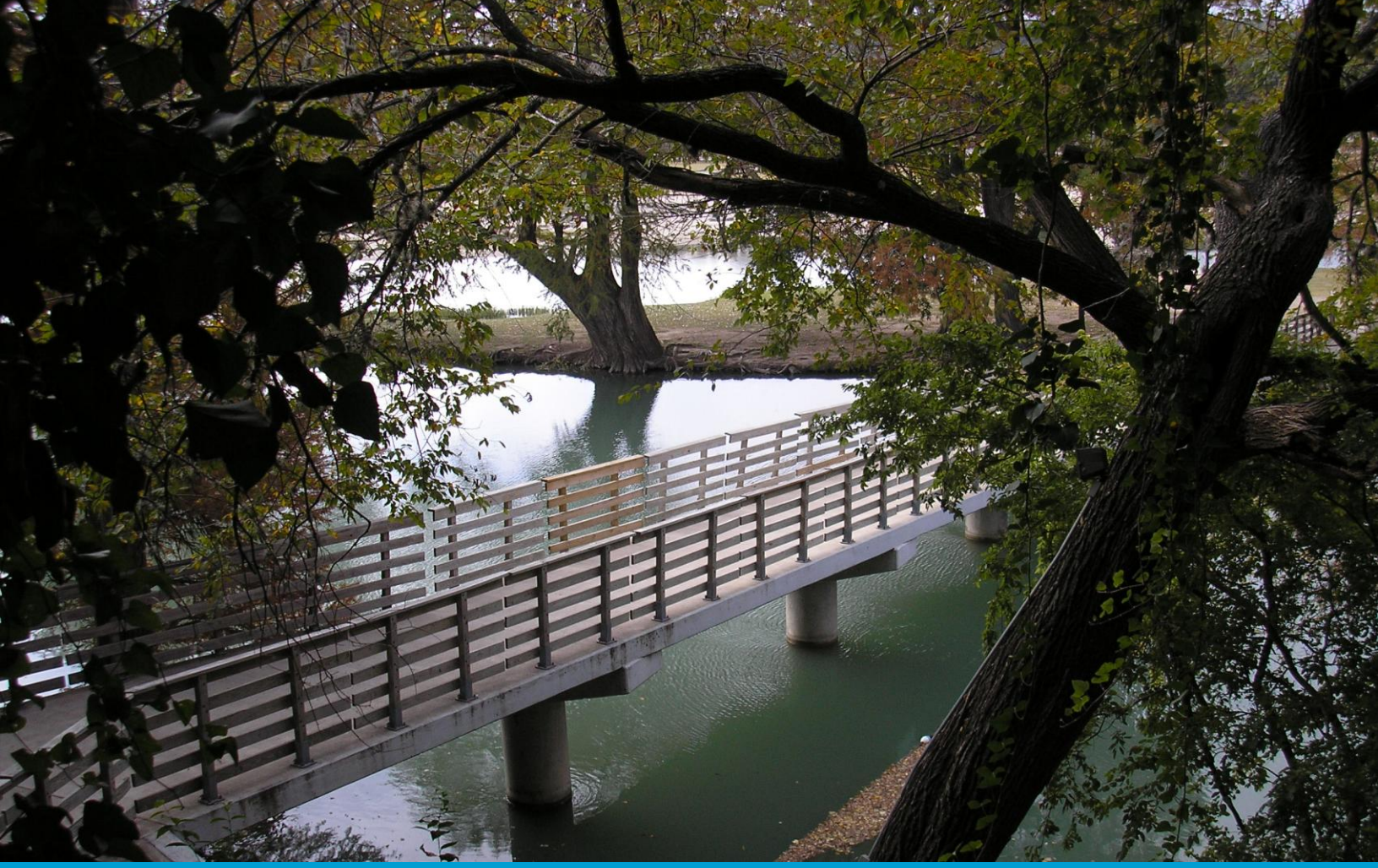

2019

Peterson Health – Peterson Regional Medical Center

Community Health Needs Assessment

- Kerr County, Texas-

Paper copies of this document may be obtained at: Peterson Regional Medical Center
551 Hill Country Drive, Kerrville TX 78028 or by phone 830-896-4200 or via the hospital website
https://www.petersonhealth.com

Photo Credit: Peterson Health

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Perspective / Overview

Creating a culture of health in the community

Action Cycle Source: the Robert Wood Johnson Foundation's County Health Rankings website: http://www.Countyhealthrankings.org/roadmaps/action-center

The Action Cycle shows how to create healthy communities. The rankings later in the document assist in understanding what makes a healthy community.

The Community Health Needs Assessment (CHNA) uses systematic, comprehensive data collection and analysis to define priorities for health improvement, creates a collaborative community environment to engage stakeholders, and an open and transparent process to listen and truly understand the health needs of Kerr County, Texas.

2019 Community Health Needs Assessment

This document is a hospital facility-specific Community Health Needs Assessment (CHNA) for Peterson Regional Medical Center.

Peterson Regional Medical Center as the sponsors of the assessment, engaged national leaders in community health needs assessments to assist in the project. Stratasan, a healthcare analytics and facilitation company based out of Nashville, Tennessee, provided the analysis of community health data, facilitated the focus groups, conducted the interviews and facilitated a community health summit to receive community input into the priorities and brainstorm goals and actions the community could take to improve health.

- Starting on June 25, 2019, this report is made widely available to the community via Peterson Regional Medical Center's website https://www.petersonhealth.com and paper copies are available free of charge at Peterson Regional Medical Center, 551 Hill Country Dr., Kerrville, TX 78028 or by phone 830-896-4200.
- Peterson Regional Medical Center's board of directors approved this assessment and the hospital's implementation plan on June 25, 2019.

PROJECT GOALS

1. To continue a formal and comprehensive community health assessment process which allows for the identification and prioritization of significant health needs of the community to assist with resource allocation, informed decision-making and collective action that will improve health.
2. To continue a collaborative partnership between all stakeholders in the community by seeking input from persons who represent the broad interests of the community.
3. To support the existing infrastructure and utilize resources available in the community to instigate health improvement in the community.

> *We initiated the Community Health Needs Assessment with the goal to assess the health and needs of the community. This process is an affirmation of what we've been doing to improve health and has jumpstarted our next implementation plan," said Cory Edmondson, CEO Peterson Health.*
>
> *The information gathered both from public health data and from community stakeholders provided the insight the community needed to set priorities for significant health issues and will be used by the community to inform and support our implementation plans," added Lisa Winters, Director of Marketing & Community Relations, Peterson Health.*

Community

Input and Collaboration

Data Collection and Timeline

In March 2019, Peterson Regional Medical Center began a Community Health Needs Assessment for Kerr County, and sought input from persons who represent the broad interests of the community using several methods:

- Information gathering, using secondary public health sources, occurred in March 2019.
- 30 community members, not-for-profit organizations representing medically underserved, low-income, minority populations, the elderly, health providers, education providers, and the health department participated in two focus groups and individual interviews for their perspectives on community health needs and issues on April 4th, 2019.
- A Community Health Summit was conducted on May 22, 2019 with 30 community stakeholders. The audience consisted of healthcare providers, business leaders, government representatives, schools, not-for-profit organizations, employers and other community members.

Photo Credit: Peterson Health

Information Gaps

While this assessment was quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all the community's health needs.

Participants

Sixty-two individuals from thirty-six community and healthcare organizations collaborated to implement a comprehensive CHNA process focused on identifying and defining significant health needs, issues, and concerns of Kerr County. The three-month process centered on gathering and analyzing data as well as receiving input from persons who represented the broad interests of the community to provide direction for the community and hospital to create a plan to improve the health of the communities.

Participation by those Representing the Broad Interests of the Community

Participation in the focus group, interviews and at the Community Health Summit creating the Kerr County Community Health Needs Assessment and Improvement Plan included:

Organization	Population Represented (kids, low income, minorities, those w/o access)	How Involved?
Arthur Nagel Community Clinic	Medically Underserved	Focus Group
Bandera ISD Superintendent	Students and Staff	Focus Group
Christian Assistance Ministries	All	Summit
Community member	All	Summit
Counselor	Teens and Women with Trauma	Focus Group
Dietert Center	Seniors	Focus Group, Summit
Employer		Focus Group
Encompass Home Health	55+	Focus Group
Family Endeavours	Homeless Veterans	Focus Group
Hill Country Community MHDD Centers	Mental health and developmental disabilities	Focus Group, Summit
Hill Country Crisis Council	Survivors of family violence, child and adult sexual assault and other abuse.	Focus Group
Ingram ISD Superintendent	Students and Staff	Focus Group
Kerr Chamber of Commerce, Chamber Health and Wellness Committee	All	Focus Group, Summit
Kerr County Chiropractic	All	Focus Group
Kerr County Health Department	Low income, kids	Interview
Kerr County Indigent	Low income	Focus Group
Kerr County Sheriff's Office	All	Focus Group
Kerr Konnect	Seniors and others	Summit
Kerrville Fire Department	City of Kerrville 25K	Focus Group
Kerrville ISD	Children/low income	Summit
Kerrville ISD Early Childhood	Kids/All	Focus Group
Kerrville ISD Superintendent	Students and Staff	Focus Group
Kerrville Police Department	Community citizens	Focus Group
Kerrville Public School Foundation	Kids	Focus Group
Kerrville State Hospital	Mental health	Summit
Mayor, Kerrville	Community	Summit
Peterson Community Care	All, Medically Underserved, low income adults	Focus Group, Summit
Peterson Health	All, Community, Recovery community, Kids	Focus Group, Summit
Peterson Health Board Member/Community	Healthcare, Retirees	Focus Group, Summit
Peterson Medical Associates	All	Focus Group, Summit
Texas Representative	All	Interview
Tivy High School	Teens at Tivy, Adolescents	Focus Group, Summit
Tivy High School Counselor	Students and Staff	Focus Group
TX A&M Agrilife	youth, low income	Summit
Wesley Nurse	Low Income	Summit
Wesley Nurse-Hunt Methodist Church	Low income	Focus Group

In many cases, several representatives from each organization participated.

Input of the Medically Underserved, Low-Income, and Minority Populations

Input of medically underserved, low-income and minority populations was received during the focus groups, interviews, surveys, and the Community Health Summit. Agencies representing these population groups were intentionally invited to the focus groups, interviews and Summit. Additionally, the community survey was distributed through the health departments and other agencies serving the low-income, medically underserved and minority populations. The community survey was representative of the whole community – by age, income, and education.

Input of those with Expertise in Public Health

The Kerr County Health Department participated in the individual interviews. They were invited to the Health Summit, but could not attend.

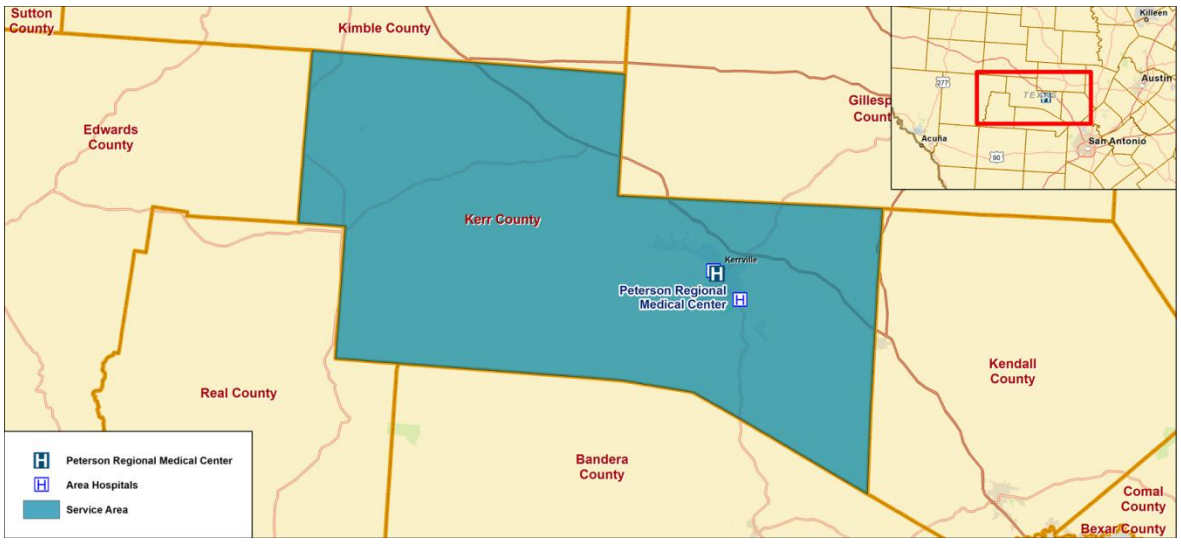
Community Engagement and Transparency

Many members of the community participated in the focus groups, individual interviews, and the Summit. We are pleased to share the results of the Community Health Needs Assessment with the rest of the community in hopes of attracting more advocates and volunteers to improve the health of Kerr County. The following pages highlight key findings of the assessment. We hope you will take the time to review the health needs of our community as the findings impact each and every citizen in one way or another; and join in the improvement efforts.

Community Selected for Assessment

Kerr County were the primary focus of the CHNA due to the service area of Peterson Regional Medical Center. Used as the study area, Kerr County provided 75% of inpatient discharges. The community includes medically underserved, low-income and minority populations who live in the geographic areas from which Peterson Regional Medical Center draws their patients. All patients were used to determine the service area without regard to insurance coverage or eligibility for financial assistance under Peterson Regional Medical Center's Financial Assistance Policy.

Peterson Regional Medical Center Study Area - 2018



Source: Peterson Regional Medical Center 2018

Key Findings

Community Health Assessment

Results

Based on the primary and secondary data, interviews, focus groups and surveys the following needs were prioritized by attendees at the Community Health Summit. The remainder of the document outlines the process and data.

1. **Access to Care and Insurance**
2. **Obesity – Healthy Eating and Active Living**
3. **Mental Health**
4. **Children's Health Issues**
5. **Socioeconomics/Housing/Environmental**
6. **Substance Abuse**
7. **Chronic Diseases**

Process and Methods

Both primary and secondary data sources were used in the CHNA.

