



**PETERSON**  
**HEALTH**

**2016**

**Peterson Regional Medical Center**

Community Health Needs  
Assessment

Kerr County, Texas

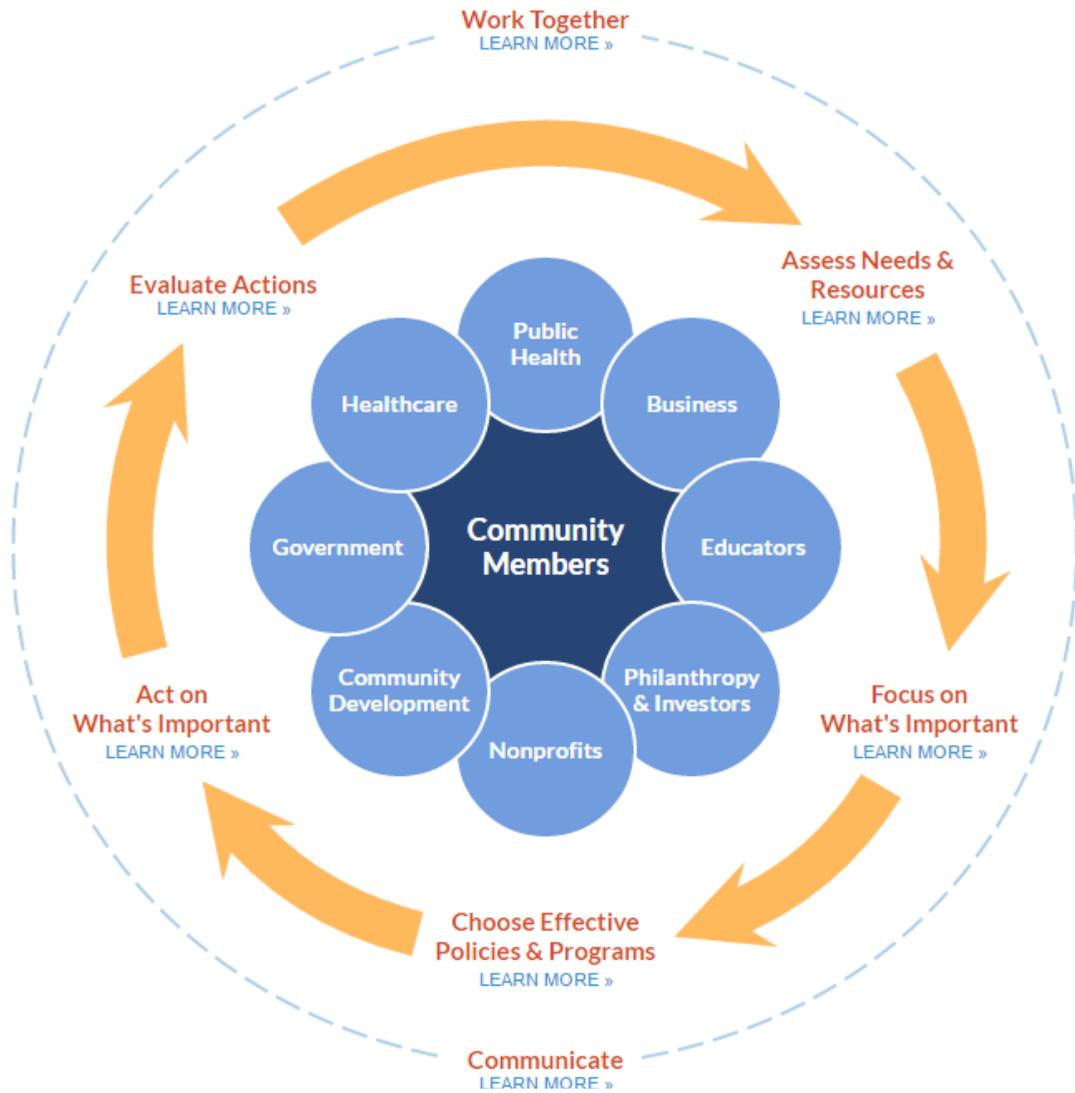
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# Perspective/Overview

## Creating a culture of health in the community



Sourced from the Robert Wood Johnson Foundation's County Health Rankings website:  
<http://www.countyhealthrankings.org/roadmaps/action-center>

The Community Health Needs Assessment (CHNA) defines 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. Peterson Regional Medical Center (PRMC) conducted a community health needs assessment in 2013. This assessment analyzes progress since the last assessment as well as defines new or continued priorities for the next three years.

Peterson Regional Medical Center, as the sponsor of the assessment, engaged national leaders in community health needs assessment to assist in the project. Stratasan, a healthcare analytics and facilitation company out of Nashville, Tennessee was engaged to marshal the process and provide community health data and facilitation expertise. Stratasan provided the analysis of community health data, facilitated the focus group, conducted the one on one interviews, and conducted the PRMC employee and community physician surveys to assist the community with determining significant health needs and goals for improvement.

- ✔ Peterson Regional Medical Center’s Board of Directors approved and adopted this CHNA along with the associated Implementation Strategy in November 2016.
- ✔ This report will be made widely available to the community via Peterson Regional Medical Center’s website, [www.petersonrmc.com](http://www.petersonrmc.com), and paper copies are available free of charge at Peterson Regional Medical Center.

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## Participants

Over sixty individuals from over forty community and health care organizations collaborated to conduct 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 and had special knowledge of or expertise in public health to provide direction for the community and hospital to create a plan to improve the health of the community.

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## Project Goals

- ① To implement a formal and comprehensive community health assessment process which will allow for the identification and prioritization of significant health needs of the community, to then inform resource allocation, decision-making and collective action that will improve health.
- ② To initiate a collaborative partnership between all stakeholders in the community by seeking input from persons who represent the broad interests of the community including medically underserved, low income and minority populations.
- 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 goals to analyze changes from 2013’s assessment in significant health needs and priorities and address those needs,” said Pat Murray, Chief Executive Officer, Peterson Regional Medical Center. “It is our plan to use our findings as a catalyst for community mobilization to improve the health of our residents.”

“The information we 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 PRMC to create an implementation plan. We invite other community organizations to join us.” added Lisa Winters, Director, Marketing and Community Relations, Peterson Health. “The Community Health Summit was the final step in the assessment process. Now the real work—improving the health of the community and implementing the ideas presented—begins.”



Photo credit: John N. Lavender [www.co.kerr.tx.us](http://www.co.kerr.tx.us)

# Community

## Input and Collaboration



## Data Collection and Timeline

In February, 2016, PRMC contracted with Stratasan to assist in conducting a Community Health Needs Assessment for Kerr County. PRMC sought input from persons who represent the broad interests of the community using several methods:

- 18 community members, employers, not-for-profit organizations (representing medically underserved, low-income, minority populations, mental health, substance abuse recovery, seniors, and children), economic development, health department, health providers, schools, and government representatives participated in a focus group for their perspectives on community health needs and issues on March 31, 2016.
- Information gathering, using secondary public health sources occurred in February and March of 2016
- 30 community physicians and 259 PRMC employees were surveyed on-line regarding their perspectives on community health status and needs from May 1-17, 2016.
- A Community Summit was conducted on May 19, 2016 with 26 community stakeholders. The audience consisted of healthcare providers, the Kerr County Health Department, business leaders, schools, government representatives, universities, not-for-profit organizations, (mental health, substance abuse recovery community, senior services) and other community members.

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

Organization	Population Represented (kids, low income, minorities, those w/o access)	How Involved
Arthur Nagel Clinic	200% FPL; all but kids	Summit
BCFS Health and Human Services	at risk youth, Foster care youth	Focus Group, Summit
Caring Senior Service	All	Summit
Chamber of Commerce	Business	Summit
Consulting with not-for-profit organizations	all county	Focus Group, Summit
Dietert Center	Elderly	Focus Group
Director of Peterson Community Care	Uninsured, Medicaid	Interview
Finley Financial Services, community member, schools	All	Summit
HCCY		Summit
Hill Country MHDD Ctrs	All	Summit
Ingram ISD, Superintendent	Kids, families, parents	Focus Group
Kerr County	Indigent Health, all	Focus Group, Summit
Kerrville Independent School District, counsellor	Kids, families, parents	Interview
Kerrville Independent School District	Students	Focus Group, Summit
Kerrville State Hospital	Mental Health	Focus Group, Summit
Methodist Healthcare Ministries	Underinsured/uninsured	Summit
New Hope Counseling Board Member	Mental Health	Interview
Peterson Health	Seniors	Summit
Peterson Hospice	PRMC	Summit
Peterson Regional Board	all county	Focus Group, Summit
Peterson Regional Foundation Board	all county	Focus Group
Peterson Regional Medical Center	All	Summit
Peterson Regional Board	Community	Summit
PRMC Practice Administrator/Physician Recruiter	All	Interview, Summit
Public Health	All community	Summit
Schreiner University	various, younger people	Focus Group
West Kerr Current		Summit
Young People in Recovery	Young adults/mental health community	Interview, Summit

## Input of Public Health Officials

At the Summit held on May 19, 2016 Rebekah Patterson, Kerr County Public Health presented information and priorities from Health Department's perspective.

Health Service Regional 8 Activities and Initiatives:

- Tuberculosis (TB) testing program
- Rabies investigations
- Child Fatality Review Team – interdisciplinary death certificate review to determine if deaths were preventable
- Immunizations – uninsured or Medicaid, working with school nurses
- Education in the community about infant safe sleep, Shaken Baby Syndrome, immunizations, hand washing, nutrition, hygiene, communicable diseases and youth suicide prevention
- Participation in Celebrate Your Pregnancy sponsored by Peterson Regional
- Distribute, install and inspect child passenger safety seats and teach parents how to use them correctly

Where there are common initiatives between the state, counties, hospitals, and community groups, coordination of efforts would be ideal.

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## **Input of Medically Underserved, Low-Income and Minority Populations - Community Engagement and Transparency**

Input was received during the focus group, interviews and community health summit. People representing these population groups were intentionally invited to participate in the process. Hospital employees and community physicians were also surveyed. They have insight into medically underserved, health needs and the community at-large.

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### **Community Engagement and Transparency**

We are pleased to share the results of the Community Health Needs Assessment with our community in hopes of attracting more advocates and volunteers to improve the health of the community. The following pages highlight key findings of the assessment. We invite you 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. The comprehensive data analysis may be obtained via a PowerPoint on the website or by contacting Peterson Regional Medical Center.



