Photo Credit: Kerrvilletx.gov

2025-2028

Community Health Needs Assessment

Kerr County, TX

Peterson Regional Medical Center

PETERSON HEALTH

Paper copies of this document may be obtained at: Peterson Health
551 Hill Country Drive, Kerrville, TX 78028 or by phone 830.896.4200 or via the hospital website. PetersonHealth.com

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Perspective / Overview

About Peterson Health and Peterson Regional Medical Center

Peterson Health is an independent, nonprofit healthcare organization comprised of 18 rooftops serving Kerrville and nine surrounding counties in the Texas Hill Country. Our daily operations, personal interactions, and strategic initiatives are driven by our Mission, Vision, and Values with the core competency of elevating health.

Our Mission

Exceptional, Compassionate, Patient-Centered Care

Our Vision

World-Class Care –
Today, Tomorrow, Always

Our Values

Caring, Accountability, Learning, Leadership, Integrity, Nurturing, Going the Extra Mile

Peterson Health is more than just a hospital. We are an independent, nonprofit healthcare organization with 18 rooftops spanning nine counties. We offer extensive health care through a robust network of providers, state-of-the-art facilities, and a growing regional footprint.

Supported by more than 100 volunteers and the strong belief and commitment of our hospital and foundation boards, Peterson Health continues to grow, thrive, and advance. As we continually work to improve the health and wellness of our regional residents, Peterson Health is always searching for more ways to take the health of our community to new heights. Offering big-city services in a small-town setting, Peterson takes great pride in providing the most comprehensive services in the region and featuring the highest level of technology and resources to ensure our residents can keep their health care close to home.

About Peterson Health

What started as a single hospital in 1949 has expanded to 18 rooftops spanning nine counties, each united with a singular purpose to elevate the health of our community. Peterson Regional Medical Center, our flagship hospital, is a 124-bed, nonprofit hospital located in Kerrville. This hub of our health network began a legacy of exceptional, compassionate, patient-centered care – forming the foundation of Peterson's vision to offer world-class care, today, tomorrow, and always.

The Peterson Health Team

As the largest employer in Kerr County, we are home to more than 1,300 full-time employees and 300+ medical professionals. We are thankful for the dedication of individuals who see healthcare as their calling. Their efforts have not gone unnoticed both here at home and on a national scale. Named Best Places to Work by Modern Healthcare four years in a row is a testament to the environment we've created for our team.

Dedicated to Patient Experience and Quality

Elevating Health is our commitment, and that dedication has earned many regional and national awards, including the highest distinction as a Top Rural Hospital in 2023 by The Leapfrog Group. This honor elevated Peterson Health's status in the healthcare arena on a national scale, serving as a benchmark for other rural hospitals as they strive to navigate the future of healthcare.

Although proud of numerous awards and accolades, we never lose focus on the real mission to provide the best patient experience and quality outcomes across all services.

Our Services and Locations

The Peterson Health Campus in Kerrville is home to Peterson Regional Medical Center, Peterson Health Surgery Center, Pevehouse Ambulatory Care Center, Cailloux Professional Building, and Peterson Hospice and Home Care.

Our main hospital, Peterson Regional Medical Center, offers 26 key service lines, including the Emergency Department, Acute Rehabilitation Unit, The Baby Place (Texas Ten Step designated maternity unit), Women's Services, Intensive Care Unit, Heart and Vascular Clinic, seven surgical suites, and an award-winning joint replacement program, "Back to Life."

In June of 2024, we opened the doors to the new Amanda and J. David Williams Surgery Center. This state-of-the-art facility boasts four operating rooms, four endoscopy suites, and a procedure room, doubling previous capacity for outpatient surgery procedures.

The Pevehouse Ambulatory Care Center offers outpatient radiology, imaging, labs, outpatient rehabilitation, and an advanced Wound Healing Center featuring two hyperbaric oxygen chambers.

Peterson's roster of facilities includes Peterson Hospice and Home Care, Peterson Medical Associates, Peterson Women's Associates, Peterson Health Medical Plaza, Peterson Community Care, and Peterson Urgent Care.

Our footprint continues to expand in neighboring counties to include primary care clinics in Bandera, Comfort, and Fredericksburg, as well as an outpatient rehabilitation clinic in Comfort. We have no intention of stopping there and will continue to discover new opportunities to provide world-class care to the Texas Hill Country at large.

Creating a Culture of Health in the Community

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

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

2025 Community Health Needs Assessment

Collaborators

Peterson Regional Medical Center, as the sponsors of the assessment, engaged national leaders in community health needs assessments to assist in the project. StrategyHealth, a healthcare consultancy based out of Nashville, Tennessee, provided analysis of community health data, facilitated the focus groups, 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.

Making the CHNA Widely Available to the Public

Starting on **July 30, 2025**, this report is made widely available to the community via Peterson Regional Medical Center's website PetersonHealth.com or at the hospital 551 Hill Country Drive, Kerrville, TX 78028 or by phone 830.896.4200.

Board Approvals

- Peterson Health, the parent of Peterson Regional Medical Center, board of directors approved this assessment on **June 24, 2025**.

Key Findings

Significant Health Priorities

Based on the previous CHNA priorities, Health Department priorities, secondary data, and focus groups, the summit participants prioritized the following significant health needs to be the focus of the work of community over the next three years. There is a complete summary of findings with prioritization criteria on page 32.

- Mental health services
- Living wages and cost of living
- Attainable housing
- Knowledge of and awareness of resources
- Substance use disorder
- Lack of activities for kids/youth
- Access to care
- Childcare
- Issues of aging
- Access to insurance

Community Input and Collaboration

Methods and Timeline

In February 2025, 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 through April 2025.
- Twenty eight community members and stakeholders participated in focus groups for their perspectives on community health needs and issues on April 17, 2025.

- A Community Health Summit was conducted on May 22, 2025, with community stakeholders. The audience consisted of healthcare providers, government representatives, schools, not-for-profit organizations, public safety, senior center, and other community members.

Participants by Those Representing the Broad Interests of the Community

Sixty individuals from thirty-nine community 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.

Participants

Organization	Population Represented	Involvement
Alchemy Cross Training + Wellness	All	Summit
BCFS HHS CSD	All	Summit
Center Point Schools	Youth	Focus Groups
Christian Women's Job Corps of Kerr County	Women	Focus Group, Summit
City of Kerrville	All	Focus Group, Summit
Dietert Center	Seniors	Focus Group, Summit
Doyle Center	Minorities	Focus Groups, Summit
DSHS Kerrville Field Office	TX Dept of State Health Services	Summit
Endeavors	Mental health	Summit
Hill Country CASA	Children/youth	Focus Group, Summit
Hill Country Christian Counseling Center New Hope Counseling Center	Mental health	Focus Group, Summit
Hill Country Council on Alcohol & Drug Abuse	Alcohol & drugs	Summit
Hill Country Crisis Council	Violence/sexual assault	Focus Group, Summit
Hill Country MHDD Centers	Mental health	Summit
Hill Country Veterans Center	Veterans	Focus Groups
Home Health/Hospice/Providers at Home	All	Focus Group, Summit
Ingram Schools	Youth	Focus Groups
Kerrville Area Chamber of Commerce	Businesses	Summit
Kerrville Fire Department	All	Focus Groups
Kerrville Government	All	Focus Groups
Kerrville Police Department	All	Focus Groups, Summit
Kerrville Schools	Youth	Focus Groups
Kerrville Welcome Lady	Newcomers	Focus Groups
KROC Center	All	Focus Groups, Summit
Light on the Hill	All	Summit

Mercy Gate Ministries	All	Summit
Methodist Healthcare Ministries	All	Summit
Peterson Health	All	Summit
Peterson Health Patient/ Family Advisory Council	Patients, families	Focus Groups
Peterson Medical Associates	All	Summit
Peterson Health Board of Directors	All	Focus Group, Summit
Rep. Chip Roy, TX-21	All	Summit
SACADA	Alcohol & Drugs	Summit
SALT Wellness & Sports Recovery	All	Summit
Schreiner University	Young adults	Focus Group, Summit
SJRC Texas Belong	Abuse and neglect	Summit
The Center for Fitness and Big Brothers Big Sisters	Youth	Summit
Young Life	Youth	Focus Groups

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 though the focus groups, community survey, and the community health summit. Agencies representing these population groups were intentionally invited to the focus groups and summit.

Input of Those with Expertise in Public Health

The Kerr County Health Department was a key participant serving on the steering committee, the data committee, attending the focus group, and the summit. They were involved in creating the community needs list and prioritizing the most significant community needs.

Input on the Most Recently Conducted CHNA and Most Recently Adopted Implementation Strategy

Peterson Regional Medical Center did not receive any written comments on its most recent CHNA or implementation strategy.

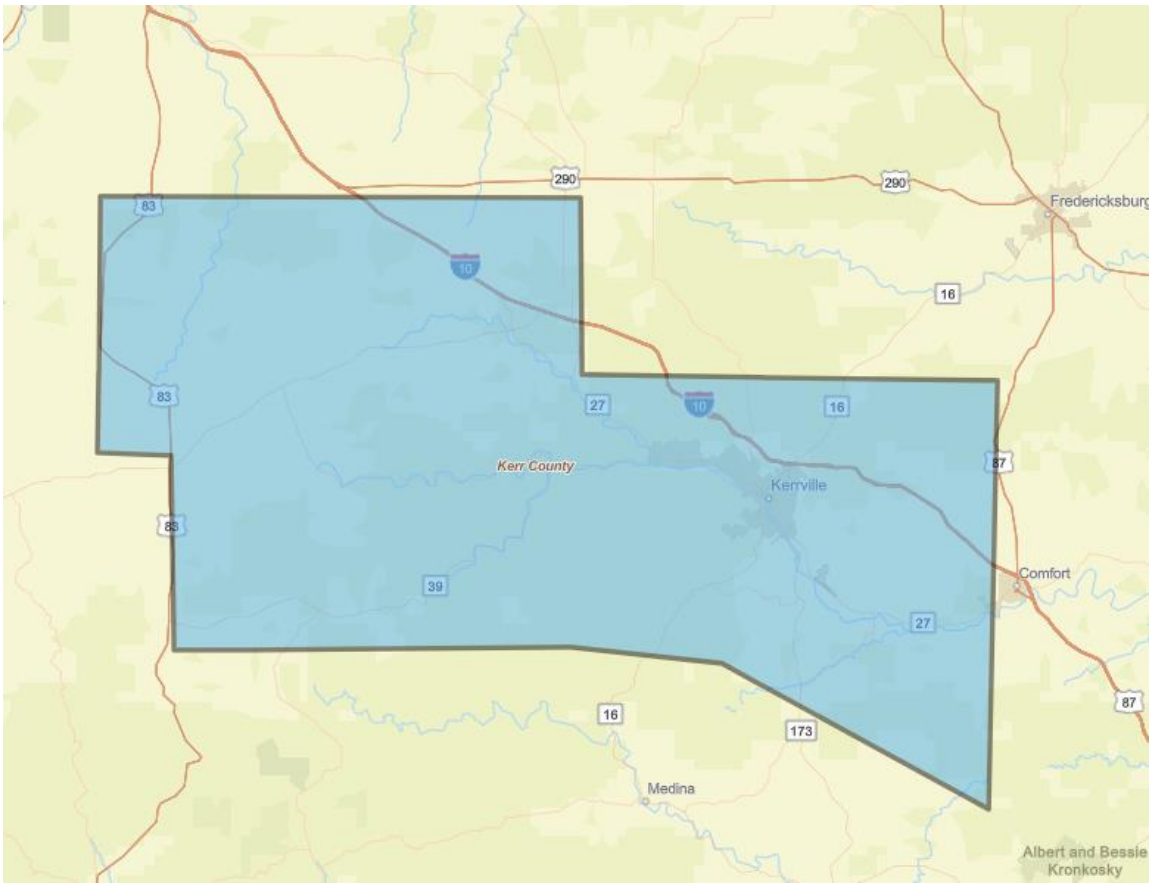
Process and Methods Used

Community Selected for Assessment

Kerr County was the primary focus of the CHNA due to the service area of Peterson Regional Medical Center. Used as the study area, Kerr County provided 57% of January 1, 2024, through December 31, 2024, 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 its 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.

CHNA Study Area – 2025



Data and Other Information Used in the Assessment

Primary methods included:

- Focus groups with community members and stakeholders
- Community Health Summit

Secondary methods included:

- Public health data – death statistics, County Health Rankings, cancer incidence
- Demographics and socioeconomics – population, poverty, uninsured, unemployment

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

Photo Credit: Peterson Regional Medical Center website

Description of the Communities Served

Demographics Indicators

The following tables and graphs summarize the demographics of Kerr County compared to TX and the U.S.

	Kerr Co.	TX	USA
Population 2024	54,066	30,857,478	338,440,954
Population 2029	55,103	32,581,174	344,873,411
% Population Change 2024-2029	1.9%	5.6%	1.9%
Percent of Population below 18	16.8%	23.9%	21.0%
Percent of Population 18-64	51.0%	61.8%	60.8%
Percent of Population 65+	32.2%	14.5%	18.1%
Racial and Ethnic Make-up			
Non-Hispanic White	66.6%	38.1%	56.3%
Non-Hispanic Black	1.4%	12.0%	12.1%
Non-Hispanic Asian	1.2%	5.8%	6.3%
Native American/Alaska Native	0.3%	0.3%	0.7%
Pacific Islander	0.1%	0.1%	0.2%
Two or More Races	2.0%	3.2%	4.3%
Other Race	0.3%	0.4%	0.5%
Hispanic Origin	27.0%	40.2%	19.6%

Source: Esri

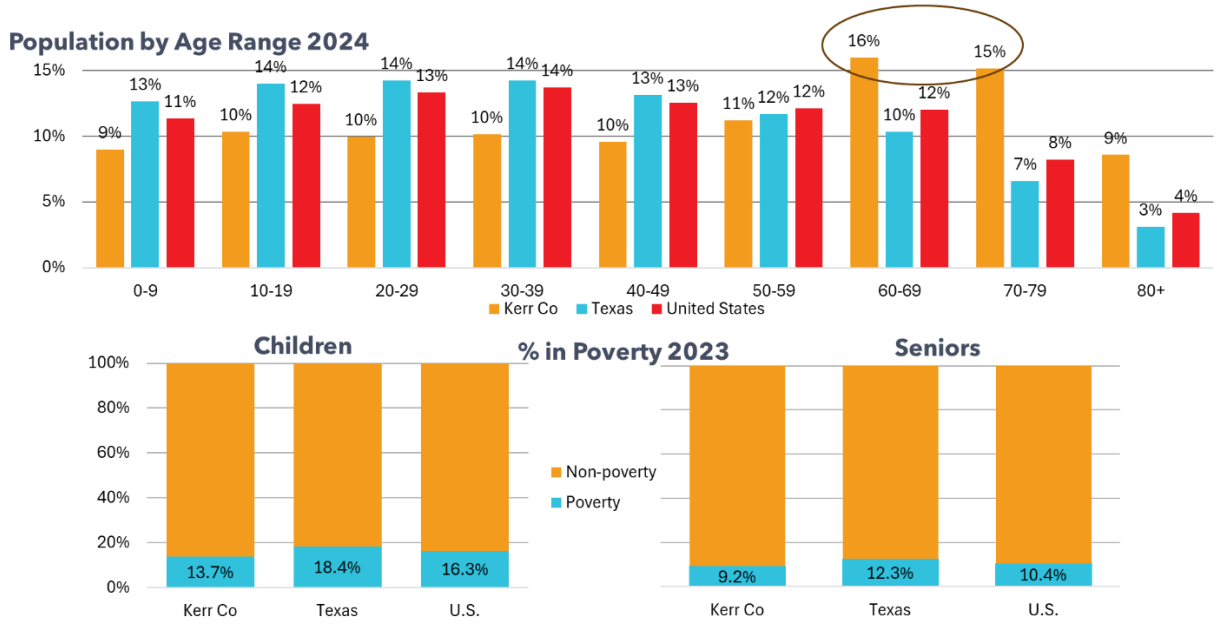
The median is the value at the midpoint of a frequency. There is an equal probability of falling above or below the median.