Primary methods included:

- Community focus groups
- Individual interviews with community members
- Community Health Summit

Secondary methods included:

- Public health data – death statistics, County Health Rankings, cancer incidence
- Demographics and socioeconomics – population, poverty, uninsured, unemployment
- Psychographics – behavior measured by spending and media preferences

Photo Credit: Peterson Health

Demographics of the Community 2018-2023

Description of the Communities Served

The table below shows the demographic summary of Kerr County compared to Texas and the U.S.

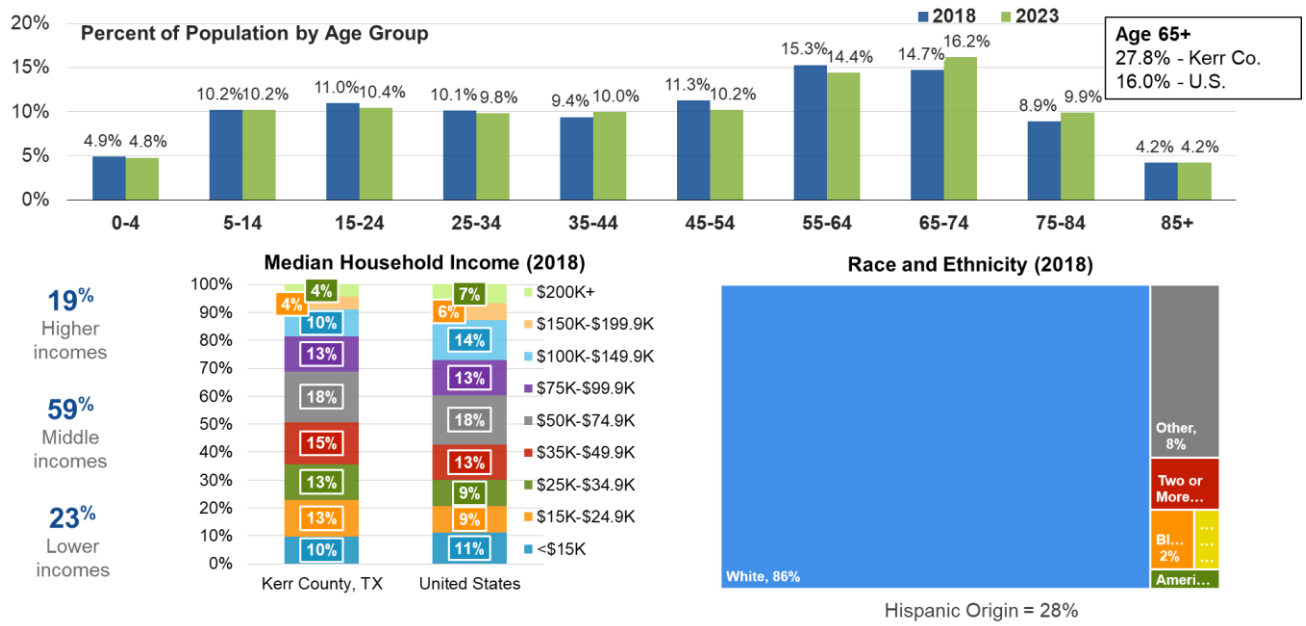
	Kerr County, TX	Texas	USA
Population	**53,589**	28,954,616	330,088,686
Median Age	**49.2**	34.8	38.3
Median Household Income	**$49,089**	$57,286	$58,100
Annual Pop. Growth (2018-2023)	**0.90%**	1.65%	0.83%
Household Population	**21,953**	10,211,287	124,110,001
Dominant Tapestry	**Silver & Gold (9A)**	Up and Coming Families (7A)	Green Acres (6A)
Businesses	**2,604**	887,900	11,539,737
Employees	**23,656**	11,557,213	151,173,763
Medical Care Index*	**97**	99	100
Average Medical Expenditures	**$1,883**	$1,928	$1,950
Total Medical Expenditures	**$41.3 M**	$19.7 B	$242.0 B
Racial and Ethnic Make-up			
White	**86%**	68%	70%
Black	**2%**	12%	13%
American Indian	**1%**	1%	1%
Asian/Pacific Islander	**1%**	5%	6%
Other	**8%**	11%	7%
Mixed Race	**2%**	3%	3%
Hispanic Origin	**28%**	40%	18%

Source: ESRI

*The Medical Care Index is household-based, and represents the amount spent out of pocket for medical services relative to a national index of 100.

The median is the value at the midpoint of a frequency. There is an equal probability of falling above or below the median.

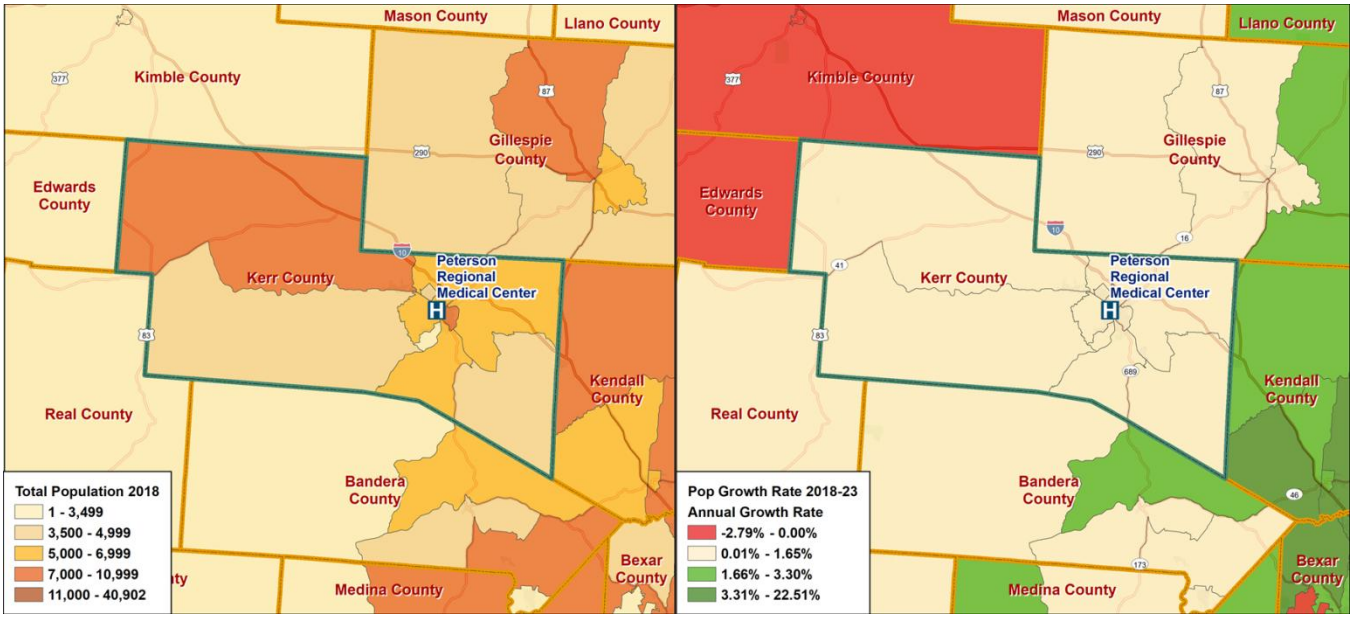
Kerr County



Source: ESRI

- The population of Kerr County is projected to increase from 2018 to 2023 (0.9% per year). Texas is projected to increase 1.65% per year. The U.S. is projected to increase 0.83% per year.
- Kerr County had a higher median age (49.2 median age) than TX 34.8 and the U.S. 38.3. Kerr County percentage of the population 65 and over was 27.8%, higher than the US population 65 and over at 16%.
- Kerr County had lower median household income at $49,089 than TX ($57,286) and the U.S. ($58,100). The rate of poverty in Kerr County was 13.3% which was lower than TX (14.7%) and the U.S. (13.4%).
- The household income distribution of Kerr County was 19% higher income (over $100,000), 59% middle income and 23% lower income (under $24,999).
- The medical care index measures how much the populations spent out-of-pocket on medical care services. The U.S. index was 100. Kerr County was 97, indicating 3% less spent out of pocket than the average U.S. household on medical care (doctor's office visits, prescriptions, hospital visits).
- The racial and ethnic make-up of Kerr County was 86% white, 28% Hispanic Origin, 8% other, 2% black, 2% mixed race, 1% Asian/Pacific Islander, and 1% American Indian. *(These percentages total to over 100% because Hispanic is an ethnicity, not a race.)*

2018 Population by Census Tract and Change (2018-2023)



Source: ESRI

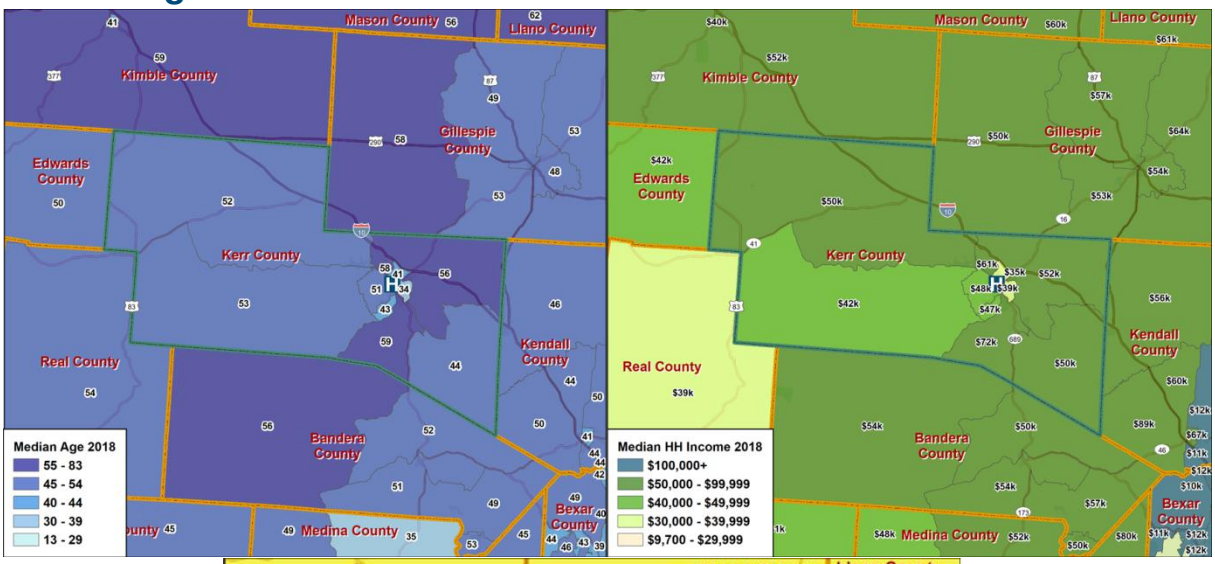
Red is population decline
Yellow is positive up to the TX growth rate
Green is greater than the TX growth rate
Dark Green is twice the TX growth rate

Census tracts generally have a population size between 1,200 and 8,000 people, with an optimum size of 4,000 people.

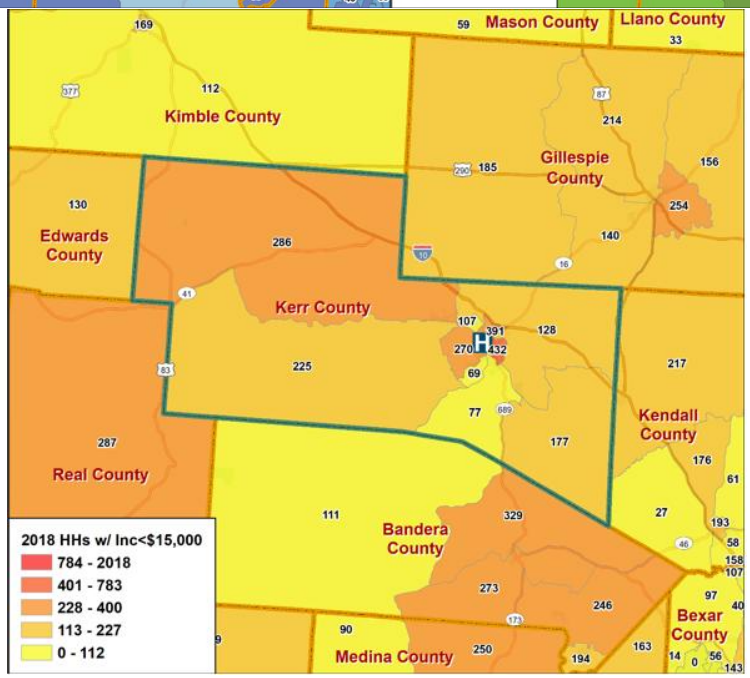
Kerr County's population was projected to increase from 2018 to 2023, 0.9% per year. All of the census tracks in Kerr County are projected to grow at the same rate.

The Census tracts in the Northwest region of Kerr County and the census tract east of the hospital have the largest total populations.

2018 Median Age & Income



Source: ESRI



These maps depict median age and median income by census tract. Looking at age and income by census tract is helpful to demonstrate all areas of a county are not the same. The health needs may be very different in the census tract south of the hospital with a median age of 59 and the census tract east of the hospital with a median age of 34.

Looking at median household income by census tract also gives insight into health status. The lower income areas may require more assistance than the higher income tracts. The lower income census tracts are east and north of the hospital with $39K and $35K median household incomes.

The lower map is the number of households making less than $15,000 per year. Again further attempting to identify those areas within the county that may have lower health status. The census tract east of the hospital has 432 households making less than $15K per year.

Additionally, Kerr County's December 2018 preliminary unemployment was 3.0% compared to 3.7% for Texas and 3.9% for the U.S., which is a large decline in unemployment since 2014. These figures do not include those who have ceased looking for work and dropped out of the workforce. However, indications are these people have begun to reenter the workforce.

Business Profile

66.7% percent of employees in Kerr County were employed in:

- Health care and social assistance (18.7%)
- Retail trade (15.8%)
- Accommodation & food services (14.8%)
- Other services (8.9%)
- Public administration (8.5%)

Source: ESRI Other Services: Establishments in this sector are primarily engaged in activities, such as equipment and machinery repairing, promoting or administering religious activities, grantmaking, advocacy, and providing dry-cleaning and laundry services, personal care services, death care services, pet care services, photofinishing services, temporary parking services, and dating services.