*Photo: Peterson Health*

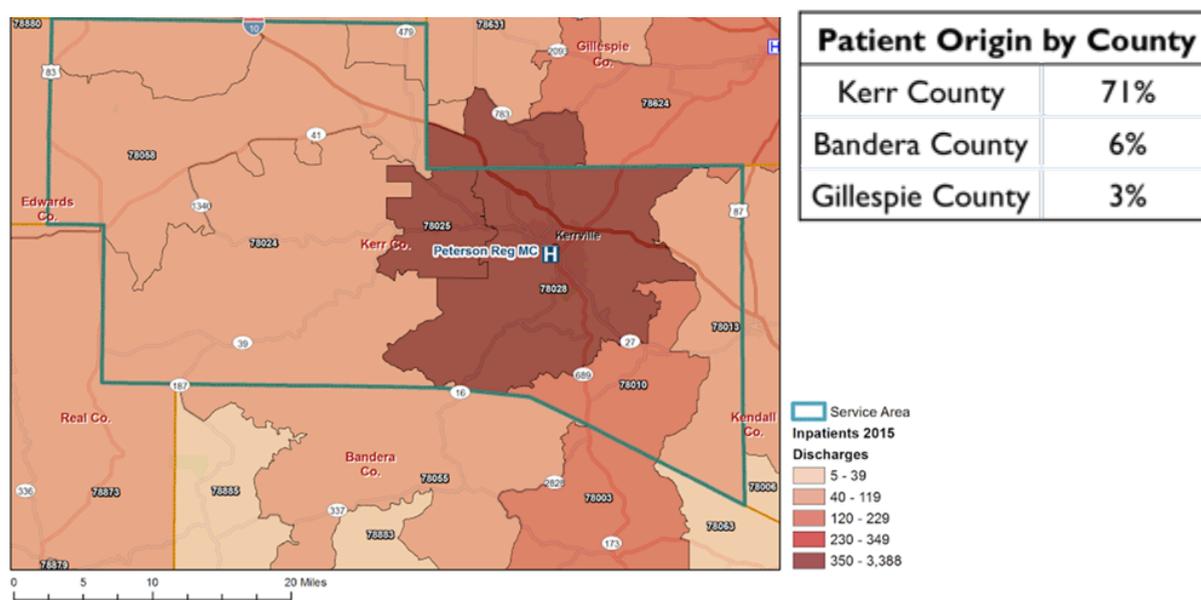
# Community

## Selected for Assessment

PRMC’s health information provided the basis for the geographic focus of the CHNA. The map below shows where PRMC received its patients; most of PRMC’s inpatients came from Kerr County (71%). Therefore, it was reasonable to select Kerr County as the primary focus of the CHNA. However, surrounding counties should benefit from efforts to improve health in Kerr County.

The community included medically underserved, low-income or minority populations who live in the geographic areas from which PRMC draws its patients. All patients were used to determine the service area without regard to insurance coverage or eligibility for financial assistance under PRMC’s Financial Assistance Policy.

### Peterson Regional Medical Center Patients - 2015



Source: Peterson Regional Medical Center, 2015

# Key Findings

## Community Health Assessment

### 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 of the community's health needs.

For example, certain population groups (such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish) were not represented in the primary data.

Other population groups (for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups) might not be identifiable or might not be represented in numbers sufficient for independent analyses.

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### Process and Methods

Both primary and secondary data sources were used in the CHNA. Primary methods included:

- Community focus group
- Community interviews
- Hospital employee and community physician on-line survey

Secondary methods included:

- Public health data – death statistics, county health rankings
- Demographics – population, poverty, uninsured
- Psychographics



*Photo credit: Peterson Health*

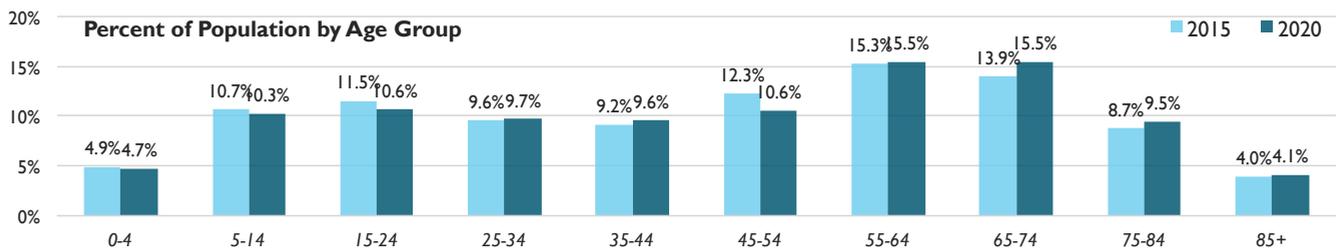
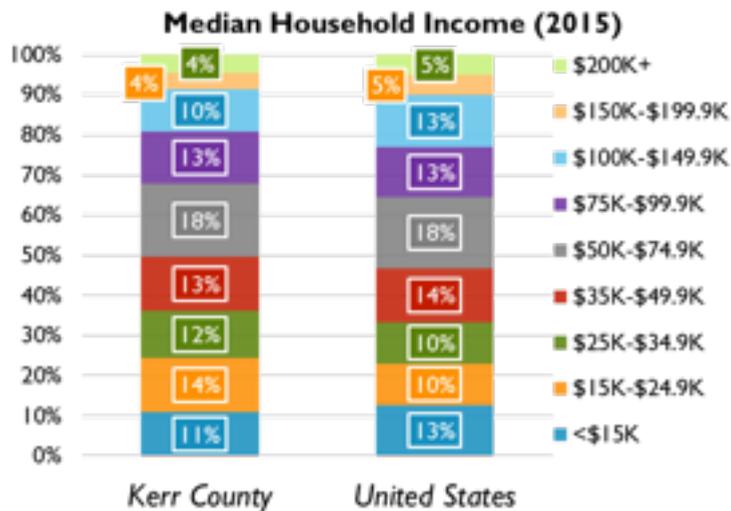
# Demographics of the Community

The table below shows the demographic summary of Kerr County compared to Bexar County, Texas and the U.S. - Source: ESRI

	Kerr County	Bexar County	Texas	USA
Population (2015)	51,523	1,840,280	26,964,627	318,536,439
Median Age (2015)	48.8	33.7	34.3	37.9
Median Household Income (2015)	\$50,385	\$50,719	\$53,616	\$53,217
Annual Pop. Growth (2015-20)	0.51%	1.57%	1.52%	0.75%
Household Population (2015)	21,418	656,792	9,570,133	120,746,349
Dominant Tapestry (2015)	Silver & Gold (9A)	Southwestern Families (7F)	Up and Coming Families (7A)	Green Acres (6A)
Businesses (2015)	3,061	60,923	1,001,996	13,340,415
Employees (2015)	25,479	851,789	11,995,350	158,567,719
Medical Care Index* (2015)	105	90	99	100
Average Health Expenditures (2015)	\$2,210	\$1,898	\$2,071	\$2,098
Total Health Expenditures (2015)	\$47.3 M	\$1,246.7 M	\$19.8 B	\$253.3 B

### Racial and Ethnic Make-up

White	86%	72%
Black	2%	8%
American Indian	1%	1%
Asian/Pacific Islander	1%	3%
Mixed Race	8%	13%
Other	2%	4%
Hispanic Origin	26%	60%

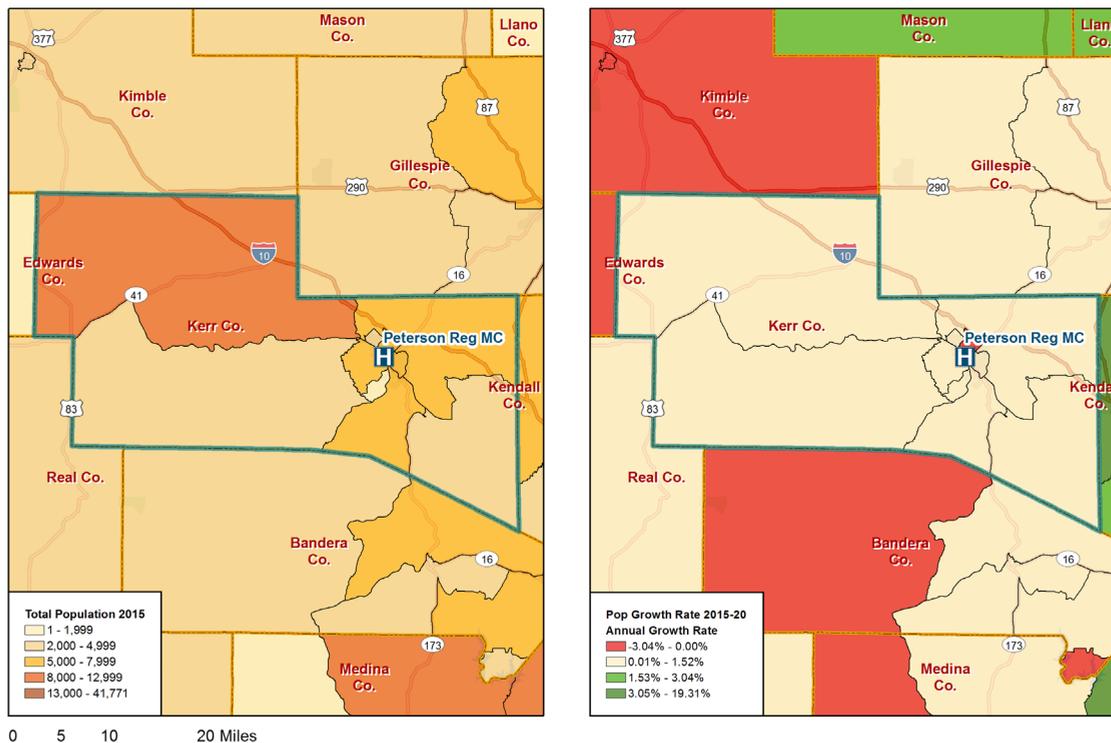


- Source: ESRI

## Kerr County, Texas

- The population of Kerr County was projected to increase from 2015 to 2020 (.51% per year), lower than the rate of TX at 1.52%, the U.S. at .75%. Bexar County was projected to grow more than TX at 1.57% per year.
- Kerr County was older (48.8 median age) than TX and the U.S. and had lower median household income (\$50,385) than both TX and the U.S.
- The medical care index measures how much the county spent out of pocket on medical care services. The U.S. index was 100. Kerr County (105 index) spent 5% more than the average U.S. household out of pocket on medical care (doctor's office visits, prescriptions, hospital).
- The racial make-up of Kerr County was 86% white, 2% black, 1% American Indian, 1% Asian/Pacific Islander, 8% mixed race, 2% some other race, and 26% Hispanic origin. (Total over 100% due to Hispanic being an origin not a race)
- The median household income distribution of Kerr County was 18% higher income (over \$100,000), 57% middle income and 25% lower income (under \$24,999).