Socioeconomic Indicators

	Kerr Co.	TX	USA
Median Age 2024	51.0	36.0	39.1
Median Household Income 2024	$70,792	$77,169	$75,149
Percent with Incomes Below the Federal Poverty Guideline	12.0%	13.7%	11.5%
Percent of Asset Limited, Income Constrained, Employed (ALICE) HH	28%	29%	29%
Percentage speaking a language other than English	13.7%	34.9%	21.7%
% of Income for Mortgage	26.3%	24.0%	25.6%
Population Receiving SNAP Benefits 2022	7.6%	11.0%	12.5%
Percent Unemployed – 2024	3.7%	3.9%	3.5%
Percent Uninsured	12.1%	12%	10%
Percent with a Disability <age 65	10.4%	8.4%	8.9%

Source: Esri, Census Bureau, United Way

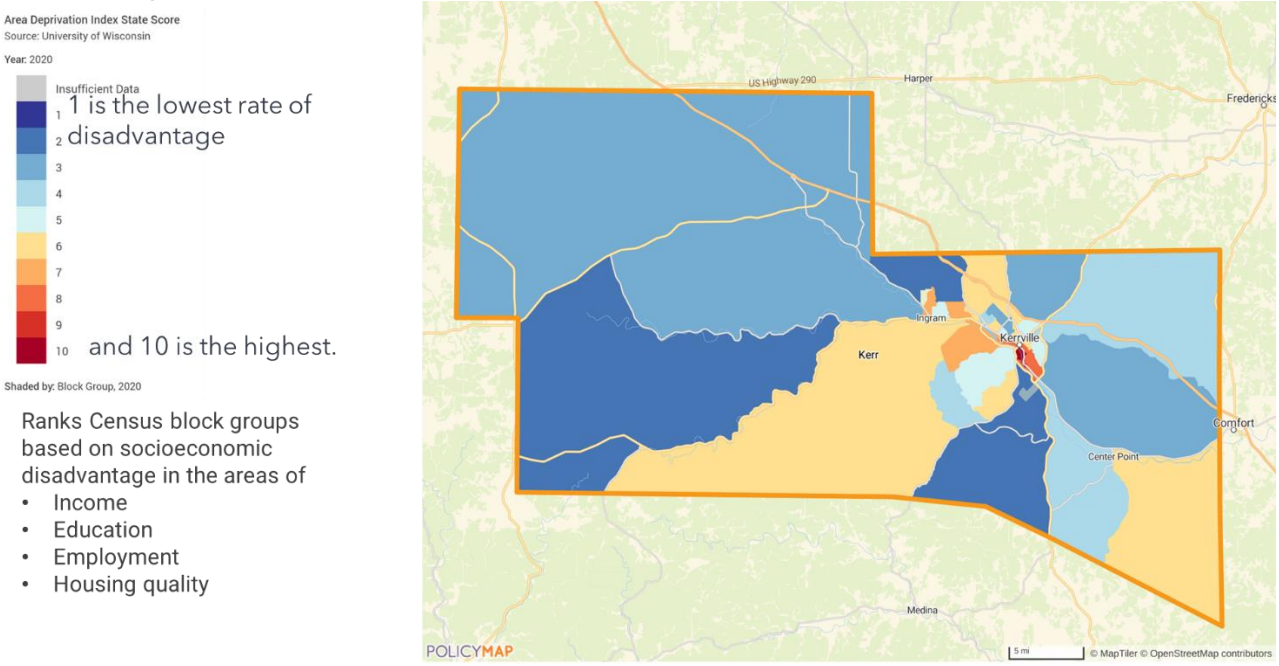
- Kerr County's population in 2024 was 54,066.
- The population of Kerr County is projected to increase 1.9% from 2024 to 2029. Texas is projected to increase 5.6%. The U.S. is projected to increase 1.9%.
- Kerr County had a higher median age (51 median age) than TX (36.0) and the U.S. (39.1). In Kerr County the percentage of the population 65 and over was 32.2%, higher than TX and the U.S. population 65 and over at 14.5% and 18.1% respectively.
- Kerr County median household income at $70,792 was lower than TX ($77,169) and the U.S. ($75,149).
- The rate of poverty in Kerr County was 12.0% which was lower than TX (13.7%) but higher than the U.S. (11.5%). The percent of asset limited, income constrained, and employed (ALICE) households in Kerr County was 28%, which was less than TX and the U.S. at 29%.
- The household income distribution of Kerr County was 33.4% higher income (over $100,000), 46.7% middle income, and 19.9% lower income (under $35,000).
- The racial and ethnic make-up of Kerr County was 66.6% Non-Hispanic White, 1.4% Non-Hispanic Black, 27% Hispanic origin, 2% more than one race, .7% other.
- Kerr County's 2024 unemployment was 3.7% compared to 3.9% for Texas and 3.5% for the U.S.
- 7.6% of Kerr County received SNAP benefits compared to 11% of Texas and 12.5% for the U.S. in 2022.



Source: Esri, ACS 2023 1-year estimates

Area Deprivation Index (by block group)

The area deprivation index is based on socioeconomic disadvantage in the areas of income, education, employment and housing quality. The block groups in the red are the most disadvantaged and would be a priority location for health improvement activities.



Business Profile

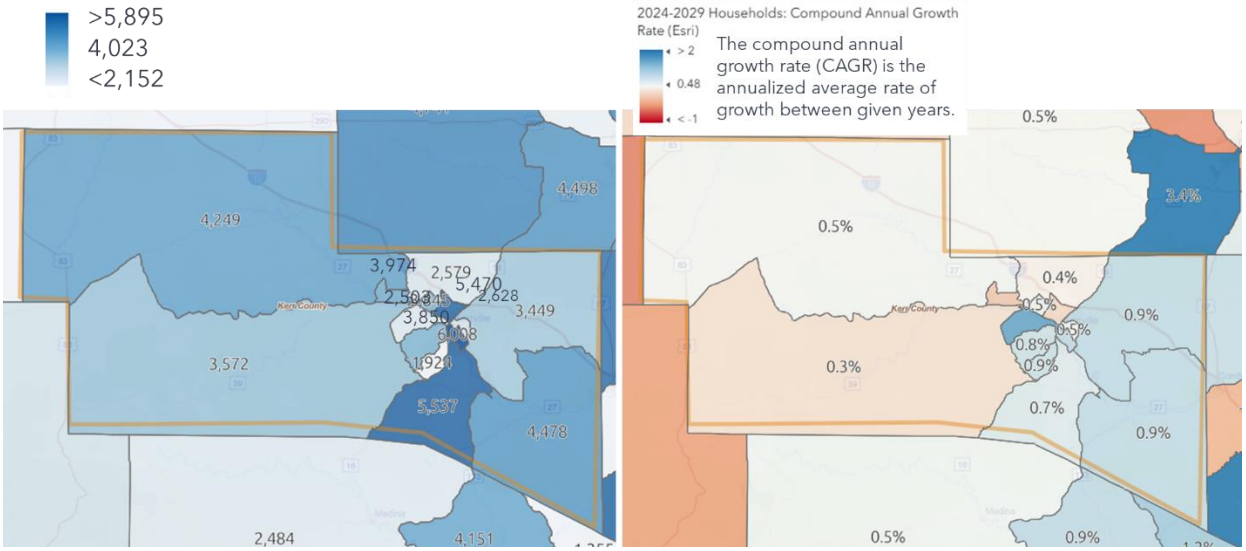
57% percent of employees in Kerr County were employed in:

- Education, Health Care & Social Assistance (16.2%)
- Retail trade (12.9%)
- Construction (10.4%)
- Accommodation and food services (8.9%)
- Education (8.1%)

Source: ACS, 2023

Retail, accommodation, and food service offer health insurance at a lower rate than healthcare and educational services.

2024 Population by Census Tract and Population Change (2020-2024)

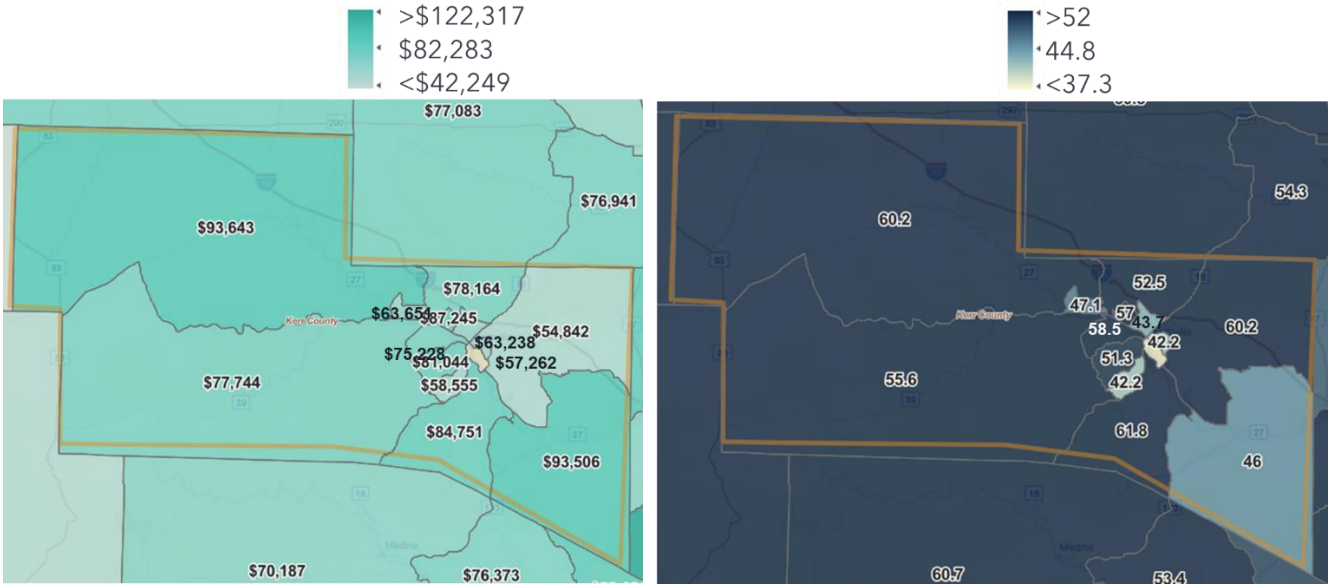


Source: Esri

Census tracts generally have a population size between 1,200 and 8,000 people, with an optimum size of 4,000 people. The higher populated census tracts are smaller geographically and the less populated census tracts are larger in geography. This can be seen by looking at the western census tracts in Kerr County with 4,249 and 3,572 population compared to the much smaller census tracts in and around Kerrville with similar population numbers.

Kerr County census tracts are projected to grow ranging from .3% to 2% per year.

2024 Median Household Income and Age



Source: Esri

The two maps depict median household income and median age by census tract. Looking at age and income by census tract is helpful to demonstrate all areas of a county are not the same and will therefore have differing health needs. The health needs may be very different in the dark blue census tracts with higher median ages (51.3 to 61.8) than the tracts closer to Kerrville with a median ages of 42.

Looking at median household income by census tract also gives insight into health status. The lower income areas may have compromised health status compared to the higher income tracts. The census tract southeast and northwest of Kerrville with higher median household incomes of $93,506 and $93,643 will probably have different needs than the tracts in Kerrville making $57,262 median household income.

Focus Groups Summary

Twenty five community stakeholders representing the broad interests of the community as well as those representing low income, medically underserved, and minority populations participated in focus groups on April 17, 2025, for their input into the community's health. Community participation in focus groups represented a broad range of interests and backgrounds. Below is a summary of the focus groups.

Health is on a spectrum based on income and education, socioeconomics.

The participants defined health physical, mental, emotional, social, spiritual and financial health, quality of life, and overall wellbeing. They believe health status is poor or on a spectrum based on socioeconomic status and education.

The most significant health issues for the communities were:

- Mental health
- Access to care and insurance
- Healthy eating and active living
- Substance use disorder
- Lack of reliable transportation
- Knowledge/awareness of resources
- Incomes and cost of living
- Chronic diseases
- Issues of aging

There is a lack of affordable insurance and many high deductible plans.

If given a magic wand and no resource restrictions, the participants selected the following solutions to improve health.

- Increase access to care
- Improve mental health facilities, resources and reduce stigma
- Improve and increase health information and communication
- Add activities for kids
- Improve services for seniors
- Add transportation
- Improve nutrition
- Add affordable housing
- Improve quality of care
- Improve coordination of resources
- Create water

Photo Credit: Peterson Regional Medical Center

Health Status Data and Comparisons

Health Status Data

The 2025 County Health Rankings study performed by the Robert Wood Johnson Foundation and the University of Wisconsin[2], analyzes community conditions such as health infrastructure, physical environment and social and economic factors and how they contribute to health outcomes or population health and well-being measured by length and quality of life. To become the healthiest community in TX and eventually the nation, Kerr County must close several community condition gaps.

County Health Rankings suggested the areas to explore for improvement in Kerr County were:

- High uninsured

The strengths were:

- Lower population to primary care physician *(this County Health Ranking finding was disputed by the HRSA data on page 28, and the focus groups)*
- Lower preventable hospital stays
- Higher high school completion

When analyzing the health status data, county results were compared to TX, the U.S., and the top 10% of counties in the U.S. (the 90th percentile) (where available). For additional perspective, TX was ranked the 40th healthiest state out of the 50 states. (Source: 2024 America's Health Rankings; lower is better) TX challenges were:

- Low prevalence of high school completion
- Low number of primary care providers per 100,000 population
- High insured rate

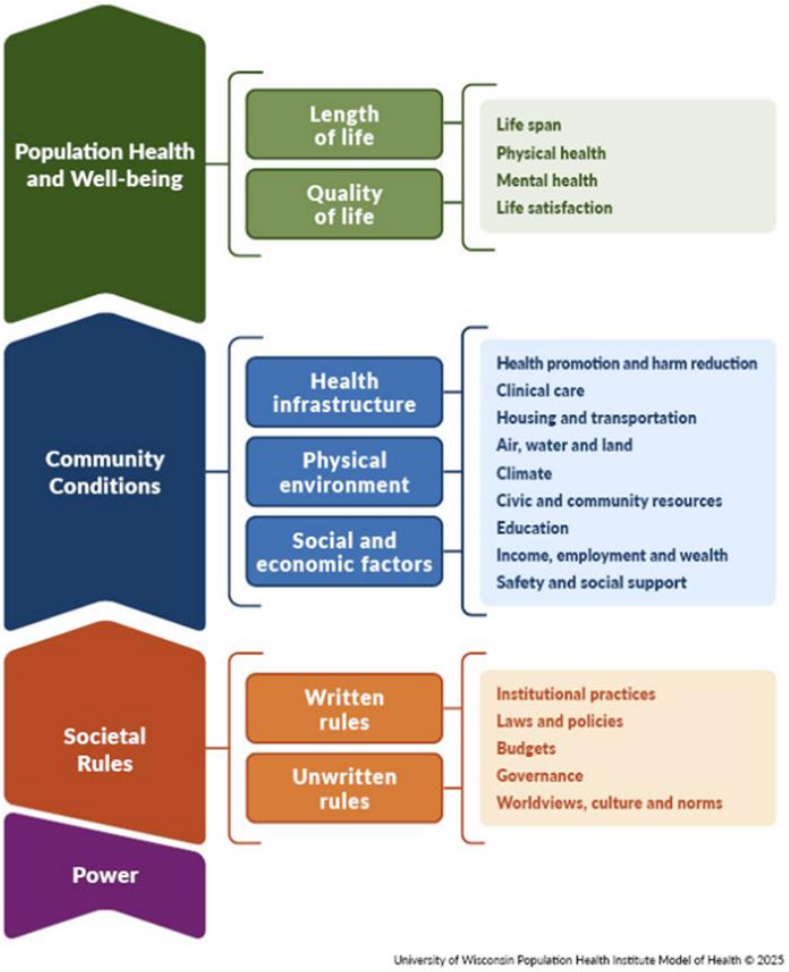
The strengths were:

- Low prevalence of multiple chronic conditions
- Low prevalence of cigarette smoking
- High prevalence of adults meeting the federal physical activity guidelines

Information from County Health Rankings and America's Health Rankings was analyzed in the CHNA in addition to the previously reviewed sociodemographic information and other public health data. Other data analyzed is referenced in the data below, such as causes of death, demographics, socioeconomics, and primary research. If a measure was better than TX, it was identified as a strength, and where an indicator was worse than TX, it was indicated as an opportunity for improvement. To prevent strengths from becoming opportunities for improvement, it's important to continually focus on them.

[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 measure the health of Texas's counties every year since 2003.*

Although not all of the health status data was derived from County Health Rankings, the data is organized using the following model focusing on community conditions such as health infrastructure, physical environment, and social and economic factors and their contribution to population health and well-being which is measured by length and quality of life.



Rankings and Comparisons of Health Status

The following tables compare Kerr County to the TX and the U.S. for health outcomes and community conditions. The trend column indicates whether the trend is increasing or decreasing, green indicates improvement, red indicates decline. If the trend cell is empty, there is no change over the last four years or the data was a point in time. Trended graphs are available in Appendix 3.

Health Outcomes (Length of Life and Qualify of Life)

Health Outcomes are a combination of length of life and quality of life measures. Health outcomes tell us how long people live on average within a community and how much physical and mental health people experience in a community while they are alive.

Indicators	Trend	County	TX	U.S.	Description
Length of Life					
Premature death		9,189	8,233	8,400	Years of potential life lost before age 75 per 100,000 population (age-adjusted). 2020-2022
Life expectancy		76.5	76.7	77.1	Average number of years people are expected to live. 2020-2022
Infant mortality		7.1	5.6	6.0	Number of infant deaths (within 1 year) per 1,000 live births. 2016-2022
Child mortality		68.4	52.9	50.0	Number of deaths among residents under age 20 per 100,000 population. 2019-2022
Quality of Life					
Physical Health					
Poor or fair health		21%	20%	17%	Percentage of adults reporting fair or poor health (age-adjusted). 2022
Poor physical health days		4.4	3.8	3.9	Average number of physically unhealthy days reported in past 30 days (age-adjusted). 2022
Frequent physical distress		13%	12%	12%	Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted). 2022
Low birth weight babies		9%	9%	8%	Percentage of live births with low birth weight (< 2,500 grams or 5lbs 8oz) 2017-2023
Diabetes prevalence		12.0%	13.3%	10%	Percentage of adults aged 20 and above with diagnosed diabetes (age-adjusted). 2022
Adult obesity		35%	36%	34%	Percentage of the adult population (age 18 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2 (age-adjusted). 2022
HIV prevalence		137.7	425.2	387	Number of people aged 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population. 2022

Cancer incidence		447.1	457.3	444.4	Incidence rates (cases per 100,000 population per year) age-adjusted. 2017-2021
Sexually transmitted infections		201	538.1	495.0	Number of newly diagnosed chlamydia cases per 100,000 population. 2022
Mental Health					
Poor mental health days		6.0	5.1	5.1	Average number of mentally unhealthy days reported in past 30 days (age-adjusted). 2022
Frequent mental distress		19%	16%	16%	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted). 2022
Suicide rate		24.0	13.8	14.0	Number of deaths due to suicide per 100,000 population (age-adjusted). 2018-2022
Feelings of loneliness		35%	34%	33%	Percentage of adults reporting that they always, usually or sometimes feel lonely. 2022

Community Conditions

Community conditions include the social and economic factors, physical environment and health infrastructure in which people are born, live, learn, work, play, worship and age. Community conditions are also referred to as the social determinants of health. (County Health Rankings, 2025)

Indicators	Trend	County	TX	U.S.	Description
Health Infrastructure					
Substance Misuse					
Excessive drinking		21%	19%	19%	Percentage of adults reporting binge or heavy drinking (age-adjusted). 2022
Adult smoking		16%	12%	13%	Percentage of adults who are current smokers (age-adjusted). 2022
Alcohol impaired driving deaths		33%	25%	26%	Percentage of driving deaths with alcohol involvement. 2018-2022
Drug overdose deaths		31	16.5	12	Number of drug poisoning deaths per 100,000 population. 2020-2022
Healthy Eating/Active Living					
Physical inactivity		28%	25%	23%	Percentage of adults age 18 and over reporting no leisure-time physical activity (age-adjusted). 2022
Access to exercise opportunities		62%	82%	84%	Percentage of population with adequate access to locations for physical activity. 2024, 2022 & 2020
Food environment index		7.3	5.7	7.4	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best). 2019 & 2022