Retail and accommodation and food service jobs offers health insurance at a lower rate than manufacturing, healthcare, public administration and educational services. Kerr County gains 237 net commuters per day commuting into the county for work, with 20,168 commuting out of the county and 20,405 commuting into the county.

Source: US Census Bureau, American Community Survey (2009-2013)

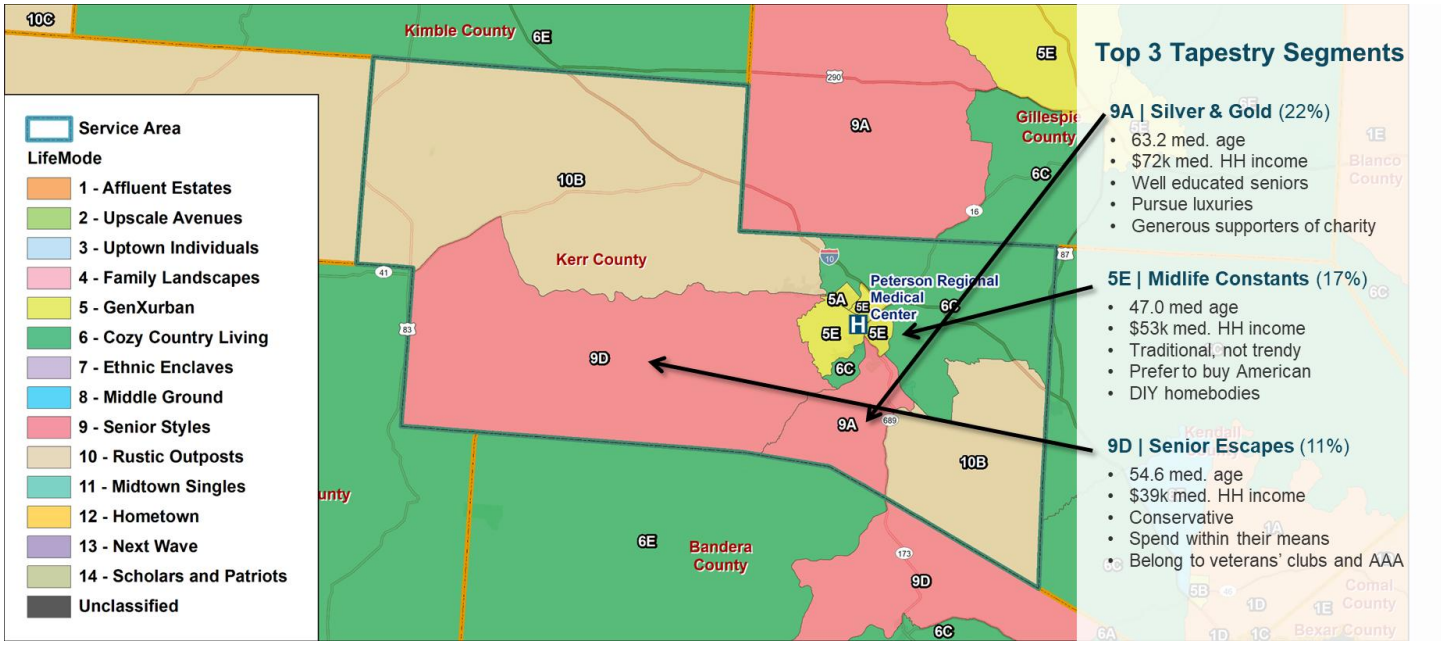
It is beneficial to contact people in groups to improve health. There are three primary places people gather during the week, work, church and school. These are three excellent places to reach people to create a culture of health.

Tapestry Segmentation

Demographics are population, age, sex, race. Psychographics are adding behavior data in the form of spending habits and survey data on top of demographics. 50% of Kerr County are included in three Tapestry Segments. The map below is color coded by LifeMode, which are groupings of Tapestry Segments that behave similarly.

The dominant Tapestry Segments in the county was Silver & Gold (22%), Midlife Constants (17%), and Senior Escapes (11%). The map below demonstrates the dominant Tapestry Segment by census tract.

There is a very brief description of the segments on the right of the map. There is much more information on Tapestry Segments, at http://doc.arcgis.com/en/esri-demographics/data/tapestry-segmentation.htm. Studying the Tapestry Segments in the study area helps determine health habits and communication preferences of residents enabling more effective communication and implementation of solutions to improve health. Many spoke of meeting people where they are in the focus group and interviews. Studying their Tapestry Segment can help do that.



Source: ESRI

Tapestry Segmentation, cont.

LifeMode Group: Senior Styles

Silver and Gold

9A

Households: 942,900

Average Household Size: 2.03

Median Age: 63.2

Median Household Income: $72,100

WHO ARE WE?

Almost the oldest senior market (second to *The Elders*), the difference of 9 years in median age reveals a socioeconomic difference: This is the most affluent senior market and is still growing. The affluence of *Silver and Gold* has afforded the opportunity to retire to sunnier climates that feature exclusive communities and vacation homes. These consumers have the free time, stamina, and resources to enjoy the good life.

OUR NEIGHBORHOOD

- Residents of *Silver and Gold* prefer a more bucolic setting, but close to metropolitan cities.
- Predominantly single-family, owner-occupied homes that have a median value of $385,700 (Index 186).
- Neighborhoods include seasonal or vacation homes, reflected in the high vacancy rate of 43%.
- Mostly older married couples with no children, average household size is 2.03.

SOCIOECONOMIC TRAITS

- Well-educated seniors, 47% have college degree(s).
- Primarily retired, but many still active in the labor force, participation rate of 41%.
- Low unemployment at 4.4% (Index 81); with self-employment highest among Tapestry markets (Index 218).
- More than half of the households with income from wages/salaries, Social Security, or investments, many drawing retirement income (Index 213).
- Connected, but primarily to get news and track investments, more likely to own an e-reader or tablet than a smartphone.

LifeMode Group: GenXurban

Midlife Constants

5E

Households: 3,068,400

Average Household Size: 2.31

Median Age: 47.0

Median Household Income: $53,200

WHO ARE WE?

Midlife Constants residents are seniors, at or approaching retirement, with below average labor force participation and above average net worth. Although located in predominantly metropolitan areas, they live outside the central cities, in smaller communities. Their lifestyle is more country than urban. They are generous, but not spendthrifts.

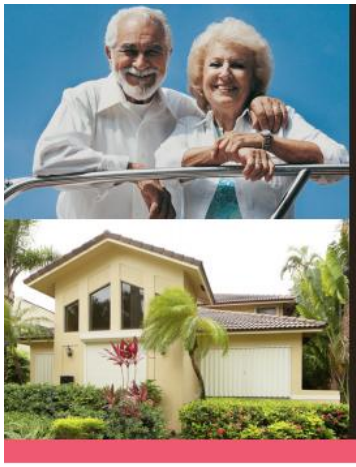
OUR NEIGHBORHOOD

- Older homes (most built before 1980) found in the suburban periphery of smaller metropolitan markets.
- Primarily married couples, with a growing share of singles.
- Settled neighborhoods with slow rates of change and residents that have lived in the same house for years.
- Single-family homes, less than half still mortgaged, with a median home value of $154,100 (Index 74).

SOCIOECONOMIC TRAITS

- Education: 63% have a high school diploma or some college.
- Unemployment is lower in this market at 4.7% (Index 86), but so is the labor force participation rate (Index 91).
- Almost 42% of households are receiving Social Security (Index 141); 27% also receive retirement income (Index 149).
- Traditional, not trendy; opt for convenience and comfort, not cutting-edge. Technology has its uses, but the bells and whistles are a bother.
- Attentive to price, but not at the expense of quality, they prefer to buy American and natural products.
- Radio and newspapers are the media of choice (after television).

Tapestry Segmentation, cont.



LifeMode Group: Senior Styles

Senior Escapes

9D

Households: 1,116,000

Average Household Size: 2.20

Median Age: 54.6

Median Household Income: $38,700

WHO ARE WE?

Senior Escapes neighborhoods are heavily concentrated in the warmer states of Florida, California, and Arizona. These areas are highly seasonal, yet owner occupied. Many homes began as seasonal getaways and now serve as primary residences. Nearly forty percent are mobile homes; over half are single-family dwellings. About half are in unincorporated and more rural areas. Nearly one-fifth of the population is between 65 and 74 years old. Most are white and fairly conservative in their political and religious views. Residents enjoy watching TV, going on cruises, playing trivia games, bicycling, boating, and fishing. They are very conscious of their health and buy specialty foods and dietary supplements.

OUR NEIGHBORHOOD

- Neighborhoods include primary and second homes in rural or semirural settings.
- One quarter of all housing units are vacant; many are for seasonal use only.
- More than one-third of the households are married couples without children; a third are single-person households.
- More than half the homes are single family; nearly 40% are mobile homes.
- Three-quarters of all homes are owner occupied, and the majority own their homes free and clear.
- Still actively driving, most households have one or two vehicles.

SOCIOECONOMIC TRAITS

- Labor force participation is low, but more than half the households are drawing Social Security income.
- They have conservative political views.
- They spend majority of their time with spouse/significant other or alone.
- They are limited by medical conditions but still enjoy gardening and working on their vehicles.
- They take good care of vehicles, but haven't bought a new one in over five years.
- They only spend within their means, do their banking in person, and do not carry a balance on their credit card.

Focus Groups and Interview Results

Thirty community stakeholders representing the broad interests of the community as well as representing low income, medically underserved and minority populations participated in two focus groups and individual interviews on April 4th 2019 for their input into the community's health. Community participation in the focus groups and interviews represented a broad range of interests and backgrounds. Below is a summary of the 90-minute focus group discussions and the individual interviews.

1. **How do you define health?**
   - Nine dimensions of wellness- physical, mental, financial, social, spiritual, etc.
   - Comprehensive, wholistic
   - Balance
   - Quality of life
   - Social emotional
   - Safety
   - Physically fit, don't need medication or therapy

2. **Generally, how would you describe the community's health?**
   - Depends: above average, not good, fair, poor, pretty good
   - Strong as a community
   - Strong medically- pharmaceuticals, urgent care
   - People with insurance have more opportunities

3. **What are the most important health issues facing Kerr County?**
   - Access to healthcare – expensive, high drug costs, EMS as primary healthcare
   - Quality and quantity of healthy food- food desert, expensive
   - Lack of transportation
   - Employment- need full-time jobs, post rehab opportunities, labor shortage with aging population
   - Mental illness
   - Substance use disorder
   - Lacking affordable/transitional housing
   - Maslow's hierarchy- if people don't have a safe home, they can't focus on anything else
   - Lack of education on resources, prevention, parenting
   - Lack of general and dental hygiene
   - Older population- lack mobility, vulnerable

Focus Group Results, cont.

4. **What are the most important health issues facing medically-underserved, low-income and minority populations?**
   - Literacy problems
   - Domestic abuse
   - Nutrition- lack of knowledge, poor food choices, diabetes
   - Lack of access- healthcare, healthy lifestyle, housing, resources, healthy food
   - Lack of birth control – Health Department does not provide
   - Don't receive preventative or dental care
   - Many life stressors- don't see a need for healthcare
   - Transportation
   - Doyle community- large African American population that endures hardships due to poverty
   - Homelessness and housing – high cost of housing, couch surfing

5. **What are the most important health issues facing children/adolescents?**
   - Need after school activities - gyms open for children, summer programs
   - Vaping/smoking, alcohol
   - Nutrition- obesity, junk/fast food, need education for children and parents
   - Lack of physical activity
   - Poverty- free and reduced lunch, lack school supplies, basic needs
   - Emotional disturbance - poor home situations, lack of parenting, trauma
   - Behavioral issues create barriers to learning
   - Lack of mental health treatment
   - Teen pregnancy- STDs, no-sex education

6. **What are the most important health issues facing seniors?**
   - Depression- loneliness, isolation
   - Grandparents raising grandkids
   - Retirement expenses- prescription drugs, housing, dementia services, transportation, care, etc.
   - Health issues- heart disease, stroke, dementia, diabetes, obesity, hypertension, cardiovascular
   - Lack of home treatment
   - Transportation- not able to get around, loss of driving privileges
   - Poor housing conditions
   - Education- need treatment knowledge, new strategies for selfcare
   - Elderly neglect, abuse and fraud
   - Insurance not paying for Shingles and pneumonia vaccines

Focus Group Results, cont.

7. The community performed a CHNA in 2016 and identified priorities for health improvement

1. Mental health/substance abuse
2. Access to care and insurance
3. Lifestyle/wellness/education
4. Obesity
5. Socioeconomics
6. Chronic diseases
7. Children's issues

What has changed most related to health status in the last three years?

Better

- Promoting health and wellness better- built community River Trail
- Progress in coordinating/directing- still need more coordination between resources
- Substance abuse- made some strides, sober living homes, Kerrville recovery coalition
- Crisis stabilization unit
- Access to care has improved- more doctors, physician recruitment
- Not working in silos as much; working together

Worse

- Need lifestyle changes- obesity, education
- Not reaching poverty areas
- Lack of treatment options
- Need specialists- gynecologists, cardiologists, specialists
- Need to bring services to people
- Need more transportation and financial assistance
- Kids mental health and substance abuse are worse

8. What behaviors have the most negative impact on health?

- Struggle with school attendance, transportation, poverty
- Grandparents raising grandkids
- Physical inactivity- electronics, social media, violent video games
- Teen pregnancy- abstinence based sex education, unsafe sex
- Sex trafficking
- Lack of self-control and discipline - bullying, vaping/smoking, excessive drinking/drug use
- Substance abuse - heroin, opioids, alcohol, meth, marijuana
- Lack of resources treatment for juveniles
- Poor post rehab transitional assistance

9. What environmental factors have the most negative impact on health?

- Allergies
- Good air quality
- Animal and rabies control
- Park system- River Trail, open spaces, lots of infrastructure, not great for seniors, unsafe at night
- New sports complex
- Expensive fitness centers
- Insurance discounts for exercise
- Some neighborhoods are better for children than others, varies by economics
- Anti-immunization movement

Focus Group Results, cont.