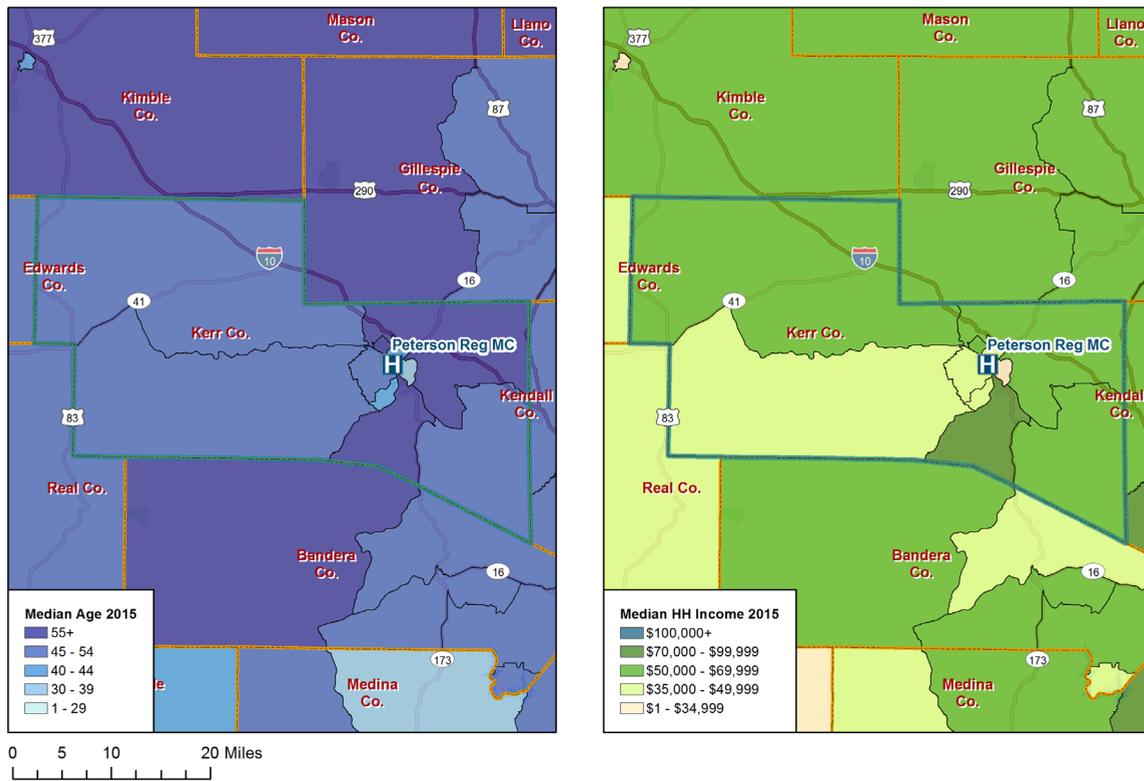
## 2015 Population by Census Tract and Change (2015-2020)



- Source: ESRI

Census tracts generally have a population size between 1,200 and 8,000 people, with an optimum size of 4,000 people. There was a higher population census tract, 8,000-12,999 in the upper northwest section of the county. The area around Kerrville has tracts with population 5,000 to 7,999. The remainder of the county is more rural with tracts containing 2,000 to 4,999 population. The population was projected to grow in all but one census tract in the County from .01% up to the TX growth rate. One tract north of the hospital is projected to decline. However the previous table shows the whole county growing at a modest .51% per year.

## 2015 Median Age & Income



- Source: ESRI

These maps depict median age and median income by census tract. There were two large areas of older population (55+ median age), to the north and south of Kerrville. There were two small areas of younger population in east Kerrville (30-39) then directly south (40-44). The remainder of the county's tracts had median ages between 45 and 54.

There was one tract of lower income (\$1-\$39,999) east of PRMC.. There were four tracts of median household income (\$35,000 - 49,999) in the census tract in the southwest corner of the county and west and north of PRMC. <sup>[1]</sup> Not all households were at the median in a census tract, but these are indicators of segments of the population that may need focused attention. There was one higher median income (\$70,000 - \$99,999) tract south of Kerrville to the county line. The remainder of the county has a median income of \$50,000 to \$69,999.

The rate of poverty in Kerr County was 14.9% (2009-2013 data), which was above TX (17.6%) and the US (15.4%). The poverty percentage was in the middle of the surrounding counties with the highest being Real at 20.2% and the lowest being Kendall at 9.3%

Kerr County's unemployment was 3.7% compared to 4.4% for Texas and 4.9% for the US. Unemployment decreased significantly in the last few years.

<sup>1</sup>The median is the value at the midpoint of a frequency. There is an equal probability of falling above or below the median.

## Health Status Data

The major causes of death in Kerr County were heart disease, followed by cancer, stroke, chronic lung disease, accidents, Alzheimer's disease, influenza and pneumonia, diabetes, suicide, and kidney disease. Source: 2014 Texas Vital Statistics Annual Report, TX Dept. of Health and Human Services; National Center for Health Statistics

Based on the latest County Health Rankings study performed by the Robert Wood Johnson Foundation and the University of Wisconsin <sup>[2]</sup>, Kerr County ranked as the 72<sup>nd</sup> healthiest county in Texas out of the 241 counties ranked (1= the healthiest; 241 = unhealthiest), placing Kerr County in the second quintile. County Health Rankings suggest the areas to explore for improvement in Kerr County were: adult smoking, adult obesity and uninsured. The areas of strength were identified as population to primary care physicians and mental health providers, preventable hospital stays, relatively high mammography screening, higher high school graduation percentage, lower unemployment and lower air pollution as measured in particulate matter.

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 the State and U.S., there is an opportunity for group and individual actions that will result in improved community ratings. There are several lifestyle gaps that need to be closed to move Kerr County up the ranking to be the healthiest community in Texas and eventually the Nation. For additional perspective, Texas was ranked the 34<sup>th</sup> healthiest state out of the 50 states.

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Source: Peterson Health Community Health Summit; Stratasan (2016)

<sup>2</sup> 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 Wisconsin's counties every year since 2003.

# Focus Group, Interview Results, Health Status Comparisons

## Focus Group and Interviews

Eighteen community stakeholders representing the broad interests of the community participated in a focus group for their input into the community's health. There was broad community participation in the focus group representing a range of interests and backgrounds. Below is a summary of the 90 minute discussion.

- When asked to describe the community's health, the group responses varied:
  - Fair
  - Good holistically
  - Socioeconomic disparities
  - Older seniors depends on socioeconomics
  - Older population has more health problems
  - There is a diverse population – the university, retirement community, rehab and sober living community, homelessness
  - Mentally ill veterans
  - Dual diagnosis issues
  - The recovery community is an issue when they return to using and become part of the justice system
  - Smoking
  - Vaping places increasing
  - The community also has an awareness of second chances and successes of people who are now in a very different place as a result of the recovery community
- We reviewed the priorities from 2013 and then discussed the biggest health or healthcare concerns for Kerr County today. The group mentioned:
  - Access to primary care, especially Medicaid and uninsured, and specialty care
  - Mental health and substance abuse for both youth and adults
  - Healthy Eating, Active Living
  - Socioeconomics
  - Dental
  - Chronic Diseases – diabetes, hypertension, respiratory diseases
  - Children's issues:
    - Lack of parenting skills
    - Accessibility of parents
    - Immunizations
    - Childcare issues
    - Teen pregnancy
- The group thought the following issues changed most in the last three years:
  - The hospital and physician community have done a good job adapting and changing to the shifting ground of healthcare.
  - More doctors than 3 years ago
  - More access for the uninsured – Peterson Community Cares Clinic opened
  - Peterson Urgent Care opened

- Schreiner University Clinic – PRMC provides a Nurse Practitioner open to students and employees
- River trail – well-used, has improved activity level, biking
- Kroc Center – Salvation Army affordable place to exercise
- Ingram ISD – give random drug tests which has reduced drug use. There is also less smoking than in the past. However, there is still alcohol use and teen pregnancy is a huge issue.
- New Hope Counseling is struggling and if they don't survive, there will be no place for low income to receive counseling.
- Schreiner University has become more and more involved in the community. The community mentor program.
- Cutting is down in the high school
- Synthetic drug use is down in the high school
- The group believed the behaviors that have the most negative impact on health are:
  - Fast food – healthy food is expensive
  - There are opportunities to use the existing community gardens for low income
  - Lots of pride, and will not partake of services available
  - The community doesn't speak with one voice – so many not-for-profits scrambling for the same dollars. There's not enough money to fund everything. There are 200+ NFPs in Kerr County including churches. Perhaps could merge projects if the NFPs themselves can't be merged.
- The group believed the environmental factors that have the biggest impact on health are:
  - Mental health family support – TX is cutting back on mental health funding
  - Victims support takes 6 weeks to get approval for support whereas ten years ago it took one day
  - Cedar Pollen
  - Water – but the water authority ensures the water meets state regulations. But will it be safe in 5 years?
- The group thought the biggest barriers to improving health in the last three years and moving forward were:
  - Insurance frustration not knowing about the coverage changes. Required to have insurance but can't afford the premiums.
  - People not getting health insurance
  - City and County governments conflict
  - Transportation
  - Lack of affordable housing. Housing is very expensive in the county, little section 8 housing choice voucher program.
  - Difficulty bringing reasonably paying jobs into the community to grow the community
  - The legislature removed health classes from the curriculum so there's less opportunity to discuss, health, wellness, abstinence
  - Fixed income retirees on Medicare and don't have money
  - Seniors like easy to fix food, but it isn't necessarily good for them.
  - Retiree population isn't going down will probably increase
  - Seniors don't utilize technology as much as others
  - Private practice physicians quitting practice displacing patients
  - Doctors and hospitals level of reimbursement struggles
  - Community knowledge and acceptance of mental health and substance abuse issues
  - Mental health and substance abuse cases tie up the ED for hours – takes 8-9 hours to get them placed

- The culture of self-sufficiency – take care of yourself instead of getting help
- The group listed the following as community assets to support health:
  - The not-for-profit organizations
  - Volunteerism in the community
  - Schreiner University
  - Peterson Regional Medical Center
  - Kerrville State Hospital
  - Kerrville is an awesome place to live
  - Faith-based community
  - Wesley Nurse program
  - Support system for low income of neighbors and family
  - Public education is great
  - Airport – attracts people to the community
  - Access to activities – pickle ball, flag football, softball leagues
  - Races and triathlon
  - There are opportunities for kids’ activities in school, PE, weightlifting, organized sports
  - The high school provides daycare for students
  - Mental Health and Developmental Disabilities MHDD
  - BCFS Health & Human Services
  - Hill Country Cares – Battered women’s help
  - KStar
  - Institute of Trauma and loss
  - Alamo College, a 2 year community college
  - Rotary
  - Hill Country Community Foundation
  - School district
  - Riverwalk adding exercise stations
  - Club Ed program
  - Kiwanis Club
  - Companies have wellness programs, some offer incentives to go to health clubs, Trio motion device insurance plan – pedometer give real \$ to spend on copay and expenses
  - Mental Health Developmentally Disabled crisis stabilization unit (CSU)
  - New Hope Counselling Center
  - Peterson Regional Community Clinic
- When asked what priority health improvement actions should Kerr County focus on, the group listed:
  - Coordinating people and services
  - Continue to market health
  - Education – teachable moment, benefits of healthy lifestyle, mechanism to support them if they want to make a change
  - Availability of healthy food
  - Reduction in gap of people who don’t qualify for Medicaid or subsidies for health insurance
  - Medicaid expansion
  - Access to dental care for uninsured and Medicaid
  - Consistent primary care available outside the ED
  - Create a holding area or building for psych and substance abuse patients from the ED until placement.
  - Primary Care Physicians to follow psych and substance abuse patients
  - Transportation
  - Psych facility or more beds at CSU – PRMC has to deal with these issues every day, so better to be part of the plan. Needs to be community involvement, all can work together – CSU, MHDD, County, PRMC

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## Community Physician and PRMC Employee On-line Surveys

30 community physicians and 259 PRMC employees were surveyed on-line regarding their perspectives on community health status and needs from May 1 – May 17, 2016. Most of the PRMC physicians and employees are members of the local community and have unique insight into the health status of the community.