Food insecurity		17%	16%	14%	Percentage of population who lack adequate access to food. 2022
Limited access to healthy foods		5%	8%	6%	Percentage of population who are low-income and do not live close to a grocery store. 2019
Insufficient sleep		39%	37%	37%	Percentage of adults who report fewer than 7 hours of sleep on average (age-adjusted). 2022
Access to Care					
Primary care physicians		1,236	1,657	1,330	Ratio of population to primary care physicians. 2021
Dentists		1,378	1,590	1,360	Ratio of population to dentists.2022
Mental health providers		295	590	300	Ratio of population to mental health providers. 2024
Other primary care providers		749	871	710	Ratio of population to primary care providers other than physicians. 2024
Uninsured		19%	19%	10%	Percentage of population under age 65 without health insurance. 2022
Uninsured children		13%	11%	5%	Percentage of children under age 19 without health insurance. 2022
Uninsured adults		21%	22%	11%	Percentage of adults under age 65 without health insurance. 2022
Prevention					
Mammography screening		50%	41%	44%	Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening. 2022
Flu vaccines		45%	45%	48%	Percentage of fee-for-service (FFS) Medicare enrollees who had an annual flu vaccination. 2022
Preventable hospital stays		1,897	2,968	2,666	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. 2022
COVID vaccines		52.6%	63.5%	70%	Percentage of fully vaccinated recipients. May 2023
Teen births		24	23	16	Number of births per 1,000 female population ages 15-19. 2017-2023
Physical Environment					
Drinking water violations		Yes	Yes	Yes	Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation. 2023
Air pollution particulate matter		7.7	8.1	7.3	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5). 2020
Broadband access		90%	90%	90%	Percentage of households with broadband internet connection. 2019-2023
Childcare centers		4.9	4.9	7	Number of child care centers per 1,000 population under 5 years old. 2010-2022

Long commute-driving alone		22%	39%	37%	Among workers who commute in their car alone, the percentage that commute more than 30 minutes. 2019-2023
Access to parks		44%	46%	51%	Percentage of the population living within a half mile of a park. 2024 & 2020
Library access		3	1	2	Library visits per person living within the library service area per year. 2022
Housing					
Severe housing cost burden		13%	15%	15%	Percentage of households that spend 50% or more of their household income on housing. 2019-2023
Severe housing problems		14%	18%	17%	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. 2017-2021
Home ownership		70%	63%	65%	Percentage of owner-occupied housing units. 2019-2023
Social & Economic Factors					
Economic Stability					
Median HH income		$70,792	$77,169	$75,149	The income where half of households earn more, and half of households earn less. 2024
Unemployment		3.7%	3.9%	3.5%	Percentage of population ages 16 and older unemployed but seeking work. 2024
Poverty		12.0%	13.7%	11.5%	Percentage of population living below the federal poverty line. 2023
ALICE HH		28%	29%	29%	Percentage of households who are asset limited, income constrained, employed. 2022
Children in poverty		19%	18%	16%	Percentage of people under age 18 in poverty. 2023 & 2019-2023
Seniors in poverty		9.2%	12.3%	10.4%	Percentage of people 65 and over in poverty. 2023
Income inequality		4.3	4.8	4.9	Ratio of household income at the 80th percentile to income at the 20th percentile. 2019-2023 (lower is better)
Living wage		$40.06	$44.46		The hourly wage needed to cover basic household expenses plus all relevant taxes for a household of one adult and two children. 2024
Childcare cost burden		27%	25%	28%	Childcare costs for a household with 2 children as a percent of median household income. 2023, 2024
Educational Attainment					
3rd grade math scores		3.4	3.2	3.0	Average grade level performance for 3rd graders on math standardized tests. 2019
3rd grade reading level		3.0	2.9	3.1	Average grade level performance for 3rd graders on English Language Arts standardized tests. 2019

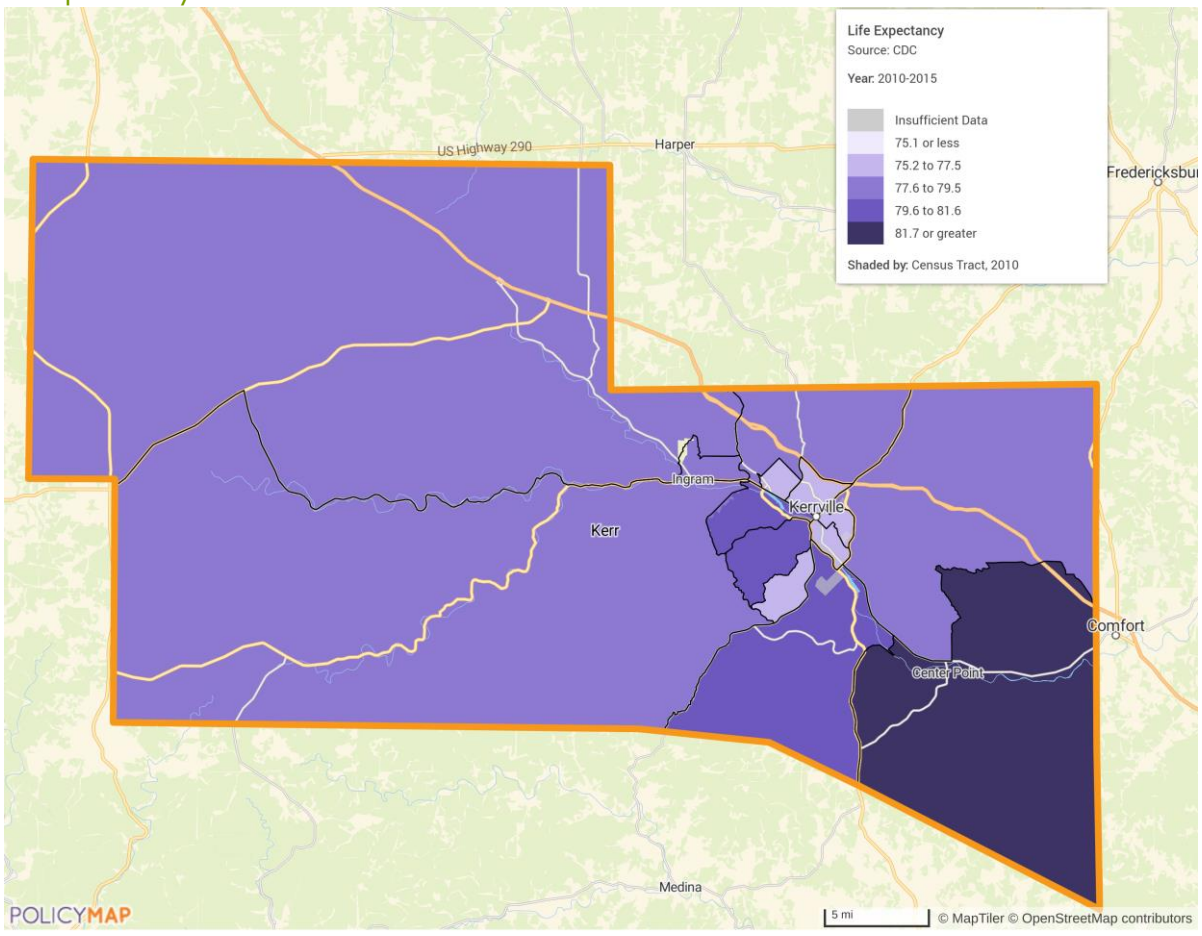
High school completion		90%	86%	89%	Percentage of adults ages 25 and over with a high school diploma or equivalent. 2019-2023
Some college		57%	65%	68%	Percentage of adults ages 25-44 with some post-secondary education. 2019-2023
Family & Social Engagement					
Children in single-parent HH		20%	27%	25%	Percentage of children that live in a household headed by a single parent. 2019-2023
Social associations		14.1	7.4	9.1	Number of membership associations per 10,000 population. 2022
Lack of social & emotional support		27%	29%	25%	Percentage of adults reporting that they sometimes, rarely, or never get the social and emotional support they need. 2022
Voter turnout		69.3%	60.9%	67.9%	Percentage of citizen population aged 18 or older who voted in the 2020 U.S. Presidential election. 2020 & 2016-2020
Census participation		61.4%		65.2%	Percentage of all households that self-responded to the 2020 census (by internet, paper questionnaire or telephone). 2020
Community Safety					
Homicide rate		4.3	6.5	7.0	Number of deaths due to homicide per 100,000 population. 2016-2022
Firearm fatalities		19.6	14.0	13.0	Number of deaths due to firearms per 100,000 population. 2018-2022
Motor vehicle crash deaths		16.8	13.8	12.0	Number of motor vehicle crash deaths per 100,000 population. 2016-2022
Injury deaths		93.3	66.2	84.0	Number of deaths due to injury per 100,000 population. 2018-2022

Mapping Analyses

The following maps show the significant differences in populations by census tract within the county. Much of the demographic and health status data is available by county and it is beneficial to see differences by geographic location to enact local solutions.

Life expectancy was different in several census tracts within the county. The darker the color the longer life expectancy. The census tract in the lower right corner (southeast corner) had a longer life expectancy than the census tracts around Kerrville. Where you live may affect your chances of living a long, healthy life. Different neighborhoods may have different access to stable housing, quality schools, good jobs, and affordable healthcare. Medical history is important, but much of health begins at home. (Robert Wood Johnson Foundation)

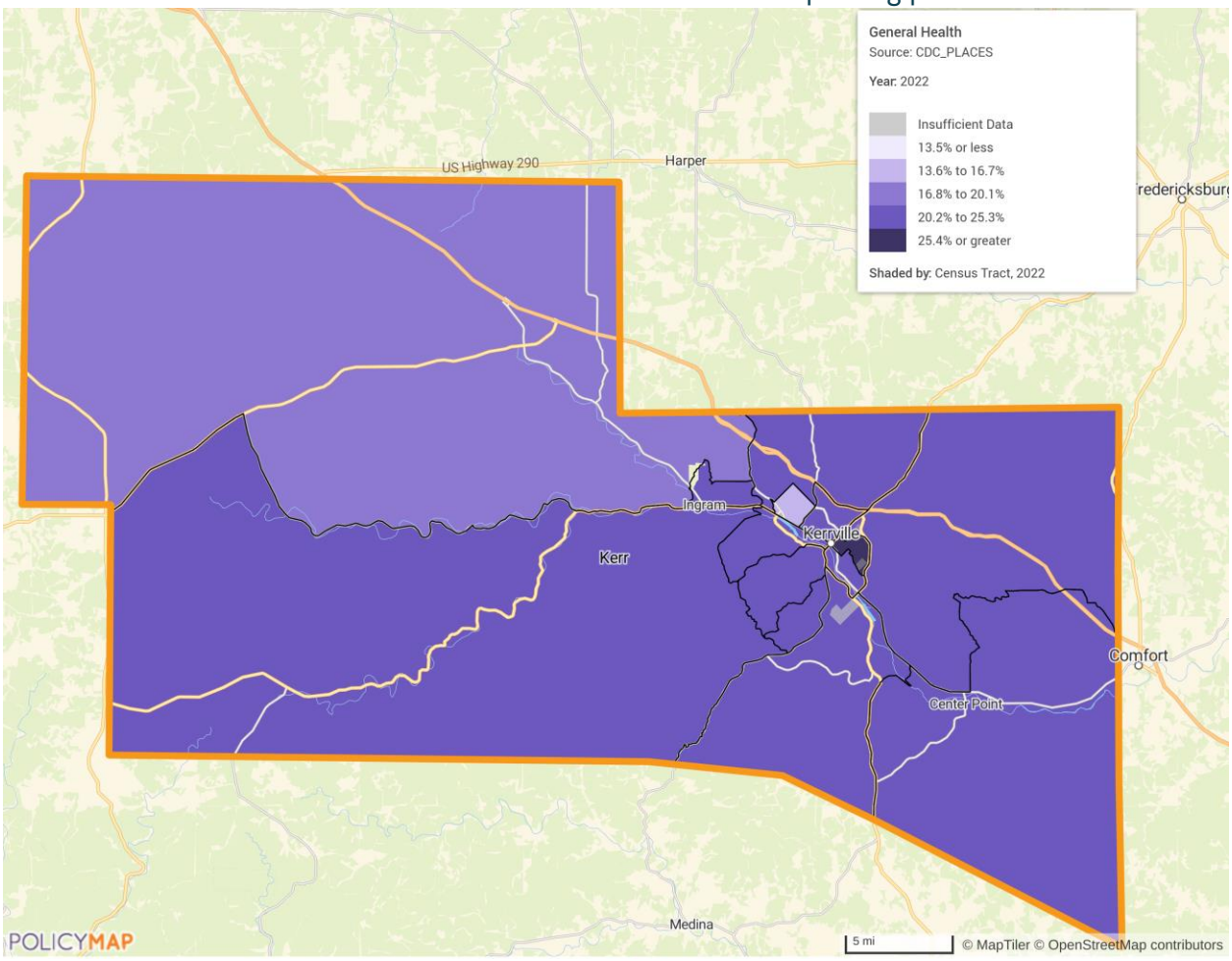
Life Expectancy at Birth



Source: CDC, Census Bureau, 2010-2015

Percentage in Fair or Poor Health (by census tract)

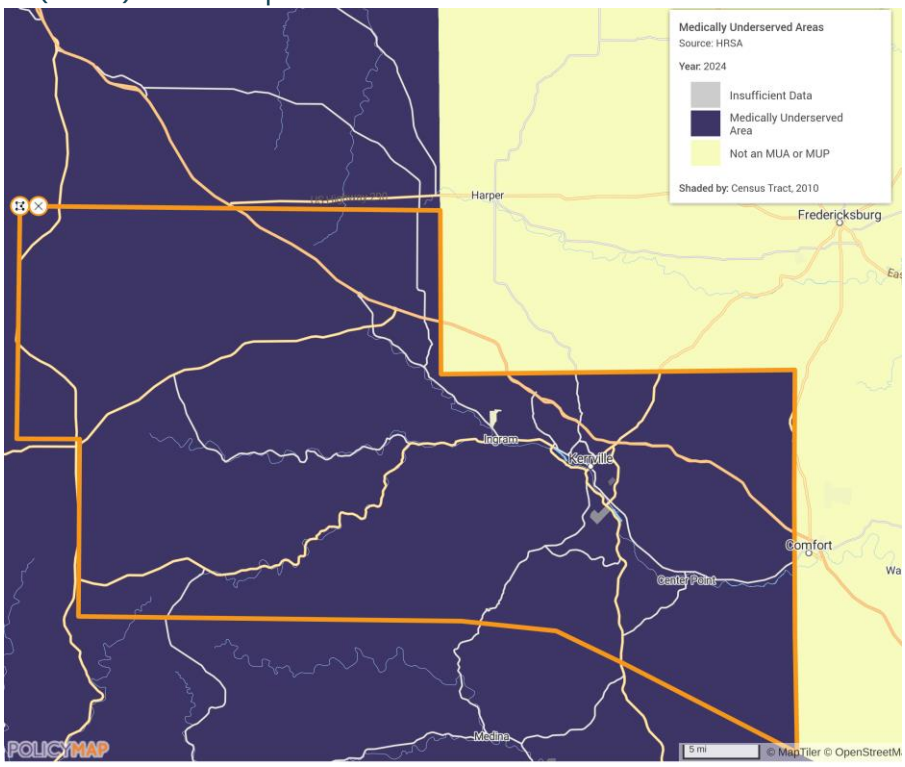
The darker the color the larger the percentage of adults self-reporting poor or fair health. There is a census tract east of Kerrville that has 25.4% poor or fair health. There is also a tract northwest of Kerrville that has 13.5% or less of adults reporting poor or fair health.



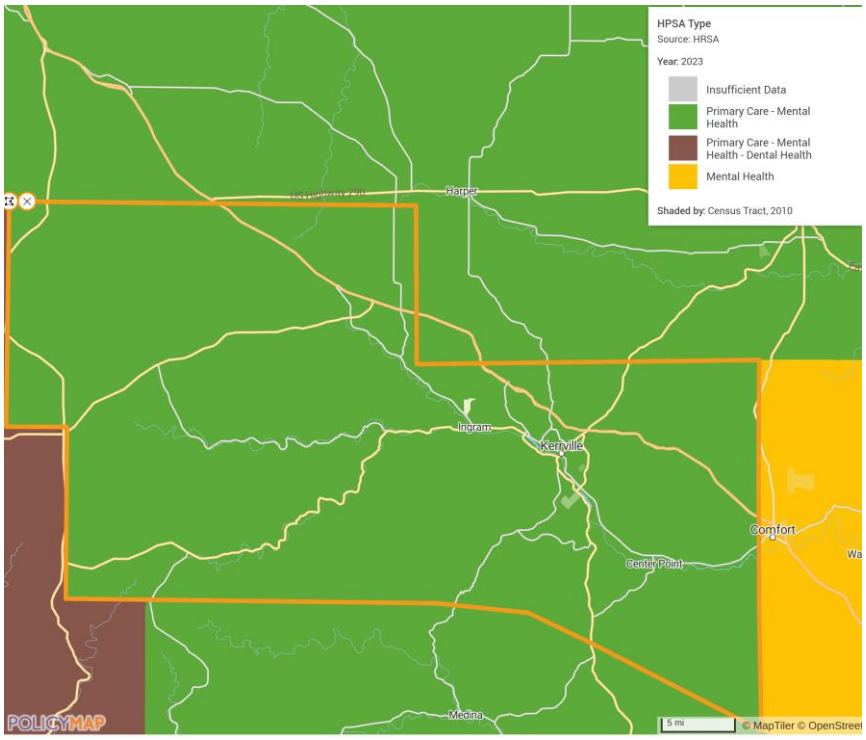
Source: CDC, Places, 2022

Medically Underserved and Health Professional Shortage Areas

Kerr County is a medically underserved area according to Health Resources and Services Administration (HRSA) of the Department of Health and Human Services.



Kerr County is also designated as a primary care and mental health shortage area by the same department.



Summary of Primary and Secondary Data – Most Significant Health Needs

The chart below summarizes the primary and secondary data revealing the significant health needs in the community. These needs were used to create the list the health summit participants used to prioritize the most significant health needs.

2022 Health Needs	Secondary Data	Focus Groups
Mental health	High uninsured	Mental health
Access to care & insurance		Access to care & insurance
Coordination of resources		Healthy eating/active living
Healthy eating/active living		Substance use disorder
Substance misuse		Knowledge/awareness of resources
Socioeconomic issues, social determinants of health		Issues of aging
Staffing shortages/work skills		Chronic diseases
		Incomes & cost of living
		Transportation
		Affordable housing
		Childcare
		Lack of activities for kids/youth
		Safety
		Developmental disorders

Photo Credit: Peterson Regional Medical Center Website

Results of the CHNA: Prioritized Health Needs

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	How big is the problem? How many individuals does the problem affect, either actually or potentially?
Seriousness of the Consequences	What would happen if the issue were not made a priority?
Equity	Does this affect one group more than others?
Feasibility	Is the problem preventable? How much change can be made? What is the community's capacity to address it?