10. What do you think the barriers will be to improve health in the communities?

- Cost- medication, health care, dental care, insurance, high deductibles, housing
- Lack of health insurance
- Poverty – generational poverty
- Transportation- isolation, need to bring services to people
- Peers need to volunteer to help each other/community
- Complex system- lack of knowledge and confidence to ask for help
- Language barriers
- Lack of organizational/life skills
- Health is not a priority- no future orientation, ignorance, unwillingness to change
- Mental health provider burn out and turnover

11. What community assets support health and wellbeing?

- Dietert Center
- Meals on Wheels
- Interagency Network
- Peterson Health- Community Care
- Peterson Health – good hospital
- Hospital assistance program
- Ministerial Alliance
- Magdalen House- Mercy Ministries
- Glory community garden
- KStar- youth and family crisis center
- Salvation Army
- Red Cross
- 5Ks
- Rotary colleges
- Shattered Dreams Program
- Churches in the community
- Christian Assistance Ministries
- Food bank
- School nurses
- Friday blessings in a back-pack program
- Summer Feed federal program
- ART bus
- Kerr-Konnect
- River trail, aquatic center, bike trails, nice parks
- Enhanced Horizon Transitional Living
- Hill Country MHDD- work with disabled and mental health
- Hill Country Cares
- Extension Service through A&M
- Institute Healthcare Improvement
- Wesley Nurses
- Pregnancy Resource Center
- Plenty of doctors
- In general, a loving community

12. Where do members of the community turn for basic healthcare needs?

- Google
- Peterson Regional Medical Center
- Peterson Community Care
- Hard to get into primary care
- Raphael Community Free Clinic- hard to get into
- Urgent cares, doctors
- Self-pay and Medicaid find it very hard to get help

Focus Group Results, cont.

13. What improvement activities should be a priority for the county to improve health?

- More partnerships, collaborations within the community
- Promotion of a unified effort and holistic approach to improve health
- Centric support to existing organizations, educate/inform people
- Mentorship programs
- Focus on removing barriers
- Increasing the local job market with incentives
- Affordable housing
- Teach balanced lifestyle to kids- sleep, healthy eating habits, exercise, sex education
- Nutrition- education, counseling, cooking, neighborhood walks
- Partner with churches and minister to reach people/donation
- Access- ongoing preventative checkups, elderly resources, mental health providers, chronic pain management, dental care
- Addiction- prevention, detox, sober living community, transitional housing, affordable rehab
- More healthcare providers- specialists

Photo Credit: 2013 PRMC wheelchair bball; Peterson Health

Health Status Data

Based on the 2018 County Health Rankings study performed by the Robert Wood Johnson Foundation and the University of Wisconsin[2], Kerr County ranked 54th healthiest County in Texas out of the 254 counties ranked (1= the healthiest; 244 = unhealthiest), 91st for health outcomes and 17th for health factors.

County Health Rankings suggest the areas to explore for improvement in Kerr County were: higher adult smoking, higher adult obesity percentage, higher percentage of uninsured. The areas of strength were identified as lower percentage of excessive drinking, lower sexually transmitted infection rates, lower population to primary care physician, lower population per mental health provider, lower preventable hospital stays, higher mammography screenings, higher high school graduation, lower unemployment and lower income inequality.

When analyzing the health status data, local results were compared to Texas, the U.S. (where available), and the top 10% of counties in the U.S. (the 90th percentile). Where Kerr County's results were worse than TX and U.S., groups and individuals have an opportunity to act and improve these community measures. To become the healthiest community in Texas and eventually the Nation, Kerr County must close several lifestyle gaps. For additional perspective, Texas was ranked the 37th healthiest state out of the 50 states. (Source: 2018 America's Health Rankings) Texas strengths were high percentage of high school graduation, low drug death rate, low cancer death rate. Texas challenges were high percentage of uninsured population, high prevalence of diabetes and high prevalence of physical inactivity..

Comparisons of Health Status

Information from County Health Rankings and America's Health Rankings was analyzed in the CHNA in addition to the previously reviewed information and other public health data. Other data analyzed is referenced in the bullets below, such as: causes of death, demographics, socioeconomics, consumer health spending, focus groups, and surveys. If a measure was better than Texas, it was identified as a strength, and where an indicator was worse than Texas, it was indicated an opportunity for improvement. To prevent strengths from becoming opportunities for improvement, it's important to continually focus on them. Opportunities were denoted with red symbols, and strengths were denoted with green stars for easy interpretation. The years displayed on the County Health Rankings graphs show the year the data was released. The actual years of the data are contained in the source notes below the graphs.

There are 254 counties in TX, but only 244 were included in County Health Rankings, so counties ranked are ranked out of 244.

[2] The Rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play. Building on the work of America's Health Rankings, the University of Wisconsin Population Health Institute has used this model to rank the health of Texas's counties every year since 2003.

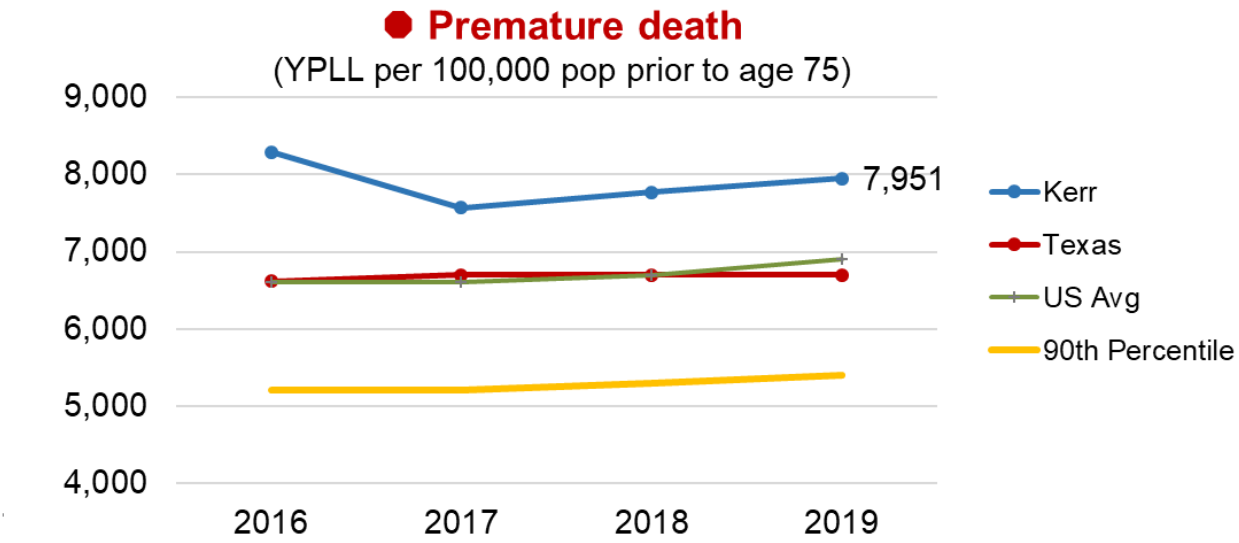
In most of the following graphs, Kerr County will be blue, Texas (TX) will be red, U.S. green and the 90th percentile of counties in the U.S. gold. * indicates a change in the BRFSS Survey calculations of results. 2016 forward cannot be compared to prior year results.

Health Outcomes (Length of Life and Quality of Life)

Health Outcomes are a combination of length of life and quality of life measures. Kerr County ranked 91st in Health Outcomes out of 244 Texas counties.

Length of Life

Length of life was measured by years of potential life lost per 100,000 population prior to age 75, lower is better. For example, if a 25-year-old is killed in an accident, that is 50 years of potential life lost prior to age 75. Kerr County ranked 99th in length of life in TX. Kerr County lost 7,951 years of potential life per 100,000 population which is higher than TX and the U.S.



Source: County Health Rankings; National Center for Health Statistics – Mortality File 2015-2017

Leading Causes of Death: Age-Adjusted Death Rates per 100,000

Cause of Death	Kerr County	Texas	US
Heart diseases	144.6	169.2	165.0
Cancer	148.5	146.5	152.5
Accidents (unintentional injuries)	43.0	38.8	49.4
Chronic Lower Respiratory diseases	52.9	40.5	40.9
Cerebrovascular disease	39.7	41.3	37.6
Alzheimer's Disease	25.8	38.5	31.0
Diabetes	16.4	21.2	21.5

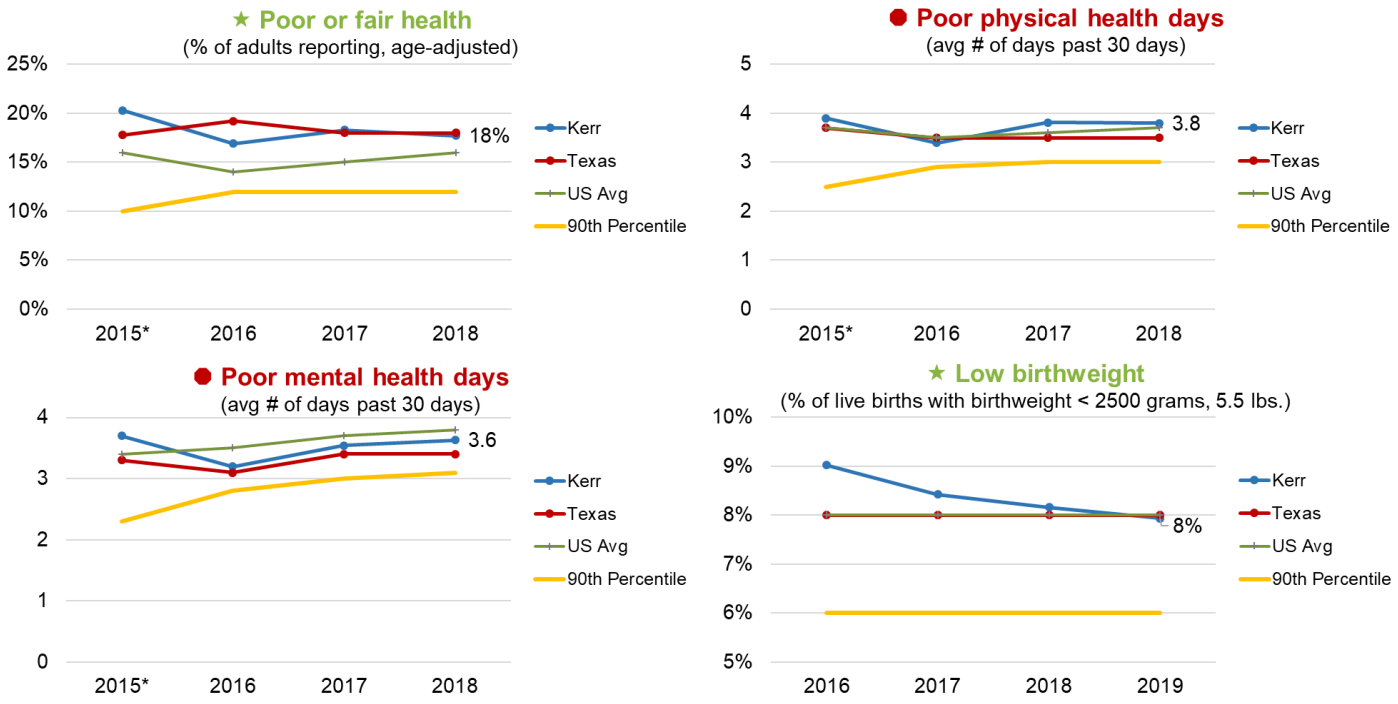
*Source(s): Wonder CDC.gov (2017) Age-adjusted rates per 100,000 population. Kerr County data from 2016, 2017 combined. TX, US data from 2017. *Rates that appear in red for a county denote a higher value compared to state data. Age Adjustment Uses 2000 Standard Population.*

Red areas had death rates higher than TX. The leading causes of death in Kerr County were cancer followed by heart disease. Lagging as causes of death were chronic lower respiratory diseases, accidents, cerebrovascular disease or strokes, Alzheimer's Disease and diabetes.

Photo Credit: Fire Safety lesson; Kerrville Daily Times

Quality of Life

Quality of life was measured by: % reporting fair or poor health, the average number of poor physical health days and poor mental health days in the past 30 days, and % of live births with birthweight less than 2500 grams, or 5.5 lbs. Kerr County ranked 105th in Texas for quality of life.



Source: County Health Rankings; Behavioral Risk Factor Surveillance System (BRFSS) 2016 Source: County Health Rankings: National Center for Health Statistics – Natality files (2011-2017)

Quality of Life STRENGTHS

- Kerr County had a lower death rate for heart disease, cerebrovascular disease, Alzheimer's Disease and diabetes than TX.
- Kerr County had the same percentage of adults reporting poor or fair health as TX, 18%.
- Kerr County had the same percentage of low birthweight babies at 8% as TX and the U.S.

Quality of Life OPPORTUNITIES

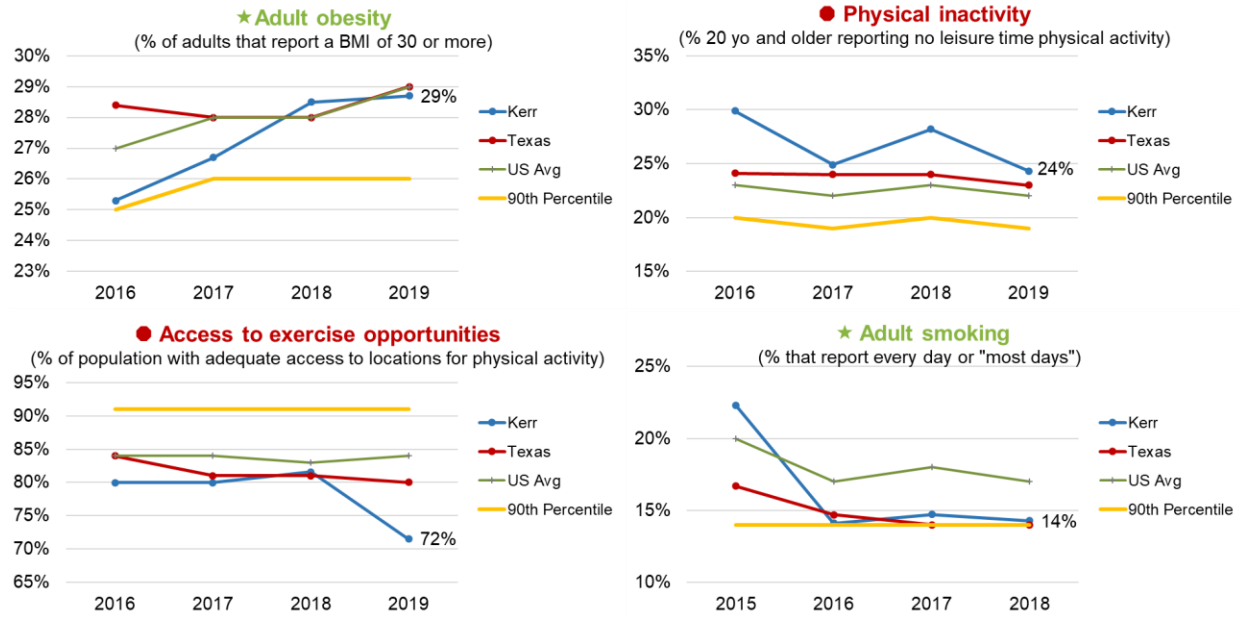
- Kerr County had a higher death rate for cancer, accidents (unintentional injuries), and respiratory disease.
- Kerr County had higher years of potential life lost prior to age 75 than TX and the U.S.
- Kerr County had average 3.8 days of poor physical health days in the past 30 days, which was higher than TX and the U.S.
- Kerr County also had higher average number of poor mental health days at 3.6 than TX, but lower than the U.S.

Health Factors or Determinants

Health factors or determinants rankings are comprised of measures related to health behaviors (30%), clinical care (20%), social & economic factors (40%), and physical environment (10%). Kerr County ranked 17th out of 244 Texas counties for health factors.

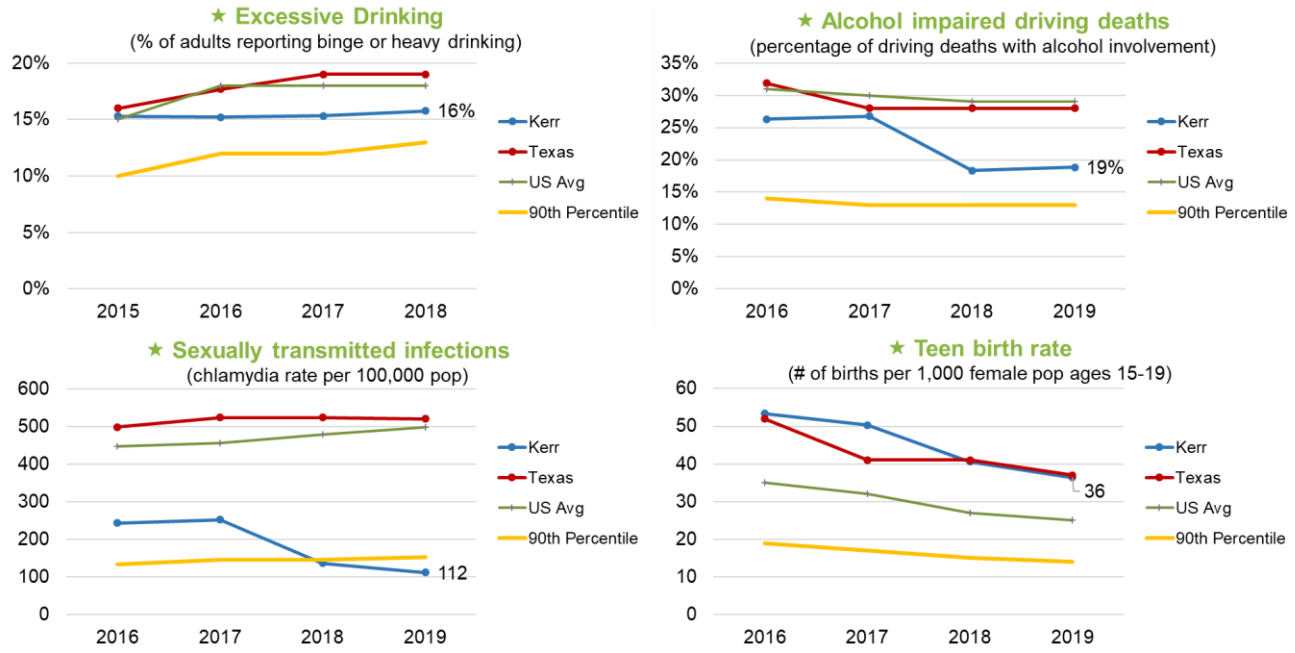
Health Behaviors

Health behaviors are made up of nine measures and account for 30% of the county rankings. Kerr County ranked 18th out of 244 counties in Texas.

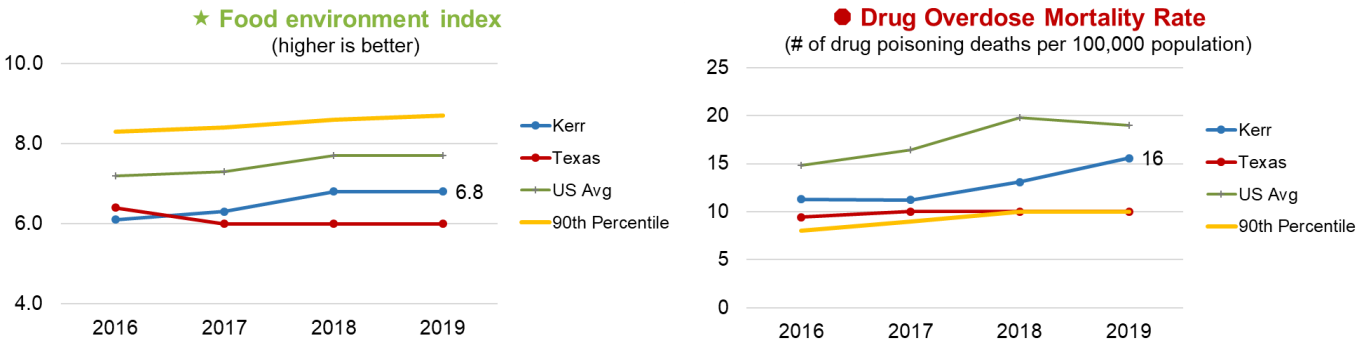


Source: Obesity, physical inactivity - County Health Rankings; CDC Diabetes Interactive Atlas based on responses to BRFSS and Census Bureau's population estimates program, 2015 Source: Access to exercise opportunities - County Health Rankings; ArcGIS Business Analyst, Delorme map data, Esri and U.S. Census Tigerline Files, 2010 and 2018. Measures the percentage of individuals in a County who live reasonably close to a location for physical activity, defined as parks or recreational facilities (local, state national parks, gyms, community centers, YMCAs, dance studios and pools based on SIC codes) Source: Smoking - County Health Rankings; Behavioral Risk Factor Surveillance System (BRFSS), 2016

Health Behaviors, Cont.



Source: Excessive drinking - County Health Rankings; Behavioral Risk Factor Surveillance System (BRFSS), 2016 Source: Alcohol-impaired driving deaths - County Health Rankings; Fatality Analysis Reporting System, 2013-2017 Source: STIs - County Health Rankings; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2016 Source: Teen birth rate – County Health Rankings; National Center for Health Statistics – Natality files, 2011-2017



Source: Food environment: County Health Rankings; USDA Food Environment Atlas, Map the Meal Gap from Feeding America, 2015 & 2016; Drug overdose rate: CDC WONDER mortality data, 2015-2017

The food environment index is a comprised of % of the population with limited access to healthy foods and % of the population with food insecurity. Limited access to foods estimates the % of the population who are low income and do not live close to a grocery store. Food insecurity is the % of the population who did not have access to a reliable source of food during the past year.

Health Behaviors, Cont.

The Impact of E-Cigarettes on the Lung

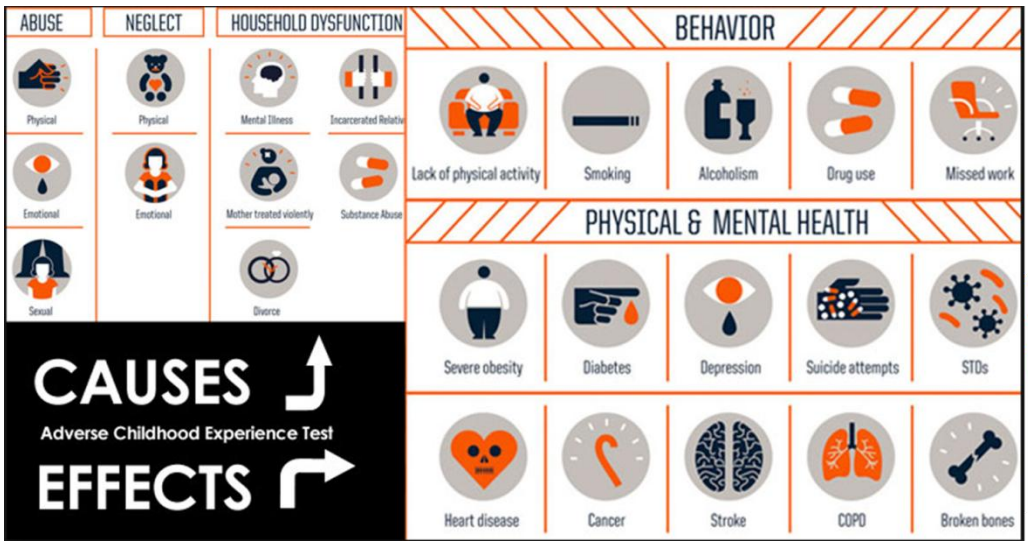
Following excerpt taken from American Lung Association website, www.lung.org, “The Impact of E-Cigarettes on the Lung”

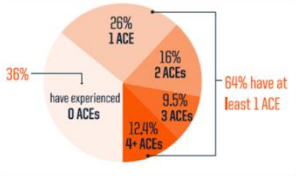
“In January 2018, the National Academies of Science, Engineering and Medicine[1] released a consensus study report that reviewed over 800 different studies.
That report made clear: using e-cigarettes causes health risks. It concluded that e-cigarettes both contain and emit a number of potentially toxic substances. The Academies' report also states there is moderate evidence that youth who use e-cigarettes are at increased risk for cough and wheezing and an increase in asthma exacerbations.
A study from the University of North Carolina found that the two primary ingredients found in e-cigarettes—propylene glycol and vegetable glycerin—are toxic to cells and that the more ingredients in an e-liquid, the greater the toxicity.[2]
E-cigarettes produce a number of dangerous chemicals including acetaldehyde, acrolein, and formaldehyde. These aldehydes can cause lung disease, as well as cardiovascular (heart) disease.[3]
E-cigarettes also contain acrolein, a herbicide primarily used to kill weeds. It can cause acute lung injury and COPD and may cause asthma and lung cancer.[4]”

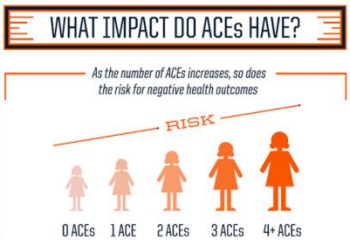
1. NAM Report - https://www.nap.edu/resource/24952/012318ecigaretteConclusionsbyEvidence.pdf
2. Sassano MF, Davis ES, Keating JE, Zorn BT, Kochar TK, Wolfgang MC, et al. (2018) Evaluation of e-liquid toxicity using an open-source high-throughput screening assay. PLoS Biol 16(3): e2003904. https://doi.org/10.1371/journal.pbio.2003904
3. Ogunwale, Mumiye A et al. (2017) Aldehyde Detection in Electronic Cigarette Aerosols. ACS omega 2(3): 1207-1214. doi: 10.1021/acsomega.6b00489].
4. Bein K, Leikauf GD. (2011) Acrolein - a pulmonary hazard. Mol Nutr Food Res 55(9):1342-60. doi: 10.1002/mnfr.201100279.

Adverse Childhood Experiences (ACEs)

Abuse, neglect and household disfunction have the effect of poor health behaviors as well as poor physical and mental health. The more ACES a child has the higher risk they are for poor outcomes







Health Behaviors STRENGTHS

- Kerr County was in the 90th percentile of all counties in the U.S. for adult smoking with 14%.
- Sexually transmitted infections measured by chlamydia rate per 100,000 population were lower in Kerr County (112) than TX (520), and the 90th percentile of all counties in the U.S. (153).
- Alcohol impaired driving deaths were lower in Kerr County (19%) than in TX and the U.S.
- 16% of Kerr County reported binge or heavy drinking, lower than TX (19%) and the U.S. (18%)
- The teen birth rate in Kerr County was 36 births per 1,000 female population ages 15-19 was lower than TX at 37 births, but higher than the U.S. at 25 births. The trend has decreased since 2016.
- The food environment index was higher in Jefferson County (6.8) than TX (6.0).
- Adult obesity in Kerr County was same as TX and the U.S. at 29%. However, obesity trend had been increasing in Kerr County. Obesity in Texas and the U.S. continue to rise, putting people at increased risk of chronic diseases including: diabetes, kidney disease, joint problems, hypertension and heart disease. Obesity can cause complications in surgery and with anesthesia. It has been implicated in Alzheimer's and often leads to metabolic syndrome and type 2 diabetes.

Health Behaviors OPPORTUNITIES

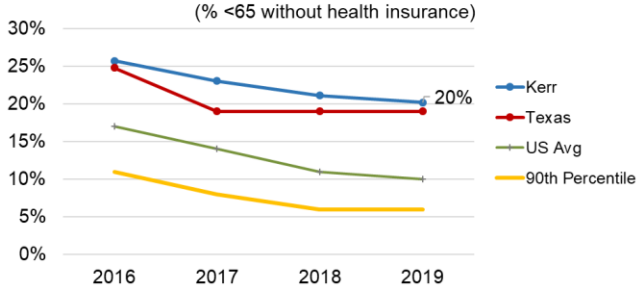
- Physical inactivity was higher in Kerr County at 24% than in TX at 23% and the U.S. at 22%.
- Access to exercise opportunities in Kerr County was 72%, lower than TX at 80% and the U.S. at 84%.
- The number of drug poisoning deaths per 100,000 population was 16 in Kerr County, higher than Texas at 10 but lower than the U.S. at 19.

Photo Credit: Peterson Health

Clinical Care

Clinical care ranking is made up of seven indicators, and account for 20% of the county rankings. Kerr County ranked 4th out of 244 Texas counties in clinical care.

● Uninsured
(% <65 without health insurance)



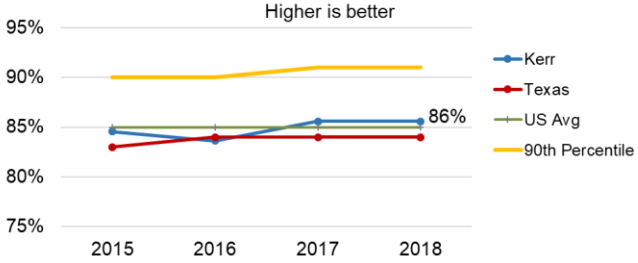
★ Preventable hospital stays
(hospitalization rate for ambulatory-sensitive conditions per 100,000 Medicare enrollees)

	2019
Kerr County	2,600
Texas	4,966
US Avg	4,520
90th Percentile	2,765

★ Mammography screening
(% female Medicare enrollees receiving mammo screening)
Higher is better

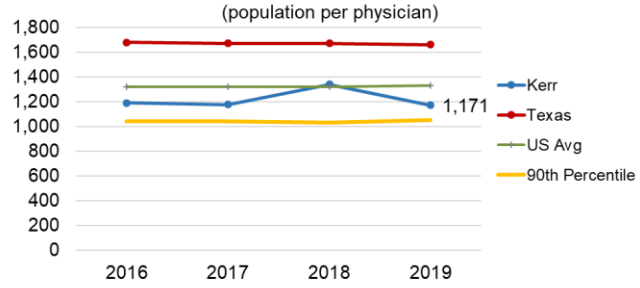
	2019
Kerr County	45%
Texas	37%
US Avg	41%
90th Percentile	49%

★ Diabetic screening
(% diabetic Medicare enrollees receiving HbA1c screening)
Higher is better

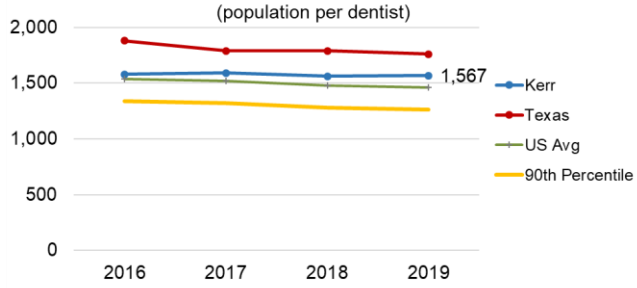


Source: Uninsured - County Health Rankings; Small Area Health Insurance Estimates, 2016
Source: Preventable hospital stays, mammography screening – County Health Rankings, CMS Mapping Medicare Disparities Tool, 2016
Source: diabetic screening - County Health Rankings; Dartmouth Atlas of Health Care, Medicare claims data, 2016

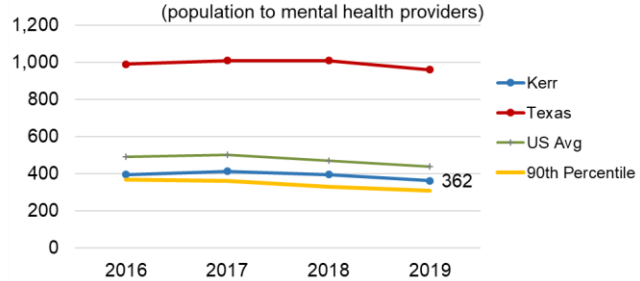
★ Primary care physicians
(population per physician)



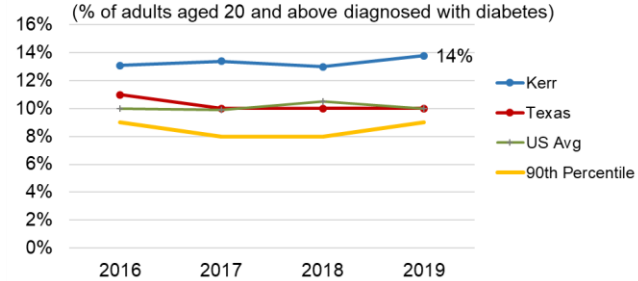
★ Dentists
(population per dentist)



★ Mental health providers*
(population to mental health providers)

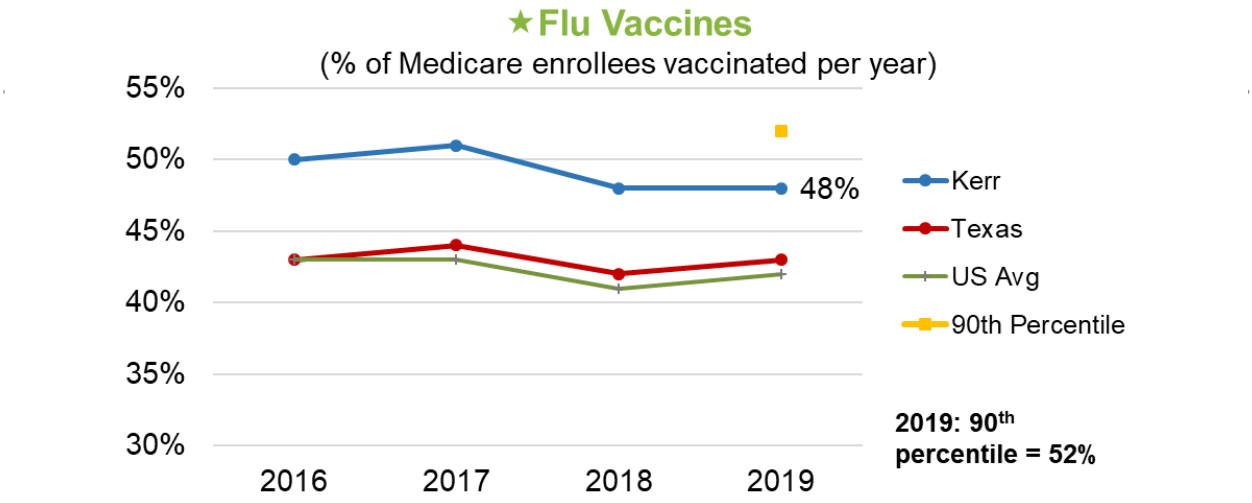


● Diabetes
(% of adults aged 20 and above diagnosed with diabetes)



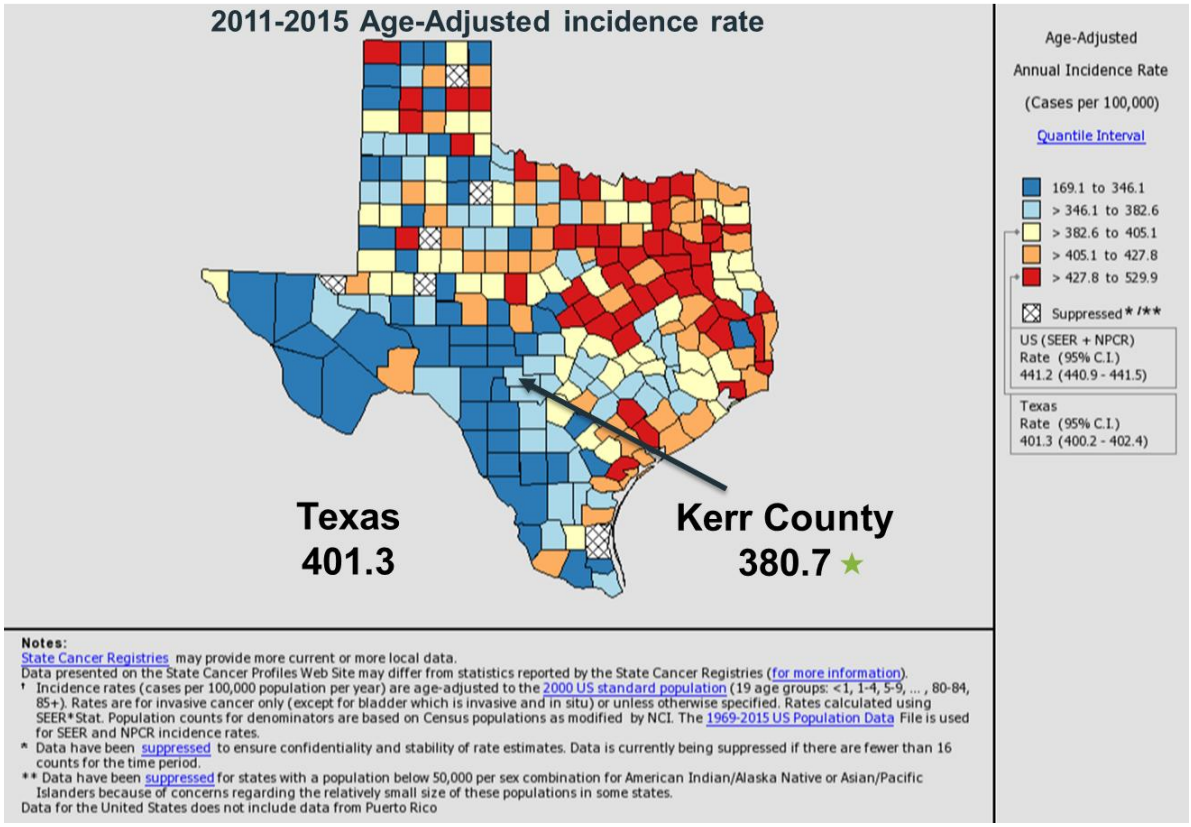
Source: Pop to PCP - County Health Rankings; Area Health Resource File/American Medical Association, 2016
Source: Pop to Dentists - County Health Rankings; Area Health Resource File/National Provider Identification file, 2017
Source: Pop to mental health provider (psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental health) County Health Rankings; CMS, National Provider Identification, 2018

Clinical Care, cont.



Source: The Centers for Medicare & Medicaid Services Office of Minority Health's Mapping Medicare Disparities (MMD) Tool , 2016

Cancer Incidence Rates – TX Counties



Clinical Care STRENGTHS

- Preventable hospital stays in Kerr County were 2,600 per 100,000 Medicare enrollees which was lower than TX (4,966) and the U.S. (4,520).
- Mammography screening was higher in Kerr County at 45% than TX at 37% and the U.S. at 41%.
- Diabetic screening was 86% in Kerr County which was higher than TX at 84% and the U.S. at 85%.
- The population per primary care physician was lower in Kerr County than TX and the U.S. at 1,171.
- The population per dentists was lower in Kerr County than TX, but higher than the U.S. at 1,567.
- The population per mental health providers was lower in Kerr County than TX and the U.S. at 362.
- The cancer incidence rate in Kerr County was 380.7 cases per 100,000 population which was lower than TX (401.3).
- The percent of Medicare enrollees with flu vaccines per year was higher in Kerr County at 48% than TX at 43% and the U.S. at 42%.

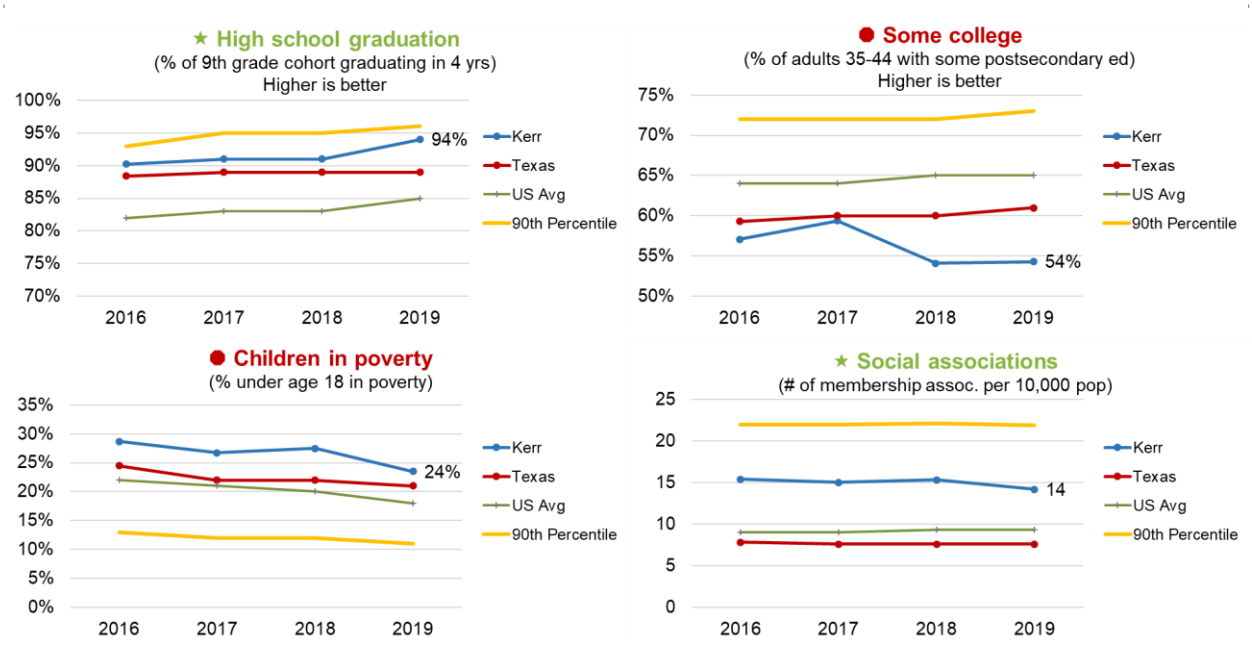
Clinical Care OPPORTUNITIES

- The percent of population under sixty-five without health insurance was 20% in Kerr County which was higher than TX at and 19% and the U.S. at 10%.
- The percentage of adults with diabetes in Kerr County at 14% was higher than TX and the U.S. both at 10%.

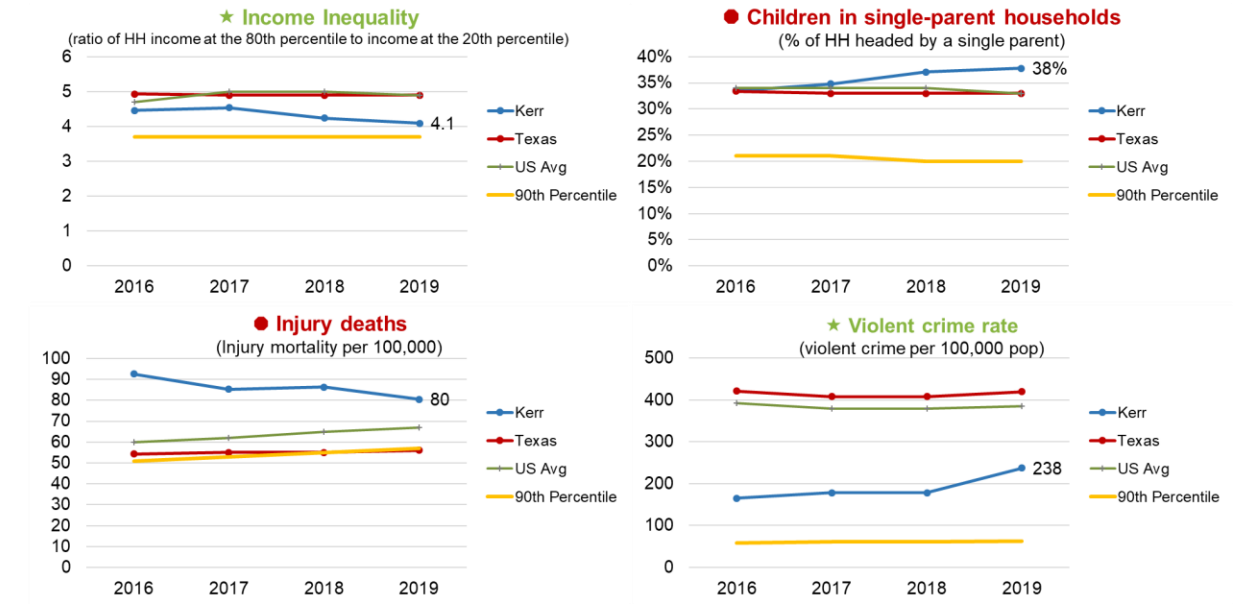
Photo Credit: Kerrville Schreiner Park; kervilletexascvb.com

Social & Economic Factors

Social and economic factors account for 40% of the county rankings. There are eight measures in the social and economic factors category. Kerr County ranked 75th out of 244 Texas counties.



Source: High School graduation – County Health Rankings; TX Dept of Public Instruction, 2016-2017 Source: Some college - County Health Rankings; American Community Survey, 5-year estimates, 2013-2017. Source: Children in poverty - County Health Rankings; U.S. Census, Small Area Income and Poverty Estimates, 2017 Source: Social associations - County Health Rankings; County Business Patterns, 2016



Source: Income inequality and children in single-parent households - County Health Rankings; American Community Survey, 5-year estimates 2013-2017. Source: Injury deaths – County Health Rankings; CDC WONDER mortality data, 2013-2017. Source: Violent crime - County Health Rankings; Uniform Crime Reporting – FBI, 2014 & 2016

Social & Economic Factors STRENGTHS

- The high school graduation rate was higher in Kerr County at 94% than TX at 89% and the U.S. at 85%.
- Social associations were higher in Kerr County at 14 memberships per 10,000 population than TX at 8 and the U.S. at 9 memberships. Associations include membership organizations such as civic organizations, bowling centers, golf clubs, fitness centers, sports organizations, religious organizations, political organizations, labor organizations, business organizations, and professional organizations.
- The violent crime rate in Kerr County was 238 violent crimes per 100,000 population, which was lower than in TX at 420 and the U.S. at 386.
- Income inequality represents the ratio of house hold income at the 80th percentile compared to income at the 20th percentile. Income inequality was lower in Kerr County at 4.1 than in TX and the U.S. both at 5.
- The poverty estimates for 2017 has poverty in Kerr County at 13.3%, lower than TX (14.7%) and the U.S. (13.4%).

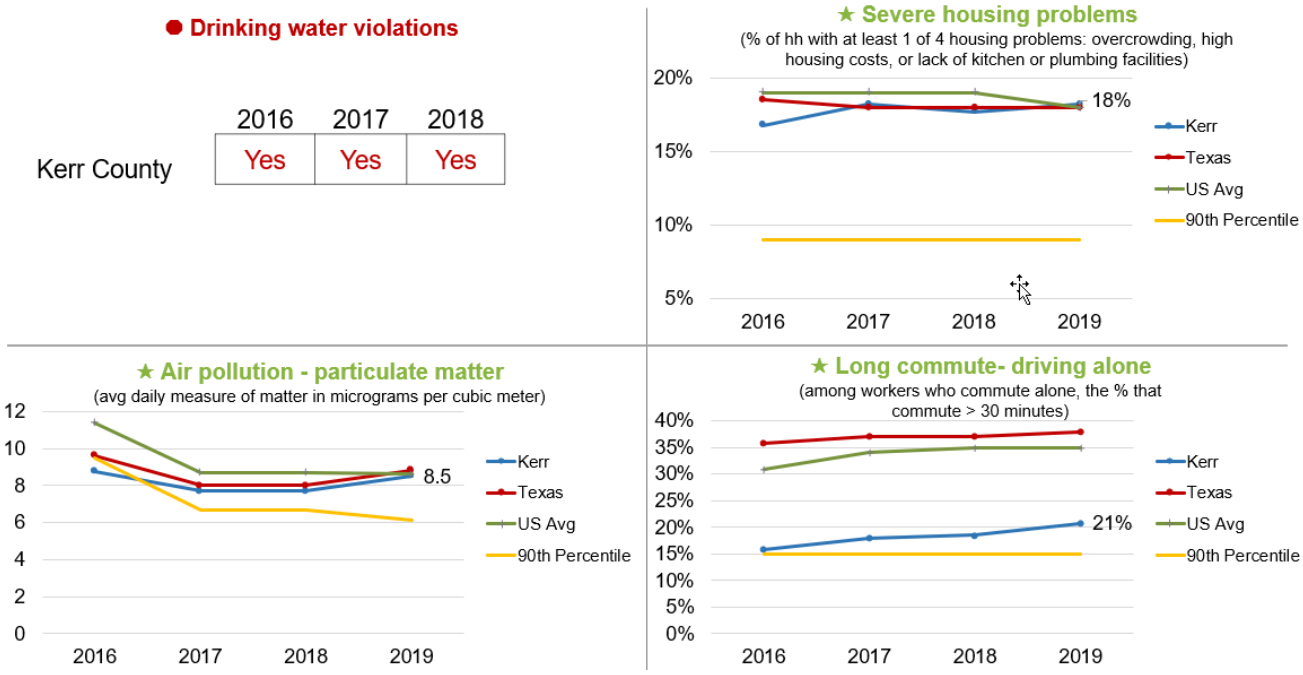
Social & Economic Factors OPPORTUNITIES

- 54% of Kerr County adults had some postsecondary education which was lower than TX (61%) and the U.S. (65%).
- The children in poverty rate was higher for Kerr County (24%) than TX (21%) and the U.S. (18%). However, Kerr County has experienced a decrease since 2016.
- The percentage of children in single-parent households was 38% in Kerr County and 26% which is higher than TX and the U.S. both at 31%.
- Injury deaths were higher in Kerr County at 80 per 100,000 population than TX and the U.S.
- The median household income in Kerr County was lower than TX and the U.S. at $49,089.

Photo Credit
kerrvilletx.gov

Physical Environment

Physical environment contains four measures in the category and accounts for 10% of the County rankings. Kerr County ranked 148th out of 244 Texas counties in physical environment.



Source: Drinking water violations – County Health Rankings; EPA, Safe Drinking Water Information System, 2017. Source: Severe housing problems – County Health Rankings; HUD Comprehensive Housing Affordability Strategy data, 2011-2015. Source: Driving alone to work and long commute – County Health Rankings: American Community Survey, 5-year estimates, 2013-2017. Source: Air pollution – County Health Rankings: CDC National Environmental Health Tracking Network, 2014

Physical Environment STRENGTHS

- Kerr County had the same percentage of severe housing problems as TX and the U.S. at 18%.
- The average daily measure of matter in micrograms per cubic meter at 8.5 in Kerr County was lower than TX and the U.S. both at 9.
- 21% of workers in Kerr County who commute alone commute over 30 minutes which was lower TX at 38% and the U.S. at 35%.

Physical Environment OPPORTUNITIES

- Kerr County had drinking water violations.

There were Four Broad Themes that Emerged in this Process:

- Kerr County need to create a “Culture of Health” which permeates throughout the towns, employers, churches, and community organizations to engender commitment to health improvement.
- There is a direct relationship between health outcomes and affluence (income and education). Those with the lowest income and education generally have the poorest health outcomes.
- While any given measure may show an overall good picture of community health, subgroups such as the lower income census tracts may experience lower health status measures.
- It will take a partnership with a wide range of organizations and citizens pooling resources to meaningfully impact the health of the community. However, Kerr County has many assets to improve health.

Photo Credit: Kerrville Folk Festival; kervilletexascvb.com

Results of the CHNA: Community Health Summit Prioritized Health Needs, Goals and Actions

Prioritization of Health Needs

Photo Credit: Peterson Health

Prioritization Criteria

At the Community Health Summit, the attendees reviewed the community health information and used the criteria below to prioritize the health needs in the community.

Magnitude / scale of the problem	How big is the problem? How many people does the problem affect, either actually or potentially? In terms of human impact, how does it compare to other health issues?
Seriousness of Consequences	What degree of disability or premature death occurs because of this problem? What would happen if the issue were not made a priority? What is the level of burden on the community (economic, social or other)?
Feasibility	Is the problem preventable? How much change can be made? What is the community's capacity to address it? Are there available resources to address it sustainably? What's already being done, and is it working? What are the community's intrinsic barriers and how big are they to overcome?

Most Significant Community Health Needs

The following needs were prioritized by attendees at the Community Health Summit. Using a nominal group technique, each attendee received three sticky notes and selected their top three health needs and posted their ideas on paper at the front of the room. The results of the activity are below with higher numbers indicating the number of "votes" or priority by topic. The bullets below the health need are many of the comments received on the sticky notes.

1. **Access to Care and Insurance**
2. **Obesity – Healthy Eating and Active Living**
3. **Mental Health**
4. **Children's Health Issues**
5. **Socioeconomics/Housing/Environmental**
6. **Substance Abuse**
7. **Chronic Diseases**

1. Access to Care and Insurance (25 sticky notes)

- Transportation (3)
- Access/transportation
- Transportation to appointments for seniors
- Dental care (3)
- Lack of affordable health services
- Ability to navigate the community
- Lack of resources for affordable care
- Uninsured
- Access to care (for vulnerable population)
- Access to healthcare -Navigation/resources
- Uninsured
- Need for better in-home care for seniors (full time care)
- Affordable Preventive health care
- Navigating resources
- Lack of connecting health records and healthcare
- Socioeconomic access to consistent care
- Senior Health access and understanding of processes
- Lack of access/knowledge for affordable health care/healthy lifestyle
- Affordable healthcare and insurance
- Additional help for uninsured
- Affordable insurance

2. Obesity- Healthy Eating and Active Living (10 sticky notes)

- Obesity (8)
- Cost of good, healthy food
- Food insecurity
- Healthy eating education and access
- Access to healthy options and healthcare, esp. children
- Inactivity
- Less expensive options for physical activity
- Low priced gyms for exercise
- Healthy lifestyle
- Healthy lifestyle education
- Physical health
- Education of minority population regarding health

3. Mental Health (18 sticky notes)

- Mental Health (9)
- Poor mental health/stress
- Child/adolescent mental health
- Mental health/substance abuse
- Depression (2)
- Care/support for mental health/emotional distress
- Psych/mental health
- Access to mental health care
- Mental health – we appear to be a depressed community

Most Significant Community Health Needs, Cont.

4. Children's Health Issues (9 sticky notes)

- Parent education for healthy lifestyle
- Wellness/education (sex ed. in schools)
- Childhood obesity/overweight
- Children in poverty
- Children's issues
- Physical activity
- Immunization of kids
- Child health to prevent obesity

5. Socioeconomics/Housing/Environmental (8 sticky notes)

- Opportunities for good full-time employment
- Socioeconomic issues
- Low income
- Housing
- Drinking water violations
- Available affordable housing
- Affordable housing and employment (livable wages)
- Affordable Housing

6. Substance Abuse (5 sticky notes)

- Substance abuse (2)
- Drug abuse
- Drug problems
- Vaping (school-aged children)

7. Chronic Diseases (4 sticky notes)

- Diabetes (2)
- Cardiac care
- Chronic disease management

Photo Credit: Peterson Health

Community Health Summit Brainstorming

Community Health Goals and Actions Brainstorming

Significant Health Need 1: Access to Care and Insurance

Goal 1 - Establish a primary care medical home and primary resource home

Action 1 - Identify the highest risk populations

Action 2 - Survey our populations, build trusting relationships

Resources/Collaborators Needed: Social workers, care coordinators, navigators, volunteers, primary medical home for referral, community resources

Goal 2 – Navigation of resources (education/information)

Action 1 - Identify barriers to healthcare including social determinants of health

Action 2 - Focus and strengthening local partnerships; support what's working and connect patients with resources

Resources/Collaborators Needed: Interagency network, outside resources, HIS, Kerr-Konnect, SSI, SSDI, FAA, MHM Financial assistance through Peterson Health/Peterson Medical Associates

Goal 3 – Ongoing support, moving from crisis to stabilization

Action 1 - Follow up survey to confirm continuing care

Action 2 - Further intervention as needed with overall goal to follow high risk populations to facilitate outpatient care, support group resources, ongoing education, support, resources to prevent ER visits, hospitalizations

Resources/Collaborators Needed: Support groups, dental, vision, outpatient and ED services

Photo Credit: Stratasan

Significant Health Need 2: Obesity – Healthy Eating and Active Living

Goal 1 – Increase access to healthy eating and education

Action 1 - Collaborate with Kerr County ISD/HEB to create a community garden. Master gardeners need more volunteers to help with the gardens.

Action 2 - Create a healthy food pantry at each school

Action 3 - Include more healthy food in backpacks that go home

Resources/Collaborators Needed: Kerr County ISD, master gardeners, Lowes, Home Depot, Salvation Army, CAM, HEB, local food pantries

Goal 2 – Increase activity

Action 1 - Perform a gap analysis of parks and activities focusing on places for kids to go, including older kids.

Action 2 - Organize various exercise groups into a community event- have a walk with a doctor, walk with a dietician, walk with a physical therapist, etc. and the hospital could be a sponsor.

Resources/Collaborators Needed: Triathlon, walking group, running group, kayak club, tennis, bike shop, Parks and Rec. Dept., fishing group, Bistro for healthy snacks

Goal 3 – Decrease obesity

Action 1 - Provide education on what obesity is and how it affects you, the community and physicians. Stress how obesity leads to chronic diseases and its never too late to start being healthy. Present at schools, PTO meetings. Send menus home for a week from schools.

Action 2 - Explore a clinical intervention (bariatric surgery) at Peterson Health

Resources/Collaborators Needed: Physicians, local clubs, Rotary club, endocrinologist, cardiologist, dieticians, rehab, Peterson Health, weight loss groups.

Significant Health Need 3: Mental Health

Goal 1 – Decrease the need for crisis interventions

Action 1 - Expand treatment options – find resources and funding

Action 2 - Identify resources and link coordinated care efforts throughout the complete spectrum of care

Resources/Collaborators Needed: Community resources, funding, MHDD, care coordinators

Goal 2 – Develop mental health coalition to increase community collaborative initiatives

Action 1 - Develop a coalition – important for funding opportunities, include youth, recruit leadership

Action 2 - Develop a strategic plan

Resources/Collaborators Needed: Churches, schools, leaders, community members, community resources

Significant Health Need 4: Children's Health Issues

Goal 1 – Reduce childhood obesity

Action 1 - Provide education to the kids in schools about healthy eating; provide after school activities

Action 2 - Reach the parents and overcome time and financial barriers. Provide parent education at work and church on healthy eating and healthy lifestyles.

Resources/Collaborators Needed: HEB, 4-H, Peterson Health, pediatricians, church communities, Wesley nurses

Significant Health Need 4: Children's Health Issues Cont.

Goal 2 – Increase the number of safe activities for children to encourage outdoor play

Action 1 - Implement security at playgrounds

Action 2 - Secure financing for affordable activities for children

Resources/Collaborators Needed: Churches, schools, leaders, community members, community resources

Goal 3 – Increase education on responsible sexual behavior, vaping and healthy choices

Action 1 - Put programs in schools in place and increase resources to attract multiple age groups

Action 2 - Increase activities to make a bigger impact

Resources/Collaborators Needed: Schools, teachers, curriculum

Significant Health Need 5: Socioeconomics/Housing/Environmental

Goal 1 – Increase inventory of attainable, affordable housing

Action 1 - Create city and county incentives for housing development at lower income price point housing options

Action 2 - Revise city codes to allow and encourage high density housing options

Resources/Collaborators Needed: Government, developers, housing authority

Goal 2 – All Kerr County residents will have access to safe, quality drinking water

Action 1 - Identify the EPA drinking water violations

Action 2 - Develop action plan to address the root cause

Resources/Collaborators Needed: Government, health department

Goal 3 – Improve access to care by increasing income through better employment; improve employability

Action 1 - Identify and address the top 3 obstacles to employability among the underemployed. Decrease discrimination in the job market.

Action 2 - Support the effort to make health insurance available to employees of small businesses/employers

Resources/Collaborators Needed: Businesses, employers, employees, government

Significant Health Need 6: Substance Abuse

Goal 1 – Educate those in recovery and the community. Provide a continuum of care for individuals and families struggling with substance use disorder. Determine current gaps and add services.

Action 1 - With House Bill 4298, drug abuse organizations may offer services in satellite offices under the protection of the home license. Expand drug abuse services to satellite locations.

Action 2 - Collaborate with the Kerrville Recovery Coalition to provide educational/informational events and provide a continuum of care using person-first language.

Action 3 - Schedule a meeting and develop a plan of support for those suffering from substance use disorder. Be an example of a community where a person can walk into the fire department and ask for help and receive a partner and wrap around services.

Resources/Collaborators Needed: Kerrville Recovery Coalition, government, drug abuse services, wrap around services, funding, community partners

Significant Health Need 6: Substance Abuse Cont.

Goal 2 – Collaboratively develop programming targeting substance misuse education and resistance to be available by the 2020 academic school year. Target sophomore in Kerr County.

Action 1 - Identify subject matter experts in community (focus on Peterson Health staff) and make them available to the school for programming.

Action 2 - Restructure sophomore curriculum to designate time to receive substance misuse education.

Resources/Collaborators Needed: Peterson Health staff, community expert, schools

Goal 3 – Improve information sharing between inpatient and outpatient settings, between Peterson Regional emergency department and local provider offices

Action 1 - Research programs/ EMR database which can support patient information sharing

Action 2 - Develop policies and provide training to all staff members

Resources/Collaborators Needed: Peterson Regional Medical Center, local providers, health department, communication networks/database

Significant Health Need 7: Chronic Diseases

Goal 1 – Increase educational opportunities for chronic disease management by monthly intentional meetings and support groups (at different levels of knowledge – beginners to advanced level)

Action 1 - Monthly chronic disease education (cardiac, diabetes, etc.) by community partners for relevant community members. Encourage physicians to refer to the support groups.

Action 2 – Monthly meeting location and time rotations. Create a “traveling group” not just at the hospital which can be intimidating.

Resources/Collaborators Needed: Peterson Health, physicians, community leaders, media, educational resources

Goal 2 – Create a resource guide and promote the River Trail and other county resources/locations for weekly group walks that improves physical and mental wellness.

Action 1 - Weekly promoted group walks for those with chronic diseases and promote yoga this summer at the Dietert Center.

Action 2 – Provide listing of community locations and spaces for exercise and promote to chronic disease patients/clients. Identify the surface, gravel or pavement, location of restrooms, etc.

Resources/Collaborators Needed: Dietert center, community locations/centers, recourse guide, group leaders

Goal 3 – Promote community resources to help offset medical expenses for proactive chronic care in monthly support groups

Action 1 - Promote resources to people before the chronic disease has a major impact. Research and educate about genetic testing and opportunities for those who are pre-disposed to chronic diseases.

Resources/Collaborators Needed: Peterson Regional Medical Center, support groups, resource guide

Impact of 2016 CHNA and Implementation Plan

Impact

On May 19, 2016, the CHNA attendees at the Summit identified and prioritized the most significant health needs in the community for the next three-years, as follows:

1. Substance Abuse and Mental Health
2. Access
3. Lifestyle/Wellness/Education
4. Obesity
5. Socioeconomics
6. Chronic Diseases
7. Children

Over the past three years, Peterson Health has actively focused on these specific areas and become highly involved with other health care and community partners to meet these needs or work together to offer programs, events or resources that support these issues. Here are just a few ways we have been able to impact the community and address these needs:

Mental Health and Substance Abuse

- Steve Pautler has served on the City of Kerrville's Recovery Council for the past two years and actively worked with other members of government and citizens to address addiction, as well as focus on the issue and regulation of area recovery houses.
- Tracy Davis established regular meetings with Mental Health Mental Disabilities staff and worked closely with local law enforcement on the best protocol for patients being detained in the ER with mental issues.
- In February of 2017, Peterson Health hosted a Mental Health Summit with State Representative Andrew Murr. Over 50 people from nine-counties dealing with mental health patients or issues attended. The goal of this meeting was to discuss common issues and for the participants to identify and share resources. This summit also provided Representative Murr with issues to consider taking to the next legislative session.
- In February 2018, Peterson Health participants attended the 2nd Mental Health Summit with Representative Murr at the Kerrville State Hospital. The focus of the second summit was the growing tie between substance abuse and mental health. Peterson Health continues to work with state legislators and the recovering community to address this issue.
- Lisa Winters continues to serve on the Student Health Advisory Committee in Kerrville ISD where mental health and suicide are commonly discussed.
- Peterson Health continues to offer a support group, NAMI, which meets twice a month at the hospital for community members dealing with mental health issues.
- Peterson Health is an annual fundraising sponsor for New Hope Counseling, a not-for-profit mental health/psychology assistance program.

Impact of 2016 CHNA and Implementation Plan

Impact

- Peterson Health works with several organization, The Kerrville State Hospital, Dementia Care Advocacy Group, local law enforcement to offer community education or programs with speakers as needed.

Access

- Peterson Medical Associates has successfully recruited over 40 new physicians and nurse practitioners and physician assistants over the last three years to offer better access to primary care and specialty services.
- The Marketing Department works tirelessly to educate and inform the population of the healthcare services and programs offered and physicians to meet their needs. Monthly community and organization presentations are offered and coordinated at the hospital, civic centers, community centers, and schools.
- Peterson Health works diligently to create opportunities for healthcare for our under-insured or uninsured. We have continued to provide great care at Peterson Community Care and have expanded our work these last three years with Methodist Healthcare Ministries, the Raphael Clinic, the Texas Department of Health, school and Shreiner nurses, the Pregnancy Resource Center, the Dietert Senior Center and the local food banks.

Life/Wellness/Education with Obesity

- Peterson Health offers free community workshops on a monthly basis, with two large annual events, “Remarkable Women” Event each February during National Heart Health Month and in June, “The Men’s Event”. For the past three years these events have grown to over 100 attendees all learning about heart disease, diabetes and obesity.
- Over the past three years, Peterson has sponsored over 15 family-oriented races/walks/runs to include the Kerrville Triathlon (title sponsor), Riverside Nature Center 5K walk or run, the Run Like a Warrior 5K for Ingram ISD, Shatter the Stigma 5K/10K for the Kerrville State Hospital, as well as organizing employee teams for other health related activities. Peterson Health also regularly sponsor school walk-a-thons and events encouraging kids to be active and exercise.
- Peterson Health dietician Christina Grafe offers cooking classes and cooking demos at our local grocery stores throughout the year.
- For the past three years, Peterson Health has continued to employ a diabetes educator who works out of the Peterson Community Care. In addition to assisting patients with diabetes education, she facilitated monthly support groups and classes for the community at the hospital.
- Peterson Health has been very active in promoting and utilizing the new downtown river trail.

Impact of 2016 CHNA and Implementation Plan

Impact

Socioeconomics

- Lisa Winters and Tracy Davis served on the Transportation Steering Committee for the past three years, working with other community members to create a public transportation service. Proudly, after many years, Kerr Konnect was finally formed as a not-for-profit volunteer-based transportation service. As of December 2018, they have over 100 clients receiving transportation services to local medical offices, the hospital, pharmacies, grocery stores and other key quality of life stops.
- Peterson Health works closely with the Wesley Nurse's from Methodist in Kerrville and Hunt, the Raphael Clinic, the Texas Department of Health, the Christian Assistance Ministry and other agencies that can assist families who do not have access to resources (food, medications, and counseling.)
- Peterson Health's Care Coordination team, under the direction of Tracy Davis, daily provide resources to patients and their families upon discharge and beyond. The department maintains a formal list of resources and agencies and go the extra mile to provide families with the resources they need to remain healthy and well.

Chronic Diseases

- Peterson Health offers free community workshops or presentations throughout the year to educate the public on chronic diseases and treatment. We participate in numerous health fairs and offer free screenings on a monthly basis (heart, vascular, diabetes, skin cancer)
- Our dietitian, Christian Grafe, as well as our Food & Nutrition Services department offer cooking demonstrations for our cardiology patients, as well as to the general public. Our local media has covered many of our classes and courses and have shared the positive impact we are making in the community with these healthy offerings.
- Peterson Health also works with our pharmacy to provide medication side-effect presentations to senior living centers and The Dietert Center to better manage chronic conditions.
- Tracy Davis continues to participate in DSRIP (Delivery System Reform Incentive Payment) and is highly successful in creating program or identifying resources related to chronic diseases.

Impact of 2016 CHNA and Implementation Plan

Impact

Access to and Utilization of Medical Dental Care (other children's issues)

- Peterson Health was the primary sponsor in 2017 of the Smiles Foundation dental health event held at the First United Methodist Church. Lisa Winters served on the steering committee with dozens of key leaders (local dentists, Wesley Nurse, local volunteers and not-for-profit organizations) to attract this volunteer group of dentists to travel to Kerrville. Over 500 children and families received free dental care over two days. This was the first time the Smiles Foundation volunteer/traveling dentists had come to Kerrville. While helping children with free or reduced dental care is a challenge in Kerrville, we were able to get local dentists to also participate for the first time.
- Peterson Health is the only hospital in the area to offer a birth navigator. In 2018, Jennifer Harris was hired by Peterson Women's Associates to help support new moms from pregnancy to post partum. Her dedicated efforts guide new moms and parents through a healthier pregnancy and more positive post partum.
- Peterson Health continues to focus on breastfeeding and remains a Texas Ten Step designee, with over 80% of new mom's giving birth at Peterson breastfeeding instead of using formula.
- Peterson's Baby Place is a designated "Sleep Safe" facility moving away from traditional swaddling to a new apparatus that is designed to reduce sudden infant syndrome. The nurses at The Baby Place have completed the training and certification for this important program. Every family is sent home with the newest and safest swaddler.
- Peterson Health offers a community event for expectant mothers, "Celebrate Your Pregnancy" twice a year and has offered these expos for over 7 years. The event provides resources, education and demonstrations in breastfeeding, CPR, safe sleep, and includes the staff and providers from Peterson Women's Associates.
- Peterson Health remains active with children in the school district. From serving on student health committees and working with school nurses at all grades to promote health and wellness, to sponsoring school walks and runs.

Peterson Health has met the requirements of the 2012 and 2016 Community Health Needs Assessment in every category, but in additional identified areas as well. Because of this required exercise, our level of involvement and collaboration with city and county officials, state legislators, community partners, and schools to now include Ingram and Bandera Independent School Districts have been elevated.

We look forward to continuing our work on the 2016 goals and await the new challenges of 2019.

Community Asset Inventory

Community Asset Inventory

The Peterson Health Care Coordination Department can provide a list of community assets and resources that can help improve the health of the community and assist with implementation of the plan upon request at (830)258-7223. In addition, the focus groups who met in April 2019 also identified community resources to improve health, which are listed on page 21.

Photo Credit: Kerrville Independent School District

Community Health Needs Assessment for Kerr County

Completed by Peterson Regional Medical Center in partnership with:

Stratasan