung, and Blood Institute, 2017; https://www.nhlbi.nih.gov/health/educational/hearttruth/lower-risk/what-is-heart-disease.htm

FIGURE 23. HEART DISEASE MORTALITY RATE PER 100,000 POPULATION, BY COUNTY AND STATE, 2012 AND 2015

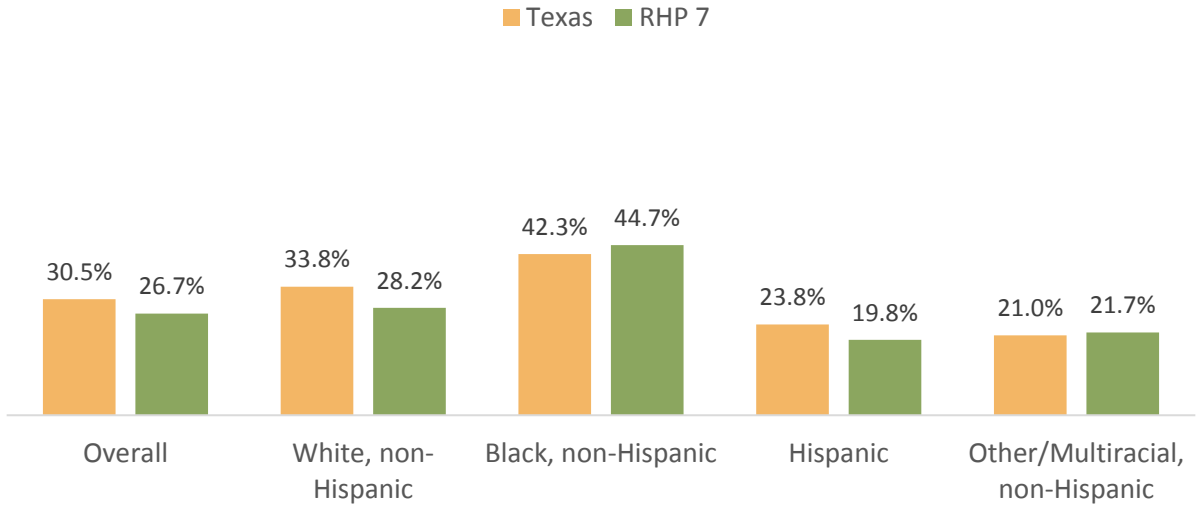


DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, 2012 and 2015
NOTE: Heart Disease Includes ICD-10 codes I00-I02, I05-I09, I11.0, I11.9, I13.0, I13.1, I13.2, I13.9, I20-I25; rates shown are age-adjusted; N/A denotes insufficient sample size to calculate a reliable rate or data suppressed due to confidentiality constraints

As previously noted, heart disease has remained leading causes of death in Texas and across RHP 7. Between 2012 and 2015, the state rate for heart disease mortality increased dramatically and exceeded the rate in each of the RHP 7 counties (**Figure 23**). Within RHP 7, deaths due to heart disease are highest in Caldwell (131.9 deaths per 100,000) and Fayette (142.2 deaths per 100,000) counties.

High blood pressure and hypertension were considered top health concerns by respondents of the stakeholder survey. Among providers, 54.9% considered it a Top 5 concern, as did 41.2% of community members.

FIGURE 24. ADULTS REPORTED TO HAVE HAD HIGH BLOOD PRESSURE, BY RACE/ETHNICITY, REGION, AND STATE, 2015

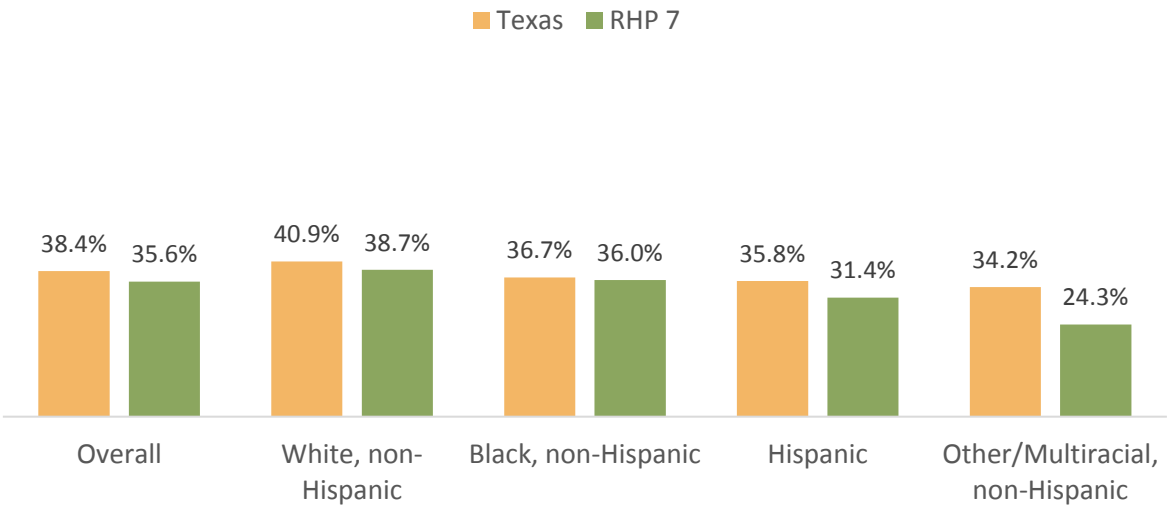


DATA SOURCE: Texas Behavioral Risk Factor Surveillance Survey (BRFSS), 2011-2015
NOTE: Survey data based upon self-report

Texas BRFSS data aggregated across RHP 7 counties showed that over a quarter of adults (26.7%) reported they have had high blood pressure (**Figure 24**), which was slightly lower than the state average

of 30.5%. When examined by race/ethnicity, Black adults were much more likely to report high blood pressure (44.7%) compared to all other race and ethnic groups living in RHP 7.

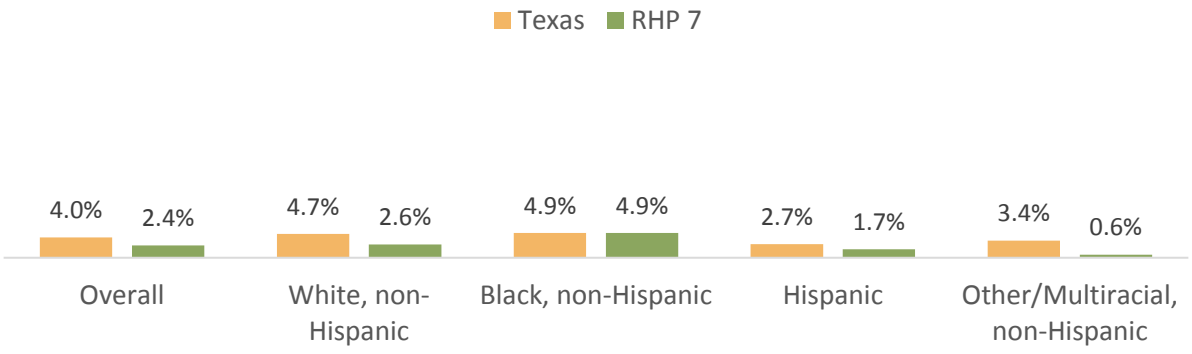
FIGURE 25. ADULTS REPORTED TO HAVE HAD HIGH BLOOD CHOLESTEROL, BY RACE/ETHNICITY, REGION, AND STATE, 2015



DATA SOURCE: Texas Behavioral Risk Factor Surveillance Survey (BRFSS), 2011-2015
NOTE: Survey data based upon self-report

Texas BRFSS data aggregated across RHP 7 counties showed that 35.6% of adults reported they have had high blood cholesterol (**Figure 25**) which was similar to the state. Only slight differences by race/ethnicity were observed. However, when asked whether they had had their blood cholesterol checked in the prior 5 years, the proportion of adults RHP 7 reporting they hadn't, varied greatly by race and ethnicity: 20.4% of White, non-Hispanic adults, 37.0% of Black adults, 36.5% of Hispanic adults, and 31.6% of other/multiracial adults. Furthermore, the observed disparity between White, non-Hispanic and Black adults for this indicator was more pronounced in RHP 7 compared to Texas (20.6% White, non-Hispanic and 24.0% Black in Texas overall).

FIGURE 26. ADULTS REPORTED TO HAVE HAD A HEART ATTACK BY RACE/ETHNICITY, REGION AND STATE, 2015

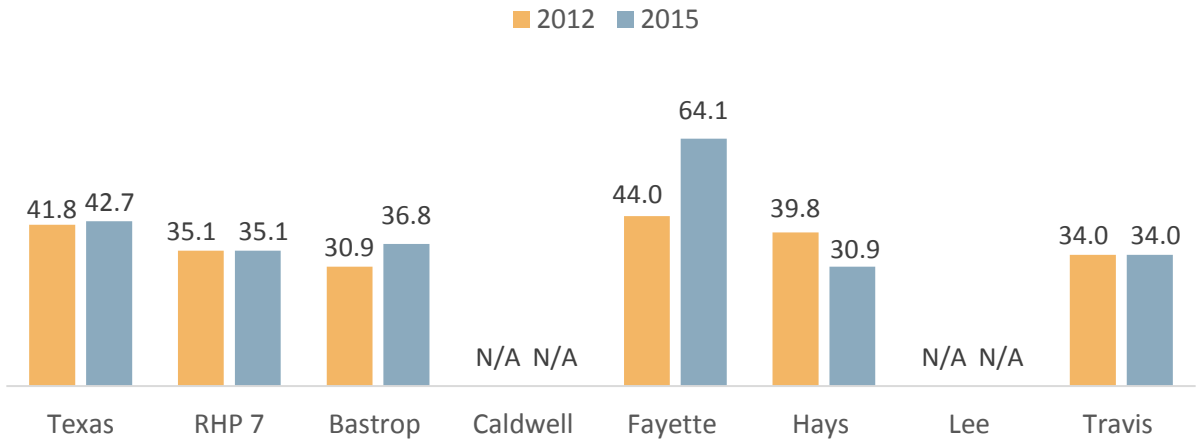


DATA SOURCE: Texas Behavioral Risk Factor Surveillance Survey (BRFSS), 2011-2015
NOTE: Survey data based upon self-report

The proportion of adults in RHP 7 that reported having had a heart attack was about half the state's rate (2.4% in RHP 7 vs. 4.0% in Texas) (**Figure 26**). This region-state difference was not observed among Black adults in RHP 7 who had a rate of 4.9% which mirrored the state rate for Black adults.

While the prevalence of self-reported heart attack is relatively low among the general adult population, it was a concern within the community. Heart disease and heart attack were frequently identified as a Top 5 health concerns affecting the community by community members (28.3%) and providers (36.8%) that responded to the stakeholder survey.

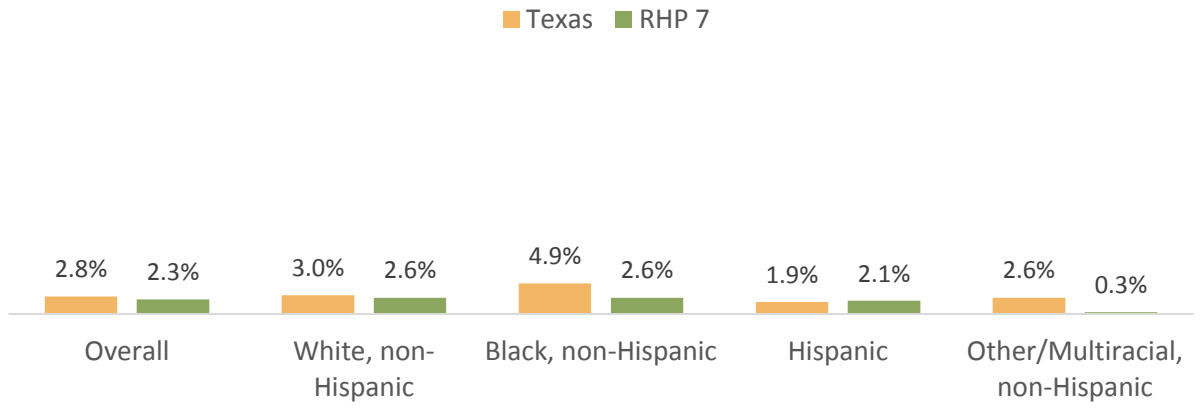
FIGURE 27. CEREBROVASCULAR DISEASE MORTALITY RATE PER 100,000 POPULATION, BY COUNTY AND STATE, 2012 AND 2015



DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, 2012 and 2015
NOTE: Cerebrovascular disease includes ICD-10 codes I60-I69; rates shown are age-adjusted; N/A denotes insufficient sample size to calculate a reliable rate or data suppressed due to confidentiality constraints

While reliable estimates for cerebrovascular (i.e. stroke) mortality were not available for all counties and all years, rates in Bastrop, Hays, and Travis counties were all lower than the state rate of 42.7 deaths per 100,000 in 2015 (**Figure 27**). In contrast, Fayette County had higher rates and a notable increase in cerebrovascular deaths, from 44.0 deaths per 100,000 in 2012 to 64.1 deaths per 100,000 in 2015.

FIGURE 28. ADULTS REPORTED TO HAVE HAD A STROKE BY RACE/ETHNICITY, REGION, AND STATE, 2015



DATA SOURCE: Texas Behavioral Risk Factor Surveillance Survey (BRFSS), 2011-2015
NOTE: Survey data based upon self-report

The proportion of adults in RHP 7 that reported having had a stroke was similar to the state (2.3% in RHP 7 vs. 2.8% in Texas) (**Figure 28**). Rates were also similar across most racial and ethnic groups in RHP 7, although a very low proportion of adults who identified as multiracial or an 'other' race reported having had a stroke (0.3%).

Strokes are indicators of cerebrovascular disease and are most often experienced by individuals age 65 or older, so while the self-reported prevalence of stroke is relatively low in the general adult population, it does remains a concern for the region given that cerebrovascular disease was a leading cause of death across the RHP 7 counties. Additionally, 'aging health concerns' as a broad category was identified as a Top 5 concern by 27.8% of community members that responded to the stakeholder survey.

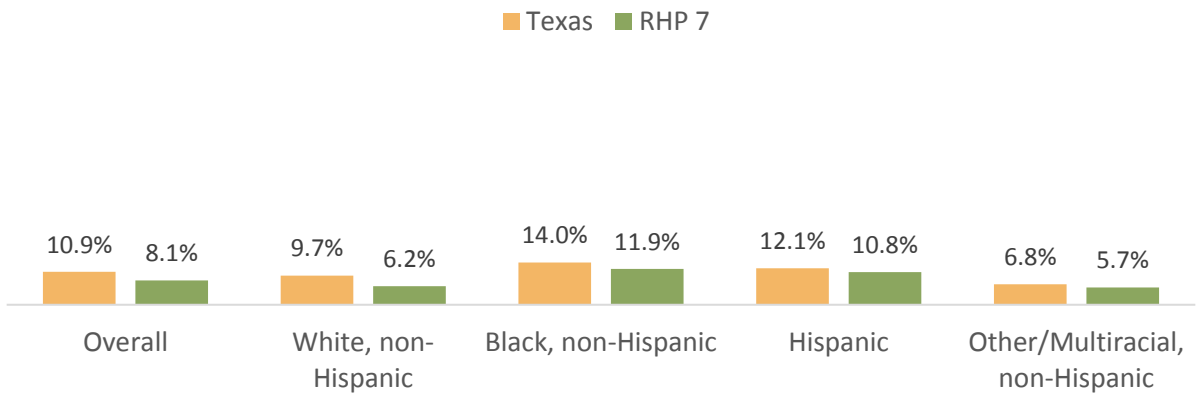
Diabetes

As noted previously, diabetes was consistently identified as a pressing health concern by key informants, providers, and community members across RHP 7. Diabetes was the most frequently selected Top 5 health concern by community members (64.2%) and the second most frequently selected Top 5 health condition by providers (69.9%) on the stakeholder survey.

During interviews and focus groups, several key informants and providers noted that diabetes is directly impacted by other upstream factors such as access to and affordability of healthy food, opportunities for physical exercise, and the cost of medications. This can create challenging health care situations as one provider clearly stated: *"We want to send someone home with a diabetes care plan [to follow] but they have housing insecurity, they have food insecurity, and they're just trying to eat at all."*

One key informant shared that their vision for the future of the region was for a county-level 'Metabolic Initiative' that could focus on achievable interventions, such as walking paths, to address chronic health conditions like diabetes and hypertension.

FIGURE 29. ADULTS REPORTED TO HAVE BEEN DIAGNOSED WITH DIABETES BY RACE/ETHNICITY, REGION, AND STATE 2015



DATA SOURCE: Texas Behavioral Risk Factor Surveillance Survey (BRFSS), 2011-2015
NOTE: Survey data based upon self-report

Texas BRFSS data aggregated across RHP 7 counties showed that approximately 8% of adults reported they had diabetes (**Figure 29**), which was lower than the state average of 10.9%. When data were examined by race/ethnicity, Black adults (11.9%) and Hispanic adults (10.8%) were more likely to report diabetes compared to other race or ethnic groups living in RHP 7. These differences by race and ethnicity were consistent with differences observed at the state level.

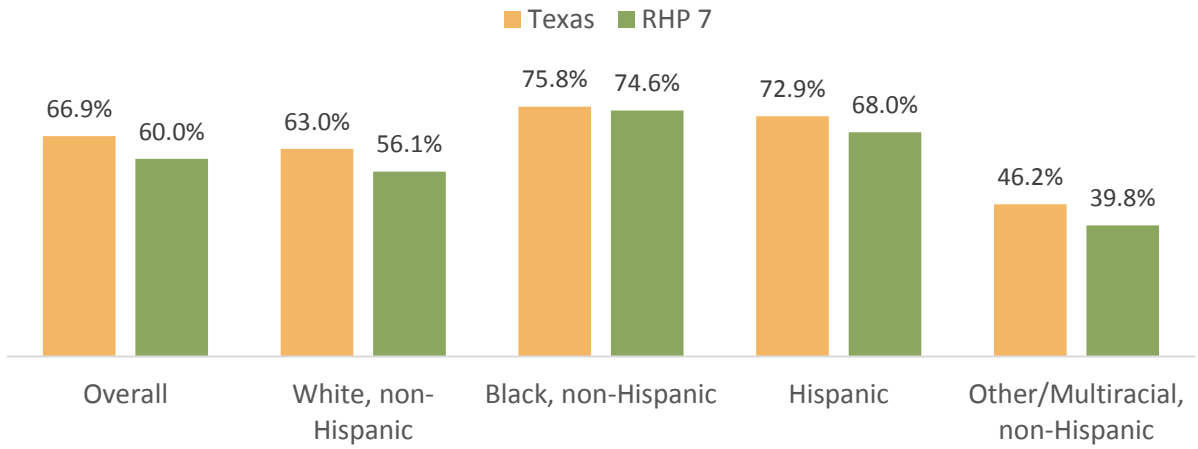
Obesity

Obesity arose frequently during key informant interviews and focus groups when the topic of diabetes was discussed. Overweight and obesity are a major risk factor for the development of type II diabetes, as

well as other chronic health conditions like hypertension, high cholesterol, sleep apnea, asthma, musculoskeletal disorders, and some cancers.[18]

Obesity was the second most frequently selected Top 5 health concerns of concern by community members (57.2%) and the third most frequently selected Top 5 health concern by providers (69.2%) on the stakeholder survey.

FIGURE 30. ADULTS REPORTED TO BE OVERWEIGHT OR OBESE BY RACE/ETHNICITY, REGION, AND STATE, 2015



DATA SOURCE: Texas Behavioral Risk Factor Surveillance Survey (BRFSS), 2011-2015
NOTE: Survey data based upon self-report; Overweight/Obese defined by BMI ≥ 25

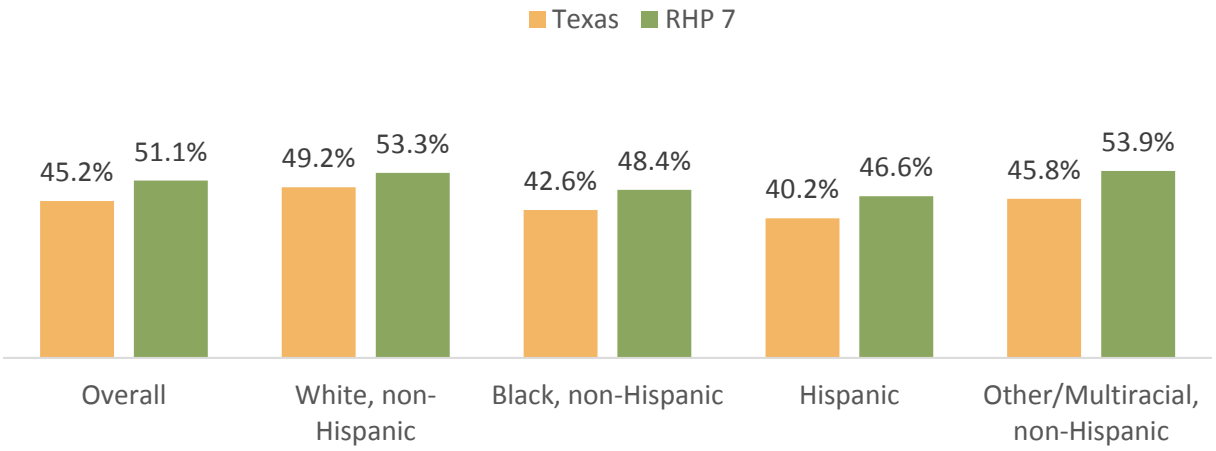
Texas BRFSS data aggregated across RHP 7 counties showed that 60.0% of adults were categorized as overweight or obese, based upon a Body Mass Index (BMI) of 25 or higher (**Figure 30**). This rate was lower than the state average of 66.9%. When data were examined by race/ethnicity, Black adults (74.6%) and Hispanic adults (68.0%) were more likely to be overweight or obese compared to other race and ethnic groups living in RHP 7. These differences by race and ethnicity were consistent with differences observed at the state level.

Physical Activity

Regular physical activity provides numerous health benefits. Independent from the effect of helping to maintain a healthy body weight, physical activity can reduce the risk of type II diabetes, cardiovascular disease, and some cancers. In addition, physical activity supports bone density and is associated with improved mood and mental health.[19]

[18] Explore Overweight and Obesity, National Heart, Lung, and Blood Institute, 2017; https://www.nhlbi.nih.gov/health/health-topics/topics/obe
[19] Physical Activity and Health, Centers for Disease Control and Prevention, 2015; https://www.cdc.gov/physicalactivity/basics/pa-health/index.htm

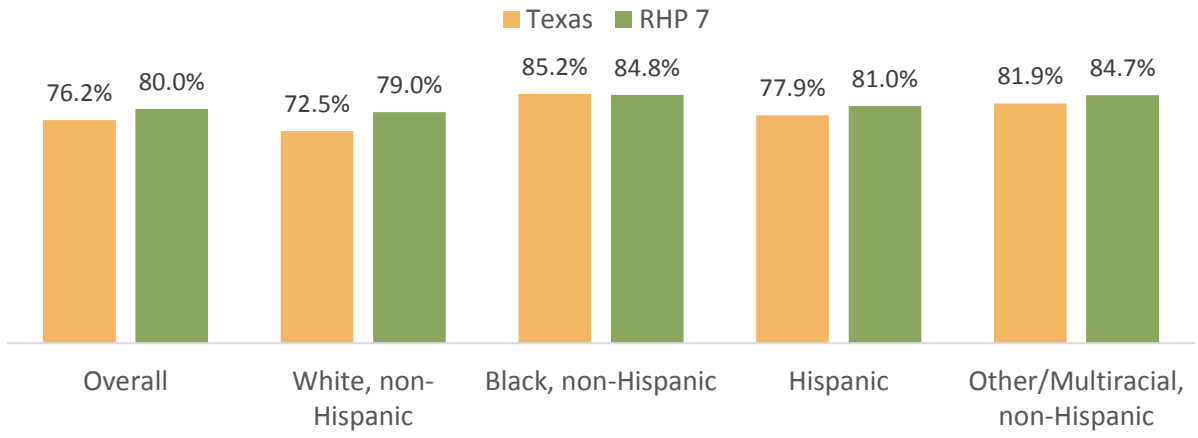
FIGURE 31. ADULTS REPORTED TO HAVE MET AEROBIC RECOMMENDATIONS BY RACE/ETHNICITY, REGION, AND STATE, 2015



DATA SOURCE: Texas Behavioral Risk Factor Surveillance Survey (BRFSS), 2011-2015
NOTE: Survey data based upon self-report

Texas BRFSS data aggregated across RHP 7 counties showed that about half of all adults (51.1%) reported physical activity at a level that met aerobic recommendations[20] (**Figure 31**). This rate was slightly higher than the state average of 45.2%. When data were examined by race/ethnicity, Black adults (48.4%) and Hispanic adults (46.6%) were slightly less likely to meet recommendations compared to other race and ethnic groups living in RHP 7. These differences by race and ethnicity were consistent with differences observed at the state level.

FIGURE 32. ADULTS REPORTED TO HAVE NEIGHBORHOOD ACCESS TO PHYSICAL ACTIVITY BY RACE/ETHNICITY, REGION, AND STATE, 2015



DATA SOURCE: Texas Behavioral Risk Factor Surveillance Survey (BRFSS), 2011-2015
NOTE: Survey data based upon self-report

The Centers for Disease Control and Protection recommends municipalities create environments that encourage physical activity by providing adequate space and opportunity. Texas BRFSS data showed that 80% of adults in RHP 7 reported having neighborhood access to physical activity (**Figure 32**). When

[20] Aerobic recommendations are defined by the Texas BRFSS as at least 300 minutes/week of moderate-intensity aerobic physical activity or 150 minutes/week of vigorous-intensity aerobic activity, or an equivalent combination.

examined by race/ethnicity, Black adults (84.8%) and adults that identified as multiracial or an 'other' race (84.7%) were slightly more likely to report access to physical activity than other race or ethnic groups living in RHP 7. These differences by race and ethnicity were consistent with differences observed at the state level.

> "The community does have membership gyms but you have to have money for a membership. Lots of people don't have money to throw away. [In other cities] you see the community itself doing it and taking control."
>
> -Community Member Focus Group Participant

> "A good number of folks don't have access to rec[reational] space which contributes to obesity and obesity related issues."
>
> -Key Informant Interviewee

Despite the data suggesting there is a high level of neighborhood access to physical activity, several community member focus group participants expressed a need for more affordable options for physical activity in their communities. While several community members cited rivers, lakes, and parks as positive strengths to their community, these were not discussed as locations for physical activity. Rather, many community members shared ideas about low- or no-cost exercise activities that could be organized that would improve health and build a great sense of community and overcome the need to join a costly gym. This focus on the affordability of fitness facilities was echoed by key informants who noted the lack of opportunities for physical activity contributed to chronic diseases.

Food Access and Food Insecurity

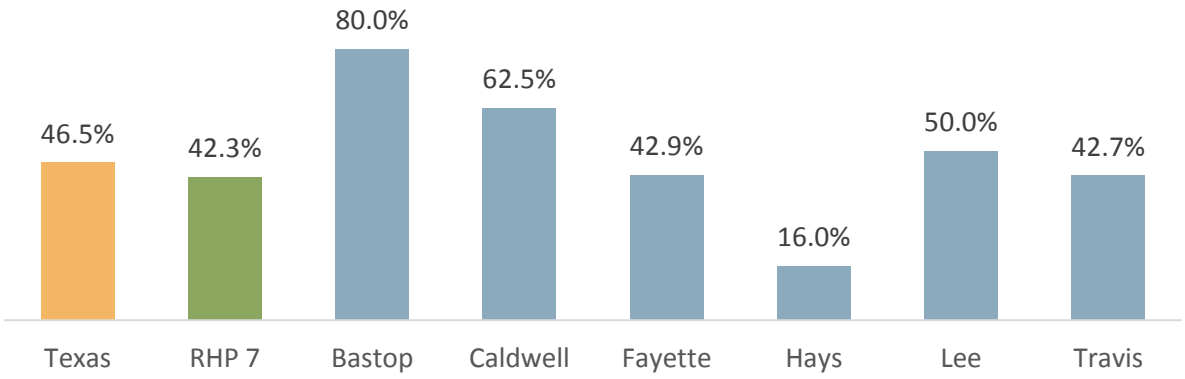
Access to healthy, affordable food was noted as a pressing health concern for low-income community members by several key informant interviewees. Many linked the lack of access to healthy food to perceived high rates of chronic disease, like diabetes. Others discussed how the population growth in Austin is impacting access to health food. Specifically, as the high cost of living leads people to move away from Austin's city center, they end up farther away from grocery stores. The high cost of living was also implicated by key informants as causing residents to sacrifice buying healthy food in order to afford their housing and/or transportation costs.

> "Our population does not have access to fresh food and they live in food deserts. They tend not to build nice shiny grocery stores in poor places."
>
> -Key Informant Interviewee (Travis County)

The commonly understood definition of a 'food desert' is a geographic area that lacks access to affordable and healthy foods, largely because of a lack of grocery stores, farmers' markets, or healthy

food providers. However, accessibility and distance to these types of food sources is also considered.[21] Individuals living in food deserts and who have low-incomes or those who lack transportation, may end up relying on smaller neighborhood stores which often do not carry healthy foods or may only offer them at higher prices.

FIGURE 33. CENSUS TRACTS IDENTIFIED AS FOOD DESERTS, BY COUNTY AND STATE, 2015



DATA SOURCE: U.S. Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2015, as cited by Community Commons
NOTE: Tracts in which at least 500 people or 33% of the population lives farther than 1 mile (urban) or 10 miles (rural) from the nearest supermarket

According to the USDA, just over 40% of census tracts across RHP 7 meet the definition of a 'food desert' (**Figure 33**). While this regional average is on par with the state rate, there is a lot of variation among RHP 7 counties. Most notably, 80% of census tracts in Bastrop County and 62.5% of census tracts in Caldwell County were identified as food deserts, while in Hays County, only 16% of census tracts were considered food deserts.

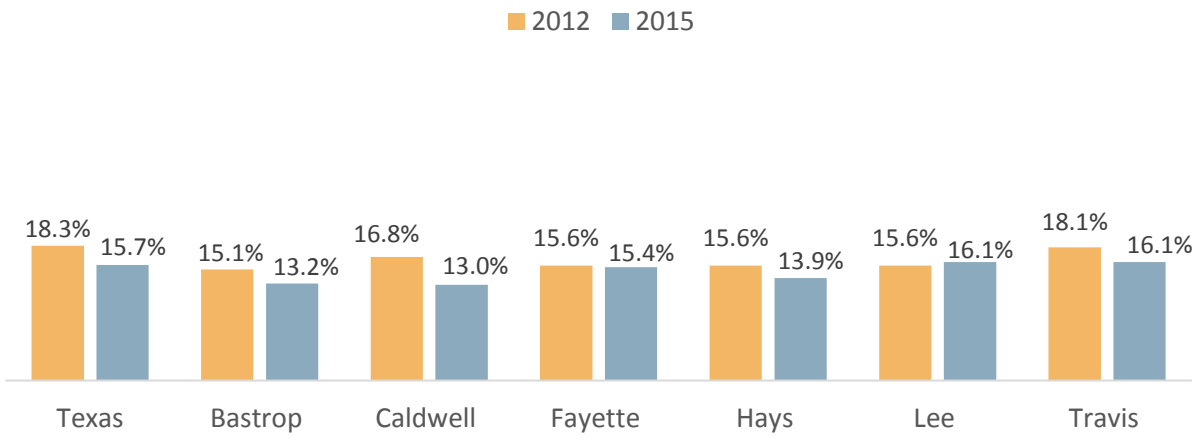
Other measures of healthy food access and environmental influences on dietary behaviors include business data related to the numbers and rates of different types of retail food establishments. Detailed data related to the concentrations of supermarkets, convenience stores, and fast food restaurants within each RHP 7 county can be found in the **RHP 7 CNA Appendix.**

Food insecurity is defined by Feeding America as *"the lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods."* They further emphasis that food insecurity may also require a household to make trade-offs between basic needs, such as housing, and buying nutritionally adequate foods.

The health implications of food insecurity are far-reaching across the lifespan. In children, food insecurity increases the risk for iron-deficiency anemia, asthma, mental health problems, and behavioral disorders. Food insecure adults are at increased risk of diabetes, hypertension, and high blood pressure, as well as mental health problems. Older adults may experience a decreased ability to maintain their independence as they age.[22]

[21] Food Access Research Atlas Documentation, USDA Economic Research Service; https://www.ers.usda.gov/data-products/food-access-research-atlas/documentation/
[22] Food Insecurity, Health, and Health Care, Feeding America, 2016; https://cvp.ucsf.edu/resources/Seligman_Issues_Brief_1.24.16.pdf

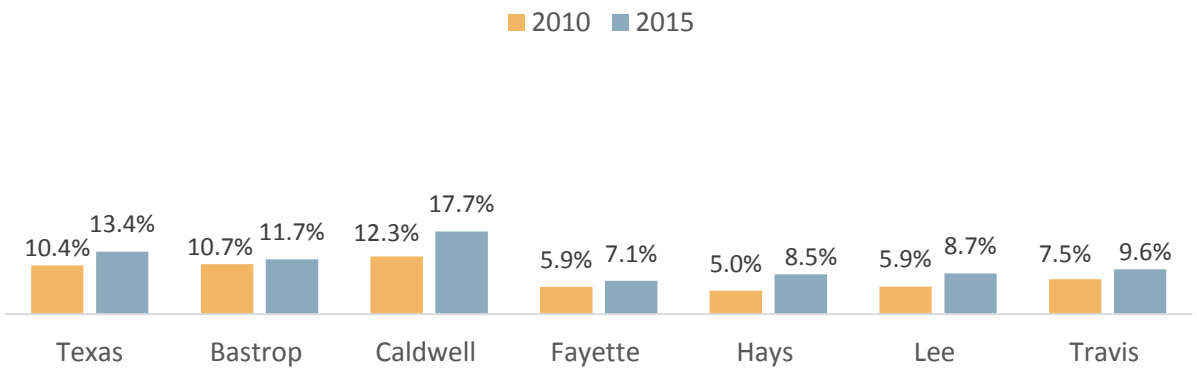
FIGURE 34. POPULATION THAT IS FOOD INSECURE, BY COUNTY AND STATE, 2012 AND 2015



DATA SOURCE: Feeding America, Map the Meal Gap, Food Insecurity and Child Food Insecurity Estimates at the County Level, 2012 and 2015

As of 2015, approximately 13% to 16% of individuals in RHP 7 counties were food insecure (**Figure 34**). The rate was highest in Lee (16.1%) and Travis (16.1%) counties and lowest in Bastrop (13.2%) and Caldwell (13.0%) counties. Importantly, except for Lee County which increased slightly, the rates of food insecurity had declined from 2012 for most RHP 7 counties. When examined by age group, food insecurity was found to be more prevalent for children under 18 years. According to further data from Feeding America, approximately 22% of children were food insecure in RHP 7 and rates were similar between counties in 2015.

FIGURE 35. HOUSEHOLDS RECEIVING SNAP BENEFITS, BY COUNTY AND STATE, 2010 AND 2015



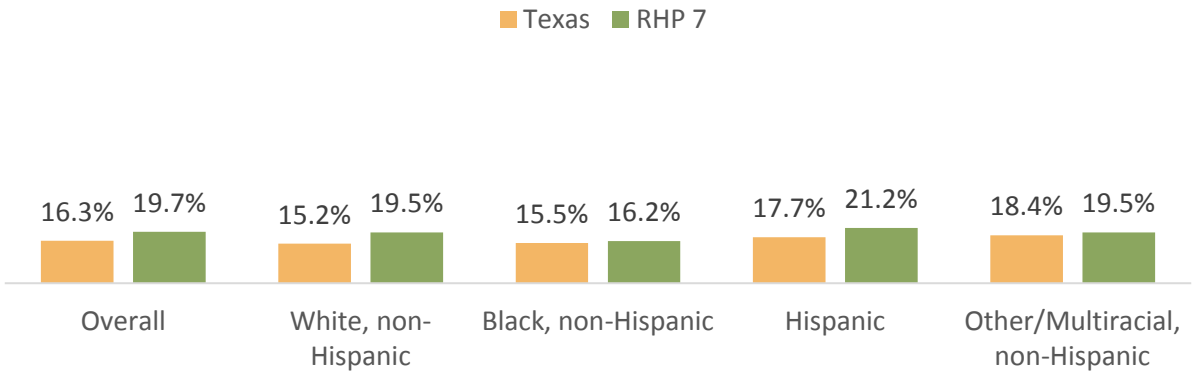
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2006-2010 and 2011-2015

For households with income below 130% FPL, the Supplemental Nutrition Assistance Program (SNAP)[23] is the main federal nutrition assistance program that helps buy healthy foods. The proportion of households receiving SNAP benefits increased between 2010 and 2015 at the state level as well as in each RHP 7 county (**Figure 35**). As of 2015, SNAP utilization was highest in Caldwell (17.7%) and Bastrop (11.7%) counties, but lower than 10% in Fayette, Hays, Lee, and Travis counties.

[23] Supplemental Nutrition Assistance Program (SNAP), USDA Food and Nutrition Service; https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap

While food insecurity and poverty are related to one another, they are not the same thing. According to the U.S. Department of Agriculture, 26% of food-insecure households in the U.S. live above 185% of the poverty line[24] and thus, families with incomes well above 130% FPL who reside in high cost of living areas, may find their resources do not extend far enough to include a healthy and adequate diet.