Most Significant Community Health Needs – Prioritized

Based on the secondary data, and community focus groups using the criteria above, community stakeholders selected the following significant health needs in the counties. They voted using Mentimeter, selecting three priorities. The issues with the most votes are listed below with the number of votes received.

1. Mental health services (26)
2. Living wages and cost of living (17)
3. Attainable housing (13)
4. (tie) Knowledge of and awareness of resources (10)
4. (tie) Substance use disorder (10)
6. (tie) Lack of activities for kids/youth (7)
6. (tie) Access to healthcare (7)
7. (tie) Childcare (6)
7. (tie) Issues of aging (6)
10. Access to insurance (5)

Community Health Summit Brainstorming

Once the stakeholders prioritized the most significant health issues, the five table groups discussed what might be done to improve the top five health issues. The notes from the brainstorming are included in Appendix 1. We encourage other community organizations to use this list when deciding on projects and initiatives.

Impact of 2022 CHNA and Implementation Plan

Peterson Regional Medical Center engaged in numerous initiatives to help address the identified significant health needs from the CHNA that was conducted in 2022.

In 2022, Peterson Health selected five areas for its community health improvement plan:

1. Substance abuse/misuse
2. Affordable housing
3. Mental health
4. Diabetes
5. Improved education as it pertains to escaping poverty and improving health

Substance Abuse/Misuse

- Kerrville Recovery Community Coalition was tasked with creation and distribution of a Community Resource Guide to direct those who need access to substance abuse and mental health resources.
- Peterson Health led monthly smoking cessation classes providing education and resources to quit smoking.

Affordable Housing

- Peterson CEO participated in a task force of local government and community leaders to identify solutions for the lack of affordable housing, resulting in the planning and construction of new housing and apartment complexes.

Mental Health

- Through the Kerr County Mental Health Coalition, under the direction of the local MHDD created the Rural Communities Opioid Response Program and conducted a needs assessment to determine how to best support the community. This resulted in improved collaboration among PH, MHDD, local law enforcement, and area non-profits. Gaps identified include:
  - Opioid education to reduce opioid prescription rates
  - How to close funding gaps created by the reduction in state funding
  - Prescriber education to better comply with the state's Prescription Monitoring Program
- Organized support groups for caregivers supporting family members with chronic conditions and those suffering grief from loss of a loved one.
- Deployed the XFER+ALL app-based tool in our emergency department. This tool helps us identify psychiatric facilities with bed capacity to support psychiatric patients who present for emergency services and need facility placement.

Diabetes

- In collaboration with the Doyle Community Center, provided diabetic education for patients and caregivers and diabetes screening clinics.
- Provide access to our diabetic educator and dietician to develop personalized plans for improved diet and outcomes for diabetic patients.

Improve Education to Escape Poverty and Improve Health

- To better track and understand social determinants of health, developed and implemented new patient screening questions via our electronic medical record.
- Conducted monthly community education at area senior centers, churches, and community centers across a broad array of health care topics.
- Organized community support groups for breastfeeding mothers, caregivers, and Parkinson's and stroke patients.

Photo Credit: Theresa Dimenno, Texas Highways

Appendices

1. Health Summit Brainstorming
2. Focus Group Summary
3. Health Status Trended Data
4. Community Asset Inventory

1. Community Health Summit Brainstorming

Once the stakeholders prioritized the most significant health issues, the five table groups discussed what might be done to improve the top five health issues. Below are notes from the brainstorming. We encourage other community organizations to use this list when deciding on projects and initiatives.

Significant Health Need 1: Mental Health

Goal 1: Provide access to immediate care for 24-to-48-hour acute care.

Action 1 – Create a facility for mental health holding instead of the ER or jail.
Action 2 – Obtain funding for the facility through bond issue
Resources/collaborators needed – Politicians, service providers, law enforcement, schools, churches, workplaces, variety of stakeholders for funding

Goal 2: Increase community awareness and education of the mental health crisis in Kerrville

Action 1 – Gather all data on mental health throughout the county and communicate to the citizens
Action 2 – Determine needs for those without insurance and how to get them care
Resources/collaborators needed – Law enforcement, mental health DD , PH, New Hope, KISD

Additional ideas from other attendees:

- Increase participation in mentoring programs like Big Brothers Big Sisters as mentoring programs have good outcomes for improving kids' health.
- Mental health is a major issue in the veteran community. We need to ensure they know they have help here.
- Mental health is a broad issue – What is it going to mean in 10 or 20 years when the child autism population are adults? There is no right place for some people. Mental health is a large umbrella with lots of pockets within it.
- The community could hold a community mental health summit to focus on the mental health data sharing and planning for solutions with key stakeholders.
- 80% of a person's mental health is dependent on the community conditions. 96% need food resources, 72% need housing

Significant Health Need 2: Living Wages and Cost of Living

Goal 1: Create, support, and sustain education systems

Action 1 – Provide affordable daycare so more people can work
Action 2 – Provide more financial support for people attending school, graduation, fees., supplies for those getting an associate's degree
Resources/collaborators needed – childcare resources, funding

Goal 2: Create a culture where education is valued

Action 1 – Provide parenting support groups
Action 2 – Provide health navigators who can go into homes and be supportive of families and provide reading materials for example.

Goal 3: Continue to improve affordable, accessible public transportation so people can get to and from jobs

Action 1 – Support the App-based pilot program
Action 2 – Provide a service to provide labor for car repairs using people in auto trade students

Additional ideas from other attendees:

- The Alamo Area Workforce Solutions has a program that reduces employer risk for hiring high risk employees offering employers a 6-month fidelity bond.

Significant Health Need 3: Attainable Housing

Goal 1: Increase availability of attainable, diverse housing

Action 1 – Encourage more creativity among developers to look at multi housing developments and grow into larger houses for different stages of life. Look at mixed use developments, shopping, housing, encourage foot traffic.
Action 2 – Reform property tax and homeowners insurance to make them more affordable
Resources/collaborators needed – Engage the community on housing needs, developers, large employers, non-profits

Goal 2: Utilize trendsetting designs

Action 1 – Explore multiuse developments
Action 2 Model after similar community developments with same issues
Resources/collaborators needed – developers, large employers, non-profits

Additional ideas from other attendees:

- Always run into the issue of water. There's a big demand for large acreage and well issues.
- The growth in Kerr County is manageable.
- Per capita water use is decreasing a less water culture is developing around water conservation. People are using water more wisely. We're getting creative on water but not housing. We must rely on creativity. Use others to show the way.
- If we're going to affect change, we have to educate the people/constituents

Significant Health Need 4: Knowledge and Awareness of Resources

Goal 1: Consolidate and update the existing resource lists

Action 1 – Identify all current lists, which ones are most updated, bring onto an online platform KerrKind and print copies also.
Action 2 – Determine oversight and systematic process for updating the list.
Resources/collaborators needed – All social service organizations

Goal 2: Provide the resource list to the public, organizations, businesses

Action 1 – Create a marketing plan
Action 2 – Create a local call center with rotating volunteers

Additional ideas from other attendees:

- All organizations need to put the list on their website
- Make QR code magnets to the list, use bathroom door advertising
- Use the Interagency Group
- Reminder – can use Schreiner University students to help with projects

Significant Health Need: Substance Use Disorder

Goal 1: Increase access to care

Action 1 – Identify existing resources in the community and publicize, communicate, and educate on existing resources

Action 2 – Cross promote on one another's website, social media, events, ads, newspaper, radio, etc.

Resources/collaborators needed – Social services, addiction care services, primary care, health care orgs, after care services, health care coalition, vocational training and education, faith communities

Goal 2: Identify the gaps that still exist and work together to address what's lacking

Resources/collaborators needed - Kerrville Recovery Community Coalition

Additional ideas from other attendees:

- Reduce the stigma of addiction
- Create a community center for deflection and diversion activities where people can turn in their drugs manned by peer support with a day recovery center.
- People from other parts of the country come to Kerrville to receive care and fail recover and get stuck here. Focus on those individuals who have come to the point they want help wrap them back into service.
- We need better exit plans from even successful recovery persons. Who are now in a community where they don't know anyone and don't have transportation.

2. Focus Group Results

Community stakeholders representing the broad interests of the community as well as those representing low income, medically underserved, and minority populations participated in focus groups on April 16, 2025, for their input into the community's health. Below is a summary of the focus groups.

1. **How do you define health?**
    - Health = quality of life
    - Mind, body, spirit
    - Physical, social, mental, emotional, financial, spiritual health
    - Mind, body, spirit, physical, mental, emotional wellbeing
    - All-encompassing mental, emotional, spiritual, social health
    - Whole person health, Wholeness, balance, Wholistic approach
    - Wellbeing
    - Wellness, treating conditions and illness, lots of prevention
    - Goal of aging with quality of life
    - Viable community contributor living life to its fullest
    - Balance in all things – work/life, discipline/joy, etc.
    - Ever changing mindset of striving for mind, body, spirit health, interaction and relevance
    - Working together for the best life
    - Having kids in school
    - Can't separate mental health from physical health
    - Wellbeing, exercising, eating right, whole lifestyle, daily routine
    - Feeling good
    - Taking care of yourself, wellness, self-care
    - Managing mental health with the support of trusted people and family
    - Feeling safe, basic needs met, housing, having a safe space
    - Proactively involved with diet, exercise so they need less medical intervention

2. **For the purposes of this CHNA, the community is Kerr County, generally, how would you describe the community's health?**
    - Poor – people don't take care of themselves and pass down to younger generations; its like people have given up
    - Not healthy – lack of health self-awareness that they're unhealthy
    - More unhealthy than most
    - Negative outlook – individuals make poor decisions that lead to less than ideal outcomes. It is human nature to conform to the group you see everyday, some people don't see a lot of good examples of healthy, balanced lifestyle. Sees police, teachers, nurses that are obese as examples and they may be unhealthy.
    - Poor for the group who are younger and struggle financially and also for the older group who struggle financially. 5 on a 10 point scale.
    - Physical health ok, emotional and mental health struggles
    - We're divided by socioeconomics and educational background
    - Household that saw doctors or ones that never saw a doctor
    - Different for different people – some are healthy, some not healthy depending on economics and insurance
    - Spectrum based on socioeconomic status, overall not good
    - Attitude is an important aspect, but it's very hard with 2 jobs

- Bimodal distribution not a bell curve, people without means struggle to make ends men. They can't achieve wholeness when focusing on the urgent and emergent.
- Depends on socioeconomics – affluent have access to services others may not have the opportunity, polarization of income
- Which group? Some are not good, victims of sexual violence and trauma creates deterioration of mental health. Women who have suffered a trauma usually have bad health because they can't meet basic needs.
- There's also a lot of resiliency and see good mental health, so generally good
- The opportunity to be healthy, better than most with outdoor recreation opportunities

3. **What are the biggest health needs, concerns or issues for the community today?**

- Mental Health
    - Too busy, too distracted
    - Rise in mental health issues, PTSD
    - Stress in people's lives – phones, inflation, so interconnected in the world today
    - Normalize access to mental healthcare or being a member of the recovery community – be more accepting. People don't understand trauma
    - Lack of mental health resources
    - Law enforcement spends hours out of the community driving people out of the community for mental health care. A person is in crisis and there's nothing here. Tasking police officers to be counselors and a car service for mental health patients.
    - It takes a long time to get a psychiatry appointment for prescriptions
    - Not enough psychiatric providers or a facility in the area. Geri-psych patients are particularly difficult to place. No one takes dementia patients.
- Access to care & insurance
    - Accessibility to providers
    - Can't get into primary care providers; not taking new patients
    - It takes 6 months to get an appointment if you're an established patient
    - Takes forever to get into a doctor, particularly if on Medicare
    - Doctors not taking new patients; not able to get into primary care doctors
    - Peterson Community Care- can get in, but not primary care
    - Access to insurance or have a high deductible that you can't pay
    - Lots of uninsured people seeking resources
    - Some insurance isn't taken here, United
    - Need lower cost for medical services-vision, dental, healthcare, cost creates stress
    - Not a lot of choice of providers; couldn't find a provider when moved here. Ensure we have enough primary care and specialty care
    - Need regular visits with the doctor
- Healthy Eating/Active Living
    - Struggle with weight and enough activity; too many don't have the time, energy or opportunity to live a healthy lifestyle. Requires intentionality
    - Obesity – unhealthy lifestyle, diet, physical activity
    - People not taking the time or being able to afford exercise; not taking advantage of workout facilities available to them
    - Nutritious food
    - Food deserts – 10 miles to a grocery store with healthy food
    - Obesity is driving chronic diseases
    - Poor dietary habits, obesity, no exercise; poor health choices – fast food, fried food

    - Lack of awareness of losing muscle (sarcopenia) as you age, which is key to fall prevention
- Substance use disorder
    - Drug recovery
    - Substance use disorder – self medicating
    - Alcoholism and chemical dependency
    - Very high DUI rate, alcohol culture
- Lack of reliable transportation
    - Need more transportation options – there are long waits or Dietrich is always full
    - Don't have good reliable transportation; people can't make it to appointments
- Incomes and cost of living
    - Poverty/low income
    - Cost of living – high monthly bills cause stress and mental strain
    - Cost of healthcare is a stress creates a financial blow people have to deal with a long time
- Knowledge/awareness
    - Awareness of research and education best practices
    - People need current information
    - It is difficult to navigate the health system, need a coach
    - Lack of knowledge of resources available and then lack of using those resources
    - Accessibility of resources, advocacy, don't know where to go or understand the process
- Chronic diseases
    - Diabetes II
    - Hypertension
    - COPD
    - Allergies
    - Cancer
- Issues of aging
    - Aging
    - Geriatric issues
    - Aging population with physical and mental health needs
    - Retirement community Aging not knowing how to exercise
    - Dementia
    - Alzheimer's
- Others
    - Huge influx of people in their 40s and 50s – perimenopause and menopause and there are no resources or information
    - Mentality of "doctors won't do anything for me." Won't take advantage of resources available – we have doctors, information, health centers and they choose not to go and then say "no one wants to help me."
    - Kerr County is a healing area with places for recovery, good healthcare
    - The newcomers moving here are majority under age 59
    - Childcare
    - Sustainable housing
    - Medical issues from being in the service – toxic exposure, PTSD, addiction and recovery
    - There is a stigma of women wanting to take care of themselves

    - Birth control, hormone replacement therapy, family planning assistance- where can women go for more resources
    - Violence against children
    - Humor is so important for health

4. **What are the most important health issues facing various populations?**

    a) **Low-income populations, medically underserved?**

- Access to care
    - Working two jobs and it's hard to take care of medical needs
    - Affordable medications
    - Getting appropriate healthcare is a little like going to college for someone who has never gone to college; feels esoteric and doesn't know what's going on.
    - Finding providers who will serve them
    - Access – can't leave work for health care
    - Insurance costs; Lack of affordable health insurance
    - High deductibles
    - Can't afford to go to the doctor once, much less multiple times to get something figured out. People get discouraged and don't go back.
    - Oncology – if uninsured have to go to San Antonio
    - No resources for dialysis patients
    - Most providers don't take Medicaid, especially dentists
    - The uninsured pay cash and go to urgent care for primary care and lose the care management benefit of a primary care physician
- Healthy eating
    - Health and nutrition; low-income people need calories at a low cost and don't have funds for healthy foods; families go hungry if they miss a food delivery at the food bank
    - Cultural differences, eating vegetables and fruit not ingrained in their culture
    - Many low-income kids rely on the backpack program in schools for food
    - Access to real, whole foods can be cost prohibitive and selection may not be great
    - Nutrition – getting backpack meals and aren't getting healthy foods
    - Healthy food is not affordable, too expensive
    - Access to nutritious food
    - People may not know how to prepare fresh foods. They buy what they're able to buy.
- Transportation
    - Transportation – current resources overwhelmed
- Shame and stigma
    - Some with Medicaid believe there is a stigma associated with their insurance
    - Shame to admit you need help
- Knowledge/awareness of resources
    - Knowing how to get help; Knowledge of resources to get care
    - Education and awareness of what is healthy and resources to make good decisions
    - Lack of information on what resources are available and don't think those resources are for them
    - People don't know how to access the correct site for their healthcare, primary care v. urgent care, v. emergency room.
- Childcare
    - Working, single moms have limited childcare options and limit their ability for success
    - Cost of daycare

- Others
    - Paperwork; never ending road of applications
    - People rely on schools to get care and help
    - Some people are surprised and don't know the socioeconomic issues people are in; so, organizations may be surprised by it too
    - Diabetes
    - Heart disease
    - Lack of computer and internet access
    - Cost of staying healthy
    - Facilities they may not have access to
    - Mental health
    - Addiction
    - We need to get at the root cause of why people don't want to fill out the paperwork to get Medicaid or other resources
    - Those in poverty or low income are making it through the day, hierarchy of needs, they're in survival mode. Medical and dental care aren't accessible to them in their mind.

b) Minority populations:

- Trust/fear
    - Mistrust in community and organized systems
    - Immigrant families fear of deportation and don't want to be noticed; only use the ER when needed
    - They lack trust in the system in general and distrust is a barrier to seek care and may be unbanked and only use the ER
    - Hispanic population feeling nervous and want to be under the radar
- Access to care
    - Access to care and insurance – more tied to economics
    - Lack of resources – money and insurance
    - Similar issues to the others – affordability, education, awareness, access to programs
    - Lack of invitations to resources and services; we need to see people who look like us in the invitations and in the media
    - Lack of seeking preventive services mostly due to lack of income
- Language barriers – don't like to use the computer translator; need more inhouse translators, also for sign language
- Chronic diseases
    - Diabetes
    - Hypertension
    - Dialysis – kidney disease
    - Eye disease
- Others
    - Shame to admit you need help
    - Connecting the dots, need navigation assistance; they don't understand how to get care
    - Have seen differences in treatment between a white male being uninsured and a Hispanic female being uninsured. The white male received much more attention.
    - Some feel they're treated differently based on skin color. Stereotyped based on race or ethnicity. Has heard someone say, "Hispanics have higher pain tolerance."

c) Children/youth:

- Access to care
    - Lack of pediatricians; kids go to urgent care and miss out on care management a pediatrician can provide
    - Not enough pediatricians, the ones we have are overwhelmed
    - Not being able to afford health insurance if not on parents' plan
    - Difficult to get to pediatric specialists in San Antonio with transportation issues; for kids telemedicine isn't an option
    - Speech, occupational, physical therapists and mental health professionals are limited and don't have capacity to take new clients; 6 month waiting list for kids
    - Routine vaccinations
    - Need bilingual providers
    - Parents need help navigating care for their kids; they utilize the ED inappropriately
- Engagement
    - Schools and parents do not do the kids justice; lack of engagement, big schools where kids are just a number
    - Need to build self confidence in kids, kids are in such structured environments, we've removed opportunities to let them grow and make mistakes
    - Need to be ok interacting with people
    - Lacking in social skills
- Mental health
    - Lack of children's mental health and eating disorders
    - Need more and more mental health at younger grade levels
    - Increase in mental health, depression, low self-esteem – mixture of Internet and comparisons to others
    - See so much more mental health in schools
- Healthy eating/Active living
    - Overweight and obese, aren't healthy lifestyles; Getting larger and larger
    - Healthy eating – obesity, sedentary
    - Not cheap to eat healthy
    - Need physical activity beyond organized sports; there are less and less opportunities to be active
    - Childhood obesity – using devices and less activity
    - Kids who get breakfast and lunch at school, teachers saw the attention spans increase
- Lack of activities
    - No activities for teens or kids
    - Need healthy outlets for kids and youth
- Screens, phones, & social media
    - Kids on screens
    - Phones – too much information searching for external approval and affirmation
    - Access to social media and reliance/addiction to cell phones causes depression; for a lot of parents, the screen is a babysitter
    - Technology & social media woven into their hierarchy
    - Completely banning cell phones in the Ingram school district has made kids more mentally healthy; they've made new friends
- Substance use
    - Alcohol and drug use
    - Vapes – THC, Delta 8

    - Alcohol use is very high here; drugs not as much, but there's no stigma to underage drinking
    - Babies born with choices made for them such as drug addiction
- Safety
    - There's so much more mental, physical and emotional abuse discovered in schools than previously
    - Not safe to go out and play
- Developmental disorders
    - Lots of kids are over diagnosed with ADHD and mental health issues
    - Increase in ADHD diagnoses, dependence on Adderall
    - Local resources for children on the spectrum
- Others
    - There is an infinite number of future options for kids – college, trade schools, apprenticeships, but they don't seem to know it
    - Sexual health – need information on contraceptives and drug use
    - Helicopter parents
    - Single parent homes, grandparents raising grandchildren
    - Wanting instant gratification, not having patience
    - Historically, Kerr County has focused on the older population and hasn't focused on the younger population but is a little better now.
    - Lack of education for parents – cycle, parents taught to live life a certain way and kids pick it up. It has a lot to do with income
    - Daycare 6 months wait for daycare
    - Lack of support from CPS, APS also.

d) Seniors:

- People to help them
    - Inability to care for themselves – food, medication, paperwork
    - It's very defeating not being as self sufficient
    - Less support from family than we used to see; harder when kids don't' live here
    - Losing the ability to take care of themselves
    - Availability and affordability of people to come into their home to help
    - Aging here with no kids to help out or take care of them
    - An elderly couple where one takes care of the other, Medicare doesn't pay for care in the home, how are they supposed to manage? Who is going to care for those with limited resources?
- Isolation
    - Social interactions
    - Loneliness, depression, isolation
    - Seniors having a place in the community to socialize, exercise, be around people and not so isolated to keep their mobility and be as independent as possible.
    - Connecting with others, lack of a network, intergenerational relationships
- Transportation
    - Lack of transportation and can't make medical appointments.
- Issues that come with aging
    - Demands that come with aging – dementia, falls.
    - Wear and tear of aging-maintain ability and mobility, quality of life.
    - Falls, sarcopenia (muscle loss)
- Others
    - Caregivers need breaks; need caregiver care.

    - Have heard the need for a care community going from independent living to memory care.
    - Enough options for elderly beyond western medicine, complementary medicine
    - Lack of knowledge of resources with those not on technology
    - Communication – computer literacy
    - The senior population needs adequate and professional healthcare
    - Built environment – curbs, accessibility
    - Affordable healthcare and home health
    - Seniors who have neglected their health and don't know where to go

5. **What progress has been made on the 2022 priorities?**
    1) ***Mental health***
    2) ***Access to care & insurance***
    3) ***Coordination of resources***
    4) ***Healthy eating/active living***
    5) ***Substance misuse***
    6) ***Socioeconomic issues, social determinants of health***
    7) ***Staffing shortages/work skills***

    - Most agree these are all good issues to continue to work on. There is, however, some disagreement on whether these issues have improved or not.
    - Mental Health
        - Same, not better. Hasn't changed, Still needs attention
        - Worse
        - We still have a lot to learn, everyone and the police need to know how to deal with mental health issues or have someone else to deal with them.
        - Mental health is still a challenge and has gotten worse over time or it is more easily discussed, and the stigma has decreased.
        - No change, dementia at the forefront; mental health groups have done a good job educating the community
        - A little better since COVID because people are willing to talk about it
        - The unhoused population has mental health issues and no place to send them – no easy solution, such a big problem, too difficult
    - Access to care and insurance
        - It has gotten harder to get into see doctors, so has gotten worse; urgent cares are full too
        - Has gotten better with more specialists here and don't have to travel. Community Cares Clinic
        - More access with new doctors; availability of specialists are good; can get care at Raphael Clinic if don't have insurance
        - Cost of insurance has had a huge impact on access to care
        - Insurance is very expensive impacting lifestyles. There are few large employers offering good health insurance. We have wonderful small businesses who can't afford to offer health insurance
        - Access to insurance is better with the Affordable Care Act Healthcare Marketplace
        - Those on Medicare and Medicaid are able to get what they need
    - Healthy Eating/Active Living (HEAL)
        - Healthy eating to preserve health not just prevent obesity and diabetes
        - Decline in Farmer's Market, fewer local farmers
        - HEAL not improved; but there is more active living infrastructure
        - River trail feels like it is helping people with exercise

- Coordination of resources
    - More coordination would have a huge impact
    - Coordination has not improved, siloed, needs to be broken down
    - We are more collaborative community – KSTAR, Wesley Nurse, Kendall/Kerr Opioid Consortium, Resiliency Group has 12 organizations as members, Alamo Area Community Network (AACN), mental health coalition, Still have a closed loop referral system as a long-term goal
    - This is the most important need because it impacts and filters down to the others
    - Coordination has gotten better
- Substance Use Disorder
    - Substance misuse is worse
    - CBD, fentanyl, vapes
    - We're well known for having treatment centers and halfway houses, but these aren't always affordable. Need a place where lower income people can go. There's not a quick connection to substance use treatment.
- Socioeconomic issues, social determinants of health
    - Socioeconomics are in decline
    - Teach and learn, break the cycle of poverty
- Workforce
    - Schreiner has helped with the nursing shortage
    - Workforce – nominal improvement
    - Still needs attention
- Missing Needs
    - Addressing needs of the elderly and coordinate and educate on how to utilize social media
    - Add housing

6. **What environmental factors have the biggest impact on community health?**

- Housing
    - Limited subsidized housing, lack of attainable housing
    - Housing ongoing challenge employees living outside the county due to housing
    - Housing for seniors and families and low income
    - Not enough because we don't have enough water. Wells are going dry. This affects the ability to recruit workers to the county, nurses, doctors.
    - More and more kids are homeless, living in RVs, multiple families living together, parents working two jobs each.
    - High rents, don't know if they can afford food after their rent is paid
    - Affordable housing is loosely defined and need some
    - Housing insecurity and shortage of low-income HUD and section 8 housing. People are living in sheds in backyards. People that serve those with means can't afford to live here. We need workforce housing.
- Parks, trails, & sidewalks
    - Good trails and parks, river trail
    - Inclusive park for disabled
    - Sidewalks outside Kerrville; add sidewalks
    - Lack of sidewalks on major roads hampers the ability to get around
- Transportation
    - Lack of transportation or limited
- Safety

    - Safety gets in the way of living life due to past trauma that affects everyday life. Creates anxiety and depression.
    - Safety – creepy stalker guy
    - People stay inside because they don't feel safe and don't have resources for a gym
    - Unsafe drivers – distracted, older drivers, but they have no other transportation options. I-10 is horrible
    - People drive too fast, high number of accidents
    - Relatively low crime community except for family violence issues
- Pollen/air quality
    - Drought, Pollen, Cedar fever
- Activities for kids
    - Nothing for kids to do in Kerrville
    - Lack of options for teenagers; need activities
- Others
    - West Kerr County is a food desert
    - Hard to find jobs for 2 professionals; coordinate hiring between the professional organizations to find positions for spouses
    - Leadership changes at Peterson creates anxiety
    - We have good air and water
    - Three golf courses
    - Government cutting program funding

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

- Cost of healthy food
    - Cost of healthy food – they won't spend money on healthy food for fear they'll run out of money for enough food; it is expensive to eat healthy
    - Cost of groceries – fresh and quality produce
    - Money – eating healthy is expensive, but cheaper than medical bills, but don't think that far down the road
    - Artificial sugars
    - Cheap fast food
    - Times we're going through right now SNAP families depend on food assistance
- Transportation
    - Transportation – need a very reliable source of transportation that helps get people in and out of their homes.
- Lack or misalignment of resources
    - Financial inequity
    - There has been less philanthropy since COVID
    - Potential decline in not-for-profit funding due to federal government cuts; will need more philanthropic dollars
    - Worried about resources going away with the new administration such as Head Start
    - The federal government can't afford all that we've been doing; have to cut back
    - Financial resources
    - All comes back to money, don't have enough
    - Resources – money, people, workforce
    - Cost of living – 2 household parents both have to work and some kids have to work too to support the family
    - Resources going to the older population instead of the younger population
- Collaboration/alignment

    - Intentionality and alignment is key
    - Not enough collaboration of key stakeholders, city, county, organizations to make things happen long term, don't agree on priorities
    - Goals and aspirations of local officials focus on older population who have means. We have working class population erosion
    - Lack of collaboration between agencies; have lots of the same ideas. We need a vision of where we want to go.
- Attitude/culture
    - Personal, psychological barriers
    - Attitudes
    - Closed mindedness around alternative medicine – acupuncture, chiropractic, herbalist
    - Would like more open discussion about mental health and caregiver support
    - Trust in the system, trust in PRMC – build relationships with the community
    - Mindset of "what happens at home stays at home" and enables victimization
    - Attitude of people everything is fine, independent streak here resistant to seeking or taking help. People must want to change.
- Lack of access to care
    - Navigating insurance – in network, out of network, Medicare Advantage plans
    - Lack of a public health department
    - Difficulty recruiting doctors due to not being able to employ spouses in professional occupations
    - Deficit of physicians
    - Cost of healthcare leads to attitude of "rub some dirt on it"
- Others
    - People who do not understand what they should and should not be doing
    - Access to information

8. **What community assets support health and wellbeing?**

- Peterson Regional Medical Center (PRMC) and physicians
    - Peterson Wellness Center
    - PMRC offers high level technology and continuum of care, good outreach, grief support group, suicide support group, offers services for those without resources
    - Every Peterson physician office has someone who speaks Spanish
    - PRMC is an asset, people can't believe the services offered here
    - PRMC- doctors, good outreach, suicide support group, for a community this size, services for those without resources
    - Wellness center and program is fantastic
    - Physicians are asking about mental health during primary care and specialty care visits
    - Have good providers, just hard to get into
- Parks and trails
    - Parks, River trails, bike trails
    - Parks & Recreation
    - Opportunities for free play – soccer, baseball, parks, trails
    - Access to open spaces, highest park acreage per population, but park service is stretched
- River, outdoors, location
    - River is an asset, river access

    - Place - central TX encourages outdoor activities
    - Location of Kerrville – distance from San Antonio and not too rural
- Not-for-profit and other organizations
    - Dietert Center – provides a noon meal for 40 to 50 people and delivery meals on wheels to 300 people per day, offers medical equipment, respite care
    - Community Care Clinic
    - Lots of not-for-profit organizations especially for a community this size. They'll be called on to more in the future
    - Doyle Community Center II
    - Kroc Center – kids recreation center, summer camps
    - Lots of food pantries – can get food if needed
    - Veterans Service Center
    - Area food banks
    - Raphael Clinic
    - Methodist Healthcare Ministries
    - MHDD, NAMI, Hill Country Counseling Center – getting out more and in touch with the community
    - Hill Country Veterans suicide prevention
    - Blessed to have the VA
    - Police department – very involved in the community
    - School district – supports physical education programs; they way the community supports the schools
    - AA and other support group meetings
- Philanthropy
    - Significant number of nonprofits providing support in the community have great financial support and give grants
    - Philanthropy – HEB foundation
    - Large donor base – great financial support
- Churches
    - Churches - food distribution, support for community
- Facilities for active living
    - There are lots of workout centers and fitness facilities
    - City building/improving baseball fields, soccer fields, pool
    - Actively promoting parks
- Others
    - School summer feeding programs
    - Urgent cares
    - Very pro-health community
    - MHDD has a reduced cost pharmacy, but still very expensive
    - Pace and culture of the community. If you can afford to live here, it's a great place
    - Relationship between the hospital, fire, police, county law enforcement. We got really good at working together
    - Great weather most of the time

9. **If you had a magic wand, what improvement activities should be a priority for the counties to improve health?**

- Increase access to care
    - Affordable access to care for all patients right here in Kerrville
    - More primary care to manage people's care

    - Get more doctors in Kerrville
    - Cancer treatment, cancer support groups
    - Continue to add primary care providers and those who take Medicare
    - Put the mobile clinic in the Raphael parking lot back in service to deliver care and information out in the community where people are
    - Have a mobile medical unit out in the community. So many use the ER as their family doctor and don't catch issues early
    - Create a place where there's a doctor, dentist, mental health professional, optometrist with glasses out in the community where they can rotate one day a week and everyone knows what day they'll be there
    - Bilingual primary care
    - Have an immunization clinic at the schools
    - Bring in industry so people can have good paying jobs with health insurance
    - We need a clinic that takes cash equivalent to Franklin Clinic
- Mental health
    - Prioritize mental health; help first responders, give them resources to manage mental health
    - Add more beds/spaces for mental health stabilization
    - Increase mental health awareness and training – going to jail reaction isn't helpful
    - More mental health resources and mental health advocates
    - More crisis alcohol and drug abuse treatment centers
    - Add a short-term acute mental health unit so people can get appropriate care
    - Accessible services; get healing for trauma
    - Change attitude and beliefs of those seeking mental health services. Reduce stigma; we stand for grace
- Improve and increase health information communication
    - All communications should also be in Spanish
    - Communicate in churches and schools with accurate health information
    - Health and wellness education on social media prevention focus, same message at clubs, in newspapers, on radio, in churches
    - Update the PRMC website with latest health news like the measles outbreak, keep current and updated
    - Educate people about resources for people who can't afford healthcare or dental care with the message that resources are there "for them"
- Add activities for kids
    - Expand the skate park to make kids more active
    - Increase the Kroc capacity and set up more scholarships for memberships and youth programs. This would have a huge impact on the community
- Add affordable housing
    - Build more affordable homes for the workforce
    - Build a neighborhood of well-built homes for $250-$300K so the middle class can live here
- Services for the senior population
    - Make it so older people can stay in their house and get the care they need or go to assisted living or skilled care. In Denmark older people live on college campuses to interact with younger people.
    - Wellbeing of the elderly – take care of them at home, have someone help them to take medicine, get food

    - Grow the Dietert Center- Feed more seniors, get more volunteers, more funding, help more seniors and families navigate services
    - Add a community paramedic program to visit the elderly
    - Start a Buddy Program call and check-in with people
    - Older single people without family – get them out into the community and a sense of purpose
- Add transportation
    - Transportation – extend the river trail and bring the trails up into neighbors so people can use bikes as transportation.
    - Build transportation infrastructure for those without the ability to drive
    - Provide transportation to doctor appointments
    - Additional ways to transport patients to San Antonio; plan trips to San Antonio
- Improve nutrition
    - Educate on and make available healthy food options and healthy eating
    - Change what people eat, get more activity. Eliminate the standard Kerrvillian diet. There are ways to change your health with diet and exercise.
    - Create more victory gardens for access to fresh food
- Improve quality of care
    - Remove time limit providers have with patients so they can focus on that one person and make more of a difference.
    - Align priorities for organizations that care for people like nursing homes, home health because patients get lost, competing regulations, red tape
- Create water
    - Make more water
    - Ensure water isn't an issue at a constant level and accessible
- Improve coordination of resources
    - Add a public health department to coordinate health resources
    - Form more partnerships
    - Have navigators to help people navigate "the system"
    - Peterson and the schools partner for better health of students
- Others
    - Create a rural healthcare teaching environment for nurses, doctors, other healthcare workers
    - Keep PRMC independent
    - More focus on healthy lifestyles to keep people out of doctors offices
    - Get people to participate in parenting education groups, drug education sessions, mental health education, get people to attend helpful events
    - Ask people what they need
    - Bring back the human, personal connection, bring back the desire to meet in person. We pay more attention if we're in person rather than on Zoom.
    - Keep Head Start program as it helps with stable childhoods
    - Fully fund the beneficial programs in the community
    - Build stable, quality childcare with health insurance for childcare workers
    - Change the attitude and belief of the community stigma of those who use drugs or those in recovery who stay in the community

3. Health Status Data Trended

Rankings and Comparisons of Health Status

In most of the following graphs, Kerr County will be light blue, TX will be orange, U.S. will be blue and the 90th percentile of counties in the U.S. will be gold.

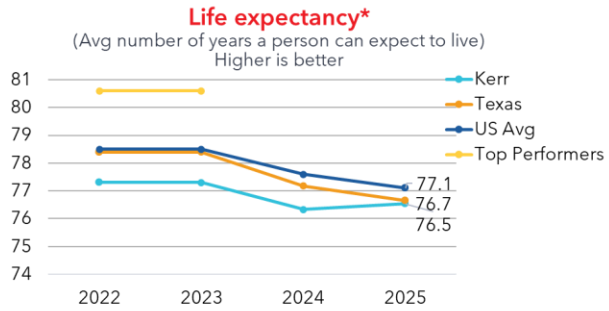
Health Outcomes (Length of Life and Qualify of Life)

Health Outcomes are a combination of length of life and quality of life measures.