### Responses:

- 57% of physicians and 48% of employees responded that the overall health status of Kerr County was fair, 27% of physicians and 41% of employees responded good, 17% and 4% poor and no physicians, but 1% of employees responded excellent.
- 73% of physicians believed obesity was the most prevalent disease followed by diabetes and high blood pressure (70%). Employees believed diabetes (74%) was the most prevalent chronic disease followed by high blood pressure and heart disease.
- When asked about the top three issues impacting people's health, physicians listed mental health and behavioral health services (52%), people taking more responsibility for their own lifestyle/health (48%) and access to primary care (45%). Employees listed affordable health insurance (36%), affordable healthcare (33%) and people taking more responsibility for their own lifestyle/health (28%) as their top three issues.
- The top health concerns for children were the same for both groups, physical inactivity (61%, 57%), lack of a healthy diet (54%, 46%), and responsible, involved parents (54%, 45%).
- Physicians listed affordable healthcare (44%), financial assistance for doctor visits, medical supplies, etc. and compliance to drug therapies/prescriptions, both at 41% as most needed for people to manage their health more effectively. Employees listed affordable healthcare (50%), insurance that's more affordable for more people (47%), and financial assistance for doctor visits, medical supplies, etc. (35%) as needed for people to manage their health more effectively.



## Health Status Analysis and Comparisons

Information from County Health Rankings and America's Health Rankings was analyzed in the Community Health Needs Assessment in addition to the previously reviewed information and other public health data. Other data was analyzed, such as: causes of death, demographics, socioeconomics, consumer health spending, focus group, and surveys of community physicians and hospital employees. When data was available for Texas, the U.S. or the top 10% of counties (90th percentile), they were used as comparisons. Where the data indicated a strength or an opportunity for improvement, it is called out below. Strengths are important because the community can build on those strengths and it's important to continue focus on strengths so they don't become opportunities for improvement. The full data analysis can be seen in the complete CHNA PowerPoint. There were strengths and opportunities identified for measures and for the counties. Opportunities were denoted with red stars, and strengths were denoted using green stars. The years displayed on the County Health Rankings graphs show the year the data was released. The actual years of the data was contained in the source notes below the graphs.

### Leading Causes of Death: Age-adjusted deaths per 100,000

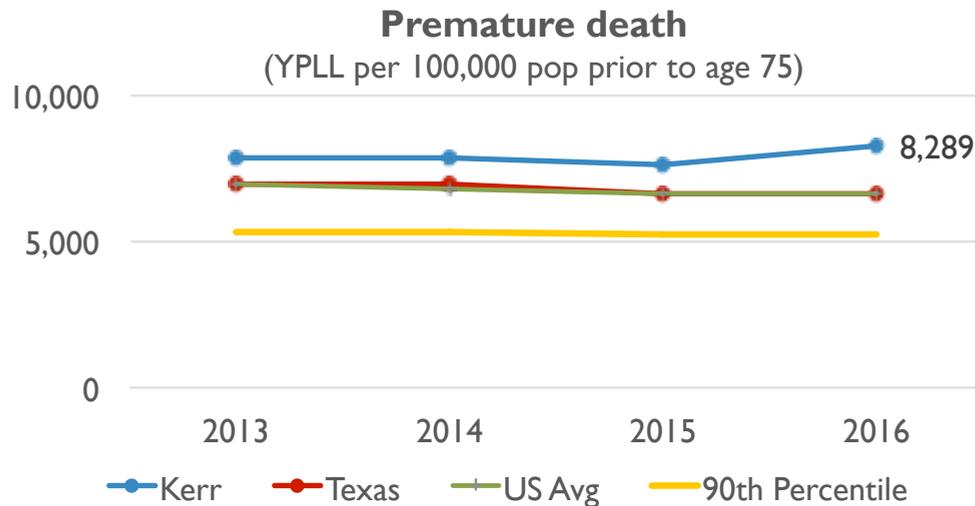
Cause of Death	Kerr Co. 2013	Bexar Co. 2013	Texas 2014	US 2014
Heart Disease	149.0	182.0	170.7	167.0
Cancer	131.0	155.2	156.9	161.2
Stroke	44.0	40.8	40.2	36.5
Chronic Lung Disease	41.0	34.0	42.4	40.5
Accidents	34.0	39.8	37.0	40.5
Alzheimer's Disease	32.0	18.3	24.3	25.4
Influenza and Pneumonia	27.0	11.4	14.4	15.1
Diabetes	19.0	25.4	21.6	20.9
Suicide	8.0	10.2	11.7	13.0
Kidney Disease	7.0	17.1	15.9	13.2

- Source(s): 2013 Texas Vital Statistics Annual Report. Division for Vital Records & Health Statistics, Texas Department of Health & Human Services; CDC: 1999-2014 Final Data

Red areas had death rates higher than the state. The leading causes of death in all three geographies was heart disease followed by cancer. Lagging behind as causes of death were stroke, chronic lung disease, accidents, Alzheimer's disease, influenza and pneumonia, diabetes, suicide and kidney disease.

## 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 123rd in Health Outcomes out of 241 Texas counties, in the third quintile. Length of life was measured by years of potential life lost per 100,000 population prior to age 75. Kerr County ranked 138th in length of life.

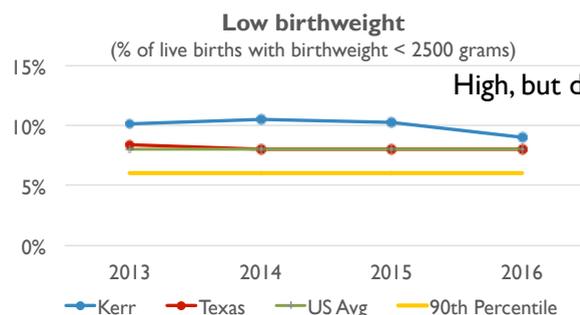
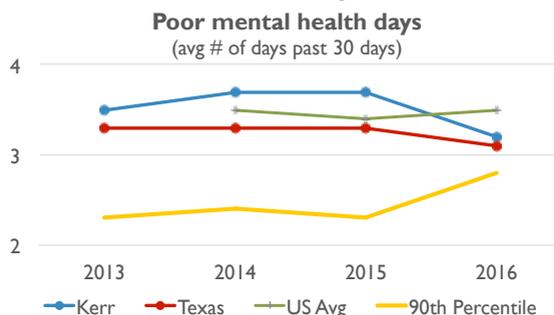
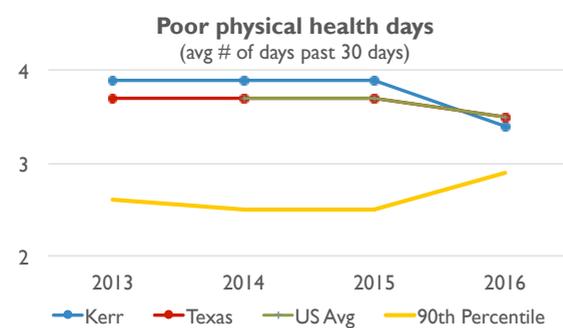
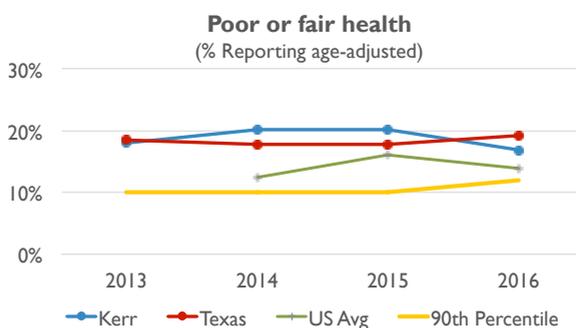


Source: County Health Rankings; National Center for Health Statistics – Mortality File, 2011-2013

In most of the following graphs, Kerr County will be blue, Texas red, US green and the 90th percentile gold.

### 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 (5lbs 8ozs). Kerr County ranked 138th out of 241 counties for quality of life.



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Source: County Health Rankings; Behavioral Risk Factor Surveillance System (BRFSS) 2014

Source: County Health Rankings; National Center for Health Statistics – Natality files (2007-2013)

\*indicates a change in the Behavioral Risk Factor Surveillance System Survey calculations of results or changes in survey methodologies. 2016 cannot be compared to prior year results.

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## Quality of Life OPPORTUNITIES

- Years of potential life lost (YPLL) per 100,000 population prior to age 75, is higher in Kerr County, 8,289 years, higher than Texas and the U.S.
- The percent of low birthweight babies, less than 5.5 pounds, is higher in Kerr County than TX and the U.S.

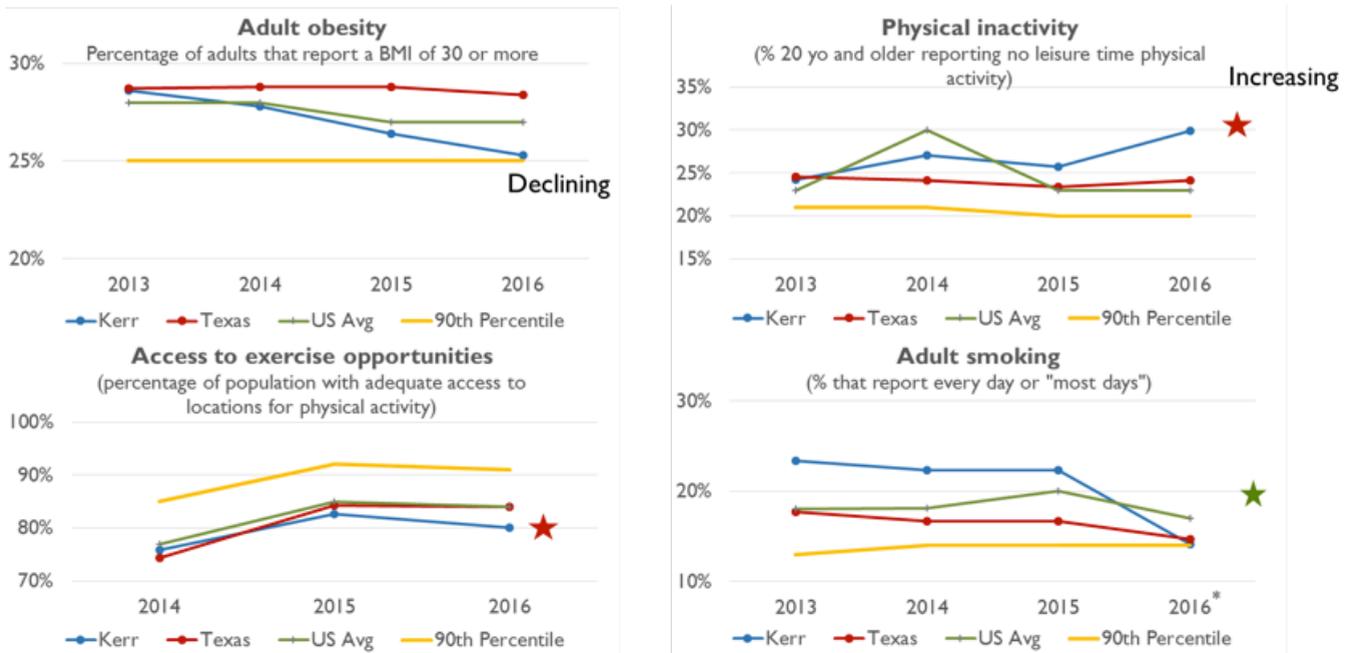
In the other quality of life measures, Kerr County's measures were between TX and the U.S.