FIGURE 36. ADULTS REPORTED TO CONSUME FRUITS AND VEGETABLES FIVE OR MORE TIMES PER DAY, BY RACE/ETHNICITY, REGION, AND STATE, 2015

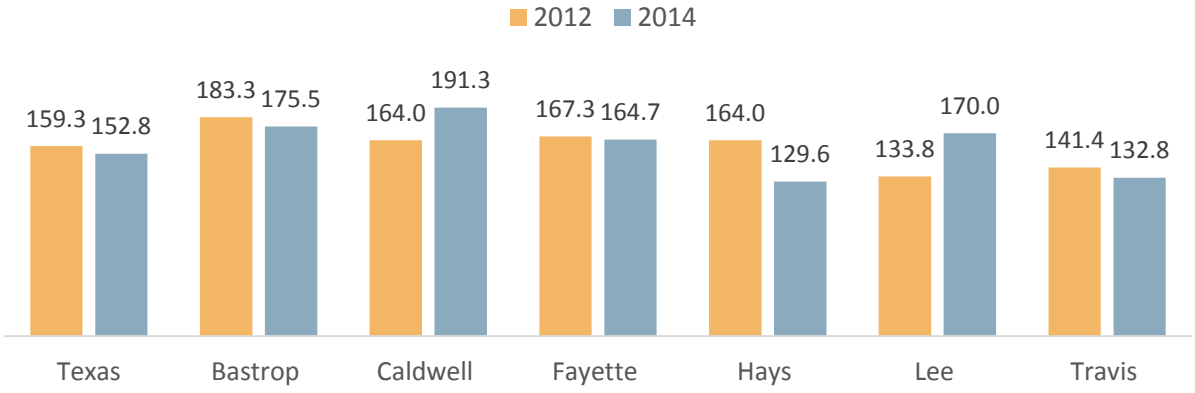


DATA SOURCE: Texas Behavioral Risk Factor Surveillance Survey (BRFSS), 2011-2015
NOTE: Survey data based upon self-report

A healthy and nutritious diet includes adequate servings of fruit and vegetables. Texas BRFSS data aggregated across RHP 7 counties showed that less than 20% of adults in RHP 7 are consuming fruit and vegetables five or more times per day (a proxy for the recommended five servings of fruit and vegetables per day) (**Figure 36**). When data were examined by race and ethnicity, Hispanic adults had the highest rate of recommended fruit and vegetable consumption (21.1%) while Black adults had the lowest rate (16.2%). This difference by race was similar to the difference observed at the state level.

Cancer

FIGURE 37. OVERALL CANCER MORTALITY RATE PER 100,000 POPULATION, BY COUNTY AND STATE 2012 AND 2014



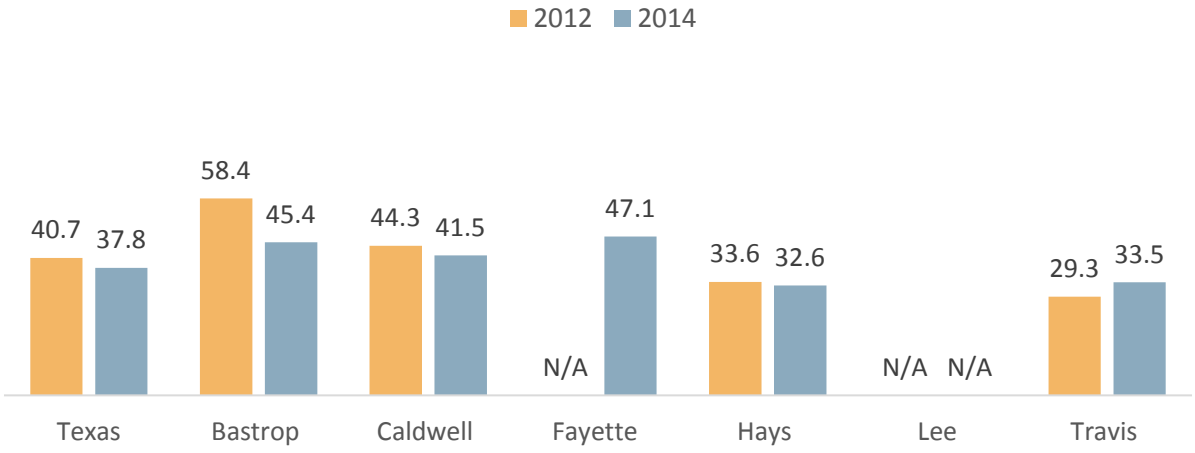
DATA SOURCE: Texas Department of State Health Services, Texas Cancer Registry, 2012 and 2014
NOTE: Rates shown are age-adjusted

Texas Cancer Registry data are shown in **Figure 37**. As of 2014, Bastrop, Caldwell, Fayette, and Lee counties all had cancer mortality rates that exceeded the state average of 152.8 deaths per 100,000.

[24] Food Insecurity in the United States, Map the Meal Gap, Feeding America; http://map.feedingamerica.org/

Within RHP 7, Caldwell (191.3 deaths per 100,000) and Lee (170.0 deaths per 100,000) counties had the highest cancer mortality rates and both had increased since 2012. In contrast, cancer deaths in Hays and Travis counties for 2014 were lower than the state average and had declined somewhat since 2012.

FIGURE 38. LUNG CANCER MORTALITY RATE PER 100,000 POPULATION, BY COUNTY AND STATE, 2012 AND 2014



DATA SOURCE: Texas Department of State Health Services, Texas Cancer Registry, 2012 and 2014
NOTE: Rates shown are age-adjusted; N/A denotes insufficient sample size to calculate a reliable rate or data suppressed due to confidentiality constraints

Lung cancer is the most common cause of cancer-related deaths, statewide and across RHP 7. While reliable estimates for lung-cancer mortality were not available for all counties and all years (**Figure 38**), data do mirror the overall cancer mortality data. Lung-cancer mortality in Bastrop, Caldwell, and Fayette counties exceeded the state average of 37.8 deaths per 100,000. Lung cancer mortality was lower in Hays (32.6 deaths per 100,000) and Travis (33.5 deaths per 100,000) counties.

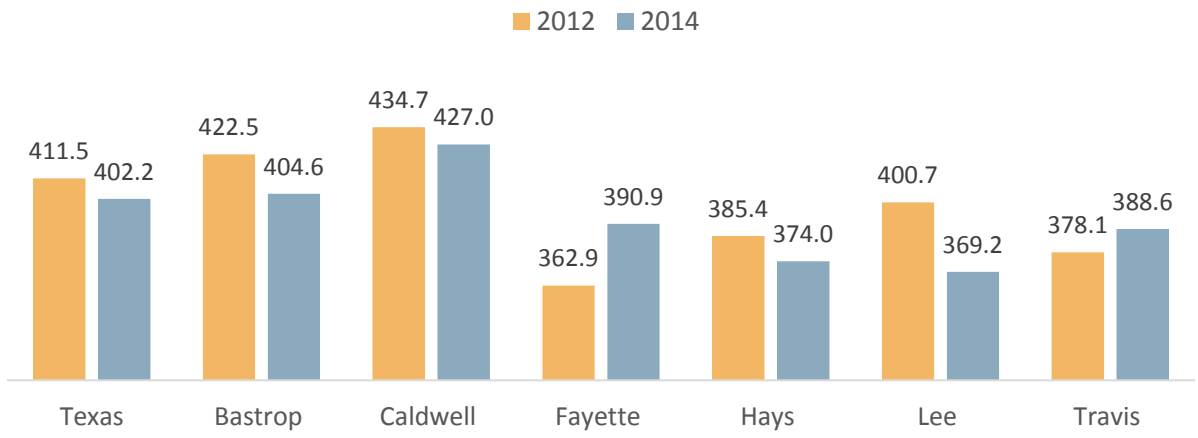
Due to lower sample sizes, mortality rates for other specific types of cancer are not generally available at the county-level. However, the other leading causes of cancer death for the state of Texas include prostate cancer among men (17.3 deaths per 100,000 men), breast cancer among women (19.8 deaths per 100,000 women), and colorectal cancer (14.0 deaths per 100,000).

Cancer is a leading cause of death nationally, however the population of individuals living beyond a cancer diagnosis is expected to rise in the U.S. from 14.5 million in 2014 to 19 million by 2024.[25] In RHP 7, the number of deaths due to cancer each year was far lower than the number of individuals that were diagnosed. The size of the population living with a cancer diagnosis is likely to increase in the future following the national trend.

Cancer was selected as a Top 5 health concern by nearly a quarter of community member respondents and 16.5% of providers responding to the stakeholder survey.

FIGURE 39. OVERALL CANCER INCIDENCE RATE PER 100,000 POPULATION, BY COUNTY AND STATE, 2012 AND 2014

[25] Understanding Cancer, Cancer Statistics, National Cancer Institute; https://www.cancer.gov/about-cancer/understanding/statistics



DATA SOURCE: Texas Department of State Health Services, Texas Cancer Registry, 2012 and 2014
NOTE: Rates shown are age-adjusted

Overall, cancer incidence rates (i.e. number of new diagnoses per 100,000) declined slightly in Texas and most RHP 7 counties between 2012 and 2014 (**Figure 39**). Fayette County was the only rate that increased in the same time period. Cancer incidence in Caldwell County was higher than the state and the highest of the RHP 7 counties in both 2012 and 2014.

TABLE 6. CANCER INCIDENCE RATES PER 100,000 POPULATION BY TYPE, COUNTY AND STATE, 2012 AND 2014

	Female Breast Cancer		Prostate Cancer		Lung Cancer		Colorectal Cancer	
	2012	2014	2012	2014	2012	2014	2012	2014
Texas	111.8	110.7	95.8	86.3	55.6	51.7	38.3	37.2
Bastrop County	125.0	106.7	99.9	74.8	65.9	48.4	29.6	43.2
Caldwell County	79.8	99.9	96.2	69.7	76.8	40.3	52.2	N/A
Fayette County	97.9	109.5	N/A	N/A	50.0	N/A	49.5	N/A
Hays County	125.0	123.0	64.0	86.3	46.4	43.3	22.0	30.2
Lee County	N/A	N/A	N/A	N/A	N/A	72.8	N/A	N/A
Travis County	111.9	126.4	97.4	81.4	39.9	45.9	32.1	28.5

DATA SOURCE: Texas Department of State Health Services, Texas Cancer Registry, 2012 and 2014
NOTE: Rates shown are age-adjusted; N/A denotes insufficient sample size to calculate a reliable rate or data suppressed due to confidentiality constraints

Incidence rates for the four most common types of cancer are detailed in Table 6**.** Breast cancer was the most common type of cancer diagnoses in Texas and each of the RHP 7 counties in 2014. The rates of breast cancer ranged from a low of 99.9 cases per 100,000 population in Caldwell County to a high of 126.4 cases per 100,000 population in Travis County. Due to smaller numbers, reliable incidence rates for other cancer types were not available for all RHP 7 counties or years, however the available data suggested that as of 2014, prostate cancer incidence was highest in Hays County (86.3 cases per 100,000 population), lung cancer incidence was highest in Lee County (72.8 cases per 100,000 population), and colorectal cancer incidence was highest in Bastrop County (43.2 cased per 100,000 population).

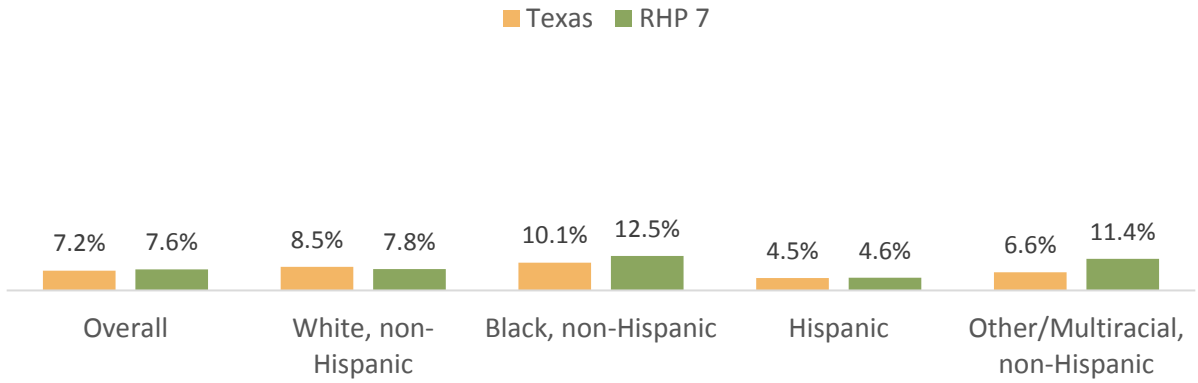
While cancer incidence data were not available stratified by race and ethnicity or by socio-economic status, it is important to note that some population groups are at increased risk of developing or dying from cancer. Low-income and medically underserved populations are less likely to receive recommended cancer screenings tests and tend to be diagnosed at later stages. These populations also

tend to have more behavioral risk factors for cancer such as smoking, obesity, excessive alcohol intake, or physical inactivity.[26]

Asthma

National statistics indicate the number of people with asthma in the U.S. is growing along with the medical costs associated with its management.[27] In 2013, 1.6 million visits to emergency rooms in the U.S. had asthma as a primary diagnosis. Despite these national trends, asthma was not identified as a Top 5 community health concern among respondents to the stakeholder survey. Less than 8.3% of providers and 17.6% of community members selected it as one of their top concerns.

FIGURE 40. ADULTS REPORTED TO CURRENTLY HAVE ASTHMA BY RACE/ETHNICITY, REGION, AND STATE 2015



DATA SOURCE: Texas Behavioral Risk Factor Surveillance Survey (BRFSS), 2011-2015
NOTE: Survey data based upon self-report

Texas BRFSS data estimate that 7.2% of adults currently have asthma (**Figure 40**). This rate was slightly higher (7.6%) for adults living in RHP 7 counties. When data were stratified by race and ethnicity, Black, non-Hispanic adults (12.5%) and adults identifying as multiracial or an 'other' race (11.4%) had the highest rates, while Hispanic adults had the lowest rate (4.6%). These differences by race were similar to the differences observed at the state level.

Asthma is likely more prevalent among youth in RHP 7. Recent county-level was unavailable. However, the Texas Youth Risk Behavior Survey data for 2013 suggested that nearly a quarter of high school students had been told they had asthma. Black high school students in Texas were more likely to report having received an asthma diagnosis (36.7%) compared to White, non-Hispanic (26.0%) or Hispanic (18.3) students[28].

Behavioral Health

Among providers responding to the RHP 7 stakeholder survey, 'mental health/behavioral health' was the most frequently (79.7%) selected Top 5 health condition affecting the low-income populations in

[26] Understanding Cancer, Cancer Disparities, National Cancer Institute; https://www.cancer.gov/about-cancer/understanding/disparities
[27] FastStats, Asthma, National Center for Health Statistics, Centers for Disease Control and Prevention; https://www.cdc.gov/nchs/fastats/asthma.htm
[28] High School YRBS, Youth Online, Youth Risk Behavioral Surveillance System, Centers for Disease Control and Prevention, 2013; https://nccd.cdc.gov/youthonline/App/Default.aspx

RHP 7 counties. Additionally, 'substance use and abuse' was selected as a Top 5 concern by 45.1% of providers and was the 5th most frequently selected health concerns. Concern over behavioral health was echoed throughout key informant interviews and provider focus groups.

Participants perceived increases in the prevalence of behavioral health issues across the spectrum, including depression and anxiety, PTSD, and bipolar disorder. Many further suggested that the increasing prevalence was occurring particularly among low-income communities, such as those receiving indigent care services. Several interviewees clarified behavioral health as co-occurring disorders which frequently include substance use or abuse. As one interviewee stated, *"From a hospital perspective, [substance abuse disorders] seem to go hand and hand with behavioral health issues."*

> "Mental health support and access is woeful compared to many other places."
>
> -Key Informant Interviewee
>
> "[We're] continuing to see a need for mental health services across the board, whether they be primary counseling services and medication management services through to in-patient care for substance use and behavioral health services."
>
> -Key Informant Interviewee
>
> "The leading provider of mental health care in Texas is the Harris County jail and that's an expensive place to be providing health care."
>
> -Key Informant Interviewee

Despite behavioral health featuring prominently in key informant interviews and provider focus groups, it was not a major theme that arose from the community member focus groups. Participants of these focus groups tended to point to chronic health conditions and concerns around housing, transportation, and accessibility of services as major issues in the community. However, 'mental health/behavioral health' was the third most frequently (43.3%) selected condition as a Top 5 concern among community members that responded to the stakeholder survey. And over a quarter (28.3%) also selected 'substance use and abuse' as a Top 5 concern.

While accessibility and barriers to health care are covered more generally in later sections of this report, it is important to note here that key informants and provider focus group participants stressed that the limited availability and accessibility of behavioral health services in RHP 7 was a critical issue.

Key informants from across the region identified behavioral health as an area of major gaps in the over-all social service and health care landscape. Interviewees perceived that a shortage of mental health providers, especially providers that accept Medicaid, limited access to necessary services and negatively impacted community members' mental health status.

Several interviewees indicated that the lack of mental health providers was compounded by stigma, which stopped community members from seeking care, as one interviewee stated: *"The stigma around mental health prevents it from being addressed like other issues."* Interviewees and provider focus group participants shared a perception that stigma was more prevalent in rural communities than urban ones.

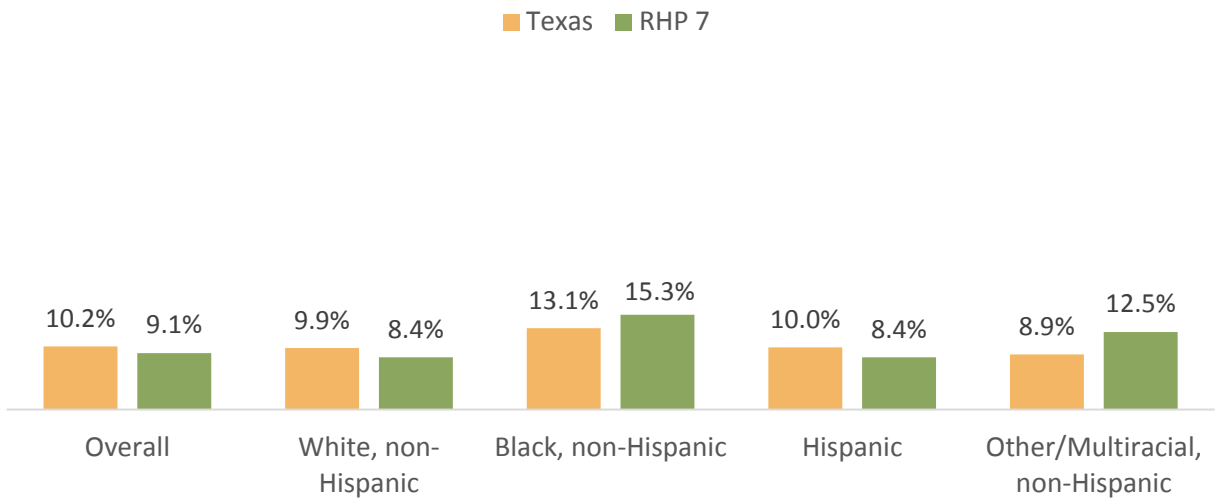
Interviewees also shared that there was a need for behavioral health care providers at every point along the spectrum of care which is consistent with the gaps and needs identified through the 2012 CNA process. Several providers noted that patients with mental health needs often ended up "languishing" in emergency departments or on involuntary commitment in mental health treatment facilities while they waited for appropriate services. Interviewees shared this perception that untreated mental health issues resulted in an increase in the number of patients seeking crisis care and emergency services.

> "We don't have good continuum of care models so the mental health [services] that has popped up is either for crisis care or long-term care but there's nothing in the middle and that's where the majority of the need is."
>
> -Key Informant Interviewee

Stakeholder survey respondents also highlighted the need for improved access to behavioral health care. Over half (51.3%) of providers that responded to the survey selected access to 'behavioral/mental health care' as one of their Top 5 focus areas to improve the delivery of healthcare to the low-income populations in RHP 7. Among community members that responded to the stakeholder survey, 29.7% selected access to behavioral/mental health care as one of their Top 5 focus areas for improvement.

Mental Health

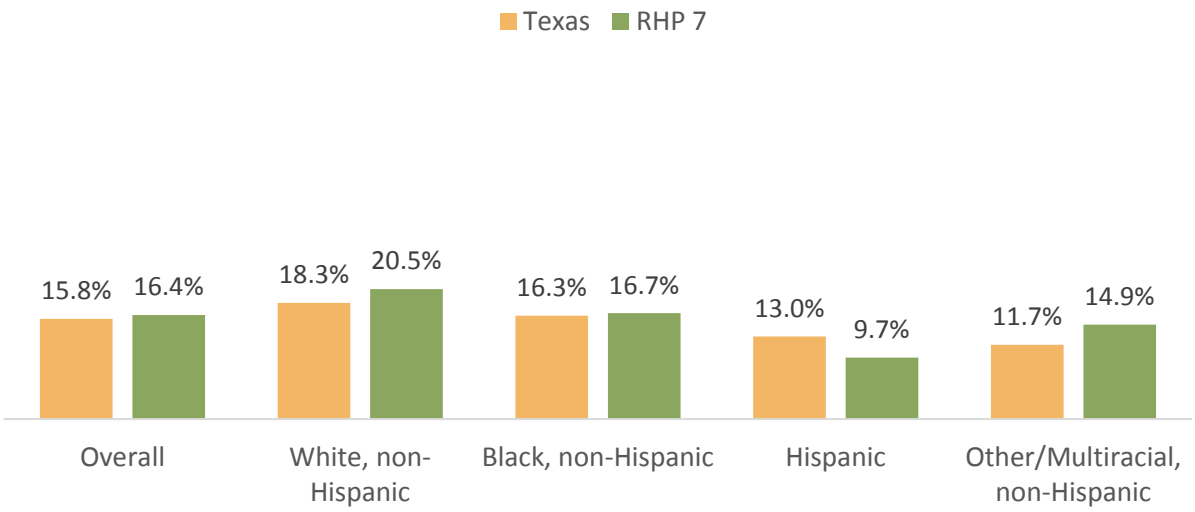
FIGURE 41. ADULTS REPORTED TO HAVE POOR MENTAL HEALTH FOR TWO WEEKS OR MORE, BY RACE/ETHNICITY, REGION, AND STATE, 2015



DATA SOURCE: Texas Behavioral Risk Factor Surveillance Survey (BRFSS), 2011-2015
NOTE: Survey data based upon self-report

The Texas BRFSS showed that 9.1% of adults in RHP 7 having poor mental health (**Figure 41**). When data were examined by race/ethnicity, Black adults (15.3%) and adults identifying as multiracial or another race (12.5%) were more likely to report having poor mental health. While differences by race were also observed at the state level, the difference between White, non-Hispanic and Black adults in RHP 7 was more pronounced than the difference at the state level.

FIGURE 42. ADULTS REPORTED TO HAVE HAD DEPRESSIVE DISORDER DIAGNOSIS, BY RACE/ETHNICITY, REGION, AND STATE 2015

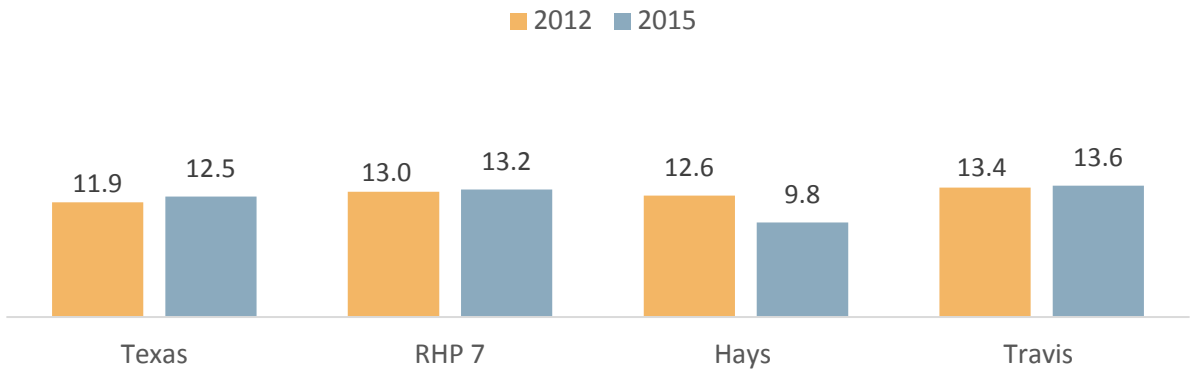


DATA SOURCE: Texas Behavioral Risk Factor Surveillance Survey (BRFSS), 2011-2015
NOTE: Survey data based upon self-report

The Texas BRFSS showed that 16.4% of adults in RHP 7 had ever received a diagnosis of depressive disorder (**Figure 42**). The overall rate among adults in RHP 7 was similar to the state (16.4%). When data were examined by race/ethnicity, White, non-Hispanic adults (20.5%) were more likely to report a diagnosis than other groups. These differences by race and ethnicity were consistent with differences observed at the state level.

County/regional level data on the prevalence of depression were unavailable for youth, however state level data from the Substance Abuse and Mental Health Services Administration (SAMSHA) suggested that 11.2% of all adolescents (age 12 to 17) in 2013–2014 had at least one major depressive episode in the prior year. The rate had increased from 7.9% in 2010-2011.[29]

FIGURE 43. SUICIDE MORTALITY RATE PER 100,000 POPULATION, BY COUNTY AND STATE, 2012 AND 2015



DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, 2012 and 2015
NOTE: Suicide includes ICD-10 Codes U03, X60-84, Y87.0; Rates shown are age-adjusted

Suicide mortality was slightly higher in RHP 7 compared to the state for both 2012 and 2015 (**Figure 43**). As of 2015, there were 13.2 suicide deaths per 100,000 population across the region. County level data were only available for Hays and Travis counties. The suicide mortality rate was lower in Hays County

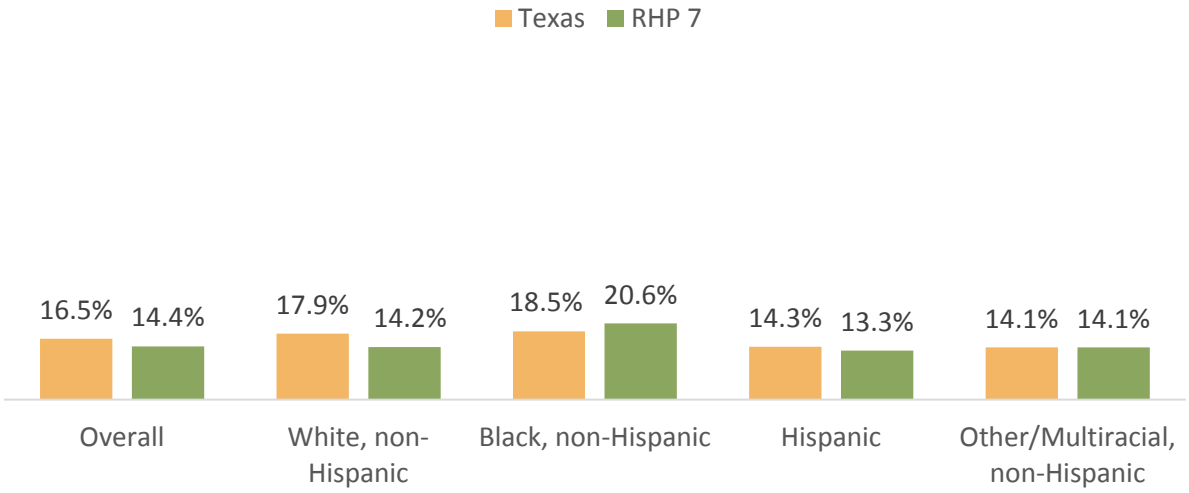
[29] Behavioral Health Barometer, Texas, Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration (SAMHSA), 2015; https://www.samhsa.gov/data/sites/default/files/2015_Texas_BHBarometer.pdf

and had declined between 2012 and 2015, while the rate in Travis County was higher and was more consistent over time.

County/regional level data on the age-specific rates of suicide mortality were unavailable, however state level data for 2014 showed the suicide mortality rate was highest among adults age 45 to 65 years (17.7 per 100,000 population) and lower among adults age 25 to 44 (14.7 per 100,000) and those age 15 to 24 years (11.3 per 100,000)[30].

Substance Use

FIGURE 44. ADULTS REPORTED TO BE CURRENT SMOKERS BY RACE/ETHNICITY, REGION, AND STATE, 2015



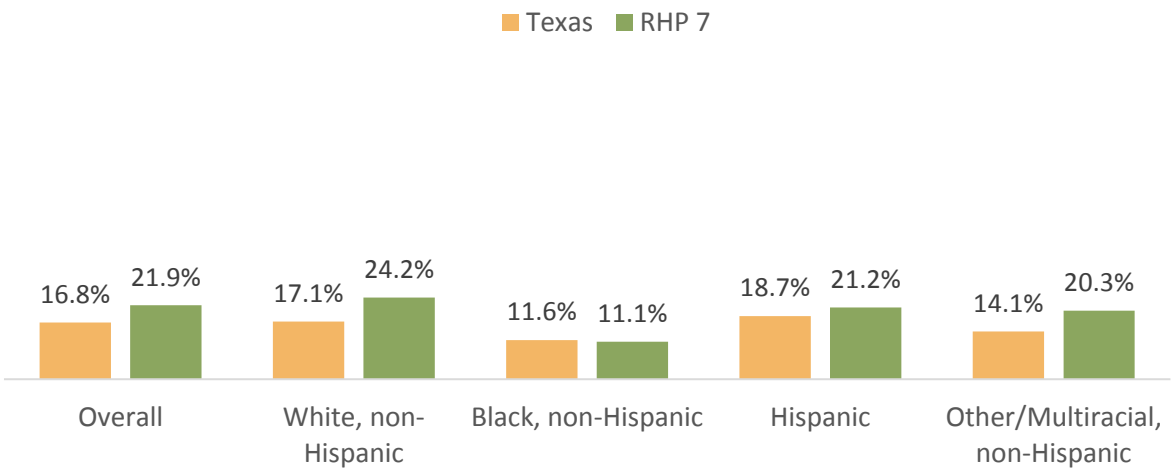
DATA SOURCE: Texas Behavioral Risk Factor Surveillance Survey (BRFSS), 2011-2015
NOTE: Survey data based upon self-report

Smoking and tobacco use is a major risk factor for a number of chronic health conditions, including respiratory diseases, cardiovascular disease, and lung cancer[31]. The Texas BRFSS showed that 16.5% of adults in the state, and 14.4% of adults in RHP 7 counties, were current smokers (**Figure 44**). When examined by race/ethnicity, Black adults were more likely to be current smokers (20.6%) compared to other groups (approximately 14%). This differences by race was consistent with the difference observed at the state level.

County/regional level data on smoking were not available for youth, however state level data from the SAMSHA suggested 4.3% of all adolescents (age 12-17) in 2013–2014 reported using cigarettes in the prior month. The rate had decreased from 7.1% in 2010-2011[32].

FIGURE 45. ADULTS REPORTED BINGE DRINKING IN PAST MONTH BY RACE/ETHNICITY, REGION, AND STATE, 2015

[30] TX Injury Data Brief, Injury Epidemiology & Surveillance Branch, Texas Department of State Health Services, 2016; https://www.dshs.texas.gov/injury/EPI/Suicide2016Update.pdf
[31] Health Risks of Smoking Tobacco, American Cancer Society, 2015; https://www.cancer.org/cancer/cancer-causes/tobacco-and-cancer/health-risks-of-smoking-tobacco.html
[32] Behavioral Health Barometer, Texas, Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration (SAMHSA), 2015; https://www.samhsa.gov/data/sites/default/files/2015_Texas_BHBarometer.pdf



DATA SOURCE: Texas Behavioral Risk Factor Surveillance Survey (BRFSS), 2011-2015
NOTE: Survey data based upon self-report; Binge drinking defined as consuming 5 or more drinks in a row

Nationally, adult consumption and abuse of alcohol has increased in recent years and has included most demographic groups. Despite clear impacts on health (death, unintentional injuries, alcohol exacerbated crime and violence, and alcohol dependence), excess drinking or alcohol abuse often receives less attention from public health or policy makers than tobacco or illicit drugs do.[33]

The Texas BRFSS showed that 21.9% of adults in RHP 7 binge drank in the prior 30 days (defined as 5 or more drinks in a row) (**Figure 45**). This rate was higher than the state average of 16.8%. When examined by race/ethnicity, binge consumption of alcohol was highest among White, non-Hispanic adults (24.2%). However Hispanic adults (21.2%) and adults that identified as multiracial or another race (20.3%) also had rates that were higher than the state averages for those groups. Binge consumption of alcohol was lowest among Black adults (11.1%) in RHP 7.

County/regional level data on alcohol consumption were not available for youth, however state level data from SAMSHA suggested 12.7% of all individuals age 12 to 20 years in 2013–2014, reported binge alcohol use in the prior month. The rate had decreased from 15.5% in 2010-2011.[34]

TABLE 7. RETAIL ALCOHOLIC BEVERAGE ESTABLISHMENTS PER 10,000 POPULATION, BY COUNTY AND STATE, 2015

	Beer, Wine, and Liquor Stores		Bars, Taverns, or Nightclubs	
	Count	Rate	Count	Rate
Texas	1,869	0.7	2,696	1.0
RHP 7	129	0.8	323	2.1
Bastrop County	8	1.0	3	0.4
Caldwell County	2	0.5	2	0.5
Fayette County	3	1.2	5	2.1
Hays County	18	0.9	25	1.3
Lee County	0	0.0	1	0.6
Travis County	98	0.8	287	2.4

DATA SOURCE: U.S. Census Bureau, County Business Patterns, 2015
NOTE: Rates calculated based on U.S. Census Population Estimates for 2015; rates shown are per 10,000 population

[33] Prevalence of 12-Month Alcohol Use, High-Risk Drinking, and DSM-IV Alcohol Use Disorder in the United States, 2001-2002 to 2012-2013, JAMA Psychiatry, September 2017; http://jamanetwork.com/journals/jamapsychiatry/article-abstract/2647079
[34] Behavioral Health Barometer, Texas, Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration (SAMHSA), 2015; https://www.samhsa.gov/data/sites/default/files/2015_Texas_BHBarometer.pdf

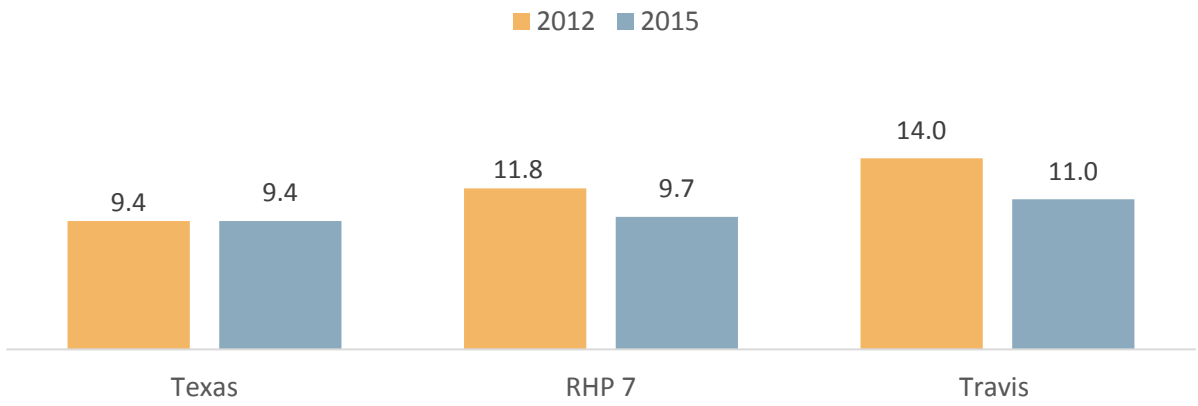
Business pattern data for RHP 7 showed that several counties had higher rates of retail establishments where alcohol could be purchased or consumed. Fayette County had the highest rate of beer/wine/liquor stores (1.2 per 10,000 population), followed by Bastrop County (1.0 per 10,000 population) (**Table 7**). Travis County had the highest rate of bars (2.4 per 10,000 population), followed by Fayette County (2.1 bars per 10,000 population). Note, these data do not capture full-service restaurants that may also serve alcoholic beverages.

One provider focus group participant working in one of the smaller RHP 7 counties held the perception that alcoholism was more prevalent in rural communities and was negatively impacted by stigma and a lack of services for substance use. Several focus group participants and key informant interviewees noted that synthetic drugs (such as K2 or spice) and opiates were a growing concern in the region, especially for urban areas.

> "In our rural areas, we see a lot of domestic violence and alcoholism."
>
> -Provider Focus Group Participant
>
> "We haven't seen as much of the opiate crisis but we have methamphetamine and K2."
>
> -Key Informant Interviewee

Data on the prevalence of illegal or illicit drug use was not available at a county-level. State-level data from the SAMHSA showed that 2.2% of all individuals age 12 or older in 2013–2014 were dependent on or had abused illicit drugs in the prior year. Among these individuals, it was reported that only 8.6% had received treatment for their illicit drug use within the year prior to being surveyed.[35]

FIGURE 46. DRUG POISONING MORTALITY RATE PER 100,000 POPULATION, BY COUNTY AND STATE, 2012 AND 2015



DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, 2012 and 2015
NOTE: Rates shown are age-adjusted; drug poisoning includes *ICD-10 Codes X40-44, 60-64, 85 and Y10-14*

[35] Behavioral Health Barometer, Texas, Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration (SAMHSA), 2015; https://www.samhsa.gov/data/sites/default/files/2015_Texas_BHBarometer.pdf

County-level mortality data related to drug poisoning (i.e. overdoses) can serve as an indicator of the magnitude of the illicit drug problem in an area, particularly for opioids which comprise a majority of overdose deaths.[36] As shown in **Figure 46**, the drug poisoning mortality rate has remained steady in Texas for 2012 and 2015 (9.4 deaths per 100,000 population each year), while the rate declined slightly across RHP 7 (from 11.8 deaths per 100,000 population in 2012 to 9.4 deaths per 100,000 population in 2015). The rate in Travis County also declined between 2012 and 2015, but remained higher than the regional and state averages in 2015.

Disability

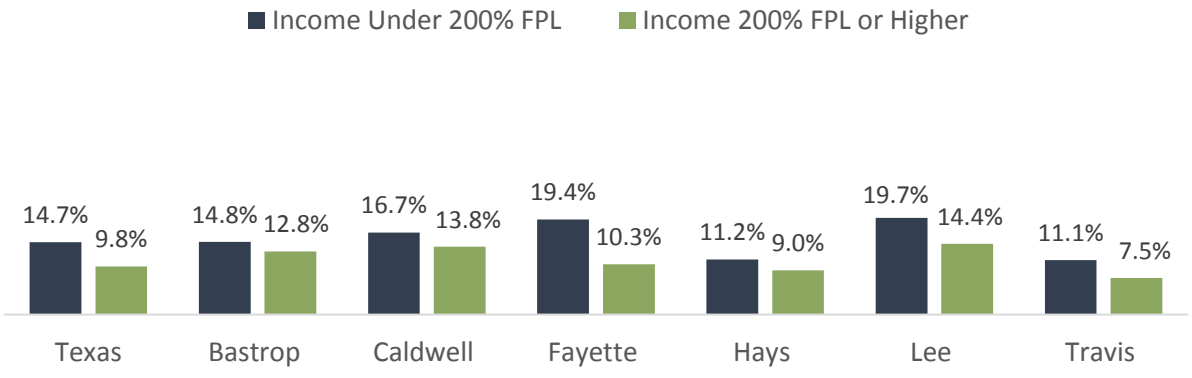
TABLE 8. PERCENT OF POPULATION WITH DISABILITIES, BY COUNTY AND STATE, 2015

	Any Disability		Cognitive Difficulty		Ambulatory Difficulty		Self-Care Difficulty		Independent Living Difficulty	
	Count	%	Count	%	Count	%	Count	%	Count	%
Texas	3,028,251	11.6%	1,115,138	4.6%	1,589,326	6.6%	622,032	2.6%	1,017,848	5.4%
Bastrop	10,171	13.6%	3,576	5.1%	5,346	7.6%	1,946	2.8%	3,550	6.4%
Caldwell	5,661	15.1%	2,119	6.0%	2,401	6.8%	861	2.5%	1,712	6.1%
Fayette	3,239	13.3%	1,105	4.8%	1,558	6.7%	693	3.0%	1,113	5.8%
Hays	16,958	9.6%	6,528	4.0%	7,914	4.8%	2,757	1.7%	4,849	3.6%
Lee	2,629	16.3%	961	6.3%	1,393	9.1%	541	3.5%	993	8.0%
Travis	96,046	8.6%	38,586	3.7%	44,872	4.3%	16,837	1.6%	29,617	3.5%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015
NOTE: Percentages based upon the total civilian non-institutionalized population; data on vision or hearing difficulty are not shown

Numbers and proportions of residents in RHP 7 counties with disabilities or difficulty with self-care and independent living are detailed in Table 8. Overall, residents in the more rural counties (Bastrop, Caldwell, Fayette, and Lee counties) were more likely to have a disability or difficulty than the state average. In contrast, residents of Hays and Travis counties were less likely to have any disability than the state average. Lee County had the highest rate in each disability category explored, which is consistent with the older age distribution of Lee County residents.