Length of Life

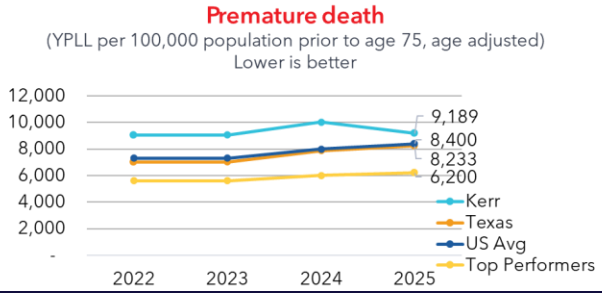
Length of life was measured by years of potential life lost per 100,000 population prior to age 75; here, lower is better. For example, a 25-year-old killed in an accident equates to 50 years of potential life lost prior to age 75. Kerr County lost 12,103 years of potential life per 100,000 population which was higher than TX and the U.S.

Kerr County residents can expect to live 4.5 years less than the average U.S. resident.

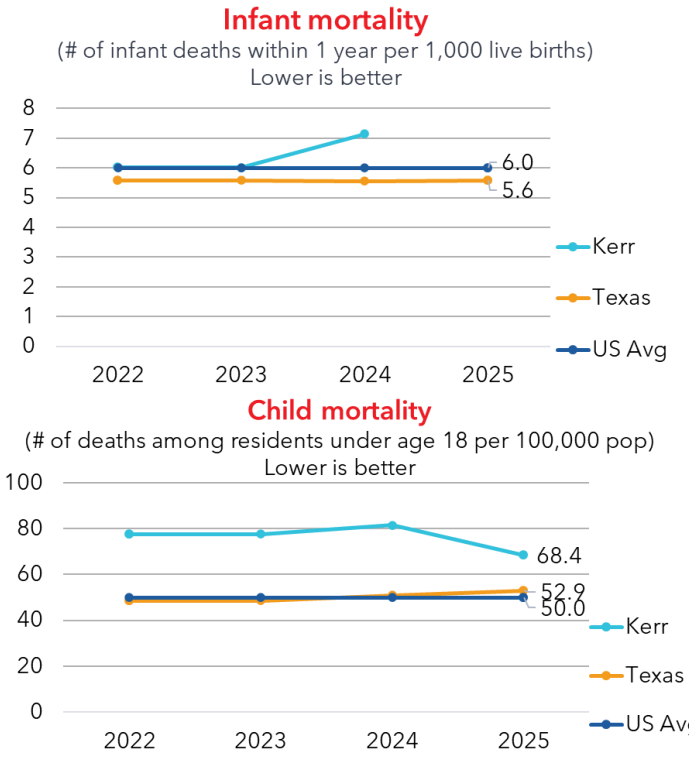


Life Expectancy by Race/Ethnicity 2019-2021
(Avg number of years a person can expect to live)

	Hispanic	NH Black	NH White	Males	Fem
US	80.0	72.8	77.5	74.2	79.9



Source: County Health Rankings; National Center for Health Statistics – Mortality File 2020-2022



Source: CHR; National Center for Health Statistics – Natality & Mortality File 2016-2022
Child Mortality: CHR; National Center for Health Statistics – Mortality files; Census 2019-2022

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

Cause of Death	Kerr	TX	US
Heart Disease	337.0	168.1	207.9
Cancer	288.5	144.6	182.7
Accidents (Unintentional injuries)	70.3	50.2	67.5
COVID-19	105.1	69.2	65.3
Cerebrovascular Diseases	81.5	40.1	49.1
Chronic Lower Respiratory Disease	82.1	33.2	43.5
Alzheimer's Disease	62.2	34.2	35.4
Diabetes	41.0	26.2	30.0
Nephritis	23.0	15.4	16.8
Liver Disease	24.9	17.2	16.4
Suicide	23.6	11.8	14.7
Influenza & Pneumonia	18.7	10.0	13.2

Rates in red had death rates higher than TX. The leading causes of death in Kerr County were heart disease, cancer, accidents, COVID-19, followed by cerebrovascular disease and chronic respiratory disease.

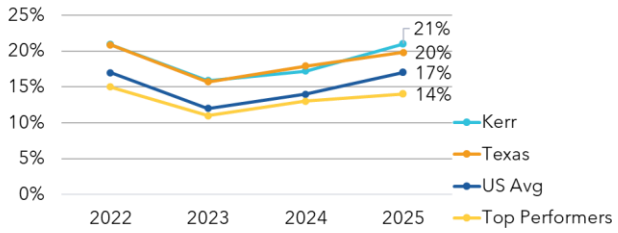
Source: Wonder CDC.gov (2021-2022) Age-adjusted rates per 100,000 population.

Quality of Life

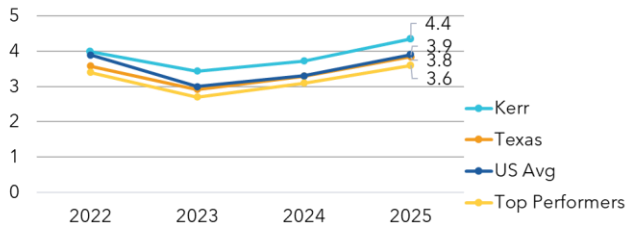
Physical Health

Quality of life was measured by % reporting fair or poor health, the average number of poor physical health days, frequent physical distress, and low birthweight babies.

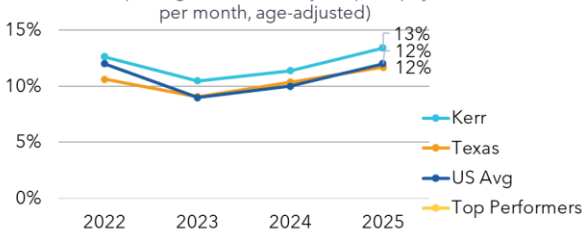
Poor or fair health
(% of adults reporting, age-adjusted)



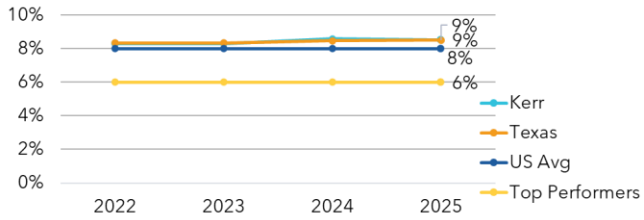
Poor physical health days
(avg # of days in past 30 days)



Frequent physical distress
(% of adults reporting 14 or more days of poor physical health per month, age-adjusted)

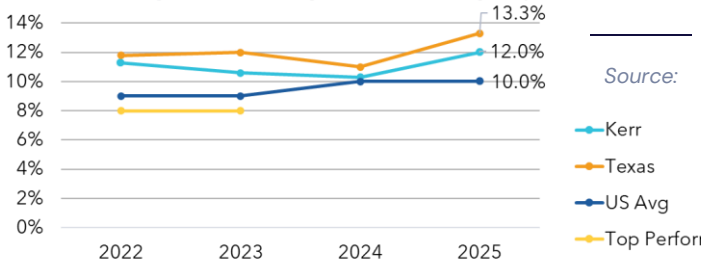


Low birthweight babies
(% of live births w birthweight <2,500 grams or 5lbs, 8oz.)

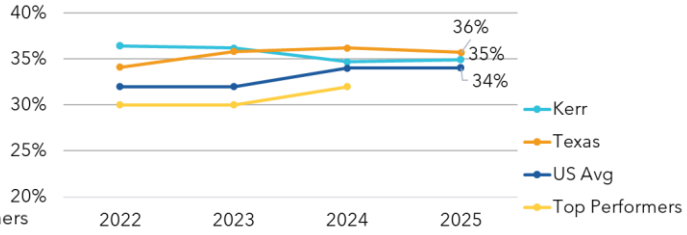


Source: County Health Rankings; Behavioral Risk Factor Surveillance System (BRFSS) 2022
Source: County Health Rankings: National Center for Health Statistics – Natality files (2017-2022)

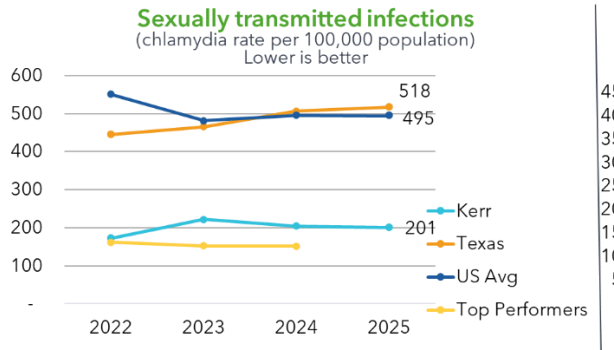
Diabetes prevalence
(% of adults aged 20 + with diagnosed diabetes, age-adjusted)

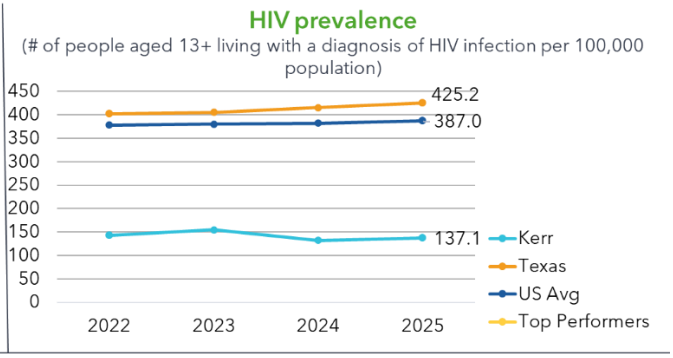


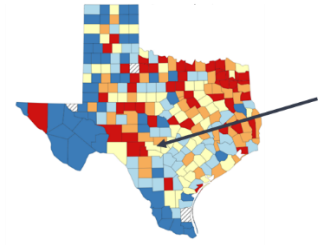
Adult obesity
(% of adults that report a BMI of 30 or more)
Lower is better



Diabetes - CHR; CDC, BRFSS, 2022
Source : Obesity - CHR; CDC, BRFSS, 2022







Cancer incidence rates

(All cancer sites, age-adjusted cases per 100,000 population)

Age-Adjusted
Annual Incidence Rate
(Cases per 100,000)
208.0 to 395.8
>395.8 to 424.9
>424.9 to 452.7
>452.7 to 476.0
>476.0 to 679.5
Suppressed

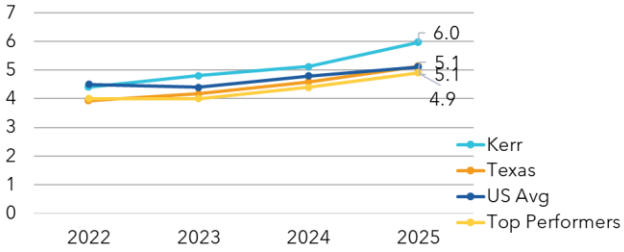
	2017-2021	Trends
Kerr Co	447.1	↗
Texas	457.3	→
U.S.	444.4	↘

Source: STIs – CHR; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2022
HIV Prevalence – CHR; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2022
Cancer incidence rates – NIH, CDC State Cancer Profiles, 2017–2021

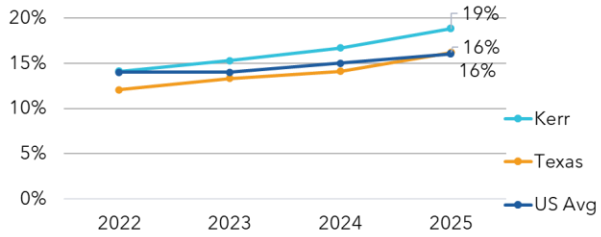
Mental Health

Quality of life was measured by poor mental health days, frequent mental distress, suicide rate, and feelings of loneliness.

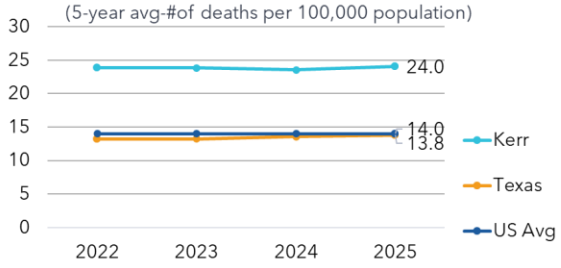
Poor mental health days
(avg # of days in past 30 days)



Frequent mental distress
(% of adults reporting 14 or +days of poor mental health per mo., age-adjusted)



Suicide rate*
(5-year avg-#of deaths per 100,000 population)



Feelings of loneliness
(% of adults reporting they always, usually or sometimes feel lonely)

Kerr Co	35%
Texas	34%
U.S.	33%

Source: Poor mental health days, Frequent mental distress, Feelings of loneliness - County Health Rankings; Behavioral Risk Factor Surveillance System (BRFSS) 2022

Source: Suicide rate - County Health Rankings: National Center for Health Statistics, Mortality files (2018-2022)

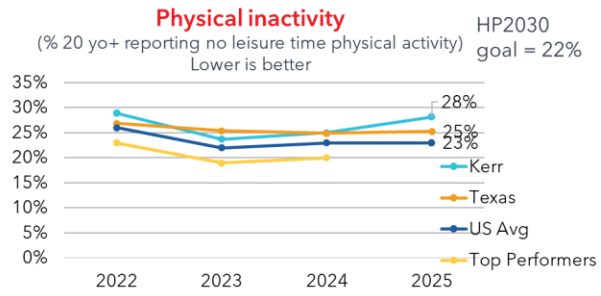
Community Conditions

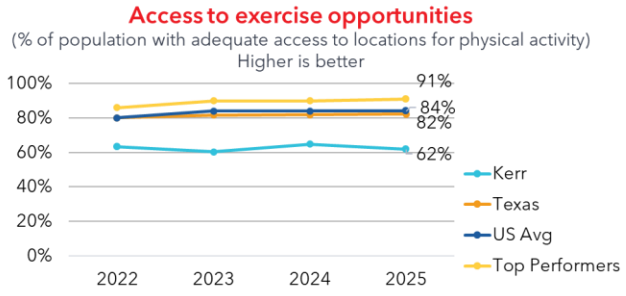
Community conditions include the social and economic factors, physical environment and health infrastructure in which people are born, live, learn, work, play, worship and age. Community conditions are also referred to as the social determinants of health. (CHR, 2025)

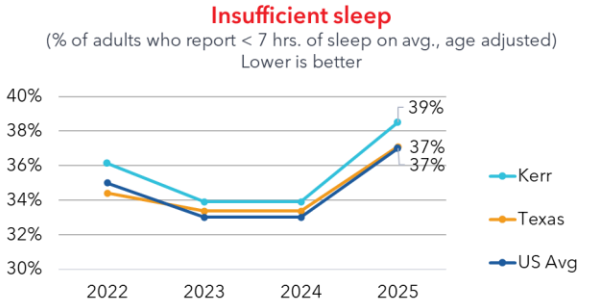
Health Infrastructure

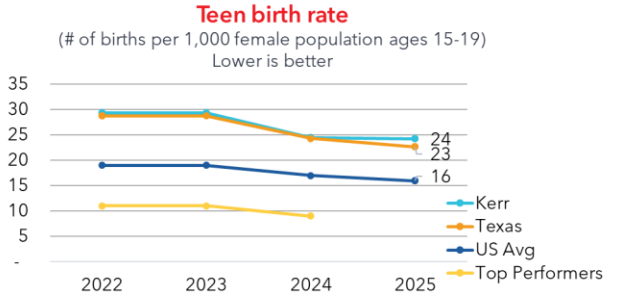
Health infrastructure is comprised of prevention, healthy eating, and active living, substance misuse, and clinical care.