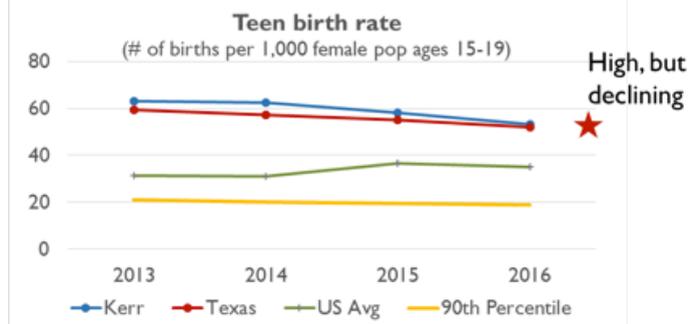
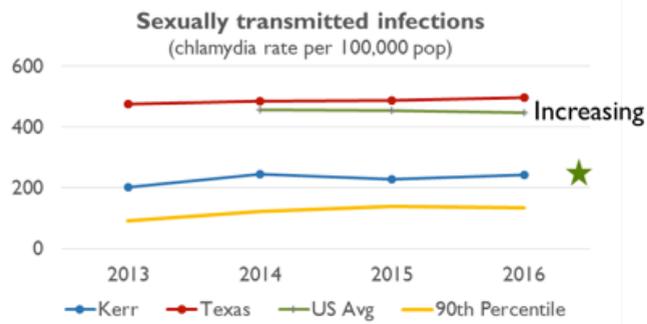
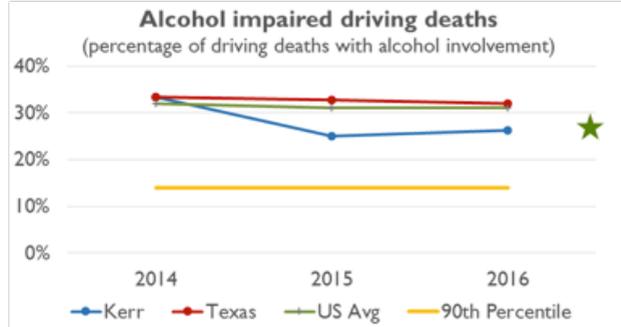
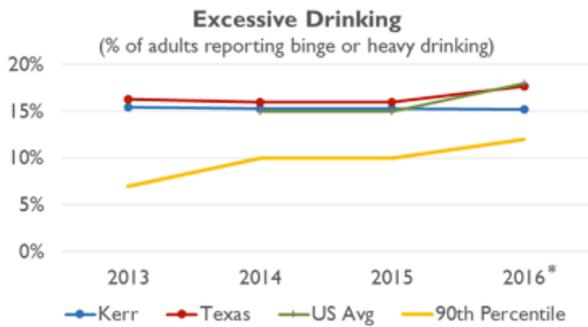
## Health Factors or Determinants

Health factors or determinants were comprised of measures of related to health behaviors, clinical care, social & economic factors, and physical environment. Health behaviors were made up of nine measures. Health behaviors account for 30% of the county rankings. Kerr County ranked 18th out of 241 counties in Texas.

### Health Behaviors



Source: Obesity, physical inactivity - County Health Rankings; CDC Diabetes Interactive Atlas, 2012  
 Source: Access to exercise opportunities - County Health Rankings; ArcGIS Business Analyst, Delorme map data, ESRI and US Census Tigerline Files, 2013  
 Source: Smoking - County Health Rankings; Behavioral Risk Factor Surveillance System (BRFSS)

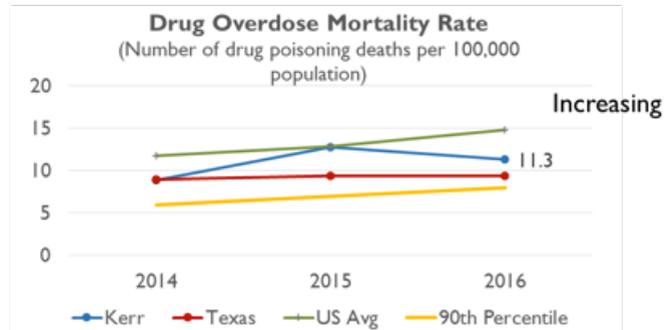
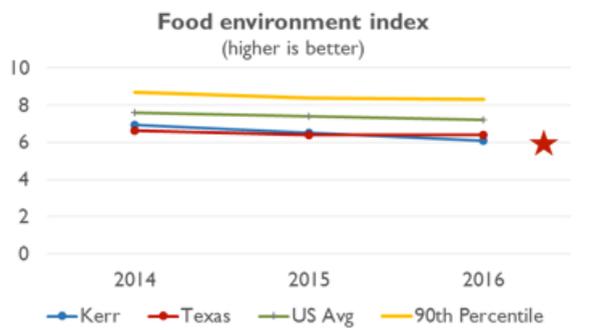


Source: Excessive drinking - County Health Rankings; Behavioral Risk Factor Surveillance System (BRFSS), 2014

Source: Alcohol-impaired driving deaths - County Health Rankings; Fatality Analysis Reporting System, 2010-2014

Source: STDs - County Health Rankings; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2013

Source: Teen birth rate - County Health Rankings; National Center for Health Statistics - Natality files, 2007-2013



The food environment index is 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.

Source: County Health Rankings; USDA Food Environment Atlas, 2012-2013

Source: County Health Rankings; CDC WONDER mortality data, 2012-2014

## Health Behaviors STRENGTHS

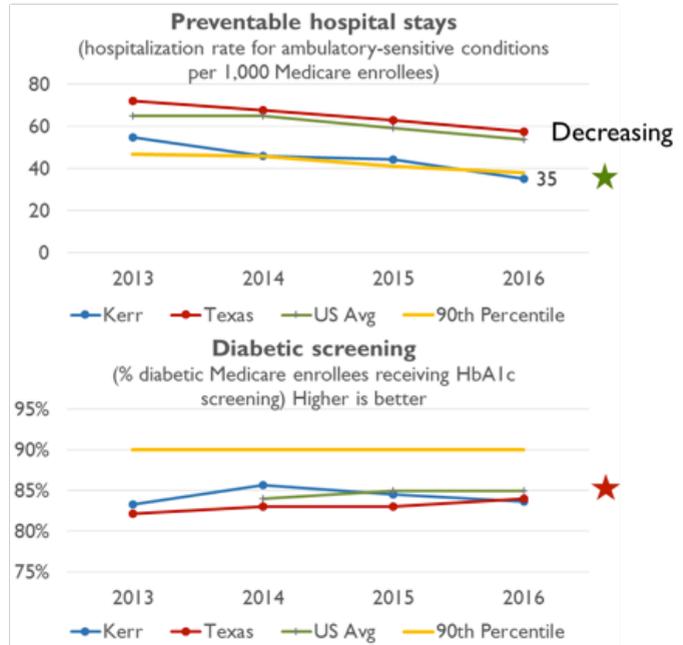
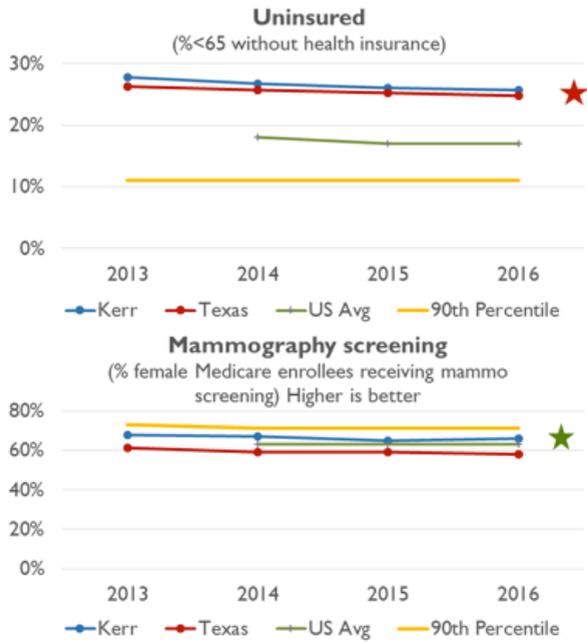
- Adult obesity, although lower than Texas and the U.S. was still above 25%. Kerr County was approaching the top ten percent of counties in the U.S. This measure is a strength for Kerr County, however obesity puts people at increased risk of chronic diseases: diabetes, kidney disease, joint problems, hypertension and heart disease. Obesity can cause complications in surgery and with anesthesia. It has been implicated in Alzheimer's. It often leads to metabolic syndrome and type 2 diabetes. It is a factor in cancers, such as ovarian, endometrial, postmenopausal breast cancer, colorectal, prostate, and others.
- Adult smoking in Kerr County was lower than the U.S. and slightly lower than TX, making the measure a strength. However, the Healthy people 2020 goal is 12%. Each year approximately 443,000 premature deaths can be attributed to smoking. Cigarette smoking is identified as a cause of various cancers, cardiovascular disease, and respiratory conditions, as well as low birthweight and other adverse health outcomes.
- The percentage of driving deaths with alcohol involved was lower than TX and the U.S.
- Sexually transmitted diseases as measured by Chlamydia rate per 100,000 population was lower in Kerr County than Texas and the US, but increased slightly since 2013's release.

## Health Behaviors OPPORTUNITIES

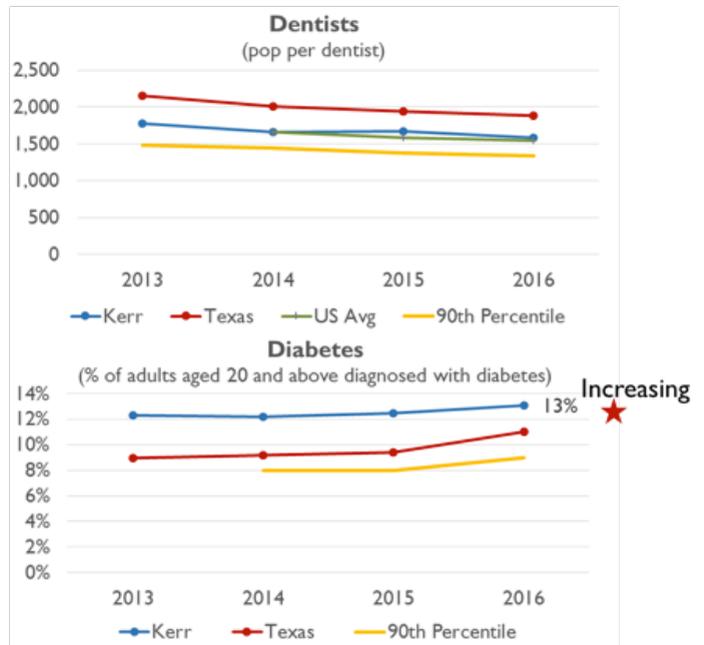
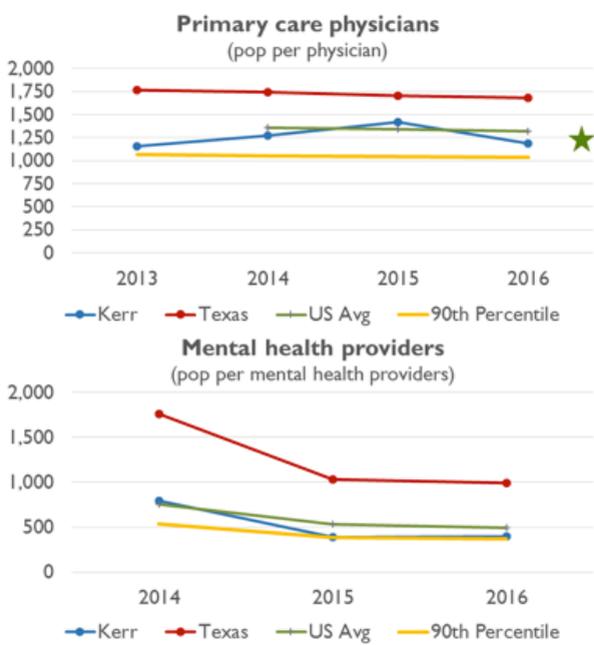
- Physical inactivity was higher in Kerr County than TX and the U.S.
  - The percentage of the population with adequate access to locations for physical activity was lower in Kerr County than TX and the U.S.
  - The teen birth rate in Kerr County was higher than the U.S. and slightly higher than TX, but the trend is declining.
  - The food environment index is lower than TX and the U.S. The index is a blend of access to healthy food and food insecurity.
  - Substance abuse as a primary reason for treatment in TX increased from 2010 each year.
-

## Clinical Care

Clinical care ranking is made up of eight indicators, and they account for 20% of the county rankings. Kerr ranked 9th out of 241 Texas counties in clinical care.



Source: Uninsured - County Health Rankings; Small Area Health Insurance Estimates, 2013  
 Source: Preventable hospital stays, mammography screening, diabetic screening - County Health Rankings; Dartmouth Atlas of Health Care, 2013



Kerr County is a health professional shortage area (HPSA) for mental health, but not dental or primary care. However, Kerr County is listed as a medically underserved area due to low income population.

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*Source: Pop to PCP - County Health Rankings; Area Health Resource File/American Medical Association, 2013*  
*Source: Pop to Dentists - County Health Rankings; Area Health Resource File/National Provider Identification file, 2014*  
*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, 2014*  
*Source: County Health Rankings; CDC Diabetes Interactive Atlas, 2013*

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### **Clinical Care STRENGTHS**

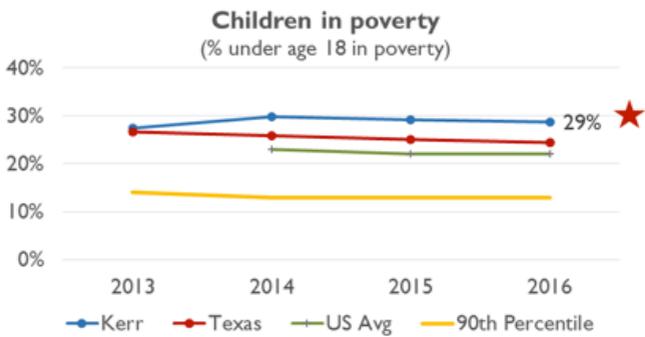
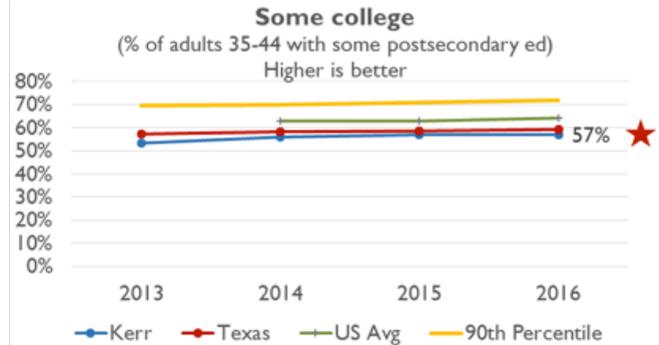
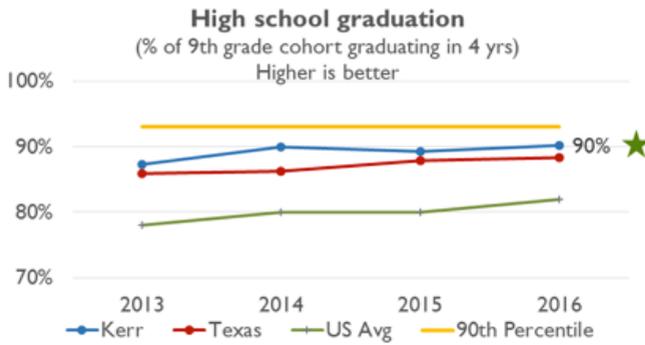
- The hospitalization rate for ambulatory-sensitive conditions per 1,000 Medicare enrollees was low, to the top 10% of all counties in the U.S.
- Mammography screening was higher in Kerr than TX and the U.S.
- The population per primary care physician was lower in Kerr County than TX and the U.S. However, many primary care physicians are employed by the VA or retired and are not in the community seeing patients.

### **Clinical Care OPPORTUNITIES**

- The percent of population under sixty-five without health insurance was higher in Kerr County than TX and the U.S.
  - The percent of diabetic Medicare enrollees receiving screening was lower in Kerr than TX and the U.S.
  - Thirteen percent of Kerr County has diabetes, which was higher than TX
- .....

## 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 ranked 107th out of 241 Texas counties in social and economic factors.

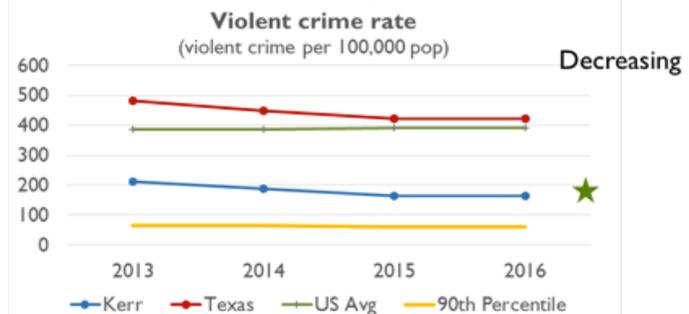
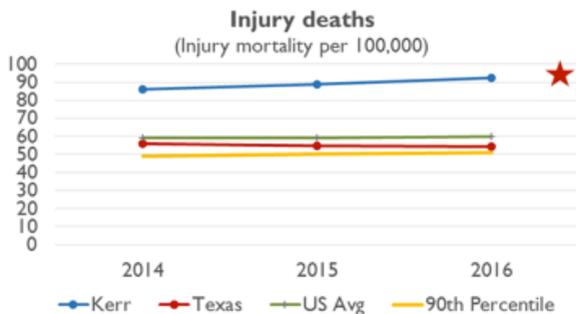
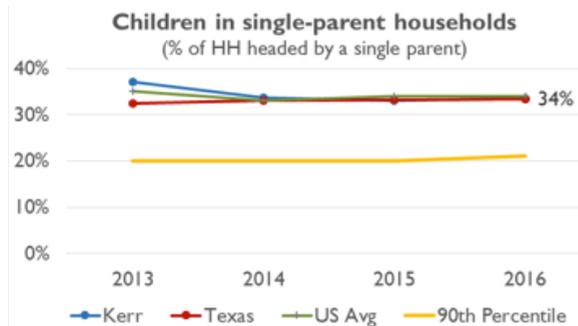
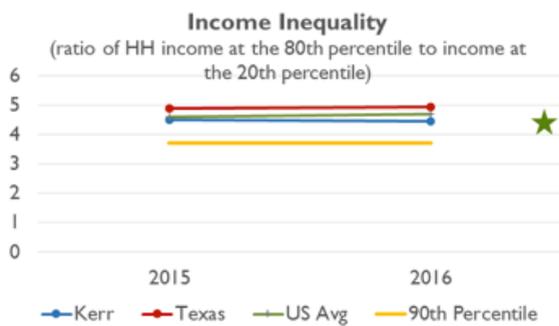


Source: High School graduation - County Health Rankings; States to the Federal Government via EDfacts, 2012-2013

Source: Some college - County Health Rankings; American Community Survey, 5-year estimates, 2010-2014

Source: Children in poverty - County Health Rankings; US Census, Small Area Income and Poverty Estimates, 2014

Source: Social associations - County Health Rankings; County Business Patterns, 2013



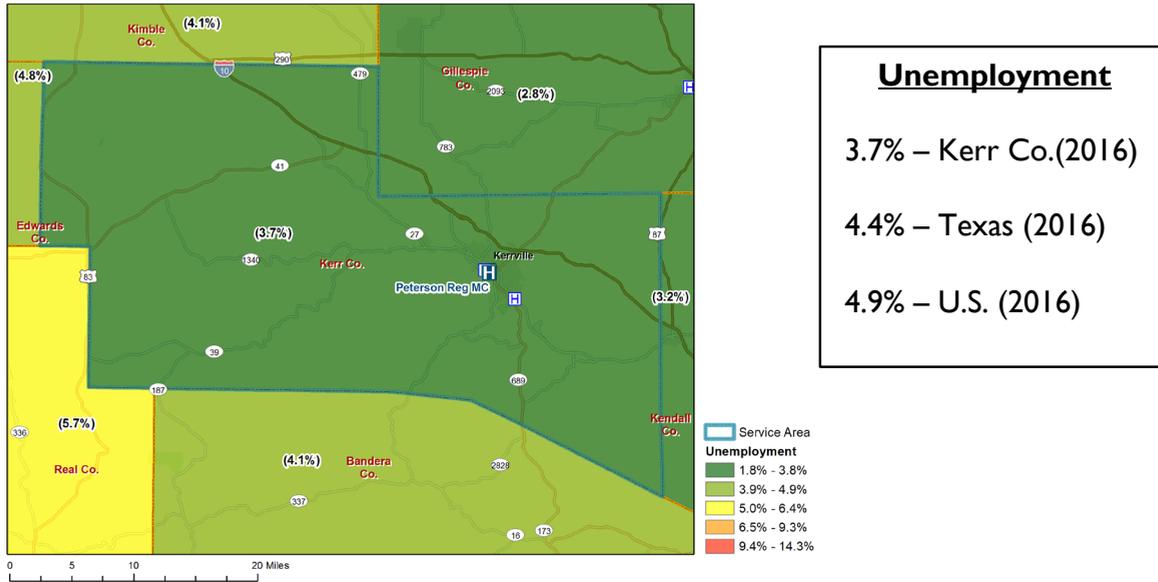
Source: Income inequality - County Health Rankings; American Community Survey, 5-year estimates 2010-2014

Source: Children in single parent households - County Health Rankings; American Community Survey, 5-year estimates, 2010-2014

Source: Injury deaths - County Health Rankings; CDC WONDER mortality data, 2009-2013

Source: Violent crime - County Health Rankings; Uniform Crime Reporting - FBI, 2011 - 2013

## Unemployment Rate by County



Source: Bureau of Labor Statistics

## Social & Economic Factors STRENGTHS

- High school graduation was higher in Kerr County than TX and the U.S.
- Social associations were higher in Kerr County than TX and the U.S. 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. Poor family support, minimal contact with others, and limited involvement in community life are associated with increased morbidity and early mortality.
- Income inequality, the ratio of household income at the 80th percentile to income at the 20th percentile, was higher in Kerr than TX and the U.S.
- Violent crime rate per 100,000 population is lower in Kerr County than in TX and the U.S., approaching the top 10%

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## Social & Economic OPPORTUNITIES

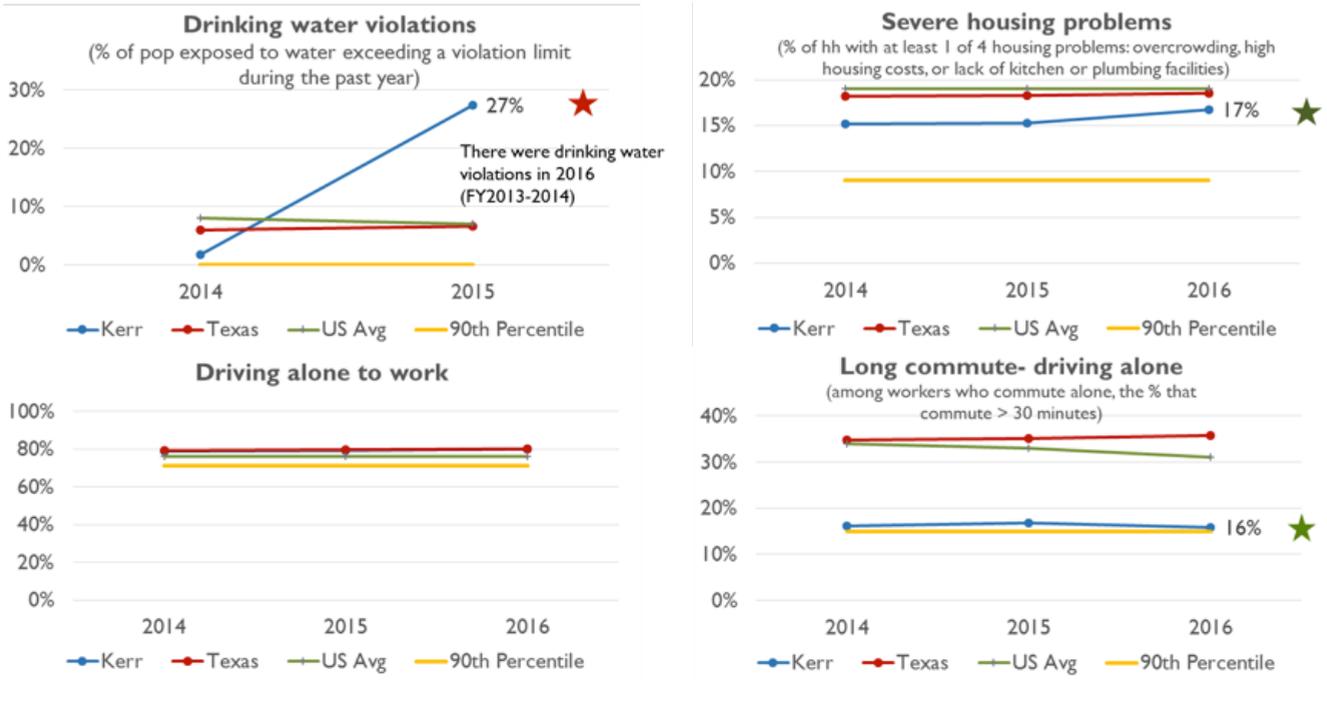
- The percent of adults with some college was lower than TX and the U.S.
- The percentage of children in poverty was higher in Kerr County than Texas and the U.S. at 29%.
- Injury deaths were higher than TX and the U.S. and increasing.
- Lower median household income than Texas and the U.S.
- Higher poverty than Texas and the U.S.



Photo credit: Peterson Health

## Physical Environment

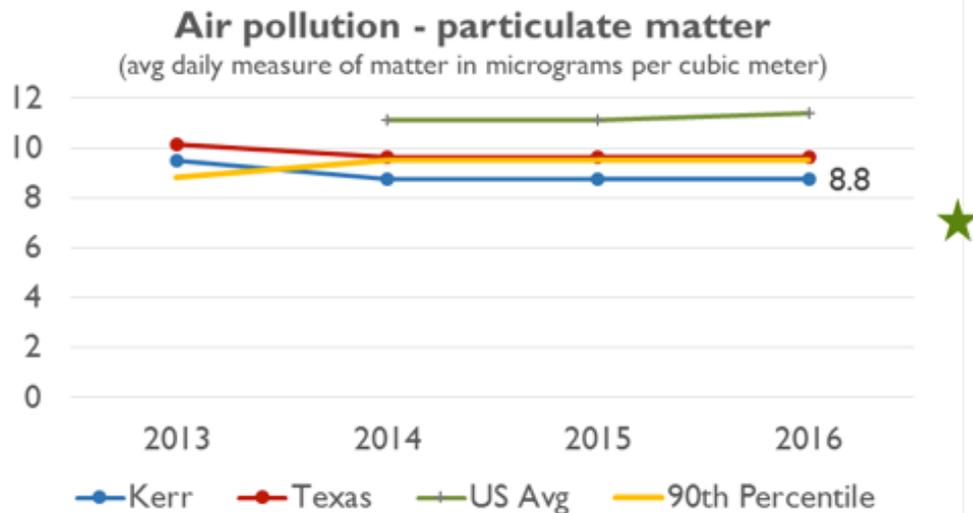
Physical environment contains five measures in the category. Physical environment accounts for 10% of the county rankings. Kerr County ranked 110<sup>th</sup> out of 241 Texas counties in physical environment.



Source: Drinking water violations – County Health Rankings; EPA, FY 2013-2014

Source: Severe housing problems – County Health Rankings; HUD Comprehensive Housing Affordability Strategy data, 2008-2012

Source: Driving alone to work and long commute – County Health Rankings; American Community Survey, 5-year estimates, 2010-2014



Source: Air pollution – County Health Rankings; CDC WONDER environmental data, 2010

## Physical Environment STRENGTHS

- Kerr County had fewer severe housing problems than TX and the U.S.
- Kerr County did not have long commute times or drive alone to work, at or lower than the top 10% of counties. A 2012 study in the American Journal of Preventive Medicine found that the farther people commute by vehicle, the higher their blood pressure and body mass index. Also, the farther they commute, the less physical activity the individual participated in. Source: County Health Rankings: [1] Hoehner, Christine M., et al. "Commuting distance, cardiorespiratory fitness, and metabolic risk." American journal of preventive medicine 42.6 (2012): 571-578.
- Kerr County had fewer air particulate matter in micrograms per cubic meter than TX and the U.S.

## Physical Environment OPPORTUNITIES

- There were drinking water violations in Kerr County. The U.S. statistics are prior to the Flint, MI water crisis.

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### There were Four Broad Themes that Emerged in this Process:

- Kerr County needs to create a "Culture of Health" which permeates throughout the cities, employers, churches, and community organizations to engender total 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 had the poorest health outcomes.
  - While any given measure may show an overall good picture of community health, there are significantly challenged subgroups such as the census tracts east of PRMC.
  - It will take a partnership with a wide range of organizations and citizens pooling resources to meaningfully impact the health of the community. Many assets exist in the county to improve health.
-

# Results of the CHNA

## Prioritization of Health Needs



*Peterson Health Community Health Summit; Stratasan, 2016*

### Prioritization Criteria

At the Community Health Summit, the attendees identified and prioritized the most significant health needs in the community for the next three-year period. The group used the criteria below to prioritize the health needs.

Magnitude / scale of the problem	How big is the problem? How many individuals does the problem affect, either actually or potentially? In terms of human impact, how does it compare to other health issues?
Seriousness of the 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 it is working? What are the community's intrinsic barriers, and how big are they to overcome?

The following needs were prioritized and goals and actions were brainstormed by the table groups at the Community Health Summit and formed the foundation of Kerr County's health initiatives. 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 the actual comments received on the sticky notes.

- ① Substance Abuse & Mental Health (25)
- ② Access (19)
- ③ Lifestyle/Wellness/Education (14)
- ④ Obesity (9)
- ⑤ Socioeconomics (8)
- ⑥ Chronic Diseases (7)
- ⑦ Children (4)

**1. Substance Abuse & Mental Health (25)**

- Mental health – 10
- Mental health services/issues/access/counseling
- Mental health care for emergent and follow-up
- Serving the mental health needs
- Collaboration among all providers and entities to improve access to mental health services
- Suicide (mental health problems) in children
- Access to mental health services for students from low-income families
- Mental health/substance abuse
- Drug use/abuse
- Substance Abuse
- Drug and alcohol use
- Support for recovering community

**2. Access (19)**

- Underserved for all types of healthcare
- Better access to underserved population
- Access to dental care for students from low-income families
- Access to medical services for students from low-income families
- Healthcare
- Access to healthcare/affordable healthcare/primary care/healthcare coverage
- Healthcare affordability
- Money for healthcare – affordable insurance/affordable healthcare and care
- Insurance coverage/ uninsured

- Primary care physicians for all age groups and payors - 2
  - Improve funding for health care for uninsured population in Kerr and surrounding counties
  - Collaboration between existing health providers
- 3. Lifestyle/Wellness/Education (15)**
- Lifestyle improvements/education
  - Education and classes to create physical activity
  - Wellness education strong focus on children for stronger impact on human health
  - Wellness and lifestyle education
  - Healthy lifestyle
  - Wellness and lifestyle education
  - Smoking cessation education
  - Pneumonia education/prevention strategies
  - Education
  - Lack of resources health behavior knowledge
  - Decrease percentage of low birthweight babies
  - Improve/increase community awareness and ownership of health status
  - Prevention
  - Premature death
- 4. Obesity (9)**
- 5. Socioeconomics (8)**
- Affordable housing - 2
  - Childhood poverty - 2
  - Transportation – 2
  - Poverty as a social determinant of health
  - Homelessness
- 6. Chronic Diseases (7)**
- Health disparities
  - Lack of neurology coverage; lack of proper screening for dementia
  - Chronic disease – pulmonology/diabetes/COPD/pneumonia
  - Chronic disease management (help to lower mortality rates)
  - Metabolic disease
- 7. Children (4)**
- Abuse and neglect of children
  - Child fatalities

# Community Health Summit Brainstorming

## Focus Areas, Goals



*Peterson Regional Medical Center Community Health Summit; Stratason, 2016*

The most significant health needs resulted in seven categories and table groups brainstormed goals and actions around the most important health needs listed above. These suggested goals and actions have been organized below.

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### **Significant Health Need: Mental Health and Substance Abuse**



#### *Goal 1 - Access to mental health*

Action 1 - Petition legislature for funding to increase access

Action 2 - Recruit mental health professionals



#### *Goal 2 - Maintenance of care*

Action 1 - Decrease wait times to see providers

Action 2 - Increase peer support



#### *Goal 3 - Community awareness and ownership*

Action 1 - Conduct a mental health summit similar to this one focused on mental health

Action 2 - Community education

*Resources Needed: Funding, people and media exposure*

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## Significant Health Need: Access

- ✔ *Goal 1 - Ensure ALL citizens have access to primary care*
  - Action 1 – Recruit physicians and nurse practitioners and physician assistants
  - Action 2– Work with existing doctors to keep them in community. Create alignment.
- ✔ *Goal 2 - Educate population on avenue off access. Access to primary care has direct impact on healthy community.*
  - Action 1 – Marketing
  - Action 2 – Follow-up
  - Action 3 – Improve navigation
- ✔ *Goal 3 - Analyze impact of expanded safety net for Medicaid and Uninsured*
  - Action 1 - Cost benefit analysis
  - Action 2 - Work with specialists and area resources for unified approach. Ex. Methodist Healthcare Ministries, Peterson Community Care Clinic, Raphael Clinic, Texas Department of Health, Churches, Pregnancy Resource Center, others.

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## Significant Health Need: Lifestyle/Wellness/Education with Obesity

- ✔ *Goal 1 - Increase percentage of quality of life for all*
  - Action 1 – Educate community on wellness issues (heart disease, diabetes, obesity, immunizations (1 per month, 12th month recap)
  - Action 2 – Monthly/weekly public service tip in newspaper, e-mail blast, social media “topic of the month”
- ✔ *Goal 2 – Weight reduction - obesity prevention*
  - Action 1 – Increase opportunities for group exercise and promote it (walking trail, PRMC, marketing certain day) – Community partners, sponsors.
  - Action 2 – Provide education on nutritional cooking (agriflife)
- ✔ *Goal 3 – Increase awareness to Kerr County children about healthy choices*
  - Action 1 – Provide education to children and families at daycares, Pre-K, Head start and other schools about healthy eating and exercise.
  - Action 2 – Promote wellness activities for families, walking playgrounds (elementary schools)

## Significant Health Need: Socioeconomics



### *Goal 1 - Housing*

Action 1 – Obtain donated real estate, approach Foundations

Action 2 – Habitat for Humanity, but for multi-family units due to high land cost



### *Goal 2 – Transportation*

Action 1 – Buddy system from seniors – Elder Uber

Action 2 – Coordinate with Dietert Center



### *Goal 3 – Poverty (address the real issues – breakdown of family, mental health and substance abuse)*

Action 1 – Coordinate counseling services through churches and other non-profits

Action 2 – Explore clinics that are governmentally supported

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## Significant Health Need: Chronic Diseases



### *Goal 1 - Reduce illness by education and implementation - Awareness*

Action 1 – Education

Action 2 – Healthy community movement - Teach to grow nutritious vegetables, feed the poor healthy meals



### *Goal 2 – Outreach through civic groups, public health education - Ownership*

Action 1 – Educate with media onsite demonstrations

Action 2 – Create opportunities for change, walking groups



### *Goal 3 – Create jobs within needs sector – poor and elderly*

Action 1 – Create a movement for healthy, strong, nation. Start with volunteers, raise a team funds with flow to pay staff

Action 2 – Movement into national and state governments for faster-term effect on public health



### *Goal 4 – Collaborative Treatment*

Action 1 – Medication management

Action 2 – Advocates/instigators

## Significant Health Need: Access to and utilization of medical dental care for children



### *Goal 1 - Increase access to primary care and dentistry*

Action 1 – Assess barriers within the community compared to what’s currently available

Action 2 –Engage professionals in the community



### *Goal 2 – Increase pre-natal care utilization*

Action 1 – Raise awareness of low birthweight babies and its causes/effects

Action 2 – Educate parents about “safe sleep”



### *Goal 3 – Increase access to medication and medical management for chronic diseases (asthma, diabetes)*

Action 1 – Increase funding for medicines

Action 2 – Increase medical management – home health providers

Action 3 – Identify chronic users of the Emergency Room and address populations’ health needs; coordinate with school nurses

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## 2013 Peterson Regional Medical Center Implementation Plan/Impact Evaluation

### Written Comments

Peterson Regional Medical Center adopted an implementation plan in 2013. The results of this plan were reviewed at the Community Health Summit. The plan’s results are below.

One of the questions asked during the focus group was, what comments do you have regarding the 2013 PRMC CHNA and implementation plan. The only response received was to combine mental health and substance abuse into one initiative since they are so closely linked. At the community health summit, a worksheet asking for written comments was distributed to all participants. One response was received, “Well done – need at least semi-annual ‘touch base’ with participants.

Since the October 2012 Community Summit, Peterson has been diligent in finding all possible avenues to address the unmet health needs of the community and follow the action plan through collaboration with targeted organization, relationships and connections with outside organizations, and through direct facilitation of community workshops and educational opportunities relating to the most unmet health needs. The following actions have been taken to address the unmet health needs of the region and meet the requirements from the 2012 CHNA:

### Access and Affordability

Recruit three additional primary care providers. Peterson has met the outlined action plans to use/retain physician recruiters, achieved through PMA administrator Tim Rye and the improved employee practice model. Mr. Rye is credited for recruiting four new primary care physicians and two new obstetrics/gynecology providers within one year. The addition of new ob/gyn providers and adding our nurse midwives to the practice has helped meet another goal.

## Obesity

Create health education alliance for Kerr County and implement by the end of 2013. According to [countyhealthrankings.org](http://countyhealthrankings.org), Kerr County has maintained the 29% obesity rate. While continuing to focus on reducing that rate by 2017, Peterson is proud of its efforts to partner with a variety of businesses, organizations, or individuals to increase awareness of the problems related to obesity. Educational offerings such as our annual 'Remarkable Women's' event and 'The Men's Event' always offer topics on weight management/diet and nutrition, monthly radio interviews address the topic of health and wellness, specifically every 3rd Wednesday of the month for 'Wellness Wednesday,' and a higher level of partnerships with area fitness centers and race organizations to encourage employees and general community members to become members or participate in special races or health events round out an informal but strong health and wellness alliance. Peterson offers or participates in multiple health screenings throughout the year in Kerrville and surrounding towns and has focused on sponsoring/assisting events geared toward physical fitness and exercise (The Kerrville Triathlon, Hill Country Multi-sports memberships, sponsoring teams for races and promoting employee accomplishments at racing events.) Internal efforts have increased through the PRMC Wellness program, from logging activities and exercise, to participating in in-house exercise classes, or weight watching programs, or fitness challenges.

## Chronic Diseases and Education

Develop community education strategies for specific chronic diseases, e.g. diabetes. Peterson has actively developed community education strategies for specific chronic diseases, primarily diabetes. We have actively improved community awareness through the media in both articles, interviews, and advertising and we have increased the number of screenings at public venues to include screenings at the annual flu clinic, local health club facilities, area health fairs, and special events like the Kerrville Public School Foundation Great Family Day and Duck Race. Proudly, Peterson hired Mary Ann Jones last spring as Peterson's Diabetic Education Coordinator. In this role, Ms. Jones focuses on the treatment and management of diabetes for patients admitted to the hospital, but additionally supports diabetic support group, and special workshops. Peterson's Marketing Department assisted Ms. Jones with the first ever Diabetes Day and Screening, held in conjunction with American Diabetes Day, to offer community member's free screenings and educational talks by physicians in the area that specialize in diabetes and the management of chronic diseases, including a special cooking demonstration. Both upcoming 'Remarkable Women' and 'The Men's Event' lecture series will feature topics on diabetes and chronic diseases and the women's event will be expanded to feature a cooking demonstration targeted at residents with diabetes. With targeted focus on diabetes and chronic diseases through Peterson's participation in DSRIP (Delivery System Reform Incentive Payment), the hiring of a Diabetes Education Coordinator, elevated educational events and screenings, and expanded focus on patients with diabetes from hospital to discharge.

## Smoking/Tobacco Use

Continue the reduction of youth tobacco use from 12% to 10%. The rate of tobacco use among teens has remained unchanged in 2013 but Peterson has made the public more aware of the abuse of tobacco among adults and youth through workshops and civic presentations; though a more developed awareness campaign needs to be considered. Peterson has continued to work directly with the American Cancer Society and support their efforts and activities, always a high level supporter for the annual 'Relay for Life' event, and had authored or created articles in Your Health Matters of for the general media on the adverse effects of smoking/tobacco. In several publications, cancer victims and survivors candidly tell their stories of survival of their battles with cancer, many related to smoking/tobacco use. Peterson has recently joined KISD's Student Health Advisory Committee and smoking/tobacco use is one of the main topics of discussion, specifically the difficult situation of enforcing the smokless, vapor cigarettes. Working with the school district on this topic meets this important goal.

## Mental Health/Substance Abuse

Recruit a psychiatrist. Peterson continues to actively recruit/hire psychiatrist. Connect mental health/substance abuse resources. Peterson actively seeks contacts and connections with mental health/substance abuse resources. The hospital, through the Emergency Department, Care Coordination, and participating community contacts maintains a list of resources for patients or residents and adds or updates resources continuously to stay current. This list is housed on the PRMC Intranet. In addition, Peterson offers the meeting space and advertising for a mental health support group and the recent boost in advertising has led to growth for this group. Recently, Marketing initiated a meeting with New Hope Counseling Center to discuss the needs and opportunity to partner in an educational or lecture series to discuss the needs and opportunity to discuss the mental health needs of our community. Mental health and counseling organizations like New Hope will be included in upcoming educational lectures in order to share materials and resources and answer questions posed by attendees or the general public. As more mental health providers and mental health resources or agencies are contacted, Peterson will consider the opportunity for a mental health summit in 2014.

## Aging Issues

Several education offerings are geared specifically toward our older population including the 'Remarkable Women,' 'The Men's Event,' 'Know Your Stats,' 'Advanced Directives,' 'End of Life Journey,' and 'Have the Conversation' are all great examples of topics/workshops tailored for seniors. Peterson also took the lead in creating a new medical lecture series for residents of Comanche Trace addressing a number of topics, primarily addressing the older population, as well as hosting a community-wide Coalition on Aging at the hospital twice this past year. With great excitement, the Marketing Department and Peterson Hospice will offer a new luncheon series working with the Dietert Staff to discuss topics identified by our older population as important to the community. The series will start in March of 2014 through July 2014. Peterson Regional Medical Center is making progress addressing the unmet healthcare needs of our community and will continue toward meeting the goals outlined in the CHNA and improving the healthcare needs of our community.

# Community Assets and Resources

## Community Asset Inventory



*Photo Credit: Peterson Regional Medical Center*

A separate document that includes list of community assets and resources that can help improve the health of the community and assist with implementation of the plan accompanies this document.

The focus group and interviews also identified community resources to improve health, which are listed on pages 17 above.

## Peterson Regional Medical Center's Selected Initiatives and Implementation Plan 2016

### PRMC Implementation Plan

To successfully make our community healthier, it was necessary to have a collaborative venture which brought together all of the care providers, citizens, government, schools, churches, not-for-profit organizations, and business and industry around an effective plan of action. PRMC selected key elements of the assessment to address, as set forth in the Implementation Plan, and encouraged other organizations in the community to do the same.

Based on the results of this CHNA, PRMC selected three (3) of the identified significant health needs to address.

1. Mental Health/Substance Abuse
2. Chronic Diseases
3. Access to Healthcare

PRMC will monitor the progress through the Hospital's Executive Team and will annually report the progress to their Board and the community.

The Peterson Regional Medical Center board of directors approved this assessment and the hospital's implementation plan on November 22, 2016.

Community input into the 2016 implementation plan will be received at various public forum events planned throughout the year. Where possible the implementation plan will be altered/updated to reflect this input.

# Community Health Needs Assessment

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*completed by Peterson Regional Medical Center in partnership with:*

Stratasan

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