FIGURE 47. PERCENT OF POPULATION WITH ANY DISABILITY BY INCOME, BY COUNTY AND STATE, 2015

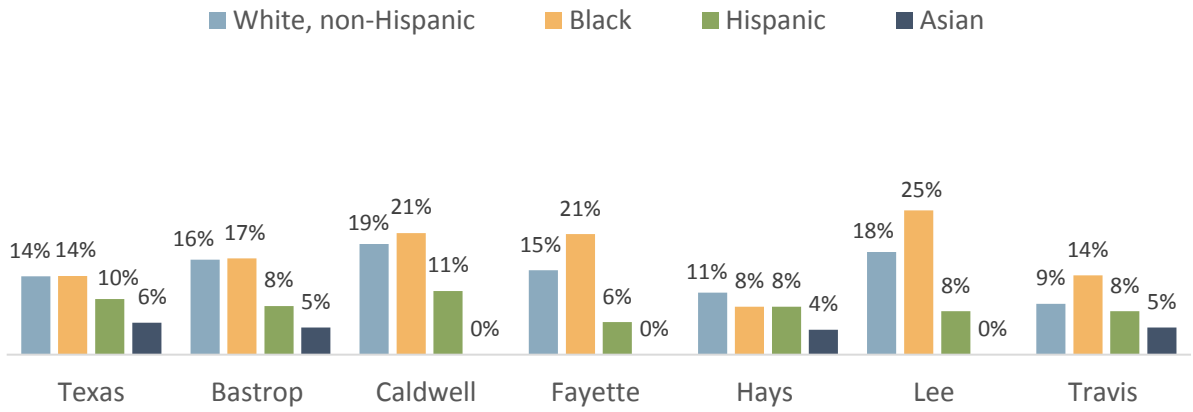


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015
NOTE: Percentages based upon the total civilian non-institutionalized population

[36] Brief Report on Current Epidemic of Drug Poisoning Deaths, Addiction Research Institute, University of Texas at Austin School of Social Work, 2014; https://socialwork.utexas.edu/dl/files/cswr/institutes/ari/pdf/opioid-overdose-2014.pdf

In Fayette and Lee counties, the rate of disability was particularly high in the low-income group; nearly 20% of individuals with incomes below 200% of FPL had a disability (**Figure 47**). Across RHP 7, disability was more common in the lower-income population.

FIGURE 48. PERCENT OF POPULATION WITH ANY DISABILITY BY RACE/ETHNICITY, BY COUNTY AND STATE, 2015

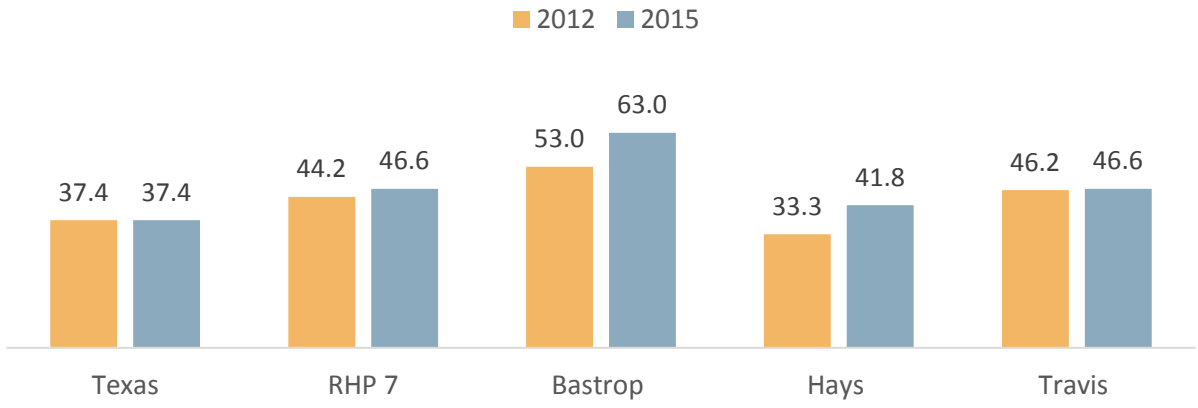


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015
NOTE: Percentages based upon the total civilian non-institutionalized population

In Caldwell, Fayette, and Lee counties the rate of any disability among Black residents was markedly higher, affecting up to a quarter of the population (**Figure 48**). The disability rate was higher than the state average among White, non-Hispanic and black residents in each RHP 7 county except for Hays where rates were lower. Within RHP 7, White, non-Hispanic and Black residents were more likely to have any disability compared to Hispanic or Asian residents.

Injuries

FIGURE 49. UNINTENTIONAL INJURY MORTALITY RATE PER 100,000 POPULATION, BY COUNTY AND STATE, 2012 AND 2015

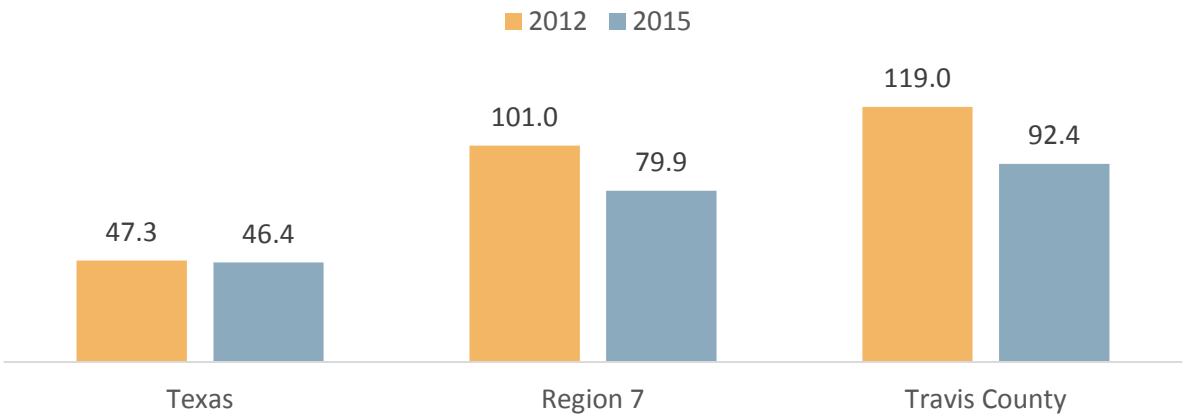


DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, 2012 and 2015
NOTE: Rates shown are age-adjusted; Unintentional injury (i.e. accidents) includes ICD-10 Codes V01-V99, W00-W59, Y85.0, Y85.9, Y86

Unintentional injuries (i.e. accidents) are one of the leading causes of death across RHP 7. As of 2015, accidents were the 3rd leading cause of death in Bastrop, Hays, and Travis counties (data were unavailable for Caldwell, Fayette, and Lee counties). As **Figure 49** illustrates, the mortality rate due to

accidents in RHP 7 was higher than the state rate in both 2012 and 2015. Within RHP 7, Bastrop County had the highest rate in 2015 and the largest increase between 2012 and 2015, from 53.0 deaths per 100,000 population to 63.0 deaths per 100,000 population.

FIGURE 50. UNINTENTIONAL FALLS MORTALITY RATE (65 AND OVER) PER 100,000 POPULATION, BY COUNTY AND STATE, 2012 AND 2015

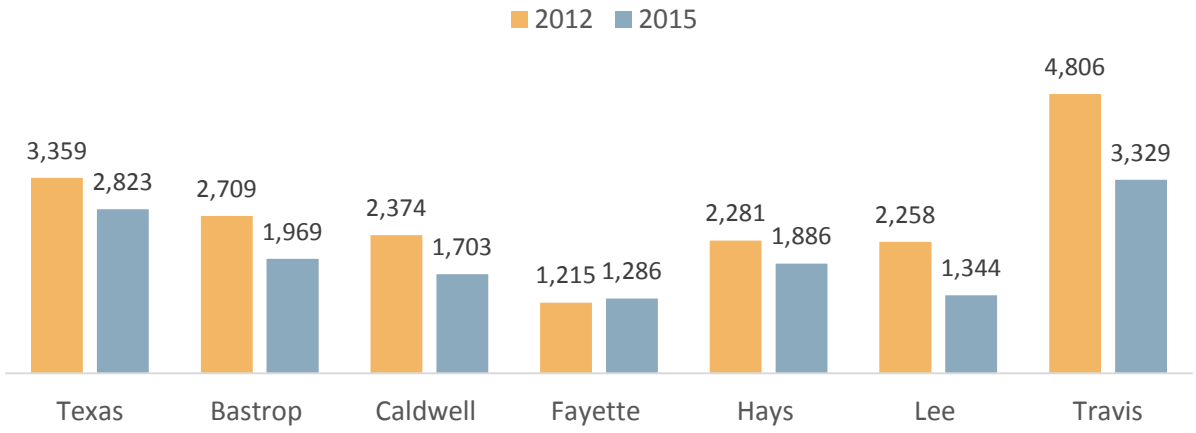


DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, 2012 and 2015
NOTE: Rates shown are crude rates, for 65+ population; unintentional falls include ICD-10 Codes W00-W19

Death due specifically to unintentional falls among individuals age 65 an older was also higher in RHP 7 compared to the state (79.9 deaths per 100,000 vs. 46.4 deaths per 100,000 in 2015) (**Figure 50**). Travis County had a rate (92.4 deaths per 100,000 in 2015) that was higher than both the state and the RHP 7 average. However, the rates in Travis County and RHP 7 overall had declined between 2012 and 2015.

Crime and Violence

FIGURE 51. PROPERTY CRIME RATE PER 100,000 POPULATION, BY COUNTY AND STATE, 2012 AND 2015

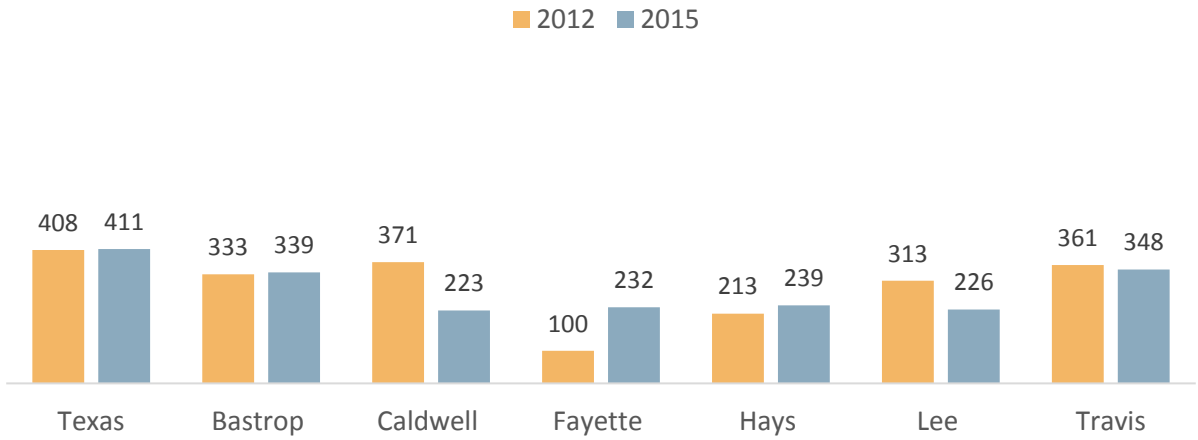


DATA SOURCE: Texas Department of Public Safety, Crime in Texas, Texas Crime Report, 2012 and 2015
NOTE: Property crime includes burglary, larceny, and auto theft

Crime in the U.S. has declined steadily over the past couple of decades and currently rates are at historic lows for most areas of the country.[37] In Texas, between 2012 and 2015, the property crime rate declined at the state level as well as in most of the RHP 7 counties (**Figure 51**). In both 2012 and 2015, Fayette County had the lowest property crime rate of all RHP 7 counties.

As of 2015, Travis County had the highest property crime rate compared to the state and other RHP 7 counties. When compared to the average rate of property crime for large cities across the United States (4,011 per 100,000), the rate in Austin (3,771 per 100,000) was slightly lower. Austin's rate was also lower when compared to property crime rates in San Antonio (5,029 per 100,000) and Houston (4,398 per 100,000)[38].

FIGURE 52. VIOLENT CRIME RATE PER 100,000 POPULATION, BY COUNTY AND STATE, 2012 AND 2015



DATA SOURCE: Texas Department of Public Safety, Crime in Texas, Texas Crime Report, 2012 and 2015
NOTE: Violent crime includes murder, robbery, and assault

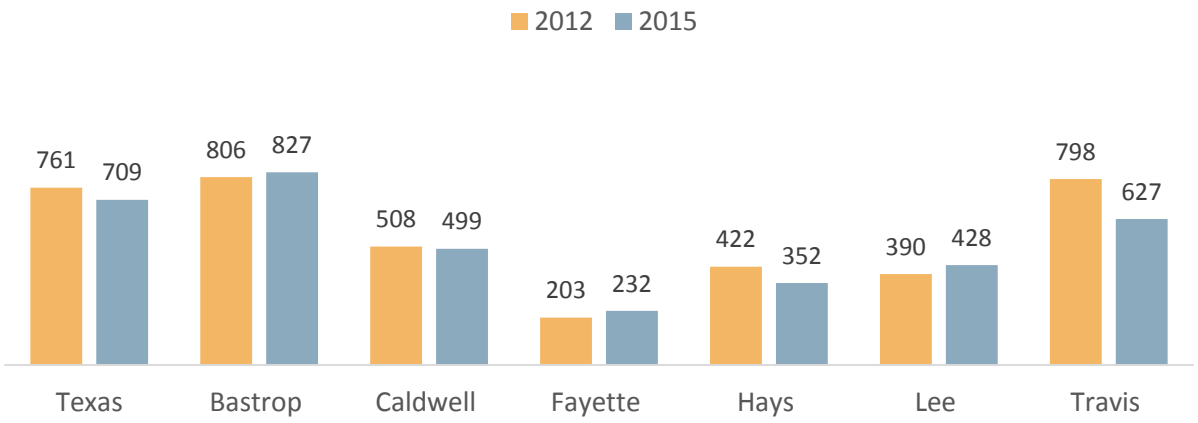
Rates of violent crime were much lower than property crime in RHP 7. Rates remained fairly steady between 2012 and 2015 for many of the RHP 7 counties (**Figure 52**). In addition, the violent crime rates in each of the RHP 7 counties was below the state rate. Fayette County did have fairly large increase in the violent crime rate from 100 crimes per 100,000 population in 2012 to 232 crimes per 100,000 population in 2015. In context of the level of property crime rate observed for Fayette County above, this may suggest a worsening in the safety and security of Fayette County residents.

Homicide mortality rates, unlike crime rates in general, are trending upward in Texas and the RHP 7 region. Per the CDC, the state rate increased from 5.1 deaths per 100,000 population in 2012 to 5.6 deaths per 100,000 population in 2015. And it increased in RHP 7 from 2.0 deaths per 100,000 population in 2012 to 2.9 deaths per 100,000 population in 2015.[39]

FIGURE 53. FAMILY VIOLENCE INCIDENCE RATE PER 100,000 POPULATION, BY COUNTY AND STATE, 2012 AND 2015

[37] Crime Trends: 1990-2016, Brennan Center for Justice, New York University School of Law, 2016; https://www.brennancenter.org/sites/default/files/publications/Crime%20Trends%201990-2016.pdf
[38] Annual Crime and Traffic Report: 2015 Final Report, Austin Police Department, 2015: http://www.austintexas.gov/sites/default/files/files/2015_crime_and_traffic_report_120516.pdf

[39] Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, 2012 and 2015



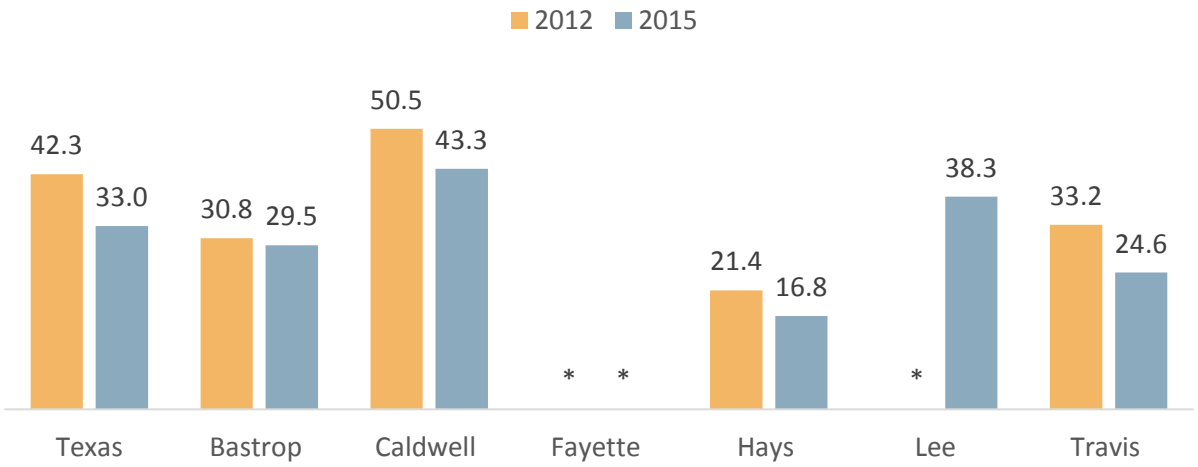
DATA SOURCE: Texas Department of Public Safety, Crime in Texas, Texas Crime Report, 2012 and 2015
NOTE: Family violence as defined as an act by a member of a family or household against another member that is intended to result in physical harm, bodily injury, assault, or a threat that reasonably places the member in fear of imminent physical harm

Family violence data, which are not included as part of the violent crime rates shown above, were also available by county (**Figure 53**). Bastrop County had the highest rate of family violence (approximately 800 incidents per 100,000 population) compared to the state and other RHP 7 counties in both 2012 and 2015. Travis (627 incidents per 100,000 population in 2015) and Caldwell (499 incidents per 100,000 population in 2015) counties had the next highest rates. Rates declined between 2012 and 2015 for both Travis and Hays counties.

Maternal and Child Health

This section includes indicators for maternal and child health, including the teen birth rate, preterm birth and associated risk factors, and prenatal care.

FIGURE 54. TEEN BIRTH RATE PER 1,000 FEMALES AGES 15-19, BY COUNTY AND STATE, 2012 AND 2014



DATA SOURCE: Texas Department of State Health Services, Center for Health Statistics, Texas Birth Certificate Data, 2012 and 2015
*NOTE: *Rates were not calculated for years/geographies where the total number of births to teens <21*

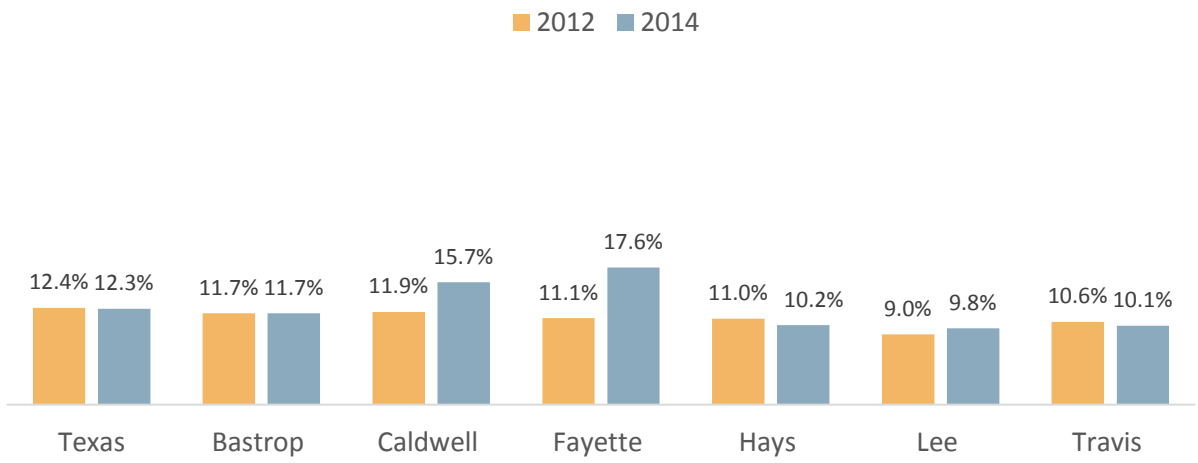
As of 2015, Texas ranked 46th in the nation (rank of 50 = highest) for teen birth rates. Racial and ethnic disparities were clear in 2015: 20.9 births per 1,000 for White, non-Hispanic teens, 34.3 births per 1,000 for Black, non-Hispanic teens, and 47.6 births per 1,000 for Hispanic teens[40].

Teen birth rate data were not available for every county in RHP 7 (**Figure 54**). Between 2012 and 2014, the teen birth rate declined at the state level and in RHP 7. As of 2015, teen birth rates were highest in Caldwell (43.3 per 1,000) and Lee (38.3 per 1,000) counties. Each of these counties had rates that exceeded the state average of 33.0 per 1,000. Teen pregnancy did not emerge as concern from focus group or the stakeholder survey. However, one key informant interviewee from Hays County shared that they wanted to see the community invest in more education and after school programs for pregnant and parenting teens.

Birth Outcomes

Preterm delivery is negatively associated with mortality and morbidity for infants and children. Preterm birth can put infants at risk for breathing, hearing, and vision problems, as well as developmental delays later in life. It can also increase the risk of infant death. Preterm birth is also associated with low birthweight which can result is similar problems and is associated with higher risk for diabetes, heart disease, and other chronic health conditions later in life. Women with chronic diseases, such as diabetes, or who use tobacco, alcohol or recreational drugs during their pregnancies have increased risk of premature and low-birth weight births.[41]

FIGURE 55. PERCENT OF BIRTHS THAT WHERE PREMATURE, BY COUNTY AND STATE, 2012 AND 2014

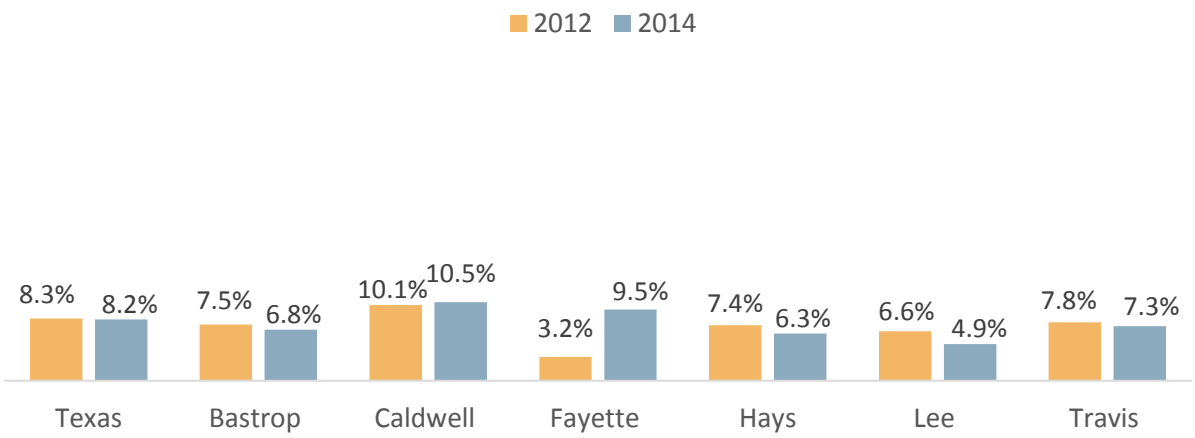


DATA SOURCE: Texas Department of State Health Services, Center for Health Statistics, Texas Health Data, Vital Statistics Annual Report, 2012 and 2014
NOTE: Premature birth defined as prior to the 37th week of gestation

In 2014, the proportion of births that were premature (prior to 37th week of gestation) was highest in Caldwell (15.7%) and Fayette (17.6%) counties (**Figure 55**). Both counties had rates that increased between 2012 and 2014 and that exceeded the state rate of 12.3% of births in 2014.

[40] Texas Data, The National Campaign to Prevent Teen and Unplanned Pregnancy, 2015; https://thenationalcampaign.org/data/state/texas
[41] Long-term health effects of premature birth, March of Dimes, http://www.marchofdimes.org/complications/long-term-health-effects-of-premature-birth.aspx

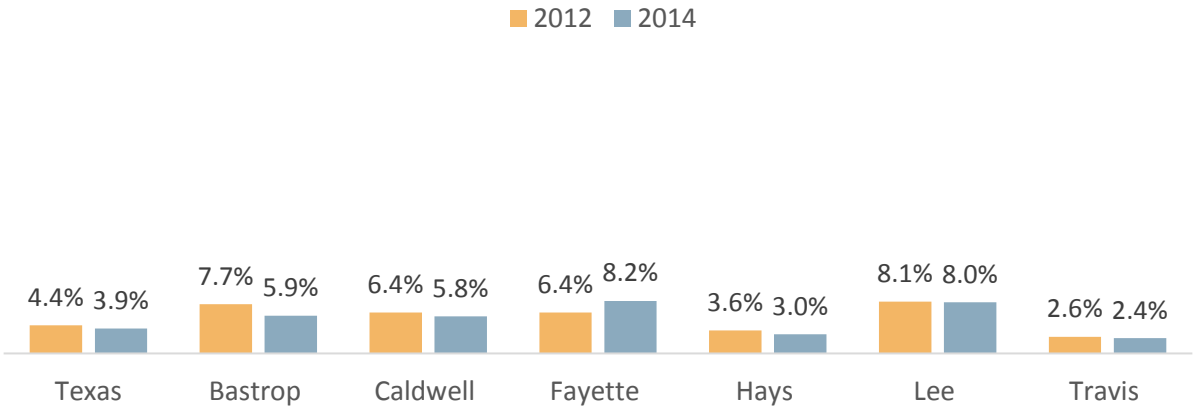
FIGURE 56. PERCENT BIRTHS THAT ARE LOW-BIRTH WEIGHT INFANTS, BY COUNTY AND STATE, 2012 AND 2014



DATA SOURCE: Texas Department of State Health Services, Center for Health Statistics, Texas Health Data, Vital Statistics Annual Report, 2012 and 2014; NOTE: Low-Birth Weight defined as weight less than 2,500 grams

Similarly, in 2014 the proportion of births that were low-birth weight (<2,500 grams) was highest in Caldwell (10.5%) and Fayette (9.5%) counties (**Figure 56**). Both counties had rates that increased between 2012 and 2014 and that exceeded the state rate of 8.2% of births in 2014. State level data for 2014 further showed that low-birth weight births were more common among Black mothers (13.4% of births), than among White, non-Hispanic (7.5%) or Hispanic (7.5%) mothers.

FIGURE 57. PERCENT OF BIRTHS WHERE CIGARETTE USE WAS PRESENT DURING PREGNANCY, BY COUNTY AND STATE, 2012 AND 2014



DATA SOURCE: Texas Department of State Health Services, Center for Health Statistics, Texas Health Data, Vital Statistics Annual Report, 2012 and 2014

Smoking during pregnancy is one of the primary risk factors for low-birth weight and premature birth. It also increases the risk of some birth defects, miscarriage, and even Sudden Infant Death Syndrome in the first year of life.[42] The percentage of births where smoking occurred during pregnancy were higher than the state rate in Bastrop, Caldwell, Fayette, and Lee counties in both 2012 and 2014 (**Figure 57**). The rate was particularly high in Fayette County (8.2%) and Lee County (8.0%) in 2014.

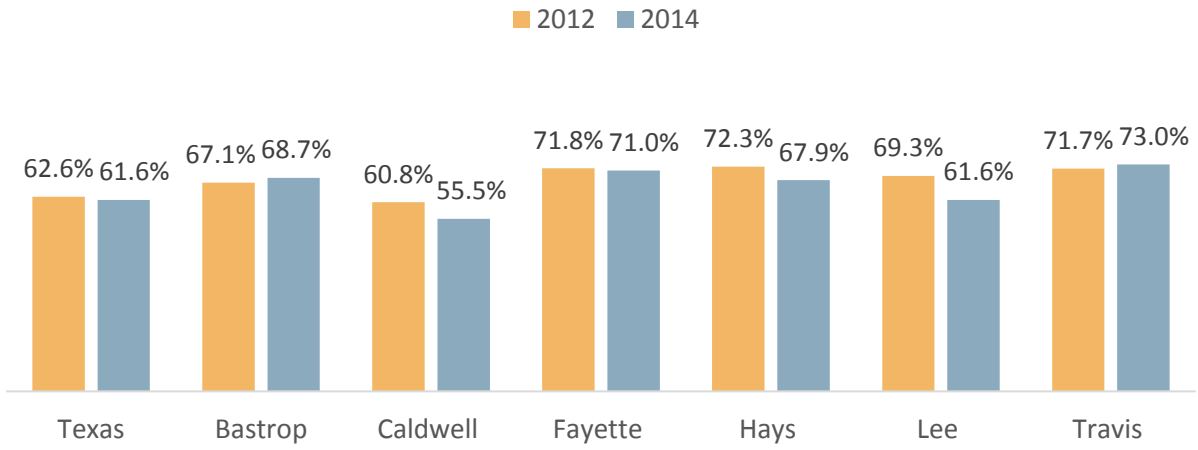
[42] Tobacco Use and Pregnancy, Maternal and Infant Health, Centers for Disease Control and Prevention; https://www.cdc.gov/reproductivehealth/maternalinfanthealth/tobaccousepregnancy/index.htm

While infant mortality rates across RHP 7 were extremely low (4.8 per 1,000 births in 2014), data on premature birth, low-birth weight, and smoking during pregnancy suggest that there may be some gaps in prenatal care for some areas of RHP 7. Timely access to quality prenatal and maternal health care services are an important element of insuring a health pregnancy and optimal birth outcomes for infants.[43]

> "Prenatal care is huge – [it has] so much impact on outcomes and we want more of that. We get drop-ins from everywhere and so many people have never had prenatal care."
>
> -Key Informant Interviewee

Key informants indicated during interviews that it was harder to access maternity care for community members in rural areas. Key informants reported that this led patients to not have any prenatal care during their pregnancies. Several interviewees shared that they would like to see more prenatal care services across the RHP 7 counties. One interviewee also shared that they wanted to see programs reach out specifically to young mothers whom they perceived as being the least likely to access prenatal care. Among providers that responded to the stakeholder survey, 63% rated access to 'prenatal/maternal care' as 'hard' or 'very hard' for the low-income community.

FIGURE 58. PERCENT OF BIRTHS WITH PRENATAL CARE IN FIRST TRIMESTER, BY COUNTY AND STATE, 2012 AND 2014



DATA SOURCE: Texas Department of State Health Services, Center for Health Statistics, Texas Health Data, Vital Statistics Annual Report, 2012 and 2014

These perceptions are echoed by quantitative data that suggest prenatal care is unevenly accessed across RHP 7 (**Figure 58**). As of 2014, the percent of births with prenatal care that had begun in the first trimester generally exceeded the state rate of 61.6% in most RHP 7 counties. However, Caldwell County had a rate (55.5%) that was lower than the state and other RHP 7 counties in 2014. These data further suggested that the percent of births without any prenatal care had increased between 2012 and 2014 in Caldwell (from 1.9% to 2.5%) and Fayette (from 0.5% to 1.2%) counties.

[43] Prenatal Care, Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health; https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/Pages/prenatal-care.aspx#prenatal

State data for 2014 showed that a larger proportion of White, non-Hispanic women began prenatal care in the 1st trimester (69.5%), compared to Black (53.3% of births) or Hispanic (56.6%) women. Secondary data that were included in the recent Travis County Community Health Assessment report, showed that Black and Hispanic mothers were more than twice as likely to have late or no prenatal care compared to White, non-Hispanic mothers in Travis County.[44]

Maternal mortality has also been identified as a rising public health issue in Texas. The overall rate increased from 8.6 deaths per 100,000 in 2005 to 32.8 deaths per 100,000 in 2014. Rates were also shown to be higher in Black women compared to White or Hispanic women.[45] Data on maternal mortality were not available at the county-level.

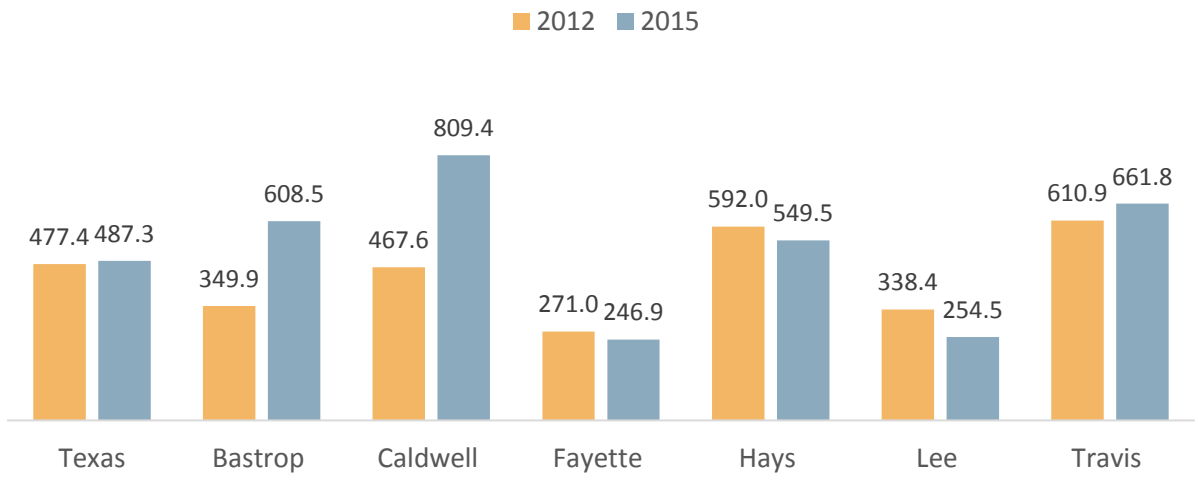
Communicable Disease

Sexually Transmitted Infections

Some participants in the stakeholder dialogue activity highlighted education around sexually transmitted infections (STIs) as a gap in the current health care delivery system. STIs are a leading cause of pelvic inflammatory disease and chronic pelvic pain, and can lead to infertility when left untreated.[46] The incidence of chlamydia, gonorrhea, and syphilis have all increased in Texas since 2009.

As of 2015, Texas was ranked 13th in the nation (rank 1=highest rate) for chlamydia infection, 11th for gonorrhea, and 16th for syphilis infection. Age groups with the highest rates of infection in Texas included youth (age 15-19) and young adults (age 20-24) for chlamydia and gonorrhea, and adults under 30 (age 20 to 29) for syphilis.[47]

FIGURE 59. CHLAMYDIA CASE RATE PER 100,000 POPULATION, BY COUNTY AND STATE, 2012 AND 2015



DATA SOURCE: Texas Department of State Health Services, TB/HIV/STD Epidemiology and Surveillance Branch, Texas STD Surveillance Report, 2015

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[44] Community Health Assessment – Austin/Travis County, September 2017 Draft; http://austintexas.gov/sites/default/files/files/Health/CHA-CHIP/ATC_CHA_DRAFT_09_26_17__002_.pdf

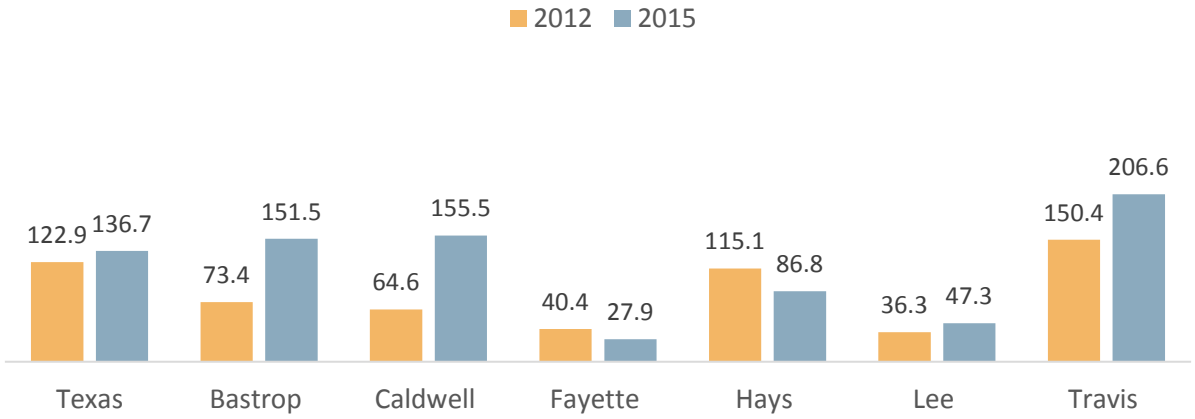
[45] Maternal Mortality in Texas, Texas Department of State Health Services, 2016; https://www.dshs.texas.gov/mch/pdf/2016BiennialReport.pdf

[46] Diseases & Related Conditions, Sexually Transmitted Diseases (STDs), Centers for Disease Control and Prevention, 2014; https://www.cdc.gov/std/general/default.htm

[47] Texas STD Surveillance Report, TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services, 2015; https://www.dshs.texas.gov/hivstd/reports/STDSurveillanceReport2015.pdf

Chlamydia infections increased slightly in Travis County between 2012 and 2015 (**Figure 59**). Larger increases occurred in Bastrop and Caldwell counties, while rates declined slightly in Fayette, Hays, and Lee counties. As of 2015, chlamydia rates in all but Fayette and Lee counties exceeded the state average.

FIGURE 60. GONORRHEA CASE RATE PER 100,000 POPULATION, BY COUNTY AND STATE, 2012 AND 2015

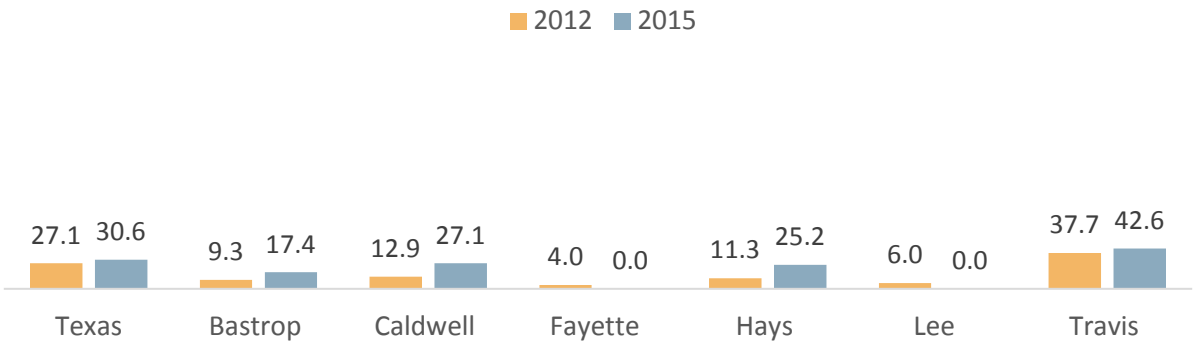


DATA SOURCE: Texas Department of State Health Services, TB/HIV/STD Epidemiology and Surveillance Branch, Texas STD Surveillance Report, 2015

Between 2012 and 2015, Bastrop and Caldwell counties had increased gonorrhea rates (**Figure 60**)**.** The rates in both counties more than doubled between 2012 and 2015. Gonorrhea rates in Lee and Travis counties also increased, but to a lesser extent. As of 2015, gonorrhea rates in Bastrop, Caldwell, and Travis counties exceeded the state average.

As described in the recently completed Travis County Community Health Assessment[48], STIs were among the most commonly mentioned health concerns during focus group discussions. Participants identified stigma as one factor that may prevent area residents from seeking screening services for STIs. Secondary data that were included in the Travis County report, further suggested the Black residents were experiencing higher rates of chlamydia and gonorrhea than other racial/ethnic groups.

FIGURE 61. SYPHILIS CASE RATE PER 100,000 POPULATION, BY COUNTY AND STATE, 2012 AND 2015



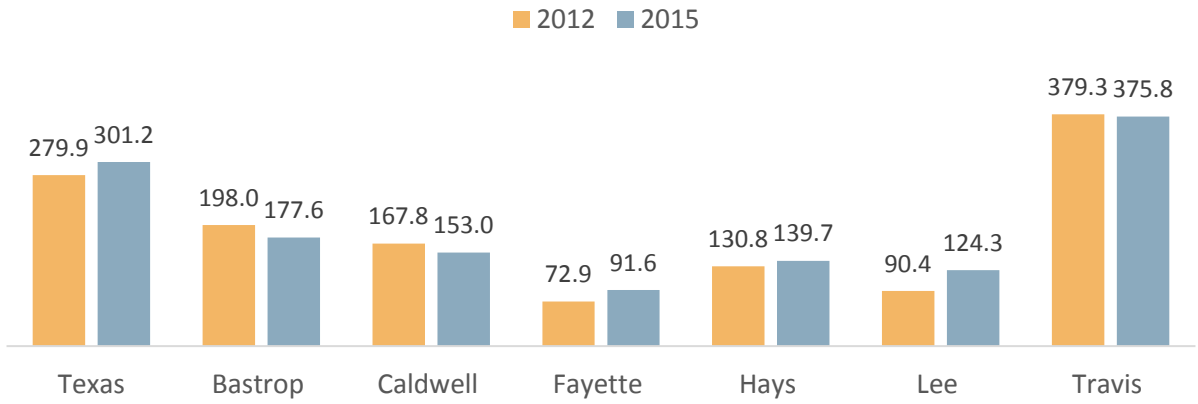
DATA SOURCE: Texas Department of State Health Services, TB/HIV/STD Epidemiology and Surveillance Branch, Texas STD Surveillance Report, 2015

[48] Community Health Assessment – Austin/Travis County, September 2017 Draft; http://austintexas.gov/sites/default/files/files/Health/CHA-CHIP/ATC_CHA_DRAFT_09_26_17__002_.pdf

Rates of syphilis cases increased between 2012 and 2015 in Bastrop, Caldwell, Hays, and Travis counties (**Figure 61**). Caldwell and Hays counties experienced the largest increases. As of 2015, only Travis County had a syphilis rate that exceeded the state average.

HIV Infection

FIGURE 62. RESIDENTS LIVING WITH HIV PER 100,000 POPULATION, BY COUNTY AND STATE, 2012 AND 2015



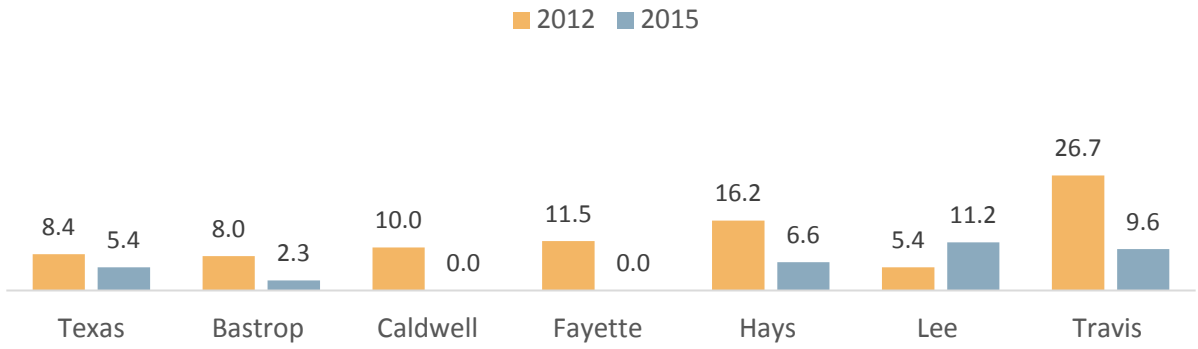
DATA SOURCE: Texas Department of State Health Services, TB/HIV/STD Epidemiology and Surveillance Branch, Texas STD Surveillance Report, 2015

The rate of residents living with human immunodeficiency virus (HIV) in Bastrop, Caldwell, and Travis counties decreased slightly between 2012 and 2015 (**Figure 62**). The rate increased in Fayette, Hays, and Lee counties. As of 2015, only Travis County had an HIV prevalence rate that exceeded the state average.

Pertussis

Pertussis (also known as whooping cough) has been increasing over the previous decade. Factors contributing to this increase include diminishing immunity in adults and adolescents, greater awareness of the disease among clinicians, school nurses, parents, and general public, better laboratory testing methodologies, and improved disease surveillance. However, examining trend data for pertussis can be misleading as it is known to occur in 3 to 5 year cycles.[49]

FIGURE 63. PERTUSSIS CASE RATE PER 100,000 POPULATION, BY COUNTY AND STATE, 2012 AND 2015



DATA SOURCE: Texas Department of State Health Services, Infectious Disease Control Unit, 2012 and 2015

[49] Pertussis, Infectious Disease Control, Texas Department of State Health Services, 2017; https://www.dshs.texas.gov/idcu/disease/pertussis/

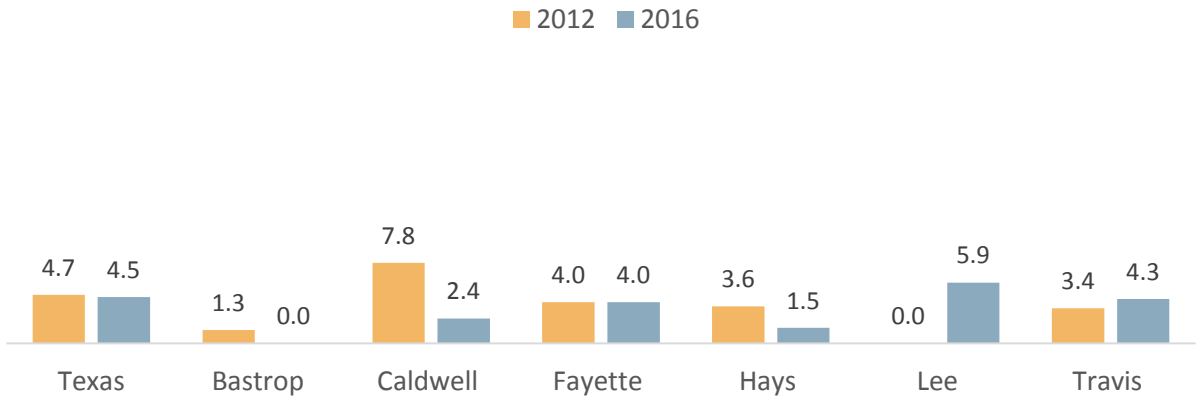
According to the Texas Department of State Health Services *'the last peak year in Texas was 2013 with 3,985 cases, the highest annual case count since 1959. There were 1,504 cases in 2015, marking the beginning of the valley of the three to five-year cycle."*

This 'valley' in pertussis cases is evident in the county-level data (**Figure 63**) which showed large declines in pertussis cases between 2012 and 2015. Lee County appeared to be an exception. The rate of pertussis cases increased between 2012 and 2015. Based upon the known cyclic nature of this infection, pertussis in 2018 is likely to again be a 'peak' year for cases and it may exceed peaks that occurred in 2012/2013.

Tuberculosis

Prevention of tuberculosis (TB) transmission is a public health concern in areas with large numbers of foreign-born residents arriving from countries with higher TB incidences. As of 2015, Texas ranked 4th in TB (rank 1 = highest rate) and clear disparities by race/ethnicity were evident. In Texas, nearly 60% of cases occurred among foreign-born residents and TB rates were high among Asian individuals.[50]

FIGURE 64. TUBERCULOSIS CASE RATE PER 100,000 POPULATION, BY COUNTY AND STATE, 2012 AND 2016



DATA SOURCE: Texas Department of State Health Services, TB/HIV/STD Epidemiology and Surveillance Branch, Texas TB Surveillance Report, 2016

Between 2012 and 2016, Bastrop, Caldwell, and Hays counties experienced decreases in TB case rates (**Figure 64**). While Lee and Travis counties each had an increase.

Oral Health

Poor oral health is associated with a number of chronic conditions, such as diabetes, heart disease and stroke, and respiratory disease. These risks are further exacerbated by low-income and inadequate access to dental care. Low-income adults (less than 200% FPL) have been shown to have the highest rate of untreated cavities and tooth decay.[51]

Inadequate access to dental care was identified in the 2012 CNA as a key community need. Results from the 2017 assessment confirm that it remains a need. Providers and community members that responded to the stakeholder survey consistently identified dental care as an area of concern.

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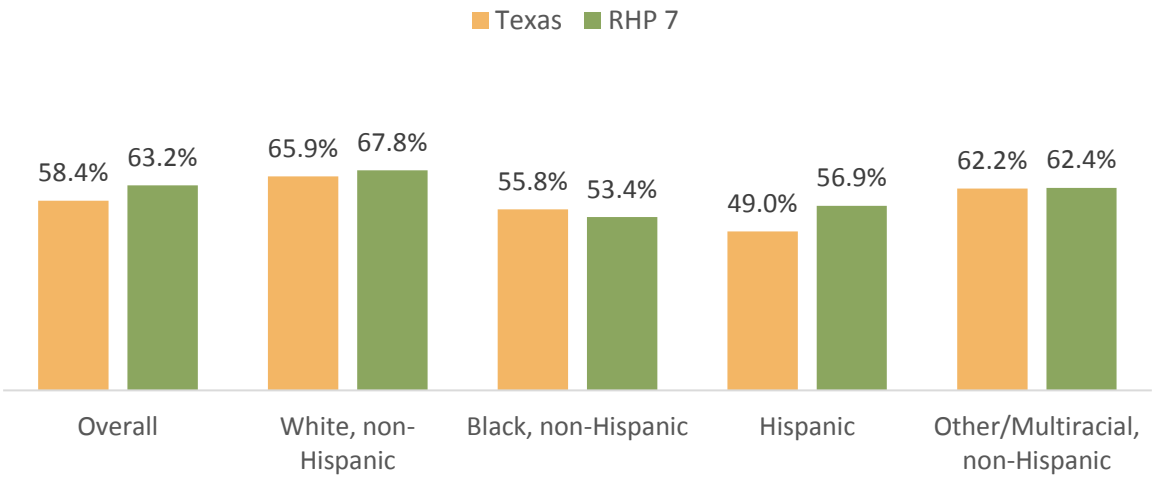
[50] Texas TB Surveillance Report, TB/HIV/STD Epidemiology and Surveillance Branch, Texas Department of State Health Services, 2015; https://www.dshs.texas.gov/IDCU/disease/tb/statistics/Reports/TB-Surveillance-Report-2015.pdf

[51] Oral Health and Low-Income Nonelderly Adults: A Review of Coverage and Access, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, 2012; https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7798-02.pdf

'Dental/oral health' was the fifth most frequently selected Top 5 health concern by community members (37.4% selected) and the sixth most frequently selected health concern by providers (36.8% selected).

In addition, the vast majority (89.0%) of providers, and nearly half (45.9%) of community members, rated access to dental care in the community as 'hard' or 'very hard.' The stakeholder survey also asked respondents to identify their Top 5 focus areas to improve the delivery of health care in the community. 'Access to dental care' was the most frequently selected focus area among community members (45.3% selected) and the sixth most frequently selected focus area for providers (31.9% selected).

FIGURE 65. ADULTS REPORTED DENTAL VISIT IN PAST YEAR BY RACE/ETHNICITY, REGION, AND STATE, 2011-2015



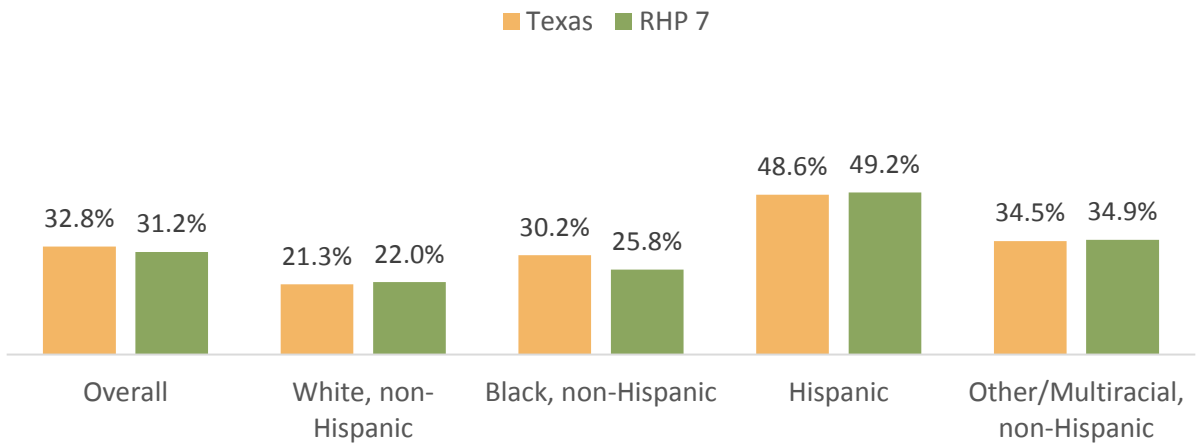
DATA SOURCE: Texas Behavioral Risk Factor Surveillance Survey (BRFSS), 2011-2015
NOTE: Survey data based upon self-report

The Texas BRFSS showed that 63.2% of adults in RHP 7 had a dental visit in the prior year (**Figure 65**). This rate was slightly higher than the state (58.4%). When data were examined by race/ethnicity, White, non-Hispanic adults (67.8%) were more likely to report a dental visit than other groups. Black (53.4%) and Hispanic (56.9%) were less likely to report having a dental visit in the prior year. These differences by race and ethnicity were consistent with differences observed at the state level.

Healthcare Utilization

The data presented in this section are indicators of both health care utilization but also of lack of access (and therefore low levels of utilization of certain services). There are a multitude of factors that may create barriers to care and impact utilization. Those factors are discussed later in the report.

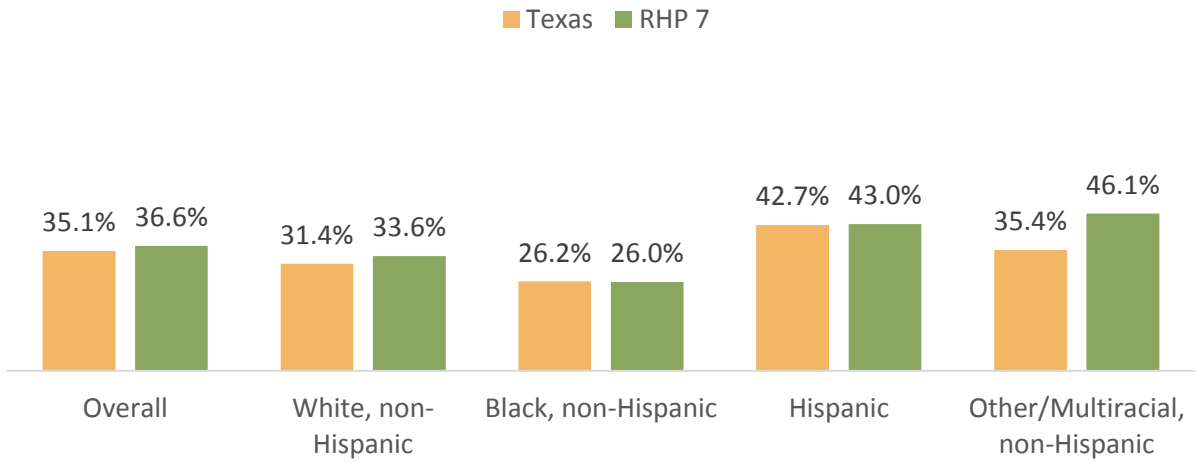
FIGURE 66. PERCENT OF ADULTS BY RACE/ETHNICITY WITHOUT A PERSONAL DOCTOR OR PROVIDER, BY STATE AND COUNTY, 2015



DATA SOURCE: Texas Behavioral Risk Factor Surveillance Survey (BRFSS), 2011-2015

The Texas BRFSS included several items that are related to primary care utilization. **Figure 66** shows the percent of adults who did not have a personal provider. In Texas and RHP 7, approximately one third of adults did not have a personal doctor. When data were explored by race/ethnicity some differences emerged. Almost half of Hispanic adults in RHP 7 counties (49.2%) and in Texas (48.6%) did not have a personal provider. This was more than double the rate for White, non-Hispanic adults.

FIGURE 67. PERCENT OF ADULTS BY RACE/ETHNICITY WITHOUT A ROUTINE CHECK-UP IN PRIOR YEAR, BY STATE AND COUNTY, 2015



DATA SOURCE: Texas Behavioral Risk Factor Surveillance Survey (BRFSS), 2011-2015

Figure 67 shows the percent of adults that did not have a routine check-up in the prior year. In Texas and RHP 7, just over a third of adults reported they did not have a routine check-up. When data were explored by race/ethnicity, some differences were observed. Black adults in RHP 7 were less likely to report not having a routine check-up (26.0%) and Hispanic (43.0%) and multiracial/other (46.1%) adults were more likely.

TABLE 9. NUMBER OF POTENTIALLY PREVENTABLE HOSPITALIZATION, BY COUNTY AND STATE, 2012 AND 2014

	2012 Count	2014 Count	Difference

Texas	230,629	243,616	+12,987
Bastrop County	788	826	+38
Caldwell County	707	614	-93
Fayette County	274	241	-33
Hays County	1,185	1,285	+100
Lee County	141	139	-2
Travis County	7,095	7,135	+40
RHP 7 Total	10,190	10,240	+50

DATA SOURCE: Texas Department of State Health Services, Center for Health Statistics, Texas Health Data, 2012 and 2014

Preventable hospitalizations can be an indicator of limited access to primary care and preventative services, as these services could help to prevent conditions from becoming serious enough to require hospitalization. The distribution of potentially preventable hospitalizations across RHP 7 counties remained relatively stable between 2012 and 2014 (**Table 9**). The change in the number of preventable hospitalizations ranged from a reduction of 93 in Caldwell County to an increase of 100 in Hays County.

Several key informants that worked outside of Travis County spoke about preventable hospitalizations and ED visits, particularly for mental health conditions. Interviewees linked these hospitalizations to limited availability of behavioral health providers that accepted Medicaid. Interviewees also connected these preventable hospitalizations with inconsistent access to necessary medications for behavioral health and chronic conditions. Other interviewees indicated that limited access to primary care providers was leading to health conditions that could have be dealt with upfront, such as in primary care.

> "Behavioral health is a huge issue in our county that can't be understated. It floods our ER because there's not enough beds, not enough psychiatrists."
>
> -Key Informant Interviewee

> "There's limited access to [primary care physicians] so something that could be dealt with upfront is showing up in our ED."
>
> -Key Informant Interviewee

Healthcare Delivery System

This section includes findings relating to the distribution, availability, and accessibility of care across RHP 7. This includes brief summaries of the current safety net system in the region and an examination of the adequacy of the health care workforce. Factors identified as impacting access to the health care system in RHP 7 are also discussed in detail.

Key Themes

Infrastructure

Over the course of the 1115 Waiver period, many health care infrastructure expansions occurred in RHP 7. Most notably, six new hospitals opened, including the addition of Baylor Scott and White in Lakeway. The aging University Medical Center at Brackenridge moved to a newly constructed, state-of-the-art facility owned and operated by Seton Healthcare Family under the name of Dell Seton Medical Center at the University of Texas ("DSMC"). DSMC also serves as a teaching hospital for the newly created Dell Medical School at the University of Texas at Austin. DSRIP-funded projects opened or expanded 54 clinics or mobile units (primary, dental, specialty and behavioral health services) to serve primarily the Medicaid and uninsured populations in the region. Fifteen new free-standing emergency centers (for profit entities) have also opened in Travis and Hays counties since 2012. Despite these significant expansions, key informant interviewees and provider focus group participants perceived that the centralized location of health care services remained a major challenge to the delivery of care to vulnerable populations. Several noted specific types of services needed to expand outside of Travis County, such as emergency, behavioral health, and specialty care.

Workforce Shortages

All RHP 7 counties were designated in whole or in part as Health Professional Shortage Areas (HPSAs) or Medically Underserved Areas (MUAs) in 2012, and no changes in these designations have occurred in subsequent years. As was noted in the 2012 CNA, uneven geographic distribution of health providers was observed across RHP 7, and this was found generally to persist in 2017. Secondary data suggested that rates of primary care providers were particularly low in Bastrop and Lee counties, while behavioral/mental health providers were notably few in Fayette County. A lack of dentists was noted more widely across RHP 7, including Bastrop, Caldwell, Hays, and Lee counties. Information gathered from focus groups and interviews corroborated the need for additional providers across the region, particularly in the rural RHP 7 counties. Shortages of primary care providers was viewed as having a large impact on community members' ability to access routine care for conditions such as diabetes and hypertension. The limited numbers of behavioral health providers were similarly viewed as severely impairing the ability of community members from getting the care they needed. Community member focus group participants discussed their own challenges in accessing the care of specialists outside of Travis County, particularly when uninsured or covered by Medicaid.

Insurance Coverage

Texas's uninsured rate has declined since the launch of the Affordable Care Act in 2010. Between 2012 and 2016, the proportion of those under age 65 without health insurance declined across RHP 7. Among those age 18 or younger, the uninsured rate also declined, but to a lesser extent. Texas elected not to expand Medicaid eligibility and currently has very narrow eligibility criteria for non-disabled adults. Declines in the uninsured rate are therefore likely due to individuals participating in the insurance

market. Federal data show that over 80% percent of those who enrolled in a federal marketplace health plan in Texas have received a premium tax credit to assist with payments.[52]

Despite some progress in coverage, insurance remained a barrier to care in RHP 7. Many adults remain uninsured. Insurance problems, such as lack of coverage or not enough coverage, high cost of co-pays, or not understanding insurance, were frequently identified as barriers to care by community member and provider respondents to the stakeholder survey.

Broad Definition of Accessibility

During provider focus groups, participants were asked to define what health care access meant for the populations they serve. While providers identified many factors that they saw as playing a part in access, the overarching message was that access was much more complex than just the presence/absence of a provider or service. Rather, providers discussed access as including timeliness, the availability of different services and provider types, and navigability of the system. Key informant interviewees also frequently identified access to health care a key issue in their communities. They too sought to expand the definition of access and frequently pointed out that knowledge or awareness of available services was a crucial aspect of access.

Transportation and Location of Services

Secondary data, key informant interviews, focus groups, and the stakeholder survey consistently identified a lack of transportation as an issue for health care access in RHP 7. This emerged as one of the strongest themes in the CNA and was clearly related to the location of services in the region. Interviewees and focus group participants consistently pointed out that health care providers and social services in RHP 7 were concentrated in urban areas, presenting barriers for those living in rural areas which had minimal transportation infrastructure. Community members reported, and secondary data confirmed, that many patients outside of Travis County do seek care outside of their county of residence. While an option for some individuals, social services providers pointed out that this was not always an option. Particularly for social services or assistance programs that have limitations on whom they can serve based on the person's city or county of residence.

Similar barriers arose within Travis County as well. Key informants from Travis County perceived that the social service infrastructure was lacking outside of the Austin's city center. As residents moved outward within the city, or further out within Travis County, in search of affordable housing, they faced transportation and location barriers in accessing care and services. This emerged as well in the recently completed Travis County Community Health Needs Assessment[53], which concluded that physical access to health care remained a significant barrier within Travis County.

The sub-sections that follow, explore in greater depth the data that were examined around each of these themes. Specific data are discussed in terms of trends and differences between counties and within particularly vulnerable sub-populations.

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[52] Health Insurance Marketplaces 2017 Open Enrollment Period – Final Enrollment Report: November 1, 2016 – January 31, 2017, Centers for Medicare and Medicaid Services, 2017; https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html

[53] Community Health Assessment – Austin/Travis County, September 2017 Draft; http://austintexas.gov/sites/default/files/files/Health/CHA-CHIP/ATC_CHA_DRAFT_09_26_17__002_.pdf

Health Care Infrastructure

Health care infrastructure pertains to the existing providers that comprise the current safety net system in the region. This includes hospital systems and acute care providers, behavioral health providers, outpatient and community health clinics. This section also includes a brief description of 1115 Waiver and DSRIP-led efforts to expand facilities and services available to RHP 7 residents.

Hospitals and Acute Care

Six new hospitals have opened in RHP 7 since 2012, including the addition of a new hospital system, Baylor Scott and White. Currently, there are a total of 18 hospitals providing inpatient and emergency care in RHP 7, with all but Lee County having an inpatient facility.[54] In 2014, St. David's Healthcare opened a 14-bed children's hospital, with pediatric emergency department, at its St. David's North Austin Medical Center.[44] Since 2012, St. Mark's Medical Center, in La Grange, expanded its bed capacity, and both Seton and St. David's healthcare systems are planning expansions to their medical centers or hospitals. Meanwhile, in Bastrop County, Smithville Hospital Authority decided to reduce services at Seton Smithville Regional Hospital due to dwindling patient numbers over the past several years.

In May 2017, the aging University Medical Center at Brackenridge moved to a newly constructed state-of-the-art hospital facility and is now owned and operated by Seton Healthcare Family under the name of Dell Seton Medical Center at the University of Texas ("DSMC"). Under a contractual agreement, DSMC serves as the public hospital for Travis County and is the primary safety net hospital in the region. As of September 2016, 12 hospitals in RHP 7 participated in the Waiver's uncompensated care pool which is designed to help offset hospital costs of uncompensated care provided to patients who are unable to pay for services.[55]

DSMC also serves as a teaching hospital for the newly created Dell Medical School at the University of Texas at Austin, which welcomed its first class of medical school students in June 2016. Through the medical school's partnership with Seton, the number of medical residents providing care in community clinics and hospitals grew 32%, from 218 in 2012 to 287 in 2017.[56] The medical school building anchors a new healthcare innovation zone that also includes the UT School of Nursing building and other new buildings dedicated to innovative education and research. The medical school aims to be a force in the region for redesigning medical education and the healthcare delivery system to achieving better health and improved value for people in Central Texas.

Since 2012, 15 free-standing emergency centers have opened in Travis and Hays counties by for profit entities.[47] Currently, DSMC and Dell Children's Medical Center continue to operate the only Level 1 Trauma Centers in the region. Several key informants who worked outside of Travis County voiced a need for more emergency services in the outlying counties. Interviewees that worked with rural populations shared that community members often had to travel considerable distances to Travis County for emergency care.

Of note is Lee County which currently has no local emergency care providers. As one key informant from Lee County stressed: *"If someone has an emergency like a snake bite, they have to go to Bastrop which is*

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[54] Directories of Facilities by Type, Health Facilities, Texas Department of State Health Services, Texas Health and Human Services; https://www.dshs.texas.gov/facilities/find-a-licensee.aspx

[55] 2016 DY5 Uncompensated Care Expenditures, Payment Information, Uncompensated Care Payments, Texas Health and Human Services Commission; http://rad.hhs.texas.gov/hospitals-clinic/hospital-services/uncompensated-care-payments

[56] 2017 Community Benefit Report, Community Investment, Dell Medical School at the University of Texas; https://utexas.app.box.com/s/1bf91px3mjd7cf5ryjgst0ghgwrg2ezt

36 miles away. We don't have somewhere we can go for immediate care. We don't have anybody here who would be able to save that life." A quarter of providers that responded to the stakeholder survey rated 'emergency services' as 'hard' or 'very hard' to access for low-income community members across RHP 7. However, fewer (6.7%) identified "access to urgent care" as one of their Top 5 focus areas that would improve delivery of healthcare.

Behavioral Health

In addition to the state-owned Austin State Hospital, there are six private psychiatric hospitals in the region.[57] Twenty-four licensed narcotic and substance abuse treatment facilities are being operated in Austin and San Marcos.[47] DSRIP-funded projects brought to the region several new or expanded psychiatric crisis response clinics or mobile units, including a dedicated psychiatric emergency department. Behavioral health programming comprised the largest number of individual DSRIP projects (n=36) in the region.

Outpatient and Community Clinics

Tax exempt hospitals are mandated by the IRS to conduct a Community Health Needs Assessment (CHNA) every 3 years. As part the assessment, most elect to conduct an environmental scan or map the community's assets or health care infrastructure. A number of CHNA reports were released in 2016 by health care systems located within RHP 7, including Seton Family of Hospitals, St. David's Foundation, St. Mark's Medical Center, and Central Texas Medical Center. **Table 10** summarizes the outpatient safety-net health care services available across RHP 7 as identified from each of these reports.[58]

Safety net providers are ones that provide a certain level of care to uninsured patients or those with Medicaid, including federally qualified health centers (FQHCs), clinics, and local mental health authorities (LMHAs). These providers help to increase access to traditionally underserved populations.

TABLE 10. OUTPATIENT AND COMMUNITY HEALTH SERVICES AVAILABLE, BY COUNTY AND TYPE OF SERVICE, 2017

County	Type of Service	Provider
Bastrop	**FQHCs**	Lone Star Circle of Care Bastrop Health Clinic Bastrop Community Health Center - Community Health Centers of South Central Texas
	Safety Net Clinics	Smithville Community Clinic Family Health Center in Elgin
	LMHAs	Bluebonnet Trails Community Services
	Other	Community Indigent Health Care Programs Women, Infant and Children Program (WIC) Catholic Charities YMCA Bastrop Community Cares
Caldwell	**FQHCs**	Lockhart Community Health Services - Community Health Centers of South Central Texas
	Safety Net Clinics	Seton Lockhart Family Health Center Brazos Valley Community Action Agency - Caldwell Community Health Clinic Brazos Valley Community Action Agency – Health Point (n=2)
	LMHAs	Bluebonnet Trails Community Services
	Other	Seton Luling Family Medicine Clinic Community Health Centers of South Central Texas Clinic Seton Care-a-Van County Indigent Health Care Program Warm Springs Rehabilitation Women, Infants and Children Program (WIC)

[57] Directories of Facilities by Type, Health Facilities, Texas Department of State Health Services, Texas Health and Human Services; https://www.dshs.texas.gov/facilities/find-a-licensee.aspx

[58] See Data Sources for the full list of Community Health Needs Assessment reports that were included

County	Type of Service	Provider
		Catholic Charities
Fayette	**FQHCs**	Tejas Healthcare (n=2)
	Safety Net Clinics	-
	LMHAs	Bluebonnet Trails Community Services
	Other	Flatonia Community Clinic
Hays	**FQHCs**	CommuniCare (n=6, including 3 school-based)
	Safety Net Clinics	Hays County (n=2)
	LMHAs	Hill Country MHDD Centers
	Other	Oceans Behavioral Hospital Live Oak Health Partners Community Clinic (n=2) Seton RediClinics (n=2) Seton Primary Care practice in Kyle Warm Springs Rehabilitation Hospital of Kyle Women, Infants and Children program (WIC) County Indigent Health Care Program Catholic Charities YMCA
Lee	**FQHCs**	Tejas Health Care (n=1)
	Safety Net Clinics	-
	LMHAs	Bluebonnet
Travis	**FQHCs**	CommUnityCare (n=24) Ben White Health Clinic - Lone Star Circle of Care (n=1) Lone Star Circle of Care (n=2) People's Community Clinic (n=6, included 3 off site locations)
	Safety Net Clinics	Seton Community Clinics (n=3) Volunteer Healthcare Clinic (n=1) El Buen Samaritano Episcopal Mission (n=1)
	LMHAs	Austin Travis County Integral Care
	Other	Seton Shoal Creek Hospital – Behavioral health inpatient Seton Psychiatric Emergency Department Seton Mind Institute Texas Children's Study Center Austin State Hospital Medical Assistance Program (MAP) Central Health

DATA SOURCE: Caldwell County CHNA, Seton Family of Hospitals CHNAs (Caldwell County, Hays County, Seton East Region, Seton Shoal Creek Hospital, Travis County); St. Mark's Medical Center CHNA; Central Texas Medical Center CHNA

The DSRIP program had a direct impact on the number of facilities and services available to RHP 7 residents. In total, DSRIP-funded projects opened new or expanded 54 clinics or mobile units (primary, dental, specialty and behavioral health services) to serve primarily the Medicaid and uninsured populations in the region.

Travis County organizations, through the creation of the Community Care Collaborative, used the DSRIP opportunity to link disparate elements of the safety net health system together into an integrated delivery system, better connecting safety net clinics, specialty services, and hospital services across the continuum to achieve better health for its populations. Outside of Travis County, advances in infrastructure focused on expanding access to care for populations with multiple barriers.

Despite considerable expansions in healthcare infrastructure over the past five years, key informants and providers discussed that the uneven distribution of healthcare infrastructure remained a challenge in care delivery for low-income populations in the region. As described in previous sections, key informant interviewees and provider focus group participants perceived that an increasing burden was being placed on safety net providers outside of Austin-Travis County as low-income populations moved

outward. Many providers perceived that the number of community members needing these services had increased outside of Travis County, but without corresponding growth in capacity or funding.

Within Travis County, key informants also perceived a lack of safety net providers, as one interviewee in Travis County stated there were *"limited options for health care if you're using indigent care or Medicaid."* Interviewees affiliated with Travis County also indicated that the services that did exist for low-income populations, were not adequately reaching those the vulnerable population outside of the city. They identified a need for more services located within Travis County, but outside of Austin.

Health Care Workforce

A clear gap in the size of RHP 7's health care workforce was identified in the 2012 CNA. Currently, all of RHP 7's counties continue to be designated as HPSAs[59] and/or MUAs [60] by the federal government. These designations were based on both primary care and behavioral health care. They are determined by a comprehensive scoring system based upon the number of health professionals relative to the population size as well as locations, clinical hours worked, and the size of vulnerable sub-populations. Shortages may be geographic-, population-, or facility-based.[61]

Current population per provider ratios, by provider type, are detailed in **Table 11**. While these ratios are not the sole basis used to designate an area as a HPSA or MUA, they do allow for comparisons between the RHP 7 counties and the state. Additionally, the ratio from the top performing county in the U.S. for each provider type is included as a high-performance benchmark. These ratios and benchmarks are consistent with how the data are presented by County Health Rankings.

TABLE 11. POPULATION PER TYPE OF PROVIDER, BY COUNTY AND STATE, 2014-2016

	Primary Care Provider	Other Providers	Mental Health Providers	Dentists
Benchmark - Top Performing U.S. County	1,040	853	360	1,320
Texas	1,670	1,646	1,070	1,850
Bastrop	3,900	3,355	1,920	3,500
Caldwell	2,840	2,701	1,840	3,120
Fayette	2,260	3,139	5,020	1,930
Hays	2,610	2,164	1,170	3,140
Lee	3,350	8,449	1,880	3,382
Travis	1,170	1,383	450	1,470

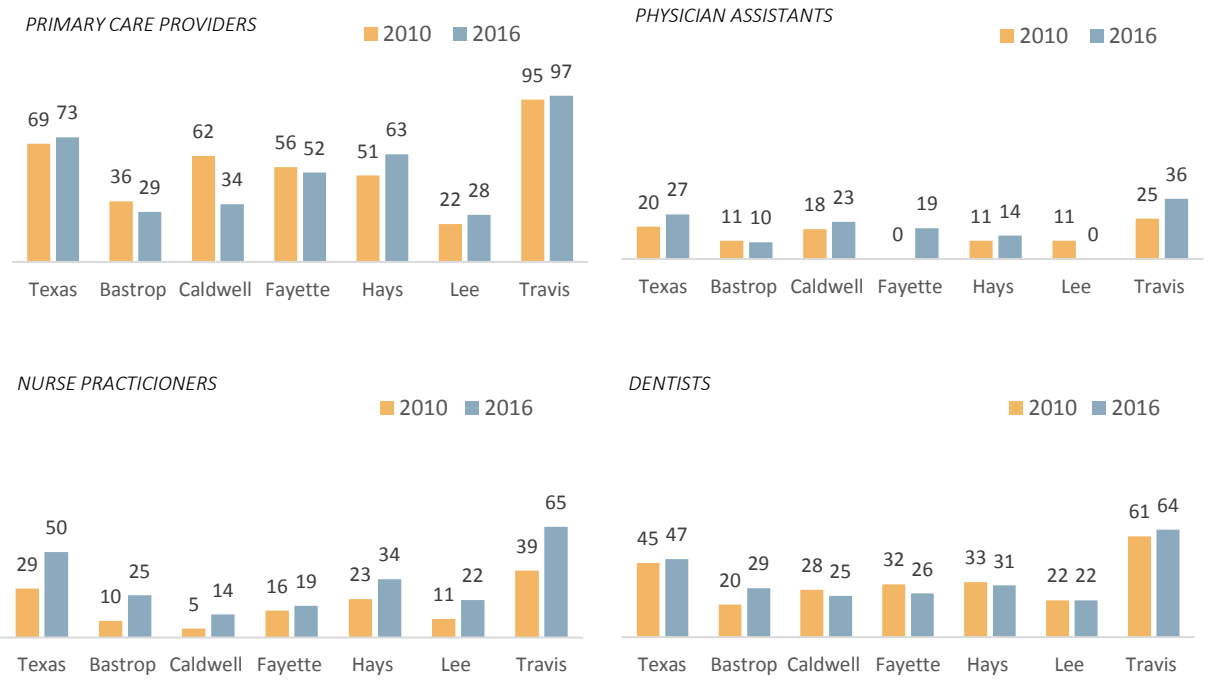
DATA SOURCE: Area Health Resource File/American Medical Association, 2014/2015 (Primary Care and Dentists), as cited by County Health Rankings; CMS, National Provider Identification, 2016 (Mental Health and Other), as cited by County Health Rankings
NOTE: Mental health providers included psychiatrists, 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; other providers included nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists

Data showed provider ratios in Travis County were lower than the ratios observed for the state, suggesting there are more providers available in Travis County for each provider type than the state

[59] Health Professional Shortage Area (HSPA) Find, Data Warehouse, Health Resources and Services Administration (HRSA), 2017; https://datawarehouse.hrsa.gov/Tools/Analyzers/hpsafind.aspx
[60] Medically Underserved Areas/Populations (MUA) Find, Data Warehouse, Health Resources and Services Administration (HRSA), 2017; https://datawarehouse.hrsa.gov/tools/analyzers/MuaFind.aspx
[61] Shortage Designation, HRSA Health Workforce, Health Resources and Services Administration; https://bhw.hrsa.gov/shortage-designation

averages. The other counties fell well above the state or Travis County ratios to varying degrees. For primary care providers, the ratio was particularly high in Bastrop and Lee counties. For other providers (i.e. nurse practitioners, physician assistants, and clinical nurse specialists) the ratio was markedly high in Lee County. For the broad category of mental health providers, Fayette County had the highest population to provider ratio that was over 4 times the state ratio. The ratios for dentists were elevated across RHP 7. Bastrop, Caldwell, Hays, and Lee counties each had a ratio that was higher than the state or Travis County ratio.

FIGURE 68. RATE OF HEALTHCARE PROVIDERS PER 100,000 POPULATION, BY COUNTY AND STATE, 2010 AND 2016



DATA SOURCE: Texas Department of State Health Services, Center for Health Statistics, Health Professions Resource Center, 2010 and 2016; NOTE: Data represent only licensed providers who are currently practicing.

Charts in **Figure 68** show the rate of providers per 100,000 population for primary care providers, physician assistants, nurse practitioners, and dentists in RHP 7 counties. A higher rate indicates better access to care for that area. For all four professions, providers tend to be concentrated in Travis County, which is consistent with discussions among key informants and providers. Bastrop, Caldwell, and Fayette counties experienced decreases in the rate of primary care providers between 2010 and 2016, while the other counties in RHP 7 increased their rates of providers or remained steady. The rate of nurse practitioners increased in all six counties, as well as in Texas overall.

Shortages of primary care providers was a concern raised by several key informants. One interviewee from Hays County indicated that the lack of primary care providers hit rural communities especially hard and impacted community members' ability to access routine care for conditions such as diabetes and hypertension. The same interviewee indicated that competition for a limited pool of primary care providers had partly led to the shortage.

> "[There's] competition for our providers – smack in the middle of San Antonio and Austin makes it hard to compete with them."
>
> -Key Informant Interviewee (Hays County)

> "Access is about having a provider. One concern is that, outside of Travis County, there are not health care providers available, so people don't go to the doctor."
>
> -Provider Focus Group Participant

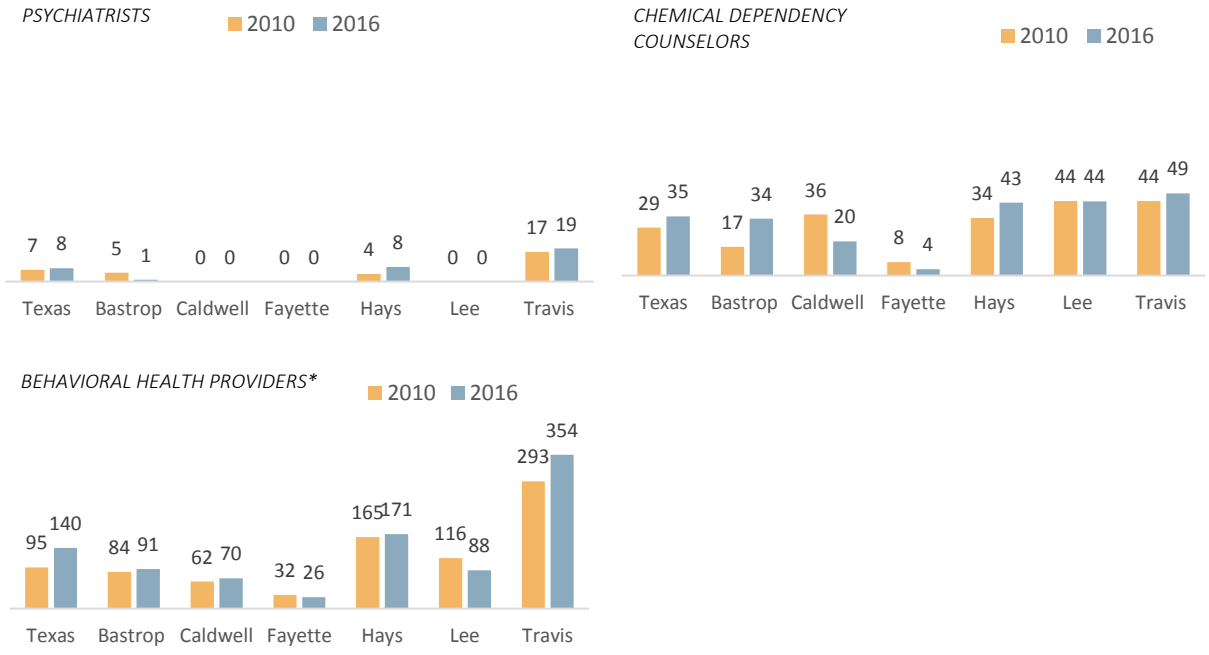
> "Providers don't accept [your insurance] or they're not taking new patients or it's 3 or 4 months before you can get an appointment."
>
> -Community Member Focus Group Participant

Provider focus group participants and key informant interviewees perceived that the lack of routine care resulted in community members developing more serious conditions and experiencing preventable hospitalizations or crisis. They also perceived this as occurring with behavioral health conditions due to a similar shortage of behavioral health providers.

Recent community health needs assessments, released in 2016 by several health care systems located within RHP 7, almost universally noted there was a shortage of primary care providers in the region.[62] Each stressed that this was a persistent problem that impacted access to timely preventative care. These assessments further noted that specialty care and specialty procedures were lacking as well, particularly within the safety net setting and outside of Travis County.

[62] See Data Sources for the full list of Community Health Needs Assessment reports that were included

FIGURE 69. RATE OF BEHAVIORAL HEALTH PROVIDERS PER 100,000 POPULATION, BY COUNTY AND STATE, 2010 AND 2016



DATA SOURCE: Texas Department of State Health Services, Center for Health Statistics, Health Professions Resource Center, 2010 and 2016
NOTE: Behavioral health providers include marriage and family therapists, psychiatrists, licensed professional counselors, licensed psychologists, and licensed clinical social workers; data represent only licensed providers who are currently practicing

Charts in **Figure 69** show the rates of psychiatrists, chemical dependency counselors, and other behavioral health providers. As with medical and dental providers, Travis County had a higher rate of each type of behavioral health care provider than other counties in RHP 7. However, Hays and Lee counties did have rates of chemical dependency counselors in 2016 that were nearly as high as Travis County.

Shortages of behavioral health care providers in counties outside of Travis County was also a consistent theme that emerged from key informant interviews and provider focus groups. Participants perceived that this shortage of behavioral health care providers occurred across the board, but especially for providers that accepted Medicaid or that partnered with indigent health programs.

Key informants perceived that the limited resources that were available to Medicaid or indigent populations for behavioral health care did not have the capacity to meet the high level of demand being placed on them. Key informants and provider focus group participants highlighted that the local mental health authority was only able to provide services to community members in direct crisis. Social service provider focus group participants corroborated this by sharing experiences of community members being turned away from services and told to come back once they were experiencing a crisis.

Based on the secondary data shown above, Fayette County appears to be experiencing the greatest behavioral health workforce shortages. However, within Travis County, key informants also perceived a need for more providers along the continuum of behavioral health care, for what one interviewee called "*pre-crisis services*" such as counseling and medication management. Several interviewees noted an

increasing need for these services, due to a perceived increase in behavioral health conditions and poor mental health in the community. One key informant Travis County indicated that there was a need for more services specifically for substance abuse in the county and perceived that strides that had been made with mental health care had not been matched in substance abuse services.

> "[Travis County is] continuing to see a need for mental health services across the board, whether they be primary counseling services and medication management through to substance use services to in-patient care for substance use and behavioral health."
>
> -Key Informant Interviewee

> "There's people who don't have phone or a computer or a reliable way to get anywhere, so getting to see a PCP is difficult, let alone a neurologist or a cardiologist."
>
> -Key Informant Interviewee

Limited availability of specialty care providers or access to specialty procedures was also raised as a concern by many key informant interviewees and focus group participants. Most identified specialty care as the type that was least available in RHP 7. Provider and community member focus group participants shared that specialty care options for patients with Medicaid or on indigent health programs were limited, especially outside of Travis County. Interviewees perceived that the specialists that do accept those coverages often had long waits for appointments or were located far away from where patients lived, amplifying the barriers of time and transportation. Given time, cost, and transportation barriers, many participants indicated that community members often end up waiting as long as possible to access these types of services, potentially exacerbating chronic health conditions and increasing the need for more health care down the line.

Insurance Coverage

Each county is responsible for providing health care services to indigent populations not covered by other state health programs. Indigent in this context is defined in state law as individuals with incomes below 22% of FPL. Counties with a public hospital or a hospital district use the taxing authority of those entities to collect revenue to support these health care services. In counties without a hospital district or public hospital, county governments have responsibility for providing indigent care. This may be accomplished either directly or through a contract.

Within RHP 7, only Travis County has a hospital district/public hospital. Travis County uses hospital district revenue to expand eligibility to as high as 100% of FPL for most populations. For people with even higher income levels, people with chronic conditions may now be eligible for coverage – a policy effort aimed at better managing chronic disease. Outside Travis County, smaller county budgets limit capacity for indigent care programs that go beyond the minimum eligibility requirement.

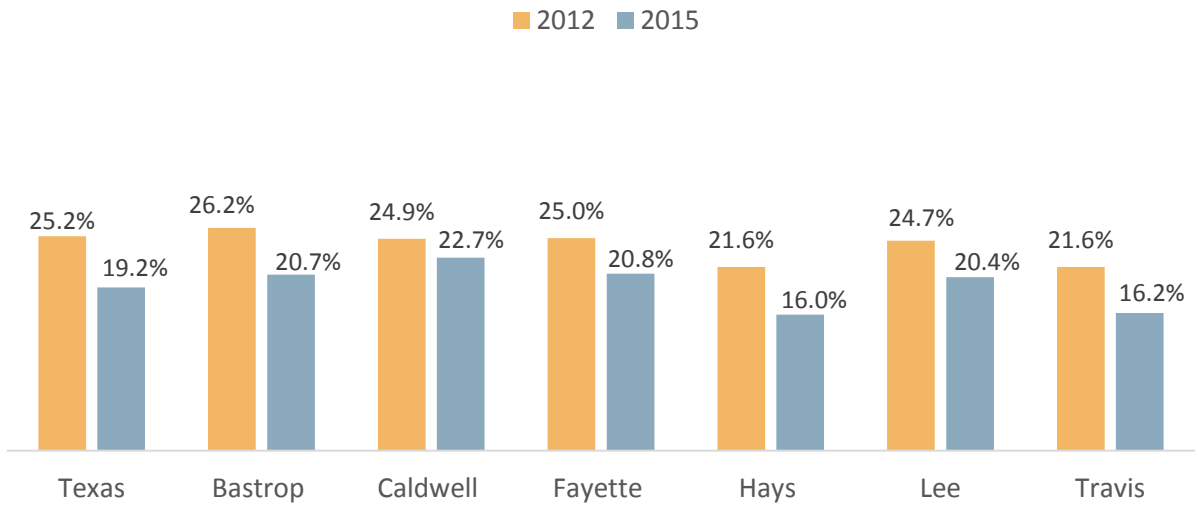
Due to the availability of private coverage through the Affordable Care Act's (ACA) health insurance exchange, the state's uninsured rate has declined since 2010.[63] Texas elected not to expand Medicaid

[63] The Uninsured & the ACA in Texas, Episcopal Health Foundation; http://www.episcopalhealth.org/en/research/ehf-research/

eligibility and currently has very narrow eligibility criteria for non-disabled adults (eligible only if caring for children and income <15% if FPL)[64]. Declines in the uninsured rate are therefore likely due to individuals participating in the insurance market. Federal data show that over 80% percent of those who enrolled in a federal marketplace health plan in Texas have received a premium tax credit to assist with payments.[65]

At the time of the 2012 CNA report, Bastrop, Caldwell, and Lee counties had the highest rates of uninsured adults across RHP 7. During this same time, 15-22% of children were uninsured across RHP 7. It was unclear in 2012 whether Texas would participate in Medicaid expansion (expanding coverage to all legal residents living at or below 133% FPL). However, some analyses and projections conducted at that time suggested that the region's uninsured population would decline based upon moderate scenarios of public and private health insurance enrollments during the 1115 Waiver period.[66]

FIGURE 70. PERCENT OF POPULATION UNDER 65 YEARS OLD THAT IS UNINSURED, BY COUNTY AND STATE, 2012 AND 2015



DATA SOURCE: U.S. Census Bureau, Small Area Health Insurance Estimates, Interactive SAHIE Data and Mapping Tool, 2012 and 2015

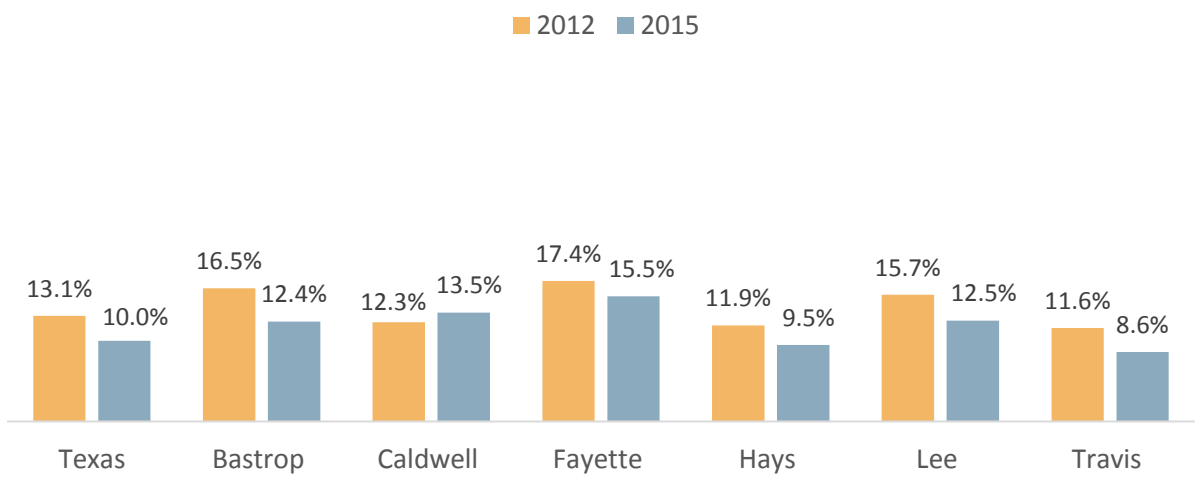
As of 2015, the uninsured rate for those under age 65 had declined in Texas and across all RHP 7 counties (**Figure 70**). Caldwell County had the smallest decline and had the highest uninsured rate in the region (22.7%). Bastrop, Fayette, and Lee counties each had rates of approximately 20%, while Hays and Travis counties declined to rates of approximately 16%.

FIGURE 71. PERCENT OF POPULATION AGE 18 OR YOUNGER THAT IS UNINSURED, BY COUNTY AND STATE, 2012 AND 2015

[64] Texas and the ACA's Medicaid Expansion, HealthInsurance.org, 2017; https://www.healthinsurance.org/texas-medicaid/

[65] Health Insurance Marketplaces 2017 Open Enrollment Period – Final Enrollment Report: November 1, 2016 – January 31, 2017, Centers for Medicare and Medicaid Services, 2017; https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html

[66] Estimates of the Impact of the Affordable Care Act on Counties in Texas, Rice University Hobby Center for the Study of Texas for Methodist Healthcare Ministries, 2012; http://www.mhm.org/home-mhm?task=document.viewdoc&id=11



DATA SOURCE: U.S. Census Bureau, Small Area Health Insurance Estimates, Interactive SAHIE Data and Mapping Tool, 2012 and 2015

Among children, age 18 or younger, most RHP 7 counties experienced small declines in the uninsured rate between 2012 and 2015 (**Figure 71**). Only Caldwell experienced an increase, going from 12.3% in 2012 to 13.5% in 2015. Fayette County remained the county with the highest percentage of uninsured children.

Stakeholder survey data showed that insurance was a key barrier to getting needed health care. 'Insurance problems/lack of coverage/not enough coverage' was the second most frequently identified issue among both community members (40.4%) and providers (77.3%) that responded to the survey. In addition, issues related to 'cost of care/co-pays' (38.8% of community members and 69.7% of providers), and 'insurance is complicated/don't know how insurance works' (24.7% of community members and 66.4% of providers) were also identified by survey respondents as barriers to care.

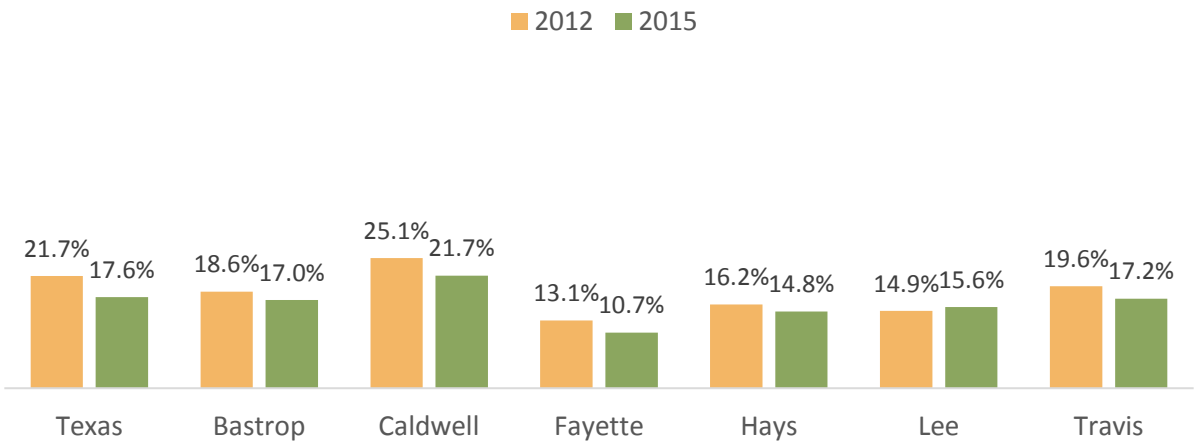
TABLE 12. MEDICAID ENROLLMENT COUNT AND RATE, BY COUNTY AND STATE, 2012 AND 2016

	Count		Rate per 100,000	
	2012	**2016**	**2012**	**2016**
Texas	3,656,060	4,070,328	13,992	14,413
Bastrop County	10,177	12,861	12,931.8	14,474.1
Caldwell County	6,036	7,176	15,066.6	16,152.5
Fayette County	2,282	2,637	9,041.3	9,851.7
Hays County	14,314	16,955	8,300.5	8,221.8
Lee County	1,925	2,272	11,248.6	12,530.6
Travis County	118,030	120,713	11,022.1	10,308.8

DATA SOURCE: Texas Health and Human Services, Medicaid Enrollment Statistics, 2012 and 2016
NOTE: Count is defined as "Yearly Average"

Table 12 shows Medicaid enrollment in Texas and RHP 7. In all RHP 7 counties, except Hays and Travis counties, there were modest increases in enrollment rates between 2012 and 2016. Medicaid enrollment was highest in Bastrop (14,474.1 individuals per 100,000) and Caldwell (16,152.5 per 100,000) counties and lowest in Fayette (9851.7 per 100,000) and Hays (8,221. 8 per 100,000) counties.

FIGURE 72. MEDICARE RECIPIENTS ELIGIBLE FOR MEDICAID (DUAL ELIGIBLES), BY COUNTY AND STATE, 2012 AND 2015



DATA SOURCE: Centers for Medicare and Medicaid Services, Medicare Geographic Variation, Public Use File
NOTE: defined as the percent of Medicare fee-for-service beneficiaries who are eligible for Medicaid for at least one month in the year

"Dual eligibility" refers to individuals that qualify for both Medicaid and Medicare. These are typically low-income seniors or younger adults with disabilities. People who are dually eligible often have complex health needs that require more care from the system.[67] Between 2012 and 2015 the proportion of Medicare recipients that were also eligible for Medicaid declined slightly in most RHP 7 counties (**Figure 72**). Caldwell County had the highest proportion of Medicare recipients that were dually eligible for Medicaid.

> "Insurance does make a difference for some people, they will sit at home and suffer if they don't have insurance."
>
> -Community Member Focus Group Participant
>
> "I have Medicaid and there's only certain programs that you can get on, depending on the type of Medicaid you have."
>
> -Community Member Focus Group Participant

Accessibility

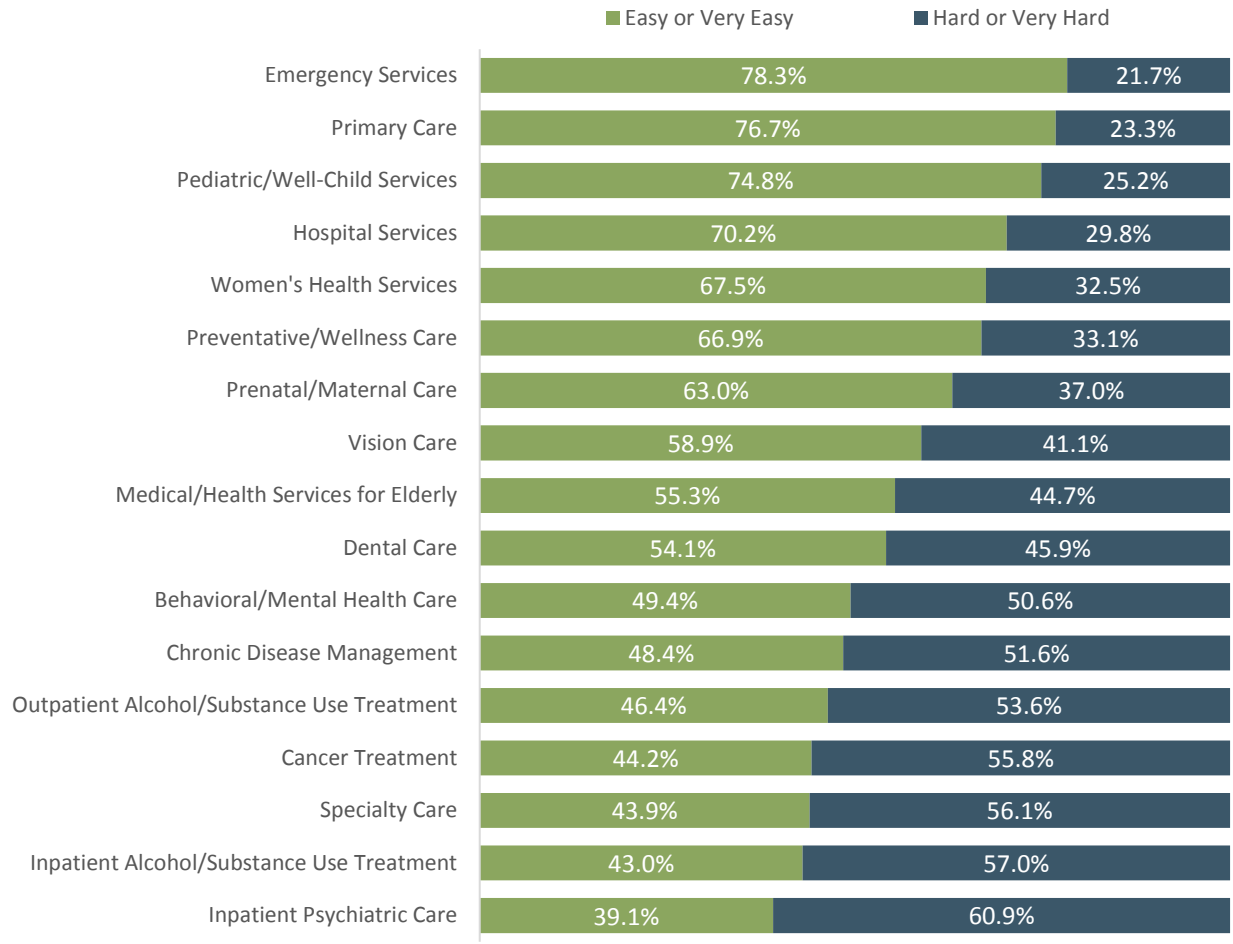
Health care access is generally defined as "timely use of personal health services to achieve the best health outcomes" and it relies on entry to the health care system (e.g. insurance coverage), location or geographic availability where services are needed, and a relationship with a trusted provider.[68] This section examines data related to perceived accessibility of services in RHP 7 and explores some of the factors that may be limiting access.

[67] Dual Eligible, Kaiser Family Foundation; http://www.kff.org/tag/dual-eligible/
[68] Access to Health Services, Healthy People 2020; Office of Disease Prevention and Health Promotion; https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

Perceived Ease of Access

Perceptions around ease of access were captured by the stakeholder survey. **Figure 73** (community members) and **Figure 74** (providers) summarize these results.

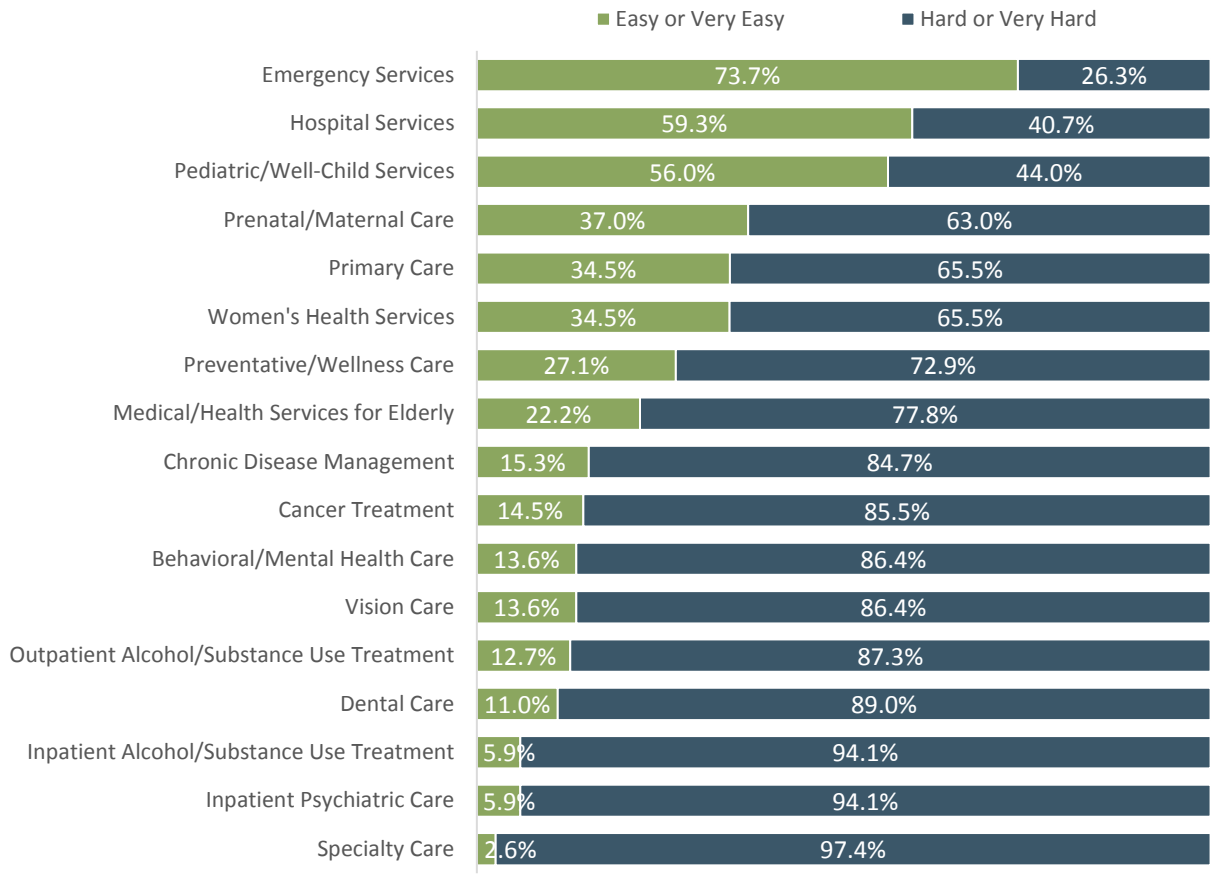
FIGURE 73. COMMUNITY MEMBER SURVEY RESPONDENTS PERCEPTION OF ACCESSIBILITY OF HEALTH CARE SERVICES, 2017



DATA SOURCE: RHP 7 Community Needs Assessment Stakeholder Survey, 2017
NOTE: Community Members responded based upon their own community

Inpatient behavioral health services (both psychiatric and substance use services) were most frequently rated as 'hard' or 'very hard' to access by community member respondents (**Figure 73**).' Specialty care', 'cancer treatment', 'outpatient substance use treatment', and 'chronic disease management' were also rated as 'hard' or 'very hard' to access by over half of community members. In contrast, the majority of community members rated 'emergency services', 'primary care', 'pediatric/well-child services', and 'hospital services' as 'easy' or 'very easy' to access.

FIGURE 74. PROVIDER SURVEY RESPONDENTS PERCEPTIONS OF ACCESSIBILITY OF HEALTH CARE SERVICES, 2017



DATA SOURCE: RHP 7 Community Needs Assessment Stakeholder Survey, 2017
NOTE: Providers responded based upon the low-income population served

In the stakeholder survey, providers were asked to rate the ease of access for low-income individuals in the communities they serve. Overall, providers ranked far more services as difficult to access than community members did. Consistent with the community member responses, the majority of providers rated 'emergency services', 'hospital services', and 'pediatric/well child services' as 'easy' or 'very easy' to access. Both groups of survey respondents also identified inpatient behavioral health services (both psychiatric and substance use services), 'specialty care', and 'inpatient psychiatric care' as 'hard' to access.

Timeliness

During focus groups, timeliness was defined as "when services were available." Many providers noted that services were only offered during traditional work hours which created a barrier for patients who were not able to take time off work or arrange child care. This was a sentiment echoed by community member focus group participants who were often unable to fit health care appointments in their daily schedules. One provider participant in the social service provider focus group said that expanding hours for medical care was *"a low-hanging fruit"* to increase community member's access to health care.

Provider focus group participants also connected timeliness with social services having reliable schedules, especially for their community outreach services. Participants shared that dependable services increased access and helped community members develop relationships with providers.

> "Some patients just can't afford to take off work during the middle of the day or [to take] their kids out of school. We have to look at accessibility from the patient point of view."
>
> -Provider Focus Group Participant
>
> "When I work, I need a 7 am appointment to have time to go before work."
>
> -Community Member Focus Group Participant

Stakeholder survey data were consistent with focus group findings. Among community members that responded to the survey, 42.1% indicated that the 'lack of evening and weekend services' had made it harder for them to access the care they needed. This barrier was the most frequently identified barrier among community members. Many community members also selected 'long waits for appointments' (40.4%) and 'lack of child care' (18.5%) as factors that had made it hard for them to get the care they needed.

A majority of providers that responded to the stakeholder survey identified these same issues as barriers to care for low-income communities. A 'lack of evening and weekend services' was selected by 58.0% of providers, 'long waits for appointments' by 76.5% of providers, and 'lack of child care' by 64.7% of providers.

Navigation and Awareness

In discussions, providers described an accessible system as one that patients could easily understand and navigate to get the care they needed. Several provider focus group participants shared that navigability could be improved by bolstering navigator services in the region. Providers also suggested the creation of central hubs that could facilitate information sharing and system navigation for patients and organizations alike.

Key informant interviewees expanded on this theme by emphasizing the community's lack of awareness of services that are available. Many interviewees stressed the fact that many community members simply do not know what services exist, what they are eligible for, or even how to find them. Community members also discussed in focus groups the challenges of finding information on resources or someone to help them navigate the system.

Recent community health needs assessments, released in 2016 by several health care systems located within RHP 7, frequently noted navigation and awareness of services as a key need or gap in the community.[69] They concluded that many community members do not know where to go or whom to ask for help. They also stressed that navigation needed to extend to helping individuals with insurance and other financial issues.

[69] See Data Sources for list of community health needs assessments

Most of the providers (71.4%) that responded to the stakeholder survey identified 'don't know services are available' as a barrier for low-income community members. Over half of providers also identified 'difficulty scheduling appointments' (57.1%) and 'difficulty coordinating care between providers' (54.6%) as barriers, further highlighting the navigability of the system as an issue. However, only about 1 in 4 community members that responded to the stakeholder survey also identified these issues as barriers.

> "The patients need to know how to engage that service if it's available. We've done a really good job of creating a system that's really confusing."
>
> -Provider Focus Group Participant

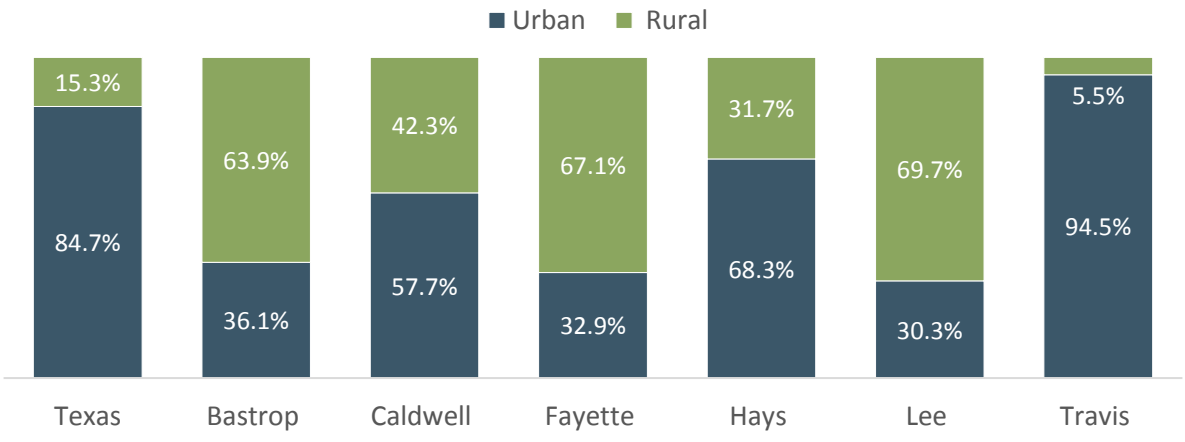
> "There's a lot of things available here but the main problem is that people just don't know. We need to have one main place where someone can come and find out where to go."
>
> -Community Member Focus Group Participant

> "We often think of social services as navigators, but they aren't. If you are a food bank…you are not using your resources to direct people to the next step because you are focused [on what you are doing]. You can't help them along."
>
> -Key Informant Interview

> "It becomes tiresome to call one organization and they refer you to the next one and you have to answer all of the same questions again. And it is frustrating to tell your story over and over again, but there is no way to share data."
>
> -Key Informant Interviewee

Location of Services

FIGURE 75. URBAN AND RURAL POPULATION, BY COUNTY AND STATE, 2010



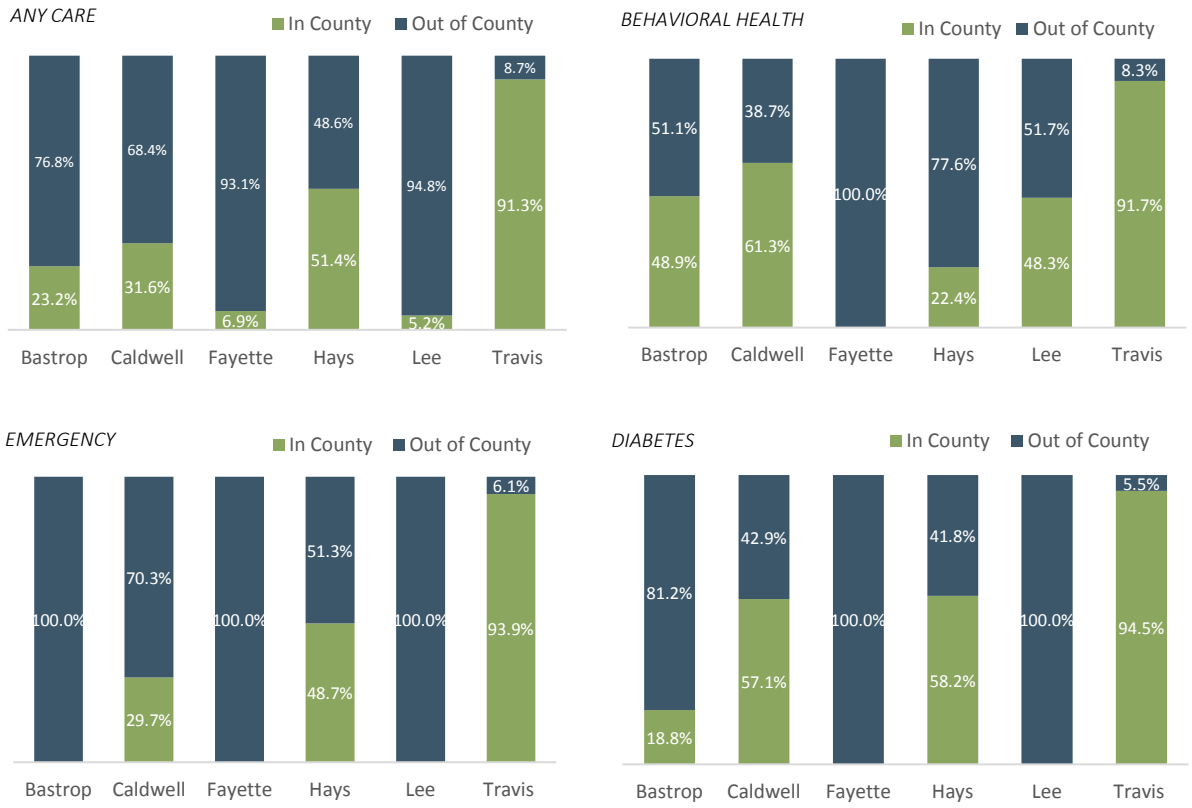
DATA SOURCE: U.S. Census Bureau, 2010 Census

NOTE: U.S. Census Bureau identifies two types of urban areas: Urbanized Areas (UAs) of 50,000 or more people and Urban Clusters (UCs) of at least 2,500 and less than 50,000 people; "rural" encompasses all population, housing, and territory not included within an urban area.

RHP 7 counties differ greatly in the proportion of their populations that live in urban or rural areas, based on 2010 U.S. Census data. Nearly all of Travis County residents lived in urban areas (95%) as of 2010, and in Caldwell and Hays counties, over half of residents lived in urban areas (**Figure 75**). In contrast, most residents in Bastrop, Fayette, and Lee counties lived in rural areas.

A consistent theme that emerged across focus groups, key informant interviews, and the stakeholder dialogue activity was the geographic differences in where providers and services are located in the region. Participants indicated that health care providers and social services are concentrated in urban areas, presenting barriers related to transportation and timing of appointments for those living in rural areas. Several participants noted that, for community members that do not live in urban centers, one doctor's appointment can mean a whole days' worth of travel, potentially leading to lost wages or additional child care costs.

FIGURE 76. CROSS-COUNTY CARE RECEIVED BY PATIENTS SERVED BY SAFETY NET PROVIDERS IN RHP 7, 2016



DATA SOURCE: RHP 7 Cross County Care Reporting, Integrated Care Collaboration, 2016
NOTE: Data represents only patients who accessed care from providers who share data with the Integrated Care Collaboration, the local Health Information Exchange; counts and percentages are based upon unique patients who have had at least one encounter of the type indicated; Proportions are estimates only, patients may have been counted multiple times if they received care in more than one county.

Figure 76 summarizes the proportion of patients during 2016 that received care (by type of care) outside of their county of residence. Among patients living in Fayette and Lee counties, nearly every patient received every type of care outside of their home county. All (100%) patients living in Bastrop, Fayette, and Lee counties that received emergency department services did so outside their home county. Large proportions of patients living in Bastrop, Fayette, and Lee counties also received care for diabetes outside of their home county.

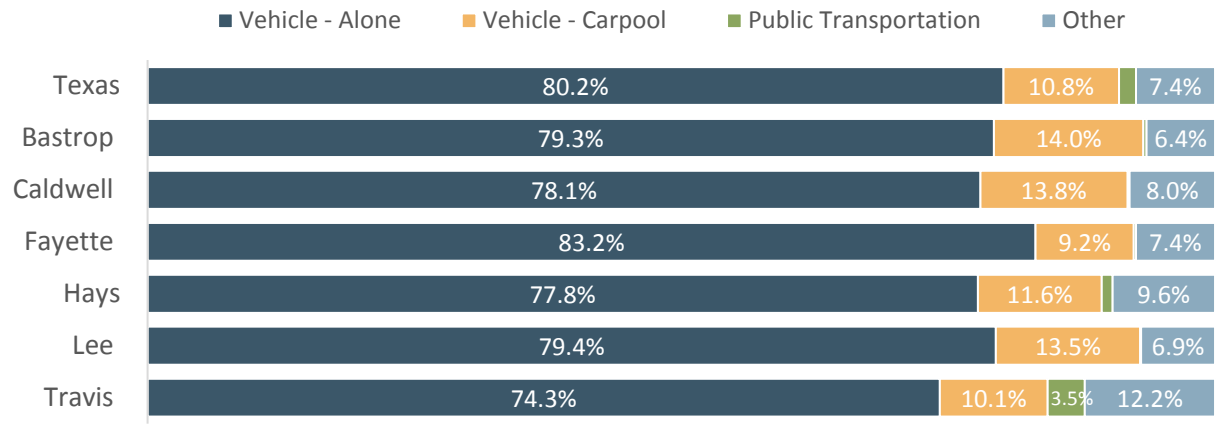
Community member focus group participants spoke to the experience and challenge of having to leave the county to access care. However, several social service providers indicated in focus groups that crossing county lines is not always an option for individuals, particularly for social services or assistance programs that have limitations on whom they can serve based on the person's city or county of residence. As discussed previously in the section on migration, providers frequently discussed county lines as *"invisible boundaries"* that stopped people from getting the care that they needed.

> "For me, I have COPD and it's hard because when I was in San Antonio I used to have all my doctors there. Now I have to drive to Austin to find a doctor and even then, they don't want to take my Medicaid."
>
> -Community Member Focus Group Participant
>
> "Some organizations have the capacity to serve other communities [through] satellite services but may not actually be present – we say we serve a 5-county region, but we can't go out there because we already have long waits."
>
> -Provider Focus Group Participant
>
> "[Providers] are only in the city on limited days and times. If you can't get an appointment, you have to go out to them…It's hard to get there only on certain days and then if you're trying to see multiple doctors on the same day and it overlaps, it's really hard."
>
> -Community Member Focus Group Participant

Transportation

Except for the central Austin area, RHP 7 was described as having limited public transportation infrastructure by focus group participants and key informant interviewees. In Austin, the Capital Metro service is available within the urbanized area of Travis County and the Capital Area Rural Transit System (CARTS) provides regional transportation for the non-urbanized areas of Bastrop, Caldwell, Fayette, Hays, Lee, and Travis counties and the San Marcos urbanized area.

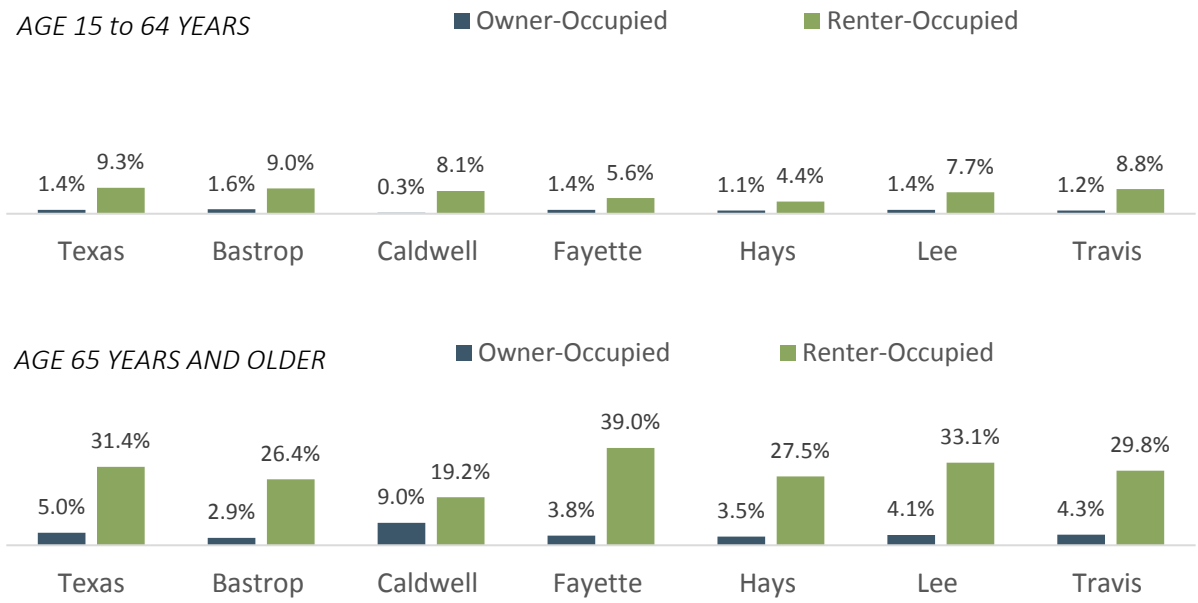
FIGURE 77. MEANS OF TRANSPORTATION TO WORK FOR POPULATION 16 YEARS AND OLDER, BY COUNTY AND STATE, 2015



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015
NOTE: Vehicle includes using a car, truck, or van

Generally, residents in RHP 7 rely on driving their own vehicle for their transportation needs. The majority of the working population in each county utilized a personal car, truck, or van to get to work (range of 74.3% in Travis County to 83.2% in Fayette County) (**Figure 77**). Smaller proportions utilized carpools, public transportation, or other means to travel to work.

FIGURE 78. PERCENT OF HOUSEHOLDS WITH NO VEHICLE AVAILABLE, BY COUNTY AND STATE, 2015



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2006-2010 and 2011-2015

Despite heavy reliance on vehicles, household access to a vehicle was not universal in RHP 7. Differences were observed between owner and renter-occupied households, as well as by age group (**Figure 78**). Among those age 15 to 64 years, a larger proportion of renter-occupied households had no vehicle available compared to owner-occupied households across RHP 7. This ranged from a low of 4.4% of renters in Hays County to a high of 9.0% of renters in Bastrop County. Among individuals age 65 and older, the proportion without access to a vehicle was much higher in renter-occupied households compared to owner-occupied households. This ranged from a low of 19.2% in Caldwell County to a high of 39.0% in Fayette County. In both age groups, the availability of a car was not an urban/rural issue. The rates of households without access to a car were as high in Travis County as the other RHP 7 counties.

Nearly all providers that responded to the stakeholder survey (91.4%) identified 'lack of transportation' as a factor that made it hard for low-income community members to get the health care they needed. Over half (58.8%) also selected 'the distance to closest provider' as a barrier. Among community members that responded to the stakeholder survey, about 1 in 3 identified 'lack of transportation' or 'distance to closest provider' as factors that had made it harder for them to access care.

The cost of transportation was a factor noted by several key informants as a burden on those who did not live near transportation hubs. Provider focus group participants shared a perception that the cost of gas could be a deterrent to community members in more rural areas accessing services. Several interviewees noted that low-income community members often had to make a choice between affordable housing and affordable transportation, which aligns with the downstream impacts of migration out of the urban centers that were described earlier.

"I can get someone engaged if I can pay for their gas."

-Provider Focus Group Participant

"If families can find housing that they can afford it's not in the city core…so whatever savings they're getting from finding low-income housing they're spending on getting to work and getting kids to school and just getting around."

-Key Informant Interviewee (Travis County)

Interviewees and provider focus group participants did mention that CARTS provided a number of transportation options that are helpful to RHP 7 residents who are disabled or are low-income and Medicaid eligible. These services include the "Country Bus" which picks up at an individual's home or workplace and "Medical Transportation" which provides non-emergency transportation at no cost for individuals using certain Medicaid programs.[70]

Community member focus group participants were familiar with the CARTS services in their area. However, many felt services were limited and often not convenient for those that use them. Participants who had used CARTS services shared that they had to make multiple calls to schedule transportation. Several community members also described instances where their scheduled transportation did not show up on time, or at all, or they were not able to get to appointments because CARTS was not available at the time needed. As one community member stated: *"You have to be literally calling them [CARTS] constantly when you need to get somewhere."* The limitations of CARTS and other services that provide transportation to medical appointments was echoed by several key informants as well.

Participants in community member focus groups voiced a need for more mobile health care and in-home health care services to address barriers created by lack of transportation. Key informants and provider focus group participants shared this perception and indicated that mobile health programs helped *"meet people where they were at,"* instead of expecting community members to navigate systems by themselves. Provider focus group participants stressed that mobile visits needed to be done on a routine schedule that patients could rely on and that would allow them to develop a consistent relationship with their providers.

"Take a group of doctors and visit the homes of those who can't make it in – older adults and those without transportation."

-Community Member Focus Group Participant

"Getting providers to where people already are is huge [like with] mobile units out to rural areas. Even if it can't be all the time but at least on a regular schedule so people can rely on it."

-Provider Focus Group Participant

Key informant interviewees from Travis County shared similar perceptions about the barriers presented by transportation and location of services. Interviewees that worked in Travis County indicated that

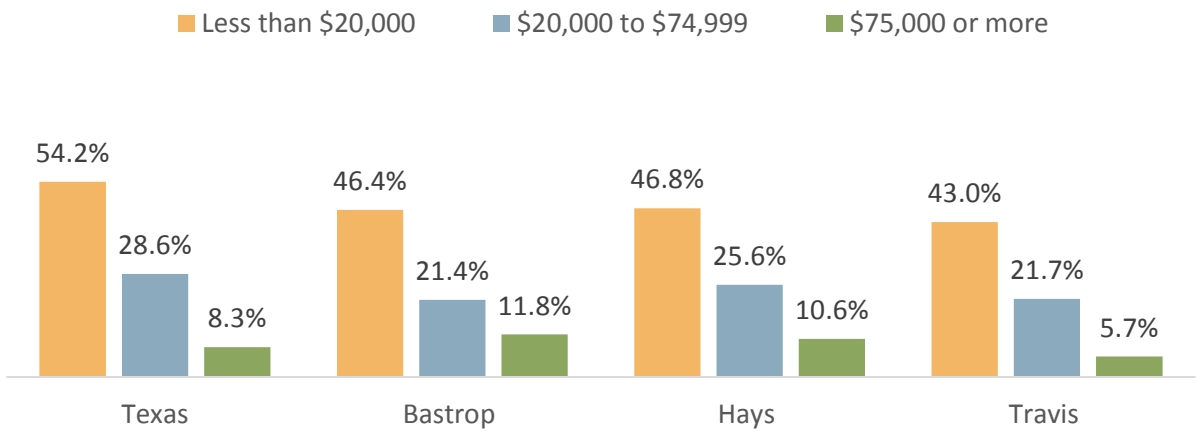
[70] Capital Area Rural Transit System (CARTS); http://www.ridecarts.com/

access barriers increased the farther people move away from the city center, and that low-income community members faced distance and transportation difficulties even if they remained within city or county limits. One key informant from Travis County shared *"A doctor's appointment for your child, if you take public transit, is probably going to cause you to take a full day off work."* Interviewees indicated a need for bolstering the health care and social service infrastructure in Travis County, outside of the Austin city center. Transportation also arose as critical need in the recent Travis County Community Health Assessment report.[71] In it, issues of limited public transportation options, inconvenient house of operation, and amount of time it takes to travel into the Central Austin via public transportation were all highlighted.

Technology

Several Healthy People 2020 objectives relate directly to increasing individual's access to the internet and use of mobile devices as a way of improving health care quality and population health outcomes in the U.S.[72] As the healthcare delivery system increases its use of the internet or other technologies to delivery care or deliver health information. Populations without access to the internet or those with limited literacy skills may not benefit from these technological advances. National data have suggested that over a third of those without home broadband service felt it impaired their ability to get health information (40% also felt it impaired their ability to learn about or access government services).[73]

FIGURE 79. HOUSEHOLDS BY INCOME LEVEL WITHOUT AN INTERNET SUBSCRIPTION, 2015



DATA SOURCE: U.S. Census Bureau, American Community Survey 1-Year Estimates, 2015

Across RHP 7, household internet access was found to vary greatly by income level (**Figure 79**). In Bastrop, Hays, and Travis counties, slightly over 40% of households with annual income less than $20,000 had no internet access. Nearly a quarter of households with incomes between $20,000 and $74,999, also had no internet access. However, national data show that rates of smart-phone and cell-

[71] Community Health Assessment – Austin/Travis County, September 2017 Draft; http://austintexas.gov/sites/default/files/files/Health/CHA-CHIP/ATC_CHA_DRAFT_09_26_17__002_.pdf

[72] Health Communication and Health Information Technology, Healthy People 2020; Office of Disease Prevention and Health Promotion; https://www.healthypeople.gov/2020/topics-objectives/topic/health-communication-and-health-information-technology

[73] Home Broadband 2015, Internet & Technology, Pew Research Center, 2015; http://www.pewinternet.org/2015/12/21/home-broadband-2015/

phone ownership are generally high in the U.S., which may mean access to online content and communication is not as limited as internet subscription data may suggest.

As of 2016, it was estimated that 64% of individuals in the U.S. with incomes less than $30,000 owned a smart phone and an additional 29% owned a standard cell phone. Rates of ownership were similar among individuals living in rural areas (67% and 27% respectively).[74]

Other Factors

The stakeholder survey asked providers and community members to select factors that made it harder for them to access health care from an extensive list. Most survey respondents selected factors related to insurance, navigation or awareness of services, timeliness, or transportation – all which have been described in previous sections. Additional categories that were included in the survey list were related to comfort seeking care, communication, and customer service.

Nearly 65% of providers selected 'fear due to immigration status' as a barrier to health care for low-income individuals. It was selected more frequently than factors such as 'lack of evening or weekend hours', 'difficulty scheduling appointments', or 'distance to closest provider'. In contrast, only about 12% of community members that responded to the stakeholder survey selected 'fear due to immigration status.'

Another factor that differed between provider and community member respondents was 'language problems/cannot communicate with provider or office'. While it was selected as a barrier by more than half of providers (58%), only about 12% of community members selected it.

Factors that were not selected frequently by either group of stakeholder survey respondents may represent areas in which the health care system is functioning well. These factors related to customer service. Relatively few respondents (<15% of community members and <32% of providers) selected 'poor customer service,' 'discrimination by provider or staff,' 'afraid to have health check-up,' or 'health care information is not kept confidential.'

[74] Mobile Fact Sheet, Internet & Technology, Pew Research Center, 2017; http://www.pewinternet.org/fact-sheet/mobile/

Stakeholder Perceptions of Delivery System

A broad range of RHP 7 stakeholders were engaged as part of the CNA through the stakeholder dialogue activity, focus groups, key informant interviews, and the stakeholder survey. Each of these data collection activities sought the stakeholder's perspective on the current state of the social service and health care delivery system in RHP 7. Questions focused on strengths of the system, current challenges to the system, and priority areas for future improvement. Perceptions of DSRIP impact were also collected from stakeholders who were knowledgeable about those efforts.

Key Themes

Communication and Collaboration

RHP 7 stakeholders noted that a growing sense of collaboration in the region was one of the most positive impacts of the 1115 Waiver and DSRIP projects. Key informant interviewees and focus group participants perceived that DSRIP projects increased collaboration between organizations and improved the delivery of care. Despite these successes, many stakeholders shared that more work was needed to increase communication between organizations and providers. They suggested that there was a specific need for more data sharing between health care delivery systems and social service agencies/community organizations to help community members navigate these systems easily and to prevent people from falling through gaps.

Access to Care

Interviewees and provider focus group participants noted that DSRIP-led efforts had enhanced co-location and wrap-around services, removing some access barriers for community members. Additionally, key informants noted that additional evening and weekend hours at some locations, as well as telehealth and mobile health services, improved access to care. Despite these successes, provider focus group participants and key informant interviewees indicated that more work was needed to increase access to health care and social services, especially to rural communities and communities experiencing the impacts of migration out of Austin-Travis County.

Social Determinants of Health

Stakeholders identified a growing recognition of the social determinants of health and their impact on individual and community members' health as a strength of the delivery system. With this growing recognition, many participants recognized that the system currently faced challenges in helping people address those factors. Several interviewees saw opportunities for health care providers to begin working on social determinants of health, particularly in education and transportation, which would help to improve population health across RHP 7.

The sub-sections that follow, explore in greater depth the data that were examined around each of these themes. Specific data are discussed in terms of trends and differences between counties and data source.

Strengths and Challenges

Stakeholder dialogue participants, provider focus groups, and key informant interviewees consistently identified the level of collaboration that existed between organizations and agencies as major strength of the health care delivery system in RHP 7. During the stakeholder dialogue, it was evident that the spirit of collaboration was a characteristic that individuals most appreciated about working in the region.

Several stakeholders pointed out that the health care delivery system currently employs caring individuals who deliver high-quality care.

> "There's a lot of collaboration in this region. Every organization that's sitting at this table has points of interaction with each other."
>
> -Provider Focus Group Participant
>
> "Often times the most immediate impact [of DSRIP] we see is from different organizations working together differently than they have before."
>
> -Key Informant Interviewee

Stakeholders saw collaboration as the both the health system's greatest strength and its greatest challenge. Stakeholders, providers, and key informants consistently identified the need for even greater collaboration to better serve community members. This was specifically related to information and data sharing.

Stakeholder dialogue participants expressed that the lack of information and data sharing between social services and health care entities had created a system that was siloed and fragmented. Which in turn was perceived as making it difficult for patients to navigate the system and access needed care. Provider focus group participants shared this perspective. They suggested that despite growing co-location and collaboration, the health care delivery system remained siloed. Several key informant interviewees noted that greater information sharing between organizations could help to decrease service duplication in certain regions.

> "State agencies don't even share info – 17 HHSC agencies all record data differently and are not aware of what each agency can do"
>
> -Stakeholder Dialogue Participant
>
> "It's still more fragmented than we know it should be. Anytime there's a gap for a patient to fall through it's not a good thing"
>
> -Provider Focus Group Participant
>
> "For those of us who work with the LMHA, the state's involvement in decision making is a real barrier. Someone makes a decision and they don't realize what it looks like on the ground."
>
> -Provider Focus Group Participant

Provider focus group participants, key informant interviewees, and stakeholder dialogue participants also shared the perception that there is growing recognition within the system of the social determinants of health and their impact on community members' health. Stakeholders saw this as a positive shift and a potential strength of the current health care delivery system. Stakeholders agreed that focusing on upstream factors, such as housing or transportation, would have a stabilizing, positive impact on individual and population health. Providers specifically suggested that this shift could lead to better delivery of care in the future, particularly improving care management.

While there has been a growing recognition of these factors within the system, several provider focus group participants perceived that the delivery system was not set up to address the social determinants of health. They noted that health services could not be completely successful until the delivery system could impact these upstream factors as well. As one provider clearly stated, "*Care management isn't realistic when there's a lot of other social determinants going on.*"

> "There's a growing acknowledgment among leadership that health and wellness is more than just clinical – that there's the social determinants of health, that transportation and housing effect health."
>
> -Provider Focus Group Participant
>
> "Concept of social determinants wasn't part of the discussion five years ago, and now they are"
>
> -Stakeholder Dialogue Participant

Other barriers or challenges faced by the health care delivery system included consistent, sustainable funding, provider shortages, and state/federal policies. The need for culturally and linguistically appropriate care was noted as a need within the system, as several stakeholders indicated that stigma around substance abuse and behavioral health treatment among different racial and ethnic groups deterred community members from seeking care.

Impact of 1115 Waiver and DSRIP Projects

Many stakeholder dialogue participants and provider focus group participants perceived that the 1115 Waiver and DSRIP projects have helped to improve collaboration between different services and sectors across the region. Providers and key informant interviewees stated that the requirements around the DSRIP programing had facilitated this improvement. They noted that collaborations in referrals had also improved as better connections between projects and initiatives were established, and perceived that this connectivity was being measured more intentionally.

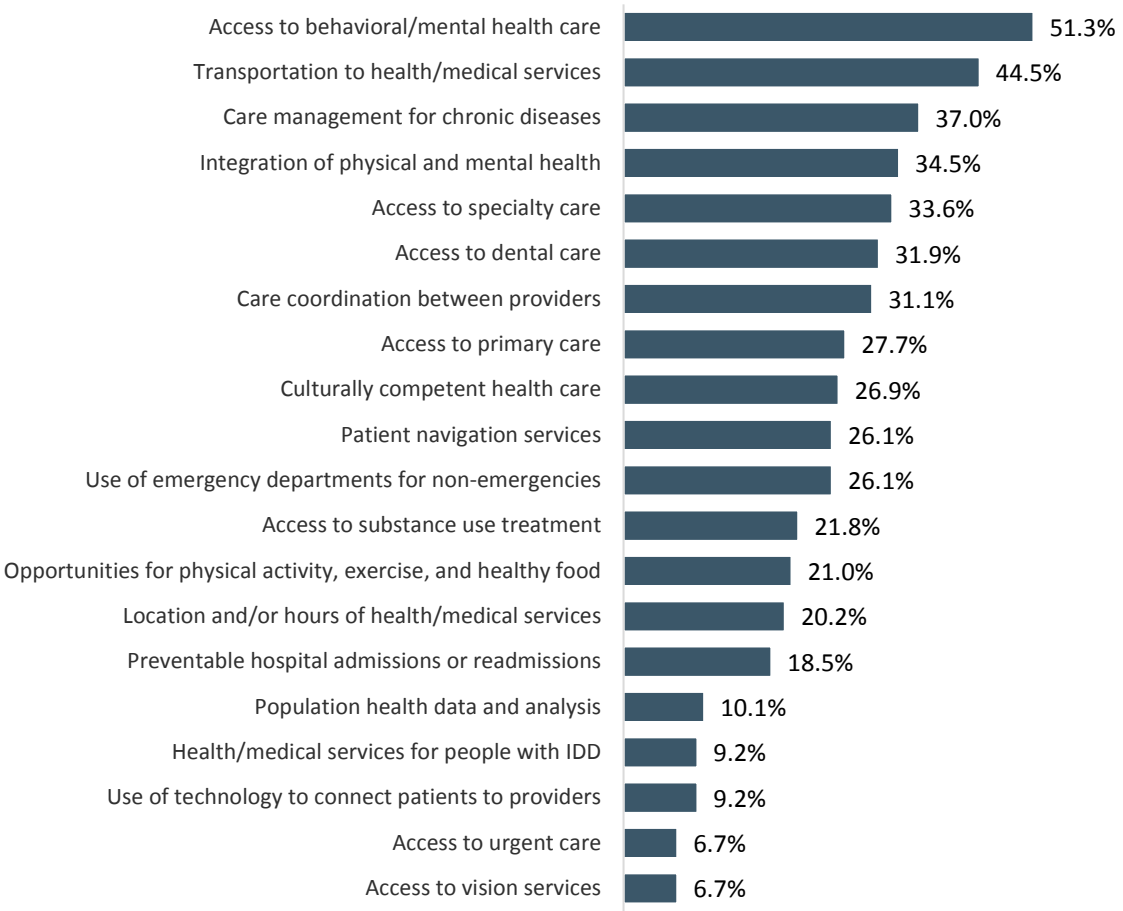
> "We had the opportunity to try some things on to improve the way we could serve the patients. We had the opportunity try something out we wouldn't have been able to otherwise."
>
> -Key Informant Interviewee
>
> "I think our community looks a lot better because of the waiver."
>
> -Provider Focus Group Participant

Interviewees also saw the move of social service systems towards co-location and wrap-around models as having a positive effect within the community. Several interviewees noted the collaboration encouraged by DSRIP projects supported the growth of these models. They perceived that when providers co-located, or delivered services at community members homes, it helped to overcome barriers to services including transportation issues and timing (e.g. co-located services would allow patients to schedule multiple appointments in one day, in one location).

In addition to increasing collaboration and access as a result of the 1115 Waiver and DSRIP projects, key informant interviewees perceived that DSRIP projects had begun to fill in gaps in the health care and social service system; *"We have been able to build out some missing parts of the delivery system."* Other key informants indicated that 1115 Waiver funding had given their organizations the flexibility to try new projects or models to improve the delivery of care to community members.

Priority Areas for Future Work

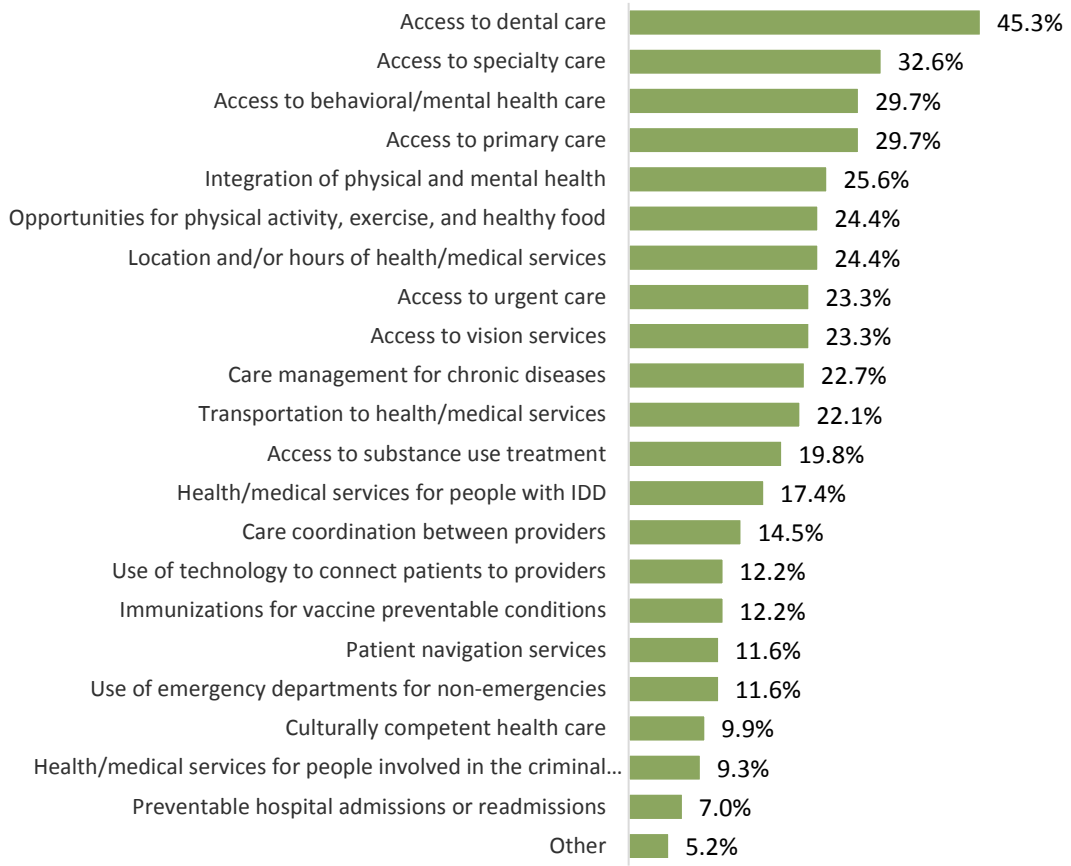
FIGURE 80. FOCUS AREAS FOR IMPROVING DELIVERY OF HEALTH CARE IN RHP 7 MOST FREQUENTLY IDENTIFIED BY PROVIDERS, 2017



DATA SOURCE: RHP 7 Community Needs Assessment Stakeholder Survey, 2017
NOTE: Providers responded based upon the low-income population served; Data shown are Focus Areas where 5% or more of providers had selected it as a 'Top 5'.

The stakeholder survey asked respondents to select, from an extensive list, the Top 5 focus areas that would improve the delivery of healthcare to low-income community members in RHP 7 (**Figure 80**). 'Access to behavioral/mental health care' was the most frequently selected focus area (51.3% of providers). 'Transportation to health/medical services' (44.5% of providers) and 'care management for chronic diseases' (37.0%) were the second and third most frequently selected focus areas. These areas of focus are consistent with data collected as part of the CNA which identified a lack of accessible behavioral health care services in the region, clear limitations in the transportation system, and the high rates of chronic conditions in the population.

FIGURE 81. FOCUS AREAS FOR IMPROVING DELIVERY OF HEALTH CARE IN RHP 7 MOST FREQUENTLY IDENTIFIED BY COMMUNITY MEMBERS, 2017



DATA SOURCE: RHP 7 Community Needs Assessment Stakeholder Survey, 2017
NOTE: Community Members responded based upon their own community; data shown are Focus Areas where 5% or more of community members had selected it as a 'Top 5'.

The focus areas that were most frequently selected by community members to improve the delivery of care in RHP 7 are ranked in **Figure 81. '**Access to dental care' was the most frequently selected focus area (45.3% of community members). 'Access to specialty care' (32.6% of community members), 'access to behavioral health care services' (29.7% of community members), and 'access to primary care' (29.7% of community members) were the second and third (tie) most frequently selected focus areas. These areas of focus were also consistent with data collected as part of the CNA which identified a lack of accessible primary care, dental care, specialists, and behavioral health care in the region.

Generally, focus areas identified consistently between providers and community members included access to behavioral health care, dental care, specialty care, and primary care. The integration of physical and mental health was also frequently and consistently selected by both groups. Integration was the 4th most frequently selected focus areas by providers and the 5th most frequently selected focus areas by community members. Responses selected by only a small proportion of respondents in each group included 'health services for those involved in the criminal justice system', 'the use of technology to connect patients to providers', and 'immunizations for vaccine preventable conditions'.

In contrast, providers were far more likely to select the focus areas of transportation to health/medical services, care management for chronic diseases, or care coordination between providers. This could

reflect their insight into the delivery system and their own perceptions of patient needs system wide. Community members were more likely to select the focus areas of location/and or hours of health/medical services, opportunities for physical activity, exercise, and healthy food, access to urgent care, and access to vision services. Community members may have been more likely to select responses that reflect their personal experiences interaction with the health care delivery system, which may not be as evident to providers.

Consistent with their perceptions of major challenges, participants of the stakeholder dialogue, provider focus groups, and key informant interviews identified communications, collaboration, and information/data sharing as key targets for improving the delivery of care in RHP 7.

Stakeholders indicated improvement could be achieved using common electronic medical record systems or by developing a unified data infrastructure to track patients/clients across the continuum of services. Per RHP 7 Anchor, work around a unified data infrastructure has begun in Travis County. Focus group participants also shared that there was a need for centralized information and referral services, both for clinical or social service providers, but for patients or community members as well.

Provider focus group participants stated that they would like to see health care systems address social determinants of health alongside patients' acute physical and mental health needs. They emphasized that to achieve this there needs to be centralized navigation services or co-located services to help patients access services and resources across sectors. Community member focus group participants suggested similar ideas for the future and particularly noted that they liked programs where multiple services or providers were available in the same location.

Additionally, many participants also touched on ways to improve the delivery of services in rural areas. An overall theme aligned with one stakeholder's statement, *"Take care to the people instead of making people come to the care."* Stakeholder dialogue participants suggested building up the telehealth and transportation systems to increase access to the centralized system or implementing more mobile outreach with fully equipped vans. Incentivized system for clients to help decentralize services. Key informant interviewees shared a similar sentiment and indicated that, while there were many great services already available to suburban and rural communities, their capacity needed to be increased to meet the growing demand.

> "[The] ability to develop telehealth services has been really critical to reach out to rural populations and these [DSRIP] dollars have allowed those discussions to happen and hopefully they will be able to continue."
>
> – Key Informant Interviewee

> "[We need] to continue and expand the use of technology to connect with folks - check in with them in a preventative manner and not just wait until an issue or problem happens."
>
> -Key Informant Interviewee

Through direct delivery of care via telehealth, or by educating patients on health conditions and the availability of services in an area, technology is a clear tool to improving health care in rural areas.[75] As described in earlier sections, barriers to health care in RHP 7 include transportation, location of services, and timing of appointments. It is possible that technological approaches could help overcome some of these issues. Several key informant interviewees shared that the increase of telehealth programs in rural areas had already yielded a positive impact in the region. Provider focus group participants also shared this perspective, with one participant indicating a perception between the use of telemedicine and a perceived decrease in ED visits that could potentially be costly and time consuming for the patient. Others suggested using technology to connect and engage with patients more frequently.

[75] Health Communication and Health Information Technology, Healthy People 2020; Office of Disease Prevention and Health Promotion; https://www.healthypeople.gov/2020/topics-objectives/topic/health-communication-and-health-information-technology

Conclusions

Overarching Themes

This report provides an overview of the social and economic environment of the community served by RHP 7, health conditions and behaviors that most affect the population, and perceptions of the health care delivery system in the current environment. Through a review of secondary data, a stakeholder survey of patients and community members, focus group discussions with providers and community members, and the engagement of stakeholders representing diverse sectors. The following section presents a synthesis of findings and summarizes the identified health needs of the community.

Housing Affordability and Implications of Migration out of Central Austin

The impacts of considerable growth in the RHP 7 region emerged as one of the overarching themes of the 2017 CNA and highlights some of the major economic forces at work in the region. Impacts of growth included rising housing costs within Central Austin and Travis County, relocation towards more suburban and rural areas of RHP 7, and subsequent challenges in accessing health care or social services due to location, distance, and capacity. The reported co-occurrence of increased demand, yet fewer services and insufficient transportation in more rural areas of RHP 7, presents a key challenge to health care delivery in the region.

Population growth was highest in Hays, Travis, and Bastrop counties between 2010 and 2016. Reportedly driven by higher housing costs, key informant interviewees, providers, and community members perceived that over this period of population growth, many lower income individuals and families were moving outward from Central Austin and Travis County seeking more affordable options. Secondary data confirmed that median monthly housing costs were highest in Travis and Hays counties, and costs had increased between 2010 and 2015 across all RHP 7 counties. By 2015, a third or more of renters in RHP 7 were housing cost burdened (i.e. spending 35% or more of monthly income towards housing costs).

Migration out of Central Austin and Travis County and into neighboring counties was perceived by key informants and providers to have far reaching effects on access to needed health care or social services. Individuals were moving further away from the centralized health care infrastructure and social service resources and this distance presented access challenges. Secondary data, key informant interviews, focus groups, and the stakeholder survey consistently identified a lack of transportation as an issue that made it harder to access care outside of Central Austin and in more rural areas of RHP 7, presenting barriers related to transportation availability, transportation cost, and travel time.

Additionally, the growing numbers of low-income residents in outlying areas of RHP 7 was reported to have increased the demand for health care and social services in those areas. Providers from outside of Travis County reported they were finding it challenging to meet the growing demand, and that capacity and resources were not increasing in step with the population growth. Several provider focus group participants further noted than many individuals who had moved found themselves no longer eligible for needed services in their new county.

Economic and Health Inequality in the Region

Inequalities between racial and ethnic groups and between urban and rural areas in RHP 7 emerged as a theme across health and economic indicators in this report. A growing base of evidence has begun to show that living in communities with greater economic inequality is linked to poorer health outcomes, such as infant mortality, obesity, and stress.[76] Disparities were observed in RHP 7 between groups for economic indicators as well as indicators of health outcomes and health care utilization. As the region continues to become increasingly diverse, with larger populations of White, non-Hispanic residents, these economic and health disparities pose a growing challenge in meeting the region's health needs in the future.

Unemployment rates across RHP 7 have declined sharply over the past five years, mirroring trends at the state and national level. However, state data show stark differences in unemployment by race and ethnicity. Hispanic and Black individuals in Texas had unemployment rates that were 1.5 to 2 times higher than their Asian or White, non-Hispanic counterparts in 2015. While the overall median household income increased between 2010 and 2015 across RHP 7, large income inequalities by race and ethnicity were also observed. Median household incomes were lower among Black resident (average of -$19,744 less) and Hispanic residents (average of -$15,139 less) compared to White, non-Hispanic residents. Income differences varied by county, with the largest inequalities observed in Travis County.

Secondary data also illustrated some prominent disparities in chronic health conditions by race and ethnicity in RHP 7. Black adults in RHP 7 were more likely to report having hypertension than other groups. Diabetes was reported more frequently by Black and Hispanic adults, and overweight or obesity affected more Black or Hispanic adults compared than White, non-Hispanic adults. Self-reported poor mental health was also more common among Black adults compared to other groups, although they were less likely to report receiving a depression diagnosis. Utilization and connection to preventative care was also found to differ greatly by race and ethnicity. Hispanic adults were twice as likely as White, non-Hispanic adults to report they did not have a primary care doctor and were less likely to report having had a routine check-up in the prior year.

Chronic Conditions, Disease Management, and Social Determinants of Health

The prevention and management of chronic health conditions consistently emerged as a concern for RHP 7 from secondary data, key informant interviews, focus groups, and the stakeholder survey. Key informant interviewees and provider focus group participants also frequently discussed a number of social determinants of health that presented challenges to the prevention or management of these health conditions. Secondary data further supported these perceptions and highlighted that lifestyle-related risk factors were common across the region.

Many key informant interviewees pointed to several social determinants of health as important contributors to the problems of diabetes and obesity. In addition to poverty and high housing costs forcing individuals to make choices in their spending, these upstream factors included the lack of opportunity to be physically active, low access to healthy foods, and a lack of nutrition education. Secondary data did identify many census tracts across RHP 7 as food deserts in 2015, and approximately 15% of the population in RHP 7 was identified as food insecure in 2015. Providers further discussed how many of the key social determinants of health impaired their ability to help patients manage chronic

[76] Inequality and Health, Institute for Policy Studies; https://inequality.org/facts/inequality-and-health/

conditions. Individuals who are faced with unaffordable or unstable housing, limited transportation options, and little access to healthy and nutritious foods are much less likely to be able to comply with clinical recommendations and manage their chronic conditions. These factors present barriers to achieving optimal health outcomes in the population served.

Accessibility of Health Care Remains a Key Concern

Access to health care was a major concern for the low-income and Medicaid populations in RHP 7 that was consistently brought up by stakeholder dialogue participants, key informants, providers, and community members alike. Barriers to care were multifaceted and included insurance, shortages of providers, particularly ones that accepted Medicaid or indigent health programs, and the timeliness and navigability of services. Providers and key informants further identified the lack of knowledge or awareness of services by community members as another aspect of accessibility.

Due to the availability of private coverage through the ACA, the uninsured rate has declined in Texas and each RHP 7 county since 2010. The state did not elect to expand Medicaid as part of the ACA, and continues to have narrow eligibility criteria for non-disabled adults. Insurance problems such as lack of coverage or not enough coverage, high cost of co-pays, and not understanding insurance were frequently identified as barriers to care by community member and provider respondents to the stakeholder survey.

As in the 2012 CNA, the availability of providers or specific types of health care services was identified as limited in many areas of RHP 7. All of RHP 7 continues to be designated, in whole or in part, as HPSAs or MUAs. Furthermore, the uneven geographic distribution of health care providers has persisted across RHP 7 despite significant healthcare infrastructure expansion during the 1115 Waiver period. Secondary data suggested that numbers of primary care providers, behavioral/mental health providers, and dentists were low in many RHP 7 counties. Indicators of birth outcomes also provided some evidence that there are gaps in prenatal care for some areas of RHP 7, particularly Caldwell and Fayette counties.

Focus group and interview findings corroborated the need for these types of providers across the region and particularly in more rural counties. Community member focus group participants further identified challenges in accessing maternal/prenatal care or specialty care outside of Travis County. Specialty care was a particular challenge for those that are uninsured or covered by Medicaid. Several noted specific types of services needed to expand outside of Travis County, including emergency, behavioral health, and specialty care.

In focus groups and interviews, key informants and providers in RHP 7 frequently described access to health care as including the timeliness of available appointments and the navigability of the system. Key informant also expanded the definition of access to include community members' knowledge or awareness of available services. Interviewees and providers identified that many community members did not know what services exist, what they are eligible for, or even how to find them. Community members also discussed in focus groups the challenges of finding information on resources or someone to help them navigate the system.

Behavioral Health Remains a Key Concern

Nearly 80% of providers responding to the stakeholder survey identified 'mental/behavioral health' as a leading health concern for the low-income population in RHP 7. This concern was further echoed throughout the provider focus groups and key informant interviews and was one of the most consistent themes of the CNA. Participants voiced their perceptions that mental health conditions, including

depression and anxiety, PTSD, and bipolar disorder, were increasing in prevalence among low-income populations. Many key informants also described substance use and abuse as areas of concern for communities in the region.

Most interviewees and focus group participants identified the main barriers to behavioral health care as being the shortage of providers in the region and the persistent stigma about mental health within the community. DSRIP-funded projects focused heavily on behavioral health services and included the opening or expansion of clinics or mobile units serving the Medicaid and uninsured populations in the region. Many interviewees and provider focus group participants did note that DSRIP-led efforts had enhanced co-location and wrap-around services and had improved access to care for many community members, but perceived that more could be done, especially it the rural communities.

Positive Impacts of 1115 Waiver and DSRIP

Key informants and stakeholders that were familiar with DSRIP projects described many positive impacts the programming had on their communities. These included increased access to services for low-income communities, growth in collaboration and communication between organizations doing complimentary work, and the recognition that the social determinants of health were important factors for the health care delivery system to consider.

Over the course of the 1115 Waiver, many health care infrastructure changes or expansions occurred in RHP 7 including new hospitals, the opening of Dell Medical School at the University of Texas in Austin, and DSRIP-funded projects which opened or expanded 54 clinics or mobile units (primary, dental, specialty, and behavioral health services). Interviewees and provider focus group participants perceived that these efforts had helped removed some barriers to access for community members. Additionally, key informants noted that access had been improved through the inclusion of additional evening and weekend hours as some locations, as well as telehealth and mobile health projects.

Growing collaboration between social service and health care providers was identified as one of the most positive impacts of the 1115 Waiver, according to stakeholder dialogue participants, key informants, and providers alike. Interviewees and focus group participants suggested that the performance of the DSRIP projects had necessitated increased collaboration between organizations and thereby improved the delivery of care. The work was also seen as fostering the growing recognition of the social determinants of health and their impact on individual and community members' health. This was also discussed as a strength of the current health care delivery system by stakeholder, key informants, and providers. There was broad agreement that, while DSRIP laid a strong foundation for future work, much remained to be done.

Focus Areas for Improving the Delivery of Health Care in RHP 7

Access to care was also identified as a key focus area for improvement by stakeholder dialogue participants, key informant interviewees, and provider focus group participants. Despite clear success around expanding services during the 1115 Waiver period, most stakeholders indicated that much remained to be done to increase access to health care and social services, especially to rural communities and communities experiencing the impacts of migration out of Austin-Travis County. Access to care also arose as the key focus area among provider and community member stakeholder survey respondents. Both groups identified access to behavioral/mental health care, dental care, specialty care, and primary care as top focus areas.

Communication, collaboration, and information/data sharing were also identified as important focus areas for improving the delivery of care by stakeholder dialogue participants, key informants, and providers. While much progress had been made through the DSRIP work, many suggested more work was needed to further increase communication between organizations and providers and breakdown the remaining silos. They further highlighted the need for more data sharing between the health care delivery system and social service agencies in order to help community members navigate these systems more easily and prevent people from falling through the gaps. Working to build community members' awareness of available services was another target for improvement that was frequently mentioned by key informants.

Community Needs Summary Table

The community needs summary table represents outliers in the community health needs data that show significant need for improvement in the region. In addition, the table incorporates the top five health conditions as identified by community members and by providers, where those were not already identified in secondary data. Finally, the list incorporates major social determinants of health outliers that have clear impact on achieving health outcomes.

TABLE 13. UPDATED RHP 7 COMMUNITY NEEDS TABLE, 2017

Accidents and Injuries
Behavioral Health Care*
Chronic Conditions*
Dental Health*
Infectious and Vaccine Preventable Diseases*
Lack of Affordable Housing
Lack of Convenient Service Locations and Times*
Maternal and Child Health*
Preventive Care and Wellness*
Primary Care*
Racial and Ethnic Disparities*
Specialty Care
Transportation to Healthcare Services*

*Also identified in 2012 Community Needs Summary Table

Summary of Stakeholder Feedback

At the conclusion of the 2017 CNA process, stakeholders from across RHP 7 were invited to provide feedback on the key themes and identified needs presented in this report. A draft version of the report was available to the public on the Anchor's website for two weeks beginning 10/5/17. Anchor staff shared the report link via email with its more than 800-member stakeholder mailing list inviting them to review the draft report and fill out a short online opinion survey. The survey asked about their level of agreement with the needs identified by the 2017 CNA and included space for comments on other findings in the report. The survey also asked stakeholders to identify other needs that they perceived as prevalent in RHP 7 that were not identified by the CNA.

Stakeholders were also invited to attend to a stakeholder meeting set for October 19th in Austin to hear a data presentation of the overarching themes that arose from the 2017 CNA. Attendees at the October 19th meeting were asked to respond to the same survey questions as the online survey to indicate their level of agreement with identified needs. A discussion about the findings was facilitated after the data presentation. Thirty-two stakeholders, including providers and community members, attended the event.

Feedback from stakeholders indicated there was a high level of agreement with the needs identified by the CNA. All respondents to the feedback survey indicated that they "agreed" or "strongly agreed" with the identification of racial and ethnic disparities, preventive care and wellness, maternal and child health, lack of affordable housing, and chronic conditions as areas that show significant need in RHP 7. A table with a complete summary of responses to this question can be found in the **RHP 7 CNA Appendix.**

When asked if there were existing needs that were not identified in the CNA, stakeholders highlighted education as an area for future work in RHP 7, particularly early childhood education and its connection with life-long health outcomes. Other needs stakeholders perceived as not being identified in depth by the CNA included health literacy, patient navigation, alcohol abuse, teen births, and unintended teen pregnancies.

Stakeholders pointed out the consistency and alignment between data collected from community members and providers in the CNA as a surprising and positive finding. Stakeholders indicated that this would help them to better align priorities for their work going forward. Stakeholders also provided suggestions for future CNAs or considerations for future work. They suggested adding additional comparison data points, such as including national level data as an additional benchmark, and suggested stratifying data by sex to better understand the maternal/child health and prenatal care data.

Stakeholders were particularly interested in data presented on cross-county care and county in-migration. They expressed an interest in further analyses of those data to better understand the barriers facing RHP 7 community members in accessing care. Several stakeholders suggested this data was evidence for the need for greater and more equitable geographic distribution of health care and social service resources across the region. Following the CNA presentation, stakeholders began a conversation about the sustainability of DSRIP projects and the work that has been achieved so far. Many providers explained they were completing return on investment analysis to inform the sustainability of on-going and future work.

Data Sources

Stakeholders

Name	Title
DSRIP Provider Exchange Members	
Ann Berghammer	Director of HIM, Central Texas Medical Center
Kimberly Macakiage	Director of Practice Management, 1115 Medicaid Waiver Projects, Integral Care
Kristie Jacoby	1115 Waiver DSRIP Director, Hill Country MHDD Center
Kyle Landry	Associate Chief Operating Officer, St. David's Medical Center
Lydia Long	DSRIP Program Manager, Ascension, Seton Healthcare Family
Meghan Nadolski	1115 Waiver Director, Bluebonnet Trails Community Services
Melanie Diello	Director, Project Management and Implementation, Community Care Collaborative
Richard Waite	Grants Program Manager, 1115 Waiver, Austin Public Health
Key Informant Interview and Social Service Focus Group Participant Organizations	
Abundant Rain Christian Fellowship	
Any Baby Can	
Austin Public Health	
Austin/Travis County Emergency Medical Centers	
Bastrop County Officials (2)	
Caldwell County Officials	
Central Texas Medical Center & Live Oak Health Partners (2)	
City of Lockhart Officials	
Community Advancement Network	
Community Care Collaborative	
CommUnityCare Health Centers	
Community Health Centers of South Central Texas	
Fayette County Officials	
Hays County Food Bank	
Hays County Officials (2)	
Hospice Austin	
Insure Central Texas/Foundation Communities	
Lone Star Circle of Care	
Lee County Officials (3)	
Migrant Clinicians Network	
NAMI Austin	
New Life Lutheran Church of Dripping Springs	
Seton Healthcare Family	
Seton Medical Center Hays (3)	
St. David's Foundation	
Travis County Health and Human Services	
University of Texas at Austin - Dell Medical School	

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October 31, 2017

Regional Healthcare Partnership 7

2017 Community Needs Assessment

Appendix

Submitted to:
Central Health

Health Resources in Action
Advancing Public Health and Medical Research

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Stakeholder Survey Data Tables

TABLE 1. ORGANIZATION TYPE OF PROVIDER RESPONDENTS TO STAKEHOLDER SURVEY, 2017

	Providers (N=144)	
	Count	Percent
Type of Organization*		
Children's hospital	5	3.6%
Community clinic	36	26.1%
Elected official/Government	9	6.5%
Faith-based organization	1	0.7%
Health plan or insurer	11	8.0%
Hospital	11	8.0%
Housing	10	7.2%
Mental health	32	23.2%
Patient advocate	11	8.0%
Physician/Dentist (private practice)	0	0.0%
Public health	13	9.4%
School, college, or university	7	5.1%
Social service agency	24	17.4%
Substance abuse	10	7.2%
Transportation	1	0.7%
Other	14	10.1%

DATA SOURCE: RHP 7 Community Needs Assessment Stakeholder Survey, 2017

** Multiple responses were allowed in the provider survey, percentages may not sum up to 100%*

TABLE 2. DEMOGRAPHIC CHARACTERISTICS STAKEHOLDER SURVEY RESPONDENTS, 2017

	Provider (N=144)		Community member (N=210)	
	Count	Percent	n	%
County Where Services Provided*/of Residence				
Bastrop	33	24.1%	48	23.2%
Caldwell	24	17.5%	16	7.7%
Fayette	21	15.3%	4	1.9%
Hays	32	23.4%	15	7.2%
Lee	19	13.9%	12	5.8%
Travis	123	89.8%	112	54.1%
Other	10	7.3%	0	0.0%
Sex				
Male	24	20.3%	53	28.3%
Female	94	79.7%	133	71.1%
Other	0	0.0%	1	0.5%
Age				
Under 18 years	0	0.0%	2	1.1%
18-24 years	1	0.8%	14	7.5%
25-29 years	10	8.5%	20	10.7%
30-39 years	30	25.4%	52	27.8%
40-49 years	32	27.1%	35	18.7%

50-64 years	44	37.3%	51	27.3%
65-74 years	1	0.8%	9	4.8%
75 years or over	0	0.0%	4	2.1%
Race/Ethnicity				
White, non-Hispanic	66	56.4%	63	34.6%
Hispanic or Latino, any race	38	32.5%	89	48.9%
Black or African American, non-Hispanic	8	6.8%	23	12.6%
Asian, non-Hispanic	3	2.6%	2	1.1%
Other	0	0.0%	3	1.6%
Two or more races	2	1.7%	2	1.1%
Educational Attainment				
Less than high school	0	0.0%	28	15.1%
High school graduate/GED	1	0.8%	51	27.4%
Some college	6	5.1%	33	17.7%
Associate's degree or technical/vocational degree or certificate	4	3.4%	14	7.5%
College graduate	41	34.7%	32	17.2%
Graduate or professional degree	66	55.9%	28	15.1%
Survey Language				
English	143	99.3%	176	83.8%
Spanish	1	0.7%	34	16.2%

DATA SOURCE: RHP 7 Community Needs Assessment Stakeholder Survey, 2017

** Multiple responses were allowed in the provider survey, percentages may not sum up to 100%*

TABLE 3. SURVEY RESPONSES TO STAKEHOLDER SURVEY, 2017

	Provider (N=144)		Community member (N=210)	
	n	%	n	%
Perception of overall health of community				
Excellent	0	0.0%	15	7.6%
Very Good	0	0.0%	38	19.2%
Good	12	9.0%	71	35.9%
Fair	81	60.4%	60	30.3%
Poor	41	30.6%	14	7.1%
Health conditions of concern in community				
Aging health concerns	19	14.3%	52	27.8%
Asthma	11	8.3%	33	17.6%
Cancer	22	16.5%	45	24.1%
Children's health concerns	25	18.8%	33	17.6%
Dental/oral health	49	36.8%	70	37.4%
Diabetes	93	69.9%	120	64.2%
Heart disease/heart attacks	49	36.8%	53	28.3%
High blood pressure/hypertension	73	54.9%	77	41.2%
Mental health/behavioral health	106	79.7%	81	43.3%
Obesity/overweight	92	69.2%	107	57.2%
Prenatal/maternal health concerns	24	18.0%	18	9.6%
Substance use and abuse	60	45.1%	53	28.3%

	Provider (N=144)		Community member (N=210)	
	n	%	n	%
Tobacco use/smoking	28	21.1%	62	33.2%
Vaccine preventable conditions	2	1.5%	8	4.3%
Vision	3	2.3%	34	18.2%
Other	11	8.3%	8	4.3%
Ease of access to the following in the community:				
Dental care				
Very easy	0	0.0%	36	19.7%
Easy	13	11.0%	62	33.9%
Hard	54	45.8%	54	29.5%
Very hard	51	43.2%	29	15.8%
Vision care				
Very easy	0	0.0%	31	17.5%
Easy	16	13.6%	72	40.7%
Hard	57	48.3%	53	29.9%
Very hard	45	38.1%	19	10.7%
Primary care				
Very easy	0	0.0%	32	18.6%
Easy	40	34.5%	100	58.1%
Hard	66	56.9%	27	15.7%
Very hard	10	8.6%	13	7.6%
Preventative/wellness care				
Very easy	0	0.0%	27	16.0%
Easy	32	27.1%	86	50.9%
Hard	65	55.1%	42	24.9%
Very hard	21	17.8%	14	8.3%
Chronic disease management				
Very easy	1	0.8%	20	12.6%
Easy	17	14.4%	57	35.8%
Hard	69	58.5%	59	37.1%
Very hard	31	26.3%	23	14.5%
Pediatric/well-child services				
Very easy	4	3.4%	24	14.7%
Easy	61	52.6%	98	60.1%
Hard	42	36.2%	29	17.8%
Very hard	9	7.8%	12	7.4%
Women's health services				
Very easy	3	2.5%	31	18.7%
Easy	38	31.9%	81	48.8%
Hard	67	56.3%	40	24.1%
Very hard	11	9.2%	14	8.4%
Prenatal/maternal care				
Very easy	6	5.0%	26	16.9%
Easy	38	31.9%	71	46.1%
Hard	63	52.9%	47	30.5%

	Provider (N=144)		Community member (N=210)	
	n	%	n	%
Very hard	12	10.1%	10	6.5%
Medical/health services for elderly				
Very easy	1	0.9%	21	13.2%
Easy	25	21.4%	67	42.1%
Hard	69	59.0%	53	33.3%
Very hard	22	18.8%	18	11.3%
Cancer treatment				
Very easy	0	0.0%	18	11.5%
Easy	17	14.5%	51	32.7%
Hard	57	48.7%	57	36.5%
Very hard	43	36.8%	30	19.2%
Specialty care				
Very easy	0	0.0%	21	13.4%
Easy	3	2.6%	48	30.6%
Hard	47	40.5%	55	35.0%
Very hard	66	56.9%	33	21.0%
Behavioral/mental health care				
Very easy	1	0.8%	24	14.3%
Easy	15	12.7%	59	35.1%
Hard	55	46.6%	47	28.0%
Very hard	47	39.8%	38	22.6%
Inpatient psychiatric disorder treatment				
Very easy	0	0.0%	19	12.2%
Easy	7	5.9%	42	26.9%
Hard	44	37.3%	54	34.6%
Very hard	67	56.8%	41	26.3%
Inpatient alcohol/substance use disorder treatment				
Very easy	1	0.8%	19	12.0%
Easy	6	5.1%	49	31.0%
Hard	39	33.1%	47	29.7%
Very hard	72	61.0%	43	27.2%
Outpatient alcohol/substance abuse treatment				
Very easy	0	0.0%	20	13.1%
Easy	15	12.7%	51	33.3%
Hard	52	44.1%	47	30.7%
Very hard	51	43.2%	35	22.9%
Hospital care services				
Very easy	12	10.2%	30	17.9%
Easy	58	49.2%	88	52.4%
Hard	35	29.7%	30	17.9%
Very hard	13	11.0%	20	11.9%
Emergency care services				
Very easy	21	17.8%	40	24.1%
Easy	66	55.9%	90	54.2%
Hard	23	19.5%	21	12.7%

	Provider (N=144)		Community member (N=210)	
	n	%	n	%
Very hard	8	6.8%	15	9.0%
Barriers to accessing health care				
Lack of child care	77	64.7%	33	18.5%
Lack of transportation	112	94.1%	56	31.5%
Distance to closest provider	70	58.8%	57	32.0%
Lack of evening and weekend services	69	58.0%	75	42.1%
Long waits for appointments	91	76.5%	72	40.4%
Difficulty scheduling appointments	68	57.1%	40	22.5%
Don't know services are available	85	71.4%	41	23.0%
Insurance is complicated/don't know how insurance works	79	66.4%	44	24.7%
Insurance problems/lack of coverage/not enough coverage	92	77.3%	72	40.4%
Cost of care/co-pays	83	69.7%	69	38.8%
Difficulty coordinating care between providers	65	54.6%	31	17.4%
Language problems/cannot communicate with provider or office staff	69	58.0%	22	12.4%
Poor customer service of provider or office staff	38	31.9%	26	14.6%
Discrimination by provider or office staff	26	21.8%	11	6.2%
Health care information is not kept confidential	6	5.0%	6	3.4%
Afraid to have health check-up	38	31.9%	20	11.2%
Afraid due to immigration status	77	64.7%	23	12.9%
Other	6	5.0%	17	9.6%
Focus areas to improve delivery of healthcare in community				
Access to behavioral/mental health care	61	51.3%	51	29.7%
Access to dental care	38	31.9%	78	45.3%
Access to primary care	33	27.7%	51	29.7%
Access to specialty care	40	33.6%	56	32.6%
Access to substance use treatment	26	21.8%	34	19.8%
Access to urgent care	8	6.7%	40	23.3%
Access to vision services	8	6.7%	40	23.3%
Care coordination between providers	37	31.1%	25	14.5%
Care management for chronic diseases	44	37.0%	39	22.7%
Culturally competent health care	32	26.9%	17	9.9%
Health/medical services for people with intellectual and developmental disabilities	11	9.2%	30	17.4%
Health/medical services for people involved in the criminal justice system	3	2.5%	16	9.3%
Integration of physical and mental health	41	34.5%	44	25.6%
Immunizations for vaccine preventable conditions	4	3.4%	21	12.2%
Location and/or hours of health/medical services	24	20.2%	42	24.4%
Opportunities for physical activity, exercise, and healthy food	25	21.0%	42	24.4%
Patient navigation services	31	26.1%	20	11.6%
Population health data and analysis	12	10.1%	8	4.7%
Preventable hospital admissions or readmissions	22	18.5%	12	7.0%

	Provider (N=144)		Community member (N=210)	
	n	%	n	%
Transportation to health/medical services	53	44.5%	38	22.1%
Use of emergency departments for non-emergencies	31	26.1%	20	11.6%
Use of technology to connect patients to providers	11	9.2%	21	12.2%
Other	3	2.5%	9	5.2%

NOTE: Questions were asked to providers about low-income community members

TABLE 4. LANGUAGE PREFERENCES OF STAKEHOLDER SURVEY COMMUNITY MEMBER RESPONDENTS, 2017

	Community member (N=210)	
	n	%
English	137	74.5%
Spanish	45	24.5%
Chinese	1	0.5%
Vietnamese	0	0.0%
Other	1	0.5%

NOTE: The question read as "What language would you prefer to use to communicate with a doctor or other health care professional?" The question was only asked in the Community Member portion of the survey.

Additional Secondary Data Tables

TABLE 5. POPULATION COUNTS OF INDIVIDUALS LIVING BELOW 200% AND 100% OF FEDERAL POVERTY LEVEL, BY COUNTY AND STATE, 2010 AND 2015

	Individuals Under 200% FPL				Individuals Under 100% FPL			
	2010		2015		2010		2015	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Texas	8,957,285	37.8%	9,861,649	38.0%	3,972,054	16.8%	4,472,451	17.3%
Bastrop County	25,376	36.3%	26,156	35.1%	9,870	14.1%	10,664	14.3%
Caldwell County	19,905	41.6%	17,722	47.8%	6,557	19.6%	7,169	19.3%
Fayette County	7,871	33.6%	7,844	32.2%	2,591	11.0%	3,021	12.4%
Hays County	42,887	30.9%	57,861	33.9%	22,731	16.4%	28,783	16.9%
Lee County	4,696	29.3%	5,623	34.8%	1,727	10.8%	2,374	14.7%
Travis County	324,906	33.8%	368,571	33.6%	156,270	16.2%	180,220	16.4%
RHP 7 Total	419,641	33.7%	483,777	34.0%	199,746	16.1%	232,231	16.3%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2006-2010 and 2011-2015

TABLE 6. POPULATION COUNTS OF INDIVIDUALS BY RACE/ETHNICITY LIVING BELOW 100% OF FEDERAL POVERTY LEVEL, BY COUNTY AND STATE, 2015

	Individuals Under 100% FPL (2015)							
	White		Black		Hispanic		Asian	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Texas	1,047,845	9.2%	710,752	23.6%	2,524,283	25.2%	128,356	11.6%
Bastrop County	3,053	7.3%	878	15.8%	6,623	25.9%	89	13.3%
Caldwell County	2,088	13.1%	1,020	44.7%	3,988	21.6%	n/a	n/a
Fayette County	1,659	9.4%	495	24.1%	803	16.7%	n/a	n/a
Hays County	13,092	13.5%	878	16.2%	13,992	22.2%	430	18.8%
Lee County	970	9.2%	489	27.9%	911	24.6%	n/a	n/a
Travis County	48,334	8.9%	20,458	22.6%	98,446	26.4%	9,561	14.3%
RHP 7 Total	69,196	9.5%	24,218	22.6%	124,763	25.6%	10,080	14.4%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015

TABLE 7. RETAIL FOOD ESTABLISHMENT RATE PER 10,000 POPULATION, BY COUNTY AND STATE, 2015

	Supermarkets Grocery Stores		Convenience Stores		Specialty Food Stores		All Restaurants		Fast Food Restaurants	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
Texas	3,460	1.3	2,825	1.0	1,253	0.5	41,426	15.1	19,385	7.1
RHP7	184	1.2	155	1.0	86	0.6	2,693	17.6	1,125	7.3
Bastrop	11	1.4	11	1.4	3	0.4	93	11.5	39	4.8
Caldwell	3	0.7	0	0.0	0	0.0	47	11.6	20	4.9
Fayette	4	1.7	3	1.2	4	1.7	51	21.2	19	7.9
Hays	11	0.6	7	0.4	4	0.2	294	15.1	138	7.1
Lee	4	2.4	3	1.8	4	2.4	29	17.2	12	7.1
Travis	151	1.3	131	1.1	71	0.6	2,179	18.5	897	7.6

DATA SOURCE: US Census Bureau, County Business Patterns, 2015; rates calculated based on US Census Population Estimates for 2015

NOTE: Rates shown are per 10,000 population; Specialty food stores include fruit and vegetable markets, meat and seafood markets, etc.

Stakeholder Feedback Survey Data Table

TABLE 8. EXTENT OF AGREEMENT TO EXISTENCE OF PROPOSED NEEDS IN RHP 7, STAKEHOLDER FEEDBACK SURVEY

	n	%
Accidents and Injuries		
Strongly agree	2	7.1%
Agree	20	71.4%
Disagree	0	0.0%
Strongly disagree	0	0.0%
Don't know	6	21.4%
Behavioral Health Care		
Strongly agree	22	78.6%
Agree	5	17.9%
Disagree	0	0.0%
Strongly disagree	0	0.0%
Don't know	1	3.6%
Chronic Conditions		
Strongly agree	17	60.7%
Agree	11	39.3%
Disagree	0	0.0%
Strongly disagree	0	0.0%
Don't know	0	0.0%
Dental Health		
Strongly agree	16	57.1%
Agree	7	25.0%
Disagree	0	0.0%
Strongly disagree	0	0.0%
Don't know	5	17.9%
Infectious and Vaccine Preventable Diseases		
Strongly agree	8	28.6%
Agree	18	64.3%
Disagree	1	3.6%
Strongly disagree	0	0.0%
Don't know	1	3.6%
Lack of Affordable Housing		
Strongly agree	23	82.2%
Agree	5	17.8%
Disagree	0	0.0%
Strongly disagree	0	0.0%
Don't know	0	0.0%
Lack of Convenient Service Locations and Times		
Strongly agree	16	57.2%
Agree	11	39.3%
Disagree	0	0.0%
Strongly disagree	0	0.0%
Don't know	1	3.6%

	n	%
Maternal and Child Health		
Strongly agree	13	46.4%
Agree	15	53.6%
Disagree	0	0.0%
Strongly disagree	0	0.0%
Don't know	0	0.0%
Preventive Care and Wellness		
Strongly agree	12	42.9%
Agree	16	57.1%
Disagree	0	0.0%
Strongly disagree	0	0.0%
Don't know	0	0.0%
Primary Care		
Strongly agree	11	39.3%
Agree	16	57.1%
Disagree	0	0.0%
Strongly disagree	0	0.0%
Don't know	1	3.6%
Racial and Ethnic Disparities		
Strongly agree	23	82.1%
Agree	5	17.9%
Disagree	0	0.0%
Strongly disagree	0	0.0%
Don't know	0	0.0%
Specialty Care		
Strongly agree	16	57.2%
Agree	11	39.3%
Disagree	0	0.0%
Strongly disagree	0	0.0%
Don't know	1	3.6%
Transportation to Healthcare Services		
Strongly agree	18	64.3%
Agree	9	32.1%
Disagree	0	0.0%
Strongly disagree	0	0.0%
Don't know	1	3.6%

RHP 7 Provider and Community Member Survey

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Provider and Community Survey

Central Health, as the anchor organization for Regional Health Partnership 7, is**conducting a community needs assessment to gain a greater understanding of the health issues facing low-income communities in Travis, Hays, Caldwell, Bastrop, Lee, and Fayette counties and how those needs are currently being addressed .** The assessment will be used to inform future programming and services under the Texas 1115 Medicaid Waiver in our region.

We are interested in the perspective of community members, health care and social service providers, and other stakeholders. **We invite you to participate in a brief 5-minute survey to help improve the region's health.** All responses are anonymous.

Your input is valuable and we appreciate your participation by taking this survey!

****

Central Health, como organización ancla de la iniciativa Regional Health Partnership 7, **está llevando a cabo una evaluación de las necesidades de la comunidad para comprender mejor los problemas de salud que enfrentan las comunidades de bajos ingresos de los condados de Travis, Hays, Caldwell, Bastrop, Lee y Fayette, y la manera en que se les está dando respuesta.** La información de la evaluación se usará para diseñar futuros programas y servicios en nuestra región conforme al programa Medicaid Waiver 1115 de Texas.

Nos interesan los puntos de vista de los miembros de la comunidad, los proveedores de servicios sociales y de salud, y de otras partes interesadas. **Lo invitamos a participar en una encuesta breve de 5 minutos para ayudar a mejorar la salud en la región.** Todas las respuestas son anónimas.

Su aporte es valioso y le damos las gracias por contestar esta encuesta!

1. Would you like to take the survey in English or Spanish?
¿Prefiere contestar la encuesta en inglés o en español?

- ◯ English/ Inglés
- ◯ Spanish/ Español

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

RHP 7 Stakeholder

1. Do you LIVE or WORK in one of the Region 7 counties (Bastrop, Caldwell, Fayette, Hays, Lee, and Travis counties)?

- ◯ Yes
- ◯ No

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Type of Respondent

1. Are you a PROVIDER (health care or social services) who works with community members within the Region 7 counties (Bastrop, Caldwell, Fayette, Hays, Lee, and Travis counties)?

- ◯ Yes
- ◯ No

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Provider Survey

1. Which of the following best represents the type of organization or sector that you work for? *(Please select all that apply.)*

- ☐ Hospital
- ☐ Children's hospital
- ☐ Community clinic
- ☐ Physician/Dentist in private practice
- ☐ Health plan or insurer
- ☐ Mental health
- ☐ Substance abuse
- ☐ Social service agency
- ☐ Patient advocate
- ☐ School, college or university
- ☐ Elected official
- ☐ Housing
- ☐ Transportation
- ☐ Faith-based organization
- ☐ Other (please specify):

2. Please select the county where your organization provides services. (*Please select all that apply.*)

- [ ] Bastrop
- [ ] Caldwell
- [ ] Fayette
- [ ] Hays
- [ ] Lee
- [ ] Travis
- [ ] Other (please specify):

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Provider Survey - General Health of Your Community

*Please note that for the purposes of this survey, the phrase **"low-income community members"** refers to people who live in the RHP 7 counties and earn less than 200% of the federal poverty level ($24,120 for a single adult or $49,200 for a family of four). Many are recipients of Medicaid or are uninsured.*

1. In general, how would you describe the overall health of low-income community members in these counties?

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

2. Please select the TOP 5 HEALTH CONDITIONS impacting low-income community members in these counties. (*Please select five.*)

- [ ] Aging health concerns (e.g. falls prevention, dementia, Alzheimer's)
- [ ] Asthma
- [ ] Cancer
- [ ] Children's health concerns
- [ ] Dental/oral health
- [ ] Diabetes
- [ ] Heart disease/heart attacks
- [ ] High blood pressure/hypertension
- [ ] Mental health/behavioral health (e.g. depression, anxiety)
- [ ] Obesity/overweight
- [ ] Prenatal/maternal health concerns
- [ ] Substance use and abuse
- [ ] Tobacco use/smoking
- [ ] Vaccine preventable conditions (e.g. measles, mumps, pertussis)
- [ ] Vision
- [ ] Other (please specify):

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Provider Survey - Access to Care in Your Community

1. How easy or hard is it for low-income community members toACCESS the following services in these counties?

	Very Easy	Easy	Hard	Very Hard
Dental Care	◯	◯	◯	◯
Vision Care	◯	◯	◯	◯
Primary Care	◯	◯	◯	◯
Preventative/wellness care	◯	◯	◯	◯
Chronic disease management	◯	◯	◯	◯
Pediatric/well-child services	◯	◯	◯	◯
Women's health services	◯	◯	◯	◯
Prenatal/maternal care	◯	◯	◯	◯
Medical/health services for elderly	◯	◯	◯	◯
Cancer treatment	◯	◯	◯	◯
Specialty care	◯	◯	◯	◯
Behavioral/mental health care	◯	◯	◯	◯
Inpatient psychiatric disorder treatment	◯	◯	◯	◯
Inpatient alcohol/substance use disorder treatment	◯	◯	◯	◯
Outpatient alcohol/substance abuse treatment	◯	◯	◯	◯
Hospital care services	◯	◯	◯	◯
Emergency care services	◯	◯	◯	◯

2. To your knowledge, have any of the following issues made it harder for low-income community members in these counties to get the health care they need. (*Please select all that apply.*)

- ☐ Lack of child care
- ☐ Lack of transportation
- ☐ Distance to closest provider
- ☐ Lack of evening and weekend services
- ☐ Long waits for appointments
- ☐ Difficulty scheduling appointments
- ☐ Don't know services are available
- ☐ Insurance is complicated/don't know how insurance works
- ☐ Insurance problems/lack of coverage/not enough coverage
- ☐ Cost of care/co-pays
- ☐ Difficulty coordinating care between providers
- ☐ Language problems/cannot communicate with provider or office staff
- ☐ Poor customer service of provider or office staff
- ☐ Discrimination by provider or office staff
- ☐ Health care information is not kept confidential
- ☐ Afraid to have health check-up
- ☐ Afraid due to immigration status
- ☐ Other (please specify):

3. Please select your TOP 5 FOCUS AREAS to improve the delivery of healthcare to low-income community members in the counties where you provide services. (*Please select five.*)

- ☐ Access to behavioral/mental health care
- ☐ Access to dental care
- ☐ Access to primary care
- ☐ Access to specialty care
- ☐ Access to substance use treatment
- ☐ Access to urgent care
- ☐ Access to vision services
- ☐ Care coordination between providers
- ☐ Care management for chronic diseases
- ☐ Culturally competent health care
- ☐ Health/medical services for people with intellectual and developmental disabilities
- ☐ Health/medical services for people involved in the criminal justice system
- ☐ Integration of physical and mental health
- ☐ Immunizations for vaccine preventable conditions
- ☐ Location and/or hours of health/medical services
- ☐ Opportunities for physical activity, exercise, and healthy food choices
- ☐ Patient navigation services
- ☐ Population health data and analysis
- ☐ Preventable hospital admissions or readmissions
- ☐ Transportation to health/medical services
- ☐ Use of emergency departments for non-emergencies
- ☐ Use of technology to connect patients to providers
- ☐ Other (please specify):

Demographic Information

1. What is your gender?

- ◯ Male
- ◯ Female
- ◯ Other (please specify):

2. What category best describes your age?

- ◯ Under 18 years old
- ◯ 18-24 years old
- ◯ 25-29 years old
- ◯ 30-39 years old
- ◯ 40-49 years old
- ◯ 50-64 years old
- ◯ 65-74 years old
- ◯ 75 years old or over

3. How would you describe your ethnic/racial background?*(Please select all that apply.)*

- ☐ White
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other (please specify):

4. What is the highest level of education that you have completed?

- ◯ Less than high school
- ◯ High school graduate/GED
- ◯ Some college
- ◯ Associate's degree or technical/vocational degree or certificate
- ◯ College graduate
- ◯ Graduate or professional degree

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Survey is complete. Thank you for your participation!

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Community Member Survey

1. Please select the county where you live. (*Please select all that apply.*)

- [ ] Bastrop
- [ ] Caldwell
- [ ] Fayette
- [ ] Hays
- [ ] Lee
- [ ] Travis
- [ ] Other (please specify):

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Community Member Survey - General Health of Your Community

1. In general, how would you describe the overall health in the community where you live?

- ◯ Excellent
- ◯ Very Good
- ◯ Good
- ◯ Fair
- ◯ Poor

2. Please select the TOP 5 HEALTH CONDITIONS in the community where you live. (*Please select five.*)

- [ ] Aging health concerns (e.g. falls prevention, dementia, Alzheimer's)
- [ ] Asthma
- [ ] Cancer
- [ ] Children's health concerns
- [ ] Dental/oral health
- [ ] Diabetes
- [ ] Heart disease/heart attacks
- [ ] High blood pressure/hypertension
- [ ] Mental health/behavioral health (e.g. depression, anxiety)
- [ ] Obesity/overweight
- [ ] Prenatal/maternal health concerns
- [ ] Substance use and abuse
- [ ] Tobacco use/smoking
- [ ] Vaccine preventable conditions (e.g. measles, mumps, pertussis)
- [ ] Vision
- [ ] Other (please specify):

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Community Member Survey - Access to Care in Your Community

1. How easy or hard is it to get the following services in your community?

	Very Easy	Easy	Hard	Very Hard
Dental Care	◯	◯	◯	◯
Vision Care	◯	◯	◯	◯
Primary Care	◯	◯	◯	◯
Preventative/wellness care	◯	◯	◯	◯
Chronic disease management	◯	◯	◯	◯
Pediatric/well-child services	◯	◯	◯	◯
Women's health services	◯	◯	◯	◯
Prenatal/maternal care	◯	◯	◯	◯
Medical/health services for elderly	◯	◯	◯	◯
Cancer treatment	◯	◯	◯	◯
Specialty care	◯	◯	◯	◯
Behavioral/mental health care	◯	◯	◯	◯
Inpatient psychiatric disorder treatment	◯	◯	◯	◯
Inpatient alcohol/substance use disorder treatment	◯	◯	◯	◯
Outpatient alcohol/substance abuse treatment	◯	◯	◯	◯
Hospital care services	◯	◯	◯	◯
Emergency care services	◯	◯	◯	◯

2. Have any of the following issues every made it harder for you to get the health care you need in your community? (*Please select all that apply.*)

- ☐ Lack of child care
- ☐ Lack of transportation
- ☐ Distance to closest provider
- ☐ Lack of evening and weekend services
- ☐ Long waits for appointments
- ☐ Difficulty scheduling appointments
- ☐ Don't know services are available
- ☐ Insurance is complicated/don't know how insurance works
- ☐ Insurance problems/lack of coverage/not enough coverage
- ☐ Cost of care/co-pays
- ☐ Difficulty coordinating care between providers
- ☐ Language problems/cannot communicate with provider or office staff
- ☐ Poor customer service of provider or office staff
- ☐ Discrimination by provider or office staff
- ☐ Health care information is not kept confidential
- ☐ Afraid to have health check-up
- ☐ Afraid due to immigration status
- ☐ Other (please specify):

3. Please select your TOP 5 FOCUS AREAS to improve the delivery of healthcare in your community. (*Please select five.*)

- ☐ Access to behavioral/mental health care
- ☐ Access to dental care
- ☐ Access to primary care
- ☐ Access to specialty care
- ☐ Access to substance use treatment
- ☐ Access to urgent care
- ☐ Access to vision services
- ☐ Care coordination between providers
- ☐ Care management for chronic diseases
- ☐ Culturally competent health care
- ☐ Health/medical services for people with intellectual and developmental disabilities
- ☐ Health/medical services for people involved in the criminal justice system
- ☐ Integration of physical and mental health
- ☐ Immunizations for vaccine preventable conditions
- ☐ Location and/or hours of health/medical services
- ☐ Opportunities for physical activity, exercise, and healthy food choices
- ☐ Patient navigation services
- ☐ Population health data and analysis
- ☐ Preventable hospital admissions or readmissions
- ☐ Transportation to health/medical services
- ☐ Use of emergency departments for non-emergencies
- ☐ Use of technology to connect patients to providers
- ☐ Other (please specify):

4. What language would you prefer to use to communicate with a doctor or other health care professional? (*Please select one.*)

- ◯ English
- ◯ Spanish
- ◯ Chinese
- ◯ Vietnamese
- ◯ Other (please specify):

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Demographic Information

1. What is your gender?

- ◯ Male
- ◯ Female
- ◯ Other (please specify):

2. What category best describes your age?

- ◯ Under 18 years old
- ◯ 18-24 years old
- ◯ 25-29 years old
- ◯ 30-39 years old
- ◯ 40-49 years old
- ◯ 50-64 years old
- ◯ 65-74 years old
- ◯ 75 years old or over

3. How would you describe your ethnic/racial background?*(Please select all that apply.)*

- ☐ White
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other (please specify):

4. What is the highest level of education that you have completed?

- ◯ Less than high school
- ◯ High school graduate/GED
- ◯ Some college
- ◯ Associate's degree or technical/vocational degree or certificate
- ◯ College graduate
- ◯ Graduate or professional degree

5. What language would you prefer to use to communicate with a doctor or other health care professional? (*Please select one.*)

- ◯ English
- ◯ Spanish
- ◯ Chinese
- ◯ Vietnamese
- ◯ Other (please specify):

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Survey is complete. Thank you for your participation!

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

RHP 7 Parte Interesada

1. ¿VIVE o TRABAJA usted en uno de los condados de la Región 7 (Bastrop, Caldwell, Fayette, Hays, Lee o Travis)?

- ◯ Sí
- ◯ No

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Tipo de Encuestado

1. ¿Es usted un PROVEEDOR DE SERVICIOS O DE SALUD QUE TRABAJA con la comunidad dentro los condados de la Región 7 (Bastrop, Caldwell, Fayette, Hays, Lee y Travis)?

- ◯ Sí
- ◯ No

2. Indique el condado en que usted vive (Por favor, seleccione uno.)

- ◯ Bastrop
- ◯ Caldwell
- ◯ Fayette
- ◯ Hays
- ◯ Lee
- ◯ Travis

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Proveedores de Servicios

1. ¿Cuál de las siguientes categorías indica el tipo de organización o sector en que usted trabaja? (*Marque todas las que correspondan*)

- ☐ Hospital
- ☐ Hospital de niños
- ☐ Clínica comunitaria
- ☐ Práctica privada de un médico o dentista
- ☐ Plan o seguro medico
- ☐ Salud mental
- ☐ Agencia de servicios por abuso de sustancias
- ☐ Agencia de servicios sociales
- ☐ Defensor del paciente
- ☐ Escuela o universidad
- ☐ Funcionario
- ☐ Vivienda/alojamiento
- ☐ Transporte
- ☐ Organización religiosa
- ☐ Otra respuesta (favor de especificar: _____)

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Proveedores de Servicios - Salud General en su Comunidad

Tenga en cuenta que para los fines de esta encuesta, la frase "miembros de la comunidad de bajos ingresos" se refiere a personas que viven en los condados de la RHP 7 y ganan menos del 200% del nivel federal de pobreza ($24.120 para un adulto solo o $49.200 para una familia de cuatro). Muchos son beneficiarios de Medicaid o no tienen seguro.

1. En general, ¿cómo describiría la salud general de la comunidad de bajos ingresos en estos condados?

◯ Excelente ◯ Muy bien ◯ Bien ◯ Imparcial ◯ Mal

2. Seleccione los 5 PROBLEMAS PRINCIPALES DE SALUD que afectan la comunidad de bajos ingresos en estos condados. (*Por favor, seleccione 5.*)

- ☐ Problemas relacionados con la edad (por ejemplo, prevención de caídas, demencia o Alzheimer)
- ☐ Asma
- ☐ Cáncer
- ☐ Problemas de salud infantil
- ☐ Salud dental o bucal
- ☐ Diabetes
- ☐ Enfermedad del corazón o infartos
- ☐ Presión alta o hipertensión
- ☐ Salud mental o conductual (por ejemplo, depresión o ansiedad)
- ☐ Obesidad o sobrepeso
- ☐ Problemas de salud prenatal o materna
- ☐ Uso y abuso de sustancias
- ☐ Uso de tabaco o fumar
- ☐ Enfermedades prevenibles con vacunación (como sarampión, papeleras o tos ferina)
- ☐ Problemas de la vista
- ☐ Otro (favor de especificar):

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Proveedores de Servicios - Acceso a Servicios de Salud en su Comunidad

1. ¿Qué tan fácil o difícil es conseguir a los siguientes servicios para la comunidad de bajos ingresos en estos condados?

	Muy Fácil	Fácil	Difícil	Muy difícil
Cuidado dental	◯	◯	◯	◯
Cuidado de la vista	◯	◯	◯	◯
Atención primaria	◯	◯	◯	◯
Servicios de prevención y bienestar	◯	◯	◯	◯
Manejo de enfermedades crónicas	◯	◯	◯	◯
Servicios pediátricos y de bienestar infantil	◯	◯	◯	◯
Servicios de salud para la mujer	◯	◯	◯	◯
Servicios prenatales y de salud materna	◯	◯	◯	◯
Servicios médicos y de salud para personas ancianas	◯	◯	◯	◯
Tratamiento de cáncer	◯	◯	◯	◯
Servicios de especialistas	◯	◯	◯	◯
Servicios de salud conductual o mental	◯	◯	◯	◯
Tratamiento de trastornos psiquiátricos como paciente interno	◯	◯	◯	◯
Tratamiento de alcoholismo o trastornos por uso de sustancias como paciente interno	◯	◯	◯	◯
Tratamiento ambulatorio de alcoholismo o uso de sustancias	◯	◯	◯	◯
Servicios de hospital	◯	◯	◯	◯
Atención de emergencias	◯	◯	◯	◯

2. Según lo que sabe usted, ¿algunos de los siguientes problemas han sido un obstáculo para la comunidad de bajos ingresos reciban cuidado de la salud necesaria? (Marque todas las que correspondan)

- [ ] Falta de cuidado de niños
- [ ] Falta de transporte
- [ ] Distancia del proveedor más cercano
- [ ] Falta de servicios después del trabajo o en fines de semana
- [ ] Mucho tiempo de espera para las citas
- [ ] Dificultad para hacer las citas
- [ ] Falta de información sobre la disponibilidad de los servicios
- [ ] El seguro medico es complicado, no se comprende cómo funciona
- [ ] Problemas con el seguro medico, falta de cobertura, cobertura insuficiente
- [ ] Costo de la atención medica, copagos
- [ ] Dificultad para coordinar la atención entre proveedores
- [ ] Problemas con el idioma, dificultad para comunicarse con el médico o el consultorio
- [ ] Mal servicio al cliente por parte del proveedor o del personal en la oficina
- [ ] Discriminación por parte del proveedor o del personal en la oficina
- [ ] La información médica no se mantiene confidencial
- [ ] Temor de hacerse un chequeo de salud
- [ ] Temor por la situación inmigratoria
- [ ] Otro (favor de especificar):

3. Seleccione los 5 ASUNTOS PRIORITARIOS para mejorar la manera en que se prestan los servicios de salud para la comunidad de bajos ingresos en los condados donde usted trabaja. (*Por favor, seleccione 5.*)

- [ ] Acceso a servicios de salud conductual o mental
- [ ] Acceso a cuidado dental
- [ ] Acceso a atención primaria
- [ ] Acceso a especialistas
- [ ] Acceso a tratamiento por abuso de sustancias
- [ ] Acceso a atención de urgencias
- [ ] Acceso a servicios de cuidado de la vista
- [ ] Coordinación del cuidado entre proveedores
- [ ] Manejo del cuidado de enfermedades crónicas
- [ ] Cuidados de salud culturalmente competentes
- [ ] Servicios médicos o de salud para personas con discapacidades intelectuales y del desarrollo
- [ ] Servicios médicos y salud para personas con casos en el sistema de justicia penal
- [ ] Integración de la salud física y mental
- [ ] Vacunas para enfermedades prevenibles
- [ ] Lugar y horario de los servicios médicos y de salud
- [ ] Oportunidades de actividad física, ejercicio y opciones de alimentos saludables
- [ ] Servicios de navegador del paciente
- [ ] Datos y análisis de salud de la población
- [ ] Admisiones y readmisiones prevenibles al hospital
- [ ] Transporte a los servicios médicos y de salud
- [ ] Uso del departamento de emergencias para problemas que no son emergencias
- [ ] Uso de tecnología para conectar a pacientes y proveedores
- [ ] Otro (favor de especificar):

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Proveedores de Servicios - Información Demográfica

1. ¿Cuál es su género?

- ◯ Hombre
- ◯ Mujer
- ◯ Otro (favor de especificar):

2. ¿Cuál de estas categorías corresponde a su edad?

- ◯ Menos de 18 años
- ◯ Entre 18 y 24 años
- ◯ Entre 25 y 29 años
- ◯ Entre 30 y 39 años
- ◯ Entre 40 y 49 años
- ◯ Entre 50 y 64 años
- ◯ Entre 65 y 74 años
- ◯ 75 años o más

3. ¿Cómo describiría su raza o grupo étnico? (*Marque todo lo que corresponda.*)

- ☐ Blanco
- ☐ Negro o afroamericano
- ☐ Hispano o latino
- ☐ Amerindio (indígena americano) o nativo de Alaska
- ☐ Asiático
- ☐ Nativo de Hawái o de otra isla del Pacífico
- ☐ Otro (favor de especificar):

4. ¿Cuál es el nivel más alto de educación que usted ha completado?

- ◯ Parte de la escuela secundaria
- ◯ Terminé high school (escuela secundaria) u obtuve el certificado equivalente (GED)
- ◯ Algunos estudios universitarios
- ◯ Título universitario de dos años o escuela de formación profesional o técnica
- ◯ Graduado de la universidad
- ◯ Título de posgrado o profesional

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

¡Gracias por Participar!

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Miembros de la Comunidad

1. Indique el condado en que usted vive. (*Seleccione uno.*)

- [ ] Bastrop
- [ ] Caldwell
- [ ] Fayette
- [ ] Hays
- [ ] Lee
- [ ] Travis
- [ ] Otro (favor de especificar):

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Miembros de la Comunidad - Salud General en su Comunidad

1. En general, ¿cómo describiría la salud general de la comunidad en que usted vive?

◯ Excelente ◯ Muy bien ◯ Bien ◯ Imparcial ◯ Mal

2. Seleccione los 5 PROBLEMAS PRINCIPALES DE SALUD que afectan a la comunidad en que usted vive. (*Seleccione 5.*)

- [ ] Problemas relacionados con la edad (por ejemplo, prevención de caídas, demencia o Alzheimer)
- [ ] Asma
- [ ] Cáncer
- [ ] Problemas de salud infantil
- [ ] Salud dental o bucal
- [ ] Diabetes
- [ ] Enfermedad del corazón o infartos
- [ ] Presión alta o hipertensión
- [ ] Salud mental o conductual (por ejemplo, depresión o ansiedad)
- [ ] Obesidad o sobrepeso
- [ ] Problemas de salud prenatal o materna
- [ ] Uso y abuso de sustancias
- [ ] Uso de tabaco o fumar
- [ ] Enfermedades prevenibles con vacunación (como sarampión, papeleras o tos ferina)
- [ ] Problemas de la vista
- [ ] Otro (favor de especificar):

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Miembros de la Comunidad - Acceso a Servicios de Salud en su Somunidad

1. ¿Qué tan fácil o difícil es conseguir los siguientes servicios en su comunidad?

	Muy Fácil	Fácil	Difícil	Muy Difícil	
Cuidado dental	◯	◯	◯	◯	◯
Cuidado de la vista	◯	◯	◯	◯	◯
Atención primaria	◯	◯	◯	◯	◯
Servicios de prevención y bienestar	◯	◯	◯	◯	◯
Manejo de la atención crónica	◯	◯	◯	◯	◯
Servicios pediátricos y controles del niño sano	◯	◯	◯	◯	◯
Servicios de salud para la mujer	◯	◯	◯	◯	◯
Servicios prenatales y de salud materna	◯	◯	◯	◯	◯
Servicios médicos y de salud para personas ancianas	◯	◯	◯	◯	◯
Tratamiento de cáncer	◯	◯	◯	◯	◯
Servicios de especialistas	◯	◯	◯	◯	◯
Servicios de salud conductual o mental	◯	◯	◯	◯	◯
Tratamiento de trastornos psiquiátricos como paciente interno	◯	◯	◯	◯	◯
Tratamiento de alcoholismo o trastornos por uso de sustancias como paciente interno	◯	◯	◯	◯	◯
Tratamiento ambulatorio de alcoholismo o uso de sustancias	◯	◯	◯	◯	◯
Servicios de hospital	◯	◯	◯	◯	◯
Atención de emergencias	◯	◯	◯	◯	◯

2. ¿Alguno de los siguientes problemas le dificultó alguna vez conseguir los cuidados de salud que necesitaba en su comunidad? (*Marque todo lo que corresponda.*)

- [ ] Falta de cuidado de niños
- [ ] Falta de transporte
- [ ] Lejanía del proveedor más cercano
- [ ] Falta de servicios después del horario de trabajo o en fines de semana
- [ ] Mucho tiempo de espera para las citas
- [ ] Dificultad para hacer las citas
- [ ] Falta de información sobre la disponibilidad de los servicios
- [ ] El seguro es complicado, no se comprende cómo funciona
- [ ] Problemas con el seguro, falta de cobertura, cobertura insuficiente
- [ ] Costo de la atención, copagos
- [ ] Dificultad para coordinar la atención entre proveedores
- [ ] Problemas con el idioma, dificultad para comunicarse con el médico o el consultorio
- [ ] Mal servicio al cliente por parte del proveedor o del personal del consultorio
- [ ] Discriminación por parte del proveedor o del personal del consultorio
- [ ] No se mantiene la confidencialidad de la información de salud
- [ ] Miedo a hacerse un chequeo de salud
- [ ] Temor por la situación inmigratoria
- [ ] Otro (favor de especificar):

3. Seleccione los 5 ASUNTOS PRIORITARIOS para mejorar la manera en que se prestan los servicios de salud en su comunidad. (*Seleccione 5.*)

- [ ] Acceso a servicios de salud conductual o mental
- [ ] Acceso a cuidado dental
- [ ] Acceso a atención primaria
- [ ] Acceso a especialistas
- [ ] Acceso a tratamiento por abuso de sustancias
- [ ] Acceso a atención de urgencias
- [ ] Acceso a servicios de cuidado de la vista
- [ ] Coordinación del cuidado entre proveedores
- [ ] Coordinación del cuidado de enfermedades crónicas
- [ ] Cuidados de salud culturalmente competentes
- [ ] Servicios médicos o de salud para personas con discapacidades intelectuales y del desarrollo
- [ ] Servicios médicos y salud para personas con casos en el sistema de justicia penal
- [ ] Integración de la salud física y mental
- [ ] Vacunas para enfermedades prevenibles
- [ ] Lugar y horario de los servicios médicos y de salud
- [ ] Oportunidades de actividad física, ejercicio y opciones de alimentos saludables
- [ ] Servicios de navegador del paciente
- [ ] Datos y análisis de salud de la población
- [ ] Ingresos y reingresos prevenibles al hospital
- [ ] Transporte a los servicios médicos y de salud
- [ ] Uso del departamento de emergencias para problemas que no son emergencias
- [ ] Uso de tecnología para conectar a pacientes y proveedores
- [ ] Otro (favor de especificar):

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

Miembros de la Comunidad - Información Demográfica

1. ¿Cuál es su género?

- ◯ Hombre
- ◯ Mujer
- ◯ Otro (favor de especificar):

2. ¿Cuál de estas categorías corresponde a su edad?

- ◯ Menos de 18 años
- ◯ Entre 18 y 24 años
- ◯ Entre 25 y 29 años
- ◯ Entre 30 y 39 años
- ◯ Entre 40 y 49 años
- ◯ Entre 50 y 64 años
- ◯ Entre 65 y 74 años
- ◯ 75 años o más

3. ¿Cómo describiría su raza o grupo étnico? (*Marque todo lo que corresponda.*)

- ☐ Blanco
- ☐ Negro o afroamericano
- ☐ Hispano o latino
- ☐ Amerindio (indígena americano) o nativo de Alaska
- ☐ Asiático
- ☐ Nativo de Hawái o de otra isla del Pacífico
- ☐ Otro (favor de especificar):

4. ¿Cuál es el nivel más alto de educación que usted ha completado?

- ◯ IParte de la escuela secundaria
- ◯ Terminé high school (escuela secundaria) u obtuve el certificado equivalente (GED)
- ◯ Algunos estudios universitarios
- ◯ Título universitario de dos años o escuela de formación profesional o técnica
- ◯ Graduado de la universidad
- ◯ Título de posgrado o profesional

5. ¿Qué idioma prefiere usar para comunicarse con un médico u otro profesional de la salud? (Seleccione uno.)

- ◯ Inglés
- ◯ Español
- ◯ Chino
- ◯ Vietnamita
- ◯ Otro (por favor, especifique):

Regional Healthcare Partnership 7: COMMUNITY NEEDS ASSESSMENT SURVEY

¡Gracias por Participar!

Key Informant Interview Guide

Health Resources in Action
Regional Health Partnership 7 (RHP 7) Community Health Needs Assessment
Key Informant/Stakeholder Interview Guide

Goals of the interview:
• To identify the perceived needs and barriers to health for low-income, uninsured populations and Medicaid populations
• To gain an understanding of the delivery system for Medicaid, low-income, and uninsured populations
• To identify areas of opportunity for RHP 7 to improve these systems

[NOTE: THE QUESTIONS IN THE INTERVIEW GUIDE ARE INTENDED TO SERVE AS A GUIDE, NOT A SCRIPT.]

I. BACKGROUND (3 MINUTES)

- My name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to talk with me today.

- As you may know, Regional Health Partnership, led by the anchor Central Health, is conducting a community health needs assessment to gain a greater understanding of the health issues low-income, uninsured community members or those with Medicaid, how those needs are currently being addressed, and where there are opportunities to address these issues more effectively in Lee, Bastrop, Fayette, Caldwell, Hays, and Travis counties.

- As part of this assessment, we are speaking with service providers and community leaders to gather their perspective. In addition to our conversation today, we will also be conducting a focus group with patients, interviews with representatives from each county, and collecting data from a survey, as well as sources like the Census Bureau and local public health entities. We are interested in hearing people's feedback on the strengths and needs of the community and suggestions for the future. We greatly appreciate your insight and honesty.

- Our discussion today will last about 45-60 minutes. After we finish all the data collection for this project, we will be writing a summary report of the general themes that have come up. We will not include any names or identifying information in that report. Nothing that you say here will be connected directly to you in the report.

- Do you have any questions before we begin?

II. ORGANIZATION/AGENCY (5-10 MINUTES)

1. Can you tell me a bit about your organization/agency and your role there?
   a. What county or counties does your organization serve?

   b. What is the mission/main goals of the agency/organization that you work for?

c. Who are the main recipients of your services? [PROBE: AGE, SOCIOECONOMIC STATUS, RACE/ETHNICITY]

2. How familiar are you with 1115 Medicaid Waiver or the DSRIP projects that have been developed and funded as part of the 1115 Waiver?

   IF INTERVIEWEE IS NOT FAMILIAR, PROVIDE A BRIEF DESCRIPTION OF THE WAIVER AND RECORD ANY COMMENTS INTERVIEWEE MIGHT HAVE AND ONLY ASK SUB-QUESTIONS IF SEEMS RELVEVANT

   IF INTERVIEWEE IS AT LEAST SOMEWHAT FAMILIAR, PROVIDE A BRIEF DESCRIPTION OF THE WAIVER AND PROCEED WITH SUB-QUESTION:

   a. What has been the impact of DSRIP projects/RHP 7 on the community that your organization/agency serve?

   b. What has been the impact of DSRIP projects/RHP 7 in the larger RHP 7 region? What areas do you see the most change?

   c. Do you or your agency refer patients/families/clients to DSRIP programs? If yes, which ones?

   d. Have you or your agency ever partnered with a DSRIP project or provider? If yes, how?

   e. Does your entity provide funding for DSRIP projects and/or uncompensated care under the 1115 waiver? If yes, what project?

III. COMMUNITY ISSUES (20-25 minutes)

3. How would you describe the community your organization/agency serves?

   a. What do you consider to be the community's greatest strengths/assets?

   b. What are some of the biggest challenges/concerns for the low-income/uninsured/Medicaid population in the community that you serve? What challenges do they face day to day? [PROBES: FOOD, HOUSING, EDUCATION, TRANSPORTATION, ETC.)

   c. What do you think are the most pressing <u>health</u> concerns for the low-income/uninsured/Medicaid population in the communities that you serve? [PROBE: SPECIFIC HEALTH CONDITIONS, BARRIERS TO CARE/ACCESS TO CARE, COVERAGE, AVAILABILITY OF AND ACCESS TO SPECIALITY CARE]

      i. What factors do you think are causing/influencing these issues?

      ii. How have these health issues affected the community?

4. What are community members' biggest barriers in addressing these health issues? [PROBE: INSURANCE, AVAILABILITY OF SERVICES, LOCATION OF SERVICES, TRANSPORTATION]

    a. Which populations face the most barriers to being healthy and accessing health care? Why do you think that is?

IV. PERCEPTIONS OF COMMUNITY SERVICES (20-25 MINUTES)

5. Let's talk about some of the challenges that you mentioned earlier [REFER BACK TO ONE OR TWO ISSUES FROM 3B AND 3C]. To your knowledge, what programs/services/policies already exist or that are in the works in the community to address these issues?

    a. In your opinion, how effective have these programs/services/policies been at addressing these issues? Why?

    b. What issues do members of the community face in accessing these services?

6. Thinking broadly about the current health and social service system in the region, what are the assets/strengths?
    a. Where are there gaps in the system? What programs, services, or policies are currently not available that you think should be?

    b. What opportunities have you seen that might address these gaps? For example, are there some "low hanging fruit" – current collaborations or initiatives that can be strengthened or expanded?
    c. Are there areas of the social determinants of health that could be addressed to close these gaps [EXAMPLES: INCOME, TRANSPORTATION, HOUSING, ETC.?]

V. VISION FOR THE COMMUNITY (5 MINUTES)

7. When you think about the communities that you serve 3-5 years from now, what you like to see? What is your vision for the future?

    a. What is your vision specifically related to people's health and the community conditions that influence their health?

        iii. What do you think needs to happen in the community to make this vision a reality?

VI. CLOSING (2 minutes)

Thank you so much for your time. That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today?

As I mentioned, after all of the discussions are completed, we're going to be writing up a report. Central Health/RHP 7 wants to share these report findings with people who are interested in the results. Please let us know if you would like a copy of the final report.

Thank you again. Have a good afternoon.

Provider Focus Group Guide

Health Resources in Action
Regional Health Partnership 7 (RHP 7) Community Health Needs Assessment
Provider Focus Group Guide

Goals of the focus group:
• To identify the perceived needs and barriers to health for low-income, uninsured populations and Medicaid populations
• To gain an understanding of the delivery system for Medicaid, low-income, and uninsured populations
• To identify areas of opportunity for RHP 7 to improve these systems

[NOTE: THE QUESTIONS IN THE FOCUS GROUP GUIDE ARE INTENDED TO SERVE AS A GUIDE, NOT A SCRIPT.]

V. BACKGROUND (5-10 minutes)

- Welcome everyone. My name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. I have a colleague with me today, [NAME], who is taking notes during our discussion. She works with me on this project. I want to give you my full attention, so she is helping me out by taking notes during the group.

- We're going to be having a focus group today. Has anyone here been part of a focus group before? You are here because we want to hear your opinions. I want everyone to know there are no right or wrong answers during our discussion. We want to know your opinions, and those opinions might differ. This is fine. Please feel free to share your opinions, both positive and negative.

- Central Health/Region 7 is conducting a community health needs assessment to gain a greater understanding of the health issues low-income, uninsured community members or those with Medicaid, how those needs are currently being addressed, and where there are opportunities to address these issues more effectively in Lee, Bastrop, Fayette, Caldwell, Hays, and Travis counties. The information you provide is a valuable part of this assessment and improving health services in the community. In addition to our conversation today, we will also be conducting a focus group with patients, interviews with representatives from each county, and collecting data from a survey, as well as sources like the Census Bureau and local public health entities.

- Our discussion today will last about 90 minutes. After we finish all the data collection for this project, we will be writing a summary report of the general themes that have come up. We will not include any names or identifying information in that report. Nothing that you say here will be connected directly to you in the report.

- You might also notice that I have a stack of papers here. I have a lot of questions that I'd like to ask you today. I want to let you know that so if it seems like I cut a conversation a little short to move on

to the next question, please don't be offended. I just want to make sure we cover a number of different topics during our discussion.

- Lastly, please turn off your cell phones, beepers, or pagers or at least put them on vibrate mode. If you need to take a call or go to the restroom during the discussion, please feel free to leave, but we'd appreciate it if you would go one at a time.

  Any questions before we begin our introductions and discussion?

VI. INTRODUCTION AND WARM-UP (5-10 MINUTES)

1. Now, first let's spend a little time getting to know one another. Let's go around the table and introduce ourselves. Please tell me: Your first name and one thing that you enjoy doing in your free time

VII. ORGANIZATION/AGENCY (10 minutes)

2. Can you tell me a bit about your organization/agency?

   d. What is your organization and your role in the organization?
   e. What county or counties does your organization serve?
   f. Who are the main clients/patients of your services? [PROBE: AGE, SOCIOECONOMIC STATUS, RACE/ETHNICITY]

VIII. COMMUNITY ISSUES (25-30 minutes)

3. How would you describe the community your organization serves?

   a. What do you consider to be the community's greatest strengths/assets?

   b. What are some of the biggest challenges/concerns for the low-income/uninsured/Medicaid population in the community that you serve? What challenges does this group of residents face day to day? [PROBES: FOOD, HOUSING, EDUCATION, TRANSPORTATION, ETC.)

   c. What do you think are the most pressing <u>health</u> concerns for the low-income/uninsured/Medicaid population in the communities that you serve? [PROBE: SPECIFIC HEALTH CONDITIONS, BARRIERS TO CARE/ACCESS TO CARE, COVERAGE, AVAILABILITY OF AND ACCESS TO SPECIALITY CARE]

      i. What factors do you think are causing/influencing these major issues?

      ii. How have these health issues affected the community?

4. [IF ACCESS IS MENTIONED IN PREVIOUS QUESTION] You mentioned healthcare access as a major concern for the community, what are the specific challenges low-income/uninsured/Medicaid

populations in the community experience in accessing health care? [PROBE: INSURANCE, AVAILABILITY OF SERVICES, LOCATION OF SERVICES]

a. What does healthcare access mean to you?

b. Which populations face more barriers to care? Why do you think that is?

c. What can be done to address these barriers?

OR

[IF ISSUES RELATED TO ACCESS ARE NOT MENTIONED IN THE PREVIOUS QUESTION] What challenges do low-income/uninsured/Medicaid population in the communities you serve have in accessing health care? [PROBE: INSURANCE, AVAILABILITY OF SERVICES, LOCATION OF SERVICES]

a. What does healthcare access mean to you?

b. Which populations face more barriers to care? Why do you think that is?

c. What can be done to address these barriers?

5. What do you think needs to be done to address [KEY ISSUE HERE] for the low-income/uninsured/Medicaid Population?

a. What opportunities have you seen that might address these issues? For example, are there some "low hanging fruit" – current collaborations or initiatives that can be strengthened or expanded?

IX. PERCEPTIONS OF HEALTH CARE SYSTEM (25-30 MINUTES)

6. What is the state of the health and social service systems right now in your county or the region? [PROBE FOR: SERVICE SYSTEMS SPECIFICALLY FOR LOW-INCOME/UNINSURED/MEDICAID POPULATIONS].

a. What external factors have the biggest impact in shaping the health care or social service system [PROBES: CHANGES/UNCERTAINTIES AT THE FEDERAL LEVEL, CHANGING MODELS OF HEALTH CARE DELIVERY, EMERGING HEALTH NEEDS]

b. Where are there gaps in the system? What programs, services, or policies are currently not available that you think should be?

7. Thinking back to some of the issues we discussed before such as [NAME SOME OF THE HEALTH OR ACCESS ISSUES DISCUSSED IN PREVIOUS SECTION] – what impact do these health concerns/issues have on the social service and healthcare delivery system in the county your organization serves?

a. What are the biggest challenges that the social service/healthcare delivery system face in addressing these issues?

8. Given RHP 7's work related to 1115 Waiver and the DSRIP Projects over the past 5 years, what has been accomplished [FACILITATOR: REFER PARTICIPANTS TO LIST OF DSRIP PROJECTS PROVIDED AT BEGINNING]?

    a. What still needs to be done? What are priority populations/topics/geographies that you think Central Health/RHP 7 should focus on moving forward?

    b. What opportunities do you see for collaboration to address the social service/health care system?

9. When you think about the communities that you serve 3-5 years from now, what you like to see? What is your vision for the future?

    a. What is your vision specifically related to people's health and the community conditions that influence their health?

        i. What do you think needs to happen in the community to make this vision a reality?

VII. CLOSING (5 minutes)

Thank you so much for your time. That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today?

As I mentioned, after all of the discussions are completed, we're going to be writing up a report. Central Health/RHP 7 wants to share these report findings with people who are interested in the results. If you are interested in receiving updates about the assessment or a copy of the final report, please add your contact information to the sheet we will be passing around.

Thank you again. Have a good afternoon.

Community Member Focus Group Guide

Health Resources in Action
Regional Health Partnership 7 (RHP 7) Community Health Needs Assessment
Patient Focus Group Guide

Goals of the focus group:
• To identify the perceived needs and barriers to health for low-income, uninsured populations and Medicaid populations in the RHP-7 counties
• To gain an understanding of the delivery system for Medicaid, low-income, and uninsured populations
• To identify areas of opportunity for RHP 7 to improve these systems

[NOTE: THE QUESTIONS IN THE FOCUS GROUP GUIDE ARE INTENDED TO SERVE AS A GUIDE, NOT A SCRIPT.]

X. BACKGROUND (5-10 minutes)

- Welcome everyone. My name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. I have a colleague with me today, [NAME], who is taking notes during our discussion. She works with me on this project. I want to give you my full attention, so she is helping me out by taking notes during the group.

- We're going to be having a focus group today. Has anyone here been part of a focus group before? You are here because we want to hear your opinions. I want everyone to know there are no right or wrong answers during our discussion. We want to know your opinions, and those opinions might differ. This is fine. Please feel free to share your opinions, both positive and negative.

- Regional Health Partnership 7 (RHP 7) is a partnership of hospitals in six counties (Travis, Hays, Caldwell, Bastrop, Fayette, and Lee counties) that focuses on projects addressing critical health needs for community members. The partnership is led by Central Health. RHP 7 is conducting a community health needs assessment to gain a greater understanding of the health issues in communities in Bastrop, Lee, Fayette, Caldwell, Hays, and Travis counties, how those needs are currently being addressed, and where there are opportunities to address these issues more effectively. The information you provide is a valuable part of this assessment and improving health services in the community. In addition to conversations like the one we are having today, we will be collecting data from a survey, as well as sources like the Census Bureau and local public health entities.

- Our discussion today will last about 90 minutes. After we finish all the data collection for this project, we will be writing a summary report of the general opinions that have come up. We will not include any names or identifying information in that report. Nothing that you say here will be connected directly to you in the report.

- You might also notice that I have a stack of papers here. I have a lot of questions that I'd like to ask you today. I want to let you know that so if it seems like I cut a conversation a little short to move on to the next question, please don't be offended. I just want to make sure we cover a number of different topics during our discussion.

- Lastly, please turn off your cell phones, beepers, or pagers or at least put them on vibrate mode. If you need to take a call or go to the restroom during the discussion, please feel free to leave, but we'd appreciate it if you would go one at a time.

  Any questions before we begin our introductions and discussion?

I. INTRODUCTION AND WARM-UP (5-10 MINUTES)

1. Now, first let's spend a little time getting to know one another. Let's go around the table and introduce ourselves. Please tell me: 1) Your first name; 2) What city you live in 3) One thing you like about living in this area

XI. COMMUNITY ISSUES (30-35 MINUTES)

10. How would you describe your community *[refer to the places named in the introduction]* to someone thinking about moving there?

    a. What are some of the biggest strengths or most positive things about the area?

    b. What are some of the biggest problems or concerns in your community? What are the day-to-day challenges that you or your neighbors deal with? [PROBE FOR HOUSING, TRANSPORTATION, SOCIAL ISSUES, UNEMPLOYMENT, WAGES, ETC.]

    c. What do you think are the pressing health concerns in your community? Why? [PROBE FOR HEALTH CARE ACCESS, MENTAL HEALTH, CHRONIC DISEASE, SUBSTANCE USE]

        i. What do you think is causing these major health issues?
        ii. How have these health issues affected your community?
        iii. What populations are most vulnerable or at risk for these conditions/issues?

11. What make it easier to be healthy in your community? [PROBE FOR SERVICES, PROGRAMS, SOCIAL ENVIRONMENT, BUILT ENVIRONMENT] What makes it harder?

XII. PERCEPTIONS OF COMMUNITY SERVICES (25-30 MINUTES)

12. Let's talk about a few of the community health issues you mentioned previously. [MODERATOR: SELECT TOP ISSUES]. What programs or services are you aware of in the community that address these issues?

a. In your opinion, how effective have these programs, services, or policies been at addressing these issues? Why?

b. What's missing? What programs or services are currently not available that you think should be?

13. What challenges do you or people in your community face in accessing services to address these issues?

    i. What changes need to happen to address these challenges and make it easier for people to access these services?

XIII. Perceptions of Health Care Services

14. Have you or someone close to you ever experienced any challenges in trying to get the health care you needed? What specifically was challenging? [*PROBE FOR SPECIFICS: e.g. insurance issues, language barriers, cultural differences, hours of operation, transportation, childcare, lack of providers, etc.*]

    a. What do you think would help so that people don't experience the same type of problem in getting health care?

15. What do you think of the overall health care services that are currently available to people in your community? [*PROBE ON POSITIVE AND NEGATIVE ASPECTS OF THE HEALTH CARE SERVICES*]

    a. What services/programs/topic areas would you like to see health care providers focus on in the next 3-5 years?

XIV. CLOSING (5 minutes)

Thank you so much for your time. That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today?

As I mentioned, after all of the discussions are completed, we're going to be writing up a report. Central Health/RHP 7 wants to share these report findings with people who are interested in the results, so we will pass around a sign-up sheet that you can add your e-mail to if you're interested in receiving updates about the assessment.

Thank you again. Have a good afternoon.