Healthy Living

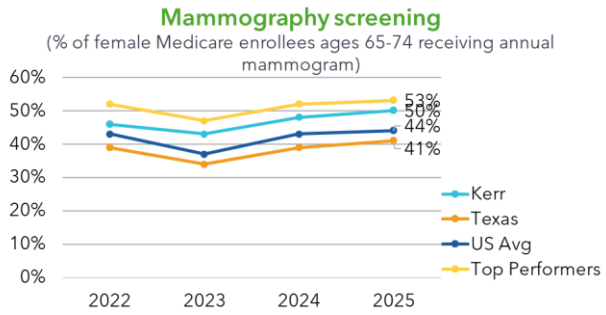








Source: Physical Inactivity – CHR, Behavioral Risk Factor Surveillance System, 2022
Source: Access to exercise opportunities – CHR, ArcGIS Business Analyst, YMCA, & US Census Tigerline Files, 2024, 2021 and 2020. Measures the percentage of individuals in a County who live reasonably close to a location 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: Insufficient sleep – CHR, Behavioral Risk Factor Surveillance System (BRFSS), 2022
Source: Teen birth rate – CHR, National Center for Health Statistics-Natality Files; Census Population, 2017-2023

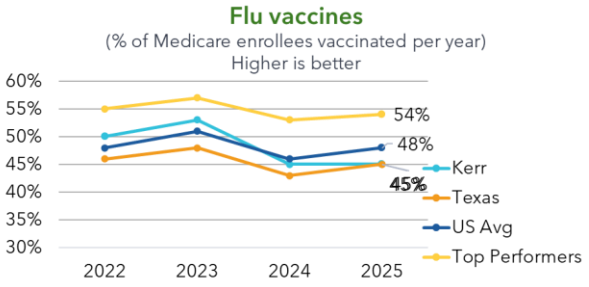


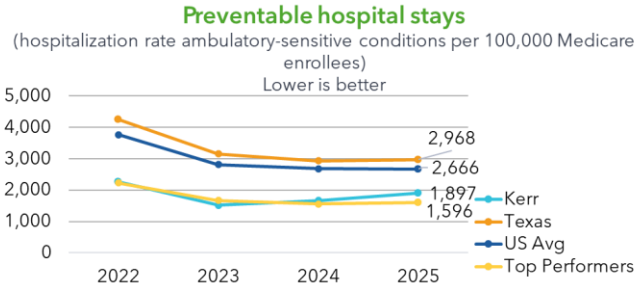
COVID vaccines

(% of fully vaccinated recipients age >11)
Higher is better

Kerr Co	TX	U.S.
52.6%	63.5%	70%

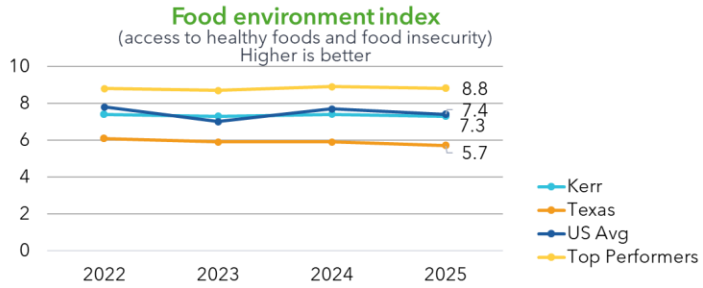
As of May 2023

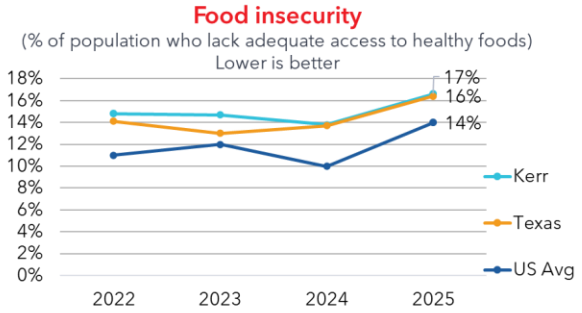


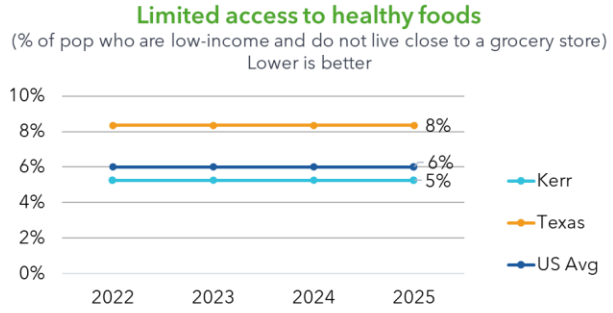


Source: Preventable hospital stays, mammography screening, flu vaccinations – CHR, CMS Mapping Medicare Disparities Tool, 2022
Source: COVID-19 Vaccinations – CDC May 2023

Access to Healthy Foods



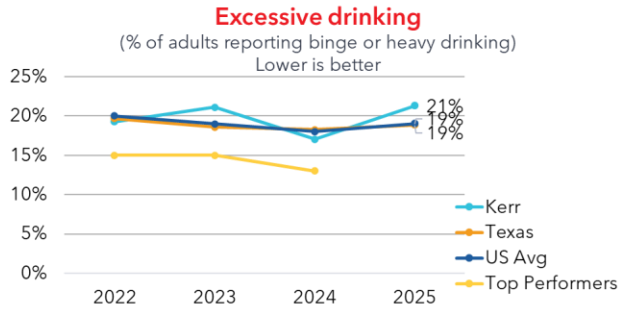


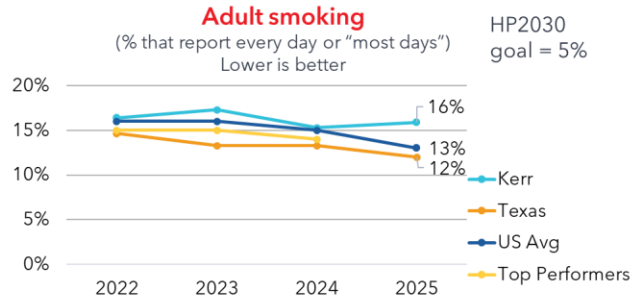


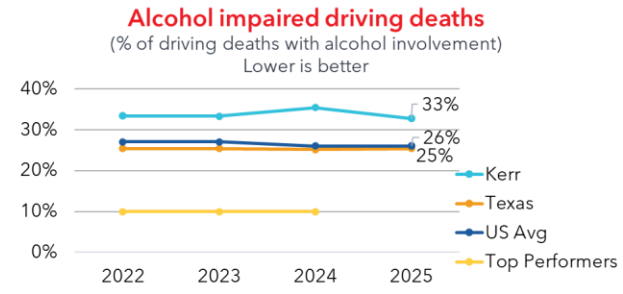
The food environment index is comprised of % of the population with limited access to healthy foods and % of the population with food insecurity. Limited access to foods estimates the % of the population who are low income and do not live close to a grocery store. Food insecurity is the % of the population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

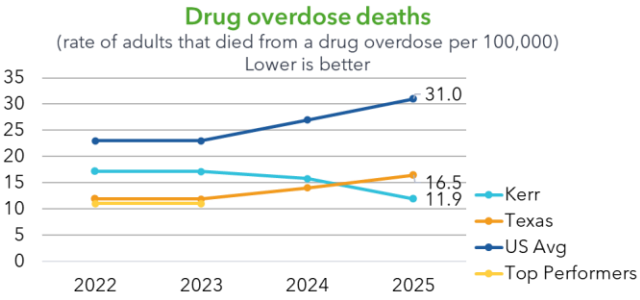
Source: Food environment: CHR; USDA Food Environment Atlas, Map the Meal Gap from Feeding America, 2019 & 2022
Source: Food insecurity – Map the Meal Gap, 2022
Source: Limited access to healthy foods – USDA Food Environment Atlas, 2019

Substance Use





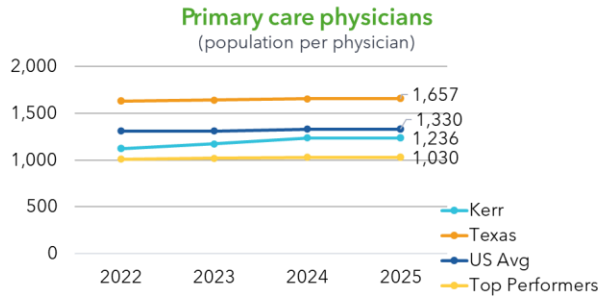


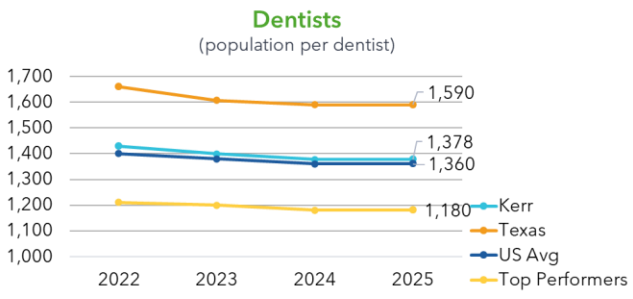


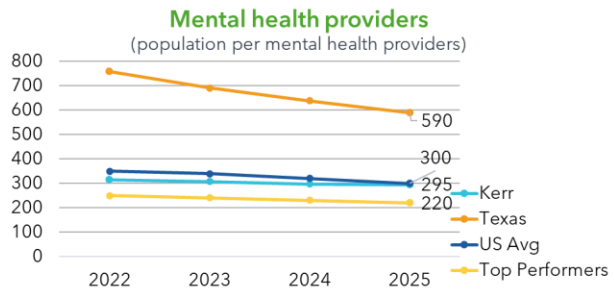
Source: Excessive drinking - CHR; Behavioral Risk Factor Surveillance System (BRFSS), 2022
Source: Smoking - CHR; Behavioral Risk Factor Surveillance System (BRFSS), 2022
Source: Alcohol-impaired driving deaths - CHR; Fatality Analysis Reporting System, 2018-2022
Source: Drug overdose deaths – National Center for Health Statistics – Mortality Files, Census Population, 2020 - 2022

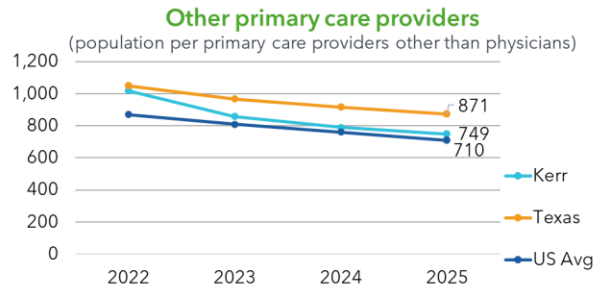
Clinical Care

Clinical care ranking is made up of population per primary care physicians, dentists, mental health providers and other primary care providers.



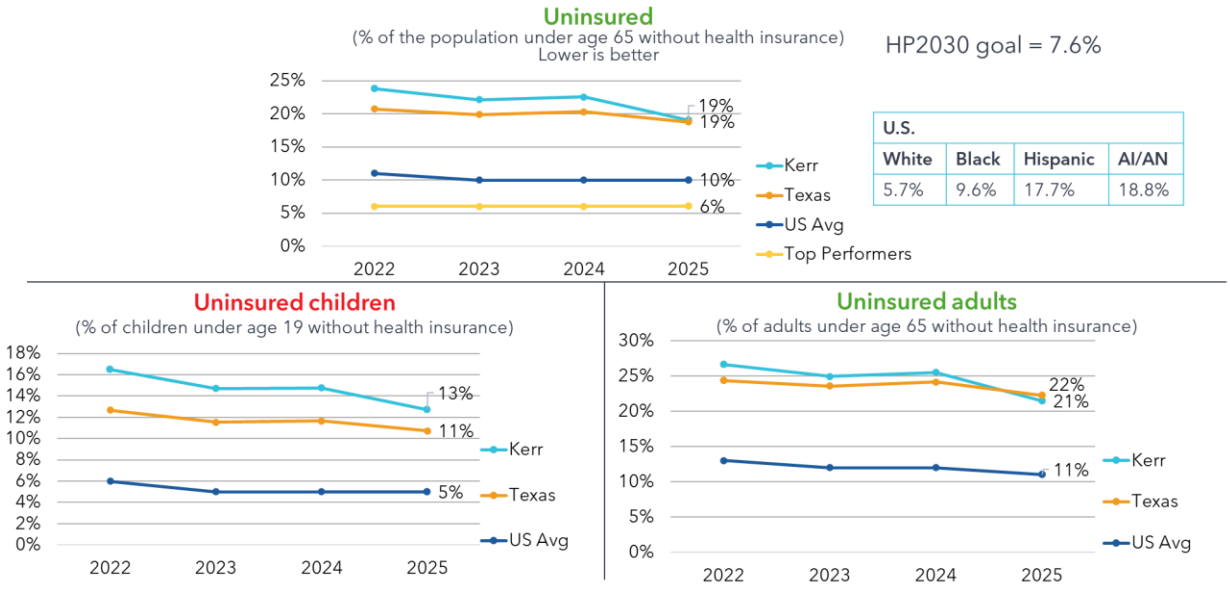






Source: Pop to PCP - CHR; Area Health Resource File/American Medical Association, 2021
Source: Pop to Dentists - CHR; Area Health Resource File/National Provider Identification file, 2022

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) CMS, National Provider Identifier File, 2022
Source: Population to other primary care providers - CHR; CMS, National Provider Identification, 2024



Source: Uninsured - CHR; Small Area Health Insurance Estimates, 2022

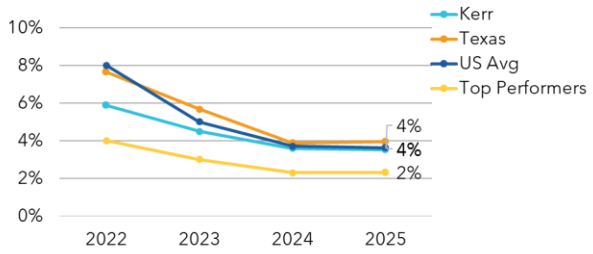
Social and Economic Factors

Social and economic factors are comprised of education, income, employment and wealth, social support, and safety.

Economics

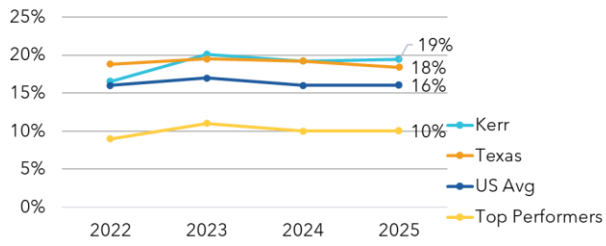
Unemployment

(Percentage of population ages 16 and older unemployed but seeking work.)
Lower is better



Children in Poverty

(% under age 18 in poverty)



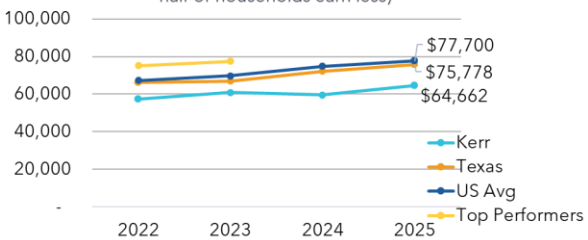
Living wage

(The hourly wage needed to cover basic household expenses plus all relevant taxes for a household of one adult and two children)

Kerr Co	$40.06
Texas	$44.46

Median HH income

(The income where half of households in a county earn more and half of households earn less)

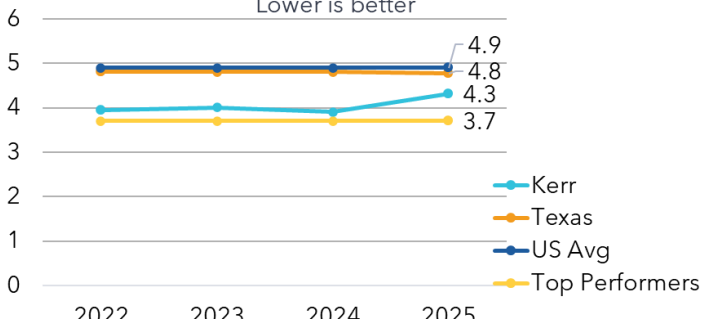


Small Area Income and Poverty Estimates; American Community Survey, five-year estimates

2023

Income inequality

(ratio of HH income at the 80th percentile to income at the 20th percentile)
Lower is better

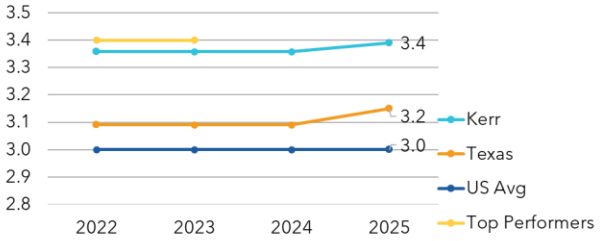


Source: Unemployment – CHR, Bureau of Labor Statistics, 2023
Source: Children in Poverty, Median HH income - Small Area Income and Poverty Estimates; American Community Survey, five-year estimates, 2019-2023
Source: Living wage – The Living Wage Institute, 2024
Source: Income inequality - CHR; American Community Survey, 5-year estimates, 2019-2023

Education

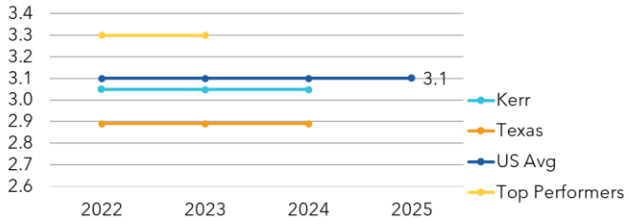
3rd grade math scores

(Avg. grade level performance on math standardized tests)
Higher is better



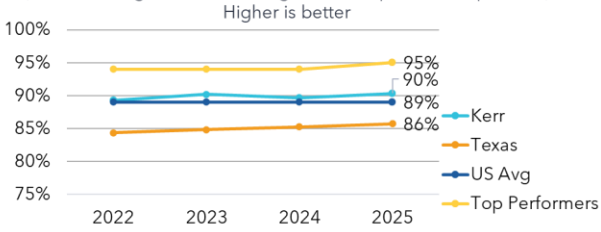
3rd grade reading level

(Avg. grade level performance on English language arts standardized tests)
Higher is better



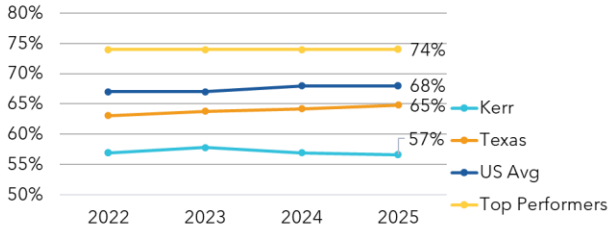
High school completion

(% of adults ages 25 + with a high school diploma or equivalent)
Higher is better



Some college

(% of adults ages 35-44 with some postsecondary education)



Source: Rading and Math scores – CHR Stanford Education Data Archive, 2019
Source: High school completion– CHR, American Community Survey, 5-yr estimates, 2019-2023
Source: Some college CHR; American Community Survey, 5-year estimates, 2019-2022

School funding adequacy

(The average gap in dollars between actual and required spending per pupil among public school districts. Required spending is an estimate of dollars needed to achieve U.S. average test scores in each district)
Higher is better

Kerr Co	$-4,857
Texas	$-5,341
U.S.	$1,411

2016-2020

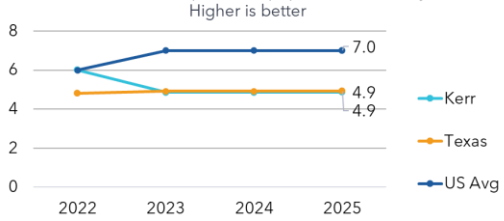
Childcare cost burden

(Childcare costs for a HH w/2 children as a percent of median HH income)
Higher is better

Kerr Co	27%
Texas	25%
U.S.	28%

Childcare centers

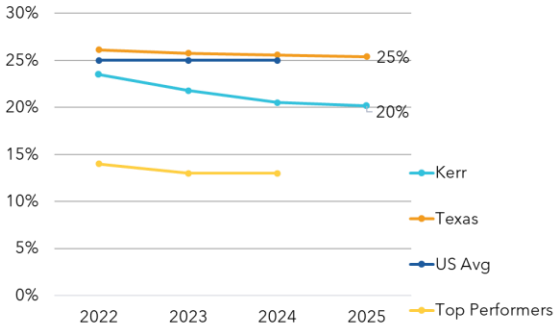
(# of childcare centers per 1,000 population under 5-yrs old)
Higher is better



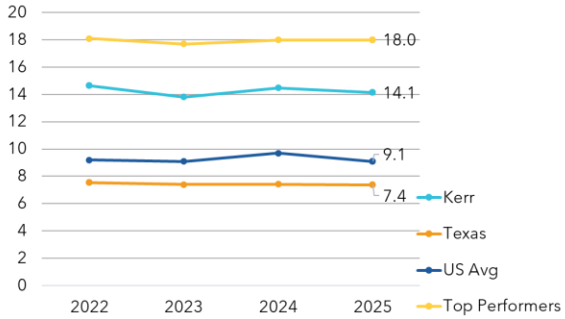
Source: School funding adequacy – CHR; School Finance Indicators Database, 2022
Source: Childcare Cost Burden – The Living Wage Institute; Small Area Income and Poverty Estimate, 2024
Source: Childcare centers – CHR; Homeland Infrastructure Foundation-Level Data, 2010-2022

Social Support

Children in single-parent households
(% of HH headed by a single parent)



Social associations
(# of membership assoc. per 10,000 population)
Higher is better



Source: Children in single-parent households - CHR; American Community Survey, 5-yr. est., 2019-2023
Sources: Social associations – CHR-County Business Patterns, 2022

Census participation
(% of HH that self-responded to the 2020 census)
Higher is better

Kerr Co	61.4%
U.S.	65.2%

Lack of social and emotional support
(% of adults reporting they sometimes, rarely, or never get the social & emotional support they need)
Lower is better

Kerr Co	27%
Texas	29%
U.S.	25%

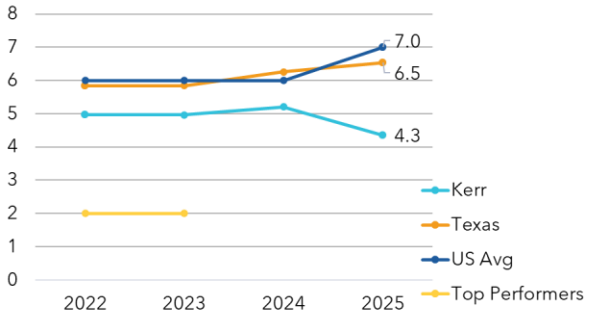
Voter turnout
(% of citizen pop aged 18+ who voted in the 2020 U.S. Presidential election)
Higher is better

Kerr Co	69.3%
Texas	60.9%
U.S.	67.9%

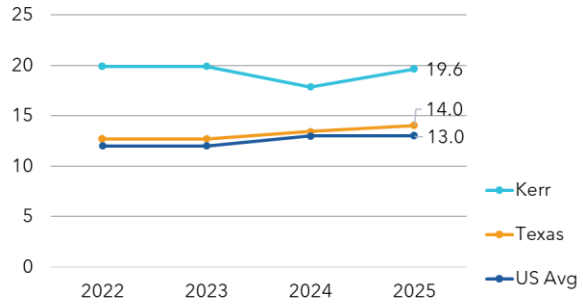
Source: Census participation - CHR; Census Operational Quality Metrics, 2020
Sources: Lack of social & emotional support – CHR, Behavioral Risk Factor Surveillance System, 2022
Source: Voter turnout – CHR, MIT Election Data & Science Lab; American Community Survey, 5-yr. est., 2020 & 2016-2020

Community Safety

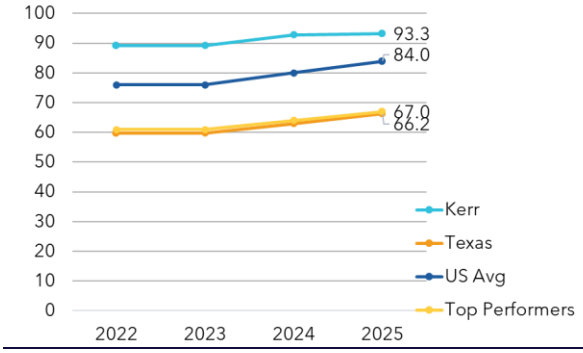
Homicide rate
(# of deaths due to homicide per 100,000 population)
Lower is better



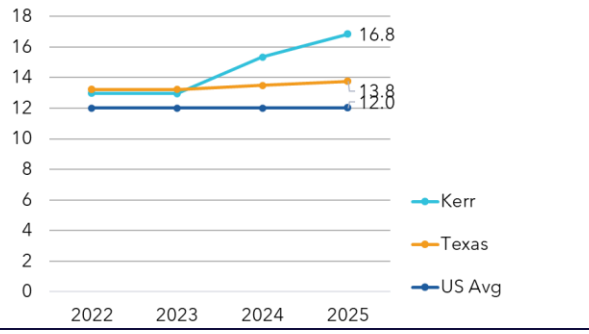
Firearm fatalities*
(# of deaths due to firearms per 100,000 population)
Lower is better



Injury deaths*
(injury mortality per 100,000 population)
Lower is better



Motor vehicle crash deaths
(# of motor vehicle crash deaths per 100,000 pop)
Lower is better
HP2030 goal = 10.0



Source: Homicide rate & Firarm fatalities- CHR; National Center for Health Statistics – Mortality files; Census population, 2016-2022
Source: Injury deaths - CHR; National Center for Health Statistics – Mortality files; Census population, 2018-2022
Source: Motor vehicle crash deaths – CHR, National Center for Health Statistics – Mortality Files, Census population, 2016-2022

Physical Environment

Physical environment contains housing and transportation, air, water, and land, civic and community resources.

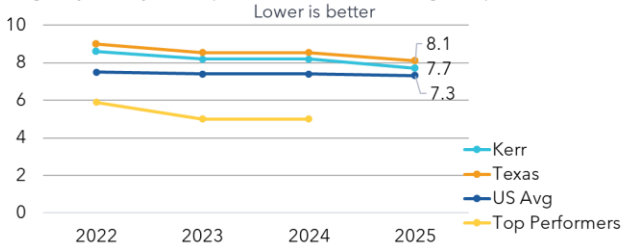
Drinking water violations

(indicator of the presence of health-related drinking water violations)

	2021	2022	2023
Kerr Co.	Yes	Yes	Yes

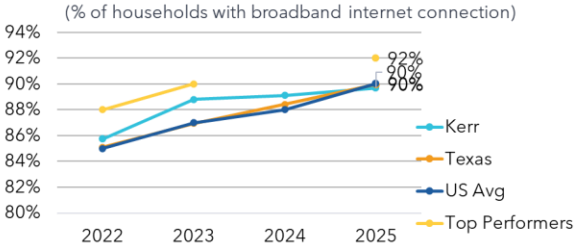
Air pollution particulate matter

(avg daily density of fine particulate matter in micrograms per cubic meter)
Lower is better



Broadband access

(% of households with broadband internet connection)



Adverse climate events

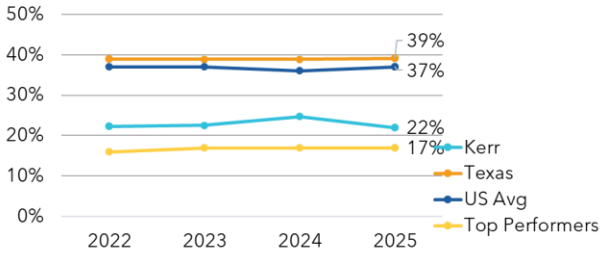
(Indicator of thresholds met for the following adverse climate and weather-related event categories: extreme heat (300 or more days above 90F), moderate or greater drought (65 or more weeks), and disaster (2 or more presidential disaster declarations) over the five-year period.)

3 adverse climate events

2019-2023

Long commute- driving alone

(among workers who commute alone, the % that commute >30 min.)



Access to parks

(Percentage of the population living within a half mile of a park)

Kerr Co.	44%
Texas	46%
U.S.	51%

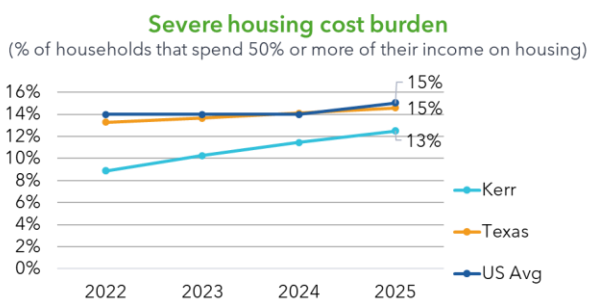
Library access

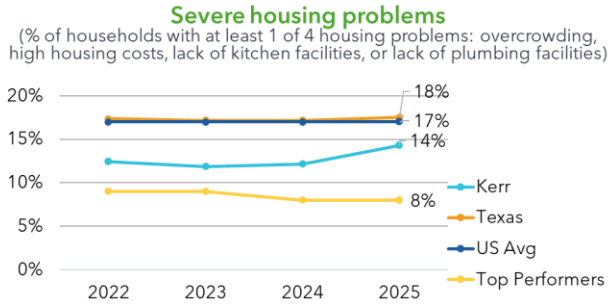
(Library visits per person living w/in the library service area per year)

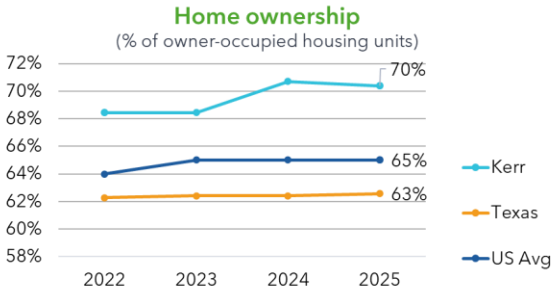
Kerr Co.	3
Texas	1
U.S.	2

Source: Drinking water violations – CHR; EPA, Safe Drinking Water Information System, 2023
Source: Air pollution – CHR: CDC National Environmental Public Health Tracking Network, 2020
Source: Broadband access – CHR; American Community Survey, 5-yr estimates, 2019-2023
Source: Adverse Climate Events - Environmental Public Health Tracking (EPHT) Network; U.S. Drought Monitor (USDM); OPEN FEMA Disaster Declaration Summaries, 2019-2023
Source: Driving alone to work and long commute – CHR- American Community Survey, 5-year estimates, 2019-2023
Source: Access to Parks – ArcGIS Online; US Census TIGER/Line Shapefiles, 2024 & 2020.

Housing







Source: Severe housing cost burden & home ownership– CHR; American Community Survey, five-year estimates, 2019-2023
Source: Severe housing problems – CHR; HUD Comprehensive Housing Affordability Strategy data, 2017-2021.

4. Community Asset Inventory

The section contains a list of community assets and resources that can help improve the health of the community and assist with implementation of the plan that accompanies this document. This asset inventory is not exhaustive and may have inadvertently omitted community resources. There are instructions for making changes after the inventory. The focus group also identified community resources to improve health, which are listed on page 48 of the Community Health Needs Assessment.

Mental Health Services		
Organization/Service	Website	Phone
Kerr County Mental Health Center	https://hillcountry.org/services/kerr-county-mh-center/	830-257-6553
Faithful Recovery		
Hill Country ADHD Coaching	hillcountryadhd.com	830-315-6400
Hill Country Mental Health	hillcountry.org	830-792-3300
BCFS Health and Human Services	bcfscsd.org	210-733-7932
Resiliency Through Healing	https://bcfscsd.org/data_post/resiliency-through-healing-rth/	210-733-7932
Mental Health Navigation Line - Here for Texas		972-525-8181
National Alliance on Mental Illness	https://namitexas.org/about-nami-texas/nami-affiliates-in-texas/nami-kerrville/	512-693-2000
New Hope Counseling Services	https://www.newhopecounselingtx.org/	830-257-3009
Elevate Mental Health	https://www.elevatemh.com/	830-383-2260
Live Oak Psychiatric Services	https://www.liveoakps.com/	830-538-0127
Behavior Resource Center	https://www.ababehaviorcenter.com/	830-896-6319
New Beginnings Youth and Family Services	550 Earl Garrett St #103, Kerrville, TX 78028	830-460-6022
K'Star Counseling and Shelter Services	https://kstar.org/	830-896-5404
Raphael Community Free Clinic	https://www.raphaelclinic.org/	830-895-4201
Cardinal Counseling Services	https://cardinalcounselingservices.com/	956-367-5689
Creekview Counseling	https://www.creekviewcounseling.com/	210-280-0262

Living Wages and Cost of Living		
Organization/Service	Website	Phone
Texas Workforce Commission Program	https://bcfscsd.org/data_post/texas-workforce-commision-twc/	210-733-7932
TRWA Registered Apprenticeship Program	https://www.trwa.org/general/custom.asp?page=rap	512-472-8591
BCFS Health and Human Services	https://bcfscsd.org/location_regions/kerrville/	
Vocational Rehabilitation Adults Program	https://twcgov.service-now.com/com.glideapp.servicecatalog_cat_item_view.do?v=1&sysparm_id=e05bd29c1bf5e41016a1caab234bcb94&sysparm_preview=true&sysparm_domain_restore=false&sysparm_stack=no	512-936-6400
Vocational Rehabilitation Youth & Students Program	Email: vr.office.locator@twc.texas.gov	830-257-3171; 512-936-6400
Unemployment Benefits Services	https://apps.twc.texas.gov/UBS/security/logon.do	800-939-6631
Christian Men's Life Corps	www.cmlifeskills.com	830-257-3545; 830-377-1881
Christian Women's Job Corps	www.cwjckerrcounty.org	830-895-3660
Texas Dept. of Assistive & Rehabilitation Service	www.dars.state.tx.us	830-257-7556; 800-845-3916
Texas Alamo Workforce Development	https://www.wfsolutions.org/	888-261-3286

Attainable Housing		
Organization/Service	Website	Phone
Habitat for Humanity	https://habitatkerr.org/home-ownership/	
Alamo Area Council of Governments	https://www.aacog.com/weatherization-assistance	210-362-5229
Texas Department of Housing Homebuyer U Program	https://education.myfirsttexashome.com/	
Single Family HOME Program	504 Sidney Baker Street, Kerrville, TX 78028	830-257-4667
Home Sweet Texas Home Loan Program	https://www.tsahc.org/homebuyers-renters/home-sweet-texas-home-loan-program	877-508-4611
Texas Housing Assistance Line		855-802-0014
Affordable Housing - Volunteers of America (Texas)		817-529-7300
BCFS Health and Human Services	https://bcfscsd.org/location_regions/kerrville/	
Transitional Living Services (TLS)	https://www.dfps.state.tx.us/Child_Protection/Youth_and_Young_Adults/Transitional_Living/default.asp	800-252-5400
Mortgage Credit Certificate (MCC) Program	https://www.tsahc.org/homebuyers-renters/mortgage-credit-certificates	512-477-3555
Home and Rental Assistance	https://www.ccsct.org/rental-assistance/	

Substance Use Disorder		
Organization/Service	Website	Phone
Overdose Prevention and Harm Reduction	https://redcap.uthscsa.edu/REDCap/surveys/?s=YN4397TMW47HLLXJ	
Hill Country Council on Alcohol & Drug Abuse	https://hccada.org/	830-367-4667
Naloxone Services	Email: aaron@urbansurvivorsunion.org	
La Hacienda Treatment Center	https://www.lahacienda.com/outreach/kerrvilleoutreach	844-908-9767
The Fullbrook Center A&D Rehab	https://fullbrookcenter.com/	855-924-3579
MHDD Substance Use Disorder Outpatient Services	https://hillcountry.org/substance-use-disorder-outpatient-services/	830-258-5440 ext. 2065
Starlite Recovery Center	https://www.starliterecovery.com/about/location/kerrville-iop/	866-814-3495
North Star Sober Living	http://www.northstarsoberwomen.com/about.html	214-293-7353
Hill Country Rehab House		830-257-2737
New Traditions Sober Living	https://www.newtraditionssoberliving.com/	361-815-7611
Thompson House	https://www.facebook.com/thompsonsoberhouse?ref=hl#	830-955-6876
Women-only Outpatient Rehab	https://fullbrookcenter.com/treatment-centers/kerrville-tx/	855-924-3579
KerrKind.org	https://www.kerrkind.org/drug-prevention-and-treatment.html	

Access to Healthcare		
Organization/Service	Website	Phone
Peterson Regional Medical Center	https://www.petersonhealth.com/	830-896-4200
Texas Health Steps	https://www.txhealthsteps.com/	512-776-7745
Community Services Block Grant	504 Sidney Baker Street, Kerrville, TX 78028	830-767-2019
Adult Day Health Care - Veterans	3600 Memorial Boulevard, Kerrville, TX 78028	830-896-2020
Texas CHIP (Children's Health Insurance)	https://www.hhs.texas.gov/services/health/medicaid-chip	
Texas Health and Human Services	https://www.hhs.texas.gov/services/health	
Texas Drug Card - Prescription Assistance	https://texasdrugcard.com/create	
County Indigent Health Care Program (CIHCP)	https://www.hhs.texas.gov/services/health/county-indigent-health-care-program	Email:cihcp@hhs.texas.gov
Texas Mission of Mercy (Dental)	https://tdasf.org/tmom-inc/about/	
Planned Parenthood Texas		210-736-2262
Kerr County Health Department		830-896-5515
Kerrville City Health Department		830-792-8354
Peterson Community Care Clinic	https://www.petersonhealth.com/services/community-care/	830-258-7900
Raphael Community Free Clinic	https://www.raphaelclinic.org/	830-895-4201
Franklin Clinic and Urgent Care	https://franklinclinickerrville.com/	830-792-5800
Peterson Medical Associates	https://www.petersonhealth.com/providers/?_provider_type=peterson-medical-associates	830-258-7762
Peterson Specialty Care	https://www.petersonhealth.com/providers/?_provider_type=peterson-specialty-care	
Peterson Women's Associates	https://www.petersonhealth.com/providers/?_provider_type=peterson-womens-associates	830-258-6237
Peterson Urgent Care	https://www.petersonhealth.com/services/urgent-care/	830-258-7669
Hillside Primary Care	www.hillsideprimarycare.com	830-955-8241
830 Wellness	https://830wellness.com/	830-208-0588
OptumHealth	https://optimumhealthdoc.com/	830-895-5599
Family Practice Associates	https://www.myprivia.com/kerrvillefamilydoctor	830-896-4711
The Pregnancy Resource Center	https://tprck.org/	830-315-4541

Change Form

To update or add information, complete the form below

Name of Organization:

Contact Name:

Phone #: Fax #:

Email:

Web page:

Mailing Address:

List services:

Please describe your organization's purpose, services, etc.

Submit updated information to:
Peterson Regional Medical Center Marketing Department

Tim Rye, Chief Strategic Development Officer
Email: TRye@PetersonHealth.com
Phone: 830.258.7091
Address: 551 Hill Country Drive, Kerrville, TX 78028

Community Health Needs Assessment for Kerr County

Completed in partnership with: